
**COMMITTEE ON PUBLIC HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2012**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
83ND TEXAS LEGISLATURE**

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Committee On
Public Health

November 15, 2012

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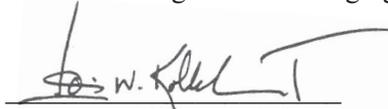
The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on Public Health of the Eighty-second Legislature hereby submits its interim report including the committee's findings and policy recommendations for consideration by the Eighty-third Legislature. The committee held six public hearings, logging in over 45 hours, on the interim charges and gathered a broad requisite of knowledge from the leading experts and leaders in all the policy areas outlined by the interim charges. We hope this report will be a useful guide and point of reference for the policies developed and considered by the Eighty-third Legislature.

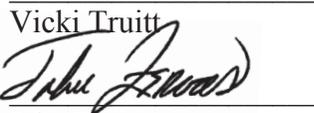
We thank you for providing this committee the opportunity to serve the people of Texas by studying these important issues of public health for all Texans during these challenging times.

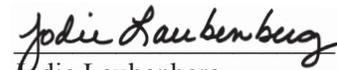
Respectfully submitted,


Lois Kolkhorst, Chair

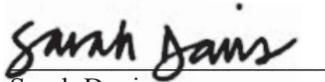

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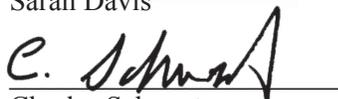
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The Committee also extends gratitude to all the expert witnesses, state agency representatives, organizations, and members of the public who provided invaluable testimony to the Committee that helped to shape the following recommendations and content of this report.

HOUSE COMMITTEE ON PUBLIC HEALTH INTERIM STUDY CHARGES

1. Examine the adequacy of the primary care workforce in Texas and assess the impact of an aging population, the passage of the Patient Protection and Affordable Care Act, and state and federal funding reductions to graduate medical education and physician loan repayment programs. Study the potential impact of medical school innovations, new practice models, alternative reimbursement strategies, expanded roles for physician extenders, and greater utilization of telemedicine. Make recommendations to increase patient access to primary care and address geographic disparities.
2. Study the various health registries maintained by the state, including the similarities and differences in reporting, consent, security, and portability of data. Assess registry compliance with standards for the protection and transmission of registry data and identify any additional steps necessary to ensure security, efficiency, and utilization.
3. Monitor implementation of the federal Patient Protection and Affordable Care Act, including any changes that may result from ongoing litigation or legislative modification or repeal. (*Joint with the House Committee on Insurance*)
4. Identify policies to alleviate food insecurity, increase access to healthy foods, and incent good nutrition within existing food assistance programs. Consider initiatives in Texas and other states to eliminate food deserts and grocery gaps, encourage urban agriculture and farmers' markets, and increase participation in the Summer Food Program. Evaluate the desirability and feasibility of incorporating nutritional standards in the Supplemental Nutrition Assistance Program (SNAP). Monitor congressional activity on the 2012 Farm Bill and consider its impact on Texas. (*Joint with the House Committee on Human Services*)
5. Monitor the agencies and programs under the Committee's jurisdiction and the implementation of relevant legislation passed by the 82nd Legislature.

CHARGE # 1

Examine the adequacy of the primary care workforce in Texas and assess the impact of an aging population, the passage of the Patient Protection and Affordable Care Act, and state and federal funding reductions to graduate medical education and physician loan repayment programs. Study the potential impact of medical school innovations, new practice models, alternative reimbursement strategies, expanded roles for physician extenders, and greater utilization of telemedicine. Make recommendations to increase patient access to primary care and address geographic disparities.

INTRODUCTION

The Committee met at The University of Texas School of Public Health on May 15, 2012, in order to receive invited and public testimony on interim charge #1. The Committee also received testimony on the Texas Healthcare Transformation and Quality Improvement Program.

The May 15 hearing included numerous witnesses representing a variety of organizations, state entities and the general public. The Committee received testimony in the following areas:

- State primary care workforce trends.
- Graduate medical education (GME) and potential funding reforms.
- Primary care delivery innovations and telemedicine utilization.
- Medical and nursing regulation reforms.
- Health economics and medical provider price transparency.

The Committee heard stunning testimony that Texas will not be able to produce enough doctors to meet the needs of a growing and aging population. Compounding the problem is a reduction in state funding for residency slots in Texas and a frozen Medicare GME funding program, occurring at a time when Texas is producing more medical graduates than previous years.

Other factors contributing to the problem include: medical price inflation, overhead and administrative costs of the third party system, a patchwork of delegation and supervision rules for nurse practitioners, and a lack of price transparency with non-traditional market forces that would help consumers navigate both the quality and costs of healthcare. Texas is a rapidly growing state whose immense geographical size and diverse population demand dynamic, flexible and regional approaches to address the unique healthcare needs of each region of the state.

Therefore, the recommendations set forth in this section seek to address the problems through regulatory reform and adjustment of business practices to better allow for price transparency and consumer directed healthcare.

RECOMMENDATIONS

1. The Legislature should consider replacing and/or revising the current opaque regulatory scheme of physician delegation and supervision with a simpler regulatory framework based upon physician led collaboration with advanced nurse practitioners and physician assistants to allow more flexibility and increase patient access to primary care and address geographic disparities.
2. The Legislature should consider restoring funding for the Medicaid match for GME and also seek a waiver for the GME match to be used in clinical and community settings.
3. The Legislature should consider restoring physician loan repayment funding for medical undergraduates who agree to become primary care physicians that serve in rural and underserved areas in Texas for five years after graduation.
4. The Legislature should consider adjustments in formula funding that reward institutions that produce additional primary care physicians through accelerated programs.
5. The Legislature should pass a resolution encouraging Congress to replace the current funding of GME through Medicare and instead develop a new residency funding program.
6. The Higher Education Coordinating Board should develop in collaboration with medical schools an alternative medical degree track for APRNs and PAs who wish to become primary care physicians.
7. HHSC should work with Regional Health Partnerships (RHPs) and the Centers for Medicare and Medicaid (CMS) to develop residency program slots funded by intergovernmental transfers and matched by the federal government through the Transformation Waiver.
8. The Legislature should place a cap on the number of medical schools to be established or built until the residency slots in Texas represent 110 percent of medical undergraduates produced.
9. The Legislature should pass legislation that allows consumers to more easily obtain healthcare pricing information.
10. The Texas Medical Board and the Board of Nursing should be allowed to keep a higher percentage of fees collected in order to operate more effectively and efficiently if the above recommendations are adopted. Performance measures should be required with these additional funds.

DISCUSSION

The Legislature should consider replacing and/or revising the current opaque regulatory scheme of physician delegation and supervision with a simpler regulatory framework based upon physician led collaboration with advanced nurse practitioners and physician assistants to allow more flexibility and increase patient access to primary care and address geographic disparities.

According to Section 157.001 of the Texas Occupations Code, physicians have the general authority to delegate reasonably sound medical acts to a qualified and properly trained nurse practitioner (NP) or physician assistant (PA). However, the NPs and PAs must be under the physician's supervision. Unlike Section 157.001, prescriptive delegation is more specific and complicated. It allows NPs and PAs to prescribe certain prescriptions under supervision of a physician in the following areas: sites serving certain medically underserved populations, physician primary practice sites, alternate sites, and facility-based practice sites.¹ The complication arises from the differences in requirements for NPs and PAs between each site. Examples of these differences include:

- The distance limits. There are limits for alternate sites, but not for the other sites.
- NP and PA full-time equivalents (FTE) limits. Physicians may supervise up to 4 FTE in all sites, except in certain medically under-served population sites (allowed 5 FTEs).
- Chart review requirements. Physicians must review at least 10 percent of the patients' charts in the medically under-served population and alternative sites. However, this is not addressed in the other two sites.

Ms. Mari Robinson, Executive Director of the Texas Medical Board, agreed in her testimony before the Committee on May 15, 2012, that the inconsistencies within the different site-specific prescriptive delegation statutes and rules create a struggle for physicians to comply. While outreach programs have been put in place to promote awareness, much confusion remains.

Considering this, the Legislature should work with physicians and physician extenders to replace and revise the current scheme with a new model that provides clarity and consistency for physicians, NPs, and PAs to follow. This will better allow NPs and PAs to practice to the full extent of their scope of practice and increase patient access to primary care and address geographic disparities, while the physician reasonably delegates and supervises the NPs and/or PAs.

The Legislature should consider restoring funding for the Medicaid match for GME and also seek a waiver for the GME match to be used in clinical and

¹ Texas Medical Board. (2012). Texas medical board, quick reference - site specific prescriptive delegation statute and rule chart. Retrieved from <http://www.tmb.state.tx.us/professionals/np/Site-SpecificPrescriptiveDelegationStatueAndRule-2010-08-25.pdf>

community settings.

Historically, graduate medical education (GME) in Texas was largely funded through Medicare, Medicaid, hospital operations, and the Department of Veteran Affairs. Medicaid was the second largest contributor to state GME behind Medicare.² If restored, Medicaid GME funds may provide stipends for medical residents, salaries and fringe benefits for hospital faculty and administrative staff, and facility overhead.

The Health and Human Services Commission (HHSC) contributed \$51 million in its last payments to Medicaid GME in 2005, and the Legislature has since discontinued funding the program due to budget constraints. Budgeted traditional Medicaid match for GME is the standard state Federal Medical Assistance Percentages (FMAP) rate.

The Legislature is losing appropriated funds and taxpayer investments when medical students pursue residencies in other states; we are essentially subsidizing physicians for other states. However, Medicaid funds could provide an opportunity for federal match for the State to preserve and ensure that investment. Further, restoring Medicaid funds could beneficially serve needy populations and medical graduates looking for residencies here in Texas.

The Legislature should consider restoring physician loan repayment funding for medical undergraduates who agree to become primary care physicians that serve in rural and underserved areas in Texas for five years after graduation.

The Committee heard compelling testimony predicting the upcoming shortage of primary care physicians for the general population. According to the Graduate Medical Education Report prepared by the Texas Higher Education Coordinating Board, more than 180 medical graduates are estimated to leave the state for their first-year residency training due to the lack of residency slots by 2016. Texas is essentially paying to provide doctors for other states.

Dr. Fiesinger from the Texas Academy of Family Physicians testified that the 82nd Legislature cut programs intended to increase primary care physicians by almost 80 percent. Budget constraints cut funding to the Physicians Education Loan Repayment Program (PELRP), the Texas Statewide Primary Care Preceptorship Program, and THECB GME funds for primary care residency training in fiscal years 2012-2013. In some well-conducted programs, effective use of primary care has been proven to increase patient health and reduce hospital emergency use, thus lowering costs.

In addition to a shortage of primary care physicians, Dr. Patrick Carter of the Texas Medical Association confirmed Texas faces a shortage in many other specialties. Of the 40 medical

² Henderson, T. M. (2010). *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey*. Association of American Medical Colleges.

specialty groups, 36 are below the national average for physicians per capita. Texas ranks 42nd in physicians per 100,000 population and the deficiency will only be exacerbated with the confirmed rapid growth in the state's population from high birth rates, migration and immigration to the state.³

Dr. Carter also testified that the PELRP was the single most effective incentive program at encouraging physicians to practice in underserved areas in return for financial assistance towards their education-related loans. The PELRP required each physician to work in a federally designated Health Professional Shortage Area (HPSA) where access to health care services is limited. In 2011, Texas lawmakers reduced funding in the program and eliminated the primary care residency and primary care preceptorship programs in response to budget cuts. Dr. Carter illustrated that in 2010, the PELRP program was provided with \$22.2 million in funding. However, the amount was significantly reduced to \$5.6 million in 2012. The Legislature should consider reinvesting in programs that provide incentives to join the primary care physician workforce, especially in rural or underserved areas, with a commitment of five years. This could be done by using the existing funds to create a new and innovative program that incentivizes students to choose primary care through the reduction of their costs on the front end.

The Legislature should consider adjustments in formula funding that reward institutions that produce additional primary care physicians through accelerated programs.

Dr. Ronald Cook from the Texas Tech University provided testimony regarding its accelerated program called Family Medicine Accelerated Track (FMAT), which accelerates primary care physicians into practice. The program adjusts the traditional four-year curriculum to a three-year program for qualified individuals and saves students 25 percent on overall school debt. Additionally, scholarships and stipends provided by the school contribute an additional 25 percent financial incentive. Students enrolled in the accelerated program may receive up to a 50 percent reduction in educational costs. Thus, medical school debt can range from \$140,000 - \$160,000 depending on the institution, making the accelerated track an appealing option for prospective students to enter primary care.

A common misconception addressed by Dr. Ronald Cook was the effectiveness of an accelerated three-year program. The program does not reduce the years of study; in fact, it takes advantage of the summer months that are traditionally a break from study and introduces students to clinical medicine. The formal family medicine rotation is made into a longitudinal internship in the second year of medical school and rotations in areas like dermatology and orthopedics are removed. The traditional four-year curriculum at Texas Tech University is 160 weeks, while the FMAT curriculum is 149 weeks leaving the student with half the debt of the full curriculum. Further, when compared with traditional medical students' board scores, these students' scores have been reported to be equal to their peers if not better in some cases.

³ Carter, P. (May 15, 2012). Public testimony to the house committee on public health.

The Legislature should pass a resolution encouraging Congress to replace the current funding of GME through Medicare and instead develop a new residency funding program.

The Committee received testimony on the inadequacy of graduate medical education (GME) funding in the state. Texas is quickly approaching a statewide crisis if we continue with the current Medicare GME funding. Medicare is the largest contributor to GME in Texas. The current formula funding of GME through Medicare is antiquated and needs to be updated to represent the rapid population growth in Texas and to incorporate training in clinical settings. In 2002, Texas increased medical school enrollment by 31 percent to address the shortage in the health care workforce, as recommended by the Association of American Medical Colleges, to keep up with the national standards. However, if the state does not address the shortage of residency programs, more medical students will be forced to leave the state in search of a residency program elsewhere.

In 2011, the 82nd Legislature passed House Bill 2908 to assess the adequacy of GME relative to the number of graduating medical students in the state. The Texas Higher Education Coordinating Board reported that Texas currently pays \$42,000 annually per student; an average of \$168,000 per undergraduate medical student. In 2011, Texas was able to achieve a 1:1 ratio with 1,458 medical school graduates and 1,494 first year residency positions. However, based on the 2011 first-year undergraduate medical education enrollment, the Texas Higher Education Coordinating Board estimates that at least 180 medical student graduates will be forced to leave the state in 2016 due to the lack of first-year residency slots. If 180 medical students leave Texas, \$30.2 million of the annual undergraduate medical student education dollars Texas has invested in the students will not benefit the state.

Testimony by Dr. Ben Ramier from The University of Texas Medical Branch revealed that half of the medical graduates that leave Texas never return to Texas, additionally 80 percent of those that complete their residencies end up staying in that same state. Medical graduates tend to stay where they complete their residencies. It is imperative the state receive its fair share of funding for GME through Medicare with a new and sustainable national residency program to prevent losing medical graduates to other states that are not experiencing tremendous growth while we invest in their education and in the best interest of Texans. Additionally, Medicare payment models pay for time spent in hospitals and not in clinical settings. A new national residency program should include all types of residency settings, not just hospital slots.

The Balanced Budget Act of 1997 imposed a freeze on the number of residents to address the rapid growth of residents. This freeze was based on the number of residents reported by hospitals and cost report given to Medicare in 1996. As a result, teaching hospitals do not receive additional Indirect Medical Education (IME) or Direct Graduate Medical Education (DGME) payments for each trained resident above this cap. The Texas Higher Education Coordinating Board reports the cap only supports a third of the cost of the 4,598 positions in Texas; leaving Texas with the full costs of the remaining 543 positions.⁴ Texas is currently 13

⁴ Texas Higher Education. (2012). Coordinating board, graduate medical education report. Retrieved from

percent over its Medicare cap and the state incurs all additional costs. Medical residencies may range from three to eight years and are very expensive to the state and hospitals. The state invests \$4,400 for graduate medical education per resident; therefore, it is important the state's congressional delegation secure Texas' fair share of funding in order to retain its medical graduates to address the rapid growth in the population.

The Higher Education Coordinating Board should develop in collaboration with medical schools an alternative medical degree track for APRNs and PAs who wish to become primary care physicians.

The course of study for advanced practitioner registered nurses (APRNs) and physician assistants (PAs) often times intersect with physician courses of study and training. These overlapping experiences and courses should be transferable and deemed relevant in an accelerated program for APRNs and PAs that wish to continue their study to become primary care physicians. The cost of tuition for medical students varies by state and school. The costs of medical education in Texas are relatively low for in-state students compared to other states. Medical school education is expensive and post-graduate training is long and arduous. According to the Texas Higher Education Coordinating Board, the national average debt for a medical graduate is \$200,000. While the amount is less for Texas medical graduates, it still exceeds \$100,000. Efforts to prevent duplication of study and training will ease the shift from APRNs and PAs to primary care physicians, while accelerating the timeline for producing primary care physicians at lower costs.

HHSC should work with Regional Health Partnerships (RHPs) and the Centers for Medicare and Medicaid (CMS) to develop residency program slots funded by intergovernmental transfers and matched by the federal government through the Transformation Waiver.

The Committee heard overwhelming testimony from numerous invited guests who shared their enthusiasm for the Transformation Waiver and its opportunities to provide residency slots. The Texas Medical Association believes the state's new Transformation Waiver's Delivery System Reform Incentive Payment Pool (DSRIP) presents an opportunity to provide financial support for GME, the State Physician Education Loan Repayment Program, and the Statewide Primary Care Preceptorship Program. The Transformation waiver will effectively move away from traditional fee-for-service payments, forcing physicians and providers to change their delivery systems with an incentive to provide high quality care. The Transformation Waiver also offers opportunities for RHPs to develop residency slots in various clinical settings outside of the hospital.

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HHSC reported that within the Transformation Waiver, Category 1 will work to develop infrastructure. Two of the 14 project areas in this category may allow for the development of residency slots. This may be done under project areas 1.2 and 1.9, which will increase the training of primary care workforce and expand specialty care capacity, respectively.⁵

Unlike Medicare's strict DGME and IME payment models to hospitals, Medicaid is more versatile in their system to deliver health care in various other settings. The Transformation Waiver's regional health plan structure represents a strong state and local solution and should be aggressively pursued to solve long-standing regional needs throughout the state.

The Legislature should place a cap on the number of medical schools to be established or built until the residency slots in Texas represent 110 percent of medical undergraduates produced.

As mentioned earlier in this report, Texas is facing a crisis in which medical graduates are quickly out-pacing the number of available residency slots. In 2002, the state increased medical school enrollments by 31 percent in response to national recommendations to address population growth. However, the 1996 Medicare GME freeze has placed a debilitating effect on the state's ability to deliver adequate health care. The freeze has made it difficult to expand current slots and start new residency programs.

Compounding this problem, there were 554 Texas residency programs in 2011, but only 165 were available for first-year residents. That same year, the ratio of medical students graduating and the number of first-year residencies was 1:1. However, as stated in recommendation number 6, at least 180 students will not be able to obtain a first-year residency slot in Texas in 2016. If 180 medical students leave Texas, \$30.2 million of the annual undergraduate medical student education dollars Texas has invested in the students will not benefit the state.⁶

Due to the issues stated above, building new medical schools will not remedy the shortage of first year medical residencies and, simply stated, it is putting the cart before the horse. Until additional residency slots are created, enrolling more medical students will eventually force more medical graduates to leave the state for residency training, thus resulting in the subsidizing of medical education for other states. To prevent the students from leaving Texas, it is crucial the state and stakeholders work together to increase the number of residency programs for first-year residents. The Texas Higher Education Coordinating Board recommends that the state do so by

⁵ HHSC. (2012). Category 1: infrastructure development. Retrieved from <http://www.hhsc.state.tx.us/1115-docs/RHP/Category-1-RHP.pdf>

⁶ Texas Higher Education. (2012). Coordinating Board, Graduate Medical Education Report. Retrieved from https://docs.google.com/viewer?a=v&q=cache:JBABeBcqAVEJ:www.thecb.state.tx.us/download.cfm%3Fdownloadfile%3DE5379727-A0CD-8D96-011F9F3C60AF8F57%26typename%3DdmFile%26fieldname%3Dfilename+&hl=en&gl=us&pid=bl&srcid=ADGEEShm0toDZznsuTQ64_-9roi-14-r4RPooZHyZj2vOclQv3t71YeRlqM9Jc8VgC2KAL01uPBWc3XYCtqorFUvYU9i40cB7XCEXNfx6f0zFvbU-gaYQCm4IEWYUewPrJXLIgaIewqP&sig=AHIEtbSMwszfE7sQ1187vzEzWVkf5nGFxQ

developing methods and strategies that ensure that the number of residency slots represents at least 110 percent of the number of first-year medical graduates. Alternative, non-traditional sources of funding these slots are imperative.

The Legislature should encourage a market where consumers can more easily obtain healthcare pricing information.

To illustrate the benefits of more consumer information, Mr. Michael Cohen of White Glove Health presented to the Committee a new service delivery model that has gained national attention and business participation due to the model's price certainty and transparency. To participate, each employee and his/her dependent(s) must pay an annual \$300 membership fee. In addition, a fixed fee of \$35 is charged per visit. This fee covers the medical visit and prescribed medications. This also caps the cost for routine medical care for the employer and employee. The White Glove Model effectively utilizes nurse practitioners to the fullest of their scope of practice to deliver medical care to its members at home, in the office, or anywhere within their service area 365 days a year from 8 a.m. to 8 p.m. This unique delivery model allows employees to remain productive while receiving quality care under their own discretion, employers to take control of their health care costs, and lower high health insurance premiums that have increased business costs.

Ms. Robyn Jacobson, Co-Chair of the Legislative Affairs Committee with the Texas Association of Benefit Administrators, also testified on price transparency. Ms. Jacobson stated that price transparency is the key to bending the cost curve of health care downward. The current third party payer system and managed care models have removed the patient from financial accountability. Additionally, high medical costs have forced many individuals to file for bankruptcies and caused damages to credit reports have increased at an alarming rate.

In addition, health care expenditures increased to 17.9 percent of the national gross domestic product (GDP) in 2010.⁷ The rise in medical costs are reaching dangerous limits for many Texans and price transparency may be an avenue to lower healthcare costs while improving quality as it shifts the control and individual responsibility back to consumers. Price transparency will allow consumers to make decisions on services and options they value. Such a market force may be a solution for lowering both health care costs and insurance premiums.

The Texas Medical Board and the Board of Nursing should be allowed to keep a higher percentage of fees collected in order to operate more effectively and efficiently if the above recommendations are adopted. Performance measures should be required with these additional funds.

If the above recommendations are adopted, the Texas Medical Board and the Board of Nursing

⁷ The World Bank. (2012). Retrieved from Health expenditure, total (% of GDP). Retrieved from <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

will need more funding to monitor and regulate the increase in physicians and nurse's workforce.

CHARGE #2

Study the various health registries maintained by the state, including the similarities and differences in reporting, consent, security, and portability of data. Assess registry compliance with standards for the protection and transmission of registry data and identify any additional steps necessary to ensure security, efficiency, and utilization.

INTRODUCTION

The House Committee on Public Health met on April 11, 2012, to receive testimony on health registries provided by both state agencies and professional organizations. The Committee heard testimony on the following issues:

- Usages of different health registries.
- Different reporting methods.
- Security measures, system efficiencies, and future improvements.
- Relevance of accurate reporting and disseminating information for prevention initiatives and cost effective delivery of health care services.

The Texas Department of State Health Services (DSHS) captures disease-specific information reported by health providers. The main registries include the Birth Defects Registry, Cancer Registries, Trauma Registries, and ImmTrac. The data from state health registries is used to evaluate and study the disease burden on the state, monitor trends to facilitate health care resource planning, and conduct research on the causes of disease. All data collected is secure, confidential, and only entities authorized by statute have access to the data. However, the state may sell de-identified data to entities authorized to receive such information.

The success of an effective and fully integrated health registry relies heavily on the cooperation and partnership of physicians, their patients, and the state. A major challenge to participation and data sharing is the fragmented procedures and system interfaces between different registries. The different registries are not inter-operable, create a burden on users, and prevent timely provider reporting. Another challenge is the submission of inaccurate or incomplete data. Currently, there is not an effective validation system in place to report user inaccuracies and inconsistencies to correct such errors.

RECOMMENDATIONS

1. The Texas Department of Health and Human Services (DSHS) should develop a long-term plan for the inter-operability of the health and disease registries.
2. The Texas Department of Health and Human Services should implement a data quality validation system at the hospital and state level to ensure data integrity.
3. The Texas Department of Health and Human Services should evaluate the numbers of trauma registry staff at the state level to increase health research and public reporting of data through collaboration with academic institutions.

DISCUSSION

The Texas Department of State Health Services (DSHS) should develop a long-term plan for the inter-operability of the health and disease registries.

Texas has many health and disease registries that provide important health information. However, many of them do not communicate with one another. This creates unnecessary barriers for user and system inefficiencies. The lack of communication between the registries inadvertently creates burdens for providers and regulatory agents. Testimony by Dr. Gary Floyd from the Texas Medical Association shed some light on barriers that exist on the provider side of reporting to registries. With the range of different registries not integrated, providers are required to have different log-ins and passwords for each system. The inconvenience of registries not communicating with one another creates a burden for providers and their staff to report data when they are required to duplicate data entry for different registries. DSHS should develop inter-operable registries for current and future registries. This effort will further improve efficiency for providers, reduce paper reporting and encourage timeliness of reporting.

The Texas Department of State Health Services should implement a data quality validation system at the hospital and state level to ensure data integrity.

Ms. Jorie Klein, Chair of the GETAC Trauma System Committee and Trauma Registry Manager at Parkland Memorial Hospital, provided testimony on the current method hospitals use to report data to the trauma system. The trauma data is invaluable to the hospital and the state. Hospitals use the data to evaluate the performance of their trauma centers, and the State uses the data to monitor trends and prevent injury. In 2010, the most common reasons reported for injury and death in Texas were due to falls and motor vehicle crashes. The trauma data collected is used to develop injury prevention programs and outreach initiatives for the state.

Presently, hospitals' submissions of incomplete data to the trauma registry go undetected by the DSHS due to the trauma registry's inefficient screening processes. The DSHS response to the submission of incomplete data is inadequate and does not require the hospital to be accountable for follow-up corrections in a timely manner. The inaccuracies of data submission create data inconsistencies within the trauma registries at the state level. Therefore, the data in the registry is unrepresentative of the actual population. It is critical to collect accurate quality data for public health monitoring, hospital performance evaluations, access to uncompensated care grants and research purposes.

The Texas Department of State Health Services should evaluate the numbers of trauma registry staff at the state level to increase health research and public reporting of data through collaborations with academic institutions.

The Committee heard candid testimony by both Dr. Adolfo Valadez, the then Assistant

Commissioner for Prevention and Preparedness Services Division from the Texas Department of State Health Services and Ms. Jorie Klein, Trauma Registry Manager at Parkland Memorial Hospital. Under the supervision of Dr. Valadez, the state's Birth Defects Registry operates with 50 staff members, the Cancer Registry has 52 staff members to check and validate 200,000 reports a year, and the Trauma Registry has six staff members to check and validate 2,000,000 reports a year or approximately 167,000 reports a month with 636 facilities reporting. Ms. Klein testified that her hospital has six certified registrars to manage the trauma center with 3,200 patient reports a month and that the national average to process good quality data is one full-time equivalent (FTE) for every 500 reports. The American College of Surgeons, Committee on Trauma recommends one FTE to every 750-1000 patients. The number of FTEs responsible for the Texas Trauma Registry undermines the integrity and quality of the data. The Texas Trauma Registry should strive to increase their staff members to at least one FTE for every 750 reports in order to adequately monitor the large number of monthly reports and ensure the integrity of data.⁸

According to the 2009 Trauma Report, there were reported individuals over the age of 126 years old. This error clearly misrepresents the actual statistics and may misguide downstream research and injury prevention initiatives. DSHS should consider collaborating with academic institutions that have special interests in the data, especially accurate quality data for health research. So long as strict privacy protections are in place, collaboration between DSHS and academic institutions to eliminate duplicative workforces may reduce costs for both entities while providing valuable shared data for research. DSHS should consider a shift in personnel to appropriately staff the Trauma Registry.

⁸ American College of Surgeons, Committee on Trauma. (2006). Resources for optimal care of the injured patient. Chicago, IL: American College of Surgeons.

CHARGE #3

Monitor implementation of the federal Patient Protection and Affordable Care Act, including any changes that may result from ongoing litigation or legislative modification or repeal. (*Joint with the House Committee on Insurance*)

INTRODUCTION

The Patient Protection and Affordable Care Act also known as the Affordable Care Act (ACA) was signed into law on March 23, 2010. While the main provisions of the law do not take effect until January 1, 2014, numerous insurance reforms, mandates and federal grant programs have been implemented by the states. The State of Texas has reviewed, planned for and implemented several of these reforms, mandates, and grant-funded programs since the passage of the law.

The House Committee on Public Health held a joint public hearing with the House Committee on Insurance on February 27, 2012 in Austin, Texas. The main focus of the hearing was to provide both Committees information on the status of the implementation of the ACA in Texas.

The Committee heard testimony from Dr. Thomas Savings, Ph.D. on the long-term economic and national budgetary implications of the ACA. The Committee also heard testimony from the Health and Human Services Commission and the Texas Department of Insurance on how their respective agencies have planned for and implemented provisions of the ACA. The Committee also registered the public's testimony on the ACA.

On June 28, 2012, the United States Supreme Court in *National Federation of Independent Business v. Sebelius* (2012) upheld the constitutionality of the law requiring individuals to obtain health insurance. Under the ACA, individuals who do not obtain health insurance must pay a "penalty" each year he/she is without insurance. During the court proceedings, the Federal Government argued that Congress had the authority to enforce the individual mandate based on the Commerce Clause, Necessary and Proper Clause, and the Taxing Clause (Article 1, §8, clause 1). The Court ruled that the Commerce Clause and Necessary and Proper Clause did not grant Congress the authority to enforce the individual mandate. However, through Congress' power to "lay and collect Taxes" under the Taxing Clause, Congress has the authority to tax individuals who do not obtain health insurance.⁹

Additionally, the provision for states to expand Medicaid was left ruled to be optional. On July 9, 2012, Governor Rick Perry announced Texas would not expand Medicaid or implement a state insurance exchange in a letter to the U.S. Health and Human Services Secretary Kathleen Sebelius stating that he would "not be party to socializing healthcare and bankrupting my state in direct contradiction to our Constitution and our founding principles of limited government".¹⁰ If Medicaid Expansion is implemented with the ACA, 91 percent of the Texas population (23,024,861 individuals) will be expected to become insured either through Medicaid or insurance. However, 9 percent (2,349,139 individuals) will remain uninsured. The uninsured population includes individuals that do not qualify for subsidies, are eligible for subsidies but chose not to participate, are eligible for Medicaid but not enrolled, and undocumented individuals.¹¹

⁹ *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* 567 U.S. _ (2012)

¹⁰ Office of Governor Rick Perry. (2012) Gov. perry: texas will not expand Medicaid or implement health benefit exchange. Retrieved from <http://governor.state.tx.us/news/press-release/17408/>

¹¹ Millwee, B. (2012). Presentation to house committee on public health on implementation of the federal pateitn protection and affordable care act (ACA). Retrieved from

Overall, the Committee found that both the Texas Health and Human Services Commission and the Texas Department of Insurance are preparing properly to implement the ACA, pending guidance and statutory authority from both the Legislature and the Governor's office.

RECOMMENDATIONS

1. The Legislative Budget Board and the Texas Health and Human Services Commission should monitor the potential additional costs to the state's Medicaid program from the premium tax levied on managed care organizations in the baseline budget.
2. The Legislature should pass a joint resolution to Congress requesting a comprehensive reform of both the Medicaid and Medicare programs to ensure the future solvency of both programs.
3. The Legislature should extensively study the impact of expanding or not expanding Medicaid. The study should include impact to individuals, medical providers, local governments, and the state budget.
4. The Legislature should study the impact of the Transformation Waiver and its role within and without the Medicaid expansion.
5. The Legislature should study the role of a State Health Insurance Exchange versus a federally mandated exchange. The study should include cost advantages, competition, and ease of use. The study should also include a view of the enforceability of the Federal Health Insurance Exchange.
6. The Legislature should study the impact of the Affordable Care Act to businesses who employ over 50 employees.

DISCUSSION

The Legislative Budget Board and the Texas Health and Human Services Commission should monitor the potential additional costs to the state's Medicaid program from the premium tax levied on managed care organizations in the baseline budget.

Starting January 1, 2014, the Affordable Care Act (ACA) will place a fee (also considered as a non-deductible, excise tax) on the health insurance industry. Health insurers will be allocated a portion of the fee based on their market share of the premium revenue. Market share will include the commercial, Medicare, Medicaid, and State Children's Health Insurance Plan (SCHIP) premium revenues. During the first year, the health insurance industry will pay an annual fee of \$8 billion, which will increase to \$14.3 billion in 2018. After 2018, the fee will be indexed according to the rate of premium growth. Some non-profit insurers will be exempt from the fee or may exclude 50 percent of their premium revenue from the fee calculation. Exemptions will be provided to non-profit insurers that receive over 80 percent of their premium revenue from Medicare, Medicaid, SCHIP, and dual eligible plans.¹²

The federal premium tax is expected to be applied to most Health Maintenance Organizations (HMOs) with some not-for-profits being exempt. The 2 percent federal tax is expected to be applied to HMOs. However, according to Former Deputy Executive Commissioner of Health and Human Services Commission (HHSC), Billy Millwee, there is an outstanding question as to whether it applies to Medicaid HMOs. In 2010, when the HHSC set the rates in Texas, the federal tax was not incorporated in the process. HHSC recognizes the implications of the excise tax and is assessing the tax in the rate setting process and how much it is expected to cost Texas.

The Legislature should pass a joint resolution to Congress requesting a comprehensive reform of both the Medicaid and Medicare programs to ensure the future solvency of both programs.

Professor of Economics from Texas A&M University, Dr. Tom Savings, testified before the Committees that 10,000 individuals reach Medicare eligibility every day and will continue to do so for the next 20 years. The growth of Medicare recipients is rising quickly. In 2010, Medicare had 47 million recipients and is expected to grow to 63.2 million by 2020. This rapid rate of increase poses a great concern for taxpayers and the country as a whole as health care costs quickly consumes the gross domestic product. In addition, the US spent \$2.6 trillion on healthcare in 2010. That year, healthcare expenditures increased to 17.9 percent of the national gross domestic product (GDP),¹³ compared to 7.2 percent in 1970. Since 1970, the healthcare

¹² Meerschaert, J. D. & Doucet, M. (2012). PPACA health insurer fee estimated impact on state medicaid programs and Medicaid health plans. Retrieved from <http://insight.milliman.com/article.php?cntid=8018>

¹³ The World Bank. (2012). Health expenditure, total (% GDP). Retrieved from <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

costs per capita have grown an average of 2.4 percentage points faster than the GDP.¹⁴

Currently, Medicare only pays a percentage of what private payers are paying providers. In 2010, Medicare reimbursed 80 percent of what private payers pay for health care, and in 2019 the reimbursements are expected to decrease to 68 percent. Reduced rates could make it difficult for providers to remain profitable. As a result, Richard Foster, Chief Actuary for CMS predicts providers will be less inclined to provide Medicare services making Medicare services less accessible for beneficiaries.¹⁵

Additionally, without reform to the Medicaid and Medicare Entitlement programs, taxes will potentially increase for taxpayers and premiums will increase for the elderly. Therefore the Legislature should continue to carefully monitor the provisions of the Entitlement programs in accordance with the Affordable Care Act to prevent future non-sustainable outcomes.

The Legislature should extensively study the impact of expanding or not expanding Medicaid. The study should include impact to individuals, medical providers, local governments, and the state budget.

The Supreme Court ruled in *National Federation of Independent Business v. Sebelius* (2012) that the expansion of Medicaid coverage is optional for states.¹⁶ Current federal Medicaid law requires states to cover at minimum, the following:

- Pregnant women and children less than 6 years of age with a family income at or below 133 percent of the federal poverty level (FPL). For a family of four, the FPL is \$30,657 in 2012.
- Children ages 6-18 with a family income at or below 100 percent of the FPL. The 2012 FPL is \$23,050 for a family of four.
- Parents and caretaker relatives who meet the requirements for the former Aid to Families with Dependent Children cash assistance program.
- Elderly or disabled individuals who qualify for the Supplemental Security Income (SSI) benefits.¹⁷

Before the Court ruled the Medicaid Expansion as optional, the Affordable Care Act (ACA) required that all states expand Medicaid eligibility by 2014. Medicaid eligibility would have expanded to cover nearly all people under the age of 65, including childless adults, with an income at or below 138 percent of the FPL (\$15,415 per year for an individual in 2012). The

¹⁴ The Henry J. Kaiser Family Foundation. (2012). Health care costs, a primer, key information on health care costs and their impact. Retrieved from <http://www.kff.org/insurance/upload/7670-03.pdf>

¹⁵ Foster, R. (2011). The estimated effect of the affordable care act on medicare and medicaid outlays and total national health care expenditures. Retrieved from <http://www.hhs.gov/asl/testify/2011/03/t20110330e.html>

¹⁶ *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* 567 U.S. _ (2012)

¹⁷ The Henry J. Kaiser Family Foundation. (2012). A guide to the supreme court's decision on the aca's medicaid expansion. Retrieved from <http://www.kff.org/healthreform/upload/8347.pdf>

Federal Government would provide 100 percent of the funding from 2014 to 2016; however, the percentage would incrementally decrease to 90 percent in 2020. The most contentious part of the law penalized states that refuse to expand Medicaid. The Secretary of Health and Human Services had the authority to withhold Medicaid dollars to these states. The Congressional Budget Office first estimated that the planned expansion would cover 17 million uninsured Americans by 2020, but revised the number of eleven million after the Court's ruling.¹⁸

In its final decision, the Court ruled the Medicaid Expansion as optional to states. The Court stated that, while there have been previous amendments to the Medicaid eligibility, these amendments were merely alterations and expansions of the boundaries of the mandated groups for coverage. The Court further explained that the ACA mandate to expand Medicaid would transform Medicaid "into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level. It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage."¹⁹ Therefore, the Medicaid Expansion was ruled to be unconstitutionally coercive because states were not given adequate notice to voluntarily consent and all existing Medicaid funds could be held by the Secretary of Health and Human Services if a state did not expand.²⁰ Instead of being penalized for non-compliance, states now have the ability to decide whether expanding Medicaid is in their best interest.

In deciding what is best for the state of Texas, the Legislature should extensively study the impact of the Medicaid Expansion by researching, monitoring, and evaluating the healthcare environment in the state. Former HHSC Executive Commissioner, Tom Suehs, shared his concern over expanding Medicaid. Former Commissioner Suehs stated that without reform, the Medicaid Expansion "only multiplies the tremendous budget pressure the program puts on states. Medicaid already consumes a quarter of the state budget in Texas, and enrollment and costs would mushroom under the Affordable Care Act."²¹ While Texas is expected to add 1.8 million residents to the Medicaid Program,²² HHSC estimates 2.9 million residents will still remain uninsured.²³ As some states have decided to expand Medicaid, many have not. This provides an opportunity for Texas to study and compare the impact states will face by expanding Medicaid. The Legislature should also consider the impact on the state if Medicaid is not expanded. This comprehensive study should include findings on how the Medicaid Expansion affects Texas residents, medical providers, and the state budget.

¹⁸ Ibid.

¹⁹ *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* 567 U.S. _ (2012)

²⁰ The Henry J. Kaiser Family Foundation. (2012). A guide to the supreme court's decision on the aca's medicaid expansion. Retrieved from <http://www.kff.org/healthreform/upload/8347.pdf>

²¹ Suehs, T. M. (June 28, 2012). HHSC statement on affordable care act ruling. Retrieved from <http://www.hhs.state.tx.us/news/release/062812-Affordable-Care.shtml>

²² Galewitz, P. & Serafini, M. W. (June 28, 2012). Ruling puts pressure on states to act. *Kaiser Health News*. Retrieved from <http://www.kaiserhealthnews.org/stories/2012/june/28/pressure-on-states-to-act-after-supreme-court-ruling.aspx>

²³ HHSC. (September 20, 2012). Email correspondence with the house committee on public health.

The Legislature should study the impact of the Transformation Waiver and its role within and without the Medicaid expansion.

In December 2011, the Texas Health Care Transformation and Quality Improvement Program (Transformation Waiver) was approved by the Center for Medicare and Medicaid Services (CMS). The Transformation Waiver, developed under Section 1115 of the Social Security Act, provides up to \$29 billion over 5-years to Texas and expires on September 30th, 2016. The Transformation Waiver is expected to reduce state healthcare costs by expanding Medicaid managed care while preserving hospital funding, providing incentive payments for health care improvements, and directing more funding to hospitals that serve large numbers of uninsured patients.²⁴

Beyond these new dollars from the Transformation Waiver, the optional Medicaid Expansion provides states with federal funding to expand coverage to nearly all people under the age of 65, including childless adults, with an income at or below 138 percent of the FPL (\$15,415 per year for an individual in 2012). The Federal Government will provide 100 percent of the funding from 2014 to 2016, then will decrease to 90 percent in 2020.²⁵ If Texas decides to expand Medicaid, in addition to receiving new Transformation Waiver funds, the State must continue to follow strict federal guidelines that are economically unreliable. While Medicaid consumes 25 percent of the Texas state budget and continues to grow, this leaves less funding for other state programs.

However, if Texas does not expand Medicaid, and the Transformation Waiver proves to be cost-effective, Texas could potentially meet the health care needs of Medicaid recipients through the implementation of the Transformation Waiver. This would allow the State greater flexibility in developing a plan that better fits the diverse and unique health needs of the residents in Texas. Therefore, the Legislature should study the impact of the Transformation Waiver and its role within and without the Medicaid Expansion.

The Legislature should study the role of a State Health Insurance Exchange versus a federally mandated exchange. The study should include cost advantages, competition, and ease of use. The study should also include a view of the enforceability of the Federal Health Insurance Exchange.

The United States allows each state to have its own separate insurance codes, mandates, licensure requirements, and unique insurance markets. Therefore, implementing a national one-size-fits all insurance scheme will be difficult to incorporate the unique arrangements crafted over past centuries. Under the ACA, states are mandated to operate a State-run Insurance Exchange, partner with the federal government, or have the federal government, exclusively run

²⁴ Texas Health and Human Services. (2011). Texas gets approval or cost-saving medicaid improvements. Retrieved from http://www.hhs.state.tx.us/news/release/121211_Medicaid-Improvements.shtml

²⁵ The Henry J. Kaiser Family Foundation. (2012). A guide to the supreme court's decision on the aca's medicaid expansion. Retrieved from <http://www.kff.org/healthreform/upload/8347.pdf>

the Exchange. A State-run Insurance Exchange plan must be certified by the U.S. Department of Health and Human Services (HHS) no later than January 1, 2013. States were also required to submit a letter of intent and application to operate a state-run exchange by November 16, 2012. However, on November 15, 2012, the Secretary of HHS extended the deadline to December 16, 2012. Currently, the states have made the following decisions related to implementation of an Health Exchange: 18 have declared a State-based Exchange; six are planning for a Partnership Exchange; 10 are undecided; and 17 will default to a Federal Exchange.²⁶

The ACA requires providing essential health benefits to everyone. However, the changing standards and regulations in the ACA attempt to redefine essential health benefits. On November 20, 2012, HHS issued new standards related to essential health benefits, actuarial value, and accreditation. Furthermore, additional regulations related to the Exchanges or the other parts of the ACA have yet to be crafted. As a result, the real and full impact of the ACA and Exchanges upon states is still unknown.

Illustrating the complexity of state implementation of ACA, HHS has stated through various statements and bulletins that flexibility will be provided to states when implementing exchange benefits. However, states are required to provide a benchmark plan that would typically be offered by an employer. States' "flexibility" is limited to the state requiring to choose one of the following benchmark health insurance plan options:

- One of the three largest small group plans in the State by enrollment.
- One of the three largest State employee health plans by enrollment.
- One of the three largest federal employee health plan options by enrollment.
- The largest HMO plan offered in the State's commercial market by enrollment.²⁷

If a state does not choose to offer a benchmark plan, HHS requires the state benchmark plan be the small group plan with the largest enrollment in the state. State-run Insurance Exchanges must pay for the costs of state-specified benefit requirements outside of the defined Qualified Health Plans offered by the Federal Exchange.

Insurance plans under state-specified benefit requirements²⁸ incorporated into a Federal Exchange must be studied to offer a state solution for an effective health insurance exchange. The Legislature should study the role of a State Health Insurance Exchange versus a federally mandated Exchange. The study should include cost advantages, competition, potential federal surcharges, and ease of use. The study should explore markets that encourage competition to lower health care costs to consumers, and ease of use should be targeted toward the general public.

²⁶ Kaiser Family Foundation,

<http://statehealthfacts.kff.org/comparemappable.jsp?typ=5&ind=962&cat=17&sub=205&sortc=1&o=a>

²⁷ Essential Health Benefits: HHS Informational Bulletin, Posted on: December 16, 2011, updated: February 24, 2012

²⁸ Texas state required benefit, <http://cciio.cms.gov/resources/EHBBenchmark/tx-state-mandate-template.pdf>

The Legislature should study the impact of the Affordable Care Act to businesses who employ over 50 employees.

According to 2012 statistics, 94 percent of businesses with 50 to 199 workers offered health benefits to its workers. Ninety-seven percent of businesses with 200 to 999 workers and 100 percent of businesses with 1,000 or more workers provided workers with health benefits.²⁹ While the ACA does not require businesses with 50 or more employees to offer health benefits to its workers beginning in 2014, Section 1003 of the ACA and Section 4980H of the Internal Revenue Code^{30 31} allow these businesses to be assessed a penalty if any of the workers obtain a tax credit when purchasing insurance from a Health Exchange.

In addition, businesses that already offer insurance may still be subject to penalties. If the health benefits offered by businesses to their employees do not cover at least 60 percent of the cost of services covered for a typical population or if the premium of the coverage is over 9.5 percent of the worker's income, then the worker is eligible to receive coverage from a Health Exchange and receive a tax credit toward health benefits. Employers with workers that receive the tax credit must pay a penalty of \$3,000 up to a maximum of \$2,000 times the number of workers in excess of 30 workers.³² A study done by the Deloitte Center for Health Solutions and Deloitte Consulting found that less than 2 percent of larger businesses with more than 1,000 workers consider dropping coverage. However, 13 percent of smaller businesses with 50 to 100 workers consider dropping coverage within the next 3 years.³³ These businesses may feel the impact more than the businesses that have over 1,000 workers. Therefore, to further understand the implications of the ACA on businesses over 50 employees, the Legislature should conduct a study of how the ACA will impact these businesses.

²⁹ The Henry J. Kaiser Family Foundation. (2012). Employer health benefits 2012 annual survey. Retrieved from <http://ehbs.kff.org/?page=charts&id=1&sn=3&p=1>

³⁰ US Department of Labor. (February 9, 2012). Technical Release No. 2012-01. Retrieved from <http://www.dol.gov/ebsa/newsroom/tr12-01.html>

³¹ Patient Protection and Affordable Care Act, Section 1003, Employer Responsibility. Retrieved from <http://www.healthcare.gov/law/resources/authorities/section/1003-employer-responsibility.pdf>

³² The Henry J. Kaiser Family Foundation. (2012). Health reform source, will employers that don't provide health benefits have to pay a penalty? Retrieved from <http://healthreform.kff.org/faq/will-employers-pay-a-penalty.aspx>

³³ Deloitte Center for Health Solutions & Deloitte Consulting. (2012). 2012 Deloitte survey of u.s. employers: opinions about the u.s. health care system and plans for employee health benefits. Retrieved from http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_dchs_employee_survey_072512.pdf

CHARGE #4

Identify policies to alleviate food insecurity, increase access to healthy foods, and incent good nutrition within existing food assistance programs. Consider initiatives in Texas and other states to eliminate food deserts and grocery gaps, encourage urban agriculture and farmers' markets, and increase participation in the Summer Food Program. Evaluate the desirability and feasibility of incorporating nutritional standards in the Supplemental Nutrition Assistance Program (SNAP). Monitor congressional activity on the 2012 Farm Bill and consider its impact on Texas. *(Joint with the House Committee on Human Services)*

INTRODUCTION

In 2011, 18.5 percent of Texas households experienced food insecurity, compared to the national average of 14.9 percent. Food insecurity is defined as difficulty in securing adequate food for a household. Falling behind only Arkansas and Missouri (both at 19.2 percent), Texas has the 3rd highest percentage of food insecurity.³⁴ Food insecurity touches every county in Texas and remains a relevant concern due to the high poverty rate, existence of food deserts, increase in SNAP utilization, poor access to healthy foods, and continuing rise of obesity.

In a proactive effort to alleviate food insecurity, increase access to healthy foods, and incentivize good nutrition within existing food assistance programs, the House Committee on Public Health held a joint hearing with the House Committee on Human Services. The May 22, 2012, hearing brought together many organizations and agencies, including the: Department of State Health and Human Services (DSHS), Texas Department of Agriculture (TDA), Health and Human Services Commission (HHSC), Texas Food Bank Network, Sustainable Food Center, Texas Farm and Ranch Freedom Alliance, Walgreens, and Texas Hunger Initiative.

The Committees heard concerns over the low availability of healthy and nutritious foods, lack of nutrition standards in the Supplemental Nutrition Assistance Program, difficulty in maintaining and establishing urban agriculture, initiatives to increase participation in the Summer Food Program, and the current congressional activity on the 2012 Farm Bill. In addition to these issues, concerns were raised by Members over waste in school breakfast programs, where some school districts mandate breakfast to every child. As a result, food is wasted in districts where breakfast is served at home by parents and then again by schools in the morning. Drew DeBerry, Deputy Commissioner of TDA, stated that because the decision to provide universal breakfast is a district decision, districts can resolve this concern at the local level. To reduce waste in food programs, schools should explore avenues that ensure food programs are used effectively to deliver food to eligible students.

³⁴ U.S. Department of Agriculture (USDA). (2012). *Household food security in the united states in 2011* (ERS Report Summary Number 141). Retrieved from <http://www.ers.usda.gov/media/884525/err141.pdf>

RECOMMENDATIONS

1. The Legislature should pass legislation establishing a Local Foods and Small Farms Council. The council will study and make recommendations to reform and simplify all relevant regulations that currently hinder, harm or limit small-scale food production. This council should work with DSHS, TDA, TPWD, and stakeholder groups to submit a biannual report to the Legislature and be subject to Sunset Review every four years.
2. The Legislature should consider how agricultural property tax evaluation could include a local option for small-scale commercial farmers in order to increase local food production in urban areas and encourage a new generation of farmers.
3. The DSHS should evaluate its communication strategies with the general public and work towards providing clear and consistent answers on food safety regulations.
4. Pending available resources, DSHS and HHSC should promote awareness to encourage healthy eating and should collaborate with TDA to include messages that promote Texas food production and consumption that pushes healthful food purchases with SNAP.
5. The Legislature should request a waiver from the Federal Government to reform SNAP. This waiver will incorporate nutritional guidelines into the program similar to those found in the WIC program. If the waiver is approved, the Legislature should consider distributing SNAP benefits similar to the WIC smart Card in order to reduce SNAP fraud and potentially pre-load acceptable food items. A demonstration pilot could also be an alternative policy pursued.
6. The Legislature should explore avenues to encourage media advertisements and in-store promotions for SNAP which promote healthy food choices.
7. The Intergovernmental Coordinating Group (ICG) should work with the Texas AgriLife Extension Service to develop a nutritional education model that better fits individual lifestyles in urban and rural areas. A new partnership with local faith and community based groups needs to be created in order achieve better nutritional education outreach.
8. The Legislature should encourage non-traditional grocery stores that currently provide food products to introduce fresh food items.

DISCUSSION

The Legislature should pass legislation establishing a Local Foods and Small Farms Council. The council will study and make recommendations to reform and simplify all relevant regulations that currently hinder, harm or limit small-scale food production. This council should work with DSHS, TDA, TPWD, and stakeholder groups to submit a biannual report to the Legislature and be subject to Sunset Review every four years.

In Texas, the U.S. Department of Agriculture (USDA) reported that there were 245,000 farms in 2011. Of this number, 97 percent of the farms fell under the category of small-scale. According to the USDA, small-scale farms generate annual sales of \$250,000 or less (farms that generate sales above this are large or commercial farms). However, an overwhelming number of the Texas small-scale farms (74 percent) make less than \$10,000 in sales per year.³⁵ Facilitating the growth of these small-scale farms may help to improve access to healthy food around the state. Ms. Judith McGearry with the Farm and Ranch Freedom Alliance shared her concerns on the barriers to producing healthy food:

- City zoning restrictions that restrict small urban and suburban farmers from producing and selling fresh agricultural products (ie: fruit, vegetables, and eggs).
- Health regulations that are unclear due to differences in municipal, county, and state interpretations.
- Multiple permit fees required by different government entities to sell or produce agricultural products. For example, farmers interested in selling produce in multiple locations within a city, county, or state may have to hold a different permit for each location. The cost of multiple permits may discourage farmers from participating in certain markets.
- Health regulations that mainly apply to large scale farms. For example, the current Texas Food Establishment Rules require that all foods, except for uncut fruits and vegetables, to be stored in a licensed facility. Therefore, small-scale farmers are unable to store meat that has been processed at a USDA or state processing plant at a freezer on the farm because it qualifies as a home. Small-scale farmers that are required to build or rent an additional facility to meet these regulations may incur high costs.

Although these regulations were created with good intention, they may also interrupt the ability of small-scale farmers to be profitable. The Committees also received testimony from Mr. Jack Waite, owner of Aquaponics Farming in Austin, Texas. He expressed the financial burden he faced with his 3-acre urban fish farm. To start his business, Mr. Waite had to acquire 10 different permits costing approximately \$1,500. Permits were needed from the Texas Department of Agriculture (TDA), Department of State Health Services (DSHS), Texas Parks and Wildlife Department (TPWD), Texas Commission on Environmental Quality, Environmental Protection

³⁵ USDA. (2011). *2011 State agriculture overview, texas*. Retrieved from http://www.nass.usda.gov/Statistics_by_State/Ag_Overview/AgOverview_TX.pdf

Agency (EPA), Food and Drug Administration (FDA), and the City of Austin. Excessive regulatory fees and health restrictions make it difficult for small-scale farmers to run their businesses and to remain financially viable, and also reduce economic growth of these small businesses.

To help alleviate some of the difficulties small-scale farmers face, the Legislature should establish the Local Foods and Small Farm Council. The council will consist of members from stakeholder groups, the public, TDA, TPWD, and DSHS. Members of the council will represent both rural and urban areas. The council will be responsible for investigating current rules and regulations that may unnecessarily impede on the production and sale of agricultural products by small-scale farmers. Furthermore, the council will provide a biannual report to the Legislature a report of findings and recommendations on what can be done to simplify, clarify, and reform those regulations and restrictions. In addition, the Council will be subject to Sunset Review every four years.

The Legislature should consider how agricultural property tax evaluation could include a local option for small-scale commercial farmers in order to increase local food production in urban areas and encourage a new generation of farmers.

Agriculture continues to be a large industry in Texas. Texas led the nation in the number of farms and ranches with 245,000 in 2011. The top ten commodities include: cattle, cotton, milk, boilers, greenhouse and nursery, corn, wheat, timber, grain sorghum, and vegetables. However, the majority of farms in Texas are small-scale farms and 74 percent of these farms make less than \$10,000 per year.

In 1978, the Legislature added Section 1-d-1 to Article 8 of the Texas Tax Code. This was added to “promote the preservation of open-space land.”³⁶ This open-space agricultural use property tax evaluation (“ag-use property tax evaluation”) provides tax relief for open-space land that is “currently devoted principally to agricultural use to the degree of intensity generally accepted in the area and that has been devoted principally to agricultural use or to production of timber or forest products for five of the preceding seven years or land that is used principally as an ecological laboratory by a public or private college or university,” as defined by Chapter 23, Subchapter D, Section 23.51 of the Texas Tax Code.

The section also defines the term “agricultural use,” stating that the definition “includes but is not limited to cultivating the soil, producing crops for human food, animal feed, or planting seed or for the production of fibers; floriculture, viticulture, and horticulture; raising or keeping livestock; raising or keeping exotic animals for the production of human food or of fiber, leather, pelts, or other tangible products having a commercial value; planting cover crops or leaving land idle for the purpose of participating in a governmental program, provided the land is not used for residential purposes or a purpose inconsistent with agricultural use; and planting cover crops or

³⁶ Article 8, Section 1-d-1. Retrieved from <http://www.statutes.legis.state.tx.us/Docs/CN/htm/CN.8.htm>

leaving land idle in conjunction with normal crop or livestock rotation procedure ... The term also includes the use of land for wildlife management ... [and] ... the use of land to raise or keep bees for pollination or for the production of human food or other tangible products having a commercial value, provided that the land used is not less than five or more than 20 acres.”³⁷

Currently, the statutory definitions and language do not allow the vast majority of small-scale farms, community gardens, and urban farms to qualify for the ag-use property tax evaluation. Some counties also impose minimum acreage requirements, such as a ten-acre minimum that further hinder participation from these farms. The most recent census reported 21,000 farms as covering less than ten acres, and most of these falling under five acres.³⁸ Counties that impose the ten-acre minimum disqualify small farms from receiving the ag-use property tax evaluation. Furthermore, the definition of agricultural use does not include the production of fruit and vegetable products.

Clarifying the agricultural property tax evaluation will create improved participation by small-scale farmers. It will provide an incentive for small-scale farmers to start-up or continue in the industry. In addition, it may provide fiscal relief for small scale and urban farmers; as well as encourage a generation of young farmers at a time when the average age of farmers and ranchers in Texas is 59 years old.³⁹

The Department of State Health Services should evaluate its communication strategies with the general public and work towards providing clear and consistent answers on food safety regulations.

The Committees heard testimony from Ms. Judith McGeary that complex and layered food safety regulations between the federal, state, and local governments may create confusion for farmers. Differing interpretations of various laws, ordinances, and regulations by the three levels of government may result in miscommunication between local health departments and farmers over the food safety requirements. The different interpretations may also cause inconsistent enforcement by local jurisdictions. Texas Administrative Code §221.12 currently exempts farmers that process less than 10,000 birds or rabbits from having an inspector on-site during the slaughter process. However, these same farmers may face other government regulations that basically require the equivalence of an on-site inspector.

Egg farmers also face similar confusion. State storage regulations require that eggs be cleaned and stored in a licensed facility. Due to this, farmers are not allowed to store clean eggs in a refrigerator in the home. However, many local jurisdictions do not enforce this regulation.⁴⁰ To ensure food safety and prevent confusion over regulations, the Department of State Health Services should evaluate the current food safety regulations and consider how the agency is

³⁷ Ibid.

³⁸ Texas Department of Agriculture. (2012). Texas ag stats. Retrieved from <http://www.texasagriculture.gov/About/TexasAgStats.aspx>

³⁹ Ibid.

⁴⁰ McGeary, J. (November 6, 2012). [Email communication].

communicating the information to farmers. The agency should also improve the consistency of the food safety regulations across varying levels of state governments to curb the differing interpretations of the same regulations.

Pending available resources, DSHS and HHSC should promote awareness to encourage healthy eating and should collaborate with TDA to include messages that promote Texas food production and consumption that pushes healthful food purchases with SNAP.

The Committees heard testimony from Lauren Dimitry with Partnership for a Healthy Texas that in 2010, Texas had the 13th highest adult obesity rate and 7th highest child obesity rate. It is estimated that 70 percent of the children will become overweight or obese as adults. Obesity greatly increases an individual's risk for Type II Diabetes, heart disease, cancer, and high blood pressure. In addition to increased health issues associated with high obesity rates, health care costs also rise. In 2011, the Texas Comptroller of Public Accounts reported that obesity costs businesses \$9.5 billion alone in 2009.

As obesity rates continue to climb, it is becoming more urgent that measures are taken to prevent increased health problems and costs associated with obesity. Media and education campaigns that incorporate community participation may provide an effective way to encourage healthy eating behavior and to promote local food production and consumption. Collaboration between TDA, DSHS, and HHSC may be an efficient way to deliver the message to a larger population of the public. The agencies are encouraged to utilize and share the resources that are already available to them.

The Legislature should request a waiver from the Federal Government to reform SNAP. This waiver will incorporate nutritional guidelines into the program similar to those found in the WIC program. If the waiver is approved, the Legislature should consider distributing SNAP benefits similar to the WIC smart Card in order to reduce SNAP fraud and potentially pre-load acceptable food items. A demonstration pilot could also be an alternative policy pursued.

During the 82nd Regular Legislative Session, State Representative Susan King proposed legislation to adopt a policy that would focus on improving the health outcomes among recipients of the Supplemental Nutrition Assistance Program (SNAP). HB 3451 required the Executive Commissioner of the Health and Human Services Commission to develop and seek a waiver or other appropriate authorization from the United States Secretary of Agriculture under the federal Food and Nutrition Act of 2008 to make changes to SNAP. The bill would authorize the Executive Commissioner, in developing the waiver or other authorization, to consider the feasibility of restricting minimally nutritious foods. The bill also requires the Executive Commissioner, in developing the waiver or other authorization, to solicit input from interested

persons, including state agencies that administer nutritional assistance programs, nonprofit organizations that administer hunger relief programs, health care providers, nutrition experts, food retailers, and food industry representatives.

The nutritional guidelines that are utilized in the WIC program are intended to supplement the women's and children's diets with nutritious foods and could serve as a guideline for similar nutritional standards in the SNAP program. Federal regulations require WIC service providers to offer participants at least two nutrition education sessions during each certification period, which occurs roughly every six months. State WIC agencies and their local WIC service providers design educational programs that are appropriate for their participant caseloads. A 1994 FNS WIC Nutrition Education Demonstration Study proved the program to be effective in educating preschoolers about good nutrition. The study found that the nutrition education lessons improved children's knowledge about certain nutrition topics like the Food Guide Pyramid, food groups, and eating food that makes them healthy and strong. Additionally, it proved that short interventions appear to be practical strategies for teaching preschoolers about nutrition.

If the waiver is approved, the Legislature should consider distributing SNAP benefits similar to the WIC smart card. In 2011, HHSC reported that \$438.2 million in SNAP benefits was issued to 3.6 million individuals on average each month. In total, HHSC issued \$5.32 billion in Supplemental Nutrition Assistance Program (SNAP) benefits to recipients in 2011. SNAP is 100 percent federally funded and the benefit amounts are established at the federal level. The program provides low-income families with a monthly benefit amount to purchase food issued through the Lone Star Card once a month. The Lone Star Card is a plastic card that recipients can use to pay at the cash register, similar to using a credit card.⁴¹ Although the card must be swiped to deduct the benefit amount, the card cannot track what is being purchased, potentially allowing recipients to purchase items that are not allowed. In addition, the Lone Star card is loaded with both the Temporary Assistance for Needy Families (TANF), a cash assistance program, and SNAP benefits. This may make it difficult for retailers to differentiate between TANF and SNAP purchases. Currently, the Lone Star card does not have restrictions on purchases, but rather relies solely on retailer agreements to monitor the purchases. Stephanie Muth, Deputy Executive Commissioner of Social Services from the Health and Human Services Commission, confirmed that retail agreements are difficult to enforce and not effectively regulated.

To prevent SNAP fraud, pre-loading the acceptable food items onto smart cards may be a viable option. Mr. Mike Montgomery, Director of Nutritional Standards for WIC, discussed at the hearing that the Women, Infants, and Children (WIC) recipients currently use smart cards to purchase pre-approved WIC products. The smart cards contain a microchip that prohibits the purchase of non-WIC items with the card. The transfer of WIC benefits for the purchase of acceptable food items occur between the vendor and the state's electronic benefits transfer (EBT) host system. Vendors that want to participate in WIC must demonstrate that they have the capability to accept the WIC program benefits electronically with an authorized electronic cash

⁴¹ Health and Human Services Commission. (2012). SNAP food benefits. Retrieved from <http://www.hhsc.state.tx.us/help/Food/snap.shtml>

reader system. This system can be the vendor's own multifunctional equipment or a separate system that transacts only WIC EBT smart card redemptions.⁴²

This same process can also be used to transition the current Lone Star cards into a smart card. Pre-loading the card will ensure that only SNAP acceptable foods are purchased. Additionally, purchases made with SNAP should be reported to HHSC to ensure the benefits are being used as intended. These changes will be an effective means for reducing SNAP fraud on both the provider and consumer ends. Given the millions of Texas dollars dedicated to diabetes and obesity treatments in the Medicaid population, we are essentially promoting unhealthy foods that cause diabetes in SNAP.

Another healthy food incentive to consider would be the USDA Healthy Incentive Pilot or HIP. Implemented after the passing of the Farm Bill in 2008, HIP strove to test and evaluate the impact of financial incentives on fruit, vegetables, and other healthy food purchases among SNAP participants. A sample of 1,500 households out of 7,500 would be randomly selected to participate in the incentive program. The Pilot program was designed to determine if the financial incentive provided by HIP actually increased healthy food purchases, as well as to attempt to identify common characteristics in households that did take advantage of the incentive program. The results of the incentive program will not be available until January of 2013. However, the results may provide useful information for the State to consider when evaluating nutrition incentives for Texans in the future.

The Legislature should explore avenues to encourage media advertisements and in-store promotions for SNAP which promote healthy food choices.

The Supplemental Nutrition Assistance Program, formally known as the Food Stamp Program, is a federally funded program intended to assist low-income individuals supplement their diet with nutritious foods. The new name for the Food Stamp Program was changed as of Oct. 1, 2008, to reflect changes in the program that focus on nutrition.⁴³

According to the SNAP eligible food items list, households can use SNAP benefits to purchase: breads and cereals, fruits and vegetables, meats, fish, poultry, dairy products, seeds and plants which produce food for the household to eat. Households cannot use SNAP benefits to purchase: beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products, household supplies, vitamins and medicines, foods that will be eaten in the store and hot foods.⁴⁴

The USDA has outreach programs that are intended to promote SNAP participation to individuals in need. In the summer of 2012, USDA released media campaigns in Texas to

⁴² DSHS. (2012). Additional vendor agreement policies. Retrieved from <http://www.dshs.state.tx.us/wichd/vo/policy.shtm>

⁴³ United States Department of Agriculture. (2011). Supplemental Nutrition Assistance Program. <http://www.fns.usda.gov/snap/snap.htm>

⁴⁴ United States Department of Agriculture. (2012). Supplemental Nutrition Assistance Program. <http://www.fns.usda.gov/snap/retailers/eligible.htm>

promote the program in an appealing light rather than the assistance program it was intended to be. However, some found the ads to be controversial and they have since been removed from the air.

During the hearing on May 22, 2012, State Representative Naomi Gonzalez expressed her concerns regarding a Walgreens in her district advertising “We accept SNAP” in the high sugary, low nutrition food aisle that clearly violates the intent of the nutrition program. The Legislature should explore avenues to encourage media advertisements and in-store promotions for SNAP which promote healthy food choices to ensure SNAP benefits are used to nutritiously supplement ones’ diet.

The Intergovernmental Coordinating Group (ICG) should work with the Texas AgriLife Extension Service to develop a nutritional education model that better fits individual lifestyles in urban and rural areas. A new partnership with local faith and community based groups needs to be created in order achieve better nutritional education outreach.

The Legislature created the Intergovernmental Coordinating Group (ICG) in 2009 (under HB 492), to work on finding ways to improve faith-based/community organizations and state government partnerships. Currently, the ICG comprises of one employee designated as a liaison from faith based/community organizations and 14 state agencies. Some of the agencies involved include the: Office of the Governor, Department of Public Safety (DPS), Texas Department of Insurance (TDI), Public Utility Commission of Texas, Office of the Attorney General (OAG), Department of Agriculture (DOA), Office of the Comptroller of Public Accounts, Department of Information Resources, Office of State-Federal Relations, Office of the Secretary of State, and an institution of higher education.

The Texas AgriLife Extension Service (“Extension”) has served Texans for almost a century by providing community-based education. The Extension provides information on the following topics: how to live and maintain a healthy lifestyle, manage money, raise children to be successful adults, improve stewardship of the environment, and utilization of economic tools to have a secure and stable future.⁴⁵ The Extension works with the state legislature, local communities, Texas A&M System partners, and approximately 900 educators in 250 offices around the State to provide expertise.

A partnership between the ICG and Extension will create a greater wealth of resources and knowledge that can be effectively and efficiently utilized to provide nutritional education and programs for urban areas. Together, the two organizations should research and work to develop a nutritional education model that would best fit the health needs of urban and rural communities.

⁴⁵ Texas A&M AgriLife Extension. (2012). What is extension? Retrieved from www.agrilifeextension.tamu.edu/about/

The Legislature should encourage non-traditional grocery stores that currently provide food products to introduce fresh food items.

The U.S. Department of Agriculture defines a food desert as a low-income census tract where urban residents live over one mile and rural residents live more than ten miles from a grocery store.⁴⁶ A major challenge for residents that live in food deserts is the accessibility of fresh and nutritious foods. Often times, the only food available in food deserts are non-nutritious fast-food options and food from convenience stores.

Mr. Vince Wilkinson, the Austin District Manager of Walgreens, shared Walgreen's goals to increase healthy foods in convenience stores in food deserts to improve access and combat obesity in food deserts. In 2011, Walgreens began the Food Oasis Program to provide healthy and fresh food options, as well as clinic services to medically underserved areas. Over a period of the next five years, Walgreens will convert or open at least 1,000 food oasis stores across the country.⁴⁷ Although increasing health foods in convenience stores can provide great access in these areas, concerns have been raised over how convenience stores can offer these foods at an affordable price.

To promote greater access to affordable and healthy food in food deserts across Texas, the Legislature should encourage non-traditional grocery stores that currently provide food products to introduce fresh food items. They should also consider working with local small food suppliers as a local solution to food deserts. In addition to improving access and lowering cost, fostering these relationships can promote job growth for small businesses.

A barrier that many small businesses may face is the lack of refrigeration equipment for fresh food. They may not be able to purchase refrigerators, shelving, or other equipment for fresh food due to high costs. The Legislature should explore avenues that encourage and enable non-traditional grocery stores and small businesses in a food desert to provide fresh food.

⁴⁶ USDA. (2012). Food desert locator. Retrieved from <http://www.ers.usda.gov/data-products/food-desert-locator/about-the-locator.aspx#Defined>

⁴⁷ Walgreens. (July 20, 2011). Walgreens commits to converting or opening at least 1,000 food oasis stores over the next five years. Retrieved from http://news.walgreens.com/article_print.cfm?article_id=5451

CHARGE #5

Monitor the agencies and programs under the Committee's jurisdiction and the implementation of relevant legislation passed by the 82nd Legislature.

TEXAS STATE BOARD OF DENTAL EXAMINERS

Texas has had a long history of protecting the dental health of the public. In 1897, district judges saw the importance of dental licensure and appointed a Board of three dentists for their district. Following their lead, the State - through SB 84 - created the Texas State Board of Dental Examiners (TSBDE) in 1905. This was done to ensure that only qualified individuals are licensed to practice dentistry and individuals who violate dentistry laws and rules are appropriately sanctioned.⁴⁸ Today, the TSBDE consists of an agency with 36 authorized full-time equivalents (FTEs) and a 15 member Dental Board. The Dental Board comprises of eight dentists, two dental hygienists, and five public members, all appointed by the Governor. In 2011, the TSBDE issued 59,853 renewal and new licenses to dental professionals, compared to 44,590 in 2007. As the number of licenses continue to grow each year, it is imperative that appropriate measures are continually being taken to ensure the health and safety of the public.

In light of recent reports of high and unnecessary dental and orthodontia Medicaid utilization,⁴⁹ the House Committee on Public Health held a public hearing on April 11, 2012, to gain a better understanding of the operations and functions of the TSBDE. At the hearing, the Committee heard testimony from the Dental Board, the Texas Dental Association (TDA), and Texans for Dental Reform (TDR). Just days prior to the hearing, Sherri Meeks resigned her position as Executive Director of the Dental Board, and Mr. Glen Parker became the then acting Executive Director. The Dental Board addressed questions on whether the TSBDE has jurisdiction over the Medicaid dental investigations, stating that based on the current Dental Practice Act, it does not. Instead, the authority to investigate these cases lie with the Federal Bureau of Investigations (FBI), Health and Human Services Commission (HHSC), Office of the Investigator General (OIG), Office of the Attorney General's (AG), and local district attorneys (DAs). The Dental Board also expressed concern over the limited funds appropriated to the TSBDE. Mr. Glen Parker contended that because the TSBDE is only appropriated around 24 percent of the revenue it brings in, it is difficult to maintain the authorized number of staff needed to run efficiently or make improvements such as simplifying the website.

TDR testified that the TSBDE website is not user-friendly and is difficult to navigate. In addition, although some documents are available for public viewing, the documents may be difficult for some members of the public to comprehend because of the technical terms and language used. TDR further contended that dentists should not receive a new license number after the old one has expired for more than a year. In response, Mr. Parker agreed that the website does need to be more user-friendly. However, he noted that additional appropriations would be needed to make the changes.

Since the hearing, Mr. Parker has become the Executive Director of the Dental Board, and the TSBDE has reported to the Committee that additional staff has been hired. At the hearing, Mr. Parker stated that the agency had 29 FTEs. As of November 1, 2012, all 36 authorized FTEs slots have been filled. Although the number of FTEs have increased, Mr. Parker has expressed

⁴⁸ Texas State Board of Dental Examiners. (2012). History, philosophy, & history. Retrieved from http://www.tsbde.state.tx.us/index.php?option=com_content&task=view&id=73&Itemid=93

⁴⁹ Harris, Byron. (December 27, 2012). Crooked teeth. medicaid millions. *WFAA*. Retrieved from <http://www.wfaa.com/news/investigates/Crooked-Teeth-Medicaid-Millions-136287563.html>

that authorizing an additional 11 FTEs would greatly improve the efficiency of the agency by providing more staff in the enforcement, legal, investigation, and licensing departments. Minor changes have been made to the website to make it easier to access disciplinary actions. However, additional funds are still needed to ensure better efficiency and effectiveness of the agency, such as decreasing the average days to resolve a complaint, as well as to make greater improvement on the website. TSBDE also stated that as of September 1, 2012, dental professionals licensed by the Dental Board are no longer given a new license number after the old one has expired for more than a year. The Dental Board has worked hard to make sure that all dental professionals with multiple licenses have all license numbers and histories linked. Based on the hearing and most recent updates, the Committee makes the following recommendations:

RECOMMENDATIONS

1. The Texas State Board of Dental Examiners should implement an appeals process.
2. The Legislature should allow the Texas State Dental Board to retain a greater percentage of their licensing fees as other legislative oversight boards, with performance measures in place to insure proper expenditure.
3. The Texas State Board of Dental Examiners should improve its website to allow greater transparency to the general public.
4. The Legislature should allow the Texas State Board of Dental Examiners authority to register and monitor non-dentist owned and run clinics, especially those owned by dentists from out of state.

DISCUSSION

The Texas State Board of Dental Examiners should implement an appeals process.

According to the current TSBDE policy, cases that have been closed may only be reopened if a complainant can provide new and sufficient evidence. Although complainants have the ability to provide new evidence to the TSBDE and potentially reopen a case, there is not a formal appeals process in place that explicitly states what complainants should do in this situation. In 2003, the Texas Medical Board (TMB) amended Texas Administrative Code, Title 22, Part 9, §178.8 to provide a formal appeals process for complainants. The TSBDE may be able to use this as an example on how to develop and implement a formal appeals process.

The appeals process for the TMB stipulates that to be considered for an appeal, a complainant must submit the appeal request in writing and list the reasons for the appeal. The reasons for appeal must contain sufficient information to warrant additional review of the case. When the case is considered eligible for review, the case then goes to be considered by a disciplinary committee of the Board. Once the appeal has been reviewed, and with the approval from TMB, the committee may either choose to reopen the case, or keep the case closed. With the review process, the complainant has the right to personally appear before the board, which he/she may schedule with TMB staff. The appearance before TMB is subject to the time restrictions placed by the chair. After the appeal has been reviewed, the complainant will be notified of TMB's final decision concerning the appeal. Only one appeal may be allowed per complaint.⁵⁰

While TMB's appeal process is not statutory, it is in place to ensure that those who desire an appeal are allowed the opportunity. Implementing an appeals process as such may enable the Texas Board of Dental Examiners to provide complainants with the same opportunity provided by the Texas Medical Board.

The Legislature should allow the Texas State Dental Board to retain a greater percentage of their licensing fees as other legislative oversight boards, with performance measures in place to insure proper expenditure.

In the presentation to the Committee, the Dental Board reported that the TSBDE is completely self-supported. The TSBDE generates revenue from statutory fees related to licensing, credentialing, examinations and is appropriated a part of the revenue for its operations. Executive Director Glenn Parker testified that in 2011, the TSBDE generated \$8,944,497 in revenue. The TSBDE was appropriated \$2,220,878 or about 24 percent of the revenue generated. The Medical Board, on the other hand, brought in an estimated revenue of \$33,077,289 and was appropriated around 33 percent back (\$10,939,739).

⁵⁰ Texas Administrative Code, Title 22, Part 9, §178.8

Mr. Parker also testified that no funds have previously been appropriated toward improving the website. Between 2004 and 2009, the appropriations stayed below the 2009 amount of \$1,749,475. However, the appropriations increased above \$2 million for 2011 and 2010 to fund a new database. This database replaced the outdated, 30-year-old database. Despite misconceptions that the funds were also to be used for the website, Mr. Parker asserted that the additional appropriation was only to be used to update the new database, not for improving the website. Currently, the website is being maintained by a staff member, not a web professional. Increased funding may allow the TSBDE to work with the Health Professions Council to hire a web professional that will improve and make the website easier to navigate.

The Committee further heard from Mr. Parker that, in 2011, the Dental Board handled 1,238 complaints. Each complaint took an average of 409.51 days to resolve. For years 2012 and 2013, the Dental Board is projected to handle 1,250 complaints and will take an average of 400 days to resolve each complaint. While the Dental Board has improved the average days to resolve complaints by about 40 days since 2010, the Dental Board should continue to strive to decrease the average.

In addition, Mr. Parker expressed his goals for improving the quality of staff within TSBDE. Quality staff members are important for the advancement and effectiveness of agencies. However, to maintain and attract quality, experienced, and knowledgeable staff, the agency must increase the pay for these positions. Therefore, the Dental Board should be appropriated a greater percentage of the revenues it brings in. This will allow the Dental Board to provide better online access to the public, respond to complaints in a timely manner, protect dental patients, improve the quality of staff, and ultimately increase agency efficiency.

The Texas State Board of Dental Examiners should improve its website to allow greater transparency to the general public.

The TSBDE website is difficult to navigate and disciplinary actions are difficult to read and decipher due to the usage of technical language and terms. The TSBDE should strive to summarize and simplify disciplinary actions, decrease the number of pages one must navigate through, and improve the communication on the website. Improved communication between the TSBDE and public will resolve many of the complaints brought against the TSBDE. The number of license revocations, probations/suspensions, and further disciplinary actions taken against a dentist should be clear to the public.

The Legislature should allow the Dental Board authority to register and monitor non-dentist owned and run clinics, especially those owned by dentists from out of state.

In the April 11, 2012 hearing, the issue of non-dentist owned clinics was brought before the Committee. Dr. Richard Black from the Texas Dental Association shared his concerns over the TSBDE's "limited ability to help protect the public in situations where dental care is delivered

by unlicensed persons and/or non-dentist owned entities such as corporations.”⁵¹ Non-dentist owned clinics have significantly increased in recent years and have become very popular in the state. The role of these clinics have been questioned due to the opaque relationships between dental services organizations (DSO) or dental management services organizations (DMSO) and the practicing dentists. DSOs are not legally defined in the law, leaving their practice and authoritative roles in dental offices vague and unregulated. The lack of oversight raises great concern when the relationships between DSOs and dentists are in question. It may also enable DSOs to potentially and/or unintentionally manipulate the system without any disciplinary actions. The DSOs are intended to provide administrative support allowing dentists to solely focus on the care of their patients. However, there is great concern whether DSOs may also be interfering and influencing the practice of dentistry to meet organizational financial quotas. If so, it is clearly a violation of Rule 108.70 of the Texas Administrative Code. The code states:

“Any dentist entering into any contract, partnership or other agreement or arrangement which allows any person other than a dentist any one or more of the following rights, powers or authorities shall be presumed to have violated the provisions of the Dental Practice Act, Section 251.003 regarding controlling, attempting to control, influencing, attempting to influence or otherwise interfering with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition.”⁵²

To prevent the influence of DSOs, registration with the TSBDE is needed. This will allow the TSBDE to monitor and regulate any violations of the code to ensure the safety of Texas citizens. According to Mr. Parker, the TSBDE does not have authority over DSOs based on current state statutes and regulations. If a dentist violates the Dental Practice Act, such as fraud or substandard treatment, the TSBDE may only take disciplinary action against the dentist. The TSBDE, however, may not take the same actions against individuals who are not dentists or are organizations that practice dentistry without a license because it is outside of the TSBDE’s authority. Instead, the TSBDE must refer the cases to the Office of the Attorney General and/or local district attorneys.

In a written testimony to the Committee, Mr. Parker stated at the October 15, 2012, hearing that if given the authority, TSBDE could “enact a licensing program under which DSOs would be required to register with the Board annually. In addition, information could be gathered regarding DSO ownership and the contracts DSOs sign with dentists and dental entities that own and operate dental practices. Linkages could be made between dentists, dental practices, and DSOs so that any systematic abuses or violations of the Dental Practice Act or other state laws could become more apparent.”⁵³ The regulation of non-dentist owned entities by the TSBDE will allow the state to regulate and monitor the number of corporate clinics in Texas when complaints are filed with the Board.

⁵¹ Dr. Richard Black, Texas Dental Association, Public Testimony, 2012.

⁵² Ibid.

⁵³ Parker, G. (October 15, 2012). Written testimony to the house committee on public health. Retrieved from <http://www.legis.state.tx.us/tlodocs/82R/handouts/C4102012101509001/392e77ab-20e6-489b-a905-300b26fccc02.PDF>

MEDICAID ORTHODONTIA

On January 24, 2012, the Committee first received testimony on the rising concerns of high utilization of orthodontia services in Medicaid brought to light by media sources. Testimony from Dr. Richard Black with the Texas Dental Association revealed Texas has seen a 78 percent increase in the number of active participating Medicaid dentists since 2007.⁵⁴ Chris Traylor, recently selected Chief Deputy Commissioner of the Texas Health and Human Services Commission by Governor Rick Perry, agreed that there has been a large increase in the number of providers enrolled in the Medicaid program. In August 2007, there were 142 orthodontists, but the number has more than doubled to 368 in 2012. The number of dentists also increased from 4,687 in August 2007 to 7,399 in 2012.⁵⁵ The Texas State Board of Dental Examiners (TSBDE) does not license dental professionals by specialty and dentists that practice orthodontia are not required to disclose that information.⁵⁶ Therefore, the exact number of dentists practicing orthodontia is essentially unknown. Prior to the fee-for-service policy changes, general dentists were allowed to practice orthodontia. That service is now limited to board certified and board-eligible orthodontists in Medicaid.

In 2007, the Texas Legislature addressed the under-utilization of Medicaid services for children in response to a class action lawsuit known as *Frew*. In doing so, dental rates increased 50 percent.⁵⁷ Following *Frew*, Medicaid rates increased for services in the Texas Medicaid Program to increase Medicaid utilization. This cost the state an estimated \$1.8 billion for the 2008-2009 biennium.⁵⁸ Additionally, a Wall Street Journal article reported that the Texas Medicaid program paid out \$1.4 billion to dentists and orthodontists last year, a roughly fourfold increase since 2006.⁵⁹ David Maxwell from the Medicaid Fraud Control Unit at the Office of the Attorney General testified the unit currently investigates dentists involved in fraudulent billing. In 2011, seven dentists were adjudicated with 82 months of incarcerations and court ordered restitution of \$1.8 million.

As a follow up to the January hearing, the House Committee on Public Health held an additional hearing on October 15, 2012, to further examine the state-wide concerns of dental and orthodontic services gaining nationwide attention. According to Medicaid policy, orthodontic services are limited to medically necessary cases. Medicaid does not allow orthodontia for cosmetic reasons.⁶⁰ However, a report released on April 25, 2012, by the U.S. House of Representatives Committee on Oversight and Government Reform entitled *Uncovering Waste, Fraud, and Abuse in the Medicaid Program* revealed that "by 2010 Texas's Medicaid program

⁵⁴ Ibid.

⁵⁵ Traylor, C. (October 15, 2012). Presentation to the house public health committee on delivery of dental services in Medicaid.

⁵⁶ Parker, G. (November 29, 2012). [Correspondence with the house committee on public health].

⁵⁷ Ibid.

⁵⁸ HHSC. (2011). Texas Medicaid and CHIP in perspective, 8th edition. Retrieved from <http://www.hhsc.state.tx.us/medicaid/reports/PB8/PinkBookTOC.html>

⁵⁹ Koppel, N. (August 19, 2012). Texas drills down on Medicaid dental fraud. Retrieved from <http://online.wsj.com/article/SB10000872396390444233104577591243154716520.html>

⁶⁰ Traylor, C. October 15, 2012. Presentation to the house public health committee on delivery of dental services in Medicaid.

was spending more on braces than the other 49 state Medicaid programs spent of braces combined."⁶¹

In response to the alleged fraud, abuse, and mismanagement of the Texas dental program, HHSC, its Office of the Inspector General (OIG), and the Office of the Attorney General (OAG) created a task force to investigate Medicaid dental and orthodontia fraud.⁶² According to Deputy Attorney General of Civil Litigation, John Scott, the Joint Task Force between the OAG and OIG was created in response to significant increases in cases that fall under the purview of the OIG, Civil Medicaid Fraud, and the Medicaid Fraud Control Unit (MFCU). Because fraud investigation units are extremely resource intensive, the Task Force serves to eliminate duplicative efforts and reduce costs. The MFCU deals with the criminal aspect of fraud but does not have access to data mining because it is prohibited by a grant given to MFCU from the Federal Government. Therefore, cases are mainly referred from the OIG. Since 2003, there has been 12,000 criminal referrals referred by the OIG, and 140 of those cases were referred in 2012. So far, there has been 125 convictions (eight of which were dental), two plea agreements awaiting sentencing, four indicted awaiting trial, and nine awaiting grand jury indictment. Out of the current 1,100 active criminal cases in MFCU, 153 are dental cases. Of the 153 cases, 45 are from orthodontia billing fraud. The agencies work together to identify over-utilizers of dental and orthodontic services and improvements in policy within HHSC and the contractor, Texas Medicaid & Healthcare Partnerships (TMHP). According to where the error lies, HHSC will seek reimbursement from TMHP or the dentist.

In addition to Medicaid orthodontia, HHSC discussed the implementation of Dental Managed Care. On March 1, 2012, children's Medicaid dental services were transitioned into managed care and administered by Delta Dental, DentaQuest, and MCNA. However, in September 2012, HHSC and Delta Dental announced the departure of Delta Dental on November 30, 2012. Delta Dental members will receive services through the remaining two providers. Concerns were raised over whether the remaining two managed care organizations have the capacity to receive and manage the clients following the departure of Delta Dental.

Another issue of concern is the rise in dental services organizations (DSOs) or dental management services organizations (DMSOs) in Texas. Executive Director of the TSBDE Glenn Parker's written testimony to the Committee stated DSOs provide dentists and dental practices business services so the dentists can concentrate on providing care to patients. Allegations have been made that DSOs illegally influence and interfere with the practice of dentistry. However, TSBDE is unable to identify the number of actual DSOs operating in the state because they do not register with the Board.

Furthermore, Mr. Parker stated that the TSBDE does not have authority over DSOs based on current state statutes and regulations. Mr. Parker further asserted that if a dentist violates the

⁶¹ U.S. Committee on Oversight and Reform. (2012). Uncovering waste, fraud, and abuse in the Medicaid program. Retrieved from <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>

⁶² Aaronson, B. (2012). Lawmakers want answers on dental, orthodontic fraud. *Texas Tribune*. Retrieved from <http://www.texastribune.org/texas-health-resources/medicaid/joint-task-force-tackles-medicaid-dental-fraud/>

Dental Practice Act, such as fraud or substandard treatment, the TSBDE may take disciplinary action against the dentist. The TSBDE, however, may not take the same actions against individuals who are not dentists or organizations that practice dentistry without a license because it is outside of the TSBDE's authority. Instead, the TSBDE must refer the cases to the Office of the Attorney General and/or local district attorneys.

In addition, liability concerns were raised by Members regarding providers who have decided to or are thinking about continuing the care for children with braces that have been abandoned by their previous provider. Deputy Inspector General Jack Stick, confirmed the OIG and OAG understand the implications of the situation and clarified that the primary dentists that provided the initial braces to the children are the ones under scrutiny. The dentists providing orthodontia services to patients that were not medically necessary will be responsible for the patient's continuation of care. Providers who do not comply will be referred to the Texas Office of Inspector General and the dental board.⁶³ The new provider will not be held liable for continuing care for a patient even if the underlying cases were cosmetic as long as the new provider was preapproved to do so.

⁶³ Texas Health and Human Services, 2012, CHIP and Children's Medicaid Dental Services, <http://www.hhsc.state.tx.us/medicaid/Children-Medicaid-Dental-Services.shtml>

RECOMMENDATIONS

1. The Texas Health and Human Services Commission should form an annual review Committee to revise and evaluate their current policies to reflect and respond to trending issues involving over utilization of Medicaid services.
2. The Texas Health and Human Services Commission should reconsider their contract with TMHP and reinvestigate to clarify future liability.
3. The Texas Health and Human Services Commission should work in collaboration with DMO's to contact Medicaid orthodontic patients that were abandoned by their previous provider to ensure every patient has a follow-up plan.

DISCUSSION

The Texas Health and Human Services Commission should form an annual review Committee to revise and evaluate their current policies to reflect and respond to trending issues involving over utilization of Medicaid services.

At the January 24, 2012 hearing, Executive Commissioner Thomas Suehs testified before the Committee that the state agency did not have the appropriate policies in place to detect improper utilization of Medicaid services. HHSC reports from 2008 to 2010 Medicaid expenditures for orthodontia increased from \$102 million to \$185 million. The report from the Committee on Oversight and Government Reform quoted Former Deputy Executive Commissioner Billy Millwee through an email that "the rise in Medicaid's dental program masked the stunning increase in claims Texas was paying for orthodontic services, which did not receive a payment rate increase as part of the state's Corrective Action Plan."⁶⁴

On August 28, 2008, the Texas Office of Inspector General issued a TMHP Performance Audit Report and found the orthodontic prior authorization request process needed improvement and that the prior authorization staff approved requests that were not in compliance with the Texas Medicaid Providers Procedure Manual. However, no actions were taken to address the findings. A follow-up audit was conducted with the United States Department of Health and Human Services' review. On August 1, 2012 the Internal Control Report was issued and the following significant finding were discovered: TMHP did not hire medically knowledgeable personnel to process dental prior authorization requests as contractually required, the dental director was not approving all orthodontic prior authorization requests, TMHP's Quality Assurance Review tool did not address medical necessity, and TMHP was approving multiple prior authorization requests for the same client and the same service.⁶⁵

At the October 15, 2012 hearing, HHSC Inspector General Doug Wilson, reported the Health and Human Services Commission-Office of Inspector General (HHSC-OIG) had identified more than 50 probable over-utilizers of orthodontia services. The data analysis experts found overutilization rates range from 39 percent to 100 percent with an average error rate of 93 percent. The HHSC-OIG completed 27 investigations with potential overpayments of \$229 million and 26 orthodontic providers have payment holds based on credible allegations of fraud. In addition to orthodontia claims, HHSC-OIG identified 89 probable over-utilizers of general dental services. The analysis experts identified potential overpayments of \$154 million.⁶⁶ At the end of September 2012, the Centers for Medicare and Medicaid Services (CMS) approved HHSC-OIG to purchase and implement the most advanced comprehensive data analysis system in the country. HHSC-OIG received financial support from CMS and implementation began October 1, 2012 with the initial deployment phase scheduled for January 2013. With the new

⁶⁴ U.S. Committee on Oversight and Reform. (2012). Uncovering waste, fraud, and abuse in the Medicaid program. Retrieved from <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>

⁶⁵ Wilson, D. October 15, 2012. Presentation to the house public health committee on delivery of dental services in Medicaid.

⁶⁶ Ibid.

sophisticated data analysis system, the HHSC-OIG is confident in early detection and prevention of Medicaid overutilization trends.⁶⁷

To assure the safety of patients, HHSC should annually revise and evaluate their current policies to reflect and respond to trending issues involving over utilization of Medicaid services.

The Texas Health and Human Services Commission should reconsider their contract with TMHP and reinvestigate to clarify future liability.

On January 24, 2012, Former Executive Commissioner Thomas Suehs affirmed allegations that the state contractor Texas Medicaid & Healthcare Partnership (TMHP) did not follow policy procedures set forth by HHSC. On October 15, 2012, Deputy Attorney General of Civil Litigation John Scott from the Office of Attorney General, also contended that TMHP did not meet contract requirements. The prior authorization process required by TMHP was clearly neglected. The Committee on Oversight and Government Reform report exposed TMHP for essentially rubber-stamping forms for approval. The Texas Office of the Inspector General brought in an orthodontist to audit prior authorization forms and found that 95 percent of the approved authorizations should have been denied.⁶⁸

Texas Health and Human Services Commission (HHSC) contracts with ACS State Healthcare, LLC., to process claims for Texas Medicaid and other state healthcare programs. ACS, a XEROX company, subcontracts these healthcare responsibilities in Texas with TMHP. The Wall Street Journal revealed that the Texas Office of Inspector General performed an audit in 2008, and found that there was only one dentist on staff at ACS to review thousands of Medicaid requests. As a result, the dentist only reviewed about 10 percent of the requests. In response to this, ACS stated that the contract with the state did not require “all requests to be reviewed by a licensed dental professional.”⁶⁹

On October 15, 2012, Mr. Chris Traylor testified HHSC had reviewed their contract with Texas Medicaid & Healthcare Partnership (TMHP) and their prior authorization evaluation process. Several areas for improvement were identified: the review and retention of clinical information, collection of additional clinical information, and employment of sufficient and qualified staff. TMHP has since hired a new Dental Director and increased the number of qualified staff to respond to the volume of claims.⁷⁰

In conjunction with the changes implemented by TMHP, HHSC also revised their own policies. Some of the changes included: the hiring of a full-time Medicaid Dental Director to oversee

⁶⁷ Ibid.

⁶⁸ U.S. Committee on Oversight and Reform. (2012). Uncovering waste, fraud, and abuse in the Medicaid program. Retrieved from <http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf>

⁶⁹ Koppel, N. (August 19, 2012). Texas drills down on medicaid dental fraud. Retrieved from <http://online.wsj.com/article/SB10000872396390444233104577591243154716520.html>

⁷⁰ Traylor, C. October 15, 2012. Presentation to the house public health committee on delivery of dental services in medicaid.

Medicaid contracts, implementation of a quarterly random sampling of TMHP approved orthodontia prior authorizations to assess accuracy of claims, review of the policy for orthodontia reimbursement in regards to the severity and number of visits per year, requiring full-cast dental models submission for authorization, and limiting Medicaid orthodontia services to board certified and board-eligible orthodontists. Mr. Chris Traylor reports TMHP has received no new requests for orthodontia services since the transition to managed care on March 1, 2012.⁷¹ Texas Health and Human Services Commission continues to redefine the definition of Orthodontic Medical Necessity, recruit new orthodontic providers in potential low access-to-care areas, encourage current providers to continue client treatment and referring those that decline to the licensure board, and encourage new providers to accept transfer cases.⁷² HHSC should continue to revise their policies and contract with TMHP to clarify future liability and to avoid future preventable events with TMHP and future contractors.

To ensure the trust of taxpayers, the new policies and contracts should reflect accountability and communication between HHSC and the contractors for clear delegation of duty. HHSC should provide clear rules for TMHP and the new managed care providers, DentaQuest, and MCNA to follow and implement while actively maintaining oversight and enforcing new policies.

Additionally, dental providers were found manipulating the system for improper utilization. The report from the Committee on Oversight and Government Reform stated, "in 2010 several individual orthodontists in Texas billed the Medicaid program for an amount greater than the entire state of Florida spent on orthodontics through Medicaid that year."⁷³ HHSC should develop clear rules for providers to follow in addition to their new safeguard data analysis system to detect high utilization trends among providers.

The Texas Health and Human Services Commission should work in collaboration with DMOs to contact Medicaid orthodontic patients that were abandoned by their previous provider to ensure every patient has a follow-up plan.

As a result of the on-going investigations regarding orthodontic fraud, many patients have been abandoned from their course or care. Some patients have been transferred to other orthodontists, while some have been completely abandoned. Currently, the dental maintenance organizations (DMO) are responsible for reviewing individual cases then deciding whether the care will be continued or not. Dentists providing orthodontia services to patients that were not medically necessary will be responsible for the patient's continuation of care. Providers who do not comply will be referred to the Texas Office of Inspector General and the Texas State Board of Dental Examiners for further disciplinary action. In addition, HHSC has developed a payment option (CDT code D8999) to encourage new providers to accept transfer cases.

⁷¹ Ibid.

⁷² Ibid.

⁷³ Koppel, N. (August 19, 2012). Texas drills down on medicaid dental fraud. Retrieved from <http://online.wsj.com/article/SB10000872396390444233104577591243154716520.html>

HHSC and the DMOs should inform the patients with discontinued care of the current situation and how to proceed forward. To ensure the safety of the abandoned patients, HHSC in collaboration with DMOs, DentaQuest, and MCNA should contact every patient with a follow-up plan to the treatment.

HB 300

Advances in health information technology have developed quickly in recent years, allowing for improved patient health information (PHI) record keeping and tracking, easier accessibility for patients, and a reduction in medical errors. However, this has also opened the door for increased patient susceptibility to illegal access, selling, hacking, and sharing of PHI. Recent media reports on ABC News have exposed this ongoing crisis by illustrating how at the click of a button, patient information can be purchased for as little as \$14. In addition, the investigations show that the illegal release of PHI often begins within some part of the healthcare chain.⁷⁴

On June 17, 2011, HB 300 was signed into law to further protect PHI and provide administrative, civil, and criminal penalties in the case of a breach. The law has since been implemented and gone into effect beginning September 1, 2012. Throughout the implementation process, the House Committee on Public Health has received updates on what organizations and stakeholders have encountered. At the January 24, 2012 hearing, the House Committee on Public Health heard from the Health and Human Services Commission (HHSC), Texas Department of Insurance (TDI), Texas Office of e-Health Coordination, and Texas Health Services Authority (THSA). Each reported that the implementation process has gone relatively smoothly. However, there has been concern over who will provide the health privacy training and what level of training is appropriate. The media and other stakeholders have also expressed concerns over the definition of "covered entities," contending that the definition is too expansive. It must be noted that HB 300 did not change the definition of covered entities under HIPAA and the Texas Health and Safety Code. Section 181.001 of the Texas Health and Safety Code has and continues to define covered entities as any person who:

- “(A) For commercial, financial, or professional gain, monetary fees, or dues, or on a cooperative, nonprofit, or pro bono basis, engages, in whole or in part, and with real or constructive knowledge, in the practice of assembling, collecting, analyzing, using, evaluating, storing, or transmitting protected health information. The term includes a business associate, health care payer, governmental unit, information or computer management entity, school, health researcher, health care facility, clinic, health care provider, or person who maintains an Internet site;
- (B) Comes into possession of protected health information;
- (C) Obtains or stores protected health information under this chapter; or
- (D) Is an employee, agent, or contractor of a person described by Paragraph (A), (B), or (C) insofar as the employee, agent, or contractor creates, receives, obtains, maintains, uses, or transmits protected health information.”

As the law continues to be implemented, the process is being closely monitored to ensure compliance and a successful transition with the Texas Medical Association (TMA) and other agencies. In addition, greater clarity to health privacy training guidelines should be considered to ensure that agencies and affected entities are properly trained and informed.

⁷⁴ Avila, J. (2012, September 13) Your medical records may not be private: abc news investigation. *ABC News*. Retrieved from <http://abcnews.go.com/Health/medical-records-private-abc-news-investigation/story?id=17228986>

STATE HOSPITAL SAFETY

On January 24, 2012, the Committee received testimony to address the concerns of patient safety at state hospitals due to the lack of interagency communication. Dr. David Lakey, Executive Commissioner of the Department of State and Health Services (DSHS) provided testimony on the challenges the Department has faced to protect and deliver safe care to vulnerable patients. DSHS continues to work diligently with the Legislature, the Health and Human Services Commission, the Department of Family and Protective Services (DFPS), the Medical Board and law enforcement authorities to provide transparency and improve safety to patients.

Recent events involving criminal investigation, led DSHS to review policies and identify critical areas within their own department and the Mental Health Hospital Systems to be revised and improved to protect and ensure the safety of patients in hospitals. DSHS implemented immediate changes to prevent future cases of abuse while continuing to identify issues and work on recommendations for future guidance and approval from the Legislature. These changes include but are not limited to: maintaining adult protective service facility investigation records for 20 years instead of 5, having DSHS and DFPS review previous cases of employees with 2 or more allegations of sexual abuse or exploitation, establishing guidelines for investigations of multiple allegations of client abuse/neglect, reviewing policies and practices related to the dispensation of staff with allegations of Class I abuse, installing windows in treatment rooms, and evaluating the possibility of video cameras in hospitals.⁷⁵

⁷⁵ Dr. David Lakey, DSHS, Presentation to House Committee on Public Health, 2012.

TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM

In December 2011, the Center for Medicare and Medicaid Services (CMS) approved the Texas Health Care Transformation and Quality Improvement Program ("Transformation Waiver") under Section 1115 of the Social Security Act. The innovative Transformation Waiver provides \$29 billion over 5-years and expires on September 30th, 2016 allowing Texas to "expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements and directs more funding to hospitals that serve large numbers of uninsured patients."⁷⁶

The Transformation Waiver redirects the supplemental payments that currently exist under Medicaid by transforming the Upper Payment Limit (UPL) program into the Uncompensated Care (UC) pools and the Delivery System Reform Incentive Payment (DSRIP). The UC pool will pay hospitals based on uncompensated care costs, rather than charges. The DSRIP pool is designed to incentivize activities that support hospitals' collaborative efforts to improve access to care and health of patients and their families.⁷⁷ Under DSRIP, public entities that contribute intergovernmental transfers (IGTs) will lead Regional Healthcare Partnerships (RHPs). RHPs will facilitate partnerships with public and private hospitals and local stakeholders to create coordinated health care delivery plans using waiver funding for system transformation. Twenty RHPs were formed with anchors administering reports and being the primary contact between HHSC and performing providers. The plan development, system improvement metrics and reporting will serve as the basis for accountable, effective investments in health care and related waiver payments.⁷⁸

During the 82nd Interim, the House Committee on Public Health held three public hearings⁷⁹ to monitor the implementation and progress of the Transformation Waiver. On October 15, 2012, the Committee received testimony from HHSC, eight RHPs from across the state and stakeholders sharing their success stories and challenges planning for and implementing the waiver.

There has been mixed reports of RHPs level of involvement with the community. Katrina Lambrecht, Vice President and Chief of Staff for the University of Texas Medical Branch, representing Region 2, observed strong state leadership in support of the waiver and high levels of collaboration between all partners. Ms. Lambrecht also commended the Transformation Waiver on how the required community needs assessment has helped shape the discussion for improvement of health and the transparency in the HHSC planning process. Mr. Mike

⁷⁶ Texas Health and Human Services. (2011). Texas gets approval or cost-saving medicaid improvements. Retrieved from http://www.hhs.state.tx.us/news/release/121211_Medicaid-Improvements.shtml

⁷⁷ M. Tavenner. (December 12, 2011). Approval letter to Mr. Billy Millwee and HHSC. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/TexasHealthcareTransformationandQualityImprovementProgramCurrentApprovalDocuments.pdf>

⁷⁸ Texas Health and Human Services. (2011). Texas health care transformation and quality improvement program, 1115 waiver. Retrieved from <http://www.hhsc.state.tx.us/Program-Brief-080411.pdf>

⁷⁹ The House Committee on Public Health held hearings on January 24, May 15, and October 15, 2012.

Campbell, Chief Executive Officer of La Esperanza Health and Dental Centers, testified on behalf of the Texas Association of Community Health Centers regarding the challenges community health centers has faced regarding their participation in the Transformation Waiver. While some community health centers have been successful in forming partnerships with RHPs, some have been excluded entirely. Mr. Campbell shared his concerns regarding community health centers and their lack of involvement in RHP plans stating, "in some regions of the state, performing providers and anchor entities have not given health centers a seat at the table."⁸⁰ This issue raises concern, considering the Transformation Waivers intent is to facilitate community involvement to improve health care delivery. Regional Health Partnership plans should reflect the needs of the community and involve local stakeholders to coordinate the care.

There is, however, a general consensus among many of the RHPs. They agreed that the short HHSC timelines and lack of IGTs have created many challenges in the planning process. Ms. Angie Alaniz, Project Director for RHP 17, testified to the Committee that delays and adjustments made to the issuance of the final planning protocol and timeline has created difficulty in standing firm with "regional due dates of projects, affiliation agreements, and even the finalization of funding commitments." This has made it difficult to keep stakeholders and healthcare providers engaged in the waiver process. The lack of IGT funds has also been a barrier for many RHPs. For example, Dr. Kirk Calhoun, President of the University of Texas Health Science Center at Tyler, discussed that the biggest challenge his region (Region 1) faces is a lack of IGT funds for match. The majority of the hospital beds in Region 1 are owned or controlled by private hospitals; but because IGT funds must be non-federal public dollars, there is limited access to IGT for the region. Ms. Lambrecht spoke on this concern, as well, stating that Region 2 has had difficulty finding sufficient IGT match to support participation by private providers in UC and DSRIP.

In addition, some RHPs have expressed concerns over whether the IGTs that counties provide will be countable toward the 8 percent threshold and how changes to DSH funding will disproportionately affect private hospital and providers. This threshold is required for the county to receive state financial assistance. As of November 20, 2012, HHSC has reported that there has not yet been a decision on whether the IGTs will count toward the 8 percent threshold. The agency plans to submit a request and opinion from the Office of the Attorney General; however, stated that each county will need to decide whether to use some of their 8 percent based on their risk tolerance.⁸¹ Concerns over the changes in DSH funding stem from the disproportionately large number of care provided to Medicaid patients from private hospitals and providers.

HHSC imparted to the Committee that about 79 percent of all hospitals in Texas are non-public hospitals. Furthermore, 75 percent of all hospital services provided to Medicaid patients were from non-public hospitals in 2010. Mr. Michael Zucker, Chief Development Office for Vanguard Health Systems testified at the October 15 hearing that he is concerned about the future of private hospitals in response to the expected reduction in DSH funding and limited

⁸⁰ Cambell, M. (October 15, 2012). Testimony to the public health committee. Retrieved from <http://www.legis.state.tx.us/tlodocs/82R/handouts/C4102012101509001/e952a143-516c-41dc-b8c9-648efbcf5c9c.PDF>

⁸¹ HHSC. (November 20, 2012). [Email correspondence from Marisa d. Luera.]

opportunities within the Transformation Waiver. Mr. Zucker illustrated that in 2011, Texas provided roughly \$600 million in DSH funds to help over 100 private hospitals defray its costs; however, these hospitals are expected to receive only \$170 million for 2012. Private hospitals contribute largely to the care of Texas citizens, especially those that administer the bulk of healthcare services to Medicaid patients and operate in areas with a high number of low income and needy individuals.⁸² This is may result in great consternation if private hospitals are unable to remain in a viable and financially sustainable position.

While the Transformation Waiver provides the state an opportunity to transform the delivery system for health care to facilitate regional collaboration, there were many concerns that were raised by the Committee Members at the October 15 hearing. Lisa Kirsch, Deputy Director Health Care Transformation Waiver at HHSC, testified HHSC is expected to receive between 1,000 to 2,000 DSRIP plans. HHSC has designated a direct team of 10 staff members with additional staff members from different departments to review and approve the plans before they are submitted to CMS. However, Members of the Committee were greatly concerned that HHSC did not have the capacity to review all the plans, adequately assess whether the plans address community needs, assess cost saving measures for the state, and build the infrastructure and adequate workforce to monitor and regulate \$29 billion. Compounding these problems are HHSC's short review and pre-approval timeframe for projects. The team is expected to review and preapprove nearly \$30 billion worth of state health plans within 30 days before forwarding them to CMS. Additionally, CMS found that California's Waiver protocols were not detailed enough and eventually paid for services that should not have been funded. HHSC should prevent such unfortunate events from occurring in Texas.

Another issue of concern Members of the Committee raised was the dual role of the anchors. Some of the performing providers also serve as the anchor for the region. The anchor is responsible for administrative reports and being the main contact between HHSC and performing providers. Members were concerned that there may not be enough oversight or regulation over some of the anchors that are also the performing providers in the region from controlling the waiver money and projects. In other words, they are both in charge of receiving and distributing project funds. Anchors receive projects and are informed to forward them along to HHSC for approval; however, there is little regulation.

Since the approval by CMS, HHSC and waiver participants have worked diligently in planning for and implementing the new innovative waiver under limited time constraints. However, it must be noted that the concerns raised must be evaluated and addressed to ensure an effective implementation.

⁸² Zucker, M. (October 15, 2012). Testimony to the committee on public health. Retrieved from <http://www.legis.state.tx.us/tlodocs/82R/handouts/C4102012101509001/36581f39-7ca5-490a-8c8a-be472d53fdc2.PDF>

COMMITTEE MEMBER LETTERS

STATE of TEXAS
HOUSE of REPRESENTATIVES



GARNET F. COLEMAN

STATE REPRESENTATIVE
DISTRICT 147

December 18, 2012

Re: House Committee on Public Health Report

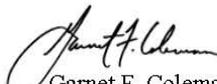
Allow me to begin by expressing what an honor it is to serve on the House Committee on Public Health with Chair Kolkhorst and the other members of the committee. I am attaching my signature to the Committee's Report, but I do disagree with some of the language and want to ensure that my signature is not construed to be an endorsement of that language.

First, I am hesitant to fully endorse the recommendation that the Texas Legislature pass a resolution requesting "comprehensive reform" of both the Medicaid and Medicare programs "to ensure the future solvency of both programs." My concern with this language is not because I am opposed to any entitlement reform; rather, it is because this is the same language that has previously been used to justify past "reforms" to which I am strongly opposed: namely, block granting Medicaid and turning Medicare into a "voucher" or "premium support" model.

Second, my views are not completely in line with those expressed in the recommendation that SNAP be reformed in a way to allow the "pre-loading" of "acceptable" food items. While I share the goals contained in the committee report regarding a healthier Texas, I would prefer to see healthy eating encouraged in ways that do not involve making decisions for needy families. I am especially concerned that excluding items from SNAP benefits will negatively affect families in ways we might not intend, such as making it harder for families to purchase enough food.

I therefore kindly request that these concerns be attached with my signature to the report. I want to again thank Chair Kolkhorst and the other members of the committee for their rigorous efforts over the interim, and I look forward to working with everyone to ensure that we enact the best policy for Texas.

Sincerely,


Garnet F. Coleman
District 147


Carol Alvarado
District 145

The State of Texas
House of Representatives

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Bobby Guerra
STATE REPRESENTATIVE
DISTRICT 41

December 20, 2012

RE: House Committee on Public Health Interim Report

I would like to begin by saying that my short time serving with Chair Kolkhorst and the other members of the House Committee on Public Health has been both a great honor and opportunity. I look forward to working with each of these members in the future. I will attach my name to the Committee's Interim Report but I do have suggestions and comments in line with those voiced by Representative Garnett Coleman.

Therefore, I respectfully ask that along with my signature on the Committee's Interim Report, my name also be attached to the concerns voiced by Representative Garnett Coleman. Again, I would like to thank Chair Kolkhorst and the members of the Public Health Committee for their rigorous efforts in shaping sound policy and I look forward to working with the committee in the future to build a better Texas.

Sincerely,

A handwritten signature in black ink, appearing to read "Bobby Guerra".

R.D. "Bobby" Guerra

