

REFORM HEALTHCARE PAYMENT AND DELIVERY SYSTEMS TO REDUCE STATE EXPENDITURES

LBB RECOMMENDATIONS

1 Amend statute to create a committee to prioritize statewide healthcare cost and quality outcomes and related measurement methodologies.

2 Amend statute to authorize certain hospital-physician relationships.

3 Include a contingency rider providing \$900,000 in General Revenue to fund pilot programs to test payment and delivery system reform pilots.

Recommendations 1 and 2 require statutory change. The introduced 2012–13 General Appropriations Bill includes a contingency rider implementing Recommendation 3.

These recommendations would not have a net fiscal impact for the 2012–13 biennium. They would encourage innovation and the testing of new payment and delivery reform models that could improve healthcare quality and reduce state costs.

Cost containment and quality improvement are two of the greatest challenges confronting the U.S. healthcare system. The fee-for-service reimbursement methodology, used by Medicare; Medicaid; some private payers; and managed care organizations, contributes to these cost and quality problems. Many promising payment and delivery reform models seek to change the way healthcare is purchased and delivered in an attempt to reduce costs and improve quality, and many demonstration and pilot programs are occurring nationwide to test their effectiveness. The federal government and some states have provided leadership to encourage this experimentation.

Statewide leadership in Texas is needed to provide a vision and set priorities for improved health outcomes and eliminate barriers to private sector experimentation. Creation of the committee recommended in this report would facilitate identification of desired outcomes for reform and improve communication among state health purchasing agencies. Authorizing the formation of certain hospital-physician relationships and providing funds to test payment and delivery reform pilot programs would eliminate some of the barriers to private sector innovation.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 193.

FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2012 TO 2016

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS—INSURANCE COMPANIES MAINTENANCE TAX AND INSURANCE DEPARTMENT FEES	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS—INSURANCE COMPANIES MAINTENANCE TAX AND INSURANCE DEPARTMENT FEES	PROBABLE CHANGE IN FULL-TIME-EQUIVALENT POSITIONS FROM THE 2010–11 BIENNIUM
2012	\$350,000	(\$350,000)	1
2013	\$550,000	(\$550,000)	1
2014	\$0	\$0	0
2015	\$0	\$0	0
2016	\$0	\$0	0

SOURCE: Legislative Budget Board.

IMPLEMENTATION OF AN ALL-PAYER CLAIMS DATABASE IN TEXAS

LBB FACTS AND FINDINGS

- ◆ Existing healthcare data available to most states is limited.
- ◆ APCDs are a tool for states to use in understanding healthcare quality and cost issues across the state's population and in designing and monitoring healthcare reform initiatives.
- ◆ As of September 2010, eight states have state-administered APCDs in operation, four are developing them, and three have non-state administered systems.
- ◆ Texas does not have an APCD.
- ◆ The Texas Department of State Health Services collects APCD discharge data that could provide the foundation for an APCD.

This report does not include any recommendations. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of this report.

This report would not have a fiscal impact for the 2012–13 biennium. The report provides information on all-payer claims databases which would help Texas identify opportunities for cost containment and quality improvement across state health programs and support payment and delivery system reforms.

Robust data on healthcare costs, utilization, and outcomes provides the foundation necessary to implement payment and delivery system reforms that seek to contain healthcare costs and improve quality of care. One tool that states have developed to support reforms is an all-payer claims database (APCD). This database is typically established by legislative mandate, and includes health insurance claims data from medical, eligibility, provider, pharmacy, and dental files provided by public and private insurers.

Texas does not have an APCD. Access to the comprehensive data collected by an APCD would be beneficial to healthcare payers in Texas, providers, researchers, and the public.

Prior to implementation, several logistical issues would need to be addressed including securing funding and determining how to access data on populations and from sources that have not traditionally been included in other state's APCDs but potentially represent large segments of the Texas population.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 205.

REDUCE MEDICAID COSTS THROUGH BUNDLED PAYMENTS

LBB RECOMMENDATIONS

1 Include a rider requiring HHSC to implement a bundled payment initiative, including use of shared savings, with providers in the Texas Medicaid Program.

2 HHSC should apply for any federal funding that becomes available for bundling pilots during the 2012–13 biennium.

The introduced 2012–13 General Appropriations Bill includes a rider implementing Recommendation 1.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would allow the state to test the feasibility of payment reform in the Medicaid program and determine whether savings could be realized.

The fee-for-service payment methodology, a predominant healthcare payment system, is an obstacle in addressing many of the cost drivers in healthcare including medical errors; preventable hospital readmissions; and chronic disease management. The methodology incentivizes increased volume of services rather than quality outcomes or care coordination. Previous experiments with cost containment and quality reforms in the Texas Medicaid Program did not overcome the underlying incentives of the fee-for-service system and have not had a significant impact on cost and quality as intended.

Bundled payments are episode-based payments that help align the interests of hospitals and physicians, and encourage the provision of services not currently compensated by the fee-for-service system. Payment reform options including bundled payments offer an opportunity to alter provider incentives and encourage efficient delivery of care. As part of a strategy to further healthcare payment and delivery system reforms in Texas, the Texas Medicaid Program should implement a bundled payment initiative that includes use of shared savings with providers assuming providers achieve quality outcome measures.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 213.

REPEAL THE PROHIBITION OF HEALTH MAINTENANCE ORGANIZATIONS IN MEDICAID IN SOUTH TEXAS

LBB RECOMMENDATION

1 Amend statute to repeal the prohibition of the use of health maintenance organizations in Medicaid in Cameron, Hidalgo, and Maverick counties.

This recommendation requires statutory change. The introduced 2012–13 General Appropriations Bill includes adjustments that are contingent upon implementation of this recommendation.

The recommendation would not have a direct fiscal impact for the 2012–13 biennium. If the prohibition is repealed and HHSC expands managed care in south Texas, the fiscal impact to the state would depend on multiple variables such as the date of implementation, the specific service delivery models implemented, the regions covered, the populations served, and the caseload and costs funded in the General Appropriations Act.

Medicaid managed care was first implemented in Texas in the early 1990s. Since then, the use of managed care and capitated service delivery has increased in Texas' Medicaid program. In fiscal year 2009, 71 percent of Texas Medicaid clients were served through some form of managed care representing 68 percent of total client service cost.

For the 2012–13 biennium, the Health and Human Services Commission has proposed further expansion of managed care. However, the use of health maintenance organizations within the Medicaid program is statutorily prohibited in Cameron, Hidalgo, and Maverick counties. Repealing the prohibition would expand the service delivery options available in these counties and make them consistent with the rest of the state. This would allow the Health and Human Services Commission to determine and implement the most cost-effective service delivery model to serve Medicaid clients in all areas of the state.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 221.

ENSURE TRANSPARENCY AND ACCOUNTABILITY FOR PROPOSED MEDICAID DENTAL MANAGED-CARE SERVICES

LBB RECOMMENDATION

1 Include a rider requiring HHSC to submit findings to the Governor and the Legislative Budget Board on the impact of providing dental services through a managed-care model on access, quality, and cost outcomes. This requirement is contingent on HHSC changing from a fee for service model to a capitated rate model for Medicaid dental services.

The introduced 2012–13 General Appropriations Bill includes a rider implementing this recommendation.

This recommendation would not have a fiscal impact for the 2012–13 biennium. It would provide data to monitor the impact of a new service delivery model on quality of dental services provided to Medicaid clients.

In fiscal year 2009, 2.4 million Medicaid clients in Texas were eligible to receive dental services on a fee-for-service basis. From fiscal years 2005 to 2009, total spending on Medicaid dental services increased by 165 percent. Based on the STAR Health managed-care experience, a program comparable to the Medicaid fee-for-service program in terms of population covered and services provided, moving Medicaid dental services to a capitated managed-care model has the potential for cost savings. The Texas Health and Human Services Commission (HHSC) estimates that the state could save \$101.6 million in General Revenue Funds for the 2012–13 biennium if dental services were provided through a capitated managed-care model. While there are potential savings associated with managed care, the impact of providing Medicaid dental services through a capitated managed-care model should be evaluated to ensure that quality care is provided and expected cost savings are achieved.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 227.

REDUCE THE NEED FOR EMERGENCY ROOM UTILIZATION IN THE MEDICAID PROGRAM

LBB RECOMMENDATIONS

1 Include a rider requiring HHSC to evaluate whether the cost of the physician incentive programs implemented by health maintenance organizations participating in the Texas Medicaid program has been offset by reduced use of the emergency room and submit a report on the evaluation findings to the Governor and the Legislative Budget Board by August 31, 2012.

2 Amend statute to require HHSC to implement a cost-effective physician incentive program throughout the Texas Medicaid program.

3 Include a rider requiring HHSC to determine the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers and submit a report on the findings to the Governor and the Legislative Budget Board by August 31, 2012.

4 Include a rider requiring HHSC to use financial incentives and disincentives to encourage health maintenance organizations participating in the Medicaid STAR and STAR+PLUS managed care programs to reduce non-emergent use of the emergency room among their clients.

The introduced 2012–13 General Appropriations Bill includes a rider implementing Recommendations 1, 3, and 4. Recommendation 2 requires statutory change.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They could result in savings in the Texas Medicaid program by reducing non-emergent use of the emergency room.

Medicaid clients use the emergency room for conditions that could be treated in a primary care setting, such as a doctor's office or clinic. Treatment for these non-emergent conditions in the emergency room costs more than if this care is delivered in a primary care setting. Redirecting clients with non-emergent conditions from the emergency room to the primary care setting could result in potential savings of \$184.2 million in All Funds per year. In an effort to reduce Medicaid spending, the Texas Health and Human Services Commission (HHSC) should implement efforts to reduce non-emergent use of the emergency room, including implementing a cost-effective physician incentive program throughout the Texas Medicaid program, determining the feasibility of enrolling urgent care centers as Medicaid clinic providers, and encouraging health maintenance organizations in Medicaid managed care to reduce non-emergent use of the emergency room among their clients.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 233.

IMPLEMENT AN OBJECTIVE CLIENT ASSESSMENT PROCESS FOR ACUTE NURSING SERVICES IN THE TEXAS MEDICAID PROGRAM

LBB RECOMMENDATION

1 Amend statute to require HHSC to implement an objective client assessment process for acute nursing services provided to Texas Medicaid clients.

This recommendation requires statutory change. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of this recommendation.

This recommendation would not have a fiscal impact for the 2012–13 biennium. It could reduce inappropriate allocation of nursing services and result in savings in the Texas Medicaid program.

The Texas Health and Human Services Commission (HHSC) lacks an objective, independent process for assessing the acute nursing needs of Texas Medicaid clients enrolled in fee-for-service or the non-capitated managed care model known as Primary Care Case Management. Specifically, the providers contracted by HHSC to assess a client's acute nursing needs also deliver those services, resulting in a potential conflict of interest. Also, the agency requires that the client assessment conducted by providers include certain elements, such as an evaluation of the client's health, but does not require that the providers use a standard form to assess client needs. As a result, there is potential for providers to recommend an inappropriate amount of nursing services. Furthermore, Medicaid claims administrators may not detect inappropriate service requests because the information they use to authorize the amount of nursing services is primarily supplied by providers contracted to deliver those services. Additionally, some of the health maintenance organizations participating in Medicaid managed care have not implemented an objective, independent process for assessing acute nursing needs.

Requiring HHSC to implement an objective client assessment process for acute nursing services provided to Texas Medicaid clients could help ensure that clients with acute nursing needs are allocated appropriate amounts of nursing services by removing any conflict of interest that may result from having the same entity both complete client assessments and deliver services. To the extent that implementing an objective client assessment process reduces inappropriate allocation of nursing services, there could be cost savings to the Texas Medicaid program.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 243.

INCREASE THE USE OF TELEMONTORING IN THE TEXAS MEDICAID PROGRAM TO IMPROVE PATIENT OUTCOMES

LBB RECOMMENDATIONS

1 Amend statute to require HHSC to include telemonitoring in the THMP for select diabetes patients if the current diabetes telemonitoring pilot program is cost-neutral. If it is not, then HHSC must determine the feasibility of implementing a new, cost-effective diabetes telemonitoring pilot within the THMP.

2 Amend statute to require HHSC to determine the feasibility of adding a new pilot to the THMP for conditions other than diabetes.

3 Amend statute to require HHSC to identify successful telemonitoring strategies implemented by Medicaid HMOs and share information on them with other such providers.

4 Include a contingency rider requiring HHSC to report on their progress implementing Recommendations 1 through 3.

Recommendations 1, 2, and 3 require statutory change. The introduced 2012–13 General Appropriations Bill includes a rider implementing Recommendation 4.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would allow the state to assess the potential for using telemonitoring to improve patient outcomes and reduce health care costs in the Texas Medicaid program.

“Telemonitoring” refers to the remote monitoring of patients, most often at their homes, by healthcare providers. Used effectively, telemonitoring can improve patient care and reduce the rate of costly complications from chronic illnesses or other conditions. The Texas Medicaid program does not reimburse providers for telemonitoring, and it is being used in only one Medicaid managed care organization.

While patient health benefits from telemonitoring have been somewhat consistent, the cost-effectiveness of this service depends heavily on program design. To determine the best approach for the state Medicaid program, the Texas Health and Human Services Commission (HHSC) should further pilot the use of telemonitoring within the Texas Health Management Program (THMP) and should ensure that cost-effective telemonitoring services employed by Medicaid health maintenance organizations (HMOs) are shared among all such providers. If well designed, increased use of telemonitoring could improve client outcomes and reduce Medicaid spending on more costly care.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 249.

2011 UPDATE ON A NEW SUBSTANCE ABUSE TREATMENT BENEFIT FOR ADULT MEDICAID CLIENTS

LBB FACTS AND FINDINGS

- ◆ HHSC began implementing a new Medicaid substance abuse treatment benefit on September 1, 2010, with full implementation scheduled for January 2011.
- ◆ The new benefit is available to adults enrolled in fee-for-service as well as the non-capitated Primary Care Case Management program, and the capitated STAR and partially-capitated STAR+PLUS managed care programs.
- ◆ Covered substance abuse treatment services include: assessment, outpatient detoxification, outpatient counseling, medication assisted therapy, and residential treatment services.
- ◆ For fiscal year 2011, HHSC estimates the total cost to provide Medicaid-funded substance abuse treatment services to adult clients is \$7.6 million in All Funds.
- ◆ The Legislative Budget Board is evaluating the new Medicaid substance abuse treatment benefit to determine its cost-effectiveness and will issue a report to the Eighty-third Legislature in 2013.

The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of this report.

This report would not have a fiscal impact for the 2012–13 biennium. It provides an update on implementation of new substance abuse treatment benefits for adult Medicaid clients.

Senate Bill 1, Article IX, Section 17.15, Eighty-first Legislature, Regular Session, 2009, directed the Texas Health and Human Services Commission (HHSC) to use existing Medicaid funds to implement a comprehensive Medicaid substance abuse treatment benefit for adults beginning January 1, 2010, but allowed the agency to delay implementation pending federal approval. The legislation assumed that the cost to provide comprehensive substance abuse treatment to Medicaid adults would be offset by reductions in other Medicaid spending in the same year that treatment services are provided. These reductions are expected due to declines in the use of acute care medical services for clients receiving substance abuse treatment. This report provides an update on implementation of the new Medicaid substance abuse treatment benefit.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 255.

CONTINUE AND EXPAND THE TEXAS MEDICAID WOMEN'S HEALTH PROGRAM TO MAXIMIZE FEDERAL FUNDS AND STATE SAVINGS

LBB RECOMMENDATIONS

1 Amend statute to require HHSC to seek a waiver extension for the Medicaid Women's Health Program.

2 Amend statute to expand program eligibility.

3 Amend statute to require HHSC to establish an outreach campaign about the program directed at women covered by Medicaid before their post-partum coverage expires.

4 Include a contingency rider in the 2012–13 General Appropriations Bill that would reduce funding for strategy B.1.3, Pregnant Women, reduce funding for strategy B.1.4, Children and Medically Needy, and increase funding for strategy B.2.4, Medicaid Family Planning.

These recommendations require statutory action and an appropriation increase and decrease in the General Appropriations Bill. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of these recommendations.

These recommendations would save \$3.8 million in General Revenue Funds for the 2012–13 biennium and help contain pregnancy-related Medicaid costs.

The Texas Medicaid Women's Health Program avoids pregnancy-related Medicaid costs by providing preventative health screenings and family planning services to Texas women whose income and family size puts them below the level at which they would be eligible for Medicaid if they were pregnant. These preventative services cost much less than pregnancy services and the state pays for a smaller portion of them. The federal government pays for 90 percent of Women's Health Program services, and the state pays 10 percent.

Without an extension from the Centers for Medicaid and Medicare Services, the program will expire in December 2011. The current program eligibility threshold excludes potential clients whose income, if they were pregnant, would fall under 185 percent of the federal poverty level. Expanding program eligibility to include these potential clients would reduce the amount the state would otherwise be obligated to spend on pregnancy-related Medicaid services. Extending the program and expanding eligibility would save approximately \$3.8 million in General Revenue Funds for the 2012–13 biennium.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 259.

FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2012 TO 2016

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS		PROBABLE GAIN/(LOSS) IN FEDERAL FUNDS	PROBABLE SAVINGS/(COST) IN FEDERAL FUNDS	
2012	(\$216,618)		\$597,236	(\$1,949,558)		\$839,118
2013	(\$433,235)		\$3,896,842	(\$3,899,115)		\$5,261,423
2014	(\$438,867)		\$5,424,975	(\$3,949,803)		\$7,324,671
2015	(\$444,572)		\$4,620,024	(\$4,001,151)		\$6,237,847
2016	(\$450,352)		\$4,682,075	(\$4,053,166)		\$6,321,626

SOURCE: Legislative Budget Board.

IMPLEMENT A MEDICATION THERAPY MANAGEMENT PILOT PROGRAM IN MEDICAID

LBB RECOMMENDATIONS

1 Include a rider requiring HHSC to spend up to \$170,000 in General Revenue Funds from appropriated amounts to establish a MTM Pilot Program.

2 Include a rider requiring HHSC to conduct a study to determine the effectiveness of the MTM Pilot Program and submit a report to the Governor and the Legislative Budget Board by December 1, 2012.

The introduced 2012–13 General Appropriations Bill includes a rider implementing these recommendations.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They could result in reduced spending from adverse drug events in the Texas Medicaid Program.

The Texas Health and Human Services Commission (HHSC) estimates that the Texas Medicaid Program spent \$17.9 million on medication-related adverse events for all Medicaid clients in fiscal year 2009. Medication therapy management (MTM) is a patient-centered service that seeks to improve the quality of medication use and results among patients who are at high risk of having adverse reactions from medications. A MTM Program in the Minnesota Medicaid Program realized savings that exceeded the cost of providing services by more than 2 to 1. Implementing a MTM Program in the Texas Medicaid Program could reduce adverse drug events, overall healthcare spending, and save state funds.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 267.

A COMPARISON OF BEHAVIORAL HEALTH DATA ACROSS NORTHSTAR AND OTHER SELECTED SERVICE DELIVERY AREAS

LBB RECOMMENDATIONS

1 Include a rider requiring DSHS to improve the measurement, collection, and reporting of behavioral health client outcome data.

2 Include a rider directing DSHS to submit a report on efforts planned or implemented to improve the measurement, collection, and reporting of behavioral health client outcome data to the Governor and the Legislative Budget Board by December 1 of each year of the biennium.

3 Include a rider directing DSHS, in consultation with the Texas Health and Human Services Commission, to conduct a comparative analysis of publicly funded behavioral health systems in Texas that serve medically indigent persons and Medicaid clients, and submit a report on the study's findings to the Governor and the Legislative Budget Board by December 1, 2012.

The introduced 2012–13 General Appropriations Bill includes a rider implementing these recommendations.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would improve the accuracy of data available to evaluate the outcomes of behavioral health services provided by NorthSTAR and other delivery models in Texas.

The Texas Department of State Health Services (DSHS) contracts with 38 local mental health authorities and more than 200 substance abuse treatment providers to ensure the provision of behavioral health services to persons in crisis, Medicaid clients, and medically indigent persons living in communities across Texas. Medicaid clients may also receive behavioral health services through other behavioral health providers contracted with the Texas Medicaid program. Medicaid clients and medically indigent persons who meet eligibility criteria residing in the seven-county service delivery area surrounding Dallas receive all behavioral health services through NorthSTAR—a publicly funded managed care program.

Behavioral health process indicators related to spending, utilization, and level and amount of care, comparing NorthSTAR to other selected service delivery areas, are mixed or unknown. Furthermore, inadequate measurement of behavioral health client outcomes prevents the state from determining NorthSTAR's overall effectiveness relative to the rest of the state. Improving the measurement and reporting of behavioral health client outcomes could help ensure that services effectively meet client needs, thus reducing spending on more expensive types of care, and improve the state's ability to monitor program performance and make system improvements.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 275.

INCREASE ACCESS TO PRIMARY CARE SERVICES BY ALLOWING ADVANCED PRACTICE REGISTERED NURSES TO PRESCRIBE

LBB RECOMMENDATIONS

1 Amend statute to include advanced assessment, diagnosing, prescribing, and ordering in the scope of practice for APRNs.

2 Amend statute to require BON to adopt rules for assigning prescriptive authorization to a qualified APRN who has completed 3,600 hours of practice in a delegated prescriptive authority arrangement and to allow BON to establish a surcharge to cover the administration of tiered prescriptive authority.

3 Include a contingency rider in the 2012–13 General Appropriations Bill to appropriate surcharge revenue to BON to administer the tiered prescriptive authority.

These recommendations require statutory change. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of these recommendations.

These recommendations have no net fiscal impact in the 2012–13 biennium. They would increase the availability of primary healthcare providers in Texas.

Both nationally and in Texas, advanced practice registered nurses (APRNs) have helped mitigate the effects of a general practice physician shortage. APRNs are registered nurses with an advanced degree who have passed a national board certification exam and practice as one of four types of healthcare providers, in most cases with a focus on a defined population. They adhere to nationally accepted scope of practice models but are licensed and regulated at the state level.

Although APRNs practice as autonomous or nearly autonomous primary care providers in 20 states and the District of Columbia, Texas limits their authority to establish a diagnosis or prescribe medication. In Texas, an APRNs ability to diagnose and prescribe is delegated by a physician. State laws govern the conditions under which a physician delegates to APRNs. These conditions vary depending on the practice site location. This inconsistency limits patient access to qualified primary care providers and is especially onerous for APRNs and physicians in rural areas. Allowing APRNs to diagnose and prescribe up to the limits of their education and certification would allow them to provide lower-cost primary care for patients within their professional scope. Recommendation 2 would require the Board of Nursing (BON) to adopt rules for assigning an autonomous prescriptive authority for APRNs who have worked in a delegated prescriptive authority arrangement for two years.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 297.

FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2012 TO 2016

FISCAL YEAR	PROBABLE GAIN/(LOSS) TO GENERAL REVENUE FUNDS	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	CHANGE IN FULL-TIME-EQUIVALENT POSITIONS FROM THE 2010–11 BIENNIUM
2012	\$67,657	(\$67,657)	1
2013	\$60,692	(\$60,692)	1
2014	\$60,692	(\$60,692)	1
2015	\$60,692	(\$60,692)	1
2016	\$60,692	(\$60,692)	1

SOURCE: Legislative Budget Board.

INCREASE INFORMATION AVAILABLE ABOUT INTEREST LISTS FOR LONG-TERM CARE PROGRAMS

LBB RECOMMENDATIONS

1 Convert the existing performance measure on interest list size for each home and community-based waiver program from a non-key to a key performance measure.

2 Add a new key explanatory performance measure for each home and community-based waiver program with an interest list that would require DADS to report the number of persons who declined or were found to be ineligible for services offered in the past fiscal year.

3 Add a new key explanatory performance measure for each home and community-based waiver program with an interest list that would require DADS to report the average monthly number of persons on the interest list receiving services from other programs offered by the agency.

4 DADS should collect information on whether persons on interest lists who are receiving other department services have unmet needs.

The introduced 2012–13 General Appropriations Bill includes performance measures implementing Recommendations 1, 2, and 3.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would improve the information available to the Texas Legislature regarding the size of interest lists.

The Department of Aging and Disability Services (DADS) manages interest lists for several home and community-based services waiver programs. **Figure 1** shows the number of persons on each interest list, as of June 30, 2010. These lists identify persons who have expressed interest in receiving services that are currently unavailable due to limitations on the number of program participants.

FIGURE 1
INTEREST LIST BY WAIVER PROGRAM, AS OF AUGUST 31, 2010

WAIVER PROGRAM	NUMBER OF PERSONS ON INTEREST LIST
CBA	35,220
STAR+PLUS	5,288
CLASS	32,650
DB/MD	316
HCS	45,756
MDCP	18,404
Total	140,480
Unduplicated Total (without STAR+PLUS)	103,145

SOURCE: Department of Aging and Disability Services.

The agency reports the size of the interest lists to the Texas Legislature through performance measures, and this information is a primary method used by the Legislature to measure demand for community services and make appropriation decisions. However, information on the size of the interest lists is of limited use. The information does not take into account the number of persons who decline or are denied services once they become available. According to DADS, as of June 30, 2010, of the 15,902 persons released or removed from the interest lists for fiscal years 2010 and 2011, 8,878 were denied/declined (34.3 percent). In addition, current information does not reflect the number of persons who receive services from other DADS programs while they wait for waiver services. Of the 136,463 persons on the interest lists as of June 30, 2010, 30 percent (40,991) were receiving services from another DADS program.

Converting existing performance measures on the size of the interest lists to key measures and establishing new key performance measures to reflect the percentage of persons who receive services from other agency programs and the number of persons who declined or were found ineligible for services when they were offered would provide the Legislature with more complete information to use in making appropriation decisions about whether to expand the programs.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 303.

STRENGTHEN CERTIFIED NURSE AIDE TRAINING TO IMPROVE THE QUALITY OF LONG-TERM CARE

LBB RECOMMENDATIONS

1 Amend statute to increase the number of hours required for CNA certification from 75 hours to no less than 120 hours and no more than 359 hours.

2 Amend statute to require 12 hours of continuing education annually for CNA certification renewal.

3 Amend statute to require DADS to add an expiration date to each CNA certificate.

These recommendations require statutory change. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of these recommendations.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would improve the training and knowledge of certified nurse aides.

Nurse aides are direct-care workers who provide the bulk of bedside care, such as assistance with eating, bathing, housekeeping, and observing and reporting changes in a client's condition. Federal law requires nurse aides who work in nursing homes participating in Medicare or Medicaid to be certified. To become a certified nurse aide (CNA), candidates must complete a state-approved training program, pass a competency test, and be listed in the state's nurse aide registry. The Texas Department of Aging and Disability Services (DADS) administers the certification and regulation of CNAs.

During licensing inspections of Texas nursing homes nurse aides under observation have not been able to demonstrate the proper skills to care for patients. According to DADS, this was the fourth most frequently cited health code deficiency in fiscal year 2009 and raises questions about CNAs' abilities to provide adequate care to vulnerable populations. In November 2009, DADS formed the Certified Nurse Aide Stakeholder Workgroup to generate ideas and discussion as to how the agency could improve activities related to the training and regulation of CNAs within DADS' existing authority. The workgroup consisted of representatives from nursing facilities, home health agencies, hospitals, DADS regulatory staff, as well as CNAs and nurses. The workgroup recommended that DADS raise the minimum requirement of training hours and suggested the current CNA curriculum would need to be reviewed to determine the number of additional hours that would be appropriate to accommodate new or expanded topics.

Twenty-six states require more education than the federal standard. Texas requires the federal minimum of 75 hours, with 51 hours devoted to classroom training and 24 hours for practical or clinical training. Federal regulations also require nursing facilities to offer at least 12 hours of continuing education each year to CNAs, but there is no state or federal requirement for CNAs to attend continuing education as a condition to renew their certification. Without a requirement tying continuing education to the recertification process a regulatory gap exists. Increasing nurse aide training hours and strengthening the recertification process by requiring continuing education hours would help improve the quality of long-term care.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 315.

IMPROVE ABUSE REPORTING OF LICENSED PROFESSIONALS

LBB RECOMMENDATION

1 Include a rider directing DADS and DSHS to review their processes for reporting licensed professionals employed at state facilities who have committed confirmed acts of abuse to their respective licensing board and to report on actions taken to ensure the agencies are complying with statutory requirements.

The introduced 2012–13 General Appropriations Bill includes a rider implementing Recommendation 1.

This recommendation would not have a fiscal impact for the 2012–13 biennium. It would improve client safety and the reporting of confirmed acts of abuse by licensed professionals employed in state facilities.

Professional licensing boards ensure licensees comply with laws and regulations regarding competence and safe practice. Reports of misconduct to professional licensing boards are investigated and disciplinary action is taken, if warranted, to ensure the safety of clients regardless of where the licensed professional is employed. Employers of certain licensed professions, like nurses, are required by state law to report misconduct to the licensing board.

Despite a statutory requirement for state agencies to report misconduct by nurses to their licensing board, confirmed acts of abuse, neglect, and exploitation by nurses employed at state facilities are not reported consistently to the Texas Board of Nursing (BON). From fiscal year 2005 to August 2010, only 24 percent of nurses employed at state supported living centers and 33 percent of nurses employed at state hospitals who had committed a confirmed act of abuse at a state facility had been reported to BON. To improve reporting to state licensing boards, the Texas Department of Aging and Disability Services (DADS) and the Texas Department of State Health Services (DSHS) should identify gaps in policies and procedures that prevent consistent notification to state licensing boards about licensees who have committed confirmed acts of abuse and report actions taken to ensure each agency's compliance with statutory requirements to the Governor and Legislative Budget Board.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 321.

REGULATE URGENT CARE CENTERS IN TEXAS TO STANDARDIZE QUALITY OF CARE

LBB RECOMMENDATIONS

1 Amend statute to require DSHS to regulate urgent care centers and the use of related terminology and impose a fee to pay for the cost of regulation.

2 Include a contingency rider appropriating fee revenue for the regulation of urgent care centers to DSHS.

Recommendation 1 requires statutory change. The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of this report. Recommendation 2 requires a contingency rider.

These recommendations would generate \$22,618 in General Revenue Funds during the 2012–13 biennium, and would standardize the quality of care provided by urgent care centers and assist patients in selecting the appropriate provider for their medical care.

Alternative care delivery models to hospital-based emergency care and office-based primary care have emerged in Texas in recent years in response to consumer demand for increased convenience and access to care. A 2009 Legislative Budget Board report contained recommendations to regulate freestanding emergency medical centers and urgent care centers. The Eighty-first Legislature, 2009, enacted legislation to regulate freestanding emergency medical centers; however, as many as 300 urgent care centers in Texas remain unregulated and do not have to meet staffing, equipment, and facility requirements. This lack of standardization could cause patient harm because these facilities hold themselves out to the public as capable of providing varying degrees of urgent care, but may not be able to deliver the level of care patients expect. In addition, the Department of State Health Services (DSHS) receives complaints about urgent care centers, but lacks the authority to investigate them. Comprehensive complaint data regarding urgent care centers is unavailable.

Regulation of these facilities and use of related terminology by the DSHS would standardize the quality of care provided and assist patients in selecting the appropriate location to receive medical care.

The full text of this report can be found in the *Government Effectiveness and Efficiency* report (Legislative Budget Board, January 2011), page 325.

FIVE-YEAR FISCAL IMPACT, FISCAL YEARS 2012 TO 2016

FISCAL YEAR	PROBABLE GAIN/(LOSS) IN GENERAL REVENUE FUNDS	PROBABLE SAVINGS/(COST) IN GENERAL REVENUE FUNDS	PROBABLE CHANGE IN FULL-TIME- EQUIVALENT POSITIONS FROM THE 2010–11 BIENNIUM
2012	\$1,372,500	(\$1,575,360)	12.75
2013	\$915,000	(\$689,523)	7.5
2014	\$915,000	(\$689,523)	7.5
2015	\$915,000	(\$689,523)	7.5
2016	\$915,000	(\$689,523)	7.5

Source: Legislative Budget Board.

DECREASE THE NUMBER OF STATE SUPPORTED LIVING CENTERS TO REDUCE COSTS AND IMPROVE CARE

LBB RECOMMENDATIONS

- 1 Include a rider directing DADS to close at least one SSLC by May 31, 2013.
- 2 Include a rider requiring DADS to submit a closure plan.
- 3 Include a rider authorizing DADS to reclassify 1 full-time equivalent position to direct the closure process.
- 4 Include a rider requiring HHSC to certify and report the savings associated with the closure.
- 5 Amend statute to establish a commission on SSLC realignment.
- 6 Include a contingency rider reimbursing commission members' travel.

The introduced 2012–13 General Appropriations Bill includes riders implementing Recommendations 1, 2, 3, 4, and 6. Recommendation 5 requires statutory change.

These recommendations would save \$3.2 million to \$16.4 million in General Revenue Funds for the 2012–13 biennium, and would enable the state to concentrate resources on persons remaining in the system and redirect savings to expand community programs.

Texas' reliance on the institutional model of care for persons with intellectual and developmental disabilities persists despite 40-year nationwide trends of deinstitutionalization and expansion of community services. Texas has the largest institutionalized population with intellectual and developmental disabilities of any state and comprises a disproportionate amount of the U.S. total. Texas continues to operate 13 state supported living centers (SSLCs) for persons with intellectual and developmental disabilities, even as demand for these services has declined. Decreasing the number of residents in SSLCs instead of closing facilities has resulted in a costly arrangement of dual-funded systems of care in which funding for community and institutional services continues to increase. Closing at least one institution and establishing a process to continually review the size of Texas' system of SSLCs would enable the state to decrease the number of centers as demand changes and realize additional savings that could be redirected to the expansion of community programs.

The full text of this report can be found in *Transform State Residential Services for Persons with Intellectual and Developmental Disabilities* (Legislative Budget Board, January 2011).

TWO-YEAR FISCAL IMPACT, FISCAL YEARS 2012 TO 2013

	PROBABLE SAVINGS/(COST) TO GENERAL REVENUE-RELATED FUNDS		
	FISCAL YEAR 2012	FISCAL YEAR 2013	TOTAL
Abilene	\$2,529,080	\$11,449,451	\$13,978,531
Austin	\$1,979,413	\$6,937,370	\$8,916,783
Brenham	\$1,626,626	\$5,535,376	\$7,162,001
Corpus Christi	\$1,725,724	\$6,387,642	\$8,113,366
Denton	\$3,253,948	\$12,056,644	\$15,310,592
El Paso	\$661,374	\$2,259,814	\$2,921,188
Lubbock	\$1,788,461	\$7,301,963	\$9,090,424
Lufkin	\$1,675,675	\$5,119,835	\$6,795,511
Mexia	\$2,731,942	\$10,386,588	\$13,118,529
Richmond	\$2,651,822	\$10,161,569	\$12,813,392
San Angelo	\$1,539,145	\$5,782,109	\$7,321,253
San Antonio	\$1,039,517	\$2,905,674	\$3,945,191

SOURCE: Legislative Budget Board.

MODERNIZE CARE DELIVERY AT STATE SUPPORTED LIVING CENTERS

LBB RECOMMENDATIONS

1 Include a rider directing DADS to use \$250,000 of existing General Revenue Funds to hire a consultant to provide training to staff at one SSLC to implement the culture change model of care. DADS would also submit a report on the culture change process and its progress to the Governor and the legislature.

2 Include a rider directing DADS to report quarterly on non-key measures added to the Legislative Budget Board's Automated Budget and Evaluation System of Texas for each SSLC.

3 Include new key performance measures relating to DADS administration of SSLCs.

The introduced 2012–13 General Appropriations Bill includes riders implementing Recommendations 1 and 2. Key and non-key measures for SSLCs have been added to the introduced bill as a result of Recommendations 2 and 3.

These recommendations would not have a fiscal impact for the 2012–13 biennium. They would modernize how services and supports are designed and delivered and improve resident safety and workforce quality at SSLCs.

Texas operates 13 state supported living centers (SSLCs) which provide intermediate care services for persons with intellectual or developmental disabilities. Concerns surrounding the quality of care provided to these individuals have been long-standing. The U.S. Department of Justice continues to monitor Texas' efforts to address deficiencies and prevent additional civil rights violations. The Department of Aging and Disability Services (DADS) is working to improve the intermediate care facility system; implementing changes required by the Eighty-first Legislature, Regular Session, 2009 and adopting policies aimed at reducing the incidence of resident abuse and retaining qualified staff.

Due to changes in consumer demand, the census of state supported living centers continues to decline, which leaves the state favorably positioned to implement the culture change model of care. This model focuses on the values of individuals receiving care instead of asking individuals to adapt to the institution. It also incorporates workforce and quality improvement practices. The implementation of the culture change model of care would modernize how services and supports are designed and delivered to state supported living center residents and improve workforce quality and residents' safety. First implementing the culture change model at one state supported living center would allow the state to improve care and identify lessons that may be transferable to the entire intermediate care facility system.

The full text of this report can be found in *Transform State Residential Services for Persons with Intellectual and Developmental Disabilities* (Legislative Budget Board, January 2011).

MANAGING AND FUNDING STATE MENTAL HOSPITALS IN TEXAS, LEGISLATIVE PRIMER

REPORT HIGHLIGHTS

1 The Texas Legislature appropriated \$770.3 million for SMHs for the 2010–11 biennium; including \$614.9 million in General Revenue Funds, \$35.1 million in Federal Funds, and \$117.8 million in Other Funds. The SMHs were also appropriated \$2.5 million in funds provided under the federal American Recovery and Reinvestment Act.

2 In fiscal year 2010, the total number of mental health beds at SMHs was 2,461 beds including 1,558 civil beds and 903 forensic beds.

3 Some SMHs have experienced a significant increase in the number of forensic patients they serve. As of December 2010, there are 282 persons on the waiting lists for forensic beds at SMHs.

4 The average cost per patient served increased from \$11,912 in fiscal year 2006 to \$15,325 in fiscal year 2010, an increase of 28.6 percent.

5 Other factors impacting SMHs include increasing average lengths of patient stay, increasing outside mental and dental costs, workforce shortages, and aging hospital infrastructure.

The introduced 2012–13 General Appropriations Bill does not include any adjustments as a result of this report.

This report would not have a fiscal impact for the 2012–13 biennium. It provides information on the 10 state mental hospitals in Texas.

The Texas Department of State Health Services manages 9 state-owned mental hospitals and one state-owned inpatient residential treatment facility for adolescents. This report refers to the 10 entities as state mental hospitals or SMHs. Together the state mental hospitals are one component of the statewide mental health delivery system that includes inpatient care and community-based care. This report provides an overview of the state mental hospitals in Texas including information on who the hospitals serve, the services provided, how the hospitals are funded and factors affecting hospital operations and costs. The report also provides statistical information regarding selected performance indicators maintained by the agency.

The full text of the report can be found in *Managing and Funding State Mental Hospitals in Texas, Legislative Primer* (Legislative Budget Board, January 2011).