Medicaid Reform Strategies for Texas

Strategy	Low-Income Pools
Background:	One major component of several recently approved Medicaid reform waivers are low-income pools, which are lump sums of federal funds that states receive in exchange for restructuring their Disproportionate Share Hospital (DSH) and/or upper payment limit (UPL) programs. Based on each state's agreement with the federal government, these lump-sum pools may be used to: 1) make supplemental payments to healthcare providers for the Medicaid shortfall and/or uncompensated care, 2) pay for infrastructure improvements, and 3) expand insurance coverage. Each state's waiver spells out how the funds may be expended and any requirements on state receipt of the funds. The waivers with low-income pools that have been approved by the Centers for Medicare and Medicaid Services (CMS) have the following characteristics: • The state receives a fixed amount of federal dollars for the pool in exchange for restructuring UPL and/or DSH funds. This caps the federal government's liability for these programs. (Currently, DSH is a fixed allotment per state and there are aggregate UPL caps for three classes of hospitals in each state.) • CMS must approve the source of the state's matching funds to draw down the federal dollars, and is moving toward requiring certified public expenditures[i] for state match rather than intergovernmental transfers (IGTs). • Some of the federal funds may be tied to specific state actions, such as expanding managed care or expanding healthcare coverage to the currently uninsured. **Texas** If Texas opts to negotiate a low-income pool with the federal government, a major negotiation point will be the level of federal funds in the pool. Texas currently has a fixed DSH allocation and a number of existing and recently-approved UPL programs. A recently-approved Texas Medicaid state plan amendment establishes aggregate Texas UPL cap for three classes of hospitals: 1) state-owned and operated hospitals, 2) public, non-state hospitals, and 3) private hospitals. One key issue for Texas will be whether the pool amount is based on Texas' current UPL funding, or whether it is based on Texas' potential funding up to the three aggregate caps.
Other States:	**California** negotiated to receive federal funds up to $766 million per year for five years; capped at $3.83 billion to be used for 1) payments to providers for uncompensated medical services and 2) a new coverage initiative to expand insurance coverage in the last three years of the waiver. Safety Net Care Pool (SNCP) funds may be accessed only by providers operated by the state, counties, or cities or other government entities for uncompensated

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	costs of medical services provided to uninsured individuals. Certified public expenditures or state appropriations may be used as state match. Safety Net Care Pool funds will also be available for a non-entitlement coverage initiative in the last three years of the demonstration, when $180 million from the pool must be used to expand health-care coverage to uninsured individuals. California submitted a concept paper for the coverage initiative in January 2006, and was to submit a waiver amendment by September 1, 2006, in order to begin enrollment by September 1, 2007. In 2006, Senate Bill 1448 was enacted to implement the coverage initiative. S.B. 1448 allows a county, city, consortium of more than one county, or health authority to apply for the initiative funds. The California Department of Human Services (DHS) is to select at least five entities and to seek to balance the allocations throughout geographic areas of the state. Allocations would be made for a three-year period, and selected entities would be required to provide local funds or intergovernmental transfers necessary to claim federal funds. The programs must have defined eligibility criteria, a screening and enrollment process, a medical records system, and a benefits package that includes preventive and primary care services. DHS is to monitor each program and evaluate the initiative. **Florida** - $1 billion all funds per year for five years. Florida's low-income pool funds may be used for health care expenditures (medical care costs or premiums) incurred by the state, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured and the Medicaid shortfall. Up to 10 percent of the capped annual allotment of the low-income pool funds may be used for hospital expenditures other than payments to providers for the provision of health care services to a un- or underinsured individual. Local governments, such as counties, hospital districts and state agencies provide the non-federal share of the $1 billion low-income pool distributions through IGTs. The state then pays low-income pool funds directly to providers. CMS has approved a detailed reimbursement and funding methodology for the pool, which divides the funds between seven categories (a provider may be in more than one): 1) former UPL hospitals, 2) non-state public hospitals, 3) hospitals in communities where local government support for uninsured and underinsured hospital costs is more than $1 million; 4) hospitals that receive little or no local government support for un/underinsured; 5) hospitals with poison control programs; 6) federally qualified health centers (FQHCs); and 7) county health initiatives to expand primary care services. As directed by House Bill 3B from the 2005 Florida Legislature, the Florida Agency for Health Care Administration appointed a 17-member Low-Income Pool Council to develop the funding methodology and allocation of pool funds. The

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<tr><th>Strategy</th><th>Low-Income Pools</th></tr>
<tr><td></td><td>council includes representatives from hospital groups and local governments.

Massachusetts - $1.3 billion all funds per year for three years. May be used to pay for unreimbursed Medicaid costs, improve infrastructure, provide services to the uninsured, and for sliding scale premiums for individuals up to 300 percent FPL in the Commonwealth Care Health Insurance Program.

Chapter 58 of the Acts of 2006 is the state law regarding the use of the pool. Funds will shift over time from financing uncompensated care to expanding healthcare coverage. In FY 2007, the law projects that $610 million will be needed for uncompensated care. But, as more people gain coverage through Medicaid and the Commonwealth Care Health Insurance Program, it is anticipated that the pool will need less funding, projected to decline to $320 million in FY 2009. At the same time, spending on coverage from the pool will increase over time, due to Medicaid expansion and the Commonwealth Care program, which is expected to spend $160 million in FY 2007 growing to $725 million in FY 2009. Two health plans will continue to receive the $287 million per year that they received in supplemental payments in FY 2006, through premium increases and direct payments. Finally, there will be increased rates for hospitals and physicians each year.</td></tr>
<tr><td>Application to Texas –
Advantages & Disadvantages:</td><td>If Texas opts to include a low-income pool in its negotiation of a federal waiver, then the state may have more flexibility on how to spend funds to pay for the Medicaid shortfall and uncompensated care along with coverage expansions. In exchange for this flexibility, the federal government likely would cap pool funding and may require certified public expenditures as state match rather than IGTs. Texas would need to consider the long-term impact of these changes in its waiver deliberations.
Advantages:
If Texas negotiated a pool and used some of the funds to expand coverage, this would provide a non-entitlement option to reduce the number of uninsured in the state.</td></tr>
<tr><td>Meets Medicaid Reform Goal(s):</td><td>
<table>
<tr><td>Cost Reduction or Avoidance</td><td></td><td>Maximizes federal funds</td><td></td><td>Improves Program Sustainability</td><td></td><td>Consumer Choice/ Responsibility</td><td></td></tr>
<tr><td>Reduces Number of Uninsured</td><td>X</td><td>Supports Private Market Coverage</td><td>X</td><td>Improves Quality</td><td></td><td>Improves Access</td><td></td></tr>
<tr><td>Benefit Options</td><td></td><td colspan="6"></td></tr>
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<tr><td>Populations Affected:</td><td>If Texas opted to use low-income pool funds to expand insurance coverage, then significant numbers of currently uninsured individuals may be affected. There are about 2 million uninsured adults (ages 19-64) with incomes below 200 percent of the federal poverty level (FPL).[ii] The Texas counties with the highest number of uninsured residents are Harris, Dallas, Bexar, Tarrant, El Paso, Hidalgo and Travis.[iii]</td></tr>
<tr><td>General Revenue</td><td>The GR Impact of low-income pool operations depends on how Texas decides to</td></tr>
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<tr><td>Strategy</td><td colspan="6">Low-Income Pools</td></tr>
<tr><td>Impact:</td><td colspan="6">expend the funds in the pool. There will be administrating resources required to distribute funds directly to providers or to operate a coverage initiative.</td></tr>
<tr><td>Other Considerations</td><td colspan="6">
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<tr><td>Stand Alone Option</td><td></td><td>This Option should be considered in conjunction with other Medicaid Reform Strategy(ies)</td><td>X</td></tr>
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A low-income pool could be implemented in conjunction with hospital financing reform (as has been done in other states). If Texas negotiates a low-income pool with the federal government and decides to use funds from the pool to increase coverage, it could do so either through a statewide program (Massachusetts' approach) or by allowing local communities to develop and implement programs using funds from the low-income pool (California's approach). A statewide approach would enable Texans throughout the state to participate in the program, whereas a local approach would allow local communities to develop programs that best meet their community needs. Also, Texas might be able to use a health insurance exchange like Massachusetts's Connector to facilitate participation in either type of coverage initiative.

Another potential Medicaid reform strategy includes locally based three-share/multi-share programs. Like low-income pool coverage initiatives, these three-share programs seek to increase healthcare coverage for low-income individuals. The fundamental difference between locally based three-share programs (Michigan) and statewide coverage initiatives (New Mexico, Oklahoma, Massachusetts) is whether programs are developed and administered locally or at a state level. Existing locally based three-share programs are developed and administered at the local level, and use local funds to pay for a portion of the coverage. They also often limit coverage to a closed, local network of providers. Another difference between locally based three-share programs and statewide coverage initiatives is that three-share programs inherently focus on covering the working uninsured, whereas statewide coverage initiatives may seek to cover both the working and non-working uninsured.</td></tr>
<tr><td>State and Federal Approval(s) Required:</td><td>Federal</td><td>1115 Waiver</td><td>X</td><td>State</td><td>Rules</td><td>X</td></tr>
<tr><td></td><td></td><td>Other Waiver(s), [LIST]</td><td></td><td></td><td>Legislation</td><td>X</td></tr>
<tr><td></td><td></td><td>State Plan Amendment</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Implementation Considerations & Timeframes:</td><td colspan="6"><u>Affected Stakeholders</u>
• Hospitals and other providers.
• If coverage expansion – uninsured individuals and their employers.
• Local governments' tax bases.

<u>Systems and Resource Considerations</u>
If a low-income pool is used to increase healthcare coverage, at a minimum, the</td></tr>
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	following operational functions would need to be in place: • A system and process for eligibility screening for individuals, including determining the public subsidy amount. Also would need to screen for Medicaid/CHIP eligibility, and ensure against crowd-out. May also have a certification process to qualify businesses as eligible to participate. • A premium payment system to pay the public share of the coverage, and also to track (and possibly collect) contributions from the employer and individual. • An enrollment broker to inform participants of coverage options and to assist individuals and/or businesses select a coverage plan. Other states have used web portals and call centers to perform these functions. • Certification of coverage plan as meeting minimum state requirements. May include existing regulatory oversight, rate development and actuarial analysis. • Interfaces between the eligibility and premium payment systems, and between the state or its contractor, health coverage plans, and businesses. The development of a coverage program also would require policy and program development along with outreach and education to ensure that the program is designed in a way that it will work for employers, individuals and insurance companies who offer coverage. Finally, to the extent that public dollars are being used to finance part of the program, there would need to be reporting mechanisms to evaluate the outcomes of the program and make improvements as needed. **Implementation Timeframes (in months)** • At least one year — Depends on the purpose of Texas' pool and how related state legislation directs HHSC to implement. In other states with low-income pools, CMS has required that multiple documents be submitted after the initial waiver approval related to how funds from the pool can be spent, allowable sources of state match, and design of new coverage initiatives.

[i] Certified public expenditures are typically referred to as CPEs
[ii] U.S. Census Bureau, March 2005 and March 2006 Current Population Surveys for Texas, Compiled by the HHSC Strategic Decision Support Department, January 2007. The 2 million figure is HHSC's estimate of U.S. citizens and legal permanent residents in Texas ages 19-64 below 200 percent FPL.
[iii] Texas Health and Human Services Commission, 2000.