TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

Health and Human Services Commission Council

Subcommittee on Medicaid Reform & Hospital Financing

October 30, 2007
10:00 a.m
Brown Heatly Public Hearing Room
4900 North Lamar
Austin, Texas

1. Call to Order
2. Medicaid Reform Update
3. Medicaid Reform Options and Considerations
4. Public Comment on Medicaid Reform Options and Considerations
5. Adjourn

Public comment will be taken following each item and/or after staff presentation.

Contact: External Relations Division, (512) 487-3300, Health and Human Services Commission, 4900 N. Lamar Blvd., Austin, TX 78751-2316.

Persons with disabilities who will need auxiliary aids or services for this meeting are asked to contact the External Relations Division at (512) 487-3300 at least 72 hours prior to the meeting so that appropriate arrangements can be made.

Health and Human Services Commission (HHSC) Council Subcommittee on Medicaid Reform and Hospital Financing CHARTER

SUBCOMMITTEE CHARGE

The HHSC Council Subcommittee on Medicaid Reform and Hospital Financing will be responsible for reviewing rules related to hospital financing and Medicaid reform; making recommendations regarding these rules to the full HHSC Council; reviewing and providing input to HHSC on the development of the Medicaid Reform waiver; and reviewing the work and recommendations of the Work Group on Uncompensated Hospital Care. Public testimony may be taken and recommendations may be made by the Subcommittee on these matters at the discretion of the Subcommittee Chair.

KEY ASSUMPTIONS

Rules should be reviewed and input and recommendations based on the following assumptions:

- All timelines and project areas are subject to the direction of the Medicaid Reform Legislative Oversight Committee and the direction provided by Senate Bill 10.
- HHSC will submit an 1115 Demonstration Waiver to the Center for Medicare and Medicaid Services (CMS) with the goals of:
    - Reducing the number of uninsured Texans by, among other things, creating a Texas Health Opportunity Pool Trust Fund to provide subsidies to eligible Texans;
    - Restructuring Medicaid financing to gain flexibility and increase the effectiveness of health care system investments;
    - Promoting consumer choice and responsibility, with a focus on keeping Texans healthy;
    - Promoting public-private partnerships;
    - Enhancing quality and value through better management and performance improvement incentives; and
    - Establishing an infrastructure to facilitate the accomplishment of reform goals.
- The Subcommittee shall receive periodic or as requested updates on waiver development status and waiver content and shall facilitate stakeholder input on the waiver.
- The Subcommittee shall review and provide input on the work of the Work Group on Uncompensated Hospital Care (work group) as established in Senate Bill 10, shall review rules developed by the work group, and shall facilitate stakeholder input on those rules.

KEY REVIEW AREAS

Major development areas for the waiver and for Subcommittee review will include the following:

- Identification of the subsidy-eligible population
- Definition of benefit packages and cost sharing
- Designation of delivery systems
- Protection of health care funds at risk;
- Waiver, hospital and health care financing, including funding of the HOP trust fund;
- HOP trust fund allocation options; and
- Provider use of HOP trust funds and requirements for use of funds.

Other review areas include review of uncompensated care provision and uncompensated care reporting.

SUBCOMMITTEE ORGANIZATION

The subcommittee shall be comprised of four members of the HHSC Council. The HHSC Council Chair will appoint the Subcommittee Chair and members. Meetings will be scheduled at the call of the Subcommittee Chair.

The Subcommittee will report to the HHSC Council on activities related to Medicaid Reform and Hospital Financing.

TEXAS Health and Human Services Commission

HHSC Council Subcommittee on Medicaid Reform and Hospital Financing

October 30, 2007

1

TEXAS Health and Human Services Commission

Medicaid Reform Update –Context and Reform Waiver Process

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Context -- The Need For Reform

- **5.5 million uninsured Texans in 2005**
  - 25% of all Texans
  - Poor health status
  - Increased pressure on premiums and costs
- **Current inefficient investment in health care**
- **Unsustainable pressure on safety net providers and tax base**
- **Federal health care funds at risk**
- **Current policy driven by funding**
- **Local expenditures on health care not matched**

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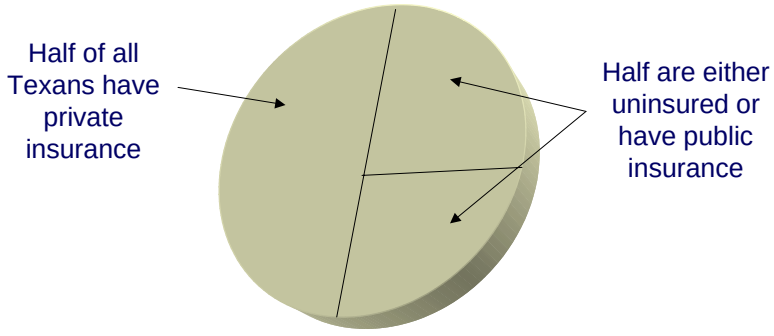
Insurance Status in Texas
25% or 5.5 million Texans uninsured



Odds are 50/50 that any Texan will have private insurance, or be either uninsured or in a public program (e.g., Medicaid, CHIP, Medicare, Veterans' Assistance).

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Summary of Texas Uninsured Data

Who Are the 5.5 million uninsured Texans?

Summary of 2005 CPS Data on Uninsured Citizen and Legal Permanent Resident Adults with Incomes <200% FPL:

- 60% (2.1 million) of the total uninsured adult population have incomes at or below 200% FPL.
  - 51% of these adults (1.1M) are between the ages of 19 and 34.
  - 55% (1.2M) are childless adults and 45% (960,000) are parents.
  - 62% (592,000) of all uninsured parents are females.
    - Uninsured parents are generally employed:
      - 88% of male parents
      - 50% of female parents

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Coverage Considerations
2007 HHS Poverty Guidelines

- **100% FPL:**
  - 1 $10,210/annual $851/month
  - 2 $13,690/annual $1,141/month
  - 3 $17,170/annual $1,431/month
  - 4 $20,650/annual $1,721/month

- **200% FPL:**
  - 1 $20,420/annual $1,702/month
  - 2 $27,380/annual $2,282/month
  - 3 $34,340/annual $2,861/month
  - 4 $41,300/annual $3,442/month

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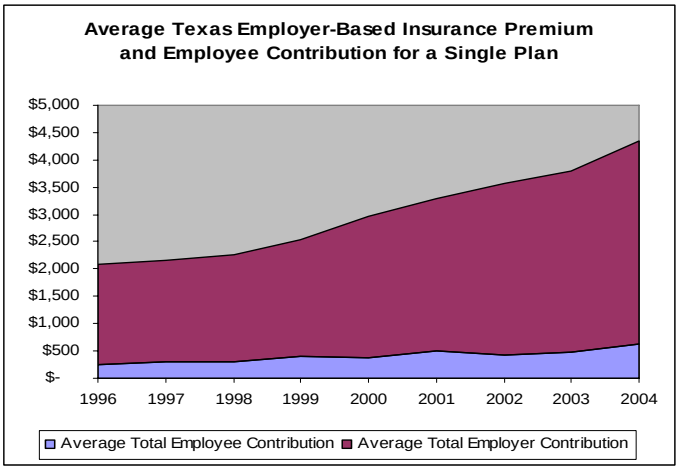
Texas Employer Premium Rates- Contributing to Uninsurance



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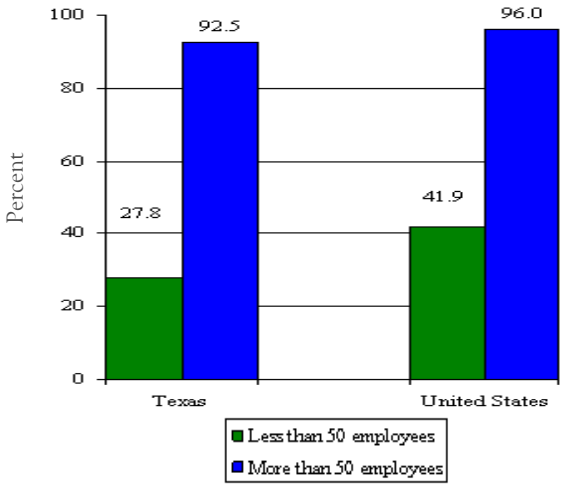
Texas and US Private Sector Establishments that Offer Health Insurance 2004



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Impacts of High Rate of Uninsured

- Poorer health outcomes due to less access to primary and preventive care
- Uninsured more likely to be hospitalized for conditions that were avoidable, with $3,300 costs per avoidable stay.
- Increased costs of private insurances, subsidies for the uninsured through higher premiums (2005 - $550 single; $1551 family)
- Over-reliance on safety net providers, including hospitals, and emergency rooms for more expensive care
- Over-crowded emergency rooms, and costs for indigent care that out-weigh available resources, stressing local, state, federal and safety net capacities
  - One-quarter of Harris County ER visits were non-emergency; the uninsured accounted for 40% of these visits and 40% of all primary care-sensitive visits in the ER
- Increasing pressure on tax bases

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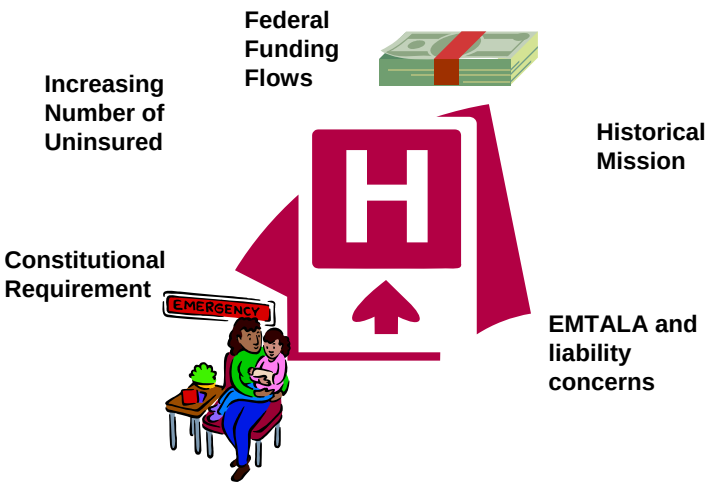
Impact of Uninsured on Safety Net Hospitals



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Over-burdened Safety Net Hospitals

- Federal funding preferences hospital care – DSH and UPL (over $3 billion)
- Funding drives policy
- Increasing numbers of uninsured without usual source of care
- Increasing premium costs, enrollee contributions, lead to less coverage, more uninsured
- Constitutional requirements for indigent care – hospital districts and public hospitals
- Emergency room "guaranteed" point of access
- Historical missions as safety net providers
- EMTALA requirements; liability concerns
- While DSH and UPL can help offset indigent care costs, reform needs to address the underlying dynamics creating these costs

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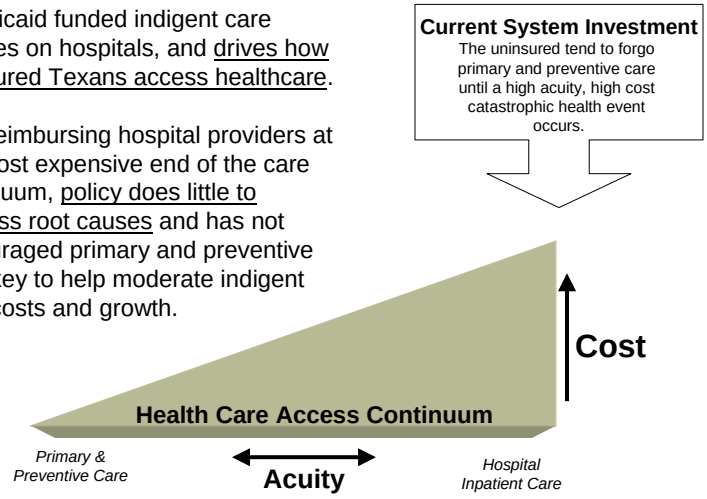
Medicaid Funded Indigent Care

• Medicaid funded indigent care focuses on hospitals, and drives how uninsured Texans access healthcare.

• By reimbursing hospital providers at the most expensive end of the care continuum, policy does little to address root causes and has not encouraged primary and preventive care key to help moderate indigent care costs and growth.



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Federal Pressure on Hospitals Funding At-Risk

- Recent CMS pressure on Medicaid funding
- CMS Rule: cost limit for public providers:
  - One year moratorium expires May, 2008
  - Potential impact to Texas hospitals: est. $500 million
- Private UPL CMS deferral: over $100 million
  - Public providers' IGT to private providers for offset of services to private hospitals

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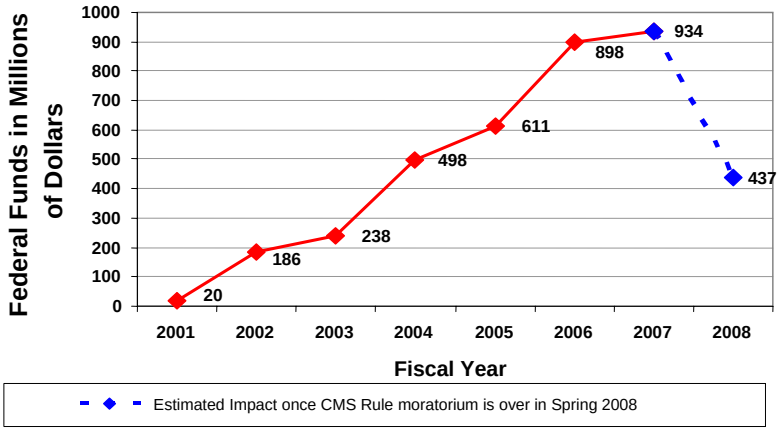
Historic UPL Allocations and Rule Change Impact



Note: Fiscal Year 2006 allocations includes retroactive payments made in fiscal year 2007.

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Reform Goals

- **OVERARCHING GOAL:** Optimize investment in health care to ensure more efficient use of available funding and best health outcomes for Texans.
  - Focus on keeping Texans healthy
  - Reduce the number of uninsured Texans
  - Protect and optimize Medicaid funding
  - Establish infrastructure to facilitate accomplishment of reform goals

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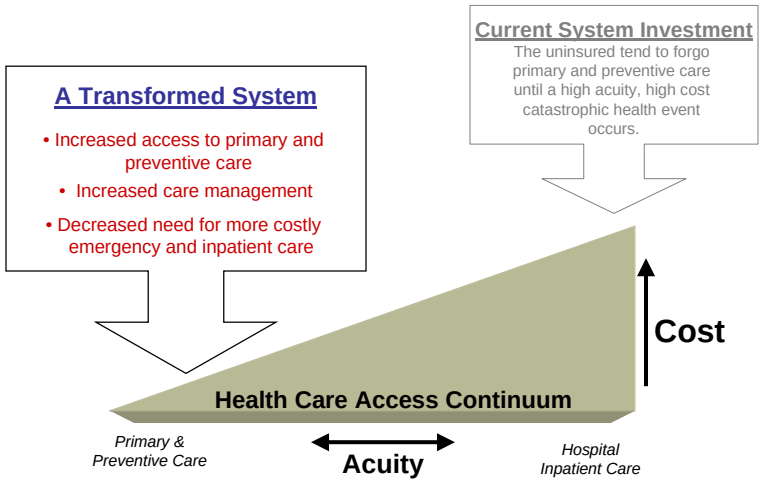
Transforming Access and Quality for Provision of Health Care to Uninsured Texans



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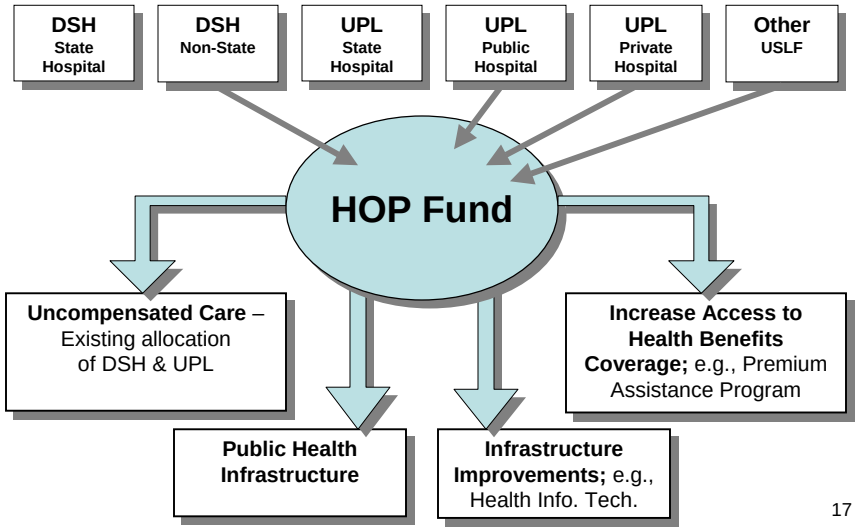
Health Opportunity Pool Allocation



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HOP Trust Fund Pool

Allocation

- Reimbursement for Uncompensated Care Providers who have in place initiatives to reduce Uncompensated Care
- Infrastructure Grants
- Funding for Premium Assistance Programs

Funding Allocation to be determined

- Hold Harmless Language – IGT leveraged funds for DSH and UPL
- Rebasing of Hospital DRG payments – funds for HOP
- Allocation options to be considered and Key Decisions for Public Input published as process continues.

The current Key Design Questions focus on development of Premium Assistance Program; the following slides discuss preliminary financing background.

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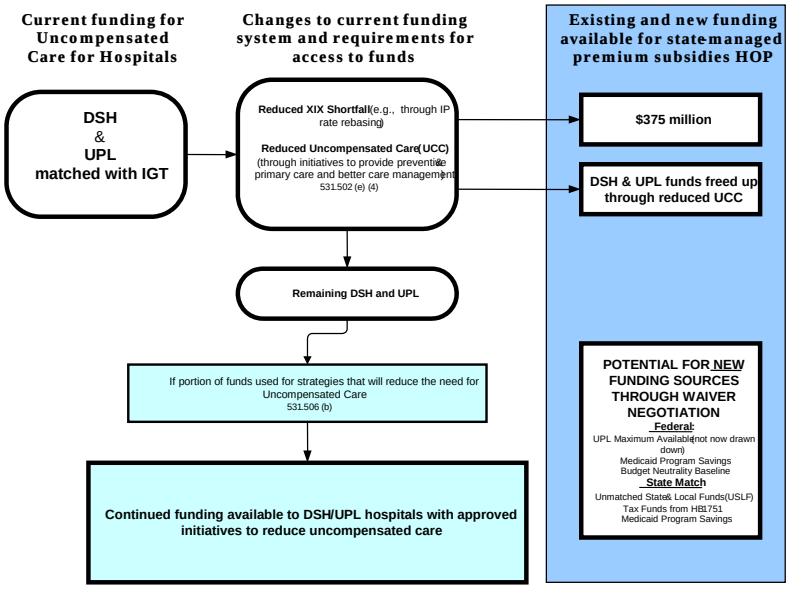
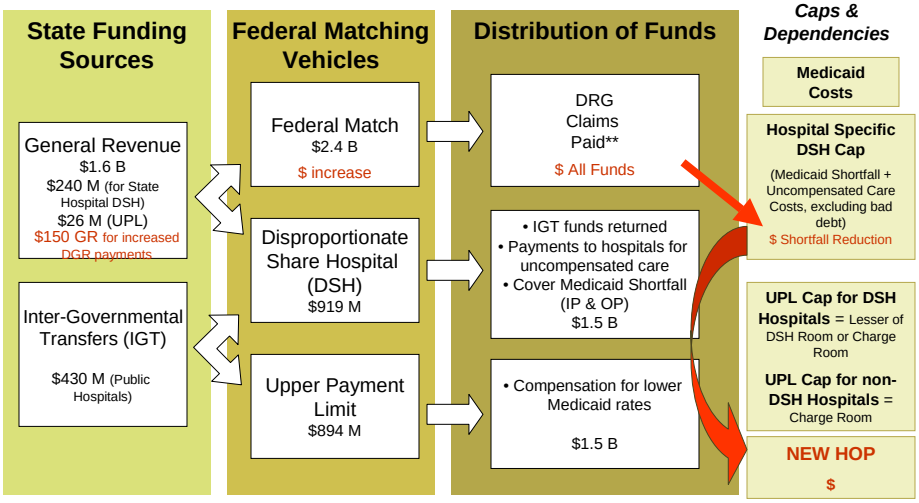
TEXAS HEALTH OPPORTUNITY POOL FUNDING



Rebasing – source of HOP Funds



Cap Definitions

****Medicaid Shortfall ($900 M) = Medicaid Costs – Actual Payments**

DSH Room = Hospital Specific DSH Cap – DSH payments

Charge Room = Medicaid charges – Medicaid payments

Unmatched State and Local Funds

Current Funding

- Based on Public Hospital Fund Transfers -- IGTs
- Increasingly at Risk

Options for Leveraging Local Expenditures without Fund Transfers

Unmatched State and Local Funds

- IGT- Intergovernmental transfer
- CPE – Certified public expenditures

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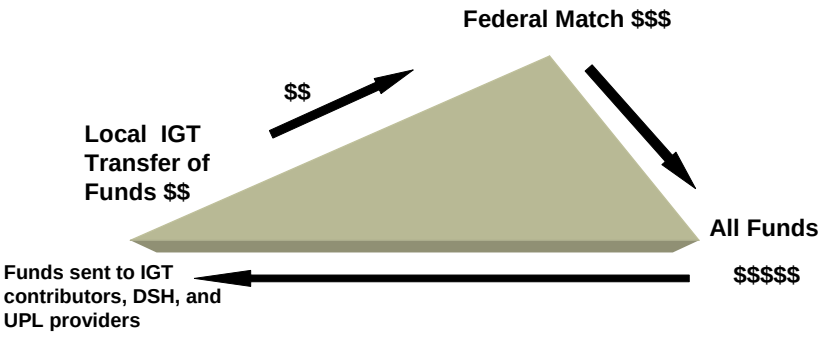
Current Medicaid DSH and UPL Financing and Distribution



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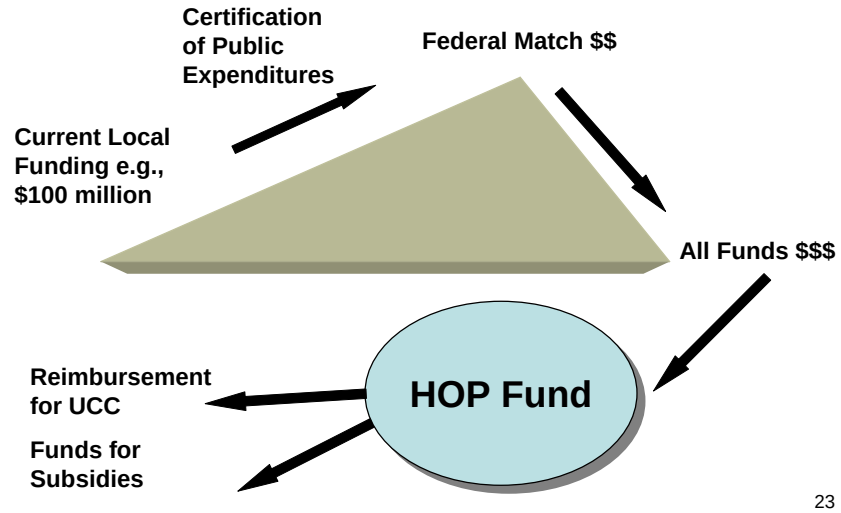
Medicaid DSH and UPL Financing and Distribution – Option for CPE



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Premium Assistance: Key Program Decision Points

- Eligible Populations for Premium Assistance Programs
- Coverage Options
- Subsidy Levels and Duration
- Administration and Implementation

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HHSC Development of Medicaid Reform Concept Paper

- HHSC Request for Public Input
  - HHSC is seeking public input on key decision areas that will be discussed in the Texas Medicaid Waiver Concept Paper that will be submitted to CMS later this fall.
  - Comments at today's HHSC Council Subcommittee on Medicaid Reform and Hospital Financing meeting.
  - Additional comments may be provided by:
    - **E-mail:** medreform@hhsc.state.tx.us
    - **Fax:** (512) 424-6991
    - **Mail:** Health and Human Services Commission, 4900 Lamar Blvd., Mail Code BH-4001, Attention: Medicaid Reform, Austin, Texas 78751
  - All comments are **due by noon November 6, 2007**

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HHSC Development of Medicaid Reform Concept Paper

- **Waiver Process and Tentative Timeline:**
  - Concept Paper
    - November 2007
    - Level of Detail—Outline of eligible populations for premium assistance programs, coverage options, subsidy levels and duration, administration and implementation, and sources of state and general financing.
  - Waiver Submission
    - January 2008
    - Level of Detail—More specific information and data to support key items above. Special Terms and Conditions such as reporting requirements and program conditions would be developed and agreed upon following the waiver approval.

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Ongoing Public Input on Medicaid Reform

- As process continues:
  - Subsequent Public Meetings
    - Legislative Oversight Committee
    - HHSC Council Subcommittee on Medicaid Reform and Hospital Financing
  - Concept Paper Draft
  - Draft Waiver Components
  - Waiver Financing Highlights
  - Public input will be considered in the development of the concept paper, and further input will be sought as we develop the waiver.

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Medicaid Reform Input and Information

- Medicaid Reform Legislative Oversight Committee
- HHSC Council Subcommittee on Medicaid Reform
- Stakeholders

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Information About Medicaid Reform

- Website
  - http://www.hhs.state.tx.us/Medicaid/Reform.shtml
  - E-mail alerts
  - Updated information

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Development of Medicaid Reform Concept Paper
HHSC Request for Public Input

Background

Senate Bill 10, 80th Regular Legislative Session, sets the stage for comprehensive health-care reform designed to increase the percentage of Texans with health-care coverage, focus on prevention, and emphasize individual choice. Under the direction of the Medicaid Reform Legislative Oversight Committee, the Health and Human Services Commission (HHSC) will develop a Texas reform plan to submit to Centers for Medicare & Medicaid Services (CMS) for federal approval.

Waiver Process

The waiver process includes the following steps:

1. Submission of a Texas Medicaid Waiver Concept Paper, which provides an outline of the state's plan, target populations, delivery systems, benefits and funding sources.
2. Submission of the Texas Medicaid Waiver, which includes more specific information and data to support key elements of the waiver. Special Terms and Conditions such as reporting requirements and program conditions would be developed and agreed upon following the waiver approval.

Senate Bill 10 establishes the Texas Health Opportunity Pool Trust Fund to provide premium subsidies to eligible Texans and help offset uncompensated care costs for providers who implement innovative measures to provide primary and preventive care.

HHSC is seeking public input on key decision areas that will be discussed in the Texas Medicaid Waiver Concept Paper that will be submitted to CMS later this fall. The key decision areas are:

- Eligible Populations for Premium Assistance Programs,
- Coverage Options,
- Subsidy Levels and Duration and
- Administration and Implementation.

Eligible Populations for Premium Assistance Programs

Decision Principles

- Must be low-income Texas residents and U.S. citizens or Legal Permanent Residents.
- Cannot be eligible for or enrolled in Medicaid, CHIP or Medicare.
- Should be encouraged to utilize affordable employee-sponsored insurance options if available.
- Premium assistance is not an entitlement; enrollment is subject to availability of program funds.

Design Questions

1) At what income level should individuals be eligible for subsidies?

Preliminary Assessment
HHSC suggests that the program pursue statewide implementation for all uninsured Texans at or below 200% FPL.

2) What methods should be implemented to minimize or eliminate crowd-out?
Preliminary Assessment
HHSC suggests that individuals be uninsured for three months in order to qualify for premium assistance.

3) Should other conditions of eligibility be established for participation in the premium assistance program?

<u>Coverage Options</u>
Decision Principles

- Coverage options should leverage and build on the existing insurance market both for what is commercially available and for employer-sponsored insurance.
- Coverage should be consumer-driven and focused on consumer choice, recognizing that one size does not fill all in Texas' uninsured population.
- Access to primary and preventive services should be promoted and encouraged.
- Cost-sharing of some type should be a component of every coverage package and should be calibrated based on income.
- Program structure should strive for administrative efficiency for the carriers, covered individuals, and program administration.
- Premium assistance funds should be used to expand the availability of coverage, rather than supplant existing coverage options.
- Program decisions should maximize value for enrollees and the state.

Design Questions

1) Which qualified products should be eligible for purchase by enrollees?
Options

- Only insurance products, including HMOs, regulated by the Texas Department of Insurance (TDI).
- Other products or coverage options such as discount programs, or hospital-based uncompensated care programs.
- Health Savings Accounts options.
- Three-share programs and regional/local programs.

Preliminary Assessment
HHSC suggests that a variety of products be available for consumer choice.

2) What types of insurance packages can premium assistance be used to purchase?
Options

- Coverage packages made available by the market that meet regulatory standards and allow consumers to choose from the entire commercial market array.
- Define minimum benefits required and solicit coverage that satisfies those requirements.

- Convey to the commercial market that basic, comprehensive and catastrophic coverage options should be available for this population, based upon the individual's desired level of coverage, and solicit coverage options in each of those categories.

Preliminary Assessment
HHSC suggests that the state convey to the commercial market that basic, comprehensive and catastrophic coverage options should be available for this population, based upon the individual's desired level of coverage, and solicit coverage options in each of those categories. The state would identify some minimum benchmarks, and the market would respond with available benefits, or create benefit options. Enrollees would have choices of plans and benefit structures that could be purchased with the premium assistance, without having an overwhelming number of plan and benefit choices.

3) How will qualified carriers be chosen to participate in the premium assistance program?

Options
- A limited number of plans from which enrollees may choose could be competitively selected.
- Allow any qualified carrier or coverage program to participate so that insurance carriers/coverage programs within the market, rather than the state, determine which plans are available to enrollees.

Preliminary Assessment
HHSC suggests the state consider competitive selection to leverage overall program value for the state and enrollees.

4) Should the number of coverage options available to consumers be limited?

Options
- Consumers should be presented with an unlimited number of options provided by the market.
- Coverage options should be limited to maximize individual choice without overwhelming consumers.

Preliminary Assessment
To avoid an overwhelming array of plan choices, coverage options should be limited. The number of options available to consumers should be manageable while allowing for the selection of the option that best meets the consumer's individual needs.

5) What incentives could be established to assist small businesses in providing coverage?

Senate Bill 10 directs HHSC and the Texas Department of Insurance (TDI) to

jointly study a small employer premium assistance program to provide financial assistance to purchase employer health benefit plans. Results of this study will be available and submitted to the legislature by November 1, 2008.

6) Should other coverage options or considerations be included?

Subsidy Levels and Duration

Decision Principles

- The level of the premium assistance should be related both to the income of the eligible individual and the value of the coverage selected.
- Program structure should strive for administrative efficiency for the carriers, covered individuals, and program administration.
- The level or amount of the premium should help support access to primary and preventive care.
- Policies to minimize crowd out must be reflected in program design.
- The program should align with common practices in the commercial market.
- The term of enrollment would apply as long as coverage is maintained through a qualified coverage plan.
- Premium assistance is not an entitlement; enrollment is subject to availability of program funds.

Design Questions

1) How should premium assistance levels be established?

Options

- A set amount available for each enrollee.
- A set amount based on individual's income.
- Set subsidy at a level based on the cost of a basic benefit plan.

Preliminary Assessment

HHSC suggests that premium amounts should be based on the cost of a basic benefit plan.

2) What is the term of enrollment for premium assistance?

Preliminary Assessment

HHSC suggests that the term be twelve months.

3) Should any other approaches be taken in establishing subsidy levels or duration?

Administration and Implementation

Decision Principles

- Program structure should strive for administrative efficiency for the carriers, covered individuals, and program administration.
- The program should reflect and support commercial market approaches to the degree possible.

- The state must maintain program solvency, with a method to control or cap program enrollment based on available funds.
- As funding is available, the state should make premium assistance available.

Design Questions

1) Given the large number of uninsured Texans and the time-limited nature of a demonstration waiver (5 years), how should the program be implemented to begin making subsidies available?

Options

- Implementation could be phased-in based on administrative and financial capacity.
    - Phase one could leverage existing state administrative systems and eligibility information to cover certified low-income individuals whose eligibility income information is already available in state databases. This phase could be implemented by the end of calendar year 2008. Phase two would involve the development of the administrative design structure to support the premium assistance program, procure assistance for administrative functions, and fully implement the program consistent with key decision principles. This phase is estimated to take 18-24 months.
- The state could fully implement the program after all administrative functions are procured and in place. This would include developing the administrative design structure to support the premium assistance program and procuring administrative functions. This may take 18 – 24 months.

Preliminary Assessment

HHSC suggests that the state phase-in implementation based on administrative and financing capacity. The state should leverage existing eligibility information for certified low-income individuals whose information is already available in state databases.

2) Given the funding available and the fact that the demand for subsidies may exceed initial funding, how should enrollment in the program be managed?

Options

- Enrollment could be phased-in based on Federal Poverty Level.
- Enrollment could be phased in by geographic area to all eligible populations.
- Enrollment could be based on a first-come, first-served approach for initial enrollments, with open enrollment periods as additional funds are available.

Preliminary Assessments

Phase-in should be based on a statewide first come-first served basis with an initial program eligibility period and subsequent periodic open enrollment periods based on available funding.

3) Based on the design principles, is there another approach that should be taken to implement the premium assistance program?

Comments are due by noon Nov. 6, 2007.

You may use any of the following methods to submit your survey form and additional comments:

E-mail: medreform@hhsc.state.tx.us

Fax: (512) 424-6991

Mail:

Health and Human Services Commission
4900 Lamar Blvd.
Mail Code BH-4001
Attention: Medicaid Reform
Austin, Texas 78751