Texas Medicaid Policy Summit

Texas Medicaid:
Where We Are and Where We're Going

November 16, 2006

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Medicaid in Perspective

- Over a period of four decades, Congress transformed Medicaid (a jointly funded state-federal program) from a narrowly defined program available to persons eligible for cash assistance, into a large program with complex eligibility rules.
- In 2009, Texas Medicaid will cover nearly 3.0 million people. During the late 1980s and early 1990s, Congress expanded Medicaid eligibility to include a greater number of elderly, people with disabilities, children and pregnant women.
- Medicaid pays for basic health care (physician services, inpatient, outpatient, pharmacy, lab and x-ray services). It also covers long-term care services for aged and disabled clients.

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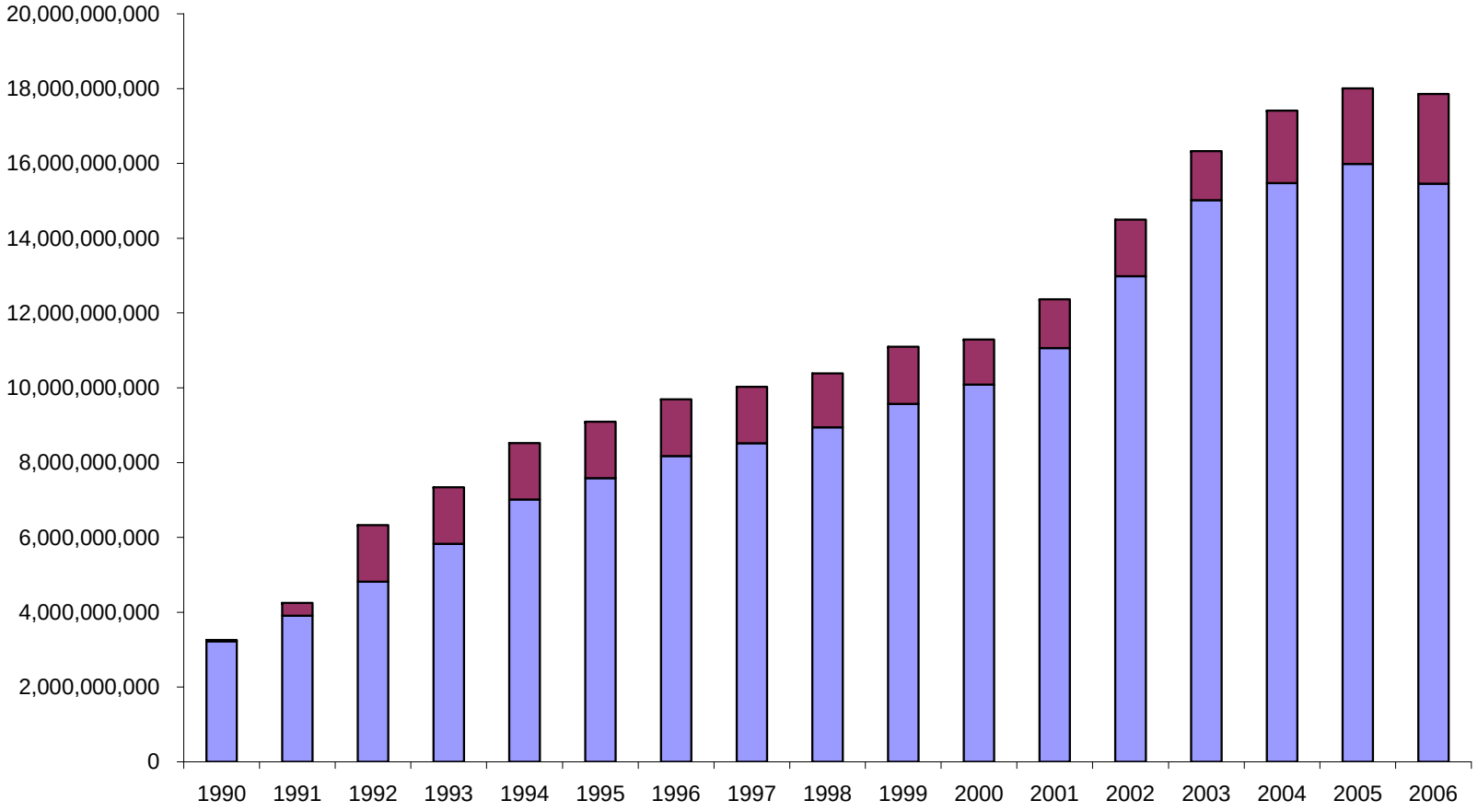
Medicaid in Perspective

- The Federal Medical Assistance Percentage (FMAP) is the share of state Medicaid benefit costs paid for by the federal government.
  - Fiscal year 2007 Texas FMAP rates are 39.23 state and 60.77 federal.
  - Fiscal year 2008 rates should be published soon. A special adjustment for states with significant numbers of hurricane Katrina evacuees is being considered.
- In fiscal year 2007, state/federal funds for Medicaid are projected to comprise 26 percent (approximately $18 billion) of all state expenditures.
- Texas Medicaid caseloads have grown historically as a result of the expansion of eligibility groups, most notably Children's groups.

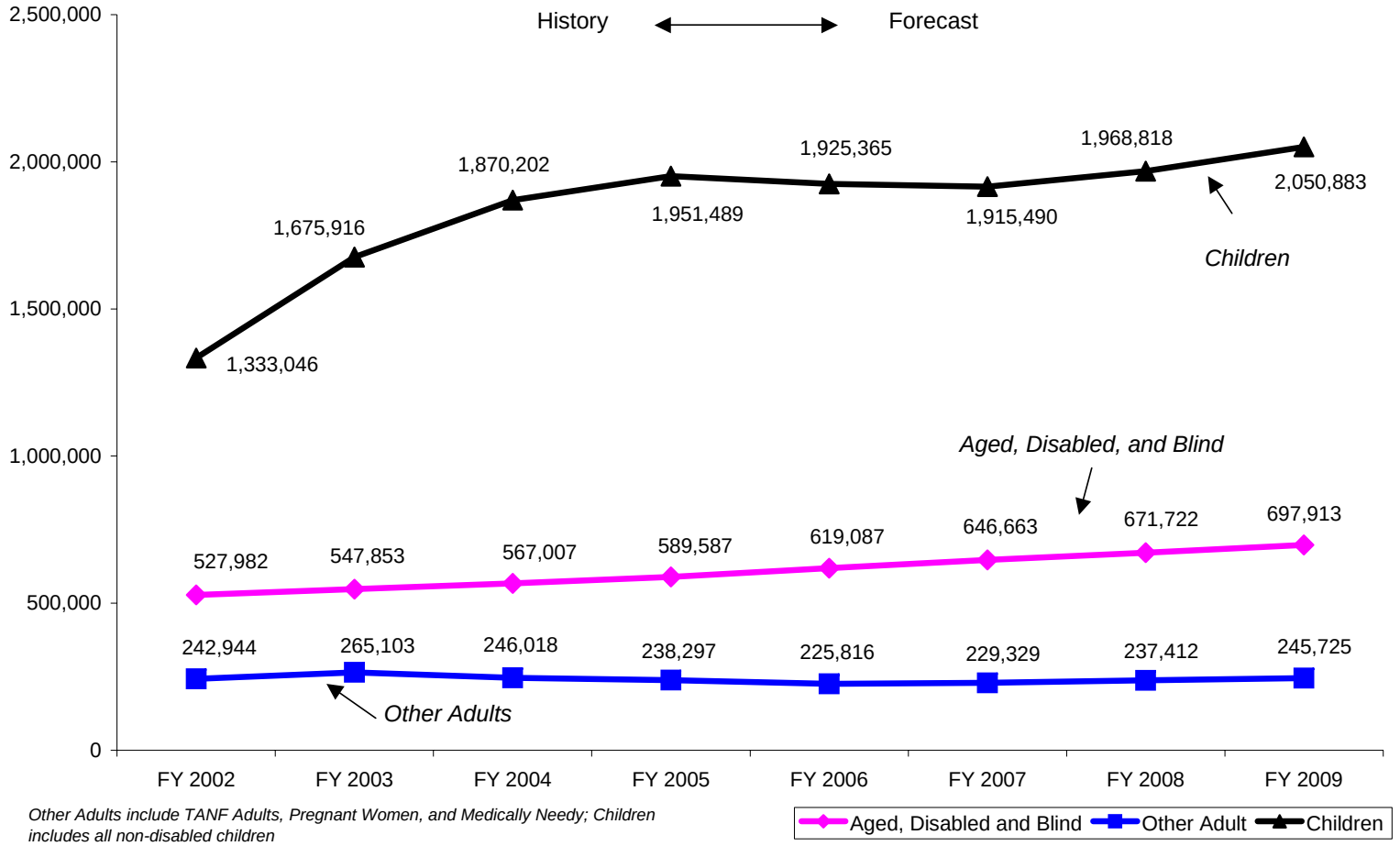
Total Medicaid Spending
Including Disproportionate Share and Upper Payment Limits
FFY 1990 - 2006*



*Source: HHSC Financial Services, Expenditure Reports, *FFY 2006 is estimated*

Medicaid Caseload by Risk Groups

Medicaid Acute Care Caseload by Risk Groups, FY 2002 - FY 2009, Fall 2006 Forecast



Other Adults include TANF Adults, Pregnant Women, and Medically Needy; Children includes all non-disabled children

Medicaid Costs

- Cost Per Recipient Month 2002-2006
  - Fiscal Year 2002 = $ 471 / Recipient Month
  - Fiscal Year 2006 = $ 468 / Recipient Month
    - Cost per Recipient Month includes all Medicaid costs, including Long-Term Care, Vendor Drugs, and Texas Health Steps Programs for both Managed and Non-Managed Care.
    - Other adults include adult caretakers of TANF Children, Medically Needy Pregnant Women, and Pregnant Women. These costs have dropped due to policy changes eliminating the Medically Needy program for non-caretaker adults, beginning FY 2004.

Total Medicaid Costs

	FY 2002	FY 2006
Aged, Blind and Disabled	$1,165	$1,292
Other Adults	$585	$530
Children	$196	$195
Total	**$471**	**$468**

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Medicaid Costs

- Cost Per Recipient Month by Program Type, Fiscal Year 2006
  - Fee-for-Service = $ 225 / Recipient Month
    - 48 percent FFS Recipient Months are in the Aged, Blind & Disabled Risk Group; 43 percent are non-disabled children; Texas Health Steps Programs not included in the costs
  - HMO = $ 166 / Recipient Month
    - 88 percent of HMO Recipient Months are non-disabled children, with Texas Health Steps programs included in the capitated rate
  - PCCM = $ 184 / Recipient Month
    - 86 percent of PCCM Recipient Months are non-disabled children, with Texas Health Steps programs included in the costs
  - The costs detailed above are for Acute Care client services, and do not include Long-Term Care or Vendor Drugs

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Medicaid Costs

- Total Costs by Service Location, Fiscal Year 2006
  - The following costs are based on FY 2006 Fee-for-Service claims and excludes managed care.
    - Inpatient Hospital = $ 1,192.6 million
    - Outpatient Hospital = $ 376.6 million
    - Professional/Other = $1,025.4 million
  - Vendor drug costs include managed care and fee-for-service client costs.
    - Vendor Drug = $ 1,963.4 million

Medicaid Reform in Texas: Where We've Been

- Since 2003, significant changes have been incorporated into the Texas Medicaid Program. These changes have focused on:
  - Containing Costs
  - Managing Care
  - Improving Health Outcomes

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Texas Medicaid: Recent Initiatives

- Changes in Managed Care
  - There has been significant growth and change – for 2008 an estimated 72% of the Texas Medicaid population is projected to be enrolled in managed care compared to 40% in 2003.
  - Primary care Case Management (PCCM) expanded to rural areas serve a total of 202 counties.
  - New HMO contracts include strong performance requirements and expanded sanctions and remedies for poor performance.
- Preferred Drug List (PDL)
  - HHSC implemented a PDL for Medicaid in February 2004 whereby pharmaceutical companies are required to offer a supplemental rebate or a program benefit proposal to be considered for the PDL.
  - Currently more than 55 drug classes represent approximately 70% of Texas' Medicaid pharmacy expenditures.
  - Since inception, PDL has reached a savings of $488 million (All Funds).

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Texas Medicaid: Recent Initiatives

- Disease Management (DM)
  - Statewide Texas Medicaid Enhanced Care Program (DM) began on November 1, 2004 with a contracted Disease Management Organization.
  - Program developed for Fee-for-Service (FFS) clients with specific targeted chronic illnesses (chronic pulmonary disease, congestive heart failure, coronary artery disease, diabetes, and asthma).
  - DM expanded to PCCM client population on September 1, 2005.
  - DMO is at risk for reducing overall expenditures and meeting specific quality variable metrics.

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Texas Medicaid: Recent Initiatives

- Care Management
  - *Integrated Care Management* (ICM) is a non-capitated managed care model that includes integrated acute and long-term care services/supports to aged, blind and disabled clients in the Dallas and Tarrant service areas; services to approximately 70,000 enrollees is expected with implementation planned for July 1, 2007.
  - In January 2007, *STAR+PLUS* will expand to Harris contiguous Nueces, Bexar, and Travis service areas. STAR+PLUS HMOs will provide both acute and long-term services and supports to an estimated 140,000 SSI members. Inpatient hospital services are carved out to preserve hospital Upper Payment Limit payments.
- Provider Payments
  - Rates have not been increased for some services in over 10 years.
  - Beginning in fiscal year 2004, provider payment rates were reduced: 2.5 percent for physician and professional services and 5 percent for inpatient hospital services.
  - Increased efforts by the Centers for Medicare and Medicaid services to reduce allowable federal reimbursement has occurred, for example, stringent reviews of federal cost allocation methodologies and extended review periods of state plan amendments.

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Texas Medicaid: Recent Initiatives

- Programmatic/Eligibility Changes
  - *Women's Health Program (WHP)* – expands health services to low-income women by January 1, 2007. Eligible services include comprehensive health history and evaluations, physical exams, health screenings for diabetes, STDs, high blood pressure, cholesterol, tuberculosis, and breast and cervical cancers, family planning services and non-emergency contraception. By the end of fiscal year 2008, savings of $49.6 million projected and more than 200,000 women served.
  - *CHIP Perinatal* – provides for prenatal benefits for unborn children with health benefit coverage under CHIP beginning in January 1, 2007. The State could draw down the more advantageous CHIP match rate (approximately 70%) for services being provided at the Medicaid match rate (60%).
  - *Medicaid Buy-In* – implemented statewide September 1, 2006, allows people of any age who have a disability and are working to receive Medicaid by paying a monthly premium.

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Texas Medicaid: Recent Initiatives

- Employer Based Coverage
  - CHIP Premium Assistance – authorized by 78th Legislature, allows the state to obtain a waiver that would offer a private sector coverage alternative to CHIP families and allow Texas to gain experience with public sector subsidies for private health coverage. The number of uninsured parents should decrease.
    - Parents of CHIP-eligible children and their spouses, and other siblings of CHIP-eligible children.
    - Waiver submitted to CMS in December 2004; working with CMS to answer all outstanding questions.
  - 3-Share Waiver – authorized by 78th Legislature, expands employer-based group health insurance coverage in Galveston County. Working with UTMB and UTMB Health Plans to enroll working parents of potentially eligible or enrolled Medicaid of SCHIP children.
    - Employees who earn less than 200 percent FPL (subject to asset tests if above 150 percent FPL) and who have been uninsured for 90 days are eligible.
    - Businesses located in Galveston county with two or more employees and have not offered group health coverage for past 12 months.
    - Waiver submitted to CMS in December 2005; working with CMS to answer all outstanding questions.

Medicaid Reform: CMS Priorities

- Centers for Medicare and Medicaid (CMS) priorities for state reforms:
  - Address perceived IGT and provider financing concerns
  - Reduce Uninsured
  - Cover individuals with insurance-based payments
  - Build on private market approach
  - Strengthen employer-sponsored insurance
  - Cost and trend/containment

Medicaid Reform: State Options and Approaches

- State Options:
  - Reduce uninsured, address cost-trends; consumer empowerment and choice
  - Through DRA authority or waivers
  - Cost and trend/containment
- Approaches:
  - Medicaid/CHIP Buy-Ins (employer sponsored insurance): HIPP; CHIP-PA
  - Leverage Medicaid funds – 3-Share; low income pools
  - Market and system changes: basic benefit, risk pools, tax incentives; mandates, connector; leverage Medicaid volume

Medicaid Reform:
Deficit Reduction Act (DRA) Provisions

- Long Term Services and Supports:
  - Five year vs. three year look-back; penalty application changes; home equity limit for LTC eligibility
  - Long Term Care Partnership
  - State Plan Amendment in lieu of waivers for some community services
  - Money Follows the Person – enhanced federal match

Medicaid Reform:
Deficit Reduction Act (DRA) Options

- Cost Sharing: Premiums, Co-Payments, Deductibles
  - Cost-sharing: enforceability; premiums (non-empted over 150% FPL); co-payments non-exempted over 100% FPL); provisions for ER and pharmacy – limited application in Texas
- Basic Benefit Package Options:
  - For non-exempted populations; includes children but need EPSDT wrap
  - Kentucky, West Virginia; Idaho have DRA based basic benefit plans

Medicaid Reform: Deficit Reduction Act (DRA) Options

➢ Disabled Children Buy-In Option

- DRA allows states to expand Medicaid to children up to 300% FPL who meet SSI disability criteria; would require SPA
  - Current eligibility is approximately 74% FPL

➢ Health Opportunity Accounts (HOA)

- CMS will allow up to 10 states to pilot HOA demonstrations starting in 2007. Populations include non disabled adults and children and limited numbers of MCO enrollees (no more than 5% of an HMO's total)
- Accounts funded at $2,500 for adults and $1,000 for children

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Hospital Reimbursement and Uncompensated Reports

October 2006

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HHSC Rider 61, Uncompensated Care

- Uncompensated care in Texas is a central component of a larger public policy debate regarding:
  - Medicaid eligibility
  - Charity care
  - The uninsured
  - Medicaid reform
  - Local tax decisions

- Uncompensated care is reported in charges and without standardized rules for adjusting these charges to costs with respect to non-patient-specific revenue.
  - There is a need to adjust reported charges to identify the actual amount of uncompensated care costs.

HHSC Rider 61, Uncompensated Care

continued

- The amount of uncompensated care affects hospital rates in Texas and can impact private insurance premiums.
- Uncompensated care is a factor in the Medicaid reimbursement system.
- Uncompensated care is a component in the Disproportionate Share Hospital Reimbursement (DSH) formula, and the level of DSH funding will impact the availability of Upper Payment Limit (UPL).
- Uncompensated care impacts a hospital's not-for-profit tax status and ultimately the trade-off between tax revenue forgone by the state and the value of charity care provided.
- Uncompensated care impacts local charity care and the level of tax to support charity care.

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Estimating the Costs of Uncompensated Care in 2004: An Example

Item	HHSC Interpretation Scenario Using	Alternative Scenario Using
	Medicaid RCC	**Medicare RCC**
2004 Bad Debt and Charity Care Charges Adjustment from Charges to Costs (via RCC)	$9,200,000,000 x 34%	$9,200,000,000 x 54%
2004 Bad Debt and Charity Care at Estimated Cost	$3,128,000,000	$5,152,000,000
Less Federal Portion of DSH Less Federal Portion of UPL Less Charitable Contributions Received Less Tax Revenue	(345,000,000) (458,000,000) (82,000,000) (1,800,000,000)	(345,000,000) (458,000,000) (82,000,000) (1,800,000,000)
Estimate of Aggregate Uncompensated Care	**$443,000,000**	**$2,283,000,000**

Other Revenue Not Included In Estimated Aggregate Due to Uncertainty: Local Government Funding - $688,000,000 Tobacco Settlement Funding - $28,500,000	**$716,500,000**	**$716,500,000**

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HHSC Rider 60, Hospital Reimbursement

- Hospital expenditures represent over 62 percent of the Medicaid acute care expenditures.
- Approximately 42 percent of current level of state funding for hospital providers is through intergovernmental transfers (IGTs).
- The adequacy of Medicaid rates impacts the amount of DSH that can be spent on uncompensated care.
- The amount of DSH funding spent on uncompensated care impacts local taxing districts.
- Inadequate Medicaid rates result in Hospital Medicaid Reimbursement Shortfall.

HHSC Rider 60, Hospital Reimbursement

continued

- The cost of uncompensated care is passed to the local community through local taxes or private citizens through increased premiums.
- The multiple funding streams of Medicaid hospital reimbursement are intertwined with uncompensated care, community tax burden, insurance premiums, and the number of uninsured in Texas.
- Hospital supplemental payment methodologies, e.g., DSH and UPL, encourage hospital use by the uninsured.

HHSC Rider 60, Hospital Reimbursement

continued

The state's ability to be a prudent purchaser of Medicaid healthcare by determining the amount of hospital cost that should be reimbursed by Medicaid should be enhanced.

- Currently, hospital payments are directly linked to the mix of patients treated by each individual hospital and expenditure decisions made by each individual hospital (Standard Dollar Amount or SDA).
- Consequently, there is considerable variation in SDA costs across hospitals.
- This variation is not adequately explained by the different types of services provided or local market factors. However, there is a general perception that there is some "value-added" effect from the variation.
- There is no objective standard or measure by which to determine whether expenditures are reasonable and necessary. Rather, reimbursement for Medicaid services is driven by the individual hospital's decisions regarding expenditures and accounting.
- Medicaid reimbursement should be informed by objective measures that demonstrate that expenditures are reasonable and necessary.

A New Structure for Hospital Reimbursement

- A major purpose for transforming the hospital reimbursement methodology is to enhance Medicaid's ability to be a prudent purchaser of healthcare. Should Medicaid continue to reimburse at different rates for the "same" DRG-based treatment or should HHSC seek the best value? Is the amount of variation that exists across hospitals value-added, and should it be Medicaid reimbursed?
  - There is variation across hospitals in what Medicaid pays for the "same" DRG.
  - The industry is concerned about how the considerable variation across virtually all hospitals will be addressed as we attempt to determine value-added variation.
- A strategy for enhancing HHSC's ability to be a prudent purchaser of Medicaid services is to develop a structure that guides the reform of the hospital rates.
  1) Reform Hospital Reimbursement
     - Market area hospital rates
     - Cap the reimbursement of administration and capital costs
  2) Rebase Hospital Rates
  3) Raise Hospital Rates
     - Goal is to increase rates to remove the hospital inpatient portion of the Medicaid Shortfall

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Key Provisions in Other States: Waiver Options

- Waivers continue to provide states with broader authority to pursue reform and program changes not allowed, even under the DRA.
- Several states have developed waivers to achieve differing state objectives with some common reform elements, including:
  - Restructuring of Hospital Funding
  - IGT, DSH and UPL Funding Changes and Low Income Pools to preserve federal share of IGTs
  - Expanded Coverage of Uninsured
  - Expanded Use of Managed Care
  - Tailored Benefit Plans
  - Consumer Directed Care: Increased consumer Responsibility; Healthy Rewards

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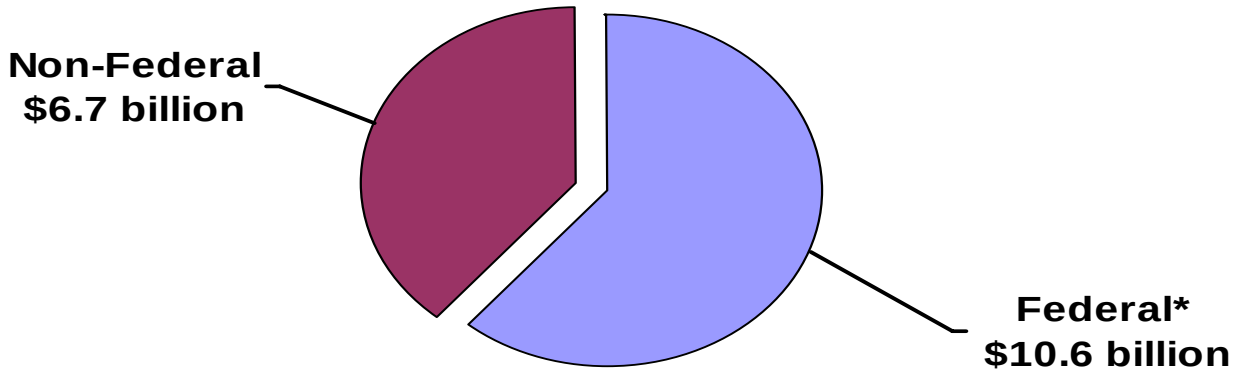
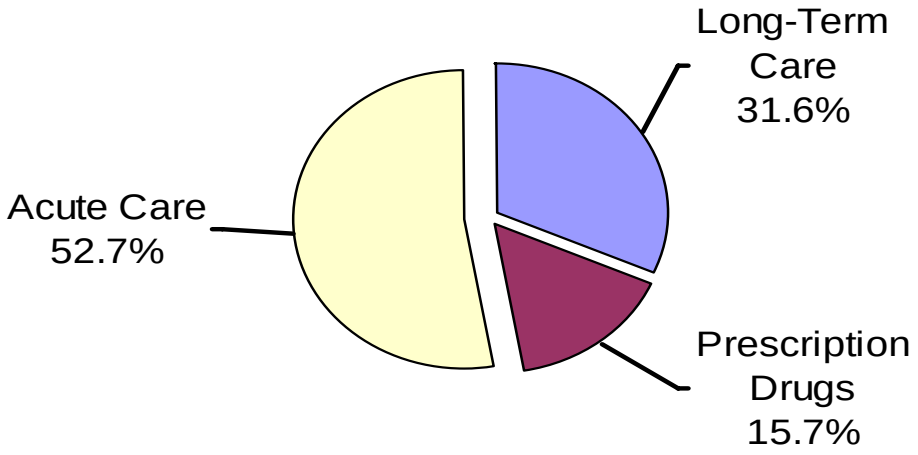
FY 2005 Medicaid Expenditures in the State Budget

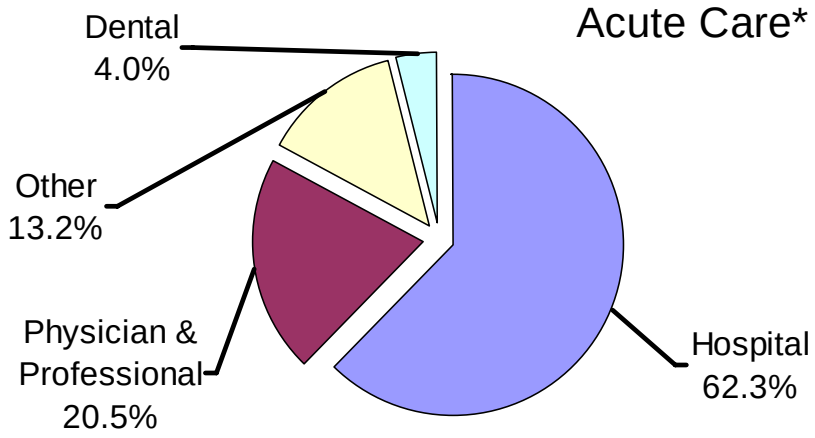
$17.3 Billion Total*



*Excludes UPL and DSH payments to the hospitals totaling $903 million and $1,487 million, respectively.

Texas Medicaid Spending by Major Function, FY 2005





*Includes UPL and DSH payments to the hospitals totaling $903 million and $1,487 million, respectively.

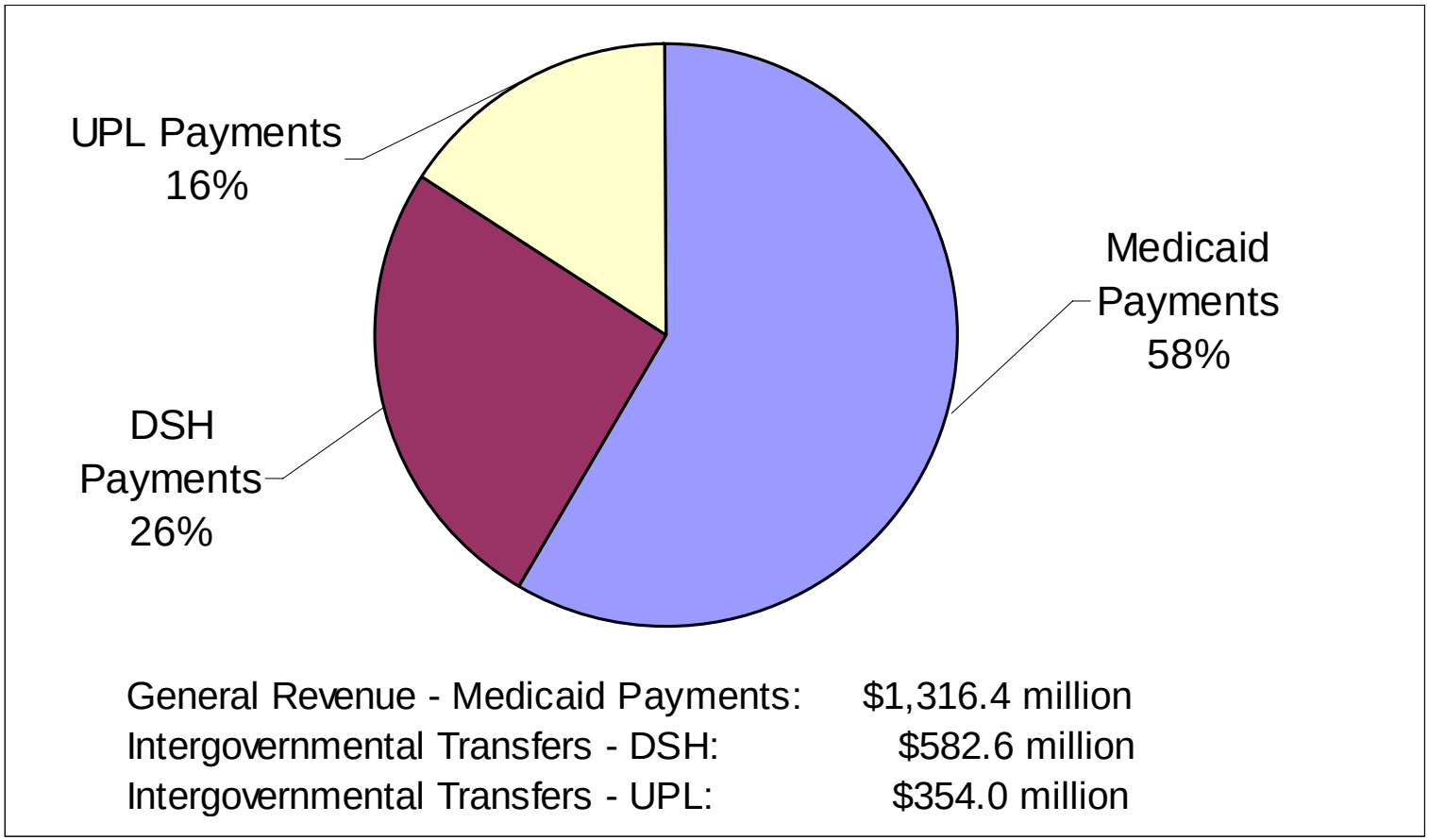
Medicaid Hospitals by Ownership/Classification FY2005 Funding (State & Federal)

Hospital Type	# of Hospitals	Medicaid Payments**	DSH Payments	# Hospitals Receiving DSH Pmts	UPL Payments	# Hospitals Receiving UPL Pmts	Total	% of Total Payments
State Owned	14	$165,675,634	$600,990,747	14	$65,264,559	4	$831,930,940	14.5%
Public	129	$701,829,752	$565,049,110	90	$764,277,099	41	$2,031,155,961	35.3%
Private Not for Profit	135	$1,577,600,087	$208,694,696	49	$49,488,019	47	$1,835,782,802	31.9%
Private for Profit	128	$914,805,235	$112,313,036	27	$24,442,578	23	$1,051,560,849	18.3%
Total	406	$3,359,910,708	$1,487,047,589	180	$903,472,255	115	$5,750,430,552	100.0%
State Share		$1,316,413,015	$582,625,245*		$353,980,430*		$2,253,018,690	

*Use of IGT

**Inpatient and Outpatient

Medicaid Hospitals
FY 2005 Funding



General Revenue - Medicaid Payments:	$1,316.4 million
Intergovernmental Transfers - DSH:	$582.6 million
Intergovernmental Transfers - UPL:	$354.0 million