Senate Committee on Health and Human Services

Medicaid Reform in Texas

September 19, 2006

TEXAS
Health and Human Services Commission

Since 2003, significant changes have been incorporated into the Texas Medicaid Program. The changes have focused on:

- **Containing Costs**
- **Managing Care**
- **Improving Health Outcomes**

TEXAS Health and Human Services Commission

Provider Payments

- Over the years, there has been a lack of recognition of increased provider costs. Rates have not been increased for some services in over 10 years.

- Beginning in FY 2004, provider payment rates were reduced:
  - 2.5% Physician and Professional Services
  - 5% Inpatient Hospital Services

- Increased efforts by CMS to reduce allowable federal reimbursement; for example:
  - Required revisions to the School Health and Related Services (SHARS) SPA will likely result in reduced funds to Texas schools
  - Much more stringent reviews of federal cost allocation methodologies
  - Extended lengths of time for review of state plan amendments that would provide additional federal reimbursement

TEXAS
Health and Human
Services Commission

Changes in Managed Care

Managed Care in Texas Medicaid has seen significant growth and change over the last few years. In 2003, 39.7% of the Texas Medicaid population was enrolled in a managed care program. That number has risen to 66.3% in 2006 and is projected to rise to approximately 72% by FY 2008.

- **HMO networks in place in all urban SDAs- most recently Nueces**
- **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**

TEXAS Health and Human Services Commission

Preferred Drug List (PDL)

HHSC implemented a PDL for Medicaid in February 2004. Pharmaceutical companies are required to offer a supplemental rebate or a program benefit proposal to be considered for the PDL.

- **The PDL now covers 55 drug classes that represent approximately 70% of the Medicaid pharmacy expenditures**
- **The PDL controls spending growth by increasing the use of preferred drugs**
- **Non-preferred drugs require prior authorization but are still available through the Medicaid program**
- **Since its inception, the PDL has reached a savings of approximately $488 million All Funds**

TEXAS
Health and Human
Services Commission

Disease Management (DM)

Statewide Texas Medicaid Enhanced Care Program (DM) began on November 1, 2004 with a contracted Disease Management Organization (DMO).

- **Program developed for Fee-for-Service (FFS) clients with specific targeted chronic illnesses (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, and Asthma)**
- **DM program expanded to include the Primary Care Case Management (PCCM) client population on September 1, 2005**
- **The DMO is at risk for reducing overall expenditures and meeting specific quality variable metrics**

Current Initiatives

- Care Management
- Programmatic/ Eligibility Changes
- SPA and Waiver Requests
- Hospital Studies

Care Management

- **Integrated Care Management (ICM)**
- **STAR+PLUS**
- **Senate Bill 1188 Projects**
  - Case Management
  - Emergency Room Utilization

TEXAS Health and Human Services Commission

Care Management

Integrated Care Management (ICM)

- Authorized by Senate Bill 1188 and House Bill 1771, 79th Legislature, Regular Session 2005 & Senate Bill 1, 79th Legislature, Regular Session 2005, Article II, HHSC, Special Provisions Sec. 49
- A non-capitated managed care model that includes integrated acute and long-term care services and supports to Aged, Blind and Disabled clients in the Dallas and Tarrant service areas; expected to serve app. 70,000 enrollees
- Final Request for Proposals was released August 14; responses are due October 6; Contract execution targeted for mid-January, 2007; Implementation planned for July 1, 2007
- Federal waivers will be required

TEXAS Health and Human Services Commission

Care Management

STAR+PLUS

- In January 2007, STAR+PLUS will expand to Harris contiguous, Nueces, Bexar and Travis service areas
- STAR+PLUS HMOs will provide both acute care and long-term services and supports to approximately 140,000 SSI members (includes the 60,000 currently enrolled in Harris County)
- Inpatient hospital services are carved out to preserve hospital UPL payments

TEXAS Health and Human Services Commission

SB 1188 Projects

Senate Bill 1188, 79th Legislature, Regular Session 2005, included provisions for approximately 87 projects relating to the Texas Medicaid Program. Two significant projects include Case Management and Emergency Room Utilization.

S.B. 1188 § 8 requires HHSC to optimize Case Management to enhance quality outcomes and cost savings throughout the HHS enterprise.

Pursuing contract with outside vendor to assist in optimization analysis:

- Proposals due – September 21, 2006
- Contract start date – November 2006

Reports required of contractor:

- Analysis of current case management
- National best practices in case management
- Waiver feasibility (and application if feasible)
- Recommendations for case management optimization
- Stakeholder involvement

TEXAS
Health and Human
Services Commission

SB 1188 Projects

Emergency Room Utilization

- **Fiscal Year 2004 data analysis of Medicaid non-emergency visits:**
  - More than 1.6 millions emergency department (ED) visits serving more than 880,000 clients
  - Infants and toddlers are more likely to use the ED than others.
  - Non-metro clients are more likely to use the ED than metro clients.
  - Clients who frequent the ED more than 3 visits during the year are much more likely to use the ED for non-emergency medical conditions.

TEXAS Health and Human Services Commission

SB 1188 Projects

Emergency Room Utilization, continued

The average cost per visit by facility type:

- ED setting & Outpatient Hospital Clinic - $144.51
- Doctor’s office - $36.13
- Rural Health Clinic - $66.29
- Federally Qualified Health Center - $123.95

TEXAS Health and Human Services Commission

SB 1188 Projects

Emergency Room Utilization, continued

Senate Bill 1, 79th Legislature, Regular Session 2005, Article II, HHSC Rider 55:

- **Medicaid Quality Initiative Pilot Project in a PCCM service delivery area to reduce inappropriate utilization of EDs**
  - Region 7 – McLennan County
  - Targeted Implementation of January 2007
  - Public awareness and case management
  - Availability of alternative health care providers and settings in the region
  - Opportunity to decrease high ED utilization

TEXAS
Health and Human
Services Commission

Programmatic/Eligibility Changes

- Women’s Health Program (WHP)
- CHIP Perinatal
- Medicaid Buy-In

TEXAS Health and Human Services Commission

Programmatic/Eligibility Changes

Women's Health Program (WHP)

Set forth in Senate Bill 747, 79th Legislature, Regular Session 2005, and Senate Bill 1, 79th Legislature, Regular Session 2005, Article II, HHSC, Rider 71

Purpose:

- To expand 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

Eligible Population Women:

- ages 18-44
- Net family income at or below 185 percent FPL
- US Citizens and Texas residents

Impact

- $49.6 million in savings by end of SFY 2008
- Expansion of women's health services to 200,000 more women by end of SFY 2008

TEXAS Health and Human Services Commission

Programmatic/Eligibility Changes

CHIP Perinatal

- Senate Bill 1, 79th Legislature, Regular Session 2005,Article II, HHSC Rider 70, authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP
- Beginning January 1, 2007, provides prenatal benefits for CHIP Perinates (unborn children) and services related to labor and delivery
- Upon birth, CHIP Perinate Newborns will have access to the same CHIP benefits as regular CHIP Members
- Eligible for 12 months of continuous coverage, beginning with the month of enrollment as a CHIP Perinate
- Allows the state to draw down the more advantageous CHIP match rate (app. 70%) for services currently being provided by Medicaid (app. 60% match rate)

TEXAS Health and Human Services Commission

Programmatic/Eligibility Changes

Medicaid Buy-In

Required by Senate Bill 566, 79th Legislature, Regular Session 2005

- 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
- Disability criteria must be met if not already receiving disability benefits from SSA

TEXAS
Health and Human Services Commission

State Plan Amendment (SPA)/ Waiver Requests

- CHIP Premium Assistance
- 3-Share Waiver
- Upper Payment Limit (UPL) SPAs

TEXAS Health and Human Services Commission

SPA/ Waiver Requests

CHIP Premium Assistance

SB 240, 78th Legislature, Regular Session 2003, changed Texas law to meet the requirements necessary to obtain a Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Waiver

- **Purpose:**
  - **Decrease number of uninsured parents.**
  - **Offer a private sector coverage alternative to CHIP families and allow Texas to gain experience with public sector subsidies for private health coverage**
- **Benefits:**
  - **Health care benefits offered under the parent's private health plan and must include certain basic services**

TEXAS Health and Human Services Commission

SPA/ Waiver Requests

CHIP Premium Assistance, continued

- **Eligibility:**
  - Parents of CHIP-eligible children and their spouses, and other siblings of CHIP-eligible children
- **Waiver Status:**
  - Waiver Submitted in December 2004
  - CMS has sent a series of questions to HHSC; HHSC submitted a response to the most recent questions in September 2006
- **Other Cost Sharing**
  - The employee would be responsible for any coinsurance, co-payments, or deductibles required by the employer plan

TEXAS Health and Human Services Commission

SPA/ Waiver Requests

3-Share Waiver

Authorized by HB 3122, 78th Legislature, Regular Session 2003

Purpose:

- **Expand employer-based group health insurance coverage in Galveston County**
- **Working with the University of Texas Medical Branch (UTMB) and UTMB Health Plans to enroll working parents of potentially eligible or enrolled Medicaid or SCHIP children.**
- **3-Share health premiums paid by:**
  - **Employees:** **1/3**
  - **Employers:** **1/3**
  - **UTMB:** **1/3 = Uses state/federal unspent SCHIP funds**

TEXAS Health and Human Services Commission

SPA/ Waiver Requests

3-Share Waiver, continued

Benefits:

- Limited package

Eligibility:

- Employees:
  - Earn less than 200 percent FPL (subject to asset tests if above 150 percent FPL)
  - Have been uninsured for 90 days
- Businesses:
  - Primary location in Galveston County, with two or more employees
  - Have not offered group health coverage for past 12 months

Waiver Status

- Submitted 1115 HIFA waiver to CMS December 2005
- Working with CMS to answer all outstanding questions

TEXAS Health and Human Services Commission

Upper Payment Limit – Active and Recently Approved Programs

Urban Non-State Public Hospital

- Non-state owned or operated publicly owned hospitals or hospitals affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Potter, Randall, Travis Counties. Annual amounts total $659.4 million ($259.4 million IGT and $400 million Federal).

Rural Hospital

- Public, non-state rural hospitals affiliated with a hospital district. Annual amounts total $75.1 million ($29.6 million IGT and $45.5 million Federal).

State Hospital UPL

- State-owned hospitals including UTMB, MD Anderson, UT Tyler, and the Texas Center for Infectious Disease. Annual amounts total $65.2 million ($25.6 million IGT and $39.6 million Federal).

- Recently received CMS approval
- Next steps- Agency rule-making to complete final implementation and begin paying

Select Private Hospitals (recently approved)

- Non-public hospitals in Bexar, Hidalgo, Maverick, Midland, Montgomery, Potter, Randall, Travis, and Webb counties. Annual estimated payments will total $200.4 million ($78.8 million IGT and $121.5 million Federal).

Statewide Hospitals (recently approved)

- UPL supplement reimbursement for Medicaid inpatient and outpatient hospital services provided by privately owned hospitals with an indigent care affiliation agreement with a hospital district or other local government entity. Annual estimated payments will total $369.8 million ($145.5 million IGT and $224.3 million Federal).
  - May impact approximately 75 hospitals.

TEXAS Health and Human Services Commission

Upper Payment Limit – Proposed Programs

Children's Hospital

- HHSC Rider 73 directs the use of $25.0 million General Revenue for the 2006-2007 biennium to provide UPL reimbursement for children's hospitals. If approved, annual estimated payments would total $31.25 million ($12.5 million General Revenue and $18.75 million Federal).
- Waiver submitted April 2006; CMS is reviewing

State University Physicians

- Members of practice plans affiliated with a state academic heath center. If approved, annual estimated payments would total $111.9 million ($43.9 million IGT and $68 million Federal).
- Waiver submitted May 2006; CMS is reviewing

Tarrant County Physicians

- Members employed by, or under contract with, non-state owned or operated publicly owned hospitals or hospitals affiliated with a hospital district in Tarrant County. If approved, annual estimated payments would total $6 million ($2.4 million IGT and $3.6 million Federal).
- Waiver submitted November 2004; CMS is reviewing

TEXAS Health and Human Services Commission

Hospital Studies

SB 1, 79th Legislature, Regular Session 2005, Article II, HHSC Riders 60 and 61 required HHSC to conduct studies on certain Topics related to hospital financing and uncompensated care.

Rider 60- Medicaid Provider Reimbursement HHSC shall:

- **Study and recommend changes to the hospital reimbursement rate methodology, including waivers to combine GME, DSH and UPL**
- **Report with options and fiscal impact of recommendations due October 1, 2006**

Rider 61- Study Regarding Uncompensated Care HHSC shall:

- **Study the components and assumptions used to calculate uncompensated care in Texas hospitals**
- **Report with recommendations on standardizing hospitals' uncompensated care amounts due to the 80th Legislature**

TEXAS Health and Human Services Commission

Deficit Reduction Act (DRA)

- DRA Mandatory Provisions
- Options Under the DRA

TEXAS Health and Human Services Commission

DRA Mandatory Provisions

Citizenship Verification

Effective July 1, 2006, applicants for Medicaid must provide documentary evidence to establish both citizenship and identity – previous policy allowed self-declaration.

- Acceptable verification is prescribed in the law and through Centers for Medicare and Medicaid Services (CMS) guidance
- Current recipients are allowed until their next review to provide proof
- New requirement is delaying eligibility determination, and increasing workload

TEXAS Health and Human Services Commission

DRA Mandatory Provisions

Third Party Recovery

The DRA improves states' ability to recover third party payments by:

- **Expanding the definition of health insurer to include self-insured plans, managed care organizations, pharmacy benefit manger or other parties that are responsible for paying claims for health care**

- **Stipulates that state laws must require health insurers to:**
  - **Provide States with eligibility and coverage information;**
  - **Honor the States assignment of rights**
  - **Not deny claims based on procedural reasons (e.g. timely filing, failure to present card at point of sale, claim format, etc.)**
  - **Allow 3-years for a state to file a claim**
  - **Allow 6-years from the date a claim was submitted to address procedural issues before a claim is denied**

TEXAS Health and Human Services Commission

DRA Mandatory Provisions

LTC Asset Eligibility Changes

- Transfers made on or after 2/8/2006 have a 60 month look-back period, instead of 36 months
- If asset transfers are made before eligibility for Medicaid, new DRA requirements begin the penalty period (for transfers made on or after 2/8/2006) at the time of eligibility for Medicaid- current policy begins asset transfer penalties on the 1st day of the month the transfer was made

TEXAS Health and Human Services Commission

DRA Mandatory Provisions

LTC Asset Eligibility Changes, continued

- **Current Texas Medicaid Eligibility requirements for long term care exempt individuals' home equity from consideration**

- **The DRA limits home equity to $500,000**
    - **Does not apply if spouse or children reside in home**
    - **Amounts increase starting in 2011 based on CPI**
    - **Effective January 1, 2006**

- **The DRA provides a state option to increase the home equity criterion to $750,000**

- **Agency rule for Texas Medicaid LTC eligibility maintains the DRA limit of $500,000**

TEXAS Health and Human Services Commission

Options Under the DRA

Cost Sharing: Premiums, Co-payments, Deductibles

- The DRA makes costsharing enforceable-- If premiums required and not paid, eligibility can be denied; If costsharing not paid, providers can deny service
- Limited to annual cap of 5% of family income

Premiums: For non-exempt adults over 18 with income over 150% FPL

- Exemptions include: pregnant women; children in mandatory coverage groups and foster care; clients in institutional care
- In Texas, only a small number of Medicaid clients could be required to pay premiums (under 5000 clients)

TEXAS Health and Human Services Commission

Options Under the DRA

Cost Sharing: Premiums, Co-payments, Deductibles

Co-payments and Deductibles can be required for those: over 100% FPL; aged 18 or older; and children in non-mandatory groups

- Can not be required for pregnant women when service affects pregnancy; foster or adopted care coverage children; those in institutions; family planning services
- No co-pays or deductibles for any preventive services for any client
- Can require cost-sharing for non-emergent use of E.R. only if actual access available for care at other setting and if other conditions met
- In Texas, cost-sharing largely limited to a small group of non-mandatory children up to 5 years old

TEXAS Health and Human Services Commission

Options Under the DRA

Basic Benefits Packages

- The DRA allows states to use a basic or benchmark benefit (like the SCHIP benefit) for a limited group of Medicaid enrollees
- Exempted populations include individuals who are: pregnant, blind or disabled, dual eligibles, in institutions; medically frail or have special needs; receiving long-term care services; and TANF eligibles
- Children under 19 can be provided a basic benefit package, but only if they are also provided additional medically necessary services meeting EPSDT requirements
- The basic benefit package can not be used for a Medicaid expansion; it is only for those groups eligible at the time the DRA become law
- In Texas, a small group of Medicaid eligibles could be provided the basic benefit package: foster children with incomes between 200 – 400% FPL and pregnant women with incomes between 133% FPL and 185% FPL. Texas could provide a basic benefit to children IF it has provisions to provide EPDST services to those children needing them.

TEXAS
Health and Human
Services Commission

Options Under the DRA

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 SSI eligibility is about 74% FPL
- Coverage phases in by age groups starting 2007
  - Up to age 6 in January 2007
  - Up to age 12 in 2008
  - Up to age 18 in 2009
- If families have coverage under group health plans, parents must apply for, enroll in and pay premiums for that coverage if the employer pays at least 50% of premiums and coverage is effective at reducing Medicaid
- States can choose to implement sliding scale premiums

TEXAS
Health and Human
Services Commission

Options Under the DRA

Disabled Children Buy-In Option, continued

State Decision whether to pursue this optional coverage.

If Yes:

- Income level of families (up to 300% FPL)
- Whether to impose premiums
- Whether to use sliding premium scale

Would require:

- additional state match
- systems and eligibility processing changes
- a Medicaid state plan amendment

Children included would have access to all EPSDT services

TEXAS
Health and Human
Services Commission

Options Under the DRA

Long-Term Care (LTC) Partnerships

- The DRA allows states to implement Partnership programs through State Plan Amendments to:
  - Support purchase of private LTC insurance
  - Allow individuals who purchase LTC insurance to protect some of their assets and still qualify for Medicaid
  - Help shift LTC funding from public to private sector: Medicaid changes to payor of last resort instead of payor of first resort
- Goal: to delay, shorten or avoid use of Medicaid to pay for LTC for those who, without the Partnership insurance, would seek Medicaid
- Thought to provide an incentive for those who would have used Medicaid, to buy insurance
- Four states have programs that started in 1992 and 1993; and claim Medicaid savings: New York, California, Indiana, Connecticut

TEXAS Health and Human Services Commission

Options Under the DRA

Money Follows the Person (MFP) Grant

- The federal Deficit Reduction Act (DRA) includes an opportunity to expand MFP initiatives
  - Under the DRA – MFP grant, any Medicaid-eligible individual who has resided in a nursing facility, hospital, or ICF/MR for a specified period of time depending on state policy (at least 6 months up to 2 years) would be eligible for MFP
  - CMS would pay an enhanced rate for 12 months for qualifying individuals who choose to receive services in the community
  - For Texas, the enhanced rate would result in an increase in the federal match from 60 percent to 80 percent of eligible client costs for one year
- DADS will work with HHSC to submit a grant application in order to provide more services in community settings at an increased Medicaid match

TEXAS Health and Human Services Commission

Options Under the DRA

Home & Community Based Services (HCBS) for Mental Health

- Effective 1/1/07, States may provide certain HCBS under their State Plans to Medicaid clients who are under 150% poverty

- Criteria for receiving the HCBS services must be less strict than for receiving institutional care

- States:
  - can limit the number of individuals served and limit the services geographically
  - are not required to demonstrate cost effectiveness in relation to institutional care
  - may allow consumer-directed care

- DADS anticipates maintaining current waiver programs without moving to a SPA; DSHS assessing SPA as a possibility for serving MI populations

TEXAS Health and Human Services Commission

Options under the DRA

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; limited number of MCO enrollees (no more than 5% of state total)
- Accounts funded with:
  - Adults—$2,500
  - Children—$1,000
- Clients use HOA funds:
  - To pay for medical services
  - To pay for applicable deductibles and co-pays
  - To rollover to following year
  - To pay for private insurance or approved self-advancement expenditures
- Traditional Medicaid is payor of last resort