House Committee on Public Health

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Deputy Executive Commissioner for Health Services

February 9, 2005

TEXAS
Health and Human
Services Commission

Presentation Overview

- HHSC Consolidation Update
- Introduction to Medicaid
- Introduction to Children's Health Insurance Program (CHIP)

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HHSC Consolidation Update

- 12 HHSC agencies consolidated into 5.
  - **Department of Family and Protective Services (DFPS)**
    - Created February 1, 2004
  - **Department of Assistive and Rehabilitative Services (DARS)**
    - Created March 1, 2004
  - **Department of Aging and Disability Services (DADS)**
    - Created September 1, 2004
  - **Department of State Health Services (DSHS)**
    - Created September 1, 2004
  - **Health and Human Services Commission (HHSC)**
    - Consolidation completed September 1, 2004

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HHSC Consolidation Update

Agency Consolidation Guiding Principles

- Focus on service delivery.
- Foster direct management accountability.
- Reorganize around common service delivery.
- Promote integration and consistency.
- Achieve administrative support efficiencies.

• Transition accomplishments:

- Realignment and transfer of 46,000 employees to new agencies
- Created 5 new organizational structures
- Maintained all client service delivery functions
- Re-established Federal Cost Allocation Plan for approximately 100 different Federal funding streams
- Completes major H.B. 2292 restructuring
- Implemented Consolidated Financial Management and Human Resource Management System (HHSAS)
  - Standardized system for all five agencies
  - Over 10,000 contracts transferred between agencies
  - Nearly 2,000 contracts entered into HHSAS for payment by end of the month

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HHSC Consolidation Update

- **Support functions consolidated at HHSC**
  - Human Resources
  - Administrative Procurement/Contracting
  - Office of Inspector General
  - Strategic Planning
  - Civil Rights
  - Leasing and Facilities Management
- **Partially consolidated functions**
  - Financial Services
  - Legal Services
  - Information Technology
  - Ombudsman

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HHSC Consolidation Update

The Consolidated Texas Health and Human Services Enterprise

as directed by H.B. 2292, 78th Legislature

Governor

HHS Transition Legislative Oversight Committee

2 Senate members
2 House members
3 Public members
HHSC Exec. Commissioner, ex-officio

Health and Human Services Commission

Albert Hawkins, Executive Commissioner

- HHS Rate Setting
- Vendor Drug Program
- Medicaid
- Nutritional Services
- Eligibility Determination
- Consolidated Support Services
- Immigration and Refugee Affairs
- Children's Health Insurance Program (CHIP)
- Temporary Assistance for Needy Families (TANF)
- Family Violence Services
- HHS Ombudsman
- Interagency Initiatives
- HHS Program Policy

Office of Inspector General

Health & Human Services Council

HHSC
DHS

Aging & Disability Services Council

State Health Services Council

Family & Protective Services Council

Assistive & Rehabilitative Services Council

Department of Aging and Disability Services

Jim Hine, Commissioner

- Mental Retardation Services
  - State Schools
  - Community Services
- Community Care Services
- Nursing Home Services
- Aging Services

DHS
MHMR
TDoA

Department of State Health Services

Dr. Eduardo Sanchez, Commissioner

- Health Services
- Mental Health Services
  - State Hospitals
  - Community Services
- Alcohol & Drug Abuse Services

MHMR
TCADA
TDH
THCIC

Department of Family and Protective Services

Carey Cockerell, Commissioner

- Child Protective Services
- Adult Protective Services
- Child Care Regulatory Services
- Prevention and Early Intervention Services

PRS

Department of Assistive and Rehabilitative Services

Terry Murphy, Commissioner

- Rehabilitation Services
- Blind and Visually Impaired Services
- Deaf and Hard of Hearing Services
- Early Childhood Intervention Services

ECI
TCB
TCDHH
TRC

Agencies formerly providing programs

Introduction to Medicaid

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Introduction to Medicaid Table of Contents

- Overview
- Program Administration
- Who Does Medicaid Serve?
- What Services Does Medicaid Provide?
- Who Provides Medicaid Services?
- How is Medicaid Funded?
- Caseload and Cost Trends

What is Medicaid?

- **Medicaid is a jointly funded state-federal program that provides medical coverage to eligible needy persons. Federal laws and regulations:**
  - Require coverage of certain populations and services; and
  - Provide flexibility for states to cover additional populations and services.
- **Medicaid is an entitlement program, meaning:**
  - Guaranteed coverage for eligible services to eligible persons;
  - Open-ended funding based on the actual costs to provide eligible services to eligible persons.

Joint State and Federal Program

- **Both the federal and state governments have a role in overseeing and funding the Medicaid program.**
- **At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS) within the U. S. Department of Health and Human Services**
- **Each state has a State Plan that constitutes that state's agreement with the federal government on:**
  - Who will receive Medicaid services – all mandatory and any optional eligibles
  - What services will be provided– all mandatory and any optional services
  - How the program will be administered
  - Financial Administration of the program
  - Other program requirements

Waivers

- **Provide states with options for their Medicaid programs. Federal law allows states to apply to CMS for permission to deviate from certain Medicaid program requirements through waiver applications.**
  - States typically seek waivers to:
    - Provide different kinds of services
    - Provide Medicaid to new groups
    - Target certain services to certain groups
    - Test new service delivery and management models
  - Waivers have some limits in what they can be used for:
    - Not all provisions can be waived by CMS
    - Waivers must meet budget neutrality standards
    - Waivers must be justified to meet a purpose consistent with Medicaid goals.

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Texas Medicaid Administrative Support (TMAS) Contracts

- **Texas contracts with private companies to operate the following administrative components of the program:**
  - Claims Administrator for Fee for Service and PCCM
    - Contract with Affiliated Computer Systems (ACS). ACS subcontracts with the following entities and they are jointly referred to as the Texas Medicaid & Healthcare Partnership (TMHP): Accenture, Computer Associates (CA), Hewlett Packard, MMC Group, Public Consulting Group, and SBC Communications
  - PCCM Program Administration
    - Contract with Affiliated Computer Systems (ACS). ACS and its subcontractors are jointly referred to as TMHP.
  - Managed Care Member Enrollment (Contract with MAXIMUS)
  - Managed Care Quality Assessment (Contract with the Institute for Child Health Policy (ICHP))

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Medicaid Eligibility

- **Medicaid eligibility is financial and categorical**
  - Eligibility factors include:
    - Family income;
    - Age; and
    - Other factors such as being pregnant or disabled or receiving TANF
- **Medicaid serves:**
  - Low-income families
  - Children
  - Related caretakers of dependent children
  - Pregnant women
  - Elderly
  - People with disabilities

Texas Health and Human Services Commission

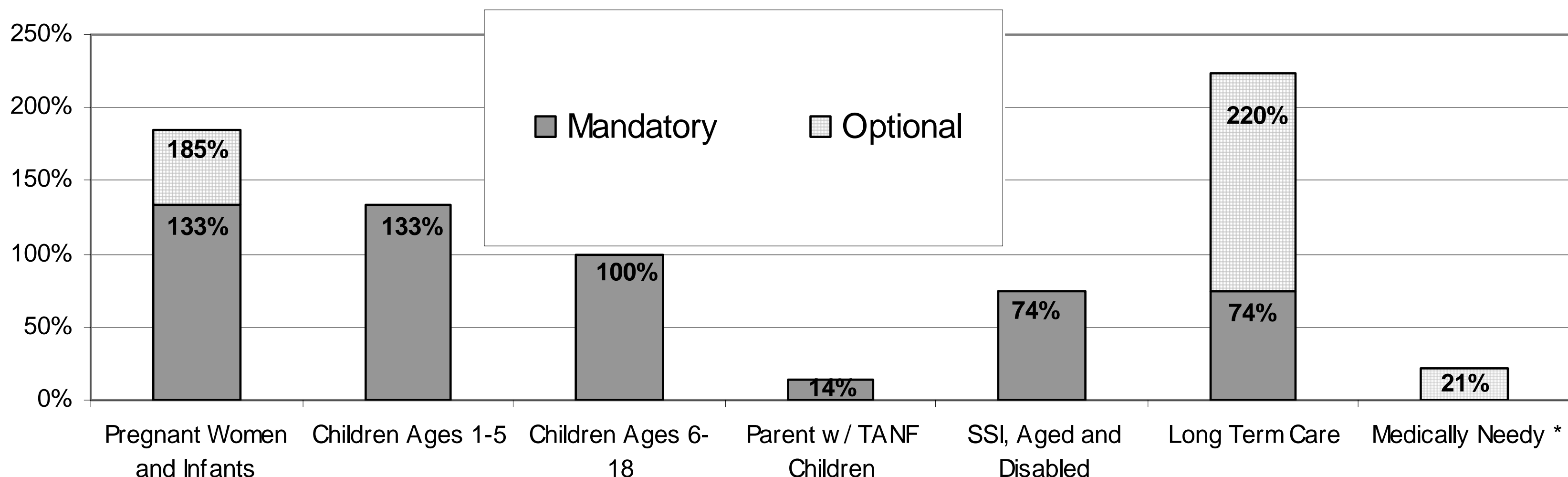
Mandatory and Optional Eligibles

- The federal government requires that people who meet certain criteria be eligible for Medicaid. These are “mandatory” Medicaid eligibles and all state Medicaid programs must include these mandatory populations.
- The federal government also allows states to provide services to additional individuals and still receive the federal share of funding for services provided to them. These are “optional” Medicaid eligibles.
- Texas covers some people in “optional” eligibility categories such as certain pregnant women and long term care clients.

Income and Federal Poverty Levels

- **Financial eligibility for Medicaid and many other social programs is based on a family's income level as compared to Federal Poverty Levels (FPLs)**

Figure 3.2: Texas Medicaid Income Eligibility Levels
for Selected Categories, November 2004



In SFY 2005, for TANF parents with children, eligibility is determined based on an income no higher than $188 a month for a family of 3, which translates into 14% of poverty. For medically needy pregnant women and children, the maximum monthly income limit is $275.

Source: Texas Health and Human Services Commission, Texas Medicaid Program

Medicare and Medicaid

- **Medicare beneficiaries pay premiums (Part B), deductibles, and coinsurance.**
  - Part A covers hospital costs
  - Part B covers physician outpatient services
  - Part C is Medicare+Choice, a managed care alternative to Parts A and B
  - Part D will cover pharmacy costs
- **It is important to note that Medicaid, not Medicare, pays for most Long Term Care.**

Texas Health and Human Services Commission

Medicare and Medicaid: Dual Eligibles

- **Medicare Prescription Drug, Improvement and Modernization Act of 2003: Federal legislation passed in December of 2003 provides pharmacy coverage for people with Medicare.**
  - Starting 1/1/06, the federal government will offer prescription drug coverage under the Medicare program (Medicare Part D).
  - Starting 1/1/06, Medicaid will not provide drug coverage for dual eligibles; but will be required to pay the federal government a percentage of what Texas would have paid for pharmacy coverage for dual eligibles (ie., "clawback").

Mandatory Services

- **Federal law requires that all state Medicaid programs pay for certain services to Medicaid clients. The following are mandatory Medicaid services:**
  - Early Periodic Screening, Diagnosis and Treatment (EPSDT) also known as Texas Health Steps for children under age 21
  - Federally Qualified Health Centers
  - Home health care
  - Inpatient and outpatient hospital
  - Family planning/genetics
  - Lab and X-ray
  - Nursing facility care
  - Pregnancy-related services
  - Rural Health Clinics
  - Physicians
  - Certified Nurse Midwife
  - Certified Pediatric and Family Nurse Practitioner

Texas Health and Human Services Commission

Optional Services

- **Optional services provided in Texas include services such as:**
  - Prescription drugs
  - Case management for women with high-risk pregnancies and infants
  - Emergency medical services
  - Hospice care
  - Intermediate Care Facilities for people with Mental Retardation or Developmental Disabilities (ICF-MR)
  - Institutions for Mental Disease (IMD)
  - Medically necessary surgery and dentistry (not routine dentistry)
  - Personal care services in the home
  - Physical therapy
  - Some rehabilitation services
  - Certified Registered Nurse Anesthesiologists

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Pharmacy Services

- **In Medicaid, pharmacy services are provided through the "Vendor Drug" program**
  - The state contracts with pharmacies to provide Medicaid clients with pharmacy benefits.
  - Over 3,700 or approximately 70% of all licensed Texas pharmacies under contract.
  - Pharmacies submit bills called "claims" to the state, and are reimbursed for providing appropriate prescriptions to Medicaid enrollees.
  - HHSC Vendor Drug Program performs most administrative functions.

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Medicaid Delivery Models

- **Fee for Service (Traditional Medicaid)**
- **Managed Care:**
  - Managed Care Models in Texas:
    - Health Maintenance Organizations (HMO)
    - Primary Care Case Management (PCCM)
  - Managed Care Programs in Texas:
    - STAR (State of Texas Access Reform) – Acute Care HMO and PCCM for children, pregnant women, and TANF adults
    - STAR+PLUS – Acute & Long-Term Care HMO and PCCM
    - NorthSTAR – Behavioral Health Care HMO

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Medicaid HMOs by SDA

Medicaid Managed Care
Statewide Service Areas

Bexar
Community First, Superior, PCCM

Dallas
Amerigroup, Parkland, PCCM

El Paso
El Paso First, Superior, PCCM

Harris
Amerigroup, Community Health Choice, Texas Children's, PCCM

Lubbock
First Care, PCCM

Travis
Amerigroup, Superior

Tarrant
Amerigroup, JPS STAR

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Provider Reimbursement: Claims Payment

- **Payment and processes vary by delivery model**
- **HMO Model:**
  - Providers are paid reimbursement rates established by the HMO
  - Bills for services, called “claims” are sent to the HMO for payment
- **Fee for Service and PCCM Models:**
  - Providers are paid Medicaid reimbursement rates for providing eligible Medicaid services to eligible clients.
  - Bills for services, called “claims” must be sent to the state within 95 days of the date the service was provided.
  - Claims may be submitted electronically or on paper:
  - 800,000 - Weekly average of electronic claims received
  - 200,000 – Weekly average of paper claims received
  - Claims processed for over 20,000 providers

Federal Medical Assistance Percentage (FMAP)

- **The portion of total Medicaid costs paid by the federal government is known as the Federal Medical Assistance Percentage (FMAP).**
  - Based on average state per capita income compared to the U.S. average
    - 83% - maximum percentage under federal law
    - 50% - minimum percentage under federal law
    - 53% to 80% - range for all states in Federal Fiscal Year (FFY) 2005
  - 60.87% - Texas FMAP for FFY 2005
    - Of each dollar spent on Medicaid services in Texas, the federal government pays 60 cents.
  - Small Changes in the FMAP result in loss of federal funds
    - Example - a decrease of one percent would result in a decrease of about $150 million federal dollars to the state.

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Disproportionate Share Hospitals (DSH)

- **The Medicaid Disproportionate Share Hospital (DSH) Program is a source of reimbursement to state-operated and non-state (local) Texas hospitals that treat indigent patients.**
  - Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients.
  - DSH funds, unlike other Medicaid payments, are not tied to specific services for Medicaid-eligible patients.
- **Total all funds to all DSH hospitals in SFY 2004 $1.449 Billion**
- **State DSH Hospitals: $591.6 Million**
- **Non-state DSH Hospitals: $858 Million**

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Upper Payment Limit (UPL)

UPL refers to a financing mechanism used by states to provide supplemental payments to hospitals or other providers.

- Federal regulations allow states to pay providers up to what Medicare would have paid, or the amount the hospital charges for services.
- States may use local funds transferred to the state to fund the supplemental payments.

- **HHSC currently makes UPL payments to 4 state-owned hospitals; 11 non-state large urban public hospitals, and 100 non-state owned rural public hospitals.**
- **Proposed changes at the federal level may put continued UPL funding at risk.**

Introduction to Children's Health Insurance Program (CHIP)

Introduction to CHIP
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- Overview
- Who Does CHIP Serve?
- What Services Does CHIP Provide?
- Who Provides CHIP Services?
- How is CHIP Funded?
- Caseload Trends

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What is CHIP?

- **CHIP is a joint state-federal program that provides medical coverage to eligible children up to age 19, who are not already insured.**
- **Federal law and regulations:**
  - Requires each state to set eligibility guidelines, service levels, and delivery systems; and
  - Requires each state to operate a state plan listing these elements.
- **CHIP is NOT an entitlement program, meaning:**
  - The state can determine age and income eligibility;
  - The state can cap enrollment; and
  - The state can limit service benefits as approved by the U.S. Secretary of Health and Human Services.
  - Total federal financial participation is limited to Block Grant amounts allocated to each state.

CHIP Eligibility

- **In April 2000, Texas offered CHIP as a separate health insurance program for children who:**
  - Are under the age of 19;
  - Have family incomes up to 200 percent FPL;
  - Are not eligible for Medicaid or enrolled in private insurance;
  - Are uninsured; and
  - Are U.S. citizens or legal Permanent Residents.

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CHIP Benefits

- Inpatient Hospital Services, including Inpatient Rehabilitation Hospital.
- Outpatient Hospital and Ambulatory Health Care Services.
- Lab and X-ray for inpatient, outpatient and ambulatory health care.
- Physician/Physician Extender Professional Services (surgical and medical), including services such as immunizations and well-baby and well-child examinations.
- Prescription Drugs.

Texas Health and Human Services Commission

CHIP Benefits

- **Physical/Speech/Occupational Therapy**
- **Home Health**
- **Emergency Services**
- **Transplants**
- **Behavioral Health and Substance Abuse Benefits**
  - Eliminated, then the following CHIP mental health and substance abuse benefits reinstated effective February 1, 2004:
    - 30 days of inpatient mental health services
    - 30 outpatient visits for mental health treatment
    - 5 days of inpatient detoxification/stabilization services for substance abuse
    - 30 days of residential treatment for substance abuse
    - 30 outpatient visits for substance abuse treatment

CHIP Delivery Models

- **CHIP Service Delivery Models include:**
  - HMO: A type of health care plan that arranges for or provides benefits to covered clients
    - Client selects an HMO and a Primary Care Provider (PCP)
    - PCP authorizes services within the network
  - EPO: A type of health care plan offered by an issuer that arranges for or provides benefits to covered persons through a network of exclusive providers, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or approved referral
    - Limited to services provided to client in network, except for emergencies

CHIP Premium Assistance Program

- **HHSC has submitted a CHIP Premium Assistance (PA) Waiver Program to CMS for approval.**
- **Under the Texas proposal:**
  - If a CHIP family enrolls their children in their employer or other group coverage, they would receive a flat subsidy of about $150 per month. At least one parent would also be enrolled, since most employer coverage offers “employee plus children” or “employee plus family” options.
  - A continued employer contribution to the cost of coverage will be required.
  - Point of service cost sharing (doctor’s office, prescription co-pays, etc.) will be whatever the group plan requires.
  - A CHIP family’s participation in premium assistance will be optional.

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How is CHIP Funded? Federal Match Rate

- **As in Medicaid, the federal government pays a percentage of CHIP program costs.**
- **The federal government pays a higher percentage for CHIP than for Medicaid:**
  - The federal government pays 72.61% of CHIP medical care expenditures; compared to 60.87% of Medicaid medical care expenditures.
  - In CHIP, each $1.00 of state funds draws $2.65 in federal funds.
  - Of every dollar spent on CHIP medical costs, $0.72 is paid for by the federal government.

How is CHIP Funded? State and Other Funding

- **State Match for SFY 04-05 (Feb. update) from:**
  - Tobacco match: $202,500,000
  - Tobacco settlement receipts: $75,000,000
  - GR Match for CHIP: $26,000,000
  - Other State Funds
    - CHIP Drug Rebates: $6,500,000
    - CHIP Experience Rebates: $3,000,000
    - Cost Sharing: $35,500,000
- **Member Cost Sharing (Premium Co pays)**
  - Used to offset total CHIP costs
  - Can not be used for federal match

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Proposed CHIP Cost Sharing

- **Annual enrollment fee proposal:**
  - $50 for families between 133-150% FPL
  - $70 for families between 151-185% FPL
  - $100 for families between 186-200% FPL
- **Families beginning or re-enrolling in CHIP would be required to pay the enrollment fee in semi-annual installments (upon enrollment and at six months)**
  - Suspend CHIP enrollment for up to three months if the family fails to make timely payment of the second installment
  - If the family pays within the three months, CHIP enrollment resumes with no 90-day waiting period
- **An annual enrollment fee would not be in effect until integrated eligibility is implemented**

Average Total Monthly Enrollment In CHIP

- Actual Enrollment
- January 2005 Enrollment = 322,055
- FPL level for January:
- Up to 100%: 24,693 (7.4%)
- 100-150%: 167,637 (50.5%)
- 151-185%: 111,718 (33.6%)
- 186-200%: 28,007 (8.4%)