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Health and Human
Services Commission

Major Appropriation Issues

Presented to the House Appropriations Subcommittee on Health and Human Services

February 11, 2005

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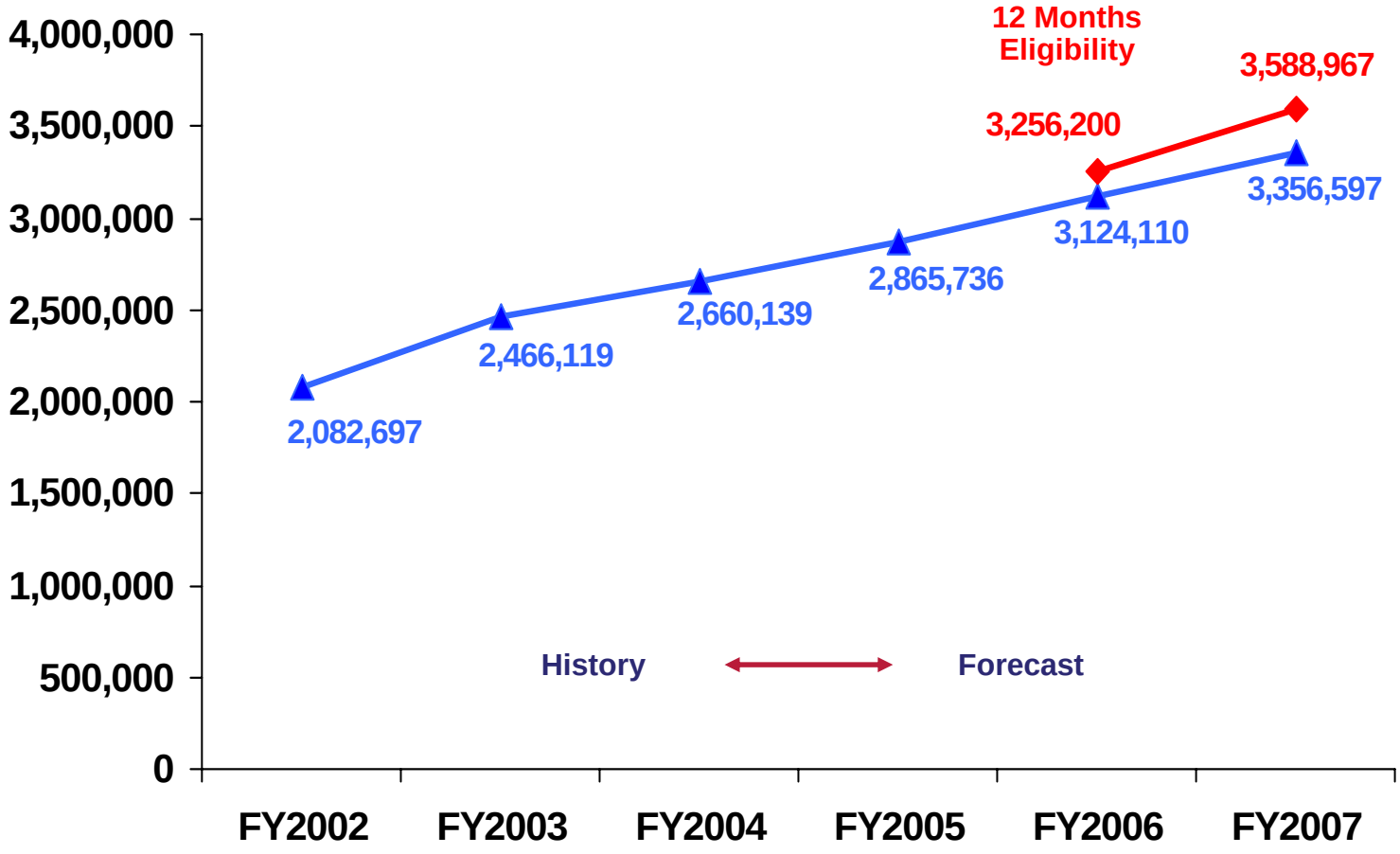
Major Caseload Projections

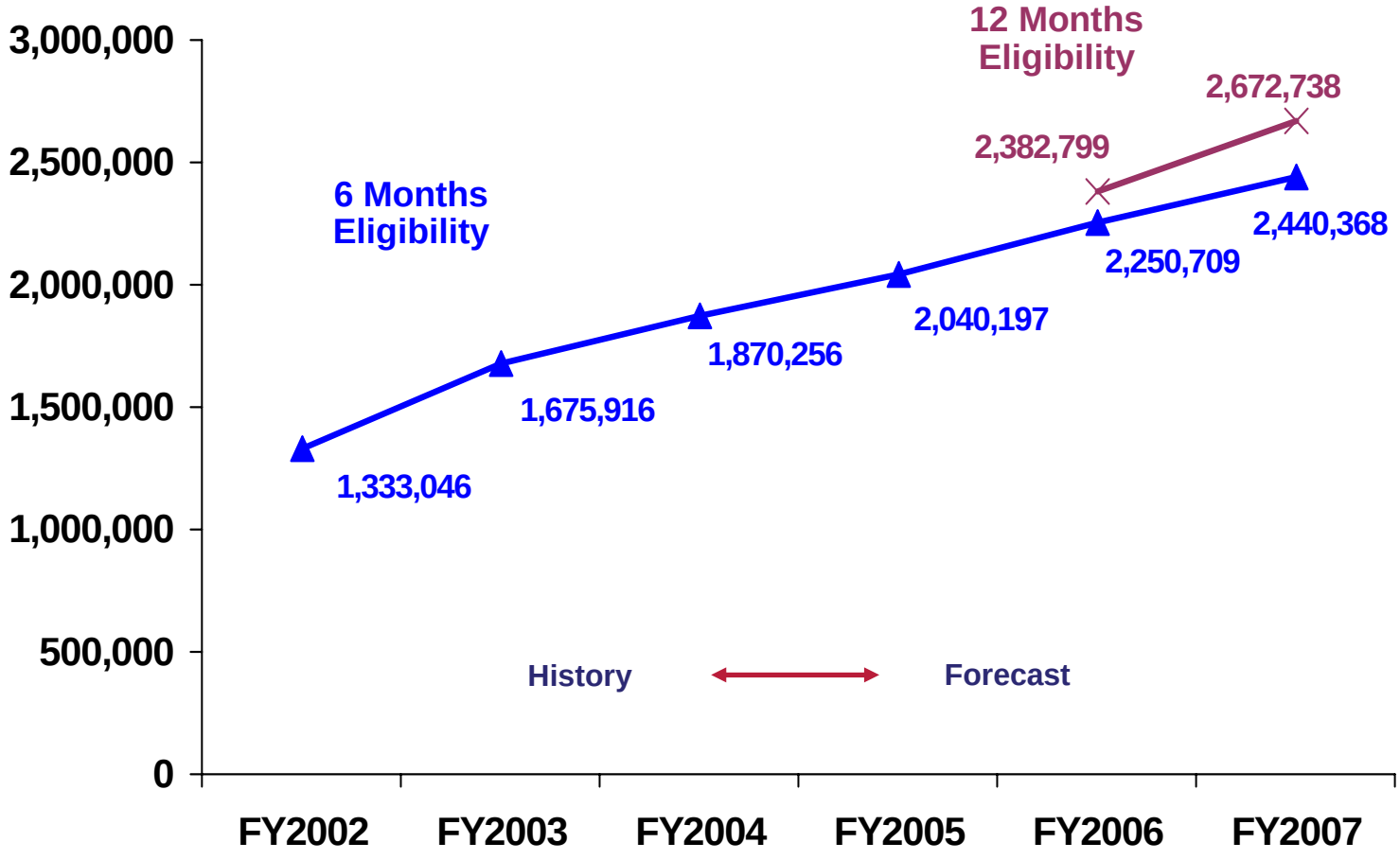
Major Caseload Projections

- **Medicaid Acute Care Caseload, February 2005**



Major Caseload Projections

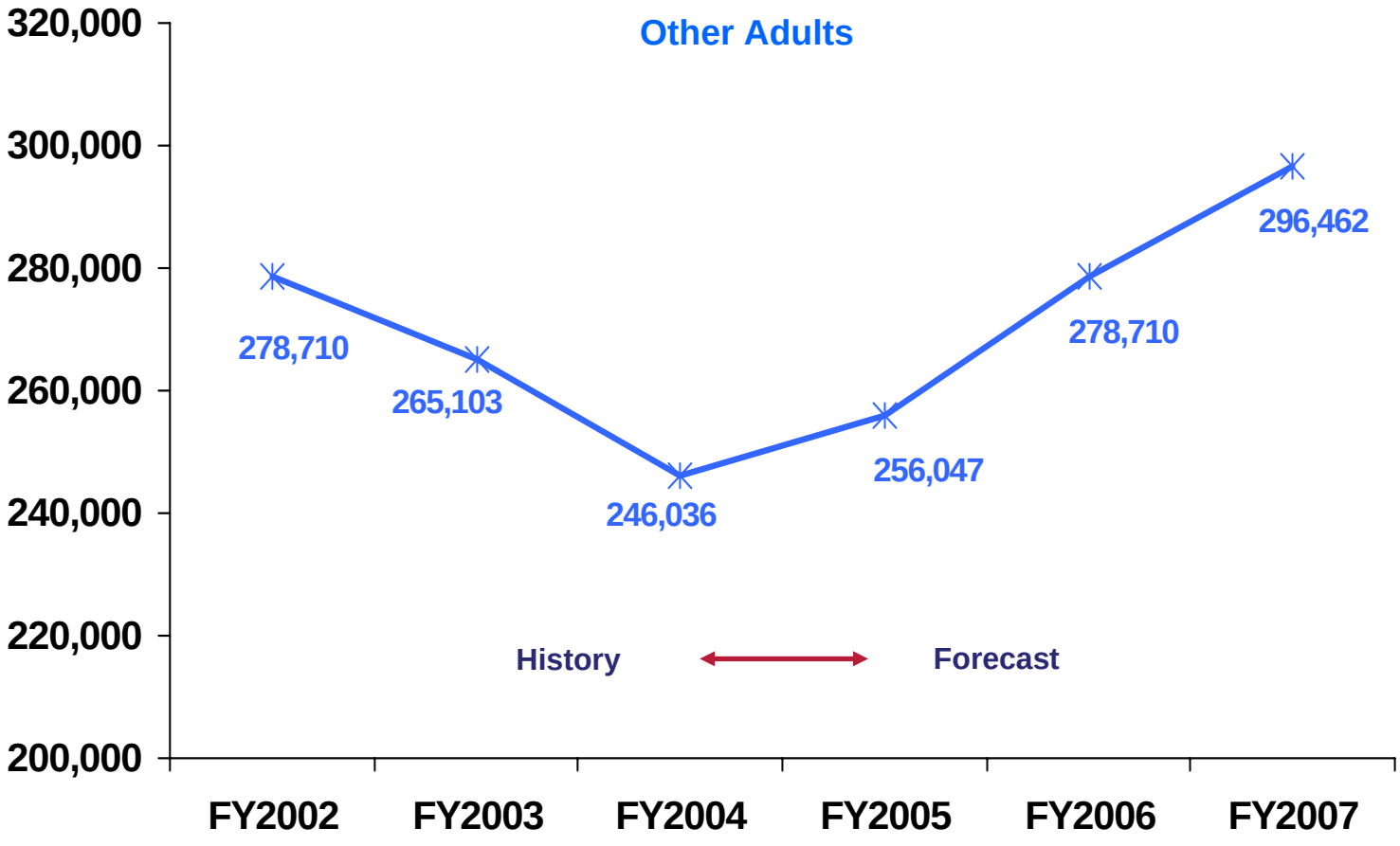
- **Medicaid Children's Risk Groups, LAR Update, February 2005**



Children's Risk Groups include all non-disabled children (ages 0 – 18, 19 & 20 for TANF)

Major Caseload Projections

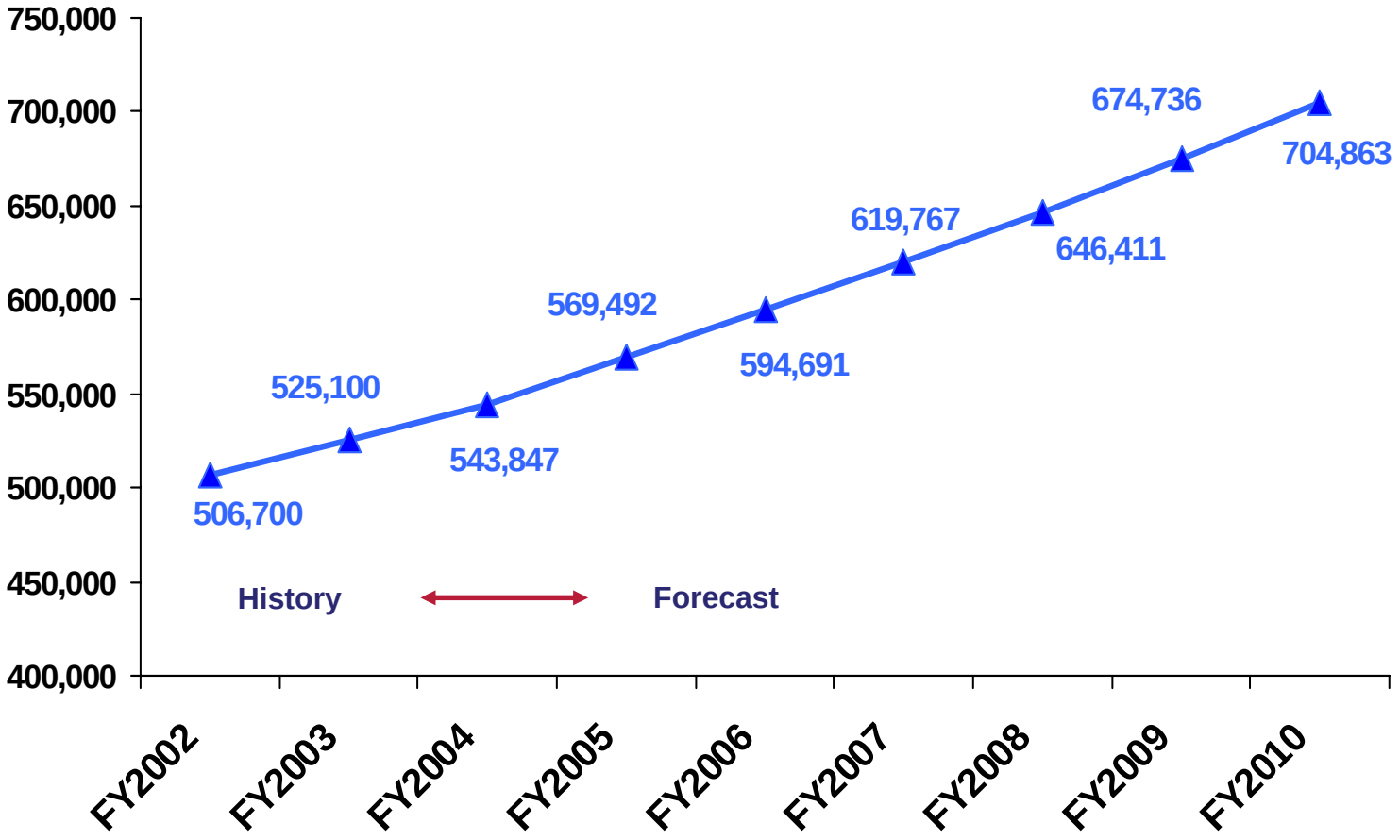
- **Medicaid Other Adult Risk Groups, LAR Update, February 2005**



Other Adults include TANF Adults, Pregnant Women, and Medically Needy

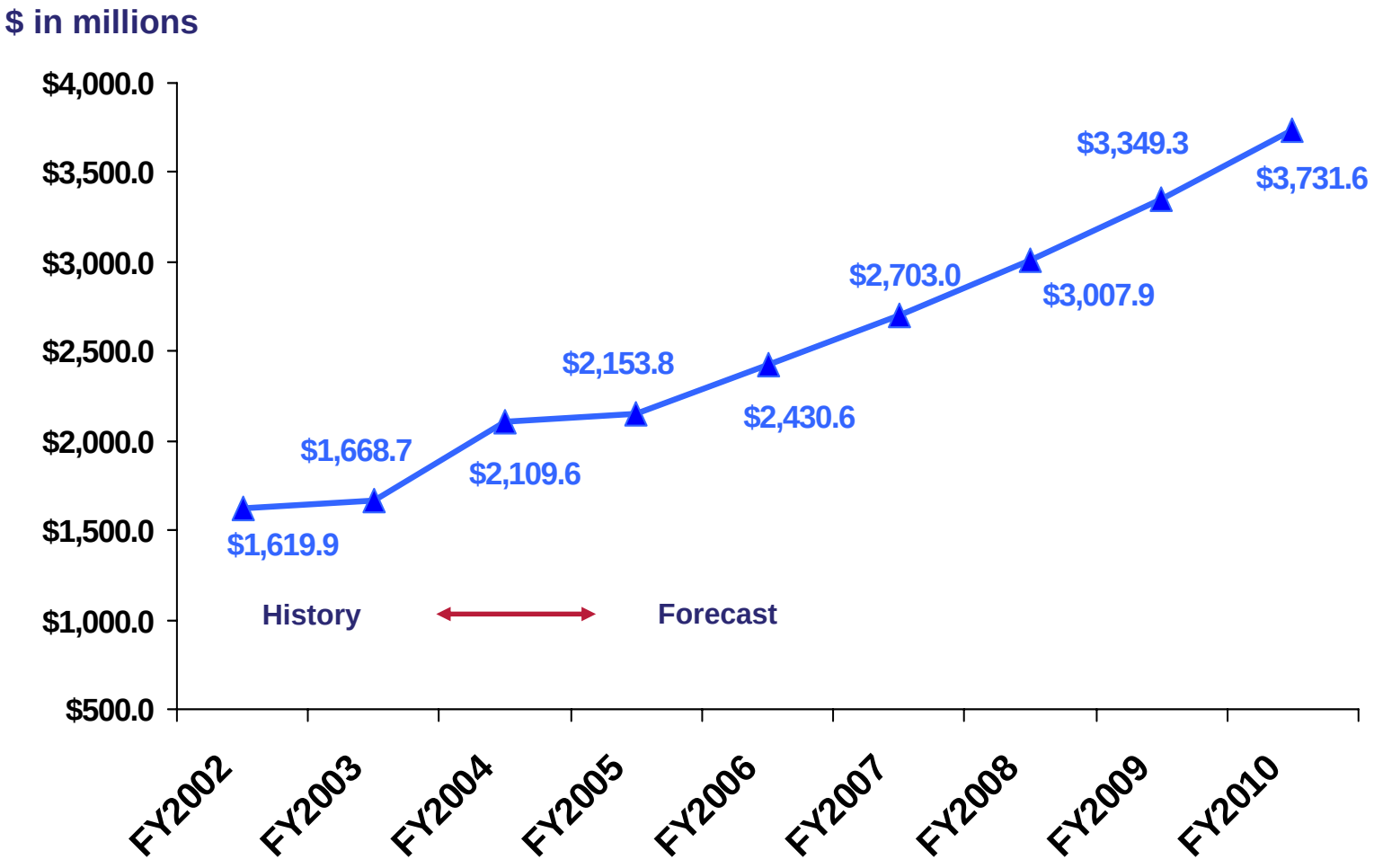
Major Caseload Projections

- **Medicaid Acute Care Aged, Blind, and Disabled Caseloads**



Major Caseload Projections

- **Medicaid Acute Care Aged, Blind, and Disabled Costs, All Funds**



Costs do not include rate restoration.

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Rate Restoration and Rate Increases

Recent HHS Rate Changes

	Change from FY03		Change from FY05	
	FY04	FY05	FY06	FY07
HHSC				
Physician/Professional (includes FFS, PCCM and HMO)	-2.50%	-2.50%	7.50%	12.50%
Outpatient Hospital (includes FFS, PCCM and HMO)	-2.50%	-2.50%	7.10%	11.70%
Intpatient Hospital (includes FFS, PCCM and HMO)	-2.50%	-5.00%	5.00%	5.00%
CHIP	-2.50%	-2.50%	7.50%	12.50%
DFPS				
Foster Care	-1.99%	-1.99%	5.35%	5.35%
Adoption Subsidy	0.00%	0.00%	0.00%	0.00%
DADS				
Nursing Facilities	-1.75%	-1.75%	25.16%	25.16%
Community Based Alternatives	-1.10%	-1.10%	5.95%	5.95%
Community Living Assistance and Support Services	-1.10%	-1.10%	4.30%	4.30%
Primary Home Care	-1.10%	-1.10%	4.00%	4.00%
Community Attendant Services	-1.10%	-1.10%	3.98%	3.98%
Day Activity and Health Services	-1.10%	-1.10%	4.44%	4.44%
Medically Dependent Children Program	-1.10%	-1.10%	9.40%	9.40%
Community ICF/MR	-1.75%	-1.75%	7.84%	7.84%
HCS	-1.10%	-1.10%	8.17%	8.17%
MR Service Coordination	-1.75%	-1.75%	3.76%	3.76%
Texas Home Living Waiver *	-1.10%	-1.10%	8.54%	8.54%
DSHS				
MH Service Coordination	-1.75%	-1.75%	0.00%	0.00%
Rehabilitation Services	-1.75%	-1.75%	0.00%	0.00%

* This is being reviewed and is subject to change for 06 and 07.

2/9/2005

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CHIP Cost Sharing

CHIP Cost Sharing

Annual Enrollment Fee Proposal:

- $50 for families between 133-150 percent FPL
- $70 for families between 151-185 percent FPL
- $100 for families between 186-200 percent FPL

Annual Enrollment Fee Proposal (cont.):

- **Families beginning or re-enrolling in CHIP would be required to pay the enrollment fee in semi-annual installments (upon initial 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 and the child is not subject to the 90-day waiting period.
- **An annual enrollment fee will not be in effect until integrated eligibility is implemented.**

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Major Cost Containment Strategies

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Disease Management

HB 727 (78th Legislature) requires HHSC to contract with vendor(s) to implement Disease Management in fee-for-service.

- Increase focus on preventive care
- Increase patient compliance with physician treatment plans
- Decrease unnecessary hospital and outpatient services

Status:

- On November 1, 2004, HHSC launched the Texas Medicaid Enhanced Care Program.
- The program targets diabetes, coronary artery disease, congestive heart failure, asthma, and chronic obstructive pulmonary disease.
- The program serves approximately 55,000 clients.

HB 1735 (78th Legislature) requires disease management in managed care.

- Build on existing health plans' case management programs.

Status:

- Focus on asthma as initial targeted disease.
- Report to the legislature with baseline data related to health plans complete.
- HMO procurement includes disease management program requirement.

Preferred Drug List (PDL)

- **House Bill 2292 (78th Legislature) required HHSC to establish a preferred drug list for Medicaid/CHIP**
  - **Pharmaceutical companies are required to enter into a supplemental agreement or a program benefit proposal to be considered for the PDL.**
  - **The Governor-appointed Pharmaceutical and Therapeutics Committee (P&T) considers three factors when reviewing drugs: clinical efficacy, safety, and cost effectiveness.**
  - **Non-preferred drugs require prior authorization.**
- **Texas Pharmaceutical and Therapeutics Committee has reviewed drug classes representing 70% of Medicaid drug spend at six meetings from December 2003 – August 2004.**
- **Began its annual re-review of initial drug classes in November 2004.**
- **Plans to review drug classes for the CHIP PDL in August 2005.**

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Preferred Drug List (PDL)

Based on actual savings to date and future forecasts, HHSC estimates FY2004-2005 PDL savings of over $140.5 million General Revenue ($356.9 million All Funds) on an incurred basis

- **Prescribing patterns are shifting toward preferred products.**
- **For January-September 2004, manufacturer supplemental rebate invoices totaled about $82 million All Funds.**

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Clinical Edits

HHSC began to roll out new clinical edits in the Medicaid Vendor Drug Program in August 2004 to encourage prescribing of cost effective drugs.

- **Evidence-based edits check a patient's Medicaid medical and drug claims histories at the pharmacy point of sale.**
  - **If available information indicates the patient meets the edit criteria, the claim is paid.**
  - **If not, the prescriber's office must call the Texas Prior Authorization Call Center to get the drug approved for the patient.**
- **HHSC estimates the clinical edits will save the state up to $22 million state funds in the 2004-2005 biennium.**

Improve Rate Setting Principles

- **Movement from cost reimbursement toward prospective payment systems**
  - **Cost settlement systems do not encourage providers to contain costs**
  - **Comprehensive Outpatient Rehabilitative Facilities, Federally Qualified Health Centers and Rural health centers are three provider types that HHSC will pay on a prospective basis by the end of 2005.**

- **Capping administrative costs when determining HMO capitation rates.**

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Managed Care Expansion

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Traditional Medicaid vs. Medicaid Managed Care

- **Traditional Medicaid**
  - Client must search for a doctor who will accept Medicaid
  - Treats people after they become sick
  - Clients tend to have high ER Utilization
- **Medicaid Managed Care**
  - Provides a medical home through a Primary Care Provider (PCP)
  - Improved access to a defined network of providers
  - Promotes preventive care
  - Promotes continuity of care
  - Encourages appropriate utilization of care

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Medicaid Managed Care Program Goals

- Establish a medical home for Medicaid clients through a Primary Care Provider (PCP)
- Emphasize preventive care
- Improve access to care
- Ensure appropriate utilization of services
- Improve health outcomes
- Improve quality of care
- Improve client and provider satisfaction
- Improve cost effectiveness

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Medicaid Managed Care Member Benefits

- Traditional Medicaid benefit package
- Prescription drugs
- Annual adult well checks
- Removal of limit for length of stay for hospitalization
- PCP provider directories
- Access to PCP 24-hour, 7-day/week health care
- 24-hour nurse helpline (through their health plan)
- Member services helpline (through their health plan)
- Member handbooks and health education
- Case management for members with special health care needs

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STAR+Plus Program

- STAR+Plus program structured as an integrated delivery system for disabled and chronically ill Medicaid enrollees
- Risk-based, capitated managed care
- Serves aged and disabled
- Most aged and disabled adults not in institutions are required to join
- Includes dual eligibles (Medicare / Medicaid) clients (almost half of members)

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STAR+Plus Program

- **STAR+Plus is based on a combined 1915(b) and 1915(c) waiver.**
  - **Implemented in Harris County in 1998**
  - **Provides home and community services**
- **Goal is to achieve a seamless continuum of care by integrating acute and long term care in a managed care environment.**
- **Managed care organizations (MCOs) are responsible for coordinating acute and long term care needs through the use of a care coordinator.**

STAR+Plus Program

- **Care coordinator is responsible for:**
  - **Formulating an individualized plan covering acute and long term care needs, and**
  - **Overseeing smooth transition from acute to long term care.**
- **Beneficiaries also assigned a Primary Care Provider (PCP)**

Medicaid Managed Care
Additional STAR+Plus Member Benefits

- **Long term care benefits**
  - **Traditional Medicaid community based LTC services**
    - **Personal Attendant Services (PAS)**
    - **Day Activity and Health Services (DAHS)**
  - **Community Based Alternative (CBA) waiver services**

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STAR+Plus
Better Health Care Management

- **Inpatient stays have decreased by 28%.**
- **Members receiving DAHS (adult day care) have increased by 38% since September 2000.**
- **Members receiving PAS (Personal Assistance Services) have increased by 32% since September 2000.**

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STAR+Plus Satisfied Members

- 88% knew how to reach their health plan
- 76% found it easy to get help from their care coordinator
- 75% had no problem getting needed home health or attendant care
- 80% were satisfied or very satisfied with how care coordinator explained information

STAR+Plus Program

- **STAR+Plus Expansion Proposal**
  - **Harris County**
    - Expand Harris County to include the following additional counties: Brazoria, Fort Bend, Galveston, Montgomery, Waller, Austin, Colorado, Matagorda, Washington, Wharton
  - **NEW STAR+Plus Areas**
    - Bexar Service Area (Bexar, Atascosa, Comal, Guadalupe, Kendall, Medina, Wilson)
    - Dallas Service Area (Dallas, Collin, Ellis, Hunt, Kaufman, Navarro, Rockwall, Fannin, Garyson)
    - El Paso Service Area (El Paso)
    - Lubbock Service Area (Lubbock, Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lynn, Terry)
    - Travis Service Area (Travis, Bastrop, Burnet, Caldwell, Hays, Lee, Williamson)

STAR+Plus Program

- **NEW STAR+Plus AREAS (cont.)**
  - **Tarrant Service Area**
    - **Tarrant, Denton, Hood, Johnson, Parker, Wise, Cooke, Erath, Palo Pinto, Somervell**
  - **Nueces Service Area**
    - **Aransas, Bee Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria**

STAR HMO

- **STAR Expansion Framework**
  - **Nueces County**
    - Expand Nueces County to include the following additional counties: Aransas, Bee Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria
  - **Expand STAR HMO model into designated counties adjacent to existing service areas**
    - At least 2 viable HMOs within service area
    - Adequate provider network

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Fiscal Impact *($ in millions)*

Total Managed Care Expansion

	FY 2006	FY 2007	Biennium	Annualized FY 2010
Program Savings All Funds	$ (59.1)	$ (102.0)	$ (161.1)	$ (148.1)
General Revenue	$ (25.4)	$ (43.8)	$ (69.2)	$ (62.6)
Program Savings Net Premium Tax Gain	$ (21.4)	$ (21.1)	$ (42.5)	$ (29.1)
Total Fiscal Impact to State	$ (46.8)	$ (64.9)	$ (111.7)	$ (91.7)

STAR+Plus Expansion

Program Savings All Funds	$ (35.8)	$ (70.2)	$ (106.0)	$ (87.6)
General Revenue	$ (14.6)	$ (28.7)	$ (43.3)	$ (35.7)
Program Savings Net Premium Tax Gain	$ (11.6)	$ (11.7)	$ (23.3)	$ (15.9)
Total Fiscal Impact to State	$ (26.2)	$ (40.4)	$ (66.6)	$ (51.6)

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Maximizing Federal Funding for Local Hospitals

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Maximizing Federal Funding for Local Hospitals

Issue: Impact of STAR+Plus Expansion on Federal UPL Revenue

- The state's plan to implement STAR+Plus managed care in urban areas will result in a reduction of supplemental payments that 11 Texas hospitals currently receive under the upper payment limit (UPL) guidelines. UPL payments are not allowed by federal regulations under capitated managed-care arrangements, such as the STAR+Plus program. However, managed care offers the best tool for controlling rising Medicaid costs. Since 1995, Medicaid costs in Texas have more than doubled, and Medicaid now accounts for more than 25 percent of the state's total budget.

Solution:

- HHSC has developed a comprehensive plan to maximize federal funding available to Texas hospitals. HHSC's plan will result in:
  - an immediate infusion of $59 million in FY 2005 to 11 public hospitals, and in excess of $200 million for fiscal year 2006-2007, and
  - a long-term option to allow counties to draw down additional federal dollars by expanding Medicaid coverage.

Maximizing Federal Funding for Local Hospitals

Dallas County Issues

- **Potential impact of STAR+Plus expansion on statewide UPL:**
  - **Dallas estimate - $150 million**
  - **HHSC estimate - $75 million**
  - **HHSC estimate for Dallas - $25 million**

- **Potential opportunity for future UPL:**
  - **Dallas estimate - $100 million***

*** plan does not conform to CMS requirements**

*** assumes continued federal availability as funding source**

Maximizing Federal Funding for Local Hospitals

Hospital Public Financing Sources:

- Local tax funds
- Medicaid payments
  - Inpatient/outpatient payments
  - Disproportionate Share Hospitals (DSH)
  - Upper Payment Limit (UPL)
  - Graduate Medical Education (GME)
- Trauma Funds

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Maximizing Federal Funding for Local Hospitals

Short-term federal fund gains

HHSC will retroactively claim additional UPL for FY2004-2005:	**$38 million**
Increase disproportionate share limit to local public hospitals to 175% of hospitals' cost:	**$21 million**
Retroactively claim additional GME payments for Parkland Hospital:	**$44.6 million**
Total	**$103.6 million**

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Maximizing Federal Funding for Local Hospitals

Long-term federal funding (FY2006-2007)

Revise state hospital DSH calculation:	**$40 million**
Leverage Trauma funds for additional GME (voluntary):	**$75 million**
Re-establish limited Medically Needy program statewide to increase Medicare DSH payments:	**$40 million**
Local option to expand coverage to Medically Indigent	
- Dallas	**$60 million**
- Other areas	**$$ +++**
Total Gain	**$215 million**

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Maximizing Federal Funding for Local Hospitals

Federal Fund Gains to Dallas

HHSC will retroactively claim additional UPL for 2004:	**$13.5 million**
Revise state hospital DSH calculation:	**$10.3 million**
Retroactively claim GME programs for Parkland:	**$44.6 million**
Local option to expand coverage to Medically Indigent - Dallas	**$60 million**
Re-establish limited Medically Needy program statewide to increase Medicare DSH payments:	**$$ +++**
Total Gain	**$128.4 million**