Health and Human Services Commission

Don A. Gilbert, Commissioner

Presented to the
House Committee on Appropriations
and House Committee on Insurance

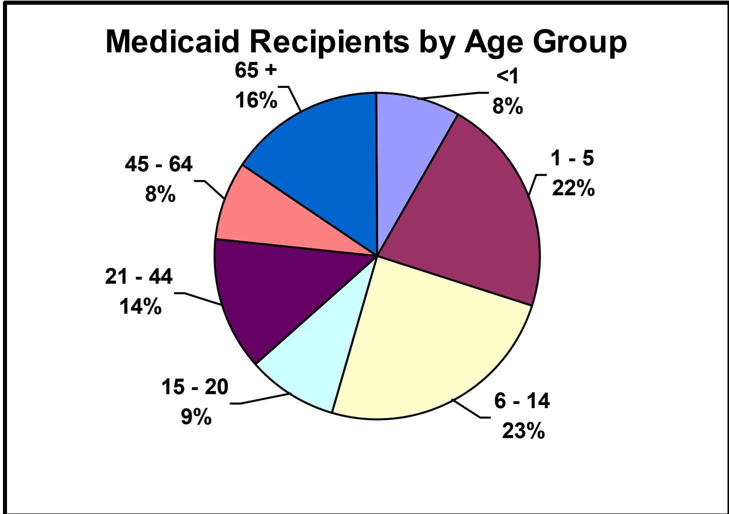
April 24, 2002

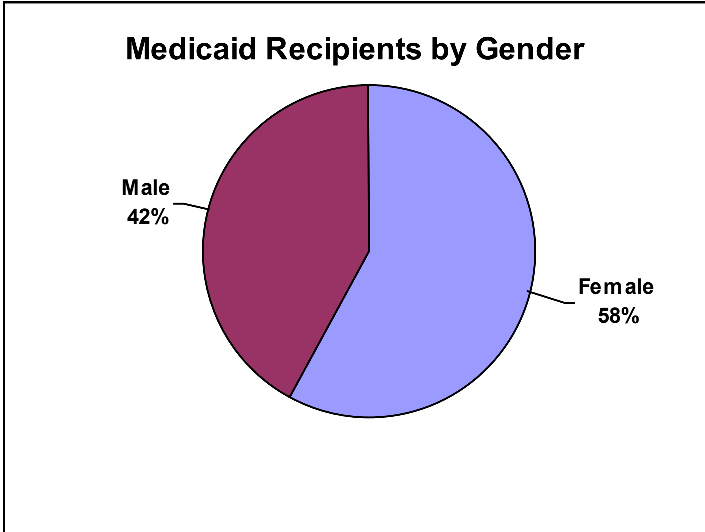
Overview of Medicaid Expenditures

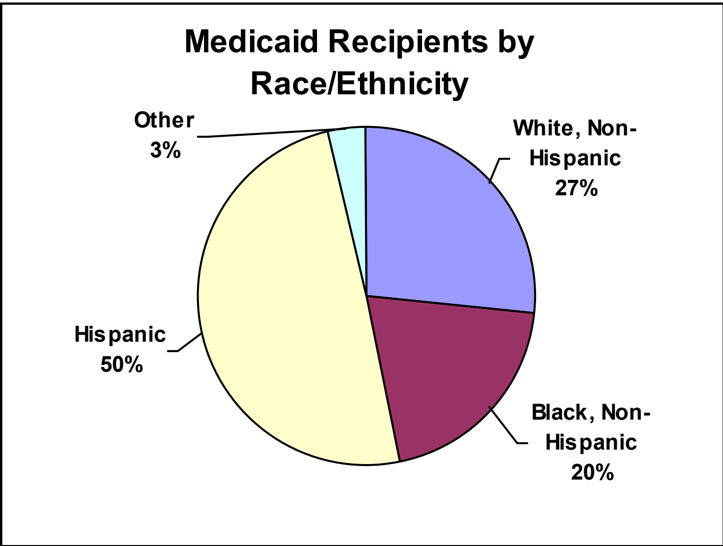
- Medicaid Program Summary
- Caseloads
- Vendor Drug Program
- Budget Projections
- SB 43 Medicaid Enrollment
- Cost Containment Initiatives

Medicaid Program Summary

Medicaid Demographics – FY 2002
(Estimated Enrollment 1,982,140)





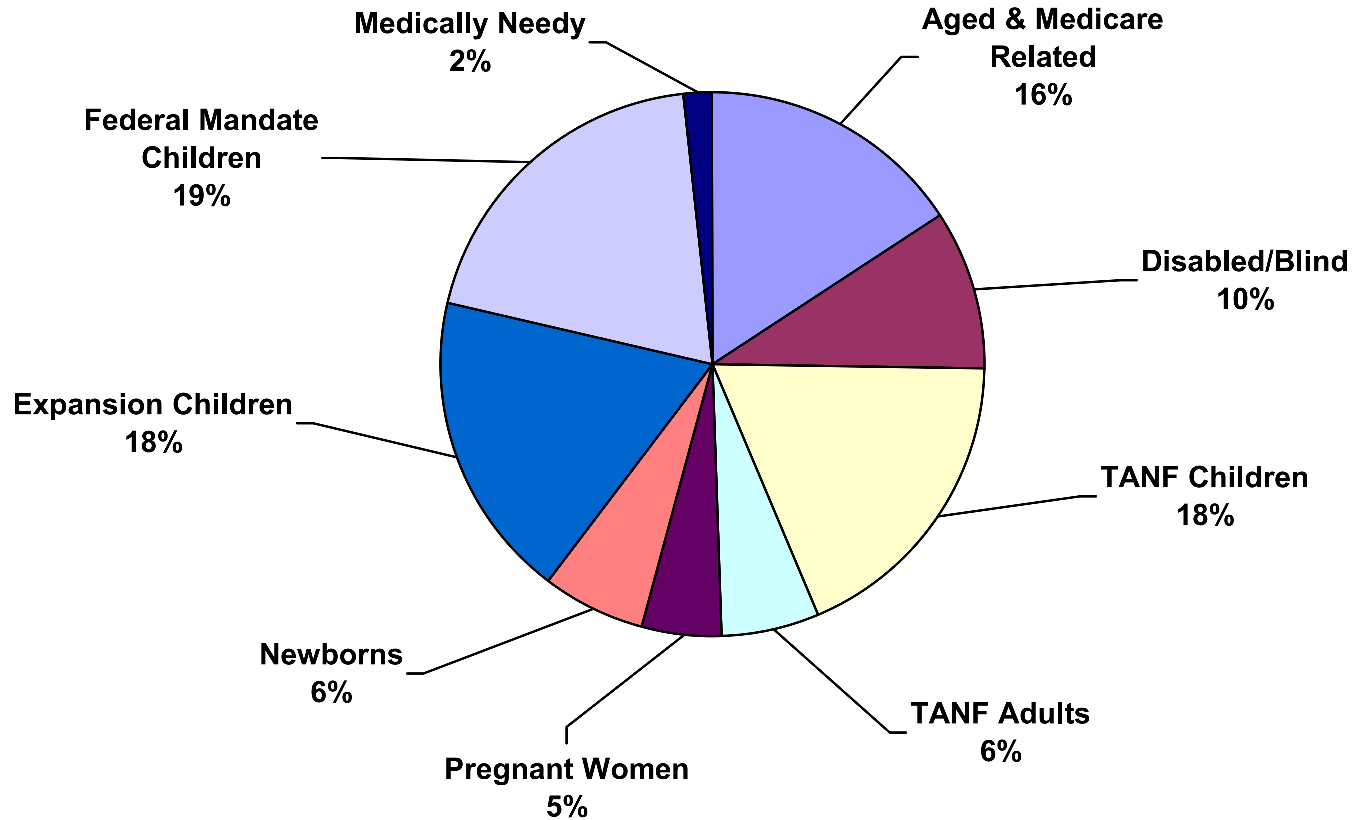


What is Medicaid? Medicaid pays for health care expenses for low-income persons who meet eligibility guidelines and who have no other way to pay for care.

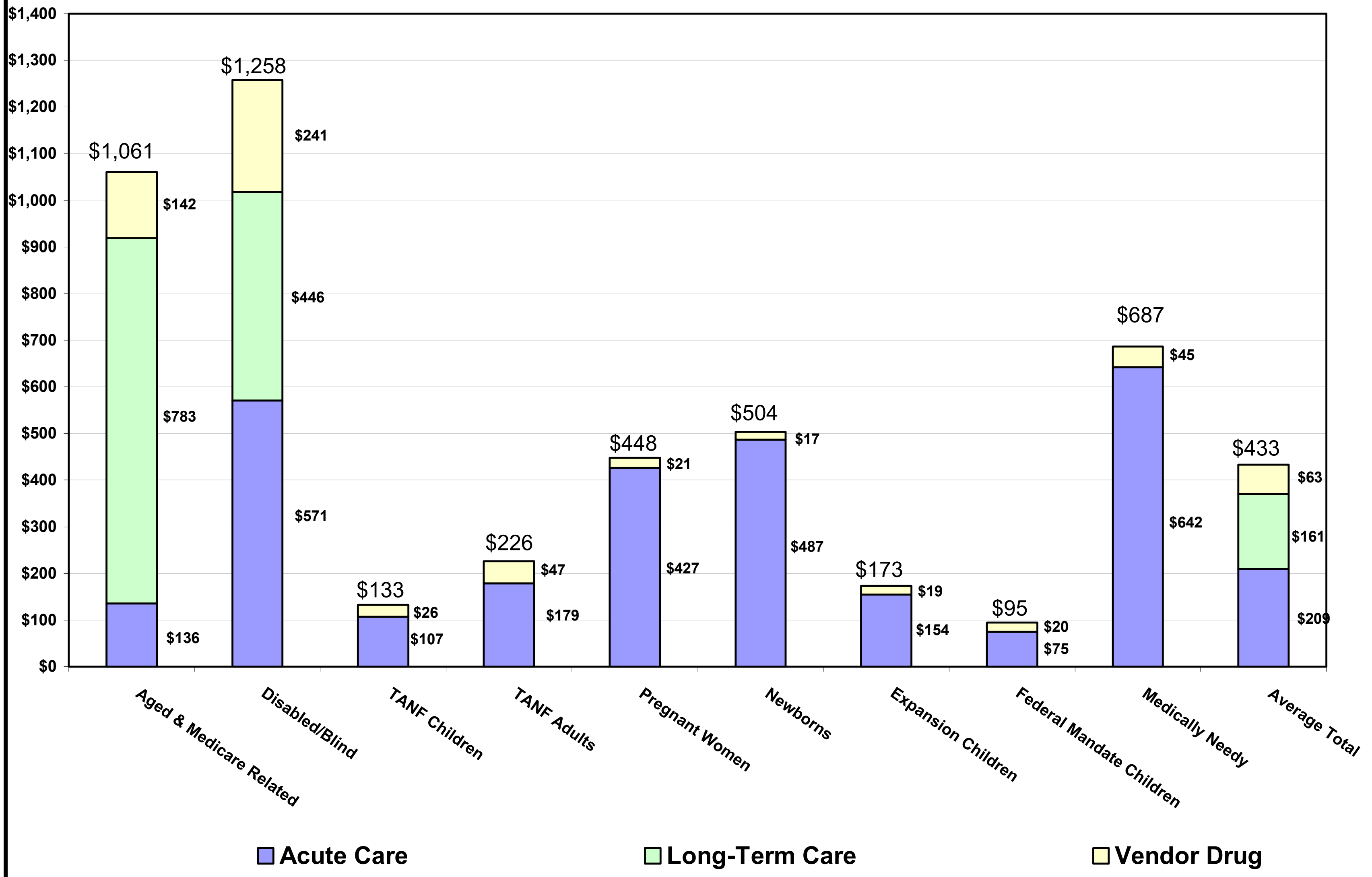
Who is covered? Beneficiaries include children, single parents, pregnant women, and poor and low-income elderly or disabled individuals. Approximately 62 percent of Texas Medicaid recipients are under age 21.

What are the benefits? The acute care component of the Medicaid program pays for typical health services including physician and other medical professional services, inpatient and outpatient hospital services, lab and x-ray services and pharmaceuticals. Medicaid makes all payments directly to service providers instead of to recipients. The long-term care component of Medicaid covers services in facilities such as nursing homes and state schools as well as community care for the aged and people with disabilities.

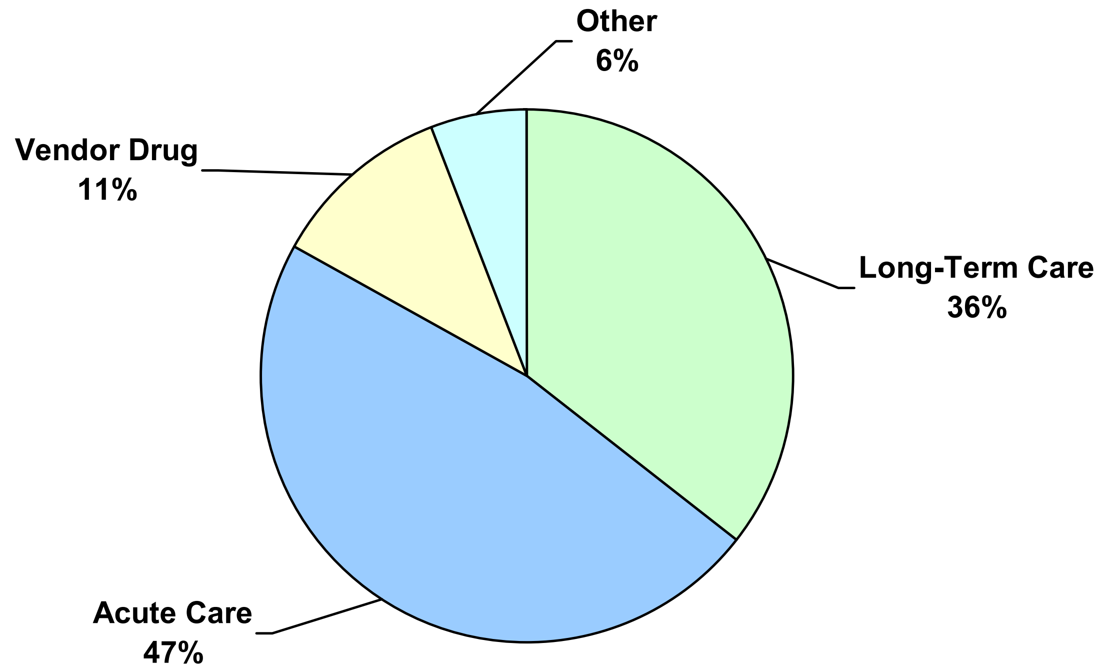
FY 2002 Medicaid Recipients
(Non-Managed Care and Managed Care Combined)



- Medicaid enrollees are categorized into nine separate groups for the purpose of monitoring and projecting costs. Each risk group represents unique patterns of utilization and; therefore, costs to the program. The chart above illustrates the proportion of the nine risk groups in the Medicaid population.


Estimated Monthly Costs by Risk Group FY 2002
$1,400
$1,300
$1,200
$1,100
$1,000
$900
$800
$700
$600
$500
$400
$300
$200
$100
$0
$1,061
$142
$783
$136
$1,258
$241
$446
$571
$133
$26
$107
$226
$47
$179
$448
$21
$427
$504
$17
$487
$173
$19
$154
$95
$20
$75
$687
$45
$642
$433
$63
$161
$209
Aged & Medicare Related
Disabled/Blind
TANF Children
TANF Adults
Pregnant Women
Newborns
Expansion Children
Federal Mandate Children
Medically Needy
Average Total
Acute Care
Long-Term Care
Vendor Drug

Medicaid Program Budget - FY 2002

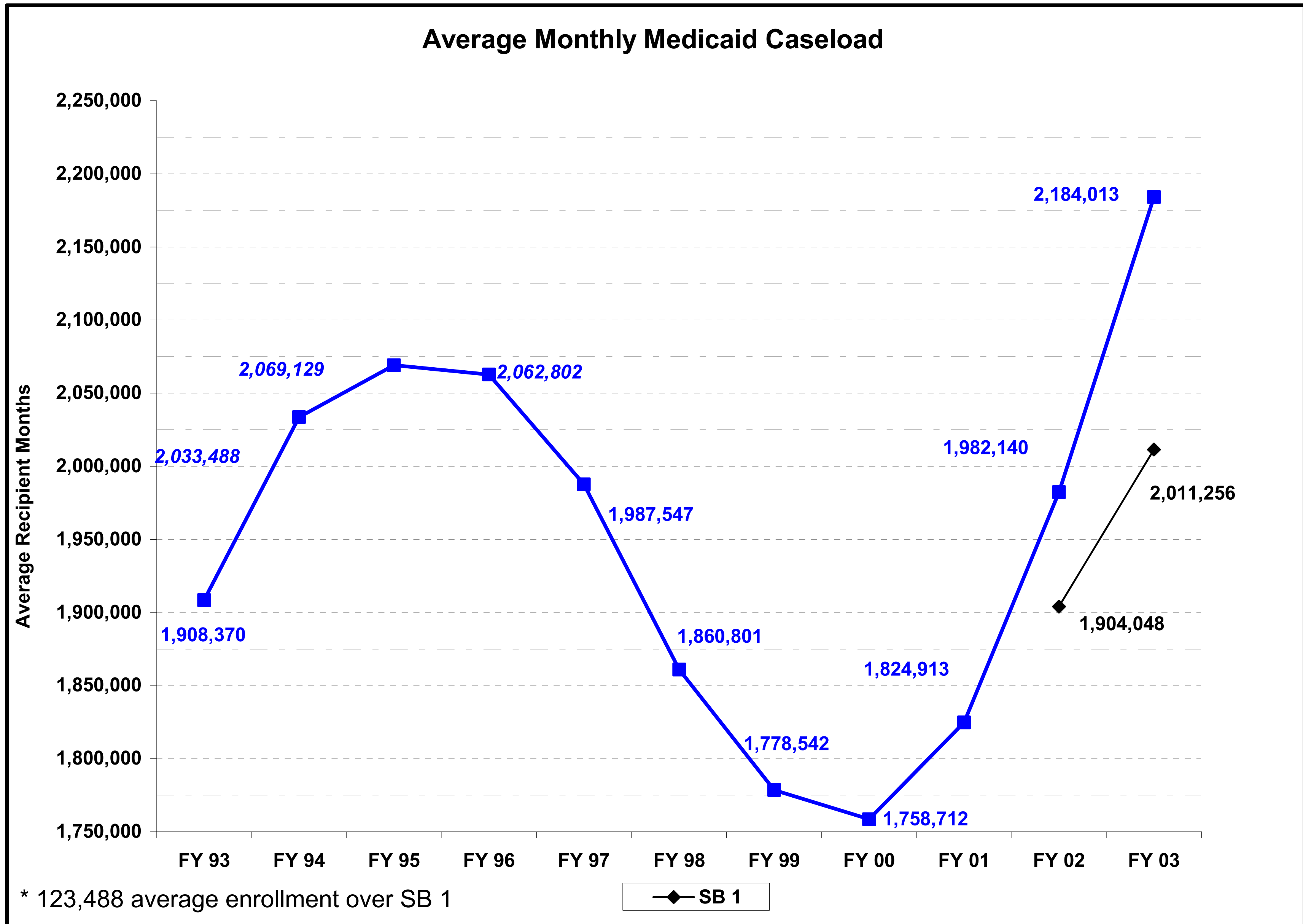


Total Dollars = $13.1 billion (Estimated 23 percent of state spending)

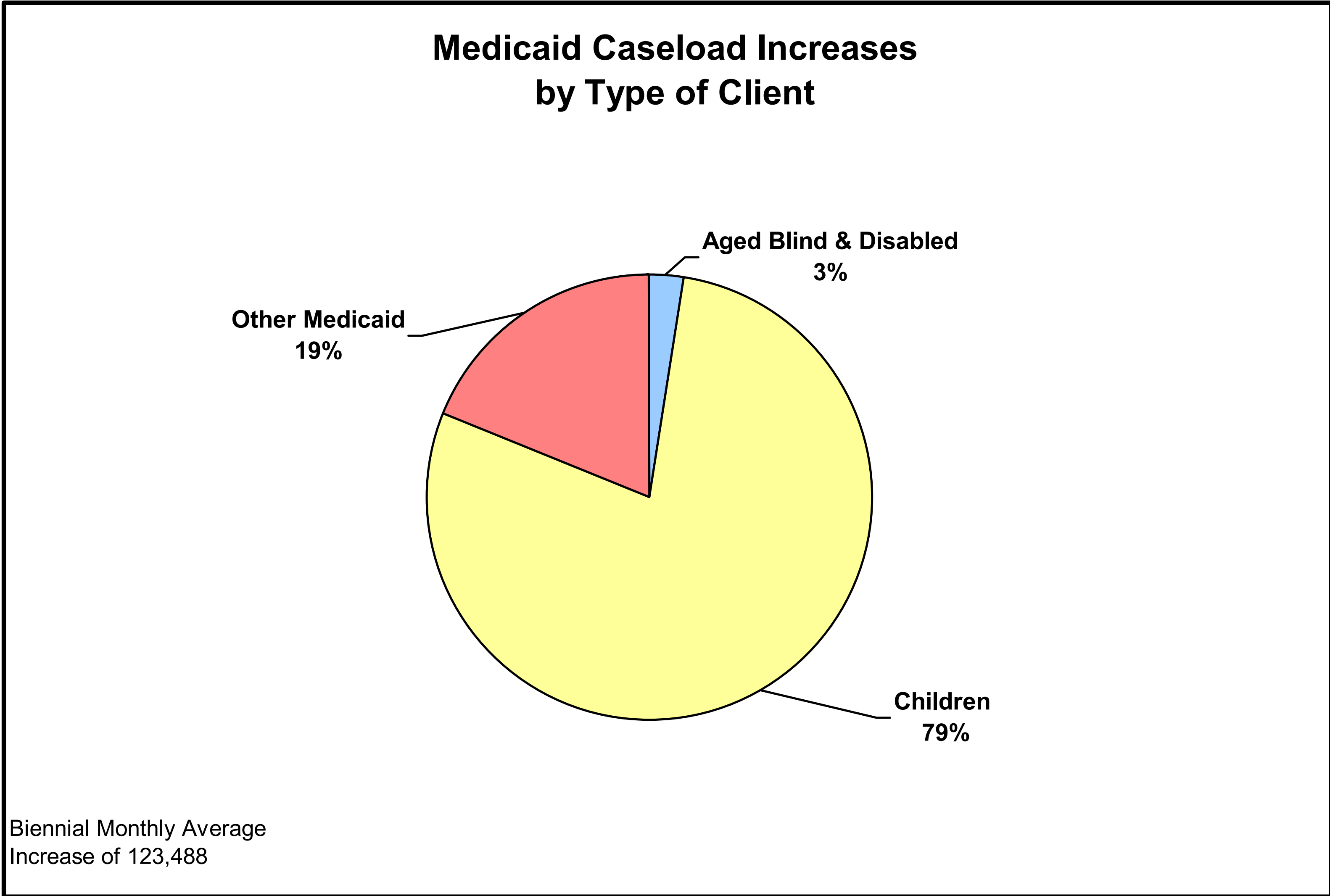
Note: Other includes administration, targeted case management, rehabilitation services, service coordination.
Total does not include disproportionate share hospital payments and SHARS.

Caseloads

Medicaid Caseloads



Medicaid Caseload Growth



1) Children includes TANF Children, Expansion Children and Federal Mandate Children.
2) Other Medicaid includes TANF Adults, Pregnant Women, Newborn and Medically Needy. Premiums for Medically Needy, Pregnant Women and Newborn are much larger than TANF Adults.

Factors Influencing Caseloads

- Economy
- TANF Rolls
- SSI Determination
- Outreach
- Program Changes

Caseload forecasting relies on time series models, which use historical trends as predictors of future caseloads.

Vendor Drug Program

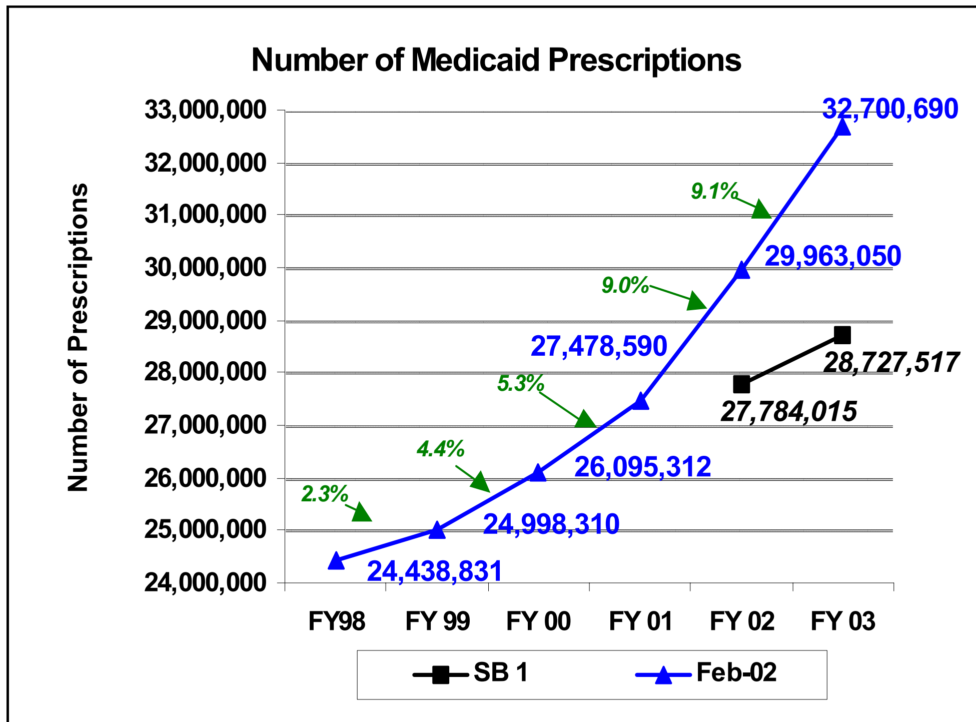
Medicaid Vendor Drug Program

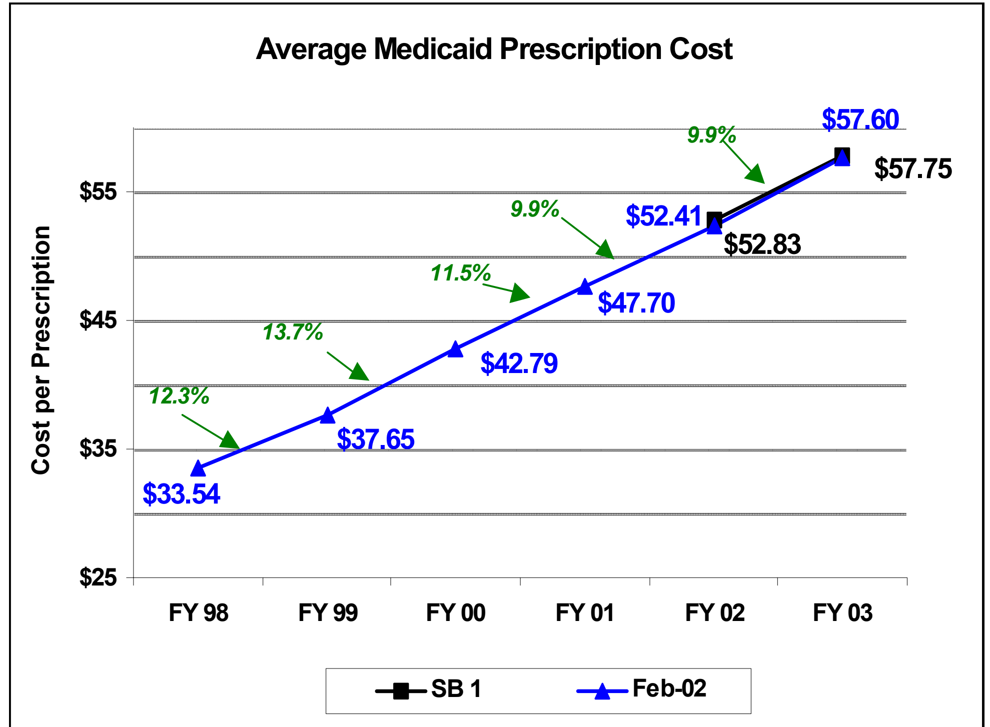
Spending:

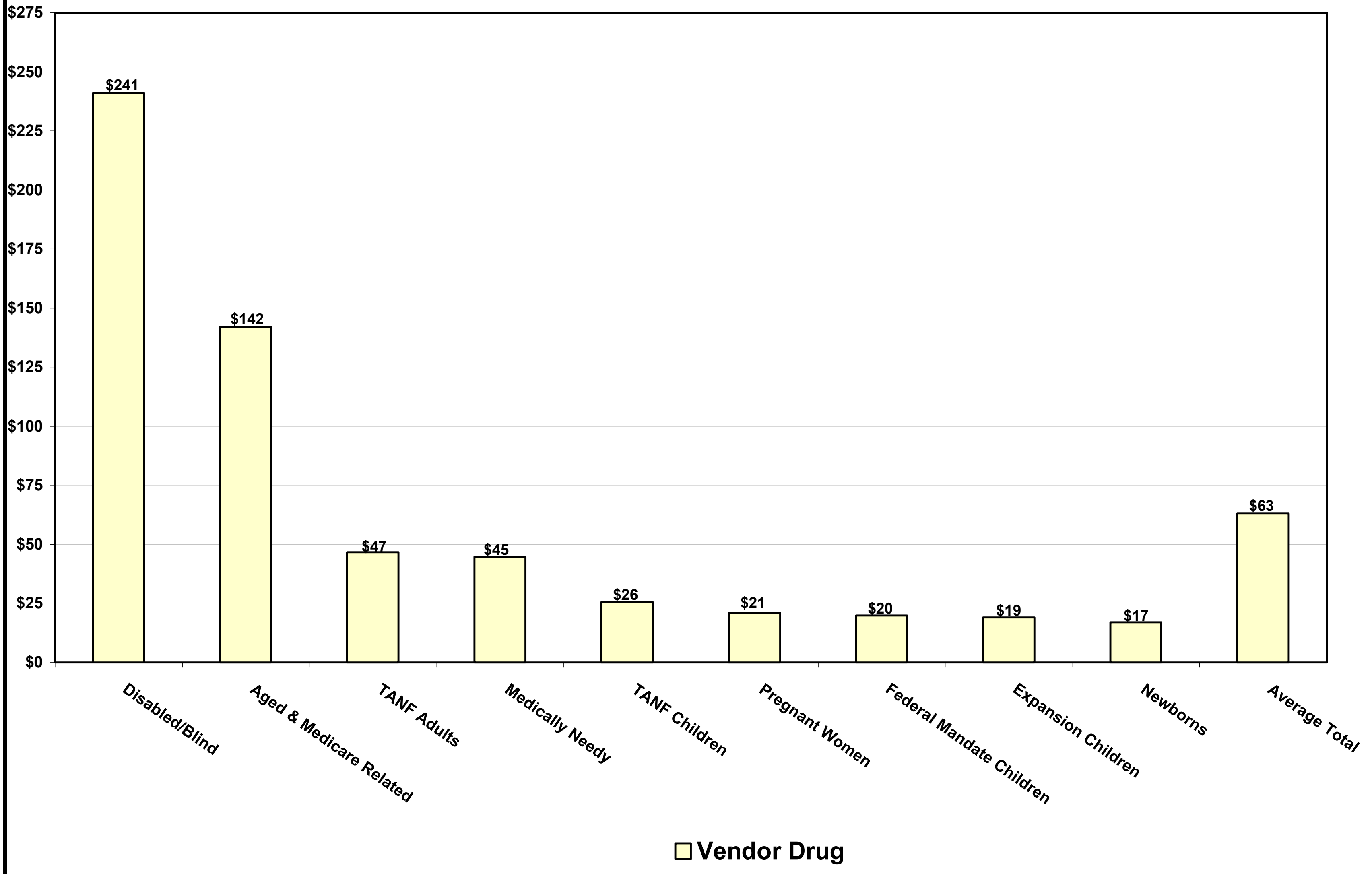
1998	**$ 819.8 m**	
1999	**947.6 m**	
2000	**1,123.0 m**	
2001	**1,321.3 m**	
2002	**1,586.6 m**	**estimated**
2003	**1,913.6 m**	**estimated**

Note: Excludes administration

Federal government estimates that prescription drug costs will increase an average of 12.6 percent per year for the next 10 years. If that projection holds, biennial expenditures will reach $10.5 billion by 2010/2011.





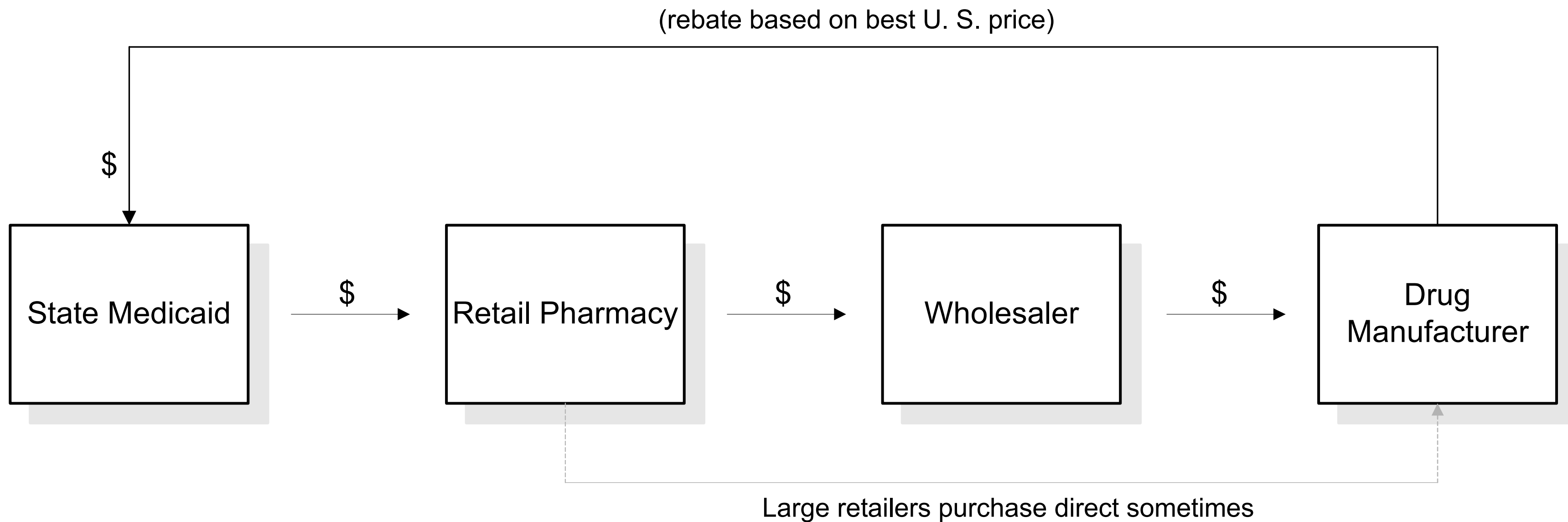


Estimated Vendor Drug Monthly Costs by Risk Group FY 2002
$275
$250
$225
$200
$175
$150
$125
$100
$75
$50
$25
$0
$241
$142
$47
$45
$26
$21
$20
$19
$17
$63
Disabled/Blind
Aged & Medicare Related
TANF Adults
Medically Needy
TANF Children
Pregnant Women
Federal Mandate Children
Expansion Children
Newborns
Average Total
Vendor Drug

Drug Manufacturer Rebates

- The national drug rebate program assures that state Medicaid programs have access to the "best price" on all drug products – in exchange for open formularies. Rebates are calculated for each product, and represent the difference between the manufacturer's lowest U. S. contracted price for the product and the estimated retail cost.
- For generic drugs, rebates are set at a flat rate of 11 percent.
- Rebate revenues for Medicaid in 2001 were $268 million.
- Texas Medicaid rebates average 21 percent of the total cost.
- Rebates are shared with the federal government at the FMAP rate.

Vendor Drug Program Purchasing Relationship



Budget Projections

Medicaid Budget Projections for FY 2002/2003

Early projections indicate a $142 million GR shortfall for FY02/03. Cost drivers include:

- Caseload increases [1] (123,488 over SB 1)
- Vendor Drugs (6.2 million scripts over SB 1)
- FMAP change ($18.1 million)

[1] Caseload estimates will likely increase when May forecast is released.

SB 43 – Medicaid Enrollment

Implementation of SB 43 – Medicaid Simplification

- Began using the new simplified eligibility process on January 2, 2002.
- Application can be processed through the mail or over the phone – no interview is required
- A new, joint CHIP/Medicaid children's application is available from DHS offices, CHIP community-based organizations, and online through the TexCare partnership.
- Uses the same verifications as CHIP - verifies income, immigrant status, dependent care costs, and child support payments made by the family and eliminates verification of assets and residence. Accepts same documentary verifications as CHIP (i.e., one check stub, last tax statement). Screens for assets using same questions as CHIP
- As of January 1, children applying for or renewing Medicaid coverage are continuously eligible for Medicaid for six months. Changes in income or resources will not need to be reported until renewal. A family does need to report: change of address; if the child dies, moves out of state, or is institutionalized; or a child needing health care coverage joins the household.
- SB 43 requires that the parent or guardian of new Medicaid enrollees receive a Health Care Orientation (HCO). The Texas Health Steps program along with volunteer community-based organizations is providing this orientation.

- Although it is difficult to isolate the impact of SB 43 from other factors affecting the Medicaid caseload, the change in the monthly caseload since the simplified eligibility process was implemented provides an indication of the impact of the legislation.

Month	Caseload	Change From Previous Month	
		#	%
September 2001	1,935,661	11,698	0.6
October 2001	1,977,895	42,234	2.2
November 2001	1,980,319	2,424	0.1
December 2001	1,993,681	13,362	0.7
January 2002	2,055,179	61,498	3.1
February 2002	2,089,672	34,493	1.7
March 2002	2,139,056	49,384	2.4
April 2002	2,165,559	26,503	1.2

Cost Containment Initiatives

Medicaid Cost Containment Initiatives

The 77th Legislature directed the Health and Human Services Commission to achieve a total of $205 million in general revenue cost savings in the Medicaid program. Strategies to achieve these savings include the following:

Pharmaceutical benefits – Estimated $63 million GR savings.
In an effort to mitigate the escalating pharmaceutical costs in Medicaid, several strategies have been developed and are in varying stages of implementation. The following initiatives intended to reduce spending in the VDP have been, or soon will be implemented.

Initiative	Biennial Savings
• Audit-related drug pricing reductions	$10.9 million
• New MACs related to federal price changes	$ 1.5 million
• Reimbursement formula change due to statewide audits – RFP to evaluate appropriateness of dispensing fee	$21.3 million
• Increased utilization review activities – New MACs related to patent expiration – Maximum daily dosage limits – Age and gender limits for certain drugs – Physician notices for high volume users – Clinical pathway development (best practice) for eight drug classes – Pharmacy data management system	$25.8 million
• Rebates for drugs administered in physicians' offices	$ 0.4 million
• Bulk purchasing	$ 3.0 million
Total	$62.9 million

Other strategies to reduce drug costs in FY03 are currently under development, including:

- Co-pay for pharmaceuticals (non-generic) – waiver approval required — $2.5-$3.0 million
- Four brand/34 day supply limits — $25.0 million
- MAC of "AB"-related generic products (drugs with narrow therapeutic index) — $ 1.8 million
- Mail order prescriptions for homebound clients — $ 1.0 million
- Additional manufacturer rebates/product discounts in proportion to the budget shortfall for VDP have been discussed with the industry. Negotiations are ongoing.

Medicaid Administration – Estimated $89 million GR savings.

Reducing the Trust Fund Balance – The trust fund will be reduced by 8/31/03. The funds are available for transfer at this time; however, interest earnings should be allowed to continue to be earned through the balance of the biennium. Other TMAS contract adjustments have been made (THQA and B & D) for a total estimated savings of $89M.

Hospital Payments – Estimated $48.5 million GR savings.

Targeted reductions in hospital reimbursements were to begin 4/1/02 and yield an estimated $48.5M. The Hospital Payment Advisory Committee and the hospital associations have developed an alternative plan that has been submitted to HHSC and is currently under review. This plan will also yield $48.5 million. A final decision on this initiative will be made within 30 days.

Savings at MHMR due to CHIP – Estimated GR savings $5.8 million

MHMR's community mental health services budget will be reduced as a result of enrolling children, who previously received these services, in CHIP.

Strategies planned but not yet begun.

Several other cost savings measures will be implemented including:

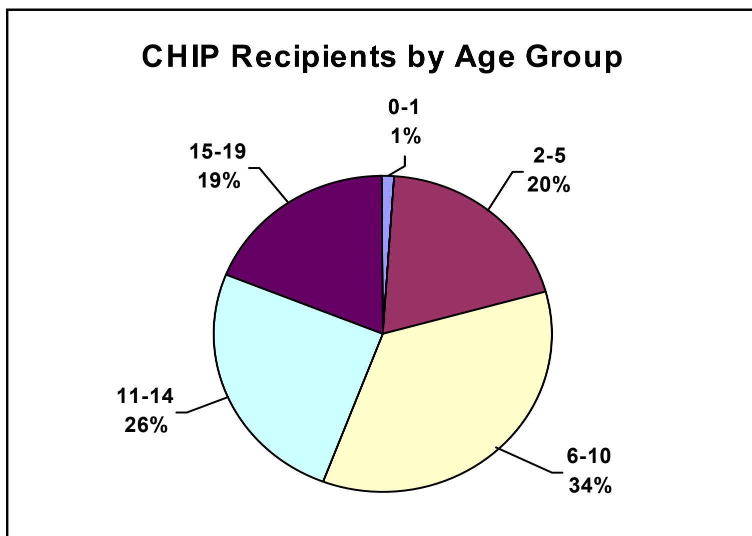
- Competitive contracting for medical equipment and supplies
- Amending the administration support contract with NHIC for FY03
- Implementing case management for high cost/high need individuals
- Move toward market-based reimbursement of hospital inpatient care

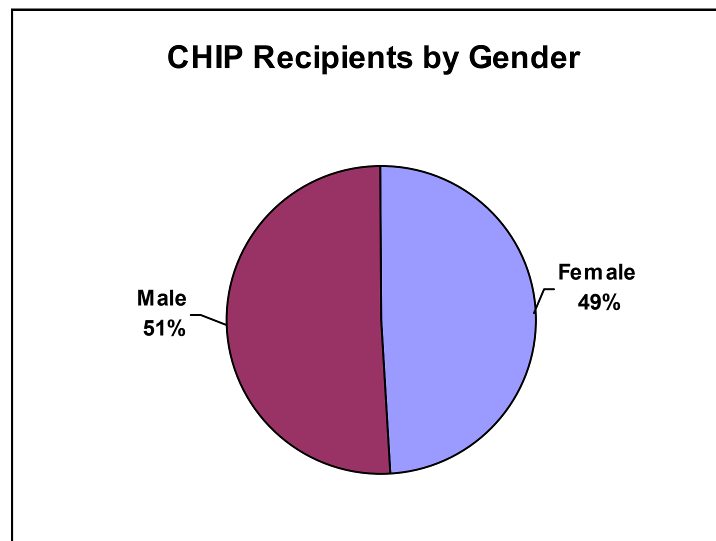
Options to avoid FY 02/03 shortfall – Estimated spending reduction $225 million in GR.

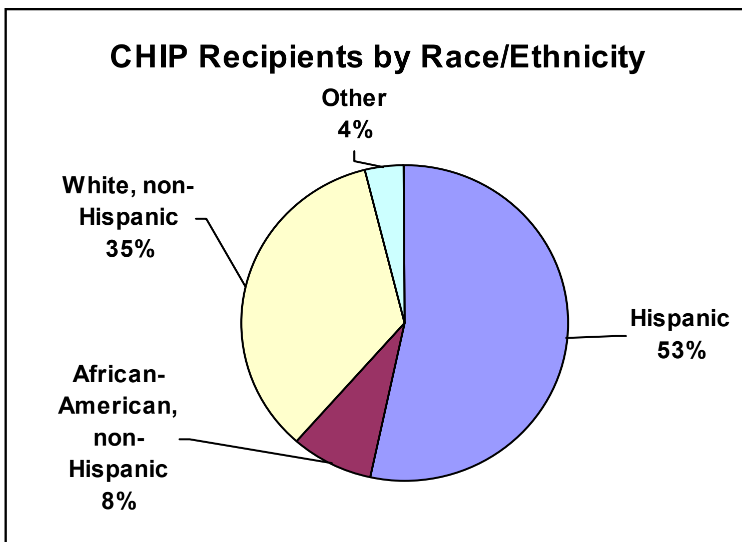
- Moving from ‘insured’ arrangement to fiscal agent
- Moving from accrual to cash basis

CHIP

CHIP Demographics – FY 2002





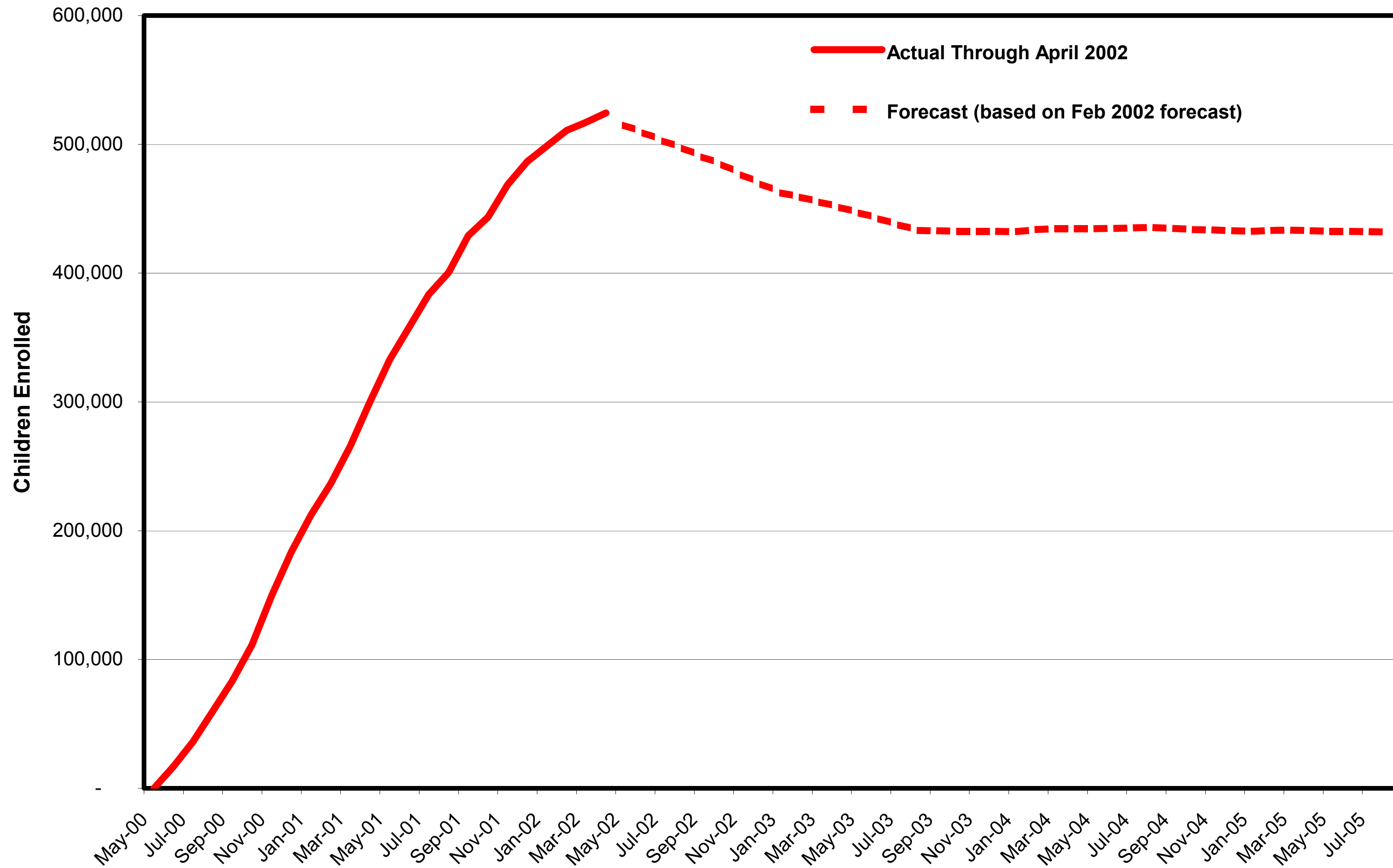


Note: Percentages may not total due to rounding.

<u>What is CHIP?</u> CHIP provides health insurance for children from low-income families.

<u>Who is covered?</u> The program serves Texas children under the age of 19, whose household income does not exceed 200 percent of the federal poverty level ($36,200 for a family of four), and who are deemed ineligible for Medicaid.

<u>What are the benefits?</u> CHIP enrollees receive health care and dental care from participating health plans, medical groups and dentists. The health and dental care includes services that are similar to those offered to state employees.


CHIP Caseload Forecast - Total Enrollment
Actual Through April 2002
Forecast (based on Feb 2002 forecast)
Children Enrolled
600,000
500,000
400,000
300,000
200,000
100,000
-
May-00
Jul-00
Sep-00
Nov-00
Jan-01
Mar-01
May-01
Jul-01
Sep-01
Nov-01
Jan-02
Mar-02
May-02
Jul-02
Sep-02
Nov-02
Jan-03
Mar-03
May-03
Jul-03
Sep-03
Nov-03
Jan-04
Mar-04
May-04
Jul-04
Sep-04
Nov-04
Jan-05
Mar-05
May-05
Jul-05

CHIP Caseload (April 2002) - Includes CHIP Phase II and Legal Immigrants

Month	Total Enrollment	New Enrollment	Renewals	Total Disenrollment
May-00	30	30		-
Jun-00	17,048	17,023		5
Jul-00	36,196	19,431		284
Aug-00	59,926	24,305		583
Sep-00	83,538	24,297		887
Oct-00	111,317	28,900		1,156
Nov-00	149,935	39,664		1,123
Dec-00	183,597	34,870		1,219
Jan-01	212,066	30,087		1,626
Feb-01	236,547	25,979		1,567
Mar-01	265,805	31,189		1,961
Apr-01	299,896	36,932		2,841
May-01	332,802	35,816	21	2,910
Jun-01	358,163	30,603	12,525	6,429
Jul-01	383,588	35,582	13,346	10,157
Aug-01	400,456	29,647	16,415	12,779
Sep-01	429,066	38,467	16,345	9,857
Oct-01	443,468	30,749	19,132	16,347
Nov-01	468,790	42,444	24,927	17,329
Dec-01	486,574	37,236	20,966	19,452
Jan-02	498,818	30,506	17,620	18,260
Feb-02	510,878	30,549	13,501	18,489
Mar-02	517,025	29,156	14,480	23,009
Apr-02	524,392	31,827	16,417	24,460

What is Driving CHIP Costs?

The CHIP premium rates for the second year of the program increased approximately 17.7 percent, on average, as compared to first-year rates.

- Over the first 13 months of operation, 11 of 16 CHIP health plans reported significant losses. Reported losses totaled $36 million.

- In developing the premium rates for this year, we assumed that the average cost of medical services would increase six percent and the average cost of prescription drugs would increase 18 percent per year. These cost increase factors include both utilization and inflation components.

- Regarding utilization rates, while trend assumptions for inpatient hospital services utilization was as expected, outpatient hospital services, physician services, lab and X-ray services, behavioral health, prescription drugs, and other services utilization exceeded expectations by 25 percent on average.

CHIP Shortfall Projection

A shortfall of $20.3 million is projected for the FY02-03 biennium. This projection does not include any savings from the drug benefit carve-out, which is estimated to be $15-20 million in GR for the biennium.

Note: The projected shortfall includes approximately $6.3 million that has been set aside for inflation increases in FY03.

CHIP Cost Containment Initiatives

CHIP Prescription Drug Benefit (PDB) Carve-out

- Prescription drugs remain a significant cause of inflation in the cost of health care services purchased by CHIP, conservatively estimated at 18 percent per year.
- Carving out the CHIP prescription drug benefit (PBD) was first raised with the CHIP health plans last spring as a possible strategy for helping to address the financial risk faced by the program over the long term.
- HHSC is in a better position than individual health plans to negotiate prices and rebates with manufacturers because of the volume of prescription medications purchased by the Medicaid and CHIP programs.
- Implemented on March 1, 2002
- Planning has included making improvements to the data provided to both CHIP and Medicaid health plans by the Vendor Drug Program (VDP) to facilitate their on going utilization management.
- Key assumption: Medicaid-level rebates (21 percent)
- Federal share of rebates must be returned to the federal government.
- Estimated impact of carve-out is $15-20 million in GR for ’02-’03 biennium.
- HHSC has requested authority to have rebates applied to the program.

CHIP Cost-Sharing Effective March 1, 2002

Federal Poverty Level	Office Visit Copay	Emergency Room Visit	Generic Prescription	Brand Name Prescription	Facility Copay	Annual Enrollment Fee	Monthly Family Premium	Annual Cost Sharing Caps
Below 100%	$0	$3	$0	$3	$0	$0	$0	$100 per family
101%-150%	$2	$5	$0	$5	$25 per inpatient hospital admission	$15	$0	$100 per family
151%-185%	$5	$50	$5	$20	$50 per inpatient hospital admission	$0	$15	5 % of annual income
186%-200%	$10	$50	$5	$20	$100 per inpatient hospital admission	$0	$18	5 % of annual income

- Co-pays for medical services or prescription drugs are paid to the health care provider at the time of service.
- No co-pays are made for dental services or for preventive care such as well-child or well-baby visits or immunizations.
- Federal law places a cap on the amount families can pay for CHIP-related expenses within a CHIP enrollment period (12 months).
- Expenses applicable to the cost sharing caps include copays, the enrollment fee and monthly premiums
- Families are responsible for tracking expenses and reporting that they have reached the cap.

CHIP Renewal Update
April 2002

(Based on information from B&D administrative system and preliminary information from Institute for Child Health Policy member survey)

- CHIP monthly renewal rate for the FY 2002 to date has averaged about 72% of those completing their twelve-month enrollment period.

- Non-renewers (averaged about 28% in FY 2002) include members who did not complete the renewal process and also those who did, but were no longer eligible for CHIP.

- Of those who completed the renewal process, but were not renewed in CHIP-

  - A little over half were Medicaid-eligible
  - The other half either had income >200% FPL or were otherwise no longer eligible for CHIP (SKIP children, aged out, etc.).

- Of those children who were disenrolled in the 13th month, 26% reenrolled within 1 to 3 months.

- 80% of families report the renewal process is “ as easy as it could be.” About half of those surveyed thought too much documentation was required.

- The most common reason reported for not completing the renewal process was that they “forgot” or “did not get around to doing it.” The second most common reason was that they were planning on getting other health insurance coverage for their children.

- Institute for Child Health Policy is finalizing a comprehensive report that surveyed CHIP members on renewal and disenrollment outcomes.

Attachment

Description of Medicaid Services and Risk Groups

Services Covered by the Pure Premium

The premiums paid under managed care and fee-for-service include most acute care services including inpatient hospital, physician, lab, X-ray, and outpatient hospital services. The premiums do not cover prescription drugs, medical transportation, or nursing home care. The fee-for-service premiums do not cover services classified as cost reimbursed which include services provided by Federally Qualified Health Centers, State Hospital Physicians, Texas Health Steps medical screens, Family Planning, and charges under the Comprehensive Care program. Unlike fee-for-service, the managed care premium includes Texas Health Steps medical screens, family planning and Comprehensive Care program services. Cost reimbursed services represent a minority of acute care services provided by Medicaid.

Risk Group Definitions

The Medicaid program pays a premium for people in the following nine risk groups:

Aged & Medicare Related:

- Individuals over age 65 and any individual with Medicare coverage.

Disabled & Blind:

- Individuals who are Blind or Disabled. The majority of these people receive Supplemental Security Income (SSI).

TANF (formerly AFDC) Adults:

- Individuals age 21 and over that are eligible for the TANF program. This group may include some women who are pregnant.

TANF (formerly AFDC) Children:

- Individuals under age 21 that are eligible for the TANF program. This group may include some women who are pregnant and children less than one year of age.

Pregnant Women:

- Pregnant women having family income below 185 percent of the Federal Poverty Limit.

Newborn:

- Children under age one born to Medicaid-eligible mothers. The premiums for this risk group are broken into two sub-groups:
    - Regular Newborn: Newborn children less than 4 months of age.
    - Extended Newborn: Newborn children 4 through 12 months of age.

Expansion Children:

- Children under age 18, ineligible for TANF because of the applied income of their stepparents or grandparents.
- Children under age 1 with family income below 185 percent of Federal Poverty Limit.
- Children ages 1-5 with family income below 133 percent of Federal Poverty Limit.

Federal Mandate Children:

- Children under age 19 born after 10-1-83 with family income below 100 percent of Federal Poverty Limit. These children are between 6 and 18 years old.
- Children under age 19 born before 10-1-83 with family income below the Medically Needy (about 25 percent of poverty) standards limit. These children are between 17 and 19 years old.

CHIP Phase I:

- Children under age 19 born before 10-1-83 with Family income between the Medically Needy standards limit and 100 percent of poverty. These children are between 18 and 19 years old.

Medically Needy:

- Spend Down: Individuals whose family income is below the Medically Needy Standard limit (about 25 percent of poverty) after qualified medical bills are subtracted from their income.
- Non-Spend Down: Children under age 18 in families with income between the TANF level (about 17 percent of poverty) and the Medically Needy Standard limit. This group also includes many adults who are parents or guardians of these children as well as parents or guardians of children in some of the other risk groups.