Healthcare Services

Presentation to
Joint Interim Committee on Health Services
October 30, 2001
Don Gilbert, HHSC

Article II, Special Provisions
Medicaid Cost Containment Rider 33

a. Statewide rollout for TANF population ($17.9 million)

Status: Planned implementation of PCCM model has been delayed in response to concerns from physicians and hospitals, especially along the border. THA has proposed an alternative cost saving strategy to be available for implementation January 1, 2003.

Next steps:

- Evaluate THA cost containment initiative—finalize decision by mid-November for January implementation date.
- Consider modifications to PCCM model in response to public testimony—finalize decision by February for Sept implementation date.

b. Require SSI population to participate in STAR ($6.1 million)

Status: Deferred, potential savings in medical costs are offset by pharmaceutical costs when 3 prescription limit is waived

c. Establish a case management program for complex cases ($3.0 million)

Status: Pending outcome in strategy a.

Next step:

- Case management for difficult cases will be implemented by Sept 2002, either as part of PCCM, or under a separate initiative.

d. Selective contracting in urban areas for inpatient services ($24.5 million)

Status: THA proposal, referenced in strategy a, assumes the cost containment goal for this strategy.

Next step:

- See strategy a

e. Move from current formula for drug pricing in Medicaid to a "best price" structure ($22.0) million)

Status: Adopted rules were published October 12 that will allow HHSC to price drugs at the "best price" at which pharmacies can buy in the market place. Statewide audits are currently underway to allow changes to be made in general reimbursement under these rules.

Next steps:

- When the audits are completed, the data will be analyzed and general reimbursement percentages proposed. This is anticipated to take place by early Spring 2002. Also, rate setting staff are working on an RFP for a dispensing fee analysis. This activity is anticipated to be completed by the end of May, 2002.

f. Require supplemental rebates in selected therapeutic categories ($14.0 million)
Status: Manufacturers have tentatively committed to providing rebates in CHIP.

Next step:

- Negotiate removal of pharmacy benefit from CHIP health plans to the Vendor Drug Program, for January start date.

g. Reduce outlier payment percentage ($6.1 million)
Status: Completed. Rules were published Sept. 1, 2001.

h. Competitive pricing for medical equipment and supplies ($7.3 million)
Status: Pending

Next steps:

- Meet with provider/consumer representatives; develop RFPs. Implementation in Spring 2002.

i. Vision Care ($1.0 million)
Status: Pending; combine with strategy (h) above.

Next steps:

- Meet with provider/consumer representatives; develop RFPs. Implementation in Spring 2002.

j. Expand Health Insurance Premium Payments System (HIPPS) ($3.2 million)
Status: Working with Texas Workforce Commission to develop market strategies to distribute to employers.

k. Establish sliding scale copayments ($3.0 million);
Status: Pending; combine with strategy (h) above.

Next steps:

- Meet with provider/consumer representatives; implement in FY 2003.

l. Use the Title XIX Trust Fund Balance ($60 million);
Status: GR identified.

Next step:

- GR will be transferred at end of FY 2002.

m. Increase utilization review activities through Pharmacy Benefit Managers or in-house function ($6.0 million in General Revenue);
Status:

1. A rule to increase the early refill edit to 75% from 50% of a drug having to be used before it can be refilled. These rules were approved by MCAC in September and are anticipated to be published in the Texas Register in November.

Next steps: These rules also contain a provision for use of Average Manufacture Price in determining reimbursement. The rules must therefore be coordinated with the publication of rules regarding HB 915.

2. Additional DUR rejection edits have already been put in place to limit high doses, therapeutic and ingredient duplications (July 2001), as well as to limit maximum doses of some 40 drugs subject to overuse. (October, 2001).

Next steps: Staff is working out the details of a report of all clients receiving 9 or more medications in a single month. This report will allow staff to target clients who are overusing medications and education their physicians and pharmacies to prevent additional inappropriate use. VDP staff is also working on age and gender specific edits for some drugs that are misused. Examples: pre-natal vitamins for males and Viagra for females. The report and edits are anticipated to be completed in early 2002.

3. Incorporation of an automated voice response system for VDP. This would allow callers to more quickly contact the appropriate individual and allow the help desk staff to deal only with individuals who need to talk to the help desk. This provision would make DUR and other activities more efficient as it would allow direct caller connections with the appropriate staff.

Next steps: Analyze the cost effectiveness of this type system, which would allow additional customer service without additional staff.

n. Pilot automatic dispensing machines in nursing facilities ($3.2 million);
Status: Pending

Next steps:

- Meet with nursing home representatives; develop procurement strategy for FY 2003 implementation.

o. Savings due to Children's Health Insurance Program ($18.8 million)
Status: MHMR savings identified and available; TDH savings through CSHCN program unavailable due to anticipated program shortfall.

p. Lowest contract price/Medicaid pricing for all retail purchases ($3.0 million)
Status: HB 915 task force met October 26, 2001.

Next step:

- Workplan to be developed by task force.

q. Medicaid waiver for psychotropic medications ($5.9 million).
Status: 1115 waiver submitted; CMS questions received.

Next step:

- Answers to CMS by Nov. 1, 2001.

SB 43 Implementation Update

- **Four interagency work groups, co-chaired by HHSC and DHS, have been evaluating and planning the operational changes needed to implement the provisions of SB 43.**

- **Work groups are divided into functional areas:**

  - **Simplification (mail in application/continuous eligibility)**
  - **Eligibility Transition (eliminate Medicaid/CHIP coverage gaps)**
  - **Health Care Orientation (new member education effort)**
  - **Texas Health Steps (ensuring good primary and preventive care)**

- **Timelines and work plans for the project have been developed at both the project and the work group levels. Major projects targeted for January 1, 2002 completion:**

  - **Simplified application and process**
  - **Assets testing and renewal same as CHIP**
  - **Development of Health Care Orientation and Texas Health Steps Process**

- **DHS will be publishing proposed rules on SB 43 on November 23. Final rule adoption will be effective in January. These rules will address the simplified application, six-month continuous eligibility, and compliance with the Health Care Orientation and Texas Health Steps.**

- **The work groups have developed a basic outline of the SB 43 processes and HHSC/DHS will be requesting public input on this planning during November.**

- **HHSC will be seeking this input through website postings and through meetings with legislative staff and other stakeholders.**

- **Some of the topics that HHSC will seek input on include:**

  - **Joint application**
  - **Use of Social Security numbers**
  - **Health Care Orientation process and providers**
  - **Texas Health Steps check-ups**
  - **Transition between CHIP and Medicaid**
  - **Continuous eligibility**

DRAFT

Title 40, Social Services & Assistance, Part I, Texas Dept. of Human Services
Chapter 4, Medicaid Programs--Children and Pregnant Women
Subchapter A, Eligibility Requirements
TAC Section Number(s) §§4.1002, 4.1012, 4.1016

Proposed Action
X Amendment

Proposed Date of Adoption:
X 20 Days after Filing

The Texas Department of Human Services (DHS) proposes to amend §4.1002, concerning application procedures, §4.1012, concerning Medicaid Eligibility, and §4.1016, concerning client reporting requirements, in its Medicaid Programs--Children and Pregnant Women chapter. The purpose of the proposed amendment to §4.1002 is to allow mail or telephone processing of Medicaid applications or renewals for children under age 19, to allow any health and human services agency office to accept Medicaid applications for children under age 19, and to allow DHS to contract with others to accept Medicaid applications. The proposed amendment to §4.1012 allows six-month continuous Medicaid eligibility for children under age 19 and requires that children under age 19 be in compliance with the regimen of care prescribed by the Texas Health Steps Program. Proposed amendments to §4.1012 also requires that a parent or guardian attend a counseling session with a DHS representative, accompany the child to an appointment with a health care provider for a health care orientation, or have a face-to-face interview to renew the child's eligibility for Medicaid and to receive appropriate counseling on the need for comprehensive health care. Proposed amendments to §4.1016 disregards changes in income or resources for children under age 19 who have continuous eligibility.

James R. Hine, Commissioner, has determined that for the first five-year period the proposed sections will be in effect there will be fiscal implications for state government as a result of enforcing or administering the sections. There will be no fiscal implications for local government as a result of enforcing of administering the sections.

The effect on state government for the first five-year period the sections will be in effect is an estimated additional cost of $240,090 in fiscal year (FY) 2002;and an estimated reduction in cost of $7,112,451 in FY 2002; $12,837,292 in FY 2003; $12,541,771 in FY 2004; $14,989,059 in FY 2005, and $15,351,995 in FY 2006.

Mr. Hine also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of adoption of the proposed rules will be greater access to Medicaid programs for children under age 19. Preventative care may decrease the number of children who would miss school because of an illness as well as the number of parents who would miss work to stay with them. These rules also encourage personal responsibility by requiring parents or guardians to follow a regimen of preventative care for their children, including immunizations and regular medical and dental check-ups. Eligible children will be guaranteed six months of continuous coverage, regardless of changes in their family's income or expenses. There is no effect on small or micro businesses as a result of enforcing or administering the sections, because the proposed rules apply to simplifying the Medicaid enrollment process for children under age 19, not the operation of businesses. There is no anticipated economic cost to persons who are required to comply with the proposed sections. There is no fiscal impact on local employment.

Questions about the content of this proposal may be directed to Eric McDaniel at (512) 438-2909 in DHS's Programs and Policy Section. Written comments on the proposal may be submitted to Supervisor, Rules and Handbooks Unit-15, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the Texas Register.

Under §2007.003(b) of the Texas Government Code, the department has determined that Chapter 2007 of the Government Code does not apply to these rules. Accordingly, the department is not required to complete a takings impact assessment regarding these rules.

The amendments are proposed under the Human Resources Code, Title 2, 32, which authorizes the department to administer public and medical assistance programs.
and under Texas Government Code §531.021, which provides the Health and Human Services Commission with the authority to administer federal medical assistance funds.

The amendments implement the Human Resources Code, §32.001-32.042.

§4.1002. Application Procedures. Applicants for Medicaid programs follow the application procedures for Temporary Assistance for Needy Families (TANF) described in §3.301(a)(1) through 3.301(a)(3); §3.301(a)(5); §3.301(b); §3.301(c) of this title (relating to Responsibilities of Clients and the Texas Department of Human Services (DHS)); §3.302 of this title (relating to Definitions Relating to the Application Process); §3.303(a) of this title (relating to Receipt of Application - Acceptability Factors); §3.304(a) of this title (relating to Application Interview); and §3.307(a) of this title (relating to Authorized Representative), with the following exceptions:

(1)-(3) (No change.)

(4) Allow mail or telephone processing, or a face to face interview for Medicaid applications for children under age 19 at initial application and renewal.

(5) Applications for Medicaid for children under age 19 may be accepted at any office of a health and human services agency.

(6) DHS may contract with hospital districts; hospitals, including state-owned teaching hospitals; federally qualified health centers; and county health departments to accept applications for Medicaid for children under age 19.

§4.1012. Medicaid Eligibility.

(a)-(g) (No change.)

(h) Medicaid eligibility for children under age 19 who are determined eligible for medical assistance on or after January 1, 2002 continues for a six-month period without additional review and regardless of changes in resources or income, until the earlier of

(1) the 180th day after the date on which the child's eligibility was determined, or

(2) the child's 19th birthday.

(i) A parent or guardian of a child under 19 receiving Medicaid must

(1) attend an in-person counseling session with a department representative not later than the 31st day after the date the child originally establishes eligibility; or

(2) accompany the child to an appointment with a health care provider for a comprehensive health care orientation not later than the 61st day after the date the child originally establishes eligibility; or

(3) have a face to face-to-face interview to renew the child's eligibility for Medicaid and to receive appropriate counseling on the need for comprehensive health care.

(j) Children under 19 who are receiving Medicaid and are eligible for the Texas Health Steps program must be in compliance with the regimen of care prescribed by the Texas Health Steps program or have a face-to-face interview to renew the child's eligibility for

Medicaid and to receive appropriate counseling on the need for comprehensive health care.

§4.1016. Client Reporting Requirements.

(a)-(c) (No change.)

(d) Texas Department of Human Services (DHS) processes changes to determine if the client's eligibility for CPW is affected. DHS notifies the client if he is no longer eligible. **Exception: Changes in income or resources for children under age 19 who have continuous eligibility are disregarded. No action is taken on reported changes in income or resources until the next renewal.**

(e) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on _____.

CHIP Coalition – SB 43 Advisory Group

DRAFT- Project Options – **DRAFT**

October 24, 2001

Please note: Working assumptions, subject to change and refinement.

Simplified Application - January 1:

- TCP/DHS applications will be identical. Both will include a mandatory SSN field and directions/assistance on getting an SSN.

- Header will be "TexCare Partnership Application."

- As an interim approach, B&D/TCP will discontinue/recycle existing TCP application stock and start sending out an application that is exactly the same as one available at DHS. Application may be black and white with updated instructions for SSN.

- The online application will be changed to be consistent with the written application and the SSN change.

- TCP will continue to process any old stock applications. If SSN is not provided, family will get a missing information letter (similar to any of the other missing information letters). Currently, about 75% of TCP applicants provide SSNs on the submitted application.

- Assets questions and additional questions for Medicaid will be an identical second step at TCP or DHS. Medicaid-only questions will be edited/separated to make it clear that those questions do not need to be answered if answers to assets questions would send child to CHIP.

- Still an open question: Should DHS-provided applications mail to TCP? Or have DHS-provided applications mail to DHS and TCP-provided mail to TCP, for time being. Issues: Many folks at DHS also seeking TANF, food stamps; budget for increased application processing volume at TCP?

- All of the above are interim steps to implement key provisions of SB 43. Additional consolidation and changes will be made after field testing and further reengineering of TCP and/or DHS business processes.

DRAFT

CHIP Coalition – SB 43 Advisory Group

DRAFT- Project Options – **DRAFT**

October 24, 2001

Please Note: Working assumptions, subject to change and refinement.

Health Care Orientation (HCO):

- The HCO can be done at more than one place (CBOs, doctors offices, etc.) but Texas Health Steps program will be primarily and ultimately responsible for seeing that the HCO gets done and for managing the HCO service.

- THS will develop and train additional providers for the HCO. This would include interested CBOs. Training would emphasize a consistent delivery and content. THS and DHS will need to develop a low-tech method for finding out who has had an HCO from someone other than THS and getting that information on SAVERR

- THS will develop alternative venues for HCOs. This could include access TV sessions with a mail-in verification, check-out videos, or other alternatives.

- A Health Steps Screen will be considered to be an HCO. The provider will not need to hand out any additional information. Work group will evaluate whether other types of medical visits could qualify as an HCO.

- A mail-out or handout of HCO materials (two pager) will be done by either DHS or TX Steps soon after an initial enrollment as possible. This will ensure that everyone gets at least the basic written HCO information and will alleviate having to ask health care providers to handle, order materials, etc.

- HCO will be available in various forms from a variety of sources in the community with content coordinated by TH Steps staff. If a member has not been able to get the orientation through any of those means, but has had the phone orientation with TH Steps staff, they will be considered as having met the HCO.

- Anyone initially applying in-person at a DHS office or anyone renewing who has not complied with the HCO gets an HCO from DHS at that time.

Tb/hhsc

Status of Key Fee-for-Service Rate-Setting Issues

Acute Care Issues

- **Professional Fee Increase - EPSDT Fee to $70**. Riders 28, 29, and 54. Estimated cost for the EPSDT fee increase over the biennium is ~$31 million GR. The fee Increase is statewide and became effective 9/1/01. Additional office-based, primary care/preventive, volume and geographic adjustments have been taken to the Physician Payment Advisory Committee (PPAC). The first PPAC met on September 15th to discussed how to spend the remaining ~$19 million GR available for the biennium. HHSC staff is preparing analysis for an October 27 meeting. Preliminary recommendations are to provide additional increases for high-volume providers, which will include those practicing along the border, in rural and medically underserved inner city areas. Anticipated implementation is 1/1/02.

- **Dental Fee ($20 million GR).** Riders 28 and 30. Reimbursement for 33 procedures that are billed most often was increased by ~13.5% effective 10/1/01. Of the $20 million in biennial GR available, $16 million went for increasing payment for exams, preventive, and selected restorative procedures. The remaining $4 million is to be used for an additional increase for practitioners who provide a high volume of services, particularly along the border and in rural areas. The Oral Health Advisory and Best Practices Committees will be meeting in October and November to provide additional input. Anticipated implementation is 1/1/02.

- **OP Hospital Discount Factor.** Riders 28, 48 and 54. Per Rider 54, the increase is to be targeted to high volume providers, especially those along the Texas-Mexico border and in medically underserved inner city areas. To that end, the $35 million in biennial GR was used to increase payments to high-volume Outpatient Hospitals by 5.2%, effective 10/1/01. ASC/HASCs and Birthing Centers, which qualified as high-volume, also received a 5.2% increase in payment rates, effective 10/14/01. The increased payment for these high-volume outpatient services affects an estimated 95% of total outpatient services provided.

Long Term Care Issues:

- **DHS community care rates ($50 million GR).** Basic SFY 2002-03 rates have been adopted and will be effective September 1, 2001. Enhanced rates for attendant staff wages and benefits also have been determined effective September 1, 2001.

- **Nursing Facility rates ($175 million).** A basic rate increase was implemented effective September 1, 2001, and further adjustments are scheduled for

implementation effective September 1, 2001, in conjunction with rule changes necessary to comply with legislative direction. At least $20 million in GR will be earmarked specifically for quality enhancements which will be implemented effective December 1, 2001, following an October enrollment period. Overall, nursing facility rates for FY02-03 are expected to increase by an average of approximately 11.5 percent compared to FY01.

- **MHMR rates**. HCS and other waiver rates will be increased effective September 1, 2001, expending $2.5 million GR for the biennium. ICF-MR rate increases will be funded through a Quality Assurance Fee that will be assessed beginning September 1, 2001. Proceeds of the initial fee, set by legislation at $5.25 per resident day, will fund rate increases in the ICF-MR program effective September 1, 2001. An increase in the fee to 5.5% of provider revenues is planned for November 1, 2001, and this fee increase will fund further rate adjustments in the ICF-MR program and potentially in HCS and other waivers as appropriate.

Introduction

- This document provides an overview of the methodology used to set Medicaid Managed Care capitation rates.

Constraints

- The Center for Medicare and Medicaid Services (CMS – formerly HCFA) requires cost effectiveness.

  Federal regulations require that waiver programs cost no more than if there had been no waiver. Medicaid managed care operates under a waiver because it is a different model than the Fee-for-Service (FFS) model specified in the state plan for Medicaid. To be cost effective managed care may not cost more than what FFS would have cost.

  CMS could deny managed care waivers that are not cost effective. CMS could also deny federal match for waivers that are not cost effective. Without Federal match, the State would have to use 100% state dollars to cover Medicaid costs. However, State law prohibits expenditure of non-matched funds for Medicaid.

- Appropriations limit available funds.

  The total dollar amount available for inclusion in managed care rates must be supported by state appropriations.

- Rate setting methodology must be actuarially sound.

  Managed care rates must be determined using an actuarially sound methodology which is reviewed and attested to by an external actuary.

Base Rates

- A discounted fee-for-service (FFS) methodology is used to set base rates.

  This method is common around the country. It guarantees meeting the cost effectiveness requirement.

  FFS costs are available for each service delivery area (SDA). Costs by risk group are projected into the plan year for each SDA using statewide FFS trends.

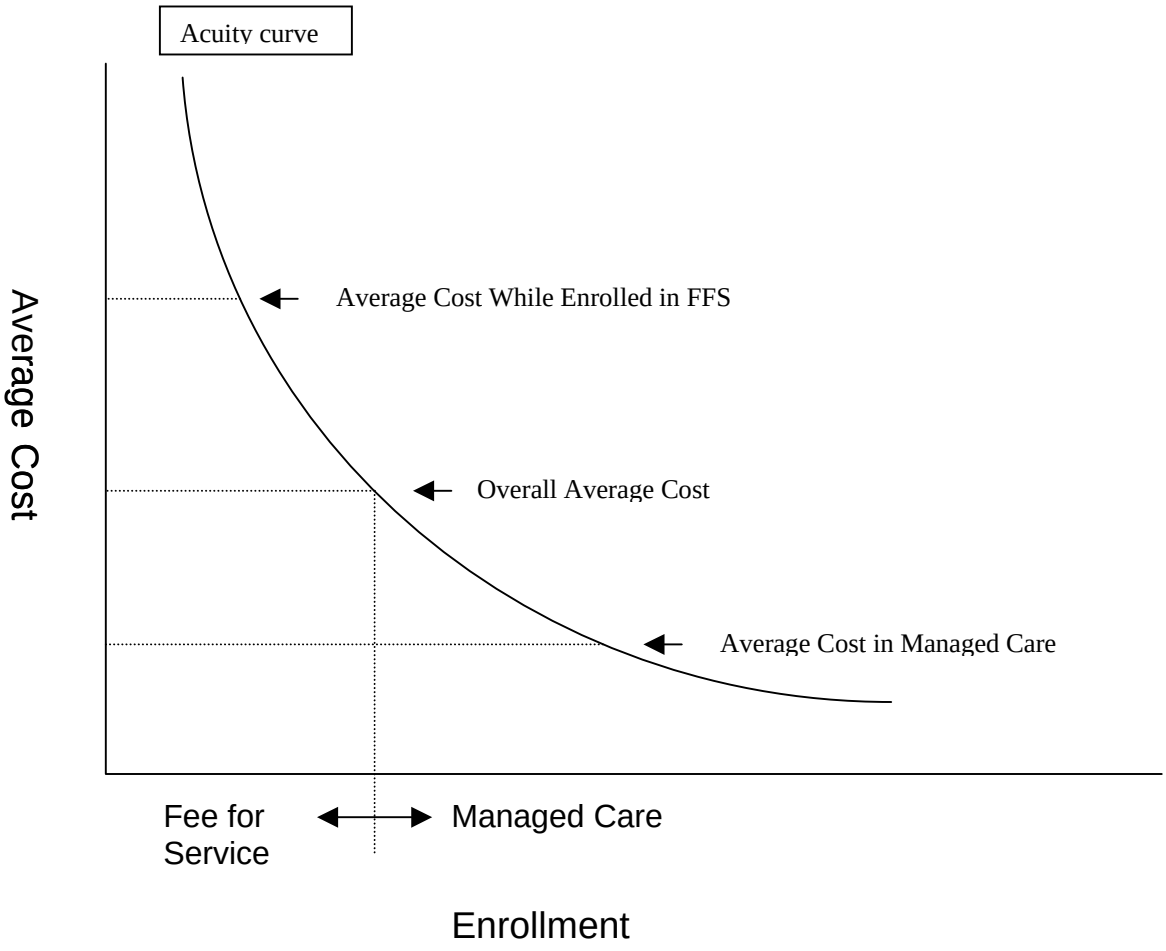
- Delayed enrollment factor is applied.

  Enrollment into managed care can take up to two months because clients are given time to choose a plan. During this period clients are enrolled in FFS. An adjustment is made to the rates to account for higher initial costs in FFS. These higher initial costs can occur because new Medicaid clients often seek services for immediate medical problems.

- Discounts are applied.

  Discounts are applied by SDA and range from 6 to 12%. The discounts must be enough so managed care savings can be achieved and cost effectiveness demonstrated. The discounts also cover the additional state administrative cost for having managed care such as additional staffing and for the PCCM contractor, and must cover the cost of additional services offered to managed care clients such as unlimited prescription drugs.

Delayed Enrollment



- Because many clients come to Medicaid with immediate healthcare needs, the average cost tends to decline over time.
- Because it can take up to two months to enroll in managed care, the overall average cost would not be appropriate for setting managed care rates
- Delayed enrollment factors adjust the overall average cost to the average cost after the time when managed care enrollment would have occurred.

Update for FY 2002

- HMO rate methodology was updated using the most recent data.

  For example, recent data were used to update cost trends and delayed enrollment factors.

- Adjustments were made for appropriated dollars.

  HMO rate increases for SFY 02 were made based on legislative appropriations. The Texas Legislature appropriated $87.5 million all funds for FY02-03 specifically for HMO rate increases. Per member per month amounts were computed and added on to the base rates.

- Adjustments were made for appropriated increases for physician and outpatient hospital fee increases.

  About $8.6 million all funds for outpatient reimbursement and $12.7 million all funds for physician fees were added to the HMO rates for FY2002. The plans have been instructed to pass these funds on to the providers and a mechanism is being developed to verify the pass-through.

- Adjustment were made for programmatic changes (expedited enrollment).

  A programmatic change, expedited enrollment, was mandated by the 76th Legislature and was implemented in FY 2000. This change impacted the delayed enrollment factors.

- Enhancements were included for Dallas and El Paso.

  Dallas and El Paso rate increases were enhanced to be about 6% and 15% respectively. These increases are in accordance with HB2896 of the 76th Legislature that directs HHSC to consider plan viability and regional costs when setting managed care rates.

Risk Adjustment

- The risk adjustment for delivery supplemental payment and the uniform newborn rates is intended to be budget neutral.

  As of September 1999, the State began paying a delivery supplemental payment (DSP) for each delivery in order to more accurately compensate HMOs that tended to serve more pregnant women. In addition, a uniform newborn rate for all newborns 12 months and under was established. Newborns are found in more than one risk group and thus would otherwise receive different rates.

  To maintain budget neutrality, the base rates are adjusted to off set the delivery payment and to compensate for the uniform newborn rate. Because these adjustments are budget neutral, there is no regional impact.

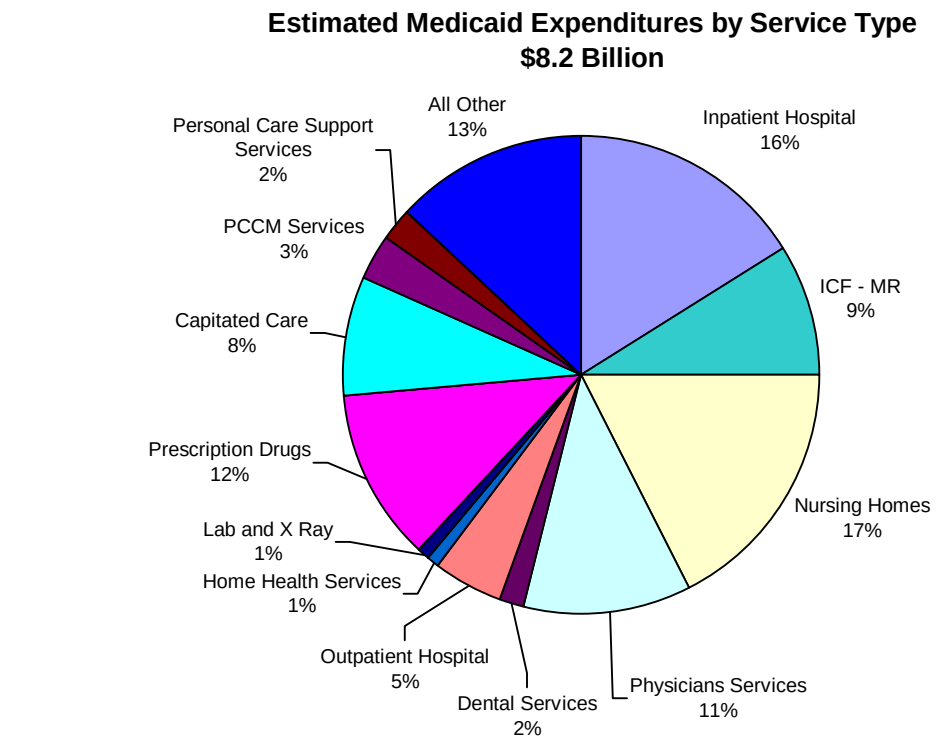
  Updated delivery rates, newborns costs and numbers of newborns were used to determine the premium rates paid to HMOs for FY 2002.

Rate Adjustments
Authorized in SB 1

Type of Rate	Description of Adjustment	Effective Date	Appropriated Amount FY02-03 GR
Medicaid			
Professional fees	Increased the EPSDT fee from $49.01 to $70.00. Additional office-based, primary care/preventive, volume, and geographic adjustments will be considered.	9/1/2001	$50 million
Dental fees	13.5% increase for the 33 procedures that are billed most often. Additional increases will be considered for high-volume providers, particularly in the border region	10/1/2001	$20 million
Outpatient hospital services	A 5.2% increase for high-volume providers, which include those in the border region.	10/1/2001	$35 million
Community Care	Increases for attendant wages in six community care programs at DHS	9/1/2001	$50 million
Nursing facilities	An average of 11.5% increase. Further adjustments for quality enhancements will be implemented in December.	9/1/2001	$175 million
Intermediate Care Facilities for people with Mental Retardation (ICF-MR)	Private ICF-MR providers received an average rate increase, net of the Quality Assurance Fee, of approximately 5 percent.	9/1/2001	Proceeds from Quality Assurance Fee
Home and Community-Based Services (HCS) waiver	1.2% increase over FY01 rates.	9/1/2001	$2.5 million
Health Maintenance Organizations	Rates increases vary according to service delivery area and risk groups.	9/1/2001	$35 million
STAR-Plus	Rate negotiations not yet completed.	1/1/2002 (estimated)	$4.5 million
Non-Medicaid			
Children's Health Insurance Program (CHIP)	19.7% average increase for CHIP health plans.	10/1/2001	SB 1 did not specify an amount.
Foster Care rates	Based on an updated methodology, PRS implemented the legislatively mandated 3% rate increase and was able to enhance federal funding to achieve an overall increase of 5.6%.	9/1/2001	$11.2 million

Costs

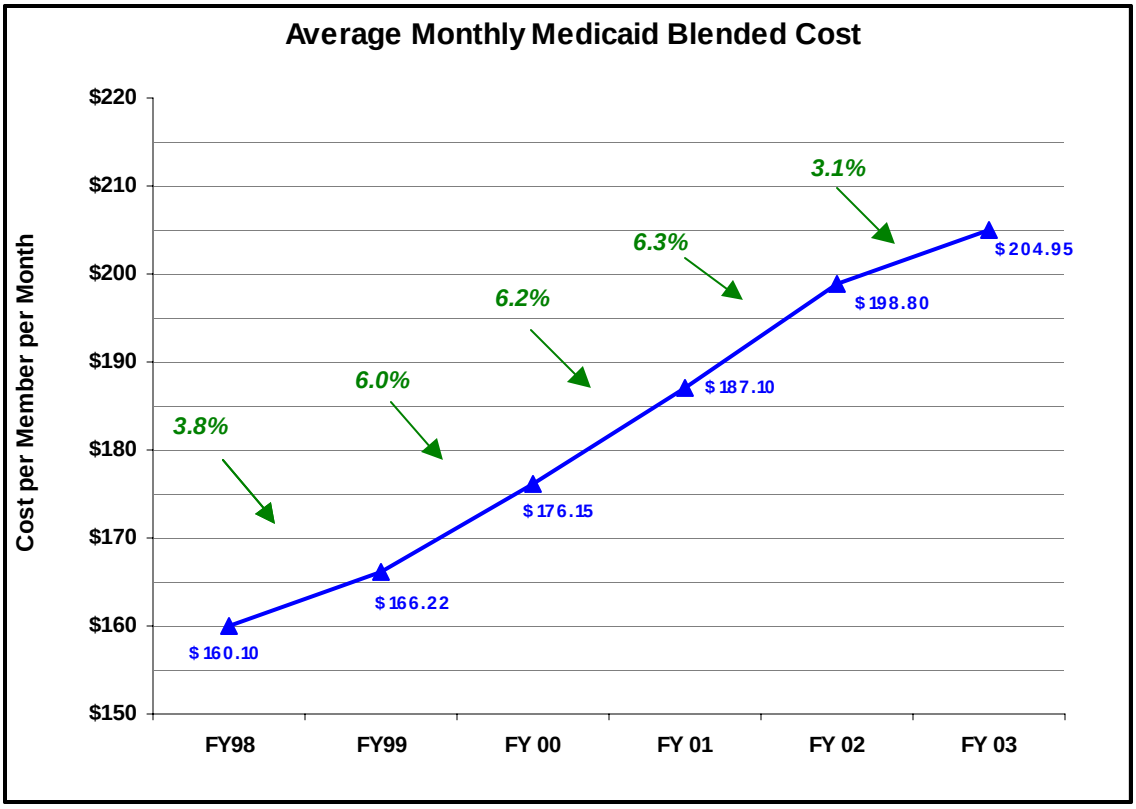
Health Care Costs in Medicaid



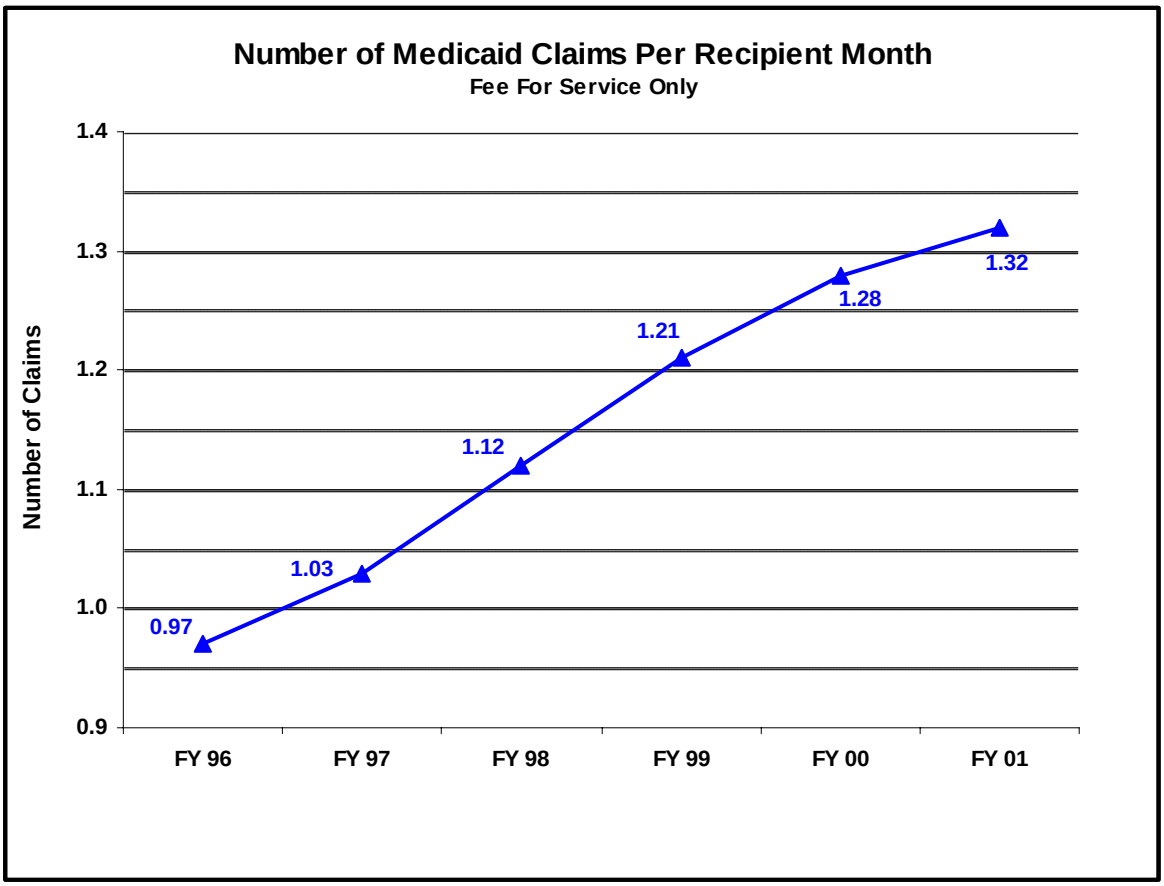
Source: HCFA 2082 FFY 99

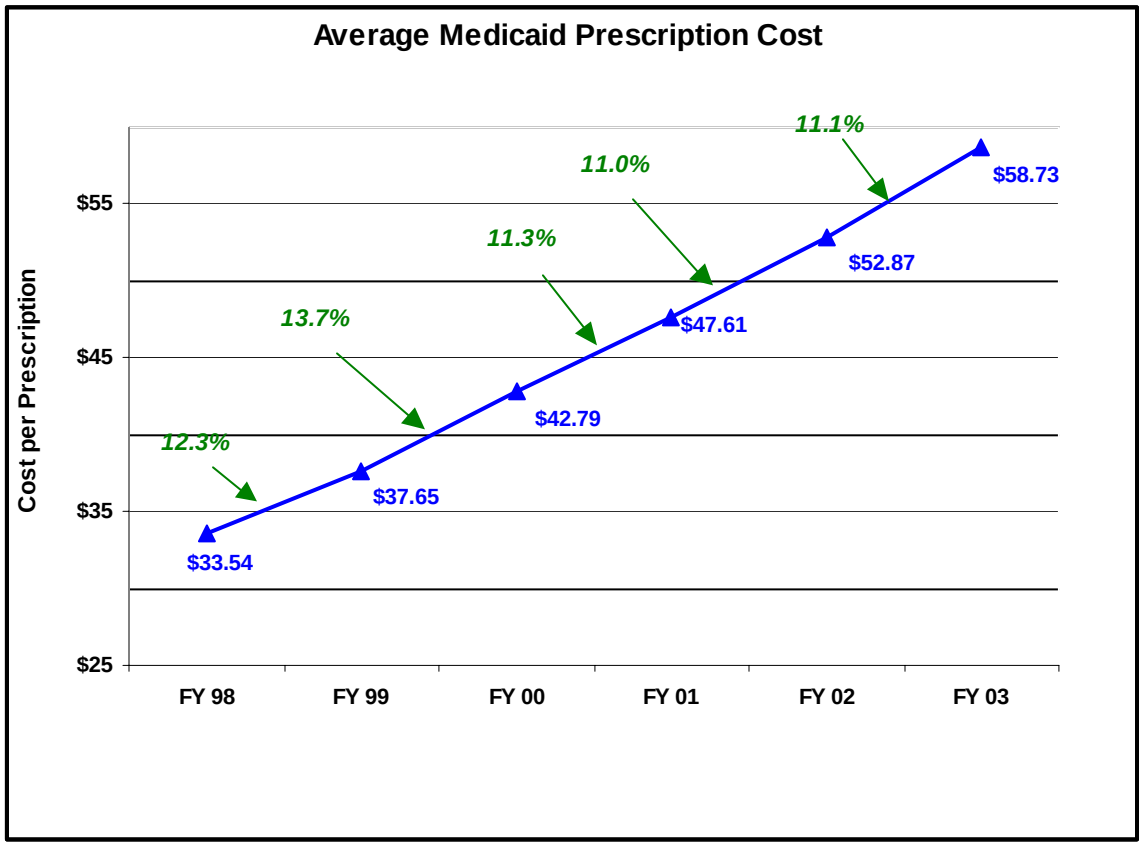
For the purposes of this presentation, Medicaid costs will be described as the cost per service as differentiated from the expense to the state budget. Expense to the state budget is the multiplication of service cost and service utilization. Service cost, therefore, will be discussed in the rather narrow context of cost per service.

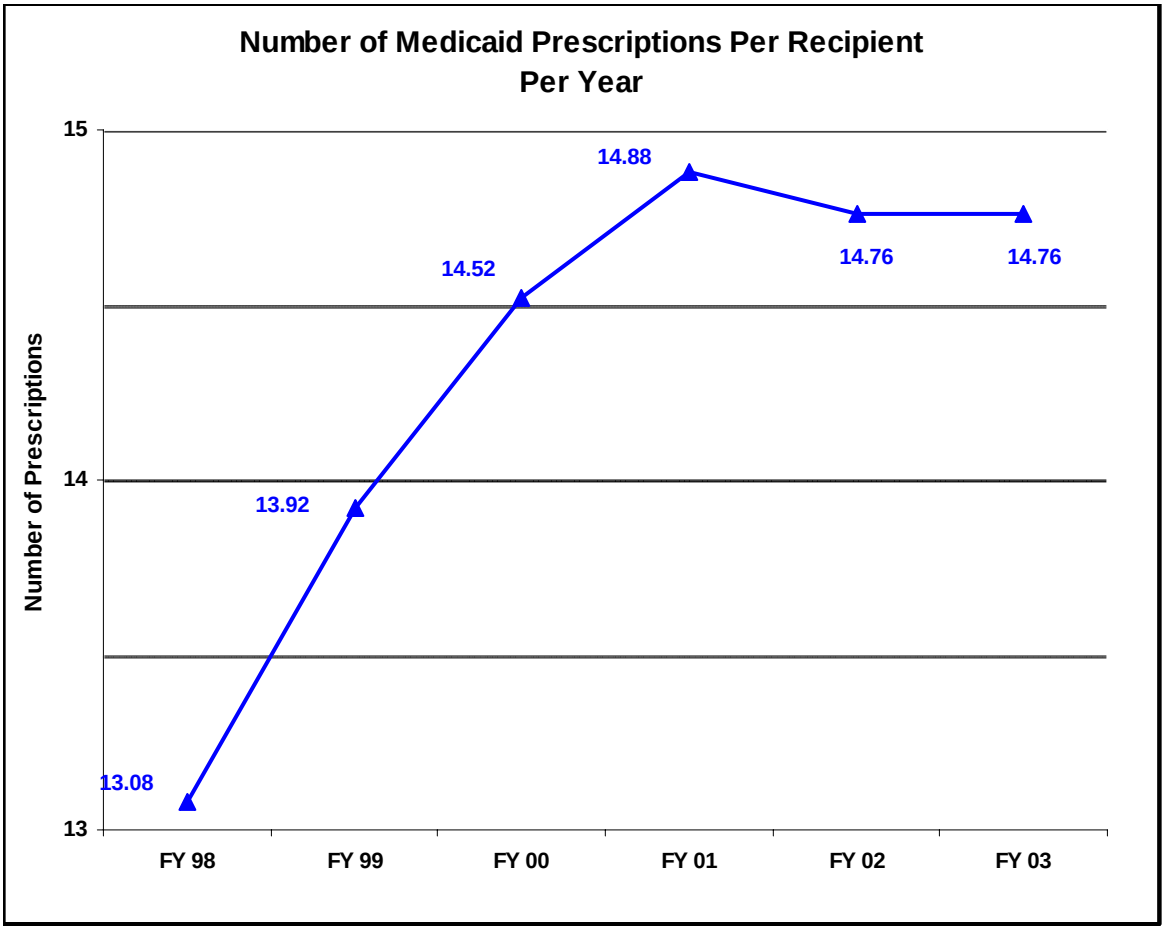
The only major Medicaid Service in which the rate of reimbursement operates independent from the appropriation is the vendor drug program. Reimbursement rates are based on the fluctuating acquisition cost to the pharmacy plus a fixed dispensing fee.



Note: Fee for Service and Managed Care for all Risk Groups.




Average Medicaid Prescription Cost
Cost per Prescription
$55
$45
$35
$25
$33.54
$37.65
$42.79
$47.61
$52.87
$58.73
12.3%
13.7%
11.3%
11.0%
11.1%
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03


Number of Medicaid Prescriptions Per Recipient Per Year
Number of Prescriptions
15
14
13
13.08
13.92
14.52
14.88
14.76
14.76
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03

- Prescription drug costs account for 12 percent of Texas Medicaid spending in FY 2000.
- Department of Health and Human Services projects prescription drug costs to increase by an average of 12.6 percent per year over the next 10 years.
- Increases in prescription drug costs since 1993 appear to be attributable to:

Price changes to existing products	18%
New/more expensive products	39%
Increased utilization	43%

- The Vendor Drug Program establishes reimbursement for each prescription drug. The general formula includes the acquisition cost of the drug (which includes a number of purchase options) plus a dispensing fee, an inventory management factor, and a delivery incentive. The total of this formula is then compared to the reported Usual and Customary price and the lower of the two is paid.
- The new pharmacy services reimbursement rules were adopted with an effective date of October 21, 2001. Under these new rules, the Commission may use whatever reliable market resources are available to set drug product pricing for the Medicaid Vendor Drug Program. This allows us to respond more quickly to changes in the marketplace that influence reimbursement.

What are the main drivers in health care costs other than caseload for major HHS programs?

Medicaid Fee for Service

In the Medicaid Fee for Service program, the cost per Medicaid recipient has increased by 30 percent over the last five years.

- The primary driver of the increased cost per Medicaid recipient (cost per recipient month) is an increase in the number of services that recipients are getting; not an in increase in the cost of those services.
- That is, over the last five years, while the average cost of individual services has remained fairly stable, the number of services per recipient has increased an average of six percent each year.

Vendor Drug Program

In the Vendor Drug Program, the cost per recipient per month has more than doubled (122.5 percent) over the last five years.

- While there has been an increase in both the cost per prescription and in the number of prescriptions per recipient, the primary driver of the increased cost per Medicaid recipient is the increase in the cost per prescription.
- That is, over the last five years, the average cost per prescription has increased by 69 percent while the average number of prescriptions per recipient has increased by 30 percent.

CHIP

The CHIP premium rates for the second year of the program increased approximately 19.7 percent, on average, as compared to first year rates.

- In developing the premium rates for this year we assumed that the average cost of medical services would increase 6 percent and the average cost of prescription drug services 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.

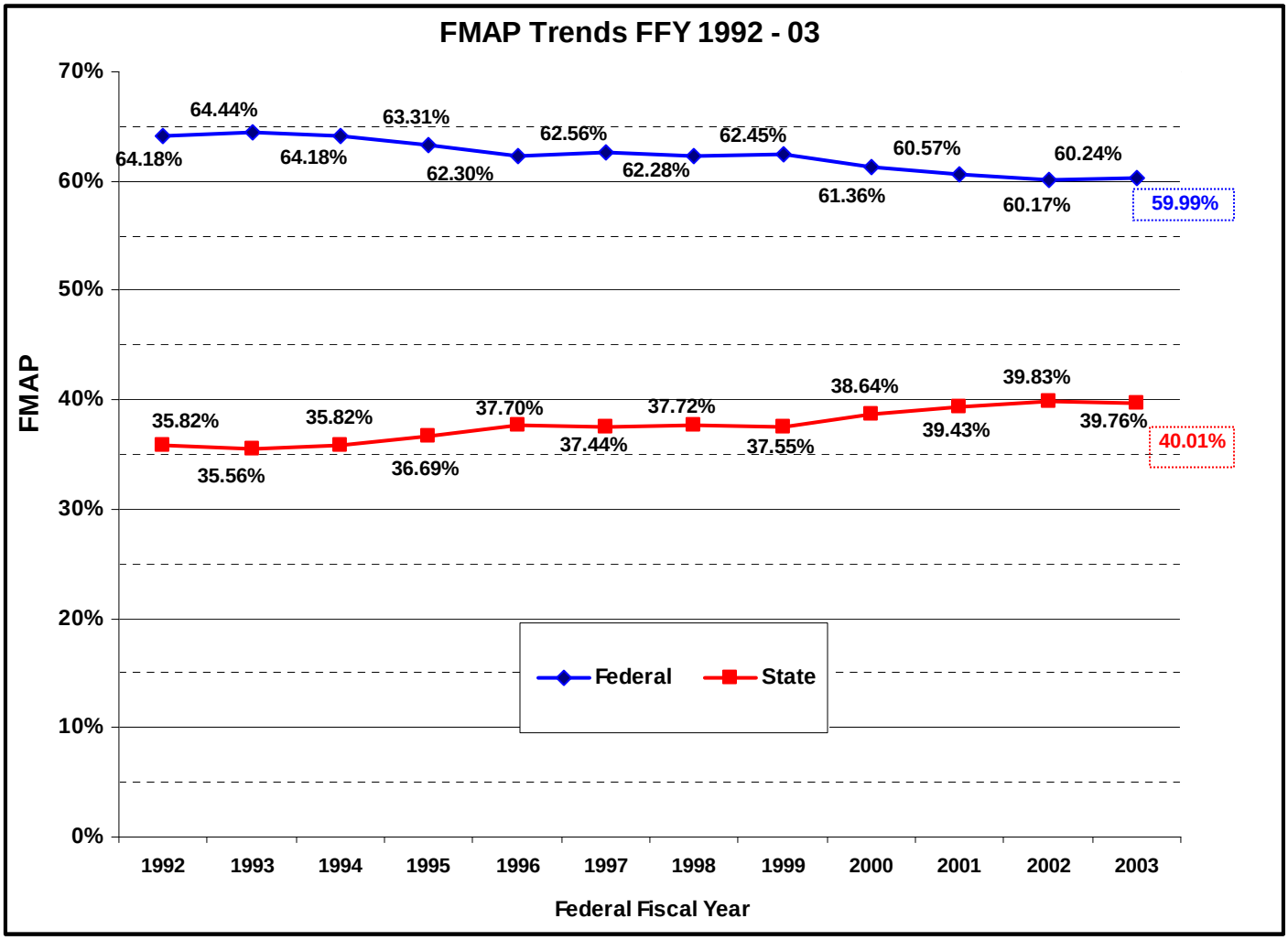
Long-Term Care

- In Nursing Homes the major cost driver is employee compensation (including benefits) primarily associated with nurses and nurse aides. Employee compensation is one of many costs that increase with inflation.
- Professional liability insurance has seen a significant rise in cost. While the cost of liability insurance is rising, it currently makes up about two percent of the overall average nursing home cost. Relative to employee compensation, liability insurance is not as major a driver of costs. HHSC Rate Setting Division is conducting a survey seeking to ascertain what portion of providers carry which insurance type in an effort to determine which providers would receive an associated rate adjustment that is being developed.
- Also the acuity of Long-Term Care clients is increasing one or two percent per year.
- In the Community Care program likewise, the average number of hours of service needed by residents (acuity) is increasing one or two percent per year.

FMAP

The federal match on state spending on medical care can change from year to year with significant impact to the state. This federal match for Medicaid is referred to as the Federal Medical Assistance Percentage (FMAP) rate. The federal match for CHIP is also based on an enhanced version of this rate (the EFMAP).

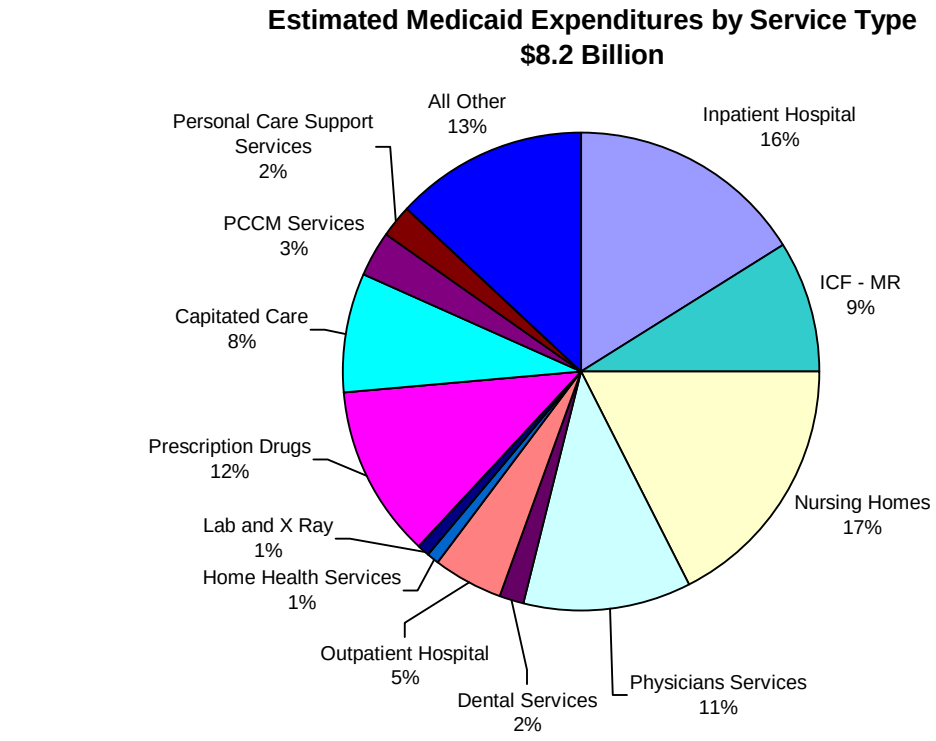
- The FMAP formula is based on a state's three year average per capita income compared to the national per capita income. So, if the state has a healthier economy than the rest of the nation, the federal share of these expenses will decrease requiring the state to pick up a larger portion.
- Because of the volume of spending covered by the FMAP, what may be a minor percentage change in this rate can mean millions of dollars of increases or decreases in required state spending.



- The most recent information we have (October 19, 2001) from the Federal Funds Information for States (FFIS) projects the FMAP for federal FFY2003 to be 59.99 for Medicaid and 71.99 for CHIP.
- The April projection for the FFY2003 FMAP from FFIS used in the appropriations process was 60.24 for Medicaid (0.18 percent higher than now projected) and 72.17 for CHIP (0.13 percent higher than now projected). The HHS CFOs are preparing an estimate of the impact based on these new FFY 03 projected expenditures.

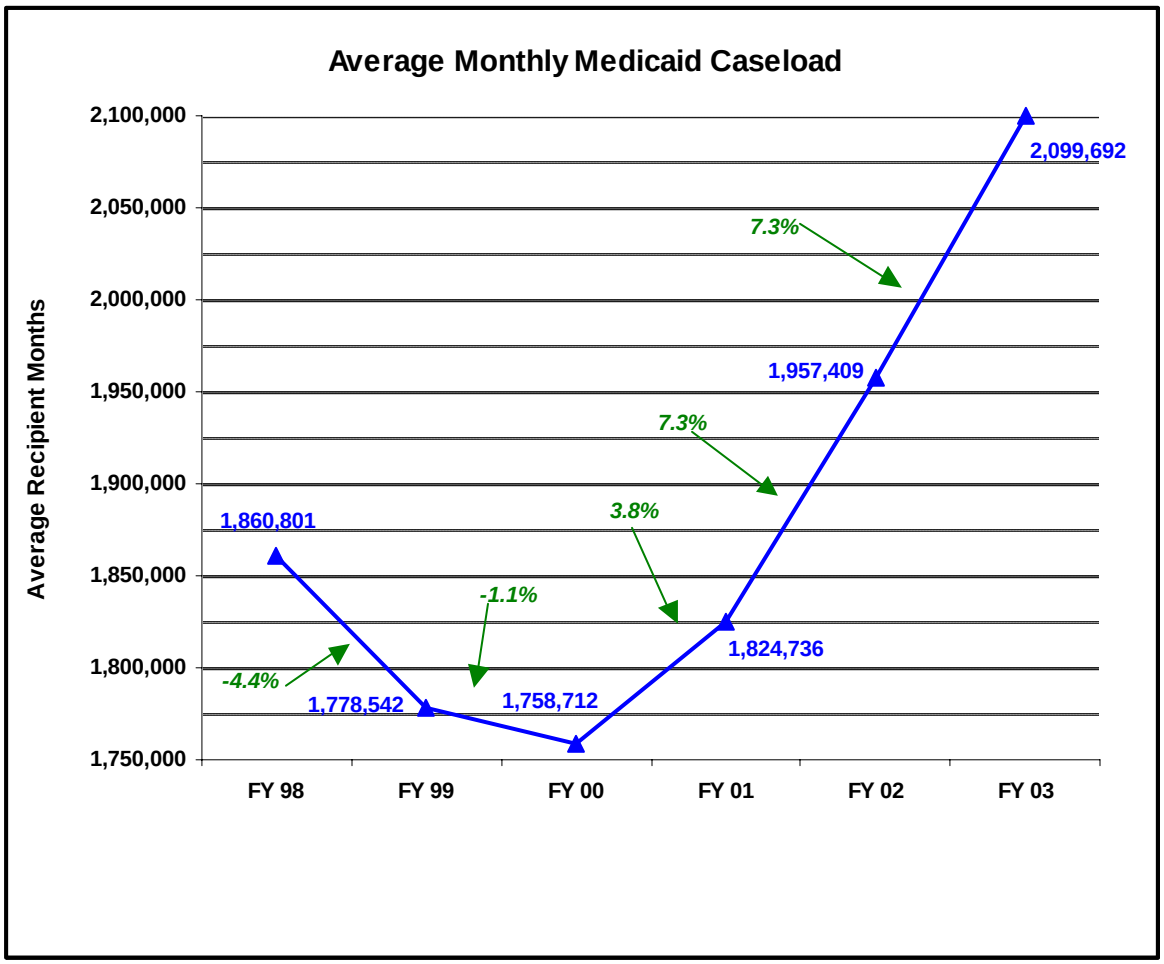
Caseload

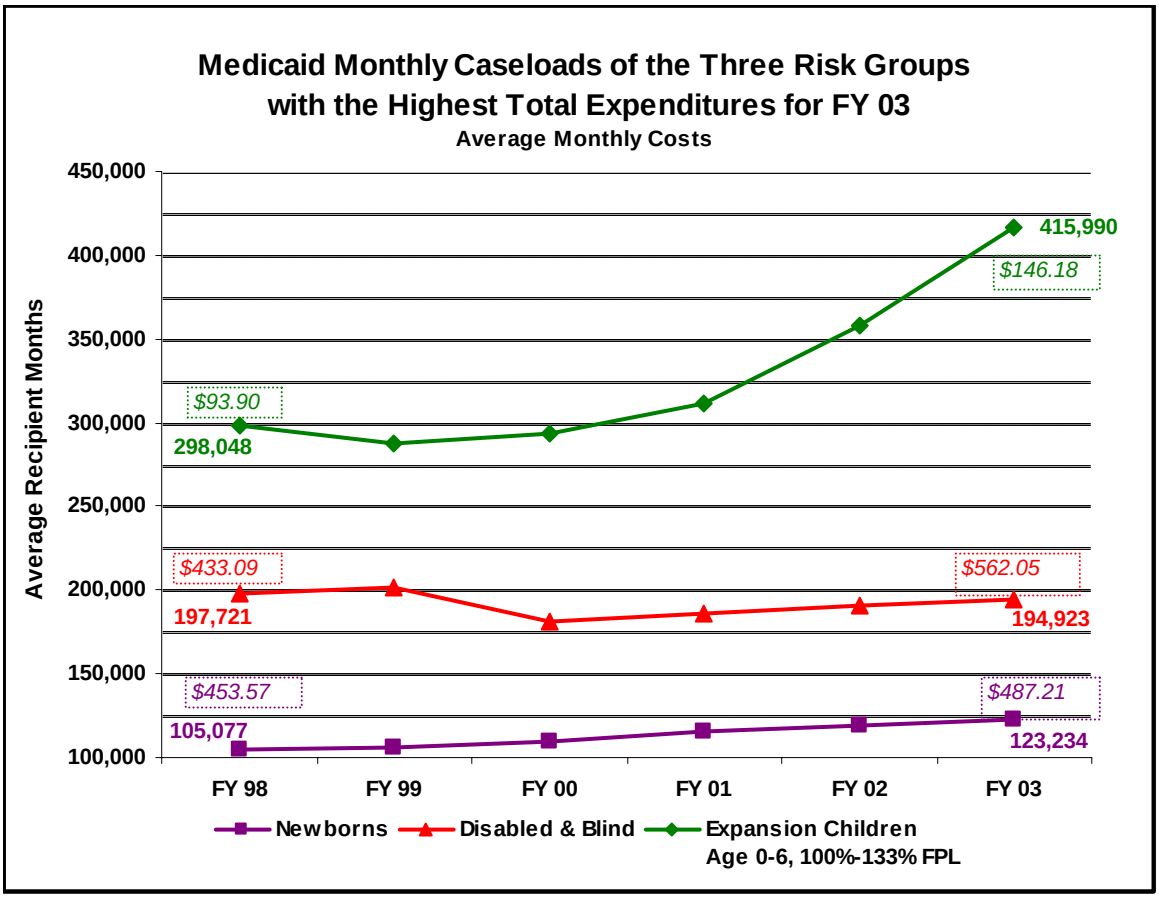
Demand for Services

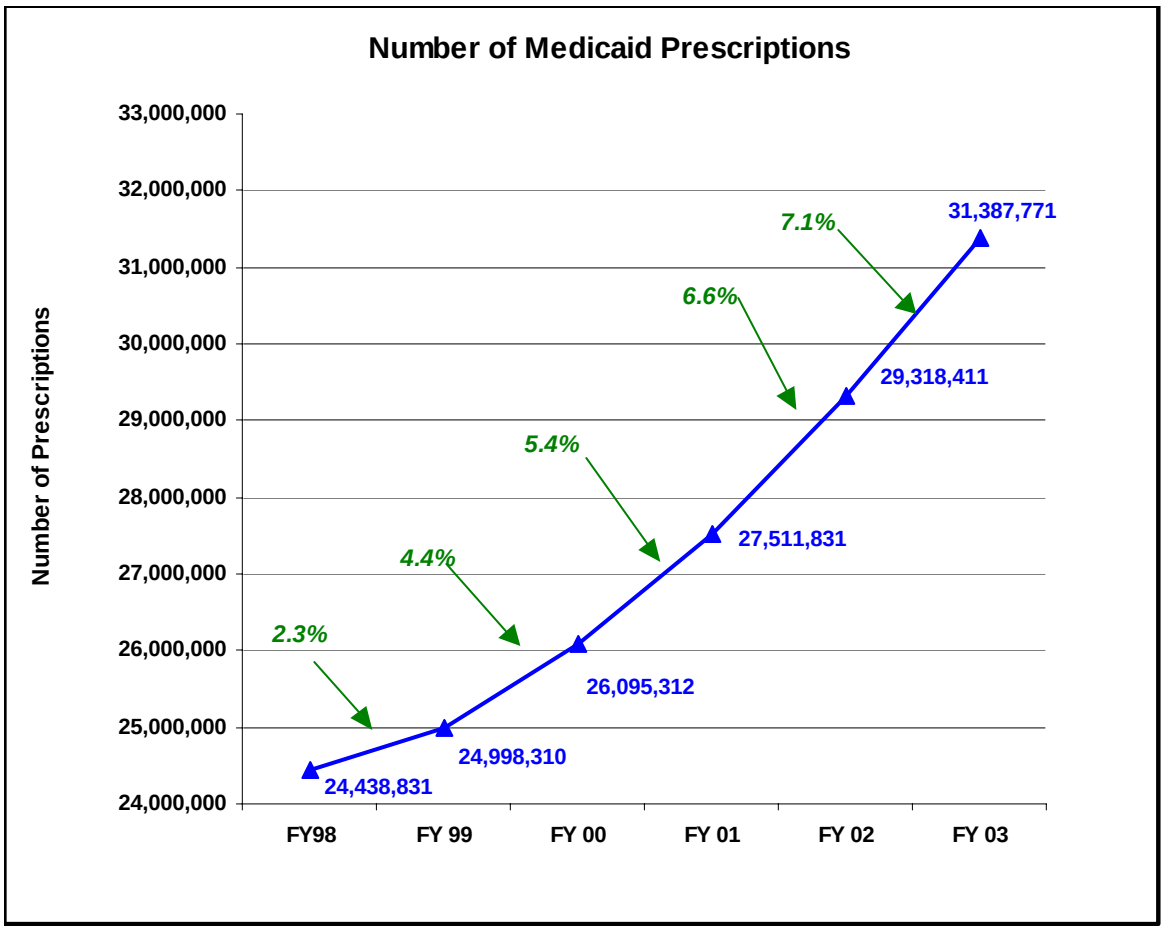


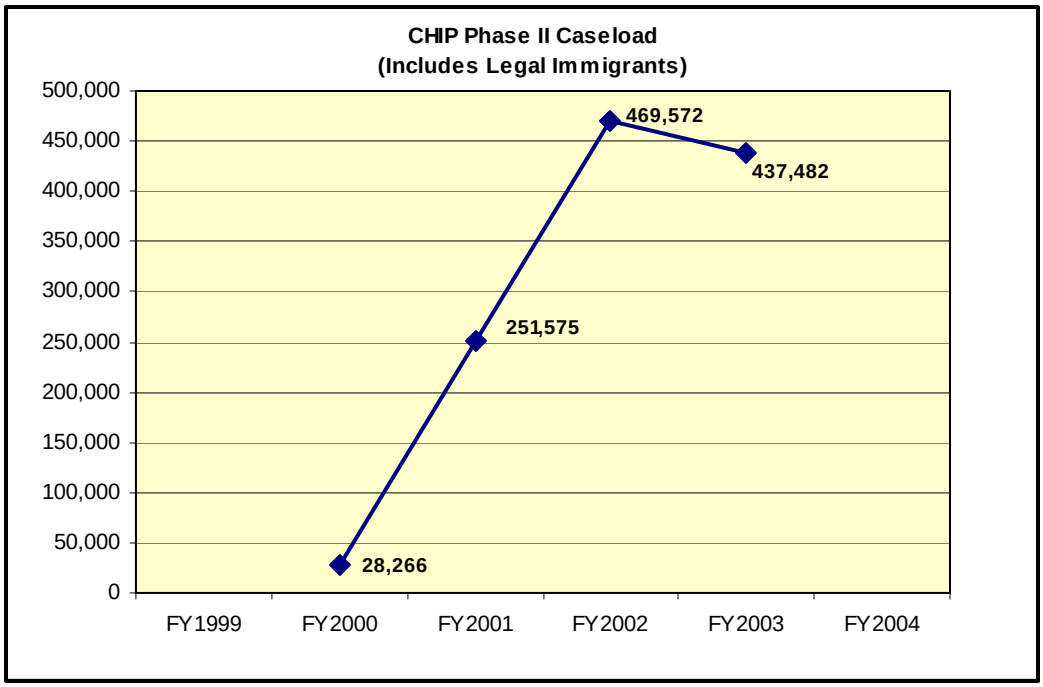
Source: HCFA 2082 FFY 99

Demand for Medicaid services is a function of caseload size and case mix. The case mix in Medicaid refers to the proportion of specific sub populations within the Medicaid program. There are nine sub populations, or risk groups, within the Medicaid population, each with its own estimated demand for service and cost.


Average Monthly Medicaid Caseload
Average Recipient Months
2,100,000
2,050,000
2,000,000
1,950,000
1,900,000
1,850,000
1,800,000
1,750,000
1,860,801
1,778,542
1,758,712
1,824,736
1,957,409
2,099,692
-4.4%
-1.1%
3.8%
7.3%
7.3%
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03


Medicaid Monthly Caseloads of the Three Risk Groups
with the Highest Total Expenditures for FY 03
Average Monthly Costs
Average Recipient Months
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
$93.90
298,048
415,990
$146.18
$433.09
197,721
$562.05
194,923
$453.57
105,077
$487.21
123,234
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03
Newborns
Disabled & Blind
Expansion Children
Age 0-6, 100%-133% FPL


Number of Medicaid Prescriptions
Number of Prescriptions
33,000,000
32,000,000
31,000,000
30,000,000
29,000,000
28,000,000
27,000,000
26,000,000
25,000,000
24,000,000
FY98
FY 99
FY 00
FY 01
FY 02
FY 03
24,438,831
24,998,310
26,095,312
27,511,831
29,318,411
31,387,771
2.3%
4.4%
5.4%
6.6%
7.1%


CHIP Phase II Caseload
(Includes Legal Immigrants)
500,000
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
469,572
437,482
251,575
28,266
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004