Presentation to the House Appropriations Committee

Albert Hawkins, Executive Commissioner

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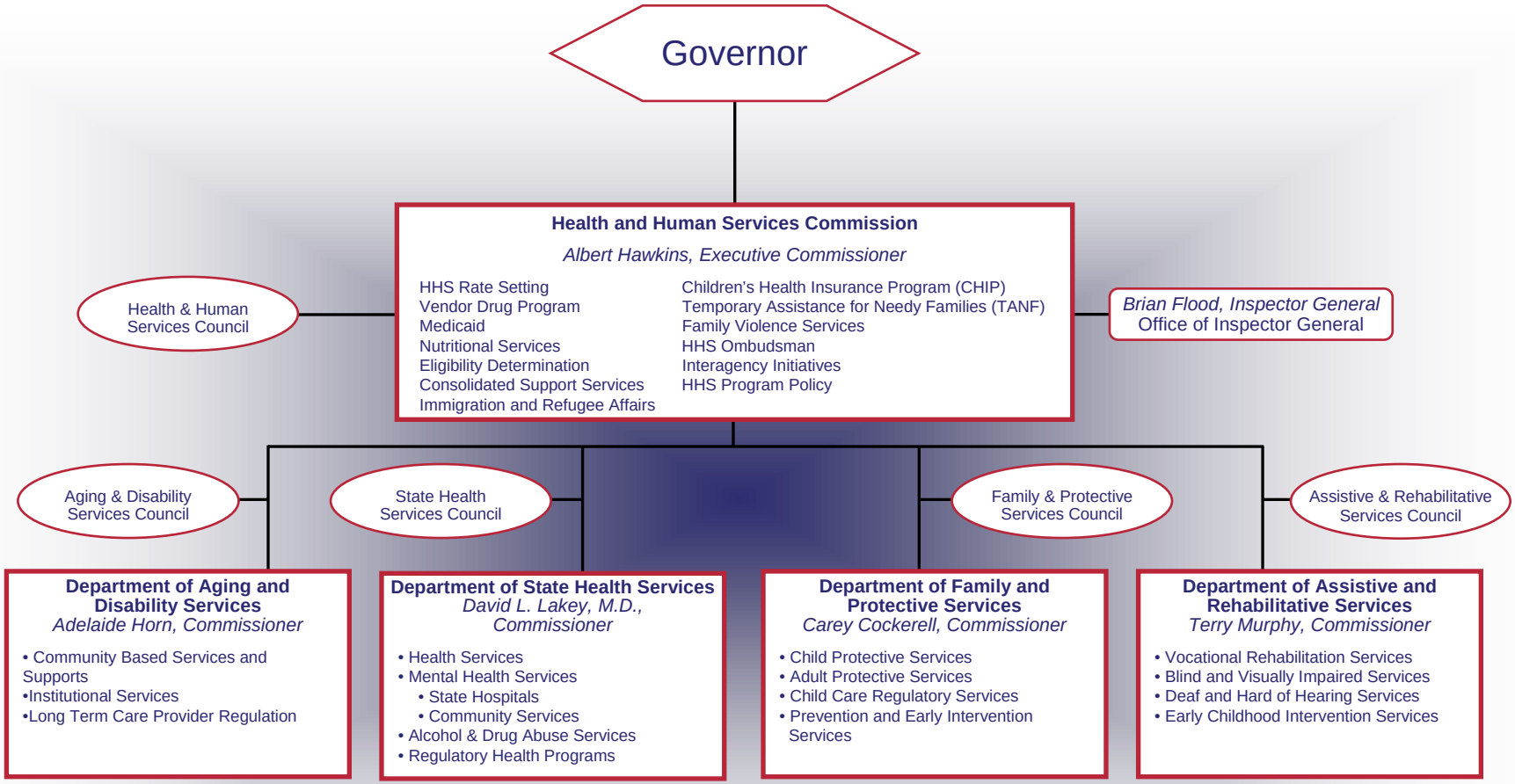
February 1, 2007

TEXAS Health and Human Services System

HHS Organization



Overview of Health and Human Services

- Health and Human Services Key Budget Drivers FY 2008-09
  - Caseloads
  - Costs and Rates
  - Federal Program and Financial Requirements
  - Professional Staffing
  - Technology

HHS Overview

- **Department of Aging and Disability Services (DADS)**
  - **Program Areas**:
    - Community Based Services and Supports
    - Institutional Services
    - LTC Provider Regulation
  - **Key Budget Drivers in FY08-09:**
    - Community Services Caseloads and Costs/Rates
    - Nursing Facilities Caseloads and Costs/Rates
    - Intermediate Care Facilities for People with Mental Retardation

HHS Overview

- **Department of State Health Services (DSHS)**
  - **Program Areas:**
    - Health Services
    - Mental Health Services (State Hospitals and Community Services)
    - Alcohol and Drug Abuse Services
    - Regulatory Health Programs
  - **Key Budget Drivers in FY08-09:**
    - Community Mental Health and Substance Abuse Services
    - State Mental Health Hospital System
    - Public Health Services
      - Regulatory Mandates
      - Public Health Preparedness
      - State Laboratory
    - Prevention of Chronic Disease Services
    - Control of Infectious Diseases
    - Outdated Technology

HHS Overview

- **Department of Family and Protective Services (DFPS)**
  - **Program Areas**:
    - Child Protective Services
    - Adult Protective Services
    - Child Care Regulatory Services
    - Prevention and Early Intervention Services
  - **Key Budget Drivers in FY08-09:**
    - Foster Care Caseloads and Rates
    - Adoption Subsidy Caseloads
    - Child Protective Services Reform

HHS Overview

- **Department of Assistive and Rehabilitative Services (DARS)**
  - **Program Areas:**
    - Vocational Rehabilitation Services
    - Blind Services
    - Early Childhood Intervention Services
    - Disability Determination Services
  - **Key Budget Drivers in FY08-09:**
    - Vocational Rehabilitation Services
    - Early Childhood Intervention Services
    - Disability Determination Services

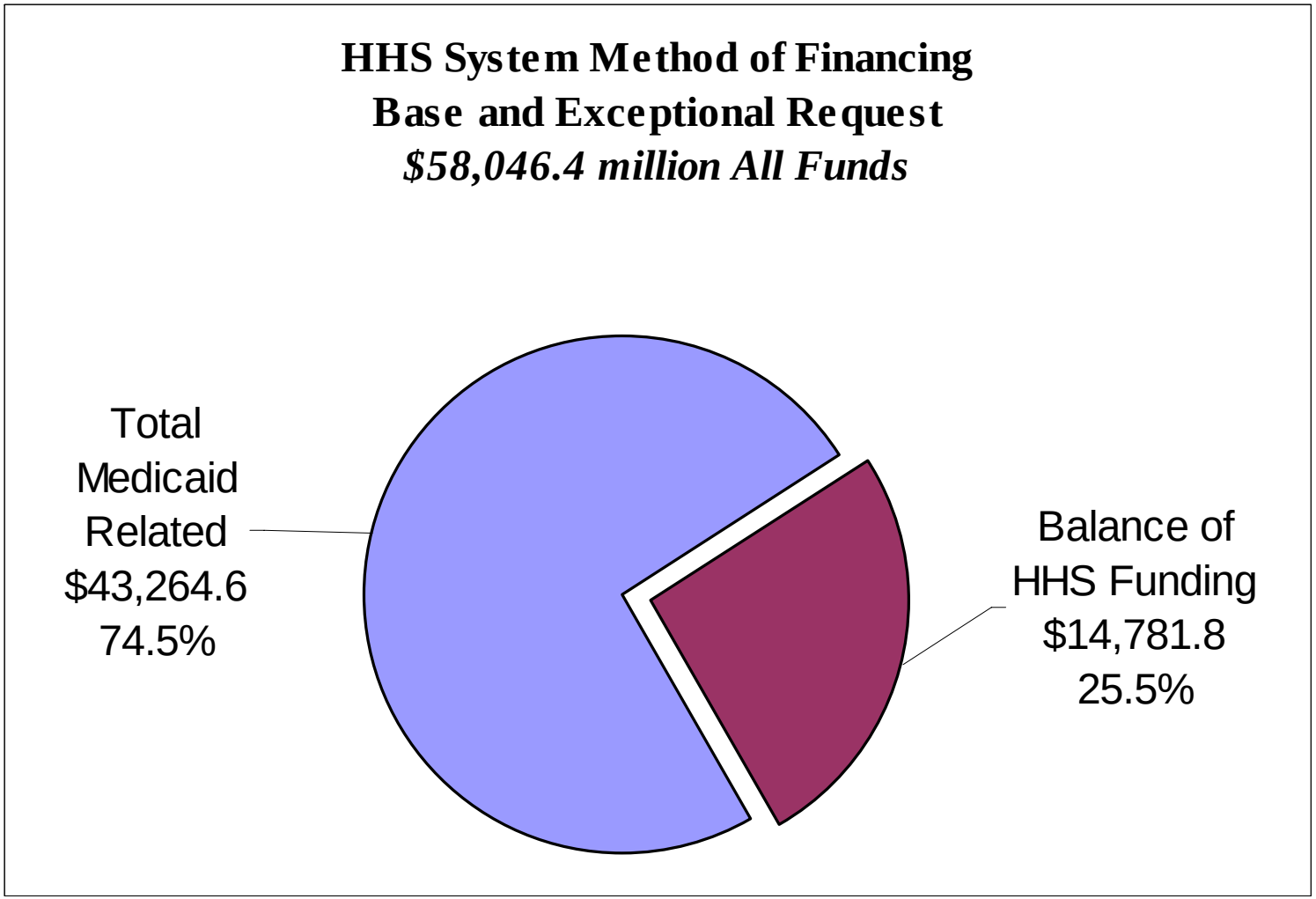
HHS Overview

Health and Human Services Commission (HHSC)

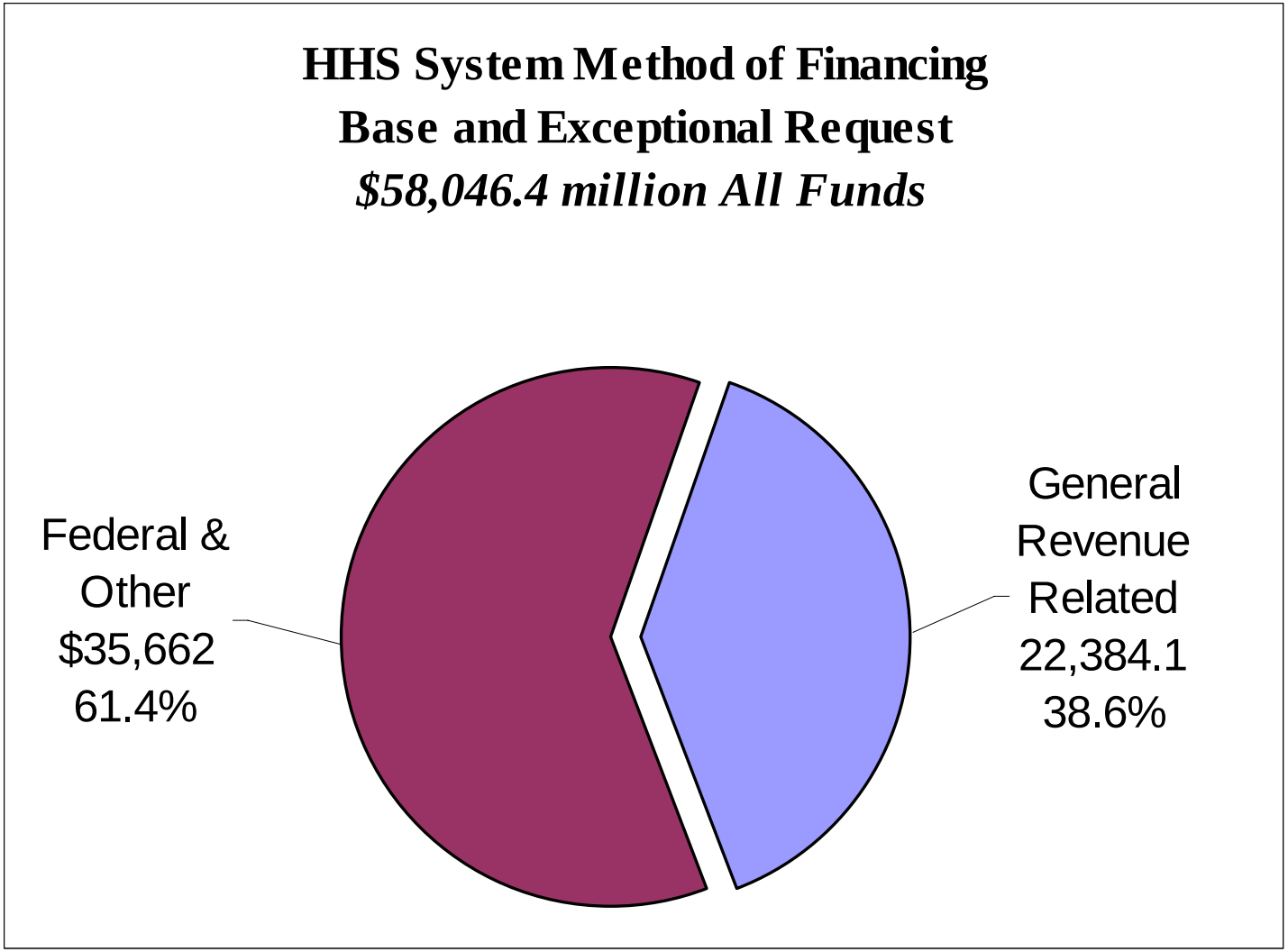
- **Program Areas:**
  - Texas Medicaid Program
  - Children's Health Insurance Program (CHIP)
  - Temporary Assistance for Needy Families (TANF)
  - Food Stamps and Nutritional Programs
  - Family Violence Program
  - Immigration and Refugee Affairs
- **Support functions consolidated at HHSC:**
  - Human Resources
  - Procurement/Contracting for Administrative Services
  - Planning and Evaluation
  - HHS Rate Setting
  - Office of Inspector General
  - Strategic Planning
  - Civil Rights
  - Leasing and Facilities Management
- **Partially consolidated functions:**
  - Financial Services
  - Legal Services
  - Information Technology
  - Ombudsman

- **Key Budget Drivers in FY 08-09:**
  - Medicaid Caseloads and Costs/Provider Rates
  - Children's Health Insurance Caseloads and Costs/Provider Rates
  - Temporary Assistance to Needy Families Caseloads

HHS System Method of Finance



HHS System Method of Finance



TEXAS
Health and Human
Services System

Presentation to the House Appropriations Committee

Albert Hawkins, Executive Commissioner

Chris Traylor, Associate Commissioner for Medicaid/CHIP Division

February 1, 2007

Texas Medicaid Program Overview

Medicaid Program Overview

- 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.

Medicaid Eligibility

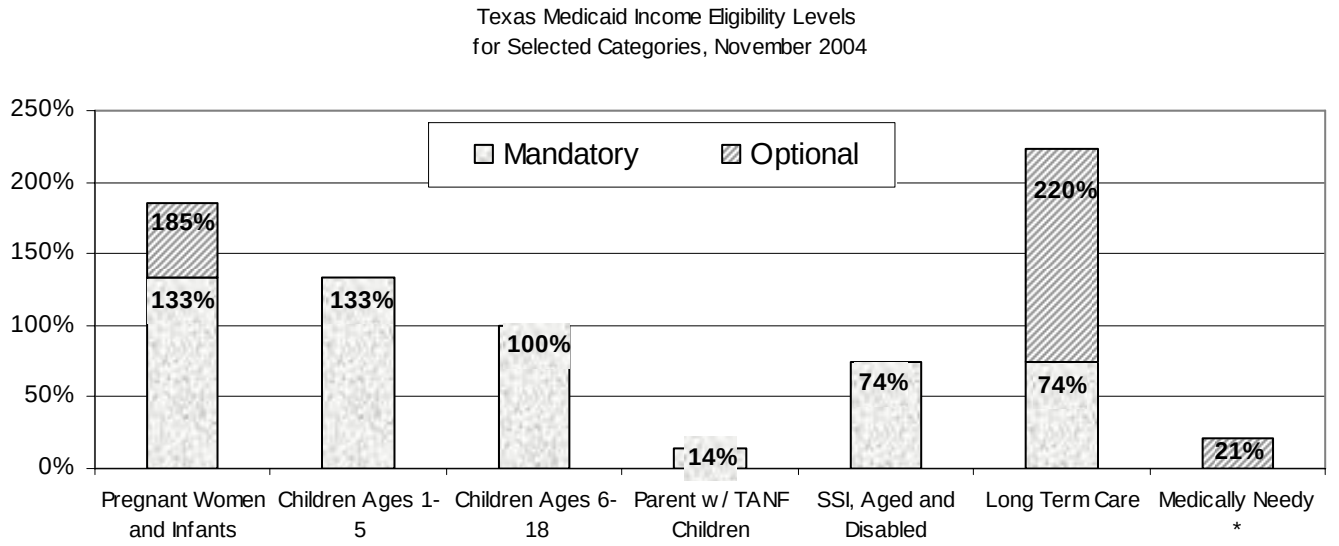
- Medicaid serves:
  - Low-income families
  - Children
  - Pregnant women
  - Elderly
  - People with disabilities
- Texas Medicaid does not serve:
  - Non-disabled, childless adults

Medicaid Eligibility

- Medicaid eligibility is financial and categorical:
  - Low income alone does not constitute eligibility for Medicaid
- Eligibility factors include:
  - Family income;
  - Age; and
  - Other factors such as being pregnant or disabled or receiving TANF.

Texas Medicaid Percent of Poverty Income Levels

- 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.

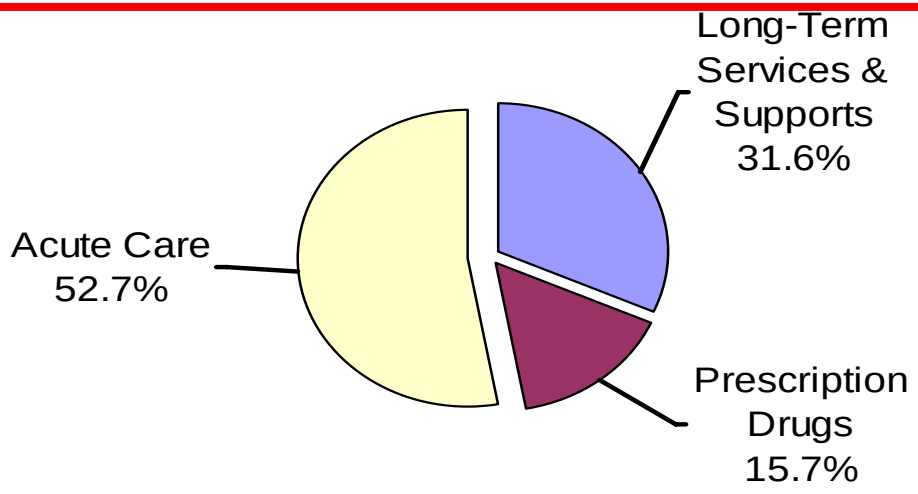


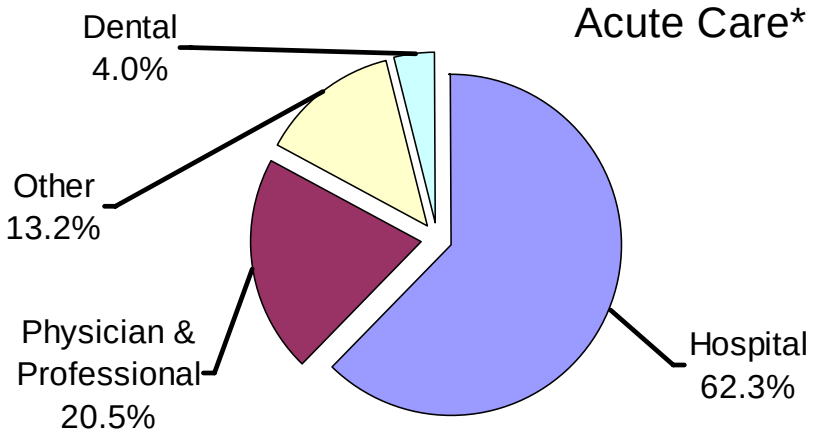
In SFY 2005, for TANF parents with children, eligibility is determined based on an adjusted gross income no higher than $188 a month for a family of 3, which translates into 14% of poverty. For medically needy pregnant women and children, the maximum monthly adjusted gross income limit is $275. **Medically Needy is defined as a pregnant woman, or child whose family income exceeds the program income limits. The family must deplete their excess income with unpaid medical bills.

Acute and Long Term Services and Supports

- The acute care program:
  - refers to the provision of health care for episodic health care needs. This includes care provided by physicians, hospitals, labs and medical supplies.
- The long term services and supports program:
  - refers to services provided to persons who are elderly and those with a disability who need long term assistance and supports to remain as independent as possible. Many of the services provided assist persons with activities of daily living, such as eating, dressing and mobility.
- This presentation focuses on acute care Medicaid.

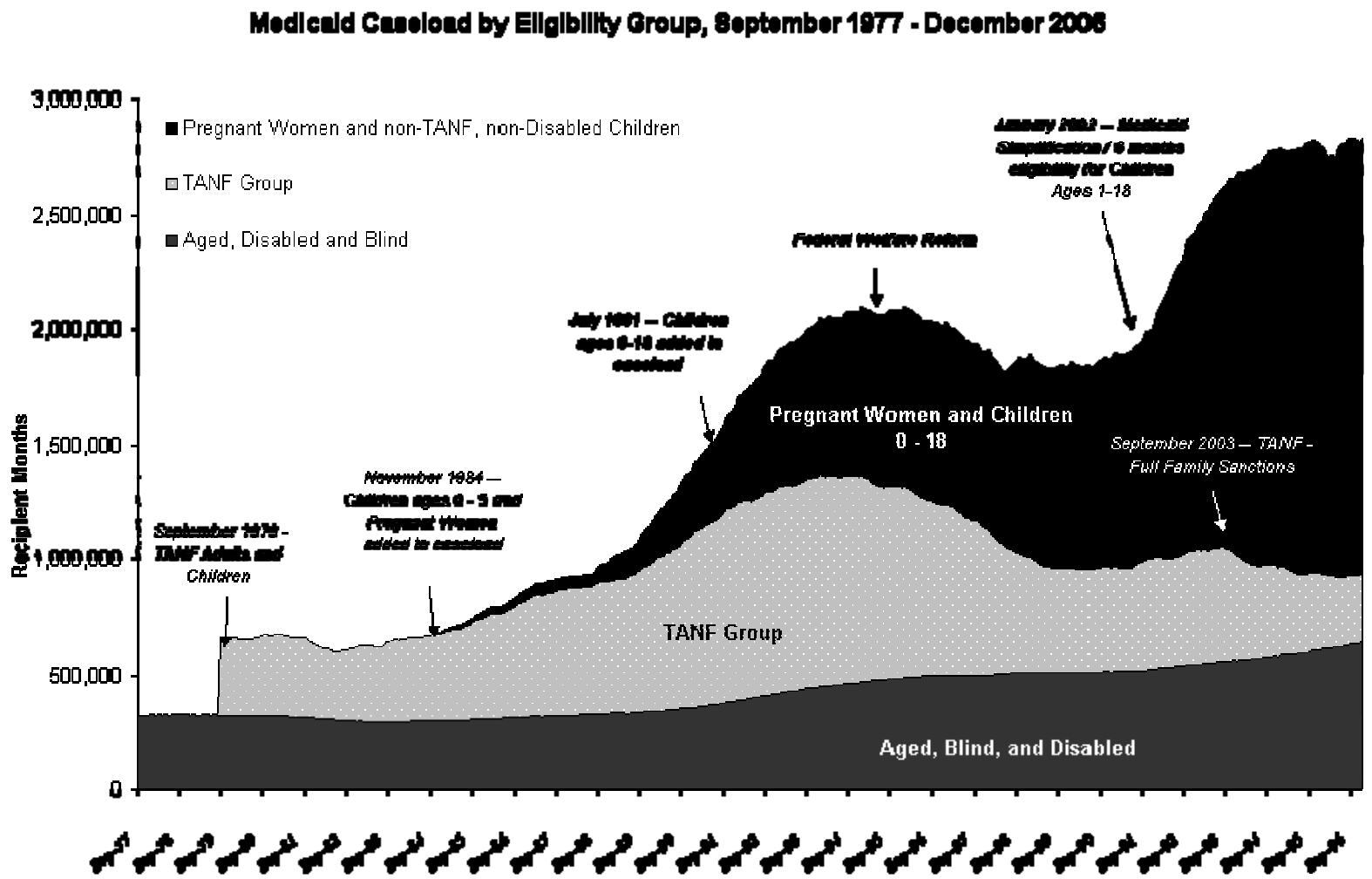
Texas Medicaid Spending by Major Function, FY 2005





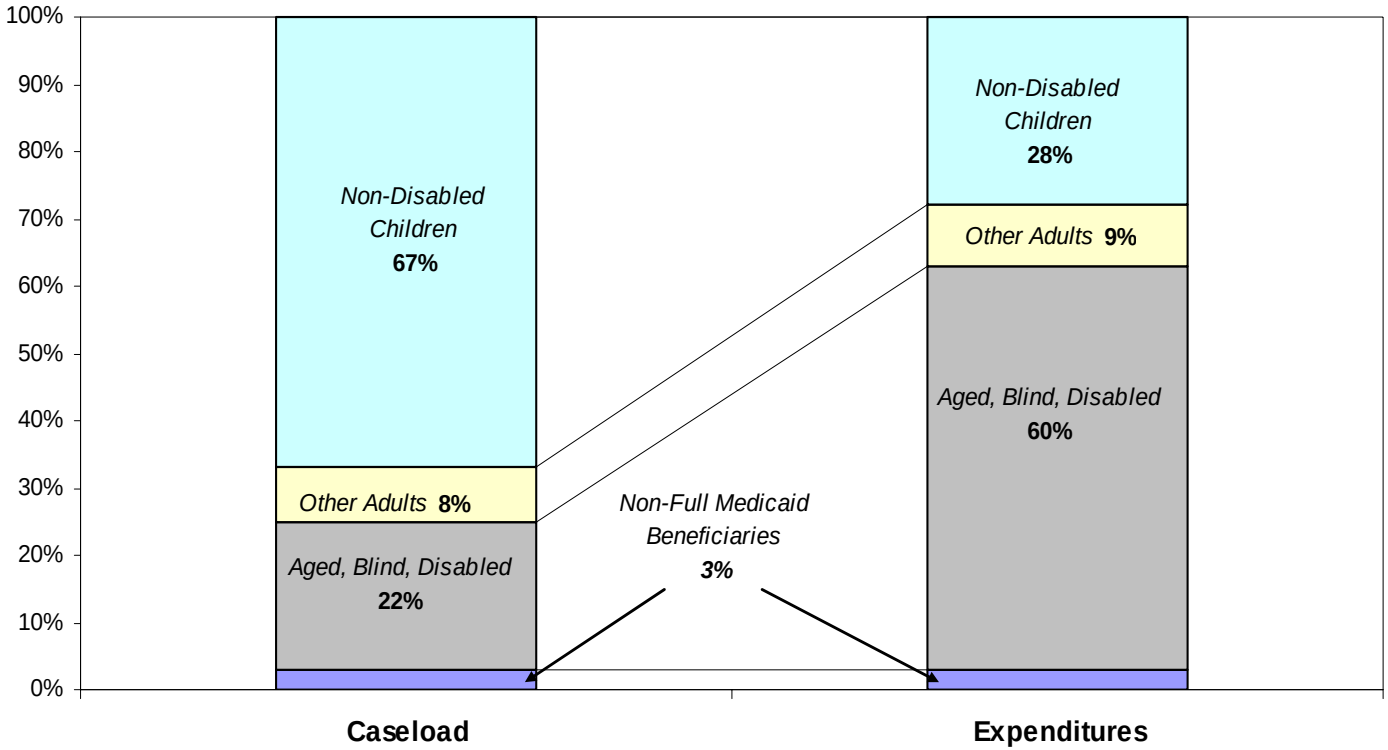
*Includes UPL and DSH payments to the hospitals totaling $903 million and $1,487 million, respectively.

Texas Medicaid Caseload by Eligibility Group



Medicaid Beneficiaries and Expenditures - FY 2006

In 2006, 2,792,566 people received full Medicaid benefits on average each month.



Source: Estimated 2006 Medicaid Expenditures, CMS/ PPS Systems Notes: Aged, Blind, and Disabled includes clients under 21; Total Expenditures includes all Acute and Long-Term Care expenditures, including Vendor Drugs and Case Management. Expenditures and caseload for non-full Medicaid beneficiaries are not included.

Program Administration

Medicaid State Plan:

- 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; and
  - Other program requirements.
- State Plan Amendment (SPA):
  - Required to change existing optional coverages or other components of the program.
  - Must be submitted to CMS for approval.
  - Must be approved by CMS to ensure the federal matching funds will be provided to the program.

Program Administration

Waivers:

- 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; and
  - Test new service delivery and management models.

Program Administration

Waivers (continued):

- 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

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

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 Persons with Mental Retardation (ICF-MR)
  - Institutions for Mental Disease (IMD) for children
  - Medically necessary surgery and dentistry (not routine dentistry)
  - Personal care services in the home
  - Physical therapy
  - Some rehabilitation services
  - Certified Registered Nurse Anesthesiologists
  - Eyeglasses/contact lenses
  - Hearing aids
  - Services provided by podiatrists
  - Mental health services

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
    - STAR+PLUS – Acute & Long-Term Services and Support HMO
    - PCCM - Managed care model that provides a medical home for Medicaid clients through primary care providers
    - NorthSTAR – Behavioral Health Care HMO
    - ICM – Dallas and Tarrant Pilot planned for implementation July 1, 2007
  - An estimated 65.9% (HMO+PCCM) of the Texas Medicaid population was enrolled in managed care in Fiscal Year 2006 compared to 40% in 2003.

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Medicaid Funding

- 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
    - 50% to 76% - range for all states in Federal Fiscal Year (FFY) 2007
  - 60.78% - Texas FMAP for FFY 2007:
    - Of each dollar spent on Medicaid services in Texas, the federal government pays 60 cents
  - Small decreases in the FMAP could result in significant loss of federal funds.

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 2006 $1.553 Billion
  - State DSH Hospitals: $453 Million
  - Non-state DSH Hospitals: $1.1 Billion

Disproportionate Share Hospitals (DSH)

- State-Operated Hospitals
  - GR transferred for match and DSH federal reimbursements deposited to GR
- Non-State DSH Financing – Intergovernmental Transfers
  - Nine large public hospitals provide funds to the state – as an "intergovernmental transfer." These funds constitute the state portion of DSH funds, and the federal government contributes its share based on the FMAP.
  - For SFY 2006
    - $432.5 million - intergovernmental transfers
    - $667.5 million - federal matching funds
    - $1,100.0 million - total distributed to non-state DSH hospitals
  - SFY 2006 distribution to nine contributing hospitals
    - $647.0 million ($254.4 million in intergovernmental transfers, and $392.6 million federal matching funds)

Disproportionate Share Hospitals (DSH)

- Non-State Hospitals Receiving DSH Payments:
  - In SFY 2006, the state identified and reimbursed 168 non-state hospitals from the Medicaid DSH fund.
  - 9 large urban public hospitals
  - 7 children's hospitals in urban areas
  - 67 other urban hospitals
  - 85 rural hospitals

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; 100 non-state owned rural public hospitals; 7 children's hospitals; 11 State University physician group practices; and an unknown number of privately-owned hospitals in the new Private Hospital UPL program.
- Proposed changes at the federal level may put continued UPL funding at risk.

Medicaid Program Funding

Factors affecting program expenditures are:

- Caseload – How many people are eligible for Medicaid?
- Utilization -- How many and what kinds of services are Medicaid clients using?
- Cost – what is the cost of providing the services?

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Albert Hawkins, Executive Commissioner

Maureen Milligan, Deputy Chief of Staff

February 1, 2007

Medicaid Reform

Medicaid Reform in Texas: Where We've Been

- Since 2003, significant changes have been incorporated into the Texas Medicaid Program. These changes have focused on:
  - Containing Costs
  - Managing Care
  - Improving Health Outcomes

Texas Medicaid: Recent Initiatives

- Increases in Managed Care:
  - In 2008, an estimated 72% of the Texas Medicaid population is projected to be enrolled in managed care, compared to 40% in 2003
  - Primary Care Case Management (PCCM) expanded to rural areas serve a total of 202 counties
- Preferred Drug List (PDL):
  - HHSC implemented a PDL for Medicaid in February 2004, whereby pharmaceutical companies are required to offer a supplemental rebate or a program benefit proposal to be considered for the PDL
  - Currently more than 55 drug classes represent approximately 70% of Texas' Medicaid pharmacy expenditures
  - Since inception, PDL has reached a savings of $488 million (All Funds)
- Disease Management (DM):
  - Implemented in November 1, 2004, for FFS clients with specifically targeted chronic illnesses (chronic pulmonary disease, congestive heart failure, coronary artery disease, diabetes, and asthma)
  - DM expanded to PCCM client population on September 1, 2005

Texas Medicaid: Recent Initiatives

- Employer Based Coverage:
  - CHIP Premium Assistance – authorized by 78th Legislature
  - Waiver submitted to CMS in December 2004; Pending CMS approval
- Three-Share Waiver:
  - Authorized by 78th Legislature
  - Expands employer-based group health insurance coverage in Galveston County
  - Waiver submitted to CMS in December 2005; Pending CMS approval
- Women's Health Program:
  - Authorized by 79th Legislature
  - Provides limited family planning services to women age 18-44 at or below 185% FPL
  - Implementation as of January 2007
- Managed Care Initiatives, in progress:
  - STAR+PLUS Expansion
  - Integrated Care Management Model (Dallas and Tarrant SAs)
  - Foster Care Model

Medicaid Reform

Objectives:

- To make health insurance accessible to more Texans and reduce the level of uninsured in the State.
- To shift utilization of health care services to the most cost effective service point.

Medicaid Reform

- Centers for Medicare and Medicaid (CMS) priorities for state reforms:
  - Address perceived IGT and provider financing concerns
  - Reduce Uninsured
  - Cover individuals with insurance-based payments
  - Build on private market approach
  - Strengthen employer-sponsored insurance
  - Contain costs and trends

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Medicaid Reform

- State Vehicles:
  - DRA provides a limited list of reform options with variable applicability to different states
  - Waivers allow states to waive some federal requirements; negotiated with the federal Medicaid administration (the Centers for Medicare and Medicaid Services – CMS)
- State Options include:
  - Reform within the Medicaid program such as program expansions, changes to Medicaid benefits or program requirements
  - Reform options that leverage Medicaid, such as leveraging Medicaid funds to provide insurance to non-Medicaid populations

Options Within Medicaid

- Cost Sharing: Premiums, Co-Payments, Deductibles
- Basic Benefit Package Options
- Employer Sponsored Insurance Incentives
  - Health Insurance Premium Payments program (State pays private premiums for employer-sponsored insurance—in lieu of Medicaid premiums, if cost-effective).
  - CHIP Premium Assistance Program
- Disabled Children Buy-In Option
- Health Opportunity Accounts (HOA)
- Expanded Medicaid Benefits
- Consumer Responsibility, Choice and Incentives
  - Consumer Directed Health Accounts or Enhanced Benefit Accounts (EBA)
- Variable Benefits

Leveraging Medicaid

- Protection of IGT federal funding through creation of Low Income Pools
  - California, Massachusetts, Florida all negotiated waivers to protect federal funds by creating low income pools to help cover the uninsured
- State subsidies for existing employer insurance – to make it more affordable
  - Utah provides $50/month for identified low-income individuals
- State funds to create affordable employer-based insurance. Three-share programs: covers employees otherwise uninsured with premium contributions from: employer, employee, public funds
  - UTMB Three-Share Waiver now with CMS (no new state GR)
    - One-third premium funding each from employers, employees, and UTMB/Federal funds
    - Benefit package created by the community based on coverage and perceived needs/value
  - Maine– Employer/Employee and State/Federal funds
  - Tennessee– Employer/Employee and State/Federal funds

Leveraging Medicaid

- Massachusetts' Connector
  - Quasi-public entity created to provide advantages such as:
    - Broader access to benefits of employer-sponsored health insurance, such as:
      - Paying with pre-tax dollars
      - Ability to pool funds from multiple part time jobs, or husband & wife benefits
    - Reduces employer administrative burden for finding and negotiating coverage by offering a group of approved plans from which employees can choose
    - Supports portability – if employees change jobs, they can still keep their Connector health insurance plans
    - A pool for sliding scale state subsidies for individuals with incomes under 300% FPL
    - Mandates health insurance

Texas Medicaid: Recent Reports

- Uncompensated Care (Rider 61):
  - Analysis of Uncompensated Care Reporting components and assumptions and recommendations for standardizing reporting and calculations
- Hospital Reimbursement (Rider 60):
  - Study and make recommendations for changes in hospital reimbursement rate methodology, including waivers to combine Disproportionate Share Hospitals (DSH), Graduate Medical Education (GME) and Upper Payment Level (UPL) fund
  - Alternatives should be considered to reward efficient providers; incentives for hospitals to serve Medicaid clients and control medical costs should also be considered
  - Potential waiver considerations include creation of a Low Income Pool for uncompensated care provided in a healthcare network

Medicaid Reform

- HHSC has initiated a Medicaid Reform Project Team collecting, analyzing and assessing reform initiatives and potential applicability to Texas.
- Research topics have been identified from national and state sources, which include options made possible under the Deficit Reduction Act of 2005 (DRA), and through federal waiver negotiations and agreements.
- Medicaid Reform Research Papers are available online through the HHSC website at the following link: **http://www.hhs.state.tx.us/medicaid/reform.shtml**