TEXAS
Health and Human
Services Commission

House Appropriations Committee Subcommittee on Health and Human Services

Medicaid Cost-Containment Opportunities

October 9, 2006

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Since 2003, significant changes have been incorporated into the Texas Medicaid Program. The changes have focused on:

- **Managing Care**
- **Containing Costs**
- **Improving Health Outcomes**

Changes in Managed Care

Managed Care in Texas Medicaid has seen significant growth and change over the last few years. In FY 2003, 39.7 percent of the Texas Medicaid population was enrolled in a managed Care program. That number has risen to 66.3 percent in FY 2006 and is projected to rise to approximately 72 percent by FY 2008.

- **HMO networks in place in all urban SDAs- most recently Nueces**
- **Primary Care Case Management (PCCM) expanded to rural areas serve a total of 202 counties**
- **New HMO contracts include strong performance requirements and expanded sanctions and remedies for poor performance**

Changes in Managed Care

STAR+PLUS

- In January 2007, STAR+PLUS will expand to Harris contiguous, Nueces, Bexar and Travis service areas
- STAR+PLUS HMOs will provide both acute care and long-term services and supports to approximately 140,000 SSI members (includes the 60,000 currently enrolled in Harris County)
- Inpatient hospital services are carved out to preserve hospital UPL payments

Changes in Managed Care

Integrated Care Management (ICM)

- Authorized by Senate Bill 1188 and House Bill 1771, 79th Legislature, Regular Session 2005 & Senate Bill 1, 79th Legislature, Regular Session 2005, Article II, HHSC, Special Provisions Sec. 49

- A non-capitated managed care model that includes integrated acute and long-term care services and supports to Aged, Blind and Disabled clients in the Dallas and Tarrant service areas; expected to serve app. 70,000 enrollees

- Final Request for Proposals was released August 14; responses are due October 6; Contract execution targeted for mid-January, 2007; Implementation planned for July 1, 2007

- Federal waivers will be required

Preferred Drug List (PDL)

HHSC implemented a PDL for Medicaid in February 2004. Pharmaceutical companies are required to offer a supplemental rebate or a program benefit proposal to be considered for the PDL.

- **The PDL now covers 55 drug classes that represent approximately 70 percent of the Medicaid pharmacy expenditures**
- **The PDL controls spending growth by shifting use to preferred drugs**
- **Non-preferred drugs require prior authorization but are still available through the Medicaid program**
- **Since its inception, the PDL has reached a savings of approximately $488 million All Funds**

Disease Management (DM)

Statewide Texas Medicaid Enhanced Care Program (DM) began on November 1, 2004 with a contracted Disease Management Organization (DMO).

- **Program developed for Fee-for-Service (FFS) clients with specific targeted chronic illnesses (Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease, Diabetes, and Asthma)**
- **DM program expanded to include the Primary Care Case Management (PCCM) client population on September 1, 2005**
- **The DMO is at risk for reducing overall expenditures and meeting specific quality variable metrics**

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UPL State Plan Amendments (SPAs)

Upper Payment Limit – Active Programs

State-Owned Hospital UPL

- **Supplemental payments are made to the General Revenue Fund for inpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas. This UPL program became effective on December 13, 2003**
  - **SFY 2006 $65,200,000 All Funds; $39,200,000 Federal Funds**
  - **SFY 2007 $65,200,000 All Funds; $39,200,000 Federal Funds**

Large Urban Public Hospitals

- **Supplemental payments are made for inpatient and outpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, Potter, and Randall counties. This UPL program makes supplemental payments to 11 of the largest public hospitals in Texas. This UPL program became effective on July 6, 2001**
  - **SFY 2006 $659,398,464 All Funds; $399,991,108 Federal Funds**
  - **SFY 2007 $659,398,464 All Funds; $400,782,387 Federal Funds**

Upper Payment Limit – Active Programs

Rural Hospital UPL

- Supplemental payments are made for inpatient hospital services provided by approximately 118 rural hospitals that are either publicly owned or affiliated with a local governmental entity. For purposes of this program, "rural hospital" means a hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census. This UPL program became effective on January 1, 2002
  - SFY 2006 $75,090,336 All Funds; $45,549,798 Federal Funds
  - SFY 2007 $75,090,336 All Funds; $45,639,906 Federal Funds

Urban Non-Public Hospitals (High-Volume Payments to Private Hospitals)

- High-volume payments not exceeding $26,400,000 would be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties. This became effective on September 1, 2005. The state share for this UPL program would come from General Revenue instead of IGT's. However, this program was not funded by the Legislature for the 2006-07 biennium. Funds were requested for the 2008-09 biennium
  - SFY 2006 $0 All Funds; $0 Federal Funds
  - SFY 2007 $0 All Funds; $0 Federal Funds

Upper Payment Limit – Active Programs

Regional UPL for Private Hospitals (NEW)

- **UPL program that was created as a result of the recently approved SPA TX-05-001. It is the private hospital UPL for just Bexar, Montgomery, Webb, Hidalgo, Potter, Maverick, Travis, Randall and Midland counties. This SPA became effective retroactive to June 10, 2005**
  - **SFY 2006 $251,691,309 All Funds; $152,783,497 Federal Funds**
  - **SFY 2007 $200,353,741 All Funds; $121,534,580 Federal Funds**

Statewide UPL for Private Hospitals (SPA TX-05-011) (NEW)

- **This would create a statewide UPL program for privately owned hospitals with an indigent care affiliation agreement with a hospital district or other local governmental entity. This SPA became effective retroactive to November 12, 2005**
  - **SFY 2006 $292,825,602 All Funds; $177,628,010 Federal Funds**
  - **SFY 2007 $369,831,643 All Funds; $224,339,875 Federal Funds**

UPL-Related State Plan Amendments Currently Pending with CMS

State Hospital Physician UPL (SPA TX-04-010)

- **Creates a physician UPL for practitioners employed by state academic health systems, specifically hospitals that are part of the systems of the University of Texas, Texas Tech University, and the University of North Texas. This SPA has an effective date of May 11, 2004**
  - **SFY 2007 $382,063,712 All Funds; $231,923,879 Federal Funds**
  - **SFY 2008 $111,878,908 All Funds; $68,000,000 Federal Funds**

Tarrant County Physician UPL (SPA TX-04-029)

- **Creates a physician UPL for practitioners employed by Tarrant County. This SPA has an effective date of November 26, 2004**
  - **SFY 2007 $11,074,243 All Funds; $6,668,909 Federal Funds**
  - **SFY 2008 $6,040,496 All Funds; $3,665,977 Federal Funds**

Children's Hospital UPL (SPA TX-06-021)

- **Results in UPL payments to certain in-state children's hospitals for the 2006-07 biennium. State share for this UPL program is GR. The legislature would have to extend these appropriations for this to continue next biennium. This SPA is set to have an effective date of September 1, 2006**
  - **SFY 2007 $63,742,988 All Funds; $38,742,988 Federal Funds**

Totals shown for FY 2007 include retroactive amounts

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Deficit Reduction Act (DRA)

- DRA Mandatory Provisions
- Options Under the DRA

DRA Mandatory Provisions

Citizenship Verification

Effective July 1, 2006, applicants for Medicaid must provide documentary evidence to establish both citizenship and identity – previous policy allowed self-declaration.

- **Acceptable verification is prescribed in the law and through Centers for Medicare and Medicaid Services (CMS) guidance**
- **Current recipients are allowed until their next review to provide proof**
- **New requirement is delaying eligibility determination, and increasing workload**

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DRA Mandatory Provisions

Third Party Recovery

The DRA improves states' ability to recover third party payments by:

- **Expanding the definition of health insurer to include self-insured plans, managed care organizations, pharmacy benefit manager or other parties that are responsible for paying claims for health care**

- **Stipulates that state laws must require health insurers to:**
  - **Provide States with eligibility and coverage information;**
  - **Honor the States assignment of rights**
  - **Not deny claims based on procedural reasons (e.g. timely filing, failure to present card at point of sale, claim format, etc.)**
  - **Allow 3-years for a state to file a claim**
  - **Allow 6-years from the date a claim was submitted to address procedural issues before a claim is denied**

DRA Mandatory Provisions

LTC Asset Eligibility Changes

- **Transfers made on or after 2/8/2006 have a 60 month look-back period, instead of 36 months**

- **If asset transfers are made before eligibility for Medicaid, new DRA requirements begin the penalty period (for transfers made on or after 2/8/2006) at the time of eligibility for Medicaid- current policy begins asset transfer penalties on the 1st day of the month the transfer was made**

DRA Mandatory Provisions

LTC Asset Eligibility Changes, continued

- **Current Texas Medicaid Eligibility requirements for long term care exempt individuals' home equity from consideration**
- **The DRA limits home equity to $500,000**
  - **Does not apply if spouse or children reside in home**
  - **Amounts increase starting in 2011 based on CPI**
  - **Effective January 1, 2006**
- **The DRA provides a state option to increase the home equity criterion to $750,000**
- **Agency rule for Texas Medicaid LTC eligibility maintains the DRA limit of $500,000**

Options Under the DRA

Cost Sharing: Premiums, Co-payments, Deductibles

- The DRA makes costsharing enforceable-- If premiums required and not paid, eligibility can be denied; If costsharing not paid, providers can deny service
- Limited to annual cap of 5% of family income

Premiums: For non-exempt adults over 18 and individuals with income over 150% FPL, including optional children under age 1

- Exemptions include: pregnant women; children in mandatory coverage groups and foster care; clients in institutional care
- In Texas, only a small number of Medicaid clients could be required to pay premiums (under 5000 clients)

Options Under the DRA

Cost Sharing: Premiums, Co-payments, Deductibles

Co-payments and Deductibles can be required for those: over 100% FPL; aged 18 or older; and children in non-mandatory groups

- **Cannot be required for pregnant women when service affects pregnancy; foster or adopted care coverage children; those in institutions; family planning services**
- **No co-pays or deductibles for any preventive services for any client**
- **Can require cost-sharing for non-emergent use of E.R. only if actual access is available for care at alternative setting and if other conditions met**
- **In Texas, cost-sharing largely limited to a small group of non-mandatory children up to 5 years old**

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Options Under the DRA

Basic Benefits Packages

- The DRA allows states to use a basic or benchmark benefit (like the SCHIP benefit) for a limited group of Medicaid enrollees
- Exempted populations include individuals who are: pregnant, blind or disabled, dual eligibles, in institutions; medically frail or have special needs; receiving long-term care services; and TANF eligibles
- Children under 19 can be provided a basic benefit package, but only if they are also provided additional medically necessary services meeting EPSDT requirements
- The basic benefit package can not be used for a Medicaid expansion; it is only for those groups eligible at the time the DRA become law
- In Texas, a small group of Medicaid eligibles could be provided the basic benefit package: foster children with incomes between 200 – 400% FPL and pregnant women with incomes between 133% FPL and 185% FPL. Texas could provide a basic benefit to children IF it has provisions to provide EPDST services to those children needing them.

Options Under the DRA

Disabled Children Buy-In Option

- DRA allows states to expand Medicaid to children up to 300% FPL who meet SSI disability criteria; would require SPA
  - Current SSI eligibility is about 74% FPL
- Coverage phases in by age groups starting 2007
  - Up to age 6 in January 2007
  - Up to age 12 in 2008
  - Up to age 18 in 2009
- If families have coverage under group health plans, parents must apply for, enroll in and pay premiums for that coverage if the employer pays at least 50% of premiums and coverage is effective at reducing Medicaid
- States can choose to implement sliding scale premiums

Options Under the DRA

Disabled Children Buy-In Option, continued

State Decision whether to pursue this optional coverage.

If Yes:

- **Income level of families (up to 300% FPL)**
- **Whether to impose premiums**
- **Whether to use sliding premium scale**

Would require:

- **additional state match**
- **systems and eligibility processing changes**
- **a Medicaid state plan amendment**

Children included would have access to all EPSDT services

Options Under the DRA

Long-Term Care (LTC) Partnerships

- The DRA allows states to implement Partnership programs through State Plan Amendments to:
  - Support purchase of private LTC insurance
  - Allow individuals who purchase LTC insurance to protect some of their assets and still qualify for Medicaid
  - Help shift LTC funding from public to private sector: Medicaid changes to payor of last resort instead of payor of first resort
- Goal: to delay, shorten or avoid use of Medicaid to pay for LTC for those who, without the Partnership insurance, would seek Medicaid
- Thought to provide an incentive for those who would have used Medicaid, to buy insurance
- Four states have programs that started in 1992 and 1993 and claim Medicaid savings: New York, California, Indiana, Connecticut

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Options Under the DRA

Money Follows the Person (MFP) Grant

- **The federal Deficit Reduction Act (DRA) includes an opportunity to expand MFP initiatives**
  - **Under the DRA – MFP grant, any Medicaid-eligible individual who has resided in a nursing facility, hospital, or ICF/MR for a specified period of time depending on state policy (at least 6 months up to 2 years) would be eligible for MFP**
  - **CMS would pay an enhanced rate for 12 months for qualifying individuals who choose to receive services in the community**
  - **For Texas, the enhanced rate would result in an increase in the federal match from 60 percent to 80 percent of eligible client costs for one year**
- **DADS will work with HHSC to submit a grant application in order to provide more services in community settings at an increased Medicaid match**

Options Under the DRA

Home & Community Based Services (HCBS) for Mental Health

- Effective 1/1/07, States may provide certain HCBS under their State Plans to Medicaid clients who are under 150% poverty
- Criteria for receiving the HCBS services must be less strict than for receiving institutional care
- States:
  - can limit the number of individuals served and limit the services geographically
  - are not required to demonstrate cost effectiveness in relation to institutional care
  - may allow consumer-directed care
- DADS anticipates maintaining current waiver programs without moving to a SPA; DSHS assessing SPA as a possibility for serving MI populations

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Options under the DRA

Health Opportunity Accounts (HOA)

- **CMS will allow up to 10 states to pilot HOA demonstrations starting in 2007. Populations include:**
  - **Non-disabled adults and children; limited number of MCO enrollees (no more than 5% of an HMO's total)**
- **Accounts funded with:**
  - **Adults—$2,500**
  - **Children—$1,000**
- **Clients use HOA funds:**
  - **To pay for medical services**
  - **To pay for applicable deductibles and co-pays**
  - **To rollover to following year**
  - **To pay for private insurance or approved self-advancement expenditures**
- **Traditional Medicaid is payor of last resort**

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Key Waiver Provisions in Other States

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Waiver Options

Waivers continue to provide states with broader authority to pursue reform and program changes not allowed, even under the DRA.

Several states have developed waivers to achieve differing state objectives with some common reform elements, including:

- **Restructuring of Hospital Funding**
- **IGT, DSH and UPL Funding Changes and Low Income Pools to preserve federal share of IGTs**
- **Expanded Coverage of Uninsured**
- **Expanded Use of Managed Care**
- **Tailored Benefit Plans**
- **Consumer Directed Care; Increased Consumer Responsibility; Healthy Rewards**

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Hospital Funding

Hospital-based healthcare is a major component in the Medicaid provider network. Efforts at Medicaid reform must envision the role hospitals will play in a future Medicaid healthcare system.

- **Hospital expenditures are conservatively estimated to be approximately 63 percent of acute care Medicaid costs in 2005**
- **Approximately $2.5 billion of 2005 Medicaid hospital funding is through DSH and UPL supplemental payments which are not subject to the direct legislative appropriations process**
  - **The burden of state match is on local communities through the IGT mechanism**
  - **The local funding burden is magnified by local communities indigent care funding through such funding streams as tax appropriations, (e.g., hospital districts), and County Indigent Care Program (e.g., for counties without public hospitals)**

Impact of Hospital Funding Streams on Medicaid Reform

Hospitals have 3 major and interrelated Medicaid funding streams:

1) Standard Dollar Amount (SDA)
2) Disproportionate Share Hospitals (DSH), and
3) Upper Payment Limit (UPL)

SDAs reimburse hospital claims for services to Medicaid patients. However, current SDA reimbursement rates are less than many hospitals' Medicaid allowable costs. The difference between allowable cost and reimbursement is the hospital Medicaid Shortfall.

The existence of a hospital Medicaid Shortfall is important because:

- Its presence means that DSH payments to hospitals go first to make up the Shortfall, and in doing so, reduces the funds available to the hospital to pay for uncompensated care costs (DSH funding was initially envisioned as a supplemental payment to offset a hospital's uncompensated care costs).
- The state match for DSH comes from a small number of local communities through the IGT mechanism. Thus, the presence of a Medicaid Shortfall represents the shifting of costs from the state (because the SDA payment does not cover the full amount of allowable costs) to local communities.

UPL supplemental payments are based on the difference between what Medicare would have paid and what Medicaid did pay for the same patient. These supplemental payments are used to reimburse uncompensated care.

Impact of Hospital Funding Streams on Medicaid Reform

- **Both DSH and UPL supplemental payments are intended to offset uncompensated care costs of hospitals. However, the approximately $2.5 billion in funding from these two sources reimburses for care provided at the most expensive access point in a provider network, and frequently at a point in the patient's illness when symptoms have grown most acute**

- **Because this supplemental funding is targeted to individual hospitals for reimbursement of uncompensated care, it is not available to provide a funding mechanism for patient care at less costly access points, e.g., primary care**

Texas Medicaid Hospital Funding

Medicaid Hospitals by Ownership/Classification FY2005 Funding (State & Federal)

Hospital Type	# of Hospitals	Medicaid Payments**	DSH Payments	# Hospitals Receiving DSH Pmts	UPL Payments	# Hospitals Receiving UPL Pmts	Total	% of Total Payments
State Owned	14	$165,675,634	$600,990,747	14	$65,264,559	4	$831,930,940	14.5%
Public	129	$701,829,752	$565,049,110	90	$764,277,099	41	$2,031,155,961	35.3%
Private Not for Profit	135	$1,577,600,087	$208,694,696	49	$49,488,019	47	$1,835,782,802	31.9%
Private for Profit	128	$914,805,235	$112,313,036	27	$24,442,578	23	$1,051,560,849	18.3%
Total	406	$3,359,910,708	$1,487,047,589	180	$903,472,255	115	$5,750,430,552	100.0%
State Share		$1,316,413,015	$582,625,245*		$353,980,430*		$2,253,018,690	

*Use of IGT

**Inpatient and Outpatient

Current Texas Hospital Studies

SB 1, 79th Legislature, Regular Session 2005, Article II, HHSC Riders 60 and 61 required HHSC to conduct studies on certain topics related to hospital financing and uncompensated care.

Rider 60- Medicaid Provider Reimbursement HHSC shall:

- **Study and recommend changes to the hospital reimbursement rate methodology, including waivers to combine GME, DSH and UPL**
- **Report with options and fiscal impact of recommendations due October 1, 2006**

Rider 61- Study Regarding Uncompensated Care HHSC shall:

- **Study the components and assumptions used to calculate uncompensated care in Texas hospitals**
- **Report with recommendations on standardizing hospitals' uncompensated care amounts due to the 80th Legislature**

Waiver Options with Hospital Funding

Several other states have implemented IGT, DSH and UPL Funding Changes and Low Income Pools to preserve federal share of IGTs

- California used its waiver to stabilize the public hospital systems that now must use Certified Public Expenditures
- Massachusetts creates Safety Net Care Pool with conversion of IGTs and MCO supplemental payments
- Florida maintains current UPL programs and creates Low Income Pool to replace some hospital funding

Expanded Coverage

Expanded Coverage Offered

- Massachusetts mandated health care for all citizens; extended coverage to all uninsured
- Iowa extended coverage to uninsured, childless adults, higher income pregnant woman and children with disabilities
- Oklahoma expanded to uninsured and childless adults
- California expanded coverage to uninsured

Expanded Use of Managed Care

- California implemented mandatory managed care enrollment for certain seniors and persons with disabilities and expanded program to additional counties
- Florida implemented PA requirements, a pharmacy benefits manager and more management of the provider network
- Kentucky implemented a pharmacy benefit manager and a DM program for chronic diseases, with cardiovascular, pulmonary, diabetes and obesity

Tailored Benefits Plan

Florida offering three levels of coverage/care:

- **Comprehensive**
- **Catastrophic and**
- **Enhanced**

Initially intended to create market competition and more flexibility in benefit packages; but limited by actuarial data

Waiver Options

Consumer Directed Care; Increased Consumer Responsibility; Healthy Rewards

- **West Virginia- <u>Health Rewards Accounts:</u> Credits can pay for items/services not covered in the State Plan; credits debited for certain behaviors or non-compliance with the member agreement**

Waiver Options

Consumer Directed Care; Increased Consumer Responsibility; Healthy Rewards

- **Kentucky- Get Healthy Accounts: provides incentives for clients with certain diseases who practice healthy behaviors; credited funds can pay for co-pays, alternative therapies, etc.**

- **Florida- Enhanced Benefit Accounts: credits upon completion of healthy activity; funds can pay for health related good and services**