TEXAS
Health and Human
Services Commission

Medicaid Reform Legislative Oversight Committee Meeting

Albert Hawkins, Executive Commissioner

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Reform Goals

Optimize investment in health care to achieve more efficient use of available funding and best health outcomes for Texans.

- Focus on primary and preventive care to keep Texans healthy
- Reduce the number of uninsured Texans
- Protect and optimize Medicaid funding
- Establish infrastructure to facilitate accomplishment of reform goals

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Status: Texas Proposal

Draft Concept Paper

- Submitted to Centers for Medicare and Medicaid Services (CMS) December 5th, 2007

- Initial CMS meeting January 10th
  - SB 10 and system transformation through improved investment strategy
  - Legislative and financial catalysts to protect safety net and begin transformation
    - SB 10 policy direction and $150 GR appropriations
  - Texas dynamics – e.g., uninsured, local investment in healthcare, fastest growing population

- Ongoing Waiver Development and Key Go Forward Work
  - Benefit Package and Cost Sharing
  - Financing
  - Budget neutrality

- Benefit Package Design for Health Opportunity Pool (HOP) Phase I
  - Focus on robust primary and preventive care
  - Alternatives can be developed with interactive modeling to show relationship of costs, number of people who could be covered, and services provided.
  - Preliminary alternatives for discussion include packages with varying amounts of inpatient hospital coverage

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Texas Health Opportunity Pool (HOP)

Introduction to Waiver Financial Structure

Current Medicaid Funded Indigent Care Focus

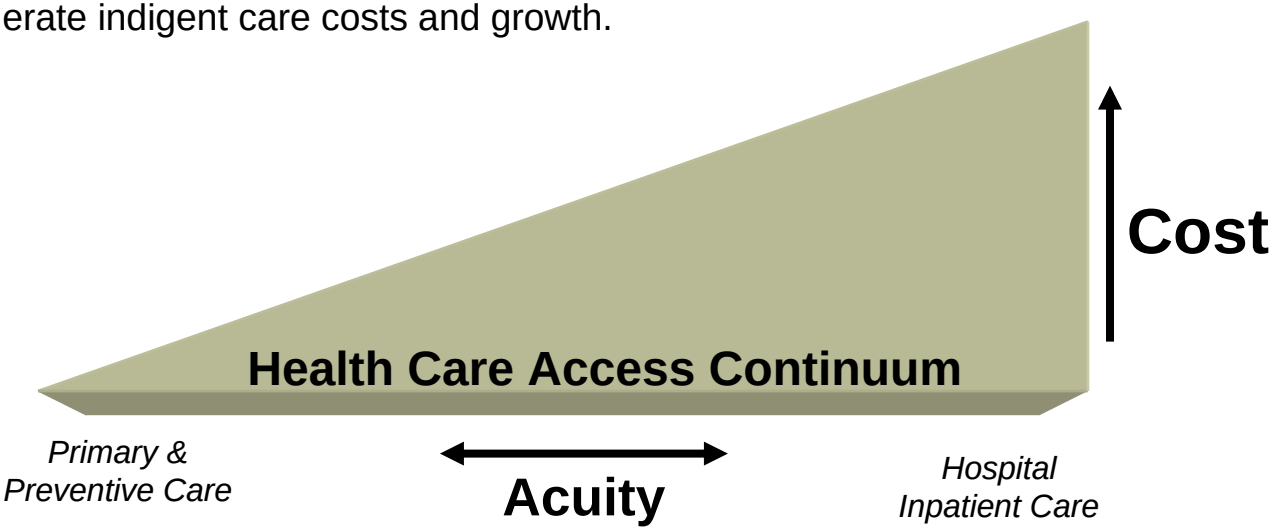
While DSH and UPL can help offset indigent care costs, reform needs to address the underlying dynamics creating these costs.

Medicaid funded indigent care focuses on hospitals and drives how uninsured Texans access healthcare.

Reimbursing hospital providers at the most expensive end of the care continuum does little to address root causes. Improving access to primary and preventive care will moderate indigent care costs and growth.

Current System Investment

The uninsured tend to forgo primary and preventive care until a high acuity, high cost catastrophic health event occurs.



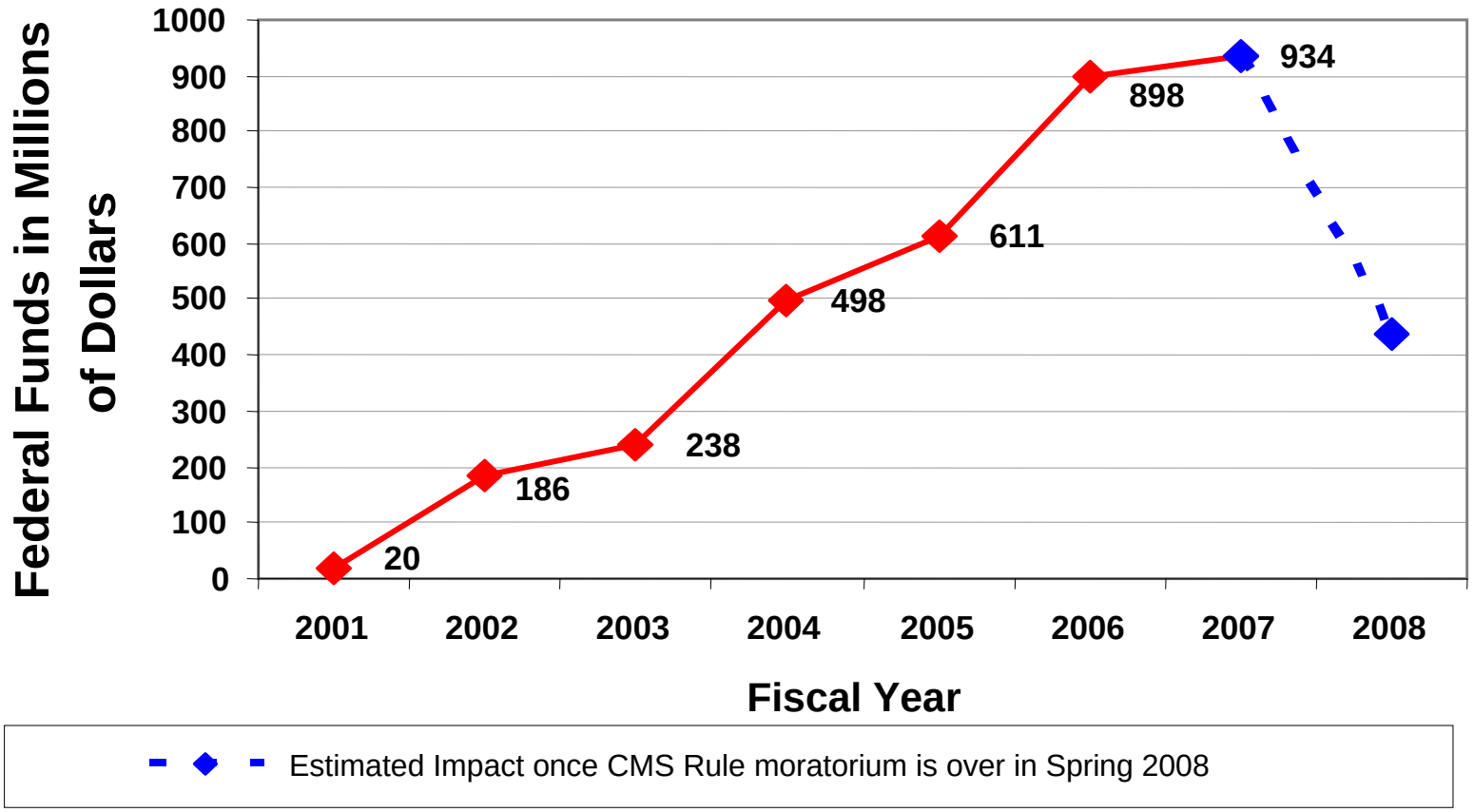
HOP Overarching Policy, and Funding Structure

- Overarching Policy
  - Improve efficiency of health investment
  - Effect a gradual, but critical system transformation
- HOP Funding Structure
  - Subsidize insurance premiums for uninsured individuals
  - Fund hospitals to help offset uncompensated care
  - Provide infrastructure funding to create efficiencies in health care provider base

Context: Federal Landscape Will Change Hospital Funding - How?

- CMS Rules that will change Medicaid hospital funding and hospital programs:
  - Provider Cost Based Rule moratorium expires May 2008
    - Limit UPL to cost
    - Hospital losses of $480 Million (over $500 million all programs)
  - DSH Audit Rule final adoption expected by March 2008
  - GME Rule moratorium expires May 2008
- Three scenarios to consider with regard to reform:
  - Current hospital and health system funding world will change
  - Future world dictated by CMS changes, no state action, rules implemented with related Texas health care system losses
  - Future world created in part through proactive state negotiation
    - Strategically developed approaches that best meet Texas' needs within CMS authority
- There is no "no change" scenario. The policy question is about how the change will be managed, and what the changes will be.

Historic UPL Allocations and Rule Change -- Hospital Impact



Note: Fiscal Year 2006 allocations includes retroactive payments made in fiscal year 2007.

Policy Guidance for Budget Neutrality

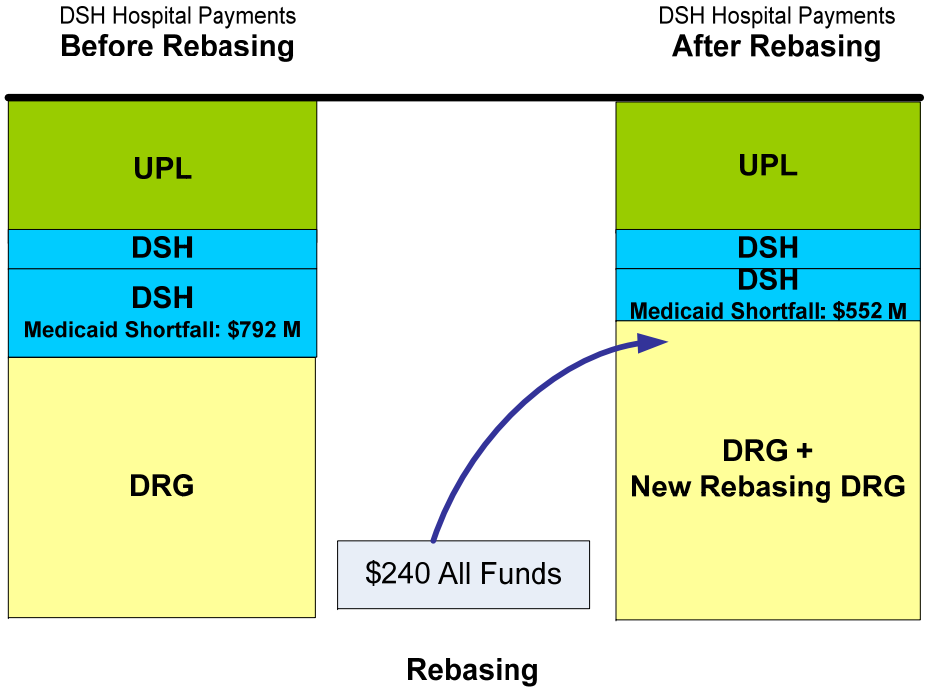
- Preserve full DSH and UPL funding (including trend growth over the life of the waiver)
- Maintain funding to hospitals to address uncompensated care costs as the system transitions
  - Revised definitions and reporting of uncompensated care (transparent, uniform, reliable)
- Fund Subsidies for the Uninsured
  - Redirecting federal funds to premium subsidies
- Leverage existing Texas health coverage programs

Medicaid Shortfall – key to DRG-DSH "Swap"

- Hospitals receive DSH based on the care they provide to Medicaid clients, and the care they provide to uninsured clients.
- Medicaid payments to hospitals for Medicaid clients are less than Medicaid costs.
- The difference between the costs and payments is called "Medicaid shortfall".
- By increasing Medicaid payments, the additional DRG funding reduces the Medicaid shortfall. This therefore reduces the DSH funds that hospitals would need to use to make up for that shortfall.
- The DSH funds that would have been used for the shortfall can now be used for HOP funding, with no change in the amount of funds hospitals will have to allocate to provide care for the uninsured.

Financing Approach
DRG-DSH "Swap"

HOP Financing – DSH Hospital Perspective

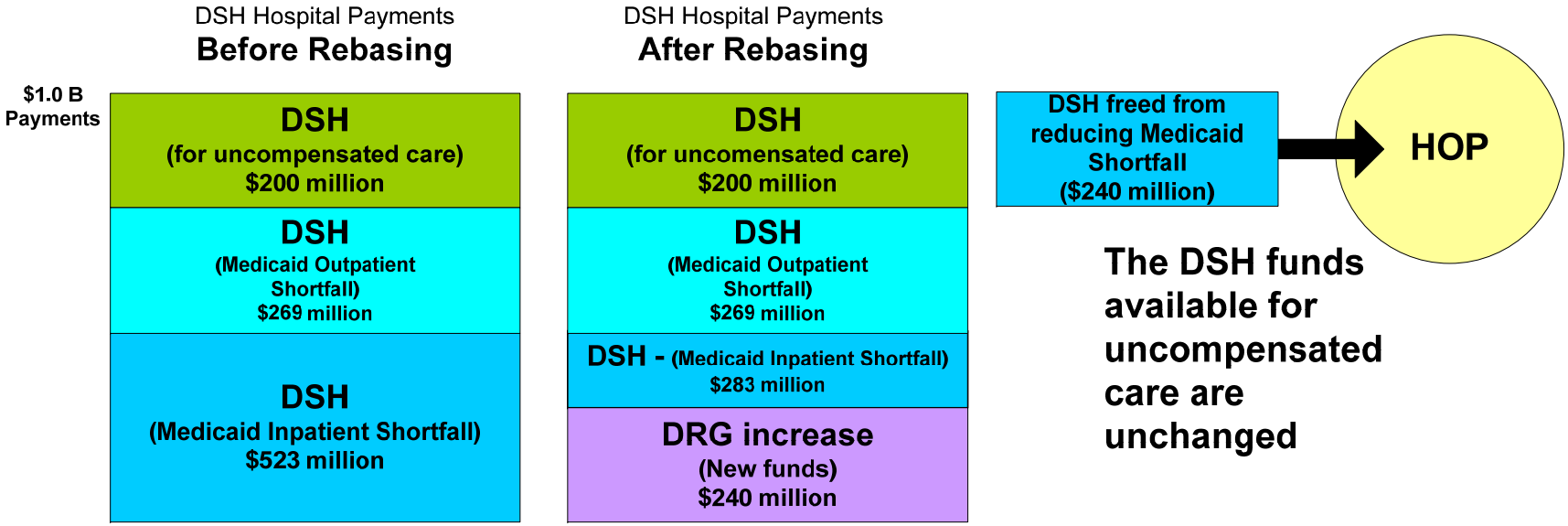


- No Net Total Payment Change
- Method of Finance change: substitute DRG for DSH
- IGT for DSH amount lowered by $ 160M

HOP
$240 million
HOP Subsidy Funds

Financing Approach
DRG-DSH "Swap"

HOP Financing – Illustration
Non-State DSH Hospitals' DSH Funds



Financing Approach: Hospitals

- Effects of Rebasing on Hospitals
  - DSH Hospitals “swap” DSH for increased DRG Payments – no net loss, no change in DSH funds available for uncompensated care, only a change in funding sources
  - Non-DSH and State hospitals have increased Medicaid payments from increased DRG rates with no DSH Swap
  - DSH Transferring hospitals keep more of their IGT funds

HOP Subsidy and Hospital Funding

- Two Legislative Catalysts for Reform:
  - SB 10 provides policy direction
  - $150 GR appropriations is basis for HOP subsidy funding
- New appropriations to HOP through DRG-DSH “swap”
  - Allows for continued hospital receipt of funds for uncompensated costs while funding investment in premium subsidy program
- Uncompensated care charges have increased from $5.5 billion to $11.3 billion over a five-year period
  - Simply allocating more funds to hospital uncompensated care won’t address underlying dynamics driving increased uncompensated care
- HOP subsidy program is a strategic start for long-term change
  - Addresses uncompensated care by investing in primary and preventive care that is not covered today, or that is covered with 100% local tax funds

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HOP Subsidy – Impacts to Uncompensated Care

- HOP subsidy, as envisioned, would have direct and indirect positive impacts on hospitals, including:

- Direct impacts
  - Increased insurance revenues. For example, under a five-day inpatient benefit alternative, 40 percent of the projected premium amounts are for hospital inpatient and outpatient related services.
    - Under this alternative, up to an estimated $130 million in new HOP insurance payments could be made to hospitals.
  - Additional utilization of employer sponsored insurance brings more employer-based funding into the health care system and hospitals

- Indirect impacts
  - Longer term reduction in uncompensated care due to availability of preventive services

Financing Scenario

- HOP subsidy start-up funding is approximately $302 million in All Funds, including
  - ➢ Estimated $240 million in DSH funds available as a result of Medicaid DRG rebasing
  - ➢ Estimated $62 million in GR available from HB1751

State Matching Sources	State Match	Federal Funds
• HB1751 (GR)	= $62M is match for →	$95M
• Certified Texas Coverage Programs	= $95M is match for →	$145M

Total HOP Funding →

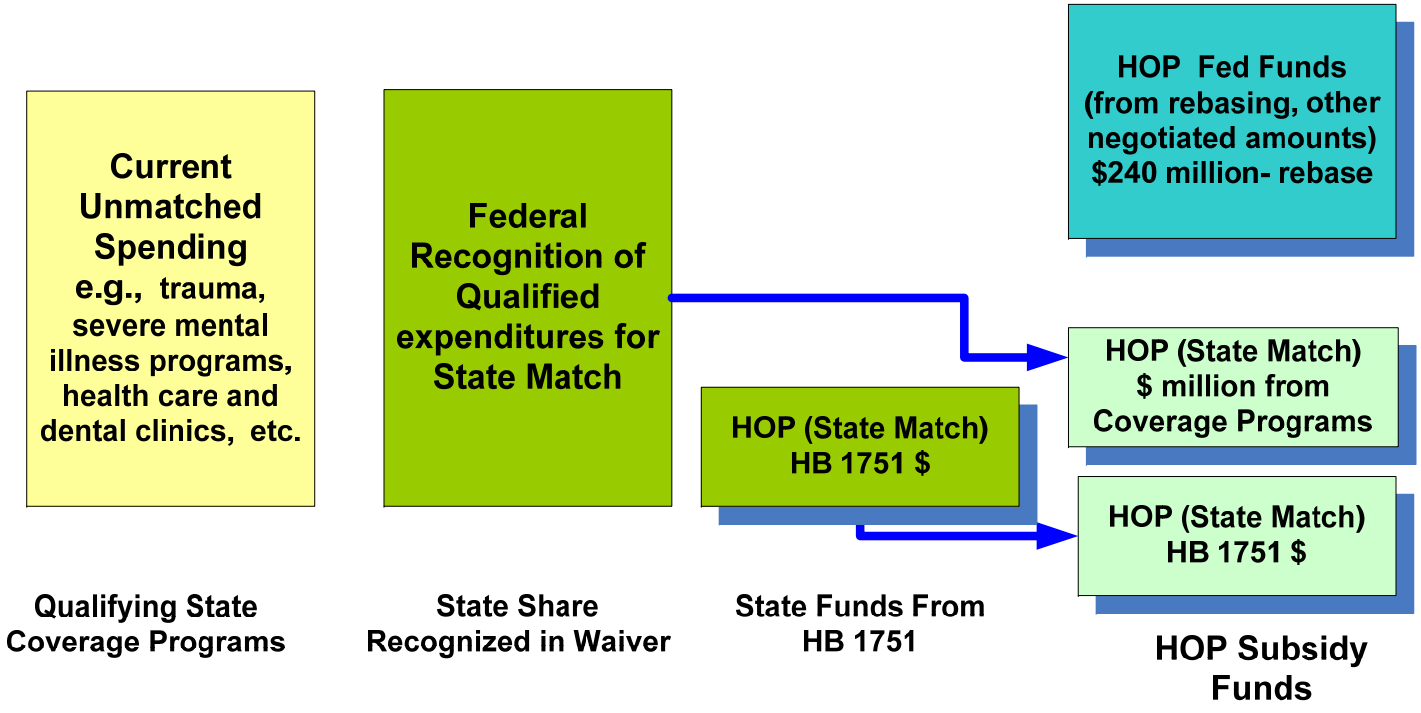
= $240M FF

\+ $62M HB1751 GR

= $302M All Funds

Financing Approach: Illustrative Examples

Identifying State Match for Federal HOP Funds - Health Coverage Programs



Identifying Sources of State Match

- Replace some IGT with match based on qualifying, unmatched state and local health care expenditures
  - Qualifying Texas health coverage programs
- Includes existing GR funded programs at HHS, existing local expenditures such as county indigent health care provided by hospital districts, public hospitals, county indigent health care programs
  - Preliminary estimated non-federal: over $400 million. Ongoing existing health program analysis and review

Budget Neutrality Structure

- Budget Neutrality
  - Federal waivers require that federal funding with the waiver is no more than federal funding without the waiver
  - Over a five-year waiver period
- Calculation of without waiver (WOW) funding
  - Includes DSH and UPL
- Calculation of with waiver (WW) funding
  - Some federal funds convert to subsidy funding in HOP

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Next Steps in Budget Neutrality Work

- Develop trends for DSH and UPL funds for 5 years of waiver
- Identify without waiver federal expenditures
- Identify the amount of state match required
- Identify:
  - the amount of funding available for subsidies,
  - the estimated premiums (per member per month) based on benefit costs, and
  - the estimated number of enrollees (based on take up)

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Texas Health Opportunity Pool (HOP) – Phase I Interactive Benefit Design Model Demonstration

Presented by:

Deloitte Consulting

Purpose of Interactive Benefit Design Model

- **The model estimates the cost implications of different benefit designs and benefit limitations for the adult uninsured expansion program**
- **The model provides the following estimates:**
  - The percent of eligible members who elect coverage
  - HOP share of costs per member per month (PMPM)
  - The overall HOP dollars required for the given benefit structure
- **The model is directionally correct, but is still being refined**
  - More in-depth analysis will be performed prior to implementation

Benefit Design Model Assumptions

- **Based on the benefit design, population, and year, the model adjusts for:**
  - Health status
  - Take-up percentage
  - Anti-selection
- **Detailed claim distributions based on Medstat data, Deloitte Consulting proprietary databases, and other industry data**

Benefit Design Model Assumptions (continued)

- **Data is organized into the following 10 service categories:**
  - Inpatient Facility
  - Outpatient Surgery
  - Outpatient Emergency Room
  - Other Outpatient Facility
  - Mental Health & Substance Abuse
  - Primary Care Physician – Preventive Visits
  - Primary Care Physician – Other Visits
  - Specialty Care Physician – Visits
  - Other Ancillary & Other Physician
  - Pharmacy

Benefit Design Model Assumptions (continued)

- **Benefit design can vary in any service category based on:**
  - Limits: Both dollar limits and utilization limits
  - Co-payments: On the appropriate categories
  - Deductible
  - Member premium
  - Member out-of-pocket (OOP) maximum: Includes member premium and deductible
  - Annual benefit maximum
  - Supports use of subsidy for Employer Sponsored Insurance (ESI)
  - Allows option to include/exclude Physician claims that occurred during an Inpatient stay

Take-Up Model Assumptions

- **Variables that affect the take-up percentage:**
  - Member premium
  - Co-payments
  - Deductible
  - Out-of-pocket maximum
  - State subsidization of ESI
  - Inclusion/exclusion of coverage for Physician services that occurred during an Inpatient stay
- **Uses Phase I population: parents of either Medicaid or CHIP children**
- **Assumes a comprehensive outreach program**
- **Assumes a 12-month guaranteed benefit/eligibility period**
  - Longer guaranteed benefit/eligibility periods lead to improved take-up

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Goals and Considerations for HOP Phase I - Basic Benefit Design

- Design a robust primary and preventive care package
- Encourage access to qualifying, affordable employer sponsored insurance if available
- Discourage crowd-out
- Include a broad range of services which would meet the basic healthcare needs of most enrollees
- Include cost sharing for all participants
- Include behavioral health services
- Develop a model to show relationship of costs, number of people who could be covered, and services provided.