Managing the Demand for Health and Human Services Programs

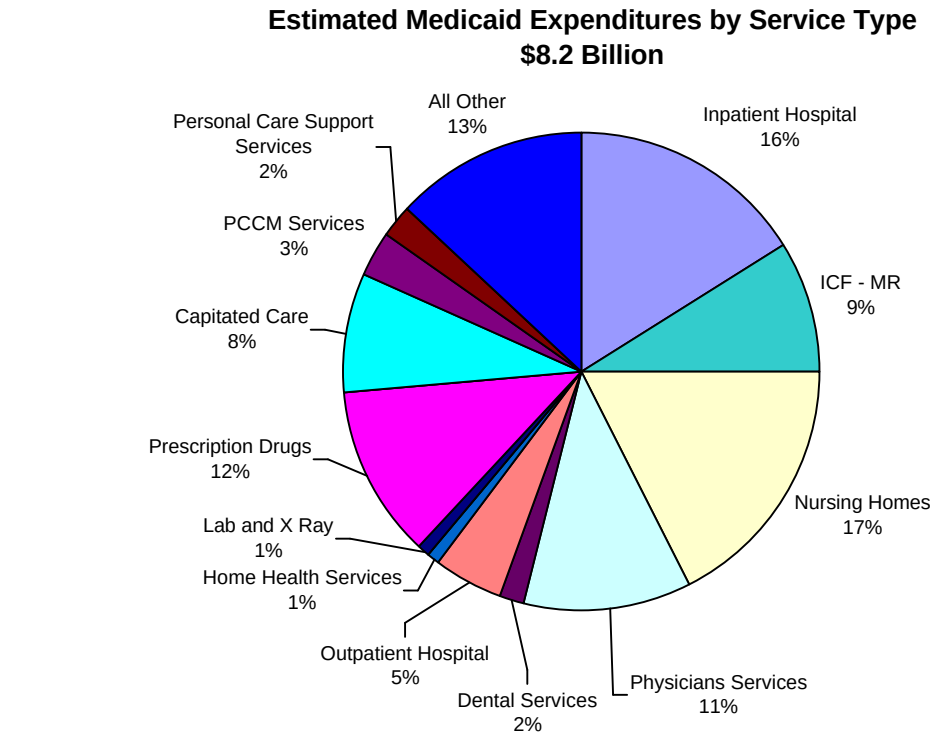
- Caseload Issues
- Waiver Programs Caseload and Waiver Interest Lists
- Rate Setting

Presentation to
Senate Finance Committee
October 24, 2001
Don Gilbert, HHSC

Demand for Services

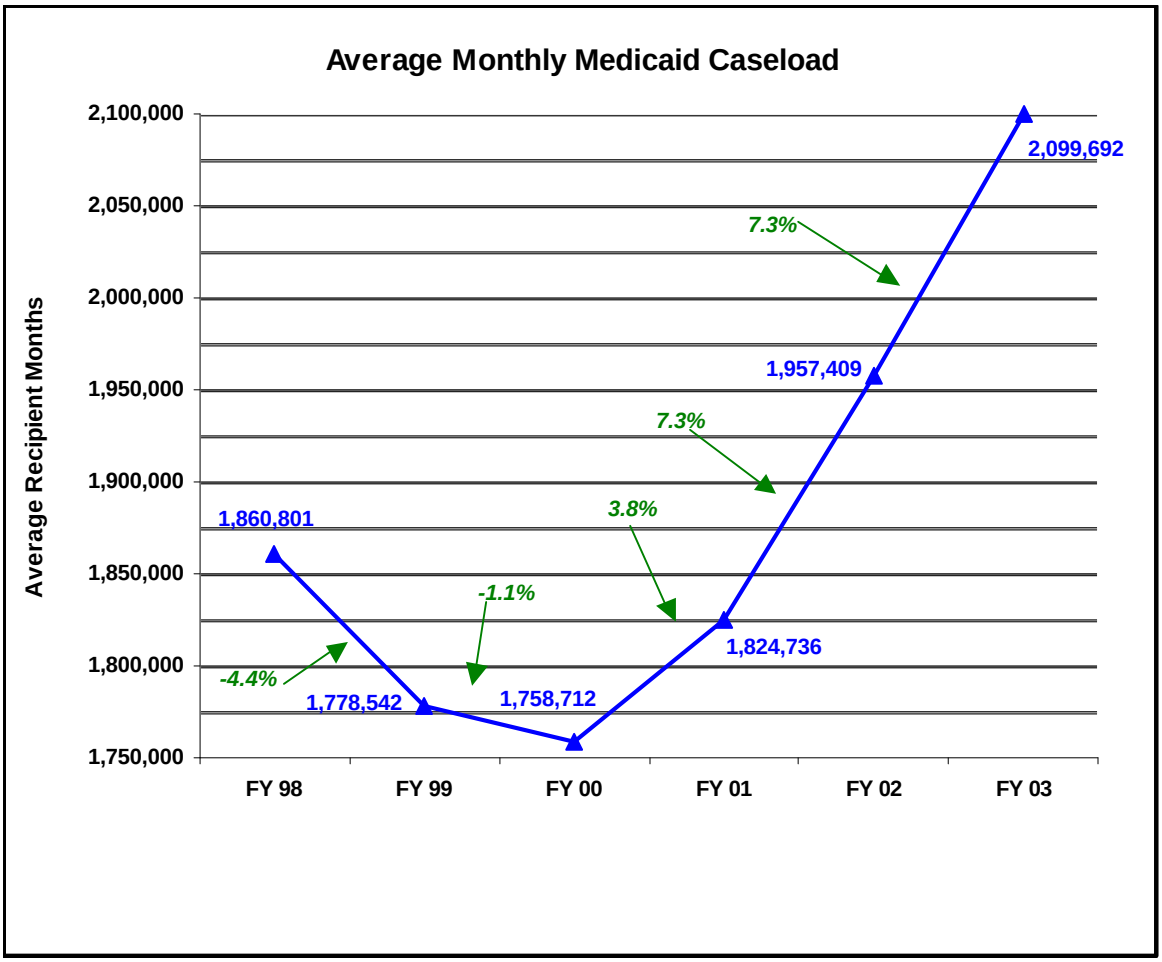
Caseload

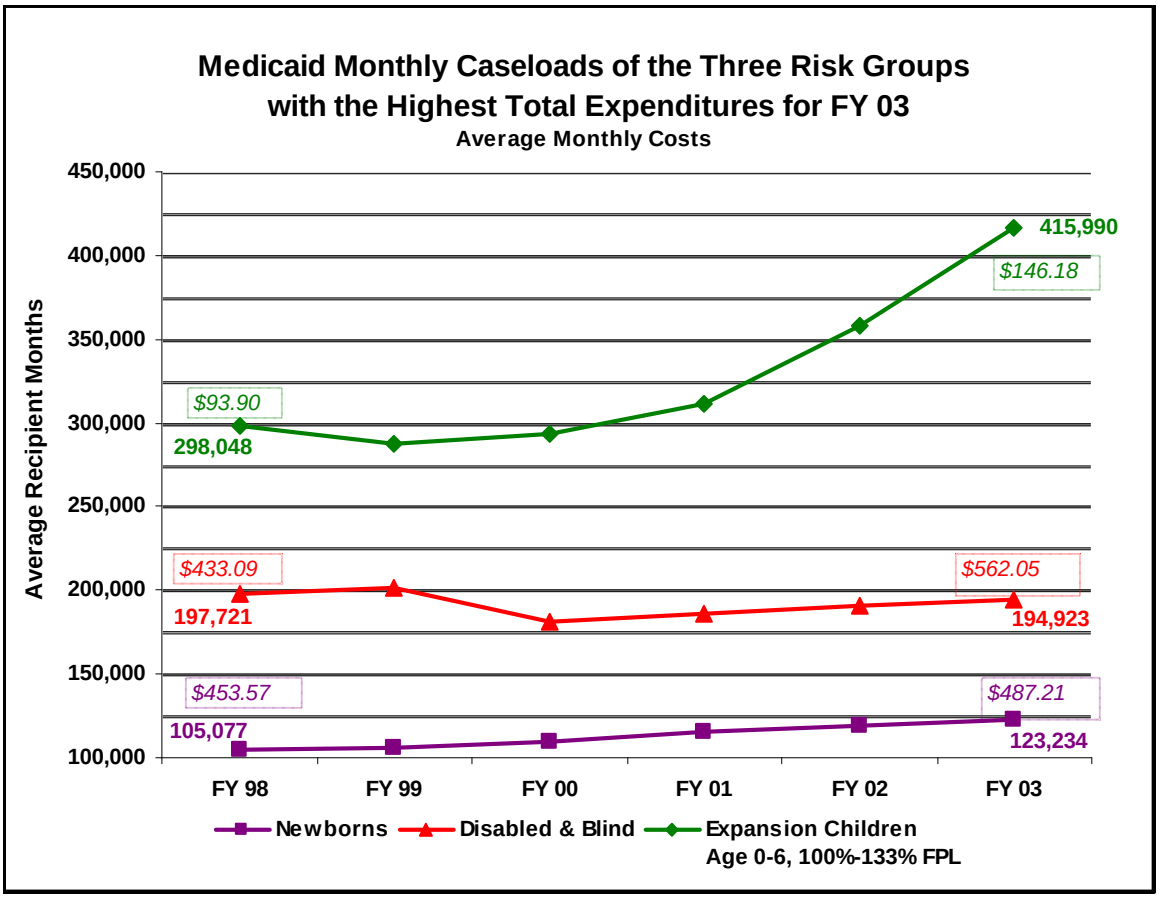
Demand for Services

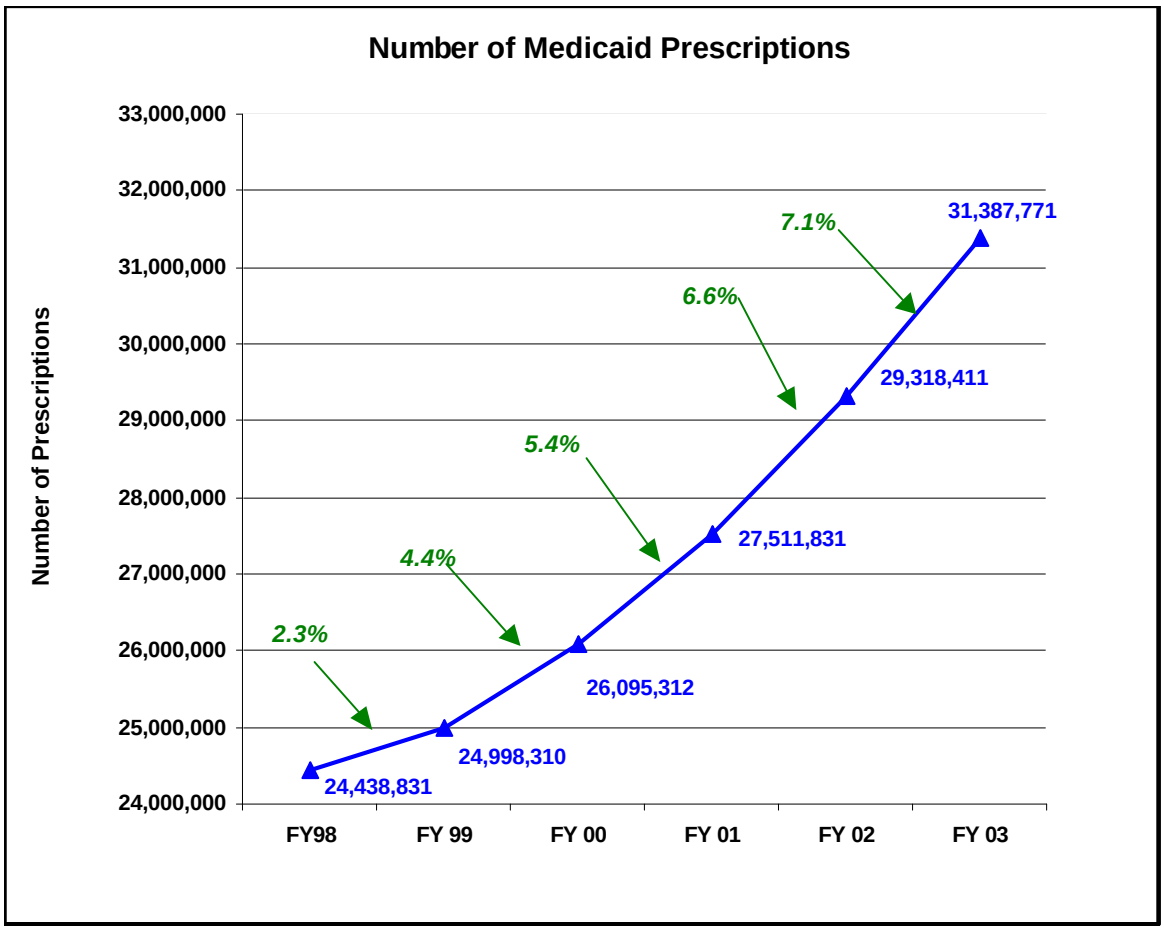


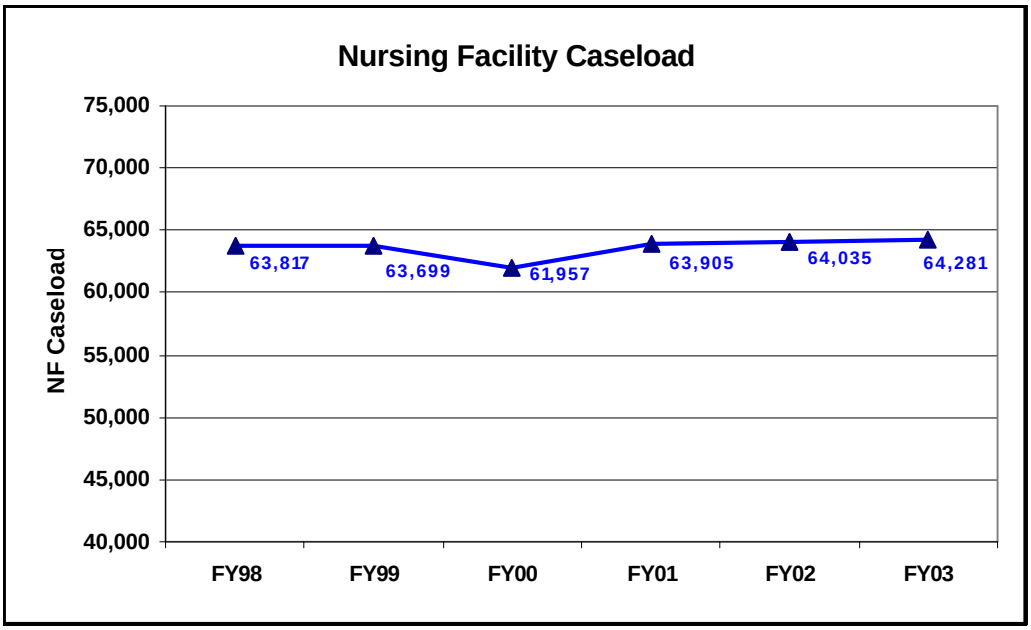
Source: HCFA 2082 FFY 99

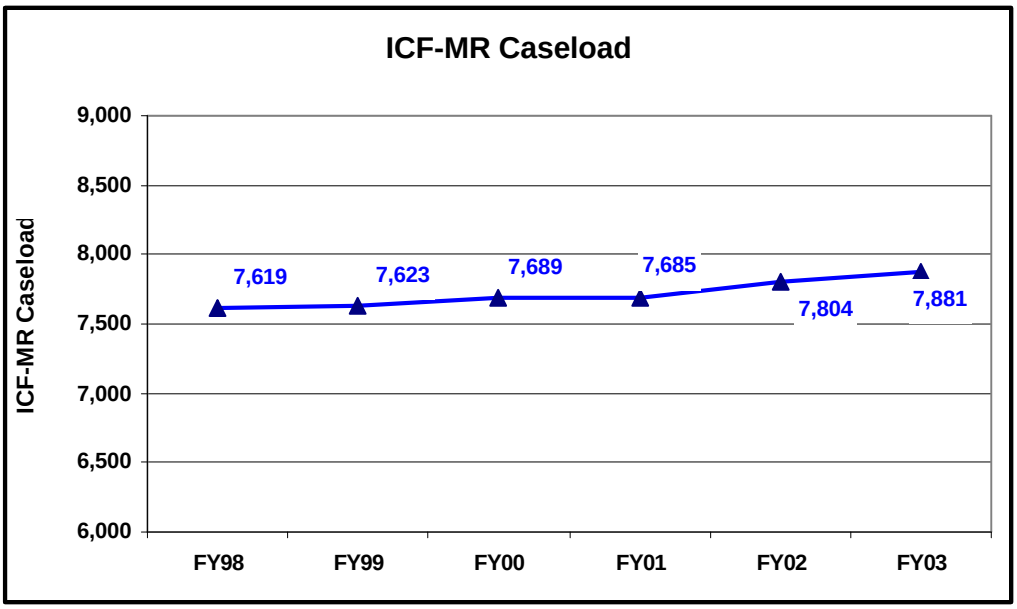
Demand for Medicaid services is a function of caseload size and case mix. The case mix in Medicaid refers to the proportion of specific sub populations within the Medicaid program. There are nine sub populations, or risk groups, within the Medicaid population, each with its own estimated demand for service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

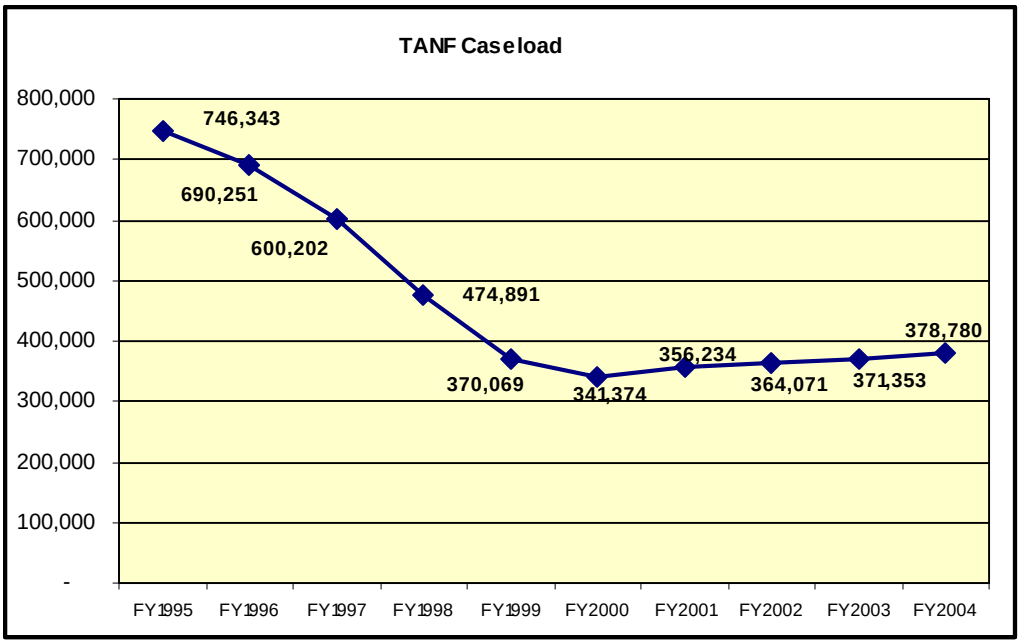

Average Monthly Medicaid Caseload
Average Recipient Months
2,100,000
2,050,000
2,000,000
1,950,000
1,900,000
1,850,000
1,800,000
1,750,000
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03
1,860,801
1,778,542
1,758,712
1,824,736
1,957,409
2,099,692
-4.4%
-1.1%
3.8%
7.3%
7.3%

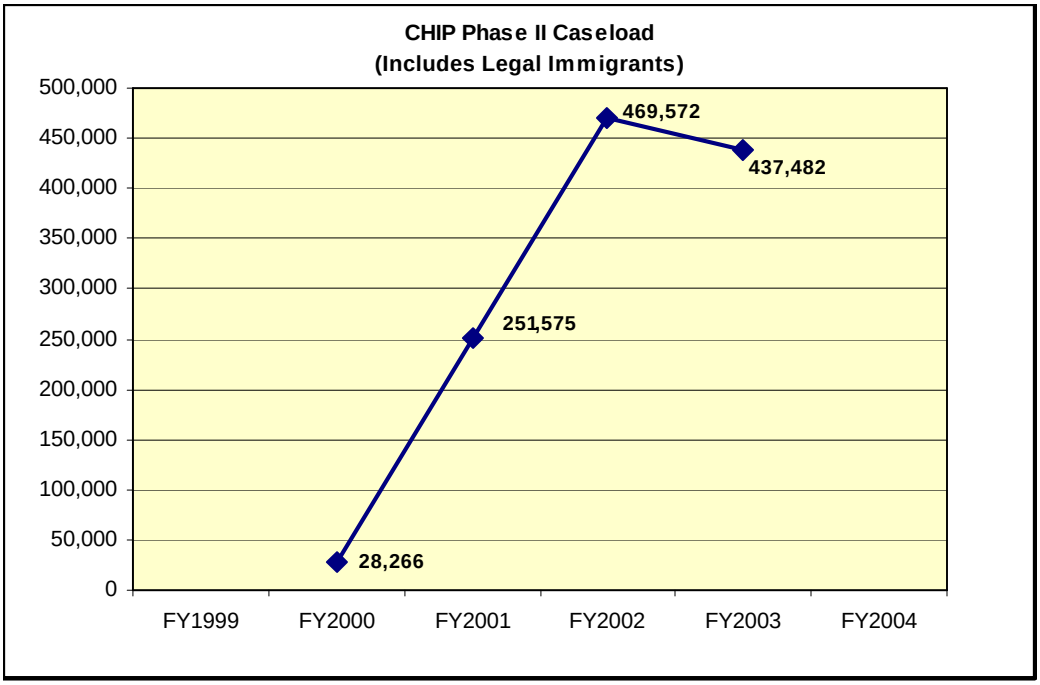

Medicaid Monthly Caseloads of the Three Risk Groups
with the Highest Total Expenditures for FY 03
Average Monthly Costs
Average Recipient Months
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
FY 98
FY 99
FY 00
FY 01
FY 02
FY 03
$93.90
298,048
$146.18
415,990
$433.09
197,721
$562.05
194,923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

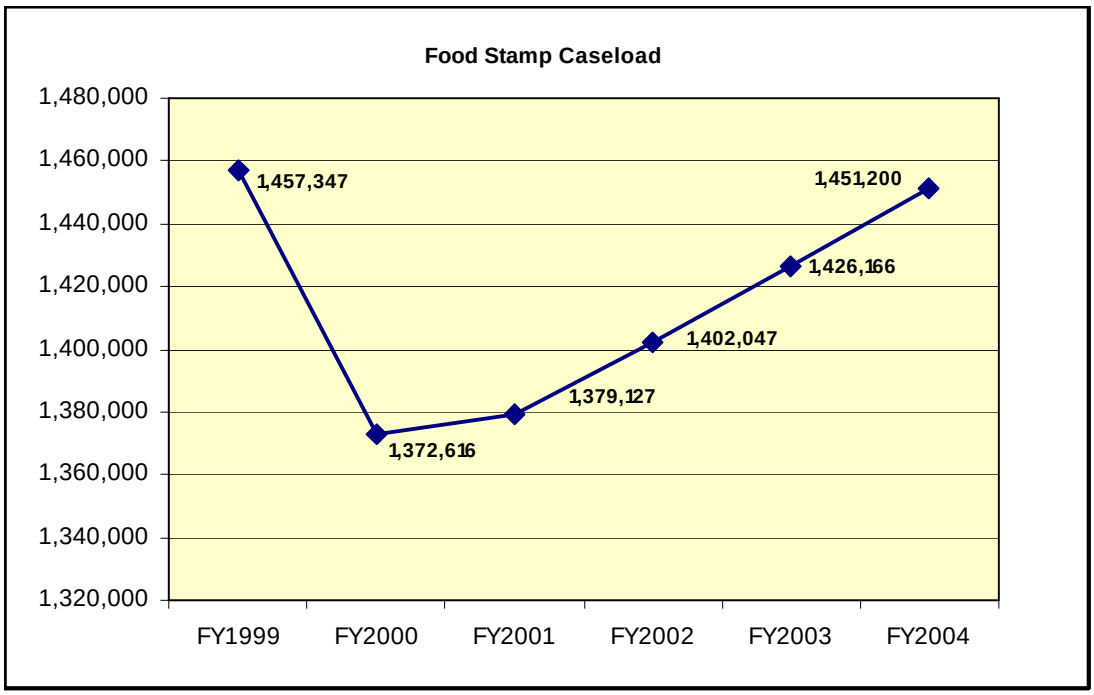

Number of Medicaid Prescriptions
Number of Prescriptions
33,000,000
32,000,000
31,000,000
30,000,000
29,000,000
28,000,000
27,000,000
26,000,000
25,000,000
24,000,000
FY98
FY 99
FY 00
FY 01
FY 02
FY 03
2.3%
4.4%
5.4%
6.6%
7.1%
24,438,831
24,998,310
26,095,312
27,511,831
29,318,411
31,387,771

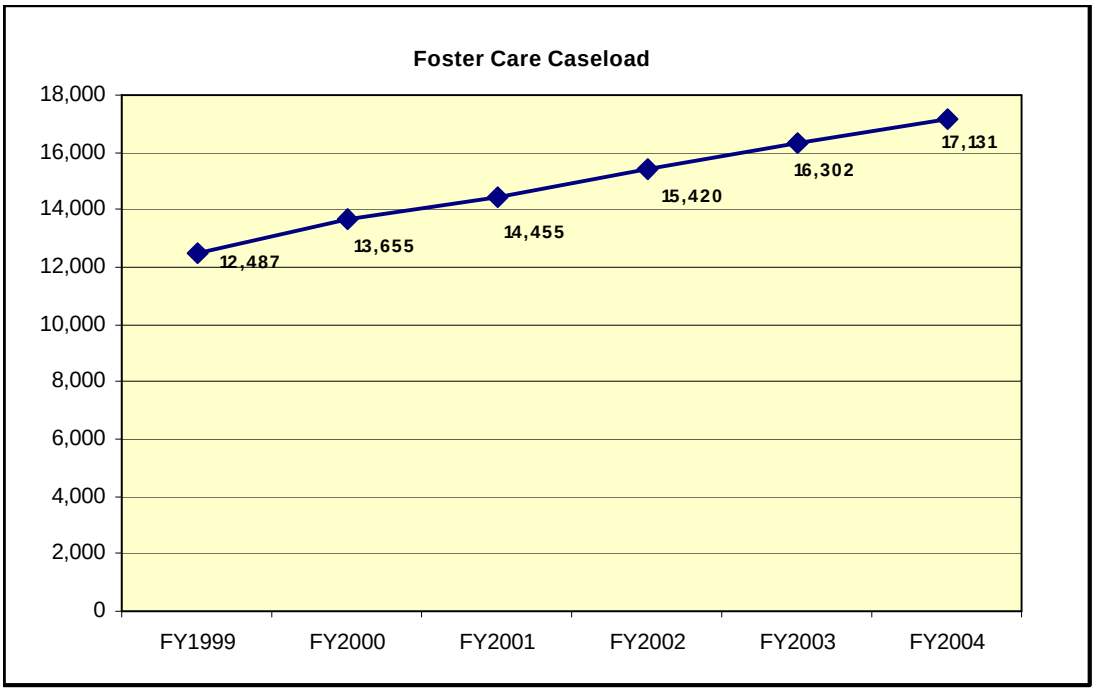

Nursing Facility Caseload
NF Caseload
75,000
70,000
65,000
60,000
55,000
50,000
45,000
40,000
63,817
63,699
61,957
63,905
64,035
64,281
FY98
FY99
FY00
FY01
FY02
FY03

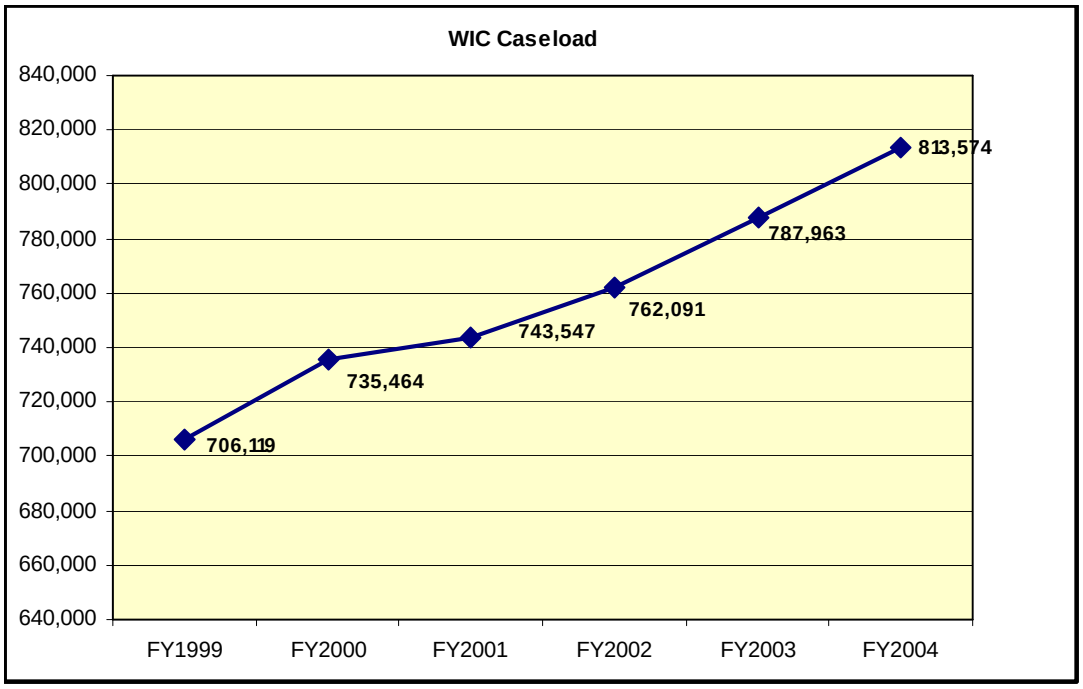

ICF-MR Caseload
ICF-MR Caseload
9,000
8,500
8,000
7,500
7,000
6,500
6,000
7,619
7,623
7,689
7,685
7,804
7,881
FY98
FY99
FY00
FY01
FY02
FY03


TANF Caseload
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
746,343
690,251
600,202
474,891
370,069
341,374
356,234
364,071
371,353
378,780
FY1995
FY1996
FY1997
FY1998
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004


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
28,266
251,575
469,572
437,482
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004


Food Stamp Caseload
1,480,000
1,460,000
1,440,000
1,420,000
1,400,000
1,380,000
1,360,000
1,340,000
1,320,000
1,457,347
1,372,616
1,379,127
1,402,047
1,426,166
1,451,200
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004


Foster Care Caseload
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
12,487
13,655
14,455
15,420
16,302
17,131
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004

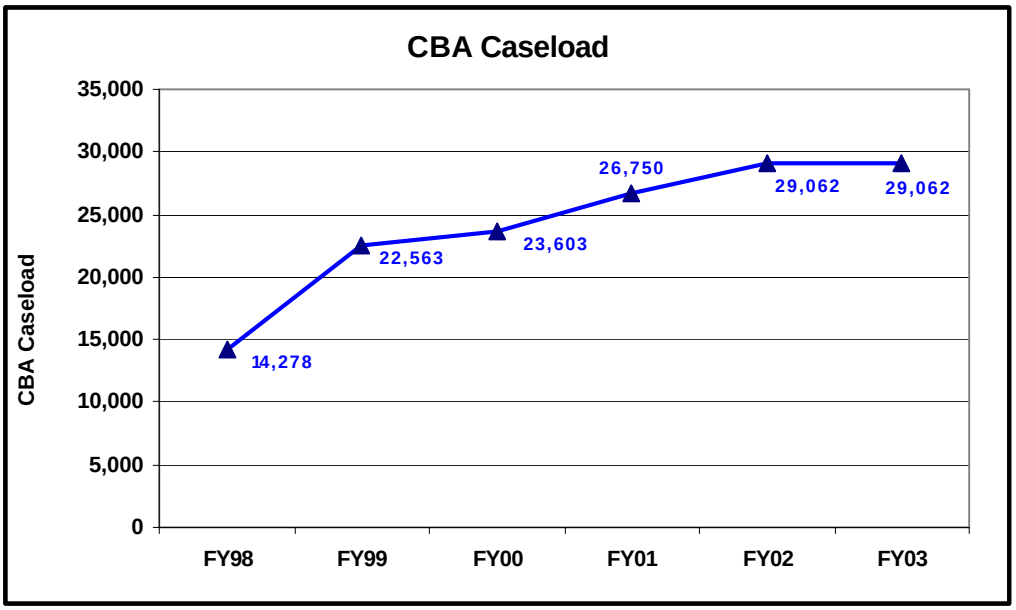

WIC Caseload
840,000
820,000
800,000
780,000
760,000
740,000
720,000
700,000
680,000
660,000
640,000
706,119
735,464
743,547
762,091
787,963
813,574
FY1999
FY2000
FY2001
FY2002
FY2003
FY2004

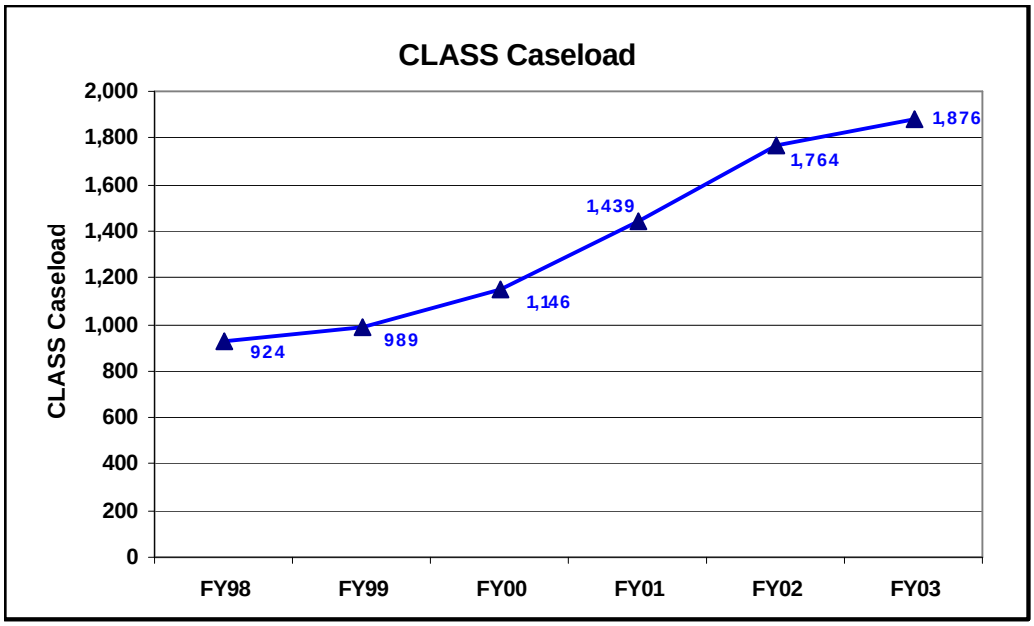
Caseload Forecasting Process

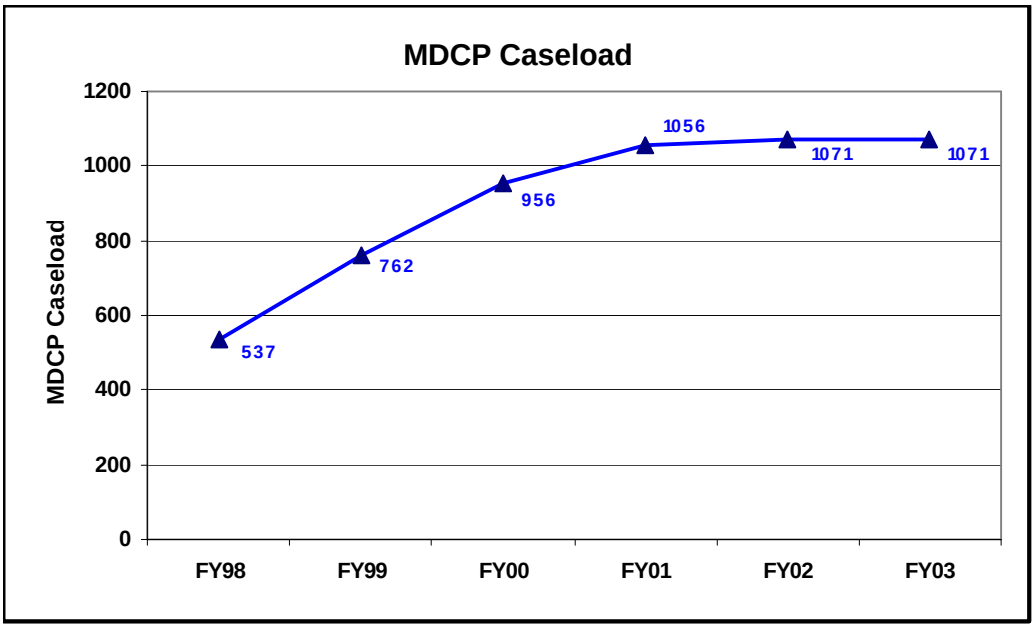
- In general, the process for caseload forecasting is very similar for all programs:
  - Based on time series models
  - Several models are followed over time to determine which is the best performer
  - Adjustments may be made to forecasts based on:
    - Program issues
    - Population limits and demographic information
    - Historical trends
    - Policy changes
- External actuaries provide a second opinion on forecasts.
- TDH (now HHSC) and DHS have come to a consensus agreement on trends for similar series.
- Because of the lack of historical data, the CHIP caseload forecast is based on the size of the eligible population.

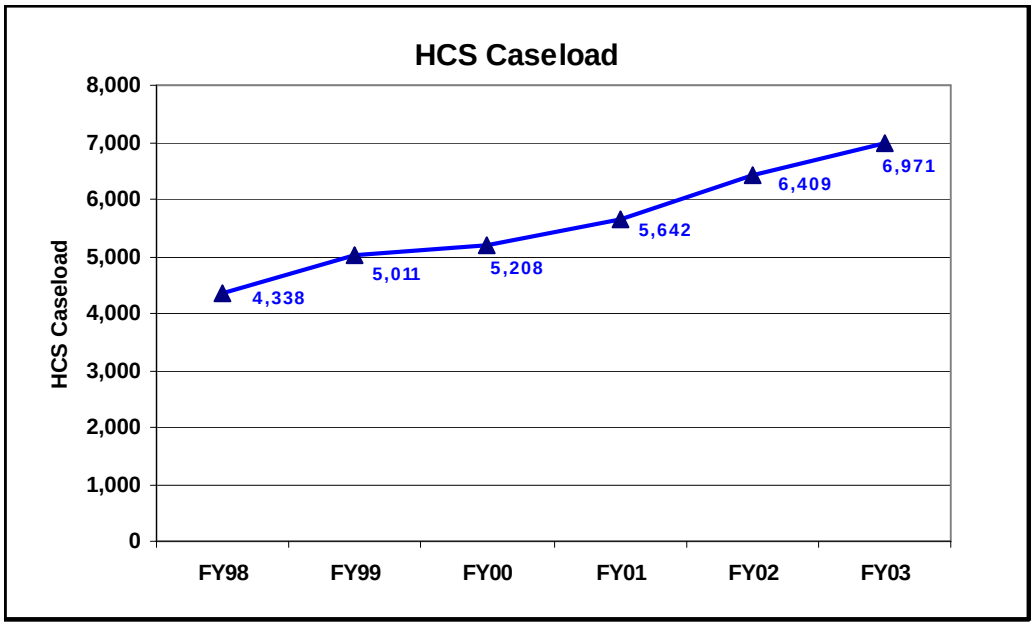
Demand for Services

Waiver Programs Caseload
and
Waiver Interest Lists


CBA Caseload
CBA Caseload
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
14,278
22,563
23,603
26,750
29,062
29,062
FY98
FY99
FY00
FY01
FY02
FY03


CLASS Caseload
CLASS Caseload
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
924
989
1,146
1,439
1,764
1,876
FY98
FY99
FY00
FY01
FY02
FY03


MDCP Caseload
MDCP Caseload
1200
1000
800
600
400
200
0
537
762
956
1056
1071
1071
FY98
FY99
FY00
FY01
FY02
FY03


HCS Caseload
HCS Caseload
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
4,338
5,011
5,208
5,642
6,409
6,971
FY98
FY99
FY00
FY01
FY02
FY03

DHS Waiver Programs
Interest List Information

Program	Date	Number of Individuals on Interest List	How to Get on Interest List
Community Based Alternatives (CBA)	10/01/2001	33,400	➢ Calls to local DHS field offices/State office ➢ Data entered on MAPPER Community Care Interest List Database
Medically Dependent Children Program (MDCP)	10/18/2001	2,754	➢ Call to State Office 1-877-438-5658 or write to MDCP Program ➢ Centralized database with MDCP State Office (FoxPro System)
Community Living Assistance and Support Services (CLASS)	10/04/2001	6,736	➢ Write to State Office or call 1-877-438-5658 ➢ Information maintained on centralized list in CLASS Program (D-base)
Program for People Who are Deaf-Blind with Multiple Disabilities (DB-MD Waiver)	10/17/2001	50	➢ Referred to DB-MD Program by DHS ➢ Consultant maintains Access database

TDMHMR Waiver Program
Interest List Information

Program	Number of Individuals on Interest List	How to Get on an Interest List
Mental Retardation Local Authority (MRLA) 8 MRAs	4,348	➢ People get their name on the list by making a request to the MRA to be added to the list. MRA staff register the person into the CARE system (if not already) and enter a waiting code and effective date for HCS in the Waiting List Data Entry screen. ➢ Eligibility for the Waiver is not formally determined until an available slot has been identified for the person. Diagnostic eligibility for GR services will be established if the person receives interim services. ➢ Lists are centralized at TDMHMR in the CARE system. MRAs do have access to information about their local waiting list. ➢ Unless program vacancies are specifically targeted to a group (i.e., residents leaving state mental retardation or mental health facilities, residents who are moving out of large ICF/MR facilities, and residents of ICF/MR facilities that are closing), program vacancies are offered to the first person named on the MRA's HCS waiting list for which a slot is available.
Home and Community-Based Services (HCS) 34 MRAs	10,578	
TOTAL:	**14,926**	

Demand for Services

Rate Setting Process

HHSC Rate Setting Function

- Medicaid rate setting is centralized at HHSC. On September 1, 2001 all Medicaid rate setting staff were transferred from MHMR, DHS and TDH to HHSC. The consolidation of Medicaid rate setting responsibility will improve coordination and consistency of rate setting processes.
- The rate setting function encompasses numerous programs and services, each requiring a separate rate methodology.
- Typically, Medicaid rates for service providers such as hospitals, physicians, ICFs-MR and nursing homes, are based on a fee-for-service rate system. The fee-for-service rate setting process may involve a number of steps, including:
    - developing rate methodologies for incorporation into the Medicaid State Plan and the Texas Administrative Code;
    - securing federal approval for Medicaid State Plan amendments;
    - consulting the appropriate advisory committees on rules to be incorporated into the Texas Administrative Code;
    - gathering, auditing and analyzing cost data;
    - utilizing prescribed methodologies in conjunction with analysis of costs and other pertinent information to develop proposed rates;
    - assessing the fiscal impact of proposed rates; and
    - conducting public hearings and evaluating public input prior to adoption of final rates.

- In addition to cost reports and formulas included in approved methodologies, rate setting is influenced by appropriations (as illustrated in the following table) and legislative directive. For example:

    - The Legislature directed HHSC to target Medicaid acute care increases to support specific providers and services, such as high-volume providers, providers along the border, and preventive care.
    - In the area of community care and nursing facility care, increases were directed toward wages for personal attendants, nursing facility aides, and nurses.

Inpatient Hospital Services

- DRG rates are set using historical costs by hospital to approximate a standardized average cost per stay or "Standard Dollar Amount" (SDA). A weighted DRG factor is then applied to the SDA to determine the actual reimbursement for each hospital stay. The SDA is rebased every third year, using audited hospital cost reports and claims data. For years when rebasing does not occur, SDA's are updated for cost report changes and inflated by a general inflation index which has averaged 4.25 percent over the past decade.
- Exceptions include children's hospitals, which receive an interim rate and are retrospectively cost-settled under federal TEFRA principles to ensure cost-based reimbursement; and hospitals with 100 beds or less, which also are cost-settled per TEFRA.
- The rebasing of SDA's effective September 1, 2001, resulted in an average increase of 4.17 percent.

Outpatient Hospital Services

- Rates are determined retrospectively on a cost-based payment system. An interim payment rate is used, which is cost-settled after a year ends.
- A discount factor is applied to each outpatient payment.
- The discount factor for high-volume outpatient hospital providers increased from 80.3 percent to 84.48 percent as of October 1.

Physician Services

- Some of the fees are based on the Medicare Resource Based Relative Value Scale (RSBVS).
- The Texas methodology has no geographical or specialty differentiation.
- The conversion factor of $27.28 is multiplied by the appropriate Relative Value Unit to determine payment.
- There are also some 800 Access-Based Fees (ABFs) that were developed specifically for Texas Medicaid because many obstetric and pediatric procedures were not appropriately considered in the Medicare system. ABFs have been implemented to assure adequate access for Texas Medicaid clients.

ICF-MR

- State Schools and other state-operated facilities receive rates based on cost reports. State Schools are cost-settled.
- Private ICF-MR providers receive modeled rates that are updated periodically based on cost surveys and trends. FY 02-03 funding for rate

increases is based on a provider Quality Assurance Fee (QAF) that draws down federal matching funds. Private ICF-MR rates include 5 levels of need as determined by assessments of client functioning, and 3 facility size classes. Effective September 1, 2001, private ICF-MR providers received an average rate increase, net of the QAF, of about 5 percent.

Nursing Facilities

- Rates are based on historical cost reports with adjustments for inflation and other factors. Basic rates include 11 case-mix groups (the TILE or Texas Index for Level of Effort system) and add-ons for residents who are ventilator-dependent and children with tracheostomies. Providers have the option of participating in an enhanced rate system and receiving additional payments for maintaining enhanced staffing levels and/or paying enhanced compensation to direct care staff. Rates increased effective September 1, 2001, and an opportunity to receive increased enhancements is scheduled for December 1, 2001. In combination, these adjustments represent an increase of about 11.5 percent above the rates in effect through August 31, 2001.
- Exceptions are pediatric homes and state veteran's homes, which receive rates based on the individual home's cost of service.

Community Care Programs

- Home and Community-based Services (HCS)
  - Basic fee-for-service rates are based on pro forma models established in 1997 and rebased every three years using cost surveys and other pertinent data, with interim inflation adjustments made using the PCE index.
  - Facilities are paid basic rates that are uniform statewide by level of need and type of setting, with additional statewide uniform fee-for-service rates by type of service. Basic payments for direct care services staff compensation are subject to a minimum-spending requirement with potential recoupment of unspent funds.

- The Community Based Alternatives (CBA), Community Living and Support Services (CLASS), Primary Home Care (PHC), Day Activity and Health Services (DAHS)
  - Statewide unit rates are based on annual cost reports submitted by providers or are modeled pro forma rates. Unit rates are determined using cost reports based on the weighted median cost by cost center of all providers plus 4.4%, except for residential care/assisted living services

which is plus 7%. The DAHS program is based on the median cost of all providers plus 4.4%.

- Providers have the option to participate in enhanced funding for attendant compensation.
- Attendant compensation costs for non-participants are based on the 1997 data base inflated to FY 2000 and attendant compensation costs for participants is based on a pro forma model. The attendant compensation cost rate component for participants will be retroactively adjusted based upon failure to meet specific spending requirements.

Medicaid Managed Care

- The State uses a reduced Fee-For-Service (FFS) methodology to compute base rates. FFS data from before managed care implementation is trended forward using statewide trends. Rates vary by caseload risk group and by service delivery area.
- Certain adjustments such as area factors, and delayed enrollment factors, are applied to produce the base rates.

Children's Health Insurance Program (CHIP)

- The first year CHIP premium rates were determined using a bid process. HHSC specified a set of target premium rates, but HMOs were allowed to propose any rate they determined to be appropriate. The target rates were developed based on Medicaid experience.
- The second year CHIP premium rates were negotiated with each individual health plan based on the experience of the health plan and actuarial projections.

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