



Presentation to the House Appropriations Committee

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CHIP Reauthorization

- Congress re-authorized the Children's Health Insurance Program (CHIP) through federal fiscal year 2027 which:
 - Continues 23 percent "bump" to the CHIP match rate for two years (FFY 2018-19) and 11.5 percent for one year (FFY 2020); and
 - Extends the maintenance of effort requirement through 2023, but after 2019 this only applies to children in families up to 300 percent federal poverty level (FPL).



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1115 Waiver Overview

- HHSC received federal approval of a waiver that allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements, and directs more funding to hospitals.
- The 1115 Waiver consists of:
 - Managed care;
 - Uncompensated Care (UC);
 - Delivery System Reform Incentive Program (DSRIP); and
 - Other supplemental payment programs.



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1115 Waiver Approved December 21, 2017

- UC and DSRIP pools received funding at current levels through FFY 2019.
 - \$3.1 billion for each pool each year
 - DSRIP phased out by FFY 2022
 - UC pool resized in FFY 2020, based on hospital charity care costs
- The UC payment protocol and payment rules will list all of the services eligible for a UC payment and the methodology for paying providers.

UC and DSRIP Funding

	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	FFY 18	FFY 19	FFY 20*	FFY 21*	FFY 22*
UC	\$3.7B	\$3.9B	\$3.5B	\$3.4B	\$3.1B	\$3.1B	\$3.1B	\$3.1B	\$2.3B	\$2.3B	\$2.3B
DSRIP	\$500M	\$2.3B	\$2.7B	\$2.9B	\$3.1B	\$3.1B	\$3.1B	\$3.1B	\$2.9B	\$2.5B	\$0

*UC funding for FFYs 2020-2022 serves as a placeholder until Texas' UC pool size is finalized.



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Timeline of Key 1115 Waiver Activities

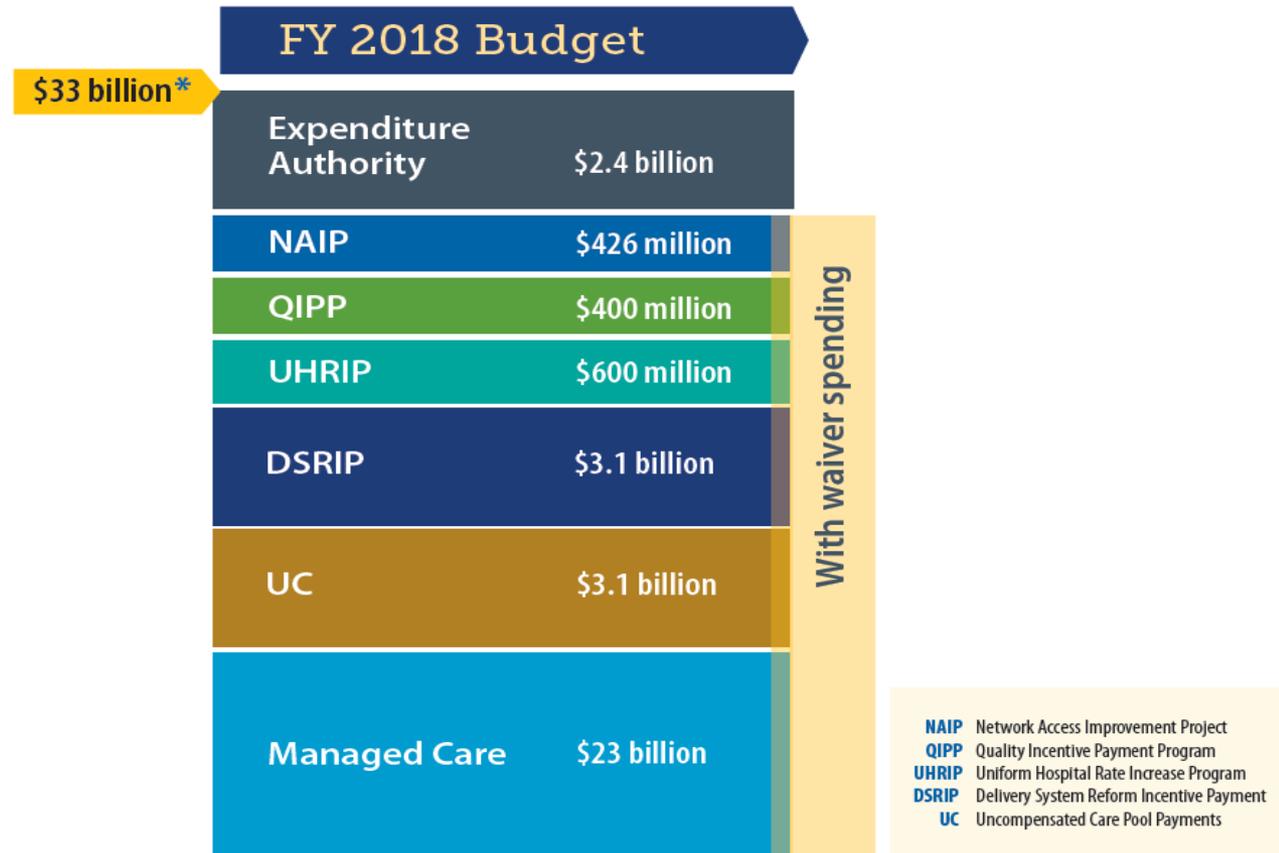
Failure to meet certain deadlines will result in a 20 percent reduction in expenditure authority from the UC pool for the program year.

- **March 30, 2018:** Submitted draft UC payment protocol to the Centers for Medicare and Medicaid Services (CMS).
- **July 31, 2018:** Draft rule on UC payments will be published.
- **January 30, 2019:** Publish final rule on UC payments.
- **May 1, 2019:** Submit revised draft UC application tools for all provider types to CMS.
- **August 31, 2019:** Receive CMS approval on revised UC tools.
- **September 30, 2019:** Final rule on UC payments will be effective.
- **October 1, 2019:** Implement approved UC protocol.



Budget Neutrality

- Budget Neutrality "room" is the difference between HHSC's With Waiver costs and Without Waiver costs.



*Estimated Traditional Medicaid spending including renewal policy adjustments



Budget Neutrality

Budget Neutrality “room” can be used for programs such as:

- Quality Incentive Payment Program (QIPP)
 - Payments made by managed care organizations (MCOs) to nursing facilities based on the facilities’ performance related to agreed-upon metrics.
 - Estimated \$400 million in All Funds for FFY 2018.
- Uniform Hospital Rate Increase Program (UHRIP)
 - Raises reimbursement rates for specific hospitals and directs MCOs to make those increased payments.
 - Estimated \$600 million in All Funds for FFY 2018.
- Network Access Improvement Program (NAIP)
 - NAIP began as an incentive program under which MCOs partnered with health-related institutions and public hospitals to develop and implement initiatives that improved access to primary care, specialty care, and related services.
 - CMS subsequently determined the program was a pass through.
 - Estimated \$427 million in All Funds for FFY 2018.



Block Grants and Per Capita Caps Overview

- **Block Grants** – A fixed amount of money that the federal government gives to states to provide benefits or services.
- **Per Capita Caps** – Total federal funding would be determined by a cap established per individual enrolled.
- Intended to provide federal Medicaid cost certainty by setting limits on such spending, as well as provide states with flexibility over eligibility and benefit design.



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American Health Care Act, HR 1628

115th Congress, 1st Session, 2017

(Not Enacted)

- Converts federal Medicaid financing to a per capita cap.
 - Established for the following groups: elderly, blind, disabled, children, expansion adults, and other adults.
- Initial cap amount is based on prior year expenditures.
 - Supplemental hospital payments are included in cap allotment.
- Inflationary factor built in based on Medical Consumer Price Index.



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American Health Care Act, HR 1628

115th Congress, 1st Session, 2017

(Not Enacted)

- Includes state option to elect a Medicaid block grant in addition to a per capita cap.
 - If elected, states have a 10 year lock-in.
 - Block grant may be elected for children and non-expansion adults.
 - ❖ Provides additional flexibility in conditions of eligibility.
 - ❖ States required to provide hospital, surgical, obstetrical, medical care and treatment, prenatal, drugs, and prosthetics.
 - ❖ States determine cost sharing and delivery system.
 - ❖ Populations not covered under block grant would be covered under the per capita cap.
- Cost Trend: Medical Consumer Price Index, no adjustment for caseload growth.



Other Medicaid Options

The current administration has signaled a willingness to assist state Medicaid programs in their requests for greater flexibility.

- Federal approval of the 1115 Waiver has changed the landscape for Texas' Medicaid program.
- Before contemplating future changes to the Medicaid program, the state should consider recent federal guidance and rule changes.
 - Work requirements
 - Expansion populations
- HHSC will seek Executive and Legislative input prior to making changes to the Medicaid program.



Other Medicaid Options

Medicaid Work Requirements

- Allows states to seek an 1115(a) waiver to test incentives for work requirements or other community engagement activities for continued Medicaid eligibility.
- Work and community engagement activities can be applied among non-elderly, non-pregnant adult Medicaid beneficiaries who are eligible on a basis other than disability.
 - In Texas, eligible population would include Temporary Assistance for Needy Families (TANF) eligible adults not participating in the TANF program.
- States are encouraged to align Medicaid work requirements with TANF and Supplemental Nutrition Assistance Program (SNAP) policies.



Other Medicaid Options

Medicaid Work Requirements, Cont.

- Waiver must provide strategies linking individuals who experience barriers to meeting the work requirements to services such as child care and transportation.
 - Does not authorize Medicaid funding for these services.
- Budget neutrality must be demonstrated to the federal government.
- Independent evaluation of health outcomes for individuals who remain enrolled in Medicaid and those who lose Medicaid eligibility must be conducted.



Other Medicaid Options

Below are a list of options that CMS has approved.

- Healthy behavior incentives tied to premium or cost sharing reductions.
- Eliminating non-emergency medical transportation.
- Cost sharing (premiums and co-pays) imposed.
- Eligibility changes:
 - Waive retroactive eligibility;
 - Lock-out for failure to timely renew; and
 - Lock-out for failure to timely report eligibility changes.



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Quality Incentive Payment Program (QIPP)

- **Authority:**
 - Federal - 42 CFR 438.6(c).
- **Concept:** Payments will be made quarterly by the STAR+PLUS MCOs to nursing facilities based on the facilities' performance related to agreed-upon metrics, which include restraints, falls, pressure ulcers, and antipsychotic drug use.
- **Implementation:** September 1, 2017
- **Participants:** Public and private nursing facilities are permitted to participate based on Medicaid bed days threshold.
 - About 500 of the state's 1,200 nursing facilities are currently participating.
- **Payment Type:** Directed payment; quality-based.
- **Funding:** Estimated \$400 million in All Funds for FFY 2018.
 - Costs are included in 1115 Waiver budget neutrality calculation.
 - Non-federal share of funding will be provided by participating local governmental entities with taxing authority.



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Uniform Hospital Rate Increase Program (UHRIP)

- **Authority:**
 - Federal - 42 CFR 438.6(c).
- **Concept:** Raises reimbursement rates for specific hospitals in an SDA and directs MCOs to make those increased payments.
- **Implementation:** December 1, 2017 – Bexar and El Paso Service Delivery Area (SDA) Pilot; March 1, 2018 – Statewide, except for Travis SDA.
- **Participants:** This is a voluntary program that cannot be implemented in an SDA unless all MCOs and the hospitals with which they contract commit to participate.
 - STAR and STAR+PLUS managed care programs only.
- **Payment Type:** Directed payment; at risk
- **Funding:** Estimated \$600 million in All Funds for FFY 2018.
 - Costs are included in the 1115 Waiver budget neutrality calculation.
 - Non-federal share of funding will be provided by participating local governmental entities with taxing authority.



Network Access Improvement Program (NAIP)

- **Authority:**
 - Federal – CMS approved NAIP concept paper in September 2014 as an incentive payment program (prior to revised Medicaid managed care rules).
- **Concept:** NAIP began as an incentive program under which MCOs partnered with health-related institutions and public hospitals to develop and implement initiatives that improved access to primary care, specialty care, and related services.
- **Implementation:** March 2015
 - November 2016 - CMS determined NAIP is a pass through payment under 42 CFR § 438.6(d), not an incentive payment program.
- **Participants:** Voluntary program – In FFY 2017 10 MCOs, 10 public hospitals, and five health-related institutions are participating.
 - At least one NAIP initiative serves STAR or STAR+PLUS members in each Medicaid SDA.
- **Payment Type:** Pass through; not at risk
- **Funding:** Estimated \$427 million in All Funds for FFY 2018
 - As a pass through, NAIP amounts in FFY 2018 cannot exceed those of FFY 2017.
 - Costs are included in the 1115 Waiver budget neutrality calculation.



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Medicaid Eligibility Graph

