# 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).

# 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.

# 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.

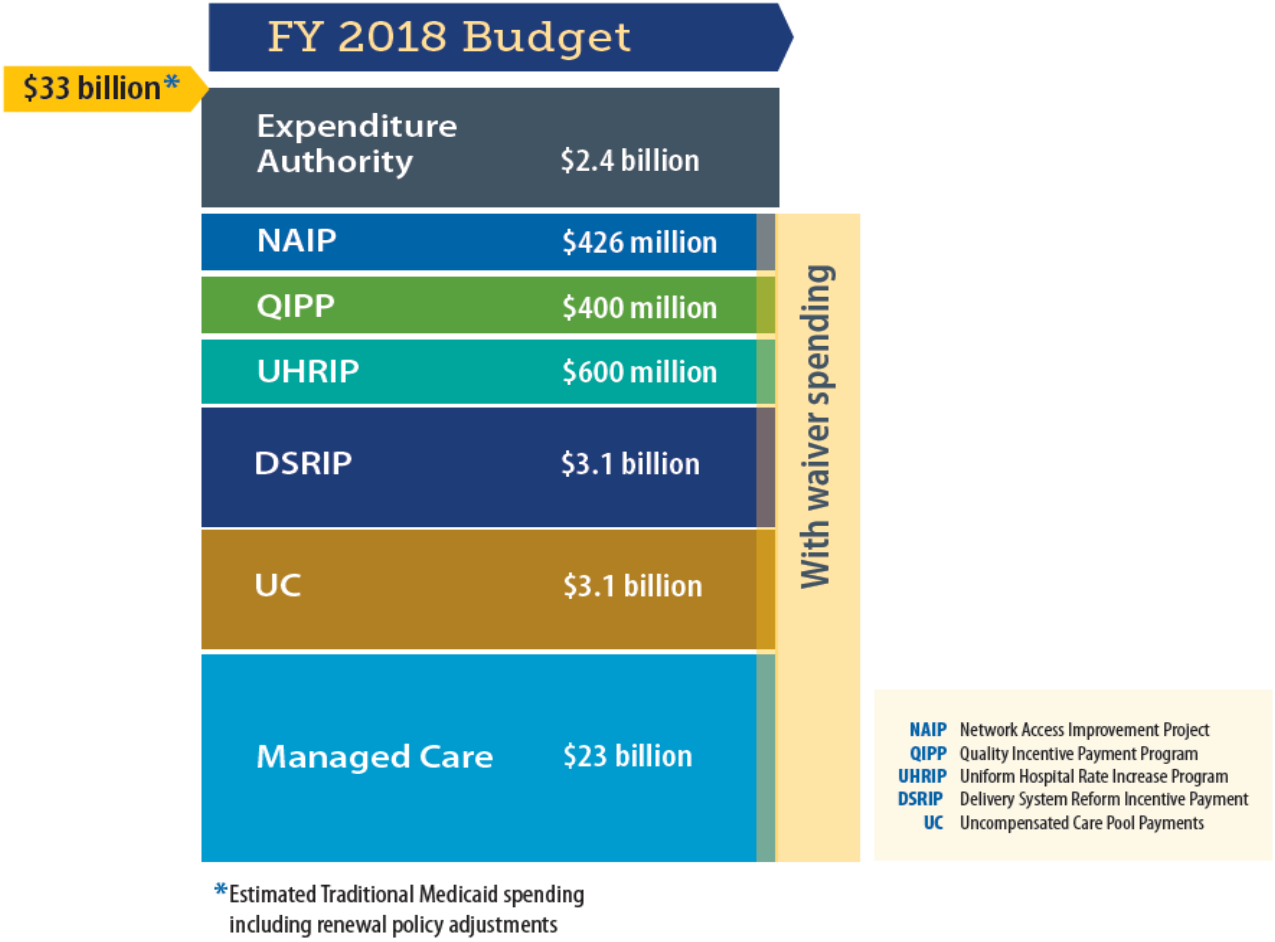
# Timeline of Key 1115 Waiver Activities

**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.



# 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.

# 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.

# 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.

# Appendix

# 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.

# 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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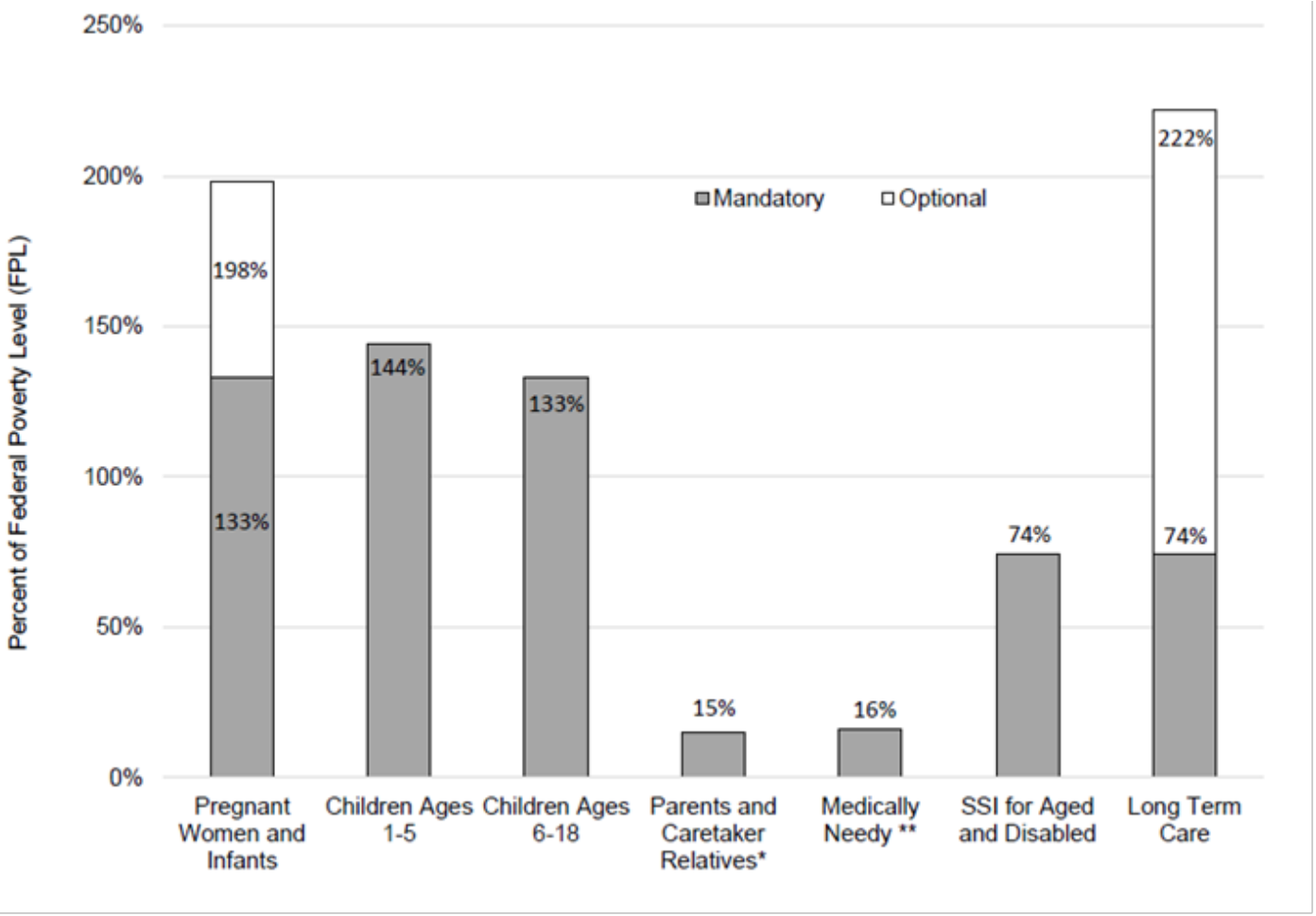
# Medicaid Eligibility Graph



# Update on HHSC's Cost Containment Plan

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April 4, 2018

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# Medicaid Cost Containment SFY 2018-19

**HHSC has identified and begun implementing cost savings initiatives that total $411 million in GR ($594 million in All Funds).**

- Rider 33 directs HHSC to achieve at least $350 million in General Revenue (GR) savings.
- In its cost containment plan, HHSC has identified $337 million in GR savings ($791 million in All Funds).
- These estimates do not include $74 million in GR ($197 million in All Funds) from adjusting the managed care risk margin (Rider 37).

# Managed Care Capitation Rates

- Identifies $101 million in GR savings through an incremental increase in the managed care savings factor based on:
  - STAR and STAR +PLUS expansions;
  - Movement of children from fee-for-service to STAR Kids; and
  - Full implementation of the managed care model.

# Seek flexibility from the federal government to improve the efficiency of the Medicaid program

- The current administration has signaled a willingness to assist state Medicaid programs in their requests for greater flexibility.
- This could include flexibility in eligibility, benefits, cost sharing requirements, and innovative program elements that encourage personal responsibility for health care.
- Now that the 1115 Waiver has been renewed, amendments to the waiver involving program flexibility can be considered.
- HHSC will seek Executive and Legislative input prior to making changes to the Medicaid program.

# Independent audit of Medicaid managed care premiums using an external actuarial firm, adjust premiums accordingly

- HHSC is currently procuring the services of an independent auditor to inform future premium rate development.
- HHSC and external actuaries currently develop the capitation rates, and external actuaries provide the actuarial soundness certification required by 42 CFR 438.4.
- Rates are approved by the Executive Commissioner, Office of the Governor, Legislative Budget Board, and CMS Office of the Actuary.

# Reinstate previous hospital eligibility criteria for Medicaid reimbursement

- HHSC identified nearly $90 million in GR savings from reinstating hospital eligibility criteria regarding rural hospital designation.
- During the 2016-17 biennium, nine hospitals began billing Medicaid at higher reimbursement levels for inpatient and outpatient services previously intended for rural hospitals only.
- These hospitals received Medicare designation as a Rural Referral Center, Sole Community Hospital, or Critical Access Hospital that were not consistent with Texas Legislative appropriation levels.
- HHSC strengthened its rules to be consistent with Rider 46 of the 2018-19 General Appropriations Act to avoid additional costs.

# Increase fraud, waste and abuse prevention, detection, and collections

- The Inspector General has eight initiatives in the cost containment plan, including:
  - $10 million in GR savings by recovering provider overpayments, which are refunded to HHSC as an offset to future Medicaid payments; and
  - $5.1 million in GR savings from increasing hospital utilization reviews in managed care.

# Overview of Nursing Facility and Assisted Living Reimbursement

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April 4, 2018

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# Nursing Facility Reimbursement Rate Methodology

- Nursing facility rates vary according to the assessed characteristics of the recipient.
- Rates are determined for 34 case mix classes of service, based upon the Resource Utilization Group (RUG) of the individual client.
- Reimbursements comprise five cost-related components: direct care staff; other recipient care; dietary; general and administration; and fixed capital asset component.
- Cost information is derived from the nursing facility cost report, which is required to be submitted to HHSC on an annual basis.

# Nursing Facility Base Rate Comparison

- The base rate for clients in a nursing facility ranges from $82.56 to $193.36 per day.
  - Clients receiving a RUG score that would pay at the lowest rate might need assistance with bathing, cooking, dressing themselves, and other activities of daily living.
  - Clients receiving a RUG score that would pay at the highest rate must need extensive care and interventions. They must also need at least one of the following interventions: feeding tube; a ventilator or tracheostomy; IV medications; suctioning; extensive assistance with activities of daily living; or need a an extensive amount of rehabilitative therapies (PT, OT, or Speech Therapy).
  - Per Legislature direction, the base rates were adjusted on September 1, 2014.
- Sec. 533.00251(c) requires HHSC to ensure that there is a "minimum reimbursement rate paid to a nursing facility under the managed care program."
- HHSC requires all managed care organizations (MCOs) to pay rates at or above the fee-for-service (FFS) rate schedule.
- Approximately, 12 percent of clients are served in FFS and 88 percent of clients are in managed care.

# Nursing Facility Rate Add-Ons

## Liability Insurance Coverage Add-on

- 76.4 percent of nursing facilities participate.
- Add-on is $1.67 per resident per day.

## Direct Care Staff Compensation Program

- 82.4 percent of nursing facilities enrolled in SFY 2018.
- 27 levels of participation.
- Add-on is $0.40 for each level per resident per day.

# Nursing Facility Rate Add-Ons

## Quality Incentive Payment Program (QIPP)

- QIPP encourages nursing facilities to improve the quality and innovation of their services, using certain quality measures from the CMS 5-star rating system as criteria for payment.
- QIPP is funded through Intergovernmental Transfers (IGTs) and federal funds.
- 514 out of 1,228 Nursing Facilities currently participate, including:
  - 430 Non-State Government Owned (NSGO); and
  - 84 Private Providers.
- In QIPP Year 1, participating nursing facilities received an average total daily rate increase of over $18 per day per client.
- QIPP Year 1 effective September 1, 2017; $400 million All Funds.
- QIPP Year 2 launches September 1, 2018; $550 million All Funds.

# Contracted Assisted Living Facilities

- Assisted Living Program – STAR+PLUS
- Residential Care Program – Fee-for-service
- Majority of days of service in contracted assisted living facilities are private pay
  - 39 percent STAR+PLUS Assisted Living and Residential Care
    - Of the 39 percent, 31 percent are in managed care and 8 percent are in FFS
  - 61 percent Private Pay

# Assisted Living / Residential Care Rates

## Fee-for-Service Residential Care

- 35 Rate Enhancement Levels
- $30.29 to $40.60 (per client per day) depending on setting and participation level
- 33.3 percent of FFS Residential Care providers enrolled in rate enhancement in SFY 2018

## STAR+PLUS Assisted Living

- Number of Rate Enhancement Levels vary by MCO
- FFS rates are proxy rates used for informational purposes by providers and MCOs
- $21.27 to $64.79 (per client per day) depending on setting and participation level