



Presentation to the House Appropriations Subcommittee on Article II: Medicaid Long-Term Services and Support

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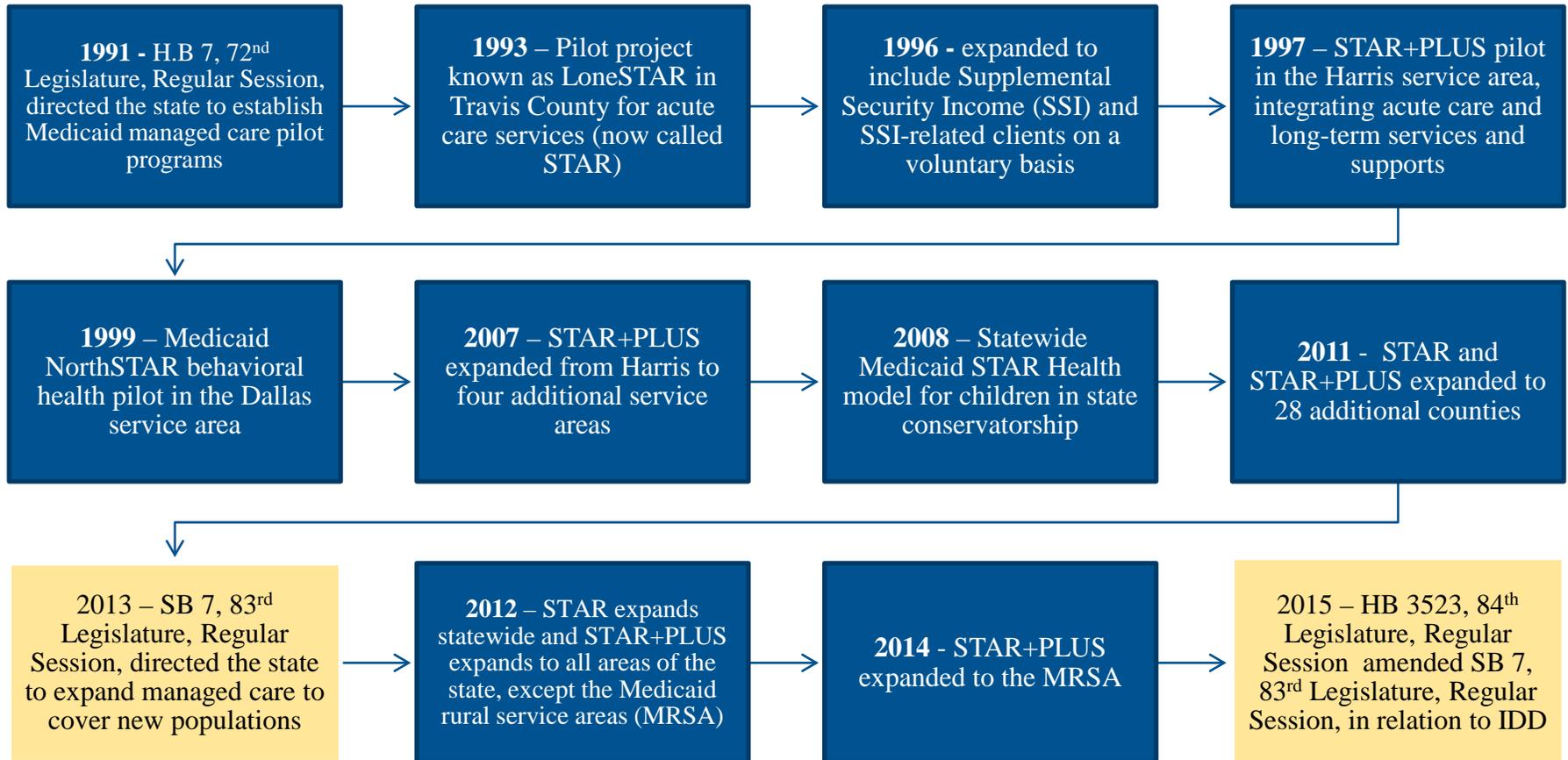
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History of Managed Care

Medicaid Managed Care Timeline



Managed Care Objectives

- Establish a medical home for clients through a Primary Care Provider (PCP)
- Emphasize preventative care
- Improve access to and quality of care
- Ensure appropriate utilization of services
- Improve health outcomes
- Improve client and provider satisfaction
- Improve cost effectiveness
- Provide disease management
- Main feature of STAR+PLUS – service coordination
 - Members in the IDD waivers are provided a named service coordinator

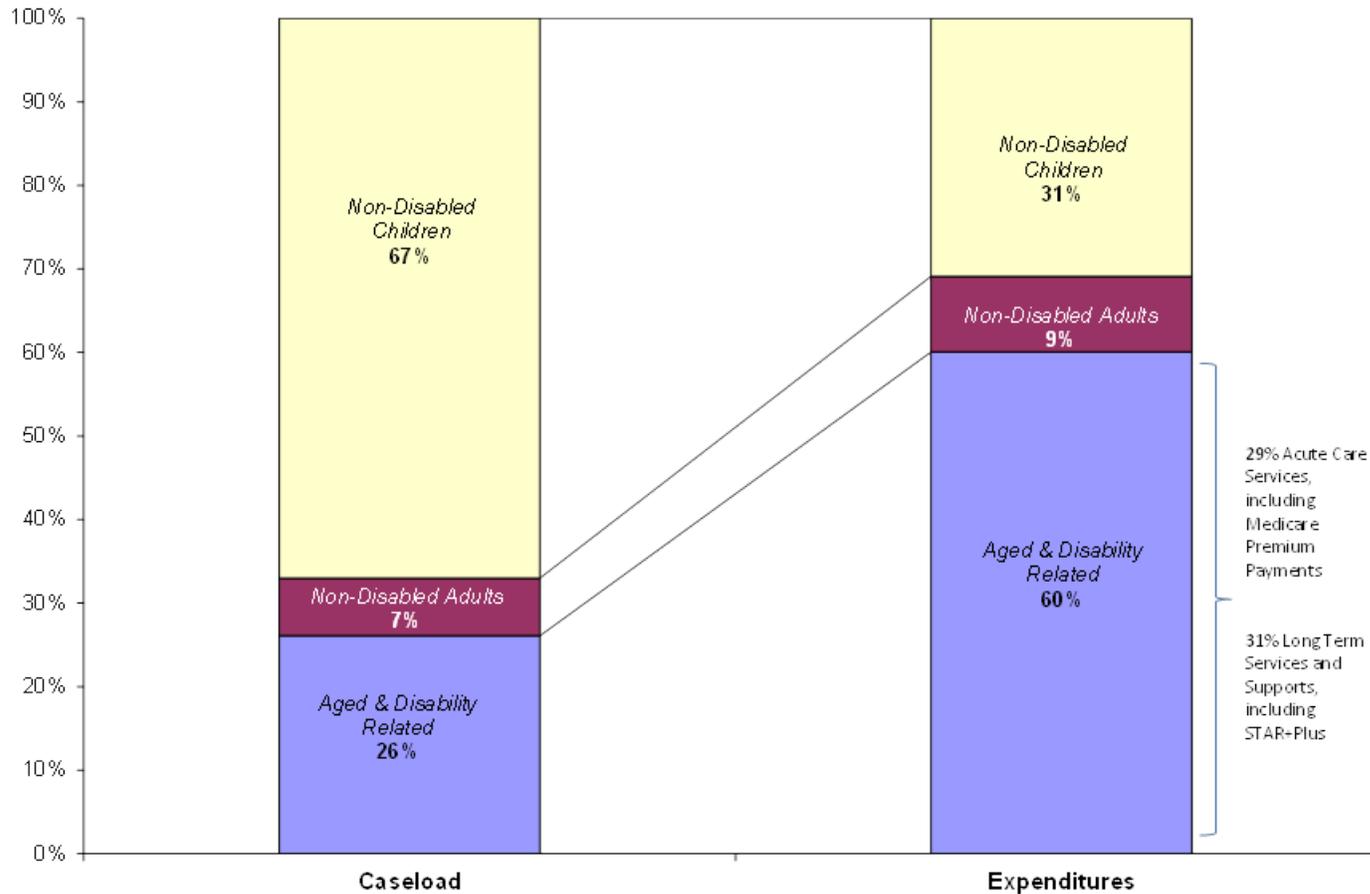
Existing Medicaid Managed Care Programs

- STAR+PLUS
 - Persons with disabilities and “dual eligibles” (eligible for both Medicare & Medicaid)
 - Integrates acute & Long-Term Services and Supports (LTSS)
 - About 581,727 members currently served
 - Main feature – service coordination
 - Specialized care management service that is available to all members and performed by an MCO service coordinator
 - Available statewide as of September 1, 2014
 - Mandatory populations
 - Voluntary populations
- Other managed care programs include STAR, STAR Health, children’s Medicaid dental services, and NorthSTAR

Recent Initiatives

- STAR+PLUS available statewide on September 1, 2014
- Individuals receiving intellectual and developmental disabilities (IDD) waiver services began receiving acute care services through STAR+PLUS on September 1, 2014
- Nursing facility services carved into STAR+PLUS on March 1, 2015
- The Medicare-Medicaid Dual Eligible Integrated Care Project (Dual Demonstration) began enrolling individuals on March 1, 2015
- Behavioral health integrated on September 1, 2014
- Community First Choice (CFC) in June 2015
- STAR Kids in November 2016
- IDD pilot in 2016

Medicaid LTSS Client Enrollment and Expenditures



Overview of Long-Term Services and Support Rate Setting

Overview of LTSS Rate Setting

Relationship between FFS Rates and Managed Care

- FFS rates and rate changes are incorporated into the calculation of managed care capitation rates.
 - Fiscal impact estimates for changes in FFS rates include the impact on both FFS and MC expenditures.
- Most contracts between managed care organizations (MCOs) and LTSS providers incorporate payment rates based on a percentage of the FFS rate for the same service.
 - Texas Government Code Sec. 533.00251(c)(1) indicates that HHSC is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program.
- HHSC produces “proxy” rates for former FFS services that have been totally carved into managed care such as Community Based Alternatives (CBA) and Star+Plus Community First Choice (CFC).
- HHSC administers the Nursing Facility Direct Care Rate Enhancement program for the MCOs.
- HHSC is currently working with the MCOs to increase HHSC oversight of the Community Care Attendant Compensation Rate Enhancement program.

Overview of LTSS Rate Setting Service & Provider Types - Timeframes

LTSS Services / Providers include:

- Currently Administered by DADS
 - Nursing Facilities (NF)
 - Private ICF/IDD
 - IDD Community-based waivers (HCS, TxHmL)
 - Non-IDD Community-based waivers (CLASS, MDCP, DBMD)
 - State plan Community-based services (PHC, DAHS)
 - State Supported Living Centers (SSLC)
- Administered by DFPS
 - Child Foster Care including Foster Care Redesign (24 RCC and FCR)
- Administered by DSHS
 - MH Community-based waivers (YES, HCS-AMH)
- Administered by HHSC
 - Star+Plus

Timing: Frequency of LTSS FFS Rate Updates

- Majority of programs: Only updated as a result of appropriations – typically biennially
- Hospice, Veterans NFs, Pediatric NFs, SSLC - annually

Methodology: Prospective, cost report based

- Applies to NF, private ICF/IDD, HCS/TxHmL, CLASS, PHC, DAHS, 24-RCC
- Based on historical Medicaid cost report financial information from providers, projected to rate period
- Established in advance of service provision; no retrospective cost settlement
- Typically adjusted at beginning of state biennium and effective for two years
- Adjusted to reflect appropriations
- Associated rate enhancement programs (except for 24-RCC) to incentivize increased direct care worker pay, benefits and, for NFs, staffing ratios.
- Minimum wage requirements for all community care attendants (\$8.00 per hour)

Methodology: Cost based

- Applies to Veterans NFs, SSLCs, Pediatric NFs
- Interim rates are paid and cost settlement occurs after end of rate year
- Costs determined through cost reports
- Adjusted annually

Methodology: Modeling

- Applies to MDCP, DBMD, YES, HCS-AMH, CFC
- When historical costs are unavailable (new programs, small programs), reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

Methodology: Dictated by Federal Law

- Applies to Hospice (both Hospice-NF and Hospice-Community)
- Hospice-NF – federally required to be at least 95% of rate paid to NF for non-Hospice resident; updated whenever NF rates are updated (will not be carved-in to managed care)
- Hospice-Community – federally mandated; updated annually every October

- LTSS Medicaid cost reports are designed and maintained by HHSC.
- Administered through web-based application
- Cost report preparers are required to take web-based training every other year.
- Cost reports are collected from both FFS and managed care providers. Currently, HHSC collects cost reports from over 6,000 providers annually.
- Allowable and unallowable costs are regulated by Texas Administrative Code rules that are similar to Medicare and Office of Management and Budget (OMB) rules.
 - No related-party mark-ups
 - 30-year useful lives; no accelerated depreciation
 - No advertising, luxury vehicles
 - Costs must be related to provision of services
- 100% of cost reports are reviewed by HHSC Rate Analysis cost report auditors.
- Costs are inflated from the reporting period to the rate period.
- Rates are typically based on average costs (for direct care) or median costs (for non-direct care) costs.

Overview of LTSS Rate Setting Attendant Compensation

- Attendants provide the majority of services to consumers in DADS and HHSC community-based programs.
- Demand for new attendants is expected to increase over the next decade due to:
 - Aging of baby boomers, family caregivers and existing attendant workforce
 - Increasing prevalence of various disabilities
- Retention of attendants is challenging, in part due to low compensation levels.
- Legislative actions regarding attendant compensation:
 - 83rd Legislature:
 - Appropriated \$68.7 million GR for the 2014-15 biennium to support increases in base wage of attendants to \$7.50 per hour in FY 2014 and to \$7.86 per hour in FY 2015.
 - Appropriated \$20 million GR for the 2014-15 biennium for additional Attendant Compensation Rate Enhancement levels for DADS community care programs and HHSC Star+Plus
 - 84th Legislature:
 - Appropriated \$38.0 million GR for the 2016-17 biennium to support increases in base wage of attendants to \$8.00 per hour.
 - Appropriated \$7.5 million GR for the 2016-17 biennium for additional Attendant Compensation Rate Enhancement levels for DADS community care programs and HHSC Star+Plus
- HHSC 2018-19 Consolidated Budget will include a table of attendant hourly wages currently included in rates and cost of increasing attendant wages by \$1.00 per hour for various community care programs at DADS and HHSC.

Overview of LTSS Rate Setting Rate Enhancement Programs

Attendant Compensation Rate Enhancement

- Created by 76th Legislature through DADS Rider 37 to incentivize increased compensation for community care attendants.
- Voluntary program.
- Participating providers must spend approximately 90% of their total attendant revenues, including their enhancement funds, on attendant compensation (salaries, payroll taxes, benefits and mileage reimbursement).
- Participants failing to meet their spending requirements are subject to recoupment of enhancement funds associated with unmet spending requirements.
- Non-IDD providers can access up to \$1.75 per hour in additional funds for their attendants; IDD providers can access up to \$1.25 per hour in additional funds.

Direct Care Staff Rate Enhancement

- Created by 76th Legislature through DADS Rider 38 to incentivize increased direct care (RN, LVN, nurse aide) staffing, wages and benefits in NFs.
- Similar to Attendant Compensation Rate Enhancement except that requirements can be met through a combination of direct care staff hours and compensation.
- NFs can access up to \$10.80 per day of service in additional funds for their direct care staff.

“Medicaid Shortfall”

- In general, LTSS rates are below those calculated through the adopted rate methodologies. For example, fully-funding the NF rate methodology for 2016-17 would have required an additional \$43.5 million AF.
- Rates for IDD programs, which are typically over 99% Medicaid, are closer to fully funding the adopted rate methodologies due to the limited ability of these providers to cross-subsidize from private pay and Medicare claims.

Supplemental Payments

- NF upper payment limit (UPL) program for non-state government-owned & operated NFs; terminated 2/28/15 with NF carve-in to managed care.
- ICF UPL program for non-state government-owned and operated ICFs.
- NF minimum payment amounts program (not a supplemental payment program), effective 3/1/15, replaced NF UPL program for non-state government-owned and operated NFs.
 - Currently flows approximately \$500 million AF per year in additional payments to 250 NFs
- Non-federal share is funded through intergovernmental transfers (IGT)

Sec. 43 - Rate Limitations and Reporting Requirements (as applies to FFS rates)

- Requires LBB and Governor approval for any rate that would result in expenditures that exceed, in any fiscal year, the amounts appropriated to a strategy for the services to which the rate applies.
- Exceptions to required approval:
 - Rates for new procedure codes required to conform to Federal Healthcare Common Procedure Coding System (HCPCS) updates;
 - Revised rates occurring as a result of a biennial calendar fee review;
 - Any rate change estimated to have an annual fiscal impact of less than \$500,000 in General Revenue-related Funds or TANF Federal Funds.
- Requires quarterly reporting of all exceptions.
- Requests for approval are considered to be approved unless the LBB or the Governor issues a written disapproval within 15 business days of the date on which the staff of the LBB concludes its review of the request for authorization for the rate.

Overview of LTSS Rate Setting Consolidated Budget

Produced by HHSC prior to each legislative session; includes information on provider rates: 1) % rate increase required to fully-fund rate methodology for each program/service; 2) cost of a 1% rate change by program/ service. The 1% rate increment figures can be used to estimate the cost/savings to the state for each 1% rate increase/decrease. Example is included below; full document is available at: http://www.hhsc.state.tx.us/about_hhsc/finance/2016-2017.pdf

Estimated Cost of 1 Percent Rate Change													
KEY - A - Access based													
B - Based on rates from other Medicaid programs													
CR - Cost Reports used for prospective rate - trend to FY 2016-17													
T - Trending from current rate to FY 2016-17													
M - Based on Medicare rates													
BR - Blue Ribbon file of claims data													
CD - Percent of claims data													
PA - Pro forma analysis													
Program by Budget Agency	Last Rate Increase		Rate Reduction Since Last Rate Increase		Method of Determining Rate Change	Estimated 2014-2015 Biennial Cost		Percentage Rate Change to Fully Fund Methodology		Estimated Biennial Cost of Rate Change		Estimated Biennial Cost of 1 Percent Rate Change	
	Date	Percent	Date	Percent		AF	GR	2016	2017	AF	GR	AF	GR
	DADS												
Service Coordination (ID)	6/1/2010	5.00%	NA	NA	CR	180,794,540	75,174,370	2.60%	2.60%	5,507,806	2,353,761	2,118,386	905,292
PASRR Assessment	NA	NA	NA	NA	T	1,467,854	366,964	0.00%	0.00%	0	0	0	0
PASRR Specialized Services	NA	NA	NA	NA	T	3,667,290	1,524,859	0.00%	0.00%	0	0	0	0
Community Attendant Services	9/1/2014	Increase in attendant base wage rate to \$7.86 per hour	NA	NA	CR	1,133,125,395	448,616,808	2.81%	2.81%	34,199,956	14,615,511	12,170,803	5,201,250
Community Living Assistance and Support Services	8/1/2009	\$0.80 per hour minimum wage rate increase	NA	NA	CR	435,278,270	168,406,968	2.80%	2.80%	13,427,462	5,133,990	4,795,522	1,833,568
Day Activity and Health Services – Title XIX	9/1/2014	Increase in attendant base wage rate to \$7.86 per hour	NA	NA	CR	18,062,040	7,273,957	5.19%	5.19%	757,192	323,590	145,783	62,301
Deaf-Blind Multiple Disabilities	6/15/2010	18% increase for Intervenor	NA	NA	B	20,560,127	8,053,322	3.91%	3.91%	1,024,596	412,041	262,046	105,382

Recruitment and Retention Strategies for Community Attendants

Overview of LTSS Rate Setting Recruitment and Retention Survey

- HHSC Rider 89 Recruitment and Retention Strategies: Out of funds appropriated above, the Health and Human Services Commission shall develop recruitment and retention strategies for community attendants to address the projected shortage of attendants.
- HHSC Rate Analysis is collecting data for this project through cost reports and a provider survey.
- 2015 cost reports will collect data on attendant average hourly wages, benefits and turnover.
- On-line survey will collect detailed data on:
 - Initial wages paid to attendants
 - Basis of wage increases (e.g., additional training completed; length of employment; merit-based increases).
 - Additional opportunities wage enhancements (e.g., for bilingual and ASL proficient attendants; attendants working in high wage areas of the state; attendants working in remote areas of the state; attendants working with high needs consumers, etc.)
 - Estimated time required to fill an attendant vacancy
 - Average length of employment for direct care workers
- Results should be available in early summer 2016

Overview of LTSS Rate Setting

Potential Topics of Interest

- Impact of ACA employer mandated health insurance coverage on provider costs
- Impact of federal Department of Labor (DOL) elimination of the attendant exemption from the Fair Labor Standards Act (FLSA) on provider and consumer directed service (CDS) costs
- Impact of new federal home and community based service (HCBS) Setting rule on provider costs relating to day habilitation

APPENDIX

SB 7, 83rd Legislature, Regular Session, 2013
HB 3523, 84th Legislature, Regular Session, 2015
Side-by-Side Timeline Comparison of Managed Care Changes
March 2016

Date	SB 7 Requirement	HB 3523 Changes to SB 7 Requirement	Advisory Committee Changes by SB 200*
2013			
9/1/2013	Deadline to convert outpatient hospital reimbursement systems to PPS Requirement to establish STAR Kids Advisory Committee Implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with disabilities under the STAR+PLUS Medicaid managed care program ➤ Requires HHSC to seek to maximize federal funding for the delivery of services for that program <i>Note: Community First Choice (CFC) implemented 6/1/2015</i> Bill effective date		
9/15/2013	Deadline to appoint STAR+PLUS Nursing Facility (NF) Advisory Committee members		
10/1/2013	Deadline to appoint Intellectual and Developmental Disabilities (IDD) System Redesign Advisory Committee (SRAC) members Deadline to appoint STAR+PLUS Quality Council members Deadline to appoint additional members to the State Medicaid Managed Care Advisory Committee Deadline to complete Phase I of NF transition into STAR+PLUS and submit report		Removes this committee from statute. HHSC EC directed this committee to continue operations with expanded scope to include the functions of the STAR+PLUS Nursing Facility Committee.
12/1/2013	Deadline for first state Medicaid managed		

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	care advisory committee meeting with additional members		
2014			
1/1/2014	Deadline to adopt rules and guidelines regarding transition of functions to managed care organizations (MCOs)		
	Deadline to implement expanded Department of State Health Services (DSHS) mental health priority populations		
	Deadline for local mental health authorities to incorporate jail diversion strategies into disease management practices		
7/15/2014	Deadline for Phase II of NF transition into STAR+PLUS and submit report		
9/1/2014	First date STAR+PLUS can expand statewide <i>Note: STAR+PLUS expanded statewide on this date.</i>		
	First date NF services can transition into STAR+PLUS Note: Full implementation occurred on 3/1/2015.		
	First date for IDD acute care carve-in to STAR+PLUS <i>Note: IDD acute care carve-in was implemented through STAR+PLUS on this date.</i>		
9/30/2014	Due date for annual IDD system redesign report		
11/1/2014	Due date for annual STAR+PLUS Quality Council report		
12/1/2014	Due date for report on role of local authority as service provider		
	Due date for Prader-Willi Syndrome report		
12/1/2014	Due date for automatic managed care		

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	enrollment report		
	Due date for HHSC STAR+PLUS Quality Council report		
2015			
1/15/2015	Due date for Income disregard report		
	Due date for Senate Health and Human Services Committee and House Human Services Committee report regarding STAR+PLUS NF carve-in		
6/19/2015		<p>Bill effective date</p> <p>Requires DADS to consult and collaborate with the Intellectual and Developmental Disabilities System Redesign Advisory Committee. This broadens the committee's role in development of the IDD pilot and to make changes to the goals of the pilots.</p>	
9/1/2015	<p>First date for STAR Kids implementation (including MDCP transition into STAR Kids)</p> <p><i>Note: Full implementation is scheduled for 11/1/2016.</i></p>		
9/30/2015	Due date for annual IDD system redesign report		
11/1/2015	Due date for annual STAR+PLUS Quality Council report		

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2016			
6/1/2016	Due date for report on basic attendant and habilitation services program (CFC)		
9/1/2016	Date STAR+PLUS NF Advisory Committee is abolished		Removes this committee from statute. HHSC EC directed to consolidate functions into the State Medicaid Managed Care Advisory Committee.
	Date STAR Kids Managed Care Advisory Committee is abolished		Statutory authority - Texas Government Code §533.00254. Removed this committee from statute on the first anniversary of the date HHSC completes implementation of the STAR Kids program. HHSC EC directed this committee to continue operations and changes addressed in rule.
	Deadline to implement IDD pilots	Delays this implementation to 2017 and allows the pilots to operate for <u>up to</u> 24 months rather than for <u>at least</u> 24 months.	
9/30/2016	Due date for annual IDD system redesign report	Requires HHSC to consult and collaborate with the IDD SRAC on the report.	
11/1/2016	Due date for final STAR+PLUS Quality Council report		
12/1/2016	Due date for annual MDCP report		
	Due date for HHSC STAR+PLUS Quality Council report		
12/1/2016	Due date for IDD pilot report	Requires the IDD pilot	

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		report to be incorporated as a part of the IDD system redesign report due September 30 th of each year.	
2017			
1/1/2017	Date STAR+PLUS Quality Council is abolished		Removes this committee from statute. HHSC EC directed this committee reconstitute as a subcommittee of the State Medicaid Managed Care Advisory Committee until 9/1/2016. At that time, the State Medicaid Managed Care Advisory Committee will make a recommendation to the HHSC EC on the effectiveness of structure.
8/31/2017	Date NF significant traditional provider (STP) provision expires <i>Note: The bill language indicated 9/1/2014 was the first date NF services can transition into STAR+PLUS. Full implementation occurred on 3/1/2015 and this required the date the NF STP provision expired to be extended six months to 2/28/2018.</i>		
9/1/2017	Deadline to transition provision of some or all TxHmL benefits to STAR+PLUS	Delays this deadline by one year to September 1, 2018.	
		Deadline to implement IDD managed care pilot.	
9/30/2017	Due date for annual IDD system redesign report		
12/1/2017	Due date for annual MDCP report		
2018			

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2/28/2018	Date NF STP provision expires <i>Note: The bill language indicated 9/1/2014 was the first date NF services can transition into STAR+PLUS. Full implementation occurred on 3/1/2015 and this required the date the NF STP provision expired to be extended six months to 2/28/2018.</i>		
8/31/2018	Provision requiring state management of formulary and preferred drug lists expires		
9/1/2018	Deadline for IDD pilots to terminate	<i>Note: This date could change to 9/1/2019. HB 3523 text in one part requires termination by 9/1/2018, but also states the pilot can operate for up to 24 months and requires implementation by 9/1/2017.</i>	
9/1/2018		Deadline to transition provision of some or all TxHmL benefits to STAR+PLUS	
9/30/2018	Due date for annual IDD system redesign report (must include information about the pilot program)		
12/1/2018	Due date for annual MDCP report		
2019			
9/1/2019	Expiration of certain provisions relating to nursing facilities. HHSC requirements relating to minimum credentialing standards, claims processing timeframes, utilization management criteria, minimum reimbursement, and prior authorization expire		
		Deadline for IDD pilots to terminate	

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9/30/2019	Due date for annual IDD system redesign report (including evaluation of STAR+PLUS transition outcomes and IDD pilot information)		
12/1/2019	Due date for annual MDCP report		
2020			
9/1/2020	Deadline to transition provision of some or all HCS, CLASS, DBMD, and community ICF benefits to STAR+PLUS <i>Note: This provision is subject to other SB 7 provisions allowing individuals to remain in their waivers and allowing HHSC to keep operating the waivers or ICF program only for purposes of providing supplemental LTSS not available in managed care.\</i>	Changed this date to 9/1/2021.	
9/30/2020	Due date for annual IDD system redesign report (including evaluation of STAR+PLUS transition outcomes)		
12/1/2020	Due date for annual MDCP report		
2021			
9/1/2021		Changed the deadline from 9/1/2020 to 9/1/2021 to transition provision of some or all HCS, CLASS, DBMD, and community ICF benefits to STAR+PLUS <i>Note: This provision is subject to other SB 7 provisions allowing individuals to remain in their waivers and allowing HHSC to keep operating the waivers or ICF program only for purposes of providing supplemental LTSS not available in managed care</i>	

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9/1/2021		HHSC no longer sets minimum nursing facility unit rates (directed by HB 3523).	
9/30/2021	Due date for annual IDD system redesign report		
2022			
9/30/2022	Due date for annual IDD system redesign report (includes evaluation of STAR+PLUS transition outcomes)		
2023			
9/30/2023	Due date for final annual IDD system redesign report	Extended the expiration date of this report. HB 3523 statute expires January 1, 2026, so final report due date moved to 9/30/2025.	
2024			
1/1/2024	Date IDD System Redesign Advisory Committee is abolished	Delayed the committee's expiration date to 2026.	Statutory authority - Texas Government Code - §534.053. Removes this committee from statute on the first anniversary of the date HHSC completes implementation. HHSC EC directs this committee to continue operations and changes addressed in rule.
2025			
9/30/2025		Due date for final annual IDD system redesign report. Statute expires January 1, 2026.	

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2026			
1/1/2026		Date the IDD System Redesign Advisory Committee is abolished	Removed this committee from statute. HHSC EC recommended to continue operations and changes addressed in rule.

*SB 200, 84th Legislature, Regular Session, 2015 - HHSC Sunset legislation

Advisory Committees:

In SB 200 legislation, most advisory committees were eliminated from statute as of 12/31/2015 (the article took effect 1/1/2016), but some of the committees still exist in statute, and the HHSC Executive Commissioner is directing most to continue in rule. Complete information on the HHSC transformation website: <http://www.hhsc.state.tx.us/hhs-transformation/advisory-committees.shtml>