



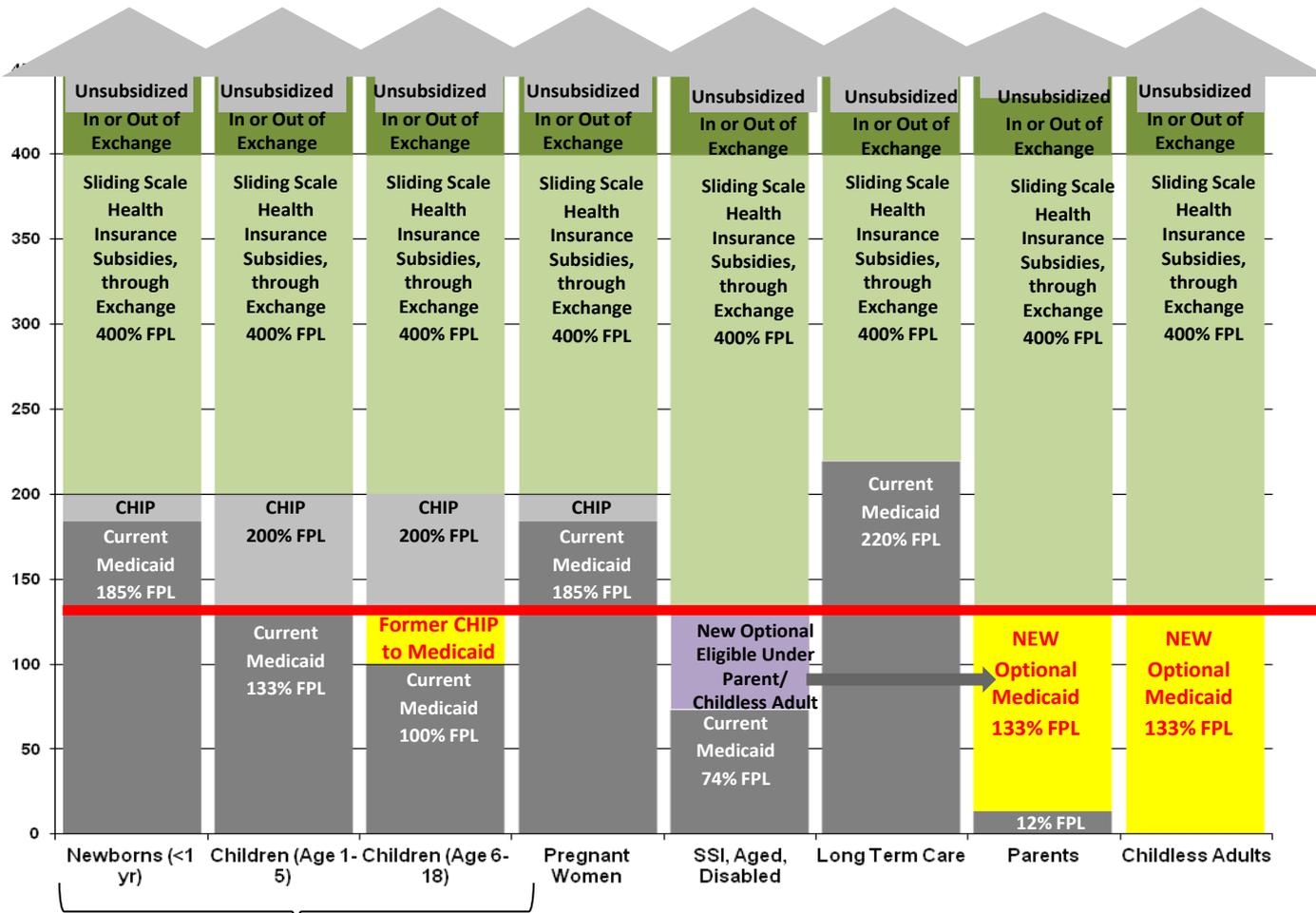
Presentation to the Senate Committee on Health and Human Services: Medicaid and the Affordable Care Act

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August 14, 2014

Texas Medicaid: Eligibility



MOE for Children expires September 30, 2019

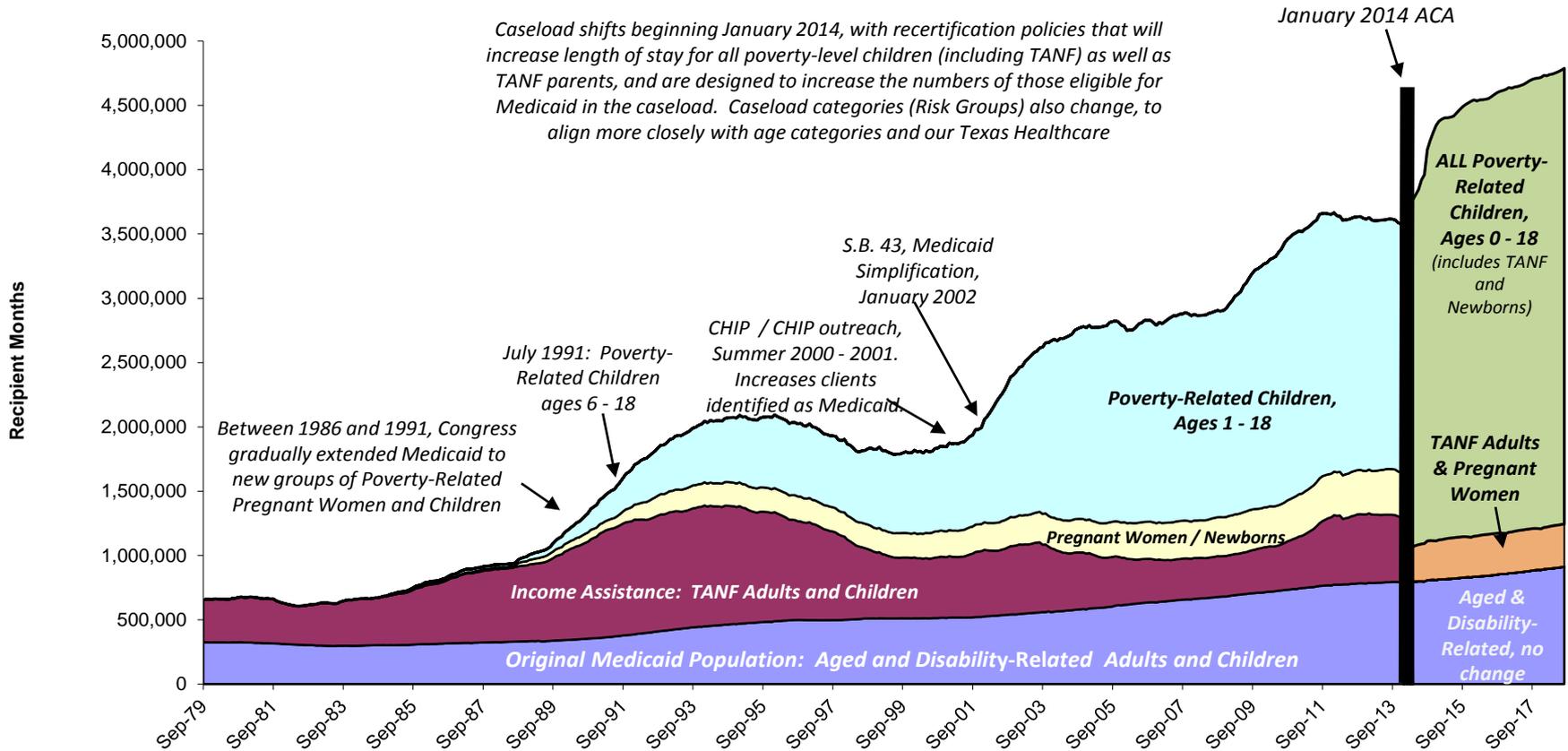
133%*

*Eligibility determination for the ACA Medicaid Expansion population includes a 5 percentage point income disregard, effectively bringing the eligibility limit to 138% FPL.

Texas Medicaid: Caseload

Texas Medicaid Caseload by Group, September 1979 - August 2018

Caseload shifts beginning January 2014, with recertification policies that will increase length of stay for all poverty-level children (including TANF) as well as TANF parents, and are designed to increase the numbers of those eligible for Medicaid in the caseload. Caseload categories (Risk Groups) also change, to align more closely with age categories and our Texas Healthcare



Texas Medicaid: Caseload

Policy Impacts of Affordable Care Act on Medicaid Caseload

ACA-Related Caseload Additions to Medicaid - June 2014 Forecast

ACA-Related Caseload Additions to Medicaid	FY 2014	FY 2015	FY 2016	FY 2017
<i>12-Month Recertification</i>	8,893	168,016	222,364	244,461
<i>Previously Eligible, Newly Enrolled</i>	39,848	138,694	167,281	170,310
<i>Foster Care to Age 26</i>	1,498	4,952	5,317	5,623
<i>Hospital Presumptive Eligibility</i>	-	4,374	13,433	13,488
<i>CHIP to Medicaid (not "New" clients)</i>	40,190	248,939	283,337	288,668
Total	90,429	564,976	691,732	722,549

HHSC Financial Services, June 2014

April 2014 Forecast, Update June 2014

Note: All FY 2014 numbers are average monthly Recipient Months (annualized)

Previously Eligible, Newly Enrolled clients are those who come on to caseload through marketplace referrals or "welcome mat" impact, and serve to increase our take-up rate

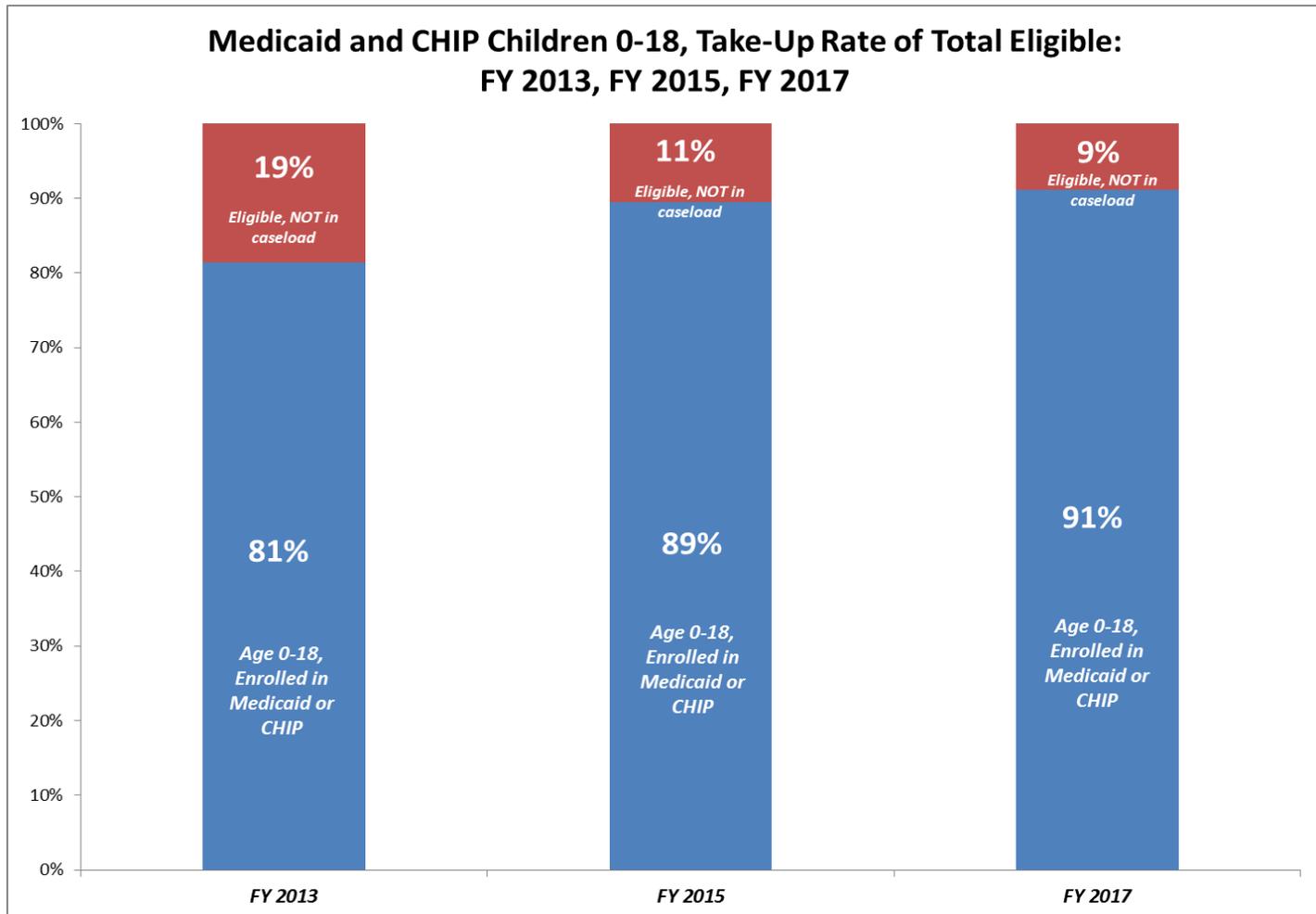
Texas Medicaid: Caseload

Average Monthly Recipient Months

Fiscal Year	Medicaid				CHIP	Total Medicaid and CHIP
	Aged and Disability Related	Adults	Children	Total		
FY 2004	567,007	246,018	1,870,202	2,683,227	409,865	3,093,092
FY 2005	589,587	238,297	1,951,489	2,779,373	333,707	3,113,080
FY 2006	619,495	226,601	1,945,910	2,792,007	308,762	3,100,768
FY 2007	642,940	215,802	1,973,472	2,832,214	325,744	3,157,958
FY 2008	665,012	207,761	2,004,429	2,877,203	447,651	3,324,854
FY 2009	690,078	208,562	2,105,740	3,004,380	534,091	3,538,471
FY 2010	717,849	218,927	2,359,582	3,296,358	570,333	3,866,691
FY 2011	747,475	230,115	2,563,696	3,541,286	577,102	4,118,388
FY 2012	772,686	244,232	2,635,571	3,652,489	606,899	4,259,388
FY 2013	787,075	251,453	2,615,407	3,653,935	630,683	4,284,619
FY 2014 YTD	796,394	266,907	2,678,887	3,742,188	561,141	4,303,329

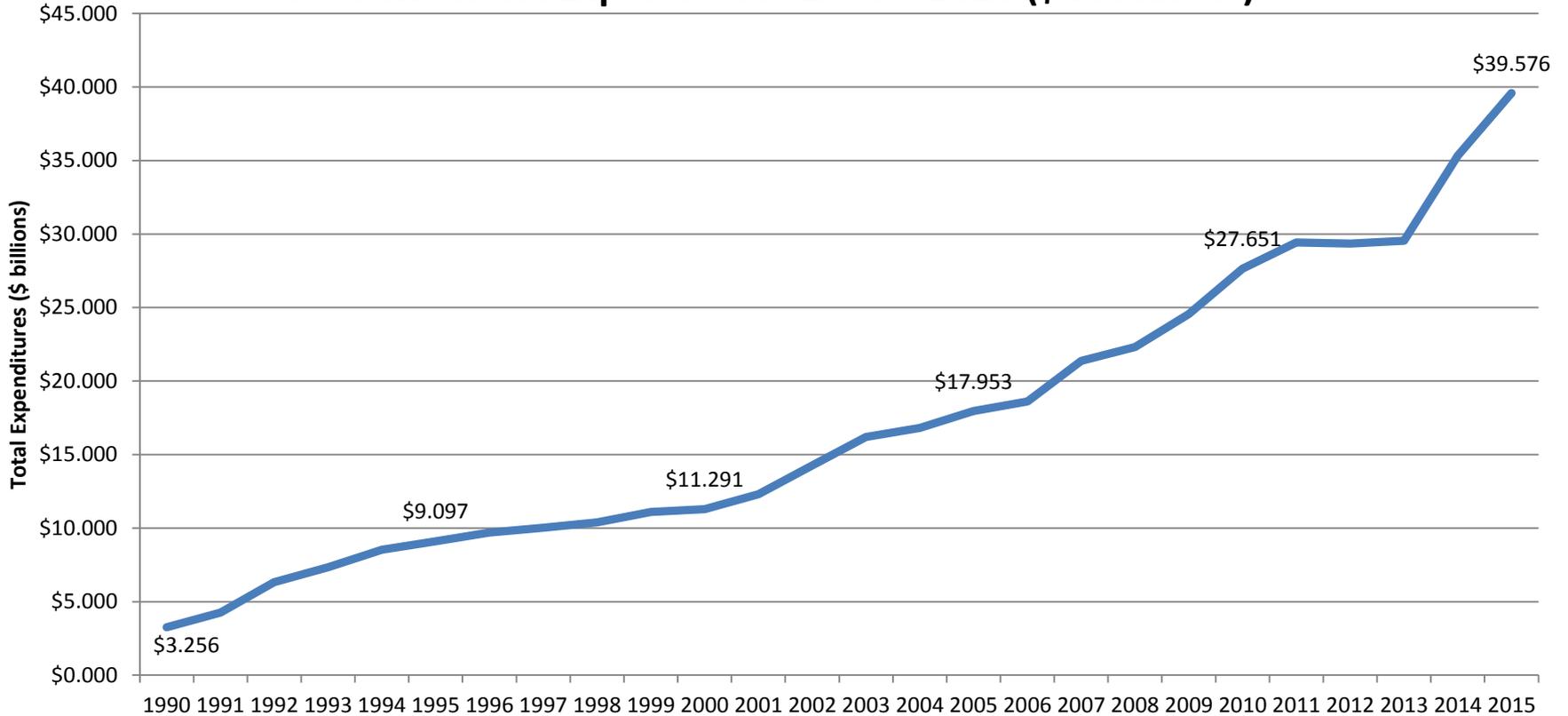
Medicaid data from February 2014 and forward is estimated using data received (over 90% of data is received in the first month) and historical completion factors. These numbers will change until final (at 8 months). CHIP includes traditional CHIP and the CHIP perinatal program. CHIP Perinatal data is not final, and data from November 2013 forward are pending. Shaded areas represent estimates.

Texas Medicaid: Caseload



Texas Medicaid: Cost

Total Medicaid Expenditures 1990 – 2015 (\$ in billions)



Expenditures include client services, administration, and supplemental payments (DSH, UPL, UC, and DSRIP).

HHSC Strategic Decision Support

Uncompensated Care

Uncompensated Care Costs (\$ in billions)			
	2010	2011	2012
Uncompensated Care Costs	\$5.278	\$6.198	\$6.467

Uncompensated Care Costs by Hospital Type (\$ in billions)			
	2010	2011	2012
Public	\$2.559	\$2.929	\$2.930
Private Not-for-Profit	\$1.976	\$2.260	\$2.542
Private For Profit	\$0.743	\$1.008	\$0.994

*May not sum due to rounding.

Average per Hospital Uncompensated Care Costs by Hospital Type (\$ in millions)			
	2010	2011	2012
Public	\$20.643	\$23.814	\$24.834
Private Not-for-profit	\$11.981	\$13.617	\$15.501
Private For Profit	\$2.375	\$3.443	\$3.359

Uncompensated Care: Supplemental Payment Programs

	Disproportionate Share Hospital (DSH) (All Funds)	Uncompensated Care (UC) (All Funds)	Total (All Funds)
2012	\$1,682,033,626	\$3,700,000,000	\$5,382,033,626
2013	\$1,694,336,015	\$3,900,000,000	\$5,594,336,015
2014	\$1,737,625,449	\$3,534,000,000	\$5,271,625,449

Texas Medicaid: Initiatives to Reduce ED Use

Managed Care

- Over the past several legislative sessions, HHSC has been directed to implement expansions of the Medicaid managed care model.
- Continued inclusion of more populations and services within the MCO capitation structure is expected to increase care coordination and integration, and create the conditions for innovative payment models to support these goals.
- Pay-for-Quality (P4Q) Program:
 - Provides financial incentives and disincentives to MCOs by placing 4% of their capitation at risk.
 - Includes performance measure for potentially preventable emergency department visits (PPVs).

Reimbursement Changes

- S.B. 1, Rider 51, 83rd Regular Legislative Session, 2013, directed HHSC to develop more appropriate reimbursement for non-urgent emergency department visits.
- Beginning September 1, 2013:
 - MCO premiums were reduced to reflect non-payment when a Medicaid client returns to the emergency department (ED) for a non-emergency within 36 hours; and
 - HHSC implemented a flat rate (125% of physician office visit) for non-urgent emergency department visits for both FFS and managed care.

Texas Medicaid: Premium Assistance

Health Insurance Premium Payment (HIPP) Program

- Reimburses Medicaid clients for their share or a portion of their share of an employer-sponsored health insurance premium.
- To qualify:
 - An employee or a family member must be Medicaid-eligible
 - State has determined paying premium is cost-effective
- When HIPP clients receive Medicaid-covered services from a Medicaid-enrolled provider, Medicaid pays the provider for:
 - Copayments and deductibles
 - Services not covered by the private insurance policy

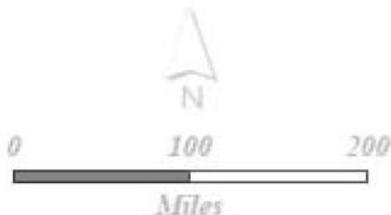
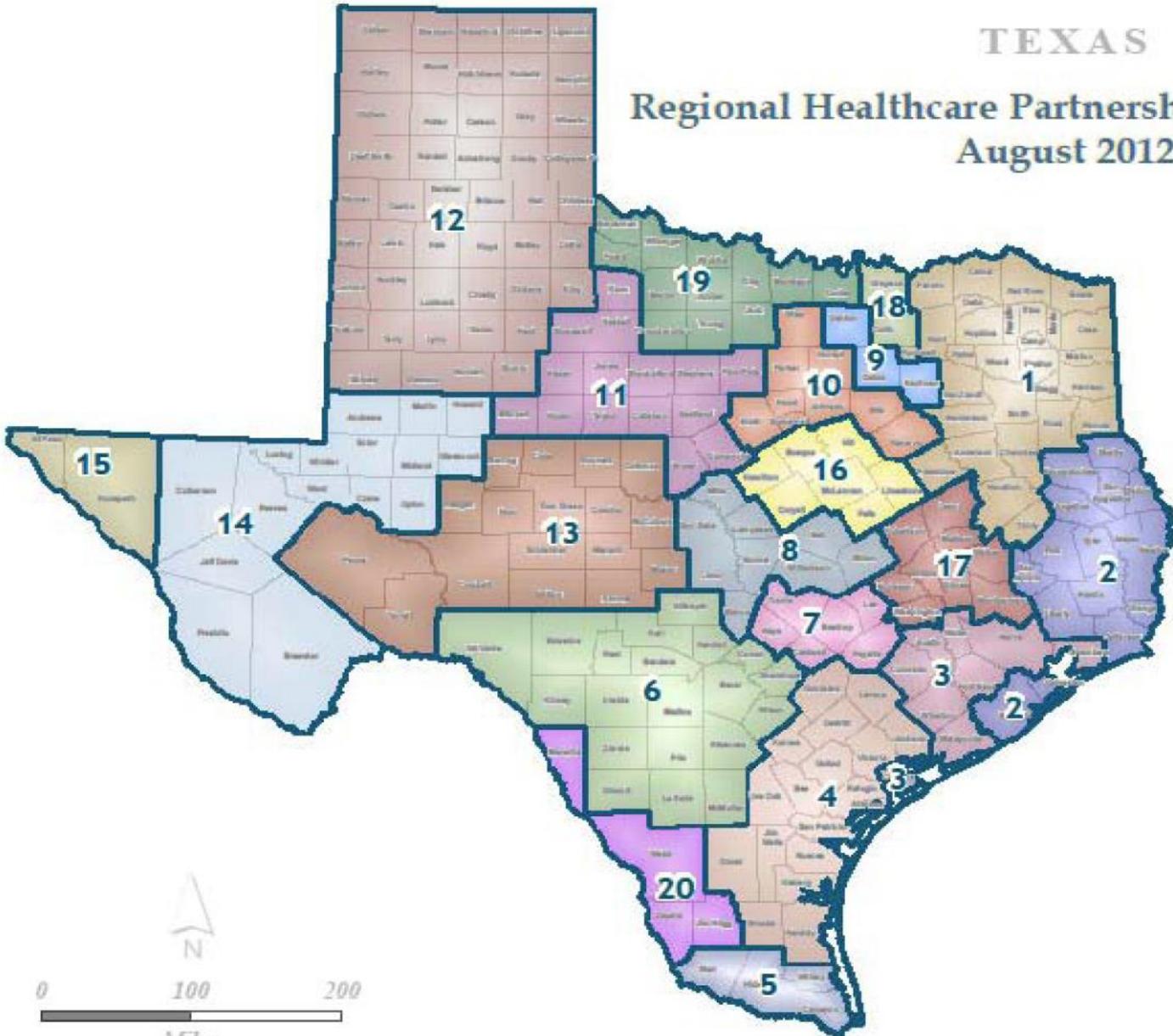
www.getHIPPTexas.com

1115 Transformation Waiver: Overview

- **Five-Year Medicaid 1115 Demonstration Waiver (2011 – 2016)**
 - Allows expansion of managed care while protecting hospital supplemental payments under a new methodology
 - Incentivizes delivery system improvements and improves access and system coordination
 - Establishes Regional Healthcare Partnerships (RHPs) anchored by public hospitals or another public entity in coordination with local stakeholders
- **Historic Upper Payment Limit (UPL) funds and new funds are distributed to hospitals and other providers through two pools:**
 - **Uncompensated Care (UC) Pool (\$17.6 billion, All Funds)**
 - Replaces UPL
 - Costs for care provided to individuals who have no third party coverage for hospital and other services
 - **Delivery System Reform Incentive Payments (DSRIP) Pool (\$11.4 billion, All Funds)**
 - New program to support coordinated care and quality improvements through 20 RHPs
 - Transform delivery systems to improve care for individuals (including access, quality, and health outcomes), improve health for the population, and lower costs through efficiencies and improvements
 - DSRIP providers include hospitals, physician groups, community mental health centers, and local health departments

TEXAS

Regional Healthcare Partnership (RHP) Regions August 2012



Map Prepared by: Strategic Division Support Department,
Texas Health and Human Services Commission,
August 7, 2012

1115 Transformation Waiver: DSRIP Projects

- There are 1491 approved and active DSRIP projects across the 20 regions.
 - 1274 4-year projects
 - 217 3-year projects
- DSRIP participants have earned over \$2.5 billion All Funds through July 2014 for submission of the regional plans and project achievement in waiver years 2 and 3.
- Most DSRIP projects have completed their start-up phase, and have successfully reported achievement of initial project activities.
- Projects have begun reporting their direct patient impact and establish benchmarks for project outcomes.
 - Providers report twice a year on project metrics and milestones completed to earn DSRIP payments.
- In the final two years of the waiver, providers will report improvement in outcome measures related to each project.
 - HHSC will conduct a mid-point assessment this year to evaluate the progress of the projects so far, including a review of each project's health outcomes of those served.

1115 Transformation Waiver: DSRIP Projects

- Many of the active DSRIP projects focus on primary care, including:
 - 232 projects to expand primary care capacity, including new clinics, mobile clinics and expanded space, hours and staffing
 - 39 projects to enhance or expand medical homes
 - 30 projects to increase training of primary care workforce
 - 21 projects to increase, enhance and expand dental services
 - 7 projects to redesign primary care.
- Almost one third of the active DSRIP projects have a behavioral healthcare focus, including:
 - 116 interventions to prevent unnecessary use of services (in the criminal justice system, ED, etc.)
 - 78 projects to enhance BH service availability (hours, locations, transportation, mobile clinics)
 - 59 projects to develop BH crisis stabilization services
 - 54 projects to integrate primary and BH care services
 - 41 projects to deliver BH care services through telemedicine/telehealth
- Over 22% (336 projects) of the active DSRIP projects have an explicit goal of reducing ED use, including:
 - 186 projects that have a proposed outcome related to reducing ED visits; and
 - 150 projects that in their brief descriptions of the project and its target population reference ED utilizers as a target population or a goal of reducing ED visits.

County Indigent Health Care Program

- Provides assistance to counties not fully served by a public hospital or hospital district that spend more than 8% of their general revenue tax levy (GRTL) on health care services.
- Counties may be reimbursed for services provided to county residents who earn up to 21% of the federal poverty level (FPL) who are not eligible for Medicaid.
- In fiscal year 2013, a total of \$269,000 in state assistance was distributed to seven counties.
- CIHCP also submits Medicaid claims for counties who have provided services to clients determined eligible for Supplemental Security Income (SSI) benefits; these claims are approximately \$500,000 to \$600,000 annually.
- County-run programs are obligated to provide basic services and may provide optional services to their eligible residents, such as:
 - Inpatient/outpatient hospital
 - Physician services
 - Prescription drugs (3 per month)
 - Labs, x-rays, and others
 - Maximum of \$30,000 each fiscal year for each eligible resident, or
 - Maximum 30 days in hospital or skilled nursing facility
 - Optional services – psychological counseling, durable medical equipment, adult dental, and transportation

Mental Health/Substance Abuse

- S.B. 58, 83rd Regular Legislative Session, 2013, directed HHSC to include covered mental health rehabilitation and targeted case management in Medicaid managed care.
- DSHS received over \$300 million in additional funding for fiscal years 2014-2015 to implement several major mental health and substance abuse initiatives that share a common set of priorities:
 - Increasing the public's understanding of mental illness
 - Providing timely access to services in the most appropriate setting
 - Providing services close to home
- \$25 million (biennium) in new funds was appropriated to expand mental health crisis alternatives to hospitals, emergency rooms, or jail.
 - Requires at 25% local match and LMHAs competed for funds
 - Funds were used to expand crisis projects in 16 LMHA service areas
- Texas received a \$9.9 million grant as part of the Medicaid Incentive for the Prevention of Chronic Disease Management Model to implement the Wellness Incentives and Navigation (WIN) Program.
 - Targets Medicaid managed care members (21-55 years old) in the Harris service delivery area that have either serious mental illness or behavioral and chronic health conditions.
 - Individuals with behavioral health conditions are significantly more likely to suffer chronic physical disease and die at a younger age.
 - Prevention goals include tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and diabetes management or prevention.

Women's Health

- The Health and Human Services Enterprise administers several programs that provide women's health care services and other primary care services to low income, uninsured women:
 - Texas Women's Health Program (\$72.4 million FY 14-15)
 - DSHS Family Planning (\$43.2 million FY 14-15)
 - Expanded Primary Health Care (\$100 million FY 14-15)
 - Breast and Cervical Cancer Services (\$24.5 million FY 14-15)
 - Title V Prenatal (\$2.9 million FY 14-15)
- Title X funding shifted to the private sector (Women's Health and Family Planning Association of Texas) in 2013.
 - Approximately \$13.7 million annually in Title X Funding
 - 28 Contractors
 - Approximately 93 Clinics

Healthcare Options Survey

- HHSC is compiling a list of healthcare options for low-income, uninsured Texans using a two-phase survey designed to identify existing sources of care for this population.
- The first stage entails a survey to community-based organizations, local government and non-profit organizations.
 - This survey requests information about local providers that currently serve this population.
 - HHSC is asking for high-level information; provider name, address and contact information.
 - This survey is currently in the field; it was implemented on July 16th.
 - To date, HHSC has received 450 responses.
- The second phase of the survey will be directed to the healthcare providers identified during Phase One.
- This phase will ask for more detailed information about the healthcare provider's practice, including:
 - Eligibility requirements
 - Range of services provided
 - Location
 - Cost to clients, cost-sharing, and payment arrangements
- The purpose of this survey is to collect as much information as possible about entities that can provide healthcare services to low-income, uninsured Texans.

Federal Flexibilities

- **Flexibilities Recently Approved or Pending:**

- Health Related Institutions – Network Access Improvement Projects
- Nursing Facility Upper Payment Limit

- **Additional Flexibilities:**

- State Defined Essential Benefits
- Personal Accountability (premium sharing, missed appointment fees, independent health accounts, wellness incentives, consumer education)
- Maximize Medicaid Premium Assistance (HIPP)
- Annual Health Plan Enrollment
- Work and Job Training
- Asset and Absent Parent Information
- DSH Limit
- Expedited Federal Approval (“file and use”)
- Future of the 1115 Transformation Waiver