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Services Commission

Presentation to
SB 7 Medicaid Reform Waiver
Legislative Oversight Committee

Thomas M. Suehs, Executive Commissioner, HHSC

Billy Millwee, Deputy Executive Commissioner for Health Services Operations, HHSC

Chris Traylor, Commissioner, DADS

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SB 7 Medicaid Reform Waiver Overview

Background Information

- SB 7 Waiver Direction
- Federal Section 1115 Waivers
- Medicaid Program Information
- The Changing Medicaid Landscape

Reform Opportunities

- Acute Care Reform Opportunities
- Long Term Services and Supports (LTSS) Reform Opportunities

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SB 7 Medicaid Reform Waiver Goals and Objectives

- SB 7 directs HHSC to pursue a federal waiver seeking flexibility in the way Texas operates its Medicaid program.
- Article 13 of the bill provides guidance on the types of reforms to be pursued under the Texas waiver, including:
  - Provide flexibility to determine Medicaid eligibility categories, income levels, and benefits design
  - Encourage use of the private health benefits coverage market and employer-based health benefits
  - Establish Medicaid copayments
  - Establish health savings accounts
  - Redesign LTSS to increase access to cost-effective patient-centered care
  - Establish vouchers for consumer-directed LTSS

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Key Features of a Section 1115 Waiver

- Section 1115 of the Social Security Act allows waiver of certain federal requirements to test new or existing approaches to financing and delivering Medicaid and CHIP services.
- However, most federal requirements cannot be waived, and the flexibilities allowed by the Centers for Medicare & Medicaid Services (CMS) under 1115 waivers can often only be applied to higher income populations.
- 1115 Waivers must:
  - Be budget neutral to the federal government
  - Include stakeholder input
  - Comply with federal maintenance of effort (MOE) requirements designed to maintain coverage levels until January 2014 (for adults) and October 2019 (for children)

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Approval Process for Section 1115 Waivers

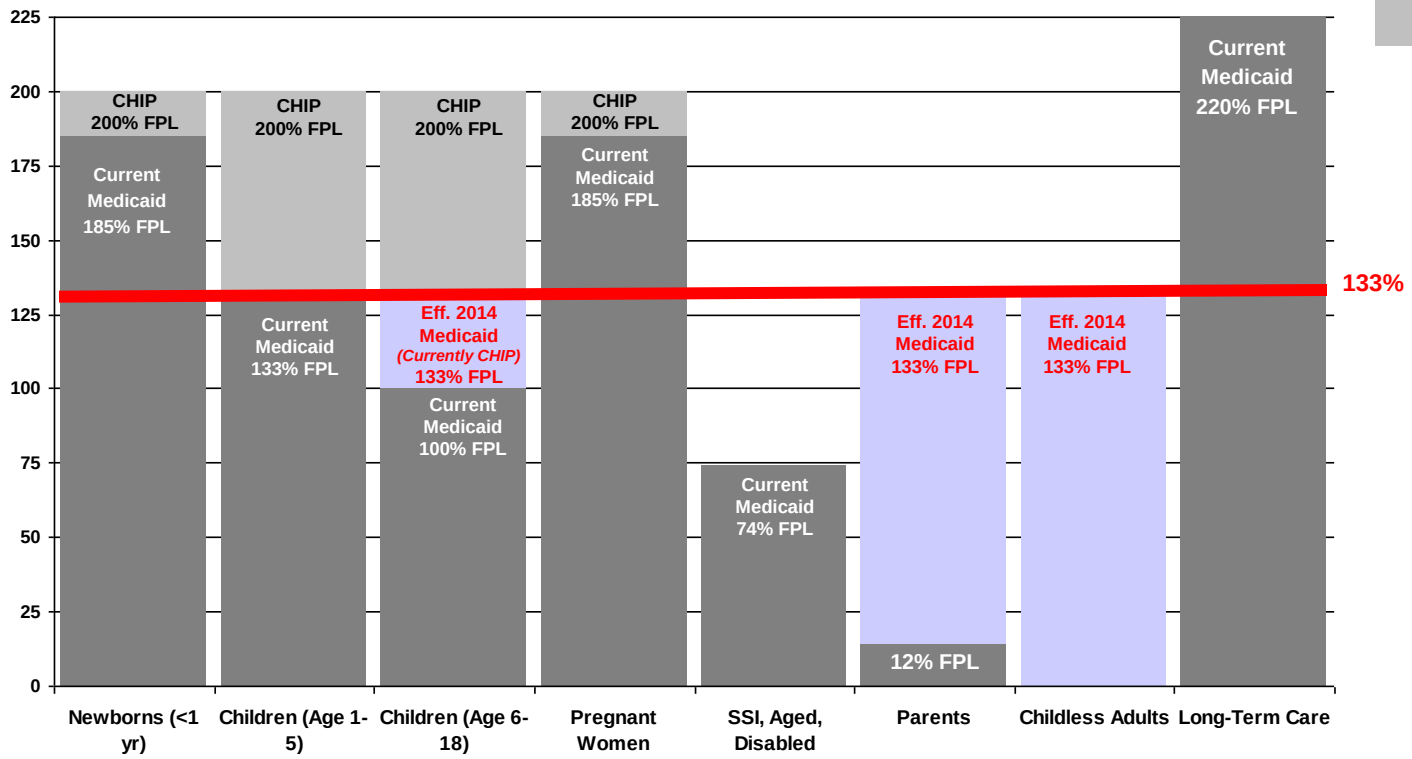
Step 1	Fall 2011/ Winter 2012	State develops high-level reform concepts based on Legislative direction
Step 2	Spring 2012	State establishes an ongoing public input process
Step 3	Spring/Summer 2012	State refines waivers concepts based on research and stakeholder input
Step 4	Fall/Winter 2012	State develops and submits a waiver concept paper
Step 5	Winter 2012	CMS initiates ongoing discussions and negotiations with the State
Step 6	Winter 2012 – Ongoing	State develops and provides detailed information on programmatic reform components and budget neutrality
Step 7	After agreement is reached	Once agreement is reached, CMS develops Special Terms and Conditions (STCs) for the Waiver
Step 8		CMS approves Waiver (generally for 5 years, with 3-year renewals)
Step 9		State begins implementation activities

Medicaid and CHIP Eligibility Levels

FY 2011 ENROLLMENT

Medicaid
3.5 million

CHIP
577,000



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How Medicaid Services are Provided

Medicaid Recipients in Managed Care in FY 2013
Post Managed Care Expansion Implementation in HB1

Service Delivery Model	FY 2011	FY 2013
Fee-for-Service	27.8%	23.5%*
STAR	40.7%	52.0%
STAR+PLUS	5.9%	10.0%
Primary Care Case Management	24.7%	0.0%
STAR Medicaid Rural Service Area	0.0%	13.6%
STAR Health (Foster Care)	0.8%	0.9%
Managed Care Total	**72.2%**	**76.5%**

The proportion of capitated Medicaid expenditures in FY 2013 will be 64% (up from 29% in FY 2011).

*Individuals remaining in FFS include: children with SSI who opt out of managed care; Children receiving adoption subsidies and children in foster care who are in transition; and Medicaid retroactive enrollment.

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2012 Federal Poverty Level (FPL)

Monthly Income Levels

Family Size	50%	100%	133%	185%	200%	400%
1	$465	**$931**	$1,238	$1,722	$1,862	$3,723
2	$630	**$1,261**	$1,677	$2,333	$2,522	$5,043
3	$795	**$1,591**	$2,116	$2,943	$3,182	$6,363
4	$960	**$1,921**	$2,555	$3,554	$3,842	$7,683

Annual Income Levels

Family Size	50%	100%	133%	185%	200%	400%
1	$5,585	**$11,170**	$14,856	$20,665	$22,340	$44,680
2	$7,565	**$15,130**	$20,123	$27,991	$30,260	$60,520
3	$9,545	**$19,090**	$25,390	$35,317	$38,180	$76,360
4	$11,525	**$23,050**	$30,657	$42,643	$46,100	$92,200

Recent Poverty Population Trends in Texas: Years 2005-2010

(Population numbers are in the thousands)

Population - Annual Income Below Poverty Level (Below 100% FPL)				
Year	Under Age 18	Age 18-64	Age 65 +	All Ages
2005	1,419	1,955	307	3,681
2006	1,436	2,042	338	3,816
2007	1,665	1,940	298	3,903
2008	1,565	1,956	314	3,835
2009	1,774	2,226	263	4,263
2010	1,900	2,481	253	4,635

Percent of Population - Annual Income Below Poverty level (Below 100% FPL)				
Year	Under Age 18	Age 18-64	Age 65 +	All Ages
2005	22.0%	14.1%	12.6%	16.2%
2006	22.0%	14.5%	13.1%	16.4%
2007	25.0%	13.4%	12.1%	16.5%
2008	23.1%	13.1%	12.5%	15.9%
2009	25.6%	14.6%	10.8%	17.3%
2010	27.0%	16.0%	10.0%	18.4%

Source:

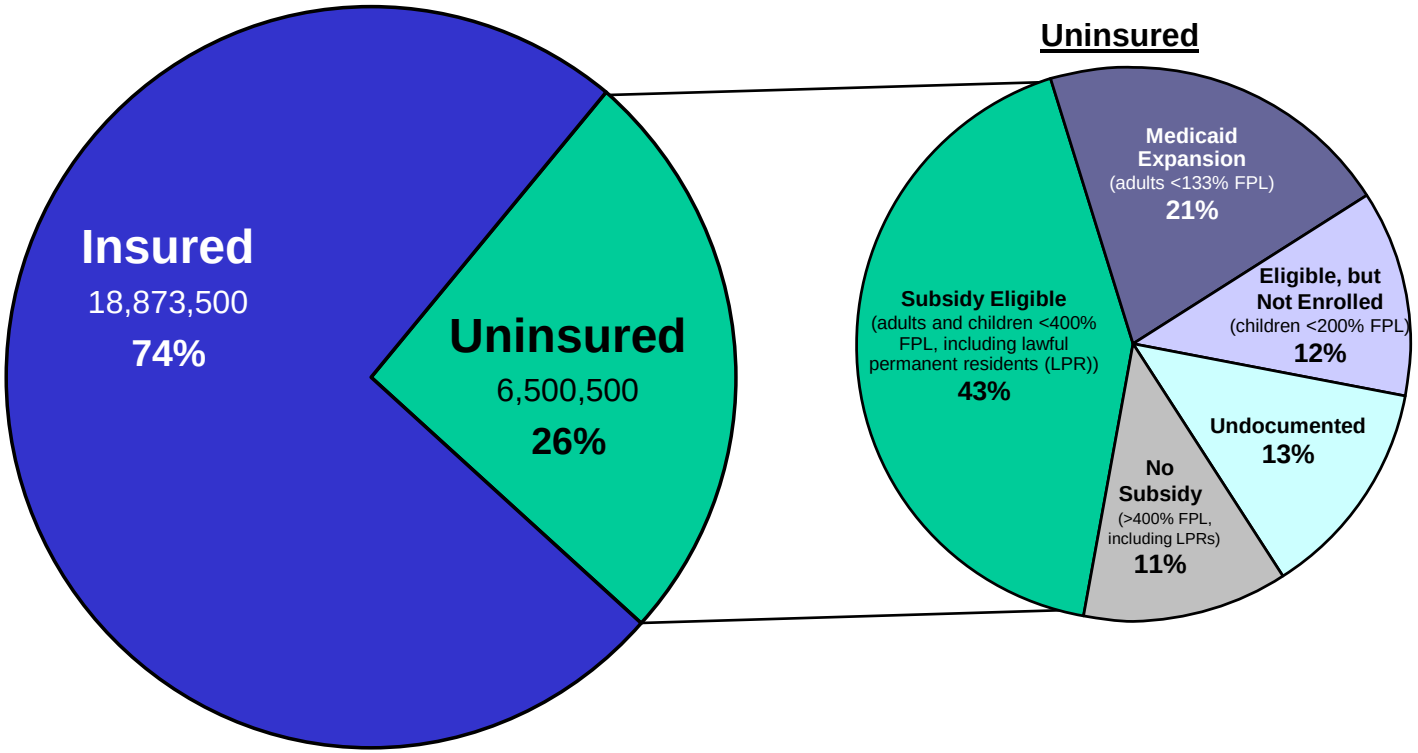
U.S. Census Bureau. March Current Population Survey (CPS). Years 2006-2011

Data Tabulated By:

Strategic Decision Support Department, Texas Health and Human Services Commission

Updated February 15, 2012

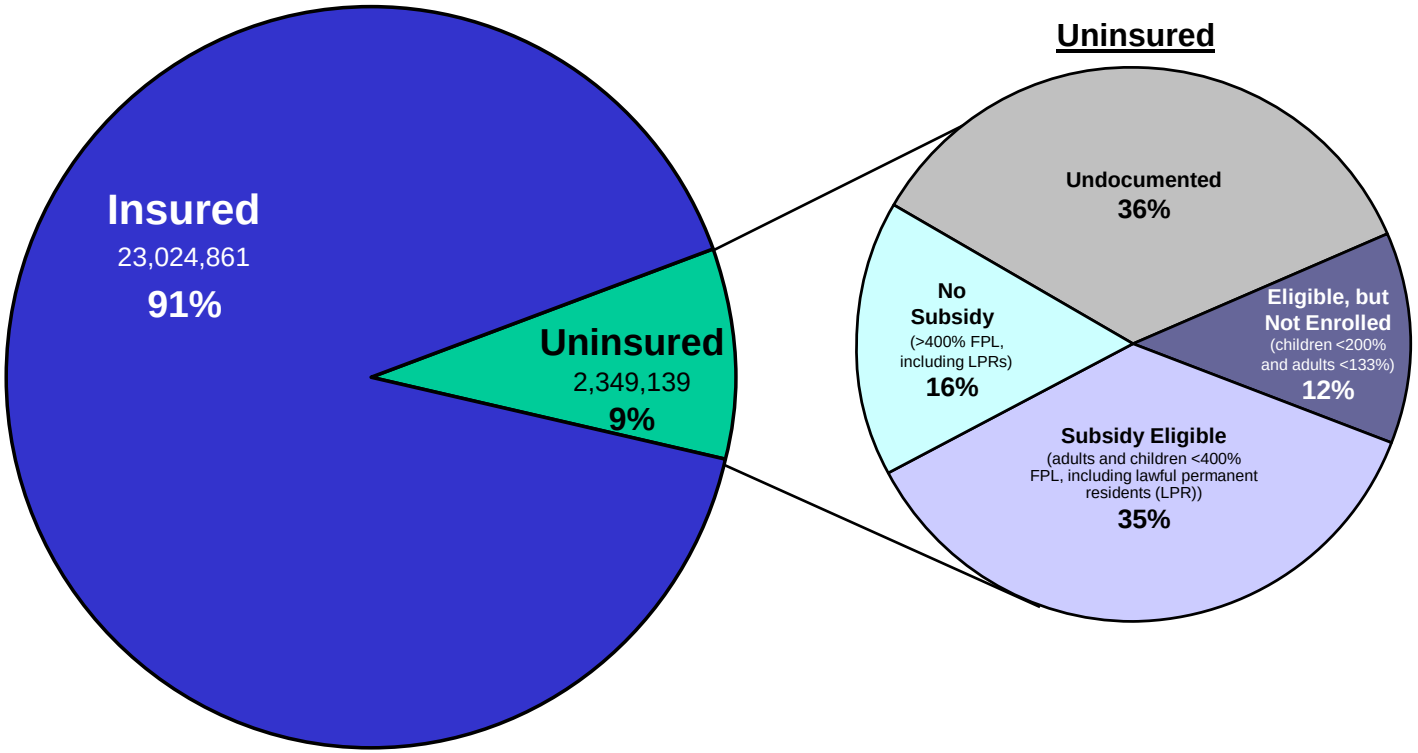
Texas Uninsured Demographics Current



Source: U.S. Census Bureau, March 2009 Current Population Survey (CPS), Texas State Data Center at the University of Texas at San Antonio. Population projections for year 2010 based on 200-2007 Migration Scenario, Published 2/2009.

Prepared by: The Center for Strategic Decision Support, Texas Health and Human Services Commission, April 2010.

Texas Uninsured Demographics Post 2014



Note: Due to rounding, percentages may not total 100%.

Source: U.S. Census Bureau, March 2009 Current Population Survey (CPS), Texas State Data Center at the University of Texas at San Antonio. Population projections for year 2010 based on 200-2007 Migration Scenario, Published 2/2009.

Prepared by: The Center for Strategic Decision Support, Texas Health and Human Services Commission, April 2010.

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Opportunities for Reform

Acute Care

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Acute Care Reform Opportunities

- Elimination of Retroactive Medicaid Reimbursement
- Medicaid Benefits Flexibility
- Medicaid Copayments
- Increased Use of Private Insurance
- Incentives for Healthy Behaviors

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Elimination of Retroactive Medicaid Reimbursement for Unpaid Medical Bills

- The Social Security Act (SSA) requires that states provide Medicaid eligibility three months prior to the date of application, if the client has reimbursable Medicaid expenses during that time period.
- This requirement primarily affects hospitals.
- The fiscal impact of this initiative depends on the populations to which waiver of retroactive coverage applies.

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Estimated FY 2011 Expenditures for Retroactive Coverage by Medicaid Population

Medicaid Population	All Funds *(in millions)*	General Revenue *(in millions)*
Medicare Related	$ 26.2	$ 10.5
Non-Medicare (Blind/Disabled)	$148.9	$ 59.6
TANF Adults	$ 29.1	$ 11.7
TANF Children	$ 17.2	$ 6.9
Pregnant Women	$105.0	$ 42.0
Newborns	$142.2	$ 56.9
Non-disabled Children Ages 1-18	$140.3	$ 51.2

Note: This table reflects an estimate of the amount HHSC spent on retroactive claims in fiscal year (FY) 2011 for various Medicaid populations.

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Medicaid Benefits Flexibility

- Texas could use the waiver to implement a more flexible benefit package for the Medicaid population, similar to what is offered through the CHIP and commercial health plans.
- This benefit package could:
  - Provide flexibility in benefit design and ensure consistency in covered benefit categories
  - Align Medicaid coverage with the commercial market and CHIP
  - Align the benefit design for the Medicaid expansion group (in 2014) and the traditional Medicaid population
- For children and people with disabilities, regardless of age, “wraparound” services could complement the basic benefit package to account for additional services needed by these populations.

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Medicaid Copayments

- Texas could utilize a waiver to implement Medicaid copays, and to ease administrative costs to the state by seeking flexibility in the way cost sharing is implemented, such as:
  - Request waiver from the requirement to reduce provider payments by the amount of cost sharing required of individuals
  - Request waiver from the requirement that the state tracks all cost sharing collected at the individual level (and instead utilize the CHIP method of individual self-reporting)

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Maximum Allowable Medicaid Copayments

Maximum Medicaid Cost Sharing Amounts for Selected Services and Prescription Drugs by Income (Fiscal Year 2012)

Income Level	FPL ≤ 100%	FPL 100% - ≤ 150%	FPL > 150%
Non-emergency ED Visit Co-pay	$3.80	$7.60	Not specified
Generic Drug Co-pay[1]	$1.30	$1.30	$1.30
Brand-Name Drug Co-pay[2]	$3.80	$3.80	$3.80
Office Visit Co-pay[3]	$2.45	$3.67	$7.34
5% Annual Cost-Share Cap[4]	$0 to $1,153	$1,154 to $1,729	$1,730 and above

[1] Allowable Medicaid generic drug co-pays based on State Fiscal Year (SFY) 2010 average generic drug cost for all clients of $22.77.

[2] Allowable Medicaid brand drug co-pay based on SFY 2010 average brand drug cost for all clients of $195.93.

[3] Allowable Medicaid office visit co-pays based on SFY 2010 average office visit payment for established, adult, fee-for-service and primary care case management clients of $36.69.

[4] Based on federal poverty level for a family of four in fiscal year 2012.

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Increased Use of Private Insurance

- S.B.7 includes a directive to increase participation in employer based and other private market insurance options.
- Beginning in 2014, all states must operate Health Insurance Premium Payment (HIPP) programs.
  - Because of the upcoming Medicaid managed care expansion, and in preparation for upcoming changes in federal law, Texas will need to review and restructure existing HIPP processes.
  - Changes to existing statute may be needed to accommodate these changes.
- Texas may want to consider adding a premium assistance program for CHIP.
- Texas may consider pursing the basic health plan option for individuals who are ineligible for Medicaid.
- There may also be opportunities to develop blended funding methodologies to help increase the use of private market coverage for families whose insurance eligibility may cross over multiple programs such as, Medicaid, CHIP, and premium subsidies required by federal law.

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Incentives for Healthy Behaviors

- Incentives for healthy behaviors could be built into a waiver.
- Wellness programs are often designed to incentivize individuals (financial and other) to improve their health by engaging in healthy behaviors.
- These programs are widely used by commercial health plans, and have also been established for some Medicaid programs.

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Opportunities for Reform

Long Term Services and Supports

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Long Term Services and Supports Reform Opportunities

- Improving Coordination of Eligibility Determination
- Balancing Incentives Program
- Shared Savings Program to Integrate Care for Dual Eligibles
- Community First Choice
- Other LTSS Reform Opportunities
  - Quality Incentives for Nursing Facilities
  - Increased Flexibility for Consumer Directed Services
  - Restructuring Intellectual and Developmental Disabilities (IDD) Service System

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Medicaid Entitlement LTSS Services

- Entitlement Institutional Services
  - Nursing facilities
  - Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)
- Entitlement Home and Community-Based Services
  - Attendant care services for individuals 21 years of age and older with a physical disability through Primary Home Care (PHC) and STAR+PLUS for individuals on SSI
  - Attendant care services for individuals 21 years of age and older with a physical disability through the Community Attendant Services Program (CAS) for individuals up to 300% above the SSI income limit
  - Adult "Day Care" for individuals 18 years of age and older* through the Day Activity and Health Services (DAHS) program; also available in STAR+PLUS
  - Personal Care Services for children up to age 21
- DADS also administers Program of All-inclusive Care for the Elderly (PACE) and hospice services

*Individuals under 18 not ineligible; however, those under 18 are not able to attend a licensed adult day care due to licensure requirements

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Medicaid Community Service Waivers

- Texas has seven Medicaid Community Services waiver programs providing LTSS:
  - Three waive off nursing facility eligibility:
    - STAR+PLUS
    - Community-Based Alternatives (CBA)
    - Medically Dependent Children Program (MDCP)
  - Four waive off ICF/ID eligibility:
    - Home and Community-based Services (HCS)
    - Community Living Assistance and Support Services (CLASS)
    - Deaf-Blind with Multiple Disabilities Program (DBMD)
    - Texas Home Living (TxHmL)
- Waiver programs are administered by DADS, with the exception of STAR+PLUS, which is administered by HHSC.
- Legislative appropriations determine the availability of waiver services.

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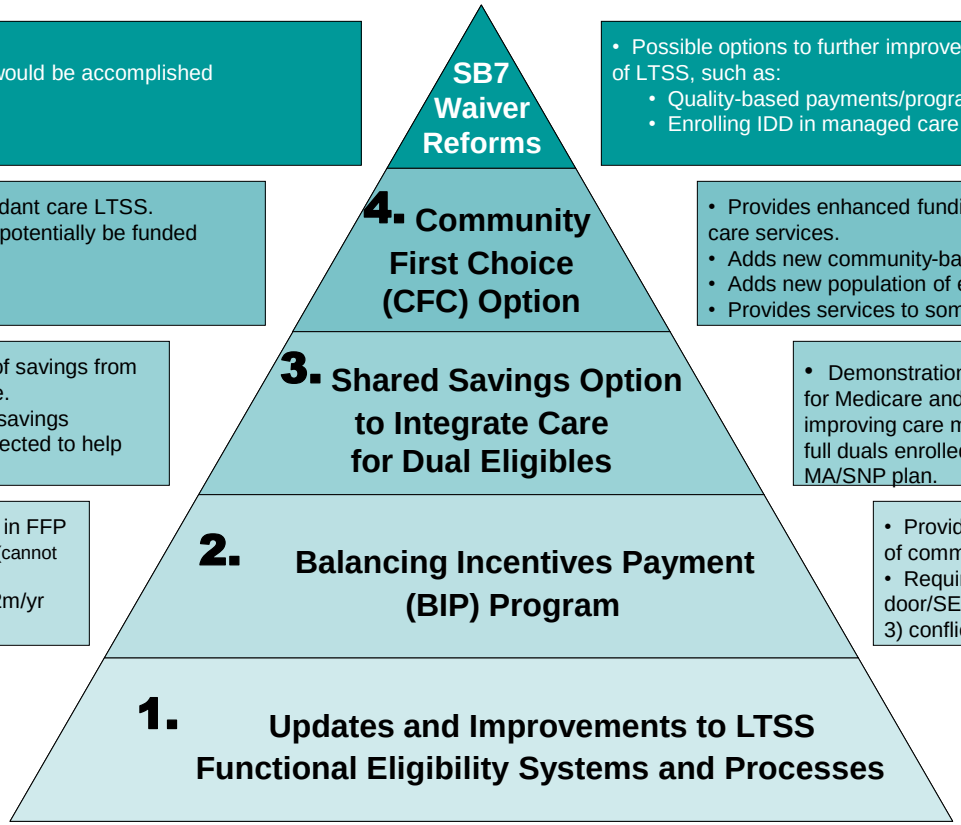
Medicaid LTSS
A Framework for Reform

Financing Opportunities

Goals



- Unknown at this time.
- It is assumed that additional reforms would be accomplished through a federal 1115 Waiver.

- Possible options to further improve quality, access and cost for the delivery of LTSS, such as:
  - Quality-based payments/programs for nursing facilities
  - Enrolling IDD in managed care for acute care services

- Ongoing 6% increase in FFP for attendant care LTSS.
- Estimated Annual Cost: $45 m (could potentially be funded through savings from the Duals Model)

- Provides enhanced funding for community-based attendant care services.
- Adds new community-based services under the state plan
- Adds new population of eligible individuals (IDD)
- Provides services to some individuals on waiver waiting lists

- Texas would negotiate a percentage of savings from this integrated care model with Medicare.
- Texas would ask that a portion of the savings generated through this program be redirected to help fund the CFC Option (above).

- Demonstration program to generate shared savings for Medicare and Medicaid through integrating and improving care management of health care services for full duals enrolled in STAR+PLUS and a corresponding MA/SNP plan.

- Temporary 2% increase (until 9/2015) in FFP for increase in community-based LTSS (cannot overlap w/MFP)
- Texas est. avg. annual increase = $82m/yr

- Provides funding for states to increase use of community-based LTSS
- Requires states to move towards:1) No wrong door/SEP; 2) standardized assessment tools; 3) conflict-free CM. Encourages EIE.

- 100% Money Follows the Person (MFP) funding available for IT improvements
- 100% enhanced IT funding

- Update and improve electronic functional eligibility determination capabilities
- Systematically link (interface) eligibility data for financial and functional eligibility

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Improving Coordination of Eligibility Determination

- In planning for improvements to the LTSS system in Texas, DADS and HHSC identified a need to improve administrative and systematic processes for functional eligibility determination and effectively link the functional and financial eligibility systems.

- This work will improve electronic communication among the various entities involved in eligibility screening, referral and functional eligibility determination (e.g., local authorities, DADS regional offices, aging and disability resource centers).

- Efforts are already underway to begin this work and will provide a foundation for the LTSS reforms to occur under the waiver.

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Balancing Incentive Payment Program

- This federal option is intended to incentivize states to increase their capacity for community-based LTSS.
- Funding is available to states that spend less than 50 percent of their total LTSS expenditures on community-based LTSS programs, through September 30, 2015.
- Texas is eligible to receive a two percent increase in FMAP in exchange for making structural and programmatic changes, such as:
  - Establish a No Wrong Door/Single Entry Point (SEP) System (Example – Aging and Disability Resource Centers in Texas)
  - Utilize a Core Standardized Assessment Instrument (or set of instruments)
  - Ensure Conflict-Free Case Management Services
  - Additionally, Electronic Information Exchange (EIE) is not required, but highly recommended by CMS
- This option could be pursued outside of the waiver process.

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Shared Savings Program to Integrate Care for Dual Eligibles

- CMS is encouraging states to participate in a new demonstration program to provide more integrated health services to dual Medicare and Medicaid enrollees.
- The state and CMS would negotiate an agreement in which each would share a portion of the savings achieved through improved coordination of benefits and alignment of goals.
- Texas provides services to approximately 350,000 fully dual Medicare/ Medicaid eligibles.
- Texas could potentially utilize savings generated through the implementation of this option to fund other LTSS reforms.

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Community First Choice (CFC)

- The CFC federal option allows states to provide home and community-based attendant services and supports for individuals at or below 150 percent FPL, through a State Plan amendment, with a six percent increase in FMAP.
- Implementing this option would:
  - Add a new population group - individuals with intellectual and developmental disabilities
  - Add new services - habilitation, personal emergency response systems
  - Allow some individuals on LTSS waiver waiting lists to receive community-based attendant services
- There is a requirement to maintain or exceed state Medicaid expenditures for individuals from the prior fiscal year, in the first fiscal year of implementation.
- There is no end date for the FMAP increase.

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Modified CFC-like Waiver Option Increased Community Care

- Texas may want to seek a waiver for a modified version of CFC that would allow more individuals to receive community-based attendant care, but would reduce expenditures by not adding additional services:
  - Include the new IDD population, but not the additional services that would be required under the new State Plan option
- Texas could negotiate a percentage of the FMAP increase available under the new federal option (+six percent for community-based services) into the waiver.
  - General revenue costs for this option would vary depending on the percentage of increased FMAP that the state could negotiate with CMS
- Texas could negotiate to use a portion of the shared savings from the dual eligibles project to fund the GR portion of this option.

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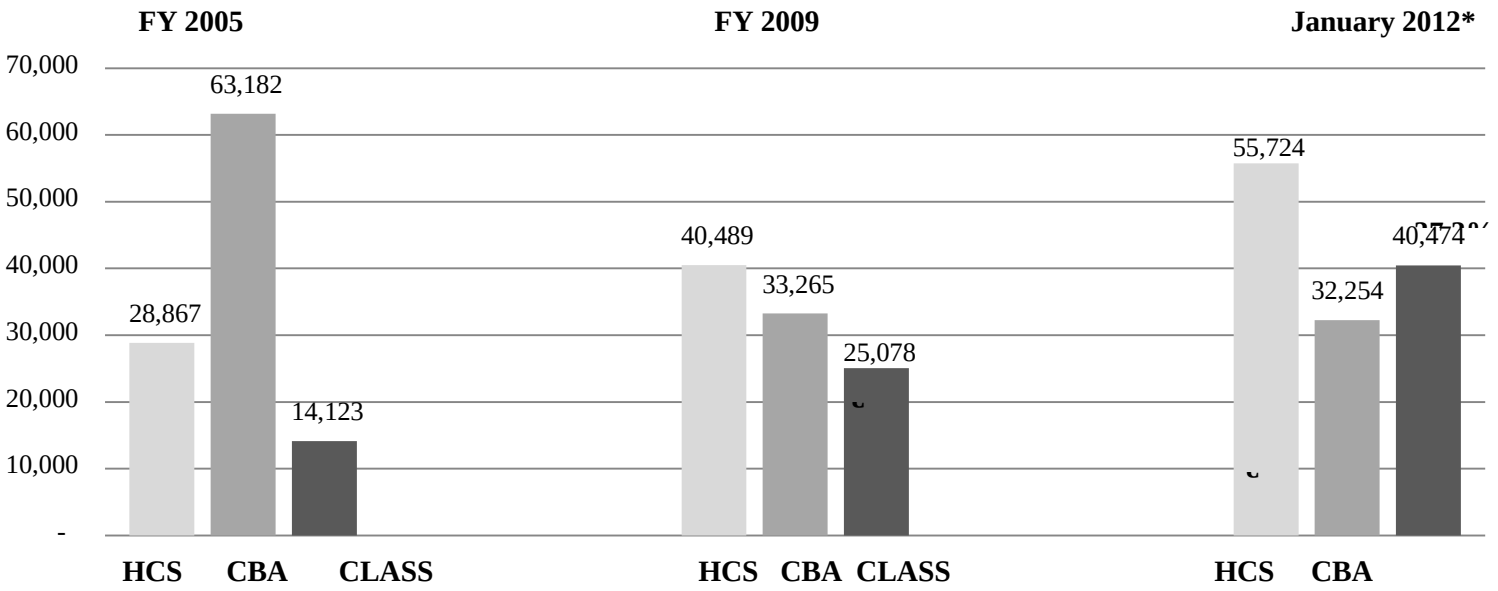
Other LTSS Reform Opportunities

- Quality Incentives for Nursing Facilities
  - Establish a program to incentivize nursing facilities to improve quality and reduce avoidable acute care expenditures (such as hospitalizations)
  - If Texas moves forward with a duals shared savings initiative, Texas could target quality indicators such as reduced inpatient admissions for nursing facility clients.
- Increased Flexibility for Consumer-Directed Services
  - Although a number of Texas LTSS programs allow individuals to manage employer functions, some states extend individual authority to management of a budget that includes decision-making on a choice of goods and services needed to remain independent (such as a ramp for home access, or cooking equipment to prepare meals without the assistance of an attendant)
- Restructuring of IDD Service System
  - Attendant care entitlement for IDD
  - Tiered IDD waiver structure

Interest Lists

Number of Individuals on Interest Lists for Selected Waivers



*** CBA counts include individuals on the IL for CBA as well as STAR+PLUS. The CBA counts for January 2012 are the estimated number of individuals who will be on the IL after the March 1, 2012 STAR+PLUS expansion.**

Public Input and Questions

Public Input and Questions concerning the S.B. 7 Waiver can be sent to HHSC at:

MedicaidProgramInnovation@hhsc.state.tx.us