TEXAS
Health and Human
Services Commission

Joint Hearing of the Senate Health and Human Services and State Affairs Committees

Federal Health Care Reform – Impact to Texas Health and Human Services

Executive Commissioner Thomas M. Suehs
Health and Human Services Commission
March 31, 2010

TEXAS Health and Human Services Commission

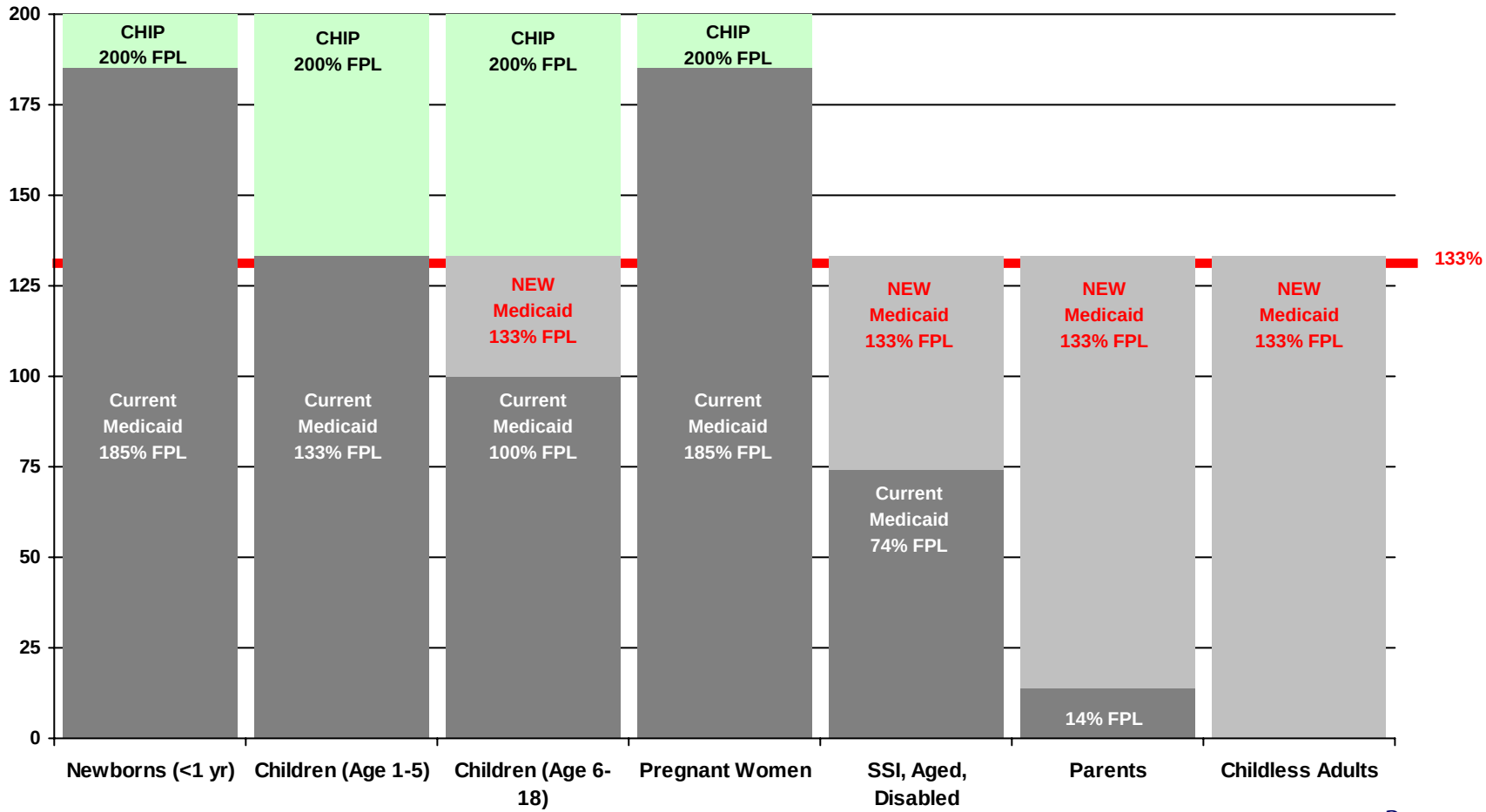
Summary of Key Provisions: Medicaid Eligibility

- Expands Medicaid eligibility to individuals under age 65 with incomes up to 133% FPL*
  - On or after April 1, 2010 – December 2013: Eligibility expansion optional for states
  - January 2014: States required to begin expansion
- Requires benchmark or benchmark-equivalent coverage for Medicaid expansion populations.
  - Benchmarks include the federal employees Blue Cross preferred provider plan, plans offered or available to state employees, the plan of the HMO in the state with the largest non-Medicaid enrollment, or any other plan approved by the Secretary.
- Changes Medicaid income eligibility requirements.
  - Requires use of modified gross income and prohibits assets test and most income deductions.
- Requires Texas to maintain existing Medicaid eligibility until the state's exchange is fully operational.

*Income deduction allowance of five percentage points creates effective eligibility level of 138% FPL.

TEXAS Health and Human Services Commission

Current & Future Medicaid/CHIP Eligibility



TEXAS Health and Human Services Commission

Caseload Impact

Average Annual Enrollment per Month, SFY 2014 – 2023

HHSC Estimate as of 03/30/2010

Provision	Average Caseload (1,000s)
Baseline Medicaid Current Law	3,504
Currently Eligible but not Enrolled (Medicaid)	567
[1]Medicaid Expansion	1,709
Total Medicaid Caseload Under Act	5,780
Baseline CHIP Current Law	591
Currently Eligible but not Enrolled (CHIP)	88
[2]Transfer to Medicaid Program	(237)
Total CHIP Caseload Under Act	443
Total Medicaid/CHIP Caseload Baseline	4,095
Total Medicaid/CHIP Caseload Under Act	6,223
Net Change Medicaid/CHIP Caseload Under Act	2,127

[1]Medicaid expansion includes newly eligible adults and older children along with children who would be transferred from the existing CHIP program into Medicaid.
[2]Individuals currently qualifying for CHIP at 133% FPL or below would be transferred to Medicaid.

TEXAS Health and Human Services Commission

Costs

Summary Cost Estimate: SFY 2014 – 2023

*HHSC Estimates (billions $)		
Provision	**All Funds Cost**	**GR Cost**
[1]Changes to Existing Medicaid Program	$34.3	$13.1
[2]Medicaid Expansion	$146.2	$13.1
[3]Administrative Cost	$14.2	$7.1
[4]Savings from Changes in CHIP Program	($3.4)	($2.0)
[5]Increased Drug Rebate Related Revenue	--	($4.3)
Total	**$191.2**	**$27.0**

*Assumptions for the HHSC Model include additional rate support (~5% increase beyond the small rate increase assumed by CBO) to promote the growth in the provider base that will be necessary to meet demand from 2 million more clients.

[1]Changes to the existing Medicaid program include additional enrollment by the eligible but not insured population and new expenditures related to the provider rate increase proposed in the reconciliation bill.
[2]Medicaid expansion includes newly eligible adults and older children along with children who would be transferred from the existing CHIP program into Medicaid.
[3]Administrative services are estimated at 8% of program spending with a projected FMAP of 50%.
[4]Individuals currently qualifying for CHIP at 133% FPL or below would be transferred to Medicaid resulting in a savings for the CHIP program. CHIP would also benefit from a temporary increase in FMAP.
[5]Vendor Drug rebate revenue is likely to increase under the proposals due to large projected gains in enrollment and pharmaceutical utilization.

TEXAS Health and Human Services Commission

Costs

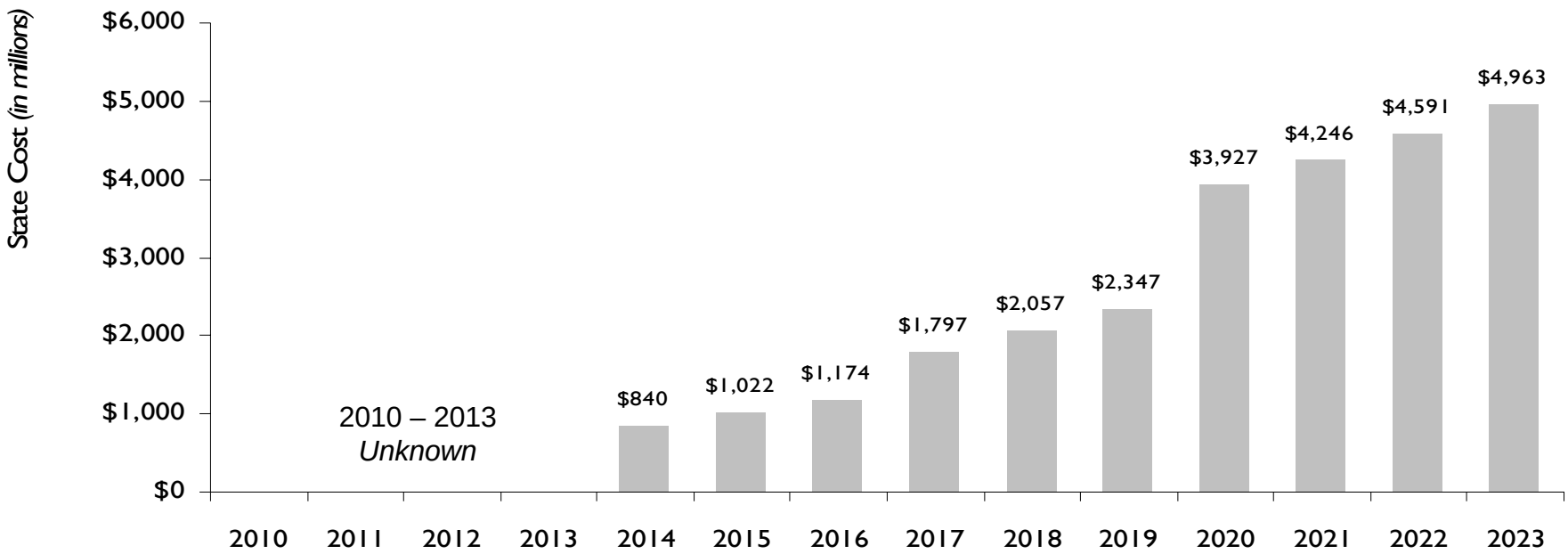
Year by Year Cost Estimate: SFY 2014 – 2023

SFY	*HHSC Model General Revenue *(in millions)*	*Notes on HHSC Model
2014	$840.10	·Effectively expands Medicaid to 138% of FPL.
		·Includes a permanent SuperFMAP for Medicaid expansion, starting with100% for 3 years.
		·Includes a reimbursement increase for certain services provided by primary care physicians.
2015	$1,022.30	
2016	$1,174.20	·Federal government ends SuperFMAP support for the primary care physician rate increase. HHSC assumes additional, ongoing rate support to increase provider capacity to meet demand from 2 million new clients.
		·Includes a 95.39% SuperFMAP for CHIP through 2019.
2017	$1,797.00	·Medicaid SuperFMAP reduced from 100% to 95%.
2018	$2,056.90	·Medicaid SuperFMAP reduced to 94%.
2019	$2,347.20	·Medicaid SuperFMAP reduced to 93%.
2020	$3,927.00	·The years 2020 - 2023 (the first years beyond the CBO scoring horizon) include additional costs related to the expected reauthorization of CHIP without SuperFMAP and a reduction in Medicaid SuperFMAP to 90% in perpetuity.
2021	$4,245.80	
2022	$4,590.60	
2023	$4,963.40	
TOTAL	**$26,964.30**	

*Assumptions for the HHSC model include additional rate support (~5% increase beyond the small rate increase assumed by CBO) to promote the growth in the provider base that will be necessary to meet demand from 2 million more clients.

Texas Medicaid & CHIP Costs

State Fiscal Years 2010 - 2023



TEXAS Health and Human Services Commission

Immediate Costs

Loss of Supplemental Drug Rebate Revenue: SFY 2010-2013

- The bill makes several changes to Medicaid drug rebate policy that apply upon enactment, including increasing the minimum manufacturer rebate on brand name products from 15.% to 23.1%.
- The federal government is utilizing this difference in percent and therefore states will not see the increased revenue.
- The estimated loss of supplemental drug rebate revenue for state fiscal years 2010-2013 is outlined in the table below.

State Fiscal Year	General Revenue
2010	$2.1 million
2011	$16.9 million
2012	$19.8 million
2013	$21.4 million
Total	$60.2 million

- This becomes a cost savings to the state in later years due to the volume of Medicaid enrollees.

*Assumed an implementation date of July 1, 2010, so the first year estimate is only for 2 months.

Summary of Key Provisions: Federal Financial Participation

- For the first three calendar years of the mandated expansion, the federal government bears the full cost of coverage for new eligibles in most states.
- Expansion states are those that at enactment offers full coverage to both parents and childless adults at 100% of FPL.
- Texas FFP and Expansion states' FFP
  - Expansion states' federal share increase is phased in based on the percent of difference between a state's FFP at enactment and the FFP for non-expansion state.
  - All states at the same FFP for federal expansion populations by 2020.

Texas (Reg. Enhanced)		Expansion States Phase-In
2014	100%	+ 50% of difference
2015	100%	+ 60% of difference
2016	100%	+ 70% of difference
2017	95%	+ 80% of difference
2018	94%	+ 90% of difference
2019	93%	+ 100% of difference = 93%
*2020	90%	90% FFP

*and beyond

TEXAS Health and Human Services Commission

Summary of Key Provisions: Medicaid Financing

- Increases Medicaid payments for certain services provided by primary care physicians to at least 100 percent of Medicare payment rates in 2013 and 2014. Rate increases are 100 percent federally-funded for these two years.
- Reduces aggregate Medicaid disproportionate share hospital (DSH) allotments and requires a methodology to reduce state DSH allotments.
  - Largest percentage reductions will be for states with the lowest percentage of uninsured or that do not target DSH payments. Low-DSH states will receive smaller percentage reductions.
- Extends prescription drug rebates to Medicaid managed care and increases minimum rebate percentages.

TEXAS Health and Human Services Commission

Summary of Key Provisions: Medicaid Long Term Care (LTC)

- Community Living Assistance Services and Supports (CLASS) program
  - Establishes a voluntary, public LTC insurance program that provides a cash benefit to adults who develop functional impairments for the purchase of community-based supports and services. Vesting in five years; then can offset some Medicaid LTC costs.
- Home and Community-Based Services (HCBS)
  - Provides states incentives to move Medicaid clients out of nursing homes and into home and community-based services.
- Community First Choice Option
  - A new optional Medicaid benefit that provides states an increased FMAP for providing community-based attendant supports and services to individuals with disabilities who require an institutional level of care.

TEXAS Health and Human Services Commission

Summary of Key Provisions:
Children's Health Insurance Program

- Extends federal CHIP funding through 2015.
- From October 2015 to September 2019, increases the federal CHIP match rate by 23 percentage points (not to exceed 100 percent).
- Requires states to maintain existing CHIP eligibility through September 2019.
- Requires use of modified gross income beginning January 2014.

TEXAS Health and Human Services Commission

Impact on Texas Provider Rates

Medicaid Rates and CHIP rates

- States are required to increase Medicaid rates to 100% of Medicare rates in 2013 and 2014 for certain services provided by primary care physicians. 100% Federal Financial Participation (FFP) for incremental rate costs for only 2013 and 2014.
- State will need to decide whether to continue these rates at regular FFP after 2014 or choose not to continue.
- State will likely need to provide the same increase for CHIP rates as for Medicaid.
  - CHIP rates have historically been in line with Medicaid provider rates
  - Any increase in CHIP provider rates will be at the CHIP FFP for all years
  - CHIP FFP increases by 23 points in 2016

Ancillary Rates Impact

- Currently, the majority of direct care Nursing Facility and Home Health Care staff lack health insurance. Costs for these providers will increase to provide insurance to employees under the new mandates. Providers may seek rate increases to help defray increased costs of providing care.

TEXAS Health and Human Services Commission

State Policy Considerations

- Medicaid Expansion Benchmark Benefit
  - States will need to create a Secretary-approved benchmark benefit package for newly eligible Medicaid groups for use in Medicaid by January 2014.
  - Benchmarks include the federal employees Blue Cross preferred provider plan, plans offered or available to state employees, the plan of the HMO in the state with the largest non-Medicaid enrollment, or any other plan approved by the Secretary.
- States can expand Medicaid coverage to 133% FPL on or after April 1, 2010 without a waiver at regular FFP until 2014 when federal enhanced FFP would apply.
  - Managed Care Organizations could be utilized for earlier expansion implementation
- In 2010 states no longer lose access to federal pharmacy rebates if drugs are included in managed care plan benefits and capitation. State could choose to "carve in" drugs for Medicaid HMOs.
- State policymakers will need to consider the impact to current funds supporting health care programs including: Trauma funds, Tobacco settlement funds, the County Indigent Health Care Program and other programs administered by the Department of State Health Services.

TEXAS Health and Human Services Commission

State Pilots & Policy Options

- Medicaid bundling demonstration to start January 2012. Eight states to be selected—must identify episode of care to be covered and show opportunity for cost savings.
- Up to five states could create a global capitated, bundled payment system for a large safety-net Hospital system to evaluate changes in health care spending and outcomes: 2010 – 2012.
- Allows qualified pediatric providers to be recognized and receive payments as Accountable Care Organizations under Medicaid.
- Creates three-year Medicaid demonstration project in up to eight states for reimbursement of certain institutions for mental disease (IMDs) for services provided to Medicaid beneficiaries between 21 – 65 who are in need of medical assistance to stabilize an emergency psychiatric condition.

TEXAS Health and Human Services Commission

State Pilots & Policy Options

- Authorizes $75 million for demonstration projects in up to eight states to expand the number of emergency inpatient psychiatric care beds. States could receive match to demonstrate that covering these patients in hospitals will improve timely access to emergency psychiatric care, reduce overcrowded ERs, and improve efficiency and cost-effectiveness of inpatient psychiatric care.

- Creates a new state plan option for beneficiaries with chronic conditions to designate a health home. Individuals must have at least one serious and persistent mental health condition to receive services under this option.

- States could design a proposal and apply for funds to provide incentives to Medicaid enrollees who improve their health status and complete scientifically based healthy lifestyle programs.