Texas Medicaid 101
One Voice Texas 2014 Healthcare Conference
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Overview

Medicaid & CHIP Background

• Benefits
• Eligibility & Enrollment
• Costs & Financing
• Delivery Models

Texas Specifics

Current HHSC Initiatives
Medicaid and CHIP Overview
Medicaid: What is it?

Provides medical coverage to eligible individuals primarily:

- Low-income families
- Non-disabled children
- Related caretakers of dependent children
- Pregnant women
- People age 65 and older
- People with disabilities

Entitlement program = no enrollment limitation
Medicaid: What is it?

Federal / State Program

- Funded jointly by state and federal governments
- Administered by states
- Subject to federal law and regulation:
  - Requires coverage of certain populations and services
  - Allows states to cover additional populations and services
Medicaid: Who runs it?

Federal level

• Centers for Medicare & Medicaid Services (CMS)
• Within the U.S. Department of Health and Human Services:
  – Sylvia Burwell expected to be confirmed Secretary of Health and Human Services (Kathleen Sebelius outgoing)
  – Cindy Mann – Director, Center for Medicaid and CHIP Services

Texas level

• Administered by single state agency – HHSC
• Kay Ghahremani – Texas State Medicaid Director
  – Single point of contact with federal government
  – Establishes Medicaid Policy
  – Administers state plan or agreement with the federal government
  – Administers Medical Care Advisory Committee (MCAC) mandated by federal Medicaid law
Medicaid in the Federal Budget, Federal Fiscal Year 2009

Medicaid and CHIP 8%
Medicare 13%
Net Interest 6%
Other Mandatory 16%
Discretionary (including Defense) 36%
Social Security 20%

Source: Budget of the United States Government, Federal Fiscal Year 2013, Table S-4, p. 208.
Medicaid State Plans: State & Federal Program

State Plans = agreements with federal government on:

- Eligibility
- Services
- Program administration
- Financial administration
- Other program requirements

State Plan Amendments (SPA) = requests to CMS to change:

- Optional services provided, or
- Manner benefits are offered.
Medicaid Waivers: State & Federal Program

Waivers = state request to CMS for permission to deviate from certain requirements, often to:

- Provide services beyond those in state plan.
- Limit geographical areas.
- Limit free choice of providers.
- Implement innovative new service delivery and management models.

Common Types of Medicaid Waivers

- 1115 Waiver – Research and Demonstration – Test policy innovations likely to further Medicaid program objectives.

- 1915(b) Waiver – Freedom of Choice – Allow states to implement managed care delivery systems or otherwise limit individuals' choice of provider under Medicaid (i.e. STAR+PLUS).

- 1915(c) Waiver – Home and Community-Based Services – Waive Medicaid provisions to deliver long-term care services and supports in community settings as an alternative to institutional settings.
Medicaid Benefits: Acute and Long-Term Care

Acute Care
- Physician, inpatient, outpatient, pharmacy, behavioral health, lab, X-ray services
- Health care for children and pregnant women for episodic health care needs.

Long-Term Services and Supports
- Chronic health conditions requiring ongoing medical care & often social support.
- Includes care:
  - In facilities, e.g. nursing homes
  - For behavioral health conditions

Distinction based on:
- Cognitive and medical condition
- Need for assistance with activities of daily living
- Degree to which a disability is chronic
- Nature of services provided
- Setting in which services are provided
Medicaid Benefits: Mandatory vs. Optional

Mandatory

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Smoking cessation for pregnant women
Medicaid Benefits: Mandatory vs. Optional

Optional

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services

- Optometry services
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Other services approved by HHS Secretary
## Medicare and Medicaid Eligibility

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Federally funded</td>
<td>• Jointly funded by federal and state government</td>
</tr>
<tr>
<td>• Federally administered</td>
<td>• Administered by state</td>
</tr>
<tr>
<td>• Eligibility</td>
<td>• Eligibility</td>
</tr>
<tr>
<td>• People age 65+</td>
<td>• Low-income individuals</td>
</tr>
<tr>
<td>• People with disabilities</td>
<td>• Pays for most long-term care services &amp; supports</td>
</tr>
<tr>
<td>• People with end stage renal disease</td>
<td></td>
</tr>
</tbody>
</table>
Medicaid & Medicare: Dual Eligibles

Dual eligibles

- Individuals who are aged or disabled (Medicare eligible) AND
- Limited income (eligible for some Medicaid coverage)

Full Dual Eligibles

- Entitled to Medicaid benefits that Medicare does not cover.
- Include low-income individuals who are aged or disabled in community, waiver programs, nursing homes, and state schools.

Other Dual Eligibles

- Eligible only for Medicaid payments for Medicare premiums, deductibles, and coinsurance for Medicare services.
- Not entitled to Medicaid services.
- Include several categories of eligibility; incomes generally up to 135% of FPL.
Children’s Health Insurance Program (CHIP)

- Medical coverage for uninsured children up to age 19.
- Joint state-federal program, either:
  - Extension of state Medicaid program
  - Separate program
- Federal funding
  - Limited to block grant amounts allocated to each state.
- Not entitlement program, so states can:
  - Determine age and income eligibility.
  - Cap enrollment.
  - Limit service benefits (as approved by HHS).
CHIP Eligibility

CHIP covers children in families who:

• Have too much income to qualify for Medicaid.
• Cannot afford to buy private insurance.
• Generally are below 200% of the FPL.

States can design their CHIP program as:

• Medicaid expansion (7 states, D.C. and 5 territories)
• Separate from Medicaid (17 states)
• Combination of the two approaches (26 states)
Medicaid & CHIP: Texas Specifics
Medicaid serves:

- Low-income families
- Non-disabled children
- Related caretakers of dependent children
- Pregnant women
- People age 65 and older
- People with disabilities

Texas Medicaid does not currently serve:

- Non-disabled, childless adults
Texas CHIP: Eligibility

General eligibility

• Uninsured children under age 19.
  – CHIP Perinatal serves unborn children meeting eligibility requirements.

• Gross income up to 200% FPL.
• U.S. citizens or legal permanent residents.
• Not eligible for Medicaid.
• Eligibility is determined for a 12-month period
Federal Poverty Level (FPL)

- Compared to family’s income level.
- Basis for Medicaid financial eligibility.
- Intended to identify the minimum amount of income a family would need to meet certain, very basic, family needs.
- Indicate annual income levels by family size and are updated each year by the U.S. Department of Health and Human Services.
Federal Poverty Income Levels, 2014

U.S. Department of Health and Human Services poverty guidelines based on annual income

<table>
<thead>
<tr>
<th>Family Size</th>
<th>100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,670</td>
</tr>
<tr>
<td>2</td>
<td>15,730</td>
</tr>
<tr>
<td>3</td>
<td>19,790</td>
</tr>
<tr>
<td>4</td>
<td>23,850</td>
</tr>
<tr>
<td>5</td>
<td>27,910</td>
</tr>
<tr>
<td>6</td>
<td>31,970</td>
</tr>
<tr>
<td>7</td>
<td>36,030</td>
</tr>
<tr>
<td>8</td>
<td>40,090</td>
</tr>
</tbody>
</table>

At 100% of poverty, for families larger than 8, add $4,060 for each additional person.

https://federalregister.gov/a/2014-01303
Medicaid & CHIP Income Limits

Note: Federal Poverty Limits (FPLs) have been converted for use with Modified Adjusted Gross Income methodology.
Texas Medicaid: Optional Benefits

The state may choose to provide some, all, or no optional services specified under federal law.

Optional services provided in Texas include:

• Prescription drugs
• Physical therapy
• Occupational therapy
• Targeted case management
• Some rehabilitation services
• Certified Registered Nurse Anesthesiologists
• Eyeglasses/contact lenses
• Hearing aids
• Services provided by podiatrists
• Certain mental health provider types
Texas Medicaid: Pharmacy Benefits

HHSC Vendor Drug Program (VDP) manages the drug benefits for recipients that receive their benefits through the fee-for-service (FFS) model and oversees the administration of drug benefits by HHSC's contracted Medicaid managed care organizations.

HHSC Vendor Drug Program performs most pharmacy services functions, including policy and program oversight, contract compliance, formulary management, and pharmacy customer services.

- Contracts with 4,600 pharmacies to provide Medicaid clients with pharmacy benefits.

- Manages the formulary (list of covered drugs) and preferred drug list for all Medicaid recipients.
Texas Medicaid: Pharmacy Benefits

Contracts with private companies for:

• Pharmacy claims processing
• Prior authorization services
• Administration of drug rebate program
• Drug utilization review

VDP is conducting a major study on FFS reimbursement and is examining the possibility of adopting a new reimbursement methodology.
Texas CHIP: Benefits

- Inpatient general acute & rehabilitation hospital services
- Surgical services
- Transplants
- Skilled nursing facilities
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic & ambulatory health care center services
- Physician/physician extender professional services (including well-child exams & preventive health services)
- Laboratory & radiological services
- Durable medical equipment, prosthetic devices, & disposable medical supplies
- Home & community-based health services
- Nursing care services
- Inpatient mental health services
- Tobacco cessation
- Outpatient mental health services
- Inpatient & residential substance use treatment
- Outpatient substance use treatment
- Rehabilitation and habilitation services
- Hospice care services
- Emergency services
- Emergency medical transportation
- Care coordination
- Case management
- Prescription drugs
- Dental services
- Vision
- Chiropractic services
Texas CHIP Perinatal Program

Provides prenatal & post-partum care to pregnant women ineligible for Medicaid due to:

- income (whose income 186%-200% FPL), or
- immigration status (with income below 200% FPL).

Upon delivery, CHIP Perinatal newborns in families:

- With incomes at or below 185% FPL:
  - are deemed to Medicaid
  - receive 12 months of continuous Medicaid coverage

- With incomes above 185% FPL up to 200% FPL:
  - remain in CHIP Perinatal Program
  - receive CHIP benefits for the remainder of the 12-month coverage period

Members receiving CHIP Perinatal benefits are exempt from:

- 90-day waiting period & all cost-sharing, including enrollment fees & co-pays
Perinatal benefits = limited, basic prenatal care including:

- **Prenatal & postpartum visits**
  - First 28 weeks of pregnancy: 1 visit every 4 weeks
  - 28 to 36 weeks of pregnancy: 1 visit every 2-3 weeks
  - 36 weeks to delivery: 1 visit per week
  - 2 postpartum visits
  - Additional visits if medically necessary

- **Delivery**
  - Hospital facility charges
  - Professional services charges

- **Other**
  - Pharmacy (based on CHIP formulary)
  - Prenatal vitamins
  - Limited laboratory testing
  - Assessments
  - Planning services
  - Education and counseling

- **No cost-sharing requirements**
Texas Women’s Health Program (TWHP)

HHSC created the state-funded TWHP program to provide women with continued family planning service.

Implemented on November 1, 2012

Fully state-funded on January 1, 2013

HHSC continues ongoing outreach to enroll additional providers and educate clients about how to access providers.
Women can receive TWHP benefits if they are:

• 18 to 44 years old
• Not pregnant
• A U.S. citizen or a legal resident and live in Texas
• Not covered by health insurance (including Medicaid and CHIP)

Unless family planning services are not covered; or
Unless filing a claim with health insurance would cause physical, emotional, or other harm from a spouse, parent, or other person

• Not sterile or infertile
• Income at 185% or less of the Federal Poverty Level (FPL)
TWHP Client Benefits

• One family planning exam each year that may include:
  • Pap test
  • Screening for breast and cervical cancers, diabetes, sexually transmitted infections, and high blood pressure
• Family planning counseling and education, which can include natural family planning and abstinence
• Treatment of certain sexually-transmitted infections
• Birth control (not including emergency birth control)
• Follow-up family planning visits related to the method of birth control

*This program pays only for the services listed above. If a doctor finds a health problem such as diabetes or cancer, the doctor should refer the client to a doctor or clinic that can treat that problem. Clients might have to pay for those extra services.
The Texas Medicaid program has grown considerably in recent years.

- Texas Medicaid served over 3.54 million people in SFY 2011
- SFY 2011, persons who are aged, blind or disabled represent:
  - 25% of Texas Medicaid recipients.
  - 58% of Texas Medicaid costs.
  - They often have complex medical conditions, needing both
    - Acute care (e.g. hospitalization, outpatient services, and laboratory), and
    - Long term services and supports (LTSS) provided in the home or community (e.g. assistance with daily living, skilled nursing, and therapy services).
Texas Medicaid:
Historical Enrollment

Medicaid Caseload by Group
September 1977 - August 2012

Caseload has grown by almost 60% in the last decade, September 2002 to August 2012, growing by 1.4 million clients.


Poverty-Related Children, Ages 1 - 18

Incorporation of Pregnant Women / Newborns.

Income Assistance: TANF

Original Medicaid Population: Aged and Disability-Related Adults and Children
Texas Medicaid: Enrollment by Age, State Fiscal Year 2011

Unduplicated Clients, SFY 2011 = 4,567,077

Source: HHSC Strategic Decision Support.
Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.
Texas Medicaid: Enrollment & Spending

Average number of Texans with Medicaid each month, SFY 2011: 3.54 million
- Children who do not have a disability total 73 percent of Texas Medicaid full-benefit clients, and averaged 2.6 million clients per month in state fiscal year (SFY) 2011.

**Texas Medicaid beneficiaries & expenditures, state fiscal year 2011**
Texas CHIP: Average Monthly Enrollment, State Fiscal Year 2002-2012

Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.
Texas CHIP Perinatal Program: Enrollment, State Fiscal Years 2007-2011

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Caseload</th>
<th>Perinates under 185% FPL</th>
<th>Perinates over 185% FPL</th>
<th>Newborns under 185% FPL</th>
<th>Newborns over 185% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007*</td>
<td>20,465</td>
<td>16,602</td>
<td>351</td>
<td>3,440</td>
<td>72</td>
</tr>
<tr>
<td>2008</td>
<td>58,589</td>
<td>31,631</td>
<td>586</td>
<td>25,854</td>
<td>519</td>
</tr>
<tr>
<td>2009</td>
<td>67,849</td>
<td>36,186</td>
<td>511</td>
<td>30,694</td>
<td>458</td>
</tr>
<tr>
<td>2010</td>
<td>67,148</td>
<td>36,158</td>
<td>433</td>
<td>30,215</td>
<td>342</td>
</tr>
<tr>
<td>2011</td>
<td>44,214</td>
<td>36,775</td>
<td>546</td>
<td>6,582</td>
<td>310</td>
</tr>
</tbody>
</table>

* Averages are for Jan - Aug 2007 only, the first eight months of program implementation.
Texas Medicaid: FMAP

Federal Medical Assistance Percentages (FMAP)

• Portion of total Medicaid costs paid by the federal government.

• Texas FMAP for federal fiscal year 2014: 58.69
  – Of each dollar spent on Medicaid services in Texas, the federal government pays approximately 59 cents.

• Based on average state per capita income compared to the U.S. average.

• Small changes in the FMAP could result in significant loss or gain of federal funds.
### Texas Medicaid: State Budget
**FFYs 1998-2011***

<table>
<thead>
<tr>
<th></th>
<th>Medicaid Budget** All Funds</th>
<th>Total State Budget*** All Funds</th>
<th>Annual Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>$ 8.943</td>
<td>$ 43.014</td>
<td>20.79%</td>
</tr>
<tr>
<td>1999</td>
<td>$ 9.527</td>
<td>$ 45.278</td>
<td>21.04%</td>
</tr>
<tr>
<td>2000</td>
<td>$10.000</td>
<td>$ 49.453</td>
<td>20.22%</td>
</tr>
<tr>
<td>2001</td>
<td>$10.952</td>
<td>$ 52.440</td>
<td>20.88%</td>
</tr>
<tr>
<td>2002</td>
<td>$12.678</td>
<td>$ 56.621</td>
<td>22.39%</td>
</tr>
<tr>
<td>2003</td>
<td>$14.593</td>
<td>$ 59.058</td>
<td>24.71%</td>
</tr>
<tr>
<td>2004</td>
<td>$14.585</td>
<td>$ 61.507</td>
<td>23.71%</td>
</tr>
<tr>
<td>2005</td>
<td>$15.561</td>
<td>$ 65.204</td>
<td>23.86%</td>
</tr>
<tr>
<td>2006</td>
<td>$16.534</td>
<td>$ 69.961</td>
<td>23.63%</td>
</tr>
<tr>
<td>2007</td>
<td>$17.275</td>
<td>$ 75.099</td>
<td>23.00%</td>
</tr>
<tr>
<td>2008</td>
<td>$19.053</td>
<td>$ 82.150</td>
<td>23.19%</td>
</tr>
<tr>
<td>2009</td>
<td>$20.798</td>
<td>$ 89.981</td>
<td>23.11%</td>
</tr>
<tr>
<td>2010</td>
<td>$22.821</td>
<td>$ 92.056</td>
<td>24.79%</td>
</tr>
<tr>
<td>2011</td>
<td>$24.815</td>
<td>$ 95.461</td>
<td>26.00%</td>
</tr>
</tbody>
</table>

*Dollars in billions.

**Excludes Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funds

***State budget reflects state fiscal year beginning in September.

Texas Medicaid Budget
FFYs 1987-2011

*Includes DSH and UPL funds.
Texas Medicaid: DSH Payment

Medicaid Disproportionate Share Hospital (DSH) Program

- Source of reimbursement to state-operated and non-state (local) Texas hospitals that treat indigent patients.
- Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients.
- Not tied to specific services for Medicaid-eligible patients, unlike other Medicaid payments.

Total funds to all DSH hospitals in state fiscal year 2012: $1.576 billion

- State DSH Hospitals: $374.5 million
- Non-state DSH Hospitals: $1.201 billion
Uncompensated Care (UC)

- Financing mechanism allowed under the 1115 Waiver to provide supplemental payments to hospitals or other providers.
- Covers same costs as DSH plus uncompensated costs for physicians, pharmacy and clinics.
- Non-federal share primarily provided through local funds transferred to the state.

HHSC currently makes UC payments to:

- 14 state-owned hospitals
- 6 non-state large urban public hospitals
- 97 non-state small public hospitals
- 194 privately-owned hospitals
- 21 physician group practices
Enhanced Federal Medical Assistance Percentage (EFMAP)

- Portion of total CHIP costs paid by the federal government.
- Generally higher than Medicaid
  - In FY2014, the federal government pays 71.08% of CHIP medical care expenditures
  - Compared to 58.69% of Medicaid medical care expenditures.
Texas CHIP: Historical Spending, State Fiscal Year 2000-2012

Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

Final SFY 2012 is estimated.
Texas CHIP: Cost Sharing

CHIP annual enrollment fee:

- $0 for families with income at or below 150% FPL
- $35 for families 151-185% FPL
- $50 for families 186-200% FPL

Families are required to pay the enrollment fee upon enrollment or renewal of CHIP.
Families enrolled in CHIP are responsible for co-payments for certain plan benefits.

<table>
<thead>
<tr>
<th>Service</th>
<th>At or below 100% FPL</th>
<th>101% to 150% FPL</th>
<th>151% to 185% FPL</th>
<th>186% to 200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative Health Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$3</td>
<td>$5</td>
<td>$20</td>
<td>$25</td>
</tr>
<tr>
<td>Non-Emergency ER Use</td>
<td>$3</td>
<td>$5</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Generic Prescription</td>
<td>$0</td>
<td>$0</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Name-brand Prescription</td>
<td>$3</td>
<td>$5</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Inpatient Care (per admission)</td>
<td>$15</td>
<td>$35</td>
<td>$75</td>
<td>$125</td>
</tr>
<tr>
<td>Cost-sharing Cap (percent of family income)</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Medicaid Managed Care
What is Managed Care?

Healthcare provided through a network of doctors, hospitals and other healthcare providers responsible for managing and delivering quality, cost-effective care.

The State pays a managed care organization (MCO) a capped rate for each client enrolled, rather than paying for each unit of service provided.
Medicaid Delivery Models: Managed Care vs. FFS

Managed Care Programs in Texas

- STAR – provides acute care services to children, pregnant women, and families.
- STAR+PLUS – provides acute and long-term services and supports to individuals with disabilities and elderly people.
- NorthSTAR – provides behavioral health services to individuals in a multi-county area in and around Dallas.
- STAR Health – provides a comprehensive managed care program for children in foster care.

Fee-for-Service (FFS)/Traditional Medicaid

- A few eligibility categories remain in FFS.
- Individuals in FFS can choose any provider.
- FFS does not offer the management or utilization controls that managed care provides.
Payment and processes vary by delivery model

• **Managed Care:**
  – HHSC pays MCOs a capitated rate.
  – MCOs pay providers reimbursement rates established by contracts with the providers.
  – Providers send claims (bills for services) to the MCO for payment.

• **FFS:**
  – HHSC establishes FFS methodologies to pay providers.
  – Claims are sent to state for payment.
Managed Care Client Enrollment

As of August 2013:
3,643,414 clients are enrolled in Texas Medicaid
2,959,403 members are enrolled in:
  – STAR
  – STAR Health
  – STAR+PLUS
Affordable Care Act Impact
Affordable Care Act

• Changes how HHSC determines eligibility for certain Medicaid programs and CHIP
• Establishes a federal Marketplace where people can shop for health insurance and apply for help paying for health insurance
• Requires HHSC to coordinate eligibility determinations with the federal Marketplace
The following programs use the new federal rules to determine eligibility:

- Children’s Medicaid (CMA)
- Children’s Health Insurance Program (CHIP) and CHIP Perinatal
- Pregnant Women’s Medicaid (PW)
- Medicaid for Transitioning and Foster Care Youth (MTFCY)
- Transitional Medicaid
- Medically Needy Spend Down
- Refugee Medical Assistance (RMA)
- Parents and Caretaker Relatives Medicaid (formerly TANF-Level Families Medicaid)
Certain programs do not use the new federal rules to determine eligibility, including, but not limited to:

- Medicaid for Breast and Cervical Cancer (MBCC)
- Texas Women’s Health Program (TWHP)
- Medicaid for the Elderly and People with Disabilities (MEPD)
- Former Foster Care Children (new program)
The Affordable Care Act requires changes to how HHSC determines eligibility for certain Medicaid and CHIP groups. Some of these changes include:

- New income rules based on federal tax rules
- Prohibition of assets tests and most income disregards
- Changes to applications, including the availability of a new streamlined application (for Medicaid only)
- 12-month certification periods for most programs
- Eligibility renewals based on available information to the extent possible
Households under the New Federal Rules

The new federal rules change the way we view households when determining eligibility for certain Medicaid programs and CHIP.

Prior to January 1, 2014
- Viewed households based on people’s relationships (family relationships) to one another and people’s living arrangements

As of January 1, 2014
- View households based on:
  - Tax status
  - Tax relationships
  - Family relationships
  - Living arrangements
The new federal rules change how income is calculated for affected Medicaid programs and CHIP.

**Prior to January 1, 2014**

- Income was determined by calculating the value of resources (for example, the family’s car)
- Income calculation used current types of countable and exempt income, and allowable deductions

**As of January 1, 2014**

Programs using the new federal rules:
- Prohibit resource tests
- Change some countable and exempt income
- Exclude most common expenses and deductions
The new federal rules change certification periods for certain Medicaid programs and CHIP.

Prior to January 1, 2014

• Medicaid programs and CHIP have certification periods that vary in length

As of January 1, 2014

• Certain Medicaid programs and CHIP have a 12-month certification period
1115 Texas Healthcare Transformation Waiver
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
- Incentivize delivery system improvements and improve access and system coordination
- Establishes Regional Healthcare Partnerships (RHPs) anchored by public hospitals or another public entity in coordination with local stakeholders.
Uncompensated Care (UC) and DSRIP

• Under the waiver, 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.
DSRIP in Texas

• Across the 20 RHPs, 300 DSRIP performing providers submitted projects:
  • 224 hospitals (public and private)
  • 18 physician groups
  • 38 community mental health centers
  • 20 local health departments.

• As of March 12, 2014, there were 1,277 approved and active DSRIP projects. Most common project types:
  • Expand access to primary and specialty care
  • Behavioral health interventions to prevent unnecessary use of services in certain settings (e.g. emergency department (ED), jail)
  • Programs to help targeted patients navigate the healthcare system.

• More than 200 additional proposed 3-year DSRIP projects currently are under review with federal approval anticipated by June 2014.
DSRIP Payments

- DSRIP participants are eligible to earn $4.66 billion All Funds for the first three years of the waiver.
- While the valuations for the last two years of the waiver are not final, DSRIP projects for those years are estimated to be valued at over $5 billion total.
- For successful submission of the 20 regional plans in the first year, RHP anchors and DSRIP providers received almost $500 million.
- For project metrics achievement in the second year of the waiver, DSRIP providers received about $1.6 billion (as of January 2014).
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, and to determine if they require any modifications or technical assistance to be successful.

- This assessment will include a review each project’s health outcomes of those served and particularly Medicaid and uninsured individuals, and how the project could be strengthened.
DSRIP Projects – Measuring Success

• Groups of providers and other DSRIP participants are meeting across the state to work collaboratively to identify best practices, share ways to improve projects, and promote continuous quality improvement.
  • These learning collaboratives are underway in many regions, and a statewide learning collaborative summit for all RHPs will be held September 9-10, 2014.

• Common topics for the regional learning collaboratives:
  • Behavioral healthcare, including integrated behavioral/primary healthcare
  • Care transitions and patient navigation
  • Chronic care and disease management
  • Reducing unnecessary emergency room use, potentially preventable readmissions
  • Primary care/access

• HHSC’s formal evaluation of the waiver also will help provide information for the waiver renewal.
  • An interim evaluation report is due to CMS in 2015.
DSRIP Projects – Primary Care

- Many of the approved DSRIP projects focus on primary care, including:
  - 199 projects to expand primary care capacity, including new clinics, mobile clinics and expanded space, hours and staffing
  - 36 projects to enhance/expand medical homes
  - 27 projects to increase training of primary care workforce
  - 18 projects to increase, enhance and expand dental services
  - 7 projects to redesign primary care
Examples of promising primary care-related projects from the regions

- City of Houston Department of Health and Human Services (RHP 3) - Expand oral health services for children, expand a dental sealant program for elementary school children in clinics, and initiate new oral health services for eligible perinatal women.

- UT Health Science Center San Antonio (RHP 5) - Expand existing Family Medicine residency faculty at McAllen Medical Center.

- University Hospital (RHP 6) - Expand primary care access by developing and implementing school-based health centers alongside mobile screenings.

- Texas A&M Physicians (RHP 17) – Transform primary care clinics into patient centered medical homes.

- Hamilton Hospital (RHP 19) - Open a rural health clinic in Archer City.
• About 400 of the approved DSRIP projects focus on behavioral healthcare, including:
  • 90 interventions to prevent unnecessary use of services (in the criminal justice system, ED, etc.)
  • 58 projects to enhance BH service availability (hours, locations, transportation, mobile clinics)
  • 59 projects to develop BH crisis stabilization services
  • 49 projects to integrate primary and BH care services
  • 21 projects to deliver BH care services through telemedicine/telehealth
Examples of promising behavioral healthcare projects from the regions

- Coastal Plains Community Center (RHP 4) - Integrate primary healthcare and substance abuse services at 5 BH clinics.
- Center for Health Care Services (RHP 6) - Establish a centralized, accessible campus from which systems or families can obtain care for children and adolescents with a serious emotional and/or behavioral problem or developmental delay.
- Austin Travis County Integral Care (RHP 7) – Expand Mobile Crisis Outreach Team capacity at key community intercept points.
- Metrocare (RHP 9) – Integrate BH into the outpatient obstetrics setting to provide increased access to mental health services for the treatment of postpartum depression.
- Hill Country Community MHMR Center (RHPs 6, 7 & 13) – Implement Trauma Informed Care Services
Waiver Renewal Timeframe

• April 1, 2014 marked the mid-point of the waiver.

• The waiver expires on September 30, 2016.

• HHSC must submit a renewal request to the Centers for Medicare & Medicaid Services (CMS) no later than September 30, 2015, to extend the waiver.

• HHSC is beginning to discuss renewal with key stakeholders and plans to hold public meetings in 2014 and 2015 to solicit public input.
Waiver Renewal
Next Steps

• In anticipation of waiver renewal, HHSC is working with all of the regions to ensure that the DSRIP projects show measurable improvements in healthcare access and outcomes, particularly for Medicaid and the low-income uninsured patients.

• Possible next steps for DSRIP
  • Reflect a unified quality strategy for Texas Medicaid managed care and DSRIP.
  • Establish shared incentives within regions to make improvements in healthcare delivery and population health indicators.
Additional Resources

Medicaid Managed Care Initiatives
http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml

Healthcare Transformation 1115 waiver
www.hhsc.state.tx.us/1115-waiver.shtml

HHSC News Releases
www.hhsc.state.tx.us/news/release.shtml

Texas Medicaid Pink Book
http://www.hhsc.state.tx.us/medicaid/about/PB/toc.shtml