



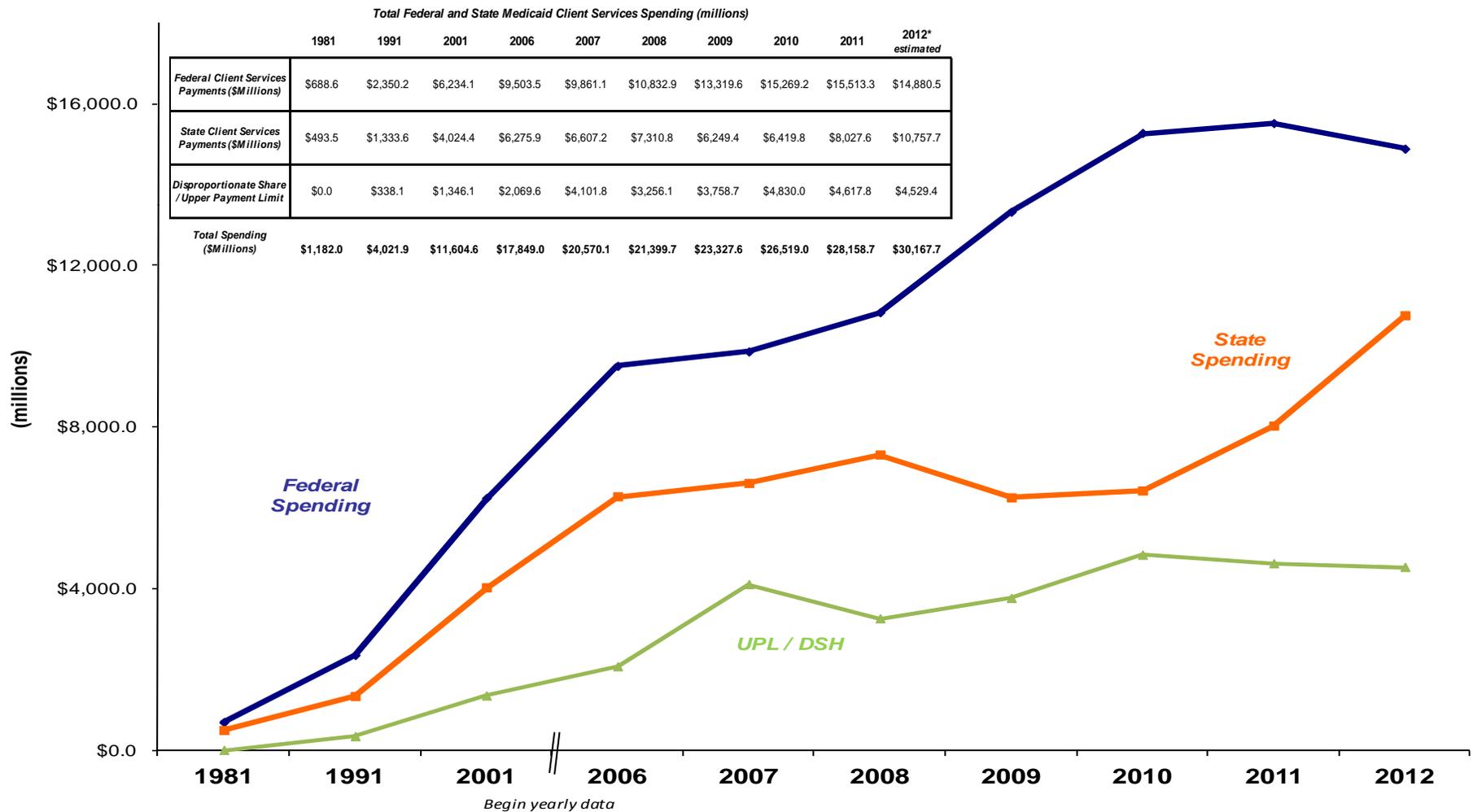
Presentation to the House Appropriations Subcommittee on Article II: Medicaid

**Greta Rymal, Deputy Executive Commissioner for Financial Services
Billy Millwee, Deputy Executive Commissioner for Health Services Operations
May 7, 2012**

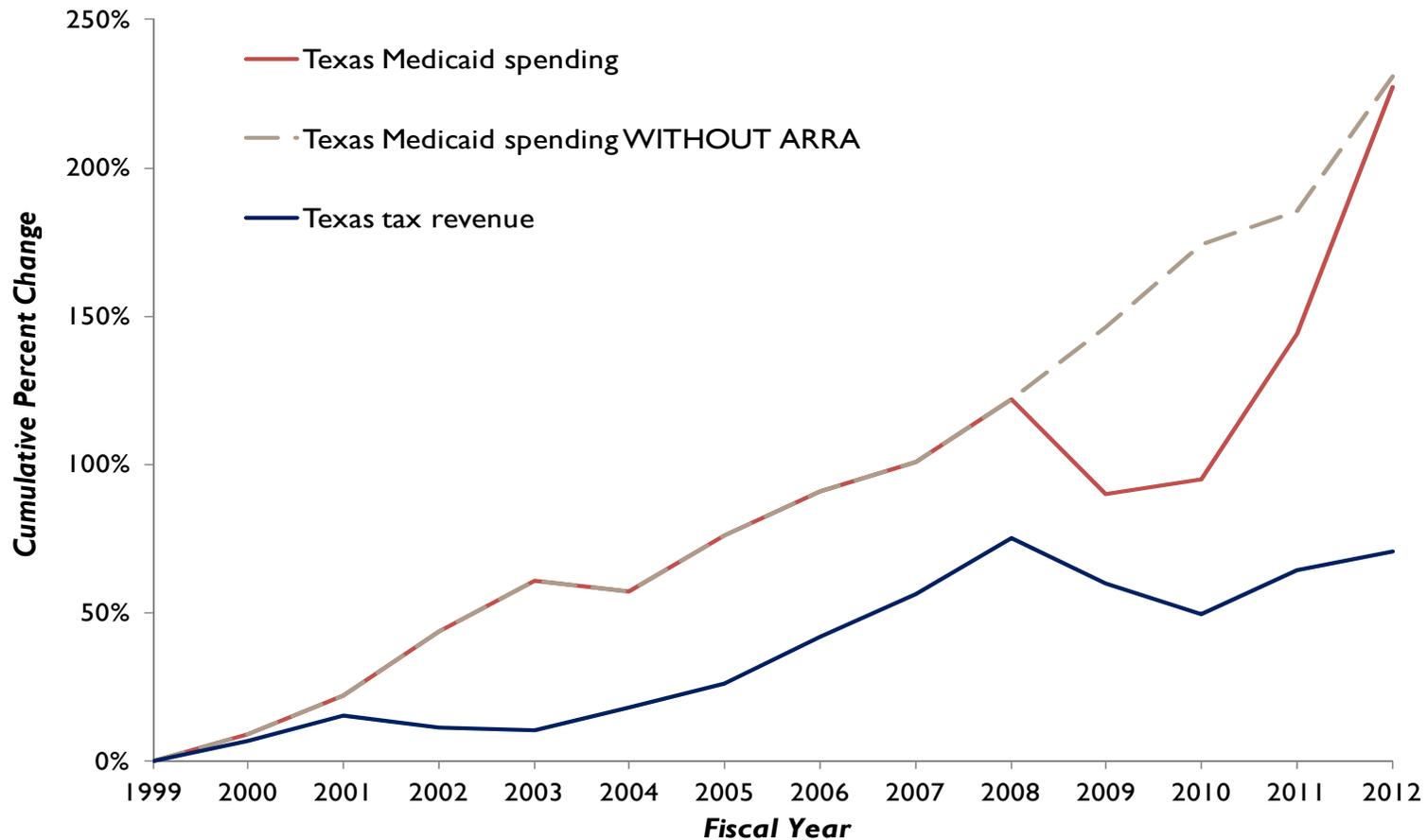
Overview

- Medicaid Trends in Expenditures and Caseload
- Cost Containment Initiatives
- Hospital Payment Reform Initiatives

Medicaid Trends: Historical State & Federal Medicaid Spending



Texas Tax Revenue & General Revenue Medicaid Spending, With and Without ARRA



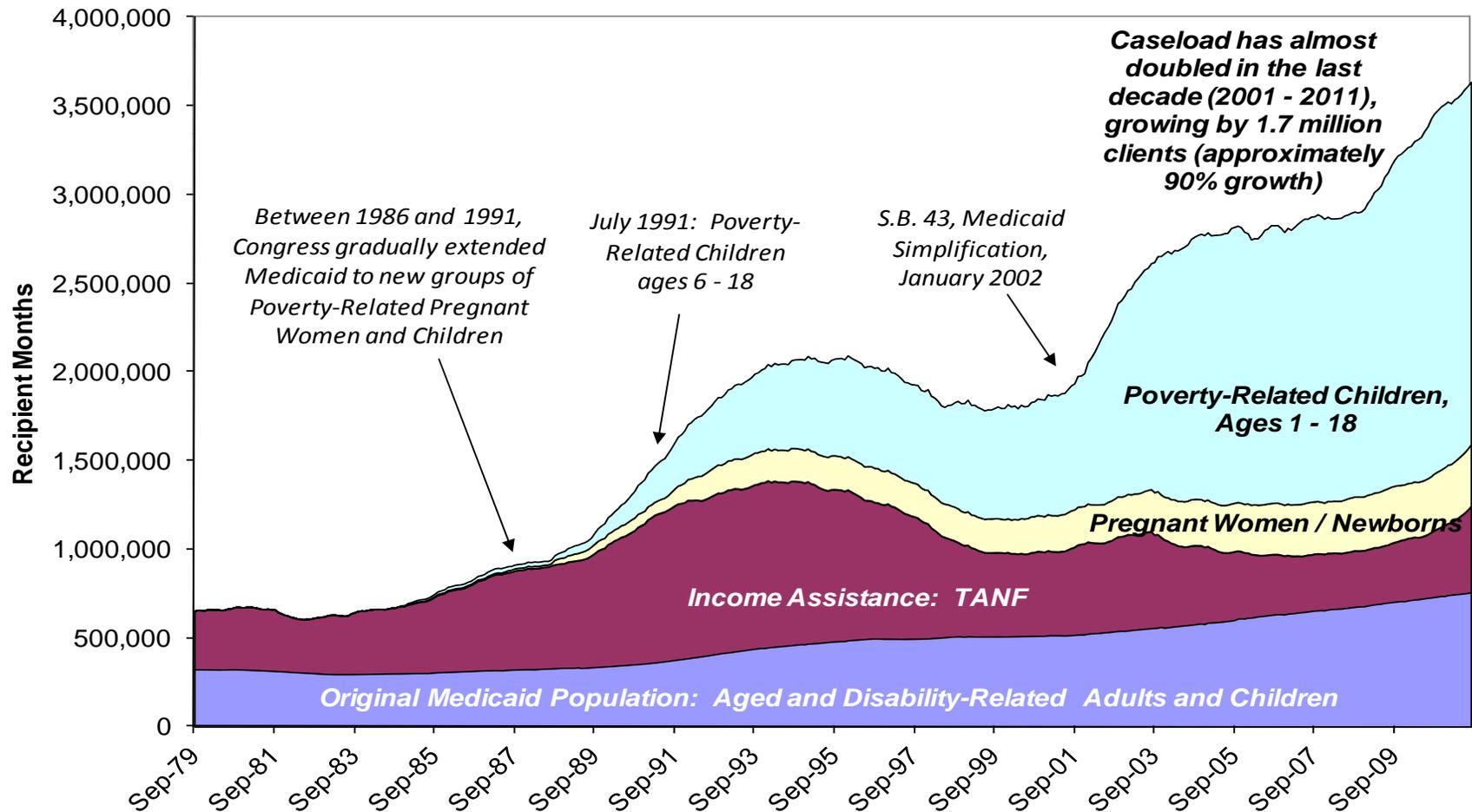
Notes: Tax revenue does not include other types of state revenue. Actual tax collections for 2011-2012 may vary. 2012 Medicaid spending is estimated. Tax data is from state fiscal years, Medicaid spending is from federal fiscal years.

Sources: Tax revenue - Legislative Budget Board Fiscal Size-Up reports; Medicaid spending - CMS37 report (15 NOV 11).

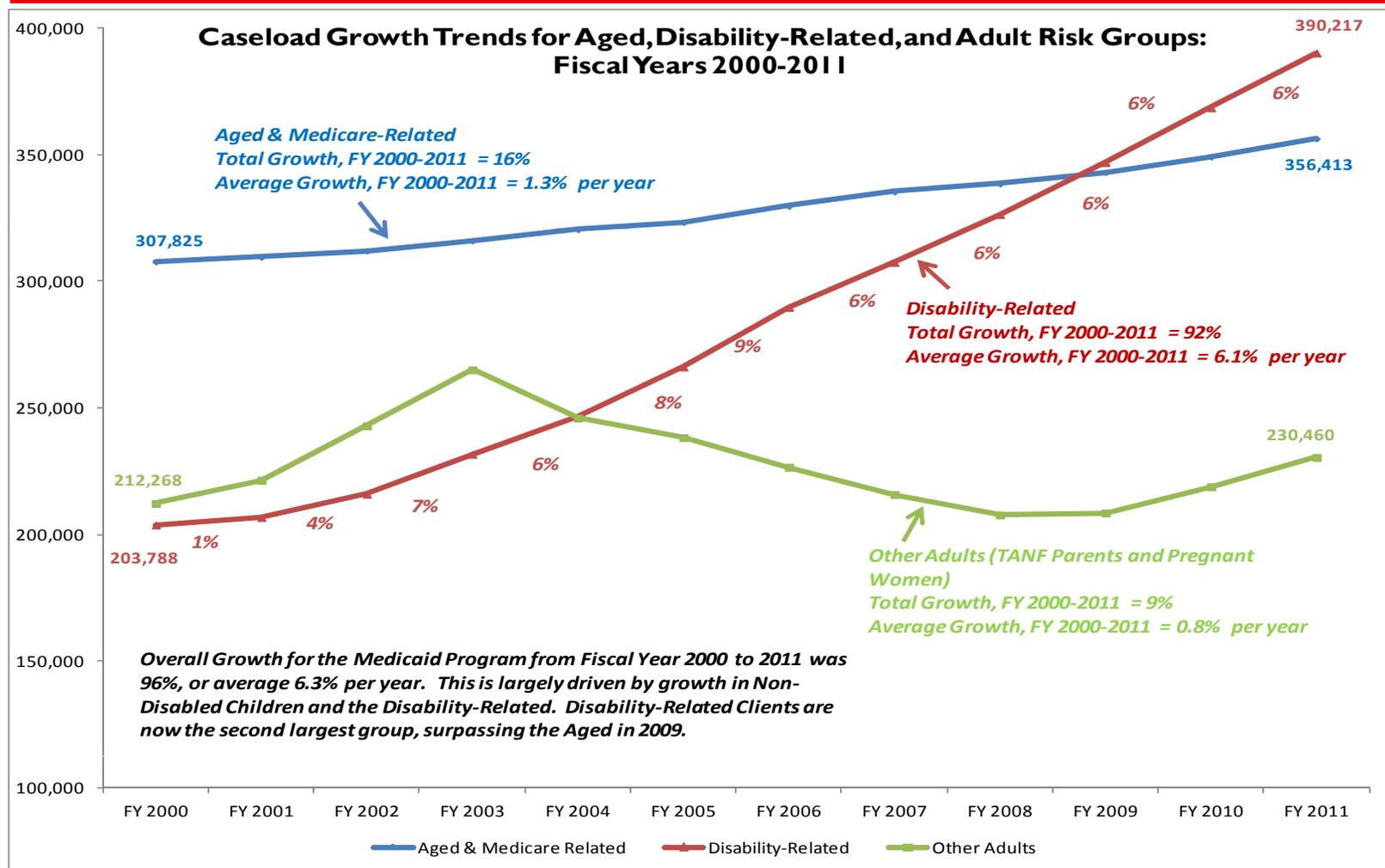
Prepared by: Strategic Decision Support, Texas Health and Human Services Commission, February 2012.

Medicaid Caseload Trends: Who Does Medicaid Serve?

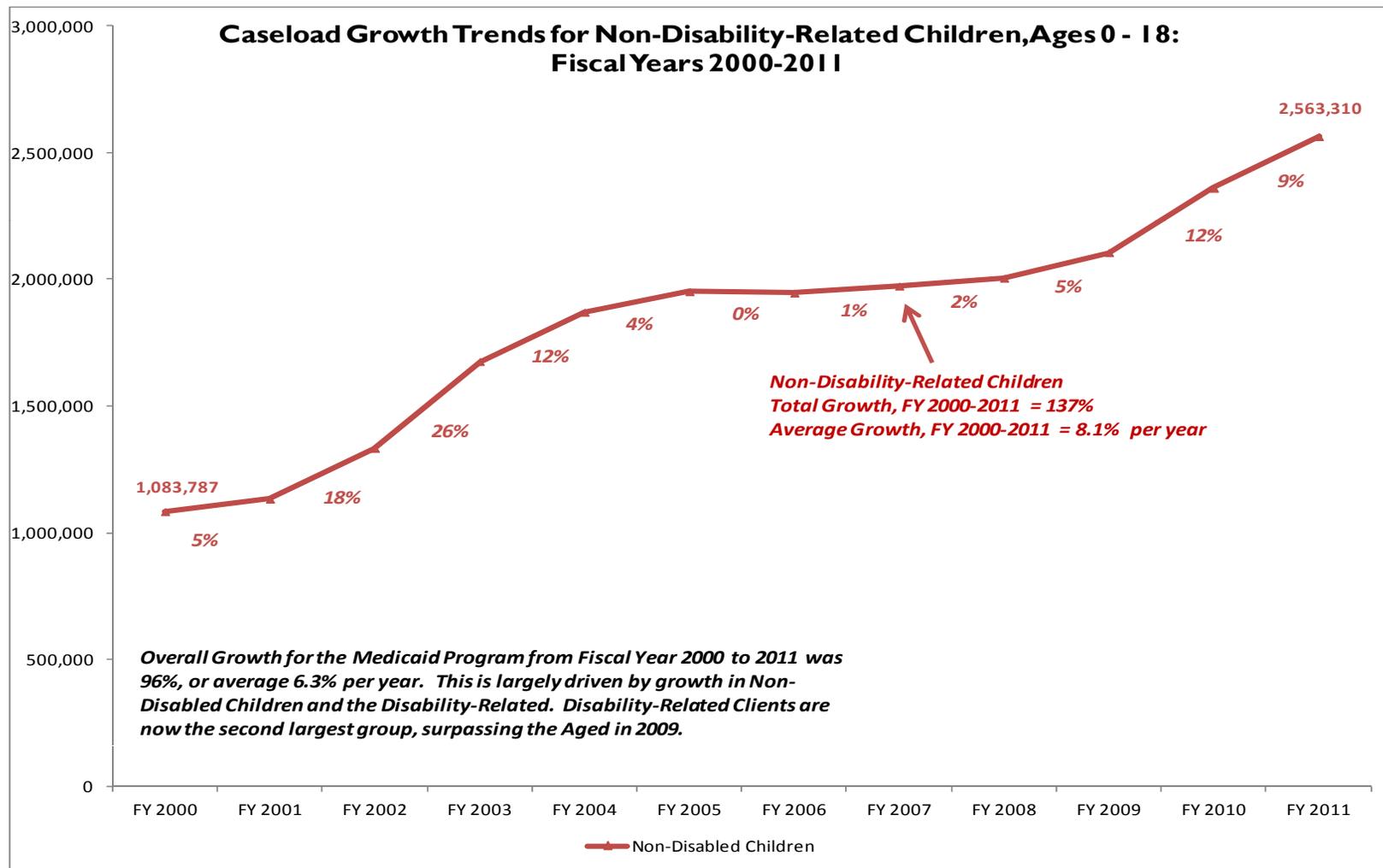
Texas Medicaid Caseload by Group, September 1979 - August 2011



Medicaid Caseload Trends by Risk Group: Aged, Disability-Related and Other Adults

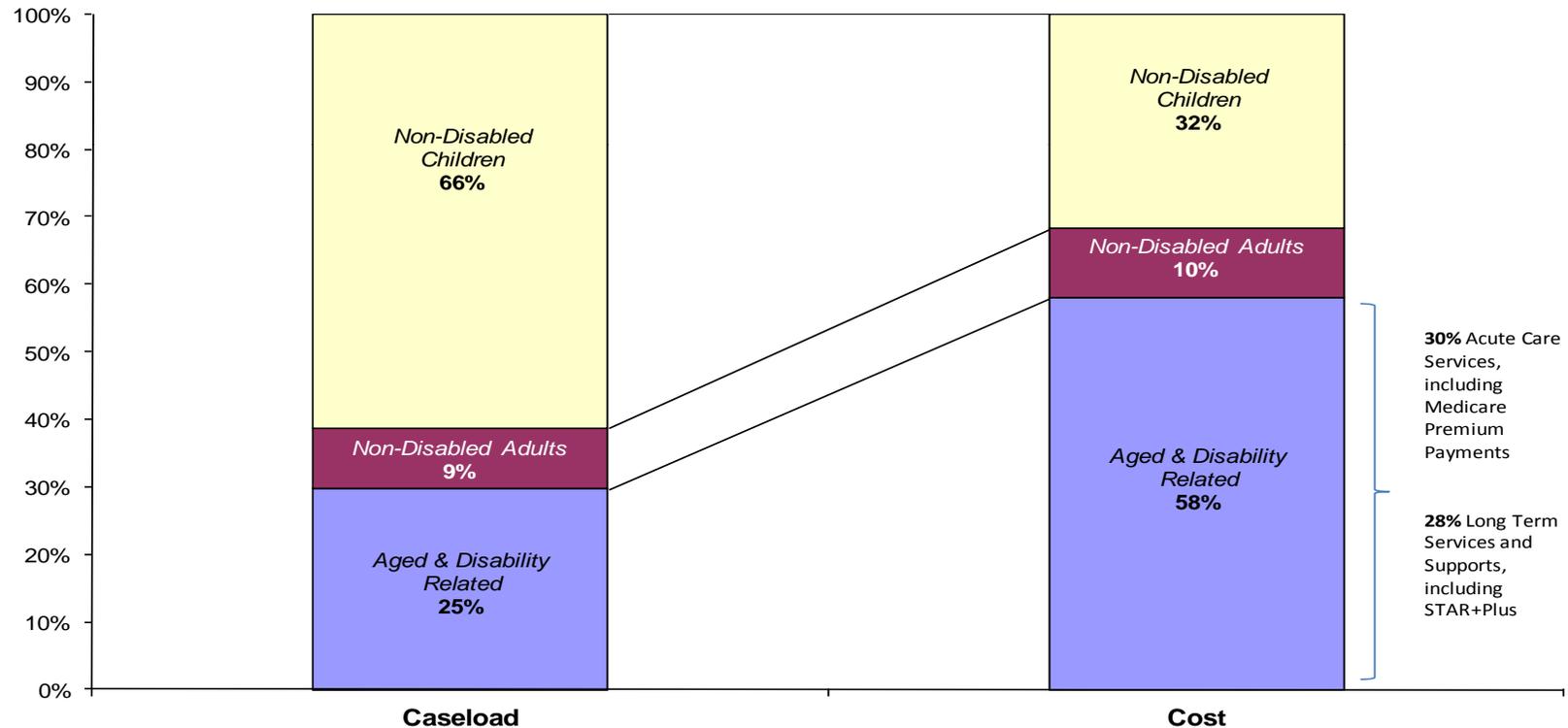


Medicaid Caseload Trends by Risk Group: Non-Disabled Children



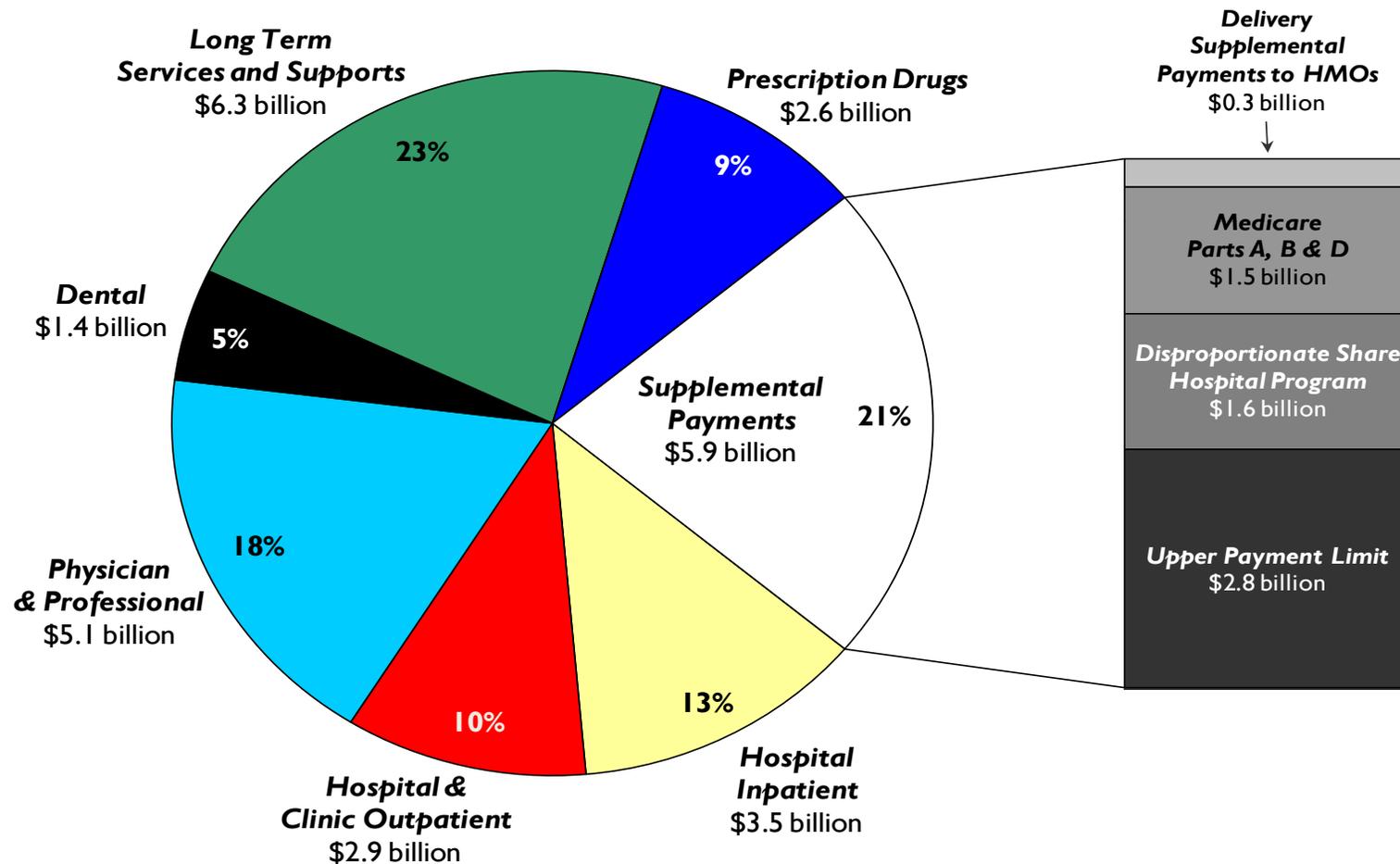
Medicaid Caseload and Cost: Who Does Medicaid Serve at What Cost?

**Texas Medicaid Beneficiaries and Expenditures
Fiscal Year 2010**



Source: HHS Financial Services, 2010 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Care. Costs and caseload for all Medicaid payments for full and non-full beneficiaries (Women's Health Waiver, Emergency Services for Non-Citizens, Medicare payments) are included. Children are all Poverty-Level Children, including TANF. Disability Related Children (under age 21) are in the Aged & Disability-Related Group.

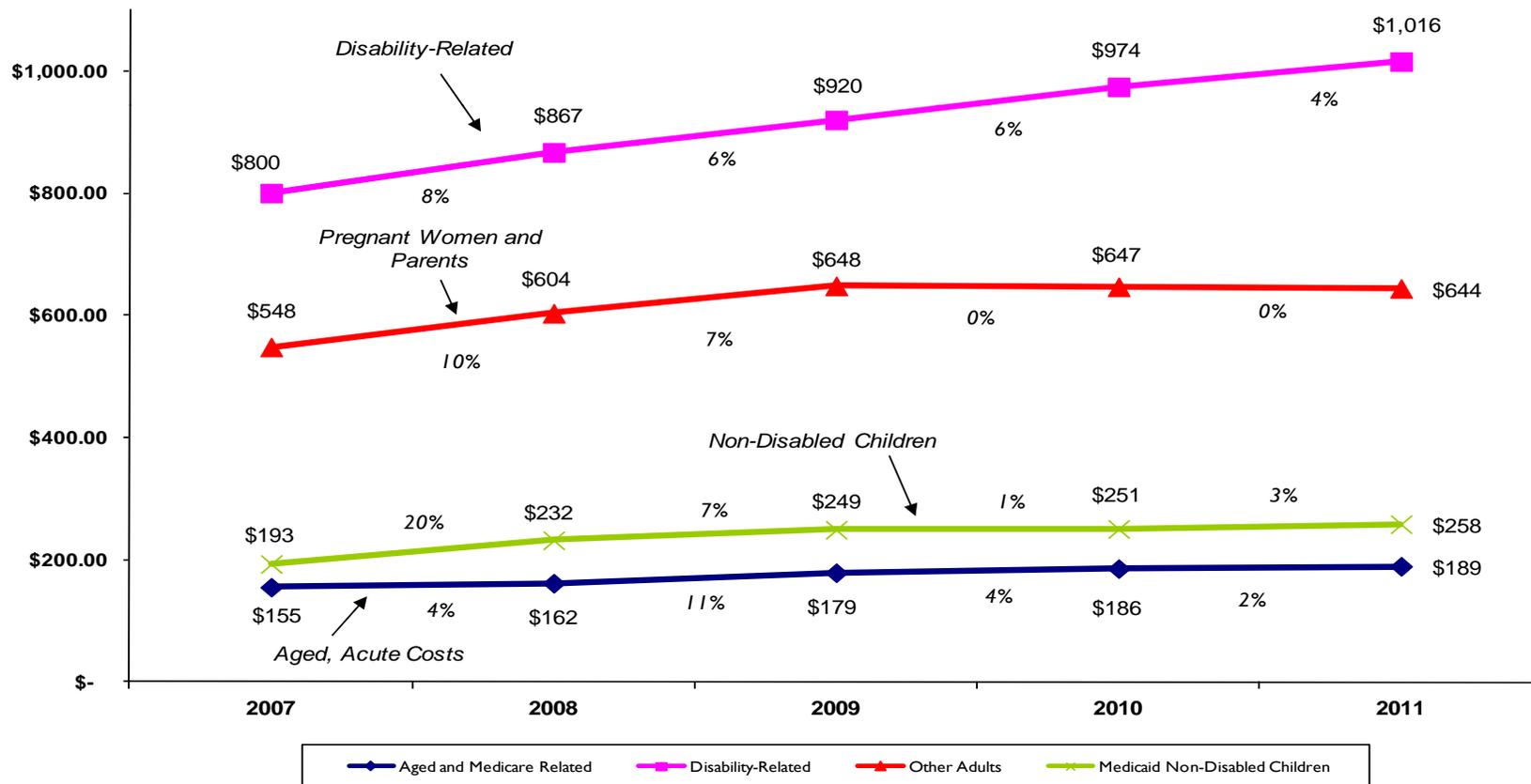
Texas Medicaid Expenditures, SFY 2011* by Service Type — Total \$28 billion



* Source: Medicaid Management Information System (MMIS).
Prepared By: Strategic Decision Support, Texas Health and Human Services Commission, April 2012.
Note: Due to rounding, totals may not add up exactly.

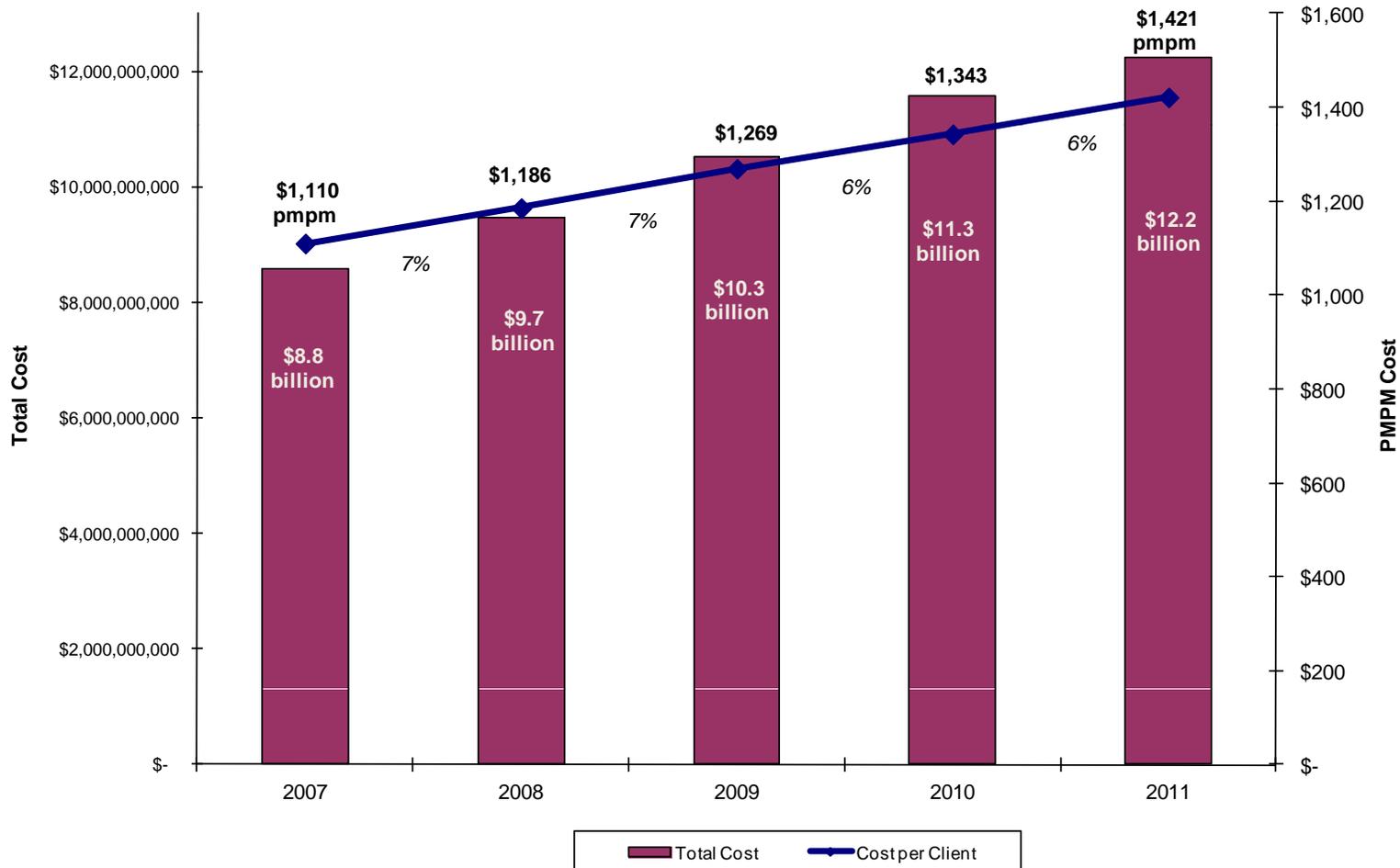
Medicaid Cost Trends: Acute Care Cost Per Client, by Risk Group

Cost per Recipient Month by Risk Group, 2007 - 2011
Costs are Acute Care with no STAR+Plus Long Term Care, and include all Drug and Dental



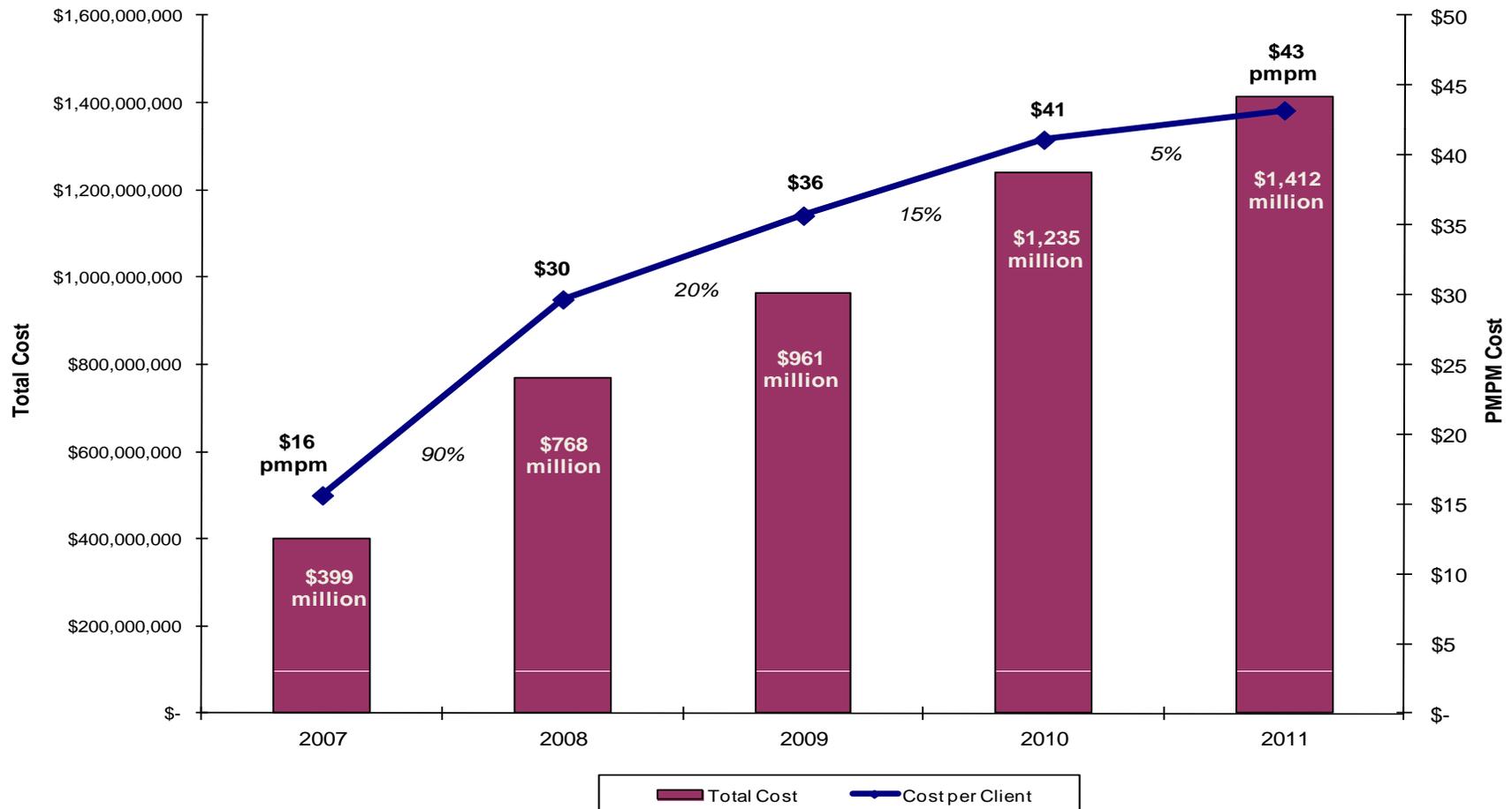
Medicaid Cost Trends: Total Cost and Cost Per Client, Aged & Disability-Related

Total Cost, including Long Term Services and Supports, and Cost per Recipient Month, Aged and Disability-Related Clients, 2007-2011



Medicaid Cost Trends: Dental Costs

Total Cost and Cost per Recipient Month, Medicaid Dental Services, FY 2007- FY 2011



Cost Containment: Overview

HHS Cost Containment Initiatives
2012-13 General Appropriations Act, H.B. 1
General Revenue (\$ in mil.)

Cost Containment Initiative	H.B. 1 Target
HHSC Rider 61: Medicaid Funding Reduction	\$450.0
Special Provisions, Section 16: Provider Rates	\$571.3
Special Provisions, Section 17: Additional Cost Containment Initiatives	\$705.0
HHSC Rider 51: Managed Care Expansion	\$385.7
Other Initiatives	\$85.6
Total, Cost Containment Initiatives	\$2,197.6
Estimated Premium Tax from Managed Care Expansion	\$238.0
HHSC Rider 59: Federal Flexibility	\$700.0
Total, Cost Containment Initiatives, Premium Tax, and HHSC Rider 59	\$3,135.6

Cost Containment: Overview

- Based on current estimates 88% of the savings for cost containment initiatives will be achieved, including:
 - 89% of Rider 61 Medicaid cost containment target
 - Rider 61 includes 30 initiatives with a focus on improving quality of care and health outcomes
 - 85% of Section 16 rate reduction target
 - All rates effective September 2011, with reductions ranging from 1% to 10.5%
 - 82% of Section 17 additional cost containment target
 - Section 17 includes 14 initiatives affecting DADS, DSHS, and HHSC, including Medicare equalization

Cost Containment: HHSC Rider 61

Medical Imaging Fee Schedule

- Effective September 1, 2011 in fee-for-service and in managed care rate assumptions.

Reductions in Payments for Non-Emergency Services Provided in Hospital Emergency Departments

- Effective September 1, 2011.

Durable Medical Equipment (DME) and Laboratory Fees

- Rate changes and new policies effective September 1, 2011 in fee-for-service and in managed care rate assumptions.
- Additional DME rate changes were implemented March 1, 2012.

Cost Containment: HHSC Rider 61

Amount, Duration, and Scope Adjustments

- Renal dialysis policy changes – effective January 1, 2012.
- Cranial orthotic therapy policy changes – effective February 1, 2012.
- Porcelain crowns limited to front, permanent teeth – expected May 2012.
- Changes to policies for hearing, vision, and therapies under review.

Medical Transportation Program

- Effective April 2011, Federal funds leveraged with approved federal waiver.
- Per Rider 55, S.B. 1, 81st Legislature, the Full-Risk Broker Pilot was implemented in two areas:
 - Houston/Beaumont in March 2012
 - Dallas/Ft. Worth in April 2012
- Strategic redesign of the program is under development.

Cost Containment: Special Provisions, Sections 16 and 17

Provider Rate Reductions

- Effective September 1, 2011 in fee-for-service and in managed care rate assumptions.
- Rate reductions range from 1% to 10.5%.
- 8% reduction for hospitals.

Reduction in Managed Care Administrative Portion of Premiums

- Effective September 1, 2011.

Medicare Equalization

- Effective January 1, 2012.
- Limits HHSC Medicare Part B cost sharing for dual eligible patients to no more than the Medicaid payment amount for the same service.
- HHSC is implementing adjustments related to the policy for cancer medications, psychiatry/psychology services, including licensed social workers, and portable x-rays.

Cost Containment: Hospital Payment

- 8% reduction
- Statewide standard dollar amount (SDA) with add-ons to recognize high-cost circumstances (wage index, trauma, teaching hospitals)
 - For FY 2012 only, \$20 million general revenue appropriated to provide a transition for the most affected hospitals
- Outlier payments reduced 10%
- Reduction in payments for non-emergency services provided in hospital emergency departments
- Medical imaging fee schedule (outpatient hospital services)

Hospital Payment Reform: Quality-Based Payments

Pay for Quality – P4Q Adjustment

- Adjusts payments by linking quality to payment.
- Removes incentives that reward poor quality by adjusting claim reimbursement or overall hospital reimbursement.
- Encourages hospitals to focus on quality outcomes rather than volume.

Hospital-Acquired Conditions

- Using present on admission (POA) indicators, adjust payment for inpatient stays for hospital-acquired conditions effective September 1, 2010.
- Currently applied to hospitals prospectively reimbursed under the Diagnosis Related Group (DRG) method by determining the DRG without the inclusion of the hospital-acquired condition.
- HHSC will apply to all inpatient hospital services, including TEFRA cost reimbursed inpatient services, effective September 1, 2013.

Hospital Payment Reform: Quality-Based Payments

Potentially Preventable Events (PPE)

- Potentially Preventable Readmissions (PPR)
- Potentially Preventable Complications (PPC)
- Potentially Preventable Admissions (PPA)
- Potentially Preventable Emergency Room Visits (PPV)
- Potentially Preventable Ancillary Services (PPS)

Hospital Payment Reform: Quality-Based Payments

Potentially Preventable Events (PPE)

- HHSC will begin adjusting hospital payments based on PPRs in September 2012 and based on PPCs in September 2013.
- Potentially preventable events (PPR and PPC) are not based on individual instances of a hospital stay, but on overall rates of such events compared to other hospitals.
- PPR and PPC will be implemented as an overall hospital percentage reimbursement adjustment applied to each hospital claim.
- Hospital adjustment will be implemented as an “end of the payment” adjustment (not to the hospital standard dollar amount).

Hospital Payment Reform: Quality-Based Payments

Inpatient Hospital Conversion from MS-DRG to APR-DRG

- HHSC will transition from Medicare Severity Diagnosis Related Grouping (MS-DRG) to the All Patient Refined Diagnosis Related Grouping (APR-DRG) effective September 1, 2012.
- The MS-DRG has limitations related to an under-65 population which may not result in an equitable payment system addressing the Medicaid population.
- The APR-DRG is an expansion of the basic DRG concept to better reflect the attributes of non-Medicare populations to include newborn birth weight, pediatric illnesses, and high-risk pregnancies.

Hospital Payment Reform: Quality-Based Payments

- All Patient Refined Diagnosis Related Grouping (APR-DRG)
 - A clinical model for different types of patients that has been extensively refined with historical data.
 - Offers enhanced equity in determining prospective payments and a bridge to other pay-for-performance efforts like Potentially Preventable Readmissions (PPR) and Potentially Preventable Complications (PPC).
 - Provides for severity adjustments in numerous quality assessment initiatives.

Hospital Payment Reform: Standard Dollar Amount (SDA) Changes

- Prior to September 1, 2011, Texas Medicaid reimbursed each general acute care hospital based on its costs to provide services (cost-based SDA) and its mix of clients (case mix).
- This cost-based methodology had the potential to reward inefficient and high-cost hospitals and resulted in significant disparities in payments to hospitals for the same services.

Hospital Payment Reform: Standard Dollar Amount (SDA) Changes

An Example of Cost-based SDA Variation Across Hospitals for
“Same” DRG-Reimbursable Patients (Pre-Reform)

Hospital	Neonatal Extreme Immaturity or Respiratory Distress DRG-790		Normal Delivery DRG-795		Heart Failure DRG-293		
	Total Paid Amount	Paid Per Day Billed	Total Paid Amount	Paid Per Day Billed	Total Paid Amount	Paid Per Day Billed	
Baylor University Medical Center	\$72,659	\$1,239	\$568	\$304	\$7,344	\$1,487	
St. Paul Hospital	\$91,452	\$2,218	\$571	\$240	\$7,260	\$1,242	
Parkland Memorial Hospital	\$62,414	\$1,476	\$401	\$187	\$5,065	\$1,192	
Harris Hospital - Ft. Worth	\$58,501	\$1,307	\$449	\$219	\$5,936	\$900	
John Peter Smith	\$72,085	\$1,996	\$452	\$286	\$5,892	\$992	
Memorial Hermann Healthcare	\$54,477	\$1,260	\$452	\$249	\$5,884	\$1,167	
Harris County Hospital District	\$76,204	\$1,645	\$472	\$232	\$6,037	\$818	
Range	Low	\$30,702	\$998	\$306	\$154	\$4,315	\$582
	High	\$91,452	\$2,218	\$997	\$441	\$8,335	\$1,704

Hospital Payment Reform: Standard Dollar Amount (SDA) Changes

- Effective September 1, 2011, Texas Medicaid pays each general acute care hospital a statewide SDA in accordance with Rider 61, plus add-ons for geographical wage variances, teaching programs, and trauma designation.
- A statewide base SDA is intended to eliminate the significant disparities in payment to hospitals for the same services.

Hospital Payment Reform: Standard Dollar Amount (SDA) Changes

An Example of Statewide SDA Plus Add-on Across Hospitals for
“Same” DRG-Reimbursable Patients (Post-Reform)

Hospital	Neonatal Extreme Immaturity or Respiratory Distress DRG-790		Normal Delivery DRG-795		Heart Failure DRG-293		
	Statewide SDA	SDA with Add-on	Statewide SDA	SDA with Add-on	Statewide SDA	SDA with Add-on	
Baylor Univeristy Medical Center	\$28,625	\$40,603	\$330	\$469	\$2,898	\$4,111	
St. Paul Hospital	\$28,625	\$35,534	\$330	\$410	\$2,898	\$3,598	
Parkland Memorial Hospital	\$28,625	\$43,886	\$330	\$507	\$2,898	\$4,444	
Harris Hospital - Ft. Worth	\$28,625	\$34,388	\$330	\$397	\$2,898	\$3,482	
John Peter Smith	\$28,625	\$40,209	\$330	\$464	\$2,898	\$4,071	
Memorial Hermann Healthcare	\$28,625	\$44,478	\$330	\$513	\$2,898	\$4,504	
Harris County Hospital District	\$28,625	\$44,478	\$330	\$513	\$2,898	\$4,504	
Range	Low	\$28,625	\$21,440	\$330	\$247	\$2,898	\$2,171
	High	\$28,625	\$44,478	\$330	\$513	\$2,898	\$4,504

Hospital Payment Reform: Disproportionate Share Hospital (DSH)

Disproportionate Share Hospital (DSH) Program Reform

- Coalition of transferring hospitals (hospitals that provide funding for the DSH program through intergovernmental transfers [IGTs]) petitioned to change the DSH methodology:
 - The transferring hospitals will continue to provide a minimum level of IGT funding for the DSH program.
 - The allocation of DSH funds must revert back to its original intent, that of funding uncompensated care.
 - All hospitals participating in the DSH program must be responsible for their share of the state match, excluding those hospitals which are held harmless in DSH.
 - Establish pre-determined funding pools for:
 - Children's hospitals at \$125 million.
 - Rural hospitals at their 2011 DSH allocation amount.

Hospital Payment Reform: Disproportionate Share Hospital (DSH)

Two factors are leading the transferring hospitals to request this change:

- The proportion of the federal matching funds generated by the transferring hospitals' IGTs that are returned to them through DSH payments has declined from approximately 50 percent in federal fiscal year 1996 to an estimated 14 percent for federal fiscal year 2012.
- Transferring hospitals will receive a higher return on their investment of IGT funds through funding the non-federal share of their uncompensated physician, clinic and pharmacy costs under the 1115 Waiver than they would receive through funding DSH under its current configuration.

Hospital Payment Reform: Disproportionate Share Hospital (DSH)

- April 20 – proposed rule amendment based on petition published in *Texas Register* opening a 30-day public comment period.
- May 3 – proposed rule amendment presented to Hospital Payment Advisory Committee.
- May 10 – proposed rule amendment presented to Medical Care Advisory Committee (serves as initial public hearing)
- May 18 – second public hearing on proposed rule amendment.
- May 20 – 30-day public comment period closes. At the end of the 30-day public comment period, HHSC will compile and review all comments and make a determination on how or whether to proceed.

Hospital Payment Reform: Transformation Waiver

Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

- **Managed care expansion**
 - Allows statewide Medicaid managed care services.
- **Hospital financing component**
 - Preserves upper payment limit (UPL) hospital funding under a new methodology.
 - Creates Regional Healthcare Partnerships (RHPs).

Hospital Payment Reform: Transformation Waiver

Trended historic UPL funds and additional new funds are distributed to hospitals through two pools:

- Uncompensated Care (UC) Pool
 - Costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers (beginning in first year).
- Delivery System Reform Incentive Payments (DSRIP)
 - Support coordinated care and quality improvements through RHPs to transform care delivery systems (beginning in later waiver years).

Hospital Payment Reform: Transformation Waiver

RHPs and DSRIP

- Anchors will bring RHP participants and stakeholders together to develop plans for public input and review.
- Participants will select incentive projects and identify hospitals to receive payments based on incentive projects.
- Participating hospitals will report performance metrics and receive state incentives if metrics are reached.

Hospital Payment Reform: Transformation Waiver

RHPs and DSRIP

- RHP Plans include:
 - Regional health assessments.
 - Participating local public entities.
 - Hospitals receiving incentives and yearly performance measures.
 - Incentive projects by DSRIP categories.

DSRIP Categories:

- Infrastructure Development
- Program Innovation and Redesign
- Quality Improvements
- Population-focused Improvement

Hospital Payment Reform: Transformation Waiver

UC & DSRIP Pool Funding Distribution

Type of Pool	DY 1 (2011-2012)	DY 2 (2012- 2013)	DY 3 (2013- 2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Totals
UC	3,700,000,000	3,900,000,000	3,534,000,000	3,348,000,000	3,100,000,000	\$17,582,000,000
DSRIP	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000	\$11,418,000,000
Total/DY	4,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	\$29,000,000,000
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

SB 7 Waiver

- SB 7, Article 13, 82nd Legislature, First Called Session, 2011 directs HHSC to pursue a Medicaid Reform Waiver.
- This waiver would allow Texas to implement reforms to eligibility, benefits, and long-term care services and implement copayments.

SB 7 Waiver Components

- S.B. 7 directs HHSC to design a waiver to achieve the following objectives and alternatives:
 - Provide flexibility to determine eligibility categories and income levels;
 - Provide flexibility to design Medicaid benefits;
 - Encourage use of the private health benefits coverage market;
 - Encourage people to access employer-based health benefits;
 - Establish copayments;
 - Promote affordable primary, preventive and other health care to the uninsured on a sliding scale; and
 - Redesign long-term care services to increase access to cost-effective patient-centered care.

SB 7 Legislative Oversight Committee

- S.B. 7 also establishes a Medicaid Reform Waiver Legislative Oversight Committee to facilitate reform waiver efforts.
- Membership includes four members each, from the House and Senate.

Senate Membership

Bob Deuell
Jane Nelson
Dan Patrick
Royce West

House Membership

Garnet Coleman
Brandon Creighton
Lois Kolkhorst
John Zerwas