



TEXAS

Health and Human
Services Commission

**House Select Committee on Federal Legislation
Federal Health Care Reform –
Impact to Texas Health and Human Services**

Executive Commissioner Thomas M. Suehs

April 22, 2010

Impact on Health and Human Services Agencies

Direct Impact

- Medicaid eligibility expansion
- Health Insurance Exchange
 - Front door to access healthcare coverage
 - Use simplified process to determine eligibility
 - Medicaid, CHIP and private insurance plans must all be able to interface
 - Applications must be “deemed” to Medicaid and CHIP with no required action by the applicant

Secondary Impact

- Client base for existing state and local programs serving the uninsured
- Employer insurance mandates may impact providers of health and human services

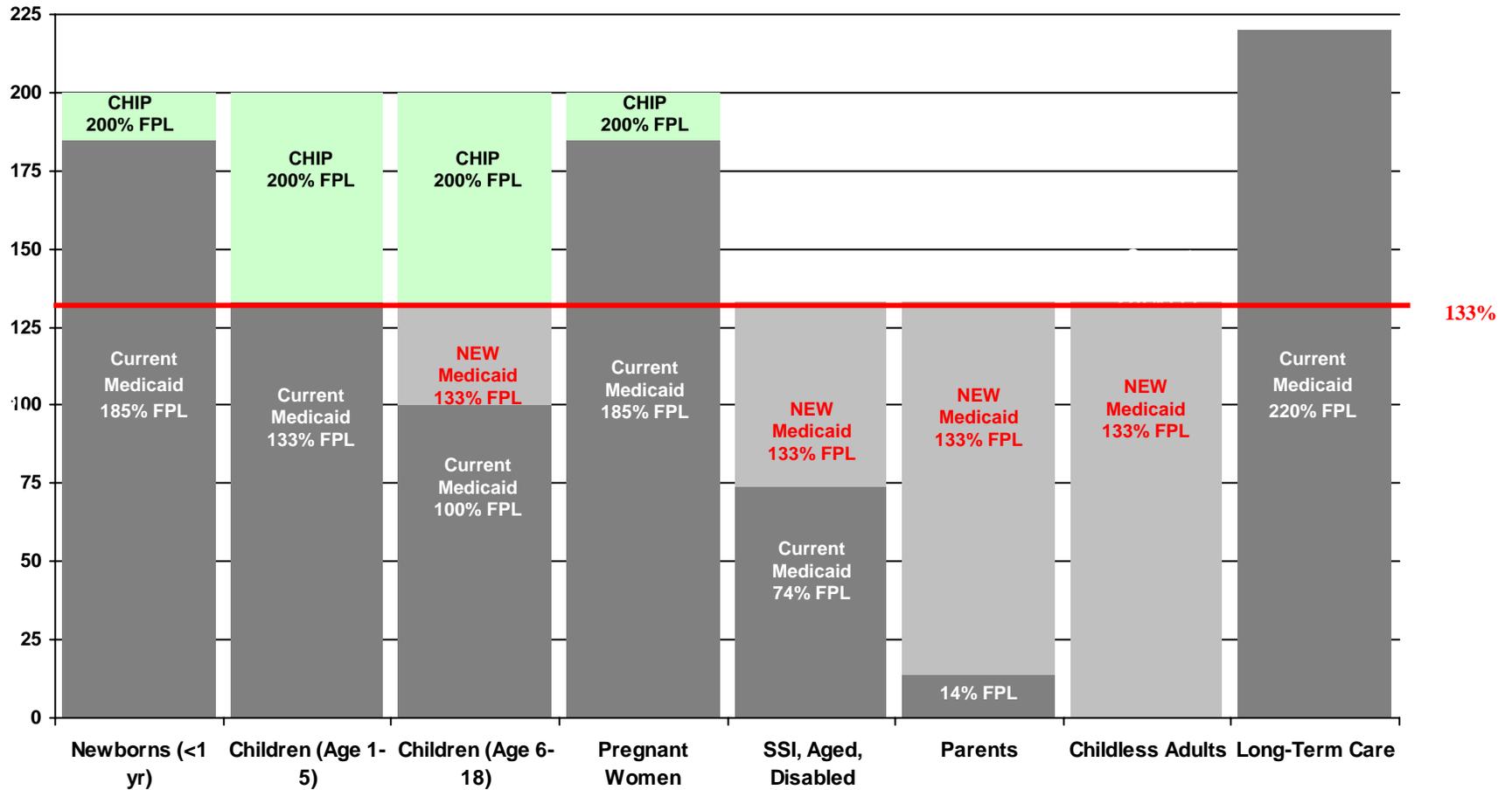
Medicaid Expansion: Caseload Impact

- **Expands Medicaid eligibility to individuals under age 65 with incomes up to 133% of the Federal Poverty Limit (FPL)**
 - Income deduction allowance of five percentage points creates effective eligibility level of 138% FPL
- **New client populations in Texas include:**
 - Parents and caretakers 14%- 133%
 - Childless adults up to 133% FPL
 - Emergency Medicaid in Expansion Populations
 - Foster-care through age 25
- **Texas will experience caseload growth both from newly eligible individuals and those individuals who are currently eligible but not enrolled**
 - With an individual mandate, enrollment of current eligibles is projected to increase

Medicaid Expansion: Caseload Impact

- **Changes Medicaid income eligibility requirements**
 - Requires use of modified gross income and prohibits assets test and most income deductions
- **Requires that states maintain existing Medicaid eligibility until the state's exchange is fully operational**
 - Optional populations covered above 133% FPL may be moved to the Exchange upon implementation

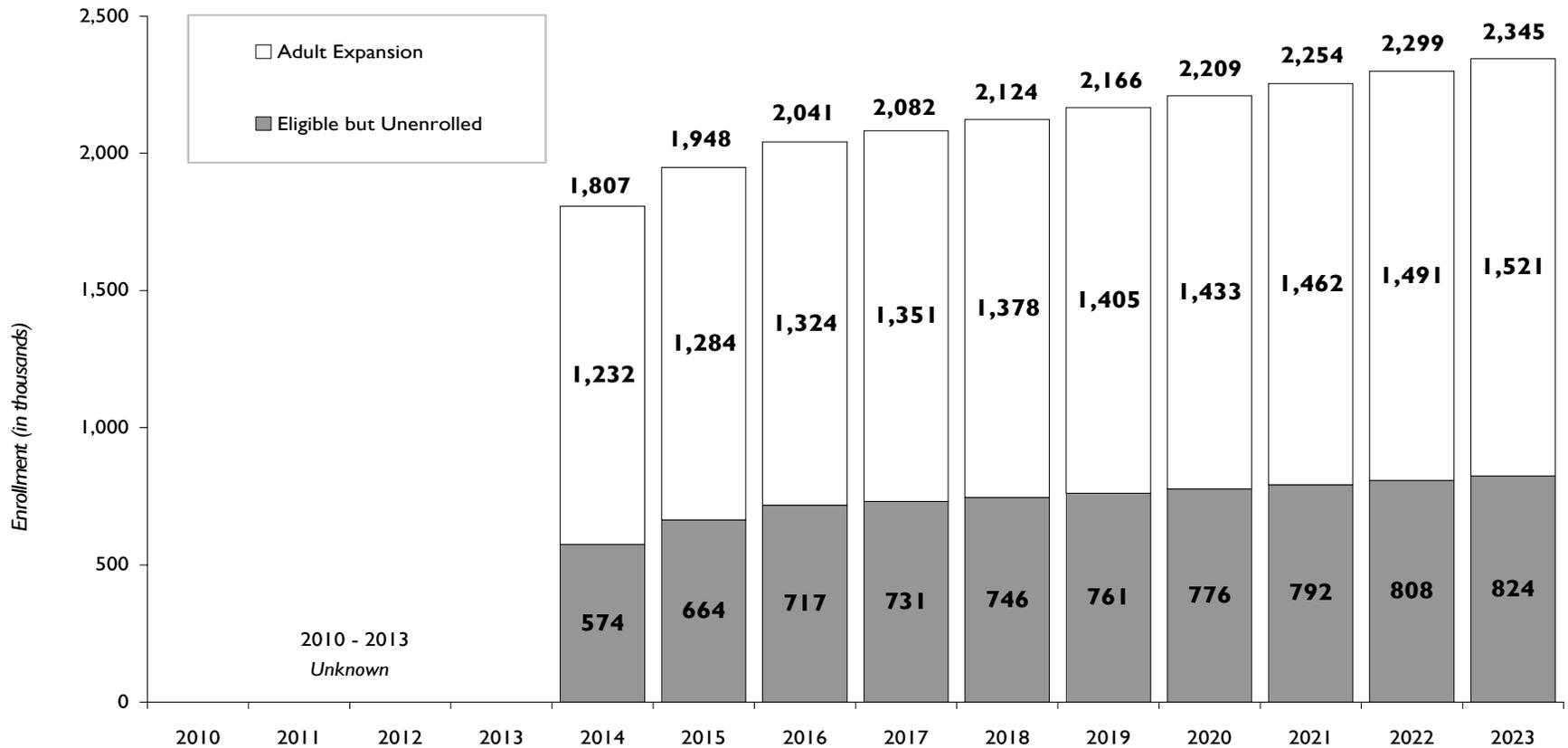
Current & Future Medicaid/CHIP Eligibility Levels



Medicaid Expansion: Caseload Impact

Patient Protection and Affordable Care Act (PPACA)

HHSC Medicaid/CHIP Caseload Estimates, 2010 - 2023 *



* Note: Due to rounding, some component totals may not equal their respective grand total.

Costs Estimates By Policy Option, SFY 2014-2023

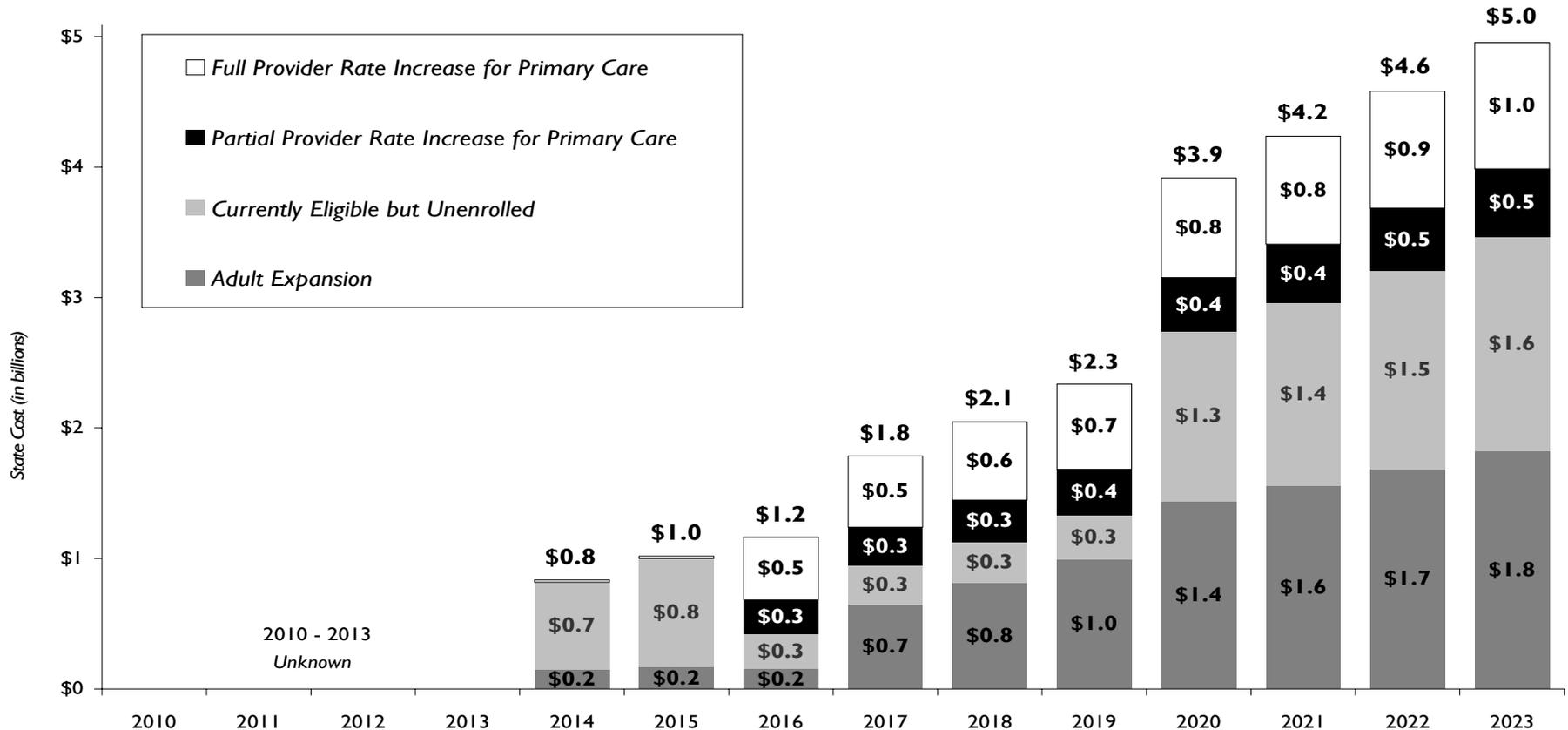
**Patient Protection and Affordable Care Act
HHSC Medicaid/CHIP Cost Estimates by Level of Implementation
State of Texas, SFYs 2014 – 2023**

Level of Implementation	All Funds Cost (billions \$)		Federal Cost (billions \$)		GR Cost (billions \$)	
	increment	total	increment	total	increment	total
Medicaid Expansion Adults (<133% FPL)	---	\$122.2	---	\$112.7	---	\$9.5
Medicaid Expansion Adults and Current Eligible but Unenrolled	+\$39.6	\$161.8	+\$31.0	\$143.7	+\$8.6	\$18.1
with <i>Partial</i> Provider Rate Increase for Primary Care*	+\$10.3	\$172.1	+\$7.2	\$150.9	+\$3.1	\$21.2
with <i>Full</i> Provider Rate Increase for Primary Care*	+\$19.1	\$191.2	+\$13.3	\$164.2	+\$5.8	\$27.0

* Assumes provider rate increase applied in Medicaid will also apply to CHIP.

Patient Protection and Affordable Care Act (PPACA)

HHSC Medicaid/CHIP Cost Estimates by Level of Implementation, 2010 - 2023 *



* Note: Due to rounding, some component totals may not equal their respective grand total.

- **Medicaid Expansion** - Medicaid eligibility expanded to individuals age 19 – 64 years living at up to 133% FPL
 - For the first three calendar years of the mandated expansion, the federal government bears the full cost of coverage for new eligibles.
 - In 2017, the federal share begins decreasing.

Texas (Reg. Enhanced)	
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
*2020	90%
*and beyond	

HHSC Estimate of Direct Costs and Modeling Assumptions SFY 2014 - 2023

Federal Medicaid Assistance Percentage (FMAP)

- *Regular FMAP* – Assumed at 60.56% for all years.
 - Applies to individuals that are currently eligible but not enrolled
 - Likely to become enrolled because of the individual mandate
- *Super FMAP* – Assumed at 100% for 2014 – 2016, 95% for 2017, 94% for 2018, 93% for 2019, and 90% for 2020 and beyond.
 - Applies only to the Medicaid expansion population.
- *Regular Enhanced FMAP (EFMAP)* – Assumed at 72.39% in 2014 – 2015 and 2020 - 2023.
 - Applies to individuals that are currently eligible for but not enrolled in CHIP.
 - Children who would have enrolled in CHIP under existing eligibility criteria, but will instead enroll in Medicaid under the new criteria.
- *Super EFMAP* – Assumed at 95.39% for 2016 – 2019.
 - Assumed for the same population groups as the Regular EFMAP, but for different years
 - The Act includes no language establishing a perpetual CHIP Super EFMAP.
 - The model assumes that CHIP will be reauthorized with a Regular EFMAP at historical levels in 2019.

Estimate of Direct Costs and Modeling Assumptions SFY 2014 - 2023

- **Children’s Health Insurance Program (CHIP)** - CHIP eligible populations up to 133% FPL would move to the Medicaid program in 2014. All other CHIP populations would remain in the current program
 - The model assumes that CHIP will be reauthorized in 2019 in a form that is consistent with the program’s history
- **Take-up Rates** – The model assumes a take up rate of 91% in 2014; 93% in 2015, and 94% ongoing for Medicaid and CHIP due to the individual insurance mandate
- **Administrative Costs** – HHSC assumed an 8 percent adjustment for administrative costs. This is a flat rate estimate and does not include initial increased start-up costs for systems and operational development, which will be significant
 - HHSC has assumed a standard 50% FMAP rate for administrative costs

HHSC Estimate of Direct Costs and Modeling Assumptions SFY 2014 - 2023

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- **Provider Reimbursement Rates** – The Act requires that reimbursement for certain services provided by primary care providers be increased to 100% of Medicare rates for 2013-2014. This covers about 30% of primary care services and is 100% federally funded.
 - Model assumes parity in CHIP reimbursement rates.
 - **Pharmacy Rebate Changes** – The Act increases minimum manufacture rebates for pharmaceuticals from 15.% to 23.1%, but the federal government is utilizing this difference. This increase in the federal rebate program will cause a decrease in the state supplemental rebate program.
 - The model assumes an 8.25% increase in the per capita rebate amounts for Medicaid individuals. However, 100% of the increased rebates accrue to the federal government. In Texas, the state supplemental rebate program associated with products on the preferred drug list is anticipated to provide fewer rebate funds because of the required increase in federal rebates.
 - As a result, the net rebate per person accruing to general revenue is expected to decrease by 4.5%. In the future, rebate revenue will likely increase under the plan due to large projected gains in enrollment and pharmaceutical utilization.

Medicaid Expansion: Major Policy Considerations

Additional Policy Considerations Modeled for Cost Implications

- **Medicaid Rate Increases**
 - States are required to increase Medicaid rates to 100% of Medicare rates in 2013 and 2014 for certain services provided by primary care providers (PCPs) The incremental rate costs for 2013 and 2014 are 100% federally funded.
 - The model assumes the mandated reimbursement increase to 100% of Medicare rates for 2013-2014, which covers about 30% of primary care services and is funded with a 100% Super FMAP (no cost to the state).
 - State will need to decide whether to continue these rates at regular FFP after 2014 or choose not to continue (Partial Rate Increase)
 - State will need to decide whether to apply the rate increase to additional services provided by primary care providers after 2014 (Full Rate Increase)
- **Children's Health Insurance Program (CHIP) Rates**
 - Historically CHIP and Medicaid provider rates have been aligned
 - State will need to decide whether to provide the same increase for CHIP rates as for Medicaid
 - Any increase in CHIP provider rates will be at the CHIP FFP for all years
 - CHIP FFP increases by 23 points from 2016 to 2019
 - Current models assume CHIP rate increase at a cost of no more than \$2 million general revenue per year

Medicaid Expansion: Major Policy Considerations

- When to Implement Medicaid Expansion
 - States may opt to expand Medicaid coverage to 133% FPL on or after April 1, 2010 without a waiver at regular Federal Financial Participation (FFP)
 - Expansion is mandatory in 2014
- Medicaid Expansion Benchmark Benefit Plan
 - States are required to create a Secretary-approved benchmark benefit package for newly eligible Medicaid groups by January 2014.
 - Benchmark packages 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
 - This could result in different benefit packages for existing and expansion Medicaid populations
 - Potential differences in current Texas Medicaid benefits and a benchmark plan include:
 - Prescription Drug Limit
 - In-Patient Hospitalization Limits
 - Mental Health Benefits

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- Increased Premium Revenue from health care policies
 - Savings to Department of State Health Services Programs as Client Bases Decrease
 - State policymakers will need to consider the impact to current funds supporting health care programs such as: Trauma funds, Tobacco settlement funds, the County Indigent Health Care Program and other programs administered by DSHS.
 - Increased Funding Opportunities for the Department of State Health Services
 - Redirecting Services from High Cost Emergency Departments to Lower Cost Primary Care

Impact to Texas Healthcare Delivery Systems

- Many of the state's indigent care and charity statutes may need to be restructured
- Core functions of the Department of State Health Services and the populations it serves will likely be altered
- Public hospitals will have less uncompensated care
- The role of city and county health departments may need to be redefined
- Unknown impact to Local Mental Health Authorities

Impact to Texas Workforce Planning

- Demand for primary care providers and specialists will increase as more Texans are insured
- State will need to examine this increased demand as it relates to the supply of healthcare providers
- Strategies for meeting increased demand will need to be explored
 - Telemedicine
 - Additional use of ancillary service providers



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SUPPLEMENTAL INFORMATION

2009 Federal Poverty Guidelines

2009 Poverty Guidelines for the Continental United States*

Annual Poverty Guidelines								
Family Size	50%	100%	133%	138%	150%	200%	250%	300%
1	\$5,415	\$10,830	\$14,404	\$14,945	\$16,245	\$21,660	\$27,075	\$32,490
2	\$7,285	\$14,570	\$19,378	\$20,107	\$21,855	\$29,140	\$36,425	\$43,710
3	\$9,155	\$18,310	\$24,352	\$25,268	\$27,465	\$36,620	\$45,775	\$54,930
4	\$11,025	\$22,050	\$29,327	\$30,429	\$33,075	\$44,100	\$55,125	\$66,150
5	\$12,895	\$25,790	\$34,301	\$35,590	\$38,685	\$51,580	\$64,475	\$77,370
6	\$14,765	\$29,530	\$39,275	\$40,751	\$44,295	\$59,060	\$73,825	\$88,590
7	\$16,635	\$33,270	\$44,249	\$45,913	\$49,905	\$66,540	\$83,175	\$99,810
8	\$18,505	\$37,010	\$49,223	\$51,074	\$55,515	\$74,020	\$92,525	\$111,030
Add'l	\$1,870	\$3,740	\$4,974	\$5,161	\$5,610	\$7,480	\$9,350	\$11,220
Monthly Poverty Guidelines								
Family Size	50%	100%	133%	138%	150%	200%	250%	300%
1	\$451	\$903	\$1,200	\$1,245	\$1,354	\$1,805	\$2,256	\$2,708
2	\$607	\$1,214	\$1,615	\$1,676	\$1,821	\$2,428	\$3,035	\$3,643
3	\$763	\$1,526	\$2,029	\$2,106	\$2,289	\$3,052	\$3,815	\$4,578
4	\$919	\$1,838	\$2,444	\$2,536	\$2,756	\$3,675	\$4,594	\$5,513
5	\$1,075	\$2,149	\$2,858	\$2,966	\$3,224	\$4,298	\$5,373	\$6,448
6	\$1,230	\$2,461	\$3,273	\$3,396	\$3,691	\$4,922	\$6,152	\$7,383
7	\$1,386	\$2,773	\$3,687	\$3,826	\$4,159	\$5,545	\$6,931	\$8,318
8	\$1,542	\$3,084	\$4,102	\$4,256	\$4,626	\$6,168	\$7,710	\$9,253
Add'l	\$156	\$312	\$415	\$430	\$468	\$623	\$779	\$935
US DHHS, Federal Register, Vol 74, No. 14, January 23, 2009								

*FFY 2009 Poverty Guidelines will remain in effect through FFY 2010

Newborns = 238,573

Children Age 1-5 = 1,023,057

Children Age 6-18 = 1,595,154

Pregnant Women = 159,495

SSI, Aged, Disabled* = 711,629

Parents = 90,341

Childless Adults = 0

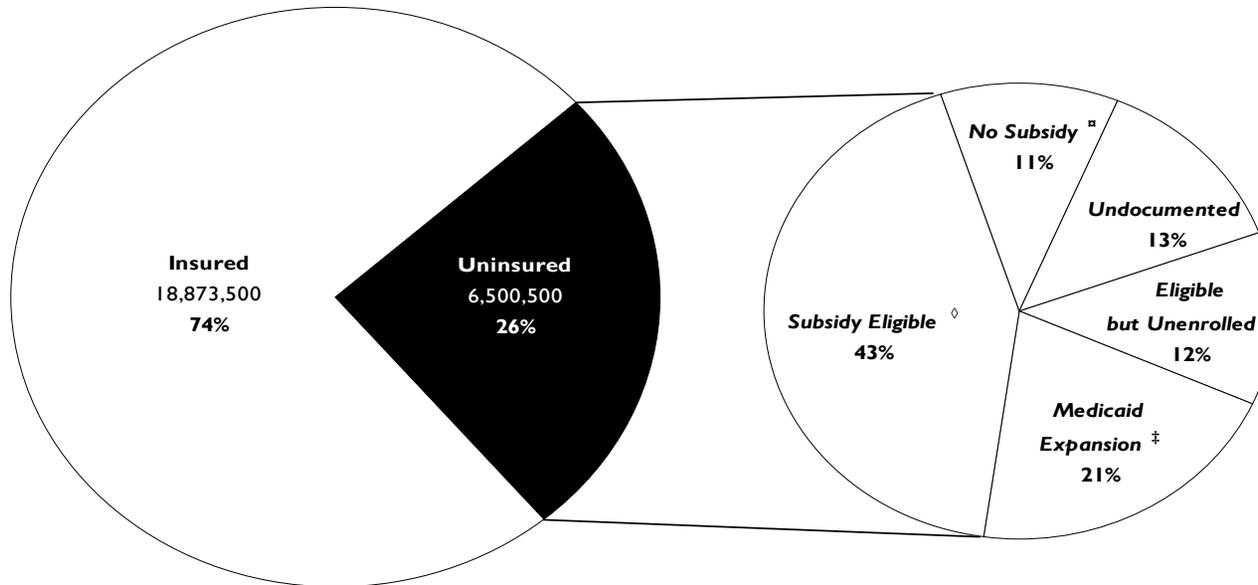
- These figures represent the sum of current Medicaid, CHIP and CHIP Perinatal and correspond to the caseload chart on slide 5.
- All figures represent FY 2010 year-to-date average monthly enrollment.

**Long-Term Care Medicaid enrollment is included in SSI, Aged Disabled.*

Texas Uninsured Demographics

Current

Current: Insured & Uninsured



Current: Uninsured by Act Subsidy Type

KEY

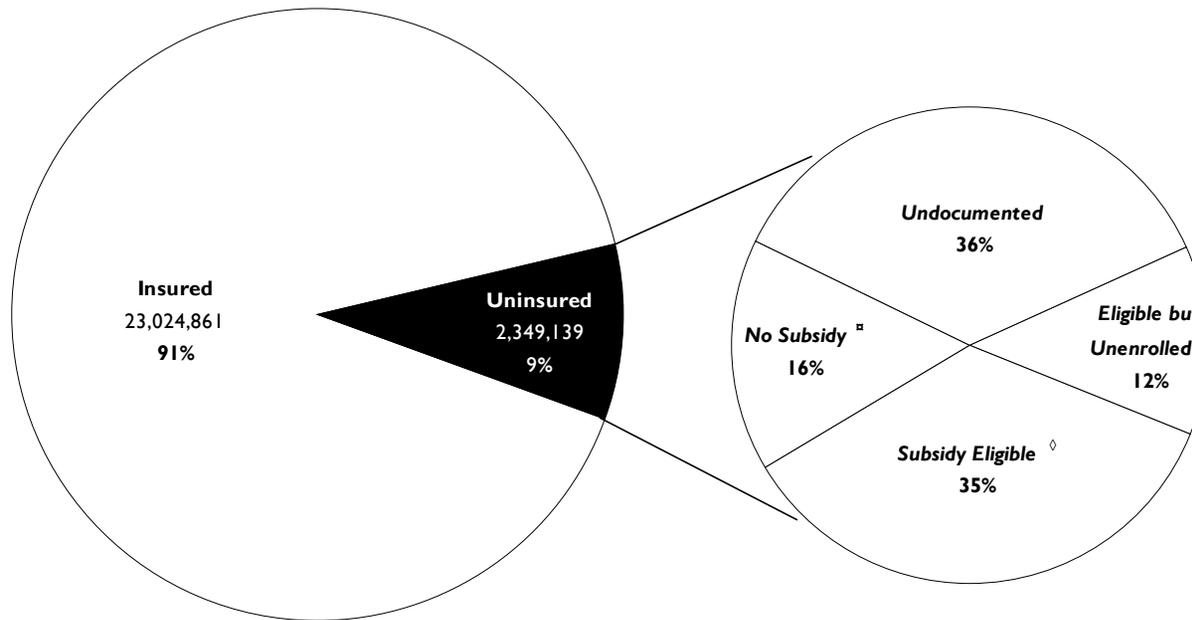
- ‡ **Medicaid Expansion**
(adults <133% Federal Poverty Level (FPL))
- † **Eligible but Unenrolled**
(children <200% FPL)
- ◊ **Subsidy Eligible**
(adults and children <400% FPL, including Lawful Permanent Residents (LPRs))
- **No Subsidy**
(>400% FPL, including LPRs)

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 2000-2007 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-Implementation

Under Act: Insured & Uninsured



Under Act: Uninsured by Act Subsidy Type

KEY
† Eligible but Unenrolled (children < 200% Federal Poverty Level (FPL)) and (adults < 133% FPL)
◇ Subsidy Eligible (adults and children < 400% FPL, including Lawful Permanent Residents (LPRs))
▫ No Subsidy (>400% FPL, including LPRs)

Note: Due to rounding, percents may not total one hundred percent.

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 2000-2007 Migration Scenario. Published 2/2009.

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

Patient Protection and Affordable Care Act

Key Provisions Timeline

2010

- Exchange planning and Federal grants
 - HHS Secretary will award grants to states no later than March 2011.
 - Grants renewable by HHS Secretary through end of 2014.
- Ombudsman Program for people with private coverage in individual and small group markets
- Establishment of an annual insurance premium review process
 - Grants available beginning 2010.
- High-Risk Pool
 - HHS Secretary may contract with states by June 2010.
- Family Planning services option through Medicaid State Plan
- Face-to-Face encounter with patient required for certification of eligibility for home health services or durable medical equipment
- Money Follows the Person rebalancing demonstration extended through 2016
- Increase in federal prescription drug rebates

Patient Protection and Affordable Care Act

Key Provisions Timeline

2010 (continued)

- Prevention and Public Health Fund
 - Funding begins in 2010 and increases incrementally in FY 2015.
- Optional Medicaid Expansion up to 133% of FPL
 - Expand Medicaid to non-pregnant individuals under 65.
- Pharmacy reimbursement limits
- Funding for Aging and Disability Resource Centers
 - \$10 million for each of fiscal years 2010 through 2014.
- Postpartum condition grants
- Medicare Part D
 - \$250 rebate for all Part D enrollees who enter coverage gap (donut hole).
 - Phase down from 100% to 25% by 2020.
- Elimination of pre-existing conditions for children
- Elimination of lifetime limits on benefits

Patient Protection and Affordable Care Act

Key Provisions Timeline

2010 (continued)

- Medicaid coverage for freestanding birth center services
- Extended coverage of young adults up to 26 years of age on parent's health insurance plan
- Rating areas for small and individual markets
- School-Based Health Center Grants
 - Preference given to centers that serve a large population of children and families eligible for Medicaid and CHIP.
 - Could require changes to Medicaid and CHIP provider enrollment and claims payment.
- Collection period for overpayments due to fraud
 - Extends period to repay overpayments to one year.
- Trauma care services grants
 - States may not use more than 20% of the federal funds for administration of the program.

Patient Protection and Affordable Care Act

Key Provisions Timeline

2010 (continued)

- Emergency care response grants
- Personal responsibility grants
- Maternal, Infant, and Early Childhood Home Visitation Program
 - Must conduct new statewide needs assessment no later than 6 months after date of enactment.
 - After completing new needs assessment, could apply for new home visiting program grant as early as FY10.
- New option to provide Home and Community-Based Services through the Medicaid State Plan
- Mandatory use of National Correct Coding Initiative
- Tobacco Cessation for Pregnant Women
- Expansion of the recovery audit contractor program
- Website
 - Secretary of HHS to establish an Internet website providing information on affordable health insurance coverage options.

Patient Protection and Affordable Care Act

Key Provisions Timeline

2011

- Community Health Centers
 - Increase funding by \$11 billion.
- Medicaid Emergency Psychiatric Demonstration Project
- Primary Care Extension Program (workforce)
 - Increases training programs for primary care and nursing workforce.
- Health IT Grant to facilitate enrollment in health subsidy programs
 - HHS Secretary will establish standards, with grants available in 2011.
- Elimination of Medicaid for certain adults above 133% FPL
 - January 1, 2011 – December 31, 2013
- Health homes for enrollees with chronic conditions
 - Allows the HHS Secretary to award \$25 million in planning grants.

Patient Protection and Affordable Care Act

Key Provisions Timeline

2011 (continued)

- Community Living Assistance Services and Supports (CLASS)
 - Long-term care insurance program that provides a cash benefit to adults who develop functional impairments for the purchase of community-based supports and services.
- NPI on enrollment applications and claims
- Beginning January 1, 2011, or later if legislation is required:
 - Termination of provider participation under Medicaid if terminated under Medicare or other state plan
 - Provider exclusion from participation
 - Alternate payees required to register under Medicaid
 - Reporting of data elements under MMIS to detect fraud and abuse
 - Prohibition on payments to entities located outside of the USA

Patient Protection and Affordable Care Act

Key Provisions Timeline

2011 (continued)

- Healthy Lifestyles Grants (Incentives for prevention of chronic diseases)
- Medicaid preventive and obesity-related services public awareness campaign begins March 1, 2011
- Enhanced screening for new health care providers
- Provider disclosure requirements
- Health Care Acquired Conditions
 - Tracking of hospital readmission rates.
 - Effective September 1, 2010, Texas is applying Medicare regulations on payment for health care-acquired conditions to Medicaid.
- Community First Choice Option
- Incentives for Home and Community-based Services
- Elder Justice Act
 - Authorization for \$100 million in funding for 2011-2014.
 - Texas would receive approximately \$6 million in 2011.

Patient Protection and Affordable Care Act

Key Provisions Timeline

2012

- Pediatric Accountable Care Organization Demonstration Project
- Demonstration Project to evaluate integrated care around a hospitalization
- Medicaid payment bundling Demonstration Project
- Screening of existing providers
 - Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

2013

- Enhanced reimbursements for certain primary care services
- Federal evaluation of State Exchange implementation status
 - States evaluated for significant progress toward having exchange operational by 2014.
- Coverage of prevention services for adults in Medicaid

Patient Protection and Affordable Care Act

Key Provisions Timeline

2014

- Reduction of DSH allocations
- State Exchanges begin January 1, 2014
- Reinsurance program for plan in the individual market
- Medicaid Expansion to 133% of FPL
 - Expand Medicaid to non-pregnant individuals under age 65
 - For 2014-2016, Federal government will pay 100% of costs for coverage for newly eligible individuals in Medicaid
 - States have option to expand Medicaid above 133% FPL
- Use of Modified Gross Income for Medicaid and CHIP income eligibility
- Medicaid for Former Foster Care Children

2014 (continued)

- Health Insurance Mandate
- Premium assistance tax credits
 - Prohibits state from requiring an individual to apply for employer-sponsored family coverage as a condition of Medicaid eligibility.
- Premium Assistance
 - Extends CHIPRA premium assistance option to adults.
- Elimination of exclusion of coverage of certain drugs
- Hospitals permitted to make presumptive eligibility determinations

2015

- Annual Medicaid Enrollment Report
- Hospital Contracting Requirements for Qualified Health Plans Offering Coverage in the Exchange
- Extension of CHIP Funding
 - Federal funding expires on September 30, 2015
- Increase the CHIP Match Rate
 - States eligible for 23% point increase in regular CHIP match rate from October 1, 2015 through September 30, 2019

2016

- Health insurance plans may be offered in more than one state

2017

- Medicaid FMAP decreases to 95%

2018

- Medicaid FMAP decreases to 94%
- Premium Taxes on “Cadillac Plans”

2019

- Medicaid FMAP decreases to 93%

2020

- Medicaid FMAP decreases to 90%