



Presentation to the House Appropriations Subcommittee on Health & Human Services

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February 22, 2011

Hospitals

Hospital Financing

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 - Cost Reduction Proposals
 - Acute Care Spending
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Summary for Medicaid Hospital Cost Reduction Proposals (in millions)

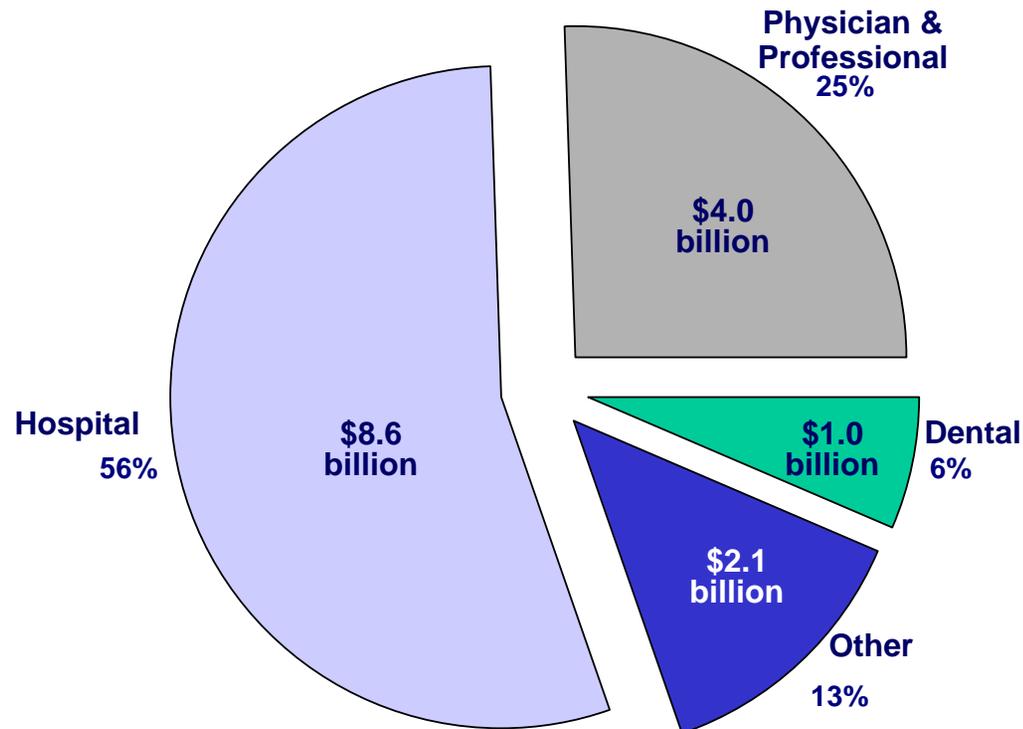
Medicaid Cost Reduction Proposals for Hospital Services		Total GR	Total All Funds
1	Payment Reform	\$ 8.9	\$ 20.8
2	Neonatal Intensive Care Unit Management and Maternity Care Services	\$ 13.7	\$ 32.5
3	Hospital Reimbursement in Managed Care	\$ 35.0	\$ 83.2
4	Outpatient Fee Schedule	\$ 11.9	\$ 28.0
5	Medical Imaging Fees	\$ 16.7	\$ 39.6
6	Reimburse Flate Fee of \$25 for Non-Emergent Visits	\$ 34.1	\$ 81.0
7	Reduce Payment by 40% for ED Non-Emergent Services	\$ 16.8	\$ 40.0
8	Apply Utilization Limits to Non-Emergent Use of the Emergency Room (ER)		
9	Limit Reimbursement for Visits to the ER to a 24-hour Period	\$ 0.0	\$ 0.0
10	Elective Inductions/C-Sections	\$ 1.7	\$ 4.0

Summary for Medicaid Cost Reduction Proposals (in millions)

Medicaid Cost Reduction Proposal for Hospital Services		Total GR	Total All Funds
11	Reduce Payments to Institutions for Mental Diseases (IMD) for Patients Receiving Medicare Part D Drugs	\$ 0.0	\$ 0.0
12	Reduce Hospital Rates for Medical Devices and Supplies Purchased through Group Purchasing Organizations	\$ 0.0	\$ 0.0
13	Implement an Average Statewide Standard Dollar Amount (SDA)	\$30.9	\$74.3
14	Amend Statutory Language that Currently Limits the Standard Dollar Amount (SDA) to the \$1,600 minimum	\$1,175.2	\$ 2,793.1
15	1% Change on NICU Utilization	\$ 3.1	\$ 7.4
16	1% Change on C-Section Rates	\$ 1.4	\$ 3.4
17	Allow Trauma and Tobacco Funds to Draw Medicaid Match	\$ 0.0	\$ 155.2
18	Implement Rate Reductions for Tax-exempt Hospitals		

Acute Care Spending – FY 2009

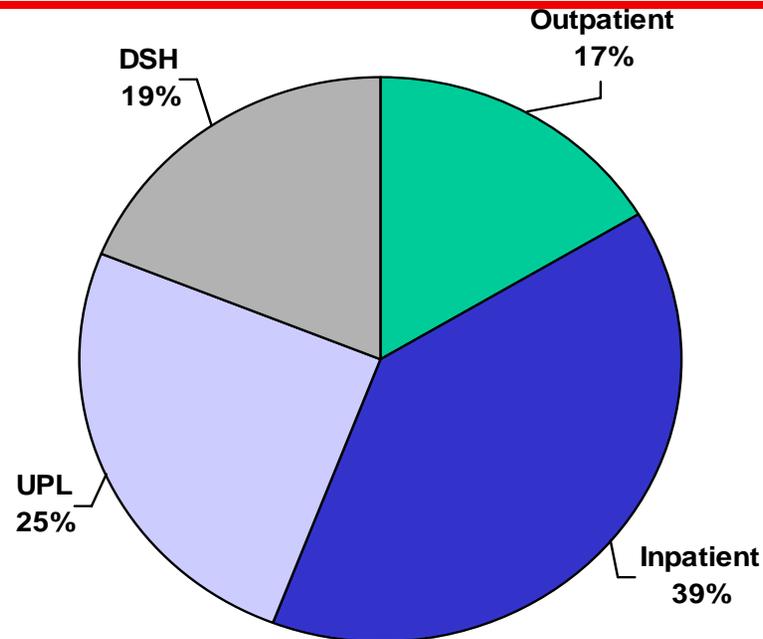
Total Acute Care Spending with HMO Payments to Providers – \$15.7 billion



Notes:

- Acute Care spending includes all Fee-for-Service, PCCM claims and payments to providers by HMOs.
- Hospital total includes Disproportionate Share and Upper Payment Limit payments.
- Other costs include Medicare Part A and Part B premium payments, Medicare Part D give-back payments, and payments to HMOs not captured in service encounter data that reflects delivery supplemental payments, administrative and unreported service costs.
- Due to the rounding component, totals and percentages may not total exactly.

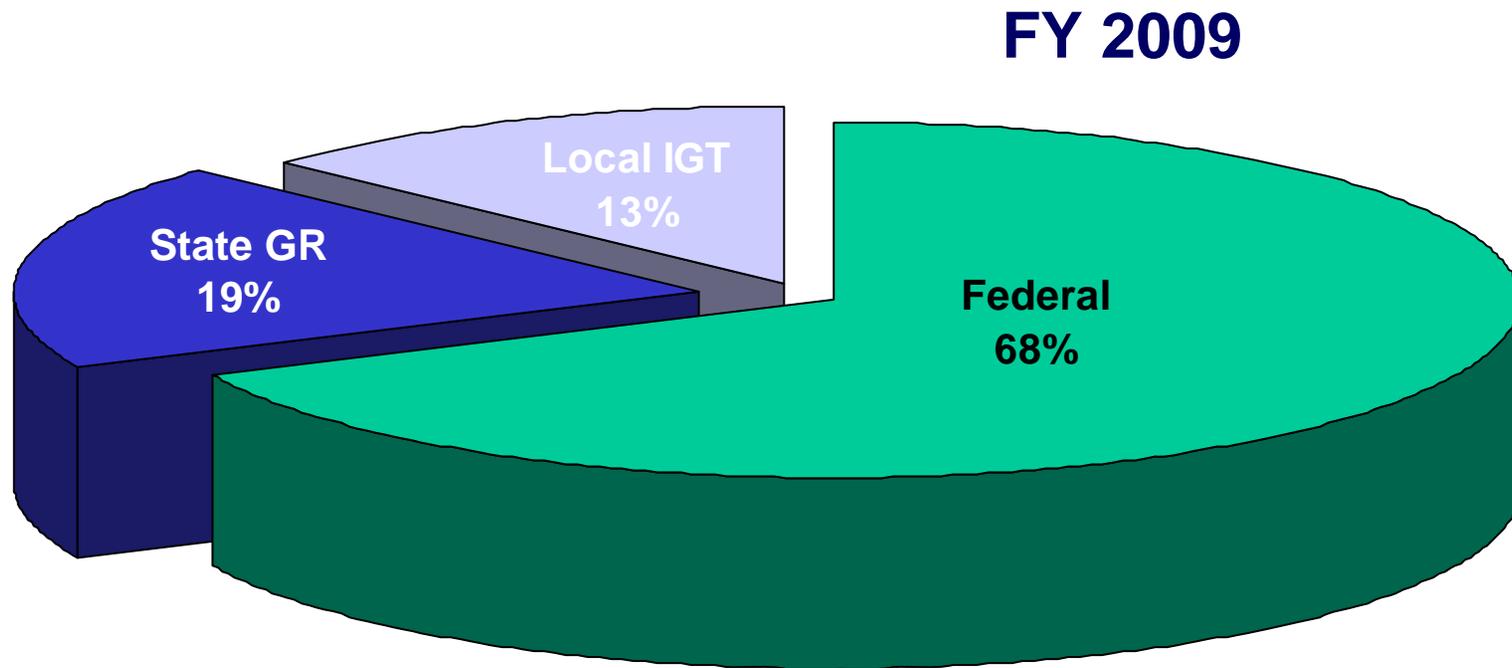
Hospital Financing – FY 2009



<u>Hospital Financing</u>	<u>Total Payments (billions)</u>	<u>State Match (billions)</u>	<u>Match Type</u>
Inpatient	\$3.4	\$1.1	GR
Outpatient	\$1.4	\$.4	GR
UPL (non-appropriated funding)	\$2.2	\$.01 / \$.6	GR / IGT
DSH (non-appropriated funding)	\$1.6	\$.1 / \$.5	GR / IGT
Total	\$8.6	\$1.7 / \$1.1	GR / IGT

Notes: Of the total state match required for FY 2009 hospital payments, 40% is provided through inter-governmental transfers.
Numbers may not add due to rounding.

Hospital Funding by Source of Funds



Inpatient Hospital – FFS and PCCM

- General Acute Care Hospitals
- Texas Medicaid uses a reimbursement methodology for general acute care hospitals that is based on the Medicare reimbursement methodology.
- Texas Medicaid pays each general acute care hospital a different amount for inpatient services based on the:
 - Hospital's costs to provide services
 - Clients served (case mix) at the hospital
- For PCCM, HHSC negotiates a discount on the FFS reimbursement rates.
- For STAR+PLUS, inpatient hospital services are carved out of the HMO capitation payments and reimbursed based on the FFS rates.

Inpatient Hospital – FFS and PCCM

- Texas Medicaid uses the following formula to determine reimbursement for
- an inpatient hospital admission:

Standard Dollar Amount X Diagnosis Related Group Relative Weight

- Standard Dollar Amount (SDA)
- The SDA is an estimate of the average cost for an inpatient stay at a specific hospital.
- The SDA is different for each hospital, because the cost for each hospital to provide inpatient services and the severity of patients served at each hospital is different.
- Diagnosis-Related Group (DRG)
- DRGs are used to classify similar patients into groups based on diagnosis and other clinical information. For example: Heart failure = DRG 293; Renal failure = DRG 682.
- HHSC gives each DRG a relative weight. For example, the DRG relative weight for renal failure (2.00) is two times the DRG relative weight for heart failure (1.00), because the average cost is twice as much.
- The DRG relative weight is the same for all hospitals.



An Example of Variation Across Hospitals for “Same” DRG-Reimbursable Patients

Hospital	Neonatal 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		
HERMANN HOSPITAL	\$75,044	\$1,217	\$620	\$314	\$7,950	\$1,704		
Range		Low	\$30,702	\$998	\$306	\$154	\$4,315	\$582
		High	\$91,452	\$2,218	\$997	\$441	\$8,335	\$1,704

Inpatient Hospital – FFS and PCCM

- The Texas Medicaid program reimburses other hospitals differently than general acute care hospitals.
- Children's and state-owned teaching hospitals receive cost-based reimbursement.
 - Based on reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cost principles.
- Rural hospitals in counties with less than 50,000 are reimbursed the greater of DRG-based reimbursement or cost-based reimbursement (TEFRA).
- Freestanding psychiatric hospitals are reimbursed a per diem.
 - Based on federal per diem with facility specific adjustments for wages, rural location, and length of stay.

Outpatient Hospital – FFS and PCCM

- Outpatient hospital services are reimbursed using a different methodology than inpatient services.
- The Texas Medicaid program reimburses outpatient hospital services at reasonable cost.
- Reasonable cost is:
 - 84.48 percent of allowed costs for high-volume providers
 - High volume provider: a provider that Medicaid paid at least \$200,000 for outpatient services during calendar year 2004
 - 80.3 percent of allowed costs for other providers

Managed Care

- Unlike FFS, Medicaid managed care organizations (MCOs) negotiate the reimbursement rates for inpatient and outpatient services with hospitals.
- Inpatient Hospital Reimbursement
 - Often set at a percentage, which could be higher or lower, than the Medicaid FFS rates
 - Some MCOs use per diems, based on DRGs
 - Non-contracted hospitals are reimbursed:
 - 95 percent of the FFS rate if in the MCO's service area
 - 100 percent of the FFS rate if out of the MCO's service area
- Outpatient Hospital Reimbursement
 - Negotiated with contracted hospitals
 - Non-contracted hospitals use the above inpatient rules

Hospital Upper Payment Limit (UPL)

- The UPL program provides supplemental payments to hospitals to make up for the lower reimbursement rates paid by Medicaid for inpatient services.
- UPL payments represent the difference between Medicaid reimbursement rates and the lesser of what Medicare would reasonably pay or the hospital's charges.
- Inter-governmental transfers from state-owned or local governmental entities finance the state share of UPL payments.
- There are federal restrictions on making UPL payments for managed care claims.

Upper Payment Limit (UPL)

- Federal Medicaid rules impose limits on Medicaid payments to hospitals. These rules provide the basis for making UPL payments to hospitals.
- Limit by hospital class: Medicaid payments made to all hospitals within a class may not exceed a reasonable estimate of what Medicare would pay.
- Hospital classes:
 - State-owned
 - Non-state publicly owned
 - All other hospitals
- Hospital-specific limit: Medicaid payments may not exceed a hospital's aggregate charges to the general public.

Upper Payment Limit (UPL)

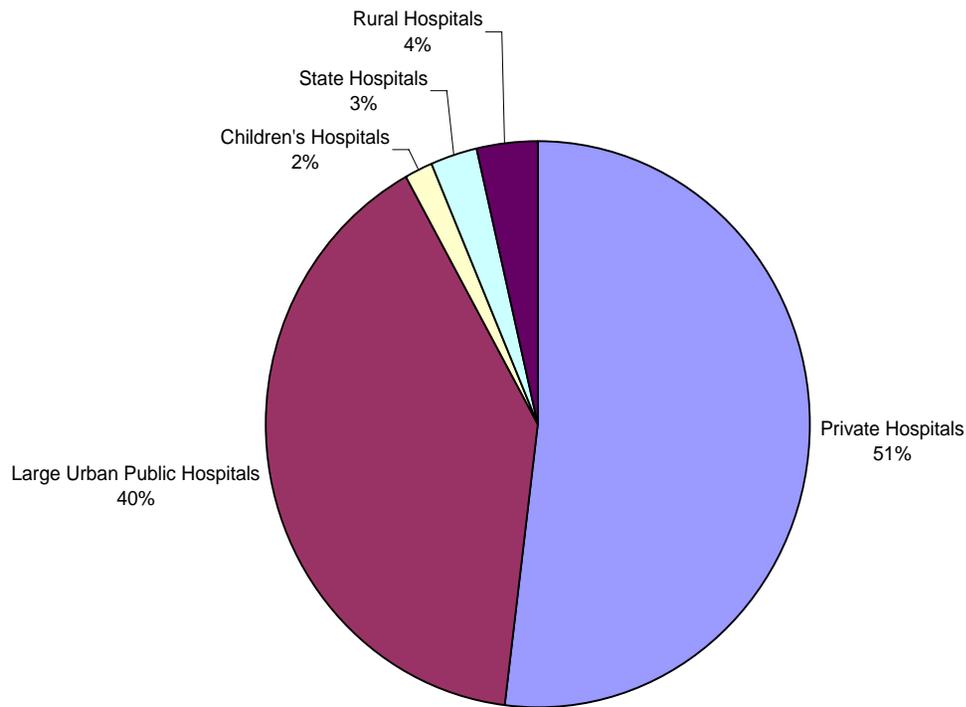
Texas Upper Payment Limit (UPL) Programs	
Hospital UPL Programs	Effective Dates
Large Public Hospitals	Jul 2001
Rural Hospitals	Jan 2002
State-Owned Hospitals	Dec 2003
Private Hospitals	Jun 2005 & Nov 2005*
Children's Hospitals	Apr 2006
Physician UPL Programs	Effective Dates
State-Owned Hospital Physicians	May 2004
Tarrant County Hospital District Physicians	Nov 2004

* The UPL program for private hospitals required two state plan amendments with different effective dates.

Note: There are two pending Medicaid state plan amendments to add Texas A&M Health Science Center and Scott and White Memorial Hospital to the Physician UPL Program.

Upper Payment Limit (UPL)

Hospital Funding Categories



**Total FY 2009 UPL
Payments -\$2,177,567,579**

Total FY 2009 UPL Payments by Type of Hospital		
Type of Hospital	Number of Hospitals	Payments (in millions)
Private	112	\$ 1,133.1
Large Urban	11	\$ 866.6
Rural	85	\$ 77.3
State-owned	4	\$ 60.2
Children's	7	\$ 40.4
Total	219	\$ 2,177.6

Disproportionate Share Hospital (DSH) Payments

- Federal law requires Medicaid programs to make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients.
- These hospitals are called disproportionate share hospitals (DSH) and receive DSH funding.
- DSH funds are different from most other Medicaid payments because they are not tied to specific services for Medicaid-eligible patients.
 - Hospitals may use DSH payments to cover the cost of uncompensated care for indigent or low-income patients.
 - DSH payments help hospitals:
 - Expand health care services to the uninsured
 - Defray the costs of treating indigent patients
 - Recruit physicians and other health care professionals



Disproportionate Share Hospital (DSH) Payments

- DSH payments are funded using the same Medicaid matching rate as for medical services.
- Large public hospitals provide the inter-governmental transfers (IGT) that provide the state matching dollars to fund the DSH program.
- The state match for the state hospitals that participate in the DSH program is funded with state appropriations to state-owned hospitals (teaching, psychiatric, and chest).
- Managed care claims are included in the calculation of DSH payments.

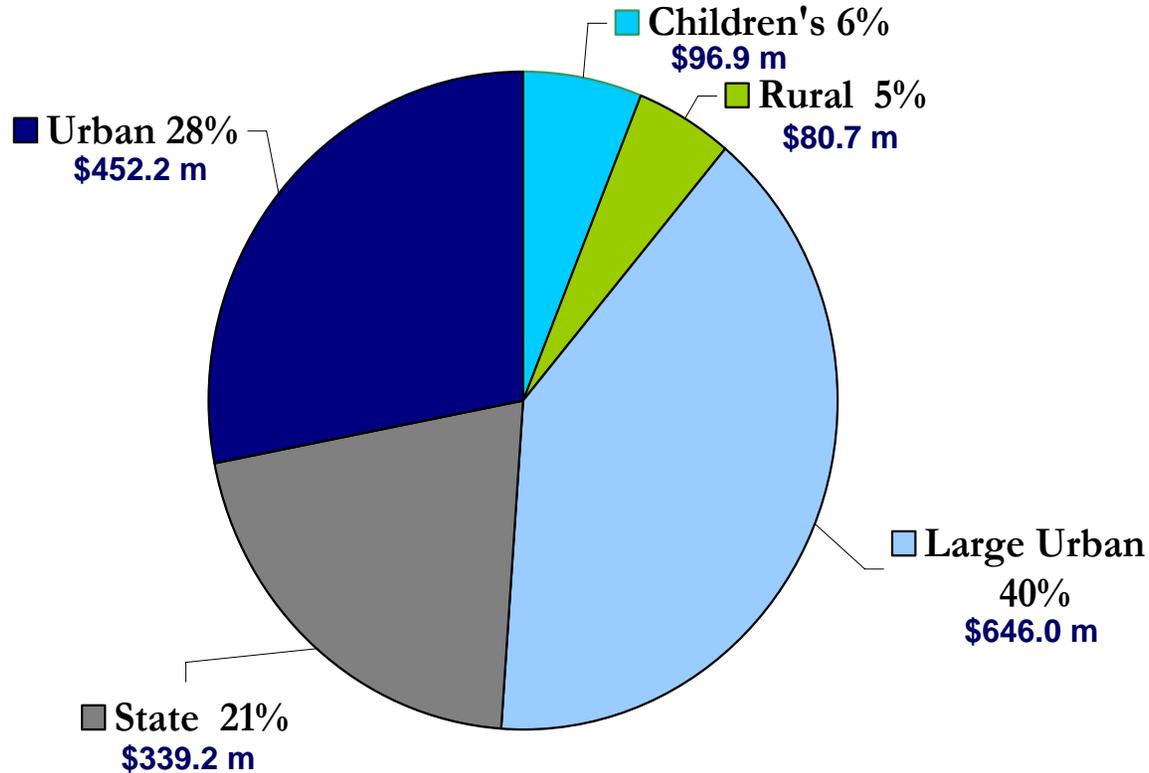
Disproportionate Share Hospital (DSH) Payments

- Texas began making DSH payments to providers in 1987.
- In 2009, 182 Texas hospitals qualified to receive DSH payments:
 - 85 were public
 - 57 were private non-profit
 - 40 were private for-profit
- Of the total DSH providers:
 - 101 were located in urban areas
 - 8 were large urban public facilities
 - 8 were children's hospitals
 - 81 were located in rural areas

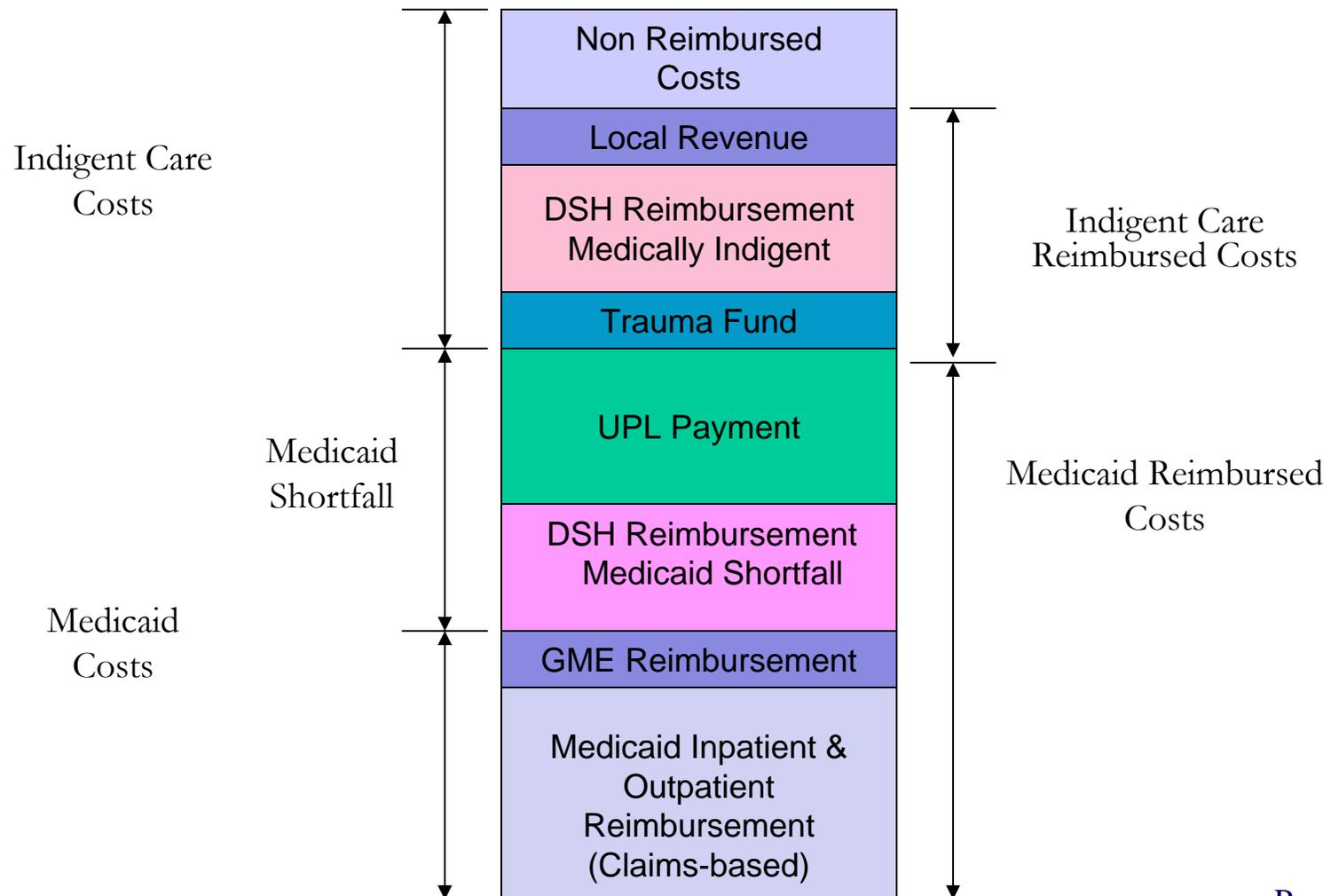
Disproportionate Share Hospital (DSH) Payments

Hospital Category Funding

Total FY 2009 DSH Payment: \$1,615,026,519



Overview of the Dynamic Interdependence of a Hospital's Medicaid & Medically Indigent Cost Reimbursement



Additional Information

Hospital Financing Terms

- **Cost Based** - Reimbursement to hospitals based on the Tax Equity and Fiscal Responsibility Act of 1985 (TEFRA) rules which reimburse hospitals for their allowable costs. This is to be distinguished from DRG-based reimbursement, whose rates are prospectively determined.
- **Diagnosis Related Group (DRG)** – A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. This system of classification is used in the calculation of acute care hospital reimbursement.
- **Inter-Governmental Transfers (IGT)** – Methodology employed by Texas to obtain state match for federal funding and does not require state general revenue. An IGT can only be provided by a governmental entity and must be considered to be public funds.
- **Disproportionate Share Hospital (DSH)** – Federal law requires Medicaid to make additional reimbursement to hospitals that serve a disproportionate share of Medicaid and low income patients. Federal funding to Texas is capped at an annual amount. Texas uses IGT's to fund the state match for non-state hospitals.
- **Standard Dollar Amount (SDA)** – Is the hospital payment rate paid to a DRG prospectively reimbursed hospital based on the hospital's standardized average cost of treating a Medicaid inpatient admission.
- **Upper Payment Limit (UPL)** – Financing mechanism used by Texas to provide supplemental payments to hospitals. The basis for this funding is the difference between what Medicare and Medicaid pays for essentially the same patient. The formula results in increased payments because Medicare's aggregate payments are higher than Medicaid's. Texas uses IGTs to fund the state match for UPL payments.
- **Primary Care Case Management (PCCM)** – A non-capitated model, where each PCCM participant has a primary care physician (PCP). PCPs receive fee-for-service reimbursement and a monthly case management fee and the PCPs and hospitals contract directly with the state.
- **Health Maintenance Organizations (HMO)** – An organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost and administrative costs.

Medicaid and CHIP Cost Sharing

Summary of Medicaid and CHIP Cost Sharing Reduction Proposals (in millions)

SFC Medicaid and CHIP Cost Reduction Proposals for Acute Care Cost Sharing		Total GR	Total All Funds
1	Establish Medicaid Co-Payments	\$ -2.7	\$ -5.4
2	Maximize Co-Payments in CHIP	\$ 8.2	\$27.6

Acute Care Medicaid and CHIP Co-Payments

Maximum and Allowable Medicaid and CHIP Co-Payments									
		< 100% FPL*		FPL		151 - 185 % FPL		> 185 % FPL	
		Current	Allowable	Current	Allowable	Current	Allowable	Current	Allowable
Medicaid	Non-Emergent ED	0	\$3.65	0	\$7.30	0	Not specified	N/A	N/A
	Generic Drugs	0	\$1.25	0	\$2.27	0	\$4.55	N/A	N/A
	Brand Drugs	0	\$3.65	0	\$19.59	0	\$39.18	N/A	N/A
	Office Visits	0	\$2.45	0	\$3	0	\$6	N/A	N/A
CHIP	Non-Emergent ED	\$3	\$3	\$5	\$5	\$50	Not specified	\$50	Not specified
	Generic Drugs	0	\$3	\$0	\$5	\$8	Not specified	\$8	Not specified
	Brand Drugs	\$3	\$3	\$5	\$5	\$25	Not specified	\$25	Not specified
	Office Visits	\$3	\$3	\$5	\$5	\$12	Not specified	\$16	Not specified

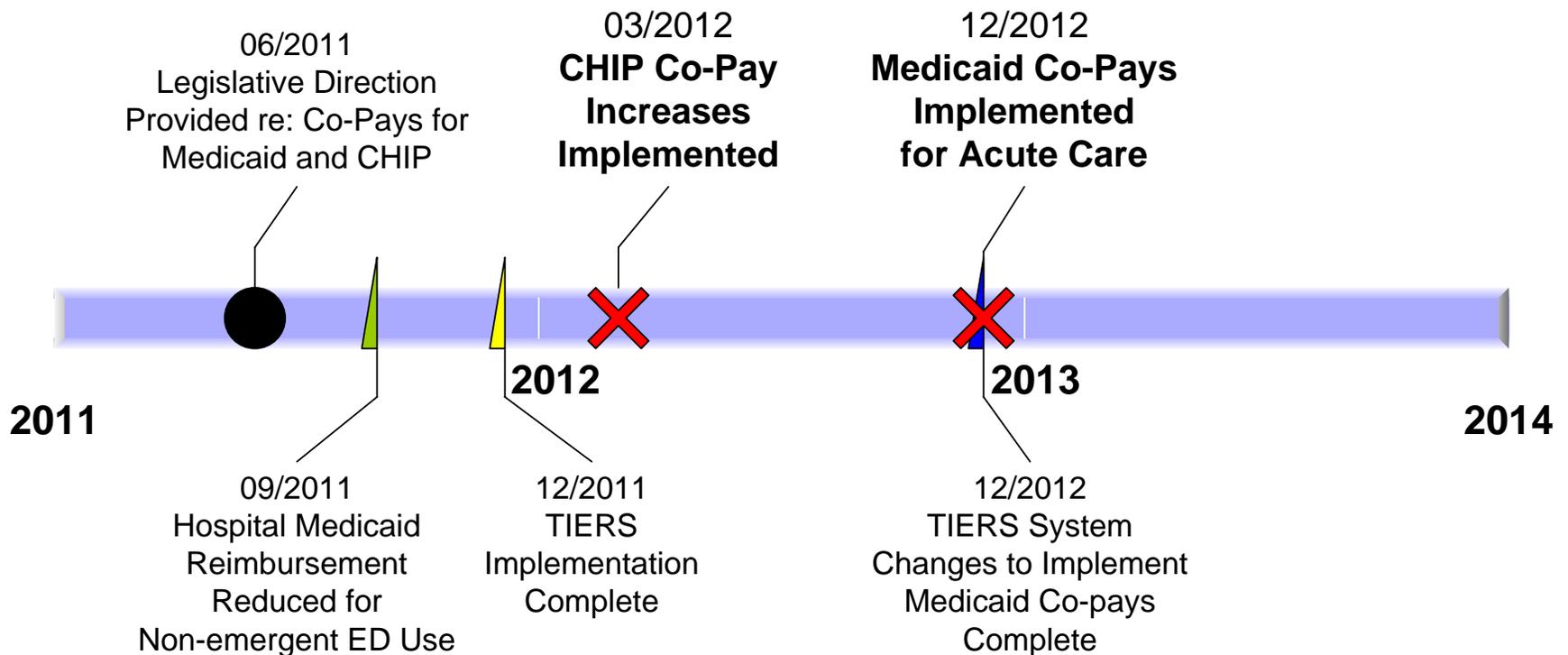
* Services cannot be denied to clients under 100% FPL who do not pay the co-pay.

Note: "Not specified" means federal law does not dictate a maximum in this category.

2011 Federal Poverty Level (FPL) Annual Incomes

Family Size	100% FPL	150% FPL	185% FPL	200% FPL
1	\$10,890	\$16,335	\$20,147	\$21,780
2	\$14,710	\$22,065	\$27,214	\$29,420
3	\$18,530	\$27,795	\$34,281	\$37,060
4	\$22,350	\$33,525	\$41,348	\$44,700

Medicaid and CHIP Co-Payment Estimated Implementation Timeline



Medicaid Co-Payments

- There are currently no cost-sharing requirements in the Texas Medicaid program.
- Co-payments may be charged in Medicaid for prescription drugs and medical services, including special provisions for non-emergent visits to the hospital emergency department.
- Due to maintenance of effort requirements in the Affordable Care Act, no enrollment fees or premiums may be added for:
 - Medicaid adults prior to January 2014, or
 - Medicaid children until October 2019.

Medicaid Co-Payments – Exempt Populations

- Most Medicaid clients are exempt from paying co-pays:
 - Infants and children ages 0-5 under 133% federal poverty limit (FPL).
 - Children ages 6-18 under 100% FPL.
 - Children in foster care or adoption assistance.
 - Pregnant women (for pregnancy-related services).
 - Individuals in hospice care.
 - Women in the breast and cervical cancer program.
 - Facility patients required, as a condition of eligibility, to apply most of their income to the cost of care.
 - Certain American Indians and Alaska Natives.
- Exception: exempt populations can be charged a co-pay for non-emergent use of the emergency department

Medicaid Co-Payments – Eligible Populations

- Texas options for requiring co-pays:
 - Parents that continue to receive Medicaid during the transitional period off Temporary Assistance for Needy Families (TANF) over 100% FPL.
 - Infants, from 133% -185% FPL.
 - Home and community care clients who receive Medicaid acute care services because they have eligibility for long term care waiver services.
- Texas options for charging co-pays with no requirement for clients to pay (all at/below 100% FPL)
 - Parents receiving TANF or transitioning off TANF.
 - Adults with disabilities with Supplemental Security Income
 - Adults receiving long-term services and supports through home and community based care programs

Medicaid Co-Payments – Additional Limitations

- The following services are exempt from co-pays:
 - Preventive care for children under age 18
 - Emergency care
 - Family planning
- Total cost-sharing cannot exceed 5 % of the family's income on a monthly basis.

Medicaid Co-Payments— for Non-Emergent Use of ED

- All Medicaid populations may be charged nominal co-payments for non-emergency services provided in the hospital emergency department (ED), even exempt populations
 - under 100% FPL would not be required to pay co-pay.
- To charge an ED co-pay, the hospital must first provide the following information to the client :
 - Name and location of an alternate provider that is available and accessible, and
 - Referral to coordinate scheduling of the treatment.

Medicaid Co-Payments – Addressing Non-Emergent ED Use

- Option for discouraging use of EDs for non-emergent care and encourage referrals to lower cost, alternative care settings:
 - Implement a co-pay for Medicaid clients, and
 - Reduce reimbursement rate for non-urgent care provided in the ED
- To assist hospitals in identifying providers who can provide urgent care after hours and during weekends, HHSC could establish a new provider type and begin enrolling providers in this new provider category.
 - Systems/administrative changes would cost roughly \$1 million initially with ongoing costs thereafter.

Medicaid Co-Payment – Implementation Assumptions

- Anticipated implementation date: December 1, 2012, with state and federal approval.
- Impact to providers:
 - Providers would collect co-pays from patients.
 - According to CMS, payment to providers must be reduced by the amount of the co-pay, regardless of whether the co-pay is collected; however, provider rates may be increased correspondingly

Medicaid Co-Payment – Implementation Assumptions

- Medicaid Systems Changes
 - Extensive Medicaid systems changes will be needed.
 - Implementation of Medicaid cost sharing would follow the completion of the TIERS rollout (December 2011).
 - Medicaid ID and health information card will be used to track Medicaid co-pays (tracking is required for clients and providers).
- Estimated general revenue systems and administrative costs to implement Medicaid cost sharing:
 - \$2.8 million in fiscal years 2012-13 (not including establishing new provider type for urgent care providers)
- Assumptions about decreased utilization or increased costs resulting from delayed treatment are not included.

Proposed Medicaid Co-Payment Levels

Proposed Medicaid Acute Care Co-Payments*						
	< 100% FPL**		101 – 150% FPL		> 150% FPL	
	Maximum Allowable	Proposed	Maximum Allowable	Proposed	Maximum Allowable	Proposed
Non-Emergent ED	\$3.65	\$3	\$7.30	\$5	Not specified	\$75
Generic Drugs	\$1.25	\$0	\$2.27	\$2	\$4.55	\$4
Brand Drugs	\$3.65	\$3	\$19.59	\$5	\$39.18	\$35
Office Visits	\$2.45	\$2	\$3	\$3	\$6	\$6

* Final co-payment amounts yet to be determined

** Services cannot be denied to clients under 100% FPL who do not pay the co-pay.

Note: "Not specified" means federal law does not dictate a maximum in this category.

CHIP Cost Sharing

- Texas CHIP currently has the following cost sharing requirements:
 - Annual enrollment fees for members over 150% of FPL.
 - Co-payments for members at all income levels.
- CHIP co-payments may be increased, within federal limitations, but enrollment fees may not be increased until October 2019 due to maintenance of efforts requirements in the Affordable Care Act.

CHIP Cost Sharing – Limitations

- American Indians and Alaska Natives are exempt from all cost sharing in CHIP.
- States cannot impose cost-sharing that in the aggregate exceeds 5% of a family's total income for the enrollment period.
- CHIP enrollment fees and co-payment amounts may vary based on family income levels, but lower income CHIP members may not be charged more than higher income CHIP members for the same services.

CHIP Co-Payment – Exempt Services

- Cost-sharing is prohibited for covered well-baby or well-child medical or dental services, including:
 - Healthy newborn physician visits,
 - Routine physical examinations,
 - Certain laboratory tests,
 - Immunizations and related office visits, and
 - Routine preventive and diagnostic dental services.

CHIP Co-Payment – Estimated savings

- If the proposed co-payments are implemented, GR cost savings would be:
 - \$2.5 million in fiscal year 2012, and
 - \$5.6 million in fiscal year 2013.

CHIP Co-Payment – Implementation Assumptions

- Estimated implementation date: March 1, 2012, with state and federal approval.
- Assumptions about decreased utilization or increased costs resulting from delayed treatment are not included.

Proposed CHIP Co-Payments

Up to 100% FPL			
<i>Note: Areas which are eligible for increased cost sharing are shaded in gray.</i>			
	Current	Federal Max. Allowable	<i>PROPOSED Co-Payments</i>
Office Visit	\$3	\$3	\$3
Non-emergency ED	\$3	\$3	\$3
Generic drug	0	\$3	0 **
Brand drug	\$3	\$3	\$3
Cost-sharing limit	1.25% of family income, per 12-month term	5%* of family income, per enrollment period	5%* of family income, per enrollment period
Inpatient Hospital	\$10	Not to exceed 50% of Medicaid FFS payment for the first day's hospital facility charges per admission	\$15

* 5% of family income for this group is from \$0 to \$1,118 per year for a family of 4.

** Generic drugs \$0 to encourage choice of generic drugs over brand-name drugs

Proposed CHIP Co-Payments

101% - 150% FPL			
<i>Note: Areas which are eligible for increased cost sharing are shaded in gray.</i>			
	Current	Federal Max. Allowable	<i>PROPOSED Co-Payments</i>
Office Visit	\$5	\$5	\$5
Non-emergency ED	\$5	\$5	\$5
Generic drug	0	\$5	\$2**
Brand drug	\$5	\$5	\$5
Cost-sharing limit	1.25% of family income, per 12-month term	5%* of family income, per enrollment period	5%* of family income, per enrollment period
Inpatient Hospital	\$25	Not to exceed 50% of Medicaid FFS payment for the first day's hospital facility charges for each admission	\$35

* Note: 5% of family income for this group is from \$1,118 to \$1,676 per year for a family of 4.

** Generic drug cost lower to encourage choice of generic drugs over brand-name drugs

Proposed CHIP Co-Payments

151% - 185% FPL			
<i>Note: Areas which are eligible for increased cost sharing are shaded in gray.</i>			
	Current	Federal Max. Allowable	<i>PROPOSED Co-Payments</i>
Office Visit	\$12	Not specified	\$20
Non-emergency ED	\$50	Not specified	\$75
Generic drug	\$8	Not specified	\$15
Brand drug	\$25	Not specified	\$35
Cost-sharing limit	2.5% of family income, per 12-month term	5%* of family income, per enrollment period	5%* of family income, per enrollment period
Inpatient Hospital	\$50	Not specified	\$75

* 5% of family income for this group is from \$1,676 to \$2,067 per year for a family of 4.
Note: "Not specified" means federal law does not dictate a maximum in this category.

Proposed CHIP Co-Payments

186% - 200% FPL			
<i>Note: Areas which are eligible for increased cost sharing are shaded in gray.</i>			
	Current	Federal Max. Allowable	<i>PROPOSED Co-Payments</i>
Office Visit	\$16	Not specified	\$25
Non-emergency ED	\$50	Not specified	\$75
Generic drug	\$8	Not specified	\$15
Brand drug	\$25	Not specified	\$35
Cost-sharing limit	2.5% of family income, per 12-month term	5%* of family income, per enrollment period	5%* of family income, per enrollment period
Inpatient Hospital	\$100	Not specified	\$125

* 5% of family income for this group is from \$2,067 to \$2,235 per year for a family of 4.
 Note: "Not specified" means federal law does not dictate a maximum in this category.

Physician and Other Proposals

Summary for Medicaid Physician and Other Cost Reduction Proposals (in millions)

HAC Medicaid Cost Reduction Proposals for Physician and Other Services		Total GR	Total All Funds
1	Medicaid Cost Sharing Payments for Physician Services for Dual Eligibles	\$ 324.1	\$ 761.6
2	Reimburse Physicians - Quality Measures		
3	Provider-Administered Drugs	\$ 0.2	\$ 1.8
4	Consolidate Physician Loan Reimbursement Programs	\$ 41.2	\$ 41.9
5	Federal Waiver Medical Transportation	\$ 10.4	\$ 0.0
6	Medical Transportation Program Pilot	\$ 6.0	\$ 14.1
7	Medical Transportation Rate Reduction Rider 59	\$ 5.4	\$ 12.9
8	Statewide with Full-risk Broker for the Medical Transportation Program	\$ 14.4	\$ 30.6
9	Reduce Claims Administrator Contract	\$ 1.4	\$ 2.8
10	SKIP and CHIP	\$ 15.9	\$ 0.0
11	TRS CHIP Children	\$ 41.6	\$ 0.0
12	Match for LPRs in CHIP	\$ 16.7	\$ 0.0

Summary for Medicaid Physician and Other Cost Reduction Proposals (in millions)

HAC Medicaid Cost Reduction Proposal for Physician and Other Services		Total GR	Total All Funds
13	Elimination of Finger Imaging Contract	\$ 2.8	\$ 5.7
14	Medicare billing prohibition	\$ 8.4	\$ 19.6
15	Advanced Practice Nurses (APN)		
16	Advanced Practice Nurses (APN) - SSLC and SH	\$ 1.2	\$ 1.2
17	Opt-out Experience and Limitations: Assumes Mandating Disabled Children into MC	\$ 6.1	\$ 14.4
18	Private Duty Nursing Management, LBB GEER	\$ 1.9	\$ 4.5
19	Inmate Care in Non-State Facilities	\$ 0.7	\$ 0.0
20	APNs	\$ 0.4	\$ 0.9
21	Other Fraud/Waste		
22	Medicaid Waiver	TBD	TBD
23	Medicaid Waiver	TBD	TBD
24	Tort Reform		



Summary for Medicaid Physician and Other Cost Reduction Proposals (in millions)

Medicaid Cost Reduction Proposal for Physician and Other Services		Total GR	Total All Funds
25	Faster Automatic Enrollment of Clients into Managed Care	\$ 21.5	\$ 21.5
26	Benchmark Medicaid Benefit Packages		
27	Expand the Long Term Care Partnership		

Physician and Other Services

- The presentation provides an overview of the following
- physician and other services:
- Cost Sharing for Physician Services
- Nursing Services
- Medical Transportation Services
- Medicaid Managed Care Services
- CHIP Services
- 1115 Waiver Services

Cost Sharing for Physician Services

- Medicaid pays Medicare cost sharing for:
- Individuals who are eligible for Medicare and Medicaid (dual eligibles)
- Medicare Part A
 - Inpatient hospital services
- Medicare Part B
 - Primarily physician services
 - Also includes medical suppliers, ambulance services, x-ray and lab services, ambulatory surgical centers, and other services

Cost Sharing for Physician Services

- Inpatient Services (Part A)
 - Texas Medicaid payments for Medicare cost sharing for inpatient hospital services do not exceed what Medicaid would pay for the services.
 - If the Medicare paid amount is higher than what Medicaid would pay, then the state does not make a cost-sharing payment.
- Physician Services (Part B)
 - Currently, Texas Medicaid pays the full amount owed after Medicare has made payment, which may include a deductible and/or co-insurance payment.
 - Texas Medicaid could limit payments for Medicare cost sharing for physician services to what Medicaid would pay for the services.

Nursing Services

- **Advanced Practice Nurses (APNs)**
- APNs include registered nurses, nurse practitioners, nurse midwives, and clinical nurse practitioners.
- Services are usually billed under physician's billing information.
- Options include:
 - Require APN to bill and pay lower APN rate
 - Require increased use of APNs in state-supported living centers and state hospitals
 - Implement pilot program to allow APNs to practice independently as physician extenders
- **Private Duty Nurses (PDNs)**
- PDNs provide medically necessary nursing services to clients who require individualized, continuous skilled care.
- Private Duty Nursing services are provided by home health agencies, or by registered nurses, licensed vocational nurses, or licensed practical nurses.
- Options include:
 - Implement stronger utilization management of private duty nursing services

Medical Transportation Services

- Medical transportation is a required Medicaid service.
- HHSC administers the Medical Transportation Program (MTP) for Medicaid clients.
- MTP arranges non-emergency transportation to and from Medicaid-covered services for individuals who have no other means of transportation.
- Most MTP services receive the federal medical assistance percentage (FMAP). However, some MTP services receive the administrative match rate (50/50).

Medical Transportation Services

- **Medical Transportation Options**
- Federal waiver for certain medical transportation services
 - Allows FMAP for on-demand medical transportation services
 - HHSC has received federal approval to begin April 1, 2011
- Pilot full (at-risk) broker program
 - The broker would arrange, provide, and pay for all medical transportation services
 - Proposed Pilot Areas: Dallas, Fort Worth, Houston, and Beaumont areas
 - HHSC has released a request for proposals for the pilot
- Other Options
 - Expand the broker program statewide
 - Include medical transportation services in managed care

Medicaid Managed Care

- **Medicaid Managed Care for Children with Disabilities**
- Currently, children eligible for Supplemental Security Income (SSI) are voluntary enrollees in the STAR+PLUS program.
- Federal law allows states to mandate SSI children into managed care.
- **Enrollment Period Lock-in**
- Texas allows Medicaid managed care members to change plans every six months.
- Federal law allows states to lock members into a plan for up to 12 months.
- **Options**
- Require children with disabilities to enroll in managed care
- Change the lock-in period for managed care

Children's Health Insurance Program (CHIP)

- Texas has used general revenue to provide health care to the following
- CHIP income eligible children:
- **School Employee Children**
 - Texas received federal approval to begin claiming federal CHIP match for school employee children enrolled in CHIP retroactive to September 1, 2010.
- **State Employee Children**
 - The introduced budget assumes CHIP eligible children will move from the Employee Retirement System of Texas to federally-matched CHIP.
- **Legal Immigrant Children**
 - The introduced budget assumes the state will receive federal CHIP match for legal immigrant children.
 - HHSC received federal approval to claim federal CHIP match for legal immigrant children in CHIP and Medicaid (retroactive to May 2010).

1115 Waiver Services

Section 1115 Research and Demonstration Waivers

- **Section 1115 waivers:**
 - Provide broad flexibility for states to test new service delivery models, increase access to services, and achieve cost savings
 - Must receive federal approval (there is no time limit on federal approval)
 - Must be budget neutral
 - Typically approved for a 5-year period
- **Texas currently has two Section 1115 waivers:**
 - **Women's Health Program:** Statewide program that provides family planning and related health screenings
 - **Program of All Inclusive Care for the Elderly (PACE):** Capitated program that provides comprehensive medical and community-based services for persons over age 55 (Operates in El Paso and Amarillo)