Texas Medicaid and CHIP in Perspective

Ninth Edition

MEDICAID & CHIP

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Data Sources

Medicaid is a complex program involving multiple agencies and external partners that collect program statistics and financial information. Information contained within the 9th edition was current as of August 2012; however program and financial information may change after publication due to unforeseen changes such as changes to federal and state regulations and the state of the economy.

The following are the primary sources of data utilized in this publication.

Premiums Payable System (PPS) data, which is collected from the System of Application, Verification, Eligibility, Referral, and Reporting (SAVERR) and the Texas Integrated Eligibility Redesign System (TIERS) databases, and compiled by data management staff at the Department of Aging and Disability Services and the Health and Human Services Commission, provides a summary of all Medicaid-eligible clients each month. Both monthly PPS files and final 8-month files, which contain all retroactivity, are used in the analyses.

Expenditure information is obtained from the Texas Medicaid and Healthcare Partnership (TMHP) through the databases in the Vision 21 universe, which includes paid claims, managerial reporting of cash flow, provider and client information, and managed care encounter information. Expenditures include direct payments to physicians, hospitals, and entities that provide ancillary services. Financial information is provided using the Form CMS 64 – Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, and the Medicaid Program Budget Report – CMS 37. Additional financial information is provided by the Medicaid Statistical Information System. Unpublished analyses conducted by HHSC Financial Services staff are also utilized to provide financial information.

The Medicaid Numbers

Medicaid as a percentage of Texas budget, SFY 2011: **26 percent**[i]

Percentage of Texas Medicaid budget spent on children, SFY 2011: **33 percent**[ii]

Dollars spent on Texas Medicaid, FFY 2011: **$29.4 billion**[iii]

Texas Medicaid payments to nursing homes, FFY 2010: **$2.3 billion**

Texas Medicaid prescription drug expenditures, SFY 2011: **$2.5 billion**[iv]

Percentage of Texas Medicaid clients under age 21, SFY 2011: **77 percent**[v]

Percentage of Texas children on Medicaid or CHIP, CY 2011: **47 percent**

Percentage of nursing home residents covered by Medicaid, CY 2010: **59 percent**

Percentage of births covered by Texas Medicaid in 2011, CY 2011: **56.4 percent**

Percentage of Texas Medicaid clients in managed care, SFY 2011: **76 percent**[vi]

Unduplicated number of Texans receiving Medicaid, SFY 2011: **4.57 million**

Average number of Texans with Medicaid each month, SFY 2011: **3.54 million**

Percentage of Texas population covered by Medicaid, CY 2011: **14 percent**

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[i] All funds, excluding disproportionate share hospital (DSH) and upper payment limit (UPL).
[ii] Includes children under 19 in child risk categories (excludes blind and disabled children).
[iii] All funds, including DSH and UPL.
[iv] Includes Medicare "clawback" payments.
[v] Receiving full Medicaid benefits.
[vi] Receiving full Medicaid benefits.

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Chapter 1: Texas Medicaid in Perspective

What is Medicaid? What is Medicaid managed care? How is Texas Medicaid changing?

What Is Medicaid?

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by the Health and Human Services Commission (HHSC). In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. States can apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver of federal law to expand health coverage beyond these groups. Medicaid is an entitlement program, which means the federal government does not, and a state cannot, limit the number of eligible people who can enroll, and Medicaid must pay for any services covered under the program. In December 2011, about one in seven Texans (3.7 million of the 25.9 million) relied on Medicaid for health insurance or long-term services and supports.

Medicaid pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services), and long-term services and supports (home and community-based services, nursing facility services, and services provided in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICFs/IID)) for people age 65 and older and those with disabilities. In state fiscal year (SFY) 2011, total expenditures (i.e. state and federal) for Medicaid

were estimated to represent 26 percent (about $24.8 billion) of all expenditures.[i] The federal share of the jointly financed program is determined annually based on the average state per capita income compared to the U.S. average. This is known as the federal medical assistance percentage (FMAP). Each state's FMAP is different; in Texas, the federal government funded 66.46 percent of the cost of the Texas Medicaid program in federal fiscal year (FFY) 2011, while the state funded the other 33.54 percent. (See Chapter 5 for the Texas FMAPs for FFYs 1998-2014.)

This FMAP represents a more favorable federal match than Texas has seen in previous years due to a temporarily higher match resulting from American Recovery and Reinvestment Act (ARRA) funding. (See Chapter 2 for more information about ARRA.) Due to the size of the Texas Medicaid program, even small changes in the FMAP can result in federal funding fluctuations worth millions of dollars.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Initially, the program was only available to people receiving cash assistance Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI). During the late 1980s and early 1990s, Congress expanded the Medicaid program to include a broader range of people, including older adults, people with disabilities and pregnant women. While individuals receiving TANF and SSI cash assistance continue to be automatically eligible for Medicaid, these and other federal changes de-linked Medicaid eligibility from receipt of cash assistance.

In SFY 2011, women and children accounted for the largest percentage of the Medicaid population. Based on the total number of unduplicated clients receiving Medicaid in SFY 2011, 55 percent of the Medicaid population was female and 77 percent was under age 21. While non-disabled children make up the majority (66 percent) of all Medicaid clients, they account for a relatively small portion (33 percent) of Texas Medicaid program spending on direct health-care services.[ii] By contrast, people who are elderly, blind, or have a disability represent 25 percent of clients but account for 58 percent of estimated expenditures. **Figure 1.1** shows the

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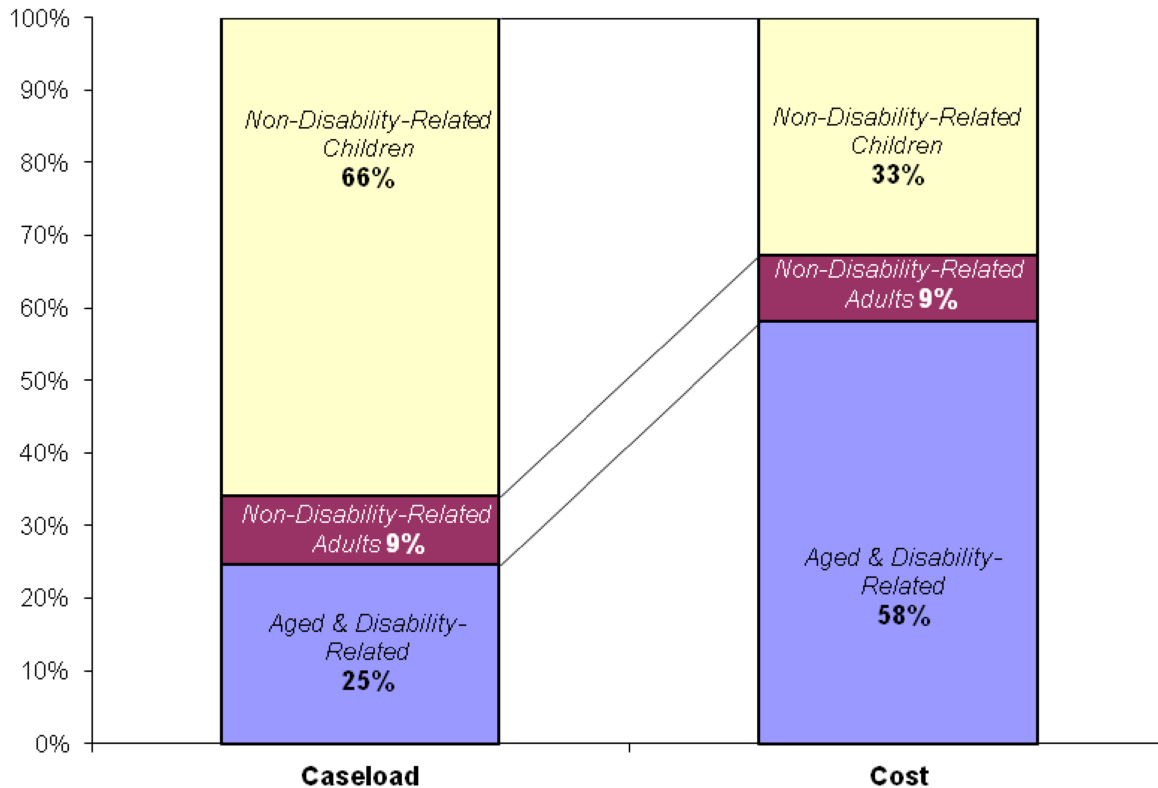
[i] This percentage does not include disproportionate share hospital (DSH) and upper payment limit (UPL) funds. Source: Texas Medicaid History Report May 15, 2012 and Fiscal Size-Up(s) Appendix E Medicaid Expenditure History (FFYs 1987-2011).

[ii] "Medicaid clients" refers to clients who receive any Medicaid benefits and includes clients who receive only Medicare premium assistance or emergency medical services.

percentage of the Medicaid population by category and the estimated portion of the Medicaid budget spent on each category in SFY 2011 for direct health services.

Figure 1.1: Texas Medicaid Beneficiaries and Expenditures SFY 2011



Source: HHS Financial Services, HHS System Forecasting. 2011 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Services and Supports. Costs and caseload for all Medicaid payments for all beneficiaries (Emergency Services for Non-Citizens, Medicare payments) are included. Children include all Poverty-Level Children, including TANF. Disability-Related Children are not in the Children group.

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories that states are allowed, but not required, to cover under their Medicaid programs. For example, Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 185 percent of the federal poverty level (FPL). The federal requirement for pregnant women and infants is 133 percent of the FPL. Another optional group Texas covers is known as the “medically needy” group. This group consists of children and pregnant women whose income exceeds Medicaid eligibility limits, but who do not have the resources required to meet their medical expenses. A “spend down” amount is calculated for each of these individuals by subtracting their income from the medically needy income limit for their household size. If their medical expenses

exceed the spend down amount, they become Medicaid eligible. Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after they are determined to be medically needy. (See Chapter 2**, Figure 2.2**, “Texas Medicaid Income Eligibility Levels for Selected Programs June 2012.”)

Medicaid Managed Care

Texas Medicaid provides health care services to most clients through a managed care model that engages multiple health plans as described below.

As of February 2012, the number of Medicaid managed care members represented almost 2.9 million of the state's 3.7 million Medicaid clients.[iii] (See **Appendix D** for Medicaid and CHIP Service Areas.)

State of Texas Access Reform (STAR)

Medicaid’s State of Texas Access Reform (STAR) program is the managed care program in which HHSC contracts with managed care organizations (MCOs) to provide, arrange for, and coordinate preventative, primary, and acute care covered services, including pharmacy. STAR administers services to different eligible populations in different locations.

In the metropolitan service areas STAR provides services for pregnant women and children with limited income and TANF clients. On March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties. The Medicaid Rural Service Area (Medicaid RSA) STAR program serves clients who were previously covered by the Primary Care Case Management (PCCM) program if they had Medicaid only. STAR in the Medicaid RSA provides services to pregnant women and children with limited income, TANF clients, and adults receiving SSI.

STAR Health

HHSC worked with the Texas Department of Family and Protective Services (DFPS) to develop a medical care delivery system for children in foster care, who are a high-risk population with greater medical and behavioral health care needs than most children in Medicaid, and whose changing circumstances make continuity of care an ongoing challenge. Called STAR Health, the program began

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[iii] This total includes STAR, PCCM, STAR Health and STAR+PLUS members. It does not include NorthSTAR Medicaid members who are not enrolled in STAR.

in April 2008, serving children as soon as they enter state conservatorship and continuing to serve them in two transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements, and
- Young adults younger than 21 years of age who were previously in foster care and are receiving transitional Medicaid services.

HHSC administers the program under contract with a single MCO. STAR Health clients receive medical, dental, and behavioral health benefits, including unlimited prescriptions through a medical home. The program also includes a 7-days-per-week, 24-hours-per-day nurse hotline for caregivers and DFPS caseworkers. Use of psychotropic medications is carefully monitored, and in 2010 trauma-informed care was initiated, based on best practices for positive outcomes, effectively managing behavior issues that can destabilize children's health status and foster family placement.

STAR+PLUS

STAR+PLUS is the agency's program for integrating the delivery of acute and long-term services and supports through a managed care system. People who are eligible include SSI/SSI-related clients with a disability or who are age 65 and older and have a disability. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant and Travis Service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a provider network contracted with MCOs.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. It is an initiative of the Texas Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR clients in a seven-county area around Dallas receive behavioral health services through NorthSTAR.

Dental Managed Care

Effective March 1, 2012, children's Medicaid dental services are provided through a managed care model to children under age 21, those eligible for Medicaid Texas Health Steps Comprehensive Care services, including SSI recipients. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist serves as the

client's dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care.

Through the following efforts and policies, HHSC facilitates the provision of dental services focused on quality outcomes for children in the Medicaid programs:

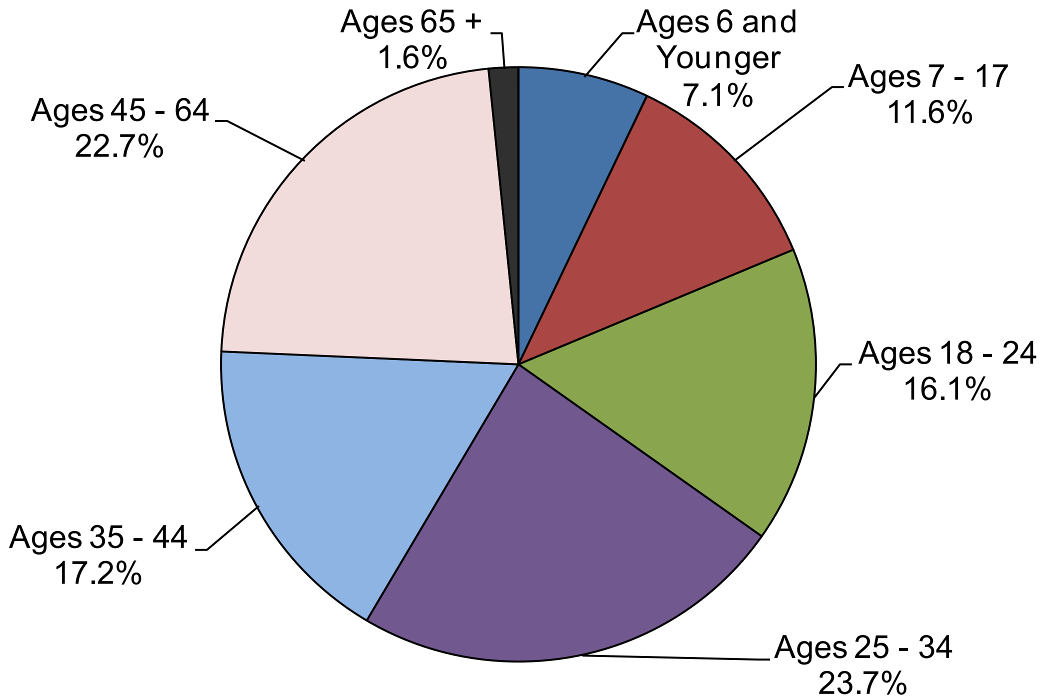
- Quality, comprehensive dental services through qualified and accessible Texas dental providers,
- Improvement of oral health through preventive care and health education initiatives and activities,
- Intervention strategies to avoid disparities in the delivery of dental services to diverse populations, and providing dental services in a culturally competent manner, and
- A choice of dental plans.

Who are the Uninsured?

An estimated 6.2 million Texans, or 24.6 percent of the state population, had no health insurance in 2010.[1] Texas has the highest rate in the nation for people without insurance.[2] In 2010, approximately 1.2 million or 16.3 percent (down from 16.5 percent in 2009) of Texas children under age 18 had no insurance.[3] The national average was 9.8 percent.[4]

Most of the uninsured in Texas are adults under age 65. Most adults over age 65 have Medicare. **Figure 1.2** depicts the uninsured population in Texas by age group.

Data indicate that about two-thirds of uninsured, non-retired Texans age 18 and older have a job.[5] Uninsured adults may work in jobs that do not offer employer-sponsored coverage, or they may not be able to afford the coverage that is offered. Unless they are caretakers of children eligible for TANF, are pregnant, or have disabilities that qualify them for SSI, most of these adults are ineligible for Medicaid.

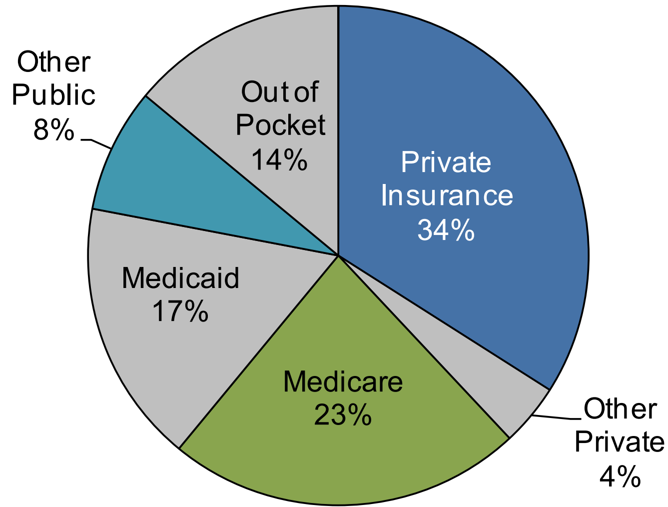


Source: U.S. Census Bureau. March 2011 Current Population Survey (CPS) for Texas.

Private Insurance

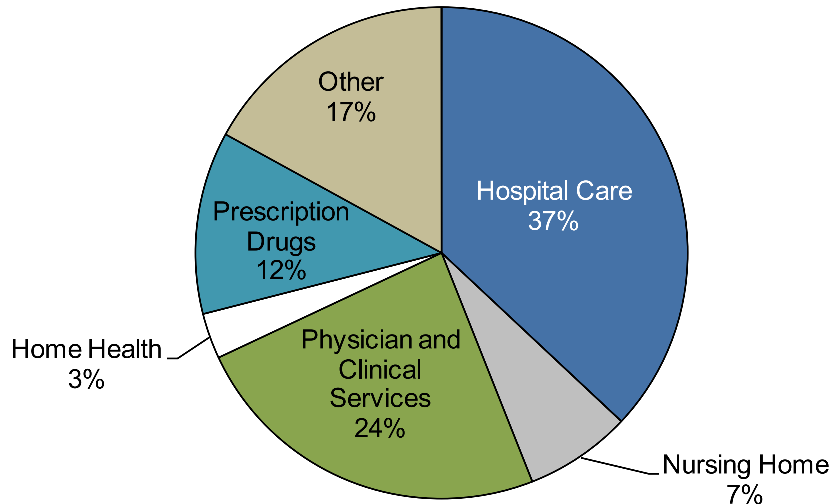
The limits of private insurance also affect Medicaid. In 2010, 65 percent of the non-elderly population had private health insurance coverage, most often in the form of employer-based coverage.[6] That same year, private insurance paid for 34 percent of total national personal health care expenditures.[7] **Figure 1.3** and **Figure 1.4** show national health care spending and sources of coverage.

Figure 1.3: U.S. Personal Health Care Expenditures by Source of Funding, 2010



Source: U.S. Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group.

Figure 1.4: U.S. Personal Health Care Expenditures by Category, 2010



Source: U.S. Centers for Medicare & Medicaid Services Office of the Actuary, National Health Statistics Group.

In Texas, the proportion of the population covered by employer-based health insurance is lower than the national average. Fifty-nine percent of Americans under age 65 were covered by employer-sponsored health coverage in 2010, compared with 51 percent of Texans.[8] In 2010, 22 percent of working adults age 18 to 64 in the United States were uninsured, compared with 30 percent in Texas.[9] Certain working uninsured individuals with low incomes may turn to Medicaid to meet their health care needs or those of their dependants when employer-sponsored coverage is not available or affordable.

Private insurance tends to cover healthy individuals. Many of the sickest and most expensive patients do not have health insurance and must rely on government programs or out-of-pocket spending to pay their bills. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits insurers from excluding individuals because of health problems or disabilities, in most cases, insurers may exclude treatment of pre-existing conditions for up to 12 months. The Patient Protection and Affordable Care Act (PPACA) of 2010 prohibits health plans from denying or limiting coverage for pre-existing conditions for children under age 19 starting September 23, 2010 and for adults starting January 1, 2014.

Medicaid vs. Private Insurance

Comparing the costs and benefits of Medicaid with those of private insurance is difficult. The Medicaid population includes people who are age 65 and older and those who have disabilities or chronic illnesses. These individuals typically do not have comprehensive health insurance. Moreover, the Texas Medicaid program pays for long-term services and supports, such as nursing facility and personal attendant care, which are not typically covered by private health insurance. Texas Medicaid also pays for comprehensive services to children that exceed those offered by most private insurance plans.

Given the unique concentration of medically high-risk people enrolled in Texas Medicaid, no commercial insurance pool would resemble its client population. Nevertheless, **Table 1.1** provides a high-level comparison of benefits offered under Texas Medicaid with those a typical private employer-sponsored health insurance package might offer.

Table 1.1: Comparison of Medicaid Benefits and a Typical Private Employer-Sponsored Health Insurance Benefit Package[10]

	Medical (Inpatient Hospital, Acute Care)	Dental	Long-Term Services and Supports	Prescription Drugs	Lifetime Maximum Benefit	Deductible
Medicaid: Children	Yes	Yes	Yes	Yes (unlimited)	None	None
Adults	Yes	No	Yes	Yes*	None	None
Typical Employee Benefit Package (individual adult or child)	Yes (Usually requires a co-pay)	Yes (Separate optional coverage with additional contribution)	No	Yes (Usually requires a co-pay)	no limit**	$675 - $1,908 (varies by plan type and region)

* Some exceptions apply. For example, nursing facility residents, home and community-based waiver clients, and STAR and STAR+PLUS adult enrollees receive unlimited prescription benefits.

** Based on H.R. 3590, Sec. 2711(a)(1)(A) and H.R. 4872, Sec. 122 (a)(3), insurance companies are now prohibited from imposing lifetime dollar limits on essential benefits for all health plan years beginning on or after September 23, 2010.

Premium Assistance Under Medicaid Programs

The Health Insurance Premium Payment (HIPP) program, implemented in Texas in 1994, is a Medicaid program that reimburses eligible individuals for their share of an employer-sponsored health insurance premium payment. In 2011, an average of 9,096 Medicaid clients were enrolled in the Texas HIPP program.

To qualify for HIPP, an employee must either be Medicaid eligible or have a family member that is Medicaid eligible. A client who is in Medicaid managed care can be considered for enrollment in HIPP; however, if they qualify for HIPP enrollment they cannot stay enrolled in Medicaid managed care. There are some categories of clients that require mandatory Medicaid managed care enrollment and those clients are not eligible to be enrolled in HIPP. The reimbursement may pay for clients and their family members to get employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums is less than the

cost of projected Medicaid expenditures. For example, a Medicaid eligible child and the child's parent could be enrolled in the parent's employer-sponsored health insurance (ESI) plan reimbursed through HIPP, if the cost of enrolling both individuals is less than the cost of the Medicaid expenditures.

Medicaid eligible HIPP enrollees do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for health care services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses. HIPP enrollees who are not Medicaid eligible must pay deductibles, co-payments, and co-insurance required under the employer's group health insurance policy. Additionally, if a Medicaid eligible HIPP enrollee needs a Medicaid covered service that is not covered by their ESI plan, Medicaid will provide this wrap-around service at no cost to the enrollee as long as the services are provided by an enrolled Medicaid provider.

In certain circumstances, employers may receive a one-time tax refund of up to $2,000 per employee for employees that participate in HIPP. The Texas Workforce Commission administers the tax refund program, while the HHSC Office of Inspector General (OIG) oversees the administration of the Texas Medicaid HIPP program.

Currently, it takes three to five days to process reimbursement checks for eligible individuals. In an effort to shorten the reimbursement timeframes even more, the use of electronic funds transfer (EFT) began in August 2009 and in 2011 an average of 72% of all premium reimbursements were made by EFT.

Federal Health Care Reform

PPACA was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). The ACA includes:

- Provisions intended to expand health insurance coverage, including an individual insurance mandate; sliding-scale health insurance subsidies for individuals and families up to 400 percent of the FPL; tax incentives for small employers to offer health insurance to their employees; and an optional expansion of Medicaid up to 133 percent of the FPL for individuals under age 65.
- Health Benefit Exchanges to connect individuals and small employers with affordable health care coverage.
- Funding to help build the health care infrastructure and workforce.

- Measures to improve quality, reduce fraud and abuse, and reform payment methodologies.

Chapter 3 provides information on the federal health care reform requirements and the impacts to Texas.

Texas Health Care Transformation and Quality Improvement Program 1115 Waiver

The Texas Health Care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as upper payment limit (UPL) payments. UPL payments were supplemental payments paid to hospitals and certain other providers (totaling about $3 billion in FFY 2011 to offset the difference between what Medicaid pays for a service and what Medicare would pay for the same service.

The 1115 Transformation Waiver, which was approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds. The 1115 Transformation Waiver contains two funding pools, one based on costs and the other based on performance outcomes. (See Chapter 4 for more information.)

Uncompensated Care (UC) payments are cost-based and will help offset the costs of uncompensated care provided by hospitals and other providers.

Delivery System Reform Incentive Payment (DSRIP) funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance:

- Access to health care services,
- Quality of health care and health systems,
- Cost-effectiveness of services and health systems, and
- Health of the patients and families served.

Regional Healthcare Partnerships (RHPs), which are anchored by public hospitals or other local governmental entities, collaborate with participating providers to establish a RHP plan designed to achieve quality outcomes and learn more about local needs through population-based reporting. Performing providers in a RHP can access waiver DSRIP funding by performing improvement projects leading to quality outcomes. Performance improvement projects and outcome reporting in the RHP plan align with the following four categories:

- Infrastructure development,
- Program innovation and redesign,
- Quality improvements, and
- Population-focused improvements.

Endnotes

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[1] U.S. Census Bureau, Health Insurance Historical Tables, “Table HIB-4: Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2010,” http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (August 2012).

[2] U.S. Census Bureau, Health Insurance Historical Tables, “Table HIB-4: Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2010,” http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (August 2012).

[3] U.S. Census Bureau, Health Insurance Historical Tables, “Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2010,” http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (August 2012).

[4] U.S. Census Bureau, Health Insurance Historical Tables, “Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2010,” http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (August 2012).

[5] U.S. Census Bureau, “Current Population Survey,” March 2011. Data analysis completed by the Strategic Decision Support Department of the Texas Health and Human Services Commission.

[6] U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State--1999 to 2010, Historical Health Insurance Data: http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (August 2012).

[7] Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, “Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010,” http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html (August 2012).

[8] U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State--1999 to 2010, Historical Health Insurance Data:

http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (October 2012).

[9] U.S. Census Bureau, “Current Population Survey,” March 2011. Data analysis done by Strategic Decision Support of the Texas Health and Human Services Commission.

[10] The Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits 2011 Annual Survey,” 2011, pp. 91-100, 139-148, and 181-191.

Chapter 2: Medicaid History and Organization

Texas Medicaid operates within a framework established by federal law, but the state of Texas manages key elements of the program. Over time, both federal and state changes have affected Medicaid in Texas. This chapter outlines the history and organization of the Medicaid program in Texas.

History and Background

Congress established the Medicaid program under Title XIX of the Social Security Act of 1965 to pay medical bills for low-income persons who have no other way to pay for care. Texas began participating in the Medicaid program in September 1967.

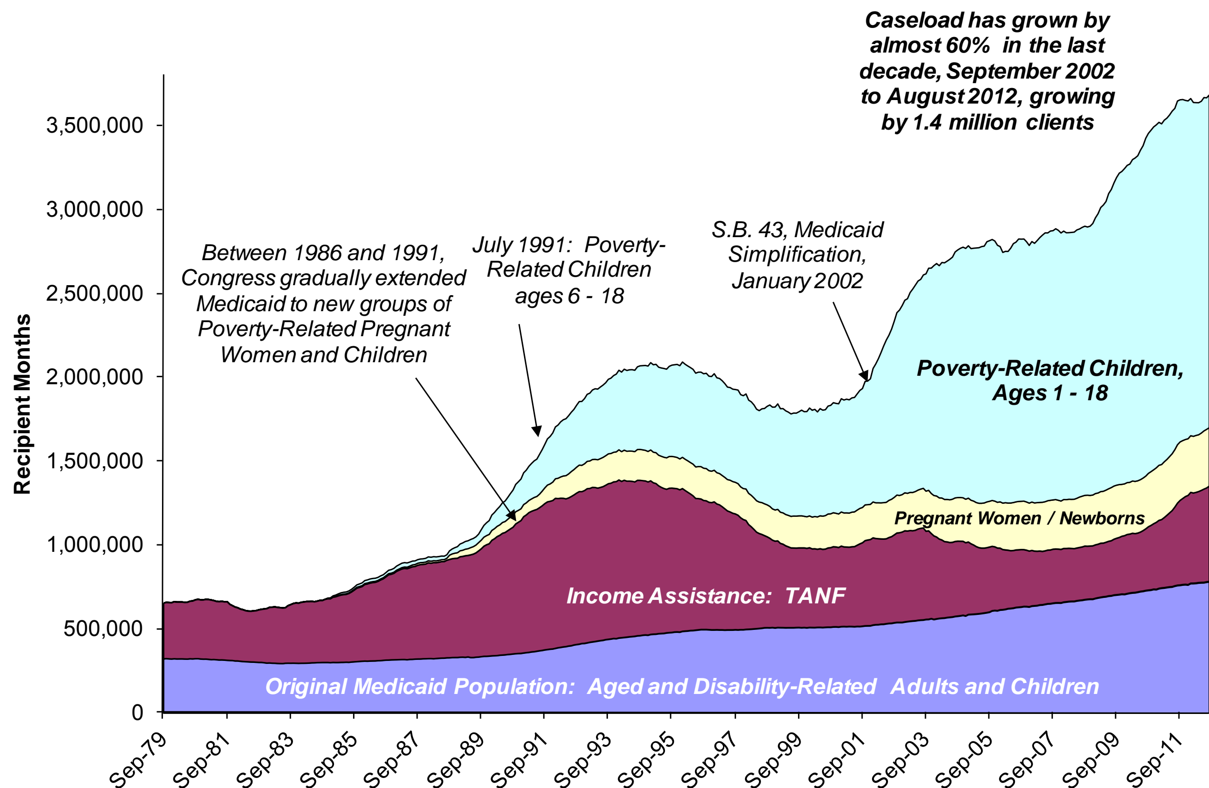
Medicaid was intended to ensure access to health care for low-income Americans. However, the expense of the program and the number of Americans served has grown beyond original expectations. Congress has transformed Medicaid from a narrowly defined program available only to persons eligible for cash assistance into a large insurance program with complex eligibility rules.

During the late 1980s and early 1990s, Congress expanded Medicaid eligibility to include a greater number of people with disabilities, children, pregnant women, and older persons. These changes helped fuel the growth of the Medicaid program, and the Texas Medicaid population tripled in just a decade, adding more than one million people between 1990 and 1995 alone. In the mid to late 1990s, caseload declined in part due to the de-linking of Medicaid from cash assistance and stricter eligibility requirements for Temporary Assistance for Needy Families (TANF). In 2002, the number of children enrolled in Medicaid grew sharply due to Medicaid application simplification and six-month continuous eligibility as required by Senate Bill (S.B.) 43, 77th Legislature, Regular Session, 2001. In 2003, TANF populations began declining due to sanctions against adults not complying with the Personal

Responsibility Agreement. The Personal Responsibility Agreement is a document a child's parent or relative that is also approved for TANF must sign and follow.

Currently, over 3.6 million Texans are served each month in Medicaid, more than 72 percent of whom are non-disability-related children under age 21. **Figure 2.1** illustrates Texas Medicaid enrollment trends by category for September 1979 through August 2012.

Figure 2.1: Medicaid Caseload by Group
September 1979 – August 2012



Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid's Early Years

Linked to Financial Assistance Programs

As originally enacted, Medicaid coverage was available only to persons eligible for Aid to Families with Dependent Children (AFDC), now referred to as TANF. TANF

is the federal-state cash assistance program for low-income families, usually headed by a single parent. To be able to receive Medicaid, individuals were required to be receiving cash assistance or welfare. In this sense, Medicaid was "linked" to welfare. Historically, Medicaid coverage has also been available to persons eligible for Supplemental Security Income (SSI) in Texas. SSI is a federal cash assistance program for low-income people age 65 and older or who have disabilities. In Texas, SSI recipients are automatically eligible for Medicaid. Therefore, Medicaid has also been "linked" to SSI in Texas.

Temporary Assistance for Needy Families

Children under age 19 and their related caretakers who qualified for TANF cash assistance qualified for Medicaid. With the passage of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), cash assistance and Medicaid are no longer "linked." If households need both TANF cash assistance and Medicaid they must apply for both. Otherwise they may only apply for TANF cash assistance or Medicaid.

Each state sets its own income eligibility guidelines for TANF. Texas has historically maintained low TANF income caps. As of 2012, the income cap for a parent with two children is $188 per month. The TANF monthly cap is based on a set dollar amount and is not determined by federal poverty levels (FPLs). This amount is what is used to determine Medicaid eligibility for households that consist of adult caretaker relatives who reside with a Medicaid eligible dependent child.

Supplemental Security Income

In 1972, federal law established the SSI program, which provides federally-funded cash assistance to low-income people age 65 and older and those with disabilities. The Social Security Administration determines the eligibility criteria and cash benefit amounts for SSI. States may supplement SSI payments with state funds, and many states choose to do so. Texas does not, but does allow for a slightly higher personal needs allowance (PNA) for SSI clients in long-term care facilities. The PNA is the amount of the SSI check clients may keep for personal use while living in a long-term care facility.

To be eligible for SSI, an individual must be at least 65 years old or have a disability, and have limited assets and income. A child may be eligible for SSI beginning as early as the date of birth; there is no age requirement. The individual's income must be below the federal benefit rate (FBR). In 2012, the limit for an individual is $698 a month in countable income and no more than $2,000 in countable resources. The limit for couples is $1,048 a month with no more than

$3,000 in countable resources.[i] The amount of the SSI payment is the difference between the person's countable income and the FBR.

De-Linking Medicaid and Cash Assistance

Historically, all Medicaid enrollees were either on SSI or welfare. Federal laws passed in the late 1980s mandated Medicaid coverage for groups of people ineligible for TANF or SSI. This resulted in a major expansion of the eligible population. Members of working families and others with low incomes were now also eligible to receive Medicaid.

The following program expansions resulted from federal mandates:

- Coverage of prenatal and delivery services for certain pregnant women and their infants,
- Expansion of services to low-income families who do not receive TANF cash assistance,
- Expansion of Medicaid to fill gaps in Medicare services for low-income people age 65 and older and those with disabilities, and
- Coverage of the full array of federally-allowable Medicaid services as medically necessary and appropriate for all children on Medicaid.

Figure 2.2 depicts the current Texas Medicaid income eligibility levels in the most common Medicaid eligibility categories. Mandatory levels identify the coverage levels required by the federal government. Optional levels show coverage Texas has implemented at higher levels allowed but not mandated by the federal government.

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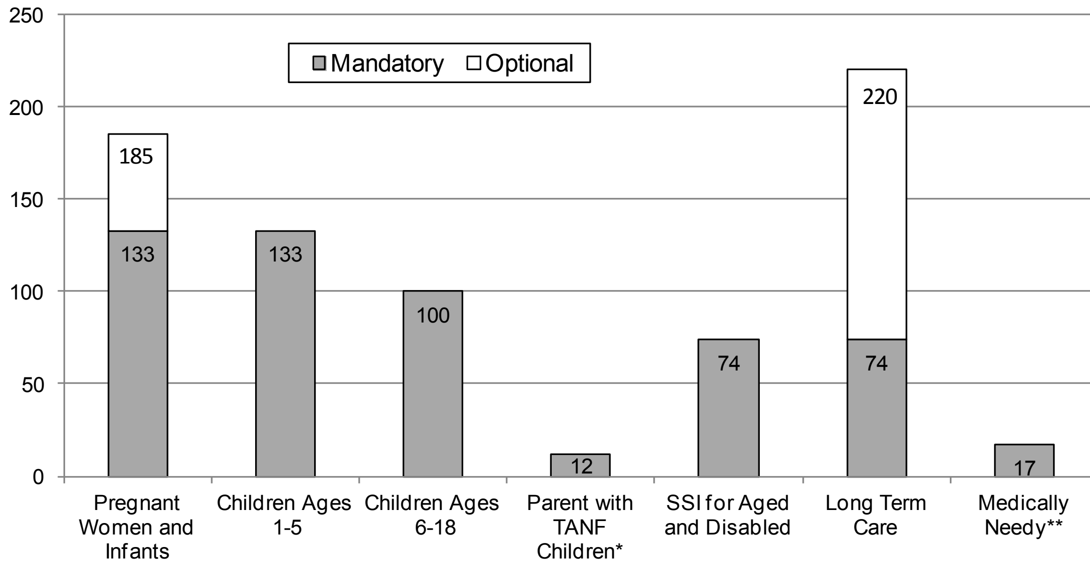
[i] Countable income is income that counts against the SSI income limit for an individual or couple. An example of income that is not counted is the first $65 of earnings and 50 percent of earnings over $65 earned in a month. Countable resources are things that one owns that count against the SSI resource limit for an individual or couple. An example of a resource that is not counted is the home that one lives in and the land it is on.

Figure 2.2: Texas Medicaid Income Eligibility Levels for Selected Programs, June 2012 (As a Percent of FPL)



*In State Fiscal Year (SFY) 2012, for a parent with two TANF children, the maximum monthly income eligibility is $188, which is the equivalent of 12% of the FPL for a family of three
**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2012 is $275, which is the equivalent of 17% of FPL for a family of three.

Medicaid Coverage

An Insurance Program

Medicaid is both a basic health insurance program and also an insurance program for people in need of chronic care or long-term services and supports. Other than the Health Insurance Premium Payment (HIPP) program (discussed in Chapter 1), Medicaid does not make cash payments to clients, but instead makes payments directly to health care providers or managed care organizations (MCOs).

“Health care providers” is a general term that includes:

- Health professionals - doctors, nurses, physician assistants, chiropractors, physical therapists, clinical social workers, dentists, psychologists, and nutritionists,
- Health facilities - hospitals, nursing homes, institutions and homes for people with intellectual disabilities, clinics, and community health centers, and

- Providers of other critical services like pharmaceuticals or drugs, medical supplies and equipment, and medical transportation.

Acute Health Care

Medicaid pays for typical health services such as physician and other practitioner services, inpatient and outpatient hospital services, prescribed drugs, lab, and x-ray services. These five areas accounted for approximately 32.6 percent of the Texas Medicaid program health expenditures in federal fiscal year (FFY) 2010 (see Chapter 8, **Figure 8.11** Texas Medicaid Spending by Service Type for FFY 2010). Medicaid also provides a broader array of acute health services to children than do most private health plans, such as dental benefits.

Long-Term Services and Supports

Medicaid covers a broad range of long-term services and supports (LTSS) to enable people age 65 and over and those with disabilities to experience dignified, independent, and productive lives in safe living environments through a continuum of services and supports ranging from in-home and community-based services to institutional services. The demand for LTSS in Texas continues to grow, and is influenced by two key trends: the aging of the population and the continuing prevalence of individuals with co-occurring behavioral health needs. These services and supports account for approximately 28 percent of all Texas Medicaid services expenditures in FFY 2010.

People age 65 and Older and those with Physical Disabilities: LTSS for people age 65 and older and those with physical disabilities include home and community-based services and nursing facility services. Nursing facilities provide services for people whose medical conditions require the skills of a licensed nurse on a regular basis.

People with Intellectual and Developmental Disabilities: LTSS for people with intellectual and developmental disabilities include home and community-based services and services in intermediate care facilities for individuals with an intellectual disability or related conditions (ICFs/IID). ICFs/IID provide long-term services for people requiring residential, medical, and habilitative services.

Mandatory vs. Optional Spending

The federal government mandates certain benefits and coverage levels. In addition, Texas has also chosen to cover some of the optional services allowed but not required by the federal government (see Chapter 6, **Table 6.1,** Mandatory and

Optional Services Covered by Texas Medicaid). Eliminating some optional services and eligibility categories could actually increase Medicaid costs. For example, dropping the option of covering prescription drugs could ultimately cost Medicaid more. People who do not receive needed drugs may require more physician services, increased hospitalizations, or even LTSS. Similarly, Texas potentially saves money by covering pregnant women up to 185 percent of the FPL because some women may not otherwise receive adequate prenatal care. This coverage helps prevent poor and costly pregnancy outcomes.

In addition, some of the optional services covered by Texas Medicaid were originally paid with 100 percent state or local funds, by adding coverage for those services through Medicaid, part of the cost is now covered by federal matching dollars. For example, services for persons with intellectual disabilities provided through state supported living centers and in community residential settings now receive federal Medicaid matching dollars in addition to state dollars.

The American Recovery and Reinvestment Act (ARRA) of 2009 prohibits states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however can be made. The Patient Protection and Affordable Care Act (PPACA) continues this maintenance of effort (MOE) requirement. (See Chapter 3, Federal Health Care Reform, for more information on the MOE requirement.)

Basic Principles

The Social Security Act sets out the following fundamental principles and requirements for the Medicaid program.

Statewideness: All Medicaid services must be available on a statewide basis and may not be restricted to residents of particular localities.

Comparability: Except where federal Medicaid law specifically creates an exception, the same level of services (amount, duration, and scope) must be available to all clients. A 1989 federal law, the Omnibus Budget Reconciliation Act (OBRA) of 1989, created an exception to this principle by mandating that all state Medicaid programs cover any service that is medically necessary for a Medicaid eligible child, as long as that service is allowable under federal Medicaid law. As a result, children are generally entitled to a broader range of services under Medicaid than are adults. Another exception allows states to provide a reduced package of services to persons who are eligible for Medicaid because they qualify as medically needy. This means they only meet income requirements after taking into account their medical expenses.

Freedom of Choice: Clients must be allowed to go to any Medicaid health care provider who meets program standards.

Amount, Duration, and Scope: States must cover each service in an amount, duration, and scope that is “reasonably sufficient.” States may impose limits on services only for Medicaid clients who are age 21 and over. A state may not arbitrarily limit services for any specific illness or condition.

In general, state Medicaid programs must follow these basic principles and comply with all mandates related to eligibility and covered services. However, a state can require, under an approved state plan, certain Medicaid clients to enroll in managed care without being out of compliance with statewideness, freedom of choice, and comparability requirements.

The Centers for Medicare & Medicaid Services (CMS) can also grant exemptions to certain Medicaid requirements via a waiver to the state. Waivers are discussed in more detail later in this chapter.

How Medicaid Is Financed

As currently defined, Medicaid is an entitlement program and states set individual eligibility criteria within federal minimum standards. The federal government does not, and states cannot, limit the number of eligible people who can enroll and Medicaid must pay for any services covered under the program. States must provide medically necessary care to all eligible individuals who seek services.

Medicaid is jointly financed by the federal government and the states. The Secretary of the U.S. Department of Health and Human Services (U.S. HHS) determines each state’s federal share of most health care costs (federal medical assistance percentage - FMAP) using a formula based on average state per capita income compared to the U.S. average. These matching rates are updated every year to reflect changes in average income.

Texas’ matching rates for FFYs 2013 and 2014 are 59.30 and 58.69 percent; that is, the state must pay 40.70 and 41.31 percent respectively. Texas uses what is called a “one month differential” FMAP figure. This takes into account differences between the FFY (October through September), on which the federal FMAP rate is based, and the state fiscal year (SFY: September through August). The “one month differential” FMAP for Texas in SFY 2013 (which includes one month of the FFY 2012 rate of 58.22 percent and 11 months of the FFY 2013 rate of 59.30 percent) results in a “blended” or adjusted FMAP of 59.21 percent.

The federal government matches program costs in addition to client services at different rates. Medicaid administrative costs, related to program administration, are generally matched at 50 percent. Administrative services that can be performed only by skilled professional medical personnel draw a 75 percent federal match. Family planning services draw a 90 percent federal match and certain approved information system development costs are matched at 90 percent.

States may use local government funding for up to 60 percent of the state's share. Texas uses local government funding for the disproportionate share hospital (DSH) reimbursement program and other Medicaid programs such as the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver. Through the waiver, Texas hospitals can receive supplemental funds to cover the costs of providing care to Medicaid and uninsured individuals traditionally provided under the upper payment limit (UPL) program. The waiver also enables hospitals and other providers to use their local funding to receive additional federal matching funds to reform their delivery systems and improve quality of care in an evidence-based and transparent manner. (See Chapter 4 for additional information on the 1115 Transformation Waiver.)

Federal law specifies that taxes on health care providers cannot make up more than 25 percent of the state's share of total Medicaid expenditures. Texas assesses quality assurance fees for ICFs/IID.

How Medicaid Operates in Texas

The Texas Medicaid program, under the direction of the Health and Human Services Commission (HHSC), involves multiple state departments. This section explains the different parts of the program and how they interrelate.

Federal Oversight

The Social Security Act and federal regulations establish minimum levels of health care coverage that states must provide in order to operate a Medicaid program. Federal law and regulations also establish optional coverage categories, all or part of which states may choose to cover. Each state covers the required services and eligibility groups, but develops a unique program by determining which optional services and eligibility groups to cover.

While states are responsible for the hands-on operation of Medicaid, the federal government plays a very active oversight role. CMS, a part of the U.S. HHS, oversees the Medicaid program. CMS approves the Medicaid state plan that each

state creates. The Medicaid state plan is a dynamic document that functions as a state's contract with CMS. The state plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas Medicaid program. Significant changes to a state's Medicaid program require the state to submit a state plan amendment for CMS approval. CMS also approves any waivers for which states can apply. Medicaid waivers allow states the flexibility to test new or existing ways to deliver and pay for health care services.

Single State Agency

Federal Medicaid regulations require that each state designate a single state agency responsible for the state's Medicaid program. HHSC has been the single state agency for the Medicaid program since January 1993. Within HHSC, the Associate Commissioner for Medicaid and the Children's Health Insurance Program (CHIP) is the State Medicaid and CHIP Director and administers both programs.

As the single state agency, HHSC's Medicaid responsibilities include:

- Serving as the primary point of contact with the federal government,
- Establishing policy direction for the Medicaid program,
- Administering the Medicaid state plan,
- Working with the various state departments to carry out certain operations of the Medicaid programs,
- Operating the state's acute care, vendor drug, 1115 Transformation Waiver, and managed care programs (except NorthSTAR, a managed care program overseen by the Department of State Health Services (DSHS) that provides integrated behavioral health care to eligible residents in Dallas and contiguous counties),
- Determining Medicaid eligibility,
- Approving Medicaid policies, rules, reimbursement rates, and oversight of operations of the state departments' operating Medicaid programs,
- Organizing and coordinating initiatives to maximize federal funding, and
- Administering the Medical Care Advisory Committee (MCAC) mandated by federal Medicaid law. The MCAC reviews and makes recommendations to the State Medicaid/CHIP Director on proposed Medicaid rules.

Operating Departments in Texas

Federal law allows the single state agency to delegate some of its functions to other state departments, so long as it retains administrative discretion in the administration or supervision of the program and the adoption or approval of

program policy, and monitors quality of care and program integrity for delegated functions. Functions that may be delegated include:

- Determining eligibility (currently only functional assessment for some Medicaid programs are performed by departments other than HHSC),
- Processing claims,
- Certifying that health providers meet program standards,
- Collecting data on Medicaid spending and services,
- Evaluating appropriateness and quality of institutional care, and
- Determining the amount of program benefits.

In Texas, HHSC delegates some day-to-day operations of the Medicaid program to other state administrative departments; these departments are known as operating departments. The passage of House Bill (H.B.) 2292, 78th Legislature, Regular Session, 2003, resulted in a reorganization of Texas' Health and Human Services (HHS) operating departments. **Figure 2.3** (next page) shows the Medicaid-related responsibilities of each operating department.

Medicaid Waivers

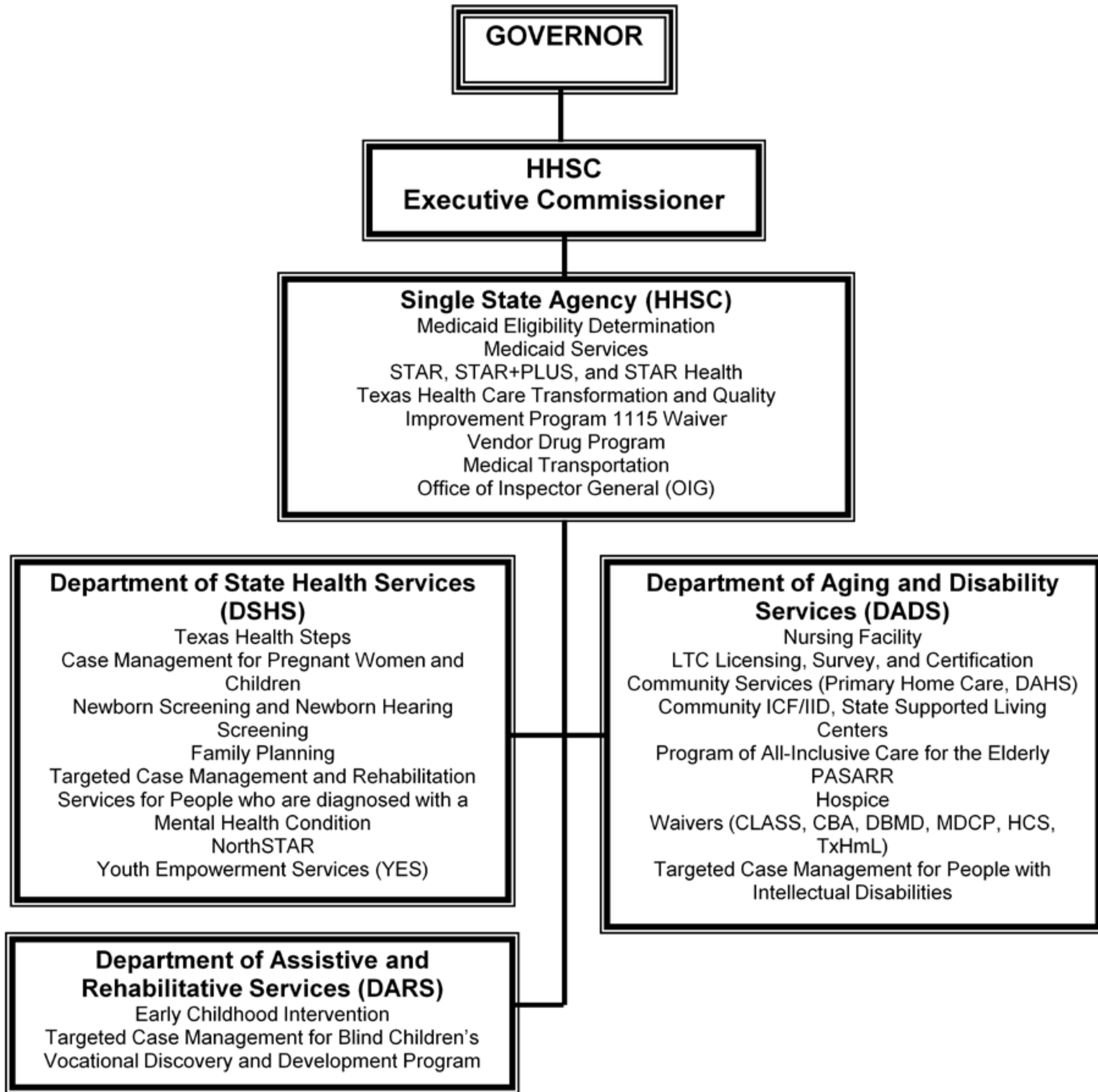
Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These waivers allow states to operate programs that include exceptions to Medicaid's basic principles, required array of benefits, mandated eligibility and income groups, or combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.[1]

States seek waivers to:

- Provide services above and beyond state plan services to selected populations,
- Limit geographical areas,
- Limit free choice of providers, and
- Implement innovative new service delivery and management models.

Federal law allows three major types of waivers including Research and Demonstration 1115 Waivers, Freedom of Choice 1915(b) Waivers, and Home and Community-based Services 1915(c) Waivers.

Figure 2.3: Medicaid Operating Departments, 2013



Research and Demonstration 1115 Waivers

Purpose: Allow flexibility for states to test substantially new ideas for operating their Medicaid programs and waives a variety of requirements, such as comparability or statewideness.

States may use these waivers to structure statewide health system reforms and to test the value of access to new services or service delivery mechanisms for cost effectiveness and efficacy. They also use the waivers to maximize coverage of health insurance for people below 200 percent of FPL (Health Insurance Flexibility and Accountability Waiver).

Requirements: Must be budget neutral to the federal government for the duration of the waiver.

Timeframe: Generally they are five-year waivers, subject to renewal. CMS analyzes impact on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction.

Freedom of Choice 1915(b) Waivers

Purpose: With 1915(b) waivers, states can mandate Medicaid enrollment into managed care, use a "central broker" (e.g., enrollment broker) to assist people in making MCO choices, use cost savings to provide additional services, and/or limit the number of providers for clients.

States may use these waivers to limit clients' choice of Medicaid providers, and to require Medicaid clients to join MCOs in order to receive Medicaid services. The state has used the waivers to provide an enhanced benefit package (beyond what is available through the state plan) with cost savings from managed care and to selectively contract with hospitals and other types of health care providers to increase cost effectiveness and to better control quality of services.

Requirements: Must be cost-effective; client access, quality of care and cost must not be negatively impacted by implementation of waiver.

Timeframe: 1915(b) waivers are two-year waivers, subject to renewal. CMS requires an independent assessment to show that cost, quality, and access have not been compromised.

Home and Community-based Services 1915(c) Waivers

Purpose: Allow states to provide community-based services to people who meet eligibility criteria for care in an institution (nursing home, ICF/IID, or hospital) or who would otherwise meet eligibility criteria for care.

States may use these waivers to serve people age 65 and older and those with physical and/or developmental disabilities, intellectual disability, or mental illness. States may also target more specialized populations such as clients with traumatic brain injuries or those with sensory impairment. States may develop community-based treatment alternatives to institutional care in hospitals, nursing facilities, or ICFs/IID. States may provide services which are not found in the Medicaid state plan or which extend Medicaid state plan services. Examples include case management, homemaker/home health aide, personal care, habilitation, respite care, non-medical transportation, in-home support, special communication, minor home modifications, and adult day care.

Requirements: Must be cost neutral for the duration of the waiver. Must assure safeguards are in place to protect clients' health and welfare.

Timeframe: 1915(c) waivers are initially approved for three years and may be renewed at five-year intervals.

Texas Medicaid Administrative System

In order to meet its administrative systems and management information system requirements, the state contracts with private organizations to obtain specialized services to support the Texas Medicaid program. The state and its contractors coordinate and work closely together in an enhanced system to support Medicaid clients and Children with Special Health Care Needs (CSHCN) program clients and their health care providers. Administrative contract functions include the following:

Claims Administrator Contractor: Processes and adjudicates all claims for Medicaid acute care, long-term care, and CSHCN program services that are outside the scope of capitated arrangements between the MCOs and the state. The claims administrator also collects and validates encounter data from the MCO to use in the evaluation of quality and utilization of services.

Texas Medicaid Managed Care: The state's initial managed care program, State of Texas Access Reform (STAR), began in the early 1990s, targeted low-income families, non-disability-related children, and pregnant women.

As Texas gained more experience with managed care, the state initiated pilot programs through Medicaid managed care to serve clients who are age 65 and older and those with disabilities. The goal was to address the complex needs of these populations in a more coordinated, comprehensive manner, thus resulting in both increased quality of care and decreased Medicaid costs. In 1998, the state implemented STAR+PLUS, a managed care pilot integrating acute and long-term

services and supports for clients who are age 65 and older and those with disabilities in Harris County. In 1999, the state implemented a mental health and substance abuse pilot called NorthSTAR in the Dallas service area that integrates funding and delivery of services to Medicaid and indigent clients, providing a continuum of care across public funding sources.

In 2003, the 78th Legislature directed HHSC to expand managed care even further. In 2005, HHSC expanded Primary Care Case Management (PCCM) to the counties not covered by STAR MCOs. In 2006, HHSC entered into new STAR contracts in nine urban service areas and withdrew PCCM from these areas. HHSC also entered into new contracts for CHIP in 2006. (See Chapter 9 for additional information on CHIP.)

In 2005, the 79th Legislature directed HHSC to utilize cost-effective models to better manage the care of Medicaid clients who are age 65 and older and those with disabilities. The STAR+PLUS Hospital Carve-Out model, created by the 2006-2007 General Appropriations Act (GAA) (Article II, Special Provisions, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), was a partially-capitated managed care model designed to integrate acute and long-term services and supports. The STAR+PLUS Hospital Carve-Out model was implemented in the Harris, Harris-Expansion, Nueces, and Travis service areas in February 2007. In-patient hospital services (with some exceptions for certain behavioral health services) were “carved out” of the MCO’s capitation and paid through the traditional Medicaid fee for service (FFS) system.

The 79th Legislature also directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for children in foster care. This program, known as STAR Health, was implemented in April 2008. STAR Health is designed to better coordinate the medical and behavioral health care of children in foster care and kinship care.

The 2010-11 GAA (Article II, Special Provisions, Section 46, S.B. 1, 81st Legislature, Regular Session, 2009), required HHSC to implement the most cost-effective integrated managed care model for clients who are age 65 and older and those with disabilities in the Dallas and Tarrant service areas. After analyzing current managed care models, HHSC determined STAR+PLUS was the most appropriate cost-effective model to meet the legislative mandate. HHSC expanded STAR+PLUS to the Dallas and Tarrant service areas in February 2011.

The 2012-2013 GAA, (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011), assumes a cost savings to the state budget resulting from the expansion of Medicaid managed care statewide. Effective September 1, 2011,

PCCM Medicaid clients in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR program or STAR+PLUS Medicaid managed care program. In March 2012, HHSC entered into new contracts with MCOs in 11 service areas and eliminated PCCM from 174 counties. Other changes implemented included pharmacy benefits in managed care, in-patient hospital services in STAR+PLUS, and expanding the dental managed care model for children in Medicaid.

Eligibility Support Services and Enrollment Contractor: Provides business services that support the state's determination of client eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps), and TANF programs; determines eligibility for CHIP; enrolls clients in Medicaid and CHIP managed care, and educates them about their choices for a medical and dental plan, a primary care physician (PCP), and a dentist; and processes medical and dental plan changes. While the eligibility support services and enrollment contractor performs some Medicaid eligibility support functions, CMS requires state eligibility workers to make the final eligibility determination.

Quality Monitor: Provides an annual external independent review of the quality outcomes, timeliness of, and access to services provided by Medicaid and CHIP MCOs.

HHSCs external quality review organization (EQRO) following CMS protocols, assesses access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

Pharmacy Administration

The state also contracts with several organizations to administer functions of the Medicaid Vendor Drug Program (VDP). Administrative contract functions of VDP include the following:

Pharmacy Claims and Rebate Administrator: Processes and adjudicates all claims for CHIP and Medicaid FFS outpatient prescription drugs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores MCO encounter data to support program oversight of prescription drug benefits in managed care.

Pharmacy Prior Authorization Vendor: Evaluates prior authorization requests submitted through a call center and from the pharmacy point-of-sale system for

drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

Preferred Drug List Vendor: Provides information to the Pharmaceutical and Therapeutics (P&T) Committee on the clinical efficacy, safety, and cost effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the P&T Committee with the development and maintenance of the PDL.

Retrospective Drug Utilization Review Vendor: Performs drug use review (DUR) retrospective interventions to assist health care providers in delivering appropriate prescription pharmaceutical drugs to Texas Medicaid VDP clients.

Compass 21

The state Medicaid Management Information System (MMIS) is called Compass 21 (C21). C21 is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and includes the following capabilities:

- The ability to support multiple claims systems, such as traditional FFS Medicaid, and other non-Medicaid programs,
- A data warehouse that improves access to data for analysis,
- The flexibility to add benefit plans and pricing methodologies,
- An electronic data interchange subsystem, and further integration with the provider portal, and
- The claims processing system supporting claim status inquiry, remittance and status report access, eligibility verification, and claim submission via the Internet.

Integrated Eligibility Determination

HHSC uses an integrated system to determine eligibility for Medicaid, CHIP, SNAP, and TANF. The eligibility system offers convenient access to eligibility services through multiple channels, including a network of local eligibility offices, phone, mail, fax, and the Internet. Clients can call 2-1-1 to apply for benefits and obtain basic information about their case.

HHSC eligibility staff use the Texas Integrated Eligibility Redesign System (TIERS) to support the eligibility determination process. In December 2011, HHSC completed the transition from the legacy System for Application, Verification, Eligibility, Reports and Referrals (SAVERR) to TIERS.

HHSC also contracts with an eligibility support services vendor that operates three call centers and one document processing center to determine eligibility for CHIP; assist with case support for TANF, Medicaid, and SNAP; and enroll Medicaid and CHIP clients in MCOs.

To continue to improve the efficiency and effectiveness of the eligibility system, HHSC is enhancing the self-service options available to clients through www.YourTexasBenefits.com. Clients can create an online account and view case details, submit applications and redeterminations, report changes, and print temporary Medicaid identification cards. HHSC also plans to allow clients to view and receive electronic communications, and to receive text reminders.

To help clients apply for benefits online, HHSC is building a statewide network of community-based organizations to participate in the Community Partner Program. Community partners include non-profit, faith-based, local, and statewide community groups. Community partners may participate in the program as self-service or assistance sites. Self-service sites provide access to computers with Internet connection, while assistance sites provide computer access, as well as trained navigators to help clients apply and manage their cases online.

Detecting Fraud and Abuse

The 78th Legislature created the Office of Inspector General (OIG) in 2003 to strengthen HHSC's authority and ability to combat fraud, waste, and abuse in HHS programs. To fulfill its mandate, OIG maintains clear objectives, priorities, and performance standards, which emphasize coordinating investigative efforts, ensuring allocation of resources to cases with the strongest supporting evidence and greatest potential for monetary recovery, and maximizing opportunities to refer cases to the Office of the Attorney General.

The OIG is divided into five divisions: Compliance, Enforcement, Operations, Internal Affairs and Chief Counsel. These divisions help OIG to fulfill its responsibilities by:

- Issuing sanctions and performing corrective actions against providers and clients,
- Auditing the use of state and federal funds,
- Researching, detecting, and identifying fraud and abuse to ensure accountability and responsible use of resources,
- Conducting investigations and reviews and making referrals to the appropriate outside agencies for further action,

- Recommending policies to enhance the prevention of fraud, waste, and abuse, and
- Providing education, technical assistance, and training to promote cost-avoidance activities and to sustain improved relationships with providers.

Since its creation, the OIG has sought to maximize the use of technology in order to increase the efficiency and effectiveness of fraud, waste, and abuse reporting by clients, providers, HHS employees, and other stakeholders. In addition, the OIG initiated the process to conduct criminal history background checks for existing providers and all other providers seeking to enroll in the Medicaid and CSHCN programs through Texas' claims administrator.

The OIG continues to identify ways to fulfill its mission. In recent years, OIG has:

- Produced the nation's first Prosecutor's Predicate Manual on fraud cases,
- Worked with the private sector to study technological innovations to help strengthen fraud detection and deterrence in the HHS system,
- Published an HHS enterprise-wide policy on fraud and abuse identification and reporting,
- Conducted a risk assessment of all HHS agencies, which allowed OIG to allocate its resources in the resulting audit plan to the highest risk areas, and
- Reorganized its Enforcement Division to enhance efficiency in the investigation of provider fraud cases.

The OIG has recovered or avoided more than $6.6 billion in HHS costs since 2003. In SFY 2011, OIG recovered or identified for recovery $466 million and saved the state an additional $344 million through cost-avoidance initiatives.

The OIG continues to assess and enhance policies and procedures, and streamline its integrated fraud and abuse prevention and detection functions.

Federal and State Legislation Affecting Texas' CHIP and Medicaid Programs

Nationally and in Texas, CHIP and Medicaid programs change in response to legislative requirements. The following sections include highlights from recent state legislation and a summary of relevant federal legislation since 1965.

Highlights of Texas Legislation Affecting Medicaid and CHIP

Cost-Containment and Other Quality Measures

With guidance from Texas policy leaders, HHSC works to ensure the provision of quality health care within funds allocated by the state. The overall challenge for HHSC is to keep the cost of care as affordable as possible, meet quality standards, and ensure enough physicians, hospitals, and other providers are available to treat the growing Medicaid population.

Medicaid costs are the primary budget driver for HHSC. To improve outcomes and cost-effectiveness, new approaches are being developed based on recent trends: rising caseloads and the rising cost of care.

Given these circumstances, HHSC is working on several fronts to improve quality and cost-effectiveness in Medicaid service provision. Many of the initiatives were authorized through the 2012-2013 GAA (H.B. 1, 82nd Legislature, Regular Session, 2011) and S.B. 7, 82nd Legislature, First Called Session, 2011. These and other efforts are described below.

Hospital Payment System Reform – Texas Health Care Transformation and Quality Improvement Program 1115 Waiver

The 1115 Transformation Waiver is a five-year demonstration waiver that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as UPL payments. UPL payments were supplemental payments to offset the difference between what Medicaid pays for a service and what Medicare would pay for the same service. As authorized by H.B. 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011, the 1115 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funding with a program and process that is more transparent and accountable. (See Chapter 4 for additional information.)

Managed Care Expansion

Managed care is a method of health care service provision that has proven cost-effective, and the 82nd Legislature directed HHSC to expand managed care to cover more Medicaid clients. As authorized by H.B. 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011, HHSC

expanded the Medicaid managed care STAR+PLUS and STAR programs, and replaced the PCCM program with the STAR program. Other directives included incorporating the prescription drug benefit into managed care, including inpatient hospital services in the STAR+PLUS capitation rate, and placing Medicaid dental services into managed care. The total estimated savings for these initiatives is $645.3 million all funds over the biennium. (See Chapter 7 for more information.)

Pharmacy Benefits in Managed Care

Effective March 1, 2012, managed care clients in the Medicaid STAR, STAR+PLUS, and STAR Health programs and CHIP began receiving outpatient prescribed drug benefits through pharmacy benefits managers (PBMs) that contracted with MCOs.

Under managed care, Medicaid clients receive the same prescription drug benefits as clients served through the traditional Medicaid FFS model. However, adults are not subject to the three-prescription-per-month limit that applies to adults served under the FFS model. Children and adults enrolled in STAR, STAR+PLUS, or STAR Health receive unlimited prescriptions for Medicaid-covered drugs and biologicals. CHIP clients also receive unlimited prescriptions for CHIP-covered drugs and biologicals.

Dental Benefits in Managed Care

Effective March 1, 2012, children’s Medicaid dental services are provided through a managed care model. Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist (dental home). A main dentist means a provider who has agreed with a dental plan to provide a dental home to members and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as main dental home providers are Federally Qualified Health Centers (FQHCs) and individuals who are general dentists or pediatric dentists.

Dental managed care focuses on quality outcomes through the following:

- Quality, comprehensive dental services through qualified and accessible Texas dental providers,
- Improvement of oral health through preventive care and health education initiatives and activities, and
- A choice of dental plans.

The First Dental Home Initiative, a package of services aimed at improving the oral health of children 6-35 months of age, is included in the children's Medicaid dental managed care contract. While most children and young adults age 20 and younger enrolled in Medicaid receive dental services through a managed care dental plan, those still receiving dental services through traditional FFS methods are Medicaid clients, regardless of age, who live in Medicaid paid facilities such as nursing homes, state supported living centers, or ICFs/IID.

Children and young adults in the state's foster care program that are enrolled in STAR Health continue to receive their dental benefits through the STAR Health program.

All children enrolled in CHIP continue to receive dental services through a managed care dental plan. CHIP clients receive up to $564 in dental benefits a year. Emergency dental services are not included under this cap. Clients are also able to receive certain preventive and medically necessary services beyond the $564 annual benefit limit through a prior authorization process. To help offset the costs of covering additional dental services HHSC raised the CHIP cost-sharing amounts.

Medicaid Cost Sharing

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC to implement Medicaid cost-sharing that encourages personal accountability and appropriate utilization of health care services, including a cost-sharing provision applicable to a client who receives a non-emergency medical service through a hospital emergency room. The 2012-13 GAA (Article II, HHSC, Rider 61, H.B. 1, 82nd Legislature, Regular Session, 2011), also includes maximizing co-payments in all Medicaid and non-Medicaid programs as an option for HHSC to achieve cost savings.

The federal Deficit Reduction Act of 2005 (DRA) provided states with new options and requirements for charging Medicaid clients cost-sharing. States must track co-payments to ensure they do not exceed five percent of a client's family income. There are also added requirements for states that charge co-pays for non-emergency use of the emergency department (ED). HHSC is considering Medicaid co-payment options.

Nursing Services Assessment

S.B. 7, 82nd Legislature, First Called Session, 2011, directs HHSC to develop an objective assessment process for determining the medical needs for nursing services in the home, such as therapy services, personal care services, or durable

medical equipment. This comprehensive assessment is required for people in the traditional Medicaid FFS program, and managed care contracts will be updated as necessary to require the comprehensive nursing assessment.

CHIP Coverage for Dependents of Public Employees

The Affordable Care Act (ACA) made children of public employees eligible to receive federally-matched coverage in CHIP. Previously, Texas could not claim federal match for the dependents of public employees. The state paid for CHIP coverage of eligible dependents of Teacher Retirement System (TRS) ActiveCare members with 100 percent general revenue (GR) funding. The Employees Retirement System (ERS) also provided a 100 percent GR premium subsidy towards eligible dependent coverage under the State Kids Insurance Program (SKIP).

Texas began providing federally-matched CHIP coverage to qualifying TRS school-employee children as of September 1, 2010 and to former SKIP participants as of September 1, 2011. The receipt of federal match for CHIP coverage for TRS school-employee children is projected to increase the federal share of CHIP funding by $42.4 million during the 2012-13 state fiscal biennium. The receipt of federal match for CHIP coverage for public employee children formerly eligible for SKIP is projected to save the state a total of $14.7 million GR in SFY 2012.

Streamline 1915(c) Waiver Programs

S.B. 7, 82nd Legislature, First Called Session, 2011, requires the Department of Aging and Disability Services (DADS), in consultation with the HHSC, to explore efforts to streamline the administration of and delivery of services through Section 1915(c) waiver programs. Specifically, the bill directs DADS to perform a utilization review of services in all 1915(c) waiver programs; explore the development of uniform licensing and contracting standards for 1915(c) waiver programs; and if cost-effective, requires DADS to implement an electronic visit verification system for appropriate Medicaid programs that allows providers to electronically verify and document basic information for the delivery of services.

Physician Incentive Program

The 2012-13 GAA (Article II, HHSC Rider 56, H.B. 1, 82nd Regular Session, Legislature, Regular Session, 2011), required HHSC to submit a report by August 31, 2012, on steps taken to reduce non-emergent use of the ED in the Medicaid program. Rider 56 specifically directed HHSC to evaluate whether the cost of physician incentive programs implemented by Medicaid MCOs participating in the STAR and STAR+PLUS managed care programs had been offset by reduced use

of the emergency department, determine the feasibility of amending the Texas Medicaid state plan to permit freestanding urgent care centers to enroll as clinic providers, and use financial incentives and disincentives to encourage Medicaid MCOs participating in STAR and STAR+PLUS to reduce non-emergent ED use among their clients.

This report specifically reviewed strategies undertaken by the Texas Medicaid program to reduce non-emergent ED use through targeting initiatives specific to MCOs, providers, and clients. The study may be viewed at http://www.hhsc.state.tx.us/reports/2013/Rider-56-Report.pdf.

The evaluation of whether the cost of Medicaid MCO physician incentive programs is offset by reduced use of the emergency department is in progress and the physician incentive programs that will yield relevant data have been identified. Reporting on the outcome of the physician incentive program evaluation will occur by August 31, 2013, as a requirement of S.B. 7, 82nd Legislature, First Called Session, 2011.

Texas Institute of Health Care Quality and Efficiency

S.B. 7, 82nd Legislature, First Called Session, 2011, established the Texas Institute of Health Care Quality and Efficiency to make recommendations to the legislature that will:

- Improve the quality and efficiency of health care delivery by:
  - Providing a forum for regulators, payers, and providers to promote best practices, increase collaboration, improve health care outcomes, and contain health care costs,
  - Determining the most effective measures of quality and efficiency using nationally accredited measures; or, if none exist, measures based on expert consensus,
  - Reducing the incidence of potentially preventable events, and
  - Creating a state plan to encourage improvement in the quality and efficiency of health care services.
- Improve reporting, consolidation, and transparency of health care information, and
- Implement and support innovative health care collaborative payment and delivery systems under Chapter 848 of the Insurance Code (health care collaborative).

The Institute is governed by a board of directors appointed by the Governor and also includes representation from a number of state agencies and institutions of higher education serving as ex officio, nonvoting members. Appointed members

include 15 individuals from a range of professional backgrounds who have demonstrated the highest level of accomplishment, expertise, and leadership in a field of health care.

While the Institute's work and recommendations are independent of any agency or other body, S.B. 7 charges HHSC with coordinating its administrative responsibilities.

Medicaid/CHIP Quality-Based Payment Advisory Committee

The Medicaid and CHIP Quality-Based Payment Advisory Committee is authorized by S.B. 7, 82nd Legislature, First Called Session, 2011. The committee's focus is on the Medicaid/CHIP program where it advises HHSC on:

- Reimbursement systems used to compensate physicians or other health care providers that reward high-quality, cost-effective health care,
- Standards and benchmarks for quality performance, quality of care outcomes, efficiency, and accountability by MCOs and physicians and other health care providers,
- Programs and reimbursement policies that encourage high-quality, cost-effective health care delivery models that increase appropriate provider collaboration, promote wellness and prevention, and improve health outcomes, and
- Outcome and process measures.

This includes recommendations on reimbursement models, bundled payments, and payment incentives that promote quality health outcomes and reduce administrative burden and cost.

Committee members are appointed by the HHSC Executive Commissioner from physicians and other health care providers, representatives of health care facilities, representatives of MCOs, and other stakeholders interested in health care services provided in this state.

The Physician Payment Advisory Committee

This committee was established by the 2012-2013 GAA (Article II, HHSC, Rider 68, H.B. 1, 82nd Legislature Regular Session, 2011), to prevent payment for unnecessary services. The committee will determine the ten most overused services performed by physicians in Texas Medicaid, using national guidelines related to unnecessary medical procedures as the basis for this determination. Based on these determinations, HHSC will decrease Medicaid payments for those services that should not be provided. Physicians will maintain the right to appeal the decision in individual cases.

Potentially Preventable Events

The federal Medicare Program and state Medicaid programs across the country have begun reducing or denying payment for services that result from events that should not have occurred if quality health care had been provided. S.B. 7, 82nd Legislature, First Called Session, 2011, defines potentially preventable events (PPEs) as the following services if they could have been potentially prevented: hospital admissions, ancillary services, complications that occur in the hospital, hospital readmissions, or a combination of events. Reducing PPEs will reduce health care costs and will improve the quality of health care. HHSC is in the process of defining each of these PPEs and developing payment methodologies that discourage providers from billing for these services. Although PPEs are generally preventable, they will never be totally eliminated, even with optimal care. Therefore, proper risk adjustment and scoring is required in order to use PPEs in provider profiling and payment systems. HHSC has begun implementation for the following PPEs: hospital-acquired conditions, potentially preventable readmissions and potentially preventable complications.

Hospital-Acquired Conditions

In line with Medicare, HHSC began imposing payment denials/reductions on September 1, 2010, for conditions that occurred in the hospital that resulted in the need for more care, such as treatment for surgical-site infections and ventilator-associated pneumonia.

Potentially Preventable Readmissions

Readmissions to hospitals are expensive, but are often preventable. H.B. 1218, 81st Legislature, Regular Session, 2009, requires HHSC to identify potentially preventable readmissions (PPRs) in the Texas Medicaid population and report results confidentially to each hospital. The law also requires each hospital to make this data available to the clinical staff working at the hospital. In January 2011, HHSC began applying PPR analytics to Medicaid-paid hospital claims. The analytics established state and hospital-specific PPR rates by disease condition and other variables. The information is provided to hospitals which are required to make this data available to the clinical staff working at the hospital. Hospitals received their first PPR report in January 2011 and their second report in February 2012.

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC to implement quality-based payments to hospitals on the basis of the results of PPR analytics. Payment reductions related to PPR will begin in Spring 2013.

Potentially Preventable Complications

HHSC has defined potentially preventable complications (PPCs) hospital-acquired conditions plus additional conditions that result from adverse events in the hospital. PPCs include such conditions as post-operative hemorrhage and reopening wound site. HHSC began communicating with hospitals about their rates of PPCs, and will begin payment reductions as early as Fall 2013.

Non-Urgent Use of Emergency Department

Hospitals and physicians began receiving a 40 percent reduction for treatment of any non-emergent/urgent service rendered in the emergency room on or after September 1, 2011 to Medicaid FFS and CSHCN clients. Hospitals will continue to be reimbursed for the Emergency Medical Treatment and Labor Act (EMTALA) screen so that a client's medical status can be ascertained. If the EMTALA screen deems the client not emergent or urgent, the hospital/physician can opt to not treat the client.

Reimbursement for emergent or urgent services provided by outpatient hospital providers in an outpatient hospital emergency department are not affected by this reduction.

Maternity Care Management

On July 1, 2012, HHSC introduced two new programs to help pregnant women and their babies:

- The Neonatal Care Management Program (NCMP), and
- Medicaid Healthy Moms and Babies.

NCMP provides help for low-birth-weight, medically complex, and high-risk infants in the neonatal intensive care unit (NICU). The program provides educational materials, care management nurses, and a 24-hour help line.

Medicaid Healthy Moms and Babies is a program that provides obstetrical (OB) risk assessment and educational services to expectant mothers and case management services to mothers who have high-risk pregnancies. The program provides educational materials, health assessments, and a help line for questions and concerns.

These programs serve only eligible Texas Medicaid FFS clients who agree to participate in the program. Clients who are enrolled in managed care are not eligible.

Neonatal Intensive Care Unit Council

The NICU Council was established by H.B. 2636, 82nd Legislature, Regular Session, 2011, to make recommendations regarding NICU operating standards and reimbursement through the Medicaid program for services provided to an infant admitted to a NICU. Specifically, the council will:

- Develop standards for operating a NICU in Texas,
- Make recommendations regarding best practices and protocols to lower admissions to a NICU, and
- Develop an accreditation process for a NICU to receive reimbursement for services provided through the Medicaid program.

The NICU Council, appointed by the HHSC Executive Commissioner, is required to report its recommendations to the Executive Commissioner, Governor, Lieutenant Governor, Speaker of the House of Representatives, and chairs of appropriate legislative committees.

Reduce Pre-39 Week Elective Deliveries

Effective October 2011, Medicaid stopped paying for elective inductions prior to 39 weeks of pregnancy, based on research and recommendations discouraging elective inductions prior to 39 weeks gestation. HHSC also concluded that these elective inductions may contribute to avoidable NICU stays and Caesarean section births. This initiative was initially based on an HHSC Quality-Based Payment Committee recommendation to pursue improvements in birth outcomes and is consistent with H.B. 1983, 82nd Legislature, Regular Session, 2011. To ensure compliance with the new policy, while accommodating the allowed exception of medical necessity, the HHSC OIG conducted medical record reviews of claims for the first three months of the policy, October through December 2011. OIG reviewed claims that were billed with the modifier indicating that the delivery took place prior to 39 weeks gestation and was medically necessary. The OIG review indicated a high level of compliance with the new policy.

Medicaid Wellness Program for Children with Disabilities

The Texas Medicaid Wellness Program (TMWP), previously named the Texas Health Management Program, was implemented March 1, 2011, to provide chronic care management statewide to high-cost/high-risk PCCM and FFS clients. In October 2011, HHSC shifted the focus of the TMWP to children receiving SSI who voluntarily remained in FFS after the March 1, 2012 managed care expansion.

The TMWP is a community-based care management program that enrolls high-risk clients with complex, chronic, or co-morbid conditions. Extensive case

management focuses on the whole person (rather than the disease) through telephonic and face-to-face interventions that aim to improve health outcomes. The client's care team is led by a registered nurse and includes social workers, community health workers, pharmacists, and behavioral health specialists among others. Wellness clients receive telephonic and/or face-to-face visits, receive quarterly educational mailings, and have access to a 24-hour nurse advice line.

Evaluation of STAR+PLUS Services

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC to conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the STAR+PLUS Medicaid managed care program who are eligible to receive health care benefits under both Medicaid and Medicare programs. The EQRO for Texas Medicaid Managed Care conducts annual surveys with members in the STAR+PLUS Program to assess member experiences and satisfaction with the health services they receive through STAR+PLUS.

In prior years, surveys have been conducted exclusively with members 18 to 64 years old who were enrolled only in Medicaid. As required by S.B. 7, these surveys now include members who were both Medicaid-only and dual-eligible (eligible for both Medicaid and Medicare).

Medicare Equalization

The Texas Medicaid program pays the coinsurance and deductibles for Medicare services provided to certain people, called dual eligibles, who are eligible for both Medicare and Medicaid. On January 1, 2012, revisions were made to align Medicaid policies on payment of cost sharing for Medicare Parts A and B services provided to dual eligibles, as directed by the 2012-13 GAA (Article II, HHSC, H.B. 1, 82nd Legislature, Regular Session, 2011). These revisions are referred to as Medicare Equalization.

Medicare Equalization limited payments for Medicare Part B services provided to dual eligibles to no more than the Medicaid payment amount for the same service, with the exception of renal dialysis services. This is now the policy for both Medicare Part A, which covers hospital services, and for Medicare Part B, which covers physician and other outpatient services.

Since Medicare Equalization became effective, a HHSC rule was adopted to allow HHSC to adjust the payment amount for certain services if higher payment is needed to ensure access to care or is more cost effective to the state. As of May 1, 2012, HHSC had made adjustments to Medicare Equalization for services provided

by psychologists, psychiatrists, licensed clinical social workers, and specific services related to the transport of portable x-ray equipment. Effective January 1, 2013, HHSC began paying Part B deductibles for dual eligibles according to the Medicare rate.

Study of the State Mental Health System

The Public Consulting Group (PCG), on behalf of HHSC and DSHS, conducted a comprehensive analysis of the public behavioral health system in Texas[2], as required by the 2012-2013 GAA (Article II, DSHS, Rider 71, H.B. 1, 82nd Legislature, Regular Session, 2011). PCG's efforts focused on two major components: (1) a comprehensive study of the current public behavioral health system in Texas and (2) short and long term recommendations for the Texas behavioral health system.

PCG's comprehensive analysis of the current public behavioral health system in Texas included a review of the programmatic structure of the system. This work included the identification of various provider types delivering services, service delivery mechanisms, service offerings, and the various populations receiving services throughout the behavioral system. PCG also reviewed the financial structure of the current behavioral health system to understand the current and existing sources of funding leveraged to pay for behavioral health services. Lastly, PCG's analysis of the current behavioral health system included a review of other states' behavioral health systems to identify potential options for Texas to improve its behavioral health service delivery system. This initial phase of the analysis resulted in the comprehensive report to DSHS on the current state of the public behavioral health system in Texas.

Upon submission of the comprehensive report to DSHS, PCG began work on the second phase of the analysis, which concluded in the Fall of 2012 with the final recommendation to focus on managed care solutions to better coordinate care.[3]

Program of All-inclusive Care for Elderly

The Program of All-inclusive Care for the Elderly (PACE) model is centered on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible.

PACE serves individuals who are:

- Age 55 or older,
- Certified by their state to need nursing home care,
- Able to live safely in the community at the time of enrollment, and

- Living in a PACE service area.

Although all PACE participants must be certified to need nursing home care to enroll in PACE, only about seven percent of PACE participants nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

PACE uses a comprehensive care approach, providing an array of services for a capitated monthly fee. Services include:

- Inpatient and outpatient medical care,
- Specialty services, such as dentistry and podiatry,
- Social services,
- In-home care,
- Meals,
- Transportation,
- Day activity, and
- Housing assistance.

Currently, there are three PACE sites in Texas serving the Amarillo/Canyon, El Paso, and Lubbock areas of the state.

H.B. 2903, 82nd Legislature, Regular Session, 2011, required HHSC to ensure that PACE is available as an alternative to Medicaid managed care for eligible recipients and that Medicaid managed care plans consider the availability of PACE when considering whether a person needs a nursing facility or other long-term facility. HHSC was also charged with adopting a reimbursement methodology that would encourage an increase in the number of PACE sites throughout the state.

H.B. 2903 also created a PACE program team, which is charged with studying the feasibility of implementing a statewide reimbursement rate for PACE. The bill also requires the DADS to make PACE an option under the “Money Follows the Person” demonstration or related projects.

Diabetes Reporting

S.B. 796, 82nd Legislature, Regular Session, 2011, requires the development of three reports related to diabetes prevention and treatment in Texas. The three reports will provide the legislature, HHSC and the general public with information regarding the overall impact of diabetes on the state economy while also clarifying the current scope of services, public and private, available statewide to individuals with diabetes. Finally, one of the reports requires HHSC to articulate the Medicaid priorities for treating and preventing diabetes. Altogether the reports will give a

clearer picture of the current state of diabetes care in Texas and highlight potential service gaps.

Texas Diabetes Council

H.B. 3278, 82nd Legislature, Regular Session, 2011, changed the membership of several advisory committees and councils, including the Texas Diabetes Council (TDC). The bill eliminated the Texas Education Agency (TEA) as a member and reduced the number of required representatives from the Department of Assistive and Rehabilitative Services (DARS) to one. The membership of TDC now includes 11 voting members and three non-voting members representing HHSC, DARS and DSHS for a total of 14 members.

Hospital Standard Dollar Amount Rate Adjustment

As directed by S.B. 7, 82nd Legislature, First Called Session, 2011, HHSC is transitioning from the Medicare Severity Diagnosis Related Grouping (MS-DRG) to the All Patient Refined Diagnosis Related Grouping (APR-DRG) for inpatient hospital reimbursement. The APR-DRG allows for additional refinement and levels of severity for children's claims. The APR-DRG, through expanded diagnosis and procedure codes, will more appropriately reimburse Medicaid claims. The transition to the APR-DRG will require that the statewide standard dollar amount (SDA), existing add-ons, and proposed new add-on(s) be rebased using SFY 2010 claims data to ensure the reimbursement to hospitals remains within available funds.

Elimination of the Consolidated Waiver Program

S.B. 705, 81st Legislature, Regular Session, 2009, directed DADS to eliminate the Consolidated Waiver Program (CWP) and transfer the waiver's funding to Medicaid 1915(c) LTSS waiver programs that would serve CWP clients. CWP ended on December 31, 2011, and of the 157 clients enrolled in CWP, 156 were transferred to another Medicaid1915(c) waiver or other community service.

CWP served Bexar County clients who were on interest lists for the following 1915(c) waiver programs: Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), Community Based Alternatives (CBA), and Medically Dependent Children Program (MDCP). CWP provided an alternative to living in a nursing facility or in an ICF/IID.

Historical Major Federal Medicaid and CHIP Legislation, 1965 to Present

Social Security Amendments of 1967

Mandated

- Early periodic screening, diagnoses, and treatment (EPSDT) program for children's health.
- Freedom of choice of providers.

Public Law 92-223 of 1971

Optional

- Allows states to cover services in an ICF/IID.

Social Security Amendments of 1972

Optional

- Allows states to cover care for Medicaid clients under age 22 in-inpatient psychiatric hospitals.

Omnibus Budget Reconciliation Act of 1981 (OBRA)

Optional

- Allows states to provide home and community-based services to persons who would otherwise require institutional (hospital, ICF/IID, or nursing home) services under "1915(c)" or "2176" waivers.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Optional

- Allows states to extend coverage to children with disabilities under age 18 living at home who would be eligible for SSI if in a hospital, ICF/IID, or nursing home.

Deficit Reduction Act of 1984 (DEFRA)

Mandated

- Provides coverage of children up to age five born after September 30, 1983 whose families meet AFDC (now TANF) income and resource limits, even if the family does not qualify for AFDC (i.e., if both parents are in the home). Texas also covers children from ages 6 to 19 in such families.
- Provides coverage of pregnant women in households that would meet AFDC (now TANF) income/resource limits after a child is born, including households with an unemployed "principal wage earner" present.
- Provides automatic coverage of infants born to and living with Medicaid-eligible mothers.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Mandated

- Extends coverage of pregnant women to households with an employed principal wage earner if TANF financial standards are met.
- Discretionary distributions from a "Medicaid-qualifying trust" are countable regardless of whether such distributions are made.

Optional

- Allows states to immediately cover DEFRA children up to age five (no phase-in required).

OBRA of 1986

Mandated

- Provides coverage of emergency care services (including labor and delivery) for undocumented immigrants.
- Provides coverage of homeless persons. Lack of home address may not be grounds for denial of eligibility.

Optional

- Allows states to cover infants up to age one and pregnant women under 100 percent of poverty. Creates phase-in for children up to age five under 100 percent of poverty. Also allows coverage for prenatal care while Medicaid application is pending and guaranteed coverage for the full-term of pregnancy and postpartum care. Allows states to waive assets tests for this group.

OBRA of 1987

Mandated

- Extends coverage to age seven for children born after September 30, 1983, whose families meet AFDC (now TANF) financial standards, even if the family does not qualify for AFDC (extension to age eight at state's option).
- Makes sweeping changes in nursing home standards, including requirement that all current and prospective nursing home clients be screened to identify persons with mental illness, intellectual disability, or related conditions (pre-admission screening and resident reviews).

Optional

- Allows states to cover infants up to age one and pregnant women under 185 percent of poverty and allows immediate coverage (no phase-in) of children up to age five under 100 percent of poverty.
- Allows states to develop systems of care for home and community-based and institutional long-term services and supports via 1915(d) waivers. (Not applicable in most states.)

Medicare Catastrophic Coverage Act of 1988

Mandated

- Provides phased-in coverage of out-of-pocket costs (premiums, deductibles, co-insurance) for Qualified Medicare Beneficiaries (QMBs) under 100 percent of the poverty level.
- Provides phased-in coverage of infants up to age one and pregnant women under 100 percent of the poverty level.
- Requires more comprehensive coverage of hospital services for infants.
- Requires the deduction of incurred medical expenses in the post-eligibility treatment of income.
- Establishes minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.
- Establishes a 30-month penalty period for transfers of assets to establish Medicaid eligibility.
- Expands payments for hospital services for infants in all hospitals, and for children up to age six in disproportionate share hospitals.
- Once eligibility is established, coverage of pregnant women may not be terminated until two months postpartum. Infants born to Medicaid-eligible mothers must be covered through their first birthday if the mother remains eligible or if she would be eligible if she were pregnant.

Optional

- Allows states to create home and community care programs for people with disabilities (1929(b) “Frail Elderly”) and to apply for funding services for persons with developmental disabilities (1930 Community Supported Living Arrangements).

OBRA of 1989

Mandated

- Does not permit states to limit amount, duration, scope, or availability of state plan services to children on Medicaid.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Mandated

- Restricts use of voluntary donations from health-care providers to state Medicaid programs.
- Caps spending on DSH reimbursement.
- Sets strict standards for taxes on health care providers and ceilings on the share of state Medicaid funds that may be financed through provider taxes.

OBRA of 1993

Mandated

- States must distribute federally-provided vaccines to Medicaid providers.
- States without medically needy spend-down programs for nursing home services must allow eligibility of persons with certain trusts.
- Sets new standards for participation in and payments under the disproportionate share reimbursement program.
- Sets stricter standards for transfer-of-assets penalties for nursing facility care and home and community-based waiver services. Also sets new standards for the treatment of trusts in determining Medicaid eligibility.

Optional

- States may create a new eligibility category for persons infected with tuberculosis who meet Medicaid financial standards for persons with disabilities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191)

Mandated

- Requires standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid.
- Protects the security of electronically transmitted or stored information, and the privacy of individuals.
- Implements the new National Provider Identifier to be used on all electronic transactions between providers and health plans.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193)

PRWORA is federal legislation that requires adult TANF clients to participate in work activities within two years of entering the program and prohibits them from receiving federally funded TANF benefits for more than 60 months over a lifetime. The impact of welfare reform is thought to be partly responsible for the state's Medicaid caseload drop in the mid to late 1990s. Individuals who qualified for TANF comprised approximately 18 percent of the Medicaid population in 1999, down from 28 percent in 1997.[4]

PRWORA also gave states the option to decide whether or not to continue providing Medicaid to most legal immigrants. Most immigrants entering the United States after August 22, 1996, are subject to a five-year "bar" period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act of 1997 (BBA) restored SSI benefits for legal immigrants who arrived in the United States (U.S) prior to August 22, 1996, but limited the benefit until after the

first seven years of a person's residence in the U.S. Beginning in 2003, some persons began to reach the seven-year limit. Those arriving after August 22, 1996, are still ineligible for the SSI program.

Medicaid benefits have never been available to undocumented immigrants, thus PRWORA made no changes in this area. However, states are mandated to reimburse health providers for costs of emergency services to undocumented persons who would otherwise be income-eligible for Medicaid, including costs of labor and delivery.

The BBA of 1997 (P.L. 105-33)

Under the BBA, both Medicaid and Medicare statutes and regulations were significantly altered. Total federal Medicaid spending was cut by $17.2 billion through:

- Reduction of payments to DSH.
- Allowances for states to lower what they paid for Medicare co-payments, deductibles, and coinsurance for QMBs.
- Repeal of the Boren Amendment, eliminating minimum payment guarantees for hospitals, nursing homes, and community health centers that serve Medicaid clients.[5]

Under the BBA, states no longer needed a waiver, such as an 1115 or 1915(b), to require most Medicaid-eligible pregnant women and children to enroll in managed care plans. A waiver is still required if a state wants to expand Medicaid eligibility, require SSI recipients and foster children to enroll in managed care plans, or expand benefits.[6]

States also gained new eligibility options:

Guaranteed eligibility: This option allows states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests. Pursuant to S.B. 1863, 79th Legislature, Regular Session, 2005, Texas' continuous eligibility period for Medicaid children remains at six months.

Medicaid Buy-in: This option allows states to offer individuals with disabilities and income below 250 percent of the FPL an opportunity to "buy-in" to the Medicaid program. Each state creates guidelines for its own Medicaid buy-in program. In September 2006, Texas implemented a buy-in program that enables working persons with disabilities to receive Medicaid coverage. Individuals with incomes up to 250 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Medicaid Buy-In for Children: This option allows states to offer children up to age 19 with disabilities an opportunity to "buy-in" to the Medicaid program. Texas implemented a Medicaid Buy-in for Children (MBIC) program in January 2011. Children with family income up to 300 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Balanced Budget Refinement Act of 1999 (BBRA) (Incorporated by reference in P.L. 106-113)

The Balanced Budget Refinement Act of 1999 (BBRA) provided approximately $17 billion in "BBA relief" over five years. Most of the provisions of the BBRA were focused specifically on rural health care delivery and access to services for rural Medicare beneficiaries; however, there were provisions specific to the Medicaid program. In particular, the BBRA made the following changes:[7]

- Extended the phase-out of cost-based reimbursement for community health centers, and called for a study to evaluate the impact of changing Medicaid reimbursement to community health centers.
- Changed Medicaid DSH payments and rules. The base-year data used to set the DSH allotments in the BBA were flawed for some states and adjustments were made. The DSH transition rule was also made permanent and states were prohibited from using enhanced federal matching payments under CHIP for DSH. (See Chapter 9 for additional information on CHIP.)

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (P.L. 106-170)

- Expands the BBA by creating two optional categorically needy Medicaid buy-in groups for individuals age 16 to 64 who, except for earned income, would be eligible for Medicaid.
- Creates a new demonstration to help people at-risk for disability maintain their independence and employment.
- Extends Medicare coverage for persons with disabilities who return to work.
- Enhances the employment services system by creating a "Ticket to Work Program." This system is intended to enable SSI or Social Security Disability Income beneficiaries to obtain vocational rehabilitation and employment services from either participating public or private providers. If the beneficiary goes to work and achieves substantial earnings, providers would be paid a portion of the benefits saved.[8]
- Provides Medicaid Infrastructure Grants to states to develop state infrastructures that support working individuals with disabilities.

Breast and Cervical Cancer Prevention and Treatment Act of 2000 (P.L. 106-354)

- Allows states to create a new Medicaid eligibility category for persons screened by the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program, found to be in need of treatment for cancer, and not otherwise eligible for Medicaid. Texas implemented this option in 2002.
- Provides federal funds for services at the same enhanced rate as for CHIP.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. 106-554)

- Increased 2001 and 2002 DSH payment state allotments.
- Required new federal rules to be issued by the end of 2000 limiting Medicaid UPL to government facilities, and provided for a transition period.
- Allowed unspent 1998 and 1999 CHIP funds to be carried forward to subsequent years, and allowed up to ten percent of retained 1998 allotments to be used for outreach activities.

Improper Payments Information Act of 2002 (IPIA)

- Requires federal agencies to identify programs that may be susceptible to significant improper payments and conduct annual program reviews, submit estimates to Congress on the amount of improper payments, and report on the agencies' actions to reduce improper payments.
- In response to the IPIA, CMS created the Payment Error Rate Measurement (PERM) program for Medicaid and CHIP. The PERM program determines states' error rates for Medicaid and CHIP eligibility determinations and claims payments.
- HHSC Internal Audit Division is responsible for coordination and implementation of the PERM Program across all HHS agencies, including acting as the single point of contact with CMS on PERM issues. The HHSC Eligibility Support Services performs PERM eligibility reviews. CMS contractors performed medical and data processing claims reviews of Texas Medicaid and CHIP claims payments for FFY 2011 as part of the state's second PERM review. Each state will be reviewed once every three years.

Jobs and Growth Tax Relief Reconciliation Act of 2003 (TRRA) (P.L. 108-27)

- Temporarily increased the FMAP for five calendar quarters (April 2003 through June 2004) as part of a "state fiscal relief" package.
- As a condition for receiving the enhanced FMAP, required states to maintain the same Medicaid eligibility requirements as were in effect on September 2, 2003. This provision prevented states from receiving additional federal funds while simultaneously enacting more stringent eligibility policies to reduce the number of people eligible for their Medicaid programs.

CHIP Allotment Extension (P.L. 108-74)

- Allowed states to retain unexpended FFY 1998-1999 federal allocations through FFY 2004.
- Allowed states additional time to spend 50 percent of unused FFY 2000-2001 federal allocations (through FFY 2004 and FFY 2005, respectively).
- Allowed approximately ten states that had expanded Medicaid prior to the enactment of CHIP to use their CHIP funds to cover the cost of some of those expansions. This provision did not apply to Texas.

Welfare Reform Extensions and Reauthorizations

Various laws have been passed to extend PRWORA beyond its expiration date of September 30, 2002. The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) reauthorized TANF through September 30, 2010, although supplemental grants to states such as Texas were only extended through September 30, 2008. A related program, Transitional Medical Assistance, was extended until June 30, 2009 under the Medicare Improvements for Patients and Providers Act of 2008.

Medicare Prescription Drug Improvement and Modernizations Act of 2003 (MMA) (P.L. 108-173)

The most historic feature of the MMA was the creation of an outpatient prescription drug benefit in Medicare. The bill also changed many provider payments, some of which had been reduced or constrained under previous legislation. Major provisions affecting the Medicaid program include the following:

- Implementation of a voluntary prescription drug discount card program that also provided a subsidy for low-income beneficiaries. The discount card program was in effect in 2004 and 2005.
- Implementation of a prescription drug benefit, offered through private sector plans, which began January 1, 2006. Called Part D, the benefit is available to all Medicare beneficiaries, including those who are also eligible for Medicaid (dual eligibles). Preparation for transitioning Medicaid enrollees to Part D required extensive state involvement, and the state has a continuing role in eligibility determination.
- Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the “clawback” provision).
- Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
- Increased Medicare Part B premiums (physician, lab services, etc.), which Medicaid pays on behalf of certain dual eligibles.
- Increased state allotments for DSH payments for 2004-2010.

- Appropriation of $250 million annually for FFYs 2005-2008 to compensate medical providers for emergency care provided to undocumented immigrants. Payments are made directly by the federal government to providers.

American Jobs Creation Act of 2004 (P.L. 108-357) (Sickle Cell Benefit)

- Provides a new optional Medicaid benefit for sickle cell disease.
- Makes federal matching funds available for education and outreach to Medicaid-eligible adults and children with sickle cell disease.

Deficit Reduction Act of 2005 (DRA) (P.L. 109-171)

DRA, a comprehensive budget reconciliation bill, was signed into law February 8, 2006. The federal government estimated that the DRA would reduce federal spending on Medicaid and Medicare by $39 billion for the five-year period 2006-2010 in the following five major categories of spending:

- Prescription drugs,
- Asset transfer changes for long-term care eligibility,
- Fraud, waste, and abuse,
- Cost-sharing and benefit flexibility, and
- State financing (including changes in funding targeted case management and restrictions on provider taxes).

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (P.L. 110-028)

The U.S. Troop Readiness, Veteran's Care, Katrina Recovery, and Iraq Accountability Appropriations Act was signed into law May 25, 2007. The Act included $6 billion for Hurricane Katrina relief and:

- Requires providers to use tamper-resistant prescription pads/paper when writing prescriptions for any drugs for Medicaid recipients effective April 2008.
- Limits reimbursement for written prescriptions to only those executed on tamper-resistant prescription pads/paper. Prescriptions transmitted to pharmacies via telephone, fax, or electronically are exempt from this requirement.[9]

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (P.L. 110-343)

MHPAEA was incorporated into the Emergency Economic Stabilization Act of 2008 that was signed into federal law on October 3, 2008.

- Requires group health plans that offer behavioral health benefits (mental health and substance use disorder benefits) to provide those services at parity with medical and surgical benefits.

- Parity requirements apply to financial requirements (e.g., co-payments), treatment limitations (e.g., number of visits or days of coverage), and availability of out-of-network coverage.
- Behavioral health and medical benefits are required to meet parity based on the following benefit classifications: 1) Inpatient, in-network; 2) Inpatient, out-of-network; 3) Outpatient, in-network; 4) Outpatient, out-of-network; 5) Emergency care; and 6) Prescription drugs.
- MHPAEA does not impact traditional Medicaid FFS; however the requirements apply to Medicaid managed care and state CHIP programs.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3)

CHIPRA authorized CHIP federal funding through FFY 2013, and the ACA extended the program through at least 2015. CHIPRA increased the amount of federal CHIP funding available to Texas and included significant policy changes that have impacted Texas.

For FFY 2011, the federal CHIP allotment for Texas was $832.7 million. The CHIP allotment is adjusted annually based upon a formula that takes into account actual CHIP expenditures, child population growth, and a measure of health care inflation. Texas has two years to spend its CHIP allotment.

HHSC has implemented the following changes in accordance with federal CHIPRA guidance:

- Requiring CHIP MCOs to pay federally-qualified health centers and rural health centers their full encounter rates,
- Applying certain Medicaid managed care safeguards to CHIP,
- Verifying citizenship for CHIP,
- Implementing mental health parity in CHIP (see Chapter 9 for additional information),
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children, and
- Expanding dental services.

The American Recovery and Reinvestment Act (ARRA) (P.L. 111-5)

ARRA was signed into law in February of 2009, and provided $762 billion in economic stimulus funding through a multitude of new and existing programs.

- Temporarily increased the FMAP rate during the 27-month recession adjustment period, from October 2008 through December 2010.

- Temporarily increased the federal share for Medicaid in Texas by approximately nine to eleven percentage points above the pre-ARRA FMAP rate during the stimulus period. Congress later extended the FMAP increase for an additional six months at phased-down rates. In all, the FMAP increase spanned a 33-month period. For Texas, the ARRA FMAP increase affected 11 months of SFY 2009, 12 months of SFY 2010, and 10 months of SFY 2011.
- Temporarily prohibited states from making any Medicaid eligibility standards, methodologies, or procedures changes that were more restrictive than those in effect as of July 1, 2008.
- Implemented prompt payment requirements for Medicaid providers.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Contingency Fund, increased the DSH allotment, allocated funding for Health Information Technology (HIT), and provided supplemental funding for existing public health cooperative agreements and competitive grant opportunities through the Prevention and Wellness Fund.
- Established the Recovery Accountability and Transparency Board (RATB) to help prevent waste, fraud, and abuse and the Recovery.gov website to foster greater accountability and transparency in the use of funds made available by the Act.

Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) and Health Care and Education Reconciliation Act of 2010 (HCERA) (P.L. 111-152)

PPACA was signed into law on March 23, 2010 and HCERA was enacted on March 30, 2010. Together they are called ACA. Among a number of other things, ACA mandates that all individuals have health coverage, provides individuals up to 400 percent of the FPL with subsidies to purchase coverage, and gives states the option to expand Medicaid eligibility to 133 percent of FPL for uninsured individuals up to age 65. It directs that each state will have a health benefit exchange to assist individuals and small businesses purchase affordable health care options. These changes will affect all HHS agencies, especially HHSC and DSHS. (See Chapter 3 for additional information on ACA.)

What Is Medicare?

The Social Security Act of 1965 created both Medicaid and Medicare, but the two programs are very different. Medicare is a federally-paid and administered health insurance program. As of July 2010, it covered 47.0 million Americans.[10]

Medicare has four parts: A, B, C and D. Parts A and B cover different acute care services (such as hospital and physician services) and have different eligibility and cost-sharing requirements. Part C provides for a managed care delivery system for

Medicare services. Part D is a prescription drug benefit program that was implemented on January 1, 2006.

Most Americans age 65 and over automatically qualify for Medicare Part A (hospital insurance for inpatient hospital services) in the same way they qualify for Social Security, based on their work history and their payroll deductions while they were working. Qualifying individuals receive Part A coverage with no premium payment, but some cost-sharing through coinsurance and deductibles is required. People who do not qualify may purchase the hospital coverage. The federal government finances the hospital insurance program primarily through a payroll tax on employers and employees.

Medicare Part B is a voluntary program covering physician and related health services. Medicare Part A beneficiaries may choose to enroll in Part B. In addition, any American age 65 and over may enroll in Part B, even if not eligible for Part A. Part B requires payment of a monthly premium. For low-income seniors who qualify, Medicaid pays the monthly premium. In addition to enrollee premiums, federal revenues finance the cost of the Medicare program. Both Part A and Part B have cost-sharing requirements whereby enrollees must pay coinsurance and deductibles. The Texas Medicaid program covers these costs for eligible low-income beneficiaries.

Part C establishes a managed care delivery option in Medicare called Medicare Advantage (previously called Medicare+Choice). Part C combines Part A and Part B coverage. Beneficiaries who live in an area in which Medicare managed care plans operate may choose to receive their Medicare services through such a plan. These plans may offer additional benefits not available in the traditional Medicare program, or charge lower premiums.

Part D, the Medicare prescription drug benefit, was created by MMA of 2003. Part D represents the most significant change to the program in nearly 40 years. Previously, Medicare did not cover any outpatient prescription drugs, except for a few drugs that were covered under Part B. For those Medicare beneficiaries who qualified for Medicaid (called dual eligibles), Texas and other states offered prescription drugs through Medicaid.

The major impact of Part D on the Texas Medicaid program was that, as of early 2006, dual eligibles began receiving prescription drugs from Medicare, rather than Medicaid. In SFY 2011, approximately 360,000 dual eligibles received prescription drug coverage through Medicare Part D.[11] Once determined eligible for Medicare, CMS requires dual eligible clients to enroll in a Medicare Prescription Drug Plan for all their prescription drugs. However, Texas Medicaid continues to provide some

limited drug coverage to dual eligibles for a few categories of drugs that are not covered under Medicare Part D.

Although the new benefit shifted prescription drug coverage from Medicaid to Medicare, it did not provide full fiscal relief to states. A significant share of the cost of providing the Part D benefit to dually eligible clients is financed through monthly payments made by states to the federal government.

Federal Health Care Reform Changes to Medicare Part D

ACA provided for a $250 rebate in 2010 for all Part D enrollees who enter the coverage gap (donut hole) and includes a gradual phase down of the beneficiary coinsurance rate in the donut hole from 100 percent to 25 percent by 2020. Clients in Texas pharmaceutical support programs such as the human immunodeficiency virus (HIV) and Kidney Health Care (KHC) programs at the DSHS benefit from these changes.

State Role in Medicare

Medicare is financed and administered wholly at the federal level. Historically, states played no role in Medicare administration, but since 1988, federal law has required that state Medicaid programs pay Medicare deductibles, premiums, and coinsurance for some low-income Medicare beneficiaries. Medicare also affects Medicaid because of its coverage scope and limitations. For instance, Medicare does not currently cover some categories of medications that Medicaid covers, including some cough and cold products, vitamins and minerals, and over-the-counter medications. The Texas Medicaid program pays all of the cost of these drugs for dual eligibles. The Texas Medicaid program also pays the federal government to provide Medicare drug coverage for individuals who are dually eligible through what is commonly known as “clawback” payments. It is estimated that in SFY 2011, Texas Medicaid program paid about $1.2 billion for Medicare premiums and deductibles (Part A and Part B), and another $282 million (all GR) for Medicare Part D “clawback” or give back. Taken together this accounts for approximately six percent of the Texas Medicaid program budget, excluding DSH and UPL funds.

Medicare does not play a major role in funding long-term care services and supports. For example, Medicare only covers nursing home care required following a hospitalization. Coverage is limited to 100 days per “spell of illness,” and the beneficiary must be making progress toward rehabilitative goals for Medicare to cover the stay. In other words, the Medicare nursing home benefit does not cover

long-term institutional services and supports. Medicaid, however, covers long-term institutional services and supports and thus covers the cost of nursing home care for dually eligible clients not paid by Medicare. Medicaid also covers a broad range of community-based long-term care services and supports, which are not included under Medicare.

Endnotes

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[1] More information on Medicaid waivers can be found at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (November 2012).

[2] PCG with assistance from DMA Health Strategies and Civic Initiatives, "Analysis of the Texas Behavioral Health System," http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf (June 2012).

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[4] Health Care Financing Administration, 2082 Report, "Statistical Report on Medical Care: Eligible, Recipients, Payments, and Services," 1997 and 1999.

[5] Center on Budget and Policy Priorities, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33," September 8, 1997, http://www.cbpp.org/908mcaid.htm (July 2012).

[6] Center on Budget and Policy Priorities, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33," September 8, 1997, http://www.cbpp.org/908mcaid.htm (July 2012).

[7] Rural Policy Research Institute, "Rural Implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of the Health Policy Provisions," December 1999, pp. 2-3.

[8] Centers for Medicare & Medicaid Services, "Employment Initiatives: Ticket to Work and Work Incentives Improvement Act," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html (October 2012).

[9] U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Tamper-Resistant Prescription Pads), May 25, 2007, http://waysandmeans.house.gov/media/pdf/tax/HR_2206_text.pdf (July 2012).

[10] Centers for Medicare & Medicaid Services, "Medicare Enrollment Reports," http://www.cms.hhs.gov/MedicareEnRpts/ (August 2012).

[11] Health and Human Services Commission, *Monthly MMA Dual Eligible Counts*.

Chapter 3: Federal Health Care Reform

Federal health care reform legislation increases access to health insurance by creating an individual mandate for health insurance coverage, giving states the option to expand Medicaid and subsidizing health insurance for some individuals. There will be significant costs and challenges to the state to implement federal health care reform, which is not fully federally funded.

History and Background

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA) and make significant changes to state health care programs and to the health insurance market. Among a number of other changes, ACA mandates that all individuals have health insurance coverage and provides individuals up to and including 400 percent of the federal poverty level (FPL) with subsidies to purchase health insurance coverage. It also expanded Medicaid eligibility up to and including 133 percent of the FPL for individuals under age 65 (now optional, see below).

The United States Supreme Court (SCOTUS) recently considered the constitutionality of two major provisions of ACA as a result of two cases in the 11th Circuit Court of Appeals, National Federation of Independent Business v. Sebelius, and Florida v. Department of Health and Human Services (U.S. HHS). Twenty-six states were represented in the lawsuit, including Texas.

On June 28, 2012, the SCOTUS issued a decision on ACA provisions under consideration. The court ruled that the entire ACA is constitutional, with five votes in favor.

- **Individual Mandate.** The individual mandate requiring all Americans to purchase health insurance was upheld as a tax, and was found constitutional.

- **Medicaid Expansion.** The court upheld the Medicaid Expansion, with limitations. It determined that the Medicaid expansion could not be required of states as a condition of receiving federal funding for their existing Medicaid programs, making it optional for States.

ACA also requires the establishment of Health Benefit Exchanges (Exchange) by January 1, 2014, to assist individuals and small employers in accessing affordable health insurance. The Exchange must be operated by a governmental entity, or non-profit organization.

States have the option of establishing a state-run Exchange, partnering with the federal government to establish an Exchange, or having the federal government run the State's Exchange[i]. States initially opting for a federally-run Exchange may request to move to a state-run Exchange over time.

Beginning January 1, 2014, qualified individuals and employees of participating small employers may use the Exchange to purchase health insurance coverage from qualified health plans. Individuals above 100 up to and including 400 percent of the FPL may be eligible for premium subsidies and cost sharing reductions for coverage purchased through the Exchange.

The new health insurance requirements will impact the number of uninsured in Texas. If Texas moves forward with an optional Medicaid expansion, there would be additional impacts to the number of uninsured Texans. **Figure 3.1, Figure 3.2 and Figure 3.3** show the percentage of uninsured in Texas before and after implementation of ACA, including the impact if Texas moved forward with an optional expansion of Medicaid to include uninsured adults 19 to 65.

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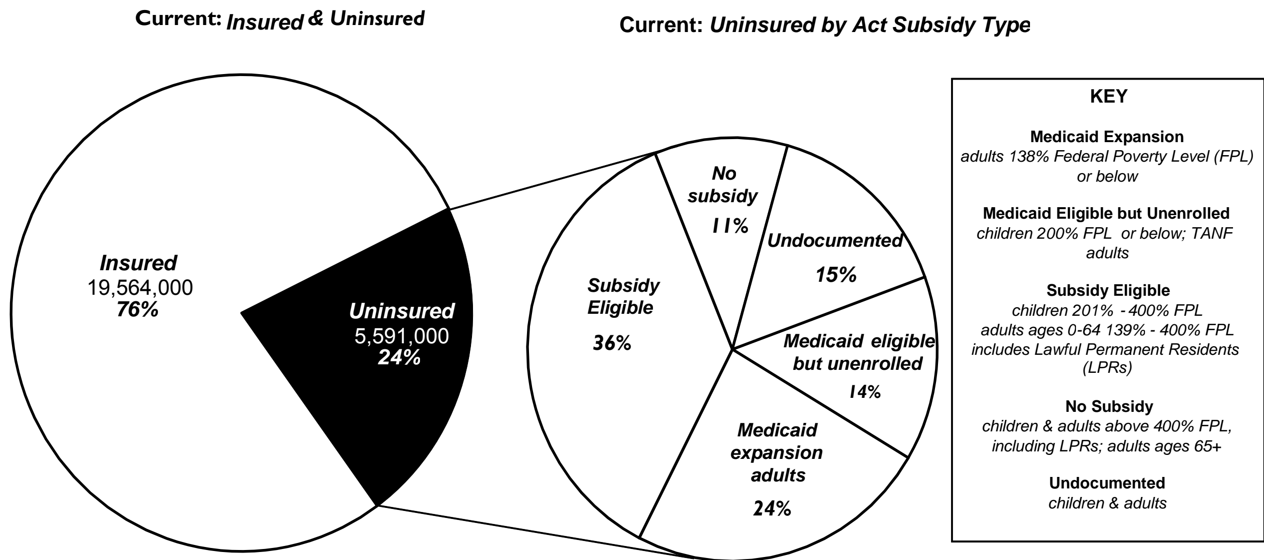
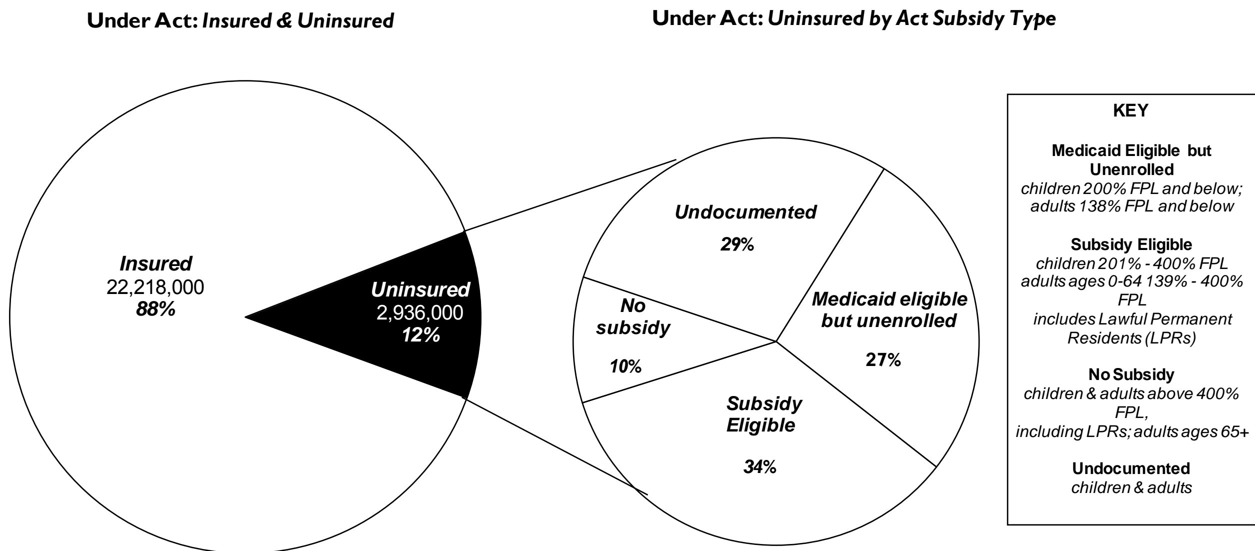
[i] States building state-based exchanges had to submit a blueprint consisting of a declaration letter signed by the Governor and an application to the federal Department of Health and Human Services (HHS) by December 14, 2012. States opting for a state-federal partnership exchange must submit a blueprint to HHS by February 15, 2013.

Figure 3.1: Texas Population
Current: Insured and Uninsured, by ACA Subsidy Type



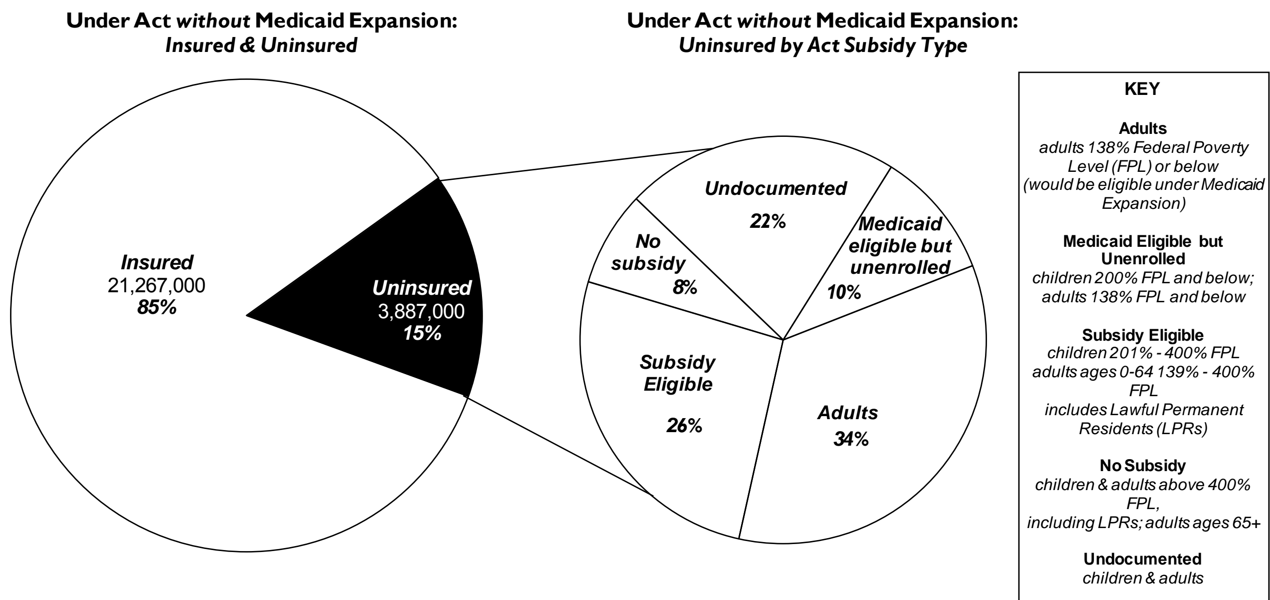
Note: Due to rounding, percents may not total one hundred percent.
Source: U.S. Census Bureau. March 2011 CPS. Prepared by: HHSC, July 2012.

Figure 3.2: Texas Population
Under Act WITH FULL MEDICAID EXPANSION: Insured and Uninsured, by ACA Subsidy Type



Note: Due to rounding, percents may not total one hundred percent.
Source: U.S. Census Bureau. March 2011 CPS. Prepared by: HHSC, July 2012.

Figure 3.3: Texas Population
Under Act WITHOUT IMPLEMENTING MEDICAID EXPANSION:
Insured and Uninsured,
by ACA Subsidy Type



Note: Due to rounding, percents may not total one hundred percent.
Source: U.S. Census Bureau. March 2011 CPS. Prepared by: HHSC, July 2012.

While the majority of ACA provisions do not become effective until 2014, Texas agencies are working to implement the requirements and options since the passage of ACA in March 2010. The following sections provide more information on the changes that will impact the Health and Human Services Commission (HHSC) and other agencies, including the work that is underway to implement the required changes to Texas' Medicaid programs and the Children's Health Insurance Program (CHIP).

Directives Implemented

While some of the major provisions of ACA impacting HHSC do not become effective until 2014, there are a number of provisions with earlier effective dates. The provisions implemented to date include Medicaid benefit changes, pharmacy changes, changes to federal matching funds, and some program integrity provisions.

Medicaid Benefit Changes

Hospice

ACA requires states to provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP. Under ACA, a family that elects to receive hospice care for a child can no longer be required to waive treatment for the child's terminal illness. Texas implemented this change in Medicaid and CHIP effective August 1, 2010.

Birthing Centers

At the direction of the Centers for Medicare & Medicaid Services (CMS), Texas stopped providing direct Medicaid payments to birthing centers on September 1, 2009. However, ACA added birthing centers as a required Medicaid provider. In response, HHSC reinstated birthing centers as a Medicaid provider, which allows birthing centers to provide covered Medicaid services and receive direct Medicaid reimbursement effective September 1, 2010.

Comprehensive Tobacco Cessation Services for Pregnant Women

As a result of ACA, HHSC implemented comprehensive tobacco cessation services for pregnant women on January 1, 2012. Comprehensive tobacco cessation services for pregnant women include prescription and non-prescription tobacco cessation agents approved by the Federal Drug Administration and tobacco cessation counseling services. Prior to implementation, Texas covered tobacco cessation drugs, but not tobacco cessation counseling.

Pharmacy Changes

The Omnibus Budget Reconciliation Act (OBRA) of 1990 established the federal Medicaid drug rebate program. OBRA requires drug manufacturers as a condition of participation in the Medicaid program to pay rebates that are shared by the federal and state governments for covered outpatient drugs that are dispensed to Medicaid patients. In exchange, state Medicaid programs are required to cover all of a manufacturer's contracted drug products.

Effective January 1, 2010, ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay for participation in the Medicaid program and specified that all of the revenues collected due to these changes will be paid to the federal government. ACA also enables states to collect rebates for drugs dispensed through managed care organizations. With the March 2012, managed care expansion, pharmacy benefits were carved into the Medicaid managed care delivery system.

Additionally, effective January 1, 2014, states that provide a prescription drug benefit may no longer exclude the following drug classes and must provide coverage of those drugs not covered by Medicare to individuals who are dually eligible for Medicare and Medicaid (Texas already meets this requirement):

- Smoking cessation drugs, including over-the-counter products,
- Barbiturates, and
- Benzodiazepines.

Changes to Federal Matching Funds

ACA provided opportunities to receive federal matching funds for services previously reimbursed through General Revenue (GR). Texas has pursued the following:

- Allowing for receipt of federal matching funds for CHIP coverage of state employee's (Teachers Retirement System) children who previously qualified for ActiveCare and were paid for with state GR funding, and
- Allowing for receipt of federal matching funds for CHIP coverage of state employee's children who previously qualified for State Kids Insurance Program (SKIP) and were paid for with state GR funding.

Fraud and Abuse

There are approximately 19 ACA provisions related to program integrity that impact Texas' Health and Human Services (HHS) programs. The effective dates for these provisions range from the date of enactment of ACA (March 2010) and beyond. The 19 provisions cover a variety of provider integrity issues, including:

- Increased use of National Provider Identifier (NPI) on claims and applications,
- Increased measures for provider screening,
- Additional data elements for the MMIS (Medicaid Management Information Systems),
- Enhanced oversight for new providers, and
- Increased provider disclosure requirements.

To date, Texas has implemented, or is in compliance with, the following program integrity provisions:

- Requiring NPI for enrolling Medicaid and CHIP providers,
- Requiring face-to-face encounters with patients for the certification of home health services and durable medical equipment,
- Use of the National Correct Coding Initiative (NCCI) in claims adjudication,
- Prohibition on payments to entities outside of the United States, and

- Suspension of provider payments pending an investigation of a credible allegation of fraud.

Additional program integrity initiatives are in the process of being implemented, including new provider screening and enrollment processes, payment reduction for health care acquired conditions and recovery audit contractor programs.

Medicaid & CHIP Caseload Growth

Eligibility Expansions

Effective January 1, 2014, ACA expands Medicaid to the following groups:

- Former foster care youth through age 25, and
- Children ages 6 to 18 above 100 and up to and including 133 percent of the FPL (currently CHIP eligible).

As a result of ACA's individual mandate for health insurance coverage, Texas expects to experience a caseload growth for individuals who are currently eligible for Medicaid or CHIP, but are not enrolled (approximately 131,070).

Optional Eligibility Expansion

ACA also included a mandatory expansion of Medicaid. However, on June 28, 2012, the U.S. Supreme Court issued a decision on the constitutionality of ACA. The court upheld the Medicaid expansion, but with limitations. It determined that the Medicaid expansion could not be required of states as a condition of receiving federal funding for their existing Medicaid programs, making it essentially optional for states.

If a Medicaid expansion is pursued by the state, Medicaid income eligibility could be expanded to adults ages 19 to 64 who are non-pregnant, non-disabled, ineligible for Medicare Parts A or B, otherwise ineligible for Medicaid, and have incomes up to and including 133 percent of the FPL.[ii] With this option Texas could expect to experience a caseload growth in State Fiscal Year (SFY) 2014 of approximately 340,976.

[ii] The ACA applies a five percent income disregard to populations that are subject to the use of modified adjusted gross income.

New Medicaid populations in Texas could include:

- Parents and caretakers above 12 and up to and including 133 percent of the FPL, and
- Childless adults up to and including 133 percent of the FPL.

Benchmark Benefit Package for Optional Medicaid Expansion

ACA requires states choosing to expand their Medicaid program to the new adult Medicaid expansion group[iii] provide a Medicaid benchmark benefit (with some exceptions). Medicaid Benchmark coverage is equal to one of three federally recognized plans, or alternatively Secretary-approved coverage, and must include certain key services.

The Deficit Reduction Act of 2005 (DRA) established an option for states to provide benchmark or benchmark-equivalent coverage in Medicaid. The ACA added prescription drugs and mental health services, and directed that benchmark coverage must include all essential health benefits (EHB) identified in the ACA. Benchmark-equivalent coverage must include:

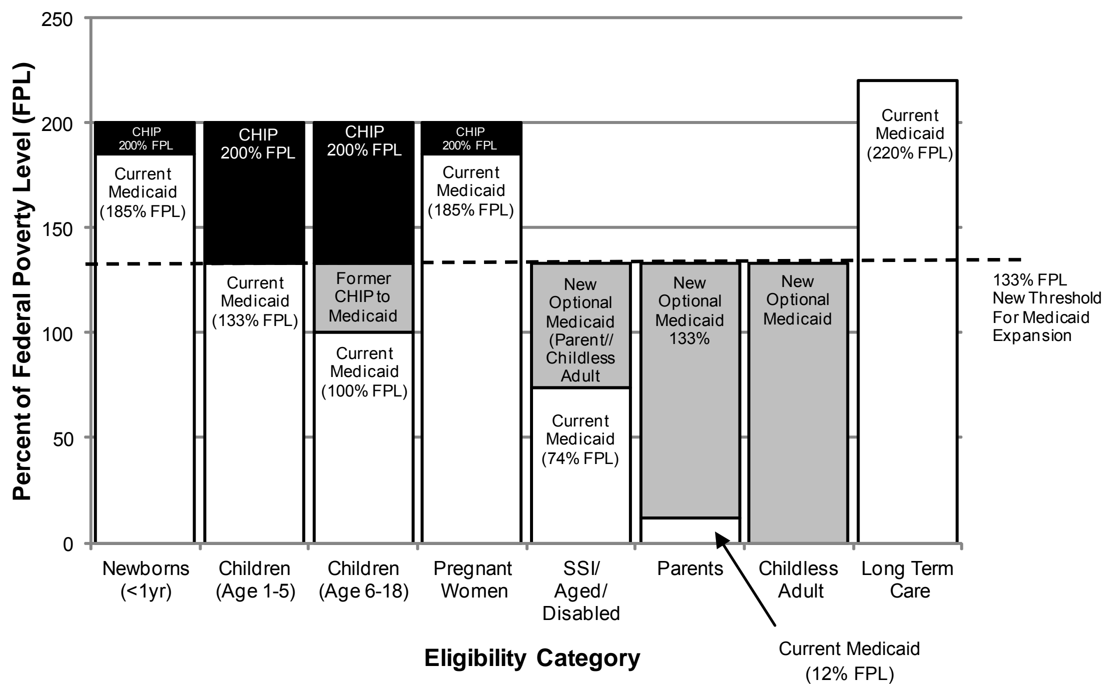
- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative/habilitative services and devices,
- Laboratory services,
- Preventive and wellness services,
- Chronic disease management, and
- Pediatric services, including oral and vision care.

[iii] The optional Medicaid expansion population is non-pregnant adults under age 65 with incomes up to 133 percent of the FPL.

Current and Future Medicaid and CHIP Eligibility Levels

Texas will experience caseload growth in newly eligible individuals and individuals who are currently eligible but not enrolled in Medicaid or CHIP. **Figure 3.4** shows the eligibility changes resulting from ACA and the potential optional Medicaid expansion groups, should Texas choose to move forward with an expansion.

Figure 3.4: Current and Future Medicaid/CHIP Eligibility Levels



Source: HHSC, Strategic Decision Support.

Maintenance of Effort Requirements

In addition to requiring eligibility expansions, ACA restricts states' ability to make changes to existing Medicaid and CHIP programs by extending maintenance of effort (MOE) requirements. The American Recovery and Reinvestment Act of 2009 (ARRA) prohibits states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however, can be made. ACA continues these MOE requirements for adults until January 1, 2014 (or when an Exchange is established), and for children, including children in CHIP, until September 30,

2019. Under ACA, states must comply with MOE requirements to receive Medicaid or CHIP funding respectively.

Federal guidance has been issued that clarifies how MOE applies to Medicaid waivers. For instance, Section 1115 and home and community-based waivers can expire and are not required to be renewed under MOE. In addition, states may renew a waiver at the end of the approved waiver period in effect as of March 23, 2010, with modifications to the waiver program.

Eligibility Changes

Effective January 1, 2014, ACA requires states to make significant changes to Medicaid and CHIP eligibility determinations.

Income Eligibility

ACA makes the following changes to income eligibility determinations:

- Requires states to determine financial eligibility for most individuals in Medicaid and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition.
- Prohibits assets tests and most income disregards for Medicaid and CHIP eligibility determinations. ACA applies a five percentage point income disregard to individuals that are subject to the MAGI methodology. Currently, Texas applies assets tests and income disregards to most Medicaid programs. In addition, Texas applies an assets test to children above 150 percent of the FPL and income disregards to determine CHIP eligibility.

The MAGI methodology applies to the existing Medicaid eligibility groups for children, pregnant women, and parents and caretakers. ACA provides exceptions to the use of the MAGI methodology and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and those with disabilities.

Other Eligibility Changes

In addition to income eligibility changes, ACA makes changes to other eligibility policies and process. ACA requires the following:

- A single, streamlined application form for Medicaid, CHIP, and the Exchange.
- Electronic verification of applicant information through a federal data hub.

- For MAGI groups, states must redetermine eligibility every 12 months and no more frequently than once every 12 months except when a change in circumstance is received by the state that may affect an individual's eligibility.
- An administrative or passive eligibility renewal process for MAGI groups. To the extent possible, states must use available information to make eligibility redeterminations without requesting information or an application from clients.
- States must establish timeliness and performance standards for making eligibility determinations promptly and without undue delay.

Coordination between Medicaid, CHIP, and the Exchange

Exchange eligibility determinations must be streamlined and coordinated with eligibility determination for the Medicaid and CHIP programs. State Medicaid and CHIP programs must establish electronic interfaces with the Exchange to facilitate coordination of eligibility determinations across programs. Applications submitted through the Exchange must be electronically transferred to Medicaid and CHIP with no additional required action by the applicant. If an applicant is determined ineligible for state Medicaid and CHIP programs, the application must be sent electronically to the Exchange with all information obtained by the state.

In the event that CHIP allotments are insufficient to cover all CHIP eligible children, the ACA requires states to ensure that CHIP eligible children (who are also determined Medicaid ineligible) receive coverage through the Exchange after September 30, 2015. In addition, ACA requires the U.S. HHS Secretary, no later than April 1, 2015, to certify that the plans in the Exchange that offer services for children have benefit and cost-sharing levels comparable to CHIP.

Health Care Reform Financing

ACA will result in significant costs over time to Texas due primarily to the increases in enrollment among individuals who are currently eligible but not enrolled. While ACA increases federal financial participation for Medicaid and CHIP, the increases do not cover the full costs to Texas of implementing ACA requirements. There will be state fiscal impacts due to provider rate increases as well as other ongoing costs.

Texas Caseload and Fiscal Impact

With the January 2014 effective date for ACA's individual mandate for health insurance coverage, Texas expects to experience Medicaid caseload growth from individuals who are currently eligible but not enrolled.

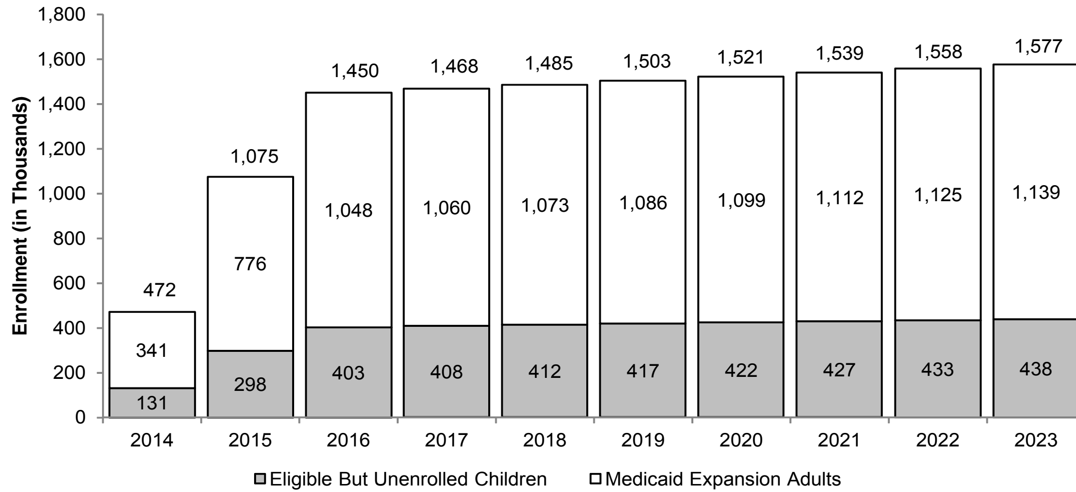
Additionally, ACA directs states to provide Medicaid coverage to:

- Former foster care youth through age 25, and
- Children ages 6 to 18 above 100 and up to and including 133 percent of the FPL (currently CHIP eligible). CHIP eligible children above 100 and up to and including 133 percent of the FPL will move to the Medicaid program in 2014.

If a Medicaid expansion is pursued by Texas, there would be additional impacts. The optional Medicaid expansion allows for coverage of individuals ages 19 to 65, who are at or below 133 percent FPL. New Medicaid client populations in Texas could include:

- Parents and caretakers between 12 and 133 percent of the FPL, and
- Childless adults up to and including 133 percent of the FPL.

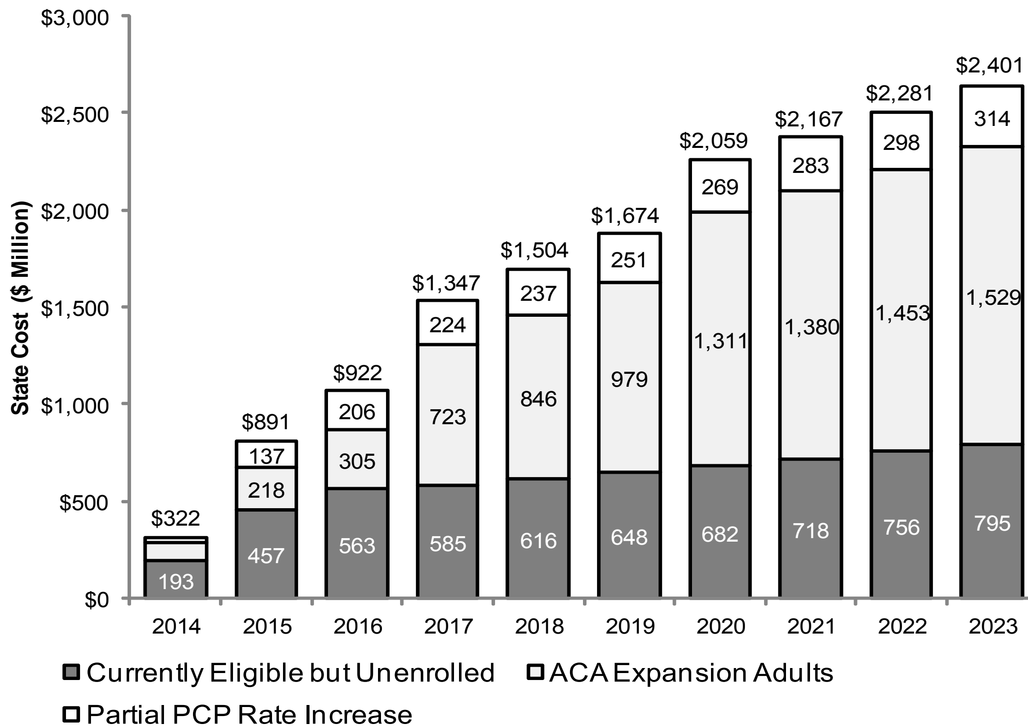
Figure 3.5 shows the projected Medicaid and CHIP caseload estimates as a result of ACA.



*Takeup Rate - 75% Adult; 50% Eligible But Unenrolled.
Phase in - 50% 2014; 75% 2015; and 100% 2016-2023.
Implementation Jan 1, 2014; 2014 has 8 months.
Note: Due to rounding, some component totals may not equal their respective grand total.
Source: HHSC Strategic Decision Support, July 25, 2012.

Figure 3.6.1 illustrates the GR cost impact to Texas Medicaid of ACA implementation for the Primary Care Provider (PCP) rate increase that is at least the Medicare rate for minimum provider types and medical services.

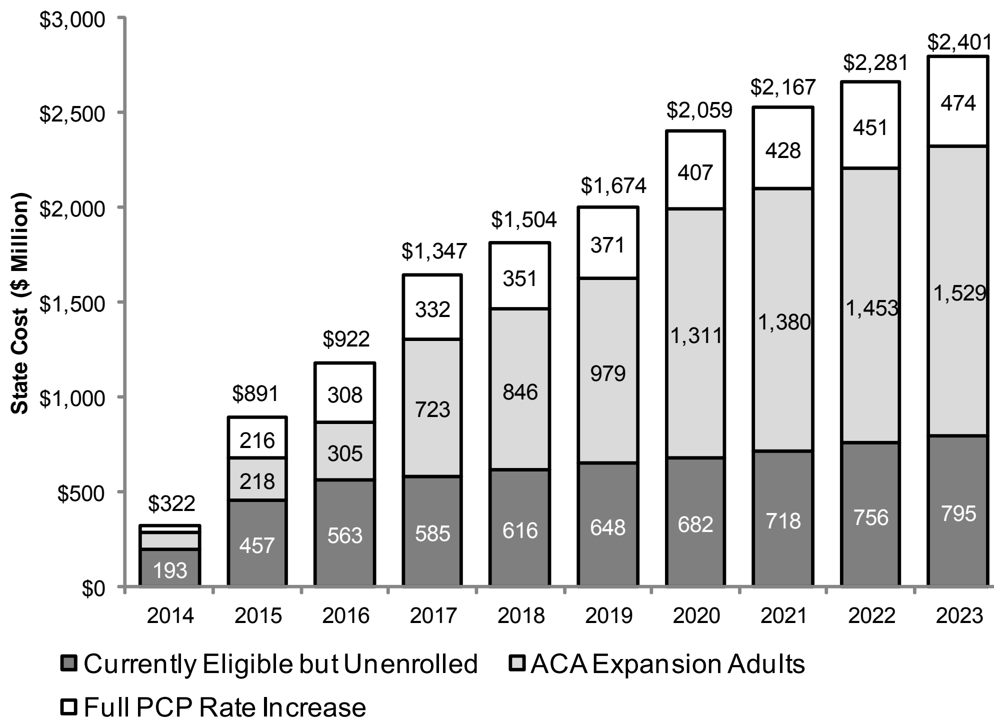
Figure 3.6.1: Impact to Texas Medicaid of ACA Implementation for Primary Care Provider Rate Increase for Minimum Provider Types and Medical Services– State Cost



Source: HHSC Strategic Decision Support, July 2012.

Figure 3.6.2 illustrates the GR cost impact to Texas Medicaid of ACA implementation for the PCP rate increase equal to the Medicare rate for additional provider types.

Figure 3.6.2: Impact to Texas Medicaid of ACA Implementation for Primary Care Provider Rate Increase for Additional Provider Types – State Cost



Source: HHSC Strategic Decision Support, July 2012.

Notes:
In Figures 3.6.1 and 3.6.2 above, the bars represent 10-Year ACA Expenditure Estimates, which are the same in both figures. Individual group breakouts do not include the bump-up of the CHIP enhanced FMAP for children remaining in CHIP from 2016 to 2019. It is included in the 10-Year estimate. In Figure 3.6.2, individual group breakouts will not add to the 10-Year estimate because of the CHIP enhanced FMAP. The two PCP rate models are independent, not additive.
Increased enrollment due to ACA includes increase in eligible but unenrolled, and the provider rate increase as stated in law.
Expansion Adult includes increase in caseload due to enrollment of adults up to and including 133% of FPL, and the required rate increase.
PCP rate increase for minimum provider types and medical services extends the required rate increase beyond 2014; this includes cost due to administration and physician extenders.
PCP rate increase for additional providers expands the rate increase to all physicians and physician extenders for all primary care services.
The required rate increase includes the added cost of physician extenders, which is not covered by 100% FFP.
Administration is included in all estimated expenditures.
Estimate does not include any savings due to reduced demand for programs at DSHS.

Table 3.1: ACA -
State and Federal Medicaid/CHIP Cost Estimates
by Level of Implementation,
State of Texas, SFYs 2014 – 2023

Level of Implementation	**All Funds Cost (billions $)**		**Federal Cost (billions $)**		**General Revenue Cost (billions $)**	
	Increment	Total	Increment	Total	Increment	Total
Medicaid Expansion Adults (<133% FPL)	---	$87.80	---	$78.96	---	$8.84
Medicaid Expansion Adults and Current Eligible but Unenrolled	$17.69	$105.49	$11.68	$90.64	$6.01	$14.85
with *PCP Rate Increase for Minimum Provider Types and Medical Services**	$7.02	$112.51	$4.78	$95.42	$2.24	$17.09
with *PCP Rate Increase for Additional Provider Types***	$10.23	$115.72	$6.85	$97.49	$3.38	$18.23

Assumes provider rate increase applied in Medicaid will also apply to CHIP.
*PCP rate increase for minimum provider types and medical services includes cost due to administration and physician extenders.
**PCP rate increase for additional provider types expands the rate increase to all physicians and physician extenders for all primary care services.
Sources: Estimates based on forecasted Medicaid/CHIP costs, and uninsured estimates from the U.S. Census Bureau.

Federal Financial Participation

ACA increases the federal match rate for the optional Medicaid expansion, and for CHIP. For the first three calendar years of the optional expansion (2014 through 2016), the federal government would cover the full cost of Medicaid for newly eligible adults, for states choosing to implement a Medicaid expansion. From 2017 through 2020, the federal share for Medicaid decreases from 95 to 90 percent.

States will receive the CHIP federal match rate, for children (ages 6 to 18 above 100 and up to and including 133 percent of the FPL) who move from CHIP to Medicaid eligibility beginning in January 2014.

ACA also increases the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015 until September 30, 2019. However, the increase does not apply to certain administrative expenditures.

Table 3.2 shows federal match rates by Medicaid and CHIP eligibility groups from 2014–2023.

Table 3.2: Federal Medical Assistance Percentage (FMAP) SFYs 2014-2023

FMAP	Applicable Population	Years	Percent
Regular FMAP	Applies to individuals that are currently eligible but not enrolled or likely to become enrolled because of the individual mandate.	All Years	58.69%*
Super FMAP	Applies only to the Medicaid expansion population	2014-2016 2017 2018 2019 2020 and beyond	100% 95% 94% 93% 90%
Regular Enhanced FMAP (EFMAP)	Applies to individuals that are currently eligible but not enrolled in CHIP	All Years	71.08%*
Super EFMAP	Assumed for the same population groups as the Regular EFMAP, but for different years.	2016-2019	94.08%*

*Updated annually. The FMAP rate is derived from each state's average per capita income. As the state's per capita income increases in relation to the national per capita income, the FMAP rate decreases.

Beginning in 2013 ACA also provides states with a one percent increase in the federal match rate for certain covered services (e.g., preventive screening) when provided without cost-sharing.

The Balancing Incentive Payment (BIP) program opportunity provides an increased federal match of two percent for certain community-based long term care services for states that agree to make a series of structural changes to their long-term care delivery system. Beginning October 1, 2012 to September 30, 2015, (or until funds are exhausted on a national level prior to this date), Texas will receive an additional two percent federal match on certain community-based long-term services and supports.

ACA also reduces the aggregate Medicaid disproportionate share hospital (DSH) allotment for all states beginning in 2014. A methodology to allocate the DSH allotment reduction to all states must be developed by federal Health and Human Services and must impose the largest percentage reduction on states that:

- Have the lowest percentage of uninsured individuals during the most recent year, or
- Do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and hospitals that have high levels of uncompensated care.

The aggregate federal DSH allotment to all states will be reduced by $500 million in federal fiscal year (FFY) 2014, $600 million in FFY 2015 and FFY 2016, $1.8 billion in FFY 2017, $5 billion in FFY 2018, $5.6 billion in FFY 2019, and $4 billion in FFY 2020.

Temporary Provider Rate Increases

ACA requires that reimbursement for certain Medicaid services provided by primary care providers be increased to 100 percent of Medicare rates for calendar years 2013 and 2014. On November 1, 2012, CMS issued regulations defining primary providers, for purpose of this provision, as specialist and subspecialists within the general category of family practice, general internal medicine, and pediatrics. CMS in the final rule also said it would allow physician extenders[iv] in certain circumstances to qualify for the increase, provided they're under the supervision of physicians who also qualify. This increase applies to physician evaluation and management services and the administration of vaccines. The rate increase is 100 percent federally funded for the difference in the Medicaid rate in place in July 2009 and the Medicare rate in 2013 and 2014. Because Texas implemented rate reductions in 2011, generally of two percent, there will be some cost to the state for a portion of the increase. Medicare co-pays and deductibles, which were reduced in 2012, may also require state matching funds for the affected primary care providers and services.

[iv] A physician extender is a health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

Chapter 4: Healthcare Transformation and Quality Improvement Program 1115 Waiver

The Quality Improvement Program 1115 Waiver makes two major changes: restructuring the financing of health care for Medicaid – eligible patients and uninsured patients, and expanding Medicaid managed care to the entire state.

History and Background

The Texas Legislature, through the 2012-2013 General Appropriations Act (GAA) (House Bill (H.B.) 1, 82nd Legislature, Regular Session, 2011), and Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, instructed the Health and Human Services Commission (HHSC) to expand its use of Medicaid managed care. The Legislature also directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment limit (UPL) program.

The Centers for Medicare & Medicaid Services (CMS) has interpreted federal regulations to prohibit UPL payments to providers in a managed care context. Therefore, CMS advised HHSC that to continue the use of local funding to support supplemental payments to providers in a managed care environment the state should employ a waiver of the Medicaid state plan as provided by Section 1115 of the Social Security Act.

Accordingly, HHSC submitted a proposal to CMS for a five-year Section 1115 demonstration waiver designed to build on existing Texas health care reforms

and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of health care without compromising quality. CMS approved the waiver on December 12, 2011.

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as UPL payments. UPL payments were supplemental payments to offset the difference between what Medicaid pays for a service and what Medicare would pay for the same service. The 1115 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds. The 1115 Transformation Waiver contains two funding pools: the Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP) pools.

Waiver Funding

Federal funds available under both the UC and the DSRIP pools require local or state intergovernmental transfer (IGT) funding, which is public funding from public hospitals or other governmental entities that may draw down federal matching funds under the waiver. IGT funds draw down approximately 60 percent federal matching funds. For example, a public hospital with $40 million IGT can receive approximately $60 million in federal matching funds for a total payment of $100 million under UC or DSRIP.

In Demonstration Year (DY) 1, up to $4.2 billion all funds was available for UC and DSRIP, and in all other years, the two pools could consist of up to $6.2 billion all funds for a potential total of $29 billion all funds over five years. In DY 1, most of the waiver funds are directed towards UC, but by DY 5, funds for UC and DSRIP are capped at equal levels.

Uncompensated Care Pool

UC pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments will be based on each provider’s UC costs as reported on a UC application.

Delivery System Reform Incentive Payment Pool

DSRIP funding provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance:

- Access to health care services,
- Quality of health care and health systems,
- Cost-effectiveness of services and health systems, and
- Health of the patients and families served.

To obtain DSRIP funding, providers must undertake projects related to categories of activities that have been provided as approved project options in a menu of projects agreed upon by CMS and HHSC in the Regional Health Care Partnership (RHP) Planning Protocol (see below for more information). Some DSRIP funding is provided for hospitals demonstrating performance improvements and reporting the community-wide impact of DSRIP projects and regional efforts at health care delivery and quality transformation.

Funds received from the DSRIP pool cannot be used to maintain existing projects or continue services already provided. DSRIP funds can be used to enhance a project or expand services provided, if such a project is outlined in a plan approved by HHSC and CMS. Potential projects are divided into four categories:

- **Category 1: Infrastructure Development** lays the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- **Category 2: Program Innovation and Redesign** includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention.
- **Category 3: Quality Improvements** include improvements in care that can be achieved within four years and outcome reporting on items such as reducing potentially preventable hospital admissions and readmissions.
- **Category 4: Population-focused Improvements** include a series of reporting measures for a hospital to demonstrate the community-wide impact of delivery system reform investments made. Reporting includes data related

to potentially preventable admissions; readmissions, and complications; patient-centered health care, and emergency department utilization.

Regional Health Care Partnerships

Under the 1115 Transformation Waiver, eligibility to receive UC or DSRIP payments requires participation in one of 20 RHPs, which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an "anchoring entity," which is a public hospital or other local governmental entity with the authority to make IGTs, such as a hospital district, a hospital authority, a university health science center, or a county.

The anchoring entity collaborates with hospitals and other regional providers to develop an RHP Plan that accelerates meaningful delivery system reforms and improves patient care for low-income populations. The RHP plans include the projects selected by regional providers from the DSRIP activities outlined in the RHP Planning Protocol, the performance improvement expectations related to projects, and the population-based reporting that the providers perform. Since health system reform requires regional collaboration, providers must select projects that relate to the community needs identified by the RHP, and RHPs must engage stakeholders in the development of RHP plans.

Various kinds of providers and governmental entities are key participants in the projects.

- **IGT entities** are public hospitals or other governmental entities that may contribute public funds to draw down federal matching funds under the waiver. IGT entities select DSRIP projects from the RHP Planning Protocol, determine estimated funding for each project, identify performing providers to implement those projects, and provide funding.
- **Performing providers**, including hospitals, community mental health centers, local health departments, and physician practice plans, may receive waiver incentive payments for completing project objectives detailed in the RHP plan. Certain entities, such as public hospitals, may serve as both an IGT entity and a performing provider.

The RHP plans must be consistent with a regional shared mission, quality goals of the RHP, and CMS' triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the

population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP and resulting plans must reflect broad inclusion of local stakeholder engagement, including:

- County medical associations/societies,
- Local government partners,
- Children's hospitals,
- Academic health science centers,
- Department of State Health Services (DSHS) regional public health directors, and
- Providers with significant Medicaid utilization.

RHPs submitted five-year plans that describe:

- The reasons for the selection of the projects, based on local data, gaps, community needs, and key challenges,
- How the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population, and
- The progression of each project year-over-year, including the expected improvements that will occur in each demonstration year.

The RHPs outline projects and estimated funding levels in plans for HHSC approval in fiscal year 2013. Only projects selected from the RHP Planning Protocol and included in an RHP plan approved by HHSC and CMS qualify for DSRIP payments.

Chapter 5: Medicaid Clients

Medicaid covers diverse client groups. The Medicaid caseload is always changing because of economic and other factors discussed in this chapter.

Who Is Covered in Texas

Medicaid clients include individuals who are eligible for full coverage of acute care services, prescription drugs, and long-term services and supports, depending on need. Medicaid clients also include individuals eligible for time-limited or specific services, such as emergency services only. The three primary categories of Medicaid clients eligible for full benefits are:

- Low income families, pregnant women, and children - Based on income level, age, caring for a related Medicaid eligible dependent child or pregnancy.
- Cash assistance recipients - Based on receipt of Supplemental Security Income (SSI).
- People age 65 and older and those with disabilities - Based on income level, age, and physical or mental disability.

Medicaid clients eligible for limited benefits include:

- Medicare Beneficiaries - Based on income level and age, certain Medicare beneficiaries qualify for partial Medicaid benefits, and
- Non-Citizens - Legal permanent residents and undocumented persons who are not eligible for Medicaid based on citizenship status may receive emergency services.[i]

[i] Individuals receive full Medicaid benefits, but for only the emergent period of time.

Cash Assistance Recipients

SSI is the federal cash assistance program for low-income people age 65 and older and those with disabilities. The federal Social Security Administration sets income eligibility caps, asset limits and benefit rates, and determines eligibility. The 2012 monthly income limit for SSI is $698 per month with an asset limit of $2,000. In Texas, all people eligible for SSI are also eligible for Medicaid. States may supplement SSI payments with state funds, and most states choose to do so. Texas does not do so, but does allow for a slightly higher personal needs allowance (PNA) for SSI clients in long-term care facilities. The PNA is a portion of their SSI check plus a state supplement that they may keep for personal use.

Families and Children

Families and children comprise the majority of clients receiving full Medicaid benefits on a monthly basis. 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.

A household that consists of an adult(s) who cares for and resides with a related Medicaid eligible dependent is eligible for Medicaid if the household income is at or below the Temporary Assistance for Needy Families (TANF) limit. Children in families with income above the TANF limit are eligible based on age, family income, and resources/assets. Newborns (under 12 months) born to mothers who are Medicaid certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday as long as the child resides in Texas.

The majority of children in foster care are categorically eligible for Medicaid until age 18. Children who age out of the foster care system at age 18 may continue to be Medicaid eligible up to the month of their 21st birthday if they have no other medical coverage and meet income and resource guidelines. Children who are adopted from the foster care system may also be Medicaid eligible, depending on the needs of the child, until age 18.

Adults under age 65 who do not have a disability or who are not pregnant must be parents and/or related caretakers of children with income below the TANF limit to receive Medicaid benefits. Children under age 19 and pregnant women with medical bills and income over the appropriate Medicaid income limit may qualify for the Medically Needy program, also known as the Spend Down program. Spend Down is the difference between an applicant’s household

income and the Medicaid income limit ($275 per month for a family of three and assets under $2,000). Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the Spend Down program. Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after the individual is determined to be medically needy. However, applicants are not required to pay outstanding medical bills to qualify for the Spend Down program.

People Age 65 and Older and those with Disabilities

People age 65 and older and those with disabilities that do not receive SSI may qualify for Medicaid long-term services and supports through community programs while living at home or in a facility, such as a nursing facility or an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).

Dual Eligibles

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D). For dual-eligibles Medicaid pays for all or a portion of Medicare Part A and B premiums, co-insurance, and deductibles.

Full Dual Eligibles

Full dual eligibles are Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the premiums, deductibles, and co-insurance for Medicare services and may cover other Medicaid services not covered by Medicare, such as long-term services and supports. As a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Medicare assumed responsibility for most prescription drug coverage for dual eligibles in 2006. As of August 2011, there were 354,547 full dual eligible clients in Texas.[1]

Partial Dual Eligibles

Medicaid also provides limited assistance to certain Medicare beneficiaries, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. As of August 2011, there were 235,640 partial dual eligibles in Texas.[2]

Medicare Savings Programs

There are several types of programs for partial dual eligibles who meet established income and resource criteria, which are described below. Beneficiaries in these programs receive assistance with Medicare premiums, deductibles, and co-insurance payments through the Texas Medicaid program. Also, anyone who qualifies for these programs does not have to pay Medicare Part D premiums or deductibles.

Texas covers a different mix of Medicare cost-sharing assistance depending on income, resources and other restrictions (with resource limits for all categories of $6,940 per individual and $10,410 per couple).

Qualified Medicare Beneficiaries (QMB): Income no greater than 100 percent of the federal poverty level (FPL). Medicaid pays all Medicare Part A and B premiums, co-insurance and deductible amounts for services covered under both Medicare Parts A and B.

Specified Low-Income Medicare Beneficiaries (SLMB): Income less than 120 percent of FPL. Medicaid pays only Medicare Part B premiums.

Qualified Individuals (QI): Income no greater than 135 percent of FPL. Medicaid pays only Medicare Part B premiums. This program is a limited expansion of SLMB that is funded differently from SLMB or QMB. Due to the different funding, federal regulation requires Medicaid to only pay for the Medicare Part B premiums. If the individual chooses to receive QI benefits, their decision disqualifies the individual for all other Medicaid programs.

Buy-In Programs

Medicaid Buy-In Program for Workers with Disabilities

The Medicaid Buy-In (MBI) Program for Workers with Disabilities enables people with disabilities to “buy-in” to Medicaid. Individuals with income up to and including 250 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented the MBI program in September 2006.

Medicaid Buy-In for Children

The Medicaid Buy-In for Children (MBIC) program allows children up to age 19 with disabilities to “buy-in” to Medicaid. Children with family income up to 300 percent of the FPL may qualify for the program and pay a monthly premium in

order to receive Medicaid benefits. Texas implemented the MBIC program in January 2011.

Income Disregards

In certain situations, some portion of a person's income may be "disregarded" when calculating eligibility for Medicaid. A family's total income may be disregarded due to work expenses, cost of living increases, or when a child (under age 18) becomes a full-time resident of a nursing facility or an ICF/IID. In some cases, including Medicaid home and community-based waiver programs, all of the parents' income can be disregarded, and only the child's own resources/income are counted in deciding Medicaid eligibility. **Table 5.1** shows the income disregards for acute care Medicaid programs in Texas.

Table 5.1: Income Disregards for the Texas Medicaid Program, 2012[ii]

Income disregards for children, pregnant women, and TANF recipients include:

- Work-related expenses – Up to $120 per month (not to exceed the person's monthly earnings).
- Dependent care – Up to $200 per month for each child under age two and up to $175 for each dependent age two or older.
- Payments made by a Medicaid household for dependents living outside the home, alimony, and child support.
- $75 disregard for child support received by a Medicaid household.

Income disregards for the people age 65 and older and those with disabilities, and SSI recipients include:

- $20 disregard – The first $20 of any kind of income is excluded.
- Earned Income – The first $65 of earned income plus half of the remainder of earned income is disregarded.
- Certain increases in Social Security benefits for persons denied SSI.
- Veteran's Administration Aid and Attendance Allowances and Housebound Allowances.

[ii] In addition to these income disregards, certain income is exempt for purposes of determining Medicaid income eligibility. Income exemptions include tax refunds, grants, scholarships, home produce for home consumption, and infrequent or irregular income.

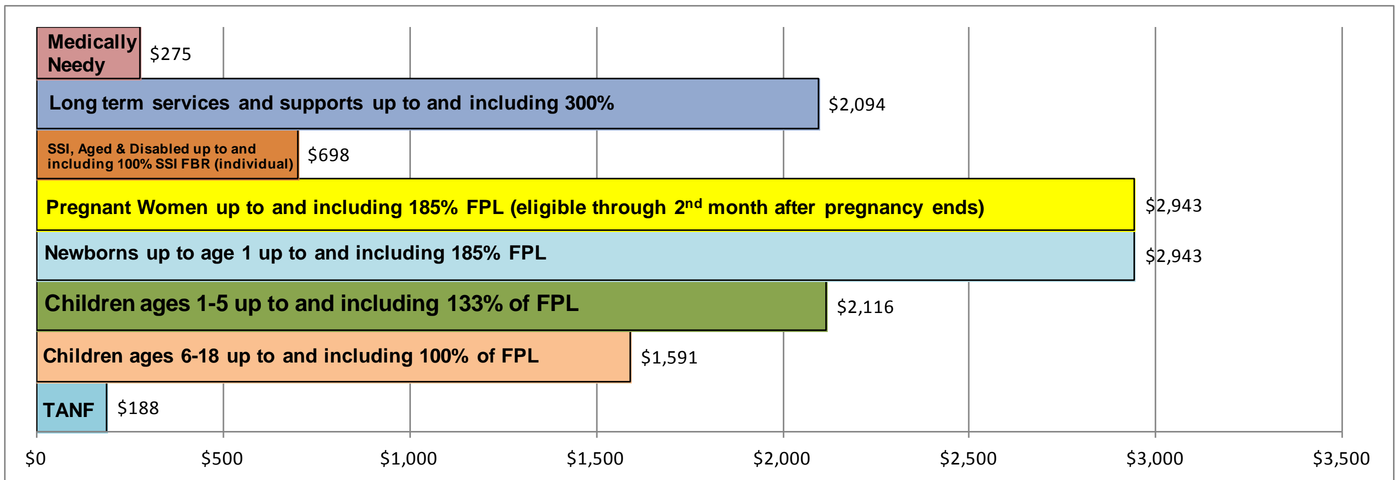
Table 5.2: Texas Medicaid Caseload by Eligibility Category SFY 2011

General Category	Eligible Category	FPL % or Income Limit	Percent of Medicaid Population
Full Medicaid Beneficiaries, n = 3,541,286			
Families and Children (Non-TANF, Non-Disability-Related)	Pregnant Women and Newborns	Up to 185%	9%
	Children 1 – 5	Up to 133%	24%
	Children 6 – 18	Up to 100%	33%
	Medically Needy	Up to $275/month	Less than 1%
Eligible Families and Children under TANF limit	TANF Adult	Up to $188/month	3%
	TANF Children (ages 0 - 19)	Up to $188/month*	9%
Aged, Medicare, and Disability-Related (Including SSI Cash Assistance)	SSI (Disability-Related) – Adult	No more than $674/month	10%
	SSI (Disability-Related) - Under 21	No more than $674/month	4%
	Aged and Medicare-Related	No more than $674/month	7%
Non-Full Medicaid Beneficiaries, n = 347,243			
Medicare-Related	Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)	Varies by program	60%
Emergency Care Only	Certain qualified aliens and Undocumented Immigrants receive full Medicaid benefits during the emergent time period.	Varies by age (based on risk categories above)	3%
Women's Health Program	Non-Pregnant Women ages 18 - 44	Up to 185%	37%

* This amount is dependent upon household size and is not the actual limit for all applicants.

Figure 5.1 shows the maximum monthly income limits for a family of three (unless otherwise specified) by eligibility category.

Figure 5.1: Medicaid Eligibility in Texas, 2012
Maximum Monthly Countable Income Limit
(family of three unless otherwise specified)



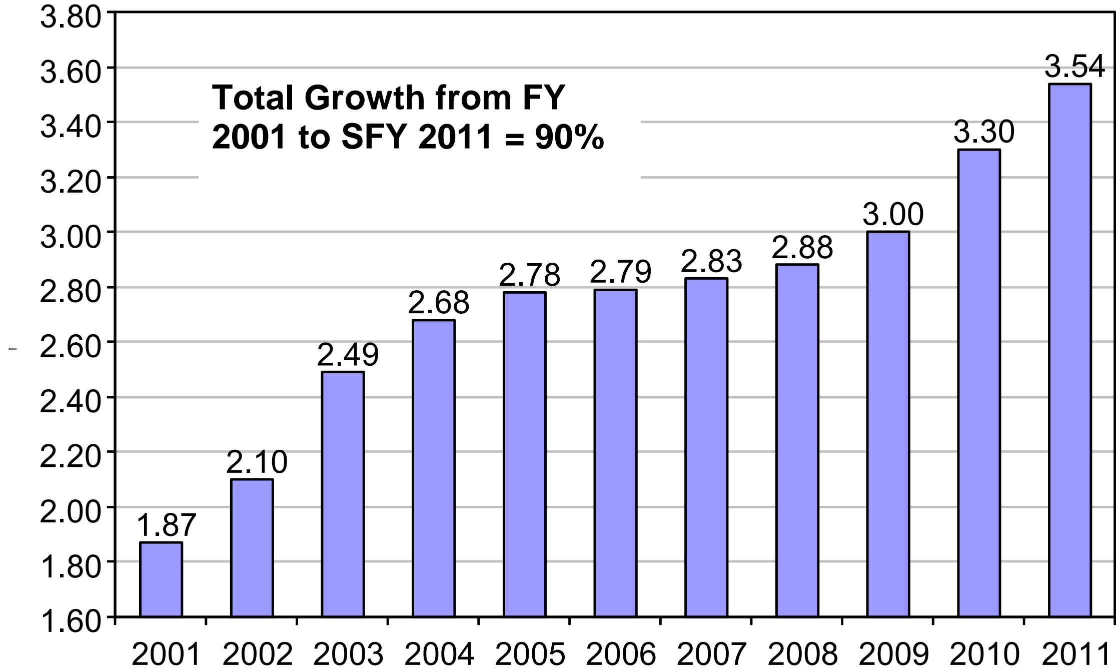
Note 1: "Countable Income" is gross income adjusted for allowable deductions, typically work-related.
Note 2: SSI does not certify families, regardless of size; it certifies individuals and couples. SSI is not tied to the Federal Poverty Level.

Size of the Medicaid Population

The number of Texas Medicaid recipients can be expressed in two ways: monthly average count and annual unduplicated count. The monthly average count is the average number of clients on Medicaid per month. This number best answers the question: "At any one time, how many individuals are enrolled in Medicaid?" The unduplicated count is the total number of individual Texans who received Medicaid-funded services over a period of time. People may gain and lose Medicaid eligibility at various points during a year. For example, eligibility status can change due to parent or caretaker income changes, a child reaching adulthood, or after childbirth. Since all clients may not remain eligible for all months of a year, the monthly average count is lower than the unduplicated count.

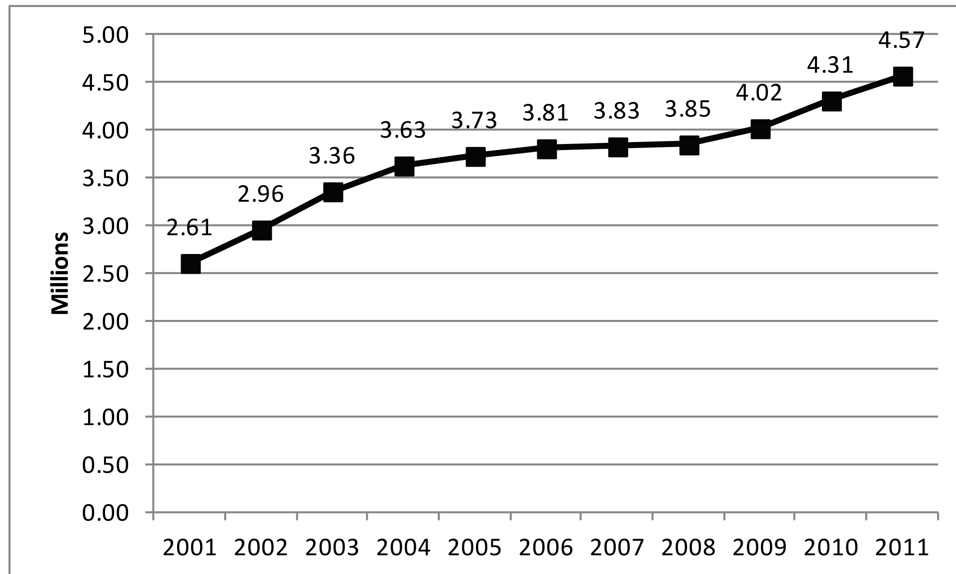
The monthly average for clients with full benefits in SFY 2011 was 3,531,381. **Figure 5.2** shows the growth in average clients per month from 2001 through 2011.

Figure 5.2: Average Monthly Medicaid Enrollment SFYs 2001 - 2011



Source: HHSC, Financial Services, HHS System Forecasting.
Note: Average monthly Medicaid clients include the average number of clients in each month of the SFY. The average monthly clients will always be a smaller number than the unduplicated clients, as clients come and go from the system.

Figure 5.3: Unduplicated Number of Texas Medicaid Recipients SFYs 2001-2011



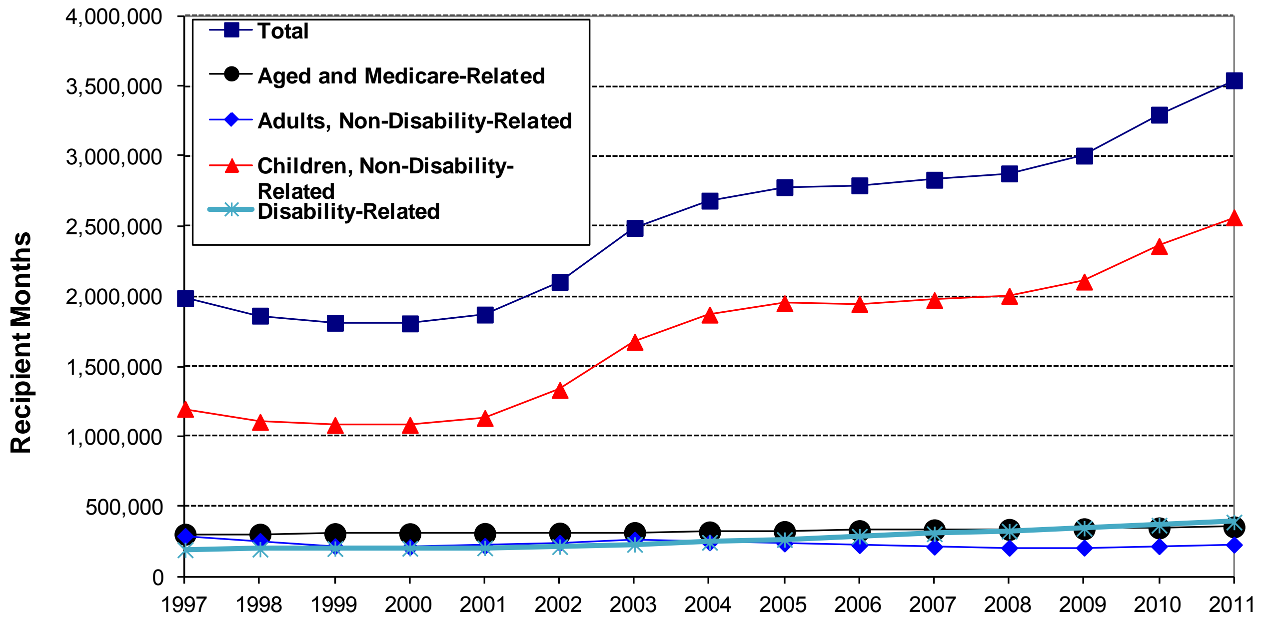
Source: HHSC Strategic Decision Support.
Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Changing Caseloads

Economic factors, the availability of other types of insurance and federal changes to Medicaid law and regulations affect the state's Medicaid program. Because these factors are always changing, the number of people on Medicaid (called the caseload) is always changing.

Figure 5.4 shows changes in the Texas Medicaid caseload from 1997 to 2011.

Figure 5.4: Texas Medicaid Caseload (Average Recipient Months)



Source: HHSC, Financial Services.

Unemployment

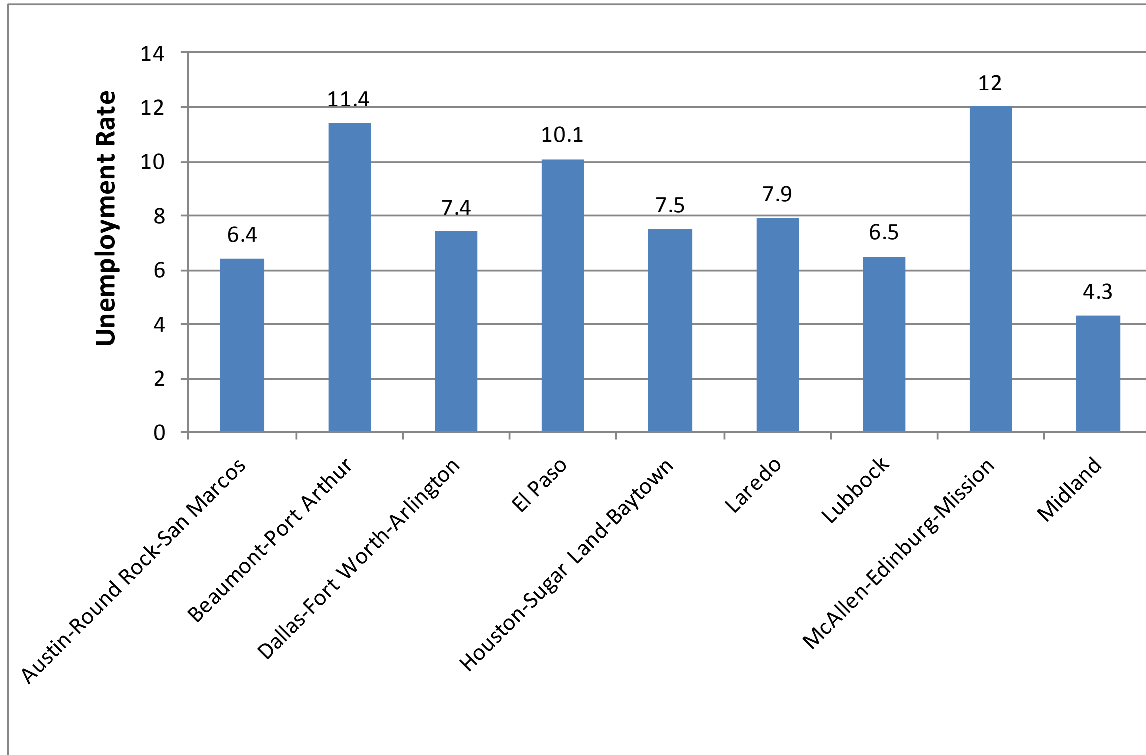
Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid due to their income level.

In June 2012, Texas' seasonally adjusted unemployment rate was 7.0 percent, which was lower than the national rate of 8.2 percent. The percentage of working-age persons (ages 16 through 64) in Texas who had a job in June 2012 was 67 percent.

The unemployment rate varies among regions of the state. In June 2012, the Metropolitan Statistical Area (MSA) with the lowest unemployment rate was Midland, with a rate of 4.3 percent. The highest unemployment rate was in the McAllen-Edinburg-Mission MSA, with a rate of 12.0 percent.[3]

Figure 5.5 illustrates the unemployment rates in selected areas of the state.

Figure 5.5: Unemployment Rates in Selected Texas Metropolitan Areas, June 2012



Source: Texas Workforce Commission.

Medicaid Demographics

Disability

Most likely, with the gradual aging of the population comes an increase in the number of people with a disability or other chronic health condition, which can cause difficulties in performing basic activities of daily living and functions, such as working, bathing, dressing, cooking, and driving. People with disabilities or chronic health conditions are more likely to need and use health and human services, so this trend could mean increased demand for the Texas Health and Human Services (HHS) agencies. The American Community Survey (ACS) for Texas, which is conducted by the U.S. Census Bureau, indicates that in 2010 there were approximately three million, or 12 percent of all Texans, who lived with a disability. Among adults aged 18-64, the ACS reports that 10.5 percent had a disability in 2010. Among adults aged 65 and older, the ACS reports that 42.3 percent live with a disability.

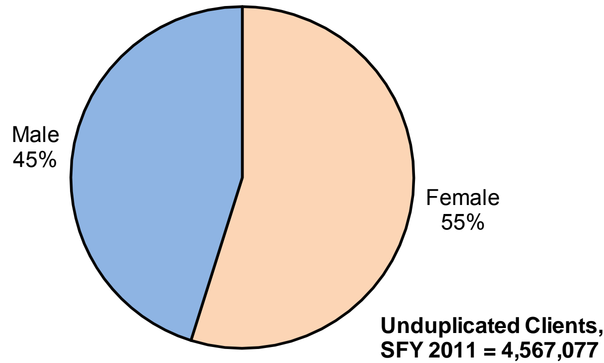
As of SFY 2011, about 13 percent of the people (children and adults) receiving Texas Medicaid services became eligible because of a disability. These clients may have been receiving Medicaid for a number of years, and, if they became eligible through a waiver program, may not receive SSI cash assistance. The proportion of disability-related clients likely understates the actual frequency of disabling conditions among Texans in the Medicaid program, because many people age 65 and older also have a disability, but are classified as part of the elderly Medicaid population rather than as Medicaid clients with disabilities.

Gender

Figure 5.6 shows Medicaid client population by gender. Texas Medicaid clients are disproportionately female, for several reasons:

- The poverty rate is slightly higher among women than men. For example, in 2010 the poverty rate for women in Texas was 19 percent while the rate for men was 18 percent.[4]
- Women live longer, on average, and the rate of poverty among women in Texas age 65 and older is higher than among their male counterparts (13 percent versus 6 percent in 2010).[5]
- TANF-related coverage targets poor single-parent families, which in Texas are usually female-headed (92 percent in August 2012). Female-headed single-parent families in Texas have higher poverty rates than their male-headed counterparts (39 percent versus 13 percent in 2010).[6]
- Medicaid covers eligible low-income women for pregnancy-related services.
- Medicaid covers eligible low-income women who are not currently receiving full Medicaid benefits for family planning services through the Women's Health Program (WHP).
- Medicaid covers eligible low-income women with a qualifying breast or cervical cancer under the Medicaid for Breast and Cervical Cancer Program (MBCC).

Figure 5.6: Texas Medicaid Recipients by Gender SFY 2011

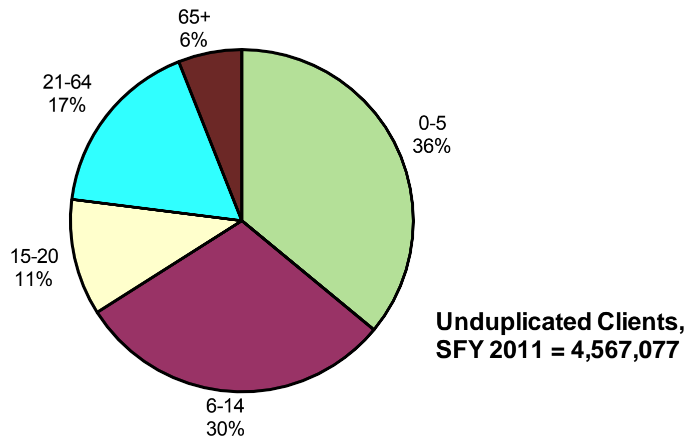


Source: HHSC, Strategic Decision Support. Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Age

Figure 5.7 shows the age groups of clients receiving Texas Medicaid at some point during SFY 2011. Children and persons age 65 and older make up 83 percent of the program's clients. Seventy-seven percent of the program is comprised of people under age 21, and 66 percent are age 14 or younger.

Figure 5.7: Texas Medicaid Recipients by Age SFY 2011

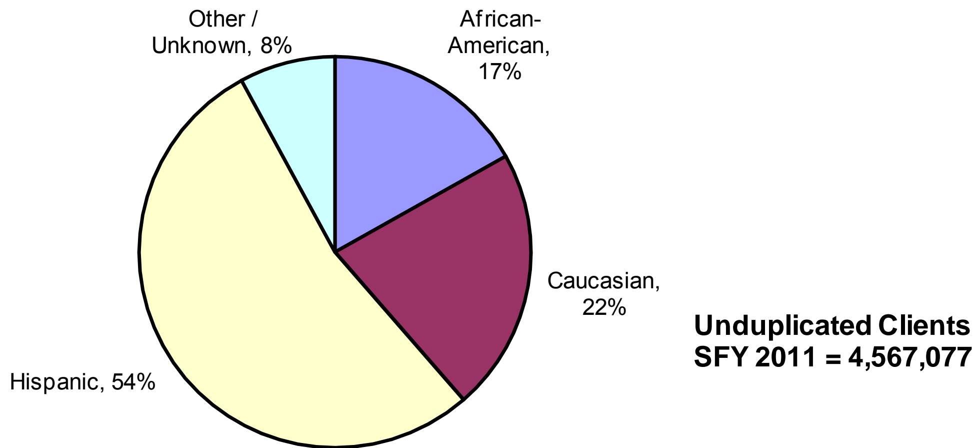


Source: HHSC Strategic Decision Support. Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Ethnicity

Figure 5.8 shows the ethnicity of clients receiving Medicaid at some point during SFY 2011. Hispanics account for the largest portion of Medicaid clients, comprising 54 percent of the Medicaid population. African-American and Hispanic Texans comprise higher percentages of the Medicaid population than of the general population.

Figure 5.8: Texas Medicaid Recipients by Ethnicity SFY 2011



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

Poverty

Since Medicaid primarily serves low-income individuals, poverty in the state affects the number of people eligible for the Medicaid program. In 2010, about 4.6 million Texans (18.4 percent of the state's population) lived at or below the federal poverty level, and approximately 41 percent of these were children under age 18. Approximately 27 percent of all Texas children under age 18 were living at or below the federal poverty level in 2010.[7] Approximately 29 percent of Hispanics and 23 percent of African-Americans in Texas were living at or below the poverty level in 2010, along with 8 percent of Caucasians.

Federal Poverty Level

The federal government sets poverty thresholds, called the federal poverty level (FPL), for different family sizes. The U.S. Department of Health and Human Services annually develops simplified guidelines based on those thresholds. The annual updates include adjustments for inflation and are not changed in real dollar terms. In other words, the 2012 federal poverty guideline of $23,050 for a family of four represents the same purchasing power as the 1963 value of $3,100 for a family of this size.[8] **Table 5.3** lists FPLs by family size for 2010-2012.

Table 5.3: Federal Poverty Guidelines, 2010-2012
(For the 48 Contiguous States)

Size of Family Unit	Annual Income		
	2010	2011	2012
1	$10,830	$10,890	$11,170
2	$14,570	$14,710	$15,130
3	$18,310	$18,530	$19,090
4	$22,050	$22,350	$23,050
5	$25,790	$26,170	$27,010
6	$29,530	$29,990	$30,970
7	$33,270	$33,810	$34,930
8	$37,010	$37,630	$38,890
For each additional person, add	$3,740	$3,820	$3,960

Source: U.S. Department of Health and Human Services, HHS Poverty Guidelines, http://aspe.hhs.gov/poverty/ (October 2012).

Federal Medical Assistance Percentage

The poverty rate also affects Medicaid through the federal medical assistance percentage (FMAP) rate. The FMAP rate is derived from each state's average per capita income. As the state's per capita income increases in relation to the national per capita income, the federal match rate decreases. The federal fiscal year (FFY) 2013 FMAP rate of 59.30 percent is a slight increase from Texas' FFY 2012 FMAP rate of 58.22 percent.

Table 5.4 shows Texas' FMAP and Enhanced FMAP (used for CHIP federal match) percentages for FFYs 1998-2014.

Table 5.4: Texas Federal Medical Assistance Percentages FFYs 1998-2014

Federal Fiscal Year	Federal Medical Assistance Percentage	Enhanced Federal Medical Assistance Percentage	American Reinvestment and Recovery Act (ARRA) Enhanced FMAP[iii]
1998	62.28%	73.60%	N/A
1999	62.45%	73.72%	N/A
2000	61.36%	72.95%	N/A
2001	60.57%	72.40%	N/A
2002	60.17%	72.12%	N/A
2003	59.99%	71.99%	N/A
2004	60.22%	72.15%	N/A
2005	60.87%	72.61%	N/A
2006	60.66%	72.46%	N/A
2007	60.78%	72.55%	N/A
2008	60.56%	72.39%	N/A
2009	59.44%	71.61%	69.03%
2010	58.73%	71.11%	70.94%
2011	60.56%	72.39%	66.46%
2012	58.22%	70.75%	N/A
2013	59.3%	71.51%	N/A
2014	58.69%	71.08%	N/A

Births in Texas

The number of births reported in Texas has seen a slight decrease in recent years, and the proportion of births paid by Medicaid in SFY 2011 is 56.4 percent.

Table 5.5 shows the births in Texas by ethnicity and percent Medicaid paid from Calendar Years (CYs) 2005-2009 the most recent data available.

[iii] The American Recovery and Reinvestment Act (ARRA) (P.L. 111-5) temporarily increased the FMAP from October 2008 through December 2010.

A substantial percentage of all live births in Texas are attributed to Hispanic women. The proportion of all births attributable to Hispanic mothers has steadily increased from 37 percent of all births in 1990 to 50.1 percent of all births in 2009. During that same period, the proportion of births to African-American mothers peaked at 14 percent in 1990, but has decreased to 11.3 percent in 2009. In 2009, 5.6 percent of African-American births and 6.5 percent of Hispanic births were to mothers under 18 years of age. In contrast, of all Caucasian births, 2.1 percent were to mothers under age 18. **Table 5.6** illustrates the percent distribution of births in CY 2009 according to age of the mother by race/ethnicity. The data show that in Texas, Hispanic and African-American women under the age of 20 are more likely to become young mothers than Caucasian women.

Table 5.5: Births in Texas, CYs 2005-2009

	2005	2006	2007	2008	2009
Births	385,537	399,309	407,453	405,242	401,599
% Hispanic	49.7%	49.6%	50.2%	50.1%	50.1%
% Caucasian	35.5%	34.7%	34.1%	34.1%	33.9%
% African American	11.0%	11.5%	11.3%	11.3%	11.3%
% Other	3.8%	4.2%	4.4%	4.6%	4.7%
% Medicaid Paid	55.8%	55.9%	56.0%	55.4%	55.9%

Source: Texas Department of State Health Services, Texas Health Data. HHSC, Financial Services.

Table 5.6: Percent Distribution of Live Births in Texas by Mother's Age and Ethnicity, CY 2009

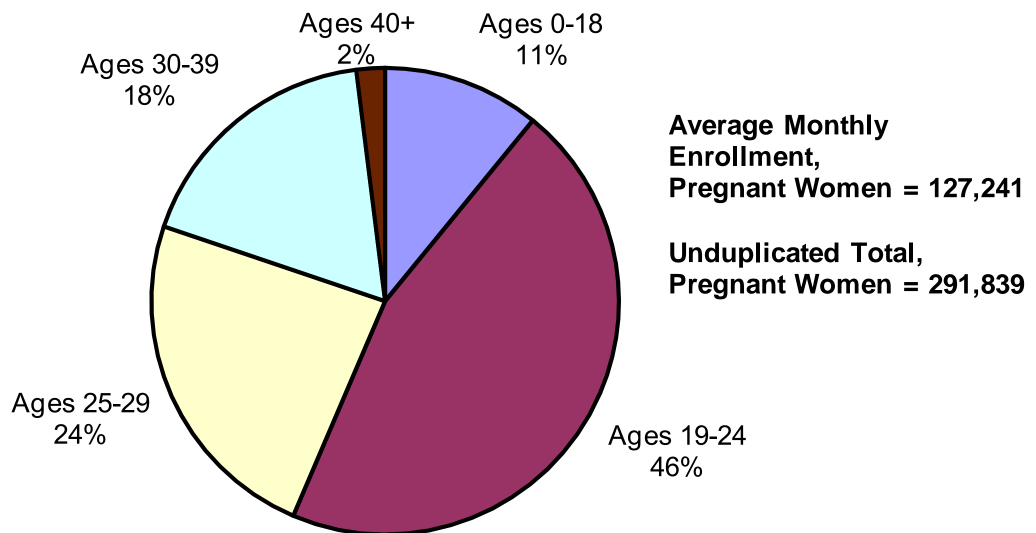
Age	Hispanic	Caucasian	African American	Other	All
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%
10 to 14	0.3%	0.0%	0.4%	0.0%	0.2%
15 to 17	6.2%	2.1%	5.2%	0.9%	4.5%
18 to 19	10.4%	6.2%	10.8%	2.0%	8.6%
20 to 29	54.8%	54.0%	58.2%	39.6%	54.2%
30 to 39	26.5%	35.2%	23.6%	53.7%	30.4%
40 plus	1.8%	2.5%	1.8%	3.8%	2.2%

Source: Texas Department of State Health Services, Texas Health Data.

Age of Pregnant Women

Figure 5.9 shows the number of pregnant women served by the Texas Medicaid program in SFY 2011 by age group. Almost one-half (46 percent) of the pregnant women in the Texas Medicaid program are between the ages of 19 and 24, while 11 percent are under age 19. While private insurance companies can no longer exclude pregnant women seeking health insurance, many young pregnant women are less likely to be able to afford insurance. They are also more likely to work at low-level jobs that do not provide health coverage. The Texas Medicaid program extends pregnancy-related coverage to women with incomes up to 185 percent of FPL ($34,281 for a family of three in 2011).

Figure 5.9: Pregnant Women on Medicaid in Texas by Age Group SFY 2011

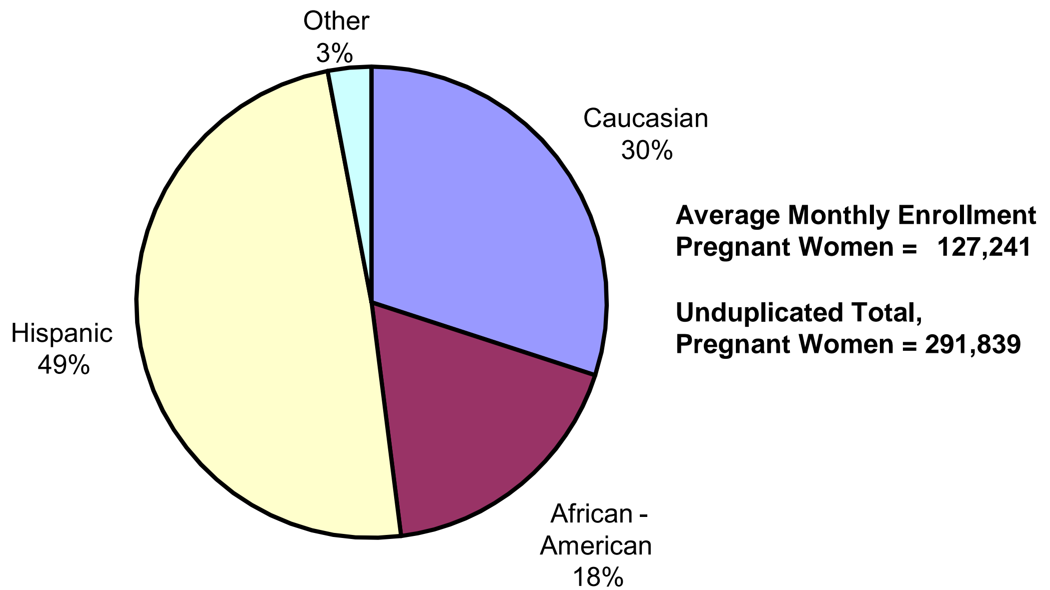


Source: HHSC, Strategic Decision Support.

Ethnicity of Pregnant Women

Figure 5.10 shows the ethnicity of pregnant women served by the Texas Medicaid program in SFY 2011.

Figure 5.10: Pregnant Women on Medicaid in Texas by Race/Ethnicity SFY 2011



Source: HHSC, Strategic Decision Support.

Endnotes

[1] HHSC, *Monthly MMA Dual Eligible Counts*.

[2] HHSC, *Monthly MMA Dual Eligible Counts*.

[3] Texas Workforce Commission, http://www.twc.state.tx.us/ (October 2012).

[4] U.S. Census Bureau, "Current Population Survey for Texas," March 2011.

[5] U.S. Census Bureau, "Current Population Survey for Texas," March 2011.

[6] U.S. Census Bureau, "Current Population Survey for Texas," March 2011.

[7] U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement," 2011. Data analysis done by staff of the Texas Health and Human Services Commission.

[8] *Federal Register*, Vol. 77, No. 17, January 26, 2012, pp. 4034-4035.

Chapter 6: Medicaid Benefits

Medicaid covers a diverse array of medical and long-term services and supports.

Medicaid Benefits

The Social Security Act specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. **Table 6.1** displays the current set of benefits covered by the Texas Medicaid program.

Federal law allows states to define what constitutes reasonably sufficient amount, duration, and scope of Medicaid benefits. This means that state Medicaid programs can, for example, limit the number of visits per year for a certain service or limit a service to outpatient settings.

Limits on Texas Medicaid services include:

- A 30-day annual limit for adults on inpatient hospital stays per spell of illness. More than one 30-day hospital visit can be paid for in a year, if stays are separated by 60 or more consecutive days. The annual limit does not apply to State of Texas Access Reform (STAR) enrollees or for a prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. This exception allows an additional 30 days of inpatient care that begins with the date of the transplant. There is no limit on inpatient behavioral health services for individuals enrolled in STAR+PLUS.
- Three prescriptions per month for adults in fee-for-service (FFS). This applies to outpatient drugs. Family planning drugs are exempt from the three drug limit. There are no limits on drugs for children under age 21, adults enrolled in managed care, clients in nursing facilities, or clients enrolled in certain 1915(c) waiver programs.

These limits are not applicable for children under 21 whenever there is a medical necessity for additional services.

Table 6.1: Mandatory and Optional Services Covered by Texas Medicaid

The state may choose to provide some, all, or no optional services specified under federal law. Some optional services Texas chooses to provide are available only to clients under age 21, and one optional inpatient service is available for clients who are under 21 or are 65 or over in an institution for mental disease (IMD). *Note: If the client is under age 21, all federally allowable and medically necessary services must be provided as required under federal law.*

Mandatory and optional services provided in Texas include:

<table>
<tr><th colspan="2">Acute Care Services</th></tr>
<tr><td>Mandatory
• Inpatient hospital services
• Outpatient hospital services
• Laboratory and x-ray services
• Physician services
• Medical and surgical services provided by a dentist
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21
• Family planning services and supplies
• Federally qualified health centers
• Rural health clinic services
• Nurse midwife services
• Certified pediatric and family nurse practitioner services
• Home health care services</td>
<td>Optional*
• Prescription drugs
• Medical or remedial care furnished by other licensed practitioners:
  o Physician extenders
    o Nurse practitioners/certified nurse specialists
    o Certified registered nurse anesthetists
    o Physician assistants
  o Mental health providers
    o Psychology
    o Licensed professional counselors
    o Licensed marriage and family therapists
    o Licensed clinical social workers**
• Podiatry***
• Limited chiropractic
• Optometry, including eyeglasses and contacts
• Hearing instruments and related audiology
• Renal dialysis
• Rehabilitation and other therapies
  o Mental health rehabilitation
  o Rehabilitation facility services
  o Substance use disorder treatment
  o Physical, occupational, and speech therapy
• Clinic services
  o Maternity service clinics
• Targeted case management for pregnant women</td></tr>
</table>

Table 6.1: Mandatory and Optional Services Covered by Texas Medicaid (Continued)

Long-Term Services and Supports (LTSS)	

Mandatory
• Nursing facility (NF) services for clients 21 or over
	Optional*
	• Intermediate Care Facility services for an Individual with Intellectual Disability or Related Conditions (ICF/IID)
	• Inpatient services for clients 65 and over in an institution for mental diseases (IMD)
	• Services furnished under a Program of All-Inclusive Care for the Elderly (PACE)
	• Day Activity and Health Services
	• Home and community-based waiver services
	• Attendant services
	  o Primary Home Care
	  o Community Attendant Services
	• Targeted case management for individuals with intellectual disabilities and mental health conditions
	• Hospice services

Notes:
*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.
**Except when delivered in a federally qualified health center (FQHC) setting.
***Except when delivered by an M.D. or D.O.

Coverage for Children

Children with Medicaid coverage are eligible to receive a broader array of health care services than commercial health insurance policies or Medicaid services for adults. Medicaid for children provides certain health care services including long-term physical, occupational, and speech therapies, and comprehensive dental services.

Texas Health Steps

EPSDT, known in Texas as Texas Health Steps (THSteps), provides medical and dental prevention and treatment services for children of low-income families from birth through age 20. THSteps' mission is to provide preventive medical and dental care to Medicaid children to allow early treatment of any identified

problems. THSteps offers comprehensive and periodic screening of children, adolescents, and young adults' physical, developmental, mental health, and nutritional status, as well as vision, hearing, and dental screenings and care.

The foundation of THSteps is preventive health care checkups. The medical checkup is preferably conducted by a primary care provider, or "medical home," and the dental checkup is preferably conducted by a primary dental care provider or "dental home." Medical and dental home providers have accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to the child, including referrals to other health care providers as necessary. Medicaid providers, such as physicians, dentists, advanced practice nurses, school clinics, migrant health clinics, and other community clinics such as Federally Qualified Health Centers (FQHCs) enroll specifically as a THSteps provider of medical and dental checkups and treatment.

THSteps medical and dental checkups are provided periodically. The interval between scheduled medical checkups depends on the child's age. More medical checkups are scheduled for the birth through two years of age population and annual checkups are indicated for children ages three through 20. A THSteps medical checkup includes:

- Medical history,
- A complete physical examination,
- Screening of nutritional, developmental, and mental-health needs,
- Age appropriate laboratory tests (including lead screening),
- Routine immunizations,
- Health education,
- Vision and hearing screening,
- Oral health screening and referral to a dental home, and
- Referrals to other health care providers as needed.

In addition to a medical checkup, children are referred to a dentist at six months of age and every six months thereafter until a dental home has been established.

Families receiving Temporary Assistance for Needy Families (TANF) benefits may lose cash assistance for failing to take their children to regularly scheduled THSteps medical checkups and/or failing to keep their children's immunizations current. This sanction applies until the family is in compliance with THSteps medical checkups and immunization requirements.

THSteps provides periodic dental checkups and preventive care for children six months through 20 years of age. The intervals between dental checkups depend

on the child's age and risk for dental disease. THSteps supports the initiative to reach children with preventive oral health screening and care at the earliest appropriate age (six months) and to establish a dental home for them. The objective is to identify those at high risk for developing dental disease, start preventive services, treat decay early, and educate families about the importance of good oral health habits. More frequent dental checkups are available for children 6 through 35 months of age with semi-annual checkups available for children, adolescents and young adults 3 through 20 years of age. Recipients or their caretakers may self-refer for dental care at any time and any age from birth through 20 years of age.

THSteps services include more than the provision of medical and dental checkups. THSteps outreach staff provide coordinated services to expand family awareness of health services, increase use of preventive services, and help families obtain comprehensive services available through a network of private and public providers.

Table 6.2 highlights THSteps program services and outreach activities.

Table 6.2: THSteps Program Highlights and Outreach Activities

Services provided in 2011:

- 1,845,144 THSteps eligible recipients received at least one initial or periodic medical checkup.
- 64 percent of population eligible for services received services.
- At least one preventive dental service was provided to 1,731,603 children.
- Therapeutic dental services were provided to 1,163,311 recipients.

Outreach and Education:

THSteps operates an outreach program designed to contact the parents and caretakers of children receiving Medicaid to inform them of the benefits under the program, including:

- The value of using preventive health services and reinforcing the concept of the medical home and dental home.
- How to effectively access and use the medical, dental, and case management care systems.
- How to use the medical transportation system and other related services available to them (e.g., Women, Infants and Children (WIC), immunizations, and Children's Health Insurance Program (CHIP).

Table 6.2: THSteps Program Highlights and Outreach Activities (Continued)

To promote the efficient and effective use of THSteps, THSteps program staff proactively liaison with related children's health programs and agencies such as: • Head Start. • Independent school districts. • Institutions of higher education. • Other state programs such as Immunizations, Childhood Lead Poisoning Prevention Program (CLPPP), Children with Special Health Care Needs Services Program (CSHCN), WIC, Maternal and Child Health, and Early Childhood Intervention (ECI). • Community-based organizations. • Medical, dental, and case management providers and their professional organizations.

Source: CMS-416 Annual EPSDT, State Fiscal Year (SFY) 2011.

Federal changes made in the Omnibus Reconciliation Act of 1989 (OBRA 89) expanded Medicaid services and EPSDT/THSteps services in particular. Under OBRA 89, children and youth younger than age 21 are eligible for any medically necessary and appropriate health care service that is covered by Medicaid, regardless of the limitations of the state's Medicaid program. The state is responsible for defining the phrase "medically necessary and appropriate." In Texas, this expanded benefits portion of THSteps is known as the Comprehensive Care Program (CCP). THSteps-CCP services include benefits which were not available to children before OBRA 89, including, but not limited to:

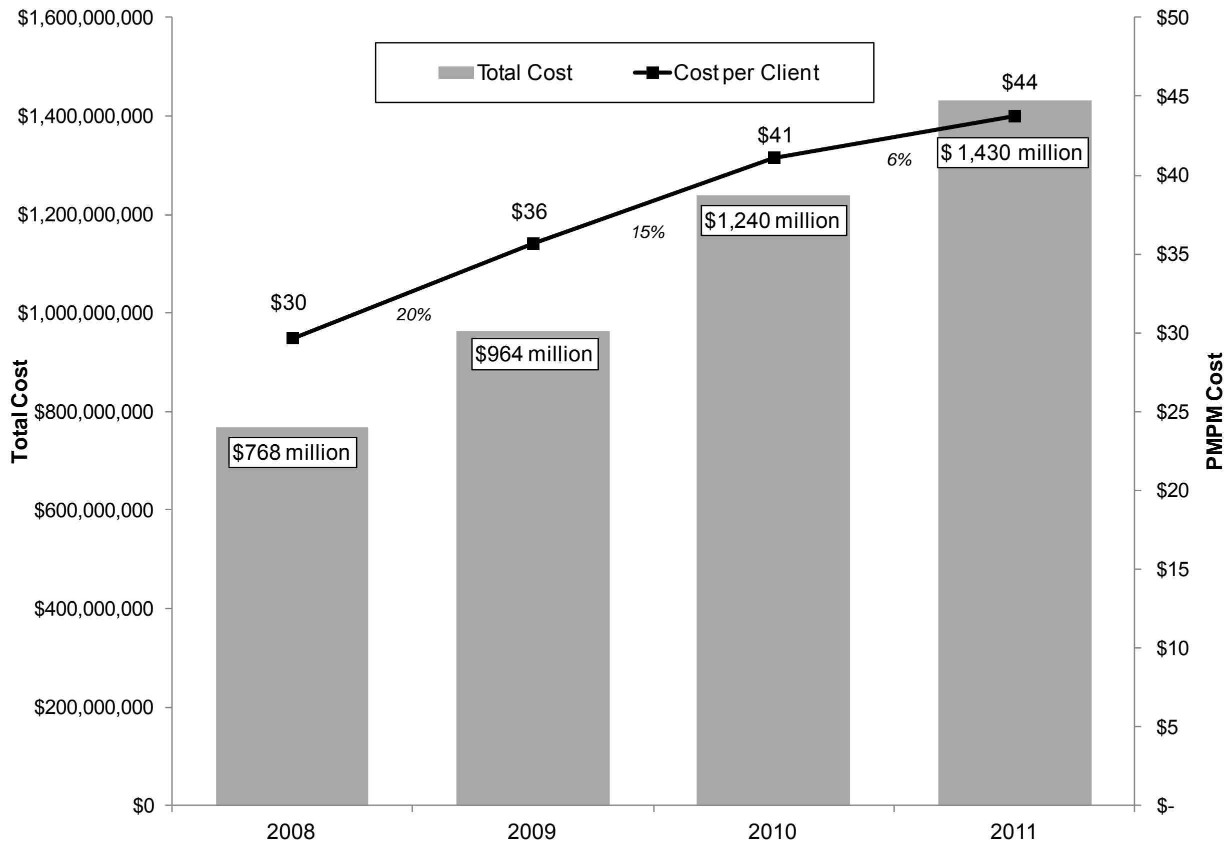
- Treatment in freestanding psychiatric hospitals,
- Oral health care,
- Developmental speech therapy,
- Developmental occupational therapy, and
- Private duty nursing.

THSteps Spending

THSteps medical and CCP service costs are included in capitated managed care organization (MCO) rates for children enrolled in managed care. Children not in capitated managed care or children receiving retroactive coverage have their medical and CCP costs paid through Medicaid FFS. All THSteps dental costs for children were paid through FFS until the inclusion of dental services in managed care on March 1, 2012.

Figure 6.1 shows the total dental (and orthodontic) THSteps costs and the cost per client from 2008–2011. From 2008 to 2009, there was a 20 percent increase in the “per member per month” (PMPM) cost. From 2009 to 2010, the PMPM increase was 15 percent, and a 6 percent increase in 2011. Overall, cost for dental services has risen from $30 PMPM in 2008 to $44 PMPM in 2011.

Figure 6.1: Total Cost and Cost per Recipient Month, Medicaid Dental Services SFYs 2008 – 2011



Source: HHSC, Financial Services, HHS System Forecasting.

Frew, et al. v. Janek, et al.

Filed in 1993, *Frew*, et al. v. Janek, et al. (commonly referred to as *Frew*), was brought on behalf of children birth through age 20 enrolled in Medicaid and eligible for the EPSDT benefit. The class action lawsuit alleged the Texas EPSDT program did not meet the requirements of the federal Medicaid Act.

The Texas EPSDT program, known as THSteps, provides comprehensive and preventive medical and dental services for children through age 20 enrolled in Medicaid.

The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996.[i] The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor the agencies' compliance with the orders and enforce the orders if necessary. Since entering the decree, the court has found the state defendants in violation of several of the decree's sections.

In 2007, the parties agreed to 11 corrective action orders[ii] to bring the state into compliance with the consent decree and increase access to THSteps' services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to assure access to Medicaid services for children. These include specific outreach, informing, and training of health care providers. The Texas Medicaid program must consider these obligations in all policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

Since 2007, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) have actively worked to meet the requirements of each of the corrective action orders. The 80th Texas Legislature, Regular Session, 2007, appropriated an estimated $1.8 billion all funds, including $706.7 million in general revenue (GR) funds, for the 2008-09 biennium to allow the agencies to implement required activities.

As an example, in September 2007, HHSC increased rates for services provided to *Frew* class members[iii] by Medicaid-enrolled physicians, physician specialists, dentists, dental specialists, and certain other professionals. The *Frew* orders do not require a specific level for Medicaid rates. However, the orders do include requirements regarding access to care, and that provider rates be sufficient to enlist enough providers to meet the needs of Medicaid recipients.

The 2007 corrective action orders also required the agencies to implement strategic initiatives intended to expand access to care for children on Medicaid.

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[i] The Consent Decree is available on the HHSC website at: http://www.hhsc.state.tx.us/medicaid/frew/consent-decree.shtml.

[ii] The Corrective Action Orders are available on the HHSC website at: http://www.hhs.state.tx.us/MotionCorrectiveActions/index.shtml.

[iii] The *Frew* class includes all children, from birth through age 20, who are enrolled in Medicaid.

The 80th Legislature, Regular Session 2007, appropriated $150 million to be applied toward strategic initiatives in 2008-2009. The 81st Legislature, Regular Session, 2009, authorized use of unexpended funds for the 2010-2011 biennium. The state implemented 22 strategic initiatives. The 82nd Legislature, Regular Session, 2011, provided funding for continuation of 13 of these initiatives as part of Medicaid client services or agency administrative services.

HHSC and DSHS remain bound by both the consent decree and the corrective action orders. The court continues to monitor the agencies' compliance with the orders. The consent decree does not have a specific end date, although the corrective action orders are intended to create potential endpoints for the agencies' obligations.

Alberto N. v. Janek

The federal lawsuit *Alberto N.,* et al. v. Janek requires HHSC to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for THSteps-CCP. These services include personal care services (PCS), nursing services, durable medical equipment (DME), and other Medicaid-covered services that are deemed medically necessary.

HHSC transferred personal care services for THSteps-CCP beneficiaries from the Department of Aging and Disability Services (DADS) to HHSC on September 1, 2007. Case managers with DSHS assess THSteps-CCP beneficiaries to determine eligibility for and the amount of PCS to be authorized. PCS are support services provided to a THSteps-CCP beneficiary who requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADL), and health-related functions due to physical, cognitive, or behavioral limitations related to the beneficiary's disability or chronic health condition.

The *Alberto N.* agreement required HHSC to develop and implement a new assessment instrument to further improve access to care for THSteps-CCP beneficiaries. Under a contract with HHSC, the Texas A&M University System Health Science Center's School of Rural Public Health and Texas A&M University's Public Policy Research Institute developed the Personal Care Assessment Form (PCAF). The PCAF was implemented on September 1, 2008. The PCAF provides DSHS case managers with a reliable and valid instrument with which to develop appropriate service plans for children and to identify a

child's need for other medically necessary services, such as physical, occupational, and speech therapies; nursing; and DME.

Programs for Women and Children

Case Management for Children and Pregnant Women Services

Case Management for Children and Pregnant Women Services provides health-related case management services to eligible children and high-risk pregnant women. Case Management for Children and Pregnant Women providers are licensed social workers or registered nurses working as individuals or employed by schools, health departments, counseling agencies, health clinics, and other types of agencies. Providers are approved through DSHS and enrolled with the Texas Medicaid claims administrator as Medicaid providers. Case Management for Children and Pregnant Women services include assessing the needs of eligible clients, formulating a service plan, making referrals, problem solving, advocacy, and follow-up regarding client and family needs.

Eligibility

Medicaid eligible children (birth through age 20) with a health condition or health risk qualify for Case Management for Children and Pregnant Women Services. Health condition or health risk is defined as a medical condition, illness, injury, or disability that results in limitation of function, activities, or social roles in comparison with same age peers in the general areas of physical, cognitive, emotional, or social growth and development. There must also be a need for services to prevent illness or medical conditions, to maintain function or to slow further deterioration of the condition, and a desire for health-related case management services.

Medicaid eligible pregnant women with a high-risk condition during pregnancy qualify for Case Management for Children and Pregnant Women Services. There must also be a need for services to prevent illness or medical conditions, to maintain function or to slow further deterioration of the condition, and a desire for health-related case management services. Case Management for Children and Pregnant Women case managers submit requests to DSHS for determination of eligibility for case management services.

Medicaid Buy-In for Children

Senate Bill (S.B.) 187, 81st Legislature, Regular Session, 2009, directed HHSC to implement a Medicaid buy-in program for children (up to age 19) with disabilities and family income up to 300 percent of the federal poverty level (FPL). Children in the Medicaid Buy-In program may receive FFS Medicaid or opt into managed care. Families in this program “buy in” to Medicaid by making monthly payments according to a sliding scale that is based on family income. If a payment is missed, the client has a 60-day grace period to pay the premium before they are disenrolled from the program. Premiums are waived for a three-month period if an income hardship is submitted and approved or due to a federally declared disaster. Federal law requires that a parent enroll in an employer-sponsored health insurance plan if their employer offers family coverage under a group health plan and pays at least 50 percent of the total cost of annual premiums. The Medicaid Buy-In for Children program was implemented January 1, 2011.

Texas Women’s Health Program

The Texas Women’s Health Program (TWHP) is a state-funded program that provides eligible Texas women with preventive health care, screenings, contraceptives and treatment for certain sexually transmitted diseases (STDs).

S.B. 747, 79th Legislature, Regular Session, 2005, directed HHSC to establish a five-year Medicaid demonstration project to expand access to women’s preventive health care services. After receiving approval from the federal government, HHSC established the Medicaid Women’s Health Program (WHP) on January 1, 2007.

As required by the 2012-13 General Appropriations Act (GAA) (Article II, HHSC, Rider 62, House Bill (H.B.) 1, 82nd Legislature, Regular Session, 2011), HHSC pursued a renewal of the WHP waiver program beyond its December 31, 2011 expiration date. However, S.B. 7, 82nd Legislature, First Called Session, 2011, directed HHSC to ensure that any funds spent for purposes of the Medicaid WHP or a successor program is not used to perform or promote elective abortions or to contract with an entity that performs or promotes elective abortions or that affiliates with entities that perform or promote elective abortions.

To implement this statutory requirement, HHSC adopted new rules effective March 14, 2012 barring from participation in WHP any provider that performs or promotes elective abortions or that affiliates with another entity that performs or

promotes elective abortions. Citing the adoption of these rules, the federal government denied the state's request to extend the demonstration waiver.

To prevent the loss of this program for Texas women, Governor Perry directed HHSC to transition the Medicaid program to one that is state-funded.

The program transitioned to state funding on January 1, 2013.

TWHP is for women who meet the following qualifications:

- Are ages 18 through 44 (Women can apply the month of their 18th birthday through the month of their 45th birthday),
- Are U.S. citizens or qualified immigrants,
- Reside in Texas,
- Are not eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B,
- Are not pregnant,
- Are not sterile, infertile, or unable to get pregnant due to medical reasons,
- Do not have private health insurance that covers preventive health services (unless filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent or other person), and
- Have a net family income at or below 185 percent FPL. For example, the monthly net income for a woman in a family of two cannot exceed $2,333.[iv]

Benefits for eligible participants include:

- Annual family planning exam, which may include screening for diabetes, STDs, high blood pressure, cholesterol, tuberculosis, breast and cervical cancers, and other health issues,
- Follow-up visit, if related to a contraceptive method,
- Counseling on family planning methods, including abstinence,
- Birth control, except emergency contraception,
- Female sterilization, and
- Treatment for certain STDs.

There were 205,354 women enrolled in the WHP in calendar year (CY) 2011.[1] An unduplicated total of 106,093 women had a paid Medicaid claim for WHP services in CY 2011.[2]

[iv] This amount reflects the 2011 FPL Guidelines.

In CY 2011, WHP expenditures totaled $36 million all funds. The state's expenditures totaled approximately $3.6 million GR, including expenditures for services, administration, and outreach.[v]

The most recent birth and savings data indicated a reduction of 8,215 expected births for CY 2010, and HHSC estimated the decrease in Medicaid costs to be about $90.2 million all funds. After paying all costs associated with WHP, the services provided in 2010 saved about $54.2 million all funds. The state share of the reduction in Medicaid costs totaled approximately $27.2 million GR, and the net state share of savings after paying WHP expenditures totaled approximately $23.6 million GR.

Medicaid for Breast and Cervical Cancer

Medicaid for Breast and Cervical Cancer (MBCC) was authorized by S.B. 532, 77th Legislature, Regular Session, 2001, and was implemented in December 2002. In SFY 2011, the monthly average number of clients enrolled in MBCC was 1,603. MBCC provides Medicaid to eligible women who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to have breast or cervical cancer, including pre-cancerous conditions.

DSHS receives the CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services (BCCS) program.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, she must go to a BCCS provider who will screen her for program eligibility. HHSC makes the final eligibility determination after the provider submits the application and supporting materials to the state. Application for the program cannot be made through an HHSC benefits office.

To be eligible for MBCC, a woman must be at or below 200 percent of FPL and:

- Diagnosed and in need of treatment for a biopsy-confirmed breast or cervical cancer, a metastatic or recurrent breast or cervical cancer, or certain pre-cancer conditions,
- Uninsured and not otherwise eligible for Medicaid,
- Age 18 through 64,

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[v] Medicaid claims data for 2011 are incomplete.

- A Texas resident, and
- A U.S. citizen or qualified alien.

A woman eligible for MBCC receives full Medicaid benefits beginning the day after she received a qualifying diagnosis and for the duration of her cancer treatment. Services are not limited to the treatment of breast and cervical cancer.

A woman can continue to receive full Medicaid benefits as long as she meets the eligibility criteria at her coverage renewal period and provides proof from her treating physician that she is receiving active treatment for breast or cervical cancer. Active treatment may include traditional treatments such as chemotherapy and radiation, as well as active disease surveillance for clients with triple negative receptor breast cancer, and hormonal treatment.

Prescription Drugs

The Texas Medicaid program covers most outpatient prescription drugs either through a Medicaid MCO or through the Vendor Drug Program (VDP). The Texas Medicaid drug benefit is an optional service that has been available to all Texas Medicaid clients since September 1971.

In SFY 2011, an average of 3.5 million clients per month was eligible to receive medications through the program. Texas Medicaid paid $2.5 billion for over 35.4 million prescriptions that year, with an average cost per prescription of $71.30.

Table 6.3 lists Medicaid drug benefits by client group.

Table 6.3: Drug Benefits by Client Groups

Unlimited Prescriptions:
Children under 21 years of age.
People who are age 65 and older and those with a disability and in a nursing facility.
People who are age 65 and older and those with a disability live in the community and receive waiver services.
Clients enrolled in STAR, STAR Health, STAR+PLUS.
Limited to Three Prescriptions per Month:
TANF fee-for-service (FFS) adults.
People who are age 65 and older and those with a disability, in Medicaid FFS and do not qualify for waiver services.

Prescription Benefit in Fee-for-Service

VDP directly contracts with over 4,600 dispensing pharmacies to provide prescription drugs to clients in Medicaid FFS. Texas pays for all outpatient drug coverage through the VDP, with the exception of some medications provided as part of outpatient physician services.

As of January 1, 2006, clients who are dually eligible for Medicaid and Medicare began receiving most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D. See Chapter 2 for additional information on the Medicare Prescription Drug Improvement and Modernization Act of 2003, which provided for this drug benefit for dual eligibles.

Prescription Benefit in Managed Care

On March 1, 2012, most Medicaid clients and all CHIP clients began obtaining their prescription drug benefits through a MCO as required by S.B. 7, 82nd Legislature, First Called Session, 2011, and the 2012-2013 GAA (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011). This change only impacted clients enrolled in a MCO. Outpatient prescription drugs are a benefit of CHIP and each Medicaid managed care program, STAR, STAR+PLUS, and STAR Health.

Each MCO contracted with a pharmacy benefits manger (PBM) to process prescription claims. The PBMs contract and work with pharmacies that actually dispense medications to CHIP and Medicaid managed care clients. MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

MCOs and PBMs are required by state law to adhere to the VDP Medicaid and CHIP formularies and the Medicaid preferred drug list (PDL) until August 31, 2013. Rider 81 requires MCOs to manage prior authorization (PA) for prescription drugs in a manner that is no more stringent than those PA processes used by HHSC. Prior authorization is required for non-preferred drugs and drugs subject to clinical PA edits. MCOs/PBMs may implement any of the VDP's clinical PA edits, but no more.

If a drug is neither preferred nor non-preferred on the PDL, the MCO/PBM cannot establish a drug as non-preferred and implement a PDL prior authorization. If the MCO/PBM wants to establish a clinical edit PA on a drug, the clinical PA edit must be approved by HHSC.

On June 1, 2012, MCOs began paying local pharmacies to deliver pharmaceuticals to clients. Each MCO developed its own participating pharmacy network for this delivery service. Similar to Medicaid FFS, members have access to prescription delivery services.

Federal Drug Rebate Program

In the fall of 1990, Congress passed the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). Among the provisions of this Act was the requirement for implementation of a federal Medicaid drug rebate program, to be effective January 1, 1991. Under this law, drug manufacturers are required to pay rebates for drugs dispensed under state outpatient drug programs in order to be included in state Medicaid formularies. States are required to cover all of the drugs for which a manufacturer provides rebates under the terms of the law. The basic drug rebate provisions of OBRA 90 are as follows:

- States must maintain an open formulary (except for a few categories listed in the law) for all drugs of manufacturers that have signed a federal rebate agreement.
- States may require PA of drugs to limit the use of covered drugs, but must provide PAs within 24 hours of receipt of the request. States must also provide for up to a 72-hour emergency supply of drugs if a PA cannot be granted within 24 hours.
- Rebate amounts per unit are determined by the Centers for Medicare & Medicaid Services (CMS).
- States perform the rebate billing and collection functions.

The Affordable Care Act (ACA) increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount.

Preferred Drug List and Supplemental Rebate Program

A PDL is a tool used by many states to control growing Medicaid drug costs while also ensuring program recipients are able to obtain medically necessary medicines. States have taken different approaches to developing PDLs based on federal and state law. In Texas, H.B. 2292, 78th Legislature, Regular Session, 2003, provided direction to HHSC on how to implement the Medicaid PDL.

The PDL contains medications in various therapeutic classes that are designated as “preferred” or “non-preferred” based on safety, efficacy and cost effectiveness. Prescribers who choose non-preferred medications for their patients must obtain prior approval. The Pharmaceuticals and Therapeutics (P&T) Committee provides recommendations to HHSC on which pharmaceuticals to include in the PDL.

With a preferred drug list, Medicaid clients have access to all of the drugs Medicaid is required to cover under federal law, including those covered before the PDL was established. The PDL controls spending growth by increasing the use of preferred drugs – prescription drugs selected for the PDL that are safe, clinically effective, and cost effective compared to other drugs on the market. Non-preferred drugs, which are drugs reviewed but not selected to be on the PDL, require PA. Unless Texas Medicaid has historical paid claim information that indicates a patient meets the state’s PA criteria, a physician’s office must call to obtain prior approval before a non-preferred drug can be reimbursed. By containing drug costs, the PDL helps to preserve Medicaid’s ability to meet clients’ increasing prescription drug needs as well as other health care needs.

The MCOs implemented the VDP’s PDL and do not have PA requirements more stringent than those in place for FFS as required by S.B. 7, 82nd Legislature, First Called Session, 2011 and the 2012-2013 GAA, (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011).

Supplemental rebates are collected under the PDL provisions of H.B. 2292, 78th Legislature, Regular Session, 2003. These rebates are in addition to the rebates collected under the federal drug rebate program on products selected as preferred drugs for the Texas Medicaid formulary. These rebates are based on competitive negotiations that are performed by a contractor that specializes in optimizing rebate offers for supplemental rebates. The rebate offers are used in determining cost effectiveness for possible placement on the PDL. Rebates are collected on both FFS and MCO prescription drug claims.

HHSC collected approximately $270.7 million all funds, $84.1 million in general revenue (GR), in supplemental rebates over the 2010-2011 biennium. This is a four percent increase from the $80.8 million in GR collected in the prior biennium. The ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The net impact of the ACA was an overall reduction of approximately four percent in drug manufacturer rebate revenue for SFY 2010–2011.

Medical Transportation Program (MTP)

The Texas Medical Transportation Program (MTP) or its designee[vi] is responsible for arranging and administering cost-effective, non-emergency medical transportation (NEMT) services to Medicaid, CSHCN, and Transportation Indigent Cancer Patients (TICP) clients who do not have any other means of transportation to access medically necessary covered services.

MTP or its designee performs a variety of program functions including:

- Operating call centers,
- Overseeing contracted transportation services, and
- Processing contractor and client payments and reimbursements.

Payment Models

NEMT services are reimbursed using two payment models: full risk capitation broker (FRB) transportation and state-authorized FFS transportation. Currently, the FRB model operates in the Dallas/Ft. Worth and Houston/Beaumont areas. The FFS model is used in the remainder of the state. Transportation services are the same in both models; however, the entity arranging the services differs.

Full Risk Broker

The 2010-11 GAA (Article II, HHSC, Rider 55, S.B.1, 81st Legislature, Regular Session, 2009) required HHSC to implement a full risk brokerage model in areas of the state that could sustain the model. The FRB is responsible for the full array of transportation services covered in Texas. HHSC sought one or more FRBs to coordinate transportation using a network of providers in the Dallas/Fort Worth and in Houston/Beaumont service delivery areas (SDAs).

Fee for Service

MTP uses the FFS model to reimburse providers for services in all areas of the state except those areas administered by the FRB. Whereas the FRB authorizes and arranges transportation in the Dallas/Fort Worth and in Houston/Beaumont

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[vi] In this context, “designee” refers to the full risk broker.

SDAs, MTP authorizes and arranges transportation for the rest of the state. MTP operates four call centers in Austin, Grand Prairie, McAllen, and San Antonio to arrange for transportation services.

Transportation and Related Services

Mass Transit: Mass transit is public transportation service that uses intracity and intercity bus fixed routes, rail, or air. Clients use passes, tokens, tickets, and other tender to access public transportation, when available.

Mileage Reimbursement: Mileage reimbursement is paid to an individual who drives himself, a family member, friend, or neighbor to and from a program covered health care service. Mileage reimbursement is paid only to individuals who are enrolled as Individual Transportation Providers.

Demand Response: Demand response transportation services are provided or arranged by contracted transportation providers when fixed route transportation or mileage reimbursement is not available or does not meet the client's transportation to health care needs.

Meals and Lodging: Meals and lodging are provided for Medicaid children and CSHCN, and their attendant, when accessing medically necessary health care services that require overnight or extended stays.

Program Enhancements

MTP has undergone program enhancements over the years to facilitate and improve services provided to Medicaid clients. MTP consolidated and streamlined functions and physical locations, and consolidated nine call center locations into four.

In March 2012, MTP transitioned claims processing and some enrollment functions to the Texas Medicaid claims administrator. Also in March, MTP retired its former transportation authorization system and replaced it with the new Texas Medical Transportation System.

In SFY 2011, MTP provided transportation services to approximately 164,796 clients and arranged approximately 3,902,682 transportation and related services.

Behavioral Health Services

Texas Medicaid also funds behavioral health services. Behavioral health services are defined as services used to treat a mental, emotional, or chemical dependency disorder. Services include:

- Therapy by psychiatrists,
- Therapy by psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists,
- Inpatient psychiatric care in a general acute hospital,
- Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older),
- Outpatient adolescent chemical dependency counseling by state-licensed facilities,
- Prescription medicines,
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance,
- Ancillary services required to diagnose or treat behavioral health conditions,
- Care and treatment of behavioral health conditions by a primary care physician,
- Comprehensive substance use disorder benefits for adults in Medicaid including assessment, medication assisted therapy, outpatient and residential detoxification and outpatient and residential treatment, and
- Services through the Youth Empowerment Services (YES) waiver program for children and young adults under age 21 who are at risk of hospitalization because of serious emotional disturbance.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals, and by community mental health centers and chemical dependency treatment programs. Behavioral health services are also included in Texas managed care programs such as STAR, STAR Health, STAR+PLUS, and NorthSTAR. NorthSTAR is a behavioral health managed care program that offers a broader array of behavioral health services than other managed care programs. These additional services are paid for through savings derived from better management of services.

Medicaid Substance Abuse Benefit

The 2010-2011 GAA (Article IX, section 17.15, S.B. 1, 81st Legislature, Regular Session, 2009), authorized HHSC to add comprehensive substance abuse benefits for adults in Medicaid. The Legislature assumed that the treatment of

substance abuse disorders will result in cost savings in the Medicaid program through a reduction in other medical expenditures.

The Medicaid substance abuse benefits were implemented in two phases, beginning September 1, 2010, with outpatient benefits and concluding January 1, 2011, with residential services. These benefits apply to Medicaid clients enrolled in traditional Medicaid, STAR, STAR+PLUS and STAR Health. The benefits include the following services:

- Assessment to determine a client's need for services,
- Individual and group outpatient counseling,
- Medication assisted therapy,
- Outpatient detoxification,
- Residential detoxification, and
- Residential treatment.

Youth Empowerment Services Waiver

The YES waiver is a Medicaid 1915(c) Home and Community-based (HCS) waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families.

The YES waiver is currently only available in a limited geographic area (Bexar, Tarrant, and Travis counties) and can serve up to 300 youth, ages 3-18. Children are determined financially eligible for the YES waiver using the same standards used to determine eligibility for Medicaid in psychiatric institutions. Parental income is not counted.

Texas Wellness Incentives and Navigation Project

CMS is conducting a national demonstration to evaluate the effectiveness of providing incentives to Medicaid clients to adopt healthy behaviors. Texas, one of ten states awarded a demonstration grant, chose to focus on adult STAR+PLUS members with mental health and substance use conditions. Individuals with these conditions are more likely to suffer chronic physical health problems, experience debilitating chronic physical conditions earlier in life and have elevated health care costs.

Texas Wellness Incentives and Navigation (WIN) project will include up to 1,250 voluntary participants, aged 21-55, in the Harris service delivery area, randomized into intervention and control groups. Recruitment for WIN began in May 2012.

Project goals include: improved health self-management; increased use of preventive services and more appropriate use of health care services. Examples of potential individual goals include reduced tobacco use, improved diabetes management, better weight control and improved stress management.

WIN employs a complement of research-based incentives to help intervention group participants manage their chronic health conditions. These include:

- Wellness planning and navigation facilitated by trained, professional health navigators, who will use Motivational Interviewing techniques to help participants define and achieve their health goals,
- Individual flexible wellness accounts to support specific health goals defined by the participant, with purchases authorized through the navigator, and
- Wellness Recovery Action Planning (WRAP) training for individuals with the most severe mental illnesses.

DSHS manages WIN on a day to day basis, with oversight by the state Medicaid office. WIN is independently evaluated by the same entity that serves as the Medicaid/CHIP managed care external quality review organization. WIN will conclude by December 2015, with a final report due to the CMS in October 2016.

Long-Term Services and Supports

Long–term services and supports (LTSS) helps people of all ages with physical, intellectual or developmental disabilities. These services may be provided in an institution such as Nursing Facility (NF) or Intermediate Care Facility for an Individual with an Intellectual Disability or Related Conditions (ICF/IID),in the individual’s own home (e.g., Primary Home Care or home and community-based waivers), or in other settings (e.g., Day Activity and Health Services or hospice).

The demand for long-term services and supports in Texas continues to grow, and is influenced by two key trends: the aging of the population and the continuing prevalence of individuals with co-occurring behavioral health needs.

The population of people age 65 and older is projected to increase from 2.8 million in 2013 to 7.5 million in 2040. The percentage of the total population that

is 65 years of age or older is projected to increase from 10 percent in 2013 to 17 percent in 2040.

The incidence of behavioral health issues is increasing for persons with a physical or intellectual/developmental disability and in the aging population. Nearly one-fourth of individuals across all DADS waiver programs have a dual diagnosis. The additional challenge of a behavioral health diagnosis can further limit these individuals' ability to become fully integrated in the community. The more capacity that exists in the community system to serve individuals with behavioral health needs, the less likely it is that those individuals will end up in institutional services, and the easier it will be for such individuals to transition back to the community.

In Texas, long-term services and supports account for approximately 28 percent of the overall Medicaid budget.[vii] In SFY 2011, 241,130 individuals per month received long-term services and supports.

Institutions

DADS oversees facilities that provide long-term services and supports to individuals who are age 65 and older and those with disabilities. NFs provide services for individuals whose medical conditions require the skills of a licensed nurse on a regular basis. ICFs/IID provides long-term services and supports for persons with intellectual disabilities or related conditions requiring residential, medical, and habilitative services.

Home and Community-Based Waivers

Federal law allows states to apply for waivers to exempt them from certain Medicaid requirements. One of these, called a 1915(c) waiver after the particular section of the Social Security Act that is waived, allows states to provide home and community-based services to individuals who qualify for institutional care, but can be served at home or in the community, to maintain independence and prevent institutionalization.

Home and community-based waivers allow the state to provide a broader array of support services than are available under the state plan. Examples of waiver services provided include nursing, personal attendant services, habilitation, minor home modifications, dental services, respite, therapies, adaptive aids and supplies, and emergency response services.

[vii] HHSC Financial Services Analysis. Excludes DSH and administrative costs.

According to federal rules, home and community-based waivers cannot cost any more than institutional care would have cost for the group served by the waiver. Waivers enable states to serve people in the community rather than in institutions. However, because of funding limitations, the number of clients wanting to receive waiver services generally far exceeds the number of individuals funded by the state. Most home and community-based waiver programs have lengthy interest lists of people who wish to enroll. This growth has occurred despite significant increases in waiver funding in 2007 and 2009 legislative sessions, reflecting the public's increasing awareness of and desire for community-based long-term services and supports.

The Medicaid waiver programs include:

- Community-Based Alternatives (CBA),
- Community Living Assistance and Support Services (CLASS),
- Deaf-Blind with Multiple Disabilities (DBMD),
- Home and Community-based Services (HCS),
- Medically Dependent Children Program (MDCP), and
- Texas Home Living (TxHmL).

Programs for People age 65 and older and those with Physical Disabilities

LTSS for people age 65 and older and those with physical disabilities allow people of all ages to receive services in a nursing facility or in the community. If eligible, they may receive an array of services, from non-skilled personal care to skilled nursing services. Services may be provided in peoples' home or in community settings (e.g., adult day care or hospice).

As noted previously, the population of Texans age 65 and older is projected to increase from 2.8 million in 2013 to 7.5 million in 2040. Since the prevalence of disability increases with age, the number of Texans with disabilities is also expected to increase. The general population of people with disabilities is projected to increase from 3.2 million in 2013 to 6.7 million in 2040. The population of people with disabilities under age 65 is projected to increase from two million in 2013 to 3.4 million in 2040. The population of people with disabilities age 65 and older is projected to increase from 1.2 million in 2013 to 3.3 million in 2040.

Looking only at the next ten years, the number of Texans ages 65-74 is estimated to increase by about 60 percent. If this population uses Medicaid long-

term services and supports at the same rate as the current generation of people 65-74, DADS can expect increases on the order of 60 percent–for instance, more than 5,000 additional people using Medicaid NF services and more than 20,000 additional using home and community-based services in this age group alone.[viii]

The aging of the population will also bring with it a decline in the availability of informal supports. While the current generation of people older than 75 is likely to be the parents of the baby boom and often has multiple children, the baby boomers themselves have fewer children, are more often childless, and are less likely to be currently married. Any of these factors could reduce the numbers of those who may be available to provide informal supports.

Community Services and Supports – Medicaid State Plan Services

Medicaid state plan community services and supports programs provide Medicaid-covered supports and services in homes and community settings, which will enable people age 65 and older and those with physical disabilities that qualify for nursing facility care but can be served at home or in the community, to maintain their independence and prevent institutionalization. The community services and supports Medicaid state plan programs for people age 65 and older and those with physical disabilities are Primary Home Care (PHC), Community Attendant Services (CAS) and Day Activity and Health Services (DAHS).

Primary Home Care

PHC is administered by DADS and is a Medicaid community-based entitlement service. An entitlement program means that the state must provide those services to all clients who request such services and are determined eligible. PHC is a non-technical, non-skilled service providing in-home attendant services to clients with an approved medical need for assistance with personal care tasks. PHC is available to eligible adults whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need. Covered services include escort to obtain medical diagnosis or treatment or both, home management such as laundry and housekeeping, and personal care services such as bathing, dressing, grooming and feeding. Personal care services are often the critical

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[viii] Note that these are only estimates of future utilization and that actual utilization could vary. For instance, the aging baby boom population may turn out to be healthier and need fewer services than the previous generation in that age group.

factor in keeping individuals in their own homes and out of institutions. In SFY 2011, the average number of clients served per month was 53,582 with an annual expenditure of $551.7 million. With the SFY 2012 STAR+PLUS expansion 91 percent of those who received PHC services in SFY 2011 now receive their services from a STAR+PLUS MCO.

Community Attendant Services

The CAS program, also administered by DADS, is a Medicaid entitlement program, which means that the state must provide these services to all individuals who request such services and are determined eligible. This program takes advantage of special provisions in Medicaid law that allow the state to provide personal care without other Medicaid benefits to clients whose income is too high to qualify for Medicaid in the community, but who meet the higher nursing facility income limits (300 percent of the Supplemental Security Income (SSI) federal benefit rate).

CAS is a non-technical, non-skilled service providing in-home attendant services to individuals with an approved medical need for assistance with personal care tasks. CAS is available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need.

Covered services include escort to obtain medical diagnosis or treatment or both, home management such as laundry and housekeeping, and personal care services such as bathing, dressing, grooming and feeding. In SFY 2011, the CAS program served an average of 45,656 per month with annual expenditures of $459 million all funds.

Day Activity and Health Services

DAHS provides daytime service up to a maximum of ten hours per day, five days a week (Mon-Fri) to clients residing in the community in order to provide an alternative to placement in nursing facilities or other institutions. Services include nursing and personal care, noon meal and snacks, transportation, and social, educational, and recreational activities. The client must have a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse, a functional disability related to the medical diagnosis, and the need for assistance with one or more personal care tasks. In SFY 2011, DAHS facilities provided daytime services to a monthly average of 17,948 clients with annual expenditures of $115 million. With the SFY 2012 STAR+PLUS expansion 89 percent of those who received DAHS services in SFY 2011 now receive their services from a STAR+PLUS MCO.

Community Services and Supports – Waivers

Community services and supports waiver programs provide supports and services through Medicaid waivers in homes and community settings that will enable people age 65 and older and those with physical disabilities who qualify for nursing facility care but can be served at home or in the community to maintain their independence and prevent institutionalization. Community services and supports' waivers for people age 65 and older and those with physical disabilities are CBA for non-STAR+PLUS members, LTSS for STAR+PLUS members, and MDCP.

Community-Based Alternatives for non-STAR+PLUS Members

CBA for non-STAR+PLUS members is a home and community-based services waiver and provides services to people age 21 and older with disabilities who are not enrolled in STAR+PLUS as a cost-effective alternative to nursing facility services. In SFY 2011, CBA for non-STAR+PLUS members served an average of 26,584 clients per month with annual expenditures of $511.7 million all funds. With the SFY 2012 STAR+PLUS expansion 46.8 percent of those who received CBA services in SFY 2011 now receive their services from a STAR+PLUS MCO.

Long-Term Services and Supports for STAR+PLUS Members

STAR+PLUS MCOs are responsible for providing a benefit package to members that includes all medically necessary services covered under the traditional FFS Medicaid programs. They are also responsible for providing LTSS to their members who need support living in the community as opposed to an institution. The MCOs coordinate all STAR+PLUS Medicaid services, including LTSS.

The following is a non-exhaustive, high-level listing of LTSS covered services included under the STAR+PLUS Medicaid managed care program.

- LTSS for all Members:
  - Personal attendant services (PAS), and
  - DAHS.
- Home and Community-based STAR+PLUS waiver services for those who would otherwise qualify for nursing facility care:
  - PAS,
  - In-home or out-of-home respite services,
  - In-home nursing services,
  - Emergency response services (e.g., emergency call button),
  - Home delivered meals,

- Minor home modifications,
- Adaptive aids and medical equipment,
- Medical supplies not available under Medicaid,
- Physical, occupational and speech therapy,
- Adult foster care,
- Assisted living, and
- Transition assistance services limited to a maximum of $2,500.00.

Medically Dependent Children Program

MDCP provides home and community-based services to children and young adults under 21 years of age as an alternative to residing in a nursing facility. Services include respite, adjunct supports, adaptive aids, and minor home modification. In SFY 2011, MDCP served an average of 5,183 clients per month with annual expenditures of $92.6 million, all funds.

Nursing Facilities

The NF program provides services to meet medical, nursing, and psychological needs for persons meeting a level of medical necessity requiring 24-hour care. Nursing facilities are paid a daily rate based on the individual needs of Medicaid eligible residents and must provide services and activities that enable persons residing in the facility to attain and maintain their highest feasible level of physical, mental, psychological, and social well-being. Required services include (in addition to room and board) nursing, social services and activities, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D), medical supplies and equipment, personal needs items, and rehabilitative therapies.

Texas has adopted optional eligibility standards which allow people with incomes of up to 300 percent of the SSI federal benefit rate to qualify for Medicaid-funded nursing facility care, although most of their income must be used toward the cost of their care.[ix]

In SFY 2011, NFs served approximately 56,302 clients per month through Medicaid. Also in SFY 2011, an average of 6,360 clients per month had their Medicare Skilled NF co-insurance paid by Medicaid.

[ix] The SSI federal benefit rate is the maximum amount an individual can receive in Supplemental Security Income on a monthly basis. See www.ssa.gov/ssi/text-general-ussi.htm.

Hospice

The Hospice program, administered by DADS, provides palliative care in the home or in community settings, long-term care facilities (e.g., nursing facility or ICF/IID) or in hospital settings to terminally ill clients for whom curative treatment is no longer desired and who have a physician's prognosis of six-months or less to live.[x] However, children under 21 years of age may continue to receive curative care from non-hospice acute care providers.

The goal of hospice is to provide care for individuals and their families, not to treat or cure terminal illness. A team of doctors, nurses, home health aides, social workers, counselors and trained volunteers work together to help the client and their family cope with the terminal illness. Hospice services include physician services, nursing, counseling, personal attendant services, therapies, prescription drugs, and respite care. In SFY 2011, the program served an average of 6,684 clients of whom 89.5 percent received hospice services in nursing facilities; the remaining 10.5 percent were served in the community.

Program of All-Inclusive Care for the Elderly

PACE is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE clients must be age 55 or older, live in a PACE service delivery area, and qualify for nursing facility level of care. PACE offers all health-related services for a client, including inpatient and outpatient medical care, and specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, day activity and housing assistance. PACE participants receive all medical and social services needed through the PACE provider. PACE service areas are Amarillo, El Paso, and Lubbock.

For SFY 2011, the average number of clients per month receiving PACE services was 989. In 2011, a number of changes were made to the PACE program, including changes to slot allocations. Passage of H.B. 2903, 82nd Legislature, Regular Session, 2011, expanded the program by providing clients residing in nursing facilities the ability to use the Money Follows the Person (MFP) initiative to access PACE, and provided clients being offered STAR+PLUS services the option of accessing PACE, when the PACE site has available slots.

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[x] Palliative care relieves or reduces the intensity of uncomfortable symptoms, including pain, but does not produce a cure for an individual's illness.

Programs for People with Intellectual and Developmental Disabilities

Medicaid funded long-term services and supports for people with intellectual and development disabilities includes home and community-based waiver services and services in an ICF/IID.

Home and community-based waivers provide individualized services and supports to people who live in their family's home, their own homes, or other community settings such as small group homes where no more than four people live.

Residential and habilitation services provided in ICFs/IID vary in size, serving as few as six people up to several hundred.

Community Services and Supports – Waivers

Community services and supports waiver programs provide supports and services through Medicaid waivers in homes and community settings that will enable people with intellectual and developmental disabilities who qualify for an ICF/IID, but can be served at home or in the community to maintain their independence and prevent institutionalization. Community services and supports' waivers for people with intellectual and developmental disabilities are HCS, CLASS, DBMD, and TxHmL.

Home and Community–based Services

The HCS waiver provides individualized services to clients of all ages who qualify for ICF/IID level of care yet live in their family's home, their own homes, or other settings in the community. Nearly one-fourth of clients across all DADS waiver programs have a dual diagnosis. The percentage of clients in certain waivers is even higher, such as in the HCS waiver, where 36 percent have a dual diagnosis. In SFY 2011, HCS served an average of 19,384 clients per month with annual expenditures of $805 million all funds.

Community Living Assistance and Support Services

The CLASS waiver provides home and community-based services to clients who have a "related condition" diagnosis qualifying them for placement in an ICF/IID. A related condition is a disability other than an intellectual or developmental disability which originates before age 22 and which substantially limits life

activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be “related to” an intellectual or developmental disability in their effect upon the individual’s functioning. In SFY 2011, CLASS served an average of 4,642 clients per month with annual expenditures of $193.6 million all funds.

Deaf-Blind Multiple Disabilities

DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages that are deaf, blind or have a condition that will result in deaf-blindness and have an additional disability. In SFY 2011, 151 clients per month were served with annual expenditures of $7 million all funds.

Texas Home Living

To maximize the use of state funds, the 2012-2013 GAA (Article II, DADS, Rider 45, H.B. 1, 82nd Legislature, Regular Session, 2011), directed DADS to refinance GR-funded services to create 5,000 TxHmL waiver slots. This enables the state to receive a federal match for its GR funds, thus expanding the number of individuals who can be served. The TxHmL waiver provides selected services and supports for people with intellectual developmental disabilities (IDD) who live in their family homes or their own homes. Services include adaptive aids, minor home modifications, specialized therapies, behavioral support, dental treatment, nursing, community support (similar to supported home living in HCS), respite, day habilitation, and employment services up to $13,000 per year. Clients must qualify for ICF/IID and meet the SSI income limit. In SFY 2011, TxHmL served an average of 913 clients per month with annual expenditures of $7.4 million all funds.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions

The ICF/IID program provides ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with an intellectual disability or relation conditions function to their greatest ability. A related condition is a disability other than an intellectual or developmental disability which originates before age 22 and which substantially limits life activity. Such disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and other diagnoses, are said to be "related to" an intellectual or developmental disability in

their effect upon the individual's functioning. These residential settings range in size from six beds to several hundred. In FY 2011, an average of 5,615 Medicaid-eligible individuals per month received care from community-based ICFs/IID.

DADS operates State Supported Living Centers Services (SSLCs) that are certified as ICFs/IID, as a Medicaid-funded federal/state service.

State Supported Living Center Services

SSLCs are campus-based and provide direct services and supports for persons with an intellectual disability. SSLCs provide 24-hour residential services, comprehensive behavioral treatment services, and health care services, including physician services, nursing services, and dental services. Other services include: skills training; occupational, physical and speech therapies; vocational programs and employment; and services to maintain connections between residents, their families, and natural support systems. DADS operates 12 SSLC campuses across the state: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio. In addition, DADS contracts with the Department of State Health Services to provide services at the Rio Grande State Center in Harlingen. Nearly two-thirds of the overall SSLC population has a dual diagnosis in which an individual has been diagnosed with an intellectual disability and a mental health disorder, as do almost 90 percent of those individuals who were admitted to the SSLCs in the past two years. In October 2012, 3,880 individuals lived in SSLC-operated facilities.

Resources

Money Follows the Person

LTSS includes institutional NFs and community-based service systems. Historically, NF appropriations could not be used to fund community-based services even when an individual expressed their desire to receive services in a more home-like setting. However, in response to *Olmstead vs. L.C.*, the 1999 U.S. Supreme Court decision, the state launched the Promoting Independence Initiative which provided the opportunity to change this policy.

The 2002-2003 GAA (Title II, Department of Human Services, Rider 37, S.B. 1, 77th Legislature, Regular Session, 2001), established a policy whereby the funding for individuals moving from nursing facilities to community services could

be shifted from the nursing facility budget to the community services budget. MFP allows individuals to be able to make a choice on how and where they are to receive long-term services and supports. Other supportive services have subsequently been developed to help in the identification of clients who want to leave the nursing facility and to assist them in their relocation back to the community. Rider 37 was codified by H.B. 1867, 79th Legislature, Regular Session, 2005, and a separate budgetary line item for MFP was established.

The MFP policy has been very successful. As of June 30, 2012, over 30,000 individuals living in nursing facilities have chosen to move out of those institutional settings and relocate back into the community to receive services.

HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 (DRA) Money Follows the Person Demonstration (Demonstration) award to build upon and enhance its current Promoting Independence initiatives. The Demonstration began on February 1, 2008.

The state will receive approximately $185 million in enhanced funding through calendar year 2016 to provide additional community options and/or supports for individuals who want to relocate from institutional settings. The state will work with clients residing in NFs, ICF/IID with nine beds or more, and SSLC who want to relocate. Additionally, the Demonstration will work with individuals receiving services from both the FFS and MCOs. The state will receive enhanced funding for each individual who enrolls in the Demonstration. In order to be a Demonstration participant, the client must have been in an institutional setting for three or more months and sign an informed consent.

The state will continue to work with clients who are currently under the Texas MFP or the Promoting Independence Priority Population definition. Additional projects under the Demonstration include the provision of:

- Community supports for clients with co-occurring behavioral health needs (e.g., cognitive adaptation services, substance abuse services) living in Bexar County and its contiguous counties, and Travis county.
- Incentives for providers of nine or more bed community ICFs/IID who want to voluntarily close their facilities and provide residential choice for their current residents.
- Attendant-type supportive services for clients who require someone in their home during normal sleeping hours living in the Rio Grande Valley or the Tyler regions.
- Short-term post-relocation contacts for clients who have moved back into the community to ensure a more successful relocation.

- Enhancement of data collection, reporting and quality assurance systems and provider monitoring.
- Financial assistance to local Long Term Ombudsmen to assist nursing facility residents who want to learn more about community based alternatives.
- A customized employment project for providers who want to assist their Medicaid clients move out of congregate settings and into employment at local businesses.
- Administrative assistance for Relocation Contractor Services and Workforce Development.
- Relocation specialists stationed at SSLC to increase the quality of the relocation process.
- Funding of four Aging and Disability Resource Centers (ADRCs) to hire Housing Specialists who will concentrate their efforts on the identification and expansion of affordable, accessible and integrated housing.
- Funding for two new ADRCs and four ADRCs to provide options counseling to non-Medicaid nursing residents interested in learning about community long term services and supports.
- Funding for Information Technology: relocation contractor reporting database, enhancements to the Quality Assurance and Improvement (QAI) Data Mart to meet abuse, neglect and exploitation data reporting for the Demonstration.
- Establishment of a Quality Reporting Office to provide additional in-house capabilities to monitor, discover, describe and create intervention strategies to promote quality across Demonstration activities and Medicaid 1915(c) waivers.

Aging and Disability Resource Centers

ADRCs serve as a “no wrong door” approach to services and are comprised of a network of local service agencies, coordinating information and access to public long-term services and support programs and benefits through various models of single or multiple points of entry. ADRCs also provide options counseling and person-centered care transition support services through collaboration with hospital discharge planning departments to reduce hospital readmissions

Key community partners include DADS three “front door” programs: area agencies on aging (AAAs), community services (CS) regions, and local intellectual disability authorities (LAs). There are 14 ADRCs operating in 10 of the 11 health and human services regions in Texas:

- Alamo Service Connection – serving Bexar County (San Antonio).
- Central Texas Aging and Disability Resource Center – serving Central Texas (Bell, Coryell, Hamilton, Lampasas, and Milam counties).

- Aging and Disability Resource Center of Tarrant County – serving Tarrant County.
- Care Connection Aging and Disability Resource Center – serving Harris County/Houston and 12 surrounding counties (Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller and Wharton counties).
- Lubbock County Aging and Disability Resource Center – serving Lubbock County.
- East Texas Aging and Disability Resource Center – serving East Texas (Gregg, Harrison, Marion, Panola, Rusk and Upshur counties).
- North Central Texas Aging and Disability Resource Center – serving North Central Texas (Collin, Denton, Hood, and Somervell counties).
- Connect to Care Aging and Disability Resource Center – serving Dallas County.
- Aging, Disability and Transportation Resource Center: El Paso & Far West Texas – serving El Paso/West Texas (Brewster, Culberson, El Paso, Hudspeth, Jeff Davis and Presidio counties).
- Coastal Bend Aging and Disability Resource Center – serving Coastal Bend (Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio and San Patricio counties).
- RIO-Net Aging and Disability Resource Center – serving Lower Rio Grande (Cameron, Hidalgo and Willacy counties).
- West Central Texas Aging and Disability Resource Center – serving West Central Texas (Callahan, Jones and Taylor counties).
- Brazos Valley Aging and Disability Resource Center – serving Brazos Valley (Brazos, Burleson, Grimes, Leon, Madison, Robertson and Washington counties).
- Concho Valley Aging and Disability Resource Center – Concho Valley (Coke, Concho, Irion, Runnels, Schleicher, Sterling and Tom Green counties).

Opportunities for Self-Direction of Services

Consumer Directed Services

Consumer Directed Services (CDS) is a long-term services and supports delivery option in which clients, parents of minor-aged children, or guardians have increased choice and control over the delivery of services. The CDS option allows the individual or the client’s legally authorized representative (LAR) to be the employer of record of the personal assistance or habilitation services provider, respite services provider, or in some programs, professional services provider (nursing, physical therapy, occupational therapy, and speech therapy). The individual or LAR has responsibility for hiring, training, supervising, and, if

necessary, terminating the employee. Individuals may appoint a designated representative to assist with employer responsibilities.

Those who use the CDS option are required to select a Consumer Directed Services Agency (CDSA) that will provide an orientation, pay employees and pay federal and state employer taxes on their behalf. Support Consultation is an optional support service for clients who want additional coaching and training on employer-related skills and activities.

CDS is one option for service delivery and does not preclude the use of the traditional agency-based service delivery system for those who prefer it. Informed choice is critical to the concept of consumer direction. The case manager or service coordinator is responsible for ensuring that clients and families understand the risks and benefits of the choice to direct their own services.

CDS is an option for the services in each of the following programs:

Medicaid Home and Community-Based Waiver Programs

- CBA
- CLASS
- DBMD
- MDCP
- HCS
- TxHmL

Medicaid State Plan Services

- CAS
- PCS
- PHC

Medicaid Managed Care Programs

- STAR+PLUS

Non-Medicaid Programs

- Client Managed Personal Assistance Services (CMPAS)
- Family Care (FC)

Service Responsibility Option

For clients who want greater control in selecting and managing their personal care staff but do not want the responsibilities of being an employer, the Service Responsibility Option (SRO) is available in some locations. Under the SRO, the

traditional home health agency remains the employer of record, but the consumer or the individual's representative participates in selecting and managing the attendant staff. In SFY 2013, the SRO will be offered statewide to participants in PHC, CAS, FC and STAR+PLUS.

Medicaid Estate Recovery

On March 1, 2005, Texas implemented the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws, which DADS operates.

MERP provides the authority for the state to file a claim against the estate of a deceased Medicaid recipient, age 55 or older, who applied for certain long-term care services on or after March 1, 2005. Claims include the cost of services, hospital care and prescription drugs supported by Medicaid under the following programs:

- NF,
- ICFs/IID, which includes SSLCs, and
- Medicaid waiver programs including:
  - CLASS,
  - DBMD,
  - HCS,
  - TxHmL,
  - CBA, which includes STAR+PLUS, and
  - CAS.

There are certain exemptions from recovery as required by federal and state law. When no exemptions apply, the heir(s) may request a hardship waiver if certain conditions are met. A hardship waiver specific to the homestead may be filed when one or more heirs have gross family income below 300 percent of the FPL. When no exceptions or hardship conditions exist, the state files a claim against the decedent's assets that are subject to probate. The estate representative is responsible for paying the lesser of the MERP claim amount or the estate value after all higher priority estate debts have been paid. This is paid through the estate, not the resources of any heirs or family members.

The claims filing component of the program has been contracted to a private company through a competitive procurement process. DADS has retained responsibility for program policy and procedures.

Supporting Independence and Employment

Medicaid Buy-In Program for Workers with Disabilities

In September 2006, HHSC implemented a statewide Medicaid Buy-In program to enable working persons with disabilities to receive Medicaid services. Based on direction from S.B. 566, 79th Legislature, Regular Session, 2005, the program is available to individuals with countable earned income less than 250 percent of FPL. Medicaid Buy-In participants may be required to pay a monthly premium, depending on their earned and unearned income.

Medicaid Buy-In participants are eligible for the same services available to adult Medicaid recipients, including office visits, hospital stays, x-rays, vision services, hearing services, and prescriptions. They also are eligible for attendant services, day activity health services, and home and community-based services waivers if they meet the functional requirements for these programs.

Health Information Exchange

Health Information Exchange (HIE) is the secure electronic movement of health information among treating physicians and other care providers and related organizations according to national and state laws and nationally recognized standards. The purpose of HIE is to improve the quality, safety and efficiency of health care using health information technology to enable care providers to have the right information in their hands at the right time. HIE means:

- Less waiting for paper files to be delivered from one treating physician to another when clients are referred for additional treatment or consultations,
- Less paperwork to complete in the doctor's office, with electronically-stored medical records making it faster and easier for a care provider to access and refer to records and reducing the need to fill out multiple, duplicative forms when clients arrive for a visit,
- Better coordination of care between treating physicians,
- Eliminating unnecessary duplicative tests, x-rays, and other procedures, or the possibility of adverse reactions to treatment that conflicts with prior prescribed medications or other treatment because a physician does not have the results of prior care,
- Access for care providers to up-to-date clinical research and new clinical guidelines to use when making medical decisions, and

- Patient access their own personal health information.

Implementing HIE statewide will help to ensure that Texas physicians and hospitals are eligible to receive billions in available federal meaningful use incentive payments over the next decade. In the long-term, Texas has an opportunity to leverage technology to improve the quality, safety, and efficiency of the Texas health care sector while protecting individual privacy.

Health and Human Services (HHS) currently has several HIE-related initiatives underway. The Texas Legislature directed HHSC to develop a Medicaid-based HIE system to support improved quality of care by giving providers more and better information about their patients. In 2010, HHSC was awarded $28.8 million through the State Health Information Exchange Cooperative Agreement Program. These funds are being used to implement the strategic and operational plan for HIE in Texas, which includes a local HIE grant program, a white space strategy for those areas not covered by a local HIE, and a level of statewide shared services to help facilitate exchange.

Private HIE initiatives which are not related to HHS are also being developed and implemented across the state.

Medicaid and CHIP Health Information Exchange

H. B. 1218, 81st Legislature, Regular Session, 2009, requires HHSC to develop an electronic health information exchange to improve the quality, safety and efficiency of health care services provided under Medicaid and CHIP. The bill also establishes the Electronic Health Information Exchange System Advisory Committee to assist with the development and implementation of this exchange. HIE means that providers (doctors, hospitals, etc.) share patients' health information with other providers using a private and secure internet connection, as long as they have client consent. Providers already share health information with other providers, but they currently do so with sometimes less secure methods that also limit interoperability and standards-based exchange – fax, traditional mail, courier, etc.

H.B. 1218 also directed HHSC to establish a pilot that would provide the foundation for a fully functional Medicaid/CHIP Health Information Exchange. This project includes two regional HIE organizations with at least one serving an urban area to determine the feasibility, costs, and benefits of exchanging secure

electronic health information between HHSC and the HIE organization. HHSC and HIE organizations participating in the pilot will, at a minimum, exchange a patient's medication history and may include additional health-care information. HHSC submitted a report to the Legislature on the HIE pilot and the Medicaid HIE system in 2011.

HHSC implemented the first phase of this pilot Spring 2011. This phase utilized technology already in use within HHSC systems. Participating HIEs successfully connected with HHSC to gather prescription history data. This phase was scheduled to operate as a test for a six month period, ending in October of 2011.

Planning for the second phase of the pilot began in 2011. The goals of the second phase are to provide standardized prescription history data via a robust, query-based form of Health Information Exchange. The pilot will continue in the Fall of 2012, at which time a system will be implemented to provide a consolidated prescription history resource for local HIEs that is based upon the latest accepted standards.

Electronic Health Information Exchange System Advisory Committee

The HHSC Electronic HIE System Advisory Committee for the Texas Medicaid agency was established under the authority of H.B. 1218, 81st Legislature, Regular Session 2009, and commenced in February 2010.

The purpose of the HIE Advisory Committee is to advise the Commission regarding the development and implementation of the electronic health information exchange system. In addition to any issue specified by HHSC, specific issues addressed include:

- Data to be included in an electronic health record,
- Presentation of data,
- Useful measures for quality of service and patient health outcomes,
- Federal and state laws regarding privacy and management of private patient information,
- Incentives for increasing health care provider adoption and usage of an electronic health record and the health information exchange system, and
- Data exchange with local or regional health information exchanges to enhance (a) the comprehensive nature of the information contained in electronic health records; and (b) health care provider efficiency by supporting integration of the information into the electronic health record used by health care providers.

The HHSC Executive Commissioner appoints to the advisory committee at least 12 and not more than 16 member representatives from a broad range of health professionals, consumers, advocacy groups, and individuals with knowledge and expertise in health information technology and who have experience in serving persons receiving health care through the state's Medicaid program and CHIP programs.

The advisory committee collaborates with the Texas Health Services Authority to ensure that the health information exchange system is interoperable with, and not an impediment to, the electronic health information infrastructure that the authority assists in developing.

The HIE Advisory Committee's recommendations are based on public comment or testimony taken at Committee meetings and the members' own knowledge of and experience with health information exchange and health information technology. Materials reviewed by the advisory committee are made available to the public before or after the meetings. The HIE Advisory Committee has no administrative authority in the operation of the Medicaid program.

Texas Medicaid Electronic Health Record (EHR) Incentive Program

The American Recovery and Reinvestment Act (ARRA) of 2009 increased the focus on health information technology (HIT) throughout the public and private health care delivery system. ARRA provides funding opportunities to assist physicians and other health care professionals in the adoption and meaningful use of electronic health record (EHR) technology and to advance health information exchange. A certified EHR contains the electronic records of individual patients' health-related information that includes patient demographic and clinical health information, such as medical histories and problem lists,[xi] and that has a variety of capabilities, including clinical decision support; physician order entry; capture and query of information relevant to health care quality; and the ability to exchange electronic health information with, and integrate such information from, other sources. ARRA allows state Medicaid agencies to establish programs for paying incentives to Medicaid providers for the meaningful use of EHRs.

[xi] Maintaining a "problem list" for a patient is one of the meaningful use criteria for an EHR. CMS established criteria that a provider must maintain an up-to-date problem list of current and active diagnoses for more than 80 percent of the patients seen by the provider. It is only one of many meaningful use criteria specified in CMS rules.

To be considered a "meaningful EHR user," an eligible professional or eligible hospital must demonstrate meaningful use of the EHR technology over a specified period of time in a manner that is consistent with the objectives and measures outlined in federal regulation by CMS. These objectives and measures would include the use of certified EHR technology that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information. Examples of meaningful use criteria include, but are not limited to, maintaining a problem list for patients and writing prescriptions for patients electronically.

States can receive 100 percent federal financial participation (FFP) for incentive payments to Medicaid providers to purchase, implement, and “meaningfully use” certified EHRs. This provision also provides for Medicaid agencies to obtain 90 percent federal administrative matching funds to develop and administer the EHR Incentive Payments program.

Texas Medicaid implemented the EHR Incentive Program and began disbursement of incentive payments to eligible providers in early 2011. Through this initiative, Texas had laid the groundwork for development of accountable systems of care. Quality data received through providers’ submission of meaningful use and clinical quality measures may be incorporated into the overall management of the Medicaid program.

Statewide Health Information Exchange

The creation of a statewide health information exchange will allow health information to be securely exchanged between providers within Texas. This will increase the coordination and quality of care while improving efficiency in the health care system and increasing consumer empowerment and control.

In 2010, HHSC was awarded $28.8 million through the State Health Information Exchange Cooperative Agreement Program. These funds helped the state develop a strategic and operational plan for health information exchange and are continuing to support implementation of the strategic and operational plans through the first quarter of 2014.

HHSC is contracting with the Texas Health Services Authority, an entity created through H.B. 1066, 80th Legislature, Regular Session, 2007, as a public-private non-profit charged with implementing state-level health information technology functions and catalyzing the development of a seamless electronic health information infrastructure to support the health care system in the state. The health information exchange operational plan will occur from late 2010 to the end of the cooperative agreement program in 2014.

The Texas HIE strategic and operational plans, which guide the implementation of HIE services in Texas, outline and support the implementation of the following three key strategies:

- General State-Level Operations: These are administered jointly by THSA and HHSC to support a transparent and collaborative governance structure to coordinate the implementation of HIE in Texas, develop policies and guidelines, and provide statewide HIE services.
- Local HIE Grant Program: This grant program partially funds planning, development, and operations of local and regional HIE networks. There are 12 local health information exchanges (HIEs) in various stages of operation in the HHSC grant program.
- "White space" Strategy: This coverage strategy supports HIE connectivity through Health Information Service Providers (HISPs) in regions of the state without local or regional HIEs.

E-Prescribing

To reduce adverse drug events and costs incurred in providing prescription drug benefits, HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality. New functions became available to pharmacies and providers in December 2011.

- The Medicaid/CHIP drug formulary is now available to prescribers electronically. Prescribers' EHR systems can download regularly updated formulary information that is seamlessly integrated into their prescribing interface.
- Client prescription benefit eligibility is also integrated into prescribers' EHR systems as well as pharmacies' management software. Medicaid/CHIP client eligibility will be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and speeding access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

Additionally, HHSC continues to implement the Medicaid Identification Card and Health Information System project, which will provide a web-based portal for providers to utilize a fully-functional e-prescribing solution. Medicaid/CHIP clients will be able to benefit from e-prescribing functionality even when their provider does not have their own system.

Medicaid Eligibility and Health Information Services System

HHSC is implementing the Medicaid Eligibility and Health Information Services (MEHIS) system, per direction from H.B. 1218, 81st Legislature, Regular Session, 2009. The system has replaced the previous paper Medicaid identification form with a permanent plastic card, and provides access to automated eligibility verification. Additional features are being developed that will provide access to a claims-based electronic health record for all Medicaid clients, and establish a foundation for future health information exchange.

Some of the key features of the new system include:

- Plastic magnetic stripe Medicaid ID cards,
- Rapid client check-in with automated eligibility verification,
- Multiple configuration/access options for providers,
- Near real-time eligibility data,
- Automated program notifications for periodic services,
- Provider and client portals with access to program and health information,
- Client and provider help desks,
- Web-based e-prescribing tool, and
- Support for future health information exchange.

The system will offer clients access to Medicaid program and health information including recent office visits, claims-based diagnoses and procedures, immunizations, medication history, and lab data. HHSC plans to add access to additional data sources as they become available. The system positions HHSC to respond to the emerging and anticipated health information technology initiatives that will foster improved continuity of care, increased communication with clients and providers, expanded data for health care analytics, and better health outcomes over time.

The MEHIS system, now known publically as the “Your Texas Benefits Medicaid Card” system, became operational on June 29, 2011. The initial implementation included electronic eligibility verification; card production and distribution; provider portal eligibility verification; and a help desk for providers and clients.

On January 23, 2012, the initial version of the Medicaid client portal was implemented and added the following features:

- Single-sign-on from the TIERS self-service portal at YourTexasBenefits.com.
- View client Medicaid eligibility information and Texas Health Steps data.
- View and print copies of one or more Medicaid ID cards.
- Online card replacement requests and opt-out elections.

Subsequent releases are planned that will add more robust functionality associated with electronic health history, e-prescribing, and on-line explanation of benefits.

Your Texas Benefits Medicaid Card

Medicaid recipients receive a Your Texas Benefits Medicaid card through the mail upon enrollment in Medicaid. This plastic card is the same size as a credit card. The following information is printed on the front of the card:

- Client’s name and Medicaid ID number,
- Program name (e.g. STAR, STAR Health, or STAR+PLUS), if not in fee for service,
- Date the card was issued,
- Billing information for pharmacies,
- Health plan names and plan phone numbers, and
- Pharmacy and physician information for those in the Medicaid Limited program.

The back of the card includes a statewide toll-free phone number and a website where clients can get more information on the new Your Texas Benefits Medicaid card. The card is not required for clients to access services, but does help accelerate the verification of eligibility. Since possession of the card does not guarantee current eligibility, providers need to verify eligibility at the point of service. Providers can verify Medicaid eligibility using the YourTexasBenefits.com provider portal or they can call the associated help desk.

Online Provider and Client Portal

One aspect of the Your Texas Benefits Medicaid card project is the new provider website – a foundation for the emerging electronic health network. The new card and system are designed to give providers another way to verify the client's Medicaid coverage. In the future, providers may use the website to instantly access their Medicaid patient's Medicaid-related:

- Claims and encounter data (i.e. dates, doctors, diagnosis, procedures),
- Prescription drug history,
- Lab results, and
- Immunization information.

Medicaid patients have the option of "opt out" which blocks online access to their Medicaid-related health history through the provider and client portals.

Another feature of the new provider website, which will become available soon, is e-prescribing, which will streamline the prescribing and prescription delivery process. The e-prescribing feature will allow doctors to instantly see if a drug they want to prescribe is covered by Medicaid and what negative interactions the drug is likely to have with other drugs before the doctor submits an electronic prescription to the pharmacy. This will reduce the number of calls from pharmacists proposing alternative drugs and save time for the provider, the pharmacist, and the patient.

Opportunities: Health Information Exchange, CHIP, and Health Profile Alerts

The MEHIS system offers HHSC future opportunities to participate in health information technology initiatives, leverage data to improve operational efficiency and outcomes, and support data-driven decision-making.

H.B. 1218, 81st Legislature, Regular Session, 2009, authorizes HHSC to consider future opportunities to leverage the MEHIS system. The legislation specifically indicates that HHSC may expand the use of the claims-based electronic health record to support CHIP. HHSC may also consider ways to improve data-gathering capabilities for the electronic health record so that the record may include basic health and clinical information in addition to available claims information. The legislation also suggests using evidence-based technology tools to create a unique health profile to alert health care providers regarding the need for additional care, education, counseling, or health management activities

for specific patients. HHSC will continue to evaluate opportunities to improve capabilities and operational effectiveness offered by this new system.

Endnotes

[1] Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on January 4, 2012.

[2] TMHP Ad Hoc Query Platform Claims Universe, retrieved on January 6, 2012. Medicaid claims data for 2011 are incomplete.

Chapter 7: Medicaid Managed Care

Texas began implementing Medicaid managed care in 1993. This chapter outlines Texas' experience with Medicaid managed care.

What is Managed Care?

Both in Texas and nationally, the Medicaid program has increasingly turned to managed care to deliver services more effectively. The traditional payment system, known as fee for service (FFS), pays health care providers a fee for each unit of service they provide. FFS can result in extra procedures and other issues that are not helpful for the client and that incur unnecessary costs. In a managed care program, a managed care organization (MCO) is paid a capped (or capitated) rate for each client enrolled, and the MCO has an incentive to have quality health care delivered in the most efficient way. The Health and Human Services Commission (HHSC) continues to expand Medicaid managed care and expects more than three million clients in managed care by 2013. In State Fiscal Year (SFY) 2011, nearly 79 percent of the state's Medicaid population was enrolled in some form of managed care.

HHSC continually monitors whether the MCOs are successful in creating a more efficient delivery model than FFS. Savings due to switching from a traditional Medicaid model to an MCO system have been particularly robust. For example, Medicaid managed care clients learned how to use a medical home, so that primary care is coordinated by a primary care provider, rather than going to an emergency room each time health care is needed.

The following features characterize Medicaid managed care in Texas:

Medical home: Clients in Medicaid managed care choose a primary care provider (PCP) who serves as the client's medical home by providing comprehensive preventive and primary care. The PCP also makes referrals for specialty care and other services offered by the MCO, such as case

management. In Texas Medicaid, the types of providers that generally act as PCPs are family and general practice doctors; pediatricians; internal medicine doctors; obstetricians/gynecologists; physicians' assistants; advanced practice registered nurses; and federally qualified health centers (FQHCs), rural health centers, and similar community clinics. Occasionally, specialists agree to act as the PCP for clients with special health care needs.

In addition, to comply with Senate Bill (S.B.) 7, 82nd Legislature, First Called Session, 2011, the MCOs are required to provide health home services. The MCOs must include a designated provider to serve as the health home. It may be a provider operating with a team of health professionals or a health team selected by the enrollee. The health home services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious and persistent mental or health condition.

Health Home services must include:

- Patient self-management education,
- Provider education,
- Evidence-based models and minimum standards of care,
- Standardized protocols and participation criteria,
- Provider-directed or provider-supervised care,
- A mechanism to incentivize providers for provision of timely and quality care,
- Implementation of interventions that address the continuum of care,
- Mechanisms to modify or change interventions that are not proven effective,
- Mechanisms to monitor the impact of the Health Home services over time, including both the clinical and the financial impact,
- Comprehensive care management,
- Care coordination and health promotion,
- Comprehensive traditional care, including appropriate follow-up, from inpatient to other settings,
- Patient and family support (including authorized representatives),
- Referral to community and social support services, if relevant, and
- Use of health information technology to link services, as feasible and appropriate.

HHSC encourages MCOs to develop incentive programs for designated providers who meet the requirements for patient-centered medical homes. At a minimum, the MCO must:

- Maintain a system to track and monitor all health home services participants for clinical, utilization, and cost measures,
- Implement a system for providers to request specific health home interventions,
- Give providers information, including differences between recommended prevention and treatment and actual care received by members enrolled in a health home services program, and information concerning such members' adherence to a service plan, and
- Provide reports on changes in a member's health status to his or her PCP for all members enrolled in a health home services program.

Defined network of providers: Managed care limits clients' choices of providers (with some exceptions) to those under contract with the MCO network. The MCO is obligated to maintain access to network providers based on standards developed by the state.

Utilization review and utilization management: MCOs use utilization review and utilization management to comprehensively monitor and evaluate the appropriateness, necessity, and efficacy of health care services delivered to members. Prospective utilization review includes practices such as preadmission screenings and prior authorization of expensive or invasive medical services. Concurrent utilization review is usually conducted during a hospital confinement to determine the medical necessity for continued stay. Retrospective utilization review normally examines treatment patterns over time.

Quality assessment and performance improvement: MCOs must operate quality assessment and performance improvement programs. These programs evaluate performance using objective quality standards; foster data-driven decision-making; and support programmatic improvements.

Managed Care History in Texas

In response to rising health care costs and national interest in cost-effective ways to provide quality health care, the Texas Legislature passed House Bill (H.B.) 7, 72nd Legislature, Regular Session, 1991, which directed the state to establish Medicaid managed care pilot programs. These pilots (implemented in Travis County and in the Tri-County Area of Chambers, Jefferson, and Galveston counties) were initially known as the LoneSTAR (State of Texas Access Reform) Health Initiative. The name was later shortened to STAR. The Travis County pilot was implemented in August 1993. The Tri-County pilot was implemented in

December 1993 and was expanded in December 1995 to include three additional counties (Hardin, Liberty, and Orange).

Texas lawmakers passed S.B. 10, 74th Legislature, Regular Session, 1995, and related legislation to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. Texas continued to expand its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

In September 1996, the Travis County pilot was expanded to include surrounding counties. Additionally, the Bexar, Lubbock, and Tarrant service areas were brought under managed care. The STAR program, which primarily serves non-disabled children, low-income families, and pregnant women, was expanded to include certain Medicaid clients with disabilities (Supplemental Security Income [SSI] and SSI-related) on a voluntary basis when the 1996 expansion occurred.

The Texas Legislature passed H.B. 2913 and S.Bs. 1163, 1164, and 1165, 75th Legislature, Regular Session, 1997, to strengthen Medicaid managed care client and provider protections. In December 1997, the state expanded the STAR program to the Houston area and created a new pilot to integrate acute care and long-term services and supports for SSI and SSI-related Medicaid clients in Harris County. This program is known as STAR+PLUS. The implementation of STAR and STAR+PLUS in the Harris service area doubled the number of Texas Medicaid clients in managed care.

Through S.B. 2896, 76th Legislature, Regular Session, 1999, the Texas Legislature placed a moratorium on further managed care expansion, but allowed the state to complete the Dallas and El Paso service area implementations, which were already underway. The bill directed HHSC to evaluate the effects of the Texas Medicaid managed care program on access to care, quality, cost, administrative complexity, utilization, care coordination, competition, and network retention.

The Dallas and El Paso service area implementations were completed in 1999. In addition to expanding the STAR program in Dallas, the state also implemented a unique behavioral health pilot, NorthSTAR, in the Dallas service area. NorthSTAR provides mental health and substance abuse services to Medicaid clients and certain non-Medicaid clients below 200 percent of the federal poverty level.

Over a 15-month period in 1999 and 2000, HHSC led an analysis of the STAR and STAR+PLUS programs in conjunction with a workgroup composed of representatives from the advocacy, provider, and managed care communities.

The resulting Medicaid Managed Care Report concluded that Texas had achieved many but not all of the goals set for the Medicaid managed care program.[1] The study found that implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional FFS Medicaid program. The report also concluded that managed care introduced additional program complexity both to providers and to clients. While clients were generally satisfied with the care they received under managed care, Medicaid providers were generally more dissatisfied with the increased administrative complexity and oversight required.

In 2001, following the release of the Medicaid Managed Care Report, the moratorium on managed care was lifted and HHSC was allowed to expand Medicaid managed care when cost effective.

By 2003, the Texas Legislature faced budget pressures that prompted interest in modifying Medicaid and expanding managed care throughout the state in order to obtain additional cost savings. H.B. 2292, 78th Legislature, Regular Session, 2003, directed HHSC to provide Medicaid managed care services through the most cost-effective models.

In September 2005, Primary Care Case Management (PCCM) (formerly known as the Texas Health Network) was removed as a non-capitated plan choice in the STAR service areas. It expanded to 197 primarily rural counties outside of the STAR service areas plus five STAR counties in the Southeast Region (Chambers, Hardin, Jefferson, Liberty, and Orange) moved to PCCM. This increased the number of counties covered by PCCM to 202. As a result of this expansion, all Texas counties were served by either STAR or PCCM.

The Texas Legislature passed S.B. 6, 79th Legislature, Regular Session, 2005, which directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008. The STAR Health Program is designed to better coordinate the health care of children in foster care and kinship care.

The 2006-07 General Appropriations Act (GAA) (Article II, Special Provisions, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), and H.B. 1771, 79th Legislature, Regular Session, 2005, directed HHSC to use cost-effective models to better manage the care of Medicaid clients who are age 65 and older and those with physical disabilities in certain areas of the state. In response to this direction, HHSC developed the Integrated Care Management (ICM) model and

the STAR+PLUS Hospital Carve-Out model to integrate acute and long-term services and supports. In February 2007, the STAR+PLUS Hospital Carve-out model replaced the existing STAR+PLUS model in the Harris service area and was expanded to the Bexar, Harris Expansion, Nueces, and Travis service areas. The ICM model ended in May 2009.

In addition to developing new managed care programs, HHSC has continued to expand existing programs. In 2006, Nueces was added to the STAR service areas. The 2010–2011 GAA (Article II, Special Provisions, Section 46, S.B.1, 81st Legislature, Regular Session, 2009), required HHSC to implement the most cost-effective integrated managed care model for Medicaid clients who are with disabilities in the Dallas and Tarrant service areas. After analyzing current managed care models, HHSC determined STAR+PLUS was the most appropriate cost-effective model to meet the legislative mandate. In February 2011, HHSC expanded STAR+PLUS to the Dallas and Tarrant service areas.

In September 2011, STAR and STAR+PLUS expanded to 28 counties contiguous to the existing service areas. STAR expanded to 17 counties contiguous to Bexar, El Paso, Lubbock, Nueces, and Travis service areas and STAR+PLUS expanded to 10 counties contiguous to the Bexar, Harris, Nueces, and Travis service areas. STAR and STAR+PLUS expanded to the newly formed Jefferson service area, which included 11 counties contiguous to the Harris service area. HHSC eliminated the PCCM model in the 28 contiguous counties on August 31, 2011.

The 2012-2013 GAA (Article II, HHSC, H.B., 82nd Legislature, Regular Session, 2011), assumed a cost savings to the state budget resulting from the expansion of Medicaid managed care statewide. Pursuant to these assumed savings, HHSC continued to expand managed care statewide. In March 2012, HHSC expanded the STAR+PLUS program to the El Paso and Lubbock service areas, STAR and STAR+PLUS to the Hidalgo service area, and STAR to the Medicaid Rural Service Area (MRSA). HHSC eliminated the PCCM program from all remaining areas of the state on February 29, 2012.

Significant Traditional Providers

As Texas Medicaid has evolved into a managed care system, the state has taken special measures to minimize the disruption of the relationship between Medicaid clients and their historical providers. The Legislature directed HHSC to ensure that significant traditional providers (STPs) of Medicaid services be included in MCO networks during the implementation of managed care. Before each implementation of managed care in a new area of the state, HHSC produces a

list of STPs, based on historical service patterns, for MCOs to use in establishing their provider networks.

MCOs must give STPs the opportunity to participate in their networks for a period of at least three years from the date an MCO model is implemented in an area. Providers must: (1) accept the MCO's financial terms; (2) meet any credentialing requirements of the MCO; and (3) comply with the terms and conditions of the MCO's standard subcontractor agreement.

Capitation At-Risk

Most managed care contracts place up to five percent of an MCO's capitation payments at risk, based on performance-based measures. MCOs are able to earn variable percentages of the performance targets. This gives HHSC an opportunity to focus MCO performance on specific measures that foster achievement of HHSC program goals and objectives.

Quality Challenge Pool

HHSC reallocates any unearned funds from the performance-based, at-risk portion of an MCO's capitation rate to the MCO program's Quality Challenge Award. HHSC uses these funds to reward MCOs that demonstrate superior clinical quality, service delivery, access to care, and/or member satisfaction.

Managed Care Initiatives

Expansion

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that began in December 2011. It allowed the state to preserve federal hospital funding historically received as upper payment limit (UPL) payments. (See Chapter 4 for more information.)

The 1115 Transformation Waiver enabled the state to conduct a phased transition of Medicaid beneficiaries from FFS to a managed care delivery system based on geographic service areas. These changes included the expansion of the STAR and STAR+PLUS Medicaid managed care programs to new areas of the state and the elimination of the PCCM program. Additionally, prescription drug benefits, currently administered through HHSC's Vendor Drug Program, are now primarily delivered through the Medicaid MCOs. These changes have

resulted in managed care now being the primary vehicle through which almost all Medicaid recipients receive medical services.

Effective September 1, 2011:

- HHSC expanded STAR and STAR+PLUS into 28 counties contiguous of the existing STAR and STAR+PLUS service areas and withdrew the PCCM program from the contiguous counties. STAR expanded into additional counties in the Bexar, El Paso, Harris, Lubbock, Nueces, and Travis service areas. STAR+PLUS expanded in the Bexar, Harris, Nueces, and Travis service areas. Harris and Harris Expansion service areas were combined into a single service area. Nine counties in Southeast Texas were grouped to form the Jefferson service area.

Effective March 1, 2012:

- HHSC expanded STAR+PLUS into the El Paso and Lubbock service areas, expanded STAR and STAR+PLUS into 10 counties in South Texas creating the Hidalgo service area, and replaced PCCM with the STAR program in 164 counties creating the Medicaid Rural Service Area.
- Inpatient hospital services are included in the STAR+PLUS capitation rate.
- Children's Medicaid and the Children's Health Insurance Program (CHIP) dental benefits were expanded statewide for most children and are administered through a managed care capitated model.
- Pharmacy benefits are administered by managed care organizations for STAR, STAR Health, STAR+PLUS, and CHIP participants.

Pharmacy

S.B. 7, 82nd Legislature, First Called Session, 2011, requires HHSC's contracts with MCOs to include pharmacy benefits. The 2012-13 GAA (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011), also included cost-savings related to this initiative in HHSC's Medicaid and CHIP funding. Effective March 1, 2012, Medicaid managed care clients in the STAR, STAR+PLUS, and STAR Health programs began receiving their prescription benefits through pharmacy benefits managers (PBMs) contracted with their MCOs.

Dental

As of March 1, 2012, children's Medicaid dental services are provided through a managed care model to children birth through age 20, those eligible for Medicaid Texas Health Steps Comprehensive Care services, including Supplemental Security Income (SSI) clients. The following Medicaid clients are not eligible to participate in the Dental program and will continue to receive dental services through their existing service delivery models:

- Medicaid clients age 21 and over,
- All Medicaid clients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions (ICFs/IID), and
- STAR Health program clients.

Clients who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist serves as the client's dental home and is responsible for:

- Providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care,
- Maintaining the continuity of patient care, and
- Initiating referrals for specialty care.

Provider types that can serve as main dentists are FQHCs and individuals who are general or pediatric dentists.

Performance Evaluation Projects

Federal law requires state Medicaid agencies to provide for an annual external independent review of the quality outcomes, timeliness of, and access to services provided by Medicaid MCOs. HHSC contracts with an external quality review organization (EQRO) to develop studies, surveys, and other analytical approaches. These tools help the EQRO assess the quality of care provided to clients and care outcomes, and identify opportunities for MCO improvement. The results allow comparison of findings across MCOs in each program. Results are also used in the identification and development of overarching goals and performance improvement projects (PIPs) related to the overarching goals.

HHSC is conducting several quality initiatives aimed at improving quality of care and reducing costs. Some of these initiatives include:

- HHSC awards funds from the Quality Challenge Award to incentivize MCOs who have demonstrated superior performance by meeting or exceeding pre-identified quality metrics.
- The Potentially Preventable Events Quarterly Report Series assists with identifying health care expenditures and the factors contributing to potentially preventable admissions (PPAs), potentially preventable readmissions (PPRs), and potentially preventable emergency room visits (PPVs) in the Texas STAR and STAR+PLUS Programs.

- The Dual Eligible STAR+PLUS Focus Study examines the unique needs of clients who are eligible for both Medicare and Medicaid to assess their quality of care in the STAR+PLUS program.

Texas Medicaid Managed Care Programs

STAR

Medicaid's STAR program is a statewide managed care program in which HHSC contracts with MCOs to provide, arrange for, and coordinate preventative, primary, and acute care covered services.

In STAR provides services for pregnant women, newborns, children with limited income and TANF recipients.

SSI children age birth through 20 years of age may volunteer to participate in STAR.

Clients in the STAR program have access to a PCP that knows their health care needs and can coordinate their care through a medical home. PCPs provide preventive checkups, treat the majority of conditions that STAR enrollees experience, and refer enrollees to specialty care when necessary. STAR also offers additional services not available in traditional FFS. Under the FFS program, adult clients are limited to three prescriptions per month, while STAR participants can receive unlimited medically necessary prescriptions. Additionally, STAR enrollees are not subject to the 30-day spell of illness limitation for adults that exists in the FFS program.

Clients who enroll with a MCO also have access to value-added services plus additional benefits that are not available in the FFS program. Value-added services are additional health care services that an MCO voluntarily elects to provide to its clients at no additional cost to the state. The MCOs offer various value-added services such as adult dental services and diapers for newborns to attract new clients.

Additional services may be offered to clients on a case-by-case basis at the discretion of the MCO. It may provide these services based on medical necessity, cost effectiveness, the wishes of the client, and the potential for improved health status of the client. Value-added services and additional services can vary from one MCO to another.

STAR+PLUS

STAR+PLUS is designed to integrate the delivery of acute and long-term services and supports (LTSS) for SSI and SSI-related clients.

Previously STAR+PLUS required federal approval of both a 1915(b) and a 1915(c) waiver in order to mandate participation and to provide home and community-based services. Effective December 2011, STAR+PLUS received federal approval to operate under the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver.

The STAR+PLUS program serves SSI and SSI-related clients. SSI and SSI-related adults are required to participate in the program, while SSI and SSI-related children may choose to participate.

The STAR+PLUS program is aimed at clients with chronic and complex conditions who need more than acute care services. These individuals often need LTSS as well. MCOs provide all acute and LTSS through one service delivery system. Acute care services include specialists, home health, medical equipment, lab, x-ray, and hospital services, while LTSS include services such as attendant care and adult day health care. The program also ensures that each member has a primary care doctor.

The home and community-based services (HCBS) STAR+PLUS waiver also provides LTSS to Medicaid eligibles who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing facility. These members must be age 21 or older, be a Medicaid recipient, or be otherwise financially eligible for waiver services. To be eligible for HCBS STAR+PLUS waiver services, a member must meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC on the medical necessity/level of care of the nursing facility care.

STAR+PLUS enrollees who are eligible for both Medicaid and Medicare receive long-term services and supports through STAR+PLUS and acute care services through Medicare. If enrollees meet the medical necessity criteria to be in a nursing facility, they may choose to receive HCBS through the HCBS STAR+PLUS waiver. These services are non-traditional long-term services and supports such as home modifications to make a client's home more accessible. MCO networks include providers of all long-term services and supports.

STAR+PLUS enrollees with complex medical conditions are assigned a service coordinator, an MCO employee who is responsible for coordinating acute and

LTSS. The service coordinator develops an individual plan of care with the enrollee, family members, and providers and can authorize services. The emphasis is on providing HCBS to avoid the need for institutionalization.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. It is an initiative of the Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR clients in Dallas and six contiguous counties (Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall) around Dallas receive behavioral health services through NorthSTAR.

NorthSTAR was created in 1999 to integrate the publicly funded systems of mental health and substance use disorder services. Using Medicaid, state general revenue, federal block grant funds, and some local funds, NorthSTAR is designed to create a better coordinated and more efficient and flexible system of public behavioral health care.

Most Medicaid eligible recipients who reside in the service area are automatically enrolled in the program based on their Medicaid status. Non-Medicaid eligible individuals who reside in the service area and meet clinical and income criteria are eligible to receive services through NorthSTAR via an application process.

NorthSTAR is administered through a DSHS contract with a behavioral health organization (BHO). The BHO contract includes outcome and performance measures specifically designed for behavioral health. The BHO is required to subcontract with a specialty provider network for the provision of a set of specialty treatment services and service coordination for enrollees with serious mental illness and serious emotional disturbance. The BHO is also contractually required to maintain an adequate network for other provider specialties for behavioral health. These include psychiatrists, psychologists, licensed therapists, substance use treatment facilities, and hospitals.

The Local Behavioral Health Authority (LBHA), specifically formed for the NorthSTAR project, ensures that there is local oversight and that local communities are given a voice in the delivery of publicly funded managed behavioral health care. The LBHA represents both mental health and substance use disorder interests and concerns. The LBHA for NorthSTAR is the North

Texas Behavioral Health Authority (NTBHA), formerly known as the Dallas Area NorthSTAR Authority.[i]

In 2008, DSHS collaborated with the University of Illinois at Chicago to develop a Self Directed Care (SDC) pilot program within NorthSTAR. SDC is a new way of providing mental health services in which adults with serious mental illnesses directly manage funds to assist in their recovery. With assistance from an SDC advisor, the Texas SDC participants create a person-centered recovery plan and a budget for the purchase of traditional mental health services and non-traditional goods and services in the community that are tied to their recovery. The program is overseen by specific SDC staff and NTBHA at the local level. Additional oversight is provided by the DSHS NorthSTAR office and staff representing the DSHS Mental Health Transformation Initiative, which provides funding for the administrative portion of the program. Researchers from the University of Illinois at Chicago serve as the program evaluators.

The primary question addressed by the SDC evaluation will be whether the program improves participants' mental health and enhances their quality of life, while being cost effective. Participants have a set level of funds on an annual basis to purchase traditional and non-traditional supports and services that are pertinent to their recovery plans. Services and supports may include traditional mental health services, or non-traditional services and supports necessary for recovery. The control group is composed of individuals who were randomly assigned to receive their usual services through the area's NorthSTAR managed care network. The study is scheduled to conclude in December 2012.

STAR Health

STAR Health is a statewide program designed to provide coordinated health services to children and youth in foster care and kinship care. It was implemented on April 1, 2008, by HHSC in collaboration with DFPS. The STAR Health program serves children in state conservatorship; young adults up to the month of their 22nd birthday who have voluntary foster care placement agreements; and young adults up to the month of their 21st birthday who were previously in foster care and are receiving transitional Medicaid services. Starting November 1, 2009, the STAR Health model also began covering young adults age 21 through the month of their 23rd birthday who were previously in foster care and enrolled in a higher education program. Clients can begin receiving services as soon as they enter state conservatorship.

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[i] Additional information on NorthSTAR can be obtained at http://ntbha.org (November 2012).

HHSC currently administers the program under contract with a single MCO. STAR Health members receive medical, dental, vision, and behavioral health benefits, including unlimited prescriptions, through a medical home. Additional benefits include service coordination, value-added services, and the Health Passport, which is a web-based, claims-based electronic medical record.

The program also includes a seven-days-per-week, 24-hours-per-day nurse hotline for caregivers and caseworkers. Use of psychotropic medications is carefully monitored, and in 2010 a trauma-informed care model was initiated, based on best practices for positive outcomes. This model effectively manages behavior issues that can destabilize children's health status and foster family placement.

Psychotropic medication utilization reviews are conducted with children whose medication regimens fall outside of the expectations of the guidelines. Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO formed a Psychotropic Medication Monitoring group and meets bi-monthly. This group reviews monitoring conducted by the STAR Health managed care organization and its behavioral health subcontractor. It also oversees an annual report on psychotropic utilization and the biennial review of the parameters.

Health Passport

The Health Passport is an essential element of the program that improves medical information sharing and promotes coordination of care with the child's physical and behavioral health care providers, DFPS staff, and caregivers. The Health Passport is a web-based repository of claims-based data and other health care services data for each STAR Health member, which facilitates online access to a child's medical data and history to promote continuity of care if the child moves to a new location as the result of a placement change.

Health Passport information is available to authorized users through a secure, password-protected website administered by the STAR Health managed care organization. Health care data available for viewing in the Health Passport includes current as well as historical claims data for foster care members that may have been prior enrolled in CHIP or Texas Medicaid programs. The system is updated regularly to ensure the most up-to-date information is posted to the child's records. Pharmacy, physical, and behavioral health claims are uploaded on a daily basis; immunization data from the state is received and loaded weekly. In addition, providers and other authorized individuals have the ability to add certain medical forms, patient allergy information, and patient vitals directly into

the Health Passport system; access to the information is available immediately upon entry.

The Health Passport application also has the functionality to check for interactions between medications based on a child's known allergies indicated in the system. If a foster care member is taking medications that interact with each other or any reported allergies, an alert is presented on the child's Passport medical record and accompanied with clinical information on the possible interaction.

Managed Care Enrollment

As shown in **Table 7.1**, Medicaid managed care enrollment has increased significantly between state fiscal year 1994 (when the first Medicaid managed care pilot was implemented) and 2011. Currently, Texas manages acute care for Medicaid clients through the STAR and STAR Health programs and acute and long term services through the STAR+PLUS program. **Table 7.2** shows enrollment for Texas' Medicaid managed care programs and the traditional Medicaid FFS system for state fiscal years 2005 to 2011.

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care SFYs 1994-2011

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR Implementation: Travis County (8/93) & Tri-County Area (12/93)	58,243	2.86%
1995	Same as above	65,388	3.16%
1996	Travis County and SE Region (Tri-County expanded to 3 additional counties 12/95 and renamed)	71,435	3.46%

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care (Continued)

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1997	Travis (expanded 9/96), SE Region, Bexar (9/96), Lubbock (10/96), Tarrant (10/96)	274,694	13.82%
1998	Same as above, with Harris STAR (12/97) and Harris STAR+PLUS (3/98)	364,336	19.56%
1999	Same as above, with STAR expansion to Dallas (7/99)	425,069	23.45%
2000	Same as above, with STAR expansion to El Paso (12/99)	523,832	28.98%
2001	Same as above	623,883	33.35%
2002	Same as above	755,698	35.92%
2003	Same as above	988,389	39.71%
2004	Same as above	1,112,002	41.44%
2005	Same as above	1,191,139	42.86%
2006	Same as above, with STAR expansion to 197 counties (PCCM Only)	1,835,390	65.74%
2007	Same as above, with STAR MCO expansion to Nueces (09/2006) and STAR+PLUS expansion to Bexar, Travis, Nueces, and Harris Contiguous (02/2007). Urban areas shift from PCCM to MCO Only (12/2006)	1,921,651	67.85%
2008	Same as above, with ICM rollout in Dallas and Tarrant (Aged & Disability-Related Clients) (02/2008) and STAR Health Foster Care Managed Care rollout statewide (04/2008)	2,039,545	70.88%
2009	Same as above, but with ICM removed in May 2009	2,127,382	70.81%
2010	Same as above	2,362,091	71.66%
2011	Same as above but with STAR+PLUS expansion to the Dallas and Tarrant Service Areas (2/2011)	2,676,149	75.57%

Sources: HHSC, Financial Services. Average Monthly Recipient Months including STAR, STAR+PLUS, PCCM, ICM and STAR Health.
Note: In the Dallas Service Area, most Medicaid eligible individuals receive Medicaid acute care services through the STAR program. They receive their behavioral health services through a separate program, NorthSTAR.

Table 7.2: Medicaid Clients Enrolled in Managed Care and Fee-for Service

SFYs 2007-2011

Medicaid Clients by Service Delivery Type

Service Delivery Type	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Fee-for-Service	**910,563**	**837,863**	**876,998**	**934,267**	**865,137**
Managed Care	**1,921,651**	**2,039,340**	**2,127,382**	**2,362,091**	**2,676,149**
STAR PCCM	*737,439*	*703,489*	*711,043*	*805,836*	*887,919*
STAR MCO	*1,069,208*	*1,131,583*	*1,170,905*	*1,359,957*	*1,536,422*
STAR Health	*0*	*12,578*	*30,090*	*29,762*	*31,834*
STAR+PLUS	*115,004*	*154,494*	*159,969*	*166,536*	*219,975*
ICM	*0*	*37,195*	*55,375*	*0*	*0*
Total Medicaid Clients	**2,832,214**	**2,877,203**	**3,004,380**	**3,296,358**	**3,541,286**

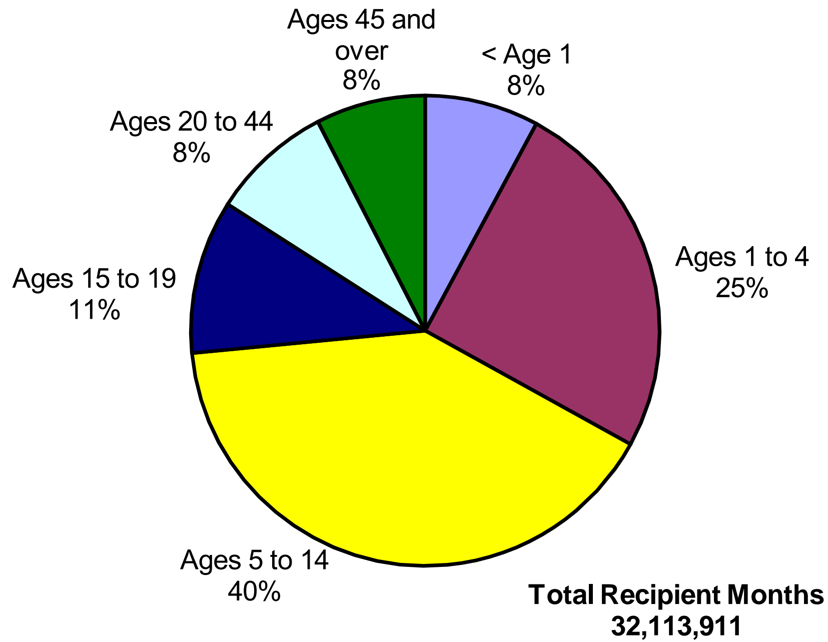
Percentage Medicaid Clients by Service Delivery Type

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Fee-for-Service	32.2%	29.1%	29.2%	28.3%	24.4%
STAR PCCM	26.0%	24.5%	23.7%	24.4%	25.1%
STAR MCO	37.8%	39.3%	39.0%	41.3%	43.4%
STAR Health	0.0%	0.4%	1.0%	0.9%	0.9%
STAR+PLUS	4.1%	5.4%	5.3%	5.1%	6.2%
ICM	0.0%	1.3%	1.8%	0.0%	0.0%

Source: HHSC, Financial Services, HHS System Forecasting.

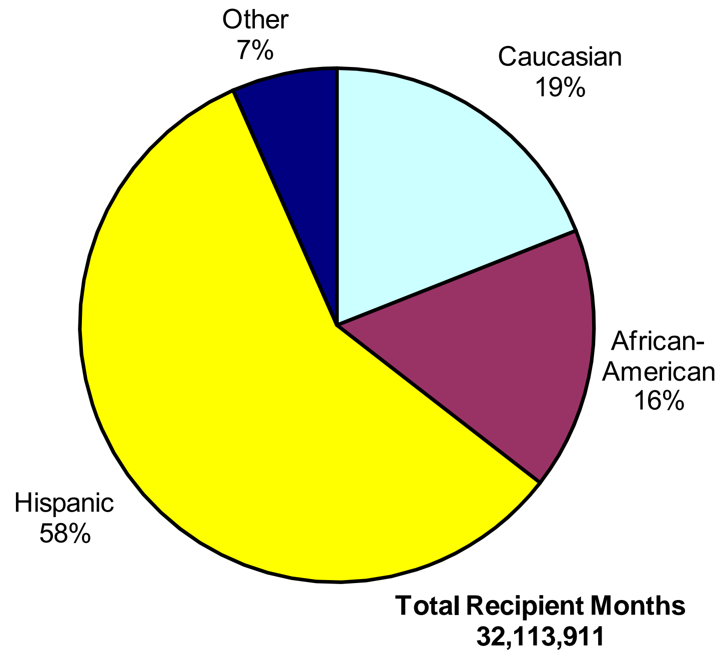
In SFY 2011, the majority of those enrolled in Medicaid managed care programs were children. Eighty-four percent of the Medicaid clients participating in managed care programs were under 20 years old. **Figure 7.1** shows Medicaid managed care average monthly enrollment by age group for SFY 2011. **Figure 7.2** shows the managed care recipient months average by race for SFY 2011.

Figure 7.1: Medicaid Managed Care Monthly Average Enrollment by Age, SFY 2011



Source: HHSC, Financial Services, HHS System Forecasting.

Figure 7.2: Managed Care Recipient Months Average by Race Group (including STAR+PLUS), SFY 2011



Source: HHSC, Financial Services, HHS System Forecasting.

Quality of Care

Federal law requires state Medicaid programs to contract with an EQRO to help evaluate Medicaid managed care programs. The EQRO produces an annual report with data to support HHSC's efforts to ensure that managed care clients have access to timely and quality care, in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and performance improvement projects for Medicaid and CHIP managed care programs.

The EQRO assesses access to care, satisfaction with care, and quality of care for Medicaid enrollees in all managed care programs. The EQRO also assesses the MCO's quality improvement program – both internal to the MCO organization and external in the MCO's delivery of services and uses a variety of nationally recognized evaluation tools and member satisfaction surveys to assess MCO quality, including:

- National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®),
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Tool,
- Children with Special Health Care Needs (CSHCN) Screener,
- The RAND® Health Survey,
- Agency for Healthcare Research and Quality (AHRQ) prevention indicators for adult and pediatric patients, and
- 3M Health Information System (HIS) software to calculate potentially preventable events including potentially preventable admissions, readmissions, emergency department visits, ancillary service use, and complications.

Texas also contracts with others to provide independent evaluations of managed care programs.

STAR

Quality of Care: The quality of care studies conducted in SFY 2010 by the EQRO indicates 63 percent of STAR children received six or more well-child visits in the first 15 months of life and 80 percent of STAR children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life compared to the 56 percent HHSC standard for this measure. Also, 63 percent of adolescents

enrolled in the STAR program had one or more well–care visits, well above the HHSC standard of 38 percent.

Access to Care: In SFY 2010, measurement of women's access to prenatal and postpartum care in STAR identified that 83 percent of pregnant women in the program received prenatal care in their first trimester and 60 percent had a postpartum visit three to eight weeks after giving birth.

Children and adolescents in STAR for SFY 2010 had good access to PCPs. Ninety-eight percent of members 12 to 24 months had a visit with a PCP in the preceding year, and 95 percent age 25 months to 6 years old had a PCP visit in the past year. Ninety-six percent of members age 7 to 11 years old had a PCP visit within the past two years, and 95 percent of members ages 12-19 had a PCP visit within the past two years.

Satisfaction with Care: The fiscal year 2011 STAR Child CAHPS survey report evaluates caregiver's experiences and satisfaction with their children's health care during enrollment in the STAR program.

- *Timeliness of Getting Care* – Seventy-eight percent of caregivers were able to get an appointment for their child with a health care provider within three days. Over half of the caregivers reported they never had to wait for an appointment due to limited hours or appointment slots available.
- *Getting Care Quickly* – Eighty-three percent of caregivers "always" or "usually" had positive experiences getting care quickly. This includes access to urgent care and routine care. Eighty-six percent of caregivers were able to access care when their child needed care right away for an illness, injury, or condition. Seventy-nine percent of caregivers "always" or "usually" were able to make a routine appointment as soon as they thought their child needed. Getting care in a timely manner often depends on approval from the MCO. Sixty-three percent of caregivers reported they never experienced delays in getting health care due to waiting on MCO approval.
- *Access to Specialist Care* – Fifteen percent of caregivers reported attempting to make an appointment to see a specialist. Of these caregivers, 68 percent indicated it was "always" or "usually" easy to get appointments with specialists.
- *Access to Specialized Services* – Caregivers reported positive experience with getting specialized services 66 percent of the time. Good access to the most commonly utilized special service – behavioral health treatment and counseling was reported by 61 percent of caregivers. Specialized medical

equipment and devices was the easiest specialized service to receive (74 percent). Sixty-four percent reported access to special therapies, and 59 percent for home health care or assistance.

STAR+PLUS

Quality of Care: The fiscal year 2010 STAR+PLUS Quality of Care Report provides descriptive information about the STAR+PLUS population and evaluation of members' access to care, utilization of services, and effectiveness of preventive care and treatment. It shows that the Texas STAR+PLUS program was generally good for most quality of care measures.

Access to Care: Some of the positive findings in the 2010 Quality of Care Report for STAR+PLUS include:

- Adults 45 years and older had an ambulatory or preventive care visit, with 88 percent of members 45 to 64 years old and 87 percent of members 65 years and older having an outpatient or preventive care visit during the measurement period. For each of these age groups, the STAR+PLUS program had higher rates of preventive care visits than what Medicaid managed care plans reported nationally.
- Ninety-four percent of STAR+PLUS members 10 to 17 years old and 91 percent of members 18 to 56 years old were appropriately treated for asthma. This exceeded the HHSC Quality Dashboard standards of 57 percent (10 to 17 year olds) and 62 percent (18 to 56 year olds).

Satisfaction with Care: The SFY 2011 STAR+PLUS Adult Member Survey provides a greater understanding of enrollee experiences and satisfaction with different facets of their health care, such as communication with their personal doctor, specialist care, service coordination, and their MCOs customer service.[2] It is important to note that this report is based on a member survey and not on empirical data.

The majority of STAR+PLUS members provided high ratings of their health care, doctors, and MCO, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were comparable to those published from Medicaid national data.

Other positive findings reported by members were:

- *Access to Specialist Referral.* The majority of members reported that it was always or usually easy to get a referral to see a specialist (64 percent) compared to the HHSC Performance Dashboard Standard (62 percent).
- *Access to Specialist Services.* The majority of members needing specialized services said it was usually or always easy to get specialized services, such

as home health care and assistance (70 percent), mental health treatment (67 percent), and special therapies (54) percent compared to the HHSC Performance Dashboard Standard (47 percent).

- *Access to Prescription Medicines.* A large majority of members reported it was usually or always easy to get the prescription medicines they needed (83 percent).
- *Presence of a Usual Source of Care.* A large majority of members reported having a personal doctor (85 percent).

Areas that offer an opportunity for improvement are:

- *Getting Needed Care.* Sixty-three percent of STAR+PLUS members said they usually or always had positive experiences with *Getting Needed Care*, compared to the 78 percent reporting for Medicaid plans nationally.
- *Good Access to Urgent Care.* Seventy-six percent of STAR+PLUS members said they usually or always received urgent care as soon as it was needed compared to the HHSC Performance Dashboard Standard (76 percent).
- *Good Access to Routine Care.* Seventy-three percent of STAR+PLUS members said they usually or always received an appointment for routine care as soon as it was needed compared to the HHSC Performance Dashboard Standard (78 percent).
- *Service Coordination.* Only 24 percent of members reported having a service coordinator, suggesting a low-level of understanding of service coordination benefits. Among the majority of members who said they did not have a service coordinator, 46 percent said they would like someone from their STAR+PLUS MCO to arrange services for them.

NorthSTAR

Quality of Care: In a 2010 analysis conducted by the EQRO, NorthSTAR achieved a 62 percent rate[ii] for follow-up care within 30 days after discharge from an inpatient psychiatric facility, as compared to the national mean of 60 percent. In addition, there are numerous quality and performance measures that the DSHS NorthSTAR staff monitor and track closely. [3]

Based on 2010 surveys conducted by HHSC, 82 percent of adults surveyed were satisfied with NorthSTAR services and 90 percent of families surveyed were satisfied with the NorthSTAR services their children received. A separate NorthSTAR Consumer Satisfaction Survey was administered in 2011 by Value

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[ii] This includes data from Medicaid NorthSTAR members.

Options, in conjunction with external stakeholders. Based on that survey, 85 percent of adult members were satisfied or very satisfied with mental health services received in NorthSTAR, and 83 percent of families were satisfied or very satisfied with mental health services their children received in NorthSTAR.

Access to Care: Based on the 2010 analysis conducted by the EQRO, 80 percent of NorthSTAR members were under the age of 18 years. Children under the age of six accounted for the largest percentage of NorthSTAR members, comprising 38 percent of the population. Across all age groups, 16 percent of NorthSTAR members were readmitted to the hospital within 30 days after an inpatient stay for mental health.[iii]

STAR Health

Service Management: The STAR Health MCO conducts a telephonic screening for each child within the first month of enrollment. The screening gathers information about medical history and current health status from the medical consenter for each child and is used by the MCOs service management team to determine the medical and behavioral health needs of all STAR Health members. Behavioral health needs are very common among the foster care population. If a need for behavioral health services is determined, the MCO will assign a service manager or service coordinator will be assigned to the child, depending upon the severity of the need. The Service Manager or Coordinator will then assist the medical consenter in obtaining the necessary services. Updates to the general screening are completed every time a child changes placements, and periodically according to their level of need, throughout their enrollment with STAR Health.

The STAR Health MCO has developed specialty service management programs that can assist children who have complex behavioral health needs. Complex Case Management supports children with the highest level of behavioral health needs, including those with dual diagnoses and/or a history of inpatient admissions. The Intellectual Developmental Disabilities Management program identifies and supports those with a diagnosis of autism, Asperger syndrome, intellectual disability or pervasive developmental disorder.

Psychotropic Drug Issues: In September 2004, the release of an Office of Inspector General report raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, DSHS, and DFPS have coordinated efforts to obtain a more detailed assessment of the

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[iii] This includes data from Medicaid NorthSTAR members.

problem and to assist providers in using psychotropic medication appropriately, both for children in foster care and for all children enrolled in Medicaid.

In 2005, the best practice guidelines *Psychotropic Medication Utilization Parameters for Foster Children* were released. The second edition was released in 2007, and the third edition in 2010. These *Parameters* include general principles for optimal practice, reference material, and a listing of commonly used psychotropic medications with dosage ranges and indications for use in children (both FDA approved and literature based).

- Annual analysis of how Medicaid prescribing practices align with these guidelines has revealed that psychotropic prescribing to children in foster care has steadily decreased since the release of the guidelines in early 2005, both in terms of the percentage of children in foster care and in the overall number of children receiving medication regimens outside of the recommended criteria.
- In April 2008, HHSC implemented the STAR Health program, a statewide Medicaid managed care program that provides comprehensive care to children in Texas foster care. The STAR Health MCO conducts ongoing Psychotropic Medication Utilization Reviews on children in foster care whose medication regimens fall outside of the expectations of the guidelines.
- Effective March 2012, with the carve-in of prescription drug coverage into managed care, all antipsychotic medication prescribed for children under the age of three years require a prior authorization. Expansion of this requirement beyond the foster care population to the Medicaid population statewide has further minimized antipsychotic medication usage in very young children. This carve-in has also provided the STAR Health MCO with opportunities to enhance its psychotropic medication monitoring.
- Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO hold bi-monthly meetings of a Psychotropic Medication Monitoring Group. This group reviews the monitoring conducted by the STAR Health MCO and its behavioral health subcontractor. It also oversees an annual report on psychotropic utilization and the biennial review of the parameters.
- The grant project entitled “Accelerating Utilization of Comparative Effectiveness Findings in Medicaid Mental Health” was developed to support evidence-based use of psychotropics in Medicaid, and includes six other state Medicaid programs (California, Maine, Missouri, New York, Oklahoma, and Washington) that collectively account for 33 percent of Medicaid enrollment nationally. Under the grant, Rutgers University will work with an existing network partnership, the Network for Evidence Based Treatment (NET), to create a consortium focused on increasing the utilization of evidence-based clinical and delivery system practices in the provision of mental health treatment for beneficiaries of state Medicaid programs previously mentioned. Texas participates in the current network of states that will collaborate as sub-

recipients of the grant. This project is a coordinated effort with DFPS, DSHS, and HHSC.

Chronic Care Management

Medicaid Wellness Program for Children with Disabilities

The Texas Medicaid Wellness Program is a community-based, holistic care management program that enrolls high-risk traditional Medicaid clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person, rather than the disease, through telephone and face-to-face conversations that aim to improve health outcomes. The client's care team is led by a registered nurse that can include social workers, community health workers, pharmacists, and behavioral health specialists, among others. In addition to working on the client's care plan with the provider, the care team also assists with transportation and housing issues, medical equipment assistance, and education on disease management and nutrition. Wellness clients receive between one and four telephone and/or face-to-face visits per quarter, receive educational mailings quarterly, and also have access to a 24-hour nurse advice line.

Managed Care for Children with Disabilities

The 2010-2011 GAA (Article II, HHSC, Rider 59, S.B. 1, 81st Regular Session, 2011), directed HHSC to develop a managed care program for children with disabilities to improve the coordination of acute care for existing Medicaid recipients. As mentioned above, on March 1, 2012, adult wellness program clients transitioned to managed care. Children with disabilities are not a part of the mandatory transition at this time, and therefore, the main focus of the Wellness Program will shift to serving children with disabilities who have SSI or SSI-related Medicaid. Once the program can be evaluated to determine whether it meets the needs of children with disabilities (approximately by September of 2013), decisions about future care coordination for children with disabilities will be made.

Managed Care Organization Requirements for Chronic Care Management

Medicaid MCOs must provide disease management services consistent with federal and state statutes, regulations and contract requirements. Disease management services must be part of a person-based approach and holistically address the needs of persons with multiple chronic conditions or a single serious

and persistent mental health condition. The MCO must develop and implement disease management services for members with chronic conditions including, but not limited to: a mental health condition; substance use disorder; asthma; diabetes; heart disease; and being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

Endnotes

[1] Texas Health and Human Services Commission, "Texas Medicaid Managed Care Review," November 1, 2000.

[2] Institute for Child Health Policy at the University of Florida Texas External Quality Review Organization, "The Texas STAR+PLUS Program Adult Member Survey Report, Fiscal Year 2011," http://www.hhsc.state.tx.us/reports/2012/EQRO-Texas-STARPLUS-Audlt-Member-Survey-FY2011-Attachment-1.pdf (December 2012).

[3] Additional information on various quality and performance measures that are tracked by DSHS can be found in the NorthSTAR data book at http://www.dshs.state.tx.us/mhsa/northstar/databook.shtm (November 2012).

Chapter 8: Medicaid Spending From All Angles

Medicaid is one of the largest line items in the Texas budget. Where does that money come from? Where does it go? How fast is the program growing?

Health Care Spending in the United States

Health care spending in the United States rose from $724 billion in 1990 to $2.59 trillion in 2010, an increase of 258 percent.[i] Over the same period, the economy grew by 150 percent. The faster growth of health spending relative to the growth of the economy is the reason that **Figure 8.1** shows a sustained long-term trend of health care spending representing a growing share of Gross Domestic Product (GDP). This increasing share of health care spending out of all spending can be attributed to a variety of factors. One of the most important of these factors is the increasing cost of care. As newer, more expensive treatments are developed and used, costs rise.[ii] Another important factor is the aging of the population. As people age, as a group they tend to spend more on health care. Because the

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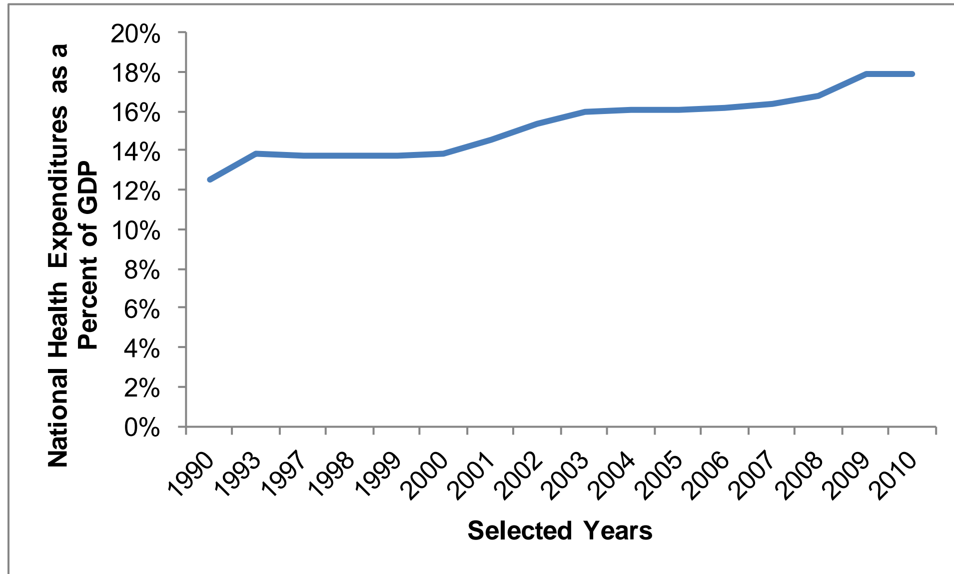
[i] The material in this section and the next, are drawn entirely from: Centers for Medicare and Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures" and "Table 17: Health Insurance Enrollment," found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html (November 2012).

[ii] Increasing the expenditure by itself does not necessarily guarantee increased quality of care or additional services.

average age of the country's population is increasing, total demand for health care is rising as a consequence.

Figure 8.1: Health Care Spending as a Percentage of GDP



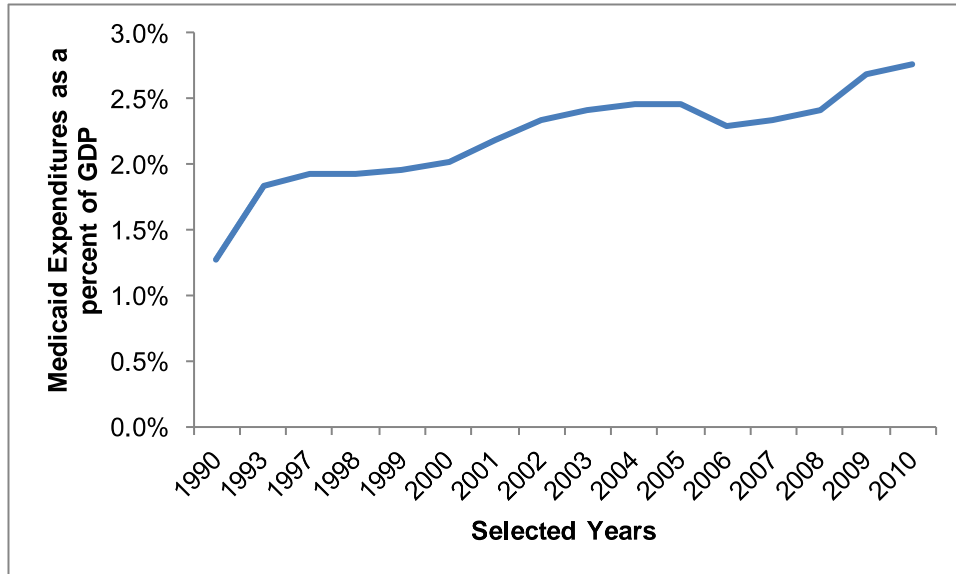
Source: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010."

Medicaid Spending as a Percentage of GDP

Just as total health expenditures have been rising, Medicaid expenditures have also been rising. See **Figure 8.2.** Total Medicaid expenditures rose from $73.7 billion in 1990 to 401.4 billion in 2010, an increase of 445 percent. The increase in Medicaid expenditures was induced partly by the same factors that affected the increase in medical expenditures for the general population, and partly by factors unique to Medicaid. The increases in expenditures for the general population were induced mainly by more expensive care and an older population. The costs for Medicaid are affected up by these causes, but have also been pushed up by increases in the Medicaid caseload, and the fact that Medicaid serves a specially selected demographic group. Over the period 1990 to 2010, the Medicaid caseload grew from 22.8 million individuals to 53.6 million individuals, an increase of 135 percent. So of the total 445 percent increase, 135 percent can be attributed to caseload growth alone. The demographic selection

of the Medicaid population occurs because eligibility to enter the Medicaid population is governed by laws designed to provide medical help to the needy. Because the needy on Medicaid tend to have many more, and more serious, untreated medical conditions per enrollee than the population as a whole has per capita, this demographic factor induces additional costs for serving the Medicaid population.

Figure 8.2: Medicaid Spending as a Percentage of GDP

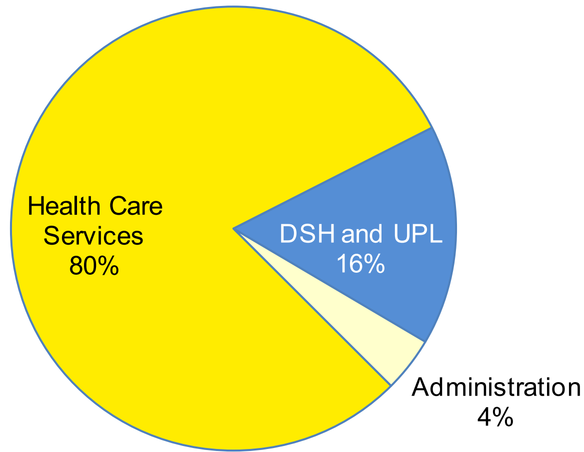


Source: Centers for Medicare and Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2010."

The Bottom Line

Since its inception in 1967, the Texas Medicaid program has grown from serving fewer than one million Texans to serving over three million Texans. Combined federal and state Medicaid spending has increased from under $200 million per year to over $24.8 billion per year in federal fiscal year (FFY) 2011. This amount excludes disproportionate share hospital (DSH) and upper payment limit (UPL) funds. When DSH and UPL funds are included, combined federal and state spending on Texas Medicaid in FFY 2011 was $29.4 billion. Health care services accounted for $26.6 billion, and administration of the program accounted for $1.3 billion, or four percent of total costs. DSH reimbursements added another $1.6 billion to program costs. **Figure 8.3** shows the percent distribution of total Texas Medicaid costs for 2011.

Figure 8.3: Texas Medicaid Budget
FFY 2011



Source: Texas Medicaid History Report May 15, 2012.

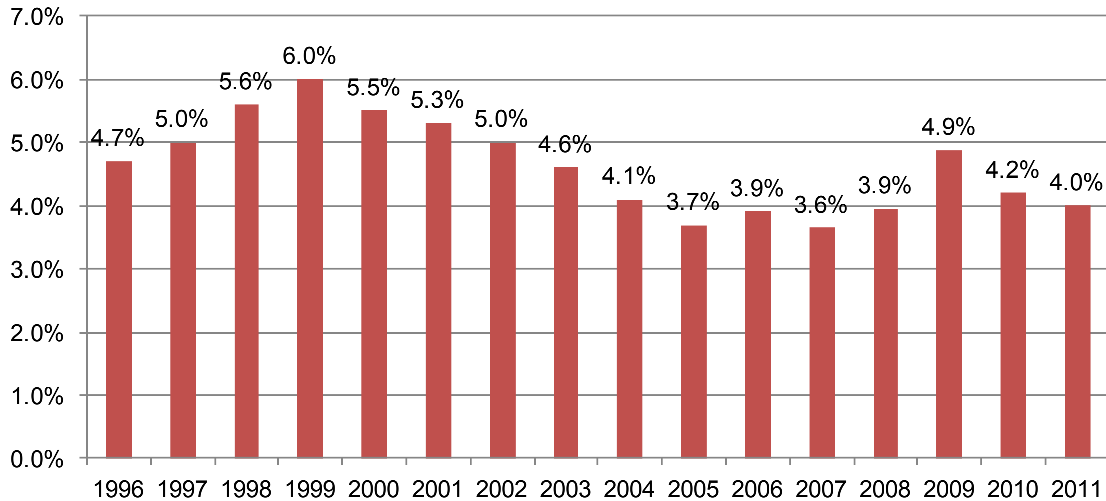
Medicaid Spending as it relates to State Tax Revenue

It is projected that state Medicaid spending, excluding federal contributions will reach $14.6 billion or 20.4 percent of the $71.6 billion in state tax revenues during the 2012-2013 biennium.[1]

Administrative Costs

Medicaid administrative costs accounted for $1.3 billion in FFY 2011, comprising four percent of the total Medicaid budget. **Figure 8.4** illustrates the changes in Medicaid administrative costs over time, from a high of 6 percent in 1999 to a low of 3.8 percent in 2007.

Figure 8.4: Administrative Costs as a Percentage of the Total Medicaid Budget
FFYs 1996-2011



Source: HHSC, Financial Services, Texas Medicaid History Report, May 15, 2012.

Historical Medicaid Spending

Medicaid has experienced steady growth in the last decade, increasing as a percentage of both federal and Texas budgets. **Table 8.1** represents the percentage of Medicaid expenditures, excluding DSH and UPL payments in the Texas state budget from 1998 through 2011. In state fiscal year (SFY) 2011, Medicaid comprised approximately 26 percent of the total state budget.[iii] **Figure 8.5** documents growth in the federal and state shares of the state's Medicaid budget since 1989.

Texas Medicaid operated for 20 years before its budget reached the $2 billion mark. The total Medicaid budget for FFY 2011, including DSH and UPL funds, was over $29.4 billion.

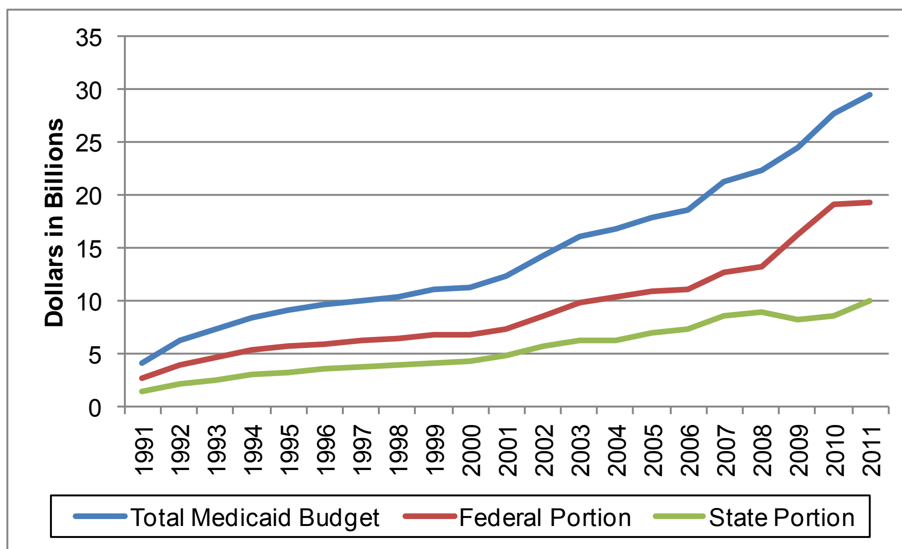
[iii] Excludes DSH and UPL funds.

Table 8.1: Percent of Medicaid Expenditures in Texas State Budget FFYs 1998-2011*

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

*Dollars in billions.
**Excludes Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funds
***State budget reflects state fiscal year beginning in September.
Source: Texas Medicaid History Report May 15, 2012 and Fiscal Size-Up(s) Appendix E Medicaid Expenditure History (FFYs 1987-2011).

Figure 8.5: Texas Medicaid Budget FFYs 1987-2011



*Includes DSH and UPL funds.
Source: Texas Medicaid History Report May 15, 2012.

Trends in Texas Medicaid Caseloads and Costs

Budget and Caseload Growth

The rapid acceleration of Texas Medicaid spending from the late 1980s to the early 1990s was primarily due to increasing caseloads and costs. Escalating DSH payments and medical inflation contributed to the increase in overall costs of the Medicaid program. At the same time, program changes contributed to the increase in the number of Medicaid beneficiaries, thereby increasing caseload.

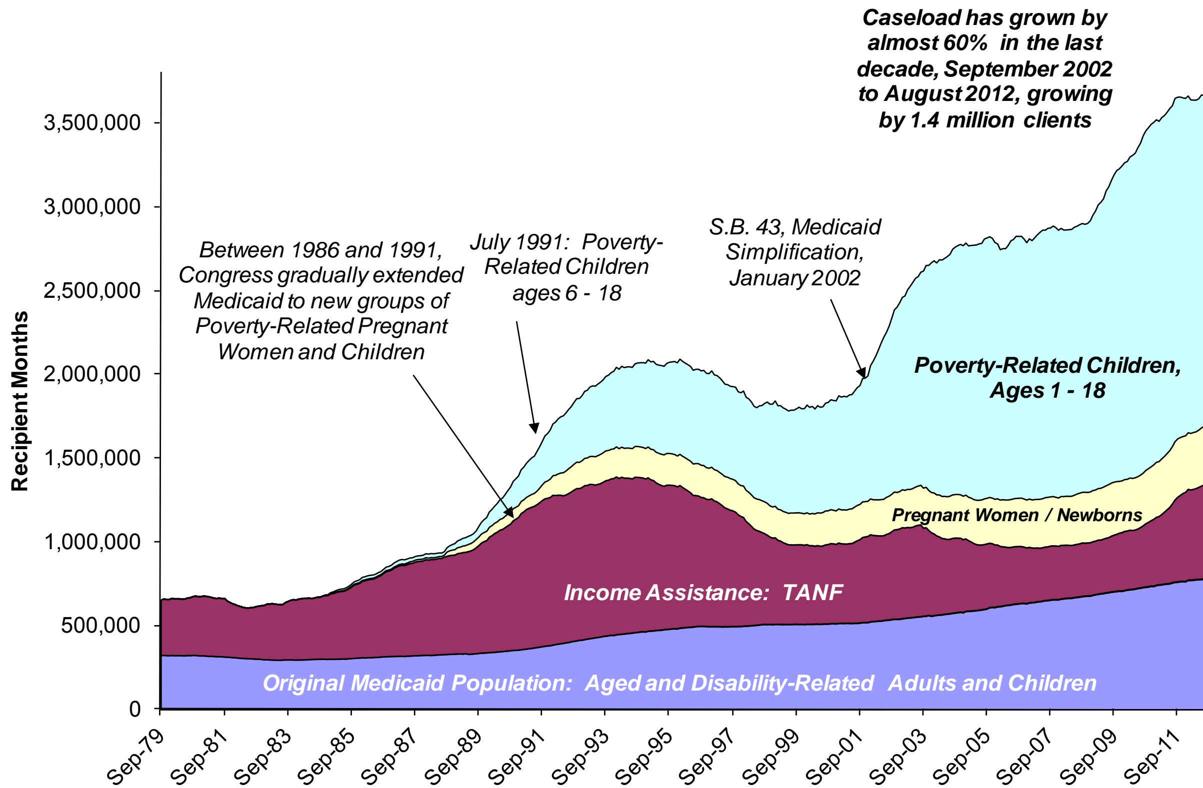
In the 1990s, Texas sought to include existing state-funded programs in the Medicaid program so that they could be eligible to receive federal matching dollars. These factors combined to increase the Texas Medicaid budget five-fold from 1987 to 2001.

In 1988, Congress dramatically expanded Medicaid eligibility standards to include groups of people with incomes higher than the Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance for Needy Families or TANF) cap. Other federal expansions and the economic recession in the early 1990s resulted in more increases in the number of children and pregnant women who became eligible for Medicaid. Beginning in the mid-1990s, welfare reform began to impact not only the size of the Medicaid caseload as TANF clients declined, but the composition of the caseload. While caseloads declined overall in the late 1990s, the numbers of clients over the age of 65 or who have a disability, as well as pregnant women and newborns, continued to increase and comprise a larger proportion of caseload. These high-cost clients offset any cost savings that could have resulted from caseload declines.

Texas' implementation of continuous eligibility for children as well as simplifying the eligibility process resulted in even more caseload increases after 2000. Again, however, the caseload for TANF-related Medicaid recipients began to decline further after September 2003 when the Full Family Sanctions policy was implemented. This policy requires TANF clients to sign a "Personal Responsibility Agreement" (PRA) whereby the family must comply with work and other requirements, such as child/medical support assignment, immunizations, school attendance, Texas Health Steps, parenting skills, and cooperation with drug and alcohol requirements. If clients fail to comply with the PRA, the family loses cash assistance. The adult family member, with the exception of pregnant women, loses Medicaid coverage for non-compliance with work requirements or

child/medical support requirements. **Figure 8.6** shows the Texas Medicaid caseload growth rates from September 1979 to August 2012.

Figure 8.6: Texas Medicaid Caseload by Group
September 1979 – August 2012



Source: HHSC, Financial Services, HHS System Forecasting.

Changing Trends

Medicaid spending slowed during the mid to late 1990s due to a combination of factors, including an improving economy, declining enrollment, and a movement to managed care in private, employer-sponsored health insurance that resulted in overall health care cost containment.

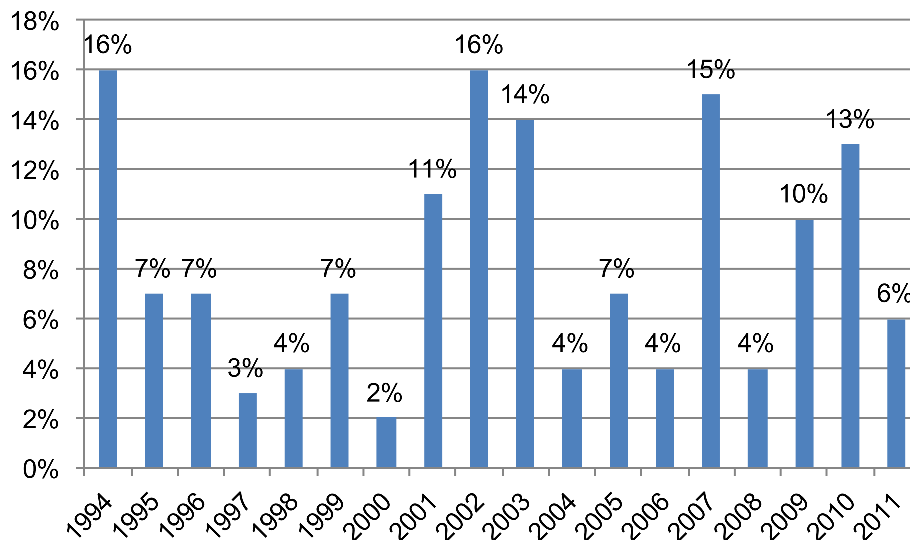
The economic slowdown experienced in the early 2000s, contributed to decreased consumer spending, increased unemployment levels, and higher caseloads. Additionally, the number of children on Medicaid continued to increase through the early 2000s, partially due to Texas' implementation of six months continuous eligibility for children's Medicaid. Expenditures also rose due to cost increases in prescription drugs and medical procedures, and greater utilization of drugs and health services. This combination of factors resulted in

the state's Medicaid expenditures once again rising by ten percent or more each year in the early 2000s. Beginning in 2004 and continuing in 2006, Medicaid budget growth slowed to single-digits, due in part to slowing caseload growth trends, cuts in rates paid to hospitals and physicians, and Medicare Part D, which resulted in savings for clients whose drug costs moved to Medicare.

Beginning in 2007, however, the caseload began growing at a slightly higher rate, though still not at the rates seen in the early 2000's, and drug costs and utilization began to increase as well. More importantly, changes in the composition of the Medicaid caseload began to be felt, with higher proportions of high-cost clients such as disability-related clients driving costs up. Additionally, rate increases for many physician groups and services contributed to rising costs in the late 2000's. Beginning in March 2009, Medicaid caseload began rising, with trends climbing to double-digit levels (10 to 11 percent for six months). However, the caseload growth tended to be in the lower cost groups, so the overall cost increases were not as large but were still seen in the trends. While caseload growth began slowing in state fiscal year (SFY) 2011, a rate cut for physicians and services slowed cost growth as well. As we move into SFY 2013 and beyond, with caseloads over 3.6 million and a continually growing population and elderly and disability-related clients, cost containment measures are being implemented to slow double digit expenditure growth in the face of rising caseloads.

Figure 8.7 shows the Medicaid budget growth rates from FFYs 1994-2011.

Figure 8.7: Texas Medicaid Annual Budget Growth Rate FFYs 1994 to 2011

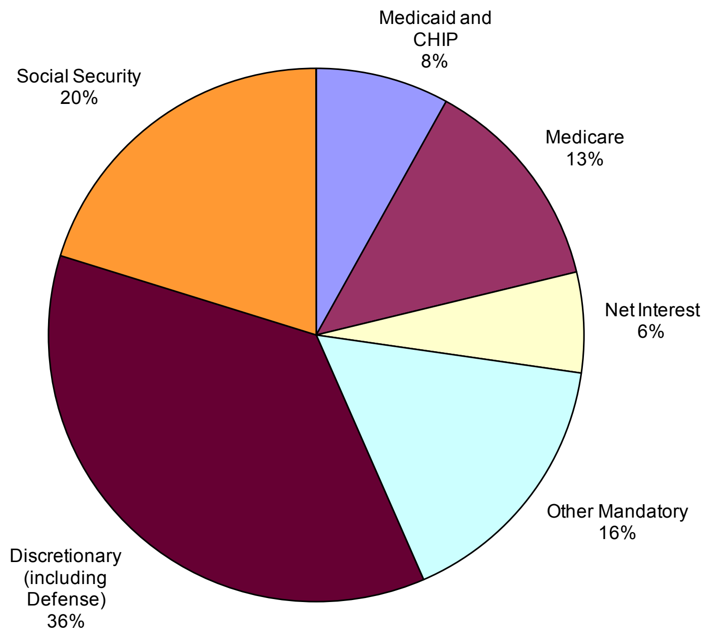


Source: HHSC, Financial Services, Texas Medicaid History Report, May 15, 2012.

Medicaid and the Federal Budget

Medicaid and the Children's Health Insurance Program (CHIP) accounted for eight percent of the $3.8 trillion federal budget in FFY 2011. Federal spending on Medicaid and CHIP totaled about $285 billion. **Figure 8.8** illustrates federal government spending by type of expenditure for FFY 2011.

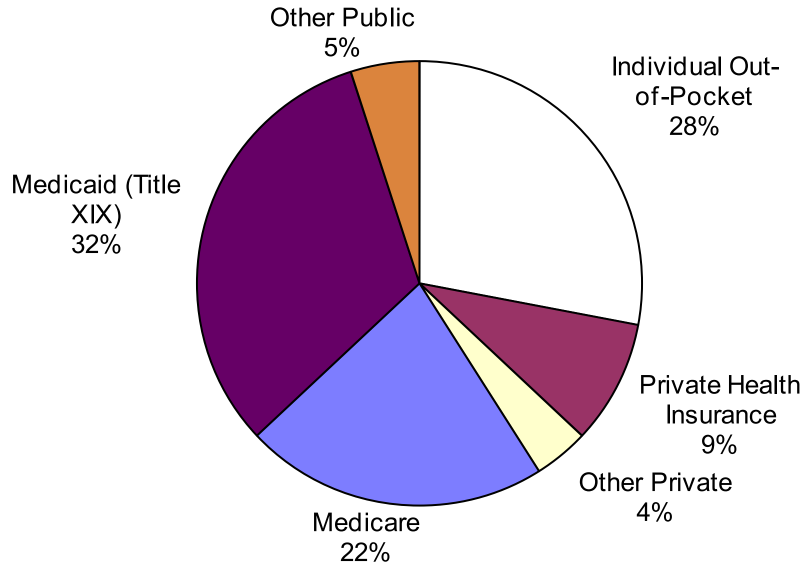
Figure 8.8: Federal Budget Expenditures FFY 2011



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

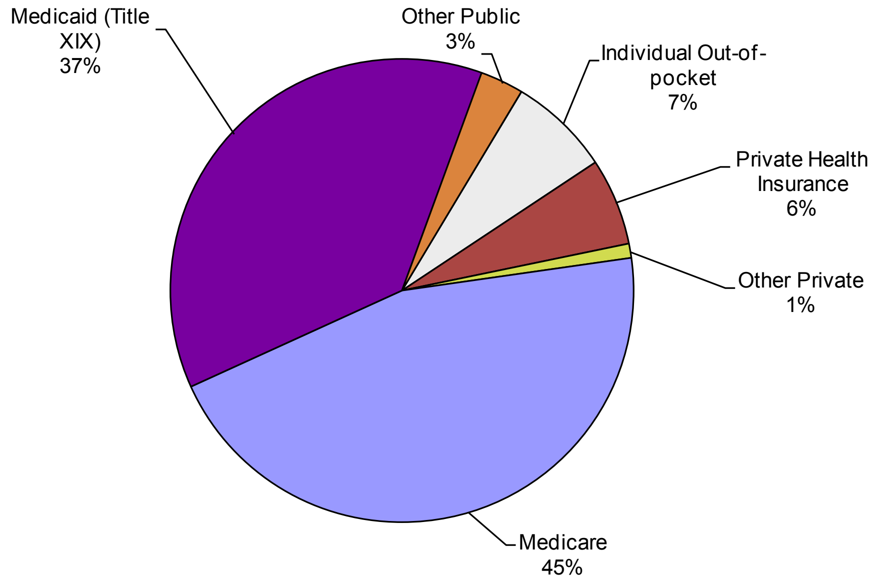
Medicaid is the largest public funding source for long-term care services nationwide. **Figure 8.9** shows the national distribution of payor sources for nursing facility care in calendar year 2010. Medicaid was the largest source, paying for almost 32 percent of nursing facility expenditures nationally. **Figure 8.10** shows the national distribution of payor sources for home health care in calendar year 2010. Medicaid accounted for about 35 percent of home health spending nationally, while Medicare, the largest payor source, accounted for 41 percent.

Figure 8.9: National Nursing Facility Payor Sources for Calendar Year 2010



Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (November 2012).

Figure 8.10: National Home Health Payor Sources for Calendar Year 2010



Source: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (November 2012).

Federal Funding

Federal funds are a critical component of health care financing for the state of Texas. For the 2010-2011 biennium, federal funds account for $42.2 billion (about 64 percent) of the total expenditures for health and human services. Of this amount, $32.2 billion (about 76 percent) is for Medicaid. Note that during fiscal years FFY 2010 and 2011 all states received additional federal funds as part of the American Recovery and Reinvestment Act.

The amount of federal Medicaid funds Texas receives is based on the federal medical assistance percentage (FMAP) or Medicaid matching rate. Derived from each state's average per capita income, the Centers for Medicare & Medicaid Services (CMS) updates the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. For FFY 2013, the Medicaid FMAP was 59.30 percent.

Building a Medicaid Budget

Staffs of the Medicaid operating departments develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This process requires projections of the number of people eligible for and applying for the program; estimations of medical inflation rates; analyses of any new federal mandates affecting eligibility or services and/or changes in program policy; and outreach efforts.

As evident from **Table 8.2**, a significant amount of time elapses between the development of the initial agency budget request and the time an appropriations bill takes effect. Medicaid enrollment trends and other factors that drive budget projections can change significantly before the budgeted period ends. Caseload or cost changes can cause considerable differences between appropriated budgets and actual expenditures. However, because Texas Medicaid is currently federally defined as an entitlement program, the state cannot stop paying if the demand for Medicaid services exceeds the appropriated level.

Table 8.2: Medicaid Timeframes in the 2014-2015 Budget Process

<table>
<tr><td>August 2012</td><td>Agencies submit Legislative Appropriations Requests (LARs) for SFYs 2014 and 2015 (September 2013 - August 2015).
Most recent program data available is through April 2012.</td></tr>
<tr><td>January 2013</td><td>Legislature convenes.</td></tr>
<tr><td>April 2013</td><td>Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bill.
Most recent program data available is through March 2013.</td></tr>
<tr><td>May 2013</td><td>Legislature finishes appropriations for SFYs 2014-2015.</td></tr>
<tr><td>September 2013</td><td>SFY 2014 begins.</td></tr>
<tr><td>August 2015</td><td>2014-2015 biennium ends.</td></tr>
<tr><td colspan="2">At the beginning of the 2014-2015 biennium in September 2013, the Medicaid data used for projections is five months old. By the end of the biennium in August 2015, the data is 29 months old. If Medicaid budget projections were too low, this could result in a budget shortfall. If projections were too high, it could result in an unexpected surplus.</td></tr>
</table>

Deferrals and Disallowances

CMS can impose deferrals and disallowances on a state’s Medicaid program based on its determination that the state acted outside of CMS regulations or the state’s Medicaid state plan. Deferrals and disallowances impact the availability of federal financial participation (FFP) for the program.

CMS often imposes deferrals or disallowances following a federal audit or a change to the Medicaid state plan, the state’s contract with CMS. A deferral or disallowance may be imposed for the federal fiscal quarter(s) for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan, and in the case of a disallowance, may retroactively encompass several years of claims.

Deferrals: CMS can reduce current Medicaid federal funding when it determines that a state is out of compliance with federal regulations or its Medicaid state plan. CMS withholds funds until it determines the state has come into compliance or until the state provides additional information to support the validity of the claim.

Disallowance: CMS can also recoup federal funds when it alleges a claim is not allowable, but states have the option to appeal the CMS determination. The state can request reconsideration by submitting a request to the chair of HHS’

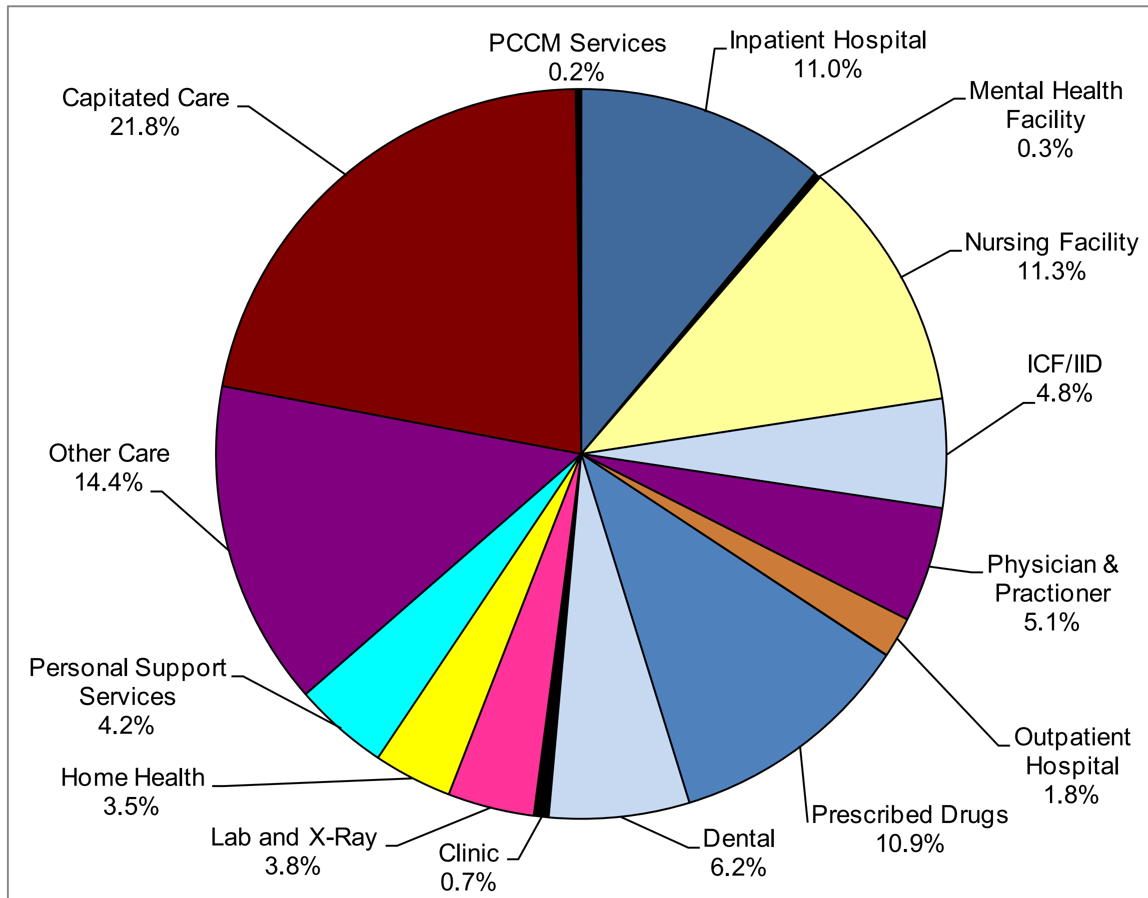
Departmental Appeals Board (DAB) within 30 days after receipt of the disallowance letter and include a statement of the amount in dispute and a brief statement of why the disallowance is incorrect. CMS then has 30 days to provide a written response to the state's argument. Within 15 days of receiving CMS' response, the state may submit a short rebuttal to CMS' argument. The DAB can make a ruling based on the written statements provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.

Spending by Service

Figure 8.11 shows the distribution of Texas Medicaid's $20.7 billion (FFY 2010) in health care service spending by type of service (it does not include funds for DSH, UPL, CHIP, administration, or survey and certification of health facilities).[iv] Inpatient hospital care, nursing facility care, prescribed drugs, capitated care, and other care were the top five cost items, accounting for over 69 percent of program expenditures. Nursing facility care comprised the largest portion of long-term care spending, accounting for over $2.3 billion all funds.

[iv] Spending by service and eligibles as presented in earlier editions of the Pink Book were based on state "2082" reports required to be produced for CMS. Changes in federal reporting requirements have altered the structure of these reports, making it more difficult to compare spending accurately across years.

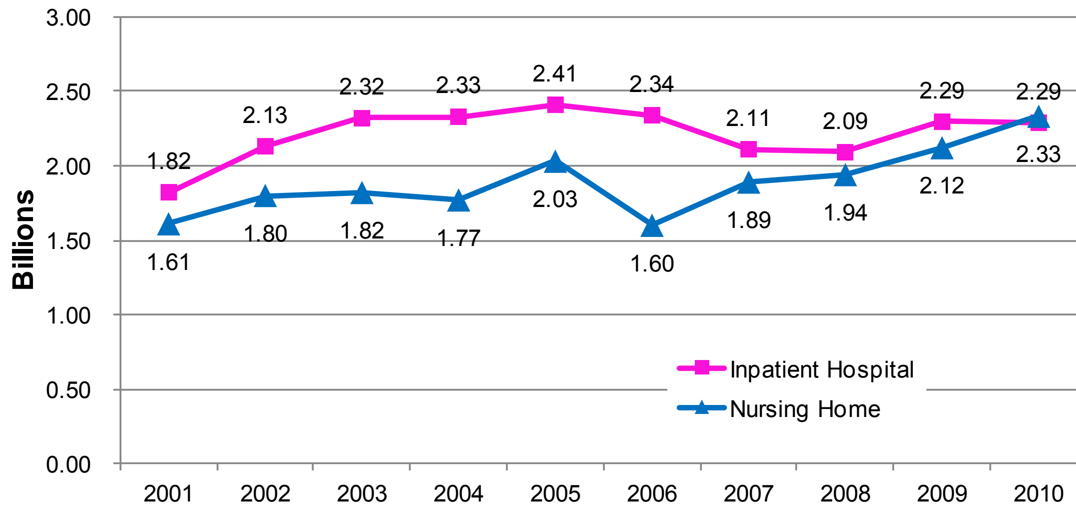
Figure 8.11: Texas Medicaid Spending by Services Type FFY 2010



Note: "Other Care" includes a variety of services that cover many Medicaid program areas.
Source: CMS Medicaid Statistical Information System Summary Mart.

Increases in Medicaid spending are caused by higher utilization and increases in the costs of services. **Figure 8.12** shows expenditure changes from 2001 to 2010 for two expensive services: nursing facility and inpatient hospital care. In FFY 2010 nursing facility and inpatient hospital expenditures combined were approximately $4.6 billion, all funds.

Figure 8.12: Texas Medicaid Nursing Facility and Inpatient Hospital Expenditures FFYs 2001 to 2010

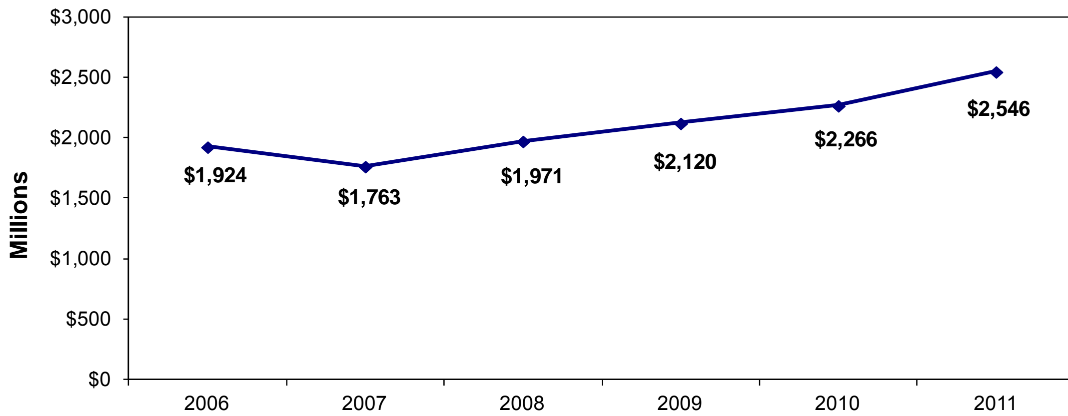


Source: CMS, Medicaid Statistical Information System, FFY 2001-2010.
Note: Inpatient hospital expenditures do not include DSH and UPL payments.

Texas Medicaid prescription drug expenditures remained fairly stable from State Fiscal Year (SFY) 2006 ($1.9 billion all funds) to SFY 2011 ($2.5 billion all funds).[V] The decreases in SFY 2006 ($1.9 billion all funds) and SFY 2007 ($1.8 billion all funds) were due to Medicare Part D. **Figure 8.13** shows the change in Texas Medicaid spending of prescription drugs for these years. The change in spending for prescription drug is attributable to increasing caseload, drug utilization, and drug prices. The 78th Legislature passed a number of initiatives to help contain rising drug costs, including a Medicaid Preferred Drug List (PDL). Effective January 2006, Medicare eligible clients began receiving most of their prescription drugs through Medicare Part D; however, prescription drug spending continues to increase due to the factors mentioned above.

[V] Total prescription drug expenditures in SFY 2009, including Medicare “clawback” payments, equals $2.4 billion.

Figure 8.13: Texas Medicaid Vendor Drug Expenditures SFYs 2006-2011



Source: HHSC, Financial Services, HHS System Forecasting, Vendor Drug Expenditures.

Total Spending by Type of Eligibility

Texas Medicaid spending patterns are not uniform across all eligibility groups. The risk group made up of people who are age 65 and older and disability-related is the smallest portion of Medicaid clients, yet it accounts for the majority of expenditures. (See Chapter 1, **Figure 1.2,** “Texas Medicaid Beneficiaries and Expenditures, SFY 2011.”) **Table 8.3** and **Table 8.4** show SFY 2011 average monthly cost per eligibility category and expenditures.

Table 8.3: Average Monthly Cost per Eligibility Category SFY 2011

The average monthly cost per recipient in SFY 2011 was $510 per client per month, with both full and non-full benefit clients considered, and with all acute and long-term services and supports included in the cost. For the acute and long-term services for full-benefit clients, the cost was $517 per client per month. Average monthly client costs look very different when examined by category:

Full-Benefit Clients:

- Non-disability-related children: $259 per client per month.
- People age 65 and over and disability-related: $1,350 per client per month.
- Adults (Pregnant Women and Parents): $640 per client per month.

Costs for non-full benefit clients are not included in the cost per client per month by group, but include costs for Medicare Part A&B premiums for partial duals, Emergency Medicaid Services for Non-Citizens costs, and Women's Health Waiver costs. Costs per client per month are lower when all services and clients are included, as many of the partial benefit clients have, by definition, expenses only for very specific, often lower cost, services, such as Medicare partial premiums or women's health services.

Source: HHSC, Financial Services, HHS System Forecasting.

Table 8.4: Texas Medicaid Clients and Expenditures SFY 2011

- Children are the least expensive population that Medicaid covers. While 66 percent of Texas Medicaid clients were Non-Disability-Related Children, they accounted for only 33 percent of expenditures.
- The Aged (65+) and Disability-Related account for a large portion of Texas Medicaid spending. Only 25 percent of Texas Medicaid clients were Aged or Disability-Related, but they accounted for 58 percent of program spending.
- Non-Disability-Related Adults are relatively inexpensive to insure. Parents and Pregnant Women accounted for 9 percent of the population and 9 percent of expenditures.

Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid Rates

The following sections discuss the different methodologies used to calculate the rates of reimbursement for some types of providers.

Fee-for-Service Rates

The Texas Health and Human Services Commission (HHSC) is responsible for establishing Medicaid fee-for-service (FFS) reimbursement methodologies by rule and/or approval by CMS. HHSC consults with stakeholders and advisory committees such as the Physician Payment Advisory Committee (PPAC) and the Hospital Payment Advisory Committee (HPAC) when considering changes to FFS reimbursement rates. All proposed rates are also subject to a public hearing and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process.

Physicians and Other Practitioners

Medicaid rates for FFS services delivered by physicians and other practitioners (which include payments for laboratory services, including x-ray services, radiation therapy services, physical and occupational therapists' services, physician services [including anesthesia and physician-administered drugs], podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services and certified nurse midwife services) are calculated in accordance with Title 1 of the Texas Administrative Code (TAC), §355.8085. Rates are uniform statewide and are either resource-based fees (RBFs) or access-based fees (ABFs).

RBFs are based on the actual resources required by an economically efficient provider to deliver a service and are calculated by multiplying the relative value units (RVUs) for a service times a conversion factor. Total RVUs are assigned to each service, covering the three components of the cost to deliver the service. The three components are intended to reflect the work, overhead and professional liability expense for a service. The Medicaid RBFs were first established in 1992 and utilized the RVUs specified in the Medicare Physician Fee Schedule at the time. As new services are added, the Medicaid RVUs for new services are based on the Medicare RVUs in effect at the time. Base units, which serve a similar function as RVUs, are used for anesthesia services.

ABFs are developed to account for deficiencies in RBF methodology related to adequacy of access to health care services for Medicaid clients and are based on historical charges, the current Medicare fee for a service, review of Medicaid fees paid by other states, survey of providers' costs to deliver a service, and/or Medicaid fees for similar services.

Nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, and physician assistants are reimbursed for covered professional services at 92 percent of the physician rate for the same professional service. Licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, and licensed psychological associates are reimbursed for covered professional services at 70 percent of the rate paid to psychiatrists and psychologists for the same professional service. Physicians are reimbursed for assistant surgery services at 16 percent of the amount paid to the primary surgeon.

Physician-Administered Drugs/Biologicals

Effective October 1, 2006, Medicaid rates for physician-administered drugs/biologicals are determined under 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their billed charges and the Medicaid fee established by HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug or biological.

Prescription Drug Reimbursement

Reimbursement for FFS pharmacy prescription claims includes two components: an amount for the ingredient cost of the drug product and a professional dispensing fee.

Ingredient cost reimbursement:

- Pharmacies' Estimated Acquisition Costs (EAC) are determined by the Medicaid Vendor Drug Program (VDP) using actual manufacturer reported prices as well as national pricing data services. The EAC is based on the pharmacy's reported source of purchase. This source of purchase could be through a wholesale company, directly from the drug manufacturer, or through a central purchasing entity such as a warehouse.
- Ingredient cost is the product of the EAC times the quantity dispensed.
- Ingredient cost represents over 90 percent of total reimbursement for VDP claims.

Dispensing fee reimbursement:

- Dispensing fees are based on an average pharmacy's cost to dispense a prescription, including costs for staff and overhead. The dispensing fee consists of two separate components, a fixed component and a variable component. Effective September 2011, the fixed component is $6.50 per prescription and the variable component is 1.96 percent of the ingredient cost plus the fixed component.
- Pharmacies that provide no-charge delivery services to Medicaid clients may be eligible for a delivery incentive, currently $0.15 per prescription.

All reimbursement amounts determined by the above methodology are reduced to a pharmacy's reported usual and customary price if that reported price is less than the total reimbursement determined by adding the ingredient cost and the professional dispensing fee.

Hospitals

Hospital funding methodologies include inpatient and outpatient hospital reimbursements, UPL funding, graduate medical education (GME) funding, and DSH funding. Not every hospital is eligible for all of these different funding sources. Only hospitals that meet certain eligibility criteria can receive UPL, GME, and DSH funds. The UPL program no longer exists in Texas with the approval of the 1115 Transformation Waiver described in Chapter 4. The waiver provides two new sources of funds for hospitals (and certain other providers) – the Uncompensated Care pool and the Delivery System Reform Incentive Payment pool.

Inpatient Hospital Reimbursement Rates

General acute care hospital reimbursement rates for FFS Medicaid clients are set using a prospective payment system (PPS) based on Medicare's diagnosis related groups (DRGs). Under PPS, each patient is classified into a DRG on the basis of clinical information and then hospitals are paid a pre-determined rate for each DRG (admission), regardless of the actual services provided. The rate is calculated using a formula based standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG. "Outlier" payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay.

Rates paid to freestanding psychiatric hospitals, in-state children's hospitals, and rural hospitals and state-owned or operated teaching hospitals are set using a

different methodology. Freestanding psychiatric hospitals are reimbursed a PPS per diem based on the federal base per diem with facility specific adjustments for wages, rural location, and length of stay. In-state children's hospitals, rural hospitals, and state-owned or operated teaching hospitals are reimbursed for their reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) cost principles. Rural hospitals must meet one of the following criteria: located in a county with 50,000 or fewer persons according to the U.S. 2000 decennial census, is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or is a Medicare-designated Critical Access Hospital (CAH), to be considered a rural hospital.

Outpatient Hospital Reimbursement Rates

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital's reasonable cost. Reimbursement for outpatient hospital services for high-volume providers is 76.03 percent of the hospital's allowable cost. With regard to outpatient services, a high-volume provider is defined as one that was paid at least $200,000 for FFS and Primary Care Case Management (PCCM) Medicaid services during calendar year 2004. For the remaining providers, reimbursement for outpatient hospital services is 72.27 percent of the allowable cost.

Upper Payment Limit Reimbursement

States have broad flexibility in setting the Medicaid rates that they pay to hospitals, nursing homes, and other providers. Federal Medicaid rules, however, specify that state Medicaid payments to groups of facilities (state-owned facilities, non-state publicly owned or operated and all other hospital providers) cannot exceed the amount Medicare would have reasonably paid for the same services. Federal Medicaid rules also specify that states cannot pay individual hospitals more than the amount of their aggregate charges for providing services to Medicaid beneficiaries. These rules collectively are known as UPL. UPL regulations have been in existence since the early 1980s. Texas' UPL payments (totaling about $3 billion in FFY 2011) offset the difference between what Medicaid paid for a service and what Medicare would have paid for the same service. The Texas Medicaid program used intergovernmental transfers from state-owned or local governmental entities to finance the state share for drawing down federal funds to make the UPL payments. The UPL program no longer

exists with the approval of the 1115 Transformation Waiver, which is described in Chapter 4.

Table 8.5 shows historical UPL spending for Texas for FFYs 2002 to 2011.

Table 8.5: Historical Upper Payment Limit (UPL) Spending FFYs 2002-2011

Year	Upper Payment Limit
FFY 2002	$ 168,056,432
FFY 2003	$ 289,181,118
FFY 2004	$ 775,847,457
FFY 2005	$ 897,899,580
FFY 2006	$ 526,735,788
FFY 2007	$1,734,191,128
FFY 2008	$1,693,792,595
FFY 2009	$2,219,683,156
FFY 2010	$2,693,221,610
FFY 2011	$2,789,436,532

Source: HHSC, Financial Services.
Includes Physician UPL.

Table 8.6 shows the Texas UPL programs and the effective date for each program.

Table 8.6: Texas Upper Payment Limit (UPL) Programs

Hospital UPL Programs	Effective Dates
Large Public Hospitals	July 2001
Rural Hospitals	January 2002
State-Owned Hospitals	December 2003
Private Hospitals	June 2005 and November 2005*
Children's Hospitals	April 2006
Physician UPL Programs	**Effective Dates**
State-Owned Hospital Physicians	May 2004
Tarrant County Hospital District Physicians	November 2004
Chapter 281 Government Hospitals	September, 2009
Texas A&M Health Science Center	October 1, 2010
Scott & White Physicians (Texas A&M)	January 2, 2011

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

Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals without training programs. The Medicaid share of these additional costs is covered by GME payments to teaching hospitals. GME payments cover the costs of residents' and teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs.

The 2012-13 General Appropriations Act (GAA) (Article II, HHSC, Rider 42, 82nd Legislature, Regular Session, 2011), authorizes HHSC to spend Appropriated Receipts–Match for Medicaid for GME payments to teaching hospitals. The payments are contingent upon receipt of intergovernmental transfers of funds from public teaching hospitals for the non-federal share of Medicaid GME payments. The Legislature directed HHSC to use only intergovernmental transfers of funds (Appropriated Receipts-Match for Medicaid) for the non-federal share of Medicaid GME payments for the 2012-13 biennium.

Disproportionate Share Hospital Funding

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and receive disproportionate share funding under the program commonly known as "DSH." DSH funds differ from all other Medicaid payments in that they are not tied to specific services for Medicaid-eligible patients. Hospitals may use DSH payments to cover the costs of uncompensated care for indigent or low-income patients. DSH payments have been an important source of revenue by helping hospitals expand health-care services to the uninsured, defray the cost of treating indigent patients, and recruit physicians and other health-care professionals to treat patients.

Who Gets DSH?

In FFY 2011, 182 Texas hospitals qualified to receive DSH payments: 79 were public, 63 were private non-profit and 40 were private for-profit. Of the 182 DSH hospitals, 99 were located in urban areas and 83 were located in rural areas. Of the urban hospitals, eight were large urban public facilities and eight were children's hospitals. Three University of Texas teaching hospitals and all children's hospitals in Texas are deemed DSH hospitals provided they meet federal and state qualification criteria. All other hospitals must qualify for DSH funds by meeting one of the following three criteria: (1) a disproportionate total

number of inpatient days are attributed to Medicaid patients; (2) a disproportionate percentage of all inpatient days are attributed to Medicaid patients; or (3) a disproportionate percentage of all inpatient days are attributed to low-income patients.

How DSH Is Funded

As in other “matching” Medicaid programs, the federal government and the state each pay a share of total DSH program costs. Payments are funded using the same matching rate as medical services (60.56 percent federal funds and 39.44 percent state funds for Texas in FFY 2011). The state share of DSH is funded through intergovernmental transfers from eight hospital districts and with state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest). In FFY 2011, $1.581 billion in federal and state DSH funds were distributed to Texas hospitals.

How DSH Can Be Spent

There are no federal or state restrictions on how DSH hospitals can use their funds. Hospitals have used DSH funds to:

- Defray the cost of treating indigent patients,
- Recruit physicians and other health-care professionals to treat patients,
- Obtain replacement or additional equipment/technology to treat patients, and
- Renovate existing structures or build new ones.

DSH reimbursement allows hospitals to make the human and capital investments necessary to continue and improve patient care.

Federal Legislation Affecting DSH

Nationally, between 1989 and 1992, federal funding for DSH significantly increased from $400 million to $10.1 billion. By 1992, DSH funds accounted for 15 percent of all federal Medicaid spending. Starting in 1991, various pieces of federal legislation were passed, limiting or capping DSH funding increases. Furthermore, as a discrete component of Medicaid funds nationally, the DSH program has on occasion been targeted as a possible source of budget savings.

In 1991, federal law capped the size of Texas’ DSH program at $1.513 billion. In 1993, a federal budget act established hospital caps on the amount of DSH funds an individual hospital could receive. The act also mandated that at least one percent of total patient-days in DSH hospitals must be from Medicaid patients. These changes reduced DSH payments to state-owned hospitals from approximately $729 million in SFY 1995 to about $427 million in SFY 2008. Total

Texas DSH funds were constant, however, and the additional residual funds went to non-state local hospitals.

The 1997 federal Balanced Budget Act (BBA) had two significant impacts on the Texas DSH program. First, it set specific annual limits on total federal contributions to the Texas DSH program. Those limits, since increased by the Benefits Improvement and Protection Act (BIPA) of 2000 and the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, have resulted in annual fluctuations in providers' DSH funding. **Table 8.7** shows Texas DSH funding for 2002-2011.

Table 8.7: Texas DSH Federal Fund Trends

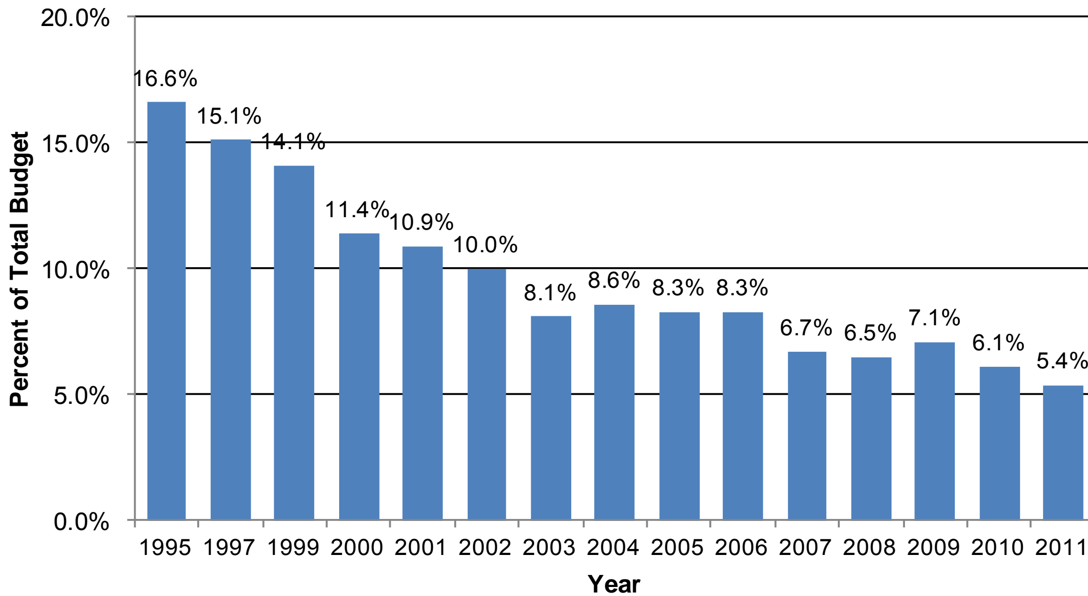
Year	Federal Funds
2002	$856 million
2003	$776 million
2004	$901 million
2005	$901 million
2006	$901 million
2007	$901 million
2008	$901 million
2009	$964 million*
2010	$988 million**
2011	$964million
* Includes $23.5 million in ARRA federal stimulus funds. **Includes $47.6 million in ARRA federal stimulus funds.	

Source: BBA 1997, BIPA 2000, and the Medicare Prescription Drug Improvement and Modernization Act of 2003.

The second impact of the BBA was to limit DSH payments to Institutions for Mental Disease (IMD) to a fixed percentage of total annual DSH funds. This provision has caused IMD payments to vary each year.

Most recently, the MMA of 2003 included increases in DSH state allotments for 2004-2011 and added requirements for an independently certified annual audit. **Figure 8.14** shows DSH funds as a percentage of the total Medicaid budget.

Figure 8.14: Disproportionate Share Hospital Funds as a Percentage of the Total Medicaid Budget FFYs 1995-1999, SFYs 2000-2011

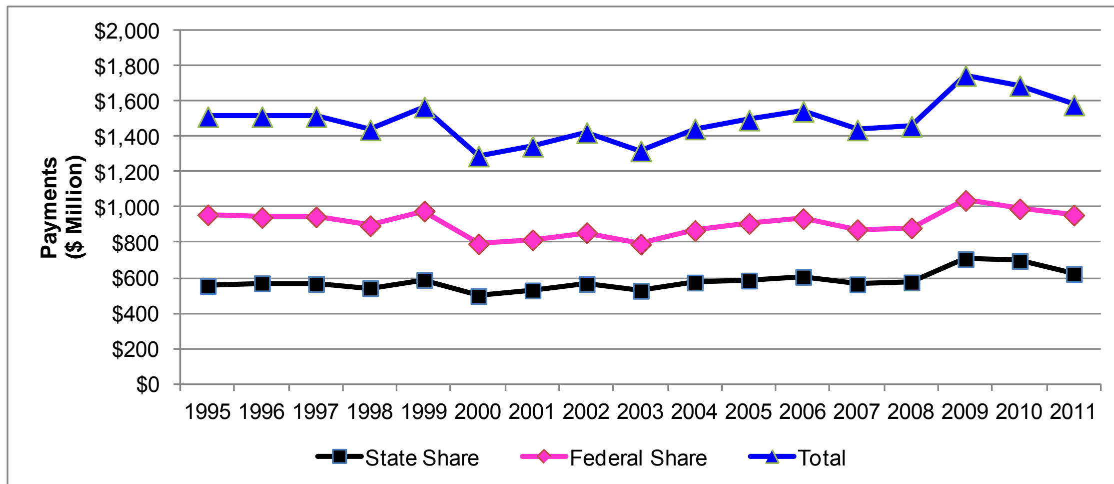


Source: HHSC, Financial Services, Texas Medicaid History Report, May 15, 2012.

Figure 8.15 shows federal, state, and total spending on the DSH program since the creation of the program.

Figure 8.15: Payments for Disproportionate Share Hospital Program

FFYs 1995-1999 and SFYs 2000-2011



Source: HHSC, Financial Services, Texas Medicaid History Report, May 15, 2012.

Uncompensated Care

Directed by Senate Bill (S.B.) 10, 80th Legislature, Regular Session, 2007, HHSC reviewed the various ways that uncompensated care is reported. A workgroup of hospital industry executives and staff from the Office of the Attorney General advised HHSC on these matters. As a product of those discussions, HHSC adopted a methodology for calculating residual uncompensated care costs.

Currently, the Department of State Health Services collects data from all Texas hospitals in a collaborative survey with the American Hospital Association and the Texas Hospital Association. In that instrument, uncompensated care has historically been reported as the sum of charity care and bad debt charges.

In a report to the 82nd Legislature, HHSC will use the new methodology for reporting residual uncompensated care costs. Bad debt and charity care charges will be converted to costs, since the charges for the same procedure can vary widely by hospital. HHSC will also include information on underpayments from governmental programs like Medicaid.

The report will also show the variety of funding sources that are available to offset residual uncompensated care costs. These funding sources include DSH, UPL, state trauma funding and tobacco settlement receipts.

Managed Care Organizations

Premium rates for the Medicaid managed care organizations (MCOs) are determined through actuarially sound methodologies. These rates determine the state's capitation payments to MCOs for contractually required services. Further detail on Medicaid managed care programs is provided in Chapter 7, Medicaid Managed Care.

STAR

The managed care rating process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. STAR MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. Then, a provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an “adjusted premium rate” for each service area. A separate lump sum payment, called the “Delivery Supplemental Payment,” is computed for each service area for expenses related to each newborn delivery.

The resulting underlying base rates vary by service area and risk group but are the same for each MCO in a service area. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. The final capitated premiums that are paid to the MCOs are based on this acuity risk-adjusted premium for each combination of service area and risk group. In addition to the final capitated premium rates, MCOs also receive the Delivery Supplemental Payment for each newborn.

Pharmacy costs associated with all STAR clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR rates above with two exceptions. First, base costs are derived primarily from the state’s Vendor Drug Program historical claims experience. As managed care pharmacy data become available, MCO pharmacy claims costs will be used for the base cost. Second, there is no acuity risk adjustment to the rates.

Medicaid Dental

The Medicaid Dental program became a managed care program March 1, 2012. Initial Medicaid dental rates were based primarily on FFS claims experience for the covered population in the base period. As managed care experience becomes available, managed care claims experience will be used for the base cost. The base cost is totaled and trended forward to the time period for which the rates apply. A reasonable provision for administrative expenses, taxes, and risk margin are added to the claims component in order to project the total cost for the rating period. These projected total costs are then converted to a set of statewide rates that vary by age group.

STAR+PLUS

The STAR+PLUS program currently rates are calculated in a similar manner as for the STAR program, except that STAR+PLUS MCOs do not receive a Delivery Supplemental Payment for newborn deliveries.

Pharmacy costs associated with all STAR+PLUS clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR+PLUS rates above with two exceptions. First, base costs are derived primarily from the state's VDP historical claims experience. As managed care pharmacy data become available, MCO pharmacy claims costs will be used for the base cost. Second, there is no acuity risk adjustment to the rates.

NorthSTAR

Capitation rates for the NorthSTAR Behavioral Health Organization (BHO) are derived primarily from BHO historical encounter experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for BHO expenses such as projected increases in Medicaid enrollment and utilization, changes in plan benefits, administrative expenses, and other miscellaneous costs. In addition to these costs, the NorthSTAR BHO rates include amounts for fixed contract fees and various other adjustments. Lastly, a provision is made for the possible fluctuation in claims by the addition of a risk margin. The NorthSTAR BHO is reimbursed using premium rates which vary by risk group.

STAR Health

The capitation rate for the STAR Health program is derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. Adjustments are applied for MCO expenditures, which include reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims by the addition of a risk margin. The rate also includes a special allowance for the additional administrative services in the program, including the Health Passport. The Health Passport is a web-based electronic medical record that is intended to improve quality of care. A single MCO provides services under the STAR Health program. The MCO is reimbursed using a single premium rate which does not vary by age, gender or area.

Pharmacy costs associated with all STAR Health clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR Health rates above with one exception, base costs are derived primarily from the state's Vendor Drug Program historical

claims experience. As managed care pharmacy data become available, MCO pharmacy claims costs will be used for the base cost.

Nursing Facilities

Nursing facilities are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service (i.e., case-mix class). Enhanced rates are available for enhanced staffing. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing and/or spending requirements.

Rates are based on costs submitted annually by providers on facility cost reports. Costs are categorized into five rate components: (1) direct care staff; (2) other resident care; (3) dietary; (4) general and administrative; and (5) a fixed capital asset use fee. Each rate component is calculated separately based on HHSC formulas and may vary according to the characteristics of residents. The total rate for each level of service is calculated by adding together the appropriate rate components.[vi]

Facility cost reports are subjected to either a desk review or on-site audit to determine that reported costs are allowable. Nursing facility rates are recalculated once every two years coincident with the legislative biennium.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions

ICFs/IID are reimbursed for services delivered to Medicaid residents through daily payment rates that are prospective and uniform statewide by facility size and level of need. The total daily payment rate may be retroactively adjusted if a provider fails to meet specific direct care spending requirements.

In 1997, initial model-based rates were determined using a representative sample of provider information (cost, financial, statistical, and operational) collected during site visits performed by an independent consultant. Currently, the modeled rates are updated, when funds are available, using the service providers' most recent audited cost reports. Enhanced rates are available for

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[vi] H.B. 154, 77th Texas Legislature, Regular Session, 2001, requires HHSC to ensure that only those facilities that purchase liability insurance acceptable to HHSC receive credit for that cost. Therefore, liability insurance costs are excluded from the rate calculation and facilities that verify liability insurance coverage acceptable to HHSC receive additional funds in the form of a liability insurance add-on.

enhanced attendant compensation. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific attendant compensation spending requirements.

Facility cost reports are subjected to either a desk review or on-site audit to determine that reported costs are allowable. ICFs/IID rates are recalculated once every two years coincident with the legislative biennium.

Endnotes

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[1] Texas Legislative Budget Board. General Appropriations Act for the 2012-2013 Biennium. http://www.lbb.state.tx.us/GAA/General_Appropriations_Act.pdf and Texas Comptroller of Public Accounts, Certified Revenue Estimate for the 2012-13 Biennium. http://www.window.state.tx.us/taxbud/cre-current/table1.html (December 2012).

Chapter 9: Children's Health Insurance Program

What is the Children's Health Insurance Program? Who does this program serve, what benefits does it provide, and how does it operate in Texas?

History and Background

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act and appropriated nearly $40 billion for the program for federal fiscal years (FFYs) 1998-2007. Like Medicaid, SCHIP is administered by the Centers for Medicare & Medicaid Services (CMS) and is jointly funded by the federal government and the states. Also like Medicaid, each state receives a different federal match for SCHIP. For FFY 2011, the federal government funded 72.28 percent of Texas' SCHIP program, while the state funded the remaining 27.72 percent. Through SCHIP, states can provide health insurance to low-income, uninsured children in families with incomes too high to qualify for Medicaid.

SCHIP offers states three options when designing a program. States can either:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program,
- Design a separate state children's health insurance program, or
- Combine both the Medicaid and separate program options.

States that choose to expand their Medicaid programs are required to provide all mandatory benefits and all optional services covered under their Medicaid state plan, and they must follow the Medicaid cost-sharing rules. States that choose to

implement a separate program have more flexibility. Within broad federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children ages 15 to 18 under 100 percent of the federal poverty level (FPL). Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

Enacting legislation for Phase II of SCHIP, a separate children's health insurance program, was passed by the 76th Legislature. This program is referred to simply as the Children's Health Insurance Program (CHIP). Senate Bill (S.B.) 445, 76th Legislature, Regular Session, 1999, specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the FPL. Coverage under Phase II of the SCHIP program began on May 1, 2000. The Health and Human Services Commission (HHSC) was given overall authority for the program. By February 2002, 516,000 children were enrolled. As of June 2012, 580,331 children were enrolled in CHIP.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized CHIP by appropriating nearly $69 billion in federal CHIP funding for states for FFYs 2009-2013.[1] The act simplified the original name of the program from "SCHIP" to "CHIP." CHIPRA made numerous policy changes to state CHIP programs which include the following:

- States must verify a CHIP applicant's citizenship,
- States may cover pregnant women above 185 percent FPL up to the income eligibility level for children in CHIP, and
- Provide Medicaid and CHIP coverage to qualified alien children and/or pregnant women without the previously required 5-year delay.

See Chapter 2 for additional information on CHIPRA.

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). ACA makes the following changes to CHIP:

- Extends federal funding for CHIP through FFY 2015. Prior to ACA, CHIP was authorized through FFY 2013,
- Requires CHIP to meet maintenance of effort (MOE) requirements,
- As of January 1, 2014, shifts from CHIP to Medicaid those children ages 6 to 18 with incomes between 100 and 133 percent of the FPL,

- Increases the federal CHIP match rate for FFYs 2016 through 2019, and
- The ACA prohibits states from restricting CHIP eligibility standards, methodologies, or procedures from enactment until September 30, 2019. Medicaid payments are contingent upon meeting the CHIP MOE requirement.

Who Is Covered in Texas

CHIP covers children in families who have too much income or too many assets to qualify for Medicaid, but cannot afford to buy private insurance.

To qualify for CHIP a child must be:

- A U.S. citizen or legal permanent resident,
- A Texas resident,
- Under age 19,
- Uninsured for at least 90 days,[i]
- Living in a family whose income is at or below 200 percent of FPL, and
- Living in a family that passes an asset test if family income is above 150 percent of the FPL.[ii]

Until the passage of the CHIPRA, children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Since the program’s inception, Texas covered certain qualified alien children under CHIP with 100 percent state funds, if they met all other Medicaid or CHIP eligibility requirements.

In the past Texas opted not to provide Medicaid coverage to qualified alien children with some exceptions, so qualified alien children at Medicaid income levels were covered in CHIP through 100 percent state funds. CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

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[i] There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom available health insurance costs 10 percent or more of the family's net income. A complete list of the exemptions can be found at http://www.chipmedicaid.org/english/qualify.asp (July 2012).

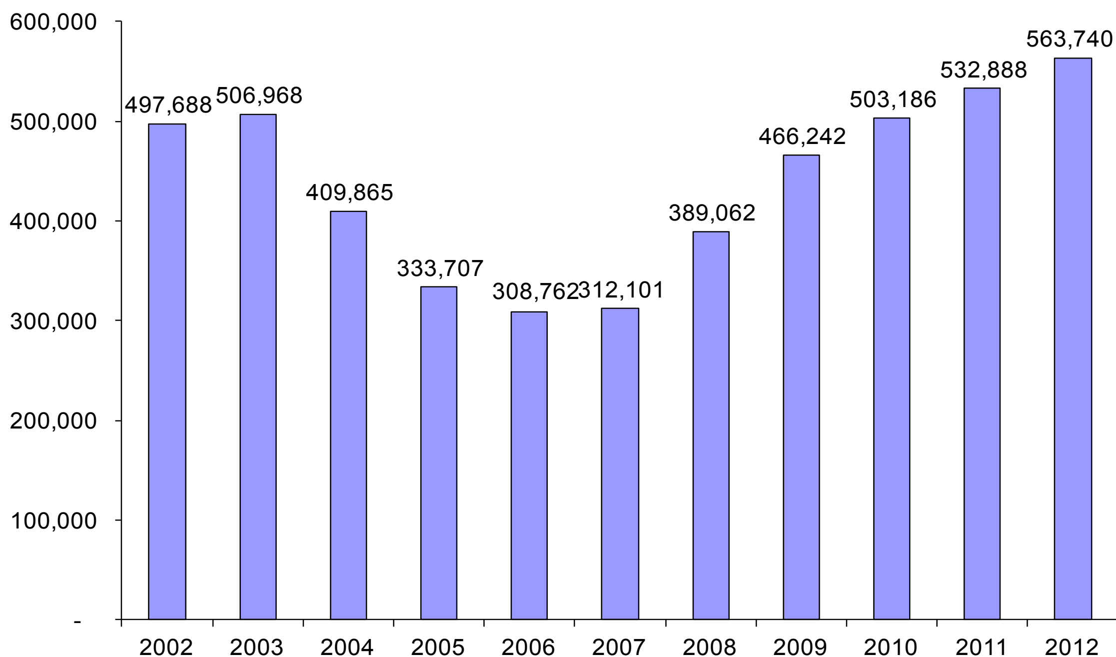
[ii] The asset limit is $10,000 and includes funds in checking or savings accounts, plus the “countable” value of vehicles.

Federal policy excludes a child from participating in federally-matched CHIP if the child's family is eligible for a state health benefits plan due to employment with a public agency (even if the family declines the coverage). ACA provides an exception to this exclusion and allows states to provide federally-matched CHIP to the children of public employees effective March 23, 2010, if the state health benefits plan meets the MOE requirements or the child qualifies for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Texas Retirement System (TRS) school-employee children as of September 1, 2010 and to other eligible public employee children as of September 1, 2011.

Size of CHIP Population

Figure 9.1 shows the average monthly caseload for the CHIP population since the program began in May 2000. A peak in CHIP caseload occurred in May 2002 at 529,211, and then gradually stabilized between 505,000 and 510,000 by September 2003. Caseload has increased in recent years, reaching a new high enrollment of 583,151 in August 2012.

Figure 9.1: Average Monthly CHIP Clients State Fiscal Year (SFYs) 2002-2012



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.

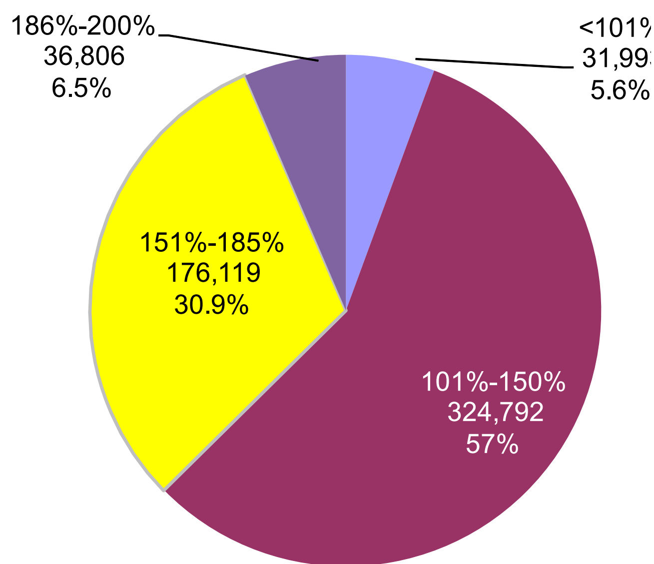
CHIP Demographics

Federal Poverty Level

The majority of CHIP enrollees (approximately 57 percent) are between 101 and 150 percent of FPL. Approximately 31 percent are between 151 and 185 percent of FPL, and 6 percent are between 186 and 200 percent of FPL. Approximately 6 percent of enrollees are below 100 percent of FPL.[iii] **Figure 9.2** shows the percent distribution of CHIP enrollees by FPL category in State Fiscal Year (SFY) 2012.

Figure 9.2: Distribution of CHIP Enrollment in SFY 2012 by Percent of FPL Category (Monthly Average)

Number and Percent by FPL



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.

[iii] Most children at or below 100 percent of FPL are Medicaid eligible. However, some of these children are not Medicaid eligible because of their immigration status or because they have too many assets. These children may be covered under CHIP instead. Due to allowable income disregards, some children may qualify for CHIP even when their family's gross monthly income is above 200 percent of FPL.

Effective January 1, 2014, the ACA requires states to use modified adjusted gross income or household income for CHIP income determinations (including for cost sharing determinations). In addition, the ACA appears to eliminate income disregards, assets tests, and resource tests for CHIP, in the same manner that these changes apply to Medicaid.

Currently, Texas applies an income disregard in CHIP for child care expenses. The income disregard is $200 per month for each child under age two or $175 per month for each child age two or older. Texas also applies an assets test to children in CHIP with incomes above 150 percent of FPL. The asset limit is $10,000 in countable liquid resources combined with excess vehicle value. Children who were previously ineligible for CHIP due to the assets test will become eligible for CHIP effective January 2014.

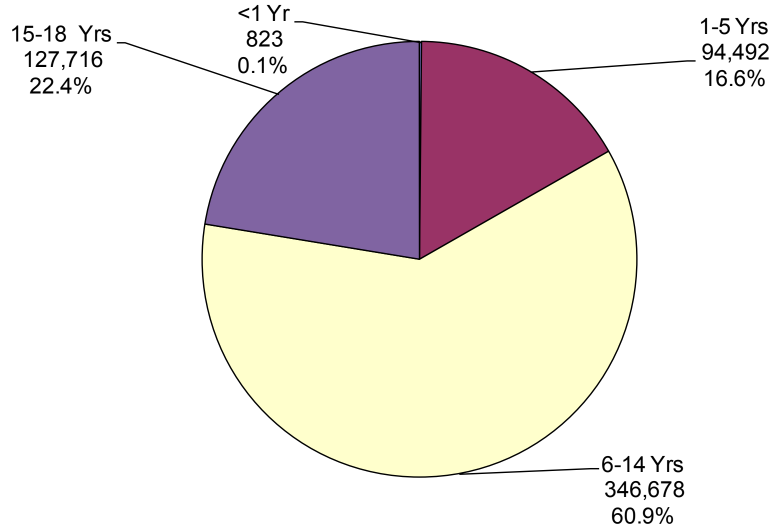
Age

Figure 9.3 shows the percentage of CHIP clients by age. The majority of CHIP clients are over age 5. Sixty-one percent of clients are between ages 6 and 14, and 22 percent of clients are between ages 15 and 18. Slightly under 17 percent are between ages 1 and 5, while less than 1 percent of clients enrolled in CHIP in SFY 2012 were under 1 year of age.

The higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid. CHIP serves all children up to 200 percent of FPL. Medicaid serves infants (12 months of age and younger) up to 185 percent of FPL, children ages 1 through 5 up to 133 percent of FPL, and children ages 6 through 18 up to 100 percent of FPL.

Figure 9.3 does not include CHIP Perinatal clients, who are all under 1 year of age. More detail on CHIP Perinatal is provided at the end of this chapter.

Figure 9.3: Average Monthly CHIP Enrollment by Age
Number and Percent by Age Group

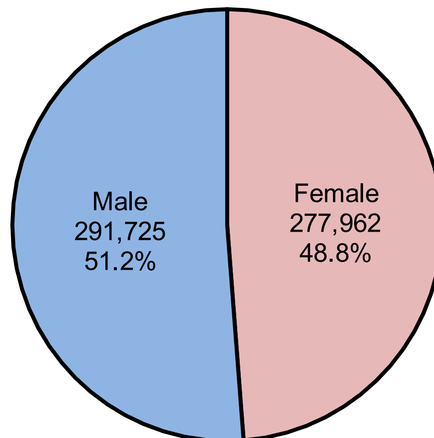


Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.

Gender

Figure 9.4 shows the proportions of CHIP enrollees by gender. Approximately 51 percent of enrollees are male, and 49 percent are female.

Figure 9.4: Average Monthly CHIP Enrollment by Gender



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.

CHIP Benefits

States like Texas that create a separate child health program have three options for determining coverage.[2]

- Benchmark coverage: Coverage that is substantially equal to one of the following: (1) The Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; (2) A health benefits plan offered by the state and made generally available to state employees; or (3) A plan offered by a managed care organization (MCO) that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
- Benchmark-equivalent coverage: Coverage that has the same aggregate actuarial value as one of the benchmark plans. States that choose to provide benchmark equivalent coverage must cover each of the benefits in the "basic benefits category." These include inpatient and outpatient hospital services, physician services, surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations. States must also provide coverage that is at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the "additional services category." These services include prescription drugs, mental health services, vision services, and hearing services.
- Any other health benefits plan that the United States Secretary of Health and Human Services determines will provide appropriate coverage.

Texas selected the third option for determining CHIP coverage – i.e., Secretary approved coverage. The state's benefit package is cost-effective, including a basic set of health care benefits that focus on primary health care needs. **Table 9.1** displays the current set of benefits covered by Texas CHIP. These benefits are subject to certain limitations and exclusions.

Over the last couple of years, Texas added several additional CHIP services pursuant to CHIPRA. Texas added services to its behavioral health and dental benefits.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into federal law on October 3, 2008. MHPAEA requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at parity with medical and surgical benefits. CHIPRA applies MHPAEA requirements to all state CHIP programs.

CMS approved a CHIP state plan amendment to remove the treatment limitations from existing CHIP behavioral health benefits, effective March 1, 2011, bringing CHIP into compliance with the mental health parity requirements in CHIPRA. To offset increased costs in the CHIP program, HHSC increased certain co-payments for CHIP members above 150 FPL effective March 1, 2011.

CHIP Dental

The Texas CHIP dental benefit package consisted of three tier levels that covered certain preventive and therapeutic services up to capped dollar amounts per 12-month coverage period. CHIPRA required all state CHIP programs to cover dental services "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." To comply with this requirement, Texas CHIP was required to cover certain services that were not previously covered, including periodontic and prosthodontic services.

Effective March 1, 2012, Texas eliminated the three-tier benefit package, now all CHIP members receive up to $564 in dental benefits per enrollment period. Emergency dental services are not included under this cap. Members can also receive certain preventive and medically necessary services beyond the $564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC raised CHIP cost-sharing amounts.

Table 9.1: Services Covered by Texas CHIP, 2013

The following services are covered under CHIP in Texas:

- Inpatient general acute and inpatient rehabilitation hospital services.
- Surgical services,
- Transplants,
- Skilled nursing facilities (including rehabilitation hospitals),
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services,
- Physician/physician extender professional services (including well-child exams and preventive health services such as immunizations),
- Laboratory and radiological services,
- Durable medical equipment, prosthetic devices, and disposable medical supplies,
- Home and community-based health services,
- Nursing care services,
- Inpatient mental health services,

Table 9.1: Services Covered by Texas CHIP (Continued)

• Outpatient mental health services, • Inpatient and residential substance abuse treatment services, • Outpatient substance abuse treatment services, • Rehabilitation and Habilitation services (including physical, occupational, and speech therapy, and developmental assessments), • Hospice care services, • Emergency services (including emergency hospitals, physicians, and ambulance services), • Emergency medical transportation (ground, air, or water), • Care coordination, • Case management, • Prescription drugs. • Dental services. • Vision. • Chiropractic services, and • Tobacco cessation.

CHIP Cost-Sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fee amounts and co-payments vary based on family income. In addition, the total amount that a family is required to contribute out-of-pocket toward the cost of health care services is capped based on family income. **Table 9.2** shows the current cost-sharing requirements and cost-sharing caps for CHIP families as well as increases to the cost-sharing requirements that became effective on March 1, 2012.

Table 9.2: CHIP Cost-Sharing Requirements

	Cost-Sharing Effective March, 2011	**Cost-Sharing Effective March 1, 2012**
Enrollment Fees (for 12-month enrollment period):	**Charge**	**Charge**
At or below 150 % of FPL	$0	$0
Above 150% up to and including 185% of FPL	$35	$35
Above 185% up to and including 200% of FPL	$50	$50
CHIP members at or below 100% of FPL	**Charge**	Co-payments effective March 1, 2012
Office visit	$3	$3
Non-emergency ER	$3	$3
Generic drug	$0	$0
Brand drug	$3	$3
Inpatient hospital	$10	$15
Cost-sharing limit	1.25% (of family's income)*	5% (of family income, per enrollment period)
CHIP members above 100% up to and including 150% of FPL	**Charge**	Co-payments effective March 1, 2012
Office visit	$5	$5
Non-emergency ER	$5	$5
Generic drug	$0	$0
Brand drug	$5	$5
Inpatient hospital	$25	$35
Cost-sharing limit	1.25% (of family's income)*	5% (of family income, per enrollment period)
CHIP members above 150% up to and including 185% of FPL	**Charge**	Co-payments effective March 1, 2012
Office visit	$12	$20
Non-Emergency ER	$50	$75
Generic drug	$8	$10
Brand drug	$25	$35
Inpatient hospital	$50	$75
Cost-sharing limit	2.5% (of family's income)*	5% (of family income, per enrollment period)

Table 9.2: CHIP Cost-Sharing Requirements (Continued)

	Cost-Sharing Effective March, 2011	Cost-Sharing Effective March 1, 2012
CHIP members above 185% up to and including 200% of FPL	**Charge**	Co-payments effective March 1, 2012
Office visit	$16	$25
Non-emergency ER	$50	$75
Generic drug	$8	$10
Brand drug	$25	$35
Inpatient hospital	$100	$125
Cost-sharing limit	2.5% (of family's income)*	5% (of family income, per enrollment period)

CHIP Delivery Network

CHIP services are delivered by managed care organizations (MCOs) selected by the state through a competitive procurement. As of March 1, 2012, there were 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide.

Enrollees residing in a CHIP service area have a choice of at least two or more MCOs. (See Appendix D for a list of CHIP service areas by county.)

In order to provide CHIP members with a choice of dental plans HHSC expanded the number of dental managed care plans from one to two.

CHIP Rates

The rate setting process for CHIP is essentially the same as for the STAR managed care program. CHIP MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. Then, a provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an "adjusted premium rate" for each service area. A

separate lump sum payment, called the “Delivery Supplemental Payment,” is computed for expenses related to each newborn delivery. While the Delivery Supplemental Payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump sum payment in the amount of $3,100 for each birth.

The resulting underlying base rates vary by service area and age groups. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium that is paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

Pharmacy costs associated with all CHIP clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the CHIP medical rates above with two exceptions. First, base costs are derived primarily from the state’s Vendor Drug Program historical claims experience. As managed care pharmacy data become available, MCO pharmacy claims costs will be used for the base cost. Secondly, there is no acuity risk adjustment to the rates.

CHIP dental benefits are reimbursed through a separate set of premium rates. The rate setting process for the CHIP dental plans are similarly derived from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward as with other programs. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental plans. A provision for possible fluctuation in claims cost is made through the addition of a risk margin.

CHIP Financing

Like Medicaid, CHIP is jointly funded by the federal government and states. However, unlike Medicaid, the total amount of federal funds allotted to the program each year is capped, as is the amount of funds allotted to each state. In the federal legislation that created CHIP, annual federal appropriations for the program totaled nearly $40 billion for the ten-year period that the program was originally authorized. Each state is allotted a portion of this amount based on a formula set in federal statute, and receives federal matching payments up to the allotment. Each year’s allotment has historically been available to states for three

years, and any funds allotted to states that are not spent by the end of the three-year period are re-distributed to states that have exhausted their allotment, with some exceptions. Under CHIPRA, this has changed to a two-year spending per annual allotment beginning with the FFY 2009 allotment.

The FFY 2011 AND 2012 allocation are estimated to be fully expended. The federal allocation for Texas in FFY 2012 is $882,577,834.

Another difference between financing for Medicaid and CHIP is that CHIP offers a more favorable federal matching rate than Medicaid. The amount of federal CHIP funds that states receive is based on the Enhanced Federal Medical Assistance Percentage (EFMAP). Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. In FFY 2013, the CHIP EFMAP for Texas is 71.51 percent and 71.08 percent for FFY 2014.

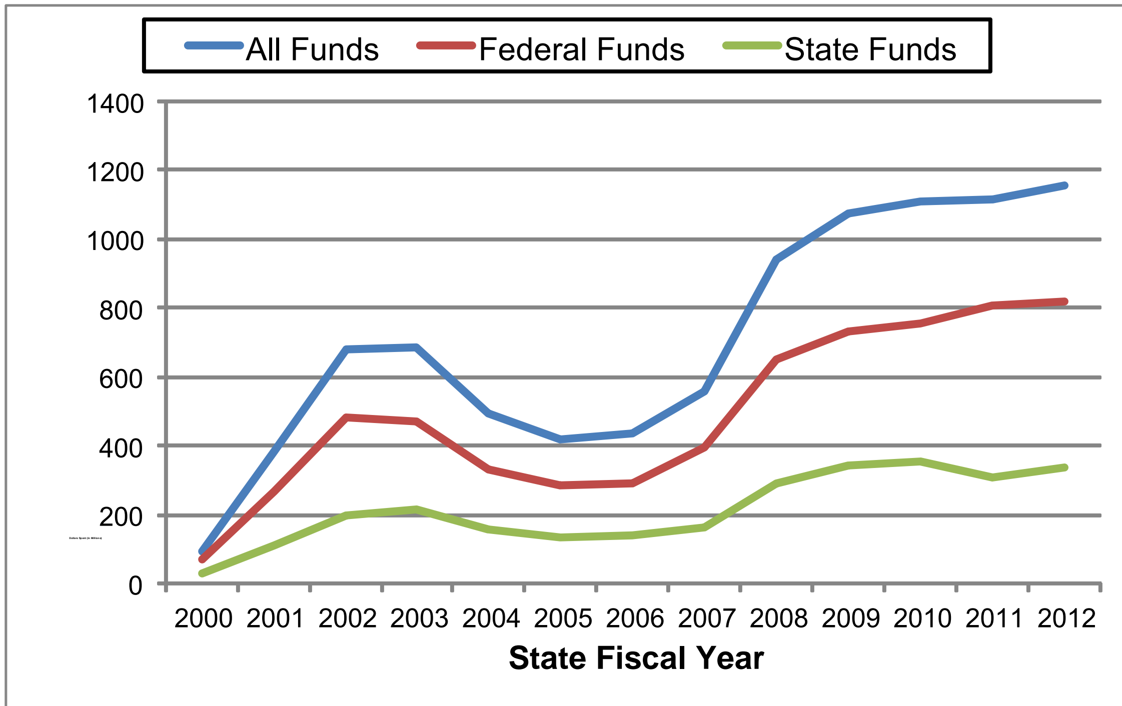
ACA increases the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015 until September 30, 2019. The increase does not apply to:

- Certain administrative expenditures,
- Citizenship documentation requirements, and
- Administration of Payment Error Rate Measurement (PERM) requirements.

CHIP Spending

Texas CHIP spending has experienced sporadic growth in recent years. **Figure 9.5** shows state and federal expenditures for CHIP between SFYs 2000 and 2012. Current estimates project that total CHIP expenditures for SFY 2012 will be over $1.15 billion. Approximately 71 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services; 19 percent on prescription drugs; and the remaining 10 percent on administration.

Figure 9.5: Texas CHIP Expenditures
SFYs 2000 – 2012



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.
Final SFY 2012 is estimated.

CHIP Perinatal Program

The 2006-07 General Appropriations Act (Article II, HHSC, Rider 70, S.B. 1, 79th Legislature, Regular Session, 2005), authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was the CHIP Perinatal program, which began in January 2007. CHIP perinatal services are for the unborn child of pregnant women who are uninsured, and do not qualify for Medicaid. The expecting mother must meet certain income requirements (income up to and including 200% FPL). Services include prenatal visits, prescription prenatal vitamins, labor with delivery, and post-partum care. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period, the asset test, and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

Upon delivery, CHIP Perinatal newborns in families with incomes at or below 185 percent of FPL are eligible to receive 12 months of continuous Medicaid coverage. For this income group (at or below 185 percent of FPL), the mother must apply for Emergency Medicaid for her labor with delivery by submitting a

completed Emergency Medical Services Certification (form H3038). This form is mailed to the mother, and she is instructed to bring it with her to the hospital at delivery. This form must be returned in order to establish Emergency Medicaid for the mother, and to enable the child to receive 12 months of Medicaid coverage from the date of birth.

CHIP Perinatal newborns in families with incomes above 185 percent of FPL up to and including 200 percent of FPL remain in the CHIP Perinatal Program and receive CHIP benefits for the remainder of the 12-month coverage period.

Size and Demographics of the CHIP Perinatal Population

Table 9.3 shows the average monthly caseload for the CHIP Perinatal population since the program began in January 2007. Beginning September 2010, newborns under 185 percent of FPL began moving out of CHIP Perinatal and into Medicaid due to changes in eligibility. The monthly caseload has begun to stabilize around 37,000 members. Approximately 99 percent of clients are perinates and only 14 percent of clients are newborns.

All clients in the CHIP Perinatal program are under the age of one, because a woman can only enroll her child in the program prior to delivery. The majority of clients are at or under 185 percent of FPL, with approximately 2.5 percent of all clients above this amount.

Table 9.3: CHIP Perinatal Caseload Summary, SFYs 2007-2011

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

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

CHIP Perinatal Rates

Premium rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP, with the differences being the absence of acuity adjustment and the more focused scope of benefits and membership in CHIP Perinate. MCO historical claims experience is totaled and trended forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits, and other miscellaneous costs. Final rates vary by risk group and service area. However due to low caseload among risk groups with income between 186 percent and 200 percent of FPL, premium rates for these risk groups are calculated on a statewide basis.

Endnote

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[1] Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, “CHIP Financing Structure,” June 2009, http://www.kff.org/medicaid/upload/7910.pdf (November 2012).

[2] Herz, E. J., Fernandez, B., & Peterson, C.L., “State Children’s Health Insurance Program: A Brief Overview,” Congressional Research Service, Washington D.C., March 23, 2005, http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3047303232005.pdf (July 2012).

Glossary

A

ACTIVITIES OF DAILY LIVING (ADLS) – Activities that are essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating.

ADVERSE EVENTS – Any unfavorable and unintended symptom or disease temporarily associated with the use of an experimental medical treatment or procedure, regardless of whether it is considered related to the medical treatment or procedure.

AGING AND DISABILITY RESOURCE CENTER (ADRC) – An initiative supported by a grant from the Administration on Aging to improve access to long-term services and supports. Texas has ADRC's in nine areas of the state.

ALBERTO N. V. JANEK – A federal lawsuit that was settled in May 2005 and requires the Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. As a result of the lawsuit, HHSC transferred personal care services for EPSDT beneficiaries from the Department of Aging and Disability Services (DADS) to HHSC on September 1, 2007, and implemented a Personal Care Assessment Form (PCAF) to improve access to care for EPSDT beneficiaries on September 1, 2008. See also **TEXAS HEALTH STEPS.**

AMOUNT, DURATION, AND SCOPE – How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus tate Medicaid plans vary in what they cover.

APPLICANT – A person who has applied for Medicaid or CHIP benefits.

THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) – A federal law passed in February 2009 that provided economic stimulus funding through a multitude of new and existing programs and provided a temporary increase in the

Federal Medical Assistance Percentage (FMAP) rate during the 27-month recession adjustment period from October 2008 through December 2010.

AVERAGE RECIPIENT (CLIENT) MONTHS PER MONTH –The arithmetic average of the number of Medicaid recipient months (the number of certified, unduplicated Medicaid clients in a given month). In most Medicaid-related reports, this average is generally cited in reference to a state or federal fiscal year. See also **CLIENT**.

B

BALANCED BUDGET ACT (BBA) – A federal law (P.L. 105-33) passed in 1997 designed to achieve substantial reductions in spending to balance the federal budget by the year 2002. The law made several changes to Medicaid and Medicare, and created the State Children's Health Insurance Program (SCHIP). See also **CHILDREN'S HEALTH INSURANCE PROGRAM.**

BALANCED BUDGET REFINEMENT ACT (BBRA) – A federal law (P.L. 106-113) passed in 1999 that included payment reforms and other technical changes intended to address the reduction in payments experienced by Medicare providers under the Balanced Budget Act (BBA).

BEHAVIORAL HEALTH CARE – Assessment and treatment of mental or emotional disorders and substance use disorders. See also **SUBSTANCE USE DISORDER.**

BEHAVIORAL HEALTH ORGANIZATION (BHO) – A managed care organization that provides or contracts for behavioral health services.

BENEFICIARY – One who benefits from a publicly-funded program. Most commonly used to refer to people enrolled in the Medicare program.

BENEFIT IMPROVEMENT AND PROTECTION ACT (BIPA) – A federal law (P.L.106-554) passed in 2000 that increased disproportionate share hospital (DSH) payments, modified the upper payment limit (UPL) for governmental facilities, and allowed federal State Children's Health Insurance Program (SCHIP) allocations to be carried forward. See also **CHILDREN'S HEALTH INSURANCE PROGRAM; DISPROPORTIONATE SHARE HOSPITAL; UPPER PAYMENT LIMIT**.

BENEFIT PACKAGE – Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

C

CAPITATION – A prospective payment method that pays a managed care organization a uniform amount on a monthly basis for each enrolled member for the provision of covered services.

CARE COORDINATION – A service available to recipients of Medicaid Managed Care, including STAR, STAR+PLUS, STAR Health, and the Children's Health Insurance Program (CHIP). (This service is called *Service Management* in STAR and CHIP and *Service Coordination* in STAR Health). Care coordination includes working with individuals and families to develop a plan of care to meet the needs of the individual and to coordinate the services of the managed care organization.

CARVE OUT – A decision to purchase separately a service that is typically part of a managed care organization (MCO) plan. For example, NorthSTAR is a managed care carve-out program for behavioral health services. See also **NORTHSTAR PROGRAM**.

CASE MANAGEMENT – Services that assist individuals receiving Medicaid to gain access to needed medical, social, educational, and other services. Case management includes assessing an individual's needs and strengths, and developing, implementing, and monitoring the implementation of a care plan. Case management is available through such resources as the Case Management for Children and Pregnant Women program; the ECI program; local mental health and mental retardation authorities; Medicaid home and community-based services waiver programs such as Community Living Assistance and Support Services and Home and Community-based Services; and through services for the visually or hearing impaired. See also **LOCAL MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY**.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN SERVICES –Health-related case management services to eligible children (birth through age 20) and pregnant women. Case managers are approved through the Texas Department of State Health Services (DSHS) and enrolled with the Texas Medicaid and Healthcare Partnership (TMHP) as Medicaid providers. See also **CASE MANAGEMENT; CASE MANAGER.**

CASE MANAGER – An experienced professional (typically a nurse, social worker, qualified mental health professional, qualified mental retardation professional, or parent case manager) who works with individuals, service providers, and others to develop and implement a care plan to coordinate all services needed to meet an individual's medical, social, educational, and other needs.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) – The federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)–CSHCN are defined in the Uniform Managed Care Contract for Medicaid and the Children's Health Insurance Program (CHIP) as children from birth up to age 19 who:

- Have a serious ongoing illness, complex chronic condition, or disability that has lasted or is anticipated to last at least twelve continuous months or more,
- Have an illness, condition, or disability that results (or without treatment would be expected to result) in limited function, activities, or social roles compared to the accepted pediatric age-related milestones,
- Require regular, ongoing therapeutic intervention and evaluation, and
- Have a need for health or health-related services at a level significantly above the usual for the child's age.

These children are provided special protections under Medicaid managed care. Protections include efforts to identify CSHCN and ensure that the state has appropriate quality and care coordination guidelines in place for CSHCN.

The CSHCN Services Program is the name of a non-Medicaid, Title V and state-funded program at the Texas Department of State Health Services (DSHS). The definition of CSHCN for the DSHS program differs from that of the Uniform Managed Care Contract and aligns with the definition in Title V legislation.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) – The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, established a new state children's health insurance program by adding Title XXI to the Social Security Act and amending the Medicaid statute. The purpose of this program is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION (CHIPRA) – Passed by Congress in February 2009, CHIPRA extends federal

Children’s Health Insurance Program (CHIP) funding to states through September 2013. CHIPRA includes multiple provisions that allow states new options for their programs. See also **CHILDREN’S HEALTH INSURANCE PROGRAM.**

CHILDREN’S HOSPITAL – A hospital within the state which is recognized under Medicare as a children’s hospital and which is exempted by Medicare from the Medicare prospective payment system. See also **MEDICARE**.

CHIP PERINATAL PROGRAM – The CHIP Perinatal program provides prenatal care to the unborn children of pregnant women up to 200 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP.

CLAIMS ADMINISTRATOR – Processes and adjudicates all claims for the Medicaid services outside the scope of capitated arrangements between health plans and the Health and Human Services Commission (HHSC).

CLAIMS PROCESSING SYSTEM – A system that enters, tracks, and processes claims from providers for payment.

CLIENT – A person who has applied for or is enrolled in the Medicaid program. See also **RECIPIENT; APPLICANT**.

COMMUNITY ATTENDANT SERVICES (CAS) – An optional state plan benefit that allows states to provide home and community-based services to individuals with functional disabilities. In Texas, this optional benefit, administered by the Texas Department of Aging and Disability Services (DADS), provides personal care services to people who have income in excess of Supplemental Security Income (SSI) limitations, but who would financially qualify to be in an institution. See also **PRIMARY HOME CARE; 1929.**

COMMUNITY BASED ALTERNATIVES WAIVER (CBA) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to adults as an alternative to nursing facility care. CBA is administered by the Texas Department of Aging and Disability Services (DADS). See also **NURSING FACILITIES; WAIVER; 1915(c).**

COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM (CLASS) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide

community-based services to people with developmental disabilities other than intellectual disability as an alternative to ICF/MR VIII institutional care. CLASS is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS; WAIVER; 1915(c)**.

COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS (CMHMRC)– Locally-governed components of the mental health and mental retardation service delivery system located in various communities throughout the state that provide community-based mental health and/or mental retardation services.

COMPARABILITY – In general, the state must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver programs for special subpopulations of Medicaid eligibles and benefits available to children through Early and Periodic Screening, Diagnosis, and Treatment/THSteps that may not be available to adults.

COMPASS 21 – Computer system that became HHSC's Medicaid Management Information System (MMIS) in August 2001. Compass 21 is an integrated system that supports fee-for-service claims and encounter data processing and analysis, and captures data for multiple health care models. It consolidates major Medicaid and non-Medicaid claims processing activities for HHSC and the Medicaid operating departments into one system and provides improved operational performance. It also provides a comprehensive data analysis capability to support business and policy-making decisions for state and external health care stakeholders. See also **MEDICAID MANAGEMENT INFORMATION SYSTEM; MEDICAID OPERATING DEPARTMENT**.

COMPREHENSIVE CARE PROGRAM (CCP) – Texas' name for the expanded portion of the Early and Periodic Screening, Diagnosis, and Treatment program/THSteps. THSteps-CCP covers services for children (until age 21) that are not usually allowed or are more limited under the Texas Medicaid State Plan. CCP is a result of a Congressional mandate, which became effective in 1990. See also **TEXAS HEALTH STEPS.**

CONSOLIDATED WAIVER PROGRAM (CWP) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allowed Texas to provide community-based services to people who met eligibility criteria for Intermediate Care Facilities for Persons with Intellectual Disabilities or

Related Conditions (ICF/IID) or nursing facilities. CWP was operational from December 2001 through December 2011. The program provided 200 people of all ages and disabilities in Bexar County with a single set of services, common providers, and consistent rates. It was administered by the Texas Department of Aging and Disability Services (DADS). See also **WAIVER; 1915(c)**.

CONSUMER DIRECTED SERVICES (CDS) – A service delivery model that allows the consumer or his/her representative to hire, fire, train, and supervise personal attendants, as well as to directly purchase services. Texas was one of the first states to receive approval from the Centers for Medicare & Medicaid Services (CMS) to implement the CDS delivery model in multiple Medicaid home and community-based waiver programs and in the Medicaid state plan. See also **MEDICAID STATE PLAN; WAIVER; 1915(c)**.

CONTINUITY OF CARE – The degree to which the care of a patient is not interrupted.

CONTRACTOR – Person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

CO-PAYMENT OR CO-PAY – A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care service is rendered.

CURRENT POPULATION SURVEY (CPS) – A U.S. Census Bureau-sponsored survey. Results from this survey are used in many states to estimate the size and composition of populations that are potentially eligible for Medicaid and the number of persons without health insurance.

D

DATA WAREHOUSE – A system that stores data in formats useful for structured query and analysis. A data warehouse is distinct in purpose and structure from a transaction system (such as the traditional Medicaid claims processing system), although it may contain some of the same data elements. Data warehouse systems can be designed to allow users with limited technical knowledge to perform queries, and to make it easier for more technical users to perform more complex queries and produce reports. Data from multiple external sources, such as claims processing, encounter processing, and enrollment systems, can be

cleaned, merged, and stored for analysis. Historical merged data from multiple systems can be maintained in the warehouse to enable analysis of patterns and trends over time.

The term “data warehouse” is often associated with a separate, but related concept of “decision support.” A data warehouse can be associated with tools that enable end users (such as state quality assurance managers) to perform computer-generated analyses of data on their own. This enables users, such as state managers, to more easily access the information they need to support the decisions they make.[i]

DAY ACTIVITY AND HEALTH SERVICES (DAHS) – Long-term services and supports offered during the day, Monday through Friday, to clients residing in the community. Services, which are provided at a licensed adult day care center, include nursing and personal care, meals, transportation, and social and recreational activities. These services are provided by adult day care centers, but administered through the Texas Department of Aging and Disability Services (DADS).

DEAF-BLIND MULTIPLE DISABILITIES WAIVER (DBMD) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people who are deaf and blind and have a third disability (e.g., intellectual disability) as an alternative to ICF/IID institutional care. Currently, DBMD is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS; WAIVER; 1915(c)**.

DEFICIT REDUCTION ACT (DRA) OF 2005 – Federal legislation that is estimated to reduce direct federal spending by $39 billion for the five-year period of 2006-2010 due to changes in drug reimbursements and policies, cost-sharing, benefit flexibility, and in asset policy for long-term care eligibility.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL– One of two payment pools available from the 1115 Transformation Waiver. Provides

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[i] Adapted from: the Data Warehousing Information Center, <http://www.dwinfocenter.org> and *The Data Warehouse Toolkit: Practical Techniques for Building Dimensional Data Warehouses* by Ralph Kimball, published by John Wiley and Sons, 1996.

financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served. See **1115 TRANSFORMATION WAIVER, UNCOMPENSATED CARE POOL, REGIONAL HEALTH CARE PARTNERSHIP**.

DEVELOPMENTAL DISABILITY – A severe, chronic disability manifested before age 22, which results in impaired intellectual functioning or deficiencies in essential skills. See also **INTELLECTUAL DISABILITY; RELATED CONDITION.**

DIAGNOSIS –

- The art of distinguishing one disease from another.
- Determination of the nature of a cause of a disease.
- A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem.
- A code for the above.

DIAGNOSIS RELATED GROUPS (DRGs) – 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 as a financing mechanism to reimburse hospitals and other providers for services rendered.

DISPROPORTIONATE SHARE (DISPRO OR DSH) – A program that provides additional reimbursement to hospitals that serve a disproportionate share of low-income patients to compensate for revenues lost by serving needy Texans. See also **DISPROPORTIONATE SHARE HOSPITAL.**

DISPROPORTIONATE SHARE HOSPITAL – A hospital designation that describes hospitals that serve a higher than average number of Medicaid and other low-income patients.

DRUG FORMULARY – A listing of prescription medications, which are available to Medicaid and Children’s Health Insurance Program (CHIP) clients. The Medicaid drug formulary is an open formulary that includes preferred and non-preferred drugs. Non-preferred drugs require prior authorization before dispensing, while preferred drugs do not require prior authorization. The CHIP formulary does not require prior authorization for non-preferred drugs.

DUAL ELIGIBLE – Individual who qualifies for both Medicare benefits and Medicaid assistance. Texas covers a different mix of Medicare cost sharing depending on the individual's/couple's income. See also **MEDICAID QUALIFIED MEDICARE BENEFICIARIES; QUALIFIED DISABLED WORKING INDIVIDUALS; QUALIFIED INDIVIDUALS; QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES.**

DURABLE MEDICAL EQUIPMENT (DME) – Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs, and oxygen equipment.

E

E- PRESCRIBING – The computer-to-computer transfer of prescription, drug, benefit, and patient information among prescribers, pharmacies, and payers. Medicaid and the Children's Health Insurance Program (CHIP) began implementing e-prescribing in 2010.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) – See **COMPREHENSIVE CARE PROGRAM; TEXAS HEALTH STEPS.**

ELECTRONIC HEALTH RECORD (EHR) – An electronic record of an individual's health-related information that includes patient demographic and clinical health information, such as medical histories and problem lists, and that has a variety of capabilities, including clinical decision support; physician order entry; capture and query of information relevant to health care quality; and the ability to exchange electronic health information with, and integrate such information from, other sources.

ELIGIBILITY SUPPORT SERVICES AND ENROLLMENT CONTRACTOR – An entity with which the state contracts to provide business services that support the state's determination of client eligibility for Medicaid, Food Stamps, and TANF programs; determines eligibility for the Children's Health Insurance Program (CHIP); assists in educating clients who are enrolling in Medicaid managed care and CHIP about their health plan and PCP choices; enrolls clients into Medicaid managed care and CHIP; and processes health plan changes.

ELIGIBLE CLIENT – An individual who has been determined to meet the eligibility criteria of a public program such as Medicaid.

EMERGENCY MEDICAL CONDITION – A medical condition with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

ENCOUNTER DATA – Information derived from a contact or service delivered by a health care provider for any capitated service provided to an eligible member.

ENHANCED MATCH RATE – Federal matching rate that is higher than the regular federal medical assistance percentage (FMAP). See also **CHILDREN'S HEALTH INSURANCE PROGRAM; FEDERAL MEDICAL ASSISTANCE PERCENTAGE**.

ENROLLEE – An individual who is enrolled in and eligible for services from a health plan either as a subscriber or as a dependent.

EXPANSION CHILDREN – Children who are generally at least one year of age, but under age six, and live in a family whose income is at or below 133 percent of the federal poverty level (FPL). Children in this coverage group have either elected to bypass Temporary Assistance for Needy Families (TANF), or are not eligible for TANF in Texas.

EXPERIENCE REBATE – Medicaid and CHIP managed care organizations (MCOs) are required to pay HHSC experience rebates, which are a form of profit sharing. The amount paid to the state (the experience rebate) is calculated using a graduated rebate method based on the excess of allowable MCO Medicaid or CHIP revenues over allowable MCO Medicaid or CHIP expenses. The rebate amount is based on pre-tax income, and varies based on the amount of pre-tax profit and the variable percentage applied.

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO) – See **QUALITY MONITOR**.

F

FEDERAL BENEFIT RATE (FBR) – The FBR is the Supplemental Security Income (SSI) limit. For 2012, the FBR is $698 per month for individuals.

FEDERAL DRUG REBATES – Payments to the state from drug manufacturers and pricing rules mandated by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L.101-508). The payment is dependent on the state's expenditures for each specific drug product. See also **OMNIBUS BUDGET RECONCILIATION ACTS**.

FEDERAL FISCAL YEAR (FFY) – The federal fiscal year is a 12-month period beginning October 1 and ending September 30.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) – The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income. In FFY 2011, the FMAP for Texas was 60.56 percent. The federal share of Medicaid administrative costs is not based on a per capita income formula. It is 50 percent for most activities. The FFY 2012 FMAP for Texas is 58.22 percent.

FEDERAL POVERTY LEVEL (FPL) – Income guideline established annually by the federal government. Public assistance programs usually define income limits in relation to the FPL.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) – A center receiving a grant under the Public Health Services Act or an entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless programs. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.

FEE-FOR-SERVICE REIMBURSEMENT (FFS) – The traditional Medicaid health care payment system, under which providers receive a payment for each unit of service they provide.

FREEDOM OF CHOICE– In general, a state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options. Texas

Health Steps (THSteps) clients have freedom of choice with regard to a medical checkup provider, even if that provider is not the child's primary care provider.

FREW V. JANEK – A class action lawsuit that was filed against Texas in 1993 and alleged that the state did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services.

G

GENERIC DRUG – A chemically-equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or "generic" name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.

GRADUATE MEDICAL EDUCATION (GME) – Payments that cover the costs of residents' and teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs for hospitals that operate medical residency training programs.

H

HEALTH AND HUMAN SERVICES COMMISSION (HHSC) – The oversight agency for health and human services in Texas. HHSC is the single state Medicaid and CHIP agency for Texas.

HEALTH INFORMATION DESIGNS, INC. – Evaluates prior authorization requests submitted through a call center and from the pharmacy point-of-sale system for drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) – Federal legislation (P.L. 104-191) that prohibits insurers from excluding individuals because of health problems or disabilities; limits insurers' ability to exclude treatment for pre-existing conditions; requires standardized electronic exchange of administrative and financial health services information for

all health plans, including Medicaid; protects the security of electronically transmitted or stored information and the privacy of individuals covered by Medicaid; and implements the new National Provider Identifier to be used on all electronic transactions between providers and health plans in May 2007. In April 2007, the Centers for Medicare & Medicaid Services (CMS) announced a contingency period for any covered entity showing a good faith effort to become compliant. The contingency period allowed covered entities to continue using legacy identifiers until May 23, 2008, without penalty.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM – A Medicaid program that pays for employer or private health insurance premiums for persons who are Medicaid-eligible, when the premiums are less expensive than providing regular Medicaid coverage for those persons.

HEALTH PASSPORT – A web-based repository of medical information for each child enrolled in the STAR Health program. The Health Passport allows authorized users immediate access to a child's basic claim-based health record through a secure, password-protected website. The Health Passport includes available claims information, immunization records, behavioral health assessments, Texas Health Steps exam forms, lab results, and other health care information. See also **STAR HEALTH.**

HEALTH PLAN – See **MANAGED CARE ORGANIZATION**.

HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS) – A core set of performance measures developed for employers to use in assessing health plans. It was established and is promoted by the National Committee for Quality Assurance (NCQA).

HOME AND COMMUNITY-BASED SERVICES WAIVER (HCS) – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people with intellectual disabilities as an alternative to ICF/IID institutional care. HCS is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c).**

HOSPICE – A treatment approach that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice is to help terminally ill individuals continue life with minimal disruption of normal activities while remaining primarily in the home environment. Hospice uses an interdisciplinary approach to deliver medical, social,

psychological, emotional, and spiritual services through a broad spectrum of professional and other caregivers with the goal of making the individual as physically and emotionally comfortable as possible.

INDEPENDENT ASSESSMENTS – Assessments of access, quality, and cost of Medicaid managed care programs operated under a 1915(b) waiver. These assessments are required by the federal government and performed by an entity external to the state agencies that oversee and operate the Medicaid program.

INFANT – Children from birth to one year of age.

INSTITUTION FOR MENTAL DISEASE (IMD) – A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs) – Activities that are essential to independent daily living including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone.

INTEGRATED ELIGIBILITY DETERMINATION - HHSC uses an integrated system to determine eligibility for Medicaid, CHIP, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), and TANF. The eligibility system offers convenient access to eligibility services through multiple channels, including a network of local eligibility offices, phone, mail, fax, and the Internet. Clients can call 2-1-1 to apply for benefits and obtain basic information about their case. See **TEXAS INTEGRATED ELIGIBILITY REDESIGN SYSTEM**.

INTELLECTUAL DISABILITY – A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

INTEREST LIST – A list of individuals who are interested in receiving 1915(c) waiver services, but for whom waiver slots are not available due to the waiver being at maximum enrollment. See also **WAIVER; 1915(c).**

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS – Optional Medicaid

state plan service, which provides residential care and services for individuals with developmental disabilities based on their functional needs. See also **INTELLECTUAL DISABILITY.**

K

KATIE BECKETT OPTION – See **TEFRA 134(a).**

L

LEGISLATIVE BUDGET BOARD (LBB) - The Legislative Budget Board is a permanent joint committee of the Texas Legislature that develops budget and policy recommendations for legislative appropriations for all agencies of state government, as well as completes fiscal analyses for proposed legislation. The LBB also conducts evaluations and reviews for the purpose of identifying and recommending changes that improve the efficiency and performance of state and local operations and finances.

LOCAL BEHAVIORAL HEALTH AUTHORITY (LBHA) – In the NorthSTAR behavioral health pilot program, the LBHA coordinates community participation and local oversight of the NorthSTAR program. The LBHA is not a provider of behavioral health services. Also known as the North Texas Behavioral Health Authority. See also **NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY**.

LOCAL MENTAL HEALTH AND MENTAL RETARDATION AUTHORITY – The local component of the mental health and mental retardation system designated to carry out the legislative mandate for planning, policy development, coordination, and resource development/allocation, and to supervise and ensure the provision of services to persons with mental illness or intellectual disability in one or more local service areas. See also **COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS.**

LONESTAR – Texas' first managed health care pilot project under the Medicaid program. The name of this program was later shortened to STAR, for state of Texas Access Reform. See also **MANAGED CARE;**

LONG-TERM SERVICES AND SUPPORTS – Assistance for persons who are over age 65 and those with chronic disabilities. The goal of long-term services

and supports is to help such individuals be as independent as possible. See also **ACTIVITIES OF DAILY LIVING**.

M

MANAGED CARE – A system in which the overall care of a patient is overseen by a single provider or organization. Many state Medicaid and CHIP programs include managed care components as a way to improve quality and control costs. See also **MANAGED CARE ORGANIZATION; LONESTAR; NORTHSTAR PROGRAM; STATE OF TEXAS ACCESS REFORM; STAR+PLUS PROGRAM; STAR HEALTH; CHIP.**

MANAGED CARE ORGANIZATION (MCO) – An organization that delivers and manages health services under a risk-based arrangement. The MCO 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. If enrollees cost more, the MCO may suffer losses. If enrollees cost less, the MCO profits. This gives the MCO an incentive to control costs. See also **1903(m); 1915(b).**

MANAGED HEALTH CARE PLAN – One or more products that integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network that delivers services and that (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

MANDATED OR REQUIRED SERVICES – Services that a state is required to offer to categorically needy clients under the Medicaid State Plan. (Medically needy clients may be offered a more restrictive service package.)

MEDICAID – A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

MEDICAID BUY-IN - A program that enables working persons with disabilities to receive Medicaid services. Medicaid Buy-In clients may be required to pay a monthly premium depending on their earned and unearned income. The program is available to individuals with countable earned income less than 250 percent of the federal poverty level (FPL).

MEDICAID BUY-IN FOR CHILDREN – A program that allows children up to age 19 with disabilities to "buy-in" to Medicaid. Children with family income up to 300 percent of the FPL may quality for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented the program in January 2011.

MEDICAID ELIGIBLE – In Texas, this term refers to persons who, after going through a certification process, become eligible to receive services and other assistance under the Medicaid program. The term does not include persons who could be eligible for Medicaid (e.g., meet all income and asset criteria tied to eligibility) that are not enrolled in the program.

MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM (MEHIS) –MEHIS replaced the paper Medicaid identification form with a permanent plastic card, automated eligibility verification, and provided an electronic health record for all Medicaid clients

MEDICAID ESTATE RECOVERY (MERP) – The Medicaid Estate Recovery Program (MERP) is required by federal and state law to recover, after the time of death, certain long-term care and associated Medicaid costs of services provided to recipients age 55 and over.

MEDICAID FOR BREAST AND CERVICAL CANCER (MBCC) – MBCC provides full Medicaid coverage for eligible uninsured women ages 18 to 64 who have been diagnosed with a qualifying breast or cervical cancer. Women may receive a qualifying diagnosis from any provider, but must apply for MBCC through the Breast and Cervical Cancer Services program administered by the Department of State Health Services (DSHS). Clients receive Medicaid benefits as long as they meet the eligibility criteria and are receiving active treatment for breast or cervical cancer.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) – The claims processing and information retrieval system that states are required to have to operate Medicaid programs. The MMIS is an integrated group of procedures and computer processing operations (subsystems) that enable management of administrative costs; services to clients and providers; inquiries; claims control; and management reporting. The capabilities needed to operate under managed care differ somewhat from those required under traditional Medicaid. See also **COMPASS 21; MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM.**

MEDICAID OPERATING DEPARTMENT – State agencies in Texas with day-to-day operational responsibility for various Medicaid-funded programs. See also **TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES; TEXAS DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES; TEXAS DEPARTMENT OF STATE HEALTH SERVICES**.

MEDICAID QUALIFIED MEDICARE BENEFICIARIES – Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the deductible and co-insurance for Medicare services and covers all other Medicaid services not covered by Medicare.

MEDICAID RECIPIENT – A Medicaid client or enrollee who has received a service paid for with Medicaid program funds.

MEDICAID REIMBURSEMENT – Amount of money the Medicaid program reimburses or pays to a health care organization or other provider for services or other forms of assistance provided to Medicaid clients.

MEDICAID RURAL SERVICE AREA - On March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties. The Medicaid Rural Service Area (Medicaid RSA) STAR program serves clients who were previously covered by the Primary Care Case Management program—if they had Medicaid only (e.g., pregnant women and children with limited income, TANF clients, and adults receiving SSI). Children age 20 and younger with Supplemental Security Income (SSI) may choose between managed care and traditional Medicaid. SSI children age birth through 20 years of age may volunteer to participate in STAR in the Medicaid RSA. See **PRIMARY CARE CASE MANAGEMENT; STAR.**

MEDICAID STATE PLAN – The document that serves as the contract between the state and the Centers for Medicare & Medicaid Services (CMS) for the Texas Medicaid program and that gives the state, particularly the Health and Human Services Commission (HHSC), authority to administer a Medicaid program in Texas. It describes the nature and scope of the state's Medicaid program including Medicaid administration, client eligibility, benefits, and provider reimbursement. It includes a "preprint" portion, which contains the broad outlines of the program and the basic choices that a state is allowed to make. The details of a particular state's plan are contained in numerous attachments, appendices, and supplements. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children's Health Insurance Program State Plan. See also **TITLES OF THE 1965 SOCIAL SECURITY ACT**.

MEDICAID WELLNESS PROGRAM FOR CHILDREN WITH DISABILITIES - Previously named the Texas Health Management Program, the Medicaid Wellness Program (TMWP) was implemented March 1, 2011, to provide chronic care management statewide to high-cost/high-risk PCCM and FFS clients. In October 2011, HHSC shifted the focus of the TMWP to SSI disabled children who voluntarily remained in FFS after the March 1, 2012 managed care expansion. The TMWP is a community-based care management program that enrolls high-risk clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person (rather than the disease) through telephonic and face-to-face interventions that aim to improve health outcomes.

MEDICAL CARE ADVISORY COMMITTEE (MCAC) – Mandated by federal Medicaid law, the MCAC reviews and makes recommendations to the State Medicaid/CHIP Director on proposed Medicaid rules.

MEDICAL NECESSITY – Health services that are:

- Reasonably necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a recipient, or endanger life.
- Provided at appropriate locations and at the appropriate levels of care for the treatment of clients' conditions.
- Consistent with health care practice guidelines and standards that are issued by professionally-recognized health care organizations or governmental agencies.
- Consistent with the diagnoses of the conditions.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

MEDICAL TRANSPORTATION PROGRAM (MTP) – MTP arranges non-emergency transportation to and from medically necessary, Medicaid-allowable health care services for persons enrolled in Medicaid who have no other means of transportation.

MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP) – A 1915(c) Medicaid waiver program that provides respite, minor home modifications, and adaptive aids to children as an alternative to nursing facility care. MDCP is administered by the Texas Department of Aging and Disability Services (DADS). See also **1915(c); WAIVER.**

MEDICALLY NEEDY PROGRAM – A program for pregnant women and children who are ineligible for regular Medicaid coverage due to excess income, but who meet Medicaid income eligibility limits after accounting for their medical expenses (a process called "spend down"). Clients are not required to pay their medical expenses in order to qualify for the medically needy program.

MEDICARE – The nation's largest health insurance program financed by the federal government. Medicare provides insurance to people who are age 65 and older and those with disabilities or permanent kidney failure.

MEDICARE EQUALIZATION - limited payments for Medicare Part A and B services provided to dual eligibles to no more than the Medicaid payment amount for the same service, with the exception of renal dialysis services. Medicare Part A covers hospital services and Medicare Part B covers physician and other outpatient services.

MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT (MMA) OF 2003 – A federal law (P.L. 108-173) that created a new Medicare prescription drug benefit (Part D) and made other program and payment changes.

MEMBER – Medicaid client who is enrolled in a managed care organization plan. See also **ENROLLEE**.

MENTAL ILLNESS (as defined in the Texas Medicaid state plan) – A single severe mental disorder, excluding intellectual disability, or a combination of severe mental disorders as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

MODIFIED ADJUSTED GROSS INCOME - Requires states to determine financial eligibility for most individuals in Medicaid and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition. The Affordable Care Act (ACA) applies a 5 percentage point income disregard to individuals that are subject to the MAGI methodology. The MAGI methodology applies to the existing Medicaid eligibility groups for children, pregnant women, and parents and caretakers. The ACA provides exceptions to the use of MAGI and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and people with disabilities.

MONEY FOLLOWS THE PERSON – Rider 28 in Article II of the General Appropriations Act (78th Legislature, Regular Session, 2003) that stipulates that as clients relocate from nursing facilities to community care services, the nursing facility funds will be transferred to the community care budget to cover the cost of their services. Also known as the "Money Follows the Person" rider. The rider language was codified by House Bill 1867, 79th Legislature, Regular Session, 2005.

N

NEWBORNS – Children up to age 1 whose family income and resources are above the current requirements for Temporary Assistance for Needy Families (TANF), but not above 185 percent of the federal poverty level (FPL). The Children's Health Insurance Program (CHIP) covers newborns up to 200 percent of the federal poverty level (FPL).

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY – The Local Behavioral Health Authority (LBHA) for the NorthSTAR program formed to ensure that local communities are given a voice in the delivery of publicly-funded, managed behavioral health care. The LBHA represents both mental health and chemical dependency interests and concerns. See also **LOCAL BEHAVIORAL HEALTH AUTHORITY; NORTHSTAR PROGRAM.**

NORTHSTAR PROGRAM – Texas' managed care carve-out pilot program for behavioral health services. Implemented in 1999 in Dallas and contiguous counties, NorthSTAR integrates Medicaid-funded and public, non-Medicaid funded mental health and chemical dependency services. The program includes state and federal Medicaid funds (through a 1915(b) waiver), non-Medicaid state and federal funds, and some county funds. See also **CARVE OUT; 1915(b)**.

NURSING FACILITIES – Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) long-term care program. The nursing facility program is administered by the Texas Department of Aging and Disability Services (DADS). See also **LONG-TERM SERVICES AND SUPPORTS.**

O

OFFICE OF THE INSPECTOR GENERAL (OIG) – The 78th Legislature created the Office of Inspector General in 2003 to strengthen the Health and Human Services Commission's (HHSC) authority and ability to combat fraud, waste, and abuse in health and human services programs. OIG is divided into four divisions: Compliance, Enforcement, Operations, and Chief Counsel.

OMNIBUS BUDGET RECONCILIATION ACTS (OBRAs) – Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.

OPTIONAL SERVICES OR BENEFITS – Over 30 different services that a state can elect to cover under a Medicaid state plan. Examples include personal care, rehabilitative services, prescription drugs, therapies, diagnostic services, Intermediate Care Facilities for Individuals with an Intellectual Disability or related condition, targeted case management, etc.

OUTLIER – An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.

P

PART A – Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency, or hospice care by a licensed and certified hospice agency. See also **MEDICARE**.

PART B – Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also **MEDICARE.**

PART C – Previously called Medicare+Choice, this part of the Medicare program was renamed Medicare Advantage and modified by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. Provides for certain managed care coverage options in Medicare, under which managed care

organizations receive a capitated monthly payment per covered beneficiary. Additional benefits and cost-sharing arrangements may be offered by Medicare managed care organizations. See also **MANAGED CARE ORGANIZATION; MEDICARE; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA).**

PART D – A voluntary Medicare prescription drug benefit created by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 that began January 1, 2006. Beneficiaries who remain in traditional Medicare may choose a private drug-only plan; those who choose to enroll in a managed care organization may choose a plan that offers a drug benefit. See also **MANAGED CARE ORGANIZATION; MEDICARE; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA).**

PER MEMBER PER MONTH (PMPM) – The unit of measure related to each member for each month the member was enrolled in a managed care plan.

PERSONAL CARE SERVICES (PCS)– Optional Medicaid benefit that allows a state to provide attendant services to assist individuals with disabilities in performing activities of daily living (e.g., bathing, dressing, feeding, grooming). Texas provides Primary Home Care services under this option. See also **PRIMARY HOME CARE**.

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 (PRWORA) – Federal legislation (P.L. 104-193) that eliminated Aid to Families with Dependent Children (AFDC) and created Temporary Assistance for Needy Families (TANF), a block grant for states to provide time-limited cash assistance for needy families, with work requirements for most clients. See also **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES**.

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE – A governor-appointed committee consisting of six physicians and five pharmacists who review data on the clinical efficacy, safety, and cost effectiveness of drug products and make recommendations to HHSC about which drugs to place on the Preferred Drug List. See also **PREFERRED DRUG LIST**.

PHARMACY BENEFITS MANAGER - Each Medicaid/CHIP managed care organization (MCO) contracts with a pharmacy benefits manger (PBM) to process prescription claims. The PBMs contract and work with pharmacies that actually dispense medications to CHIP and Medicaid managed care clients.

MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO's network.

PHARMACY CLAIMS AND REBATE ADMINISTRATOR – Processes and adjudicates all claims for Medicaid and CHIP fee-for-service out-patient prescription drugs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores managed care organization encounter data to support program oversight of prescription drug benefits in managed care.

PHARMACY PRIOR AUTHORIZATION VENDOR –Evaluates prior authorization requests submitted through a call center and from the pharmacy point-of-sale system for drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

In January 2011, HHSC transitioned prior authorization services to Health Information Designs, Inc. See also Health Information Designs, Inc.

PHYSICIAN EXTENDER - Physician extender is a health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASARR) – Screen to identify persons with mental illness, intellectual disability, or related conditions in nursing facilities

PREFERRED DRUG LIST (PDL) – A cost-control measure used by Texas and other states to manage increasing drug costs. The PDL is a list of "preferred" drugs that are safe, clinically effective, and cost effective compared to other drugs on the market. Drugs on the PDL do not require prior approval in order to be reimbursed. Medicaid also covers drugs not on the PDL, but a physician's office must call to obtain prior approval before a non-preferred drug can be reimbursed.

PREFERRED DRUG LIST VENDOR – The contracted vendor that provides information to the Pharmaceutical and Therapeutics (P&T) Committee on the clinical efficacy, safety, and cost effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the P&T Committee with the development and maintenance of the preferred drug list. See also **PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE.**

PRESCRIPTION DRUG – A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

PREVENTIVE CARE – Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

PRIMARY CARE – Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine providers.

PRIMARY CARE CASE MANAGEMENT (PCCM) – Managed care option in which each participant is assigned to a single primary care provider who must authorize most other services such as specialty physician care before they can be reimbursed by Medicaid. Effective September 1, 2011, Medicaid clients participating in the Primary Care Case Management (PCCM) program in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR program or STAR+PLUS Medicaid managed care program. In March 2012, HHSC entered into new contracts with MCOs in 11 service areas and terminated PCCM.

PRIMARY CARE PHYSICIAN (PCP) – A physician or provider who has agreed to provide a medical home to Medicaid clients and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

PRIMARY HOME CARE (PHC) – A Medicaid-funded community care program administered by the Texas Department of Aging and Disability Services (DADS) that provides personal care services. PHC is provided as an optional state plan benefit. See also **PERSONAL CARE SERVICES.**

PRIOR AUTHORIZATION – An authorization from the Medicaid program for the delivery of certain services. It must be obtained prior to providing the service. Examples of such services are goal-directed therapy and transplants.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) – A waiver of the Medicaid State Plan granted under Section 1115(a) of the Social Security Act. This waiver allows Texas to provide comprehensive medical and community-based services under a capitated, risk-based system to frail elderly people (55 and older), as a cost-effective alternative to institutional care. The waiver is part of a national demonstration project. Texas has two PACE sites in El Paso and Amarillo. PACE is administered by the Texas Department of Aging

and Disability Services (DADS). See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; WAIVER; 1115(a).**

PROMOTING INDEPENDENCE – The Promoting Independence Plan and Initiative is the Texas response to the U.S. Supreme Court *Olmstead* decision regarding Title II of the Americans with Disabilities Act. The Court ruled that states must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when certain conditions are met, or have a comprehensive, effective plan to provide community services. The Promoting Independence Plan and Initiative has been expanded to respond to two Governor's Executive Orders which seek to improve the service delivery system for persons who have disabilities and/or who are aging.

PATIENT PROTECTION AND AFFORDABLE CARE ACT- The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). The ACA includes provisions to expand health insurance coverage, including an individual mandate, sliding-scale health insurance subsidies for individuals and families up to 400 percent of the federal poverty level (FPL); tax incentives for small employers to offer health insurance to their employees, an optional expansion of Medicaid up to 133 percent FPL and measures to improve quality, reduce fraud and abuse, and reform payment methodologies.

PROVIDER – A person, group, or agency that provides a covered Medicaid service to a Medicaid client.

PROVIDER CREDENTIALING – The process through which managed care organizations ensure that each health care provider meets all professional standards, including licensure.

PROVIDER NETWORKS – Organizations of health care providers that provide services within managed care plans. Network providers are selected with the expectation that they will deliver care inexpensively, and enrollees are channeled to network providers to control costs.

Q

QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI) – Medicare beneficiaries with income less than or equal to 200 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. The Texas Medicaid program pays Medicare Part A premiums for disabled working individuals. However, the number of QDWI eligible for this benefit in Texas is small. See also **PART A.**

QUALIFIED INDIVIDUALS (QI) – Medicare beneficiaries with income less than 135 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. Medicaid pays a portion of the Medicare Part B premium. See also **PART B.**

QUALIFIED MEDICARE BENEFICIARY (QMB) – Medicare beneficiaries with income less than or equal to 100 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. Medicaid pays all Medicare Part A and B premiums, deductibles, and coinsurance. See also **PART A; PART B.**

QUALITY MONITOR – Provides external review of the access and the quality of care provided to Medicaid and CHIP clients enrolled in Medicaid/CHIP managed care. Also known as the External Quality Review Organization (EQRO).

R

RECIPIENT – A person who received a Medicaid service while eligible for the Medicaid program. People may be Medicaid eligible without being Medicaid recipients. See also **CLIENT; MEDICAID ELIGIBLE**.

RECIPIENT (CLIENT) MONTHS – This term reflects a complete count (could be actual or estimated) of all certified Medicaid clients for a given month. The count reflects all Medicaid clients, regardless of whether or not they received services during that month. For any given month, the number of recipient months is equal to the number of unduplicated clients for that month. Recipient months and unduplicated clients differ on an annualized basis. See also **CLIENT**.

REGIONAL HEALTH CARE PARTNERSHIPS – Under the 1115 Transformation Waiver, eligibility to receive Uncompensated Care (UC) or Delivery System

Reform Incentive Payment (DSRIP) requires participation in one of 20 Regional Health Care Partnerships (RHP), which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an "anchoring entity," which is a public hospital or other local governmental entity with the authority to make intergovernmental transfers, such as a hospital district, a hospital authority, a health science center, or a county. See **UNCOMPENSATED CARE; DELIVERYSYSTEM REFORM INCENTIVE PAYMENT; 1115 TRANSFORMATION WAIVER.**

REHABILITATIVE SERVICES FOR MENTAL ILLNESS – Specialized services provided to people age 18 and over with severe and persistent mental illness and people under 18 with serious emotional disturbance. Mental health rehabilitation includes:

- Crisis Intervention Services.
- Medication Training and Support Services.
- Psychosocial Rehabilitation Services.
- Skills Training and Development Services.
- Day Programs for Acute Needs.

Program design and eligibility was modified effective September 1, 2004, to reflect the Resiliency and Disease management practices required in House Bill 2292, 78th Legislature, Regular Session, 2003. See also **MENTAL ILLNESS.**

REINSURANCE – Insurance purchased by a managed care organization, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that my be incurred in the process of honoring the unusually high claims of its participating providers, policy holders, or employees and covered dependents. Also called risk control insurance or stop-loss insurance.

RELATED CONDITIONS – A disability other than an intellectual disability that manifests itself before age 22 and results in substantial functional limitations in three of six major life activities (e.g., self-care, expressive/receptive language, learning, mobility, self-direction and or capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other disabilities are said to be "related to" intellectual disability in their effect upon the individual's functioning.

RETROSPECTIVE DRUG UTILIZATION REVIEW VENDOR: Performs drug use review (DUR) retrospective interventions to assist health care providers in delivering appropriate prescription pharmaceutical drugs to Texas Medicaid VDP clients.

RISK CONTRACT – An agreement with a managed care organization (MCO) to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense, or degree. See also **MANAGED CARE ORGANIZATION.**

S

SCHOOL HEALTH AND RELATED SERVICES (SHARS) – Medicaid optional benefit that provides services related to a child's Individual Education Plan (IEP). Services are provided in a s chool setting and include audiology, physician services, occupational therapy, physical therapy, speech therapy, psychological services, nursing services, counseling, personal care services, and transportation.

SELECTIVE CONTRACTING – Option under section 1915(b) of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.

SERVICE AREA (SA) – Regions of the state in which clients receive Medicaid services through an MCO, and that are treated as a unit in terms of planning and implementation of managed care strategies.

SERVICE RESPONSIBILITY OPTION – Under the SRO, the traditional agency remains the employer of record, but the consumer participates in selecting and managing the attendant staff. The option allows consumers to select and manage their care staff but without the responsibility of being an employer.

SIGNIFICANT TRADITIONAL PROVIDER (STP) – Under Texas Medicaid law, managed care organizations (MCOs) must include in their provider networks, for at least three years, each health care provider who:

- Previously provided care to Medicaid and charity care patients at a significant level (as defined by the Texas Health and Human Services Commission).
- Agrees to accept the standard provider reimbursement rate of the MCO.
- Meets the credentialing requirements of the MCO.

- Complies with all of the terms and conditions of the standard provider agreement of the MCO.

SINGLE STATE AGENCY – The Social Security Act requires that the state designate a single agency to administer or supervise administration of the state's Medicaid plan. In Texas, the Health and Human Services Commission fulfills this function. See also **HEALTH AND HUMAN SERVICES COMMISSION; MEDICAID STATE PLAN.**

SKILLED NURSING FACILITY (SNF) – A nursing facility that is certified to treat Medicare patients.

SOCIAL SECURITY ADMINISTRATION (SSA)– Federal agency responsible for determining eligibility for Supplemental Security Income benefits in Texas and most other states.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB) – Medicare beneficiaries with income less than 120 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays the Medicare Part B premium. See also **PART B.**

SPELL OF ILLNESS – A continuous period of hospital confinement. Successive periods of hospital confinement shall be considered to be continuous unless the last date of discharge and the date of readmission are separated by at least 60 consecutive days of care.

STAR HEALTH – A statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits include medical, dental, and behavioral health services, as well as service coordination and a web-based electronic medical record (known as the Health Passport). The program was implemented on April 1, 2008. See also **HEALTH PASSPORT**.

STAR+PLUS PROGRAM – Implemented in 1998, this managed care program provides integrated acute and long-term services and supports to people with disabilities and people age 65 and older. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant and Travis Service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a credentialed provider network contracted with MCOs.

STATE FISCAL YEAR (SFY) – The Texas state fiscal year runs from September 1 through August 31 of each year.

STATE OF TEXAS ACCESS REFORM (STAR) – Texas' Medicaid managed care program in which the Health and Human Services Commission contracts with managed care organizations (MCOs) to provide, arrange for, and coordinate preventive, primary, and acute care covered services to non-disabled children, low-income families, and pregnant women. On March 1, 2012, STAR expanded to the Medicaid Rural Service Area (Medicaid RSA). See **MEDICAID RURAL SERVICE AREA.**

STATE SUPPORTED LIVING CENTERS – State Supported Living Centers provide campus-based direct services and supports to people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems.

STATEWIDENESS – In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. See also **1902(a)(1).**

SUBSTANCE ABUSE – The taking of alcohol or other drugs at dosages that place a person's social, economic, psychological, and physical welfare in potential hazard, or endanger the public health, safety, or welfare, or a combination thereof. Also called chemical dependency.

SUBSTANCE USE DISORDER – A pattern of substance use that meets the diagnostic criteria for Substance Abuse or Substance Dependence as set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

SUPPLEMENTAL DRUG REBATES – Payments to the state from drug manufacturers for drug products included on the Medicaid Preferred Drug List, based on claims for each specific drug product.

SUPPLEMENTAL SECURITY INCOME (SSI) – SSI is a federal cash assistance program for low-income older people and people of all ages with disabilities. It is administered by the Social Security Administration (SSA). In Texas, SSI recipients are automatically eligible to receive Medicaid.

SYSTEM FOR APPLICATION VERIFICATION, ELIGIBILITY, REFERRALS, AND REPORTING (SAVERR) – The state's past eligibility information system that was replaced by the Texas Integrated Eligibility and Redesign System (TIERS). See also **TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM**.

T

TARGETED CASE MANAGEMENT – An optional Medicaid state plan service. In Texas, this service is provided for people with chronic mental illness, women with high-risk pregnancies and infants, persons with intellectual disabilities and related conditions, and blind or visually impaired adolescents. Targeted Case Management encompasses activities that assist the target population in gaining access to medical, social, educational, and other services. Such activities include assessment, case planning, service coordination or monitoring, and case plan reassessment.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) – The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.

TEFRA 134(a) – Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain children with disabilities. This option is not offered in Texas.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) – Formerly Aid to Families with Dependent Children (AFDC), TANF provides financial and medical assistance to needy dependent children and the parents or relatives with whom they are living. Eligible TANF households receive monthly cash and Medicaid benefits.

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS) – The Medicaid operating department responsible for administering the Medicaid nursing facility program; long-term care licensing, survey, and certification; and a wide range of home and community-based, long-term services and supports, including the state's Medicaid 1915(c) waiver programs. DADS also administers the ICF/IID program and owns/operates Texas' state schools.

TEXAS DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES (DARS) – The Medicaid operating department responsible for administering targeted case management services for the Blind Children's Program and ECI.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS) – DFPS was created with the passage of House Bill 2292 by the 78th Texas Legislature, Regular Session, 2003. Previously called the Texas Department of

Protective and Regulatory Services, DFPS is charged with protecting children and adults who are older or have disabilities living at home or in state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The agency is also charged with managing community-based programs that prevent delinquency, abuse, neglect and exploitation of Texas children, adults age 65 and older and those adults with disabilities.

TEXAS DEPARTMENT OF INSURANCE (TDI) – TDI is mandated by the legislature to regulate the insurance industry and protect the people and businesses that are served by insurance. Functions of the agency include: resolving insurance-related complaints; conducting windstorm inspections; licensing insurance agents/agencies and adjusters; licensing insurance companies and MCOs; certifying utilization review agents (URAs), independent review organizations (IROs), workers' compensation networks and assigning requests to IROs; registering life settlement entities; assuring fair and efficient regulation; enforcing insurance laws; combating insurance fraud; fire prevention, fire safety, and fire industry regulation; and regulating and administering the Texas workers' compensation system.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS) – The Medicaid operating department responsible for administration of the Early and Periodic Screening, Diagnosis, and Treatment Program/THSteps; case management for pregnant women and children services; newborn screening, newborn hearing screening, and Program for Amplification for Children; family planning services; targeted case management and rehabilitative services for people with mental illness; and the NorthSTAR program. DSHS also owns/operates Texas’ state hospitals.

TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER - Known as the 1115 Transformation Waiver, the waiver is a five-year demonstration running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit (UPL) payments. The 1115 Transformation Waiver, which was approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds. See **UNCOMPENSATED CARE POOL; DELIVERY SERVICES REFORM INCENTIVE PAYMENT; REGIONAL HEALTH CARE PARTNERSHIPS**.

TEXAS EDUCATION AGENCY (TEA) – Provider agency for School Health and Related Services (SHARS). See also **SCHOOL HEALTH AND RELATED SERVICES**.

TEXAS HEALTH STEPS (THSteps) – The name in Texas for the Medicaid program for children that provides services under the required state plan service known as the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). THSteps provides medical and dental prevention and treatment services for children of low-income families from birth to age 21. The program offers comprehensive and periodic evaluation of a child's health, development, and nutritional status, as well as vision, dental, and hearing care. See also **COMPREHENSIVE CARE PROGRAM; EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.**

TEXAS HOME LIVING WAIVER (TxHmL) – A waiver of the Medicaid State Plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to current Medicaid recipients with intellectual disabilities or related conditions as an alternative to Intermediate Care Facility for Persons with Mental Retardation institutional care. This waiver program is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY AND RELATED CONDITIONS; WAIVER; 1915(c).**

TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM (TIERS) – The technology and automated systems that support eligibility services for programs administered by HHSC. TIERS replaced several outdated technology and automation systems with a modernized eligibility system that supports the business processes and improves service delivery.

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP (TMHP) – Entity that serves as the Medicaid claims administrator. As claims administrator, TMHP processes and adjudicates claims for Medicaid services provided in the traditional, fee-for-service system. TMHP does not process or adjudicate claims for services provided by Medicaid managed care organizations (MCOs), but does collect encounter data from the MCOs for use in evaluation of quality and utilization of managed care services. See also **CLAIMS ADMINISTRATOR; ENCOUNTER DATA.**

TEXAS WOMEN'S HEALTH PROGRAM - State-funded program that provides eligible Texas women with preventive health care, screenings, contraceptives

and treatment for certain sexually transmitted diseases (STDs). See **WOMEN'S HEALTH PROGRAM.**

TITLES OF THE 1965 SOCIAL SECURITY ACT –

II	Old Age, Survivors, and Disability Insurance Benefits (Social Security or OASDI)
IV-A	Temporary Assistance for Needy Families (TANF)
IV-B	Child Welfare
IV-D	Child Support
IV-E	Foster Care and Adoption
IV-F	Job Opportunities and Basic Skills Training
V	Maternal and Child Health Services
XVI	Supplemental Security Income (SSI)
XVIII	Medicare
XIX	Medicaid
XX	Social Services
XXI	Children's Health Insurance Program (CHIP) - Added by the Balanced Budget Act (BBA) of 1997

TRADITIONAL MEDICAID – The traditional health care payment system, also known as fee-for-service reimbursement, under which physicians, THSteps dentists, and other providers receive a payment for each unit of service they provide. See also **FEE-FOR-SERVICE REIMBURSEMENT.**

U

UNCOMPENSATED CARE POOL – One of two payment pools available from the 1115 Transformation Waiver. Uncompensated Care (UC) Pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments will be based on each provider's UC costs as reported on a UC application. See **1115 TRANSFORMATION WAIVER, DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL.**

UNDUPLICATED COUNT OF MEDICAID ELIGIBLES PER YEAR – In a given year, some persons may enter and exit the Medicaid program on more than one occasion. Under this concept, persons certified eligible for one or more months

during the year are counted only one time for the year to avoid multiple counts per eligible.

UPPER PAYMENT LIMIT (UPL) – Federal limits on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPL do not qualify for federal Medicaid matching funds. See also **TRANSFORMATION 1115 WAIVER.**

UTILIZATION – The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.

UTILIZATION MANAGEMENT (UM) – A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payors.

UTILIZATION REVIEW (UR) – A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.

V

VENDOR DRUG PROGRAM – A Texas Medicaid program that pays for up to three prescriptions a month per adult in fee-for-service (FFS) programs. Nursing facility residents, 1915(c) waiver participants, adults enrolled in managed care, and children under age 21 are not subject to the three-prescription limitation. Drugs are an optional state plan service under the Texas Medicaid Program.

W

WAIVER – An exception to the usual Medicaid requirements granted to a state by the Centers for Medicare & Medicaid Services (CMS). See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; 1115(a); 1915(b); 1915(c).**

WOMEN'S HEALTH PROGRAM (WHP) – A Medicaid waiver program that provided family planning services and related health screenings to eligible uninsured women ages 18 to 44 with net family incomes at or below 185 percent

of the federal poverty level (FPL). The Centers for Medicare & Medicaid Services approved a five-year waiver for WHP with an implementation date of January 1, 2007. The federal program transitioned to the Texas Women's Health Program (TWHP) in 2013. See also **TEXAS WOMEN'S HEALTH PROGRAM**.

X

Y

YOUTH EMPOWERMENT SERVICES (YES) WAIVER – A Texas Home and Community-Based Waiver program that provides services to children and young adults under the age of 21 who are at risk of hospitalization because of serious emotional disturbance. The program is available in Bexar and Travis Counties.

Numbered Terms

1115(a) – Section of the Social Security Act which allows states to waive provisions of Medicaid law to test new concepts which are consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY; WAIVER.**

1902(a)(1) – Section of the Social Security Act which requires that state Medicaid programs be in effect "in all political subdivisions of the state." See also **STATEWIDENESS; WAIVER; 1915(b); 1915(c)**.

1902(a)(10) – Section of the Social Security Act which requires that state Medicaid programs provide services to people that are comparable in amount, duration, and scope. See also **COMPARABILITY; WAIVER; 1915(b)**.

1902(a)(23) – Section of the Social Security Act which requires that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service. See also **FREEDOM OF CHOICE; WAIVER; 1915(b)**.

1902(r)(2) – Section of the Social Security Act which allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income eligibility for determining Medicaid eligibility. See also **SUPPLEMENTAL SECURITY INCOME**.

1903(m) – Section of the Social Security Act which allows state Medicaid programs to develop risk contracts with managed care organizations or comparable entities. See also **RISK CONTRACT**.

1915(b) – Section of the Social Security Act which allows states to waive freedom of choice. States may require that beneficiaries enroll in managed care organizations or other programs. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; WAIVER**.

1915(c) – Section of the Social Security Act which allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an Intermediate Care Facility for Persons with Mental Retardation, Nursing Facility, Institution for Mental Disease, or inpatient hospital. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; COMMUNITY BASED ALTERNATIVES WAIVER; COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM; DEAF-BLIND MULTIPLE DISABILITIES WAIVER; HOME AND COMMUNITY-BASED SERVICES WAIVER; MEDICALLY DEPENDENT CHILDREN PROGRAM; NURSING FACILITIES; STAR+PLUS PROGRAM; TEXAS HOME LIVING WAIVER; WAIVER; YOUTH EMPOWERMENT SERVICES.**

1915(c)(7)(b) – Section of the Social Security Act which allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; HOME AND COMMUNITY-BASED SERVICES; WAIVER.**

1929 – Section of the Social Security Ac, which allows states to provide a broad range of home and community-based care to individuals with functional disabilities as an optional state plan benefit. In all states but Texas, the option can serve only people over 65. In Texas, individuals of any age may qualify to receive personal care services through section 1929 if they meet the state’s

functional disability test and financial eligibility criteria. See also **COMMUNITY ATTENDANT SERVICES.**

Appendices

Appendix A: Distribution of Medicaid Enrollees by HHS Region, County, and Managed Care Areas (As of August 2012)

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004–2011)

Appendix C: Medicaid Enrollees by County by Risk Group (As of August 2012)

Appendix D: Medicaid and CHIP Service Areas

Appendix E: Medicaid Expenditure History (FFYs 1987–2011)

Appendix F: Texas Medicaid Waivers

Appendix G: Regional Health Care Partnership Regions

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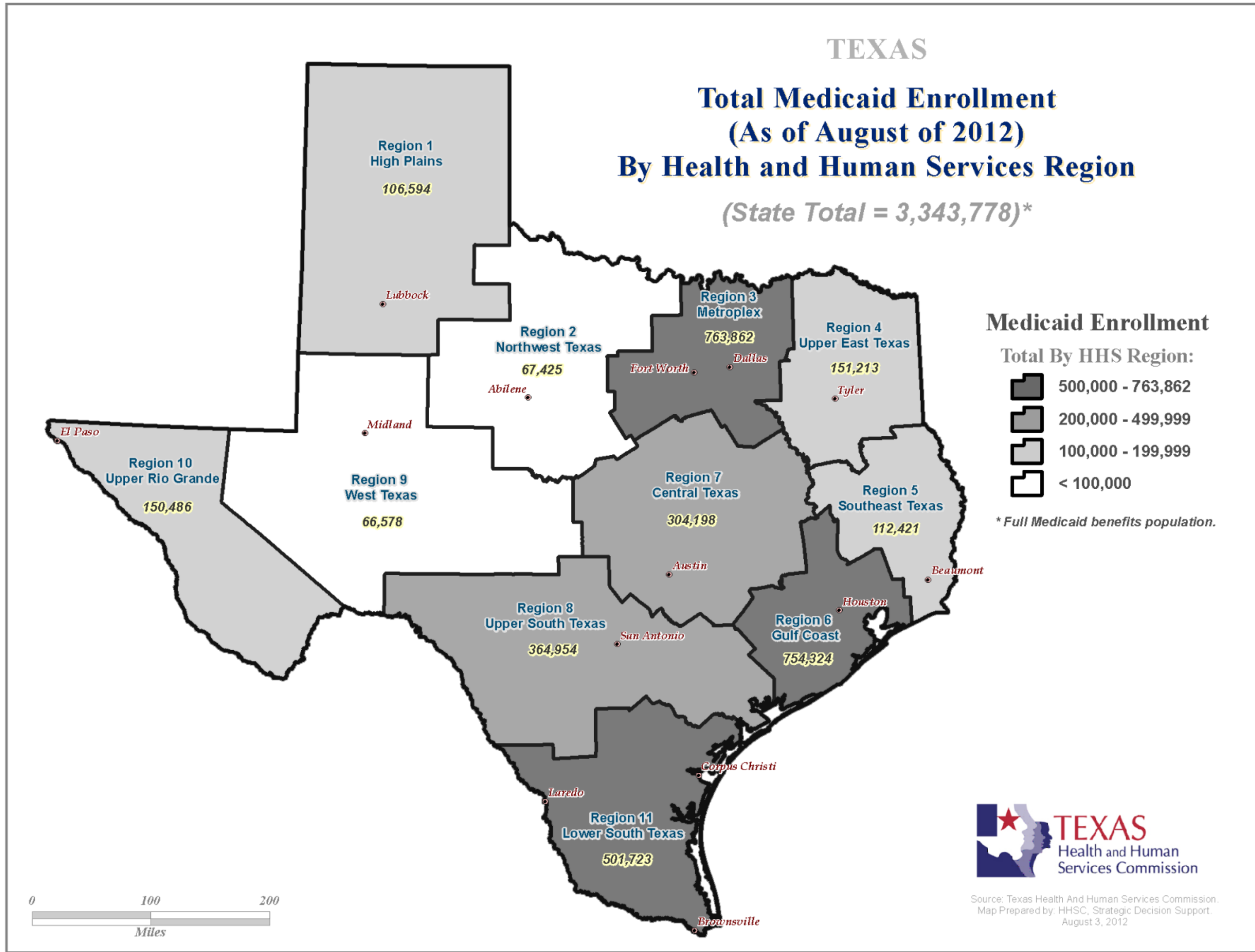

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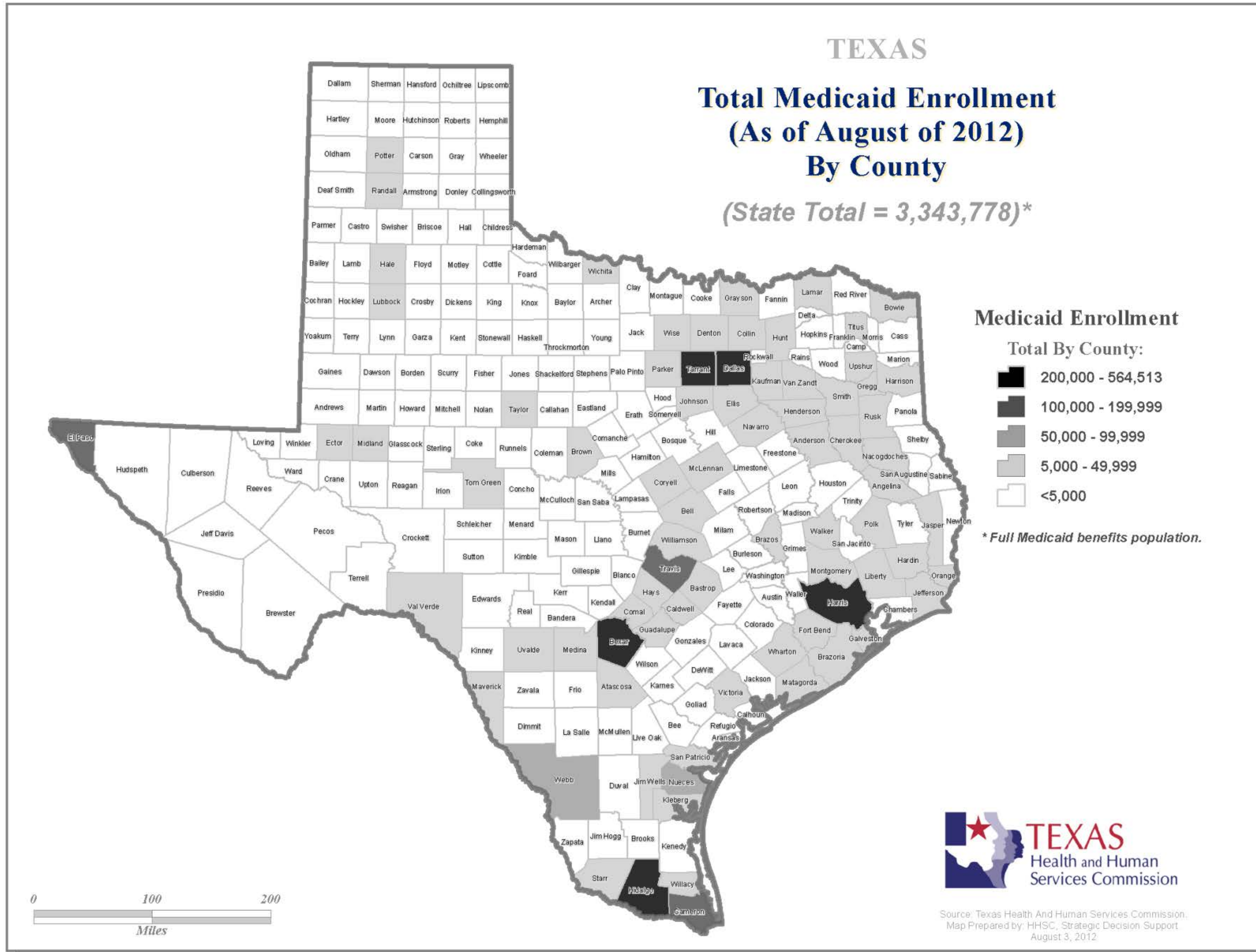

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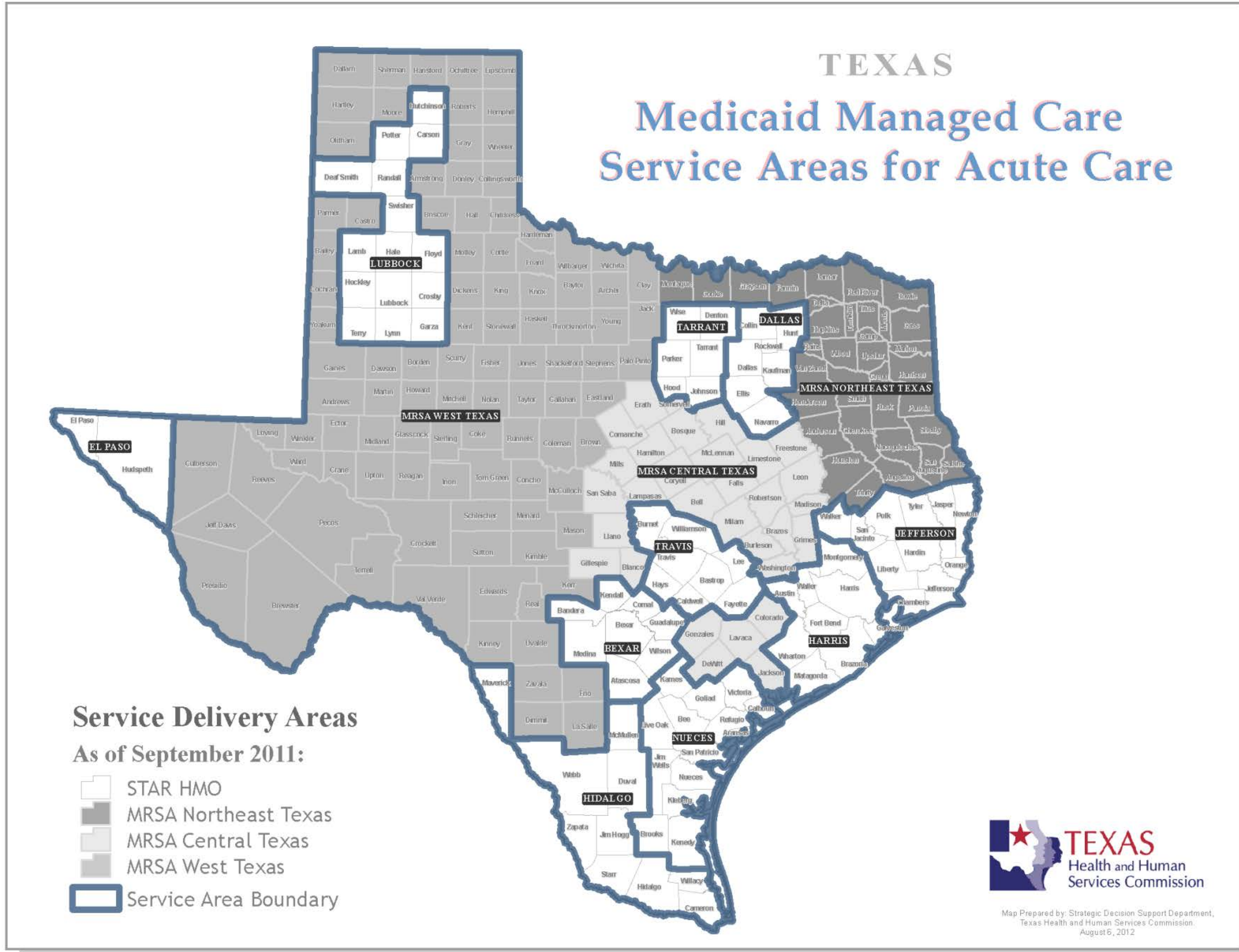

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004-2011)

Month	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adult [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Sep-03	2,620,443	1,808,608	1,878,430	320,555	239,065	142,927	380,548	109,002	130,165	622,407	675,488	286
Oct-03	2,654,029	1,839,750	1,909,638	320,769	239,531	143,993	381,289	109,723	132,201	635,325	690,935	263
Nov-03	2,654,567	1,844,764	1,916,921	321,433	242,965	138,139	367,143	107,011	131,743	644,450	701,428	255
Dec-03	2,669,872	1,867,162	1,939,362	318,198	241,633	136,044	359,490	106,549	134,300	657,017	716,355	286
Jan-04	2,681,913	1,874,043	1,947,285	320,114	242,934	135,282	350,285	109,257	135,505	662,720	725,533	283
Feb-04	2,668,982	1,861,531	1,937,281	319,887	245,722	131,131	339,887	110,436	135,260	661,535	724,849	275
Mar-04	2,688,094	1,876,009	1,952,563	320,287	247,002	131,597	332,075	112,911	137,514	671,443	734,977	288
Apr-04	2,686,233	1,874,870	1,952,628	320,301	247,927	128,684	324,349	114,154	137,473	674,470	738,578	297
May-04	2,696,408	1,881,146	1,960,716	320,292	250,766	128,435	319,931	115,424	138,155	678,770	744,290	345
Jun-04	2,707,277	1,890,218	1,970,342	320,866	251,805	127,608	315,470	116,497	138,516	683,903	752,329	283
Jul-04	2,720,062	1,899,679	1,979,898	321,528	252,805	128,359	314,290	117,433	140,033	688,316	757,040	258
Aug-04	2,750,846	1,924,647	2,006,413	322,349	255,348	129,590	314,730	118,671	141,426	697,575	770,916	241
Sep-04	2,763,253	1,936,705	2,019,135	322,655	256,791	128,324	315,970	118,499	141,839	701,711	777,185	279
Oct-04	2,772,944	1,945,213	2,027,465	322,583	258,918	128,270	313,564	117,654	143,382	705,406	782,861	306
Nov-04	2,779,721	1,952,210	2,035,143	322,689	261,649	127,018	311,729	115,933	143,848	708,897	787,736	222
Dec-04	2,772,183	1,951,922	2,035,151	319,181	261,665	124,599	308,971	114,532	145,061	709,943	787,947	284
Jan-05	2,788,010	1,958,376	2,043,521	323,809	264,989	124,180	305,858	116,423	145,435	714,537	792,546	233
Feb-05	2,770,900	1,945,288	2,031,949	323,525	266,252	119,705	299,002	115,898	143,966	712,778	789,542	232
Mar-05	2,773,386	1,946,959	2,034,568	323,689	267,038	118,170	292,081	117,252	144,809	717,297	792,772	278
Apr-05	2,774,845	1,948,807	2,037,152	323,828	268,241	115,505	283,927	118,183	144,553	722,293	798,034	281
May-05	2,776,318	1,949,404	2,039,258	323,710	269,907	113,238	278,321	119,820	145,028	725,867	800,188	239
Jun-05	2,782,940	1,953,233	2,043,963	324,547	271,052	112,884	274,025	120,987	146,490	728,238	804,480	237
Jul-05	2,785,919	1,953,941	2,045,194	324,926	272,974	112,216	272,370	121,617	147,881	728,585	805,105	245
Aug-05	2,812,057	1,975,810	2,068,570	325,340	275,083	112,137	272,472	123,436	149,632	736,322	817,384	251

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004-2011)

Month	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adult [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Sep-05	2,818,513	1,980,389	2,073,350	326,032	277,404	112,025	273,436	122,388	150,662	735,767	820,524	275
Oct-05	2,825,504	1,981,386	2,076,549	327,977	283,151	110,727	271,034	122,010	151,865	737,292	821,195	253
Nov-05	2,816,442	1,975,023	2,071,328	328,346	284,764	107,793	269,258	120,252	152,464	735,319	817,982	264
Dec-05	2,790,822	1,955,248	2,050,947	327,443	284,453	104,960	266,122	118,456	154,233	728,136	806,757	262
Jan-06	2,783,121	1,941,781	2,039,784	329,139	287,418	103,384	262,276	121,120	155,326	723,117	801,062	279
Feb-06	2,748,150	1,909,164	2,008,929	328,744	288,953	99,495	256,633	121,507	155,553	710,851	786,127	287
Mar-06	2,754,694	1,910,812	2,011,516	329,400	290,610	99,557	252,145	123,998	157,658	711,683	789,326	317
Apr-06	2,754,101	1,906,764	2,009,658	330,100	293,963	98,865	247,080	124,156	157,194	709,825	792,665	253
May-06	2,773,765	1,923,531	2,027,082	330,777	294,496	98,284	243,421	126,399	158,202	717,118	804,790	278
Jun-06	2,800,711	1,946,924	2,050,624	332,116	295,123	98,847	241,973	127,466	158,840	726,128	819,983	235
Jul-06	2,809,803	1,951,350	2,056,273	333,216	297,808	98,962	241,459	128,240	158,737	727,098	824,056	227
Aug-06	2,828,454	1,968,546	2,074,150	333,672	298,840	97,974	241,986	129,141	159,402	732,530	834,628	281
Sep-06	2,827,599	1,967,292	2,073,018	334,019	300,019	97,481	242,128	128,516	159,634	731,909	833,621	272
Oct-06	2,828,360	1,967,139	2,073,968	334,555	302,251	95,953	240,513	128,198	161,289	733,882	831,455	264
Nov-06	2,811,599	1,956,689	2,063,654	335,194	301,265	93,222	240,334	124,966	162,655	729,906	823,794	263
Dec-06	2,789,908	1,941,820	2,048,753	333,484	301,267	91,059	239,222	122,041	163,974	724,110	814,514	237
Jan-07	2,813,214	1,958,608	2,067,261	335,293	304,405	90,851	237,943	123,801	165,006	731,082	824,577	256
Feb-07	2,802,565	1,949,714	2,059,785	335,005	306,166	88,029	235,465	123,396	164,058	729,435	820,756	255
Mar-07	2,819,112	1,963,654	2,074,332	335,091	307,314	88,092	233,265	124,703	165,453	736,972	827,964	258
Apr-07	2,836,978	1,978,720	2,091,134	335,805	310,194	86,940	232,038	125,101	165,126	743,569	837,987	218
May-07	2,851,696	1,992,122	2,105,664	335,667	311,284	85,315	230,742	127,084	165,855	748,039	847,486	224
Jun-07	2,864,899	2,001,940	2,115,846	336,982	313,055	85,577	230,594	127,126	166,065	750,500	854,781	219
Jul-07	2,864,753	1,996,614	2,111,534	337,511	315,634	86,320	231,077	128,468	166,239	746,934	852,364	206
Aug-07	2,875,890	2,007,355	2,122,314	336,891	316,929	85,146	232,551	129,342	166,930	749,034	858,840	227

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004-2011)

Month	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adult [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Sep-07	2,878,261	2,008,177	2,123,662	337,048	319,401	85,126	234,440	128,296	165,817	747,113	860,807	213
Oct-07	2,889,625	2,017,494	2,133,501	338,780	319,687	85,401	233,352	128,039	166,816	750,852	866,474	224
Nov-07	2,880,182	2,012,856	2,129,011	338,981	319,790	83,303	234,456	125,036	166,374	748,050	863,976	216
Dec-07	2,864,352	2,001,543	2,118,322	336,980	321,398	82,241	234,253	122,003	166,627	742,641	858,022	187
Jan-08	2,875,754	2,005,676	2,123,602	339,008	323,703	82,603	234,995	124,584	167,388	743,838	859,455	180
Feb-08	2,865,735	1,995,113	2,114,922	338,774	325,799	80,872	234,960	124,986	166,447	739,941	853,765	191
Mar-08	2,866,257	1,993,546	2,114,505	338,261	328,329	80,758	234,162	125,209	167,417	740,514	851,453	154
Apr-08	2,867,767	1,994,688	2,116,859	337,976	329,493	79,800	233,231	125,640	167,432	741,469	852,556	170
May-08	2,869,624	1,996,532	2,118,182	338,027	329,640	79,415	232,399	125,836	168,892	742,157	853,084	174
Jun-08	2,882,625	2,005,236	2,128,331	338,707	332,333	79,643	232,501	126,569	170,340	744,374	858,021	137
Jul-08	2,888,457	2,007,452	2,131,147	339,866	333,314	79,761	233,479	127,928	173,070	742,901	858,002	136
Aug-08	2,897,792	2,014,838	2,138,577	340,464	334,384	79,896	234,822	128,068	174,889	742,701	862,426	142
Sep-08	2,904,900	2,019,845	2,144,186	341,029	336,726	80,107	236,659	127,019	175,775	740,217	867,194	174
Oct-08	2,900,052	2,014,171	2,138,912	341,682	337,913	79,289	234,899	126,805	177,641	736,490	865,141	192
Nov-08	2,905,056	2,021,097	2,146,217	341,398	339,570	78,722	235,234	124,102	177,946	736,766	871,151	167
Dec-08	2,920,992	2,038,324	2,163,273	340,089	340,764	78,446	236,711	123,219	180,025	740,761	880,827	150
Jan-09	2,954,837	2,065,047	2,190,843	342,080	343,220	79,123	237,488	125,181	181,033	749,788	896,738	186
Feb-09	2,979,664	2,085,899	2,213,421	342,416	346,410	79,096	237,860	125,675	180,177	757,510	910,352	168
Mar-09	3,016,350	2,116,731	2,244,857	343,232	348,432	81,355	238,677	126,467	181,657	768,617	927,780	133
Apr-09	3,031,422	2,128,526	2,257,832	343,507	350,888	81,095	236,839	127,239	182,247	772,554	936,886	167
May-09	3,052,398	2,145,671	2,275,377	343,653	352,360	82,658	238,764	127,887	183,371	777,065	946,471	169
Jun-09	3,099,677	2,186,336	2,316,984	345,425	354,245	84,545	238,859	128,985	184,763	791,471	971,243	141
Jul-09	3,124,224	2,206,974	2,337,885	345,829	355,153	85,335	240,350	130,787	186,478	797,557	982,589	146
Aug-09	3,162,986	2,240,260	2,371,634	346,928	357,986	87,001	243,600	130,649	186,728	807,462	1,002,470	162

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004-2011)

Month	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adult [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Sep-09	3,195,937	2,271,227	2,402,922	347,086	359,423	87,824	246,950	130,220	186,699	816,606	1,020,972	157
Oct-09	3,221,374	2,295,009	2,426,036	347,802	360,407	89,656	248,235	128,312	187,288	824,132	1,035,354	188
Nov-09	3,231,981	2,306,680	2,438,284	348,134	362,486	89,704	252,891	124,836	184,993	825,942	1,042,854	141
Dec-09	3,248,970	2,325,678	2,456,812	346,381	363,387	90,291	256,752	123,084	186,183	830,598	1,052,145	149
Jan-10	3,268,114	2,339,359	2,471,300	348,471	365,073	90,422	259,758	124,659	185,125	834,584	1,059,892	130
Feb-10	3,276,020	2,343,966	2,477,242	348,899	367,904	90,046	259,375	125,068	184,007	836,244	1,064,340	137
Mar-10	3,302,359	2,364,712	2,498,722	349,678	369,339	91,571	260,425	126,885	185,091	845,292	1,073,904	174
Apr-10	3,312,235	2,373,539	2,508,357	349,742	370,285	90,494	258,439	128,019	183,806	850,433	1,080,861	156
May-10	3,325,689	2,382,823	2,518,502	349,851	373,035	90,921	258,289	128,892	183,375	853,505	1,087,654	167
Jun-10	3,358,467	2,410,210	2,547,311	350,738	375,692	92,093	259,695	129,597	183,384	861,857	1,105,274	137
Jul-10	3,385,468	2,432,384	2,569,424	351,523	376,910	93,973	264,439	130,542	183,293	865,581	1,119,071	136
Aug-10	3,429,683	2,469,399	2,606,939	352,682	379,261	96,687	268,769	131,522	183,383	874,853	1,142,394	132
Sep-10	3,458,962	2,496,114	2,634,127	353,683	380,316	97,528	278,183	131,170	187,707	877,064	1,153,160	151
Oct-10	3,478,030	2,513,309	2,650,696	354,580	381,155	98,985	283,343	129,862	191,159	878,218	1,160,589	139
Nov-10	3,497,754	2,530,211	2,668,359	355,489	384,142	100,121	288,213	127,666	194,513	879,240	1,168,245	125
Dec-10	3,509,939	2,544,122	2,681,754	354,024	384,724	101,013	296,464	125,918	199,781	876,166	1,171,711	138
Jan-11	3,525,051	2,553,522	2,693,265	356,440	387,881	100,356	303,332	126,756	202,171	873,956	1,174,063	96
Feb-11	3,515,975	2,545,172	2,686,527	356,253	390,809	98,767	306,949	124,901	203,790	865,354	1,169,079	73
Mar-11	3,537,867	2,562,414	2,703,692	356,554	392,029	100,907	315,352	125,900	207,056	865,944	1,174,062	63
Apr-11	3,550,168	2,571,123	2,712,912	356,882	394,169	102,282	325,084	125,671	207,913	862,492	1,175,634	41
May-11	3,568,914	2,584,460	2,726,963	357,061	396,264	104,601	334,656	126,510	209,877	861,354	1,178,573	18
Jun-11	3,592,010	2,604,329	2,747,383	358,095	396,448	105,730	346,503	127,402	212,283	860,062	1,185,481	6
Jul-11	3,608,310	2,612,258	2,755,033	359,861	399,716	109,206	358,826	127,261	215,699	853,935	1,183,798	8
Aug-11	3,652,446	2,647,314	2,790,627	360,947	402,173	113,264	374,685	128,739	220,148	857,397	1,195,084	9

Appendix B: Medicaid Enrollees by Risk Group (SFYs 2004-2011)

[1] Total Enrollment in Children's Medicaid is the total number of children in the following categories: TANF Children, Foster Care Children, Newborns, Children Age 1-5 and Children Age 6-18. The children in these categories qualify for Medicaid based on their age and family income.

[2] Total Children Under Age 19 Enrolled in Medicaid is the total number of Medicaid clients under the age of 19. There are people under age 19 who qualify for Medicaid for reasons other than age and family income. For example, a 17-year-old who is pregnant may qualify for Medicaid for "Pregnant Women" or a 16-year-old boy who is blind may qualify for Medicaid for "Disabled & Blind."

[3] TANF Adults includes parents who qualify for Medicaid based on TANF income levels regardless of whether they receive Cash-Assistance.

[4] Foster Care Children are included in TANF Children.

[5] Medically Needy only contains individuals who qualify for Spend Down.

Data Source: HHSC Monthly Medicaid Eligibles File Extract and Texas Medicaid Historical (8-Month) Enrollment File.
Table Prepared By: HHSC, HHS System Forecasting.

Appendix C: Medicaid Enrollees by County by Risk Group (As of August 2012)

County	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adults [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Anderson	7,348	4,871	5,143	1,018	914	229	864	316	451	1,509	2,047	0
Andrews	1,911	1,357	1,405	214	153	64	222	123	172	401	562	0
Angelina	14,791	9,810	10,529	1,800	2,043	579	1,683	559	843	3,110	4,174	0
Aransas	3,206	2,084	2,182	435	412	128	353	147	178	605	948	0
Archer	498	303	321	83	71	18	51	23	15	96	141	0
Armstrong	131	72	65	39	14	2	11	4	9	16	36	0
Atascosa	8,286	5,657	5,903	1,028	945	374	1,135	282	441	1,499	2,582	0
Austin	3,175	2,324	2,430	334	318	105	323	94	205	688	1,108	0
Bailey	1,434	1,134	1,170	133	74	31	154	62	110	358	512	0
Bandera	1,885	1,261	1,306	219	245	91	278	69	106	324	553	0
Bastrop	10,086	7,280	7,598	994	1,136	410	1,444	266	517	2,193	3,126	0
Baylor	573	330	349	125	70	26	67	22	26	103	134	0
Bee	4,885	3,122	3,352	683	666	209	612	205	271	914	1,325	0
Bell	38,104	25,998	27,871	3,230	4,928	2,330	6,989	1,618	2,183	7,310	9,516	0
Bexar	271,950	190,331	202,652	27,212	34,966	9,302	32,543	10,139	15,513	58,119	84,156	0
Blanco	827	567	583	113	77	38	108	32	52	169	238	0
Borden	22	19	11	2	0	1	0	0	3	8	8	0
Bosque	2,293	1,554	1,609	314	242	106	296	77	104	458	696	0
Bowie	15,075	9,127	10,317	1,834	2,889	691	2,126	534	759	2,613	3,629	0
Brazoria	31,185	22,812	23,990	2,660	3,432	915	2,901	1,366	2,152	7,624	10,135	0
Brazos	19,881	14,466	15,411	1,572	2,351	787	2,547	705	1,377	4,813	5,729	0
Brewster	868	547	557	136	108	30	86	47	54	207	200	0
Briscoe	204	154	157	25	13	4	15	8	14	53	72	0
Brooks	2,353	1,404	1,506	447	324	93	252	85	123	404	625	0
Brown	5,833	3,645	3,774	952	758	254	933	224	294	998	1,420	0
Burleson	2,210	1,465	1,550	303	280	85	307	77	132	413	613	0
Burnet	4,687	3,407	3,507	463	408	214	614	195	283	1,013	1,497	0

Appendix C: Medicaid Enrollees by County by Risk Group (As of August 2012)

County	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adults [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Caldwell	5,994	4,180	4,355	777	560	278	1,005	199	336	1,148	1,691	0
Calhoun	3,216	2,330	2,449	344	336	90	322	116	199	744	1,065	0
Callahan	1,536	991	1,061	219	204	63	180	59	62	292	457	0
Cameron	111,696	80,833	85,526	13,805	10,622	3,293	13,283	3,143	5,559	23,046	38,945	0
Camp	2,579	1,836	1,952	239	344	77	289	83	131	550	866	0
Carson	356	239	238	60	24	11	66	22	25	76	72	0
Cass	4,791	2,869	3,092	791	751	198	582	182	234	829	1,224	0
Castro	1,470	1,173	1,201	129	81	36	183	51	107	382	501	0
Chambers	3,000	2,246	2,323	256	267	100	269	131	213	759	1,005	0
Cherokee	8,971	6,260	6,583	1,101	1,008	285	1,045	317	540	2,004	2,671	0
Childress	1,024	669	696	168	103	42	119	42	66	214	270	0
Clay	903	590	614	120	115	47	183	31	37	145	225	0
Cochran	624	429	443	79	61	27	57	28	41	131	200	0
Coke	304	173	184	69	40	10	27	12	15	52	79	0
Coleman	1,431	899	927	263	150	61	174	58	69	270	386	0
Collin	41,818	31,020	32,654	4,262	3,902	1,007	2,895	1,627	2,908	10,973	14,244	0
Collingsworth	550	382	402	80	47	14	47	27	39	131	165	0
Colorado	2,912	2,003	2,089	412	323	87	281	87	180	665	877	0
Comal	8,938	6,444	6,759	894	917	252	1,162	431	588	2,018	2,676	0
Comanche	1,964	1,317	1,348	316	205	51	232	75	133	408	544	0
Concho	328	217	226	52	40	9	53	10	18	72	74	0
Cooke	4,522	3,304	3,422	468	425	129	368	196	302	1,154	1,480	0
Coryell	6,096	4,135	4,425	526	836	322	941	277	377	1,204	1,613	0
Cottle	270	146	155	71	29	10	29	14	15	39	63	0
Crane	392	225	245	80	55	12	29	20	24	80	92	0
Crockett	481	343	348	72	29	16	51	21	35	102	155	0
Crosby	1,184	850	890	136	108	49	155	41	60	264	371	0

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Culberson	463	306	303	86	41	12	41	18	22	89	154	0
Dallam	1,054	811	835	85	71	34	130	53	98	270	313	0
Dallas	385,308	296,573	310,768	28,054	41,130	7,686	23,273	11,862	24,264	106,785	142,251	3
Dawson	2,278	1,608	1,663	301	229	57	248	83	116	499	745	0
Deaf Smith	3,875	3,006	3,077	373	225	107	455	164	254	1,043	1,254	0
Delta	776	444	481	152	133	14	87	33	42	130	185	0
Denton	40,427	30,467	31,989	3,402	3,796	882	2,767	1,880	3,290	11,150	13,260	0
DeWitt	2,948	1,870	1,971	474	364	123	359	117	162	554	795	0
Dickens	298	194	205	47	27	13	27	17	19	49	99	0
Dimmit	2,828	1,784	1,869	552	292	90	301	110	124	485	874	0
Donley	416	265	265	80	43	18	68	10	18	69	110	0
Duval	2,715	1,637	1,704	572	327	76	204	103	142	514	777	0
Eastland	2,838	1,805	1,881	487	362	89	316	95	157	564	768	0
Ector	22,536	15,933	16,592	2,338	2,289	783	2,782	1,193	1,699	5,079	6,373	0
Edwards	300	193	199	57	27	9	36	14	19	60	78	0
Ellis	17,178	12,696	13,322	1,454	1,878	479	1,759	671	982	4,030	5,925	0
El Paso	161,290	117,525	121,630	19,724	12,918	5,552	19,250	5,571	8,317	33,500	56,458	0
Ellis	17,178	12,696	13,322	1,454	1,878	479	1,759	671	982	4,030	5,925	0
Erath	4,159	3,069	3,137	447	347	97	327	199	307	1,085	1,350	0
Falls	2,913	1,759	1,892	452	470	141	483	91	126	477	673	0
Fannin	4,190	2,715	2,875	591	586	160	510	138	210	837	1,158	0
Fayette	2,399	1,541	1,613	435	258	83	262	82	151	498	630	0
Fisher	383	235	244	54	56	24	70	14	18	66	81	0
Floyd	1,102	826	859	117	85	33	133	41	62	258	373	0
Foard	187	103	110	41	29	3	22	11	11	18	52	0
Fort Bend	43,138	31,303	33,228	4,621	4,585	1,199	4,535	1,430	2,540	9,662	14,566	0
Franklin	1,355	923	984	165	164	41	126	62	85	316	396	0

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Freestone	2,266	1,528	1,599	292	236	119	330	91	150	459	589	0
Frio	3,808	2,624	2,734	551	368	109	444	156	215	776	1,189	0
Gaines	2,444	1,873	1,905	257	125	51	211	138	211	723	728	0
Galveston	32,330	22,602	23,871	3,132	4,240	1,009	3,236	1,347	2,036	7,227	10,103	0
Garza	690	481	508	85	73	15	56	36	49	184	192	0
Gillespie	2,195	1,551	1,607	331	177	38	154	98	155	544	698	0
Glasscock	70	62	63	2	3	1	2	2	7	28	25	0
Goliad	910	619	665	117	117	31	112	26	42	185	280	0
Gonzales	3,760	2,749	2,864	409	335	135	470	132	207	897	1,175	0
Gray	2,992	2,086	2,171	341	285	121	417	159	227	680	762	0
Grayson	15,522	10,492	11,223	1,916	2,042	418	857	654	1,033	3,703	4,899	0
Gregg	19,908	13,089	14,131	2,235	3,188	628	2,115	768	1,333	4,404	5,237	0
Grimes	3,603	2,446	2,534	440	433	183	517	101	192	688	1,049	0
Guadalupe	13,122	9,655	10,160	1,237	1,310	375	1,660	545	781	2,982	4,232	0
Hale	6,530	4,828	5,000	676	528	217	849	281	390	1,623	1,966	0
Hall	620	424	441	100	56	18	59	22	30	123	212	0
Hamilton	1,100	628	639	282	105	49	115	36	49	177	287	0
Hansford	593	473	484	62	34	9	33	15	40	167	233	0
Hardeman	589	395	408	80	71	24	85	19	31	126	153	0
Hardin	6,279	4,059	4,312	749	917	258	737	296	375	1,258	1,689	0
Harris	624,419	479,271	503,067	46,973	64,141	13,828	47,367	20,205	41,398	167,704	222,802	1
Harrison	10,049	6,745	7,224	1,080	1,481	367	1,148	376	550	2,206	2,841	0
Hartley	280	187	193	64	15	3	31	11	15	68	73	0
Haskell	839	486	518	167	117	34	106	35	33	115	232	0
Hays	13,981	10,360	10,739	1,183	1,138	743	2,299	557	854	3,079	4,128	0
Hemphill	333	253	261	35	16	9	31	20	38	108	76	0
Henderson	12,498	8,228	8,640	1,455	1,696	642	1,718	477	652	2,260	3,598	0

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Hidalgo	227,030	169,075	178,420	25,857	19,285	6,722	25,249	6,091	11,886	51,003	80,937	0
Hill	5,467	3,721	3,898	640	604	309	840	193	270	1,081	1,530	0
Hockley	3,627	2,679	2,764	344	323	136	538	145	230	799	1,112	0
Hood	5,050	3,647	3,782	473	469	214	554	247	341	1,157	1,595	0
Hopkins	5,183	3,427	3,602	847	578	140	528	191	313	1,130	1,456	0
Houston	3,726	2,185	2,347	684	609	141	438	107	165	626	956	0
Howard	4,982	3,404	3,549	613	594	173	576	198	305	1,000	1,523	0
Hudspeth	706	505	520	104	50	22	94	25	39	129	243	0
Hunt	11,692	7,900	8,367	1,339	1,634	383	1,257	436	658	2,453	3,532	0
Hutchinson	2,603	1,899	1,976	219	272	92	381	121	154	569	795	0
Irion	130	92	93	20	8	5	22	5	7	18	45	0
Jack	796	542	572	107	86	21	92	40	57	163	230	0
Jackson	2,048	1,445	1,496	270	185	69	274	79	100	465	606	0
Jasper	6,127	3,913	4,199	799	895	296	821	224	337	1,185	1,570	0
Jeff Davis	165	123	126	21	13	3	14	5	11	39	59	0
Jefferson	41,752	27,404	29,556	4,686	6,303	1,830	5,396	1,529	2,318	8,475	11,215	0
Jim Hogg	1,348	856	927	236	156	39	122	61	77	276	381	0
Jim Wells	9,103	5,702	6,072	1,662	1,112	302	890	325	497	1,767	2,548	0
Johnson	17,833	13,129	13,669	1,523	1,874	520	1,354	787	1,171	4,274	6,330	0
Jones	2,091	1,366	1,427	337	232	79	265	77	101	395	605	0
Karnes	2,265	1,373	1,452	464	266	88	218	74	119	399	637	0
Kaufman	12,724	9,523	9,944	958	1,362	412	1,376	469	739	2,934	4,474	0
Kendall	2,343	1,657	1,714	341	175	62	333	108	149	511	664	0
Kenedy	58	46	46	7	4	1	4	0	1	18	23	0
Kent	113	58	61	35	11	6	20	3	2	17	19	0
Kerr	5,606	3,933	4,137	630	616	157	744	270	307	1,266	1,616	0
Kimble	576	388	408	86	69	15	62	18	40	121	165	0

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King	7	5	5	1	0	0	0	1	2	3	0	0
Kinney	475	334	330	81	30	12	45	18	20	107	162	0
Kleberg	5,774	3,732	3,942	835	684	250	741	273	350	1,119	1,522	0
Knox	646	402	418	117	84	20	70	23	32	144	156	0
Lamar	1,368	881	927	233	162	33	115	59	66	281	419	0
Lamb	8,948	5,433	5,825	1,451	1,318	435	1,253	311	452	1,569	2,159	0
Lampasas	2,647	1,875	1,937	369	207	84	299	112	166	585	825	0
La Salle	2,471	1,694	1,750	290	252	122	442	113	131	430	691	0
Lavaca	2,367	1,416	1,506	522	285	69	215	75	120	504	577	0
Lee	1,877	1,278	1,314	307	165	70	296	57	105	372	505	0
Leon	2,098	1,442	1,509	256	228	86	278	86	135	451	578	0
Liberty	12,201	8,470	8,851	1,044	1,645	567	1,449	475	721	2,562	3,738	0
Limestone	3,662	2,418	2,570	490	476	152	494	126	194	775	955	0
Lipscomb	266	208	220	28	23	2	24	5	21	74	89	0
Live Oak	1,204	776	819	203	122	50	131	53	73	238	334	0
Llano	1,941	1,238	1,296	280	227	100	274	96	103	351	510	0
Loving	5	3	1	0	2	0	1	0	0	1	1	0
Lubbock	39,422	28,064	29,509	3,668	4,321	1,701	5,935	1,668	2,268	8,632	11,229	0
Lynn	888	657	664	83	76	30	94	42	43	203	317	0
Madison	1,961	1,354	1,416	253	207	82	263	65	106	393	592	0
Marion	1,593	905	953	309	261	70	190	48	56	276	383	0
Martin	642	475	497	62	55	11	56	39	53	163	203	0
Mason	344	244	252	49	33	3	40	15	19	58	127	0
Matagorda	6,693	4,808	5,025	655	726	241	620	263	391	1,506	2,291	0
Maverick	15,665	10,362	10,869	3,052	1,410	356	1,066	485	768	3,152	5,376	0
McCulloch	1,436	935	976	238	162	41	200	60	79	254	402	0
McLennan	37,208	25,147	26,935	4,006	4,942	1,811	5,553	1,302	1,994	7,341	10,259	0

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McMullen	52	30	31	12	7	1	2	2	8	7	13	0
Medina	6,237	4,214	4,353	907	665	243	957	208	299	1,121	1,837	0
Menard	305	191	193	70	30	4	23	10	12	51	105	0
Midland	15,275	10,930	11,447	1,582	1,455	396	1,664	912	1,304	3,607	4,355	0
Milam	4,242	2,835	2,957	552	494	230	725	131	207	722	1,181	0
Mills	656	449	460	115	57	17	167	18	25	106	151	0
Mitchell	1,105	729	752	168	123	35	133	50	54	185	357	0
Montague	2,496	1,642	1,710	380	292	85	290	97	154	498	700	0
Montgomery	43,243	32,135	33,686	3,216	4,770	1,333	3,982	1,789	3,021	10,778	14,354	0
Moore	3,364	2,698	2,775	201	183	126	409	156	292	896	1,101	0
Morris	2,346	1,457	1,553	378	354	85	279	72	100	457	621	0
Motley	125	78	82	24	16	6	20	1	6	27	25	0
Nacogdoches	10,193	6,981	7,497	1,096	1,481	301	1,144	334	517	2,432	2,888	0
Navarro	8,889	6,247	6,540	1,074	1,016	248	1,026	304	481	2,025	2,715	0
Newton	2,362	1,427	1,539	350	357	142	338	86	118	332	639	0
Nolan	2,659	1,707	1,813	434	317	100	326	101	120	513	748	0
Nueces	58,442	38,553	41,671	6,719	8,520	2,393	6,981	2,253	3,049	11,249	17,274	4
Ochiltree	1,159	933	970	80	79	24	82	43	106	334	411	0
Oldham	214	179	180	14	13	3	22	5	3	34	120	0
Orange	11,947	7,744	8,269	1,101	1,857	715	1,913	530	622	2,154	3,055	0
Palo Pinto	3,974	2,659	2,786	422	519	179	462	195	247	894	1,056	0
Panola	3,062	1,964	2,073	443	394	136	349	125	169	572	874	0
Parker	10,025	7,365	7,690	786	951	405	1,095	518	692	2,250	3,328	0
Parmer	1,383	1,043	1,074	164	77	34	129	65	102	378	434	0
Pecos	2,092	1,409	1,440	367	144	80	247	92	145	458	559	0
Polk	7,400	4,587	4,948	998	1,178	391	1,081	246	340	1,309	1,857	0
Potter	24,951	18,342	18,972	2,120	2,167	1,265	3,761	1,057	1,469	5,643	7,469	0

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Presidio	1,932	1,099	1,119	637	118	33	173	45	91	309	526	0
Rains	1,403	958	992	172	163	59	190	51	69	262	437	0
Randall	8,549	6,105	6,416	608	939	402	1,454	495	645	1,802	2,204	0
Reagan	319	233	240	43	22	9	30	12	23	77	103	0
Real	548	345	351	103	62	18	74	20	14	107	150	0
Red River	2,100	1,180	1,244	506	286	60	187	68	94	351	548	0
Reeves	2,501	1,588	1,635	456	251	123	336	83	144	429	679	0
Refugio	1,037	640	662	199	119	39	118	40	53	177	292	0
Roberts	43	30	31	3	4	4	9	2	2	7	12	0
Robertson	2,945	1,898	2,029	382	425	148	422	92	129	575	772	0
Rockwall	5,231	3,888	4,096	517	485	133	475	208	347	1,217	1,849	0
Runnels	1,534	943	999	292	192	46	163	61	84	276	420	0
Rusk	6,830	4,605	4,851	887	853	212	816	273	414	1,529	1,846	0
Sabine	1,583	943	990	242	286	58	190	54	66	247	440	0
San Augustine	1,701	968	1,051	348	281	61	230	43	60	268	410	0
San Jacinto	3,967	2,693	2,806	377	529	246	623	122	148	715	1,207	0
San Patricio	11,609	7,799	8,288	1,426	1,481	432	1,244	471	639	2,282	3,634	0
San Saba	774	529	544	112	73	21	96	39	50	151	232	0
Schleicher	322	223	225	57	26	5	28	11	19	58	118	0
Scurry	2,119	1,436	1,522	285	216	76	264	106	150	464	558	0
Shackelford	311	217	225	34	36	9	33	15	21	58	105	0
Shelby	4,824	3,202	3,409	613	695	163	612	151	219	1,094	1,277	0
Sherman	250	201	207	21	15	1	16	12	22	57	106	0
Smith	28,584	20,094	21,378	3,195	3,595	683	2,801	1,017	1,830	6,765	8,698	0
Somervell	894	623	641	128	78	37	83	28	41	192	307	0
Starr	22,776	15,914	16,503	3,950	1,768	538	2,046	606	1,147	4,539	8,182	0
Stephens	1,439	993	1,034	185	149	44	158	68	84	286	465	0

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Sterling	102	59	60	32	10	1	5	0	5	23	26	0
Stonewall	157	94	96	35	15	9	23	4	5	23	43	0
Sutton	427	320	318	55	30	9	56	13	34	89	141	0
Swisher	1,240	919	945	130	71	54	200	66	76	256	387	0
Tarrant	219,151	165,382	173,670	17,127	22,933	5,240	14,271	8,469	15,019	58,407	77,685	0
Taylor	18,890	12,623	13,478	2,238	2,461	726	2,406	841	1,141	3,871	5,205	1
Terrell	85	42	44	25	12	3	9	3	4	13	16	0
Terry	2,376	1,687	1,731	335	181	84	296	89	147	525	719	0
Throckmorton	152	98	100	33	13	5	11	3	5	27	55	0
Titus	6,014	4,664	4,876	551	502	118	409	179	368	1,798	2,089	0
Tom Green	14,573	9,752	10,281	1,898	1,734	487	1,627	702	851	3,229	4,045	0
Travis	118,347	88,050	91,526	8,513	11,700	6,515	20,527	3,569	7,097	27,840	32,586	0
Trinity	2,358	1,439	1,427	316	432	110	312	61	120	402	605	0
Tyler	2,832	1,811	1,921	374	452	109	377	86	152	530	752	0
Upshur	5,830	3,889	4,127	687	783	238	783	233	312	1,108	1,686	0
Upton	389	254	263	65	43	13	50	14	23	68	113	0
Uvalde	5,946	4,077	4,273	846	595	236	685	192	305	1,191	1,896	0
Val Verde	10,450	7,074	7,382	1,871	872	288	947	345	530	2,164	3,433	0
Van Zandt	6,636	4,458	4,650	896	783	285	909	214	321	1,279	1,949	0
Victoria	14,077	9,621	10,336	1,623	1,786	402	1,317	645	851	3,220	4,233	0
Walker	6,214	4,246	4,529	584	861	248	713	275	398	1,366	1,769	0
Waller	5,753	4,420	4,589	435	531	166	544	201	393	1,501	1,982	0
Ward	1,504	941	984	226	199	59	171	79	94	281	395	0
Washington	3,917	2,497	2,697	593	562	144	477	121	263	786	971	0
Webb	68,678	52,112	55,398	6,618	6,317	1,511	6,655	2,120	3,996	16,167	25,294	0
Wharton	6,619	4,819	5,021	755	697	132	500	216	372	1,602	2,345	0
Wheeler	574	414	427	77	45	7	57	31	39	156	162	0

Appendix C: Medicaid Enrollees by County by Risk Group (As of August 2012)

County	Total Enrollment	Total Enrollment in Children's Medicaid [1]	Total Children under Age 19 Enrolled in Medicaid [2]	Aged & Medicare Related	Disabled & Blind	TANF Adults [3]	TANF Children [4]	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy [5]
Wichita	18,029	11,434	12,481	2,196	2,835	767	2,227	797	1,104	3,557	4,546	0
Wilbarger	2,369	1,583	1,676	314	282	87	266	103	123	489	705	0
Willacy	5,996	3,993	4,190	1,007	587	236	727	173	254	1,103	1,909	0
Williamson	30,603	22,703	23,772	2,366	2,557	1,762	5,276	1,215	1,934	6,731	8,762	0
Wilson	4,732	3,079	3,262	698	586	199	668	170	249	788	1,374	0
Winkler	1,016	652	691	141	133	38	125	52	76	186	265	0
Wise	5,715	4,268	4,412	509	518	148	455	272	426	1,494	1,893	0
Wood	4,918	3,156	3,309	769	670	144	535	179	252	951	1,418	0
Yoakum	1,006	746	766	116	75	28	111	41	72	267	296	0
Young	2,665	1,744	1,829	343	364	113	353	101	146	563	682	0
Zapata	3,745	2,844	2,924	448	253	73	377	127	246	948	1,273	0
Zavala	3,704	2,429	2,546	554	437	155	465	129	153	672	1,139	0
Unknown	11,246	1,509	5,719	1,244	8,307	112	1,008	74	35	235	231	0
TEXAS	3,652,446	2,647,314	2,790,627	360,947	402,173	113,264	374,685	128,739	220,148	857,397	1,195,084	9

[1] Total Enrollment in Children's Medicaid is the total number of children in the following categories: TANF Children, Foster Care Children, Newborns, Children Age 1-5 and Children Age 6-18. The children in these categories qualify for Medicaid based on their age and family income.

[2] Total Children Under Age 19 Enrolled in Medicaid is the total number of Medicaid clients under the age of 19. There are people under age 19 who qualify for Medicaid for reasons other than age and family income. For example, a 17-year-old who is pregnant may qualify for Medicaid for "Pregnant Women" or a 16-year-old boy who is blind may qualify for Medicaid for "Disabled & Blind."

[3] TANF Adults include parents who qualify for Medicaid Based on TANF income levels regardless of whether they receive Cash-Assistance.

[4]Foster Care Children are included in TANF Children.

[5] Medically Needy only contains individuals who qualify for Spend Down.

Note: Beginning with the benefit month of April 2007, geocoding is used to determine the county of residence of Medicaid enrollees. In this process, Geographic Information Systems (GIS) technology is used to translate address data into geographic coordinates (latitude and longitude) which also provides county of residence data. Enrollees without a final county of residence designation are accounted for in the category of 'Unknown,' under the county of residence column. Compared to the period before April 2007, the number of enrollees without a final county of residence designation has increased due to the stricter address verification standards associated with GIS technology.

Data Source: HHSC Monthly Medicaid Eligibles File Extract and Texas Medicaid Historical (8-Month) Enrollment File.
Table Prepared By: HHSC, Financial Services, HHS System Forecasting.

Appendix D. Medicaid and CHIP Service Areas

Medicaid Managed Care Service Areas by County[i]

Service Area	Counties
Bexar	Bexar
	Atascosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall
El Paso	El Paso
Harris	Harris
Harris Expansion	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller

Service Area	Counties
Lubbock	Lubbock
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry
Nueces	Nueces
	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Refugio
	San Patricio
	Victoria
Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise
Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Williamson

[i] Medicaid Managed Care Service Areas as of SFY 2011

Appendix D. Medicaid and CHIP Service Areas

Medicaid Primary Care Case Management (PCCM) Counties[i]

Anderson	Duval	Kimble	Reeves
Andrews	Eastland	King	Roberts
Angelina	Ector	Kinney	Robertson
Archer	Edwards	Knox	Runnels
Armstrong	Erath	La Salle	Rusk
Austin	Falls	Lamar	Sabine
Bailey	Fannin	Lampasas	San Augustine
Bandera	Fayette	Lavaca	San Jacinto
Baylor	Fisher	Leon	San Saba
Bell	Foard	Liberty	Schleicher
Blanco	Franklin	Limestone	Scurry
Borden	Freestone	Lipscomb	Shackelford
Bosque	Frio	Live Oak	Shelby
Bowie	Gaines	Llano	Sherman
Brazos	Gillespie	Loving	Smith
Brewster	Glasscock	Madison	Somervell
Briscoe	Goliad	Marion	Starr
Brooks	Gonzales	Martin	Stephens
Brown	Gray	Mason	Sterling
Burleson	Grayson	Matagorda	Stonewall
Callahan	Gregg	Maverick	Sutton
Cameron	Grimes	McCulloch	Swisher
Camp	Hall	McLennan	Taylor
Carson	Hamilton	McMullen	Terrell
Cass	Hansford	Menard	Throckmorton
Castro	Hardeman	Midland	Titus
Chambers	Hardin	Milam	Tom Green
Cherokee	Harrison	Mills	Trinity
Childress	Hartley	Mitchell	Tyler
Clay	Haskell	Montague	Upshur
Cochran	Hemphill	Moore	Upton
Coke	Henderson	Morris	Uvalde
Coleman	Hidalgo	Motley	Val Verde
Collingsworth	Hill	Nacogdoches	Van Zandt
Colorado	Hopkins	Newton	Walker
Comanche	Houston	Nolan	Ward
Concho	Howard	Ochiltree	Washington
Cooke	Hudspeth	Oldham	Webb
Coryell	Hutchinson	Orange	Wharton
Cottle	Irion	Palo Pinto	Wheeler
Crane	Jack	Panola	Wichita
Crockett	Jackson	Parmer	Wilbarger
Culberson	Jasper	Pecos	Willacy
Dallam	Jeff Davis	Polk	Winkler
Dawson	Jefferson	Potter	Wood
De Witt	Jim Hogg	Presidio	Yoakum
Deaf Smith	Jones	Rains	Young
Delta	Karnes	Randall	Zapata
Dickens	Kenedy	Reagan	Zavala
Dimmit	Kent	Real	
Donley	Kerr	Red River	

[i]Effective September 1, 2011 Medicaid PCCM clients in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR or STAR+PLUS Medicaid managed care program. In March 2012, HHSC eliminated PCCM."

Appendix D. Medicaid and CHIP Service Areas

CHIP Service Areas by County[i]

Service Area	Counties
Bexar	Bexar
	Atascosa
	Bandera
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall
El Paso	El Paso
	Hudspeth
Harris	Harris
	Austin
	Brazoria
	Fort Bend
	Galveston
	Matagorda
	Montgomery
	Waller
	Wharton
Jefferson	Jefferson
	Chambers
	Hardin
	Jasper
	Liberty
	Newton
	Orange
	Polk
	San Jacinto
	Tyler
	Walker
Lubbock	Lubbock
	Crosby
	Carson
	Deaf Smith
	Floyd

Service Area	Counties
Lubbock (continued)	Garza
	Hale
	Hockley
	Hutchinson
	Lamb
	Lynn
	Potter
	Randall
	Swisher
	Terry
Nueces	Nueces
	Aransas
	Bee
	Brooks
	Calhoun
	Goliad
	Jim Wells
	Karnes
	Kenedy
	Kleberg
	Live Oak
	Refugio
	San Patricio
	Victoria
Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise
Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Fayette
	Hays
	Lee
	Williamson

[i] SFY 2012 CHIP Service Areas

Appendix D. Medicaid and CHIP Service Areas

Note: All counties not included in one of the service areas above are served by the Rural Service Area (RSA)

CHIP Rural Service Area (RSA) Counties

Anderson	Foard	McLennan	Uvalde
Andrews	Franklin	McMullen	Val Verde
Angelina	Freestone	Menard	Van Zandt
Archer	Frio	Midland	Ward
Armstrong	Gaines	Milam	Washington
Bailey	Gillespie	Mills	Webb
Baylor	Glasscock	Mitchell	Wheeler
Bell	Gonzales	Montague	Wichita
Blanco	Gray	Moore	Wilbarger
Borden	Grayson	Morris	Willacy
Bosque	Gregg	Motley	Winkler
Bowie	Grimes	Nacogdoches	Wood
Brazos	Hall	Nolan	Yoakum
Brewster	Hamilton	Ochiltree	Young
Briscoe	Hansford	Oldham	Zapata
Brown	Hardeman	Palo Pinto	Zavala
Burleson	Harrison	Panola	
Callahan	Hartley	Parmer	
Cameron	Haskell	Pecos	
Camp	Hemphill	Presidio	
Cass	Henderson	Rains	
Castro	Hidalgo	Reagan	
Cherokee	Hill	Real	
Childress	Hopkins	Red River	
Clay	Houston	Reeves	
Cochran	Howard	Roberts	
Coke	Irion	Robertson	
Coleman	Jack	Runnels	
Collingsworth	Jackson	Rusk	
Colorado	Jeff Davis	Sabine	
Comanche	Jim Hogg	San Augustine	
Concho	Jones	San Saba	
Cooke	Kent	Schleicher	
Coryell	Kerr	Scurry	
Cottle	Kimble	Shackelford	
Crane	King	Shelby	
Crockett	Kinney	Sherman	
Culberson	Knox	Smith	
Dallam	La Salle	Somervell	
Dawson	Lamar	Starr	
Delta	Lampasas	Stephens	
DeWitt	Lavaca	Sterling	
Dickens	Leon	Stonewall	
Dimmit	Limestone	Sutton	
Donley	Lipscomb	Taylor	
Duval	Llano	Terrell	
Eastland	Loving	Throckmorton	
Ector	Madison	Titus	
Edwards	Marion	Tom Green	
Erath	Martin	Trinity	
Falls	Mason	Upshur	
Fannin	Maverick	Upton	
Fisher	McCulloch		

Appendix E: Medicaid Expenditure History (FFYs 1987-2011)

(Shown in Dollars)

Federal Fiscal Year		Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2011	FED	14,093,145,087	956,328,092	1,829,711,562	0	20,859,639	757,489,799	23,918,822	17,681,453,001
2011	FEDARRA	1,395,373,748	0	231,747,606	0	0	0	0	1,627,121,354
2011	NONFED	7,740,645,123	622,813,407	977,218,223	277,468,044	7,982,215	490,315,493	7,912,940	10,124,355,445
2011	TOTAL	23,229,163,958	1,579,141,499	3,038,677,391	277,468,044	28,841,854	1,247,805,292	31,831,762	29,432,929,800
2010	FED	12,670,015,218	991,515,974	1,849,499,135	0	0	586,821,439	23,347,881	16,121,199,647
2010	FEDARRA	2,599,216,338	0	366,322,520	0	0	0	0	2,965,538,858
2010	NONFED	6,231,480,571	696,673,993	925,963,561	188,351,774	0	513,545,911	7,782,627	8,563,798,437
2010	TOTAL	21,500,712,127	1,688,189,967	3,141,785,216	188,351,774	0	1,100,367,350	31,130,508	27,650,536,942
2009	FED	11,459,866,620	1,039,079,294	1,201,856,755	0	0	636,883,348	23,165,283	14,360,851,300
2009	FEDARRA	1,859,683,982	0	150,021,060	0	0	0	0	2,009,705,042
2009	NONFED	5,921,806,283	706,583,565	661,117,426	327,634,996	0	561,446,142	7,721,761	8,186,310,173
2009	TOTAL	19,241,356,885	1,745,662,859	2,012,995,241	327,634,996	0	1,198,329,490	30,887,044	24,556,866,515
2008	FED	10,832,854,989	883,680,199	1,088,847,704	0	0	481,722,418	21,356,073	13,308,461,383
2008	NONFED	7,008,251,340	575,131,872	708,409,954	302,556,548	0	399,086,620	7,301,053	9,000,737,387
2008	TOTAL	17,841,106,329	1,458,812,071	1,797,257,658	302,556,548	0	880,809,038	28,657,126	22,309,198,770

Appendix E: Medicaid Expenditure History (FFYs 1987-2011)

Federal Fiscal Year		Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2007	FED	9,861,133,978	873,937,391	1,617,227,545	0	0	440,210,762	20,346,453	12,812,856,129
2007	NONFED	6,315,914,704	564,307,501	1,046,299,576	291,277,489	0	338,701,922	7,076,041	8,563,577,233
2007	TOTAL	16,177,048,682	1,438,244,892	2,663,527,121	291,277,489	0	778,912,684	27,422,494	21,376,433,362
2006	FED	9,503,544,739	936,191,170	321,502,444	0	0	410,949,395	20,456,568	11,192,644,316
2006	NONFED	6,116,652,611	606,659,285	205,233,344	159,219,288	0	316,076,674	6,969,341	7,410,810,543
2006	TOTAL	15,620,197,350	1,542,850,455	526,735,788	159,219,288	0	727,026,069	27,425,909	18,603,454,859
2005	FED	9,077,320,590	908,414,221	549,604,508		0	373,116,681	19,451,903	10,927,907,903
2005	NONFED	5,794,731,073	585,700,666	348,295,072		0	289,344,299	6,660,594	7,024,731,704
2005	TOTAL	14,872,051,663	1,494,114,887	897,899,580		0	662,460,980	26,112,497	17,952,639,607
2004	FED	8,678,745,398	869,223,358	483,303,343		(26)	389,375,329	23,084,967	10,443,732,369
2004	NONFED	5,179,267,104	574,611,677	292,544,114		(10)	305,782,584	8,345,784	6,360,551,253
2004	TOTAL	13,858,012,502	1,443,835,035	775,847,457		(36)	695,157,913	31,430,751	16,804,283,622
2003	FED	8,523,884,893	791,785,561	174,384,387		325,866	441,560,500	22,609,728	9,954,550,935
2003	NONFED	5,287,505,815	527,669,309	114,796,731		126,523	308,399,611	8,273,342	6,246,771,331
2003	TOTAL	13,811,390,708	1,319,454,870	289,181,118		452,389	749,960,111	30,883,070	16,201,322,266
2002	FED	7,200,650,505	856,845,057	101,119,555		5,293,898	385,752,228	23,561,365	8,573,222,608
2002	NONFED	4,731,656,102	566,278,053	66,936,877		2,046,304	321,007,611	8,461,063	5,696,386,010

Appendix E: Medicaid Expenditure History (FFYs 1987-2011)

Federal	Fiscal Year	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2002	TOTAL	11,932,306,607	1,423,123,110	168,056,432		7,340,202	706,759,839	32,022,428	14,269,608,618
2001	FED	6,218,950,847	816,205,002			15,175,971	356,949,745	26,815,050	7,434,096,615
2001	NONFED	4,018,594,759	529,928,950			5,784,084	299,645,937	9,642,811	4,863,596,541
2001	TOTAL	10,237,545,606	1,346,133,952			20,960,055	656,595,682	36,457,861	12,297,693,156
2000	FED	5,734,705,707	792,892,647			24,782,216	337,690,078	20,926,868	6,910,997,516
2000	NONFED	3,584,437,280	497,767,952			9,186,259	281,361,079	7,385,719	4,380,138,289
2000	TOTAL	9,319,142,987	1,290,660,599			33,968,475	619,051,157	28,312,587	11,291,135,805
1999	FED	5,502,666,857	978,836,976			34,672,162	381,132,417	20,266,100	6,917,574,512
1999	NONFED	3,280,898,782	588,918,615			12,360,559	286,083,947	9,205,869	4,177,467,772
1999	TOTAL	8,783,565,639	1,567,755,591			47,032,721	667,216,364	29,471,969	11,095,042,284
1998	FED	5,206,901,770	896,061,504			1,275,401	319,762,855	20,698,286	6,444,699,816
1998	NONFED	3,129,535,087	542,701,348			457,481	257,189,385	7,502,162	3,937,385,463
1998	TOTAL	8,336,436,857	1,438,762,852			1,732,882	576,952,240	28,200,448	10,382,085,279
1997	FED	5,009,759,115	946,502,300				269,284,914	19,617,166	6,245,163,495
1997	NONFED	2,976,831,733	566,448,944				232,368,559	6,994,174	3,782,643,410
1997	TOTAL	7,986,590,848	1,512,951,244				501,653,473	26,611,340	10,027,806,905

Appendix E: Medicaid Expenditure History (FFYs 1987-2011)

Federal Fiscal Year		Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
1996	FED	5,108,085,992	642,617,067				247,143,021	24,216,938	6,022,063,018
1996	NONFED	2,585,554,740	870,411,932				206,654,747	6,607,708	3,669,229,127
1996	TOTAL	7,693,640,732	1,513,028,999				453,797,768	30,824,646	9,691,292,145
1995	FED	4,544,466,020	957,898,654				211,689,405	20,118,316	5,734,172,395
1995	NONFED	2,612,319,858	555,130,339				188,814,022	6,981,582	3,363,245,801
1995	TOTAL	7,156,785,878	1,513,028,993				400,503,427	27,099,898	9,097,418,196
1994	FED	4,270,641,038	971,062,012				198,029,052	19,316,416	5,459,048,518
1994	NONFED	2,360,183,388	541,966,987				160,067,282	6,415,666	3,068,633,323
1994	TOTAL	6,630,824,426	1,513,028,999				358,096,334	25,732,082	8,527,681,841
1993	FED	3,569,242,225	974,995,888				155,868,466	20,513,859	4,720,620,438
1993	NONFED	1,948,029,707	538,033,111				129,153,725	5,503,221	2,620,719,764
1993	TOTAL	5,517,271,932	1,513,028,999				285,022,191	26,017,080	7,341,340,202
1992	FED	2,948,647,567	971,062,082				123,414,862	18,885,864	4,062,010,375
1992	NONFED	1,626,232,439	541,967,026				94,202,135	3,994,498	2,266,396,098
1992	TOTAL	4,574,880,006	1,513,029,108				217,616,997	22,880,362	6,328,406,473

Appendix E: Medicaid Expenditure History (FFYs 1987-2011)

Federal Fiscal Year		Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
1991	FED	2,350,151,845	214,805,534				118,060,228	15,933,352	2,698,950,959
1991	NONFED	1,333,584,342	123,311,157				89,031,684	1,770,373	1,547,697,556
1991	TOTAL	3,683,736,187	338,116,691				207,091,912	17,703,725	4,246,648,515
1990	FED	1,863,974,540	21,514,951				102,357,638	5,445,088	1,993,292,217
1990	NONFED	1,169,372,627	13,622,974				77,494,462	2,279,100	1,262,769,163
1990	TOTAL	3,033,347,167	35,137,925				179,852,100	7,724,188	3,256,061,380
1989	FED	1,340,004,922	2,856,043				74,271,644	4,280,883	1,421,413,492
1989	NONFED	918,684,239	1,981,428				64,167,288	1,753,568	986,586,523
1989	TOTAL	2,258,689,161	4,837,471				138,438,932	6,034,451	2,408,000,015
1988	FED	1,150,178,441	2,615,451				77,693,637	3,492,504	1,233,980,033
1988	NONFED	862,440,962	1,980,316				52,921,591	1,434,965	918,777,834
1988	TOTAL	2,012,619,403	4,595,767				130,615,228	4,927,469	2,152,757,867
1987	FED	1,060,126,516	7,380,910				70,690,070	3,835,413	1,142,032,909
1987	NONFED	856,998,819	6,000,000				47,919,981	1,580,832	912,499,632
1987	TOTAL	1,917,125,335	13,380,910				118,610,051	5,416,245	2,054,532,541

Appendix F: Texas Medicaid Waivers

Waiver	Type	Description	Services Covered	Operating Agency
Texas Healthcare Transformation and Quality Improvement Program	1115	Texas Healthcare Transformation and Quality Improvement Program, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit (UPL) payments. The waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds through a program and process that is transparent and accountable for public funds.	STAR, STAR+PLUS, and dental managed care services; and through approved regional health partnership projects participating providers will develop and implement programs, strategies, and investments to enhance: access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served.	HHSC
Youth Empowerment Services (YES)	1915(c)	YES is a home and community-based waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families. YES is currently only available in Bexar, Travis and Tarrant counties and can serve up to 300 youth, ages 3-18.	Respite, adaptive aids and supports, community living supports (CLS), family supports, minor home modifications, non-medical transportation, paraprofessional services, professional services, specialized psychiatric observation, supportive family-based alternatives, and transitional services.	DSHS
NorthSTAR	1915(b)	NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. STAR clients in Dallas and sic contiguous counties (Collin, Hunt, Rockwall, Kaufman, Ellis, and Navarro) around Dallas receive behavioral health services	Behavioral health services (mental health and substance use disorder) in a managed care setting, coordinated mental health and substance abuse/chemical dependency services that exceed the traditional Medicaid service array.	DSHS

Appendix F: Texas Medicaid Waivers

Waiver	Type	Description	Services Covered	Operating Agency
		through NorthSTAR. Non-Medicaid eligible individuals who reside in the service area and meet clinical and income criteria are eligible to receive services through NorthSTAR via an application process.		
Non-Emergency Medical Transportation (NEMT)	1915(b)	The Texas Medical Transportation Program (MTP) or its designee[i] is responsible for arranging and administering cost-effective, nonemergency medical transportation (NEMT) services to Medicaid, Children with Special Health Care Needs (CSHCN), and Transportation Indigent Cancer Patients (TICP) clients who do not have any other means of transportation to access medically necessary covered services. In transportation service areas (TSAs), demand response services are provided through the authority of this waiver.	Demand response transportation services are provided or arranged by contracted transportation providers when fixed route transportation or mileage reimbursement is not available or does not meet the client's transportation to healthcare needs.	HHSC
Texas Medicaid Wellness Program	1915(b)	Texas Medicaid Wellness program is a community-based, holistic care management program that enrolls high-risk traditional Medicaid clients with complex, chronic or co-morbid conditions. On March 1, 2012 adult Wellness clients transitioned to Medicaid managed care, therefore, the main focus of the	Holistic and extensive care management from a care team, telephonic and face-to-face visits, educational mailings quarterly and 24-hour nurse advice line.	HHSC

[i] In this context, "designee" refers to the full risk broker.

Appendix F: Texas Medicaid Waivers

Waiver	Type	Description	Services Covered	Operating Agency
		Wellness program shifted to children with disabilities who have SSI or SSI-related Medicaid.		
LTSS for People age 65 and older and those with physical disabilities				
Community Based Alternatives (CBA) for non-STAR+PLUS members[ii]	1915(c)	CBA for non-STAR+PLUS members is a Home and Community-Based services waiver and provides services to people age 21 and older with disabilities who are not enrolled in STAR+PLUS as a cost-effective alternative to nursing facility services.	Personal assistance services, respite, occupational therapy, physical therapy, prescribed drugs, speech, hearing, language therapy, financial management, support consultation, adaptive aids and medical supplies, adult foster care, assisted living, dental, emergency response, home delivered meals, minor home modifications, nursing, and transition assistance services.	DADS
Medically Dependent Children Program (MDCP)	1915(c)	MDCP provides community based services to children and young adults under 21 years of age as an alternative to residing in a nursing facility.	Respite, financial management, adaptive aids, adjunct support, minor home modifications, and transition assistance services.	DADS
LTSS for People with Intellectual and Development Disabilities				
Home and Community-based Services (HCS)	1915(c)	HCS provides individualized services to clients of all ages who qualify for ICF/IID level of care yet live in their family's home, their own homes, or other settings in the community.	Service coordination, day habilitation, respite, supported employment, prescriptions, financial management, support consultation, adaptive aids, dental treatment, minor home modifications, residential assistance (foster/companion care, supervised living, residential support services),	DADS

[ii] LTSS services for STAR+PLUS members are provided under the Texas Healthcare Transformation Quality Improvement Program.

Waiver	Type	Description	Services Covered	Operating Agency
			skilled nursing, specialized therapies (speech and language pathology, audiology, occupational therapy, physical therapy, dietary, behavioral support, social work), and supported home living.	
LTSS for People with Intellectual and Developmental Disabilities cont.				
Community Living Assistance and Support Services (CLASS)	1915(c)	CLASS provides home and community-based services to clients who have a “related condition” diagnosis qualifying them for placement in an Intermediate Care Facility. A related condition is a disability other than an intellectual or development disability which originates before age 22 and which substantially limits life activity.	Adult day health, case management, prevocational services, residential habilitation, respite (in-home and out–of-home), supported employment, adaptive aids/medical supplies, dental services, occupational therapy, physical therapy, prescriptions, skilled nursing, speech, hearing, and language services, financial management services, support consultation, behavioral support, continued family services, minor home modifications, specialized therapies, support family services, and transition assistance services.	DADS
Deaf-Blind with Multiple Disabilities (DBMD)	1915(c)	DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness and have an additional disability.	Case management, day habilitation, residential habilitation, respite, supported employment, prescription medications, financial management services, adaptive aids, assisted living, behavioral support, chore service, dental treatment, employment assistance, intervener, minor home modifications, nursing, orientation and mobility, specialized therapies, and transition assistance services.	DADS
Texas Home Living (TxHmL)	1915(c)	TxHmL provides selected services and supports for people with intellectual developmental disabilities who live in their family homes or their	Case management, adaptive aids, minor home modifications, audiology, speech therapy, occupational therapy, physical therapy, dietary	DADS

Waiver	Type	Description	Services Covered	Operating Agency
		own homes.	services, behavioral supports, dental treatment, nursing, residential assistance, community support, respite, supported employment, and day habilitation.	

Appendix G: Regional Health Care Partnership Regions