

Part I. Medicaid and CHIP: An Overview

**Chapter 1:
Medicaid and CHIP Basics**

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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). 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). Each state chooses its own eligibility

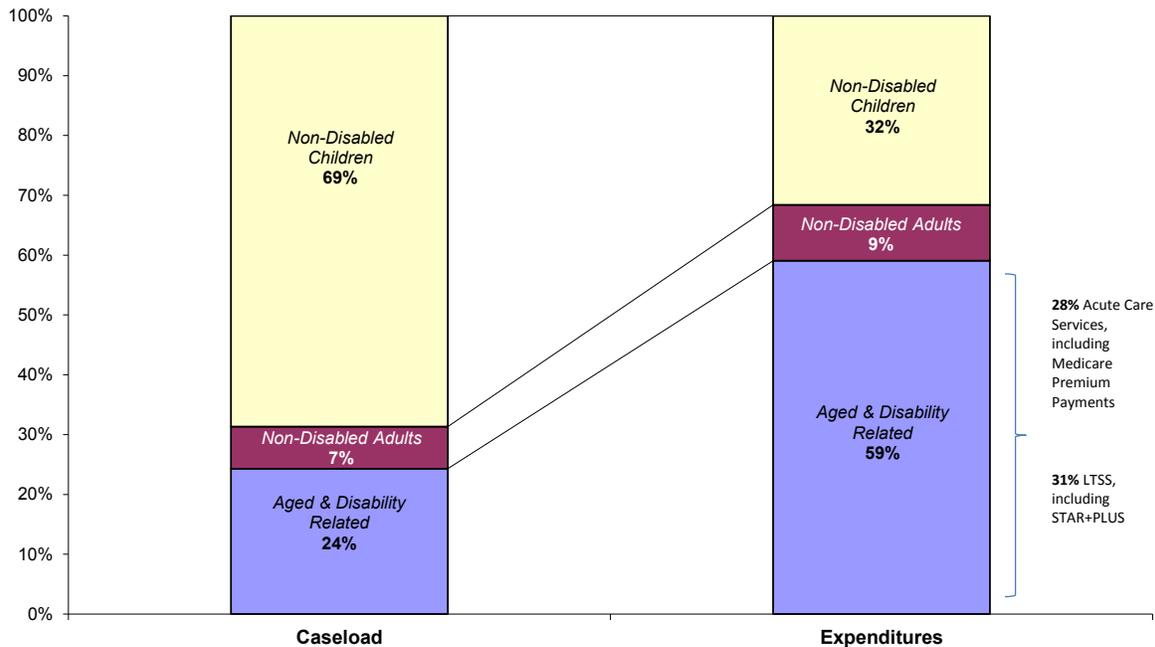
criteria within federal minimum standards. States can apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver of federal law to expand health coverage beyond these groups. Medicaid is an entitlement program, which means the federal government does not, and a state cannot, limit the number of eligible people who can enroll, and Medicaid must pay for any services covered under the program. In July 2015, about 1 in 7 Texans

(4.06 million out of 27.7 million) relied on Medicaid for health coverage or long-term services and supports (LTSS).

Medicaid pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services), behavioral health care, and LTSS. LTSS are available to individuals age 65 and older and those with disabilities and include: home and community-based services (HCBS), nursing facility (NF) services, and services provided in intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/ IID).

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 through 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 eligible for Medicaid, these and other federal changes de-linked Medicaid eligibility from receipt of cash assistance.

In state fiscal year 2015, women and children accounted for the largest percentage of the Medicaid population. Based on the total number of unduplicated clients receiving Medicaid in state fiscal year 2015, 55 percent of the Medicaid population was female, and 78 percent was under age 21. While non-disabled children make up the majority (69 percent) of all Medicaid clients, they account for a relatively small portion (32 percent) of Texas Medicaid program spending on direct health services. By contrast, people who are elderly, blind, or have a disability represent 24 percent of clients but account for 59 percent of estimated expenditures. **Figure 1.1** shows the percentage of the Medicaid population by category and the estimated portion of the Medicaid budget spent on direct health services for each category in state fiscal year 2015.

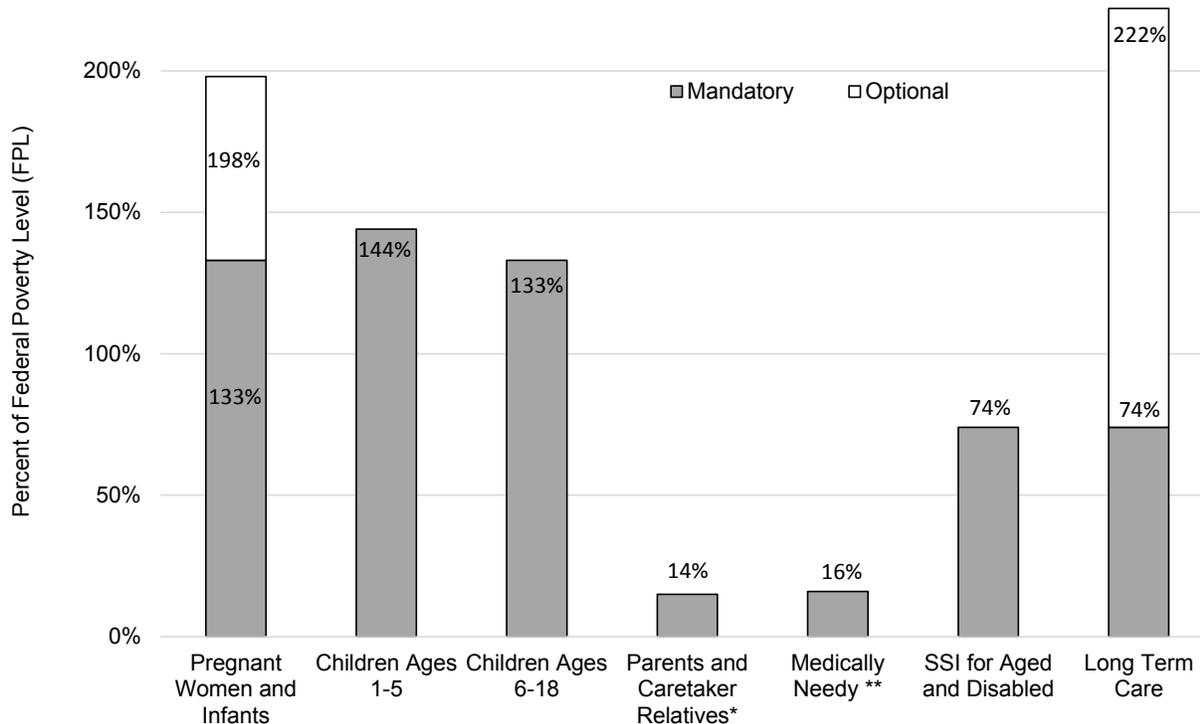
Figure 1.1: Texas Medicaid Beneficiaries and Expenditures, SFY 2015

Source: Health and Human Services (HHS) Financial Services, HHS System Forecasting. SFY 2015 Medicaid Expenditures, including Acute Care, Vendor Drug, and LTSS. Expenditures are for Medicaid clients only, and do not include any payments for Disproportionate Share Hospital or Uncompensated Care costs. Costs include all Medicaid beneficiaries, including emergency services for non-citizens, School Health and Related Services, and Medicare payments for partial dual eligibles. Non-disabled children include all poverty-level children ages 0-19.

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories 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 198 percent of the federal poverty level (FPL). The federal requirement for pregnant women and infants is 133 percent of the FPL.

Figure 1.2 depicts the current Texas Medicaid income eligibility levels for 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.

Figure 1.2: Texas Medicaid Income Eligibility Levels for Selected Programs, March 2016 (As a Percent of the FPL)



Note: Effective January 1, 2014, the Affordable Care Act required states to adjust income limits for pregnant women, children, and parents and caretaker relatives to account for Modified Adjusted Gross Income changes (i.e. the elimination of most income disregards).

*For Parents and Caretaker Relatives, the maximum monthly income limit in SFY 2016 was **\$230** for a family of three (one-parent household), which is the equivalent of approximately 14 percent of the FPL.

For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2016 was **\$275 for a family of three, which is the equivalent of approximately 16 percent of the FPL.

How Medicaid Is Financed

Medicaid is jointly financed by the federal government and the states. In state fiscal year 2015, total expenditures (i.e. state and federal) for Medicaid represented

an estimated 28.6 percent of Texas' budget.¹

The Secretary of the U.S. Department of Health and Human Services annually determines each

¹Includes expenditures for clients who receive any Medicaid benefits and those who receive only Medicare premium assistance or emergency medical services.

state's federal share of most Medicaid health care costs (federal medical assistance percentage, or FMAP) using a formula based on average state per capita income compared to the U.S. average. In Texas, the FMAP is 56.18 percent in federal fiscal year 2017 (see **Chapter 14, Finances, Table 14.3, Texas Federal Medical Assistance Percentages**). 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.

The federal government matches other program costs at a different rate than the FMAP. Medicaid administrative costs 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. Certain approved information system development costs also are matched at 90 percent.

States may use local government funding for up to 60 percent of the state's share of Medicaid matching funds. Texas uses local government funding for the disproportionate share hospital (DSH) reimbursement program and other Medicaid programs, such as the Texas Healthcare 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. The 1115 Transformation Waiver also enables hospitals and other providers to use their local funding to earn additional federal matching funds to reform their delivery systems and improve the quality of care in an evidence-based and transparent manner.

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.

1115 Transformation Waiver

The Texas Legislature, through the 2012-13 General Appropriations Act (GAA), H.B. 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011, instructed 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. 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.

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.

CMS originally approved the 1115 Transformation Waiver as a five-year demonstration waiver running through September 2016. The demonstration waiver allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as UPL payments. The 1115 Transformation Waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal matching funds. The 1115 Transformation Waiver contains two new funding pools: the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

On May 2, 2016, CMS approved HHSC's request to extend the waiver through December 31, 2017, while continuing negotiations on a longer-term agreement. On January 26, 2017, HHSC submitted a request to CMS for an additional 21-month extension at current funding levels for UC and DSRIP. For more information about the waiver, please see **Chapter 15, The 1115 Transformation Waiver**.

What is CHIP?

The Children's Health Insurance Program (CHIP) which is also a jointly funded state-federal program, provides primary and preventive health care to low-income, uninsured children up to age 19 with household incomes up to 201 percent of the FPL who do not qualify for Medicaid, and to unborn children with household incomes up to 202 percent of the FPL.

CHIP covers children in families who have too much income 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;² and
- Living in a family whose income is at or below 201 percent of the FPL.

Until the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), children who legally entered the U.S. on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Prior to CHIPRA, Texas covered certain qualified immigrant children under CHIP with 100 percent state funds if they met all other Medicaid or CHIP eligibility requirements.

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 a federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

Federal policy previously excluded a child from participating in federally-matched CHIP if the child's family was eligible for a state health

benefits plan due to employment with a public agency (even if the family declined the coverage). The Affordable Care Act (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 maintenance of effort (MOE) requirements or the child qualifies for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Teacher Retirement System school employee children as of September 1, 2010, and to other eligible public employee children as of September 1, 2011.

CHIP Perinatal

The 2006-07 GAA, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, HHSC, Rider 70), authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, which began in January 2007. CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status. The expecting mother must meet certain income requirements (income up to and including 202 percent of the FPL). Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum

² There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom their family health insurance premiums exceed 9.5 percent of the family's income. A complete list of the exemptions can be found at <http://chipmedicaid.org/en/Previous-Coverage> (July 2016).

care. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

For CHIP Perinatal clients at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor and delivery. Upon delivery, CHIP Perinatal newborns in families with incomes at or below 198 percent of the FPL are eligible to receive 12 months of continuous Medicaid coverage from the date of birth. Most CHIP Perinatal clients fall into this income range.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL up to and including 202 percent of the FPL remain in the CHIP Perinatal program and receive CHIP benefits for the remainder of the 12-month coverage period.

Medicaid and CHIP Coverage

Medicaid is similar to a basic health insurance program but also provides coverage for people in need of chronic care or LTSS. Other than the Health Insurance Premium Payment program (discussed in **Chapter 14, Finances**), 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, such as doctors, nurses, physician assistants, chiropractors, physical therapists, clinical social workers, dentists, psychologists, and nutritionists;
- Health facilities, such as hospitals, NFs, institutions and group homes for people with intellectual and developmental disabilities (IDD), clinics, and community health centers; and
- Providers of other critical services, such as pharmaceutical drugs, medical supplies and equipment, and medical transportation.

Acute Health Care

Medicaid pays for typical health services, such as physician and professional services, inpatient hospital services, and outpatient hospital and clinic services. These services accounted for approximately 44 percent of the Texas Medicaid program health expenditures in state fiscal year 2015. Medicaid also provides a broader array of acute health services to children than most private health plans, such as dental benefits (which are not included in the above statistic).

Long-Term Services and Supports

Medicaid covers a broad range of LTSS. These services 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 HCBS 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 needs of individuals with co-occurring behavioral health needs. These services and supports accounted for approximately 31 percent of all Texas Medicaid service expenditures in state fiscal year 2015.

LTSS for people age 65 and older and those with physical disabilities includes both:

- NF services for people whose medical conditions require the skills of a licensed nurse on a regular basis; and
- HCBS to help people maintain their independence and prevent institutionalization.

LTSS for people with IDD includes:

- Residential services in ICF/IIDs; and
- HCBS for individuals who qualify for an ICF/IID level of care.

Behavioral Health

Texas Medicaid covers behavioral health services, which are services used to treat a mental, emotional, alcohol, or substance use disorder.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals, community mental health centers, comprehensive provider agencies, and substance use treatment facilities. Behavioral health services are included in all CHIP and Medicaid managed care programs.

Comparing Medicaid and Private Insurance Benefits

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. In addition, the Texas Medicaid program pays for LTSS, such as NF 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

Benefit Type	Medical (Inpatient Hospital, Acute Care)	Dental	Long-Term Services and Supports	Prescription Drugs	Deductible
Medicaid: Children	Yes	Yes	Yes	Yes (Unlimited)	None
Medicaid: Adults	Yes	No	Yes	Yes*	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)	\$1,105 - \$1,836 (Varies by plan type and region)

*The three prescription per month limit only applies to certain adults in Medicaid fee-for-service. Children under age 21, skilled NF residents, home and community-based waiver clients, and STAR and STAR+PLUS adult enrollees receive unlimited prescription benefits. Certain categories of drugs do not count against the three-prescription limit, including family planning drugs and supplies, smoking cessation drugs and insulin syringes.

Source: The Kaiser Family Foundation, "2015 Employer Health Benefits Survey," http://kff.org/health-costs/report/2015-employer-health-benefits-survey/Summary_of_Findings.

Mandatory and 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 5, Benefit Basics, Table 5.1: Mandatory and Optional Services Covered by Texas Medicaid**). Eliminating some optional services

and eligibility categories could 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 198 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 with federal matching dollars. For example, services for persons with IDD provided in state supported living centers and community-based residential settings now receive federal Medicaid matching dollars in addition to state dollars.

The American Recovery and Reinvestment Act of 2009 prohibited 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 ACA continued this MOE requirement (see **Chapter 5, Benefit Basics**).

Basic Principles

The Social Security Act establishes the following fundamental principles and requirements for the Medicaid program:

- Statewideness - All Medicaid services must be available

statewide and may not be restricted to residents of particular localities.

- Comparability - The same level of services (amount, duration, and scope) must be available to all clients, except where federal law specifically requires a broader range of services, such as for Medicaid-eligible children, or allows a reduced package of services, such as for those who qualify as medically needy.
- Freedom of Choice - Clients must be allowed to go to any Medicaid health care provider who meets program standards.
- Sufficiency - 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.

State Plans

The Medicaid state plan is a document that serves as the contract between the state and CMS for the Texas Medicaid program and gives HHSC the authority to administer the 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. CMS must approve the plan and any amendments to the

plan. Texas also has a CMS-approved CHIP state plan.

Waivers

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These waivers allow states to waive certain Medicaid 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.

States seek waivers to:

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

Federal law allows three types of waivers, including Research and Demonstration 1115 Waivers, Freedom of Choice 1915(b) Waivers, and HCBS 1915(c) Waivers.

Fee-for-Service and Managed Care

Both nationally and in Texas, the Medicaid program has increasingly turned to managed care to deliver services more effectively. The traditional Medicaid payment system,

or fee-for-service (FFS), pays health care providers a fee for each unit of service they provide. This approach may result in extra procedures and costs and a lack of care coordination for the client.

In a managed care program, an MCO, sometimes called a health plan, is paid a capped (or capitated) rate for each client enrolled. In managed care, clients receive health care services and LTSS through an MCO's contracted network of doctors, hospitals, and other health care providers responsible for managing and delivering quality, cost-effective care. Medicaid MCOs must cover services in the same amount, duration, and scope as traditional FFS Medicaid. HHSC continues to expand Medicaid managed care. In state fiscal year 2015, 87 percent of the state's Medicaid population was enrolled in managed care.

HHSC continually monitors whether the MCOs are successful in creating a more efficient and effective delivery model than FFS. One of the goals of managed care is to emphasize preventive care and early interventions. Medicaid managed care members choose a primary care provider who helps coordinate care by making appropriate referrals to specialty services and providers. Members also benefit from service coordination and management to make sure services address members' needs.

STAR

Medicaid's State of Texas Access Reform (STAR) program provides primary, acute care, behavioral health care, and pharmacy services for low-income families, children, pregnant women, as well as some former foster care youth. The program operates statewide with services delivered through MCOs under contract with HHSC.

There are 13 STAR service areas. STAR Medicaid members can select from at least two MCOs in each service area. There are a total of 18 MCOs serving different STAR service areas throughout the state.

STAR+PLUS

The Medicaid STAR+PLUS program provides both acute care services and LTSS by integrating primary care, behavioral health care, pharmacy services, and LTSS for individuals who are age 65 or older or adults who have a disability. LTSS includes services such as attendant care and day activity and health services. In addition, STAR+PLUS members can access unlimited prescriptions and service coordination. Service coordinators are responsible for coordinating acute care and LTSS for STAR+PLUS members.

STAR Health

STAR Health is a medical care delivery system for children in state conservatorship. These children are

a high-risk population with greater medical and behavioral health care needs than most children in Medicaid and their changing circumstances make continuity of care an ongoing challenge. STAR Health serves children as soon as they enter state conservatorship and continues to serve them in two transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements; and
- Young adults below 21 years of age who were previously in foster care and continue to receive Medicaid services.

HHSC administers the program under a contract with a single statewide MCO.

STAR Kids

The STAR Kids program provides acute and LTSS benefits to children and young adults with disabilities. LTSS includes private duty nursing and personal care services. STAR Kids implemented statewide on November 1, 2016. There are 13 STAR Kids service areas and 10 MCOs. STAR Kids Medicaid members can select from at least two MCOs in each service area.

Dual Demonstration

The Dual Eligible Integrated Care Demonstration Project, also referred to as the Dual Demonstration, is a fully integrated managed care model

for individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program.

The demonstration operates in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties.

Medicare Advantage Dual Eligible Special Needs Plan

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to provide targeted care to individuals who are dually eligible for both Medicare and Medicaid. D-SNPs are responsible for the coordination of care between Medicare- and Medicaid-covered services.

Children's Medicaid Dental Services Program

Children's Medicaid dental services are provided through a managed care model to children and young adults under age 21 with limited exceptions. Members who receive their dental services through this program are required to select a dental plan, also known as a dental maintenance organization (DMO), and a main dentist. Members are defaulted to a dental plan as well as a main dentist if they do not make a selection. A main dentist serves as the member's dental home and is responsible for providing routine care, maintaining continuity of patient care, and

initiating referrals for specialty care. There are two DMOs available to all members throughout the state.

The Medicaid Numbers

Medicaid as a percentage of Texas budget, state fiscal year 2015:

28.6 percent¹

Percentage of Texas Medicaid budget spent on children, state fiscal year 2015:

32 percent²

Dollars spent on Texas Medicaid, federal fiscal year 2015,
including supplemental health care payments:

\$38 billion³

Texas Medicaid payments to nursing homes, federal fiscal year 2015:

\$2.7 billion

Texas Medicaid prescription drug expenditures, state fiscal year 2015:

\$3.7 billion⁴

Percentage of Texas Medicaid clients under age 21, state fiscal year 2015:

78 percent⁵

Percentage of Texas children on Medicaid or CHIP, calendar year 2015:

45 percent

Percentage of nursing home residents covered by Medicaid, state fiscal year 2014:

63 percent

Percentage of births covered by Texas Medicaid in state fiscal year 2015:

52.2 percent

Percentage of Texas Medicaid clients in managed care, state fiscal year 2015:

87 percent⁶

Unduplicated number of Texans receiving Medicaid, state fiscal year 2015:

5.07 million

Average number of Texans with Medicaid each month, state fiscal year 2015:

4.06 million

Percentage of Texas population covered by Medicaid, state fiscal year 2015:

15 percent

¹All funds, excluding DSH, UC, and DSRIP.

²Includes children under 19 in child risk categories (excludes blind and disabled children).

³All funds, including DSH, UC, and DSRIP.

⁴Includes Medicare "clawback" payments.

⁵Receiving full Medicaid benefits.

⁶Receiving full Medicaid benefits.

