

# Chapter 14: Finances

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## National Medicaid Spending

### *Health Care Spending in the United States*

Health care spending in the U.S. rose from \$1.4 trillion in 2000 to \$3.0 trillion in 2014, an increase of approximately 121 percent.<sup>1</sup> Over the same period, the economy grew by 69 percent. The faster growth of health spending relative to the growth of the economy is the reason **Figure 14.1** 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

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<sup>1</sup> The material in this and the following section is from: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data (July 2016), "Table 1: National Health Expenditures" found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

most important of these factors is the increasing cost of care. As newer, more expensive treatments are developed and used, costs rise.<sup>2</sup> Another important factor is the aging population. As people age, as a group they tend to spend more on health care. Because the average age of the country's population is increasing, total demand for health care is rising.

### *Medicaid Spending in the United States*

Just as total health expenditures have risen, Medicaid expenditures have increased (see **Figure 14.2**). Total Medicaid expenditures rose from \$200.3 billion in 2000 to \$495.8 billion in 2014, an increase of 148 percent. This increase in Medicaid expenditures was generated partly by the same factors affecting medical expenditures for the general population and partly by factors unique to Medicaid. The increases in expenditures for the general population were mainly generated by more expensive care and an older population. The costs for Medicaid are affected by these causes, but have also been pushed up by increases in the Medicaid caseload and the fact that Medicaid serves a select demographic group. Between 2000-2014, the Medicaid caseload grew from 31.7 million

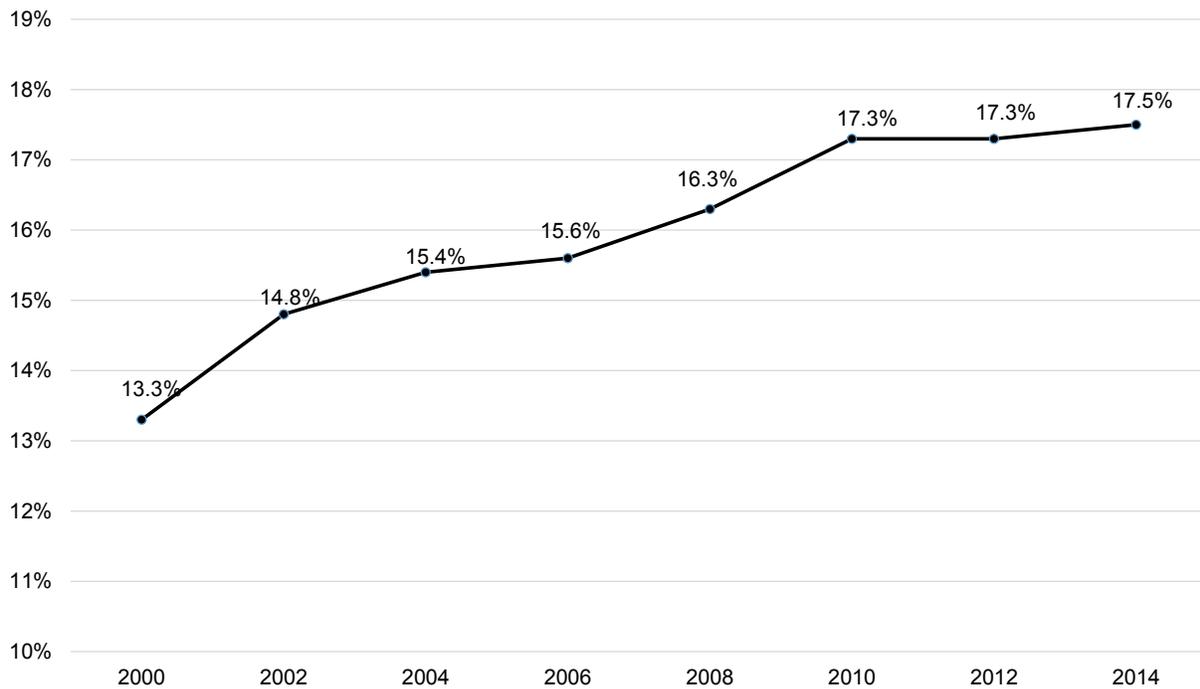
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<sup>2</sup> Increasing the expenditure by itself does not necessarily guarantee increased quality of care or additional services.

individuals to 66 million individuals, an increase of 107 percent. The demographic selection of the Medicaid population occurs because the program is designed to provide medical assistance to the needy. As a result, Medicaid enrollees tend to

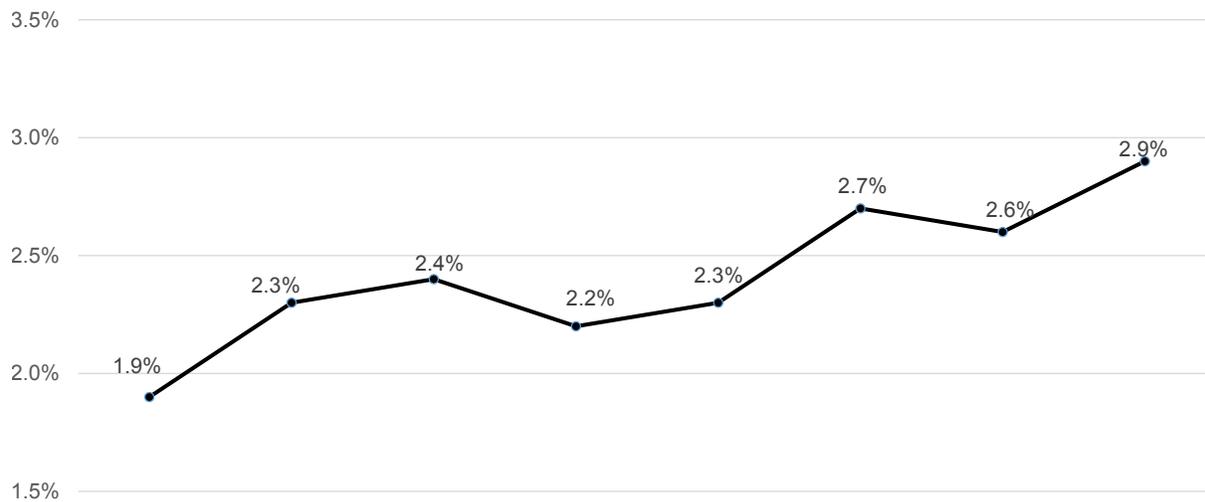
have more – and more serious – untreated medical conditions than members of the general population, which causes additional costs for serving the Medicaid population.

**Figure 14.1: National Health Care Spending as a Percentage of GDP, CYs 2000-2014**



Source: U.S. Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures; Aggregate, Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 2000-2014 (July 2016). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

**Figure 14.2: National Medicaid Spending as a Percentage of GDP, CYs 2000-2014**



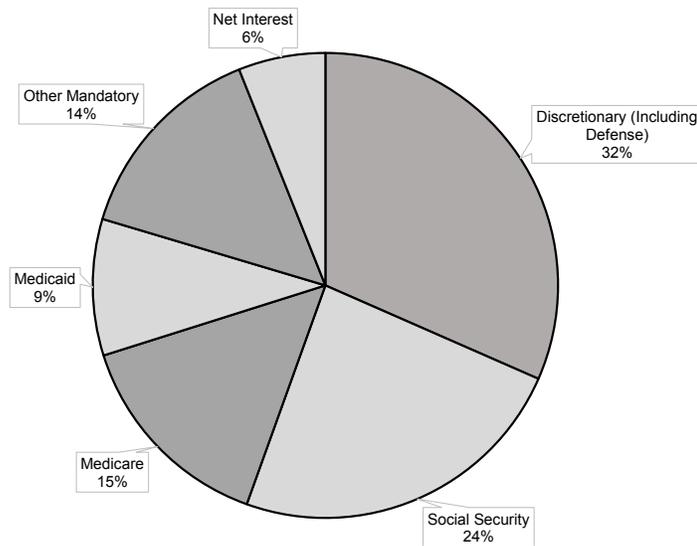
Source: U.S. Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data (July 2016), "Table 3: National Health Expenditures" found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Medicaid and the Children's Health Insurance Program (CHIP) accounted for eight percent of the federal budget in federal fiscal year 2015.

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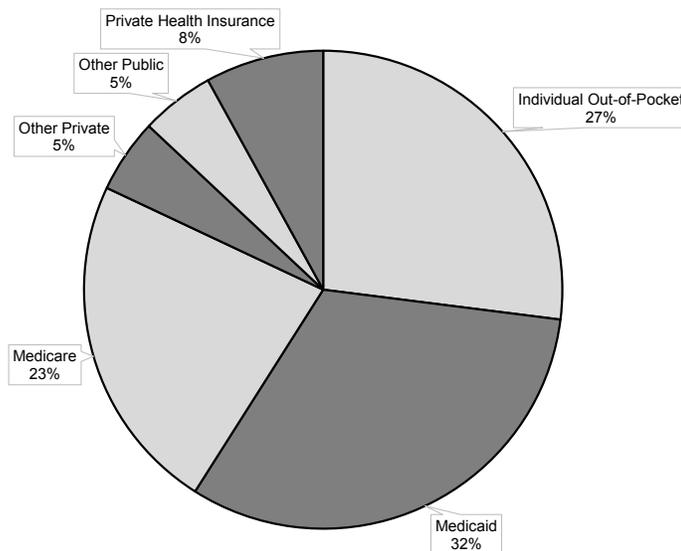
**Figure 14.3** illustrates federal government spending by type of expenditure for federal fiscal year 2015. **Figure 14.4** and **Figure 14.5** show Medicaid's role in calendar year 2014 as a national payer of nursing facilities (NFs) and home health services, respectively.

**Figure 14.3: Federal Budget Expenditures, FFY 2015**



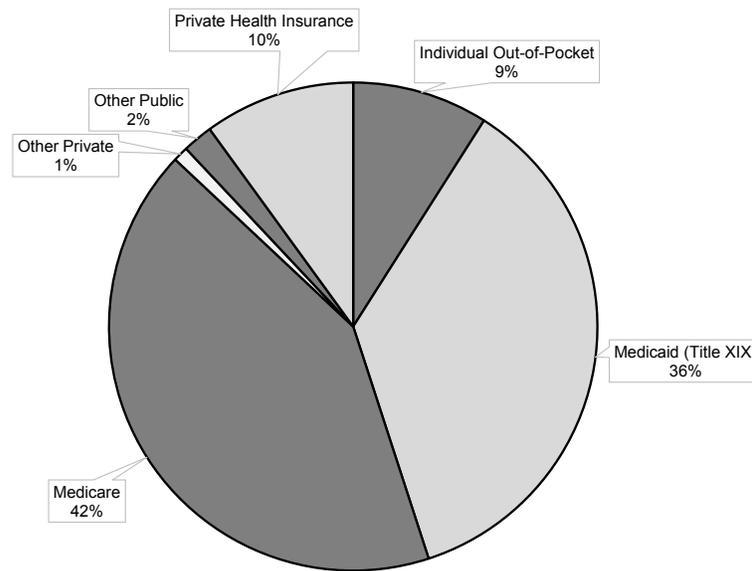
Source: Budget of the U.S. Government FFY 2015. Table S-5. Proposed Budget by Category. Page 170. <http://www.gpo.gov/fdsys/pkg/BUDGET-2015-BUD/pdf/BUDGET-2015-BUD-28.pdf>

**Figure 14.4: National Nursing Facility Payer Sources, CY 2014**



Source: U.S. Centers for Medicare & Medicaid Services. National Health Care Accounts Program. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

**Figure 14.5: National Home Health Payer Sources, CY 2014**



Source: U.S. Centers for Medicare & Medicaid Services. National Health Care Accounts Program. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

## Texas Medicaid Spending

### Budget Growth

Since its inception in 1967, the Texas Medicaid program has grown from serving fewer than one million Texans to serving just over four million. Combined federal and state Medicaid spending has increased from under \$200 million per year to over \$28.8 billion per year in federal fiscal year 2015. This amount excludes disproportionate share hospital (DSH), uncompensated care (UC), and delivery system reform incentive payment (DSRIP) funds. When these funds are included, combined federal and state spending on

Texas Medicaid in federal fiscal year 2015 was \$38 billion. Health care services accounted for \$27.9 billion, and administration of the program accounted for \$1.5 billion, or five percent of total costs. DSH, UC, and DSRIP reimbursements added another \$8.2 billion to program costs.

**Table 14.1: Percent of Medicaid Expenditures in Texas State Budget, SFYs 2000-2015**

SFY	Medicaid Budget <sup>1</sup>	Total State Budget <sup>2</sup>	Annual Percentage
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	23.87%
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	\$24,816	\$95,461	26.00%
2012	\$25,438	\$92,914	27.38%
2013	\$25,614	\$97,840	26.18%
2014	\$27,121	\$100,652	27.11%
2015	\$29,403	\$102,648	28.64%

<sup>1</sup>All Funds (in billions). Excludes DSH, Upper Payment Limit (UPL), UC, and DSRIP funds.

<sup>2</sup>All Funds (in billions). Medicaid is federal fiscal year; state budget is state fiscal year, which begins one month earlier (September 1).

Sources: Texas Medicaid History Report, Feb. 2016; Fiscal Size-Up(s); Legislative Budget Board.

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 resulted in increases 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 they could be eligible to receive federal matching dollars. These factors combined to increase the Texas Medicaid budget five-fold from 1987-2001.

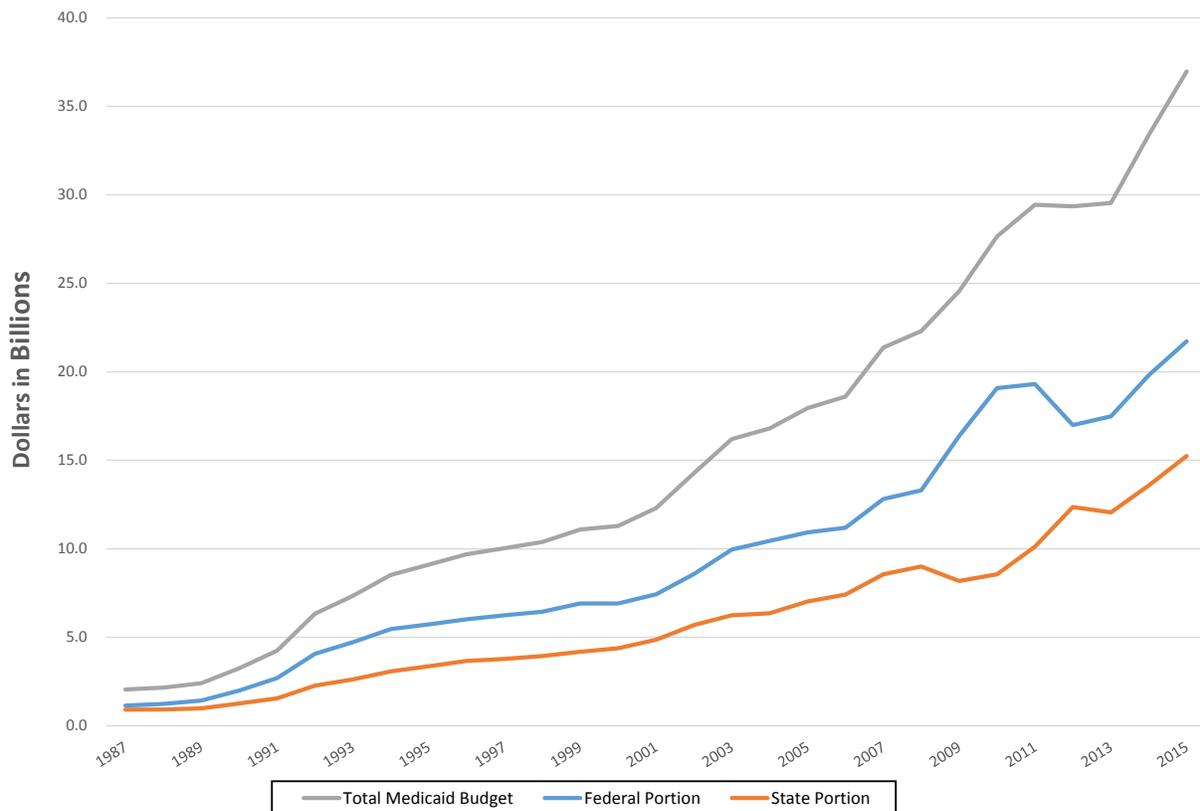
**Table 14.1** shows the percent of Medicaid expenditures in the Texas state budget between state fiscal years 2000-2015. **Figure 14.6**

shows Texas Medicaid expenditures from September 1987-2015.

In 1988, Congress dramatically expanded Medicaid eligibility standards to include groups of people with incomes higher than the Aid to Families with Dependent Children, now known as Temporary Assistance for Needy Families (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 decreased the number of Medicaid clients and changed the composition of its caseload. The late 1990s brought overall declines in caseloads, but the number of clients over the age of 65 or those 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.

Additionally, Texas implemented continuous eligibility for children and simplified the eligibility process, resulting in even more caseload increases after 2000. The caseload for TANF-related Medicaid recipients began to decline again after September 2003 with the implementation of the Full Family Sanctions policy. This policy requires TANF clients to sign a Personal Responsibility Agreement (PRA) whereby the family must comply with work and other requirements, such as maintaining child/medical support payments, immunizations, school attendance, Texas Health Steps checkups, parenting skills, and cooperation with drug and alcohol requirements. If clients fail to comply with the PRA, the family loses cash assistance. Adult family members, with the exception of pregnant women, lose Medicaid coverage for non-compliance with work requirements or medical support requirements.

**Figure 14.6: Texas Medicaid Annual Budget Expenditures, SFYs 1987-2015**



Source: HHSC, Financial Services, HHS System Forecasting.

## ***Budget Development***

Health and Human Services Commission (HHSC) staff 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 cost trends; analyses of any new federal mandates affecting eligibility, services, or changes in program policy; and outreach efforts.

As evident from **Table 14.2**, 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.

**Table 14.2: Medicaid Timeframes in the 2018-2019 Budget Process**

August 2016	Agencies submit legislative appropriations requests for state fiscal years 2018 and 2019 (September 2017 - August 2019).  <b>Most recent program data available is through April 2016.</b>
January 2017	Legislature convenes.
April 2017	Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bill.  <b>Most recent program data available is through March 2017.</b>
May 2017	Legislature finishes appropriations for state fiscal years 2018-2019.
September 2017	State fiscal year 2018 begins.
August 2019	2018-2019 biennium ends.

Note: At the beginning of the 2018-2019 biennium in September 2017, the Medicaid data used for projections is five months old. By the end of the biennium in August 2019, 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.

## Federal Funding

### Matching Funds

Federal funds are a critical component of health care financing for the State of Texas. For the 2016-17 biennial appropriations, federal funds account for \$43.2 billion (about 56 percent) of the total biennial budget of \$77.2 billion for health and human services. Medicaid represents 79 percent of this amount, with \$35.3 billion in federal funds and \$60.2 billion in all funds.

The amount of federal Medicaid funds Texas receives is based primarily 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. As the state’s per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year 2017, Texas’ Medicaid FMAP is 56.18 percent.

Texas uses what is called a “one-month differential” FMAP figure. This takes into account differences between the federal fiscal year (October through September) and the state fiscal year (September through August). The “one month differential” FMAP for Texas in state fiscal year 2017 (which includes one month of the federal fiscal year 2016 rate of 57.13 percent and 11 months of the federal fiscal year 2017 rate of

**Table 14.3: Texas Federal Medical Assistance Percentages, FFYs 1998-2018**

FFY	FMAP	Enhanced FMAP	American Recovery and Reinvestment Act (ARRA) Enhanced FMAP*
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	59.30%	71.51%	N/A
2014	58.69%	71.08%	N/A
2015	58.05%	70.64%	N/A
2016	57.13%	69.99%	N/A
2017	56.18%	69.33%	N/A
2018	56.88%	69.82%	N/A

\*ARRA temporarily increased the FMAP from October 2008 through December 2010.

56.18 percent) results in an adjusted FMAP of 56.26 percent.

**Table 14.3** shows Texas' FMAP and Enhanced FMAP (used for CHIP federal match) percentages for federal fiscal years 1998-2018.

### *Health Care Reform Financing*

Texas Medicaid has experienced significant growth due to Affordable Care Act (ACA)-related impacts. Among the causes of growth were increased enrollment rates among eligible populations, movement of CHIP clients up to 133 percent of the federal poverty level (FPL) to Medicaid, and longer lengths of stay in Medicaid due to longer periods until recertification for

modified adjusted gross income (MAGI)-related groups. While the ACA increased federal financial participation for Medicaid and CHIP, the increases did not cover the full costs to Texas of implementing ACA requirements.

The ACA increased the federal match rate for the optional Medicaid expansion and for CHIP. For the first three calendar years of the optional expansion (2014-2016), the federal government covered the full cost of Medicaid for newly eligible adults in states choosing to implement a Medicaid expansion. Between 2017-2020, the federal share for Medicaid will decrease from 100 to 90 percent.

States have received the CHIP federal match rate for children (ages 6 to 18 up to 133 percent of the FPL) who move from CHIP to Medicaid eligibility beginning in January 2014.

The ACA also increased 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 14.4** shows federal match rates by Medicaid and CHIP eligibility groups from federal fiscal years 2014–2020.

**Table 14.4: Federal Medical Assistance Percentage, FFYs 2014-2020**

FMAP	Applicable Population	2014	2015	2016	2017	2018	2019	2020
Regular FMAP	Applies to individuals who are currently eligible but not enrolled or likely to become enrolled because of the individual mandate	58.69%	58.05%	57.13%	56.18%	56.88%	56.88%	56.88%

<b>FMAP</b>	<b>Applicable Population</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
Regular Enhanced FMAP (EFMAP)	Applies to individuals who are currently eligible but not enrolled in CHIP	71.08%	70.64%	69.99%	69.33%	69.82%	69.82%	69.82%
Super EFMAP	Assumed for the same population groups as the Regular EFMAP, but for different years.	N/A	N/A	92.99%	92.33%	92.82%	92.82%	69.82%

Beginning in 2013, the ACA has provided 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 Program provided an increased federal match of two percent for certain community-based long-term services and supports (LTSS) for states that agree to make a series of structural changes to their long-term care delivery system. From October 1, 2012 to September 30, 2015, Texas received an additional two percent federal match on certain community-based LTSS.

As a component of the ACA, DSH allotments (the maximum federal share of Medicaid DSH payments) were targeted for major reductions. Medicaid and subsidized private

insurance were expected to significantly reduce the size of the uninsured population and, accordingly, reduce the UC burden. The DSH allotment reductions were originally scheduled to begin in federal fiscal year 2014; however through several pieces of legislation, the effective date has been delayed. The most recent legislation, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), delays the implementation of the cuts to federal fiscal year 2018 and extends them to federal fiscal year 2025. The statutory reductions in the federal share of DSH payments for all states under current law are:

- Federal fiscal year 2018 – \$2.0 billion
- Federal fiscal year 2019 – \$3.0 billion

- Federal fiscal year 2020 – \$4.0 billion
- Federal fiscal year 2021 – \$5.0 billion
- Federal fiscal year 2022 – \$6.0 billion
- Federal fiscal year 2023 – \$7.0 billion
- Federal fiscal year 2024 – \$8.0 billion
- Federal fiscal year 2025 – \$8.0 billion

In preparation for the reductions originally scheduled to begin in fiscal year 2014, CMS issued regulations in 2013 addressing the allocation of the cuts by state and developed a methodology to be used for the first two years. The ACA set forth several criteria that must be used in the allocation of the cuts by state and CMS considered each of these criteria in its methodology, including:

- States with low DSH allotments would receive a smaller proportion of the reduction.
- States that have lower uninsured rates relative to other states would receive a larger reduction.
- The reductions would be smaller for states that target DSH payments to hospitals with high Medicaid volume, and states that target DSH

payments to hospitals with high levels of UC.

Predicting Texas' share of the DSH reductions is difficult because CMS has yet to update the methodology for federal fiscal year 2018 and beyond, and the data inputs used are subject to change. The current state-by-state uninsured rates differ from what they were in 2013. Texas does target DSH payments to hospitals with high Medicaid volumes and those with high levels of UC; however, Texas will be judged in relation to all other states, some of which may have more aggressive policies in place or have modified their DSH policies to better target hospitals with high Medicaid volume and UC to enhance their share of future DSH allotments.

Under the most favorable assumptions, Texas Medicaid DSH reductions will range from \$134 million all funds in federal fiscal year 2018 to \$537 million all funds in federal fiscal year 2025. Under the most unfavorable assumptions, the cuts will range from \$386 million all funds in fiscal year 2018 to \$1,543 million all funds in federal fiscal year 2025.

### *Deferrals and Disallowances*

CMS can impose deferrals and disallowances on a state's Medicaid program if CMS determines the state acted outside of CMS regulations or the state's Medicaid state plan.

Deferrals and disallowances impact the availability of federal financial participation for the program.

CMS can impose 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.

- Deferral – When CMS determines a state may be out of compliance with federal regulations or its Medicaid state plan, CMS may withhold funds until it determines the state has come into compliance or until the state provides additional information to support the validity of the claim. This is called a deferral.
- Disallowance – CMS can also recoup federal funds when it alleges a claim is not allowable. This is called disallowance.

States have the option to appeal the CMS determination. The state can request reconsideration by submitting a request to the chair of the U.S. Department of Health and Human Services' (HHS) Departmental Appeals Board within 30 days after receipt of the disallowance letter and including a

statement of the amount in dispute with 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 Departmental Appeals Board can make a ruling based on the written records provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.

### ***Spending by Eligibility Type***

Texas Medicaid spending patterns are not uniform across all eligibility groups. People age 65 and over and people who are eligible due to disability are the smallest portion of Medicaid clients, yet this group accounts for the majority of spending. **Table 14.5** and **Figure 14.6** show state fiscal year 2015 average monthly cost per eligibility category and expenditures, respectively (see also **Figure 1.1**).

**Table 14.5: Average Monthly Cost Per Eligibility Category, SFY 2015**

The average monthly cost per full-benefit recipient in state fiscal year 2015 was \$529 per client per month. These costs are for all services (acute and long-term), excluding Medicare premiums paid by Medicaid. Average monthly client costs look very different when examined by category:

Full-Benefit Clients:

- Children (not including disability-related children): \$242 per client per month
- People Age 65 and Over and/or Disability-Related: \$1,559 per client per month
- Pregnant Women: \$664 per client per month
- Adult Parents: \$575 per client per month

Note: Costs for non-full-benefit clients are not included in the cost per client per month by group, nor are costs for Medicare premiums for full-benefit clients. Thus costs for Medicare Part A&B premiums for partial dual eligibles and costs for Emergency Medicaid services for non-citizens are excluded. These exclusions make costs per client per month appear higher than when all costs and clients are included. This is because many partial benefit clients receive only limited services, which may be lower cost, such as Medicare partial premiums.

**Table 14.6: Texas Medicaid Clients and Expenditures, SFY 2015**

- Children are the least expensive population covered by Medicaid. While 69 percent of Texas Medicaid clients were Non-Disability-Related Children, they accounted for only 32 percent of expenditures.
- The Aged (65+) and Disability-Related category accounts for a large portion of Texas Medicaid spending. Only 24 percent of Texas Medicaid clients fall into the Aged or Disability-Related category, but they accounted for 59 percent of program spending.
- Non-disability-related adults are relatively inexpensive to insure. Parents and Pregnant Women together accounted for seven percent of the population and nine percent of expenditures.

Source: HHSC, Financial Services.

## Medicaid Reimbursement

HHSC is responsible for establishing reimbursement methodologies for traditional fee-for-service (FFS) Medicaid. Changes may be authorized by rule and/or approval from CMS. HHSC consults

with stakeholders and advisory committees 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.

Provider reimbursement rates for services provided under managed care programs are contractually negotiated between managed care organizations (MCOs) and providers. HHSC is responsible for setting actuarially sound premium rates paid to the MCOs for coverage of contractually-required services.

### ***Physicians and Other Practitioners***

Medicaid rates for FFS services delivered by physicians and other practitioners (which include payments for laboratory services, 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 the Texas Administrative Code (TAC), Title 1, §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 used the RVUs specified in the Medicare Physician Fee Schedule at the time in concert with Texas Medicaid conversion factors. 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, anesthesiology assistants, 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, provisionally licensed psychologists, 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.

Reimbursement rates for services outlined above are evaluated at least once every two years as a part of a biennial fee review process.

### ***Physician-Administered Drugs/Biologicals***

FFS Medicaid rates for physician-administered drugs/biologicals are determined as defined in TAC, Title 1, §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. Physician-administered drugs/biologicals are reviewed semi-annually.

### ***Prescription Drugs***

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:

- Federal law required states to transition from an estimated acquisition cost (EAC) methodology to an actual acquisition cost (AAC) methodology for the reimbursement of outpatient drugs in the Medicaid program. AAC is HHSC's determination of a pharmacy provider's actual prices paid to acquire drug products marketed or sold by specific manufacturers. The change to AAC represents a more accurate reference price to reimburse pharmacies.
- As of June 1, 2016, the FFS pharmacy ingredient cost methodology utilizes the National Average Drug Acquisition Cost (NADAC), the benchmark of retail pharmacy acquisition costs developed by CMS. HHSC Vendor Drug Program (VDP) uses a drug's wholesale acquisition cost (WAC) price when no NADAC pricing is available. The pharmacy ingredient costs differ by the type of pharmacy:
  - Retail pharmacy ingredient cost equals the NADAC price or WAC minus 2 percent if no NADAC price is available.
  - Long-term pharmacy ingredient cost equals NADAC minus

2.4 percent or WAC minus  
3.4 percent if no NADAC price is  
available.

- Specialty pharmacy ingredient  
cost equals NADAC minus  
1.7 percent or WAC minus  
8 percent if no NADAC price is  
available.

Dispensing fee reimbursement:

- Dispensing fees are based on  
an average pharmacy's cost to  
dispense a prescription, including  
costs for staff, overhead, and other  
professional services.
- The dispensing fee consists of  
two separate components, a  
fixed component and a variable  
component. Effective June 1, 2016,  
the fee is equal to \$7.93 plus  
1.96 percent of the ingredient cost,  
per claim.
- Pharmacies that provide free  
delivery services to FFS Medicaid  
clients may be eligible for a  
delivery incentive, currently \$0.15  
per prescription.

Reimbursements are reduced to  
a pharmacy's reported Usual and  
Customary or Gross Amount Due  
price if either of those reported  
prices are less than the total  
reimbursement, as determined by  
adding the ingredient cost and the  
professional dispensing fee.

Pharmacy reimbursement in  
managed care is set by the MCO and

is included in the MCOs' contracts  
with pharmacies.

## **Hospitals**

Historically, Texas' hospital funding  
methodologies included inpatient and  
outpatient hospital reimbursements,  
upper payment limit (UPL) funding,  
graduate medical education (GME)  
funding, and DSH funding. Not every  
hospital was eligible for all of these  
different funding sources. Only  
hospitals meeting certain eligibility  
criteria could receive UPL, GME,  
and DSH funds. With the approval  
of the 1115 Transformation Waiver  
described in **Chapter 15**, the UPL  
program no longer exists in Texas.  
Instead, the waiver provides two  
new sources of funds for hospitals  
(and certain other providers): the UC  
pool and the DSRIP pool.

### *Inpatient Hospital Rates*

General acute care hospital  
reimbursement rates for FFS  
Medicaid clients are set using  
a prospective payment system  
(PPS) based on the All Patient  
Refined Diagnosis Related Groups  
(APR-DRG) patient classification  
system. Under PPS, each patient is  
classified into a diagnosis related  
group (DRG) on the basis of clinical  
information. 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. On September 1, 2013, children’s and rural hospitals transitioned from cost-based reimbursement to APR-DRGs. Children’s hospital payments are based on the standardized average cost of treating a Medicaid inpatient admission in a children’s hospital. Rural hospital payments are based on each rural hospital’s facility-specific cost of treating a Medicaid inpatient admission.

Rates paid to freestanding psychiatric 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. 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 cost principles.

### *Outpatient Hospital Rates*

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital’s reasonable cost. For children’s and state-owned hospitals, reimbursement for

outpatient hospital services for high-volume providers is 76.03 percent of the hospital’s allowable cost and reimbursement for all other non-rural high-volume providers is 72 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)<sup>3</sup> Medicaid services during calendar year 2004. For non-high-volume children’s and state-owned hospitals, reimbursement for outpatient hospital services is 72.27 percent of the hospital’s allowable cost. Reimbursement for all other non-rural, non-high-volume providers is 68.44 percent of the hospital’s allowable cost. Reimbursement for outpatient hospital services for rural hospitals is 100 percent of the hospital’s allowable cost. Outpatient rates were frozen effective September 1, 2013.

### *Uncompensated Care Waiver Payments*

Under the 1115 Transformation Waiver, federal matching funds for traditional supplemental payments (UPL) under the Texas Medicaid state plan are no longer available (the DSH program is not considered by CMS to be a supplemental payment program subject to this limitation, so DSH remains outside the waiver).

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<sup>3</sup> PCCM was a managed care option that ended in 2012.

Funding under the 1115 Transformation Waiver for supplemental payments is distributed through two statewide pools worth \$29 billion (all funds) over five years, with \$17.6 billion allocated for UC and \$11.4 billion allocated for DSRIP. The purpose of the UC pool, which replaced the former UPL program under a new methodology, is to reimburse providers for UC

costs. **Table 14.7** shows UPL and UC spending from 2002-2015. The purpose of the DSRIP pool is to encourage hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

For more information, see **Chapter 15, The 1115 Transformation Waiver.**

**Table 14.7: Historical UPL and UC Waiver Spending, FFYs 2002-2015**

FFY	Upper Payment Limit/ Uncompensated Care Spending
2002	\$168,056,432
2003	\$289,181,118
2004	\$775,847,457
2005	\$897,899,580
2006	\$526,735,788
2007	\$1,734,191,128
2008	\$1,693,792,595
2009	\$2,219,683,156
2010	\$2,693,221,610
2011	\$2,789,436,532
2012*	\$2,532,272,392
2012	\$1,164,001,159
2013	\$3,833,786,272
2014	\$3,322,921,086
2015	\$3,069,535,749

Source: HHSC, Financial Services. Includes Physician UPL.

\*FFY 2012 UPL payments to some hospitals were made under a transition arrangement where UC funds were used to make payments under the UPL program that was being phased out.

### *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 2014-15 General Appropriations Act (Article II, HHSC, Rider 40) authorizes HHSC to spend Appropriated Receipts–Match for Medicaid for GME payments to teaching hospitals. The payments are contingent upon receipt of intergovernmental transfers (IGT) of funds from public teaching hospitals for the non-federal share of Medicaid GME payments. The Legislature directed HHSC to use only IGT funds (Appropriated Receipts-Match for Medicaid) for the non-federal share of Medicaid GME payments for the 2014-15 biennium.

### *Disproportionate Share Hospital Funding*

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Federal law requires state Medicaid programs to 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 DSH program. 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 uncompensated costs of care for indigent or low-income patients, including Medicaid 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 federal fiscal year 2015, 186 Texas hospitals qualified to receive DSH payments: 62 were non-state public, 109 were private, and 15 were state hospitals. Of the 186 DSH hospitals, 83 were located in urban areas and 103 were located in rural or equivalent areas. Of the urban hospitals, eight were large public facilities and ten 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 (56.18 percent federal funds and 43.82 percent state funds for Texas in federal fiscal year 2017). The state share of DSH is funded through a combination of IGT from public hospitals and state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest). In federal fiscal year 2015, the DSH allocation for Texas totaled \$1.785 billion in federal and state funds. This figure was \$1.819 billion in federal fiscal year 2016.

### *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 increased

significantly 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 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 state fiscal year 1995 to about \$427 million in state fiscal year 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 of 2000 and the Medicare

Prescription Drug Improvement and Modernization Act of 2003, have resulted in annual fluctuations in providers' DSH funding.

The second impact of the BBA was to limit DSH payments to institutions for mental disease (IMDs) to a fixed percentage of total annual DSH funds. This provision has caused IMD payments to vary each year.

ACA decreases the size of the federal DSH allocations in anticipation of the reduction in the size of the uninsured population. The statute requires annual aggregate reductions in federal DSH funding from federal fiscal years 2014-2020. To implement these annual reductions, the statute requires the U.S. Secretary of HHS to develop a methodology to allocate the reductions that must take into account the following factors: impose a smaller percentage reduction on low DSH states; impose larger percentage reductions on states with the lowest percentages of uninsured individuals; impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients or with high levels of uncompensated

care; and take into account whether the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under Section 1115 as of July 31, 2009.

The Pathway for Sustainable Growth Rate Reform Act of 2013 delayed the annual aggregate reductions in federal DSH funding from federal fiscal year 2014 to federal fiscal year 2016. The act also increased the overall level of reductions and extended the timeframe for the cuts through federal fiscal year 2023. In 2015, MACRA further delayed the annual aggregate reductions in federal DSH funding to federal fiscal year 2018, increased the overall level of reductions, and extended the timeframe for the cuts through federal fiscal year 2025.

**Table 14.8** shows Texas DSH federal funding for 2002-2016. **Figure 14.7** illustrates DSH's decreasing share of the Texas Medicaid budget since 1995. State and federal DSH payments during the same time period are shown in **Figure 14.8**.

**Table 14.8: Texas DSH Federal Fund Trends, FFYs 2002-2016**

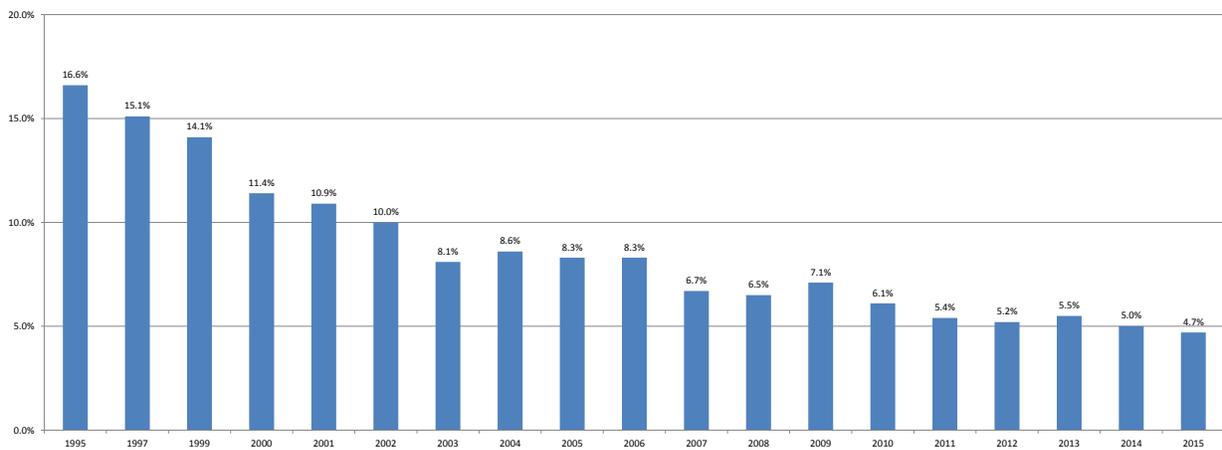
FFY	Federal Funds
2002	\$856 million
2003	\$776 million
2004	\$901 million
2005	\$901 million
2006	\$901 million
2007	\$901 million
2008	\$901 million
2009	\$964 million*
2010	\$988 million**
2011	\$964 million
2012	\$981million
2013	\$1 billion
2014	\$1.019 billion
2015	\$1.036 billion
2016	\$1.039 billion

\*Includes \$23.5 million in ARRA federal stimulus funds.

\*\*Includes \$47.6 million in ARRA federal stimulus funds.

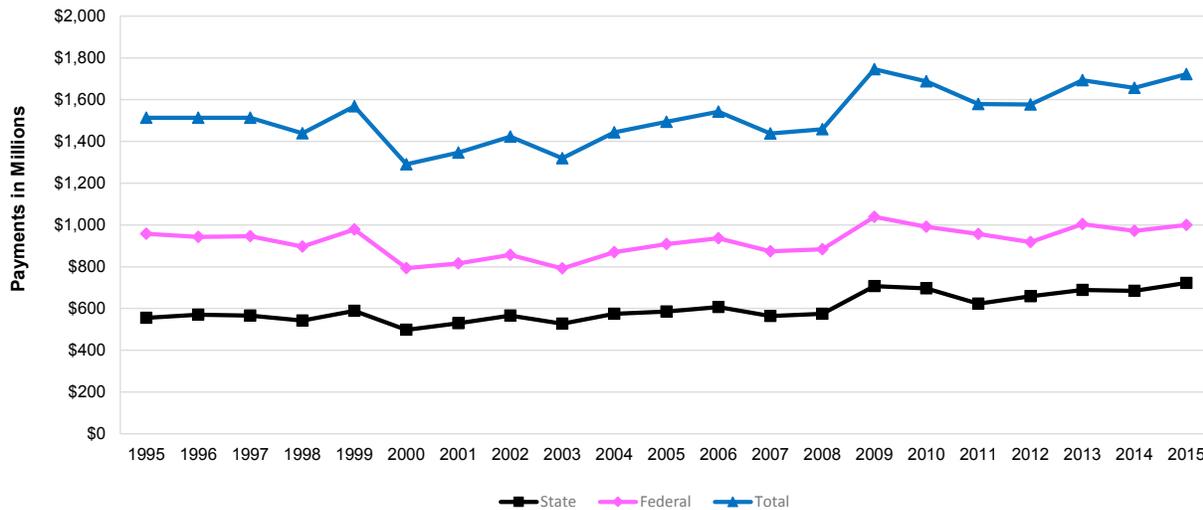
Source: HHSC, Financial Services.

**Figure 14.7: DSH Funds as a Percentage of the Total Medicaid Budget, FFYs 1995-2015**



Source: HHSC, Financial Services.

**Figure 14.8: Payments for DSH Program, FFYs 1995-2015**



Source: HHSC, Financial Services.

### Nursing Facilities

NFs are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service (for example, case-mix class as determined by recipient characteristics). 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.<sup>4</sup>

NF cost reports are subjected to either a desk review or on-site audit to determine whether reported costs are allowable. NF rates are recalculated once every two years to coincide with the legislative biennium.

<sup>4</sup>H.B. 154, 77th 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.

MCOs are currently required to reimburse NFs providing services to their members at least the same daily payment rate, including any enhancements, as would have been paid under FFS.

### ***Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition***

Intermediate care facilities for individuals with an intellectual disability or related condition (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 enhanced attendant compensation.

ICF/IID cost reports are subjected to a desk review or on-site audit to determine whether reported costs are allowable. ICF/IID rates are recalculated once every two years to coincide with the legislative biennium.

### ***Federally Qualified Health Centers***

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

### ***Participation Requirements***

To participate in the Texas Medicaid program, an FQHC must:

- Be receiving a grant under the Public Health Service Act §329, 330, or 340, or be designated by the Secretary of the U.S. Department of HHS as meeting the requirements to receive such a grant;
- Comply with all federal, state, and local laws and regulations applicable to the services provided;

- Be enrolled and approved for participation in the Texas Medicaid program;
  - Sign a written provider agreement with HHSC or its designee;
  - Comply with the terms of the provider agreement and all requirements of the Texas Medicaid program, including regulations, rules, handbooks, standards, and guidelines published by HHSC; and
  - Bill for covered services in the manner and format prescribed by HHSC.
- Services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services;
  - Visiting nurse services to a homebound individual, in the case of FQHCs located in an area that has a shortage of home health agencies as determined by the state survey agency; and
  - Any other ambulatory service offered by an FQHC and that is otherwise included in the Medicaid state plan.

### *Covered Services*

Covered services are limited to services as described in the Social Security Act<sup>5</sup> and other ambulatory services covered by the Texas Medicaid program when provided by other enrolled providers. Covered services provided by an FQHC must be reasonable and medically necessary as determined by HHSC or its designee.

When furnished to a patient of the FQHC, medically necessary services include:

- Physician services;
- Physician assistant services;
- Nurse practitioner services;
- Clinical psychologist services;
- Clinical social worker services;

### *Reimbursing FQHC Providers*

Federal law requires that FQHCs be reimbursed 100 percent of average reasonable and allowable costs for the clinic in the base year of 2000. Texas Medicaid reimburses FQHCs through a PPS or an alternative prospective payment system (APPS). FQHCs are paid an all-inclusive encounter rate for each patient visit. The two payment systems establish the initial rate utilizing the same calculation. The main difference in the two systems is the method of inflation. PPS rates are inflated annually using the Medicare Economic Index (MEI) for primary care. APPS rates are inflated annually using the MEI plus 0.5 percent. If the increases in an FQHC's costs are greater than the inflation amount in either system, the provider can request an adjustment to their rate if

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<sup>5</sup> Social Security Act, §1861(aa)(1)(A)-(C)

the provider can prove that it is operating in an efficient manner, or show that the adjustment is warranted due to a change in scope of services. If an FQHC chooses the APPS methodology, HHSC may prospectively reduce the effective rate to reflect the greater of 100 percent of its reasonable costs or the PPS rate.

### ***Rural Health Clinics***

A rural health clinic (RHC) is a clinic located in a rural area designated by the U.S. Health Resources and Services Administration as a shortage area. Medicare has a number of requirements in order for a clinic to qualify as an RHC, including that it must be located in a non-urbanized area, as defined by the U.S. Census Bureau, that is medically underserved. In addition, an RHC must employ a nurse practitioner or a physician assistant working at the clinic at least 50 percent of the time. It may not also exist as a rehabilitation agency or function primarily as a care and treatment facility for mental diseases. RHCs are neither licensed nor accredited by the state.

### ***Participation Requirements***

To participate in the Texas Medicaid program, an RHC must:

- Be enrolled and approved for participation in the Texas Medicaid program;

- Comply with all federal, state, and local laws and regulations applicable to the services provided;
- Sign a written provider agreement with HHSC or its designee;
- Comply with the terms of the provider agreement and all requirements of the Texas Medicaid program, including regulations, rules, handbooks, standards, and guidelines published by HHSC; and
- Bill for covered services in the manner and format prescribed by HHSC.

### ***Covered Services***

Covered services are limited to services as described in the Social Security Act<sup>6</sup> and other ambulatory services covered by the Texas Medicaid program when provided by other enrolled providers. Covered services provided by an RHC must be reasonable and medically necessary as determined by HHSC or its designee.

When furnished to a patient of the RHC, medically necessary services include:

- Physician services;
- Physician assistant services;
- Nurse practitioner services;
- Services and supplies incident to such services as would otherwise be covered if furnished by a by a

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<sup>6</sup>Social Security Act, §1861(aa)(1)(A)-(C)

- physician or as an incident to a physician's services;
- Visiting nurse services to a homebound individual, in the case of RHCs located in an area that has a shortage of home health agencies as determined by the state survey agency; and
- Any other ambulatory service offered by an RHC and that is otherwise included in the Medicaid state plan.

### *Reimbursing RHC Providers*

Federal law requires that RHCs be reimbursed 100 percent of average reasonable and allowable costs for the clinic in the base year of 2000. Texas Medicaid reimburses RHCs through a PPS methodology. RHCs are paid an all-inclusive encounter rate for each patient visit. It is the intent of the state to ensure that each RHC is reimbursed at 100 percent of its reasonable costs or the Medicare maximum payment per visit (federal ceiling) as applicable. PPS rates are inflated annually using the MEI for primary care. If the increases in an RHC's costs are greater than the inflation amount in either system, the provider can request an adjustment to their rate. To receive an adjustment the provider must prove it is operating in an efficient manner or show that the adjustment is warranted because of a change in scope of services.

## **Managed Care Organization Rates**

Premium rates for the 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 11, Fee-for-Service and Managed Care.**

### *STAR*

The managed care rate-setting 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. The base cost data is totaled, and trends to the time period for which the rates are to apply are calculated. 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. A provision is then made for the possible fluctuation in claims cost through the addition of a risk margin.

Newborn delivery expenses are removed 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 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 premiums 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.

The methodology for calculating the pharmacy rates is similar to the STAR rates above.

### *STAR+PLUS*

The STAR+PLUS program rates are calculated in a similar manner as the STAR program, except that STAR+PLUS MCOs do not receive a delivery supplemental payment for newborn deliveries.

### *STAR Kids*

As a new program, the STAR Kids' initial MCO rates are derived primarily from both managed care and FFS claims data for a particular

base period of time. This base cost data is totaled, and trends are calculated to the time period for which the rates are to apply. The base period data is adjusted for benefit, reimbursement, and policy changes that will be in place during the rating period. The cost data is also adjusted for MCO expenses such as reinsurance, administrative expenses, service coordination expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims cost through the addition of a risk margin.

Final rates vary by risk group and service area. However due to low caseload among risk groups for the Youth Empowerment Services waiver clients and members less than one year of age, premium rates for these risk groups are calculated on a statewide basis.

### *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 trends to the time period for which the rates are to apply are calculated. 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 repository of health care services data for each member 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.

### *Children's Medicaid Dental Services Program*

Children's Medicaid Dental Services Program rates are based on claims experience for the covered population in the base period. The base cost is totaled, and trends to the time period for which the rates apply are calculated. A reasonable provision for administrative expenses, taxes, and risk margin is 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.

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## **Recovery and Other Insurance**

### ***Medicaid Estate Recovery Program***

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

- NFs;
- ICFs/IID (including state supported living centers);
- Community Attendant Services; and
- Medicaid waiver programs (Community Living Assistance and Support Services, Deaf-Blind with Multiple Disabilities, Home and Community-based Services, Texas Home Living, STAR+PLUS)

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 exemptions or hardship conditions exist, the state files a claim against the descendant'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. HHSC is responsible for MERP program policy and procedures.

### ***Third Party Liability***

Third party liability (TPL) is the legal obligation of certain individuals, entities, or programs to pay all or part of the expenditures for Medicaid services furnished under a state plan. A third party resource (TPR) is an individual, entity, or program that has a legal obligation to pay for services.

As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf they have legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance. To the extent allowed by federal law, a health care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. Medicaid pays only after the third party has met its legal obligation to pay. Medicaid is the payer of last resort.

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for the payment of the services.

The purpose of HHSC's TPL unit is to maintain an effective TPL program to help reduce Medicaid expenditures by shifting claims expense to third party payers utilizing either cost avoidance or cost recovery.

Cost avoidance occurs when a primary payer is identified automatically through claims processing, claims are denied, and the provider is instructed to either bill the other insurance or is informed that their claim has been forwarded to the other insurance carrier for processing.

Cost recovery, also known as “pay and chase,” occurs when Medicaid seeks reimbursement from third parties whenever Medicaid has paid claims for which there are third parties that are liable for payment of the claims.

### ***Managed Care & Third Party Liability***

Texas Medicaid MCOs and dental maintenance organizations (DMOs) are subject to the state and federal requirements related to cost avoidance and cost recovery. Each MCO and DMO has the obligation to cost avoid claims and cost recover for Texas Medicaid eligible clients when there is a liable third party.

### ***Health Insurance Premium Payment Program***

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The Health Insurance Premium Payment (HIPP) program, implemented in Texas in 1994 and currently administered by HHSC, is a Medicaid program that reimburses eligible individuals for their share of an employer-sponsored health insurance premium payment. In 2015, an average of 9,700 Medicaid clients were enrolled in HIPP. To apply for HIPP, an employee must either be Medicaid-eligible or have a family member who is Medicaid-eligible.

The HIPP program may pay for clients and their family members who get, or have access to, employer-sponsored health insurance benefits when it is determined 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 plan reimbursed through HIPP if the cost of enrolling both individuals is less than the cost of the projected 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 not covered by the individual’s employer-sponsored health insurance plan, Medicaid will provide this wrap-around service at no cost to the enrollee as long as an enrolled Medicaid provider provides the services.

Historically, HIPP only included individuals enrolled in traditional

Medicaid FFS. However, S.B. 207, 84th Legislature, Regular Session, 2015, allowed managed care members, except STAR Health members, to enroll in HIPP.

In certain circumstances, employers may receive a one-time tax refund of up to \$2,000 per employee for employees who participate in HIPP. The Texas Workforce Commission administers the tax refund program.

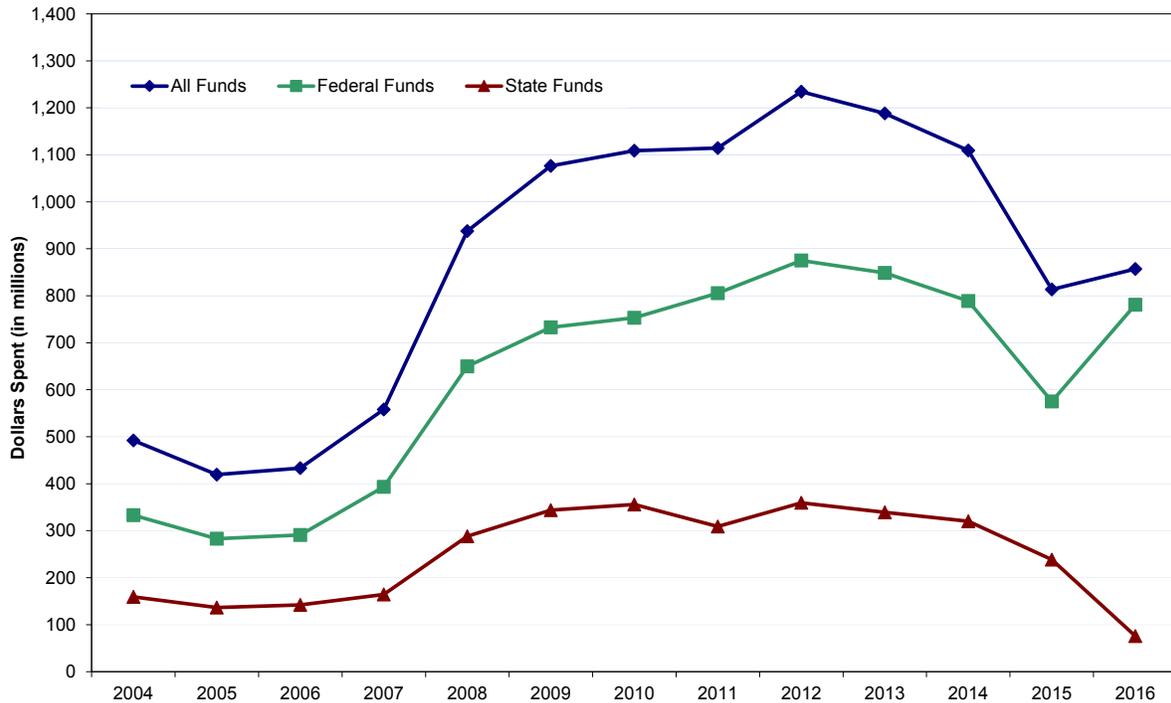
Premium reimbursements typically process in less than seven days after validation of the premium payment is received. Reimbursements can either be mailed or submitted through electronic funds transfer to eligible individuals enrolled in HIPP. In 2015, an average of 82 percent of all premium reimbursements were made by electronic funds transfer.

## CHIP and CHIP Perinatal

### *CHIP Spending*

Texas CHIP spending has experienced sporadic growth in recent years. **Figure 14.9** shows state and federal expenditures for CHIP between state fiscal years 2004-2016. Current estimates project that total CHIP expenditures for state fiscal year 2016 will be over \$1.27 billion. Approximately 70 percent of the CHIP budget is spent on inpatient and outpatient hospital services and physician services; 15 percent on prescription drugs; and the remaining 15 percent on administration.

**Figure 14.9: Texas CHIP Expenditures, SFYs 2004-2016**



Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data.

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**CHIP Financing**

Like Medicaid, CHIP is jointly funded by the federal government and states. However, unlike Medicaid, total federal funds allotted to the program each year are capped, as are the 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 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 historically was available

to states for three years, but the Children’s Health Insurance Program Reauthorizat on Act of 2009 changed the period to two years. Any funds not spent by the end of the two year period are redistributed to states that have exhausted their allotment, with some exceptions.

The federal fiscal year 2015 allocation is fully expended and the 2016 allocation is estimated to be fully expended in 2017. The federal allocation for Texas in federal fiscal year 2016 was \$1.35 billion.

Another difference between financing for Medicaid and CHIP is CHIP offers a more favorable federal matching

rate than Medicaid. The federal CHIP funds states receive are based on the 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. The CHIP EFMAP for Texas was 70.64 percent in federal fiscal year 2015 and 69.99 percent for federal fiscal year 2016.

The ACA increased 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 requirements.

### **CHIP Cost-Sharing**

Most families in CHIP pay an annual enrollment fee to cover all children in the family. All CHIP families pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP annual enrollment fees and co-payments vary based on family income. The total amount a family is required to contribute out-of-pocket toward the cost of health care services is capped at five percent of family income.

**Table 14.9** shows the current CHIP cost-sharing requirements and cost-sharing caps that became effective on March 1, 2012.

**Table 14.9: CHIP Cost-Sharing Requirements**

<b>Enrollment Fees (for 12-month enrollment period):</b>	<b>Charges</b>
At or below 151% of FPL	\$0
Above 151% up to and including 186% of FPL	\$35
Above 186% up to and including 201% of FPL	\$50
<b>CHIP Members up to and Including 151% of FPL</b>	<b>Charges</b>
Office visit	\$5
Non-emergency emergency room	\$5
Generic drug	\$0
Brand drug	\$5
Inpatient hospital	\$35
Cost-sharing limit	5% of family income, per enrollment period
<b>CHIP Members Above 151% up to and Including 186% of FPL</b>	<b>Charges</b>
Office visit	\$20
Non-emergency emergency room	\$75
Generic drug	\$10
Brand drug	\$35
Inpatient hospital	\$75
Cost-sharing limit	5% of family income, per enrollment period
<b>CHIP Members Above 186% up to and Including 201% of FPL</b>	<b>Charges</b>
Office visit	\$25
Non-emergency emergency room	\$75
Generic drug	\$10
Brand drug	\$35
Inpatient hospital	\$125
Cost-sharing limit	5% of family income, per enrollment period

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### **CHIP Rates**

The rate-setting process for CHIP is essentially the same as for the STAR managed care program. CHIP MCO rates, including pharmacy costs, are derived primarily from MCO historical claims experience for a particular base period of time. This base cost

data is totaled, and trends are predicted 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.

The removal of newborn delivery expenses from the total cost rate results 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 of \$3,100 for each birth.

The resulting underlying base rates vary by service area and age group. 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 paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

CHIP dental benefits are reimbursed through a separate set of premium rates. The rate-setting process for the CHIP dental plans is similarly derived

from MCO historical claims experience for a particular base period of time. This base cost data is totaled, and trends are calculated 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 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 an acuity adjustment and the more focused scope of benefits and membership in CHIP Perinatal. MCO historical claims are totaled, and trends are calculated 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 over 198 percent up to and including 202 percent of the FPL, premium rates for these risk groups are calculated on a statewide basis.

