

Chapter 1: Texas Medicaid in Perspective

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

What Is Medicaid?

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by the Health and Human Services Commission (HHSC). In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). 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 2013, about one in seven Texans (3.7 million of the 26.4 million) relied on Medicaid for health coverage or long-term services and supports.

Medicaid pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services), and long-term services and supports (home and community-based services, nursing facility services, and services provided in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICFs/IID)) for people age 65 and older and those with disabilities. In state fiscal year (SFY) 2013, total expenditures (i.e. state and federal) for Medicaid were estimated to represent 26.2 percent (about \$25.6 billion) of Texas' budgetⁱ. The federal share of the jointly financed program is determined annually based on the average state per capita income compared to the U.S. average. The federal share is known as the federal medical

ⁱ All funds, excluding disproportionate share hospital (DSH), uncompensated care (UC), and Delivery System Improvement Program (DSRIP). Sources: Texas Medicaid History Report, August 2014, and Fiscal Size-Up(s)..

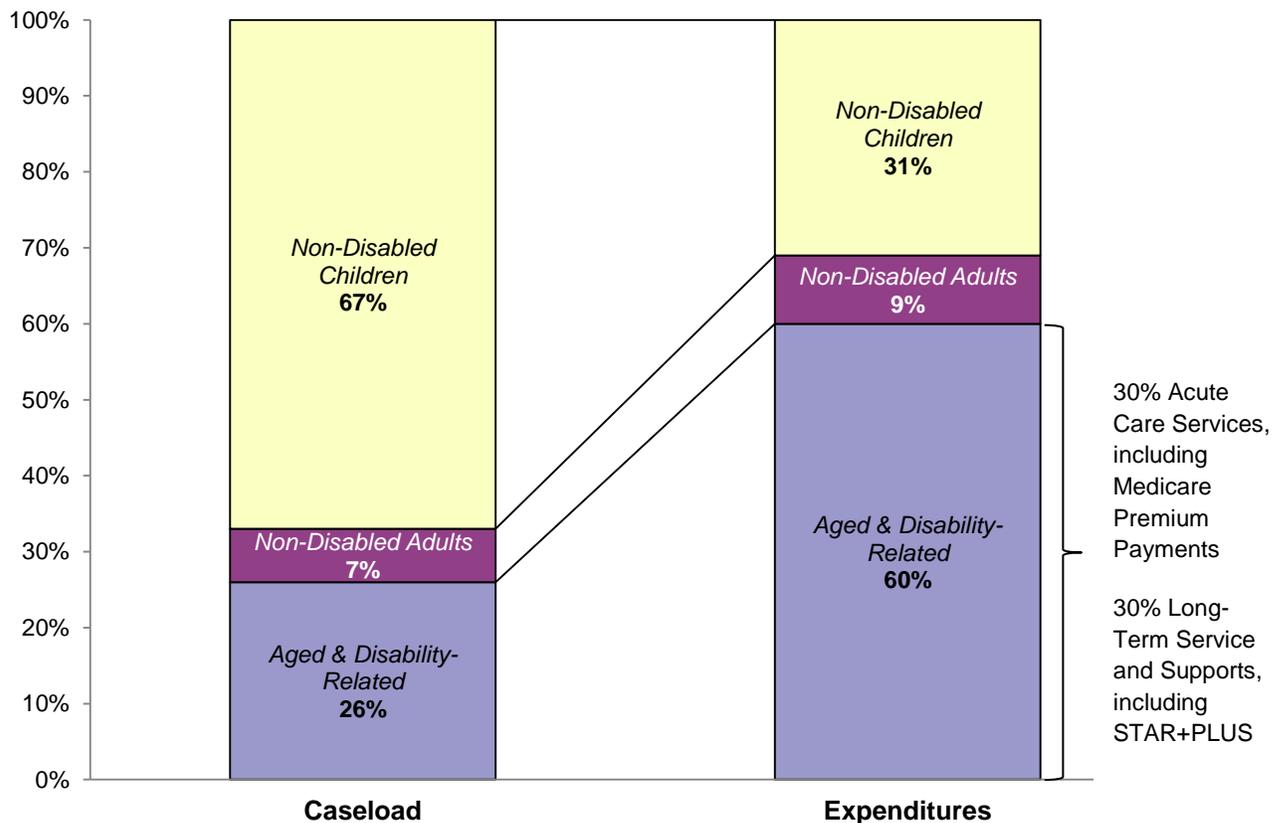
assistance percentage (FMAP). Each state's FMAP is different; in Texas, the federal government funded 59.30 percent of the cost of the Texas Medicaid program in federal fiscal year (FFY) 2013, while the state-funded the other 40.7 percent. (See Chapter 5, **Table 5.4**, Texas Federal Medical Assistance Percentages (FMAP).) Due to the size of the Texas Medicaid program, even small changes in the FMAP can result in federal funding fluctuations worth millions of dollars.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Initially, the program was only available to people receiving cash assistance 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 SFY 2013, women and children accounted for the largest percentage of the Medicaid population. Based on the total number of unduplicated clients receiving Medicaid in SFY 2013, 55 percent of the Medicaid population were female, and 82 percent were under age 21. While non-disabled children make up the majority (67 percent) of all Medicaid clients, they account for a relatively small portion (31 percent) of Texas Medicaid program spending on direct health-care services.ⁱⁱ By contrast, people who are elderly, blind, or have a disability represent 26 percent of clients but account for 60 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 SFY 2013.

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

Figure 1.1: Texas Medicaid Beneficiaries and Expenditures SFY 2013



Source: HHS Financial Services, HHS System Forecasting. SFY 2013 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Services and Supports. Expenditures are for Medicaid clients only and do not include any payments for disproportionate share hospital (DSH) or uncompensated care costs. Costs include all Medicaid beneficiaries, including Medicaid Women's Health Program clients through December 2012, emergency services for non-citizens, and Medicare payments for partial dual eligibles. Children include all FPL levels ages 0-19. Disability related children are included in Aged & Disability-Related.

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories that states are allowed, but not required, to cover under their Medicaid programs. For example, Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 198 percent of the federal poverty level (FPL). The federal requirement for pregnant women and infants is 133 percent of the FPL. Another optional group Texas covers is known as the "medically needy" group. This group consists of children and pregnant women whose income exceeds Medicaid eligibility limits, but who do not have the resources required to meet their medical expenses. A "spend down" amount is calculated for each of these individuals based on the amount their income exceeds from the medically needy income limit for their household size. If their medical expenses exceed the spend-down amount, they become Medicaid eligible.

Medicaid then pays for the unpaid medical expenses that exceed the spend down amount and for any Medicaid services provided after they are determined to be medically needy. (See Chapter 2, **Figure 2.2**, Texas Medicaid Income Eligibility Levels for Selected Programs, March 2014.)

Medicaid Service Delivery Models

Texas Medicaid provides health care services through two service delivery models: fee-for-service (Traditional Medicaid) and managed care. Texas Medicaid provides health care services to most clients through a managed care model.

Fee-for-Service

Some Medicaid clients are served through a traditional fee-for-service (FFS) delivery system in which health care providers are paid for each service they provide, such as an office visit, test, or procedure. The FFS model allows access to any Medicaid provider. The provider submits claims directly to the Texas Medicaid claims administrator for reimbursement of Medicaid covered services.

Each state must describe their specific payment methodologies for mandatory and optional Medicaid services in their Medicaid state plan. The Centers for Medicare & Medicaid Services (CMS) reviews all state plan amendments to make sure reimbursement methodologies are consistent with federal statutes and regulations.

Because services can be coordinated and delivered more efficiently through the managed care model, there is an effort underway to transition the majority of Texas Medicaid clients who remain in FFS to managed care.

Managed Care Programs

Most people in Texas who have Medicaid get their services through managed care. As of August 2014, the number of Medicaid managed care members represented 3.2 million of the state's 3.9 million Medicaid clients.ⁱⁱⁱ Under the managed care model, HHSC contracts with managed care organizations (MCOs), also known as health plans, and pays them a monthly amount to coordinate and reimburse providers for health services for Medicaid members enrolled in their health plan. Each member receives Medicaid services through a managed care plan's network of providers. Members may choose an MCO, or have one selected for them if they don't. MCOs vary by service

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

delivery area and program. See <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/Managed-Care-Service-Areas-Map.pdf> for Medicaid and CHIP Service Areas. MCOs are required to provide all covered medically necessary services to their members. (See Chapter 7, Medicaid Managed Care.)

Within Medicaid managed care there currently are three comprehensive programs: STAR, STAR+PLUS, and STAR Health. These programs serve distinct populations with varying health care needs as described below.

State of Texas Access Reform (STAR)

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

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

STAR Health

HHSC worked with the Texas Department of Family and Protective Services (DFPS) to develop STAR Health as a medical care delivery system for children in state conservatorship, because 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, which began in April 2008, serves children as soon as they enter state conservatorship and continues to serve them in three transition categories:

- Young adults up to 22 years of age with voluntary foster care placement agreements;
- Young adults below 21 years of age who were previously in foster care and continue to receive Medicaid services; and
- Young adults below 23 years of age who are not eligible under the above categories, but who enroll in higher education.

HHSC administers the program under a contract with a single statewide MCO. STAR Health clients receive medical, dental, vision, and behavioral health benefits, including unlimited prescriptions. The program includes access to an electronic health record called the Health Passport, which contains a history of each child's demographics, doctor visits, immunizations, prescriptions, and other pertinent health-related information. The program also includes a 7-days-per-week, 24-hours-per-day nurse hotline for caregivers and DFPS caseworkers. Use of psychotropic medications is

carefully monitored. In 2010, the program began training and certifying behavioral health providers in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and training in trauma-informed care was made available to all caregivers and caseworkers to effectively manage behavior issues that can destabilize children's health status and foster family placement and to promote healing from trauma associated with abuse or neglect.

STAR+PLUS

STAR+PLUS is the agency's program for integrating the delivery of acute and long-term services and supports through a managed care system. Acute care, pharmacy, and long-term services and supports are coordinated and provided through a provider network contracted with MCOs. Eligible populations for STAR+PLUS include:

- Adults 21 and older who have a disability and qualify for SSI benefits or Medicaid because of low income.
- Adults 21 and older who qualify for Medicaid because they meet a nursing facility level of care and require STAR+PLUS Home and Community Based Services.
- Adults 21 and older receiving services through a community-based intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID) or through a 1915(c) Home and Community-Based Services waiver serving individuals with intellectual and developmental disabilities (IDD) receive acute care services only through STAR+PLUS . Dual eligibles (those receiving both Medicare and Medicaid) receiving services in a community-based ICF/IID or through a 1915(c) waiver are not included.
- Most children and young adults under age 21 receiving SSI or SSI-related benefits, including those receiving services in an ICF/IID or an ICF/IID waiver, may choose to enroll in STAR+PLUS or remain in traditional Medicaid.

As of September 1, 2014, STAR+PLUS is available statewide. There are thirteen STAR+PLUS service delivery areas (SDA). STAR+PLUS Medicaid members can select from at least two MCOs in each SDA. There are a total of five MCOs serving different STAR+PLUS SDAs throughout the state.

STAR Kids

STAR Kids is the managed care program that will provide acute and community-based medical assistance benefits to children and young adults with disabilities. The targeted date for STAR Kids is September 1, 2016. Children and youth under age 21 who either receive Supplemental Security Income (SSI) Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through the STAR Kids program. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids and will continue to receive long-term services and supports through their waiver program.

Children, youth, and their families will have the choice of at least two STAR Kids health plans and will have the option to change plans.

Dual Eligibles Integrated Care Demonstration

The Dual Eligibles 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. Under this initiative, one health plan called a STAR+PLUS Medicare-Medicaid Plan (MMP) will be responsible for the full array of Medicare and Medicaid-covered services. Eligible individuals will have access to a network of medical, behavioral health, and support services including acute care services covered under Medicare and long-term services and supports under Medicaid through one MMP. The Dual Demonstration will operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties and is scheduled for implementation on March 1, 2015.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, which includes Medicaid, federal block grant, state, and local funds. It serves people who are eligible for Medicaid or who meet other eligibility criteria and is operated by the Texas Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. Medicaid and other clients in a seven-county area in and around Dallas receive behavioral health services through NorthSTAR.

Children's Medicaid Dental Services

Beginning March 1, 2012, children's Medicaid dental services were provided through a managed care model to children and young adults under age 21 with limited exceptions. (See Chapter 7, Medicaid Managed Care, Children's Medicaid Dental Services.) Members who receive their dental services through this program are required to select a dental plan and a main dentist and are defaulted to a dental plan and main dentist if they do not. A main dentist serves as the member's dental home and is responsible for providing routine care, maintaining the continuity of patient care, and initiating referrals for specialty care.

Premium Assistance under Medicaid Programs

The Health Insurance Premium Payment (HIPP) program, currently administered by the HHSC Office of Inspector General and implemented in Texas in 1994, is a Medicaid program that reimburses eligible individuals for their share of an employer-sponsored health insurance premium payment. In 2013, an average of 9,600 Medicaid clients were enrolled in the Texas HIPP program. To qualify for HIPP, an employee must either be Medicaid eligible or have a family member that is Medicaid eligible.

The HIPP program may pay for clients and their family members to get employer-sponsored health insurance benefits when it is determined that the cost of insurance premiums is less than the cost of projected Medicaid expenditures. For example, a Medicaid-eligible child and the child's parent could be enrolled in the parent's employer-sponsored health insurance plan reimbursed through HIPP, if the cost of enrolling both individuals is less than the cost of the Medicaid expenditures.

Medicaid-eligible HIPP enrollees do not have to pay out-of-pocket deductibles, co-payments, or co-insurance for health care services that Medicaid covers when seeing a provider that accepts Medicaid. Instead, Medicaid reimburses providers for these expenses. HIPP enrollees who are not Medicaid eligible must pay deductibles, co-payments, and co-insurance required under the employer's group health insurance policy. Additionally, if a Medicaid-eligible HIPP enrollee needs a Medicaid covered service that is not covered by 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.

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

Currently, it takes three to five days to process reimbursement checks for eligible individuals. In an effort to shorten the reimbursement timeframes even more the use of electronic funds transfer began in August 2009. In 2013 an average of 80 percent of all premium reimbursements were made by electronic funds transfer.

Who are the Uninsured?

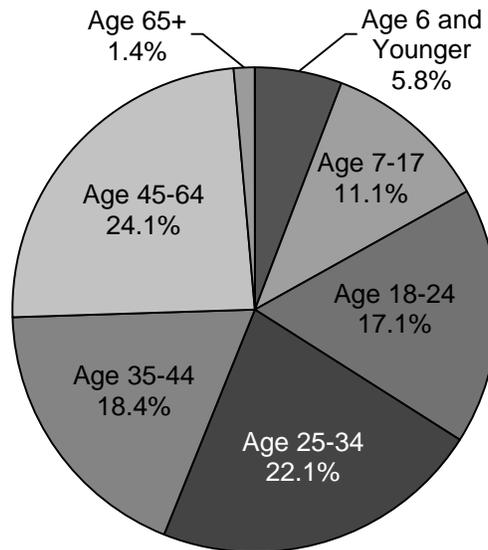
An estimated 6.4 million Texans, or 24.6 percent of the state population, had no health insurance in 2012.¹ Texas has the highest rate in the nation for people without insurance.² In 2012, approximately 1.1 million or 15.6 percent of Texas children under

age 18 (up from 15.4 percent in 2011) had no insurance.³ The national average was 8.9 percent.⁴

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

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

Figure 1.2: Total Uninsured Population in Texas by Age Group 2012



Source: U.S. Census Bureau. March 2013 Current Population Survey (CPS) for Texas.

Healthcare Coverage in Texas

Beginning in 2014, most people must have health insurance that meets minimum federal coverage standards or pay a tax penalty. Health benefit plans provided by employers and most state or federal government health plans satisfy the requirement.

Persons who do not have access to employer or government-sponsored health coverage can buy an individual plan to cover themselves and their families. Insurance

companies cannot deny coverage or charge more for those who have a preexisting condition.

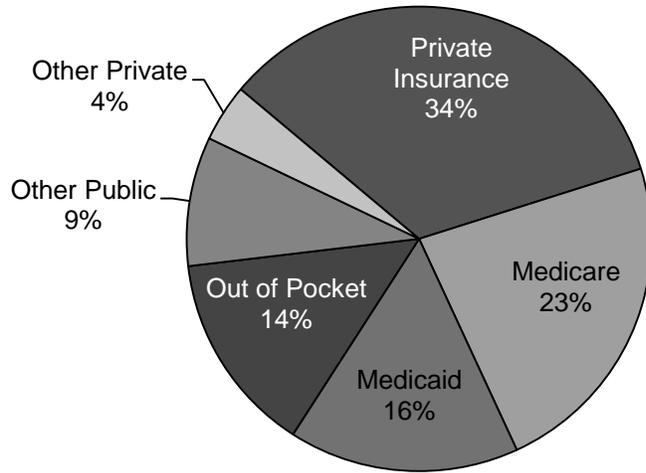
Individual plans can be purchased directly from companies and insurance agents or brokers. The Texas Department of Insurance's website www.texashealthoptions.com is a resource to help understand how to find and use health insurance. Coverage can also be purchased online through the federally operated insurance marketplace at HealthCare.gov, or by phone, toll-free at 1-800-318-2596.

Private Coverage

The limits of private insurance also affect Medicaid. In 2012, 65 percent of the non-elderly U.S. population had private health insurance coverage, most often in the form of employer-based coverage.⁶ That same year, private insurance paid for 34 percent of total national personal health care expenditures.⁷ **Figure 1.3** and **Figure 1.4** show national health care spending and sources of coverage.

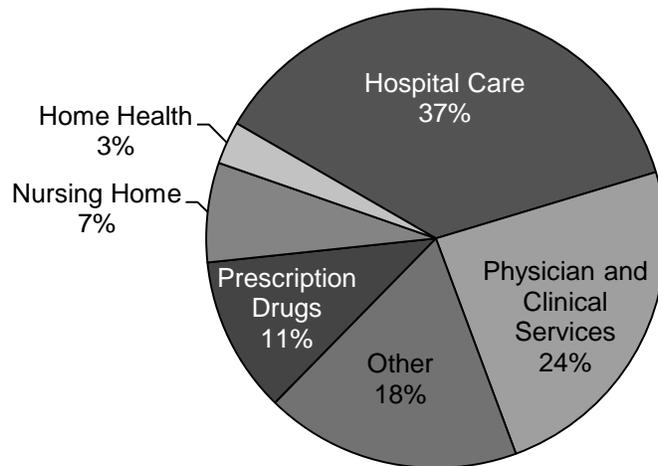
In Texas, the proportion of the population covered by employer-based health insurance is lower than the national average. Fifty-eight percent of Americans under age 65 were covered by employer-sponsored health coverage in 2012, compared with 52 percent of Texans.⁸ In 2012, 21 percent of working adults age 18 to 64 in the United States were uninsured, compared with 32 percent in Texas.⁹ Certain working uninsured individuals with low incomes may turn to Medicaid to meet their health care needs or those of their dependents when employer-sponsored, or health coverage through the health care exchange is not available or affordable.

Figure 1.3: U.S. Personal Health Care Expenditures by Source of Funding, 2012



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

Figure 1.4: U.S. Personal Health Care Expenditures by Category, 2012



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

Private insurance historically covered healthy individuals. Many of the sickest and most expensive patients did not have health insurance and had to rely on government programs or out-of-pocket spending to pay their bills. Although the Health Insurance

Portability and Accountability Act of 1996 (HIPAA) prohibited insurers from excluding individuals because of health problems or disabilities, in most cases insurers could exclude treatment of pre-existing conditions for up to 12 months. This changed with passage of the Patient Protection and Affordable Care Act (PPACA) of 2010, which prohibited health plans from denying or limiting coverage for pre-existing conditions for children under age 19 starting September 23, 2010, and for adults starting January 1, 2014.

Medicaid vs. Private Insurance

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

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

Other Forms of Government Health Coverage

There are forms of government health coverage other than Medicaid. The other programs that cover the most people are military and veterans' programs, the Children's Health Insurance Program (CHIP), and Medicare.

TRICARE is a health care plan available through the Department of Defense for those in the uniformed services and their families and for retired members of the military. The plan contracts with both military health care providers and a civilian network of providers and facilities.

CHIP provides primary and preventive health care to low-income, uninsured children up to age 19 with incomes up to 201 percent FPL, who do not qualify for Medicaid and unborn children with incomes up to 202 percent FPL. (See Chapter 9, Children's Health Insurance Program.)

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	Lifetime Maximum Benefit	Deductible
Medicaid: Children	Yes	Yes	Yes	Yes (unlimited)	None	None
Medicaid: Adults	Yes	No	Yes	Yes*	None	None
Typical Employee Benefit Package (individual adult or child)	Yes (Usually requires a co-pay)	Yes (Separate optional coverage with additional contribution)	No	Yes (Usually requires a co-pay)	No Limit**	\$675 - \$1,908 (varies by plan type and region)

* 3-prescription per month limit only applies to certain adults in fee for service. Children under age 21, nursing facility residents, home and community-based waiver clients, and STAR and STAR+PLUS adult enrollees receive unlimited prescription benefits.

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

Source: The Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2013 Annual Survey," 2013, <https://kaiserfamilyfoundation.files.wordpress.com/2012/09/8465-employer-health-benefits-2013.pdf> Section 4-Types of Plans offered, Section 7-Employee Cost Sharing, Section 9-Prescription Drug Benefits

Medicare, which is explained in greater depth in the following section, is health coverage for people age 65 or older or people under age 65 with certain disabilities. Medicaid and Medicare sometimes cover the same populations, and people eligible for both programs are called dual eligibles.

Medicare

The Social Security Act of 1965 created both Medicaid and Medicare. Medicare is a federally-paid and administered health insurance program. As of July 2012, it covered 51.8 million Americans.¹⁰

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

qualify may purchase the hospital coverage. The federal government finances the hospital insurance program primarily through a payroll tax on employers and employees.

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

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

Part D, the Medicare prescription drug benefit, was implemented in 2006. Previously, Medicare did not cover any outpatient prescription drugs, except for a few drugs that were covered under Part B. For those Medicare beneficiaries who qualified for Medicaid (called dual eligibles), Texas and other states offered prescription drugs through Medicaid.

The major impact of Part D on the Texas Medicaid program was that, as of early 2006, dual eligibles began receiving prescription drugs from Medicare, rather than Medicaid. In SFY 2013, approximately 366,000 dual eligibles in Texas received prescription drug coverage through Medicare Part D.¹¹ Once determined eligible for Medicare, CMS requires dual eligible clients to enroll in a Medicare Prescription Drug Plan for all their prescription drugs. However, Texas Medicaid continues to provide some limited drug coverage to dual eligibles for a few categories of drugs that are not covered under Medicare Part D.

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

Federal Health Care Reform Changes to Medicare Part D

The Patient Protection and Affordable Care Act provided for a \$250 rebate in 2010 for all Part D enrollees who enter the coverage gap (donut hole) and included a gradual

phase down of the beneficiary coinsurance rate in the donut hole from 100 percent to 25 percent by 2020. Clients in Texas pharmaceutical support programs such as the human immunodeficiency virus (HIV) and Kidney Health Care (KHC) programs at DSHS benefit from these changes.

State Role in Medicare

Medicare is financed and administered wholly at the federal level. Historically, states played no role in Medicare administration, however, since 1988, federal law has required that state Medicaid programs pay Medicare deductibles, premiums, and coinsurance for some low-income Medicare beneficiaries. Medicare also impacts Medicaid because of its coverage scope and limitations. For instance, Medicare does not currently cover some categories of medications that Medicaid covers, including some cough and cold products, vitamins and minerals, and over-the-counter medications. The Texas Medicaid program pays all of the cost of these drugs for dual eligibles. The Texas Medicaid program also pays the federal government to provide Medicare drug coverage for individuals who are dually eligible through what is commonly known as “clawback” payments. It is estimated that in SFY 2013, Texas Medicaid paid about \$1.1 billion for Medicare premiums and deductibles (Part A and Part B), and another \$375 million (all general revenue funds) for Medicare Part D “clawback” or give back. Taken together, this accounts for approximately six percent of the Texas Medicaid program budget, excluding disproportionate share and upper payment limit funds.

Medicare does not play a major role in funding long-term care services and supports. For example, Medicare only covers nursing home care required following a hospitalization. Coverage is limited to 100 days per “spell of illness,” and the beneficiary must be making progress toward rehabilitative goals for Medicare to cover the stay. In other words, the Medicare nursing home benefit does not cover long-term institutional services and supports. Medicaid, however, covers long-term institutional services and supports and thus covers the cost of nursing home care for dually eligible clients not paid by Medicare. Medicaid also covers a broad range of community-based long-term care services and supports, which are not included under Medicare.

Endnotes

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³ U.S. Census Bureau, Health Insurance Historical Tables, "Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2012,"
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⁴ U.S. Census Bureau, Health Insurance Historical Tables, "Table HIB-5: Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2012,"
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⁷ Centers for Medicare & Medicaid Services, Historical National Health Expenditures By Type of Service and Source of Funds: Calendar Years 1960 - 2012
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¹¹ Health and Human Services Commission, *Monthly MMA Dual Eligible Counts*.