

Texas Medicaid and CHIP in Perspective

Tenth Edition

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Texas Medicaid and CHIP in Perspective

Texas Health and Human Services Commission
Kyle L. Janek, M.D., Executive Commissioner

Office of the Chief Deputy Commissioner
Chris Traylor, Chief Deputy Commissioner

State Medicaid and CHIP Division
Kay Ghahremani, Associate Commissioner

P.O. Box 85200
Austin, TX 78708-5200
www.hhsc.state.tx.us

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Data Sources

Medicaid is a complex program involving multiple agencies and external partners that collect program statistics and financial information. Information contained in the 10th edition was current as of August 2014; however program and financial information may change after publication due to unforeseen changes such as changes to federal and state regulations and the state of the economy.

The following are the primary sources of data used in this publication:

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

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 Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information.

The Medicaid Numbers

Medicaid as a percentage of Texas budget, SFY 2013: **26.2 percent**ⁱ

Percentage of Texas Medicaid budget spent on children, SFY 2013: **27 percent**ⁱⁱ

Dollars spent on Texas Medicaid, FFY 2013, including Supplemental Health Care Payments: **\$33 billion**ⁱⁱⁱ

Texas Medicaid payments to nursing homes, FFY 2013: **\$2.4 billion**

Texas Medicaid prescription drug expenditures, SFY 2013: **\$2.7 billion**^{iv}

Percentage of Texas Medicaid clients under age 21, SFY 2013: **82 percent**^v

Percentage of Texas children on Medicaid or CHIP, CY 2013: **43 percent**

Percentage of nursing home residents covered by Medicaid, SFY 2012: **64.1 percent**

Percentage of births covered by Texas Medicaid in SFY 2013: **53.2 percent**

Percentage of Texas Medicaid clients in managed care, SFY 2013: **80 percent**^{vi}

Unduplicated number of Texans receiving Medicaid, SFY 2013: **4.67 million**

Average number of Texans with Medicaid each month, SFY 2013: **3.57 million**

Percentage of Texas population covered by Medicaid, SFY 2013: **17.5 percent**

ⁱ All funds, excluding disproportionate share hospital (DSH), uncompensated care (UC), and Delivery System Improvement Program (DSRIP).

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

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

^{iv} Includes Medicare “clawback” payments.

^v Receiving full Medicaid benefits.

^{vi} Receiving full Medicaid benefits.

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Chapter 1: Texas Medicaid in Perspective

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

What Is Medicaid?

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by the Health and Human Services Commission (HHSC). In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). 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)..

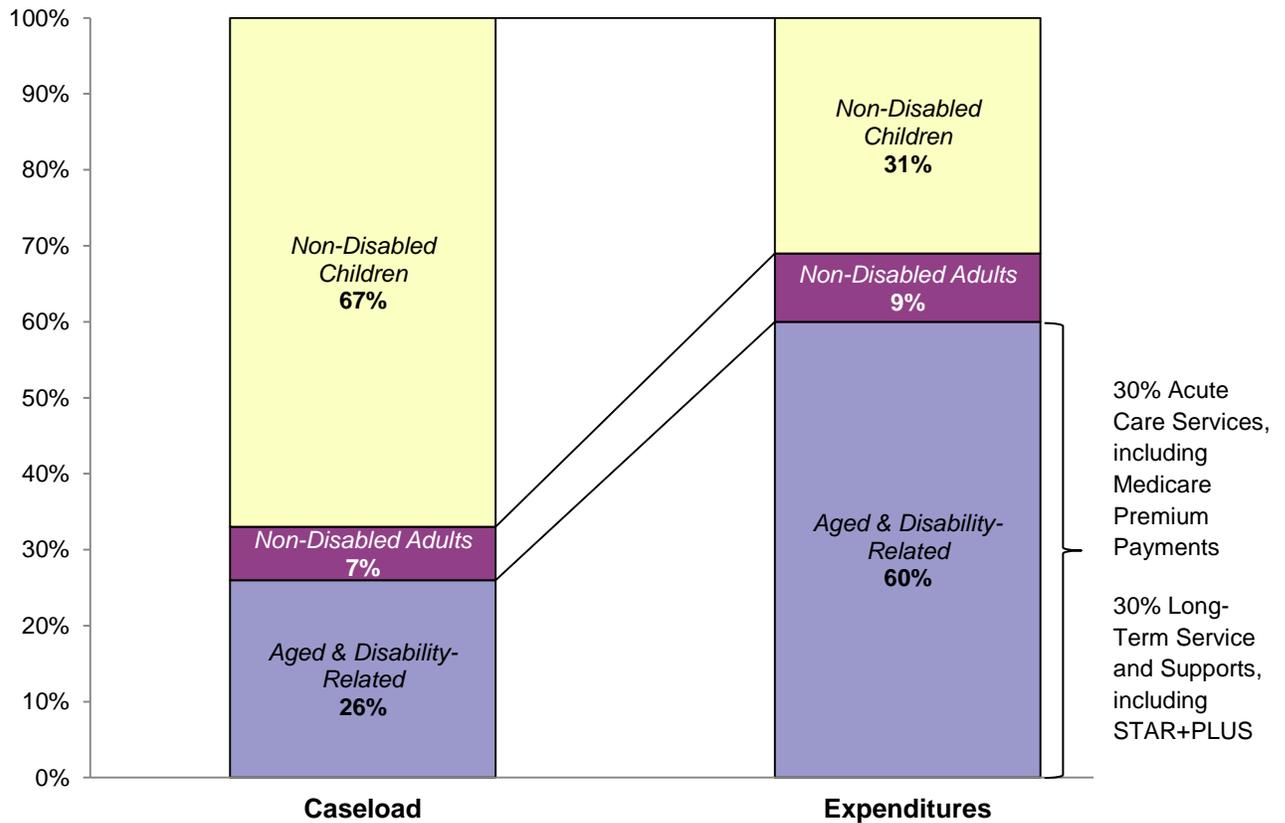
assistance percentage (FMAP). Each state's FMAP is different; in Texas, the federal government funded 59.30 percent of the cost of the Texas Medicaid program in federal fiscal year (FFY) 2013, while the state-funded the other 40.7 percent. (See Chapter 5, **Table 5.4**, Texas Federal Medical Assistance 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?

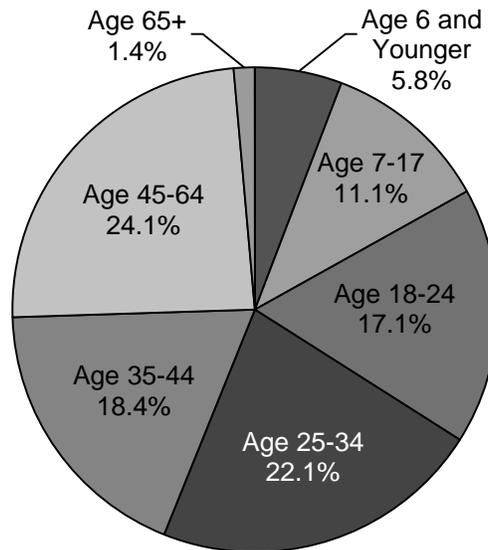
An estimated 6.4 million Texans, or 24.6 percent of the state population, had no health insurance in 2012.¹ Texas has the highest rate in the nation for people without insurance.² In 2012, approximately 1.1 million or 15.6 percent of Texas children under

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.

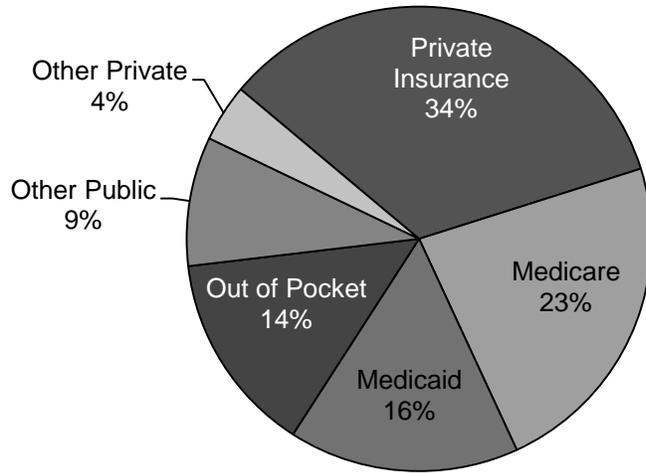
Individual plans can be purchased directly from companies and insurance agents or brokers. The Texas Department of Insurance's website www.texashealthoptions.com is a resource to help understand how to find and use health insurance. Coverage can also be purchased online through the federally operated 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.

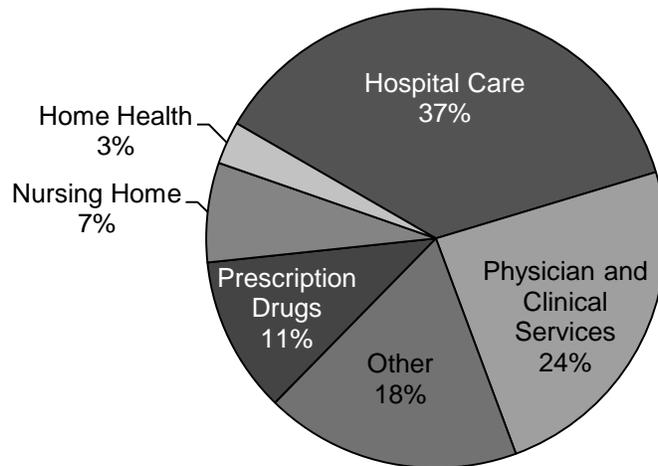
In Texas, the proportion of the population covered by employer-based health insurance is lower than the national average. Fifty-eight percent of Americans under age 65 were covered by employer-sponsored health coverage in 2012, compared with 52 percent of Texans.⁸ In 2012, 21 percent of working adults 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

¹ U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for all People--2012, Health Insurance Data:
<https://www.census.gov/hhes/www/cpstables/032013/health/toc.htm> (July 2014).

² U.S. Census Bureau, Health Insurance Historical Tables, "Table HIB-4: Health Insurance Coverage Status and Type of Coverage by State--All Persons: 1999 to 2012,"
http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (July 2014).

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,"
http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (July 2014).

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,"
http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (July 2014).

⁵ U.S. Census Bureau, "Current Population Survey," March 2013. Data analysis completed by the Strategic Decision Support Department of the Texas Health and Human Services Commission.

⁶ U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for all People--2012, Health Insurance Data:
<https://www.census.gov/hhes/www/cpstables/032013/health/toc.htm> (July 2014).

⁷ Centers for Medicare & Medicaid Services, Historical National Health Expenditures By Type of Service and Source of Funds: Calendar Years 1960 - 2012
<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html> (July 2014).

⁸ U.S. Census Bureau, Health Insurance Coverage Status and Type of Coverage by State and Age for all People--2012, Health Insurance Data:
<https://www.census.gov/hhes/www/cpstables/032013/health/toc.htm> (July 2014).

⁹ U.S. Census Bureau, "Current Population Survey," March 2013. Data analysis done by Strategic Decision Support of the Texas Health and Human Services Commission.

¹⁰ Centers for Medicare & Medicaid Services, "Medicare Enrollment Reports,"
<http://www.cms.hhs.gov/MedicareEnRpts/> (December 2014).

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

Chapter 2: Medicaid History and Organization

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

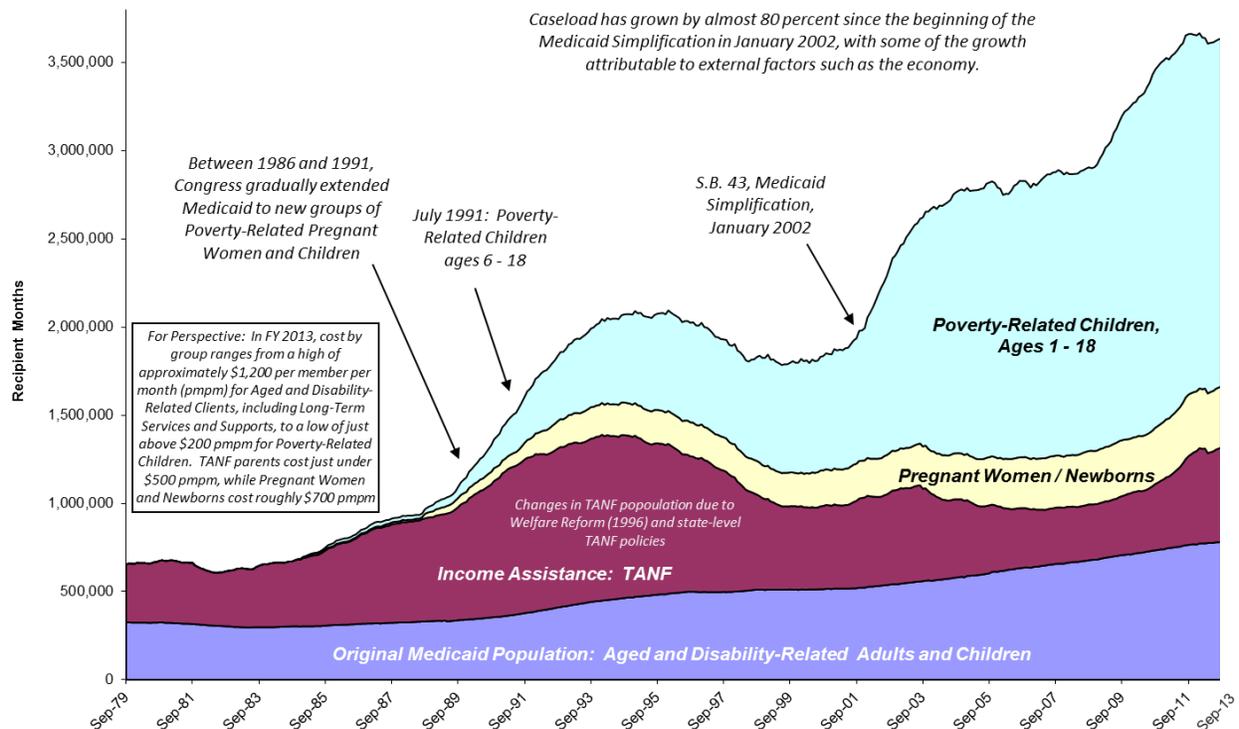
History and Background

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

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

Currently, over 3.9 million Texans are served each month by Medicaid, more than 72 percent of whom are non-disability-related children under age 21. **Figure 2.1** illustrates Texas Medicaid enrollment trends by category for September 1979 through August 2013.

**Figure 2.1: Medicaid Caseload by Group
September 1979–August 2013**



Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid's Early Years

Linked to Financial Assistance Programs

As originally enacted, Medicaid coverage was available only to persons eligible for Aid to Families with Dependent Children (AFDC), now referred to as Temporary Assistance for Needy Families (TANF). TANF is the federal-state cash assistance program for low-income families, usually headed by a single parent. To be able to receive Medicaid, individuals were required to be receiving cash assistance or welfare. In this sense, Medicaid was “linked” to welfare. Historically, Medicaid coverage has also been available to persons eligible for Supplemental Security Income (SSI) in Texas. SSI is a federal cash assistance program for low-income people age 65 and older or who have disabilities. In Texas, SSI recipients are automatically eligible for Medicaid. For this reason, Medicaid has also been “linked” to SSI in Texas.

Temporary Assistance for Needy Families

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

Each state sets its income eligibility guidelines for TANF cash assistance. Texas has historically maintained low TANF income caps. As of 2014, the TANF income cap for a parent with two children is \$188 per month. The TANF monthly cap is based on a set dollar amount and is not determined by the federal poverty level (FPL).

Supplemental Security Income

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

To be eligible for SSI, an individual must be at least 65 years old or have a disability, and have limited assets and income. A child may be eligible for SSI beginning as early as the date of birth; there is no age requirement. The individual’s income must be below the federal benefit rate (FBR). In 2014, the limit for an individual is \$721 a month in countable income and no more than \$2,000 in countable resources. The limit for couples is \$1,082 a month with no more than \$3,000 in countable resource. The amount of the SSI payment is the difference between the person’s countable income and the FBR.

De-Linking Medicaid and Cash Assistance

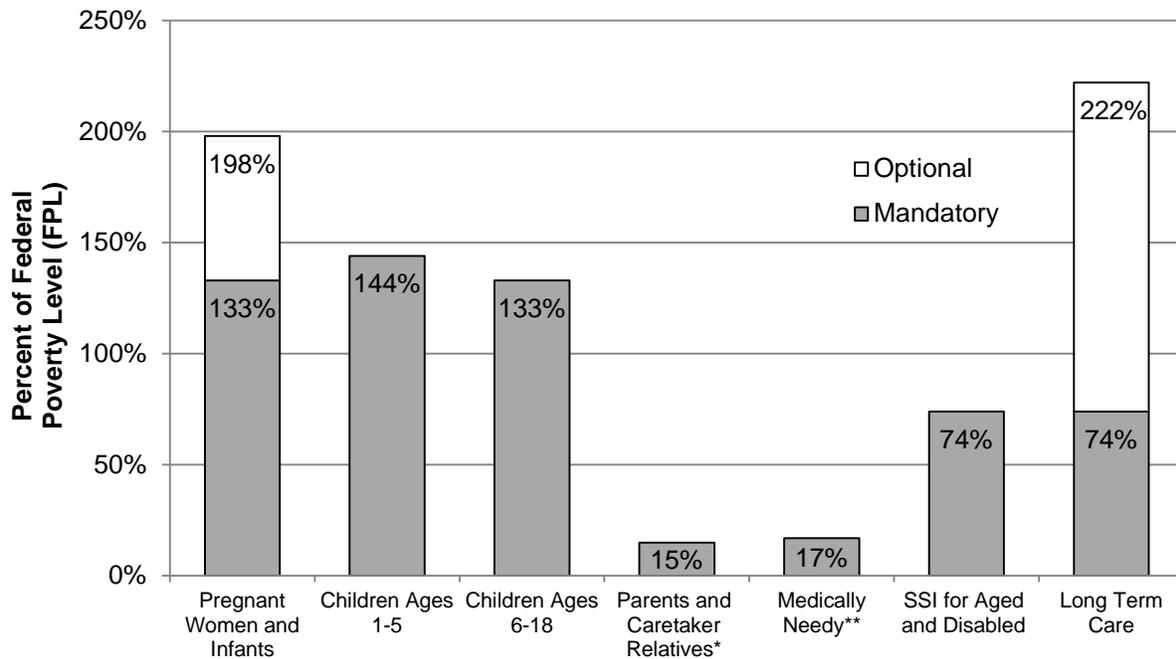
Historically, all Medicaid enrollees were either on SSI or welfare. Federal laws passed in the late 1980s mandated Medicaid coverage for groups of people ineligible for TANF or SSI. This resulted in a major expansion of the eligible population. Members of working families and others with low incomes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

The following program expansions resulted from federal mandates:

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

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

Figure 2.2: Texas Medicaid Income Eligibility Levels for Selected Programs, March 2014 (As a Percent of FPL)



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

*In SFY 2014, the monthly income limit for a *one-parent* household is **\$230** and the monthly income limit for a *two-parent* household is **\$251**.

For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2014 is **\$275 for a family of three, which is the equivalent of approximately 17 percent of FPL.

Medicaid Coverage

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

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

- Health professionals, such as doctors, nurses, physician assistants, chiropractors, physical therapists, clinical social workers, dentists, psychologists, and nutritionists;
- Health facilities, such as hospitals, nursing homes, institutions and group homes for people with an intellectual disability, clinics, and community health centers; and
- Providers of other critical services, such as pharmaceutical drugs, medical supplies and equipment, and medical transportation.

Acute Health Care

Medicaid pays for typical health services, such as physician and professional services, inpatient hospital services, and outpatient hospital and clinic services. These areas accounted for approximately 40 percent of the Texas Medicaid program health expenditures in state fiscal year (SFY) 2013. Medicaid also provides a broader array of acute health services to children than do most private health plans, such as dental benefits.

Long-term Services and Supports

Medicaid covers a broad range of long-term services and supports (LTSS) to enable people age 65 and over and those with disabilities to experience dignified, independent, and productive lives in safe living environments through a continuum of services and supports ranging from in-home and community-based services to institutional services. The demand for LTSS in Texas continues to grow and is influenced by two key trends: the aging of the population and the continuing prevalence of individuals with co-occurring behavioral health needs. These services and supports account for approximately 18 percent of all Texas Medicaid services expenditures in SFY 2013.

People age 65 and Older and Those with Physical Disabilities

LTSS for people age 65 and older and those with physical disabilities include nursing facility services for people whose medical conditions require the skills of a licensed nurse on a regular basis and home and community-based services to help people maintain their independence and prevent institutionalization.

People with Intellectual and Developmental Disabilities

LTSS for people with intellectual and developmental disabilities include residential services in intermediate care facilities for individuals with an intellectual disability or related conditions (ICF/IID) and home and community-based services for individuals who qualify for ICF/IID level of care.

Mandatory and Optional Spending

The federal government mandates certain benefits and coverage levels. In addition, Texas has also chosen to cover some of the optional services allowed but not required by the federal government (See Chapter 6, **Table 6.1**, Mandatory and Optional Services Covered by Texas Medicaid.) Eliminating some optional services and eligibility categories could increase Medicaid costs. For example, dropping the option of covering prescription drugs could ultimately cost Medicaid more. People who do not receive needed drugs may require more physician services, increased hospitalizations, or even LTSS. Similarly, Texas potentially saves money by covering pregnant women up to 198 percent of the FPL because some women may not otherwise receive adequate prenatal care. This coverage helps prevent poor and costly pregnancy outcomes.

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

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

Basic Principles

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

Statewideness

All Medicaid services must be available statewide and may not be restricted to residents of particular localities.

Comparability

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

Freedom of Choice

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

Amount, Duration, and Scope

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

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

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

How Medicaid Is Financed

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

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

Texas' matching rates for federal fiscal years (FFYs) 2015 and 2016 are 58.05 and 57.23 percent; that is, the state must pay 41.95 and 42.77 percent, respectively. Texas uses what is called a "one-month differential" FMAP figure. This takes into account differences between the FFY (October through September), on which the federal FMAP rate is based, and the SFY (September through August). The "one month differential" FMAP for Texas in SFY 2015 (which includes one month of the FFY 2014 rate of 59.69 percent and 11 months of the FFY 2015 rate of 58.05 percent) results in a "blended" or adjusted FMAP of 58.10 percent.

The federal government matches other program costs at a different rate than the FMAP rate for most direct client services. Medicaid administrative costs, related to program administration, are generally matched at 50 percent. Administrative services that can be performed only by skilled professional medical personnel draw a 75 percent federal match. Family planning services draw a 90 percent federal match. Certain approved information system development costs also are matched at 90 percent. (See Chapter 3, Federal Health Care Reform, Enhanced Funding for Eligibility, Enrollment, and Claims Systems.)

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

(See Chapter 4, Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.)

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

How Medicaid Operates in Texas

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

Federal Oversight

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

While states are responsible for the hands-on operation of Medicaid, the federal government plays a very active oversight role. The Centers for Medicare & Medicaid Services (CMS), an agency within the U.S. Department of Health & Human Services, oversees the Medicaid program. CMS approves the Medicaid state plan that each state creates. The Medicaid state plan is a dynamic document that functions as a state's contract with CMS. The state plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas Medicaid program. Significant changes to a state's Medicaid program require the state to submit a state plan amendment for CMS approval. CMS also approves any waivers for which states can apply. Medicaid waivers allow states the flexibility to test new ways to deliver and pay for health care services.

Single State Agency

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

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

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

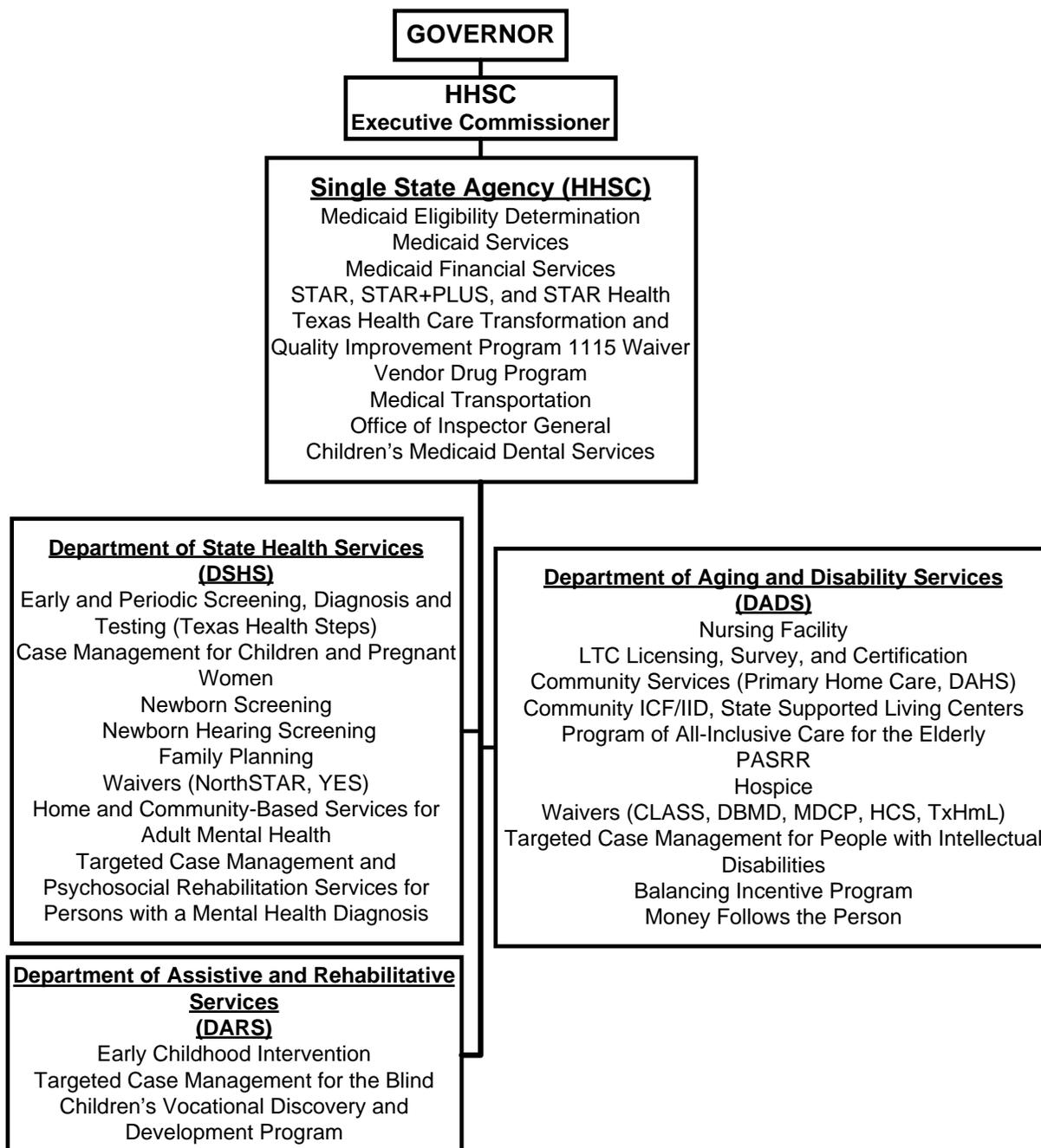
Operating Departments in Texas

Federal law allows the single state agency to delegate some of its functions to other state departments, so long as it retains administrative discretion in the administration or supervision of the program and the adoption or approval of program policy, and monitors quality of care and program integrity for delegated functions. Functions that may be delegated include:

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

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

Figure 2.3: Medicaid Operating Departments



Medicaid Waivers

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These waivers allow states to waive certain of Medicaid's basic principles, required array of benefits, mandated eligibility and income groups, or

combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.ⁱ

States seek waivers to:

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

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

Research and Demonstration 1115 Waivers

Purpose

The purpose of the 1115 Waivers is to allow flexibility for states to test substantially new ideas for operating their Medicaid programs and waives a variety of requirements, such as comparability or statewideness.

States may use these waivers to structure statewide health system reforms and to test the value of providing services not typically covered by Medicaid or allow innovative service delivery systems to improve care, increase efficiencies, and reduce costs.

Requirements

Section 1115 waivers must be budget neutral to the federal government for the duration of the waiver.

Timeframe

Generally, Section 1115 waivers are five-year waivers, subject to renewal. CMS analyzes impact on utilization, insurance coverage, public and private expenditures, quality, access, and satisfaction.

Freedom of Choice 1915(b) Waivers

Purpose

Section 1915(b) waivers allow states to use a “central broker” (e.g., enrollment broker) to assist people in making MCO choices, use cost savings to provide additional

ⁱ More information on Medicaid waivers can be found at: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (December 2014).

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

Requirements

Section 1915(b) waivers must be cost-effective; client access, quality of care, and cost must not be negatively impacted by implementation of the waiver.

Timeframe

Section 1915(b) waivers are two-year waivers. States may renew these waivers, but CMS requires an independent assessment to show that the cost, quality, and access have not been compromised.

Home and Community-based Services 1915(c) Waivers

Purpose

Section 1915(c) waivers allow states to provide community-based services as an alternative for people who meet eligibility criteria for care in an institution (nursing facility, ICF/IID, or hospital).

States may use these waivers to serve people age 65 and older, those with physical disabilities, an intellectual or other developmental disability, or mental illness. States may also target more specialized populations such as individuals with traumatic brain injuries or those with sensory impairment. Through 1915(c) waiver programs, states may provide services that are not found in the Medicaid state plan or that extend state plan services. Examples include case management, homemaker/home health aide, personal care, habilitation, respite care, non-medical transportation, in-home support, special communication, minor home modifications, and adult day care.

Requirements

Section 1915(c) waivers must be cost neutral for the duration of the waiver. In other words, the aggregated cost of serving individuals in the waiver must be the same or less than the cost to serve them in an institution. Also, the state must assure safeguards are in place to protect individuals' health and welfare.

Timeframe

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

Administration of Texas Medicaid

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

Texas Medicaid Management Information System

The majority of Texas Medicaid fiscal agent and claims administrative functions are supported through a contractual relationship between HHSC and a prime vendor (i.e., fiscal agent or claims administrator contractor). The prime vendor conducts various duties on behalf of the state and manages the Medicaid claims administrative and operational functions and manages information systems that are collectively known as the Texas Medicaid Management Information System (TMMIS). These functions include claims and encounters processing, provider enrollment, client outreach, provider outreach, provider and staff training, among many other operational and contractually required duties necessary to effectively manage and administer the Medicaid program. State programs administered by the other four HHS enterprise agencies also are served under this arrangement.

Claims Administrator and Related Functions

The TMMIS contractor currently handles the development and operation of TMMIS including, but not limited, to the following functions:

- *Managed care encounter processing and reporting for all Medicaid and state programs*—ongoing support to managed care organizations (MCOs) for successful submission and reporting of encounter and provider data. The claims administrator also collects and validates MCO encounter data for use in service and health plan quality evaluations.
- *Medicaid provider enrollment*—provider enrollment, provider education and training, and development and maintenance of the provider procedures manual.
- *Client eligibility verification*—verifying items such as client eligibility, long-term care medical necessity, long-term care client service plans, and benefit limitation/usage information.
- *Financial management and administrative reporting*—administrative and infrastructure tasks, such as the development and maintenance of the fee schedule, rate analysis, pricing activities, and other daily operations. This function also supports financial recoupment, adjustment, and accounts receivable maintenance.

Other functions to support Medicaid and state-supported programs include, but are not limited, to the following:

- *Medicaid fee-for-service (FFS) claims processing*—processes and adjudicates all FFS claims for Medicaid and other state-supported program clients not enrolled in an MCO, including Medicaid acute care, long-term care, Texas Women’s Health Program, and CSHCN program services.
- *FFS Provider reimbursement*—provider inquiry resolution, electronic claims submission support, incorporation of reference tables (i.e., diagnosis codes, procedure codes, provider tables, recipient tables, claims history tables, etc.), and ad hoc reporting.
- *Processing medical and dental prior authorizations*—the determination, approval, and referral of the prior authorization; prior authorization administrative reviews; and appeals support and coordination.
- *Fair hearing support*—supporting a client's right to receive due process in an independent, fact-based review of a denied benefit, service, or payment limitation decision made by the vendor.
- *Managing incoming client and provider calls*—call center management of provider and client inquiries, supplying information and supporting issue resolution.
- *Third party resources functions and support for identification and verification of non-Medicaid insurance*—researching, identifying, and invoicing other payment resources for services provided by Medicaid to assure Medicaid is the payer of last resort.
- *Surveillance and utilization review*—the analysis and comparison of individual providers to peer groups, thus identifying atypical practices and utilization behaviors, resulting in recognition of trends and development of forecasts used for future planning and decision making. This information is shared with HHSC Office of Inspector General to identify providers who are potentially committing waste, fraud, or abuse.

Pharmacy Administration

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

Pharmacy Claims and Rebate Administrator

The pharmacy claims and rebate administrator processes and adjudicates all FFS outpatient prescription drug claims for Medicaid and the Texas Women’s Health, DSHS Kidney Health Care (KHC), and CSHCN programs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores MCO encounter data to support program oversight of prescription drug benefits in managed care.

Pharmacy Prior Authorization Vendor

The pharmacy prior authorization vendor evaluates prior authorization requests submitted through a call center and from the FFS pharmacy point-of-sale system for drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

Preferred Drug List Vendor

The preferred drug list vendor provides information to the Pharmaceutical and Therapeutics (P&T) Committee on the clinical efficacy, safety, and cost-effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the P&T Committee with the development and maintenance of the PDL.

Retrospective Drug Utilization Review Vendor

The retrospective drug utilization review vendor performs retrospective drug utilization reviews (DUR) to assist health care providers in delivering appropriate prescription pharmaceutical drugs to FFS Medicaid clients.

Medicaid Managed Care

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

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

In 1999, the state implemented a mental health and substance abuse pilot called NorthSTAR in the Dallas service area that integrates funding and delivery of behavioral health services to Medicaid and indigent clients, providing a continuum of care across public funding sources.

In 2003, the 78th Legislature directed HHSC to expand managed care further. In 2005, HHSC expanded Primary Care Case Management (PCCM) to the counties not covered by STAR MCOs. PCCM was a form of Medicaid managed care that used a network of primary care and other health care providers to provide a medical home and health care services to individuals in Medicaid. PCCM was a state-operated plan in which providers

were contracted directly with the state. In 2006, HHSC entered into new STAR contracts in nine urban service areas and withdrew PCCM from these areas. HHSC also entered into new contracts for CHIP in 2006. (See Chapter 9, Children's Health Insurance Program.)

In 2005, the 79th Legislature directed HHSC to use cost-effective models to better manage the care of Medicaid clients who are age 65 and older and those with disabilities. The STAR+PLUS Hospital Carve-Out model, created by the 2006-07 General Appropriations Act (GAA) (Article II, Special Provisions, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), was a partially capitated managed care model designed to integrate acute and long-term services and supports. The STAR+PLUS Hospital Carve-Out model was implemented in the Harris, Harris-Expansion, Nueces, and Travis service areas in February 2007. Inpatient hospital services (with some exceptions for certain behavioral health services) were "carved out" of the MCO's capitation and paid through the traditional Medicaid fee-for-service (FFS) system.

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

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

The 2012-13 GAA, (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011), assumed a cost savings to the state budget resulting from the expansion of Medicaid managed care statewide. Effective September 1, 2011, PCCM Medicaid clients in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR or STAR+PLUS Medicaid managed care program. In March 2012, HHSC entered new contracts with MCOs in 11 service areas and eliminated PCCM from 174 counties. Other changes implemented included delivering pharmacy benefits via the managed care model, including in-patient hospital services as a capitated benefit in STAR+PLUS, and implementing the dental managed care model for children in Medicaid.

S.B. 7, 83rd Legislature Regular Session, 2013, directed several expansions of managed care impacting various populations. These expansions lay the foundation for a statewide integration into managed care of long-term services and supports for children and adults with disabilities. On September 1, 2014, STAR+PLUS expanded to the Medicaid Rural Service Area (MRSA), providing acute care and long-term services and supports to those age 65 and older and those with disabilities. Adults with intellectual and developmental disabilities (IDD) being served through a 1915(c) IDD waiver and those receiving services in a community-based Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) also began receiving their acute care services through STAR+PLUS on this date. On March 1, 2015, HHSC will begin delivering nursing facility benefits for most adults ages 21 and older through the STAR+PLUS managed care model.

In 2014, Texas partnered with the CMS to create the Texas Dual Integrated Care Project, a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid. MCOs that provide care coordination and services for Medicaid clients age 65 and older and those with disabilities in six counties through the state's STAR+PLUS program will also cover Medicare benefits for these dual eligible clients. The project is scheduled to begin March 1, 2015.

S.B. 7, 83rd Legislature, Regular Session, 2013, also directed HHSC to develop a managed care program, called STAR Kids, tailored to the needs of children and young adults with disabilities, including those receiving benefits under the Medically Dependent Children Program (MDCP) waiver. STAR Kids has a proposed implementation date of September 1, 2016.

External Quality Review Organization (EQRO)

The EQRO performs three Centers for Medicare & Medicaid Services (CMS) required functions as required by the Balanced Budget Act of 1997 related to Medicaid managed care quality. The EQRO validates MCOs' performance improvement projects, validates performance measures, and conducts a review to determine managed care organizations' compliance with certain federal Medicaid managed care regulations. The Institute for Child Health Policy (IHP) has been the external quality review organization for HHSC since 2002. HHSC's EQRO follows CMS protocols to assess access, utilization, and quality of care for members in Texas' CHIP and Medicaid programs.

Detecting Fraud and Abuse

The 78th Legislature created the Office of Inspector General (OIG) in 2003 to strengthen HHSC's authority and ability to combat fraud, waste, and abuse in HHS programs. To fulfill its mandate, OIG maintains clear objectives, priorities, and performance standards, which emphasize coordinating investigative efforts, ensuring allocation of resources to

cases with the strongest supporting evidence and greatest potential for monetary recovery, and maximizing opportunities to refer cases to the Office of the Attorney General.

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

- Issuing sanctions and performing corrective actions against providers and clients;
- Auditing the use of state and federal funds;
- Researching, detecting, and identifying fraud and abuse to ensure accountability and responsible use of resources;
- Conducting investigations and reviews and making referrals to the appropriate outside agencies for further action;
- Recommending policies to enhance the prevention of fraud, waste, and abuse; and
- Providing education, technical assistance, and training to promote cost-avoidance activities and to sustain improved relationships with providers.

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

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

- Published an HHS enterprise-wide policy on fraud and abuse identification and reporting;
- Conducted a risk assessment of all HHS agencies, which allowed OIG to allocate its resources in the resulting audit plan to the highest risk areas;
- Implemented new provider integrity initiatives required under the Affordable Care Act, including enhanced provider screening requirements and credible allegation of fraud (CAF) payment holds;
- Adopted new rules implementing S.B. 1803, 83rd Legislature, Regular Session, 2013, that enhance existing due process procedures for providers;
- Adopted new rules for the Lock-in Program, formerly known as the Limited Program. The Lock-in Program allows OIG to restrict (lock-in) a Medicaid recipient to a designated health care and/or pharmacy provider. OIG may assign a Medicaid recipient to a single primary care provider and/or pharmacy for any of the following reasons: a recipient has used health care or pharmacy services at a frequency or amount that is not medically necessary and exceeds standards established by HHSC; the client received duplicative, excessive, or conflicting

health care or pharmacy services; or a review of client use shows abuse, misuse, or suspected fraudulent actions related to Medicaid benefits and services. The Lock-In Program is designed to control the inappropriate use of medical services and promote quality care;

- Expanded criminal Abuse, Neglect, and Exploitation (ANE) investigations to include incidents arising in State Hospitals, in addition to the State Support Living Center (SSLC) investigations that have been ongoing since 2009;
- Integrated teams of performance auditors and medical professionals in its Compliance Division to improve efficiency of audits and minimize disruption of provider operations.

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

Integrated Eligibility Determination

HHSC uses an integrated system to determine eligibility for Medicaid, CHIP, Supplemental Nutrition Assistance Program (SNAP), and TANF. The eligibility system offers convenient access to eligibility services through multiple channels, including a self-service website (www.YourTexasBenefits.com), a smartphone app, a network of local eligibility offices and community-based organizations, and the 2-1-1 phone service.

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

To continue to improve the efficiency and effectiveness of the eligibility system, HHSC is enhancing the self-service options available to clients through www.YourTexasBenefits.com and the Your Texas Benefits smartphone app.

On the website, clients can:

- Create an online account and view case details;
- Submit applications and redeterminations;
- Upload verifications;
- Report changes;
- Sign up for email alerts and text reminders; and
- Print temporary Medicaid identification cards.

The smartphone app is intended to complement (not replace) [YourTexasBenefits.com](http://www.YourTexasBenefits.com). Its features focus on case management functions easily done on a smartphone. Examples include uploading documents and viewing basic case facts.

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

Eligibility Support Services and Enrollment Contractors

The eligibility support services and enrollment contractors provide business services to support the state's determination of client eligibility for Medicaid, CHIP, SNAP (formerly known as Food Stamps), and TANF programs; operate four customer care centers; assist with eligibility services case support; enroll Medicaid and CHIP clients in managed care organizations (MCOs); and conduct/provide Outreach and Informing services to Texas Health Steps clients and various community organizations.

Federal and State Legislation Affecting Texas' Medicaid and CHIP Programs

Nationally and in Texas, CHIP and Medicaid programs change in response to legislative requirements. The following sections include highlights from the 83rd Texas Legislative Session and a summary of relevant federal legislation since 1965.

Highlights of Texas Legislation Affecting Medicaid and CHIP from the 83rd Legislature, Regular Session, 2013

S.B. 7 - Improving the Quality & Delivery of Medicaid Acute Care Services and Long-Term Care Services and Supports

S.B. 7 authorizes numerous transformative initiatives for the Medicaid program. The initiatives integrate additional services and populations into Medicaid managed care and expand upon efforts to create performance-based payment systems to reward outcomes and control costs. S.B. 7 also increases community-based options for individuals with disabilities.

For individuals with intellectual and developmental disabilities (IDD), S.B. 7 requires the establishment of a pilot program to integrate acute and long-term care services to test managed care strategies based on capitation. The bill also allows for a comprehensive assessment and resource allocation process to help ensure the amount of services provided to individuals with IDD is appropriate, and-subject to the availability of federal funding-allows for specialized training and deployment of behavioral intervention teams for individuals with IDD at risk of institutionalization.

In addition to redesigning services for those with IDD, S.B. 7 carves nursing facilities into the STAR+PLUS Medicaid managed care program; requires the phasing in of acute care services for all waiver participants into managed care; requires implementation of the most cost-effective option for delivery of basic attendant and habilitation services for individuals with disabilities; and establishes the STAR Kids Medicaid managed care model for children and young adults with special needs. S.B. 7 also establishes five committees to advise and help oversee the implementation of the initiatives described in the bill.

S.B. 8 - Improving the Delivery of Certain Health & Human Services

S.B. 8 institutes several new requirements for Texas Medicaid and CHIP, mostly related to the detection and prevention of fraud, waste, and abuse. The bill requires HHSC to establish a new data analytics unit to employ data analysis designed to improve contract management, detect data trends, and identify anomalies related to utilization, providers, payment methodologies, and adherence to requirements in Medicaid and CHIP managed care and FFS contracts.

The bill limits marketing activities for Medicaid and CHIP providers and requires HHSC to establish a process for reviewing and approving marketing materials.

The bill clarifies the HHSC Office of Inspector General's scope of authority and allows the office to employ peace officers.

S.B. 8 requires revisions to the state's Medical Transportation Program (MTP), requiring HHSC to operate the program under a managed care model using what are termed "Managed Transportation Organizations" to coordinate MTP services in 11 regions.

The bill places new requirements on provider licensure for emergency medical services (EMS) providers, requiring EMS providers that participate in Medicaid to submit a surety bond to the state.

Finally, the bill establishes legislative intent regarding parental accompaniment requirements for Medicaid services. The language reinforces the requirement that a

child's parent must attend certain Medicaid appointments with the child for a provider to be eligible for reimbursement.

S.B. 45 - Provision of Employment Assistance & Supported Employment to Medicaid Waiver Participants

S.B. 45 requires HHSC to provide employment assistance and supported employment in Medicaid waiver programs to assist Medicaid clients with locating and maintaining paid employment in the community. The bill defines "employment assistance" as helping the individual locate paid employment in the community. The term includes identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions; locating prospective employers offering employment compatible with an individual's identified preferences, skills, and requirements; and negotiating the individual's employment. The bill defines "supported employment" as assisting an individual with a disability who requires intensive, ongoing support to sustain paid employment through adaptations, supervision, and training related to an individual's diagnosis.

S.B. 58 - Integration of Behavioral Health and Physical Health Services into Managed Care

S.B. 58 carves into managed care mental health rehabilitation and mental health targeted case management, which formerly were provided through the fee-for-service delivery model by the Local Mental Health Authorities (LMHAs). The bill excludes the NorthSTAR service area. It also requires that HHSC develop two health home pilots and a Behavioral Health Integration Advisory Committee. In addition, it requires DSHS to create community collaboratives for people who are homeless, people with mental illness and those with substance abuse problems. It also requires DSHS to establish and maintain a mental health and substance abuse treatment public reporting system.

S.B. 126 - Creation of a Mental Health & Substance Abuse Reporting System

S.B. 126 requires DSHS to collaborate with HHSC to establish and maintain a public reporting system on performance and outcome measures related to mental health and substance abuse. The system is intended to allow comparison between community mental health centers, the NorthSTAR program, and entities or persons that contract with the state to provide substance abuse treatment, such as Substance Abuse Prevention and Treatment (SAPT) grantees. DSHS published this information on their website in January 2014. In addition, information on Medicaid managed care performance and outcome measures specific to mental health and substance abuse are

currently available on the HHSC and DSHS websites. The bill also requires a study to determine the feasibility, costs, and impact to the state, managed care organizations, and providers of collecting the outcome measures listed in S.B. 126.

S.B. 492 - Prescribed Pediatric Extended Care Centers

S.B. 492 establishes Prescribed Pediatric Extended Care Centers (PPECCs) in Texas traditional Medicaid and Medicaid managed care. PPECCs provide non-residential, facility-based care as an alternative to private-duty nursing (PDN) for individuals under the age of 21 with complex medical needs. The bill restricts service hours to no more than 12 hours in a 24-hour period per child and directs HHSC to establish a reimbursement rate that is no more than 70 percent of the average hourly PDN rate. Receiving services in a PPECC does not supplant a child's right to PDN services when they are determined medically necessary.

S.B. 492 limits PPECC services to individuals who are "medically dependent or technologically dependent." This term is defined in S.B. 492 as a child who, "due to an acute, chronic, or intermittent medically complex or fragile condition or disability requires physician prescribed, ongoing, technology-based skilled nursing care to avert death or further disability or the routine use of a medical device to compensate for a deficit in a life-sustaining body function." The bill also requires nursing services received in a PPECC to be prescribed by the client's primary care physician.

S.B. 644 - Standardized Prior Authorization Request Form for Prescription Drug Benefits

S.B. 644 requires HHSC to implement a single, standard form adopted by the commissioner of the Texas Department of Insurance (TDI) that Medicaid and CHIP providers will use to request prior authorization of prescription drug benefits. The bill requires HHSC to participate in an advisory committee established by TDI to develop the form and make the form available on the HHSC website.

The bill requires HHSC to electronically exchange prior authorization requests with a prescribing provider who has e-prescribing capability and who initiates a request electronically not later than the second anniversary of the date national standards for electronic prior authorization of benefits are adopted.

H.B. 915 - Administration and Monitoring of Medications Provided to Foster Care Children

H.B. 915 directs the Department of Family and Protective Services to make specific changes to the management and administration of psychotropic medications for children in state conservatorship.

The bill also requires HHSC to use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for children who are dually eligible for Medicaid and Medicare and children who are residents in another state but are placed in Texas under the supervision of DFPS through an agreement under the Interstate Compact on the Placement of Children (ICPC). HHSC currently monitors psychotropic prescribing for children in foster care.

S.B. 1106 - Maximum Allowable Cost Lists under a Managed Care Pharmacy Benefit Plan

S.B. 1106 establishes several new requirements to increase transparency and access to Medicaid managed care plans' maximum allowable cost (MAC) drug lists. The bill requires the Medicaid MCOs and pharmacy benefit managers (PBMs) to ensure that drugs on the MAC lists meet a certain nationally-recognized rating and are generally available for purchase by pharmacies in the state from national or regional wholesalers. The MCOs and PBMs must provide their network pharmacies with the sources used to determine the prices for drugs on the MAC lists; make the MAC lists readily accessible to network pharmacies; and follow specific requirements when setting and updating MAC drug prices.

The bill requires MCOs and PBMs to allow a network pharmacy to challenge a MAC price for a drug. If the challenge is successful, the MCO and PBM must adjust the price. If it is denied, the MCO and PBM must provide the network pharmacy with the reason for the denial. MCOs and PBMs must report the total number of challenges made and denied every 90 days to HHSC and must notify HHSC after implementing a practice of using a MAC list for drugs dispensed at a retail pharmacy but not by mail.

S.B. 1150 - Provider Protection Plan to Ensure Efficiency & Reduce Burdens

S.B. 1150 adds protections for Medicaid health care providers including prompt payment and reimbursement, prompt credentialing, and elimination of "red tape."

The provider protection plan must provide for prompt payment and prompt and accurate adjudication of claims through provider education on claims submissions and the acceptance of uniform forms through an electronic portal, including Health Care Financing Administration (HFCA) Forms 1500 and UB-92.

Electronic processes, including the use of an Internet portal, must be established for submission of claims, prior authorization requests, appeals, clinical data and other required documentation submission, and to obtain electronic remittance advice, explanation of benefit statements, and other standardized reports.

S.B. 1216 - Standardized Request Form for Prior Authorizations

S.B. 1216 requires the commissioner of the Texas Department of Insurance (TDI) to prescribe a standard single form to be used by health insurance and benefit plans to request prior authorization for health care services. Medicaid, Medicaid managed care programs, CHIP, and plans covering employees of the state of Texas, most school districts, and the University of Texas and Texas A&M systems are required to use the single form. The form must allow electronic submission from the provider to the health benefit plan.

S.B. 1216 further requires TDI to appoint and consult a committee to advise the commissioner upon the practical, technical, and operational aspects of developing the single form. The committee will be composed of an equal number of physicians, other health care providers, hospitals, representatives of health benefit plans, and HHSC representatives. S.B. 1216 requires that the commissioner consult with the advisory committee as well as take into consideration any widely used national standards in the development of the form. Biennial review of the form is required. Once adopted, the use of the single form for prior authorization by all health insurance and benefit plans is required.

S.B. 1542 - Improvements to Quality of Care and Cost-Effectiveness of the Medicaid Program

S.B. 1542 directs HHSC to develop a quality improvement process to solicit suggestions for clinical initiatives designed to improve the quality and cost-effectiveness of care provided in Medicaid. HHSC must develop an evaluation process that includes a public comment period to analyze the feasibility of:

- Clinical initiative suggestions selected by HHSC for consideration;
- Requiring hospitals to implement evidence-based protocols, including early goal-directed therapy, in the treatment of severe sepsis and septicemia; and
- Authorizing the Medicaid program to provide blood-based allergy testing for patients with persistent asthma.

HHSC also is required to maintain an online website related to the quality improvement process, provide a report to the Legislature on the completed analysis, and implement those initiatives determined to be cost-effective that will improve the quality of care under the Medicaid program.

H.B. 3556 - Licensing & Regulation of Emergency Medical Service Providers

H.B. 3556 places a moratorium on the issuance of emergency medical services provider licenses. The bill adds a licensure provision requiring emergency medical services provider applicants to hold a letter of approval issued by a local government entity. Emergency ambulance transportation providers that are not directly operated by a government entity must provide DSHS with letters of credit and a surety bond. Additionally, certain providers are required to provide a surety bond to HHSC.

The 2014-15 General Appropriations Act

The following section highlights several budget riders with significant impacts to Medicaid and CHIP.

Riders 37, 38, and 71 - Hospital Reimbursement

- Rider 37 transitions payment of inpatient hospital fees and charges under Medicaid from the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to All Patient Refined Diagnosis Related Groups (APR-DRG) except for state-owned teaching facilities. This includes rural hospitals, which have facility-specific prospective standard dollar amounts.
- Under Rider 71, children's hospitals were transitioned to APR-DRG with a special children's hospital standard dollar amount, effective September 1, 2013.
- Rider 38 requires HHSC to implement Enhanced Ambulatory Patient Groups (EAPG), a patient classification system for outpatient hospital reimbursement designed to explain the amount and type of resources used in an ambulatory visit. The targeted implementation date in managed care is September 1, 2015.

Rider 40 - Contingency for Nursing Facility Rate Increases

- Rider 40 appropriates funds to provide for a two percent rate increase to nursing facilities in Fiscal Year 2014 and an additional four percent rate increase in Fiscal Year 2015.

Rider 51 - Medicaid Funding Reduction and Cost Containment

- Rider 51 requires HHSC to achieve \$400 million in General Revenue funds (\$962 million All Funds) savings in Medicaid.
- The rider permitted savings to be achieved from a proposed list of 25 cost containment initiatives or other initiatives identified by HHSC.
- In general, the initiatives focus on service delivery and quality improvements, payment reforms, and reduction of fraud and waste.
- Specific areas targeted include pharmacy services, outpatient hospital payments, medical transportation, and dental care.

- Activities include expanding managed care and improving care coordination; appropriate utilization of services and appropriate reimbursement; increased efficiencies in the Vendor Drug Program; improving birth outcomes; and quality-based payments.

Historical Major Federal Medicaid and CHIP Legislation, 1965 to Present

Social Security Amendments of 1967

Mandated

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

Public Law 92-223 of 1971

Optional

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

Social Security Amendments of 1972

Optional

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

Omnibus Budget Reconciliation Act of 1981 (OBRA)

Optional

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

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Optional

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

Deficit Reduction Act of 1984 (DEFRA)

Mandated

- Provides coverage for children up to age five born after September 30, 1983, whose families meet AFDC (now TANF) income and resource limits, even if the family does not qualify for AFDC (i.e., if both parents are in the home). Texas also covers children from ages 6 to 19 in such families.

- Provides coverage of pregnant women in households that would meet AFDC (now TANF) income/resource limits after a child is born, including households with an unemployed “principal wage earner” present.
- Provides automatic coverage of infants born to and living with Medicaid-eligible mothers.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

Mandated

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

Optional

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

OBRA of 1986

Mandated

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

Optional

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

OBRA of 1987

Mandated

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

Optional

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

Medicare Catastrophic Coverage Act of 1988

Mandated

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

Optional

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

OBRA of 1989

Mandated

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

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Mandated

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

OBRA of 1993

Mandated

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

Optional

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

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

Mandated

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

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

PRWORA is federal legislation that requires adult TANF clients to participate in work activities within two years of entering the program and prohibits them from receiving federally funded TANF benefits for more than 60 months over a lifetime. The impact of

welfare reform is thought to be partly responsible for the state's Medicaid caseload drop in the mid to late 1990s. Individuals who qualified for TANF comprised approximately 18 percent of the Medicaid population in 1999, down from 28 percent in 1997.¹

PRWORA also gave states the option to decide whether or not to continue providing Medicaid to most legal immigrants. Most immigrants entering the United States after August 22, 1996, are subject to a five-year "bar" period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act of 1997 restored SSI benefits for legal immigrants who arrived in the United States (U.S.) prior to August 22, 1996, but limited the benefit until after the first seven years of a person's residence in the U.S. Beginning in 2003, some persons began to reach the seven-year limit. Those arriving after August 22, 1996, are still ineligible for the SSI program.

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

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

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

- Reduction of payments to DSH.
- Allowances for states to lower what they paid for Medicare co-payments, deductibles, and coinsurance for Qualified Medicare Beneficiaries.
- Repeal of the Boren Amendment, eliminating minimum payment guarantees for hospitals, nursing homes, and community health centers that serve Medicaid clients.²

Under the BBA, states no longer needed a waiver, such as an 1115 or 1915(b), to require most Medicaid-eligible pregnant women and children to enroll in managed care plans. A waiver is still required if a state wants to expand Medicaid eligibility, require SSI recipients and foster children to enroll in managed care plans, or expand benefits.³

States also gained new eligibility options:

Guaranteed eligibility

This option allows states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests.

Medicaid Buy-in

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

Medicaid Buy-In for Children

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

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

The Balanced Budget Refinement Act of 1999 (BBRA) provided approximately \$17 billion in “BBA relief” over five years. Most of the provisions of the BBRA were focused on rural health care delivery and access to services for rural Medicare beneficiaries; however, there were provisions specific to the Medicaid program. In particular, the BBRA made the following changes:⁴

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

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

- Expands the BBA by creating two optional categorically needy Medicaid buy-in groups for individuals age 16 to 64 who, except for earned income, would be eligible for Medicaid.
- Creates a new demonstration to help people at-risk for disability maintain their independence and employment.
- Extends Medicare coverage for persons with disabilities who return to work.

- Enhances the employment services system by creating a “Ticket to Work Program.” This system is intended to enable SSI or Social Security Disability Income beneficiaries to obtain vocational rehabilitation and employment services from participating public or private providers. If the beneficiary goes to work and achieves substantial earnings, providers would be paid a portion of the benefits saved.⁵
- Provides Medicaid Infrastructure Grants to states to develop state infrastructure that supports working individuals with disabilities.

Breast and Cervical Cancer Prevention and Treatment Act of 2000

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

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

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

Improper Payments Information Act of 2002 (IPIA)

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

Jobs and Growth Reconciliation Act of 2003

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

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

- Allowed states to retain unexpended federal fiscal year (FFY) 1998-99 federal allocations through FFY 2004.
- Allowed states additional time to spend 50 percent of unused FFY 2000 and FFY 2001 federal allocations (through FFY 2004 and FFY 2005, respectively).
- Allowed approximately ten states that had expanded Medicaid prior to the enactment of CHIP to use their CHIP funds to cover the cost of some of those expansions. This provision did not apply to Texas.

Welfare Reform Extensions and Reauthorizations

Various laws have been passed to extend PRWORA beyond its expiration date of September 30, 2002. The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) reauthorized TANF through September 30, 2010, and continuing resolutions have extended the program since 2010. Most recently, a Continuing Resolution extended TANF through December 11, 2014. Supplemental grants to states such as Texas were only extended through June 2011. A related program, Transitional Medical Assistance, was extended through March 31, 2015, under Protecting Access to Medicare Act.

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

The most historic feature of the MMA was the creation of an outpatient prescription drug benefit in Medicare, known as Medicare Part D. The bill also changed many provider payments, some of which had been reduced or constrained by previous legislation.

Major provisions affecting the Medicaid program include the following:

- Implementation of a voluntary prescription drug discount card program that also provided a subsidy for low-income beneficiaries. The discount card program was in effect in 2004 and 2005.
- Implementation of a prescription drug benefit offered through private sector plans, which began January 1, 2006. Called Part D, the benefit is available to all Medicare beneficiaries, including those who are also eligible for Medicaid (dual

eligibles). Preparation for transitioning Medicaid enrollees to Part D required extensive state involvement and the state has a continuing role in eligibility determination.

- Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the “clawback” provision).
- Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
- Increased premiums for Medicare Part B, which covers physician services, lab services, etc. Medicaid pays these premiums on behalf of certain clients dually eligible for Medicare and Medicaid.
- Increased state allotments for DSH payments for 2004-2010.
- Appropriation of \$250 million annually for FFYs 2005-2008 to compensate medical providers for emergency care provided to undocumented immigrants. Payments are made directly by the federal government to providers.

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

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

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

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

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

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

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

- Requires providers to use tamper-resistant prescription pads/paper when writing prescriptions for any drugs for Medicaid recipients effective April 2008.
- Limits reimbursement for written prescriptions to only those executed on tamper-resistant prescription pads/paper. Prescriptions transmitted to pharmacies via telephone, fax, or electronically are exempt from this requirement.⁶

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

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

- Requires group health plans that offer behavioral health benefits (mental health and substance use disorder benefits) to provide those services at parity with medical and surgical benefits.
- Parity requirements apply to financial requirements (e.g., co-payments), treatment limitations (e.g., number of visits or days of coverage), and availability of out-of-network coverage.
- Behavioral health and medical benefits are required to meet parity based on the following benefit classifications: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.
- MHPAEA does not impact traditional Medicaid FFS; however, the requirements apply to Medicaid managed care and state CHIP programs.

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

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

For FFY 2014, the federal CHIP allotment for Texas was \$789.8 million. The CHIP allotment is adjusted annually based on a formula that takes into account actual CHIP expenditures, child population growth, and a measure of health care inflation. Texas has two years to spend its CHIP allotment.

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

- Requiring CHIP MCOs to pay federally-qualified health centers and rural health centers their full encounter rates;
- Applying certain Medicaid managed care safeguards to CHIP;

- Verifying citizenship for CHIP;
- Implementing mental health parity in CHIP (See Chapter 9, Children’s Health Insurance Program.);
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children; and
- Expanding dental services.

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

ARRA was signed into law in February of 2009 and provided \$762 billion to states in economic stimulus funding for a multitude of new and existing programs.

- Temporarily increased the federal share for Medicaid payment in Texas by approximately 9 to 11 percentage points above the pre-ARRA FMAP rate during the stimulus period. Congress later extended the FMAP increase for an additional six months at phased-down rates. In all, the FMAP increase spanned a 33-month period. For Texas, the ARRA FMAP increase affected 11 months of SFY 2009, 12 months of SFY 2010 and 10 months of SFY 2011.
- Temporarily prohibited states from making changes to any Medicaid eligibility standards, methodologies, or procedures that were more restrictive than those in effect as of July 1, 2008.
- Implemented prompt payment requirements for Medicaid providers.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Contingency Fund, increased the DSH allotment, allocated funding for Health Information Technology (HIT), and provided supplemental funding for existing public health cooperative agreements and competitive grant opportunities through the Prevention and Wellness Fund.
- Established the Recovery Accountability and Transparency Board (RATB) to help prevent waste, fraud, and abuse and the Recovery.gov website to foster greater accountability and transparency in the use of funds made available by ARRA.

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

PPACA was signed into law on March 23, 2010, and HCERA was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). Among a number of other changes, the ACA mandates that all individuals have health coverage, provides individuals up to 400 percent of the FPL with subsidies to purchase coverage, and gives states the option to expand Medicaid eligibility to 133 percent of FPL for uninsured individuals up to age 65. It directs that each state have a health insurance marketplace that assists individuals and small businesses with purchasing affordable health care.

States had the option to establish a state-based marketplace, partner with the federal government to establish a marketplace, or have the federal government run the state's marketplace. These changes impacted all HHS agencies, especially HHSC and DSHS. (See Chapter 3, Federal Health Care Reform.)

Protecting Access to Medicare Act (P.L. 113-93)

The Protecting Access to Medicare Act was signed into law on April 1, 2014, and extended a number of Medicare and Medicaid program authorizations.

- Extended the Qualified Individuals, Transitional Medical Assistance, and Maternal, Infant and Early Childhood Home Visiting Programs through March 2015.
- Extended the CHIP Express Lane program option through September 2015.
- Extended the State Abstinence Education Grant and Personal Responsibility Education Programs through FFY 2015.
- Delayed implementation of previously adopted changes to Medicaid third party liability law to October 1, 2016.
- Delayed transition of the standard code sets from ICD-9 to ICD-10 by one year, to October 1, 2015.
- Delayed scheduled reductions to the Medicaid disproportionate share hospital (DSH) allotment. The aggregate federal DSH allotment will be reduced by \$1.8 billion in FFY 2017; \$4.7 billion in FFY 2018, FFY 2019, and FFY 2020; \$4.8 billion in FFY 2021; \$5 billion in FFY 2022 and FFY 2023; and \$4.4 billion in FFY 2024.
- Created a demonstration program to improve community mental health services.

Endnotes

¹ Health Care Financing Administration, 2082 Report, “Statistical Report on Medical Care: Eligible Recipients, Payments, and Services,” 1997 and 1999.

² Center on Budget and Policy Priorities, “Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33,” September 8, 1997, <http://www.cbpp.org/908mcaid.htm> (November 2014).

³ Center on Budget and Policy Priorities, “Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33,” September 8, 1997, <http://www.cbpp.org/908mcaid.htm> (November 2014).

⁴ Rural Policy Research Institute, “Rural Implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of the Health Policy Provisions,” December 1999, pp. 2-3.

⁵ Centers for Medicare & Medicaid Services, “Employment Initiatives: Ticket to Work and Work Incentives Improvement Act,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html> (November 2014).

⁶ U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Tamper-Resistant Prescription Pads), May 25, 2007, http://waysandmeans.house.gov/media/pdf/tax/HR_2206_text.pdf (November 2014).

Chapter 3: Federal Health Care Reform

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

History and Background

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

The ACA also required the establishment of health insurance marketplaces by January 1, 2014, to assist individuals and small employers in accessing affordable health insurance. The marketplace must be operated by a governmental entity or non-profit organization.

States had the option to establish a state-based marketplace, partner with the federal government to establish a marketplace, or have the federal government run the state's marketplace. States that initially opted for a federally-run marketplace may request to move to a state-based marketplace over time. Texas currently has a federally-facilitated marketplace.

As of January 1, 2014, qualified individuals and employees of participating small employers can purchase health insurance coverage from qualified health plans on the marketplace. Individuals above 100 up to and including 400 percent of the FPL may be

eligible for premium subsidies and cost-sharing reductions for coverage purchased through the marketplace.

The new health insurance requirements impacted the number of uninsured in Texas.

Directives Implemented

Many of the major provisions of the ACA impacting HHSC did not become effective until 2014. However, a number of provisions had earlier effective dates. HHSC has implemented changes to Medicaid benefits, pharmacy, federal matching funds, and Medicaid eligibility policies. HHSC also has implemented a number of program integrity provisions.

Eligibility Changes

Effective January 1, 2014, the ACA required states to make significant changes to eligibility for most Medicaid programs and the Children's Health Insurance Program (CHIP).

Financial Eligibility

The ACA makes the following changes to financial eligibility:

- Requires states to determine financial eligibility for most Medicaid programs and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition.
- Prohibits assets tests and most income disregards for most Medicaid programs and CHIP. The ACA applies a five percentage point income disregard to individuals subject to the MAGI methodology. Prior to the ACA, Texas applied assets tests and income disregards to most Medicaid programs and CHIP.
- The MAGI methodology applies to most Medicaid eligibility groups for children, pregnant women, and parents and caretaker relatives. The ACA provides exceptions to the use of the MAGI methodology and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and those with disabilities.

Other Eligibility Changes

In addition to financial eligibility changes, the ACA makes changes to other eligibility policies and processes. The ACA requires the following:

- A single, streamlined application form for Medicaid, CHIP, and the marketplace.
- States must redetermine Medicaid eligibility every 12 months and no more frequently than once every 12 months except when a change in circumstance is received by the state that may affect an individual's eligibility.
- An administrative or passive eligibility renewal process for Medicaid and CHIP. To the extent possible, states must use available information to make eligibility redeterminations without requesting information or an application from clients.

Medicaid Benefit Changes

Hospice

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

Birthing Centers

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

Licensed Midwives

The ACA required states to provide Medicaid reimbursement to all providers recognized by states as a licensed birth attendant providing health care at childbirth. Licensed midwives are a licensed, recognized birth attendant in Texas. Texas Medicaid began recognizing licensed midwives as a provider type effective January 1, 2013.

Comprehensive Tobacco Cessation Services for Pregnant Women

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

Pharmacy Changes

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

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

With the March 2012 managed care expansion, pharmacy benefits were carved into the Medicaid managed care delivery system.

Section 1860D-2(e)(2)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was amended to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines. As of January 1, 2013, Texas Medicaid no longer covered barbiturates and benzodiazepines for dual eligible clients.

Changes to Federal Matching Funds

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

- Allowing for receipt of federal matching funds for CHIP coverage of state employees' children who previously qualified for Teachers Retirement System ActiveCare, which was fully paid for with state GR funding; and
- Allowing for receipt of federal matching funds for CHIP coverage of state employees' children who previously qualified for the State Kids Insurance Program (SKIP), which was fully paid for with state GR.

Temporary Primary Care Provider Rate Increase

The ACA required that reimbursement for certain Medicaid services provided by primary care providers be increased to 100 percent of Medicare rates for calendar years 2013 and 2014. On November 1, 2012, CMS issued regulations defining primary providers, for the purpose of this provision, as specialist and subspecialists within the general category of family practice, general internal medicine, and pediatrics.

This increase applies to physician evaluation and management services and the administration of vaccines. The rate increase is 100 percent federally funded for the difference in the Medicaid rate in place in July 2009 and the Medicare rate in 2013 and 2014. Because Texas implemented rate reductions in 2011, generally of two percent, there will be some cost to the state for a portion of the increase. Medicare co-pays and deductibles, which were reduced in 2012, may also require state matching funds for the affected primary care providers and services.

The state began making payments to qualified providers in February 2014. Qualified providers were eligible for the temporary rate increase for certain primary care services provided in Medicaid through December 31, 2014.

Program Integrity Initiatives

The ACA (Section 6401) established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP. The new provider screening and enrollment rules became effective March 25, 2011. Newly enrolling providers are subject to the new provider screening requirements. Texas Medicaid began re-screening existing providers in January 2013.

Pursuant to federal law,¹ states must implement the following changes to provider screening and enrollment requirements. The federal regulations allow states to rely on Medicare screening or screening in another state to ensure that a provider has met the federal requirements.

Screening Categories

Providers enrolling in Medicaid or CHIP are subject to federal and state-defined screening requirements. All applications, including applications for new practice locations, re-enrollment, or revalidation, are subject to the highest level of screening by federal- and state-defined risk categories: limited, moderate, or high.² HHSC will establish risk categories for provider types that are not federally defined or adjust federal risk categories for provider(s) who pose increased risk of fraud in Medicaid based on history of waste, fraud, or abuse.

Database Checks

Providers and any persons with five percent ownership or control interest or who are agents or managing employees of the provider shall be subject to routine federal and state database checks at a described frequency on an on-going basis. Database checks shall be used to confirm, identify and determine exclusion status through routine checks of federal databases.

Licensure Verification

Verification of provider licensure in accordance with any state laws and confirmation of licensure status (e.g., active or expired) and current licensure limitation is required.³ Verification must occur at federal- and state-defined intervals.

Site Visits

Moderate and high-risk providers must submit to an on-site pre and post enrollment visit conducted by federal agencies or a state Medicaid agency. A site visit consists of unannounced on-site inspections of any and all provider locations to verify the accuracy of the information submitted on an enrollment application and determine compliance with federal and state laws.⁴

Criminal Background Checks

Providers must consent to criminal background checks, including fingerprinting, when required to do so under state law or if they are designated as high-risk providers under the new enrollment provisions. For providers designated as high risk, each provider or persons with five percent or more direct ownership interest in the provider will be subject to the federally required criminal background check and subject to submitting to fingerprinting within 30 days of a request by federal agencies or HHSC in addition to complying with existing state laws.⁵

Application Fee

Providers enrolling in Medicaid or CHIP, with the exception of physicians and non-physician practitioners (including physician and non-physician practitioners groups), must submit an application fee for enrollment prior to the state executing a provider agreement.

An application fee is required for:

- Newly enrolling providers;
- A new practice location; and/or
- Re-enrollment/revalidation.

An application fee may be waived if the fee has been collected by Medicare, Medicaid (in the case of CHIP), or another state's Medicaid or CHIP program. In cases in which Medicare has granted a provider an exception to the application fee, an application fee will not subsequently be required in Medicaid or CHIP as the state may rely on Medicare for Medicaid or CHIP enrollment.

The application fee is non-refundable with the exception of applications denied prior to initiation of the screening process or if an application is subsequently denied as a result of an imposed temporary moratorium on enrollment.

Enrollment Revalidation

Revalidation and screening of all providers must occur at a minimum every five years. At this time, providers must be rescreened for enrollment. Revalidations will consist of a full enrollment screening, including site visits and criminal background checks as required by designated risk categories. With the exception of physicians and non-physician practitioners, providers revalidating enrollment are subject to an application fee.

National Provider Identifier (NPI)

All providers must submit their NPI for Medicaid enrollment and claims payment.

Enrollment Denial or Termination

Provider enrollment will be denied or terminated when any person with five percent ownership or controlling interest in the provider has:

- Been convicted of a criminal offense related to Medicare, Medicaid, or CHIP in the past 10 years;
- Been terminated from any Medicare, Medicaid, or CHIP program on or after January 1, 2011;

- Failed to submit fingerprints in a manner designated by the Medicaid agency within 30 days of a federal or state Medicaid agency's request;
- Failed to permit access to provider locations for any site visits;
- Failed to cooperate with any of the required screening methods under law;⁶ or
- Failed to submit accurately or timely information as a provider, person with ownership or controlling interest, agent, or managing employee of the provider.

Providers may appeal a termination or enrollment denial adhering to procedures established under state law and regulations.

Ordering or Referring Providers

All providers ordering or referring for services under the state plan or a waiver (e.g., fee-for-service, managed care, long-term care, etc.) must be enrolled as a participating provider.⁷ Verification of ordering and referring provider status is required.

Additionally, the NPI of the provider who referred or ordered an item or service is required for claims payment.⁸

An abbreviated enrollment process is used for providers who enroll for the sole purpose of ordering or referring for services.

Temporary Moratoria

Pursuant to federal law,⁹ with concurrence from the Secretary of U.S. Health and Human Services (HHS), HHSC may impose:

- Temporary moratoria on enrollment of new providers;
- Numerical caps on enrollment; or
- Other enrollment limitations identified by the state and the Secretary of HHS for providers identified as being at high-risk for fraud, waste, and abuse, if the limitations do not adversely affect beneficiaries' access to care.

Moratoria may be imposed for providers determined by the Secretary of HHS as posing an increased risk to Medicaid following a determination by HHSC that the moratorium would not adversely affect beneficiaries' access to medical assistance and has notified the Secretary of HHS in writing. Moratoriums are limited to six months and may be extended in six-month increments with Secretary of HHS approval.

Medicaid & CHIP Caseload Growth

Eligibility Expansions

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

- Former foster care youth through age 25; and
- Children ages 6 to 18 up to and including 133 percent of the FPL. (These children were CHIP-eligible prior to the ACA.)

Additionally, there are currently increases in Medicaid caseload due to use of modified adjusted gross income (MAGI), rather than income with potential disregards, and 12-month recertification with a periodic income check for children and adults, as well as increases likely due to increased focus and outreach resulting from the ACA. Overall Medicaid caseload rose above 4 million clients in September of 2014, an increase of 9.6 percent over September 2013.

Optional Eligibility Expansion

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

Benchmark Benefit Package for Optional Medicaid Expansion

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

The Deficit Reduction Act (DRA) of 2005 established an option for states to provide benchmark or benchmark-equivalent coverage in Medicaid. The ACA added prescription drugs and mental health services to the DRA requirements, and directed

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

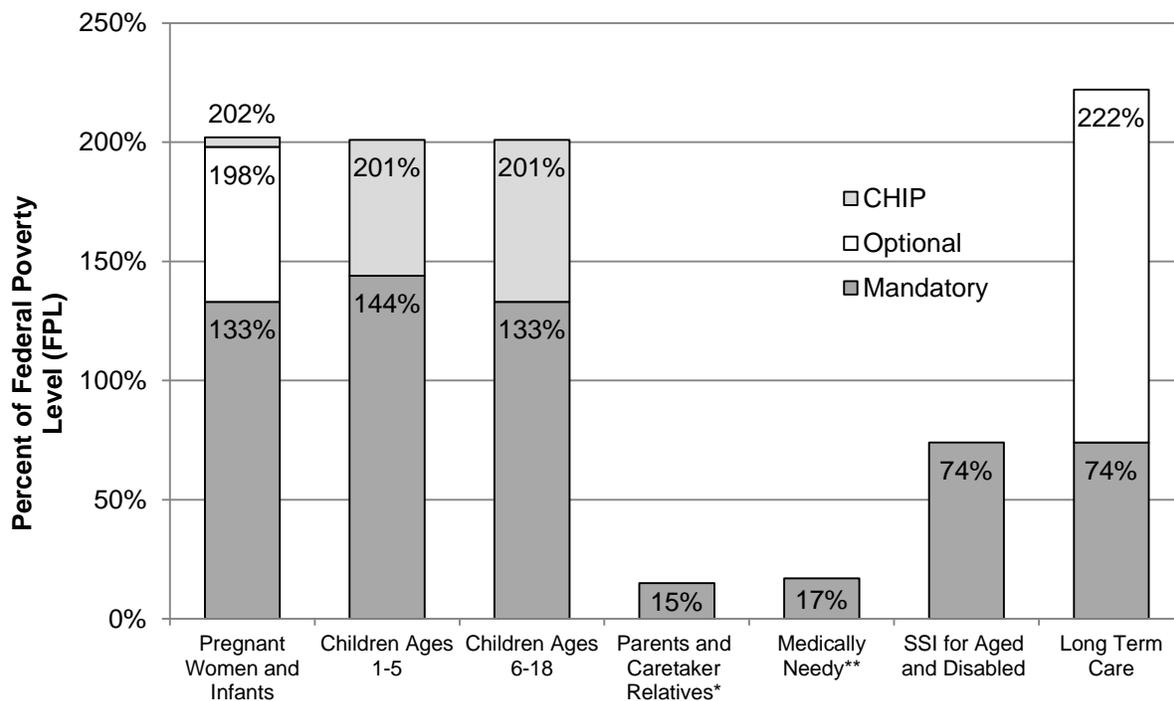
that benchmark coverage include all essential health benefits identified in the ACA. Benchmark-equivalent coverage must include:

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

Current Medicaid and CHIP Eligibility Levels

Texas will experience caseload growth in newly eligible individuals and individuals who are currently eligible, but not enrolled in Medicaid or CHIP.

**Figure 3.1: Current Medicaid/CHIP Eligibility Levels, March 2014
(As a Percent of FPL)**



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

*In SFY 2014 the monthly income limit for a *one-parent* household is **\$230** and the monthly income limit for a *two-parent* household is **\$251**.

For Medically Needy pregnant women and children, the maximum monthly income limit in SFY 2014 is **\$275 for a family of three, which is the equivalent of approximately 17 percent of FPL.

Maintenance of Effort Requirements

The ACA restricts states' ability to make changes to existing Medicaid and CHIP programs by extending maintenance of effort (MOE) requirements. The American Recovery and Reinvestment Act of 2009 (ARRA) prohibits states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however, can be made. For adults, MOE requirements were in effect until January 1, 2014 (or when an exchange was established), and for children, including children in CHIP, MOE continues through September 30, 2019. Under the ACA, states must comply with MOE requirements to receive Medicaid or CHIP funding, respectively.

Federal guidance has clarified how MOE applies to Medicaid waivers. For instance, Section 1115 and home and community-based waivers can expire and are not required to be renewed under MOE. In addition, states may renew a waiver at the end of the

approved waiver period in effect as of March 23, 2010, with modifications to the waiver program.

Coordination between Medicaid, CHIP, and the Marketplace

Marketplace eligibility determinations must be streamlined and coordinated with eligibility determinations for the Medicaid and CHIP programs. As of January 1, 2014, state Medicaid and CHIP programs were required to establish electronic interfaces with the marketplace to facilitate coordination of eligibility determinations across programs. Applications submitted through the marketplace are electronically transferred to Medicaid and CHIP with no additional required action by the applicant. If an applicant is determined ineligible for state Medicaid and CHIP programs, the application is sent electronically to the marketplace with all information obtained by the state.

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

Health Care Reform Financing

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

Federal Financial Participation

The ACA increases the federal match rate for the optional Medicaid expansion and for CHIP. For the first three calendar years of the optional expansion (2014 through 2016), the federal government will cover the full cost of Medicaid for newly eligible adults, for states choosing to implement a Medicaid expansion. From 2017 through 2020, the federal share for Medicaid decreases from 100 to 90 percent.

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

Table 3.1 shows federal match rates by Medicaid and CHIP eligibility groups from 2014–2023.

**Table 3.1: Federal Medical Assistance Percentage (FMAP)
SFYs 2014-2023**

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

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

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

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

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

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

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

Enhanced Funding for Eligibility, Enrollment, and Claims Systems

Enhanced Federal Financial Participation (FFP) at 90 percent is available for design, development, installation, or enhancement of eligibility determination and claims systems that meet required federal standards and conditions. Enhanced FFP at 75 percent is available for maintenance and operation of existing systems if those systems meet required federal standards and conditions.

Initial federal guidance had indicated that enhanced funding only would be made available for projects initiated prior to December 31, 2015. However, more recent federal guidance indicates that enhanced funding is extended indefinitely. To receive enhanced FFP, states must submit a plan for federal approval outlining how the state will comply with federal standards and conditions.

Endnotes

¹ Code of Federal Regulations (CFR) §455.400-§455.414. Application to CHIP §457.990

² CFR §455.450

³ CFR §455.412

⁴ CFR §455.432

⁵ CFR §455.434

⁶ CFR §455 Subpart E – Provider Screening and Enrollment

⁷ CFR §455.410(b)

⁸ CFR §455.440

⁹ CFR §455.470

Chapter 4: Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver

*The Quality Improvement Program 1115 Waiver makes two major changes:
expanding Medicaid managed care statewide and establishing two new
funding pools for supplemental payments.*

History and Background

The Texas Legislature, through the 2012-13 General Appropriations Act (H.B. 1, 82nd Legislature, Regular Session, 2011), and S.B. 7, 82nd Legislature, First Called Session, 2011, instructed the Health and Human Services Commission (HHSC) to expand its use of Medicaid managed care. The Legislature also directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment limit (UPL) program.

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

Accordingly, HHSC submitted a proposal to CMS for a five-year Section 1115 demonstration waiver designed to build on existing Texas health care reforms and to redesign health care delivery in Texas consistent with CMS goals to improve the experience of care, improve population health, and reduce the cost of health care without compromising quality. CMS approved the waiver on December 12, 2011.

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

The waiver expires on September 30, 2016. HHSC must submit a request to CMS no later than September 30, 2015, to extend the waiver.

Waiver Funding

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

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

Uncompensated Care Pool

UC pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments are based on each provider's UC costs as reported on a UC application. (See Chapter 8, Medicaid Spending from All Angles.)

Delivery System Reform Incentive Payment Pool

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

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

To earn DSRIP funds, providers must undertake projects from a menu of projects agreed upon by CMS and HHSC in the Regional Healthcare Partnership (RHP) Planning Protocol (see below for more information).

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

- Category 1 projects: Infrastructure Development lays the foundation for delivery system transformation through investments in technology, tools, and human resources that strengthen the ability of providers to serve populations and continuously improve services.
- Category 2 projects: Program Innovation and Redesign includes the piloting, testing, and replicating of innovative care models, such as telemedicine, patient-centered medical home, and innovations in health promotion and disease prevention.
- Category 3 outcomes: Quality Improvements assess the effectiveness of Category 1 and 2 interventions for improving outcomes in the Texas healthcare delivery system. Each project selected in Categories 1 and 2 has one or more associated outcome measures from Category 3.
- Category 4 reporting: Population-focused Improvements include a series of reporting measures for a hospital to track the community-wide impact of delivery system reform investments made. Reporting includes data related to potentially preventable admissions, readmissions, and complications, patient-centered health care, and emergency department utilization.

Regional Healthcare Partnerships

Under the 1115 Transformation Waiver, eligibility to receive UC or DSRIP payments requires participation in one of 20 Regional Healthcare Partnerships (RHPs), which

reflect existing delivery systems and geographic proximity. A map of the RHP regions can be found on the HHSC website at: <http://www.hhsc.state.tx.us/1115-docs/Regions-Map-Aug12.pdf>. The RHPs include public hospitals, public health care districts, health providers, and other stakeholders in a given region. The activities of each RHP are coordinated by an “anchoring entity,” which is a public hospital or other local governmental entity with the authority to make IGTs, such as a hospital district, a hospital authority, a university health science center, or a county.

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

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

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

The RHP plans must be consistent with a regional shared mission, quality goals of the RHP, and CMS’ triple aims to improve care for individuals (including access to care, quality of care, and health outcomes); improve health for the population; and lower costs through improvements (without any harm whatsoever to individuals, families, or communities).

RHP plans must reflect broad inclusion of local stakeholder engagement.

In December 2012, RHPs submitted five-year plans that describe:

- The reasons for the selection of the projects, based on local data, gaps, community needs, and key challenges;
- How the projects included in the plan are related to each other and how, taken together, the projects support broad delivery system reform relevant to the patient population; and

- The progression of each project year-over-year, including the expected improvements that will occur in each demonstration year.

The RHP plans outlined projects and estimated funding levels for HHSC and CMS approval in fiscal year 2013. With leftover funding, RHPs had the opportunity to propose additional 3-year projects in late 2013.

As of December 2014, there were 1,273 approved and active 4-year DSRIP projects and 218 approved and active 3-year projects.

During years 2 and 3 of the waiver (October 2012 - September 2014), the projects focused on start-up activities, including developing project infrastructure. In 2014, projects also began reporting their direct patient impact and establishing benchmarks for project outcomes. Providers report twice a year (April and October) on annual project metrics and milestones completed in order to earn DSRIP payments.

HHSC is conducting a mid-point assessment in 2014/2015 to evaluate the progress of the projects so far, and to determine if they require any modifications or technical assistance to be successful.

Groups of providers and other DSRIP participants are meeting across the state through learning collaboratives to identify best practices, share ways to improve projects, and promote continuous quality improvement. HHSC also hosts an annual Statewide Learning Collaborative beginning in 2014.

Chapter 5: Medicaid Clients

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

Who Is Covered in Texas

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

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

Medicaid clients eligible for limited benefits include:

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

Cash Assistance Recipients

SSI is the federal cash assistance program for low-income people age 65 and older and those with disabilities. The federal Social Security Administration sets income eligibility caps, asset limits and benefit rates, and determines eligibility. The 2014 monthly income limit for an individual on SSI is \$721 per month with an asset limit of \$2,000. In Texas, all people eligible for SSI are also eligible for Medicaid. States may supplement SSI payments with state funds, and most states choose to do so. Texas does not do so, but does allow for a slightly higher personal needs allowance for SSI clients in long-term

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

care facilities. The personal needs allowance is a portion of their SSI check plus a state supplement that they may keep for personal use.

Families and Children

Families and children comprise the majority of clients receiving full Medicaid benefits on a monthly basis. Children who do not have a disability total 72 percent of Texas Medicaid full-benefit clients, and averaged 2.6 million clients per month in state fiscal year (SFY) 2013.

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

Former Foster Youth

The majority of children in foster care are categorically eligible for Medicaid until age 18. If a youth's adoptive parents initially enter into an adoption assistance agreement with DFPS when the youth is 16 or 17-years-old, then the youth may be eligible to receive Medicaid until age 21 if they meet certain educational or work requirements.

Effective January 1, 2014, under the Affordable Care Act (ACA), a new Medicaid category is available for former foster care youth. Children who aged out of the foster care system at age 18 or older and who were receiving Medicaid when they aged out of foster care may continue to be Medicaid eligible up to the month of their 26th birthday. Individuals who received Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care in Higher Education as of December 2013 and meet the eligibility criteria automatically transitioned to the new Former Foster Care Children program January 1, 2014.¹

Former foster youth who were not receiving Medicaid when they aged out of foster care may be eligible for MTFCY up to the month of their 21st birthday if they have no other medical coverage and meet the income limits.

Children who are adopted from the foster care system may also be Medicaid eligible, depending on the needs of the child, until age 18.

Medically Needy Spend Down

Children under age 19 and pregnant women with medical bills and income over the appropriate Medicaid income limit may qualify for the Medically Needy with Spend Down program. Spend Down is the difference between an applicant's household income and the Medicaid income limit. For FY 2014, the income limit was \$275 per month for a family of three and the assets limit was \$2,000. Assets are not considered when determining eligibility for the Medically Needy with Spend Down program for pregnant women. Applicants must have unpaid medical bills that exceed the Spend Down amount to receive benefits under the Medically Needy with Spend Down program. Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after the individual is determined to be medically needy. However, applicants are not required to pay outstanding medical bills to qualify for the Medically Needy with Spend Down program.

Medicaid for Breast and Cervical Cancer

Medicaid for Breast and Cervical Cancer (MBCC) was authorized by S.B. 532, 77th Legislature, Regular Session, 2001, and was implemented in December 2002. In SFY 2013, the monthly average number of clients enrolled in MBCC was 4,273. MBCC provides Medicaid to eligible women who are screened under the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and are found to have breast or cervical cancer, including pre-cancerous conditions.

The Department of State Health Services receives these CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast and Cervical Cancer Services program.

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

To be eligible for MBCC, a woman must be at or below 200 percent of the federal poverty level (FPL) and:

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

- A Texas resident; and
- A U.S. citizen or qualified immigrant.

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

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

People Age 65 and Older and those with Disabilities

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

Dual Eligibles

Dual eligibles are individuals who qualify for both Medicare and Medicaid benefits. Medicare is a federally-paid and administered health insurance program. Medicare covers inpatient hospital services (Part A), physician and related health services (Part B), Medicare managed care (Part C), and prescription drugs (Part D). For dual eligibles, Medicaid pays for all or a portion of Medicare Part A and B premiums, co-insurance, and deductibles. (See Chapter 1, Texas Medicaid in Perspective, Medicare.)

Full Dual Eligibles

Full dual eligibles are Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the premiums, deductibles, and co-insurance for Medicare services and may cover other Medicaid services not covered by Medicare, such as long-term services and supports. As a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003, Medicare assumed responsibility for most prescription drug coverage for dual eligibles in 2006. As of August 2014, there were 373,835 full dual eligible clients in Texas.²

Partial Dual Eligibles

Medicaid also provides limited assistance to certain Medicare beneficiaries, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. As of August 2014, there were 260,215 partial dual eligibles in Texas.³

Medicare Savings Programs

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

Texas covers a different mix of Medicare cost-sharing assistance depending on income, resources, and other restrictions. Resource limits for 2014 are \$7,160 per individual and \$10,750 per couple, for all categories.

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

Specified Low-Income Medicare Beneficiaries (SLMB): Income between 100 and 120 percent of FPL. Medicaid pays only Medicare Part B premiums.

Qualified Individuals (QI): Income between 120 and 135 percent of FPL. Medicaid pays only Medicare Part B premiums. This program is a limited expansion of SLMB that is funded differently from SLMB or QMB. Due to the different funding, federal regulation requires Medicaid only pay the Medicare Part B premiums. If the individual chooses to receive QI benefits, their decision disqualifies the individual for all other Medicaid programs.

Qualified Disabled and Working Individuals (QDWI): This cost-sharing program is for people with disabilities who work and lose social security benefits and premium-free Medicare Part A. Income is no greater than 200 percent of the FPL. Resources are \$4,000 for an individual and \$6,000 for a couple. Medicaid only pays the Medicare Part A premium. If the individual chooses to receive QDWI benefits, their decision disqualifies the individual for all other Medicaid programs.

Buy-In Programs

Medicaid Buy-In Program for Workers with Disabilities

The Medicaid Buy-In (MBI) Program for Workers with Disabilities enables people with disabilities to “buy-in” to Medicaid. Individuals with income less than 250 percent of the FPL and \$2,000 in resources may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented the MBI program in September 2006.

Medicaid Buy-In for Children

The Medicaid Buy-In for Children (MBIC) program allows children up to age 19 with disabilities to “buy-in” to Medicaid. Children with family income up to 300 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented the MBIC program in January 2011.

Income Disregards

In certain situations, some portion of a person’s income and resources may be “disregarded” when calculating eligibility for Medicaid programs not subject to the MAGI methodology. A portion of a family’s income and resources may be disregarded due to work expenses, cost of living increases, or when a child (under age 18) becomes a full-time resident of a nursing facility or an ICF/IID. In some cases, including for some people with Medicaid home and community-based waiver programs, all of the parents’ or spouse’s income and resources are disregarded, and only the person’s own income and resources are counted in deciding Medicaid eligibility.

Persons applying for Medicaid programs subject to the MAGI methodology, including most programs for children, pregnant women, and parents and caretaker relatives, receive a standard income disregard equivalent to five percentage points of FPL (in 2014, \$82.50 for a family of 3). **Table 5.1** shows the income disregards for Medicaid programs in Texas.

Table 5.1: Income Disregards for Texas Medicaid Programs, 2014ⁱⁱ

Persons applying for Medicaid programs subject to the MAGI methodology, including most programs for children, pregnant women, and parents and caretaker relatives, receive a standard income disregard equivalent to five percentage points of FPL (in 2014, \$82.50 for a family of 3).

Persons applying for programs not subject to the MAGI methodology, including programs for people age 65 and older, those with disabilities, and SSI recipients may receive one or more of the following income disregards:

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

ⁱⁱ In addition to these income disregards, certain income is exempt for purposes of determining Medicaid income eligibility. Income exemptions include child support, grants, scholarships, and SSI.

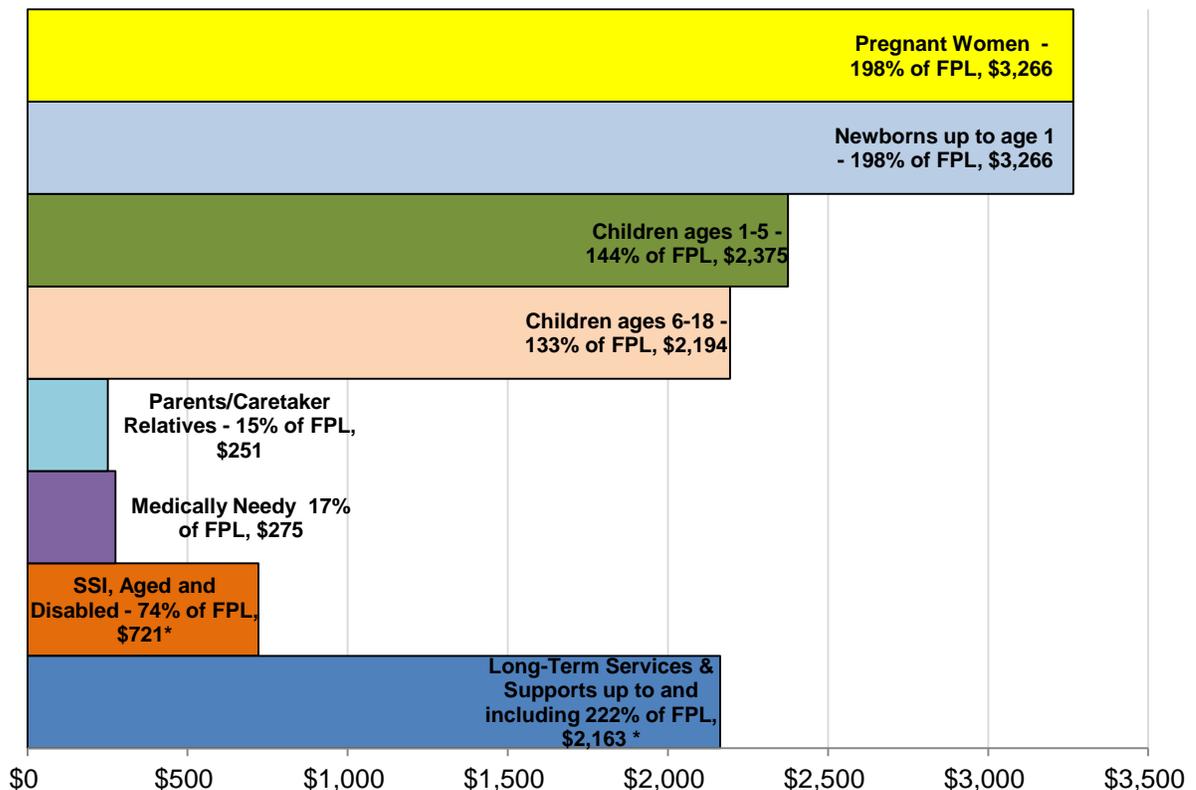
Table 5.2: Texas Medicaid Caseload by Eligibility Category SFY 2013

General Category for Full Medicaid Beneficiaries n=3,658,537	Eligible Category	FPL % or Income Limit	Percent of Medicaid Population
Families and Children (Non-Disability-Related)	Children less than 1	Up to 185%	7%
	Children 1-5	Up to 133%	25%
	Children 6-18	Up to 100%	39%
	Pregnant Women	Up to 185%	4%
	TANF Income Level Parents*	Up to \$188/month**	3%
	Medically Needy with Spend Down	Up to \$275/month**	Less than 1%
Medicaid Breast and Cervical Cancer Program	Women with an eligible breast or cervical cancer diagnosis receive full Medicaid benefits during treatment.	Up to 200%	Less than 1%
Aged, Medicare, and Disability- Related (Including SSI Cash Assistance)	SSI (Disability-Related) - Adult	No more than \$710/month**	7%
	SSI (Disability-Related) - Under 21	No more than \$710/month**	5%
	Aged and Medicare Related	No more than \$710/month**	10%
General Category for Non-Full Medicaid Beneficiaries, n = 355,482	Eligible Category	FPL % or Income Limit	Percent of Medicaid Population
Medicare-Related	Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)	Varies by program	65%
Emergency Care Only	Certain qualified immigrants and undocumented immigrants receive Medicaid for the expenses incurred for the actual days spent in the hospital based on an emergent condition.	Varies by age (based on risk categories above)	3%
Women’s Health Program	Non-Pregnant Women ages 18 - 44	Up to 185%	32%

*As of January 1, 2014, this program is referred to as Parents and Caretaker Relatives Medicaid.

**This percentage reflects the income limits for SFY 2013. As of January 1, 2014, federal rules required income limits for this program to be changed to a MAGI-converted amount.

Figure 5.1: Medicaid Eligibility in Texas, Maximum Monthly, March 2014



* Family of one adult.

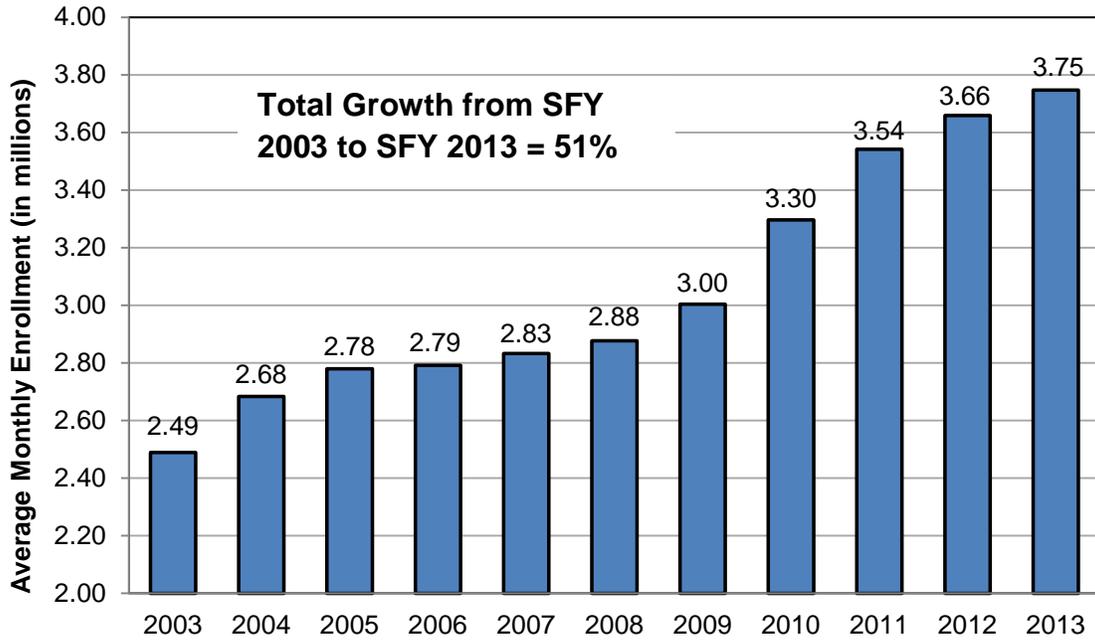
Note 1: "Countable Income" is gross income adjusted for allowable deductions, expenses, and disregards.

Note 2: SSI does not certify families, regardless of size; it certifies individuals and couples.

Size of the Medicaid Population

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

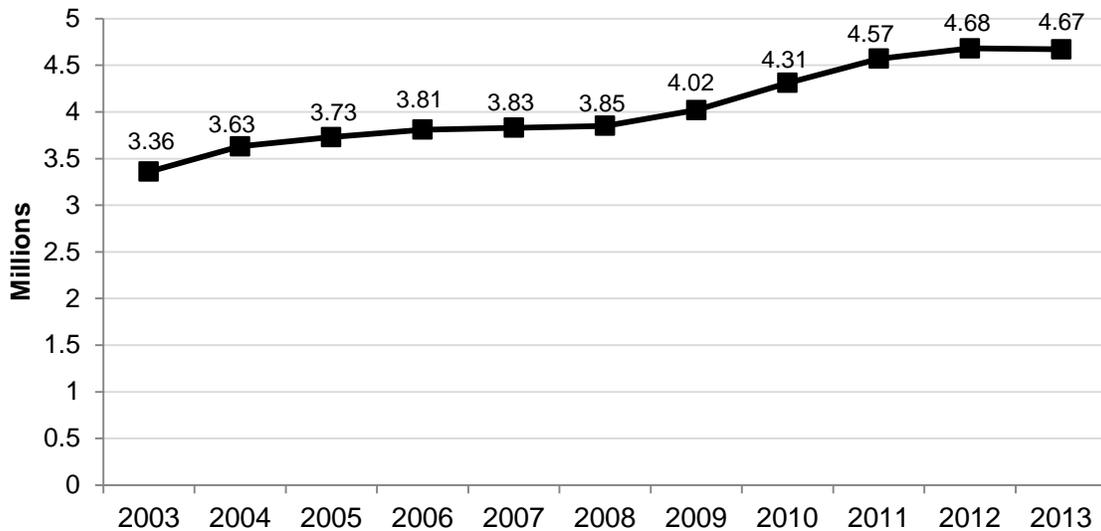
Figure 5.2: Average Monthly Medicaid Enrollment SFYs 2003-2013



Source: HHSC, Financial Services, HHS System Forecasting.

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

Figure 5.3: Unduplicated Number of Texas Medicaid Recipients SFYs 2003-2013



Source: HHSC, Financial Services, HHS System Forecasting.

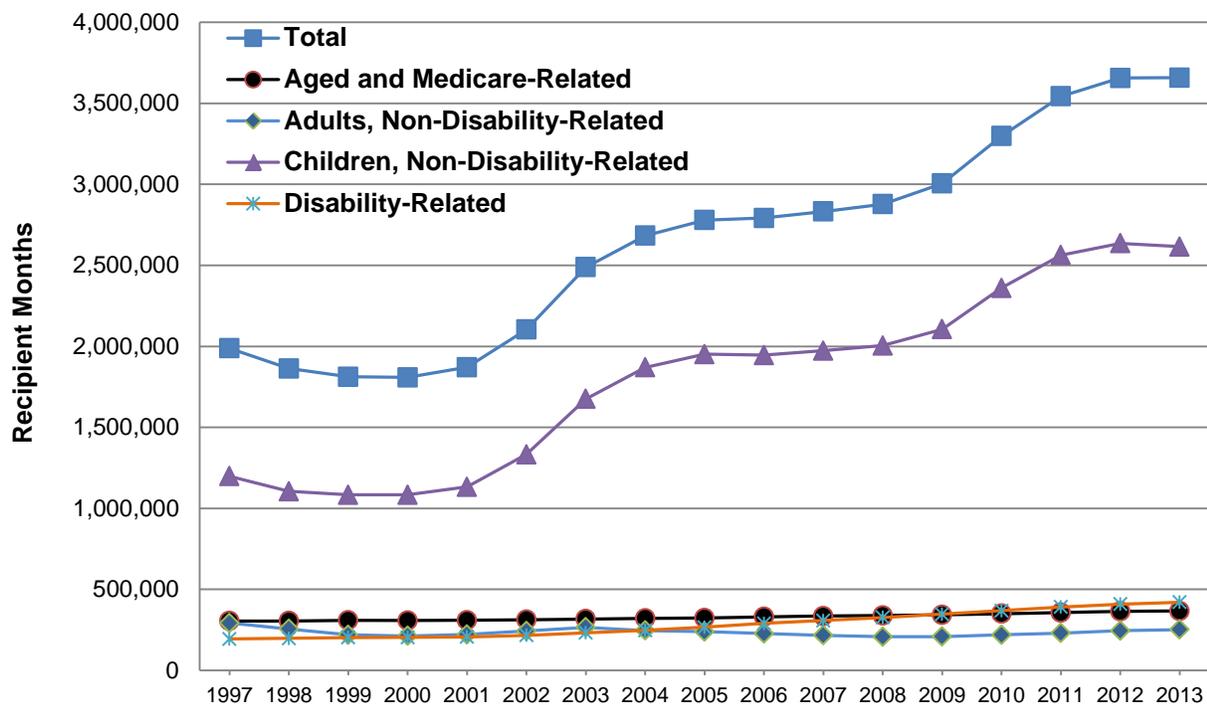
Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Changing Caseloads

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

Figure 5.4 shows changes in the Texas Medicaid caseload from 1997 to 2013.

Figure 5.4: Texas Medicaid Caseload (Average Recipient Months) SFYs 1997-2013



Source: HHSC, Financial Services, HHS System Forecasting.

Unemployment

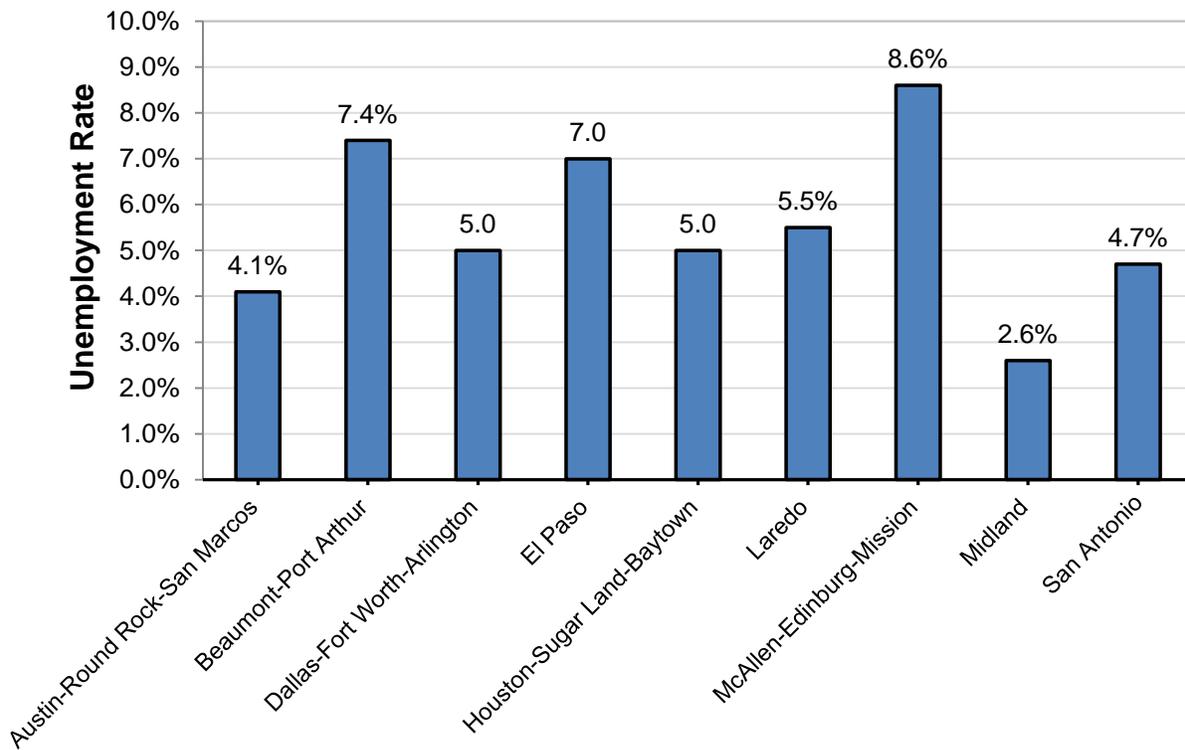
Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid due to their income level.

In May 2014, Texas’ seasonally adjusted unemployment rate was 5.1 percent, which was lower than the national rate of 6.3 percent. The percentage of working-age persons (ages 16 through 64) in Texas who had a job in May 2014 was 70 percent.

The unemployment rate varies among regions of the state, as shown in **Figure 5.5**. In May 2014, the Metropolitan Statistical Area (MSA) with the lowest unemployment rate was Midland, with a rate of 2.6 percent. The highest unemployment rate was in the McAllen-Edinburg-Mission MSA, with a rate of 8.6 percent.⁴

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

Figure 5.5: Unemployment Rates in Selected Texas Metropolitan Areas, May 2014



Source: Texas Workforce Commission.

Medicaid Demographics

Disability

Most likely, with the gradual aging of the population comes an increase in the number of people with a disability or other chronic health condition, which can cause difficulties in performing basic activities of daily living and functions, such as working, bathing, dressing, cooking, and driving. People with disabilities or chronic health conditions are more likely to need and use health and human services, so this trend could mean increased demand for services from the Texas Health and Human Services (HHS) agencies. The American Community Survey (ACS) for Texas, which is conducted by the

U.S. Census Bureau, indicates that in 2012 there were approximately three million, or 12 percent of all Texans, who lived with a disability. Among adults aged 18-64, the ACS reports that 10.3 percent had a disability in 2012. Among adults aged 65 and older, the ACS reports that 40.5 percent live with a disability.

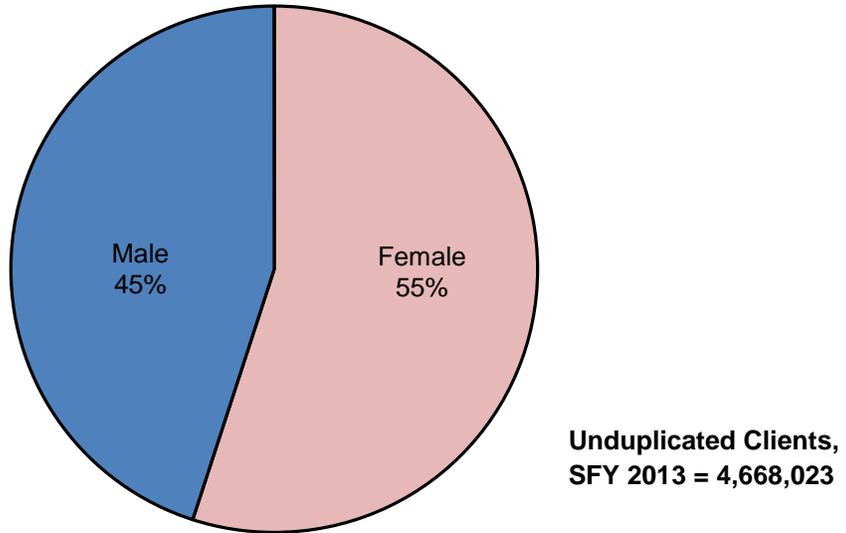
As of SFY 2011, about 14 percent of the people (children and adults) receiving Texas Medicaid services were eligible because of a disability. These clients may have been receiving Medicaid for a number of years, and, if they became eligible through a waiver program, may not receive SSI cash assistance. The proportion of disability-related clients likely understates the actual frequency of disabling conditions among Texans in the Medicaid program, because many people age 65 and older also have a disability, but are classified as part of the elderly Medicaid population rather than as Medicaid clients with disabilities.

Gender

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

- The poverty rate is slightly higher among women than men. For example, in 2012 the poverty rate for women in Texas was 19 percent while the rate for men was 16 percent.⁵
- Women live longer than men, on average, and the rate of poverty among women in Texas age 65 and older is higher than among their male counterparts (13 percent versus 9 percent in 2012)⁶.
- Medicaid for parents and caretaker relatives targets poor families, which in Texas are usually female-headed (95 percent in August 2012⁷). Female-headed single-parent families in Texas have higher poverty rates than their male-headed counterparts (34 percent versus 17 percent in 2012).⁸
- Medicaid covers eligible low-income women for pregnancy-related services.
- Medicaid covers eligible low-income women with a qualifying breast or cervical cancer diagnosis under the Medicaid for Breast and Cervical Cancer Program (MBCC).

**Figure 5.6: Texas Medicaid Recipients by Gender
SFY 2013**



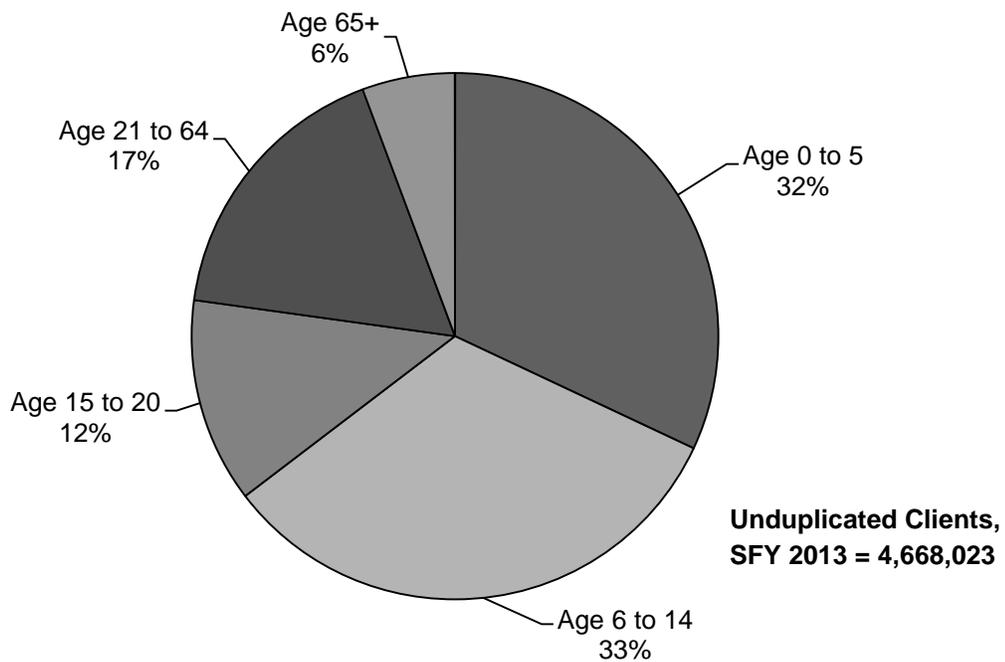
Source: HHSC, Financial Services, HHS System Forecasting.

Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Age

Figure 5.7 shows the age groups of clients receiving Texas Medicaid at some point during SFY 2013. Children and persons age 65 and older make up 83 percent of the program's clients. Seventy-seven percent of the program is comprised of people under age 21, and 65 percent are age 14 or younger.

Figure 5.7: Texas Medicaid Recipients by Age SFY 2013



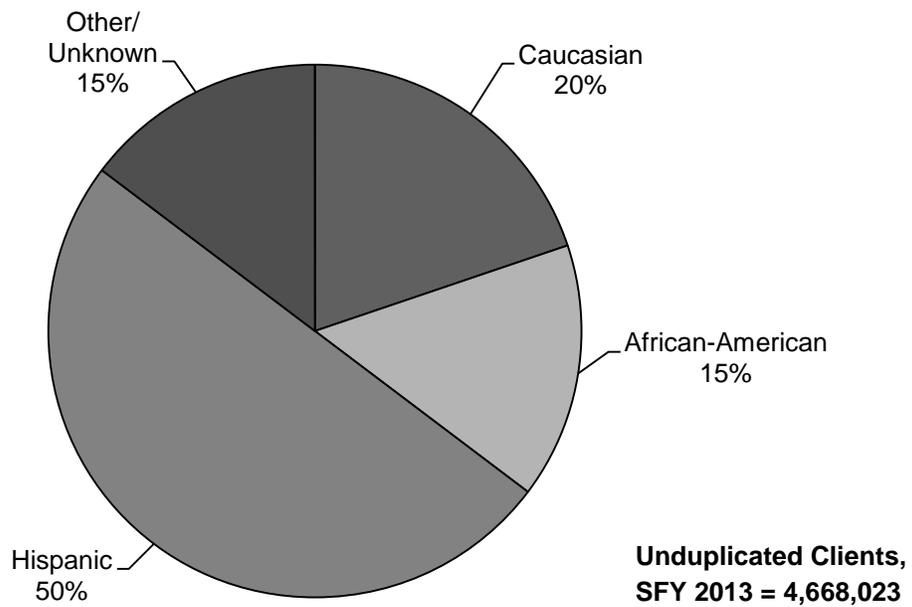
Source: HHSC, Financial Services, HHS System Forecasting.

Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Ethnicity

Figure 5.8 shows the ethnicity of clients receiving Medicaid at some point during SFY 2013. Hispanics account for the largest portion of Medicaid clients, comprising 50 percent of the Medicaid population. African-American and Hispanic Texans comprise higher percentages of the Medicaid population than of the general population.

Figure 5.8: Texas Medicaid Recipients by Ethnicity SFY 2013



Source: HHSC, Financial Services, HHS System Forecasting.

Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the year.

Poverty

Since Medicaid primarily serves low-income individuals, poverty in the state affects the number of people eligible for the Medicaid program. In 2012, about 4.6 million Texans (17.6 percent of the state's population) lived at or below the federal poverty level, and approximately 39 percent of these were children under age 18. Approximately 26 percent of all Texas children under age 18 were living at or below the federal poverty level in 2012.⁹ Approximately 26 percent of Hispanics and 23 percent of African-Americans in Texas were living at or below the poverty level in 2012, along with 9 percent of White Non-Hispanics.

Table 5.3 lists the Federal Poverty Guidelines by family size for 2012-2014

Table 5.3: Federal Poverty Guidelines, 2012-2014

(For the 48 Contiguous States)

Size of Family Unit	2012 Annual Income	2013 Annual Income	2014 Annual Income
1	\$11,170	\$11,490	\$11,670
2	\$15,130	\$15,510	\$15,730
3	\$19,090	\$19,530	\$19,790
4	\$23,050	\$23,550	\$23,850
5	\$27,010	\$27,570	\$27,910
6	\$30,970	\$31,590	\$31,970
7	\$34,930	\$35,610	\$36,030
8	\$38,890	\$39,630	\$40,090
For each additional person, add	\$3,960	\$4,020	\$4,060

Source: U.S. Department of Health and Human Services, HHS Poverty Guidelines, 2012-2014 <http://aspe.hhs.gov/poverty/> (July 2014).

Federal Medical Assistance Percentage

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

FMAP rate of 59.30 percent is a slight increase from Texas' FFY 2012 FMAP rate of 58.22 percent.

Table 5.4 shows Texas' FMAP and Enhanced FMAP (used for CHIP federal match) percentages for FFYs 1998-2015.

Table 5.4: Texas Federal Medical Assistance Percentages (FMAP)

Federal Fiscal Year	Federal Medical Assistance Percentage	Enhanced Federal Medical Assistance Percentage	American Reinvestment and Recovery 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

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

Births in Texas

The number of births reported in Texas has seen a slight decrease in recent years as shown in **Table 5.5** and **Table 5.6**.

Table 5.5 shows the births in Texas by ethnicity and percent Medicaid paid from calendar years (CYs) 2005 to 2012, the most recent data available.

A substantial percentage of all live births in Texas are attributed to Hispanic women. The proportion of all births attributable to Hispanic mothers increased steadily from 37 percent of all births in 1990 to a peak of 50.1 percent of all births in 2009, followed by a slow but steady decrease to 47.8 percent in 2012. During that same period, the proportion of births to African-American mothers peaked at 14 percent in 1990 but decreased to 11.3 percent by 2012. As shown at the bottom of Table 5.5, the percentage of Medicaid-paid births in Texas stayed fairly consistent over time. In 2012, 53.8 percent of all Texas births were paid by Medicaid.

Table 5.5: Births in Texas, CYs 2005-2012

Births	2005	2006	2007	2008	2009	2010	2011	2012
Total Births	385,537	399,309	407,453	405,242	401,599	385,746	377,274	382,438
% Hispanic	49.7%	49.6%	50.2%	50.1%	50.1%	49.0%	48.3%	47.8%
% Caucasian	35.5%	34.7%	34.1%	34.1%	33.9%	34.6%	35.0%	34.6%
% African American	11.0%	11.5%	11.3%	11.3%	11.3%	11.5%	11.4%	11.3%
% Other	3.8%	4.2%	4.4%	4.6%	4.7%	4.9%	5.2%	6.3%
% Medicaid Paid	55.8%	55.9%	56.0%	55.4%	55.9%	57.0%	56.4%	53.8%

Source for Births by Race/Ethnicity: Texas Department of State Health Services, Texas Health Data. <http://soupin.tdh.state.tx.us/birthdoc.htm>.

Source for % Medicaid Paid: Medicaid Paid Births--Texas. HHSC, Strategic Decision Support, April 2014.

Table 5.6 illustrates the percent distribution of live births in CY 2012, the most recent data available, according to the mother's age group and race/ethnicity. The data show a higher percentage of births to young mothers (women under age 20) for Hispanic women (14.4 percent) and African-American women (12.3 percent) compared to Caucasian women (6.4 percent).

Table 5.6: Percent Distribution of Live Births in Texas by Mother's Age and Ethnicity, CY 2012

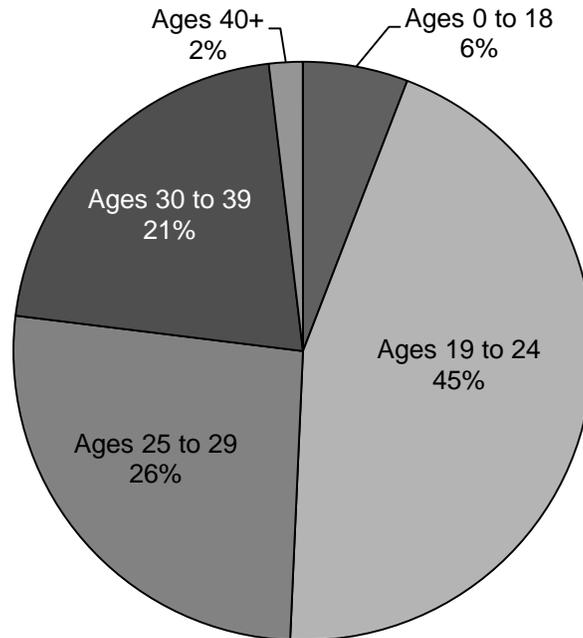
Age	Hispanic	Caucasian	African American	Other	All
Unknown	0.0%	0.0%	0.0%	0.0%	0.0%
10 to 14	0.2%	0.0%	0.2%	0.1%	0.1%
15 to 17	5.0%	1.6%	3.6%	1.0%	3.4%
18 to 19	9.2%	4.8%	8.5%	2.4%	7.2%
20 to 29	54.7%	52.3%	57.9%	40.4%	53.3%
30 to 39	28.7%	38.6%	27.6%	52.1%	33.5%
40 plus	2.2%	2.7%	2.3%	4.0%	2.5%

Source: Texas Department of State Health Services, Texas Health Data at <http://soupin.tdh.state.tx.us/birthdoc.htm>. HHSC, Financial Services.

Age of Pregnant Women

Figure 5.9 shows the number of pregnant women served by the Texas Medicaid program in SFY 2013 by age group. Almost one-half (45 percent) of the pregnant women in the Texas Medicaid program are between the ages of 19 and 24, while 6 percent are under age 19. While private insurance companies can no longer exclude pregnant women seeking health insurance, many young pregnant women are less likely to be able to afford insurance. They are also more likely to work at low-level jobs that do not provide health coverage. The Texas Medicaid program extends coverage to pregnant women with incomes up to 198 percent of FPL (\$39,192 for a family of three in 2014).

**Figure 5.9: Pregnant Women on Medicaid in Texas by Age Group
SFY 2013**

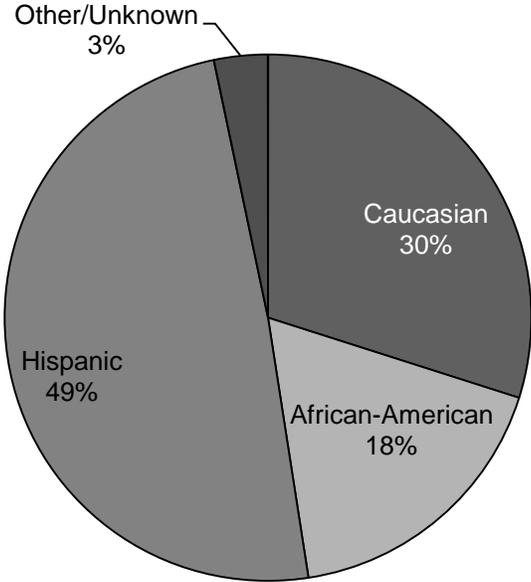


Source: HHSC, Financial Services, HHS System Forecasting.

Ethnicity of Pregnant Women

Figure 5.10 shows the ethnicity of pregnant women served by the Texas Medicaid program in SFY 2013.

Figure 5.10: Pregnant Women on Medicaid in Texas by Race/Ethnicity SFY 2013



Source: HHSC, Financial Services, HHS System Forecasting.

Endnotes

¹ TWB #14-05 - ACA implementing policy bulletin.

² HHSC, *Monthly MMA Dual Eligible Counts*.

³ HHSC, *Monthly MMA Dual Eligible Counts*.

⁴ Texas Workforce Commission, <http://www.twc.state.tx.us/> (June 2014).

⁵ U.S. Census Bureau, "American Community Survey for Texas," 2012.

⁶ U.S. Census Bureau, "American Community Survey for Texas," 2012.

⁷ August 2012, TANF Demographic Profile, HHSC

⁸ U.S. Census Bureau, "American Community Survey for Texas," 2012.

⁹ U.S. Census Bureau, "American Community Survey for Texas" 2012.

Chapter 6: Medicaid Benefits

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

Medicaid Benefits

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

Federal law allows states to define what constitutes reasonable sufficient amount, duration, and scope of Medicaid benefits. This means that state Medicaid programs can, for example, limit the number of visits per year for a certain service or limit a service to outpatient settings. The following limits are not applicable to children under 21 whenever there is a medical necessity for additional services.

Limits on Texas Medicaid services include:

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

Table 6.1: Mandatory and Optional Services Covered by Texas Medicaid

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

Mandatory and optional services provided in Texas include:

Mandatory Acute Care Services	Optional* Acute Care Services
<ul style="list-style-type: none"> • Inpatient hospital services • Outpatient hospital services • Laboratory and x-ray services • Physician services • Medical and surgical services provided by a dentist • Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21 • Family planning services and supplies • Federally Qualified Health Centers (FQHC) • Rural health clinic services • Nurse-midwife services • Certified pediatric and family nurse practitioner services • Home health care services 	<ul style="list-style-type: none"> • Prescription drugs • Medical or remedial care furnished by other licensed practitioners: <ul style="list-style-type: none"> ○ Physician extenders ○ Nurse practitioners/certified nurse specialists ○ Certified registered nurse anesthetists ○ Physician assistants ○ Mental health providers ○ Psychologists ○ Licensed professional counselors ○ Licensed marriage and family therapists ○ Licensed clinical social workers** • Podiatry*** • Limited chiropractic services • Optometry, including eyeglasses and contacts • Hearing instruments and related audiology • Renal dialysis • Rehabilitation and other therapies <ul style="list-style-type: none"> ○ Mental health rehabilitation ○ Rehabilitation facility services ○ Substance use disorder treatment ○ Physical, occupational, and speech therapy • Clinic services <ul style="list-style-type: none"> ○ Maternity service clinics • Targeted case management for pregnant women

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

<i>Mandatory Long-Term Services and Supports (LTSS)</i>	<i>Optional* Long-Term Services and Supports (LTSS)</i>
<ul style="list-style-type: none"> • Nursing facility (NF) services for clients 21 or over 	<ul style="list-style-type: none"> • Intermediate Care Facility services for an Individual with Intellectual Disability or Related Conditions (ICF/IID) • Inpatient services for clients under age 21 or 65 and over in an institution for mental diseases (IMD) • Services furnished under a Program of All-Inclusive Care for the Elderly (PACE) • Day Activity and Health Services • Home and community-based waiver services • Attendant services <ul style="list-style-type: none"> ○ Primary Home Care ○ Community Attendant Services • Targeted case management for individuals with intellectual disabilities and mental health conditions • Hospice services

Notes: *Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.

**Except when delivered in an FQHC setting.

***Except when delivered by a M.D. or D.O.

Coverage for Children

Children with Medicaid coverage are eligible to receive a broader array of health care services than commercial health insurance policies or Medicaid services for adults. Medicaid for children provides certain health care services including long-term physical, occupational, and speech therapies, and comprehensive dental services. If a child is enrolled in Medicaid medical or dental managed care, they will receive these services through the managed care model.

Texas Health Steps

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

Medicaid children to allow early treatment of any identified problems. THSteps offers comprehensive and periodic screening of children's, adolescents', and young adults' physical, developmental, mental health, and nutritional status, as well as vision, hearing, and dental screenings and care.

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

THSteps medical and dental checkups are provided periodically. The interval between scheduled medical checkups depends on the child's age. More medical checkups are scheduled for the birth through 2 years of age population, and annual checkups are indicated for children ages 3 through 20. A THSteps medical checkup includes these federally mandated components:

- Comprehensive Health and Developmental History;
- Comprehensive Unclothed Physical Examination;
- Immunizations;
- Laboratory Screening; and
- Health Education/Anticipatory Guidance.

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

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

THSteps provides periodic dental checkups and preventive care for children 6 months through 20 years of age. The intervals between dental checkups depend on the child's age and risk for dental disease. THSteps supports the initiative to reach children with preventive oral health screening and care at the earliest appropriate age (six months) and to establish a dental home for them. The objective is to identify those at high risk of

developing dental disease, start preventive services, treat decay early, and educate families about the importance of good oral health habits. More frequent dental checkups are available for children 6 through 35 months of age with semi-annual checkups available for children, adolescents and young adults 3 through 20 years of age. Recipients or their caretakers may self-refer for dental care at any time and any age from birth through 20 years of age.

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

Table 6.2 highlights THSteps program services and outreach activities.

Table 6.2: THSteps Program Highlights and Outreach Activities

Services provided in 2013:

- 1,869,728 THSteps eligible recipients¹ received at least one initial or periodic medical checkup.
- 65 percent² of the population eligible for services received services.
- At least one preventive dental service was provided to 1,641,234 children.
- Therapeutic dental services were provided to 949,577 recipients.

Outreach and Education:

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

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

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

To promote the efficient and effective use of THSteps, THSteps program staff proactively liaison with related children’s health programs and agencies such as:

- Head Start;
- Independent school districts;
- Institutions of higher education;
- Other state programs such as Immunizations, Childhood Lead Poisoning Prevention Program (CLPPP), Children with Special Health Care Needs Services Program (CSHCN), WIC, Maternal and Child Health, and Early Childhood Intervention (ECI);
- Community-based organizations; and
- Medical, dental, and case management providers and their professional organizations

Source: Form CMS-416: Annual EPSDT Participation Report, Federal Fiscal Year 2013.

¹ THSteps population and service recipients refer to children who were enrolled in the THSteps Program for at least 90 continuous days during the reporting year. This change has been implemented for CMS-416 reporting since 2011.

² This statistic is not a simple percentage, but an index that takes account of the periodicity of medical checkups and the average enrollment length for the eligibles.

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

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

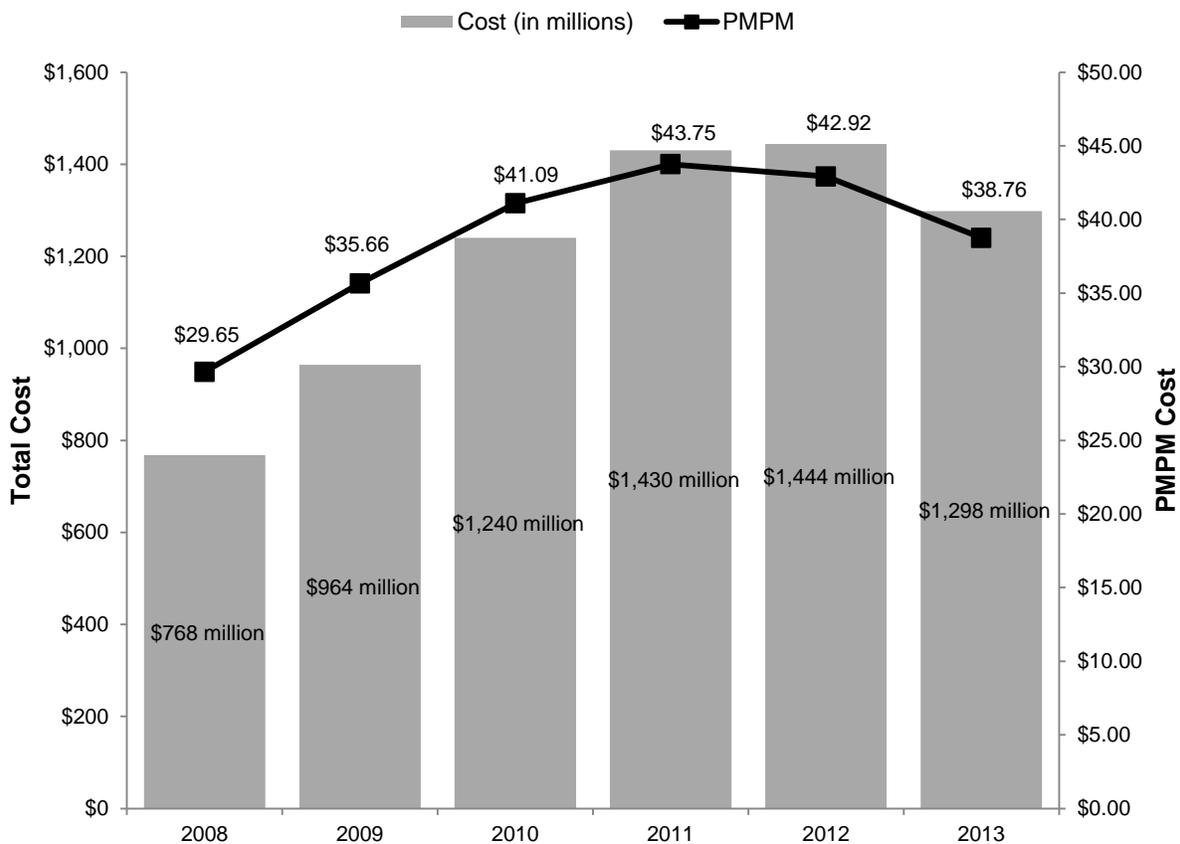
Texas Health Steps Funding

THSteps medical and CCP service costs are included in capitated managed care organization (MCO) rates for children enrolled in managed care. Children not in

capitated managed care or children receiving retroactive coverage have their medical and CCP costs paid through Medicaid FFS. All THSteps dental costs for children were paid through FFS until the inclusion of dental services in managed care on March 1, 2012.

Figure 6.1 shows the total dental (and orthodontic) THSteps costs and the cost per client from 2008–2013. From 2008 to 2009, there was a 20 percent increase in the “per member per month” (PMPM) cost. From 2009 to 2010, the PMPM increase was 15 percent, and a 6 percent increase in 2011. Costs peaked at \$44 PMPM in 2011. Overall, cost for dental services has declined to \$39 PMPM in 2013.

Figure 6.1 THSteps Total Cost and Cost per Recipient Month, Medicaid Dental Services SFYs 2008-2013



Source: HHSC, Financial Services, HHS System Forecasting.

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

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

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

The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996.ⁱⁱ The decree sets out numerous state obligations relating to THSteps. It also provides that the federal district court will monitor compliance with the orders by the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the court found the state defendants in violation of several of the decree's sections.

In 2007, the parties agreed to 11 corrective action ordersⁱⁱⁱ to bring the state into compliance with the consent decree and increase access to THSteps' services. The corrective action orders touch upon many program areas, and generally require the state to take actions intended to assure access to or measure access to Medicaid services for children. The Texas Medicaid program must consider these obligations in all policy and program decisions for Medicaid services available for persons from birth through 20 years of age.

Since 2007, HHSC and DSHS have actively worked to meet the requirements of each of the corrective action orders. H.B. 15, 80th Legislature, Regular Session, 2007, appropriated an estimated \$1.8 billion all funds, including \$706.7 million in general revenue (GR) funds, for the 2008-09 biennium to allow the agencies to implement required activities.

As an example, in September 2007, HHSC increased rates for services provided to individuals with Medicaid under age 21 by Medicaid-enrolled physicians, physician specialists, dentists, dental specialists, and certain other professionals. The *Frew* orders

ⁱ *Frew* class members are Medicaid clients, birth through age 20, who have not received all of the Texas Health Steps services to which they are entitled, unless the services were knowingly and voluntarily declined.

ⁱⁱ The Consent Decree is available on the HHSC website at:
<http://www.hhsc.state.tx.us/medicaid/frew/>

ⁱⁱⁱ The Corrective Action Orders are available on the HHSC website at:
<http://www.hhsc.state.tx.us/medicaid/frew/>

do not require a specific level for Medicaid rates. However, the orders do include requirements regarding access to care, and regarding provider rates being sufficient to enlist enough providers to meet the needs of Medicaid recipients under age 21.

The 2007 corrective action orders also required the agencies to implement strategic initiatives intended to expand access to care for children with Medicaid. The 80th Legislature, Regular Session, 2007, appropriated \$150 million to be applied to strategic initiatives in 2008-09. The 81st Legislature, Regular Session, 2009, authorized use of unexpended funds for the 2010-11 biennium. The state implemented 22 strategic initiatives. A number of these initiatives continue as part of Medicaid client services or agency administrative services (e.g. First Dental Home, Oral Evaluation and Fluoride Varnish in the Medical Home, lab courier service, and migrant services data exchange).

In 2013, the court vacated two of the eleven corrective action orders and related paragraphs of the consent decree after finding the state defendants had complied with the required actions for checkup reports and plans for lagging counties; and prescription and non-prescription medications, medical equipment, and supplies. HHSC and DSHS continue to be bound by the remaining obligations of consent decree and the corrective action orders. The court continues to monitor the agencies' compliance with the orders. The consent decree does not have a specific end date, although the corrective action orders are intended to create potential endpoints for the agencies' obligations.

Alberto N. v. Janek

The federal lawsuit *Alberto N., et al. v. Janek* requires HHSC to comply with Title XIX of the Social Security Act¹ by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for THSteps-CCP. These services include personal care services (PCS), nursing services (including Private Duty Nursing), durable medical equipment (DME), and other Medicaid-covered services that are deemed medically necessary.

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

The *Alberto N.* agreement required HHSC to develop and implement a new assessment instrument to further improve access to care for THSteps-CCP beneficiaries. Under a

contract with HHSC, the Texas A&M University System Health Science Center's School of Rural Public Health and Texas A&M University's Public Policy Research Institute developed the Personal Care Assessment Form (PCAF). The PCAF was implemented on September 1, 2008. The PCAF provides DSHS case managers with a reliable and valid instrument with which to develop appropriate service plans for children and to identify a child's need for other medically necessary services, such as physical, occupational, and speech therapies; nursing; and DME.

Programs for Women and Children

Case Management for Children and Pregnant Women Services

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

Medicaid Buy-In for Children

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

Early Childhood Intervention

Early Childhood Intervention (ECI) is a statewide program that provides services to families with children from birth to three years of age with developmental delays or disabilities. The Department of Assistive and Rehabilitative Services (DARS) contracts with local agencies to provide services in all Texas counties. Contractors include community centers, school districts, education service centers, and private nonprofit organizations. ECI contractors must enroll with Texas Medicaid to receive reimbursement for targeted case management (TCM), specialized skills training (SST), therapy, and other Medicaid benefits.

Blind Children's Vocational Discovery and Development Program

The Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program supports children from birth to 22 years of age with vision impairments and their families to develop a pathway for a successful future. Through targeted case management (TCM), the program helps consumers eligible under the state plan and their families gain access to medical, social, educational, developmental, and other appropriate services. Medicaid reimbursement for targeted case management services is limited to children up to age 20.

Texas Women's Health Program

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

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

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

elective abortions or that affiliates with entities that perform or promote elective abortions.

To implement this statutory requirement, HHSC adopted new rules effective March 14, 2012, barring from participation in the WHP any provider that performs or promotes elective abortions or that affiliates with another entity that performs or promotes elective abortions. Citing the adoption of these rules, the federal government denied the state's request to extend the demonstration waiver.

To prevent the loss of family planning services for Texas women, Governor Perry directed HHSC to create a state-funded program.

TWHP was fully implemented on January 1, 2013.

TWHP is for women who meet the following qualifications:

- Are ages 18 through 44 (women can apply the month of their 18th birthday through the month of their 45th birthday);
- Are U.S. citizens or qualified immigrants;
- Reside in Texas;
- Are not eligible to receive full Medicaid benefits, CHIP, or Medicare Part A or B;
- Are not pregnant;
- Are not sterile, infertile, or unable to get pregnant due to medical reasons;
- Do not have private health insurance that covers preventive health services (unless filing a claim on the health insurance would cause physical, emotional, or other harm from a spouse, parent or another person); and
- Have a net family income at or below 185 percent FPL. For example, the monthly net income for a woman in a family of two cannot exceed \$2,426.^{iv}

Benefits for eligible participants include:

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

^{iv} This amount reflects the 2014 FPL Guidelines.

There were 198,252 women enrolled in TWHP in calendar year (CY) 2013.² An unduplicated total of 77,031 women had a paid claim for TWHP services in CY 2013.³

In CY 2013, TWHP expenditures totaled \$21 million all funds. The state’s expenditures totaled approximately \$21 million GR, including expenditures for services, administration, and outreach.^v

The most recent birth and savings data indicated a reduction of 7,395 expected births for CY 2011, and HHSC estimated the decrease in Medicaid costs to be about \$76.7 million all funds. After paying all costs associated with WHP, the services provided in 2011 saved about \$41.6 million all funds. The state share of the reduction in Medicaid costs totaled approximately \$23.1 million GR, and the net state share of savings after paying WHP expenditures totaled approximately \$19.5 million GR.⁴

Prescription Drugs

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

In SFY 2013, an average of 3.7 million clients per month were eligible to receive medications through the program. Texas Medicaid paid \$2.7 billion for over 38.8 million prescriptions that year through FFS and managed care, with an average cost per prescription of \$69.08.

Table 6.3 lists Medicaid drug benefits by client groups.

Table 6.3: Drug Benefits by Client Group

Unlimited Prescriptions:
Children under 21 years of age.
People who are age 65 and older and those with a disability and that reside in a nursing facility.
People who are age 65 and older and those with a disability that live in the community and receive waiver services.
Members enrolled in STAR, STAR Health, or STAR+PLUS.
Limited to Three Prescriptions per Month:
TANF FFS adults.

^v Medicaid claims data for 2012 are incomplete.

Outpatient Drug Benefit in Fee-for-Service

VDP directly contracts with over 4,800 dispensing pharmacies to provide prescription drugs to clients in Medicaid FFS and managed care. Texas pays for all FFS outpatient drug coverage through VDP, with the exception of some medications provided as part of outpatient physician services.

As of January 1, 2006, clients who are dually eligible for Medicaid and Medicare began receiving most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D. (See Chapter 2, Medicaid History and Organization, Medicare Prescription Drug Improvement and Modernization Act of 2003.)

Section 1860D- 2(e)(2)(A) of the Medicare Improvements for Patients and Providers Act of 2008 was amended to include barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines. Beginning January 1, 2013, Texas Medicaid no longer covers barbiturates and benzodiazepines for dual eligible clients.

Outpatient Drug Benefit in Managed Care

Most Medicaid clients and all CHIP clients obtain their prescription drug benefits through an MCO as required by S.B. 7, 82nd Legislature, First Called Session, 2011. Outpatient prescription drugs are a benefit of CHIP and each Medicaid managed care program: STAR, STAR+PLUS, and STAR Health.

Each MCO has its own participating pharmacy network comprised of pharmacies contracted with VDP to allow local pharmacies to dispense pharmaceuticals to managed care members. The MCO contracts with a pharmacy benefits manager (PBM) to process prescription claims, and the PBM contracts and works with pharmacies that actually dispense medications to CHIP and Medicaid managed care members. MCOs must allow any pharmacy provider willing to accept the financial terms and conditions of the contract to enroll in the MCO’s network. Pharmacy providers must be contracted with VDP before participating in any network.

MCOs and PBMs are required by state law to adhere to the VDP Medicaid and CHIP formularies, and the Medicaid preferred drug list (PDL) until August 31, 2018. Prior authorization (PA) is required for non-preferred drugs and drugs subject to clinical PA edits. MCOs/PBMs may implement any of the VDP’s clinical PA edits, but no more. If the MCO/PBM wants to establish a clinical edit PA on a drug, the clinical PA edit must be submitted to HHSC for review and approval by the VDP Drug Utilization Review Board.

If a drug is neither preferred nor non-preferred on the PDL, the MCO/PBM cannot establish a drug as non-preferred and implement a PDL prior authorization.

Federal Drug Rebate Program

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

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

Two subsequent pieces of federal legislation further updated the rebate provisions. The Deficit Reduction Act (2005) extended the rebate program to outpatient drugs administered in a physician's office or another outpatient facility. The Affordable Care Act (ACA) increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The ACA also expanded the rebate program to cover claims paid by Medicaid MCOs.

The Vendor Drug Program manages the federal manufacturer drug rebate program and collects rebates for medications dispensed by pharmacies and administered by physicians to Medicaid clients in FFS and managed care. Texas negotiates additional state rebates for preferred drugs. VDP also collects rebates for drugs provided to clients in CHIP and three state health programs, including the Texas Women's Health Program. The 2014-15 General Appropriations Act (GAA) (Article II, HHSC, Rider 24, S.B. 1, 83rd Legislature, Regular Session, 2013) requires HHSC to submit an annual report to the legislature on rebate revenues and outstanding balances. The 2014-15 General Appropriations Act (GAA) (Article II, HHSC, Rider 5, S.B. 1, 83rd Legislature, Regular Session, 2013) establishes collected rebates as the first source of funding for

Medicaid and CHIP prescription drug services, before general revenue. VDP collected approximately \$1.5 billion all funds in Medicaid rebates in SFY 2013.

Drug Utilization Review

Prospective and retrospective Drug Utilization Review (DUR) plays a key role in how HHSC understands, evaluates, and improves the prescribing, administration, and use of medications.

Prospective DUR evaluates each client's drug history before medication is dispensed to ensure appropriate and medically necessary utilization. Advisory messages concerning clinically significant drug interactions or ingredient or therapeutic duplication are part of the point-of-sale claim adjudication process.

Retrospective DUR reviews the drug therapy after the client has received the medication. Reviews examine claim data to analyze prescribing practices, medication use by clients, and pharmacy dispensing practices. HHSC conducts multiple reviews each calendar year that focus on patterns of drug misuse, medically unnecessary prescribing, or inappropriate prescribing. Intervention letters are sent to physicians to help better manage clients' drug therapy.

The Texas Drug Utilization Review Board is an HHSC advisory board that consists of practicing physicians and pharmacists appointed by the HHSC Executive Commissioner. The DUR Board reviews and approves the therapeutic criteria for prospective and retrospective DUR and clinical prior authorization edits. Board meetings are held quarterly in Austin.

Preferred Drug List and Supplemental Rebate Program

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

The PDL contains medications in various therapeutic classes that are designated as "preferred" or "non-preferred" based on safety, efficacy, and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must obtain prior authorization. The Texas Pharmaceutical and Therapeutics Committee reviews drugs

and drug classes and recommends to HHSC, which pharmaceuticals should be listed as preferred or non-preferred status on the PDL.

With a PDL, Medicaid clients have access to all of the drugs Medicaid is required to cover under federal law, including those covered before the PDL was established. The PDL controls spending growth by increasing the use of preferred drugs. Unless Texas Medicaid has historical paid claim information that indicates a patient meets the state's authorization criteria, a physician's office must call to obtain approval before a non-preferred drug can be reimbursed. By containing drug costs, the PDL helps to preserve Medicaid's ability to meet clients' increasing prescription drug needs, as well as other health care needs.

The MCOs implemented the VDP's PDL and do not have prior authorization requirements more stringent than those in place for FFS as required by S.B. 7, 82nd Legislature, First Called Session, 2011 and the 2012-13 GAA, (Article II, HHSC, Rider 81, H.B. 1, 82nd Legislature, Regular Session, 2011).

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

HHSC collected approximately \$168.1 million all funds (\$70.5 million in GR) in supplemental rebates in SFY 2013. The ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount.

Medical Transportation Program

The Medical Transportation Program (MTP) is responsible for arranging and administering cost-effective, non-emergency medical transportation (NEMT) services to eligible Medicaid clients, Children with Special Health Care Needs (CSHCN) clients, and Transportation for Indigent Cancer Patients (TICP) who are diagnosed with cancer or cancer-related illness and meet program financial and residential eligibility criteria and who have no other means of transportation. MTP uses several transportation

methods that comply with federal regulations that are efficient, cost effective, and meet client needs.

Payment Models

Managed Transportation Organizations

S.B. 8, 83rd Legislature, Regular Session, 2013, required HHSC to implement a Managed Transportation Organization (MTO) model for the delivery of services. The NEMT delivery model is performed in contiguous counties within a managed transportation service region. The shift in the type of transportation model also includes a change in the payment structure that requires providers to operate under a capitated rate structure and assume financial responsibility under a full risk model.

Full-Risk Broker

The 2010-11 GAA (Article II, HHSC, Rider 55, S.B. 1, 81st Legislature, Regular Session, 2009) required HHSC to implement a full-risk brokerage (FRB) model in areas of the state that could sustain the model. The FRB provides an array of transportation services to clients in a specified geographic area. The Texas Health and Human Services system (HHS) has contracted with two FRBs to coordinate transportation using a network of providers in the Dallas/Fort Worth and Houston/Beaumont services delivery areas.

Transportation and Related Services

Mass Transit

Mass transit is intercity or intra-city transportation by bus, rail, air, ferry, or either publicly or privately owned transit which provides general or special service on a regular or continuing basis. Mass transit also involves using commercial air service to transport eligible program clients to an authorized covered health care service.

Demand Response

Demand response services are contractor provided transportation when fixed route services are either unavailable or do not meet the health care needs of clients. The MTO or Regional Contracted Broker responds to requests for individual or shared one-way trips.

Individual Transportation Participant

Individual Transportation Participant (ITP) services are provided by individuals who volunteer to participate in the MTO Individual Transportation Provider program. ITPs enter into an agreement to receive mileage reimbursement at the state established rate to provide transportation to a Medicaid eligible client. Mileage reimbursement is paid to an individual who drives himself, a family member, friend, or neighbor to and from a Medicaid covered health care service. MTP increased the mileage reimbursement rate for eligible ITPs to match the state employee rate of \$0.56 per mile effective September 1, 2014.

Meals and Lodging

Meals and lodging are provided for Medicaid and CSHCN children and their attendant when health care treatment requires an overnight stay outside the county of residence or beyond adjacent counties. The MTO provides the client and attendant (regardless of age) an allowance of \$25 per day per person.

Advanced Funds

Advanced funds are funds authorized by the MTO in advance of travel and provided to the client or attendant to cover authorized transportation services, i.e., gas money for travel to a medically necessary health care service and lodging and/or meals in connection with a medically necessary health care service.

Out-of-State Travel

The MTO provides transportation to contiguous counties or bordering counties in adjoining states (Louisiana, Arkansas, Oklahoma, and New Mexico) that are within 50 miles of the Texas border if the services are medically necessary and it is customary or general practice of clients in a particular locality within Texas to obtain services from the out-of-state provider. The MTO can arrange and pay for out-of-state travel for clients who need to travel to states outside of the adjoining states for medically necessary health care services that cannot be provided within the state of Texas.

Commercial Airline Transportation Services

The MTO is responsible for arranging commercial air transportation to meet the client's needs for the client and attendant, when applicable (i.e. out of state, out of client's resident MTO region).

Program Enhancements

The managed transportation delivery model was implemented to improve the cost effectiveness of program operations and establish efficient transportation systems in each of the designated regions. MTOs began providing NEMT services under the new model on September 1, 2014. MTP Contract Management Operations' primary role is to ensure that the provisions of the NEMT contracts are met, and performance standards and measures are achieved on a consistent basis.

Behavioral Health Services

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

- Therapy by psychiatrists;
- Therapy by psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists;
- Inpatient psychiatric care in a general acute hospital;
- Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older);
- Outpatient adolescent chemical dependency counseling by state-licensed facilities;
- Prescription medicines;
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance;
- Ancillary services required to diagnose or treat behavioral health conditions;
- Care and treatment of behavioral health conditions by a primary care physician;
- Comprehensive substance use disorder benefits for adults in Medicaid including assessment, medication-assisted therapy, outpatient and residential detoxification, and outpatient and residential treatment; and
- Services through the Youth Empowerment Services (YES) waiver program for children and young adults ages 3 to 19 that are at risk of hospitalization because of serious emotional disturbance.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals, and by community mental health centers and chemical dependency treatment programs. Behavioral health services are also included in CHIP and Texas managed care programs such as STAR, STAR Health, STAR+PLUS, and NorthSTAR. NorthSTAR is a behavioral health managed care

program that offers a broader array of behavioral health services than other managed care programs. These additional services are paid for through savings derived from better management of services.

Mental Health Parity

The Mental Health Parity Act was passed by Congress in 1996, requiring that annual or lifetime limits on mental health benefits be no lower than the limits for mental or surgical benefits offered by group health or health insurance plans. In 2008, the U.S. Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act (MHPAEA). MHPAEA requires insurance plans, public and private, to have no greater limitations or financial requirements on mental health and substance use disorder benefits than are placed on medical or surgical benefits. Specifically, MHPAEA requirements include:

- Financial requirements applied to mental health or substance use disorder (SUD) benefits can be no more restrictive than the most common limitations applied to medical or surgical benefits, including copays;
- No separate cost sharing requirements that apply only to mental health or SUD benefits;
- Treatment limitations applied to mental health or SUD benefits can be no more restrictive than treatment limits on medical or surgical benefits;
- No separate treatment limitations that apply only to mental health or SUD benefits;
- The criteria determining medical necessity with respect to mental health or SUD benefits must be made available to a current or potential participant, beneficiary, or contracting provider, and the reason for any denial of reimbursement or payment for services relating to mental health or SUD benefits must be made available within a reasonable timeframe upon request; and
- If out-of-network coverage for medical or surgical benefits is provided, out-of-network coverage for mental health and SUD benefits must also be provided.

The 2009 Children's Health Insurance Plan Reauthorization Act incorporated MHPAEA requirements to CHIP state plans. As of November 2009, all Medicaid state plans, including managed care plans similar to STAR, STAR Health, and STAR+PLUS, were required to comply with MHPAEA. In reviews conducted by HHSC in 2011 and 2014, Texas Medicaid is in full compliance with MHPAEA.

Mental Health Rehabilitation and Targeted Case Management Service

S.B. 58, 83rd Legislature, Regular Session, 2013, requires the Health and Human Services Commission (HHSC) to integrate behavioral health and physical health services into the Medicaid managed care programs by adding mental health targeted case management and mental health rehabilitation services to the array of services provided by managed care organizations (MCOs) by September 1, 2014. The legislation requires MCOs that contract with HHSC to develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services. HHSC must also develop two Medicaid health home pilots programs in two health service areas of the state for persons who are diagnosed with a serious mental illness and at least one other chronic health condition. In addition, HHSC and the Department of State Health Services (DSHS) are required to establish a Behavioral Health Integration Advisory Committee. The Behavioral Health Integration Advisory Committee is charged with providing formal recommendations to HHSC on the implementation of the S.B. 58 requirements.

Home and Community-Based Services—Adult Mental Health (HCBS-AMH)

A number of adults have resided in Texas state mental health facilities for extended periods of time—in some cases for years. Some of these individuals no longer require an inpatient level of treatment, but need specialized supports that are not otherwise available through existing community-based mental health and disability programs. In 2010, DSHS convened a continuity of care task force of stakeholders to recommend a range of reforms. Among the recommendations was the development of Home and Community-based services (HCBS) for adults with serious mental illness. The 2014-15 GAA (Article II, HHSC, Rider 81, 83rd Legislature, Regular Session, 2013), requires DSHS to create a program through a 1915(i) state plan amendment to serve these individuals.

The HCBS-AMH program provides an array of intensive home and community-based services, appropriate to each individual's assessed needs, to adults with extended tenure in state mental health facilities in lieu of their remaining supported home living; HCBS-AMH psychosocial rehabilitation; supported employment; employment assistance; minor home modifications; medical supplies; transition assistance to establish a basic household; adaptive aids; transportation; community psychiatric

supports; peer support; respite care; substance use disorder services; and nursing and recovery management. Services would be provided in a variety of home and community-based settings of the individual's choice, such as an individual's home or apartment, or in an assisted living setting or small community-based residence.

The HCBS-AMH program includes indigent services not covered by Medicaid. Services for indigent individuals enrolled in HCBS-AMH will be funded using general revenue only, as they will not be eligible for the federal match. Full implementation of the HCBS-AMH program requires approval by CMS.

Medicaid Substance Abuse Benefit

The 2010-11 GAA (Article IX, section 17.15, S.B. 1, 81st Legislature, Regular Session, 2009), authorized HHSC to add comprehensive substance abuse benefits for adults in Medicaid. The Legislature assumed that the treatment of substance abuse disorders would result in cost savings in the Medicaid program through a reduction in other medical expenditures.

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

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

Youth Empowerment Services Waiver

The YES waiver is a Medicaid 1915(c) Home and Community-based (HCS) waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents ages 3 to 19 with serious emotional disturbances and their families. Children may enroll in Medicaid managed Care to receive their non-YES waiver services.

The YES waiver is currently available in a limited geographic area (Bexar, Brazoria, Cameron, Ft. Bend, Galveston, Harris, Hidalgo, Tarrant, Travis, and Willacy counties). Under legislative direction, HHSC and DSHS are working to expand the program to

additional counties. Children are determined financially eligible for the YES waiver using the same standards used to determine eligibility for Medicaid in psychiatric institutions. Parental income is not counted.

Texas Wellness Incentives and Navigation (WIN) Project

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

The Texas WIN project includes over 1,250 voluntary participants, aged 21-55, in the Harris County service delivery area, randomized into intervention and control groups.

Project goals include: improved health self-management, increased use of preventive services, and more appropriate use of health care services. Examples of individual goals include increased activity, weight loss, improved stress management, improved diabetes management, and reduced tobacco use. WIN employs a complement of research-based incentives to help intervention group participants manage their chronic health conditions. These include:

- Wellness planning and navigation facilitated by trained, professional health navigators, who use Motivational Interviewing techniques to help participants define and achieve their health goals;
- Individual flexible wellness accounts to support specific health goals defined by the participant, with purchases authorized through the navigator; and
- Wellness Recovery Action Planning (WRAP) training to help individuals stay mentally well, increase personal responsibility, and improve their quality of life. Participants electing WRAP develop strategies to help maintain wellness, such as a daily maintenance plan, identifying triggers/early warning signs of illness, and a crisis plan.

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

Long-term Services and Supports

Long-term services and supports (LTSS) help people age 65 and older and those with physical, mental, intellectual, or developmental disabilities. These services may be provided in an institution such as a nursing facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), in the individual's own home (e.g., Primary Home Care or home and community-based waivers), or in other settings (e.g., Day Activity and Health Services).

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

The population of people age 65 and older is projected to increase from 3.1 million in 2015 to 7.5 million in 2040. The percentage of the total population that is 65 years of age or older is projected to increase from 11 percent in 2015 to 17 percent in 2040.

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

In Texas, LTSS accounts for approximately 30 percent of the overall Medicaid budget.^{vi}

Institutions

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

Home and Community-Based Waivers

Federal law allows states to apply for waivers to exempt them from certain Medicaid requirements. One of these, called a 1915(c) waiver after the particular section of the

^{vi} HHSC Financial Services Analysis.

Social Security Act that is waived, allows states to provide home and community-based services to individuals who qualify for institutional care but who can be served at home or in the community to maintain independence and prevent institutionalization. States may also offer home and community-based services to individuals who qualify for institutional care through an 1115 waiver.

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

According to federal rules, home and community-based waivers cannot cost any more than institutional care would have cost for the group served by the waiver. Waivers enable states to serve people in the community rather than in institutions. However, because of funding limitations, the number of individuals wanting to receive waiver services generally far exceeds the number of individuals funded by the state. Most home and community-based waiver programs have lengthy interest lists of people who wish to enroll. This growth has occurred despite significant increases in waiver funding by the 80th and the 81st Texas Legislature, reflecting the public's increasing awareness of and desire for community-based LTSS.

The Medicaid 1915(c) waiver programs include:

- Community Living Assistance and Support Services (CLASS);
- Deaf-Blind with Multiple Disabilities (DBMD);
- Home and Community-based Services (HCS);
- Medically Dependent Children Program (MDCP);
- Texas Home Living (TxHmL); and
- Youth Empowerment Services (YES).

The Home and Community-based Services STAR+PLUS waiver is operated under an 1115 waiver and replaced the former Community Based Alternatives (CBA) 1915(c) waiver which was administered by DADS and allowed Texas to provide community-based services to adults as an alternative to nursing facility care. (See Appendix E, Texas Medicaid Waivers.)

Programs for People age 65 and Older and People Under age 65 with Physical Disabilities

LTSS for people age 65 and older, and people under age 65 with physical disabilities include home and community-based services and NF services. If eligible for Medicaid, they may receive an array of services, from non-skilled personal care to skilled nursing services. Services may be provided in peoples' homes, in community settings (e.g., adult day care or hospice), or in NFs, which provide services for people with medical conditions that require the skills of a licensed nurse on a regular basis.

As noted previously, the population of Texans age 65 and older is projected to increase from 3.1 million in 2015 to 7.5 million in 2040. The number of Texans under age 65 with physical disabilities is also expected to increase from 924,000 in 2015 to 1.4 million in 2040. Over time, LTSS caseloads are expected to increase to meet the growing demand for Medicaid services by these two groups.

Community Services and Supports—Medicaid State Plan Services

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

Primary Home Care (PHC)

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

institutions. In SFY 2013, the average number of individuals served per month was 11,127 with an annual expenditure of \$91.1 million.

Community Attendant Services (CAS)

The CAS program is administered by DADS and is also an entitlement program. This program takes advantage of special provisions in Medicaid law that allow the state to provide personal care without other Medicaid benefits to individuals in the community whose income is too high to qualify for Medicaid, but who meet the higher NF income limit, which is 300 percent of the SSI federal benefit rate.

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

Covered services include an escort on trips to obtain a medical diagnosis or treatment or both, assistance with home management such as laundry and housekeeping and personal care services such as bathing, dressing, grooming and preparing meals. In SFY 2013, the CAS program served an average of 47,964 individuals per month with an annual expenditure of \$500.3 million all funds.

Day Activity and Health Services (DAHS)

DAHS provides daytime service up to a maximum of ten hours per day, Monday through Friday, to individuals residing in the community in order to provide an alternative to placement in NFs or other institutions. Services are designed to address the physical, mental, medical, and social needs of individuals and include nursing and personal care; noon meals and snacks; transportation; and social, educational, and recreational activities. The individual must have a medical diagnosis and a physician's order requiring care or supervision by a licensed nurse, a functional disability related to the medical diagnosis, and the need for assistance with one or more personal care tasks. In SFY 2013, DAHS facilities provided services to a monthly average of 1,886 individuals with an annual expenditure of \$11.1 million.

Community Services and Supports–Waivers

Medicaid community services and supports waiver programs provide supports and services in homes and community settings that enable people with an intellectual disability and related conditions who qualify for an ICF/IID, to be served at home or in a community-based setting in order to maintain and improve their independence and prevent institutionalization. The community services and supports waivers for people

with an intellectual disability or related conditions are HCS, CLASS, DBMD, and TxHmL. (See Appendix E, Texas Medicaid Waivers.)

Long-Term Services and Supports for STAR+PLUS Members

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

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

- LTSS for all members:
 - Personal attendant services (PAS)
 - Day Activity and Health Services (DAHS)
- Home and Community-based STAR+PLUS waiver services for those who would otherwise qualify for NF care:
 - PAS
 - In-home or out-of-home respite services
 - In-home nursing services
 - Emergency response services (e.g., emergency call button)
 - Home delivered meals
 - Minor home modifications
 - Adaptive aids and medical equipment
 - Medical supplies not available under Medicaid
 - Physical, occupational, and speech therapy
 - Adult foster care
 - Assisted living
 - Transition assistance services limited to a maximum of \$2,500
 - Dental Services limited to a maximum of \$5,000 per waiver plan year
 - Cognitive Rehabilitation Therapy
 - Financial Management Services
 - Support Consultation
 - Employment Assistance
 - Supported Employment

- Targeted for June 1, 2015, the state will provide the following Community First Choice (CFC) services to members who would otherwise qualify for care in a NF, an ICF/IDD, or an Institution for Mental Disease:
 - PAS
 - Habilitation
 - Emergency Response Service (Emergency call button)
 - Support Management (Voluntary training in selection, managing, and dismissing attendants)

Medically Dependent Children Program

The Medically Dependent Children Program (MDCP) provides home and community-based services to children and young adults under 21 years of age as an alternative to residing in a NF. Services include respite, flexible family supports, adaptive aids, and minor home modifications. In SFY 2013, MDCP served an average of 5,593 individuals per month with an annual expenditure of \$97.2 million all funds.

Nursing Facilities

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

Effective March 1, 2015, most Medicaid clients age 21 and over receiving NF services will be enrolled in STAR+PLUS, a Texas Medicaid managed care program that combines acute care and LTSS. STAR+PLUS benefits for NF residents will include service coordination and value added services. The STAR+PLUS MCOs will be responsible for adjudicating claims, including prescription drug claims for NF services. Dual eligible members with Medicare Part D will continue to have their prescriptions covered under Medicare Part D.

Texas has adopted optional eligibility standards that allow people with incomes of up to 300 percent of the SSI federal benefit rate to qualify for Medicaid-funded NF care, although most of their income must be used toward the cost of their care.^{vii}

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

In SFY 2013, NFs served approximately 56,327 individuals per month through Medicaid. Also in SFY 2013, an average of 5,831 individuals per month had their Medicare Skilled NF co-insurance paid by Medicaid.

Hospice

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

The goal of hospice is to provide care for individuals and their families, not to treat or cure terminal illness. A team of doctors, nurses, home health aides, social workers, counselors, and trained volunteers works together to help the individual and their family cope with the terminal illness. Hospice services include physician services, nursing, counseling, personal attendant services, therapies, prescription drugs, and respite care. In SFY 2013, the program served an average of 6,917 individuals, of whom 88.9 percent received hospice services in NFs. The remaining 11.1 percent were served in the community.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 or older, live in a PACE service delivery area, qualify for NF level of care, and be able to live safely in the community at the time of enrollment. PACE offers all health-related services for a participant, including inpatient and outpatient medical care, specialty services (e.g., dentistry, podiatry, physical therapy and occupational therapy), social services, in-home care, meals, transportation, day activity services, and housing assistance. PACE participants receive all medical and social services they need through the PACE provider. PACE service areas are Amarillo/Canyon, El Paso, and Lubbock. Individuals in these service areas who are also eligible for STAR+PLUS may choose to receive services either through STAR+PLUS or PACE, but not both.

For SFY 2013, the average number of participants per month receiving PACE services was 1,046. Passage of the 2013-14 GAA, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions, Section 48), expanded the program by adding a total of 96 additional slots to the existing PACE sites, and it also authorized three additional sites with up to 150 participants each.

Programs for People with an Intellectual Disability or Related Conditions

Medicaid funded LTSS for individuals with an intellectual disability or related conditions includes home and community-based waiver services and services in an ICF/IID.

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

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

Community Services and Supports–Waivers

Medicaid community services and supports waiver programs provide supports and services in homes and community settings that enable people with an intellectual disability and related conditions who qualify for an ICF/IID, to be served at home or in a community-based setting to maintain and improve their independence and prevent institutionalization. These waiver programs are HCS, CLASS, DBMD, and TxHmL. Non-dual eligible adults enrolled in these waiver programs are enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services while they receive their waiver services outside of STAR+PLUS. Children under age 21 enrolled in these waiver programs have the option to enroll in STAR+PLUS for their basic health services. LTSS will continue to be provided through the waiver programs.

Home and Community–based Services (HCS)

The HCS waiver provides individualized services to individuals of all ages who qualify for ICF/IID level of care up to \$305,877 per year, depending on the individual's level of need. Individuals live in their family's home, their own homes, or other settings in the community. Services include adaptive aids, minor home modifications, dental treatment, nursing, supported home living, respite, day habilitation, residential services, employment assistance, supported employment, and professional therapies.

Professional therapies include physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy. Financial management services and support consultation are available to individuals who use the consumer-directed services option. Residential service options include host home/companion care, supervised living, and residential support services. During SFY 2013, based on information reported by providers, about 39 percent of individuals served in HCS had a diagnosis of some type

of mental illness. In SFY 2013, HCS served an average of 20,171 individuals per month with an annual expenditure of \$844.8 million all funds.

Community Living Assistance and Support Services (CLASS)

The CLASS waiver provides home and community-based services to clients who have a diagnosis of a “related condition” by a licensed physician qualifying them for placement in an ICF/IID. A related condition is a disability other than an intellectual disability (ID) or mental illness which originates before age 22 and is found to be closely related to ID because the condition substantially limits life activity similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries.

Services include case management, prevocational services, residential habilitation, respite (in-home and out-of-home), employment assistance, supported employment, adaptive aids/medical supplies, dental treatment services, occupational therapy, physical therapy, prescriptions, skilled nursing, speech and language pathology, behavioral support, minor home modifications, specialized therapies, support family services, continued family services, and transition assistance services. Financial management services and support consultation are available to individuals who use the consumer-directed services option.

During SFY 2013, based on information reported by providers 22.5 percent of individuals served in CLASS had a diagnosed mental illness. In SFY 2013, CLASS served an average of 4,716 individuals per month with an annual expenditure of \$204.2 million all funds.

Deaf-Blind with Multiple Disabilities (DBMD)

DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages who are deaf, blind, or have a condition that will result in deaf-blindness, and who have an additional disability. Services include case management; day habilitation; residential habilitation; respite; supported employment; prescription medications; financial management services; adaptive aids/medical supplies; assisted living; audiology services; behavioral support; chore service; dental treatment; dietary services; employment assistance; intervener; minor home modifications; nursing; orientation and mobility; physical, speech, hearing, and language therapy services; and transition assistance services. Support consultation is also available to individuals who use the consumer-directed services option.

During SFY 2013, based on information reported by providers, 10.2 percent of individuals served in DBMD had a diagnosed mental illness. In SFY 2013, 151 individuals per month were served with an annual expenditure of \$7.8 million all funds.

Texas Home Living (TxHML)

TxHmL waiver provides selected services and supports up to \$17,000 per year for individuals who qualify for ICF/IID level of care and live in their family homes or their own homes. Services include adaptive aids, minor home modifications, behavioral support, dental treatment, nursing, community support (similar to supported home living in HCS), respite, day habilitation, employment assistance, supported employment, and specialized therapies. Specialized therapies include physical therapy, occupational therapy, speech and language pathology, audiology, and dietary services. Financial management services and support consultation are available to individuals who use the consumer-directed services option. During SFY 2013, based on information reported by providers, 27.1 percent of individuals served in TxHmL had a diagnosed mental illness. In SFY 2013, TxHmL served an average of 4,629 individuals per month with an annual expenditure of \$48.5 million all funds.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)

The ICF/IID program provides ongoing evaluation and individual program planning, as well as 24-hour supervision, coordination, and integration of health or rehabilitative services to help individuals with an intellectual disability or relation conditions function to their greatest ability. A related condition is a severe and chronic disability, other than an intellectual disability (ID) or mental illness, which originates before age 22 and is found to be closely related to ID because the condition substantially limits life activity similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries. Adults receiving services through the ICF/IID program will be enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services through this model. Children under age 21 receiving services through the ICF/IID program have the option to enroll in STAR+PLUS for their basic health services. LTSS will continue to be provided through the ICF/IID program.

ICF/IID residential settings range in size from six beds to several hundred. In SFY 2013, an average of 5,510 Medicaid-eligible individuals per month received services from non-state operated ICFs/IID. All ICFs/IID must be certified by DADS, and the majority must also be licensed by DADS. All ICFs/IID also must meet the State Standards for Participation in Title 40, Chapter 9, Subchapter E, Texas Administrative Code, concerning ICF/IID programs.

The State Supported Living Centers (SSLCs), described below, are operated by DADS and are an example of ICFs/IID that are certified.

State Supported Living Center Services (SSLCs)

SSLCs serve people with an intellectual disability who have significant medical or behavioral health needs in a residential campus-based community. SSLCs provide 24-hour residential services, comprehensive behavioral treatment, and health care, such as medical, psychiatry, nursing, and dental services. Other services include skills training; occupational, physical and speech therapies; adaptive aids; day habilitation, vocational programs, and employment services; participation in community activities; and services to maintain connections between residents and their families and natural support systems. Services and supports are provided at 12 SSLCs operated by DADS and the ICF/IID component of the Rio Grande State Center operated by DSHS. Each center is certified as an ICF/IID, with approximately 60 percent of the operating funding from the federal government and 40 percent from state GR and third-party revenue resources. Individuals receiving services through a SSLC are excluded from enrollment in the STAR+PLUS Medicaid managed care program.

Nearly two-thirds of the overall SSLC population has a dual diagnosis in which an individual has been diagnosed with an intellectual disability and a mental health disorder. In May 2014, 3,400 individuals lived in SSLCs.

LTSS Resources

The Promoting Independence Initiative and Money Follows the Person

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

The 2002-03 GAA (Article II, HHSC, Rider 37, S.B. 1, 77th Legislature, Regular Session, 2001), established a Money Follows the Person (MFP) policy whereby the funding for individuals moving from NFs to community-based services could be transferred from the NF budget to the community-based services budget. MFP allows individuals to be able to choose how and where they are to receive their LTSS. Other support services have subsequently been developed to help in the identification of individuals who want to leave an institutional setting and to assist them in their relocation back to the community. Rider 37 was codified by H.B. 1867, 79th Legislature, Regular Session, 2005, and a separate budgetary line item for MFP was established.

The MFP policy has been very successful. As of July 2014, over 41,000 individuals have chosen to move out of institutional settings and relocate back into the community to receive community-based LTSS.

HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 MFP demonstration award to build upon and enhance the Promoting Independence Initiatives. The demonstration began on February 1, 2008 and will continue through 2020.

Under the demonstration, the state works with individuals residing in NFs, community ICFs/IID with nine beds or more, and SSLCs who want to relocate to the community. The state receives enhanced funding for 365 days for each individual who enrolls in the demonstration. In order to be a demonstration participant, the individual must have been in an institutional setting for at least 90 days (exclusive of Medicare billable days) and be willing to sign an informed consent to enroll in the demonstration. As of July 2014, approximately 8890 individuals had enrolled in the MFP demonstration.

The demonstration funds a variety of different projects, including direct service provision as well as information technology, staff resources, and other infrastructure-related functions. Some of these projects include:

- Community supports (e.g., cognitive adaptation services, substance abuse services) for individuals transitioning from NFs with co-occurring behavioral health needs in Bexar County and its contiguous counties, and Travis county.
- Incentives for providers of community ICFs/IID with nine or more beds who want to close their facilities voluntarily and provide residential choice for their current residents.
- Hands-on assistance from relocation contractors to assist in the transition back to the community as well as short-term post-relocation contacts for individuals who have moved back into the community to ensure a more successful relocation.
- Enhancement of data collection, reporting and quality assurance systems, and provider monitoring.
- Financial assistance to local Long-term Care Ombudsmen to assist NF residents who want to learn more about community-based alternatives.
- A customized employment project for providers who want to assist individuals receiving services in an ICF/IID or an ICF/IID waiver program to achieve integrated employment at local businesses.
- Administrative assistance for Relocation Contractor Services and Direct Service Workforce Development.
- Transition specialists housed at each SSLC to improve the quality of the relocation process.

- Funding of 14 Aging and Disability Resource Centers (ADRCs) to hire housing specialists who will concentrate their efforts on the identification and expansion of affordable, accessible, and integrated housing.
- Funding for 14 ADRCs to provide options counseling to non-Medicaid nursing facility residents interested in learning about community LTSS.
- Establishment of a Quality Reporting Office to provide additional in-house capabilities to monitor, discover, describe, and create intervention strategies to promote quality across demonstration activities and Medicaid 1915(c) waivers.
- Establishment of a crisis intervention team staffed by Austin-Travis County Integral Care for individuals who reside in Travis County who have left an SSLC within the previous five years and who (1) are experiencing a behavioral or mental health crisis; or (2) have a history of intermittent behavioral challenges; and (3) require the establishment of a proactive action plan to maintain stability.

Aging and Disability Resource Centers

Aging and Disability Resource Centers (ADRC) provide a “no wrong door” approach to accessing services. Each ADRC is comprised of a network of local service agencies that coordinate information, referrals, and linkages to public and private LTSS programs and benefits. ADRCs use person-centered options counseling to assist individuals with decision-making about service choices tailored to meet their needs. ADRCs also provide assistance with system navigation and care transition support services through collaboration with hospitals and NFs.

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

- *Alamo Service Connection*—serving Bexar County (San Antonio)
- *Central Texas Aging and Disability Resource Center*—serving Central Texas (Bell, Coryell, Hamilton, Lampasas, and Milam counties)
- *Aging and Disability Resource Center of Tarrant County*—serving Tarrant County
- *Care Connection Aging and Disability Resource Center*—serving Harris County/Houston and 12 surrounding counties (Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton counties)
- *Lubbock County Aging and Disability Resource Center*—serving Lubbock County

- *East Texas Aging and Disability Resource Center*—serving East Texas (Gregg, Harrison, Marion, Panola, Rusk and Upshur counties)
- *North Central Texas Aging and Disability Resource Center*—serving North Central Texas (Collin, Denton, Hood, and Somervell counties)
- *Connect to Care Aging and Disability Resource Center*—serving Dallas County
- *Aging, Disability, and Transportation Resource Center: El Paso & Far West Texas*—serving El Paso/West Texas (Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, and Presidio counties)
- *Coastal Bend Aging and Disability Resource Center*—serving Coastal Bend (Aransas, Bee, Brooks, Duval, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio and San Patricio counties)
- *RIO-Net Aging and Disability Resource Center*—serving Lower Rio Grande (Cameron, Hidalgo, and Willacy counties)
- *West Central Texas Aging and Disability Resource Center*—serving West Central Texas (Callahan, Jones and Taylor counties)
- *Brazos Valley Aging and Disability Resource Center*—serving Brazos Valley (Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington counties)
- *Concho Valley Aging and Disability Resource Center*—serving Concho Valley (Coke, Concho, Irion, Runnels, Schleicher, Sterling, and Tom Green counties)

Opportunities for Self-Direction of Services

Consumer Directed Services Option

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

employee. Individuals may appoint a designated representative to assist with employer responsibilities.

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

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

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

Medicaid Home and Community-Based Waiver Programs

- CLASS
- DBMD
- MDCP
- HCS
- TxHmL

Medicaid State Plan Services

- CAS
- PCS
- PHC

Medicaid Managed Care Programs

- STAR+PLUS
- STAR Health

Social Services Block Grant (Title XX) Programs

- Consumer Managed Personal Assistance Services (CMPAS)

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, which includes SSLCs;
- CAS; and
- Medicaid waiver programs.
 - CLASS
 - DBMD
 - HCS
 - TxHmL
 - 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. DADS is responsible for MERP program policy and procedures.

Supporting Independence and Employment

Medicaid Buy-In Program for Workers with Disabilities

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

Medicaid Buy-In participants are eligible for the same services available to adult Medicaid recipients, including office visits, hospital stays, x-rays, vision services,

hearing services, and prescriptions. They also are eligible for attendant services, day activity health services, and home and community-based services waivers if they meet the functional requirements for these programs.

Health Information Exchange

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

- Less waiting for paper files to be delivered from one treating physician to another when clients are referred for additional treatment or consultations;
- Less paperwork to complete in the doctor's office, with electronically-stored medical records making it faster and easier for a care provider to access and refer to records and reducing the need to fill out multiple, duplicative forms when clients arrive for a visit;
- Better coordination of care between treating physicians;
- Eliminating unnecessary duplicative tests, x-rays, and other procedures, or the possibility of adverse reactions to treatment that conflicts with prior prescribed medications, treatment or allergies because a physician does not have the results of prior care; and
- Implementing HIE statewide will help to ensure that Texas physicians and hospitals are eligible to receive billions in available federal meaningful use incentive payments over the next several years.

In the long-term, Texas has an opportunity to leverage technology to improve the quality, safety, and efficiency of the Texas health care sector while protecting individual privacy.

HHS currently has several HIE-related initiatives underway:

- *Texas Medicaid Electronic Health Record Incentive Program:* HHSC administers the Medicaid EHR Incentive Program, which incentivizes Medicaid healthcare providers to adopt, implement, and upgrade to certified electronic health record technology and use it meaningfully. HHSC's goal is to assist providers to connect to the regional and state level Health Information Exchanges.
- *Statewide Health Information Exchange:* In 2010, HHSC was awarded \$28.8 million through the State Health Information Exchange Cooperative Agreement Program to develop a HIE network in Texas. This program concluded in early

2014 and included three strategies: funding for local health information exchange organizations to connect health care providers regionally; funding the development of a strategy for those areas of the state not covered by a local HIE, known as the “white space”; and funding certain statewide shared services to help facilitate exchange.

- *E-Prescribing*: HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality.
- *Medicaid Eligibility and Health Information Services System (MEHIS)*: The Texas Legislature directed HHSC to ensure the development of a HIE system to support improved quality of care for Medicaid patients by giving providers more and better information about their patients.

Electronic Health Information Exchange System Advisory Committee

The Electronic Health Information Exchange System Advisory Committee for the Texas Medicaid agency was established under the authority of H.B. 1218, 81st Legislature, Regular Session, 2009, and commenced in February 2010. The Advisory Committee was abolished by statute August 31, 2013 and reinstated April 2, 2014.

The purpose of this advisory committee is to advise the HHSC regarding the development and implementation of the electronic HIE system. In addition to any issue specified by HHSC, specific issues addressed include:

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

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

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

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

Texas Medicaid Electronic Health Record Incentive Program

The American Recovery and Reinvestment Act (ARRA) of 2009 increased the focus on health information technology (HIT) throughout the public and private health care delivery system. The Health Information Technology for Clinical and Economic Health (HITECH) Act within ARRA provides funding opportunities to assist physicians and other health care professionals in the adoption and meaningful use of electronic health record (EHR) technology and to advance HIE. A certified EHR contains the electronic records of individual patients' health-related information. Records include patient demographic and clinical health information, such as medical histories and problem lists.^{viii} Certified EHRs have a variety of capabilities including: clinical decision support, physician order entry, capture and query of information relevant to health care quality, and the ability to exchange electronic health information with other sources. ARRA allows state Medicaid agencies to establish programs for paying incentives to Medicaid providers for the meaningful use of EHRs.

To be considered a "meaningful user" of an EHR, an eligible professional or eligible hospital must demonstrate meaningful use of the EHR technology over a specified period of time in a manner that is consistent with the objectives and measures outlined in federal regulation by CMS. These objectives and measures include the use of certified EHR technology that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information. States can receive 100 percent

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

federal financial participation for incentive payments to Medicaid providers to adopt, implement, and “meaningfully use” certified EHRs. The HITECH Act also provides for Medicaid agencies to obtain 90 percent federal administrative matching funds to develop and administer the EHR Incentive Program.

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

Statewide Health Information Exchange

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

In 2010, HHSC was awarded \$28.8 million through the State Health Information Exchange Cooperative Agreement Program. These funds helped the state develop a strategic and operational plan for HIE and supported the implementation of these plans through the first quarter of 2014. To assist with the implementation of these strategies, HHSC contracted with the Texas Health Services Authority (THSA), an entity created through H.B. 1066, 80th Legislature, Regular Session, 2007, as a public-private non-profit charged with implementing state-level health information technology functions and catalyzing the development of a seamless electronic health information infrastructure to support the health care system in the state.

The Texas HIE strategic and operational plans, which guided the implementation of HIE services in Texas, outline and support the implementation of the following three key strategies:

- **General State-Level Operations:** These are administered jointly by THSA and HHSC to support a transparent and collaborative governance structure to coordinate the implementation of HIE in Texas, develop policies and guidelines, and provide statewide HIE services. Following the conclusion of grant funding through the Cooperative Agreement Program, THSA continues to operate the State-Level Shared Services which spans the entire state and enables health care providers to electronically exchange patient health information across Texas and the nation.
- **Local HIE Grant Program:** This grant program partially funded planning, development, and operations of local and regional Texas HIE networks. At the

conclusion of this program in March 2014, ten local HIEs in various stages of operation continue to provide services throughout the State of Texas.

- “White space” Strategy: This coverage strategy supports HIE connectivity through Health Information Service Providers in regions of the state without local or regional HIEs.

Electronic Prescribing (E-Prescribing)

To reduce adverse drug events and costs incurred in providing prescription drug benefits, HHSC upgraded its pharmacy benefits system to provide e-prescribing functionality. New functions became available to pharmacies and providers in December 2011.

- The Medicaid/CHIP drug formulary and preferred drug list are available to FFS and MCO prescribers electronically. Prescribers' EHR systems can download regularly updated formulary information that is seamlessly integrated into their prescribing interface.
- Client prescription benefit eligibility is also integrated into prescribers' EHR systems as well as pharmacies' management software. Medicaid/CHIP client eligibility will be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and speeding access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

Medicaid Eligibility and Health Information Services System

HHSC implemented the Medicaid Eligibility and Health Information Services (MEHIS) system, per direction from H.B. 1218, 81st Legislature, Regular Session, 2009. The MEHIS system replaced the previous paper Medicaid identification card with a permanent plastic Medicaid ID card and provides access to automated eligibility verification.

Some of the key features of the MEHIS system include:

- Plastic magnetic stripe Medicaid ID cards;
- Rapid client check-in with automated eligibility verification using near real-time data;
- Multiple configuration/access options for providers;

- Prescription and lab data;
- Provider and client portals with access to program and health information;
- Provider and client help desks; and
- Support for future HIE.

Online Client Portal

The MEHIS system, known publically as the “Your Texas Benefits Medicaid Card” system, became operational on June 29, 2011. The initial implementation included electronic eligibility verification using YourTexasBenefitsCard.com, card production and distribution, and a help desk for providers and clients.

On January 23, 2012, the initial version of the Medicaid client portal was implemented and added the following features:

- Single-sign-on at YourTexasBenefits.com;
- View client Medicaid eligibility information and Texas Health Steps data;
- View and print copies of one or more Medicaid ID cards;
- Online card replacement requests; and
- Clients have the option of “opting out” or blocking online access to their Medicaid-related health history.

New features added and planned to improve functionality to the client portal include electronic health history, detailed claims information, and the on-line explanation of benefits. Subsequent releases are planned that will allow clients to access the client portal via a mobile device.

Your Texas Benefits Medicaid Card

Medicaid recipients receive a Your Texas Benefits Medicaid card through the mail upon enrollment in Medicaid. This plastic Medicaid ID card is the same size as a credit card. The following information is printed on the front of the card:

- Client’s name and Medicaid ID number;
- Issuer ID; and
- Date the card was issued.

The back of the card includes a statewide toll-free phone number and a website where clients can get more information on the Your Texas Benefits Medicaid card. The card is not required for clients to access services, but does help accelerate the verification of eligibility. Since possession of the card does not guarantee current eligibility, providers

need to verify eligibility at the point of service by using the YourTexasBenefitsCard.com provider portal, or they can call the associated help desk.

Online Provider Portal

One aspect of the Your Texas Benefits Medicaid card project is the provider portal. The Medicaid ID card and system are designed to give providers another way to verify the client's Medicaid coverage. Providers may use the portal to access their Medicaid patient's Medicaid-related:

- Claims and encounter data (i.e., dates, doctors, diagnosis, procedures);
- Prescription drug history;
- Lab results; and
- Immunization information.

The provider portal is currently being pilot-tested.

Additional features, such as Blue Button, have been planned for the provider and client portals. This feature will give providers electronic access to their patient's medical records with a click of a button and allow them to print the patient's available records with ease. Blue Button will also help empower patients to access, use and share their health information more easily. Patients who use their health information may become more engaged with their care overall, leading to improved health outcomes.

Endnotes

¹ 42 U.S.C. §1396 et seq.

² Texas Medicaid and Healthcare Partnership (TMHP) Ad Hoc Query Platform Client Universe, retrieved on July 11, 2014.

³ TMHP Ad Hoc Query Platform Claims Universe, retrieved on July 11, 2014.

⁴ Women's Health Program Final Report to CMS, 1115(a) Research and Demonstration Waiver, Family Planning Project Number 11-W-00233/6, Health and Human Services Commission.

Chapter 7: Medicaid Managed Care

Texas began implementing Medicaid managed care in 1993. This chapter outlines Texas' experience with Medicaid managed care.

What is Managed Care?

Both in Texas and nationally, the Medicaid program has increasingly turned to managed care to deliver services more effectively. The traditional Medicaid payment system, known as fee-for-service (FFS), pays health care providers a fee for each unit of service they provide. This approach may result in extra procedures and costs and a lack of care coordination for the client. In a managed care program, a managed care organization (MCO), sometimes called a health plan, is paid a capped (or capitated) rate for each client enrolled. In managed care, clients receive healthcare services and long-term services and supports through an MCO contracted with a network of doctors, hospitals and other health care providers responsible for managing and delivering quality, cost-effective care. In Texas, Medicaid MCOs must cover the same services as traditional Medicaid. The Health and Human Services Commission (HHSC) continues to expand Medicaid managed care. In State Fiscal Year (SFY) 2013, 80 percent of the state's Medicaid population was enrolled in managed care.

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

The following features characterize Medicaid managed care in Texas:

Medical Home

Clients in Medicaid managed care choose a primary care provider (PCP) who serves as the client's medical home by providing comprehensive preventive and primary care. The

PCP also makes referrals for specialty care and other services offered by the MCO, such as case management. In Texas Medicaid, the types of providers that generally act as PCPs are family and general practice doctors; pediatricians; internal medicine doctors; obstetricians/gynecologists; physicians' assistants; advanced practice registered nurses; and federally-qualified health centers (FQHCs), rural health centers, and similar community clinics. Occasionally, specialists agree to act as the PCP for clients with special health care needs.

Health Home

MCOs are required to provide health homes to members with chronic conditions. A health home provides comprehensive and high-quality services that are provided by a designated provider and a team of health care professionals to fit the needs of persons with multiple chronic conditions or a serious and persistent mental or health condition. The health home model of service delivery expands on the medical home principles to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care. Health home services include the following: comprehensive case management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; referral to community and social support services; and use of health information technology to link services. The health home model of service delivery expands on the medical home by enhancing coordination and integration of behavioral health care to better meet the needs of patients, particularly those with chronic conditions.

HHSC encourages MCOs to develop incentive programs for designated providers serving as patient-centered medical homes and to structure payments based on quality outcomes or shared savings.

Emphasis on Preventative Care

MCOs are required to ensure that members have timely access to regular and preventive care. By emphasizing preventive care, MCOs can reduce the use of emergent care and non-urgent care. Non-urgent visits to the emergency room include inappropriate visits, avoidable visits, non-emergency visits, and minor illness visits.

Improved Access to Care

In managed care, members must have access to covered services on a timely basis. MCOs are required to have a defined network of providers to meet member needs, and provide support to members who need help finding a doctor or setting up appointments. Through its provider network, MCOs are also required to meet standards for waiting times for appointments.

Defined Network of Providers

Managed care limits clients' choices of providers (with some exceptions) to those under contract with the MCO, also known as in-network providers. The MCO is obligated to maintain access to network providers based on standards developed by the state. HHSC continually monitors the MCO networks for compliance with the standards.

Utilization review and Utilization Management

MCOs use utilization management to review requests for approval of future medical or service needs. Utilization management includes prospective and concurrent utilization review. Utilization management (often used interchangeably with utilization review) includes practices such as preadmission screenings and prior authorization of certain medical services. Concurrent utilization review is usually conducted during a hospital confinement to determine the medical necessity for continued stay.

MCOs also use utilization review to comprehensively monitor and evaluate the appropriateness, necessity, and efficacy of past medical treatment or health care services delivered to members. This type of review is often referred to as a retrospective review and examines treatment patterns over time.

Quality Assessment and Performance Improvement

MCOs must operate quality assessment and performance improvement programs. These programs evaluate performance use objective quality standards, foster data-driven decision-making, and support programmatic improvements.

Managed Care History in Texas

In response to rising health care costs and national interest in cost-effective ways to provide quality health care, the Texas Legislature passed H.B. 7, 72nd Legislature, Regular Session, 1991, which directed the state to establish Medicaid managed care pilot programs. These pilots (implemented in Travis County and in the Tri-County Area of Chambers, Jefferson, and Galveston counties) were initially known as the LoneSTAR (State of Texas Access Reform) Health Initiative. The name was later shortened to STAR. The Travis County pilot was implemented in August 1993. The Tri-County pilot was implemented in December 1993 and was expanded in December 1995 to include three additional counties (Hardin, Liberty, and Orange).

Texas lawmakers passed S.B. 10, 74th Legislature, Regular Session, 1995, and related legislation to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. Texas continued to expand its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

In September 1996, the Travis County pilot was expanded to include surrounding counties. Additionally, the Bexar, Lubbock, and Tarrant service areas were brought under managed care. The STAR program, which primarily serves children, low-income families, and pregnant women, was expanded to include certain Medicaid clients with disabilities (Supplemental Security Income [SSI] and SSI-related) on a voluntary basis when the 1996 expansion occurred.

The Texas Legislature passed H.B. 2913; and S.Bs. 1163, 1164, and 1165, 75th Legislature, Regular Session, 1997, to strengthen Medicaid managed care client and provider protections. In December 1997, the state expanded the STAR program to the Houston area and created a new pilot to integrate acute care and long-term services and supports for SSI and SSI-related Medicaid clients in Harris County. This program is known as STAR+PLUS. The implementation of STAR and STAR+PLUS in the Harris service area doubled the number of Texas Medicaid clients receiving services through the managed care model.

Through S.B. 2896, 76th Legislature, Regular Session, 1999, the Texas Legislature placed a moratorium on further managed care expansion, but allowed the state to complete the Dallas and El Paso service area implementations, which were already underway. The bill directed HHSC to evaluate the effects of the Texas Medicaid managed care program on access to care, quality, cost, administrative complexity, utilization, care coordination, competition, and network retention.

The Dallas and El Paso service area implementations were completed in 1999. In addition to expanding the STAR program in Dallas, the state also implemented a unique behavioral health pilot, NorthSTAR, in the Dallas service area. NorthSTAR provides mental health and substance abuse services to Medicaid clients and certain non-Medicaid clients below 200 percent of the federal poverty level.

Over a 15-month period in 1999 and 2000, HHSC led an analysis of the STAR and STAR+PLUS programs in conjunction with a workgroup composed of representatives from the advocacy, provider, and managed care communities. The resulting Medicaid Managed Care Report concluded that Texas had achieved many, but not all of the goals set for the Medicaid managed care program.¹ The study found that implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional FFS Medicaid program. The report also concluded that managed

care introduced additional program complexity both to providers and to clients. While clients were generally satisfied with the care they received under managed care, Medicaid providers were generally more dissatisfied with the increased administrative complexity and oversight required.

In 2001, following the release of the Medicaid Managed Care Report, the moratorium on managed care was lifted, and HHSC was allowed to expand Medicaid managed care when cost effective.

By 2003, the Texas Legislature faced budget pressures that prompted interest in modifying Medicaid and expanding managed care throughout the state in order to obtain additional cost savings. H.B. 2292, 78th Legislature, Regular Session, 2003, directed HHSC to provide Medicaid managed care services through the most cost-effective models.

In September 2005, Primary Care Case Management (PCCM) (formerly known as the Texas Health Network) was removed as a non-capitated plan choice in the STAR service areas. It expanded to 197 primarily rural counties outside of the STAR service areas plus five STAR counties in the southeast region (Chambers, Hardin, Jefferson, Liberty, and Orange). This increased the number of counties covered by PCCM to 202. As a result of this expansion, all Texas counties were served by either STAR or PCCM.

The Texas Legislature passed S.B. 6, 79th Legislature, Regular Session, 2005, which directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008. The STAR Health Program is designed to better coordinate the health care of children in foster care and kinship care through one statewide MCO.

The 2006-07 General Appropriations Act (GAA), S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Special Provisions, Section 49), and H.B. 1771, 79th Legislature, Regular Session, 2005, directed HHSC to use cost-effective models to better manage the care of Medicaid clients who are age 65 and older and those with physical disabilities in certain areas of the state. In response to this direction, HHSC developed the Integrated Care Management model and the STAR+PLUS Hospital Carve-Out model to integrate acute and long-term services and supports. In February 2007, the STAR+PLUS Hospital Carve-out model replaced the existing STAR+PLUS model in the Harris service area and was expanded to the Bexar, Harris Expansion, Nueces, and Travis service areas. The Integrated Care Management model ended in May 2009.

In addition to developing new managed care programs, HHSC has continued to expand existing programs. In 2006, Nueces was added to the STAR service areas. The 2010-

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

In September 2011, STAR and STAR+PLUS expanded to 28 counties contiguous to the existing service areas. STAR expanded to 17 counties contiguous to Bexar, El Paso, Lubbock, Nueces, and Travis service areas and STAR+PLUS expanded to 10 counties contiguous to the Bexar, Harris, Nueces, and Travis service areas. STAR and STAR+PLUS expanded to the newly formed Jefferson service area, which included 11 counties contiguous to the Harris service area. HHSC eliminated the PCCM model in the 28 contiguous counties on August 31, 2011.

In 2013, as part of the passage of S.B. 7, 83rd Legislature, Regular Session, the Texas Legislature approved several expansions of managed care to cover new populations. On September 1, 2014, STAR+PLUS expanded to the Medicaid Rural Service Area (MRSA), integrating acute care and long-term services and supports for individuals 65 and older and those with disabilities. Most adults with intellectual and developmental disabilities (IDD) being served through one of the 1915(c) waivers operated by DADS for individuals with IDD or living in a community-based ICF/IID began receiving acute care services through STAR+PLUS on this date. On March 1, 2015, HHSC will begin to deliver nursing facility services through the STAR+PLUS managed care model to most adults age 21 and over.

As a result of S.B. 58, 83rd Legislature, Regular Session, 2013, other changes implemented effective September 1, 2014 include adding mental health rehabilitation and mental health targeted case management services into managed care. These two behavioral health services have been traditionally delivered through the FFS system.

In March 2015, HHSC will also implement the Texas Dual Eligible Integrated Care Project (known as the Dual Demonstration), a fully integrated managed care model for individuals who are enrolled in Medicaid and Medicaid. The goals of the Dual Demonstration are to: have one health plan be responsible for both Medicare and Medicaid services, improve quality and individual experience in accessing care and promote independence in the community. The Dual Demonstration will be available to individuals ages 21 or older who are eligible for full Medicare and Medicaid benefits and required to receive Medicaid benefits through STAR+PLUS. The Demonstration Project will be limited to six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant.

S.B. 7 also directed HHSC to develop a managed care program, STAR Kids, tailored for children with disabilities, including children who are receiving benefits under the Medically Dependent Children Program (MDCP). STAR Kids has a proposed implementation date of September 1, 2016.

Managed Care Performance Evaluation

Federal regulations require external quality review of Medicaid managed care programs to ensure state programs and their contracted MCOs are compliant with established standards. The external quality review organization (EQRO) is required to validate MCO performance improvement projects, validate MCO performance measures, and assess MCO compliance with member access to care and quality of care standards. In addition, states may also have the EQRO validate member-level data; conduct member surveys, provider surveys, or focus studies; assess performance improvement projects, and calculate performance measures.

Ensuring the delivery of affordable, high-quality health care for beneficiaries of public insurance programs has become increasingly important in recent years, as federal and state agencies seek to address budget deficits while also improving access to health care. Texas has a strong focus on quality of care in Medicaid and the Children's Health Insurance Program (CHIP) that includes initiatives based on significant legislation such as S.B. 7, 83rd Legislature, Regular Session, 2013. S.B. 7 covers a range of health care issues including an emphasis on promoting health care quality.

Pay for Quality

Sections of S.B. 7, 83rd Legislature, Regular Session, 2013, focus on the use of quality-based outcome and process measures in quality-based payment systems by measuring potentially preventable events (PPEs); rewarding use of evidence-based practices; and promoting healthcare coordination, collaboration, and efficacy. To comply with this legislative direction, HHSC redesigned its Performance Based At-Risk/Quality Challenge Initiative, implementing a Pay-for-Quality program (P4Q). The HHSC P4Q encourages incremental improvement in MCO performance for a specified set of measures. P4Q provides financial incentives and disincentives to MCOs participating in the STAR, STAR+PLUS, and CHIP programs by placing a maximum of four percent of an MCO's capitation revenue at risk. MCOs that meet MCO-specific goals are eligible for a bonus of up to four percent of their capitation rate. MCOs demonstrating inadequate performance may lose up to four percent of their capitation rate.

Under the P4Q program, MCOs compete against their own performance from the previous year in a model developed by HHSC and the state's EQRO. Each MCO's

performance is measured using Health Effectiveness Data Information Set (HEDIS®) quality of care and PPE measures. For each measure, HHSC establishes a minimum threshold and an attainment goal. MCOs can then earn positive or negative points according to their progress towards or movement away from this goal. MCOs performing below the minimum threshold cannot receive positive points for improvements made until they have exceeded the minimum threshold, although they can be penalized for declining performance. P4Q is budget neutral to the state; all funds collected through penalties are redistributed to the better performing MCOs.

Managed Care Initiatives

HHSC is implementing several Medicaid managed care initiatives that include service area expansions, extending managed care coverage to new populations, carving in new benefits and services, and establishing a new program.

Expansion

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that began in December 2011. It allowed the state to preserve federal hospital funding historically received as upper payment limit (UPL) payments. (See Chapter 4, Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver.)

The 1115 Transformation Waiver enabled the state to conduct a phased transition of Medicaid beneficiaries from FFS to a managed care delivery system based on geographic service areas. This transition included the expansion of the STAR, and STAR+PLUS Medicaid managed care programs to new areas of the state and the elimination of the PCCM program. These changes and others detailed below have resulted in managed care being the primary vehicle through which almost all Medicaid recipients receive medical and dental services.

Effective March 1, 2012:

- HHSC expands STAR+PLUS into the El Paso and Lubbock service areas, expands STAR and STAR+PLUS into 10 counties in South Texas creating the Hidalgo service area, and replacing PCCM with the STAR program in 164 counties creating the Medicaid Rural Service Area.
- Inpatient hospital services are included in the STAR+PLUS capitation rate.
- Children's Medicaid and the Children's Health Insurance Program (CHIP) dental benefits for most children are administered through a statewide managed care capitated model.

- Pharmacy benefits are administered by MCOs for STAR, STAR Health, STAR+PLUS, and CHIP participants.

Effective September 1, 2014:

- STAR+PLUS expands to the 164 counties in the Medicaid Rural Service Area, making STAR+PLUS a statewide Medicaid managed care program.
- Most adults with intellectual and developmental disabilities receiving services through a 1915(c) IDD waiver or a community-based ICF/IID get their basic health services (acute care) through a STAR+PLUS health plan and continue to get their long-term services and supports through a DADS waiver or ICF/IID program.
- Individuals with Medicaid and Medicare coverage in six counties will receive integrated care through a STAR+PLUS Medicare-Medicaid Plan.

Effective March 1, 2015:

- Most adults living in nursing facilities receive full Medicaid coverage through a STAR+PLUS health plan.
- Individuals with Medicaid and Medicare coverage in six counties will receive integrated care through STAR+PLUS health plan.

Dual Eligibles Integrated Care Demonstration

Federal law created the Federal Coordinated Health Care Office (“Medicare-Medicaid Coordination Office”).ⁱ This office is charged with supporting the coordination of Medicare and Medicaid to allow the two programs to work together more effectively to improve care and lower costs. The Medicare-Medicaid Coordination Office is required to support state efforts to coordinate, contract and align acute care and long-term care services for dual eligibles with other items and services furnished under the Medicare program.ⁱⁱ The Dual Eligibles Integrated Care Demonstration Project, also referred to as the Dual Demonstration, was created by Medicare-Medicaid Coordination Office.

In May 2014, HHSC received federal approval for a fully integrated, capitated model that involves a three-party agreement between an MCO with an existing STAR+PLUS contract, the state, and the Centers for Medicare & Medicaid Services (CMS) for the provision of the full array of Medicaid and Medicare services. The initiative will test an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of services for dual eligibles, enhance quality of care and reduce

ⁱ Section 2606 of the Affordable Care Act

ⁱⁱ Sections 2602(d)(2) and 2602(d)(3) of the Affordable Care Act

costs for both the state and the federal government. The demonstration is scheduled to begin March 1, 2015 and will continue until December 31, 2018.

Under this initiative, one health plan called a STAR+PLUS Medicare-Medicaid Plan will be responsible for the full array of Medicare and Medicaid-covered services. Eligible individuals will have access to an adequate network of medical, behavioral health, and supportive services including acute care services covered under Medicare and long-term care services under Medicaid through one Medicare-Medicaid Plan. This includes any benefits that will be added to the STAR+PLUS service array by March 1, 2015, such as nursing facility services.

The fully integrated managed care model will serve individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. Eligible clients will be passively enrolled into the demonstration with the opportunity to opt-out on a monthly basis. Clients can be enrolled in the Dual Demonstration if they meet all of these criteria:

- Age 21 or older;
- Eligible for Medicare Part A, B, and D, and receiving full Medicaid benefits; and
- Eligible for the Medicaid STAR+PLUS program, which serves Medicaid clients who have disabilities or are age 65 and older, including those who receive STAR+PLUS Home and Community-Based Services waiver services.

The project will not include clients who reside in ICFs/IID and individuals with developmental disabilities who get services through one of these waivers:

- Community Living Assistance and Support Services (CLASS);
- Deaf Blind with Multiple Disabilities Program (DBMD);
- Home and Community-based Services (HCS); and
- Texas Home Living Program (TxHmL).

The demonstration will operate in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties. The number of clients that may be served through this model is outlined below.

County	Number of Clients	Health Plans
Bexar	26,452	Amerigroup, Molina, Superior
Dallas	27,941	Molina, Superior
El Paso	19,645	Amerigroup, Molina
Harris	47,160	Amerigroup, Molina, United
Hidalgo	27,090	Health Spring, Molina, Superior
Tarrant	16,986	Amerigroup, Health Spring

STAR Kids

Beginning September 1, 2016, children and youth age 20 or younger who either receive SSI Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through the STAR Kids program. STAR Kids is the managed care program that will provide acute and community-based Medicaid benefits to children with disabilities. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids, but will continue receiving 1915(c) waiver services through the Department of Aging and Disability Services (DADS). Children, youth, and their families will have the choice of at least two STAR Kids MCOs and will have the option to change plans.

A core component of the STAR Kids program will be a standard screening and assessment process used by MCOs to determine each individual's needs as they relate to health and independent living. In addition to traditional Medicaid services, children and young adults enrolled in STAR Kids will receive an individual service plan and service coordination to ensure the delivery of effective, coordinated Medicaid services.

Texas Medicaid Managed Care Programs

STAR

The Medicaid State of Texas Access Reform (STAR) program provides primary, acute care, and pharmacy services for pregnant women, newborns, and children with limited income. Acute care services include doctor's visits, pharmacy, home health, medical equipment, lab, x-ray, and hospital services. The program operates statewide under the authority of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver. Services are delivered through managed care organizations (MCOs) under contract with the Health and Human Services Commission (HHSC).

Other individuals may be required to enroll in STAR or have the option. Former foster care children ages 18-20 are mandated to enroll into managed care, but may choose to be in either STAR or STAR Health. Former foster care children ages 21-25 are mandated to enroll into STAR as STAR Health is not an option for this population. Individuals under the age of 19 who receive services through the Youth Empowerment Services (YES) program can voluntarily enroll into STAR. Other than those populations described above, individuals who reside in institutions or nursing facilities; receive SSI or Medicare; are in a DADS 1915(c) waiver program; or are medically needy or are in state conservatorship are generally excluded from STAR enrollment. SSI Children may voluntarily enroll in STAR.

STAR program members have access to a PCP that knows their health care needs and can coordinate their care through a medical home. PCPs provide preventive checkups, treat the majority of conditions that STAR members experience, and refer enrollees to specialty care when necessary. STAR also offers additional services not available in traditional FFS. Under the FFS program, adult clients are limited to three prescriptions per month while STAR members can receive unlimited medically necessary prescriptions. Additionally, STAR members are not subject to the 30-day spell of illness limitation for adults that exists in the FFS program.

STAR+PLUS

The Medicaid STAR+PLUS program provides acute care services plus long-term services and supports (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability. LTSS includes services such as attendant care and adult day health care. The program operates statewide under the authority of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver. Services are delivered through managed care organizations (MCOs).

The STAR+PLUS MCOs are responsible for coordinating acute care and LTSS for STAR+PLUS members with complex medical conditions. The STAR+PLUS program serves SSI, SSI-related individuals, and adults who qualify for Medicaid because they meet medical necessity criteria and, as a result, receive Home and Community Based Services (HCBS) STAR+PLUS waiver services. If eligible for STAR+PLUS, adults are required to participate in the program while children may choose to participate or receive Medicaid benefits through fee-for-service. STAR+PLUS members with complex medical conditions are assigned a service coordinator who is responsible for coordinating acute care and long-term services and supports. The service coordinator develops an individual plan of care with the member, the individual's family members, and providers and can authorize certain services. The program also ensures that each member has a primary care doctor.

The HCBS STAR+PLUS waiver is also part of the STAR+PLUS program. The STAR+PLUS HCBS waiver provides additional LTSS to clients who are elderly or who have disabilities as a cost-effective alternative to living in a nursing facility. These services are non-traditional long-term services and supports such as nursing, personal assistance services, adaptive aids, medical supplies, and minor home modifications to make member's homes more accessible. These clients must be age 21 or older, be a Medicaid recipient, or be otherwise financially eligible for waiver services. To be eligible for HCBS STAR+PLUS waiver services, a member must meet income and resource

requirements for Medicaid nursing facility care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a nursing facility.

STAR+PLUS enrollees who are eligible for both Medicaid and Medicare receive LTSS through STAR+PLUS and most acute care services through Medicare. If enrollees meet the medical necessity criteria to be in a nursing facility, they may receive the additional LTSS through the HCBS STAR+PLUS waiver.

The STAR+PLUS program provides only acute care services to non-dual eligible members receiving services from an intermediate care facility for individuals with intellectual disabilities or related conditions (ICF/IID) or a 1915(c) waiver program for individuals with intellectual and developmental disabilities (IDD) operated by DADS. Adults in an IDD waiver or residing in an ICF/IID are required to participate in STAR+PLUS for acute care services only while children may choose to participate. All dual eligible individuals who are currently living in an ICF-IID or receiving IDD waiver services or individuals residing in a state supported living center are excluded from participation in the STAR+PLUS program.

Children and young adults under the age of 21 who receive services through the YES program can voluntarily enroll into STAR+PLUS. Children and young adults under the age of 21 who receive services through MDCP cannot voluntarily enroll into STAR+PLUS unless they disenroll from MDCP.

NorthSTAR

NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. It is an initiative of the Department of State Health Services (DSHS). Services are provided via a fully capitated contract with a licensed behavioral health organization. STAR clients in Dallas and six contiguous counties (Collin, Ellis, Hunt, Kaufman, Navarro, and Rockwall) around Dallas receive behavioral health services through NorthSTAR.

NorthSTAR was created in 1999 to integrate the publicly funded systems of mental health and substance use disorder services. Using Medicaid, state general revenue, federal block grant funds, and some local funds, NorthSTAR is designed to create a better coordinated and more efficient and flexible system of public behavioral health care.

Most Medicaid eligible recipients who reside in the service area are automatically enrolled in the program based on their Medicaid status. Non-Medicaid eligible

individuals who reside in the service area and meet clinical and income criteria are eligible to receive services through NorthSTAR via an application process.

NorthSTAR is administered through a DSHS contract with a behavioral health organization (BHO). The BHO contract includes outcome and performance measures specifically designed for behavioral health. The BHO is required to subcontract with a specialty provider network for the provision of a set of specialty treatment services and service coordination for enrollees with serious mental illness and serious emotional disturbance. The BHO is also contractually required to maintain an adequate network for other provider specialties for behavioral health. These include psychiatrists, psychologists, licensed therapists, substance use treatment facilities, and hospitals.

The North Texas Behavioral Health Authority, which was specifically formed for the NorthSTAR project, ensures that there is local oversight and that local communities are given a voice in the delivery of publicly funded managed behavioral health care. The North Texas Behavioral Health Authority represents both mental health and substance use disorder interests and concerns

In 2008, DSHS collaborated with the University of Illinois at Chicago to develop a Self-Directed Care (SDC) pilot program within NorthSTAR. SDC is a new way of providing mental health services in which adults with serious mental illnesses directly manage funds to assist in their recovery. With assistance from an SDC advisor, the Texas SDC participants create a person-centered recovery plan and a budget for the purchase of traditional mental health services and non-traditional goods and services in the community that are tied to their recovery. The project study with the University of Illinois ended in December of 2012. In a randomized controlled trial, the SDC model achieved superior client outcomes for no greater service delivery expenditures than those resulting from the traditional service delivery system. The North Texas Behavioral Health Authority was able to continue the program through January of 2013.

STAR Health

STAR Health is a statewide program designed to provide medical, dental, vision, and behavioral health benefits, including unlimited prescriptions, for children and youth in conservatorship of the Department of Family and Protective Services (DFPS), including those in foster care and kinship care. Services are delivered through a single managed care organizations (MCO) under contract with the Health and Human Services Commission (HHSC).

HHSC, in collaboration with DFPS, implemented STAR Health on April 1, 2008. The STAR Health program serves children in state conservatorship; young adults up to the month of their 22nd birthday who have voluntary foster care placement agreements;

young adults up to the month of their 21st birthday who were formerly in foster care and are receiving Medicaid services under the titles Former Foster Care Children (FFCC) and Medicaid for Transitioning Foster Care Youth (MTFCY), and young adults up to the month of their 23rd birthday not eligible under the aforementioned categories, but who enroll in higher education. Clients can begin receiving services as soon as they enter state conservatorship.

STAR Health members receive services through a medical home. Additional benefits include service management, service coordination, value-added services, and the Health Passport, which is a web-based, claims-based electronic medical record. Service management is for members who have complex or high priority needs. Service managers must be licensed clinicians such as registered nurses, licensed professional counselors (LPCs), or licensed clinical social workers (LCSWs). Service coordination is for stable members who require minor assistance with a health need. Service coordinators must be degreed professionals. The program also includes a seven-days-per-week, 24-hours-per-day nurse hotline for caregivers and caseworkers. Use of psychotropic medications is carefully monitored for compliance with the *DFPS Psychotropic Medication Utilization Parameters* (known as "The Parameters"). The Parameters are best practice guidelines for the use of psychotropic medication in children. 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 in order to effectively manage behavior issues that can destabilize children's health status and foster family placement.

Health Passport

The Health Passport is an essential element of the STAR Health program that improves medical information sharing and promotes coordination of care with the child's healthcare providers, DFPS staff, and caregivers. The Health Passport is a web-based repository of claims-based data and other healthcare services data for each STAR Health member, which facilitates online access to a child's medical data and history to promote continuity of care if the child moves to a new location as the result of a placement change.

Health Passport information is available to authorized users through a secure, password-protected website administered by the STAR Health MCO. Health care data available for viewing in the Health Passport includes current as well as historical claims data for STAR Health members that may have been prior enrolled in CHIP or Texas Medicaid. The system is regularly updated to ensure the most up-to-date information is posted to the child's records. Pharmacy, dental, vision, physical, and behavioral health claims are uploaded on a daily basis; immunization data from the state is received and

loaded weekly. In addition, providers and other authorized individuals have the ability to add certain medical forms, patient allergy information, and patient vitals directly into the Health Passport system; access to the information is available immediately upon entry.

The Health Passport application also has the functionality to check for interactions between medications based on a child's known allergies indicated in the system. If a STAR Health member is taking medications that interact with each other or may cause any reported allergies, an alert is presented on the child's Health Passport medical record and is accompanied with clinical information on the possible interaction.

Service Management

The STAR Health MCO conducts a telephonic screening for each child within the first month of enrollment. The screening gathers information about each child's physical and behavioral health medical history and status from the medical consentor. The MCO's service management team uses this information to determine the physical and behavioral health needs of all STAR Health members. Depending upon the severity of the identified needs, the MCO will assign a service manager or service coordinator to the child. The service manager or coordinator will then assist the medical consentor in obtaining any necessary services. Updates to the telephonic screening are completed every time a child changes placements, and periodically according to their level of need, throughout their enrollment with STAR Health.

The STAR Health MCO has developed specialty service management programs that can assist children with complex behavioral health needs. Complex Case Management supports children with the highest level of behavioral health needs, including those with dual diagnoses and/or a history of inpatient admissions. The Intellectual Developmental Disabilities Management program identifies and supports those with a diagnosis of autism, Asperger's syndrome, intellectual disability, or pervasive developmental disorder.

Psychotropic Medication Utilization Reviews (PMUR)

In 2004, the release of an Office of Inspector General report raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, DSHS, and DFPS have coordinated efforts to obtain a more detailed assessment of the problem and to assist providers in using psychotropic medication appropriately, both for children in foster care and for all children enrolled in Medicaid.

In 2005, the best practice guidelines, Psychotropic Medication Utilization Parameters for Foster Children, were released. The second edition was released in 2007, the third edition in 2010, and the fourth edition in 2013. These parameters include general principles for optimal practice, reference material, and a listing of commonly used

psychotropic medications with dosage ranges and indications for use in children (both U.S. Food and Drug Administration-approved and literature-based).

The STAR Health MCO conducts ongoing Psychotropic Medication Utilization Reviews (PMURs) on children in foster care whose medication regimens fall outside of the guidelines set forth by the parameters. Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO formed a Psychotropic Medication Monitoring group which meets quarterly to review the monitoring conducted by the STAR Health MCO and its behavioral health subcontractor. The Psychotropic Medication Monitoring group also oversees an annual report on psychotropic utilization and the biennial review and update of the parameters.

Starting in 2011, prior authorization is required for dispensing an antipsychotic medication for any Medicaid member that is taking more than two different antipsychotic medications concurrently or under age three. The carve-in of prescription drug coverage into managed care in 2012 provided the STAR Health MCO with opportunities to enhance its psychotropic medication monitoring. Annual analysis of how Medicaid prescribing practices align with the guidelines set forth in the parameters has revealed that psychotropic prescribing to children in foster care has steadily decreased since the release of the parameters in early 2005, both in terms of the percentage of children in foster care taking psychotropic medication and in the overall number of children receiving medication regimens outside of the recommended criteria.

Children's Medicaid Dental Services

As of March 1, 2012, children's Medicaid dental services are provided through a managed care model for most children and young adults birth through age 20. The following Medicaid clients are not eligible to participate in the Children's Medicaid Dental Services program and continue to receive dental services through their existing service delivery models:

- Medicaid clients age 21 and over;
- All Medicaid clients, regardless of age, residing in Medicaid-paid facilities such as nursing homes, state supported living centers, or ICF/IID; and
- STAR Health program clients.

Members who receive their dental services through a Medicaid managed care dental plan are required to select a dental plan and a main dentist. A main dentist serves as the member's dental home and is responsible for:

- Providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care;
- Maintaining the continuity of patient care; and

- Initiating referrals for specialty care.

Provider types that can serve as main dentists are FQHCs and individuals who are general or pediatric dentists.

Additional Services Offered in Managed Care

Clients who enroll with an MCO also have access to value-added services and additional benefits that are not available in the fee-for-service program. Value-added services are additional health care services that an MCO voluntarily elects to provide to its clients at no additional cost to the state. The MCOs offer various value-added services such as adult dental services and diapers for newborns to attract new clients.

Additional services may be offered to members on a case-by-case basis at the discretion of the MCO. It may provide these services based on medical necessity, cost effectiveness, the wishes of the member, and the potential for improved health status of the member. Value-added services and case-by-case services can vary from one MCO to another.

Managed Care Organization Requirements for Chronic Care Management

Medicaid MCOs must provide disease management programs and services consistent with federal and state statutes, regulations, and contract requirements. Disease management programs and services must be part of a person-based approach and holistically address the needs of high-risk members with complex chronic or co-morbid conditions. The programs must identify members at highest risk of utilization of medical services, tailor interventions to better meet members' needs, encourage provider input in care plan development, and apply clinical evidence-based practice protocols for individualized care.

The MCOs must develop and implement disease management services for members with chronic conditions including, but not limited to: asthma, diabetes, Chronic Obstructive Pulmonary Disease, congestive heart failure, coronary artery disease, and other chronic diseases.

Members with Special Health Care Needs

Medicaid MCOs are required to identify and provide service management and service plans for members with special health care needs (MSHCN). A member with special health care needs is a member, including a child, who: (1) has a serious ongoing illness, a chronic or complex condition, or disability that has lasted or is anticipated to last for a

significant period of time and (2) requires regular ongoing therapeutic intervention and evaluation by appropriately trained personnel.

The MCO is responsible for working with MSHCN, their health care providers and their families, to develop a seamless package of care in which primary, acute care, and specialty care service needs are met through a service plan. Service management refers to administrative services performed by the MCO to facilitate coordination of services for members. Service management may include assistance with setting up appointments, locating specialty providers, and member health assessments. Service management is available to MSHCN and other populations such as women with high-risk pregnancies, individuals with mental illness and co-occurring substance abuse, children of migrant farmworkers, and former foster care child members.

Managed Care Enrollment

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care SFYs 1994-2014

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR Implementation: Travis County (8/93) & Tri-County Area (12/93)	58,243	2.86%
1995	Same as above	65,388	3.16%
1996	Travis County and SE Region (Tri-County expanded to 3 additional counties 12/95 and renamed)	71,435	3.46%
1997	Travis (expanded 9/96), SE Region, Bexar (9/96), Lubbock (10/96), Tarrant (10/96)	274,694	13.82%
1998	Same as above, with Harris STAR (12/97), Harris STAR+PLUS (3/98)	364,336	19.56%
1999	Same as above, with STAR expansion to Dallas (7/99)	425,069	23.45%
2000	Same as above with STAR expansion to El Paso (12/99)	523,832	28.98%
2001	Same as above	623,883	33.35%
2002	Same as above	755,698	35.92%
2003	Same as above	988,389	39.71%
2004	Same as above	1,112,002	41.43%
2005	Same as above	1,191,139	42.85%
2006	Same as above, with STAR expansion to 197 counties (PCCM Only)	1,835,390	65.72%

Table 7.1: Percentage of Medicaid Clients Enrolled in Managed Care SFYs 1994-2014 (Continued)

State Fiscal Year	Service Areas and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2007	Same as above with STAR HMO expansion to Nueces (09/2006) and STAR+PLUS expansion to Bexar, Travis, Nueces, and Harris Contiguous (02/2007). Urban areas shift from PCCM to HMO Only (12/2006)	1,921,651	67.83%
2008	Same as above, with ICM rollout in Dallas and Tarrant (Aged & Disability Related Clients) (02/2008) and STAR Health Foster Care Managed Care rollout statewide (04/2008)	2,039,340	70.86%
2009	Same as above, but with ICM removed in May 2009	2,127,382	70.78%
2010	Same as above	2,362,091	71.62%
2011	Same as above but with STAR+PLUS expansion to Dallas and Tarrant (2/2011).	2,676,149	75.53%
2012	Expansion to Medicaid Rural Services Area (MRSA) for non-full dual eligible clients, March 2012; Shift from PCCM to HMO for all remaining areas; Carve-in of Vendor Drug, Inpatient Hospital for all STAR+PLUS (March 2012); Dental Capitation (March 2012)	2,893,965	79.16%
2013	Same as above	2,982,923	81.53%
2014	Same as above (data not final until February 2015)	3,012,262	80.40%
2015	<i>FORECAST: STAR+PLUS expansion statewide, IDD Clients Acute Care carved into STAR+PLUS, (September 2014); Nursing Facility and Dual-Demonstration Carve-in, March 2014</i>	3,627,616	86.69%

Sources: HHSC, Financial Services, HHS System Forecasting. Average Monthly Recipient Months including STAR, STAR+PLUS, PCCM, ICM and STAR Health.

Note: In the Dallas Service Area, most Medicaid-eligible individuals receive Medicaid acute care services through the STAR program. They receive their behavioral health services through a separate program, NorthSTAR.

Table 7.2: Medicaid Clients Enrolled in Managed Care and Fee-for-Service SFYs 2010-2014

Medicaid Clients by Service Delivery Type

Service Delivery Type	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Fee-for-Service	936,008	866,908	761,964	675,706	734,427
Managed Care Total	2,362,091	2,676,149	2,893,965	2,982,923	3,012,262
<i>Managed Care: STAR PCCM</i>	805,836	887,919	402,097	0	0
<i>Managed Care: STAR MCO</i>	1,359,957	1,536,422	2,121,651	2,546,683	2,570,531
<i>Managed Care: STAR Health</i>	29,762	31,834	31,171	30,293	30,732
<i>Managed Care: STAR+PLUS</i>	166,536	219,975	339,047	405,947	410,999
<i>Managed Care: ICM</i>	0	0	0	0	0
Total Medicaid Clients	3,298,099	3,543,057	3,655,930	3,658,629	3,746,689

Percentage Medicaid Clients by Service Delivery Type

Service Delivery Type	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Fee-for-Service	28.4%	24.5%	20.8%	18.5%	19.6%
<i>Managed Care: STAR PCCM</i>	24.4%	25.1%	11.0%	0.0%	0.0%
<i>Managed Care: STAR MCO</i>	41.2%	43.4%	58.0%	69.6%	68.6%
<i>Managed Care: STAR Health</i>	0.9%	0.9%	0.9%	0.8%	0.8%
<i>Managed Care: STAR+PLUS</i>	5.0%	6.2%	9.3%	11.1%	11.0%
ICM	0.0%	0.0%	0.0%	0.0%	0.0%

Source: HHSC, Financial Services, HHS System Forecasting.

Quality of Care

Federal law requires state Medicaid programs to contract with an external quality review organization (EQRO) to help evaluate Medicaid managed care programs. The EQRO produces reports to support HHSC's efforts to ensure managed care clients have access to timely and quality care in each of the managed care programs. The results allow comparison of findings across MCOs in each program and are used to develop overarching goals and quality improvement activities for Medicaid and CHIP managed care programs. MCO findings are compared to HHSC standards and national averages, where applicable.

The EQRO assesses care provided by MCOs participating in STAR, STAR+PLUS (including the STAR+PLUS home and community-based services waiver), STAR Health, NorthSTAR, CHIP, and the Medicaid and CHIP dental managed care programs. The EQRO conducts ongoing evaluations of quality of care primarily using MCO administrative data, including claims and encounter data. The EQRO also reviews MCO documents and provider medical records, conducts interviews with MCO administrators, and conducts surveys of Texas Medicaid and CHIP members, caregivers of members, and providers.

STAR-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO indicate 73 percent of STAR children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life compared to the 71 percent HHSC standard for this measure. Fifty-eight percent of adolescents 12 to 21 years of age enrolled in the STAR program had one or more well-care visits, exceeding the HHSC standard of 51 percent.

Also, in calendar year 2012, measurement of women's access to prenatal and postpartum care in STAR identified that 74 percent of pregnant women in the STAR program received prenatal care in their first trimester, falling below the HHSC standard of 83 percent. The rate of postpartum care visits (66 percent) was slightly greater than the national mean of 64 percent.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissionsⁱⁱⁱ (PPAs): \$87,726,161
- Potentially preventable readmissions^{iv} (PPRs): \$39,042,858
- Potentially preventable emergency department visits^v (PPVs): \$270,489,647

Satisfaction with Care

The SFY 2012 STAR Adult Member Survey assesses members' experiences and satisfaction with their health care related to access to and timeliness of care, patient-centered medical home, and health plan information and customer service.

ⁱⁱⁱ Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^{iv} Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

^v Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

Greater than half of survey respondents rated the service of their health care, personal doctor, specialist, and health plan as a nine or ten on a ten-point scale. Each rating met or surpassed the Medicaid national average.

Other positive findings reported by members were:

- *Good access to special therapies.* Approximately two out of three members who needed special therapies said that it was usually or always easy to get the therapy they needed (62 percent). This rate exceeds the HHSC Dashboard standard of 58 percent.
- *Access to prescription medicines.* Approximately half of members reported that they received new prescription medicines or refilled a medication during the past six months (53 percent). Among these members, 81 percent reported that it was usually or always easy to get the medicine they needed from their health plan.
- *Shared decision-making.* Nearly four out of five members said that they were usually or always involved as much as they wanted in their health care (79 percent) and that they usually or always felt it was easy to get their doctors to agree on how to manage their health care problems (79 percent).
- *Care coordination.* Nearly two out of three members reported that they had someone helping to coordinate their health care (61 percent). Among these members, a vast majority reported that they were satisfied or very satisfied with the assistance they received (93 percent).

Areas that offer an opportunity for improvement are:

- *Getting Care Quickly.* Seventy percent of members usually or always had positive experiences with *Getting Care Quickly*, which is lower than the national Medicaid rate of 80 percent for this measure.
- *Good Access to Routine Care.* Approximately two-thirds of members reported that they had good access to routine care (67 percent). This rate is lower than the HHSC Dashboard standard for this indicator (80 percent).
- *Office Wait.* About 1 in 5 members reported having no wait greater than 15 minutes before being taken to the exam room (21 percent). This rate is lower than the HHSC Dashboard standard of 42 percent.
- *Getting Needed Care.* Sixty-six percent of members usually or always had positive experiences with *Getting Needed Care*. This percentage is lower than the national Medicaid rate of 78 percent.
- *Good Access to Specialist Referral.* Approximately two-thirds of members who needed a referral to a specialist said it was usually or always easy to get a

referral (64 percent). This rate is lower than the HHSC Dashboard standard for this indicator (73 percent).

- *Emergency department utilization.* Thirty-eight percent of members visited the emergency department at least once in the past six months. Among these members, 70 percent said they did *not* contact their personal doctor before going to the emergency department.
- *Advising Smokers to Quit.* Among members who reported they smoke cigarettes, half said that a doctor or other health provider had advised them to quit smoking in the last six months (51 percent). This rate is lower than the HHSC Dashboard standard for this indicator (70 percent).

The SFY 2011 STAR Child survey evaluates caregivers' experiences and satisfaction with their children's health care while enrolled in the STAR program.

The majority of caregivers provided high ratings of their child's health care, doctors, and health plan, indicated by a rating of nine or ten on a ten-point scale. These ratings were greater than those reported in Medicaid national data.

Other positive findings reported by members were:

- *Access to Specialist Referral.* The majority of caregivers reported that they were usually or always able to get a referral for their child to see a specialist (69 percent). All MCOs except one met the HHSC Dashboard standard of 59 percent for good access to specialist referrals.
- *Health Plan Customer Service.* Most caregivers reported that they usually or always had positive interactions with customer service at their child's health plan (84 percent).

Areas that offer an opportunity for improvement are:

- *Getting Needed Care.* Seventy-two percent of STAR caregivers usually or always had positive experiences with *Getting Needed Care*, compared to the 79 percent reporting for Medicaid plans nationally.
- *Getting Care and Assistance for Children with Special Healthcare Needs (CSHCN).* Caregivers of CSHCN were significantly less likely than caregivers of non-CSHCN to report positive experiences with their child's health plan and getting needed care for their child, such as appointments with specialists and tests and treatment, through the health plan.

- *Getting Specialized Services.* Although less than ten percent of caregivers reported that their child needed specialized services, access to these services in STAR was lower than reported nationally (66 percent versus 74 percent).
- *HHSC Performance Dashboard Indicators.* Results of the following performance indicators indicate that few health plans are meeting HHSC Dashboard standards for good access to routine care, no delays in health care while waiting for health plan approval, and no exam room wait greater than 15 minutes.

STAR+PLUS-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide descriptive information about the STAR+PLUS population and evaluation of members' quality of care based on certain outcome measures.

Rates for Effective Acute Phase Treatment and Effective Continuation Phase Treatment for Antidepressant Medication Management, a HEDIS[®] measure that assesses the percentage of members 18 years or older who were diagnosed with major depression and were newly treated with antidepressant medication, were positive. The rate for Effective Acute Phase Treatment was 60 percent, compared to the 43 percent HHSC standard for this measure. The rate for Effective Continuation Phase Treatment was 47 percent, compared to the 24 percent HHSC standard for this measure.

Program and MCO-level performance data on the HEDIS[®] Comprehensive Diabetes Care measure show this is an area that needs improvement, with the rate of HbA1c control among STAR+PLUS members with diabetes falling below the HEDIS[®] tenth percentile. Agency for Healthcare Research and Quality Prevention Quality Indicator rates of potentially avoidable admissions for diabetes short-term complications were 399 per 100,000 population, and diabetes long-term complications were 634 per 100,000 population, although a net decrease was observed for both measures across the four-year period, indicating that performance has improved.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissions^{vi} (PPAs): \$74,214,571
- Potentially preventable readmissions^{vii} (PPRs): \$49,922,346

^{vi} Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^{vii} Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

- Potentially preventable emergency department visits^{viii} (PPVs): \$84,638,638

Satisfaction with Care

The SFY 2012 STAR+PLUS Adult Member Survey assesses members' experiences and satisfaction with their health care related to access to and timeliness of care, patient-centered medical home, service coordination, and health plan information and customer service. The majority of STAR+PLUS members provided high ratings of their health care, doctors, and MCO, indicated by a rating of nine or ten on a ten-point scale. These ratings were comparable to those published from Medicaid national data.

Other positive findings reported by members were:

- *Access to Prescription Medicines.* Eighty-two percent of members who received prescription medication (new or refill) said it was “usually” or “always” easy to get prescription medications.
- *Preventive Care and Health Promotion.* Among members who reported that they smoke cigarettes, nearly three-quarters said that their doctor advised them to quit smoking during the last six months (69 percent), which is approximately equal to the HHSC Dashboard standard of 70 percent.
- *Shared Decision-Making.* A majority of members reported they “usually” or “always” were involved as much as they wanted in decisions about their health care (81 percent). Seventy-three percent of members reported that it was “usually” or “always” easy to get their doctors to agree on how to manage their health care problems.
- *Good Access to Service Coordination.* Among members who needed service coordination, 67 percent reported that they “usually” or “always” received service coordination as soon as they thought they needed it. This percentage exceeds the HHSC Dashboard standard of 63 percent for this indicator.
- *Satisfaction with Service Coordination.* Eighty-three percent of members who had a service coordinator said they were “satisfied” or “very satisfied” with their service coordinator.

Areas that offer an opportunity for improvement are:

- *Good Access to Urgent Care.* Seventy-seven percent of members reported that they “usually” or “always” received urgent care as soon as they needed. Only

^{viii} Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

three MCO service areas performed at or above the HHSC Dashboard standard of 81 percent for this indicator.

- *Good Access to Routine Care.* While approximately three in four members reported that they usually or always received an appointment for routine care as soon as it was needed (73 percent), only one MCO service area group met the HHSC Dashboard standard of 80 percent for this indicator.
- *Getting Needed Care.* Sixty percent of members “usually” or “always” had positive experiences on the CAHPS® composite Getting Needed Care, which is below the national Medicaid average (76 percent). Scores for Getting Needed Care varied by service area, with the lowest scores reported in the Bexar and Dallas service areas.
- *Communication with Providers’ Office Personnel.* Slightly more than half of members reported that someone in their provider’s office spoke with them about specific goals for their health (58 percent). This aspect of patient-centered care varied by service area, with rates in the Travis service area higher than others.
- *Health Plan Information and Customer Service.* Sixty-eight percent of members said they “usually” or “always” had positive experiences on the CAHPS® composite Health Plan Information and Customer Service, which is below the national average of 80 percent.
- *Health Plan Approval.* Thirty-eight percent of members reported having no delays in health care while waiting for health plan approval, which is below the HHSC Dashboard standard of 57 percent. None of the MCO service area groups met the HHSC Dashboard standard for this indicator.
- *Awareness of Service Coordination.* Less than half of respondents were aware that their health plan offers service coordination to its members (46 percent), although it is a service available for all STAR+PLUS members who request it.
- *Having Service Coordination.* Only 31 percent of STAR+PLUS members reported that they have a service coordinator.
- *Involvement in Service Coordination.* Although members generally had high levels of satisfaction with their service coordinators, two-thirds (64 percent) said their service coordinator involved them in making decisions about their services.

It is important to note that these survey findings were collected prior to HHSC making changes to the STAR+PLUS service coordination standards aimed at improving service coordination for members.

NorthSTAR-Significant Quality Findings

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide descriptive information about the quality of care for NorthSTAR members based on certain outcome measures. Behavioral health organization findings are compared to HHSC standards and national averages, where applicable.

Rates for Effective Acute Phase Treatment and Effective Continuation Phase Treatment for Antidepressant Medication Management, a HEDIS[®] measure that assesses the percentage of members 18 years or older who were diagnosed with major depression and were newly treated with antidepressant medication, were positive. The rate for Effective Acute Phase Treatment was 51 percent, compared to the 51 percent national mean for this measure. The rate for Effective Continuation Phase Treatment was 37 percent, compared to the 34 percent national mean for this measure.

For the HEDIS[®] measure Follow-Up Care for Children Prescribed ADHD Medication, the EQRO assesses the percentage of children six to 12 years of age with newly prescribed ADHD medication who received two types of follow-up care during 2012: first, the Initiation Phase, which reports the percentage of children with an ambulatory prescription dispensed for ADHD medication who had a follow-up visit with a provider during the 30-day initiation phase; and second, the Continuation and Maintenance Phase, which reports the percentage of children with an ambulatory prescription dispensed for ADHD medication who continued taking the medication for at least 210 days (30 weeks), and who had at least two follow-up visits with the provider within nine months after the initiation phase ended. The rate of Follow-Up Care for Children Prescribed ADHD Medication, Initiation Phase was 27 percent, compared to the 39 percent national mean for this measure. The rate of Follow-Up Care for Children Prescribed ADHD Medication, Continuation and Maintenance Phase was 37 percent, compared to the 46 percent national mean for this measure.

The HEDIS[®] measure Follow-Up after Hospitalization for Mental Illness assesses the percentage of members six years of age or older who were hospitalized for treatment of mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or a partial hospitalization with a provider during 2012. This measure provides follow-up rates for two time periods: (1) the percentage of members who received follow-up care within 7 days of discharge; and (2) the percentage of members who received follow-up care within 30 days of discharge. NorthSTAR rates of 25 percent follow-up within 7 days of discharge and 51 percent for follow-up within 30 days of discharge were lower than the national means of 47 percent and 65 percent, respectively.

The HEDIS® measure Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment assesses the percentage of adolescents and adults with an AOD diagnosis who, during the measurement period initiated treatment within 14 days of diagnosis and had two or more additional services (e.g., inpatient treatment, outpatient treatment) within 30 days of the initiation visit. NorthSTAR rates of 17 percent initiation of AOD treatment and 5 percent engagement of AOD treatment were lower than the national means of 39 percent and 12 percent, respectively.

Satisfaction with Care: MCO findings are compared to HHSC standards and national averages, where applicable. The SFY 2012 STAR Adult Behavioral Health Survey assessed the experiences and satisfaction with health care related to access to and timeliness of care, patient-centered medical home, service coordination, and health plan information and customer service for adults 18 to 64 years old who were enrolled in STAR or NorthSTAR and who had a record of one or more mental health/chemical dependency diagnoses and procedure combinations between July 2011 and December 2011. The data includes both NorthSTAR and STAR data.

Positive findings:

- *Patient Information about Treatment and Management of their Condition.* Seventy-six percent of members felt they could refuse a medicine or treatment suggested by their clinician.
- *Ratings of Clinician.* Members were satisfied with their primary clinicians, giving them a mean rating of 8.7 out of 10, with 68 percent of members giving a rating of 9 or 10.
- *Getting Treatment, Information, and Assistance.* The vast majority of members that spoke with office staff said that they were treated with courtesy and respect.
- *Perceived Improvement.* Almost half of members said they were helped a lot by their care (44 percent).

Areas that offer an opportunity for improvement:

- *Body mass index (BMI).* Over two-thirds of members were overweight or obese (72 percent), half of all members were obese (48 percent), and obesity rates were particularly high among women (50 percent).
- *Getting timely telephone counseling.* Timeliness of care for telephone counseling was low. Among members who reported they tried to get counseling on the telephone, 37 percent said they usually or always got telephone counseling in a timely manner, with 30 percent of members saying that they never got telephone counseling when needed.

- *Benefits.* Twenty-one percent of members indicated that they used up all of their benefits. Of this group, 68 percent said that they still needed counseling or treatment services, and less than half reported being told of other ways to receive counseling or treatment (41 percent).
- *Getting Treatment, Information, and Assistance.* Among members who reported they needed approval for counseling or treatment in the last six months, over a third said that they had a “big problem” with delays in treatment while they awaited approval (37 percent).

Additional information on various quality and performance measures that are tracked by DSHS can be found in the NorthSTAR data book and trending reports at <http://www.dshs.state.tx.us/mhsa/northstar/databook.shtm> (July 2014).

STAR Health-Significant Quality Findings

Quality of Care

MCO findings are compared to HHSC standards and national averages, where applicable. The quality of care study conducted in calendar year 2012 by the EQRO indicates 87 percent of STAR Health children received one or more well-child visits in their 3rd, 4th, 5th and 6th years of life compared to the 70 percent HHSC standard for this measure. Seventy-four percent of adolescents 12 to 21 years of age enrolled in the STAR program had one or more well-care visits, compared to the HHSC standard of 45 percent.

In 2013, actual expenditures for potentially preventable events (PPEs) were as follows:

- Potentially preventable admissions^{ix} (PPAs): \$7,596,095
- Potentially preventable readmissions^x (PPRs): \$4,442,868
- Potentially preventable emergency department visits^{xi} (PPVs): \$3,552,813

Satisfaction with Care

MCO findings are compared to HHSC standards and national averages, where applicable. The SFY 2012 STAR Health Caregiver Survey assesses caregivers’ experiences and satisfaction with health care related to access to and timeliness of

^{ix} Inpatient stays that may have been avoidable had the patient received high quality primary and preventive care prior to the admission.

^x Return hospitalizations that may result from deficiencies in the process of care and treatment during the initial hospital stay; and/or poor coordination of services at the time of discharge and during follow-up.

^{xi} Emergency room visits for conditions that could be treated effectively with adequate patient monitoring and follow-up, rather than requiring emergency medical attention.

care, patient-centered medical home, service coordination, and health plan information and customer service.

A majority of caregivers provided high ratings of their child's health care, doctors, and health plan, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were comparable to those published from Medicaid national data.

Other positive findings reported by members were:

- *Getting Care Quickly*. Ninety percent of caregivers usually or always had positive experiences with *Getting Care Quickly*, which is higher than the Medicaid national average of 87 percent.
- *Good Access to Urgent Care*. A vast majority of caregivers reported that their child usually or always received care for an illness, injury, or condition as soon as they thought their child needed care (96 percent). This percentage exceeds the HHSC Dashboard standard of 88 percent.
- *Good Access to Routine Care*. Eighty-four percent of caregivers reported that they usually or always were able to make a routine appointment as soon as they thought their child needed care. This percentage is greater than the HHSC Dashboard standard of 76 percent.
- *Good Access to Specialist Referral*. Eighty-four percent of caregivers reported it was usually or always easy to get a referral to a specialist for their child, which is higher than the HHSC Dashboard standard of 75 percent.

Areas that offer an opportunity for improvement are:

- *Body mass index (BMI)*. Nearly one third of children were classified as obese (30 percent). This rate is higher than the national and Texas averages for child/adolescent obesity (17 percent and 20 percent, respectively).
- *Preparing caregivers and children with special health care needs for transition to adulthood*. Among children 11 years of age and older, 13 percent of providers spoke with caregivers about their child having to eventually see providers who treat adults.
- *Service management*. Approximately one-third of caregivers said they received a call asking whether their child needed service management (38 percent). However, when service management was recommended by the service manager, nearly all caregivers agreed to participate in the program (96 percent).
- *Health plan information and customer service*. Seventy-five percent of caregivers usually or always had positive experiences on the CAHPS® composite *Health*

Plan Information and Customer Service (75 percent), which is below the national average of 83 percent.

Medicaid and Children's Health Insurance Dental Programs

Quality of Care

The quality of care studies conducted in calendar year 2012 by the EQRO provide an evaluation of access to dental care services among members enrolled in Medicaid dental services and CHIP. On December 1, 2012, one of the three dental contracts was terminated affecting the results of the quality of care measures for calendar year 2012. Some of the presented measures include data from the third contractor.^{xii}

Medicaid Dental

The overall Medicaid rates of annual dental visits were higher than their respective national rates for all age groups. For all ages combined, the overall Medicaid rate was 73 percent compared to the national mean of 45 percent. The rate of THSteps dental checkups among newly enrolled members was also low, at approximately one-quarter of members within 90 days of enrollment.

The overall Medicaid rates for the Use of Preventive Dental Services, including and excluding the third contractor, were 58.4 percent and 56.9 percent, respectively. The American Academy of Pediatric Dentistry (AAPD) recommends preventive dental services for all children and adolescents every six months, which suggests that rates of preventive dental services in Texas Medicaid could be improved.

The percentage of children and adolescents that received dental sealants was 21 percent.

CHIP Dental

The overall CHIP rates of annual dental visits including the third contractor were equal to or higher than their respective HHSC Dashboard standards with an overall rate of 64 percent for all age groups. However, the overall CHIP rates excluding the third contractor were lower than respective HHSC Dashboard standards for all age groups with an overall rate of 56 percent for all age groups.

^{xii} Measures include TMHP data from FFS Medicaid Dental. MCO data incorporated beginning 3/1/2012.

The overall CHIP rate for Use of Preventive Dental Services was 61 percent, which is higher than the HHSC Dashboard standards. However, the overall CHIP rate excluding the third contractor was 52 percent, which fell below the HHSC Dashboard standard.

Eighteen percent of CHIP members received dental sealants in 2012.

The overall utilization rate of dental services in CHIP (excluding the third contractor) was 51 percent, which fell below the HHSC Dashboard standards for this measure.

Chronic Care Management

Texas Medicaid Wellness Program for Children with Disabilities

The Texas Medicaid Wellness Program is a community-based, holistic care management program that enrolls high-risk adults and children with disabilities with complex, chronic, or co-morbid conditions receiving Medicaid in the fee-for-service system. Wellness Program nurses help program participants with finding a main doctor, managing their health between doctor visits, learning more about their health conditions, knowing how to take their medicines, and selecting the best medical care for their health. Extensive case management focuses on the whole person, rather than the disease, through telephone and face-to-face conversations that aim to improve health outcomes. The client's care team is led by a registered nurse that can include social workers, community health workers, pharmacists, and behavioral health specialists, among others. In addition to working on the client's care plan with the provider and client's family and provider, the care team also assists with transportation and housing issues, medical equipment assistance, and education on disease management and nutrition. Wellness clients receive one or two telephone and/or face-to-face visits per quarter, and receive educational mailings quarterly. Program eligible clients and participants also have access to a 24-hour nurse advice line.

Endnotes

¹ Texas Health and Human Services Commission, "Texas Medicaid Managed Care Review," November 1, 2000.

Chapter 8: Medicaid

Spending From All Angles

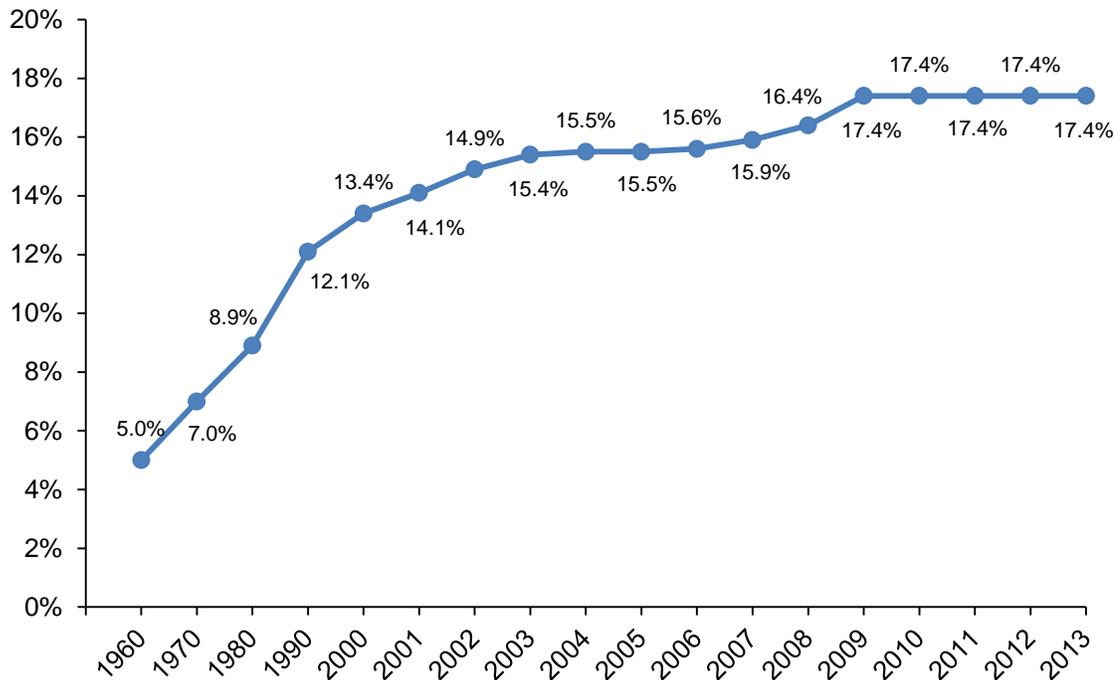
Medicaid is one of the largest programs in the Texas budget. Where does that money come from? Where does it go? How fast is the program growing?

Health Care Spending in the United States

Health care spending in the United States rose from \$724 billion in 1990 to \$2.79 trillion in 2012, an increase of 285 percent.¹ Over the same period, the economy grew by 172 percent. The faster growth of health spending relative to the growth of the economy is the reason that **Figure 8.1** shows a sustained long-term trend of health care spending representing a growing share of Gross Domestic Product (GDP). This increasing share of health care spending out of all spending can be attributed to a variety of factors. One of the most important of these factors is the increasing cost of care. As newer, more expensive treatments are developed and used, costs rise.ⁱ Another important factor is the aging of the population. As people age, as a group they tend to spend more on health care. Because the average age of the country's population is increasing, total demand for health care is rising as a consequence.

ⁱ Increasing the expenditure by itself does not necessarily guarantee increased quality of care or additional services.

Figure 8.1 Health Care Spending as a Percentage of GDP



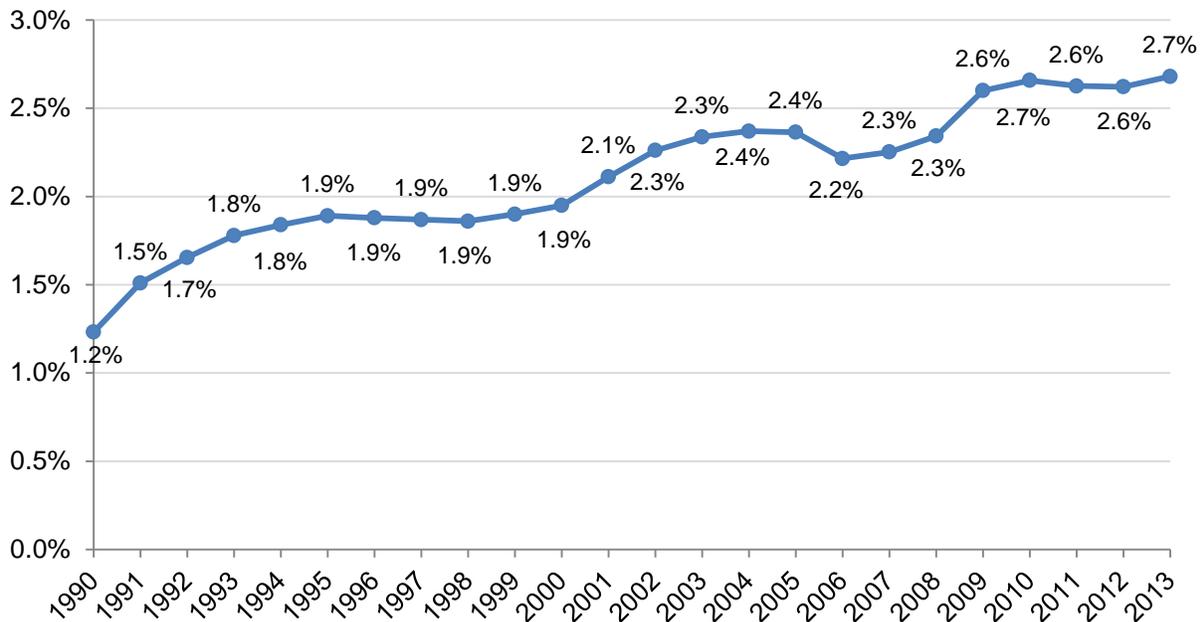
Source: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures; Aggregate, Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2013 (December 2014). <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Medicaid Spending as a Percentage of the GDP

Just as total health expenditures have been rising, Medicaid expenditures have also been rising. See **Figure 8.2**. Total Medicaid expenditures rose from \$73.7 billion in 1990 to \$449.4 billion in 2013, an increase of 510 percent. The increase in Medicaid expenditures was generated partly by the same factors that affected the increase in medical expenditures for the general population and partly by factors unique to Medicaid. The increases in expenditures for the general population were mainly generated by more expensive care and an older population. The costs for Medicaid are affected up by these causes, but have also been pushed up by increases in the Medicaid caseload and the fact that Medicaid serves a specially selected demographic group. Over the period 1990 to 2013, the Medicaid caseload grew from 22.8 million

individuals to 59.3 million individuals, an increase of 160 percent. The demographic selection of the Medicaid population occurs because eligibility to enter the Medicaid population is governed by laws designed to provide medical help to the needy. Because the needy on Medicaid tend to have many more, and more serious, untreated medical conditions per enrollee than the population as a whole has per capita, this demographic factor induces additional costs for serving the Medicaid population.

Figure 8.2: Medicaid Spending as a Percentage of the GDP



Source: Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data, "Table 1: National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Change: Selected Calendar Years 1960-2013."

The Bottom Line

Since its inception in 1967, the Texas Medicaid program has grown from serving fewer than one million Texans to serving almost four million Texans. Combined federal and state Medicaid spending has increased from under \$200 million per year to over \$25.6 billion per year in federal fiscal year (FFY) 2013. This amount excludes disproportionate share hospital (DSH), uncompensated care, and DSRIP funds. When these funds are included, combined federal and state spending on Texas Medicaid in FFY 2013 was \$33 billion. Health care services accounted for \$24.2 billion, and administration of the program accounted for \$1.4 billion, or 4.5 percent of total costs. DSH, uncompensated care, and DSRIP reimbursements added another \$7.5 billion to program costs.

Administrative Costs

Medicaid administrative costs accounted for \$1.4 billion in FFY 2013, comprising 4.5 percent of the total Medicaid budget.

Historical Medicaid Spending

Table 8.1: Percent of Medicaid Expenditures in Texas State Budget

Year	Medicaid Budget, All Funds**	Total State Budget, All Funds***	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%

* Dollars in millions

** Excludes Disproportionate Share Hospital (DSH), Upper Payment Limit (UPL), Uncompensated Care (UC) and DSRIP funds

*** Medicaid is FFY, State Budget reflects the state fiscal year, beginning one month prior (September)

Sources: Texas Medicaid History Report, August 2014, and Fiscal Size-Up(s).

Trends in Texas Medicaid Caseloads and Costs

Budget and Caseload Growth

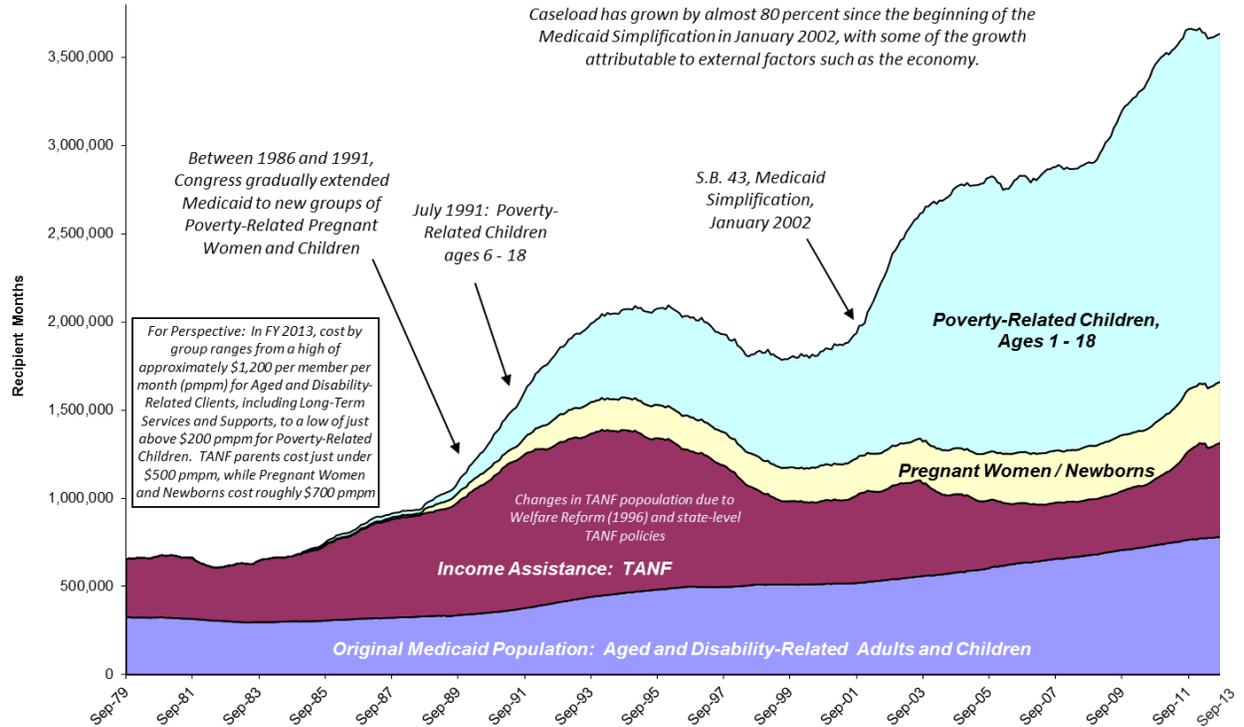
The rapid acceleration of Texas Medicaid spending from the late 1980s to the early 1990s was primarily due to increasing caseloads and costs. Escalating DSH payments and medical inflation contributed to the increase in overall costs of the Medicaid program. At the same time, program changes contributed to the increase in the number of Medicaid beneficiaries, thereby increasing caseload.

In the 1990s, Texas sought to include existing state-funded programs in the Medicaid program so that they could be eligible to receive federal matching dollars. These factors combined to increase the Texas Medicaid budget five-fold from 1987 to 2001.

In 1988, Congress dramatically expanded Medicaid eligibility standards to include groups of people with incomes higher than the Aid to Families with Dependent Children (AFDC, now known as Temporary Assistance for Needy Families or TANF) cap. Other federal expansions and the economic recession in the early 1990s resulted in more increases in the number of children and pregnant women who became eligible for Medicaid. Beginning in the mid-1990s, welfare reform began to impact not only the size of the Medicaid caseload as TANF clients declined, but the composition of the caseload. While caseloads declined overall in the late 1990s, the numbers of clients over the age of 65 or who have a disability, as well as pregnant women and newborns, continued to increase and comprise a larger proportion of caseload. These high-cost clients offset any cost savings that could have resulted from caseload declines.

Texas' implementation of continuous eligibility for children as well as simplifying the eligibility process resulted in even more caseload increases after 2000. Again, however, the caseload for TANF-related Medicaid recipients began to decline further after September 2003 when the Full Family Sanctions policy was implemented. This policy requires TANF clients to sign a "Personal Responsibility Agreement" (PRA) whereby the family must comply with work and other requirements, such as child/medical support assignment, immunizations, school attendance, Texas Health Steps, parenting skills, and cooperation with drug and alcohol requirements. If clients fail to comply with the PRA, the family loses cash assistance. The adult family member, with the exception of pregnant women, loses Medicaid coverage for non-compliance with work requirements or medical support requirements. **Figure 8.3** shows the Texas Medicaid caseload growth rates from September 1979 to August 2013.

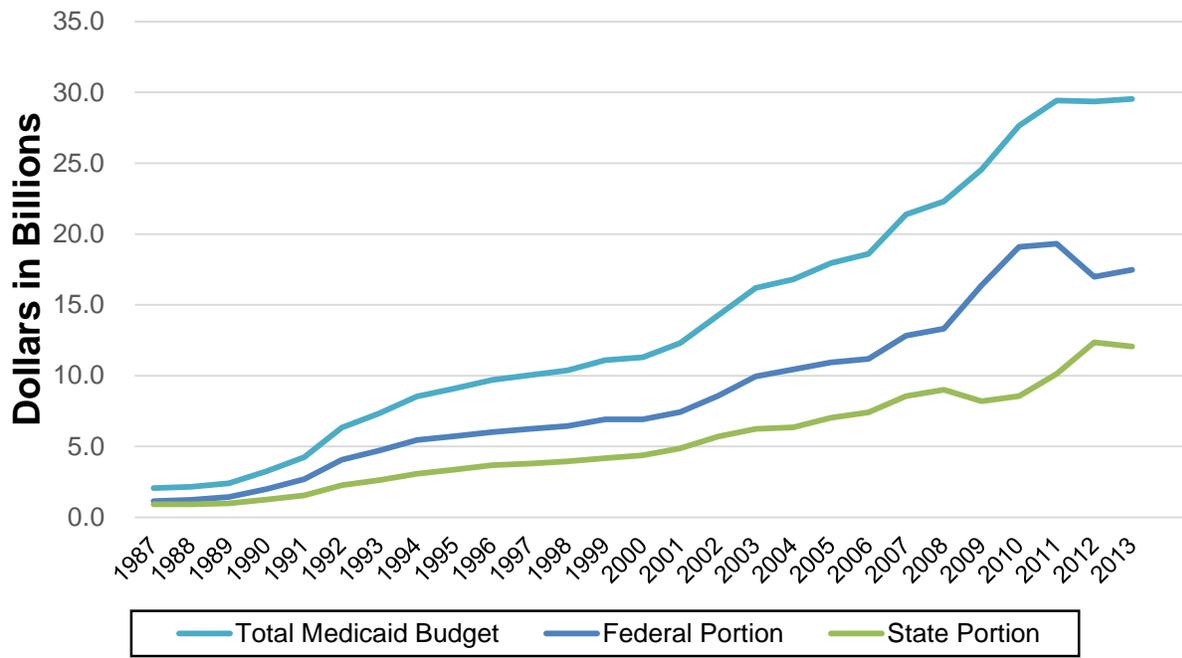
**Figure 8.3: Medicaid Caseload by Group
September 1979–August 2013**



Source: HHSC, Financial Services, HHS System Forecasting.

Changing Trends

Figure 8.4: Texas Medicaid Annual Budget Growth Rates

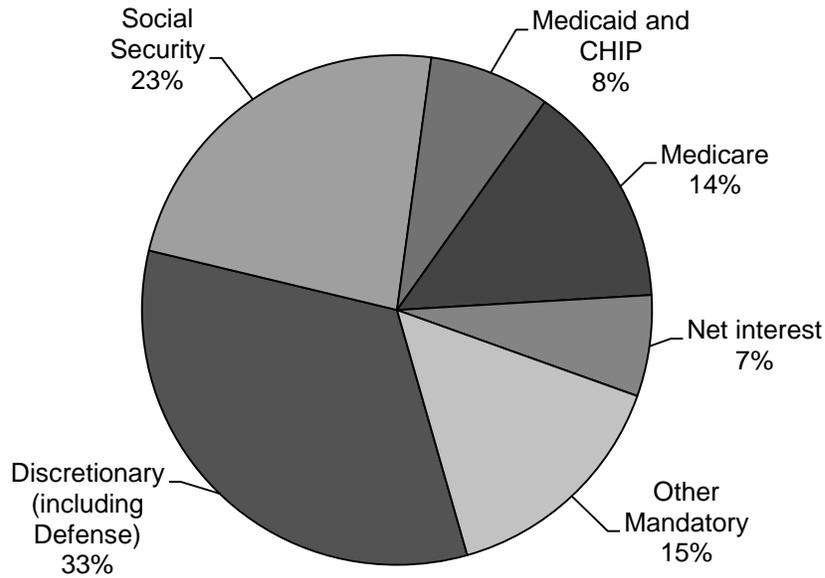


Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid and the Federal Budget

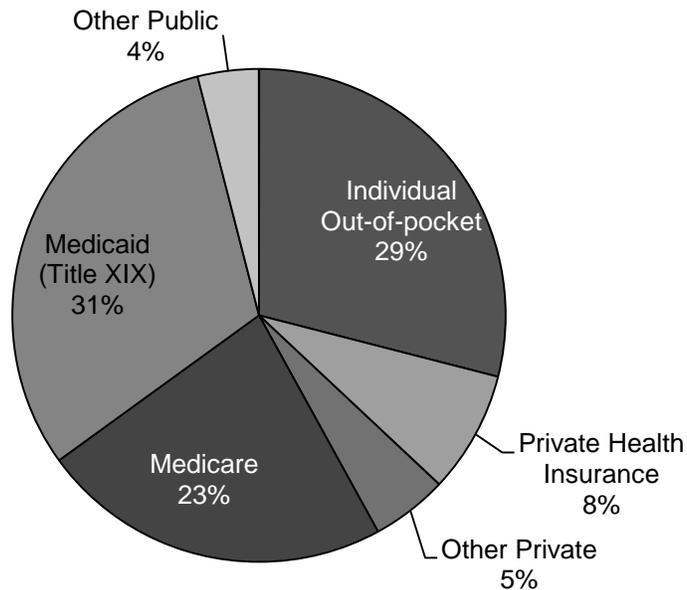
Medicaid and the Children’s Health Insurance Program (CHIP) account for eight percent of the federal budget in FFY 2015. **Figure 8.5** illustrates federal government spending by type of expenditure for FFY 2015.

Figure 8.5: Federal Budget Expenditures FFY 2015



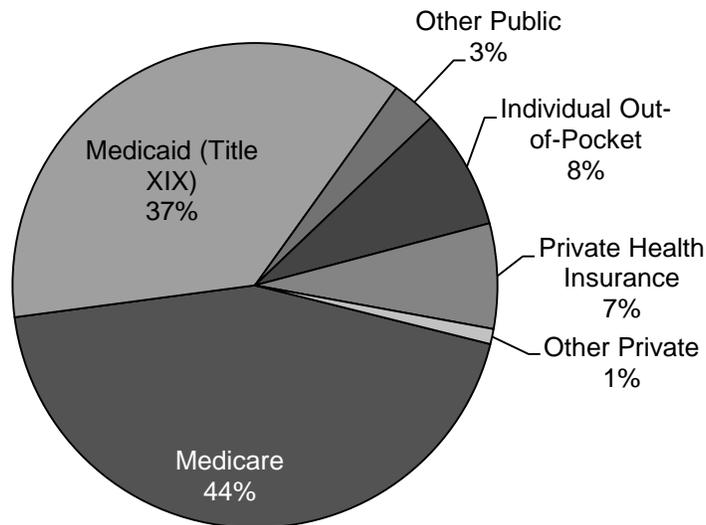
Source: Budget of the United States Government FY 2015. Table S-5. Proposed Budget by Category. Page 170. <http://www.gpo.gov/fdsys/pkg/BUDGET-2015-BUD/pdf/BUDGET-2015-BUD-28.pdf>

Figure 8.6: National Nursing Facility Payor Sources for Calendar Year 2012



Source: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Figure 8.7: National Home Health Payor Sources for Calendar Year 2012



Source: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Federal Funding

Federal funds are a critical component of health care financing for the state of Texas. For the 2014-15 biennial appropriations, federal funds account for \$42.4 billion (about 57 percent) of the total biennial budget of \$73.9 billion for health and human services. Medicaid represents 76 percent of this amount, with \$33.4 billion in federal funds and \$56.2 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. For FFY 2015, the Medicaid FMAP is 58.1 percent.

Building a Medicaid Budget

Staffs of the Medicaid operating departments develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This

process requires projections of the number of people eligible for and applying for the program, estimations of cost trends, analyses of any new federal mandates affecting eligibility or services and/or changes in program policy, and outreach efforts.

As evident from **Table 8.2**, a significant amount of time elapses between the development of the initial agency budget request and the time an appropriations bill takes effect. Medicaid enrollment trends and other factors that drive budget projections can change significantly before the budgeted period ends. Caseload or cost changes can cause considerable differences between appropriated budgets and actual expenditures.

Table 8.2: Medicaid Timeframes in the 2016-2017 Budget Process

August 2014	Agencies submit Legislative Appropriations Requests (LARs) for SFYs 2016 and 2017 (September 2014 - August 2017). Most recent program data available is through April 2014.
January 2015	Legislature convenes.
April 2015	Legislature works on appropriations bills; last chance to provide up-to-date Medicaid projections for bill. Most recent program data available is through March 2015.
May 2015	Legislature finishes appropriations for SFYs 2016-2017.
September 2015	SFY 2016 begins.
August 2017	2016-2017 biennium ends.

Note: At the beginning of the 2016-2017 biennium in September 2015, the Medicaid data used for projections is five months old. By the end of the biennium in August 2017, 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.

Deferrals and Disallowances

CMS can impose deferrals and disallowances on a state's Medicaid program based on its determination that the state acted outside of CMS regulations or the state's Medicaid state plan. Deferrals and disallowances impact the availability of federal financial participation (FFP) for the program.

CMS 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.

Deferrals: CMS can reduce current Medicaid federal funding when it determines that a state may be out of compliance with federal regulations or its Medicaid state plan. CMS withholds funds until it determines the state has come into compliance or until the state provides additional information to support the validity of the claim.

Disallowance: CMS can also recoup federal funds when it alleges a claim is not allowable, but states have the option to appeal the CMS determination. The state can request reconsideration by submitting a request to the chair of HHS' Departmental Appeals Board within 30 days after receipt of the disallowance letter and include a statement of the amount in dispute and a brief statement of why the disallowance is incorrect. CMS then has 30 days to provide a written response to the state's argument. Within 15 days of receiving CMS' response, the state may submit a short rebuttal to CMS' argument. The Departmental Appeals Board can make a ruling based on the written statements provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.

Total Spending by Type of Eligibility

Texas Medicaid spending patterns are not uniform across all eligibility groups. The risk group made up of people who are age 65 and older and disability-related is the smallest portion of Medicaid clients, yet it accounts for the majority of expenditures. (See Chapter 1, **Figure 1.1**, Texas Medicaid Beneficiaries and Expenditures, SFY 2013.) **Table 8.3** and **Table 8.4** show SFY 2013 average monthly cost per eligibility category and expenditures.

Table 8.3: Average Monthly Cost per Eligibility Category SFY 2013

The average monthly cost per full-benefit recipient in SFY 2013 was \$534 per client per month. These costs are for all services (acute and long-term) for clients considered "full-benefit" Medicaid, 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): \$240 per client per month.
- People age 65 and over and/or disability-related: \$1,470 per client per month.
- Pregnant Women: \$720 per client per month
- Adult Parents: \$455 per client per month

Source: HHSC, Financial Services, HHS System Forecasting

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. Costs for non-full clients not included are, but include costs for Medicare Part A&B premiums for partial duals, Emergency Medicaid Services for Non-Citizens costs, and Women's Health Waiver costs. Cost per client per month are lower when all services and clients are

included, as many of the partial benefit clients have, by definition, expenses only for very specific, often lower cost, services, such as Medicare partial premiums or women's health services.

**Table 8.4: Texas Medicaid Clients and Expenditures
SFY 2013**

- Children are the least expensive population that Medicaid covers. While 67 percent of Texas Medicaid clients were Non-Disability-Related Children, they accounted for only 31 percent of expenditures.
- The Aged (65+) and Disability-Related account for a large portion of Texas Medicaid spending. Only 26 percent of Texas Medicaid clients were Aged or Disability-Related, but they accounted for 60 percent of program spending.
- Non-Disability-Related Adults are relatively inexpensive to insure. Parents and Pregnant Women accounted for 9 percent of the population and 9 percent of expenditures.

Source: HHSC, Financial Services, HHS System Forecasting.

Medicaid Rates

The following sections discuss the different methodologies used to calculate the rates of reimbursement for some types of providers.

Fee-for-Service Rates

The Texas Health and Human Services Commission (HHSC) is responsible for establishing Medicaid fee-for-service (FFS) reimbursement methodologies by rule and/or approval by CMS. HHSC consults with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are also subject to a public hearing and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process.

Physicians and Other Practitioners

Medicaid rates for FFS services delivered by physicians and other practitioners (which include payments for laboratory services, including x-ray services, radiation therapy services, physical and occupational therapists' services, physician services [including anesthesia and physician-administered drugs], podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services, and certified nurse midwife services) are calculated in accordance with Title 1 of the Texas

Administrative Code (TAC), §355.8085. Rates are uniform statewide and are either resource-based fees (RBFs) or access-based fees (ABFs).

RBFs are based on the actual resources required by an economically efficient provider to deliver a service and are calculated by multiplying the relative value units (RVUs) for a service times a conversion factor. Total RVUs are assigned to each service, covering the three components of the cost to deliver the service. The three components are intended to reflect the work, overhead, and professional liability expense for a service. The Medicaid RBFs were first established in 1992 and used the RVUs specified in the Medicare Physician Fee Schedule at the time in concert with Texas Medicaid conversion factors. As new services are added, the Medicaid RVUs for new services are based on the Medicare RVUs in effect at the time. Base units, which serve a similar function as RVUs, are used for anesthesia services.

ABFs are developed to account for deficiencies in RBF methodology related to adequacy of access to health care services for Medicaid clients and are based on historical charges, the current Medicare fee for a service, review of Medicaid fees paid by other states, survey of providers' costs to deliver a service, and/or Medicaid fees for similar services.

Nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, 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, and licensed psychological associates are reimbursed for covered professional services at 70 percent of the rate paid to psychiatrists and psychologists for the same professional service. Physicians are reimbursed for assistant surgery services at 16 percent of the amount paid to the primary surgeon.

Physician-Administered Drugs/Biologicals

Effective October 1, 2006, Medicaid rates for physician-administered drugs/biologicals are determined under 1 TAC §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their billed charges and the Medicaid fee established by HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug or biological.

Prescription Drug Reimbursement

Reimbursement for MCO pharmacy prescription claims is determined by contract terms between the health plan and the pharmacy provider and is independent of FFS reimbursement rates.

Reimbursement for FFS pharmacy prescription claims includes two components: an amount for the ingredient cost of the drug product and a professional dispensing fee. HHSC will implement new FFS ingredient cost and dispensing fee methodology in SFY 2015.

Ingredient cost reimbursement:

- Pharmacies' Estimated Acquisition Costs (EAC) are determined by the Medicaid Vendor Drug Program (VDP) using actual manufacturer reported prices as well as national pricing data services. The EAC is based on the pharmacy's reported source of purchase. This source of purchase could be through a wholesale company, directly from the drug manufacturer, or through a central purchasing entity such as a warehouse.
- Ingredient cost is the product of the EAC times the quantity dispensed.
- Ingredient cost represents over 90 percent of total reimbursement for VDP claims.

Dispensing fee reimbursement:

- Dispensing fees are based on an average pharmacy's cost to dispense a prescription, including costs for staff and overhead. The dispensing fee consists of two separate components, a fixed component and a variable component. Effective September 2011, the fixed component is \$6.50 per prescription and the variable component is 1.96 percent of the ingredient cost plus the fixed component.
- Pharmacies that provide no-charge delivery services to Medicaid clients may be eligible for a delivery incentive, currently \$0.15 per prescription.

All reimbursement amounts determined by the above methodology are reduced to a pharmacy's reported Usual and Customary (U&C) or Gross Amount Due (GAD) price if either of those reported prices are less than the total reimbursement determined by adding the ingredient cost and the professional dispensing fee.

Hospitals

Historically, Texas' hospital funding methodologies included inpatient and outpatient hospital reimbursements, UPL funding, graduate medical education (GME) funding, and DSH funding. Not every hospital was eligible for all of these different funding sources.

Only hospitals that met certain eligibility criteria could receive UPL, GME, and DSH funds. The UPL program no longer exists in Texas with the approval of the 1115 Transformation Waiver described in Chapter 4. The waiver provides two new sources of funds for hospitals (and certain other providers); the Uncompensated Care pool and the Delivery System Reform Incentive Payment pool.

Inpatient Hospital Reimbursement Rates

General acute care hospital reimbursement rates for FFS Medicaid clients are set using a prospective payment system (PPS) based on 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 and then hospitals are paid a pre-determined rate for each DRG (admission), regardless of the actual services provided. The rate is calculated using a formula-based standardized average cost of treating a Medicaid inpatient admission and a relative weight for each DRG. "Outlier" payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay. Effective September 1, 2013, children's and rural hospitals were 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 (TEFRA) cost principles.

Outpatient Hospital Reimbursement Rates

Outpatient hospital services provided to FFS clients are reimbursed at a portion of the hospital's reasonable cost. For children's, state-owned, and rural 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 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) Medicaid services during calendar year 2004. For non-high-volume children's, state-owned, and rural hospitals,

reimbursement for outpatient hospital services is 72.27 percent of the hospital's allowable cost and reimbursement for all other non-high-volume providers is 68.44 percent of the hospital's allowable cost. Outpatient rates were frozen effective September 1, 2013, in preparation for a transition to an Enhanced Ambulatory Payment Groups (EAPG) reimbursement methodology.

Uncompensated Care Waiver Payments

In 2011, CMS approved the Texas Healthcare Transformation and Quality Improvement Program Section 1115(a) Medicaid demonstration waiver. Section 1115 of the Social Security Act authorizes CMS to waive compliance by a state of specific provisions of its state plan if, in the judgment of CMS, the state's proposal promotes the objectives of the Medicaid statute.

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

The funding of the Section 1115 waiver for supplemental payment is for two statewide pools worth \$29 billion (all funds) over five years, with \$17.6 billion allocated for uncompensated care and \$11.4 billion allocated for Delivery System Reform Incentive Payments (DSRIP). The purpose of the uncompensated care (UC) pool, which replaced the former UPL programs under a new methodology, is to reimburse providers for uncompensated care costs. 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. (See Chapter 4, Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, Delivery System Reform Incentive Payment Pool.)

**Table 8.5: Historical Upper Payment Limit (UPL) and Uncompensated Care Waiver Spending
FFYs 2002-2013**

Year	Upper Payment Limit
FFY 2002	\$ 168,056,432
FFY 2003	\$ 289,181,118
FFY 2004	\$ 775,847,457
FFY 2005	\$ 897,899,580
FFY 2006	\$ 526,735,788
FFY 2007	\$1,734,191,128
FFY 2008	\$1,693,792,595
FFY 2009	\$2,219,683,156
FFY 2010	\$2,693,221,610
FFY 2011	\$2,789,436,532
FFY 2012*	\$ 2,482,701,375

Uncompensated Care Waiver Program Payouts

Year	Upper Payment Limit
FFY 2012	\$ 1,152,697,475
FFY 2013	\$3,845,408,143

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 GAA (Article II, HHSC, Rider 40, S.B. 1, 83rd Legislature, Regular Session, 2013), authorizes HHSC to spend Appropriated Receipts–Match for Medicaid for GME

payments to teaching hospitals. The payments are contingent upon receipt of intergovernmental transfers of funds from public teaching hospitals for the non-federal share of Medicaid GME payments. The Legislature directed HHSC to use only intergovernmental transfers of funds (Appropriated Receipts-Match for Medicaid) for the non-federal share of Medicaid GME payments for the 2014-15 biennium.

Disproportionate Share Hospital Funding

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and receive disproportionate share funding under the program commonly known as “DSH.” DSH funds differ from all other Medicaid payments in that they are not tied to specific services for Medicaid-eligible patients. Hospitals may use DSH payments to cover the 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 FFY 2013, 180 Texas hospitals qualified to receive DSH payments: 61 were non-state public, 107 were private and 12 were state hospitals. Of the 180 DSH hospitals, 102 were located in urban areas and 78 were located in rural or equivalent areas. Of the urban hospitals, eight were large urban public facilities and nine 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 (59.30 percent federal funds and 40.70 percent state funds for Texas in FFY 2013). The state share of DSH is funded through a combination of state general revenue-dedicated, intergovernmental transfers from public hospitals and state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest). In FFY 2013, the DSH allocation for Texas totaled \$1.694 billion in federal and state funds.

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 healthcare professionals to treat patients;
- Obtain replacement or additional equipment/technology to treat patients; and
- Renovate existing structures or build new ones.

DSH reimbursement allows hospitals to make the human and capital investments necessary to continue and improve patient care.

Federal Legislation Affecting DSH

Nationally, between 1989 and 1992, federal funding for DSH significantly increased from \$400 million to \$10.1 billion. By 1992, DSH funds accounted for 15 percent of all federal Medicaid spending. Starting in 1991, various pieces of federal legislation were passed, limiting or capping DSH funding increases. Furthermore, as a discrete component of Medicaid funds nationally, the DSH program has on occasion been targeted as a possible source of budget savings.

In 1991, federal law capped the size of Texas' DSH program at \$1.513 billion. In 1993, a federal budget act established hospital caps on the amount of DSH funds an individual hospital could receive. The act also mandated that at least one percent of total patient-days in DSH hospitals must be from Medicaid patients. These changes reduced DSH payments to state-owned hospitals from approximately \$729 million in SFY 1995 to about \$427 million in SFY 2008. Total Texas DSH funds were constant, however, and the additional residual funds went to non-state local hospitals.

The 1997 federal Balanced Budget Act (BBA) had two significant impacts on the Texas DSH program. First, it set specific annual limits on total federal contributions to the Texas DSH program. Those limits, since increased by the Benefits Improvement and Protection Act (BIPA) of 2000 and the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, have resulted in annual fluctuations in providers' DSH funding.

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

The Patient Protection and Affordable Care Act (PPACA) 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 FFY 2014 through FFY 2020. To implement these annual reductions, the statute requires the Secretary of Health and Human Services to develop a methodology to allocate the reductions that must take into account five factors: impose a smaller percentage reduction on low DSH states; impose larger percentage reductions on states that have 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 the methodology must 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 SGR Reform Act of 2013 delayed the annual aggregate reductions in federal DSH funding from FFY 2014 to FFY 2016. The Act also increased the overall level of reductions and extended the timeframe for the cuts through FFY 2023.

Table 8.6 shows Texas DSH funding for 2002-2014.

Table 8.6: Texas DSH Federal Fund Trends

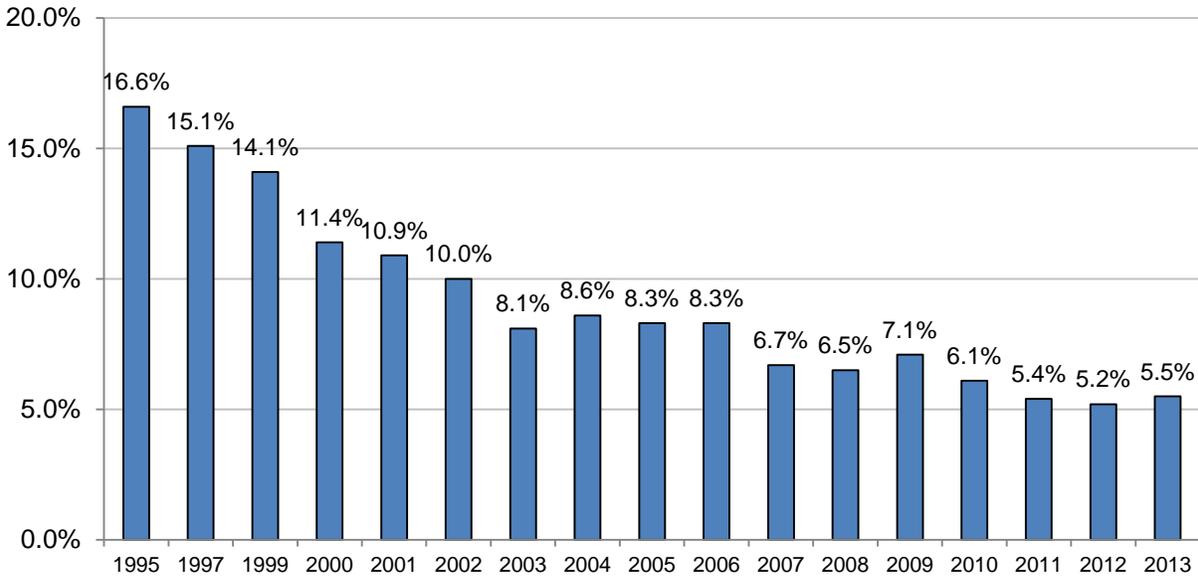
Year	Federal Funds
2002	\$856 million
2003	\$776 million
2004	\$901 million
2005	\$901 million
2006	\$901 million
2007	\$901 million
2008	\$901 million
2009	\$964 million*
2010	\$988 million**
2011	\$964 million
2012	\$981million
2013	\$1 billion
2014	\$1.019 billion

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

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

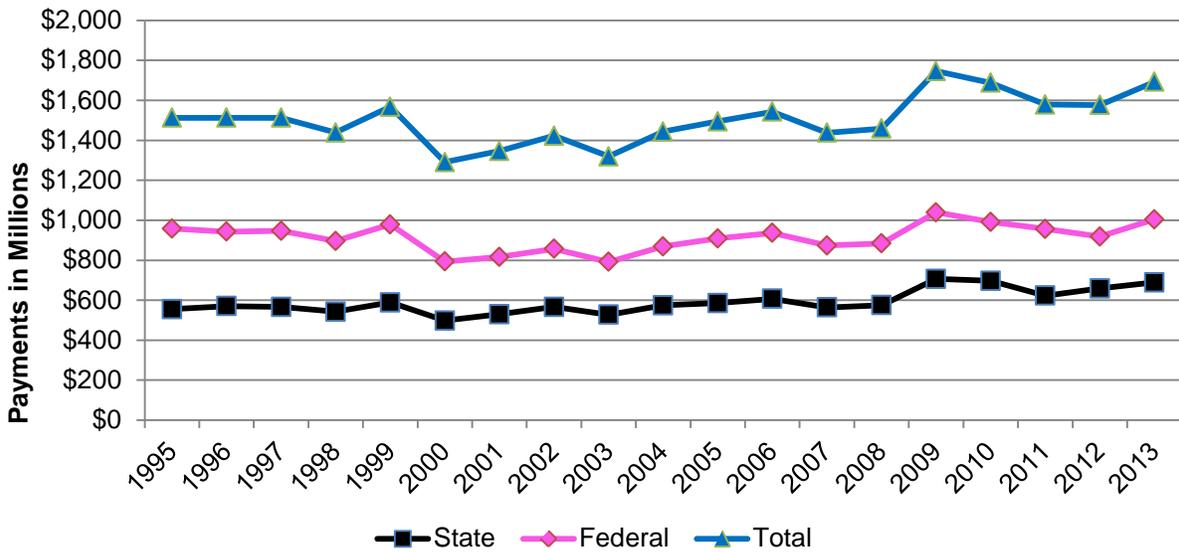
Source: BBA 1997, BIPA 2000, the Medicare Prescription Drug Improvement and Modernization Act of 2003, Federal Register, July 26, 2013 (Vol. 78 No. 144), pp. 45217, Federal Register, February 28, 2014 (Vol. 79 No. 40), pp. 11436, [Federal Register, February 28, 2014 \(Vol. 79 No. 40\), pp. 11436.](#)

Figure 8.8: Disproportionate Share Hospital Funds as a Percentage of the Total Medicaid Budget FFYs 1995-2013



Source: HHSC, Financial Services, Texas Medicaid History Report, February 18, 2014.

Figure 8.9: Payments for Disproportionate Share Hospital Program FFYs 1995-2013



Source: HHSC, Financial Services, Texas Medicaid History Report, February 18, 2014

Managed Care Organizations

Premium rates for the Medicaid managed care organizations (MCOs) are determined through actuarially sound methodologies. These rates determine the state's capitation payments to MCOs for contractually required services. Further detail on Medicaid managed care programs is provided in Chapter 7, Medicaid Managed Care.

STAR

The managed care rating process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. STAR MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an "adjusted premium rate" for each service area. A separate lump sum payment, called the "Delivery Supplemental Payment," is computed for each service area for expenses related to each newborn delivery.

The resulting underlying base rates vary by service area and risk group but are the same for each MCO in a service area. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each health plan. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. The final capitated premiums that are paid to the MCOs are based on this acuity risk-adjusted premium for each combination of service area and risk group. In addition to the final capitated premium rates, MCOs also receive the Delivery Supplemental Payment for each newborn.

Pharmacy costs associated with all STAR clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR rates above.

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.

Pharmacy costs associated with all STAR+PLUS clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR+PLUS rates above.

Medicaid Dental

The Medicaid Dental program became a managed care program March 1, 2012. Medicaid dental rates are based on claims experience for the covered population in the base period. The base cost is totaled and trended forward to the time period for which the rates apply. A reasonable provision for administrative expenses, taxes, and risk margin 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.

NorthSTAR

Capitation rates for the NorthSTAR Behavioral Health Organization (BHO) are derived primarily from BHO historical encounter experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for BHO expenses such as projected increases in Medicaid enrollment and utilization, changes in plan benefits, administrative expenses, and other miscellaneous costs. In addition to these costs, the NorthSTAR BHO rates include amounts for fixed contract fees and various other adjustments. Lastly, a provision is made for the possible fluctuation in claims by the addition of a risk margin. The NorthSTAR BHO is reimbursed using premium rates which vary by risk group.

STAR Health

The capitation rate for the STAR Health program is derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. Adjustments are applied for MCO expenditures, which include reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims by the addition of a risk margin. The rate also includes a special allowance for the additional administrative services in the program, including the Health Passport. The Health Passport is a web-based electronic medical record that is intended to improve quality of care. A single MCO provides services under the STAR Health program. The MCO is reimbursed using a single premium rate which does not vary by age, gender or area.

Pharmacy costs associated with all STAR Health clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the STAR Health rates above.

Nursing Facilities

Nursing facilities are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service (i.e., case-mix class). Enhanced rates are available for enhanced staffing. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing and/or spending requirements.

Rates are based on costs submitted annually by providers on facility cost reports. Costs are categorized into five rate components: (1) direct care staff; (2) other resident care; (3) dietary; (4) general and administrative; and (5) a fixed capital asset use fee. Each rate component is calculated separately based on HHSC formulas and may vary according to the characteristics of residents. The total rate for each level of service is calculated by adding together the appropriate rate components.ⁱⁱ

Nursing Facility cost reports are subjected to either a desk review or on-site audit to determine that reported costs are allowable. Nursing facility rates are recalculated once every two years coincident with the legislative biennium.

MCOs are required to reimburse nursing facilities providing services to their members, at minimum, the same daily payment rate, including any enhancements, as would've been paid under FFS.

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

ICF/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

ⁱⁱ H.B. 154, 77th Texas Legislature, Regular Session, 2001, requires HHSC to ensure that only those facilities that purchase liability insurance acceptable to HHSC receive credit for that cost. Therefore, liability insurance costs are excluded from the rate calculation and facilities that verify liability insurance coverage acceptable to HHSC receive additional funds in the form of a liability insurance add-on.

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. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific attendant compensation spending requirements.

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

Endnotes

¹ The material in this section and the next, is drawn entirely from: Centers for Medicare and Medicaid Services, Historical National Health Expenditure Data (December 2014), “Table 1: National Health Expenditures” found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

Chapter 9: Children's Health Insurance Program

What is the Children's Health Insurance Program? Who does this program serve, what benefits does it provide, and how does it operate in Texas?

History and Background

The Balanced Budget Act of 1997 (P.L. 105-33) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act and appropriated nearly \$40 billion for the program for federal fiscal years (FFYs) 1998-2007. Like Medicaid, SCHIP is administered by the Centers for Medicare & Medicaid Services (CMS) and is jointly funded by the federal government and the states. Also like Medicaid, each state receives a different federal match for SCHIP. For federal fiscal year (FFY) 2014, the federal government funded 71.08 percent of Texas' SCHIP program, while the state funded the remaining 28.92 percent. Through SCHIP, states can provide health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid.

SCHIP offers states three options when designing a program. States can:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program;
- Design a separate state children's health insurance program; or
- Combine both the Medicaid and separate program options.

States that choose to expand their Medicaid programs are required to provide all mandatory benefits and all optional services covered under their Medicaid state plan, and they must follow the Medicaid cost-sharing rules. States that choose to implement a separate program have more flexibility. Within broad federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children ages 15 to 18 whose family income was under 100 percent of the federal poverty level (FPL). Phase I

of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

Enacting legislation for Phase II of SCHIP, a separate children's health insurance program, was passed by the 76th Legislature. This program is referred to simply as the Children's Health Insurance Program (CHIP). S.B. 445, 76th Legislature, Regular Session, 1999, specified that coverage under CHIP be available to children in families with incomes up to 200 percent FPL. Coverage under Phase II of the program began on May 1, 2000. The Health and Human Services Commission (HHSC) was given overall authority for the program. By February 2002, 516,000 children were enrolled. As of June 2014, 593,619 children were enrolled in CHIP.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3) reauthorized CHIP by appropriating nearly \$69 billion in federal CHIP funding for states for FFYs 2009-2013.¹ The Act simplified the original name of the program from "SCHIP" to "CHIP." CHIPRA made numerous policy changes to state CHIP programs, which include the following:

- States must verify a CHIP applicant's citizenship;
- States may cover pregnant women above 185 percent FPL up to the income eligibility level for children in CHIP; and
- States may provide Medicaid and CHIP coverage to qualified immigrant children and/or pregnant women without the previously required 5-year delay. (See Chapter 2, Medicaid History and Organization, Children's Health Insurance Program Reauthorization Act of 2009.)

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

- Extends federal funding for CHIP through FFY 2015. Prior to the ACA, CHIP was authorized through FFY 2013.
- Prohibits states from restricting CHIP eligibility standards, methodologies, or procedures through September 30, 2019. Medicaid payments are contingent upon meeting this CHIP maintenance of effort (MOE) requirement.
- As of January 1, 2014, shifts from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent FPL.
- Applies new federal rules for determining financial eligibility for CHIP (known as modified adjusted gross income (MAGI) rules). The ACA eliminates assets tests and most income disregards for CHIP.
- Increases the federal CHIP match rate for FFYs 2016 through 2019.

Who Is Covered in Texas

CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance.

To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident;
- A Texas resident;
- Under age 19;
- Uninsured for at least 90 days;² and
- Living in a family whose income is at or below 201 percent FPL.

Until the passage of CHIPRA, children who legally entered the United States on or after August 22, 1996, were not eligible for CHIP or Medicaid, with certain exceptions, for five years from their date of entry. Since the program's inception, Texas covered certain qualified immigrant children under CHIP with 100 percent state funds if they met all other Medicaid or CHIP eligibility requirements.

In the past, Texas opted not to provide Medicaid coverage to qualified immigrant children with some exceptions, so qualified immigrant children at Medicaid income levels were covered in CHIP through 100 percent state funds. CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

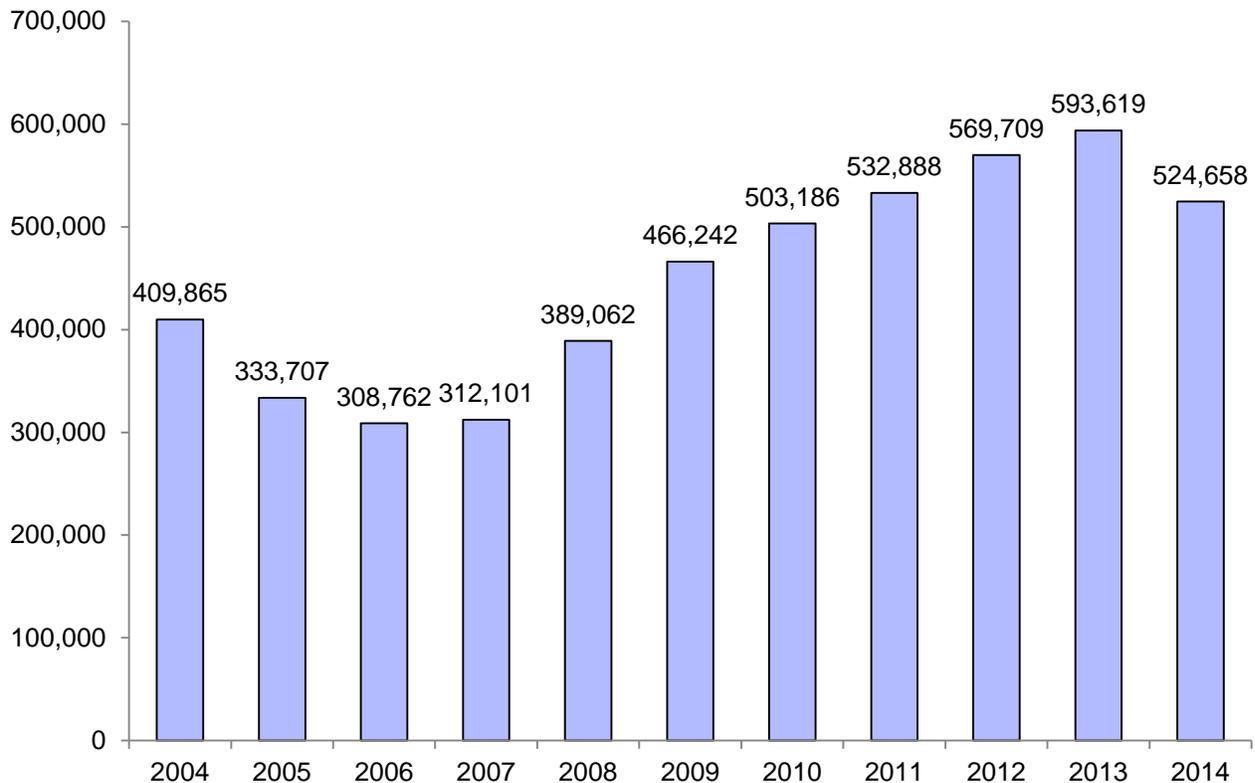
Federal policy formerly excluded a child from participating in federally-matched CHIP if the child's family was eligible for state health benefits plan due to employment with a public agency (even if the family declined the coverage). The ACA provides an exception to this exclusion and allows states to provide federally-matched CHIP to the children of public employees effective March 23, 2010, if the state health benefits plan meets the MOE requirements or the child qualifies for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Texas Retirement System school-employee children as of September 1, 2010 and to other eligible public employee children as of September 1, 2011.

Size of CHIP Population

Figure 9.1 shows the average monthly caseload for the CHIP population since state fiscal year (SFY) 2004. Earlier CHIP caseloads had peaked in May 2002 at 529,211,

declining through 308,762 in 2006. Since that time, CHIP caseload gradually increased to a new high enrollment of 607,057 in August 2013. Caseloads have subsequently decreased in CHIP under the ACA, which shifted from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent FPL.

Figure 9.1: Average Monthly CHIP Clients SFYs 2004-2014



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

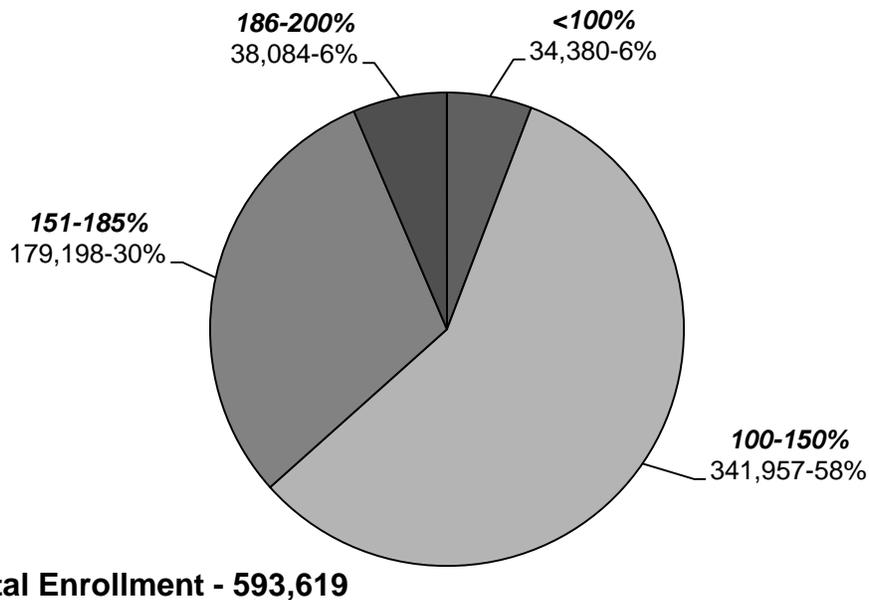
CHIP Demographics

Federal Poverty Level

During the most recent year for which full enrollment data is available, SFY 2013, the majority of CHIP enrollees (approximately 58 percent) were between 101 and 150 percent FPL. Approximately 30 percent were between 151 and 185 percent of FPL, and 6 percent were between 186 and 200 percent of FPL. Approximately 6 percent of enrollees were below 100 percent of FPL. **Figure 9.2** shows the percent distribution of CHIP enrollees by FPL category in SFY 2013. Under the new ACA eligibility criteria,

children who meet all other eligibility criteria and have incomes at or below 133 percent FPL qualify for Medicaid, not CHIP.

Figure 9.2: Distribution of CHIP Enrollment in SFY 2013 by Percent of FPL Category-Monthly Average (Number and Percent by FPL)



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

Effective January 1, 2014, the ACA required states to use modified adjusted gross income (MAGI) for household income for CHIP income determinations (including for cost sharing determinations). In addition, the ACA eliminated income disregards and assets tests for CHIP, in the same manner that these changes apply to Medicaid.

Prior to January 1, 2014, Texas applied an income disregard in CHIP for child care expenses. The income disregard was \$200 per month for each child under age two or \$175 per month for each child age two or older. Texas also applied an assets test to children in CHIP with incomes above 150 percent FPL. The asset limit was \$10,000 in countable liquid resources combined with excess vehicle value.

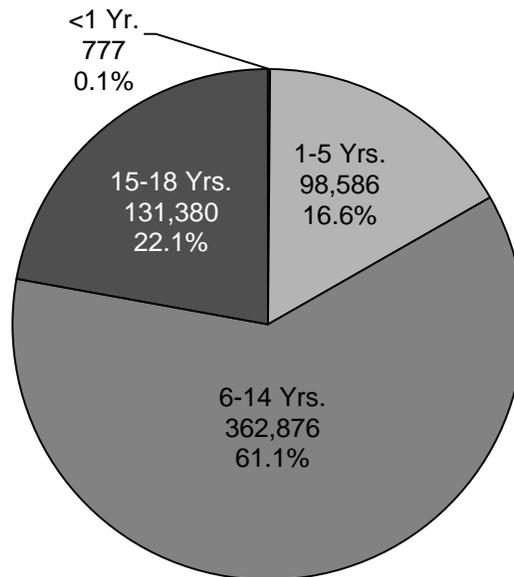
Age

Figure 9.3 shows the percentage of CHIP clients by age in SFY 2013. That year, the majority of CHIP clients were over age 5. Sixty-one percent of clients were between ages 6 and 14, and 22 percent of clients were between ages 15 and 18. Slightly under 17 percent were between ages 1 and 5, while less than 1 percent of clients enrolled in CHIP in SFY 2013 were under 1 year of age.

The higher proportion of CHIP clients in the older age groups is due in part to the different income eligibility requirements for CHIP and Medicaid. CHIP serves children through age 18 up to 201 percent of FPL. Medicaid serves infants (12 months of age and younger) up to 198 percent of FPL, children ages 1 through 5 up to 144 percent of FPL, and children ages 6 through 18 up to 133 percent of FPL.

Figure 9.3 does not include CHIP Perinatal clients, who are all under 1 year of age. More detail on CHIP Perinatal is provided at the end of this chapter.

**Figure 9.3: Average Monthly CHIP Enrollment by Age SFY 2013
(Number and Percent by Age Group)**



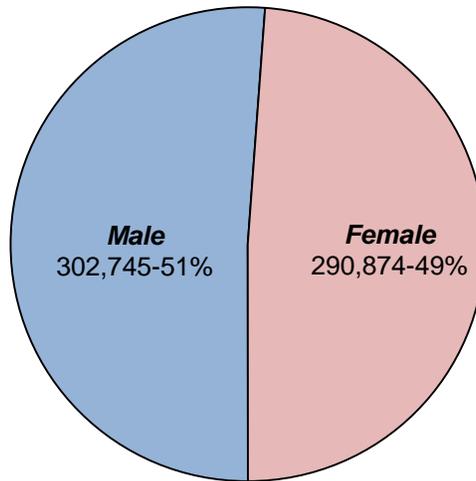
Total Enrollment - 593,619

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

Gender

Figure 9.4 shows the proportions of CHIP enrollees by gender. Approximately 51 percent of enrollees are male, and 49 percent are female.

Figure 9.4: Average Monthly CHIP Enrollment by Gender SFY 2013



Gender Total - 593,619

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

CHIP Benefits

States like Texas that operate a separate child health program have three options for determining coverage.³

- **Benchmark coverage:** Coverage that is substantially equal to one of the following: (1) The Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; (2) A health benefits plan offered by the state and made generally available to state employees; or (3) A plan offered by a managed care organization (MCO) that has the largest insured commercial, non-Medicaid enrollment of any such organization in the state.
- **Benchmark-equivalent coverage:** Coverage that has the same aggregate actuarial value as one of the benchmark plans. States that choose to provide benchmark-equivalent coverage must cover each of the benefits in the “basic benefits category.” These include inpatient and outpatient hospital services, physician services, surgical and medical services, laboratory and X-ray services,

and well-baby and well-child care, including age-appropriate immunizations. States must also provide coverage that is at least 75 percent of the actuarial value of coverage under the benchmark plan for each of the benefits in the “additional services category.” These services include prescription drugs, mental health services, vision services, and hearing services.

- Any other health benefits plan that the U.S. Secretary of Health and Human Services determines will provide appropriate coverage.

Texas selected the third option for determining CHIP coverage - i.e., Secretary approved coverage. The state’s benefit package is cost-effective, including a basic set of health care benefits that focus on primary health care needs. **Table 9.1** displays the current benefits covered by Texas CHIP. These benefits are subject to certain limitations and exclusions.

Texas most recently modified behavioral health and dental benefits pursuant to CHIPRA.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were signed into federal law on October 3, 2008. MHPAEA requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at parity with medical and surgical benefits. CHIPRA applied MHPAEA requirements to all state CHIP programs.

CMS approved a CHIP state plan amendment to remove the treatment limitations from existing CHIP behavioral health benefits, effective March 1, 2011, bringing CHIP into compliance with the mental health parity requirements in CHIPRA. To offset increased costs in the CHIP program, HHSC increased certain co-payments for CHIP members above 150 percent of FPL, effective March 1, 2011.

CHIP Dental

Prior to March 1, 2012, the Texas CHIP dental benefits package consisted of three tiers that covered certain preventive and therapeutic services up to capped dollar amounts per 12-month coverage period. CHIPRA required all state CHIP programs to cover dental services “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” To comply with this requirement, Texas CHIP was required to cover certain services that were not previously covered, including periodontic and prosthodontic services.

Effective March 1, 2012, Texas eliminated the three-tier benefit package. Now all CHIP members receive up to \$564 in dental benefits per enrollment period. Emergency dental

services are not included under this cap. Members also can receive certain preventive and medically necessary services beyond the \$564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC raised CHIP cost-sharing amounts.

Table 9.1: Services Covered by Texas CHIP, 2014

The following services are covered under CHIP in Texas:

- Inpatient general acute and inpatient rehabilitation hospital services.
- Surgical services.
- Transplants.
- Skilled nursing facilities (including rehabilitation hospitals).
- Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services.
- Physician/physician extender professional services (including well-child exams and preventive health services, such as immunizations).
- Laboratory and radiological services.
- Durable medical equipment, prosthetic devices, and disposable medical supplies.
- Home and community-based health services.
- Nursing care services.
- Inpatient mental health services.
- Outpatient mental health services.
- Inpatient and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Rehabilitation and habilitation services (including physical, occupational, and speech therapy, and developmental assessments).
- Hospice care services.
- Emergency services (including emergency hospitals, physicians, and ambulance services).
- Emergency medical transportation (ground, air, or water).
- Care coordination.
- Case management.
- Prescription drugs.
- Dental services.
- Vision.
- Chiropractic services.
- Tobacco cessation.

CHIP Cost-Sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. CHIP

annual enrollment fee amounts and co-payments vary based on family income. In addition, the total amount that a family is required to contribute out-of-pocket toward the cost of health care services is capped at five percent of family income. **Table 9.2** shows the current cost-sharing requirements and cost-sharing caps for that became effective on March 1, 2012.

Table 9.2: CHIP Cost-Sharing Requirements

Enrollment Fees (for 12-month enrollment period):	Charges
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
CHIP members up to and including 151% of FPL	Charges
Office visit	\$5
Non-emergency ER	\$5
Generic drug	\$0
Brand drug	\$5
Inpatient hospital	\$35
Cost-sharing limit	5% (of family income, per enrollment period)
CHIP members above 151% up to and including 186% of FPL	Charges
Office visit	\$20
Non-Emergency ER	\$75
Generic drug	\$10
Brand drug	\$35
Inpatient hospital	\$75
Cost-sharing limit	5% (of family income, per enrollment period)
CHIP members above 186% up to and including 201% of FPL	Charges
Office visit	\$25
Non-emergency ER	\$75
Generic drug	\$10
Brand drug	\$35
Inpatient hospital	\$125
Cost-sharing limit	5% (of family income, per enrollment period)

CHIP Delivery Network

CHIP services are delivered by MCOs selected by the state through a competitive procurement. As of September 1, 2014, there were 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide.

Enrollees residing in a CHIP service area have a choice of at least two or more MCOs. (See <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/Managed-Care-Service-Areas-Map.pdf> for a list of CHIP service areas by county.)

In order to provide CHIP members with a choice of dental plans, HHSC expanded the number of dental managed care plans from one to two.

CHIP Rates

The rate setting process for CHIP is essentially the same as for the STAR managed care programs. CHIP MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled and trended forward to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. Then, a provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

Another adjustment made is the removal of newborn delivery expenses from the total cost rate, resulting in an “adjusted premium rate” for each service area. A separate lump sum payment, called the “Delivery Supplemental Payment,” is computed for expenses related to each newborn delivery. While the Delivery Supplemental Payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump sum payment in the amount of \$3,100 for each birth.

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

Pharmacy costs associated with all CHIP clients became part of the managed care capitation rates March 1, 2012. The methodology for calculating the pharmacy rates is similar to the CHIP medical rates above.

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 trended forward as with other programs. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental plans. A provision for possible fluctuation in claims cost is made through the addition of a risk margin.

CHIP Financing

Like Medicaid, CHIP is jointly funded by the federal government and states. However, unlike Medicaid, the total amount of federal funds allotted to the program each year is capped, as is the amount of funds allotted to each state. In the federal legislation that created CHIP, annual federal appropriations for the program totaled nearly \$40 billion for the ten-year period that the program was originally authorized. Each state is allotted a portion of this amount based on a formula set in federal statute and receives federal matching payments up to the allotment. Each year's allotment has historically been available to states for three years, and any funds allotted to states that are not spent by the end of the three-year period are redistributed to states that have exhausted their allotment, with some exceptions. Under CHIPRA, this has changed to a two-year period to spend the annual allotment beginning with the FFY 2009 allotment.

The FFY 2013 and 2014 allocation are estimated to be fully expended. The federal allocation for Texas in FFY 2014 is \$955,760,207.

Another difference between financing for Medicaid and CHIP is that CHIP offers a more favorable federal matching rate than Medicaid. The amount of federal CHIP funds that states receive is based on the Enhanced Federal Medical Assistance Percentage (EFMAP). Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The CHIP EFMAP for Texas was 71.51 percent in FFY 2013 and 71.08 percent for FFY 2014.

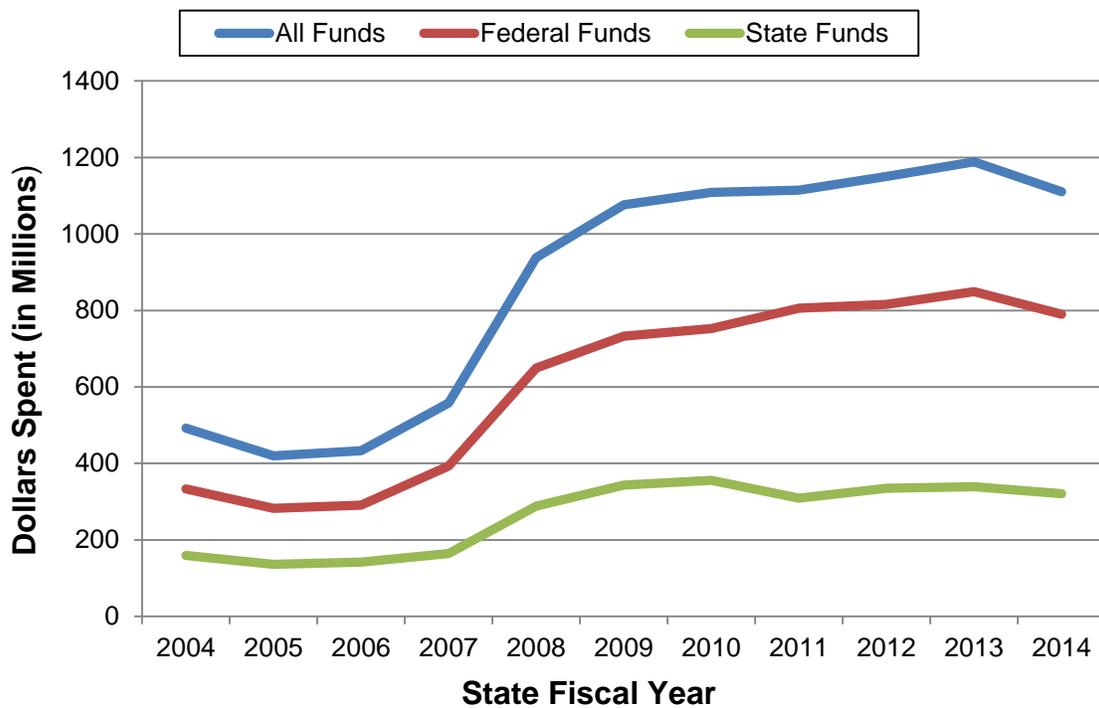
The ACA increases the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015, until September 30, 2019. The increase does not apply to:

- Certain administrative expenditures;
- Citizenship documentation requirements; and
- Administration of Payment Error Rate Measurement (PERM) requirements.

CHIP Spending

Texas CHIP spending has experienced sporadic growth in recent years. **Figure 9.5** shows state and federal expenditures for CHIP between SFYs 2004 and 2014. Current estimates project that total CHIP expenditures for SFY 2014 will be over \$1.11 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 9.5: Texas CHIP Expenditures
SFYs 2004-2014**



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

CHIP Perinatal Program

The 2006-07 GAA (Article II, HHSC, Rider 70, S.B. 1, 79th Legislature, Regular Session, 2005) authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was the CHIP Perinatal program, which began in January 2007. CHIP perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status. The expecting mother must meet certain income requirements (income up to and including 202 percent FPL). Services include prenatal visits, prescription prenatal vitamins, labor with delivery, and post-partum care. Members receiving the CHIP Perinatal benefit are exempt from the 90-day waiting period and all cost-sharing, including enrollment fees and co-pays, for the duration of their coverage period.

Upon delivery, CHIP Perinatal newborns in families with incomes at or below 198 percent of FPL are eligible to receive 12 months of continuous Medicaid coverage from date of birth. Most CHIP perinatal clients fall into this income range. For CHIP Perinatal clients at or below 198 percent of FPL, the mother must apply for Emergency Medicaid to cover her labor with delivery by submitting a completed CHIP Perinatal - Emergency Medical Services Certification (form H3038P). This form is mailed to the mother, and she is instructed to bring it with her to the hospital at delivery. This form must be returned to establish Emergency Medicaid for the mother and to enable the child to receive 12 months of Medicaid coverage from the date of birth.

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

Size and Demographics of the CHIP Perinatal Population

Table 9.3 shows the average monthly caseload for the CHIP Perinatal population since the program began in January 2007. Beginning September 2010, newborns under 185 percent of FPL began moving out of CHIP Perinatal and into Medicaid due to changes in eligibility. The monthly caseload has begun to stabilize around 37,000 members. Approximately 99 percent of clients are perinates and only 0.8 percent of clients are newborns.

All children in the CHIP Perinatal program are under the age of one because a woman can only enroll her child in the program prior to delivery. The majority of clients are at or

under 185 percent of FPL, with approximately 2.5 percent of all clients above this amount.

Table 9.3: CHIP Perinatal Caseload Summary, SFYs 2007-2014

Fiscal Year	Total Caseload	Perinates under 185% FPL	Perinates over 185% FPL	Newborns under 185% FPL	Newborns over 185% FPL
2007*	20,465	16,602	351	3,440	72
2008	58,589	31,631	586	25,854	519
2009	67,849	36,186	511	30,694	458
2010	67,148	36,158	433	30,215	342
2011	44,214	36,775	546	6,582	310
2012	37,190	36,238	652	-	300
2013	37,064	36,081	652	-	331
2014	37,718	36,841	573	2	302

* Averages are for Jan - Aug 2007 only, the first eight months of program implementation.

CHIP Perinatal Rates

Premium rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP, with the differences being the absence of acuity adjustment and the more focused scope of benefits and membership in CHIP Perinatal. MCO historical claims experience is totaled and trended forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits, and other miscellaneous costs. Final rates vary by risk group and service area. However due to low caseload among risk groups with income over 198 percent up to and including 202 percent of FPL, premium rates for these risk groups are calculated on a statewide basis.

Endnotes

¹ Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured, “CHIP Financing Structure,” June 2009, <http://www.kff.org/medicaid/upload/7910.pdf> (November 2014).

² There are exemptions to the 90-day waiting period for families who lose their health insurance or for whom premiums exceed 9.5 percent of the family's net income. A complete list of the exemptions can be found at <http://chipmedicaid.org/en/Previous-Coverage> (November 2014).

³ Herz, E. J., Fernandez, B., & Peterson, C.L., “State Children’s Health Insurance Program: A Brief Overview,” Congressional Research Service, Washington D.C., March 23, 2005, <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3047303232005.pdf> (November 2014).

Glossary

A

ACTIVITIES OF DAILY LIVING (ADLs)—Activities that are essential to daily personal care including bathing or showering, dressing, getting in or out of bed or a chair, using a toilet, and eating.

AGING AND DISABILITY RESOURCE CENTER (ADRC)—An initiative supported by a grant from the Administration on Aging to improve access to long-term services and supports. Texas has ADRC's in nine areas of the state.

ALBERTO N. V. JANEK—A federal lawsuit that was settled in May 2005 and requires the Health and Human Services Commission (HHSC) to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. As a result of the lawsuit, HHSC transferred personal care services for EPSDT beneficiaries from the Department of Aging and Disability Services (DADS) to HHSC on September 1, 2007, and implemented a Personal Care Assessment Form (PCAF) to improve access to care for EPSDT beneficiaries on September 1, 2008. See also **TEXAS HEALTH STEPS**.

ALL PATIENT REFINED DIAGNOSIS RELATED GROUPS (APR-DRG)—A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex, and presence of complications. This system of classification is used as a financing mechanism to reimburse hospitals and other providers for services rendered.

AMOUNT, DURATION, AND SCOPE—How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what they cover.

APPLICANT—A person who has applied for Medicaid or CHIP benefits.

THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA)—A federal law passed in February 2009 that provided economic stimulus funding through a multitude of new and existing programs and provided a temporary increase in the Federal Medical Assistance Percentage (FMAP) rate during the 27-month recession adjustment period from October 2008 through December 2010.

AVERAGE RECIPIENT (CLIENT) MONTHS PER MONTH –The arithmetic average of the number of Medicaid recipient months (the number of certified, unduplicated Medicaid clients in a given month). In most Medicaid-related reports, this average is generally cited in reference to a state or federal fiscal year. See also **CLIENT**.

B

BALANCED BUDGET ACT (BBA)—A federal law (P.L. 105-33) passed in 1997 designed to achieve substantial reductions in spending to balance the federal budget by the year 2002. The law made several changes to Medicaid and Medicare, and created the State Children’s Health Insurance Program (SCHIP). See also **CHILDREN’S HEALTH INSURANCE PROGRAM**.

BALANCED BUDGET REFINEMENT ACT (BBRA)—A federal law (P.L. 106-113) passed in 1999 that included payment reforms and other technical changes intended to address the reduction in payments experienced by Medicare providers under the Balanced Budget Act (BBA).

BEHAVIORAL HEALTH CARE—Assessment and treatment of mental or emotional disorders and substance use disorders. See also **SUBSTANCE USE DISORDER**.

BEHAVIORAL HEALTH ORGANIZATION (BHO)—A managed care organization that provides or contracts for behavioral health services.

BENEFICIARY—One who benefits from a publicly-funded program. Most commonly used to refer to people enrolled in the Medicare program.

BENEFIT IMPROVEMENT AND PROTECTION ACT (BIPA)—A federal law (P.L.106-554) passed in 2000 that increased disproportionate share hospital (DSH) payments, modified the upper payment limit (UPL) for governmental facilities, and allowed federal State Children’s Health Insurance Program (SCHIP) allocations to be carried forward. See also **CHILDREN’S HEALTH INSURANCE PROGRAM; DISPROPORTIONATE SHARE HOSPITAL; UPPER PAYMENT LIMIT**.

BENEFIT PACKAGE—Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

C

CAPITATION—A prospective payment method that pays a managed care organization a uniform amount on a monthly basis for each enrolled member for the provision of covered services.

CARE COORDINATION—A service available to recipients of Medicaid Managed Care, including STAR, STAR+PLUS, STAR Health, and the Children’s Health Insurance Program (CHIP). (This service is called *Service Management* in STAR and CHIP and *Service Coordination* in STAR Health). Care coordination includes working with individuals and families to develop a plan of care to meet the needs of the individual and to coordinate the services of the managed care organization.

CARVE-OUT—A decision to purchase separately a service that is typically part of a managed care organization (MCO) plan. For example, NorthSTAR is a managed care carve-out program for behavioral health services. See also **NORTHSTAR PROGRAM**.

CASE MANAGEMENT—Services that assist individuals receiving Medicaid to gain access to needed medical, social, educational, and other services. Case management includes assessing an individual’s needs and strengths and developing, implementing, and monitoring the implementation of a care plan. Case management is available through such resources as the Case Management for Children and Pregnant Women program; the ECI program; local mental health authorities; Medicaid home and community-based services waiver programs such as Community Living Assistance and Support Services and Home and Community-based Services; and through services for the visually or hearing impaired. See also **LOCAL MENTAL HEALTH AUTHORITY**.

CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN SERVICES – Health-related case management services to eligible children (birth through age 20) and pregnant women. Case managers are approved through the Texas Department of State Health Services (DSHS) and enrolled with the Texas Medicaid and Healthcare Partnership (TMHP) as Medicaid providers. See also **CASE MANAGEMENT; CASE MANAGER**.

CASE MANAGER—An experienced professional (typically a nurse, social worker, qualified mental health professional, or parent case manager) who works with individuals, service providers, and others to develop and implement a care plan to coordinate all services needed to meet an individual’s medical, social, educational, and other needs.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)—The federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)—CSHCN are defined in the Uniform Managed Care Contract for Medicaid and the Children’s Health Insurance Program (CHIP) as children from birth up to age 19 who:

- Have a serious ongoing illness, complex chronic condition, or disability that has lasted or is anticipated to last at least twelve continuous months or more,
- Have an illness, condition, or disability that results (or without treatment would be expected to result) in limited function, activities, or social roles compared to the accepted pediatric age-related milestones,
- Require regular, ongoing therapeutic intervention and evaluation, and
- Have a need for health or health-related services at a level significantly above the usual for the child’s age.

These children are provided special protections under Medicaid managed care. Protections include efforts to identify CSHCN and ensure that the state has appropriate quality and care coordination guidelines in place for CSHCN.

The CSHCN Services Program is the name of a non-Medicaid, Title V and state-funded program at the Texas Department of State Health Services (DSHS). The definition of CSHCN for the DSHS program differs from that of the Uniform Managed Care Contract and aligns with the definition in Title V legislation.

CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)—The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, established a new state children’s health insurance program by adding Title XXI to the Social Security Act and amending the Medicaid statute. The purpose of this program is to provide funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION (CHIPRA)—Passed by Congress in February 2009, CHIPRA extends federal Children’s Health Insurance Program (CHIP) funding to states through September 2013. CHIPRA includes multiple provisions that allow states new options for their programs. See also **CHILDREN’S HEALTH INSURANCE PROGRAM.**

CHILDREN’S HOSPITAL—A hospital within the state which is recognized under Medicare as a children’s hospital and which is exempted by Medicare from the Medicare prospective payment system. See also **MEDICARE.**

CHIP PERINATAL PROGRAM—The CHIP Perinatal program provides prenatal care to the unborn children of pregnant women up to 202 percent of the federal poverty level who are not eligible for other Medicaid programs or traditional CHIP.

CLAIMS ADMINISTRATOR—Processes and adjudicates all claims for the Medicaid services outside the scope of capitated arrangements between health plans and the Health and Human Services Commission (HHSC).

CLAIMS PROCESSING SYSTEM—A system that enters, tracks, and processes claims from providers for payment.

“CLAWBACK” PAYMENTS—Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles.

CLIENT—A person who has applied for or is enrolled in the Medicaid program. See also **RECIPIENT; APPLICANT**.

COMMUNITY ATTENDANT SERVICES (CAS)—An optional state plan benefit that allows states to provide home and community-based services to individuals with functional disabilities. In Texas, this optional benefit, administered by the Texas Department of Aging and Disability Services (DADS), provides personal care services to people who have income in excess of Supplemental Security Income (SSI) limitations, but who would financially qualify to be in an institution. See also **PRIMARY HOME CARE; 1929**.

COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM (CLASS)—A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people with developmental disabilities other than intellectual disability as an alternative to ICF/MR VIII institutional care. CLASS is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS; WAIVER; 1915(c)**.

COMPARABILITY—In general, the state must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver programs for special subpopulations of Medicaid eligibles and benefits available to children through Early and Periodic Screening, Diagnosis, and Treatment/THSteps that may not be available to adults.

COMPREHENSIVE CARE PROGRAM (CCP)—Texas’ name for the expanded portion of the Early and Periodic Screening, Diagnosis, and Treatment program/THSteps. THSteps-CCP covers services for children (until age 21) that are not usually allowed or are more limited under the Texas Medicaid State Plan. CCP is a result of a Congressional mandate, which became effective in 1990. See also **TEXAS HEALTH STEPS**.

CONSUMER DIRECTED SERVICES (CDS)—A service delivery model that allows the consumer or his/her representative to hire, fire, train, and supervise personal attendants, as well as to directly purchase services. Texas was one of the first states to receive approval from the Centers for Medicare & Medicaid Services (CMS) to implement the CDS delivery model in multiple Medicaid home and community-based waiver programs and in the Medicaid state plan. See also **MEDICAID STATE PLAN; WAIVER; 1915(c)**.

CONTINUITY OF CARE—The degree to which the care of a patient is not interrupted.

CONTRACTOR—Person or organization with which the state has successfully negotiated an agreement for the provision of required tasks.

CO-PAYMENT OR CO-PAY—A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care service is rendered.

CURRENT POPULATION SURVEY (CPS)—A U.S. Census Bureau-sponsored survey. Results from this survey are used in many states to estimate the size and composition of populations that are potentially eligible for Medicaid and the number of persons without health insurance.

D

DAY ACTIVITY AND HEALTH SERVICES (DAHS)—Long-term services and supports offered during the day, Monday through Friday, to clients residing in the community. Services, which are provided at a licensed adult day care center, include nursing and personal care, meals, transportation, and social and recreational activities. These services are provided by adult day care centers, but administered through the Texas Department of Aging and Disability Services (DADS).

DEAF-BLIND MULTIPLE DISABILITIES WAIVER (DBMD)—A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people who are deaf and blind and have a third disability (e.g., intellectual disability) as an alternative to ICF/IID institutional care. Currently, DBMD is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS; WAIVER; 1915(c)**.

DEFICIT REDUCTION ACT (DRA) OF 2005—Federal legislation that is estimated to reduce direct federal spending by \$39 billion for the five-year period of 2006-2010 due to changes in drug reimbursements and policies, cost-sharing, benefit flexibility, and in asset policy for long-term care eligibility.

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL— One of two payment pools available from the 1115 Transformation Waiver. Provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served. See also **1115 TRANSFORMATION WAIVER, UNCOMPENSATED CARE POOL, REGIONAL HEALTH CARE PARTNERSHIP**.

DEVELOPMENTAL DISABILITY—A severe, chronic disability manifested before age 22, which results in impaired intellectual functioning or deficiencies in essential skills. See also **INTELLECTUAL DISABILITY; RELATED CONDITION**.

DIAGNOSIS—

- The art of distinguishing one disease from another.
- Determination of the nature of a cause of a disease.
- A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem.
- A code for the above.

DISPROPORTIONATE SHARE—A program that provides additional reimbursement to hospitals that serve a disproportionate share of low-income patients to compensate for revenues lost by serving needy Texans. See also **DISPROPORTIONATE SHARE HOSPITAL**.

DISPROPORTIONATE SHARE HOSPITAL (DSH)—A hospital designation that describes hospitals that serve a higher than average number of Medicaid and other low-income patients.

DRUG FORMULARY—A listing of prescription medications, which are available to Medicaid and Children’s Health Insurance Program (CHIP) clients. The Medicaid drug formulary is an open formulary that includes preferred and non-preferred drugs. Non-preferred drugs require prior authorization before dispensing while preferred drugs do not require prior authorization. The CHIP formulary does not require prior authorization for non-preferred drugs.

DRUG UTILIZATION REVIEW (DUR)—Evaluation of client’s drug history before medication is dispensed to ensure appropriate and medically-necessary utilization. Review of drug therapy after client has received the medication, examines claims data to analyze prescribing practices, medication use by clients and pharmacy dispensing practices.

DUAL ELIGIBLE—Individual who qualifies for both Medicare benefits and Medicaid assistance. Texas covers a different mix of Medicare cost sharing depending on the individual’s/couple’s income. See also **MEDICAID QUALIFIED MEDICARE BENEFICIARIES; QUALIFIED DISABLED WORKING INDIVIDUALS; QUALIFIED INDIVIDUALS; QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES.**

DURABLE MEDICAL EQUIPMENT (DME)—Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs, and oxygen equipment.

E

E-PRESCRIBING—The computer-to-computer transfer of prescription, drug, benefit, and patient information among prescribers, pharmacies, and payers. Medicaid and the Children’s Health Insurance Program (CHIP) began implementing e-prescribing in 2010.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)— See also **COMPREHENSIVE CARE PROGRAM; TEXAS HEALTH STEPS.**

ELECTRONIC HEALTH RECORD (EHR)—An electronic record of an individual’s health-related information that includes patient demographic and clinical health information, such as medical histories and problem lists, and that has a variety of capabilities, including clinical decision support; physician order entry; capture and query of information relevant to health care quality; and the ability to exchange electronic health information with, and integrate such information from, other sources.

ELIGIBILITY SUPPORT SERVICES, ENROLLMENT, AND OUTREACH AND INFORMING CONTRACTOR—Entities with which the state contracts to provide business services that support the state’s determination of client eligibility for Medicaid, CHIP, SNAP, and TANF programs; assist in educating clients who are enrolling in Medicaid managed care and CHIP about their health plan and PCP choices; enroll clients into Medicaid managed care and CHIP; process health plan changes ,and provide outreach and informing services to Texas Health Steps Program recipients.

ELIGIBLE CLIENT—An individual who has been determined to meet the eligibility criteria for a public program such as Medicaid.

EMERGENCY MEDICAL CONDITION—A medical condition with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of any bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

ENCOUNTER DATA—Information derived from a contact or service delivered by a health care provider for any capitated service provided to an eligible member.

ENHANCED MATCH RATE—Federal matching rate that is higher than the regular federal medical assistance percentage (FMAP). See also **CHILDREN'S HEALTH INSURANCE PROGRAM; FEDERAL MEDICAL ASSISTANCE PERCENTAGE**.

ENROLLEE—An individual who is enrolled in and eligible for services from a health plan either as a subscriber or as a dependent.

EXPERIENCE REBATE—Medicaid and CHIP managed care organizations (MCOs) are required to pay HHSC experience rebates, which are a form of profit sharing. The amount paid to the state (the experience rebate) is calculated using a graduated rebate method based on the excess of allowable MCO Medicaid or CHIP revenues over allowable MCO Medicaid or CHIP expenses. The rebate amount is based on pre-tax income and varies based on the amount of pre-tax profit and the variable percentage applied.

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)—See **QUALITY MONITOR**.

F

FEDERAL BENEFIT RATE (FBR)—The FBR is the Supplemental Security Income (SSI) limit. For 2014, the FBR is \$721 per month for individuals.

FEDERAL DRUG REBATES—Payments to the state from drug manufacturers and pricing rules mandated by the federal Omnibus Budget Reconciliation Act of 1990

(OBRA 90, P.L.101-508). The payment is dependent on the state's expenditures for each specific drug product. See also **OMNIBUS BUDGET RECONCILIATION ACTS**.

FEDERAL FISCAL YEAR (FFY)—The federal fiscal year is a 12-month period beginning October 1 and ending September 30.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)—The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income. In FFY 2011, the FMAP for Texas was 60.56 percent. The federal share of Medicaid administrative costs is not based on a per capita income formula. It is 50 percent for most activities. The FFY 2014 FMAP for Texas is 58.69% percent.

FEDERAL POVERTY LEVEL (FPL)—Income guideline established annually by the federal government. Public assistance programs usually define income limits in relation to the FPL.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)—A center receiving a grant under the Public Health Services Act or an entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless programs. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.

FEE-FOR-SERVICE REIMBURSEMENT (FFS)—The traditional Medicaid health care payment system, under which providers receive a payment for each unit of service they provide.

FREEDOM OF CHOICE— In general, a state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through Medicaid waivers and special contract options. Texas Health Steps (THSteps) clients have freedom of choice with regard to a medical checkup provider, even if that provider is not the child's primary care provider.

FREW V. JANEK—A class action lawsuit that was filed against Texas in 1993 and alleged that the state did not adequately provide Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In 1995, the state negotiated a consent decree that imposed certain requirements on the state. In 2007, the state negotiated a set of corrective action orders with the plaintiffs to implement the consent decree and increase access to EPSDT services.

G

GENERIC DRUG—A chemically-equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or “generic” name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.

GRADUATE MEDICAL EDUCATION (GME)—Payments that cover the costs of residents’ and teaching physicians’ salaries and fringe benefits, program administrative staff, and allocated facility overhead costs for hospitals that operate medical residency training programs.

H

HEALTH AND HUMAN SERVICES COMMISSION (HHSC)—The oversight agency for health and human services in Texas. HHSC is the single state Medicaid and CHIP agency for Texas.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)—Federal legislation (P.L. 104-191) that prohibits insurers from excluding individuals because of health problems or disabilities; limits insurers’ ability to exclude treatment for pre-existing conditions; requires standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid; protects the security of electronically transmitted or stored information and the privacy of individuals covered by Medicaid; and implements the new National Provider Identifier to be used in all electronic transactions between providers and health plans in May 2007. In April 2007, the Centers for Medicare & Medicaid Services (CMS) announced a contingency period for any covered entity showing a good faith effort to become compliant. The contingency period allowed covered entities to continue using legacy identifiers until May 23, 2008, without penalty.

HEALTH INSURANCE PREMIUM PAYMENT (HIPPI) PROGRAM—A Medicaid program that pays for employer or private health insurance premiums for persons who are Medicaid-eligible, when the premiums are less expensive than providing regular Medicaid coverage for those persons.

HEALTH PASSPORT—A web-based repository of medical information for each child enrolled in the STAR Health program. The Health Passport allows authorized users immediate access to a child’s basic claim-based health record through a secure,

password-protected website. The Health Passport includes available claims information, immunization records, behavioral health assessments, Texas Health Steps exam forms, lab results, and other health care information. See also **STAR HEALTH**.

HEALTH PLAN—See **MANAGED CARE ORGANIZATION**.

HEALTH EFFECTIVENESS DATA INFORMATION SET (HEDIS)—A core set of performance measures developed for employers to use in assessing health plans. It was established and is promoted by the National Committee for Quality Assurance (NCQA).

HOME AND COMMUNITY-BASED SERVICES WAIVER (HCS)—A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to people with intellectual disabilities as an alternative to ICF/IID institutional care. HCS is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

HOSPICE—A treatment approach that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care. The goal of hospice is to help terminally ill individuals continue life with minimal disruption of normal activities while remaining primarily in the home environment. Hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through a broad spectrum of professional and other caregivers with the goal of making the individual as physically and emotionally comfortable as possible.



INDEPENDENT ASSESSMENT—Assessments of access, quality, and cost of Medicaid managed care programs operated under a 1915(b) waiver. These assessments are required by the federal government and performed by an entity external to the state agencies that oversee and operate the Medicaid program.

INFANT—Children from birth to one year of age.

INSTITUTION FOR MENTAL DISEASE (IMD)—A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)—Activities that are essential to independent daily living including preparing meals, shopping for groceries or personal items, performing light housework, and using a telephone.

INTEGRATED ELIGIBILITY DETERMINATION—HHSC uses an integrated system to determine eligibility for Medicaid, CHIP, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), and TANF. The eligibility system offers convenient access to eligibility services through multiple channels, including a self-service website (www.YourTexasBenefits.com), a smartphone app, a network of local eligibility offices and community-based organizations, and the 2-1-1 phone service. See also **TEXAS INTEGRATED ELIGIBILITY REDESIGN SYSTEM**.

INTELLECTUAL DISABILITY—A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

INTEREST LIST—A list of individuals who are interested in receiving 1915(c) waiver services, but for whom waiver slots are not available due to the waiver being at maximum enrollment. See also **WAIVER; 1915(c)**.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS (ICF/IID)—Optional Medicaid state plan service, which provides residential care and services for individuals with developmental disabilities based on their functional needs. See also **INTELLECTUAL DISABILITY**.

J

K

KATIE BECKETT OPTION—See **TEFRA 134(a)**.

L

LEGISLATIVE BUDGET BOARD (LBB) - The Legislative Budget Board is a permanent joint committee of the Texas Legislature that develops budget and policy recommendations for legislative appropriations for all agencies of state government, as well as completes fiscal analyses for proposed legislation. The LBB also conducts evaluations and reviews for the purpose of identifying and recommending changes that improve the efficiency and performance of state and local operations and finances.

LOCAL MENTAL HEALTH AUTHORITY—The local component of the mental health system designated to carry out the legislative mandate for planning, policy development, coordination, and resource development/allocation, and to supervise and ensure the provision of services to persons with mental illness or intellectual disability in one or more local service areas. See also **COMMUNITY MENTAL HEALTH CENTERS**.

LONESTAR—Texas' first managed health care pilot project under the Medicaid program. The name of this program was later shortened to STAR, for state of Texas Access Reform. See also **MANAGED CARE**.

LONG-TERM SERVICES AND SUPPORTS (LTSS)—Assistance for persons who are over age 65 and those with chronic disabilities. The goal of long-term services and supports is to help such individuals be as independent as possible. See also **ACTIVITIES OF DAILY LIVING**.

M

MANAGED CARE—A system in which the overall care of a patient is overseen by a single provider or organization. Many state Medicaid and CHIP programs include managed care components as a way to improve quality and control costs. See also **MANAGED CARE ORGANIZATION; LONESTAR; NORTHSTAR PROGRAM; STATE OF TEXAS ACCESS REFORM; STAR+PLUS PROGRAM; STAR HEALTH; CHIP**.

MANAGED CARE ORGANIZATION (MCO)—An organization that delivers and manages health services under a risk-based arrangement. The MCO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the MCO may suffer losses. If enrollees cost less, the MCO profits. This gives the MCO an incentive to control costs. See also **1903(m); 1915(b)**.

MANAGED HEALTH CARE PLAN—One or more products that integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network that delivers services and that (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use an information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

MEDICAID—A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

MEDICAID BUY-IN - A program that enables working persons with disabilities to receive Medicaid services. Medicaid Buy-In clients may be required to pay a monthly premium depending on their earned and unearned income. The program is available to individuals with countable earned income less than 250 percent of the federal poverty level (FPL).

MEDICAID BUY-IN FOR CHILDREN—A program that allows children up to age 19 with disabilities to “buy-in” to Medicaid. Children with family income up to 300 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented the program in January 2011.

MEDICAID ELIGIBLE—In Texas, this term refers to persons who, after going through a certification process, become eligible to receive services and other assistance under the Medicaid program. The term does not include persons who could be eligible for Medicaid (e.g., meet all income and asset criteria tied to eligibility) that are not enrolled in the program.

MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM (MEHIS)—MEHIS replaced the paper Medicaid identification form with a permanent plastic card, automated eligibility verification, and provided an electronic health record for all Medicaid clients

MEDICAID ESTATE RECOVERY PROGRAM (MERP)—The Medicaid Estate Recovery Program (MERP) is required by federal and state law to recover, after the time of death, certain long-term care and associated Medicaid costs of services provided to recipients age 55 and over.

MEDICAID FOR BREAST AND CERVICAL CANCER (MBCC)—MBCC provides full Medicaid coverage for eligible uninsured women ages 18 to 64 who have been diagnosed with a qualifying breast or cervical cancer. Women may receive a qualifying diagnosis from any provider but must apply for MBCC through the Breast and Cervical Cancer Services program administered by the Department of State Health Services (DSHS). Clients receive Medicaid benefits as long as they meet the eligibility criteria and are receiving active treatment for breast or cervical cancer.

MEDICAID OPERATING DEPARTMENT—State agencies in Texas with day-to-day operational responsibility for various Medicaid-funded programs. See also **TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES; TEXAS DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES; TEXAS DEPARTMENT OF STATE HEALTH SERVICES.**

MEDICAID QUALIFIED MEDICARE BENEFICIARIES—Medicare beneficiaries who are eligible for full Medicaid benefits. Medicaid pays the deductible and co-insurance for Medicare services and covers all other Medicaid services not covered by Medicare.

MEDICAID RECIPIENT—A Medicaid client or enrollee who has received a service paid for with Medicaid program funds.

MEDICAID REIMBURSEMENT—Amount of money the Medicaid program reimburses or pays to a health care organization or other provider for services or other forms of assistance provided to Medicaid clients.

MEDICAID RURAL SERVICE AREA (MRSA) - On March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties. The Medicaid Rural Service Area (MRSA) STAR program serves clients who were previously covered by the Primary Care Case Management program—if they had Medicaid only (e.g., pregnant women and children with limited income, TANF clients, and adults receiving SSI). Children age 20 and younger with Supplemental Security Income (SSI) may choose between managed care and traditional Medicaid. SSI children age birth through 20 years of age may volunteer to participate in STAR in the Medicaid RSA. See also **PRIMARY CARE CASE MANAGEMENT; STAR.**

MEDICAID STATE PLAN—The document that serves as the contract between the state and the Centers for Medicare & Medicaid Services (CMS) for the Texas Medicaid program and that gives the state, particularly the Health and Human Services Commission (HHSC), authority to administer a Medicaid program in Texas. It describes the nature and scope of the state’s Medicaid program including Medicaid administration, client eligibility, benefits, and provider reimbursement. It includes a “preprint” portion, which contains the broad outlines of the program and the basic choices that a state is allowed to make. The details of a particular state’s plan are contained in numerous attachments, appendices, and supplements. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children’s Health Insurance Program State Plan. See also **TITLES OF THE 1965 SOCIAL SECURITY ACT.**

MEDICAID WELLNESS PROGRAM FOR CHILDREN WITH DISABILITIES - Previously named the Texas Health Management Program, the Medicaid Wellness Program (TMWP) was implemented March 1, 2011, to provide chronic care management statewide to high-cost/high-risk PCCM and FFS clients. In October 2011, HHSC shifted the focus of the TMWP to SSI disabled children who voluntarily remained in FFS after the March 1, 2012 managed care expansion. The TMWP is a community-based care management program that enrolls high-risk clients with complex, chronic, or co-morbid conditions. Extensive case management focuses on the whole person (rather

than the disease) through telephonic and face-to-face interventions that aim to improve health outcomes.

MEDICAL CARE ADVISORY COMMITTEE (MCAC)—Mandated by federal Medicaid law, the MCAC reviews and makes recommendations to the State Medicaid/CHIP Director on proposed Medicaid rules.

MEDICAL NECESSITY—Health services that are:

- Reasonably necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a recipient, or endanger life.
- Provided at appropriate locations and at the appropriate levels of care for the treatment of clients' conditions.
- Consistent with health care practice guidelines and standards that are issued by professionally-recognized health care organizations or governmental agencies.
- Consistent with the diagnoses of the conditions.
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

MEDICAL TRANSPORTATION PROGRAM (MTP)—MTP arranges non-emergency transportation to and from medically necessary, Medicaid-allowable health care services for persons enrolled in Medicaid, who have no other means of transportation.

MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP)—A 1915(c) Medicaid waiver program that provides respite, minor home modifications, and adaptive aids to children as an alternative to nursing facility care. MDCP is administered by the Texas Department of Aging and Disability Services (DADS). See also **1915(c); WAIVER**.

MEDICALLY NEEDY WITH SPEND DOWN PROGRAM—A program for pregnant women and children who are ineligible for regular Medicaid coverage due to excess income, but who meet Medicaid income eligibility limits after accounting for their medical expenses (a process called "spend down"). Clients are not required to pay their medical expenses in order to qualify for the medically needy program.

MEDICARE—The nation's largest health insurance program financed by the federal government. Medicare provides insurance to people who are age 65 and older and those with disabilities or permanent kidney failure.

MEDICARE EQUALIZATION - limited payments for Medicare Part A and B services provided to dual eligibles to no more than the Medicaid payment amount for the same service, with the exception of renal dialysis services. Medicare Part A covers hospital services, and Medicare Part B covers physician and other outpatient services.

MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT (MMA) OF 2003—A federal law (P.L. 108-173) that created a new Medicare prescription drug benefit (Part D) and made other program and payment changes.

MEMBER—Medicaid client who is enrolled in a managed care organization plan. See also **ENROLLEE**.

MENTAL ILLNESS (as defined in the Texas Medicaid state plan)—A single severe mental disorder, excluding intellectual disability, or a combination of severe mental disorders as defined in the latest edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

MODIFIED ADJUSTED GROSS INCOME - Federal law requires states to determine financial eligibility for most individuals in Medicaid and CHIP based on the modified adjusted gross income (MAGI) methodology. The MAGI methodology uses federal income tax rules for determining income and household composition. The Affordable Care Act (ACA) applies a 5 percentage point income disregard to individuals that are subject to the MAGI methodology. The MAGI methodology applies to the Medicaid eligibility groups for children, pregnant women, and parents and caretaker relatives. The ACA provides exceptions to the use of MAGI and to the elimination of assets tests and income disregards. In Texas, the exceptions primarily apply to emergency Medicaid, foster care children, medically needy, individuals receiving Supplemental Security Income, and Medicaid programs for people age 65 and over and people with disabilities.

MONEY FOLLOWS THE PERSON—The 2002-03 GAA (Article II, HHSC, Rider 37, S.B. 1, 77th Legislature, Regular Session, 2001) stipulates that as clients relocate from nursing facilities to community care services, the nursing facility funds will be transferred to the community care budget to cover the cost of their services. Also known as the “Money Follows the Person” rider. The rider language was codified by H.B. 1867, 79th Legislature, Regular Session, 2005.

N

NEWBORNS—Children up to age 1 whose family income and resources are above the current requirements for Temporary Assistance for Needy Families (TANF), but not above 198 percent of the federal poverty level (FPL). The Children’s Health Insurance Program (CHIP) covers newborns up to 201 percent of the federal poverty level (FPL).

NORTH TEXAS BEHAVIORAL HEALTH AUTHORITY—The Local Behavioral Health Authority (LBHA) for the NorthSTAR program formed to ensure that local communities are given a voice in the delivery of publicly-funded, managed behavioral health care. The LBHA represents both mental health and chemical dependency interests and

concerns. See also **LOCAL BEHAVIORAL HEALTH AUTHORITY; NORTHSTAR PROGRAM.**

NORTHSTAR PROGRAM—Texas' managed care carve-out pilot program for behavioral health services. Implemented in 1999 in Dallas and contiguous counties, NorthSTAR integrates Medicaid-funded and public, non-Medicaid funded mental health and chemical dependency services. The program includes state and federal Medicaid funds (through a 1915(b) waiver), non-Medicaid state and federal funds, and some county funds. See also **CARVE OUT; 1915(b).**

NURSING FACILITIES (NF)—Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) long-term care program. The nursing facility program is administered by the Texas Department of Aging and Disability Services (DADS). See also **LONG-TERM SERVICES AND SUPPORTS.**

O

OFFICE OF INSPECTOR GENERAL (OIG)—The 78th Legislature created the Office of Inspector General in 2003 to strengthen the Health and Human Services Commission's (HHSC) authority and ability to combat fraud, waste, and abuse in health and human services programs. OIG is divided into five divisions: Compliance, Enforcement, Operations, internal affairs and Chief Counsel.

OMNIBUS BUDGET RECONCILIATION ACTS (OBRAs)—Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.

OPTIONAL SERVICES OR BENEFITS—Over 30 different services that a state can elect to cover under a Medicaid state plan. Examples include personal care, rehabilitative services, prescription drugs, therapies, diagnostic services, Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition, targeted case management, etc.

OUTLIER—An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.

P

PART A—Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for

home care by a home health agency, or hospice care by a licensed and certified hospice agency. See also **MEDICARE**.

PART B—Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also **MEDICARE**.

PART C—Previously called Medicare+Choice, this part of the Medicare program was renamed Medicare Advantage and modified by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. Provides for certain managed care coverage options in Medicare, under which managed care organizations receive a capitated monthly payment per covered beneficiary. Additional benefits and cost-sharing arrangements may be offered by Medicare managed care organizations. See also **MANAGED CARE ORGANIZATION; MEDICARE; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**.

PART D—A voluntary Medicare prescription drug benefit created by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 that began January 1, 2006. Beneficiaries who remain in traditional Medicare may choose a private drug-only plan; those who choose to enroll in a managed care organization may choose a plan that offers a drug benefit. See also **MANAGED CARE ORGANIZATION; MEDICARE; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**.

PER MEMBER PER MONTH (PMPM)—The unit of measure related to each member for each month the member was enrolled in a managed care plan.

PERSONAL CARE SERVICES (PCS)— Optional Medicaid benefit that allows a state to provide attendant services to assist individuals with disabilities in performing activities of daily living (e.g., bathing, dressing, feeding, grooming). Texas provides Primary Home Care services under this option. See also **PRIMARY HOME CARE**.

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 (PRWORA)—Federal legislation (P.L. 104-193) that eliminated Aid to Families with Dependent Children (AFDC) and created Temporary Assistance for Needy Families (TANF), a block grant for states to provide time-limited cash assistance for needy families, with work requirements for most clients. See also **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES**.

PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE—A governor-appointed committee consisting of six physicians and five pharmacists who review data

on the clinical efficacy, safety, and cost-effectiveness of drug products and make recommendations to HHSC about which drugs to place on the Preferred Drug List. See also **PREFERRED DRUG LIST**.

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

PHARMACY CLAIMS AND REBATE ADMINISTRATOR—Processes and adjudicates all claims for Medicaid and CHIP fee-for-service out-patient prescription drugs. The pharmacy claims administrator performs all rebate administration functions including invoicing and reconciliation of federal, state, and supplemental rebates. This vendor also stores managed care organization encounter data to support program oversight of prescription drug benefits in managed care.

PHARMACY PRIOR AUTHORIZATION VENDOR —Evaluates prior authorization requests submitted through a call center and from the pharmacy point-of-sale system for drugs that are not on the preferred drug list (PDL) or have been selected for clinical edits.

In January 2011, HHSC transitioned prior authorization services to Health Information Designs, Inc. See also Health Information Designs, Inc.

PHYSICIAN EXTENDER - Physician extender is a health care provider who is not a physician, but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.

POTENTIALLY PREVENTABLE EVENTS (PPEs)—One of, or any combination of, the following:

- An admission of a person to a hospital or long-term care facility that may reasonably have been prevented with adequate access to ambulatory care or health care coordination.
- A health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of a patient, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not reasonably be necessary for the provision of quality health care or treatment.
- A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person's admission to a hospital or long-term care facility; and may have resulted from the care, lack of

care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASARR)—Screening to identify persons with mental illness, intellectual disability, or related conditions in nursing facilities.

PREFERRED DRUG LIST (PDL)—A cost-control measure used by Texas and other states to manage increasing drug costs. The PDL is a list of “preferred” drugs that are safe, clinically effective and cost-effective compared to other drugs on the market. Drugs on the PDL do not require prior approval in order to be reimbursed. Medicaid also covers drugs, not on the PDL, but a physician’s office must call to obtain prior approval before a non-preferred drug can be reimbursed.

PREFERRED DRUG LIST VENDOR—The contracted vendor that provides information to the Pharmaceutical and Therapeutics (P&T) Committee on the clinical efficacy, safety, and cost-effectiveness of drug products; negotiates supplemental drug manufacturer rebates on behalf of the state; and assists HHSC and the P&T Committee with the development and maintenance of the preferred drug list. See also **PHARMACEUTICAL AND THERAPEUTICS (P&T) COMMITTEE**.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS (PPECC)—Provides non-residential, facility-based care as an alternative to private-duty nursing (PDN) for individuals under the age of 21 with complex medical needs.

PRESCRIPTION DRUG—A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

PREVENTIVE CARE—Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well-person care.

PRIMARY CARE—Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine providers.

PRIMARY CARE CASE MANAGEMENT (PCCM)—Managed care option in which each participant is assigned to a single primary care provider who must authorize most other services such as specialty physician care before they can be reimbursed by Medicaid. Effective September 1, 2011, Medicaid clients participating in the Primary Care Case Management (PCCM) program in 28 of the counties contiguous to existing STAR and STAR+PLUS service areas were transitioned from PCCM to the STAR program or STAR+PLUS Medicaid managed care program. In March 2012, HHSC entered into new contracts with MCOs in 11 service areas and terminated PCCM.

PRIMARY CARE PHYSICIAN (PCP)—A physician or provider who has agreed to provide a medical home to Medicaid clients and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

PRIMARY HOME CARE (PHC)—A Medicaid-funded community care program administered by the Texas Department of Aging and Disability Services (DADS) that provides personal care services. PHC is provided as an optional state plan benefit. See also **PERSONAL CARE SERVICES**.

PRIOR AUTHORIZATION—An authorization from the Medicaid program for the delivery of certain services. It must be obtained prior to providing the service. Examples of such services are goal-directed therapy and transplants.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)—A waiver of the Medicaid State Plan granted under Section 1115(a) of the Social Security Act. This waiver allows Texas to provide comprehensive medical and community-based services under a capitated, risk-based system to frail elderly people (55 and older), as a cost-effective alternative to institutional care. The waiver is part of a national demonstration project. Texas has two PACE sites in El Paso and Amarillo. PACE is administered by the Texas Department of Aging and Disability Services (DADS). See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; WAIVER; 1115(a)**.

PROMOTING INDEPENDENCE—The Promoting Independence Plan and Initiative is the Texas response to the U.S. Supreme Court *Olmstead* decision regarding Title II of the Americans with Disabilities Act. The Court ruled that states must provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when certain conditions are met, or have a comprehensive, effective plan to provide community services. The Promoting Independence Plan and Initiative have been expanded to respond to two Governor's Executive Orders which seek to improve the service delivery system for persons who have disabilities and/or who are aging.

PATIENT PROTECTION AND AFFORDABLE CARE ACT—The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted on March 30, 2010. Together they are called the Affordable Care Act (ACA). The ACA includes provisions to expand health insurance coverage, including an individual mandate, sliding-scale health insurance subsidies for individuals and families up to 400 percent of the federal poverty level (FPL); tax incentives for small employers to offer health insurance to their employees, an optional expansion of Medicaid up to 133 percent FPL and measures to improve quality, reduce fraud and abuse, and reform payment methodologies.

PROVIDER—A person, group, or agency that provides a covered Medicaid service to a Medicaid client.

PROVIDER CREDENTIALING—The process through which managed care organizations ensure that each health care provider meets all professional standards, including licensure.

PROVIDER NETWORKS—Organizations of health care providers that provide services within managed care plans. Network providers are selected with the expectation that they will deliver care inexpensively, and enrollees are channeled to network providers to control costs.

Q

QUALIFIED DISABLED WORKING INDIVIDUALS (QDWI)—Medicare beneficiaries with income less than or equal to 200 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. The Texas Medicaid program pays Medicare Part A premiums for disabled working individuals. However, the number of QDWI eligible for this benefit in Texas is small. See also **PART A**.

QUALIFIED INDIVIDUALS (QI)—Medicare beneficiaries with income between 120 and 135 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. Medicaid pays a portion of the Medicare Part B premium. See also **PART B**.

QUALIFIED MEDICARE BENEFICIARY (QMB)—Medicare beneficiaries with income less than or equal to 100 percent of the federal poverty level (FPL) who do not qualify for full Medicaid benefits. Medicaid pays all Medicare Part A and B premiums, deductibles, and coinsurance. See also **PART A; PART B**.

QUALITY MONITOR—Provides external review of the access and the quality of care provided to Medicaid and CHIP clients enrolled in Medicaid/CHIP managed care. Also known as the External Quality Review Organization (EQRO).

R

RECIPIENT—A person who received a Medicaid service while eligible for the Medicaid program. People may be Medicaid eligible without being Medicaid recipients. See also **CLIENT; MEDICAID ELIGIBLE**.

RECIPIENT (CLIENT) MONTHS—This term reflects a complete count (could be actual or estimated) of all certified Medicaid clients for a given month. The count reflects all

Medicaid clients, regardless of whether or not they received services during that month. For any given month, the number of recipient months is equal to the number of unduplicated clients for that month. Recipient months and unduplicated clients differ on an annualized basis. See also **CLIENT**.

REGIONAL HEALTH CARE PARTNERSHIPS—Under the 1115 Transformation Waiver, eligibility to receive Uncompensated Care (UC) or Delivery System Reform Incentive Payment (DSRIP) requires participation in one of 20 Regional Health Care Partnerships (RHP), which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an “anchoring entity,” which is a public hospital or other local governmental entity with the authority to make intergovernmental transfers, such as a hospital district, a hospital authority, a health science center, or a county. See also **UNCOMPENSATED CARE; DELIVERY SYSTEM REFORM INCENTIVE PAYMENT; 1115 TRANSFORMATION WAIVER**.

REHABILITATIVE SERVICES FOR MENTAL ILLNESS—Specialized services provided to people age 18 and over with severe and persistent mental illness and people under 18 with serious emotional disturbance. Mental health rehabilitation includes:

- Crisis Intervention Services.
- Medication Training and Support Services.
- Psychosocial Rehabilitation Services.
- Skills Training and Development Services.
- Day Programs for Acute Needs.

Program design and eligibility was modified effective September 1, 2004, to reflect the Resiliency and Disease management practices required in H.B. 2292, 78th Legislature, Regular Session, 2003. See also **MENTAL ILLNESS**.

REINSURANCE—Insurance purchased by a managed care organization, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the unusually high claims of its participating providers, policyholders, or employees and covered dependents. Also called risk control insurance or stop-loss insurance.

RELATED CONDITIONS—A disability other than an intellectual disability that manifests itself before age 22 and results in substantial functional limitations in three of six major life activities (e.g., self-care, expressive/receptive language, learning, mobility, self-direction and or capacity for independent living). These disabilities, which may include

cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other disabilities are said to be “related to” intellectual disability in their effect on the individual’s functioning.

REQUIRED SERVICES—Services that a state is required to offer to categorically needy clients under the Medicaid State Plan. (Medically needy clients may be offered a more restrictive service package.)

RETROSPECTIVE DRUG UTILIZATION REVIEW VENDOR— Performs drug use review (DUR) retrospective interventions to assist health care providers in delivering appropriate prescription pharmaceutical drugs to Texas Medicaid VDP clients.

RISK CONTRACT—An agreement with a managed care organization (MCO) to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also **MANAGED CARE ORGANIZATION**.

S

SCHOOL HEALTH AND RELATED SERVICES (SHARS)—Medicaid optional benefit that provides services related to a child’s Individual Education Plan (IEP). Services are provided in a school setting and include audiology, physician services, occupational therapy, physical therapy, speech therapy, psychological services, nursing services, counseling, personal care services, and transportation.

SELECTIVE CONTRACTING—Option under section 1915(b) of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.

SERVICE DELIVERY AREA (SDA)—Regions of the state in which clients receive Medicaid services through an MCO, and that are treated as a unit in terms of planning and implementation of managed care strategies.

SERVICE RESPONSIBILITY OPTION—Under the SRO, the traditional agency remains the employer of record, but the consumer participates in selecting and managing the attendant staff. The option allows consumers to select and manage their care staff but without the responsibility of being an employer.

SIGNIFICANT TRADITIONAL PROVIDER (STP)—Under Texas Medicaid law, managed care organizations (MCOs) must include in their provider networks, for at least three years, each health care provider who:

- Previously provided care to Medicaid and charity care patients at a significant level (as defined by the Texas Health and Human Services Commission).
- Agrees to accept the standard provider reimbursement rate of the MCO.
- Meets the credentialing requirements of the MCO.
- Complies with all of the terms and conditions of the standard provider agreement of the MCO.

SINGLE STATE AGENCY—The Social Security Act requires that the state designate a single agency to administer or supervise administration of the state’s Medicaid plan. In Texas, the Health and Human Services Commission fulfills this function. See also **HEALTH AND HUMAN SERVICES COMMISSION; MEDICAID STATE PLAN.**

SKILLED NURSING FACILITY (SNF)—A nursing facility that is certified to treat Medicare patients.

SOCIAL SECURITY ADMINISTRATION (SSA)—Federal agency responsible for determining eligibility for Supplemental Security Income benefits in Texas and most other states.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB)—Medicare beneficiaries with income less than 120 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays the Medicare Part B premium. See also **PART B.**

SPELL OF ILLNESS—A continuous period of hospital confinement. Successive periods of hospital confinement shall be considered to be continuous unless the last date of discharge and the date of readmission are separated by at least 60 consecutive days of care.

STAR HEALTH—A statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits include medical, dental, and behavioral health services, as well as service coordination and a web-based electronic medical record (known as the Health Passport). The program was implemented on April 1, 2008. See also **HEALTH PASSPORT.**

STAR+PLUS PROGRAM—Implemented in 1998, this managed care program provides integrated acute and long-term services and supports to people with disabilities, and people age 65 and older. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant and Travis Service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a credentialed provider network contracted with MCOs.

STATE FISCAL YEAR (SFY)—The Texas state fiscal year runs from September 1 through August 31 of each year.

STATE OF TEXAS ACCESS REFORM (STAR)—Texas' Medicaid managed care program in which the Health and Human Services Commission contracts with managed care organizations (MCOs) to provide, arrange for, and coordinate preventive, primary, and acute care covered services to non-disabled children, low-income families, and pregnant women. On March 1, 2012, STAR expanded to the Medicaid Rural Service Area (Medicaid RSA). See also **MEDICAID RURAL SERVICE AREA**.

STATE SUPPORTED LIVING CENTERS (SSLCs)—State Supported Living Centers provide campus-based direct services and supports to people with intellectual and developmental disabilities who are medically fragile or who have behavioral problems.

STATEWIDENESS—In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. See also **1902(a)(1)**.

SUBSTANCE ABUSE—The taking of alcohol or other drugs at dosages that place a person's social, economic, psychological, and physical welfare in potential hazard, or endanger the public health, safety, or welfare, or a combination thereof. Also called chemical dependency.

SUBSTANCE USE DISORDER—A pattern of substance use that meets the diagnostic criteria for Substance Abuse or Substance Dependence as set forth in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

SUPPLEMENTAL DRUG MANUFACTURER REBATES—Payments to the state from drug manufacturers for drug products included on the Medicaid Preferred Drug List, based on claims for each specific drug product.

SUPPLEMENTAL SECURITY INCOME (SSI)—SSI is a federal cash assistance program for low-income older people and people of all ages with disabilities. It is administered by the Social Security Administration (SSA). In Texas, SSI recipients are automatically eligible to receive Medicaid.

SYSTEM FOR APPLICATION VERIFICATION, ELIGIBILITY, REFERRALS, AND REPORTING (SAVERR)—The state's past eligibility information system that was replaced by the Texas Integrated Eligibility and Redesign System (TIERS). See also **TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM**.

T

TARGETED CASE MANAGEMENT—An optional Medicaid state plan service. In Texas, this service is provided for people with chronic mental illness, women with high-risk pregnancies and infants, persons with intellectual disabilities and related conditions, and blind or visually impaired adolescents. Targeted Case Management encompasses activities that assist the target population in gaining access to medical, social, educational, and other services. Such activities include assessment, case planning, service coordination or monitoring, and case plan reassessment.

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA)—The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.

TEFRA 134(a)—Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain children with disabilities. This option is not offered in Texas.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)—Formerly Aid to Families with Dependent Children (AFDC), TANF provides financial assistance to needy, dependent children and the parents or relatives with whom they are living. Eligible TANF households receive monthly cash and Medicaid benefits if they apply for Medicaid.

TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (DADS)—The Medicaid operating department responsible for administering the Medicaid nursing facility program; long-term care licensing, survey, and certification; and a wide range of home and community-based, long-term services and supports, including the state's Medicaid 1915(c) waiver programs. DADS also administers the ICF/IID program and owns/operates Texas' state schools.

TEXAS DEPARTMENT OF ASSISTIVE AND REHABILITATIVE SERVICES (DARS)—The Medicaid operating department is responsible for administering targeted case management services for the Blind Children's Program and ECI.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES (DFPS)—DFPS was created with the passage of H.B. 2292 by the 78th Texas Legislature, Regular Session, 2003. Previously called the Texas Department of Protective and Regulatory Services, DFPS is charged with protecting children and adults who are older or have disabilities living at home or in state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The agency is also charged with managing

community-based programs that prevent delinquency, abuse, neglect and exploitation of Texas children, adults age 65 and older and those adults with disabilities.

TEXAS DEPARTMENT OF INSURANCE (TDI)—TDI is mandated by the legislature to regulate the insurance industry and protect the people and businesses that are served by insurance. Functions of the agency include: resolving insurance-related complaints; conducting windstorm inspections; licensing insurance agents/agencies and adjusters; licensing insurance companies and MCOs; certifying utilization review agents (URAs), independent review organizations (IROs), workers' compensation networks and assigning requests to IROs; registering life settlement entities; assuring fair and efficient regulation; enforcing insurance laws; combating insurance fraud; fire prevention, fire safety, and fire industry regulation; and regulating and administering the Texas workers' compensation system.

TEXAS DEPARTMENT OF STATE HEALTH SERVICES (DSHS)—The Medicaid operating department responsible for administration of the Early and Periodic Screening, Diagnosis, and Treatment Program/THSteps; case management for pregnant women and children services; newborn screening, newborn hearing screening, and Program for Amplification for Children; family planning services; targeted case management and rehabilitative services for people with mental illness; and the NorthSTAR program. DSHS also owns/operates Texas' state hospitals.

TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER—Known as the 1115 Transformation Waiver, the waiver is a five-year demonstration running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit (UPL) payments. The 1115 Transformation Waiver, which was approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds. See also **UNCOMPENSATED CARE POOL; DELIVERY SERVICES REFORM INCENTIVE PAYMENT; REGIONAL HEALTH CARE PARTNERSHIPS.**

TEXAS EDUCATION AGENCY (TEA)—Provider agency for School Health and Related Services (SHARS). See also **SCHOOL HEALTH AND RELATED SERVICES.**

TEXAS HEALTH STEPS (THSteps)—The name in Texas for the Medicaid program for children that provides services under the required state plan service known as the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). THSteps provides medical and dental prevention and treatment services for children of low-income families from birth to age 21. The program offers comprehensive and periodic evaluation of a child's health, development, and nutritional status, as well as vision,

dental, and hearing care. See also **COMPREHENSIVE CARE PROGRAM; EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT.**

TEXAS HOME LIVING WAIVER (TxHmL)—A waiver of the Medicaid State Plan granted under Section 1915(c) of the Social Security Act, which allows Texas to provide community-based services to current Medicaid recipients with intellectual disabilities or related conditions as an alternative to an ICF/IID. This waiver program is administered by the Texas Department of Aging and Disability Services (DADS). See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY AND RELATED CONDITIONS; WAIVER; 1915(c).**

TEXAS INTEGRATED ELIGIBILITY AND REDESIGN SYSTEM (TIERS)—The technology and automated systems that support eligibility services for programs administered by HHSC. TIERS replaced several outdated technology and automation systems with a modernized eligibility system that supports the business processes and improves service delivery.

TEXAS MEDICAID & HEALTHCARE PARTNERSHIP (TMHP)—Entity that serves as the Medicaid claims administrator. As claims administrator, TMHP processes and adjudicates claims for Medicaid services provided in the traditional, fee-for-service system. TMHP does not process or adjudicate claims for services provided by Medicaid managed care organizations (MCOs), but does collect encounter data from the MCOs for use in evaluation of quality and utilization of managed care services. See also **CLAIMS ADMINISTRATOR; ENCOUNTER DATA.**

TEXAS MEDICAID MANAGEMENT INFORMATION SYSTEM (TMMIS)—The claims processing and information retrieval system that states are required to have to operate Medicaid programs. The MMIS is an integrated group of procedures and computer processing operations (subsystems) that enable management of administrative costs; services to clients and providers; inquiries; claims control; and management reporting. The capabilities needed to operate under managed care differ somewhat from those required under traditional Medicaid. See also **MEDICAID ELIGIBILITY AND HEALTH INFORMATION SERVICES SYSTEM.**

TEXAS WOMEN’S HEALTH PROGRAM—State-funded program that provides eligible Texas women with preventive health care, screenings, contraceptives and treatment for certain sexually transmitted diseases (STDs). See also **WOMEN’S HEALTH PROGRAM.**

TITLES OF THE 1965 SOCIAL SECURITY ACT—

II Old-Age, Survivors, and Disability Insurance Benefits (Social Security or OASDI)

- IV-A Temporary Assistance for Needy Families (TANF)
- IV-B Child Welfare
- IV-D Child Support
- IV-E Foster Care and Adoption
- IV-F Job Opportunities and Basic Skills Training
- V Maternal and Child Health Services
- XVI Supplemental Security Income (SSI)
- XVIII Medicare
- XIX Medicaid
- XX Social Services
- XXI Children's Health Insurance Program (CHIP) - Added by the Balanced Budget Act (BBA) of 1997

TRADITIONAL MEDICAID—The traditional health care payment system, also known as fee-for-service reimbursement, under which physicians, THSteps dentists, and other providers receive a payment for each unit of service they provide. See also **FEE-FOR-SERVICE REIMBURSEMENT**.

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)—A conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life

U

UNCOMPENSATED CARE POOL—One of two payment pools available from the 1115 Transformation Waiver. Uncompensated Care (UC) Pool payments are cost-based and help offset the costs of uncompensated care provided by hospitals and other providers. UC payments will be based on each provider's UC costs as reported on a UC application. See also **1115 TRANSFORMATION WAIVER, DELIVERY SYSTEM REFORM INCENTIVE PAYMENT POOL**.

UNDUPLICATED COUNT OF MEDICAID ELIGIBLES PER YEAR—In a given year, some persons may enter and exit the Medicaid program on more than one occasion. Under this concept, persons certified eligible for one or more months during the year are counted only one time for the year to avoid multiple counts per eligible.

UPPER PAYMENT LIMIT (UPL)—Federal limits on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans.

Payments in excess of the UPL do not qualify for federal Medicaid matching funds. See also **TRANSFORMATION 1115 WAIVER**.

UTILIZATION—The extent to which the members of a covered group use a program or obtain a particular service or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.

UTILIZATION MANAGEMENT (UM)—A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payors.

UTILIZATION REVIEW (UR)—A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent, or retrospective basis.

V

VENDOR DRUG PROGRAM—A Texas Medicaid program that administers the outpatient prescription drug benefit, an optional service under federal Medicaid law that has been available to all Texas Medicaid clients since September 1971. Pays for up to three prescriptions a month per adult in FFS programs. Nursing facility residents, 1915(c) waiver participants, adults enrolled in managed care, and children under age 21 are not subject to the three-prescription limitation. Provides statewide access to covered outpatient drugs for clients enrolled in either a Medicaid Managed Care Organization (MCO) or that have traditional Medicaid, also known as fee for service (FFS). Manages formularies, the preferred drug list, prior authorization criteria, rebates; defines and manages pharmacy benefit policies for both FFS and MCO clients. Performs prospective and retrospective drug utilization reviews for FFS clients.

W

WAIVER—An exception to the usual Medicaid requirements granted to a state by the Centers for Medicare & Medicaid Services (CMS). See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; 1115(a); 1915(b); 1915(c)**.

WOMEN'S HEALTH PROGRAM (WHP)—A Medicaid waiver program that provided family planning services and related health screenings to eligible uninsured women ages 18 to 44 with net family incomes at or below 185 percent of the federal poverty level (FPL). The Centers for Medicare & Medicaid Services approved a five-year waiver for WHP with an implementation date of January 1, 2007. The Medicaid waiver was not

renewed, and WHP ended on December 31, 2013. A state-funded Texas Women's Health Program (TWHP) was fully implemented on January 1, 2013. See also **TEXAS WOMEN'S HEALTH PROGRAM**.

X

Y

YOUTH EMPOWERMENT SERVICES WAIVER (YES)—A Texas Home and Community-Based Waiver program that provides services to children and adolescents ages 3 to 19 who are at risk of hospitalization because of serious emotional disturbance. The program is available in Bexar, Brazoria, Cameron, Ft. Bend, Galveston, Harris, Hidalgo, Tarrant, Travis, and Willacy counties.

Z

Numbered Terms

1115(a)—Section of the Social Security Act, which allows states to waive provisions of Medicaid law to test new concepts which are consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY; WAIVER**.

1902(a)(1)—Section of the Social Security Act, which requires that state Medicaid programs be in effect “in all political subdivisions of the state.” See also **STATEWIDENESS; WAIVER; 1915(b); 1915(c)**.

1902(a)(10)—Section of the Social Security Act, which requires that state Medicaid programs provide services to people that are comparable in amount, duration, and scope. See also **COMPARABILITY; WAIVER; 1915(b)**.

1902(a)(23)—Section of the Social Security Act, which requires that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service. See also **FREEDOM OF CHOICE; WAIVER; 1915(b)**.

1902(r)(2)—Section of the Social Security Act, which allows states to use more liberal income and resource methodologies than those used to determine Supplemental

Security Income eligibility for determining Medicaid eligibility. See also **SUPPLEMENTAL SECURITY INCOME**.

1903(m)—Section of the Social Security Act, which allows state Medicaid programs to develop risk contracts with managed care organizations or comparable entities. See also **RISK CONTRACT**.

1915(b)—Section of the Social Security Act, which allows states to waive freedom of choice. States may require that beneficiaries enroll in managed care organizations or other programs. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; WAIVER**.

1915(c)—Section of the Social Security Act which allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions, Nursing Facility, Institution for Mental Disease, or inpatient hospital. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE & MEDICAID SERVICES; COMMUNITY-BASED ALTERNATIVES WAIVER; COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM; DEAF-BLIND MULTIPLE DISABILITIES WAIVER; HOME AND COMMUNITY-BASED SERVICES WAIVER; MEDICALLY DEPENDENT CHILDREN PROGRAM; NURSING FACILITIES; STAR+PLUS PROGRAM; TEXAS HOME LIVING WAIVER; WAIVER; YOUTH EMPOWERMENT SERVICES**.

1915(c)(7)(b)—Section of the Social Security Act which allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities, but require specialized services. Waivers must be approved by the Centers for Medicare & Medicaid Services. See also **CENTERS FOR MEDICARE AND MEDICAID SERVICES; HOME AND COMMUNITY-BASED SERVICES; WAIVER**.

1929—Section of the Social Security Act, which allows states to provide a broad range of home and community-based care to individuals with functional disabilities as an optional state plan benefit. In all states but Texas, the option can serve only people over 65. In Texas, individuals of any age may qualify to receive personal care services through section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also **COMMUNITY ATTENDANT SERVICES**.

Appendices

Appendix A: Texas Medicaid Enrollment Statistics

Appendix B: Medicaid and CHIP Service Areas

Appendix C: Regional Healthcare Partnership Regions

Appendix D: Medicaid Expenditure History (FFYs 1987-2012)

Appendix E: Texas Medicaid Waivers

Appendix A:

Texas Medicaid Enrollment Statistics

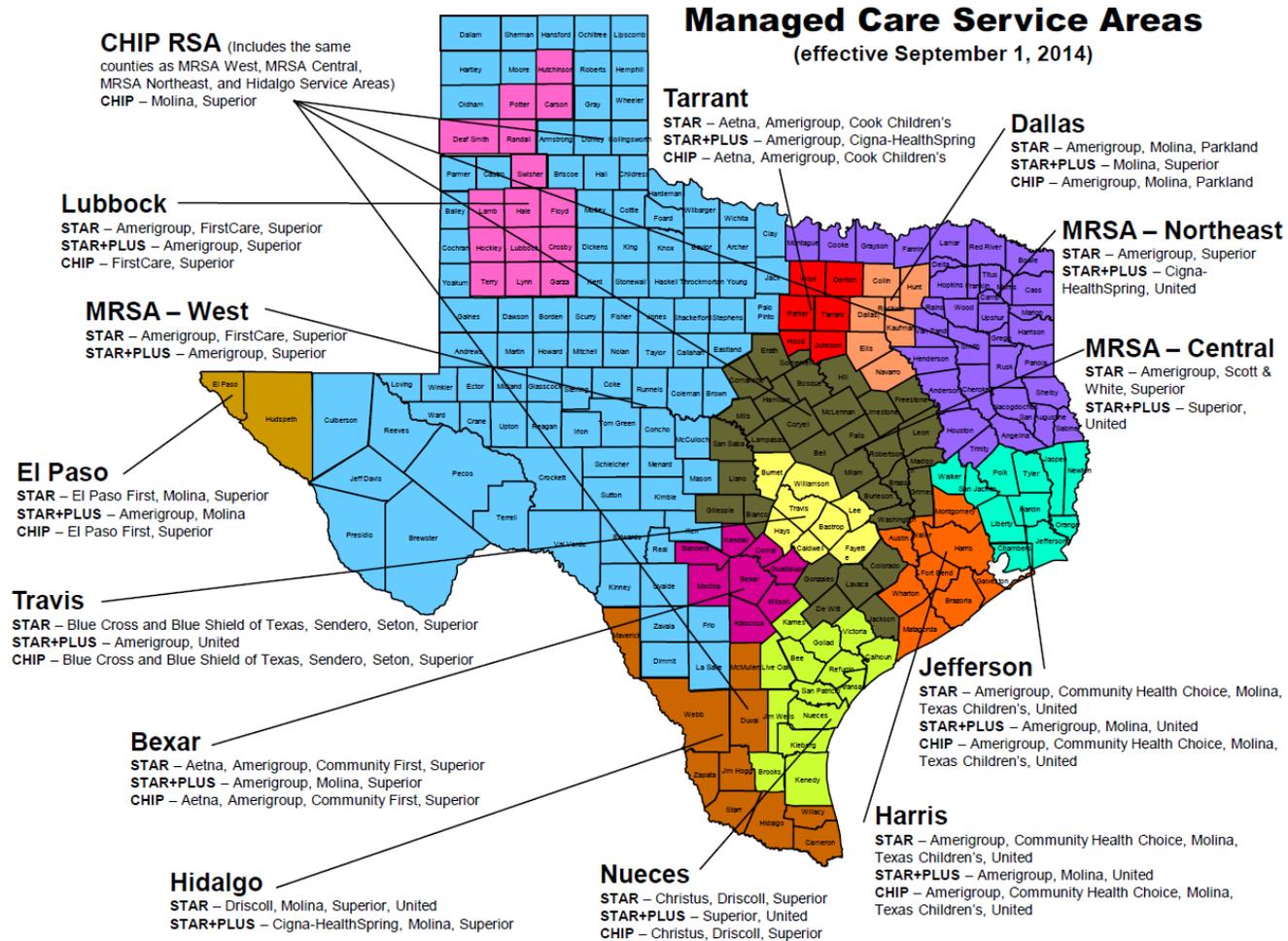
Texas Medicaid Enrollment Statistics may be accessed at the following web address:

<http://www.hhsc.state.tx.us/research/MedicaidEnrollment/MedicaidEnrollment.asp>

The statistics are not printed in this publication because they are frequently updated. The most recent authoritative statistics are available at the website.

Appendix B:

Medicaid and CHIP Service Areas



Medicaid and CHIP Service Areas

Managed Care Service Areas (effective September 1, 2014)

CHIP RSA includes the same counties as MRSA West, MRSA Central, MRSA Northeast, and Hidalgo Service Areas. CHIP - Molina, Superior

MRSA - Central

STAR - Amerigroup, Scott & White, Superior

STAR+PLUS - Superior, United

MRSA - Northeast

STAR - Amerigroup, Superior

STAR+PLUS - Cigna-HealthSpring, United

MRSA - West

STAR - Amerigroup, FirstCare, Superior

STAR+PLUS - Amerigroup, Superior

Bexar

STAR - Aetna, Amerigroup, Community First, Superior

STAR+PLUS - Amerigroup, Molina, Superior

CHIP - Aetna, Amerigroup, Community First, Superior

DALLAS

STAR - Amerigroup, Molina, Parkland

STAR+PLUS - Molina, Superior

CHIP - Amerigroup, Molina, Parkland

El Paso

STAR - El Paso First, Molina, Superior

STAR+PLUS - Amerigroup, Molina

CHIP - El Paso First, Superior

Harris

STAR - Amerigroup, Community Health Choice, Molina, Texas Children's, United

STAR+PLUS - Amerigroup, Molina, United

CHIP - Amerigroup, Community health Choice, Molina, Texas Children's, United

Hidalgo

STAR - Driscoll, Molina, Superior, United

STAR+PLUS - Cigna-HealthSpring, Molina, Superior

Jefferson

STAR - Amerigroup, Community Health Choice, Molina, Texas Children's United

STAR+PLUS - Amerigroup, Molina, United

CHIP_ Amerigroup, Community Health Choice, Molina, Texas Children's, United

Lubbock

STAR - Amerigroup, FirstCare, Superior

STAR+PLUS - Amerigroup, Molina

CHIP - FirstCare, Superior

Nueces

STAR - Christus, Driscoll, Superior

STAR_PLUS - Superior, United

CHIP - Christus, Driscoll, Superior

Tarrant

STAR - Aetna, Amerigroup, Cook Children's

STAR+PLUS - Amerigroup, Cigna-HealthSpring

CHIP - Aetna, Amerigroup, Cook Children's

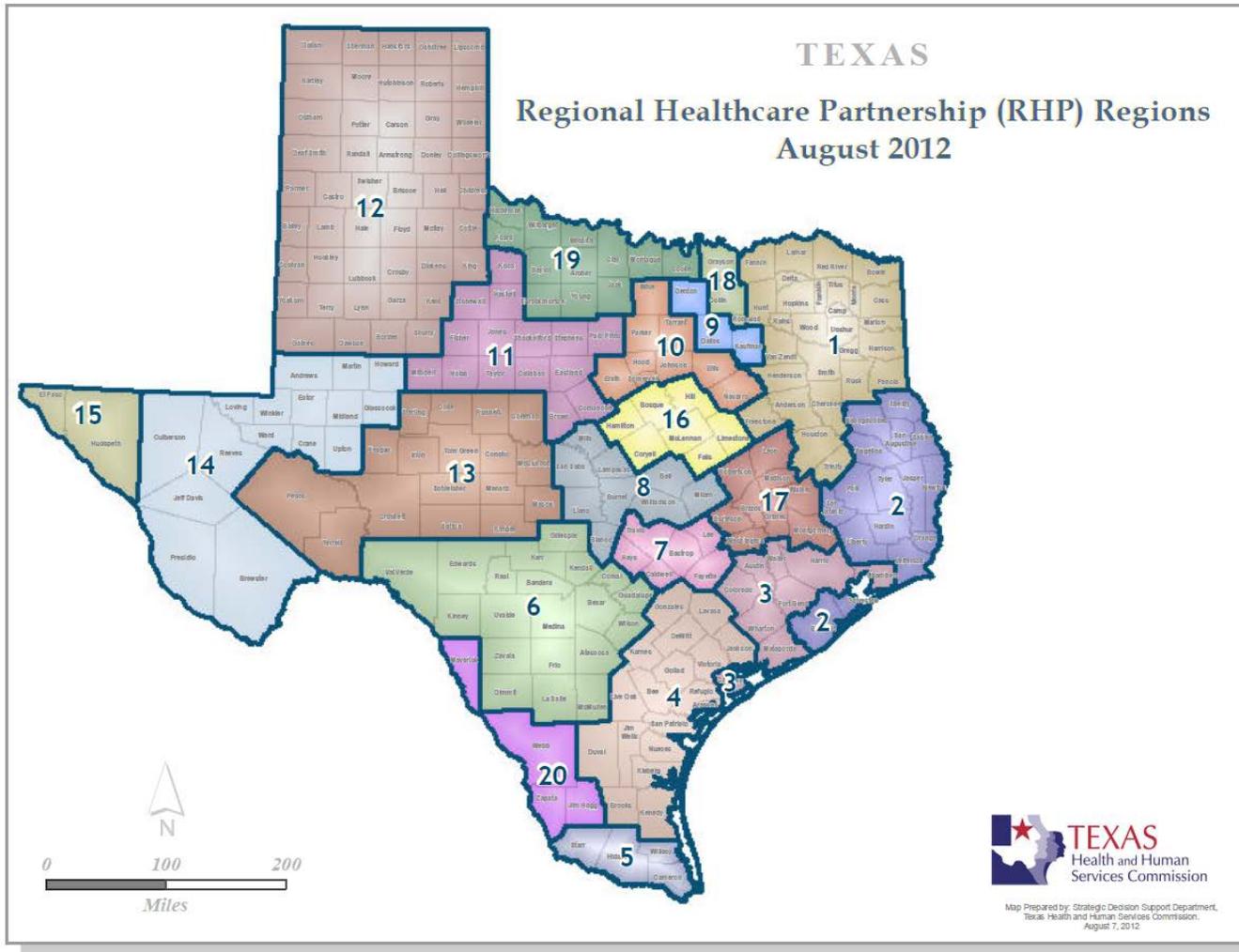
Travis

SAR - Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior

STAR+PLUS - Amerigroup, United

CHIP - Blue Cross and Blue Shield of Texas, Sendero, Seton, Superior

Appendix C: Regional Healthcare Partnership Regions



Appendix C-1

Regional Healthcare Partnership (RHP) Regions by County

RHP 1 includes the following 28 counties: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood.

RHP 2 includes the following 16 counties: Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

RHP 3 includes the following 9 counties: Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, and Wharton.

RHP 4 includes the following 18 counties: Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.

RHP 5 includes the following 4 counties: Cameron, Hidalgo, Starr and Willacy.

RHP 6 includes the following 20 counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kier, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

RHP 7 includes the following 6 counties: Bastrop, Caldwell, Fayette, Hays, Lee and Travis.

RHP 8 includes the following 9 counties: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

RHP 9 includes the following 3 counties: Dallas, Denton, and Kaufman.

RHP 10 includes the following 9 counties: Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise.

RHP 11 includes the following 15 counties: Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, and Taylor.

RHP 12 includes the following 47 counties: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Harley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, and Yoakum.

RHP 13 includes the following 17 counties: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green.

RHP 14 includes the following 16 counties: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler.

RHP 15 includes the following 2 counties: El Paso and Hudspeth.

RHP 16 includes the following 7 counties: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, and McLennan.

RHP 17 includes the following 9 counties: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington.

RHP 18 includes the following 3 counties: Collin, Grayson, and Rockwall.

RHP 19 includes the following 12 counties: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young.

RHP 20 includes the following 4 counties: Jim Hogg, Maverick, Webb, and Zapata.

Appendix D: Medicaid Expenditure History (FFYs 1987-2012)

(Shown in Dollars)

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2012	FED	13,773,119,669	882,595,210	1,400,669,919	0	28,108,056	651,723,257	22,796,293	16,759,012,404
2012	FEDARRA	6,301,635	0	12,501,171	0	0	209,039,020	0	227,841,826
2012	NONFED	9,833,604,615	633,370,455	981,318,763	344,689,503	11,194,337	549,535,172	7,598,764	12,361,311,609
2012	TOTAL	23,613,025,919	1,515,965,665	2,394,489,853	344,689,503	39,302,393	1,410,297,449	30,395,057	29,348,165,839
2011	FED	14,093,145,087	956,328,092	1,829,711,562	0	20,859,639	757,489,799	23,918,822	17,681,453,001
2011	FEDARRA	1,395,373,748	0	231,747,606	0	0	0	0	1,627,121,354
2011	NONFED	7,740,645,123	622,813,407	977,218,223	277,468,044	7,982,215	490,315,493	7,912,940	10,124,355,445
2011	TOTAL	23,229,163,958	1,579,141,499	3,038,677,391	277,468,044	28,841,854	1,247,805,292	31,831,762	29,432,929,800
2010	FED	12,670,015,218	991,515,974	1,849,499,135	0	0	586,821,439	23,347,881	16,121,199,647
2010	FEDARRA	2,599,216,338	0	366,322,520	0	0	0	0	2,965,538,858
2010	NONFED	6,231,480,571	696,673,993	925,963,561	188,351,774	0	513,545,911	7,782,627	8,563,798,437
2010	TOTAL	21,500,712,127	1,688,189,967	3,141,785,216	188,351,774	0	1,100,367,350	31,130,508	27,650,536,942
2009	FED	11,459,866,620	1,039,079,294	1,201,856,755	0	0	636,883,348	23,165,283	14,360,851,300
2009	FEDARRA	1,859,683,982	0	150,021,060	0	0	0	0	2,009,705,042
2009	NONFED	5,921,806,283	706,583,565	661,117,426	327,634,996	0	561,446,142	7,721,761	8,186,310,173

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2009	TOTAL	19,241,356,885	1,745,662,859	2,012,995,241	327,634,996	0	1,198,329,490	30,887,044	24,556,866,515
2008	FED	10,832,854,989	883,680,199	1,088,847,704	0	0	481,722,418	21,356,073	13,308,461,383
2008	NONFED	7,008,251,340	575,131,872	708,409,954	302,556,548	0	399,086,620	7,301,053	9,000,737,387
2008	TOTAL	17,841,106,329	1,458,812,071	1,797,257,658	302,556,548	0	880,809,038	28,657,126	22,309,198,770
2007	FED	9,861,133,978	873,937,391	1,617,227,545	0	0	440,210,762	20,346,453	12,812,856,129
2007	NONFED	6,315,914,704	564,307,501	1,046,299,576	291,277,489	0	338,701,922	7,076,041	8,563,577,233
2007	TOTAL	16,177,048,682	1,438,244,892	2,663,527,121	291,277,489	0	778,912,684	27,422,494	21,376,433,362
2006	FED	9,503,544,739	936,191,170	321,502,444	0	0	410,949,395	20,456,568	11,192,644,316
2006	NONFED	6,116,652,611	606,659,285	205,233,344	159,219,288	0	316,076,674	6,969,341	7,410,810,543
2006	TOTAL	15,620,197,350	1,542,850,455	526,735,788	159,219,288	0	727,026,069	27,425,909	18,603,454,859
2005	FED	9,077,320,590	908,414,221	549,604,508		0	373,116,681	19,451,903	10,927,907,903
2005	NONFED	5,794,731,073	585,700,666	348,295,072		0	289,344,299	6,660,594	7,024,731,704
2005	TOTAL	14,872,051,663	1,494,114,887	897,899,580		0	662,460,980	26,112,497	17,952,639,607
2004	FED	8,678,745,398	869,223,358	483,303,343		(26)	389,375,329	23,084,967	10,443,732,369
2004	NONFED	5,179,267,104	574,611,677	292,544,114		(10)	305,782,584	8,345,784	6,360,551,253
2004	TOTAL	13,858,012,502	1,443,835,035	775,847,457		(36)	695,157,913	31,430,751	16,804,283,622
2003	FED	8,523,884,893	791,785,561	174,384,387		325,866	441,560,500	22,609,728	9,954,550,935
2003	NONFED	5,287,505,815	527,669,309	114,796,731		126,523	308,399,611	8,273,342	6,246,771,331
2003	TOTAL	13,811,390,708	1,319,454,870	289,181,118		452,389	749,960,111	30,883,070	16,201,322,266
2002	FED	7,200,650,505	856,845,057	101,119,555		5,293,898	385,752,228	23,561,365	8,573,222,608
2002	NONFED	4,731,656,102	566,278,053	66,936,877		2,046,304	321,007,611	8,461,063	5,696,386,010

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2002	TOTAL	11,932,306,607	1,423,123,110	168,056,432		7,340,202	706,759,839	32,022,428	14,269,608,618
2001	FED	6,218,950,847	816,205,002			15,175,971	356,949,745	26,815,050	7,434,096,615
2001	NONFED	4,018,594,759	529,928,950			5,784,084	299,645,937	9,642,811	4,863,596,541
2001	TOTAL	10,237,545,606	1,346,133,952			20,960,055	656,595,682	36,457,861	12,297,693,156
2000	FED	5,734,705,707	792,892,647			24,782,216	337,690,078	20,926,868	6,910,997,516
2000	NONFED	3,584,437,280	497,767,952			9,186,259	281,361,079	7,385,719	4,380,138,289
2000	TOTAL	9,319,142,987	1,290,660,599			33,968,475	619,051,157	28,312,587	11,291,135,805
1999	FED	5,502,666,857	978,836,976			34,672,162	381,132,417	20,266,100	6,917,574,512
1999	NONFED	3,280,898,782	588,918,615			12,360,559	286,083,947	9,205,869	4,177,467,772
1999	TOTAL	8,783,565,639	1,567,755,591			47,032,721	667,216,364	29,471,969	11,095,042,284
1998	FED	5,206,901,770	896,061,504			1,275,401	319,762,855	20,698,286	6,444,699,816
1998	NONFED	3,129,535,087	542,701,348			457,481	257,189,385	7,502,162	3,937,385,463
1998	TOTAL	8,336,436,857	1,438,762,852			1,732,882	576,952,240	28,200,448	10,382,085,279
1997	FED	5,009,759,115	946,502,300				269,284,914	19,617,166	6,245,163,495
1997	NONFED	2,976,831,733	566,448,944				232,368,559	6,994,174	3,782,643,410
1997	TOTAL	7,986,590,848	1,512,951,244				501,653,473	26,611,340	10,027,806,905
1996	FED	5,108,085,992	642,617,067				247,143,021	24,216,938	6,022,063,018
1996	NONFED	2,585,554,740	870,411,932				206,654,747	6,607,708	3,669,229,127
1996	TOTAL	7,693,640,732	1,513,028,999				453,797,768	30,824,646	9,691,292,145
1995	FED	4,544,466,020	957,898,654				211,689,405	20,118,316	5,734,172,395
1995	NONFED	2,612,319,858	555,130,339				188,814,022	6,981,582	3,363,245,801

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
1995	TOTAL	7,156,785,878	1,513,028,993				400,503,427	27,099,898	9,097,418,196
1994	FED	4,270,641,038	971,062,012				198,029,052	19,316,416	5,459,048,518
1994	NONFED	2,360,183,388	541,966,987				160,067,282	6,415,666	3,068,633,323
1994	TOTAL	6,630,824,426	1,513,028,999				358,096,334	25,732,082	8,527,681,841
1993	FED	3,569,242,225	974,995,888				155,868,466	20,513,859	4,720,620,438
1993	NONFED	1,948,029,707	538,033,111				129,153,725	5,503,221	2,620,719,764
1993	TOTAL	5,517,271,932	1,513,028,999				285,022,191	26,017,080	7,341,340,202
1992	FED	2,948,647,567	971,062,082				123,414,862	18,885,864	4,062,010,375
1992	NONFED	1,626,232,439	541,967,026				94,202,135	3,994,498	2,266,396,098
1992	TOTAL	4,574,880,006	1,513,029,108				217,616,997	22,880,362	6,328,406,473
1991	FED	2,350,151,845	214,805,534				118,060,228	15,933,352	2,698,950,959
1991	NONFED	1,333,584,342	123,311,157				89,031,684	1,770,373	1,547,697,556
1991	TOTAL	3,683,736,187	338,116,691				207,091,912	17,703,725	4,246,648,515
1990	FED	1,863,974,540	21,514,951				102,357,638	5,445,088	1,993,292,217
1990	NONFED	1,169,372,627	13,622,974				77,494,462	2,279,100	1,262,769,163
1990	TOTAL	3,033,347,167	35,137,925				179,852,100	7,724,188	3,256,061,380
1989	FED	1,340,004,922	2,856,043				74,271,644	4,280,883	1,421,413,492
1989	NONFED	918,684,239	1,981,428				64,167,288	1,753,568	986,586,523
1989	TOTAL	2,258,689,161	4,837,471				138,438,932	6,034,451	2,408,000,015
1988	FED	1,150,178,441	2,615,451				77,693,637	3,492,504	1,233,980,033
1988	NONFED	862,440,962	1,980,316				52,921,591	1,434,965	918,777,834

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
1988	TOTAL	2,012,619,403	4,595,767				130,615,228	4,927,469	2,152,757,867
1987	NONFED	856,998,819	6,000,000				47,919,981	1,580,832	912,499,632
1987	TOTAL	1,917,125,335	13,380,910				118,610,051	5,416,245	2,054,532,541

Appendix E: Texas Medicaid Waivers

Waiver	Type	Description	Services Covered	Operating Agency
Texas Healthcare Transformation and Quality Improvement Program	1115	Texas Healthcare Transformation and Quality Improvement Program, known as the 1115 Transformation Waiver, is a five-year demonstration waiver that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit (UPL) payments. The waiver provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds through a program and process that is transparent and accountable for public funds.	STAR, STAR+PLUS, and dental managed care services, and through approved regional health partnership projects participating providers will develop and implement programs, strategies, and investments to enhance: access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served.	HHSC
Youth Empowerment Services (YES)	1915(c)	YES is a home and community-based waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families. YES is currently only available in Bexar, Brazoria, Cameron, Galveston, Ft. Bend, Harris, Hidalgo, Tarrant, Travis and Willacy counties and can serve up to 400 youth, ages 3 through 18.	Respite, adaptive aids and supports, community living supports (CLS), family supports, minor home modifications, non-medical transportation, paraprofessional services, professional services, specialized psychiatric observation, supportive family-based alternatives, and transitional services.	DSHS

Waiver	Type	Description	Services Covered	Operating Agency
NorthSTAR	1915(b)	NorthSTAR is an integrated behavioral health delivery system in the Dallas service area, serving people who are eligible for Medicaid or who meet other eligibility criteria. STAR and STAR+PLUS clients in Dallas and six contiguous counties (Collin, Hunt, Rockwall, Kaufman, Ellis, and Navarro) around Dallas receive behavioral health services through NorthSTAR. Non-Medicaid eligible individuals who reside in the service area and meet clinical and income criteria are eligible to receive services through NorthSTAR via an application process.	Behavioral health services (mental health and substance use disorder) in a managed care setting, coordinated mental health and substance abuse/chemical dependency services that exceed the traditional Medicaid service array.	DSHS
Non-Emergency Medical Transportation (NEMT)	1915(b)	The Texas Medical Transportation Program (MTP) or its designee (Full-risk Broker), is responsible for arranging and administering cost-effective, nonemergency medical transportation (NEMT) services to Medicaid, Children with Special Health Care Needs (CSHCN), and Transportation Indigent Cancer Patients (TICP) clients who do not have any other means of transportation to access medically necessary covered services..	Demand response transportation services are provided or arranged by contracted transportation providers when fixed route transportation or mileage reimbursement is not available or does not meet the client's transportation to healthcare needs.	HHSC
Texas Medicaid Wellness Program	1915(b)	Texas Medicaid Wellness program is a community-based, holistic care management program that enrolls high-risk traditional Medicaid clients with complex, chronic or co-morbid conditions and provides interventions to individuals at the highest risk of utilization of medical services.	Holistic and extensive care management from a care team, telephonic and face-to-face visits, educational mailings quarterly and 24-hour nurse advice line.	HHSC

Waiver	Type	Description	Services Covered	Operating Agency
Medically Dependent Children Program (MDCP)	1915(c)	MDCP provides community-based services to children and young adults under 21 years of age as an alternative to residing in a nursing facility.	Respite, financial management, adaptive aids, adjunct support, flexible family support services, minor home modifications, and transition assistance services.	DADS
Home and Community-based Services (HCS)	1915(c)	HCS provides individualized services to clients of all ages who qualify for ICF/IID level of care yet live in their family's home, their own homes, or other settings in the community.	Day habilitation, respite, supported employment, prescriptions, financial management, support consultation, adaptive aids, dental treatment, minor home modifications, residential assistance (foster/companion care, supervised living, residential support services), skilled nursing, specialized therapies (speech and language pathology, audiology, occupational therapy, physical therapy, dietary, behavioral support, social work), and supported home living.	DADS
Community Living Assistance and Support Services (CLASS)	1915(c)	CLASS provides home and community-based services to clients who have a "related condition" diagnosis qualifying them for placement in an Intermediate Care Facility. A related condition is a disability other than an intellectual or development disability which originates before age 22 and which substantially limits life activity.	Case management, prevocational services, residential habilitation, respite (in-home and out-of-home), supported employment, adaptive aids/medical supplies, dental services, occupational therapy, physical therapy, prescriptions, skilled nursing, speech, hearing, and language services, financial management services, support consultation, behavioral support, continued family services, employment assistance, minor home modifications, specialized therapies, support family services, and transition assistance services.	DADS
Deaf-Blind with Multiple Disabilities (DBMD)	1915(c)	DBMD provides home and community-based services as an alternative to residing in an ICF/IID to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness and have an additional disability.	Case management, day habilitation, residential habilitation, respite, supported employment, prescription medications, financial management services, support consultation, adaptive aids and medical supplies, assisted living, behavioral	DADS

Waiver	Type	Description	Services Covered	Operating Agency
			support, chore service, dental treatment, dietary services, employment assistance, intervener, minor home modifications, nursing, orientation and mobility, speech, hearing and language therapy services, specialized therapies, and transition assistance services.	
Texas Home Living (TxHmL)	1915(c)	TxHmL provides selected services and supports for people with intellectual developmental disabilities who live in their family homes or their own homes.	Case management, adaptive aids, minor home modifications, audiology, speech therapy, occupational therapy, physical therapy, dietary services, behavioral supports, dental treatment, nursing, residential assistance, community support, respite, supported employment, and day habilitation.	DADS