

Texas Medicaid and CHIP in Perspective

Eleventh Edition

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Texas Medicaid and CHIP in Perspective

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Acknowledgments

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Data Sources

Information contained in the 11th edition was current as of August 2016. However, program and financial information may change after publication due to unforeseen changes to federal and state regulations, the state of the economy, and other factors.

Medicaid is a complex program involving multiple agencies and external partners that collect program statistics and financial information. 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 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 & Healthcare Partnership 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 Unpublished analyses conducted by HHSC Financial Services staff are also used to provide financial information.

Foreword

Greetings -

I am pleased to introduce the 11th edition of *Texas Medicaid and CHIP in Perspective*.

The last two years have ushered in many exciting changes for Medicaid and CHIP services in Texas, including the continued expansion and advancement of managed care, which now serves 92 percent of the programs' populations.

Most notably, on November 1, 2016, Medicaid integrated over 160,000 children and young adults into managed care with the implementation of STAR Kids. STAR Kids, administered by 10 managed care organizations across 13 service delivery areas throughout the State of Texas, offers a full range of medical, behavioral health and long-term services and supports to qualifying individuals. STAR Kids also provides access to a strengths-based assessment process, person-centered planning, and ongoing service coordination.

Over the next four years, additional populations will be integrated into Texas' comprehensive managed care framework. Members receiving Adoption Assistance and Permanency Care Assistance Medicaid and services under the Medicaid for Breast and Cervical Cancer program will transition into managed care on September 1, 2017. Consistent with the direction offered by House Bill 3523, 84th Legislature, Regular Session, 2015, the Medicaid & CHIP Services Department will facilitate the transfer of Texas Home Living (TxHmL) waiver services into the STAR+PLUS program on September 1, 2018.

Additionally, on September 1, 2021, services and supports offered to individuals currently enrolled in the Community Living Assistance and Support Services (CLASS), Deaf-Blind with Multiple Disabilities (DBMD), and Home and Community-based Services (HCS) waivers, along with services and supports provided in community-based intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) will transition into STAR+PLUS.

September 1st of this year marks the 50th anniversary of Medicaid in Texas. As we reflect on the program's development over the last half century, it

is important we take note of our progress and the tremendous role the stakeholder community has played in shaping the Medicaid and CHIP service delivery system in Texas. We look forward to partnering with stakeholders and advocates in the coming years as we explore opportunities to maximize innovation, integrate critical clinical expertise, and uphold our member-focused approach to care – striving to produce better health outcomes for those we serve.

A handwritten signature in black ink, appearing to read "Jami Snyder". The signature is fluid and cursive, with the first name "Jami" and last name "Snyder" clearly distinguishable.

Jami Snyder
State Medicaid Director
Associate Commissioner, Medicaid & CHIP Services Department

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Part I. Medicaid and CHIP: An Overview

**Chapter 1:
Medicaid and CHIP Basics**

In This Chapter:

What is Medicaid?

- How Medicaid is Financed
- 1115 Transformation Waiver

What is CHIP?

- CHIP Perinatal

Medicaid and CHIP Coverage

- Acute Health Care
- Long-Term Services and Supports
- Behavioral Health
- Comparing Medicaid and Private Insurance Benefits
- Mandatory and Optional Spending

Basic Principles

State Plans

Waivers

Fee-for-Service and Managed Care

STAR

STAR+PLUS

STAR Health

STAR Kids

Dual Demonstration

Medicare Advantage Dual

Eligible Special Needs Plan

Children’s Medicaid Dental Services Program

The Medicaid Numbers

What is Medicaid?

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

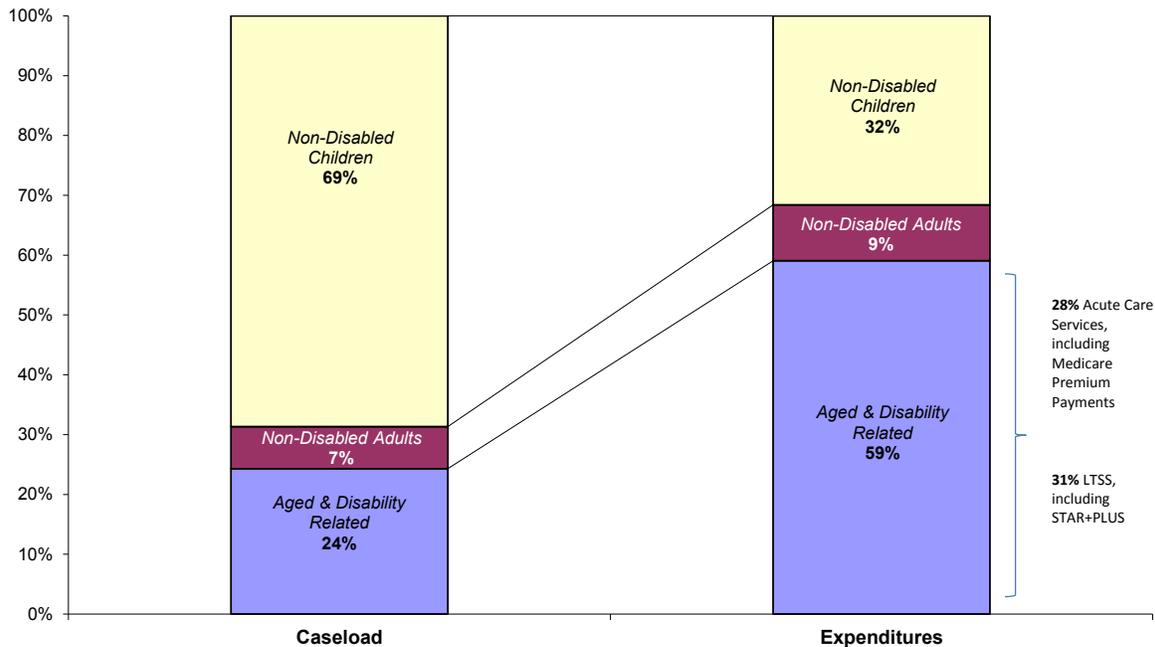
criteria within federal minimum standards. States can apply to the Centers for Medicare & Medicaid Services (CMS) for a waiver of federal law to expand health coverage beyond these groups. Medicaid is an entitlement program, which means the federal government does not, and a state cannot, limit the number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

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

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

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

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

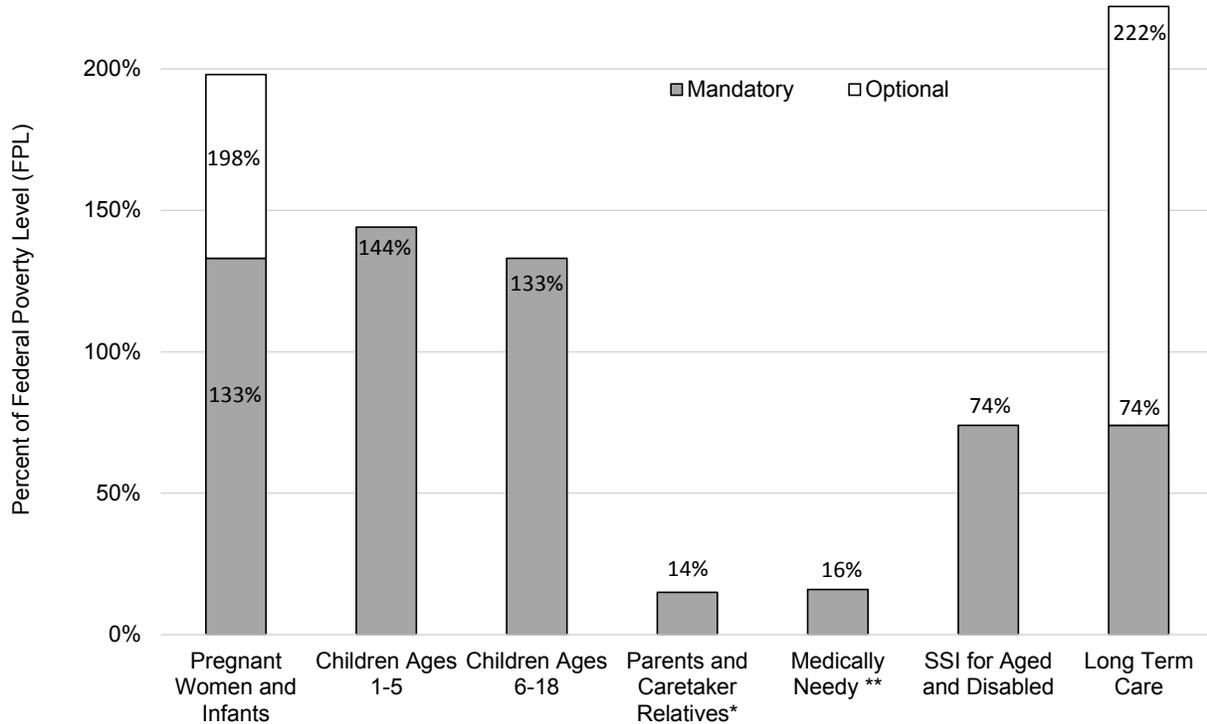
Figure 1.1: Texas Medicaid Beneficiaries and Expenditures, SFY 2015

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

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories states are allowed, but not required, to cover under their Medicaid programs. For example, Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 198 percent of the federal poverty level (FPL). The federal requirement for pregnant women and infants is 133 percent of the FPL.

Figure 1.2 depicts the current Texas Medicaid income eligibility levels for the most common Medicaid eligibility categories. Mandatory levels identify the coverage levels required by the federal government. Optional levels show coverage Texas has implemented at higher levels allowed but not mandated by the federal government.

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



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

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

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

How Medicaid Is Financed

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

an estimated 28.6 percent of Texas' budget.¹

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

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

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

The federal government matches other program costs at a different rate than the FMAP. Medicaid administrative costs are generally matched at 50 percent. Administrative services that can be performed only by skilled professional medical personnel draw a 75 percent federal match. Family planning services draw a 90 percent federal match. Certain approved information system development costs also are matched at 90 percent.

States may use local government funding for up to 60 percent of the state's share of Medicaid matching funds. Texas uses local government funding for the disproportionate share hospital (DSH) reimbursement program and other Medicaid programs, such as the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver. Through the

waiver, Texas hospitals can receive supplemental funds to cover the costs of providing care to Medicaid and uninsured individuals. The 1115 Transformation Waiver also enables hospitals and other providers to use their local funding to earn additional federal matching funds to reform their delivery systems and improve the quality of care in an evidence-based and transparent manner.

Federal law specifies that taxes on health care providers cannot make up more than 25 percent of the state's share of total Medicaid expenditures.

1115 Transformation Waiver

The Texas Legislature, through the 2012-13 General Appropriations Act (GAA), H.B. 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011, instructed HHSC to expand its use of Medicaid managed care. The Legislature also directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment limit (UPL) program. UPL payments were supplemental payments to offset the difference between what Medicaid pays for a service and what Medicare would pay for the same service.

CMS has interpreted federal regulations to prohibit UPL payments to providers in a managed care

context. Therefore, CMS advised HHSC that, to continue the use of local funding to support supplemental payments to providers in a managed care environment, the state should employ a waiver of the Medicaid state plan as provided by Section 1115 of the Social Security Act.

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

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

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

What is CHIP?

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

CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance.

To qualify for CHIP, a child must be:

- A U.S. citizen or legal permanent resident;
- A Texas resident;
- Under age 19;

- Uninsured for at least 90 days;² and
- Living in a family whose income is at or below 201 percent of the FPL.

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

CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally-matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing a federal match for these children and covering the children meeting Medicaid requirements through Medicaid rather than CHIP.

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

benefits plan due to employment with a public agency (even if the family declined the coverage). The Affordable Care Act (ACA) provides an exception to this exclusion and allows states to provide federally-matched CHIP to the children of public employees effective March 23, 2010, if the state health benefits plan meets the maintenance of effort (MOE) requirements or the child qualifies for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Teacher Retirement System school employee children as of September 1, 2010, and to other eligible public employee children as of September 1, 2011.

CHIP Perinatal

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

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

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

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

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

Medicaid and CHIP Coverage

Medicaid is similar to a basic health insurance program but also provides coverage for people in need of chronic care or LTSS. Other than the Health Insurance Premium Payment program (discussed in **Chapter 14, Finances**), Medicaid does not make cash payments to clients, but instead makes payments directly to health

care providers or managed care organizations (MCOs).

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

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

Acute Health Care

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

Long-Term Services and Supports

Medicaid covers a broad range of LTSS. These services enable people age 65 and over and those with disabilities to experience dignified, independent, and productive lives in safe living environments through a continuum of services and supports ranging from HCBS to institutional services. The demand for LTSS in Texas continues to grow and is influenced by two key trends: the aging of the population and the continuing needs of individuals with co-occurring behavioral health needs. These services and supports accounted for approximately 31 percent of all Texas Medicaid service expenditures in state fiscal year 2015.

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

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

LTSS for people with IDD includes:

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

Behavioral Health

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

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

Comparing Medicaid and Private Insurance Benefits

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

Given the unique concentration of medically high-risk people enrolled in Texas Medicaid, no commercial insurance pool would resemble its client population. Nevertheless,

Table 1.1 provides a high-level comparison of benefits offered under Texas Medicaid with those a typical private employer-sponsored health insurance package might offer.

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

Benefit Type	Medical (Inpatient Hospital, Acute Care)	Dental	Long-Term Services and Supports	Prescription Drugs	Deductible
Medicaid: Children	Yes	Yes	Yes	Yes (Unlimited)	None
Medicaid: Adults	Yes	No	Yes	Yes*	None
Typical Employee Benefit Package (individual adult or child)	Yes (Usually requires a co-pay)	Yes (Separate optional coverage with additional contribution)	No	Yes (Usually requires a co-pay)	\$1,105 - \$1,836 (Varies by plan type and region)

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

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

Mandatory and Optional Spending

The federal government mandates certain benefits and coverage levels. In addition, Texas has also chosen to cover some of the optional services allowed but not required by the federal government (see **Chapter 5, Benefit Basics, Table 5.1: Mandatory and Optional Services Covered by Texas Medicaid**). Eliminating some optional services

and eligibility categories could increase Medicaid costs. For example, dropping the option of covering prescription drugs could ultimately cost Medicaid more. People who do not receive needed drugs may require more physician services, increased hospitalizations, or even LTSS. Similarly, Texas potentially saves money by covering pregnant women up to 198 percent of the FPL because some women may not

otherwise receive adequate prenatal care. This coverage helps prevent poor and costly pregnancy outcomes.

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

The American Recovery and Reinvestment Act of 2009 prohibited states from implementing more restrictive eligibility standards, methodologies, or procedures in Medicaid than were in effect on July 1, 2008. Changes to Medicaid benefits, however, can be made. The ACA continued this MOE requirement (see **Chapter 5, Benefit Basics**).

Basic Principles

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

- Statewideness - All Medicaid services must be available

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

- Comparability - The same level of services (amount, duration, and scope) must be available to all clients, except where federal law specifically requires a broader range of services, such as for Medicaid-eligible children, or allows a reduced package of services, such as for those who qualify as medically needy.
- Freedom of Choice - Clients must be allowed to go to any Medicaid health care provider who meets program standards.
- Sufficiency - States must cover each service in an amount, duration, and scope that is “reasonably sufficient.” States may impose limits on services only for Medicaid clients who are age 21 and over. A state may not arbitrarily limit services for any specific illness or condition.

State Plans

The Medicaid state plan is a document that serves as the contract between the state and CMS for the Texas Medicaid program and gives HHSC the authority to administer the Medicaid program in Texas. It describes the nature and scope of the state’s Medicaid program, including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the

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

Waivers

Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These waivers allow states to waive certain Medicaid basic principles, required array of benefits, mandated eligibility and income groups, or combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.

States seek waivers to:

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

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

Fee-for-Service and Managed Care

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

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

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

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

STAR

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

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

STAR+PLUS

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

STAR Health

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

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

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

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

STAR Kids

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

Dual Demonstration

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

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

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

Medicare Advantage Dual Eligible Special Needs Plan

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

Children's Medicaid Dental Services Program

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

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

The Medicaid Numbers

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

28.6 percent¹

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

32 percent²

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

\$38 billion³

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

\$2.7 billion

Texas Medicaid prescription drug expenditures, state fiscal year 2015:

\$3.7 billion⁴

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

78 percent⁵

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

45 percent

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

63 percent

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

52.2 percent

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

87 percent⁶

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

5.07 million

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

4.06 million

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

15 percent

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

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

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

⁴Includes Medicare "clawback" payments.

⁵Receiving full Medicaid benefits.

⁶Receiving full Medicaid benefits.

Chapter 2: Medicaid and CHIP in Context

The Health Insurance Landscape

Who Are the Uninsured?

An estimated 5.0 million Texans, or 19.1 percent of the state population, had no health insurance in 2014.¹ Texas has the highest rate in the nation for people without insurance.² In 2014, approximately 800,000, or 11.0 percent, of Texas children under age 18 had no insurance (down from 15.6 percent in 2012).³ The national average uninsured rate for children was 6.0 percent.⁴

Most of the uninsured in Texas are adults under age 65. Most adults over age 65 have Medicare. **Figure 2.1** depicts the uninsured population in Texas by age group in 2014.

Data indicates 62 percent of uninsured, non-retired Texans age 18 and older have a job. Uninsured adults may work in jobs that do not

¹ U.S. Census Bureau, 2014 American Community Survey (ACS) for Texas.

² Ibid.

³ Ibid.

⁴ Ibid.

In This Chapter:

The Health Insurance Landscape

Who Are the Uninsured?

Unemployment

Poverty

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Medicare

Medicare Parts A-D

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Administration

Medicaid and CHIP History

Medicaid Enrollment Over Time

Linked to Financial Assistance Programs

Temporary Assistance for Needy Families

Supplemental Security Income

De-Linking Medicaid and Financial Assistance

Affordable Care Act

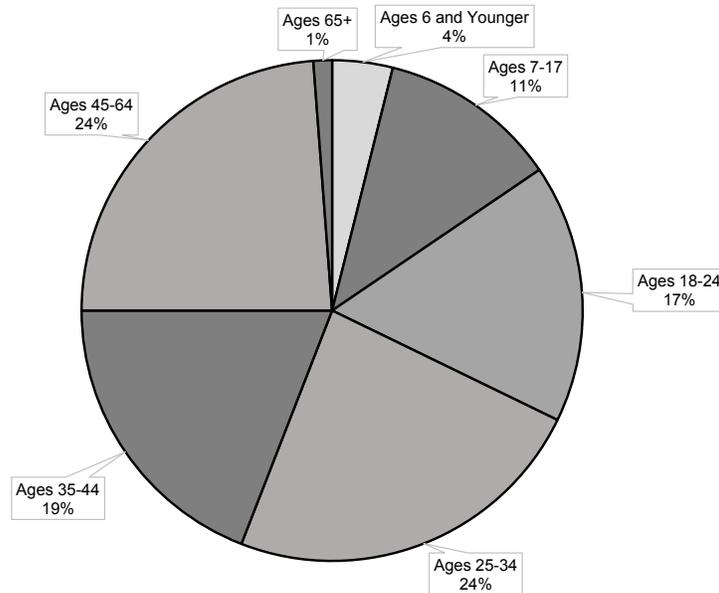
History of CHIP and CHIP Perinatal

2

offer employer-sponsored coverage, or they may not be able to afford the coverage offered. Unless they are caretakers of children eligible for Medicaid, are pregnant, or have

disabilities that qualify them for Supplemental Security Income (SSI), most of these adults are ineligible for Medicaid.

Figure 2.1: Total Uninsured Population in Texas by Age Group, CY 2014



Source: U.S. Census Bureau. 2014 ACS for Texas.

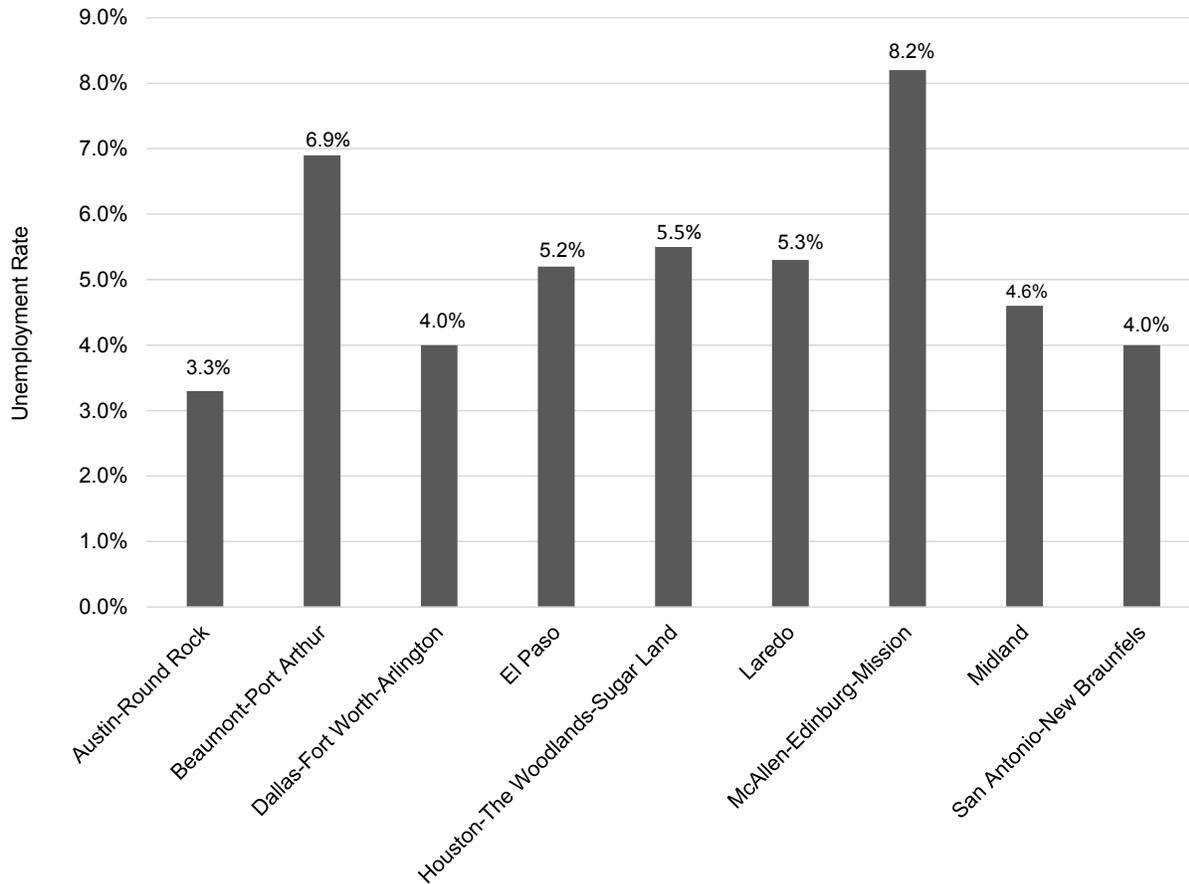
Unemployment

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

In June 2016, Texas’ seasonally adjusted unemployment rate was 4.5 percent, which was lower than the national rate of 4.9 percent. The percentage of working-age persons (ages 16 through 64) in Texas who had a job in June 2016 was 69 percent.

The unemployment rate varies among regions of the state, as shown in **Figure 2.2**. In June 2016, the Metropolitan Statistical Area (MSA) with the lowest unemployment rate was Austin-Round Rock, with a rate of 3.3 percent. The highest unemployment rate was in the McAllen-Edinburg-Mission MSA, with a rate of 8.2 percent.⁵

⁵ Texas Workforce Commission, <http://www.twc.state.tx.us/> (July 2016).

Figure 2.2: Unemployment Rates in Selected Texas Metropolitan Areas, June 2016

Source: Texas Workforce Commission

Poverty

Since Medicaid primarily serves low-income individuals, poverty in the state affects the number of people eligible for the Medicaid program. In 2014, about 4.5 million Texans (17.2 percent of the state's population) lived at or below the federal poverty level (FPL), and approximately 38 percent of these were children under age 18. Approximately 24.6 percent of all Texas children under age 18 were

living at or below the FPL in 2014.⁶ Approximately 24.9 percent of Hispanics and 23.2 percent of African Americans in Texas were living at or below the FPL in 2014, along with 9.3 percent of White Non-Hispanics.

Table 2.1 lists the Federal Poverty Guidelines by family size for 2014-2016.

⁶ U.S. Census Bureau, 2014 ACS for Texas.

Table 2.1: Federal Poverty Guidelines, 2014-2016

Size of Family Unit	2014 Annual Income	2015 Annual Income	2016 Annual Income
1	\$11,670	\$11,770	\$11,880
2	15,730	15,930	16,020
3	19,790	20,090	20,160
4	23,850	24,250	24,300
5	27,910	28,410	28,440
6	31,970	32,570	32,580
7	36,030	36,730	36,730
8	40,090	40,890	40,890
For each additional person, add	\$4,060	\$4,160	\$4,160

Source: U.S. Department of Health and Human Services, Health and Human Services Poverty Guidelines, 2014-2016 <http://aspe.hhs.gov/poverty/> (July 2016).

Note: Federal poverty guidelines are applicable to the 48 contiguous states and are effective March 1st of each year.

Health Insurance Mandate

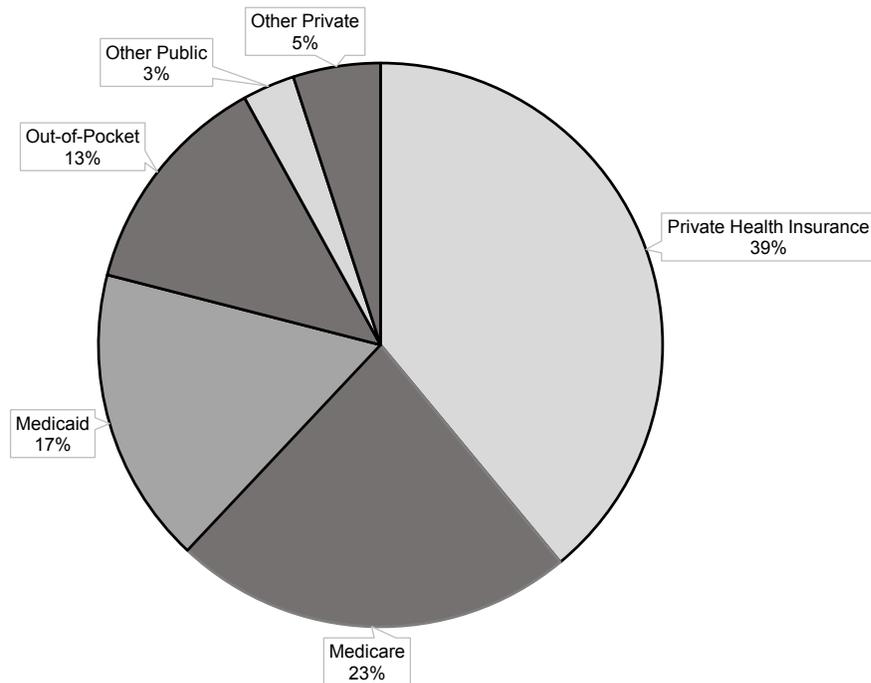
As required by the Affordable Care Act (ACA), beginning in 2014, most people must have health insurance that meets minimum federal coverage standards or pay a tax penalty. Health benefit plans provided by employers and most state or federal government health plans satisfy the requirement.

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

of the ACA, insurance companies cannot deny coverage or charge more for those who have a pre-existing condition.

Individual plans can be purchased directly from insurance 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 www.HealthCare.gov.

Figure 2.3: U.S. Personal Health Care Expenditures by Source of Funding, 2014



Source: Centers for Medicare & Medicaid Services (CMS) Office of the Actuary, National Health Expenditures Accounts.

Private Coverage

The limits of private insurance affect Medicaid. In 2014, 66 percent of the non-elderly U.S. population had private health insurance coverage, most often in the form of employer-sponsored coverage.⁷ That same year, private insurance paid for 39 percent of total national personal health care expenditures.⁸ **Figure 2.3** and **Figure 2.4** show national health care spending by

source of coverage and type of service, respectively.

In Texas, the proportion of the population covered by employer-sponsored health insurance is lower than the national average. Fifty-four percent of Americans under age 65 were covered by employer-sponsored health coverage in 2014, compared with 50 percent of Texans.⁹ In 2014, 16 percent of working adults age 18 to 64 in the U.S. were uninsured, compared with 26 percent in Texas.¹⁰ Certain working uninsured individuals with low incomes may turn to

⁷ U.S. Census Bureau, 2014 ACS for Texas.

⁸ CMS, Historical National Health Expenditures By Type of Service and Source of Funds. National Health Statistics Expenditures Accounts.

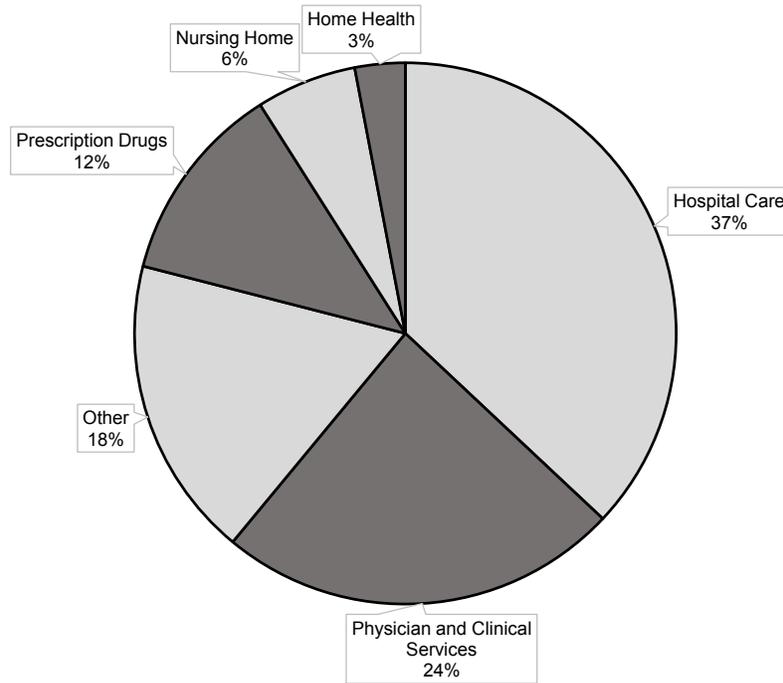
⁹ U.S. Census Bureau, 2014 ACS for Texas.

¹⁰ Ibid.

2

Medicaid to meet their health care needs or those of their dependents when employer-sponsored coverage, or health coverage through a health insurance marketplace is not available or affordable.

Figure 2.4: U.S. Personal Health Care Expenditures by Category, 2014



Source: CMS Office of the Actuary, National Health Statistics Expenditures Accounts.

The passage of the ACA prohibited health plans from denying or limiting coverage for pre-existing conditions for children under age 19 effective September 23, 2010, and for adults starting January 1, 2014.

Medicare

The Social Security Act of 1965 created both Medicaid and Medicare. Medicare is a federally-paid and administered health insurance

program. As of September 2016, it covered 57.2 million Americans.¹¹

Medicare Parts A-D

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

¹¹CMS, "Medicare Enrollment Dashboard," <http://www.cms.hhs.gov/MedicareEnRpts/> (December 2016).

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, individuals 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 revenue finances 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 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 state fiscal year 2015, approximately 374,000 dual eligibles in Texas received prescription drug coverage through Medicare Part D.¹² 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 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. As

¹²Health and Human Services Commission (HHSC), Monthly Medicare Modernization Act Dual Eligible Counts.

described below, 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.

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 state Medicaid programs to 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 covered by Medicaid, 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 state fiscal year 2015, Texas Medicaid paid approximately \$1.13 billion for Medicare premiums and deductibles (Part A and Part B), and another \$375 million (all general revenue funds) for Medicare Part

D “clawback.” Taken together, this accounts for approximately six percent of the Texas Medicaid program budget, excluding disproportionate share hospital and upper payment limit funds.

Medicare only covers skilled nursing care required following a hospitalization. Coverage is limited to 100 days per “spell of illness” following a three-night stay in the hospital. Admission to the nursing facility (NF) must occur not more than 30 days after the hospital discharge date. Medicare covers payment at 100 percent for the first 20 days only and pays 80 percent for days 21-100. Medicaid covers the 20 percent coinsurance for dual eligibles. The Medicare NF 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 NF care for dually eligible clients not paid by Medicare. Medicaid also covers a broad range of community-based long-term services and supports not covered under Medicare.

TRICARE/Veterans Administration

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

health care providers and a civilian network of providers and facilities. The Veterans Health Administration offers a wide range of health care services for U.S. military veterans through a health care system consisting of Veterans Administration medical centers and outpatient clinics.

Medicaid and CHIP History

Medicaid Enrollment Over Time

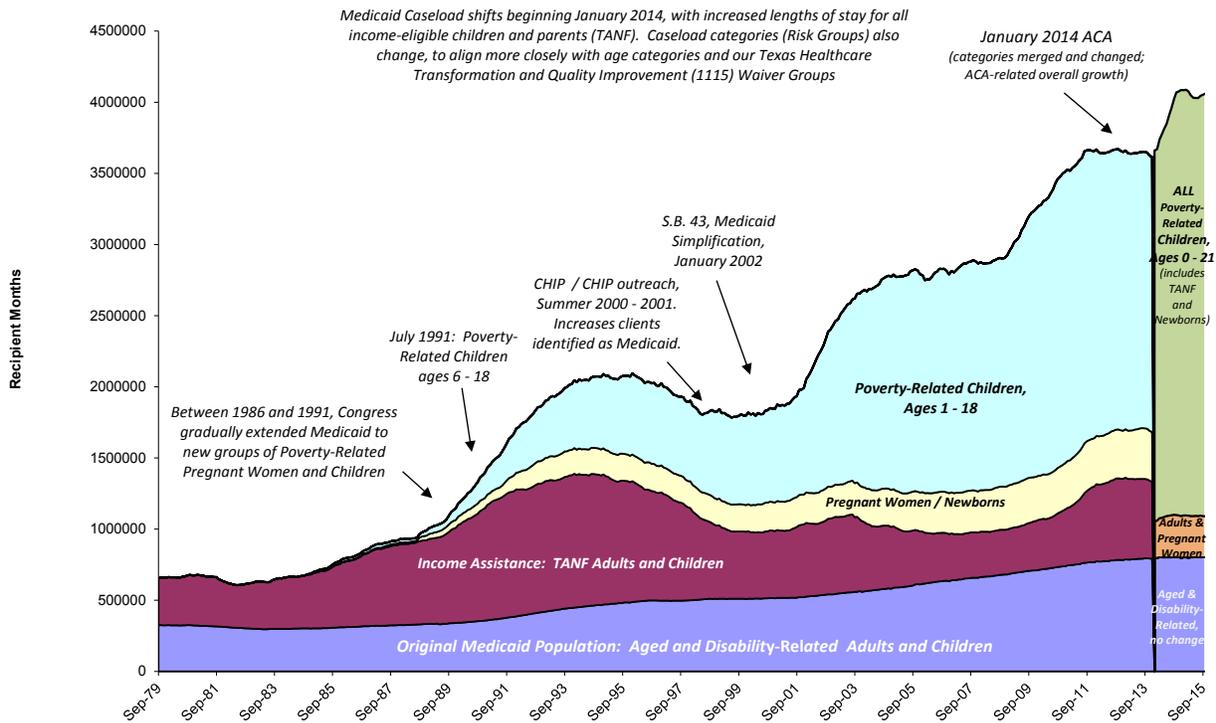
Congress established the Medicaid program under Title XIX of the Social Security Act of 1965 to pay medical bills for low-income persons who have no other way to pay for care. Texas began participating in the Medicaid program in September 1967.

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 1990-1995 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 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 (PRA). The PRA is a document a child's parent or relative who is also approved for TANF must sign and follow.

In state fiscal year 2015, an average of 4.06 million Texans were served each month by Medicaid. **Figure 2.5** illustrates Texas Medicaid enrollment trends by category for September 1979 through September 2015.

Figure 2.5: Medicaid Caseload by Group, 1979–2015



Source: HHSC, Financial Services, HHS System Forecasting.

Linked to Financial Assistance Programs

As originally enacted, Medicaid coverage was available only to persons eligible for Aid to Families with Dependent Children, now referred to as TANF. TANF is the federal-state cash assistance program for low-income families, usually headed by a single parent. To be able to receive Medicaid, individuals were required to be receiving cash assistance (or welfare). In this sense, Medicaid was “linked” to welfare. Historically, Medicaid coverage has also been available to persons eligible for SSI in Texas. SSI is a federal cash

assistance program for low-income people age 65 and older or those 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

Prior to the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), children under age 19 and their related caretakers who qualified for TANF cash assistance automatically qualified for Medicaid. With the passage of 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 lower TANF income caps compared to other states. In 2016, the TANF income cap for a parent with two children was \$188 per month. The TANF monthly cap is based on a set dollar amount and is not determined by the 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 2017, the limit for an individual is \$735 a month in countable income and no more than \$2,000 in countable resources. The limit for couples is \$1,103 a month with no more than \$3,000 in countable resources. The amount of the SSI payment is the difference between the person’s countable income and the FBR.

De-Linking Medicaid and Financial 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.

Affordable Care Act

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 was enacted on March 30, 2010. Together they are called the 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 all individuals to have health insurance coverage. It also gives states the option to expand Medicaid eligibility up to and including 133 percent of the 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 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 utilizes the 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 percent 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.

History of CHIP and CHIP Perinatal

The Balanced Budget Act of 1997 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 1998-2007. Like Medicaid, SCHIP is administered by 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 2016, the federal match for Texas' SCHIP program was 69.99 percent, while the state funded the remaining 30.01 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 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 FPL. Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

S.B. 445, 76th Legislature, Regular Session, 1999, enacted Phase II

of SCHIP, which created Texas' Children's Health Insurance Program (CHIP). S.B. 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the FPL. Coverage under Phase II of the 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 2016, 374,280 children were enrolled in CHIP.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP by appropriating nearly \$69 billion in federal CHIP funding for states for federal fiscal years 2009-2013.¹³ CHIPRA simplified the original name of the program from "SCHIP" to "CHIP," and made numerous policy changes to state CHIP programs, including:

- States must verify a CHIP applicant's citizenship.
- States may cover pregnant women above 185 percent of the FPL up to the income eligibility level for children in CHIP.
- States may provide Medicaid and CHIP coverage to qualified

¹³Kaiser 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).

immigrant children and/or pregnant women without the previously required five-year delay.

In 2010, the passage of the ACA made the following changes to CHIP:

- Extends federal funding for CHIP through federal fiscal year 2015. Prior to the ACA, CHIP was authorized through federal fiscal year 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 requirement.
- As of January 1, 2014, shifts from CHIP to Medicaid children ages 6 to 18 with incomes between 100 and 133 percent of the FPL.
- Applies new federal rules for determining financial eligibility for CHIP (known as modified adjusted gross income rules). The ACA eliminates assets tests and most income disregards for CHIP.
- Increases the federal CHIP match rate for federal fiscal years 2016-2019.

The Medicare Access and CHIP Reauthorization Act of 2015 extended federal funding for CHIP through federal fiscal year 2017.

The 2006-07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II,

HHSC, Rider 70), authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, which began in January 2007. CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income or immigration status.

Chapter 3: Eligibility

In This Chapter:

Eligibility Basics

- Eligibility Determination Process
- Financial Eligibility
- Non-Financial Eligibility Requirements

Children, Pregnant Women, and Parents and Caretaker Relatives

- Children’s Medicaid
- Pregnant Women
- Parents and Caretaker Relatives
- Medically Needy with Spend Down

People Age 65 and Older and Those with Disabilities

Supplemental Security Income Recipients

Medicaid for the Aged, Blind, and Disabled

Individuals Eligible for Medicare and Medicaid

Medicaid Buy-In Programs

Additional Medicaid Eligibility Pathways

Medicaid for Breast and Cervical Cancer Program

Incarcerated Individuals

Emergency Medicaid

Former Foster Care Youth

CHIP and CHIP Perinatal

CHIP

CHIP Perinatal

Eligibility Basics

Medicaid-eligible individuals include those eligible for coverage of acute care services, behavioral health care services, prescription drugs, and long-term services and supports (LTSS). Medicaid-eligible individuals also include those eligible for time-limited or specific services.

The four primary categories of Medicaid-eligible individuals who may receive full benefits are:

- Children, pregnant women, and parent and caretaker relatives;
- SSI recipients;
- People age 65 and older and those with disabilities; and
- Former foster care youth.

Other individuals who may be eligible for limited benefits or specific services include:

- Medicare beneficiaries – Based on income level and age, certain Medicare beneficiaries qualify for partial Medicaid benefits.
- Non-citizens – Includes legal permanent residents or undocumented individuals who are not eligible for Medicaid based on their status who may receive emergency services. Individuals receive Medicaid coverage limited to treatment of an emergent condition.

Children who do not qualify for Medicaid because of income may be eligible for CHIP.

Eligibility Determination Process

Health and Human Services Commission (HHSC) eligibility staff use the Texas Integrated Eligibility Redesign System, an integrated system used to determine eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF).

HHSC offers individuals needing assistance access to eligibility services through multiple channels, including:

- A self-service website (www.YourTexasBenefits.com);
- A smartphone application;
- A network of local eligibility offices and community-based organizations; and
- The 2-1-1 phone service.

The smartphone application is intended to complement, not replace, [YourTexasBenefits.com](http://www.YourTexasBenefits.com). Its features focus on case management functions easily completed on a smartphone. On the smartphone application, individuals can:

- View case details;
- Manage [YourTexasBenefits.com](http://www.YourTexasBenefits.com) account settings;
- Upload verifications and forms;
- View alerts;
- Report changes on the account; and
- Find a local office.

In addition, to help individuals apply for benefits online, HHSC has a 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 an 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.

Financial Eligibility

For most individuals, federal law requires states to determine financial eligibility for Medicaid and CHIP based on the Modified Adjusted Gross Income (MAGI) methodology and applies a five percentage point income disregard. The MAGI methodology uses federal income tax rules for determining income and household composition and applies to the children, pregnant women, and parents and caretaker relatives Medicaid eligibility groups. There is also not an asset test when determining Medicaid and CHIP eligibility under the MAGI methodology.

The following groups do not use the MAGI methodology when determining eligibility:

- Emergency Medicaid;
- Foster care children;
- Medically needy;
- Individuals receiving SSI; and
- Medicaid programs for people age 65 and over and those with disabilities.

In addition, these groups do have an asset test and allow for income disregards.

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 (NF) or an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). In some cases, including for some people enrolled in Medicaid home and community-based services (HCBS) 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 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

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remainder of earned income is disregarded.

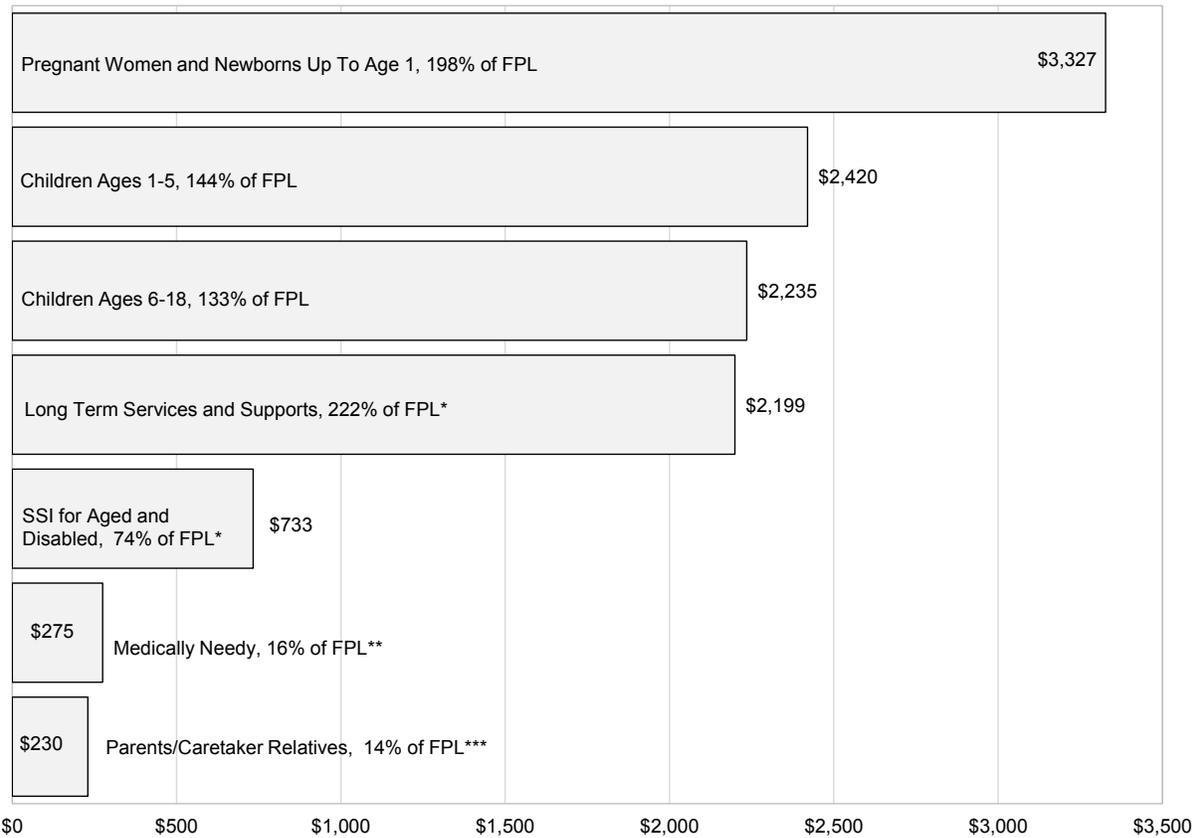
- Certain increases in Social Security benefits for persons denied SSI.
- Veteran’s Administration Aid and Attendance Allowances and Housebound Allowances.

Persons applying for Medicaid programs subject to the MAGI methodology receive a standard

income disregard equivalent to five percentage points of the FPL (in 2016, an \$84.00 disregard for a family of 3).

Figure 3.1 shows Texas Medicaid’s maximum monthly income limits by eligibility category, while **Tables 3.1** and **3.2** outline Texas’ Medicaid caseload sizes by eligibility category for full and non-full Medicaid beneficiaries, respectively.

Figure 3.1: Medicaid Eligibility in Texas, Maximum Monthly Income Limits, March 2016



* Family of one adult

** Family of three

*** Family of three (one-parent household)

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.

Table 3.1: Full Beneficiary Caseload by Eligibility Category, SFY 2015

General Category for Full Medicaid Beneficiaries n = 4,587,119	Eligibility Category	FPL% or Income Limit	Percent of Full Medicaid Beneficiaries
Families and Children (Non-Disability-Related)	Children less than 1	Up to 198%	7%
	Children 1-5	Up to 144%	22%
	Children 6-18	Up to 133%	43%
	Pregnant Women	Up to 198%	3%
	Parents and Caretaker Relatives*	Up to \$230/ month	4%
	Medically Needy with Spend Down**	Up to \$275/ month	Less than 1%
	Former Foster Care Children	No limit	Less than 1%
	Medicaid for Transitioning Foster Care Youth	413%	Less than 1%
Medicaid for Breast and Cervical Cancer Program	Women with an eligible breast or cervical cancer diagnosis receive full Medicaid benefits during treatment	Not tested by HHSC	Less than 1%
Aged, Medicare, and Disability-Related (Including SSI Cash Assistance)	SSI (Disability-Related) - Adult	No more than \$733/month	6%
	SSI (Disability-Related) - Under 21	No more than \$733/month	4%
	Aged and Medicare-Related	No more than \$733/month	9%
Presumptive Eligibility Programs	Children, Parents and Caretaker Relatives, Former Foster Care Children, Breast and Cervical Cancer determined presumptively eligible for full Medicaid coverage	Varies by corresponding program	Less than 1%

*Family of three (one-parent household)

**Family of three

3

Table 3.2: Non-Full Beneficiary Caseload by Eligibility Category, SFY 2015

General Category for Non-Full Medicaid Beneficiaries n = 362,955	Eligibility Category	FPL% or Income Limit	Percent of Non-Full Medicaid Beneficiaries
Medicare-Related	Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)	Varies by program	69%
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 eligibility categories in Table 3.1)	3%
Pregnant Women - Presumptive	Women determined presumptively eligible for Pregnant Women Medicaid for limited Medicaid coverage	198%	Less than 1%
Healthy Texas Women Program	Non-pregnant women ages 15 - 44	Up to 200%	29%

Non-Financial Eligibility Requirements

In order to qualify for Medicaid services, individuals must also meet non-financial eligibility criteria such as:

- Texas residency – Reside and intend to remain in Texas
- Age – Be within the age limits for the specific Medicaid program
- Social security status – All applicants must provide a Social Security number (SSN) or apply for one

- Citizenship or alien status – Meet citizenship or alien status program requirements

All U.S. citizens and nationals are entitled to apply for and receive Medicaid if they provide documentation of their citizenship and identity and meet all other eligibility requirements.

Qualified aliens and non-citizens include:

- Legal Permanent Residents (LPRs): Any person not a citizen of the U.S. who is residing in the U.S. under legally recognized and lawfully recorded permanent residence

as an immigrant. Also known as “Permanent Resident Alien,” “Resident Alien Permit Holder,” and “Green Card Holder” (includes Amerasians);

- Asylees;
- Refugees;
- Aliens paroled into the U.S. for at least one year;
- Aliens whose deportations are being withheld;
- Aliens granted conditional entry, prior to April 1, 1980;
- Battered alien spouses, battered alien children, alien parents of battered children, and alien children of battered parents who meet certain federal law criteria;
- Cuban/Haitian entrants; and
- Victims of human trafficking.

Limited to Seven Years

Certain aliens are immediately eligible for full Medicaid, if all other eligibility requirements are met, but are limited to seven years of Medicaid eligibility from the date an individual obtains qualified alien status, which may be the date of entry:

- Refugees (including Afghan and Iraqi special immigrants);
- Asylees;
- Aliens whose deportations are being withheld;
- Cuban/Haitian entrants; and
- Amerasians.

No Waiting Period or Limited Eligibility Period

Qualified aliens who are immediately eligible for full Medicaid, if all other eligibility requirements are met, and have no time limited period of Medicaid eligibility are as follows:

- Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children;
- Certain American Indians born outside the U.S.;
- Aliens receiving Medicaid based on receiving SSI cash benefits; and
- LPRs admitted prior to August 22, 1996, credited with 40 qualifying quarters of social security coverage.

Victims of Human Trafficking

Victims of human trafficking who the U.S. Department of Health and Human Services determines are certified and eligible are immediately eligible for full Medicaid.

Five Year Wait Period

LPRs admitted to the U.S. on or after August 22, 1996, who are not covered under an alien classification subject to the seven year limit, or who have no time limit for full Medicaid, are not eligible for full Medicaid for five years from the date of entry to the U.S.

LPRs admitted to the U.S. before August 22, 1996, who do not obtain

qualified alien status until on or after August 22, 1996, are not eligible for full Medicaid for five years from the date of obtaining qualified alien status. An exception to the five year wait period is given to aliens who can provide verification of continuous presence since the latest arrival date to the U.S. before August 22, 1996, even if the qualified alien status is obtained after August 22, 1996. A single absence of more than 30 days or a total aggregate of absences of more than 90 days interrupts continuous presence.

After the Five Year Wait Period

Once the five year period ends, individuals must meet one of the following categories:

- Naturalized citizen or meet citizenship status;
- Credited with 40 qualifying quarters of social security coverage; or
- Meet the classification for one of the following:
 - Veterans, active duty members of the U.S. armed forces, including their spouses and dependent children;
 - Certain American Indians born outside the U.S.; or
 - Aliens receiving Medicaid based on receiving SSI cash benefits.

Children Eligible Based on CHIPRA

Certain qualified alien and non-immigrant alien children qualify for Medicaid and CHIP through the month of their 19th birthday, regardless of their date of entry.

Children, Pregnant Women, and Parents and Caretaker Relatives

Children's Medicaid

Children comprise the majority of individuals receiving full Medicaid benefits on a monthly basis. Children who do not have a disability totaled 73 percent of Texas Medicaid full-benefit clients, and averaged 3 million clients per month in state fiscal year 2015.

Children's Medicaid is for children age 18 and younger. MAGI criteria is used to determine eligibility for Children's Medicaid.

To qualify for Medicaid, a child must:

- Be age 18 or younger;
- Be a Texas resident;
- Meet citizenship or alien status criteria; and
- Meet household income limits based on household size.

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 through the month of their first birthday as long as the child resides in Texas.

Children age 18 and younger who do not meet income requirements may qualify for the Medically Needy with Spend Down program if they have unpaid medical expenses or for CHIP.

Pregnant Women

The Texas Medicaid program covers a limited number of optional groups, which are eligibility categories that states are allowed but not required to cover. The federal requirement

for pregnant women and infants is 133 percent of the FPL. Texas chooses to extend Medicaid eligibility to pregnant women and infants up to 198 percent of the FPL. Individuals certified for Medicaid for Pregnant Women receive full Medicaid benefits.

To qualify for Medicaid, a pregnant woman must:

- Be a Texas resident;
- Meet citizenship or alien status criteria; and
- Meet household income limits based on household size, which includes the unborn child(ren).

Table 3.3: Medicaid for Pregnant Women Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$1,961
2	\$2,644
3	\$3,327
4	\$4,010
5	\$4,693
6	\$5,376
7	\$6,061
8	\$6,747
For each additional person, add:	\$687

Note: Income limits effective March 1, 2016

Pregnant women who do not meet income or non-citizen requirements may qualify for:

- The Medically Needy with Spend Down program or Medically Needy with Spend Down Emergency program; or

- CHIP Perinatal.

Parents and Caretaker Relatives

Adults caring for a related dependent child receiving Medicaid may themselves be eligible to receive

3

Medicaid. The adult must have a child who is:

- Eligible for and/or receiving Medicaid;
- Living with the caregiver; and
- Is age 17 or younger or age 18 and attending school full time and is reasonably expected to graduate before, or in, the month of the child’s 19th birthday.

The adult caring for the child must be a:

- Parent

- Step-parent
- Sibling
- Step-sibling
- Grandparent
- Uncle or aunt
- Nephew or niece
- First cousin
- A child of a first cousin (first cousin once removed)

Maximum monthly income limits are shown in **Table 3.4**.

Table 3.4: Parents and Caretaker Relatives Maximum Monthly Income by Family Size

Family Size	One Parent	Two Parent
1	\$103	---
2	\$196	\$161
3	\$230	\$251
4	\$277	\$285
5	\$310	\$332
Each additional person, add:	\$52	\$52

Note: Income limits effective March 1, 2016

Medically Needy with Spend Down

Children under age 19 and pregnant women with unpaid medical bills who are not eligible for Medicaid may qualify for the Medically Needy with Spend Down program.

Spend Down is the difference between an applicant’s household income and the Medically Needy income limit. Applicants must have

unpaid medical bills that exceed the Spend Down amount to receive benefits under the Medically Needy with Spend Down program. The income limit is \$275 per month for a family of three. When determining eligibility for children, the asset limit is \$2,000 or \$3,000 for an applicant with a household member who is aged or has a disability and meets relationship requirements. Assets are not considered when determining eligibility for the Medically Needy

with Spend Down program for pregnant women.

Once the individual meets the Spend Down limit, Medicaid then pays for those unpaid medical expenses and any Medicaid services provided after the individual is determined to be medically needy. Applicants are not required to pay outstanding medical bills to qualify for the Medically Needy with Spend Down program.

People Age 65 and Older and Those with Disabilities

Supplemental Security Income Recipients

SSI is a federal cash assistance program for low-income people age 65 and older and those with disabilities. The federal Social Security Administration sets income eligibility limits, asset limits and benefit rates, and determines eligibility. The monthly income limit for an individual on SSI, known as the federal benefit rate (FBR), is \$735 per month with an asset limit of \$2,000 in 2017.

In Texas, all people eligible for SSI are automatically eligible for Medicaid. States may supplement SSI payments with state funds. Texas does not do so, but does allow for a slightly higher Personal Needs Allowance (PNA) for SSI individuals

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.

Medicaid for the Aged, Blind, and Disabled

People age 65 and older and those with disabilities who do not receive SSI may qualify for Medicaid LTSS through a facility, such as a NF or an ICF/IID, or through community programs while living at home.

Individuals Eligible for Medicare and Medicaid

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

For dual eligibles, Medicaid pays for all or a portion of Medicare Part A and B premiums, co-insurance, and deductibles.

Full Dual Eligibles

Full dual eligibles are Medicare beneficiaries who are eligible for full Medicaid benefits. As of April 2016,

there were 373,892 full dual eligible individuals in Texas¹.

Partial Dual Eligibles

Medicaid provides limited assistance to certain Medicare beneficiaries, known as “partial dual eligibles,” who do not qualify for full Medicaid benefits. As of April 2016, there were 256,770 partial dual eligible individuals in Texas². Individuals who do not qualify for full Medicaid benefits may receive assistance through the following Medicare savings programs.

Medicare Savings Programs

There are several types of programs for partial dual eligibles who meet established income and resource criteria. Beneficiaries in these programs receive assistance with all or a portion of Medicare premiums, deductibles, and co-insurance payments through the Texas Medicaid program. In addition, 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 2017 are \$7,390 per individual and \$11,090 per couple for most categories of dual eligibles. The only

exception is for Qualified Disabled and Working Individuals (QDWI), where the resource limits are \$4,000 for an individual and \$6,000 for a couple.

Qualified Medicare Beneficiaries (QMB) – Medicaid pays all Medicare Part A and B premiums, co-insurance, and deductible amounts for services covered under both Medicare Parts A and B and for individuals with income no greater than 100 percent of the FPL.

Specified Low-Income Medicare Beneficiaries (SLMB) – Medicaid pays only Medicare Part B premiums for individuals with income greater than 100 percent but less than 120 percent of the FPL.

Qualified Individuals (QI) – Medicaid pays only Medicare Part B premiums for individual with income at least 120 percent but less than 135 percent of the FPL. 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. An individual cannot be certified under any other Medicaid-funded program and have QI coverage at the same time. An individual must be given the opportunity to choose which benefit they prefer to receive. If the individual chooses to receive QI benefits, their decision disqualifies

¹ HHSC, Monthly MMA Dual Eligible Counts

² HHSC, Monthly MMA Dual Eligible Counts

the individual for all other Medicaid programs.

QDWI – Medicaid pays only the Medicare Part A premium. This cost-sharing program is for people with disabilities who work and lose social security benefits and premium-free Medicare Part A with income no greater than 200 percent of the FPL. Resources must be at or below \$4,000 for an individual and \$6,000 for a couple. An individual cannot be certified under any other Medicaid-funded program and have QDWI coverage at the same time. An individual must be given the opportunity to choose which benefit they prefer to receive. If the individual chooses to receive QDWI benefits, their decision disqualifies the individual for all other Medicaid programs.

Medicaid Buy-In Programs

Medicaid Buy-In Program for Workers with Disabilities

The Medicaid Buy-In (MBI) Program for Workers with Disabilities enables working persons with disabilities to “buy in” to Medicaid. Individuals with income less than 250 percent of the FPL and \$3,000 in resources may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Based on direction from S.B. 566, 79th Legislature, Regular Session,

2005, HHSC implemented MBI in September 2006. Medicaid Buy-In participants may be required to pay a monthly premium depending on their earned and unearned income. Those 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 HCBS waivers if they meet the functional requirements for these programs.

Medicaid Buy-In for Children Program

The Medicaid Buy-In for Children (MBIC) program allows children up to age 19 with disabilities to “buy in” to Medicaid. Children with family countable income less than or equal to 150 percent of the FPL may qualify for the program and pay a monthly premium in order to receive Medicaid benefits.

Texas implemented MBIC in January 2011 following direction from S.B. 187, 81st Legislature, Regular Session, 2009. Children in MBIC may receive FFS Medicaid or may opt-in to managed care. MBIC families make 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 in the case of 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.

Additional Medicaid Eligibility Pathways

Medicaid for Breast and Cervical Cancer Program

The Medicaid for Breast and Cervical Cancer (MBCC) program 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. In state fiscal year 2015, the monthly average number of clients enrolled in MBCC was 5,136.

HHSC receives CDC funds and awards these funds to providers across the state to perform breast and cervical cancer screenings and diagnostic services under the Breast

and Cervical Cancer Services (BCCS) program.

After a woman has received an eligible breast or cervical cancer diagnosis from a provider, she must go to a BCCS provider who will screen her for Medicaid eligibility. HHSC makes the final Medicaid 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:

- 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 (not otherwise have creditable coverage) and not otherwise eligible for Medicaid, Medicare, or CHIP;
- Age 18 through 64;
- A Texas resident; and
- A U.S. citizen or qualified immigrant.

A woman eligible for MBCC receives full Medicaid benefits. Medicaid eligibility begins the date an applicant meets all eligibility criteria. The Medicaid eligibility cannot precede the day after the diagnosis date. 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.

Incarcerated Individuals

Juveniles receiving Medicaid for children age 6-18 may have their coverage suspended upon entrance into a juvenile facility and reinstated upon release. Individuals who enter a juvenile facility and receive any other type of Medicaid will have their coverage terminated and must reapply upon release.

Individuals incarcerated by the Texas Department of Criminal Justice who are under 19 or pregnant may be eligible for Medicaid coverage for inpatient medical services provided in a “free-world” medical facility not located on the premises of a jail or prison, if they meet all other eligibility criteria. If determined eligible, Medicaid covers only the services provided during the

incarcerated individual’s inpatient stay.

Emergency Medicaid

Nonimmigrants, undocumented aliens, and certain LPRs may qualify for Emergency Medicaid coverage, if all other eligibility requirements are met, except for alien status. If determined eligible, the individual is covered by Medicaid only for the duration of a qualifying emergency medical condition, as verified by a medical provider.

Former Foster Care Youth

Medicaid for Former Foster Care Children

Children who aged out of the foster care system at age 18 or older and who were receiving federally-funded Medicaid when they aged out of foster care may continue to be Medicaid-eligible up to the month of their 26th birthday.

To qualify for Medicaid for Former Foster Care Children (FFCC) the individual must:

- Be a Texas resident;
- Meet citizenship or alien status; and
- Have an SSN or have applied for one.

Income and resource limits do not apply to FFCC.

Medicaid for Transitioning Foster Care Youth

Former foster care youth who were not receiving Medicaid when they aged out of foster care may still be eligible for Medicaid under Medicaid for Transitioning Foster Care Youth (MTFCY) up to the month of their 21st birthday.

To qualify for MTFCY the individual must:

- Be age 18;
- Be a Texas resident;
- Meet citizenship or alien status;
- Have an SSN or have applied for one;
- Not have adequate health coverage; and
- Meet income limits.

Resource limits do not apply to MTFCY. In addition, individuals under an Interstate Compact on the Placement of Children (ICPC) may be eligible for MTFCY if all other requirements are met.

Former Foster Care Youth in Higher Education

HHSC uses state funds to pay for the Former Foster Care in Higher Education (FFCHE) program. Since this program is funded entirely by the state, it is not considered Medicaid and is identified as a Health Care Benefits program administered by HHSC.

Applicants are eligible to receive FFCHE benefits beginning the month after their 21st birthday through the end of the month of their 23rd birthday.

To qualify for FFCHE the individual must:

- Be a Texas resident;
- Meet citizenship or alien status;
- Have an SSN or have applied for one;
- Not have adequate health coverage; and
- Be enrolled in an institution of higher education.

Income and resource limits do not apply to FFCHE. Individuals under the ICPC may be eligible for FFCHE if all other requirements are met.

CHIP and CHIP Perinatal

CHIP

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 qualified alien;
- A Texas resident;
- Have an SSN or have applied for one;
- Under age 19;

- Uninsured for at least 90 days; and
- Living in a family whose income is at or below 201 percent of the FPL.

Maximum monthly income limits are shown in **Table 3.5**.

Table 3.5: CHIP Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$1,990
2	\$2,684
3	\$3,377
4	\$4,071
5	\$4,764
6	\$5,458
7	\$6,153
8	\$6,850
For each additional person, add:	\$697

Note: Income limits effective March 1, 2016

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. Prior to CHIPRA, Texas covered certain qualified immigrant children under CHIP with 100 percent state funds if they met all other Medicaid or CHIP eligibility requirements.

CHIPRA authorizes the option of providing Medicaid or CHIP benefits to qualified immigrant children with federally-matched funds in both Medicaid and CHIP. In May 2010, Texas began drawing 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 in March 2010 allowed states to provide federally-matched CHIP to the children of public employees, if the state health benefits plan met maintenance of effort requirements or the child qualified for a hardship exception. Texas began providing federally-matched CHIP coverage to qualifying Teacher Retirement System school-employee children on September 1, 2010, and to other eligible public employee children on September 1, 2011.

3

CHIP Perinatal

CHIP Perinatal services are for the unborn children of pregnant women who are uninsured and do not qualify for Medicaid due to income and/or immigration status, and whose household income is at or below 202 percent of the FPL.

For CHIP Perinatal individuals at or below 198 percent of the FPL, the mother must apply for Emergency Medicaid to cover her labor with delivery. Upon delivery, CHIP Perinatal newborns in families with

incomes at or below 198 percent of the FPL are eligible to receive 12 months of continuous Medicaid coverage from their date of birth.

CHIP Perinatal newborns in families with incomes above 198 percent of the FPL and at or below 202 percent of the FPL remain in CHIP Perinatal and receive CHIP benefits for the remainder of the 12-month coverage period.

Maximum monthly income limits are shown in **Table 3.6**.

Table 3.6: CHIP Perinatal Maximum Monthly Income Limits by Household Size

Household Size	Income Limits
1	\$ 2,000
2	\$ 2,697
3	\$ 3,394
4	\$ 4,091
5	\$ 4,788
6	\$ 5,485
7	\$ 6,183
8	\$ 6,884
For each additional person, add:	\$701

Note: Income limits effective March 1, 2016

Part II. Clients

Chapter 4: Beneficiaries

4

Size

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

The most current Texas Medicaid and CHIP enrollment statistics may be accessed at <https://hhs.texas.gov/about-hhs/records-and-statistics/research-and-statistics>.

In This Chapter:

Size

- The Medicaid Population
- The CHIP and CHIP Perinatal Populations
- Changing Caseloads

Demographics

- Medicaid Demographics

- Disability*

- Gender*

- Age*

- Ethnicity*

- Births*

- CHIP Demographics

- Income*

- Age*

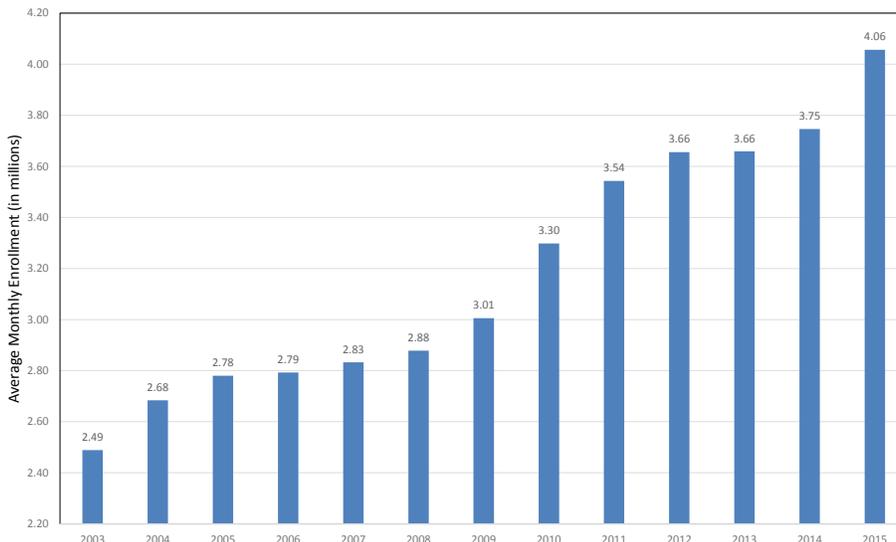
- Gender*

The Medicaid Population

Figure 4.1 shows the average monthly Medicaid enrollment from state fiscal years 2003-2015.

Figure 4.2 shows the unduplicated number of Texas Medicaid recipients from state fiscal years 2003-2015.

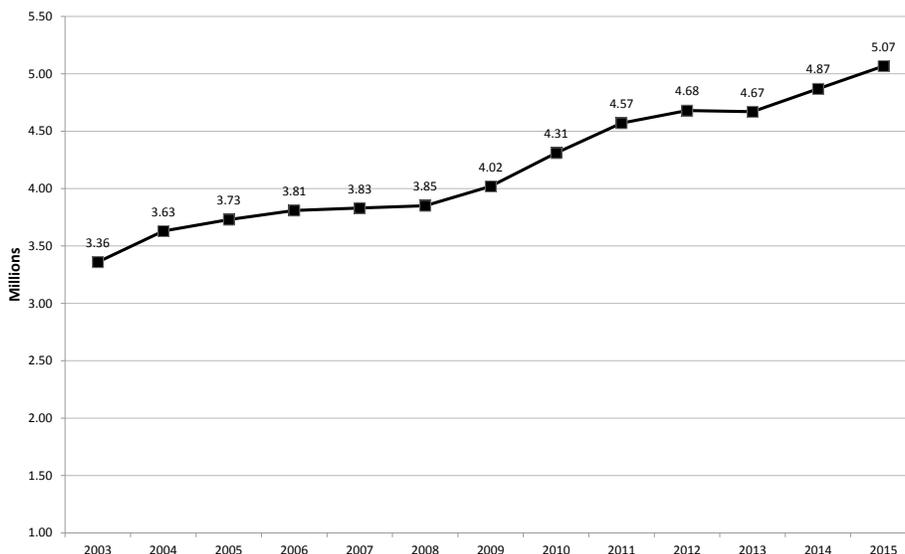
Figure 4.1: Average Monthly Medicaid Enrollment, SFYs 2003-2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

Figure 4.2: Unduplicated Number of Texas Medicaid Recipients, SFYs 2003-2015



Source: HHSC, Financial Services, HHS System Forecasting.

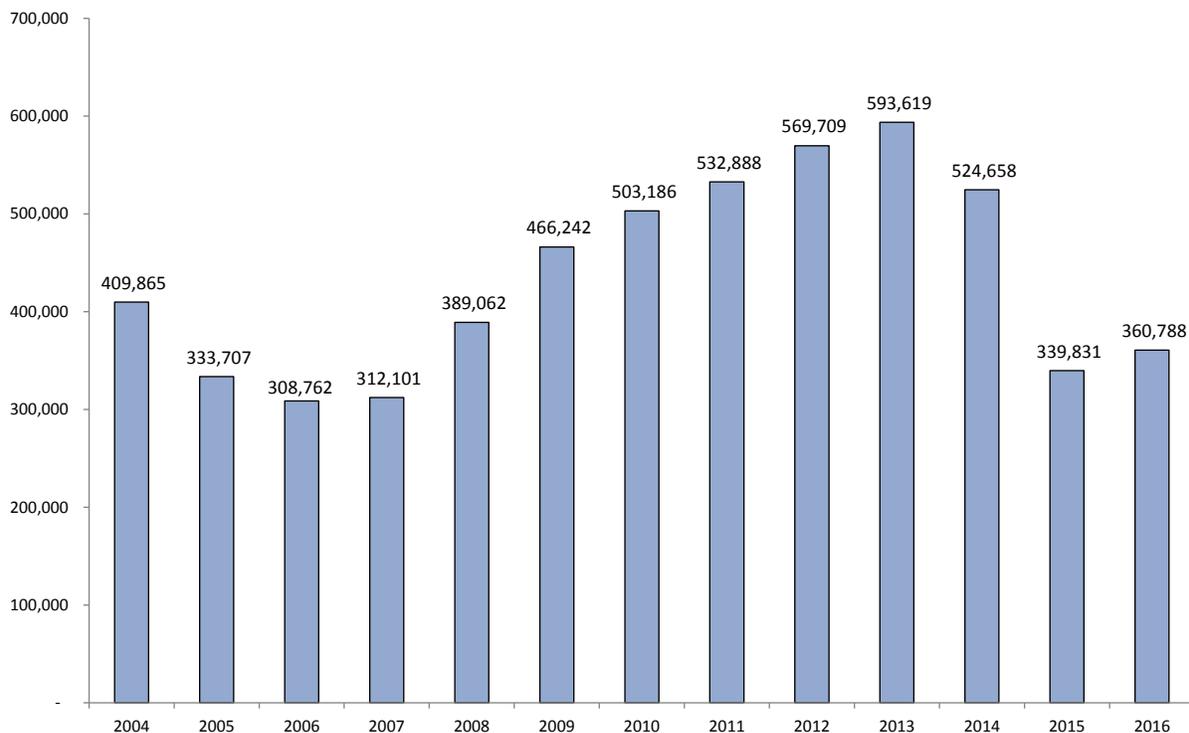
Note: Unduplicated clients include all clients who receive full Medicaid benefits at any point during the state fiscal year.

The CHIP and CHIP Perinatal Populations

Figure 4.3 shows the average monthly caseload for the CHIP population since state fiscal year 2004. Earlier CHIP caseloads had peaked in May 2002 at 529,211, declining to 308,762 in 2006. Since that time, CHIP caseloads

gradually increased to a new high enrollment of 607,057 in August 2013. Caseloads have subsequently decreased in CHIP under the Affordable Care Act (ACA), which shifted children ages 6 to 18 with incomes between 100 and 133 percent of the federal poverty level (FPL) from CHIP to Medicaid.

Figure 4.3: Average Monthly CHIP Clients, SFYs 2000-2016



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

Table 4.1 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 the FPL began moving out of CHIP

Perinatal and into Medicaid due to changes in eligibility. Effective January 1, 2014, the ACA required a one-time income conversion which began moving newborns under 198 percent of the FPL from CHIP Perinatal to Medicaid. The income

conversion also increased the income limits for CHIP Perinatal from 200 percent to 202 percent of the FPL. In recent years, the monthly caseload has stabilized around 36,000 members. Approximately 99.7 percent of clients were perinates and only 0.3 percent of clients were newborns in state fiscal year 2016.

All clients in the CHIP Perinatal program are under the age of one, because a woman can only enroll her child in the program prior to delivery. The majority of clients are at or under 198 percent of the FPL, with approximately 1.2 percent of all clients above this amount in state fiscal year 2016.

Table 4.1: CHIP Perinatal Caseload Summary, SFYs 2007-2015

SFY	Total Caseload	Perinates under 198%** FPL	Perinates over 198%** FPL	Newborns under 198%** FPL	Newborns over 198%** 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	0	300
2013	37,027	36,068	640	0	319
2014	36,800	36,203	509	0	88
2015	36,535	35,703	742	0	90
2016	35,080	34,646	331	0	104

*Averages are for January-August 2007 only, the first eight months of program implementation.

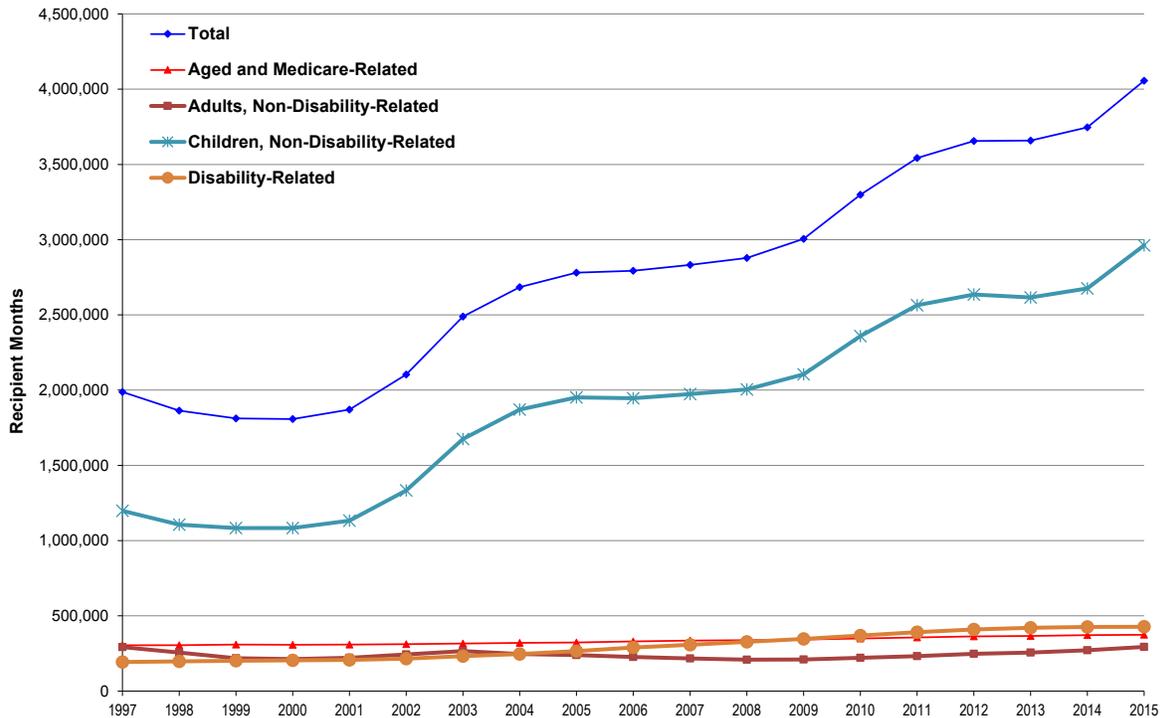
**State fiscal years 2007-2015 in the table above reflect caseloads at 185 percent FPL.

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, leading caseloads to change frequently.

Figure 4.4 shows changes in the Texas Medicaid caseload from state fiscal years 1997-2015.

Figure 4.4: Texas Medicaid Caseload, SFYs 1997-2015

Source: HHSC, Financial Services, HHS System Forecasting. Caseloads are measured in average recipient months.

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 were increases in Medicaid caseload due to use of modified adjusted gross income, rather than income with potential disregards, 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. The overall Medicaid caseload rose above 4 million clients by September of 2014, an increase of 9.6 percent over September 2013.

Demographics

Medicaid Demographics

Disability

The aging of the Texas population is accompanied by a growing number of people with a disability or other chronic health condition that can cause difficulties in performing basic activities of daily living and functions, such as working, bathing, dressing, cooking, and driving. This trend could mean increased demand for services from the Texas Health

and Human Services (HHS) system agencies. The American Community Survey (ACS) for Texas, which is conducted by the U.S. Census Bureau, indicates that in 2014 there were approximately 3.1 million, or 12 percent of all Texans, who lived with a disability. Among adults aged 18-64, the ACS reports that 9.9 percent had a disability in 2014. Among adults aged 65 and older, the ACS reports 39.4 percent live with a disability.

As of state fiscal year 2015, 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 Supplemental Security Income 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 4.5 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 2014 the poverty rate for women in Texas was 18.7 percent while the rate for men was 15.6 percent.¹
- 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 (12.6 percent versus 7.5 percent in 2014).²
- Medicaid for parents and caretaker relatives targets poor families, which in Texas are usually female-headed (95 percent in August 2012).³ Female-headed single-parent families in Texas have higher poverty rates than their male-headed counterparts (41.8 percent versus 21.2 percent in 2014).⁴
- 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.

¹ U.S. Census Bureau, 2014 American Community Survey (ACS) for Texas.

² Ibid.

³ August 2012, TANF Demographic Profile, HHSC.

⁴ U.S. Census Bureau, 2014 ACS for Texas.

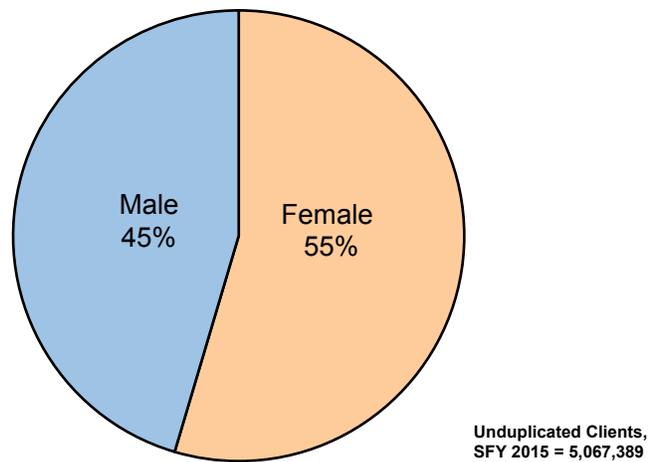
Age

Figure 4.6 shows the age groups of clients receiving Texas Medicaid at some point during state fiscal year 2015. Children and persons age 65 and older make up 82 percent of the program’s clients. Seventy-seven percent of the program is comprised of people under age 21, and 63 percent are age 14 or younger.

Ethnicity

Figure 4.7 shows the ethnicity of clients receiving Medicaid at some point during state fiscal year 2015. Hispanics account for the largest portion of Medicaid clients, comprising 51 percent of the Medicaid population. African-American and Hispanic Texans comprise higher percentages of the Medicaid population than of the general population.

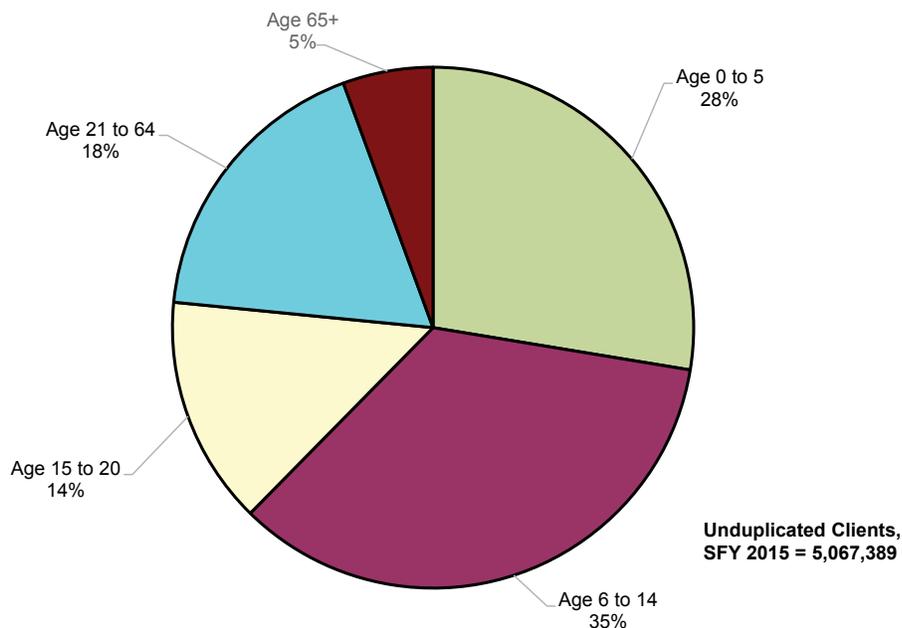
Figure 4.5: Medicaid Recipients by Gender, SFY 2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

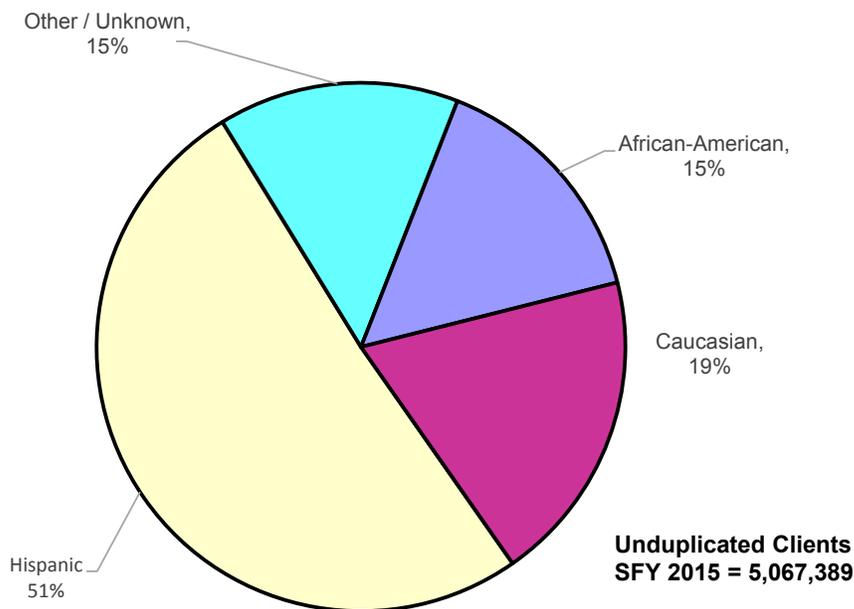
Figure 4.6: Texas Medicaid Recipients by Age, SFY 2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

Figure 4.7: Medicaid Recipients by Ethnicity, SFY 2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

Births

The number of births reported in Texas has seen a slight increase in recent years. **Table 4.2** shows the births in Texas by ethnicity and percent Medicaid paid from calendar years 2007-2014, 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 47.4 percent in 2014. During that same period, the proportion of births to African-American mothers peaked at 14 percent in 1990 but decreased to a low of 11.3 percent in 2007-2009. In 2014, 11.5 percent of births were to African-American mothers. As shown at the bottom of **Table 4.2**, the percentage of Medicaid-paid births in Texas has stayed fairly consistent over time. In calendar year 2014, 53.9 percent of all Texas births were paid by Medicaid.

Figure 4.8 shows the number of pregnant women served by the Texas Medicaid program in state fiscal year 2015 by age group. Almost one-half (42 percent) of the pregnant women in the Texas Medicaid program are between the ages of 19 and 24, while 7 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 jobs that do not provide health coverage. The Texas Medicaid program provides coverage to pregnant women with incomes up to 198 percent of the FPL (\$39,924 for a family of three in 2016).

Table 4.3 illustrates the percent distribution of live births in calendar year 2014 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 (12.2 percent) and African-American women (9.8 percent) compared to Caucasian women (5.2 percent).

Figure 4.9 shows the ethnicity of pregnant women served by the Texas Medicaid program in state fiscal year 2015.

Table 4.2: Births in Texas, CYs 2007-2014

Births	2007	2008	2009	2010	2011	2012	2013	2014
Total Births	407,453	405,242	401,599	385,746	377,274	382,438	387,110	399,482
% Hispanic	50.2	50.1	50.1	49.0	48.3	47.8	47.9	47.4
% Caucasian	34.1	34.1	33.9	34.6	35.0	34.6	34.4	34.3
% African American	11.3	11.3	11.3	11.5	11.4	11.3	11.4	11.5
% Other	4.4	4.6	4.7	4.9	5.2	6.3	6.3	6.8
% Medicaid Paid	56.0	55.4	55.9	57.0	56.4	53.8	53.9	53.9

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

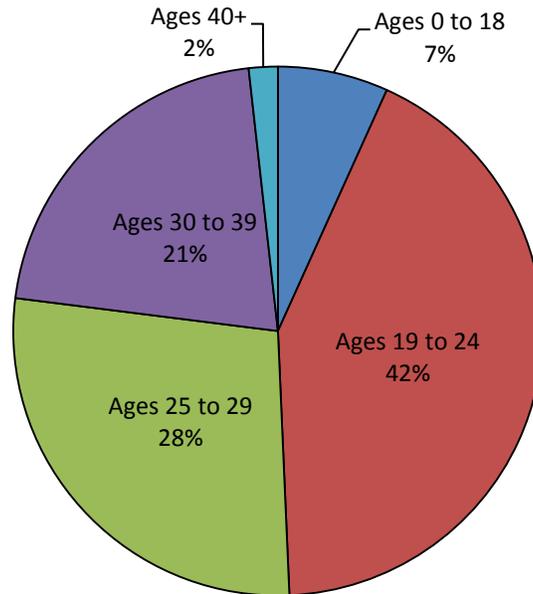
Source for % Medicaid Paid: Medicaid Paid Births—Texas. HHSC, Strategic Decision Support, September 2016.

Table 4.3: Percent Distribution of Live Births in Texas by Mother's Age and Ethnicity, CY 2014

Age	Hispanic	Caucasian	African American	Other	All
Below 15	0.2	0.0	0.2	0.1	0.1
15 to 17	4.0	1.2	2.7	0.8	2.7
18 to 19	8.0	4.0	6.9	2.2	6.1
20 to 29	55.7	51.1	57.6	39.8	53.2
30 to 39	29.8	41.3	30.2	53.2	35.4
40 Plus	2.4	2.4	2.4	3.9	2.5
Unknown	0.0	0.0	0.0	0.1	0.0

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

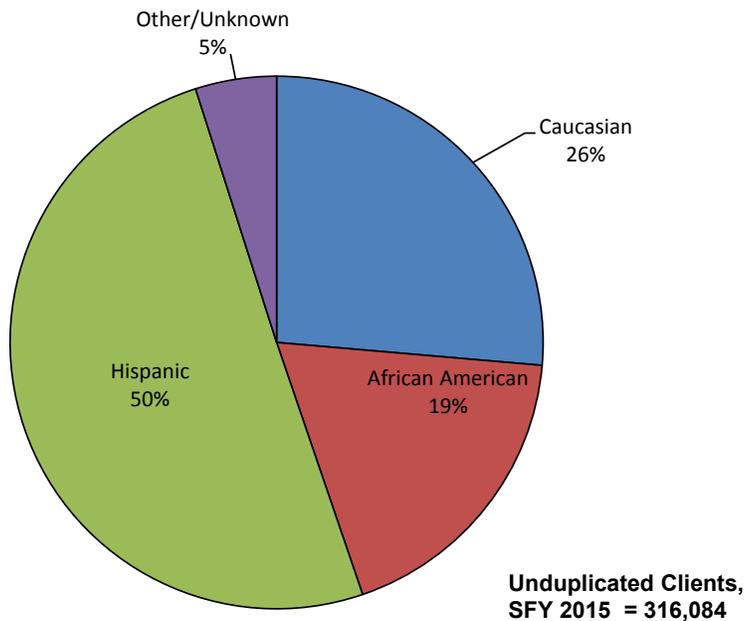
Figure 4.8: Pregnant Women on Medicaid in Texas by Age Group, SFY 2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

Figure 4.9: Pregnant Women on Medicaid in Texas by Race/Ethnicity, SFY 2015



Source: HHSC, Financial Services, HHS System Forecasting.

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

CHIP Demographics

Income

During the most recent year for which full enrollment data is available, state fiscal year 2015, approximately 41 percent of CHIP enrollees were between 101 and 150 percent of the FPL. Approximately 41 percent were between 151 and 185 percent of the FPL, and 9 percent were between 186 and 201 percent of the FPL. Approximately 9 percent of enrollees were below 100 percent of the FPL. **Figure 4.10** shows the percent distribution of CHIP enrollees by FPL category in state fiscal year 2015. Under the new ACA eligibility criteria, children who meet all other eligibility criteria and have incomes at or below 133 percent of the FPL qualify for Medicaid, not CHIP.

Age

Figure 4.11 shows the percentage of CHIP clients by age in state fiscal year 2015. That year, the majority of CHIP clients were over age five. Fifty-seven percent of clients were between ages 6 and 14, and 21 percent of clients were between ages 15 and 18. Twenty-two percent were between ages one and five, while less than one percent were under one 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.

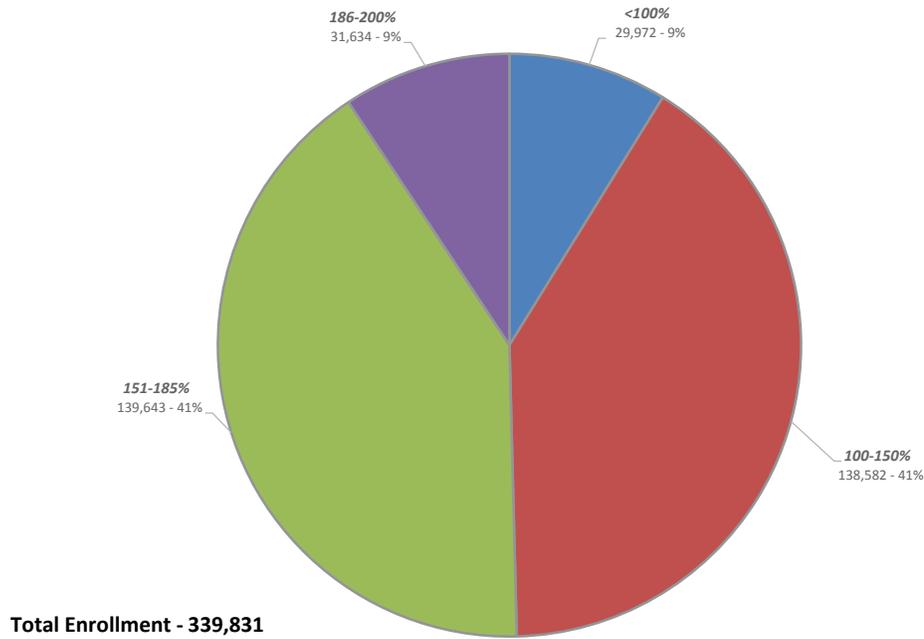
CHIP serves children through age 18 up to 201 percent of the FPL. Medicaid serves infants (12 months of age and younger) up to 198 percent of the FPL, children ages 1 through 5 up to 144 percent of the FPL, and children ages 6 through 18 up to 133 percent of the FPL.

Figure 4.11 does not include CHIP Perinatal clients, who are all under one year of age.

Gender

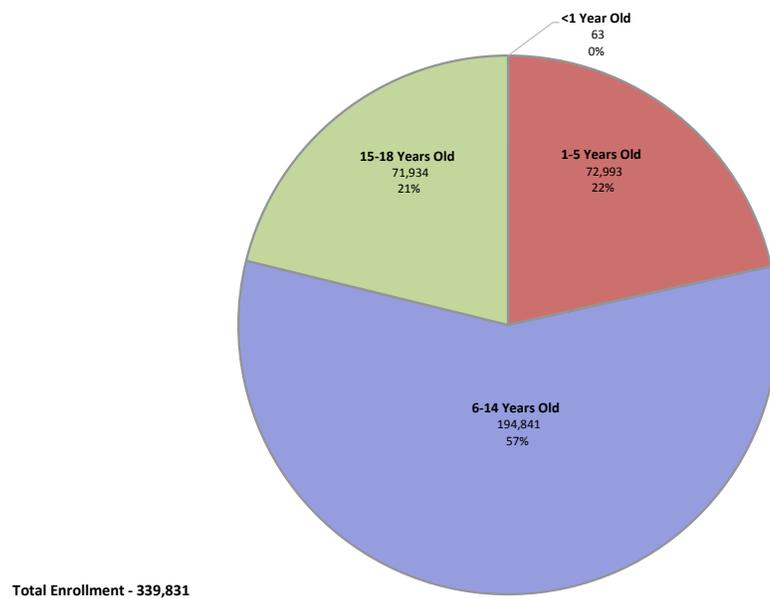
Figure 4.12 shows the proportions of CHIP enrollees by gender. Approximately 51 percent of enrollees are male, and 49 percent are female.

Figure 4.10: Average Monthly Distribution of CHIP Enrollment by FPL Category, SFY 2015



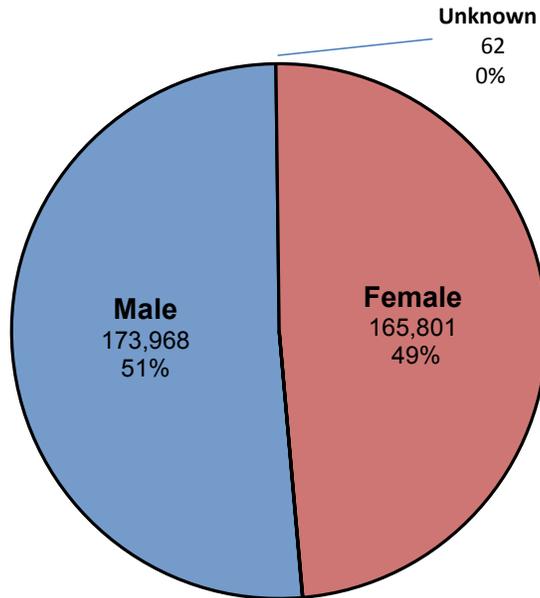
Source: HHSC, Financial Services, HHS System Forecasting, CHIP monthly enrollment data, HHSC Financial Services.

Figure 4.11: Average Monthly CHIP Enrollment by Age, SFY 2015



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

Figure 4.12: Average Monthly CHIP Enrollment by Gender, SFY 2015



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

Chapter 5: Benefit Basics

Mandatory and Optional Benefits

The Social Security Act specifies a set of benefits state Medicaid programs must provide and a set of optional benefits states may choose to provide. **Table 5.1** shows the current set of benefits covered by the Texas Medicaid program.

In This Chapter:

- Mandatory and Optional Benefits**
- Limits**
- Basic Principles**
- State Plans**
- Waivers**
- Maintenance of Effort Requirements**

Table 5.1: 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. 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 state plan 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 	<ul style="list-style-type: none"> • Prescription Drugs • Medical or Remedial Care by Other Licensed Practitioners: <ul style="list-style-type: none"> ○ Nurse Practitioners/Certified Nurse Specialists

5

Mandatory Acute Care Services	Optional* Acute Care Services
<ul style="list-style-type: none"> • Medical and Surgical Services Provided by a Dentist • Early and Periodic Screening, Diagnosis, and Treatment Services for Individuals Under 21 • Family Planning Services and Supplies • Federally Qualified Health Center Services • Rural Health Clinic Services • Nurse-Midwife Services • Certified Pediatric and Family Nurse Practitioner Services • Home Health Services • Freestanding Birth Center Services (when licensed or otherwise recognized by the state) • Transportation to Medically Necessary Services • Tobacco Cessation Counseling for Pregnant Women • Extended Services for Pregnant Women 	<ul style="list-style-type: none"> ○ Physician Assistants ○ Licensed Midwife ○ Certified Registered Nurse Anesthetists ○ Anesthesiologist Assistants ○ Psychologists ○ Licensed Clinical Social Workers** ○ Licensed Professional Counselors ○ Licensed Marriage and Family Therapists • Podiatry*** • Limited Chiropractic Services • Optometry (including eyeglasses and contacts) • Telemedicine • Home Telemonitoring • Hearing Instruments and Related Audiology • Home Health Supplies Provided by a Pharmacy • Clinic Services: <ul style="list-style-type: none"> ○ Maternity Clinic Services ○ Renal Dialysis Facility Services ○ Ambulatory Surgical Center Services • Tuberculosis Clinic Services

Mandatory Acute Care Services	Optional* Acute Care Services
	<ul style="list-style-type: none"> ● Rehabilitation and Other Therapies: <ul style="list-style-type: none"> ○ Mental Health Rehabilitative Services ○ Rehabilitation and Other Therapy Services ○ Substance Use Disorder Treatment ○ Physical, Occupational, and Speech Therapy ● Case Management Services for High-Risk Pregnant Women: <ul style="list-style-type: none"> ○ Pregnancy-Related and Postpartum Services for 60 days After the Pregnancy Ends ○ Services for Any Other Medical Conditions That May Complicate Pregnancy ○ Respiratory Care Services ○ Ambulance Services ○ Emergency Hospital Services ○ Private Duty Nursing
Mandatory LTSS	Optional* LTSS
<ul style="list-style-type: none"> ● Nursing Facility Services for Clients 21 or Over 	<ul style="list-style-type: none"> ● Intermediate Care Facility Services for Individuals With an Intellectual Disability or Related Condition ● Inpatient Services for Clients Under 21 or 65 and Over in an Institution for Mental Diseases ● Services Furnished Under a Program of All-Inclusive Care for the Elderly

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Mandatory LTSS	Optional* LTSS
	<ul style="list-style-type: none"> • Day Activity and Health Services • 1915(i) Home and Community Based Services-Adult Mental Health Services • 1915(k) Community First Choice Services: <ul style="list-style-type: none"> ○ Attendant Care (including habilitation) ○ Emergency Response Services • Attendant Services: <ul style="list-style-type: none"> ○ Personal Care/Personal Attendant Services ○ Community Attendant Services • Targeted Case Management for: <ul style="list-style-type: none"> ○ Infants and Toddlers with Intellectual or Developmental Disabilities ○ Adults with Intellectual or Developmental Disabilities ○ Individuals with Chronic Mental Illness • Nursing Facility Services for Individuals Under 21 Years of Age • Prescribed Pediatric Extended Care Centers • Services Provided in Religious Nonmedical Health Care Institutions

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 an M.D. or D.O.

Limits

Federal law allows states to define what constitutes reasonably sufficient amount, duration, and scope of Medicaid benefits. This means 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 on inpatient hospital stays per spell of illness for adults served in fee-for-service (FFS) and STAR+PLUS. 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 enrollees for a prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. The exception for prior-approved transplants allows an additional 30 days of inpatient care that begins with the date of the transplant. The limit does not apply to STAR+PLUS members admitted to an inpatient hospital due to a primary diagnosis of a severe and persistent mental illness (bipolar disorder, major depressive disorder, recurrent depressive disorder,

schizophrenia, or schizoaffective disorder).

- Three prescriptions per month for adults in FFS for 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; and
 - Clients enrolled in certain 1915(c) waiver programs.

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Basic Principles

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

- Statewideness – All Medicaid services must be available statewide and may not be restricted to residents of particular localities.
- Comparability – The same level of services (amount, duration, and scope) must be available to all clients, except where federal law specifically requires a broader range of services, such as for Medicaid-eligible children, or allows a reduced package of services, such as for those who qualify as medically needy.
- Freedom of Choice – Clients must be allowed to go to any Medicaid

health care provider who meets program standards.

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

State Plans

The Medicaid state plan is a document that serves as the contract between the state and the Centers for Medicare & Medicaid Services (CMS) for the Texas Medicaid program and gives the Health and Human Services Commission the authority to administer the Medicaid program in Texas. It describes the nature and scope of the state’s Medicaid program, including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children’s Health Insurance Program (CHIP) state plan.

Waivers

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

and income groups, or combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.

States seek waivers to:

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

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

Research and Demonstration 1115 Waivers

Purpose

Section 1115 waivers allow flexibility for states to test substantially new ideas for operating their Medicaid programs by waiving a variety of requirements such as comparability or statewideness.

States may use these waivers to structure statewide health system reforms, 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 with choosing a managed care organization (MCO), to use cost savings to provide additional services, or to 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 three-year waivers, except for those that serve individuals dually eligible for Medicare and Medicaid, which are five-year waivers. States may renew 1915(b) waivers, but CMS requires an independent assessment to show 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, intermediate care facility for individuals with an intellectual disability or related condition, or hospital).

States may use these waivers to serve people age 65 and older, or 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 day activity and health services.

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.

Maintenance of Effort Requirements

The Affordable Care Act (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 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 a health insurance exchange was established), and for children, including children in CHIP, MOE continues through September 30, 2019. Under the ACA, states must comply with Medicaid and CHIP MOE requirements to receive Medicaid funding.

Federal guidance has clarified how MOE applies to Medicaid waivers. For instance, Section 1115 and HCBS waivers can expire and are not required to be renewed under MOE. In addition, states may renew a waiver – with modifications – at the end of the approved waiver period in effect as of March 23, 2010.

Chapter 6: Services for Women and Children

In This Chapter:

Coverage for Children

- Texas Health Steps
- Medical Checkups*
- Comprehensive Care Program*
- Dental Services*
- Frew, et al. v. Smith, et al.*

Programs for Women and Children

- Case Management for Children and Pregnant Women
- Early Childhood Intervention
- Blind Children’s Vocational Discovery and Development Program

Women’s Health Services

- Better Birth Outcomes
- Immediate Postpartum LARC Payments*
- 17P Interagency Data-Sharing*
- Pregnancy Medical Home Pilot*
- Neonatal Abstinence Syndrome Prevention Pilot*
- Perinatal Advisory Council*
- MCO Transition and Auto-Enrollment Education*
- Healthy Texas Women
- Family Planning Program
- Breast and Cervical Cancer Services

Coverage for Children

Generally children with Medicaid coverage are eligible to receive a wider range of health care services than adults with Medicaid.

Examples of Medicaid services possibly available to a greater extent for children than for adults include:

- Physical, occupational, and speech therapy;

- Private duty nursing services;
- Hearing services;
- Vision services; and
- Comprehensive dental services.

Medicaid-covered services are the same whether provided through traditional fee-for-service (FFS) Medicaid or Medicaid managed care. Medicaid managed care organizations (MCOs) must provide covered services in the same amount,

duration, and scope as outlined in the Medicaid state plan.

Texas Health Steps

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, known in Texas as Texas Health Steps (THSteps), provides preventive health and comprehensive care services for children birth through 20 years of age who are enrolled in Medicaid. THSteps' mission is to provide preventive medical and dental checkups for Medicaid children to allow early identification and treatment of identified problems.

Families of children and young adults eligible for THSteps receive information about THSteps services. Health and Human Services Commission (HHSC) THSteps staff provide coordinated outreach and informing to expand a family's awareness of available health services, increase use of preventive services, and help families obtain comprehensive medically necessary services available through a network of private and public providers.

The foundation of THSteps is the preventive 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 accept the responsibility for providing accessible, continuous, comprehensive, and coordinated care, including referrals to other health care providers as necessary. Medicaid providers, such as physicians, dentists, physician assistants, advanced practice nurses, school clinics, migrant health clinics, and other community clinics, such as federally qualified health centers, may enroll as providers for THSteps medical and dental checkups and treatment.

Medical Checkups

A THSteps medical checkup includes these federally mandated components:

- Comprehensive health and developmental history;
- Comprehensive unclothed physical examination;
- Vaccinations;
- Laboratory screening; and
- Health education/anticipatory guidance.

Medical checkups are recommended periodically. The time between recommended medical checkups depends on the child's age. From birth through age two, THSteps recommends more than one medical checkup per year. From ages 3 through 20, THSteps recommends yearly checkups.

Families receiving 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

vaccinations current. This sanction applies until the family is up to date with THSteps medical checkups and vaccination requirements.

Table 6.1: THSteps Program Highlights and Outreach Activities

<p><i>Services provided in FFY 2015:</i></p> <ul style="list-style-type: none"> ● 3,932,612 persons in Texas eligible for THSteps services. ● 2,215,518 eligible persons had a THSteps medical checkup.* ● 2,228,080 eligible persons had preventive dental services. ● 1,055,932 eligible persons had dental treatment services. <p>In FFY 2015, 466 general dentists; 58 pediatric dentists; 16 dental public health providers; and 13 orthodontists, periodontists, and prosthodontists had training to provide THSteps dental services in a dental home.</p> <p>Source: Form CMS-416: Annual EPSDT Participation Report, FFY 2015. *Number of individuals enrolled for 90 continuous days who received a checkup.</p>
<p><i>Outreach and Education:</i></p> <p>THSteps provides outreach and informing services that involve contacting the parents and caretakers of children receiving Medicaid to tell them about the services and benefits they may receive. The intent of outreach is to help parents and caretakers understand:</p> <ul style="list-style-type: none"> ● The value of having medical and dental checkups. ● How to access and use medical, dental, and case management services. ● How to use Medicaid medical transportation and other services available to them.
<p><i>To promote the use of THSteps, THSteps program staff work with related children's health programs and agencies, such as:</i></p> <ul style="list-style-type: none"> ● Head Start. ● Independent school districts. ● Colleges. ● Other state programs, such as Texas Vaccines for Children, Childhood Lead Poisoning Prevention Program (CLPPP), Children with Special Health Care Needs (CSHCN) Program, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Maternal Child Health, and Early Childhood Intervention (ECI). ● Governmental and community-based organizations. ● Medical, dental, and case management providers and their professional organizations.

Comprehensive Care Program

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) and includes medically necessary health care services for treatment of all physical and mental illnesses or conditions found during a screening. These benefits, which were not available to children before OBRA 89, include but are not limited to:

- Treatment of all medically necessary services needed to correct and improve health conditions;
- Personal care services;
- Durable medical equipment to improve or maintain medical or functional status;
- Treatment in freestanding psychiatric hospitals;
- All dental and oral health care;
- Developmental speech therapy;

- Developmental physical therapy;
- Developmental occupational therapy; and
- Private duty nursing.

Costs for THSteps medical checkups and other medically necessary services are included in capitated MCO rates for children enrolled in managed care. Children not in capitated managed care or children receiving retroactive coverage have their THSteps medical checkups and other medically necessary services costs paid through Medicaid FFS.

Dental Services

In addition to medical checkups, and comprehensive medical services, THSteps offers periodic dental checkups, diagnostics, and treatment for children 6 months through 20 years of age. The objective is to identify children at high risk of developing dental disease, to start preventive services, to treat decay early, and to educate families about the importance of good oral health.

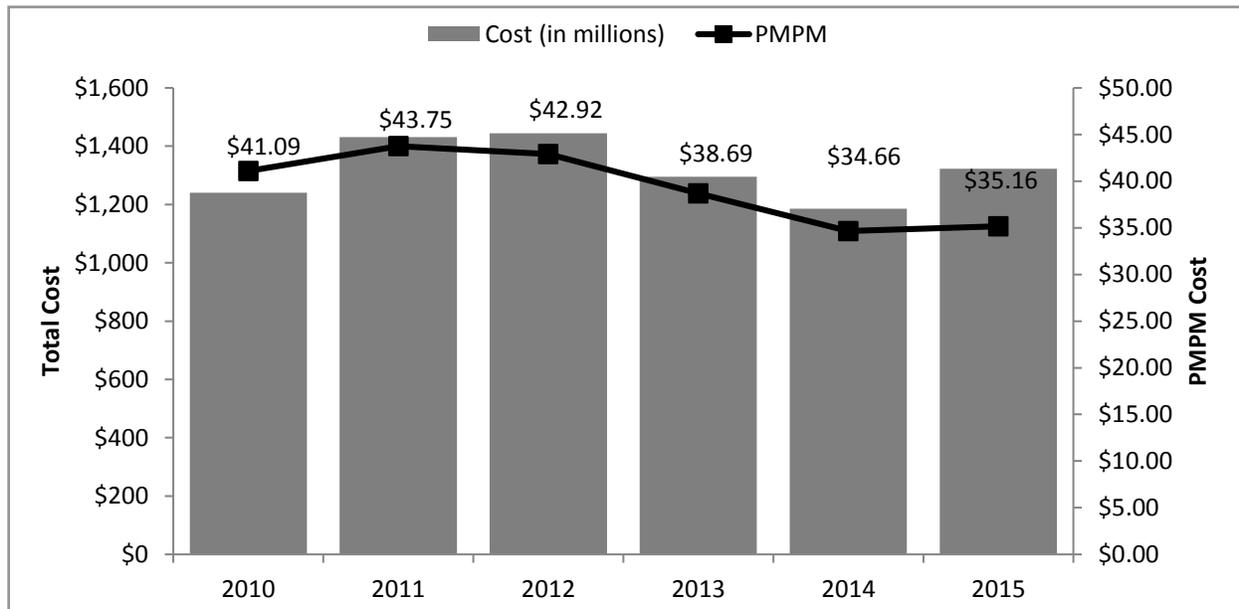
The time between dental checkups depends on the child's age and risk for dental disease. Dental checkups are available for children, adolescents, and young adults age 3 through 20 twice a year. More frequent dental checkups are available for children age 6 months through 35 months. Recipients or their caretakers may self-refer for dental care at any time from birth through 20 years of age.

All THSteps dental costs for children were paid through FFS until the inclusion of dental services in managed care through DMOs on March 1, 2012.

the cost per client for state fiscal years 2010–2015. After reaching a peak of \$44 per member per month (PMPM) in 2011, the cost for dental services declined to about \$35 PMPM in 2014 and 2015.

Figure 6.1 shows the total dental (and orthodontic) THSteps costs and

Figure 6.1: THSteps Total Cost and Cost per Recipient Month, Medicaid Dental Services, SFYs 2010-2015



Source: HHSC, Financial Services, HHS System Forecasting.

Frew, et al. v. Smith, et al.

Filed in 1993, *Frew, et al. v. Smith, 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 lawsuit¹ alleged the Texas

Medicaid program did not meet the requirements of the federal Medicaid Act² for EPSDT benefits.

The parties resolved the *Frew* litigation by entering into an agreed consent decree, which the court approved in 1996. The decree sets out numerous state obligations relating to THSteps. It also provides

¹ *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.

² Title XIX of the Social Security Act

that the federal district court will monitor compliance with the orders by HHSC and Department of State Health Services (DSHS) and that the federal district court will enforce the orders if necessary. In 2000, the federal district court found the state defendants in violation of several of the decree's provisions.

In 2007, the parties agreed to 11 corrective action orders 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 and 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 funds, for state fiscal years 2008-2009 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 do not require a specific level for Medicaid rates. However, the orders do include requirements regarding access to care and 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 also appropriated \$150 million to be applied to strategic initiatives in state fiscal years 2008-2009. The 81st Legislature, Regular Session, 2009, authorized use of unexpended funds for the 2010-2011 biennium. The state implemented 22 strategic initiatives to comply with the corrective action orders. A number of these initiatives continue as part of Medicaid client services or agency administrative services (e.g., First Dental Home).

The federal district court has dismissed 4 of the 11 corrective action orders and 75 related paragraphs of the 308 paragraph consent decree after finding that the state defendants had complied with the required actions for checkup reports and plans for lagging

counties; prescription and non-prescription medications, medical equipment, and supplies; provider training; and medical transportation. The Fifth Circuit Court of Appeals has affirmed dismissal of parts of a fifth corrective action order, *Adequate Supply of Health Care Providers*, but has remanded to the district court for further proceedings for an obligation in that corrective action order to identify shortages using a specific assessment of providers and take action to address any shortages identified. HHSC and DSHS continue to be bound by the remaining obligations of the consent decree and the corrective action orders. The court continues to monitor the agencies' compliance with the orders. The consent decree does not have a specific end date, although the corrective action orders are intended to create potential endpoints for the agencies' obligations.

Programs for Women and Children

Case Management for Children and Pregnant Women

Case Management for Children and Pregnant Women 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 HHSC 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.

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. HHSC 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 ECI targeted case management, specialized skills training, therapy, and other Medicaid benefits for children who are Medicaid beneficiaries.

Blind Children’s Vocational Discovery and Development Program

The HHSC Blind Children’s Vocational Discovery and Development Program supports children and young adults 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, independent living skills, and support services. Medicaid and CHIP reimbursement of the program is limited to targeted case management services for Medicaid- and CHIP-eligible children and youth up to age 21.

Women’s Health Services

Better Birth Outcomes

Better Birth Outcomes (BBO) is a collaborative effort between HHSC and DSHS. BBO aims to improve access to women’s preventive, interconception, prenatal, and perinatal health care. The collaboration focuses on meeting a client’s health care needs that impact her ability to have a healthy pregnancy. There are currently 20 BBO initiatives. A few of these initiatives are listed below.

Immediate Postpartum LARC Payments

In 2016, HHSC established an add-on reimbursement to incentivize

utilization of immediate postpartum long-acting reversible contraception (LARC), the most effective method of reversible contraception, for women enrolled in Pregnant Women’s Medicaid. The American College of Obstetricians and Gynecologists recommends LARC insertions in the postpartum setting, ideally before leaving the hospital after labor and delivery, to reduce unintended pregnancies and to achieve optimal birth spacing. The add-on reimbursement allows providers to bill for the LARC device and insertion in addition to the labor and delivery service.

17P Interagency Data-Sharing

In an effort to reduce preterm births, HHSC and DSHS entered into a data-sharing agreement in 2014 aimed at early identification of women who had a previous preterm delivery and are candidates for 17 Alpha-hydroxyprogesterone caproate (17P) treatment. 17P is a synthetic hormone that has been shown to reduce the recurrence of preterm births. Through the data-sharing project, a monthly matched file is provided to contracted MCOs in order to provide targeted care to mothers at risk for repeat preterm birth.

Pregnancy Medical Home Pilot

Created by H.B. 1605, 83rd Legislature, Regular Session, 2013, the Pregnancy Medical Home pilot is studying the efficacy of

a pregnancy medical home that provides coordinated, evidence-based maternity care management to women in Harris County through a Medicaid MCO model. The pilot's evaluation report will be submitted to the Legislature in September 2017.

Neonatal Abstinence Syndrome Prevention Pilot

The Neonatal Abstinence Syndrome Prevention pilot focuses on increasing the availability of intervention and treatment for high-risk populations. The pilot provides enhanced screening and outreach to women of childbearing age, including those certified for Medicaid for Pregnant Women, and has implemented specialized programs to reduce the severity of Neonatal Abstinence Syndrome.

Perinatal Advisory Council

The Perinatal Advisory Council, created by H.B. 15, 83rd Legislature, Regular Session, 2013, develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation, and recommends ways to improve neonatal and maternal outcomes, including for Medicaid, CHIP, and CHIP Perinatal enrollees.

MCO Transition and Auto-Enrollment Education

The goal of the MCO Transition and Auto-Enrollment Education

initiative is to have MCOs provide education services for women exiting Medicaid for Pregnant Women and CHIP Perinatal about Healthy Texas Women (HTW) and the Family Planning Program (FPP). Effective July 1, 2016, eligible women exiting Medicaid for Pregnant Women are automatically enrolled into HTW.

Healthy Texas Women

HTW is a state-funded program that provides women's health and family planning services at no cost to eligible, low-income Texas women.

During its review of the state's health agencies in 2014, the Texas Sunset Advisory Commission recommended consolidating the state's women's health programs to improve efficiency and effectiveness for clients and providers. In response, the 84th Legislature directed HHSC to consolidate state women's health services.

The newly created HTW program launched on July 1, 2016. It is a consolidation of the HHSC Texas Women's Health Program (TWHP) and the DSHS Expanded Primary Health Care program (EPHC).

HTW is for women who meet the following qualifications:

- Are ages 18 through 44 (women are considered 18 years of age on the day of their 18th birthday and 44 years of age through the last

- day of the month during which they turn 45);
- Are ages 15 through 17 years old and have a parent or legal guardian apply, renew, and report changes to her case on her behalf (women are considered 15 years of age the first day of the month of their 15th birthday and 17 years of age through the day before their 18th 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;
 - 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 200 percent of the federal poverty level (FPL).

Benefits for eligible participants include:

- Pregnancy testing;
- Pelvic examinations;
- Sexually transmitted infection services;
- Breast and cervical cancer screenings;

- Clinical breast examination;
- Screening and treatment for cholesterol, diabetes and high blood pressure;
- HIV screening;
- LARCs;
- Oral contraceptive pills;
- Permanent sterilization;
- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections (excluding emergency contraception); and
- Screening and treatment for postpartum depression.

In state fiscal year 2015, approximately 105,205 women were enrolled in TWHP, along with 4,603 providers. An unduplicated total of 71,610 women had a paid claim for TWHP services, and the program's expenditures totaled \$30.2 million in general revenue, including expenditures for services, administration, and outreach.

There were a total of 158,209 women served in EPHC in state fiscal year 2015, during which time 58 entities contracted with the program and a total of 280 clinic sites across the state participated in and administered the program. EPHC expenditures totaled \$42.2 million in general revenue.

Family Planning Program

FPP helps fund clinic sites across the state to provide quality, comprehensive, low-cost, and accessible family planning and reproductive health care services to women and men. These services help individuals determine the number and spacing of their children, reduce unintended pregnancies, positively affect future pregnancy and birth outcomes, and improve general health.

FPP is for women and men who meet the following qualifications:

- Reside in Texas;
- Are under the age of 64; and
- Have a net family income at or below 250 percent of the FPL.

Benefits for eligible participants include:

- Pregnancy testing;
- Pelvic examinations;
- Sexually transmitted infection services;
- Breast and cervical cancer screenings;
- Clinical breast examination;
- Screening for cholesterol, diabetes and high blood pressure;
- HIV screening;
- LARCs;
- Oral contraceptive pills;
- Permanent sterilization;

- Other contraceptive methods such as condoms, diaphragm, vaginal spermicide, and injections (excluding emergency contraception); and
- Limited prenatal benefits.

There were a total of 66,118 women and men served in FPP in state fiscal year 2015. In the same year, FPP had 18 entities contracted with the program and a total of 105 clinic sites across the state participating in and administering the program. FPP expenditures totaled \$19.0 million all funds, with \$17.3 million in general revenue expended.

Breast and Cervical Cancer Services

The Breast and Cervical Cancer Services (BCCS) program helps fund clinic sites across the state to provide quality, low-cost, and accessible breast and cervical cancer screening and diagnostic services to women. BCCS contractors are the point of access for the Medicaid for Breast and Cervical Cancer (MBCC) program regardless of how the client was diagnosed with cancer (see **Chapter 3, Eligibility**).

BCCS is for women who meet the following qualifications:

- Reside in Texas;
- Are over the age of 18;
- Don't have health insurance; and

- Have a net family income at or below 200 percent of the FPL.

Benefits for eligible participants include:

- Clinical breast examination;
- Mammogram;
- Pelvic examination and Pap test;
- Diagnostic services;
- Cervical dysplasia management and treatment; and
- Assistance applying for MBCC.

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There were 34,376 women served in BCCS in state fiscal year 2015. In the same year, BCCS had 41 entities contracted with the program and a total of 203 clinic sites across the state participating in and administering the program.

In state fiscal year 2015, BCCS expenditures totaled \$10.6 million all funds, with \$2.8 million in general revenue expended.

Part III. Benefits

Chapter 7: Long-Term Services and Supports

In This Chapter:

Overview

Who Receives LTSS

Older Individuals and Individuals with Physical Disabilities

People with Intellectual and Developmental Disabilities

Where Individuals Receive LTSS

Institutional Care

Home and Community-Based Services

Recent Initiatives

- Community First Choice
- Balancing Incentive Program
- CMS Regulations on HCBS Settings and Person-Centered Planning
- Prescribed Pediatric Extended Care Centers
- Electronic Visit Verification
- IDD Managed Care Pilot

Services for People Age 65 and Older or with Physical Disabilities

Community Services and Supports: Medicaid State Plan Services

- Personal Assistance Services*
- Community Attendant Services*
- Personal Care Services*
- Day Activity and Health Services*

Community Services and Supports: Non-State Plan Models
STAR+PLUS

STAR+PLUS HCBS Program

STAR Kids

Medically Dependent Children Program

- Nursing Facilities
- Medicaid Hospice Program
- Program of All-Inclusive Care for the Elderly
- Dual Demonstration
- Medicare Advantage Dual Eligible Special Needs Plan

Services for People with an Intellectual Disability or Related Condition

- Community Services and Supports: Waivers
- Home and Community-based Services*

(continued)

Community Living Assistance and Support Services

Texas Home Living

Deaf-Blind with Multiple Disabilities

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

State Supported Living Centers

Additional Resources and Programs

Promoting Independence Initiative and Money Follows the Person

Aging and Disability Resource Centers

Service Delivery Options

Agency Option

Consumer Directed Services Option

Service Responsibility Option

Overview

Medicaid covers a broad range of long-term services and supports (LTSS). LTSS enable people age 65 and over and those with physical, psychological, intellectual, or developmental 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 continually grows and is influenced by the aging of the population, medical advances allowing people with significant disabilities to live longer and healthier lives, and other trends such as co-occurring behavioral health needs. The population of people age 65 and older is projected to increase from 3.5 million in 2017 to 7.6 million in 2040. The percentage

of the total population that is 65 years of age or older is projected to increase from 12 percent in 2017 to 17 percent in 2040.¹ LTSS accounted for approximately 31 percent of all Texas Medicaid services expenditures in state fiscal year 2015.

LTSS, in contrast to medical care, are meant to support an individual with ongoing, day-to-day activities, rather than treat or cure a disease or condition. Individuals receiving LTSS often need assistance performing activities of daily living (ADLs) such as eating, bathing, or grooming, or other life activities such as housekeeping, working, or pursuing hobbies. Some LTSS are performed by licensed medical professionals such as nurses or therapists, while others are provided by direct care

¹ Texas Demographic Center/Office of the State Demographer at the University of Texas at San Antonio

staff without medical training. 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 condition (ICF/IID), in the individual's own home or family home, an assisted living facility, or in other settings like day activity and health services (DAHS) centers. LTSS in Texas are provided through both traditional fee-for-service (FFS) and managed care.

Who Receives LTSS

Older Individuals and Individuals with Physical Disabilities

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

People with Intellectual and Developmental Disabilities

LTSS for people with intellectual and developmental disabilities (IDD) include both institutional residential services in an ICF/IID and HCBS, which may include residential services such as a group home, for

individuals who qualify for an ICF/IID level of care.

Where Individuals Receive LTSS

Institutional Care

Institutional settings for LTSS in Texas include NFs, ICFs/IID, and state supported living centers (SSLCs). The Department of Aging and Disability Services (DADS) regulates these facilities.² 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 condition requiring residential, medical, and habilitative services.

Home and Community-Based Services

Federal law allows states to apply for waivers exempting them from certain Medicaid requirements. One of these, referred to as a 1915(c) waiver after the particular section of the Social Security Act it waives, allows states to provide HCBS to individuals who qualify for institutional care based on need in order to maximize independence and prevent institutionalization. The

² This function will transfer to the Health and Human Services Commission on September 1, 2017.

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).

Home and community-based waivers allow the state to provide a broader array of services to specific individuals. Examples of waiver services provided include nursing, personal assistance services (PAS), 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 more than institutional care would have cost for the group served by the waiver. Because of funding limitations, the number of individuals wanting to receive waiver services generally exceeds the number of individuals the state can serve through a waiver. Most home and community-based waiver programs have interest lists for people who wish to enroll. These interest lists have grown despite

significant increases in waiver funding by the Legislature.

Home and community-based LTSS can also be provided under the authority of an 1115 waiver, also named for the section of the Social Security Act it waives. The STAR+PLUS HCBS program is operated under such a waiver and allows Texas to provide community-based services to adults as an alternative to NF care (see **Appendix F, Texas Medicaid Waivers**).

Recent Initiatives

Community First Choice

S.B. 7, 83rd Legislature, Regular Session, 2013, directed the Health and Human Services Commission (HHSC) to implement the most cost-effective option for delivering basic attendant care and habilitation to Medicaid-eligible individuals. HHSC used existing program infrastructure to implement Community First Choice (CFC), a federal option for the delivery of services to assist with ADLs on June 1, 2015. Individuals in the home and community-based waivers who previously received a CFC-like service continue to receive the services as CFC state plan services, but they are delivered by their waiver providers. In this way, the state implemented CFC as seamlessly as possible for individuals who were already receiving services.

The state receives an additional six percent federal match for funds spent on CFC services.

To be eligible for CFC, an individual must be Medicaid-eligible and require the level of care provided in a hospital or NF, an ICF/IID, or a psychiatric hospital.³ An individual must have a documented need for CFC services. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program.

The following services are provided through CFC:

- PAS – Hands-on assistance with ADLs, like eating and bathing; instrumental activities of daily living (IADLs), like cleaning and grocery shopping; and health-related tasks delegated by a nurse, like medication administration and special feeding protocols.
- Habilitation – Assistance learning, maintaining, and enhancing the skills necessary for the individual to perform his or her own ADLs and IADLs. This can include hands-on assistance. Habilitation also includes teaching an individual skills related to money management, socialization, personal decision-making,

and integrating in the greater community.

- Emergency response services – A service for individuals who would otherwise require extensive routine supervision and who live alone, are alone for large parts of the day, and do not have regular caregivers for extended periods of time.
- Support Management – A voluntary service for individuals who want to learn how to better communicate their preferences and needs to their provider, including selecting, training, and dismissing an attendant.

As described in the Service Delivery Options section at the end of this chapter, CFC services are available through the traditional agency model, the consumer-directed services model (CDS), and the service responsibility option (SRO), and are provided in both FFS and managed care. CFC services must be provided in community-based settings, and are required to be delivered through a person-centered planning framework. Providers include licensed home and community support services agencies and certified waiver providers.

Balancing Incentive Program

The federal Balancing Incentive Program (BIP) authorized \$3 billion for states through September 2015

³Called an institution for mental disease (IMD) in federal rules, IMD services are limited to individuals under age 21 or over age 64.

to increase access to community-based LTSS. States spending 25-50 percent of Medicaid LTSS funding on community LTSS were eligible for a 2 percent increase in federal matching funds on certain community LTSS expenditures through September 2015, provided they made three structural changes to increase community LTSS:

- No Wrong Door/Single Entry Point System – establish a statewide coordinated system that provides information, application assistance, referrals, and eligibility determinations.
- Core Standardized Assessment Instrument(s) – ensure standardized assessment instruments are used in a uniform manner throughout the state to determine eligibility, identify needs, and inform care planning. Assessment instruments must address ADLs, medical diagnoses, cognitive functioning, and behavior concerns.
- Conflict-Free Case Management – ensure separation of case management and eligibility determination from service provision (e.g., through administrative separation of services and enhanced state oversight).

By September 2015, participating states were required to fully implement the three structural

changes and achieve at least a 50 percent benchmark of Medicaid community LTSS expenditures. In October 2012, Texas began participating in BIP, receiving a total grant award of \$283.5 million. Texas structural changes included:

- Expanding Aging and Disability Resource Center (ADRC) coverage statewide;
- Establishing a toll-free number to provide individuals with information about and access to services;
- Integrating a basic screening tool into the Your Texas Benefits self-service web portal to direct individuals to the services that best meet their needs; and
- Enhancing certain LTSS assessment instruments.

Other activities funded through BIP to increase access to community services included:

- Additional community-based waiver slots;
- CFC services;
- Specialized therapies for individuals with acquired brain injury and targeted case management in several waiver programs; and
- A base wage increase to improve recruitment and retention of direct service workers.

As of September 2015, Texas spent 56.3 percent of Medicaid LTSS funds on community LTSS.

CMS Regulations on HCBS Settings and Person-Centered Planning

In March 2014, the Centers for Medicare & Medicaid Services (CMS) issued a new rule for the delivery of Medicaid HCBS. The purpose of the rule is to ensure individuals receive services in fully integrated settings. Services cannot be provided in a setting that is institutional in nature or has the effect of isolating individuals from the greater community. The rule requires all HCBS settings meet certain standards, including:

- Integration in and support for full access to the greater community;
- Providing opportunities to work in integrated settings;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Provides opportunities for individuals to control their own schedules and activities; and
- Allows for choice regarding services and who provides them.

All HCBS must comply with the new settings rule by March 2019.

The HCBS rule also requires that people receiving HCBS have a person-centered service plan. As

such, the rule outlines the required contents of a plan. Person-centered service plans document service options that take into account an individual's strengths, goals, and preferences as well as needs.

Prescribed Pediatric Extended Care Centers

S.B. 492, 83rd Legislature, Regular Session, 2013, directed DADS to create a new licensure category and HHSC to establish a new Medicaid benefit for Prescribed Pediatric Extended Care Centers (PPECC).

A PPECC provides non-residential, facility-based care during the day as an alternative to private duty nursing (PDN) for individuals under age 21 who are medically or technologically dependent. When prescribed by a physician, the child or young adult can attend a PPECC up to a maximum of 12 hours per day to receive medical, nursing, psychosocial, therapeutic, and developmental services appropriate to their medical condition and developmental status. Per S.B. 492, the payment rate for PPECCs must not exceed 70 percent of the average hourly rate for PDN. PPECCs became a Medicaid benefit effective November 1, 2016.

Licensure requirements were amended by H.B. 2340, 84th Texas Legislature, Regular Session, 2015. H.B. 2340 requires DADS to

create three licensure categories: temporary, initial, and renewal. PPECCs must be licensed by DADS in order to enroll as a Medicaid provider.⁴

Electronic Visit Verification

Electronic visit verification (EVV) is a telephone and computer-based system that verifies individuals receive the authorized service visits for which the state is billed. EVV electronically logs the precise time a visit begins and ends using an individual's home landline telephone or a small alternate device. As of June 1, 2015, EVV is required by state rule for attendant services in certain FFS and managed care home and community-based programs, including CFC and some waivers. EVV is optional for members who have selected the CDS delivery option.

Since April 1, 2016, all Medicaid providers required to use EVV who fail to achieve and maintain an EVV compliance score of at least 75 percent per review period (90 percent starting April 1, 2017) may be subject to the corrective action plan process, liquidated damages, and the imposition of contract actions (including contract termination).

⁴ This function will transfer to HHSC on September 1, 2017.

IDD Managed Care Pilot

S.B. 7, 83rd Legislature, Regular Session, 2013, authorized HHSC and DADS to develop and implement a pilot program to test one or more service delivery models involving a capitation-based managed care strategy to deliver Medicaid LTSS to individuals with IDD. H.B. 3523, 84th Legislature, Regular Session, 2015, requires the pilot to be implemented by September 1, 2017. The pilot may operate for up to 24 months.

Per the legislation, the pilot must be voluntary and pilot participants may come from community-based ICFs/IID or the CLASS, DBMD, HCS, and TxHmL programs. HHSC determined the pilot will not include ICFs/IID or the TxHmL waiver program. HHSC was not appropriated any new or additional funds for the pilot program, so no new waiver slots are available for the pilot.

The legislation allows the pilot to be operated by managed care organizations (MCOs) or private LTSS service providers that meet requirements around offering managed care services.

The pilot must be designed to:

- Increase access to LTSS;
- Improve quality of acute care services and LTSS;
- Promote meaningful outcomes by using person-centered planning, individualized budgeting, and

self-determination, and promote community inclusion and customized, integrated, competitive employment;

- Promote integrated service coordination of acute care services and LTSS;
- Promote efficiency and the best use of funding;
- Promote the placement of an individual in housing that is the least restrictive setting appropriate to the individual's needs;
- Promote employment assistance and supported employment;
- Provide fair hearing and appeals processes in accordance with applicable federal law; and
- Promote sufficient flexibility to achieve the goals through the pilot program.

Services for People Age 65 and Older or with Physical Disabilities

LTSS for people age 65 and older or with physical disabilities include HCBS and NF services. If eligible for Medicaid, individuals may receive an array of services, from non-skilled personal care to skilled nursing services.

In addition to the growth of the population age 65 and older, the number of Texans age 5 and older with a physical disability is projected

to increase from 1.7 million in 2015 to 3.6 million in 2040.⁵

Community Services and Supports: Medicaid State Plan Services

Medicaid state plan community-based programs provide Medicaid-covered services in homes and other community settings, enabling 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. These state plan services are PAS, community attendant services (CAS), personal care services (PCS), and DAHS. CFC, discussed earlier in this chapter, is also a state plan community-based benefit.

Personal Assistance Services

PAS is a Medicaid community-based entitlement service delivered through several programs, including STAR+PLUS and traditional FFS Medicaid, where it is known as Primary Home Care. Being an entitlement means the state must provide PAS to all individuals who request services and are determined eligible. PAS is a non-technical, non-skilled service that includes

⁵Texas Demographic Center/Office of the State Demographer at the University of Texas at San Antonio; U.S. Census Bureau's 2015 American Community Survey (Texas Public Use Sample)

attendant care for individuals with an approved medical need for assistance with personal care tasks. PAS is available to eligible adults whose health conditions create limitations in their ability to perform ADLs as determined by a health care practitioner. Covered services include an escort to obtain a medical diagnosis or treatment or both, home management assistance such as laundry and housekeeping, and PCS such as bathing, dressing, grooming, and preparing meals. PAS can be the critical factor in keeping individuals in their own homes and out of institutions.

Community Attendant Services

The CAS program is an entitlement program that provides personal care without other Medicaid benefits to individuals whose income is too high to qualify for Medicaid, but who meet the higher NF income limit, which is 300 percent of the Supplemental Security Income (SSI) federal benefit rate (FBR). 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 conditions create limitations in their ability to perform ADLs as determined by a health care practitioner. 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 PCS such as bathing, dressing, grooming and preparing meals. In state fiscal year 2015, the CAS program served an average of 52,640 individuals per month, with an annual expenditure of \$611.5 million all funds.

Personal Care Services

PCS is a Medicaid benefit through which individuals receive assistance with ADLs and IADLs. To receive PCS, an individual must:

- Be under 21 years of age and have Medicaid;
- Have a disability, physical or mental illness, or a health problem that lasts for a long time;
- Have a Practitioner Statement of Need signed by a practitioner (physician, advanced practice registered nurse, or physician assistant);
- Need help with ADLs and IADLs based on an assessment; and
- Have a reason why his or her guardian cannot provide the necessary assistance.

In state fiscal year 2015, the average number of children and young adults served by non-waiver, community-based entitlement programs offering PCS was 61,031 per month with an annual expenditure of \$601.3 million all funds.

Day Activity and Health Services

DAHS provides up to 10 hours of services per day, Monday through Friday, to individuals residing in the community as 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 for care or supervision by a licensed nurse, a functional limitation related to the medical diagnosis, and the need for assistance with one or more personal care tasks. In state fiscal year 2015, DAHS facilities provided services to a monthly average of 1,207 individuals with an annual expenditure of \$7.9 million all funds.

Community Services and Supports: Non-State Plan Models

STAR+PLUS

The Medicaid STAR+PLUS program provides primary, acute care, behavioral health care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability. LTSS include services such as attendant care and DAHS. In

addition, STAR+PLUS members who do not have Medicare are eligible for unlimited prescriptions. The program operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through five MCOs under contract with HHSC. Individuals have the choice of at least two STAR+PLUS MCOs in each service area and have the option to change plans.

The STAR+PLUS program serves adults with SSI, SSI-related Medicaid, and those who qualify for Medicaid because they meet medical necessity criteria for NF services and, as a result, receive services through the STAR+PLUS HCBS Program (also called the STAR+PLUS HCBS waiver). If eligible for STAR+PLUS, adults are required to participate in the program.

STAR+PLUS enrollees who are eligible for both Medicaid and Medicare receive LTSS through STAR+PLUS and most acute care services through Medicare.

The STAR+PLUS program provides only acute care services to non-dual eligible members receiving services from an ICF/IID or a 1915(c) waiver program for individuals with IDD (HCS, CLASS, TxHmL, DBMD). Adults in an IDD waiver or residing in an ICF/IID are required to participate in STAR+PLUS for acute care services only. All dual eligible individuals who are currently living in an ICF/IID or receiving IDD waiver services and

individuals residing in an SSLC are excluded from participation in the STAR+PLUS program.

Adults with disabilities may be in the Health Insurance Premium Program (HIPP) and enrolled in STAR+PLUS at the same time. HHSC will expand STAR+PLUS to include women in the Medicaid for Breast and Cervical Cancer program in September 2017. These women will be assigned a service coordinator when they enroll in STAR+PLUS.

STAR+PLUS program members have access to a primary care provider (PCP) who knows their health care needs and can coordinate their care through a medical home. STAR+PLUS also offers services not available in traditional FFS, such as value-added or case-by-case services. STAR+PLUS members with complex medical conditions are assigned a service coordinator who is responsible for coordinating acute care and LTSS. The service coordinator develops an individual service plan with the member, the individual's family members, and providers and can authorize certain services. A STAR+PLUS member who is not assigned a service coordinator can call the MCO and ask for one.

STAR+PLUS HCBS Program

STAR+PLUS HCBS is part of the larger STAR+PLUS program. STAR+PLUS HCBS provides LTSS to clients who are elderly or who

have disabilities as a cost-effective alternative to living in a NF. Services included are nursing, PAS, adaptive aids, medical supplies, and minor home modifications to make members' homes more accessible. To be eligible for STAR+PLUS HCBS, a member must be age 21 or older, meet income and resource requirements for Medicaid NF care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a NF.

STAR Kids

STAR Kids is the managed care program that provides acute care and LTSS benefits to children and young adults ages 20 and younger with disabilities. STAR Kids was implemented on November 1, 2016 and operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through MCOs. Children, young adults, and their families have the choice of at least two STAR Kids health plans in each service area and have the option to change plans.

Children and young adults ages 20 and younger who either receive SSI or SSI-related Medicaid or are enrolled in MDCP receive all of their Medicaid services through the STAR Kids program. Children and youth who get services through the Medicaid Buy-In Program for Workers with Disabilities or the Medicaid Buy-In for Children program are also required to enroll in STAR Kids.

Children and youth who receive services through the following 1915(c) waiver programs will receive their basic Medicaid health services (acute care and some LTSS) through STAR Kids and will continue to receive their waiver LTSS through their waiver program:

- HCS
- CLASS
- DBMD
- TxHmL
- YES

Children and youth who reside in a community-based ICF/IID or a NF will receive their acute care services and service coordination through a STAR Kids health plan.

Children and youth who are dual-eligible receive most of their acute care services through Medicare, but receive LTSS and service coordination through the STAR Kids MCOs.

Children and youth may be on the HIP program and enrolled in STAR Kids at the same time.

All STAR Kids members have access to service coordination through an MCO. The service coordinator is responsible for coordinating acute care and LTSS. The service coordinator develops an individual service plan with the member, the member's family members, and providers and can authorize certain

services. The program also ensures that each member has a PCP who knows their health care needs and can coordinate their care through a medical home. STAR Kids MCOs also offer additional services not available in traditional FFS, such as value-added or case-by-case services.

Medically Dependent Children Program

MDCP provides HCBS to children and young adults under 21 years of age as an alternative to residing in a NF. Services include respite, flexible family supports, employment assistance, supported employment, adaptive aids, and minor home modifications. Transition assistance services are available for individuals transitioning from a NF to the MDCP waiver program. In state fiscal year 2015, MDCP served an average of 5,256 individuals per month with an annual expenditure of \$88.6 million all funds.

Children and young adults with disabilities receiving benefits under the MDCP waiver began receiving benefits under STAR Kids on November 1, 2016.

Nursing Facilities

NFs provide 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. Texas has adopted optional eligibility standards that allow people with incomes of up to 300 percent of the SSI FBR to qualify for Medicaid-funded NF care, although most of their income must be used toward the cost of their care.⁶

In addition to room and board, required services include nursing, social services and activities, over-the-counter drugs (prescription drugs are covered through Medicaid or Medicare Part D), medical supplies and equipment, personal needs items, and rehabilitative therapies.

Since March 1, 2015, most Medicaid clients age 21 and over receiving NF services are enrolled in STAR+PLUS. STAR+PLUS benefits for NF residents include service coordination and value-added services. The STAR+PLUS MCOs are responsible for adjudicating claims, including prescription drug claims for NF services.⁷

⁶The 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.

⁷Prescriptions for individuals who are dually eligible have their prescriptions covered under Medicare Part D.

In state fiscal year 2015, NFs served an average of 31,260 individuals per month through Medicaid at a cost of \$1.4 billion all funds. Also in state fiscal year 2015, an average of 3,487 individuals per month had their Medicare skilled NF co-insurance paid by Medicaid, with an annual expenditure of \$98.1 million all funds.

Medicaid Hospice Program

The hospice program provides palliative care in the home or in community settings, long-term care facilities (for example, 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. In accordance with federal law, 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 palliative 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, PAS, therapies,

prescription drugs, and respite care. In state fiscal year 2015, the program served an average of 7,075 individuals per month with an annual expenditure of \$256.6 million all funds.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive care approach providing an array of services for a capitated monthly fee below the cost of comparable institutional care. PACE participants must be age 55 or older, live in a PACE service area, qualify for NF level of care, and be able to live safely in the community at the time of enrollment. PACE participants receive all medical and social services they need through their PACE provider.

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 is available in 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 state fiscal year 2015, the average number of participants per month receiving PACE services was 1,110 with an annual expenditure of \$37.5 million all funds.

Dual Demonstration

The Dual Eligible Integrated Care Demonstration Project, also referred to as the Dual Demonstration, is a fully integrated managed care model for individuals age 21 or older who are dually eligible for Medicare and Medicaid and required to receive Medicaid services through the STAR+PLUS program. More information on the Dual Demonstration may be found in **Chapter 11, Fee-for-Service and Managed Care.**

Medicare Advantage Dual Eligible Special Needs Plan

A Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) is a managed care delivery model specifically designed to coordinate care between Medicare and Medicaid covered services for individuals that are dually eligible for both programs. For more information on D-SNPs, please see **Chapter 11, Fee-for-Service and Managed Care.**

Services for People with an Intellectual Disability or Related Condition

Medicaid-funded LTSS for individuals with an intellectual disability or related condition include 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 a few 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. SSLCs are one type of ICF/IID.

Community Services and Supports: Waivers

Medicaid HCBS waiver programs provide services that enable people with intellectual disabilities 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, TxHmL, and DBMD. Non-dual eligible adults enrolled in these waiver programs are also enrolled in the STAR+PLUS Medicaid managed care

program to receive their basic health services. In each of the waivers, home-based habilitation services were replaced by CFC, but are still provided by the waiver provider.

Home and Community-based Services

The HCS waiver provides individualized services to individuals of all ages who qualify for an ICF/IID level of care. 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 (now CFC habilitation but still provided by the waiver provider), 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 CDS option. Residential service options include host home/companion care, supervised living, and residential support services.

In state fiscal year 2015, HCS served an average of 22,443 individuals per month with an annual expenditure of \$947.2 million all funds.

Community Living Assistance and Support Services

The CLASS waiver provides HCBS 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 or mental illness which originates before age 22 and is found to be closely related to an intellectual disability because the condition substantially limits life activity similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for individuals with an intellectual disability. Related conditions include disabilities such as cerebral palsy, epilepsy, spina bifida, and head injuries.

Services include case management, prevocational services, residential habilitation (now CFC habilitation but still provided by the waiver provider), 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 CDS option.

In state fiscal year 2015, CLASS served an average of 4,910 individuals per month with an annual expenditure of \$225.4 million all funds.

Texas Home Living

The TxHmL waiver provides selected services and supports costing 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 (now CFC habilitation but still provided by the waiver provider), 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 CDS option.

In state fiscal year 2015, TxHmL served an average of 5,651 individuals per month with an annual expenditure of \$61.1 million all funds.

Deaf-Blind with Multiple Disabilities

DBMD provides HCBS 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 (now CFC habilitation but still provided by the waiver provider); 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 CDS option.

In state fiscal year 2015, DBMD served an average of 203 individuals per month with an annual expenditure of \$9.4 million all funds.

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

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 related condition function to their greatest ability (related conditions are described in the CLASS waiver section of this chapter).

ICFs/IID are considered institutional settings. Adults receiving services through the ICF/IID program are also enrolled in the STAR+PLUS Medicaid managed care program to receive their basic health services. Children under age 21 receiving services through the ICF/IID program receive their basic health services through STAR Kids.

ICF/IID residential settings range in size from six beds to several hundred. In state fiscal year 2015, an average of 5,177 Medicaid-eligible individuals per month received services from non-state operated ICFs/IID with an annual expenditure of \$268.4 million all funds. 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 the Texas Administrative Code, Title 40, Chapter 9, Subchapter E.

SSLCs are state-operated by DADS and are an example of ICFs/IID that are certified, but not licensed.

State Supported Living Centers

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.⁸ 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 general revenue and third-party revenue resources. Individuals receiving services through an SSLC are excluded from enrollment in Medicaid managed care.

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. During state fiscal year 2015, an average of 3,241 individuals lived in SSLCs with an

annual expenditure of \$684.1 million all funds.

Additional Resources and Programs

Promoting Independence Initiative and Money Follows the Person

LTSS include 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 the 1999 *Olmstead vs. L.C.* U.S. Supreme Court decision, the state launched the Promoting Independence Initiative, which provided the opportunity to change this policy.

The 2002-03 General Appropriations Act, S.B. 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37), 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 receive their LTSS. Other support services have subsequently been developed to help in the identification of

⁸ These functions will transfer to HHSC on September 1, 2017.

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.

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HHSC and DADS successfully competed for a federal Deficit Reduction Act of 2005 MFP demonstration (MFPD) award to build upon and enhance the Promoting Independence Initiatives. The MFPD began in 2008 and will continue through 2019.

Under MFPD, 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 MFPD. In order to be an MFPD 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 June 2016, MFPD has helped over 10,000 individuals transition from institutional to community-based services. Another 34,598 individuals transitioned under the Texas Promoting Independence Initiative.

The MFPD enhanced funding and MFP grant create opportunities to fund a variety of 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 of 14 ADRCs to provide options counseling to non-Medicaid NF 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; and
- 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 are experiencing either a behavioral or mental health crisis or have a history of intermittent behavioral challenges. Eligible individuals must also require the establishment of a proactive action plan to maintain stability.

Aging and Disability Resource Centers

ADRCs 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 both private and public LTSS programs and benefits, including Medicaid. ADRCs assist individuals with decision-making about services 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 area agencies on aging, community services regions, and local intellectual and developmental disability authorities. There are 22 ADRCs operating throughout Texas.

Service Delivery Options

Individuals have multiple options through which certain LTSS (most commonly, attendant care) may be delivered. Each option requires a different level of responsibility of the individual.

Agency Option

The Agency Option is the traditional method of service delivery where services are delivered through a provider agency. The provider agency is the employer of attendants or other direct service workers, and is responsible for:

- Recruiting, hiring, managing, training, monitoring, and dismissing employees;
- Employee payroll, taxes, and costs associated with employment;
- Determining the rate of pay and benefits for employees;
- The liability of the employee, such as an on-the-job injury;
- Retaining contractors and vendors; and
- Providing back up services.

Provider agencies are licensed or certified by DADS and must comply with DADS licensure and program rules. The provider agency⁹ or service coordinator coordinates with the individual or authorized representative to monitor services and ensure the individual is satisfied with their services.

Consumer Directed Services Option

CDS is an LTSS option in which the individual receiving services has choice and control over the delivery

of services. In some cases, parents of minor children or an individual's guardian has the control and choice on behalf of the person receiving services. The CDS option allows the individual or the individual's legally authorized representative to be the employer of record of the direct care worker providing services. The individual or legally authorized representative has responsibility for hiring, training, supervising, and, if necessary, dismissing the employee. Individuals may appoint a designated representative to assist with some employer responsibilities, like submitting time sheets.

Those who use the CDS option are required to select a financial management services agency (FMSA) that provides orientation, writes paychecks for the providers, and pays federal and state employer taxes on behalf of the employer. In addition to an FMSA, individuals who choose the CDS option may request support consultation. Support consultation is an optional support service for individuals who want additional help to coach and train their employees and other employer-related skills.

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. Individuals may choose the agency option for some services and the CDS option for

⁹ DBMD only.

others. Informed choice is important to the concept of consumer direction. An individual's case manager or service coordinator is responsible for ensuring the individual and their family understand the risks and benefits of the choice to direct their own services.

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

- Waivers: HCS, CLASS, TxHmL, DBMD, MDCP.
- State plan services: PAS, CAS, PCS, CFC.
- Managed care programs: STAR+PLUS, STAR+PLUS HCBS, STAR Kids, STAR Health.

Service Responsibility Option

SRO is available only in Medicaid managed care. SRO is a hybrid of the agency option and CDS option in which an individual, the MCO, and a provider agency work together to provide the individual with increased control over the delivery of their services. In Medicaid managed care, services with the CDS option also have SRO.

In SRO, the MCO provides the individual or their authorized representative with a list of provider agencies participating in SRO. The agency then meets with the individual to understand their preferences and service needs. The agency and the individual select their direct care workers

and train the providers to meet the individual's preferences and needs. The providers are employed by the agency and the agency is accountable for all employer-related responsibilities like payroll and employer taxes. The individual selects and trains the providers and works with the agency to develop service back-up plans and to dismiss providers when necessary.

Chapter 8: Behavioral Health Services

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

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

State Plan Services

Screening Services

Health and Behavior Assessment and Intervention

Health and Behavior Assessment and Intervention (HBAI) services became a Texas Medicaid benefit in 2014. HBAI services are designed to identify the psychological, behavioral, emotional, cognitive, and social factors that are important to prevent, treat, or manage physical health symptoms. Services are provided by licensed practitioners of

In This Chapter:

State Plan Services

Screening Services

Health Behavior Assessment and Intervention

Screening, Brief Intervention and Referral to Treatment

Texas Health Steps Mental Health Screening

Treatment Services

Mental Health Treatment Services

Substance Use Disorder Treatment Services

Home and Community-Based Services

Adult Mental Health

Youth Empowerment Services

Waiver

Behavioral Health Integration Mental Health Parity

Medicaid Managed Care Rules

NorthSTAR Transition

the healing arts who are co-located in the same office or building as the client’s primary care provider (PCP). HBAI services help promote physical and behavioral health integration.

Medicaid clients from birth through 20 years of age are eligible for this service.

Screening, Brief Intervention and Referral to Treatment

Screening, Brief Intervention and Referral to Treatment (SBIRT) is a comprehensive public health approach to the delivery of early intervention and treatment services for clients with alcohol or SUD, as well as those who are at risk of developing these disorders. SBIRT was originally made a Medicaid benefit in 2009 to allow adolescents who present at an emergency department for trauma or injury related to substance use to receive an SBIRT intervention. In July 2016, the SBIRT benefit was expanded to include adults and community-based settings. The benefit also allows providers to be reimbursed for screening-only sessions.

Texas Health Steps Mental Health Screening

Mental health screening is required at each Texas Health Steps (THSteps) medical checkup for children birth through 20 years of age per the THSteps Medical Checkup Periodicity Schedule. Beginning in 2015, a one-time mental health screening for children 12 to 18 years of age using one of four standardized screening tools is now separately payable to THSteps providers.

Treatment Services

Mental Health Treatment Services

Medicaid mental health treatment services include:

- Psychiatric diagnostic evaluation and psychotherapy performed by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists;
- Psychological and neuropsychological testing performed by psychologists and physicians;
- Inpatient psychiatric care in a general acute care hospital;
- Inpatient care in psychiatric hospitals (for persons under age 21 and age 65 and older);
- Psychotropic medications and pharmacological management of medications;
- Rehabilitative and targeted case management services for people with severe and persistent mental illness or children with severe emotional disturbance; and
- Care and treatment of behavioral health conditions by a PCP.

Substance Use Disorder Treatment Services

The 2010-11 General Appropriations Act (GAA), S.B. 1, 81st Legislature, Regular Session,

2009 (Article IX, Health-Related Provisions, Section 17.15), authorized the Health and Human Services Commission (HHSC) to add comprehensive SUD benefits for adults in Medicaid to reduce substance abuse related medical expenditures.

Medicaid SUD benefits were implemented in two phases: most outpatient benefits began on September 1, 2010, and residential benefits and detoxification (residential and ambulatory) services began January 1, 2011. These benefits apply to Medicaid clients enrolled in traditional fee-for-service Medicaid and Medicaid managed care. The benefits are provided through state licensed substance abuse treatment facilities and narcotic treatment programs. Benefits include the following services:

- Assessment to determine a client’s need for services;
- Individual and group outpatient SUD treatment counseling;
- Medication assisted therapy (e.g., methadone for opioid addiction);
- Outpatient detoxification;
- Residential detoxification; and
- Residential treatment.

Home and Community-Based Services

Adult Mental Health

Many adults with a diagnosis of serious mental illness have complex needs that lead to extended psychiatric hospitalizations, repeated arrests, and frequent emergency department visits. In 2010, the Department of State Health Services (DSHS) convened a continuity of care stakeholder task force to identify needs and recommend reforms. Among the recommendations was the development of home and community-based services (HCBS) for adults with serious mental illness.

Following these recommendations, the 2014-15 GAA, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, DSHS, Rider 81), required DSHS to create a program through a section 1915(i) state plan amendment to provide community-based services and supports for individuals who have experienced extended stays in inpatient psychiatric settings. The purpose of this program is to help these individuals remain in the community. The 2016-17 GAA, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 61b), extended HCBS to include diversion efforts for adults with frequent arrests and/or emergency department visits.

While the Centers for Medicare & Medicaid Services (CMS) has approved delivery of HCBS-adult mental health (AMH) for adults age 18 and older with extended hospitalizations, delivery of services for adults with frequent arrests or emergency department visits remains under CMS review as of December 2016.

8 The HCBS-AMH program provides an array of intensive HCBS tailored to an individual's assessed needs, in consideration of the individual's preferences and goals. HCBS-AMH provides the following services: host home/companion care, supervised living services, assisted living, supported home living, psychosocial rehabilitative services, employment services, minor home modifications, home-delivered meals, transition assistance services, adaptive aides, transportation services, community psychiatric supports and treatment, peer support, short-term respite care, SUD services, nursing, flexible funds, and recovery management.

Services are provided in CMS-approved settings, which may include an individual's home or apartment, an assisted living setting, or small community-based residence.

Youth Empowerment Services Waiver

The Youth Empowerment Services (YES) waiver is a Medicaid 1915(c)

HCBS waiver allowing for more flexibility in the funding of intensive community-based services for children and adolescents (ages 3 to 18 years) with serious emotional disturbances and their families.

YES provides the following services: adaptive aids and supports; community living supports; employment assistance; family supports; minor home modifications; non-medical transportation; paraprofessional services; pre-engagement service (for non-Medicaid applicants); respite (in-home and out-of-home); specialized therapies (animal-assisted therapy, art therapy, music therapy, nutritional counseling, and recreational therapy); supported employment; supportive family-based alternatives; and transitional services. YES waiver recipients are enrolled in Medicaid managed care and receive their non-YES waiver services through their managed care organization (MCO).

The YES waiver was initially available in a limited geographic area, but was expanded statewide in September 2015. In July 2016, children and adolescents in foster care became eligible to receive YES services.

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.

Behavioral Health Integration

S.B. 58, 83rd Legislature, Regular Session, 2013, required HHSC to integrate behavioral health and physical health services into Medicaid managed care programs by adding mental health targeted case management and mental health rehabilitative services to the array of services provided by MCOs by September 1, 2014. The legislation required the MCOs to develop a network of public and private providers of mental health rehabilitation and mental health targeted case management, and to ensure adults with serious mental illness and children with serious emotional disturbance have access to this comprehensive array of services. HHSC must also develop two Medicaid health home pilot 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 DSHS established a Behavioral Health Integration Advisory Committee as directed by the Legislature. The Behavioral Health Integration Advisory Committee provided formal recommendations to HHSC on the implementation of the S.B. 58 requirements. HHSC is working to ensure the implementation plan for behavioral health integration and

the health home pilots is consistent with the recommendations provided by the Behavioral Health Integration Advisory Committee in the fall of 2016.

Mental Health Parity

Congress has enacted various pieces of legislation over the past 20 years to make the treatment of mental health equal to treatment for physical health. Prior to the enactment of legislation, mental health coverage had been treated differently from physical health coverage.

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA did not require large group health insurance plans to offer mental health and SUD benefits, but it prohibited these plans from having differences in treatment limits, cost-sharing, and in- and out-of-network coverage between mental health and SUD benefits, if offered, and medical and surgical benefits.

The Children's Health Insurance Program Reauthorization Act of 2009 incorporated MHPAEA requirements into CHIP state plans.

As of 2009, Medicaid was required to be in compliance with MHPAEA. Reviews conducted by HHSC in 2011 and 2014 demonstrated Texas Medicaid was in full compliance with the 2008 MHPAEA requirements.

CMS issued final rules in 2016 addressing the application of MHPAEA parity requirements to MCOs, Medicaid alternative benefit plans, and CHIP. All states must be in compliance with these new regulations by October 2017.

Texas is in the process of developing processes to evaluate MCO compliance with the new parity regulations.

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Medicaid Managed Care Rules

CMS issued final Medicaid managed care rules, effective July 5, 2016, that align Medicaid managed care regulations with many of the rules governing other major sources of coverage, including qualified health plans and Medicare Advantage plans. As they relate to behavioral health, the final rules require the following:

- Managed care contracts must comply with parity requirements for mental health and SUD, and capitation rates must be based upon and include services that are necessary for compliance with parity.
- Inpatient stays in an institution for mental disease (e.g., inpatient psychiatric hospital) for individuals ages 21-64 can be no longer than 15 days a month if the stay meets the criteria of an “in lieu of” service.

HHSC is evaluating these final rules and assessing their impact on the state’s Medicaid managed care contracts.

NorthSTAR Transition

NorthSTAR was an integrated behavioral health delivery system in the Dallas service area serving people who were eligible for Medicaid or who met other eligibility criteria. When the state terminated the NorthSTAR program on December 31, 2016, individuals began receiving all Medicaid services through managed care programs, including STAR, STAR+PLUS and STAR Kids. For more information about the NorthSTAR transition, please see **Chapter 11, Fee-for-Service and Managed Care.**

Chapter 9: Prescription Drugs

Texas Medicaid and the Children’s Health Insurance Program (CHIP) cover most outpatient prescription drugs either through a 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 state fiscal year 2016, an average of 3.8 million clients per month were eligible to receive medications through the program. Texas Medicaid paid approximately \$3.7 billion for over 48 million prescriptions, with an average cost per prescription of \$75.32.

Adults enrolled in traditional fee-for-service (FFS) Medicaid are limited to three prescriptions per month. All other Medicaid-eligible individuals are allowed an unlimited amount of prescriptions.

Outpatient Drug Benefit in Fee-for-Service

The Health and Human Services Commission (HHSC) directly contracts with over 4,900 dispensing pharmacies to provide prescription

In This Chapter:

Outpatient Drug Benefit in Fee-for-Service

Outpatient Drug Benefit in Managed Care

Federal Drug Rebate Program

Preferred Drug List and Supplemental Rebate Program

Drug Utilization Review

e-Prescribing

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drugs to clients in Medicaid FFS and managed care. Texas pays for all Medicaid FFS outpatient drug coverage through VDP, with the exception of some medications provided as part of outpatient physician services.

Clients who are dually eligible for Medicaid and Medicare receive most of their prescription drugs through the Medicare prescription drug benefit known as Medicare Part D (see **Chapter 2, Medicaid and CHIP in Context**).

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 the STAR, STAR+PLUS, STAR Health, and STAR Kids managed care programs.

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Pharmacy providers must enroll with HHSC prior to participating in any managed care pharmacy network. Each MCO builds its own pharmacy network to allow local pharmacies to dispense pharmaceuticals to managed care members. The MCO contracts with a pharmacy benefits manager (PBM) to process prescription claims. 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.

MCOs and PBMs are required by state law to adhere to the 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. MCOs/PBMs

may implement any of the state's approved clinical PA, but no more. Clinical PAs may vary between plans because not all MCOs may choose to implement each clinical PA; however, there are some clinical PAs that all MCOs and FFS are required to implement.

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 PA.

Federal Drug Rebate Program

Among other provisions, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) required the implementation of a federal Medicaid drug rebate program, 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 of 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 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.

VDP 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. HHSC also collects rebates for drugs provided to clients in CHIP and three state health programs, including

the Healthy Texas Women program. The 2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 23), requires HHSC to submit an annual report to the Legislature on rebate revenues and outstanding balances. The 2016-17 GAA (Article II, HHSC, Rider 5) also establishes collected rebates as the first source of funding for Medicaid and CHIP prescription drug services, before general revenue. HHSC collected approximately \$2.1 billion all funds in Medicaid rebates in calendar year 2015.

Preferred Drug List and Supplemental Rebate Program

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

The PDL contains medications in various therapeutic classes that are designated as "preferred" or "non-preferred" based on safety, efficacy, and cost-effectiveness. Prescribers who choose non-preferred medications for their patients must

obtain PA. The Texas Drug Utilization Review (DUR) Board 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 claims information indicating 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 preserve Medicaid's ability to meet clients' increasing prescription drug needs, as well as other health care needs.

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

Supplemental rebates are collected under the PDL provisions of H.B. 2292. 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 percentage used to pay the claims.

HHSC estimates receiving a total of \$828 million in Medicaid VDP rebates in state fiscal year 2016. This amount includes \$79.1 million in supplemental VDP rebates.

Drug Utilization Review

Prospective and retrospective DURs play 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, ingredient duplication, 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 claims 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 DUR Board is an HHSC advisory board composed of 17 physicians and pharmacists who provide Medicaid services and represent different specialties, two representatives from Medicaid MCOs as nonvoting members, and a consumer advocate representing Medicaid recipients. Members are appointed by the HHSC Executive Commissioner. The board reviews and approves the therapeutic criteria for prospective and retrospective DUR and clinical PA criteria. Board meetings are held quarterly in Austin.

e-Prescribing

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

- The Medicaid/CHIP drug formulary and PDL are available to FFS and MCO prescribers electronically. Prescribers' electronic health records (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' electronic health record (EHR) systems as well as pharmacies' management software. Medicaid/CHIP client eligibility can be verified in a timely manner by providers and pharmacies, ensuring clients receive the full benefit of their enrollment and timely access to prescription drugs.
- Medication histories of Medicaid/CHIP clients are available for providers and pharmacies, integrated alongside formulary and benefit eligibility information.

The federal Drug Enforcement Administration issued rules in 2010 allowing the e-prescribing of controlled substances (ePCS). The rules included a requirement for the certification of both the prescriber software system and pharmacy software system by an independent third party auditor. The Texas Department of Public Safety has adopted the same requirements and updated their rules and regulations in October 2013 to allow controlled substances, including Schedule II,

to be prescribed and transmitted electronically. By September 2016, 94.8 percent of pharmacies in Texas were capable of accepting ePCS. Texas Medicaid has organized a statewide effort to raise awareness and use of ePCS in Texas. With ePCS, prescribers spend less time on the phone, and improve security and confidentiality. Pharmacies decrease phone calls, eliminate verbal misinterpretations and increase prescription accuracy. Patients benefit from improved safety. Texas Medicaid providers can learn how to start using ePCS and which EHR systems are ePCS enabled by going to www.getEPCS.com.

Chapter 10: CHIP and CHIP Perinatal

Children’s Health Insurance Program

States like Texas that operate a separate Children’s Health Insurance Program (CHIP) have three options for determining coverage.

- Benchmark coverage 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 has the same aggregate actuarial value as one of the benchmark plans. States choosing 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

In This Chapter:

Children’s Health Insurance Program

Mental Health Parity

CHIP Dental

Cost-Sharing

Delivery Network

CHIP Perinatal Program

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, 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. These

benefits are subject to certain limitations and exclusions. Texas most recently modified behavioral health and dental benefits

pursuant to the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

Table 10.1: Services Covered by Texas CHIP, 2016

- 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

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into federal law on October 3, 2008. MHPAEA requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at parity with medical and surgical benefits. CHIPRA 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, the Health and Human Services Commission (HHSC) increased certain co-payments for CHIP members above 150 percent of the federal poverty level (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 began covering 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.

Cost-Sharing

Most families in CHIP pay an annual enrollment fee to cover all children in the family. All CHIP families pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency room setting. Unborn children and newborns in the CHIP Perinatal program are exempt from cost-sharing requirements. CHIP annual enrollment fees and co-payments vary based on family income. 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.

See **Chapter 14, Finances**, for more information on CHIP fees and cost-sharing amounts.

Delivery Network

CHIP services are delivered by MCOs selected by the state through competitive procurement. There are 10 service areas with a total of 17 MCOs delivering services to CHIP members statewide.

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Enrollees residing in a CHIP service area have a choice of at least two MCOs (see **Appendix B, Medicaid and CHIP Service Areas**).

In order to provide CHIP members with a choice of dental plans, HHSC expanded the number of dental maintenance organizations from one to two in 2012.

CHIP Perinatal Program

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, and whose household income is at or below 202 percent of the FPL. Services include prenatal visits, prescription prenatal vitamins, labor and delivery, and postpartum care. Members receiving the CHIP Perinatal benefit

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

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

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

Chapter 11: Fee-for-Service and Managed Care

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

Medicaid Fee-for-Service

Some Medicaid clients are served through a traditional 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 its specific FFS payment methodologies for mandatory and optional Medicaid services in its 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 has been an effort underway to transition the majority of Texas Medicaid clients who remain in FFS to managed care.

Care Coordination

The Texas Medicaid Wellness Program is a whole-person care management service that supports Medicaid clients' individual health needs and challenges. The program serves clients receiving Medicaid through the FFS system who are not in another Medicaid waiver program.

The Texas Medicaid Wellness Program focuses on three main components: client self-management, provider practice and delivery system design, and technological support. Under client self-management, a client becomes an informed and active participant in the management of his

or her physical and mental health conditions and co-morbidities. Under the provider practice and delivery system design approach, medical home providers take an active role in helping their patients make informed health care decisions. Lastly, the foundation for the success of the program includes technology, such as the use of predictive modeling, to identify potential program patients and providers.

Historically, the majority of clients served by the Wellness Program were children under the age of 21 who receive Medicaid due to qualifying for Supplemental Security Income (SSI). With the implementation of the STAR Kids managed care program on November 1, 2016, children under the age of 21 with SSI Medicaid began receiving service coordination through their STAR Kids managed care organization (MCO).

Since the implementation of STAR Kids, the majority of individuals served in the Wellness Program are women ages 18 and older who are in the Medicaid for Breast and Cervical Cancer (MBCC) program and children previously in the care of the Department of Family and Protective Services (DFPS) who have been adopted or who are in permanent placements and now receive Adoption Assistance (AA) or Permanency Care Assistance (PCA) Medicaid. The contract for the Wellness Program is scheduled

to end on August 31, 2017, when the MBCC, AA, and PCA populations begin receiving services in Medicaid managed care.

Medicaid Managed Care

As shown in **Figure 11.1**, most people in Texas who have Medicaid get their services through managed care (also see **Appendix D, Managed Care History in Texas**). In state fiscal year 2015, the average monthly enrollment of managed care members receiving full Medicaid benefits was 3.5 million, or 87 percent of the state's 4.06 million Medicaid full benefit clients. Clients are referred to as "members" in managed care.

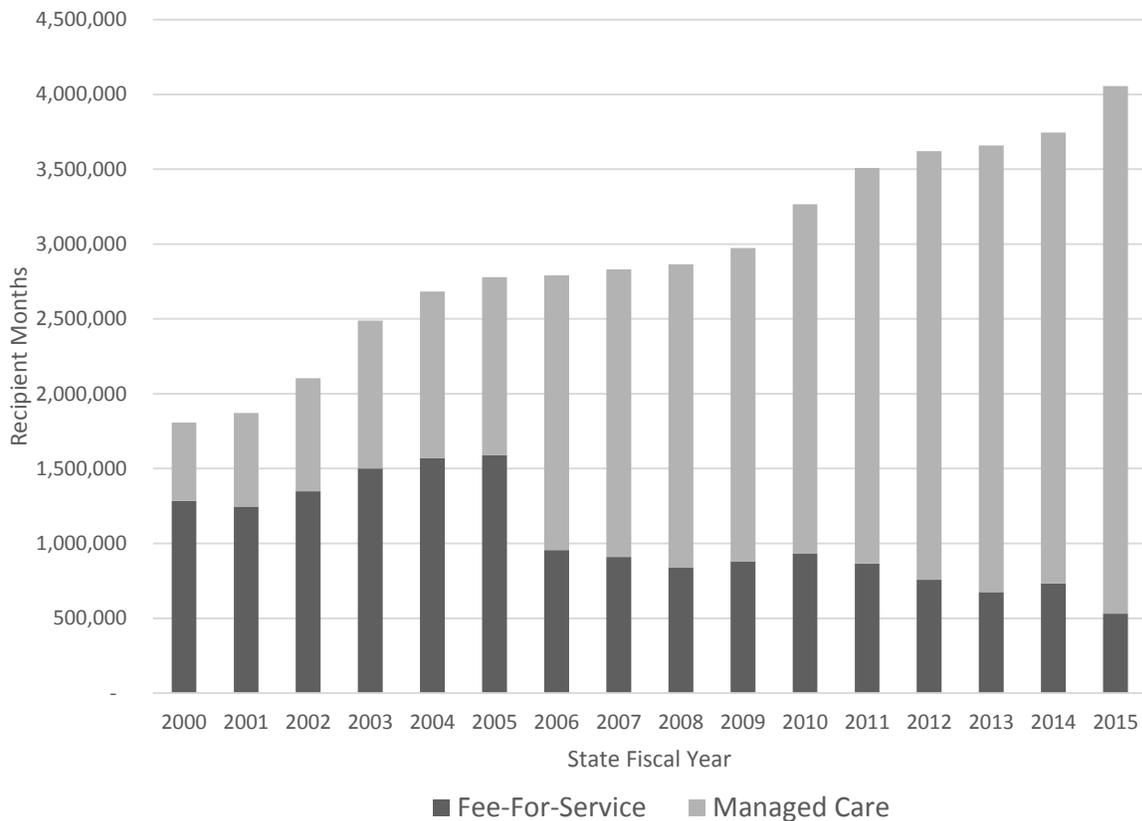
Under the managed care model, the Health and Human Services Commission (HHSC) contracts with MCOs, also known as health plans, and pays them a monthly amount to coordinate and reimburse providers for health services for Medicaid members enrolled in their health plan. MCOs are required to provide all covered medically necessary services to their members. Each member receives Medicaid services through an MCO's network of providers. Members may choose an MCO, or have one selected for them by HHSC if they do not. MCOs vary by service area and program and there are at least two MCOs for members to choose from in each

service area (see **Appendix B, Medicaid and CHIP Service Areas**).

Within Medicaid managed care, there currently are four comprehensive programs: STAR, STAR+PLUS, STAR Health, and STAR Kids. These programs serve distinct populations

with varying health care needs as described below. **Tables 11.1** and **11.2** show the number and percent, respectively, of Medicaid clients enrolled in FFS and in each managed care program.

Figure 11.1: Medicaid FFS vs. Managed Care Caseloads, SFYs 2000-2015



Source: HHSC, Financial Services, HHS System Forecasting.

Note: Caseloads reflect average monthly recipients.

Table 11.1: Medicaid Clients Enrolled in Managed Care and FFS, SFYs 2011-2015

Service Delivery Type	2011	2012	2013	2014	2015
FFS	866,908	761,964	675,706	733,859	532,121
Managed Care	2,676,149	2,893,965	2,982,923	3,012,265	3,524,581
<i>STAR PCCM*</i>	887,919	402,097	0	0	0
<i>STAR MCO</i>	1,536,422	2,121,651	2,546,683	2,570,545	2,941,333
<i>STAR Health</i>	31,834	31,171	30,293	30,727	30,909
<i>STAR+PLUS</i>	219,975	339,047	405,947	410,994	538,385
<i>Dual Demonstration</i>	0	0	0	0	13,954
Total Medicaid Clients	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702

Source: HHSC, Financial Services, HHS System Forecasting.

*Primary Care Case Management (PCCM) was a managed care option that ended in 2012.

Table 11.2: Percentage Medicaid Clients by Service Delivery Type, SFYs 2011-2015

Service Delivery Type	2011	2012	2013	2014	2015
FFS	24.5%	20.9%	18.5%	19.6%	13.1%
<i>STAR PCCM*</i>	25.1%	11.0%	0.0%	0.0%	0.0%
<i>STAR MCO</i>	43.4%	58.1%	69.6%	68.6%	72.5%
<i>STAR Health</i>	0.9%	0.9%	0.8%	0.8%	0.8%
<i>STAR+PLUS</i>	6.2%	9.3%	11.1%	11.0%	13.3%
<i>Dual Demonstration</i>	0.0%	0.0%	0.0%	0.0%	0.3%

Source: HHSC, Financial Services, HHS System Forecasting.

*PCCM was a managed care option that ended in 2012.

1115 Transformation Waiver Managed Care Authorization

The Texas Health care Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, has allowed Texas to expand its use of Medicaid managed care while preserving

federal hospital funding historically received as supplemental payments under the Upper Payment Limit program. More information about the 1115 Transformation Waiver may be found in **Chapter 15, The 1115 Transformation Waiver**.

Managed Care Delivery System Features

Medical Home

Medicaid managed care members choose a primary care provider (PCP) who serves as the member's medical home by providing comprehensive preventive and primary care. The PCP also makes referrals, when required by the MCO, 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 (OB/GYNs); physician assistants; advanced practice registered nurses; and federally qualified health centers (FQHCs), rural health clinics, and similar community clinics. Occasionally, specialists agree to act as the PCP for clients with special health care needs.

Defined Provider Network

Access to Care

In managed care, MCOs are required to ensure their members 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.

MCOs are obligated to maintain access to network providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider in order to ensure members have access to medically necessary and appropriate services.

Network Adequacy

According to federal and state requirements, MCOs must:

- Have sufficient capacity to serve the expected enrollment;¹
- Meet service area needs with geographic distribution of preventative, primary care, and specialty service providers;²
- Establish and maintain networks providing access to all services covered under the state contract by looking at the geographic location of providers and Medicaid enrollees and the physical accessibility of the location for Medicaid enrollees with disabilities;³ and
- Submit out-of-network utilization reports; HHSC is required to set benchmarks for out-of-network

¹ SSA §1932(b)(5); Texas Government Code §533.005

² 42 C.F.R. §438.207; Texas Government Code §533.005

³ 42 C.F.R. §438.206

utilization and establish standards for reasonable reimbursement rates.⁴

Medicaid managed care contracts outline requirements for MCOs, including network adequacy standards and benchmarks. HHSC continually monitors MCO compliance with network adequacy standards through various platforms including: readiness review, quarterly performance review, quarterly reports to CMS, and complaints.

- **Readiness Review:** Prior to any Medicaid managed care expansion or new initiative, HHSC will conduct a readiness review to determine each MCO's ability, preparedness, and availability to fulfill its obligations including provider access.
- **Quarterly Performance Review:** MCOs are required to submit quarterly data reports on various measures including: geoaccess, provider networks, provider terminations, and open panels. HHSC staff review data and recommend contractual remedies (e.g., corrective action plans, liquidated damages) for deficiencies.
- **Quarterly Reports to CMS:** The 1115 Transformation Waiver requires HHSC to report network adequacy requirements to CMS, such as member enrollment,

provider networks, access for members with special health care needs and geoaccess.

- **Member Complaints:** HHSC tracks member complaints by category, including access to care.

The managed care contracts give HHSC flexibility to impose a number of remedies, up to and including enrollment suspension and termination. The most commonly-enforced remedies are corrective action plans and liquidated damages.

Senate Bill 760

S.B. 760, 84th Legislature, Regular Session, 2015, requires HHSC to establish additional minimum provider access standards for Medicaid MCO provider networks. These requirements include:

- Developing new minimum distance, travel time, and appointment wait time standards for member access to providers;
- Updating the expedited credentialing process to expand the list of provider types eligible for expedited credentialing; and
- Requiring all MCOs to publish provider directories online, with provider information updated at least monthly.

In response to S.B. 760, HHSC is updating Medicaid managed care contractual requirements to implement the bill's provisions and to provide additional enhancements

⁴ Texas Government Code §533.007

to current network access requirements.

CMS Managed Care Regulations

In April 2016, CMS released final regulations revising Medicaid managed care requirements. The regulations include new network adequacy requirements for states including the development of time and distance standards. CMS requires Texas to comply with these access standards by September 2018. HHSC is developing an implementation plan for complying with the requirements.

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Appointment Availability Studies

In 2015, HHSC began performing appointment availability studies which directly monitor MCOs' provider networks and providers using a secret shopper methodology. The appointment availability studies specifically assess compliance with appointment availability and appointment wait times outlined in the Uniform Managed Care Contract for PCP, OB/GYN, vision, and behavioral health providers for members in STAR, STAR+PLUS, and CHIP.

Preventive Care

MCOs are required to ensure 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.

Utilization Review and Management

MCO utilization management (often used interchangeably with utilization review) includes prospective, concurrent, and retrospective reviews. Prospective reviews include practices such as preadmission screenings and prior authorization (PA) 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.

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 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 develop service plans for members with special health care needs (MSHCN).

An MSHCN is a member 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, specialty care, and long-term services and supports (LTSS) needs are met through a comprehensive 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. All members in STAR+PLUS and STAR Kids are considered MSHCN.

Value-Added Services

Managed care clients also have access to value-added services and additional benefits not available in the FFS program. Value-added services are additional health care services 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. An MCO 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.

Medicaid Managed Care Programs

STAR

The Medicaid STAR program provides primary, acute care, behavioral health care, and pharmacy services for pregnant women, newborns, and children and parents with limited income. Acute care services include doctor visits, pharmacy, home health, medical equipment, lab, x-ray, and hospital services. In addition, STAR members are eligible for unlimited prescriptions. The program operates statewide under the authority of the 1115 Transformation Waiver. Services are delivered through MCOs under contract with 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 in STAR as

STAR Health is not an option for this population.

Individuals who reside in institutions (including nursing facilities (NFs)), receive SSI or Medicare, are in a 1915(c) waiver program, are medically needy, or are in state conservatorship are generally excluded from STAR enrollment.

Additionally, individuals receiving AA or PCA Medicaid will be mandated to enroll in STAR in September 2017, unless they are also enrolled in Medicare, a waiver, or receive SSI.

STAR program members have access to a PCP who knows their health care needs and can coordinate their care through a medical home. PCPs provide preventive checkups, treat the majority of conditions STAR members experience, and refer enrollees to specialty care when necessary. STAR also offers additional services not available in traditional FFS. STAR members are not subject to the 30-day spell of illness limitation for adults that exists in the FFS and STAR+PLUS programs. STAR members also receive service management, which is provided to MSHCN.

STAR+PLUS

The Medicaid STAR+PLUS program provides both acute care services and LTSS by integrating primary care, behavioral health care, pharmacy services, and LTSS for

individuals who are age 65 or older or adults who have a disability. LTSS includes services such as attendant care and day activity and health services. In addition, STAR+PLUS members are eligible for unlimited prescriptions. The STAR+PLUS MCOs are responsible for coordinating acute care and LTSS for STAR+PLUS members with complex medical conditions. For more information about the STAR+PLUS program, please see **Chapter 7, Long-Term Services and Supports**.

STAR+PLUS HCBS Program

The STAR+PLUS Home and Community-Based Services (HCBS) program is part of the STAR+PLUS program. The STAR+PLUS HCBS program provides additional LTSS to clients who are elderly or who have disabilities as a cost-effective alternative to living in a NF. In addition to STAR+PLUS services and service coordination, the HCBS program includes LTSS such as nursing, personal assistance services, adaptive aids, medical supplies, and minor home modifications to make members' 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 STAR+PLUS HCBS program services, a member must meet income and

resource requirements for Medicaid NF care, and receive a determination from HHSC that they meet the medical necessity criteria to be in a NF.

STAR Kids

The STAR Kids program provides acute and LTSS benefits, including private duty nursing and personal care services, to children and young adults with disabilities. STAR Kids implemented statewide on November 1, 2016. There are 13 STAR Kids service areas and 10 MCOs. STAR Kids Medicaid members can select from at least two MCOs in each service area. For more information on STAR Kids, see **Chapter 7, Long Term Services and Supports**.

STAR Health

STAR Health is a statewide program designed to provide a comprehensive array of health care services for children and youth in conservatorship of DFPS, including those in foster care and kinship care. Services include:

- Primary care
- Acute care
- Behavioral health care
- Dental
- Vision
- Pharmacy

- LTSS

Services are delivered through a single MCO under contract with 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, and young adults up to the month of their 21st birthday who were formerly in foster care and are receiving Medicaid services under the Former Foster Care Children and Medicaid for Transitioning Foster Care Youth eligibility categories. Clients can begin receiving services as soon as they enter state conservatorship.

STAR Health program members have access to a PCP who knows their health care needs and can coordinate their care through a medical home. STAR Health also offers additional services not available in traditional FFS, including service management; service coordination; a seven-days-per-week, 24-hours-per-day nurse hotline for caregivers and caseworkers; and the Health Passport, a web-based, claims-based electronic medical record.

Use of psychotropic medications among STAR Health members is carefully monitored for compliance with the DFPS Psychotropic

Medication Utilization Parameters.

The parameters are best practice guidelines for the use of psychotropic medication in children. In 2010, the STAR Health program began training and certifying behavioral health providers in Trauma Focused Cognitive Behavioral Therapy and training in trauma-informed care was made available to all caregivers and caseworkers.

Trauma-informed care training provides education about how to effectively manage behavior issues that can destabilize children's health status and foster family placement and how to create an environment that promotes healing from trauma associated with abuse or neglect. In 2015, the program also began training and certifying behavioral health providers in other evidence-based and promising practices such as Parent Child Interaction Therapy, Trust-Based Relational Intervention, and Child Parent Psychotherapy.

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 each STAR Health member. Depending

upon the severity of the identified needs, the MCO will assign a service manager or service coordinator to the child.

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, or licensed clinical social workers. Service coordination is for moderate to low risk members who require minor assistance with a health need. Service coordinators must be degreed professionals. The service manager or coordinator will reach out telephonically to 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 also 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 high emergency department utilization or inpatient admissions. The Intellectual and Developmental Disabilities Management program identifies and supports those with

a diagnosis of autism, Asperger's syndrome, intellectual disability, or pervasive developmental disorder.

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 health care providers, DFPS staff, and caregivers. Health Passport information is available to authorized users through a secure, password-protected website administered by the STAR Health MCO.

The Health Passport is a web-based repository of health care services data for each STAR Health member. It displays a summary of care; a visit list for medical, behavioral health, vision, and dental care; a list of medications filled; and documents such as health care service plans, psychotropic review, and Child and Adolescent Needs and Strengths assessments. The Health Passport 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 care data viewable in the Health Passport includes current as well as historical health care services data for STAR Health members who may have been previously 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; and assessments are viewable the day they are uploaded. 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.

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The Health Passport 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.

In 2015, enhancements were made to the Health Passport to make the application more user friendly. The application now has a redesigned look; mobile access capability; the ability to enter future scheduled appointments and provider referrals; and an interactive growth chart that displays height and weight entries.

Psychotropic Medication Utilization Review

In 2004, a report released by the U.S. Office of Inspector General raised concerns regarding the use of psychotropic medications among Texas children in foster care. Since then, HHSC, DFPS, and the Department of State Health Services (DSHS) 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. Several new editions have been released since 2005. 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 on children in foster care whose medication regimens fall outside 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 group also oversees an annual report on psychotropic utilization and the biennial review and update of the parameters.

Starting in 2011, PA was required to dispense an antipsychotic medication to Medicaid members under age three and those taking more than two different antipsychotic medications concurrently. 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. Since the release of the parameters in early 2005, the percentage of children in foster care taking psychotropic medication and the number of children whose medication regimens fall outside of the parameters' recommendations have decreased.

Children's Medicaid Dental Services Program

As of March 1, 2012, Children's Medicaid Dental Services (CMDS) program benefits 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 CMDS 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 NFs, state supported living centers, or intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/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 dental 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.

Medicare Advantage Dual Eligible Special Needs Plan

A Medicare Advantage (MA) Dual Eligible Special Needs Plan (D-SNP)

is a managed care delivery model specifically designed to provide targeted care to individuals who are dually eligible for both Medicare and Medicaid. Eligible individuals who live in an area in which these MA plans operate may choose to receive their Medicare and Medicaid services through such a plan. Under this managed care delivery option, D-SNPs are responsible for the coordination of care between Medicare and Medicaid covered services. D-SNPs that also operate in STAR+PLUS deliver Medicaid services through the STAR+PLUS program. D-SNPs that do not also operate in STAR+PLUS are only responsible for paying beneficiary cost-sharing.

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Recent Initiatives

In addition to the establishment of the STAR Kids program on November 1, 2016, HHSC has implemented the following managed care initiatives since the 10th Edition of *Texas Medicaid and CHIP in Perspective* (February 2015).

Nursing Facility Carve-in

S.B. 7, 83rd Legislature, Regular Session, 2013, directed HHSC to provide Medicaid benefits to recipients who reside in NFs through the STAR+PLUS Medicaid managed care program. Effective March 1, 2015, NF services became a statewide covered benefit under the STAR+PLUS managed care

program for clients age 21 years and older. The goal of the NF carve-in was to improve quality of care and health outcomes for NF residents by coordinating health care and access to services, ensuring client needs are addressed in the least restrictive, most appropriate setting, and reducing unnecessary hospitalizations and potentially preventable events (PPEs). Approximately 47,000 NF residents transitioned from FFS Medicaid to the STAR+PLUS program and receive their Medicaid through a STAR+PLUS MCO.

The three Medicaid populations excluded from the NF carve-in were clients age 20 and younger, those living in the Truman W. Smith Children's Care Center, and those living in a Veterans Land Board Texas State Veterans Home.

NF residents who are participants in the Texas Dual Eligible Integrated Care Demonstration Project (known as the Dual Demonstration) receive their Medicaid and Medicare services through one Medicare-Medicaid Plan (MMP) plan, including NF services (see the Dual Demonstration section below).

All STAR+PLUS NF residents are assigned an individual MCO service coordinator, who visits residents at least quarterly.

As directed by S.B. 7, HHSC set a ten day adjudication period for clean

claims, and a minimum protected NF unit rate of reimbursement based on the NF resident's Minimum Data Set resource utilization group level. MCOs pay negotiated rates for other medically necessary acute care and add-on services. Add-on NF services include:

- Emergency dental services;
- Physician-ordered rehabilitation services (e.g., goal directed therapy); and
- Durable medical equipment such as customized power wheelchairs and augmentative communication devices.

S.B. 7 also required HHSC to establish credentialing and minimum performance standards for NF providers seeking to participate in STAR+PLUS. MCOs must use state-identified credentialing criteria for NFs and may only contract with an NF with a valid certification, license, and contract with the state. Additionally, HHSC developed a process for measuring quality of care provided to individuals residing in NFs. Measures are included in the 2015 Performance Indicator Dashboard for Quality Measures, found in the Uniform Managed Care Manual.

Dual Demonstration

In May 2014, HHSC received federal approval for a fully integrated, capitated model that involves a three-party contract between an MCO with an existing STAR+PLUS contract, the state, and CMS for the provision of the full array of Medicaid and Medicare services. The Dual Demonstration is testing 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 costs for both the state and the federal government. The demonstration began March 1, 2015.

Under this initiative, an MCO called an MMP is responsible for the full array of Medicare- and Medicaid-covered services. MMP members receive primary, acute care, behavioral health care, pharmacy, and LTSS.

The Dual Demonstration serves 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 are 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 HCBS Program services.

The Dual Demonstration does not include clients who reside in ICFs/ IID and individuals with intellectual and developmental disabilities (IDD) who receive services through the Community Living Assistance and Support Services, Deaf-Blind with Multiple Disabilities, Home and Community-based Services, or Texas Home Living waivers.

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

NorthSTAR Transition

NorthSTAR was an integrated behavioral health delivery system in the Dallas service area serving people who were eligible for Medicaid or who met other eligibility criteria. The program was overseen by DSHS and services were 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 received behavioral health services through NorthSTAR.

In accordance with the 2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, DSHS, Rider 85), the state terminated the NorthSTAR program on December 31, 2016. Upon termination of the program, individuals began receiving all of their Medicaid services through managed care programs, including STAR, STAR+PLUS and STAR Kids.

Health Insurance Premium Payment Carve-In

Information on the Health Insurance Premium Payment program's managed care carve-in may be found in **Chapter 14, Finances**.

Upcoming Initiatives

Adoption Assistance and Permanency Care Assistance Carve-Ins

Adoption Assistance

AA is a program designed to facilitate the adoption of children defined as having special needs. In Texas Child Protective Services cases, adoption

becomes an option if DFPS and the child's birth parents cannot resolve issues that made it unsafe for the child to live at home. Adoption is the legal process through which a child joins a family different from his or her birth parents and is a permanent, lifelong commitment to a child.

To be eligible for this program, the child must have special needs as defined by the Texas Administrative Code (TAC), Title 40, §700.804. Extended AA is also available for eligible individuals on behalf of certain children over the age of 18, as provided by TAC, Title 40, §700.851. Three types of benefits may be provided under this program:

- Medicaid health coverage for the child;
- Monthly payments to assist in meeting the child's needs; and
- Reimbursement for certain adoption fees up to \$1,200.

Permanency Care Assistance

PCA is a program available to persons who assume managing conservatorship of a child who was previously in the temporary or permanent managing conservatorship of DFPS. Extended PCA is also available for eligible individuals on behalf of certain children over the age of 18, as provided under TAC, Title 40, §700.1053. Three types of benefits may be provided under this program:

- Monthly cash assistance benefits through the last day of the month of the child's 18th birthday;
- Medicaid coverage on behalf of the child; and
- A one-time reimbursement of nonrecurring expenses relating to the legal process of becoming the managing conservator of the child, not to exceed \$2,000 per child.

STAR Carve-In

The 2014-15 GAA, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51(b)(15)), directs HHSC to transition remaining Medicaid FFS populations into managed care. HHSC determined children and young adults receiving AA and PCA Medicaid could benefit from a managed care model.

Most individuals in the AA or PCA programs will transition into STAR beginning September 1, 2017. Children and young adults under age 21 in AA or PCA who also receive services through a 1915(c) waiver for individuals with IDD, Medicare, or SSI will transition to STAR Kids.

Children and young adults transitioning to STAR will receive the full array of Medicaid benefits and additional services offered through the STAR program and MCOs. STAR MCOs will be required to provide additional assistance to AA and PCA members related to service management, continuity of

care, medical history sharing and psychotropic drug utilization review.

Medicaid for Breast and Cervical Cancer Carve-In

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 gave states the option to provide Medicaid medical assistance to women who were screened through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer.

To be eligible for MBCC, women must meet the following criteria:

- 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;
- Must not have creditable coverage (health insurance coverage for breast or cervical cancer);
- Be a Texas resident; and
- Be a U.S. citizen, or an immigrant with a qualifying status.

MBCC clients will continue to receive full Medicaid benefits as long as they are eligible, and every six months provide:

- Proof of active treatment for breast or cervical cancer from the treating

physician (Form H1551, Treatment Verification); and

- A completed Form H2340, MBCC Renewal.

STAR+PLUS Carve-In

In accordance with Rider 51(b)(15), HHSC determined women in MBCC could benefit from a managed care model.

Women, ages 18 through the end of the month when the woman turns 65, participating in the MBCC program, will transition into STAR+PLUS beginning September 1, 2017.

MBCC clients will receive the full array of Medicaid benefits and other services offered through the STAR+PLUS program. MBCC members will receive the highest level of service coordination available in STAR+PLUS. Coordination provides specialized care management services including two face-to-face visits annually. The service coordinator has the opportunity to align visits to assist with the MBCC eligibility renewal process to help prevent delays in services due to untimely form submission.

Intellectual and Developmental Disabilities Pilot

Information on the IDD Pilot, a program which will use a managed

care model to deliver Medicaid LTSS to individuals with IDD, may be found in **Chapter 7, Long-Term Services and Supports**.

CHIP Managed Care Programs

There are 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 MCOs in each service area (see **Appendix B, Medicaid and CHIP Service Areas**).

Managed Care Contract Oversight

HHSC routinely monitors MCO performance through managed care contracts. These contracts outline requirements related to MCO responsibilities such as member benefit packages, provider network adequacy and accessibility, member and provider call centers, claims processing, member and provider complaints and appeals, encounter submission, member enrollment data, and delivery of service management or service coordination.

HHSC receives approximately 100 deliverables from each MCO on a quarterly basis. These deliverables provide data related to each of the

requirements above and assist HHSC in monitoring MCO compliance. HHSC also researches complaints received directly from members and providers to immediately address any concerns. In addition, HHSC monitors the financial performance of each MCO and their subcontractors and affiliates.

If an MCO fails to meet a contractual requirement, the managed care contracts give HHSC the authority to use a variety of disciplinary remedies such as corrective action plans, financial remedies, contract restrictions, and contract termination. MCOs not in compliance with contractual requirements are required to immediately address any identified instances of non-compliance.

HHSC also requires MCOs to submit to various third party audits. An independent contractor audits the MCO on an annual basis and the results are submitted to HHSC. Third party risk assessments are conducted biannually, and, at HHSC's discretion, third party performance audits are conducted as a result of the risk assessment findings. In addition, the HHSC Inspector General is statutorily mandated to conduct a number of inspections and audits on an ongoing basis to investigate potential areas of waste, fraud, and abuse.

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) clients 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 to meet client needs.

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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 MTP services. The MTO delivery model operates in contiguous counties within a managed transportation service region. The shift in the type of transportation model included a change in the payment structure. The MTOs operate under a capitated

rate structure and assume financial responsibility under a full-risk model.

Full-Risk Broker

The 2010-11 GAA, S.B. 1, 81st Legislature, Regular Session, 2009 (Article II, HHSC, Rider 55), required HHSC to implement a full-risk broker (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. HHSC contracted with two FRBs to coordinate transportation using a network of providers in the Dallas/Fort Worth and Houston/Beaumont service areas.

Transportation and Related Services

Mass Transit

Mass transit is intercity or intra-city transportation by bus, rail, air, ferry, or publicly or privately owned transit that provides general or special service on a regular or continuing basis. Mass transit tickets are issued when it is determined to be the appropriate mode of transportation for the client, ensuring the client does not live more than a quarter mile from a public fixed route stop, the appointment is not more than a quarter mile from a public fixed route stop, and mass transit tickets are received by the client before the client's appointment. 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 FRB responds to requests for individual or shared one-way trips. Services must be timely and provided by licensed, qualified, and trained personnel.

Individual Transportation Request

Individual Transportation Participant (ITP) services are provided by individuals who register to participate in the MTO or FRB ITP program. An ITP is an individual who has been approved for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized health care service. Mileage reimbursement is paid to an individual who drives himself or herself, a family member, friend or neighbor to and from a Medicaid-covered health care service. ITPs are paid the mileage reimbursement rate adopted by HHSC.

Meals and Lodging

Meals and lodging are provided for Medicaid children and their attendant

when health care treatment requires an overnight stay outside the county of residence or beyond adjacent counties. The MTO or FRB 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 or FRB and are provided in advance of travel and disbursed to the eligible recipient, responsible party, or ITP for the purpose of funding transportation or transportation-related services (e.g., gasoline, meals).

Out-of-State Travel

The MTO or FRB 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 or FRB 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

When necessary, such as for medically necessary services outside a client's MTO region of residence, the MTO or FRB is responsible for arranging commercial air transportation for the client and, when applicable, the client's attendant.

Managed Care Quality Assurance

Ensuring the delivery of cost-effective, 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 CHIP that includes initiatives based on legislation such as S.B. 7 (2013) and S.B. 7, 82nd Legislature, First Called Session, 2011.

External Quality Review Organization

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) performs three CMS-required functions

related to Medicaid managed care quality. The EQRO validates MCOs' performance improvement projects (PIPs), validates performance measures, and conducts a review to determine MCOs' compliance with certain federal Medicaid managed care regulations. In addition, states may also contract with the EQRO to validate member-level data; conduct member surveys, provider surveys, or focus studies; and calculate performance measures. The Institute for Child Health Policy (IHP) has been the EQRO 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.

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 HCBS Program), STAR Health, CHIP, STAR Kids, 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.

Quality Indicators

A combination of established sets of national measures and state-developed measures validated by the EQRO are used to track and monitor program and MCO performance. Measures include:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®) – A nationally recognized and validated set of measures used to gauge quality of care provided to members. HEDIS domains include Effectiveness of Care, Access and Availability of Care, Experience with Care, and Health Care Utilization.
- Agency for Healthcare Research and Quality Pediatric Quality Indicators (PDIs)/Prevention Quality Indicators (PQIs) – PDIs use hospital discharge data to measure the quality of care provided to children and youth. PQIs use hospital discharge data to measure quality of care for specific conditions known as “ambulatory care sensitive conditions”

(ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.

- 3M® Software for PPEs – HHSC uses and collects data on Potentially Preventable Admissions, Potentially Preventable Readmissions, Potentially Preventable Emergency Department Visits, Potentially Preventable Complications, and Potentially Preventable Ancillary Services.
- Consumer Assessment of Health care Providers & Systems (CAHPS®) Surveys – CAHPS Health Plan Survey is a nationally recognized and validated tool for collecting standardized information on members’ experiences with health plans and services. ICHP conducts CAHPS surveys biannually.

Pay-for-Quality

S.B. 7 (2013) focused on the use of quality-based outcome and process measures in quality-based payment systems by measuring PPEs, rewarding use of evidence-based practices, and promoting health care coordination, collaboration, and efficacy. As directed by S.B. 7, HHSC implemented the Pay-for-Quality (P4Q) program in 2014. The P4Q program created financial incentives and disincentives for health plans

and dental plans to promote incremental improvement on a set of quality measures, including PPE and HEDIS measures. The P4Q program is currently being redesigned and a revised P4Q model will be implemented on January 1, 2018.

Performance Improvement Projects

PIPs are an integral part of Texas Medicaid's Quality Improvement Strategy. The Balanced Budget Act of 1997 requires all states with Medicaid managed care programs to ensure MCOs conduct PIPs. Federal regulations require PIPs to use ongoing measurements and interventions to achieve significant improvement over time on health outcomes and enrollee satisfaction. Health plans conduct PIPs to examine and improve areas of service or care identified by HHSC in consultation with Texas' EQRO as needing improvement. Topics are selected based on MCO performance on quality measures and member surveys. HHSC requires each MCO to conduct two PIPs per program, and one PIP per health plan must be a collaboration with another MCO or a Delivery System Reform Incentive Payment project.

MCO Report Cards

S.B. 7 (2011) requires HHSC to provide information on outcome and process measures to Medicaid

and CHIP members regarding MCO performance during the enrollment process. To comply with this requirement and other legislatively mandated transparency initiatives, HHSC develops report cards for each managed care program service area to allow members to compare the MCOs on specific quality measures. These report cards are intended to assist potential enrollees in selecting an MCO based on quality metrics. Report cards are posted on the HHSC website and included in the Medicaid enrollment packets. Report cards are updated annually.

Quality Assessment and Performance Improvement Programs

Federal regulations also require Medicaid MCOs to operate quality assessment and performance improvement (QAPI) programs. These programs evaluate performance using objective quality standards, foster data-driven decision-making, and support programmatic improvements. MCOs report on their QAPI programs each year and these reports are evaluated by Texas' EQRO.

Performance Indicator Dashboards

The Performance Indicator Dashboards include a series of measures that identify key aspects

of MCO performance to support MCO accountability. Dashboard measures include standards of performance for MCOs. The dashboards are shared on the HHSC website with the program-level performance on each measure included for comparison.

Part IV. Delivery**Chapter 12:
Operations and Support****Texas Medicaid
Management
Information System**

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. The administrative functions that comprise the Texas Medicaid Management Information System (TMMIS) are described below.

***Texas Integrated
Eligibility Redesign
System***

The Health and Human Services Commission (HHSC) uses an integrated system to determine eligibility for Medicaid, the Children's Health Insurance Program (CHIP), the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). The eligibility

In This Chapter:**Texas Medicaid Management
Information System**

- Texas Integrated Eligibility Redesign System
- Texas Medicaid & Healthcare Partnership
- Pharmacy Administration
- External Quality Review Organization
- Transformed Medicaid Statistical Information System

**Health Information
Technology**

- Electronic Health Record Incentive Program
- Health Information Exchange via Health Information Organizations
- Statewide Health Information Exchange
- e-Health Advisory Committee
- Medicaid Eligibility and Health Information Services System

Managed Care Systems

- Enrollment Broker
- Premiums Payable System

system offers access to eligibility services through multiple channels, including a self-service website (www.YourTexasBenefits.com), a mobile application, 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 has enhanced the self-service options available to clients through www.YourTexasBenefits.com and the Your Texas Benefits mobile application.

More information about the eligibility application and determination process may be found in **Chapter 3, Eligibility**.

Texas Medicaid & Healthcare Partnership

Texas Medicaid contracts with vendors to manage the majority of its fiscal agent and claims administrative functions. These vendors are known collectively as the Texas Medicaid & Healthcare

Partnership (TMHP). THMP conducts various duties on behalf of the state, most importantly management of the Medicaid claims administrative and operational functions and the information systems collectively known as 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 other Health and Human Services system agencies also are served under this arrangement.

THMP currently handles the development and operation of TMMIS including the following functions:

- Encounter processing and reporting for all managed care 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, as well as 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 and 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.
 - 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 those receiving Medicaid acute care, Medicaid long-term services and supports, Healthy Texas Women (HTW) services, and CSHCN services.
 - FFS provider reimbursement – provider inquiry resolution, electronic claims submission support, incorporation of reference tables (e.g., diagnosis codes, procedure codes, provider tables, recipient tables, claims history tables), as well as ad hoc reporting.
 - FFS medical and dental prior authorizations (PAs) – review, approval, and referral of PA requests; PA 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 – 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 the HHSC Inspector General to identify providers who are potentially committing waste, fraud, or abuse.

Pharmacy Administration

The state also contracts with organizations to administer several

HHSC Vendor Drug Program functions.

Pharmacy Claims and Rebate Administrator

The pharmacy claims and rebate administrator vendor processes and adjudicates all FFS outpatient prescription drug claims for Medicaid and the HTW, Kidney Health Care, 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. The vendor also stores data needed to create the National Drug Codes and Healthcare Common Procedure Coding System crosswalk for clinician-administered drug claim processing.

Pharmacy Prior Authorization Vendor

The pharmacy PA vendor evaluates PA 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 PDL vendor provides information to the Drug Utilization Review (DUR) Board 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 board with the development and maintenance of the PDL.

Retrospective Drug Utilization Review Vendor

The retrospective DUR vendor performs retrospective DURs to assist health care providers in delivering appropriate prescription pharmaceutical drugs to FFS Medicaid clients.

External Quality Review Organization

The External Quality Review Organization validates MCOs' performance improvement projects, validates performance measures, and conducts a review to determine MCOs' compliance with certain federal Medicaid managed care regulations (see **Chapter 11, Fee-for-Service and Managed Care** and **Appendix E, Managed Care Quality Assurance Reports** for more information).

Transformed Medicaid Statistical Information System

Until June 2014, Texas reported all Medicaid data to the Centers for Medicare & Medicaid Services (CMS) through a quarterly reporting

system called the Medicaid Statistical Information System (MSIS), which began with the passing of the Balanced Budget Act of 1997. This covered all FFS and managed care claims data and eligibility data.

CMS began Transformed MSIS (T-MSIS) as a 10-state pilot program in 2011 to expand this reporting with additional claims information and incorporate changes such as:

- Including provider and third party liability reporting;
- Increasing the number of data elements by more than 400 percent;
- Removing all error tolerances; and
- Changing the reporting cycle from quarterly to monthly.

A process was also added for states to correct and resubmit data to CMS as necessary, ideally within 30 days. In 2013, the pilot moved to an active program change, expanding to include all 54 states and territories.

Health Information Technology

Electronic Health Record Incentive Program

The American Recovery and Reinvestment Act of 2009 (ARRA) 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 health information exchange (HIE) between providers and health systems.

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, prescription histories, lab tests, and allergies. 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 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 use of certified EHR technology that improves quality, safety, and efficiency of health care delivery; patient and family engagement; care coordination; and population and public health. The objectives and measures also include ensuring adequate privacy and security protections for personal health information and reducing health care disparities.

Eligible professionals and hospitals submit self-attested data to demonstrate their compliance with program requirements. States can receive 100 percent 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. As of July 2016, the Texas Medicaid EHR Incentive Program has disbursed \$794 million in federally-funded incentives to over 10,000 individual providers and hospitals combined. Through this initiative, Texas is laying the groundwork for development of accountable systems of care. Quality data received through providers’ submission of

meaningful use and clinical quality measures may be incorporated into the overall management of the Medicaid program.

EHR Incentive Program Audits

Federal rules require states to conduct audits of EHR Incentive Program payments to limit the risk of fraud and abuse. HHSC conducts post-payment audits of providers to ensure program requirements were met and payments were made appropriately. Any participating provider may be subject to an audit and federal rules require providers to maintain auditable records related to an attestation/payment for at least six years. HHSC utilizes an independent audit firm to conduct audits of EHR Incentive Program payments.

Health Information Exchange via Health Information Organizations

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 HIT to enable health care providers to access their patients’ health information to

ensure 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
- Ensuring that Texas physicians and hospitals are eligible to receive billions of dollars in available federal meaningful use incentive payments over the next several years for implementing HIE statewide.

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.

Statewide Health Information Exchange

The creation of a statewide HIE system 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. To assist with the implementation of these strategies, HHSC contracted with the Texas Health Services Authority (THSA), created by H.B. 1066, 80th Legislature, Regular Session, 2007. THSA was established as a public-private non-profit charged with implementing state-level HIT 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 for THSA to provide state-level shared HIE services.
- Local HIE Grant Program – This grant program partially funded planning, development, and operations of 16 local and regional Texas HIE networks.
- “White space” Strategy – This coverage strategy supports HIE connectivity through Health Information Service Providers in regions of the state without local or regional HIEs.

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As of March 2016, there are six regional Texas HIE networks that were funded through the State Health Information Exchange Cooperative Agreement Program, and THSA continues to operate the state-level shared services.

e-Health Advisory Committee

In accordance with S.B. 200, 84th Legislature, Regular Session 2015, a new e-Health Advisory Committee was established in August 2016. The purpose of this advisory committee is to advise the Executive Commissioner and HHS agencies on strategic planning, policy, rules,

and services related to the use of HIT, HIE systems, telemedicine, telehealth, and home telemonitoring services.

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 with a permanent plastic Medicaid ID card and provides access to automated eligibility verification.

Key features of the MEHIS system include:

- www.YourTexasBenefits.com - Where patients are able to view their benefit and case information, print or order a Medicaid ID card, set up and view their Texas Health Steps (THSteps) alerts, and view services and treatments provided by Medicaid;
- www.YourTexasBenefitsCard.com - Where Medicaid providers get timely information on a patient’s Medicaid eligibility, services, and treatments provided by Medicaid;
- Permanent plastic magnetic stripe Medicaid ID cards;

- Multiple access options for Medicaid providers; and
- Provider and client phone help desks and interactive voice response (IVR) systems.

The MEHIS system became operational in June 2011. The initial implementation included electronic eligibility verification using YourTexasBenefitsCard.com, card production and distribution, and a help desk for providers and clients.

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 about the card. The Medicaid ID 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 or IVR.

Online Client Portal

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

- Single sign-on at YourTexasBenefits.com;
- Medicaid client benefit and program information and eligibility verification;
- Ability to view and print copies of one or more Medicaid ID cards;
- Ability to view and set up THSteps alerts and email notifications for clients and their families; and
- Ability to "opt out" to block online access to their Medicaid-related health information.

On March 28, 2016, new features were added to improve functionality to the client portal. Adult clients can now see their available health information online which includes:

- Health events
- Prescription drugs
- Vaccination information
- Lab information
- Past Medicaid visits

Clients can use the Blue Button feature to view, print, or download and store their health information online. Patients who use their

health information may become more engaged with their care overall, leading to improved health outcomes.

Online Provider Portal

Another feature of the MEHIS program includes the provider portal. This portal is designed to give providers a way to view a client's Medicaid eligibility and available health information. The specific functions provided by the portal are:

- Ability to view Medicaid patient health information such as past visits, health events (including diagnosis and treatment), lab results, vaccinations, and prescription drugs;
- Ability to view THSteps alerts;
- Verification of Medicaid patient eligibility and the ability to view patient program information;
- Ability to authorize provider-level functionality to a delegate;
- Dental maintenance organization links added to the Health Summary tab; and
- Access to use the Blue Button functionality to request a Medicaid patient's health information in a single tool. YourTexasBenefitsCard.com is the only state Medicaid portal in the nation offering the Blue Button feature.

Managed Care Systems

Enrollment Broker

The eligibility support services and enrollment contractors known as the enrollment broker provide business services to support the state's determination of client eligibility for Medicaid, CHIP, SNAP, and TANF programs; operate four customer care centers; assist with eligibility services case support; enroll Medicaid and CHIP clients in MCOs; and provide outreach and informational services to THSteps clients and various community organizations.

Premiums Payable System

The Premiums Payable System (PPS) is a group of applications that generate capitation payments for clients enrolled in the STAR, STAR Health, STAR+PLUS, Medicare-Medicaid Plan, STAR Kids, CHIP, Children's Medicaid Dental Services, Medical Transportation Program, and Medicare Advantage Programs.

The PPS applications receive client eligibility data from TIERS, the Service Authorization System, and the enrollment broker contractor. Capitation payment files are sent to departments internal to HHSC and administrative contractors serving the program. In addition to

the payment applications, PPS also supports the MCOs' deliverables tracking and performance monitoring.

Part IV. Delivery**Chapter 13:
Administration****Federal Oversight**

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 and Human Services (HHS), oversees the Medicaid program. CMS approves the Medicaid state plan that each state creates. The Medicaid state plan is a dynamic document that functions as a state's contract with CMS. The state plan documents the specific services, eligible populations, and payment methodologies that comprise the Texas Medicaid program. Significant changes to a state's Medicaid program require the state to submit a state plan amendment for CMS approval. CMS also approves any waivers for which states can apply. Medicaid waivers allow states the flexibility to test new 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

*In This Chapter:***Federal Oversight****Single State Agency****Transformation****Detecting Fraud and Abuse****Affordable Care Act Program****Integrity Initiatives**

for the state's Medicaid program. The Health and Human Services Commission (HHSC) has been the single state agency for the Texas Medicaid program since January 1993. S.B. 200, 84th Legislature, Regular Session, 2015, required the transformation of the HHS system in Texas based on recommendations made by the Sunset Commission's review of the five HHS agencies. As a result, the majority of Medicaid functions are now consolidated within HHSC's newly created Medical and Social Services (MSS) Division. The Associate Commissioner of the Medicaid & CHIP Services (MCS) Department, who also serves as the State Medicaid Director, now reports to the Deputy Executive Commissioner of MSS.

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 and waivers;
- Overseeing managed care organization (MCO) contract compliance;
- Coordinating with other HHS departments and state agencies to carry out Medicaid operations;
- Operating the state's fee-for-service (FFS), pharmacy, 1115 Transformation Waiver, and managed care programs;
- Determining Medicaid eligibility;
- Establishing Medicaid policies, rules, reimbursement rates, and oversight of Medicaid program operations;
- Organizing and coordinating initiatives to maximize federal funding; and
- Administering the Medical Care Advisory Committee, a committee mandated by federal Medicaid law that reviews and makes recommendations on proposed Medicaid rules.

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Transformation

Prior to S.B. 200, H.B. 2292, 78th Legislature, Regular Session, 2003, directed the consolidation of 12 HHS agencies into five. In the ensuing

10 years, the HHS agencies worked to provide services under this streamlined model. When the Sunset Commission began its almost two-year analysis in 2013, that review was the first formal measure of the previous consolidation. The findings and recommendations of the Sunset review formed the basis for the 84th Legislature's directive to transform today's HHS system. With the passage of S.B. 200, the HHS system was directed to develop a more streamlined, efficient organization that provides services and benefits more effectively.

The goals of HHS transformation are to produce an accountable, organized system that is easier to navigate for Texans seeking information, benefits or services; promote a culture of shared responsibility for success through teamwork, effective communication and support of HHS staff; create clear lines of accountability for decision making; and use data to measure outcomes more clearly.

The creation of the MSS Division was a key transformation initiative. This new division brings all client services together, including Medicaid eligibility determination and service delivery, rather than being spread among the five HHS agencies. On September 1, 2016, client services programs and staff from the Department of Aging and Disability Services (DADS), Department of Assistive and

Rehabilitative Services (DARS), and Department of State Health Services (DSHS) transferred to HHSC's MSS Division. The division has four departments: Access & Eligibility Services; Health, Developmental & Independence Services; Intellectual and Developmental Disabilities & Behavioral Health Services; and MCS.

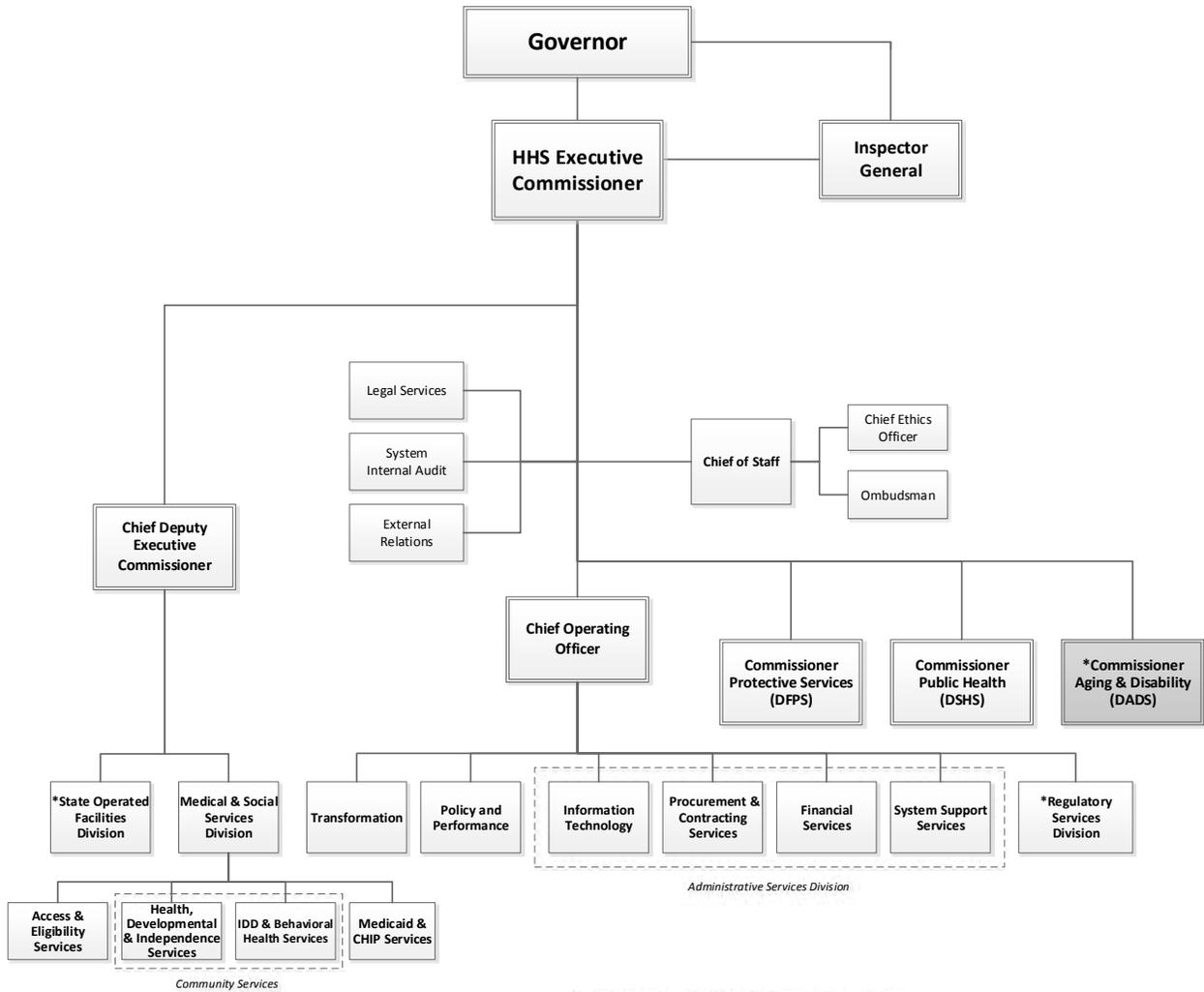
While the initial step in transformation is structural change, actual transformation will come from the improvement of processes and increased coordination across the system. The centralized structure of the MSS Division lays the foundation for better collaboration

and coordination between programs and will make it easier for individuals to locate and access a full array of services.

Figure 13.1 shows the post-transformation structure of HHSC. Within HHSC, **Figure 13.2** shows MSS' organizational structure, including the MCS Department.

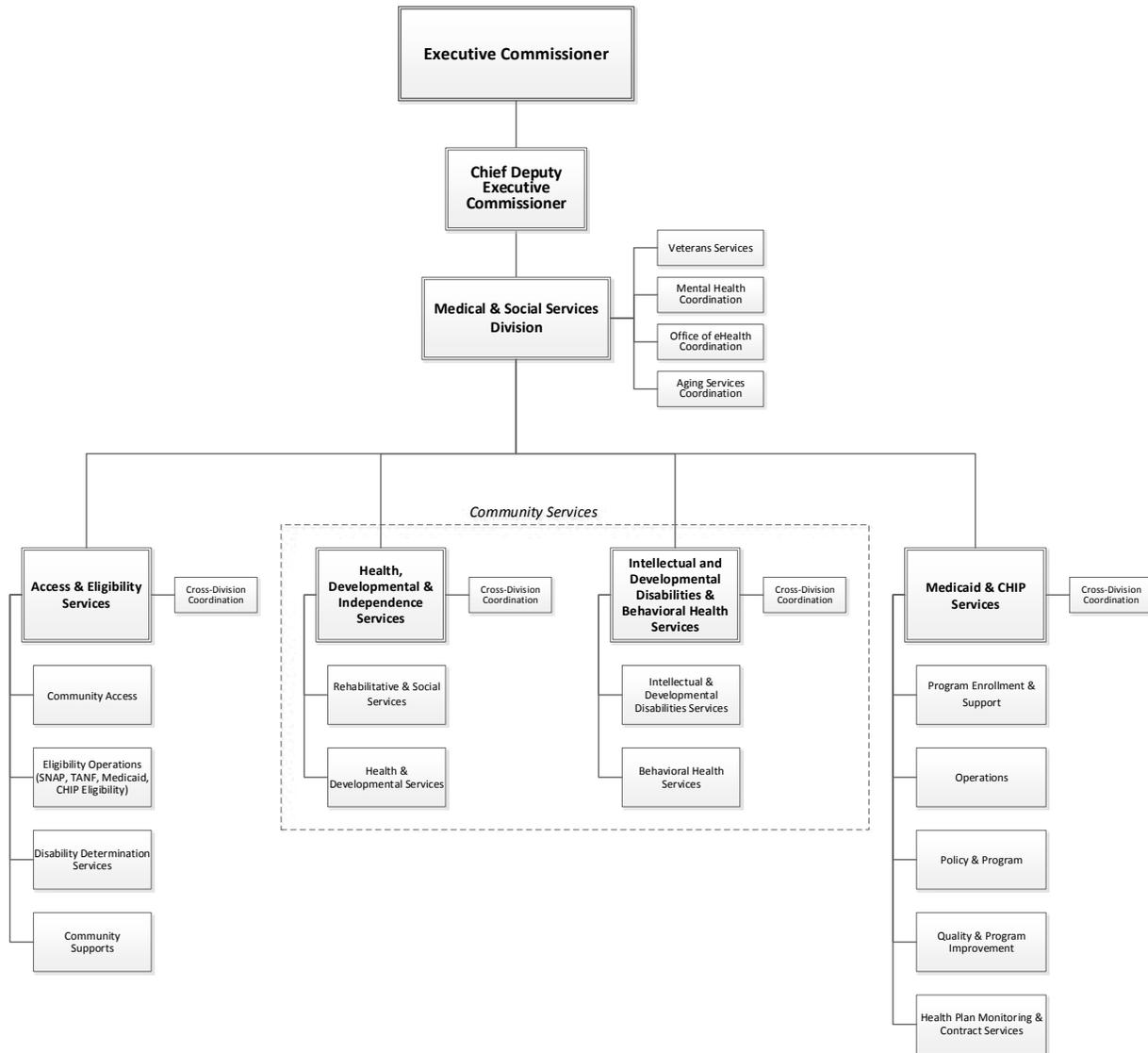
On September 1, 2017, remaining DADS programs (including operation of the state supported living centers (SSLCs)) and all regulatory functions from DADS, DSHS, and the Department of Family and Protective Services will transition to HHSC as part of the second phase of HHS transformation.

Figure 13.1: Health and Human Services Commission Organizational Structure



* On September 1, 2017, DADS ceases to exist and its remaining functions transfer to the Regulatory and State Operated Facilities Divisions.

Figure 13.2: Medical and Social Services Division Organizational Structure



Detecting Fraud and Abuse

In 2003, the 78th Legislature created the HHSC Inspector General (IG) to strengthen HHSC’s authority and ability to combat fraud, waste, and abuse in HHS system programs. The IG’s mission is to prevent, detect, audit, inspect, review, and investigate fraud,

waste, and abuse in the provision and delivery of services through the HHS system and programs in Texas. To fulfill its mandate, the IG establishes performance standards and implements best practices, emphasizes communication, collaboration and coordination with internal and external stakeholders, and adheres to its core values of professionalism, productivity, and

perseverance. The IG's guiding vision is to be the leading state-level IG organization in the country.

The IG is divided into seven divisions: Investigations, Audits, Inspections, Medical Services, Data and Technology, Operations, and Chief Counsel. These units help the IG fulfill its responsibilities by:

- Conducting investigations and making referrals to the appropriate outside agencies for further action;
- Performing risk-based performance and compliance audits involving the use of state and federal funds;
- Carrying out inspections and reviews of HHS programs and systems that provide practical recommendations for improving program efficiency and effectiveness;
- Identifying inappropriate Medicaid billings and recovering overpayments by analyzing Medicaid claims and encounter data, conducting medical policy research and performing utilization review activities;
- Supporting and leveraging cutting edge technological solutions to analyze trends and patterns of behavior and billing to detect fraud, waste, and abuse in HHS programs;
- Providing education, technical assistance, and training to the provider community and fostering

strong relationships with internal and external stakeholders;

- Issuing administrative enforcement measures and sanctions, and instituting and monitoring corrective actions against providers, contractors, and clients; and
- Recommending new policies and changes to existing policies to strengthen systems and processes that will enhance the prevention and detection of fraud, waste, and abuse.

The IG conducts criminal history background checks for existing providers and all new providers seeking to enroll in the Medicaid and Children with Special Health Care Needs programs through Texas' claims administrator, Texas Medicaid & Healthcare Partnership.

The IG continues to identify new and innovative ways to fulfill and further its mission accomplishment. To do so, the IG:

- Implemented new provider integrity initiatives required under the Affordable Care Act (ACA), including enhanced provider screening requirements;
- Adopted new rules implementing S.B. 200 and S.B. 207, 84th Legislature, Regular Session, 2015, that strengthen provider due process procedures, establish investigations timelines, and refine the extrapolation process;

- Created the IG Integrity Initiative, a voluntary collaboration between the IG, MCOs, and Medicaid providers, to strengthen collective efforts to improve the integrity of the Texas Medicaid program;
- Created the Medical Services Division to consolidate and focus clinical resources within the IG, including the Medical and Dental directors, nurses, and all clinical staff, in supporting investigations, audits, inspections, and reviews, and the rapid response to mission-critical needs;
- Expanded state hospital and SSLC criminal abuse, neglect, and exploitation investigations;
- Established an Inspections Division to conduct inspections and reviews of HHS programs, providers, and contractors, as required by the IG's enabling legislation; and
- Created a Data and Technology Division to centralize data analysis and intelligence activities to efficiently and effectively identify fraud, waste, and abuse trends in the delivery of health and human services. The new division leverages data from many sources to develop potential areas for investigation, audit, or inspection.

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

Affordable Care Act Program Integrity Initiatives

The ACA established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP effective March 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, 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 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. HHSC established risk categories for provider types that are not federally-defined and adjusted 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 or greater direct or indirect ownership or controlling 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. 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 or its designee. A site visit consists of announced or 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.

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 greater direct or indirect 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.

Application Fee

Providers enrolling in Medicaid or CHIP, with the exception of physicians and non-physician practitioners (including physician and non-physician practitioner 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;
- Re-enrollment; and
- Revalidation.

An application fee may be waived if the fee has been collected by Medicare, Medicaid (in the case of CHIP providers), 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 least every five years. Revalidations will consist of a full enrollment screening, including site visits and criminal background checks as required by designated risk categories.

National Provider Identifier (NPI)

All providers must submit their National Provider Identifier (NPI) for Medicaid enrollment and claims payment.

Enrollment Denial or Termination

Provider enrollment will be denied or terminated when any person with five percent or greater direct or indirect 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; or
- Failed to submit accurate or timely information as a provider, a person with five percent or greater direct or indirect ownership or controlling interest, an agent, or a managing employee of the provider.

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

Ordering, Referring or Prescribing Providers

All providers ordering, referring, or prescribing Medicaid services under the state plan or a waiver must be enrolled as a participating provider. Verification of ordering, referring, and prescribing provider status is required.

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

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

a determination by HHSC that the moratoria would not adversely affect beneficiaries' access to medical assistance and notification to the Secretary of HHS in writing. Moratoria are limited to six months and may be extended in six-month increments with Secretary of HHS approval.

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Temporary Moratoria

Pursuant to federal law, with concurrence from the U.S. Secretary of HHS, HHSC may impose:

- Temporary moratoria on enrollment of new providers;
- Numerical caps on enrollment; and
- 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

Chapter 14: Finances

In This Chapter:

National Medicaid Spending

Health Care Spending in the United States

Medicaid Spending in the United States

Texas Medicaid Spending

Budget Growth

Budget Development

Federal Funding

Matching Funds

Health Care Reform Financing

Deferrals and Disallowances

Spending by Eligibility Type

Medicaid Reimbursement

Physicians and Other Practitioners

Physician-Administered Drugs/Biologicals

Prescription Drugs

Hospitals

Inpatient Hospital Rates

Outpatient Hospital Rates

Uncompensated Care Waiver Payments

Graduate Medical Education

Disproportionate Share Hospital Funding

Nursing Facilities

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

Federally Qualified Health Centers

Rural Health Clinics

Managed Care Organization Rates

STAR

STAR+PLUS

STAR Kids

STAR Health

Children's Medicaid Dental Services Program

Recovery and Other Insurance

Medicaid Estate Recovery Program

Third Party Liability

Health Insurance Premium Payment Program

(continued)

CHIP and CHIP Perinatal

- CHIP Spending
- CHIP Financing
- CHIP Cost-Sharing
- CHIP Rates
- CHIP Perinatal Rates

National Medicaid Spending

Health Care Spending in the United States

Health care spending in the U.S. rose from \$1.4 trillion in 2000 to \$3.0 trillion in 2014, an increase of approximately 121 percent.¹ Over the same period, the economy grew by 69 percent. The faster growth of health spending relative to the growth of the economy is the reason **Figure 14.1** shows a sustained long-term trend of health care spending representing a growing share of Gross Domestic Product (GDP). This increasing share of health care spending out of all spending can be attributed to a variety of factors. One of the

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

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

Medicaid Spending in the United States

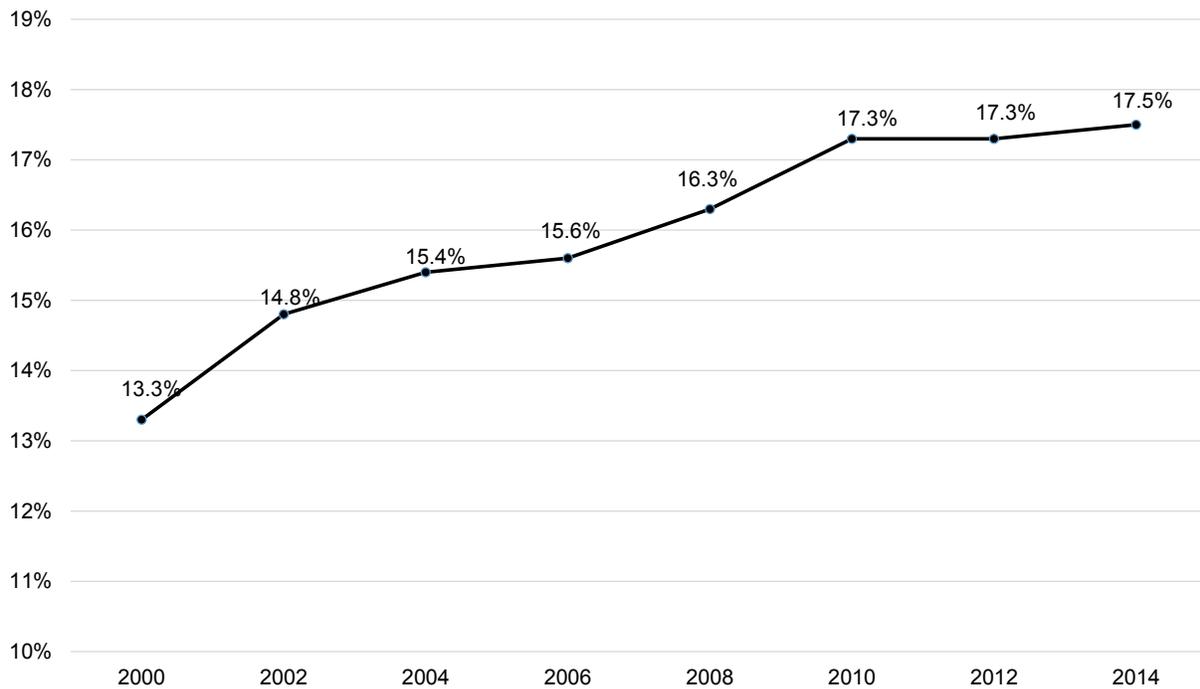
Just as total health expenditures have risen, Medicaid expenditures have increased (see **Figure 14.2**). Total Medicaid expenditures rose from \$200.3 billion in 2000 to \$495.8 billion in 2014, an increase of 148 percent. This increase in Medicaid expenditures was generated partly by the same factors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

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

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

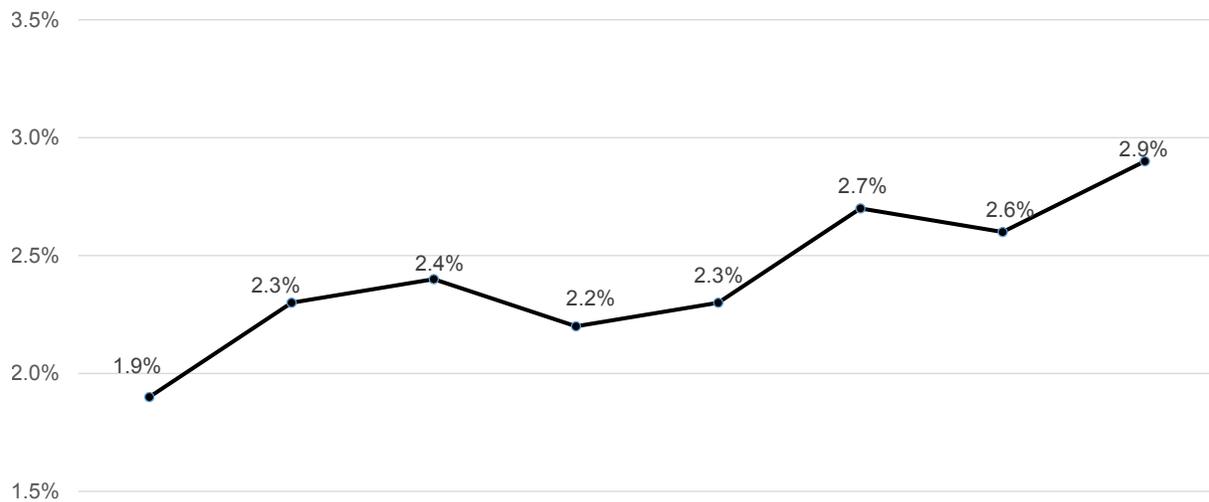
have more – and more serious – untreated medical conditions than members of the general population, which causes additional costs for serving the Medicaid population.

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



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

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



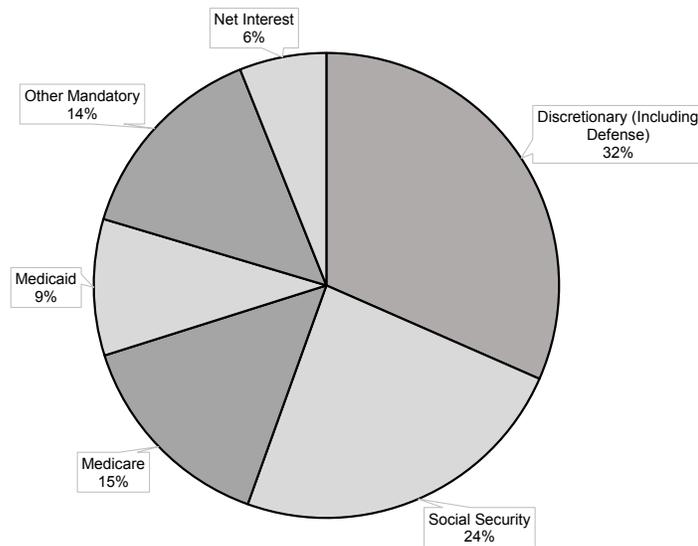
Source: U.S. Centers for Medicare & Medicaid Services, Historical National Health Expenditure Data (July 2016), "Table 3: National Health Expenditures" found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>

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

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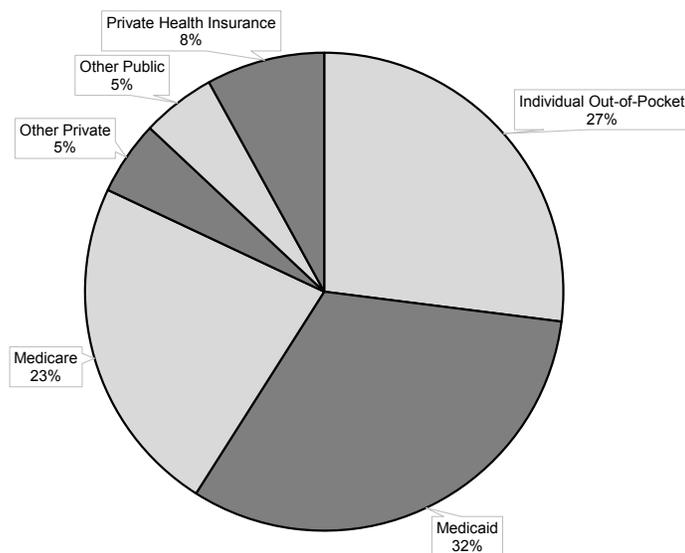
Figure 14.3 illustrates federal government spending by type of expenditure for federal fiscal year 2015. **Figure 14.4** and **Figure 14.5** show Medicaid's role in calendar year 2014 as a national payer of nursing facilities (NFs) and home health services, respectively.

Figure 14.3: Federal Budget Expenditures, FFY 2015



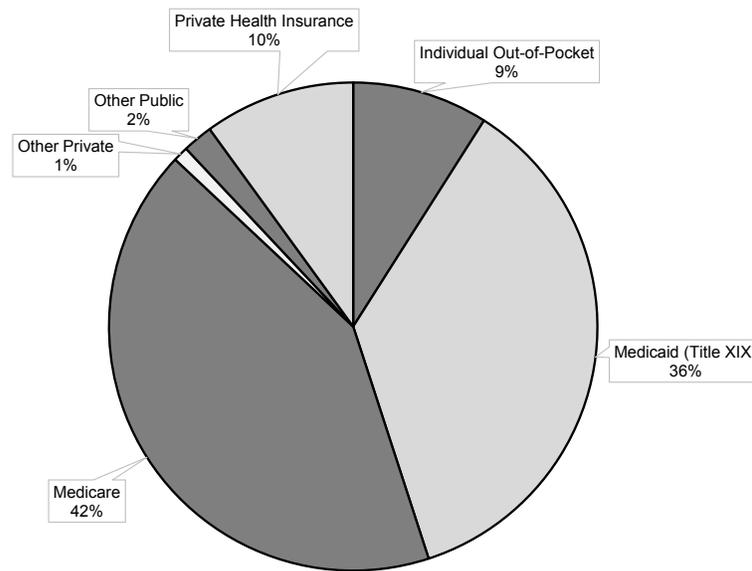
Source: Budget of the U.S. Government FFY 2015. Table S-5. Proposed Budget by Category. Page 170. <http://www.gpo.gov/fdsys/pkg/BUDGET-2015-BUD/pdf/BUDGET-2015-BUD-28.pdf>

Figure 14.4: National Nursing Facility Payer Sources, CY 2014



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

Figure 14.5: National Home Health Payer Sources, CY 2014



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

Texas Medicaid Spending

Budget Growth

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

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

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

SFY	Medicaid Budget ¹	Total State Budget ²	Annual Percentage
2000	\$10,000	\$49,453	20.22%
2001	\$10,952	\$52,440	20.88%
2002	\$12,678	\$56,621	22.39%
2003	\$14,593	\$59,058	24.71%
2004	\$14,585	\$61,507	23.71%
2005	\$15,561	\$65,204	23.87%
2006	\$16,534	\$69,961	23.63%
2007	\$17,275	\$75,099	23.00%
2008	\$19,053	\$82,150	23.19%
2009	\$20,798	\$89,981	23.11%
2010	\$22,821	\$92,056	24.79%
2011	\$24,816	\$95,461	26.00%
2012	\$25,438	\$92,914	27.38%
2013	\$25,614	\$97,840	26.18%
2014	\$27,121	\$100,652	27.11%
2015	\$29,403	\$102,648	28.64%

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

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

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

The rapid acceleration of Texas Medicaid spending from the late 1980s to the early 1990s was primarily due to increasing caseloads and costs. Escalating DSH payments and medical inflation contributed to the increase in overall costs of the Medicaid program. At the same time, program changes resulted in increases in the number of Medicaid beneficiaries, thereby increasing caseload.

In the 1990s, Texas sought to include existing state-funded programs in the Medicaid program so they could be eligible to receive federal matching dollars. These factors combined to increase the Texas Medicaid budget five-fold from 1987-2001.

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

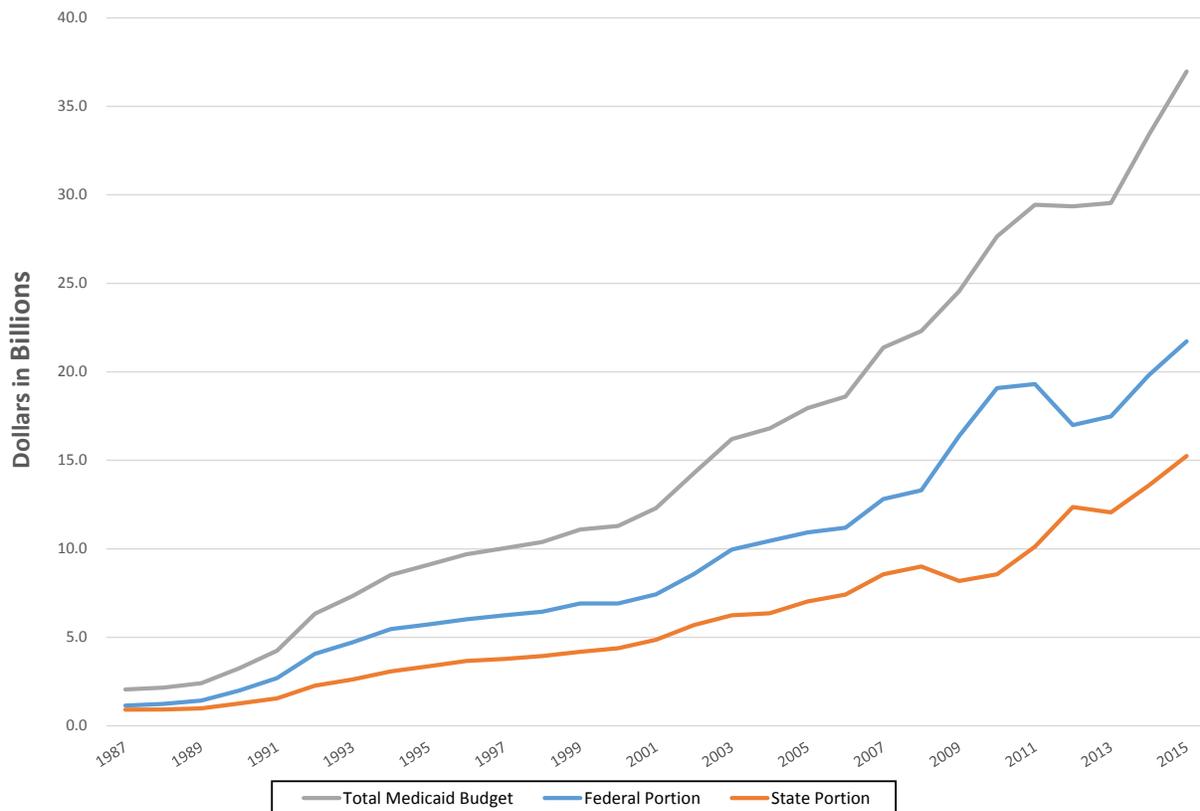
shows Texas Medicaid expenditures from September 1987-2015.

In 1988, Congress dramatically expanded Medicaid eligibility standards to include groups of people with incomes higher than the Aid to Families with Dependent Children, now known as Temporary Assistance for Needy Families (TANF), cap. Other federal expansions and the economic recession in the early 1990s resulted in more increases in the number of children and pregnant women who became eligible for Medicaid. Beginning in the mid-1990s, welfare reform decreased the number of Medicaid clients and changed the composition of its caseload. The late 1990s brought overall declines in caseloads, but the number of clients over the age of 65 or those who have a disability, as well as pregnant women and newborns, continued to increase and comprise a larger proportion of caseload. These high-cost clients offset any cost savings that could have resulted from caseload declines.

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

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



Source: HHSC, Financial Services, HHS System Forecasting.

Budget Development

Health and Human Services Commission (HHSC) staff develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations requests. This process requires projections of the number of people eligible for and applying for the program; estimations of cost trends; analyses of any new federal mandates affecting eligibility, services, or changes in program policy; and outreach efforts.

As evident from **Table 14.2**, a significant amount of time elapses between the development of the initial agency budget request and the time an appropriations bill takes effect. Medicaid enrollment trends and other factors that drive budget projections can change significantly before the budgeted period ends. Caseload or cost changes can cause considerable differences between appropriated budgets and actual expenditures.

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

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

Note: At the beginning of the 2018-2019 biennium in September 2017, the Medicaid data used for projections is five months old. By the end of the biennium in August 2019, the data is 29 months old. If Medicaid budget projections were too low, this could result in a budget shortfall. If projections were too high, it could result in an unexpected surplus.

Federal Funding

Matching Funds

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

The amount of federal Medicaid funds Texas receives is based primarily on the federal medical assistance percentage (FMAP), or Medicaid matching rate. Derived from each state’s average per capita income, the Centers for Medicare & Medicaid Services (CMS) updates

the rate annually. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually. As the state’s per capita income increases in relation to the national per capita income, the FMAP rate decreases. For federal fiscal year 2017, Texas’ Medicaid FMAP is 56.18 percent.

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

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

FFY	FMAP	Enhanced FMAP	American Recovery and Reinvestment Act (ARRA) Enhanced FMAP*
1998	62.28%	73.60%	N/A
1999	62.45%	73.72%	N/A
2000	61.36%	72.95%	N/A
2001	60.57%	72.40%	N/A
2002	60.17%	72.12%	N/A
2003	59.99%	71.99%	N/A
2004	60.22%	72.15%	N/A
2005	60.87%	72.61%	N/A
2006	60.66%	72.46%	N/A
2007	60.78%	72.55%	N/A
2008	60.56%	72.39%	N/A
2009	59.44%	71.61%	69.03%
2010	58.73%	71.11%	70.94%
2011	60.56%	72.39%	66.46%
2012	58.22%	70.75%	N/A
2013	59.30%	71.51%	N/A
2014	58.69%	71.08%	N/A
2015	58.05%	70.64%	N/A
2016	57.13%	69.99%	N/A
2017	56.18%	69.33%	N/A
2018	56.88%	69.82%	N/A

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

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

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

Health Care Reform Financing

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

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

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

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

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

Table 14.4 shows federal match rates by Medicaid and CHIP eligibility groups from federal fiscal years 2014–2020.

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

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

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

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

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

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

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

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

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

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

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

payments to hospitals with high levels of UC.

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

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

Deferrals and Disallowances

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

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

CMS can impose deferrals or disallowances following a federal audit or a change to the Medicaid state plan, the state's contract with CMS. A deferral or disallowance may be imposed for the federal fiscal quarter(s) for which CMS asserts the state is out of compliance with CMS regulations or its Medicaid state plan, and in the case of a disallowance, may retroactively encompass several years of claims.

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

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

statement of the amount in dispute with a brief statement of why the disallowance is incorrect. CMS then has 30 days to provide a written response to the state's argument. Within 15 days of receiving CMS' response, the state may submit a short rebuttal to CMS' argument. The Departmental Appeals Board can make a ruling based on the written records provided by both parties or can hold a hearing to discuss the matter prior to making a ruling.

Spending by Eligibility Type

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

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

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

Full-Benefit Clients:

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

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

Table 14.6: Texas Medicaid Clients and Expenditures, SFY 2015

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

Source: HHSC, Financial Services.

Medicaid Reimbursement

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

with stakeholders and advisory committees when considering changes to FFS reimbursement rates. All proposed rates are also subject to a public hearing, and all proposed reimbursement methodology rule changes are subject to a 30-day public comment period as part of the approval process.

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

Physicians and Other Practitioners

Medicaid rates for FFS services delivered by physicians and other practitioners (which include payments for laboratory services, x-ray services, radiation therapy services, physical and occupational therapists' services, physician services (including anesthesia and physician-administered drugs), podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services, and certified nurse midwife services) are calculated in accordance with the Texas Administrative Code (TAC), Title 1, §355.8085. Rates are uniform statewide and are either resource-based fees (RBFs) or access-based fees (ABFs).

RBFs are based on the actual resources required by an economically efficient provider to deliver a service and are calculated

by multiplying the relative value units (RVUs) for a service times a conversion factor. Total RVUs are assigned to each service, covering the three components of the cost to deliver the service. The three components are intended to reflect the work, overhead, and professional liability expense for a service. The Medicaid RBFs were first established in 1992 and used the RVUs specified in the Medicare Physician Fee Schedule at the time in concert with Texas Medicaid conversion factors. Medicaid RVUs for new services are based on the Medicare RVUs in effect at the time. Base units, which serve a similar function as RVUs, are used for anesthesia services.

ABFs are developed to account for deficiencies in RBF methodology related to adequacy of access to health care services for Medicaid clients and are based on historical charges, the current Medicare fee for a service, review of Medicaid fees paid by other states, survey of providers' costs to deliver a service, and/or Medicaid fees for similar services.

Nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, anesthesiology assistants, and physician assistants are reimbursed for covered professional services at 92 percent of the physician rate for the same professional service. Licensed

professional counselors, licensed clinical social workers, licensed marriage and family therapists, provisionally licensed psychologists, and licensed psychological associates are reimbursed for covered professional services at 70 percent of the rate paid to psychiatrists and psychologists for the same professional service. Physicians are reimbursed for assistant surgery services at 16 percent of the amount paid to the primary surgeon.

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

Physician-Administered Drugs/Biologicals

FFS Medicaid rates for physician-administered drugs/biologicals are determined as defined in TAC, Title 1, §355.8085. Physicians and other practitioners are reimbursed for physician-administered drugs and biologicals at the lesser of their billed charges and the Medicaid fee established by HHSC. The Medicaid fee is an estimate of the provider's acquisition cost for the specific drug or biological. Physician-administered drugs/biologicals are reviewed semi-annually.

Prescription Drugs

Reimbursement for FFS pharmacy prescription claims includes two

components: an amount for the ingredient cost of the drug product and a professional dispensing fee.

Ingredient cost reimbursement:

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

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

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

Dispensing fee reimbursement:

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

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

Pharmacy reimbursement in
managed care is set by the MCO and

is included in the MCOs' contracts
with pharmacies.

Hospitals

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

Inpatient Hospital Rates

General acute care hospital
reimbursement rates for FFS
Medicaid clients are set using
a prospective payment system
(PPS) based on the All Patient
Refined Diagnosis Related Groups
(APR-DRG) patient classification
system. Under PPS, each patient is
classified into a diagnosis related
group (DRG) on the basis of clinical
information. Then hospitals are
paid a pre-determined rate for each
DRG admission, regardless of the
actual services provided. The rate
is calculated using a formula-based
standardized average cost of treating

a Medicaid inpatient admission and a relative weight for each DRG. “Outlier” payments are made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay. On September 1, 2013, children’s and rural hospitals transitioned from cost-based reimbursement to APR-DRGs. Children’s hospital payments are based on the standardized average cost of treating a Medicaid inpatient admission in a children’s hospital. Rural hospital payments are based on each rural hospital’s facility-specific cost of treating a Medicaid inpatient admission.

Rates paid to freestanding psychiatric hospitals and state-owned or operated teaching hospitals are set using a different methodology. Freestanding psychiatric hospitals are reimbursed a PPS per diem based on the federal base per diem with facility specific adjustments for wages, rural location, and length of stay. State-owned or operated teaching hospitals are reimbursed for their reasonable cost of providing care to Medicaid clients using the Tax Equity and Fiscal Responsibility Act of 1982 cost principles.

Outpatient Hospital Rates

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

outpatient hospital services for high-volume providers is 76.03 percent of the hospital’s allowable cost and reimbursement for all other non-rural high-volume providers is 72 percent of the hospital’s allowable cost. With regard to outpatient services, a high-volume provider is defined as one that was paid at least \$200,000 for FFS and Primary Care Case Management (PCCM)³ Medicaid services during calendar year 2004. For non-high-volume children’s and state-owned hospitals, reimbursement for outpatient hospital services is 72.27 percent of the hospital’s allowable cost. Reimbursement for all other non-rural, non-high-volume providers is 68.44 percent of the hospital’s allowable cost. Reimbursement for outpatient hospital services for rural hospitals is 100 percent of the hospital’s allowable cost. Outpatient rates were frozen effective September 1, 2013.

Uncompensated Care Waiver Payments

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

³ PCCM was a managed care option that ended in 2012.

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

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

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

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

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

Source: HHSC, Financial Services. Includes Physician UPL.

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

Graduate Medical Education

Hospitals that operate medical residency training programs incur higher expenses than hospitals

without training programs. The Medicaid share of these additional costs is covered by GME payments to teaching hospitals. GME payments cover the costs of residents' and

teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs.

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

Disproportionate Share Hospital Funding

14

Federal law requires state Medicaid programs to make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and receive disproportionate share funding under the DSH program. DSH funds differ from all other Medicaid payments in that they are not tied to specific services for Medicaid-eligible patients. Hospitals may use DSH payments to cover the uncompensated costs of care for indigent or low-income patients, including Medicaid patients. DSH

payments have been an important source of revenue by helping hospitals expand health care services to the uninsured, defray the cost of treating indigent patients, and recruit physicians and other health care professionals to treat patients.

Who Gets DSH?

In federal fiscal year 2015, 186 Texas hospitals qualified to receive DSH payments: 62 were non-state public, 109 were private, and 15 were state hospitals. Of the 186 DSH hospitals, 83 were located in urban areas and 103 were located in rural or equivalent areas. Of the urban hospitals, eight were large public facilities and ten were children's hospitals. Three University of Texas teaching hospitals and all children's hospitals in Texas are deemed DSH hospitals provided they meet federal and state qualification criteria. All other hospitals must qualify for DSH funds by meeting one of the following three criteria: (1) a disproportionate total number of inpatient days are attributed to Medicaid patients; (2) a disproportionate percentage of all inpatient days are attributed to Medicaid patients; or (3) a disproportionate percentage of all inpatient days are attributed to low-income patients.

How DSH Is Funded

As in other "matching" Medicaid programs, the federal government and the state each pay a share of total

DSH program costs. Payments are funded using the same matching rate as medical services (56.18 percent federal funds and 43.82 percent state funds for Texas in federal fiscal year 2017). The state share of DSH is funded through a combination of IGT from public hospitals and state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest). In federal fiscal year 2015, the DSH allocation for Texas totaled \$1.785 billion in federal and state funds. This figure was \$1.819 billion in federal fiscal year 2016.

How DSH Can Be Spent

There are no federal or state restrictions on how DSH hospitals can use their funds. Hospitals have used DSH funds to:

- Defray the cost of treating indigent patients;
- Recruit physicians and other health care professionals to treat patients;
- Obtain replacement or additional equipment/technology to treat patients; and
- Renovate existing structures or build new ones.

DSH reimbursement allows hospitals to make the human and capital investments necessary to continue and improve patient care.

Federal Legislation Affecting DSH

Nationally, between 1989 and 1992, federal funding for DSH increased

significantly from \$400 million to \$10.1 billion. By 1992, DSH funds accounted for 15 percent of all federal Medicaid spending. Starting in 1991, various pieces of federal legislation were passed, limiting or capping DSH funding increases. Furthermore, as a discrete component of Medicaid funds nationally, the DSH program has on occasion been targeted as a possible source of budget savings.

In 1991, federal law capped the size of Texas' DSH program at \$1.513 billion. In 1993, a federal budget act established hospital caps on the amount of DSH funds an individual hospital could receive. The act also mandated at least one percent of total patient days in DSH hospitals must be from Medicaid patients. These changes reduced DSH payments to state-owned hospitals from approximately \$729 million in state fiscal year 1995 to about \$427 million in state fiscal year 2008. Total Texas DSH funds were constant, however, and the additional residual funds went to non-state local hospitals.

The 1997 federal Balanced Budget Act (BBA) had two significant impacts on the Texas DSH program. First, it set specific annual limits on total federal contributions to the Texas DSH program. Those limits, since increased by the Benefits Improvement and Protection Act of 2000 and the Medicare

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

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

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

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

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

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

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

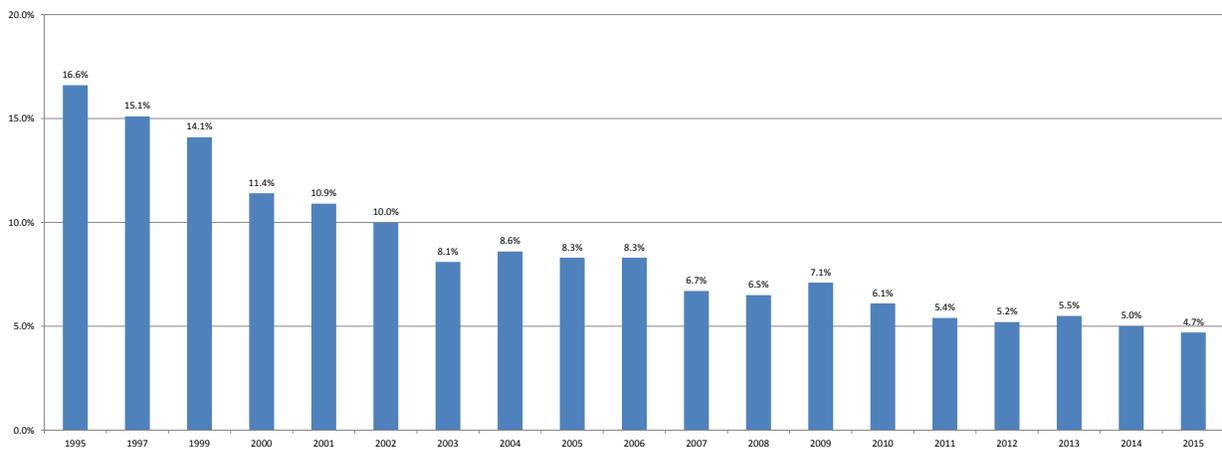
FFY	Federal Funds
2002	\$856 million
2003	\$776 million
2004	\$901 million
2005	\$901 million
2006	\$901 million
2007	\$901 million
2008	\$901 million
2009	\$964 million*
2010	\$988 million**
2011	\$964 million
2012	\$981million
2013	\$1 billion
2014	\$1.019 billion
2015	\$1.036 billion
2016	\$1.039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

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

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

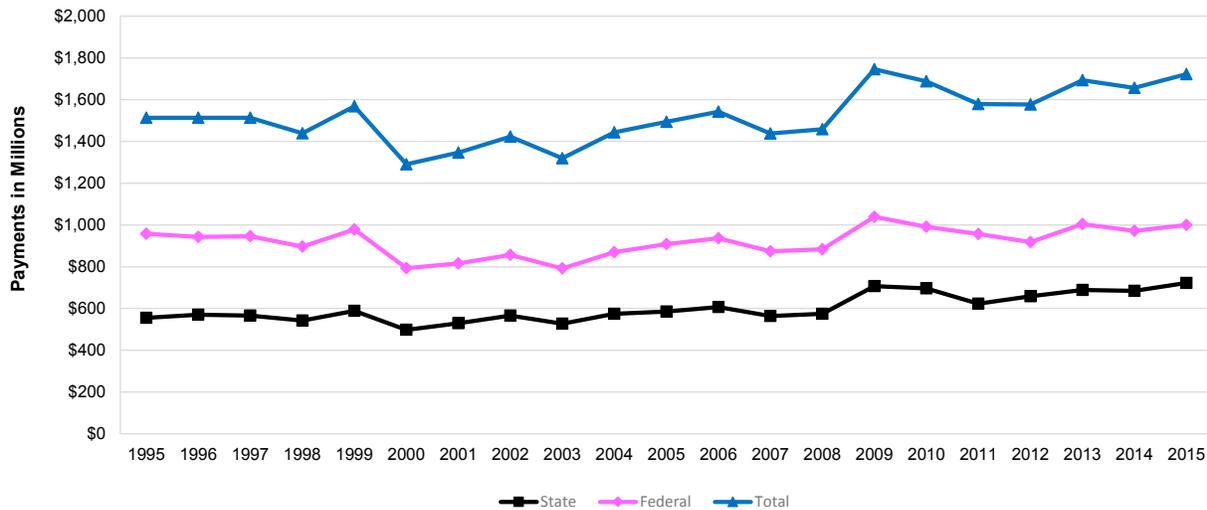
Source: HHSC, Financial Services.

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



Source: HHSC, Financial Services.

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



Source: HHSC, Financial Services.

Nursing Facilities

NFs are reimbursed for services provided to Medicaid residents through daily payment rates that are uniform statewide by level of service (for example, case-mix class as determined by recipient characteristics). Enhanced rates are available for enhanced staffing. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing and/or spending requirements.

Rates are based on costs submitted annually by providers on facility cost reports. Costs are categorized into five rate components: (1) direct care staff; (2) other resident care; (3) dietary; (4) general and administrative; and (5) a fixed capital asset use fee. Each rate component is calculated separately

based on HHSC formulas and may vary according to the characteristics of residents. The total rate for each level of service is calculated by adding together the appropriate rate components.⁴

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

⁴H.B. 154, 77th Legislature, Regular Session, 2001, requires HHSC to ensure that only those facilities that purchase liability insurance acceptable to HHSC receive credit for that cost. Therefore, liability insurance costs are excluded from the rate calculation and facilities that verify liability insurance coverage acceptable to HHSC receive additional funds in the form of a liability insurance add-on.

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

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

Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) are reimbursed for services delivered to Medicaid residents through daily payment rates that are prospective and uniform statewide by facility size and level of need. The total daily payment rate may be retroactively adjusted if a provider fails to meet specific direct care spending requirements.

In 1997, initial model-based rates were determined using a representative sample of provider information (cost, financial, statistical, and operational) collected during site visits performed by an independent consultant. Currently, the modeled rates are updated, when funds are available, using the service providers' most recent audited cost reports. Enhanced rates are available for enhanced attendant compensation.

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

Federally Qualified Health Centers

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

Participation Requirements

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

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

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

Covered Services

Covered services are limited to services as described in the Social Security Act⁵ and other ambulatory services covered by the Texas Medicaid program when provided by other enrolled providers. Covered services provided by an FQHC must be reasonable and medically necessary as determined by HHSC or its designee.

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

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

Reimbursing FQHC Providers

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

⁵ Social Security Act, §1861(aa)(1)(A)-(C)

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

Rural Health Clinics

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

Participation Requirements

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

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

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

Covered Services

Covered services are limited to services as described in the Social Security Act⁶ and other ambulatory services covered by the Texas Medicaid program when provided by other enrolled providers. Covered services provided by an RHC must be reasonable and medically necessary as determined by HHSC or its designee.

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

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

⁶Social Security Act, §1861(aa)(1)(A)-(C)

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

Reimbursing RHC Providers

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

Managed Care Organization Rates

Premium rates for the MCOs are determined through actuarially sound methodologies. These rates determine the state's capitation payments to MCOs for contractually required services. Further detail on Medicaid managed care programs is provided in **Chapter 11, Fee-for-Service and Managed Care.**

STAR

The managed care rate-setting process involves a series of mathematical adjustments to arrive at the final rates paid to the MCOs. STAR MCO rates are derived primarily from MCO historical claims experience for a particular base period of time. The base cost data is totaled, and trends to the time period for which the rates are to apply are calculated. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the possible fluctuation in claims cost through the addition of a risk margin.

Newborn delivery expenses are removed from the total cost rate, resulting in an "adjusted premium rate" for each service area. A separate lump sum payment, called the "delivery supplemental payment," is computed for each

service area for expenses related to each newborn delivery.

The resulting underlying base rates vary by service area and risk group but are the same for each MCO in a service area. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premiums paid to the MCOs are based on this acuity risk-adjusted premium for each combination of service area and risk group. In addition to the final capitated premium rates, MCOs also receive the delivery supplemental payment for each newborn.

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

STAR+PLUS

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

STAR Kids

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

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

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

STAR Health

The capitation rate for the STAR Health program is derived primarily from MCO historical claims experience for a particular base period of time. This base cost data is totaled, and trends to the time period for which the rates are to apply are calculated. Adjustments are applied for MCO expenditures, which include reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. A provision is then made for the

possible fluctuation in claims by the addition of a risk margin. The rate also includes a special allowance for the additional administrative services in the program, including the Health Passport. The Health Passport is a web-based repository of health care services data for each member that is intended to improve quality of care. A single MCO provides services under the STAR Health program. The MCO is reimbursed using a single premium rate which does not vary by age, gender or area.

Children's Medicaid Dental Services Program

Children's Medicaid Dental Services Program rates are based on claims experience for the covered population in the base period. The base cost is totaled, and trends to the time period for which the rates apply are calculated. A reasonable provision for administrative expenses, taxes, and risk margin is added to the claims component in order to project the total cost for the rating period. These projected total costs are then converted to a set of statewide rates that vary by age group.

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Recovery and Other Insurance

Medicaid Estate Recovery Program

On March 1, 2005, Texas implemented the Medicaid Estate Recovery Program (MERP) in compliance with federal Medicaid laws. MERP provides the authority for the state to file a claim against the estate of a deceased Medicaid recipient, age 55 or older, who applied for certain long-term care services on or after March 1, 2005. Claims include the cost of services, hospital care and prescription drugs supported by Medicaid under the following programs:

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

There are certain exemptions from recovery as required by federal and state law. When no exemptions apply, the heir(s) may request a hardship waiver if certain conditions are met. A hardship waiver specific to the homestead may be filed

when one or more heirs have gross family income below 300 percent of the FPL. When no exemptions or hardship conditions exist, the state files a claim against the descendant's assets that are subject to probate. The estate representative is responsible for paying the lesser of the MERP claim amount or the estate value after all higher priority estate debts have been paid. This is paid through the estate, not the resources of any heirs or family members.

The claims filing component of the program has been contracted to a private company through a competitive procurement process. HHSC is responsible for MERP program policy and procedures.

Third Party Liability

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

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

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

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

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

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

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

Managed Care & Third Party Liability

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

Health Insurance Premium Payment Program

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

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

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

Historically, HIPP only included individuals enrolled in traditional

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

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

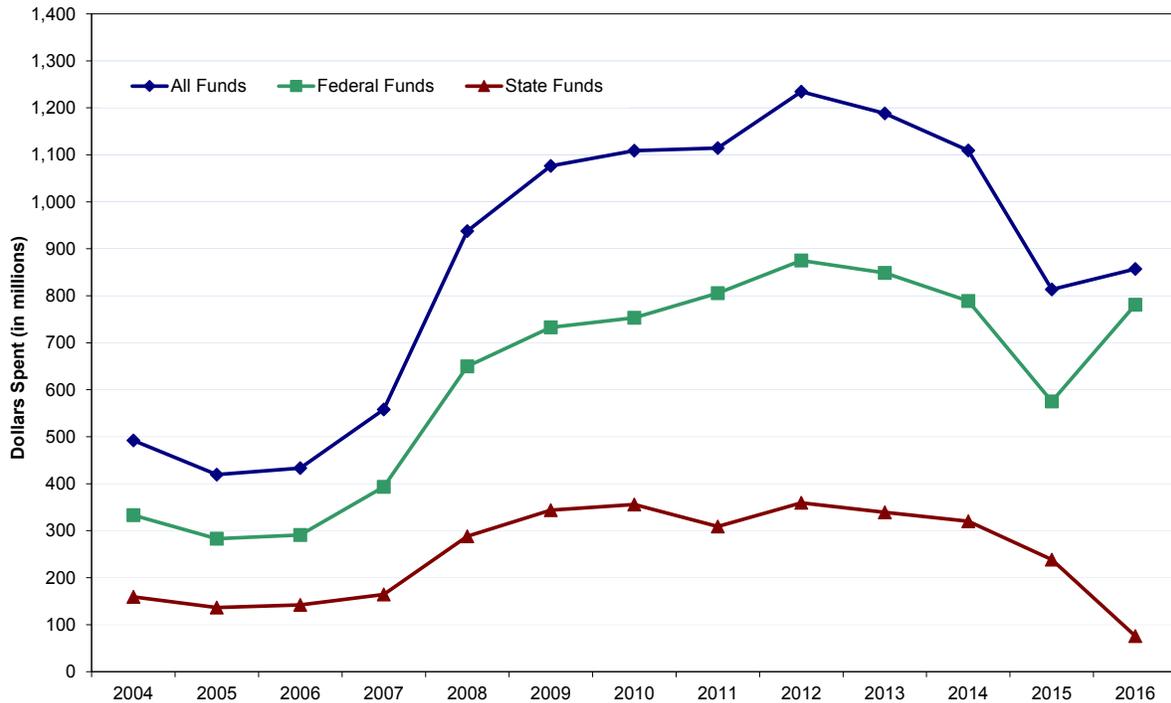
Premium reimbursements typically process in less than seven days after validation of the premium payment is received. Reimbursements can either be mailed or submitted through electronic funds transfer to eligible individuals enrolled in HIPP. In 2015, an average of 82 percent of all premium reimbursements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

CHIP and CHIP Perinatal

CHIP Spending

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

Figure 14.9: Texas CHIP Expenditures, SFYs 2004-2016



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

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CHIP Financing

Like Medicaid, CHIP is jointly funded by the federal government and states. However, unlike Medicaid, total federal funds allotted to the program each year are capped, as are the funds allotted to each state. In the federal legislation that created CHIP, annual federal appropriations for the program totaled nearly \$40 billion for the ten year period the program was originally authorized. Each state is allotted a portion of this amount based on a formula set in federal statute and receives federal matching payments up to the allotment. Each year’s allotment historically was available

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

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

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

rate than Medicaid. The federal CHIP funds states receive are based on the EFMAP. Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid for with federal funds also changes annually. The CHIP EFMAP for Texas was 70.64 percent in federal fiscal year 2015 and 69.99 percent for federal fiscal year 2016.

The ACA increased the federal match rate for CHIP by 23 percentage points (not to exceed 100 percent) from October 1, 2015, until September 30, 2019. The increase does not apply to:

- Certain administrative expenditures;
- Citizenship documentation requirements; and

- Administration of Payment Error Rate Measurement requirements.

CHIP Cost-Sharing

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

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

Table 14.9: CHIP Cost-Sharing Requirements

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 emergency room	\$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 emergency room	\$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 emergency room	\$75
Generic drug	\$10
Brand drug	\$35
Inpatient hospital	\$125
Cost-sharing limit	5% of family income, per enrollment period

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CHIP Rates

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

data is totaled, and trends are predicted to the time period for which the rates are to apply. The cost data is also adjusted for MCO expenses such as reinsurance, capitated contract payments, changes in plan benefits, administrative expenses, and other miscellaneous costs. Then,

a provision is made for the possible fluctuation in claims cost through the addition of a risk margin.

The removal of newborn delivery expenses from the total cost rate results in an “adjusted premium rate” for each service area. A separate lump-sum payment, called the “delivery supplemental payment,” is computed for expenses related to each newborn delivery. While the delivery supplemental payment can vary by service area for the STAR MCOs, all CHIP MCOs receive the same lump-sum payment of \$3,100 for each birth.

The resulting underlying base rates vary by service area and age group. A final adjustment is made to reflect the health status, or acuity, of the population enrolled in each MCO. The purpose of the acuity risk adjustment is to recognize the anticipated cost differential among multiple MCOs in a service area due to the variable health status of their respective memberships. The final capitated premium paid to the MCOs is based on this acuity risk-adjusted premium and covers all non-maternity medical services.

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

from MCO historical claims experience for a particular base period of time. This base cost data is totaled, and trends are calculated forward as with other programs. However, trend rates and cost adjustments for programmatic changes, administrative expenses, and other miscellaneous costs are considered specifically for the CHIP dental plans. A provision for possible fluctuation in claims cost is made through the addition of a risk margin.

CHIP Perinatal Rates

Premium rates for the CHIP Perinatal program are derived using a methodology similar to that described for CHIP, with the differences being the absence of an acuity adjustment and the more focused scope of benefits and membership in CHIP Perinatal. MCO historical claims are totaled, and trends are calculated forward to the time period for which rates are to apply. The cost data is adjusted for MCO expenses, changes in plan benefits, and other miscellaneous costs. Final rates vary by risk group and service area. However due to low caseload among risk groups with income over 198 percent up to and including 202 percent of the FPL, premium rates for these risk groups are calculated on a statewide basis.

Chapter 15: The 1115 Transformation Waiver

History

The Texas Legislature, through the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, First Called 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

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Regional Healthcare Partnerships

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 Texas' waiver request on December 12, 2011.

CMS originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, as a five-year demonstration waiver running through September 2016 that allowed 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 new funding pools: the Uncompensated Care (UC) pool and the Delivery System Reform Incentive Payment (DSRIP) pool.

As required by the waiver's special terms and conditions, HHSC submitted a request to CMS by September 30, 2015, to extend the waiver. HHSC requested to continue all three components of the waiver (statewide Medicaid managed care, the UC pool, and the DSRIP pool) for another five years.

In April 2016, HHSC submitted a request to CMS for a 15-month extension of the waiver (October 1, 2016-December 31, 2017), during which HHSC and CMS would continue negotiations on a longer-term agreement. CMS approved the 15-month extension on May 1, 2016. The letter from CMS approving the extension states that CMS and HHSC must agree on the size of the UC pool and DSRIP structure by the end of 2017. The letter references the independent report analyzing the UC and DSRIP pools requested by CMS in November 2015. HHSC

submitted the independent report on August 31, 2016 as required.

On January 26, 2017, HHSC submitted a request to CMS for an additional 21-month extension at current funding levels for UC and DSRIP.

Funding

Federal funds available under both the UC and 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 were capped at equal levels. The 15-month waiver extension (referred to as DY 6) continues the UC and DSRIP pools at DY 5 level funding. CMS and HHSC will negotiate funding for any years

approved beyond December 31, 2017.

Uncompensated Care Pool

UC pool payments are cost-based and help offset the costs of UC provided by hospitals and other providers to indigent or low-income patients, including Medicaid patients. UC payments are based on each provider's UC costs as reported on a UC application. See **Chapter 14, Finances**, for more information on UC.

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.

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 health care 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 RHPs, which reflect existing delivery systems and geographic proximity.

A map of the RHP regions can be found in **Appendix C: 1115 Transformation Waiver Regions**.

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 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. Because 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 providers and governmental entities are 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 public and private hospitals, community mental health centers, local health departments, and physician groups affiliated with an academic health science center, 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 include a shared regional mission; quality goals; and CMS' triple aim to improve

individual care (including access to care, quality of care, and health outcomes), improve population health, and lower costs without harming individuals, families, or communities.

RHP plans must also 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 DY.

During DY 6A, the first 12 months of the 15-month extension, Anchoring Entities will update the regional community needs assessment that was submitted with the original RHP plan in 2012. Regions will update the regional plan as appropriate to reflect major changes, including changes to the regions' priority needs. Stakeholder engagement will be required as a part of the plan update process.

At the end of state fiscal year 2016, there were 1,451 approved and active DSRIP projects. Providers report twice a year (April and October) on achievement of project metrics and milestones in order to earn DSRIP payments.

Groups of providers and other DSRIP participants use learning collaboratives to identify best practices, share ways to improve projects, and promote quality improvement. HHSC also hosts an annual statewide learning collaborative.

Appendix A: Key Medicaid and CHIP Legislation

CHIP and Medicaid change in response to legislative requirements. The following sections include highlights from the 84th Legislature and relevant federal changes to the programs since 1965.

Highlights of the 84th Legislature

H.B. 751 - Generic Equivalents

H.B. 751 allows pharmacists to substitute generic equivalents of biological products unless the practitioner certifies on the prescription that a specific brand of a biological product is medically necessary.

H.B. 839 - Presumptive Eligibility for Certain Youth Leaving the Juvenile Justice System

H.B. 839 certifies a child as presumptively eligible for Medicaid or CHIP upon the child's release from a juvenile justice facility, if the child was receiving Medicaid or CHIP

benefits prior to entering the juvenile justice facility.

H.B. 1878 - Reimbursement for School-Based Telemedicine

H.B. 1878 ensures physicians enrolled in Medicaid receive reimbursement for providing telemedicine medical services to a child in a primary or secondary school-based setting, even when the physician is not the child's PCP, if the child's parent or legal guardian consents before the telemedicine medical service is provided.

H.B. 1924 - Delegation to Psychology Interns

H.B. 1924 allows psychologists to delegate certain psychological testing and services to a person enrolled in a formal internship in accordance with Texas State Board of Examiners of Psychologists rules.

**H.B. 2280, H.B. 2809,
H.B. 2913, H.B. 3175,
H.B. 3185, S.B. 1387,
S.B. 1587 - County and
Municipal Health Care
Provider Programs**

H.B. 2280, H.B. 2809, H.B. 2913, H.B. 3175, H.B. 3185, S.B. 1387, and S.B. 1587 create county health care provider participation programs in several Texas counties. A county or municipal health care provider participation program authorizes a county or municipality to collect mandatory payments from each institutional health care provider located in the county or municipality to be deposited in a local provider participation fund established by the county or municipality. Money in the fund may be used by the county or municipality to fund indigent care programs and to provide the state with the non-federal share of a Medicaid supplemental payment program, such as the payments required for providers to participate in 1115 Transformation Waiver DSRIP projects.

**H.B. 2340 - Prescribed
Pediatric Extended Care
Center Revisions**

H.B. 2340 permits DADS to issue a temporary PPECC license, pending

issuance of an initial license, under which the PPECC could serve up to six clients for not more than 180 days.

The bill also specifies:

- PPECC nursing services must be a one-to-one replacement of other skilled nursing services, unless additional nursing services are medically necessary.
- The reimbursement rate for PPECCs, when converted to an hourly rate, cannot exceed 70 percent of the hourly rate for Medicaid PDN.
- The parent, legal guardian, or managing conservator of a minor client is not required to accompany the minor client to services provided at a PPECC.

**H.B. 3433 - Perinatal
Advisory Council**

H.B. 3433 adds two additional rural members to the PAC, bringing the total number of members to 19. The bill extends the dates by which a hospital must have a neonatal level of care designation to receive Medicaid neonatal care reimbursement and a maternal level of care designation to receive Medicaid maternal services reimbursement to September 1, 2018 and September 1, 2020, respectively.

H.B. 3519 - Home Telemonitoring

H.B. 3519 moves the sunset date for Medicaid home telemonitoring services reimbursement from September 1, 2015, to September 1, 2019, so HHSC may continue to determine whether this service reduces chronic disease exacerbations and hospitalizations in eligible clients.

H.B. 3523 - Changes to Managed Care Expansion for Intellectual and Developmental Disability Waiver Programs

H.B. 3523 builds on requirements in S.B. 7, 83rd Legislature, Regular Session, 2013 by:

- Expanding the role of the Intellectual and Developmental Disability System Redesign Advisory Committee.
- Requiring more detailed reports to the Legislature on the implementation of the LTSS system redesign.
- Removing expiration dates on existing regulations regarding NF providers seeking to participate in Medicaid managed care.

The bill delays the transition of TxHmL to Medicaid managed care by one year, to September 1,

2018, and delays the transition of other IDD waivers and ICFs/IIDs to managed care by one year, until September 1, 2021. It also delays the mandated start of the IDD pilot by one year, to September 1, 2017, and removes the requirement that the pilot last at least two years. The bill requires HHSC and the advisory committee to analyze the outcomes of the transition of LTSS under the TxHmL waiver program to Medicaid managed care.

H.B. 4001 - Habilitation Services Licensure Requirements

H.B. 4001 adds habilitation as a service provided by a HCSSA and requires a provider of habilitation to be a licensed HCSSA. Habilitation providers in the HCS and TxHmL waiver programs or the STAR+PLUS or other Medicaid managed care programs are exempt from the licensure requirements. The bill authorizes imposition of administrative penalties for HCS and TxHmL waiver programs.

S.B. 125 - Assessment for Children in State Conservatorship

S.B. 125 requires that all children must receive a trauma-informed CANS within 30 days of being removed from their homes by DFPS.

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S.B. 200 - HHS Sunset Review and Transformation

The Texas Sunset Commission began an almost two-year analysis of the HHS system in 2013. The findings and recommendations of the Sunset review formed the basis for the Legislature's directive, via S.B. 200, to consolidate and transform the HHS system.

S.B. 200 takes a phased approach to restructuring the HHS system, including transferring DARS; client services at DADS, DFPS, and DSHS; and certain administrative services to HHSC on September 1, 2016. Regulatory programs as well as SSLCs and state hospitals will transfer to HHSC on September 1, 2017.

S.B. 200 requires HHSC to develop and submit a detailed transition plan for moving all programs and functions to the newly created Transition Legislative Oversight Committee. For more information about Transformation under S.B. 200, please see **Chapter 13, Administration**.

S.B. 207 - Sunset Review of HHSC Inspector General

S.B. 207 requires that the HHSC IG will be reviewed by the Sunset

Advisory Committee every six years to establish priorities and guide the investigation process. The bill clarifies the role and authority of IG's investigations, audits, payment holds, and general operations, including greater Medicaid managed care oversight.

S.B. 460 - Pharmacy Dispensing Standards During a Disaster

S.B. 460 makes various changes to pharmacy licensure and establishes a pharmacist's authority to dispense a limited supply of a dangerous drug during a disaster. In the event of a natural or manmade disaster, a pharmacist may dispense up to a 30-day supply of a dangerous drug without the prescribing doctor's authorization if all of the following criteria are met:

- Failure to refill the prescription will interrupt the patient's therapeutic treatment or cause the patient to suffer.
- The disaster prohibits the pharmacist from contacting the patient's doctor.
- The Governor has declared a state of disaster.
- The Texas State Board of Pharmacy has notified Texas pharmacies that pharmacists may dispense up to a 30-day supply of a dangerous drug.

S.B. 760 - Medicaid Managed Care Organization Network Standards

S.B. 760 requires HHSC to establish additional minimum provider access standards for Medicaid MCO provider networks in its managed care contracts. These requirements include:

- Developing new minimum distance, travel time, and appointment wait time standards for member access to providers.
- Updating the expedited credentialing process to expand the list of provider types eligible for expedited credentialing.
- Requiring all MCOs to publish provider directories online, with provider information updated at least monthly.

Prior to serving Medicaid recipients, an MCO must demonstrate to HHSC that the MCO provider network offers sufficient access to certain types of care including: primary care; preventive care; specialty care; urgent care; chronic care; LTSS; nursing services; and therapy services. The MCO's provider network must also have the capacity to serve the number of recipients expected to enroll in that MCO's plan.

S.B. 1462 - Opioid Antagonists

S.B. 1462 provides for the prescription, distribution, administration, and possession of an opioid antagonist for the treatment of an opioid-related drug overdose. A provider may prescribe and a pharmacist may dispense an opioid antagonist to:

- A person at-risk for an opioid-related drug overdose.
- A family member, friend, or other person able to assist a person at risk for an opioid-related drug overdose.

The opioid antagonist may be prescribed or dispensed directly or under a standing order. Emergency services personnel may administer an opioid-antagonist. Any person may possess an opioid-antagonist, regardless of whether they have a prescription for it.

S.B. 1664 - Achieving a Better Life Experience (ABLE) Program

S.B. 1664 amends the Education Code to establish the Texas Achieving a Better Life Experience (ABLE) Program administered by the Prepaid Higher Education Tuition Board within the office of the Texas Comptroller of Public Accounts. The federal ABLE Act of 2014 was enacted to assist individuals and

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families in saving private funds to support individuals with disabilities to maintain health, independence, and quality of life. S.B. 1664 allows Texas to establish a savings program under which contributions can be made to an ABLE account of a Texas resident. Savings in ABLE accounts are not counted toward a beneficiary's eligibility for state assistance or benefits programs.

S.B. 1880 - DFPS Investigation of Abuse, Neglect, and Exploitation

S.B. 1880 expands DFPS authority to investigate all Medicaid providers of HCBS unless another licensing entity has the authority to conduct the investigation. The bill transfers DADS' authority to investigate allegations of abuse, neglect, or exploitation of a child under 18 receiving HCSSA services to DFPS.

HHSC Rider 50 of the 2016-17 General Appropriations Act - Medicaid Funding Reduction and Cost Containment

Rider 50 requires HHSC to achieve \$373 million in general revenue (\$870 million all funds) savings in Medicaid for the 2016-17 biennium. The rider proposes a list of 16 cost containment initiatives and permits

other initiatives identified by HHSC. In general, the initiatives focus on service delivery and quality improvements, payment reform, and reduction of fraud and waste. Examples of specific areas targeted include managed care contracting, pharmacy services, and better birth outcomes.

The rider specifies that at least \$150 million of the total General Revenue funds savings should be related to physical, occupational, and speech therapy services. Of this therapy-related savings, at least \$100 million in general revenue funds saving should be achieved through rate reductions, and the remaining \$50 million in general revenue funds savings should be achieved through medical policy initiatives or additional rate reductions.

Major Federal Changes to Medicaid and CHIP

Social Security Amendments of 1965

- Amends the Social Security Act of 1935 by adding Title XIX, creating Medicaid.
- Texas implements Medicaid September 1, 1967, as directed by S.B. 2, 60th Legislature, Regular Session, 1967.

Social Security Amendments of 1967

Mandated

- 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 HCBS 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 FPL. Creates phase-in for children up to age five under 100 percent of the FPL. 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 NF standards, including the creation of the Preadmission Screening and Resident Review (PASRR) process, a requirement that all current and prospective NF clients be screened to identify persons with mental illness, intellectual disability, or related conditions.

Optional

- Allows states to cover infants up to age one and pregnant women under 185 percent of the FPL and allows immediate coverage (no phase-in) of children up to age five under 100 percent of the FPL.
- Allows states to develop systems of care for home and community-based and institutional LTSS via 1915(d) waivers.

Medicare Catastrophic Coverage Act of 1988

Mandated

- Provides phased-in coverage of out-of-pocket costs (premiums, deductibles, and co-insurance) for QMBs under 100 percent of the FPL.
- Provides phased-in coverage of infants up to age one and pregnant women under 100 percent of the 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 DSH hospitals.
- Once eligibility is established, coverage of pregnant women may not be terminated until two months postpartum. Infants born to Medicaid-eligible mothers must be covered through their first birthday if the mother remains eligible or if

she would be eligible if she were pregnant.

Optional

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

OBRA of 1989

Mandated

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

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Mandated

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

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OBRA of 1993

Mandated

- States must distribute federally-provided vaccines to Medicaid providers.
- States without medically needy spend-down programs for NF services must allow eligibility of persons with certain trusts.
- Sets new standards for participation in and payments under the DSH program.
- Sets stricter standards for transfer-of-assets penalties for NF care and HCBS 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)

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 NPI to be used in all electronic transactions between providers and health plans.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)

PRWORA, commonly referred to as welfare reform, 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 U.S. after August 22, 1996, are subject to a five-year

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

“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 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

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

- Reduction of payments to DSH.
- Allowances for states to lower what they paid for Medicare co-payments, deductibles, and coinsurance for QMBs.
- Repeal of the Boren Amendment, eliminating minimum payment guarantees for hospitals, NFs, 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

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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).

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 the MBIC program in January 2011. Children with family income less than or equal to 150 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)

The 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.

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA)

- 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

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.

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 CDC breast and cervical cancer early detection program, found to be in need of treatment for cancer, and

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).

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)

- Increased 2001 and 2002 DSH payment state allotments.
- Required new federal rules to be issued by the end of 2000 limiting Medicaid 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

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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

- Allowed states to retain unexpended federal fiscal year 1998-99 federal allocations through federal fiscal year 2004.
- Allowed states additional time to spend 50 percent of unused federal fiscal year 2000 and federal fiscal year 2001 federal allocations (through federal fiscal year 2004 and federal fiscal year 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.

Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)

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 federal fiscal years 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 (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)

The 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.

- State financing (including changes in funding targeted case management and restrictions on provider taxes).

Welfare Reform Extensions and Reauthorizations

Various laws have been passed to extend PRWORA beyond its expiration date of September 30, 2002. The DRA reauthorized TANF through September 30, 2010, and continuing resolutions have extended the program since 2010. Most recently, a continuing resolution extended TANF through April 28, 2017. 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 the Protecting Access to Medicare Act, and was subsequently made permanent through MACRA.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007

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. Prescriptions transmitted to pharmacies via telephone, fax, or electronically are exempt from this requirement.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

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 SUD 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)

CHIPRA authorized CHIP federal funding through federal fiscal year 2013 (subsequent legislation has continued CHIP federal funding through federal fiscal year 2017). HHSC implemented the following changes in accordance with federal CHIPRA guidance:

- Applying certain Medicaid managed care safeguards to CHIP.
- Verifying citizenship for CHIP.

- Implementing mental health parity in CHIP.
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children.
- Expanding dental services.

The American Recovery and Reinvestment Act (ARRA)

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 state fiscal year 2009, 12 months of state fiscal year 2010 and 10 months of state fiscal year 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 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 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.
- Requiring individuals, with limited exceptions, to have health coverage or pay a penalty.
- Requiring states have a health insurance marketplace that assists individuals and small businesses with purchasing affordable health care.
- Providing premium subsidies and cost-sharing reductions for coverage purchased through the marketplace to eligible individuals above 100 percent up to and including 400 percent of the FPL.
- Prohibiting coverage denials, treatment denials, and higher charges based on a pre-existing condition.
- Allowing children to stay on a parent's health insurance plan until age 26.

Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 (HCERA)

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).

The ACA makes broad changes to the U.S. health care system, such as:

The following is an overview of many of the ACA requirements applicable to Medicaid and/or CHIP.

Health Insurance Marketplaces

The ACA directs that each state have a health insurance marketplace that assists individuals and small businesses with purchasing 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. Texas currently has a federally-facilitated marketplace. Marketplace eligibility

determinations must be streamlined and coordinated with eligibility determinations for the Medicaid and CHIP programs.

Eligibility Changes

States had the option to expand Medicaid eligibility to 133 percent of the FPL for uninsured individuals up to age 65 (Texas has not expanded Medicaid eligibility to adults).

- Requires states to determine financial eligibility for most Medicaid programs and CHIP based on the MAGI methodology, which 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.
- 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

The ACA required that state Medicaid programs:

- Provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP. Texas implemented this change August 1, 2010.
- Add birthing centers as a required Medicaid provider. HHSC reinstated birthing centers as a Medicaid provider, effective September 1, 2010.
- Provide Medicaid reimbursement to providers recognized by states as a licensed birth attendant. Texas Medicaid began recognizing licensed midwives as a provider type effective January 1, 2013.
- Implement comprehensive tobacco cessation services for pregnant women. Texas added coverage for tobacco cessation counseling services to Texas' existing coverage of prescription and non-prescription tobacco cessation agents approved by the federal Food and Drug Administration.

Program Integrity

The ACA established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP. Detail on the numerous ACA program integrity initiatives is described in **Chapter 13, Administration**.

Financing

The ACA made a number of revisions to Medicaid and CHIP financing in support of the ACA policy changes, such as providing federal payment for the first three calendar years for newly eligible adults, for states choosing to implement a Medicaid expansion. This decreases to a 90 percent federal share for 2020 and after. The ACA decreased DSH allotments in anticipation that the uninsured population would decrease in states implementing Medicaid expansions.

The ACA also temporarily increased the federal share of various matching payments, including a one percentage point increase for preventive care services, a two percentage point increase under the BIP program for certain community-based long-term care services for states that made structural changes to their long-term care delivery system, and a 23 percentage point increase through September 2019 in the federal match rate for CHIP. More

details are included in **Chapter 14, Finances**.

CHIP Impacts

The ACA authorized federal funding for CHIP through 2015 and made other changes related to CHIP, which are detailed in **Chapter 2, Medicaid and CHIP in Context**.

Pharmacy Changes

The ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The ACA also expanded the rebate program to cover claims paid by Medicaid MCOs. For more information, see **Chapter 9, Prescription Drugs**.

Protecting Access to Medicare Act

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

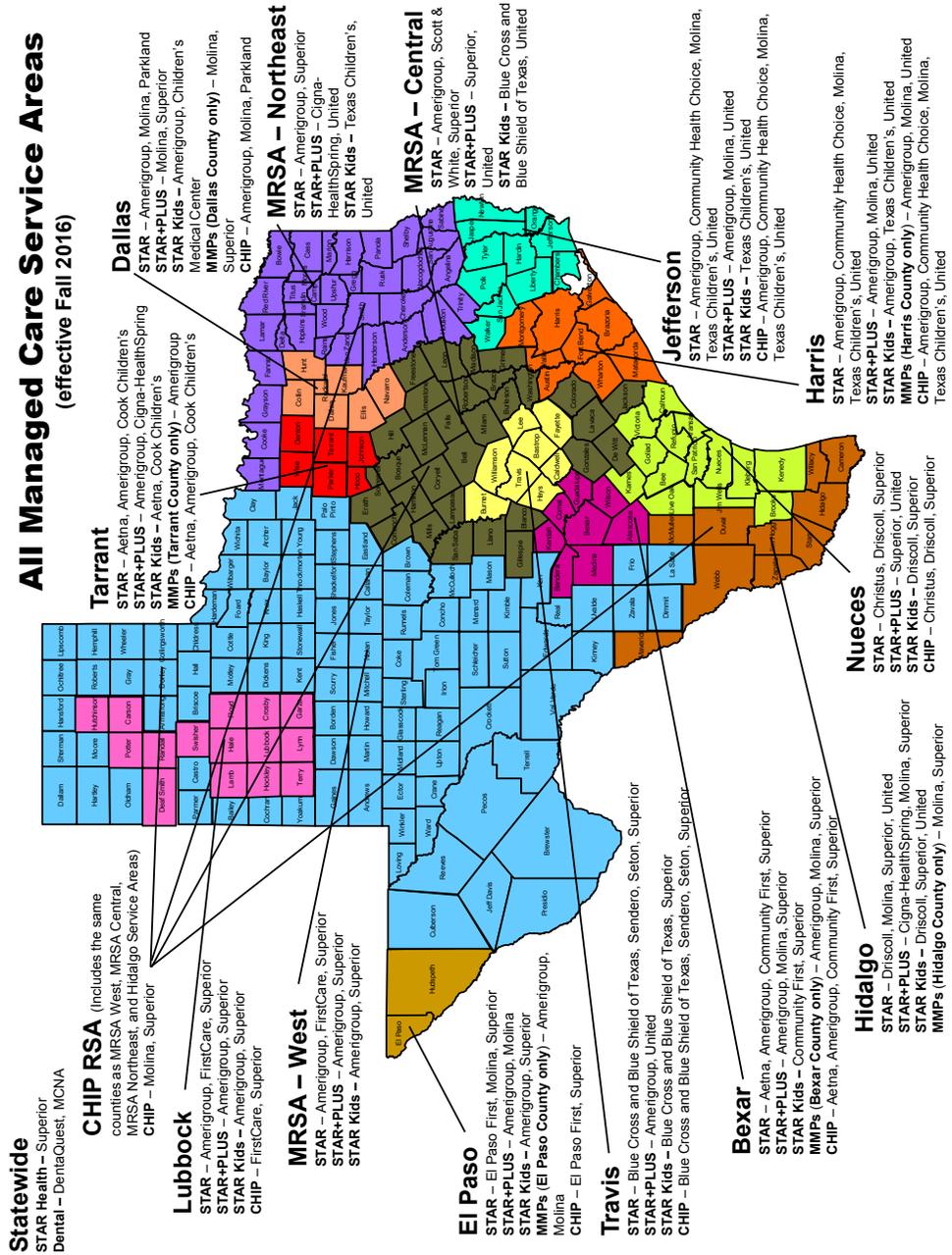
- Extended the Qualified Individuals, Transitional Medical Assistance, and Maternal, Infant and Early Childhood Home Visiting Programs through March 2015.
- Extended the CHIP Express Lane program option through September 2015.

- Extended the State Abstinence Education Grant and Personal Responsibility Education Programs through federal fiscal year 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 DSH allotment. The aggregate federal DSH allotment will be reduced by \$1.8 billion in federal fiscal year 2017; \$4.7 billion in federal fiscal year 2018, federal fiscal year 2019, and federal fiscal year 2020; \$4.8 billion in federal fiscal year 2021; \$5 billion in federal fiscal year 2022 and federal fiscal year 2023; and \$4.4 billion in federal fiscal year 2024.
- Created a demonstration program to improve community mental health services.
- Fully funds state CHIP allotments through September 30, 2017, including funding the 23 percentage-point increase in federal matching funds authorized by the ACA.
- Extends Express Lane Eligibility authorization through federal fiscal year 2017.
- Extends CHIPRA outreach and enrollment grants and CHIPRA quality provisions .
- Maintains MOE for children’s coverage in Medicaid and CHIP through 2019.
- Makes permanent the authorization for Transitional Medical Assistance, which provides time-limited Medicaid to low-income parents transitioning to employment at higher wages that otherwise would make them ineligible for Medicaid.

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

While MACRA is notable to many for the changes it makes to how Medicare pays for physician services and the inclusion of value-based payment approaches, MACRA also has the following impacts on Medicaid and CHIP:

Appendix B: Medicaid and CHIP Service Areas



CHIP Rural Service Area (RSA)

(Includes the same counties as MRSA West, MRSA Central, MRSA Northeast, and Hidalgo Service Area)
CHIP – Molina Healthcare, Superior HealthPlan

Medicaid Rural Service Area (MRSA) - Central

STAR – Amerigroup, Scott & White Health Plan, Superior HealthPlan
STAR+PLUS – Superior HealthPlan, UnitedHealthCare Community Plan
STAR Kids – Blue Cross and Blue Shield of Texas, UnitedHealthCare Community Plan

MRSA - Northeast

STAR – Amerigroup, Superior HealthPlan
STAR+PLUS – Cigna-HealthSpring, UnitedHealthCare Community Plan
STAR Kids – Texas Children’s Health Plan, UnitedHealthCare Community Plan

MRSA - West

STAR – Amerigroup, FirstCare Health Plans, Superior HealthPlan
STAR+PLUS – Amerigroup, Superior HealthPlan
STAR Kids – Amerigroup, Superior HealthPlan

Bexar

STAR – Aetna Better Health of Texas, Amerigroup, Community First Health Plan, Superior HealthPlan
STAR+PLUS – Amerigroup, Molina Healthcare, Superior HealthPlan

STAR Kids – Community First Health Plan, Superior HealthPlan
Medicare-Medicaid Plans (MMPs) (Bexar County only) – Amerigroup, Molina Healthcare, Superior HealthPlan
CHIP – Aetna Better Health of Texas, Amerigroup, Community First Health Plan, Superior HealthPlan

Dallas

STAR – Amerigroup, Molina Healthcare, Parkland Community Health Plan
STAR+PLUS – Molina Healthcare, Superior HealthPlan
STAR Kids – Amerigroup, Children’s Medical Center Health Plan
MMPs (Dallas County only) – Molina Healthcare, Superior HealthPlan
CHIP – Amerigroup, Molina Healthcare, Parkland Community Health Plan

El Paso

STAR – El Paso First Health Plan, Molina Healthcare, Superior HealthPlan
STAR+PLUS – Amerigroup, Molina Healthcare
STAR Kids – Amerigroup, Superior HealthPlan
MMPs (El Paso County only) – Amerigroup, Molina Healthcare
CHIP – El Paso First Health Plan, Superior HealthPlan

B

Harris

STAR – Amerigroup, Community Health Choice, Molina Healthcare¹, Texas Children’s Health Plan, UnitedHealthCare Community Plan
STAR+PLUS – Amerigroup, Molina Healthcare, UnitedHealthCare Community Plan
STAR Kids – Amerigroup, Texas Children’s Health Plan, UnitedHealthCare Community Plan
MMPs (Harris County only) – Amerigroup, Molina Healthcare, UnitedHealthCare Community Plan
CHIP – Amerigroup, Community Health Choice, Molina Healthcare¹, Texas Children’s Health Plan, UnitedHealthCare Community Plan

Hidalgo

STAR – Driscoll Health Plan, Molina Healthcare, Superior HealthPlan, UnitedHealthCare Community Plan
STAR+PLUS – Cigna-HealthSpring², Molina Healthcare, Superior HealthPlan
STAR Kids – Driscoll Health Plan, Superior HealthPlan, UnitedHealthCare Community Plan
MMP (Hidalgo County only) – Molina Healthcare, Superior HealthPlan, Cigna-HealthSpring

¹Effective June 1, 2017, Memorial Hermann Health Plan will replace Molina Healthcare for STAR and CHIP.

²Effective January 22, 2016, CMS prohibited new member enrollment in Cigna-HealthSpring. Current members are not affected.

Jefferson

STAR – Amerigroup, Community Health Choice, Molina Healthcare, Texas Children’s Health Plan, UnitedHealthCare Community Plan
STAR+PLUS – Amerigroup, Molina Healthcare, UnitedHealthCare Community Plan
STAR Kids – Texas Children’s Health Plan, UnitedHealthCare Community Plan
CHIP – Amerigroup, Community Health Choice, Molina Healthcare, Texas Children’s Health Plan, UnitedHealthCare Community Plan

Lubbock

STAR – Amerigroup, FirstCare Health Plans, Superior HealthPlan
STAR+PLUS – Amerigroup, Superior HealthPlan
STAR Kids – Amerigroup, Superior HealthPlan
CHIP – FirstCare Health Plans, Superior HealthPlan

Nueces

STAR – CHRISTUS Health Plan, Driscoll Health Plan, Superior HealthPlan
STAR+PLUS – Superior HealthPlan, UnitedHealthCare Community Plan
STAR Kids – Driscoll Health Plan, Superior HealthPlan
CHIP – CHRISTUS Health Plan, Driscoll Health Plan, Superior HealthPlan



Tarrant

STAR – Aetna Better Health of Texas,
Amerigroup, Cook Children’s Health
Plan

STAR+PLUS – Amerigroup, Cigna-
HealthSpring

STAR Kids – Aetna Better Health of
Texas, Cook Children’s Health Plan

MMP (Tarrant County only) –
Amerigroup

CHIP – Aetna Better Health of Texas,
Amerigroup, Cook Children’s Health
Plan

Travis

STAR – Blue Cross and Blue Shield
of Texas, Sendero Health Plan, Seton
Health Plan, Superior HealthPlan

STAR+PLUS – Amerigroup,
UnitedHealthCare Community Plan

STAR Kids – Blue Cross and Blue
Shield of Texas, Superior HealthPlan

CHIP – Blue Cross and Blue Shield of
Texas, Sendero Health Plan, Seton
Health Plan, Superior HealthPlan

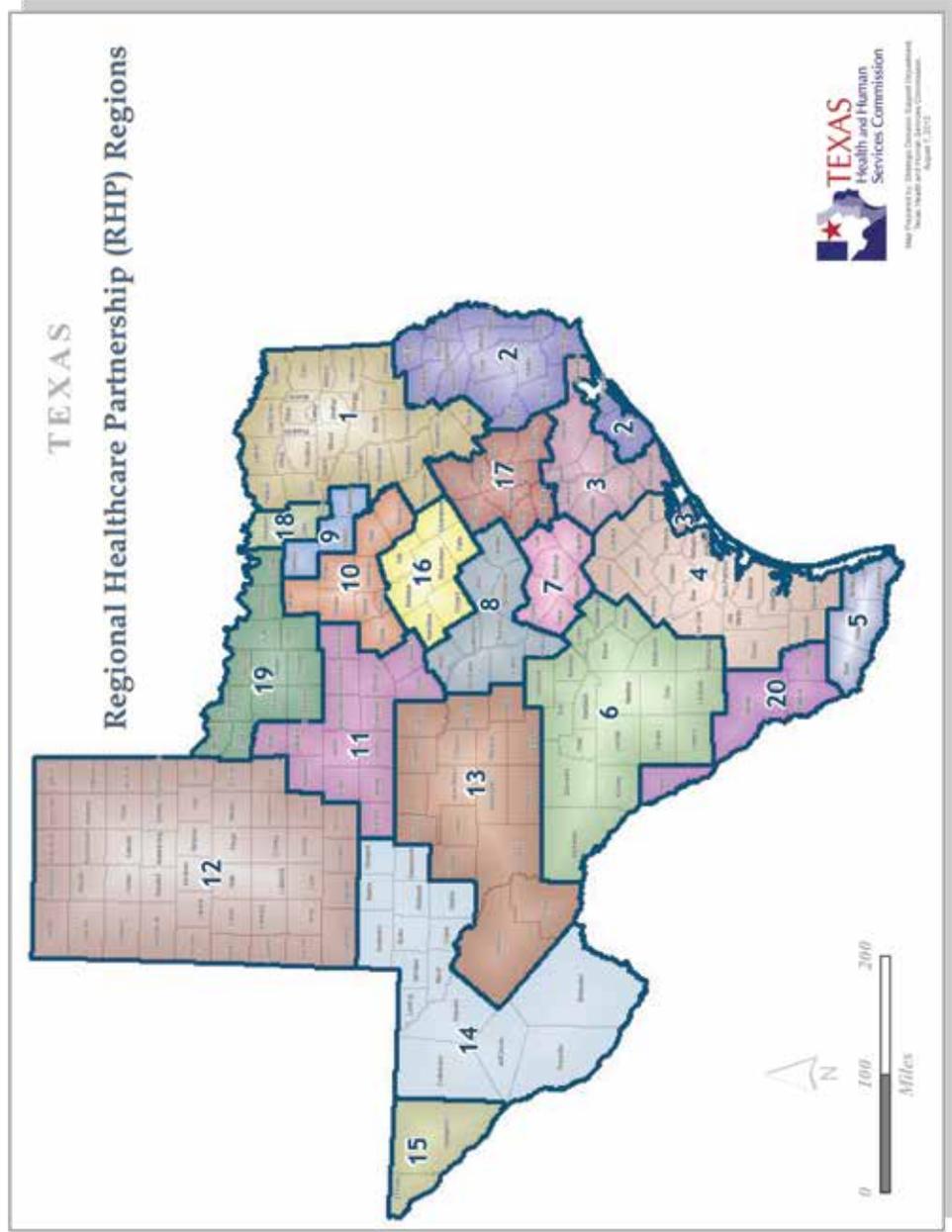
Statewide

STAR Health – Superior HealthPlan

Dental – DentaQuest, MCNA



Appendix C: 1115 Transformation Waiver Regions



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 nine 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 four counties: Cameron, Hidalgo, Starr, and Willacy.

RHP 6 includes the following 20 counties: Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr,

Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

RHP 7 includes the following six counties: Bastrop, Caldwell, Fayette, Hays, Lee, and Travis.

RHP 8 includes the following nine counties: Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

RHP 9 includes the following three counties: Dallas, Denton, and Kaufman.

RHP 10 includes the following nine 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, Hartley, 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 two counties: El Paso and Hudspeth.

RHP 16 includes the following seven counties: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, and McLennan.

RHP 17 includes the following nine counties: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington.

RHP 18 includes the following three 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 four counties: Jim Hogg, Maverick, Webb, and Zapata.



Appendix D: Managed Care History in Texas

Table D.1: Development of Managed Care in Texas, SFYs 1994-2017

State Fiscal Year	Service Areas (SA) and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR implemented in Travis county and in the Tri-County area.	58,243	2.86%
1995	No change	65,388	3.16%
1996	The Tri-county area was expanded to three additional counties and was renamed from Lone STAR Health Initiative to STAR.	71,435	3.46%
1997	STAR expanded to the Bexar, Lubbock, and Tarrant SAs, and the Travis county area was expanded to include surrounding counties.	274,694	13.82%
1998	STAR expanded to the Harris SA, and STAR+PLUS implemented in the Harris SA.	364,336	19.56%
1999	STAR expanded to the Dallas SA.	425,069	23.45%
2000	STAR expanded to the El Paso SA.	523,832	28.98%
2001	No change	623,883	33.35%
2002	No change	755,698	35.92%
2003	No change	988,389	39.71%
2004	No change	1,112,002	41.43%
2005	No change	1,191,139	42.85%
2006	Primary Care Case Management (PCCM) implemented in 197 counties.	1,835,390	65.72%
2007	STAR expanded to the Nueces SA, and STAR+PLUS expanded to the Bexar, Travis, Nueces, and Harris Contiguous SAs. STAR replaced PCCM in all urban areas.	1,921,651	67.83%
2008	ICM implemented in the Dallas and Tarrant SAs, and STAR Health implemented statewide.	2,039,340	70.86%



Appendix D: Managed Care History in Texas

State Fiscal Year	Service Areas (SA) and Implementation Dates	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2009	The ICM program was discontinued.	2,127,382	70.78%
2010	No change	2,362,091	71.62%
2011	STAR+PLUS expanded to the Dallas and Tarrant SAs.	2,676,149	75.53%
2012	STAR expanded to Medicaid Rural Service Areas (MRSAs), replacing PCCM in all rural areas and discontinuing that program. Pharmacy benefits were carved in to all managed care programs, and inpatient hospital benefits were carved in to STAR+PLUS. The Children's Medicaid Dental Services program implemented statewide.	2,893,965	79.16%
2013	No change	2,982,923	81.53%
2014	No change	3,012,262	80.41%
2015	STAR+PLUS expanded to all areas of the state, non-dual eligible clients in IDD waivers and NF benefits were carved into STAR+PLUS, mental health targeted case management and mental health rehabilitative services were carved into all managed care programs, and the Dual Demonstration program implemented in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.	3,524,581	86.88%
2016	<i>No change</i>	<i>3,569,417</i>	<i>87.92%</i>
2017	<i>STAR Kids implemented statewide. NorthSTAR was discontinued.</i>	<i>N/A</i>	<i>N/A</i>

Sources: HHSC, Financial Services, HHS System Forecasting. Average Monthly Recipient Months including STAR, STAR+PLUS, PCCM, ICM and STAR Health.

Note: Data for SFYs 2016 and 2017 is not yet final.

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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 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 Legislature passed H.B. 2913 and Senate Bills 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 (LTSS) 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 to provide mental health and substance abuse services to Medicaid clients and certain non-Medicaid clients below 200 percent of the federal poverty level (FPL).

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 Texas Medicaid Managed Care Review concluded that Texas had achieved many, but not all of the goals set for the Medicaid managed care program. 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 fee-for-service (FFS) Medicaid program. The report also concluded that managed care introduced additional program complexity both to providers and 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 Review, HHSC was allowed to expand Medicaid managed care when cost effective.

By 2003, the Legislature faced budget pressures that prompted interest in modifying Medicaid and expanding managed care throughout the state 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 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 managed care organization (MCO).

The 2006-07 General Appropriations Act (GAA), S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Special Provisions Related to All Health and Human Services Agencies, 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, HHSC developed the Integrated Care Management model and the STAR+PLUS Hospital Carve-Out model to integrate acute care and LTSS. 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 (ICM) model ended in May 2009.

In addition to developing new managed care programs, HHSC has continued to expand existing

programs. In 2006, Nueces was added to the STAR service areas. The 2010-11 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 with disabilities in the Dallas and Tarrant service areas. After analyzing current managed care models, HHSC determined STAR+PLUS was the most appropriate 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 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 LTSS for individuals 65 and older and those with disabilities. Most adults being served through one of the 1915(c) waivers for individuals with intellectual and developmental disabilities (IDD) or living in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) began receiving acute care services through STAR+PLUS on this date. On March 1, 2015, HHSC began delivering nursing facility (NF) 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 also implemented the Texas Dual Eligible Integrated Care Demonstration Project (known as the Dual Demonstration), a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid. By using a single MCO for

adults ages 21 and over who are eligible for Medicare and Medicaid through STAR+PLUS, the Dual Demonstration was designed to better coordinate Medicare and Medicaid services through a single MCO, improve quality and access to care, and promote independence in the community.

S.B. 7 also directed HHSC to develop the STAR Kids managed care program, tailored for children with disabilities, including children receiving Medically Dependent Children Program (MDCP) waiver benefits. STAR Kids was implemented statewide on November 1, 2016.

In addition, S.B. 7 directed HHSC and DADS to implement a voluntary pilot to test one or more managed care service delivery models to deliver Medicaid LTSS to individuals with IDD. Eligible individuals include those residing in a community-based ICF/IID or receiving services through a Medicaid waiver for individuals with IDD. H.B. 3523, 84th Legislature, Regular Session, 2015, allows the pilot to operate for up to 24 months and is scheduled to implement in 2017.

In accordance with the 2016-17 GAA, H.B. 1, 84th Legislature, Regular Session, 2015, (Article II, Department of State Health Services, Rider 85), the state terminated the NorthSTAR program on December 31, 2016. Upon

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termination of the NorthSTAR waiver, individuals began receiving Medicaid behavioral health care services through managed care programs, including STAR, STAR+PLUS, and STAR Kids.

The 2014-15 GAA, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51b(15)) directed HHSC to transition remaining Medicaid FFS populations into managed care as a cost containment measure. The rider stated that this reduction should be achieved through the implementation of a plan to improve care coordination through a capitated managed care program.

HHSC determined Adoption Assistance (AA), Permanency Care Assistance (PCA), and Medicaid for Breast and Cervical Cancer (MBCC) populations were three groups receiving services through traditional FFS who could benefit from a managed care model. On September 1, 2017, the AA and PCA populations are scheduled to receive services through STAR and the MBCC population is scheduled to receive services through STAR+PLUS. AA and PCA children with SSI will receive services through STAR Kids.

Appendix D: Managed Care History in Texas

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Appendix E: Managed Care Quality Assurance Reports

Quality of Care

The Balanced Budget Act of 1997 (BBA) 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 managed care organizations (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, CHIP, STAR Kids, 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. The Institute for Child Health Policy (ICHP) has been the EQRO for Texas since 2002.

STAR – Significant Quality Findings

Quality of Care

Statewide performance on measures of access to well-care visits for children and adolescents and prenatal and postpartum care in STAR showed positive findings in 2014. Well-care measures for children and adolescents were above the 50th percentile on the HEDIS® national benchmark percentiles for Medicaid, representing a good standard of care compared to the national Medicaid population. Performance on prenatal and postpartum care access measures was also above the 50th percentile

on the HEDIS® national benchmark percentiles for Medicaid.

In STAR, potentially preventable admissions per 1,000 member months dropped slightly from 0.61 in 2013 to 0.54 in 2014. The most common reasons reported for potentially preventable admissions were:

- Asthma (16 percent).
- Pneumonia (14 percent).
- Cellulitis and other bacterial skin infections (11 percent).

Potentially preventable readmissions per 1,000 member months also dropped slightly from 0.23 in 2013 to 0.20 in 2014.

Potentially preventable emergency department visits per 1,000 member months increased slightly from 9.39 in 2013 to 9.41 in 2014. The most common reason reported for potentially preventable emergency department visits in STAR was upper respiratory tract infections (26 percent).

Statewide, 4,360 unique members experienced 4,999 potentially preventable complications. Potentially preventable complications in STAR were predominantly obstetric and delivery-related events, which together account for 54 percent of events.

Measures of effectiveness of care for asthma showed that members in STAR were prescribed controller medications at a rate exceeding the HEDIS® 90th percentile. However, the percentage of members who remained on an asthma controller medication at least 75 percent of the treatment period was below the HEDIS® 10th percentile. Other key areas for improvement in STAR include appropriate testing for children and adolescents with pharyngitis, eye exams and medical attention for nephropathy as part of comprehensive diabetes care, and follow-up after hospitalization for mental illness.

Satisfaction with Care

The 2014 STAR adult member survey found high levels of satisfaction in regard to communicating with doctors and getting help and information from health plan customer service, as well as generally positive ratings of care that met or exceeded the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Medicaid national rates. Rates for *Getting Needed Care* (71 percent), *Getting Care Quickly* (76 percent), and *How Well Doctors Communicate* (88 percent), were below the CAHPS® Medicaid national rate. The lower rate for CAHPS® *Getting Needed Care* suggests a need to improve access to specialist care for STAR members.

Table E.1: STAR Adult Member Satisfaction with Care, 2014

CAHPS® Measure ("Usually" or "Always")	2014 Rate	HHSC Standard 2014	CAHPS® Adult Medicaid 2014
Getting Needed Care	71.4%	N/A	81%
Getting Care Quickly	76.3%	N/A	82%
How Well Doctors Communicate	88.1%	89%	90%
Health Plan Information and Customer Service	87.4%	N/A	86%
Personal Doctor Rating	66.2%	63%	64%
Specialist Rating	65.4%	N/A	64%
Health Plan Rating	61.3%	60%	57%
Health-care Rating	53.5%	N/A	51%

The survey conducted with caregivers of children and adolescents enrolled in STAR in 2015 found that, overall, the STAR program performed well on measures of caregiver satisfaction with care.

In particular, the percentage of caregivers who rated their child or adolescent's STAR health plan a "9" or "10" (81 percent) exceeded the national Medicaid rate by more than ten percentage points.

Table E.2: STAR Caregiver Satisfaction with Child Health Care, 2015

CAHPS® Measure ("Always")	2015 Rate	HHSC Dashboard Standard 2015	CAHPS® Child Medicaid National Rate 2015
Getting Needed Care	61.7%	N/A	60%
Getting Care Quickly	76.5%	N/A	72%
How Well Doctors Communicate	79.2%	80%	77%
Health Plan Information and Customer Service	78.3%	N/A	66%
Personal Doctor Rating	76.1%	77%	73%
Specialist Rating	77.9%	N/A	70%
Health Plan Rating	81.3%	81%	67%
Health-care Rating	72.7%	N/A	65%

The most common special health-care need among children and adolescents in STAR was dependence on prescription medications (18 percent). Almost three-quarters of child and adolescent STAR members were in “excellent” or “very good” overall health (73 percent) and mental health (72 percent). More than one-quarter of children and adolescents in STAR were obese (29 percent), as calculated using caregiver-reported height and weight.

The 2015 survey with caregivers of children and adolescents in STAR who need behavioral health services shows generally positive experiences with clinician communication, getting treatment and information from the health plan, and perceived improvement. Lower scores were observed for the timeliness of behavioral health care and getting information about treatment options.

Similar to the child and adolescent results, adult members needing behavioral health services reported positive experiences for the *How Well Clinicians Communicate* and *Getting Treatment and Information from the Plan* when surveyed in 2015. Although STAR adult members generally were satisfied with their behavioral health care, the measures with the most room for improvement were *Information about Treatment Options* and *Getting Treatment and*

Information from the Behavioral Health Organization.

STAR+PLUS – Significant Quality Findings

Quality of Care

Utilization of care generally was high in 2014 for STAR+PLUS Medicaid-only members, as expected for the more complex health conditions seen in the population. Statewide, the program had 581.1 outpatient visits per 1,000 member months.

Between 2013 and 2014, there were modest decreases in rates of potentially preventable admissions and readmissions within 30 days, while the rate of potentially preventable emergency department visits remained constant. The rate of potentially preventable admissions in 2014 was 7.80 per 1,000 member-months. The most common reasons for potentially preventable admissions were chronic obstructive pulmonary disease (COPD) (11 percent) and heart failure (ten percent). Long-term complications for diabetes, as measured by the AHRQ PQI, were 59.8 per 100,000 member months.

The rate of potentially preventable readmissions in 2014 was 4.22 per 1,000 member months. The most common reasons for potentially preventable readmissions were:

- Mental health or substance abuse readmission following an initial admission for a substance abuse or mental health diagnosis (33 percent).
- Medical readmission for acute medical condition or complication that may be related to or may have resulted from care during initial admission or in post-discharge period after initial admission (26 percent).
- Medical readmission for a continuation or recurrence of the reason for the initial admission, or for a closely related condition (21 percent).

The rate of potentially preventable emergency department visits in 2014 was 24.0 per 1,000 member months. The most common reasons for potentially preventable emergency department visits were chest or abdominal pain (14 percent), level II musculoskeletal system and connective tissue diagnoses (nine percent), and upper respiratory tract infections (eight percent).

Statewide, in 2014, 1,843 unique members experienced 2,767 potentially preventable complications. The two most frequently observed categories, renal failure without dialysis and urinary tract infection, accounted for more than one-quarter of potentially preventable complications.

Adults' access to preventive and ambulatory health services in STAR+PLUS in 2014 was above the 50th percentile on the HEDIS® national benchmark percentiles for Medicaid. Performance on the rate of assessing adult body mass index was between the 10th and 32nd percentiles on the HEDIS® national benchmark percentiles for Medicaid but exceeded the HHSC Performance Indicator Dashboard standard. The rate of screening for breast cancer was between the 10th and 32nd percentiles nationally but exceeded the HHSC Performance Indicator Dashboard standard. The statewide rate of screening for cervical cancer was in the bottom tenth nationally and did not meet the HHSC Performance Indicator Dashboard standard.

Performance on effectiveness of care measures generally was low for STAR+PLUS Medicaid-only members compared to the national Medicaid population. However, it is important to note that the STAR+PLUS program is designed to serve a population with generally greater health-care needs, and the population is not necessarily comparable to the national Medicaid population. The HEDIS® measures for appropriate medication for asthma, asthma medication ratio, avoidance of antibiotic therapy for adults with acute bronchitis, HbA1c (blood sugar) control for individuals living with diabetes,

eye exams for individuals with diabetes, controlling blood pressure for individuals with hypertension, and use of spirometry testing in the assessment and diagnosis of COPD all performed below the HEDIS® 33rd percentile. All four diabetes care measures showed improvement from 2013. The HEDIS® measure for management of asthma medications performed between the 66th and 89th percentiles, as did provision of bronchodilators following COPD exacerbation.

Satisfaction with Care

The 2014 member survey showed that STAR+PLUS members have more complex health conditions than members in STAR or in the general Medicaid population. Member-reported health status

was generally low, with 62 percent reporting “fair” or “poor” overall health and 48 percent reporting “fair” or “poor” mental health. Over half (51 percent) of members were obese, as measured from member-reported height and weight, and 24 percent were overweight. Health-related limitations to quality of life were common, with 66 percent of Medicaid-only members and 68 percent of dual-eligible members reporting they have a condition that interferes with independence, participation in the community, or quality of life.

Survey results suggested that members were in most ways satisfied with their experience of care in STAR+PLUS, with some room for improvement in access to care.

Table E.3: STAR+PLUS Medicaid-only Member Satisfaction with Care, 2014

CAHPS® Measure (“Usually” or “Always”)	STAR+PLUS Medicaid-only 2014 Rates	HHSC Dashboard Standard 2014 Rates	National CAHPS® Adult Medicaid 2014 Rates
Getting Needed Care	65.7%	N/A	81%
Getting Care Quickly	78.7%	N/A	82%
How Well Doctors Communicate	86.2%	89%	90%
Health Plan Information and Customer Service	82.3%	N/A	86%
Personal Doctor Rating	66.7%	64%	64%
Specialist Rating	70.2%	N/A	64%
Health Plan Rating	56.5%	56%	57%
Health-care Rating	52.4%	N/A	51%

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Results from the 2015 behavioral health survey conducted with adults in STAR+PLUS showed satisfaction with *How Well Clinicians Communicate and Getting Treatment and Information from the Plan*. The measures with the greatest room for improvement were *Information about Treatment Options and Getting Treatment* and *Information from the Behavioral Health Organization*.

Similar to the Medicaid-only STAR+PLUS behavioral health survey results, results from the 2015 behavioral health survey conducted with dual eligible members in STAR+PLUS showed positive experiences with clinician communication and getting treatment and information from the health plan. Dual eligible members reported lower satisfaction with getting information about treatment options. It is important to note that for dual eligible members, Medicare is the primary insurer and behavioral health services are generally provided through Medicare.

NorthSTAR – Significant Quality Findings

Quality of Care

In 2014, performance on the following HEDIS measures decreased from the prior year:

- Effective Acute Phase Treatment for Antidepressant Medication Management.

- Effective Continuation Phase Treatment for Antidepressant Medication Management.
- Initiation of Alcohol and Other Drug Dependence Treatment.
- Engagement of Alcohol and Other Drug Dependence Treatment.

In 2014, performance on the following HEDIS measures increased from the prior year:

- Follow-Up Care for Children Prescribed attention deficit hyperactivity disorder (ADHD) Medication - Initiation Phase.
- Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase.
- Follow-Up after Hospitalization for Mental Illness Within Seven Days.
- Follow-Up after Hospitalization for Mental Illness Within 30 Days.

NorthSTAR 2014 performance was below the HEDIS 50th percentile on all measures except *Follow-Up Care for Children Prescribed ADHD Medication* (both initiation and continuation and maintenance phases), *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*, and *Diabetes Monitoring for People with Diabetes and Schizophrenia*. For people with Schizophrenia in NorthSTAR, 72 percent of adults had an LDL-C test and 90 percent had

an LDL-C and HbA1c test during the measurement year.

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

In 2014, members in STAR Health utilized the emergency department at a rate of 62.1 visits per 1,000 member months, and outpatient care at a rate of 485.8 visits per 1,000 member-months. The STAR Health population is not necessarily comparable to the national Medicaid population; however, performance on well-care measures for children (89 percent) and adolescents (70 percent) in STAR Health exceeded their respective HEDIS® 90th percentiles in 2014.

Potentially preventable admissions increased from 3.35 visits per 1,000 member months in 2013 to 3.79 visits per 1,000 member months in 2014. The most common reasons for these inpatient admissions were bipolar disorders (68 percent) and major depressive

disorders and other psychoses (13 percent).

Potentially preventable readmissions increased slightly from 1.43 readmissions per 1,000 member-months in 2013 to 1.62 readmissions per 1,000 member months in 2014. The most common type of readmission was mental health or substance abuse readmission (90 percent).

Emergency department visits that were potentially preventable remained steady between 2013 and 2014. The most common condition associated with these emergency department visits was upper respiratory tract infection (25 percent).

Statewide, in 2014, 12 unique members experienced 13 potentially preventable complications. Obstetrical hemorrhage without transfusion accounted for nearly half (46 percent) of events.

Children and adolescents in STAR Health generally had excellent access to care in 2014 compared to the national Medicaid population and to Texas standards. The rate of members receiving at least six well-child visits in the first 15 months of life was in the middle third of the HEDIS® national benchmark percentiles for Medicaid and exceeded the HHSC Performance Indicator Dashboard standard. Performance on the other two

measures of well-care visits for children and adolescents were in the top ten percent nationally, with well-care visits for three- to six-year-olds exceeding the HHSC Performance Indicator Dashboard standard and well-care visits for adolescents performing below the standard. Access to PCPs for members in STAR Health was in the top decile nationally and met or exceeded the HHSC Performance Indicator Dashboard standard for all age bands.

Six in ten children and adolescents in STAR Health in 2014 (58 percent) were appropriately tested for streptococcal pharyngitis when presenting with pharyngitis, between the 10th and 32nd HEDIS® percentiles. Children and adolescents in STAR Health were very likely relative to the national Medicaid population to be prescribed an appropriate medication, to use more asthma controller medications than quick-relief medications, and to be dispensed controller medications covering at least 75 percent of days in the measurement year; the rate of being prescribed an appropriate medication and the rate of being dispensed controller medications did not meet the HHSC Performance Indicator Dashboard standards.

Satisfaction with Care

According to the 2014 STAR Health Caregiver Survey, half of all STAR Health members have special health

care needs (51 percent). The most common types of special health-care needs among children and adolescents in STAR Health were problems that require counseling (36 percent) and dependence on medications (35 percent). Nearly one-third of children and adolescents in STAR Health were obese (30 percent), as measured from caregiver-reported height and weight.

Caregivers of children and adolescents in STAR Health generally reported high satisfaction with care on the CAHPS® measures *Getting Needed Care* (72 percent), *Getting Care Quickly* (89 percent), and *How Well Doctors Communicate* (91 percent). However, all four CAHPS® ratings for STAR Health members performed below the national CAHPS® Child Medicaid rates for 2014. The widest gap in these ratings was observed for the CAHPS® specialist rating, with 61 percent of STAR Health caregivers rating their child and adolescent's specialist a "9" or "10", compared to 70 percent in the national Medicaid population.

Rates on measures of getting timely care, doctors' communication, and personal doctor rating were similar to those observed in the national Medicaid population. As with the other Texas Medicaid programs, the rate for *Getting Needed Care* was below the national average, with 72 percent of STAR Health caregivers having positive experiences with

access to care, tests, treatment, and specialists. Ratings of specialist seen most often, health plan, and all

health care were lower than those observed in the national Medicaid population.

Table E.4: STAR Health Caregiver Satisfaction with Care, 2014

CAHPS® Measure ("Usually" or "Always")	2014 Rate	HHSC Dashboard Standard 2014	CAHPS® Child Medicaid 2014
Getting Needed Care	72.3%	N/A	85%
Getting Care Quickly	89.4%	N/A	90%
How Well Doctors Communicate	91.4%	94%	93%
Health Plan Information and Customer Service	LD ¹	N/A	87%
Personal Doctor Rating	71.3%	74%	73%
Specialist Rating	61.2%	N/A	70%
Health Plan Rating	60.2%	71%	67%
Health-care Rating	61.2%	N/A	66%

¹Low Denominator.

CHIP – Significant Quality Findings

Quality of Care

In 2014, adolescents in CHIP received a high standard of well-care compared with the national Medicaid population, with statewide performance falling between the 66th and 89th percentiles on the HEDIS® national benchmark percentiles for Medicaid and exceeding the HHSC Performance Indicator Dashboard standard. Children in CHIP were largely up-to-date on recommended vaccinations on their second birthday, as measured by the Combination 4 list for HEDIS® Childhood Immunization

Status (CIS), Combination 4; performance statewide fell between the 66th and 89th percentiles on the HEDIS® national benchmark percentiles for Medicaid and exceeded the HHSC Performance Indicator Dashboard standard.

One-third of sexually active female adolescents ages 16 to 19 (34 percent) received a screening test for chlamydia, in the bottom decile on the HEDIS® national benchmark percentiles for Medicaid and below the HHSC Performance Indicator Dashboard standard.

An overwhelming majority (94 percent) of children ages one

to two had a visit with a PCP in the measurement year, a rate falling between the 10th and 32nd percentiles on the HEDIS® national benchmark percentiles for Medicaid and lower than the HHSC Performance Indicator Dashboard standard. Performance in each of the other three age bands of access to PCPs was between the 66th and 89th percentiles on the HEDIS® national benchmark percentiles for Medicaid and was also lower than the HHSC Performance Indicator Dashboard standard. Across all age bands, 92 percent of children and adolescents in CHIP had had a visit with a PCP within the past one year for children up to age six or within the past two years for children and adolescents up to age 19.

HEDIS® Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) measures the percentage of children ages three to six in CHIP who received at least one well-child visit in the measurement year. Three of 17 health plans performed in the top decile on the HEDIS® national benchmark percentiles for Medicaid. Six health plans performed between the 66th and 89th percentiles. Seven health plans performed in the middle tertile. One health plan had too few events to report (fewer than 30).

Potentially preventable admissions per 1,000 member-months increased slightly from 0.25 in 2013 to 0.28 in 2014. The most common reasons for

potentially preventable admissions were:

- Asthma (20 percent).
- Other pneumonia (11 percent).
- Major depressive disorders and other/unspecified psychoses (10 percent).

Potentially preventable readmissions per 1,000 member months decreased slightly from 0.07 in 2013 to 0.06 in 2014. The most common reason for potentially preventable readmissions was mental health or substance abuse readmission following an initial admission for a substance abuse or mental health diagnosis, accounting for just over 67 percent of potentially preventable readmissions.

Potentially preventable emergency department visits per 1,000 member months increased slightly from 3.95 in 2013 to 4.02 in 2014. The most common reason for potentially preventable emergency department visits was infection of the upper respiratory tract which accounted for 22 percent of potentially emergency department visits.

Effectiveness of care measures in 2014 in CHIP showed mixed performance. Statewide, the program performed well on HEDIS® Use of Appropriate Medications for People with Asthma (ASM), All Ages, with an overall rate of 95 percent, which meets the HHSC Dashboard

standard of 95 percent and exceeds the HEDIS® 90th percentile. However, as in STAR, the rate of HEDIS® Medication Management for People with Asthma was below the HEDIS® 10th percentile.

Satisfaction with Care

The member survey conducted with caregivers of children and adolescents enrolled in CHIP in 2015 found high levels of caregiver satisfaction in regard to communicating with doctors and health plan information and

customer service. Caregiver ratings of their child or adolescent’s personal doctor were approximately equal to those reported in the national CHIP population, while all other ratings exceeding the national rates.

The percentage of caregivers in CHIP who “always” had positive experiences with Getting Needed Care (55 percent) was lower than reported nationally (62 percent), which highlights access to care, tests, treatment, and specialists as areas for improvement.

Table E.5: CHIP Caregiver Satisfaction with Care, 2015

CAHPS® Measure (“Always”)	2015 Rate	HHSC Dashboard Standard 2015	CAHPS® CHIP 2015
Getting Needed Care	55.4%	N/A	62%
Getting Care Quickly	72.7%	N/A	74%
How Well Doctors Communicate	78.2%	78%	78%
Health Plan Information and Customer Service	74.6%	N/A	65%
Personal Doctor Rating	73.3%	72%	73%
Specialist Rating	72.0%	N/A	70%
Health Plan Rating	73.3%	72%	68%
Health Care Rating	69.8%	B/A	66%

Medicaid and CHIP Dental Programs

Quality of Care

In 2014, the EQRO evaluated access to dental care and services among members enrolled in Medicaid Dental and CHIP Dental using the HEDIS®

Annual Dental Visit (ADV) measure, Dental Quality Alliance measures, and dental prevention and treatment measures developed by the ICHIP in collaboration with HHSC.

Medicaid Dental members had higher rates than CHIP Dental members

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on all measures of dental program access and utilization. Both Medicaid Dental and CHIP Dental members had rates of HEDIS® ADV lower than HHSC Dashboard standards for most individual age bands. However, both programs performed in the top ten percent on the HEDIS® national benchmark percentiles for Medicaid on all components of HEDIS® ADV except CHIP Dental for the seven to ten age band, which performed between the 66th and 89th percentiles.

The rates for use of dental sealants among children and adolescents in Medicaid Dental and CHIP Dental were higher than the HHSC Dashboard standards for three of the four age groups.

Satisfaction with Care

A 2015 survey of caregivers of members in the Medicaid and

CHIP dental programs showed that, overall, caregivers had good experiences with care their child received from dentists and staff. In particular, 92 percent of Medicaid and CHIP Dental caregivers said their child’s regular dentist “always” treated them with courtesy and respect. About one eighth of caregivers reported that they had to spend more than 15 minutes in the waiting room for their child’s dental appointment. However, among those who reported a delay, about one-quarter said they were informed of the reasons for the delay or the expected length of the delay.

Caregivers of children in Medicaid Dental generally reported better experiences than caregivers of children in CHIP Dental, particularly in regard to access to dental care, coverage, and satisfaction with plan and care.

Table E.6: Medicaid Dental and CHIP Dental Caregiver Satisfaction with Care, 2015

Measure	Medicaid	CHIP
Care from Dentists and Staff – Responses of “Always”		
Regular dentist explained things in a way that was easy to understand.	84.9%	83.1%
Regular dentist listened carefully.	86.6%	84.5%
Regular dentist treated patient with courtesy and respect.	92.2%	92.5%
Regular dentist spent enough time with patient.	79.9%	79.0%
Dentists or dental staff did everything they could to help patient feel as comfortable as possible during dental work.	82.8%	80.5%



Appendix E: Managed Care Quality Assurance Reports

Measure	Medicaid	CHIP
Dentists or dental staff explained what they were doing during treatment.	86.0%	81.5%
Access to Dental Care – Responses of “Always”		
Member able to get a dental appointment as soon as needed.	76.5%	73.0%
Member waited more than 15 minutes in waiting room for a dental appointment.	12.8%	14.2%
Member was informed of reason for delay or length of delay if wait was longer than 15 minutes.	24.9%	27.0%
Dental Plan Costs and Services – Responses of “Usually” or “Always”		
Dental plan covered all services caregiver thought were covered.	85.6%	64.4%
The toll-free telephone number, written materials or website provided all information caregiver wanted.	58.0%	48.8%
Dental plan’s customer service gave caregiver all information or help needed.	72.3%	65.8%
Dental plan’s customer service staff treated caregiver with courtesy and respect.	92.8%	85.0%
Dental plan covered needed services for member and family.	84.6%	62.6%
Information from dental plan helped caregiver find a dentist they were happy with.	80.8%	74.1%
Caregiver Ratings		
Dentist Rating (9 or 10)	77.5%	72.2%
Dental Care Rating (9 or 10)	79.4%	70.1%
Access to Dental Care Rating (9 or 10)	76.0%	70.0%
Dental Plan Rating (9 or 10)	82.2%	69.1%

Appendix F: Texas Medicaid Waivers

Waiver	Type	Description	Services Covered
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 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, STAR Kids 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, quality, and cost-effectiveness of health care services and systems, and to improve patient health.
Youth Empowerment Services	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.	Respite, supported employment, adaptive aids and supports, community living supports, employment assistance, family supports, minor home modifications, non-medical transportation, paraprofessional services, specialized therapies, supportive family-based alternatives, and transitional services.

Waiver	Type	Description	Services Covered
Non-Emergency Medical Transportation	1915(b)	MTP or its designee (FRB) is responsible for arranging and administering cost-effective NEMT services to Medicaid, CSHCN, and Transportation Indigent Cancer Patients (TICP) clients who do not have any other means of transportation to access medically necessary covered services.	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 health care transportation needs.
Texas Medicaid Wellness Program	1915(b)	Texas Medicaid Wellness program is a community-based, holistic care management program that enrolls high-risk FFS 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, quarterly educational mailings, and a 24-hour nurse advice line.
Medically Dependent Children Program	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, flexible family support services, minor home modifications, supported employment, employment assistance, and transition assistance services.
Home and Community Services	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, prescription drugs, financial management, support consultation, adaptive aids, dental treatment, minor home modifications, transition assistance, residential assistance (host home/companion care, supervised living, residential support services), nursing, employment assistance, specialized therapies (speech and language pathology, audiology, occupational therapy, physical therapy, dietary, behavioral support, social work, cognitive rehabilitation therapy), and supported home living.

Waiver	Type	Description	Services Covered
Community Living Assistance and Support Services	1915(c)	CLASS provides home and community-based services to clients who have a "related condition" diagnosis qualifying them for placement in an ICF/IID. A related condition is a disability other than an intellectual or 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 treatment, dietary, occupational therapy, physical therapy, prescribed drugs, nursing, speech and language pathology, financial management, support consultation, auditory integration/auditory enhancement training, behavioral support, cognitive rehabilitation therapy, continued family services, employment assistance, minor home modifications, specialized therapies, support family services, and transition assistance services.
Deaf, Blind with Multiple Disabilities	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 additional disabilities	Case management, day habilitation, residential habilitation, respite, supported employment, prescription medications, financial management services, support consultation, adaptive aids and medical supplies, assisted living, audiology services, behavioral support, chore service, dental treatment, dietary services, employment assistance, intervener, minor home modifications, nursing, orientation and mobility, therapy services (physical, occupational and speech, hearing and language), and transition assistance services.

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Waiver	Type	Description	Services Covered
Texas Home Living (TxHmL)	1915(c)	TxHmL provides selected services and supports for people with intellectual developmental disabilities who live in their own homes or their family's homes.	Adaptive aids, minor home modifications, audiology, speech and language therapy, occupational therapy, physical therapy, dietary, behavioral supports, dental, skilled nursing, community support, , prescription medications, financial management services, support consultation services, respite, supported employment, employment assistance, and day habilitation.

Note: All waivers are operated by HHSC.

Appendices

Appendix G: Medicaid Expenditure History FFYs 1987-2015

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Uncompensated Care	DSRIP	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
2015	FED	15,558,933,896	1,367,834,218	1,964,060,619	1,432,632,157	0	297,843,117	886,094,144	22,605,040	21,530,003,191
2015	FEDARRA	0	0	0	0	0	0	86,157,065	0	86,157,065
2015	FED-ACA	106,855,855	0	0	0	0	0	0	0	106,855,855
2015	NONFED	10,873,355,777	970,120,562	1,382,154,637	1,035,305,295	370,092,170	123,939,980	484,172,478	7,535,012	15,246,675,911
2015	TOTAL	26,539,145,528	2,337,954,780	3,346,215,256	2,467,937,452	370,092,170	421,783,097	1,456,423,687	30,140,052	36,969,692,022
2014	FED	14,982,927,389	905,058,004	1,451,339,991	1,348,925,140	0	117,437,708	737,229,930	19,236,614	19,562,154,776
2014	FEDARRA	0	0	0	0	0	0	146,532,831	0	146,532,831
2014	FED-ACA	101,838,600	0	0	0	0	0	0	0	101,838,600
2014	NONFED	10,027,061,825	621,178,089	997,553,985	949,464,943	372,286,605	47,794,336	562,215,287	6,412,204	13,583,967,274
2014	TOTAL	25,111,827,814	1,526,236,093	2,448,893,976	2,298,390,083	372,286,605	165,232,044	1,445,978,048	25,648,818	33,394,493,481
2013	FED	14,209,243,885	133,812,750	1,885,406,398	287,667,948	0	28,657,109	646,050,231	22,731,210	17,213,569,531
2013	FEDARRA	(2,722,794)	0	0	0	0	0	185,694,886	0	182,972,092
2013	FED-ACA	82,774,190	0	0	0	0	0	0	0	82,774,190
2013	NONFED	9,540,324,425	92,935,191	1,325,138,105	197,438,203	376,596,140	11,728,774	502,399,429	7,577,070	12,054,137,337
2013	TOTAL	23,829,619,706	226,747,941	3,210,544,503	485,106,151	376,596,140	40,385,883	1,334,144,546	30,308,280	29,533,453,150

Note: Figures are shown in dollars.

Appendix G: Medicaid Expenditure History

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
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

Appendix G: Medicaid Expenditure History

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
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
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

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
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
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

Appendix G: Medicaid Expenditure History

Federal Fiscal Year	Payer	Grant Benefits	Disproportionate Share Hospital	Upper Payment Level	Clawback	CHIP Phase I	Administration	Survey and Certification	Total Medicaid
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
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 G: Medicaid Expenditure History

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.

ADOPTION ASSISTANCE (AA)

AA is a program designed to facilitate the adoption of children with special needs by providing Medicaid health coverage for the child, monthly payments to assist in meeting the child's needs, and reimbursement for some adoption fees up to a certain amount.

AGENCY OPTION (AO)

AO is the traditional method of service delivery in which services are delivered through a provider agency. The provider agency is the employer, therefore it is responsible for duties such as: hiring, training, managing, and dismissing employees; employee payroll and taxes; liability (e.g., on-the-job injuries); and providing back-up services. See also **CONSUMER DIRECTED SERVICES; SERVICE RESPONSIBILITY OPTION.**

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 ADRCs in nine areas of the state.

ALBERTO N. V. TRAYLOR

– A federal lawsuit that was settled in May 2005 and requires HHSC to comply with Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) by providing all medically necessary in-home Medicaid services to children under 21 years of age that are eligible for the Medicaid Early and Periodic Screening, Diagnosis and Treatment program. 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 providing economic stimulus funding through a multitude of new and existing programs and providing 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. 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. See also **BALANCED BUDGET ACT**.

BALANCING INCENTIVE PROGRAM (BIP) – The federal BIP authorized \$3 billion for states through September 2015 to increase access to community-based long term services and supports using a No Wrong Door system, statewide standardized assessment instruments, and administrative separation of eligibility and case management from service provision to reduce or eliminate conflict in case management. See also **LONG-TERM SERVICES AND SUPPORTS; NO WRONG DOOR**.

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 payments, modified the upper payment limit for governmental facilities, and allowed federal State Children’s Health Insurance Program 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.

BETTER BIRTH OUTCOMES (BBO) – A collaboration between HHSC and the Department of State Health Services to improve access to women’s preventive, interconception, prenatal, and perinatal health care. The collaboration focuses on meeting a client’s health care needs impacting her ability to have a healthier pregnancy.

BREAST AND CERVICAL CANCER SERVICES (BCCS) – BCCS helps fund clinic sites across the state to provide quality, low-cost, and

accessible breast and cervical cancer screening and diagnostic services to women who reside in Texas, are over the age of 18, do not have health insurance and meet income limits. See also **MEDICAID FOR BREAST AND CERVICAL CANCER.**

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. (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-IN – Refers to the transition of a Medicaid service or population from fee-for-service to managed care delivery.

CARVE-OUT – A decision to purchase separately a service that is typically part of a managed care organization plan.

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 Early Childhood Intervention 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 and enrolled with the Texas Medicaid & Healthcare Partnership (TMHP) as Medicaid providers. See also **CASE MANAGEMENT; CASE MANAGER**.

CASE MANAGER – An experienced professional (typically a nurse, social worker, qualified mental

health professional, qualified mental 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 as children from birth up to age 19 who meet all of the following criteria:

- 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.

- 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 HHSC. The definition of CSHCN for the HHSC 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 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 extended federal Children's Health Insurance

Program 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 (CHIP-P) – 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 HHSC. See also **TEXAS MEDICAID & HEALTHCARE PARTNERSHIP**.

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 provides personal care services to people who have income in excess of Supplemental Security Income limitations, but who would financially qualify to be in an institution. See also **PRIMARY HOME CARE; 1929**.

COMMUNITY FIRST CHOICE (CFC) – Senate Bill 7, 83rd Legislature, Regular Session, 2013, directed HHSC to implement the most cost-effective option for delivering basic attendant care and habilitation to Medicaid-eligible individuals. CFC is a federal option that allows states to provide home and community-based attendant services to Medicaid recipients with disabilities. Individuals can receive CFC services and keep their spot on an interest list or continue to receive services in a waiver program. CFC services must be provided in community-based settings.

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/IID institutional care. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; 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 to implement the CDS delivery model in multiple Medicaid home and community-based waiver programs and in the Medicaid state plan. See also **AGENCY OPTION; SERVICE RESPONSIBILITY OPTION; 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 – 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 day activity and health services center, include nursing and personal care, meals, transportation, and social and recreational activities.

DEAF-BLIND WITH 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 institutional care in an intermediate care facility for individuals with an intellectual disability or related condition. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; 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 (DSRIP) 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 **TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER; UNCOMPENSATED CARE POOL; REGIONAL HEALTHCARE PARTNERSHIPS (RHPs)**.

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 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.

DRUG UTILIZATION REVIEW

(DUR) BOARD – The DUR Board is an HHSC advisory board composed of physicians and pharmacists who review and approve the therapeutic criteria for DUR and clinical authorization criteria. See also **DRUG UTILIZATION REVIEW (DUR)**.

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 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.

ELECTRONIC VISIT

VERIFICATION (EVV) – EVV is a telephone and computer-based system that electronically verifies service visits occur and documents the precise time service begins and ends. EVV is used to verify that individuals/ members receive the services authorized for their support and for which the state is being billed.

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 primary care provider 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 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. 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 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 – See **QUALITY MONITOR**.

F

FEDERAL BENEFIT RATE (FBR) – The Supplemental Security Income limit.

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. The FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.

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 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. SMITH – 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.

HHSC PHARMACY BENEFIT MANAGEMENT (PBM) – A Texas Medicaid program that administers the Medicaid outpatient prescription drug benefit in both traditional Medicaid and managed care. Pharmacy Benefit 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. Pharmacy Benefit manages formularies, the preferred drug list, prior authorization criteria, and rebates; defines and manages pharmacy benefit policies for both FFS and MCO clients; and performs prospective and retrospective drug utilization reviews for FFS clients.

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 announced a contingency period for any covered entity showing a good faith effort to become compliant. The contingency period allowed covered entities to continue using legacy identifiers until May 23, 2008, without penalty.

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM – A Medicaid program that pays for employer or private health insurance premiums for persons who are Medicaid-eligible when the premiums are less expensive than providing regular Medicaid coverage for those persons.

HEALTH PASSPORT – A web-based repository of medical information for each child enrolled in the STAR Health program. The Health Passport allows authorized users immediate access to a child’s basic claim-based health record through a secure, password-protected website. The Health Passport includes available claims information, immunization records, behavioral health assessments, Texas Health Steps exam forms, lab results, and other health care information. See also **STAR HEALTH**.

HEALTH PLAN – See **MANAGED CARE ORGANIZATION**.

HEALTH 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).

HEALTHY TEXAS WOMEN (HTW) – A state-funded program that provides women’s health and family planning services at no cost to eligible, low-income Texas women.

HOME AND COMMUNITY-BASED SERVICES (HCS) WAIVER – A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act that allows Texas to provide community-based services to people with intellectual disabilities as an alternative to institutional

care in an intermediate care facility for individuals with an intellectual disability or related condition.

See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; WAIVER; 1915(c)**.

HOME AND COMMUNITY-BASED (HCBS) SETTINGS – Settings that provide access to the full benefits of community living. CMS promulgated regulations prohibiting services from being provided in a setting that is institutional in nature or has the effect of isolating individuals from the greater community. All HCBS settings must comply with the new rule by March 2019.

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.

I

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 (formerly Food Stamps), and Temporary Assistance for Needy Families. 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 CONDITION (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; RELATED CONDITION**.

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 (LMHA) – 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**.

LONG-TERM SERVICES AND SUPPORTS (LTSS) – Assistance for persons who are over age 65

and those with chronic disabilities. The goal of LTSS 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 coordinated 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; STATE OF TEXAS ACCESS REFORM; STAR+PLUS PROGRAM; STAR HEALTH; STAR KIDS; 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)**.

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 federally in 1965 under Title XIX of the Social Security Act. Texas participation in Medicaid began September 1, 1967.

MEDICAID BUY-IN PROGRAM FOR WORKERS WITH DISABILITIES (MBI)

– More commonly known as Medicaid Buy-In, this program enables working persons with disabilities to receive Medicaid services. MBI 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 and \$3,000 in resources. Texas implemented MBI in 2006.

MEDICAID BUY-IN FOR

CHILDREN (MBIC) – A program that allows children up to age 19 with disabilities to “buy-in” to Medicaid. Children with family income less than or equal to 150 percent of the federal poverty level may qualify for the program and pay a monthly premium in order to receive Medicaid benefits. Texas implemented MBIC in 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) – 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. Clients receive Medicaid benefits as long as they meet the eligibility criteria and are receiving active treatment for breast or cervical cancer.

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 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 Supplemental Social Security Income (SSI)). Children age 20 and younger with 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 for the Texas Medicaid program and that gives HHSC authority to administer the Medicaid program in Texas. It describes the nature and scope of the state’s Medicaid program including Medicaid administration, client eligibility, benefits, and provider reimbursement. CMS must approve the plan and any amendments to the plan. Texas also has a CMS-approved Children’s Health Insurance Program state plan.

MEDICAID WELLNESS PROGRAM FOR CHILDREN WITH DISABILITIES

– The Texas Medicaid Wellness Program is a community-based care management program that enrolls fee-for-service 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 Director on proposed Medicaid rules.

MEDICAL NECESSITY – Health services that are:

- Reasonably necessary to prevent illness or medical conditions, or to provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, physical deformity or limitations in function, illness or infirmity of a recipient, threaten to cause or worsen a handicap, 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; and
- 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. 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 to those with disabilities or permanent kidney failure. See also **MEDICARE PART A; MEDICARE PART B; MEDICARE PART C; MEDICARE PART D**.

MEDICARE EQUALIZATION – Limited payments for most Medicare Part A and B services provided to individuals dually eligible for both Medicaid and Medicare of no more than the Medicaid payment amount for the same service. See also **MEDICARE PART A; MEDICARE PART B**.

MEDICARE 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**.

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**.

MEDICARE PART C – Previously called Medicare+Choice, Medicare Part C was renamed Medicare Advantage and modified by the Medicare Prescription Drug Improvement and Modernization Act of 2003. It 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 **MEDICARE; MANAGED CARE ORGANIZATION; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003**.

MEDICARE PART D – A voluntary Medicare prescription drug benefit created by the Medicare Prescription Drug Improvement

and Modernization Act 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 **MEDICARE; MANAGED CARE ORGANIZATION; MEDICARE PRESCRIPTION DRUG IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)**.

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 (MAGI) – 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 applies a five 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 General Appropriations Act, Senate Bill 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37), stipulates that as clients relocate from nursing facilities to community care services, the nursing facility funds will be transferred to the community care budget to cover the cost of their services. Also known as the “Money Follows the Person” rider. The rider language was codified by House Bill 1867, 79th Legislature, Regular Session, 2005.

N

NETWORK ADEQUACY – Medicaid MCO provider networks must be adequate to ensure individuals enrolled with the MCO are able to access all medically necessary covered services. Provider networks must establish additional minimum provider access standards including: minimum distance, travel time, and appointment wait times for member access to providers; expedited credentialing to expand the list of provider types; and provider directories published online with provider information updated at least weekly.

NEWBORNS – Children up to age one whose family income and resources are above the current requirements for Temporary Assistance for Needy Families, but not above 198 percent of the federal poverty level. The Children’s Health Insurance Program covers newborns up to 201 percent of the federal poverty level.

NO WRONG DOOR (NWD) – The NWD system represents the effort to streamline access to LTSS options for all populations and all payers. In NWD systems, multiple state and community agencies coordinate to ensure that regardless of which agency people contact for help, they can access one-to-one counseling and information about all of the agencies and services available in

their communities. See also **LONG-TERM SERVICES AND SUPPORTS**.

NURSING FACILITY CARVE-IN – Effective March 1, 2015, nursing facility services became a statewide covered benefit under the STAR+PLUS managed care program for individuals aged 21 years and older. See also **CARVE-IN; NURSING FACILITIES; STAR+PLUS PROGRAM**.

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. 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 HHSC’s authority and ability to combat fraud, waste, and abuse in health and human services programs. OIG is divided into seven divisions: Investigations, Audits, Inspections, Medical Services, Data and Technology, Operations, and Chief Counsel.

OMNIBUS BUDGET RECONCILIATION ACTS (OBRA) – Federal laws that

direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.

OPERATING DEPARTMENT – State agencies with day-to-day operational responsibility for various Medicaid-funded programs. As a result of the HHS system transformation on September 1, 2016, the Texas Medicaid program’s functions are administered solely by HHSC, ending its use of operating departments. See also **TRANSFORMATION; HEALTH AND HUMAN SERVICES COMMISSION.**

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

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 of the FPL and measures to improve quality, reduce fraud and abuse, and reform payment methodologies.

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.

PERSON-CENTERED PLANNING – Person-centered service plans document service options that take into account an individual’s strengths, goals and preferences as well as needs.

PERSONAL ASSISTANCE SERVICES (PAS) – Medicaid community-based entitlement benefit delivered through several programs, including STAR+PLUS and traditional Medicaid, where it is known as Primary Home Care. PAS are non-technical, non-skilled services that offer attendant care

for individuals who need assistance with activities of daily living (e.g. bathing, dressing, eating, grooming) or instrumental activities of daily living (e.g. shopping, light house work, preparing meals). See also **PRIMARY HOME CARE**.

PERSONAL CARE SERVICES (PCS) – Medicaid community-based entitlement benefit that provides attendant services to assist individuals from birth through age 20 with disabilities in performing activities of daily living (e.g. bathing, dressing, eating, grooming) and instrumental activities of daily living (e.g. shopping, light house work, preparing meals).

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996 (PRWORA) – Federal legislation P.L. 104-193 that eliminated Aid to Families with Dependent Children and created Temporary Assistance for Needy Families, 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**.

PHARMACY BENEFITS MANAGER (PBM) – Each Medicaid and CHIP managed care organization (MCO) contracts with 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 or have been selected for clinical edits.

PHYSICIAN EXTENDER – A physician extender is a health care provider who is not a physician, but who performs medical activities typically performed by a physician. Physician extenders are most commonly nurse practitioners or physician assistants.

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 (PASRR) – 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 Drug Utilization Review (DUR) Board 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 board with the development and maintenance of the preferred drug list. See also **DRUG UTILIZATION REVIEW BOARD**.

PREMIUMS PAYABLE SYSTEM (PPS) – A group of applications that generate capitation payments for individuals enrolled in a managed care program and supports managed care organizations’ deliverables tracking and performance monitoring.

PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS (PPECC) – Provides non-residential, facility-based care as an alternative

to private duty nursing 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 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) – Former managed care option in which each participant was assigned to a single primary care provider who authorized most other services. The PCCM program was terminated in March 2012.

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) – The name of Personal Assistance Services delivered through traditional fee-for-service Medicaid. See also **PERSONAL ASSISTANCE 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 individuals (age 55 and older) as a cost-effective alternative to institutional care. The waiver is part of a national demonstration project. PACE is available in El Paso, Amarillo, and Lubbock. See also **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.

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 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 **MEDICARE PART A**.

QUALIFIED INDIVIDUALS (QI) – Medicare beneficiaries with income between 120 and 135 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays a portion of the Medicare Part B premium. See also **MEDICARE PART B**.

QUALIFIED MEDICARE BENEFICIARY (QMB) – Medicare beneficiaries with income less than or equal to 100 percent of the federal poverty level who do not qualify for full Medicaid benefits. Medicaid pays all Medicare Part A and B premiums, deductibles, and coinsurance. See also **MEDICARE PART A; MEDICARE 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.

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 (RHPs) – Under the 1115 Transformation Waiver, eligibility to receive Uncompensated Care or Delivery System Reform Incentive Payment requires participation in one of 20 RHPs, which reflect existing delivery systems and geographic proximity. The RHPs include public hospitals, public health care districts, health providers, and/or other stakeholders in a given region. The activities of each RHP are coordinated by an “anchoring entity,” which is a public hospital or other local governmental entity with the authority to make 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.

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 CONDITION – 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 Pharmacy Benefit Management clients.

RISK CONTRACT – An agreement with a managed care organization 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**.

RURAL HEALTH CLINICS (RHCs) – To qualify as an RHC, the clinic must be located in a non-urbanized and medically underserved area and have a nurse practitioner or physician’s assistant in the clinic

50 percent of the time. An RHC may not exist as a rehabilitation agency or serve primarily as a treatment facility for mental diseases.

S

SCHOOL HEALTH AND RELATED SERVICES (SHARS)

– Medicaid optional benefit that provides services related to a child’s Individual Education Plan. 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 (SRO) – 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. See also **AGENCY OPTION (AO); CONSUMER DIRECTED SERVICES (CDS)**.

SETTINGS – See **HOME AND COMMUNITY-BASED SETTINGS**

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 HHSC).
- 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, HHSC 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 (STATE OF TEXAS ACCESS REFORM) – A statewide managed care program primarily for pregnant women and low-income children and caretakers. Most people in Texas Medicaid get their coverage through STAR.

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 KIDS – A statewide managed care program for children with disabilities, including children who are receiving benefits under the Medically Dependent Children Program waiver. STAR Kids was implemented on November 1, 2016. See also **MEDICALLY DEPENDENT CHILDREN PROGRAM (MDCP)**.

STAR+PLUS – A statewide managed care program for adults with disabilities or those age 65 and older.

STATE FISCAL YEAR (SFY) – The Texas state fiscal year runs from September 1 through August 31 of each year.

STATE SUPPORTED LIVING CENTERS (SSLCs) – SSLCs 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. 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 (TCM) – An optional Medicaid state plan service. In Texas, TCM is provided for people with chronic mental illness, women with high-risk pregnancies, infants with a high risk of getting health problems, persons with intellectual disabilities and related conditions, and blind or visually impaired adolescents. TCM 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, 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) – DADS is an agency that works with Texas Medicaid by operating Texas’ state supported living centers and its regulatory programs for providers of long-term care services. DADS’ functions will transfer to HHSC on September 1, 2017. See also **STATE SUPPORTED LIVING CENTERS**.

TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

(DFPS) – 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 managed care organizations; certifying utilization review agents, 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) – DSHS is an agency that works with Texas Medicaid by operating Texas' state hospitals and certain regulatory programs for acute care and public health providers. On September 1, 2017, these regulatory programs and

the operation of state hospitals will transfer to HHSC, after which DSHS' remaining programs will focus on its core public health mission.

TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 WAIVER – Known as the 1115 Transformation Waiver, the waiver is a demonstration running through December 31, 2017, 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 payments. The 1115 Transformation Waiver, approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal matching funds. See also **UNCOMPENSATED CARE POOL; DELIVERY SERVICES REFORM INCENTIVE PAYMENT POOL; REGIONAL HEALTHCARE PARTNERSHIPS.**

TEXAS EDUCATION AGENCY (TEA) – Provider agency for School Health and Related Services (SHARS). See also **SCHOOL HEALTH AND RELATED SERVICES (SHARS).**

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. 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**.

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 intermediate care facility for individuals with an intellectual disability or related condition. See also **INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITION; 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 (MEHIS)**.

TEXAS WOMEN’S HEALTH PROGRAM (TWHP) – A state-funded program that provided eligible Texas women with preventive health care, screenings, contraceptives and treatment for certain sexually transmitted diseases. This program ended on December 31, 2013, and was replaced by the Healthy Texas Women program. See also **HEALTHY TEXAS WOMEN**.

TITLES OF THE 1965 SOCIAL SECURITY ACT –

- II Old-Age, Survivors, and Disability Insurance Benefits
- IV-A Temporary Assistance for Needy Families
- 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
- XVIII Medicare
- XIX Medicaid
- XX Social Services
- XXI Children’s Health Insurance Program

TRADITIONAL MEDICAID – The traditional Medicaid health care payment system, also known as fee-for-service reimbursement, under which providers receive a payment for each unit of service they provide. See also **FEE-FOR-SERVICE REIMBURSEMENT; MANAGED CARE; MANAGED CARE ORGANIZATION**.

TRANSFORMATION – Senate Bill 200, 84th Legislature, Regular Session, 2015, moves programs and administrative functions to HHSC in two phases – transferring all client services and most administrative support services in phase one, and transferring regulatory programs and state-operated facilities in phase two. As a result of transformation, a new Medical and Social Services division was created to promote and improve the health and welfare of individuals through streamlined access to and delivery of medical and social services. This new centralized structure connects similar programs to make it easier for individuals to locate and access a full array of services, and for the HHS system to better meet the needs of the whole person. The Medical and Social Services division is comprised of four departments, including the Medicaid & CHIP Services department, which operates all Medicaid programs for the HHS system.

TRANSFORMED MEDICAID STATISTICAL INFORMATION SYSTEM (T-MSIS) – The monthly reporting system used to report all Texas Medicaid claims and eligibility data to the Centers for Medicare & Medicaid Services.

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 experiences.

U

UNCOMPENSATED CARE (UC) POOL – One of two payment pools available from the 1115 Transformation Waiver. 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 **TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 1115 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. See also **RECIPIENT (CLIENT) COUNTS**.

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 **TEXAS HEALTH CARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM 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 payers.

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

(VDP) – The Texas Medicaid program that administers the outpatient prescription drug benefit in for traditional Medicaid (fee-for-service, (FFS) and Medicaid managed care. VDP 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. VDP manages the formulary, the preferred drug list, clinical prior authorization criteria, and drug manufacture rebates; defines and manages pharmacy benefit policies for Medicaid members; monitors MCO pharmacy compliance, performs prospective and retrospective drug utilization reviews for FFS clients, and enforces the use of rebate-eligible drugs on outpatient medical claims for both FFS and Medicaid managed care members

W

WAIVER – An exception to the usual Medicaid requirements granted to a state by the Centers for Medicare

& Medicaid Services. See also **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. 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. See also **TEXAS WOMEN’S HEALTH PROGRAM; HEALTHY TEXAS WOMEN**.

X

Y

YOUTH EMPOWERMENT

SERVICES (YES) WAIVER – A Home and Community-Based Services waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act, YES allows for more flexibility in the funding of intensive community-based services for children and adolescents age 3 to 18 with serious emotional disturbances and their families. See also **1915(c); WAIVER**.

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 & 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 condition, 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 LIVING ASSISTANCE AND SUPPORT SERVICES WAIVER PROGRAM; DEAF-BLIND WITH MULTIPLE DISABILITIES WAIVER; HOME AND COMMUNITY-BASED SERVICES WAIVER; MEDICALLY DEPENDENT CHILDREN PROGRAM; NURSING FACILITIES; STAR+PLUS; TEXAS HOME LIVING WAIVER; YOUTH EMPOWERMENT SERVICES WAIVER; WAIVER.

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 & MEDICAID SERVICES; HOME AND COMMUNITY-BASED SERVICES WAIVER; 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.**