

## **Appendix B**

Medicaid and the State Children's  
Health Insurance Program in Texas:  
History, Current Arrangements, and Options

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# **Medicaid and the State Children's Health Insurance Program in Texas: History, Current Arrangements, and Options**

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### ***Executive Summary***

Medicaid and the State Children's Health Insurance Program (SCHIP) are key programs for providing health insurance and health care to low-income people in the United States. This report reviews the history and current state of Medicaid and SCHIP in the U.S. and Texas in terms of mandatory and optional beneficiaries, mandatory and optional benefits, and options for program expansions or modifications. The report focuses on medical services and not long-term care under Medicaid. Major changes may occur soon to Medicaid on the federal level, but details are not yet available.

Medicaid was established in 1965 to pay the medical bills of low-income people and increase access to health care. Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS), part of the U.S. Department of Health and Human Services, and is a federal-state partnership, so the program varies from state to state depending on how the state has chosen to implement it, within certain basic guidelines. Federal law says that states must cover what are called mandatory populations and offer mandatory benefits, and coverage beyond these levels are called optional populations and benefits. The federal government matches each state's Medicaid spending by covering from 50 percent to 83 percent of Medicaid expenses, depending on a formula that takes into account the average income in each state each year. A few services are matched at higher percentages, such as family planning at 90 percent. The Disproportionate Share Hospital Program (DSH) is a Medicaid program established in 1981 that reimburses hospitals that serve a disproportionately large number of Medicaid patients or other low-income people to help compensate them for lost revenues.

The State Children's Health Insurance Program (SCHIP) was created in 1997 to offer health insurance to uninsured children with family incomes or assets too high to qualify for Medicaid, but who cannot afford private insurance. It is also administered by CMS. It is not an entitlement program, unlike Medicaid, so it does not have to serve everyone who qualifies — it can turn down recipients if the state depletes its SCHIP budget. The federal government matches a higher percentage of state spending in SCHIP than in Medicaid. The formula for SCHIP federal matching funds is based on each state's Medicaid matching rate; in 2004 the SCHIP matching rates varied from 65 to 84 percent.

States can get permission to waive certain Medicaid and SCHIP laws and regulations to give the states more flexibility and to allow experimentation with new approaches to delivering

services. There are two broad types of these “waivers” which refer to different sections of the Social Security Act. Section 1115 waivers are called “research and demonstration waivers” and usually involve comprehensive reform projects, while Section 1915 waivers are called “program waivers” and involve waiving specific requirements to allow more innovative programs such as managed care and community-based care. Section 1115 waivers apply to both Medicaid and SCHIP, and one type of 1115 waiver is the Health Insurance Flexibility and Accountability (HIFA) initiative implemented by the Bush Administration in 2001. Section 1915 waivers apply to Medicaid only and include 1915(b) waivers (freedom of choice) and 1915(c) waivers (home and community-based services).

Section 1931 is another section of the Social Security Act that allows changes in a state’s Medicaid program, but it does not require a waiver application to be filed; it can be implemented through amending a state’s Medicaid State Plan. This initiative gives states more flexibility to cover low-income people in families with dependent children by increasing income and assets disregards and limits.

Texas has the highest rate of uninsured people in the nation, at about 26 percent. Texas implemented Medicaid in 1967, and the federal government paid 62.67 percent of Medicaid expenses in Texas in federal fiscal year (FFY) 2004. Combined federal and state spending for Medicaid in Texas was \$15.5 billion in state FY 2004, not including DSH payments, which add another \$1.5 billion. SCHIP began in May 2000 in Texas, and the federal share for SCHIP was 72.15 percent in Texas for FFY 2004. Texas spent almost \$330 million on SCHIP in FY 2004, including both federal and state funds. Changes in Medicaid and SCHIP in Texas include major cuts in 2003 to save money and the possible restoration of some of the cut benefits in 2005.

Texas currently has five 1915(b) and seven 1915(c) waivers, and no approved 1115 waiver. An 1115 HIFA waiver was submitted in December 2004 for a SCHIP premium assistance program, and there are other 1115 waivers under consideration in the state. Other options for Texas to consider for expanding Medicaid and SCHIP to cover more low-income people, which for the most part do not require a waiver, include implementing Section 1931, eliminating assets tests and disregards for SCHIP, and implementing the Ticket to Work program. Promising alternatives to consider include a HIFA waiver using a hypothetical 1931 expansion as the basis for cost savings, offering prenatal care under SCHIP (including to undocumented women), a broader women’s health waiver, and public-private models for small businesses.

## ***Medicaid Background***

Medicaid is a federal-state matching program established by Congress under Title XIX of the Social Security Act of 1965 and administered by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services. It was created to pay the medical bills of low-income people and increase access to health care. It is an entitlement program, meaning all people who meet the eligibility requirements are entitled to services. Every state (plus Washington, D.C., and five U.S. territories) has a Medicaid program, but since implementation is left to each state, there are variations in the eligibility, benefits, reimbursements, and other details of the program among states.

Title XIX of the Social Security Act establishes some basic principles for the Medicaid program. States must follow these four principles as well as all laws related to mandated eligibility and benefits unless the Centers for Medicare and Medicaid Services approves a state’s waiver requesting an exemption from certain requirements of the program. 1) *Statewideness*: Medicaid services must be offered on a statewide basis and not in certain locations only. 2) *Comparability*: the same level of services must be available to all Medicaid beneficiaries (with

some exceptions specified in federal law such as providing medically necessary care for Medicaid-eligible children and services for medically needy people whose income would otherwise disqualify them). 3) *Freedom of choice*: beneficiaries must be allowed to have an informed choice of Medicaid health care providers who meet program standards. 4) *Amount, duration, and scope*: services must be offered in an amount, duration, and scope that is reasonably sufficient to achieve the purpose of the benefits. States may impose some limits on services for beneficiaries over 21 (such as limiting the number of hospital days covered), as long as the limits follow this guideline and do not discriminate among beneficiaries based on medical diagnosis or condition.<sup>1</sup> Federal law also specifies that each state designate a single state agency to administer that state's Medicaid program.

Medicaid pays for basic health services such as inpatient and outpatient hospital care, physician visits, pharmacy, laboratory, X-ray services, and long-term care for elderly and disabled beneficiaries. The people eligible for these services are mainly low-income families, children, related caretakers, pregnant women, the elderly and people with disabilities. Medicaid was originally available only to people receiving cash assistance from the government (TANF — Temporary Aid to Needy Families, or SSI — Supplemental Security Income), but during the late 1980s and early 1990s, Congress expanded the program to include more people such as the aged, disabled, children and pregnant women. People receiving cash assistance are still automatically eligible for Medicaid, but as a result of federal changes, Medicaid was de-linked from cash assistance and there are many people who are on Medicaid but not on cash assistance programs.<sup>2</sup>

Congress passed the Ticket to Work and Work Incentives Improvement Act in 1999 to expand Medicaid to certain disabled people whose incomes make them ineligible for SSI. Many disabled people can work but by doing so will earn too much income to qualify for Medicaid, and if they cannot obtain insurance through their employers or if the coverage is inadequate for their needs, they may still be able to get Medicaid through this provision. Simplification of enrollment procedures since 1998 has also helped to enroll more people in Medicaid. However, due to historical rules, Medicaid cannot cover low-income adults who do not have children in the home and are not disabled or elderly, except under a Medicaid waiver.<sup>3</sup>

Medicaid had just 4 million enrollees in 1966.<sup>4</sup> The total number of people on Medicaid went from 33.2 million in June 1996 to 42.7 million in June 2003 (with slight dips in 1997-1999 when the economy was better and as a result of welfare reform).<sup>5</sup> Medicaid now covers one-fifth of the children in the U.S. and pays for one-third of all childbirths, two-fifths of all long-term care costs, one-sixth of all pharmacy costs, and half of states' mental health services. Though the disabled and elderly make up less than one-third of the Medicaid population (compared to children and nonelderly adults), two-thirds of Medicaid expenditures is spent on these groups.<sup>6</sup> The portion of the Medicaid population enrolled in managed care programs climbed steadily from 40.1 percent in June 1996 to 59.1 percent in June 2003.<sup>7</sup> State interest in applying managed care methods to Medicaid began in the 1980s when rising costs and a recession put pressure on states to control spending, and managed care greatly increased in the 1990s. Less than 10 percent of Medicaid beneficiaries were enrolled in managed care in 1991.<sup>8</sup> Though Medicaid managed care has not been without its problems, it has stabilized in the last few years and is generally working better than managed care in Medicare and the private sector. Managed care penetration and types of managed care models vary among states, but most states agree that managed care has generally helped with cost control and providing a medical home to clients, and they do not want to get rid of it and go back to an all fee-for-service model, though they continue to refine their managed care programs.<sup>9</sup>

## Mandatory and Optional Covered Populations

Federal guidelines specify mandatory populations to cover and services to offer at a minimum to receive funds for the Medicaid program, and states can cover more people and/or offer additional services if they wish. The *mandatory population* is most people who receive federal assistance payments, as well as some related groups that do not receive cash payments. These groups are called “categorically needy” and include the following:

- Low-income families with children (described in Section 1931 of the Social Security Act, who meet certain eligibility requirements of the state’s AFDC plan in effect on July 16, 1996, now called TANF, or Temporary Aid to Needy Families). Since 1996, Section 1931 has allowed states to define “low-income” by giving them flexibility to increase income disregards and assets limits by amending the state’s Medicaid State Plan (instead of applying for a federal waiver).
- Supplemental Security Income (SSI) recipients.
- Infants born to Medicaid-eligible pregnant women (up to one year old as long as the infant remains in the mother’s household and she remains eligible, or would be eligible if she were still pregnant).
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty level (FPL). Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.
- Children ages 6 to 19 with family incomes up to 100 percent FPL.
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Certain low-income Medicare beneficiaries with limited resources (Medicare pays first, and Medicaid supplements the out-of-pocket medical expenses of these “dual eligibles”).
- Special protected groups who may keep Medicaid for a period of time. (For example, people who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided from 4 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to increases in various types of income).<sup>10</sup>

States have the option to extend Medicaid to other categorically needy groups who are similar to the mandatory groups using somewhat more liberal eligibility criteria. States will receive the federal matching funds for covering these groups if they choose to do so. Following are examples of these *optional groups*:

- Infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is below 185 percent of FPL (or other percentage set by each state).
- Optional targeted low-income children.
- Certain aged, blind or disabled adults who have incomes above the mandatory coverage but below the FPL.
- Children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible (AFDC now called TANF).

- Institutionalized individuals with income and resources below specified limits.
- People who would be eligible if institutionalized but who are receiving care under home and community-based services waivers.
- Recipients of state supplementary payments
- People with tuberculosis (TB) who would be financially eligible for Medicaid at the SSI level (only for TB-related ambulatory services and TB drugs).
- Low-income, uninsured women screened and diagnosed through a Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast or cervical cancer.<sup>11</sup>

States may also receive matching funds for an optional “medically needy” program to extend Medicaid coverage to additional people who have too much income or resources to qualify under the mandatory or optional categorically needy groups. This program allows people to spend down to Medicaid eligibility by having their medical expenses offset their excess income, and may also allow them to pay monthly premiums to the state for Medicaid. If a state chooses to have a medically needy program, it must include certain children under age 18, pregnant women through a 60-day postpartum period, certain newborns for one year, and certain blind people. The state may choose to provide coverage for additional medically needy people such as the aged, blind, disabled (including disabled people who work), people 21 and under who are full-time students, and relatives who live with and are caretakers of children without parental support. As of 2003, 37 states had medically needy programs within Medicaid.<sup>12</sup>

Some states also expand their eligibility requirements through Medicaid waivers (discussed in more detail below). As of 2003, there were 19 states with statewide 1115 waivers to expand eligibility, and these usually require that the beneficiaries enroll in a Medicaid managed care program in order to receive services.<sup>13</sup> These extra “waiver populations” may include people such as childless adults, low-income women needing family planning services, or HIV-positive people who are not yet disabled enough to qualify for regular Medicaid.<sup>14</sup>

### **Mandatory and Optional Medicaid Benefits**

In order to receive matching funds, a state’s Medicaid program must follow federal guidelines requiring that certain basic services be offered to the covered groups. The *mandatory benefits* include the following:

- Inpatient and outpatient hospital services;
- Prenatal care;
- Vaccines for children;
- Physician services;
- Nursing facility services for people aged 21 or older;
- Family planning services and supplies;
- Rural health clinic services;
- Home health care for people eligible for skilled-nursing services;
- Laboratory and x-ray services;
- Pediatric and family nurse practitioner services;

- Nurse-midwife services;
- Federally qualified health center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings;
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.<sup>15</sup>

There are also *optional services* for which states may receive federal funding. Of the 34 approved optional services, these are the most common:

- Diagnostic services;
- Clinic services;
- Intermediate care facilities for the mentally retarded (ICFs/MR);
- Prescribed drugs and prosthetic devices;
- Optometrist services and eyeglasses;
- Nursing facility services for children under age 21;
- Transportation services;
- Rehabilitation and physical therapy services;
- Home and community-based care to certain people with chronic impairments.<sup>16</sup>

States determine the amount and duration of their Medicaid services within guidelines. For example, states may limit the number of hospital days or doctor visits covered, but two restrictions apply. Limits must not interfere with producing a sufficient level of services to achieve the purpose of the benefits, and limits may not discriminate among beneficiaries based on medical diagnosis or condition. States are generally required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible groups. There are two exceptions to this: 1) medically necessary services under EPSDT that are included in the federal mandatory or optional benefits must be covered even if those services are not included in the state's plan, and 2) states may request Medicaid waivers to pay for otherwise uncovered home and community-based services to people who might otherwise be institutionalized. States have few limitations on the services that can be offered under waivers, as long as the services are cost-effective. Each Medicaid program generally must allow beneficiaries to have informed choices between providers and to receive appropriate and timely care.<sup>17</sup>

## **Medicaid Finances**

### **Federal Matching**

The federal share of the match for each state's medical services under Medicaid is called the FMAP (Federal Medical Assistance Percentage) and is calculated from the average per capita income of the state compared to the U.S. average. A state with its per capita income at the national average will have a FMAP of 55 percent; states with higher incomes will have a lower FMAP and state with lower incomes will have a higher FMAP. The exact formula used is the following:<sup>18</sup>

$$1 - \left[ \left( \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \right) * 0.45 \right]$$

The state matching percentages are updated every fiscal year for each state based on income data from the most recent three-year period, and cannot go below 50 percent or above 83 percent for the federal share. Program costs are matched at different rates: program administration is generally matched at 50 percent, administration services that must be performed by skilled professional medical staff are matched at 75 percent, and family planning services and certain information systems costs are matched at 90 percent. Each state must fund the remaining portion of its program from state funds (e.g., if a state's FMAP is 60 percent, the other 40 percent of each dollar spent on Medicaid must come from the state, or to put it another way, the federal government gives the state \$1.50 for every dollar of state funds used). States may use local government funding for no more than 60 percent and taxes on health care providers for no more than 25 percent of the state match.<sup>19</sup> Because there is a floor of 50 percent on the federal match, states that are wealthier than the national per capita income receive what amounts to a higher match than their relative income entitles them to.

As stated above, one of the exceptions to a state's regular FMAP is the federal matching rate for family planning services under Medicaid, which are matched at 90 percent. "Family planning" is not defined in federal law, so states can create their own definitions, as long as they follow federal, state, and Medicaid policies.<sup>20</sup> CMS's State Medicaid Manual states that family planning services eligible for the 90 percent matching rate are counseling; patient education; examination and treatment; lab tests; contraceptive methods, procedures, pharmaceuticals, and devices; and infertility services, including sterilization reversals.<sup>21</sup> Services not eligible for 90 percent matching are hysterectomy, other medically needed procedures not performed for family planning purposes such as removal of an intrauterine device due to infection, abortion, and transportation for family planning services.<sup>22</sup> Some abortions would also not qualify for the regular Medicaid state matching rate—federal funds cannot pay for abortions except in instances of rape or incest, or where the life or long-term health of the mother would be endangered if she carried the fetus to term. States can create their own policies and use state funds for abortion services.<sup>23</sup>

In federal fiscal year (FFY) 1997, total spending on Medicaid (medical and administration for all programs) was \$166 billion, of which \$94 billion was the federal share. This increased each year to FFY 2001, when total spending was \$228 billion and the federal share was \$130 billion.<sup>24</sup> Medicaid spending grew at its slowest rate in history in the mid to late 1990s, at an average of 3.6 percent a year from 1995 to 1999. However, in 2000 and 2001 Medicaid spending increased by double-digit rates, and in 2002 was projected to grow by an average of 9 percent a year for the next decade.<sup>25</sup> The federal share of Medicaid spending was \$147.5 billion in FFY 2002 and \$160.7 in FFY 2003. Federal Medicaid expenditures are projected to increase to \$177.3 billion in FFY 2004, \$182.1 billion in FFY 2005, and \$192.2 billion in FFY 2006.<sup>26</sup>

In 1995, Congress passed legislation to replace the current Medicaid program with block grants that would provide the states with a fixed amount of money and much more flexibility regarding eligibility and benefits, but President Clinton vetoed the bill.<sup>27</sup> The Bush Administration's FY 2004 and 2005 budgets reintroduced Medicaid block grants, as discussed later in this paper.



## Disproportionate Share Hospital Program

States also get federal Medicaid money for the Disproportionate Share Hospital Program. The disproportionate share program (DSH or “dispro”) provides reimbursement to hospitals that serve a disproportionately large number of Medicaid patients or other low-income people to help compensate them for lost revenues.<sup>28</sup> The program was established with the Boren Amendment in 1981 (in OBRA 1980 and 1981), which repealed a Medicaid law that made states pay for inpatient hospital services at the Medicare rate, and instead allowed them to use a rate that was “reasonable and adequate.” Congress recognized that this change would result in lower Medicaid payments for many hospitals, especially those serving a large number of Medicaid and uninsured patients, so it specified that the new payment rates take into account hospitals that serve a “disproportionate share” of low-income people. DSH funds are subject to the same federal matching rate as other Medicaid funding, though there is a ceiling on the total amount for each state, unlike regular Medicaid funds, which are open-ended. The amount of DSH payments received and their percentage of states’ total Medicaid budgets varies widely from state to state.<sup>29</sup>

States were initially slow to start using DSH payments in the 1980s, but as more states got involved and federal funding for DSH significantly increased in the late 1980s and early 1990s, Congress began passing legislation to limit DSH funding increases. Significant changes to DSH were passed in 1991, 1993, 1997, 2000, and 2003. Several of the latest acts restore some of the cuts in DSH payments to states.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 were passed to ban provider donations and cap provider taxes to 25 percent of a state’s Medicaid match. Provider donations and taxes were methods that some states had started using to draw down more federal matching funds without using any state funds, only money they collected from providers and used for the state match to get more DSH funds for hospitals. The law also capped state DSH payments at approximately their 1992 levels, and capped national DSH payments to 12 percent of total Medicaid expenditures. States whose DSH payments were less than 12 percent of their Medicaid costs could increase them at the same rate as their overall Medicaid programs, but states whose DSH payments were already 12 percent or more in 1992 could not increase their current spending in the future. This law had the intended effect of slowing DSH payment growth, and many states had to alter the financing structure of DSH and find other revenue sources besides provider donations and taxes. Many states started using intergovernmental transfer programs (IGT), where funds were transferred from local and state hospitals to the state Medicaid program, and returned to the institutions along with the extra federal matching funds.<sup>30</sup>

Congress included several provisions related to DSH in the Omnibus Budget Reconciliation Act (OBRA) in 1993 amid concerns that some hospitals who did not treat many Medicaid patients were receiving DSH payments that exceeded their costs, and that some states were keeping part of their DSH payments in the state budgets instead of directly helping safety-net providers. OBRA 1993 included laws stating that only hospitals with a Medicaid use rate of at least one percent could receive DSH payments, and that total DSH payments to a single hospital could not be more than the unreimbursed costs of providing inpatient services to Medicaid patients and uninsured patients. These laws went into effect in 1994 for most public hospitals and 1995 for private hospitals.<sup>31</sup>

The Balanced Budget Act (BBA) of 1997 targeted DSH payments, among other federal expenditures, for reduction. Some key changes in this legislation were to establish new DSH amounts for each state for 1998 to 2002 (decreasing each year), thus eliminating the limits

established in 1991, and after 2002, allowing federal DSH spending to increase by the percent changes in the Consumer Price Index (with a cap of 12 percent of each state's total annual Medicaid spending). The law also limited the amount of DSH payments that mental hospitals could receive to no more than 33 percent of a state's DSH allotment (by 2002), and stated that DSH payments for managed care patients had to be paid directly to hospitals and not to managed care organizations. BBA 1997 again required many states to alter their DSH programs and to make cutbacks in DSH payments.<sup>32</sup>

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 enacted a variety of changes related to these programs. It gave temporary relief to states dependent on DSH by making the DSH limits not decrease in 2001 and 2002 as planned, but instead to equal the year before it for each year plus inflation (as long as the increases did not make DSH over 12 percent of the state's Medicaid spending). It also temporarily increased the DSH reimbursement rate for uncompensated care at public hospitals from 100 percent (established by OBRA 1993) to 175 percent for state fiscal years 2003 and 2004. It directed states to count Medicaid managed care patients when calculating their formulas for which hospitals are eligible for DSH, and it increased states' DSH allotments to one percent for those currently under one percent. It also called for regulations to be finalized and issued to gradually phase out excess payments in the upper payment limit program, as explained below (enacted in 2001).<sup>33,34,35</sup>

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 had several provisions in it relating to Medicaid DSH payments. The act modified the planned limits on DSH growth by giving states a one-year increase of 16 percent for state FY 2004 over the states' 2003 allotment, not subject to the 12 percent cap, and subsequent years stay at the 2004 level until they match what would have been the allotment under the previous law (BIPA), then they increase annually at the previous year's level plus the consumer price index for urban consumers (CPI-U). The law also raised the DSH allotments for extremely low DSH states, and mandated more details in the annual DSH report that states must give to the federal government, including an independent audit.<sup>36,37</sup>

## Upper Payment Limits

The Upper Payment Limit (UPL) is a program that reimburses hospitals for the difference between what Medicaid pays for a service and what Medicare would have paid for it. Medicaid cannot pay more than Medicare would have paid for a service, and Medicare rates are generally higher, so this difference is called the "Medicaid upper payment limit." Medicaid's UPL rules, prior to March 2001, allowed states to maximize federal matching funds by paying certain public hospitals and nursing homes inflated amounts for treating Medicaid patients, which the federal government then matched according to the state's FMAP, as long as the payments to a particular facility did not result in a violation of an aggregate UPL applicable to all facilities (these limits apply to regular Medicaid payments and not DSH, which has its own set of limits). The UPL was based on an estimate of what would have been paid under Medicare to an entire class of providers, which usually resulted in an upper limit well above what states pay the same type of providers under Medicaid. The state would pay the providers and then keep the rest of the federal matching funds for its own uses; these were often transferred back into state general revenue funds for non-Medicaid and even non-health costs. These payments effectively increased participating states' federal matching rates over what they were supposed to be.<sup>38</sup>

UPL arrangements became more common in 2000 as more states learned about them, and states taking advantage of this began to receive criticism from the Governmental Accounting Office and the HHS Office of Inspector General for exploiting the rules. New rules took effect on

March 13, 2001, that limited the amount of federal Medicaid funds that states could get through these methods. The Congressional Budget office estimated that without the new rules, federal Medicaid UPL spending would have been \$160 billion from 2001-2010, and even though payments will be significantly less after the regulations, \$36.6 billion is still expected to be spent from fiscal years 2001-2005. Medicaid DSH payments to states are projected to be \$42.3 billion over this same five-year period.<sup>39</sup>

Two aspects of Medicaid allowed UPL arrangements to propagate before March 2001. One was intergovernmental transfers between localities to states, which was and is a legitimate source for a state's matching funds for Medicaid. The other was allowing the amount of Medicaid payments to public hospitals or nursing homes to exceed the costs of treating Medicaid patients at these facilities, as long as the UPL to all such providers in the state was not exceeded. After the repeal of the Boren Amendment as part of BBA 1997, the federal government no longer required that Medicaid payments to hospitals and nursing homes be "reasonable." The problem is that before the 2001 law, UPLs were imposed on all hospitals as a group, all nursing homes, all state-operated hospitals, and all state-operated nursing homes, but no limits were applied to aggregate payments to county-operated hospitals and nursing homes.<sup>40</sup> The March 2001 regulations established more UPL groups that include county-operated hospitals and nursing homes, but there are transition periods up to eight years (with reductions each year) for states that already had UPL plans in place.<sup>41</sup>

The law that took effect in March 2001 also established two tiers of UPL payment limits, a reasonable estimate of 100 percent of what costs would have been under the Medicare program for the same services for the same people applicable to nursing facilities and state and private hospitals, and a limit of 150 percent reimbursement of this estimate for local public hospitals. The 150 percent tier only lasted one year—it was changed to 100 percent in rules that took effect in March 2002.<sup>42</sup>

## ***State Children's Health Insurance Program Background***

The State Children's Health Insurance Program (SCHIP) was created as part of the Balanced Budget Act of 1997 and codified into Title XXI of the Social Security Act. It is administered by the Centers for Medicare and Medicaid Services. It was established to offer health insurance to the large number of uninsured children with family incomes too high to qualify for Medicaid, but who cannot afford private insurance. Every state (plus Washington, D.C., and the five U.S. territories) has implemented SCHIP plans. SCHIP is a grant program with limited funds and not an entitlement program like Medicaid, so states can place caps on the number of children enrolled or enact other restrictions that are not legal in Medicaid.

### **Eligibility and Benefits**

To qualify for SCHIP, children must be younger than 19, a U.S. citizen or legal resident, not eligible for Medicaid or state employee coverage, not have private insurance, and have a family income below 200 percent of the federal poverty level or below 50 percentage points above the state's Medicaid eligibility, whichever is greater (some states have expanded coverage above 200 percent FPL).<sup>43</sup> Families pay premiums, deductibles, and co-payments that vary according to their income levels.

The BBA gave states three options for designing their SCHIP programs: they could expand coverage for children under Medicaid (43 percent chose this option), establish a separate child health program (27 percent), or do a combination of these two strategies (30 percent).<sup>44</sup> If a state implements SCHIP by choosing to expand Medicaid, it must offer the new beneficiaries the same benefits package that current Medicaid enrollees get. If a state establishes a separate

children's health insurance program, it can choose from among five options for benefits packages. It can offer SCHIP enrollees 1) the Blue Cross/Blue Shield PPO option offered to federal employees; 2) the state employees health plan; 3) the HMO plan with the largest commercial, non-Medicaid enrollment in the state; 4) coverage that is the actuarial equivalent to one of the three previous options; or 5) another health plan approved by the U.S. Secretary of Health and Human Services.<sup>45</sup>

If a state wants to expand its SCHIP eligibility to optional populations, it can apply for an 1115 waiver (explained below in the section on waivers), as long as the state is already covering the target population of children under 19 with incomes under 200 FPL. Covering additional populations under a SCHIP waiver, instead of using a Medicaid waiver, is an attractive option for states since the federal match is higher for SCHIP. To obtain a waiver, the state must show that it is promoting enrollment and retention of eligible children. Under a policy instituted in 2000, if the waiver does not focus on enrolling children or if it proposes to cover populations other than low-income children (such as their parents), then the state had to show that it had adopted at least three of the following five enrollment and retention procedures in its Medicaid and SCHIP programs:

- A joint mail-in application and a common application procedure for Medicaid and SCHIP;
- Elimination of assets tests;
- Twelve-month continuous eligibility;
- Simplification of the renewal process by allowing parents to establish their children's continuing eligibility by mail, and by having effective procedures for transferring children between Medicaid and SCHIP if their eligibility changes without a new application or a gap in coverage;
- Presumptive eligibility for children (meaning they can get immediate temporary coverage under Medicaid or SCHIP if they appear to meet eligibility requirements of the program they are applying for, before their application is officially processed and approved).<sup>46</sup>

These requirements may have been relaxed since then, but we have been unable to find a reference for this.

## **SCHIP Finances**

SCHIP is a federal-state matching program with a higher federal share than Medicaid. The federal match is calculated by taking 70 percent of the state's FMAP for Medicaid and adding 30 percentage points (with a maximum of 85 percent).<sup>47</sup> The federal match in 2004 varied from 65 percent (in 13 states) to 84 percent (in Mississippi).<sup>48</sup> The remaining balance is funded by the states, and there are restrictions on the sources of these funds. States cannot use federal funds, provider taxes, or beneficiaries' cost-sharing to make up these funds, and states also cannot use SCHIP funds to finance the state match for Medicaid. States also have to show a maintenance of effort to receive federal funds: they cannot lower their Medicaid eligibility levels from what they had in place on June 1, 1997, and they must maintain at least the same level of spending on children's health programs that they had in 1996.<sup>49</sup> These provisions seek to ensure that SCHIP funds cover the intended target population of uninsured children without states trying to transfer additional children to the program in order to reap the higher federal matching funds.

SCHIP was appropriated approximately \$40 billion over 10 years. The amounts are \$4.295 billion for FFY 1998, \$4.275 billion for each year from FFY 1999-2001, \$3.15 billion for each

year from FFY 2002-2004, \$4.05 billion for FFY 2005 and 2006, and \$5 billion for FFY 2007.<sup>50</sup> The minimum allocation to each state from these funds is \$2 million per fiscal year. The actual annual allocation to each state (and the District of Columbia) is determined by a formula that takes two variables into account: the “number of children factor” (based on the number of low-income and uninsured children in the state) and the “state cost factor” (based on wages in the health care industry in each state). The two factors are multiplied to get a product for each state, then these are added together to get a total for all states. A ratio is then made of each state’s product over the total to determine what percentage of the available funds will go to each state.<sup>51</sup>

The *number of children factor* is calculated by adding 50 percent of the number of low-income children in the state to 50 percent of the number of low-income children without health insurance in the state. These two numbers are calculated each year using the average of low-income children and low-income uninsured children as reported and defined in the three most recent March supplements to the Current Population Survey published by the Census Bureau each year. The *state cost factor* is determined by adding 0.15 to 0.85 multiplied by the ratio of the annual average health care wages per employee for the state over the annual average health care wages per employee for all states totaled. In other words, if a state’s per capita health care wages were at the national average, this ratio would equal 1, so adding 0.85 to 0.15 would make the whole state cost factor equal to 1. If health care wages were lower than average, then this factor would be less than 1. The average annual wages per employee for each state is calculated from the wages in the health services industry (SIC code 8000) averaged from each of the most recent three years as reported by the Bureau of Labor Statistics in the Department of Labor.<sup>52</sup>

SCHIP funds to a state remain available for the state to spend for three years (the fiscal year of the award and the next two fiscal years). Any funds that have not been spent during this period are subject to reallocation by the federal government and possible redistribution to other states that have exhausted their funds.<sup>53</sup> The CHIP Allotment Extension (Public Law 108-74) allowed states to keep unspent 1998-1999 federal allocations through 2004, and gave states additional time to spend 50 percent of unused FY 2000-2001 funds (through FY 2004 and 2005, respectively).<sup>54</sup>

The federal government took back almost \$1.1 billion in state SCHIP funds on September 30, 2004, the end of the federal fiscal year, that had not been spent by the deadline (these funds were allocated to states from 1998-2000). In November 2004, 72 organizations, including health systems, associations, and non-profits, signed a letter by the Children’s Defense Fund to all members of Congress asking them to change the law and to restore these funds to states this year so states will have the resources to continue their SCHIP programs at current levels over the next few years.<sup>55</sup> There was bipartisan legislation introduced in July 2004 in both the Senate and the House, and endorsed by the National Governors Association, that would have sent a majority of the unused funds to states projecting SCHIP shortfalls in the next three years, and that would have extended the expiration of the funds, but the Bush Administration opposed the legislation.<sup>56</sup>

The Bush Administration wants to use the current unused funds for SCHIP outreach, and says that unspent funds from 2002 will be available in 2005 to be reallocated to the states with budget shortfalls (six states are projected to have SCHIP shortfalls by 2005 and 18 states by 2007 under current laws). The amount available in fiscal year 2005 is estimated to be \$623 million, and 30 states that will have spent all their funds will be eligible for these funds to be reallocated to them.<sup>57</sup> However, if most of those funds are spent on the six states with the largest shortfalls, not much will be available for the remaining states, causing problems in the

future for their SCHIP programs. The administration says that in 2005 states are projected to have much more in SCHIP allocations (\$10.7 billion) than they will spend (\$5.2 billion), however, that is for the nation as a whole, and shortages will still exist in some states.<sup>58</sup> The \$10.7 billion is not the annual allotment, but takes into account states' unused funds from previous years, because from 1998-2001 while SCHIP programs were still ramping up, there were unused funds, but since 2002 annual SCHIP expenditures have exceeded annual funding. The difference has been funded from states' unspent money, but as time goes on these reserves are being used up or expiring and reverting back to the U.S. Treasury.<sup>59</sup>

The \$1.1 billion that reverted to the federal government was the unspent funds from nine states that were not able to spend it by the deadline.<sup>60</sup> As more and more states have fully functioning SCHIP programs and spend all of their SCHIP funds, unused funds are projected to be less and less, so states that use all of their funding will not be able to rely on receiving more funds reallocated from other states in the future. Texas is not one of the 18 states projected to be unable to maintain current SCHIP enrollment levels with current funding.<sup>61</sup>

## ***Medicaid and SCHIP Waivers and Other Options for Change***

### **Waivers**

Waivers allow the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid and SCHIP laws and regulations to give states more flexibility in these programs and to encourage experimentation with new approaches to delivering services. There are two broad waiver types, which refer to different sections of the Social Security Act. Section 1115 waivers are called "research and demonstration waivers" and usually involve comprehensive reform projects, while Section 1915 waivers are called "program waivers" and involve waiving specific requirements to allow more innovative programs such as managed care and community-based care. Every state and territory has applied for and implemented at least one Medicaid waiver.<sup>62</sup>

Section 1115 of the Social Security Act allows HHS to authorize pilot projects in states that want to test new ways to promote the objectives of Medicaid and SCHIP. States can obtain federal matching funds for demonstration projects to pay for more services or extend coverage to more people. Applications must show how projects will help further the goals of Medicaid or SCHIP, and include an evaluation component. Projects are usually approved for five years and may be renewed, and they must be budget-neutral, meaning they don't cost the federal government any additional money.<sup>63</sup> Although called "demonstration" projects these arrangements often become permanent. The Arizona Medicaid program (called Arizona Health Care Cost Containment System, or AHCCCS) was introduced under an 1115 waiver in 1982 and through repeated renewals and amendments continues to operate today.<sup>64</sup>

A new type of 1115 waiver is the Health Insurance Flexibility and Accountability demonstration initiative, or HIFA waiver, announced by the Bush Administration in August 2001. This waiver, applicable to both Medicaid and SCHIP, is mainly intended to encourage new statewide approaches to increasing health insurance coverage, and proposals that meet HIFA guidelines will receive expedited review. Programs should be budget-neutral and maximize private insurance options using Medicaid and SCHIP funds to people below 200 percent FPL.<sup>65</sup>

There are two types of waivers allowed under Section 1915 of the Social Security Act, 1915(b) and 1915(c) waivers. Section 1915(b) waivers are generally granted for two years at a time and permit states to waive Medicaid's freedom-of-choice requirement regarding providers, thus letting states require enrollment in managed care plans or create local programs not available statewide. The savings from managed care often allows states to provide additional services to

Medicaid beneficiaries. Section 1915(c) waivers let states develop innovative alternatives to institutionalization, and are approved initially for three years, with five-year renewal periods. The waivers allow states to provide home- and community-based services that help keep Medicaid beneficiaries out of nursing homes, hospitals, and other institutions in order to maintain their independence and family ties as well as save money. The waivers cover elderly people or people with physical or mental problems who would qualify for Medicaid if they were institutionalized, and the programs must be budget-neutral.<sup>66</sup>

**Table 1. Main Types of Waivers**

Type of Waiver	Purpose	Requirements
<b>1115</b> — Research and Demonstration (Medicaid and SCHIP)	Waives a variety of requirements to let states have flexibility to test new ideas for operating their programs. Can implement new services or delivery methods, maximize coverage for people below 200% FPL (HIFA waiver), or extend drug coverage to certain people (Pharmacy Plus waiver).	Must be budget neutral. Five-year timeframe, subject to renewals. CMS evaluates for impact on utilization, coverage, spending, quality, access, and satisfaction.
<b>1915(b)</b> — Freedom of Choice (Medicaid only)	Waives statewideness, comparability and freedom of choice. States can require enrollment into managed care, limit the number of providers and provide additional services for some people.	Must be cost effective. Two-year timeframe, subject to renewal. Independent evaluation required to show that cost, quality, and access have not been harmed.
<b>1915(c)</b> — Home and Community-Based Services (Medicaid only)	Waives statewideness, comparability, and resource and income rules. Allows community-based services to be provided to people who are eligible for care in a nursing home, intermediate care facility for persons with mental retardation (ICF/MR), or hospital. Can serve elderly or disabled in general, or can target specific chronic conditions and diseases. Can offer extra services such as case management, home health aide services, and respite care.	Must be budget neutral. Must have safeguards in place to protect enrollees. Three-year timeframe, subject to five-year renewals.

Sources: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.*, 2004, pp. 3-12, 3-13, available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed January 6, 2005; and Social Security Act, Title XIX, Sec. 1915, available at [http://www.ssa.gov/OP\\_Home/ssact/title19/1915.htm](http://www.ssa.gov/OP_Home/ssact/title19/1915.htm), accessed January 5, 2005.

## Section 1931

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) added Section 1931 to the Social Security Act, which lets states extend Medicaid eligibility to low-income parents who are not receiving cash assistance. States must cover at a minimum those parents with incomes below those required in 1996 for welfare, whether or not they receive welfare now, ensuring that those eligible before PRWORA was passed remain eligible. States may also cover those with higher incomes, which a majority of states do. Section 1931 gives states more flexibility to cover low-income people by increasing income and assets disregards and limits, which is made easier because it can be done through amending the state's Medicaid State Plan instead of applying for a federal waiver. Enrollments can be capped

and certain benefits and eligibility criteria can be changed for new recipients, so expansion through Section 1931 does not create an entitlement program. Section 1931 expansions also do not have to be budget-neutral like waivers do.<sup>67</sup>

See Appendix A for a table showing the eligibility levels for public programs in all 50 states as of 2002 and what expansion mechanisms they have used.

## **The Future of Medicaid and SCHIP on the Federal Level**

The Bush Administration is looking for ways to save money in Medicaid and other programs, and implementing more block grants is one possibility. President Bush's FY 2005 budget proposed converting various federal programs into block grants, which are fixed amounts of funds that give the recipients (state and local governments) more flexibility in carrying out the programs that are funded. These proposals were not completely new, as a Medicaid block grant, among others, was proposed in President Bush's FY 2004 budget as well.<sup>68</sup> In these proposals for Medicaid and SCHIP block grants, states would have the option of consolidating Medicaid and SCHIP funds into acute care and long-term care allotments. The amounts would be based on historical Medicaid and SCHIP spending. The amounts would increase annually over current funding by a certain rate in the first years of the block grant but would decrease in later years to make the block grant budget-neutral over 10 years. The proposal contained certain requirements, such as that not more than 15 percent of funds could be used for program administration, up to 10 percent of funds could be transferred between allotments, and states would still have to provide benefits to currently mandated beneficiaries.<sup>69</sup>

Critics of the block grants proposals say that they overestimate the amount that can be saved with increased flexibility, and do not address the underlying reasons that Medicaid costs are growing, which are mainly increasing enrollment along with rising health care costs. The proposed increase in flexibility includes letting states tailor benefits packages to different populations, increase cost-sharing, and cap enrollments. However, the most-used benefits are unlikely to be eliminated, and more cost-sharing and caps on enrollment create inequities for low-income people who may delay getting care if they cannot afford the co-pays. Capping enrollment and getting rid of the entitlement aspect means that people who would otherwise qualify and may be worse off financially or health-wise than people already in the program could be denied benefits or put on waiting lists just because they register later. Critics also say that block grants give states an incentive to reduce coverage because they can keep any savings, take away the monetary incentive to be innovative due to no federal matching funds for expansions, and set in stone the spending inequalities of high-income and low-income states.<sup>70,71</sup> Also, states with a low base in expenditures that may be faster-growing are particularly disadvantaged.

President Bush's FY 2006 budget does not directly mention Medicaid block grants but still proposes changes and cutbacks to control growing Medicaid costs. The Administration proposes to modernize Medicaid, create more flexibility in the program, and coordinate it better with SCHIP to increase efficiency. The budget proposes to enhance Medicaid and SCHIP coverage by reauthorizing SCHIP before it ends in 2007 and extending transitional Medicaid coverage for one year for former welfare recipients who get jobs. It also proposes \$1 billion in grants over two years for a new program called Cover the Kids to enroll more Medicaid and SCHIP-eligible children in these programs.<sup>72</sup>

The Administration also wants to save money and promote program integrity by curbing financial arrangements that let states in effect increase their federal matching rates and draw down extra federal funds (through mechanisms such as intergovernmental transfers and upper payment limits). The 2005 budget also mentioned enacting more controls and continuing efforts



started in 2001 and 2002 to curb inappropriate payments.<sup>73</sup> The 2006 budget proposes some specific measures such as recovering federal funds not used for their intended purposes, limiting payments to providers to their actual costs, decreasing the percentage of provider taxes that can be used for the state Medicaid match, and elevating the importance of the oversight of Medicaid and SCHIP financial management (including more state audits and evaluations).<sup>74</sup>

### ***Poverty and the Uninsured in Texas***

Texas has the highest rate of uninsured people in the nation, at about 26 percent. In 2002, 25 percent of the uninsured were aged 17 or under, 1 percent was 65 or over, and 74 percent were in between these ages.<sup>75</sup> Almost two-thirds of the uninsured adults in Texas have jobs, but Texas has a lower percentage of employers who offer health insurance than the national average. Even if an employer does offer insurance, lower-wage workers often cannot afford to buy it.<sup>76</sup>

Medicaid and SCHIP provide health insurance for people who meet the eligibility criteria, which include having a low income. The federal poverty level (FPL) is used as a standard for determining program eligibility. The maximum annual income allowed for eligibility may be a certain percentage higher or lower than this level, depending on the program and the service. The FPL is set by the federal government each year and updated for inflation, and it varies by family size. In 2004, the FPL was \$9,310 for one person, \$12,490 for two people, \$15,670 for three people, and \$18,850 for four people (for each additional person add \$3,180). In 2002, about 25 percent of the Hispanic population in Texas lived at or below the poverty level, along with 19 percent of African-Americans and 7 percent of non-Hispanic whites.<sup>77</sup> In addition, counties are responsible for providing care to the “medically indigent.” Appendix B delineates current requirements and experience in local participation in health coverage.

When talking about assisting low-income people in obtaining health insurance, an income less than 200 percent of the FPL is often used to define “low income.” In 2003, 3,267,020 people or 61 percent of the uninsured in Texas had incomes at 199 percent FPL or less. Put another way, 38 percent of all people under 200 percent FPL in Texas do not have health insurance. Of these uninsured people under 200 percent FPL, 29 percent are children 18 or under.<sup>78</sup> Some programs target uninsured parents so that they will understand the value of health insurance and might be more likely to insure their children or take them for medical care; fewer programs include childless adults. Of the 3.3 million uninsured people under 200 percent FPL, 37 percent are parents (defined as people 19 to 64 with children under 18 living with them), and 33 percent are childless adults (ages 19 to 64 without children or with children who do not live with them).<sup>79</sup>

### ***Medicaid and SCHIP in Texas***

In 2003 the Texas Legislature passed House Bill 2292 to consolidate the state’s 12 health and human services agencies into five agencies, with the Texas Health and Human Services Commission continuing to oversee the other agencies. HHSC is the single state agency in charge of Medicaid, but it is allowed to delegate many functions to other agencies. HHSC also administers SCHIP. SCHIP and the children’s Medicaid program in Texas together are called TexCare. (SCHIP is usually called “CHIP” in Texas but we use the full acronym here for consistency.)

### ***History and Financing of Medicaid***

Texas joined the Medicaid program in September 1967. The federal government pays about two-thirds of the cost of the Medicaid program in Texas (the exact percentage varies from year to year). For federal fiscal year 2004, the federal share in Texas was effectively 62.67 percent, which is figured from a basic matching rate of 60.22 percent, an additional one-time increase of

2.95 percent for several months during the fiscal year due to federal legislation, and a factor to take into account the one-month difference between the federal fiscal year and Texas' state fiscal year.<sup>80</sup> (The basic rate, not the enhanced rate, applies to the DSH program.)

Combined federal and state spending for Medicaid in Texas was projected to be \$15.5 billion in SFY 2004, not including DSH payments (which add another \$1.5 billion, as detailed below). This has almost doubled from a budget of \$8.2 billion in 1996. The Medicaid budget (excluding DSH) has gone from being 20.5 percent of the state budget in 1996 to 26.1 percent of the budget in 2004. Of the total state Medicaid budget of \$17 billion estimated for SFY 2004, 87 percent is for payment of health services, 9 percent is for DSH payments, and 4 percent is for administration.<sup>81</sup>

**Table 2. Medicaid Fiscal Trends in Texas, Selected Years**

<b>Fiscal Year</b>	<b>Total Medicaid Budget (state plus federal, in billions), Excluding Disproportionate Share Payments</b>	<b>Percent of Total State Budget (All Funds)</b>
1996	\$8.178	20.5%
1998	\$8.943	20.8%
2000	\$10.363	21.0%
2002	\$13.128	23.1%
2004	\$15.543	26.1%

Sources: Texas Health and Human Services Commission, Texas Medicaid in Perspective, 5th ed., 2004, Chapter 5, Table 5.1, available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed December 28, 2004.

## Disproportionate Share Hospital Program in Texas

Disproportionate share hospital payments are an important source of revenue for many hospitals, helping them to defray costs of uncompensated care to indigent and uninsured patients. The DSH program is the only Medicaid program where reimbursement does not have to be solely for the treatment of Medicaid patients; it can help reimburse the uncompensated costs of treating uninsured patients as well. In state fiscal year 2003, 181 hospitals in Texas received \$1.294 billion in DSH payments (federal and state dollars combined). Of these hospitals, 14 were state hospitals, 80 were public, 50 were non-profit, and 37 were private for-profit hospitals.<sup>82,83</sup>

All children's hospitals and three University of Texas teaching hospitals are eligible to receive DSH funds as long as they meet certain federal and state qualifications.<sup>84</sup> Federal standards say that DSH-eligible hospitals must have a Medicaid utilization rate of at least 1 percent, and must have at least two doctors with admitting privileges who accept Medicaid and provide non-emergency obstetrical services (except at children's hospitals).<sup>85</sup> All other hospitals must qualify for DSH payments by meeting one of three criteria: they must have a 1) disproportionate number of inpatient days for Medicaid patients, 2) disproportionate percentage of inpatient days for Medicaid patients, or 3) disproportionate percentage of inpatient days for low-income patients.<sup>86</sup>

For a hospital in Texas to qualify for DSH using Medicaid inpatient days, its number of inpatient days of Medicaid patients must be above the mean number of Medicaid inpatient days of all Medicaid hospitals, plus one standard deviation. Medicaid hospitals in counties defined as

urban and with fewer than 250,000 people can qualify if their Medicaid inpatient days are above the mean number of Medicaid inpatient days for that group of hospitals, plus 75 percent of one standard deviation. To qualify by the Medicaid inpatient utilization percentage (number of inpatient days under Medicaid divided by total number of inpatient days at the hospital), a hospital's Medicaid inpatient percentage must be above the average for all Medicaid hospitals, plus one standard deviation. Rural Medicaid hospitals can qualify if their inpatient percentages are above the average (without adding a standard deviation), making it easier to qualify for DSH. For hospitals to qualify by their low-income utilization rate, this rate must be 25 percent or more. The low-income utilization rate is determined by adding two ratios together: 1) Medicaid, state, and local funding divided by total costs, and 2) total charity charges minus total state and local revenue, divided by all inpatient charges.<sup>87</sup>

The state has to put up its share in order to receive the federal matching funds like in the rest of Medicaid. Texas' share for DSH is funded through intergovernmental transfers to the state from eight hospital districts and one municipal hospital, and state funds from the state-owned hospitals. The current nine local transferring hospitals/districts are the University Health System (Bexar County Hospital District, San Antonio area), Parkland Health and Hospital System (Dallas County Hospital District, Dallas area), Medical Center Hospital (Ector County Hospital District, Odessa area), R. E. Thomason General Hospital (El Paso Hospital District, El Paso area), Harris County Hospital District (Houston area), University Medical Center (Lubbock County Hospital District, Lubbock area), Spohn Memorial Hospital (Nueces County Hospital District, Corpus Christi area), John Peter Smith Hospital (Tarrant County Hospital District, Fort Worth area), and Brackenridge Hospital (Austin, now part of the Travis County Hospital District). These nine hospitals or districts transfer money to the state for the state Medicaid match, then receive DSH payments back that equal what they transferred plus a portion of the federal matching funds received by the state. The remaining federal matching funds are used for the DSH payments to the other DSH-eligible non-state hospitals. The 14 state hospitals that transfer money for matching funds are the University of Texas Medical Branch at Galveston, the University of Texas M.D. Anderson Cancer Center, the University of Texas Health Center at Tyler, the Texas Center for Infectious Disease in San Antonio, and 10 mental health facilities. These state hospitals transfer to HHSC an amount equal to their unreimbursed costs for Medicaid and uninsured patients, and the federal matching funds obtained with these funds are withheld by HHSC and transferred to the state general revenue fund. The state hospitals are reimbursed at 100 percent of their federal cap amounts (discussed later in this section).<sup>88</sup>

The disproportionate share program in Texas was created in 1986 from funds appropriated by the Indigent Health Care and Treatment Act of 1985. This act appropriated \$2 million for FY 1986 and \$4 million for FY 1987 to help hospitals that served indigent patients, but did not specifically mention Medicaid. At the same time, the federal government had directed Texas to create a Medicaid disproportionate share program, so the state decided to use this \$6 million as the state match for Medicaid to receive additional federal funds for hospitals, and continued to appropriate money each year for that purpose. Texas expanded the DSH program in 1989 by requiring qualifying hospital districts (with their number of beds at least in the 84th percentile of all Medicaid hospitals) and state teaching hospitals to transfer money to the state to be used as state matching funds for DSH, as well as appropriating more state funds for this purpose, so more federal matching funds were received. Hospitals that transferred funds to the state were guaranteed to receive more in DSH payments than they had donated.<sup>89</sup>

There were some changes made to Texas' DSH program in the early 1990s amid concerns that public hospitals were not adequately reimbursed for their amount of DSH days relative to non-profit and private hospitals. The original DSH financing system, called DISPRO I, used formulas to distribute DSH payments to approximately 100 qualifying hospitals that were financed

through intergovernmental transfers, state appropriations, and federal matching funds. A performance review report from the Texas Comptroller's Office in 1991 stated that large public hospitals were not getting their fair share of DSH payments considering their assessments and large amount of uncompensated care, and that other states used more local funds plus voluntary donations and provider taxes to draw down more federal funds. The hospital districts and state hospitals agreed to an increase in their assessments in 1991 (state hospitals paid larger fixed amounts and the amount from hospital districts increased from 1 percent to 5 percent of local ad valorem tax collections), which resulted in \$52 million more in federal matching funds that year.<sup>90</sup>

Texas created several additional DSH programs in the early 1990s. A second DSH program called the Special Supplemental Payment Program was created to help three state-owned teaching hospitals (University of Texas hospitals in Galveston, Houston, and Tyler) with high amounts of uncompensated care. The DISPRO II program allowed the hospitals to transfer the amount of their annual charity care into a specific fund to be used as state matching funds to draw down more federal Medicaid dollars. A similar program called DISPRO III was created to help other hospitals with high amounts of Medicaid and indigent care. This program used monthly provider assessments of high-volume Medicaid providers, mandatory hospital assessments, intergovernmental transfers, and voluntary donations from qualifying hospitals, and additional DSH payments were made to qualifying hospitals (public hospitals paid assessments for both DISPRO I and III). A fourth program, DISPRO IV, used 5 percent of the hospital assessments from DISPRO III as a state match for funds to make additional DSH payments to about 90 rural hospitals.<sup>91</sup>

As stated in the previous section on Medicaid financing at the federal level, spending on the DSH program greatly expanded in the late 1980s, and in the 1990s Congress passed several acts aimed at curbing these expenditures. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 capped the DSH program in Texas at \$1.513 billion (state plus federal funds), and made the provider assessments in DISPRO III and IV no longer eligible for federal matching funds.<sup>92</sup> OBRA 1993 established caps on the DSH amounts that individual hospitals could receive, which was the sum of the hospital's unreimbursed costs for Medicaid patients and uninsured patients, and directed that at least one percent of the total patient-days in a hospital must be from Medicaid patients in order for the hospital to be eligible to receive DSH payments.<sup>93</sup> The state teaching hospitals in Texas lost significant funds when the hospital-specific caps were added to existing formulas.<sup>94</sup>

Due to federal changes and state recommendations, Texas modified the DSH program in 1994 and merged the four previous DSH programs into one program. A new formula was established where all hospitals must qualify each year based on several variables. There are special provisions to enhance the funds given to the large public hospitals who transfer money for the state match, and for qualifying children's and rural hospitals.<sup>95</sup> The Texas Health and Human Services Commission implemented several changes to DSH in FY 2001 and 2002. In FY 2001, the formula was weighted so transferring hospitals would receive more funds back and reimbursement for treating low-income patients would increase, and a minimum of 5.5 percent of DSH was set aside for rural hospitals. In FY 2002, DSH eligibility was expanded to include hospitals in small urban areas, so more hospitals can receive DSH payments in Abilene, Bryan, Longview, Lubbock, Midland, San Angelo, and Tyler.<sup>96</sup>

Due to these changes, DSH payments to state-owned hospitals decreased from \$729 million to \$480 million from SFY 1995 to 2003, but this was offset by more funds going to local hospitals. BBA 1997 set annual limits on the federal funds going to the Texas DSH program, but those limits were increased by the Medicare, Medicaid, and SCHIP Benefits Improvement and

Protection Act of 2000 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. These changes have resulted in fluctuations in the amount of federal DSH matching funds that Texas receives each year, and thus the total program amount, as shown in Table 3.<sup>97</sup>

**Table 3. Funding for the Disproportionate Share Hospital Program in Texas, 1999-2004**

Fiscal Year	Federal Matching Funds for DSH	Total DSH Program (Federal and State Funds)	Total DSH as a Percent of Total Texas Medicaid Budget
1999	\$950 million	\$1.52 billion	13.7%
2000	\$806 million	\$1.31 billion	11.2%
2001	\$834 million	\$1.38 billion	11.0%
2002	\$856 million	\$1.43 billion	9.8%
2003	\$776 million	\$1.29 billion	8.3%
2004	\$901 million	\$1.50 billion	8.8%

Adapted from: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.*, 2004, Chapter 5, Tables 5.1, 5.2, Figures 5.5, 5.6, available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed December 12, 2004.

Notes: Federal funding amounts are for federal fiscal years, as is the percent of budget for federal fiscal 1999; total DSH funds as well as the percent of budget for 2000-2004 are for state fiscal years (the federal fiscal year and Texas' state fiscal year differ by one month). Total DSH column was calculated using percentages from last column (from source Figure 5.5) and annual Medicaid budgets excluding DSH from Table 5.1.

The DSH program in Texas operates within two parameters, an overall state cap on federal funds and a cap on individual hospitals. These caps are set by the federal government, with the overall cap decreasing and increasing as discussed in the previous section on DSH and relevant federal legislation. The hospital-specific cap is determined annually with a formula that takes into account the unreimbursed costs of uninsured patients and Medicaid patients. The cap amount equals the sum of a hospital's cost of services to uninsured patients (updated for inflation) and its Medicaid shortfall (determined each year by its two-year prior cost report).<sup>98</sup> The 14 state-owned hospitals receive DSH reimbursement equal to their cap amounts, and the DSH payments to the remaining hospitals change each year due to the number of qualifying hospitals, how much uncompensated care each hospital has, and the amount of DSH funds available.<sup>99</sup>

There are no federal or state rules regarding how hospitals can use their DSH funds. After consulting with various hospitals and associations, HHSC recommended that DSH funds received by a hospital be used to maintain or expand existing programs for the indigent, and to create new programs to care for the indigent. The funds can be used for needs such as recruiting physicians, obtaining equipment, and renovating health care facilities. DSH providers must submit community health care needs assessments yearly to show how they are using DSH funds to meet needs in their communities.<sup>100</sup> The state has somewhat more flexibility on how to spend DSH matching funds that go to state hospitals.

### Upper Payment Limit Program in Texas

As described earlier, the Medicaid Upper Payment Limit (UPL) program allows states to reimburse hospitals and some other facilities for eligible uncompensated care provided in Medicaid at a rate that the services would have been reimbursed under Medicare, which usually

pays more, thus that is the “upper payment limit” in Medicaid. The program is separate from DSH and is financed with both state and local funds like the rest of Medicaid. Texas has a limited UPL plan that makes payments to public hospitals in rural counties under 100,000 population, as well as to the nine large urban public hospital districts.<sup>101</sup>

The state gets the state portion of the matching funds through intergovernmental transfers from the nine largest hospital districts that are in the UPL plan. These districts received \$24.9 million in additional federal funds in FY 2001 and \$105 million in FY 2002. Texas’ UPL plan complies with recent federal regulations intended to stop perceived abuses in the program (like federal matching funds being retained by states for non-health purposes), and has gone one step further by requiring that all UPL funds received by the state to be used only for higher payments to hospitals or to support medical teaching facilities.<sup>102</sup>

### History and Financing of SCHIP

The current Texas Children’s Health Insurance Program began in May 2000. There was a previous program in place from 1998-2002 that was phased out as Medicaid took over coverage of the enrollees, who were aged 15-18 under 100 percent FPL.<sup>103</sup> SCHIP covers children whose families cannot afford health insurance but who have too much income or too many assets to qualify for Medicaid. The federal share for SCHIP is 72.15 percent in Texas for FFY 2004 and the state share is 27.85 percent, meaning the federal government gives Texas \$2.59 for every state dollar spent.<sup>104</sup> Texas spent almost \$330 million on SCHIP in FY 2004, including both federal and state funds. See the following table for SCHIP finances since implementation.

**Table 4. Texas Children’s Health Insurance Program Fiscal Trends, 1998-2005**

Federal Fiscal Year	Annual Federal Allotment	Total Available	Expenditures	Balance	Returned for Redistribution
1998	\$561,331,521	\$561,331,521	\$1,308,702	\$560,022,819	\$0
1999	558,680,510	1,118,703,329	38,533,875	1,080,169,454	0
2000	502,812,459	1,582,981,913	40,981,633	1,542,000,280	170,026,270
2001	452,531,213	1,824,505,223	263,438,317	1,561,066,906	324,454,756
2002	301,839,575	1,538,451,725	535,735,403	1,002,716,323	123,664,391
2003	311,503,988	1,190,555,920	405,630,959	784,924,961	86,297,915
2004	330,851,514	1,029,478,560	329,654,580	699,823,980	57,468,477
2005 (projected)	449,972,119	1,092,327,622	307,371,548	784,956,074	4,132,440

Source: Texas Health and Human Services Commission, “FY 05 Federal Alloc LAR” (Excel spreadsheet, January 2005).

This data indicate that there has been unspent money left over each year since the SCHIP program started, and that money has been returned or is projected to be returned to the federal government for redistribution each year since 2000.

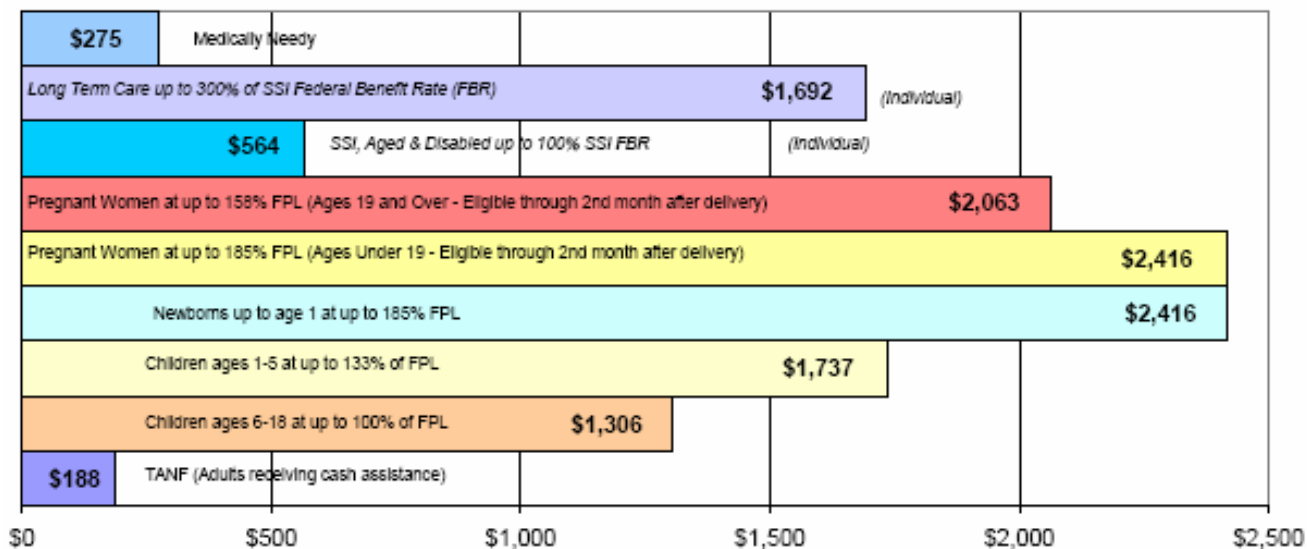
### Texas Medicaid Program Information

As of October 2004, there were 2,626,469 people enrolled in Medicaid in Texas.<sup>105</sup> Children and adults that fit into one of the eligible categories and income groups for coverage can apply for Medicaid in person (required for most adults) or by mail. Eligibility lasts for six months, at which time adults must renew in person and most children can renew by mail (unless they are not up-to-date on their Texas Health Steps check-ups or have not received a Medicaid

orientation). Recipients of Supplemental Security Income (SSI) automatically receive Medicaid and do not have to apply.<sup>106</sup> There are no monthly premiums or copays in Medicaid. See Figure 1 for a chart showing various eligibility groups and the monthly income cut-offs to qualify for Medicaid in 2004.

**Figure 1. Medicaid Eligibility in Texas, 2004**

**Maximum Monthly Countable Income Limit (Family of Three)**



Source: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.* (2004, p. 4-5), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed March 22, 2005.

Notes: “Countable income” is gross income adjusted for allowable deductions, typically work-related. SSI does not certify families of three, SSI certifies only individuals and couples. SSI is not tied to the Federal Poverty Level, but is based on the FBR, as indicated above.

Texas Medicaid provides all of the mandatory services listed previously per federal law, and also provides 36 optional services, 21 of these to all enrollees, and the rest to only children or the elderly.<sup>107</sup> See Table 5 for more details on the number of people and average costs of each eligibility group.

**Table 5. Texas Medicaid Recipient Months and Costs per Month by Strategy**

Strategy Description	2003 Experienced	2004 Estimates	2005 Budgeted
<b>Aged and Disabled Risk Groups</b>			
Average aged and Medicare recipient months per month	316,143	320,882	325,375
Average disabled and blind recipient months per month	208,957	221,711	235,235
Average aged and Medicare related cost per recipient months	\$105.07	\$136.17	\$160.20
Average disabled and blind cost per recipient months	\$573.33	\$573.13	\$542.07
<b>TANF Adults and Children Risk Groups</b>			
Average TANF adult recipient months per month	116,710	89,927	83,632
Average TANF child recipient months per month	374,821	341,435	326,070
Average TANF adult cost per recipient months	\$204.50	\$215.57	\$218.07
Average TANF child cost per recipient months	\$101.60	\$99.99	\$95.41
<b>Pregnant Women Risk Group</b>			
Average pregnant woman recipient months per month	102,736	112,234	128,350
Average pregnant woman cost per recipient months	\$526.81	\$548.09	\$564.43
<b>Children and Medically Needy Risk Groups</b>			
Average child recipient months per month	1,300,952	1,531,141	1,774,322
Average medically needy recipient months per month	45,657	43,731	52,464
Average child cost per recipient months	\$139.73	\$129.23	\$127.61
Average medically needy cost per recipient months	\$626.43	\$406.77	\$390.24
<b>Health Steps (EPSDT) Medical</b>			
Average THSteps (EPSDT) medical recipient months per month	605,072	655,417	723,183
Number of newborns receiving hearing screens	381,705	391,298	401,504
Average cost per THSteps (EPSDT) medical recipient months per month	\$117.45	\$116.76	\$122.75

Source: Texas Health and Human Services Commission, *HHSC Legislative Appropriations Request (LAR) FY 2006-2007*, available at [http://www.hhsc.state.tx.us/about\\_hhsc/finance/FY06-07\\_LAR/LAR\\_TOC.html](http://www.hhsc.state.tx.us/about_hhsc/finance/FY06-07_LAR/LAR_TOC.html), accessed January 13, 2005.

Note: Table does not include the following Medicaid strategies: STAR+PLUS, Medicare payments, cost reimbursed services, Medicaid vendor drug program, medical transportation, Medicaid family planning; health steps dental and health steps comprehensive care program, and State Medicaid Office.

Medicaid beneficiaries in Texas are enrolled in either traditional fee-for-service (FFS) Medicaid or a Medicaid managed care program, depending on their location and other factors. Managed care is an arrangement where specific health care providers agree to provide coordination and health services to a defined group of people for a specified payment per person. It has four main features that differ from FFS. 1) Managed care has primary care providers (PCPs) that provide a medical home and coordinate care for patients, 2) managed care uses a defined network of providers that the company has contracted with, so patients' choice of providers is limited, 3) managed care uses utilization review and utilization management to monitor and control services and costs, and 4) capitation is used under managed care to buy health care services at a fixed per person price, therefore the managed care organization is assuming risk if treatment costs rise above the fixed payments.<sup>108</sup>

Texas uses two different models for managed care delivery, health maintenance organizations (HMO) and primary care case management (PCCM). HMOs are licensed by the Texas Department of Insurance and receive a monthly capitation payment for each enrollee based on an estimate of average medical expenses. PCCM is a non-capitated model where each



enrollee is assigned a primary care provider (PCP), who must authorize most other services for the person before they will be paid by Medicaid. The state sets up the provider networks and contracts directly with them, and reimbursement is fee-for service, plus a small monthly case management fee for PCPs. Over one-third of Texas Medicaid clients are enrolled in managed care, and nationally, over half of enrollees are in managed care—only three states do not have managed care programs.<sup>109</sup>

House Bill 7 was passed by the Texas Legislature in 1991 to authorize Medicaid managed care pilot programs to try to control rising health care costs. The first two managed care pilots were implemented in 1993 in Travis County and in the tri-county area of Jefferson, Chambers, and Galveston Counties (three more counties were added to the tri-county pilot in 1995). In 1995, Senate Bill 10 and related legislation was passed to restructure Medicaid statewide and incorporate managed care, and the state accomplished the managed care expansion through 1915(b) waivers. The managed care program, or STAR (State of Texas Access Reform) was expanded again in 1996 to add additional counties and populations.<sup>110</sup>

In 1997, the STAR program was expanded in Harris County to include acute care and long-term care services for SSI clients, and this pilot is called STAR+PLUS. In 1999, Senate Bill 2896 put a moratorium on further expansion of managed care, after the Dallas and El Paso implementations were finished, and directed HHSC to evaluate Medicaid managed care in Texas (the moratorium was lifted after the evaluation was finished in 2001 and expansion was allowed where cost-effective). Part of the Dallas area project includes a unique behavioral health managed care pilot called NorthSTAR, which provides behavioral health and substance abuse services to Medicaid enrollees and certain other people below 200 percent FPL.<sup>111</sup>

## **Texas SCHIP Program Information**

As of November 1, 2004, there were 340,101 children enrolled in SCHIP in Texas.<sup>112</sup> Parents can mail in an application for SCHIP for their children or apply over the phone, and most children must wait 90 days before their benefits can begin.<sup>113</sup> If approved, parents must choose a health plan (if there is more than one to choose from in their location) and a primary care doctor for their enrolled children. SCHIP benefits last for six months, at which time parents need to send in a renewal form for their children if they remain eligible. Renewal can be done through the mail—parents either sign a form saying there have been no changes to their income or expenses in the last six months, or note any changes and send in proof with the renewal form.<sup>114</sup>

If approved, families pay from \$15-\$25 a month total in premiums for all their children who qualify, depending on income levels, and some people may qualify to pay no premiums. Beneficiaries pay from \$3-\$10 per office visit and \$3-\$20 per prescription, though some may be eligible to pay no copayments.<sup>115</sup> As of November 1, 2004, monthly premiums for SCHIP are temporarily suspended. A Governor's Directive was issued on August 11, 2004, to HHSC to request that it delay the implementation of a plan to disenroll families who had missed three or more premium payments, and to study effective alternatives for cost-sharing. Since it would not be fair for some families to not pay their premiums and still be eligible for services, while others with the same income levels continued to pay, HHSC suspended premium payments (not copayments for services) for all enrollees.<sup>116</sup> See the following table for the number of children in SCHIP each year since the current program started and their total costs.

**Table 6. Texas Children’s Health Insurance Program Average Caseloads and Total Costs, 2000-2005**

<b>Fiscal Year</b>	<b>Average Caseload</b>	<b>Total Cost (excluding vendor drug program)</b>
2000	28,300	\$10,549,319
2001	251,575	\$281,532,624
2002	497,705	\$574,831,539
2003	506,968	\$535,328,875
2004	409,865	\$385,363,109
2005	351,849	\$333,112,273

Source: Texas Health and Human Services Commission, “CHIP Caseload and Cost 200409- LBJ School.xls” (Excel spreadsheet, January 2005).

Notes: Prior to FY 2004, cost estimates include premiums, prescription drug (until March 2002), retroactive adjustments and supplemental delivery payments. Beginning in FY 2004, costs include premiums, retroactive adjustments, delivery supplemental payments, EPO settle-up payments, supplementals, and vaccinations. FY 2005 costs are similar to FY 2004 except that FY 2005 contains stoploss insurance payments and EPO settle-up payments.

The services that SCHIP beneficiaries can receive in Texas are the following:

- Doctor, hospital, x-ray, and lab services;
- Well-baby and well-child visits;
- Immunizations;
- Prescription drugs;
- Durable medical equipment and prosthetic devices (\$10,000 limit per enrollment period);
- Case coordination and enhanced services for children with special health care needs and children with disabilities;
- Physical, speech, and occupational therapy;
- Home health care;
- Transplants;
- Limited mental health services;
- Services that cover pre-existing conditions.<sup>117</sup>

**Recent Legislative Changes in Texas Medicaid and SCHIP**

The 78th Texas Legislature modified many aspects of Medicaid and SCHIP in 2003 in order to cut costs due to the large shortfall projected for the state’s budget. Besides directing the consolidation of the state’s health and human services agencies, House Bill 2292 contained a number of measures designed to save money in Medicaid and SCHIP, mostly by targeting eligibility and benefit reductions.<sup>118</sup> Medicaid changes due to the 2003 legislation are listed in the following table, along with the cuts that were restored in September 2004 after the Legislative Budget Board and the Governor approved HHSC’s 2004-2005 budget package in August 2004.<sup>119</sup>

**Table 7. Texas Medicaid Policy Changes, 2003-2004**

Legislation in 2003	Changes in 2004
Continued coverage for all children currently eligible for Medicaid	
Maintained the continuous eligibility period for children at six months	
Allowed more thorough procedures to verify assets to be implemented (e.g., information from consumer reporting agencies, appraisal districts, or vehicle registration records)	
Required a personal interview for initial eligibility determination if requested by the applicant; otherwise allowed a personal interview for initial eligibility determination only if eligibility cannot be determined through mail correspondence	
Required a personal interview for recertification of eligibility if requested by the recipient; otherwise allowed a personal interview to renew coverage if eligibility cannot be determined through a telephone interview or mail correspondence	
Allowed establishment of cost-sharing (i.e., co-pays and monthly premiums) based on federal maximum levels	
Required that adult cash assistance recipients comply with the personal responsibility agreement to continue to receive Medicaid coverage	
Discontinued coverage for adult pregnant women above 158% of the federal poverty level	Coverage up to 185% FPL was restored
Discontinued coverage for non-pregnant adult clients with incomes above 17% of the federal poverty level (medically needy spend-down)	
Allowed establishment of prior authorization requirements for high-cost medical services	
Directed the implementation of “disease management” efforts	
Required that medical assistance be delivered through the most cost-effective method of managed care throughout the state and that guidelines for appropriate usage of out-of-network providers be established	HHSC determined that the HMO model should be used in urban areas and PCCMs in all remaining areas not served by HMOs, and dual-model arrangements be eliminated.
Directed that a Preferred Drug List (PDL) be implemented, with prior authorization required for prescribed drugs not on PDL	
Allowed establishment of four brand-name and 34-day brand-name supply limits for clients previously eligible for unlimited prescriptions (does not affect current three-prescription limits for certain clients)	
Discontinued coverage for certain optional Medicaid services for adults over age 21: eyeglasses, hearing aids, podiatric, chiropractic, psychological services (from psychologists, therapists, counselors, and social workers)	
Established a statutory basis for estate recovery of Medicaid expenditures pursuant to federal requirements	
Discontinued reimbursement of Graduate Medical Education (GME)	GME Medicaid funds were restored to teaching hospitals
Decreased reimbursement rates by 5% for Medicaid acute care providers such as physicians, hospitals, and HMOs; Decreases reimbursement rates by 2.2% to 3.5% for non-acute care providers such as nursing homes, community care providers and ICF-MR providers	Did not reverse cuts but prevented deeper cuts from taking place: doctor’s rates were cut by 2.5%, nursing homes by 1.75%, and community care providers by 1.1% in 2004, and these were set to double in 2005 (hospital cuts remain at 5%)

Sources: Texas Health and Human Services Commission, *Medicaid Policy Changes, 78th Legislature, Regular Session, 2003* (August 2003), available at [http://www.hhsc.state.tx.us/news/post78/Medicaid\\_Policy\\_Changes.html](http://www.hhsc.state.tx.us/news/post78/Medicaid_Policy_Changes.html), accessed January 2, 2004; Center for Public Policy Priorities, *Update on Medicaid and CHIP Cuts: What Was Restored in Recent Actions?* (September 2004), available at <http://www.cppp.org/products/PP217.html>, accessed January 2, 2005; and Texas Senate Health and Human Services Committee, *Interim Report to the 79th Legislature* (December 2004, p. 17), available at [http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/rpt\\_c610\\_dec2004.pdf](http://www.senate.state.tx.us/75r/senate/commit/c610/downloads/rpt_c610_dec2004.pdf), accessed January 12, 2005.

As mentioned in the table above, funding for the Medically Needy spend-down program for parents with dependent children was discontinued in House Bill 2292. (It is inactive with the option of continuing it if sufficient funds are available.) The non-spend-down portion of the Medically Needy program is still in place (people entitled to Medicaid due to low income) as well as spend-down for pregnant women and children. The spend-down part of the program allows temporary Medicaid coverage for pregnant women and children (and before 2003 also included non-aged, non-disabled parents or caregivers with dependent children) with high medical bills who make too much to qualify for Medicaid but whose earnings after medical bills are subtracted would be reduced to qualifying levels. The qualifying level for a family of three is currently \$275 in income per month or less, as shown in Figure 1, as well as \$2000 or less in assets.<sup>120</sup>

A bill has been introduced in the 79th Texas Legislature (2005) to restore the Medically Needy program to pre-2003 levels. The fiscal note by the Texas Legislative Budget Board states the following regarding the impact of restoring this program: "HHSC projects that reestablishing the Medically Needy program would cost \$241.3 million in All Funds (\$94.9 million GR) in 2006 and \$276.4 million in All Funds (\$109.2 million GR) in 2007, with costs increasing in subsequent years. HHSC projects that the increase in average monthly recipient months (clients) would be 10,118 in 2006, 10,918 in 2007, 11,796 in 2008, 12,745 in 2009, and 13,769 in 2010."<sup>121</sup>

Many cuts were also made in the SCHIP program by the 78th Legislature in order to reduce the state budget. These changes as well as some of the cuts that were subsequently reversed are listed in the following table. These changes resulted in a dramatic drop in SCHIP enrollees in Texas after they were implemented, from 507,259 children enrolled as of September 2003 to 358,230 enrolled as of June 2004.<sup>122</sup> The number of enrollees had grown after the 77th Legislature in 2001 passed changes to simplify the program and align it closer with Medicaid enrollment, and make it easier to enroll and renew.<sup>123</sup>

**Table 8. Texas SCHIP Policy Changes, 2003-2004**

Legislation in 2003	Changes in 2004
Continued coverage for all currently covered populations, including state-funded populations	
Maintained income eligibility at 200% of Federal Poverty Level (\$36,800 for a family of four)	
Eliminated deductions to income so that eligibility is based on gross income	
Restricted eligibility for families at or above 150% of Federal Poverty Level to those with assets within allowable levels (no assets test previously)	
Allowed establishment of cost-sharing (i.e., co-pays and monthly premiums) at federal maximum levels	
Changed term of coverage (continuous eligibility period) from 12 months to 6 months	
Established a 90-day waiting period between eligibility determination and coverage (no waiting period previously)	
Reduced provider payment rates by 5%	Some rate cuts have been changed from 5% to 2.5%
Directed that a Preferred Drug List (PDL) be implemented, with prior authorization required for prescribed drugs not on the PDL	
Limited the benefit package to coverage of basic health care services	Notes: HHSC has limited authority to expand the benefit package if it remains budget-neutral; HHSC is also authorized to develop alternate financing and service delivery methods for behavioral health services.
Most behavioral health services were discontinued, except for one outpatient diagnostic visit per enrollment period, six medication management visits per enrollment period, and consultation in an inpatient or emergency setting after stabilization of an emergency condition	Some substance abuse and mental health services were restored in 2004 (effective retroactively to Sept. 1, 2003) due to concerns from the federal government.*
These services were discontinued: dental, hospice care, skilled nursing facilities, tobacco cessation programs, vision benefits (including eyeglasses and exams), chiropractic	

Sources: Texas Health and Human Services Commission, *CHIP Policy Changes, 78th Legislature, Regular Session, 2003* (September 2003), available at [http://www.hhsc.state.tx.us/news/post78/CHIP\\_Policy\\_Changes.html](http://www.hhsc.state.tx.us/news/post78/CHIP_Policy_Changes.html), accessed January 2, 2004; and Center for Public Policy Priorities, *Update on Medicaid and CHIP Cuts: What Was Restored in Recent Actions?* (September 2004), available at <http://www.cppp.org/products/PP217.html>, accessed January 2, 2005.

\* For more on substance abuse and mental health cuts in SCHIP, see Kaiser Family Foundation, *Daily Health Policy Report, State Watch: Texas To Partially Restore CHIP Program Coverage of Mental Health, Substance Use Treatment* (October 22, 2003), available at [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=20489](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=20489), accessed January 5, 2005.

A number of groups have been working to restore the cuts made to SCHIP, such as Texas Impact and the Community Action Network.<sup>124,125</sup> Recommendations have been made and bills have been filed for the 79th Texas Legislature in 2005 that aim to restore previous cuts, change other aspects of the program, or to maintain some of the previous changes. For example, the

Transition Legislative Oversight Committee made these five SCHIP recommendations in a report to the legislature in December 2004: 1) maintain six-month continuous eligibility, 2) maintain the assets test that took effect in 2004, 3) restore dental and vision benefits, 4) increase co-payments and link them directly to service benefits, and 5) require a single enrollment fee instead of monthly premiums.<sup>126</sup> Other bills have been filed to help with SCHIP funding, such as a cigarette tax with part of the proceeds going to restore SCHIP cuts.<sup>127</sup>

Several other measures were mandated by the 78th Texas Legislature to control Medicaid costs as well as enhance the effectiveness and quality of the program. These included the study and implementation of a Preferred Drug List within the Medicaid Vendor Drug Program and Disease Management guidelines for people with certain chronic diseases.<sup>128</sup>

## **Waivers and Other Expansion Initiatives in Texas**

### **Current Situation**

Texas currently has five 1915(b) waivers for Medicaid managed care and hospital contracting and seven 1915(c) waivers for home and community-based services.<sup>129</sup> Texas does not have an 1115 waiver. The state applied for an 1115 waiver in August 1995 after studying the options for controlling the state's rapidly escalating Medicaid costs. This waiver would have expanded Medicaid coverage, eligibility, and managed care. The waiver was not approved by the U.S. Health and Human Services Department for a variety of reasons, and a subsequent smaller 1115 waiver submitted in October 1996 addressing children's health care was later abandoned due to the coming of SCHIP.<sup>130</sup>

Texas Senate Bill 1156 was passed in 2001 authorizing the Texas Health and Human Services Commission (HHSC) to pursue a variety of changes and improvements in Medicaid, but it was vetoed by Governor Perry. Had it become law, it would have allowed HHSC to apply for an 1115 waiver to expand access to family planning and preventive services for women up to 185 percent FPL. Even though it would expand coverage, it was projected to save the state funds due to the enhanced 90 percent matching rate for family planning services and the fact that this population is eligible for Medicaid when pregnant.<sup>131</sup> Work on a family planning waiver had been done before this bill, and a similar bill was introduced in 2003 but did not make it out of committee. A women's health and family planning waiver is currently being considered in the 79th Texas Legislature (2005).

### **New Waivers Submitted or under Consideration**

The state has a number of expansion initiatives currently under consideration. HHSC submitted an 1115 HIFA waiver to CMS for a SCHIP premium assistance program in December 2004, and if approved, the program would begin on October 1, 2005.<sup>132</sup> This SCHIP buy-in program, authorized by House Bill 3038 of the 77th Texas Legislature and Senate Bill 240 of the 78th Legislature, would allow state and federal SCHIP funds to be used to pay part of the premiums to enroll eligible individuals into private health insurance plans. (Texas already has a premium assistance program in place for Medicaid, called HIPP, or the Health Insurance Premium Payment program.<sup>133</sup>)

The HIFA waiver would create a premium assistance option for SCHIP-eligible children and family members, if cost-effective. A flat subsidy amount would be available to all eligible children and families up to 200 percent FPL. The subsidy amount would be set at 5 percent less than the average cost per child, minus a per-child administrative cost; this is how the program will achieve budget neutrality.<sup>134</sup> The premium assistance option is expected to cover about 9,504 people.<sup>135</sup> Because this expansion could actually require higher cost-sharing for

families (through the employer's plan), it may only appeal to individuals who are eager to keep their families in the same plan.<sup>136</sup> (Note: a similar waiver done as an 1115 research and demonstration project would have to among other things maintain cost-sharing at SCHIP levels.)

There are three 1115 waivers for city-level demonstration projects authorized by House Bill 3122 of the 78th Legislature that have not been formally submitted to CMS yet, though there are plans to do so. The HB 3122 Task Force was created through this bill to explore the feasibility of the development of local expansion waivers that would seek to use local funds for the state Medicaid match to draw additional federal Medicaid matching funds to their areas.<sup>137</sup> General outlines of these waivers were submitted for preliminary review, and CMS responded that more discussion would be needed on the proposals, especially on the subject of limited enrollment options.<sup>138</sup> Currently the El Paso County Hospital District, Austin/Travis County, and Bexar County Hospital District local waivers are under review by this task force. These waivers propose to use the additional federal dollars that the local match would obtain to fund local programs to cover uninsured low-income parents not currently eligible for other programs.

The proposed Austin/Travis County waiver intends to expand designated Medicaid services to optional adults — TANF (non-disabled, 18-64) adults with dependent children. This waiver would include coverage of permanent, legal U.S. residents living in Travis County with incomes between 17 and 100 percent FPL. Budget neutrality is to be achieved through savings from implementing a reduced benefit package, and by providing a medical home, pharmaceutical management, and reduced ER visits. Savings are expected to be approximately \$565,000 in year one to over \$1,400,000 in year five.<sup>139</sup>

The Bexar County Hospital District waiver would involve a Medicaid expansion for adult health care services to needy parents (aged 21 to 64) of children on Medicaid to promote independence from welfare by providing a health care safety net for working poor between 14.4 and 100 percent FPL (optional population). The waiver proposes the use of an existing Medicaid HMO. Reenrollment would be required at 12 months. The waiver would seek to waive statewideness, freedom of choice, and cost-sharing. Budget neutrality is expected to be met through savings achieved by providing services through a medical home and using continuous eligibility versus the existing Medicaid program. Savings are expected to be \$272,000 in year one and projected to be \$4,418,000 over the five-year waiver period. Planners project enrollment of 2,500 participants in year one with annual increases to an enrollment of 5,000 in year five.<sup>140</sup>

The El Paso County Hospital District Waiver would expand Medicaid coverage to TANF and SCHIP adults (21 to 64 years) in the El Paso service delivery area between 14.4 and 200 percent FPL. The waiver would also restore the medically needy program for this area, and may try to expand coverage to a “select number of childless adults” (ages 21-64).<sup>141</sup> This waiver program would utilize an existing managed care model in the service delivery area for the TANF/SCHIP adults and would use a fee-for-service model for the medically needy program. The waiver would use health risk assessments, preventive services, simplified and continuous enrollment, and *promotores* to help achieve budget neutrality. Matching funds would come from funds currently earmarked for the hospital district's public hospital.<sup>142</sup>

Other waiver initiatives in the state over the past few years included an HIV waiver and a disability waiver. Both of these waivers would have extended Medicaid coverage to persons within these targeted populations. However, waiver focus at the federal level has shifted away from disease-specific waivers and instead has concentrated efforts on HIFA-type waivers. Neither the disability or HIV waiver proposals are currently “alive.”

As noted previously, a women's health waiver (which would receive the 90 percent match for qualified family planning services) has been developed and considered at various times over the past several years. Legislation is not necessarily needed for HHSC to pursue such a waiver, provided HHSC, the Governor, and the Legislative Budget Board agree to the program. In the 79th Texas Legislature (2005), legislation has been introduced to educate decision-makers and to build support for the concept. Waiver proponents suggest that had the 2001 legislation been implemented, Texas would have saved \$122 million in fiscal year 2005.<sup>143</sup> See Appendix C for a fiscal analysis of the current women's health bill. This analysis by the Legislative Budget Board concludes that the demonstration project as introduced in Senate Bill 747 would have "a positive impact of \$135,207,202 through the biennium ending August 31, 2007."

Women's health proposals seek to take advantage of the 90 percent federal Medicaid match as well as the "cost-beneficial nature of family planning services" to expand women's health and family planning services to millions of low-income and uninsured women at or below 185 percent FPL.<sup>144</sup> Waiver proponents point out that less than 25 percent of the over 4 million eligible women in Texas (at or below 185 percent FPL) receive care because of the lack of affordable care and/or affordable insurance, because the Medicaid income eligibility level for non-pregnant women is currently much lower. The waiver is expected to meet budget-neutrality requirements, and to produce significant cost savings, as the costs for services would be offset by savings from otherwise Medicaid-paid prenatal care, deliveries, and newborn care. Additional cost savings are expected due to early detection and treatment of breast and cervical cancers.

## ***Impact of Initiatives and Strategies for Texas***

### **Possible Federal Changes**

The Bush Administration and Mike Leavitt, Secretary of the Department of Health and Human Services, want to make major changes to Medicaid in the next year. A conversion to block grants has been one of the proposals in the past. As discussed in a previous section, critics argue that block grants create inequities for low-income people who are no longer guaranteed coverage even if they qualify due to imposed caps, and they discriminate against fast-growing states because federal funding would be locked in to certain fixed amounts. Planned periodic increases in the grants may not correspond to the growth in population or be responsive to higher costs, spending levels, or economic downturns in a state. And for states with a relatively low level of expenditure using historic allocations for the future base can be particularly unfair. If on the other hand federal funds were allocated based on the number of low-income persons in the state or some similar method there might be a circumstance under which block grants would make short-term sense in a state like Texas.

In addition to the FMAP floor issue discussed in the federal section (the 50 percent minimum for matching being an indirect subsidy to richer states), people have argued that a state's number of people in poverty should be a factor in the formula for a state's matching rate instead of the state's average income.<sup>145</sup>

### **Leveraging Local Funds**

There are thousands of local governmental units in Texas and many spend money on health care services for the uninsured. One idea that keeps coming up is to find a way to use these local dollars as part of the state match for Medicaid or SCHIP in order to draw down additional matching federal funds. There are several federal restrictions on using local money for the state match, but it can be done if it meets the following criteria: 1) at least 40 percent of the state



share of the match must come from the state (so 60 percent can be local), 2) federal dollars such as grant money cannot be used for the state match, and 3) limitations on voluntary contributions and provider-specific taxes (no contributions allowed and provider taxes can comprise no more than 25 percent of the state match).<sup>146</sup>

The Centers for Medicare and Medicaid Services (CMS) has indicated that it will give states flexibility with waiver design, but any proposed geographic variability in services, such as might happen with matching local funds, must meet certain criteria and will be handled on a case-by-case basis. No currently approved HIFA waivers leverage local funding, but six states require local governments to help finance Medicaid service costs, four require them to help with administrative costs, and 12 require both (Texas does not require any local participation). Government officials interested in leveraging local funds should do the following: 1) quantify the amount spent by local governments on health care for the uninsured, 2) develop a conceptual model for the expansion and present it for comments, 3) solicit public input, and 4) obtain formal approval from CMS.<sup>147</sup>

The following table provides financial information for the hospital districts in the five largest urban areas in Texas (not counting the new the Austin/Travis County hospital district). Though these entities represent a majority of the local funding collected for health care, not included here are over 100 smaller hospital districts and public hospitals, and over 100 county indigent health care programs, which counties are required to have if they are not part of a hospital district.

**Table 9. Funding Information for Five Large Hospital Districts, FY 2002**

Hospital/Hospital District	Total Revenue	Revenue from Local Property Taxes	Transferred to State for DSH	Net Revenue from DSH
Harris County Hospital District (Harris County)	\$588,100,000	\$315,600,000	\$116,093,329	\$25,367,343
JPS Health Network (Tarrant County)	\$309,668,000	\$170,557,000	\$22,759,514	\$26,749,572
Parkland Health and Hospital System (Dallas County)	\$743,528,000	\$310,236,000	\$100,442,003	\$51,438,695
Thomason General Hospital (El Paso County)	\$176,229,032	\$36,346,435	\$26,936,630	\$14,037,343
University Health System (Bexar County)	\$371,749,000	\$124,078,000	\$56,842,156	\$19,341,187

Sources: first two columns: Morningside Research and Consulting, Inc., *Comparison of Texas Hospital District Costs, Report to the Technical Advisory Committee* (August 2002, p. 6), available at <http://www.morningsideresearch.com/HDComparisonAug29.pdf>, accessed January 5, 2005. Second two columns: Texas Health and Human Services Commission, “Final Non-State DSH Hospitals, 2002” (Excel spreadsheet).

Local entities in addition to the three local 1115 waivers described previously are considering how to draw down more Medicaid funding. Dallas County Hospital District, for example, hired Health Management Associates, who reported that if the State Medicaid Plan could be reworked, the \$110 million the hospital district spent on low-income health services in unmatched local funds could be matched by an additional \$225 million in federal money. Strategies they believe could draw down additional funds include the following:

- 1) Increasing Parkland Hospital's charge structure could draw down up to \$16 million in additional federal funds through the Upper Payment Limit program.
- 2) Using SCHIP funds to provide prenatal care to undocumented immigrants to pay for prenatal care (currently being paid entirely from local funds)—seven other states currently have such plan amendments approved by CMS. Health Management Associates estimates this could yield an additional \$7 to \$9 million.
- 3) Increasing Medicaid payments to physicians affiliated with Parkland Hospital would bring in an unspecified amount (this would require an agreement with the University of Texas Southwestern Medical Center that this would reduce its need for funding from the hospital district).
- 4) Increasing rates for Parkland Health and Hospital System's HMO is estimated to bring in \$5.6 million with a 5 percent increase in premiums.
- 5) Dallas County could pay the state share of Medicaid UPL payments to private DSH hospitals in Dallas County. Health Management Associates estimates that the available UPL capacity of these private DSH hospitals is about \$412 million.<sup>148</sup>

## **Medicaid and SCHIP Expansion Options for Texas**

### **Sections 1931 and 1902(r)(2)**

One of the easiest mechanisms Texas could use to expand coverage is to take advantage of Section 1931 and/or Section 1902(r)(2) of the Social Security Act. As described previously, Section 1931 of the SSA allows states to extend Medicaid coverage to low-income families with children (above the TANF limits) by income and asset disregards. To expand coverage to these parents, all that is needed is an amendment to the State Medicaid Plan, and this method allows the state to cap enrollment and to alter the benefits. Similarly, Section 1902(r)(2) allows a state to use less restrictive income and resource methodologies when determining eligibility for Medicaid. This can also be done through a state plan amendment. Both of these options require additional state general revenue (GR) match dollars.

### **Women's Health Waiver**

As mentioned previously, a women's health waiver has been proposed and is being considered in the 2005 Texas Legislature. This would expand women's health and family planning services to millions of women at or below 185 percent FPL, and would receive a 90 percent federal Medicaid match for qualified family planning services. Appendix C contains a fiscal analysis of the current women's health bill by the Legislative Budget Board that concludes that the demonstration project as introduced in Senate Bill 747 would save the state over \$135 million through the biennium ending August 31, 2007.

### **Elimination of Income Disregards/Assets Tests for SCHIP**

The 78th Texas Legislature implemented a number of policy changes that led to a decline in the number of SCHIP-covered children in Texas. Among these changes were the elimination of income disregards and the implementation of asset testing. In order to expand coverage Texas could eliminate these recent changes.

## Reinstating the Medically Needy Spend-Down Eligibility for Parents

As noted previously, funding for the Medically Needy spend-down program for parents with dependent children was discontinued in 2003, leaving a spend-down option only for pregnant women and children. The spend-down part of the Medically needy program allows temporary Medicaid coverage for pregnant women and children (and before 2003 also included non-aged, non-disabled parents or caregivers with dependent children) with high medical bills who make too much to qualify for Medicaid but whose earnings after medical bills are subtracted would be reduced to qualifying levels. A bill has been introduced in the 2005 Texas Legislature to restore the Medically Needy program to pre-2003 levels in order to offer coverage to families with serious medical problems who need it most. The fiscal note to House Bill 710 states the restoring these benefits is estimated to cost \$241.3 million in All Funds (\$94.9 million GR) in 2006 and \$276.4 million in All Funds (\$109.2 million GR) in 2007, with increases in subsequent years, and that the people served (in average monthly recipient months) would be 10,118 in 2006, 10,918 in 2007, 11,796 in 2008, 12,745 in 2009, and 13,769 in 2010.<sup>149</sup>

## Hypothetical 1931/HIFA

Another expansion option for Texas takes advantage of the flexibility afforded in HIFA waivers to expand to both the 1931 (optional) population and to an additional (expansion) population of non-disabled, childless adults. Basing the HIFA cost savings on a hypothetical 1931 expansion to the full Medicaid package of benefits (that would be more costly to the federal government for less coverage), the state could offer a reduced benefit package to the 1931 population and with the “savings” cover additional childless adults.<sup>150</sup> See Appendix D for more details and estimated costs and impacts of possible alternatives. Also, note that if this waiver option were implemented, the Medically Needy spend-down eligibility could be extended to adults not living with dependent children, which could help reduce uncompensated care in hospital emergency rooms and help fund trauma care.

## Ticket to Work

The Ticket to Work Program, established in 1999 through the Ticket to Work and Work Incentives Improvement Act, was designed to support individuals with disabilities in their employment and help with employment retention efforts using infrastructure and demonstration grants to provide Medicaid and other services to eligible individuals. Texas was approved by CMS in 2001 for a demonstration grant to initiate a Ticket to Work project in two urban areas, Harris and Tarrant counties. The project would have provided Medicaid services (a somewhat reduced benefit package) to working individuals with schizophrenia, bipolar disorder or major depression, ages 18 to 64, who were not yet able to meet the SSI disability test.<sup>151</sup> However, the 78th Legislature did not appropriate the state matching funds for the expansion project.

## Covering Legal Permanent Residents

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) required states to implement a five-year wait period for legal permanent residents arriving after August 1996 to receive Medicaid or SCHIP. The act left it to the states' discretion to allow coverage after the five years. To date, Texas has not taken advantage of this coverage expansion option. This option requires only a state plan amendment.

## Prenatal Care under SCHIP

Texas could submit an amendment to the SCHIP State Plan that would allow the state to expand SCHIP eligibility to unborn children who meet certain criteria, regardless of the eligibility status of the mother, including unborn children of low-income undocumented pregnant women. These women and unborn children could receive prenatal care and other related services.

Safety-net hospitals throughout the state already provide prenatal care to some of this population using local dollars, so having SCHIP cover them would allow federal matching funds to be obtained to cover a majority of these expenses. The definition of “child” for SCHIP purposes was revised by CMS effective November 1, 2002, to include children from conception (instead of birth) to age 19, allowing for this opportunity to extend prenatal care to more women.<sup>152,153</sup> Seven states already cover this population for prenatal care.<sup>154</sup>

## Other SCHIP/Medicaid Premium Assistance Programs

Texas could develop a new public-private partnership model in which a health plan is developed specifically for small businesses. Such plans use either a state-designated board or a private insurer to administer the plan, and the state subsidizes premiums for low-income workers. This model is similar to Maine’s Dirigo Health. These plans can, using a waiver, reduce the benefit package, and take advantage of Medicaid or SCHIP funds.<sup>155</sup>

## Other Options

Several states, such as Florida, are proposing a fundamental restructuring of their Medicaid programs to control growing costs. Florida Governor Jeb Bush recently outlined a program where the state would pay the premiums for Medicaid beneficiaries to enroll in private health plans offered by insurance companies and HMOs, including an employer’s plan if a beneficiary has access to employer-sponsored insurance. Gov. Bush said the state can predict and control costs better by calculating a premium for each Medicaid patient and allowing for an appropriate rate of growth. Since the state would pay the health plans instead of the providers directly, this new government-funded insurance program would have to be approved by the state and the federal government, and the governor hopes to get these approvals by the end of 2005. He said it is not clear yet whether federal approval will include a cap on federal funds and if so, if the state or patients would be required to pay more if costs increase more than expected.<sup>156</sup>

In the Florida proposal, the private plans would set limits on care and coverage, and savings is expected to come from competition between plans for patients. Basic services covered currently (mandatory and optional Medicaid services) would still be covered, and health plans could offer additional services to attract patients, giving them a choice on the best plans for their health situations. Beneficiaries who take responsible health measures, like participating in disease management programs or immunizing their children, could earn credit for enhanced Medicaid services like over-the-counter drugs. There would be a cap on Medicaid benefits to decrease some of the financial risk for insurers, and patients who reached the cap would be covered by a catastrophic care fund created from a percentage of premiums.<sup>157</sup> A concept paper was published in March 2005 outlining the proposed reforms,<sup>158</sup> and legislation is being considered by a committee of the Florida House of Representatives to allow the state to apply for an 1115 waiver to implement some of the changes.<sup>159</sup>

More ideas for dramatic changes to Medicaid are likely to be developed by states as many struggle with rapidly growing costs.

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<sup>89</sup> Senate Finance Interim Subcommittee on Graduate Medical Education, *Final Report on Medicaid Disproportionate Share Hospital Funding* (Austin, Tex., May 2000, pp. 7-8), available at <http://www.lrl.state.tx.us/scanned/interim/76/f49meh.pdf>, accessed January 1, 2005.

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<sup>93</sup> Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.* (2004, pp. 5-9, 5-10), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed December 12, 2004.

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<sup>103</sup> Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th ed.* (2004, p. 3-19), available at <http://www.hhsc.state.tx.us/medicaid/reports/PB5/PinkBookTOC.html>, accessed December 14, 2004.

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<sup>105</sup> Texas Health and Human Services Commission, *Texas Medicaid Enrollment by Sex and Race/Ethnicity as of September 2004, Updated October 2004*, available at <http://www.hhsc.state.tx.us/research/dssi/LatestEnrollmentbyRaceSex.html>, accessed November 15, 2004.

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**Medicaid and the State Children's Health Insurance Program in Texas  
Appendix A. Status of Eligibility in State Plans as of 2002**

<b>States by Groupings with Current Eligibility Levels for Children, Parents, and Nonparents</b>						
	<b>Children</b>	<b>Parents<sup>a</sup></b>	<b>Non-parents</b>	<b>Expansion Type</b>	<b>100 hour rule elimination?</b>	<b>Notes</b>
<b>Group I</b>						
Arizona	200%	200%	100%	1115/HIFA	Yes	HIFA parent expansion (100-200%) scheduled to begin October 1, 2002.
Connecticut <sup>b</sup>	300	150	—	1931	Yes	At 185% when legislation initially passed, but scaled back to 150% prior to implementation.
Delaware	200	100	100	1115	Yes	
Hawaii	200	200	100	1115	Yes	
Massachusetts <sup>b</sup>	200	200	133	1115	Yes	Other coverage up 400% (Medical Security Plan).
Minnesota <sup>b</sup>	275 <sup>c</sup>	275	175	SCHIP 1115	Yes	
New Jersey	350	200	100	SCHIP 1115	Yes	
New York <sup>b</sup>	250	150	100	1115	Yes	
Oregon <sup>b</sup>	170	100	100	1115/SF	Yes	State plans to submit HIFA waiver.
Rhode Island <sup>b</sup>	250	185	—	SCHIP 1115	Yes	
Tennessee	400	400	400	1115	No	Enrollment for adults closed since 1995. Pending waiver will scale back to 250%.
Vermont <sup>b</sup>	300	185	150	1115	Yes	
Washington <sup>b</sup>	250	200	200	SF	Yes	Submitted 1115/HIFA waiver to receive match for state funded populations.
<b>Group II</b>						
California <sup>b</sup>	250	100	—	1931	Yes	State's budget crisis indefinitely delayed SCHIP 1115/HIFA expansion to parents to 200%.
Georgia	235	64	—	—	Yes	
Maine	200	150	—	1931	Yes	
Maryland	300	44	—	—	Yes	
Missouri	300	100,125	—	1115	Yes	Custodial parents up to 100%, non-custodial parents actively paying child support up to 125%.
New Hampshire <sup>b</sup>	300	64	—	—	No	No 100-hour rule elimination; recipient remains eligible to 102%.
New Mexico	235	60	—	—	Yes	
Ohio	200	100	—	1931	Yes	
Pennsylvania <sup>b</sup>	235	68	—	—	Yes	
Utah	200	150	150	HIFA	Yes	Comprehensive care only to TANF families; other adults eligible for only primary care services.
Wisconsin <sup>b</sup>	185	185	—	SCHIP 1115	No	No 100-hour rule elimination for Medicaid, but two parent working families are eligible through BadgerCare; recipient remains eligible to 200% FPL.

States by Groupings with Current Eligibility Levels for Children, Parents, and Nonparents						
	Children	Parents <sup>a</sup>	Non-parents	Expansion Type	100 hour rule elimination?	Notes
<b>Group III</b>						
Alabama	200	31	—	—	Yes	
Alaska	200	82	—	—	Yes	Recipient remains eligible to 124%.
Arkansas	200	22	—	—	Yes	No 100-hour rule elimination for Medicaid; recipient remains eligible to 54%.
Florida	200	33	—	—	Yes	Recipient remains eligible to 68%.
Indiana	200	32	—	—	Yes	Eligibility threshold at 100% for TANF families.
Iowa <sup>b</sup>	200	90	—	—	Yes	
Kansas <sup>b</sup>	200	42	—	—	Yes	Recipient remains eligible to 65%.
Michigan <sup>b</sup>	200	66	—	—	Yes	State plans to submit HIFA waiver.
Mississippi	200	39	—	—	Yes	Recipient remains eligible to 57%.
Nevada	200	59	—	—	Yes	Allows 134% for the first three months of coverage and then eligibility drops to 59%.
North Carolina	200	64	—	—	Yes	
South Dakota	200	68	—	—	Yes	
Texas	200	34*	—	—	Yes	Allows 45% for the first four months of coverage and then eligibility drops to 34%.
Virginia	200	32	—	—	Yes	Recipient remains eligible to 47%.
<b>Group IV</b>						
Colorado	185	43	—	—	Yes	
Idaho	150	35	—	—	Yes	
Illinois	185 <sup>c</sup>	58	—	—	Yes	Recipient remains eligible to 96%. Pending HIFA waiver.
Kentucky	200	52	—	—	No	100-hour rule applied to applicants only; recipient remains eligible to 77%.
Louisiana	200	22	—	—	No	No 100-hour rule elimination for Medicaid.
Montana <sup>b</sup>	150	71	—	—	Yes	
Nebraska	185	45	—	—	No	No 100-hour rule elimination for Medicaid.
North Dakota	140	89	—	—	Yes	Allows 151% for the first six months of coverage and then eligibility drops to 89%.
Oklahoma	185	50	—	—	No	No 100-hour rule elimination for Medicaid.
South Carolina	150 <sup>c</sup>	56	—	—	Yes	
West Virginia	150	46	—	—	No	No 100-hour rule elimination for Medicaid.
Wyoming	133	67	—	—	Yes	
<p>a. FPL levels for parent coverage estimated by the dollar amount for a family of three. Kathleen A. Maloy, Kyle Anne Kenney, Julie Darnell, and Soeurette Cyprien, <i>Can Medicaid Work for Low-Income Working Families?</i> (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2002).</p> <p>b. State has a medically need program with an eligibility level at 60% FPL or higher.</p> <p>c. State offers coverage at a higher level for infants. Minnesota, 280% FPL. Illinois, 200% FPL. South Carolina, 185% FPL.</p>						

Source: John Holahan and Mary Beth Pohl, *States as Innovators in Low-Income Health Coverage* (The Urban Institute, June 2002, Table 1), available at <http://www.urban.org/url.cfm?ID=310519>, accessed February 10, 2005.

\* In Texas, the Medicaid eligibility level for parents with dependent children is \$188 per month for a family of three (\$308 per month if one parent is working). This is a fixed dollar cap that does not increase with inflation or change in the federal poverty level. It was last increased by the Texas Legislature in 1985. In 2005, this income cap equals a cut-off level of 14 percent FPL for a family of three (23 percent if one parent works). [Source: Anne Dunkelberg, e-mail to Kristie Kimbell, March 24, 2005.]

Notes on table: “SF” means state-funded (all state funds, no federal funds used like in Medicaid and SCHIP). The four groups above are designations by the authors dividing the states into groups from most innovative (group I—highest eligibility levels) to least innovative (group IV—have not expanded coverage beyond minimum requirements for public programs or have not eliminated the 100-hour rule). The mandatory “100-hour rule” was eliminated by the U.S. Department of Health and Human Services in 1998, allowing states to change family composition rules to expand coverage regardless of the employment status of the parents; previously, two-parent families could be eligible for Medicaid only if the primary wage earner worked fewer than 100 hours per month or was incapacitated.



## ***Medicaid and the State Children's Health Insurance Program in Texas: Appendix B. Local Participation in Health Coverage***

The Texas Constitution requires counties to participate in the provision and financing of public health care for the indigent. Prior to 1985, however, Texas law contained no specific provisions regarding the definition of indigency or the extent of the health care services to be provided.<sup>1</sup> By 1983, ambiguous state statutes regarding county responsibility had led to disparate tax burdens and service provisions. This prompted the governor, lieutenant governor, and house speaker to convene the Task Force on Indigent Health Care to study medical indigency in Texas. The task force was charged with examining a potential indigent program in terms of scope of services, eligibility criteria, administrative structure and method of finance.

The task force's findings were presented in the Task Force on Indigent Health Care Final Report in December 1984. The general findings that the lack of uniformity in the definition of indigency across counties, the disproportionate provision of services statewide, and the subsequent lack of equitable financial burden, among others, led the task force to recommend expanded coverage and enhanced service provision, a uniform definition of eligibility, and greater equity of burden.<sup>2</sup>

The task force findings and recommendations led to the Indigent Health Care and Treatment Act of 1985 (Chapter 61 of the Texas Health and Safety Code), which specifies that a county would meet its health care responsibility for indigent residents in one of three ways: 1) by creating a hospital district, 2) by running a public hospital, or 3) by operating a county indigent health care program (CIHCP).

Hospital districts are special taxing districts created for the sole purpose of providing health care to people who reside within their boundaries. They are created through state legislative amendment or through county voter approval. The maximum state allowed tax rate is 75 cents per \$100 of property valuation. Public hospitals are hospitals owned, operated, or leased by a county or municipality, other than a hospital district, with geographical service districts for which they have a legal obligation to provide health care services. Unlike hospital districts, local tax support for hospitals is not always dedicated. A CIHCP is the third mechanism for a county to meet its indigent care obligation; it includes the provision of health care for some or all (dependent on presence of public hospital/hospital district) of the county's indigent residents.

Hospital districts and public hospitals are legally responsible for care to indigent individuals in a set service area. The service area may cover the entire county or cover only part of a county. A county not fully served by a hospital district or a public hospital, or served by neither, must establish a CIHCP. The act created a list of required basic health care services for counties with CIHCPs.<sup>3</sup>

There are 142 counties with CIHCPs, 131 hospital districts, and 23 public hospitals. These numbers do not total to the exact number of Texas counties as some counties are covered by more than one type of indigent care entity and some types cover more than one county.<sup>4</sup>

For CIHCPs, the Indigent Care Act defined "indigent" in terms of income and assets, originally 17 percent of the FPL; however, hospital districts and public hospitals were originally given complete freedom to self-determine eligibility standards and services provided. This led some to provide expansive services and others to provide very limited or no services. This "freedom" was restricted in 1999 with HB 1398 (described below) which required both hospital districts and public hospitals, at a minimum, to provide care to individuals with incomes below 17 percent of

the FPL. In 2001, the minimum requirement was raised to 21 percent (21 percent of the FPL for a family of one is \$167 as of April 1, 2005).<sup>5</sup> The CIHCP counties were also allowed to provide additional services or to provide services to individuals at higher income levels, however, initially they had no requirement to do so.<sup>6</sup> Application processes and procedures are now consistent with the procedures used to determine eligibility in the TANF program.<sup>7</sup>

Hospital districts and public hospitals get their money from several sources: 1) local taxes (ad valorem, sales and use); 2) the state Tertiary Care Fund; 3) private paying individuals; 4) third party payers; 5) a portion of tobacco settlement resources; and 6) two federal programs — DSH and GME. Counties served wholly or in part by a CIHCP are eligible for state matching funds. To be eligible for the matching funds, these counties must first spend a set percentage of their general revenue tax levy (GRTL), originally 10 percent, on health care for indigent persons.<sup>8</sup>

### **House Bill 1398**

In 1999, the Indigent Health Care Act was amended by HB 1398. HB 1398 reduced the amount a county must spend on their CIHCP from 10 percent to 8 percent of GRTL before being eligible for state assistance funds to pick up much of their subsequent costs. The state reimbursement rate is 90 cents for each dollar spent. Additionally, HB 1398 removed the disincentive to provide care to individuals at higher income levels by allowing counties to receive “credit” for these expenditures in order to draw down the state match funds. Counties can now also receive credit for services deemed to be cost effective, but not necessarily on the list of required basic health care services. These provisions gave counties more flexibility, added an accountability mechanism and afforded financial incentives to provide health care to the medically indigent.<sup>9</sup>

In 2003, state legislators approved a \$1.6 million per year (2004-2005 biennium) reduction in state matching funds available to counties who spend over the required 8 percent of GRTL. The appropriation for each year of the biennium was \$5.6 million, whereas, in 2002, the 25 counties receiving the state matching funds received a combined total of \$7.2 million. Such reductions were expected to have a negative impact on counties who might face the decision to raise taxes or limit services. Paradoxically, counties are both legally required to provide indigent care services and legally constrained regarding taxing amounts. Compounding the dilemma is the growing number of uninsured in the state, particularly given the most recent cuts to Medicaid and SCHIP.<sup>10</sup> However, the county is not liable for payments for health care services provided to its eligible residents once the county reaches the 8 percent expenditure level if the state fails to provide assistance funds.<sup>11</sup>

According to state department of health figures, the state had a total of approximately \$6.4 million available for the SFY 2004, including a \$1.3 million fund transfer in June 2004. The 20 counties requesting state matching funds had a combined request total of over \$5.5 million, apparently leaving a little over \$0.8 million in unused funds. The combined expenditures of all counties reporting for SFY 2004 was over \$63.9 million. That amount, less the state reimbursed amount, leaves over \$59.5 million in indigent care provided by counties. Twenty-one counties had expenditures exceeding 8 percent of their GRTL for 2004. Another 18 counties spent between 6 and 8 percent of their GRTL.<sup>12</sup> Until recently, the bulk of the state assistance funds went to two counties in south Texas, Hidalgo and Cameron. In the 2004-2005 appropriation bill for TDHS, Rider 53 imposed a cap on the distribution of assistance funds to one county. The cap was set at 35 percent of the total funds appropriated.<sup>13</sup>

## **Graduate Medical Education Program**

Another, albeit indirect, mechanism for the provision of indigent health care in Texas is the Graduate Medical Education (GME) program. GME funds are provided to teaching hospitals by the federal government to help offset the costs associated with the training of medical students (the payments are provided as a supplement to regular Medicaid and Medicare payments). The GME payments have effectively enabled teaching hospitals, many of them public hospitals or hospital district hospitals, to provide medical care to the medically indigent, by allowing them to increase their staff using medical and surgical residents. Changes to this program in recent years may have limited this provision of services.

## **Disproportionate Share Hospital Program**

It should also be briefly noted that hospitals providing a disproportionate share of health care to indigent individuals may also receive Disproportionate Share Hospital (DSH) funds to partially compensate them for their services. The disproportionate share program is discussed in detail in the main text of this paper.

## **Tobacco Settlement Trust Fund**

Counties also receive some funds from the state's settlement in 1998 with tobacco companies, which established the Tobacco Settlement Trust Fund. Counties, cities, and hospital districts signed an agreement reserving some funds for entities responsible for the provision of indigent health care — hospital districts, other local political subdivisions owning and maintaining public hospitals, and counties in Texas. The total settlement amount of \$2.8 billion was to be received over a five-year period. The funds were split into two payment methods, a series of lump-sum payments and a trust fund. The lump sum payments paid a total of \$450 million over 1999-2001.<sup>14</sup> Another \$1.8 billion was deposited in a permanent trust fund. The return on trust fund investments is to be paid to counties in perpetuity, depending on how much unreimbursed care each provides. In 2001, the first year of interest payments, a total of \$13 million was paid. County tobacco money has no spending requirements, except within hospital districts, which must use it for health care.<sup>15</sup> As a whole, in 1999, counties (those who reported) spent at least \$940 million of tobacco money on indigent health care.

SFY 2002 was to be the first year in which tobacco payments to counties were solely from the permanent trust fund created with the initial amount of \$1.8 billion. However, due to the poor economic circumstances of 2001 and heavy investment of the fund in stocks, the fund not only failed to gain interest, it lost a net \$30 million in principal.<sup>16</sup>

## **Other Indigent Health Care Providers**

Other providers of indigent health care services in the state include non-profit and for-profit private hospitals (322 in 1997) and clinics, state facilities (hospitals run by state agencies and clinics — MHMR, TDH, prisons), hospitals and clinics run by public universities (e.g., UTMB), specialty services (HIV/AIDS), federally qualified health centers (FQHCs), rural health clinics, free clinics, private physicians, and local health departments. Together these entities provided roughly \$4.3 billion in uncompensated health care in 1997. While this figure is dated, it is a good indication of the extent to which these other resources are contributing to indigent care in Texas.

Funding for these entities comes from a variety of sources. For private hospitals, revenue comes primarily from payers — out-of-pocket payers, insurance companies, DSH, Medicare and Medicaid. The state facilities are funded through these same means but also through state

general revenue funds and some federal programs. Special facilities and community and rural health centers/clinics are largely funded through federal money (Title V, Title X, Ryan White, block grants, Medicare and Medicaid) along with the state matching dollars. Local health departments rely on federal, state, and local funding sources for their programs. Free clinics on the other hand rely on fundraising and volunteers, while private physicians' contributions to the indigent are from their own earnings.<sup>17</sup>

## **Immigrant Health Care**

According to the U.S. Census Bureau, 24.6 percent of Texas residents are uninsured.<sup>18</sup> In 2003, over half of the uninsured in Texas were Hispanic, many of whom were immigrants from Mexico. In 2002, there was an estimated 1.4 million immigrants of Hispanic origin living in Texas.<sup>19</sup> It is very difficult to know how many of the immigrants living in Texas are undocumented, however some have estimated the number at over 1 million.<sup>20</sup>

These figures are notable because Hispanics, and particularly Mexican immigrants, are overrepresented in jobs with limited or no health insurance. This is important because Medicaid in Texas does not cover recent documented immigrants or undocumented immigrants.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), made legal immigrants who entered the United States after 1996 ineligible for Medicaid for five years. PRWORA gave states the option to continue Medicaid coverage for qualified immigrant adults who entered the U.S. before the law was enacted in August 1996, which Texas did. Qualified immigrant adults entering the U.S. after August 1996 were barred from Medicaid coverage for five years from date of entry (although at that time emergency Medicaid was still available).<sup>21</sup> In the 2003 legislative session, the state's emergency Medicaid program was discontinued. States do have the option to cover post-1996 qualified adult immigrants after the five-year bar, but Texas is not yet exercising this option. Senate Bill 1156 of the 77th Texas Legislature, which Governor Rick Perry vetoed, would have, among other things, exercised Texas' option to cover post-1996 qualified immigrant adults following the five-year bar period.

Because most undocumented immigrants are low-wage earners and have very limited access to formal health care coverage (public or private), they depend largely on local or county-funded programs, community health centers (FQHCs or FQHC look-alikes), and charitable organizations. County-funded programs, which are responsible for providing health care for uninsured indigent individuals, provide services regardless of immigration status. Community health centers also play a crucial role in providing health care services to Texas' poor Hispanic and immigrant populations. Patients are only required to live within the service area, and are not asked to provide documentation regarding immigration status. In 2003, there were 35 CHCs operating 195 service delivery sites across the state, serving a total of 547,816 people, 71 percent of whom were Hispanic. Of these people, 94 percent earned less than 200 percent FPL and 76 percent earned less than 100 percent FPL.<sup>22</sup> Charitable organizations also provide services similar to those of FQHCs, however they receive little or no public funding. Examples are El Buen Samaritano and People's Community Clinic in Austin.

Health care coverage for immigrant children is also somewhat limited. States have the option to use state funds to cover immigrant children on Medicaid during the five-year bar period but Texas covers these children with SCHIP funds.<sup>23</sup> All qualified immigrant children may receive state-funded care following the five-year bar. No bar is placed on qualified immigrant children arriving before 1996. Undocumented children face greater difficulty accessing acute care, preventive, and primary care services. These children often rely on FQHCs for their health care

needs, however, there is a shortage of such facilities. While federal law excludes undocumented children from Medicaid and SCHIP enrollment, states may use SCHIP funds to provide “health services initiatives” that do not screen for immigration status, including programs aimed at migrant farm worker communities, low-income immigrant communities, newborn screening, lead testing, health education, and school health programs.<sup>24</sup>

Additionally, the Maternal and Child Health Block Grant (Title V), which provides health care funds for pregnant women, mothers, infants, and children who do not have access to adequate health care, is a significant source of health care for undocumented women in Texas. The program only requires beneficiaries to be Texas residents, not necessarily citizens, to receive prenatal care.<sup>25</sup>

### **Undocumented “Responsibility?”**

Due to the limited access to primary and preventive care for over a quarter of all Texans, growing numbers of individuals, including large numbers of immigrants, must rely on hospital emergency departments for all of their care. A recent estimate put the national figure for emergency room admissions which did not involve an actual emergency at 50 percent.<sup>26</sup> In recent years, emergency departments have consequently been increasingly unable to meet care demands.

In July 2001, then-Texas Attorney General John Cornyn ruled on an inquiry from Harris County regarding the legality of using local public funds to provide nonemergency health care for undocumented immigrants. Cornyn ruled that it was illegal.\* The attorney general’s opinion was not legally binding, and the majority of Texas hospital districts continued their policy of serving residents without regard to immigration status. In the 2003 legislative session, state and local entities were granted permission to provide services to undocumented immigrants.

In January 2004, the Tarrant County District Attorney ruled that this legislation “required” its county hospital district to provide nonemergency care to undocumented immigrants, which it had not done since 1997. In February 2004, the Montgomery County Hospital District, also considering discontinuing nonemergency services to undocumented immigrants, sought a new opinion from Attorney General Greg Abbott. Abbott ruled that while undocumented workers are eligible for public health services, they are not entitled to receive services from state funds, but may be entitled to receive services from local funds if the given hospital district permits it.<sup>27</sup> Tarrant County hospital district again discontinued preventive care services to undocumented immigrants following the attorney general’s ruling.<sup>28</sup>

### **Medicare Prescription Drug, Improvement, and Modernization Act**

The Emergency Medical Treatment and Labor Act (EMTALA) of 1985 requires hospitals participating in Medicare to medically screen all persons seeking care in hospital emergency departments, and to provide the treatment necessary to stabilize those determined to have an emergency condition, regardless of income, insurance, or immigration status.<sup>29</sup>

Currently, hospitals and other providers must absorb the costs associated with this care. Section 1011 (Federal Reimbursement of Emergency Health Services Furnished to

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\* The opinion stems from a provision in the PRWORA that required state legislatures to actively affirm their intention to provide public benefits to undocumented and other “not qualified” immigrants. Those who took issue with the Cornyn opinion claimed that the Texas Legislature had complied with PRWORA in 1997 by amending a statute requiring hospital districts to provide medical care for all indigent residents.

Undocumented Aliens) of the Medicare Prescription Drug Act is intended to help offset some of the cost to these providers for caring for undocumented immigrants and other specified aliens. The amount allotted for this relief is \$1 billion, or \$250 million per year for fiscal years 2005-2008, to be allocated to hospitals and other health care providers of emergency health services for emergency care.<sup>30</sup>

Two-thirds of the funds will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented alien apprehensions.<sup>31</sup>

## Appendix Endnotes

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<sup>1</sup> State of Texas, *Task Force on Indigent Care Final Report*, December 1984.

<sup>2</sup> Ibid.

<sup>3</sup> Caton Fenz, *Providing Health Care to the Uninsured in Texas: A Guide for County Officials* (Boston, Mass.: The Access Project, August 9, 2000).

<sup>4</sup> Email interview by Kristie Kimbell with Jan Maberry, Program Manager, County Indigent Health Care Program, Texas Department of Health, November 18, 2004.

<sup>5</sup> Department of State Health Services, *County Indigent Health Care Program*, available at <http://www.tdh.state.tx.us/cihcp/default.htm>, accessed March 24, 2005.

<sup>6</sup> Caton Fenz, *Providing Health Care to the Uninsured in Texas: A Guide for County Officials* (Boston, Mass.: The Access Project, August 9, 2000).

<sup>7</sup> Department of State Health Services, *County Indigent Health Care Program*, available at <http://www.tdh.state.tx.us/cihcp/default.htm>, accessed March 24, 2005.

<sup>8</sup> Caton Fenz, *Providing Health Care to the Uninsured in Texas: A Guide for County Officials* (Boston, Mass.: The Access Project, August 9, 2000).

<sup>9</sup> Ibid.

<sup>10</sup> Texas Association of Counties, "State Budget Reductions Will Impact Counties that Receive Indigent Health Care Assistance," *County Issues*, vol. 13, issue 9, June 6, 2003, available at [http://www.county.org/resources/library/cissue/v13\\_09/12.html](http://www.county.org/resources/library/cissue/v13_09/12.html), accessed March 24, 2005.

<sup>11</sup> House Research Organization, *Interim News (78-7)*, July 22, 2004, available at <http://www.capitol.state.tx.us/hrofr/interim/int78-7.pdf>, accessed March 24, 2005.

<sup>12</sup> Texas Department of Health, *County Indigent Health Care Program Summary for FY 2004*, available at [http://www.tdh.state.tx.us/cihcp/Spending\\_Data/Summary%20FY04.doc](http://www.tdh.state.tx.us/cihcp/Spending_Data/Summary%20FY04.doc), accessed March 24, 2005.

<sup>13</sup> House Research Organization, *Interim News (78-7)*, July 22, 2004, available at <http://www.capitol.state.tx.us/hrofr/interim/int78-7.pdf>, accessed March 24, 2005.

<sup>14</sup> Texas Department of Health, Office of Policy and Planning, *Agreement Regarding the Disposition of Tobacco Settlement Proceeds* (June 8, 1999), available at <http://www.tdh.state.tx.us/dpa/tobsett.htm>, accessed January 31, 2002.

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- <sup>15</sup> Texas Association of Counties, “Tobacco Reimbursement Funds will be Distributed Later this Month,” *TACNews*, vol. 9, no. 54 (April 6, 2001), available at <http://www.county.org/resources/TACnews/news04061.html>, accessed: January 31, 2002.
- <sup>16</sup> Charlotte Huff and Kelly Melhart, “Tobacco Fund Loss Troubles Hospitals,” *Fort Worth Star Telegram* (February 21, 2002), available at <http://www.dfw.com/mld/startelegram>, accessed February 30, 2002.
- <sup>17</sup> Caton Fenz, *Providing Health Care to the Uninsured in Texas: A Guide for County Officials* (Boston, Mass.: The Access Project, August 9, 2000).
- <sup>18</sup> Kaiser Family Foundation, Statehealthfacts.org, *Texas: Distribution of Nonelderly Uninsured by Race/Ethnicity, State Data 2002-2003, U.S. 2003*, available at <http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Texas&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+Race%2FEthnicity>, accessed March 24, 2005.
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- <sup>22</sup> National Association of Community Health Centers, *Access to Community Health Databook Texas* (2004), available at <http://www.nachc.com/research/files/tx.pdf>, accessed March 25, 2005.
- <sup>23</sup> A. Morse, National Conference of State Legislatures, *SCHIP and Access for Children in Immigrant Families* (2004), available at <http://www.ncsl.org/programs.health/Forum/pub6682.htm#schipandaccess>, accessed March 24, 2005.
- <sup>24</sup> The Center for Public Policy Priorities, *CHIP and Children who are not U.S. Citizens*, available at <http://www.cppp.org/products/policyanalysis/briefingpapers/brpchip3.pdf>, accessed March 25, 2005.
- <sup>25</sup> Maternal and Child Health Bureau, *MCHB Mission*, available at <http://mchb.hrsa.gov>, accessed March 25, 2005.
- <sup>26</sup> Guy Clifton, M.D., Herman Hospital, “Addressing Houston’s Emergency Room Crisis,” Houston, Tex., October 30, 2000, p.1 (draft).
- <sup>27</sup> Bill Murphy and Terry Kliever, “Harris County to Serve Immigrants’ Health Needs; Preventive Care Will Continue, Despite Ruling it Doesn’t Have To,” *Houston Chronicle*, July 27, 2004 (Lexis Nexis).
- <sup>28</sup> Star-Telegram.com, *Impact of Immigrants Evaluated* (January 27, 2005), available at <http://www.dfw.com/mld/dfw/entertainment/television/10747343.htm?template=contentModules/printstory.jsp>, accessed March 25, 2004.
- <sup>29</sup> Centers for Medicare and Medicaid Services, *Emergency Medical Treatment and Labor Act (EMTALA) Resource*, available at <http://www.cms.hhs.gov/providers/emtala/default.asp>, accessed March 25, 2004.
- <sup>30</sup> Centers for Medicare and Medicaid Services, CMS Legislative Summary, available at <http://www.cms.hhs.gov/mmu/HR1/PL108-173summary.asp#sec1011>, accessed March 25, 2004.
- <sup>31</sup> *Ibid.*

**Medicaid and the State Children's Health Insurance Program in Texas:  
Appendix C. Fiscal Note for Women's Health Care Waiver**

**LEGISLATIVE BUDGET BOARD  
Austin, Texas  
FISCAL NOTE, 79TH LEGISLATIVE REGULAR SESSION  
March 22, 2005**

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services  
FROM: John S. O'Brien, Deputy Director, Legislative Budget Board  
IN RE: **SB747** by Carona (Relating to establishing a demonstration project for women's health care services), As Introduced

**Estimated Two-year Net Impact to General Revenue Related Funds** for SB747, As Introduced: a positive impact of \$135,207,202 through the biennium ending August 31, 2007. The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2006	\$44,403,928
2007	\$90,803,274
2008	\$92,490,636
2009	\$94,173,184
2010	\$95,954,705

All Funds, Five-Year Impact:

Fiscal Year	Probable (Cost) from GR MATCH FOR MEDICAID 758	Probable Savings from GR MATCH FOR MEDICAID 758	Probable (Cost) from FEDERAL FUNDS 555	Probable Savings from FEDERAL FUNDS 555
2006	(\$8,131,500)	\$52,535,428	(\$73,183,500)	\$81,074,511
2007	(\$16,524,000)	\$107,327,274	(\$148,716,000)	\$164,181,134
2008	(\$16,821,000)	\$109,311,636	(\$151,389,000)	\$167,076,825
2009	(\$17,127,000)	\$111,300,184	(\$154,143,000)	\$170,116,211
2010	(\$17,451,000)	\$113,405,705	(\$157,059,000)	\$173,334,384

**Fiscal Analysis**

The bill would require the Health and Human Services Commission (HHSC) to develop a five-year demonstration project in the state Medical Assistance (Medicaid) program relating to preventive health and family planning.

The bill would require HHSC to establish a five-year demonstration project through the medical assistance program to expand access to preventive health and family planning services for women. Women eligible under Subsection (b) to participate in the demonstration project may receive appropriate preventive health and family planning services, including: medical history



recording and evaluation; physical exams; health screenings, including diabetes and certain cancers; counseling and education on contraceptive methods; provision of contraceptives; risk assessment; and referral of medical problems.

The bill would state that a woman is eligible to participate in the project if she is at least 18 years old; has a net family income at or below 185% FPL; participates in or receives benefits under HHS programs, i.e, Medicaid, Food Stamps, TANF, and WIC; is presumed eligible for one of the above programs; or is a member of a family that contains at least one person who participates in or receives benefits under one of these programs.

The bill would require the department to submit a report to the legislature regarding the progress in establishing and operating the project, no later than December 1 of each even-numbered year. The bill would require that the department ensure that money spent under the project is not used for abortions.

The effective date is September 1, 2005.

### **Methodology**

HHSC states the waiver application process would take roughly six months, so the project would begin February 1, 2006.

Cost for family planning services: The cost estimate assumes that over 1.8 million women per year would be eligible for the waiver, with roughly 500,000 women enrolled and participating during each year. The number of eligible women is adjusted by the number of women estimated to receive family planning services at the Department of State Health Services (DSHS). The cost per client is estimated to be \$360 per year. The FY 2006 cost is phased in, for a cost of \$81.3 million in All Funds. Family Planning services receive a 90% federal match.

Savings from averted Medicaid costs: The above cost is offset by the savings that result from the averted cost of Medicaid-funded births, which are estimated to be 15,814 in fiscal year 2006. This figure results from the 1.8 million estimated caseload, times a 7.61 fertility rate, times 50% for the number of potential eligibles who will enroll in the waiver, times 50% for the number of these women who participate in family planning services, times 92%, which is the assumed average effective rate of contraception. The cost of delivery and newborn care is estimated to be \$8,448 in each year. The FY 2006 savings are phased in, for a savings of \$133.6 million in All Funds. Medicaid services receive a 60% federal match.

### **Technology**

There is no significant impact to the agency's information technology.

### **Local Government Impact**

The expansion of Medicaid-funded services could benefit local health districts and hospitals.

**Source Agencies:** 529 Health and Human Services Commission, 537 Department of State Health Services

**LBB Staff:** JOB, CL, PP, MB, KF

*Appendix Source:* Texas Legislative Budget Board, *Fiscal Note for SB747* (March 22, 2005), available at <http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=79&SESS=R&CHAMBER=S&BILLTYPE=B&BILLSUFFIX=00747&VERSION=1&TYPE=F>, accessed March 22, 2005.

## ***Medicaid and the State Children's Health Insurance Program in Texas: Appendix D. Alternative HIFA Proposals***

This proposal for expansion of coverage to parents and childless adults is a three-step approach:

- 1) *Consider a hypothetical section 1931 expansion to parents.* The 1931 expansion would require a state plan amendment (not a waiver) and would expand Medicaid to all parents of children under 19 up to a certain agreed-upon income. It is called "hypothetical" because the state would not actually implement the 1931 expansion in this plan unless the next two steps were going to be implemented, but by saying that the state is considering it, the state can use this expenditure projection as the "without the waiver" projection in a test for budget neutrality for the 1115 HIFA waiver (1115 waivers have to be budget-neutral but 1931 expansions do not, so 1931 would raise the expenditure level that the HIFA waiver would have to keep within).
- 2) *Propose a HIFA waiver reducing benefits and applying cost-sharing to this new population.* The HIFA waiver could propose to waive the requirement that optional populations must receive the same benefits as mandatory populations. HIFA guidelines also say that states can require a higher level of cost-sharing on optional and expansion populations.
- 3) *Propose that the HIFA waiver expand a reduced benefits package and cost-sharing to uninsured childless adults.* This would use the savings from the reduced benefits package and cost-sharing implemented to extend Medicaid to childless adults under a certain income. These benefits would be the reduced package offered to the 1931 expansion population, and enrollment could be capped if needed to control costs.

This model does not provide as many benefits as the traditional Medicaid benefits package to the new enrollees, however, it does not take away any benefits from current Medicaid eligibility groups, and it extends coverage to additional adults without health insurance.

The cost estimates in the following table were created in 2002 and used the following assumptions: 1) Texas Medicaid matching rate of \$.5999 for 2002, 2) used March Current Population Survey number of uninsured parents and childless adults averaged over last three years, 3) decreasing participation rates as premiums increase as reported in an article in *Inquiry*, 4) a specific phase-in period, 5) specified average costs per participant, and 6) a 6 percent inflation factor. (See Kegler pp. 100-112 for more details.) Note that costs, number of potentially eligible people, and other factors may have changed in the past three years and these numbers are for illustration only

### Estimates for Selected HIFA Expansion Models in Texas, 2002

FPL of Parents/FPL of Childless Adults: Cost-sharing	Percent Benefits Package of Mandated TANF Adults	Premium per Member per Month	Amount of State Revenue Needed over Five Years	Amount of State Revenue Needed for the Next Biennium	Number of Uninsured Texans Covered
100/50: 0%	54.04%	\$136.75	\$985,482,000	\$360,197,000	290,419
150/50: 0%	65.87%	\$166.64	\$1,572,433,000	\$590,920,000	390,966
200/50: 0%	71.90%	\$181.90	\$2,084,811,000	\$783,472,000	474,879
200/100: 0%	60.83%	\$153.89	\$2,084,811,000	\$783,472,000	561,325
100/50: 2%	54.05%	\$136.75	\$643,756,000	\$241,924,000	195,058
150/50: 2%	65.87%	\$166.64	\$1,056,112,000	\$369,887,000	262,589
200/50: 2%	71.90%	\$181.90	\$1,400,246,000	\$526,212,000	318,948
200/100: 2%	60.83%	\$153.89	\$1,400,246,000	\$526,212,000	377,010
100/50: 5%	54.05%	\$136.75	\$243,197,000	\$91,393,000	73,688
150/50: 5%	65.87%	\$166.64	\$398,976,000	\$149,935,000	99,200
200/50: 5%	71.90%	\$181.90	\$528,982,000	\$198,792,000	120,492
200/100: 5%	60.83%	\$153.89	\$528,982,000	\$198,792,000	142,426

Source: Elizabeth Raye Kegler, "Utilizing Federal Waiver Flexibility to Expand Medicaid to Adults in Texas" (Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, May 2002), p. 117.

*Sources for Appendix:* Elizabeth Raye Kegler, "Utilizing Federal Waiver Flexibility to Expand Medicaid to Adults in Texas" (Professional Report, Lyndon B. Johnson School of Public Affairs, The University of Texas at Austin, May 2002), pp. 100-119; and Charles Milligan, Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage (State Coverage Initiatives Issue Brief, May 2001, p. 4), available at <http://statecoverage.net/pdf/issuebrief501.pdf>, accessed February 28, 2005.

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