

# Chapter 2: Medicaid History and Organization

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

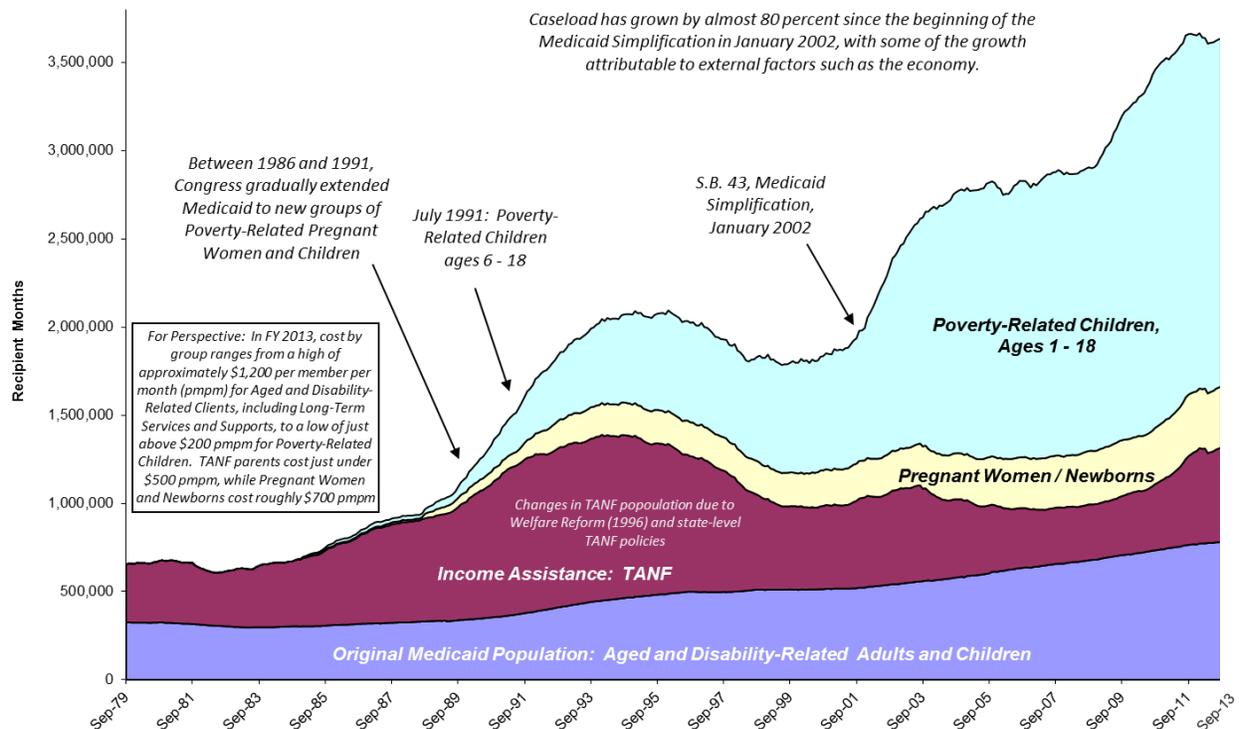
## History and Background

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

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

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

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



Source: HHSC, Financial Services, HHS System Forecasting.

## Medicaid’s Early Years

### Linked to Financial Assistance Programs

As originally enacted, Medicaid coverage was available only to persons eligible for Aid to Families with Dependent Children (AFDC), now referred to as Temporary Assistance for Needy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

## **Temporary Assistance for Needy Families**

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

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

## **Supplemental Security Income**

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

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

## **De-Linking Medicaid and Cash Assistance**

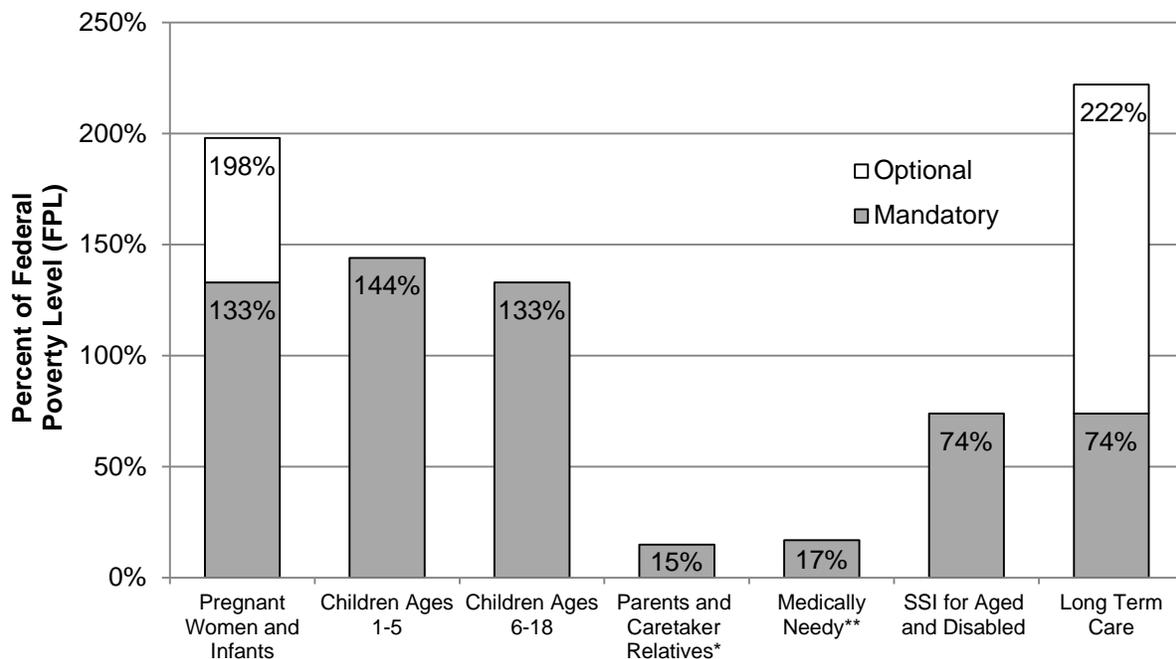
Historically, all Medicaid enrollees were either on SSI or welfare. Federal laws passed in the late 1980s mandated Medicaid coverage for groups of people ineligible for TANF or SSI. This resulted in a major expansion of the eligible population. Members of working families and others with low incomes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

The following program expansions resulted from federal mandates:

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

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

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



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

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

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

# Medicaid Coverage

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

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

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

## Acute Health Care

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

## Long-term Services and Supports

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

## **People age 65 and Older and Those with Physical Disabilities**

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

## **People with Intellectual and Developmental Disabilities**

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

## **Mandatory and Optional Spending**

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

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

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

# Basic Principles

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

## **Statewideness**

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

## **Comparability**

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

## **Freedom of Choice**

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

## **Amount, Duration, and Scope**

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

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

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

# How Medicaid Is Financed

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

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

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

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

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

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

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

## **How Medicaid Operates in Texas**

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

### **Federal Oversight**

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

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

### **Single State Agency**

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

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

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

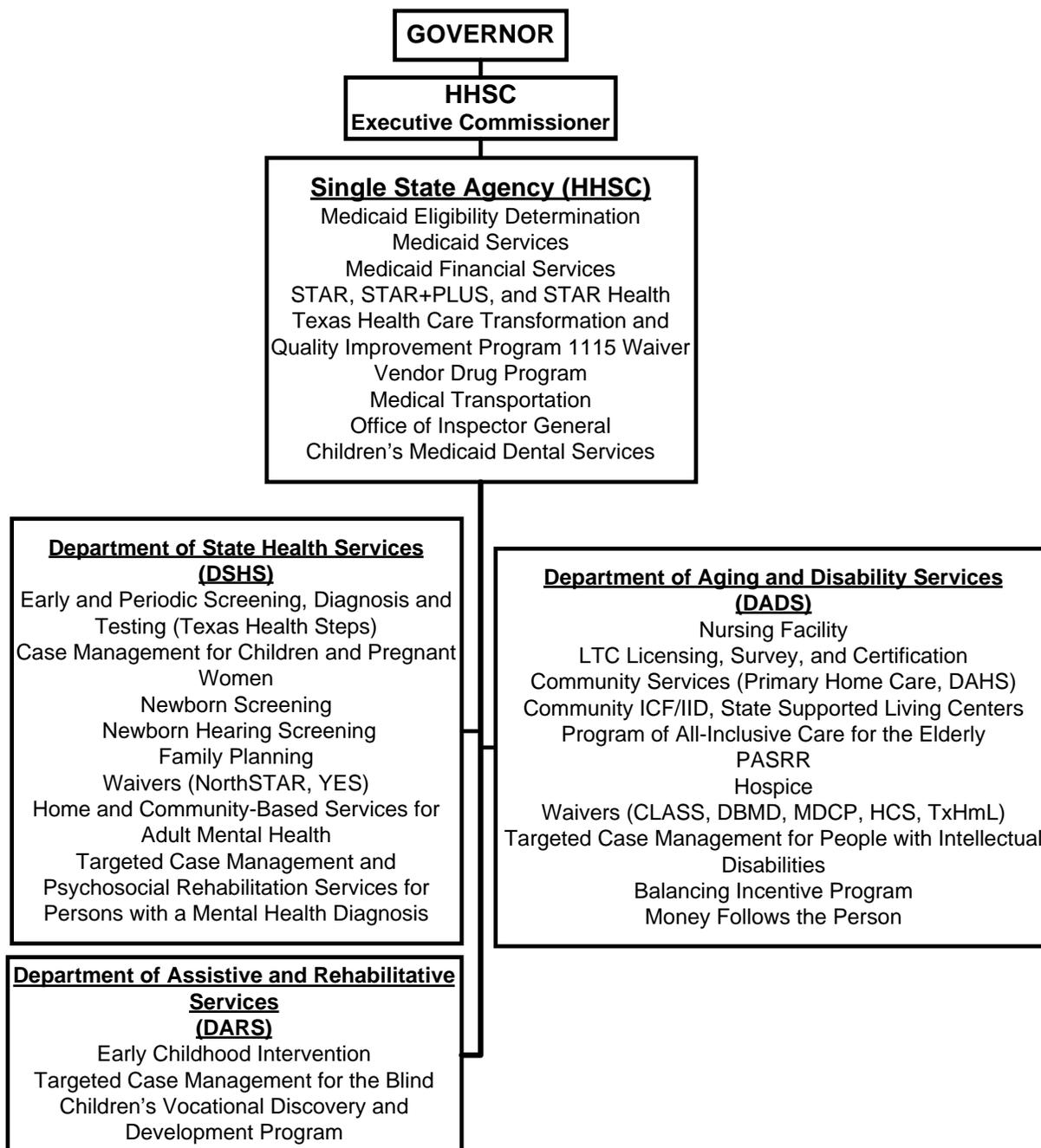
## Operating Departments in Texas

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

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

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

**Figure 2.3: Medicaid Operating Departments**



## Medicaid Waivers

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

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

States seek waivers to:

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

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

## **Research and Demonstration 1115 Waivers**

### **Purpose**

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

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

### **Requirements**

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

### **Timeframe**

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

## **Freedom of Choice 1915(b) Waivers**

### **Purpose**

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

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

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

### **Requirements**

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

### **Timeframe**

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

## **Home and Community-based Services 1915(c) Waivers**

### **Purpose**

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

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

### **Requirements**

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

### **Timeframe**

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

# Administration of Texas Medicaid

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

## **Texas Medicaid Management Information System**

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

### **Claims Administrator and Related Functions**

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

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

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

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

## **Pharmacy Administration**

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

### **Pharmacy Claims and Rebate Administrator**

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

### **Pharmacy Prior Authorization Vendor**

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

### **Preferred Drug List Vendor**

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

### **Retrospective Drug Utilization Review Vendor**

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

## **Medicaid Managed Care**

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

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

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

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

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

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

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

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

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

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

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

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

## **External Quality Review Organization (EQRO)**

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

## **Detecting Fraud and Abuse**

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

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

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

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

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

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

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

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

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

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

## **Integrated Eligibility Determination**

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

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

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

On the website, clients can:

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

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

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

## **Eligibility Support Services and Enrollment Contractors**

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

## **Federal and State Legislation Affecting Texas' Medicaid and CHIP Programs**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **S.B. 492 - Prescribed Pediatric Extended Care Centers**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **The 2014-15 General Appropriations Act**

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

### **Riders 37, 38, and 71 - Hospital Reimbursement**

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

### **Rider 40 - Contingency for Nursing Facility Rate Increases**

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

### **Rider 51 - Medicaid Funding Reduction and Cost Containment**

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

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

## Historical Major Federal Medicaid and CHIP Legislation, 1965 to Present

### **Social Security Amendments of 1967**

#### *Mandated*

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

### **Public Law 92-223 of 1971**

#### *Optional*

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

### **Social Security Amendments of 1972**

#### *Optional*

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

### **Omnibus Budget Reconciliation Act of 1981 (OBRA)**

#### *Optional*

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

### **Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)**

#### *Optional*

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

### **Deficit Reduction Act of 1984 (DEFRA)**

#### *Mandated*

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

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

## **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985**

### *Mandated*

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

### *Optional*

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

## **OBRA of 1986**

### *Mandated*

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

### *Optional*

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

## **OBRA of 1987**

### *Mandated*

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

### *Optional*

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

## **Medicare Catastrophic Coverage Act of 1988**

### *Mandated*

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

### *Optional*

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

## **OBRA of 1989**

### *Mandated*

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

## **Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991**

### *Mandated*

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

## **OBRA of 1993**

### *Mandated*

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

### *Optional*

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

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

### *Mandated*

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

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

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

welfare reform is thought to be partly responsible for the state's Medicaid caseload drop in the mid to late 1990s. Individuals who qualified for TANF comprised approximately 18 percent of the Medicaid population in 1999, down from 28 percent in 1997.<sup>1</sup>

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

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

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

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

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

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

States also gained new eligibility options:

### **Guaranteed eligibility**

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

## **Medicaid Buy-in**

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

## **Medicaid Buy-In for Children**

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

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

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

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

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

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

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

## **Breast and Cervical Cancer Prevention and Treatment Act of 2000**

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

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

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

## **Improper Payments Information Act of 2002 (IPIA)**

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

## **Jobs and Growth Reconciliation Act of 2003**

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

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

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

## **Welfare Reform Extensions and Reauthorizations**

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

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

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

Major provisions affecting the Medicaid program include the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Endnotes

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

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

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

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

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

<sup>6</sup> U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Tamper-Resistant Prescription Pads), May 25, 2007, [http://waysandmeans.house.gov/media/pdf/tax/HR\\_2206\\_text.pdf](http://waysandmeans.house.gov/media/pdf/tax/HR_2206_text.pdf) (November 2014).