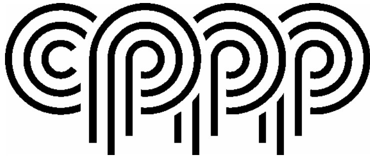

THE POLICY PAGE

An Update on State and Federal Action

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Partial Restoration of Programs Cut in 2003, Some New Investment:

How Medicaid, CHIP, other Health Services Fared in SB 1, the 2006-2007 State Budget

The Regular Session of the 79th Texas Legislature has ended and SB 1, the state budget bill for 2006 and 2007 has been passed. The Governor has vetoed certain line items in the budget. The bill incorporates funding to restore some of the Medicaid, CHIP and other health care programs cut by the 2003 Legislature, but leaves some major 2003 cuts unrepaired, and the fate of others up in the air. *Policy Page* #238 detailed how the House and Senate versions of SB 1 compared on major health care programs; this *Policy Page* reports on the outcome of those budget issues in the final budget bill. *CPPP will provide an update on any related budget changes adopted in the First Called Session ("special session").*

Key decisions on health care programs from the FY 2006-2007 budget and other legislative actions include:

- **The budget restores eyeglasses, hearing aids, mental health professional services, and podiatry benefits for adult Medicaid clients (78% of whom are elderly or disabled), which had been eliminated in September 2003.**
- **The Governor and Senator Zaffirini have pledged to recommend that the Legislative Budget Board (LBB) authorize allocation of funds to restore the Personal Needs Allowance of Medicaid nursing home residents** (the monthly amount that Medicaid nursing home residents may keep from their SSI, Social Security or other pension income; the rest goes to the nursing home).
- **The Medically Needy Spend-Down Program for Parents (temporary coverage for poor families with catastrophic medical bills) <u>may</u> be <u>partially</u> restored.** The budget assumes that the program will only be partially restored if local governments voluntarily put up $35 million in local tax funds.
- **The budget does <u>not</u> restore <u>all</u> of the 78th Legislature's Medicaid and CHIP cuts; roughly half the dollar impact remains in effect. Provider rates cut** in 2003 are restored to 2003 levels for certain Community Care programs and for residential care for persons with mental retardation (all at the Department of Aging and Disability Services, DADS), but not for doctors, other professionals, hospitals, nursing homes, or CHIP.
- **The budget restores CHIP vision and dental care, and mental health coverage to 2003 levels, and assumes a re-vamped premium policy that will be simpler and more affordable for families.**
- **The budget includes only limited funding to allow CHIP enrollment to grow.** The final budget assumes the traditional CHIP program will grow by about 24,100 above May 2005 enrollment (enrollment is now over 180,000 below September 2003). However, the budget also includes a "rider" requiring the Health and Human Services Commission (HHSC) to request additional funds from the LBB if a shortfall occurs, before capping enrollment and creating a waiting list.
- **The budget assumes large reductions in HHS eligibility workers.** Eligibility workers are assumed to drop by 3,980 in 2007, related to implementation of "Integrated Eligibility." These cuts follow a drop of more than 2,500 state HHS workers from 2003 to 2005.
- **The budget assumes lower Medicaid and CHIP caseloads and cost-per-client than HHSC projected in February.** The budget includes significantly lower LBB caseload projections, and assumes the Health and Human Services Commission (HHSC) projection for cost-per-client in 2006, but allows for no inflation in that cost for 2007. Adopting these lower caseload and cost assumptions reduced the Medicaid budget by $929.7 million GR, and CHIP by $60.6 million GR.
- **The budget includes funding at the Department of Aging and Disability Services (DADS) and several programs at other agencies to reduce <u>waiting</u> <u>lists</u> for those programs.** SB 1 provides funds to increase enrollment in a number of non-entitlement community care and health programs which the 2003 legislature had reduced. However, caseloads for some community care programs will still remain below <u>2003</u> levels.

- **The budget reduces Medicaid funding by $109.5 million GR** based on assumed savings from greater management of care for aged, blind and disabled Medicaid clients, via three models of care: a modified STAR+PLUS HMO model, a new Integrated Care Management approach, or primary care case management ("PCCM"). The HMO model must be modified to protect special federal payments to local public hospitals.
- **Proposed funding of direct service programs at the Department of State Health Services (DSHS) varies** from one program to the next. The budget increases funding and caseloads for immunizations, the HIV drug program, Children with Special Health Care Needs, substance abuse services, and state mental hospitals. Several programs including kidney health, primary health care, and community mental health care for adults and children will still serve fewer clients than in 2003, despite increased funding.
- **A proposed "Quality Assurance Fee" (QAF) to raise revenues to restore and increase Nursing Facility rates was eliminated in the last hours of the regular session, leaving the NF rates at the reduced 2003 levels, and possibly at risk of greater reduction.** Because of the way SB 1 allocated the proposed revenues, the DADS budget is also short an additional $91.4 million (30% of the QAF revenues) which were anticipated to be used in other parts of the budget. Some action will need to be taken (perhaps in the current Special Session) to avoid a nursing home deficit.

Medicaid funding across Article II is nominally $14.2 billion in GR/GR dedicated, $22.9 billion in federal match, and $841 million in other funds, for an increase of $2.3 billion in GR/GR dedicated over 2004-2005. However, actual Medicaid appropriations are $438 million GR/GR dedicated less than this (i.e., $13.7 billion). Because $438 million in GR dedicated was contingent on passage of the proposed nursing facility and hospice QAF, the effective increase in state funding for Medicaid is about $1.8 billion.

Medicaid at HHSC

As reported in *Policy Page #228*, the introduced version of the budget assumed much lower Medicaid caseload growth as well as much lower costs per Medicaid client, than was assumed by HHSC in its budget request. The original budget bill also assumed that coverage of children in Medicaid would remain at 6 months, even though current law calls for children's coverage to go to 12 months in September 2005 (historically, the base budget has reflected current law). As predicted, the agency and LBB agreed in February on a set of common assumptions, which reduced dramatically the amounts of some related exceptional items, and eliminated certain others.

The budget assumes:

1. Children's Medicaid eligibility remains at 6 months (a change was made in statute to fix children's coverage at 6 months; previous law would have phased in 12-month coverage in September 2005);
2. the LBB's lower caseload assumptions; and
3. the HHSC's higher cost-per-client assumption for 2006; but
4. holds the 2006 per-client cost assumption flat in 2007 (i.e., rather than use HHSC's assumption of inflation for 2007).

The incentive to adopt these conservative caseload assumptions was powerful, given that it reduced a $1.5 billion GR gap between the LBB and HHSC assumptions to $586.9 million GR. In other words, the change in assumptions reduced the Medicaid budget by $930 million GR. This made a balanced budget that much easier to attain and "freed up" GR for other important spending priorities (including the reversal of some 2003 cuts). It also means that a shortfall related to either caseload, cost per client, or both is more likely in 2007.

As the following table shows, final Medicaid caseloads in SB 1 are not identical to the bill as introduced, for several reasons. First, SB 566 was passed to create a new Medicaid "buy-in" program for working adults with disabilities, which will increase caseloads by an estimated 2,300 clients per month. Funding to increase capacity in Medicaid Community Care waiver programs will increase monthly enrollment by 3,200 clients per month in 2007. If partial restoration of Medically Needy coverage for parents is implemented, it will serve about 10,900 clients per month in 2007. Finally, the proposed structure for a new CHIP perinatal program will have the effect of moving some newborns who would under current rules have been served in Medicaid at birth to the CHIP rolls instead, for several months. This is projected to reduce Medicaid newborn caseloads by about 39,200 per month in 2007 (more on this program in CHIP section below). The table describes the anticipated caseloads, taking these changes into account.

Medicaid Caseloads: Actual and Projected 2006-2007		
Actual Medicaid point-in-time enrollment, May 2005 *(Final "recipient months" used in budgeting average 104% of point-in-time enrollment, after retroactive coverage is included)*	2,686,699 (equals about 2,794,167 recipient months)	
	2006	**2007**
HHSC Feb. 2005 caseload estimates, staying at 6-month coverage for children	3,124,110	3,356,597
Introduced version, SB 1 (assumes 6-month coverage of children) *(With cost-per-client assumption, reduces budget $930 million GR)*	2,987,578	3,137,045
Medicaid Buy-In for Workers with Disabilities (New Clients)	2,273	2,273
Waiting List (New Clients)	1,078	3,196
Perinatal Subtractions	(14,386)	(39,214)
Medically Needy	10,118	10,918
Final Budget, SB 1 (assumes 6-month coverage of children)	**2,986,661**	**3,114,218**
Difference, HHSC projected and budgeted in SB 1	-137,449	-242,379

As the table above notes, SB 1 funding assumes that eligibility for Children's Medicaid will remain at 6 months continuous coverage. Just as in CHIP, 12-month continuous coverage in Medicaid would result in larger caseloads. Unlike CHIP, Children's Medicaid in Texas has never provided 12 months of coverage. When SB 43 was passed in 2001 to simplify Medicaid enrollment and renewal for children, making it as much as possible like the CHIP processes, coverage was increased from month-to-month (no continuous coverage) to 6-month coverage, with a timeline in the law to implement 12-month coverage in September 2003. That deadline was then delayed by the 78th legislature to September 2005. The 79th legislature modified this key provision of SB 43 by eliminating the plan to eventually phase in 12-month coverage of children in Medicaid in SB 1863 by Ogden. Article 3 of that bill fixes the period of coverage for children on Medicaid at 6 months, and does the same for children covered by CHIP.

The tables that follow recap major Medicaid and health care funding decisions in the budget for HHSC, DADS, and DSHS. CHIP decisions are explained in a separate section.

Major Decisions in the Budget: HHSC (Biennial GR)	
Issue	**Status**
Medicaid costs and caseload above filed version of budget	+$586.9 million
Restore Medicaid Adult Services: 78th Legislature eliminated coverage of mental health, podiatry, hearing aids and eyeglasses and chiropractic services for all 863,000 adults on Medicaid, 78% of whom are aged or disabled. Recent communications indicate the various benefits will be restored on different dates: podiatry, hearing aids and eyeglasses effective September 1 2005; chiropractic October 1 2005, and mental health professional services (tentatively) December 1 2005.	YES. $55.7 million*
Restore Medicaid Provider Rates to FY 2003 levels, $204 million GR requested: All HHSC rate cuts remain (some DADS rates restored, see below). Rate cuts were the largest of the HHS budget cuts made in 2003; much larger than the CHIP cuts.	NO
Partial Medically Needy Restoration: (Temporary coverage for poor parents with high medical bills.) HHSC estimated that full restoration would cost $175 million GR for 2006-2007. Per HHSC, $35 million GR requested would reinstate payments at about 20% of normal Medicaid rates. SB 1 authorizes $35 million in local government tax funds (intergovernmental transfers or "IGT"), so restoration is dependent on voluntary contributions of local tax dollars	Uncertain

("IGT") from the big urban hospital districts. Also, rider #74 in HHSC budget authorizes additional $20 million GR IF local IGT funds are provided first (the $20 million would come from savings achieved due to the Women's Health and Family Planning Waiver; more below on this).	
Medicaid Provider Rate Increases: $227.9 million GR requested	NO
Reduce HHS Waiting Lists and prevent list growth: Includes items from DADS, DSHS, and DARS) $161.6 million GR allocated to reduce and/or prevent growth in various wait lists (see also DADS and DSHS tables below).	YES (reduces wait lists 10% in biennium)
Enhanced Family Violence Funding: $2 million GR to serve 3,753 more clients per year (a 4.5% increase).	YES
Restore TANF Supplemental payments (annual $60 per-child "back-to-school" payments), cut to $30 by the 78th Legislature. Federal TANF funds ($11.1 million), no GR	NO
New Medicaid Buy-In Program for Workers with Disabilities: Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (SB 566)	YES
2-1-1 Information & Referral	YES
Improve Contract Management & Oversight (78 FTEs); **Staff for Office of Inspector General.** SB 1 authorizes 78 new FTEs, some of whom will go to OIG.($3.7 for BOTH).	YES, reduced amount
Restore state funding (GR) for Graduate Medical Education (SB 1 authorizes up to $80.9 million in the state's share of Medicaid GME payments, but only if funded with local tax dollars via intergovernmental transfers, or "IGTs")	NO
Restore Hospital Rate "Fix" from 2002: Public hospitals have been contributing local tax dollars since 2002 to avoid a rate cut initiated in the 2001 session; this would restore $52.7 million state funding.	NO
Non-urban hospital Upper Payment Limit (UPL) program: $54 million GR requested.	NO
New Upper Payment Limit (UPL) program for Children's Hospitals: Rider #73 for HHSC directs creation of a new UPL program of $25 million GR ($12.5 million GR per year) to reimburse for actual costs of care and graduate medical education at free-standing children's hospitals.	YES
Appropriation Reduction for Medicaid Aged, Blind Disabled: SB 1 originally reduced DADS budget $109.5 million. Final bill now reduces HHSC budget by that amount via rider to reflect savings from various care management models for aged or disabled clients (more below).	Reduction Remains

System Benefit Fund for Low-Income Energy Assistance Swept, 8% goes to Medicaid. The Legislative Budget Board's *Performance Report to the 79th Legislature* recommended taking money from the System Benefit Fund (created to provide poor Texans with electric bill discounts and weatherization assistance) and re-directing it to Medicaid where it can draw federal matching dollars. This mechanism is assumed in the budget (HHSC rider 68) as the means to fund restoration of adult Medicaid mental health benefits. System Benefit Funds ($426.9 million) were "swept" to balance the budget, and none will be available for low-income electric subsidies in 2006-2007. The portion used to pay for Medicaid mental health benefits under the rider is $34.6 million, or 8% of the total SBF swept. Representative Sylvester Turner championed attempts to preserve the SBF for low-income subsidies, or at least to ensure it will be used for that purpose from FY 2008 on.

The wording of the HHSC budget rider has created some confusion about whether the adult mental health services are definitely to be restored in FY 2006. At this time, all indications are that leadership support for this decision is strong and the restorations will be made. However, further developments are possible, and recent communications indicate that restoration may be delayed until December 2005, rather at the start the fiscal year in September 2005.

LBB analysts noted a number of eligibility policy changes adopted by the Public Utility Commission which have made it harder for poor Texas families to get the energy bill assistance. Rather than fixing those problems, they recommended eliminating the assistance and using the funds for Medicaid. While it is certainly true that the investment of GR dollars in Medicaid yields a good return in the form of federal funds, this substitution will not free up any money in most poor families' budgets to pay electric bills. The restoration of Medicaid benefits cut in 2003 is an excellent decision, but the decision to eliminate another program for poor Texans is a troubling example of the perverse policies that result from failing to address our state's revenue needs in a comprehensive way.

Medicaid Income Cap for Poor Parents has not been increased for 20 years, and 2003 Elimination of Medically Needy Coverage Increases this Gap in Texas' Safety Net. The Medically Needy Spend-Down Program for parents was eliminated by the 78th legislature (coverage was retained for children and pregnant women due to federal law mandate). The program provided temporary Medicaid benefits for poor parents with catastrophic medical bills. HHSC estimates that continued elimination would result in a monthly average of over 10,900 poor parents having no coverage in FY 2007. Before the program cut, the average age of a Medically Needy parent was 34 years. Working parents could not have income (after medical bills) of more than $395 per month for family of 3 (or $275 if not working), and the family could have no more than $2,000 in resources.

With Medically Needy coverage of parents gone, **the only way working poor parents in Texas can get Medicaid now** is if they are poor enough to qualify for Temporary Assistance for Needy Families (TANF). The income cap for Texas Medicaid coverage of parents with dependent children (and for TANF, though parents no longer must enroll in TANF to receive Medicaid) remains at the **legislatively-imposed income cap of $188 per month for a family of 3 ($308 if one parent is working).** This is a fixed dollar amount cap, and does <u>not</u> increase from year to year with inflation. As a result, in 2005 this income cap denies Medicaid to parents with incomes above 14% of the federal poverty income (national average is $546 per month, or 43%). **<u>This cap was last increased by the Legislature in 1985—and it was only increased 2 other times between 1970 and 1985</u>.** Texas can increase the income threshold for parents to essentially any income level it chooses, without a federal waiver. The only limiting factor is our willingness to put up our state's share (about 40%) of the costs.

The Medically Needy elimination combined with changes in TANF policy enacted in 2003 have had a dramatic impact on the number of very poor parents with dependent children who are covered by Texas Medicaid. Because such parents can qualify for Medicaid and appear on the rolls in several categories—TANF recipients, Medically Needy/Section 1931, or Transitional Medicaid—it is easiest to combine these groups and look at how that total has changed. In July 2003 (we use July because it appears new sanction policies were applied in August 2003), 147,217 parents with dependent children were covered under Texas Medicaid (not including Maternity coverage), and as of May 2005 that number had dropped to 100,518, a drop of 46,699 (32%). Because the Legislature has chosen to limit so severely poor parents' access to Medicaid, access to Medically Needy coverage was critically important. To illustrate, a parent of 2 bringing home $600 per month in income (about 45% of the poverty income level) cannot qualify for Texas Medicaid, even though his (or her) children do. And because Medically Needy coverage is gone, if he has an accident or illness that creates high medical bills, he still will be ineligible for coverage. Under Texas rules, only if he (or she) becomes disabled or until he loses his job and income in a future month will he qualify for coverage. This creates hardship for the poorest parents, the safety net hospitals and providers who care for them, and the children who rely on them.

Will "Partial" Restoration of Medically Needy Coverage Happen? HHSC estimated that full restoration of MN would cost $175 million GR for 2006-2007. In contrast, SB1 authorizes just $35 million for "partial restoration" of the program for parents, but assumes this will be funded entirely by voluntary contributions of local tax dollars (intergovernmental transfers or "IGT") from the large urban hospital districts in Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, Lubbock, Midland-Odessa, and San Antonio. Rider #74 in the HHSC budget also says another $20 million in GR could be added to this if the local funds are provided first (the $20 million would come from savings achieved due to the Women's Health and Family Planning Waiver, more on that below). However, hospitals are not required to make this contribution, and it does not appear that this budget decision is the product of any kind of agreement with the hospitals (note that restoration of GME payments in the table above is also contingent on the nine public hospitals picking up the tab).

The IGT assumption is generally not well received by Texas' large public hospitals, which essentially would foot the MN bill for all the hospitals in Texas with no guarantee of a net benefit, since Medicaid clients can go to any hospital that contracts with the program. Furthermore, hospitals are reluctant to establish a precedent in which the Legislature cuts Medicaid benefits like MN and GME, and will only restore them if local governments provide the revenue. Clearly this approach does not save Texas taxpayers a single penny, but only concentrates the tax burden in the urban centers where most Texans live, and shifts the political heat for raising taxes to those jurisdictions.

What Would Partial Restoration Mean? Limited information has been made public about how such a policy might work, and a final policy has not yet been developed. In public hearings, HHSC officials proposed that the benefit might pay reduced fees, well below the usual (already low) Medicaid rates. This would allow hospitals to get greater payments in important Medi<u>care</u> payment programs that are tied to numbers of Medicaid patients and days. This would also allow the state's costs to be relatively low.

In a later proposal, HHSC officials laid out a scenario in which the Medically Needy income limit might be raised much higher than the roughly 25% of poverty which capped the program until it was eliminated in 2003, to as high as 50%,

75% or even 100% of the poverty line. This proposal would have limited Medically Needy benefits to those related to an inpatient hospital stay (including the related physician and ancillary costs). However, this proposal is presumably no longer on the table as the appropriated amounts would not cover the increase.

The concept of limiting MN coverage to inpatient hospital care also has serious drawbacks. No other state has taken an approach like this, but it may be acceptable under federal law and rules. However, the intent of MN programs is to provide catastrophic coverage for working poor parents, and in today's world many catastrophic, complex, and life-threatening conditions are routinely treated in an outpatient setting. Kidney dialysis and cancer treatments are two clear examples. In addition, treatment of and recovery from many catastrophic conditions depends heavily on rehabilitation and physical therapy. Limiting payments to inpatient admissions may simply force hospitals to admit patients overnight for conditions that would normally be treated on an ambulatory basis. **A Medically Needy policy should be broad enough to cover treatments for rehabilitation, renal disease, and cancer, at a minimum.**

Medicaid Managed Care, STAR+PLUS, and "Integrated Care Management". One of the most controversial HHS legislative issues of the 79th regular session was the proposed expansion of Medicaid Managed Care set in motion by HB 2292 of the 78th session, but not yet implemented. The HHSC plan assumed in SB 1 as introduced would have:

- Expanded the STAR+PLUS managed long term care HMO model for serving aged and disabled Medicaid clients from its current base in the Houston area, to all of the major urban areas that already use Medicaid Managed Care for low-income children, pregnant women, and very poor parents.
- Eliminated "primary care case management" (PCCM) from all of the existing Medicaid Managed Care urban service areas, requiring clients and doctors to instead participate in Medicaid HMOs. PCCM is a non-HMO approach to managed care, in which clients are assigned a primary care "medical home" to coordinate their care.
- All of Texas' rural counties would be brought into PCCM for the first time.
- Extended HMO-based Medicaid Managed Care to one new area, the Corpus Christi-Nueces County area.

The last two of the four bullets are likely to be implemented just as proposed. The overall proposal was met with strenuous objections from doctors, hospitals, and advocates for Texans with disabilities. Hospitals pointed to major losses in Medicaid revenues (so-called upper payment limit or "UPL" reimbursements) that would result from converting to an HMO ("capitated") model. Doctors cited a wide range of complaints, and a preference for the PCCM model. Disability advocates are not satisfied with the track record of the existing STAR+PLUS program, particularly with regard to providing access to community care supports and helping individuals leave nursing homes and return to the community.

The 79th regular session ended with important Medicaid Managed Care provisions included in SB 1 as well as two other bills, HB 1771 (Delisi) and SB 1188 (Nelson). Budget rider 49 in Special Provisions Relating to all Health and Human Services lays out a compromise in which an enhanced PCCM-type "Integrated Care Management" (ICM) model will be implemented in the Dallas service area to coordinate care for aged and disabled clients, and where the capitated STAR+PLUS model is used, the state will modify that model to protect the federal UPL payments to local public hospitals. The rider still reduces Medicaid spending by $109.5 million GR, and the savings must be achieved via the modified STAR+PLUS and ICM models. The rider guarantees the savings by allowing HHSC to reduce provider rates if the new model does not produce the required savings. Another rider (#66 in the HHSC appropriation pattern) reflects the assumption that the August 2007 Medicaid Managed Care premiums will be delayed into FY 2008, thereby "saving" SB 1 $52.7 million GR.

HB 1771 goes into greater detail about the requirements for the new ICM model, and SB 1188 adds a long list of new goals and requirements for Medicaid Managed Care overall. Though the budget and other bills are silent as to whether or not PCCM will be eliminated in the urban HMO service areas where it currently operates, HHSC appears to intend to do so, while physicians continue to oppose such a move. *The center will provide more information on the expansion of and changes to Medicaid Managed Care in Texas as the plans for implementation become clearer.*

Medicaid Women's Health and Family Planning Waiver. The Governor has signed into law SB 747 by Senator John Carona, "Relating to establishing a demonstration project for women's health care services," also known as a Medicaid Women's Health and Family Planning "waiver". Under this waiver, Texas Medicaid will provide basic medical check-ups and birth control services to adult Texas women (ages 18 and older) up to 185% of the poverty line (that's $2,481 per month pre-tax income for a family of 3 in 2005).

SB 747's Medicaid Waiver for Women's Health would allow Texas to expand the current eligibility level for Medicaid family planning services to women between the ages of 18 and 64 in families earning up to 185% of the federal poverty level (FPL) Currently in Texas, working women must live at or below 23% of the FPL to qualify for Medicaid family planning services (23% of poverty is less than $308 per month or an annual income less than $3,700 for a family of three).

The need for access to basic health care is of course very high in our state. Texas has the highest rate of uninsured women aged 18 to 64 (28.3%) in the nation (the U.S. average is 17.7%). Moreover, about 40% of all Texas women live below 200% of poverty, and 50% of them are uninsured.

Services covered by a waiver would include well-woman exams, counseling and education on contraceptive methods, provision of contraception, screenings for diabetes, breast and cervical cancer, sexually transmitted diseases, hypertension, cholesterol and tuberculosis, risk assessment and referral of medical problems to appropriate providers. It is against federal and state law to use Medicaid funds for abortion, and SB 747 specifically excludes abortion providers. The bill also excludes coverage of emergency contraceptives. SB 747 should reduce abortions, as without publicly funded family planning, abortions are estimated to increase by 40%.

This program will actually save Texas money right away. Every $1 spent on preventive family planning saves $3 in maternity and newborn care in Medicaid alone. The federal government will pay 90 cents on every dollar of family planning care, and even with the check-up services matched at a lower rate the effective match rate is projected to be 84% federal. As a result, Texas Medicaid will save at least $20 million GR in 2006 and 2007 ($92 million GR over 5 years) because of fewer pregnancies covered by Medicaid—more if participation is higher than projected.[1] The LBB originally projected this waiver would save Texas $135 million state dollars in 2006 and 2007 (and more than $417 million state dollars over 5 years), but later lowered that projection based on a lower participation assumption.

Texas must apply to the federal Medicaid authorities for a "waiver" to expand the income eligibility level for family planning. Nineteen states have Medicaid waivers that allow them to provide family planning services to many more women, and get the 90% federal match for that care (AL, AZ, AK, CA, DE, FL, IL, MD, MN, MS, MI, NM, NY, OR, RI, SC, VA, WA, WI). A recent study of these waivers found that all of them have saved their states and the federal government significant amounts of money. In 2001, Texas spent $31.1 million on Medicaid family planning; New York spent nearly twice as much, even though its population is slightly smaller. California spent over $260 million—more than 8 times as much as Texas—and its population is 1.6 times that of Texas. The main reason for this superior return in federal funding is that both states had Medicaid family planning waivers in place.

SB 747 takes effect immediately, and HHSC is directed to implement the waiver no later than September 1, 2006.

CHIP at HHSC

The budget bill as originally introduced restored CHIP vision and dental coverage, which indicates that key legislative leaders agreed on that change. The bill did not, however, allow for CHIP caseload growth or cost/inflation increases. Just like in the Medicaid program, the introduced budget assumed CHIP coverage would remain at 6 months (rather than reverting to 12 months in September 2005, as was required by law until the passage of SB 1863 in the 79th regular session).

Final CHIP Decisions in SB 1, Compared to Budget as Introduced (Biennial General Revenue Amounts)	
CHIP cost growth remaining at 6 month renewal (inflation, price increases)	$15.8 million
Revised CHIP Premium Policy	$11 million
CHIP Rate restoration (to 2003 levels)	NO
CHIP Caseload Growth, at 12 month coverage ($47.9 million requested)	$12.4 million
"Rider" Requiring HHSC to Request Additional Funds for CHIP from LBB before Capping Enrollment and starting Waiting List	Yes
CHIP Mental Health Benefits (in addition to $36.7 million included in budget as introduced for vision and dental coverage). Hospice coverage also restored, at no cost to bill.	$3.3 million
Coverage of Legal Immigrant Children. From its inception, Texas CHIP has provided coverage of legal immigrant children, even during their first 5 years in the US, when federal matching funds are not available. Eliminated in the SB 1 conference committee was a House rider authored by Rep. Isett to eliminate CHIP coverage of legal immigrant children. These children are lawful permanent residents of the U.S..	Coverage retained.

The same compromise made for Medicaid caseload and costs (described above) was mirrored for CHIP in SB 1; that is, much lower LBB caseload projections are used, along with HHSC's projected 2006 cost-per-child, held constant in 2007.

[1] Medicaid pays for nearly half the births in Texas (as in most states), and the Texas Department of State Health Services reports that Medicaid spent over $1.5 billion on Medicaid births in 2002.

However, the conference committee on SB 1 approved adding $12.4 million GR for increased enrollment. As the CHIP caseload table below illustrates, the budget now assumes that CHIP enrollment will grow by about 24,300 in 2007, compared to May 2005 enrollment.

The budget also funds HHSC's proposal to significantly reduce CHIP premiums (essentially replacing them with semi-annual enrollment fees), and allocates funds to restore mental health benefits to 2003 levels (HHSC had restored those benefits to roughly half the 2003 level back in February 2004). Also assumed is the restoration of hospice benefits, which was determined to have no cost. SB 1 assumes that August 2007 CHIP premiums will be delayed until September 2007, reducing required appropriations by $5 million GR.

Proposals for CHIP Dental Benefits and Premiums. While formal policy has not yet been developed, HHSC has outlined concepts it is exploring for revised CHIP premium policies, and for a new structure for the CHIP dental benefit. HHSC has described a premium system which would eliminate monthly payments entirely, replacing them with annual (or 6 month) enrollment fees. HHSC presentations have outlined an annual fee of:

- $25 per family per 6-month period from 133-150% of the federal poverty level (FPL)[2];
- $35 per family per 6-month period from 151%-185% FPL; and
- $50 per family per 6-month period from 186%-200% FPL.

While there will be some grace period for late payment of renewals, generally new enrollees would not be covered until the enrollment fee was received. HHSC is hoping to "reward" families who continued to pay CHIP premiums even after HHSC announced suspension of premium collection (from January 2004-October 2004). One approach under consideration is to give those who made such payments (as well as families that have paid and continue to renew and make payments "on time") some additional dental therapeutic benefits. growth in CHIP enrollment (i.e., the projected growth of about 24,300 children in 2007 is far below 2003 enrollment, which was more than 180,000 children above the current rolls). With restored benefits, an improved premium policy, and re-energized community-based outreach for CHIP, it is quite possible that enrollment will increase, even though coverage remains at six months. As the table above notes, the budget includes a "rider" (#57 in HHSC bill pattern) which requires HHSC to seek additional funding from the Legislative Budget Board if a CHIP shortfall "crisis" occurs in 2007. In floor debate on SB 1 in the House, Appropriations Chairman Pitts made repeated statements that funds would be found to ensure that all eligible children who seek enrollment will be served. Though this step does not fully guarantee that CHIP enrollment growth will ultimately be funded, it does ensure that the decision whether or not to fund the program will be made in a public process.

Many 2003 CHIP Changes Remain. None of the CHIP restoration bills filed in the regular session ever had a public hearing, not even Senator Averitt's SB 59, which was assumed to be the most likely vehicle for changes. CHIP restorations that were made were all done via the budget bill. These 2003 CHIP changes remain:

- **Coverage period reduced from 12 months to six.** Language in law now makes this permanent rather than planning for a return to 12-month coverage at a future date (SB 1863 by Ogden).
- **New coverage delayed for 90 days.** (New perinatal coverage could eliminate this for some newborns.)
- **Income deductions eliminated** (gross income determines eligibility; no deductions for child care or child support payments).
- **Asset test (limit) added for those above 150% of the poverty line** (took effect August 2004; as of April 2005 almost 6,900 children lost or denied coverage as a result).
- **Across-the-board 2.5% rate cuts for CHIP medical providers.**
- **Outreach and marketing were reduced in 2004-2005**; it will be important to monitor these activities and push for strong investment in both in 2006-2007.

New CHIP Perinatal Program. A last-minute addition to the budget authorizes the creation of CHIP coverage of prenatal care and maternity services for women whose children, when born, would be under 200% of poverty and qualify for CHIP or Medicaid. HHSC estimates that coverage of these "perinates" will increase the CHIP rolls in FY 2007 by almost 48,000.

This coverage option has been offered by federal authorities under CHIP rules since 2002, and to date seven states have exercised the option. Under this rule the Centers for Medicare and Medicaid Services (CMS) allow states to use CHIP funds to provide prenatal care and delivery to women who would not otherwise have received maternity benefits from

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[2] Families below 133% FPL will still make co-payments, but will not owe enrollment fees.

Medicaid, by defining the benefit and eligibility as belonging to the unborn child or "perinate" (during the prenatal period).

This new coverage would of course be available to mothers with incomes between 185-200% FPL (who make too much for Medicaid maternity care). It will also pick up mothers under 200% FPL who are lawful permanent residents of the U.S. (a.k.a. "green card holders", or "legal immigrants"), many of whom Texas could cover under Medicaid but has chosen not to. In addition, it will provide prenatal care for undocumented immigrant women under 200% FPL (Medicaid pays doctors and hospitals for deliveries to undocumented and legal immigrant women, but does NOT cover prenatal care).

Of course, virtually all babies born in the U.S. are U.S. citizens, so all the children of the mothers receiving prenatal care under this coverage will qualify for Medicaid or CHIP. HHSC is considering granting all perinates 12 months of coverage, so the point in time when the perinate would have to renew coverage would depend on how early in pregnancy their mother enrolled in the coverage. At that renewal point infants eligible for Medicaid would be transferred to that program, with the higher-income children remaining in CHIP.

Some controversy surrounds this approach to coverage for several reasons. First, it is not specifically authorized under CHIP federal law, but was created by the current federal administration through rule. Second, this coverage could be construed as lending the "perinate" legal status equal to that of a born child. Since there are simpler ways federal authorities could expand prenatal care access, it is not unreasonable to surmise that creating such standing for perinates was one aim of the federal administration in promulgating this policy.

CHIP Caseloads: Actual and Projected			
		2006	**2007**
September 2003 actual caseload	507,259		
May 2005 actual caseload	326,809		
decline, 9/03 to 5/05	(-180,450) 36%		
HHSC 2/05 projected enrollment, if 12-month eligibility restored		386,110	467,404
HHSC 2/05 projected enrollment (6 month renewal)		360,786	388,920
SB 1 funded caseload, traditional CHIP (6 month renewal)		**344,750**	**351,132**
Additional caseload, perinatal coverage		17,425	47,498
Total SB 1 projected CHIP caseload, traditional & perinatal CHIP		**362,175**	**398,630**

Source: Health and Human Services Commission

How "Perinatal CHIP" Changes the Official CHIP Caseload Numbers. Official CHIP caseload projections in the state budget for 2006-2007 are higher than the caseloads projected for the "traditional" CHIP program in the last hours of the legislative budget process, because of the addition of the perinatal program numbers. HHSC has provided detail on the caseload assumptions, shown in the table above, and it is expected that the agency will include a breakout of those enrollees in each month's detailed CHIP enrollment reports (available at www.hhsc.state.tx.us). HHSC assumes a start-up date of January 2006 for the perinatal coverage. Of the nearly 48,000 perinates per month projected in FY 2007, HHSC estimates that over 39,000 are infants who would have been enrolled in Medicaid under current rules, and about 8,300 are perinates who would not have been covered under either program under current rules.

Medicaid at DADS

The Department of Aging and Disability Services (DADS) is home to long term care programs including community care for elders and people with disabilities, nursing home care, and residential programs for persons with mental retardation. **Most DADS programs and services are financed by Medicaid; for example, 93% of the state general revenue dollars in the budget for DADS is state match for Medicaid**. Because long term care services can be expensive, a significant share of total Texas Medicaid funding runs through this agency.

Within the Medicaid-funded long term care programs operated by DADS, some are "entitlement" programs, meaning every individual who meets the financial and functional need criteria is served (no caps or waiting lists), while other non-entitlement programs are capped. Some substantial costs for restoration and growth in community care programs at DADS were included in the HHSC requests related to waiting lists (see HHSC table above). Like HHSC, DADS appropriations assume the lower LBB caseloads, resulting in a $25.4 million GR reduction in funding. SB 1 assumes deferral into the 2008-2009 biennium of most August 2007 long term care payments, postponing $145.5 million GR spending until the next budget period.

Major Decisions in the DADS Budget (Biennial General Revenue)	
Entitlement caseload growth staffing This request was not specifically funded; however, the agency did receive authorization for about 60 additional FTEs to accommodate increased waiting list reductions.	NO, but some FTEs funded for waiting list reduction
Restore 5% base Reduction ("Critical Accountability and Oversight") Without restoration, client workload per eligibility worker would grow to 445, up from 240 in 1999. Funds about 143 FTEs.	YES ($13.2 million)
Fund Actual 2005 costs in Waivers	YES ($3.9 million)
Restore Appropriations Reductions for STAR+PLUS Expansion. See earlier section; reduction is now in HHSC budget, but some reductions may be allocated to DADS.	Moved to HHSC budget
Fund Long Term Care Acuity Increase (SB 1 as introduced did not allow for increased cost per client trend.) Acuity Cost Increase for Community Care Services and Waivers is funded for these programs: Primary Home Care, Community Attendant Services, Day Activity and Health Services, CLASS, CBA, and Promoting Independence Services (Rider 28). **Because of the demise of the Nursing Facility Quality Assurance Fund (QAF), acuity increases for NFs are not funded ($14.7 million was requested).**	YES, for Community Care & Waivers ($36.7 million); NO for Nursing Homes
Restore rates to 2003 levels (In 2003, rates were cut 1.75% for nursing facilities and 1.1% for community care providers.) Rates restored to 2003 levels for Service Coordination, PHC, CAS, DAHS, CBA, DBMD, MDCP, CWP, TxHmL, Non-Medicaid Title XX, and Promoting Independence Services (Rider 28).[3] **HCS/CLASS QAF** was authorized, and (assuming federal approval of QAF) rates will be restored to 2003 levels. **Because of the demise of the Nursing Facility Quality Assurance Fund (QAF), rate restoration for NFs is not funded ($30.8 million was requested).**	YES, for Community Care & Waivers ($20.6 million); YES, for HCS & CLASS waivers ($12.3 million); NO for Nursing Homes
Promoting Independence Requested $4.7 million for transition of 146 clients with mental retardation from institutional settings to HCS community waiver program; budget includes $2.5 million for 95 persons in ICF-MR to move to HCS waiver.	YES, but less than requested ($2.5 million)
Re-base and Increase Provider Rates. Nursing facility rate increases of $166.1 million GR-D not funded due to demise of QAF; $3.3 million conversion cost for transition from TILES to RUGS III also unfunded due to failed QAF.	ONLY HCS, CLASS, and Cmty. ICF-MR increased ($17.7 million)
Rate Increase for Direct Care Staff (Enough to increase attendants and aides wages by an average $1 per hour; $241.4 million requested)	NO
Restore Non-entitlement Community care Services (Title XX). Replaces funds DADS redirected from state-funded community care programs in order to pay for the adult Guardianship transferred from Family and Protective Services (FPS). $5.5 million in Title XX Social Services Block Grant will fund 473 community care clients per month.	YES ($5.5 million)
Guardianship program: DADS requested $11.7 million GR for program transferred from FPS, without benefit of funding or staff. SB1 funds 27 FTEs to staff the program.	YES, but less than requested ($3.4 million)
Repair & Renovation of MR facilities and equipment	$6.5 million GR, $26.1 million bond

Nursing Home Personal Needs Allowance. Though the restoration is not in the budget or other bill, Gov. Perry and Senator Zaffirini have pledged to ask LBB for "budget execution" to allocate the $13 million in state dollars needed to return the monthly Personal Needs Allowance for nursing home residents to $60 (reduced to $45 by the Legislature in 2003). DADS officials indicate they expect to restore the PNA.

Impact of the Failure to Adopt a Nursing Facility "Quality Assurance Fee" (QAF). At the eleventh hour of the regular session, language creating a new tax or "Quality Assurance Fee" on nursing homes and hospices was stripped from both HB

[3] See following table for acronyms.

3540 and SB 1863 in their conference committees, in response to objections by the Governor. As the table above shows, SB 1 authorized rate restorations and increases for these providers, contingent on passage of the QAF. To complicate the matter, SB 1 also assumed that 30% ($91.4 million) of the $435.3 million in revenue generated by the QAF would be used to replace state general revenue in the DADS budget. As a result, the failure of the QAF leaves DADS not only without $347 million in state funding for nursing home rate restorations or updates, but also without $91.4 million in basic operating funds. Events are still unfolding on this issues, and readers should "stay tuned" for updates that might address this budget shortfall, and possibly the rate restorations and updates as well.

Why the QAF was Opposed by Some. Federal law generally requires that provider fees or taxes used to generate Medicaid match must be applied equally to all providers; for example, a nursing home fee may not be limited strictly to the homes that serve Medicaid clients (an estimated 65-70% of Texas nursing home residents are Medicaid clients, and only 57 of over 1,100 Texas nursing homes do not serve any Medicaid clients). However, there are ways that states enacting a fee can lawfully limit (but not completely eliminate) the tax impact on nursing homes that do not serve Medicaid clients. This is important, because the primary opposition to these fees comes from the more expensive nursing homes which do not accept Medicaid. The QAF legislation which failed to pass would have assessed the fee on 29 nursing homes (or 2.5% out of a total of 1,170 Texas facilities) which would not have benefited from the revenues generated.

Federal Medicaid authorities generally look unfavorably on the use of such mechanisms to simply enrich states' General Funds, as opposed to reimbursing for health and long term care services. The QAF proposal which died in the regular session would have plowed 70% of the proceeds back into nursing home care.

Community Care Programs in SB 1

As the following table illustrates, SB 1 treatment of community care programs varies from one program to the next. Under SB 1, some programs' caseloads would be frozen at 2005 levels. A number of programs are allowed to increase above 2004-2005 caseloads; however, some programs would remain below 2003 caseloads despite an increase, because of the reduced 2004-2005 caseloads imposed by the 78th Legislature's budget.

DADS Community Care Program Caseloads: 2003, 2005, and SB 1 Budgeted for 2006-2007				
Entitlement	**Expended 2003**	**Budgeted 2005**	**SB 1, 2006**	**SB 1, 2007**
Primary Home Care (PHC)	51,801	63,326	68,904	74,749
Community Attendant Services* (CAS)	34,843	44,887	49,206	53,156
Day Activity and Health Services (DAHS) (adult day care)	15,963	17,119	18,937	19,969
Waivers				
Community-Based Alternative (CBA)	30,279	26,100	26,867	28,401
Home and Community-Based Services (HCS)	7,280	8,860	9,744	11,194
Community Living Assistance (CLASS)**	1,700	1,817	2,228	3,049
Deaf-Blind Multiple Disability (DBMD)	130	143	148	156
Medically Dependent Children program (MDCP)	977	983	1,320	1,993
Texas Home Living (TxHmL)	0	2,052	2,811	2,823
Non-Medicaid				
Non-Medicaid Community Care (Title XX)	13,346	12,451	12,952	12,952
Non-Medicaid Community Care (GR)	1,153	0	0	0
Other Community Services				
Community Services for clients with mental retardation	13,305	10,137	10,137	10,137
In Home and Family Support	3,521	3,262	3,364	3,364
In Home and Family Support, MR	4,175	2,674	2,674	2,674

***formerly Frail Elderly, **a.k.a. Related Conditions Waiver**
Source: LBB's Legislative Budget Estimates, SB 1, HCSSB 1

Programs at the Department of State Health Services (DSHS)

With the reorganization of HHS services under HB 2292, far fewer Medicaid dollars are at DSHS than were in the budget of its primary precursor, the Texas Department of Health . With Family and Protective Services, Medicaid, and CHIP receiving the largest increases in Article II funding, DSHS' state funding for 2006-2007 is just 3.2% ($67.3 million GR & GR-dedicated) above 2004-2005 levels—one of the smallest increases among HHS agencies. Because agency funding in 2004-2005 was significantly reduced compared to 2002-2003, it is worth noting that the 2006-2007 state funding level is just 0.3% above 2002-2003 spending.

A number of programs are funded to allow additional clients to be served; however, in several cases the assumed cost per client is not increased for inflation, which could require reductions in service levels. A summary of funding proposed for some key health care and behavioral health programs at DSHS is provided below.

Note: *in some cases where the budget indicates that increased caseloads are supported for 2006 and 2007, it may also be assuming that the cost per client is held flat; some programs would remain below 2003 caseloads despite the increases.*

Caseloads for Selected DSHS Programs, Historical and Proposed				
	Expended 2003	**Budgeted 2005**	**SB 1 2006**	**SB 1 2007**
Children with Special Health Care Needs	1,463	2,114	2,232	2,293
Mental Health Community Services, Adult *(cost per client increased above 2005 level.)*	52,448	46,086	46,143	46,330
Mental Health Community Services, Child *(cost per client increased above 2005 level.)*	11,431	9,962	9,994	9,994
Clients Receiving New Generation Medications *(assumes monthly drug cost remains at 2005 levels.)*	15,898	18,105	17,333	17,331
Substance Abuse Treatment for Adults *(assumes a lower cost per client than in 2003, held flat since 2004.)*	43,702	52,977	53,756	53,756
Substance Abuse Treatment for Youths *(cost per client has been held constant since 2003.)*	5,661	7,377	7,477	7,477
Substance Abuse Treatment, Dual Diagnosis	4,362	6,265	6,082	6,082
State Mental Hospitals (average daily census)	2,265	2,268	2,319	2,319
Kidney Health Program	22,834	21,247	19,725	20,415
HIV Medication Program	12,317	13,107	14,851	15,148
Immunizations* *(doses administered)*	n/a*	11,788,002	12,172,394	12,458,043
Primary Health Care	95,613	84,000	84,000	84,000
Family Planning *(increase in cost per client over 2005, but lower than in 2003-2004.)*	269,105	273,986	273,986	273,986
Infants & Children Served, Maternal and Child Health	40,442	40,000	40,000	40,000
Women Served, Maternal and Child Health	58,259	53,251	53,500	53,500
Number of WIC participants, per month	851,943	881,761	924,605	924,605

***Comparable value for 2003 not available, because this measure has been re-designed.**

Family Planning Budget "Riders" Re-direct Funds. The budget includes two new "riders" that affect family planning funding. The first, Rider #50 in Special Provisions Relating to all Health and Human Services Agencies and authored by Senator Tommy Williams, directs a $5 million reduction ($2.5 million per year) from DSHS family planning program funding, and directs HHSC to use $5 million in federal TANF funds to "implement a statewide program for women seeking alternatives to abortion focused on pregnancy support services that promote childbirth." The funding will presumably be distributed through grants or contracts with entities often called "crisis pregnancy centers." This redirection of funding would eliminate family planning funding for about 16,667 clients every year.

A second rider (#81 in the DSHS budget, authored by Senator Bob Deuell) sets aside up to $22 million of DSHS family planning funds for favored providers. Up to $2 million is to be made available to clinics operated by Baylor College of Medicine. Up to another $20 million is to be reserved for reimbursing Federally Qualified Health Centers (FQHCs) for Family Planning services. FQHCs are valuable community primary health care providers, 17 of which (nearly half the total number) <u>already</u> have family planning contracts with the Texas Department of State Health Services. Any funds not

applied for and granted to FQHCs are to be made available to the rest of the other 70 currently contracted family planning providers statewide. The rider stipulates that DSHS is to allocate family planning funds across the state according to need, presumably to ensure that the focus on FQHC funding does not distort the geographical availability of family planning. FQHCs are also required by the rider to provide comprehensive primary and preventive care to their family planning clients.

Other Major Decisions in the 2006-2007 Budget: DSHS (Biennial General Revenue)	
Restore 5% base Reduction ($37.7 million requested), maintain FY '05 service levels: 95% of the cut was restored. Programs that were reduced include tobacco prevention, trauma funding, South Texas health care System, and mental health funding that had been re-allocated to mental health from other DSHS budget areas.	5% cut restored for most programs
Childhood Vaccines ($9.04 million GR requested): Adds PCV-7 and Hepatitis A vaccine	YES
Restore Substance Abuse programs to 2002-2003 Levels. Though the $9.8 million GR requested for this was not provided, the budget does provide $3 million GR which will ensure federal maintenance of effort requirements are met.	NO, but some addl. funding
Texas Cancer Registry: Funding will allow system improvements to meet "gold standard".	YES
Children with Special Health Care Needs: Funding for growth included as part of waiting list reduction Exceptional Item package ($3.9 million GR).	YES
Sexually Violent Predators: Allow caseload growth to handle civil commitment clients.	YES
State Mental Hospital Staff: ($15.3 million GR requested; adds 106.3 FTEs)	YES
Improve Newborn Screening: ($5.4 million GR requested)	YES
Repair & Renovate State Mental Hospitals:.	YES
County Indigent Health Care: 2004-2005 projected funding for the CIHC grant program was $15.8 million GR. New rider says no one county may receive more than 20% of available state funds.	$14.1 million

Summary presentations on appropriations and legislation affecting Health and Human services agencies often can be found on their web sites; links to recent presentations for HHSC, DSHS, and DADS are provided below.
http://www.hhsc.state.tx.us/news/meetings/past/2005/062405_Council.html
http://www.dshs.state.tx.us/council/agendas/063005/Agenda.pdf
http://www.dads.state.tx.us/news_info/presentations/79th_Leg_Update.pdf

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