THE POLICY PAGE
An Update on State and Federal Action

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How the Senate and House Budgets Compare On Medicaid, CHIP, Other Health Services

The Senate and House versions of the state budget differ in some important respects in their proposed funding for Medicaid, CHIP and other health care programs *(See Policy Page #228 for details on SB 1, the "base" General Appropriations Act for 2006-2007, as first introduced)*. Soon, the "conference committee" on the state budget will begin to hammer out a final compromise budget for the next two years. The budget bill as first introduced recommended $17.9 billion in state general revenue (GR) and general revenue-dedicated funds for Article II health and human services (HHS) agencies, while the Senate bill would allocate $19 billion in GR and GR-dedicated funds, and the House $18.8 billion in those state dollars. **Proposed restorations of benefits cut in 2003, funding to reduce waiting lists, and funding simply to allow for population growth and inflation may not survive in the final budget unless the legislature adopts legislation that raises additional revenue to support state government.**

Key issues and differences in health care programs in the Senate and House budgets include:

- **Both Senate and House budgets assume much lower Medicaid and CHIP caseloads and cost-per client than HHSC projected.** Both bills adopted significantly lower Legislative Budget Board (LBB) caseload projections, and assume the Health and Human Services Commission (HHSC) projection for cost-per-client in 2006, but allow for no inflation in that cost for 2007 (details below).
- **The Senate budget would restore certain benefits for adult Medicaid clients (78% of whom are elderly or disabled), but the House budget would not.** The Senate bill restores eyeglasses, hearing aids, mental health professional services, and podiatry.
- **Neither the Senate nor House budget restores all of the 78th Legislature's Medicaid and CHIP cuts.** Provider rate cuts passed in 2003 are not restored at all in the House budget, and only partly restored in the Senate's bill. Neither chamber funded 12-month coverage for Children's Medicaid or CHIP, or the reversal of the 2003 cut to nursing home residents' personal needs allowance (the latter may still be restored through a separate bill).
- **Neither the Senate nor House budget includes funding to allow CHIP enrollment to grow.** In fact, the bills assume that CHIP enrollment will continue to drop throughout 2006. Without funding for enrollment growth, enrollment could be restricted or benefits reduced. However, both bills also include a "rider" requiring HHSC to request additional funds from the LBB before capping enrollment and creating a waiting list.
- **Both House and Senate budget bills restore vision and dental care to CHIP; the Senate bill also restores mental health coverage to 2003 levels.** The appropriations bill as introduced included funding for vision and dental benefits, so neither chamber had to take action to restore those benefits.
- **Both House and Senate budget bills assume large reductions in HHS state workers.** The House bill would reduce workers by 1,626, and the Senate by 3,381, after already cutting more than 2,500 workers from 2003 to 2005. Both bills still assume large reductions in eligibility workers (House by 3,980; Senate by 4,138) related to implementation of "Integrated Eligibility."
- **Both Senate and House budgets reduce Medicaid funding by about $110 million** GR based on LBB's original assumption of savings from STAR+PLUS "managed long term care" program expansion. However, both chambers' budgets now assume savings will be derived from other sources, particularly through a new Integrated Care Management approach to managing care of Medicaid aged and disabled clients.
- **Both Senate and House budgets include funding at the Department of Aging and Disability Services (DADS) and several programs at other agencies intended to keep waiting lists for those programs from increasing. The Senate includes additional funds designed to reduce the waiting lists by 5% during the biennium.** Funding is increased for nursing homes and expansion of several community care program caseloads. However, caseloads for some community care programs would remain below 2003 levels.

- **Proposed funding of direct service programs** at the Department of State Health Services (DSHS) **varies** from one program to the next. Both versions of the budget increase GR funding for immunizations, the HIV drug program, Children with Special Health Care Needs, community mental health services, substance abuse services, and state mental hospitals. The Senate's funding to reduce waiting lists results in higher funding in the Senate bill for several DSHS programs.

Medicaid funding across Article II would be highest under the Senate bill, with $14.3 billion in GR/GR dedicated and $22.4 billion in federal match, compared to $14.0 billion GR/GR dedicated and $22.0 billion federal in the House bill. The introduced budget began with $13.5 billion in GR/GR dedicated and $21.26 billion in federal funds for Medicaid.

Medicaid at HHSC

As reported in *Policy Page #228*, the original introduced version of the budget assumed much lower Medicaid caseload growth as well as much lower costs per Medicaid client, than has been assumed by HHSC in their 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).[1] 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.

Both House and Senate budgets assume:

1. Children's Medicaid eligibility remains at 6 months (requiring a change in statute, as current law would phase 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. hold 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. This made a balanced budget that much easier to attain and "freed up" GR for other important spending priorities (including the restoration of 2003 cuts).

The caseload numbers in the House and Senate budget documents are not identical to the filed version of the budget because the two chambers made different decisions regarding Medicaid eligibility restorations, waiting lists, and expansions that would increase caseload assumptions somewhat.

Medicaid Caseloads: Actual and Projected		
Actual point-in-time Medicaid enrollment, March 2005 *(Final "recipient months" average 104% of point-in-time enrollment, after retroactive coverage is included)*	2,655,041 (equals about 2,761,243 recipient months)	
HHSC's Projected Annual Average Monthly Enrollment, FY 2005	2,865,736	
LBB assumption of Annual Average Monthly Enrollment, FY 2005	2,862,298	
	2006	**2007**
HHSC 2/05 estimated caseloads, staying at 6-month coverage for children	3,124,110	3,356,597
HHSC 2/05 estimated caseloads, WITH 12-month coverage for children	3,256,200	3,588,967
Introduced version, SB 1 (assumes 6-month coverage of children)	2,987,578	3,137,045
Senate Budget	3,001,093	3,151,360
House Budget	2,991,374	3,140,841

The tables below provide more detail comparing major Medicaid and health care funding decisions in the House and Senate budgets for HHSC, DADS, and DSHS. CHIP decisions are explained in a separate section.

[1] HB 2365 by Isett, HB 2479 by Delisi, and SB 1819 by Janek all include provisions to hold both Children's Medicaid and CHIP at 6 month coverage until after the 2007 Legislative session. HB 3540 by Pitt appears to give HHSC open-ended authority to increase or cut the eligibility period.

Certain items are not actually funded in the bills, but are instead included in Article XI of the House or Senate bill, often referred to as "the wish list." Inclusion in Article XI indicates the chamber believed the item was worthy of further consideration for funding, and means the issue can be debated and possibly funded by the conference committee that will craft a final compromise budget. By no means does it ensure funding of the item. Where noted, some items were recommended to be funded with non-GR funds (e.g., local government funds, federal block grant funds).

Major Decisions in the House and Senate Budgets: HHSC (Biennial General Revenue)		
	House	**Senate**
Medicaid costs and caseload above filed version of budget	$586.9 million	$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. $62.36 million GR requested	Article XI Only	$55.7 million* (no Chiro.)
Restore Medicaid Provider Rates to FY 2003 levels, at 6-month coverage of children. $204 million GR requested	Article XI Only ($204.2 million)	No
Partial Medically Needy Restoration: (Temporary coverage for poor parents with high medical bills.) Per HHSC, this amount would reinstate payments at about 20% of normal Medicaid rates. $35 million GR requested.	Article XI Only	No GR: $35 million in local Gov't funds
Medicaid Provider Rate Increases: ($227.9 million requested)	No	No
Reduce HHS Waiting Lists growth: (includes items from DADS, DSHS, and DARS)	$47 million	$47 million
Eliminate HHS Waiting Lists "10 year plan" ($257.6 million requested; Senate puts remainder in Article XI)	Article XI Only	$79.7 million (5% reduction
Enhanced Family Violence Funding	$2 million	$2 million
Restore TANF Supplemental payments (annual $60 per-child "back-to-school" payments), cut to $30 by the 78th Legislature. TANF funds ($11.1 million), no GR	No	No
New Medicaid Buy-In Program for Workers with Disabilities	$6.3 million	$6.3 million
2-1-1 Information & Referral	$3.06 million	$3.06 million
Improve Contract Management & Oversight (78 FTEs)	$3.74 million	$3.74 million
Staff for Office of Inspector General ($1 million GR requested)	Article XI Only	$1 million
Restore GR for Graduate Medical Education (SB 1 assumes that the state's share of Medicaid GME payments would be funded with $40 million local tax dollars via intergovernmental transfers, or "IGTs")	Article XI Only	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)	Article XI Only	No
Non-urban hospital Upper Payment Limit (UPL) payment program ($54 million GR requested)	Article XI Only	No
Restore 5% Baseline cut Re: Integrated Eligibility : 5% cut results in 157.6 eligibility workers being cut, above & beyond 3,980 to be eliminated; $29.5 million GR requested	$15 million	No
Program Administration & Support (restore 5% cut; $19.1 million requested; (House also puts $4.6 million in Art. XI)	$13.58 million	$18.15 million
Maintain critical technology (all HHS agencies, $12.2 million requested; (House also puts $1.4 million in Art. XI)	$10.8 million	$12.2 million

***System Benefit Fund: Robbing the Poor to Give to….The Poor?** The Legislative Budget Board recommended taking money from the System Benefit Fund which is now used 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 Senate budget as the means to fund restoration of adult Medicaid benefits (mental health, podiatry, hearing aids and eyeglasses).

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 recommend 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 proposed 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 people is a troubling example of the perverse policies that result from failing to address our state's revenue needs in a comprehensive way.[2]

"Partial" Restoration of Medically Needy Coverage: What it Might Mean. A partial restoration of the Medically Needy (MN) Medicaid benefit for poor parents of dependent children (Texas still has MN coverage for children and pregnant women) is included in the Senate's budget, but not the House's version (the House does include it in Article XI). This means the partial restoration may or may not survive in the final budget. Limited information has been made public about how such a policy might work, and a final policy has not yet been fully developed.

In public hearings, HHSC officials have 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 Medicare 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 scenario, 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).

Of key importance is the HHSC (and Senate) assumption that any MN restoration would be funded with local government revenues, and not by the state government. This 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 and will only restore them if local governments provide the revenue. Clearly this approach does not save Texas taxpayers a penny, but only concentrates the tax burden in the urban centers where most Texans live. On the other hand, a Medically Needy expansion to all uninsured parents under the poverty line could be of enormous benefit to both hospitals and working poor families, even if the benefits are limited to hospital care.

That said, the concept of limiting MN coverage to inpatient hospital care has serious drawbacks. No other state has taken an approach like this, but it is probably 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. **CPPP will advocate for development of a Medically Needy policy broad enough to cover treatments for renal disease and cancer, at a minimum.**

Medicaid Managed Care, STAR+PLUS, and "Integrated Care Management". One of the most controversial HHS legislative issues has been the proposed expansion of Medicaid Managed Care set in motion by HB 2292 of the 78th session, but not yet implemented. In a nutshell, the HHSC plan assumed in the original budget bill 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.
- extended HMO-based Medicaid Managed Care to one new area, the Corpus Christi-Nueces County area. All of Texas' rural counties would be brought into PCCM for the first time.

The last of the three bullets is the only one likely to be implemented 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. As a result, both budget bills now assume that an enhanced PCCM-type "Integrated Care Management" (ICM) model will instead be

[2] HB 2774 would codify the proposed elimination of the SBF low-income energy assistance programs. Several bills would restore and/or expand the use of the SBF funds for low-income energy assistance: SB 102, HB 165, HB 301, HB 324, and HB 3180.

the vehicle for achieving better care for aged and disabled clients, and for reducing Medicaid spending by $109.5 million GR (see rider 49, Special Provisions Relating to all Health and Human Services). HB 1771 by Representative Delisi would create the new model (SB 1756 by Zaffirini and SB 871 by Nelson also address this topic). The rider guarantees the savings by allowing HHSC to reduce provider rates if the new model does not produce the required savings.

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 required by current law).

The same compromise made for Medicaid caseload and costs (described above) is mirrored for CHIP in both the House and Senate bills; that is, much lower LBB caseload projections are used, along with HHSC's projected 2006 cost-per-child, held constant in 2007. As the table below illustrates, the budget now assumes that CHIP enrollment will continue to drop in 2006 (despite restored benefits and reduced premiums), recovering only slightly in 2007.

CHIP Caseloads: Actual and Projected			
		2006	**2007**
September 2003 actual caseload	507,259		
March 2005 actual caseload	328,350		
decline, 9/03 to 3/05	(-178,909) 35%		
Annual monthly average, FY 2004	409,865		
HHSC 2/05 projected monthly average, FY 2005	339,043		
HHSC 2/05 projected, with 12-month eligibility restored		386,110	467,404
HHSC 2/05 projected, stay at 6 month renewal		360,786	388,920
Assumed SB 1 caseload, Senate and House		**324,750**	**331,132**

The House and Senate budget committees made additional changes to CHIP provisions. Both chambers adopted an HHSC proposal to significantly reduce CHIP premiums (essentially replacing them with annual or semi-annual enrollment fees). The Senate allocated funds to restore mental health benefits to 2003 levels (HHSC had restored those benefits to roughly half the 2003 level back in February 2004). The House directed the restoration of hospice benefits, which was determined to have no cost. The Senate also allocated funds to restore CHIP rates to 2003 levels. The House bill assumes that August 2007 CHIP premiums will be delayed until September 2007, to reduce required appropriations by $5 million.

Finally, the full House adopted a "rider" authored by Rep. Isett to eliminate CHIP coverage of legal immigrant children. These children are lawful permanent residents of the U.S., virtually all of whom could become U.S. citizens when they reach adulthood (children may not apply for citizenship). They have been included in Texas' CHIP program since its inception.

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:

- $50 per family (or $25 per 6-month period) from 133-150% of the federal poverty level (FPL);
- $70 per family (or $35 per 6-month period) from 151%-185% FPL; and
- $100 per family (or $50 per 6-month period) from 186%-200% FPL.

While there would be some grace period for late payment of renewals, generally new enrollees would not be covered until the enrollment fee was received. HHSC is also exploring how it could "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. HHSC staff discussed several scenarios with the Texas CHIP Coalition in March meetings. While unanimous consensus was not achieved, most Coalition members agreed that the lowest "tier" of coverage (i.e., the coverage of first-time enrollees not eligible for a "reward") should include a therapeutic benefit, and not just a preventive care component.

CHIP Decisions in the Senate and House Budget Bills (Biennial General Revenue Amounts)		
	House	**Senate**
CHIP cost growth remaining at 6 month renewal (inflation, price increases)	$15.8 million	$15.8 million
Revised CHIP Premium Policy	$11 million	$11 million
CHIP Rate restoration (to 2003 levels)	No (Art. XI only)	$12.4 million
CHIP Caseload Growth, at 12 month coverage ($47.9 million requested)	No	No ($25 million, Art. XI only)
"Rider" Requiring HHSC to Request Additional Funds for CHIP from LBB before Capping Enrollment and starting Waiting List	Yes	Yes
CHIP Benefits (in addition to $36.7 million included in budget as introduced for vision and dental coverage)	Hospice, no cost	Mental Health, $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.	No -Rider by Rep. Carl Isett eliminates funding	

As noted above, the budget bills assume no growth in CHIP enrollment (i.e., they do not assume enrollment will grow back to 2003 levels, which would add nearly 180,000 children to the current rolls, but instead assume enrollment will be even lower than in 2004 and 2005). But, with restored benefits, an improved premium policy, and re-energized community-based outreach for CHIP, it is entirely possible that enrollment will increase, even if coverage remains at six months. As the table above notes, both chambers have included a "rider" in the budget requiring HHSC to seek additional funding from the Legislative Budget Board (LBB) if a CHIP shortfall "crisis" occurs in 2007. Though this step does not 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.

The CHIP benefit cuts and eligibility policy changes adopted by the 78th Legislature included:

(1) Coverage period reduced from 12 to 6 months;

(2) Elimination of CHIP dental and vision benefits, hospice; skilled nursing facilities; tobacco cessation; chiropractic services. Mental health coverage reduced to about half of the coverage provided in 2003;

(3) Across-the-board 2.5% rate cuts for CHIP medical providers;

(4) Increased premiums and co-payments;

(5) 90-day delay in new coverage taking effect;

(6) Elimination of income deductions for child care and child support;

(7) New asset "test" (limit); at least 6,000 children have lost or been denied coverage since late August 2004);

(8) Outreach and marketing were reduced by more than half.

At this point in the session, if CHIP is to be fully restored—or even restored beyond these budget assumptions—it will be via passage of SB 59 by Senator Kip Averitt, which has not yet had a public hearing.

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 dollars in the Senate's proposed 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 very substantial costs for restoration and growth in community care programs at DADS are included in the HHSC requests related to waiting lists (see HHSC table above). Like HHSC, DADS appropriations in both chambers' bills assume the lower LBB caseloads, resulting in a $25.4 million GR reduction in funding.

Major Decisions in the House and Senate Budgets: DADS (Biennial General Revenue)		
	House	**Senate**
DADS: Fund entitlement caseload growth *(*$25.4 million requested)	No	No
Entitlement caseload growth staffing ($10.26 million requested)	$7.0 million	No
Restore 5% base Reduction ("Critical Accounting and Oversight") Without restoration, client workload per eligibility worker would grow to 445, up from 240 in 1999. $13.2 million requested.)	$7.8 million	$13.2 million
Fund Actual 2005 costs in Waivers	$3.95 million	$3.95 million
Restore Appropriation Reduction for STAR+PLUS (SB 1 originally reduced DADS budget $109.5 million. Both bills now reduce HHSC budget by that amount via rider to reflect savings from a non-capitated care management model for aged or disabled clients.	No (rider)	No (rider)
Fund Long Term Care Acuity Increase (SB 1 as introduced did not allow for increased cost per client trend)	No	$52 million
Restore rates to 2003 levels (rates were cut 1.75% for nursing facilities and 1.1% for community care providers: $55.3 million requested). Senate funds for ICF-MR and community care, <u>not</u> <u>NF</u>, pending passage of QAF)	No (Art. XI only)	$23.68 million
Promoting Independence (Transition of 146 clients with mental retardation from institutional settings to HCS community waiver program.)	$4.68 million	$4.68 million
Re-base and Increase Provider Rates (Update rates to reflect actual increased costs; $503.2 million requested)	No (Art. XI only)	No
Rate Increase for Direct Care Staff (Enough to increase attendants and aides wages by an average $1 per hour; $241.4 million requested)	No	No
Restore Non-entitlement Community care Services (Title XX). DADS redirected funds from state-funded community care programs in order to pay for the adult Guardianship transferred from Family and Protective Services (FPS). ($5.5 million Title XX Social Services Block Grant funds requested)	$5.5 million Title XX (no GR)	$5.5 million Title XX (no GR)
Guardianship program: DADS requested $11.7 million GR for program transferred from FPS, without benefit of funding or staff.	$3.4 million Title XX (No GR)	No
Repair & Renovation of MR facilities ($60.3 million bond auth. & $560,000 GR requested)	$1.5 million GR, $31 million bond	$1.5 million GR, $31 million bond
Richmond State School: bonding authority for completion of planned cottages. ($2.56 million in General Obligation bonds)	No	No

Neither bill includes funding to restore the monthly Personal Needs Allowance for nursing home residents to $60 (reduced to $45 by the Legislature in 2003), but the House bill includes contingency "rider" language which will fund the restoration, or increase the allowance to $75, upon the passage of House Bills 24 or 288, taking funding from the lottery advertising budget. Restoration to $60 would cost about $12.9 million GR for the biennium.

Also of note: both bills assume deferrals into the 2008-2009 biennium of August 2007 payments for community MR services (postponing $5.5 million in GR spending), and also convert several Long Term Care programs' accounting procedures from accrual to cash basis, postponing about $100 million in GR spending to the next biennium.

Up in the Air: a Nursing Facility "Quality Assurance Fee" (QAF)? One reason that the Senate's DADS rate restorations to 2003 levels described above do <u>not</u> include nursing facilities is the uncertainty about whether or not a new tax or fee on nursing homes will be enacted (at least 2 bills have been filed to create such a "fee"). Federal law generally requires that any such fee or tax must be applied equally to all nursing homes; that is, it may not be limited to the homes that serve Medicaid clients (at least 70% of nursing home residents are Medicaid clients, and only 58 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 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 clients.

One proposed bill would raise over $200 million annually in fees, drawing well over $300 million in federal matching funds. If all the revenue were applied to nursing home reimbursement, it could fund an increase of about $16 dollars a day

(a significant increase). However, some legislators want to divert funds for other purposes, such as school finance. 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. It is not clear whether the QAF will become law, or how the revenue will be used if it does, but this issue is one with major budget implications.

Community Care Programs in SB 1

As the table above 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, two 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, Actual and Proposed						
Entitlement	**Expended 2003**	**Budgeted 2005**	**House, 2006**	**House, 2007**	**Senate, 2006**	**Senate, 2007**
Primary Home Care	51,801	63,326	69,031	75,137	68,899	74,742
Community Attendant services*	34,843	44,887	49,318	53,499	49,202	53,150
DAHS (adult day care)	15,963	17,119	18,937	19,969	18,937	19,969
subtotals	**102,607**	**125,332**		**148,605**		**147,861**
Waivers						
CBA	30,279	26,100	26,713	26,713	26,866	28,398
HCS	7,280	8,860	9,269	9,269	9,520	10,418
CLASS**	1,700	1,817	1,861	1,861	1,938	2,181
Deaf-Blind Multiple Disability	130	143	146	146	150	161
Medically Dependent Children	977	983	997	997	1,061	1,216
Consolidated Waiver	175	192	197	197	194	199
Texas Home Living	0	2,052	2,903	2,903	2,811	2,823
subtotals	**40,541**	**40,147**		**42,086**		**45,396**
Non-Medicaid						
Non-Medicaid Community Care (Title XX)	13,346	12,451	12,952	12,952	12,853	13,252
Non-Medicaid Community Care (GR)	1,153	0	0	0	0	0
subtotal (XX and GR)	**14,499**	**12,451**		**12,952**		**13,252**
Other Community Services						
Community Services for clients with mental retardation	13,305	10,137	10,137	10,137	10,137	10,137
In Home and Family Support	3,521	3,262	3,364	3,364	3,441	3,799
IHFS, MR	4,175	2,674	2,674	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, fewer Medicaid dollars are at DSHS than were in the TDH budget. A summary of funding proposed for some key health care and behavioral health programs at DSHS is provided below. ***Important 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 reduced; and some programs would remain below 2003 caseloads despite the increases.*

Caseloads for Selected DSHS Programs, Historical and Proposed						
	Expended 2003	**Budgeted 2005**	**House, 2006**	**House, 2007**	**Senate, 2006**	**Senate, 2007**
Children with Special Health Care Needs	1,463	2,114	2,375	2,416	2,530	2,596
Mental Health Community Services, Adult	52,448	46,086	48,316	48,283	46,814	47,433
Mental Health Community Services, Child	11,431	9,962	10,299	10,359	9,994	9,994
Clients Receiving New Generation Medications *(Assumes monthly drug cost remains at 2005 levels.)*	15,898	18,105	18,663	18,650	17,333	17,331
Substance Abuse Treatment for Adults *(Assumes a drop in cost per client in 2006 and 2007)*	43,702	52,977	55,470	55,470	53,756	53,756
Substance Abuse Treatment for Youths	5,661	7,377	7,701	7,701	7,477	7,477
Substance Abuse Treatment, Dual Diagnosis	4,362	6,265	6,082	6,082	6,082	6,082
State Mental Hospitals (average daily census)	2,265	2,268	2,345	2,345	2,319	2,319
Kidney Health Program	22,834	21,247	19,725	20,415	19,725	20,415
HIV Medication Program	12,317	13,107	14,851	15,148	14,851	15,148
Immunizations* *(doses administered)*	n/a*	11,788,002	12,141,155	12,426,804	12,172,394	12,458,043
Primary Health Care	95,613	84,000	84,000	84,000	84,000	84,000
Family Planning *(Assumes decline in cost per client)*	269,105	273,986	273,986	273,986	254,148	254,148
Infants & Children Served, Maternal and Child Health	40,442	40,000	40,000	40,000	40,000	40,000
Women Served, Maternal and Child Health	58,259	53,251	53,500	53,500	53,500	53,500

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

Family Planning Funding Misdirected. The Senate budget includes two "riders" that misdirect family planning funding.

One rider 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 support "nonprofit agencies whose primary function is to assist all pregnant women seeking alternatives to abortion," often called "crisis pregnancy centers." This redirection of funding would eliminate family planning funding for about 16,667 clients every year. *(See rider 50, Special Provisions Relating to all Health and Human Services Agencies.)*

A second rider (#84 in the DSHS budget, authored by Senator Bob Deuell) sets aside $22 million of DSHS family planning funds, and allows them to be used only to reimburse Federally Qualified Health Centers (FQHCs). FQHCs are valuable community primary health care providers, 17 of which (nearly half the total number) already have family planning contracts with the Texas Department of State Health Services. This would mean funding for about 70,000 family planning clients would no longer be available to the other 70 currently contracted family planning providers, and approximately 22 percent of available family planning funds would be allocated to counties where FQHCs are located.

Riders were offered in the House budget to promote a Medicaid waiver program to allow adult women up to 185% of poverty (the income limit for Medicaid maternity coverage) to access family planning services and basic check-ups, which

would draw a 90% federal match (see also SB 747 by Senator John Carona). Another rider would have required agencies receiving state or federal family planning dollars to meet basic DSHS standards ("crisis pregnancy centers" are not licensed or regulated by any state agency). Both of these riders were ultimately withdrawn in the House.

Major Decisions in the House and Senate Budgets: DSHS (Biennial General Revenue)		
	House	**Senate**
Restore 5% base Reduction ($37.7 million requested), maintain FY '05 service levels. (Senate includes more for U.T. Medical Branch, County Indigent Health Care)	$22.07 million (incl. $4.6 million fees)	$36.5 million (incl. $3.7 million fees)
One-Time Land Sales Restoration ($5.78 million GR requested)	$5.5 million	$4.54 million
HIV Medication Program	$15.02 million	$15.02 million
Childhood Vaccines ($9.04 million GR requested) Senate fully funds PCV-7 and Hep A; House funds full amount for Hep A, reduced amount for PCV-7.	$5.82 million	$9.04 million
Restore Substance Abuse programs to 2002-2003 Levels ($6.87 million GR requested)	No	No
Texas Cancer Registry	$2.2 million	$2.2 million
Sexually Violent Predators, Allow caseload growth to handle civil commitment clients. ($890,000 GR requested)	$890,000	$890,000
State Mental Hospital Staff ($15.3 million GR requested; adds 106.3 FTEs)	$15.3 million	$15.3 million
Improve Newborn Screening ($5.4 million GR requested)	$5.4 million	$5.4 million
Radiation Regulation staff funding ($600,000 GR requested)	No	$600,000 (fee increases)
Repair & Renovate State Mental Hospitals ($49.8 million General Obligation bonds requested)	$1.33 million, plus $27 million bond auth.	$1.33 million, plus $27 million bond auth.
Texas Center for Infectious Diseases, construction ($6.09 million requested)	No	$6 million bonds (no GR)
Technology, Equipment ($26.01 million requested)	$8 million MLPP	$12 million MLPP
County Indigent Health Care. 2004-2005 projected funding for the CIHC grant program was $15.8 million GR.	$10.2 million	$14.1 million

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