Texas Medicaid in Perspective

Second Edition

Texas Health and Human Services Commission,
State Medicaid Division

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MEDICAID

Texas Medicaid in Perspective

Texas Health and Human Services Commission
Dr. Michael McKinney, Commissioner

State Medicaid Division
Linda Wertz, State Medicaid Director

P.O. Box 13247
Austin, Tx 78711
Telephone: 512-424-6548; Fax: 512-424-6585

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Although every attempt has been made to ensure accuracy, there may be some mistakes. Final responsibility rests with the HHSC State Medicaid Division staff.

General Caveats for this Report

Readers should be aware of several points regarding Texas Medicaid data.

First, because of the oversight and financing role of the federal government, the bulk of Medicaid data collection and reporting is done on a **federal fiscal year** (October through September) basis. Generally speaking, a special effort is required to adapt standard Medicaid reports to a **state fiscal year** (September through August) basis. **Except where a state fiscal year or state budget biennium is specifically noted, all figures in this report are derived from federal fiscal year data.**

At the time we went to press (December 1996), data for FY96 had not been finalized. Thus, except where noted, "current" Texas Medicaid program statistics included here refer to the most recent federal fiscal year for which there is complete data, 1995.

The income eligibility limits for the various Medicaid eligibility categories are reported for the current calendar year, 1996.

The Medicaid Numbers

Percentage of FY97 Health and Human Service funding in Texas: **72 percent**[1]

Percentage of Texas 1995 total budget (all funds): **18.6 percent**[2]

Percentage of state funds: **12.7 percent**[2]

Texas ranking among states on average per recipient spending: **48th**

Texas ranking among states on total Medicaid spending: **3rd**

Percentage of Texans living in poverty: **19 percent**

Percentage of Texas children in poverty: **28 percent**

Texas ranking among states on percentage of children in poverty: **13th**

Percentage of Texans without health insurance: **24.2 percent**

Texas ranking among states on percentage of population uninsured: **1st**

Percentage of Texas Medicaid recipients who are children: **57 percent**

Percentage of Texas Medicaid budget spent on children: **23 percent**

Total dollars spent for Texas Medicaid in 1995: **$9.1 billion**

Amount of Medicaid funds paid directly to Medicaid recipients: **$0**

Total payments to nursing homes made by Texas Medicaid: **$1.2 billion**

Total payments to hospitals made by Texas Medicaid (including dispro): **$3.9 billion**

Total payments to ICFs-MR by Texas Medicaid: **$589 million**

Number of childless non-elderly, non-disabled, non-pregnant Medicaid eligible adults: **0**

Number of Texans receiving Medicaid in 1995: **2.6 million**

Annual income for a family of three at 17 percent of poverty: **$2,266**

Federal poverty level for a family of three: **$12,590**

[1] HHS funding includes employee benefits and debt service expenditures

[2] The Medicaid budget number used to calculate this ratio includes only appropriated dollars spent, and excludes Disproportionate Share Hospital funding and items where the state matching share is paid with non-state funds.

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The Texas health care system is changing, and the Texas Medicaid program along with it. What circumstances are driving these changes and where will Texas Medicaid go from here?

Texas Medicaid experienced unprecedented budget and enrollment growth during the last decade, largely due to federally mandated eligibility expansions. This has levelled off.

TEXAS MEDICAID HAS REACHED a critical juncture as it approaches the turn of the century. Rising medical costs in recent years have spawned new thinking about how health care is purchased and delivered. Across the nation, both the public and private sectors have experimented with "managed care" and other creative alternatives to the existing system.

Today in Texas, about one in seven Texans (2.6 million of the 18.6 million in 1995) rely on Medicaid for their health insurance or special long term care services at a cost of $9.1 billion in 1995. Texas Medicaid experienced unprecedented budget and enrollment growth during the last decade, largely due to federally mandated eligibility expansions. Though **Medicaid enrollment appears to have leveled off** in the mid-90s, the ramifications of this growth spurt on the state budget still resonate strongly.

Major reforms enacted in 1995 attempted to remedy this problem of rising costs in the Texas Medicaid program by shifting some populations to managed care arrangements, and restructuring important elements of Texas' health finance system. Texas Medicaid plans to expand the managed care program statewide by the year 2001. These reforms were designed to maximize cost savings and client satisfaction, while minimizing disruptions in traditional client-provider relationships.

Texas has taken the first steps toward fundamental Medicaid reform, but in order to restrain budget growth, even more will be required. This publication provides a foundation of understanding on which policymakers can knowledgably base their deliberations.

Texas Medicaid in Perspective

WHAT IS MEDICAID?

MEDICAID IS A JOINTLY FUNDED state-federal program administered in Texas by the Health and Human Services Commission. State appropriated payments for Medicaid make up 12.7 percent of Texas' FY95 expenditures.

Both Medicaid enrollment and the Medicaid budget grew substantially in the last decade, largely due to population growth and federal mandates requiring services for new populations. In 1986, 879,000 Texans received Medicaid services. By 1995 that number nearly **tripled**, to 2.6 million for the year. Meanwhile, the Texas Medicaid budget (including all federal and state funds) expanded more than **fivefold**, from $1.7 billion to $9.1 billion, over the same period. These caseload increases appear to have levelled off, and caseloads may even decline if Texas sustains its present economic growth.

A relatively small number of Medicaid's most vulnerable clients, the elderly and disabled, actually account for the greatest proportion of Medicaid costs.

Medicaid primarily serves the poor — mostly Temporary Assistance for Needy Families (TANF) recipients (TANF is formerly AFDC, Aid to Families with Dependent Children) — the elderly and people with disabilities. A relatively small number of Medicaid's most vulnerable clients, the elderly and disabled, actually account for the greatest proportion of Medicaid costs. **Figure 1.1** illustrates the percentage of the Medicaid population made up by these categories, and the portion of the Medicaid budget spent on them in 1995.

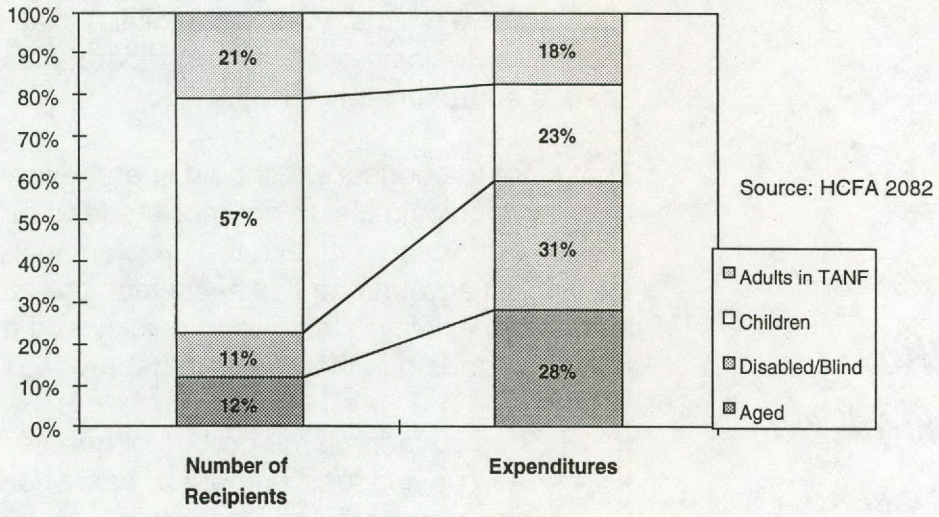
Children make up the majority of Medicaid recipients, but account for a relatively small portion of expenditures. By contrast, the aged and disabled make up just 23 percent of recipients, but account for 59 percent of Texas Medic aid health spending.

HOW CAN WE RESTRAIN MEDICAID GROWTH?

LAWMAKERS HAVE ATTEMPTED FOR years to control Medicaid spending, with limited success. Making substantial cuts in Medicaid entails real costs, because the program is the last resort for millions in need of health care, and it brings back to Texas billions of federal dollars we send to Washington in taxes.

Texas Medicaid in Perspective

Figure 1.1: 1995 Texas Medicaid Recipients & Expenditures



Texas uses some optional services to cover health costs the state previously paid for with 100 percent state or local funds.

Federal law requires Texas Medicaid to cover certain "mandatory" services and eligibility groups if it wants to participate in the program, while giving the state the opportunity to receive federal matching funds for a number of "optional" categories. Cutting these optional categories may pose problems because they serve some of Texas' most vulnerable elderly and disabled Texans who have no other medical alternatives. Conversely, other options could be eliminated, but they may only have the effect of increasing Medicaid costs. For example, dropping the "option" of covering prescription drugs for chronically ill or disabled adults could end up costing Medicaid more because people who cannot pay for, and do not receive, needed drugs may require increased hospitalization or move into a nursing home, where Medicaid will cover the drugs they need.

Texas uses some optional services to cover costs the state previously paid for with 100 percent state or local funds. For example, services for persons with mental retardation provided through state schools and in community residential settings are now funded with Medicaid, bringing in hundreds of millions of extra federal dollars for services for which Texans were already paying.

Texas Medicaid in Perspective

Medicaid brings back to Texas billions of the federal dollars we send to Washington in taxes.

Medicaid brings back to Texas billions of the federal dollars we send to Washington in taxes. In 1995, $5.7 of the $9.1 billion total for Texas Medicaid were federal, not state or local dollars. For every dollar Texas lawmakers spend on Medicaid services, the federal government spends approximately $1.67.

That's not to suggest we should spend every penny we have on Medicaid just to get more federal funds. But previous efforts to cut back the program in Texas have always run aground on this basic fact: the only way within Medicaid's existing structure to quickly and dramatically reduce spending in the state budget are to:

- Stop covering large groups of people, or
- Stop paying for a number of basic health care or long-term care services, or
- Reduce the amount we pay the providers for these services below the already conservative rates we currently pay.

In addition, every time we cut a state dollar out of Medicaid, we really cut $2.67 because of the loss of the federal match. Each of these ways to reduce spending comes with its own price, namely, that cutting Medicaid does not reduce these 2.6 million Texans' need for health care or long term care. Without Medicaid, uninsured Texans still seek medical care. When they receive it, usually at the emergency room or a public clinic, someone will have to pay, and frequently pay much more.

In Texas, we mostly pay for this uncompensated care — for those who do not qualify for Medicaid and have no private coverage — through local property taxes for our public hospitals, through higher private insurance costs for those with coverage and through other programs funded with state dollars. So, we end up paying for it anyway, too frequently with devastating effects on the patients requiring medical attention and their families.

High levels of spending on health care may not necessarily be bad, so long as we deliver these health services efficiently, because society benefits from health care in so

In Texas, we mostly pay for uncompensated care through local property taxes.

many ways. Nowhere in the industrialized world does a health system operate without sizable doses of public funds. In the United States, governments at all levels contribute 44 percent of total health care spending, less than in some other nations, but large enough to recognize that substantial government funding underpins the entire U.S. health care system. For that reason, policymakers must ensure that any large cuts in Medicaid or other health spending won't backfire by forcing higher costs for local governments or creating greater public health problems down the line.

The alternative to massive cuts in Texas Medicaid involves focusing on controlling the rate of growth in health care spending. Some states have successfully restructured their programs by using waivers to get out from under certain federal mandates. Managed care systems may help control unnecessary use of expensive services, connect patients to a physician or medical home and emphasize prevention to keep people healthy. By developing less expensive alternatives to institutionalization, the increase in Medicaid costs can be slowed. Perhaps even more importantly, the effectiveness and value of the dollars we spend can be greatly enhanced.

WHERE TEXAS MEDICAID GOES FROM HERE . . .

AS TEXAS REFORMS ITS MEDICAID program, it faces the daunting task of balancing federal mandates, the state's responsibilities as a safety net, structural deficiencies in the broader health care market, abated but continuing medical inflation, Texas' relatively high poverty levels and constraints on the state budget.

We are in the midst of fundamental changes in the health arena — public and private — that require rethinking the role, strategies and objectives of public health programs. For Medicaid, future federal legislation may resolve some issues, but Congressional reforms will likely move toward allowing states more discretion to design and implement their own programs. So, state government will continue to have an important if not primary role in how Medicaid operates into the next century.

Texas Medicaid in Perspective

The challenge in preparing this publication was to translate complex, often bureaucratic, Medicaid-ese into clear, comprehensive information for the "non-expert" reader to use. Every attempt was made to balance the desire for simple, managable information with the need to provide complete data and key details required to understand the program.

In order to design much-needed changes in Medicaid, we need to understand the byzantine system that is the current Medicaid program. *Texas Medicaid in Perspective* provides relevant information that must be taken into account as the state attempts to create a new, financially sound system for the people of Texas, who must rely on Medicaid for health care. Without such an understanding of the program and the environment in which it operates, we risk making changes that leave people who rely on Medicaid — and the people who pay for it — in worse shape than they are in today.

Chapter Two: The Big Picture

Hundreds of thousands of Texans work in health care, a $50 billion industry statewide. Medicaid and other government sources pay the biggest share, providing health care to poor, elderly and disabled Texans. Still, one in four Texans remains uninsured.

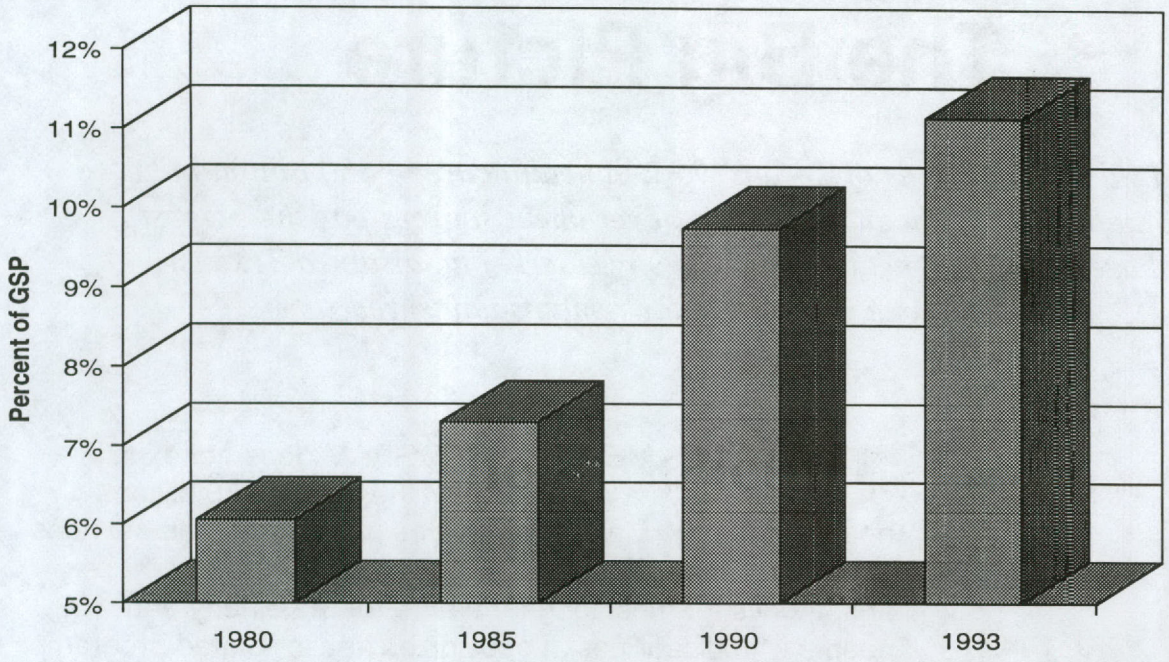
THE TEXAS MEDICAID PROGRAM does not exist in a vacuum. It's a critical part of the state's $50 billion health economy. Medicaid provides payment for the services of health care professionals who treat poor and needy Texans. It pays for most long term care for the elderly and people with disabilities. It subsidizes health-related programs at all Texas medical schools, a dozen state agencies and in many more cities, counties and school districts. In summary, Medicaid provides critical infrastructure for health care, Texas' fastest growing service industry which employs hundreds of thousands of Texans and spans the state.

THE TEXAS HEALTH ECONOMY

IN RECENT YEARS, TEXAS HEALTH care spending increased markedly. The health services industry, consisting of medical and dental practices, medical and dental laboratories, hospitals, nursing homes, home health care agencies, health maintenance organizations and other entities, makes up about 11 percent of the entire Gross State Product.[1] Health care expenditures in Texas from all sources in 1993 totaled $49.8 billion, up 292 percent from $12.7 billion in 1980.[2]

Figure 2.1 shows the growth of health services as a portion of the state economy.

Figure 2.1: Personal Health Expenditures as a Percentage of Gross State Product in Texas, Selected Years



Source: See footnote 1

Medical inflation accounts for much of this growth. Nationwide, over the period 1983-1995, medical inflation increased 70 percent more than the Consumer Price Index.[3] (See **Figure 5.4**, p. 84.)

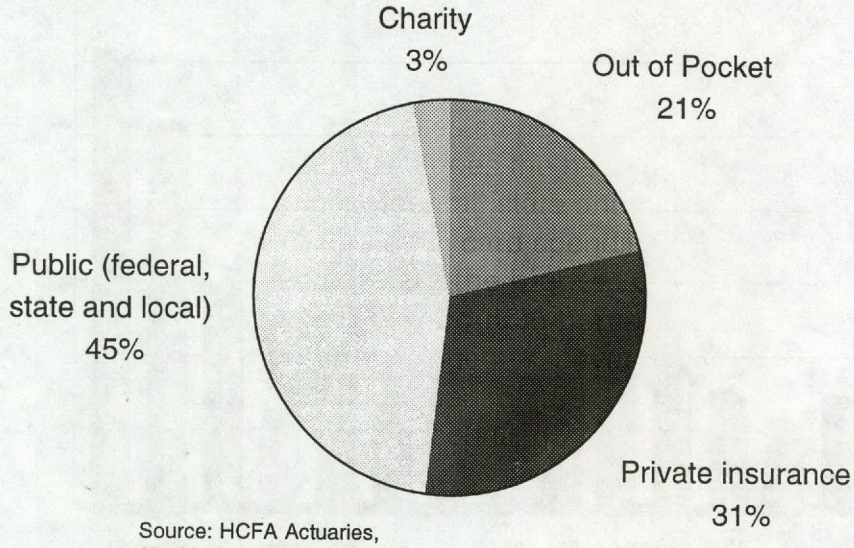
During this same period, the health care industry enjoyed a boom in job growth. In 1992, according to the Census of Service Industries (CSI), 624,000 Texans worked in the private sector health industry and hospitals—up 21 percent from the 1987 CSI. That makes health care the fastest growing sector of Texas' service economy.[4] Of those 624,000 people, 300,000 worked in hospitals, 92,000 in nursing homes or personal care facilities and 68,000 in home health services.[5] These sectors of the health economy are precisely the areas most heavily financed by the Texas Medicaid program.

SOURCES OF HEALTH CARE SPENDING

UNLIKE SOME OTHER ECONOMIC markets — for example, the markets for groceries or computers — government and private insurers make most personal health care purchases, not individual consumers. In 1965, 45 percent of all health care spending came from out-of-pocket consumer spending (excluding insurance premiums). But over the next three decades, that number dwindled to 21 percent (see **Figure 2.2**), as a result of the rise of employee-benefit plans and the creation and expansion of Medicaid and Medicare.[6]

Besides the defense industry, no other segment of the economy relies so heavily on (mostly federal) government spending as does the health care system. All told, public sources (federal, state and local) accounted for 45 percent of 1994 health care spending nationwide. **Medicaid and Medicare are the biggest government payers, together making up about 35 percent of total national health spending.** Together, private insurance and charity made up about 34 percent of 1994 national health spending with insurance accounting for 31 percent.

Figure 2.2: Sources of U.S. Health Expenditures, 1994
Total National Health Expenditures: $949.4 billion



Source: HCFA Actuaries, *Health Care Finance Review*, See footnote 6

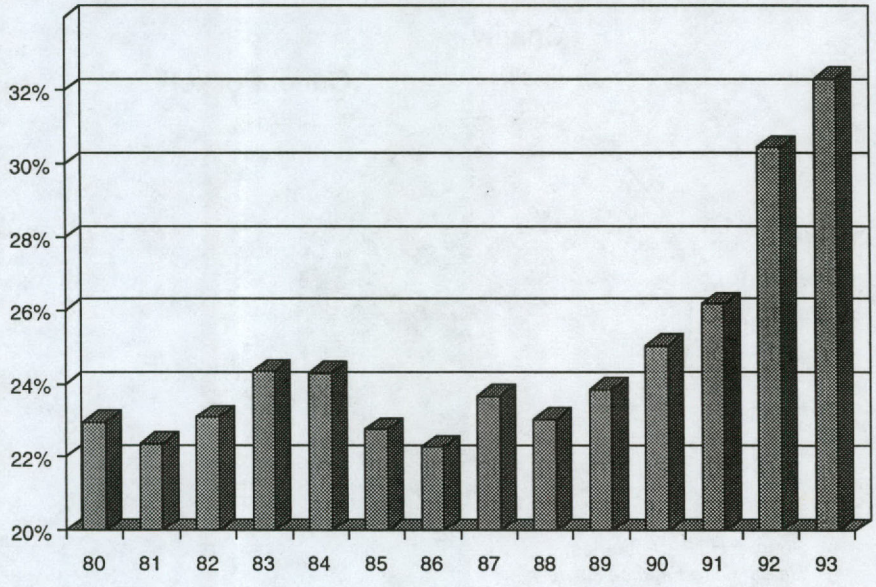
These numbers indicate that government-financed health care not only provides much-needed care to our most vulnerable Texans; it is the largest revenue source for a major segment of the economy that employs hundreds of thousands of people in every corner of the state.

MEDICAID AND THE HEALTH ECONOMY

HEALTH CARE IS A MAJOR Texas industry, on a scale with oil, construction trades and agriculture in terms of its economic importance to the state. Medicaid plays an increasingly important role in state health care spending. In 1993, the most recent year for which the statistic is available, total Medicaid spending made up nearly **15 percent** of all health care expenditures in Texas, or $7.3 billion out of the total $49.8 billion.[7] Another federal program, Medicare, added another $8.8 billion to the state health economy that year, bringing the total for the two programs to more than 32 percent of all Texas health expenditures.[8]

The following chart demonstrates how these two programs' share of Texas health spending has risen in recent years:

Figure 2.3: Medicare and Medicaid as a Percentage of Texas Health Spending, 1980 to 1993



Source: HCFA

The Big Picture

Medicaid plays an especially critical role in the health industry because it covers two very expensive groups whose medical needs defy market solutions: low-income people who are unable to pay for care, and individuals with complex conditions considered uninsurable by private health plans. For example, Texas Medicaid pays for nearly half of all births in the state — more than 157,000 out of approximately 325,000 births in 1996, including more than 38,000 teen births. Without Medicaid, hospitals would lose compensation for this indigent care, at a cost of more than $324 million in 1996.[9]

Texas Medicaid pays for about half of all births in the state.

Hospitals depend heavily on Medicaid to pay for health care services, because federal law prohibits them from turning away most indigent clients from their emergency rooms. Thus, even if Medicaid funding ended tomorrow, hospitals by law would still have to treat many of these clients. Texas Medicaid presently accounts for about 15 percent of statewide hospital income.[10] Without the Medicaid program, most of these costs would have to be paid with local property taxes which support Texas hospital districts.

Medicaid is the major payer for other niches in the health market as well. For instance, Medicaid pays more than half of all dollars spent on nursing home nationwide, compared with about two percent for long term care insurance.[11] Similarly, Medicaid is almost the sole purchaser in Texas of long-term care services for people with mental retardation and other developmental disabilities, paying more than 98 percent of all such costs in the state.

Most Medicaid dollars go to private sector health care providers and hospitals as payment for services and indigent care. In 1995, Medicaid paid $8.7 billion to providers. Of that, $3.9 billion (45 percent) went to hospitals, and $2.1 billion more (24 percent) went for long-term care services. Without this financing, providers must either absorb the medical costs of uninsured persons (and pass on the losses to paying customers) or simply refuse to provide services to those who cannot pay.

MEDICAID VS. MEDICARE

ANOTHER FEDERAL PROGRAM, Medicare, plays a significant role in the state health economy. While Medicaid covers poor and low-income people, Medicare covers the elderly and disabled, regardless of income. In 1994, Medicare provided insurance to more than 2 million elderly and disabled Texans, and paid $9.4 billion in benefits to Texas health care providers.

What is Medicare?

THE SAME SOCIAL SECURITY Amendments Act of 1965 that created Medicaid also created the Medicare program. Medicare is a two-part health insurance program that in 1994 covered 33.5 million Americans aged 65 and over, and 4.1 million Americans with disabilities. More than 2 million Texans receive Medicare; it covers 96.5 percent of Americans 65 and older.

Almost all Americans over 65 automatically qualify for the Medicare Part A or Hospital Insurance (HI) program in the same way they qualify for Social Security: based on their work history and payroll deductions while they were working. Part A coverage normally has no premium payment. People who don't qualify (usually due to lack of work history) may purchase Part A coverage at cost. The federal government finances the HI program primarily through a payroll tax on employers and employees.

Medicare Part B (Supplemental Medical Insurance or SMIB) is a voluntary program covering physician and related health services for aged and disabled persons. All Medicare Part A beneficiaries may choose to enroll in Part B. In addition, any American over age 65 may enroll, even if not eligible for Part A. Part B enrollees must pay a monthly premium. The federal government finances Part B through a combination of enrollee premiums (about 29 percent) and federal revenues (about 71 percent).

State Role in Medicare

BOTH PARTS OF MEDICARE have cost sharing provisions; that is, they require enrollees to pay deductibles and coinsurance. Unlike Medicaid, Medicare is financed and administered totally at the federal level. Texas does not have a role in either administering or funding the program. However, since 1988, federal law has required state Medicaid programs to pay for Medicare out-of-pocket costs of some low-income people . By 1995, Texas Medicaid

The Big Picture

Medicare has a big impact on Medicaid because of what it does not *cover.*

paid $655.2 million — **nine percent of the Texas Medicaid health services budget** — for Medicare premiums (Parts A and B), deductibles and copayments for more than 336,000 people.

Medicare also has a big impact on Medicaid because of what it does **not** cover. Regular Medicare does not cover prescription drugs. Clients who are "dually eligible" for Medicare and Medicaid accounted for 42.9 percent of Medicaid costs for prescribed drugs in 1994. Further, Medicare limits coverage of nursing home care to 100 days (per "spell of illness"), and then only after hospitalization. (In other words, the Medicare nursing benefit does not cover long term care.) These limitations on Medicare coverage powerfully affect the Medicaid program. Texas Medicaid expenditures for dually eligible clients totaled $1.9 billion in 1994, accounting for 30.6 percent of all payments for direct services that year.

Medicaid also pays for the care of some people while they are waiting for their Medicare coverage to take effect. Persons who receive monthly Social Security Disability Benefits (through Title II Disability Insurance Program, as contrasted with the Title XVI SSI Program) become eligible for Medicare after a two-year waiting period. Some of these people — those who have low enough income and benefits to qualify for SSI — have most of their care paid for by Medicaid during the two-year waiting period for Medicare benefits.

Texas Medicaid pays for Medicare premiums and copayments to cover these groups:

Supplemental Security Income (SSI) Recipients: Receive full Medicaid benefits; Medicaid pays Medicare Part A and B premiums and copayments. Countable income must not exceed 73 percent of the Federal Poverty Level (FPL); asset limit: $2,000.
Qualified Medicare Beneficiaries (QMBs): Do not receive full Medicaid benefits. Medicaid pays for Part A and Part B premiums and copayments. Countable income must not exceed 100 percent FPL; assets must not exceed 200% of SSI limits.
Qualified Disabled Working Individuals (QDWI): Do not receive full Medicaid benefits. QDWI status entitles disabled, working individuals to enroll in Medicare Part A, and requires Medicaid to pay their premiums, but not copayments. Recipients' countable income must not exceed 200% of FPL; assets must not exceed 200% of SSI limits.
Specified Low Income Medicare Beneficiaries (SLIMB): Do not receive full Medicaid benefits. Medicaid pays only Part B premiums. Recipients income must fall between 100 - 120 percent of FPL; assets must not exceed 200% of SSI limits.

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PRIVATE INSURANCE & THE HEALTH MARKET

Private health insurance covers most people, but private insurers pay just 31 percent of national health expenditures

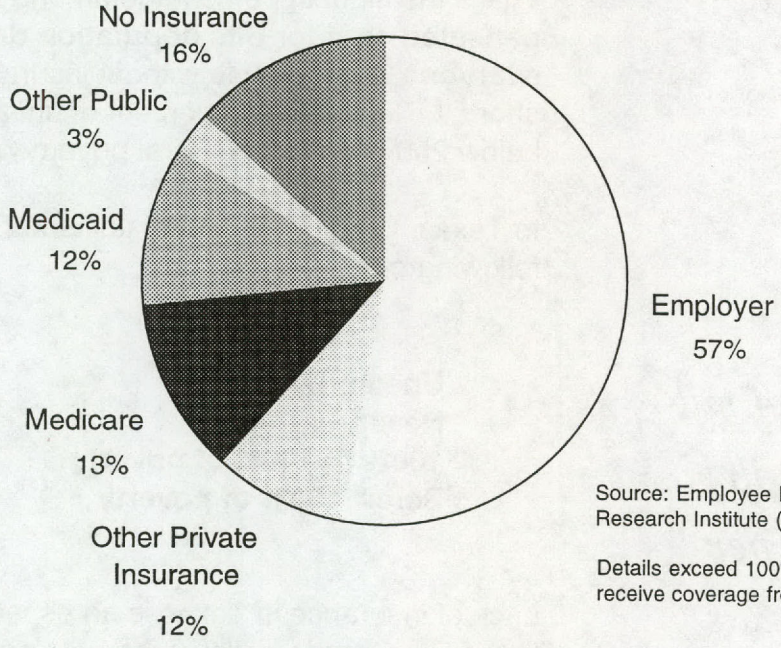
WHEN MOST PEOPLE THINK of paying for health care, they think of private health insurance. In 1994, 10.6 million Texans had private health insurance, most of them through their employer. But private insurance tends to cover more healthy individuals. Nationally, 57 percent of the population receives health coverage through their employer; 12 percent purchase non-employer-based health insurance.[12] However, private insurers pay only 31 percent of national health care expenditures.[13] **Figures 2.4** and **2.5** portray sources of coverage and national health spending for 1994.

As with Medicare, the limits of private insurance profoundly effect the Medicaid program, not so much because of who it covers but because of who it doesn't. Families typically get their insurance coverage through an employer, but people with disabilities are underrepresented in the workforce. To get individual insurance, people with disabilities typically face a strict underwriting process which weeds out people with severe health problems. Often, such persons wind up on the Medicaid rolls. For example, among insurance companies in Texas[14]:

- More than 80 percent will not sell individual insurance policies for persons who suffer from diabetes, HIV, muscular dystrophy, cerebral palsy, epilepsy or alcoholism.
- Fifty percent will not write individual policies for persons with mental retardation, and 70 percent won't write individual policies for persons with Down syndrome, though some companies will cover these two categories if no other health problems accompany the applicant's impairment.
- More than 80 percent of companies will not cover currently pregnant women or any of their family members until six weeks to six months after the birth. **Medicaid covers all of these conditions, and pays for nearly half of all live births in the state.**

This partially explains why a small number of people — the aged and disabled populations — make up such a large proportion of Medicaid spending. But because of poverty and lack of employment, even if underwriting practices were changed, most of these individuals would not be able to afford private insurance.

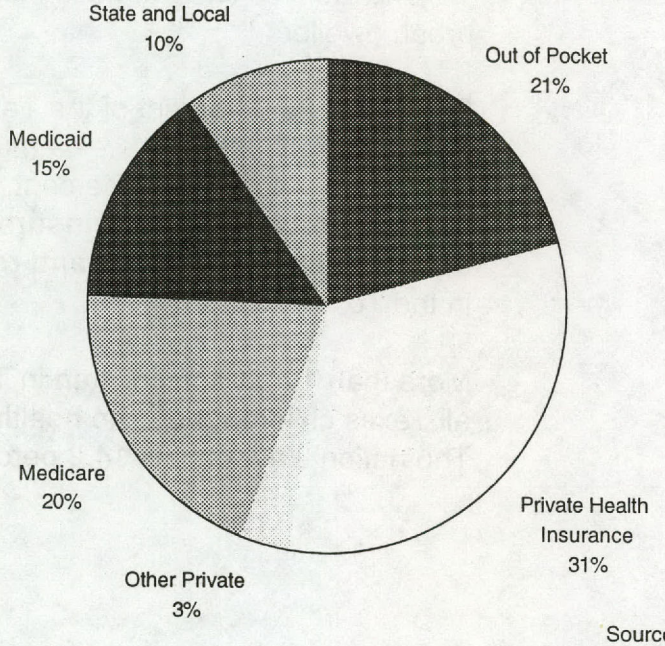
Figure 2.4: Sources of Health Insurance Coverage in the United States, 1994



Source: Employee Benefit Research Institute (see footnote 12)

Details exceed 100% because individuals may receive coverage from more than one source.

Figure 2.5: Sources of Health Expenditures in the United States, 1994



Source: HCFA actuaries, *Health Care Finance Review*, See footnote 13

The Big Picture

Who are the Uninsured?

IN 1994, 4.6 MILLION TEXANS — or 24.2 percent of the population — had no health insurance at all.[15] That's the highest percentage among all states. **Uncompensated care for this population drives up costs for everyone.** Most people without insurance simply cannot afford it. Nationally, 60 percent of uninsured persons live below 200 percent of federal poverty guidelines.

In Texas, the highest rate of uninsurance occurs with the following groups:

Unemployed	49.7%
Never married	34.0%
100% to 149% of poverty	44.0%
Below 100% of poverty	43.8%

More than 1.4 million children in Texas, or 24 percent of all Texas children, have no health insurance coverage. The national average is 14.2 percent.

Lack of insurance in Texas is an especially critical issue in the Rio Grande Valley, where 44 percent of Hidalgo County and 31 percent of Cameron County residents have no insurance at all.[16] One in five uninsured Texans is a non-citizen, and 60 percent of the 1.5 million non-citizens in Texas have no health insurance.[17] Also, rural Texans are less likely to have insurance coverage than urban dwellers.[18]

Statewide, 25.3 percent of the Texas civilian labor force have no health insurance — a much higher rate than the national average of 17.2 percent.[19] **Industries with the highest percentage of uninsured workers include agriculture, construction and retail**, all major elements in the Texas economy.

More than 1.4 million children in Texas, or 24 percent of all Texas children, have no health insurance coverage. The national average is 14.2 percent.[20]

Care for Uninsured Driving Medical Inflation

HOSPITALS ARE PARTICULARLY vulnerable to assuming the costs of the uninsured, because federal law prohibits them from turning away most patients from their emergency rooms. In Texas, uncompensated care in hospitals amounts to 10.8 percent of hospital receipts, the highest ratio in the nation.[21] A 1996 study published in the *New England Journal of Medicine* found that emergency room prices were typically *double* actual costs. "The reason ER bills are so much higher than costs is that half of all patients never pay. So those who do pay subsidize those who don't."[22]

COMPARING MEDICAID AND PRIVATE INSURANCE

IT IS DIFFICULT TO COMPARE the costs and benefits of Medicaid and private insurance. The Medicaid population consists of people who typically cannot get comprehensive health insurance, including the aged, disabled and chronically ill. Moreover, Texas Medicaid pays for long-term care and community care services not covered by most private health plans. It also pays for comprehensive services to children that far exceed the limits placed on most private insurance plans.

Given the unique concentration of medically high-risk persons in the Texas Medicaid program, no commercial insurance pool would resemble the Medicaid population enough to allow an "apples-to-apples" comparison of benefits.

Still, one may examine aggregate totals to compare the relative economic efficiency of public and private health insurance. According to data reported by insurers to the National Association of Insurance Commissioners (NAIC), Texas Health and Accident premiums (excluding self-insured employer plans) totaled $6.5 billion in 1994, while claims paid for that year amounted to just $5 billion.[23] In other words, administrative costs and profits amounted to $1.5 billion—22.8 percent of gross income.

By contrast, the Medicaid program that year spent a total of $8.5 billion, but only $358 million, or 4.2 percent, went for administrative costs. Measured in terms of overhead costs, **Texas Medicaid delivers health services at more than five times the efficiency of private health insurance.**

MEDICAID'S INSTITUTIONAL IMPACT

BESIDES ITS IMPACT ON the economy, Medicaid helps to finance hundreds of government and private sector institutions across the state.

Medicaid Operating Agencies

FOUR STATE AGENCIES OPERATE most of Medicaid's day-to-day programs: The Texas Department of Health (TDH), The Texas Department of Human Services (DHS), Texas Mental Health and Mental Retardation (MHMR) and the Texas Department of Protective and Regulatory Services (PRS). Medicaid money accounts for a sizable proportion of these agencies' budgets:

Table 2.1:
Medicaid as a Percentage of Agency Budgets

Agency	Total Medicaid Dollars Spent In '95	Medicaid as a Percentage of Total Expenditures
DHS	$1.8 billion	55%
TDH	$4.98 billion	85%
MHMR	$296 million	21%
PRS	$39 million	7%

MEDICAID MONEY TO OTHER AGENCIES

BESIDES THE OPERATING AGENCIES, numerous other state agencies receive Medicaid dollars for services to special populations. Other agencies that receive Medicaid money include:

- Texas Health and Human Services Commission
- Texas Commission for the Blind
- Interagency Council on Early Childhood Intervention
- Texas School for the Blind
- Texas School for the Deaf
- Texas Rehabilitation Commission
- Texas Commission on Alcohol and Drug Abuse

In addition, the Medicaid Fraud and Control Unit in the Attorney General's Office receives Medicaid administrative dollars for its investigative activities.

Medical Schools

ALONG WITH MEDICARE, MEDICAID is a major source of funding for Texas medical schools. The rate for medical services which Medicaid pays to teaching hospitals takes into account the extra costs of medical education and the higher cost of providing services in those institutions. Medicaid paid about $35 million in Graduate Medical Education (GME) payments in Texas in 1995. Nationally, Medicaid contributes about eight percent of all GME funding; Medicare, by far the biggest payer, contributes about 50 percent of all GME funds.[24]

Independent School Districts

MEDICAID PAID $22.9 MILLION to 261 school districts in 1995 for various programs including:

- **School Health and Related Services (SHARS) Program:** Allows school districts to obtain Medicaid reimbursement for specific services provided to Medicaid eligible **special education** students. Since HCFA approved the program in September 1992, the program has generated more than $30 million in additional revenue for school districts.

- **Texas Health Steps Screening:** Several school districts serve as screening providers for Texas Health Steps (formerly EPSDT)
- **Medicaid Administrative Claiming Project:** This program allows school districts to obtain Medicaid reimbursement for administrative outreach services to assist children in obtaining access to Medicaid services. This program gained approval from HCFA at the beginning of the 1996 calendar year (January 16, 1996).

MAJOR PROVIDERS

MEDICAID IS A MAJOR source of funds for most large health care providers in Texas.

Hospitals

NEARLY 43 PERCENT OF ALL 1995 Texas Medicaid expenditures went to hospitals — $3.9 billion out of the total Medicaid budget of $9.1 billion. Hospitals rely heavily on the Medicaid program to recoup some of their costs for treating indigent patients. Disproportionate Share Hospital (DSH) payments, which go to hospitals that treat a significant percentage of indigent clients, accounted for $1.5 billion of the $3.9 billion.

Health Maintenance Organizations

IN FALL 1996, MEDICAID expanded its managed care pilot to include four cities and their contiguous counties: Austin, Fort Worth, Lubbock and San Antonio. With the expansion, Medicaid will become the single largest purchaser of managed care from private sector HMOs in Texas, with more than 100,000 more enrollees than the state-run Employee Retirement System.[25] According to the Texas Department of Health, Texas Medicaid will spend up to $505 million on HMO capitation payments in 1997 to cover more than 325,000 people, about 20 percent of all commercial HMO premiums in Texas.[26]

Nursing Homes

NATIONALLY, MEDICAID IS THE largest single source of funds for nursing home care, paying 52 percent of all nursing home costs nationwide (See **Figure 4.7,** p. 67).[27] Like many other states, Texas has adopted more lenient optional eligibility standards for elderly

people who require nursing home care. Texas Medicaid pays for nursing facility care for elderly and disabled clients who make up to 219 percent of the federal poverty level (provided most of their income goes to pay the nursing home). The program pays some portion of the bill for more than 70 percent of all nursing home bed days in the state. In 1995, Texas Medicaid paid $1.2 billion directly to nursing homes, or more than 18 percent of all Medicaid health expenditures statewide (excluding DSH payments).

Home Health Agencies

HOME HEALTH AGENCIES provide a range of acute and long-term care services for such programs as the TDH Home Health program and the DHS attendant care program. In 1995, Texas Medicaid paid $346 million for these services.

Intermediate Care Facilities for persons with Mental Retardation (ICF-MR)

ICF-MR FACILITIES PROVIDE RESIDENTIAL services and assistance in learning to perform day-to-day living functions (habilitation) to people with developmental disabilities such as mental retardation. In 1995, Texas Medicaid paid $589 million for these services, accounting for **98 percent of all payments** to ICFs-MR in Texas.

NOTES

[1] Amount of personal health expenditures in Texas comes from Levit, Katharine, et. al., Hea*lth Care Finance Review,* "State Health Expenditure Accounts: Building Blocks for State Health Spending Analysis, Fall 1995, p. 231. Information on Gross State Product comes from the Texas Comptroller of Public Accounts' Spring 1996 Economic Forecast.

[2] Levit, 1995, p. 231, Table 11.

[3] Unpublished tables from Bureau of Labor Statistics, Consumer Price Index, U.S. City Average, All Items and Medical Care.

[4] U.S. Dept. of Commerce, 1992 Census of Service Industries Geogrpahic Area Series, Texas.

[5]The 624,000 number excludes all government-operated health services except hospitals. Total receipts for offices and clinics of medical doctors in Texas increased by 57%—the highest of any major service industry. Census of Service Industries, 1992, "Comparative Statistics for Texas: 1992 and 1987"; Press Release, "Services receipts in Texas up 66 percent over 5 years, led by offices and clinics of doctors of medicine, Census Bureau reports," January 11, 1995; Interview with Kirk Degler of the Census Bureau, 3/14/96. The next Census of Service Industries will be published in 1997.

[6]Levit, Katharine, et. Al., "National Health Expenditures, 1994," *Health Care Financing Review,* Spring 1996, p. 234. Levit, an HCFA actuary, along with her coauthors, estimated annual national health expenditures back to 1960.

[7] For total Medicaid expenditures, DHS, Title XIX Expenditure History, 2/96; for total Texas personal health expenditures, Levit, 1995, p. 231.

[8] Unpublished table from HCFA, Medicare Expenditures for Personal Health Care and Average Annual Percent Growth by Region and State, Selected Calendar Years 1980-93," 3-11-96. Figure 2.3 adds Medicaid dollars to these totals to generate a cumulative graph.

[9] TDH, "Inpatient Delivery Report for FY '96—Payments Through September 1996". These figures exclude information on births in the four counties with Medicaid managed care prior to FY97, because of incomplete encounter data on those managed care pilots. Because capitation makes cost estimates for specific services under managed care difficult if not meaningless, the cost for births funded through managed care is also excluded.

[10] Source for medical payments to hospitals: HCFA 2082, 1992; Source for dispro funds: DHS, Title XIX Expenditure History List; Source for total hospital receipts: Census of Service Industries 1992, "Comparative Statistics for Texas: 1992 and 1987." This CSI is the last statewide total available for total hospital receipts. The next CSI will appear in 1997.

[11] HCFA, *Medicaid: An Overview,* September 1995, p. 47 (pie chart).

[12] Employee Benefit Research Institute, Issue Brief #170, February 1996, p. 5. Details do not add to totals because individuals may receive coverage from more than one source. Some of the people purchasing private coverage themselves also have employer coverage or Medicare

[13] Levit, 1996, p. 234

[14] Source for underwriting statistics: Kincaid, Mark, General Counsel, Office of Public Insurance Counsel, "Health Insurance Underwriting Guidelines Used in Texas," 1-30-95, p. 7.

[15] Lam-Yip, Pam, *HHSC Demographic Facts Information Series - April Issue*, 4-29-96. Derived from the same source as the EBRI reference above (footnote 12) -- the Current Population Survey -- Lam Yip's statistics differ because she analyzes the entire population rather than only the "non-elderly," as does EBRI. Since each broke out their statistics in different but useful ways, this primer utilizes both sources in this chapter.

[16] Comptroller of Public Accounts, *Health Care Reform and the Three Faces of Texas,* May 1994. This Comptroller report is one of the only available studies which provides detailed information about insurance coverage *within* the state.

[17] EBRI Issue Brief #170.

[18] Comptroller of Public Accounts, May 1994.

[19] Lam-Yip, 1996.

[20] HHSC analysis of 1995 March Current Population Survey.

[21] *Health Care State Rankings 1995,* Morgan Quinto Press, p. 279. Numbers are for 1991, the most recent year available at the time of publication.

[22] Haley, Daniel, "Emergency room charges are double actual costs, study finds," *Austin American Statesman,* March 7, 1996, C3.

[23] Spreadsheet obtained from the Texas Department of Insurance financial division. Life companies licensed in Texas reporting Accident and Health earned premiums and incurred claims data to the National Association of Insurance Commissioners (NAIC) as reported in their annual financial statement, 1995, aggregate, unaudited. Numbers were adjusted to exclude premiums and claims for NHIC which processes Medicaid. These numbers also exclude self-funded employer plans because by federal law (ERISA) the state is not allowed to collect that data or regulate self-insurance plans in any way. Moreover, the federal government does not accumulate reliable data on these plans.

[24] Kellogg Foundation, graph from presentation by Dr. J. Guckian, M.D., of the UT System.

[25] As of December 1996, ERS paid capitation payments for more than 229,773 people - 109,295 employees and 120,478 dependents. In FY1997, TDH estimates it will pay capitation for more than 328,000 full-year equivalent clients.

[26] For total commercial HMO premiums, see TDI financial division, *HMO Financial Data Annualized as of December 31, 1995.*

[27] HCFA, *Medicaid: An Overview,* September 1995, p. 47

The Big Picture

Chapter Three: Medicaid Fundamentals

Texas Medicaid operates within a framework established by federal law, but the state of Texas manages key elements of the program. Medicaid's unique structure in Texas spreads authority and funds across several agencies, necessarily influencing any strategies for reform.

THIS CHAPTER EXAMINES TEXAS Medicaid from a "whole-program" perspective, including:

- How Federal laws created state Medicaid programs,
- Federal **standards** that state programs must follow,
- Basic **scope** of the program,
- How state Medicaid programs are overseen by the federal government,
- How Medicaid is run in Texas (which state agencies do what),
- How the state and federal government **finance** the program,
- How federal law changes have **expanded** the size and scope of Medicaid,

HISTORY

CONGRESS ESTABLISHED THE Medicaid program when it created Title XIX of the Social Security Amendments Act of 1965 - the same act that created Medicare. Texas began its Medicaid program in September 1967.

Title XIX created the Medicaid program to pay medical bills for low-income persons who have no other way to pay for care. Medicaid is funded as a **federal-state matching program**; the federal and state government each must supply a specific share of funds for every medical bill paid.

Medicaid Fundamentals

As a result of federally mandated expansions, the Texas Medicaid population tripled in just a decade.

The creators of Medicaid and Medicare intended to ensure access to health care for low income and over-65 Americans through the same "mainstream" doctors and hospitals as other Americans. However, the expense of the program and the number of Americans served have grown significantly beyond expectations.

During the late 1980s and early 1990s, Congress dramatically expanded Medicaid eligibility to include a greater number of elderly, disabled persons and pregnant women. As a result of these changes, the Texas Medicaid population nearly tripled in just a decade. Today Texas Medicaid insures about two million people, but at least 4.6 million Texans remain uninsured and not eligible for Medicaid.[1]

MEDICAID'S TRANSFORMATION

OVER A PERIOD OF THREE decades, Congress has transformed Medicaid from a narrowly defined program available only to persons eligible for federal welfare cash assistance, into a much larger program with broad and complex eligibility rules.

The expansions which had the most impact on the state budget targeted the elderly and disabled. Table 3.2 (at the end of chapter) lists only the most sweeping changes. Dozens more changes have expanded or altered eligibility and services marginally.

Most of Medicaid's expansion has been beyond the control of state governments or their Medicaid programs. Since the creation of the program in 1965, Congress has passed dozens of laws amending hundreds of Title XIX Medicaid provisions.

Medicaid Fundamentals

Medicaid: The Early Years

AS ORIGINALLY ENACTED, CONGRESS made Medicaid coverage available only to persons eligible for Aid to Families with Dependent Children (AFDC), recently changed to TANF. TANF is the federal-state program of cash assistance for impoverished families (mostly single parent) or for federal grants for old-age assistance, aid to the blind, or aid to the permanently disabled. Federal law passed in 1972 replaced the last three programs with Supplemental Security Income (SSI), the federal cash assistance program for the elderly or disabled poor, recipients of which are also automatically eligible for Medicaid.

The federal government sets income eligibility caps and cash benefit amounts for SSI. States may supplement SSI payments with state funds (about half the states supplement by $3 per month or more), but may not use a more restrictive limit. Texas uses the basic unsupplemented federal benefit of $480 per month for an individual living at 73% or less of the federal poverty level.[2]

As of 1996, the TANF income cap for a mother with two children was $188 per month, about 17 percent of the federal poverty level.

Each state makes two key eligibility decisions about TANF: family composition and income caps. Since 1962, states could choose to cover two-parent families with AFDC if one parent was unemployed. Texas was one of about 24 states that chose to cover these families. In 1988, the federal government mandated that states provide some two-parent families with AFDC benefits.

Each state sets its own income eligibility guidelines for TANF/AFDC, and Texas has historically maintained very low income caps. As of 1996, the income cap for a mother with two children was $188 per month, or 17 percent of the poverty level.[3] Because the state's income cap limited the growth in AFDC, it also limited growth in the Medicaid program. Only two states, Alabama and Mississippi, have lower caps than Texas. The national average cap is 41 percent of poverty.[4]

Medicaid Expansion: Federal Mandates

FEDERAL LAWS PASSED IN THE LAST decade mandated coverage of groups of people without TANF or SSI eligibility, resulting in major expansions of the Medicaid-eligible population. The Medicaid program also expanded the services it covers in significant ways. Most of the following program expansions resulted from federal mandates:

- Significant increases in payment to hospitals that serve large numbers of poor uninsured Texans or Medicaid recipients ("dispro payments"). These payments slowed or mitigated local property tax increases in Texas' large urban areas and has slowed the rate of rural hospital closures.
- Coverage of prenatal and delivery services for pregnant women and their infants who have no other insurance up to 185 percent of poverty.
- Expanded services to many children in low-income families who are not on cash welfare.
- Expanded Medicaid to fill gaps in Medicare services to poor elderly and to Texans with disabilities.
- Expanded coverage to include the full array of federally allowable Medicaid services without limits for all children on Medicaid.

As a result of these and other changes, the eligibility determination process is far more complicated today than in years past. **Figures 3.1 and 3.2** contrast the relative simplicity of Medicaid eligibility categories in earlier decades (1975 and 1985 appear here) with the more complex structure in 1996. Computer systems designed for a smaller and simpler program must now manage hundreds of pieces of information for nearly 3 million people in dozens of different technical eligibility groups.

COVERAGE

MEDICAID FUNCTIONS IN TWO major ways: (1) as of basic health insurance program, and (2) as a funding source for services to people with chronic or long-term care needs. Medicaid pays no cash benefits to the people covered; instead, Medicaid makes all payments directly to "health care providers."

Figure 3.1: Texas Medicaid Eligibility Levels 1975 and 1985

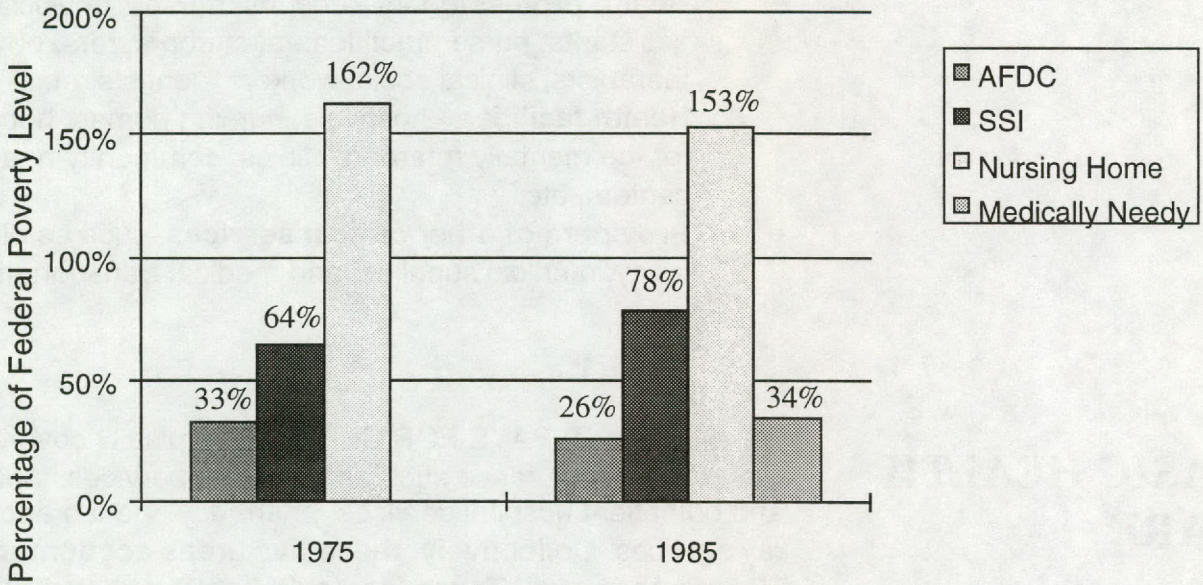
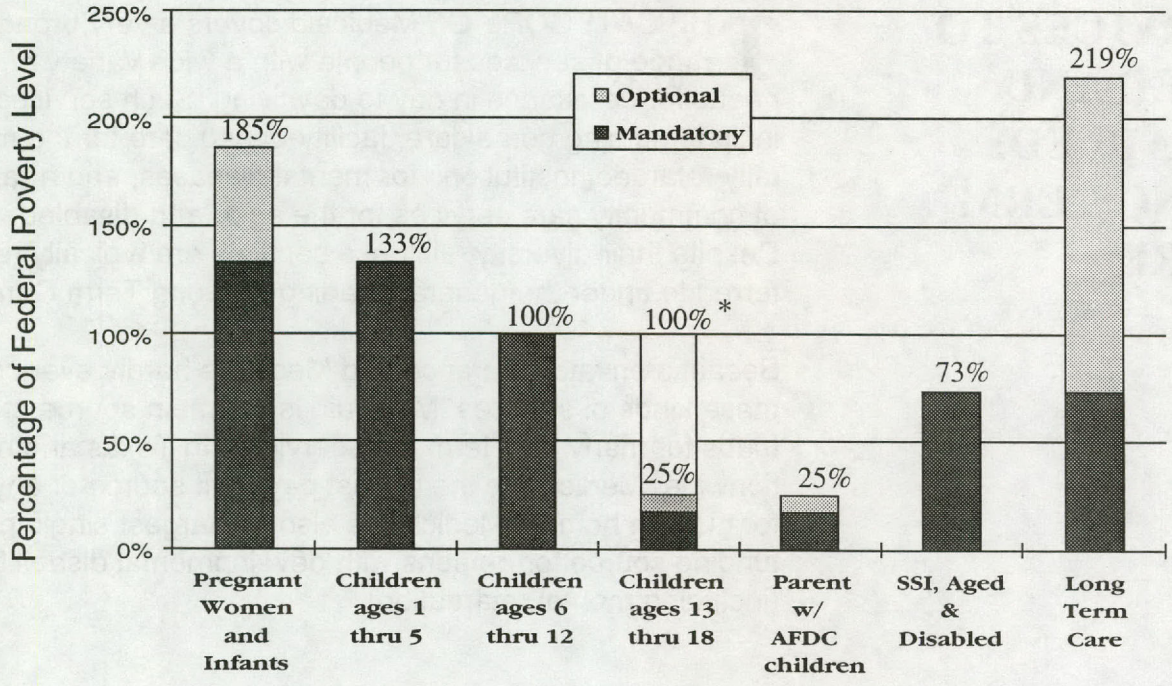


Figure 3.2: Texas Medicaid Income Eligibility Levels (As of April 1996)



* Phase-in of children born after 10/1/83 (up to age 18 in 2001)

Source: HHSC

"Health care providers" is a general term that includes:

- **Health professionals** - doctors, nurses, physician assistants, nurse practitioners, chiropractors, physical therapists, clinical social workers, dentists, etc.
- **Health facilities** - hospitals, nursing homes, homes for the mentally retarded, clinics, community health centers, etc.
- **Providers of other critical services**, such as pharmacy, medical supplies, and medical transportation.

BASIC HEALTH CARE

MEDICAID PAYS FOR SERVICES typically covered by health insurance such as physician services, inpatient and outpatient hospital services, pharmacy and lab and x-ray services. **Collectively, these five areas accounted for 57.5 percent of all Texas Medicaid health expenditures in 1995.** Medicaid also provides a broader array of basic health services to children than most private health plans.

SERVICES TO AGED AND DISABLED: LONG TERM CARE

THE CATEGORY OF Medicaid covers a very broad range of services for people with a wide variety of needs for assistance in day to day living. Such services include nursing home care, facility-based care for the mentally retarded, institutions for mental diseases, and a range of community care services for the aged and disabled. Despite their diversity, all these services are typically referred to under the general heading of "Long Term Care."

Because private insurance and Medicare hardly ever cover these kinds of services, Medicaid is the main source of funds for many long term care services. In Texas and nationwide, Medicaid is the largest payment source of any type for nursing homes. Medicaid is also the largest single public funding source for persons with developmental disabilities (including mental retardation).

MANDATORY VS. OPTIONAL SPENDING

ABOUT 30 PERCENT OF TEXAS Medicaid spending covers "optional" services and clients not mandated by federal law. (See **Table 4.2**) Although "optional," from a federal standpoint, these Medicaid services assist our most vulnerable elderly or disabled Texans who have no other alternatives.

Eliminating the few optional services or categories of clients would prove harmful to beneficiaries, and could result in greater costs to state and local government. For example, dropping the "option" of covering prescription drugs could end up costing Medicaid more. That's because people who cannot pay for, and do not receive, needed drugs may require more physician services, increased hospitalization or even long term care. Similarly, if Medicaid did not provide optional coverage for pregnant women, many would never receive adequate prenatal care or have insurance to pay for their hospital bills. **It costs much less to subsidize a woman's prenatal care than it does to pay for her unhealthy infant.**

Finally, some of the optional services covered by Texas Medicaid are ones for which the state traditionally paid prior to Medicaid coverage with 100 percent state or local funds. For example, services for persons with mental retardation provided in state schools, ICFs-MR and community-based settings are now funded with Medicaid dollars. Previously, these funds came entirely from the Texas state budget.

BASIC PRINCIPLES

THE SOCIAL SECURITY ACT INCORPORATES fundamental rules that apply to nearly every aspect of the Medicaid program.

"Statewideness": all Medicaid services must be available on a statewide basis and may **not** be restricted to residents of particular localities.

Comparability: except where federal Medicaid law specifically creates an exception, the **same level of services** (amount, duration, and scope) has to be available to **all clients**. A 1989 federal law created a major exception to

this principle when it declared that all state Medicaid programs have to cover **any medically necessary service** that's needed by a Medicaid-eligible child, as long as that service is allowable under federal law. As a result, children are generally entitled to a broader range of services under Medicaid than adults. There is one other major exception: persons eligible for coverage under the "Medically Needy" program (see p. 55) can also be offered a reduced package of services. (Texas has not implemented this option.)

Freedom of Choice: clients must be allowed to use any Medicaid health care provider meeting program standards.

Amount, Duration, & Scope: States must cover each service in an amount, duration, and scope that is "reasonably sufficient." States **may** impose limits on services only for Medicaid clients who are over age 21. But the state must **not** arbitrarily limit services for any specific illness or condition.

State Medicaid programs must follow these basic principles - plus all mandates related to eligibility and covered services - unless granted a specific exemption (**waiver**) by the federal Medicaid oversight agency (see p. 36).

HOW MEDICAID IS PAID FOR

IN GENERAL, MEDICAID IS an **entitlement** program. This means that the federal government does not (and states **cannot**) put a cap on either the number of people who can enroll **or** on the amount of money available for health services provided to enrollees. States must provide health care to all eligible individuals who seek services.

Medicaid is financed jointly by the federal government and the states. HCFA determines the federal share (**federal medical assistance percentage - FMAP**) using a formula based on average state per capita income compared to the U.S. average. The Health Care Financing Administration (**HCFA**), part of the U.S. Department of Health and Human Services, updates these matching rates every year to reflect changes in average income. Under current law, the federal share can pay no more than 83 percent of the total cost of services; the minimum is 50 percent. In 1996, 17 states

were matched at the 50 percent "floor" rate, and no state was at the cap (Mississippi had the highest match at 78.07 percent).[5]

Texas' matching rate for federal fiscal year 1997 is 62.56 percent; that is, the state must pay 37.44 percent of most Medicaid benefit costs.

The federal government matches different parts of the program at various standard rates unaffected by the FMAP percentages. Medicaid **administrative costs** (costs related to running the program, as contrasted with direct health care services) are generally matched at 50 percent, except for information services and administrative services that can only be performed by skilled professional medical personnel, which draw a 75 percent federal share. Family planning services draw a 90 percent federal match.

States may use **local government funding sources** for up to 60 percent of the state's share (i.e., 60 percent of Texas' 37.44 percent could legally come from local government sources). In 1996, Texas used local government funds to pay the state share for the federally matched Disproportionate Share Hospital (DSH) program (see p. 70). Federal law also specifies that **taxes on health care providers** cannot make up more than 25 percent of the state's share of total Medicaid expenditures. Texas presently does not levy taxes on health care providers for Medicaid purposes.

HOW MEDICAID OPERATES IN TEXAS

THE TEXAS MEDICAID PROGRAM combines the federal funding component with a unique state structure. This section explains the different parts of the program and how they relate to each other.

Federal Oversight

THE SOCIAL SECURITY ACT AND federal regulations establish a set of mandates and options for the operation of state Medicaid programs. Within those guidelines, each state develops a distinct program. While states are responsible for the hands-on operation of Medicaid, the federal government plays an active oversight role. HCFA oversees the Medicaid program.

Single State Agency

FEDERAL REGULATIONS GOVERNING THE Medicaid program require each state to designate a "single state agency" responsible for the Medicaid program. The Texas Health and Human Services Commission (HHSC) has acted as the single state agency for the Medicaid program since January 1993.[6] Within HHSC, the State Medicaid Director administers the Medicaid program.

As the single state agency, HHSC has final authority for Medicaid programs carried out by the Medicaid operating agencies. HHSC's State Medicaid Division responsibilities include:

- Serving as the primary point of contact with the federal government
- Contracting with various state agencies (e.g., TDH, TDHS, TDMHMR - see **Figure 3.3**) to carry out the technical operations of the Medicaid programs;
- Overseeing Medicaid policies, rules, and operations carried out by Medicaid "operating agencies";
- Monitoring and evaluating Medicaid programs;
- Establishing policy directions for Texas Medicaid;
- Administering the Medicaid State Plan;
- Organizing and coordinating initiatives to maximize federal funding; and
- Administering the Medical Care Advisory Committee (mandated by federal Medicaid law).

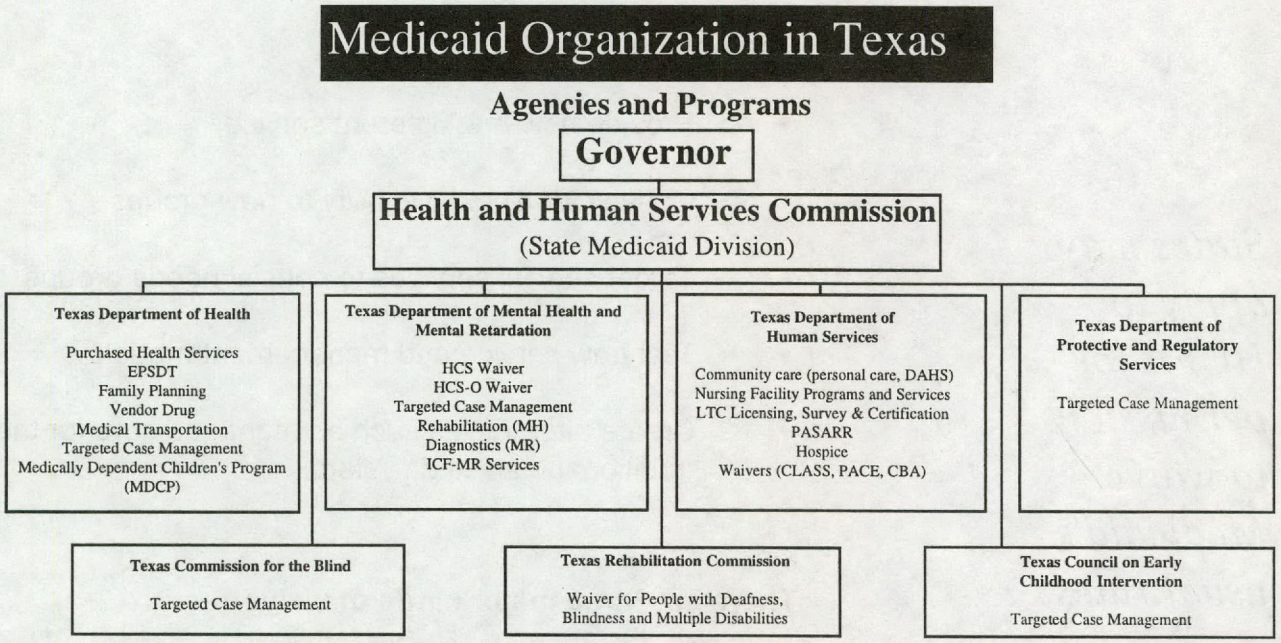
OPERATING AGENCIES IN TEXAS

TEXAS MEDICAID OPERATING AGENCIES are state agencies overseen by voluntary boards of citizens appointed by the Governor. These boards play an essential role in initiating policy changes and developing them for implementing approval, though the Medicaid Director has final decisionmaking authority. Operating agencies are where the rubber meets the road; they perform the day-to-day operations of Medicaid. As they do so, they must abide by all federal and state program requirements.

Federal law requires state Medicaid programs to monitor quality of care and program integrity for a variety of functions which in Texas have been delegated to the operating agencies. These functions include:

- determining eligibility,
- processing claims,
- certifying that health providers meet program standards,
- collecting data on Medicaid spending and services used,
- evaluating appropriateness and quality of institutional care, and
- detecting fraud and abuse by providers or clients.

Figure 3.3



MEDICAID STATE PLAN

THE MEDICAID STATE PLAN, the contract between the state and HCFA, is a comprehensive document that describes the nature and scope of the state's Medicaid program, such as:

- groups of clients served,
- services provided,
- how providers are paid, and
- other program requirements.

Most significant changes to Texas' Medicaid program require the state to submit a "State Plan Amendment" for HCFA

approval. HHSC's State Medicaid Division administers and maintains the Medicaid State Plan. There are 35 to 40 amendments to the state plan every year.

MEDICAID WAIVERS

UNDER FEDERAL LAW, STATES may apply to HCFA for permission to depart from Medicaid's usual rules. These "waivers" allow states to operate programs that involve exceptions to the Medicaid's basic principles, the required array of benefits, the mandated eligibility and income groups, or combinations of these. Waivers allow states to develop creative alternatives to more traditional ways of doing business.

States may apply to HCFA for permission to waive Medicaid's usual rules.

States use waivers to-

- Provide new and different services
- Convey Medicaid eligibility to new groups
- Target special services to special needs groups
- Test new service and management models
- Create alternatives such as managed care for the traditional Medicaid system

There are three major kinds of waivers-

- **Freedom of Choice, 1915(b) -** enables states to pilot test managed care alternatives (such as HMOs), which provide a medical home for recipients, and which require people to choose a primary care doctor or selectively contract with providers to negotiate better rates for services.

- **Research and Demonstration, (1115) -** enables states to test new ideas for meeting the goals of the Medicaid program.

- **Home and Community-based services (1915(c) -** enables states to provide community-based services to people who would otherwise require care in an institution.

INSURED ARRANGEMENT

A MAJORITY OF STATES CONTRACT OUT part or all of their Medicaid claims processing to private claims administration entities, or perform claims processing functions in house. Texas is one of only two states that contracts for a **modified insurance arrangement** to pay for a substantial share of program services. The essential difference between this arrangement and what other states do is that Texas Medicaid pays premiums to an insurance company - presently the National Heritage Insurance Company (NHIC) - which is responsible for paying many of the Medicaid claims. The insuring agent assumes some **limited risk** for losses, and has the possibility of **limited sharing in savings** to the state. This creates an incentive for the contractor to keep claims costs down, unlike a simple claims-processing arrangement.

The Texas Department of Health manages the insured arrangement with NHIC - the largest contract of any type between the state of Texas and a private company. NHIC is a subsidiary of Electronic Data Systems.

What Is Insured?

THE PREMIUM INCLUDES most basic health services covered by Medicaid including:

- Hospital Services;
- Physician & other health professional services;
- Lab & X-ray.

In addition, claims related to certain Medicaid services and eligibility groups are processed by the insuring agent, but aren't included under the premium. Some examples are:

- Texas Health Steps (children's benefits, formerly EPSDT)
- Family Planning
- Texas Health Steps Screens & Dental Services
- Emergency Services for Undocumented Aliens
- Services provided by Federally Qualified Health Centers
- Targeted Case Management services.
- Rehabilitation services for persons with severe mental illness.

Medicaid services neither included under the premium nor processed by NHIC include:

- nursing home, community care for the aged and disabled, hospice;
- ICF-MR;
- Prescription Drugs;
- Medical Transportation.
- Medicare Part A and B premiums
- Home and Community Based Waiver programs

How the Premiums Work

PAYMENTS TO NHIC HAVE TWO components: (1) **pure premiums,** which are strictly for direct payments to health care providers (doctors, hospitals, labs, etc.), and (2) **administrative premiums**, which are to cover the costs of operating the claim-paying system. The contract in force in 1996 allows NHIC to earn some profits on both components, but limits the profit on pure premiums.

DETECTING FRAUD AND ABUSE

THE MEDICAID PROVIDER SANCTIONS Division at HHSC has primary responsibility for detecting Medicaid provider fraud and abuse across state agency lines, regardless of which agency administers the provider contract.

The Sanctions Division investigates all allegations of Medicaid provider fraud and abuse. If an allegation produces tangible evidence of potential fraud, the Sanctions Division automatically refers the case to the Attorney General's Medicaid Fraud Control Unit for a full-scale investigation and possible criminal prosecution.

The Sanctions Division may impose either of two types of penalties on wayward providers: administrative actions or sanctions. Providers have no recourse to appeal an administrative action, but sanctions may be appealed through the operating agency that administers their contract. Any Medicaid payments made to providers for services delivered under fraudulent or abusive circumstances are recouped. In addition, the Sanctions Division has the authority to assess a

Civil Monetary Penalty on providers who submit false claims for payment. In 1995, the Sanctions Division had 505 cases result in exclusions, and just under $3 million in recoupments.

The Sanctions Division is presently developing a new automated fraud and abuse detection system. This system uses neural network technology to identify providers with aberrant practice patterns. This should increase the Sanctions Division's success in identifying and sanctioning fraudulent providers.

Table 3.1:
MAJOR TEXAS MEDICAID LEGISLATION, 74TH SESSION
Selected Provisions

Senate Bill 10

Senate Bill 10 establishes the framework for a new Medicaid financing and Medicaid health care delivery system in Texas.

Background: Federal Waiver
A waiver from the federal government is necessary to allow Texas to use managed care for Medicaid clients and to lock in federal Medicaid funding for five years. Experience with Medicaid managed care in other states shows that it can save money and improve access to and the quality of care. Locking in federal funding should put Texas in the best position to guard against the negative impact of likely federal cutbacks in the Medicaid program. Otherwise, the full brunt of these changes will be borne by local taxpayers.

The new financing and delivery systems will improve coordination and reduce duplication among the many entities now involved in indigent health care.

Financing
SB 10 requires certain local public entities (Funding Entities) to make available for federal matching certain public funds or resources they now spend on indigent health care.

Funding Entities receive back, as part of the matching process, at least as much as the amount that they originally make available.

Cost Containment and Competition
The health care delivery system must be designed to realize cost savings. Competition to participate in the health care delivery system promotes efficient and effective use of public funds.

Both private and public health care entities have an opportunity to participate in the local health care delivery plan and will be provided notice of the bid process. Medicaid clients have a choice of managed care plans or providers. Requiring a uniform method for setting capitation rates and selecting providers ensures fairness to managed care plans and providers.

Rural Issues
SB 10 recognizes unique role of rural providers. Legislation recognizes importance of providing care within recipients local community. Legislation recognizes need for different managed care models, for example, PCCM as well as HMO.

SB 600
Required the following agencies to develop standards for managed care organizations serving Medicaid clients; effective September 1, 1995.

- Texas Department of Health to develop quality of care, marketing, and financial standards and standards relating to children's access to good quality health care services.
- Texas Department of Mental Health and Mental Retardation to develop performance, operation, quality of care, marketing, and financial standards for the provision of mental health and mental retardation services.
- The State Board of Insurance, in conjunction with the Texas Department of Health, to establish fiscal solvency standards and complaint system guidelines for managed care organizations that serve Medicaid clients. A managed care organization's complaint process must be made available to each Medicaid client when the person enrolls.

SB 601
Related to educational programs and support services for Medicaid clients and managed care organizations serving Medicaid recipients, and included the following requirements:

HHSC was directed to establish guidelines for and require managed care organizations to provide education programs for providers and clients which include information on:

- Medicaid policies, procedures, eligibility standards, and benefits
- specific problems and needs of Medicaid clients; and
- rights and responsibilities of Medicaid clients

Each MCO client education program approved by the state must include:
- rights and responsibilities
- accessing health care services
- complaint and appeal procedures
- Medicaid policies, procedures, eligibility standards, and benefits
- the policies and procedures of the managed care organization; and
- the importance of prevention, early intervention, and appropriate use of services.

HHSC was directed to adopt a bill of rights and responsibilities for clients

HHSC was directed to provide support and information services to clients who experience barriers to receiving health care services including:

- a statewide toll-free assistance telephone number
- intervention on behalf of people with urgent needs to assist them with Medicaid application and enrollment
- education to enable clients to self advocate
- quarterly statistical information on calls received on the toll-free assistance line(s)
- assisting the state Medicaid office, managed care organizations and providers, and the Texas Department of Health in identifying and correcting problems

SB 602
Required HHSC and other state agencies operating Medicaid programs to create an integrated state Medicaid database to:

- detect Medicaid fraud and abuse, and
- enable a complete analysis of the use of prescription medications, including the medical effect denial of Medicaid coverage for more than three medications has had on Medicaid clients.

SB 604
Creates a pilot project to test the concept of medical savings accounts for Medicaid recipients HHSC to develop a plan by December 1, 1995 that uses Medicaid funds to establish individual medical savings accounts (IMSA's) for recipients of acute care services. federal waiver allowing the project is granted, if later) unless HHSC determines that there will be no cost savings.

HHSC studied this issue and decided not to implement a pilot; the agency reported its findings to the governor, lieutenant governor, speaker of the house of representatives, chair of the Senate Health and Human Services Committee, and the chair of the House Public Health Committee.

SCR 55
Directs the State Medicaid Office to develop the following, applying for federal waivers to

do so, if necessary -

- allow copayments by Medicaid clients for services if those clients have access to a 24-hour telephone health advice line
- exempt prenatal and well-child visits from the copayment for office visits and include provisions for capping contributions from a client who a physician determines should make regular office visits to address a chronic medical condition and from a long-term care client who has already made a copayment
- encourage managed care organizations to develop policies in addition to copayments to encourage a client's responsibility for the client's own care
- allow a guaranteed Medicaid eligibility period of 12 months for Medicaid clients enrolled in managed care plans
- develop an integrated managed care pilot program for long-term care for the elderly and for persons with disabilities in both an urban and a rural area, if possible;
- develop an integrated managed care pilot program for mental health and substance abuse services in both an urban and a rural area, if possible. HHSC to submit preliminary plan for statewide expansion of integrated mental health and substance abuse services to the Senate Health and Human Services Committee by November 1, 1996. Plan for statewide expansion due November 1, 1998. Plan to be included in consolidated budget request.
- develop a consumer-oriented pilot program for individuals with mental retardation and other developmental disabilities which includes a decision support system and functional assessment.
- develop a cost-sharing pilot program for certain recipients of ICF-MR and waiver services, to be implemented in both an urban and a rural area, if possible.

SCR 56
Directs the State Medicaid Office to:

- Continue to administer the Medicaid prescription drug benefit under the state's fee for service Vendor Drug Program
- accelerate the implementation of computer-based rebate monitoring and prospective drug utilization review
- commit the savings achieved from computer-based rebate monitoring and prospective drug utilization review to reducing costs in other Medicaid line items or raising or eliminating the three-prescription limit

SCR 57
Directed the State Medicaid Office not to request federal waivers of certain rules regarding Federally Qualified Health Centers. The effect of this directive would be that -

- services provided by Federally Qualified Health Centers would continue to be mandated in new system, and
- cost-based reimbursement for Federally Qualified Health Centers would continue for the first three years of any new waiver program.

This would give FQHCs time to transition into managed care.

SCR 58
Directed the State Medicaid Office and Medicaid operating agencies to better facilitate cost-effective community-based services for people with mental retardation and people who require home health services.

The State Medicaid Office, in conjunction with the Texas Department of Mental Health and Mental Retardation and with participation from consumers, family members, and providers, was directed to structure a range of service and delivery options under the authority of Section 1915(c) of the Social Security Act (home and community-based services) in order to provide more flexibility for people eligible to receive services in the six-bed Level I ICF-MR program, and in a manner that ensures that service alternatives will be cost-effective, will meet the needs of the individual, and will not increase overall Medicaid program costs.

The Texas Department of Health was directed to complete a feasibility study by May 1, 1996, and to include input from physicians, hospitals, home and community support services agencies, and consumers to identify and remove barriers to the use of cost-effective home health care services, including:

(1) the array of services available;
(2) arbitrary limits on number of visits allowed;
(3) the definition of "medically necessary";
(4) coverage of preventive services; and
(5) the interpretation of "homebound" for children

SCR 60
Directs the State Medicaid Office to -

- develop a plan for a pilot project that uses Medicaid funds to establish medical

savings accounts for recipients of acute care services under the state Medicaid program, and

- study the feasibility of using Medicaid funds for the Texas Health Insurance Risk Pool

Table 3.2:
MAJOR FEDERAL MEDICAID LEGISLATION, 1965 TO PRESENT:
Selected Provisions

Social Security Amendments of 1967
Mandated:
- EPSDT program for children's health.
- Freedom of choice of providers.

P.L. 92-223 of 1971
Option:
- Allows states to cover services in ICF and ICF/MR.

Social Security Amendments of 1972
Option:
- Allows states to cover care for Medicaid recipients under age 22 in inpatient psychiatric hospitals. **(NOT IMPLEMENTED IN TEXAS)**

Omnibus Budget Reconciliation Act (OBRA) of 1981
Option:
- Allows states to provide home- and community-based services to persons who would otherwise require institutional (in a hospital, ICF-MR, or nursing home) services under "1915(c)" or "2176" waivers.

Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982
Option:
- Allows states to extend coverage to disabled children under age 18 living at home who would be eligible for SSI if in a hospital, ICF-MR, or nursing home (the "Katie Beckett law"). **(NOT IMPLEMENTED IN TEXAS)**

Deficit Reduction Act of 1984 (DEFRA)
Mandated:
- Coverage of children up to age 5 born after 9/30/83 whose families meet AFDC income and resource limits, even if the family doesn't qualify for AFDC (i.e., if both parents are in the home). Texas also exercised its option to cover children from 6-19 in such families.

- Coverage of pregnant women in households that would meet AFDC income/resource limits after child is born, including households with unemployed "principal wage earner" present.

- Automatic coverage of infants born to (and living with) Medicaid-eligible mothers.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Mandated:
- Extends coverage of pregnant women to households with an employed principal wage earner if

TANF financial standards met. Discretionary distributions from a "medicaid-qualifying trust" are countable regardless of whether such distributions are made.

Option:
• Allows states to cover DEFRA children up to age 5 without waiting to phase in.

OBRA 1986

Mandated:
• Coverage of emergency care services (including labor and delivery) provided to undocumented aliens.

• Coverage of homeless persons: lack of home address may not be grounds for denial of eligibility.

Option:
• Allows states to cover infants up to age 1 and pregnant women under 100% of poverty; creates phase-in for kids up to age 5 under 100% poverty. Also allows coverage for prenatal care while Medicaid application is pending, and guaranteed coverage for full term of pregnancy and postpartum care. Allows states to waive assets tests for this group.

• Allows states to cover Medicare-eligible persons under 100% of poverty (**qualified Medicare beneficiaries - QMBs**); either for full Medicaid benefits or for Medicare out-of-pocket costs only (state option).

OBRA 1987

Mandated:
• Extends **to age 7** coverage of kids born after 9/30/83 whose families meet AFDC financial standards, even if the family doesn't qualify for AFDC (extension to age 8 at state's option).

• Makes sweeping changes in nursing home standards, including requirement that all current and prospective nursing home clients be screened to identify persons with mental illness, mental retardation, or related conditions (**pre-admission screening and annual resident reviews - PASARR**).

Option:
• Allows states to cover infants up to age 1 and pregnant women under 185% of poverty, and allows immediate coverage (no phase-in) of kids up to age 5 under 100% of poverty.

• Allows states to develop **capped** programs for home- and community-based and institutional long-term care via waivers {1915(d) waiver}. **(NOT IMPLEMENTED IN TEXAS)**

Medicare Catastrophic Coverage Act of 1988

Mandated:
• Phased-in coverage of out-of-pocket costs (premiums, deductibles, co-insurance) of Medicare-eligible persons under 100% of poverty (**QMBs**).

• Phased-in coverage of infants up to age 1 and pregnant women under 100% of poverty.

• Requires more comprehensive coverage of hospital services for infants.

• Requires the deduction of incurred medical expenses in the post-eligibility treatment of income.

• Established minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.

• Established a 30-month penalty period for transfers of assets.

Family Support Act of 1988

Mandated:

• 12 months of transitional Medicaid coverage for families under 185% of poverty who lose their AFDC and Medicaid coverage due to new employment or increased income.

• Coverage for two-parent families (with dependents) if the principal wage earner is unemployed and if all other AFDC guidelines are met. Principal wage earner must have been employed in at least six of the last 13 calendar quarters prior to application.

OBRA 1989

Mandated:

• Coverage of children up to age 6 and pregnant women up to 133% of poverty.

• Coverage under EPSDT of any service allowable under federal Medicaid law determined to be medically necessary for persons up to age 21.

• Coverage by state Medicaid programs of Medi**care** Part A (hospital) premiums for qualified working disabled individuals (**QWDIs**) under 200% poverty.

• Coverage of services provided to Medicaid clients by Federally Qualified Health Centers (FQHCs).

OBRA 1990

Mandated:

• Coverage of children born after 9/30/83 up to 100% of poverty.

• Phases in coverage of Medi**care** Part B premiums for persons between 100-120% of poverty (**specified low-income Medicare beneficiaries - SLMBs**). Accelerates implementation of QMB coverage.

• States must pay FQHCs under Medicare reasonable cost method.

• States must pick up group health premiums and cost-sharing and COBRA coverage premiums for Medicaid-eligible persons if less costly than Medicaid coverage.

• Expands payments for hospital services for infants in all hospitals, and for children up to age 6 in Disproportionate Share hospitals.

• Once eligibility is established, coverage of pregnant women may not be terminated until two months postpartum. Infants born to Medicaid-eligible mothers must be covered through first birthday if mother remains eligible, or if she would be eligible if she were pregnant.

Option:

• Allows states to create capped home and community care programs for functionally disabled persons {1929(b) "Frail Elderly"} and to apply for funding services for persons with developmental disabilities {1930 Community Supported Living Arrangements}.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Mandated:

• Restricts use of voluntary donations from health care providers to state Medicaid programs.

• Caps spending on disproportionate share hospital (**DSH**) reimbursement.

• Sets strict standards for taxes on health care providers, and a ceiling on the maximum share of state Medicaid funds that may be financed through provider taxes.

OBRA 1993

Mandated:

• States must distribute federally-provided vaccines to Medicaid providers.

• States without medically needy spend-down programs for nursing home services must allow eligibility of persons with certain trusts.

• Sets new standards for participation in and payments under the Disproportionate Share reimbursement program.

• Sets stricter standards for transfer-of-assets penalties for nursing facility care and home and community based waiver services.

Option:

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

Table 3.3:
RECENT FEDERAL LEGISLATION AFFECTING MEDICAID:
Selected Provisions

Several changes occurred during 1996 which affect eligibility for SSI and thus affect Medicaid eligibility. These changes, if implemented as passed, will result in fewer Texans receiving Medicaid coverage.

Public Law 104-121, the "Contract with America Advancement Act"
Prohibits SSI / SSDI benefits from being paid to people considered disabled because of Drug Addiction or Alcoholism (DAA). Existing eligibles whose benefits are based on DAA will have cash benefits and health coverage (Medicare and / or Medicaid) **terminated** as of January 1, 1997. As of October 1996, the federal government estimated that there were 2,787 DAA clients in Texas who might be terminated if they had no other disability which qualified them for SSI.

The Personal Responsibility and Work Opportunity Act (P. L. 104-193) made major changes in the federal statute underlying a variety of public assistance programs. While comprehensive restructuring of the Medicaid program was not included in the new law, PRWORA indirectly will affect Medicaid. Among the key provisions are the following:

- Any state adopting more restrictive income and resource standards for its cash assistance program must also test applicants against the old standards for purposes of determining Medicaid eligibility. Texas to date has elected to maintain current standards. Consequently, the requirement to operate dual eligibility systems does not apply.

- SSI cash payments no longer will be made on behalf of children whose disability determination is based solely on a diagnosis of maladaptive behavior. The federal Social Security Administration estimates that roughly 12,000 Texas children will lose SSI cash payments. Of those, most are likely to continue to qualify for Medicaid coverage under other eligibility categories.

- Non-citizens who are in the country legally will no longer be eligible for SSI cash payments. As a result, more than 37,000 aged and disabled individuals may lose Medicaid coverage.

- Non-citizens who lawfully entered the country prior to August 22, 1996 may continue to receive Medicaid services at the state's option. Those entering legally after that date are barred for five years, after which time the state must deem sponsor income in determining eligibility. Regardless of the state's decision, all Medicaid-eligible individuals regardless of citizenship status remain eligible for emergency medical care, including labor and delivery services. To date, Texas has opted to continue Medicaid coverage for non-citizens who legally entered the country.

More detailed discussion of PRWORA and projected Medicaid impacts may be found in "1996 Federal Welfare Reform: Major Implications for the State of Texas," issued by HHSC on November 1, 1996.

NOTES

[1] Lam Yip, Pam, HHSC Demographic Facts Information Series, Issue 5, Volume 1, April 1996.

[2] LBB, *Fiscal Size Up 1996-97,* p. 5-22, Table 5 "Income eligibility for Selected Programs Estimated Maximum Countable Income and Corresponding Percent of Federal Poverty Guidelines."

[3] TDHS Income Assistance Handbook.

[4] State Policy Research Inc., *States in Profile '95: The State Policy Reference Book,* Table H-5. Average calculated from numbers in the table.

[5] CCH, ¶ 14,905, pp. 6470-71.

[6] Article 4413(502) _16, Texas Revised Civil Statutes.

Chapter 4: What Does Medicaid Do?

Texas Medicaid doesn't just pay for poor people's health care, though that's certainly part of its mission. Medicaid covers a vast array of medical services — from maternity to nursing home care — and all manner of people with special needs.

IN THIS CHAPTER

CHAPTER 4 TAKES A DETAILED look at the people who qualify for Texas Medicaid, and the services for which the program pays. Because looking at lists of "eligibility groups" and covered services doesn't really paint an adequate portrait of all that Medicaid does, we have also provided brief descriptions of some of Texas Medicaid's special programs.

BENEFITS

THE SOCIAL SECURITY ACT specifies a set of benefits that state Medicaid programs **must** cover, and a set of optional benefits which states may **choose** to provide. Table 4.1 shows the current set of benefits covered by Texas Medicaid, as well as the optional services **not** covered in this state. (See **Table 4.1** at the end of this chapter.)

Federal law allows states to put limits on the "amount, duration, or scope" of Medicaid benefits. This means Medicaid programs can, for example, limit the number of visits per year for a certain service, or put an annual dollar cap on how much will be paid per-person for a given service, or limit a service to outpatient settings.

Important limits on Texas Medicaid include:

- 30-day annual limit on inpatient hospital stays "per spell of illness." This means more than one 30-day hospital visit **can** be paid for in a year, **if** stays are separated by 60 days or more.
- 3 prescriptions per month. This applies to **outpatient** drugs; there are no limits on drugs people need while they are hospitalized or in a nursing home.

What Does Medicaid Do?

A very important exception is that these caps must be lifted for children whenever there is medical necessity for additional services. In effect, this means that limits apply only to **adults** covered by Medicaid.

WHO IS COVERED?

CHILDREN MAKE UP THE biggest share (57 percent - 1.45 million) of Texas Medicaid recipients. Most of them (60 percent) are **very** poor - from families that meet the TANF/AFDC income standards, which means they live on $188 per month (for a family of three) or less. That's about 17 percent of the federal poverty income level.

SINGLE PARENTS: Parents of children in TANF families make up 21 percent of the Texas Medicaid population. Virtually all of these families live at or below the TANF income standard ($188 per month for a family of 3). The most common TANF caretaker is an unemployed female approximately 30 years old with one or two children under age 11. She receives an TANF grant of $184 or less and has no other income. This "typical" TANF parent dropped out of school between the 8th and 11th grades and has no job training. Besides her lack of education, the typical TANF parent may have trouble holding a job because of a lack of affordable day care and unreliable transportation.

PREGNANT WOMEN: Medicaid pays for pregnancy-related health care needs (their coverage ends two months after the baby is born) for approximately half of all births statewide. This time-limited coverage is available to low-income women - those with family incomes up to 185 percent of poverty ($1,941 per month for a family of 3). This group of women made up 6.3 percent of all persons in Texas Medicaid for 1995.

What Does Medicaid Do?

Income Disregards

There are a number of situations in which some portion of a person's income may be "disregarded" (not counted) when calculating eligibility for Medicaid. In most cases, the amounts of money are quite small, resulting from work expenses. cost-of-living increases or increased collection of child support. Larger disregards can occur when a child (under 18) becomes a full-time resident of a nursing home or a home for persons with mental retardation or developmental disabilities. In that case all of the parent's income can be disregarded, so only the child's own resources are counted in deciding Medicaid eligibility. Similar disregards are also used in some waiver programs designed to keep children in community settings.

Medically Needy Spenddown

If a family has medical bills that, once paid, reduce its income to a special income limit ($275 per month for a family of three), they may be eligible for coverage of additional medical bills by Medicaid under the "Medically Needy" spend-down program. These clients must still fall under the TANF assets limit of $1,000.

Temporary Assistance to Needy Families (TANF) is the federal-state program of cash assistance for impoverished families (mostly single parent). Effective October 1996, Texas replaced its Aid to Families with Dependent Children program with the TANF block grant program. As with AFDC, states set their **own** income eligiblility guidelines for TANF. Texas' income cap for a mother with 2 children is $188 per month; the assets limit is $1,000. Presently, TANF-eligible persons are automatically entitled to Medicaid

Supplemental Security Income (SSI): the federal cash assistance program for the elderly or poor persons with disabilities. Income eligibility caps, asset limits and benefit rates are set by the federal government. States may **supplement** SSI payments with state funds (about half the states do), but may not use a more restrictive limit. Texas uses the basic unsupplemented federal eligiblity cap of $480 per month (73 percent of poverty) for an individual; the asset limit is $2,000. All SSI-eligible persons are also entitled to Medicaid.

What Does Medicaid Do?

About 11 percent of the people receiving Texas Medicaid services in 1995 became eligible because of a major disability.

POOR AND LOW-INCOME ELDERLY: Elderly Texans make up 12 percent (about 308,000) of the state's Medicaid program. Most of them are poor - 57 percent live at or near the SSI income cap of 73 percent of the federal poverty level. Medicaid pays Medicare premiums and copayments for some low income elderly. Most of the rest of the Medicaid-eligible aged receive long-term care services - the 65,000 aged Medicaid recipients in nursing homes are allowed incomes up to about 219 percent of poverty ($1,410 per month) - but almost all of that income must be given to the nursing home to reduce Medicaid's costs.

TEXANS WITH DISABILITIES: About 11 percent of the people receiving Texas Medicaid services in 1995 were eligible because of a major disability. This category encompasses people with a wide variety of very different disabilities, such as blindness, mental retardation, severe and persistent mental illness, and physical conditions that affect mobility but not mental capacity. People in this group fall under the same income caps as the elderly described above; that is, they are poor (at or near SSI cap) or low-income in a nursing facility or ICF-MR (income up to $1,410 per month **allowed**, but almost all must be spent on costs of care) or enrolled in certain home and community based waiver programs.

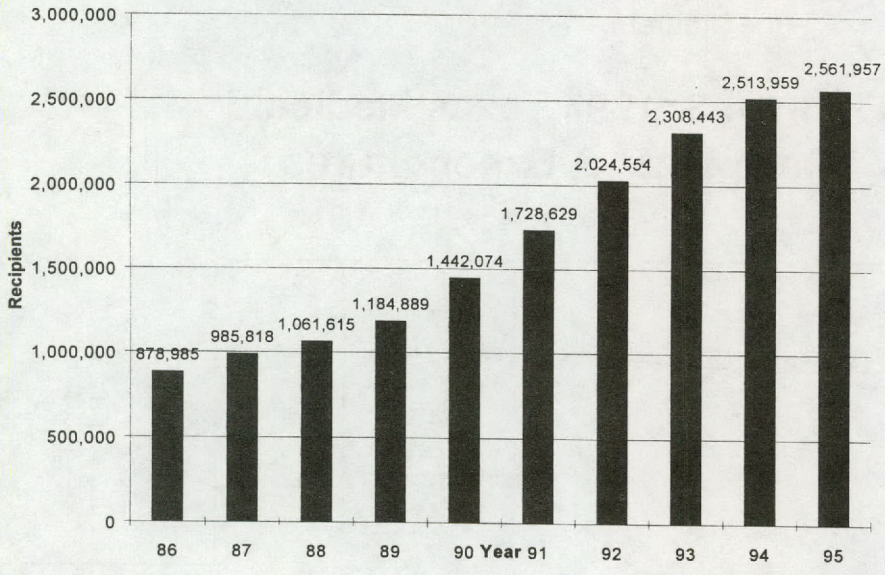
As with Medicaid benefits, federal law dictates very specific categories of people who **must** be covered by state Medicaid programs, and defines optional coverage groups which states may choose to adopt. **Table 4.2** describes all of Texas Medicaid's eligibility groups (as of February 1996), and notes those groups (or portions of groups) which are optional to the state.

The number of Texas Medicaid recipients is usually expressed in one of two ways. The total "unduplicated count" for federal fiscal year 1995 was 2,561,959 persons; that's the number of individual Texans who received Medicaid-funded services at any point during that year.

What Does Medicaid Do?

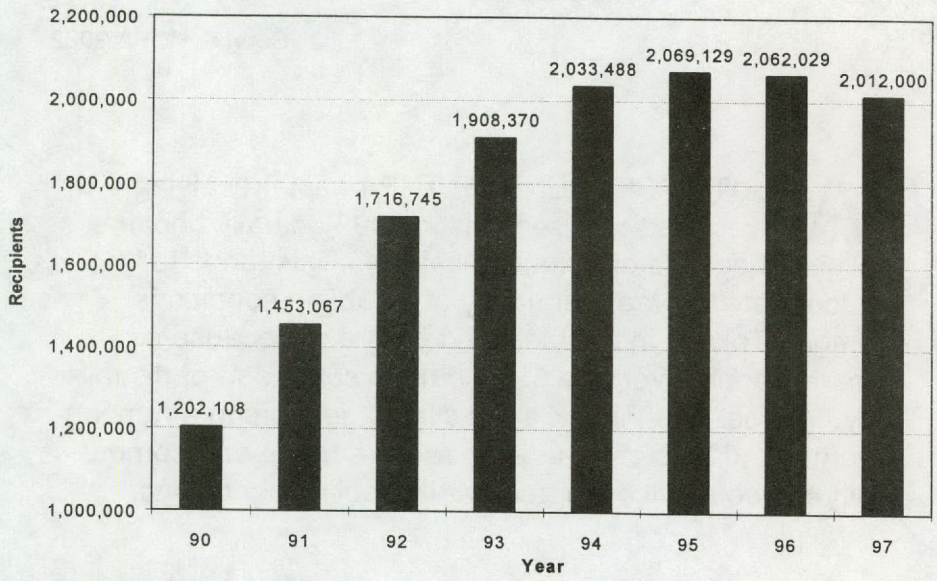
Figure 4.1 shows the growth in the total unduplicated Medicaid client count from 1986 to 1995.

Figure 4.1:
Texas Medicaid Recipients, 1986 to 1995



Source: HCFA 2082

An alternative way to look at the Medicaid caseload is the monthly average number of recipients. Over any period of time some people gain coverage while others lose their eligibility (e.g., due to changes in income, when children reach adulthood, certain mothers after the birth of a child, etc.). As a result, the monthly average Medicaid recipients (2,069,129 for FY95) is a lower number than the unduplicated count of recipients (2,561,959 for FY95). **Figure 4.2** shows the growth in average recipients per month from 1990 through 1995, with projections for 1996 and 1997.



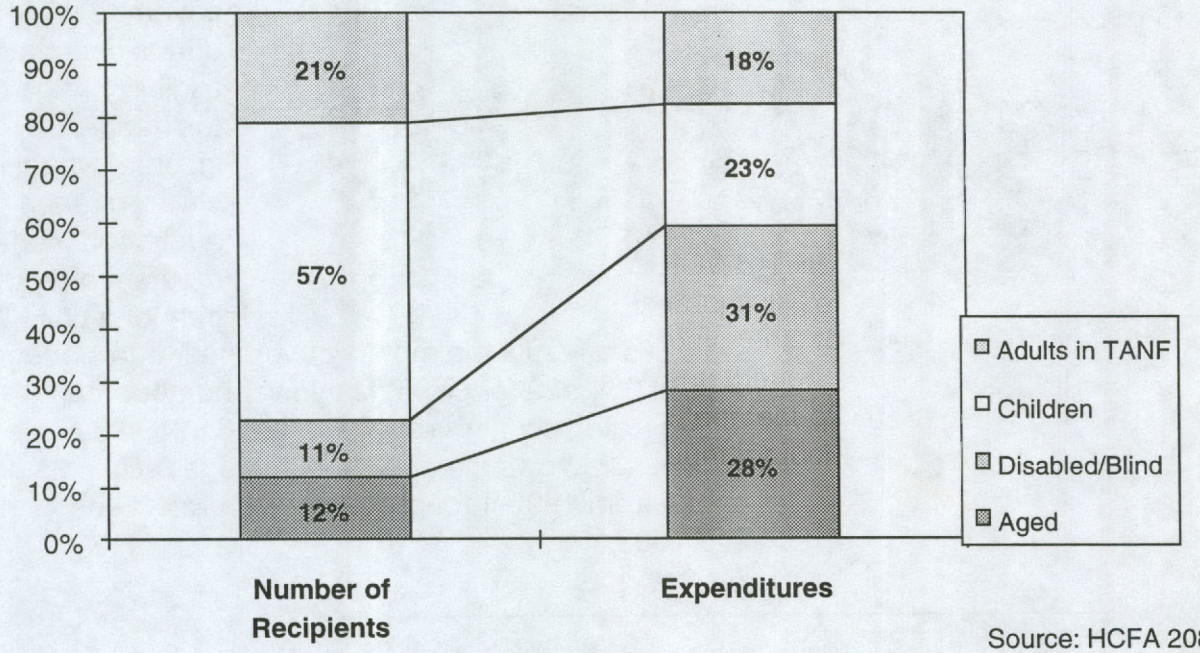
Source: TDH

Figure 4.2:
Texas Medicaid Monthly Average Recipients 1990-1997

ELIGIBILITY

FIGURE 4.3 SHOWS THE RELATIVE sizes of different eligibility groups in Texas Medicaid. The distribution of Medicaid payments for services by eligibility group is very different: though poor children and their families make up 78 percent of people eligible for Texas Medicaid, they account for just 41 percent of the cost of the program.

Figure 4.3: 1995 Texas Medicaid Recipients & Expenditures



Source: HCFA 2082

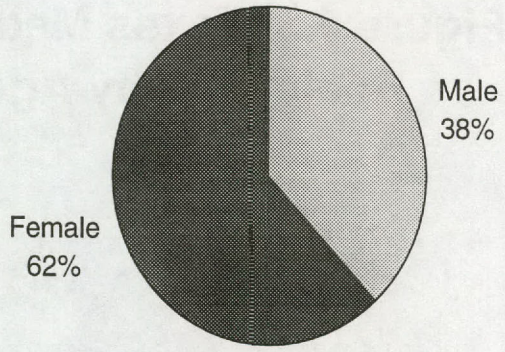
PEOPLE WITH DISABILITIES

ABOUT 11 PERCENT OF THE people receiving Texas Medicaid services in 1995 actually became eligible because of a major disability. This tends to understate the real frequency of disabling conditions among Texans in the Medicaid program, because so many people over age 65 also have some sort of disability. Almost one-third of aged clients get care in a nursing home, and tens of thousands receive home and community-based services to help with disabling conditions.

GENDER

FIGURE 4.4 SHOWS THE PROPORTIONS of Medicaid recipients by gender.

Figure 4.4: 1995 Medicaid Clients by Gender



Source: HCFA 2082

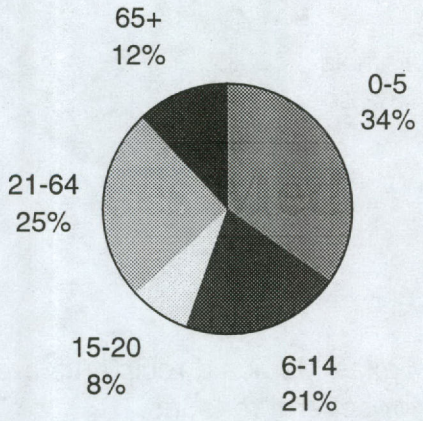
Texas Medicaid recipients are disproportionately female, for several reasons:

- The poverty rate is substantially higher among females (21.2 percent) compared with males (17.0 percent).[1]
- AFDC-related coverage targets poor single-parent families, which in Texas are usually (84 percent) female-headed.
- Women covered only for pregnancy-related services accounted for about 6 percent of all Texas Medicaid recipients in 1995.
- There are more elderly female recipients than male, because women live longer on the average, and the gap between male and female poverty rates is even higher among the elderly - 16.7 percent for elderly women compared with 10.5 percent for elderly men.[2]

AGE

CHILDREN AND THE ELDERLY make up just under 70 percent of the program. **Figure 4.5** shows the portion of Texans with Medicaid in various age groups. The biggest share of the program - 63 percent - is made up of people under age 21; **55 percent are age 14 or younger**.

Figure 4.5: Texas Medicaid Recipients by Age

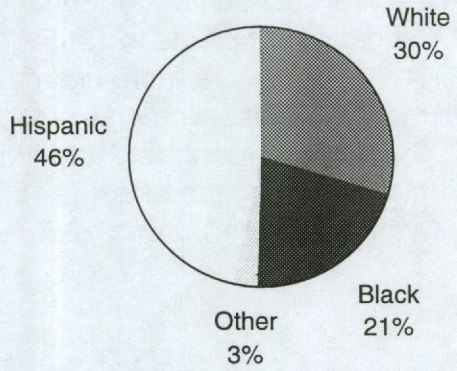


Source: HCFA 2082

ETHNICITY

FIGURE 4.6 SHOWS THE relative proportions of Texas Medicaid recipients by ethnic group.

Figure 4.6: 1995 Medicaid Recipients by Ethnicity



Source: HCFA 2082

Most (73 percent) of the Hispanic Texans covered by Medicaid are under age 21.

Black and Hispanic Texans are over-represented in the Medicaid population (compared to their proportions of the general population) for several reasons:

- Birth rates among Hispanic Texans are substantially higher than for the general population (Black Texan birth rates are also higher than for the general population, but by a much smaller margin). **Most (73 percent) of the Hispanic Texans covered by Medicaid are under age 21** - a much bigger share of children and adolescents than in the TOTAL Medicaid population.
- White Texans make up 30 percent of Texans with Medicaid, though they are 60 percent of the general population. The poverty rate for non-Hispanic white Texans is significantly lower (9 percent) than for the general population (19 percent).[3] A much higher percentage (51 percent) of the over-65 Medicaid population are white Texans.
- Poverty rates are higher among black (30 percent overall) and Hispanic Texans (33 percent overall) than the general population (19 percent overall);

SPECIAL POPULATIONS

MEDICAID PAYS FOR MUCH more than the health insurance to which most of us are accustomed. It covers gaps and provides medical services that the private sector does not address.

For example, Texas Medicaid continues to care for children long after traditional insurance plans would cut off services or refuse to renew coverage. In fact, Texas families frequently seek Medicaid coverage only after their private insurance benefits run out or their insurer has dropped them. Moreover, Medicaid funds long-term care services to help elderly Texans and people with disabilities, whether in the home or in institutional care. Just a tiny fraction of long-term care costs are paid for with private health insurance.

What Does Medicaid Do?

CHILDREN'S HEALTH: TEXAS HEALTH STEPS

IN 1996, TEXAS CHANGED the name of its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to "Texas Health Steps." Originally, EPSDT provided medical and dental screening and limited treatment for children (up to age 21) to detect and correct health problems. Federal mandates in 1989 (the Omnibus Reconciliation Act of 1989) greatly expanded the program. Federal law now requires states to cover any service that's medically necessary and allowable under federal Medicaid regulations (even optional services that a state does not offer to its general Medicaid population) without limits on the amount, duration and scope of the service. In Texas, the expanded benefits portion of Texas Health Steps is known as the Comprehensive Care Program (CCP). CCP removes the limits on Medicaid covered services for children when a doctor deems them medically necessary.

Services covered under CCP in addition to what Medicaid usually covers include:

- Psychiatric hospitals
- Private duty nurses (LVN or RN)
- Occupational Therapy
- Speech Therapy
- Durable Medical Equipment
- Medical Supplies
- Dietitians

MEDICAID AND MATERNITY

TEXAS MEDICAID FUNDS nearly half of all Texas births each year. In 1996, the program paid for more than 157,000 births out of an approximate statewide total of 325,000. Teen mothers accounted for 26 percent of those Medicaid-funded births. This percentage is so high because young pregnant women are less likely to be able to afford insurance, and are more likely to work at low-level jobs that don't provide health coverage.

To counter these trends, Texas Medicaid extends optional pregnancy coverage to women with incomes up to 185 percent of poverty ($24,013 for a family of three), more than 1,000 percent of the income eligibility level for regular adult TANF clients. Their child is covered under this optional category until age one.

LONG TERM CARE

WHEN MOST PEOPLE THINK OF Medicaid they think of traditional health care benefits such as hospital services and check-ups. But for nearly 200,000 Texans with disabilities, Medicaid also funds **long term care** services. Texans who benefit from these services include many elderly, people of all ages with developmental disabilities (such as mental retardation), and people with physical disabilities.

Long term care includes a broad range of both institutional and community-based services. For example, services such as attendant care help people with physical disabilities with day-to-day needs such as bathing, dressing, eating and preparing meals. Habilitative services can help teach persons with mental retardation to do more things for themselves.

COMMUNITY CARE SERVICES

IN 1979, THE LEGISLATURE ordered TDHS to develop more community-based long term care options. Over the next 17 years, Texas focused more resources on community-based services. By 1995, the number of Medicaid recipients who receive community care had grown to an average of 66,900 per month, while the Medicaid population in nursing homes remained relatively steady at 65,000 per month. Medicaid also pays coinsurance to Medicare for in nursing home residents.

The Community Care program operated by TDHS offers a range of services - funded by state general revenues, Medicaid and federal grants - that enable elderly individuals and people with disabilities to live in their homes.

What Does Medicaid Do?

Community care can be a cost-effective alternative to institutionalization. The average monthly cost per Medicaid nursing home client is $1,053, compared with $315 per month for community care.

Personal Care

IN 1995, 37,600 PEOPLE ACROSS the state received Medicaid-funded personal care assistance with daily activities (e.g., dressing, eating, grooming, bathing, food preparation) through the Primary Home Care program. Any Texans meeting the "**functional impairment**" and income limits are entitled to receive Medicaid-funded personal care services. Licensed home health agencies provide the services across the state. Special provisions in the Medicaid law allow Texas to provide personal care without other Medicaid benefits to individuals who have income too high to qualify for Medicaid in the community, but who meet the more generous nursing home income limits (219 percent of the federal poverty level). More than 21,500 of the people receiving personal care services do so through this special provision, known as the Frail Elderly program.

Day Activity and Health Services (DAHS)

ONE HUNDRED FORTY DAY ACTIVITY and Health Services (DAHS) facilities provide daytime services Monday through Friday to more than 6,200 clients residing in the community. DAHS offers an alternative to placement in nursing homes or other institutions, by providing a much-needed temporary break for family caregivers during weekdays. Medicaid funds DAHS services up to a maximum of ten hours per day, five days a week. Services include the following:

- nursing and personal care
- physical rehabilitation
- noon meal and snacks
- transportation
- social, educational and recreational activities

PACE Program

IN 1992, TEXAS IMPLEMENTED a program for All-inclusive Care for the Elderly (PACE) in El Paso, administered by an adult day health center called Bienvivir Senior Health Services. PACE participants are over 55, must live in certain areas of El Paso, and have been certified eligible for nursing facility care. Bienvivir receives a pre-paid, capitated payment from Medicaid and Medicare. The program pools resources and provides all primary, acute and long-term care services needed by each of the clients on an "as needed" basis. Services continue as long as needed without restrictions.

Texas Home and Community Based Waivers

HOME AND COMMUNITY BASED waivers provide a broad array of support services to special needs populations. These waiver services differ from those normally offered to Medicaid clients. For example, waivers for people developmental disabilities (mental retardation, cerebral palsy, deaf-blindness, etc.) include habilitation services which help individuals learn to perform the activities of daily living. Texas' six home and community-based waivers are described in **Table 4.3** at the end of this chapter.

Most waiver programs currently have five to seven year waiting lists of people who wish to enroll.

All current waiver programs include respite services to relieve families from the stress of caring for the person with a disability. Some allow people to modify their homes to make it easier to live independently. Community-based waivers use the same rules as nursing homes or ICFs-MR to decide if someone is financially qualified for Medicaid. This means that some people who would have been forced to enter an institution to get Medicaid have even more incentive to stay in the community.

Because of funding limitations, home and community-based waiver programs in Texas are relatively small. The six waivers currently have a capacity to serve about 26,000 people. Thus demand for waiver services far exceeds current supply. Most waiver programs currently have five to seven year waiting lists of people who wish to enroll.

What Does Medicaid Do?

According to federal rules, home and community-based waivers cannot cost any more than institutional care would have cost for the group served by the waiver. Waivers have the potential to serve significantly more people than institutions for the same amount of funding.

Because they provide cost effective quality care in a flexible manner that disabled people typically prefer to institutional care, Texas has chosen to increasingly emphasize waivers. SCR 58 requires that HHSC and MHMR develop community based options for people who qualify for institutional care. For example, when funds are available for expansion the state limits future growth of ICF-MR facilities in favor of creating or expanding waiver options.

Community Based Alternatives Waiver

THE "COMMUNITY BASED Alternatives" Waiver provides long-term care services outside of institutional settings to people over 21 who qualify for nursing care and people with disabilities. Services offered include personal care nursing, durable medical equipment and therapy, but are delivered in the home, in foster care, or in an assisted living arrangement. The CBA waiver complements current nursing facility services by developing a seamless array of services that are less costly than institutionalization and improve the individual's quality of life. As of September 1996, some 819 providers served about 16,000 clients through this CBA waiver.

INSTITUTIONAL SERVICES

DESPITE TEXAS' BEST EFFORTS to utilize community care options rather than institutionalization, about four percent of Texas Medicaid clients require institutional long term care services. Texas Medicaid paid 27 percent of its health expenditures — $1.8 billion — in FY 1995 for institutional care in nursing homes or Intermediate Care Facilities for the Mentally Retarded.

Nursing Facilities

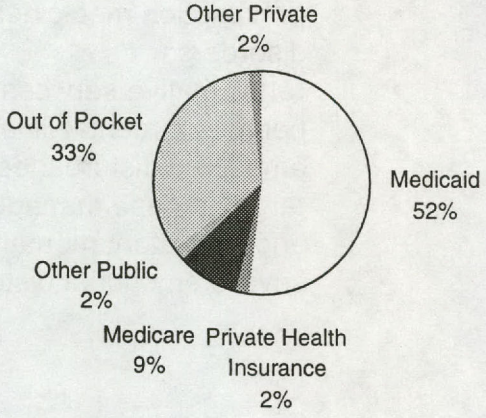
IN 1995, MEDICAID PAID FOR $1.2 billion worth of nursing facility services to 1,072 facilities. Texas Medicaid pays for 72 percent of the total bed days for those facilities. In 1995, Medicaid averaged about 65,000 nursing home clients per month; all told, it funded nursing facility services for more than 94,000 people that year.

Nursing facility services include skilled nursing care and related services for residents who require them. Medicaid requires nursing facilities to provide services and activities which allow residents to attain and maintain their highest practical levels of physical, mental, psychological and social well-being. These include room and board; social care; regular, special and supplemental diets; over the counter drugs (with the exception of insulin); medical equipment, supplies and adaptive aids; personal needs items and rehabilitative therapies.

Medicaid pays for many nursing home costs not covered by most major medical plans.

Medicaid pays for many nursing home costs not covered by most major medical plans. While individuals may purchase long-term care insurance, the cost is high. Private long term care insurance charges about $185 per month for healthy 65 year olds — a prohibitive cost for most seniors, many of whom live on a fixed income.[4] As a result, private insurance pays for only two percent of national nursing home costs, while Medicaid pays more than half.[5]

Figure 4.7: National Nursing Home Expenditures by Source: 1993



Source: HCFA Office of the Actuary

What Does Medicaid Do?

Nursing Home Rehabilitative Services

MEDICAID PAYS FOR REHABILITATIVE services for nursing home clients who have an acute onset of illness or injury which can benefit from therapy. These services include speech therapy, physical therapy and occupational therapy.

Hospice Program

THE HOSPICE PROGRAM SERVES clients diagnosed as terminally ill by their doctor, including patients with AIDS, cancer and other terminal illnesses. Hospice services include physician services, nursing care, counseling, home health care, various therapies, drugs and respite care. In 1994, the program served 4,476 clients.

BEHAVIORAL HEALTH SERVICES

TEXAS MEDICAID ALSO FUNDS behavioral health services. Behavioral health is defined as services used to treat a mental, emotional or chemical dependency disorder. Services include:

- therapy by psychiatrists, psychologists, licensed professional counselors and Master's Level Social Workers (Advanced Clinical Practitioners);
- inpatient care for chemical dependency or mental health;
- inpatient care in psychiatric hospitals for children (under 21)
- outpatient chemical dependency counseling for children (under 21) in TCADA licensed facilities;
- prescription medicines used to treat behavioral disorders;
- rehabilitative services for people with severe and persistent mental illness or children with severe emotional disturbance; and
- targeted case management for people with severe and persistent mental illness or children with severe emotional disturbance.

Behavioral health services are provided by therapists in private practice, physicians, private and public psychiatric hospitals and by Local Mental Health Authorities (LMHAs) in the TXMHMR system.

It is difficult to estimate the total cost of behavioral health services in the traditional Medicaid Program because services are not always provided by specialists and a single claim for non-specialist care may include both behavioral and physical medicine diagnoses. Texas spent more than $240 million in state and federal dollars on specifically identified inpatient and outpatient behavioral health services in FY 1995. That figure does not include prescription medicines related to specific behavioral health diagnoses.

Over the last several years Medicaid has become an important source of revenue for the TXMHMR system. In FY 1995 Medicaid billings for rehabilitative and targeted case management services generated approximately $33 million in federal revenue for the TXMHMR system. **Medicaid revenues have helped offset state funding cut backs to the TXMHMR system.**

Intermediate Care Facilities for persons with Mental Retardation (ICF-MR)

ICF-MR FACILITIES PROVIDE residential services and assistance in learning to perform day-to-day living functions (habilitation) to people with developmental disabilities such as mental retardation. ICF-MR providers include state schools for mentally retarded persons, community MHMR centers, for profit providers and non-profit providers. **Texas Medicaid pays for more than 98 percent of all ICF-MR services.**

- The ICF-MR program includes 880 facilities, and served more than 14,200 people in 1995.
- Texas Medicaid paid $589 million for ICFs-MR in 1995, for a yearly average of $41,446 per recipient.
- About 68 percent of ICFs-MR are for-profit, but the share of ownership-type differs by size of facility (small facilities have higher share of not-for-profits) and by level of facility (those that serve persons with

mild retardation include a higher share of public facilities). **Sixteen state schools serve more than half the Texans in ICFs-MR.**

This type of specialized long term care has become more expensive in recent years. Medicaid payments for ICF-MR services increased by 81 percent in the last decade ('86-'95). Almost all of that increase occurred due to medical inflation rather than increases in numbers of people served; over that same period, the average cost per ICF-MR client rose from $24,334 to $41,446. Nearly all facilities added to the program over the last few years have been small (6 beds or less).

Medicaid pays ICF-MR costs not just for the mentally retarded but also for others with related conditions, i.e., a disability other than mental retardation which occurs before the individual turns 22 (during the person's developmental period) and severely limits the individual's ability to function without assistance and support. Related conditions may include over 200 diagnoses such as cerebral palsy, spina bifida and head injuries.

DISPRO FUNDING

FEDERAL LAW **REQUIRES** STATE Medicaid programs to make special payments to hospitals that serve a large number of low-income patients called Disproportionate Share Hospital funds ("DSH" or "Dispro"). Dispro differs from all other Medicaid payments because it is **not** tied to services for Medicaid-eligible patients. Hospitals may use DSH funds to pay for uncompensated care for indigent or low-pay patients.

The DSH program distributed $1.513 **billion** to Texas hospitals in federal fiscal year 1993. "Dispro" or "DSH" funds have been a major shot in the arm for hospitals, helping them to expand health care services to the uninsured, to make major medical equipment purchases and to make critical repairs and renovations. Since many DSH hospitals are public, these funds enable local governments to do more while reducing the pressure for tax increases.

What Does Medicaid Do?

Who Gets Dispro?

AS OF AUGUST 1996, 164 Texas hospitals were qualified to receive DSH payments. By ownership status, 95 are public, 40 are private nonprofit, and 29 are for-profit. Most public and private hospitals qualify based on a formula that looks at their total **number** of hospital days for Medicaid patients, what **percent** of all days are for Medicaid patients, and what **percent** of all days are for other low-income patients. State-owned teaching and psychiatric hospitals are paid under a formula based on their charges for charity care.

How Dispro is Funded?

THE FEDERAL GOVERNMENT subsidizes dispro at the same matching rate as medical services (62.56% federal funds, 37.44% state funds for 1997). Texas uses intergovernmental transfers of local tax dollars from hospital districts and public hospitals, and of state-appropriated funds from state-owned hospitals (teaching, psychiatric, and chest hospitals) to fund the state's share. **Because of this funding method, the dispro program creates no funding burden for the state.**

This funding approach:

- avoids additional state taxes to fund Dispro
- uses federal funds to reduce the need for more local taxes
- helps Texas get back its fair share of federal taxes we send to Washington each year.

A 1991 federal law capped Texas' dispro program at $1.5 billion. The 1993 federal budget act established new hospital qualifying standards for dispro (a minimum of one percent of total patient-days must be Medicaid patients), and new limits on the size of dispro payments to public hospitals (may not exceed the difference between the hospital's actual costs of care for Medicaid patients and the uninsured and what the hospital was actually paid by Medicaid and by uninsured patients). These changes took effect for Texas' dispro program in the 1996-97 biennium; DSH payments to state-owned hospitals (mental, chest, and teaching hospitals) are projected to drop by around $200 million per year.

What Does Medicaid Do?

HOW DISPRO MAY BE USED

THERE ARE NO **FEDERAL** restrictions on how Dispro is used by the receiving hospitals. However, Texas Medicaid has adopted by rule **Conditions of Participation** (effective in 1994), which require each dispro hospital to:

- report its charity care eligibility policy, number of charity patients and services they receive;
- meet specific charity care percentage targets;
- maintain level of local tax support (in major urban areas);
- show how dispro funds are used to meet community health needs;
- develop alternatives to the emergency room for primary care;
- actively participate in regional trauma system development;
- report annually on how it spent dispro funds.

In addition, the Texas Hospital Association, the Texas Association of Public and Non-Profit Hospitals, and the Texas Catholic Hospitals Association worked with state Medicaid officials to develop **voluntary** guidelines for how hospitals should and should not spend dispro funds.

What Does Medicaid Do?

Table 4.1
Who Gets Medicaid in Texas: 1996

TANF-Related Categories

(dollar amounts = maximum income limit for eligibility; asset cap: $1,000)

TANF (Temporary Assistance to Needy Families) Recipients - single parents and their dependent children.

($2,256/year for family of 3)

Adults from two-parent households meeting TANF income criteria in which one spouse is certified disabled.

($2,256/year for family of 3)

Children up to age 19 from two-parent households whose family income and assets meet TANF guidelines.

($2,256/year for family of 3)

Families with children in the categories above whose income is too high to qualify for TANF but is still less than 133 1/3 % of the state's maximum TANF grant. This is called the "Medically Needy" program.

($3,300/year for family of 3, with spend-down)

Children up to age 6 whose income is less than 133% of the federal poverty level.

($17,263/year for family of 3)

Pregnant women and newborns up to age 1 with household income less than 185% of federal poverty level. Coverage of pregnant women ends 2 months after delivery.

($24,013/year for family of 3)

Children born after 9/30/83 up to 100% of federal poverty level; by the year 2002 all children under 100% of federal poverty level up to age 19 will be covered.

($12,980/year for family of 3)

Persons who lose TANF eligibility due to higher earned income must be given 12 months of transitional Medicaid coverage (up to 185% of federal poverty level).

($24,013/year for family of 3)

Two-parent families (with dependents) if the principal wage earner is unemployed and if all other TANF guidelines are met. Principal wage earner must have been employed 1.5 out of the last 3 years and unemployed for the 30 days prior to application.

($2,256/year for family of 3)

Note: Coverage "up to" a specific age ends when that age is reached.

What Does Medicaid Do?

SSI-Related Categories

(asset cap: $2,000 per individual; $3,000 per couple)

Supplemental Security Income (SSI) Recipients - individuals who are blind, disabled or over age 65 and whose income is less than the maximum SSI federal benefit rate.

($480 per month)

Persons residing in Medicaid-approved long-term care facilities whose income is less than 300% of the maximum SSI benefit rate.

($1,410 per month)

Several groups of individuals denied SSI due to increases in Social Security benefits are protected from losing Medicaid coverage. (Disregards certain cost-of living adjustments (COLAs) for aged and disabled, disabled adult children, widows and widowers.)

($480 per month after income disregards)

Special Needs Categories

Certain disabled children who are denied SSI due to parental income or resources may receive home and community based services.

(must meet criteria for care in an institution (NF/ICF-MR) and be enrolled in a 1915(c) waiver program)

Certain children in the managing conservatorship of the Texas Department of Protective and Regulatory Services.

Limited Coverage Categories

Medicaid must pick up out-of-pocket costs (premiums, deductibles, and coinsurance) of Medicare population up to 100% of FPL; referred to as "qualified Medicare beneficiaries" (QMBs).

($7,740/year for individual; asset limit $4,000 for individual)

Coverage of Medicare Part B premiums only for persons up to 110% of federal poverty level by 1993, and up to 120% of federal poverty level in 1995; referred to as "specified low-income Medicare beneficiaries" (SLMB).

($9,288/year for individual; asset limit $4,000 for individual)

Working disabled persons with incomes under 200% of federal poverty level have their Medicare Part A (hospital insurance) premium paid by state Medicaid programs.

($15,480/year for individual; asset limit $4,000 for individual)

What Does Medicaid Do?

Certain Aged and Disabled persons not currently Medicaid-eligible may receive community care services designed to prevent need for nursing home care.

($1,410 per month)

Emergency Services (includes labor and delivery) for undocumented aliens who meet all other criteria for an TANF -related or SSI-related Medicaid eligibility group.

Optional Categories

Of the eligible groups listed in the table above, the following are optional:

Pregnant Women and children under age one from 133-185% of federal poverty level.

Medically Needy

Children age 12 and older from two-parent households whose family income and assets meet AFDC guidelines.

Nursing home and ICF-MR residents who do not receive SSI: those with incomes from $480-$1,410 per month.

Community Care for Aged and Disabled

Home and Community-Based Services for mentally retarded

What Does Medicaid Do?

Table 4.2
Services Covered by Texas Medicaid, 1996

Mandated Services:

ALL state Medicaid programs must pay for certain services to Medicaid recipients, including:

- A program of regular medical and dental check-ups for minors, and treatment of any conditions identified by the Texas Health Steps program.
- Ambulance service
- Family planning
- Federally Qualified Health Centers' (and certain similar organizations) services
- Home health care
- Inpatient and outpatient hospital services
- Kidney Dialysis
- Lab and X-ray services
- Medical transportation (non-emergency)
- Nursing facility care
- Rural Health Clinics
- Services of certified nurse midwives, family and pediatric nurse practitioners
- Physicians
- ICF-MR Dental
- Dentists (when providing physician services)

<u>All</u> optional services must be provided to persons under age 21 if the service is medically necessary. Optional services provided to <u>adults</u> in Texas include:

- Birthing center services (limited)
- Case management for people with chronic mental illness, women with high-risk pregnancies and infants, and persons with mental retardation and related conditions
- Certified Registered Nurse Anesthetists' services
- Chiropractic (limited)
- Christian Science Sanitarium services
- Day surgery
- Diagnostic services: assessments of persons with mental retardation
- Emergency medical services
- Hearing aids and related audiologists' services
- Hospice care
- Intermediate care facilities for the mentally retarded
- Maternity Care Clinics (limited)

What Does Medicaid Do?

- Medically needed oral surgery and dentistry (not routine dentistry)
- Optometry and eyeglasses
- Personal care services in the home
- Physical therapy
- Podiatry
- Prescription drugs (three per month in Texas; all drugs for nursing home residents and persons under 21 are covered)
- Psychologist's services (limited)
- Rehabilitation services: limited to chronic mental illness, chronic medical conditions
- Respiratory Care in the home
- Tube Feeding in the home (total parenteral hyperalimentation)
- Home and Community Based Services

Optional Services Texas does <u>Not</u> provide for adults:

- Christian Science Nurses
- Clinic services (except for limited maternity care clinic and family planning services)
- Dental Care
- Dentures
- Diagnostic, screening, preventive, and rehabilitative services not specifically described above
- Durable medical equipment such as wheelchairs, walkers and crutches, except when provided by a Medicaid home health agency
- Institutions for Mental Disease, persons over 65
- Occupational, hearing, language, or speech therapy
- Private duty nursing

Table 4.3
Texas Home and Community Based Waivers: Who Do They Serve?

Medically Dependent Children's Program	children who need nursing home care
Home and Community-Based Services (HCS)	people of all ages with mental retardation who need ICF-MR level care.
Home and Community-Based Service - OBRA (HCS-O)	people with mental retardation or other severe developmental disabilities who were placed in nursing homes but could be more appropriately served by the waiver.
Community Living Assistance and Support Services	people with severe developmental disabilities other than mental retardation who require ICF-MR care in a Level VIII facility.
Deaf-Blind-Multiple Disabilities	people who are deaf-blind and multiply disabled who require ICF-MR care in a Level VIII facility
Community Based Alternatives Waiver	adults who need nursing home care.

NOTES

[1] Lam Yip, Pam, *HHSC Demographic Facts Information Sheet,* March 1996.

[2] Lam Yip, Pam, *HHSC Demographic Facts Information Sheet,* May 1996.

[3] Lam Yip, Pam, *HHSC Demographic Facts Information Sheet,* March 1996.

[4] The $185 figure comes from Hopper, Leigh, "Prospect of Long Term Care Worries Elderly," *Austin American Statesman,* 3-2-96. Hopper's source was AARP, which sells long-term care insurance.

[5] HCFA, Office of the Actuary, *Medicaid: An Overview,* September 1995, p. 47.

What Does Medicaid Do?

Chapter 5: Medicaid Spending from All Angles

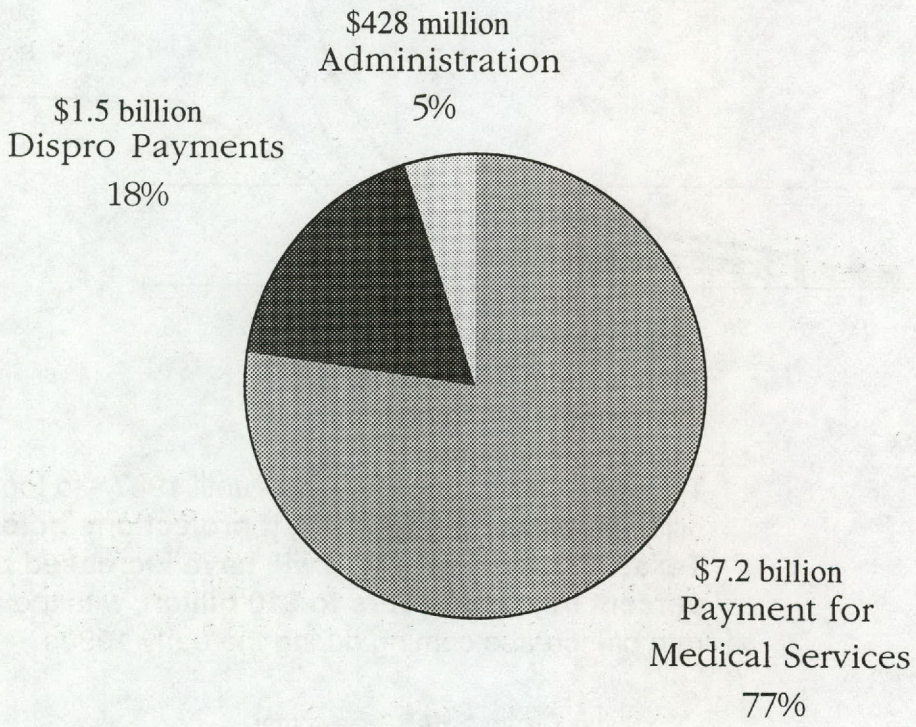
At nearly $10 billion per year, Medicaid is by far the largest line item in the Texas state budget. Where does that money come from, where does it go, how fast is the program growing, and what are state taxpayers getting for their money?

THE BOTTOM LINE

TOTAL TEXAS MEDICAID SPENDING - state and federal combined - for federal fiscal year 1995 came to $9.1 billion. The portion that paid for health care services was $7.2 billion. Disproportionate Share Hospital (DSH) reimbursements totaled $1.5 billion. Administration of the program accounted for $428 million, for a total administrative share of about 4.7 percent.

Figure 5.1 shows the distribution of total Texas Medicaid costs for 1995.

Figure 5.1: 1995 Texas Medicaid Budget



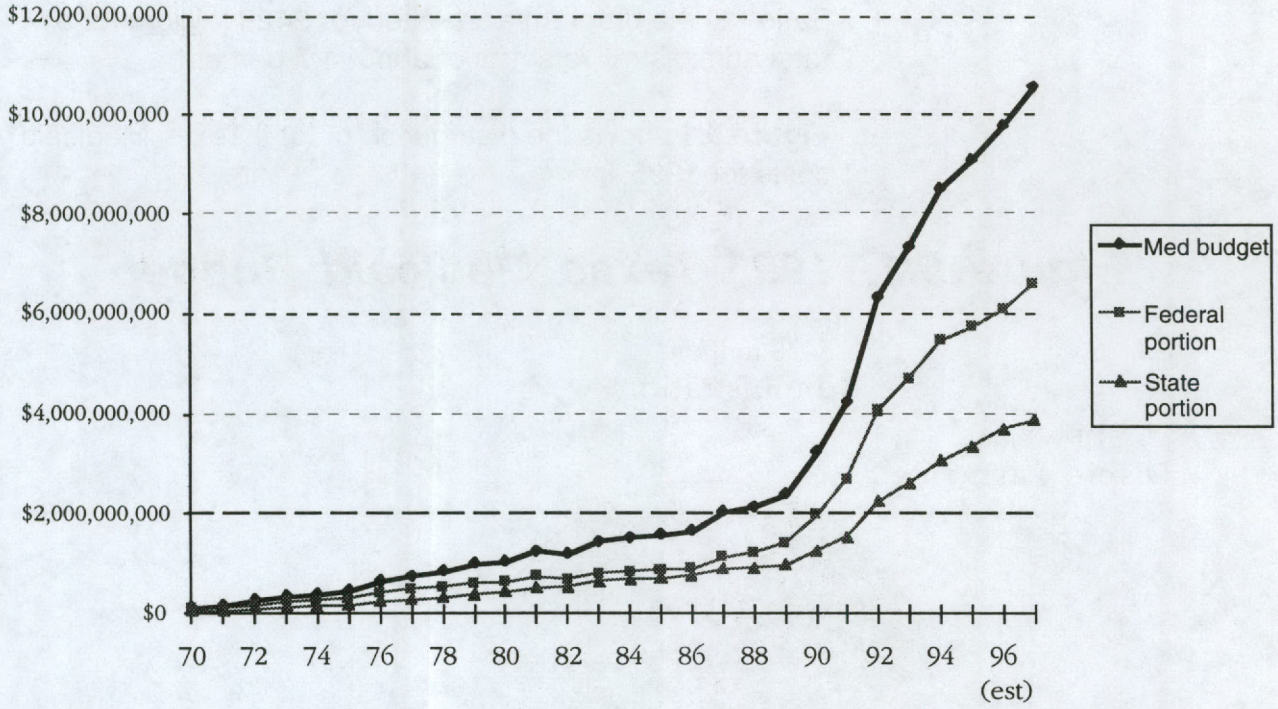
Medicaid Spending from All Angles

GROWTH IN SPENDING

TEXAS MEDICAID EXPERIENCED unprecedented growth in recent years, increasing dramatically as a percentage of both the federal and the Texas state budget. Texas Medicaid accounted for 18.6 percent of all 1995 state expenditures, and 12.7 percent as a share of state funds expenditures.*

Figure 5.2 documents growth in the federal and state shares of Texas Medicaid's budget since 1970.

Figure 5.2: Medicaid Budget Over Time Including Federal and State Shares



Source: DHS Title XIX Expenditure History

Texas Medicaid took 20 years - until 1987 - to top the $2 billion budget mark. **By 1997, if projections hold true, Texas Medicaid's budget will have increased by 400 percent in just 10 years to $10 billion,** with the greatest rate of increase coming during the early 1990s.

* Excludes Dispro, SHARS, and other programs funded with non-state dollars.

Medicaid Spending from All Angles

WHAT'S DRIVING MEDICAID BUDGET GROWTH?

THE TEXAS MEDICAID SPENDING boom from the late 1980s to the present stems primarily from program changes at the federal level and medical inflation. In addition, the 1990s have witnessed efforts by the state of Texas to bring existing, state-funded programs under the Medicaid umbrella. These factors combined to increase the Texas Medicaid budget fivefold in 10 years.

Enrollment Growth

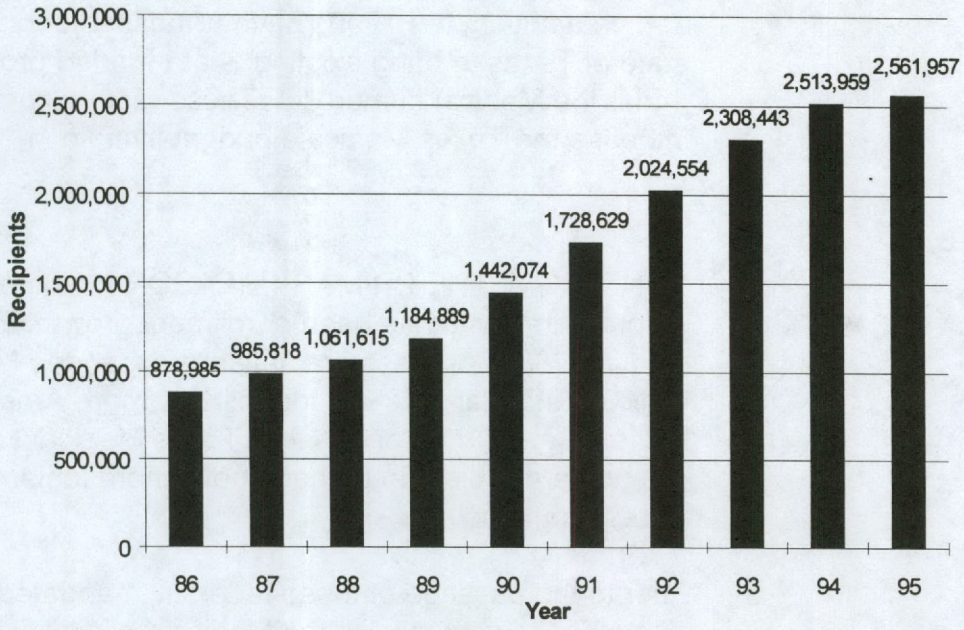
IN TEXAS, THE PRIMARY REASON for increased program costs has been enrollment growth. Beginning in 1988, Congress dramatically expanded Medicaid eligibility standards to include millions more Americans. By 1995, more than one in four Texas Medicaid recipients were eligible due to these new, more lenient eligibility requirements.

Prior to the passage of these federally mandated expansions, Texas severely limited Medicaid eligibility by virtue of its low AFDC income cap. This meant that the state had much "further to go" when Congress extended coverage to groups of people with incomes higher than the AFDC cap.

In addition, changes in the economy have boosted Texas' poverty rate, so the Texas program would have grown even without changes in federal law. As a result, increases in the number of people eligible for Medicaid have contributed more significantly to Texas program growth than the national average.

Figure 5.3 depicts the growth in "unduplicated" Medicaid recipients during the past decade.

Figure 5.3: Texas Medicaid Recipients 1986-1995



Source: HCFA 2082

Medical Inflation

Medical inflation in recent years has dramatically outstripped inflation in the economy as a whole. The combination of expanding enrollment and double-digit price increases for health services dramatically amplified Texas Medicaid's budget growth. **Figure 5.4** compares medical inflation since 1983 with the overall consumer price index.

This ballooning medical inflation has impacted not just Medicaid and government health care programs, but on private sector insurers as well. Some critics have accused government health care programs of driving up medical costs. But the record indicates that while inflation has significantly affected the program, Medicaid has done a better job holding down costs than private insurers. During the past decade, Medicaid cost-per-recipient inflation grew at a lesser rate than that for private insurance during all but two years. **Figure 5.5** charts Medicaid cost increases relative to those experienced by private insurance carriers.

Figure 5.4: Medical Inflation vs. the Consumer Price Index

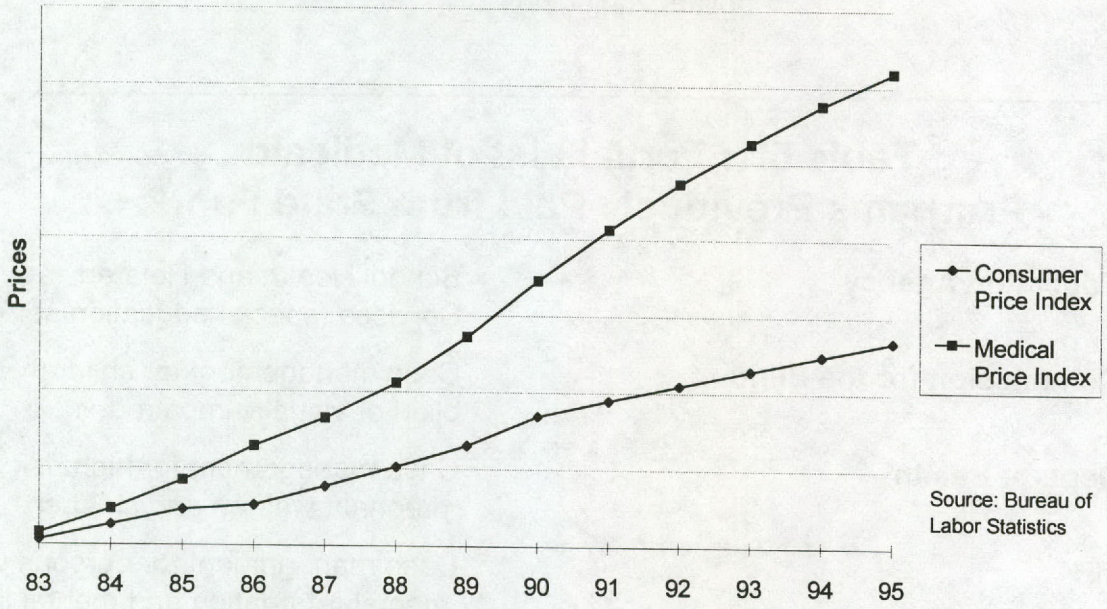
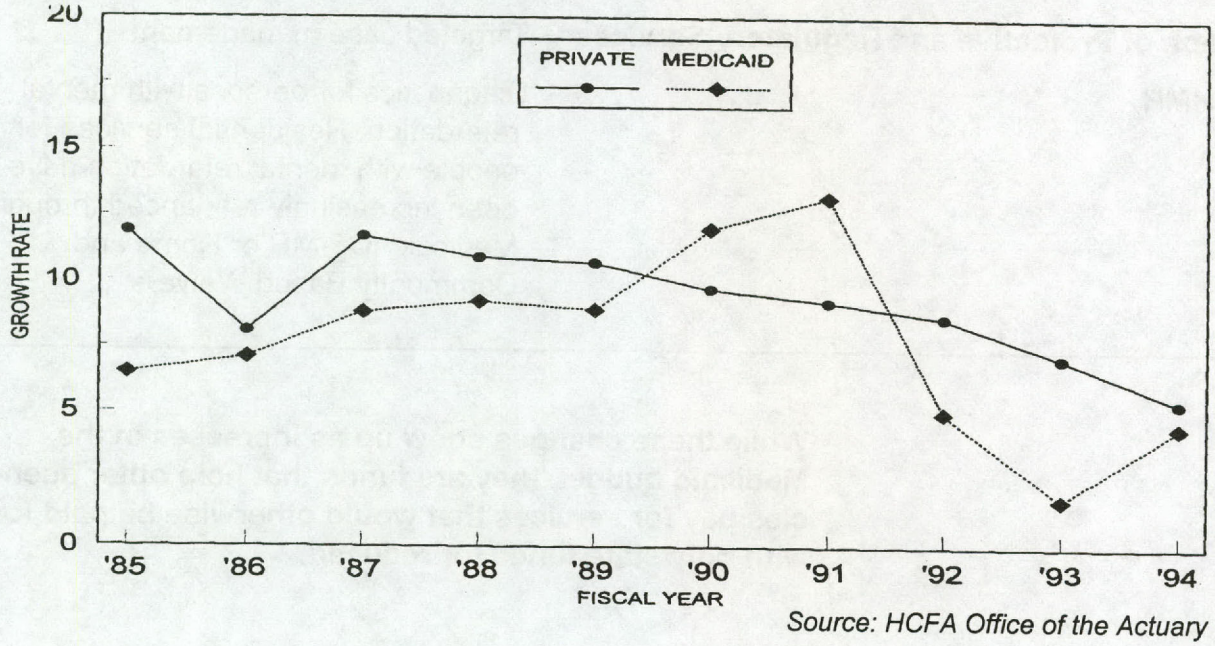


Figure 5.5: National Percent increase in per Capita Expenditures: Medicaid Beneficiaries vs. Privately Insured Fiscal Years 1985-1994



Source: HCFA Office of the Actuary

Medicaid Spending from All Angles

FEDERAL FUNDS MAXIMIZATION

BEGINNING IN 1990, TEXAS obtained approval for federal Medicaid matching funds for numerous agency programs previously funded with pure state dollars, including:

Table 5.1: Partial List of Medicaid Programs Previously Paid from State Funds

•Texas Education Agency	School Health and Related Services (special education services)
•Texas Commission for the Blind	Case management for children who are blind or visually impaired.
•Texas Dept. of Health	Case management for high risk pregnant women and children
•Tx MHMR	Case management for persons with mental retardation and mental illness
•Tx MHMR	Rehabilitation services for person with severe mental illness
•Tx Early Childhood Intervention Council	Case management for early childhood Intervention.
•Tx Commission on Alcohol and Drug Abuse	Children's outpatient chemical dependency services
•Tx Dept. of Protective and Regulatory Services	Targeted case management
•Tx MHMR	Diagnostics for persons with mental retardation. Residential services for people with mental retardation have been increasingly refinanced through Medicaid ICF-MR or Home and Community Based Waivers.

While these changes show up as increases in the Medicaid budget, they are funds that help other agencies pay for services that would otherwise be paid for with only state funds, or reduced.

Medicaid Spending from All Angles

MEDICAID AND STATE BUDGETS

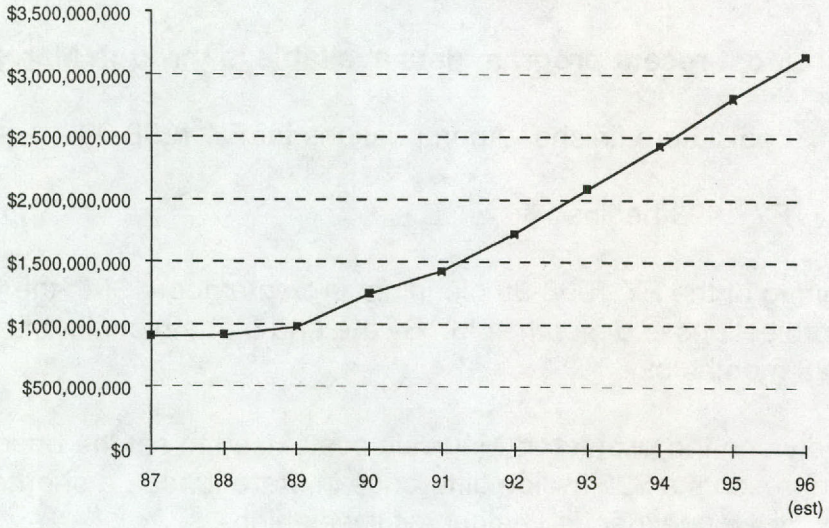
TEXAS MEDICAID SPENDING projected for 1996-97 represents 12.7 percent of budgeted state funds, and 18.6 percent of total state appropriations including all federal, state and other revenues. **Even though the federal share of Medicaid costs varies from state to state, all states get most of their federal dollars from Medicaid.**

This means that a state's total Medicaid spending typically will account for a larger share of its "all funds" spending (the state's budget including federal funds) than the state's share of Medicaid spending as a percentage of state only funds. The state-only format represents the actual demand on state revenues.

To determine the actual funding required from the state budget, we must also exclude Disproportionate Share Hospital funding, because the matching funds for Dispro come from local governments and hospital districts, not the state budget. Similarly SHARS (see p. 19) and a handful of other small programs also fund the state matching share with non-state funds.

All told in 1995, Texas paid $2.8 billion for Medicaid from the state budget, out of a total of $9.1 billion. **Figure 5.6** graphically demonstrates increases in the state budget's share of Medicaid over the last decade.

Figure 5.6 State Share of Texas Medicaid Budget (excluding dispro)



Source: DHS Title XIX Expenditure History

Medicaid Spending from All Angles

Building a Medicaid Budget

Staff for the Medicaid Operating Agencies develop the estimates of future Medicaid caseloads and spending that form the basis for state appropriations. This process requires projections of numbers of people eligible for **and** applying for the program, medical inflation rates, and any new federal mandates affecting eligibility or services.

Because a significant amount of time elapses between the development of initial agency budget requests and the time an appropriations bill actually takes effect, the Medicaid data that drove the projections also lags. Significant caseload or cost pattern changes over that period can have major implications for the accuracy of appropriated amounts. And, since Medicaid is an entitlement program, the state cannot easily just "stop paying" if the demand for Medicaid services exceeds the appropriated level.

MEDICAID TIMEFRAMES IN THE '98-'99 BUDGET PROCESS

August 1996:	Agencies submit Legislative Appropriations Requests (LAR) for fiscal years 1998 and 1999 (September 1997 - August 1999)
	Most recent program data available is through May 1996
January 1997:	Legislature convenes
April 1997:	Legislature working on Appropriations bills; last chance to provide up-to-date Medicaid projections for bill
	Most recent program data available is through March 1997
May 1997:	Legislature finishes Appropriations for FY 1998-99
September 1997:	FY 1998 begins

Thus, at the beginning of the FY 1998-99 biennium in September 1997, the Medicaid data used for projections is 5 months old. By the end of the biennium in August 1999, the data is 29 months old.

A 1% difference between the **projected** Medicaid costs used to set the budget and the **actual** costs represents a $20 million difference in **state** funds - a shortfall if the projection was low, or an unexpended balance if it was high.

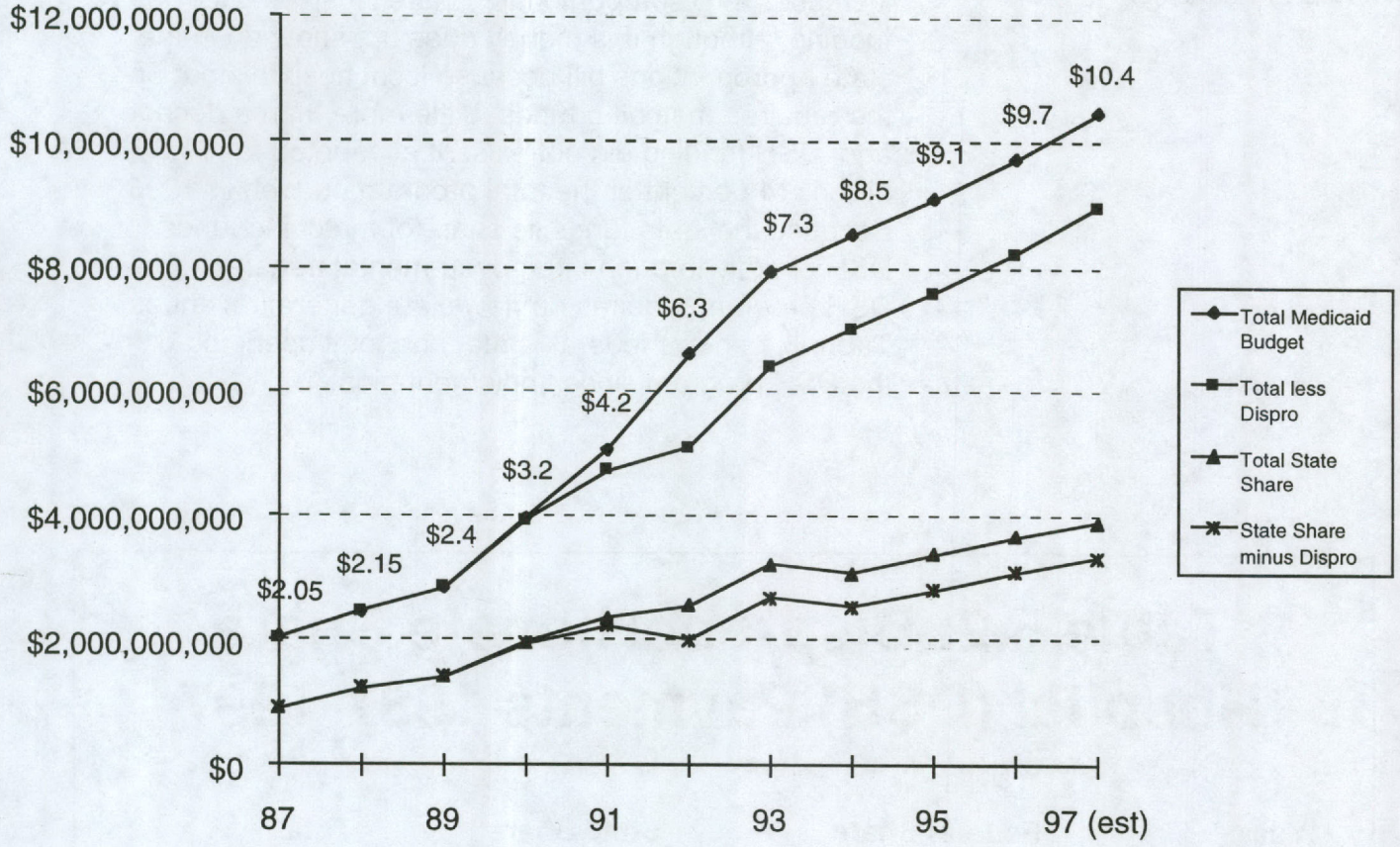
DISPRO SPENDING

ANOTHER MAJOR FACTOR CONTRIBUTING to growth in the Texas Medicaid budget has been increases in Disproportionate Share Hospital (DSH) funding, although this money does not show up in the state appropriations bill because local hospitals put up the required matching funds. Little more than a decade ago, DSH funding did not exist. It accounted for $1.5 billion, 14 percent of the total program budget, in 1995. Because the state funds its share of matching funds for DSH entirely through intergovernmental transfers, the DSH program requires no new state general revenues. **Table 5.1** shows federal, state, and total spending on the DSH program since implementation.

Table 5.2: Disproportionate Share Hospital (DSH) Payments 1987-1997

Year	Federal Share	State Share	Total
1987	$7,380,910	$6,000,000	$13,380,910
1988	$2,615,451	$1,980,318	$4,595,767
1989	$2,856,043	$1,981,428	$4,837,471
1990	$21,514,951	$13,622,974	$35,137,925
1991	$214,805,534	$123,311,157	$338,118,691
1992	$971,062,082	$541,967,026	$1,513,029,108
1993	$974,996,000	$538,004,000	$1,513,000,000
1994	$971,062,000	$541,967,000	$1,513,029,000
1995	$957,525,000	$555,504,000	$1,513,029,000
1996 (est.)	$942,626,000	$570,403,000	$1,513,029,000

Figure 5.7: Texas Medicaid Spending 1987 to Present



Source: DHS Title XIX Expenditure History

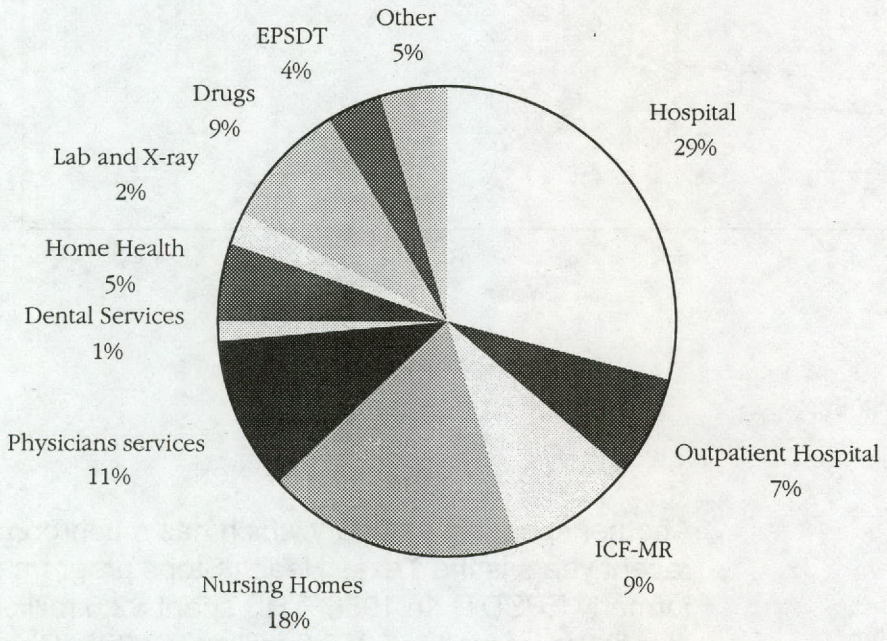
Figure 5.7 shows trends in Texas Medicaid spending from 1987 through 1997, with and without DSH payments included.

Medicaid Spending from All Angles

SPENDING BY SERVICE

FIGURE 5.8 SHOWS THE distribution of the $7.2 billion in 1995 health care service spending by type of service. Inpatient hospital care, nursing home care, ICF-MR care and physician services were the top four cost items, accounting for 67 percent of program expenditures. Long-term care spending of all types - nursing facilities, ICFs-MR, and home health services - totaled 32 percent of the budget.

Figure 5.8: 1995 Texas Medicaid Health Spending By Service Type

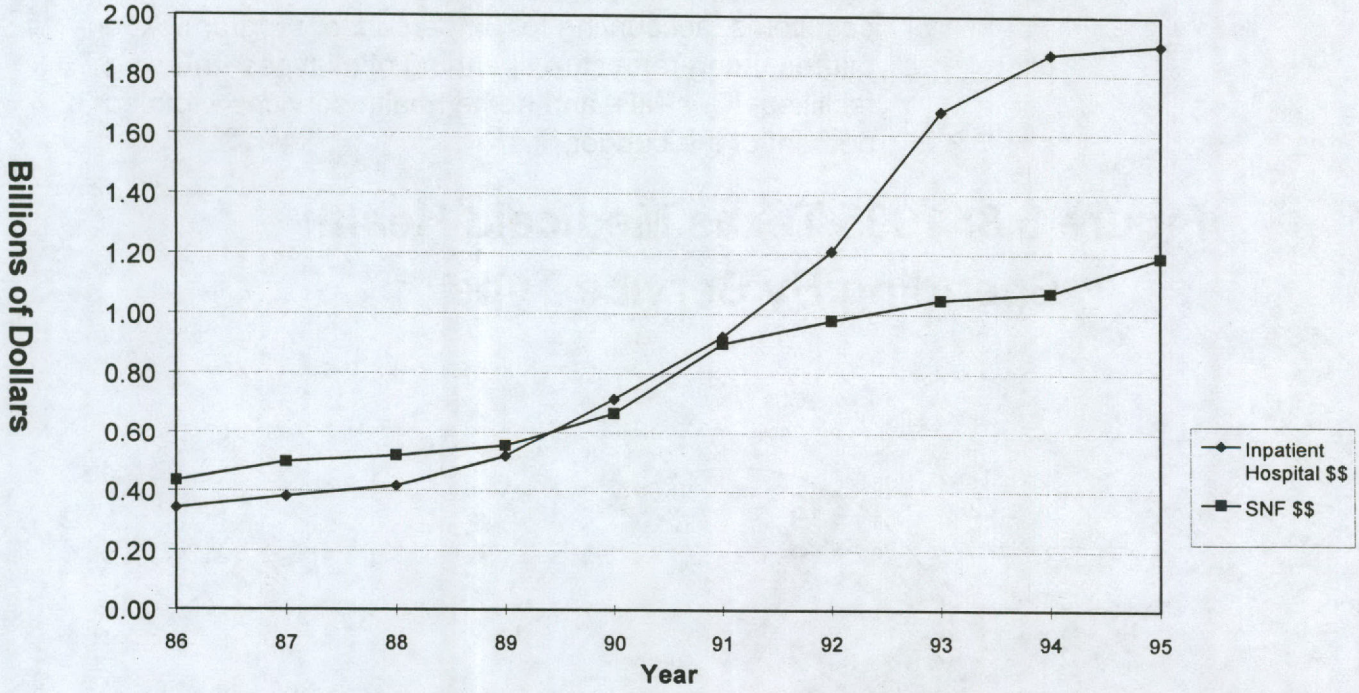


Source: HCFA 2082

SPENDING BY SERVICE OVER TIME

INCREASES IN MEDICAID spending hinge on large increases in payments for specific services, either because of increased enrollment, changes in scope of service or federal mandates. **Figure 5.9** demonstrates the impressive growth in two very expensive areas for Medicaid: Skilled Nursing Facilities (SNF—Nursing homes) and Inpatient Hospital services.

Figure 5.9: Texas Medicaid SNF and Inpatient Hospital Expenditures 1986-95

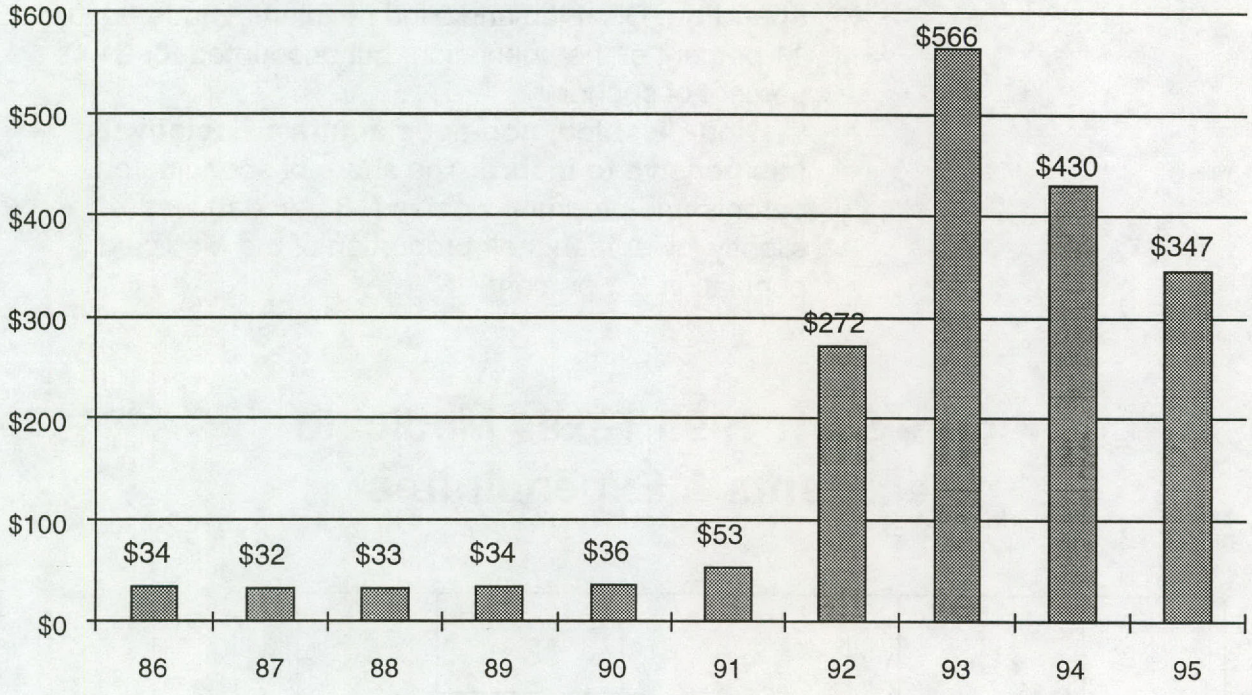


Source: HCFA 2082

Another spending category which has mushroomed in recent years is the Texas Health Steps program (THS, formerly EPSDT). In 1986, THS spent $2.6 million, but that figure inflated to $257.9 million in 1995. Changes in federal law explain most of these increases. In 1989, Congress mandated that Medicaid could not restrict covered services to children if a doctor deems them medically necessary.

Figure 5.10 documents increases in THS spending per recipient over the last decade.

Figure 5.10: EPSDT/Texas Health Steps Dollars per Recipient 1986 - 1995



Source: HCFA 2082

TOTAL SPENDING BY TYPE OF ELIGIBILITY

TEXAS MEDICAID SPENDING BY eligibility group looks very different from the numbers of people themselves because of the concentration of spending on aged and disabled Medicaid recipients.

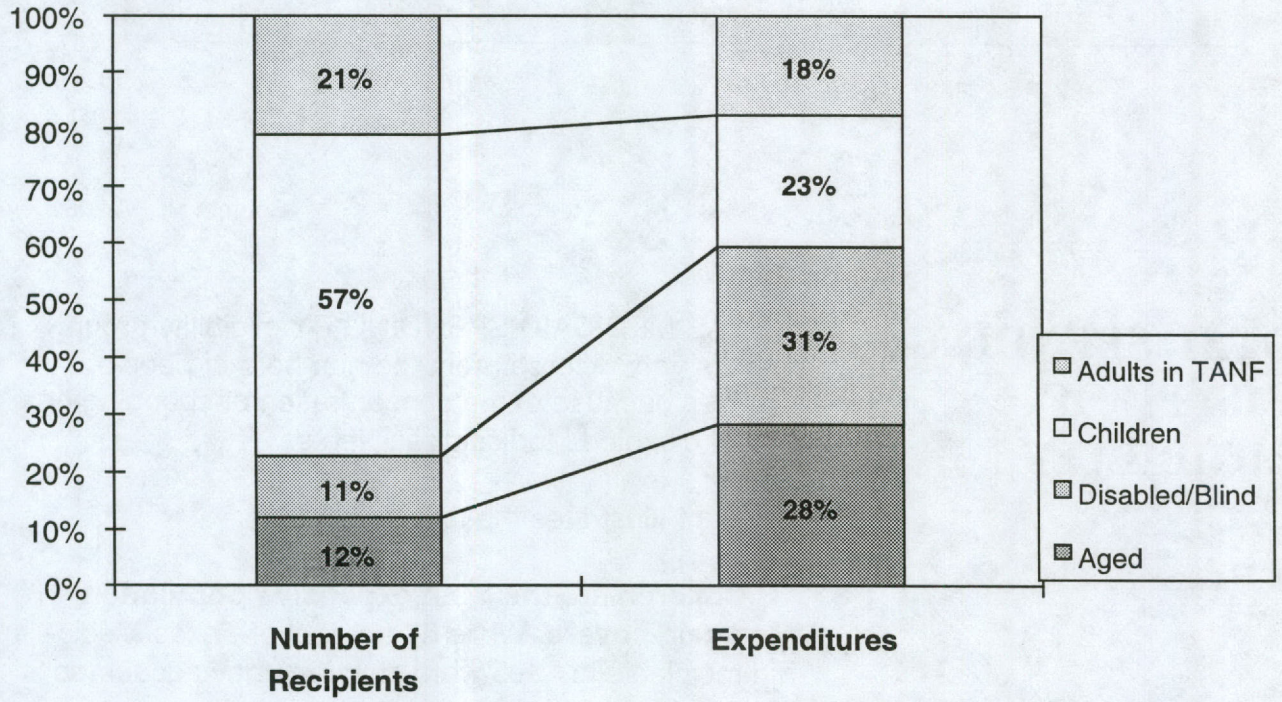
Figure 5.11 illustrates the following points:

- **Children are the least expensive population Medicaid covers.** While 57 percent of Texas Medicaid recipients in 1995 were children, they accounted for only 23 percent of program costs.
- **The aged are more expensive than younger populations.** In 1995, 12 percent of Texas Medicaid recipients were aged (65+) but they accounted for 28 percent of program spending.

Medicaid Spending from All Angles

- **Health care for people with severe disabilities accounts for a big portion of Texas Medicaid spending.** Disabled and blind recipients made up just 11 percent of the population, but accounted for 31 percent of spending.
- **Non-disabled, non-aged adults are relatively inexpensive to insure.** The share of spending on parents and pregnant women (18 percent) was slightly lower than their proportion of the Medicaid population (21 percent).

Figure 5.11: 1995 Texas Medicaid Recipients & Expenditures



Source: HCFA 2082

Medicaid Spending from All Angles

Looking at the average actual spending in 1995 on each type of Medicaid recipient sheds more light on how Medicaid spending is concentrated.

The average annual cost per person was $2,415. Here's the average annual cost per person for several other important categories:

All children: $1,365
Disabled children: $6,993
Disabled adults: $7,795
Aged: $5,977
Blind: $5,491
Caretaker relatives/pregnant women: $2,160
All TANF Clients: $1,317

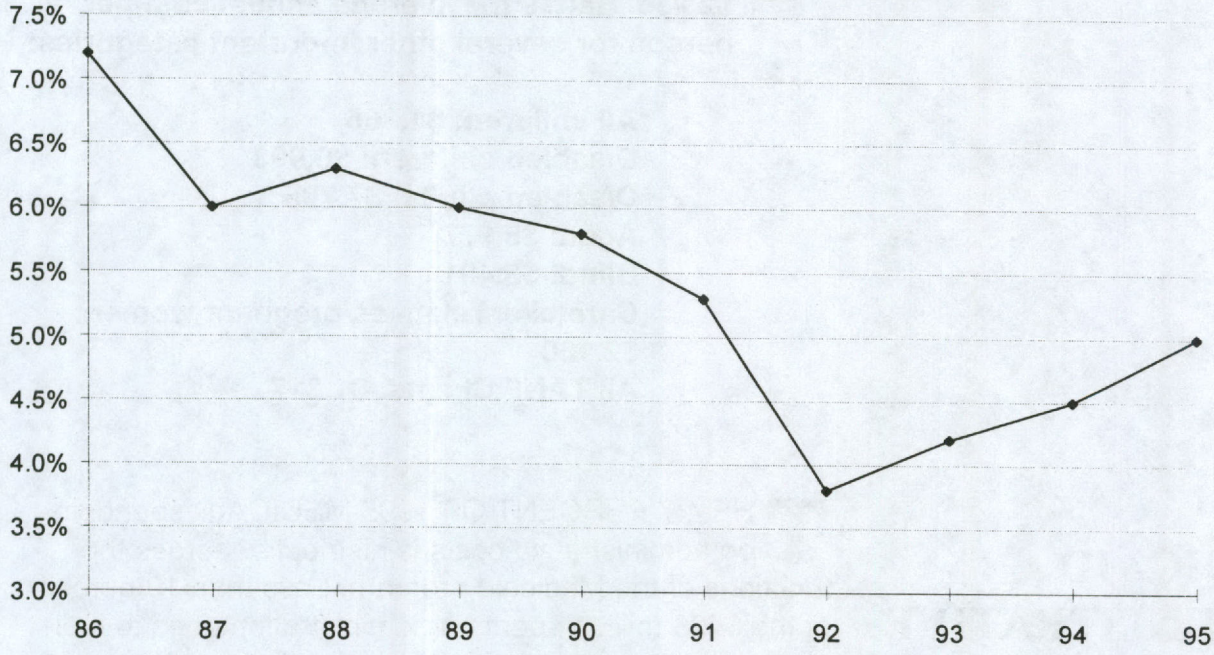
MEDICAID ADMINISTRATIVE COSTS

THE 4.7 PERCENT OF 1995 MEDICAID spending on administrative costs is distributed across the functions of the Medicaid program. Less than 19 percent of the $428 million spent on administration goes to indirect or overhead-type costs. The remainder, 81 percent, goes directly to program operations. These cover activities from eligibility determination to claims processing, from screening people in nursing homes to doing case management for special populations.

Many state employees split their time between Medicaid and one or more other programs. The estimated number of "full-time equivalents" devoted to the program statewide today is about 10,363. There are about 6,333 TDHS eligibility workers statewide who determine eligibility for AFDC, Food Stamps, and Medicaid. They spend about 24 percent of their time (or the equivalent of 1,471 workers) on Medicaid.

Figure 5.12 illustrates the changes in Medicaid administrative costs over time, from a high of 7.2 percent during the mid-'80s to a low of 3.8 percent in 1992. Since that low ebb, the expanding number of people eligible for Medicaid drove up administrative expenses, as the state hired more workers to handle the augmented load.

Figure 5.12: Administrative Costs as a Percentage of the Texas Medicaid Budget 1986-95



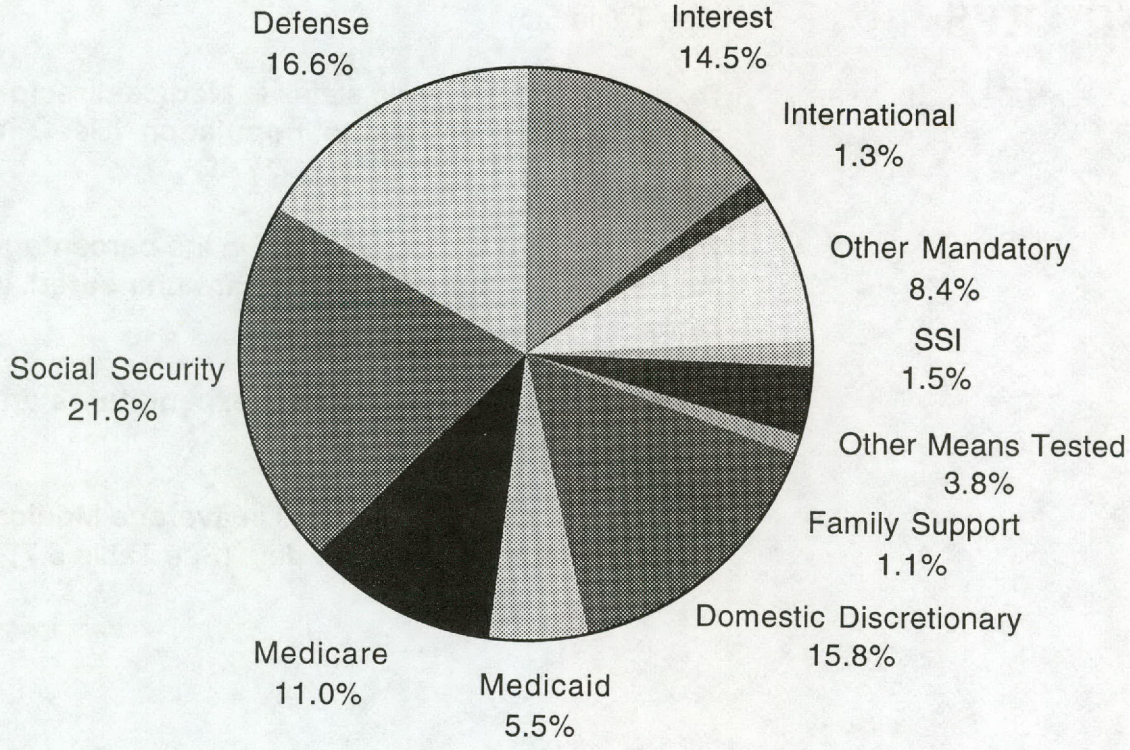
Source: DHS Title XIX Expenditure History

MEDICAID AND THE FEDERAL BUDGET

MEDICAID MAKES UP 5.5 PERCENT of all federal spending, and 30 percent of all federal spending on health programs. The federal government spends twice as much money on Medicare as on Medicaid. Together, these two health programs cost nearly as much as defense and international spending.

Figure 5.13 illustrates Medicaid's share of total federal government outlays in 1995.

Figure 5.13:
FY 1995 Federal Spending Summary



Source: Kaiser Family Foundation, *Primer on the Federal Budget,* May 1995

Medicaid Spending from All Angles

HOW TEXAS COMPARES

Texas ranks **44th** among states in **average Medicaid spending per recipient**, at $2,443 per person in 1994. (See Table 5.5)

Texas ranks **18th** among states in **Medicaid recipients as a percentage of the total population**. (See Table 5.4)

Texas ranks **1st** among all states in the **percentage of the non-elderly population who are uninsured**. (See Table 5.3)

Texas ranks **5th** among states in **expenditures on long term care**. (See Table 5.6)

Texas ranks **47th** among states in **average Medicaid nursing home payment per day**. (See Table 5.7)

Table 5.3: Percentage of Non-Elderly Population without Health Insurance by State 1994

State		State	
Texas	**26.6%**	Missouri	14.3%
New Mexico	26.4%	Maryland	14.3%
California	23.7%	Massachusetts	14.3%
Arizona	23.3%	Virginia	13.9%
Alabama	21.9%	Colorado	13.9%
Louisiana	21.5%	New Hampshire	13.6%
Oklahoma	21.0%	Rhode Island	13.5%
Florida	20.8%	Illinois	12.9%
Mississippi	20.6%	Utah	12.9%
Arkansas	20.2%	Ohio	12.5%
West Virginia	19.1%	Michigan	12.3%
New York	18.3%	Nebraska	12.3%
District of Columbia	18.3%	Pennsylvania	12.2%
Georgia	18.3%	Connecticut	12.2%
Nevada	17.8%	Indiana	11.8%
Kentucky	17.4%	Hawaii	11.6%
Total	17.3%	South Dakota	11.5%
Wyoming	17.3%	Tennessee	11.5%
Montana	16.1%	Iowa	11.3%
South Carolina	15.9%	Minnesota	10.6%
North Carolina	15.7%	North Dakota	10.1%
Delaware	15.6%	Wisconsin	9.8%
Idaho	15.6%	Vermont	9.6%
Kansas	15.5%		
Alaska	15.5%		
Maine	15.2%		
Oregon	14.8%		
New Jersey	14.7%		
Washington	14.6%		

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Table 5.4: Medicaid Recipients as a Percentage of the Population by State 1994

State	
District of Columbia	20.8%
Mississippi	19.1%
Rhode Island	19.1%
West Virginia	19.1%
Tennessee	17.8%
Louisiana	17.5%
Kentucky	16.3%
California	15.5%
New York	15.1%
New Mexico	14.9%
Arkansas	14.0%
Vermont	14.0%
Georgia	13.8%
Maine	13.6%
Ohio	13.5%
South Carolina	13.0%
North Carolina	12.9%
Texas	**12.8%**
Florida	12.7%
Massachusetts	12.7%
Alabama	12.5%
Michigan	12.4%
Oklahoma	12.0%
Washington	12.0%
Illinois	11.9%
Missouri	11.6%
Alaska	10.9%
Oregon	10.7%

State	
Montana	10.6%
Iowa	10.3%
Arizona	10.2%
Connecticut	10.2%
Nebraska	10.2%
Pennsylvania	10.2%
New Jersey	10.1%
Delaware	9.9%
Indiana	9.9%
Wyoming	9.8%
North Dakota	9.7%
South Dakota	9.7%
Kansas	9.6%
Hawaii	9.4%
Minnesota	9.4%
Wisconsin	9.3%
Idaho	9.0%
Maryland	9.0%
Virginia	8.9%
Utah	8.0%
Colorado	7.9%
New Hampshire	7.1%
Nevada	6.4%

Source: HCFA 1995 Data Compendium

Table 5.5: 1994 Payments per Medicaid Recipient by State

State	Recipients	Total Payments	Dollars per Recipient
New York	2,907,963	$18,730,573,473	$6,441
Rhode Island	114,850	$685,373,896	$5,968
Connecticut	354,473	$1,943,232,816	$5,482
Minnesota	425,563	$1,981,799,277	$4,657
New Jersey	789,692	$3,611,552,287	$4,573
Maine	176,998	$806,670,427	$4,558
New Hampshire	85,555	$388,853,734	$4,545
North Dakota	62,769	$283,815,478	$4,522
Maryland	415,101	$1,874,977,683	$4,517
District of Columbia	127,208	$550,313,020	$4,326
Massachusetts	710,490	$3,052,320,196	$4,296
South Dakota	72,151	$283,996,976	$3,936
Wisconsin	473,740	$1,830,045,147	$3,863
Indiana	604,770	$2,250,251,850	$3,721
Delaware	74,800	$276,650,481	$3,699
Arkansas	339,920	$1,253,201,340	$3,687
Nebraska	164,440	$592,661,063	$3,604
Alaska	68,854	$243,148,386	$3,531
Louisiana	778,223	$2,684,149,768	$3,449
Pennsylvania	1,255,358	$4,223,951,062	$3,365
Illinois	1,441,034	$4,825,701,539	$3,349
Colorado	289,423	$951,757,815	$3,288
Ohio	1,523,296	$4,995,019,954	$3,279
Iowa	302,535	$981,559,664	$3,244
Nevada	95,411	$306,511,172	$3,213
Montana	96,206	$302,895,832	$3,148
Wyoming	50,544	$157,240,004	$3,111
Kansas	251,742	$781,575,625	$3,105
West Virginia	366,638	$1,106,524,084	$3,018
Idaho	110,043	$331,284,156	$3,010
South Carolina	486,110	$1,395,749,712	$2,871
Utah	157,099	$450,995,731	$2,871

Table 5.5: 1994 Payments per Medicaid Recipient by State (continued)

State	Recipients	Total Payments	Dollars per Recipient
Hawaii	120,793	$337,921,714	$2,798
Kentucky	637,558	$1,778,598,714	$2,790
Michigan	1,186,621	$3,274,071,844	$2,759
Vermont	94,150	$259,497,517	$2,756
North Carolina	985,273	$2,684,541,117	$2,725
Missouri	668,765	$1,808,746,654	$2,705
Virginia	642,947	$1,723,156,104	$2,680
Georgia	1,084,929	$2,845,492,944	$2,623
Oregon	411,311	$1,035,976,076	$2,519
Oklahoma	390,628	$974,139,706	$2,494
Florida	1,727,034	$4,266,221,164	$2,470
Texas	**2,513,959**	**$6,140,737,724**	**$2,443**
Alabama	543,537	$1,311,836,517	$2,414
New Mexico	268,204	$638,424,255	$2,380
Washington	668,363	$1,573,683,030	$2,355
Tennessee	938,711	$1,964,815,563	$2,093
Mississippi	536,916	$1,090,026,187	$2,030
California	5,007,635	$9,988,067,826	$1,995
Virgin Islands	16,499	$7,894,052	$478
Arizona	509,663	$198,945,010	$390
Puerto Rico	926,518	$233,000,000	$251

Source: HCFA Medicaid Statistics, 1994

Table 5.6: Medicaid Long Term Care Expenditures by State, 1994

State	Total	State	Total
New York	$6,285,945,124	Mississippi	$329,305,825
Pennsylvania	$2,373,951,154	Kansas	$307,227,081
California	$2,315,461,758	Maine	$292,947,048
Ohio	$2,054,991,956	Colorado	$277,823,455
Texas	**$1,693,369,426**	Rhode Island	$245,900,295
Illinois	$1,634,117,679	West Virginia	$245,585,113
Massachusetts	$1,553,940,147	Oregon	$236,216,333
New Jersey	$1,408,865,349	Nebraska	$222,389,896
Florida	$1,276,950,010	District of Columbia	$219,491,084
Michigan	$1,111,373,394	New Hampshire	$186,457,018
Minnesota	$1,076,374,250	New Mexico	$145,514,344
Indiana	$1,044,698,993	Hawaii	$134,362,770
North Carolina	$970,543,695	North Dakota	$133,367,477
Connecticut	$947,495,353	Utah	$121,087,377
Wisconsin	$875,681,504	South Dakota	$118,635,588
Louisiana	$814,081,491	Idaho	$112,330,429
Georgia	$692,157,642	Montana	$109,166,013
Tennessee	$688,560,221	Nevada	$93,216,356
Washington	$657,300,847	Delaware	$87,633,839
Missouri	$570,527,073	Vermont	$75,775,503
Virginia	$532,916,442	Alaska	$62,226,362
Maryland	$479,842,172	Wyoming	$46,901,839
Alabama	$462,007,004	Arizona	$12,800,042
Kentucky	$441,989,214	Virgin Islands	$976,164
South Carolina	$405,538,132	All Jurisdictions	$37,299,052,167
Iowa	$401,642,795		
Arkansas	$366,727,180		
Oklahoma	$344,394,692		

Source: HCFA, Medicaid Statistics, 1994

Table 5.7: 1992 Average Nursing Home Costs per Day by State

State	Avg NF cost per day
New Jersey	unavailable
Alaska	$196.76
District of Columbia	$138.20
New York	$129.67
Hawaii	$128.56
Connecticut	$117.28
Massachusetts	$103.98
Delaware	$99.94
New Hampshire	$97.96
Rhode Island	$97.02
Nevada	$95.62
Pennsylvania	$91.70
Arizona	$90.96
Washington	$90.82
Maine	$88.11
Florida	$85.66
Maryland	$84.31
Virginia	$83.61
Wisconsin	$80.91
Colorado	$80.32
Ohio	$80.12
Idaho	$77.86
Oregon	$77.10
California	$76.93
Wyoming	$76.79
North Dakota	$76.22
West Virginia	$74.55
Michigan	$74.20
Indiana	$73.86
North Carolina	$72.26
Minnesota	$71.98
Montana	$71.41
South Carolina	$70.43
Vermont	$70.14
New Mexico	$70.01
Utah	$66.96
Illinois	$66.44
Alabama	$63.25
Tennessee	$61.63
Kentucky	$60.47
Missouri	$59.51
Georgia	$58.67
Mississippi	$57.03
South Dakota	$55.40
Nebraska	$55.30
Iowa	$54.44
Kansas	$53.68
Texas	$52.04
Louisiana	$49.34
Arkansas	$49.24
Oklahoma	$45.54

Source: AARP Reforming the Health Care System, State Profiles 1995

Chapter 6:
Medicaid Managed Care
New Strategies for Vexing Problems

The Texas Legislature mandated that HHSC and TDH expand Medicaid managed care statewide by the end of the decade. This chapter describes Texas' three-year pilot, recent expansions, and future plans.

TEXAS MEDICAID RECENTLY launched major reforms that will bring most of the state's Medicaid population under **"managed care"** arrangements by the turn of the century. In 1993, Texas Medicaid began two pilot programs under a 1915(b) waiver - one in Travis county and the other in the Gulf Coast area around Galveston. In September 1996, Texas expanded these pilots to include the San Antonio, Fort Worth and Lubbock metropolitan areas and their contiguous counties.

WHAT IS MANAGED CARE?

MANAGED CARE REFERS TO a health system in which a network of health care providers agrees to coordinate and provide health care to a population, typically, but not always, in exchange for a specific sum of money. Four major features distinguish managed care from traditional health financing arrangements.

- **Primary Care Providers (PCPs)** - the foundation of managed care, a PCP provides clients with a "medical home," including comprehensive preventive and primary care on a 24 hour/7 day a week basis.
- **Defined network of providers** - managed care limits clients' choices of providers (with some exceptions), to those under contract with the managed care organization (MCO) network.
- **Utilization Review and Utilization Management** (UR/UM) - a comprehensive monitoring program by a managed care organization (MCO) over the network of providers. UR may be prospective, as in preadmission

Managed care offers distinct advantages to the fee for service Medicaid program by providing budget certainty for the state, and ensuring client access to care through PCPs.

screenings and prior authorization of expensive or invasive medical services. UR may be concurrent, as in case management situations. Or it may be retrospective, examining treatment patterns over time.

- **Capitation** - the unique financing mechanism that distinguishes managed care from traditional fee for service. Under capitation, health care payers such as Medicaid or employers purchase care at a fixed, per person rate. The arrangement allows a fixed price for the purchaser, while the MCO assumes the risk of providing all contracted medically necessaryservices. (See below.)

Managed care offers distinct advantages to the fee for service Medicaid program by providing **budget certainty** for the state, and **ensuring client access** to care through PCPs. For Texans covered by traditional Medicaid, persuading enough physicians to accept Medicaid has been a major problem. But managed care offers Medicaid clients a **"medical home,"** which may be their first chance to establish a relationship with an office-based physician committed to their ongoing care.

Managed care may also reduce inappropriate, high cost emergency room use. Ear aches, sore throats and fever top the list of most common emergency room diagnoses for Medicaid clients. It costs **three times** as much to treat these ailments in an emergency room compared with a more appropriate primary care setting. Ironically, managed care may actually **increase** clients' access to health care by **limiting** their access to a defined network of providers.

CAPITATION VS. FEE FOR SERVICE

CAPITATED HEALTH DELIVERY SYSTEMS differ markedly from the traditional "fee for service" system. In a fee for service environment, clients theoretically may choose any one of a number of health care providers who treat them in exchange for a fee for each service delivered. Health care providers in a fee for service system have no obligation to coordinate care with other providers. Clients could go to an expensive specialist or an emergency room when a family doctor could have

treated the condition. Worse, a client could go to several different specialists for one or more medical conditions. Without **coordination**, the client could be subjected to duplicate and unnecessary medical tests or treatments.

Under "capitation," an MCO receives a fixed sum of money per client per month, and must manage the client's care within that fixed amount or budget. The MCO, therefore, risks losing money if the client's care costs more than the capitation payment. Under capitation, the provider must assist the client in staying healthy and ensure that the care rendered to the client is appropriate and delivered in the most cost effective setting.

FORMS OF MANAGED CARE UNDER TEXAS MEDICAID

TEXAS MEDICAID MANAGED care pilots utilized three different managed care "models":

Health Maintenance Organizations (HMOs): Organizations licensed by the Texas Department of Insurance that deliver and manage health services under a risk-based arrangement. The HMO usually receives a monthly "capitation" payment for each person enrolled based on a projection of what all medically necessary care for the typical patient will cost. If enrollees cost more, the HMO may suffer losses. If the enrollee costs less, the HMO profits. This gives the HMO incentives to control costs.

Primary Care Case Management (PCCM): Managed care option allowed under section 1915(b) of the Social Security Act in which each participant chooses a single Primary Care Provider who must authorize most other services such as specialty physician care before they can be reimbursed by Medicaid. The state sets up the physician networks, and contracts directly with the PCP. Presently this model is not capitated; providers receive fee for service reimbursement plus PCPs receive a small monthly case management fee for each client.

Prepaid Health Plan: An entity that either contracts on a prepaid, capitated risk basis to provide a non-comprehensive selection of services, or which contracts on a non-risk basis. Non-capitated services are paid for on a fee for service basis. This model was tested under the Travis County pilot but is not being used currently.

MANAGED CARE PILOTS

RISING COSTS AND POOR ACCESS to doctors by Medicaid patients first spurred interest in managed care, and two successful pilot programs convinced the Legislature to expand the program.

In 1991, the Legislature adopted House Bill 7 authorizing a two-year pilot program in Travis County and in the Gulf Coast area of Galveston, Jefferson and Chambers counties. The STAR (State of Texas Access Reform) Program, as it's called, established health care delivery systems based on managed care principles for AFDC recipients. The initial pilot models consisted of a Health Maintenance Organization (HMO), a partially capitated Prepaid Health Plan (PHP) and Primary Care Case Management (PCCM).

Texas implemented its first pilot program on August 1, 1993 in Travis County. The Travis County program then included approximately 30,000 Medicaid clients, incorporating an HMO and a PHP in a single health care delivery system. The HMO and the PHP received a capitated monthly fee for providing covered health care services. This arrangement terminated on August 31, 1996, and was replaced by a system in which three HMOs provide services for this population.

The state implemented its second pilot program on December 1, 1993 in the Gulf Coast area of Galveston, Jefferson and Chambers counties, and expanded it in 1995 to include the contiguous counties of Hardin, Liberty and Orange. This project operates under a PCCM model and presently serves approximately 42,000 clients. Under this system, primary care providers receive fee for service reimbursement plus a monthly case management fee of $3 per client for providing primary care services.

Managed Care

MANAGED CARE EXPANSIONS

IN MAY 1995, THE TEXAS Legislature adopted Senate Bill 10 (SB10) which authorized HHSC to restructure the Texas Medicaid program statewide to incorporate managed care delivery systems. SB10 authorized additional managed care pilots in other areas of the state. Like the initial pilots, these new geographically localized pilot programs operate under "1915(b) waivers" (See Waivers, p. 36)

Beginning in September 1996, Texas Medicaid expanded its managed care pilots to include the the San Antonio, Lubbock and Fort Worth metropolitan areas and their contiguous counties.

Texas Medicaid presently does not require every client to participate in a managed care arrangement. In areas where managed care has been implemented, the program is mandatory for AFDC parents and children, but is **voluntary for aged and disabled populations**, who may continue using traditional fee for service Medicaid. Clients who are dually eligible for both Medicaid and Medicare, as well as a handful of other small eligibility categories such as foster children, are presently not included in the managed care pilots.

Table 6.1 at the end of this chapter indicates the HMOs chosen by TDH as contractors for the expanded pilots, the present status of the pilot, and the managed care models used in that area.

SIGNIFICANT TRADITIONAL PROVIDERS

AS TEXAS MEDICAID EVOLVES into a managed care system, the state has taken special care to ensure minimum disruption between Medicaid clients and their historical providers. The Legislature directed HHSC to ensure that, during the implementation of managed care, "significant traditional providers" of Medicaid services be included in the managed care organization (MCO) networks. TDH produced the list of significant traditional providers based on historical service factors.

Medicaid MCOs must allow significant traditional providers to participate in the their network for a period of at least three years

Medicaid MCOs must give significant traditional providers the opportunity to participate in the contractor's network for a period of at least three years from the time managed care is implemented in an area, so long as the provider:

1) agrees to accept the MCO's pay scale for services;
2) meets any credentialing requirements of the MCO; and
3) agrees to comply with the terms and conditions of the MCO's standard subcontractor agreement.

An exception to the Significant Traditional Provider rule is the case of Federally Qualified Health Centers (FQHCs). By federal law, FQHCs must be included in any managed care provider network, and must receive reimbursement for their services based on their costs. These requirements may not be altered except through a HCFA approved 1115 waiver. Texas recently submitted such a waiver to HCFA (see p. 118). However, the 74th Legislature approved SCR 57, which stated that any 1115 waiver submitted by the state should not end cost-based reimbursement for FQHCs for three years, and should not waive the requirement that FQHC services are "mandatory."

MANAGED CARE AND BEHAVIORAL HEALTH

SENATE CONCURRENT RESOLUTION 55 required HHSC to pilot the integration of behavioral health care in Medicaid managed care systems that also provide physical medicine services. Research suggests that enhanced access to behavioral health services can improve physical outcomes and "offset" medical costs.

Four pilot projects were implemented in the fall of 1996 in the STAR managed care sites and more may be considered. The pilot projects were implemented by an interagency team which includes TDH, TXMHMR and HHSC staff as well as input from TCADA and advocates for people with behavioral health disorders. The interagency team developed extensive selection criteria, contract standards and two special focused studies of significant behavioral health care issues which HMOs are required to conduct.

Managed Care

The pilot projects include behavioral health services historically funded by the Medicaid program, and additional "value-added" services which HMOs provide as a substitute for more traditional Medicaid services

The pilot projects include inpatient and outpatient behavioral health services historically funded by the Medicaid program, and additional "value-added" services such as partial hospitalization, day treatment or intensive in-home services which HMOs provide as a substitute for more traditional Medicaid services such as inpatient psychiatric care. Specialized rehabilitative and targeted case management services provided by TXMHMR were not included in risk based, capitated systems in the initial pilot projects. Reasons for not including these services include a lack of accurate cost and potential demand for services data, concerns about continuity of care for severely ill clients and lack of private sector HMO experience with significant numbers of persons with severe mental illness. MHMR is presently revising the rehabilitative services reimbursement methodology and reconfiguring the services to improve efficiency and gather more accurate cost data on the needs of people with severe mental illness.

SCR 55 requires HHSC to submit a plan for integrating behavioral health services statewide to the Senate Health and Human Services Committee by November 1, 1998.

Senate Bills 600 and 601 establish the duties of state agencies for Medicaid managed care. SB 600 makes MHMR responsible for developing performance, operation, quality of care, marketing and financial standards for the mental health component of Medicaid managed care. The law also makes TDH responsible for developing Medicaid managed care rules related to quality of care, marketing, financial and children's access to good quality health care services. SB 601 charges HHSC with developing rules related to client and provider education and client rights and responsibilities. HHSC, TXMHMR and TDH have collaborated to develop rules for Medicaid managed care which address these issues.

Managed Care

STAR+PLUS

TEXAS SENATE CONCURRENT Resolution 55 directed HHSC to develop and implement a long term care integrated model in a demonstration pilot. This model, known as STAR+PLUS, will be implemented in Harris County in October, 1997. STAR+PLUS is a cost-neutral demonstration pilot which will provide comprehensive managed care for people 65 years and older, and people with disabilities. TDHS will contract with qualified health care plans at capitated amounts to provide both acute and long term care services for all clients, including aged and disabled populations not served through the regular STAR program. These include infants, children or adults who are eligible for Medicaid through SSI or SSI-related Medical Assistance Only (MA), including those dually eligible for Medicare. Clients will have a choice among at least three contracted STAR+PLUS HMOs. Contractors are expected to improve the quality of care through managed care plans that emphasize continuity of care; education; preventive services; primary care services and access to specialized services; home and community based services; and institutional services.

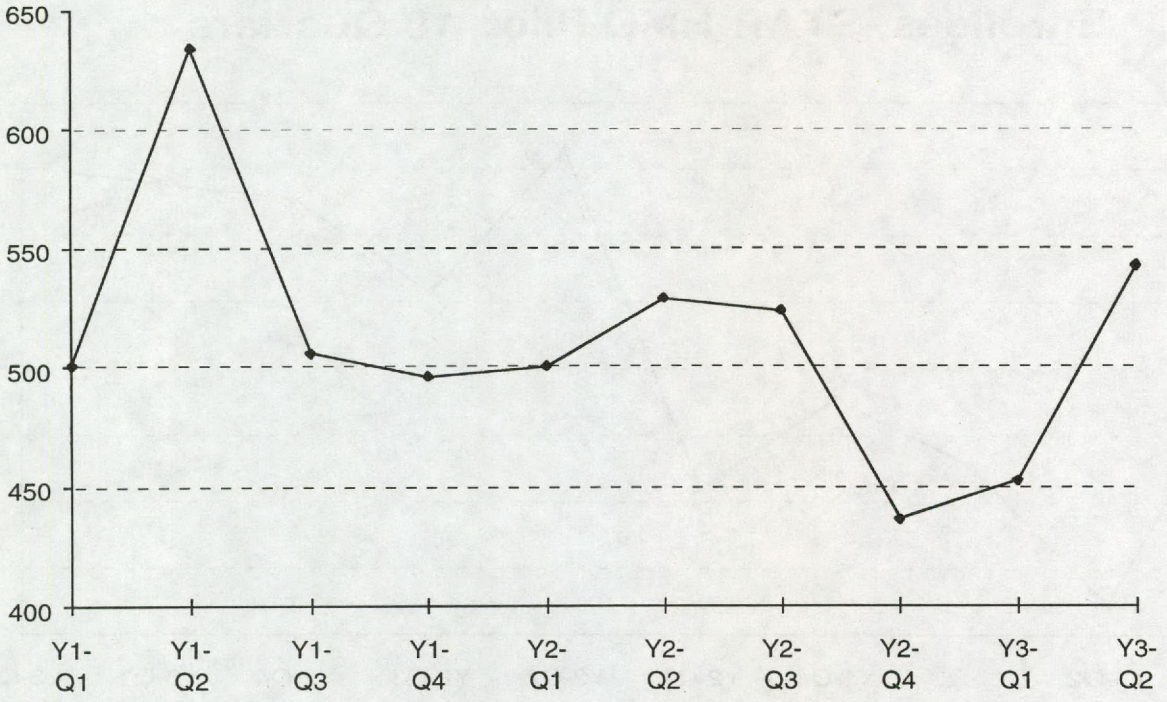
MANAGED CARE PILOTS BY THE NUMBERS

IN 1995, TEXAS MEDICAID covered 107,383 "unduplicated" Medicaid eligible persons under its managed care pilots in Travis County and the Gulf Coast area.[1] The Travis County pilot tested Health Maintenance Organization (HMO) and Prepaid Health Plan (PHP) models, while the Gulf Coast area utilized a Primary Care Case Management (PCCM) arrangement.

In 1995, Medicaid paid $40.3 million in capitation payments to PCA, the HMO with the Austin contract, to cover a total of 42,800 Medicaid eligibles over the course of the year. Medicaid spent an additional $6.1 million in payments for services not covered by the capitation rate for that population. That brings the average cost per eligible for the STAR HMO pilot to $1,085, about **3.7 percent less** than fee for service costs for similar populations.[2]

For the PCCM population in 1995, whose bills were paid on a fee for service basis, Medicaid paid $66.8 million in premium payments to NHIC to cover 55,500 Medicaid eligibles; 47,000 of those actually received Medicaid-funded services. The PCCM cost per eligible was **6.8 percent higher** than fee for service costs for TANF clients.

Figure 6.1: STAR ER Encounters per 1,000 Enrollees



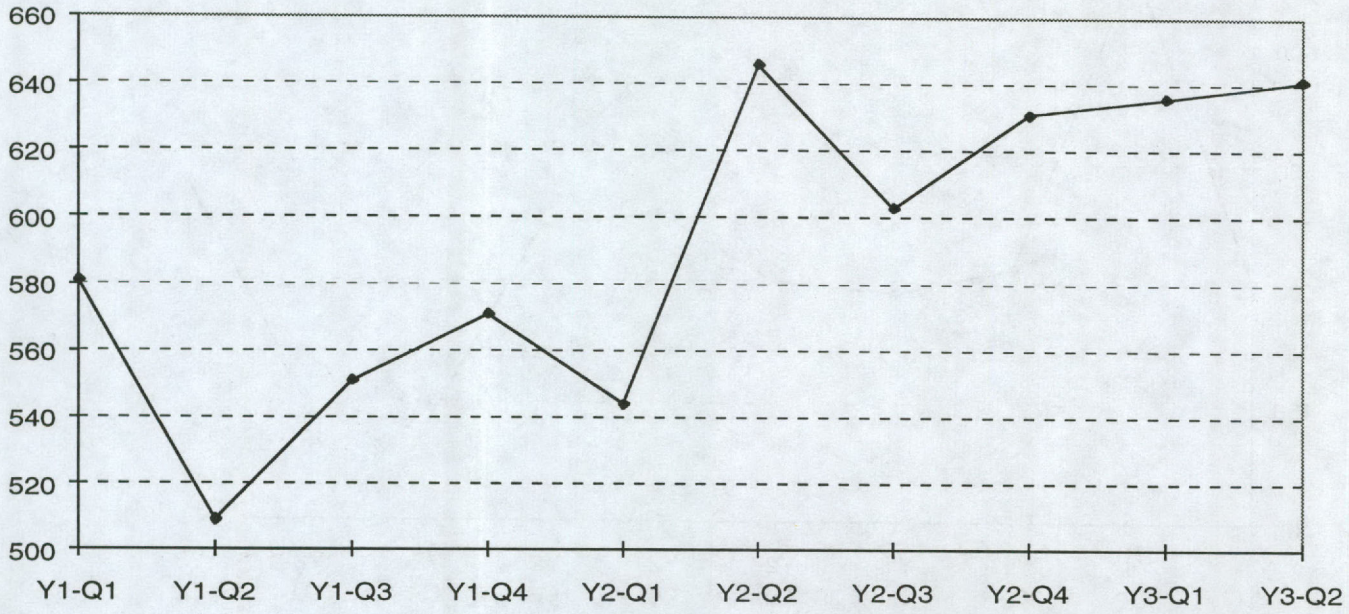
Source: PCA

Texas Medicaid paid $7.4 million in premiums to the Austin-based PHP to cover 9,100 people, and spent an additional $3.4 million for services not covered by the capitation rate. The PHP cost per eligible was **6.3 percent higher** than fee for service costs for TANF clients. (Texas discontinued this model in the 1996 expansions.)

Preliminary analyses indicate that STAR managed care has had mixed results in limiting expensive treatments.

For example, **Figure 6.1** demonstrates that emergency room (ER) encounters in the STAR-HMO portion of the Travis County pilot have fluctuated significantly over time.[3] Utlization reports indicate that STAR clients still tended to use the emergency room for flu-like illnesses or infections. In December 1995, for example, 30 percent of all approved STAR-HMO emergency room encounters were for fever symptoms. While the state encourages managed care organizations to limit ER utilization, the state incurs

Figure 6.2: Inpatient Bed Days per 1,000 Enrollees, STAR-HMO Pilot, 10 Quarters



Source: PCA Quarterly STAR Utlization Management Reports

no additional costs even if clients still use hospital emergency services because emergency room visits are covered under the capitation payment.

Similarly, the Travis County HMO pilot enjoyed mixed results in limiting inpatient hospital stays. **Figure 6.2** illustrates the trend in one common measure of hospital utilization, inpatient bed days per 1,000 enrollees.[4]

Ideally, under managed care this figure would decline as Medicaid clients benefit from the effects of increased preventive care and guaranteed access to their primary care physician. In the early stages of the HMO portion of the Travis County pilot, this statistic actually increased steadily. Part of this increase may result from the decision to waive the limit of 30 days of inpatient care "per spell of illness" for adults under the STAR program.

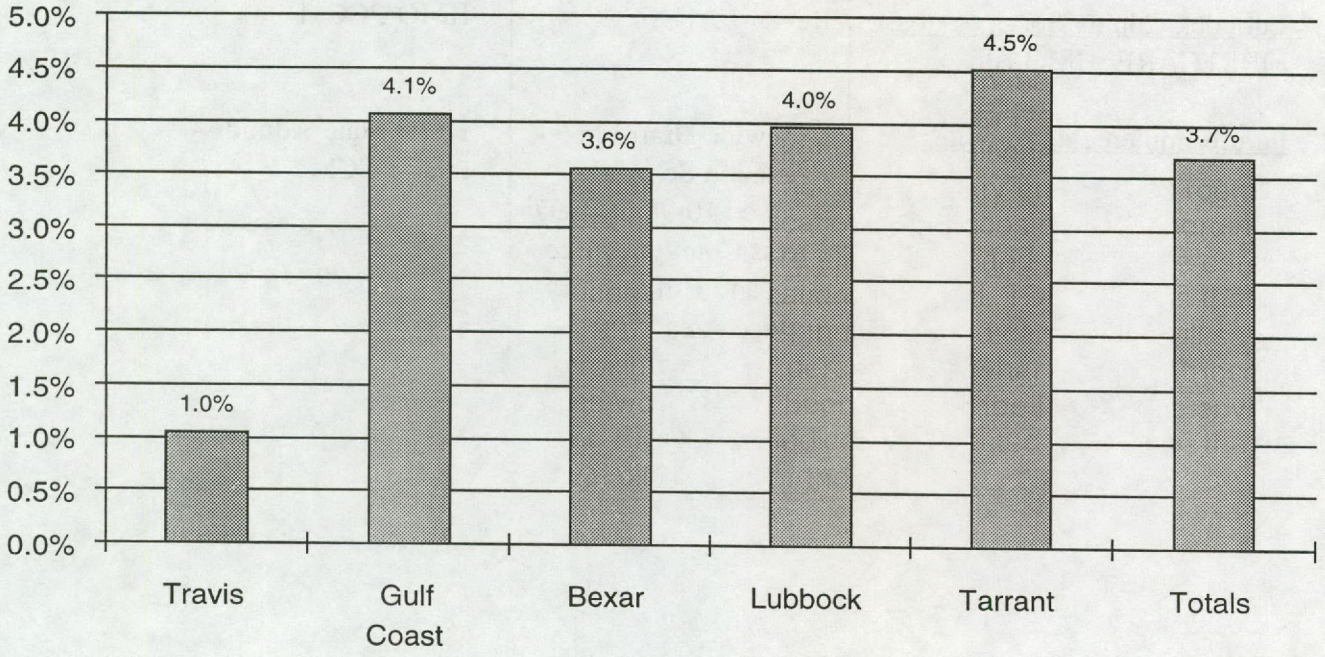
Managed Care

ECONOMICS OF MANAGED CARE EXPANSION

THE NEW MANAGED CARE pilots will make Texas Medicaid the largest purchaser of managed care in the state. TDH estimates that Texas Medicaid could spend $505 million in capitation payments to cover 328,000 full-time equivalent clients in FY 1997, more than 100,000 more than the largest HMO payer, the Texas Employee Retirement System, covered in 1995.[5]

Medicaid programs do not receive as significant a one-time savings when they shift to managed care as a large employer might, because Medicaid fees already considerably undercut market rates. Additional savings may accrue more slowly, as unnecessary emergency room visits are reduced, duplication of services by non-coordinated health providers are eliminated, and preventive care reduces hospitalizations. Overall, TDH projects that over FY 1997 and 1998, the managed care pilots will save approximately 3.7 percent over what costs for those areas would have been under a fee for service environment. **Figure 6.3** indicates projected savings in the individual pilot sites for those years:

Figure 6.3: Projected Savings in Managed Care Pilots FY '97 & '98



Source: 1915(b) waivers

Managed Care

Table 6.1: Texas Medicaid Managed Care Rollout Summary

Service Area and HMOs	Status	Managed Care Model
Travis County Pilot: PCA & Vista. Expansion: PCA, HMO Blue, Foundation Health.	Pilot began 9-1-93; Expanded to contguous counties 9-1-96	Pilot: HMO/PHP; Expansion: HMO.
Gulf Coast Region: Chambers, Jefferson, Galveston. Expansion: (renamed Southeast region): Liberty, Hardin, Orange.	Pilot began 12-1-93; Expanded 12-1-95.	PCCM
Bexar County Service Area: PCA, Community First, HMO Blue.	Began 9-1-96.	HMO/PCCM
Tarrant County Service Area: PCA, HMO Blue, AMERICAID, Harris Methodist	Began 10-1-96.	HMO
Lubbock County Service Area: FIRSTCARE, HMO Blue.	Began 10-1-96.	HMO/PCCM
Future Implementation Sites	Statewide Draft Implementation Schedule released 10-96. (9-1-97: Harris County Service Area and Hill Country Service Area.)	HMO/State Administered PCCM

NOTES

[1] This means that 107,383 persons were eligible for Medicaid services under the pilot for some or all of FY 1995. The "monthly average" number of eligibles was much lower — approximately 30,000 for both Travis County models combined, and 40,000 in the Gulf Coast area — because turnover among AFDC eligibles (the only population covered in the pilots) is relatively high.

[2] HMO costs included (1) premiums paid to PCA, (2) fee for service costs processed through NHIC and (3) FQHC cost reimbursement over and above HMO payments. These figures do not include state government oversight costs for the pilots, such as salaries and overhead at the TDH Bureau of Managed Care. Nor do they include $2 million in unpaid or disputed claims for which PCA may ultimately receive compensation.

[3] These number contradict those reported in PCA's quarterly Utilization Management reports submitted by PCA to NHIC. Significant problems emerged with the STAR data system, and with the quarterly UM reports, so PCA reran these numbers from their own system. HHSC has no way to confirm or refute these data, but considers them the most reliable presently available.

[4] Inpatient data is from the quarterly Utilization Management reports submitted by PCA to NHIC. Significant problems emerged with the STAR data system, and with the quarterly UM reports, so these numbers are not directly comparable to statistics on regular fee for service Medicaid. These numbers were confirmed and updated by PCA's data technicians.

[5] As of December 1996, ERS paid HMO premiums for 229,773 persons. Information provided via fax by Kate Tavakolian, HMO Contracts Supervisor, ERS, on 12-10-96.

Managed Care

Chapter 7: New Directions for Medicaid

As Texas Medicaid enters its fourth decade, it continues to pursue innovations that will improve efficiency, increase cost effectiveness, and better serve its clients. These two initiatives constitute major reforms that will transform the way Texas Medicaid does business.

A PROGRAM AS LARGE AND complicated as Medicaid must constantly adjust and reform its efforts in order to maximize efficiency and cost effectiveness. Two major reform efforts -- an 1115 waiver and the Texas Integrated Enrollment Service -- will transform the program by:

- expanding Medicaid eligibility for children;
- implementing managed care statewide; and
- integrating eligibility determination for various state programs

Texas plans to implement both these projects in 1997.

1115 WAIVER MODIFICATIONS

THE TEXAS HEALTH AND HUMAN Services Commission submitted Texas' original 1115 waiver to the Health Care Financing Administration (HCFA) on August 31, 1995. A modified waiver was submitted to HCFA on November 1, 1996 to replace the original 1115 waiver submission. If approved by HCFA, this modified 1115 waiver will expand Medicaid eligibility to currently unserved low-income children, will create state and local partnerships to finance and deliver services to the newly eligible children, and will implement managed care across the state.

New Directions

Expanded Medicaid Coverage

WITH THE IMPLEMENTATION OF THE 1115 waiver, Texas will expand Medicaid coverage to currently ineligible children age 6 through age 18 with incomes at or below 133 percent of the federal poverty level (FPL).

The estimated number of new children and projected costs are as follows:

Table 7.1: Number and Cost of New Children under the Amended 1115 Waiver

	1998	1999	2000	2001	2002
New Children	432,691	390,446	348,958	307,024	265,164
Total Cost	$327.1 M	$312.7 M	$293.3 M	$271.0 M	$246.0 M
State/Local Share	$123.2 M	$117.9 M	$110.6 M	$102.2 M	$92.7 M

Public funding entities and the state will work in concert to expand Medicaid services to the children made eligible for Medicaid pursuant to this waiver. Public funding entities include eight large hospital districts, the City of Austin, and the University of Texas Medical Branch (UTMB). The entities acting collectively will assure the state share of costs for all newly eligible children statewide. Every local dollar will be matched with $1.67 in federal funds.

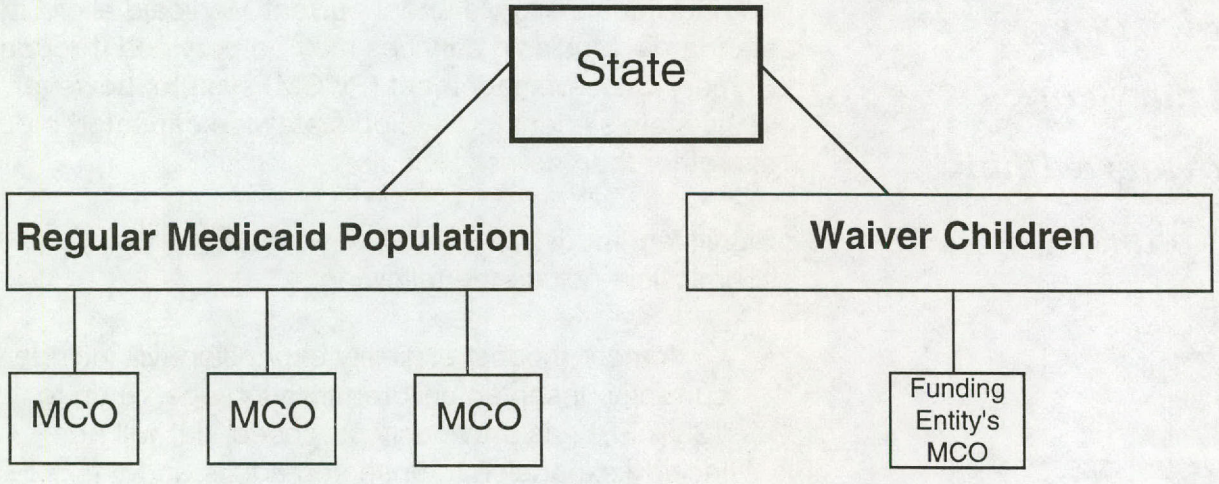
These public funding entities will assume responsibility for delivering care, or arranging for the delivery of care, to all newly eligible children. The state-local partnership created under the revised waiver will use direct contracting between the state and public funding entity managed care organizations (MCOs) operated by the funding entities to deliver care to newly eligible children. The state will contract with public funding entity MCOs on a capitated basis to deliver or arrange for care.

New Directions

To implement the program, the state has been divided into regions with one public funding entity per region. Respecting county boundaries, regions were determined based on inter-county patient flow and historical relationships. Each public funding entity will form an MCO to serve the newly eligible children within its region. The state will enter into exclusive contracts with the public funding entity MCOs for the provision of Medicaid services to all newly eligible children. Public funding entity MCOs will be responsible for providing all eligible services to all newly eligible children within their respective regions.

Newly eligible children will be eligible to receive the same benefit package and will receive the same level of quality care afforded to other Medicaid managed care clients around the state. The state will require public funding entity MCOs to meet the same contractual requirements for access and quality of care that all managed care organizations contracting with the state must meet.

Figure 7.1: STAR Program Service Delivery



MCO = May include HMOs, Public Funding Entity MCOs and State Administered Plans

New Directions

Managed Care Models

THE 1115 WAIVER WILL AUTHORIZE Texas to implement managed care statewide. Texas expects to have sufficient managed care capacity in the vast majority of the significantly populated areas. Senate Bill 10 requires that, to the extent possible, the restructured Medicaid program lower the cost of providing Medicaid services through the use of primary care case management systems, partially capitated systems, or fully capitated systems, or a combination of one or more of those systems.

Waiver eligible children will be assigned exclusively to the public funding entity's managed care plan, but will be assured of a choice of primary care provider within the plan.

In the case of clients qualifying under current Medicaid eligibility standards, Medicaid services will be provided (where possible) through multiple, competing managed care organizations, one of which may be the public funding entity. Assuming clients remain eligible, they will be committed to their MCO for six month intervals; although during the first 30 days of enrollment, a client may change MCOs without cause.

Waiver eligible children will be assigned exclusively to the public funding entity's managed care plan, but will be assured of a choice of PCP within the plan. The public funding entity MCO will be paid a monthly capitation fee, which will cover all eligible services.

For individuals eligible under current Medicaid eligibility standards, Medicaid services may be provided through a Primary Case Management (PCCM) system; however, it is the state's intent to develop statewide capitated models rather than no-risk models.

Significant modifications to last year's 1115 waiver submission include the following:

- A more modest eligibility expansion will include currently unserved children through age 18 up to 133% FPL, as previously proposed, but will not include expansion to unserved adults up to 45% FPL at this time.

- Ten public funding entities acting collectively will pay the state share of costs for the newly eligible children statewide, but will not need to commit dispro-

portionate share program (DSH) funds to cover the expansion.

- The state-local partnership will use direct contracting between the state and public funding entity managed care organizations (MCOs) operated by the funding entities to deliver care to the newly eligible children. The intergovernmental initiatives (IGI) concept for financing and administering the Medicaid program was deleted.

TEXAS INTEGRATED ENROLLMENT SERVICES (TIES)

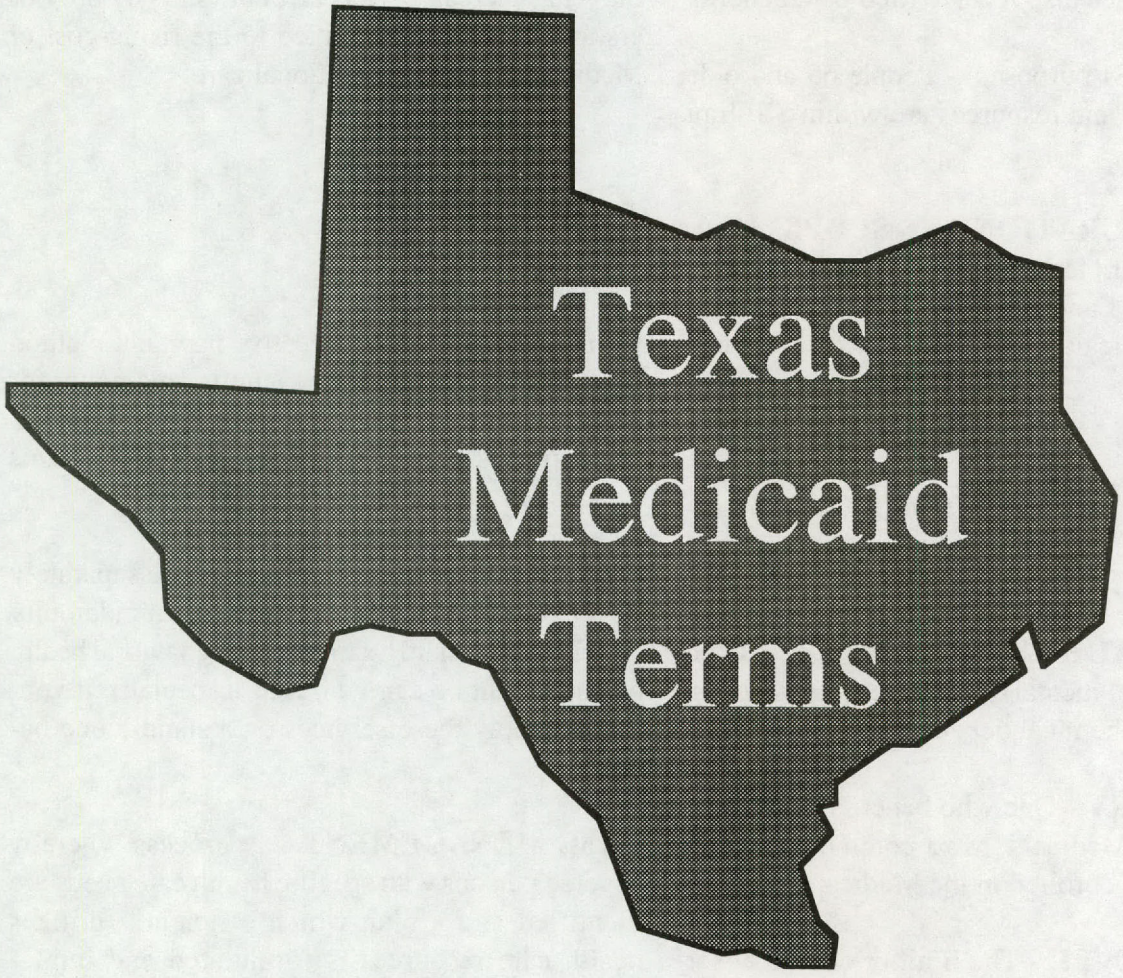
TEXAS MEDICAID IS PARTICIPATING in another exciting project, Texas Integrated Enrollment Services (TIES), which is developing an integrated system to determine client eligibility for Medicaid and other health and human service programs. TIES will allow people to be screened for and enrolled in services offered by different agencies at the same time. It will enroll clients in programs such as food stamps, Medicaid, TANF, women and children's programs and employment services.

Texas' welfare reform legislation, enacted in June 1995, directed the Health and Human Services Commission to develop and implement a plan for integration of eligibility determination. The legislation also directed the Health and Human Services Commission, in consultation and coordination with the Council on Competitive Government, to make and implement recommendations on services or functions of the integrated eligibility determination system that could be provided more effectively through the use of competitive bidding or by contracting with local governments and other entities.

HHSC and the Council studied such programs as Medicaid, Aid to Families with Dependent Children (TANF) and Food Stamps, in which a "means test" (income limits and categorical criteria) is employed to determine whether or not individuals and/or families are eligible for benefits or services. Having determined the programs whose eligibility will be integrated via TIES, HHSC and the Council plan to issue a Request for Offers.

New Directions

Glossary



A Partial Listing of Frequently Used Medicaid Terms

A

AFDC - Aid to Families with Dependent Children. This program's name was recently changed to **TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF).** Children who qualify for AFDC assistance also receive Medicaid benefits.

AGED (for SSI purposes) - People 65 and older whose income and resources are within SSI limitations.

AMOUNT, DURATION AND SCOPE - How a Medicaid benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.

B

BEHAVIORAL HEALTH CARE - Assessment and treatment of mental or emotional disorders and treatment for chemical dependency disorders.

BENEFICIARY - One who benefits from a program such as Medicaid. Most commonly used to refer to people enrolled in the Medicare program.

BENEFIT LEVEL - The limit or degree of services a person is entitled to receive based on his/her contract with a health plan or insurer.

BENEFIT PACKAGE - Services an insurer, government agency, or health plan offers to a group or individual under the terms of a contract.

BOREN AMENDMENT - An amendment to OBRA 80 (P.L. 96-499) which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities and ICFs/MR under the Medicaid program. The amendment substituted language which required states to develop payment rates which were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid- funded institutional care.

C

CAPITATION - A prospective payment method pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.

CARVE OUT - A decision to purchase separately a service which is typically a part of an indemnity a health HMO plan. Example: the behavioral health benefit might be carved out to a specialized vendor to supply these services on a stand-alone basis.

CASE MANAGEMENT - A process whereby covered persons with specific health care needs are identified and a plan which efficiently utilizes health care resources is formulated and implemented to achieve the optimum outcome in the most cost- effective manner.

CASE MANAGER - An experienced professional (e.g., nurse, doctor or social worker) who works with clients, providers and insurers to coordinate all services deemed necessary to provide the client with a plan of medically necessary and appropriate health care.

CLASS WAIVER PROGRAM - (Community Living Assistance and Support Services) A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act which allows Texas to provide community-based services to people with developmental disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by TDHS. See also **ICF MR, 1915(c), WAIVER**.

CLIENT - A person who is enrolled in the Medicaid program and thus is eligible to receive services funded through Medicaid. See also **RECIPIENT**.

CCAD (COMMUNITY CARE FOR THE AGED AND DISABLED). A group of services managed by TDHS. CCAD provides services in the community for aged or disabled Texans who have functional limitations. Services are funded by Medicaid, Social Services Block Grant Title (XX) and state funds. CCAD services include:

1. Adult Foster Care - Residential services and care in a family home or a small group home. (Title XX)

2. Client Managed Attendant Services - personal care program in which the attendant is supervised by the individual receiving the service (State funds).

3. Congregate and Home-delivered meals - a program that provides a nutritious meal served in either a central dining area or taken to the client's home (Title XX, State and local funds)

4. Day Activity and Health Services (DAHS) - Medical,personal care and socialization for up to 10 hours per day, five days a week in a licensed facility (Title XIX, XX, State funds)

5. Emergency Response Services - An electronic signaling device for use in emergencies. (Title XX, State funds)

6. Family Care - Assistance with personal care and housekeeping tasks. (Title XX, State Funds)

7. In-home and Family Support Services - provides direct grant benefits to individuals with physical disabilities or his family for purchasing services that enable the individual to live in the community.
(State funds)

8. Primary Home Care - Assistance with personal care and housekeeping tasks, for persons with medically related personal care needs. (Title XIX, State funds)

9. Residential Care - 24-hour care in a group setting for emergency care or supervised living. (State funds)

10. Respite Care - short-term services for elderly and disabled adults who require care and supervision while giving temporary relief to caregivers. (State funds)

11. Special Services for People with Disabilities - A variety of in-home care and advocacy services for persons with disabilities. (Title XX, Local Revenue, State Funds)

12. Waiver services for special needs populations include MDCP, CLASS and the Community Based Alternatives waiver. (Title XIX, State Funds)

See also **CLASS, MDCP, COMMUNITY BASED ALTERNATIVES WAIVER, PRIMARY HOME CARE, PERSONAL CARE, TITLE XX, TITLE XIX, WAIVER**.

CO-INSURANCE - See **COST SHARING**

COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTERS (CMHMRCS) - Non-profit, locally governed components of the TXMHMR service delivery system located in various communities throughout the state, providing community-based mental health and/or mental retardation services.

COMPARABILITY - In general, the state must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver programs for special subpopulations of Medicaid eligibles and benefits available to children through EPSDT which may not be available to adults.

COMPREHENSIVE CARE PROGRAM (CCP) - CCP is Texas' name for the expanded portion of the EPSDT program, which in 1996 changed its name to Texas Health Steps. CCP covers services for children (until age 21) which are not usually allowed or are more limited under the Texas Medicaid Plan. CCP is a result of a Congressional mandate which took effect in 1990. See also **EPSDT.**

CO-PAYMENT OR CO-PAY - A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as $10 for an office visit. The covered person is usuallyn responsible for payment at the time the health care is rendered. See also **COST SHARING**.

COST SHARING - The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (e.g., 20%) which an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending which an individual or a family must incur
before insurance begins to make payments.

D

DEVELOPMENTAL DISABILITY - mental retardation or a related condition. A severe, chronic disability manifested during the developmental period which results in impaired intellectual functioning or deficiencies in essential skills. See also **MENTAL RETARDATION, RELATED CONDITION.**

DIAGNOSIS.
1. The art of distinguishing one disease from another.
2. Determination of the nature of a cause of a disease.
3. A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem.
4. A code for the above.
See also: **DRG**.

DIAGNOSIS RELATED GROUPS (DRGs) - A system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.

DRUG FORMULARY - A listing of prescription medications which are preferred for use by the

health plan and which will be dispensed through participating pharmacies to covered persons. This list is subject to periodic review and modification by the health plan. A plan that has adopted an "open or voluntary" formulary allows coverage for both formulary and nonformulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.

DURABLE MEDICAL EQUIPMENT (DME) - Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

DISPROPORTIONATE SHARE (DISPRO OR DSH) - A program which provides additional reimbursement to hospitals which serve a disproportionate share of low income patients to compensate for revenues lost by serving needy Texans. See also **DSH HOSPITAL.**

DSH HOSPITAL - Disproportionate Share Hospital. A hospital which serves a higher than average number of Medicaid and other low-income patients. In FY97 there were 164.

DUAL ELIGIBLE - A person enrolled in Medicare and Medicaid.

E

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) - Medicaid program for children (until age 21), recently renamed Texas Health Steps (THS). THS now covers any medically necessary service allowable under Medicaid regulations. See also **COMPREHENSIVE CARE PROGRAM.**

1115(a) - Section of the Social Security Act which allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by HCFA. See also **HEALTH CARE FINANCING ADMINISTRATION, PACE, WAIVER.**

EXCLUSIVE PROVIDER ORGANIZATION (EPO) - An arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also **PREFERRED PROVIDER ORGANIZATION**

F

FACILITY SPECIFIC - Rate methodology which pays providers delivering the same type of service at different rates. Rates are tied explicitly to facility expenditures on items most directly related to patient care.

FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) - The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capita income. In 1997 the FMAP for Texas is approximately 62.56 percent for most services. The federal share of Medicaid administrative costs is not based on a per capita income formula. It is a flat 50 percent for most activities.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) - A center receiving a grant under the Public Health Services Act or an entity receiving funds through a contract with a grantee. These

include community health centers, migrant health centers and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education and mental health services.

FEDERAL POVERTY LEVELS (FPL) - income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.

POVERTY INCOME LEVEL
Federal Fiscal Year 1997

FAMILY SIZE	ANNUAL INCOME
1 Person	$7,740
2 People	$10,360
3 People	$12,980
4 People	$15,600

FEE-FOR-SERVICE REIMBURSEMENT - The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also **INDEMNITY INSURANCE.**

FLAT RATE - reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a uniform rate.

FREEDOM OF CHOICE - In general, a state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.

G

GENERIC DRUG - A chemically equivalent copy designed from a brand-name drug whose patent has expired. A generic is typically less expensive and sold under a common or "generic" name for that drug (e.g., the brand name for one tranquilizer is Valium, but it is also available under the generic name diazepam). Also called generic equivalent.

GROUP MODEL HMO - A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

H

HCS WAIVER (Home and Community-based Services) - A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act which allows Texas to provide community-based services to people with mental retardation as an alternative to ICF MR institutional care. See also **ICF MR I, V AND VI; 1915(c); WAIVER**

HCS-O WAIVER (Home and Community-based Services-OBRA) - A waiver of the Medicaid state plan granted under section 1915(c)(7)(b) of the Social Security Act which allows Texas to pro-

vide community-based services to certain people with developmental disabilities who were placed in nursing facilities but require specialized services according to the PASARR process. See also, **1915(c)(7)(b), PASARR, WAIVER.**

HEALTH CARE FINANCING ADMINISTRATION (HCFA) - The federal agency responsible for administering Medicare and overseeing states's administration of Medicaid.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO may suffer losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also **1903(m), 1915(b), PHP, PPO, PRIMARY CARE CASE MANAGEMENT.**

HEDIS - HEALTH PLAN EMPLOYER DATA AND INFORMATION SET - A core set of performance measures developed for employers and Medicaid and Medicare to use in assessing health plans.

HOME AND COMMUNITY CARE FOR THE FUNCTIONALLY DISABLED - An optional state plan benefit which allows states to provide home and community-based services to functionally disabled individuals (in Texas, this optional benefit is used by TDHS to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision although Texas can serve people of any age under this provision. See also **1929, PRIMARY HOME CARE.**

I

INDEMNITY INSURANCE - An insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also FEE FOR SERVICE.

INDIVIDUAL PRACTICE ASSOCIATION (IPA) MODEL HMO - A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

ICF MR - (Intermediate Care Facility for Mentally Retarded Persons) Optional Medicaid service which provides residential care and services for individuals with developmental disabilities based on their functional needs. See also **MENTAL RETARDATION.**

K

KATIE BECKETT OPTION - See **TEFRA 134(a)**

L

LEWIN-VHI STUDY OF NF/ICF - Analysis of Texas' reimbursement system for nursing facilities and ICFs-MR commissioned by TDHS. The

study, completed by Lewin VHI, Inc. in 1993, recommended options for restructuring the reimbursement system. Options recommended in the study included facility specific rate methodologies. See also **FACILITY SPECIFIC, TDHS.**

LOCAL MENTAL HEALTH AUTHORITY: the local component of the TXMHMR system designated to carry out the legislative mandate for planning, policy development, coordination and resource development/allocation and for supervising and ensuring the provision of mental health services to persons with mental illness in one or more local Service Areas.

LONG TERM CARE - Assistance and care for persons with chronic disabilities. Long term care's goal is to help people with disabilities be as independent as possible; thus it is focused more on caring than on curing. Long term care is needed by a person who requires help with the activities of daily living (ADLs) or who suffers from cognitive impairment.

LONESTAR - Texas' first managed health care pilot project under the Medicaid program, the name of this program was later shortened to STAR, for State of Texas Access Reform. See also **MANAGED CARE, 1915(b), STAR, PCA, VISTA, PRIMARY CARE CASE MANAGEMENT.**

M

MANAGED CARE - A system in which the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuing quality in a cost efficient manner. See also **LONESTAR, STAR, 1915(b), HMO, PPO, PRIMARY CASE MANAGEMENT.**

MANAGED CARE ORGANIZATION (MCO) - An entity which provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also **HMO, PREPAID HEALTH PLAN.**

MANAGED HEALTH CARE PLAN - One or more products which integrate financing and management with the delivery of health care services to an enrolled population; employ or contract with an organized provider network which delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and use and information system capable of monitoring and evaluating patterns of covered persons' use of medical services and the cost of those services.

MANDATED OR REQUIRED SERVICES - Services which a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services are:

- hospital (IP & OP)
- lab/x-ray
- nursing facility care (21 and over)
- home health care
- family planning
- physician
- nurse midwives
- dental (medical/surgical)
- rural health clinic
- certain nurse practitioners
- federally qualified health centers
- renal dialysis services
- EPSDT (under age 21)
- medical transportation

MEDICAID - A joint federal-state entitlement program that pays for medical care on behalf of

certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

MEDICAID OPERATING AGENCY - State agencies in Texas with day-to-day operational responsibility for various Medicaid-funded programs. The Medicaid operating agencies are TDHS, TDMHMR, TDH, TRC, TCB, DPRS, and ECI.

MEDICAID PLAN - see **TEXAS STATE PLAN FOR MEDICAL ASSISTANCE**

MEDICALLY DEPENDENT CHILDREN'S PROGRAM (MDCP) - A 1915(c) Medicaid waiver program that provides nursing, respite and Medicaid benefits to children as an alternative to nursing facility care. See also **1915(c), WAIVER**.

MEDICALLY NECESSITY - means health services which are:
a) reasonably necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life;
b) provided at appropriate facilities and at the appropriate levels of care for the treatment of members' conditions;
c) consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
d) consistent with the diagnoses of the conditions;
e)no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency.

MED-SURG - An abbreviation for medical-surgical. A term used to refer to managed care organizations which provide acute care benefits.

MENTAL ILLNESS - (as defined in the Texas Medicaid plan) - A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

MENTAL RETARDATION - Significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

N

NETWORK MODEL HMO - An HMO type in which the HMO contracts with more than one physician group, and may contract with single and multi-specialty groups. The physician works out of his/her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.

1902(a)(1) - Section of the Social Security Act which requires that state Medicaid programs be in effect "in all political subdivisions of the state". See also **STATEWIDENESS, 1915(a), 1915(b), 1915(c), WAIVER**.

1902(a)(10) - Section of the Social Security Act which requires that state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also **COMPARABILITY, 1915(b), WAIVER**.

1902(a)(23) - Section of the Social Security Act which requires that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service. See also **FREEDOM OF CHOICE, 1915(b), WAIVER**.

1903(m) - Section of the Social Security Act which allows state Medicaid programs to develop risk contracts with HMOs or comparable entities. See also **HMO, RISK CONTRACTS**.

1902(r)(2) - Section of the Social Security Act which allows states to use more liberal income and resource methodologies than those used to determine SSI eligibility for determining Medicaid eligibility. See also **SSI**.

1915(c) - Section of the Social Security Act which allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF- MR, Nursing Facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by HCFA. See also **CLASS, HCS, MDCP, HCFA, NF, WAIVER.**

1915(b) - Section of the Social Security Act which allows states to waive freedom of choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by HCFA. See also **HCFA, WAIVER**.

1915(c)(7)(b) - Section of the Social Security Act which allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by HCFA. See also **HEALTH CARE FINANCING ADMINISTRATION, HCS- O, WAIVER.**

1929 - Section of the Social Security Act which allows states to provide a broad range of Home and Community Care to functionally disabled individuals as an optional state plan benefit. In all states but Texas the option can serve only people over 65. In Texas, individuals of any age may qualify to receive personal care services through section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also **HOME AND COMMUNITY CARE FOR THE FUNCTIONALLY DISABLED.**

NURSING FACILITIES - Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) long term care program. See also: **LONG TERM CARE, TILE.**

COMMUNITY BASED ALTERNATIVES WAIVER- A waiver of the Medicaid state plan granted under Section 1915(c) of the Social Security Act which allows Texas to provide community-based services to adults as an alternative to nursing facility care. See also **NURSING FACILITIES, 1915(c), WAIVER.**

O

OMNIBUS BUDGET RECONCILIATION ACTS (OBRAs) - Federal laws which direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.

OPTIONAL SERVICES OR BENEFITS - Over 30 different services which a state can elect to cover under a State Medicaid plan. Examples include Personal Care, Rehabilitative Services, Prescribed Drugs, Therapies, Diagnostic Services, ICF-MR, Targeted Case Management, etc.

OUTCOME MEASURES - Assessments which gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as

well as objective measures of mortality, morbidity and health status.

OUTCOMES - Results achieved through a given health care service, prescription drug use or medical procedure.

OUTCOMES MANAGEMENT - Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying-often in a formal program of continuous quality improvement.

OUTCOMES RESEARCH - Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.

OUTLIER - An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.

P

PACE (Program of All-inclusive Care for the Elderly) - A waiver of the Medicaid state plan granted under Section 1115(a) of the Social Security Act. This waiver allows Texas to provide comprehensive community and medical services under a capitated, risk-based system to frail elderly people (55 and older) as a cost-effective alternative to institutional care. The waiver is part of a national demonstration project. There is one site in Texas (in El Paso). See also **1115(a), HEALTH CARE FINANCING ADMINISTRATION, WAIVER.**

PART A - Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also: **MEDICARE, BENEFICIARY**.

PART B - Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also: **MEDICARE, SMIB, BUY-IN.**

PER MEMBER PER MONTH (PM/PM) - The unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is: # of units/member months.

PERSONAL CARE - Optional Medicaid benefit which allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (e.g., bathing, dressing, feeding, grooming...). Texas provides Primary Home Care Services under this option. See also **PRIMARY HOME CARE**.

PHYSICIAN HOSPITAL ORGANIZATION - An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self- insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.

PHYSICIAN'S CORPORATION OF AMERICA (PCA) - The HMO which provided health benefits to Medicaid clients during the initial Travis County pilot. For an updated list of HMOs participating in the managed care expansions, see **Table 6.1.** See also **STAR HEALTH PLAN.**

POINT OF SERVICE (POS) - A commercial insurance plan that combines characteristics of both HMOs and PPOs to balance cost control with freedom of choice. Enrollees select a primary care physician gatekeeper from a network of physicians contracted to the plan. The cost to the enrollee for care provided by a network provider is very low or nothing. Enrollees may obtain care from out-of-plan providers but with significantly higher cost sharing.

POOL (RISK POOL) - A defined account (e.g., defined by size, geographic location, claim dollars that exceed "x" level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.

PREFERRED PROVIDER ORGANIZATION (PPO) - An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also **EXCLUSIVE PROVIDER ORGANIZATION**.

PREPAID HEALTH PLAN (PHP) - A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also **VISTA.**

PRESCRIPTION MEDICATION - A drug which has been approved by the Food and Drug Administration and which can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

PREVENTIVE CARE - Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization and well person care.

PRIMARY CARE - Basic or general health care, traditionally provided by family practice, pediatrics and internal medicine.

PRIMARY CARE CASE MANAGEMENT (PCCM) - Managed care option allowed under section 1915(b) of the Social Security Act in which each participant is assigned to a single primary care provider who must authorize most other services such as specialty physician care before they can be reimbursed by Medicaid. See also **MANAGED CARE, 1915(b)**.

PRIMARY CARE PHYSICIAN (PCP) - a physician or provider who has agreed to provide a medical home to Medicaid recipients and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care and initiating referral for care.

PRIMARY HOME CARE (PHC) - Medicaid-funded community care program, administered by TDHS, which provides personal care services to over aged or disabled Texans. PHC is provided as an optional state plan benefit. See also **PERSONAL CARE.**

PRIOR AUTHORIZATION - An authorization from the Medicaid program for the delivery of certain services. It must be obtained prior to the service for benefits to be provided. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.

PROVIDER - A person, group or agency who provides a covered Medicaid service to a Medicaid client. See also: **NHIC, INSURED ARRANGEMENT.**

PROVIDER NETWORKS - Organizations of health care providers that provide services within managed care plans. Network providers are selected with the expectation that they will deliver care inexpensively, and enrollees are channeled to network providers to control costs.

Q

QUALITY IMPROVEMENT - A continuous process that identifies problems in health care delivery, tests solutions to those problems and constantly monitors the solutions for improvement.

QUALITY ASSURANCE REFORM INITIATIVE (QARI) - Guidelines established by the federal government for quality assurance in Medicaid managed care plans.

R

RECIDIVISM - The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.

RECIPIENT - A person who received a Medicaid service while eligible for the Medicaid program. People may be Medicaid eligible without being Medicaid recipients.

REHABILITATIVE SERVICES FOR MENTAL ILLNESS - specialized services provided to people age 18 and over with severe and persisitent mental illness and people under 18 with severe emotional disturbance. Mental health rehabilitation includes:

- plan of care oversight
- community support services
- day programs services - adults
- day programs services - children

REINSURANCE - Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that my be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. Also call risk control insurance or stop-loss insurance.

RELATED CONDITION - A disability other than mental retardation which manifests itself during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (e.g., self-care, expressive/receptive language, learning, mobility, self-direction and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries and a host of other diagnoses are said to be "related to" mental retardation in their effect upon the individual's functioning.

RESERVES - Funds for incurred but not reported health services or other financial liabilities. Also refers to deposits and/or other financial requirements that must be met by an entity as defined by various state or federal regulatory authorities.

RISK CONTRACT - An agreement with a managed care organization (MCO) to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See **also MCO, RISK POOL, POOL**.

S

SCHOOL HEALTH AND RELATED SERVICES (SHARS) - Medicaid optional benefit which provides services related to a child's Individual Education Plan (IEP). Services include au-

diology, medical services, occupational therapy, physical therapy, speech therapy, psychological services, school health services, assessment and counseling.

SELECTIVE CONTRACTING - Option under section 1915(b) of the Social Security Act which allows a state to develop a competitive contracting system for services such as inpatient hospital care.

SINGLE STATE AGENCY - The Social Security Act requires that the state designate a single agency to administer or supervise administration of the state's Medicaid plan. In Texas the Medicaid Division of the THHSC fulfills this function. See also Medicaid State Plan, Texas Health & Human Services Commission.

SOCIAL SECURITY ADMINISTRATION (SSA) - Federal agency responsible for determining eligibility for SSI benefits in Texas and most other states. See also Supplemental Security Income.

STAFF MODEL HMO - A health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.

STANDARD BENEFIT PACKAGE - A set of specific health care benefits that would be offered by delivery systems. Benefit packages could include all or some of the following: preventive care; hospital and physician services; prescription drugs; limited mental health and chemical dependency services; and long- term care.

STAR HEALTH PLAN - Texas Medicaid's managed care pilot program.

STATE MEDICAID OFFICE - Division of the Texas Health and Human Services Commission responsible for administering the Medicaid program in Texas.

STATEWIDENESS - In general, a state must offer the same benefits to everyone throughout the state. Exceptions to this requirement are possible through Medicaid waiver programs and special contracting options. See also **1902(a)(1).**

STOP-LOSS INSURANCE - Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance:

1. Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000.

2. Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also **REINSURANCE**.

SUBSTANCE ABUSE - The taking of alcohol or other drugs at dosages that place a person's social, economic, psychological and physical welfare in potential hazard, or endanger public health, safety or welfare, or a combination thereof. Also called **CHEMICAL DEPENDENCY.**

T

TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) - The federal law which created the current risk and cost contract provisions under which health plans contract with

HCFA and which define the primary and secondary coverage responsibilities of the Medicare program.

TEFRA 134(a) - provision of the Tax Equity and Fiscal Responsibility Act of 1982 which allows states to extend Medicaid coverage to certain disabled children. See also Katie Beckett option.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) - Formerly Aid to Families with Dependent Children (AFDC), TANF is a product of recent Congressional welfare reform. See **AID TO FAMILIES WITH DEPENDENT CHILDREN.**

TEXAS COMMISSION FOR THE BLIND (TCB) - Medicaid operating agency responsible for Targeted Case Management for the Blind and Visually Impaired children.

TEXAS DEPARTMENT OF HEALTH (TDH) - Medicaid operating agency responsible for Purchased Health Services, the Vendor Drug program, Medical Transportation, EPSDT, and family planning. TDH also provides assistance with claims processing to certain other operating agencies through a contract with NHIC, and establishes some rules related to Medicaid managed care.

TEXAS DEPARTMENT OF HUMAN SERVICES - Medicaid operating agency responsible for a numberof services and programs including Personal Care,DAHS, Nursing Facilities, Swing Bed, Emergency Dental, PASARR, Hospice, Goal-Directed Therapy, Long Term Care Licensing, Survey and Certification, Nurse Aide Training , and Waivers (CLASS, MDCP, PACE, NF). TDHS also provides assistance to other Medicaid operating agencies in the areas such as automated systems, Medicaid eligibility determination, rate setting, federal funds analysis and appeals.

TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (TDMHMR) - Medicaid operating agency responsible for ICF-MR, Targeted Case Management for people with Mental Retardation or Mental Illness, Mental Health Rehabilitative Services, Diagnostic Services for People with Mental Retardation, HCS Waiver program and the HCS-O Waiver program.

TEXAS EDUCATION AGENCY - Provider agency for School Health and Related Services (SHARS). See also **SHARS**.

TEXAS HEALTH STEPS - See **EPSDT**.

TEXAS REHABILITATION COMMISSION (TRC) Medicaid operating agency responsible for the waiver for people with deaf-blindness and multiple disabilities. (See also **1915(c), WAIVER**)

TEXAS STATE PLAN FOR MEDICAL ASSISTANCE - the document which serves as the contract between the state and HCFA in the Texas Medicaid Program, giving the state, particularly the Health and Human Services Commission, the authority to administer a Medicaid program in Texas. It describes the nature and scope of the state's Medicaid program including Medicaid administration, client eligibility, benefits, and provider reimbursement. It includes a "preprint" portion which contains the broad outlines of the program and the basic choices that a state is allowed to make. The details of a particular state's Plan are contained in numerous attachments, appendices and supplements. The Health Care Financing Administration (HCFA) must approve the Plan and any amendments to the Plan. See also **Medicaid State Plan, Title XIX and XX**.

TITLES OF THE 1965 SOCIAL SECURITY ACT -

II - Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI)
IV-A - AFDC; WIN Social Services
IV-B - Child Welfare
IV-D - Child Support
IV-E - Foster Care and Adoption
IV-F - Job Opportunities and Basic Skills Training
V - Maternal and Child Health Services
XV - ISSI
XVIII - Medicare
XIX - Medicaid
XX - Social Services

TRIAGE - The classification of sick or injured persons according to severity in order to direct care and ensure the efficient use of medical and nursing staff and facilities.

U

UTILIZATION - The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.

UTILIZATION MANAGEMENT (UM) - A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

UTILIZATION REVIEW (UR) - A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.

V

VENDOR DRUG PROGRAM - A Texas Medicaid program that pays for up to three prescriptions a month per adult client living in the community to pharmacies participating in the program. Nursing facility residents and children are not subject to the three prescription limitation. Drugs are an optional state plan service under the Texas Medicaid program.

VISTA - A prepared Health Plan providing services to Medicaid recipients in Travis County. See also **PREPAIED HEALTH PLAN**.

W

WAIVER - An exception to the usual requirements of Medicaid granted to a state by HCFA. See also **1115(a), 1915(b), 1915(c), HCFA.**

Appendices:
Texas Medicaid Eligibles
Federal Fiscal Year 1996

The tables that follow are reproduced courtesy of the Texas Department of Health, Statistics and Analysis Division

- Appendix A: Texas Medicaid Monthly Eligibles by eligibility category, race.
- Appendix B: Texas Medicaid Monthly Eligibles by major program types.
- Appendix C: Texas Medicaid Monthly Eligibles by age
- Appendix D: Texas Medicaid Monthly Eligibles by county and eligibility category.
- Appendix E: Texas Medicaid Monthly Eligibles by county, age.
- Appendix F: Texas Medicaid Monthly Eligibles by county, race

Appendix A: FY 1996 Medicaid Eligibles by Eligibility Category and Race

(Based on eligibility as of 1st of month.)

	Category:					Ethnicity:					
		1	2	3	4	1	2	3	4	5	6
Month	Total	Aged	AFDC [1]	Blind	Disabled	White	Black	Hispanic	Amer. Ind.	Asian	Unknown
Sep-95	2,035,779	281,811	1,489,588	5,590	258,790	579,772	472,018	910,448	5,136	21,575	46,830
Oct-95	2,059,057	282,216	1,511,837	5,561	259,443	584,263	475,589	926,288	5,185	21,734	45,998
Nov-95	2,058,809	283,222	1,507,826	5,579	262,182	582,878	473,830	927,495	5,182	21,625	47,799
Dec-95	2,060,592	283,446	1,508,671	5,581	262,894	581,521	472,422	932,859	5,152	21,544	47,094
Jan-96	2,049,193	282,881	1,499,040	5,522	261,750	576,486	468,278	931,810	5,144	21,427	46,048
Feb-96	2,065,333	283,081	1,511,916	5,572	264,764	579,279	470,046	942,875	5,238	21,662	46,233
Mar-96	2,064,652	282,918	1,510,674	5,560	265,500	577,336	467,225	947,223	5,288	21,715	45,865
Apr-96	2,055,810	283,131	1,501,188	5,540	265,951	575,348	463,743	944,390	5,303	21,652	45,374
May-96	2,043,000	283,787	1,485,670	5,553	267,990	572,471	458,578	936,552	5,205	21,623	48,571
Jun-96	2,045,291	284,632	1,486,939	5,529	268,191	574,146	457,970	938,769	5,273	21,639	47,494
Jul-96	2,009,402	285,738	1,448,337	5,545	269,782	566,615	451,672	917,336	5,139	21,183	47,457
Aug-96	2,003,814	286,623	1,440,574	5,571	271,046	565,712	452,018	912,563	5,147	21,195	47,179
State Average	2,045,894	283,624	1,491,855	5,559	264,857	576,319	465,282	930,717	5,199	21,548	46,829

[1] Category 5, Refugees, included.

Appendix B: FY 1996 Medicaid Eligibles by Major Program Type

(Based on eligibility as of 1st of month.)

Month	Major Program Types: 1 Money Grant	13 SSI	40 Preg. W.	44 Fed. Mand.	45 Newborn	48 1- 5/133%	All Others	Totals
Sep-95	671,672	401,206	73,330	182,095	94,324	268,711	344,441	2,035,779
Oct-95	680,568	401,409	74,728	188,874	95,656	273,356	344,466	2,059,057
Nov-95	676,125	404,384	73,853	192,141	95,159	272,937	344,210	2,058,809
Dec-95	671,481	404,795	72,360	196,056	94,355	274,487	347,058	2,060,592
Jan-96	665,468	402,652	68,974	198,379	92,811	273,832	347,077	2,049,193
Feb-96	665,966	405,902	68,658	203,385	94,954	277,202	349,266	2,065,333
Mar-96	659,360	406,321	70,326	206,684	96,036	277,839	348,086	2,064,652
Apr-96	650,708	406,540	71,304	208,311	96,286	276,869	345,792	2,055,810
May-96	639,387	408,445	71,490	209,462	95,575	274,672	343,969	2,043,000
Jun-96	632,503	408,024	74,019	212,929	97,511	275,987	344,318	2,045,291
Jul-96	612,098	409,412	72,350	210,530	95,947	268,939	340,126	2,009,402
Aug-96	608,972	410,516	72,237	211,974	96,055	266,936	337,124	2,003,814
State Average	652,859	405,801	71,969	201,735	95,389	273,481	344,661	2,045,894

Appendix C: FY 1996 Medicaid Eligibles by Age

(Based on eligibility as of 1st of month.)

Month	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Totals
Sep-95	150,123	508,875	486,101	139,529	342,937	124,449	127,309	94,594	61,862	2,035,779
Oct-95	152,957	513,864	495,074	141,919	345,837	125,238	127,420	94,684	62,064	2,059,057
Nov-95	152,697	512,440	496,624	141,479	344,108	126,287	128,026	94,780	62,368	2,058,809
Dec-95	152,253	513,325	499,304	141,150	342,136	127,074	128,240	94,661	62,449	2,060,592
Jan-96	149,542	511,044	500,223	139,420	337,340	126,841	127,693	94,558	62,532	2,049,193
Feb-96	152,515	513,836	506,115	140,488	339,460	127,937	128,233	94,617	62,132	2,065,333
Mar-96	155,000	511,347	505,989	140,627	338,562	128,311	128,345	94,511	61,960	2,064,652
Apr-96	155,043	507,537	504,034	139,991	335,916	128,241	128,413	94,614	62,021	2,055,810
May-96	154,429	501,088	501,385	138,909	332,571	128,898	128,941	94,818	61,961	2,043,000
Jun-96	155,414	500,274	502,505	139,188	332,089	129,282	129,374	95,192	61,973	2,045,291
Jul-96	151,172	488,042	494,046	134,905	324,725	128,910	129,803	95,592	62,207	2,009,402
Aug-96	148,750	484,463	494,645	134,103	323,980	129,354	130,301	95,903	62,315	2,003,814
State Average	152,491	505,511	498,837	139,309	336,638	127,569	128,508	94,877	62,154	2,045,894

Appendix D: FY 1996 Monthly Average Medicaid Eligibles by County, Eligibility Category

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Category: Total	1 Aged	2 AFDC [1]	3 Blind	4 Disabled	Total
1	ANDERSON	4,915	993	3,154	16	753	4,915
2	ANDREWS	1,674	173	1,322	3	176	1,674
3	ANGELINA	8,722	1,544	5,106	25	2,047	8,722
4	ARANSAS	2,917	437	1,979	7	494	2,917
5	ARCHER	438	81	287	-	70	438
6	ARMSTRONG	99	33	43	-	23	99
7	ATASCOSA	5,634	892	4,034	12	696	5,634
8	AUSTIN	1,688	454	995	6	233	1,688
9	BAILEY	1,062	170	808	1	83	1,062
10	BANDERA	832	111	601	1	120	832
11	BASTROP	4,052	736	2,640	13	663	4,052
12	BAYLOR	524	154	295	2	73	524
13	BEE	4,610	754	3,272	13	572	4,610
14	BELL	17,017	2,383	12,066	32	2,536	17,017
15	BEXAR	164,809	19,419	121,427	427	23,535	164,809
16	BLANCO	348	139	169	-	40	348
17	BORDEN	4	1	1	-	2	4
18	BOSQUE	1,530	434	895	3	198	1,530
19	BOWIE	10,142	1,859	6,277	43	1,964	10,142
20	BRAZORIA	16,086	1,709	12,398	39	1,939	16,086
21	BRAZOS	9,423	1,048	7,277	29	1,069	9,423
22	BREWSTER	828	170	572	1	85	828
23	BRISCOE	195	35	145	-	16	195
24	BROOKS	2,573	495	1,749	13	316	2,573
25	BROWN	4,489	987	2,680	15	808	4,489
26	BURLESON	1,784	355	1,126	8	295	1,784
27	BURNET	2,546	488	1,630	8	420	2,546
28	CALDWELL	3,792	892	2,328	15	558	3,792
29	CALHOUN	2,500	337	1,855	9	299	2,500
30	CALLAHAN	1,121	251	681	6	183	1,121
31	CAMERON	75,144	10,853	57,064	227	7,000	75,144
32	CAMP	1,145	195	866	-	83	1,145
33	CARSON	241	55	149	1	36	241
34	CASS	4,453	1,126	2,481	20	827	4,453
35	CASTRO	1,379	193	1,075	4	107	1,379
36	CHAMBERS	1,563	204	1,128	5	227	1,563
37	CHEROKEE	5,461	1,308	3,319	15	820	5,461
38	CHILDRESS	837	221	527	2	87	837
39	CLAY	551	146	313	-	92	551
40	COCHRAN	670	83	506	4	77	670
41	COKE	327	130	154	1	42	327
42	COLEMAN	1,462	378	899	5	181	1,462
43	COLLIN	9,594	1,633	6,539	21	1,401	9,594
44	COLLINSWORTH	520	124	336	2	59	520
45	COLORADO	2,105	516	1,303	10	276	2,105
46	COMAL	4,107	785	2,618	6	699	4,107
47	COMANCHE	1,638	477	944	4	213	1,638
48	CONCHO	302	110	140	2	51	302
49	COOKE	2,887	511	2,022	4	350	2,887
50	CORYELL	2,978	496	1,983	11	489	2,978
51	COTTLE	330	101	188	1	40	330
52	CRANE	417	41	329	1	46	417
53	CROCKETT	473	106	311	-	56	473
54	CROSBY	1,466	245	1,076	5	140	1,466
55	CULBERSON	595	122	406	2	64	595

Appendix D: FY 1996 Monthly Average Medicaid Eligibles by County, Eligibility Category
(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Category: Total	1 Aged	2 AFDC [1]	3 Blind	4 Disabled	Total
56	DALLAM	787	114	602	1	71	787
57	DALLAS	176,119	17,764	135,427	400	22,529	176,119
58	DAWSON	2,513	446	1,748	6	313	2,513
59	DEAF SMITH	3,164	408	2,440	7	309	3,164
60	DELTA	777	227	429	3	119	777
61	DENTON	11,662	1,342	7,900	32	2,387	11,662
62	DEWITT	3,219	913	1,772	8	527	3,219
63	DICKENS	300	107	156	-	37	300
64	DIMMIT	3,187	689	2,219	3	276	3,187
65	DONLEY	451	99	305	-	47	451
66	DUVAL	3,354	707	2,169	11	467	3,354
67	EASTLAND	2,189	610	1,200	8	371	2,189
68	ECTOR	16,814	1,767	13,241	38	1,769	16,814
69	EDWARDS	376	18	340	1	18	376
70	ELLIS	7,510	1,313	5,076	17	1,104	7,510
71	EL PASO	113,901	15,003	88,620	253	10,025	113,901
72	ERATH	2,735	548	1,798	8	381	2,735
73	FALLS	2,856	706	1,667	18	465	2,856
74	FANNIN	2,897	945	1,460	5	487	2,897
75	FAYETTE	1,824	700	850	5	269	1,824
76	FISHER	411	118	230	-	64	411
77	FLOYD	1,414	210	1,084	1	119	1,414
78	FOARD	243	74	142	2	26	243
79	FORT BEND	14,859	1,880	10,744	39	2,196	14,859
80	FRANKLIN	633	181	365	1	86	633
81	FREESTONE	1,738	431	1,083	6	218	1,738
82	FRIO	3,317	671	2,239	10	396	3,317
83	GAINES	1,558	182	1,212	3	161	1,558
84	GALVESTON	21,737	2,319	16,531	54	2,832	21,737
85	GARZA	699	129	479	1	90	699
86	GILLESPIE	1,384	511	508	9	356	1,384
87	GLASSCOCK	42	4	34	-	4	42
88	GOLIAD	876	172	598	5	101	876
89	GONZALES	2,882	543	1,976	5	358	2,882
90	GRAY	2,003	347	1,355	1	299	2,003
91	GRAYSON	9,350	2,007	5,920	23	1,401	9,350
92	GREGG	11,685	1,949	7,500	46	2,191	11,685
93	GRIMES	2,339	558	1,383	5	394	2,339
94	GUADALUPE	7,224	1,112	5,184	12	916	7,224
95	HALE	5,324	710	4,011	10	593	5,324
96	HALL	664	157	428	6	72	664
97	HAMILTON	808	301	409	1	97	808
98	HANSFORD	289	74	172	-	43	289
99	HARDEMAN	606	197	319	2	87	606
100	HARDIN	4,068	795	2,639	21	613	4,068
101	HARRIS	309,322	29,274	240,574	775	38,700	309,322
102	HARRISON	7,069	1,302	4,537	27	1,203	7,069
103	HARTLEY	34	3	24	-	7	34
104	HASKELL	838	251	486	1	100	838
105	HAYS	4,912	945	3,221	19	728	4,912
106	HEMPHILL	116	31	69	-	16	116
107	HENDERSON	7,088	1,486	4,399	26	1,177	7,088
108	HIDALGO	126,722	16,809	100,011	312	9,590	126,722
109	HILL	3,607	819	2,263	7	519	3,607
110	HOCKLEY	2,896	452	2,081	14	349	2,896

Appendix D: FY 1996 Monthly Average Medicaid Eligibles by County, Eligibility Category

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Category: Total	1 Aged	2 AFDC [1]	3 Blind	4 Disabled	Total
111	HOOD	2,158	415	1,417	5	322	2,158
112	HOPKINS	2,733	796	1,412	16	508	2,733
113	HOUSTON	3,662	960	1,969	17	717	3,662
114	HOWARD	4,079	619	2,819	10	631	4,079
115	HUDSPETH	374	75	251	2	46	374
116	HUNT	6,975	1,212	4,563	29	1,171	6,975
117	HUTCHINSON	1,757	236	1,249	4	269	1,757
118	IRION	135	19	102	-	15	135
119	JACK	649	117	442	1	88	649
120	JACKSON	1,594	400	963	1	230	1,594
121	JASPER	4,459	882	2,795	15	767	4,459
122	JEFF DAVIS	161	45	92	1	23	161
123	JEFFERSON	31,391	3,812	22,380	87	5,112	31,391
124	JIM HOGG	1,157	269	775	2	111	1,157
125	JIM WELLS	8,294	1,527	5,584	13	1,170	8,294
126	JOHNSON	8,840	1,304	6,163	24	1,349	8,840
127	JONES	1,989	486	1,208	4	290	1,989
128	KARNES	2,518	694	1,498	12	314	2,518
129	KAUFMAN	5,737	973	4,052	19	694	5,737
130	KENDALL	1,140	276	737	2	125	1,140
131	KENEDY	11	5	2	-	4	11
132	KENT	53	35	9	0	8	53
133	KERR	3,322	406	2,677	4	236	3,322
134	KIMBLE	438	130	252	-	57	438
135	KING	9	4	5	-	-	9
136	KINNEY	407	30	358	-	19	407
137	KLEBERG	5,347	630	4,151	9	557	5,347
138	KNOX	665	199	378	2	86	665
139	LAMAR	6,378	1,506	3,796	23	1,052	6,378
140	LAMB	2,298	463	1,561	7	267	2,298
141	LAMPASAS	1,727	368	1,140	5	214	1,727
142	LASALLE	1,292	277	858	6	151	1,292
143	LAVACA	1,865	723	913	2	227	1,865
144	LEE	995	321	502	1	171	995
145	LEON	1,526	443	838	7	237	1,526
146	LIBERTY	7,200	1,070	5,076	18	1,035	7,200
147	LIMESTONE	3,486	653	1,825	15	993	3,486
148	LIPSCOMB	126	33	74	-	18	126
149	LIVE OAK	1,233	280	771	5	177	1,233
150	LLANO	944	274	518	1	150	944
151	LOVING	2	-	2	-	-	2
152	LUBBOCK	26,884	2,970	19,998	85	3,830	26,884
153	LYNN	921	127	678	5	111	921
154	MADISON	1,284	296	819	3	167	1,284
155	MARION	1,703	371	1,054	8	270	1,703
156	MARTIN	574	107	418	0	49	574
157	MASON	356	122	192	-	42	356
158	MATAGORDA	4,737	753	3,425	13	545	4,737
159	MAVERICK	13,513	2,403	9,800	43	1,267	13,513
160	McCULLOCH	1,332	344	790	3	195	1,332
161	McLENNAN	23,389	3,591	16,173	49	3,576	23,389
162	McMULLEN	41	12	27	-	1	41
163	MEDINA	4,508	1,022	2,698	9	780	4,508
164	MENARD	355	111	204	-	40	355
165	MIDLAND	10,659	1,169	8,126	18	1,347	10,659

Appendix D: FY 1996 Monthly Average Medicaid Eligibles by County, Eligibility Category

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Category: Total	1 Aged	2 AFDC [1]	3 Blind	4 Disabled	Total
166	MILAM	3,327	795	2,112	7	413	3,327
167	MILLS	646	169	346	1	130	646
168	MITCHELL	988	256	588	4	141	988
169	MONTAGUE	1,838	532	986	7	313	1,838
170	MONTGOMERY	15,601	1,430	12,216	36	1,920	15,601
171	MOORE	1,345	228	1,001	5	112	1,345
172	MORRIS	1,683	414	1,026	6	237	1,683
173	MOTLEY	125	39	63	-	24	125
174	NACOGDOCHES	6,323	1,163	4,070	31	1,059	6,323
175	NAVARRO	5,464	1,116	3,283	19	1,046	5,464
176	NEWTON	1,951	351	1,237	4	358	1,951
177	NOLAN	2,386	452	1,578	8	348	2,386
178	NUECES	45,166	5,635	33,323	132	6,076	45,166
179	OCHILTREE	681	65	537	3	77	681
180	OLDHAM	80	15	50	-	15	80
181	ORANGE	9,190	967	6,810	24	1,388	9,190
182	PALO PINTO	3,095	548	2,100	13	434	3,095
183	PANOLA	2,312	522	1,364	4	422	2,312
184	PARKER	4,060	669	2,623	13	755	4,060
185	PARMER	856	163	589	2	103	856
186	PECOS	2,134	471	1,426	1	237	2,134
187	POLK	4,864	960	3,069	17	818	4,864
188	POTTER	16,543	1,712	12,629	27	2,175	16,543
189	PRESIDIO	1,763	504	1,090	5	165	1,763
190	RAINS	644	170	383	1	90	644
191	RANDALL	2,939	335	2,407	4	193	2,939
192	REAGAN	349	59	270	1	20	349
193	REAL	510	52	434	0	25	510
194	RED RIVER	2,131	722	1,011	4	395	2,131
195	REEVES	2,485	463	1,744	7	271	2,485
196	REFUGIO	1,161	233	791	8	129	1,161
197	ROBERTS	15	4	7	-	4	15
198	ROBERTSON	2,772	536	1,809	6	421	2,772
199	ROCKWALL	1,415	270	973	4	168	1,415
200	RUNNELS	1,378	358	840	7	174	1,378
201	RUSK	4,602	1,073	2,756	16	757	4,602
202	SABINE	1,305	371	697	7	231	1,305
203	SAN AUGUSTINE	1,430	426	656	16	332	1,430
204	SAN JACINTO	2,209	293	1,609	9	299	2,209
205	SAN PATRICIO	10,175	1,416	7,700	29	1,030	10,175
206	SAN SABA	763	250	410	-	103	763
207	SCHLEICHER	348	101	207	-	40	348
208	SCURRY	1,840	364	1,241	7	227	1,840
209	SHACKELFORD	282	87	165	2	29	282
210	SHELBY	3,545	942	1,942	16	645	3,545
211	SHERMAN	126	23	90	1	13	126
212	SMITH	15,675	2,736	10,415	64	2,459	15,675
213	SOMERVELL	635	127	440	1	67	635
214	STARR	16,591	2,421	12,874	44	1,252	16,591
215	STEPHENS	1,100	244	706	3	147	1,100
216	STERLING	89	31	42	-	16	89
217	STONEWALL	175	58	96	-	21	175
218	SUTTON	430	110	284	1	34	430
219	SWISHER	1,083	154	811	4	114	1,083
220	TARRANT	89,821	10,032	66,660	251	12,878	89,821

Appendix D: FY 1996 Monthly Average Medicaid Eligibles by County, Eligibility Category

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Category: Total	1 Aged	2 AFDC [1]	3 Blind	4 Disabled	Total
221	TAYLOR	12,824	1,703	8,617	35	2,470	12,824
222	TERRELL	107	33	60	2	12	107
223	TERRY	2,160	351	1,577	5	227	2,160
224	THROCKMORTON	156	57	76	1	22	156
225	TITUS	2,876	608	1,851	6	412	2,876
226	TOM GREEN	11,142	1,852	7,441	32	1,817	11,142
227	TRAVIS	47,636	5,465	33,865	264	8,042	47,636
228	TRINITY	1,374	235	1,017	4	118	1,374
229	TYLER	2,146	483	1,248	8	407	2,146
230	UPSHUR	3,492	751	2,186	7	548	3,492
231	UPTON	422	57	315	-	50	422
232	UVALDE	5,193	925	3,621	19	627	5,193
233	VAL VERDE	8,410	1,688	5,882	23	816	8,410
234	VAN ZANDT	3,930	989	2,293	10	638	3,930
235	VICTORIA	9,565	1,297	6,841	27	1,401	9,565
236	WALKER	3,985	634	2,837	18	496	3,985
237	WALLER	3,398	412	2,610	4	372	3,398
238	WARD	1,530	225	1,128	1	176	1,530
239	WASHINGTON	3,196	692	1,638	4	862	3,196
240	WEBB	38,702	5,767	29,720	95	3,121	38,702
241	WHARTON	4,643	1,001	2,958	13	671	4,643
242	WHEELER	576	195	313	-	69	576
243	WICHITA	11,712	1,964	7,744	32	1,972	11,712
244	WILBARGER	1,734	462	1,024	6	242	1,734
245	WILLACY	5,827	1,026	4,203	19	579	5,827
246	WILLIAMSON	7,914	1,637	5,073	21	1,184	7,914
247	WILSON	3,218	800	1,866	15	538	3,218
248	WINKLER	942	164	667	0	111	942
249	WISE	2,514	489	1,671	4	351	2,514
250	WOOD	3,340	933	1,856	14	537	3,340
251	YOAKUM	701	76	557	2	66	701
252	YOUNG	1,885	448	1,101	4	332	1,885
253	ZAPATA	2,473	389	1,878	6	200	2,473
254	ZAVALA	3,915	684	2,850	15	365	3,915
	COUNTY UNKN.	47	13	-	1	33	47
	STATE TOTALS	2,045,894	283,624	1,491,855	5,559	264,857	2,045,894

[1] Includes Category 5

Appendix E: FY 1996 Monthly Average Medicaid Eligibles by County, Age

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Total
1	ANDERSON	351	1,052	1,029	314	816	355	347	370	281	4,915
2	ANDREWS	139	435	442	116	255	112	75	66	34	1,674
3	ANGELINA	571	1,739	1,758	563	1,714	826	581	573	397	8,722
4	ARANSAS	150	581	732	196	542	276	216	125	99	2,917
5	ARCHER	38	97	95	29	65	34	28	31	22	438
6	ARMSTRONG	7	12	19	4	16	7	8	18	8	99
7	ATASCOSA	335	1,181	1,462	412	917	430	392	323	182	5,634
8	AUSTIN	122	326	351	98	220	114	145	156	157	1,688
9	BAILEY	86	306	262	66	118	54	86	45	39	1,062
10	BANDERA	57	185	222	56	146	55	45	38	27	832
11	BASTROP	267	829	959	283	638	336	278	257	206	4,052
12	BAYLOR	20	91	113	27	72	47	56	57	41	524
13	BEE	253	985	1,162	352	765	335	336	263	160	4,610
14	BELL	1,198	4,167	4,105	1,180	3,019	951	893	860	645	17,017
15	BEXAR	11,178	40,790	43,284	11,045	28,829	10,145	9,208	6,468	3,861	164,809
16	BLANCO	18	62	61	8	37	22	35	49	56	348
17	BORDEN	-	1	2	-	-	-	1	0	-	4
18	BOSQUE	88	248	370	83	196	109	103	169	165	1,530
19	BOWIE	629	2,035	2,214	806	1,768	815	670	681	523	10,142
20	BRAZORIA	1,502	4,278	3,810	1,226	2,695	858	745	560	411	16,086
21	BRAZOS	751	2,478	2,496	665	1,561	415	378	372	307	9,423
22	BREWSTER	61	197	176	47	128	49	90	48	32	828
23	BRISCOE	11	36	60	14	26	14	15	16	4	195
24	BROOKS	129	530	619	165	424	206	235	188	76	2,573
25	BROWN	320	774	932	274	787	415	339	354	296	4,489
26	BURLESON	98	314	455	136	275	149	140	110	109	1,784
27	BURNET	202	531	532	152	431	209	166	165	159	2,546
28	CALDWELL	230	669	866	271	555	302	360	312	227	3,792
29	CALHOUN	186	631	590	189	419	148	149	125	64	2,500
30	CALLAHAN	65	210	258	71	173	91	71	97	85	1,121
31	CAMERON	5,176	19,794	19,175	5,099	10,481	4,479	6,321	3,237	1,384	75,144
32	CAMP	85	299	268	84	163	50	56	68	72	1,145
33	CARSON	23	49	39	18	37	19	15	19	21	241
34	CASS	231	728	885	305	748	419	349	438	349	4,453
35	CASTRO	95	343	381	116	185	66	100	59	35	1,379
36	CHAMBERS	119	349	355	134	288	113	106	64	35	1,563
37	CHEROKEE	357	1,149	1,115	307	782	436	416	491	411	5,461
38	CHILDRESS	46	157	174	66	110	62	73	84	65	837
39	CLAY	38	107	101	27	84	49	48	54	44	551
40	COCHRAN	40	141	189	49	104	62	36	39	10	670
41	COKE	15	49	61	17	28	26	29	49	52	327
42	COLEMAN	82	286	307	90	202	115	132	131	118	1,462
43	COLLIN	876	2,240	1,985	671	1,620	564	627	551	461	9,594
44	COLLINSWORTH	25	93	136	36	68	39	39	48	38	520
45	COLORADO	115	402	481	132	297	160	157	189	174	2,105
46	COMAL	330	895	812	291	742	250	269	274	244	4,107
47	COMANCHE	103	313	331	73	194	145	145	180	154	1,638
48	CONCHO	14	46	52	17	31	31	46	36	29	302
49	COOKE	209	665	673	173	494	161	158	188	166	2,887
50	CORYELL	218	678	706	198	497	183	150	172	177	2,978
51	COTTLE	13	59	67	17	39	32	38	35	29	330
52	CRANE	48	95	107	39	65	23	19	13	9	417
53	CROCKETT	43	104	100	33	60	27	47	40	19	473
54	CROSBY	70	331	403	110	203	101	97	84	66	1,466
55	CULBERSON	48	132	158	30	61	41	65	38	22	595

Appendix E: FY 1996 Monthly Average Medicaid Eligibles by County, Age

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Total
56	DALLAM	81	226	173	47	110	37	50	27	37	787
57	DALLAS	15,689	46,037	43,067	12,434	31,272	9,731	8,448	5,650	3,792	176,119
58	DAWSON	162	533	621	184	354	210	215	147	88	2,513
59	DEAF SMITH	251	807	791	248	480	175	201	125	87	3,164
60	DELTA	39	128	130	55	130	67	63	99	65	777
61	DENTON	1,145	2,693	2,331	719	2,618	805	481	458	413	11,662
62	DEWITT	128	554	658	191	469	305	302	351	262	3,219
63	DICKENS	17	44	54	17	33	29	38	41	29	300
64	DIMMIT	131	653	783	219	486	224	350	244	97	3,187
65	DONLEY	26	113	89	32	63	29	35	35	29	451
66	DUVAL	180	654	805	222	513	269	297	284	130	3,354
67	EASTLAND	132	393	410	116	322	204	179	237	198	2,189
68	ECTOR	1,341	4,377	4,342	1,230	2,746	1,001	894	556	328	16,814
69	EDWARDS	27	110	129	28	43	22	9	7	2	376
70	ELLIS	630	1,662	1,683	567	1,185	461	467	455	400	7,510
71	EL PASO	8,649	31,377	28,905	7,048	17,046	5,779	8,857	4,402	1,837	113,901
72	ERATH	230	593	604	146	434	178	151	191	208	2,735
73	FALLS	142	566	585	174	430	245	257	245	212	2,856
74	FANNIN	147	425	529	167	424	257	266	359	324	2,897
75	FAYETTE	105	296	266	84	221	149	175	268	260	1,824
76	FISHER	30	83	66	18	60	37	34	48	36	411
77	FLOYD	93	368	391	92	183	76	88	65	58	1,414
78	FOARD	12	46	69	11	20	11	16	28	30	243
79	FORT BEND	1,140	3,580	3,592	1,100	2,767	784	913	625	359	14,859
80	FRANKLIN	42	135	127	30	86	32	46	62	75	633
81	FREESTONE	98	325	386	111	265	117	123	166	147	1,738
82	FRIO	177	743	791	219	465	248	332	218	125	3,317
83	GAINES	177	391	418	99	195	95	95	53	35	1,558
84	GALVESTON	1,556	5,365	5,266	1,817	4,123	1,266	1,121	777	446	21,737
85	GARZA	47	152	173	44	88	65	47	47	36	699
86	GILLESPIE	99	195	157	63	213	144	158	162	193	1,384
87	GLASSCOCK	5	12	11	4	6	-	2	2	-	42
88	GOLIAD	41	174	223	54	132	78	61	58	55	876
89	GONZALES	151	639	716	205	421	203	207	202	137	2,882
90	GRAY	152	465	430	134	323	152	95	133	119	2,003
91	GRAYSON	599	1,939	1,950	570	1,563	712	588	778	652	9,350
92	GREGG	843	2,494	2,490	892	2,124	875	698	689	582	11,685
93	GRIMES	132	426	485	174	371	194	209	196	153	2,339
94	GUADALUPE	550	1,703	1,783	466	1,163	439	422	404	295	7,224
95	HALE	378	1,336	1,386	374	789	345	316	241	159	5,324
96	HALL	42	124	143	50	99	45	66	56	40	664
97	HAMILTON	50	124	149	45	90	48	62	122	117	808
98	HANSFORD	26	62	68	15	25	18	27	20	27	289
99	HARDEMAN	46	98	109	33	69	50	73	71	55	606
100	HARDIN	310	822	845	315	648	329	295	289	217	4,068
101	HARRIS	25,313	86,308	78,338	21,095	52,688	16,096	15,362	9,235	4,889	309,322
102	HARRISON	411	1,402	1,583	543	1,228	593	506	462	342	7,069
103	HARTLEY	4	7	11	1	6	3	2	1	-	34
104	HASKELL	38	136	183	51	108	70	91	91	71	838
105	HAYS	381	1,053	1,058	359	787	325	365	342	242	4,912
106	HEMPHILL	13	24	25	3	14	7	8	6	17	116
107	HENDERSON	478	1,341	1,519	449	1,222	582	573	537	387	7,088
108	HIDALGO	9,142	35,144	33,100	8,205	16,747	7,438	10,100	4,834	2,012	126,722
109	HILL	212	691	824	215	540	303	257	310	257	3,607
110	HOCKLEY	203	596	756	239	460	189	188	159	107	2,896

Appendix E: FY 1996 Monthly Average Medicaid Eligibles by County, Age

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Total
111	HOOD	177	422	500	118	384	141	128	138	151	2,158
112	HOPKINS	215	474	439	151	409	245	234	305	262	2,733
113	HOUSTON	133	606	784	231	589	352	356	343	268	3,662
114	HOWARD	260	873	1,012	285	714	313	281	203	139	4,079
115	HUDSPETH	21	74	98	27	46	33	49	14	12	374
116	HUNT	493	1,423	1,542	478	1,284	538	412	461	344	6,975
117	HUTCHINSON	159	411	402	134	298	115	84	91	64	1,757
118	IRION	9	34	38	11	18	7	9	6	3	135
119	JACK	36	124	167	39	112	51	43	37	39	649
120	JACKSON	100	281	348	92	243	129	151	148	101	1,594
121	JASPER	296	824	944	350	764	392	331	321	237	4,459
122	JEFF DAVIS	8	17	35	25	16	14	22	13	11	161
123	JEFFERSON	1,981	7,125	7,745	2,427	6,050	2,221	1,570	1,325	947	31,391
124	JIM HOGG	72	252	280	63	152	69	108	109	52	1,157
125	JIM WELLS	420	1,651	2,036	594	1,372	686	733	526	277	8,294
126	JOHNSON	705	1,860	2,127	645	1,607	581	455	463	397	8,840
127	JONES	116	379	444	106	278	179	164	181	142	1,989
128	KARNES	113	422	592	156	341	191	280	260	163	2,518
129	KAUFMAN	406	1,323	1,330	389	949	360	317	376	286	5,737
130	KENDALL	84	241	249	82	148	59	63	90	124	1,140
131	KENEDY	-	2	-	-	2	2	3	2	-	11
132	KENT	0	2	9	1	3	3	2	14	20	53
133	KERR	291	876	855	262	484	145	141	147	120	3,322
134	KIMBLE	34	79	85	29	46	36	50	46	33	438
135	KING	0	2	3	-	0	-	1	2	1	9
136	KINNEY	31	122	115	23	74	13	17	8	6	407
137	KLEBERG	331	1,218	1,460	364	1,036	306	305	208	119	5,347
138	KNOX	35	115	147	35	82	51	65	68	67	665
139	LAMAR	415	1,289	1,210	413	1,018	521	455	595	462	6,378
140	LAMB	123	490	585	167	301	166	194	161	112	2,298
141	LAMPASAS	111	346	422	120	264	95	113	119	137	1,727
142	LASALLE	65	263	323	90	167	107	130	97	50	1,292
143	LAVACA	106	298	307	80	219	131	163	303	259	1,865
144	LEE	78	151	166	68	130	81	94	108	119	995
145	LEON	74	255	287	86	252	125	152	174	121	1,526
146	LIBERTY	485	1,529	1,676	589	1,319	524	460	401	217	7,200
147	LIMESTONE	151	608	648	202	743	473	219	245	196	3,486
148	LIPSCOMB	12	26	22	8	9	14	10	11	13	126
149	LIVE OAK	74	231	295	75	156	120	125	91	66	1,233
150	LLANO	62	179	164	50	134	80	67	113	95	944
151	LOVING	-	2	1	-	-	-	-	-	-	2
152	LUBBOCK	1,926	6,521	6,735	2,060	4,959	1,695	1,366	968	653	26,884
153	LYNN	46	191	289	63	133	70	69	40	20	921
154	MADISON	85	243	280	94	198	86	87	118	93	1,284
155	MARION	78	285	384	132	272	177	131	147	98	1,703
156	MARTIN	42	127	165	35	71	28	40	39	28	574
157	MASON	21	59	79	13	39	24	39	45	38	356
158	MATAGORDA	313	1,051	1,233	331	742	310	326	254	178	4,737
159	MAVERICK	863	3,306	3,384	762	1,875	904	1,446	712	261	13,513
160	McCULLOCH	84	231	284	86	179	123	121	119	106	1,332
161	McLENNAN	1,537	5,505	5,565	1,682	3,828	1,659	1,308	1,272	1,034	23,389
162	McMULLEN	1	8	12	1	5	3	4	5	3	41
163	MEDINA	223	874	1,013	273	683	415	450	340	237	4,508
164	MENARD	18	63	84	12	36	30	45	34	32	355
165	MIDLAND	924	2,785	2,639	763	1,719	656	553	387	235	10,659

Appendix E: FY 1996 Monthly Average Medicaid Eligibles by County, Age

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Total
166	MILAM	193	689	718	240	479	208	245	292	263	3,327
167	MILLS	27	87	147	55	68	90	49	67	54	646
168	MITCHELL	53	180	210	57	138	94	90	91	77	988
169	MONTAGUE	115	313	343	116	257	161	139	202	192	1,838
170	MONTGOMERY	1,404	4,152	3,811	1,137	2,771	883	609	479	356	15,601
171	MOORE	193	371	258	93	145	58	79	81	68	1,345
172	MORRIS	95	297	368	121	255	129	130	170	119	1,683
173	MOTLEY	1	16	35	7	18	10	18	14	7	125
174	NACOGDOCHES	428	1,429	1,320	451	1,030	491	394	447	332	6,323
175	NAVARRO	349	1,094	1,158	359	907	472	358	403	364	5,464
176	NEWTON	130	339	426	159	356	189	172	113	68	1,951
177	NOLAN	149	471	534	185	422	172	168	143	144	2,386
178	NUECES	2,985	10,633	11,060	3,457	8,439	2,910	2,657	1,921	1,104	45,166
179	OCHILTREE	76	192	172	43	98	35	29	20	17	681
180	OLDHAM	5	18	23	3	11	5	7	6	2	80
181	ORANGE	696	2,121	2,206	712	1,827	656	426	329	217	9,190
182	PALO PINTO	189	703	733	202	490	226	226	184	143	3,095
183	PANOLA	139	415	457	171	370	234	167	214	144	2,312
184	PARKER	342	865	931	252	697	302	234	250	189	4,060
185	PARMER	84	214	192	47	106	50	66	51	47	856
186	PECOS	145	464	471	159	257	168	204	176	92	2,134
187	POLK	312	914	1,056	350	849	416	371	344	252	4,864
188	POTTER	1,379	4,249	4,205	1,192	2,844	956	747	544	427	16,543
189	PRESIDIO	103	359	395	99	163	137	292	154	61	1,763
190	RAINS	46	120	121	46	92	49	55	69	46	644
191	RANDALL	326	778	681	230	508	80	90	133	113	2,939
192	REAGAN	41	84	77	24	55	10	22	27	11	349
193	REAL	36	139	135	43	82	22	13	22	17	510
194	RED RIVER	94	340	319	121	315	218	232	272	219	2,131
195	REEVES	164	585	617	154	329	170	231	179	56	2,485
196	REFUGIO	60	243	271	95	160	97	94	91	50	1,161
197	ROBERTS	1	2	4	-	2	3	2	2	-	15
198	ROBERTSON	138	621	612	204	445	211	200	192	149	2,772
199	ROCKWALL	120	319	307	95	226	77	73	101	98	1,415
200	RUNNELS	81	266	303	88	184	96	127	123	111	1,378
201	RUSK	288	904	893	362	678	398	392	385	303	4,602
202	SABINE	71	196	249	77	222	119	142	135	96	1,305
203	SAN AUGUSTINE	66	166	259	100	235	168	141	167	129	1,430
204	SAN JACINTO	115	453	582	152	427	184	128	116	53	2,209
205	SAN PATRICIO	678	2,315	2,732	745	1,597	679	725	432	273	10,175
206	SAN SABA	45	112	157	49	92	59	82	95	73	763
207	SCHLEICHER	23	68	83	20	34	20	46	34	21	348
208	SCURRY	131	418	421	113	260	130	129	126	112	1,840
209	SHACKELFORD	16	52	58	16	36	17	20	29	39	282
210	SHELBY	176	594	681	217	568	361	312	353	283	3,545
211	SHERMAN	14	39	20	11	14	6	7	7	9	126
212	SMITH	1,191	3,584	3,501	983	2,606	1,056	988	966	799	15,675
213	SOMERVELL	56	133	141	43	95	40	30	48	50	635
214	STARR	1,147	4,195	4,228	1,051	2,443	1,092	1,414	785	236	16,591
215	STEPHENS	87	224	227	65	158	94	91	89	65	1,100
216	STERLING	6	14	12	5	12	9	15	6	10	89
217	STONEWALL	7	28	37	7	21	17	18	18	23	175
218	SUTTON	39	92	90	20	56	23	56	29	26	430
219	SWISHER	70	241	322	90	133	70	69	53	34	1,083
220	TARRANT	7,459	22,501	22,324	6,025	16,058	5,344	4,174	3,334	2,601	89,821

Appendix E: FY 1996 Monthly Average Medicaid Eligibles by County, Age

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Age: 0	1 - 5	6 - 14	15 - 20	21 - 44	45 - 64	65 - 74	75 - 84	85+	Total
221	TAYLOR	923	2,952	2,995	852	2,453	938	670	578	462	12,824
222	TERRELL	5	16	25	4	16	7	11	10	11	107
223	TERRY	135	480	581	169	296	148	155	103	93	2,160
224	THROCKMORTON	14	27	23	7	18	10	16	18	23	156
225	TITUS	291	729	517	159	369	203	193	219	196	2,876
226	TOM GREEN	776	2,473	2,616	716	1,774	920	767	664	436	11,142
227	TRAVIS	3,964	11,640	11,141	3,392	8,887	3,090	2,497	1,880	1,146	47,636
228	TRINITY	84	265	378	109	223	77	68	94	74	1,374
229	TYLER	144	370	443	148	343	212	189	170	128	2,146
230	UPSHUR	213	681	722	260	561	301	219	292	244	3,492
231	UPTON	23	88	118	42	71	24	22	20	15	422
232	UVALDE	328	1,246	1,280	316	702	390	468	285	178	5,193
233	VAL VERDE	518	1,947	2,118	505	1,080	545	944	541	213	8,410
234	VAN ZANDT	259	666	778	238	667	330	297	378	317	3,930
235	VICTORIA	743	2,287	2,252	719	1,614	643	548	438	321	9,565
236	WALKER	288	827	935	325	699	272	248	222	170	3,985
237	WALLER	285	862	878	229	565	168	134	159	119	3,398
238	WARD	113	324	396	109	245	116	98	79	49	1,530
239	WASHINGTON	142	502	594	201	785	276	218	240	238	3,196
240	WEBB	3,204	11,426	9,791	2,132	4,596	1,739	3,244	1,718	852	38,702
241	WHARTON	285	957	1,044	305	698	350	385	326	293	4,643
242	WHEELER	37	106	104	31	70	34	60	82	54	576
243	WICHITA	864	2,596	2,494	829	2,065	890	744	710	522	11,712
244	WILBARGER	119	362	356	89	212	132	161	167	137	1,734
245	WILLACY	311	1,382	1,471	394	835	399	590	308	137	5,827
246	WILLIAMSON	678	1,695	1,665	530	1,210	494	505	648	490	7,914
247	WILSON	169	584	679	210	491	279	276	312	219	3,218
248	WINKLER	76	205	222	60	145	71	74	47	43	942
249	WISE	205	539	580	155	378	167	141	188	161	2,514
250	WOOD	211	623	603	186	492	287	284	365	290	3,340
251	YOAKUM	74	158	192	60	97	43	31	28	18	701
252	YOUNG	122	318	402	116	304	172	141	161	149	1,885
253	ZAPATA	156	670	671	151	307	126	207	129	56	2,473
254	ZAVALA	191	932	982	275	612	229	358	246	91	3,915
	COUNTY UNKN.	-	2	5	3	15	9	8	5	0	47
	STATE TOTALS	152,491	505,511	498,837	139,309	336,638	127,569	128,508	94,877	62,154	2,045,894

Appendix F: FY 1996 Monthly Average Medicaid Eligibles by County, Race

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Ethnicity: 1 White	2 Black	3 Hispanic	4 Amer. Ind.	5 Asian	6 Unknown
1	ANDERSON	2,454	1,886	453	10	1	112
2	ANDREWS	641	56	946	4	1	25
3	ANGELINA	4,786	2,725	991	11	5	204
4	ARANSAS	1,581	97	978	7	178	76
5	ARCHER	386	1	40	1	-	9
6	ARMSTRONG	92	1	3	-	-	4
7	ATASCOSA	1,532	24	3,972	4	6	96
8	AUSTIN	649	664	329	0	-	46
9	BAILEY	252	26	755	-	-	28
10	BANDERA	644	7	148	2	2	29
11	BASTROP	1,734	1,212	979	12	5	110
12	BAYLOR	355	57	97	-	-	16
13	BEE	951	139	3,432	5	-	83
14	BELL	7,310	5,832	3,097	48	220	510
15	BEXAR	29,387	17,201	113,334	217	528	4,143
16	BLANCO	233	3	100	-	-	13
17	BORDEN	3	1	-	-	-	-
18	BOSQUE	1,192	83	225	2	-	28
19	BOWIE	4,488	5,276	112	19	11	236
20	BRAZORIA	7,762	2,804	5,022	61	116	321
21	BRAZOS	2,654	3,995	2,525	47	48	154
22	BREWSTER	267	16	526	2	2	15
23	BRISCOE	85	16	85	0	-	8
24	BROOKS	288	2	2,257	2	1	22
25	BROWN	3,275	350	746	10	5	104
26	BURLESON	712	794	223	4	-	52
27	BURNET	1,791	108	570	10	2	66
28	CALDWELL	1,289	603	1,786	8	2	105
29	CALHOUN	827	144	1,428	2	57	42
30	CALLAHAN	973	7	97	6	5	33
31	CAMERON	6,293	153	67,085	35	27	1,551
32	CAMP	473	520	142	1	-	9
33	CARSON	213	1	21	-	-	6
34	CASS	2,381	1,912	32	5	3	120
35	CASTRO	205	69	1,084	1	-	21
36	CHAMBERS	813	544	160	3	5	38
37	CHEROKEE	2,931	1,824	585	14	2	106
38	CHILDRESS	419	114	279	2	0	23
39	CLAY	507	2	24	2	0	17
40	COCHRAN	129	73	454	0	0	13
41	COKE	229	0	87	-	-	11
42	COLEMAN	1,128	71	223	5	-	35
43	COLLIN	5,336	1,641	2,055	50	127	384
44	COLLINSWORTH	226	83	189	3	-	20
45	COLORADO	689	836	525	1	3	51
46	COMAL	2,212	94	1,677	8	4	112
47	COMANCHE	1,044	3	536	2	-	53
48	CONCHO	163	3	127	0	-	10
49	COOKE	2,313	219	281	15	3	57
50	CORYELL	1,963	629	260	13	28	86
51	COTTLE	135	90	99	0	-	6
52	CRANE	141	28	244	0	-	4
53	CROCKETT	107	7	343	3	-	14

Appendix F: FY 1996 Monthly Average Medicaid Eligibles by County, Race

(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Ethnicity: 1 White	2 Black	3 Hispanic	4 Amer. Ind.	5 Asian	6 Unknown
54	CROSBY	308	128	1,011	0	1	18
55	CULBERSON	86	3	491	1	-	14
56	DALLAM	476	35	257	2	2	16
57	DALLAS	39,100	80,517	47,132	665	4,178	4,526
58	DAWSON	528	186	1,741	2	2	54
59	DEAF SMITH	614	110	2,378	1	-	61
60	DELTA	560	188	11	3	1	15
61	DENTON	7,650	1,658	1,806	66	170	313
62	DEWITT	1,135	666	1,307	1	-	111
63	DICKENS	151	30	109	1	0	10
64	DIMMIT	381	27	2,743	0	-	36
65	DONLEY	301	93	46	-	-	12
66	DUVAL	467	6	2,829	3	-	50
67	EASTLAND	1,851	65	201	2	2	68
68	ECTOR	5,573	1,557	9,328	21	22	313
69	EDWARDS	73	-	303	-	-	-
70	ELLIS	3,306	2,188	1,810	16	4	187
71	EL PASO	11,607	2,504	96,545	158	139	2,948
72	ERATH	1,984	54	641	4	1	52
73	FALLS	842	1,566	380	2	1	64
74	FANNIN	2,180	558	63	13	5	78
75	FAYETTE	958	486	314	3	1	62
76	FISHER	204	54	139	-	-	15
77	FLOYD	276	112	1,008	1	1	17
78	FOARD	144	15	80	-	-	4
79	FORT BEND	2,874	4,832	6,091	49	409	605
80	FRANKLIN	476	98	42	4	2	11
81	FREESTONE	879	711	101	6	2	39
82	FRIO	453	8	2,803	1	0	52
83	GAINES	602	45	876	3	1	30
84	GALVESTON	7,733	9,042	4,164	66	347	386
85	GARZA	236	108	337	1	-	17
86	GILLESPIE	863	18	408	4	-	91
87	GLASSCOCK	11	-	29	-	-	2
88	GOLIAD	198	129	533	0	0	16
89	GONZALES	797	564	1,456	1	1	63
90	GRAY	1,397	195	337	25	0	49
91	GRAYSON	6,975	1,596	493	69	20	198
92	GREGG	5,608	5,082	658	27	11	299
93	GRIMES	835	1,128	301	3	3	70
94	GUADALUPE	2,643	842	3,572	6	16	145
95	HALE	1,252	524	3,454	3	1	91
96	HALL	241	139	269	1	-	13
97	HAMILTON	692	0	87	0	-	30
98	HANSFORD	154	-	121	-	-	14
99	HARDEMAN	363	121	111	3	-	8
100	HARDIN	3,007	960	32	2	-	68
101	HARRIS	53,071	128,127	110,488	1,245	9,191	7,200
102	HARRISON	2,455	4,147	271	24	3	169
103	HARTLEY	19	5	9	-	-	1
104	HASKELL	403	66	348	2	1	18
105	HAYS	1,873	317	2,559	8	12	143
106	HEMPHILL	86	-	26	1	-	4

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(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Ethnicity: 1 White	2 Black	3 Hispanic	4 Amer. Ind.	5 Asian	6 Unknown
107	HENDERSON	5,262	1,215	411	23	13	164
108	HIDALGO	8,072	155	116,185	71	46	2,192
109	HILL	2,192	858	482	6	1	69
110	HOCKLEY	959	238	1,636	7	1	57
111	HOOD	1,861	59	178	12	3	45
112	HOPKINS	1,917	518	188	3	3	103
113	HOUSTON	1,306	2,112	133	6	1	105
114	HOWARD	1,747	295	1,910	13	3	111
115	HUDSPETH	73	0	286	0	-	16
116	HUNT	4,439	1,918	427	19	18	153
117	HUTCHINSON	1,185	144	382	7	1	38
118	IRION	57	2	73	-	-	3
119	JACK	557	12	70	1	-	9
120	JACKSON	587	374	584	-	1	48
121	JASPER	2,483	1,800	85	7	3	80
122	JEFF DAVIS	74	4	75	0	-	8
123	JEFFERSON	7,749	19,855	1,806	50	1,402	529
124	JIM HOGG	140	-	992	1	-	24
125	JIM WELLS	1,330	54	6,776	11	0	122
126	JOHNSON	6,887	591	1,107	24	39	192
127	JONES	1,164	212	554	6	4	49
128	KARNES	665	104	1,685	2	-	61
129	KAUFMAN	3,166	1,951	520	11	6	83
130	KENDALL	638	16	449	1	-	36
131	KENEDY	3	-	6	-	-	1
132	KENT	41	4	4	-	-	4
133	KERR	1,968	166	1,151	2	5	30
134	KIMBLE	277	-	142	4	3	12
135	KING	2	-	6	-	-	1
136	KINNEY	61	12	330	2	-	1
137	KLEBERG	766	274	4,224	1	7	76
138	KNOX	248	130	267	-	-	20
139	LAMAR	4,047	2,076	67	51	5	130
140	LAMB	553	244	1,429	2	0	70
141	LAMPASAS	1,155	86	433	3	2	48
142	LASALLE	162	0	1,109	3	-	18
143	LAVACA	1,054	421	334	1	1	54
144	LEE	451	329	175	-	-	39
145	LEON	802	585	107	3	0	29
146	LIBERTY	4,744	1,772	556	10	4	114
147	LIMESTONE	1,778	1,304	321	3	1	79
148	LIPSCOMB	82	1	37	-	-	6
149	LIVE OAK	492	5	699	-	1	36
150	LLANO	815	7	92	1	2	26
151	LOVING	2	-	-	-	-	-
152	LUBBOCK	8,254	5,334	12,650	83	68	495
153	LYNN	201	59	641	-	-	20
154	MADISON	624	540	95	1	-	24
155	MARION	675	972	12	5	-	39
156	MARTIN	156	32	371	1	0	14
157	MASON	210	2	129	-	-	15
158	MATAGORDA	1,364	1,371	1,785	9	100	108
159	MAVERICK	1,040	16	11,774	230	14	439

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(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Ethnicity: 1 White	2 Black	3 Hispanic	4 Amer. Ind.	5 Asian	6 Unknown
160	McCULLOCH	799	38	452	4	1	38
161	McLENNAN	8,702	9,273	4,879	37	48	450
162	McMULLEN	12	-	28	-	-	-
163	MEDINA	1,499	33	2,801	3	7	165
164	MENARD	167	4	170	2	-	12
165	MIDLAND	3,275	2,197	4,882	37	28	240
166	MILAM	1,514	922	810	2	0	79
167	MILLS	480	13	121	-	-	32
168	MITCHELL	485	95	375	2	1	30
169	MONTAGUE	1,690	5	86	7	0	50
170	MONTGOMERY	10,624	2,213	2,434	25	59	245
171	MOORE	525	3	767	4	12	33
172	MORRIS	736	875	35	2	0	34
173	MOTLEY	63	14	43	-	-	4
174	NACOGDOCHES	2,853	2,605	704	16	6	138
175	NAVARRO	2,581	2,218	508	8	14	135
176	NEWTON	1,022	874	16	3	1	34
177	NOLAN	1,157	249	925	5	-	51
178	NUECES	9,561	3,152	31,422	64	90	877
179	OCHILTREE	408	1	252	7	-	13
180	OLDHAM	62	1	15	-	-	2
181	ORANGE	6,497	2,306	153	20	85	130
182	PALO PINTO	2,425	129	471	5	1	65
183	PANOLA	1,127	1,053	70	3	4	55
184	PARKER	3,535	78	315	16	4	112
185	PARMER	261	13	554	1	-	28
186	PECOS	423	21	1,638	7	1	45
187	POLK	3,158	1,238	286	74	4	105
188	POTTER	7,921	3,010	5,035	98	160	318
189	PRESIDIO	225	2	1,473	0	-	63
190	RAINS	544	53	28	3	3	14
191	RANDALL	2,283	137	482	12	10	16
192	REAGAN	110	28	206	0	-	6
193	REAL	328	1	179	2	-	0
194	RED RIVER	1,215	783	56	4	-	74
195	REEVES	296	75	2,055	5	1	53
196	REFUGIO	310	211	619	0	-	21
197	ROBERTS	9	-	3	1	-	1
198	ROBERTSON	788	1,632	302	3	-	48
199	ROCKWALL	992	180	196	8	2	37
200	RUNNELS	774	50	518	0	-	35
201	RUSK	2,174	2,008	273	13	1	132
202	SABINE	952	313	9	1	1	30
203	SAN AUGUSTINE	643	720	24	1	-	43
204	SAN JACINTO	1,410	703	46	3	2	46
205	SAN PATRICIO	2,607	264	7,182	16	8	98
206	SAN SABA	538	8	194	-	-	24
207	SCHLEICHER	102	3	228	2	-	15
208	SCURRY	802	165	810	6	3	54
209	SHACKELFORD	225	4	49	-	-	5
210	SHELBY	1,830	1,495	120	5	2	94
211	SHERMAN	74	-	47	1	-	3
212	SMITH	6,450	6,836	1,996	35	31	326

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(Based on Eligibility as of 1st of the Month)

TDHS Cty Code	County Name	Ethnicity: 1 White	2 Black	3 Hispanic	4 Amer. Ind.	5 Asian	6 Unknown
213	SOMERVELL	466	2	152	3	1	11
214	STARR	934	7	15,433	3	-	214
215	STEPHENS	813	53	205	1	-	28
216	STERLING	46	-	38	-	1	4
217	STONEWALL	115	36	21	-	-	4
218	SUTTON	107	1	304	2	-	14
219	SWISHER	278	165	618	3	-	18
220	TARRANT	33,524	31,183	20,319	346	2,359	2,089
221	TAYLOR	6,811	1,860	3,796	45	35	277
222	TERRELL	33	-	69	0	-	5
223	TERRY	529	185	1,409	0	-	37
224	THROCKMORTON	132	-	19	2	-	3
225	TITUS	1,356	824	598	8	3	86
226	TOM GREEN	4,989	977	4,846	23	24	282
227	TRAVIS	12,643	13,108	19,901	120	606	1,258
228	TRINITY	843	470	44	2	-	16
229	TYLER	1,557	533	16	6	-	35
230	UPSHUR	2,329	998	78	6	1	80
231	UPTON	145	7	254	-	1	15
232	UVALDE	1,026	28	4,037	7	1	93
233	VAL VERDE	1,002	60	7,123	11	2	212
234	VAN ZANDT	3,269	338	207	14	1	102
235	VICTORIA	2,677	1,175	5,476	11	9	218
236	WALKER	1,436	2,027	439	4	18	61
237	WALLER	1,066	1,549	710	2	18	53
238	WARD	549	139	814	2	-	26
239	WASHINGTON	1,166	1,670	223	4	30	103
240	WEBB	2,453	26	35,204	16	7	996
241	WHARTON	1,136	1,555	1,824	2	2	125
242	WHEELER	402	52	105	5	1	10
243	WICHITA	6,920	2,800	1,599	60	72	261
244	WILBARGER	921	320	447	5	-	42
245	WILLACY	515	28	5,202	2	-	80
246	WILLIAMSON	4,104	1,188	2,289	15	56	262
247	WILSON	1,275	88	1,766	2	-	87
248	WINKLER	359	30	528	2	0	23
249	WISE	2,025	58	349	3	3	76
250	WOOD	2,624	459	181	6	-	70
251	YOAKUM	210	18	454	0	-	20
252	YOUNG	1,565	48	223	11	0	38
253	ZAPATA	228	4	2,219	0	-	22
254	ZAVALA	351	15	3,473	3	2	70
	COUNTY UNKN.	23	8	12	0	0	5
	STATE TOTALS	576,319	465,282	930,717	5,199	21,548	46,829