



# Presentation to the House Appropriations Committee: Medicaid Overview

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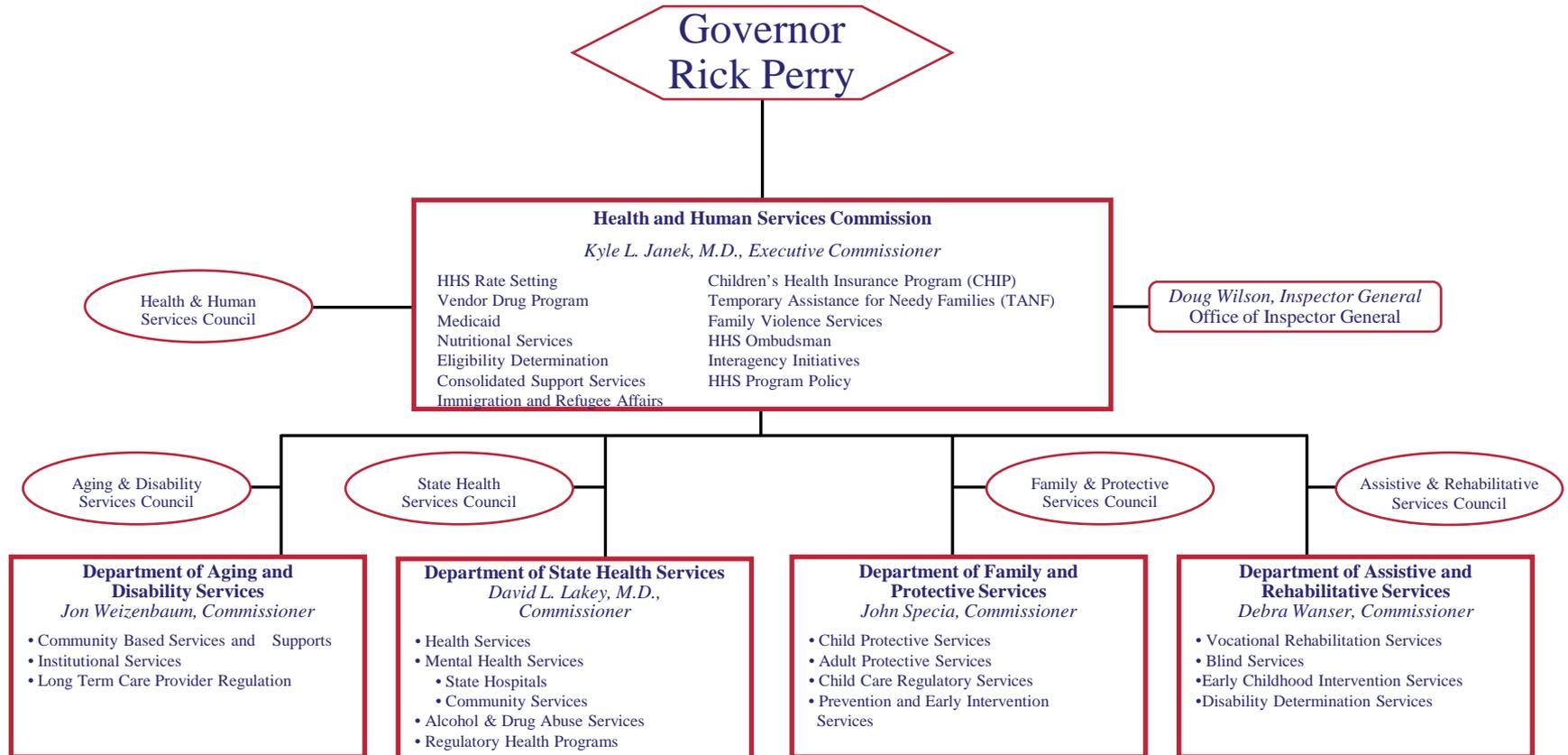
Chris Traylor, Chief Deputy Commissioner

Douglas Wilson, Inspector General

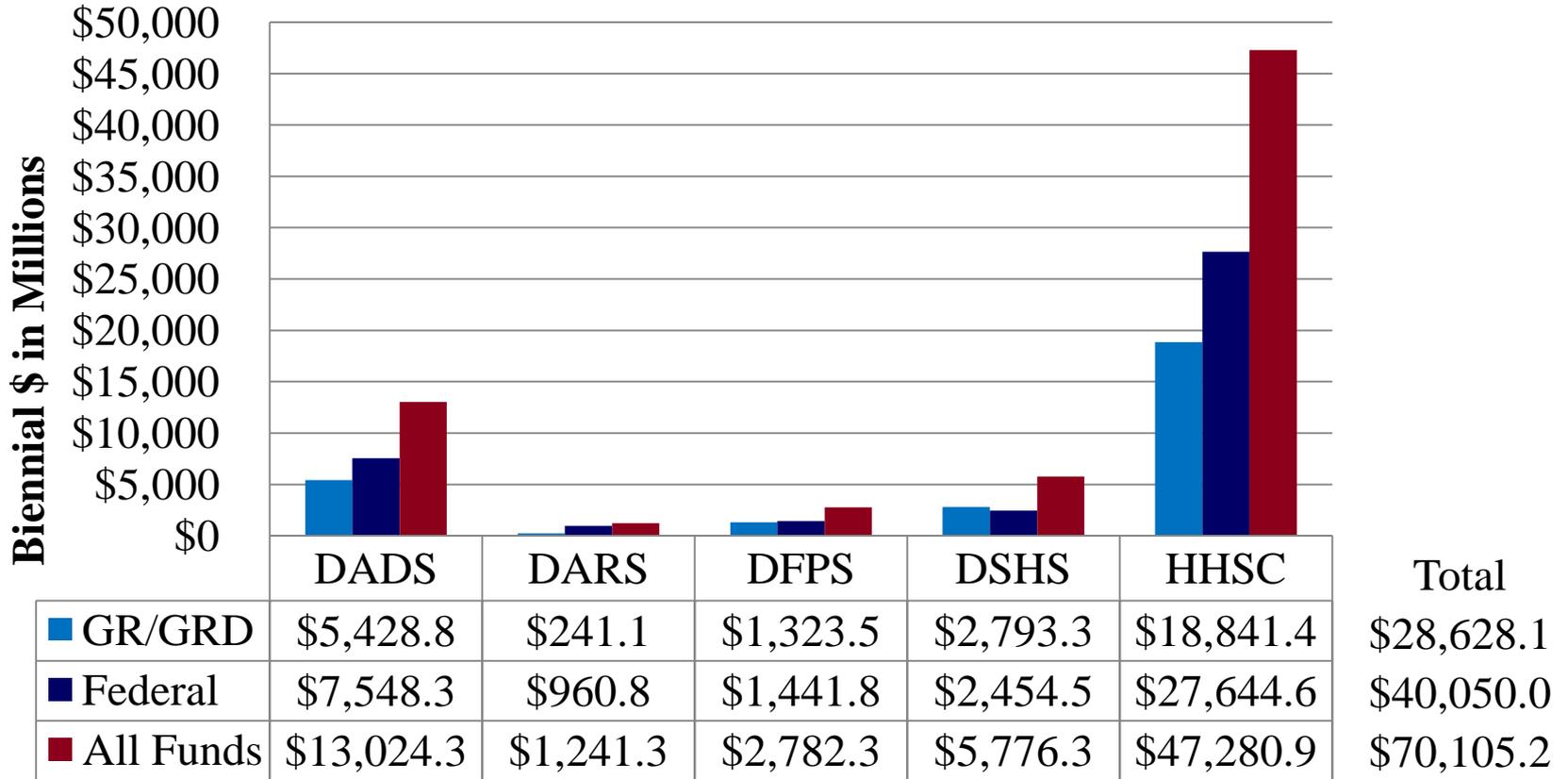
February 4, 2013

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- Health and Human Services (HHS) Organization
  - H.B. 1 – FYs 2014-15 by Agency
  - Medicaid Overview
  - Medicaid Cost Drivers
  - Where Texas Spends Medicaid Dollars
  - Fraud, Waste, and Abuse Initiatives
  - 2012-13 Medicaid Cost Containment Initiatives
  - Summary of Medicaid in H.B. 1

# HHS Organization

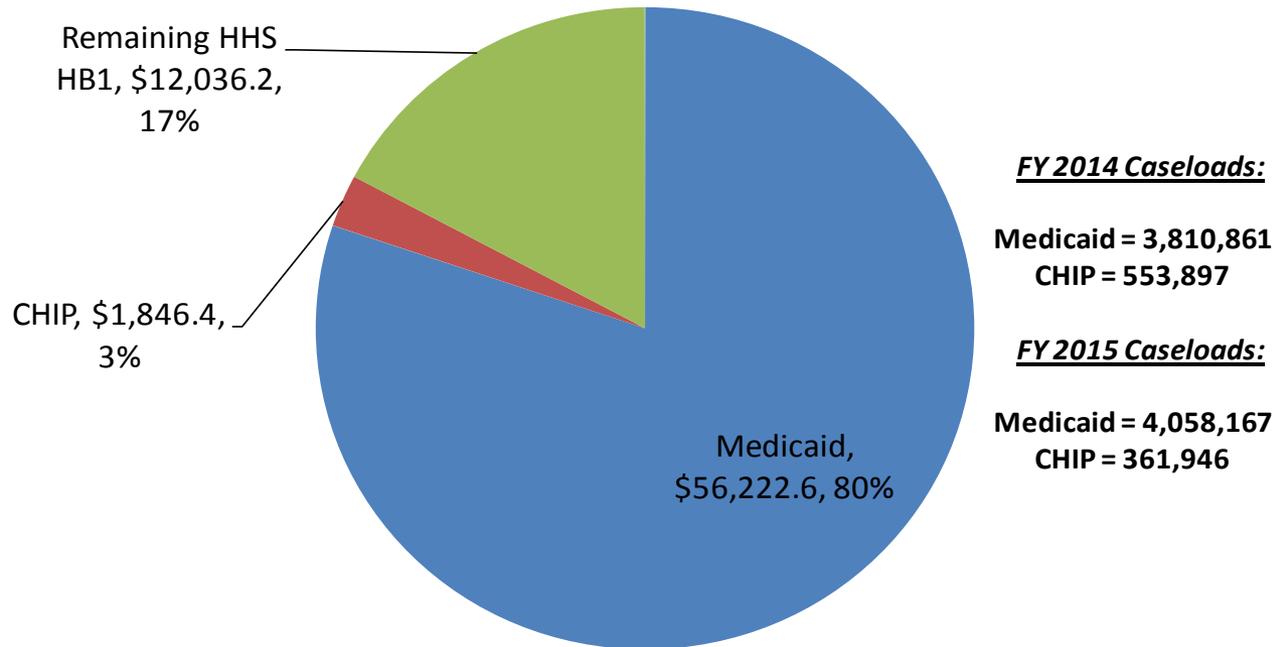


# H.B. 1 – FYs 2014-15 by Agency



# Medicaid Overview

**FY 2014-15 HB1 Recommended - All Funds  
(\$ in Millions)**



# Medicaid Overview

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Medicaid is a jointly funded state-federal program that provides health coverage to low income and disabled people.

- At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS) within the U. S. Department of Health and Human Services.
- At the state level Medicaid is administered by the Health and Human Services Commission (HHSC).
- Federal laws and regulations
  - Require coverage of certain populations and services
  - Allows states to cover additional populations and services
- Medicaid is an entitlement program, meaning:
  - Guaranteed coverage for eligible services to eligible persons
  - Open-ended federal funding based on the actual costs to provide eligible services to eligible persons

# Medicaid Overview: Who Does Medicaid Serve?

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- Texas Medicaid serves:
  - Low-income families
  - Children
  - Pregnant women
  - Elders
  - People with disabilities
  - Effective January 1, 2014, the ACA expands Medicaid to individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care.
- Texas Medicaid does not serve:
  - Non-disabled, childless adults under the age of 65

# Medicaid Overview: Who Does Medicaid Serve?

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- Eligibility criteria includes:
  - Residency in Texas
  - U.S. citizenship or certain qualified aliens
  - Income and resource limits
  - Applicants for long-term services and supports may be required to meet certain functional or medical criteria
  - Most child applicants must be under age 19

# Medicaid Overview: Who Does Medicaid Serve?

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Medicaid eligibility is financial *and* categorical

- Low income alone does not constitute eligibility for Medicaid.
- Eligibility factors include:
  - Family income;
  - Age; and
  - Other factors such as being pregnant or disabled or receiving TANF
- Individuals receiving SSI cash assistance are automatically eligible for Medicaid.

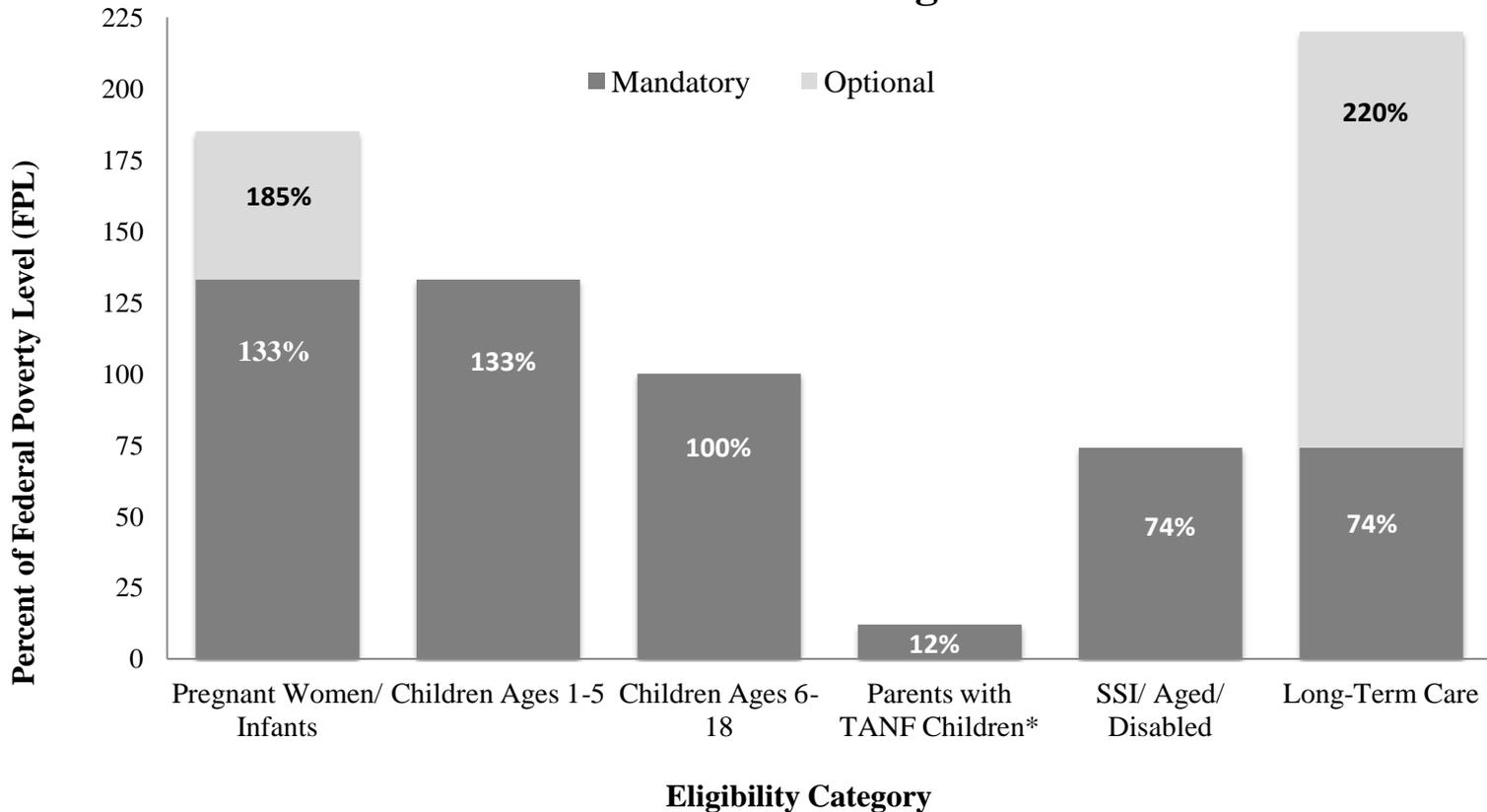
# Medicaid Overview: Who Does Medicaid Serve?

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- The federal government requires that people who meet certain criteria be eligible for Medicaid.
  - These are “mandatory” and all state Medicaid programs must include these populations.
- The federal government also allows states to cover additional individuals and still receive the federal share of funding. These are “optional” Medicaid eligibles.
  - Texas covers some “optional” populations.
- The Affordable Care Act contains a maintenance of effort provision that prohibits states from reducing eligibility standards that were in effect on March 23, 2010.
  - This applies to optional populations.
  - This provision is in effect for adults until January 1, 2014, and for children, including children in CHIP, until September 30, 2019.

# Medicaid Overview: Who Does Medicaid Currently Serve?

**Texas Medicaid Income Eligibility Levels  
for Selected Programs**



# Medicaid Overview: What Services Does Medicaid Provide?

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Similar to mandatory and optional populations, the federal government requires that certain Medicaid services be provided and others are optional. Mandatory Medicaid services include:

- Laboratory and x-ray services
- Physician services
- Medical and surgical services provided by a dentist
- Emergency medical services for non-citizens
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) also known as Texas Health Steps for children under age 21
  - Check-up includes: medical history, complete physical exam, assessment of nutritional, developmental and behavioral needs, lab tests, immunizations, health education, vision and hearing screening, referrals to other providers as needed.
- Inpatient hospital services
- Outpatient hospital services
- Family planning services and supplies
- Federally qualified health centers
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Home health care services
- Medical transportation services
- Nursing facility services for individuals 21 or over
- Rural health clinic services

# Medicaid Overview: What Services Does Medicaid Provide?

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Optional services provided in Texas Medicaid include:

- Prescription drugs
- Medical care or remedial care furnished by other licensed practitioners
  - Nurse Practitioners/Certified Nurse Specialists
  - Certified Registered Nurse Anesthetists
  - Physician Assistants
  - Psychology
  - Licensed Professional Counselors
  - Licensed Marriage and Family Therapists
  - Licensed Clinical Social Workers
- Podiatry (except when delivered in a FQHC setting)
- Limited chiropractic
- Optometry

# Medicaid Overview: What Services Does Medicaid Provide?

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## Optional services continued:

- Clinic services (maternity)
- Hearing instruments and related audiology
- Intermediate Care Facility services for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
- Inpatient services for individuals 65 and over in an institution for mental diseases (IMD)
- Home and community-based waiver services
- Attendant services
  - Primary Home Care
  - Community Attendant Services
- Rehabilitation and other therapies
  - Mental health rehabilitation
  - Rehabilitation facility services
  - Substance Use Disorder Treatment
  - Physical, occupational, and speech therapy
- Targeted Case Management for pregnant women, individuals with intellectual disabilities, and mental health conditions
- Services furnished under a Program of All-Inclusive Care for the Elderly (PACE)
- Hospice Services
- Renal dialysis
- Day Activity and Health Services (DAHS)

# Medicaid Overview: What Services Does Medicaid Provide?

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Medicaid provides acute services and long-term services and supports (LTSS).

- **Acute Care**

- Provision of health care to eligible recipients for episodic health care needs, including: physician, hospital, pharmacy, laboratory, and x-ray services.

- **Long-term Services and Supports (LTSS)**

- Care for people with long-term care needs and chronic health conditions that need ongoing medical care, and often social support.
- Many of the services provided assist persons with activities of daily living, such as eating, dressing and mobility. This includes care in facilities such as nursing homes.
- Nursing facility services for clients 21 or over is a mandatory benefit.
- Texas provides community care to many LTSS clients through federal waivers.

# Medicaid Overview: How are Services Provided?

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Medicaid services are delivered *by* certain provider types *through* certain delivery models.

The following providers deliver Medicaid services:

- Health professionals - doctors, nurses, physical therapists, dentists, psychologists, etc.
- Health facilities - hospitals, nursing homes, institutions and homes for persons with Intellectual and Developmental Disability (IDD), clinics, community health centers, school districts.
- Providers of other critical services like pharmaceuticals or drugs, medical supplies and equipment, medical transportation.

# Medicaid Overview: How are Services Provided?

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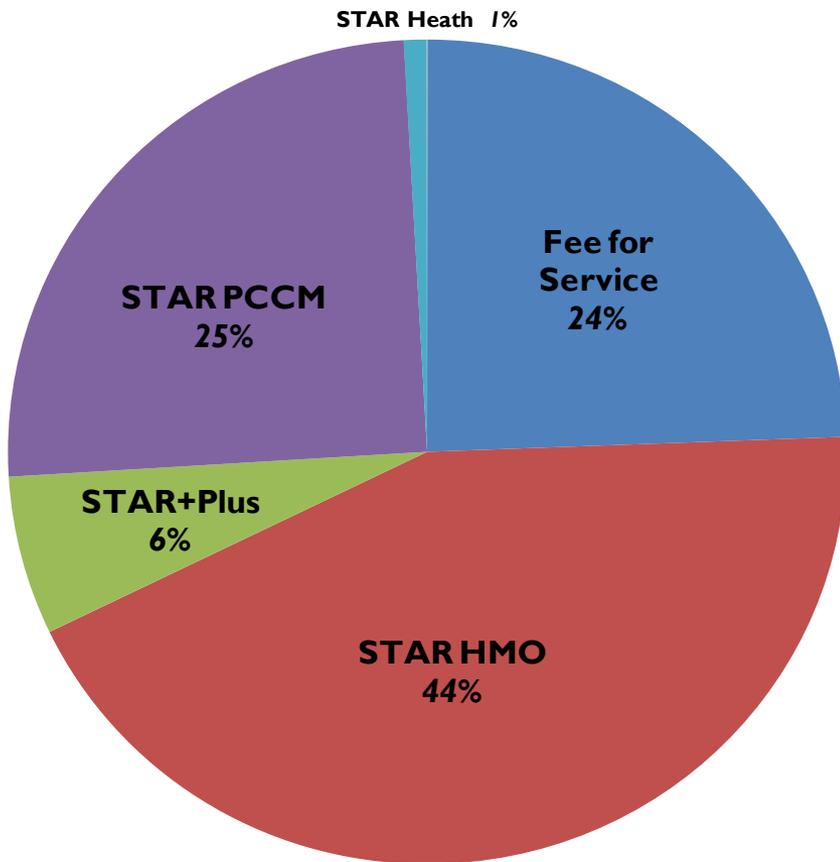
The Texas Medicaid program provides services to Medicaid eligibles through different “delivery models.”

- Fee for Service (Traditional Medicaid)
- Managed Care:
  - **Managed Care Models in Texas:**
    - Health Maintenance Organizations (HMO) - capitated
  - **Managed Care Programs in Texas:**
    - STAR (State of Texas Access Reform) – Acute Care HMO
    - STAR+PLUS – Acute & Long-Term Services and Supports HMO
    - NorthSTAR – Behavioral Health Care HMO
    - STAR Health – Comprehensive managed care program for children in Foster Care

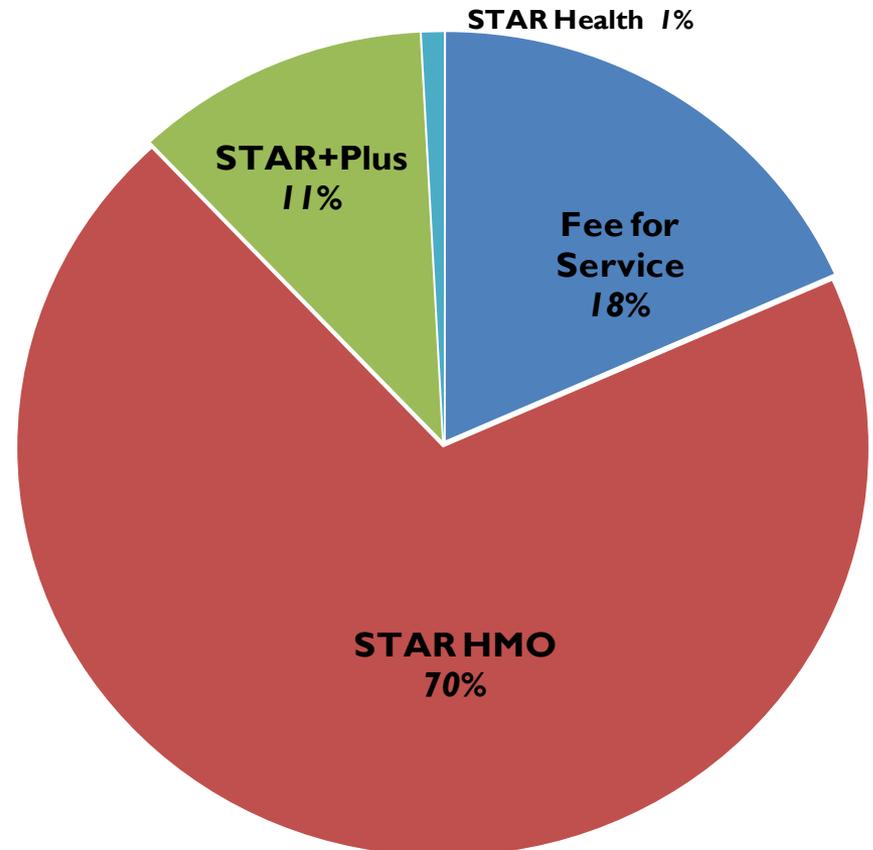
# Medicaid Overview: How are Services Provided?

**Medicaid Recipients in Managed Care in  
FY 2011**

**Medicaid Recipients in Managed Care in FY 2013  
Post –Managed Care Expansion Implementation**



Proportion of Total Medicaid Expenditures Capitated: 23%



Proportion of Total Medicaid Expenditures Capitated: 49%

# Medicaid Overview: How is Medicaid Financed?

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- Medicaid is funded by both the state and federal governments.
- The federal share of Medicaid funds Texas receives is based on the Federal Medical Assistance Percentage (FMAP).
- The FMAP is calculated annually using each state's per capita personal income in relation to the U.S. average.
- Generally, Texas receives an FMAP of approximately 60%, meaning the federal/state share of Medicaid funding is around 60/40 for most client services.
  - Some clients receiving Medicaid are matched at the higher Enhanced FMAP, which is used for the Children's Health Insurance Program (CHIP), and is typically around 70%.
  - Some Medicaid services are matched at rates as high as 90%, while most administrative costs are matched at 50%.
- Texas FMAP percentage is 59.21 for state fiscal year 2013, and 58.74 for state fiscal year 2014. H.B. 1 uses a rate of 58.20 for state fiscal year 2015.

# Medicaid Overview: Transformation Waiver

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- Five year demonstration waiver (2011-2016)
- Managed care expansion
  - Allows statewide Medicaid managed care services
  - Includes legislatively mandated pharmacy carve-in and dental managed care
- 20 Regional Healthcare Partnerships (RHPs)
  - RHP plans received by December 31, 2012
  - 1,335 DSRIP projects proposed (\$9.9 billion all funds)
  - Projects received from 224 hospitals, 38 community mental health centers, 20 local health departments, and 18 physician practices (included 12 affiliated with academic health science centers)
  - Projects include infrastructure (e.g. expand primary/specialty care capacity) and innovation (e.g. patient navigation, chronic care management)

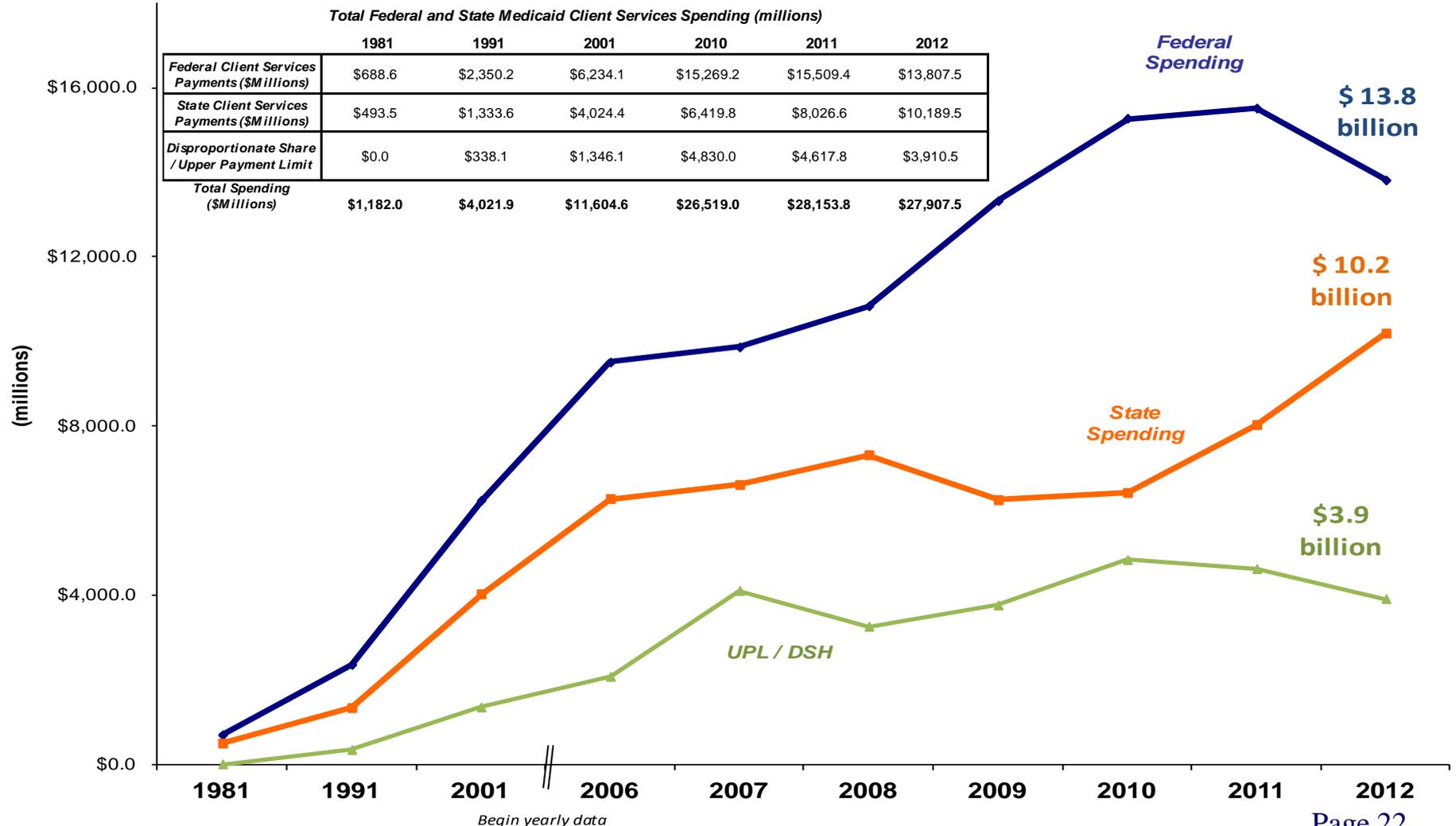
# Medicaid Overview: Supplemental Funding

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States also receive supplemental federal funding:

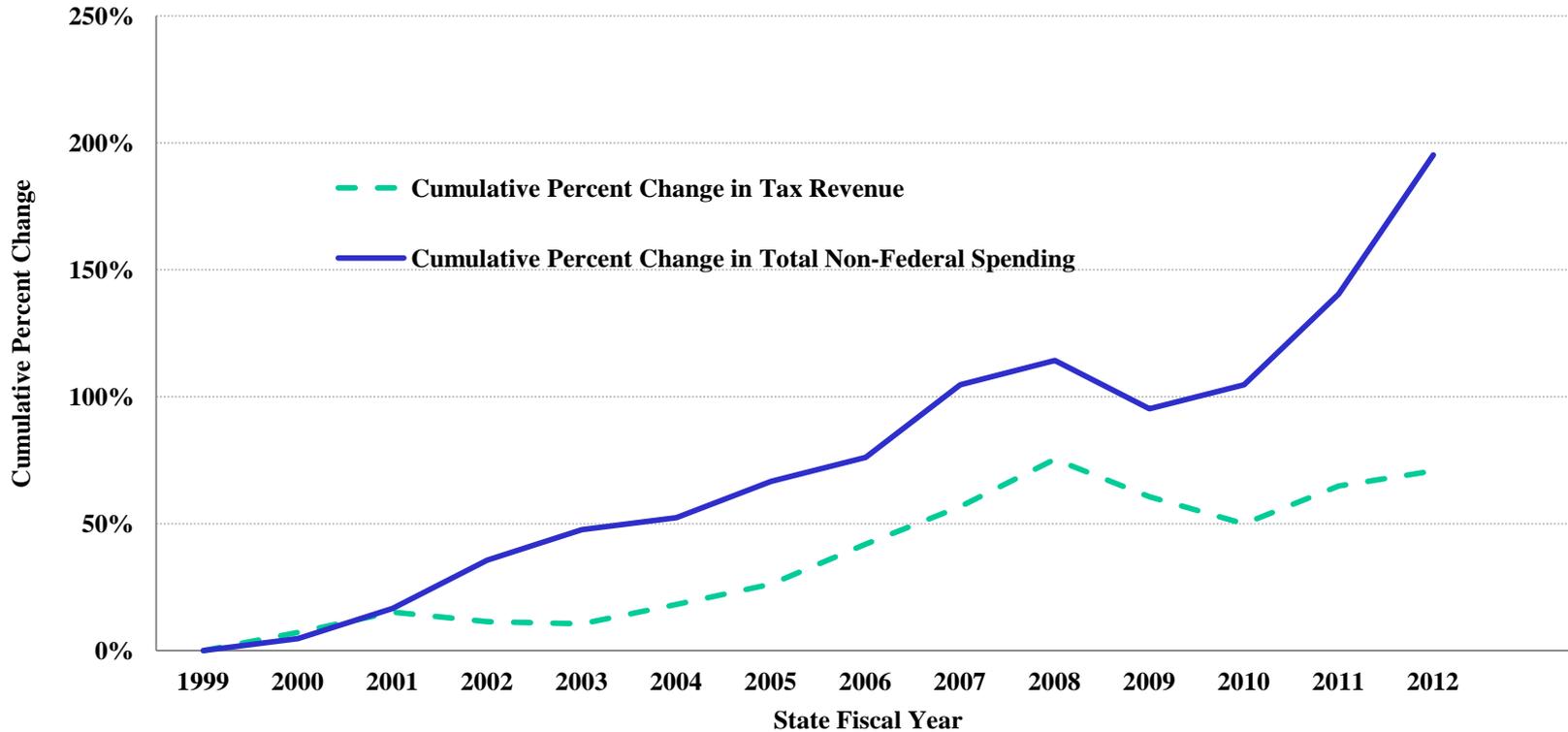
- Disproportionate Share Hospital (DSH) Program- federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients.
- Under the waiver, historic Upper Payment Limit (UPL) funds and additional new funds are distributed to hospitals and other providers through two pools:
  - **Uncompensated Care (UC) Pool**
    - Costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers (beginning in first year).
    - Medicaid Shortfall - The unreimbursed cost of Medicaid inpatient and outpatient hospital services furnished to Medicaid patients.
  - **Delivery System Reform Incentive Payments (DSRIP)**
    - Support coordinated care and quality improvements through Regional Healthcare Partnerships (RHPs) to transform care delivery systems (beginning in later waiver years).

# Medicaid Overview: Historical State & Federal Medicaid Spending



# Medicaid Overview: Historical Percent Change in State Medicaid Spending & State Tax Revenue

## Cumulative Percent Change in Texas Tax Revenue vs Total Non-Federal Medicaid Spending



# Medicaid Cost Drivers

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Medicaid Cost is determined by the Caseload and Cost per Client.

- Caseload: Volume or number of individuals served in each category.
- Case Mix: A subset of caseload – the mix or type of clients in the caseload.
  - Certain groups cost more than others, for example Disability-Related Clients and Pregnant Women/Newborns are high cost, whereas Non-Disabled Children ages 6-18 are lower cost.
- Cost per Client: A function of the number, type, and cost of the services a client receives, and how those services are provided.
  - Even within a low-cost client group, a client can have higher needs (“acuity”) and be more costly.
- Utilization: A function of both caseload and service volume (and case mix), utilization can be viewed as:
  - Number of services (volume) an individual client or group receives.
  - Type of services an individual client or group receives.
  - The mix of type of services (more to less costly, or technologically advanced) with overall number of services.

# Medicaid Cost Drivers

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The mix of caseload, cost, and utilization is further impacted by:

- The type and mix of services including service location (office, clinic, hospital) and the provider type
- Payer type
  - The use of capitated payments for comprehensive services can be used to manage utilization
- Payer payment rates and policies
  - Payer payment rates and policies also factor in the cost mix, and include:
    - Actuarial-based payments (capitated payments)
    - Cost-based reimbursements
    - Cost-report based prospective payments (e.g. nursing homes)
    - Medicare-linked payments
    - CMS mandated methods, such as Federally Qualified Health Centers (FQHCs)
- General inflation, regulatory costs
- Evolutionary advancements in medical technology
  - Increased use of MRIs vs X-Ray
- Revolutionary advancements in medical technology
  - New cancer drugs, or stents for heart disease
- Defensive medicine
- Changes in clinical practice standards

# Medicaid Cost Drivers

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## External Factors Modifying Medicaid Costs Include:

- **Changes in federal policy**
  - Eligibility expansions (see following charts)
  - Evolving CMS Interpretation
- **Changes in state policy**
  - Medicaid Buy-In for Adults and Children
  - New benefits, such as adult substance abuse
- **Population growth and changing demographics**
  - Aging baby-boomers - increasing the aged population
  - Obesity epidemic - increasing certain chronic diseases (diabetes)
  - Changing ethnic composition of the state
- **Economic Factors**
  - Texas economy has recovered from the recent economic downturn and Comptroller predicts continued economic growth
  - FMAP, evolving federal policy, imperfect indicators
- **Natural Disasters**
  - Influenza outbreaks
  - Hurricanes -- medical costs actually decline in the short term following an event such as a hurricane, but Texas has seen long-term impacts from recent hurricanes
- **Consumer expectations and awareness**
  - Program outreach, such as outreach that occurs during school re-enrollment
  - Affordable Care Act may provide an arena for clients to seek health care assistance
- **Litigation**

# Medicaid Cost Drivers: ACA

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- In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act were signed into federal law, collectively known as the Affordable Care Act (ACA).
- Following challenges by 26 state attorneys general and the National Federation of Independent Business, the Supreme Court of the United States considered, among other questions:
  - Whether the law's individual mandate to purchase health insurance was constitutional, and
  - Whether the Medicaid expansion was unconstitutionally coercive for states.
- On June 28, 2012, the U.S. Supreme Court ruled the individual mandate constitutional, but determined that Medicaid expansion was optional for the states.
- HHSC continues to assess impacts and consider options related to the changes in the Medicaid provisions of the law as a result of the court decision.

# Medicaid Cost Drivers: ACA

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- Beginning January 1, 2014, the Affordable Care Act (ACA) requires states to determine financial eligibility for Medicaid and CHIP based on Modified Adjusted Gross Income (MAGI).
  - MAGI applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities
  - Tax filing rules are used to determine income and household composition
  - Assets tests and most income disregards are prohibited, but a 5 percentage point across-the-board income disregard is applied

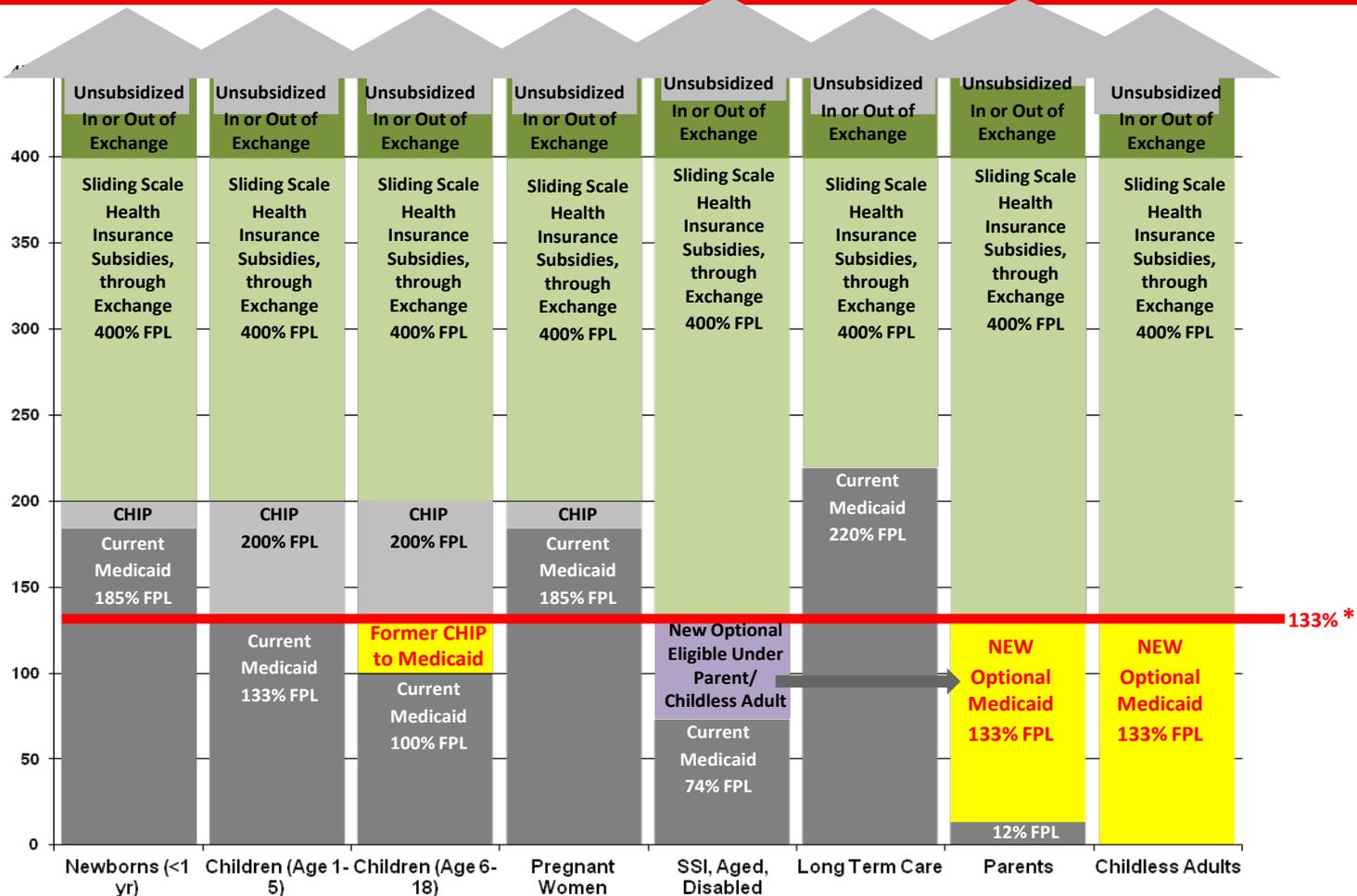
# Medicaid Cost Drivers: ACA

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- The ACA also requires changes to the Medicaid and CHIP application and renewal process.
  - Requires a single streamlined application
  - Requires eligibility redeterminations once per 12 months and no more frequently, unless there is a change that affects eligibility
  - Requires administrative renewals

# Medicaid Cost Drivers:

## Who Medicaid Currently Serves and ACA Requirements

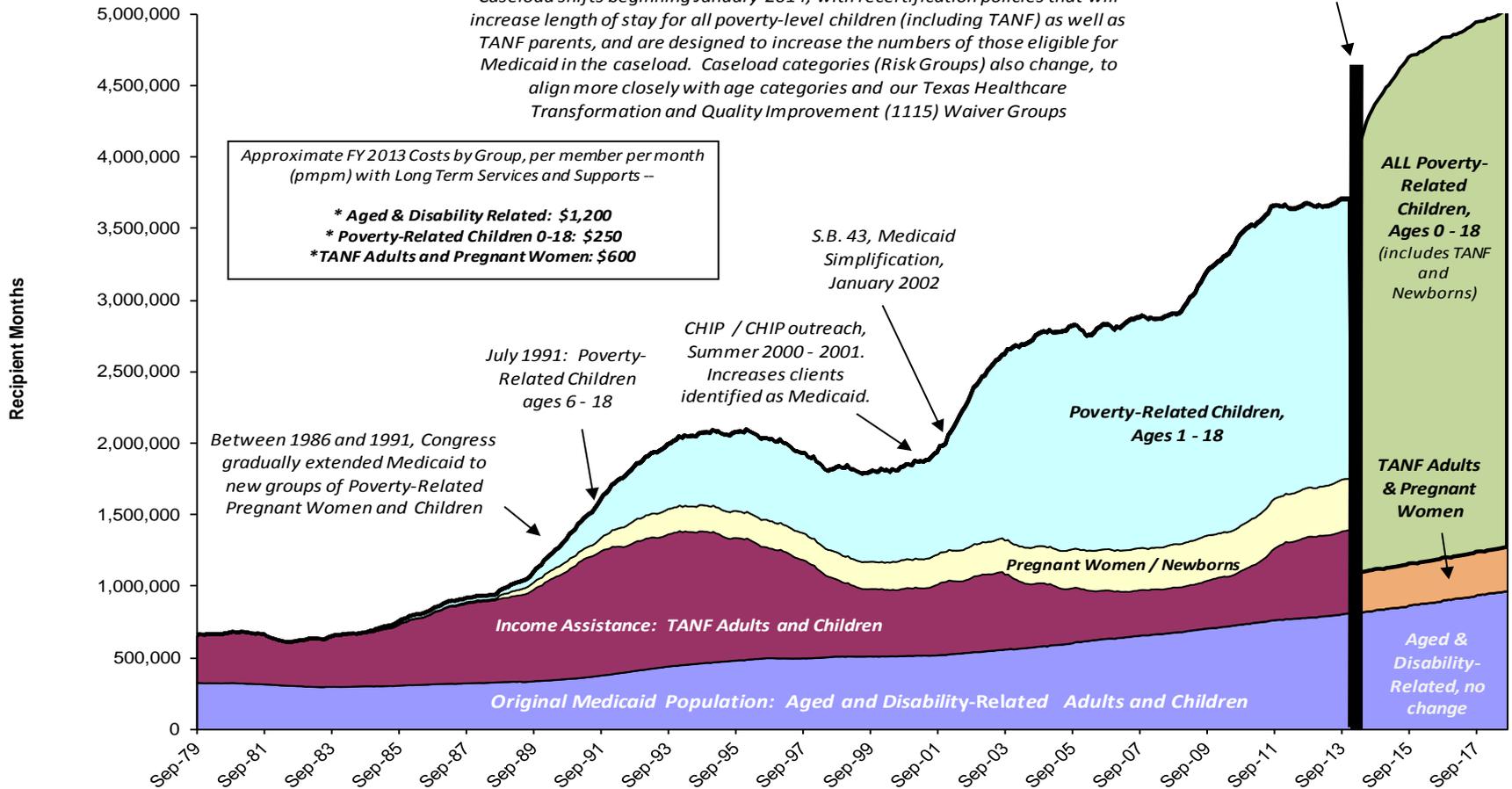


\* Eligibility determination for the ACA Medicaid Expansion population includes a 5 percentage point income disregard, effectively bringing the eligibility limit to 138% FPL.

# Where Texas Spends Medicaid Dollars – Caseload

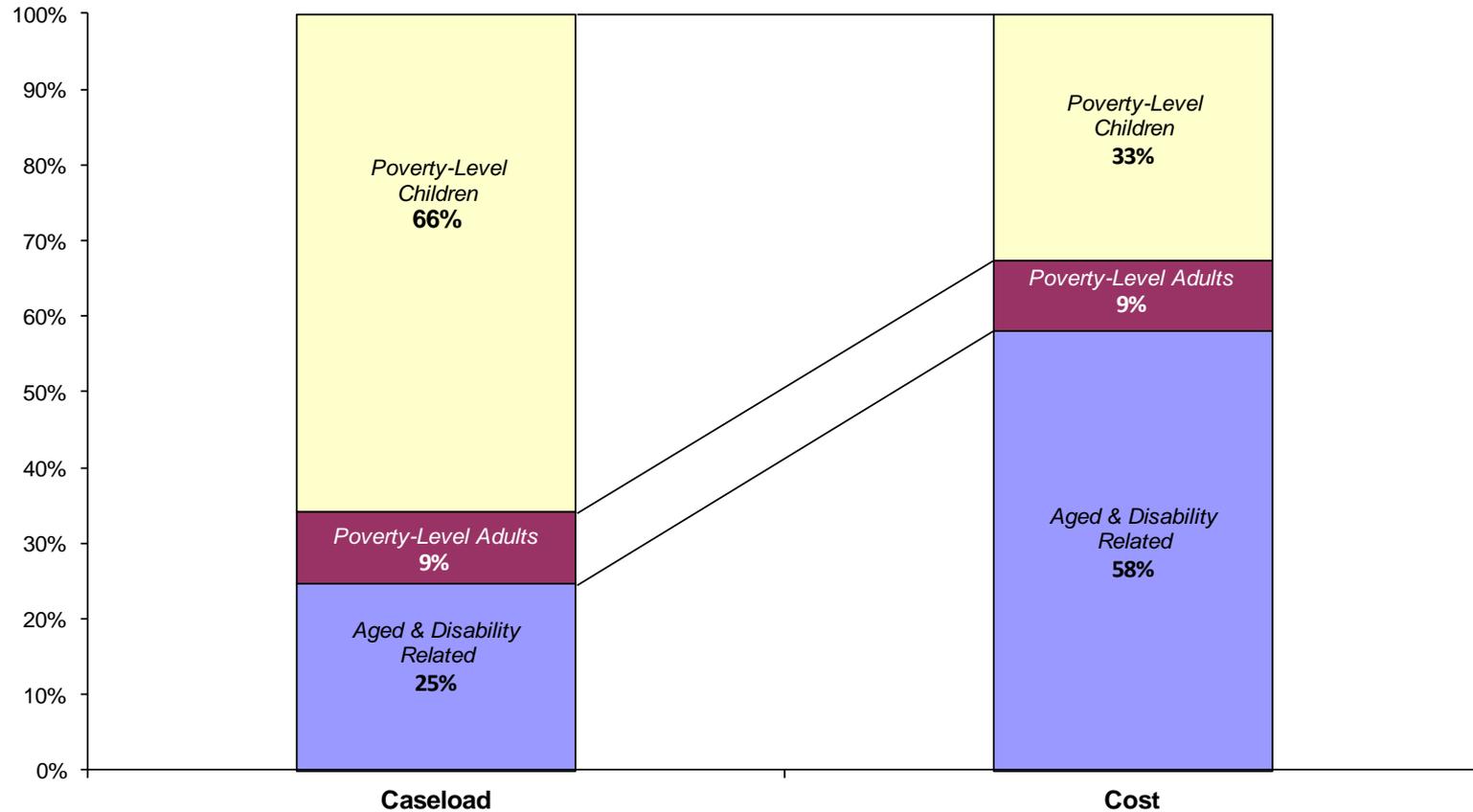
**Texas Medicaid Caseload by Group, September 1979 - August 2018**  
Forecast December 2012 - August 2018 showing ACA Policy Changes

*Caseload shifts beginning January 2014, with recertification policies that will increase length of stay for all poverty-level children (including TANF) as well as TANF parents, and are designed to increase the numbers of those eligible for Medicaid in the caseload. Caseload categories (Risk Groups) also change, to align more closely with age categories and our Texas Healthcare Transformation and Quality Improvement (1115) Waiver Groups*



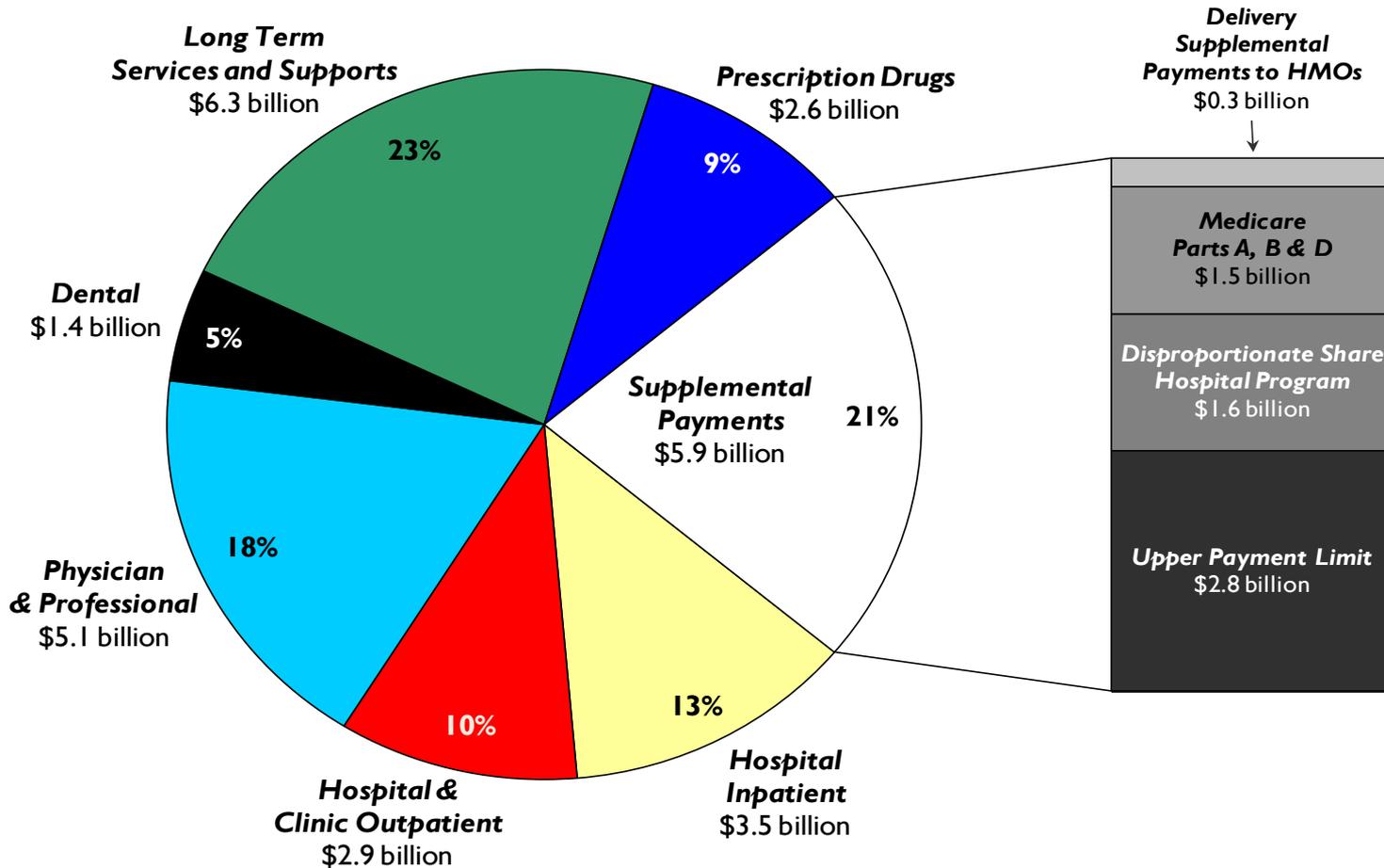
# Where Texas Spends Medicaid Dollars – Caseload

**Texas Medicaid Beneficiaries and Expenditures  
State Fiscal Year 2011**



Source: HHS Financial Services, 2011 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Care. Costs and caseload for all Medicaid payments for all beneficiaries (Emergency Services for Non-Citizens, Medicare payments) are included. Children include all Poverty-Level Children, including TANF. Disability Related Children are not in the Children group.

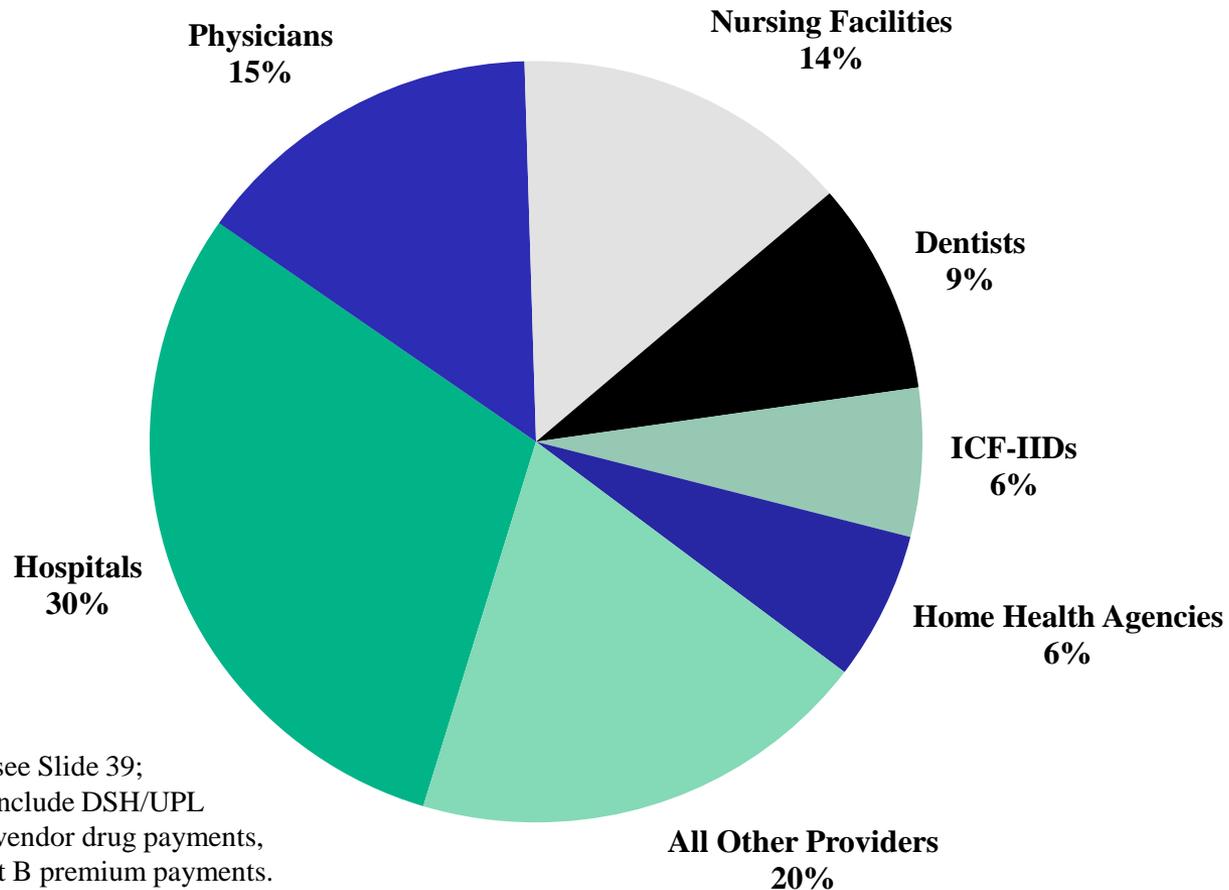
# Where Texas Spends Medicaid Dollars – Services (FY 2011)



\* Source: Medicaid Management Information System (MMIS).  
Prepared By: Strategic Decision Support, Texas Health and Human Services Commission, April 2012.  
Note: Due to rounding, totals may not add up exactly.

# Where Texas Spends Medicaid Dollars – Providers

**Texas Medicaid Expenditures by Provider Type**  
FY 2011



For more information, see Slide 39;  
\$16.2 billion does not include DSH/UPL  
payments to hospitals, vendor drug payments,  
or Medicare Part A/Part B premium payments.

# Fraud, Waste, & Abuse Initiatives

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Texas HHSC OIG has implemented various initiatives to help strengthen the detection and prevention of fraud, waste and abuse in the Medicaid program.

- Targeted Case Investigation Process
  - Identifies and groups major investigations by provider category, permitting rapid and effective use of OIG resources. Effect is significantly shortened case completion time, greater accuracy and greater probability of recoupment.
  - Increased performance from 12 cases in SFY2011 to 108 in SFY2012.
- Major Initiative Program
  - Uses technology to identify areas at highest risk of overutilization or abuse and focuses resources on concentrated efforts.
  - Orthodontia (\$303.8 million), general dentistry (\$101.6 million), therapy (\$50.7 million), hearing aids (\$103.8 million).
  - Increased identified potential overpayments from \$28 million in SFY2011 to \$531.5 million in SFY2012.
  - Completed 707 hospital reviews in SFY2012, identifying over \$31 million in net overpayments for recovery.
  - Completed 1,036 state supported living center investigations in SFY2012.

# Fraud, Waste, & Abuse Initiatives

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Texas has implemented various initiatives to help strengthen the detection and prevention of fraud, waste and abuse of the Medicaid program.

- Medicaid Billing Coordination System (BCS):
  - Identifies within 24 hours whether another entity has primary responsibility for paying a claim and submits the claim to the primary payer; all private health insurers allow HHSC access to health insurance enrollment databases (HHSC implemented a pharmacy claims BCS in 2009).
- OIG Third Party Recovery:
  - Compares known health insurance coverage against paid claims history using the Texas Automated Recovery System (TARS) to identify potentially recoverable funds.
- OIG Medicaid Fraud and Abuse Detection System (MFADS):
  - Analyzes established patterns and trends of provider billing and client utilization activities, particularly any outliers, which may lead to recoveries, provider education, referrals to other state agencies, and legal action.
  - Used daily by OIG staff to pull pre-defined automated analyses of claim activity and related data, as well as to extract custom reports of paid claim data and related information for human intelligence analysis.

# Fraud, Waste, & Abuse Initiatives

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Texas HHSC OIG has implemented various initiatives to help strengthen the detection and prevention of fraud, waste and abuse in the Medicaid program.

- Joint OIG/OAG Task Force
  - Links resources of OIG to OAG civil and criminal Medicaid fraud units
  - Avoids duplication of efforts
  - National model for interagency cooperation
- OIG/CMS Cooperation
  - CMS provided APD funding for advanced analytics
  - Participated in first ever CMS Command Center Mission to coordinate resource efforts
- DME Sweep
  - OIG conducted statewide sweep of DME providers for compliance with state and federal requirements. Project is 61% complete with over 450 likely exclusions identified with an annual cost avoidance exceeding \$43 million.

# Fraud, Waste, & Abuse Initiatives

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## Implemented ACA-Required Credible Allegation of Fraud (CAF)

### Holds

- Stops payments when there is a credible allegation of fraud
- Failure to implement creates financial risk for the State; implementation creates prepayment protection for Title XIX expenditures
- As of December 29, 2012, 91 providers were subject to a payment hold
- Robust internal review process prior to hold; due process afforded to providers after hold is issued

## Adopted New Provider Enrollment Rules Effective December 31, 2012

- Strengthens OIG's ability to prevent providers likely to engage in fraud, waste or abuse from enrolling in the program
- New ACA required screening requirements based on categorical risk levels of limited, moderate, or high

# 2012-13 Medicaid Cost Containment Initiatives

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- In the 2012-13 General Appropriations Act, the 82<sup>nd</sup> Legislature identified over 60 initiatives to improve service efficiency and outcomes while containing costs. These efforts include statewide expansion of managed care, provider rate reductions, and other Medicaid funding reductions.
- Based on current implementation plans, \$1.8 billion general revenue (\$4.1 billion all funds) in savings will be achieved in the 2012-13 biennium, approximately 80% of the target.

# 2012-13 Medicaid Cost Containment Initiatives

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## Managed Care Expansion

- The expansion of Medicaid managed care statewide encompasses six different initiatives.
  - Expand Medicaid Managed Care in Urban & Contiguous Counties
  - Expand Medicaid Managed Care in South Texas
  - Create Dental Managed Care Model for Medicaid
  - Carve in Medicaid & CHIP Prescription Drug Programs
  - Carve Inpatient Hospital Services into STAR+PLUS
  - Expand Medicaid Managed Care to Rural Service Areas
- The expansion resulted in 3 million clients per month in managed care as of July 2012, or 82 percent of all Medicaid clients.
- The expansion to regions contiguous to existing managed care areas began on September 1, 2011.
- The remaining initiatives began March 1, 2012.

# 2012-13 Medicaid Cost Containment Initiatives

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## Medicare Equalization

- Changed provider payments for outpatient and professional services by limiting deductibles and coinsurance for dual eligible clients (clients who receive Medicaid and Medicare) to no more than what Medicaid would have paid for the same service.
- The Legislature provided for a phase-in implementation for dialysis services.
- The initiative began January 2012.
- To more fairly distribute the impact on providers, in January 2013 payment of the annual deductible (\$147 in calendar year 2013) was resumed.

# 2012-13 Medicaid Cost Containment Initiatives

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## Amount, Duration, and Scope

- Amount refers to the number of services, duration refers to the amount of time, and scope refers to the service itself.
- States may determine benefit levels for optional and mandatory Medicaid services.
- HHSC initiatives include:
  - Renal dialysis can be administered on an outpatient basis and no longer requires hospital admission. Effective January 2012.
  - Reimbursement for infant cranial helmets is limited to cases of medical necessity. Effective February 2012.
  - Porcelain crowns is limited to front, permanent teeth. Effective May 2012.
  - Limitation on provision of hearing aids.
- DADS implemented utilization review controls.

# 2012-13 Medicaid Cost Containment Initiatives

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## Provider Rate and Related Reductions

- Rate reductions for most providers began in September 2011. Programs impacted include:
  - Most hospital services (inpatient and outpatient)
  - Home and community-based services
  - Hospice services provided in a nursing facility
  - Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)
  - Durable medical equipment (DME)
  - Laboratory services
  - Medical imaging fee schedule
  - Reductions in payments for non-emergency services provided in hospital emergency departments
  - Certain other ancillary services

# 2012-13 Medicaid Cost Containment Initiatives

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## Additional Cost Containment Initiatives

- Electronic visit verification (EVV) was implemented to ensure proper payment for home health providers. DADS began a pilot in March 2011 in West Texas and expanded to two additional areas (Northwest and East Texas) in February 2012, with plans for a statewide expansion.
- Utilization reviews to improve nursing facilities' billing procedures were implemented by the Office of Inspector General, resulting in more accurate payments for services.

# Summary of Medicaid in H.B. 1

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H.B. 1 contains various assumptions for the Medicaid program:

- Client Services

- Medicaid current services are assumed at average costs for fiscal year 2013 levels

- Medicaid caseload – 3,810,861 in FY 2014 and 4,058,167 in FY 2015
- Funding for growth of cost and utilization trends is not included

- Acknowledges movement of CHIP children under 133% FPL to Medicaid pursuant to the Affordable Care Act

- 68,117 clients in FY 2014
- 261,521 clients in FY 2015

# Summary of Medicaid in H.B. 1

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Medicaid estimates do not include the following caseload impacts resulting from the implementation of the Affordable Care Act:

- Medicaid coverage for former Foster Care children to age 26.
- Requirement for 12-month eligibility certification and administrative renewals which results in a net increase in clients eligible for services.
- Estimated impact of caseload growth from children eligible but not enrolled as their families seek health care coverage from the exchange.

## Medicaid Cost Containment

- Medicaid and CHIP funding require the implementation of additional savings and cost containment initiatives - \$250 million GR (\$602 million AF)
- HHSC would focus on cost containment initiatives to achieve efficiencies and ensure appropriate use of Medicaid services rather than reducing services or benefits.
- Maintain savings from cost containment initiatives implemented in FYs 2012-13.

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# APPENDICES

# Medicaid Income and Federal Poverty Levels

Financial eligibility for Medicaid and many other social programs is based on a family's income level as compared to the Federal Poverty Level (FPL).

- The FPL is intended to identify the minimum amount of income a family would need to meet certain, very basic, family needs.
- FPLs indicate annual income levels by family size, and are updated each year by the Federal Census Bureau.
  - The amounts corresponding to 100% of poverty are based on the U.S. Department of HHS poverty income guidelines for 2013:

Based on Annual Income

<u>Family Size</u>	<u>100%</u>	<u>138%</u>
1	\$11,490	\$15,856
2	\$15,510	\$21,404
3	\$19,530	\$26,951
4	\$23,550	\$32,499
5	\$27,570	\$38,047
6	\$31,590	\$43,594
7	\$35,610	\$49,142
8	\$39,630	\$54,689

At 100% of poverty, for families larger than 8, add \$4,020 for each additional person. At 138% of poverty, add \$5,548 for each additional person.

# Medicaid LTSS Waiver Services

## Texas Medicaid Home and Community-Based Waiver Programs

<i>Waiver</i>	<i>Population Served</i>
<i>Medically Dependent Children's Program (MDCP)</i>	Individuals under 21 who meet medical necessity for a nursing facility level of care
<i>Home and Community-Based Services (HCS)</i>	Individuals of all ages who qualify for ICF/IID Level of Care I
<i>Community Living Assistance and Support Services (CLASS)</i>	Individuals of all ages who qualify for ICF/IID Level of Care VIII
<i>Deaf Blind with Multiple Disabilities (DBMD)</i>	Individuals of all ages who are deaf, blind or who have a condition that will result in deaf blindness and an additional disability who qualify for ICF/IID Level of Care VIII
<i>Community Based Alternatives (CBA)</i>	Individuals age 21 and over who meet medical necessity for nursing facility level of care
<i>HCSBS STAR+PLUS</i>	Individuals age 21 and over who meet medical necessity for a nursing facility level of care
<i>Texas Home Living (TxHmL)</i>	Individuals of all ages, living with their families or in their own homes, who qualify for ICF/IID Level of Care I.

# Comparison of FFY 2013 and 2014 Federal Medical Assistance Percentages (FMAPs)

## *Federal Fiscal Years (FFYs) 2013 and 2014 FMAPs, District of Columbia, States, and Territories*

State	FFY 2013	FFY 2014	Point Change	State	FFY 2013	FFY 2014	Point Change
Alabama	68.53	68.12	-0.41	Montana	66.00	66.33	0.33
Alaska	50.00	50.00	0.00	Nebraska	55.76	54.74	-1.02
Arizona	65.68	67.23	1.55	Nevada	59.74	63.10	3.36
Arkansas	70.17	70.10	-0.07	New Hampshire	50.00	50.00	0.00
California	50.00	50.00	0.00	New Jersey	50.00	50.00	0.00
Colorado	50.00	50.00	0.00	New Mexico	69.07	69.20	0.13
Connecticut	50.00	50.00	0.00	New York	50.00	50.00	0.00
Delaware	55.67	55.31	-0.36	North Carolina	65.51	65.78	0.27
District of Columbia	70.00	70.00	0.00	North Dakota	52.27	50.00	-2.27
Florida	58.08	58.79	0.71	Ohio	63.58	63.02	-0.56
Georgia	65.56	65.93	0.37	Oklahoma	64.00	64.02	0.02
Hawaii	51.86	51.85	-0.01	Oregon	62.44	63.14	0.70
Idaho	71.00	71.64	0.64	Pennsylvania	54.28	53.52	-0.76
Illinois	50.00	50.00	0.00	Rhode Island	51.26	50.11	-1.15
Indiana	67.16	66.92	-0.24	South Carolina	70.43	70.57	0.14
Iowa	59.59	57.93	-1.66	South Dakota	56.19	53.54	-2.65
Kansas	56.51	56.91	0.40	Tennessee	66.13	65.29	-0.84
Kentucky	70.55	69.83	-0.72	<b>TEXAS</b>	<b>59.30</b>	<b>58.69</b>	<b>-0.61</b>
Louisiana	65.51	60.98	-4.53	Utah	69.61	70.34	0.73
Maine	62.57	61.55	-1.02	Vermont	56.04	55.11	-0.93
Maryland	50.00	50.00	0.00	Virginia	50.00	50.00	0.00
Massachusetts	50.00	50.00	0.00	Washington	50.00	50.00	0.00
Michigan	66.39	66.32	-0.07	West Virginia	72.04	71.09	-0.95
Minnesota	50.00	50.00	0.00	Wisconsin	59.74	59.06	-0.68
Mississippi	73.43	73.05	-0.38	Wyoming	50.00	50.00	0.00
Missouri	61.37	62.03	0.66	Puerto Rico & Territories	55.00	55.00	0.00

# Where Texas Spends Medicaid Dollars – Providers

## Expenditures by Type of Provider - FY 2011

Provider Group	Expenditures	% of Total Expenditures	Number of Providers
Hospitals	\$4,873,766,893.98	30.00%	644
Physicians	\$2,403,564,289.39	14.79%	53,442
Nursing Facilities	\$2,307,641,238.20	14.20%	1,189
Dentists	\$1,463,141,820.99	9.01%	7,095
ICF-IDDs	\$1,023,310,903.38	6.30%	634
Home Health Agencies	\$1,025,394,826.80	6.31%	1,746
Durable Medical Equipment (DME) Suppliers	\$574,363,714.97	3.54%	6,674
Ambulance	\$354,446,083.94	2.18%	1,227
Rehabilitation Centers	\$393,227,003.74	2.42%	516
Ambulatory Surgical Centers	\$188,435,215.97	1.16%	715
Laboratories	\$178,247,222.21	1.10%	680
Dialysis Centers	\$122,698,427.97	0.76%	443
Allied Health Providers	\$144,953,419.99	0.89%	3,535
Federally Qualified Health Centers (FQHCs)	\$118,671,638.68	0.73%	167
School Health & Related Services (SHARS)	\$161,450,208.65	0.99%	723
Comprehensive Care Program Providers	\$210,839,412.00	1.30%	3,344
Rural Health Centers	\$80,840,969.17	0.50%	313
Behavioral Health Providers	\$75,421,520.86	0.46%	6,254
Nurses (APNs and CRNAs)	\$45,579,800.19	0.28%	8,870
Physical/Occupational	\$38,417,165.37	0.24%	1,512
Maternity Clinics/Birthing Centers	\$357,526.46	0.00%	32
TB Clinics	\$150,390.78	0.00%	20
Other and Unknown	\$462,283,005.99	2.85%	--

Includes FFS/PCCM claims and payments to providers by HMOs.

Other Providers include provider types such as Genetics, Indian Health Services, Early Childhood Intervention (ECI), and County Indigent Health Care programs.

Does not include DSH and UPL