



# Presentation to the House Appropriations Committee: Medicaid Overview

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Thomas M. Suehs, Executive Commissioner

Chris Traylor, Commissioner, Department of Aging and  
Disability Services

Billy Millwee, State Medicaid Director

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- Medicaid Overview
  - Medicaid Cost Drivers
  - Where Texas Spends Medicaid Dollars
  - Fraud and Abuse Initiatives
  - Cost Containment Initiatives
  - Medicaid Assumptions in HB 1
  - Summary of Medicaid Issues in HB 1
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# 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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- Medicaid serves:
  - Low-income families
  - Children
  - Pregnant women
  - Elders
  - People with disabilities
- Eligibility criteria includes:
  - Residency in Texas
  - U.S. citizenship or qualified aliens who are legally admitted for permanent residency
  - 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
- Texas Medicaid does not serve:
  - Non-disabled, childless adults under the age of 65

# 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 TANF and SSI cash assistance are automatically eligible for Medicaid.

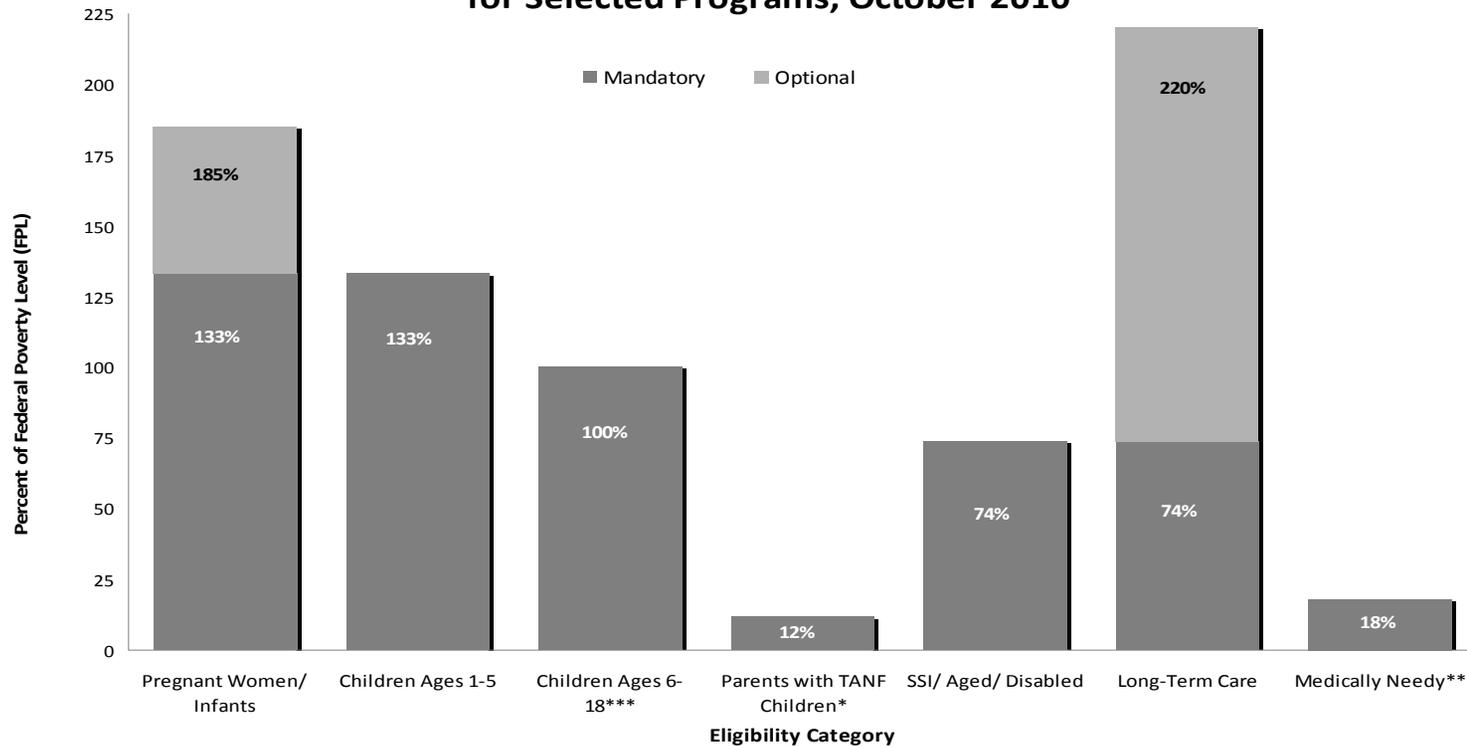
# Medicaid Overview: Who Does Medicaid Serve?

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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 Serve?

**Texas Medicaid Income Eligibility Levels  
for Selected Programs, October 2010**



\*In SFY 2010, 12% FPL is a monthly income limit of \$188 for a family of three.  
 \*\*In SFY 2010, 18% FPL is a monthly income limit of \$275 for a family of three.  
 \*\*\*In SFY 2010, 100% FPL is a monthly income limit of \$1,526 for a family of three.

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, including for optional populations.

# 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
- 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

## What Services Does Medicaid Provide?

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Optional services provided in Texas 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
  - Chiropractic
  - Optometry, including eyeglasses and contacts

## What Services Does Medicaid Provide?

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### Optional services continued:

- Primary care case management
- Clinic services (maternity)
- Hearing instruments and related audiology
- Intermediate care facility services for the mentally retarded (ICF/MR)
- Inpatient services for individuals 65 and over in an institution for mental diseases (IMD)
- Home and community based services
- Rehabilitation and other therapies
  - Mental health rehabilitation
  - Rehabilitation facility services
  - Substance Use Disorder Treatment
  - Physical, occupational, and speech therapy
- Targeted Case Management
- Services furnished under a Program of All-Inclusive Care for the Elderly (PACE)
- Hospice Services
- Renal dialysis

# Medicaid Overview: What Services Does Medicaid Provide?

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Medicaid provides acute services and long term services and supports.

- **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**

- 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 care 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?

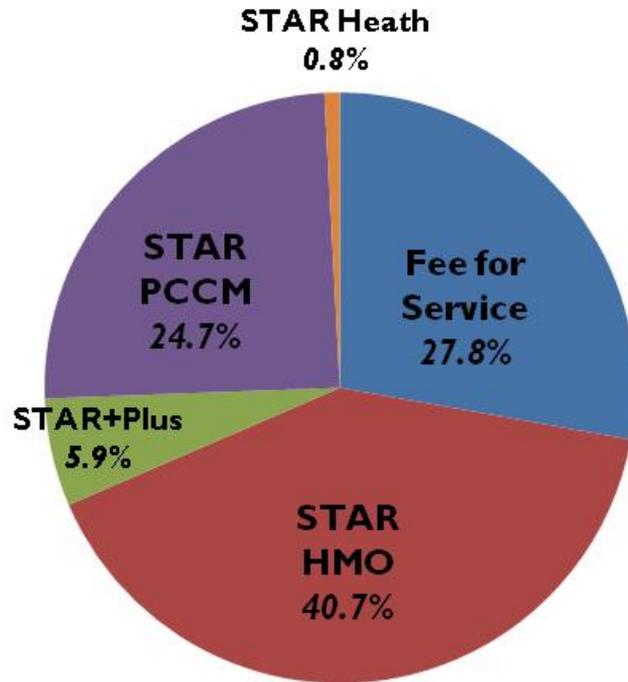
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The Texas Medicaid program provides services to Medicaid Eligibles through different “delivery models.”

- Fee for Service (Traditional Medicaid)
- Managed Care:
  - **Managed Care Models in Texas:**
    - Primary Care Case Management (PCCM)- non capitated
    - Health Maintenance Organizations (HMO)- capitated
  - **Managed Care Programs in Texas:**
    - PCCM - Managed care model that provides a medical home for Medicaid clients through primary care providers
    - 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
  - **The following chart depicts the percentage of the Medicaid population in managed care currently and post-implementation of the managed care expansion items assumed in HB 1.**

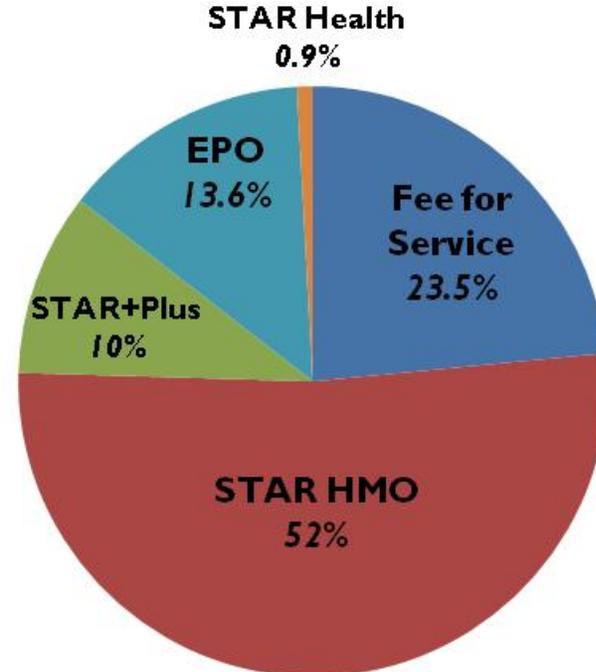
# Medicaid Overview: How are Services Provided?

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



*No Exclusive Provider Organizations (EPO) until 2012  
Managed Care Expansion*

**Medicaid Recipients in Managed Care in FY  
2013 Post –Managed Care Expansion  
Implementation in HB 1**



*Primary Care Case Management (PCCM) = 0 with  
Managed Care Expansion*

# 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 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.
  - The American Recovery and Reinvestment Act temporarily provided an increased FMAP of approximately 71% that is currently being phased down. Texas will return to regular FMAP in July 2011 of 60.56%.
- The FY 2012 FMAP calculation reduced Texas' federal financial participation to 58.42%, which will shift approximately two percentage points of Medicaid funding from the federal to the state government.

# Medicaid Overview: How is Medicaid Financed?

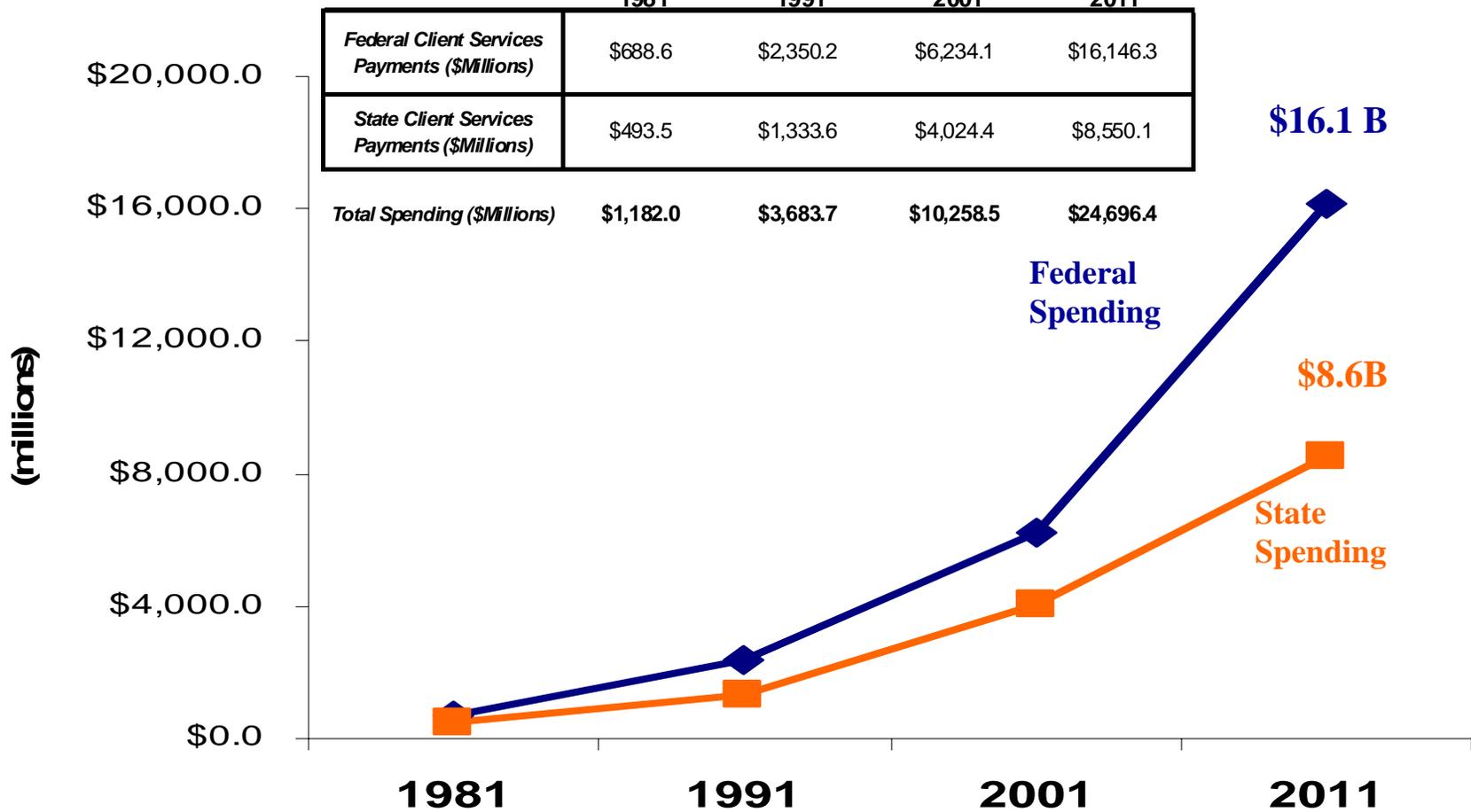
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- States also receive supplemental federal funding
  - Upper Payment Limit Program (UPL)- Supplemental payments are made to certain hospitals and physicians to make up the difference between what Medicaid actually paid for their Medicaid patients and what Medicare would have paid for the same services.
  - 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.

# Historical State & Federal Medicaid Spending

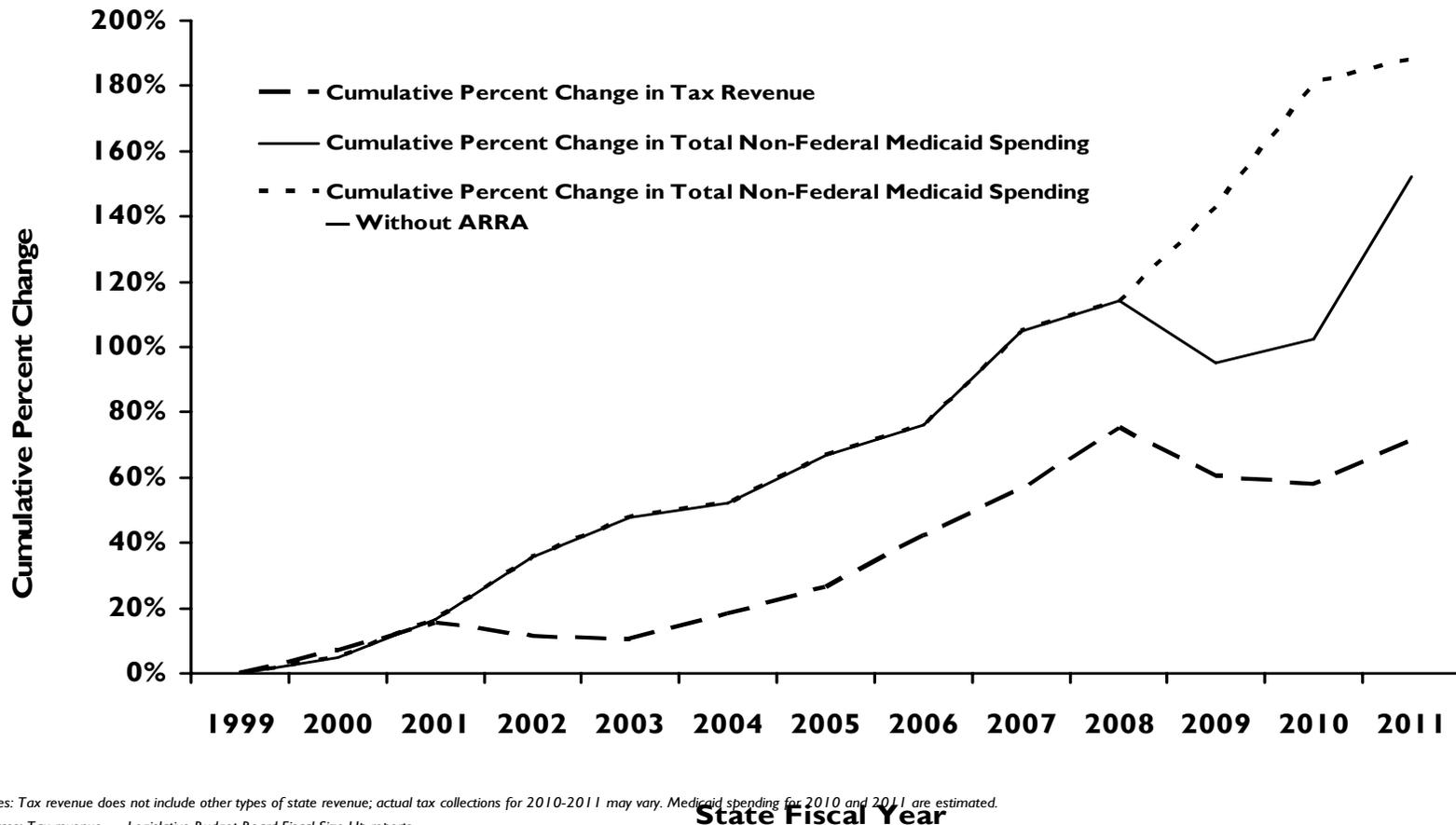
*Total Federal and State Medicaid Client Services Spending (millions)*

	1981	1991	2001	2011
<i>Federal Client Services Payments (\$Millions)</i>	\$688.6	\$2,350.2	\$6,234.1	\$16,146.3
<i>State Client Services Payments (\$Millions)</i>	\$493.5	\$1,333.6	\$4,024.4	\$8,550.1



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

**Cumulative Percent Change in Texas Tax Revenue Versus Total Non-Federal Medicaid Spending, With and Without ARRA, SFYs 1999-2011**



Notes: Tax revenue does not include other types of state revenue; actual tax collections for 2010-2011 may vary. Medicaid spending for 2010 and 2011 are estimated.

Sources: Tax revenue — Legislative Budget Board Fiscal Size-Up reports.

Medicaid spending — Financial Services, Texas Health and Human Services Commission.

# 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
- 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 (e.g. Children's Hospitals)
    - Cost-report based prospective payments (e.g. Nursing Homes)
    - Medicare-Linked payments, such as hospital diagnosis related groups
    - CMS Mandated Methods, such as FQHCs
- General cost of doing business
- Evolutionary advancements in medical technology
  - Increased use of MRIs vs X-Ray
- Revolutionary advancements in medical technology
  - New cancer drugs, or stints for heart bypass
- Defensive medicine
- Changes in clinical practice standards

# Medicaid Cost Drivers

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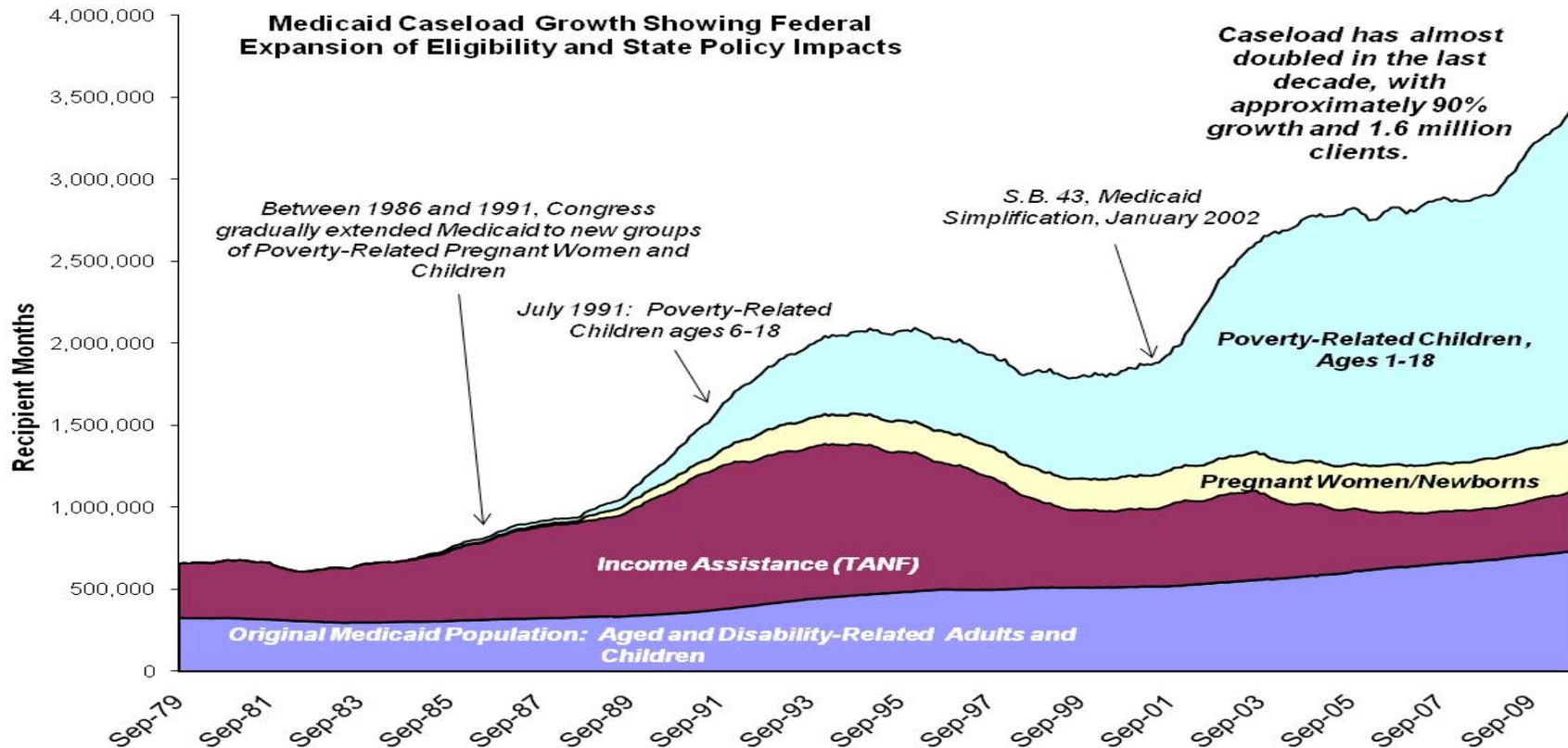
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## External Factors Modifying Medicaid Costs Include:

- **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
- **Economy**
  - Increased caseloads as families lost jobs and insurance coverage
  - Lengthening spells of coverage as economic conditions are not improving for Medicaid populations
  - Increased FMAP rate due to ARRA – TIER III FMAP adjustment for high unemployment states
- **Natural Disasters**
  - H1N1
  - 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**
  - FREW outreach efforts and rate increases may be increasing utilization
  - Health Care Reform may provide an arena for clients to seek health care assistance

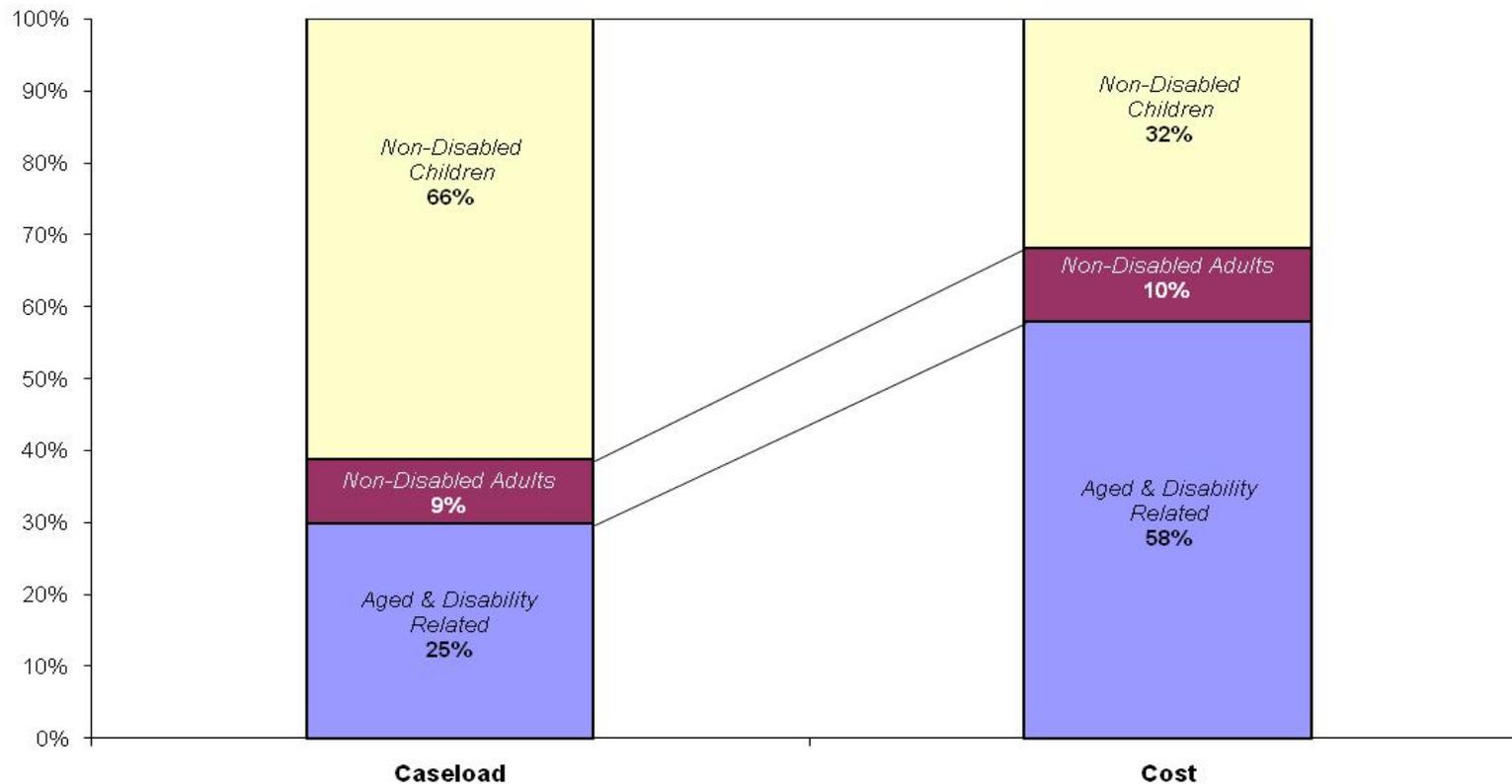
# Where Texas Spends Medicaid Dollars – Caseload

## History of Medicaid Eligibility: Caseload September 1977- August 2010



# Where Texas Spends Medicaid Dollars – Caseload

**Texas Medicaid Beneficiaries and Expenditures  
Fiscal Year 2010**

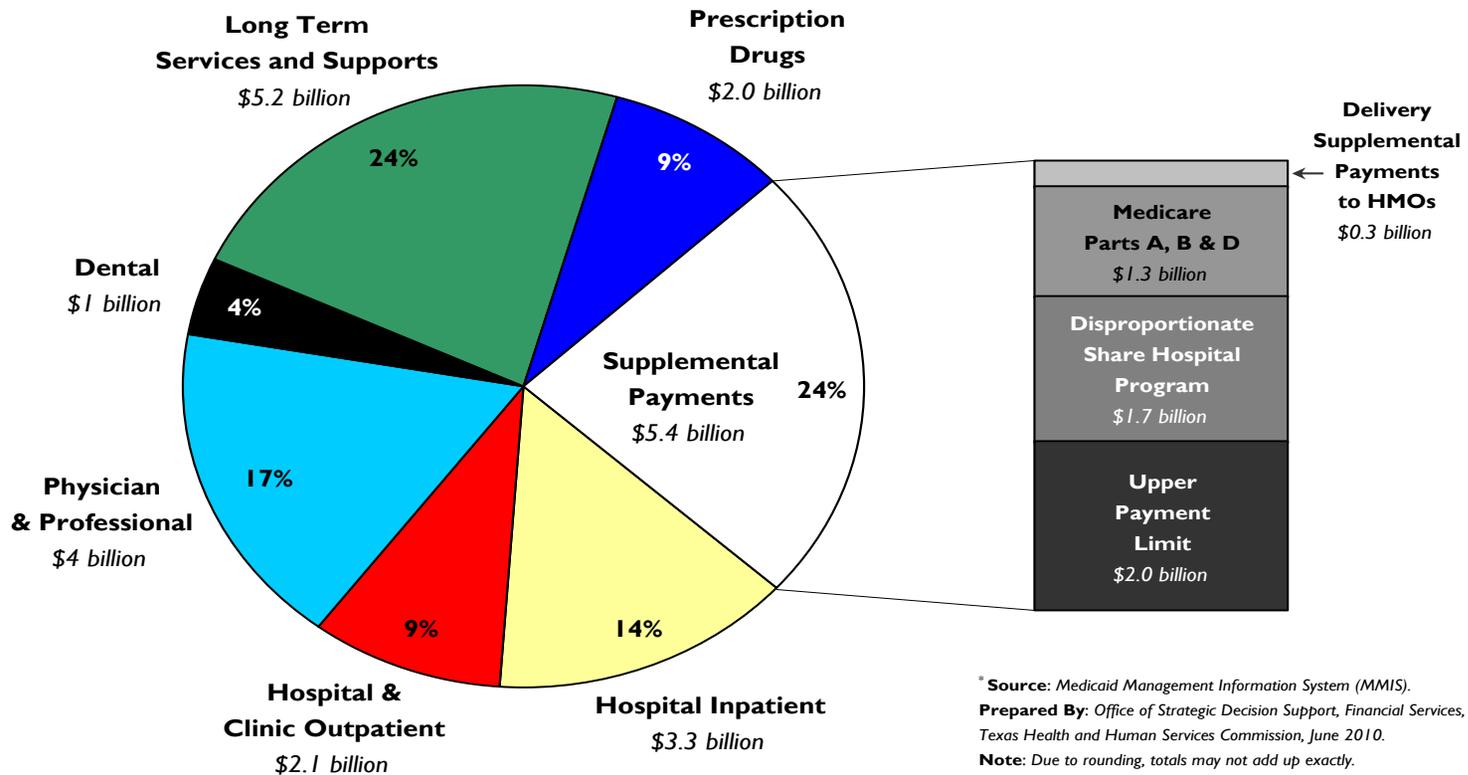


Source: HHS Financial Services, 2010 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Care. Costs and caseload for all Medicaid payments for full beneficiaries and non-full beneficiaries (Women's Health Waiver, Emergency Services for Non-Citizens, Medicare payments) are included. Children include all Poverty-Level Children, including TANF. Disability Related Children are not in the Children group.

# Where Texas Spends Medicaid Dollars – Services

## Texas Medicaid Expenditures, SFY 2009\*

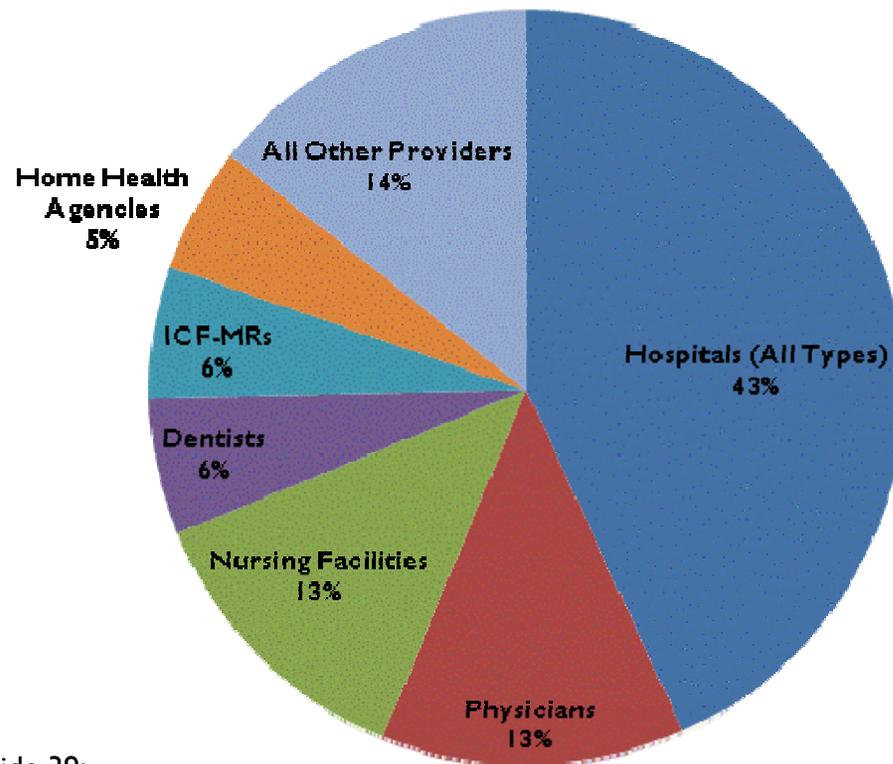
By Service Type — Total \$22.9 billion



\* Source: Medicaid Management Information System (MMIS).  
Prepared By: Office of Strategic Decision Support, Financial Services,  
Texas Health and Human Services Commission, June 2010.  
Note: Due to rounding, totals may not add up exactly.

# Where Texas Spends Medicaid Dollars – Providers

**Texas Medicaid Expenditures by Provider Type**  
Fiscal Year 2009 - Total \$16.9 billion



For more information see slide 39;  
\$16.9 billion does not include DSH/UPL payments to hospitals;  
Vendor Drug Payments, or Medicare Part A/Part B Hospital Premium  
Payments;

# Fraud & 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 & Abuse Initiatives

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- Medicaid/OES Data Matches:
  - Updates on a daily basis the Medicaid claims payment information with the state's eligibility information to ensure claims are paid only for eligible clients.
- OIG Data Matches:
  - Determines if clients have undisclosed or undeclared income or are disqualified by law (death, imprisonment, etc.) from receiving benefits.
- OIG Surveillance and Utilization Review:
  - Utilization review identifies providers with practice patterns that are inconsistent with federal/state requirements, and fall outside the norm of provider peer groups.
    - Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions.
- OIG Research, Analysis, and Detection (RAD) Unit
  - Performs a variety of utilization review activities to monitor FFS and PCCM Medicaid services and performs pre-payment review of claims submitted by certain providers.

## Cost Containment Initiatives

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- The Texas Medicaid program is currently growing at a 9% annual rate of growth and currently consumes more than 25% of the state budget.
- Although the ability to contain costs is largely restricted at the federal level, HHSC has begun implementing various cost containment initiatives that may be done at the state level.

# Medicaid Cost Containment Initiatives

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- High cost imaging management
  - Requires prior authorization (PA) for high cost imaging services.
- New drug classes added to Preferred Drug List (PDL)
  - Effective July 2009, Medicaid implemented a PDL for cough and cold products.
  - HHSC was able to increase savings by adding this class of medications.
- Billing coordination system expansion
  - Expanded BCS to pharmacy claims.
  - Identifies other insurance and defers Medicaid payment.
- Managed Care Organization (MCO) Rates
  - Tighten up experience rebate methodology.
  - Increase third-party recovery requirements.
  - Reduce administrative cost component in rates.

# Medicaid Cost Containment Initiatives

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Smaller cost containment and policy changes implemented in the past 12 months (or in the next fiscal year) may have some bearing on overall cost containment as well.

- These changes are small, and an example of the constant “evolution” in Medicaid cost management and efficiencies.
- Most of these changes involve aligning codes, services or recovery with national standards (such as Medicare or private pay standards).

A sampling of these changes include:

- National Corrective Coding Initiative (NCCI)
- Global Surgical Periods
- Diagnosis Related Group (DRG) Recovery
- Ambulance Policy Changes
- Administrative Cost Containment Initiatives

# Medicaid Assumptions in HB 1

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HB 1 contains various assumptions for the Medicaid program:

- Rates for all Medicaid providers reduced by 10% - (\$1.6 billion GR)
  - Rate increases in current biennium considered one-time and also reduced, except minimum wage increases.
  - 10% reduction is in addition to 1% reduction to certain providers implemented in September 2010.
- Additional future cost containment efforts (HHSC Rider 61) - \$450 million GR.
- Managed care expansion net savings (HHSC Rider 52)- \$367 million GR.
- Medicaid optional services reduced - \$45 million GR.

## Summary of Medicaid Issues in HB 1

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- Caseload Growth and Cost Trends in Medicaid.
- Managed care savings and costs need to be reconciled to SB 1 assumptions for costs and caseloads.
- Administrative and Information Technology (IT) reductions that support managed care expansions with caseload growth.

# Implementing HB 1

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- Medicaid and CHIP Client Services.
- Implement Savings Initiatives assumed in HB 1 - \$2.5 billion GR.
  - Includes a 10 percent provider rate reduction, reduces \$450 million GR for savings achieved through Rider 61 (e.g. payment reform), \$45 million GR savings for reducing or eliminating certain optional Medicaid acute services, expands managed care for net HHS savings, and obtains federal match for children of state employees in CHIP.
- Affordable Care Act provides no flexibility to reduce caseloads through changing eligibility criteria.
- If savings cannot be met, target additional reductions.
  - Impose Substantial Rate Reductions, e.g., reimburse hospitals at the minimum SDA per DRG.
  - Maximize Client Cost Sharing (current federal law limits ability to impose cost sharing)
  - Reduce or Eliminate Other Medicaid Optional Services.
- Seek Funding Flexibility from CMS.
- Take every effort to avoid across-the board provider reductions and try to protect access to care.

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# APPENDICES

# Medicaid Income and Federal Poverty Levels

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- 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 2011: <http://aspc.hhs.gov/poverty/figures-fed-reg.shtml>.

## Based on Annual Income

Family Size	
1	\$10,890
2	\$14,710
3	\$18,530
4	\$22,350
5	\$26,170
6	\$29,990
7	\$33,810
8	\$37,630

At 100% of poverty, for families larger than 8, add \$3,820 for each additional person.

# Medicaid LTSS Waiver Services

## Texas Medicaid Home and Community-Based Waiver Programs

<b>Waiver</b>	<b>Population Served</b>
<i>Medically Dependent Children's Program (MDCP)</i>	Children and young adults under age 21 who are at risk of nursing facility placement because of complex medical needs.
<i>Home and Community-Based Services (HCS)</i>	People of all ages who qualify for ICF/MR/RC Level of Care I as described in rule.
<i>Community Living Assistance and Support Services (CLASS)</i>	People of all ages who have a qualifying disability, other than mental retardation, which originated before age 22 and which affects their ability to function in daily life.
<i>Deaf-Blind Multiple Disabilities (DBMD)</i>	People age 18 and older who are deaf, blind, and have a third disability who qualify for ICF/MR/RC Level of Care VIII.
<i>Community Based Alternatives (CBA)</i>	Adults (age 21 and older) who qualify for nursing facility services.
<i>STAR+PLUS</i>	The CBA, Primary Home Care, and Day Activity and Health Services population in the Travis, Nueces, Bexar and Harris County expansion areas. Services are provided through a 1915(b) waiver and a 1915(c) waiver program.
<i>Consolidated Waiver Program (CWP)*</i>	People of all ages in Bexar County who qualify for services in a nursing facility or an ICF/MR/RC.
<i>Texas Home Living (TxHmL)</i>	People of all ages, living with their families or in their own homes, who qualify for ICF/MR Level of Care and meet the SSI income limit.

\* There are two waivers for this program



# Comparison of FFY 2012 Federal Medical Assistance Percentage (FMAP)

**Federal Fiscal Years (FFYs) 2011 and 2012 FMAPS, District of Columbia and by State**

State	FFY 2011	FFY 2012	Point Change	State	FFY 2011	FFY 2012	Point Change
Alabama	68.54	68.62	0.08	Missouri	63.29	63.45	0.16
Alaska	50.00	50.00	0.00	Montana	66.81	66.11	-0.70
Arizona	65.85	67.30	1.45	Nebraska	58.44	56.64	-1.80
Arkansas	71.37	70.71	-0.66	Nevada	51.61	56.20	4.59
California	50.00	50.00	0.00	New Hampshire	50.00	50.00	0.00
Colorado	50.00	50.00	0.00	New Jersey	50.00	50.00	0.00
Connecticut	50.00	50.00	0.00	New Mexico	69.78	69.36	-0.42
Delaware	53.15	54.17	1.02	New York	50.00	50.00	0.00
District of Columbia	70.00	70.00	0.00	North Carolina	64.71	65.28	0.57
Florida	55.45	56.04	0.59	North Dakota	60.35	55.40	-4.95
Georgia	65.33	66.16	0.83	Ohio	63.69	64.15	0.46
Hawaii	51.79	50.48	-1.31	Oklahoma	64.94	63.88	-1.06
Idaho	68.85	70.23	1.38	Oregon	62.85	62.91	0.06
Illinois	50.20	50.00	-0.20	Pennsylvania	55.64	55.07	-0.57
Indiana	66.52	66.96	0.44	Rhode Island	52.97	52.12	-0.85
Iowa	62.63	60.71	-1.92	South Carolina	70.04	70.24	0.20
Kansas	59.05	56.91	-2.14	South Dakota	61.25	59.13	-2.12
Kentucky	71.49	71.18	-0.31	Tennessee	65.85	66.36	0.51
Louisiana	63.61	61.09	-2.52	<b>TEXAS</b>	<b>60.56</b>	<b>58.22</b>	<b>-2.34</b>
Maine	63.80	63.27	-0.53	Utah	71.13	70.99	-0.14
Maryland	50.00	50.00	0.00	Vermont	58.71	57.58	-1.13
Massachusetts	50.00	50.00	0.00	Virginia	50.00	50.00	0.00
Michigan	65.79	66.14	0.35	Washington	50.00	50.00	0.00
Minnesota	50.00	50.00	0.00	West Virginia	73.24	72.62	-0.62
Mississippi	74.73	74.18	-0.55	Wisconsin	60.16	60.53	0.37
				Wyoming	50.00	50.00	0.00

Note: American Recovery and Reinvestment Act of 2009 (ARRA) FMAP increases are not included.

Source: Federal Funds Information for States, 2010.

# Historical Medicaid Caseload

## Average Monthly Recipient Months

Fiscal Year	ADULTS & SSI RELATED			CHILDREN'S RISK GROUPS			TOTAL Medicaid	
	Aged & Medicare Related	Disabled & Blind	Pregnant Women and TANF Adults	New borns	TANF Children (with Foster Care)	Ages 1 - 18 Poverty-Related Children	TOTAL Medicaid	Annual Caseload Trend <sup>†</sup>
<b>FY 2004</b>	320,548	246,459	246,018	136,024	341,624	1,392,554	<b>2,683,227</b>	7.8%
<b>FY 2005</b>	323,374	266,213	238,297	145,160	294,024	1,512,305	<b>2,779,373</b>	3.6%
<b>FY 2006</b>	329,747	289,749	226,601	155,845	255,569	1,534,497	<b>2,792,007</b>	0.5%
<b>FY 2007</b>	335,458	307,482	215,802	164,357	235,489	1,573,626	<b>2,832,214</b>	1.4%
<b>FY 2008</b>	338,573	326,439	207,761	168,459	233,921	1,602,049	<b>2,877,203</b>	1.6%
<b>FY 2009</b>	343,106	346,972	208,562	181,487	237,995	1,686,258	<b>3,004,380</b>	4.4%
<b>FY 2010</b>								
<b>Sep-09</b>	347,086	359,423	218,201	186,699	246,950	1,837,578	<b>3,195,937</b>	<b>10.0%</b>
<b>Oct-09</b>	347,802	360,407	218,156	187,288	248,235	1,859,486	<b>3,221,374</b>	<b>11.1%</b>
<b>Nov-09</b>	348,134	362,486	214,681	184,993	252,891	1,868,796	<b>3,231,981</b>	<b>11.3%</b>
<b>Dec-09</b>	346,381	363,387	213,524	186,183	256,752	1,882,743	<b>3,248,970</b>	<b>11.2%</b>
<b>Jan-10</b>	348,471	365,073	215,211	185,125	259,758	1,894,476	<b>3,268,114</b>	<b>10.6%</b>
<b>Feb-10</b>	348,899	367,904	215,251	184,007	259,375	1,900,584	<b>3,276,020</b>	<b>9.9%</b>
<b>Mar-10</b>	349,678	369,339	218,630	185,091	260,425	1,919,196	<b>3,302,359</b>	<b>9.5%</b>
<b>Apr-10</b>	349,742	370,285	218,669	183,806	258,439	1,931,294	<b>3,312,235</b>	<b>9.3%</b>
<b>May-10</b>	349,851	373,035	219,980	183,375	258,289	1,941,159	<b>3,325,689</b>	<b>9.0%</b>
<b>Jun-10</b>	350,738	375,692	221,827	183,384	259,695	1,967,131	<b>3,358,467</b>	<b>8.3%</b>
<b>Jul-10</b>	351,523	376,910	224,651	183,293	264,439	1,984,652	<b>3,385,468</b>	<b>8.4%</b>
<b>Aug-10</b>	352,634	379,442	228,444	183,327	270,382	2,017,305	<b>3,431,533</b>	<b>8.5%</b>
<b>FY 2010 YTD Avg</b>	349,245	368,615	218,935	184,714	257,969	1,917,033	<b>3,296,512</b>	<b>9.7%</b>
<b>Sep-10</b>	353,393	380,969	229,015	187,606	278,251	2,030,466	<b>3,459,699</b>	<b>8.3%</b>
<b>Oct-10</b>	354,287	382,219	229,276	190,989	283,470	2,039,466	<b>3,479,708</b>	<b>8.0%</b>
<b>Nov-10</b>	355,195	384,682	228,424	193,371	288,398	2,050,339	<b>3,500,408</b>	<b>8.3%</b>
<b>Dec-10</b>	353,763	385,449	229,343	197,215	297,497	2,064,114	<b>3,527,382</b>	<b>8.6%</b>
<b>Jan-11</b>	356,514	389,002	233,100	204,796	304,915	2,077,650	<b>3,565,977</b>	<b>9.1%</b>
<b>Feb-11</b>	356,918	393,418	232,226	211,919	308,778	2,089,426	<b>3,592,686</b>	<b>9.7%</b>
<b>FY 2011 YTD Avg</b>	355,012	385,956	230,231	197,650	293,551	2,058,577	<b>3,520,977</b>	<i>na</i>

Annual Caseload Trend is based on that month's average (or the FY average), compared to the same period 12 month's prior.  
All data prior to and including July 2010 will not change, August 2010 forward are estimated with completion ratios

# Where Texas Spends Medicaid Dollars – Providers

## Expenditures by Type of Providers -- FY 2009

Provider Group	Expenditures	% of Total Expenditures	# of Providers
Hospitals (All Types)	\$ 7,324,893,872	43.2%	620
Physicians	\$ 2,217,228,553	13.1%	49,797
Nursing Facilities	\$ 2,133,926,620	12.6%	1,068
Dentists	\$ 995,165,572	5.9%	6,336
ICF-MRs	\$ 953,753,414	5.6%	527
Home Health Agencies	\$ 916,462,721	5.4%	1,571
Durable Medical Equipment (DME) Suppliers	\$ 466,306,107	2.7%	5,917
Ambulance	\$ 363,392,037	2.1%	1,105
Rehabilitation Centers	\$ 337,556,876	2.0%	423
Ambulatory Surgical Centers	\$ 311,374,466	1.8%	677
Labs	\$ 143,372,663	0.8%	627
Dialysis Centers	\$ 140,428,457	0.8%	416
Allied Health Providers	\$ 123,442,613	0.7%	3,201
Federally Qualified Health Centers (FQHCs)	\$ 110,545,052	0.7%	152
School Health & Related Services (SHARS)	\$ 99,558,373	0.6%	625
Comprehensive Care Program Providers	\$ 86,720,457	0.5%	2,666
Rural Health Centers	\$ 71,326,161	0.4%	297
Behaviorial Health Providers	\$ 67,517,978	0.4%	5,241
Nurses (APNs and CRNAs)	\$ 34,468,643	0.2%	7,274
Physical Therapy/Occupational Therapy	\$ 21,346,862	0.1%	1,215
Maternity Clinics / Birthing Centers	\$ 377,899	0.0%	26
TB Clinics	\$ 49,431	0.0%	19
Other Providers	\$ 54,450,961	0.3%	2,375

Includes FFS/PCCM claims and payments to providers by HMOs

Other Providers include: Genetics, Indian Health Services, ECI, County Indigent Health  
Does not include DSH/UPL