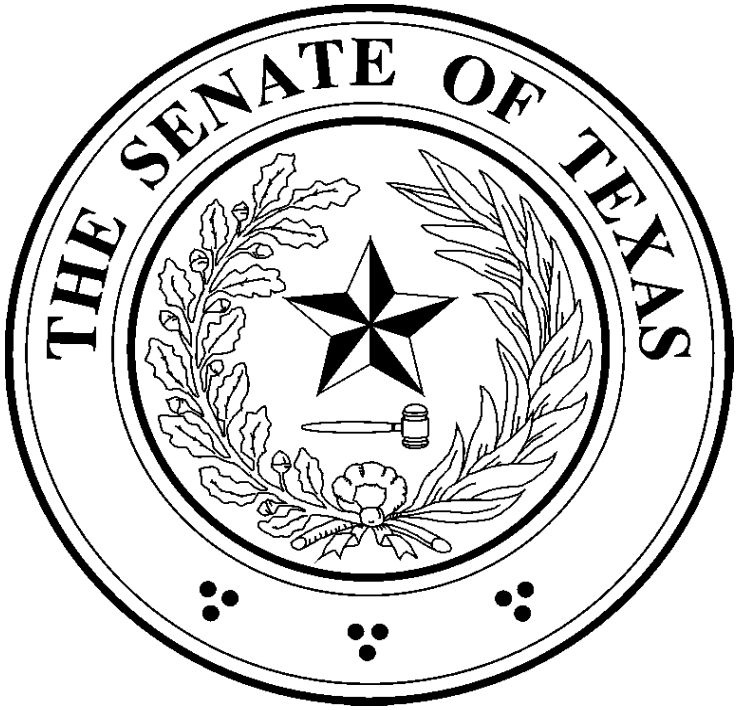

Senate Finance Subcommittee on Health and Human Services Demand

Interim Report

November, 2002

Please direct questions and comments to:

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Senate Finance Subcommittee on Health and Human Services Demand
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Cristina Gonzalez, Chris Hudson, PhD, and Kathryn Weiner, representing Senator Judith Zaffirini; Darren Whitehurst and Michael Grimes, representing Senator Chris Harris; Lara Wendler, representing Senator John Whitmire; Perla Cavazos, representing Senator Eddie Lucio; Jennifer Chambers, representing Senator Robert Duncan; Terry Franks, representing Senator Jon Lindsay; Kelly Ferguson and Paul Priest, Legislative Budget Board; Blaine Brunson and Amber Martin, representing Senate Finance Committee; and Laura Smith, representing Lieutenant Governor William R. Ratliff.

The Committee appreciates also the numerous stakeholders for their involvement in this report, especially those who provided testimony during public hearings.

November 15, 2002

The Honorable
Rodney Ellis, Chair
Senate Finance Committee
P.O. Box 12068
Austin, TX 78711

Dear Chair Ellis:

The Senate Finance Subcommittee on Health and Human Services Demand submits this interim report. We thank you for providing us this opportunity to address these important health and human services issues and to present options that may benefit Texas.

The options outlined in this report are based on extensive testimony and suggestions from state agencies, organizations and other interested persons. Throughout our deliberations our priority was to improve the health and the lives of all Texans.

Respectfully submitted,

Senator Judith Zaffirini Chair	Senator John Whitmire	Senator Chris Harris
Senator Eddie Lucio	Senator Robert Duncan	Senator Jon Lindsay

Texas Senate Committee on Finance

Interim Subcommittee on Health and Human Services Demand

Interim Report

Contents

Executive Summary

On Sept. 2, 2001, Lieutenant Governor William R. Ratliff issued six charges to the Senate Finance Committee. On Oct. 24, 2001, Senator Rodney Ellis, Chair, Senate Finance Committee, announced the creation of the Subcommittee on Health and Human Services Demand, appointing Senator Judith Zaffirini as chair, and issued the following interim charges corresponding to Charge Three (Appendix A):

1. *Focus on a review of health and human service caseload forecasting and projection methodology including a look at current projections for future health care demands and a review of per-capita cost trends since 1996.*

2. *Examine methodologies used by each agency in developing their client waiting lists, including the development of a more accurate account of the number of persons on each waiting list including how each agency determines how new slots are to be rolled out and how that translates into cost per client.*

3. *Study the process by which Medicaid provider reimbursement rates are reviewed and what factors contribute to their adjustments. In addition, foster care/adoption subsidy reimbursement rates will also be reviewed.*

The Committee held public hearings related to the interim charges on Feb. 8, 2002, and May 9, 2002 (Appendix B).

This report includes background, an overview of the methodology used for caseload and cost projections and options identified by the Sub-Committee (Appendix C). The Committee provides these options to assist the 78th Legislature (2003) determine funding priorities.

Charge 1: Caseload and Cost Projections

Forecasting in Health and Human Services (HHS) agencies typically focuses on projecting caseloads and costs for services to predict future budget needs. The Health and Human Services Commission (HHSC) coordinates, reviews and approves HHS agency caseload forecasts, and also produces caseload and cost forecasts for Medicaid, the Children's Health Insurance Program (CHIP) and programs at other agencies.

Most HHS forecasts are based on time-series models with adjustments for program issues, population limits and demographic information, historical trends and policy changes. Time-series models use historical value in a mathematical model to pattern historical data and project future values. Recent trends are weighted more heavily, as caseload growth in recent months is more likely to reflect future growth. Several models are followed over time to determine which most accurately reflect caseload change. The model that best predicts caseload or cost change is used for the next period. Nevertheless, multiple models continue to be monitored as data characteristics impacting model performance can rapidly change.

Acute Care Medicaid Forecasts

Time-series models are used to determine caseloads and for most cost forecasts for Acute Care Medicaid programs. Forecasts are used to determine the number of clients served and the average cost of services for those clients. Caseload and cost forecasts are produced at the risk group or service level. Several factors affect the accuracy of forecasting models used for Medicaid acute care. Time-series models are reliable only for short-term forecasts of between 6 and 18 months. Because of the caseload and expenditures involved, slight changes in either can make significant changes in the program's course. In light of these factors, HHSC put in place a system of checks and balances to ensure the most accurate forecasts.

CHIP

CHIP forecasting is based on an estimate of the potentially eligible population. This potentially eligible population includes CHIP income-eligible, uninsured, Medicaid income-eligible uninsured with assets that exceed the Medicaid asset limit, and CHIP and Medicaid income-eligible children who have had insurance and who will wait 90 days prior to enrolling in CHIP. Anticipated impacts of policy changes lead to adjustments in the base forecast, as was the case in 2002. As with other programs' enrollment, forecasts are updated each month to reflect the most recent data. Cost forecasting is based on three different components: aggregate amount paid for Health Plan and Dental Plan Premiums, cost of prescription drugs under the CHIP Prescription Drug Program, and immunization costs.

Foster Care

Time-series models are used by PRS to determine foster care caseloads, child abuse/neglect investigations, and for the adoptions of children in state conservatorship caseloads. Each of these forecasts is performed based upon the historical numbers of children (for adoptions and for foster care) and families (for investigations) involved in each area being projected. As foster care involves multiple levels of care and two primary funding sources, each level of care for each funding source is projected independently of the others, with the forecasts combined into totals for each funding source as well as overall totals. Projections of days of care and expenditures for foster care are derived from these forecasts of the numbers of children based upon a foster care caseload model developed and maintained by PRS.

Current Trends in Caseload and Cost Projections

Two major programs that face shortfalls are Medicaid and CHIP. Acute Care Medicaid as of June, 2002, is facing a $281.3 million projected shortfall. The driving factor for the shortfall is an increase of 175,065 in caseload over what was appropriated in Senate Bill 1. Other factors contributing to this shortfall include $6.25 million more than appropriated for in Senate Bill 1 for Vendor Drug prescriptions, a 30 percent, or $55 million, increase in cost-reimbursed services expenditures above Senate Bill 1 and the estimated effect of $18.1 million at HHSC and $0.8 million at TDH for a change in the Federal Medical Assistance Percentage (FMAP). CHIP also faces an increase in caseload per month of 31,760 more than what was appropriated in Senate Bill 1. In addition to an increase in caseload, premiums and participation rates also are driving factors in the shortfall.

Charge 2: Waiting Lists

The 77th Legislature appropriated an increase of $238.7 million in All Funds ($104.4 million in General Revenue/Tobacco Settlement Receipts) for waiting lists and waiver services. Senate Bill 1 contained 10 riders related to client waiting lists. The Texas Department of Health (TDH), the Texas Department of Mental Health and Mental Retardation (MHMR), and the Texas Department of Human Services (DHS) all use either waiting lists or interest lists for services. Some of these people are eligible for services and are on a waiting list, and others have expressed an interest in services and are on an interest list.

Texas Department of Health
Currently the benefits of the Children With Special Health Care Needs (CSHCN) program include a comprehensive health benefits package and family support services for children with special health care needs who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) or who do not have private insurance. Also included are medical wrap-around services and family support services to children with special health care needs who are eligible for Medicaid, CHIP, or have private insurance.

Currently there are 1,653 people on the waiting list for the CSHCN program. The average length of time for current CSHCN clients on the program is 5.9 years, while the range of time for clients on the program is from 10 months to 38 years. For clients on the waiting list for medical services, 565, or 49.3 percent, of clients have some type of health care coverage (Medicaid/CHIP and/or private insurance), and 581, or 50.7 percent, of clients have no other type of health care coverage.

Texas Department of Human Services
The Texas Department of Human Services (DHS) estimates that it will serve an average of 138,848 clients in the Community Care programs in Fiscal Year (FY) 2002. Interest lists exist for Non-Entitlement Community Care Waiver programs, such as Community Based Alternatives (CBA), and for other (Title XX; State Funded) Community Care programs. Interest lists include all individuals that have contacted DHS requesting services or programs that are non-entitlement services. No screening or eligibility determination for the services requested has been done for these individuals registered on the interest list. As funds become available to serve new clients in these programs, the individuals on the interest list are contacted to begin the eligibility determination process.

Because the demand for community care services exceeds the available slots, DHS has maintained interest lists for these programs since the early 1980s. The Department maintains interest lists for community care services on a first come, first served basis. It does not maintain a "needs based" waiting list in which eligibility and level of care are determined when an individual requests services. Currently, there are no federal statutes regarding the maintenance of these community care interest lists. As of Aug. 15, 2002, there are 57,114 persons waiting for services, 29,926 of whom are already receiving some level of care within DHS long-term care.

Texas Department of Mental Health and Mental Retardation
The Texas Department of Mental Health and Mental Retardation (MHMR) provides services to more than 190,000 Texans annually.

Mental Retardation Services
Mental Retardation services include Home and Community-Based Services, Mental Retardation Local Authority, Home and Community-Based Services OBRA, and Community Mental Retardation Services. After going through an intake process at a local mental retardation authority, a person requesting community mental retardation services will be placed on a waiting list if the service cannot be provided within 30 days. If a person is receiving some mental retardation services but other requested services such as HCS are unavailable, the person will be placed on a waiting list for the services not being received. There are 20,856 people currently waiting for mental retardation services in Texas.

Mental Health Services
Since the inception of the mental health waiting list in 1998, the most consistently needed services for which adults must wait have been medication-related services, supported employment services, supported housing services and service coordination (case management). The most consistently needed services for which children must wait have been medication-related services and skills training. Persons placed on a waiting list for mental health services must be removed from the waiting list and entered into services when the needed services become available. The local authority uses clinical judgement to determine who is entered into services from the waiting list. This determination is based on the individual's symptoms and functioning level. There are 6,015 people waiting for mental health services in Texas.

Charge 3: Rates

In the Medicaid program payments are made directly to the providers. Medicaid providers must accept the Medicaid reimbursement level as payment in full. States have the flexibility to determine the reimbursement methodology and the rate for services. Reimbursement rates must be sufficient to enlist adequate participation in the Medicaid Program by physicians and other practitioners and to ensure the ability of the eligible Medicaid population to receive adequate health care services in an appropriate setting. States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such copayments. The total federal dollars matched for Medicaid has no set limit. As long as a state provides services within the federal law for its eligible recipients, the federal government must match that spending according to the Federal Medical Assistance Percentage (FMAP).

In Texas the Health and Human Services Commission (HHSC) has broad oversight responsibility under Government Code §531.0055 for the overall operations of health and human services agencies, including their rate-setting activities. Medicaid reimbursement rates

can be categorized as one of the following: fee for service, capitated, or facility based and community care rate. Each program and service require a separate rate methodology. Rates are set based on factors such as historical costs, modeling, and budgetary limitations. In addition to cost reports and formulas included in approved methodologies, rate setting is influenced by appropriations and legislative directive. The 77th Legislature appropriated $1.1 billion in All Funds, including $436 million in General Revenue funds, for Medicaid rate and related increases at health and human services agencies.

Introduction

On Sept. 2, 2001, Lieutenant Governor William R. Ratliff issued six charges to the Senate Finance Committee. On Oct. 24, 2001, Senator Rodney Ellis, Chair, Senate Finance Committee, announced the creation of the Subcommittee on Health and Human Services Demand, appointing Senator Judith Zaffirini as chair, and issued the following interim charges corresponding to Charge Three (Appendix A):

1. *Focus on a review of health and human service caseload forecasting and projection methodology including a look at current projections for future health care demands and a review of per-capita cost trends since 1996.*

2. *Examine methodologies used by each agency in developing their client waiting lists, including the development of a more accurate account of the number of persons on each waiting list including how each agency determines how new slots are to be rolled out and how that translates into cost per client.*

3. *Study the process by which Medicaid provider reimbursement rates are reviewed and what factors contribute to their adjustments. In addition, foster care/adoption subsidy reimbursement rates will also be reviewed.*[1]

The Committee held public hearings related to the interim charges on Feb. 8, 2002, and May 9, 2002 (Appendix B).

This report includes background, an overview of the methodology used for caseload and cost projections and options identified by the Subcommittee (Appendix C). Unless otherwise noted all charts, graphs and tables were created from information provided by the Legislative Budget Board, Mental Health and Mental Retardation, Department of Health, Department of Human Services and Health and Human Services Commission. The Committee identifies these options to assist the 78th Legislature (2003) in determining funding priorities. The Joint Interim Committee on Health Services Interim Report, November, 2002, provides additional information about caseload and cost projections of major health and human services agencies.

Charge 1: Caseload and Cost Projections

CHARGE 1: Focus on a review of health and human service caseload forecasting and projection methodology including a look at current projections for future health care demands and a review of per-capita cost trends since 1996.

Overview

Forecasting in Health and Human Services (HHS) agencies focuses on projecting caseloads and costs for services to predict future budget needs. Forecasting allows agencies to estimate what future caseloads and costs will be if trends continue. HHSC coordinates, reviews and approves HHS agency caseload forecasts. It also produces caseload and cost forecasts for Medicaid, the Children's Health Insurance Program (CHIP) and programs at other agencies. [2]

The process for caseload forecasting is similar for all programs. Most HHS forecasts are based on time-series models with adjustments for program issues, population limits and demographic information, historical trends and policy changes. Time-series models use historical value in a mathematical model to pattern historical data and to project values. Recent trends are weighted more heavily, as caseload growth is more likely to reflect future growth. Several models are followed over time to determine which most accurately reflect caseload change. The model that best predicts caseload or cost change is used for the next period. Nevertheless, multiple models continue to be watched, as data characteristics impacting model performance can rapidly change[3].

The following programs use time-series models for forecasting:

- HHSC Medicaid caseloads;
- Texas Department of Human Services (DHS) - Temporary Assistance for Needy Families (TANF), Food Stamps, Client Support Services Medical Assistance and Long-Term Care caseloads;
- Texas Department of Mental Health and Mental Retardation (MHMR)- Mental Health Community Services caseloads;
- Texas Department of Health (TDH) - Women, Infants and Children (WIC), HIV/STD Treatment and Prevention, and immunization caseloads;
- Texas Rehabilitation Commission (TRC) - Vocational Rehabilitation Program and Comprehensive Rehabilitation Services caseloads;
- Interagency Council on Early Childhood Intervention (ECI) - Comprehensive Services caseloads; and

- Texas Department of Protective and Regulatory Services (PRS) - Child Abuse /Neglect Investigations, Foster Care, and Adoptions of Children in state conservatorship caseloads. [4]

Programs for which caseload forecasts are performed fall into two general categories, entitlement programs and non-entitlement programs. Some of the larger health and human services programs are entitlement programs, meaning that the state is legally obligated to serve everyone who meets the eligibility criteria and who asks for services. Accurate caseload forecasting is critical for these types of programs since an agency cannot deny services based on a lack of funds. (A current example of this can be found in the caseload forecast for Medicaid.) If a caseload forecast is too low at the time of the appropriation, the only options available to the state has been to change the eligibility mid-biennium (but federal law sets minimum eligibility criteria) or to provide additional emergency funding between legislative sessions. In the case of Medicaid, HHSC is considering deferring approximately $225 million in Medicaid expenditures by moving from an accrual basis of finance to a cash basis.[5]

Agency Forecasting - How much does it cost?

DHS - The FY 02 budget for DHS demographics and forecasting unit is $126,525. The unit consists of three full-time employees (FTE): one FTE for a demographer and two FTEs for forecasters. Neither the demographer nor the forecaster is program specific.

TDH - Expenditure projections of client services for the CSHCN Program are prepared under a contractual arrangement for actuarial services. The actuarial projections of client services are based on historical expenditures in the program, using trend analysis and specific program information. For FY 02 the contract amount is anticipated to be $63,000, and for FY 03 $70,000. In November, 2001, it was recommended by HHSC that TDH periodically bring in a secondary actuary to review the performance and methodology of the contracted actuary. Payment for the second contract will be $33,000 from FY 03 funds, to be paid when results of the review are provided to TDH.

MHMR - Medicaid programs do not operate in an entitlement environment like the programs operated by DHS and HHSC. The major MHMR program, ICF-MR, has bed capacity controlled by the Long Term Care Bed Plan. The caseloads for the waiver programs are capped according to the written agreements between the Federal CMS and the state, and they are adjusted upward only when requested by the state. MHMR does not have personnel that perform economic and caseload forecasting due to this.

Many variables (economic trends, policy changes, etc.) influence caseload projections of health and human services programs. Because of these factors, forecasting must be an ongoing process. Because no method accurately can forecast caseload far into the future, each forecast must be updated as new historical data become available. For this reason, most health and human service agencies have ongoing forecasting activities and either produce new forecasts monthly or at least monitor the estimates monthly. [6]

Acute Care Medicaid Forecasts

Time-series models are used to determine caseloads and most cost forecasts for acute care Medicaid programs. Forecasts are used to determine the number of clients served and the average cost of services for those clients. Caseload and cost forecasts are produced at the risk group or service level. Raw data for clients come from reports generated by DHS, while cost data come from various sources, including reports of claims and vouchers paid at National Heritage Insurance Company (NHIC) and from paid pharmacy claims. HHSC follows several models to determine which performs best. Data are updated monthly and rerun quarterly to adjust for any changes.

HHSC reported that a change of .05 percent in monthly caseload would result in a $1 million impact on general revenue expenditures.

Several factors affect the accuracy of forecasting models used for Medicaid acute care. Time-series models are reliable only for short-term forecasts, between 6 and 18 months. Anticipated or unanticipated policy also can affect the accuracy for forecasts. Changes in the poverty level population affect the potential client pool, which also leads to less accurate forecasts. Because of the caseload and expenditures involved, slight changes in either can make significant changes in the program's course. HHSC reported that a change of .05 percent in monthly caseload would result in a $1 million impact on general revenue expenditures.

In light of these factors, HHSC put in place a system of checks and balances to ensure the most accurate forecasts. First, HHSC contracts with an outside consultant for second opinions about forecasts and methodology. Second, NHIC produces independent forecasts on a regular basis. Finally, HHSC submits caseload and expenditure data and forecasts to the Legislative Budget Board (LBB) and to the Governor's Office. The State Auditor's Office last review of HHSC's forecasting methodology was favorable. [7]

CHIP

Potential Eligible Population for CHIP

According to HHSC, "There are an estimated 740,000 children eligible for CHIP. That estimate includes children who are currently enrolled in CHIP and those who have not enrolled in CHIP. This estimate is based on the March, 2001, Current Population Survey (CPS) conducted by the U.S. Census Bureau. The estimate includes both children in the CHIP income range and an estimate of the number of children who are in the Medicaid income range, but would not qualify for Medicaid."

Because the CHIP program began in May, 2000, data are not available for time-series forecasting. Instead, CHIP forecasting is based on an estimate of the potentially eligible population. This potentially eligible population includes CHIP income-eligible, uninsured, Medicaid income-eligible uninsured with assets that exceed the Medicaid asset limit, and CHIP and Medicaid income-eligible children who have had insurance and will wait 90 days prior to enrolling in CHIP. HHSC assumed, based on other states' information, that 75 percent of the eligible population would enroll. This figure was used to compute the CHIP base forecast. Anticipated impacts of policy changes lead to adjustments in the base forecast, as was the case in 2002. As with other programs' enrollment, forecasts are updated each month to reflect most recent data. Cost forecasting is based on three different components: aggregate amount paid for Health Plan and Dental Plan Premiums, cost of prescription drugs under the CHIP Prescription Drug Program and immunization costs. Total cost forecasting incorporates these components and caseload forecasts. [8]

Foster Care

Time-series models are used by PRS for foster care, child abuse/neglect investigations, and for the adoption of children in state conservatorship caseloads. Each of these forecasts is performed based upon the historical numbers of children (for adoptions and foster care) and families (for investigations) involved with each area being projected. Foster care caseloads are projected on a monthly basis and provided to the HHSC, the Governor's Office, and the LBB in accordance with budget Rider 15 requirements. As foster care involves multiple levels of care and two primary funding sources, each level of care for each funding source is projected independently of the others. Then forecasts are combined into totals for each funding source as well as overall totals. Projections of days of care and expenditures for foster care are derived from these forecasts of the numbers of children based upon a complex foster care caseload model developed and maintained by PRS. All forecasts are generated using a process that determines the best fit of available and applicable mathematical models. [9]

Status

Comparison of Major Health and Human Services Program Caseloads

As previously noted, there are numerous factors that can affect caseload projections. Even a .05 percent change in caseload can affect general revenue expenditures by millions of dollars.

Table 1.1 Comparison of Major Health and Human Services Program Caseloads

Program/ Fiscal Year	Appropriated	Actual/ Projected
HHSC		
Medicaid Caseload		
1998	1,944,020	1,860,801
1999	1,929,551	1,778,522
2000	1,719,409	1,758,712
2001	1,704,879	1,824,755
2002	1,904,048	2,062,390
2003	2,011,256	2,293,450
HHSC		
CHIP Caseload		
1998		
1999		
2000	96,553	28,300
2001	280,811	251,476
2002	467,952	499,332
2003	492,799	535,615
DHS - TANF Caseload		
1998	543,885	474,891
1999	523,217	370,069
2000	348,087	341,396
2001	312,514	349,853
2002	361,225	363,565
2003	364,476	362,829
DHS - Nursing Homes Caseload		
1998	65,522	63,817
1999	65,116	63,629
2000	64,991	61,598
2001	65,082	61,726
2002	64,072	60,062
2003	64,009	59,089
MHMR - State Hospital Daily Census		
1998	2,575	2,447
1999	2,575	2,309
2000	2,456	2,346
2001	2,456	2,395
2002	2,235	2,292
2003	2,237	2,368

Program/ Fiscal Year	Appropriated	Actual/ Projected
MHMR		
State School Average Monthly Number of Enrollments		
1998	5,213	5,434
1999	5,038	5,297
2000	5,457	5,338
2001	5,457	5,246
2002	5,425	5,049
2003	5,425	4,950
MHMR - HCS Average Monthly		
1998	4,586	4,338
1999	5,017	4,980
2000	5,672	5,325
2001	5,812	5,975
2002	6,667	6,461
2003	6,667	6,792
PRS - Foster Care Caseload		
1998	11,804	12,205
1999	12,306	12,480
2000	11,897	13,704
2001	12,242	14,548
2002	13,028	15,964
2003	13,527	17,444
MHMR - Community ICF-MR Average # Persons		
1998	7,624	7,537
1999	7,624	7,619
2000	7,627	7,623
2001	7,627	7,650
2002	7,644	7,683
2003	7,644	7,689

Current Trends in caseload and cost projections

Acute Care Medicaid

Senate Bill 1 appropriated $15 billion for Acute Medicaid for the 2002-2003 biennium. Acute Care Medicaid as of June, 2002, is facing a $281.3 million dollar projected shortfall. The driving factor for the shortfall is an increase of 175,065 in caseload over what was appropriated in Senate Bill 1 (Chart 1.1). Senate Bill 1 appropriations were made on caseload projections of 1,904,048 persons in FY 02 and 2,011,256 in FY 03. The actual caseload was 8.7 percent higher, or a caseload of 2,062,390, for FY 02. The FY 03 projections were then adjusted to reflect a 14 percent increase, or 2,293,450 cases.

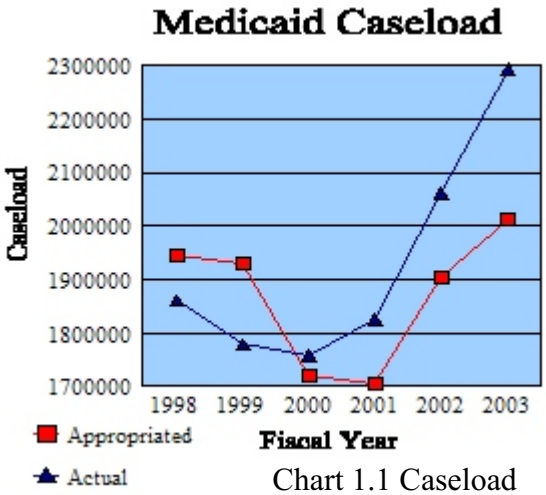


Chart 1.1 Caseload

According to HHSC, the main factors for caseload growth are the economy and Medicaid simplification. [10] Other factors contributing to this shortfall include: $6.25 million more than appropriated for in Senate Bill 1 for Vendor Drug prescriptions; a 30 percent, or $55 million, increase in cost-reimbursed services expenditures above Senate Bill 1; and the estimated effect of $18.1 million at HHSC and $0.8 million at TDH of a change in the Federal Medical Assistance Percentage (FMAP). (Charts 1.2 through 1.4 and Table 1.2 related to shortfall).

Other Factors Contributing to the Shortfall

According to HHSC (2002):

> In the Legislative Appropriations Request for FY 02 there is a surplus of $120 million which is offset by a deficit of $401.6 million in FY 03 for a biennial deficit of $281.3 million. Caseload growth contributes significantly to the deficit as there are increases in premium strategies as well as non-premium strategies such as drugs and CCP. Over 90 percent of the caseload growth has been related to children. The FY 02 average monthly caseload is 141,000 more than what was assumed in Senate Bill 1 and 262,000 more for FY 03. These numbers exclude spillover which is an increase of 9,100 average recipient months in FY 02 and 46,800 in FY 03. Caseload also effects the number of prescriptions. HHSC is estimating that there will be over four million more Medicaid prescriptions provided in the FY 02-03 biennium than the 58.5 million assumed in Senate Bill 1. Cost assumptions are lower than what was originally assumed because children generally are less expensive than adults. Two areas where average cost increase are the average Part A premium paid for Medicare recipients and the average cost of emergency services for aliens in Cost Reimbursed.

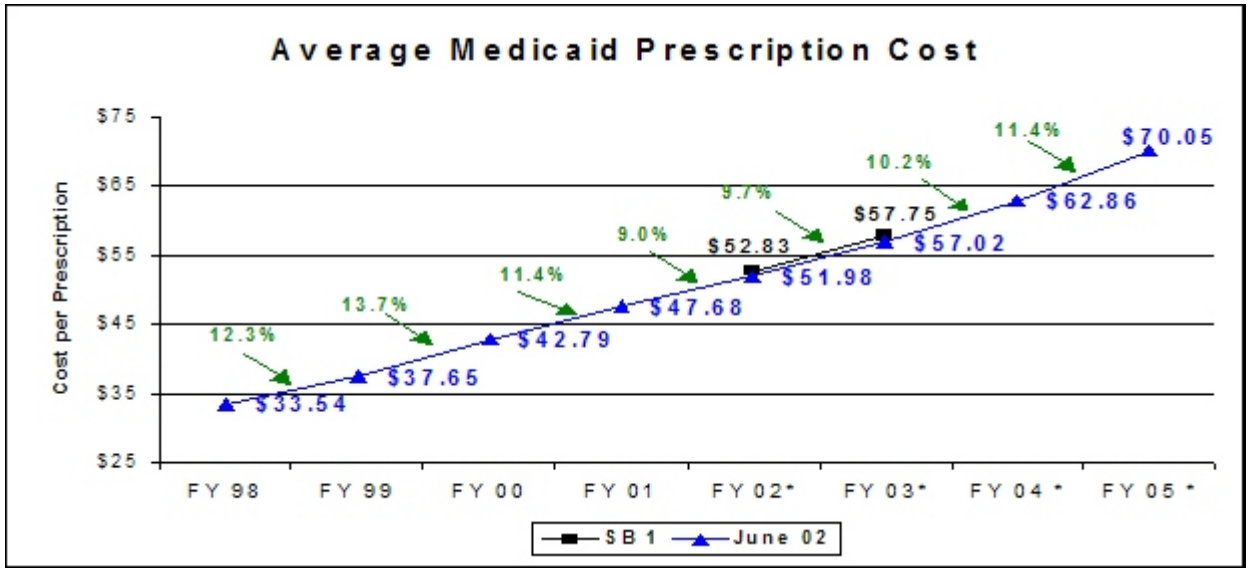


Chart 1.2 Average Medicaid Prescription Cost [11]

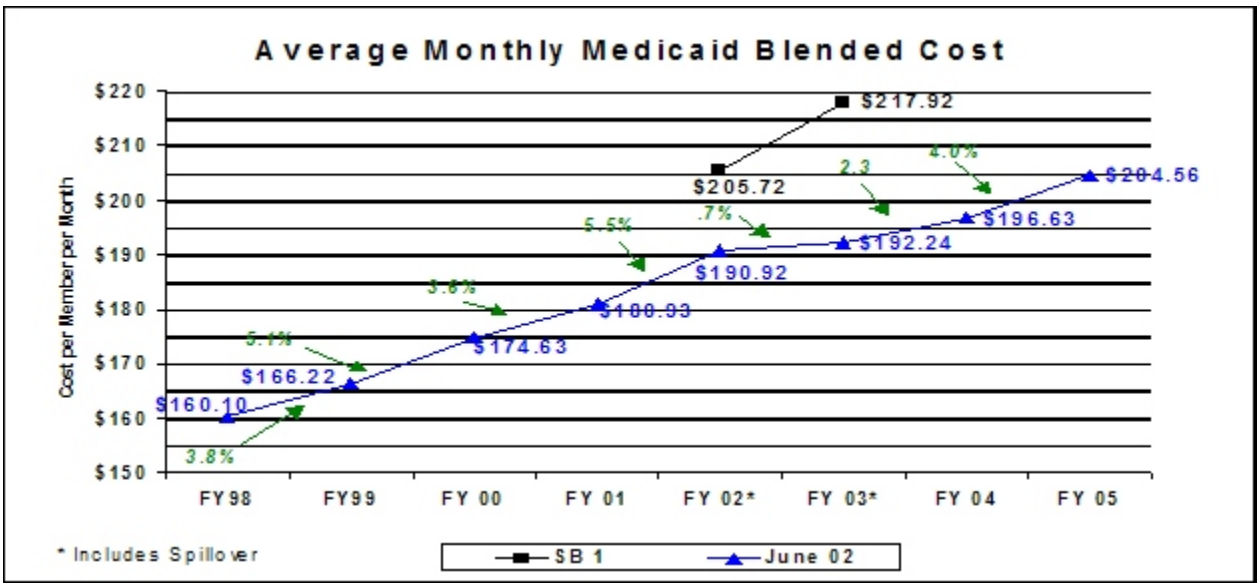


Chart 1.3 Average Monthly Medicaid Blended Cost[12]

Acute Medicaid Key Measures

Average Premium Per Recipient Month (Non-Managed Care and Managed Care Combined)

Item/Group	Projected FY 2001	Projected FY 2002 as of Sep-01	Projected FY 2002 as of Jul-02	Projected FY 2003 as of Sep-01	Projected FY 2003 as of Jul-02
Aged & Medicare Related	87.65	82.59	81.52	95.30	99.54
Disabled/Blind	506.53	543.15	539.02	562.05	575.13
B.1.1 Subtotal	**244.65**	**257.33**	**256.99**	**273.85**	**284.12**
TANF Children	84.26	96.86	96.39	105.56	98.58
TANF Adults	180.35	204.50	202.53	211.48	203.64
B.1.2 Subtotal	**106.95**	**122.14**	**121.62**	**130.64**	**123.28**
Pregnant Women	507.67	548.86	527.62	547.04	527.38
B.1.3 Subtotal	**507.67**	**548.86**	**527.62**	**547.04**	**527.38**
Newborns	453.16	477.99	475.86	487.21	507.02
Expansion Children	133.80	134.16	134.18	146.18	144.92
Federal Mandate Children	47.90	54.17	53.84	58.35	58.08
Medically Needy	709.45	704.03	684.92	801.56	635.80
B.1.4 Subtotal	**162.39**	**166.92**	**159.91**	**174.90**	**162.21**
Total (Less CHIP I and Spillover)	**187.97**	**197.80**	**192.34**	**206.03**	**197.96**

Table 1.2 Medicaid Blended Cost by Population Category[13]

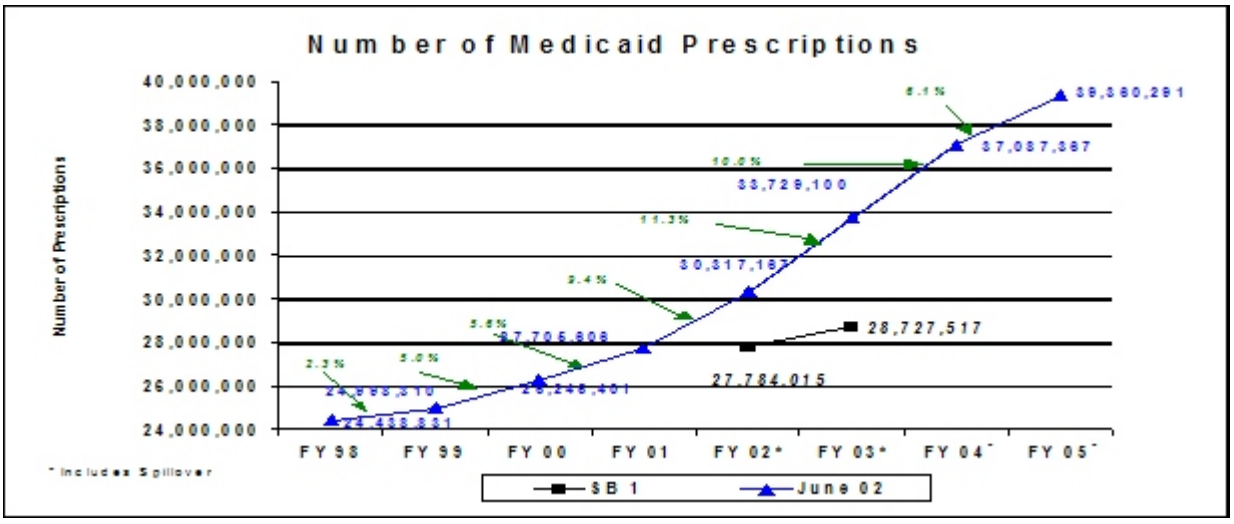


Chart 1.4 Medicaid Prescriptions [14]

Children's Health Insurance Program (CHIP)

CHIP faces an increase in caseload per month of 31,760 more than the $1.27 billion appropriated in Senate Bill 1 for the 2002-2003 biennium. Appropriations were based on a caseload of 467,952 for FY 02 and 492,799 for FY 03. The actual caseload for FY 02 was 6.7 percent higher, with a caseload of 499,332. The projected caseload for FY 03 is 8.7 percent higher, with an adjusted projected caseload of 535,615. There are 19,000 more children enrolled in CHIP than what was assumed in Senate Bill 1. Factors that influenced higher than predicted caseload growth include continued strong demand for the program and effective outreach efforts at the local, state and national level. Indirect factors may include the increasing cost of employer-based and private individual insurance coverage and the downturn in the economy.[15]

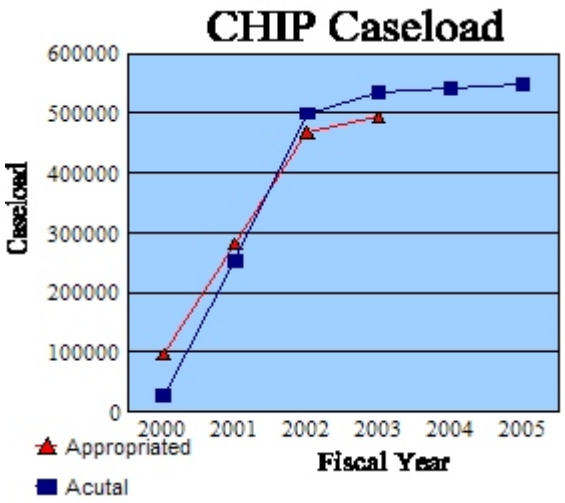


Chart 1.5 Caseload

In addition to an increase in caseload, premiums and participation rates also are driving factors in the shortfall. Second-year premium rates for CHIP have an increase of approximately 17.7 percent on average compared with first-year rates. The first-year rates were based on Medicaid experience since there were no historical CHIP cost experience to base rates on at that time. Actual CHIP health plan actuarial experience was significantly higher than these rates, and a number of CHIP health plans lost significant amounts of money. The 17.7 percent increase for the second year was necessary to address the amount that the first year rates that understated actual health plan risk and to address the health care cost trend for the period covered by the second rates. Third-year rates will not increase 17 percent. Since CHIP now has some actuarial cost history, rates will be based on CHIP cost experience, plus a reasonable projection of health care cost trends.[16] Additionally, the premiums in the State Employee Health Insurance and participation in the Employee Retirement System's State Kids Insurance Program (SKIP) have increased, creating a shortfall of $11.3 million.[17] (Chart 1.6 CHIP Caseload, Chart 1.7 CHIP Estimated Benefit and Table 1.3 CHIP Top Ten Prescription Drugs contain information about projections and shortfalls.)

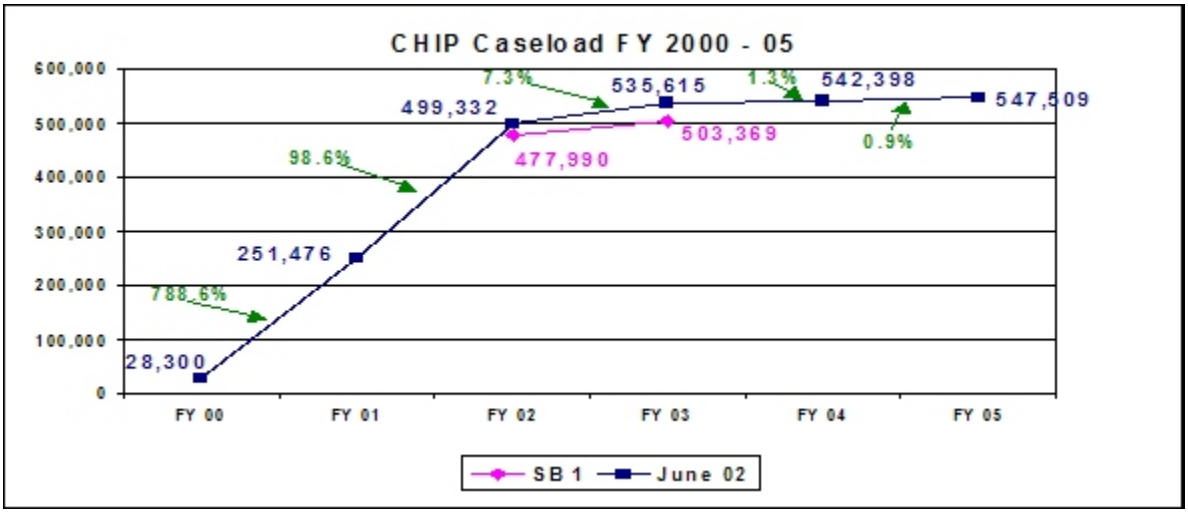


Chart 1.6 CHIP Caseload[18]

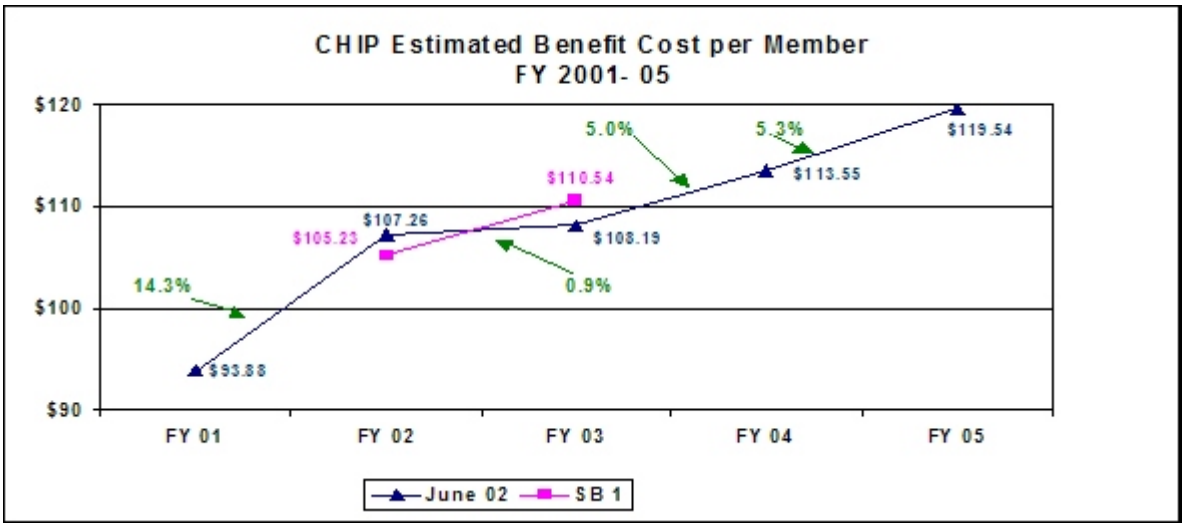


Chart 1.7 Estimated Benefit [19]

CHIP PRESCRIPTION BENEFIT*

May 2000 - September 2001

Top 10 Drug Items by Prescription Volume

Rank	NDC #	Description	# RX (PMPM)	$/RX	Estimated Unit Cost	Member Months	Count for Period	Total Payments
1	00472127016	IBUPROFEN*	0.0069	$12.28	0.05537	3,559,808	24,573	$301,756
2	00085112802	CLARITAN	CLARITAN	$81.50	2.52089	3,559,808	23,880	$23,880
3	00003173845	TRIMOX 250	0.0052	$8.53	0.05324	3,559,808	18,620	$158,829
4	00029609251	AUGMENTIN	0.0049	$65.11	0.62930	3,559,808	17,600	$1,145,936
5	00085119701	NASONEX	0.0045	$57.68	2.89521	3,559,808	15,863	$914,978
6	00085045803	CLARITAN	0.0043	$79.50	2.14645	3,559,808	15,477	$1,230,422
7	00093415580	AMOXICILLIN	0.0041	$8.22	0.05214	3,559,808	14,636	$120,308
8	59930156001	ALBUTEROL	0.0041	$20.74	0.9692	3,559,808	14,576	$302,306
9	00087771964	CEFZIL	0.0040	$56.38	0.56562	3,559,808	14,406	$812,210
10	00085122301	CLARITAN	0.0039	$41.17	0.26520	3,559,808	13,817	$568,846

*Prescription Ibuprofen

Top 10 Drug Items by Estimated Cost*

Rank	NDC #	Description	# RX (PMPM)	$/RX	Estimated Unit Cost	Member Months	Count for Period	Total Payments
2	00085112802	CLARITAN	CLARITAN	$81.50	2.52089	3,559,808	23,880	$23,880
6	00085045803	CLARITAN	0.0043	$79.50	2.14645	3,559,808	15,477	$1,230,422
4	00029609251	AUGMENTIN	0.0049	$65.11	0.62930	3,559,808	17,600	$1,145,936
5	00085119701	NASONEX	0.0045	$57.68	2.89521	3,559,808	15,863	$914,978
9	00087771964	CEFZIL	0.0040	$56.38	0.56562	3,559,808	14,406	$812,210
10	00085122301	CLARITAN	0.0039	$41.17	0.26520	3,559,808	13,817	$568,846
8	59930156001	ALBUTEROL	0.0041	$20.74	0.9692	3,559,808	14,576	$302,306
1	00472127016	IBUPROFEN	0.0069	$12.28	0.05537	3,559,808	24,573	$301,756
3	00003173845	TRIMOX 250	0.0052	$8.53	0.05324	3,559,808	18,620	$158,829
7	00093415580	AMOXICILLIN	0.0041	$8.22	0.05214	3,559,808	14,636	$120,308

Table 1.3 CHIP Top 10 Prescription Drugs[20]

Other Waivers and Programs

Clients							
	1996	1997	1998	1999	2000	2001	2002
HCS	2532	3185	3868	4980	5219	5618	6411
ICF/MR	7596	7780	7490	7626	7713	7691	7556
State Schools	5724	5568	5433	5298	5433	5345	5123

Appropriations							
	1996	1997	1998	1999	2000	2001	2002
HCS			$196,500,063	$238,369,677	$230,332,043	$235,430,089	$280,252,748
ICF/MR			$344,252,378	$352,076,434	$355,073,249	$357,732,170	$398,802,053
State Schools	$301,268,088	$308,864,786	$303,110,588	$296,746,013	$307,529,771	$327,781,597	$356,696,956

Cost Per Clients							
	1996	1997	1998	1999	2000	2001	2002
HCS	$2,886	$3,321	$3,843	$3,989	$3,678	$3,484	$3,643
ICF/MR	$3,611	$3,480	$3,426	$3,847	$3,836	$3,920	$4,543
State Schools	$4,181	$4,024	$4,648	$4,667	$4,915	$5,058	$5,802

Table 1.4 Overview of HCS, ICF/MR and State Schools.

When looking at the HCS waiver program and ICF/MR (discussed in Charge 2) versus state schools, several trends begin to appear. The ICF/MR and state school programs have seen a steady decline in population (chart 1.8). In FY 97, for example the actual number of IFC/MR waivers were 7,780. In FY 03 that number is projected to be 7,517. Nevertheless, considering the downward trend in ICF/MR and state school populations, appropriations for these programs have steadily increased (chart 1.9 Appropriations). ICF/MR funding for FY 03 ($397.8 million) is approximately 15.5 percent higher than FY 98 ($344.3 million), yet caseloads are down 3.4 percent. State school funding for FY 96 was $301.3 million and in FY 02 is now at $356.7 million. Again in the case of state schools, the number of clients steadily declined from 5,771 in FY 96 to 5,136 in FY 02. This is a total decline of 11 percent, or an average decline of 1.8 percent per year. [21]

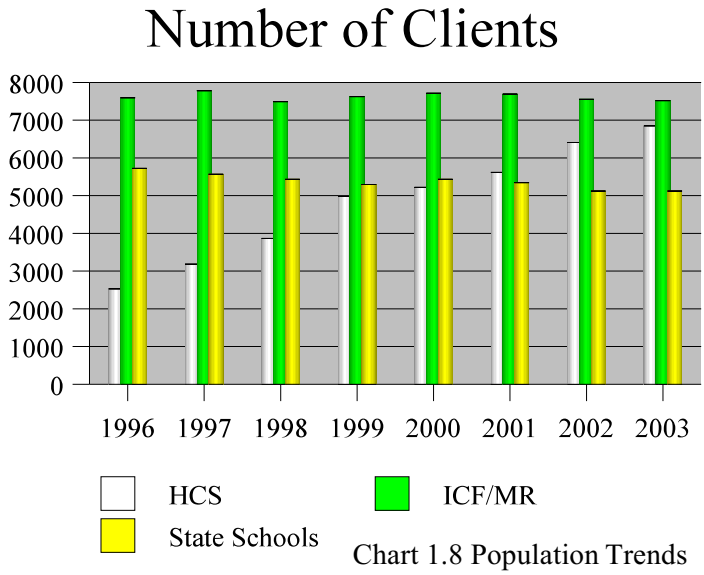
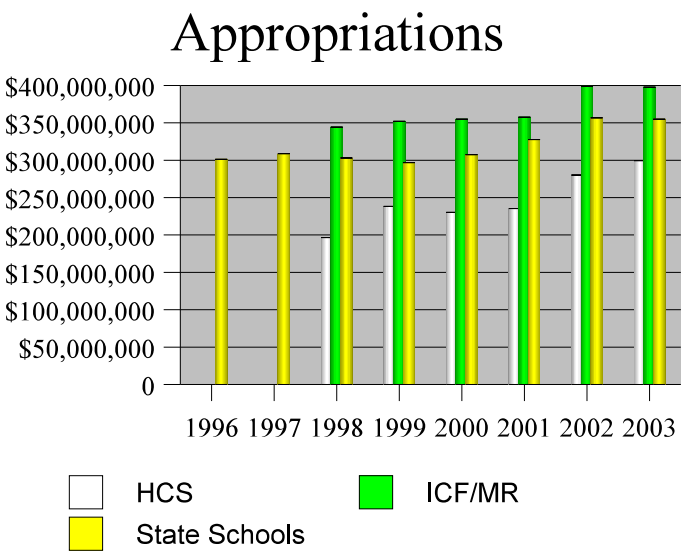


Chart 1.8 Population Trends

Chart 1.9 Appropriations



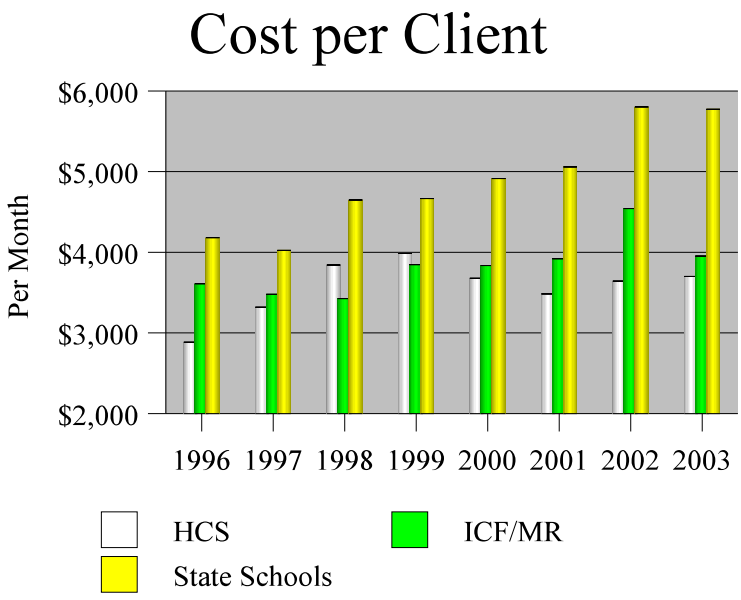


Chart 1.10 Cost per Client (per month)

State school costs did not decrease during this period, but rather increased by $46.7 million or 13 percent. Several factors account for the fact that total cost increased during this time of declining enrollment. The primary factors are increases in FTE salary costs; inflation and medical cost inflations; and changes in state funding of workers' compensation costs. The declining number of persons served, in the face of inflationary cost pressures, has helped to avoid even larger funding increases. It has not created an actual reduction or savings in the dollars needed to run the state schools in comparison with FY 96 funding levels.

As a result of ongoing cost pressures, the average annual operating cost per state school resident increased from $54,038 in FY 96 to $69,803 in FY 02. This was a total per capita increase of 29.2 percent or an average increase of 3.8 percent per year. This rate of per capita increase per year is slightly higher than the average per year rate of medical cost inflation which was 2.6 percent during those years. It is less, however than the average per year rate of medical cost inflation, which was 4.5 percent during those years. The state schools are providers of medical services to a significant degree. [22]

Other Programs - Overview

CLIENTS								
	1996	1997	1998	1999	2000	2001	2002	2003
Nursing Facilities *	72045	70241	70053	69428	66672	67649	67911	68775
Entitlement Community Care **			72249	74885	77404	83605	90423	97812
CLASS	763	843	924	986	1150	1425	1535	1876
MDCP	594	537	635	673	869	978	965	1071
CBA	7119	13442	14240	22595	23632	26337	27728	29062
APPROPRIATIONS								
	1996	1997	1998	1999	2000	2001	2002	2003
Nursing Facilities *	$1,333,781,299	$1,386,650,374	$1,465,694,667	$1,527,442,892	$1,559,755,796	$1,658,851,300	$1,801,729,169	$1,829,535,735
Entitlement Community Care **			$404,272,296	$426,541,045	$445,958,502	$502,362,380	$575,887,072	$665,719,954
CLASS	$21,747,057	$24,530,693	$26,296,744	$27,835,608	$33,445,680	$41,526,153	$44,655,422	$56,402,015
MDCP	$12,535,515	$12,328,145	$11,338,560	$11,281,041	$14,717,454	$16,640,005	$16,134,298	$18,211,027
CBA	$86,003,785	$166,648,002	$178,265,434	$269,751,763	$300,570,682	$355,675,918	$388,376,114	$429,457,311
COST PER CLIENT								
	1996	1997	1998	1999	2000	2001	2002	2003
Nursing Facilities *	$1,534	$1,567	$1,623	$1,658	$1,709	$1,774	$1,945	$1,969
Entitlement Community Care **			$467	$469	$480	$501	$531	$567
CLASS	$2,375	$2,425	$2,372	$2,353	$2,424	$2,428	$2,424	$2,505
MDCP	$1,759	$1,913	$1,488	$1,397	$1,411	$1,418	$1,393	$1,417
CBA	$1,007	$1,033	$1,043	$995	$1,060	$1,125	$1,167	$1,231

Table 1.5 Overview of other major programs/waivers.

During the last couple of years the CBA waiver caseloads and the number of persons in Entitlement Community Care have continued to grow. CBA waivers since FY 96 have grown from 7,119 slots to 29,062 slots, while Entitlement Community Care since FY 98 grew from a caseload of 72,249 to 97,812. From an appropriations standpoint, however, the largest increase occurred in nursing facilities. Nursing home appropriations rose from $1.3 billion in FY 96 to a projected $1.8 billion in FY 03. This increase occurred despite caseloads dropping from 72,045 in FY 96 to a projected 68,775 in FY 03. A large portion of this increase has to do with a steady increase in cost per client. Because of the influences of cost per client each major program's caseload, appropriation and cost per client is listed below. [23]

Charge 2: Waiting Lists

CHARGE 2: Examine methodologies used by each agency in developing their client waiting lists, including the development of a more accurate account of the number of persons on each waiting list. The review should also detail how each agency determines how new slots are to be rolled out and how that translates into cost per client.

Waiting Lists and Interest Lists

TDH, MHMR, and DHS use waiting lists or interest lists, to track those waiting for health and human services in Texas. These lists are for Medicaid waiver or non-Medicaid programs. As of Aug. 15, 2002, there were a total of 76,663 persons waiting for services in Texas. Just more than 50 percent of those people on a waiting or interest lists are receiving some level of service from the State. Table 2.1 provides an overview of all the programs in Texas that have a waiting or interest list. Some of the numbers represent an unduplicated count and others represent a duplicated count. The Frequently Used Terms section on page 47 provides a complete definition of these terms.

An Overview of all waiting lists and interest lists in Texas

Table 2.1 Overview of Waiting Lists and Interest Lists

Program	Agency	Total Number of Persons Waiting for Services	Of the Total Waiting, the Number of Persons Receiving Some Level of Service
Children With Special Health Care Needs (CSHCN)	TDH	1,653 (unduplicated)	802 *
MDCP (Medically Dependent Children Program)1915 (c)	DHS	3,470** (duplicated)	1,770***
CLASS (Community Living Assistance and Support Services)1915 (c)	DHS	8,094 (duplicated)	3,874
HCS (Home and Community-based Waiver Services)1915 (c)	MHMR****	18,005 total for all three waivers (unduplicated)	10,342
HCS-OBRA (Home and Community-based Waiver Services)1915 (c)	MHMR		
MRLA (Mental Retardation-Local Authority Program) 1915 (c)	MHMR		

Program	Agency	Total Number of Persons Waiting for Services	Of the Total Waiting, the Number of Persons Receiving Some Level of Service
DB-MD (Deaf Blind, Multiply Disabled) 1915 (c)	DHS	31 (duplicated)	16
CBA (Community-Based Alternatives)1915 (c)	DHS	41,198 (duplicated)	36,203
In Home Family Support	DHS	11,364 (duplicated)	5,889
Adult Foster Care	DHS	61 (duplicated)	28
Residential Care	DHS	1,360 (duplicated)	613
Emergency Response Systems	DHS	6,882 (duplicated)	4,912
Home Delivered Meals	DHS	7,127 (duplicated)	4,539
Client Managed Personal Assistance Services	DHS	130 (duplicated)	25
Special Services to Persons with Disabilities	DHS	24 (duplicated)	14
Day Activity and Health Services	DHS	1175 (duplicated)	589
Respite	DHS	708 (duplicated)	390
Family Care	DHS	2,314 (duplicated)	386

Duplicated refers to the number of services being administered rather than the number of people receiving services. For example an agency might have a list of 25,000 services but only 10,000 people receiving services.

Unduplicated is the number of people receiving services rather than the number of services being administered. For example an agency might have a list of 10,000 people but those people are receiving 25,000 services.

***TDH:** The "number of persons receiving some level of service" refers to children on the waiting list for CSHCN who are eligible for Medicaid or CHIP. These children may or may not be receiving Medicaid or CHIP.

****DHS**: The total number of unduplicated persons (individual people who have made requests) waiting for services is 57,114. The total number of requests for services is 83,938 (this is the unduplicated number reported). The total number of people on the unduplicated list who are receiving some level of service within long-term care is 29,926. A total of 27,188 people are on a waiting list for services and not receiving any other services within long-term care at DHS.

***** **DHS:** These numbers are related ONLY to long-term care programs within DHS. DHS does not collect data on any other services being delivered other than within long-term care at DHS. If a person is on a waiting list for home delivered meals and also is receiving food stamps, they would not be included in this "receiving some other level of service" count.

*****MHMR**: There are 1,950 people waiting for additional services, in addition to the 18,005 waiting for waiver services. These 1,950 people are waiting for any one of the following; ICF/MR, In Home Family Support, Eligibility Determination, Service Coordination, Personal and Family Assistance, Supported Home Living, Respite, Family Support Services, Residential services, Vocational Training, Vocational Services, Employment Assistance/Competitive Employment, Site-Based Habilitation, Specialized Therapies, or Early Childhood Intervention.

Financing

The 77th Legislature appropriated an increase of $238.7 million in All Funds ($104.4 million in General Revenue/Tobacco Settlement Receipts) for waiting lists and waiver services. The Texas Department of Human Services (DHS) received $125.9 million in All Funds, including $59.4 million in General Revenue Funds/Tobacco Settlement Receipts, to reduce Long-term Care interest lists for Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Deaf-Blind (DB), Medically Dependent Children's Program (MDCP) and In-home and Family Support. The Texas Department of Mental Health and Mental Retardation (MHMR) received $68.6 million in All Funds, including $27.3 million in General Revenue Funds/Tobacco Settlement Receipts. The Health and Human Services Commission (HHSC) received $17.6 million in General Revenue Funds and an increase of $26.6 million in federal funds to address acute care expenditures associated with Medicaid waiver expansions at DHS and MHMR[24] (Appendix D, waiting and interest list riders).

The Texas Department of Health

Currently the benefits of the Children With Special Health Care Needs (CSHCN) program include a comprehensive health benefits package and family support services for children with special health care needs who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) or who do not have private insurance. Also included are medical wrap around services and family support services to children with special health care needs who are eligible for Medicaid, CHIP, or have private insurance. These "wrap around" services covered by CSHCN are not covered by Medicaid, CHIP or the client's private insurance.

> Jane Smith is three-years old, a United States citizen and has epilepsy. The child has Medicaid, and the application indicates that the child needs case management, dental services, durable medical equipment, medical supplies, family support services, home health/ nursing services, medications, and inpatient hospital and physician services. This child was not indicated as having urgent need and was placed on the medical services waiting list on Oct. 8, 2001.

Program Components

The CSHCN program components include:

- direct medical and specialized dental services;
- enabling services (including private insurance premiums and copayments, meals, lodging and transportation);
- case management;
- family support such as respite care and minor home modifications; and
- systems development for CSHCN and their families (education and training, information and referral, needs assessment, and interagency collaboration).[25]

CSHCN Costs

Prior to July 1, 2001, the CSHCN served clients who met income and assets requirements and who had a qualifying diagnosis (including adults with cystic fibrosis). Healthcare coverage was limited to the coverage of services related to the qualifying diagnosis. Stricter requirements for Medicaid application and expanded availability of Medicaid services reduced client numbers beginning in the mid-1990s.

Program costs decreased from Actual Year (AY) 96 through AY 98, but has since begun to increase due to increasing client service obligations. Beginning on July 1, 2001, with the implementation of Senate Bill 374, 76th Legislative Session (1999), by Senator Judith Zaffirini and Representative Patricia Gray, the qualifying diagnosis list and asset requirement were removed. Clients now are made eligible based on meeting a functional definition, certified by a physician/dentist statement. Healthcare coverage no longer is limited to the coverage of services related to the child's chronic, disabling condition.

> Tommy Smith is a 14-year-old, a United States citizen and has cleft palate. The child has coverage from CHIP and the application indicates that the child needs audiological services, case management, dental services, durable medical equipment, medical supplies, orthotics/prosthetics, and physician services. The child is not indicated as having urgent need and was placed on the medical services waiting list on Oct. 8, 2001.

Prior to July 1, 2001, the CSHCN Program covered applicants with only certain specific diagnoses. The program covered services related to the "coverable" diagnosis. So, for example, a child with strabismus (an imbalance of the tone of the muscles controlling movement of the eye and causing vision difficulties) would be covered for eye surgery to help correct the strabismus, but the child would not be covered for his/her flu shots, a visit to the doctor or hospitalization for pneumonia unrelated to the strabismus, medical care for a broken leg, etc. On or after July 1, 2001, however, this same child with strabismus, once eligible for the CSHCN Program, would have health insurance that would cover the child much more comprehensively. So, for this same child after July 1, 2001, the CSHCN Program would cover the flu shots, the visit to the doctor or hospitalization for pneumonia, medical care for a broken leg, etc.[26]

> *As of September 1, 2002, there are 317 clients on the family support services waiting list and 1,395 on the medical services waiting list. There are 59 clients on both the family support services and medical services waiting list. The total unduplicated number of clients on the Children With Special Health Care Needs program waiting list is 1,653.*

Given the increase in client service obligations from AY 98-01 and in light of the program's expanded eligibility criteria and health coverage benefits, the CSHCN program implemented a waiting list for medical services on Oct. 5, 2002. Senate Bill 374 permitted this cost containment measure. The AY 02 figures in chart 2.1 are for a year in which new clients, and continuing clients with lapses in eligibility periods, are placed on a waiting list for medical services. Note that the AY 01 and AY 02 figures in chart 2.1 are through July 31, 2002.[27]

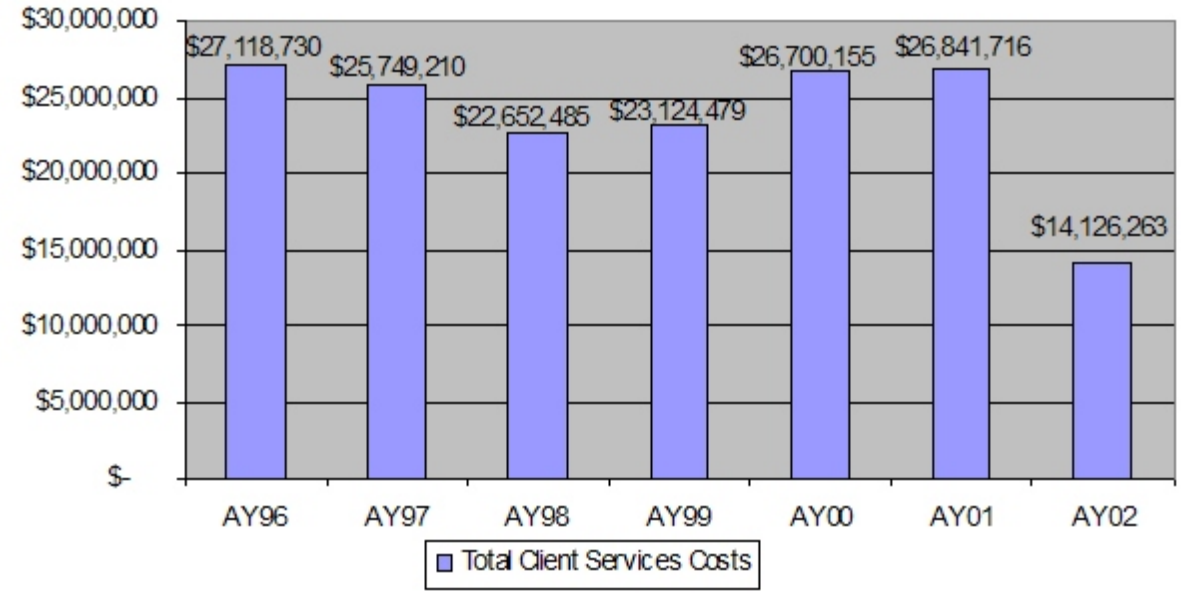
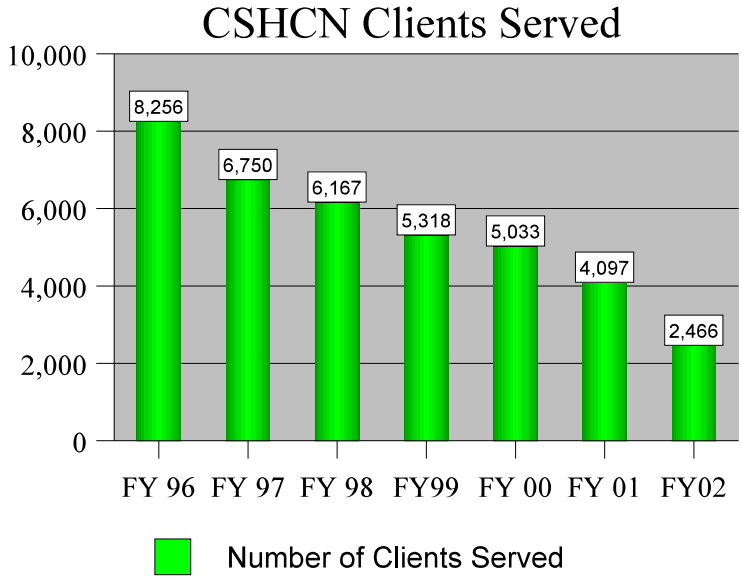


Chart 2.1 Appropriations

Note: Represents amounts in All Funds incurred for services provided in appropriation year



The number of CSHCN clients served (those who have had a paid claim) has decreased steadily since AY 96. In AY 02, the CSHCN program had many additional unserved clients on a waiting list (not included in the AY 02 figures in chart 2.2). Although CSHCN is serving fewer clients, the average cost per client continued to rise through AY 01. (chart 2.3) Note that the AY 00, AY 01 and AY 02 figures in chart 2.3 are through July 31, 2002.[28]

Chart 2.2 Number of Clients Served in CSHCN

CSHCN Waiting List for Services

A client is placed on the waiting list once a completed application for the CSHCN program is processed and the client has been determined to be eligible for program services. These clients are considered enrolled in the CSHCN program, but do not receive services beyond case management.

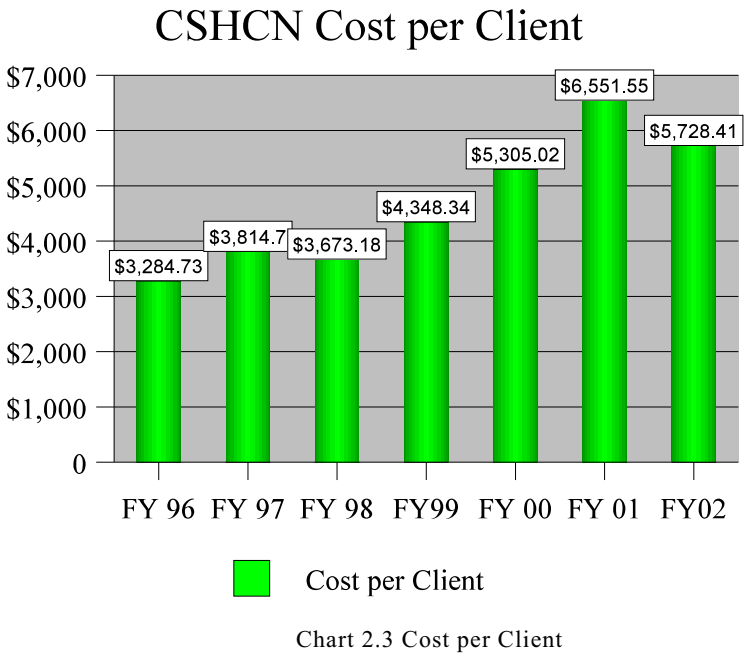


Chart 2.3 Cost per Client

To date no CSHCN clients have been removed from the waiting list to receive services, as the CSHCN program remains in a budget shortfall. Under current rule, clients may be removed if funds are available on a first come, first served basis or on the basis of urgent need or the severity of illness. The CSHCN program is undertaking rule revision, which may address other mechanisms for prioritizing clients going on or off the waiting list. A cost per client methodology has not been determined.[29]

The average length of time for current CSHCN clients on the program is 5.9 years, while the range of time for clients on the program is 10 months to 38 years. For clients on the waiting list for medical services, 565, or 49.3 percent, of clients have some type of health care coverage (Medicaid/CHIP and/or private insurance), and 581, or 50.7 percent, of clients have no other type of health care coverage.[30]

The CSHCN is funded with general revenue and Federal Title V Maternal & Child Health funds. The current shortfall estimate for FY 03 is $2,142,620 million in general revenue. This assumes continuation of the waiting list and no removals of clients off the waiting list.

The Texas Department of Human Services

(DHS) estimates that it will serve an average of 138,848 clients in the Community Care programs in Fiscal Year (FY) 2002. Nevertheless, even with a large number of persons being served, interest lists still exist for various services. Interest lists exist for Non-Entitlement Medicaid and Community Care Waiver programs and Non-Entitlement Non-Medicaid Community Care Programs.

Interest Lists for All Community Care Services

Because the demand for community care services exceeds the available slots, DHS has maintained interest lists for these programs since the early 1980s. The Department maintains interest lists for community care services on a first come, first served basis. It does not maintain a "needs based" waiting list in which eligibility and level of care are determined when an individual requests services. Currently there are no federal statutes regarding the maintenance of these community care interest lists. As of July 31, 2002, there were a total of 83,938 requests are registered on Community Care interest lists. There were 31,145 requests about Non-Medicaid Community Care interest lists. As of July 31, 2002, 57,114 persons were waiting for Medicaid waiver services (CBA, CLASS, MDCP, and DB-MD). As of July 31, 2002, 35,893 persons currently were receiving services under the waiver programs broken down as follows: 32,499 persons were enrolled in CBA; 1,480, CLASS; 981, MDCP; and 118, DB-MD. [31] DHS reports the unduplicated number of persons receiving these services by counting a person only once within a month of service, whether the person received one or several of these services at the same time. For example, a client who received Family Care, Meals, and Emergency Response in a given month would be reported as one client, rather than as three.

Interest lists include all individuals who have contacted DHS requesting services or programs that are non-entitlement services. No screening or eligibility determination for the services requested has been done for these individuals registered on the interest list. As funds become available to serve new clients in these programs, the individuals on the interest list are contacted to begin the eligibility determination process.

Community Care Services Interest Lists

An individual requesting Medicaid waiver and non-Medicaid Community Care services receives notification from DHS that he or she has been placed on the interest list for the program(s) they requested. To help to ensure that the interest list remains timely, DHS staff regularly monitors continued interest in the requested program(s). This monitoring is conducted every 180 days for Community Based Alternatives and annually for other Medicaid waiver and non-Medicaid community care programs. During the monitoring contact, DHS staff verifies information previously collected from the individual or family.

Sylvia Garza is a 46-year-old female whose sister registered her on the CBA interest list. The sister reports that Sylvia suffered a closed head injury from a motorcycle accident, has arthritis, lacks equilibrium, has paranoid schizophrenia and is taking 14 different medications. She lives in New Braunfels, Texas, and has been on the interest list since Aug. 28, 2000. Sylvia's name came to the top of the interest list on Sept. 18, 2002, and the eligibility determination process has now begun.

When a slot becomes available in a Medicaid waiver and non-Medicaid community care program the first individual on the interest list is contacted by a DHS caseworker. If the individual is not ready to begin services, he or she is placed back on the interest list for that particular service. If he or she is ready to begin services, the eligibility determination process is undertaken.[32]

Intake process for Community Care Services

During the initial intake process, DHS obtains information from individuals and/or family members regarding the needs of the individual. The individual is placed on an interest list for the appropriate service. The individual and/or family also is informed about other services without interest lists, such as Primary Home Care. A more intensive process is not conducted during the initial intake process, given the length of time an individual may wait for services. Eligibility status and level of need often change during this period, which would make the initial assessment invalid.[33] Appendix F is an explanation of the intake process.

Medicaid Waiver and Non-Medicaid Programs

Medicaid Waiver Programs include CBA, MDCP, CLASS, DB-MD and CWP waivers. Examples of services provided with one of the Medicaid waivers include adaptive aids, medical supplies, adult foster care, assisted living and residential care services, emergency response services, nursing services, minor home modifications, occupational therapy, personal assistance services, physical therapy, respite care, speech pathology services and home delivered meals.

Medicaid Waiver Programs at DHS

Community Based Alternatives (CBA)

The CBA program provides home and community-based services to aged and disabled adults as alternatives to institutional care in nursing facilities. An individual must be determined at risk for nursing facility placement using the Resident Assessment Instrument for Home Care (RAI-HC) and meet the medical necessity determination for nursing facility care. Applicants cannot exceed the nursing facility payment rate and must choose waiver services instead of nursing facility care based on an informed choice.

Table 2.2 Department of Human Services Appropriated Waiver Service Levels

Year	CBA	Increase Above Previous Year
FY 1998	18,275	5,455
FY 1999	22,275	4,000
FY 2000	23,900	1,625
FY 2001	26,575	2,675
FY 2002	29,250	2,675

To be eligible for CBA services, a person must be 21 or older and Medicaid eligible in the community under the Supplemental Security Income (SSI); Medical Assistance Only (MAO) protected status; or meet the income and resource requirements for Medicaid benefits in nursing facilities. Table 2.2 and Graphs 2.2, 2.3 and 2.4 show the number of waiver slots funded by the Legislature. Table 2.3 provides longitudinal data regarding clients, expenditures and appropriations in the CBA waiver program.

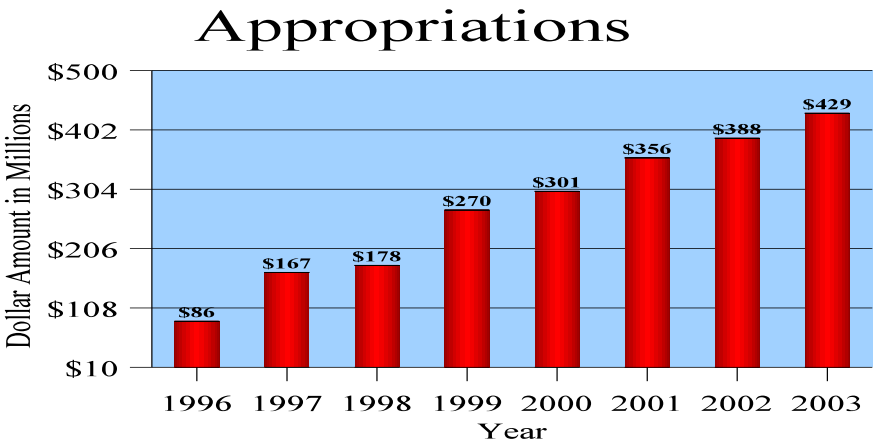
The Most Utilized Service in the CBA Waiver Program

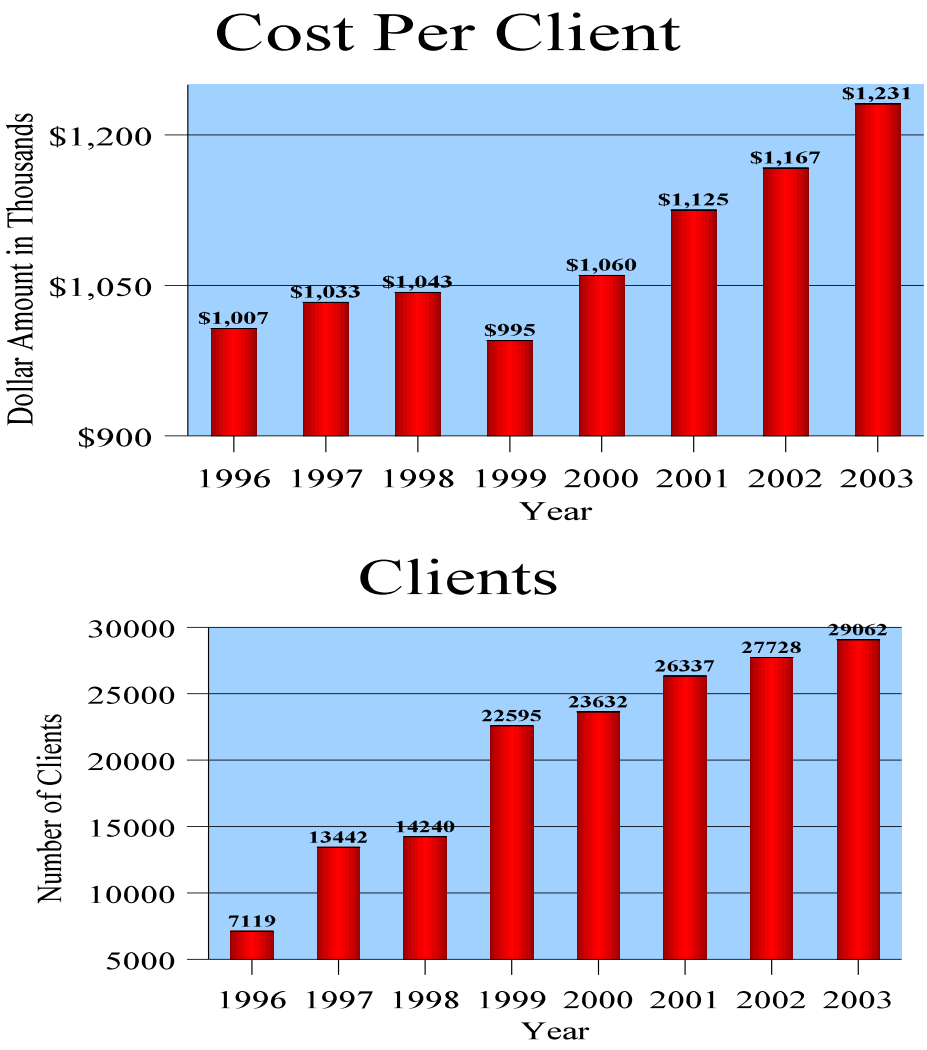
The most utilized service in the CBA waiver program is Personal Assistance Services. In FY 02, 75.70 percent of the clients receiving the CBA waiver receive this service. Personal assistance services cost $897.23 per client per month. Assisted Living was the second most utilized service, 6.61 percent of clients in the CBA waiver program used this service. Assisted living costs $78.35 per client per month.

Table 2.3 Medicaid Waiver - Community Based Alternatives FY 2000-FY 2002[34]

	FY 2000	FY 2001	FY 2002
Average clients per month	23,641	26,335	27,857
Average Interest List	17,905	29,458	39,235
Expenditures	$300,741,889	$355,367,650	$400,153,713
State	$116,206,666	$140,121,464	$159,381,224
Federal	$184,535,223	$215,246,186	$240,772,489

Graphs 2.2, 2.3, and 2.4, Appropriations, Number of Clients and Cost per client (monthly) in the CBA Program





Medically Dependent Children's Program (MDCP)

MDCP provides a variety of services to support families caring for children who are medically dependent and to encourage deinstitutionalization of children in nursing homes. Regional DHS staff provides case management. Waiver services include respite, adjunct supports, minor home modifications, and adaptive aids. To be eligible for MDCP, a person must be under the age of 21, live in Texas, be Medicaid eligible, and receive SSI or meet the SSI disability criteria as well as financial criteria based on the child's Income and Resources (I & R). A person also must meet the medical necessity determination for nursing facility care.

Juanita Martinez is the next person who will be released from the interest list (the one who has been on the interest list the longest). Born on March 19, 1985, she was added to the interest list on Jan. 20, 1999, and at that time was number 1,065. This child has mental retardation, developmental delays and attention deficit disorder. She cannot perform the normal daily hygienic activities. At the time of entry onto the interest list she was not receiving SSI and was not receiving any other services. She is covered by private insurance and is receiving her education in the public school setting.

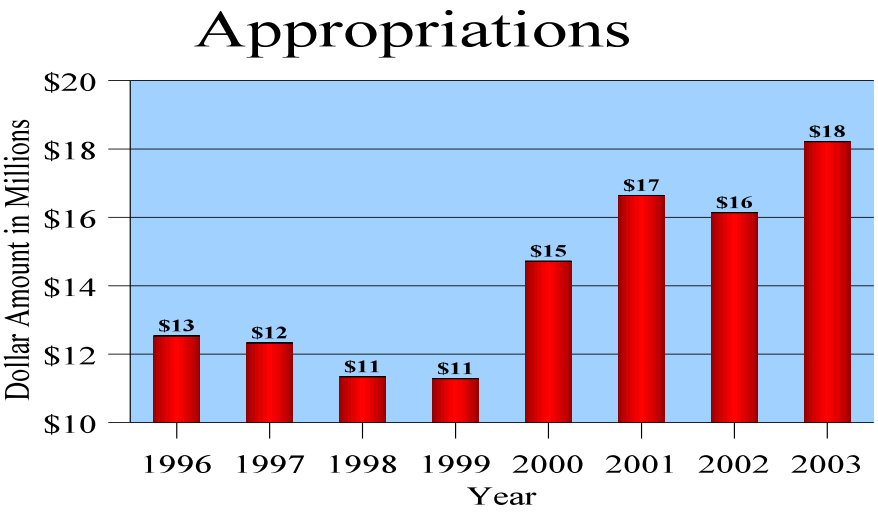
The Most Utilized Service in the MDCP Waiver Program

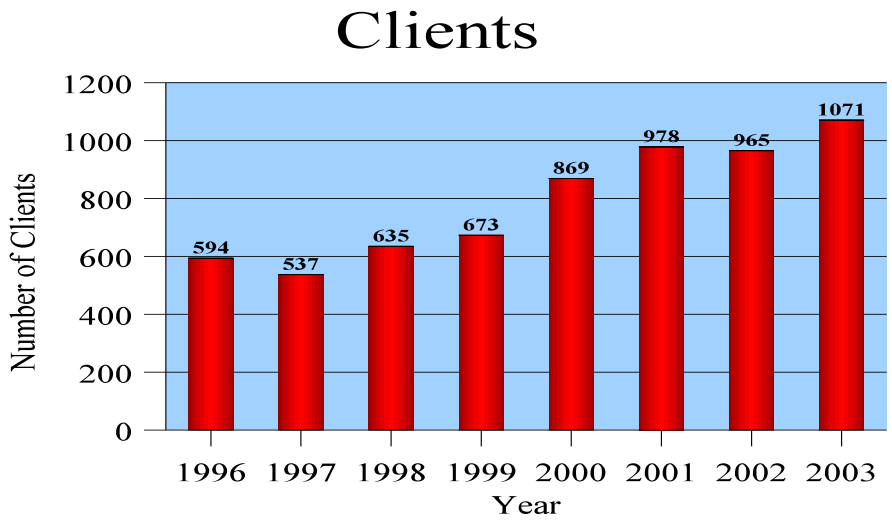
The most utilized service in the MDCP waiver program is Respite Care. In FY 02, 93.40 percent of the clients receiving the MDCP waiver receive this service. Respite Care services cost $1,297.70 per client per month. Table 2.4 reflects the total clients, expenditures, and appropriations for the MDCP program. Graphs 2.4, 2.5 and 2.6 show financing, number of clients and cost per client analyses.

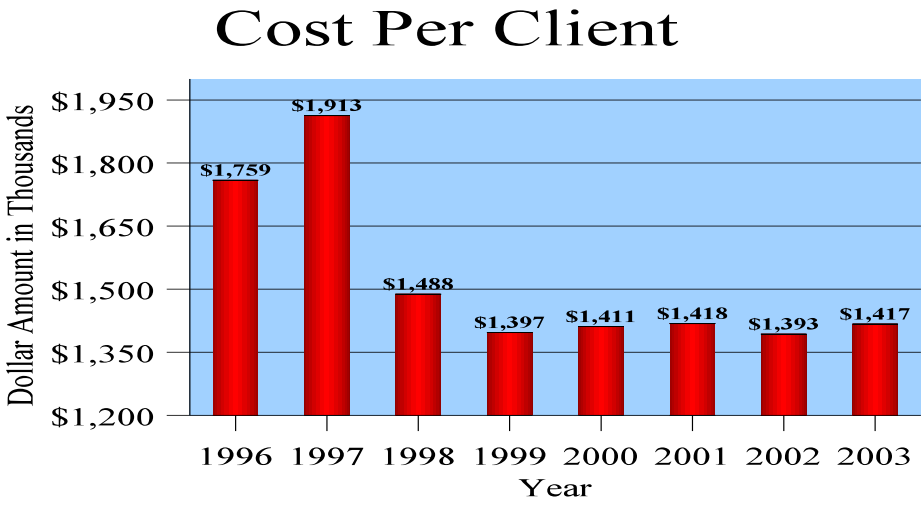
Table 2.4 Medicaid Waiver- Medically Dependent Children's Program[35]
FY 2000-FY 2002

	FY 2000	FY 2001	FY 2002
Average clients per month	**868**	**975**	**919**
Average Interest List	**1500**	**2151**	**3065**
Expenditures	**$14,698,955**	**$16,583,463**	**$15,181,145**
State	**$5,679,676**	**$6,538,859**	**$6,046,650**
Federal	**$9,019,279**	**$10,044,604**	**$9,134,495**

Graphs 2.4, 2.5 and 2.6, Medically Dependent Children's Program Financing, Number of Clients and Cost per Client (per month)







Community Living Assistance and Support Services (CLASS)

The CLASS program provides home and community-based services to individuals with related conditions or developmental disabilities as a cost-effective alternative to an Intermediate Care Facility for persons with Mental Retardation and/or Related Conditions (ICF-MR/RC) institutional placement. Persons with related conditions have a qualifying disability, other than mental retardation, which originated before age 22 and which affects their ability to function in daily life. Autism is an example of a qualifying diagnosis. Services include case management, habilitation, respite care, nursing services, psychological services, physical therapy, occupational therapy, speech pathology, adaptive aids/supplies, minor home modifications, specialized therapies, and consumer directed services. There is no age limit to be eligible, but the age of the onset of disability must be prior to age 22. The applicant must be eligible financially for Medicaid; SSI eligible; eligible for Medicaid benefits under a federally mandated protective status; or a disabled child who would be eligible for Medicaid if institutionalized and if parental income is not deemed to the child. An applicant also must meet the institutional Level-of-Care (LOC) criteria for ICF-MR/RC LOC VIIII. An individual must have a demonstrated need for habilitation services and case management, have an Individual Service Plan for waiver services approved by DHS that does not exceed 125 percent of the cost of ICF-MR/RC institutional care, and reside in a geographic catchment area. Table 2.5 provides the number of waiver slots funded by the Legislature for CLASS waivers. [36]

Table 2.5 Department of Human Services Appropriated Waiver Service Levels

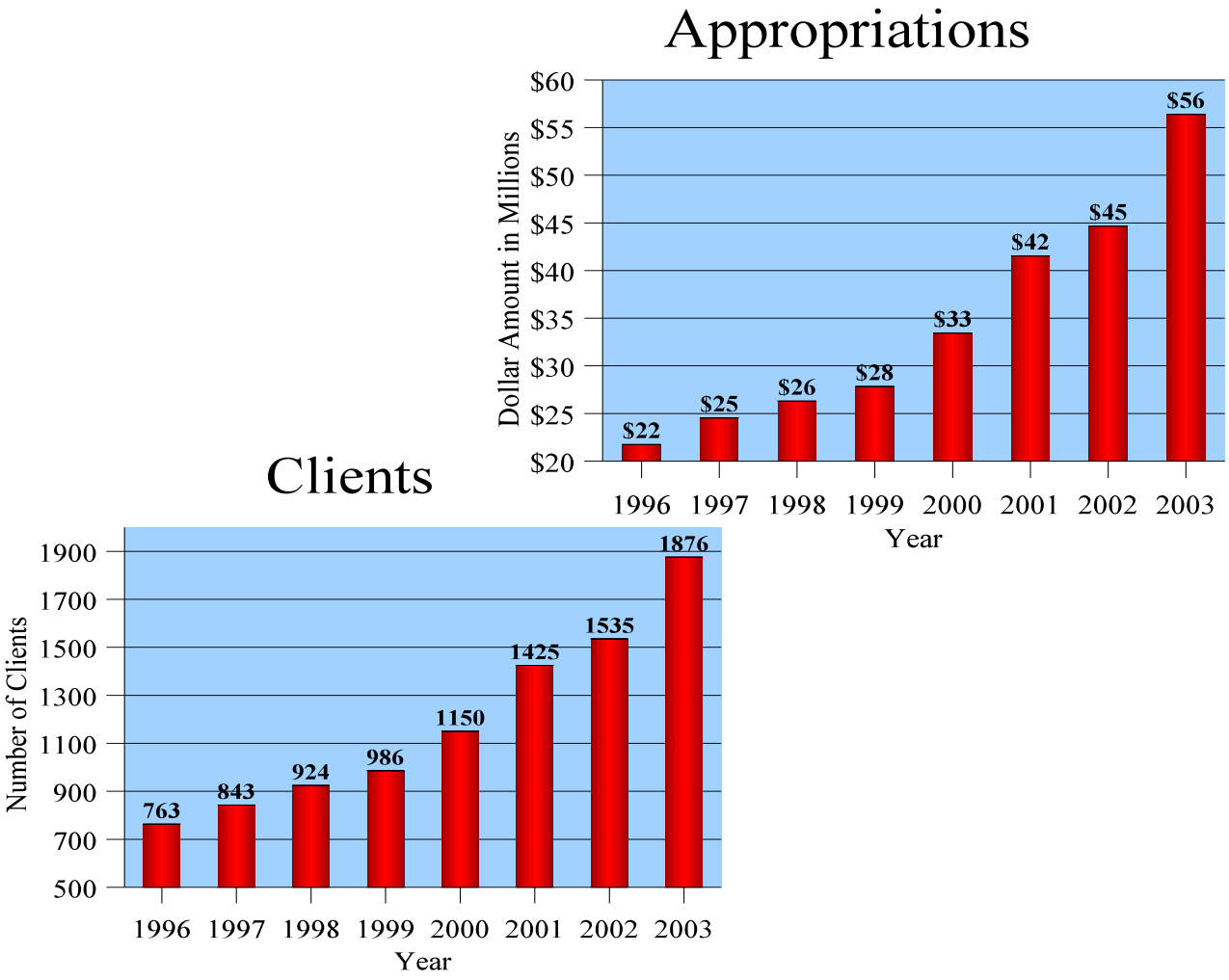
Year	CLASS	Increase Above Previous Year
FY 1998	1,052	209
FY 1999	1,052	0
FY 2000	1,249	197
FY 2001	1,449	200
FY 2002	1,836	387
FY 2003	1,836	0

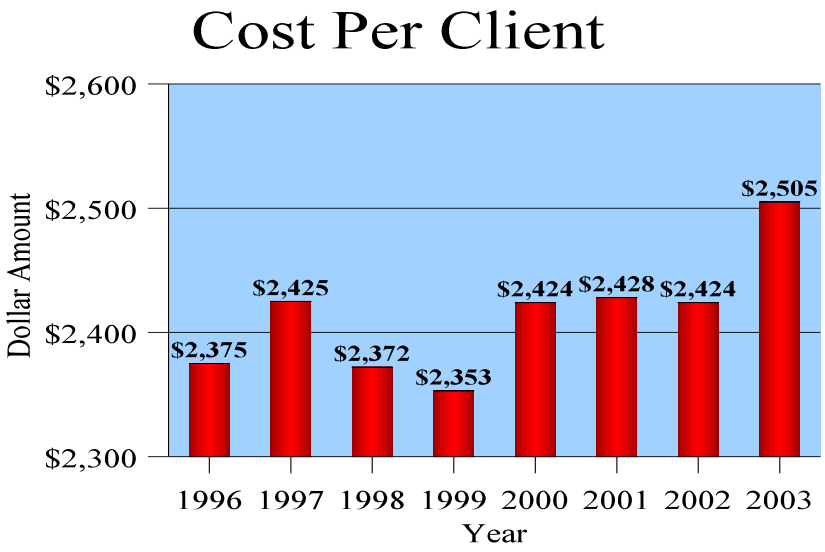
The Most Utilized Service in the CLASS Waiver Program

The most utilized service in the CLASS waiver program is habilitation. In FY 02, 76.26 percent of the clients receiving the CLASS waiver receive this service. Habilitation services cost $2,003.07 per client per month. Case Management is the second most utilized service, 6.36 percent of clients in the CLASS waiver program used this service. Case Management costs $167.05 per client per month. Table 2.6 and Graphs 2.5, 2.6 and 2.7 provide an explanation of total clients, expenditures and appropriations for the CLASS program.

Table 2.6 Medicaid Waiver - Community Living and Assistance and Support Services [37]			
	FY 2000-FY 2002		
	FY 2000	FY 2001	FY 2002
Average clients per month	1,148	1,406	1,459
Average Interest List	5,014	6,177	7,335
Expenditures	$33,390,407	$40,927,423	$46,596,141
State	$12,902,053	$16,137,683	$18,559,243
Federal	$20,488,354	$24,789,740	$28,036,898

Graphs 2.5, 2.6 and 2.7, Community Living and Assistance and Support Services





Deaf-Blind with Multiple Disabilities (DB-MD)

This Medicaid waiver program provides home and community-based services to people who are deaf and/or blind with multiple disabilities as a cost-effective alternative to ICF-MR/RC institutional placement. The DB-MD program provides consumers with a choice of three options for residential support: residing in one's own home or apartment with supports; residing with one's parents/guardians with support; or residing in small group homes with support. The DB-MD program focuses on increasing opportunities for consumers to communicate and interact with their environment. Services include case management, assisted living, intervener, habilitation, respite care, nursing services, orientation and mobility, behavior communication services, physical therapy, occupational therapy, speech therapy, chore provider, adaptive aids/supplies, and environmental accessibility. To be eligible, an applicant must be 18 years or older, SSI eligible, eligible for Medicaid benefits under a federally mandated protective status, meet ICF-MR/RC LOC criteria, have deaf/blindness with a third disability resulting in a demonstrated need for daily habilitation services, and an Individual Plan of Care for waiver services approved by DHS.

The Most Utilized Service in the DB-MD Waiver Program

The most utilized service in the DB-MD waiver program is Assisted Living. In FY 02, 60.16 percent of the clients receiving the DB-MD waiver receive this service. Assisted living services cost $2,074.73 per client per month. Habilitation is the second most utilized service, 11.87 percent of clients in the DB-MD waiver program used this service. Habilitation services costs $409.36 per client per month. Table 2.7 reflects the clients, expenditures, and appropriations for the DB-MD program.

Table 2.7 Medicaid Waiver - Deaf-Blind with Multiple Disabilities [38]			
FY 2000-FY 2002			
	FY 2000	**FY 2001**	**FY 2002**
Average clients per month	**98**	**101**	**116**
Average Interest List	**83**	**50**	**37**
Expenditures	**$3,937,201**	**$4,130,969**	**$4,895,845**
State	**$1,521,334**	**$1,628,841**	**$1,950,015**
Federal	**$2,415,867**	**$2,502,128**	**$2,945,830**

Consolidated Waiver Program

Consolidated Waiver Program (CWP), a pilot program required by House Bill 2148 by Representative Glen Maxey and Senator Mike Moncrief has began in Bexar County. CWP is testing consolidation of five of the state's §1915(c) Medicaid waivers; Community Based Alternatives (CBA), Community Living Assistance Support Services (CLASS), Deaf Blind – Multiple Disabilities waiver (DB-MD), Home and Community-based Services (HCS) and Medically Dependent Children Program (MDCP).

The CWP is the only §1915(c) Medicaid waiver program that provides services to persons with different types and levels of physical development. The program has one set of rates and services and one set of providers and is testing the Texas Instrument for Functional Assessment (TIFA), a single functional assessment regardless of age or type of disability. It offers a wide array of services and incorporates person-directed planning for every waiver participant.

DHS is operating the pilot, with oversight by HHSC. Rules were adopted in August, 2001, and amended in May, 2002, to incorporate Rider 37 and Rider 7. Field staff were hired and trained in July and August, 2001, (six case managers). In September, 2001, the waivers were approved, and contract enrollment and provider training began.

The CSP started serving participants in December, 2001. The pilot is limited to 200 slots. It is targeted to serve 100 individuals who qualify for nursing facility care (50 adults and 50 children) and 100 individuals who qualify for ICF-MR care (50 adults and 50 children, with both groups evenly divided between individuals with mental retardation and individuals with developmental disabilities). Participants are selected from interest lists of existing waivers in the pilot area, with priority given to children in nursing facilities.

As of Oct. 8, 2002, CWP had 159 participants enrolled with 47 applications pending. Participants include 91 adults and 78 children and the funding slots filled are 35 CLASS (19 adults and 16 children), 44 HCS (24 adults and 21 children), 38 CBA, 41 MDCP, and 0 DB-MD. As of Oct. 8, 2002, DHS had contracts with 34 providers and have providers of every waiver except DB-MD represented in the group. The most utilized service in the CWP waiver program is Personal Assistance Services. In FY 02, 33.71 percent of the clients receiving the CWP waiver receive this service. Personal Assistance Services cost $491.32 per client per month. Habilitation is the second most utilized service, 20.39 percent of clients in the DB-MD waiver program used this service. For CWP clients, habilitation services cost $297.18 per client per month.

HHSC is conducting the evaluation of the CWP. Currently there has not been sufficient data captured to indicate statistically significant outcomes. Outcomes that will be investigated include consumer and provider satisfaction, adequacy of reimbursement rates, and administrative costs. [39]

Appendix G is a review of the history of waivers in the State of Texas.

Table 2.8 Non- Medicaid Community Care Services[40]						
Programs	**Current Level of Service**	**FY 2000 Expenditures**	**FY 2001 Expenditure**	**FY 2002 Expenditure**	**# on Interest List as of March, 2002**	**Median Length of Stay**
Adult Foster Care	**196**	**$1,259,614**	**$1,1147,361**	**$1,020,501**	**91**	**4.39 months**
Residential Care	**791**	**$6,338,900**	**$6,159,571**	**$6,523,402**	**1344**	**8.4 months**
Emergency Response Systems	**14,476**	**$3,315,850**	**$3,692,781**	**$3,839,650**	**6328**	**10.61 months**
Home Delivered Meals	**12,911**	**$10,417,072**	**$11,170,877**	**$12,313,811**	**7380**	**8.36 months**
Client Managed Personal Assistance Services	**645**	**$6,524,290**	**$6,847,960**	**$6,644,881**	**113**	**15.75 months**
Special Services to Persons with Disabilities	**179**	**$1,137,817**	**$1,211,990**	**$1,200,613**	**20**	**6.72 months**
Day Activity and Health Services	**642**	**$3,008,165**	**$3,390,113**	**$3,320,405**	**1035**	**9.86 months**
Respite	**447**	**$1,270,416**	**$1,125,240**	**$1,535,363**	**387**	**4.91 months**
Family Care	**8520**	**$37,503,397**	**$41,564,525**	**$46,296,759**	**2488**	**3.65 months**

The Frequently Used Terms provides an explanation of services and eligibility for each of these Non-Medicaid Community Care Services.

The Texas Department of Mental Health and Mental Retardation

The Texas Department of Mental Health and Mental Retardation (MHMR) is the state authority for the coordination, regulation and provision of mental health services and services to people with mental retardation. [41] As Texas' population continues to grow, the number of people requiring mental retardation services increases. It is projected that in 2003 approximately 2,563,251 adults in Texas will have mental illness. Of this number, 403,016 are estimated to meet MHMR mental illness priority population definition. An estimated 104,777 Texans are in the MHMR mental retardation priority population. Not all persons, however, in the priority population will seek services from the Texas mental health and mental retardation system. [42]

MHMR Services

MHMR provides service to more than 190,000 Texans annually. Services may be provided through a performance contract between MHMR and local community mental health and mental retardation centers or through a Medicaid Waiver such as Home and Community Based Services (HCS), Mental Retardation Local Authority (MRLA) or Home and Community Based Services – OBRA (HCS-O).

Community Mental Retardation Services

> ***Mental Health at MHMR***
> The Department's priority population for adult mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

Community mental retardation services are provided through performance contracts with local Mental Retardation Authorities. These Mental Retardation Authorities use state general revenue funds which are available for a variety of activities that are not available from other federal funding sources. Services provided by Community Mental Retardation Services include eligibility determination and service coordination. Support services include supported home living, respite services, supported employment, specialized therapies, family support services, and in-home and family supports. Day training services include vocational training and site-based habilitation service. Residential services include family living, residential living, and contracted specialized services.

Community Mental Health Services

Community mental health services are community services offered by the Mental Health Authorities that are designed to allow a person with mental illness to attain and maintain the most independent lifestyle available to them. Services for adults may include service coordination, crisis services, assertive community treatment, supported housing, and

supported employment. Rehabilitation services include skills training and residential services, counseling and psychotherapy, consumer supports, medication-related services, inpatient services, acute day treatment, and intensive crisis residential services. Services for children include assessment, medication-related services, crisis resolution services, day treatment, family services, skills home support and parent education. To qualify for services, adults and children must meet the requirements of the MHMR priority population for mental illness.

Mental Retardation Services

After going through an intake process at a local mental retardation authority, a person requesting community mental retardation services will be placed on a waiting list if the service cannot be provided within 30 days (Appendix H). If a person is receiving some mental retardation services but other requested services, such as HCS, are unavailable, the person will be placed on a waiting list for the services not being received.

Mental Retardation at MHMR

Specifically, this population is composed of people who meet one or more of the following descriptions:

- Mental retardation as defined by the Section 591.003 (13), Title 7, Texas Health and Safety Code Section;
- Autism as defined in the current edition of the Diagnostic and Statistical Manual (DSM);
- Pervasive Developmental Disorder (PDD) as defined in the current edition of the DSM;
- Eligibility for Early Childhood Intervention Services (with the requirement that MHMR memorandum dollars may not be used by the Local Authority (LA) to pay for the same services purchased through the LA's memorandum with the Early Childhood Intervention Council).
- Eligibility of OBRA '87 mandated services for mental retardation or a related condition

As of July 31, 2002, there were 19,955 persons who were waiting for mental retardation services. Of this number 18,005 persons were waiting for Medicaid waiver services (HCS, MRLA and HCS-O), and the remaining 1,950 persons were waiting for a variety of other mental retardation services. In comparison, as of Aug. 2, 2002, 6,639 persons were currently enrolled for services under the waiver programs broken down as follows: 4,227 persons were enrolled in HCS, 69 persons were enrolled in HCS-O and 2,343 persons were enrolled in MRLA.[43]

The Prevalence of Mental Retardation

Based on national research of school-based and identified service populations, MHMR estimates that while most persons with moderate, severe or profound mental retardation have needs for services, only about one-third of persons with mild mental retardation are likely to have service needs. Most of these service needs for persons with mild levels of mental retardation are for education, vocational and skills training or are due to complications in addition to their mental retardation status, such as medical or behavioral difficulties.[44] Table 2.9 provides a projection of the prevalence of mental retardation in Texas.

Table 2.9 The Prevalence of Mental Retardation

Year	Texas Population	Persons with Mental Retardation	MHMR Priority Population
2003	21,828,569	595,920	104,777
2007	23,157,431	632,198	111,156
Percentage Increase: 6%			

Monitoring and Maintenance Requirements of Waiting Lists for Mental Retardation

Since 2000 MHMR contractually has required each local authority annual to contact each person, family member or legally authorized representative waiting for mental retardation services to verify that they still desire waiver services. The contact may be by telephone or face to face. All attempts to contact a consumer must be documented by the local authority. If an individual cannot be contacted, the person's waiting list status must be changed to inactive. Continued efforts, however, may be made to contact the consumer. If the consumer is not reached within 90 days of placement on inactive status, his or her name is removed from the waiting list. (An exception to the procedure for removing persons names from the waiting list is that, pursuant to Senate Bill 368, names of individuals 22 years of age or younger are not removed from the waiting list.)[45]

Mental Retardation Services - In the Community

During an initial intake interview with an individual and/or family member(s), the local authority gathers information regarding the types of services or supports desired. If the individual is seeking only placement on the waiver waiting list, no Medicaid eligibility determination process or diagnostic process is required. Medicaid eligibility is not determined at this time because a high percentage of persons with mental retardation are eligible for Medicaid. A more specific diagnostic process is not conducted at this time because, given the multi-year wait for HCS services, it is more valuable and more efficient in terms of conserving diagnostic resources to do more detailed diagnostic work closer to the time of actually being offered services.

A somewhat different process is used when an individual is requesting general revenue funded mental retardation services. When GR services are sought, the local authority should, at that time, establish diagnostic and income eligibility. A Determination of Mental Retardation (DMR) documenting the individual's diagnostic eligibility is necessary for most GR services. If the DMR cannot be conducted within 30 days of the request, the local authority staff registers the individual in the MHMR CARE system and indicates a waiting status for Eligibility Determination in the waiting list system. When an individual begins receiving a service for which he or she has been waiting, and enrollment is completed for that service, the individual's name is removed from the waiting list.

Robert is a 16-year-old male with mild mental retardation, adaptive Behavior Level 1 (mild). He received services through In-Home & Family Support from the time he was two until he began attending public school, at age seven. His family also has received in-home services through General Revenue funded Personal Family Assistance type services. These consisted mainly of some self-help training and respite. This service continued until 1997, when the family moved from Dallas at that time. The family has returned to the Dallas area, but Robert does not currently receive services from Dallas MetroCare Services. He is receiving transition services through the public school. He will need some vocational training, as well as supports in the future to possibly live independently in the community. Robert has been on the waiting list since Sept. 22, 1993.

Waiver Services Offered by MHMR

Medicaid home and community-based waiver services provide services and supports to persons with mental retardation in their own or their family's home or in other home-like settings in the community. These services are provided through the Home and Community-based Services Program and the Mental Retardation Local Authority Program. Public or private providers may provide these services and supports.

The Texas Department of Human Services licenses waiver providers as Home and Community Support Service Agencies. MHMR certifies all waiver providers initially, then reviews each provider annually to ensure the provider continues to meet the program certification principles. DPRS receives and investigates complaints of abuse, neglect or exploitation in waiver programs and investigates each complaint. MHMR receives and investigates other types of complaints.

Waiting lists still exist for Medicaid waiver services as well as other (general revenue funded) community mental health and mental retardation services.[46] As of Sept. 1, 2001, nearly 15,000 persons were on the waiting list. As of May 31, 2002, 20,259 persons were on MHMR

Waiting List.[47] Each year the agency requires annual contact to be made by the local authority with each person listed on the waiting list to verify the continual need for HCS services.

Overview of MHMR Waiver Programs

Funding for Waiver Programs

During FY 02-03, $27.3 million in GR and $41.3 million in federal funds were appropriated to address the promotion of independence and the waiting list for community mental retardation services. These funds were set aside in Senate Bill 1, the General Appropriations Bill, which funded 665 new waiver slots. Of the 665 slots, 259 were used for persons on the waiting list, 271 persons in state school facilities and 135 for persons in ICF/MR facilities.[48]

Methodology for allocating waiver slots

New waiver slots for persons on community waiting lists are allocated to local mental retardation authorities. The local authorities then use their allocation slots on a first-come, first- served, basis. (Equity of funding levels is a consideration in these allocations to local authorities.) New waiver slots related to the Promoting Independence Plan are allocated for the persons referred for waiver services who are residing in state schools and large community ICF-MR. [49]

Home and Community-based Services (HCS)

The HCS Program provides individualized services to people living in their family's home or their own homes in the community. HCS is a waiver program authorized under Section 1915 of Title XIX of the Social Security Act. Covered services include adaptive aids, service coordination, counseling and therapies, minor home modifications, dental treatment, nursing, residential assistance, respite, day habilitation, and supported employment. To be eligible for the HCS Program, a person must be eligible for SSI or be in one of the optional categorical coverage groups as specified in the HCS Waiver Renewal Request 1998-2003. The client must be eligible for an ICF/MR 1 to 8 level of care, have a determination of mental retardation in accordance with state law; have an Individual Plan of Care for waiver services that does not exceed the dollar limit for services and have chosen HCS over the ICF/MR program and not be enrolled in another 1915 waiver program.

The Home and Community-Based Services (HCS) waiver was

> Sammy is a 34-year-old male, with mild mental retardation. Assessments indicate that he would be classified as an LON 1 (Medicaid Level of Need category indicating the need for only Intermittent support, the mildest level). He lives alone in his own apartment. He however, has a life-threatening disease and is in need of nursing services. Other needed services identified in his waiting list application include supported home living (training), transportation, assistance with finances, and dental services. He has been on the Medicaid Waiver waiting list since Oct. 21, 1993.

implemented Sept. 1, 1985, in Texas to allow families who chose to keep their family member at home to receive Medicaid funded services in the home that address the person's mental retardation. Prior to the implementation of HCS, a person with mental retardation had to be admitted into an Intermediate Care Facility for persons with Mental Retardation that provided 24-hour residential care in order to receive Medicaid funded services.

Total Expenditures for Waiver Services/HCS Lapse

Through June 30, 2002, total expenditures under the Medicaid waiver totaled $216.0 million. Current projections indicate an unexpended balance in the waiver programs. Estimated lapse dollars of $8.2 million GR, according to MHMR, are due to lower average costs and the ramp up required for implementing new waiver slots. These lapse dollars do not prevent the waiver program from reaching its full expansion target in this biennium, and the dollars cannot be used to further expand the program beyond legislative targets because such an additional expansion could not be supported without additional funds in the next biennium. Additionally, funds appropriated for the waiver program are restricted by rider for use only in that program.

The average monthly cost per person based on paid claims information through March, 2002, for persons enrolled into the 665 new waiver slots is; in Large Community Intermediates Care Facility per persons with mental retardation is $3,834, State Schools is $4,312 and services to those on the waiting list is $2,403.[50]

Sarah is a 24-year-old female with moderate mental retardation. Assessment results indicate she would be classified as an LON 5 (Medicaid Level of Need indicating Limited support needs, a moderate category). Additionally, she has a diagnosis of ADHD (Attention Deficit – Hyperactive Disorder). She lives with her parents, who are in their 60s. According to her waiting list application she needs supported home living (training), transportation, respite, dental and nursing services.

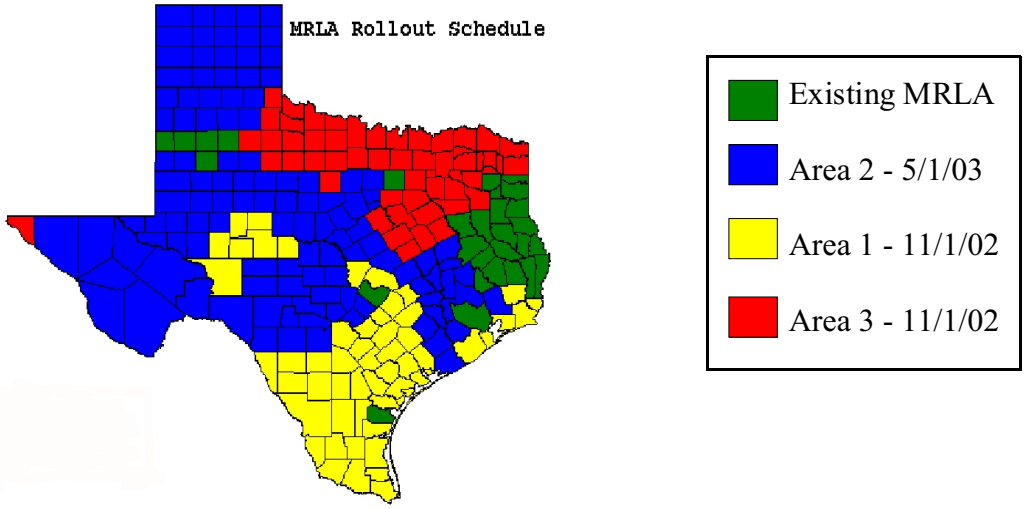
Mental Retardation Local Authority Waiver Program (MRLA)

The MRLA Program is a 1915 waiver program that provides individualized services in a community setting for persons with mental retardation and related conditions. Local authorities recommend eligibility, and MHMR makes the final eligibility determination for this program. The local mental retardation authority, rather than the provider, performs service coordination. The MRLA Program provides services to individuals who live either with their family, in their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services. The MRLA Program provides services to meet the individuals needs so that persons can live in the community and have opportunities to participate as a citizen to the maximum extent possible.

In the MRLA Program, individuals pay for their room and board either with their SSI check or other personal resources. More than 1,900 individuals receive MRLA services via private providers; and an additional 400-plus receive MRLA services through public providers. In the MRLA program the supported home living service provider must be employed by the program provider rather than working as an independent contractor, as is allowed in the HCS program. Under the MRLA the provider must hire a person designated by the consumer or parent as a service provider as long as the person meets the minimum qualifications and will provide the service for the reimbursement rate.

The MRLA program is available in Anderson, Angelina, Cherokee, Cochran, Gregg, Harris, Harrison, Hockley, Houston, Jasper, Lubbock, Lynn, Marion, Nacogdoches, Newton, Nueces, Panola, Polk, Rusk, Tarrant, Travis, Trinity, Tyler, Sabine, San Augustine, San Jacinto, Shelby and Upshur. Statewide expansion of the MRLA Program will occur in FY 03 for the remaining counties in the state. This expansion will be implemented over three geographic areas. Area 1, encompassing South Texas and the upper Gulf Coast, will be converted on Nov. 1, 2002. Area 2, encompassing West Texas and the Panhandle, will convert on May 1, 2003. Area 3, in North Texas, will convert on Sept. 1, 2003. On completion of the expansion, all of the current HCS and HCS-O waiver services will have been converted to the MRLA Waiver and the terms HCS and HCS-O, as references to the separate waivers, will no longer be utilized. Chart 2.8 is a map of MRLA expansion in Texas. [51]

Chart 2.8 MRLA Expansion



Most Utilized Services in HCS and MRLA Waiver Programs

In an effort to understand the most utilized services and cost of the services provided in the waiver programs, MHMR reported both the HCS and MRLA combined. The reason for this is due to the fact that HCS is being rolled into MRLA. Reporting on HCS separately would only reflect a 6-month period.

The most-utilized service combined for HCS and MRLA is dental care. Dental care costs $29.14 per month per person. The second most utilized service is day habilitation, which costs $356.95 per month per person. Nursing care is the third most utilized service costing $79.54 per month per person. Residential Support and Supervised Living is the fourth most utilized service, which costs $2,478.73 per month per person.

Home and Community-Based Services Waiver Program (HCS-O)

The Home and Community-Based Services-Ominbus Budget Reconciliation Act (OBRA) (HCS-O) Program provides individualized services to persons with mental retardation and/or a related condition to support their return to their family's home or other settings in the community from Medicaid certified nursing facilities. (Waiver Program authorized under Section 1915 of Title XIX of the Social Security Act.) Covered Services include adaptive aids, service coordination, dietary services, habilitation, minor home modifications, nursing, occupational therapy, physical therapy, psychology, respite, social work, and speech/language pathology. To be eligible for the HCS-O program, a person must meet the same eligibility requirements as for HCS, but also must be discharged directly from a Medicaid certified nursing facility.

The HCS-O waiver was implemented June 1, 1992. HCS-O was implemented to assist persons with mental retardation or related conditions who had been displaced from nursing facilities as a result of OBRA '87 to locate alternate services. Provisions in the OBRA '87 mandated that states develop a system to move persons with mental retardation or related conditions out of nursing facilities if these individuals did not have a medical condition that would warrant their continued stay in the nursing facility.

Most Utilized Services in the HCS-O Waiver Program

The most-utilized service in the HCS-O waiver program is adaptive aids which costs $23 per month per person. Supported living is the second most utilized service in the HCS-O waiver program which costs $3,087.49 per month per person. The third most-utilized service is Habilitation and Training which costs $552.41 per month per person in the HSC-O waiver program. Nursing is the fourth most-utilized service, costing $62.91 per month per person.

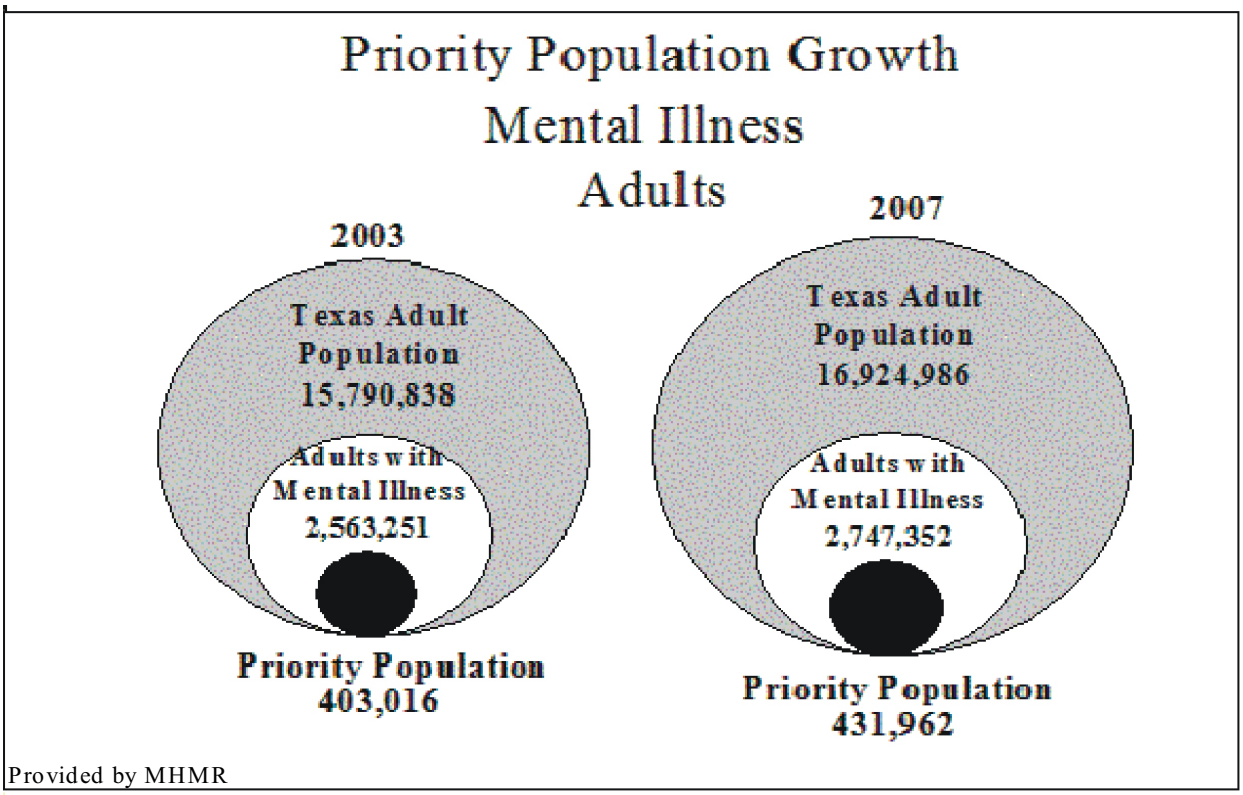
Mental Health Services at MHMR

The Prevalence of Mental Illness

Research indicates that mental illness occurs in all ages, race/ethnicity groups, genders and socioeconomic groupings. Approximately 19 percent of the population aged 18/64 will experience some diagnosable mental disorder (as defined by the Diagnostic and Statistical Manual, edition IV), excluding substance abuse disorders, during a lifetime. The more serious mental illnesses have been estimated to affect between 2.6 percent and 2.8 percent of adults.

It is estimated by MHMR that only approximately 25 percent of persons with mental disorders obtain treatment from the health care system. Significantly, it is also estimated that about 40 percent of persons with serious mental illness do not seek treatment. The priority population prevalence projections represent the number of persons who are estimated to meet MHMR priority population definition. Not all persons in the priority population will seek services from the Texas mental health and mental retardation system. In general, potential customers choose to access the private system of care if they can afford it. Additionally, some eligible persons do not seek services, engage in activities that place them in other settings (such as the Texas Department of Criminal Justice and jails), are assisted by family or non-traditional caregivers, or are not able to access systems of care.

During FY 01, 139,383 adults were served in mental health campus and community based programs, representing approximately 36 percent of the potentially eligible population[52]**.** Since the inception of the mental health waiting list in 1998, the most consistently needed services for which adults must wait have been medication–related services, supported employment services, supported housing services and service coordination (case management). The most consistently needed services for which children must wait have been medication-related services and skills training. As of July 31, 2002, the number of persons waiting for mental health services was 6,015. Of those waiting, 91 percent were adults, and nine percent were persons under the age of 18. These individuals have waited an average of one year and three months for services. Approximately 47 percent of the persons waiting for mental health services are receiving some mental health services.



Provided by MHMR

Waiting List for Mental Health Services

The waiting list for adults with mental illness and children with serious emotional disturbance is required through the MHMR's performance contract with the local authorities. Each local authority is required to develop and implement procedures to triage and prioritize service needs of consumers who are determined eligible for mental health services for which the local authority has reached or exceeded its capacity. These procedures must include a process for the assessment of the individual's urgency of needs and a requirement that he or she be placed immediately on a waiting list for the services for which he or she is determined to be eligible.[53]

Children and Adolescents

State law requires that MHMR identify its children's priority population and the minimum array of services necessary to address the needs of the children and families in this priority population. The statute also requires that services be offered first to those most in need and that state dollars be used only for services provided to the children's priority population.

Children and adolescents do not meet the priority population criteria if they have a single diagnosis of autism, pervasive developmental disorder, mental retardation, or substance abuse.

Mental Health Services Waiting List

Persons placed on a waiting list for mental health services must be removed from the waiting list and entered into services when the needed services become available. The local authority is required to monitor the waiting list at a frequency sufficient to determine and prioritize needs. This may include consumers receiving some needed services but waiting for others or individuals not served while waiting for services. The local authority uses clinical judgment to determine who is entered into services from the waiting lists. This determination is based on the individual's symptoms and functioning level.[54]

Frequently Used Terms[55]

Adult Foster Care (AFC) - AFC provides a 24-hour living arrangement with supervision in an adult foster home for persons who, because of physical, mental, or emotional limitations, are unable to continue independent functioning in their own homes. With the exception of family members, no more than three adults may live in the foster home unless DHS licenses it. Services may include minimal help with personal care, help with activities of daily living, and provision of or arrangement for transportation. To be eligible, a client must be 18 years of age or older. Additionally, the client must either be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client also must have resources of $5,000 or less for an individual or $6,000 or less for a couple. Also, the client must have a functional assessment score of 18+.A functional assessment is an assessment that measures an individual's need for assistance with activities of daily living due to physical or mental limitation or disability. Activities of daily living include such things as bathing, grooming, dressing, meal preparation and laundry.

Community Mental Health Mental Retardation Centers - Centers are nonprofit, locally governed and state contracted components of the MHMR service delivery system. TDMHMR contracts with all 42 community MHMR centers to provide services to individuals within the priority populations as defined by TDMHMR.

Client Managed Personal Assistance Services (CMPAS) - CMPAS services are provided to consumers with physical disabilities who are mentally competent and willing to supervise their attendant or who have someone who can provide the personal assistant's supervision. The program empowers clients to interview, select, train, supervise and release their personal assistants. In the "agency model" of CMPAS, the provider agency is the employer of record for the personal assistant. In the "consumer directed" and "block grant" models of CMPAS, the consumer is the employer of record. Licensed Personal Assistance Service agencies determine client eligibility and the amount of care needed. CMPAS providers develop a pool of potential personal assistants and provide emergency back-up personal assistants. To be eligible, a person must be 18 years of age or older. A sliding fee will be used when income is greater than $1,200 per month for an individual. The individual must be mentally and emotionally capable of self-directing the care. The client's disability must be expected to last at least six months from the date that eligibility is determined and must need at least one personal care task.

Day Activity and Health Services (DAHS) - DAHS facilities provide daytime services Monday through Friday to clients residing in the community in order to provide an alternative to placement in nursing homes or other institutions. The facility is required to be open 10 hours a day. Services are designed to address the physical, mental, medical and social needs of clients. Services include nursing and personal care, physical rehabilitation, noon meal and snacks, transportation, and social, educational and recreational activities. To be eligible for

DAHS, a person must be 18 years of age or older and have an income not in excess of $1,635 per month for an individual or $3,270 per month for a couple. His/her resources must be $5,000 or less for an individual if not SSI eligible or $6,000 or less for a couple if not SSI eligible. Also, the client must have a medical diagnosis and physician's orders requiring care or supervision by a licensed nurse, a functional disability related to medical diagnosis, prior approval granted by a regional nurse, and the need for assistance with one or more personal care tasks.

Emergency Response - Emergency response services are provided through an electronic monitoring system used by functionally impaired adults who live alone or who are socially isolated in the community. In an emergency, the client can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven-day-a-week monitoring capability, helps to ensure that the appropriate person or service agency responds to an alarm call from a client. To be eligible, a client must be 18 years of age or older, be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client must have resources of $5,000 or less for an individual or $6,000 or less for a couple. Also, the client must have a functional assessment score of more than 20 and must be at home alone routinely for eight or more hours per day, have the mental capacity to operate the equipment, have a telephone with a private line, and be willing to sign a release statement that allows the responder to make a forced entry into the client's home if the responder is asked to respond to an activated alarm call and has no other means of entering the home to respond.

Family Care (FC) - Family care provides a non-skilled, non-technical attendant care service available to eligible adults who are functionally limited in performing activities of daily living. FC services are provided by an attendant and do not require the supervision of a registered nurse. Covered services follow:

- Personal Care services include assistance with activities related to the care of the client's physical health.
- Home Management services include assistance with housekeeping activities that support the client's health and safety. These activities include changing bed linens, housekeeping, laundering, shopping, storing purchased items, and washing dishes.
- Escort services include accompanying the client on trips to obtain medical diagnosis or treatment or both. This service does not include the direct transportation of the client by the attendant. Additional time may not be allocated for escort services for purposes other than to accompany the client on trips to obtain medical diagnosis and/or treatments. The client, however, may elect to substitute escort services for time allotted to any other task.

To be eligible, a client must be 18 years of age or older. Additionally, the client must either be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client also must have resources of $5,000 or less for an individual or $6,000 or less for a couple. Also, the client must have a functional assessment score of more than 24 and have an unmet need for home management and/or personal care tasks.

Habilitation - Accommodates the day programming needs of those who are not ready to participate in vocational training. These services provide the training needed to help the individual participate in the community. Day Habilitation services can be provided by a local authority program or a private provider that contracts with the local community MHMR center.

Home and Community Based Services (HCS) - 1915(c) Medicaid waiver which assists individuals with mental retardation to return to or remain in their home by providing individualized services.

Home and Community Based Services (HCS-O) - A Medicaid 1915(c) waiver program which provides individualized services to people with mental retardation or related conditions who are eligible for Medicaid and SSI and who require specialized services and are inappropriately residing in nursing facilities as determined by the Annual Resident Review Assessment.

Home Delivered Meals - The Home Delivered Meals program provides a nutritious meal delivered to the client's home. This helps to ensure that a client gets at least one healthy meal per day. To be eligible, an individual must be 18 years of age or older, be a Medicaid recipient or have an income not in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client's resources must be $5,000 or less for an individual or $6,000 or less for a couple. Also, the client must have a functional assessment score of more than 20 and functionally be limited in preparing meals.

In-Home and Family Support - The In-Home and Family Support program provides direct grant benefits to individuals with physical disabilities and/or their family to purchase services that enable them to live in the community. Eligible individuals are empowered to choose and purchase services that help them to remain in their own home. Services include purchase or lease of special equipment or architectural modifications of a home to facilitate the care, treatment therapy, or general living conditions of a person with a disability, medical, surgical, therapeutic, diagnostic and other health services related to a person's disability. Services also include counseling and training programs that help to provide proper care of an individual with a disability, attendant care, home health services, home health aide services, homemaker services, chore services that provide assistance with training, routine body functions, dressing,

preparing and consuming food, and ambulating, respite care, transportation services, pre-approved transportation and room and board cost incurred by a person with a physical disability or by his family during evaluation or treatment and other disability related services previously approved by DHS. To be eligible, a person must be four years of age or older. A client must make a copayment according to a schedule that will be established (begins at 105 percent of the state median income for household size); and must have a physical disability that substantially limits the individual's ability to function independently.

Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) - ICFs provide 24-hour residential and habilitation services in a variety of settings ranging from large institutions to small (four-six bed) community homes.

In Home & Family Support Services - Provide another means of funding service on an annual or one-time basis, including:

- Medical services and equipment
- Medications
- Modifications to a home to accommodate the special needs
- Therapies
- Skills training
- Adaptive aids
- Community inclusion training
- Personal assistant services for the medically fragile
- Transportation
- Respite provided by a person of the family's choice

Families are required to provide receipts and other proof that the grant funds were used as stated in the contract. Eligibility for grant funds is based on family size and income; funding per individual is limited to $3,600 in a year.

Interest List (DHS) - Interest lists include all individuals that have contacted DHS requesting services or programs that are non-entitlement services. No screening or eligibility determination for the services requested has been done for these individuals registered on the interest list. As funds become available to serve new clients in these programs, the individuals on the interest list are contacted to begin the eligibility determination process.

Medicaid - A state-federal program providing health care to people with disabilities and low-income families. Texas receives a 63/37 match for money spent on Medicaid health care programs.

Medicaid Eligible - Eligible to receive Medicaid benefits.

Medicare - A federal health care program for the elderly and disabled persons, regardless of income. Medicare does not pay for long-term care or prescription drug benefits.

Mental Retardation Local Authority Waiver (MRLA) - 1915(c) Medicaid waiver. Provides individualized services in a community setting for people with mental retardation and related conditions.

Medicaid Long-terms Care Waivers - Federal law allows states to apply to CMS for permission to depart from certain Medicaid requirements. These "waivers" allow states to operate programs that include exceptions to Medicaid's basic principles, required array of benefits, mandated eligibility and income groups or combinations of these. Waivers allow states to develop creative alternatives to the traditional Medicaid program.

States seek waivers to:

- provide different kinds of services,
- provide Medicaid eligibility to new groups,
- target certain services to certain groups, and/or
- test new service delivery and management models.

The Research and Demonstration Waivers or the 1115 waivers give states the flexibility to test substantially new ideas for operating their Medicaid programs. It waives a variety of requirements, such as comparability or statewideness. The states can use this waiver to expand managed care programs. The states may use savings to finance coverage to individuals previously not covered by Medicaid. Under the 1115, states may also use savings to provide enhanced services, not otherwise available to the population. The waiver must be budget neutral for its duration. It generally lasts five years and is then subject to renewal.

The Home and Community-Based Service Waivers or 1915 (c) waivers allow states to provide community-based services to people who meet eligibility criteria for care in an institution (nursing home, ICF/MR or hospital) or who would otherwise meet eligibility criteria for care.

These waiver programs can serve elderly persons with physical and/or developmental disabilities, mental retardation or mental illness. States may also target other special populations (e.g. AIDS). The 1915 (c) waivers must be cost neutral for the duration of the waiver and the state must assure that safeguards are in place to protect recipients. The 1915(c) waivers are initially approved for three years and may be renewed at five year intervals.

Residential Care (RC) - The Residential Care program provides services to eligible adults in assisted living facilities who require access to care on a 24-hour basis but do not require daily nursing intervention. Services include, but are not limited to, personal care, home management, escort, 24-hour supervision, social and recreational activities, transportation, food and room. Services provided under the RC program are delivered through one of two arrangements, supervised living and emergency care. *Supervised living* is a state-funded 24-hour living arrangement in which the client is expected, if able, to contribute to the total cost of his care. The client keeps a monthly allowance for personal and medical expenses, and the remainder of his income is contributed to the total cost of his care. *Emergency care* is a state or Title XX funded living arrangement that provides services to eligible clients while caseworkers seek a permanent care arrangement. Emergency care clients do not contribute toward the cost of their care. To be eligible a client must be 18 years of age or older. Additionally, the client must either be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client must also have resources of $5,000 or less for an individual or $6,000 or less for a couple. Also, the client must have a functional assessment score of more than 18 and have needs that do not exceed the facility's capability under its licensed capacity.

Respite Care (RESP) - The Respite Care program provides short-term services for elderly and disabled adults who require care and/or supervision while allowing their caregivers temporary relief. Services may be provided inside or outside of the home. Services may provided in a nursing home or hospital and include personal care, nursing intervention, supervision, meal preparation, and a room. In an adult foster care home or personal care home, services include personal care, housekeeping, supervision, meal preparation, transportation, and a room. In an adult day health care facility, services include personal care, nursing services, supervision, meal preparation, and transportation. In the individual's own home, services provide a home care attendant and include personal care, housekeeping, meal preparation, supervision, and transportation. In the individual's own home, services include a home-sitter, housekeeping, meal preparation and supervision. To be eligible, a client must be 18 years of age or older. Additionally, the client must either be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. A client also must need care or supervision or both and have an unpaid caregiver who needs relief from care giving responsibilities because of severe stress or who is temporarily unable to provide care.

Residential Services - Provides 24-hour residential programs to individuals and family members who are seeking residential services provided within TDMHMR's service network, including state mental retardation facilities.

Respite - Provides temporary and short-term care as a relief for the primary service provider. This service can be provided in the home or at another location. Typically, a variety of providers are available to enable families to have access to respite services for specialized populations (individuals who are medically fragile and who have behavioral problems).

Service Coordination: (formerly known as Case Management) - The term service coordination refers to services which will assist Medicaid eligible individuals in gaining access to needed medical, social, educational and other appropriate services that will help them achieve or maintain a quality of life and community participation acceptable to each person. In addition, a service coordinator assists with consultation and coordination when changes in services are needed.

Special Services to Persons with Disabilities - The Special Services to Persons with Disabilities program includes services provided to community care clients in a variety of settings. These services are designed to assist clients in developing the skills needed to remain in the community as independently as possible, and include counseling, personal care, and help with the development of skills needed for independent living in the community. To be eligible, a client must be 18 years of age or older. Additionally, the client must either be a Medicaid recipient or not have an income in excess of $1,635 per month for an individual or $3,270 per month for a couple. The client also must have resources of $5,000 or less for an individual or $6,000 or less for a couple and have a functional assessment score of more than nine.

State Mental Health Facilities - Ten state mental health facilities provide specialized services to assist individuals with mental illness who need inpatient treatment.

State Mental Retardation Facilities - 11 state schools and two state centers provide assessment, treatment, support and medical services. These specialized, long-term, residential services for people with mental retardation or related conditions have historically been called “schools.”

Utilization Review - A formal assessment of the medical necessity and/or appropriateness of health care services and treatment plan.

Vocational - Provides training and support needed to obtain and retain employment. Services include traditional vocational workshops as well as innovative programs to help individuals secure community-based jobs. Specific services are tailored to fit each individual's needs and abilities. Vocational services may be provided by a local authority program or by a private provider that contracts with the local authority.

Waiver - An exception to the usual federal Medicaid requirements granted to a state by the federal Center for Medicaid and Medicare Services (CMS). The usual waivers are provisions in the federal Social Security Act, usually under section 1115(a), 1915(b) and 1915(c).

Waiting List (DHS) - At DHS the waiting list implies that an individual seeking services has been determined eligible for those services and is waiting on the list to receive the service. The implied eligibility would be for financial determination and functional assessment.

Waiting List (MHMR) - Mental Retardation Services - The name of each individual who requests a mental retardation service that will not be available within 30 calendar days from the date of the request, the specific type of service requested, and the date of such request, to be entered into the CARE waiting list system within seven calendar days of the request. Identification of the types of services requested as specifically as known, using the performance Contract Mental Retardation Services array, even for those individuals applying for Medicaid programs.

Waiting List (MHMR) - Mental Health Services - The Local Mental Health Authorities establish, manage and maintain the community mental health waiting list. A person's name is placed on the community mental health waiting lists for specific services for which the person is determined eligible but for which the local MHA has reached or exceeded its capacity to provide services. Services are provided based on prioritization of need. A person's name is removed from the list when the person begins to receive services.

Waiting List (TDH) - The CSHCN Program's waiting list for medical services is a waiting list for all the services for which the program pays providers except for family support services, contractual services, and case management services provided by TDH regional staff. These medical services include, but are not limited to, services such as hospital care, physician/ dentist care, therapies, durable medical equipment, medications, etc. Only CSHCN clients who apply to the program on or after Oct. 5, 2001, (either as first-time applicants or as re-applicants after a period of lapsed eligibility), and who are determined eligible, are placed on the waiting list. The waiting list is composed of CSHCN who definitely are eligible and would be covered by the program if funding were available. CSHCN clients are place on the waiting list in the order of the date they are determined to be eligible for the program. Clients on the medical services waiting list (as well as clients who are not on the medical services waiting list) may receive case management services.

The CSHCN Program also has a waiting list for a specific service- family support services. Not all eligible CSHCN clients need or request family support services. As of July 1, 2001, the program was able to provide family support services as a regular program benefit; however, due to budgetary constraints, the program instituted a waiting list for these services. Thus, the program's waiting list for family support services includes clients who are currently receiving medical services, as well as clients who are on the medical services waiting list. CSHCN clients are placed on the family supports waiting list in the order of the date that they request such services.

Charge 3: Rates

CHARGE 3: Study the process by which Medicaid provider reimbursement rates are reviewed and what factors contribute to their adjustments. In addition, foster care/adoption subsidy reimbursement rates will also be reviewed.

Overview

In the Medicaid program, states have the flexibility to determine the reimbursement methodology and the rate for services. Reimbursement rates must be sufficient to enlist adequate participation in the Medicaid Program by physicians and other practitioners and to ensure the ability of the eligible Medicaid population to receive adequate health care services in an appropriate setting. Medicaid providers must accept the Medicaid reimbursement level as payment in full.

States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Emergency services, family planning services and hospice care services must be exempt from such copayments. Certain Medicaid recipients must be excluded from this cost sharing; including pregnant women, children under age 18, persons who are inpatients in hospitals and persons in institutional care who "spend down" to Medicaid eligibility.

The total amount of federal dollars matched for Medicaid has no set limit. As long as states choose to provide services, within the law, for its eligible recipients, the federal government must match the states' spending according to the Federal Medical Assistance Percentage (FMAP). However, in recent years Texas has seen a decline in its FMAP. The FMAP is based on the relationship between each state's per capita personal income and the national average per capita personal income over three calendar years. The declines in FMAP increases the state's share of program costs. Appendix I shows the changes in FMAP for Texas from 1992 to 2004.

In Texas the Health and Human Services Commission (HHSC) has broad oversight responsibility under Government Code § 531.0055 for the overall operations of health and human services agencies, including their rate-setting activities. The Medicaid rate setting function was centralized at HHSC effective Sept. 1, 2001, as directed by Government Code § 531.021(b) to improve consistency and coordination in setting Medicaid reimbursement rates. Government Code § 531.0057 and § 531.034 give HHSC responsibility for reviewing the rules of other health and human services agencies for compliance with the coordinated strategic plan, existing statutory authority, rules of other health and human services (HHS) agencies, budgetary and other implications.

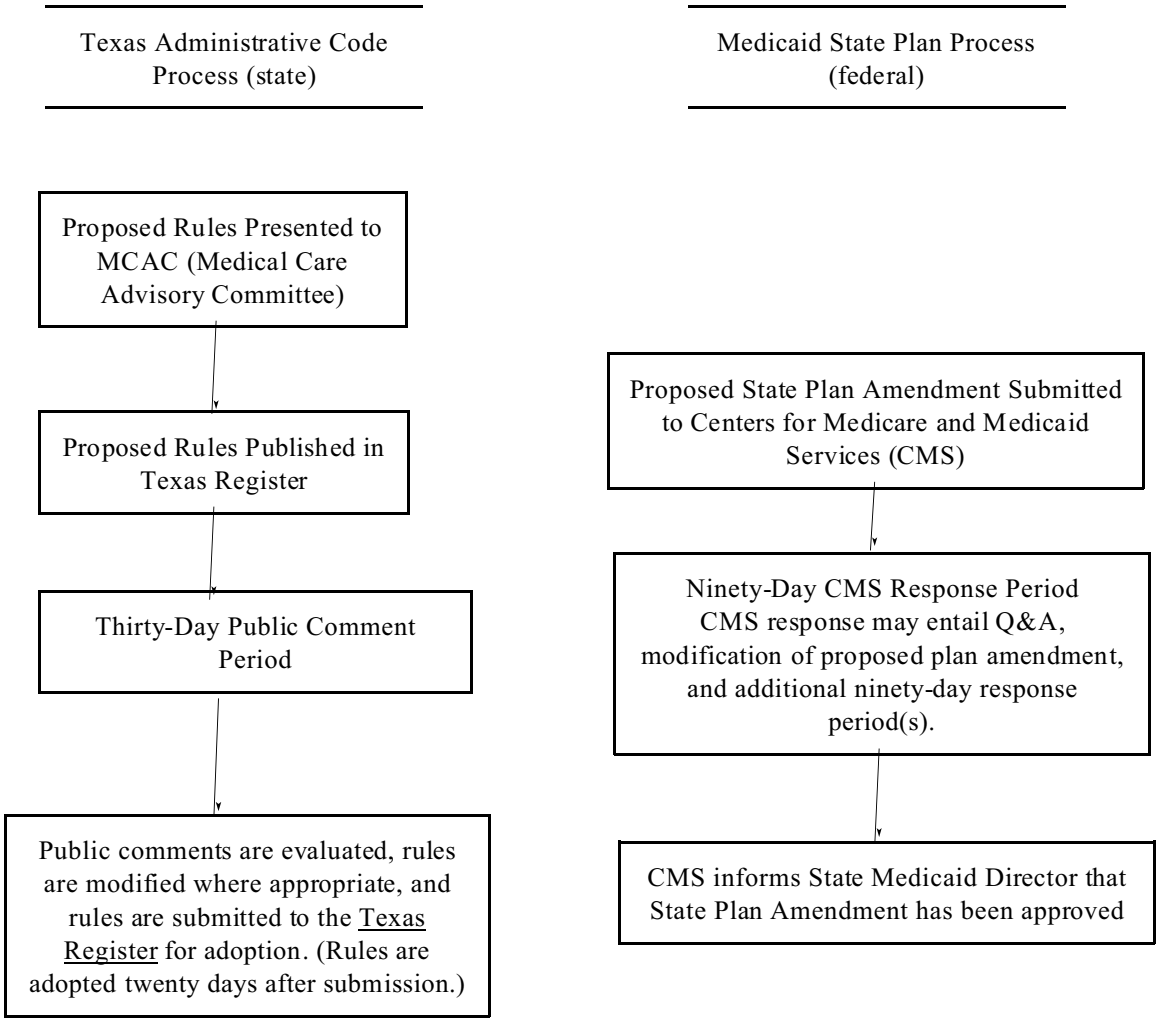
The review process includes a review of rules and the establishment of reimbursement methodologies for health and human services agencies.

Key Steps in the Rate Setting Process

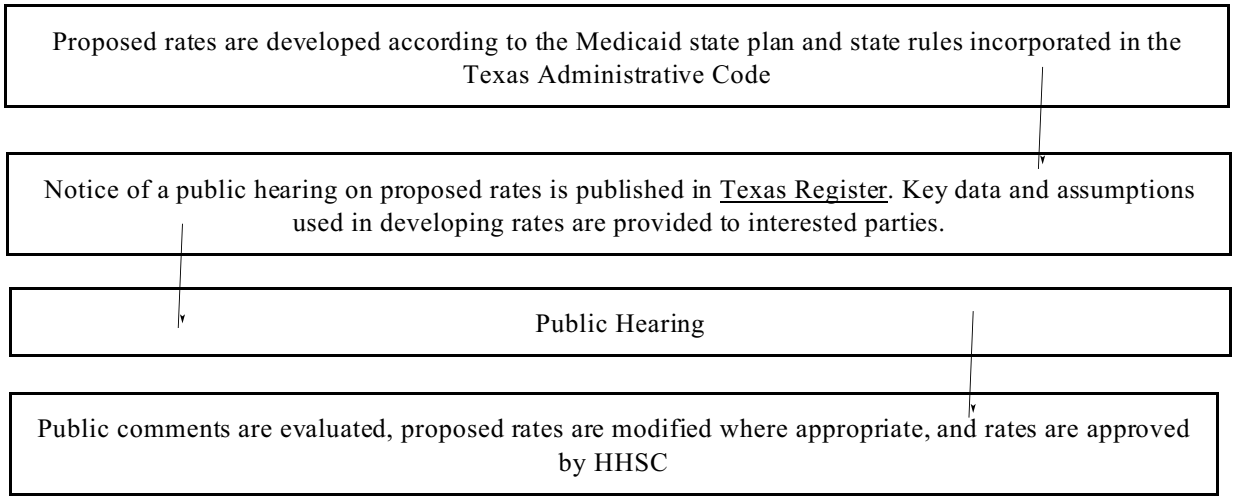
There are key steps according to state and federal Medicaid rules that must be followed before a rate can be implemented including the following:

- developing rate methodology for incorporation into the Medicaid State Plan, where applicable, and the Texas Administrative Code;
- securing federal approval for Medicaid State Plan amendments;
- consulting the appropriate advisory committees on rules to be incorporated into the Texas Administrative Code;
- gathering, auditing and analyzing cost data;
- utilizing prescribed methodologies in conjunction with analysis of costs and other pertinent information to develop proposed rates;
- assessing the fiscal impact of proposed rates; and
- conducting public hearings on the proposed rate and giving interested parties an opportunity for review and comment about the proposed methodology.[56]

Key Steps in the HHSC Medicaid Rate Methodology Rule-Making Process [57]



Key Steps in HHSC Medicaid Rate Determination Process for Long Term Care Rates or Rate Components Which Are Uniform Statewide by Class of Service or Provider Type



Rate Increase

This report focuses on the major Medicaid reimbursement rates established under the coordination of HHSC. Medicaid reimbursement rates can be categorized as one of the following: fee for service, capitated, or facility based and community care rate.

Table 3.1 Medicaid Rates

Fee for Service Rates	Capitated Rates	Facility-based and community care rates
Inpatient Hospital	HMO STAR	Nursing Homes
Outpatient Hospital	Star + Plus	Intermediate Care Facilities - Mental Retardation/Related Conditions
Physician Services		Community Care Programs • Home and Community Base Services • Community-Based Alternatives • Community Living and Support Services • Primary Home Care • Day Activity and Health Services
Early Periodic Screening, Diagnosis, and Treatment Program		
Primary Care Case Management		

Each program and service require a separate rate methodology. Rates are set based on factors such as historical costs, modeling, and budgetary limitations.

In addition to cost reports and formulas included in approved methodologies, rate setting is influenced by appropriations and legislative directive. The 77th Legislature, for example, directed HHSC to target Medicaid acute care increases to support specific providers and services, such as high-volume providers, providers along the border and preventive care. In the area of community care and nursing facility care, increases were directed toward wages for personal attendants, nursing facility aides and nurses.

The 77th Legislature appropriated $1.1 billion in All Funds, including $436 million in General Revenue funds, for Medicaid rate and related increases at health and human services agencies. [58]

Two bills related to Medicaid rates directed HHSC to establish a task force to report on increasing Medicaid reimbursement rates and financial incentives for physicians providing services to certain Medicaid and CHIP enrollees in the border region and to evaluate comprehensively reimbursement rates statewide. Senate Bill 1053 by Senator Eliot Shapleigh and Representative Norma Chavez directs HHSC to establish a task force to issue a strategic plan to eliminate rate disparities along the border compared to the rest of the state. Senate Bill 1299 by Senator Eddie Lucio and Representative Garnet Coleman creates a task force to comprehensively evaluate reimbursement rates statewide. HHSC established a single task force to issue both of these reports by December, 2002. Moreover, the Joint Interim Committee on Health Services chaired by Senator Judith Zaffirini and Representative Patricia Gray was charged to monitor the implementation of Senate Bill 1053 and Senate Bill 1299.

Table 3.2 Medicaid Rate Increases Authorized, 77th Legislative Session[59]

Type of Rate	FY02-FY03 General Revenue Increase Appropriated	Description of Adjustment	Effective Date
Professional Fees	$50 million	Increased EPSDT fee from $49.01 to $70.00 for all EPSDT providers	09/01/01
		High-volume primary care providers (providing minimum average of 300 services per month) received a 1.9 percent add-on payment for all professional services performed.	01/18/02
		High-volume specialists (providing the top 50 percent of services) received a 6.1 percent add-on payment for all professional services performed.	01/18/02
		For all providers, the most often billed office visit for an established patient increased from $27.28 to $29.52 or 8.2 percent.	01/18/02
		Capitated payments to HMOs also included funding for increased payments to high volume providers	
Dental Fees	$20 million	Increased payments for 33 specific procedures that include exams, preventive measures, and selected restorative procedures for an overall rate increase of 13.5 percent.	10/01/01
		Additional increase of 3.7 percent for each dental service for high-volume (providing an average of 300 services per month) practitioners. High volume dentists are particularly represented in border and rural areas.	01/18/02

Outpatient Hospital Services	$35 million	Payments to high-volume outpatient hospitals (including Ambulatory Surgical Centers (ASCs), Hospital-Based ASCs and birthing centers) were increased by 5.2 percent. Capitated payments to HMOs including funding for increased payments to high-volume providers	10/01/01
Dept. of Human Services (DHS) Community Care Rates	$50 million	Increase in wage through the Attendant Compensation Rate Enhancement option. FY 02, the average enhanced payment rate across all providers in all community programs is about $.50 per hour of which $0.47 must be spent on attendant compensation.	09/01/01
Nursing Facilities	$175 million	Increase of approximately 12.6 percent over FY 01. Increases are primarily for general base rate (buildings, dietary, administration, medical supplies, equipment, laundry and basic staff compensation). A portion of the increase ($40 million) was designated for funding enhanced staffing rates and direct care staffing.	09/01/01
Home and Community Service Waiver (HCS)	$2.5 million	Increase of 1.2 percent over FY 01 rates.	09/01/01
Intermediate Care Facilities-Mental Retardation (ICF-MRs)	Collected as of 8/31/02 - $19 million Expended as of 8/31/02 - $16.8 million	Private ICF-MR providers received an average rate increase, net of the Quality Assurance Fee of approximately five percent.	09/01/01
Star+Plus	$4.5 million	Overall rate increase of approximately 1.6 percent over FY 01 rates.	01/01/02
STAR	$35 million	Overall increase of approximately 10 percent over FY 01 rates	09/01/01

Non-Medicaid Rates Increases Authorized, 77th Legislative Session			
Children's Health Insurance Program (CHIP)	Senate Bill 1 did not specify an amount.	An average increase of 17.7 percent for CHIP health plans in FY 02.	10/01/01
Foster Care Rates	$14,141,811 million	Agency was appropriated a three percent increase, but due to enhanced federal funding the increase was 5.6 percent in FY 02.	09/01/01

Riders

Senate Bill 1 contained several riders related to increases in rates:

- Rider 28, under Article II, Special Provisions, "allocated $197 million in General Revenue for Medicaid rate increases."[60]

- Rider 29, under Article II, Special Provisions, "allocated $50 million in General Revenue for increasing medical professional services rates. The rider expressed legislative intent that the increases were for enhanced client access, attraction and retention of Medicaid providers and rewarding high-volume providers, especially along the Texas-Mexico border."[61]

- Rider 30, under Article II, Special Provisions, "allocated $20 million in General Revenue for dental rate increases. The rider expressed legislative intent that the increases was for enhanced client access, attraction and retention of Medicaid providers and rewarding high-volume providers."[62]

- Rider 31, under Article II, Special Provisions, "stipulated that none of the funds intended for rate increase could be used for other purposes."[63]

- Rider 48, under Article II, HHSC, "allocated $35 million in General Revenue for reimbursement increases in outpatient hospital services and stated the intent is for fee increases be passed directly to providers."[64]

- Rider 44, under Article II, DHS, "directed $20 million in General Revenue per year to be used to improve quality of care in nursing homes."[65]

- Rider 45, under Article II, DHS, "contingency appropriation for House Bill 154, appropriated $7.1 million in General Revenue per year to increase the personal needs allowance and directed that some funding be transferred to the Department of Mental Health and Mental Retardation."[66]

- Rider 7, under Article II, PRS, stated that "it was the intent of the legislature that the agency not reduce foster care rates during the biennium. This rider also allows transfers of funds into Foster Care/Adoption Payments for the purpose of maintaining foster care rates and prohibits the agency for transferring funds out of this strategy."[67]

- Article IX, Sec. 10.80, Contingency Appropriation for Senate Bill 1839 by Sen. Moncrief, "appropriates $37 million in General Revenue funds and $55.8 million in Federal funds to MHMR to provide rate increases to non-state operated public ICF/MR providers and to private ICF/MR providers. This funding was contingent upon collection of $37 million in revenues related to the Quality Assurance Fee."[68]

The following section will provide a brief description of each Medicaid reimbursement rate, as well as implementation of the Medicaid rate increases appropriated by the 77th Legislature.

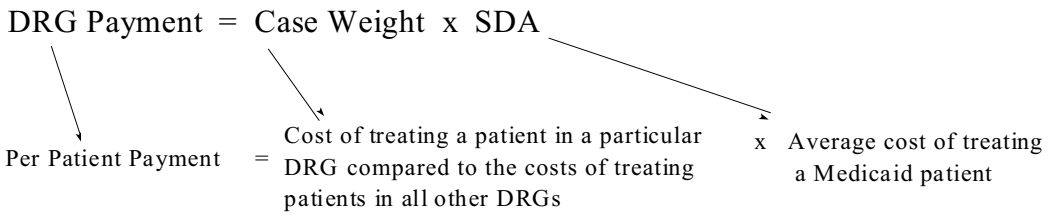
Inpatient Hospital Services

Inpatient hospital services include semi-private accommodations, meals, nursing services, newborn care, and all necessary ancillary services/supplies ordered by a physician. There are 450 general/acute care and rehabilitation hospitals, six Children's hospitals, approximately 25 psychiatric hospitals (Medicaid services covered for children only), and 15 state-owned hospitals in this provider base[69].

Inpatient hospital stays, except for children's hospitals and freestanding psychiatric facilities, are reimbursed using a Texas-based Diagnosis Related Groups (DRG) prospective payment system. DRG is a classification system for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, gender and presence of complications. Rates for Inpatient Hospital Services are set using historical costs by hospitals to approximate a standardized average cost per stay or "Standard Dollar Amount" (SDA). The DRG case weight is then applied to the SDA to determine the actual reimbursement for each hospital stay. The SDA is rebased every three years. For years in which the SDA is not rebased, it is updated for cost report changes and inflated by a general inflation index. Additional payments are made for exceptionally costly inpatient stay or exceptionally long stays for children only. Acute care hospitals in 27 Metropolitan Statistical Areas (MSAs) are subject to participation in the LoneSTAR Select I Contracting Program. Under LoneSTAR Select I,

hospitals are asked to bid a discount off their SDA in order to achieve cost savings to the state. The Medicaid benefit for inpatient hospitalization is limited to $200,000 per federal fiscal year per client, except for clients under the age of 21.[70]

Methodology



Children's hospitals, hospitals with under 100 beds and freestanding psychiatric facilities, are cost-settled under the federal Tax Equity and Fiscal Responsibility Act (TEFRA) principles methodology, a retrospective cost-based reimbursement system. Certain freestanding psychiatric facilities located in four MSAs are subject to LoneSTAR Select II Contracting Program. Under LoneSTAR Select II, providers are asked to bid an all-inclusive per diem rate for inpatient psychiatric services in order to achieve cost savings to the state. Inpatient services in freestanding psychiatric facilities is a benefit only to those clients under 21 years of age.[71]

In the General Appropriations Act the Legislature directed HHSC in Special Provisions Sec. 33 Medicaid Cost Containment to identify $48.5 million in general revenue savings out of the Medicaid Inpatient Hospital services.[72]

Effective Sept. 1, 2001, the inpatient hospital outlier payment percentage was reduced from 75 percent to 70 percent for a savings of $3.5 million. To accomplish the additional $45 million in savings, a two-pronged approach was developed by the Hospital Payment Advisory Committee that involved changes in the distribution of Disproportionate Share Hospital Payments (DSH) and in the SDA calculations.

- Changes in the DSH rules would redistribute FY 03 DSH funds such that the largest DSH transferring hospital would receive approximately $45 million in additional DSH funding.[73]

- The DSH transferring hospitals receiving this additional $45 million would transfer $45 million to the state as an intergovernmental transfer (IGT). This IGT would cover the state portion of funding necessary to maintain SDA and outlier payments

at current levels for the remainder of the biennium. This would constitute the required general revenue savings for the biennium.[74]

- Changes in the SDA methodology would retain the FY 02 inflation adjustment currently in place, but would not make a further across-the-board inflation adjustment for SFY 03. Instead, for FY 03 SDAs of hospitals meeting the following criteria would be enhanced: non-state, non-public, DRG-reimbursed FY 00 Medicaid inpatient days greater than 100,000. These are primarily hospitals receiving less DSH funding.[75]

Outpatient Hospital Services

Outpatient hospital services may be delivered in an emergency room, clinic setting or observation room of a hospital. Outpatient hospital services are diagnostic, therapeutic or rehabilitative services delivered by or under the direction of a physician in a licensed hospital setting. There are approximately 500 hospital-based and satellite facility sites associated with a hospital and there are approximately four million patient encounters per year.[76]

Hospital outpatient services are reimbursed a discounted percentage of the hospital's TEFRA allowed cost based on the hospital's audited cost report. When hospitals submit outpatient claims for payment, they are reimbursed a percentage of the allowed charges billed on the claim. This amount is then reduced by an appropriate discount factor. The payment received by a hospital on the claims they submit is only an interim payment. The final reimbursement is based on the hospital's audited cost report. The discount factor for high-volume designated providers is 84.4 percent. The factor applied to payments for all other hospitals is 80.3 percent.[77]

The Legislature directed HHSC in Rider 48, Article II Special Provisions, to target the rate increase for high-volume outpatient hospital providers. High-volume providers are defined as those that were paid a minimum of $200,000 during calendar year 2000. This captured 95 percent of total outpatient hospital spending. In FY 02, 235 hospitals qualified as high-volume providers. Payments to high-volume providers were increased by 5.2 percent. Ambulatory surgical centers (freestanding and hospital based) and birthing centers that qualified as high-volume provider under the same high-volume criteria also received a 5.2 percent increase in payment rates.[78]

Professional Medical Services

These services include office visits, diagnosis, surgery and treatment. The service must be performed or ordered by a physician or under the personal supervision of a physician and within the scope of practice of his/her profession as defined by state law. There are

approximately 16,000 enrolled physicians who are licensed to practice in the state and are certified and enrolled in the Medicaid program.

Generally, physicians bill for services using the Texas Medicaid Reimbursement Methodology. Each physician Current Procedure Terminology code (CPT) is reimbursed by either a Relative Value Unit (RVU) times the current state conversion factor (27.276) or a maximum fee. The RVU is a case weight, which includes the physician's labor, office expense, and incidental supplies to provide the services and is based for the most part on the time required to provide the services. The conversion factor is the dollar amount by which the RVU is multiplied in order to obtain the reimbursement amount for each individual service. For example, CPT code 99204, which is one of the codes for the evaluation and management of new patient office visit, is assigned an RVU of 2.59. The Medicaid reimbursement for procedure code 99204 is 2.59 * 27.276, which equals $70.64. This is the Medicaid maximum allowable fee for this procedure. The CPT codes are developed and copyrighted by the American Medical Association[79].

Riders 29 and 30 Article II Special Provisions, directs HHSC to develop a rate methodology to target high-volume primary providers and high-volume specialty care providers, and in particular providers along the Texas-Mexico border. High-volume primary care providers are defined as those that provided an average of 300 or more services per month, during the period from July 1, 2000, through June 30, 2001. For FY 02, 777 primary care physicians and 1,296 specialists qualified as high-volume providers. Qualifying primary care providers receive a 1.9 percent add-on for all services performed on or after Jan.18, 2002. High-volume specialty providers receive a 6.1 percent add-on for services provided on or after Jan.18, 2002. Recent data indicate that of the high volume providers, 10 percent of the physicians provide 70 percent of services and 3.7 percent of professionals provide 50 percent of services.[80]

Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

This program also is known as Texas Health Steps (THSteps). It provides comprehensive prevention and treatment services to low-income children from birth to 21 years of age, who are enrolled in Medicaid. The federal requirements of the EPSDT program consist of two mutually supportive operational components, which are assuring the availability and accessibility of required health care resources, and helping Medicaid recipients and their parents or guardians effectively use these resources.[81]

Eligible providers include physicians, public and private facilities such as regional and local health departments, migrant health clinics, maternity clinics and school districts. There are approximately 2,500 enrolled providers. EPSDT providers receive a flat fee for performing periodic medical check-ups or screens. The fee was increased from $49.01 to $70 per screen effective Sept.1, 2001.[82] As of July, 2002, data from the Department of Health show that the number of screening providers changed from 2,320 in July, 2001, to 2,138 in July, 2002.

This, however, is not an accurate reflection of actual provider participation. Providers in managed care bill under a single provider code and would not be counted individually under this circumstance. [83]

EPSDT Dental

This program provides dental care for Medicaid clients under the age of 21. Services include emergency, preventive, therapeutic and orthodontic services. There are approximately 1,700 active providers, who are dentists licensed by the Texas State Board of Dental Examiners and enrolled in the Medicaid program.[84] The reimbursement methodology is the lesser of the provider's usual fee and a maximum fee schedule.

The Legislature directed HHSC to target increased rates for the most common procedures and for high-volume practitioners. Payments were increased for 33 specific procedures, including exams, preventive measures, and selected restorative procedures (Appendix J). Additionally, an add-on was included for practitioners providing an average of 300 or more services per month.[85] Since the implementation of the EPSDT dental provider increase, the number of dental providers has increased from 4,665 to 4,803 as of June, 2002. In FY 02, 452 dentists qualified as high-volume provider. [86]

Intermediate Care Facility - Mentally Retarded/Related Conditions (ICF-MR/RC)

There are state-operated and non-state-operated ICF-MR/RC facilities. The ICF-MR/RC program provides services to people with mental retardation and/or a condition related to mental retardation. Services include residential services, habilitation services, medical services, skills training, and adjunctive therapy services. Eligible clients must meet income and resource limit requirements of Social Security Insurance (SSI) or Medicaid; have a determination that a disability exists; and have a determination of mental retardation or a related condition.[87] There are 13 state operated facilities, also known as state schools which have 6,001 beds and 43 state operated group home facilities that have 271 beds. There are also non-state operated ICF-MR/RC facilities for which there are 145 private providers and 28 community MHMR centers that operate 730 facilities and 117 facilities. [88]

State schools, which are also large ICF-MRs, along with other state-operated facilities receive rates based on individual facility cost reports. State schools are cost-settled. One rate is established for all facilities and based on information from cost reports on the Medicaid eligible clients, costs are settled for each facility at the end of the state fiscal year. Non-state ICF-MR/RC providers receive modeled rates based on cost surveys and trends. Facilities are paid rates that are uniform statewide by level of need and facility size-class. Rates include a portion for direct care activities and a portion for indirect care. Providers are required to pay at least 90 percent of the direct care portion for direct care, or repay the state all or a part of the excess direct care funds[89]. For 1998, 1999 and 2000 recoupments in the ICF-MR program have totaled approximately $1,438,000, $972,000 and $282,000, respectively. [90]

Current rate increases are based on a provider Quality Assurance Fee (QAF) that draws down federal matching funds. Senate Bill 1839 by Senator Mike Moncrief requires a quality assurance fee to be collected from all non-state operated ICF-MR/RCs and private ICF-MR/RCs. The collected amounts are to be deposited into a Quality Assurance Fund and are to be used to provide rate increases for these same ICF-MR/RC providers. The amount collected per bed is based on the facility size and a consumer's level of need (LON). The following table presents the current quality assurance fees.[91]

Table 3.3 ICF-MR/RC Quality Assurance Fee Schedule [92]

Level of need	8 or less beds	9-13 beds	14+ beds
1 Intermittent	7.62	6.4	4.97
5 Limited	8.5	7.04	5.62
8 Extensive	9.71	8.21	6.3
6 Pervasive	11.91	9.95	8.77
9 Pervasive +	20.96	19.65	19.4

The ICF-MR/RC rate was set two times during FY 02 based on stipulations outlined in Senate Bill 1839. An initial rate was set for September, 2001, and October, 2001, and then another rate was set for November, 2001, to date. During September and October, the QAF was set by rule at $5.25 per day per consumer. As of August 31, 2002, $19,037,364 has been collected and $16,815,487 has been expended. The increase to the ICF-MR facilities was an eight percent direct care wage rate increase and a 7.54 percent indirect rate increase for large facilities. Starting in November, the QAF was set by rule at 5.5 percent of the total rate.[93]

Nursing Facilities

Nursing facilities provide institutional nursing care to Medicaid recipients with a documented medical condition requiring regular care from a licensed nurse. There are approximately 1,035 proprietary and not-for-profit nursing facilities that are licensed, certified and contracted with DHS. The current nursing home census has been around 60,000 clients per month during the last several months. This figure represents just the Medicaid eligible clients in nursing homes. There are approximately 90,000 nursing home clients in Texas. [94]

Nursing facilities are reimbursed through rates that are uniform statewide by level of services for each day of service delivered to an eligible Medicaid resident. Rates are based on facility cost reports submitted annually by providers. Once cost reports have been subjected to either a desk review or an on-site audit to determine that they contain only allowable costs, costs

are categorized into five rate components: Direct Care staff, Other Resident Care, Dietary, General and Administrative, and a Fixed Capital Asset Use Fee.[95]

HHSC determines the reimbursement rates for the Direct Care Staff and Other Resident Care rate components that vary according to the Texas Index for Level of Effort (TILE) Case Mix Classification System. TILE is the classification system for patient service need or acuity. There are 11 case-mix classes of service. Each class is assigned an index representing the relative amount of time required, on average, to deliver care to residents in that class as compared to the average resident overall.

Nursing homes also can participate in the enhanced staffing/benefits program to receive enhanced rates. The total daily payment rate for each level of service may be retroactively adjusted based upon failure to meet specific staffing and/or spending requirements. In addition, all nursing facilities spending less than 85 percent of the designated direct care component of medicaid rates on wages payroll taxes and employee benefits for nurses and aides are subject to recoupment of unexpended funds. This 85% direct care spending floor applies to all homes, whether they opt into the enhanced staffing/benefits program or not. Facilities participating in the enhanced direct care rate must meet minimum staffing ratios and/or expend the enhanced funds on direct care staff to avoid recoupment of enhanced funds.[96]

The Legislature provided an $175 million GR increase in funding for an 12.6 percent rate increase above FY 01. Increases were primarily for the general base rate, which includes buildings, dietary, administration, medical supplies, equipment, laundry and basic staff compensation. For each year of the biennium, $20 million GR of this appropriation is directed to specifically improve the quality of care in nursing homes. This funding, along with other funds, is used to support enhanced nursing home staffing and wages for direct care staff, such as registered nurses, licensed vocational nurses, certified nurse aides and medication aides through the Enhanced Direct Care Staff Rate reimbursement option. Under this option, providers can choose to receive additional funds to increase or maintain higher levels of staffing, effective Sept.1, 2001, or if they meet a minimum staffing requirement, to increase or maintain higher levels of compensation (salaries, bonuses, payroll taxes, and benefits) for direct care staff.[97]

Facilities participating in the enhancement program at the minimum level required for participation receive, on average, approximately $1.74 per resident day above the nonparticipant rate. In return for receiving these additional monies, the provider is required to meet certain minimum staffing requirements. Facilities also may choose to participate in the enhancement program at a level greater than the minimum required level[98]. HHSC determines the minium staffing requirements for each participating facility. Facilities have the flexibility to substitute registered nurses (RN), licensed vocational nurses (LVN) and aides to meet the requirements. The minimum staffing requirement is expressed in an LVN equivalent minute

per resident day of service. The minimum LVN equivalent minute per resident per day of service is determined for each TILE case mix group.

Facilities can participate up to 27 levels of enhancement. For each enhancement level above the level 0, the facility receives an additional $0.30 per resident per day. The enhanced rate increment of $0.30 per day reflects the statewide average cost for one minute of LVN time with a three percent mark-up. The mark-up is to account for statewide cost variations. Thus a facility receiving payment at enhancement level 27 receives an additional $8.10 per resident day above the level 0 enhancement base rate. For example, this would be equivalent to an additional $236,520 in enhancement payments per year in a 100-bed facility with 80 percent Medicaid occupancy. In return for receiving these additional monies, such a 100-bed facility would be required to staff above the minimum required staffing level with an additional three RNs, 4.5 LVNs, or 8.4 aides (or a combination of these staff types that meets the additional staffing requirements). The difference between the average nonparticipant rate and the average enhanced payment rate across all providers in the nursing facility program is approximately $5.04.[99] Enhanced funding is granted beginning with the lowest level of enhancement and successive levels will be granted until requested levels are within available funds. Appendix K shows an example of the payment rate for each TILE case mix group. There are 27 direct care staff enhancement levels for each TILE. The entire payment chart is located on HHSC's Medicaid website at the following address: http://www.hhsc.state.tx.us/Medicaid/programs/rad/NF/Enhance/Enhance.html.

House Bill 154, by Representative Senfionia Thompson and Senator Mario Glaaegos requires HHSC to ensure that the rules governing the determination of nursing facility rates provide for the rate component derived from reported liability insurance costs to be paid only to those homes that purchase liability insurance acceptable to HHSC. For FY 02 and FY 03, providers with purchased professional liability insurance receive $2.20 per day of service. Providers with purchased general liability insurance will receive $0.20 per day of service. These rates are paid in addition to the daily payment rate for nursing facility service.

Since the implementation of the nursing facility accountability period, HHSC recouped approximately $5.4 million for the period between June, 2000, through August, 2000, from facilities for failure to meet staffing and/or spending requirements. For the next accountability period (September, 2000 through February, 2001), HHSC has recouped approximately $3.4 million. The staffing and spending recoupments for the remainder of FY 01 will be based on FY 01 annual accountability reports currently being processed. Recouped funds are reinvested in participating facilities achieving higher staffing levels than they were awarded. [100]

Home and Community-Based Services -MHMR

Home and Community-Based Services (HCS) is a program for persons with mental retardation to provide individualized services to them in the community. It is a waiver

program to institutional care authorized under section 1915(c) of Title XIX of the Social Security Act. Covered services include adaptive aids, case management, counseling and therapies, minor home modification, dental treatment, residential assistance, respite, day habilitation, and supported employment.[101]

HCS basic fee-for-service rates are based on pro forma models established in 1997. These rates are rebased every three years using cost surveys and other relevant data, with interim inflation adjustments made using the personal consumption expenditure index. Basic rates paid to facilities are uniform statewide by level of need and type of setting, with additional statewide uniform fee-for-service rates by type of service. Direct care services staff basic payments are subject to a minimum-spending requirement with potential recoupment of unspent funds.[102] Beginning in 1998, HCS providers who spend less than 90 percent of the designated direct service component of Medicaid on wages, payroll taxes and employee benefits for direct care staff have been subject to recoupment of unexpended funds. For 1998, 1999 and 2000 recoupments have totaled approximately $256,000, $235,000 and $155,000, respectively.[103] The Legislature appropriated $2.5 million in general revenue, which provided for a 1.2 percent increase over FY 01 rates.

Community-Based Alternatives, Primary Home Care, Community Living and Support Services, and the Day Activity Health Services Program - DHS

The Community-Based Alternatives (CBA), Community Living and Support Services (CLASS), Primary Home Care (PHC) and the Day Activity Health Services (DAHS) Program at the Texas Department of Human Services were established as alternatives to institutional care. The CBA and CLASS programs are Medicaid waiver programs to institutional care authorized under section 1915(c) of Title XIX of the Social Security Act. PHC and DAHS are non-waiver Medicaid programs.

Table 3.4 Overview[104]

CBA	CLASS	PHC	DAHS
Case management	Case management	Attendant care	Transportation
Adaptive aides	Habilitation services		Physical rehabilitation
Adult foster care	Nursing services		Noon meal and snacks
Assisted living/ residential care services	Physical therapy		Nursing and personal care

Emergency response services	Occupational therapy		Social, educational and recreational activities
Nursing services	Speech pathology		
Minor home modifications	Psychological services		
Occupational therapy	Respite Care		
Personal assistance services	Minor home modifications		
Physical therapy	Adaptive aids		
Respite care			
Speech pathology			
Home delivered meals			

All the rates for these community programs are set similarly. Statewide unit rates are based on annual cost reports submitted by providers or are modeled on pro forma rates. These unit rates are determined using cost reports based on the weighted median cost by cost center of all providers plus 4.4 percent, except for residential care/assisted living service, which is plus seven percent. The 4.4 percent mark-up is to account for cost variability across the state.[105]

In addition, under the Attendant Compensation Rate Enhancement program, providers have the option of participating in receiving enhanced funding for attendant compensation. Rates for non-participants are based on the 1997 database and rates for participants are based on a pro forma model. Participants' attendant compensation rates are adjusted retroactively upon failure to meet specific spending requirements. [106]

The community care program was appropriated $50 million in general revenue to enhance attendant wages. Under the Attendant Compensation Rate Enhancement reimbursement option, providers can choose to receive add-ons to their payment rates for which they are held accountable for spending on attendant compensation. Participating providers agree to maintain a certain level of attendant compensation in return for increased attendant compensation revenues. This includes wages, bonuses, payroll taxes, travel reimbursement costs and benefits. Providers may retain a portion of the enhanced payment rates, but must repay the state for any of the portion of the enhanced payment rate required to be spent on attendant compensation that is not spent for that purpose.[107]

CBA provides home and community-based services to aged and disabled adults as alternatives to institutional care in nursing facilities. A unit payment rate is determined for each of these services. Appendix L shows the payment rates adopted for FY 03, beginning Sept. 1, 2002. Appendix M shows the payment rate for personal attendant services at each enhanced participation level. For each enhancement level above 0, the provider receives an additional $0.05. Providers can participate up to an enhancement level of 20. There are approximately 1,717 contracts to provide CBA services. Providers may have separate contracts for more than one CBA service. [108]

The PHC program provides medically related personal care services prescribed by a physician as part of a client's plan of care. Services are provided by an attendant and assist the client in performing activities of daily living. For each enhancement level above 0, the payment rate increases by $0.05. Providers can participate up to an enhancement level of 20. There are approximately 532 contracted PHC providers.[109]

The CLASS program provides home and community-based services to people with related conditions as an alternative to ICF-MR/RC institutional placement. There are two types of contracted providers in CLASS: Case Management and Direct Service Agency providers. Appendix N shows the payment rates for FY 03 for the services provided in this program. There are approximately 60 contracted CLASS providers. [110]

The DAHS program facilities provide daytime services to clients residing in the community as an alternative to nursing homes or other institutional facilities. Appendix O shows the payment rate for attendant compensation in the DAHS program. For each enhancement level above 0, the payment rate increases by $0.05. Providers can participate up to an enhancement level of 20 There are approximately 327 contracted DAHS providers.[111]

If the minimum spending requirement is not met, DHS will recoup the difference between the attendant compensation revenue per unit of service and the attendant compensation cost per unit of service multiplied by 1.07 for each unit of service provided to a DHS client during the rate year.[112]

For example, in the Primary Home Care program for non-priority clients, the payment rate for providers choosing not to receive the enhanced funding includes $6.27 per hour in total compensation. In the enhancement option, a provider may choose to increase the payment rate by $0.05 per hour to increase attendant compensation up to a participation level 15 in FY 02 and level 20 in FY 03. Therefore, if a provider chooses to participate in the enhanced rate option at the highest level in FY 03, the provider would have $7.27 ($6.27+$1.00) per hour available to spend on attendant compensation. The provider would be required to spend $6.79 per hour on attendant compensation or have the difference between the actual spending and the $6.79 recouped. Appendix P shows payment rate for attendant compensation in Primary Home Care. [113]

The average enhanced payment rate across all providers in all community care programs is approximately $0.50 per hour, of which $0.47 must be spent on attendant compensation[114]. As of September, 2002, recoupment information for DHS community care programs has not been completed. All funds recouped will be reinvested to contractors whose spending on attendant compensation exceeds the amount awarded. [115]

Medicaid Managed Care

Capitation rates for HMO's are computed using discounted fee-for-services (FFS) costs. The FFS data collected before managed care implementation are trended forward using statewide trends. Rates will vary by risk group and by service delivery area. Adjustments are made based on area factors and delayed enrollment factors and are applied to produce the base rates. After FFS costs for each risk group are determined, a discount factor is applied to yield a capitation rate for each risk group. For example, STAR+PLUS estimated costs are discounted with a factor of 0.95. This five percent reduction ensures that estimated costs under managed care will be below fee for service costs, and provides funds to cover the state cost of administration and any other costs such as the provision of unlimited prescriptions for targeted groups.[116]

The 77th Legislature provided $35 million GR for STAR for an overall increase of approximately 10 percent over FY 01 rates. The Star + Plus program received $4.5 million GR for an overall increase of approximately 1.6 percent over FY 01 rates.

Summary of Rate Cycle

Table 3.5 details each of the Medicaid rates and when and how often they are reviewed, as well as any automatic inflation factors and projected total annual expenditures for FY 02. In the rule-making process for establishing reimbursement rates, there is a provision that limits the adjustments in rates to the availability of funds.

Table 3.5 Medicaid

Program[117]	Methodology	Automatic inflator in program rules	Rate per contract or uniform statewide?	Unit of Payment	Rate Cycle	Cost Rebasing Frequency	Program spending requirements	FY 02 All Funds for Total Program Expenditures
Inpatient Hospital	Texas-based Diagnosis Related Group prospective payment system	Automatic inflation adjustment at the beginning of each fiscal year	Facility specific	Per admission	Annual review	SDA rebased every 3 years	None	$1,646,687,298
Outpatient Hospital Services	Retrospective cost-based payment system, which is cost settled at the end of each hospital year according to cost report	No, however rates of payment are based on current costs which include inflationary effects	Facility specific	Per service and lump sum for cost settlement	Reviewed as appropriations are available	Self-rebasing since current charges are used to determine payments after discounts	None	$419,950,563
Professional Medical Services	Resource Based Relative Value Scale fee schedule	No	Uniform statewide	Per procedure	Reviewed as appropriations are available	No rebasing	None	$1,155,954,128
EPSDT Medical	Fee schedule	No	Uniform statewide	Per service	Reviewed as appropriations are available	No rebasing	None	$94,352,023

Program[118]	Methodology	Automatic inflator in program rules	Rate per contract or uniform statewide?	Unit of Payment	Rate Cycle	Cost Rebasing Frequency	Program spending requirements	FY 02 All Funds for Total Program Expenditures
EPSDT Dental	Fee schedule	No	Uniform statewide	Per service	Reviewed as appropriation are available	No rebasing	None	$196,128,090
Managed Care	Estimated cost per member under fee for service system less a discount by risk group	No	Uniform for each service delivery area	Per member by risk group	Reviewed at the beginning of each fiscal year and adjusted as appropriation s are made available	Rebased when funds are available for increases in capitation rates	None	$1,586,685,814 (Preimum costs for HMO and PCCM, administrative costs not included)
ICF-MR/RC (private)	Individual facility cost report	Automatic inflation adjustment at the beginning of each fiscal year if appropriations are available	Uniform statewide by level of need		Adjusted at the beginning of each fiscal year or as appropriation s are made available	Modeled rates are reviewed every third year	Spending minimum on direct care portion of rates	$334,217,578
ICF-MR/RC (state)	Statewide uniform rate based on cost report with retrospective cost settlement	Yes, through annual rebasing with adjustments to project cost	Uniform statewide with facility cost settlement	Per day	Adjusted at the beginning of each calendar year	Rebased annually	None	$55,668,575

Program[119]	Methodology	Automatic inflator in program rules	Rate per contract or uniform statewide?	Unit of Payment	Rate Cycle	Cost Rebasing Frequency	Program spending requirements	FY 02 All Funds for Total Program Expenditures
Nursing Facilities	Based on cost reports submitted by providers	Automatic inflation adjustment across the biennium	Uniform statewide for non direct care and adjustments by case mix class and by contract for direct care	Per day	Established at the beginning of each biennium	Every other year	Spending minimum on direct care potion of rates for all contract and staffing minimum for contracts receiving enhanced funds	$1,859,727,541
HCS/MRLA/ HCS-O	Fee for service rates based on base year cost surveys	Automatic inflation adjustment at the beginning of each fiscal year or as appropriations are available	Uniform statewide	Hourly or daily depending on service	Adjusted at the beginning of each fiscal year or as appropriations are available	Modeled rates are reviewed every third year	Spending minimum on direct care portion of rates	HCS - $161,213,460 MRLA - $97,929,126 HCS-O - $3,404,650
CBA/PHC/CLASS/ DAHS	Based on cost reports submitted by providers	Automatic inflation adjustment across the biennium	Uniform statewide with adjustments by contract for attendant care	Hourly, daily or partial day depending on service	Established at the beginning of each biennium	Rebased every other year	Spending minimum for contracts receiving enhanced funds	CBA - $400,153,713 CLASS - $46,596,141 PHC - $311,888,676 DAHS - $78,526,045

In addition to the Medicaid programs, there are a number of non-Medicaid programs that provide services that use a reimbursement methodology. (Appendix Q)

Non-Medicaid Rates
This report will focus on two major cost-driving, non-Medicaid programs and their rate reimbursement structure; foster care and Children's Health Insurance Program.

Foster Care

Overview of Level of Care & Foster Care System[120]
Children come into the managing conservatorship of the Texas Department of Protective and Regulatory Services (PRS) as a result of a court order following a validated abuse or neglect investigation. If it is determined that a child is not safe in his or her home of origin, PRS staff search for appropriate family members as a first placement resource. If appropriate family resources are not available, PRS staff seek a foster care placement.

In most cases, the goal of the Department and the courts is to return the child to their family of origin. This can occur after the home has been established as a safe environment through the Department's casework services to the family. In some cases return to the family is not a safe option. Adoption becomes the goal or, in the case of older children, preparation for independent living upon their emancipation from PRS, usually at age 18.

During the time the child is in PRS conservatorship, the Department makes placement decisions on two parallel but interrelated sets of choices, the type of care that best suits the child, and the type of facility best able to deliver the type of services required.[121]

Appendix R shows the percentage of children in FY 02 in PRS conservatorship placed in each facility type.

Determining a Child's Needs and Level of Care[122]
Children come into the custody of PRS with a wide range of medical, social and therapeutic needs. As part of determining the best range of services for an individual child, the PRS caseworker submits family, behavioral, medical, social, psychological, and educational history to Youth for Tomorrow (YFT), an independent contractor that determines the child's level of care.

All children who enter foster care are assigned a Level of Care One. Upon request by a PRS caseworker, professionals at YFT evaluate the child's information to determine a therapeutic Level of Care (LOC) for the child, ranging from two to six. The LOC is an indicator of the child's current level of functioning and helps the caseworker to select the best type of placement. A child whose behaviors are such that the child cannot function in a foster home may be appropriate for some types of more structured residential care. Though there are occasional exceptions, the LOC generally corresponds to the type of care a child will need.

A child assigned a Level of Care One is a child in need of basic care. Typically, this would be a child appropriate for placement in the routine environment of a basic care foster home.

> Level of Care One - Typically assigned to a child with no notable medical or behavior problems. Level One is the baseline level for all children entering PRS foster care; they will remain at Level One until a PRS caseworker requests that the child's information be reviewed by Youth for Tomorrow.

Therapeutic care is for children with an assigned Level of Care Two through Six. These are children whose needs usually demand a therapeutic foster home or other more structured setting, with additional counseling from professional staff.

> Level of Care Two - Typically one with occasional and brief behavioral difficulties. A foster home can provide a routine home environment with some supplemental guidance and discipline to meet the needs of the child.
>
> Level of Care Three - Designates a child who has more frequent or repetitive minor problems or who may engage in some non-violent but antisocial acts.
>
> Level of Care Four - Typically a child at moderate risk of causing harm to his or herself or others, and has poor social skills and frequent episodes of aggressive or antisocial behavior.
>
> Level of Care Five - Assigned to children who may exhibit unpredictable aggression or be withdrawn and isolated due to either mood or thought disturbance. They have made suicidal attempts or gestures.
>
> Level of Care Six - Designates a child in the most urgent need of immediate professional assistance and who exhibits severely aggressive or self-destructive behavior. The child may be actively suicidal. A child assigned this level would be in need of constant supervision.

The Level of Care system serves not only as a behavioral marker for treatment purposes, but also as the basis of a rate structure for reimbursement to foster care providers. The Department contracts with providers for foster care services. The rate of reimbursement rises with the child's assigned level of care.[123]

Determining a Child's Placement Options

An array of different types of foster care placements is available to meet the individual needs of children at all levels of care. Children in foster care may be placed into homes directly licensed and monitored by PRS, placed into foster homes licensed and monitored by child placing agencies, or placed into facilities regulated by the Texas Department of Mental Health and Mental Retardation or the Texas Department of Human Services. PRS staff strive

to place children in settings that are as "home-like" as possible, but many children require a higher degree of supervision or therapeutic services. [124]

Foster Homes
The most commonly used placements are foster homes where families that agree to take children into their homes and act as substitute parents. Children in foster homes most often attend school in the community in which they live. Foster homes may be approved to operate either directly by PRS, or by a private Child Placing Agency (CPA). A CPA must have a license to operate issued by the PRS licensing division.

There are several different types of foster homes that accept children with various types of need, from basic homes that deal primarily with children who have no special needs, to primary medical homes that serve children with serious health problems, to therapeutic homes, where children receive professional therapy services for behavioral or emotional issues.[125]

Facilities
Children with severe behavioral or psychological problems not appropriate for a foster home may be placed in Residential Treatment Centers (RTC), which are staffed with professional staff and may have a higher level of constant supervision. Basic Care Facilities are most often campus-like settings serving primarily basic care children.[126]

Emergency Shelters
When children first come into the care of PRS or are otherwise in need of an immediate placement, emergency shelters may be a short-term option for them until a more appropriate setting can be arranged.[127]

All of these placement types are subject to PRS contract monitoring and the minimum licensing standards of the PRS Child Care Licensing Division or other state agencies that may license the facility.

Table 3.6 shows the average monthly number of full-time equivalent (FTE) counts by facility type, the increase in the number of children in PRS care and the shifts in placement type since FY 98. The FTE figures are calculated numbers and represents the days and dollars that PRS paid for during the fiscal year for all levels of care in each facility type.

The Table 3.6 Child Placements by Facility Type[128]

Facility Type	FY 98 Average Monthly Number of FTEs	Percentage of Total	FY 02 Average Monthly Number of FTEs	Percentage of Total
PRS Foster Homes/Facilities	5,087	47 percent	4,687	33.1 percent
CPA Foster Homes/Facilities	3,226	29.8 percent	6,621	46.8 percent
Residential Treatment Center	1,935	17.9 percent	2,020	14.3 percent
Emergency Centers	572	5.2 percent	808	5.7 percent
Total	10,820	100 percent	14,136	100 percent

Key Components of Foster Care Rate Setting[129]
The foster care rate-setting methodology establishes a biennial rate-setting process with annual cost reports being completed every other year. The cost reports serve as the basis for rate setting with a rate model applied to distribute costs in a fair and equitable manner among the levels of care of children served.

In FY 00-01 the Department was directed by PRS Rider 21 of the FY 00-01 General Appropriations Act to revise the foster care rate-setting methodology with input from providers, clients, advocates and key stakeholders. The methodology was revised with input as directed. In August, 2001, the PRS Board approved the methodology by rule at Title 40 of the Texas Administrative Code, Chapter 700, Section 1802, and this methodology was used to establish the FY 02 foster care rates.

The foster care rate structure was expanded from 7 to 14 rates for two key reasons:

1) the new methodology establishes additional payment levels within each level of care for children in different types of provider settings; and

2) two rates were established for Level of Care One with an age differential of 0-11 years and another rate for children ages 12 and above.

The methodology provides for the same minimum payment rates for child placing agency homes as provided to PRS foster homes. It also establishes an add-on rate to reimburse child placing agencies for the additional cost of services to maintain a network of foster homes. These additional costs are similar in nature to those incurred by PRS for PRS foster homes and include: foster parent recruitment, screening, training and monitoring; matching children

to the most appropriate homes, transportation, supervised visits with biological parents; attending required court appointments, permanency planning and treatment team meetings and maintaining children's records.

The methodology allocates costs in child placing agencies and residential care facilities between levels of care based upon three allocation methods, depending upon the type of cost incurred. A staffing model, validated by a foster care time study, was developed to allocate most direct care costs between levels of care. Certain other costs, such as building and equipment expenses, are allocated proportionately based upon the days of care at each level of care. Administrative costs are allocated based upon a combination of the other two allocation methods.

The methodology includes a mechanism to adjust the calculated rates to the appropriated level of funding. The PRS Board may adjust the rates to help address other state or agency priorities, but adjusted rates must match the appropriated level of funding. In FY 02 PRS adjusted rates to balance within the appropriated level of funding for general revenue and Temporary Assistance for Needy Families (TANF) funding, as opposed to the all funds total.

Once applied, the new rates resulted in some ability for PRS to reduce foster care rates. PRS however, did not reduce rates and included a "hold harmless" provision that complies with PRS Rider 7 in the FY 02-03 General Appropriations Act (GAA), which states legislative intent that PRS not reduce foster care rates during FY 02-03. This provision allowed some rates to continue at a higher level than the methodology would have established for the biennium. The effect of this provision is that some providers will continue to receive a higher percentage reimbursement for their allowable costs at certain levels of care than other providers. PRS plans to request that Rider 7 language be amended to allow for foster care rates to be adjusted according to the rate-setting methodology. The following table shows the change in the rate structure from FY 01 to FY 02.[130]

Table 3.7. Comparison of FY 01 and FY 02 Foster Care Rate Structures[131]

Level of Care (LOC)	FY 01 Rate Structure	FY02 Revised Rate Structure
LOC 1		
PRS Homes - Age <12	$16.96	$17.12
CPA Pass Through-Age<12	$13.74	$17.12
PRS Homes - Age >12	$16.96	$17.50
CPA Pass Through - Age >12	$13.74	$17.50
CPA	$16.96	$27.86
Residential	$16.96	$27.86

LOC 2		
PRS Homes	$36.33	$36.33
CPA Pass Through	$27.25	$27.31
CPA	$36.33	$53.46
Residential	$36.33	$53.46
LOC 3		
PRS Homes	$36.33	$36.33
CPA Pass Through	$29.96	$30.57
CPA	$62.15	$67.10
Residential	$62.15	$81.88
LOC 4		
PRS Homes	$36.33	$36.33
CPA Pass Through	$29.96	$30.57
CPA	$62.15	$67.10
Residential	$62.15	$81.88
LOC 5		
Residential	$106.66	$121.55
LOC 6		
Residential	$200.98	$206.60
Emergency Shelter	$97.50	$99.47

The following time line documents the process used to prepare and adopt foster care rates. [132] The process for establishing the FY 2003 is used as an example:

June, 2000 - September, 2000 - The 24-Hour Residential Child Care 2000 Cost Report is formatted to streamline the report and to incorporate any new federal, state or program requirements. Instructions for completion of the report are updated and cost report training curriculum is prepared.

October, 2000 - March, 2001 - Cost report training for residential child-care providers is conducted.

October, 2000 - March, 2001 - Cost reports are prepared based on the provider's fiscal year end. Providers have three months after their fiscal year end to prepare and submit their cost report. For example, providers with a December, 2000, fiscal year end must submit their cost report by March 2001. In some cases, extensions are granted to provide more time to complete the report.

February, 2001 - April, 2002 - Cost reports are desk-audited and selected providers receive on-site field audits by PRS' Cost Reporting and Fiscal Analysis Unit.

Audited cost report data are entered into a rate-setting database and are finalized for submission from the Cost Reporting and Fiscal Analysis Unit to PRS Budget for rate-setting purposes. The actual database is submitted May 1.
Note: Every other biennium a foster care time study will be conducted to update assumptions used in the rate-model to distribute costs among the levels of care served.

January, 2002 - April, 2002 - The rate model is updated by PRS Budget to accommodate any changes that have occurred on the cost report or according to the results of the foster care time study.

May, 2002 - PRS budget receives the rate-setting database from the Cost Reporting and Fiscal Analysis Unit and applies the data to the updated rate model. Rate options are prepared for executive and Board consideration.

May, 2002 - Rate options are presented to the PRS Board for consideration, and guidance on options to distribute to the foster care providers for comment.

June, 2002 - By PRS rule, before the open meeting where rates are presented for adoption, PRS is required to distribute rate packets to the provider association groups for comment.

July, 2002 - Comments are received in early July and are summarized for presentation to the Board. Based on comments received, new rate options may be developed for Board consideration. The Board is provided a detailed overview of the comments, and the rate options during the July Board work session.

August, 2002 - In late August the Board meets to adopt FY 03 rates. Rates are presented for adoption in the Board meeting. Public testimony regarding the rates is received during the Board meeting, and the Board adopts the rates. A letter with FY 03 adopted rates is prepared and mailed to all contracted foster care providers. New rates are entered into PRS' automated system for proper payment in September, 2002.

Appropriations
The Legislature appropriated $697 million in all funds for FY 02-03 in strategy A.1.5: Foster Care and Adoption Subsidy. Included in the appropriation is a three percent rate increase in FY 2002 and an additional two percent rate increase in FY 03. For the FY 02-03 biennium, PRS has moved to an annual rate setting process because the agency was appropriated different percentage increases for each year of the biennium. In FY 02, PRS granted a 5.6 percent rate increase rather than the appropriated amount of three percent. As part of the process to establish a new foster care methodology, PRS contracted for a time-study of foster care providers to provide data to validate the allocation of provider costs between levels of care. Analysis of this data in June, 2001, showed an increase in the percentage of child placing agency costs that were Title IV-E allowable. This provided a basis for enhanced federal funds, which the agency applied to increase foster care rates. As mentioned earlier, PRS did not reduce rates and included a "hold harmless" provision. By not reducing the rates not justified

by the new methodology, less funding was available to apply to rates that should have been increased according to the methodology. PRS directed the enhanced federal dollars to some of the relatively under-reimbursed rates based on their share of allowable costs using the new rate-setting methodology. This increase in federal dollars resulted in a 5.6 percent rate increase for FY 02. PRS balanced to the GR and TANF appropriations and not the all funds appropriations when applying the enhanced federal funding to increase the rates.

PRS is projecting a deficit in the Foster Care and Adoption Subsidy payment strategy because there are more children in foster care than anticipated in the 2002-2003 GAA, as well as higher needs of the children in foster care reflected by a migration toward higher levels of care than anticipated, and an unexpected shift in the number of children that are eligible for Title IV-E funding. The deficit is estimated to be $35.7 million for FY 02 and $60.8 million for FY 03. At the end of the FY 02 fiscal year, the Legislative Budget Board and the Governor's office approved two transfers of TANF in the amount of $ 10.4 million each time to assist the agency in meeting their FY 02 budget needs. In addition, the agency was able to utilize Title IVB-2, lapsing general revenue and earned federal fund dollars to meet the remaining FY 02 need. The current FY 03 deficit is projected to be $60.8 million all funds. Of this amount, $9.8 million is in general revenue and $34.1 million is in TANF. [133] The PRS Board approved on Aug. 22, 2002, to continue the FY 02 foster care rates in FY 03.

Children's Health Insurance Program (CHIP) Premium Rates Overview

Premium rates for the first year for CHIP were determined by a bid process. HMOs were allowed to propose any rate, though HHSC specified a set of target premium rates. These rates were based on Medicaid experiences from other states. Premium rates for the second year were negotiated with each individual health plan based on experience of the health plan and actuarial projections. [134]

CHIP First Rating Period (May, 2000-September, 2001)

The first year CHIP premium rates were determined using a competitive bid process. HHSC specified a set of target premium rates but HMOs were allowed to propose any rate they determined to be appropriate. The area-specific target rates were developed based largely on Medicaid experience. The initial rates covered the period of May 1, 2000, through Sept. 30, 2001. There are four rate categories by age bracket: under age one; ages 1-5; ages 6-14; and ages 15-18.

Because CHIP was new and there was no historical experience upon which to base projections, it was necessary to base projections of anticipated costs on the experience of other comparable plans. In establishing the target rates, HHSC utilized the financial experience of the Medicaid fee-for-service (FFS) plan as well as information from the Texas Uniform Group Insurance Program and other commercial plans. The target rates were determined based on FY 1997 FFS program experience. The population used in the rate development was all Medicaid FFS participants under age 19. Several policy changes and managed care expansions occurred between the experience period and CHIP implementation. The baseline experience data were adjusted to reflect these changes using benefit adjustments

and trend factors. In addition to the premiums paid to the CHIP health plans, a $3,000 supplemental payment is made for each birth in the program.[135]

CHIP Second Rating Period (October, 2001 - February, 2002)
The second year CHIP premium rates covered the period from Oct. 1, 2001, through Sept. 30, 2002. The rates were negotiated with each individual health plan based on the actual experience of the health plan.

In those cases with a significant difference between the plan's original proposed rate increase and the final amount, the primary reason for the difference was the plan's overly conservative evaluation of its historical experience. The plan's rate proposal included a detailed analysis of its claims experience. HHSC staff and the consulting actuary then performed an independent analysis of the experience and attempted to reconcile any material discrepancies. In several cases, it was determined that the health plan administrators had made assumptions that the actuary determined to be overly conservative. In the actuary's opinion, this had resulted in an overstatement of the plan's claims cost experience. Other areas that resulted in reductions to the originally proposed rates were: (1) correction of errors made by the plans and (2) reduction of proposed administrative fees deemed excessive by HHSC staff and the consulting actuary. In developing the renewal rates the state used a six percent trend factor for medical services (other than prescription drugs) and an 18 percent trend factor for prescription drugs. These trend factors include provision for anticipated changes in utilization and case-mix of services and inflation.[136]

Third Rating Period (March, 2002 - September, 2002)
The following is a brief description of the methodology used to determine the impact on the health plan premium rates of removing prescription drugs from capitated services. In general, the cost impact was derived based on the same assumptions as those used in developing the second year premium rates. The rate adjustment factor was developed by dividing projected incurred prescription drug claims by total premium. For most health plans, the amounts used in determining the carve-out adjustment were provided by the plans during the rate negotiation process. For some plans, some amount of negotiation was involved in setting the final carve-out adjustment.[137]

For FY 02 funding adjustments for the CHIP program included the following:

- Initial average rate increase to health plans of 19.7 percent in Octobe,r 2001
- Drug benefit was “carved out” in March 2002, reducing average rate increase from to 17.7 percent

- Distribution of three "bridge financing" payments as a result of intergovernmental transfers from three public hospitals and one medical school for a the total amount of $30 million all funds. Funds were distributed in June, July and August, 2002. This is a one time fund transfer.

- Implementation of new copayment structure beginning March, 2002.

FY 02-03 CHIP Budget Deficit

As of September, 2002, HHSC is projecting a budget deficit in FY 02-03 of $106 million in general revenue. Of this shortfall, 48 percent is related to CHIP, legal immigrants, and school employees, 38 percent is related to Medicaid spillover, and 14 percent is related to increases in SKIP costs. The deficit is due to increases in cost and caseloads above appropriated amounts in the GAA. The following table shows the current projected cost and caseload estimates as compared to the GAA.[138]

Table 3.8. CHIP Caseload

	FY 02	**FY 03**
GAA	476,000	501,000
Current Estimates	499,000	531,000

Table 3.9. CHIP Average Monthly Costs

	FY 02	**FY 03**
GAA	$105.23	$110.54
Current Estimates	$107.26	$108.19

Summary of Non-Medicaid Reimbursement Rates

Table 3.8 Non-Medicaid Reimbursement Rates

Program[139]	Methodology	Automatic inflator in program rules	Rate per contract or uniform statewide?	Unit of Payment	Rate Cycle	Cost Rebasing Frequency	Program spending requirements	FY 02 All Funds for Total Program Expenditures
CHIP	Estimated cost per health plan and administrative fee not to exceed $15 by risk group	No	Health Plan Specific	Per member per month by risk group	Annual review	Rebased when rate adjustments are made	No	$738,485,160
Foster Care	Based on provider cost reports	Yes	Statewide by facility type and level of care	Daily rate	Annual reports submitted even number years	Established at the beginning of each biennium	Not Applicable	$297,731,630

Conclusion

The Texas Senate Finance Sub-Committee on Demand focused its attention on the major Health and Human Services caseloads and cost projections per interim charges from Senate Finance Committee Chair, Senator Rodney Ellis. As stated in the report, forecasting methodology and cost projections are complex mathematical equations that only are as accurate as the data used. Health and Human Services agencies continually are updating projections as new historical data become available. Even with these updates, however, cost projections and caseload forecasts are subject to inaccuracies because of a variety of factors. Health and Human Services agencies must continue to seek improved methods of forecasting and cost projections. As of Aug. 15, 2002, there were 76,663 persons waiting for services in Texas. More than 50 percent of the people on a waiting or interest list are receiving some level of service from the State Agencies must continue to seek better ways to track and process these waiting and interest lists.

In response to charges by Lt. Gov. William R. Ratliff, the Sub-Committee submits 13 options relating to caseloads and cost projections, waiting and interest lists and reimbursement rates for the major health and human services agencies.

Members of the Finance Subcommittee on Health and Human Services Demand worked diligently to address these important charges and as members of the Senate Finance Committee will continue to work with representatives of state agencies, organizations, interested parties and other legislators and their staffs to ensure that Texas' human services needs are met.

The Joint Interim Committee on Health Services Interim Report, November, 2002, provides additional information about caseload and cost projections of major health and human services agencies.

Endnotes

1. Letter from Senator Ellis outlining interim demand changes.

2. Heath and Human Services Commission, Commissioner Gilbert Testimony, Senate Finance Sub-Committee on Demand, Hearing # 2, May 9, 2002

3. Heath and Human Services Commission, Commissioner Gilbert Testimony, Senate Finance Sub-Committee on Demand, Hearing # 2, May 9, 2002

4. Heath and Human Services Commission, Commissioner Gilbert Testimony, Senate Finance Sub-Committee on Demand, Hearing # 2, May 9, 2002

5. *Interim Report of the Senate Finance Committee on Selected State Agency Performance*, Senate Finance, 75th Legislature, Dec. 3, 1996

6. *Interim Report of the Senate Finance Committee on Selected State Agency Performance*, Senate Finance, 75th Legislature, Dec. 3, 1996

7. Heath and Human Services Commission, Testimony, Senate Finance Sub-Committee on Demand, Hearing # 2, May 9, 2002

8. Heath and Human Services Commission, Testimony, Senate Finance Sub-Committee on Demand, Hearing # 2, May 9, 2002

9. Health and Human Services Commission, email from Rick Allgeyer, 8/9/2002

10. Provide by HHSC Sept. 4, 2002

11. Provided by Health and Human Services Commission, 2002

12. Ibid.

13. Ibid.

14. Ibid.

15. Ibid.

16. Ibid.

17. Legislative Budget Board, Senate Finance Sub-Committee Hearing on Demand, Hearing # 1

18. Provided by Health and Human Services Commission, 2002

19. Ibid.

20. Ibid.

21. Legislative Budget Board, Senate Finance Sub-Committee Hearing on Demand, Hearing # 1 and Legislative Budget Board, email from Melitta Bustamante, 8/14/2002

22. Provided by MHMR 9/27/2002

23. Legislative Budget Board, Senate Finance Sub-Committee Hearing on Demand, Hearing # 1 and Legislative Budget Board, email from Melitta Bustamante, 8/14/2002

24. Legislative Budget Board, Hearing Material #1, 2/8/2002

25. Health and Safety Code, Chapter 35. Children with Special Health Care needs; TAC, Title 25, Part 1, Chapter 38. Children with Special Health Care Needs Services Program

26. Health and Safety Code, Chapter 35. Children with Special Health Care needs; TAC, Title 25, Part 1, Chapter 38. Children with Special Health Care Needs Services Program (38.2, 38.3, 38.4)

27.Texas Department of Health, email correspondence with ND, 8/14/02

28. TDH Report to Meredith Delk-Pruiett and Karen Cheng on 8/12/02. Information in report from the TDH July, 2002 Rider 8 report and a CSHCN Budget Impact Report (½9/01).

29. Texas Department of Health, email correspondence with Becky Brownlee, 8/14/02

30. Ibid..

31. Ibid.

32. Ibid.

33. Ibid.

34. Information provided by Texas Department of Human Services, 2002

35. Ibid.

36. Table 2.5 provided by Department of Human Services

37. Texas Department of Human Services, 2002

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41. Texas Department of Mental Health and Mental Retardation, Presentation to Senate Finance Committee, May 9, 2002.

42.Texas Department of Mental Health and Mental Retardation Strategic Plan, 2002

43. Texas Department of Mental Health and Mental Retardation, CARE system, August 26,2002.

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45. Texas Administrative Code, Title 29, Chapter 419 governing Home and Community Based Services (HCS) Programs, Section 419.165.

46. Texas Department of Mental Health and Mental Retardation, Presentation to Senate Finance Committee, May 9, 2002.

47. Texas Department of Mental Health and Mental Retardation, CARE system, August 2002

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34. Texas Department of Mental Health and Mental Retardation, Medicaid Administration, August 2002.

51. Texas Department of Mental Health and Mental Retardation, MLRA Map

52. Texas Department of Mental Health and Mental Retardation, Strategic Plan.

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79. Health and Human Services Commission, Doug Odle, Program Specialist Bureau of Reimbursement Analysis and Contract Compliance, 9/11/2002

80. HHSC, Leilani Rose, 9/16/2002

81. Texas Health and Human Services, Overview of Selected Medicaid Rate Methodologies, 2/8/02

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83. HHSC, Leilani Rose, 9/16/2002

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87. Texas Health and Human Services, Overview of Selected Medicaid Rate Methodologies, 2/8/02

88. MHMR, Cindy Brown, 9/16/2002

89. Senate Finance Subcommittee on Demand, Hearing #2, Health and Human Services Commission, 5/9/02

90. HHSC, Leilani Rose, 9/11/2002

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93. Ibid.

94. Texas Health and Human Services, Overview of Selected Medicaid Rate Methodologies, 2/8/02

95. Senate Finance Subcommittee on Demand, Hearing #2, Health and Human Services Commission, 5/9/02

96. HHSC, Carolyn Pratt, Manager Rate Analysis Division for Aged and Disabled, 9/9/2002

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132. Texas Department of PRS Time line for Preparing FY2003 Foster Care Rates

133. Donna Krueger, Interim Director of Budget and Federal Funds Division, PRS staff, October 4, 2002

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Appendix A

Charges from Lieutenant Governor William R. Ratiff to Senate Finance Committee on September, 2001. The Interim Committee on Demand was formed to answer charge 3 of the interim Finance Charges.

SENATE COMMITTEE ON FINANCE

Interim Charges

The Committee shall:

1. Survey and assess Texas' current tax system, including taxation authority given to units of local government. The survey should identify the economic value associated with al current taxes, as well as current exemptions and abatements. The Committee's report should include the information provided by the survey.

2. Study the issue of rising medical costs and its impact on the state budget, including health and human services, correctional managed health care, education and state employee benefits. The Committee may review private pay insurance. The Committee's report should recommend ways to control cost increases and identify best practices and opportunities for savings.

3. ***Evaluate the processes by which health and human services agencies assess the demand for services and allocate their appropriations to address program demands and requested rate increases.***

4. Monitor the implementation of SB 813, 77th Legislature, the creation of the Spaceport Trust Fund.

5. Review the sources of revenue dedicated to the Crime Victims Compensation Fund and the purposes for which that Fund is expended. The Committee's report should recommend ways to ensure future revenues adequately address statutorily provided spending priorities.

6. Evaluate the infrastructure, capacity and funding of trauma care, and develop recommendations to address the state's trauma care needs.

Reports

The Committee shall submit copies of its final report as soon as possible, but no later than November 15, 2002. This date will allow the findings of the Committee to be considered when the Legislative Budget Board is developing performance and budget recommendations to the 78th Legislature. Copies of the final report should be sent to the Lieutenant Governor, Secretary of the Senate, Legislative Council and Legislative Reference Library.

The final report of the Committee should be approved by a majority of the voting members of the Committee and include any recommended statutory changes. Draft legislation containing recommended statutory changes should be attached to the report. Recommended agency rule changes should also be attached to the report.

Budget and Staff

The Committee shall use its existing staff and utilize the budget approved by the Senate Committee on Administration. Where appropriate, the Committee should obtain assistance form the Senate Research Center and legislative agencies, including the Legislative Budget Board, the Legislative Council, and the State Auditor. The Committee should also seek the assistance of appropriate Executive Branch agencies with responsibilities in the areas related to the Committee's interim charges.

Interim Appointments

Pursuant to Section 301.041, Government Code, it may be necessary to change the membership of a committee if a member is not returning to the Legislature in 2003. This will ensure that the work of interim committees is carried forward into the 78th Legislative Session.

Public Hearing
Texas State Capitol Extension
E2.030
Friday, February 8, 2002
1 p.m.

Agenda

I. Call to Order

II. Roll Call

III. Approval of October 30, 2001, Minutes

IV. Invited Testimony on the following interim charges:

A. **Briefing regarding Medicaid and CHIP caseloads and cost projections**
Don Gilbert, commissioner, Texas Health and Human Services Commission

B. **Briefing regarding Medicaid and CHIP reimbursement rates**
Don Gilbert, commissioner, Texas Health and Human Services Commission

C. **Update on reorganization of Medicaid and CHIP administration**
Don Gilbert, commissioner, Texas Health and Human Services Commission

D. **Update on Implementation of SB 43, Medicaid Simplification**

Panel
Don Gilbert, commissioner, Texas Health and Human Services Commission
Jim Hine, commissioner, Texas Department of Human Services

V. Public Testimony

VI. Other Business

VII. Recess

MINUTES

SENATE COMMITTEE ON FINANCE

Subcommittee on Subcommittee on Health and Human Service Demand
Friday, February 8, 2002
9:00 a.m.
Capitol Extension, Room E1.036

*****

Pursuant to a notice posted in accordance with Senate Rule 11.18, a public hearing of the Senate Committee on Finance was held on Friday, February 8, 2002, in the Capitol Extension, Room E1.036, at Austin, Texas.

*****

MEMBERS PRESENT:
Senator Judith Zaffirini, Chair
Senator Chris Harris
Senator Robert Duncan
Senator Eddie Lucio, Jr.

MEMBERS ABSENT:
Senator Jon Lindsay
Senator John Whitmire

*****

Senator Judith Zaffirini, the acting chair, called the meeting to order at 9:00 a.m. The following business was transacted:

Chair Zaffirini made opening remarks and recognized all subcommittee members and their staff. The chair then reviewed the interim charge issued by Lt. Governor Ratliff.

The chair addressed the tentative schedule for the subcommittee on Health and Human Services and welcomed Representative Patricia Gray. Representative Kyle Janek was also present during a portion of the hearing.

A quorum was established at 9:35 a.m. At that time, the chair laid out the proposed rules for the subcommittee. Senator Duncan moved that the subcommittee rules be adopted and the rules were adopted by unanimous consent. The tentative interim schedule was reviewed.

The Chair called invited witnesses to brief the subcommittee members about rate increases and rate-setting procedures.

The following persons provided oral testimony:

Kelly Furgason, team manager, Legislative Budget Board, P.O. Box 12666, Austin, Texas 78711-2666.

Paul Priest, analyst, Legislative Budget Board, P.O. Box 12666, Austin, Texas 78711-2666.

Don Gilbert, commissioner, Health and Human Service Commission, 4900 North Lamar, 4th Floor, Austin, Texas 78711-3247.

Richard Hoffman, board chair, Texas Department of Protective and Regulatory Services, 701 West 51st Street, P.O. Box 149030, Austin, Texas 78714-9030.

Thomas Chapman, executive director, Texas Department of Protective and Regulatory Services, 701 West 51st Street, P.O. Box 149030, Austin, Texas 78714-9030.

With no other business to come before the subcommittee, Senator Zaffirini recessed the subcommittee by unanimous consent at 11:55 a.m., subject to the call of the chair.

There being no further business, at 11:55 a.m. Senator Zaffirini moved that the Committee stand recessed subject to the call of the chair. Without objection, it was so ordered.

_____
Senator Judith Zaffirini, Chair

_____
Amber Martin, Clerk

Public Hearing
Texas State Capitol Extension
E1.036
Thursday, May 9, 2002
9 a.m.

Agenda

I. Call to Order

II. Roll Call

III. Opening Remarks

IV. Invited Testimony on the Following Interim Charges:

A. Agency Testimony on Caseload and Cost Projections
Don Gilbert, commissioner, Health and Human Services Commission

B. Legislative Budget Board Testimony on Performance Measures and Legislative Action on Waiting Lists in SB 1
Mike Leo, analyst
Melitta Bustamante, analyst

C. Agency Testimony on Waiting Lists

Panel
Jim Hine, commissioner, Department of Human Services
Karen Hale, commissioner, Mental Health and Mental Retardation
Dr. Eduardo Sanchez, commissioner, Texas Department of Health

V. Public Testimony on Waiting Lists

VI. Other Business

VII. Recess

MINUTES

SENATE COMMITTEE ON FINANCE
Subcommittee on Health and Human Services Demand
Thursday, May 9, 2002
9 a.m.
Capitol Extension, Room E1.036

*****

Pursuant to a notice posted in accordance with Senate Rule 11.18, a public hearing of the Senate Committee on Finance was held on Thursday, May 9, 2002, in the Capitol Extension, Room E1.036, at Austin, Texas.

*****

MEMBERS PRESENT:	**MEMBERS ABSENT:**
Senator Judith Zaffirini, Chair	Senator Robert Duncan
Senator Jon Lindsay	Senator Chris Harris
Senator Eddie Lucio	Senator John Whitmire

*****

Senator Judith Zaffirini, chair, called the meeting to order at 9 a.m. The following business was transacted:

The following persons provided oral testimony:

Don Gilbert, commissioner, Health and Human Service Commission, 4900 North Lamar, 4th Floor, Austin, Texas 78751.

Mike Leo, analysts, Legislative Budget Board, 1501 Congress Avenue, 5th Floor, Austin, Texas 78701.

Melitta Bustamante, analysts, Legislative Budget Board, 1501 Congress Avenue, 5th Floor, Austin, Texas 78701.

Jim Hine, commissioner, Department of Human Services, 701 West 51st Street, Austin, Texas 78751.

Karen Hale, commissioner, Mental Health and Mental Retardation, 909 West 45th Street, Austin, Texas 78751.

Dr. Eduardo Sanchez, commissioner, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78701.

The chair called the following persons who registered as public witnesses to provide testimony:

Charles Ferguson, associate, Texans Supporting State Schools, 7243 Lane Park, Dallas, Texas 75225.

Brenda Darlene Wissinger, parent, Texans Supporting State Schools, 3477 Bradley Lane, Brenham, Texas 77833.

Cindy Ferguson, parent, Texans Supporting State Schools, 7243 Lane Park, Dallas, Texas 75225.

Jim Miller, Texans Supporting State Schools, 1430 North Trail Drive, Carrollton, Texas 75006.

Colleen Horton, children's policy specialist, Center for Disability Studies, 2425 Trail of Madrones, Austin, Texas 78746.

Amy Mizcles, governmental affairs, The Arc of Texas, 1600 West 38th Street, Austin, Texas 78731.

Gladys I. Conner, self, 2009 Shady Lane, Richmond, Texas 77469.

Ben F. Conner, self, 2009 Shady Lane, Richmond, Texas 77469.

Shirley Glandon, self, 1926 Green Ridge Court, Abilene, Texas 79602.

Mike Stephens, president, Parent Association for the Retarded of Texas, 2011 Mistywood, Denton, Texas 79209

Evelyn S. Higgins, presdent-parent, Austin State School Parent's Association, 115 Sandra Drive, San Antonio, Texas 78223.

Nancy Ward, governmental affairs, Parent Association for the Retarded of Texas, 4441 Cartagena Drive, Fort Worth, Texas 76133.

Ruth Snyder, self, 8301 Franwood Lane, Austin, Texas 78757.

Luisa Kluger, parent, Texans Supporting State Schools, 4722 Post Oak Timber, Houston, Texas, 77056.

Evelyn Cherry, self, 2038 Millcreek, Garland, Texas, 75044.

Celia Hagert, senior policy analyst, Center for Public Policy Priorities, 900 Lydia Street, Austin, Texas 78702.

Kim Suiter, public policy director, National Multiple Sclerosis Society, 1601 Rio Grande, Austin, Texas 78701.

Susan Murphree, program specialist, 7800 Shoal Creek, Austin, Texas 78757.

Ron Cranston, advocate, ADAPT, 1339 Lamar Square Drive, Austin, Texas 78704.

Debra Wanser, associate commissioner for family health, 1100 West 49th Street, Austin, Texas 78756.

With no other business to come before the subcommittee, the chair recessed the subcommittee by unanimous consent at 12:50 p.m., subject to the call of the chair.

_____
Senator Judith Zaffirini, Chair

_____
Amber Martin, Clerk

Appendix C

The following options were identified by the members of the Finance Subcommittee on Heath and Human Services Demand. These options are the result of extensive public testimony, stakeholder meetings, suggestions from state agencies, organizations and other interested persons. In identifying these options, the members of the committee are aware of the fiscal implications of some of the options. The committee acknowledges that the state budget will be of utmost importance during this next legislative session and respectfully submits these options for consideration by the 78th Texas Legislature.

Options

1. Direct all state agencies to improve the methodology used to request additional funding for new programs or waiting-list elimination to ensure that money is not appropriated in areas where the infrastructure is not adequately in place to handle the new client load.

2. Direct all state agencies to conduct eligibility tests prior to placing clients on a waiting lists, where economically feasible.

3. Direct all state agencies with waiting or interest lists to conduct quarterly or annual reviews of all client waiting lists and report their findings to the Legislative Budget Board, Senate Finance and House Appropriations. Reviews should include how many people applied for services, were eligible for the services, received services, and dropped off the list and why, if this is deemed economically feasible by the Legislature.

4. Consider centralizing the rate setting for all non-Medicaid programs at HHSC.

   The Payment rates for 24-Hour Residential Child Care are the responsibility of PRS. The 24-Hour Residential Child Care program contracts with approximately 220 providers that are required to submit cost reports every two years. In addition, surveys are conducted on foster families. For the FY 2002-2003 rates, PRS surveyed 188 specialized foster families overseen by Child Placing Agencies. For the FY 2004-2005 rates, additional specialized foster families not under the CPA will be surveyed. The rate analyst and support staff will need to be transferred to HHSC if this function is centralized.

   At a minimum, if the foster care rate setting function is not transferred to HHSC, require approval and review of PRS foster care rates by HHSC.

   DHS also has some responsibility for rate setting for community care programs. This function is shared with HHSC and should be consolidated at HHSC.

5. Consider reviewing PRS Rider 7. Agency is requesting to change Rider 7 as follows: Foster Care Rates. In the event funds are appropriated to provide a rate increase for foster care, the department shall implement the rate increase using the same assumptions for the percentage increase, client caseloads and placements by level of care as used by the legislature in appropriating the rate increase. The department may not transfer funds out of Strategy A.1.5, Foster Care/Adoption Payments.

6. HHSC regularly should assess physician and hospital rates in relation to rates paid by Medicare and by commercial insurance.

7. Review the rules for Medicaid reimbursement rates with automatic cost inflators.

8. Require all state agencies to provide the specific costs for providing Medicaid waiver services to the first 100 clients on their waiting list, if cost effective and is determined that this function will not delay or duplicate services to clients.

9. Examine the cost effectiveness of the Consolidated Waiver and determine whether the program should be expanded or discontinued.

10. Direct HHSC to review the impact of targeted provider rate increases on access to services.

11. Consider targeted appropriations for the most frequently requested waiver services such as habilitation and respite care.

12. Review the current target for average monthly cost of HCS program compared to the actual cost of providing services.

13. Require MHMR to develop a pilot program to research the effectiveness of moving the funding for state school and ICF-MR clients with the client into the community.

Appendix D

Riders*

Senate Bill 1 contained the following riders related to client waiting lists:

1. Rider 7, under Article II, DHS, Nursing Home Program Provisions, B. Limitation of Per Day Cost At Alternate Care, "expresses legislative intent that the Department of Human Services may not disallow or jeopardize community services for clients currently receiving services under Medicaid waivers if these services are required for the individual to be in the most integrated setting."

2. Rider 16, under Article II, DHS, "requires the Department of Human Services to submit to the Legislative Budget Board and the Governor (a) a copy of each Medicaid report or petition submitted to the federal government (b) monthly Medicaid caseload and expenditure reports and (c) monthly reports on expenditures and encumbrances by strategy, as well as reports on waivers."

3. Rider 35, under Article II, DHS is an "informational rider outlining Tobacco funding appropriated in Article XII to the Department of Human Services identifying specific programs and allocations to be used in the Community Care Strategy."

4. Rider 37, under Article II, DHS, "expresses legislative intent that as clients relocate from nursing facilities to community care, funds will be transferred from Nursing Facilities to Community Care Services to cover the cost of the shift in services."

5. Rider 13, under Article II, MHMR, "requires the average annual HCS expenditure per client to be no more than 80 percent of the average annual ICF-MR expenditure per client. It also limits the average expenditure per client to $3,511 per month and requires a report to the LBB and GOBPP on measures taken to decrease the average cost per person and to increase the number of clients served."

6. Rider 16, under Article II, MHMR, "states the intent of the Legislature that any funds appropriated to expand or improve community mental health and mental retardation services or to address the waiting list for HCS services to be allocated via the methodology recommended in MHMR's Equity Task Force Report. The agency is required to report on its progress every year."

7. Rider 61, under Article II, MHMR, "provides MHMR the authority to seek approval from the federal government for an HCS mid-range waiver, which would provide services and supports to persons with mental retardation who do not require out-of-home residential support. The waiver would be capped at $25,000 per year."

8. Rider 65, under Article II, MHMR, "requires a cost-comparison report with analysis of state and federally funded residential and non-residential services for people with mental retardation. The report shall examine state-operated and non-state-operated Intermediate Care Facilities for the Mentally Retarded as well as the HCS, HCS-O and MRLA Medicaid waivers."

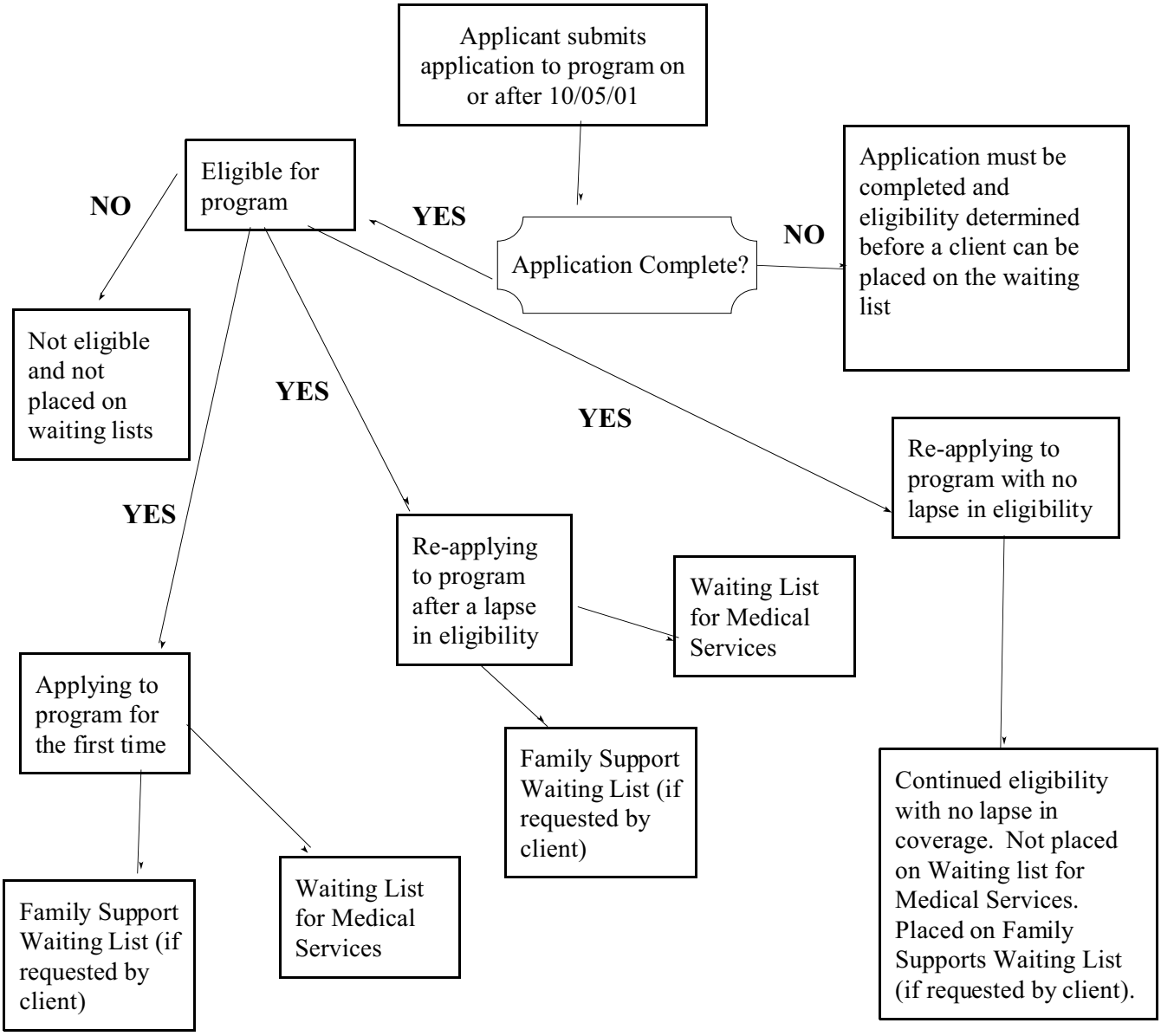
9. Rider 16, under Article II, Special Provisions, "authorizes the Health and Human Services Commission to develop and implement a pilot waiver program to consolidate waiver services to eligible clients."

10. Rider 22, under Article II, Special Provisions, "states that funds appropriated to DHS and MHMR for long-term care waiver slots must be used to establish and maintain waiver slots and provide wrap around or other similar services."

* Health and Human Services Commission, 2002

Appendix E

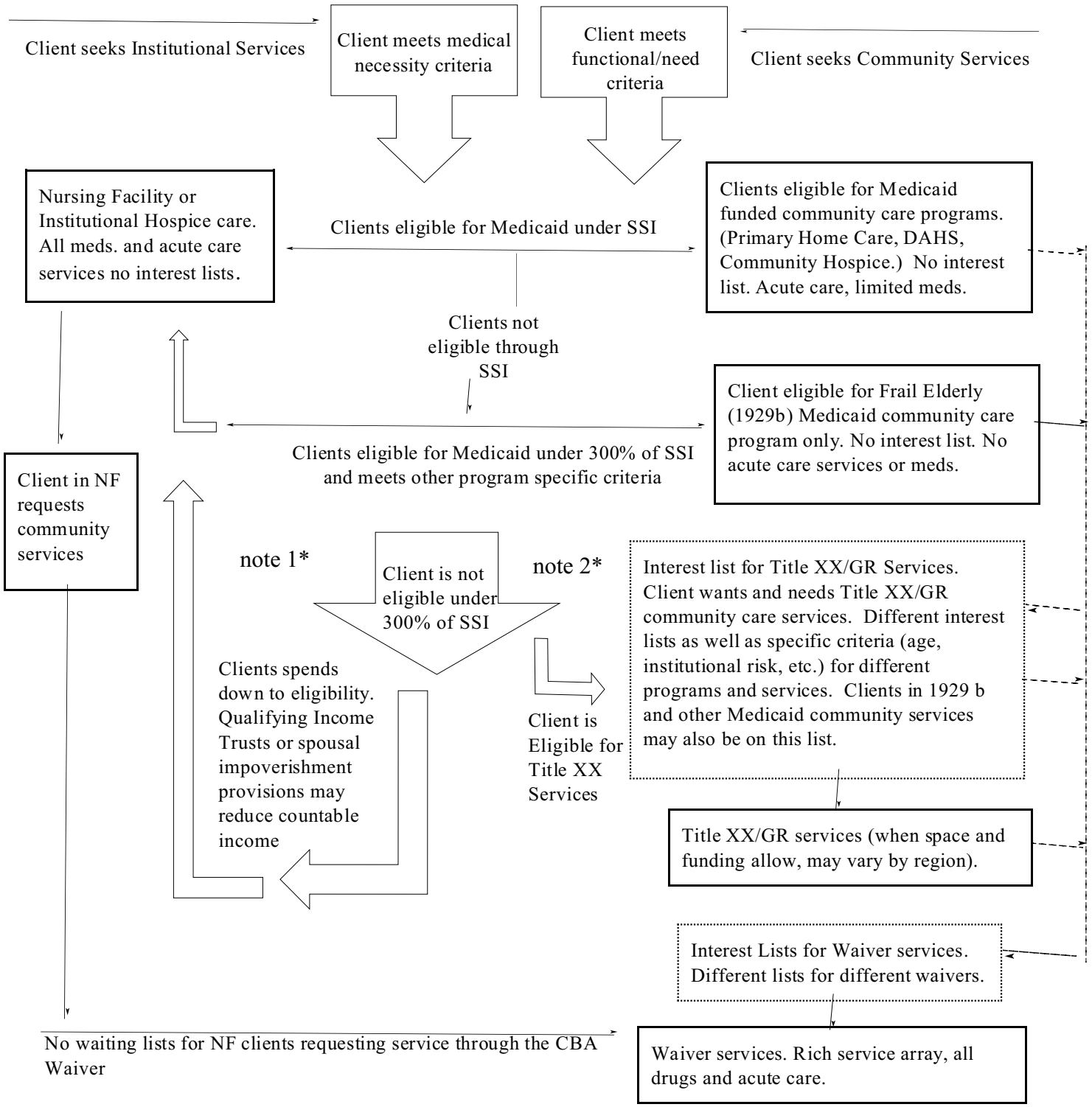
Children with Special Health Care Needs Process*



* Health and Human Services Commission, 2002

Appendix F

DHS Overview of Community and Institutional Services and Eligibility*



Notes:

1* Institutional clients typically receive services pending eligibility. 30 days residence is required before billing can begin. Additional eligibility criteria may include age, institutional risk, etc.

2* Community clients typically do not receive services pending eligibility. Additional community criteria may include age, institutional risk, unmet need, etc. Dotted lines indicate interest list processes.

* Department of Human Services, 2002

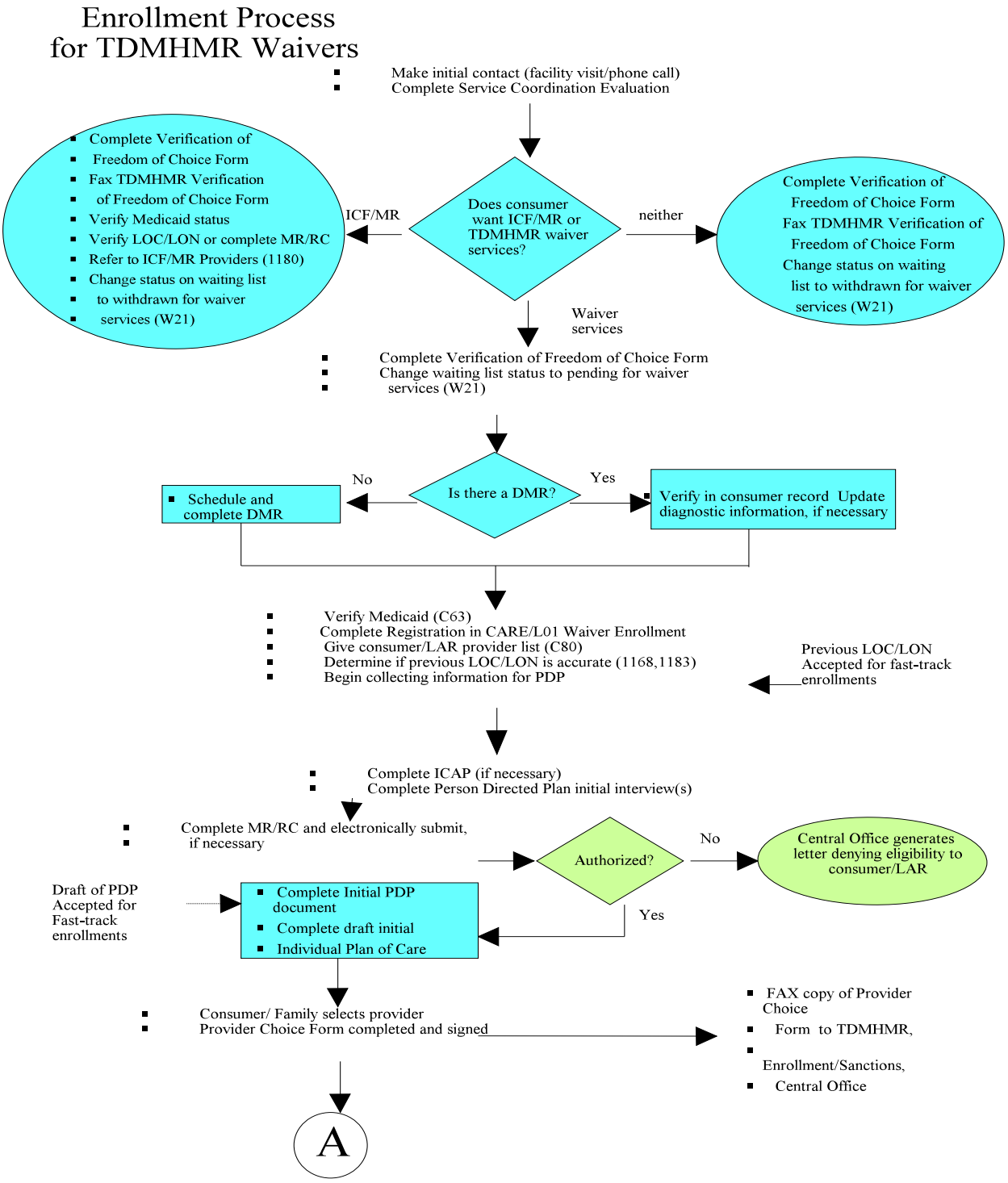
Appendix G

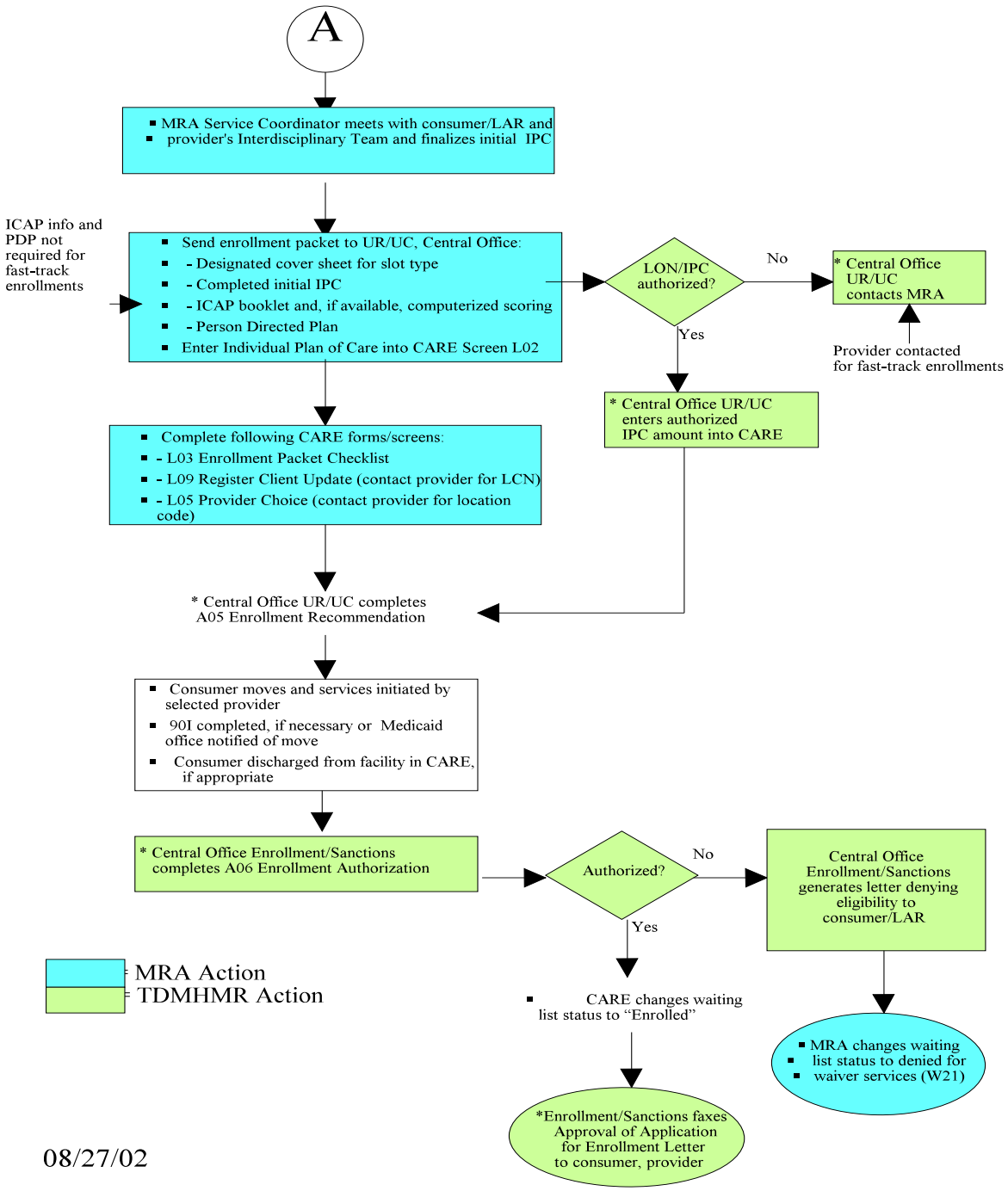
Texas Medicaid 1115 and 1915 (c) Waivers*

Year of Inception	Name of Waiver	Operating Agency	Enrollment
1984	MDCP (Medically Dependent Children Program)1915 (c)	DHS (transferred from TDH in 9/1/01)	966 (as of 3/31/02)
1990	CLASS (Community Living Assistance and Support Services)1915 (c)	DHS	1,457 (as of 03/31/02)
1986	HCS (Home and Community-based Waiver Services)1915 (c)	MHMR	4,003 (as of 02/28/02)
1991	HCS-OBRA (Home and Community-based Waiver Services)1915 (c)	MHMR	73 (as of 02/28/02)
1995	DB-MD (Deaf Blind, Multiply Disabled) 1915 (c)	DHS	115 (as of 04/01/02)
1994	CBA (Community-Based Alternatives)1915 (c)	DHS	29,383 (as of 2/28/02)
1998	CBA – STAR+PLUS (State of Texas Access Reform PLUS Long Term Care Pilot Project) 1915(c)	DHS	1799 CBA waiver enrollees (as of 04/01/02)
1998	MRLA (Mental Retardation-Local Authority Program) 1915 (c)	MHMR	2,238 (as of 02/28/02)
2001	CWP(Consolidated Waiver Program) 1915 (c)	DHS	88 (as of 04/01/02)
1992	PACE Program 1115	DHS	575 (as of 2/28/02)

* Health and Human Services Commission, 2002

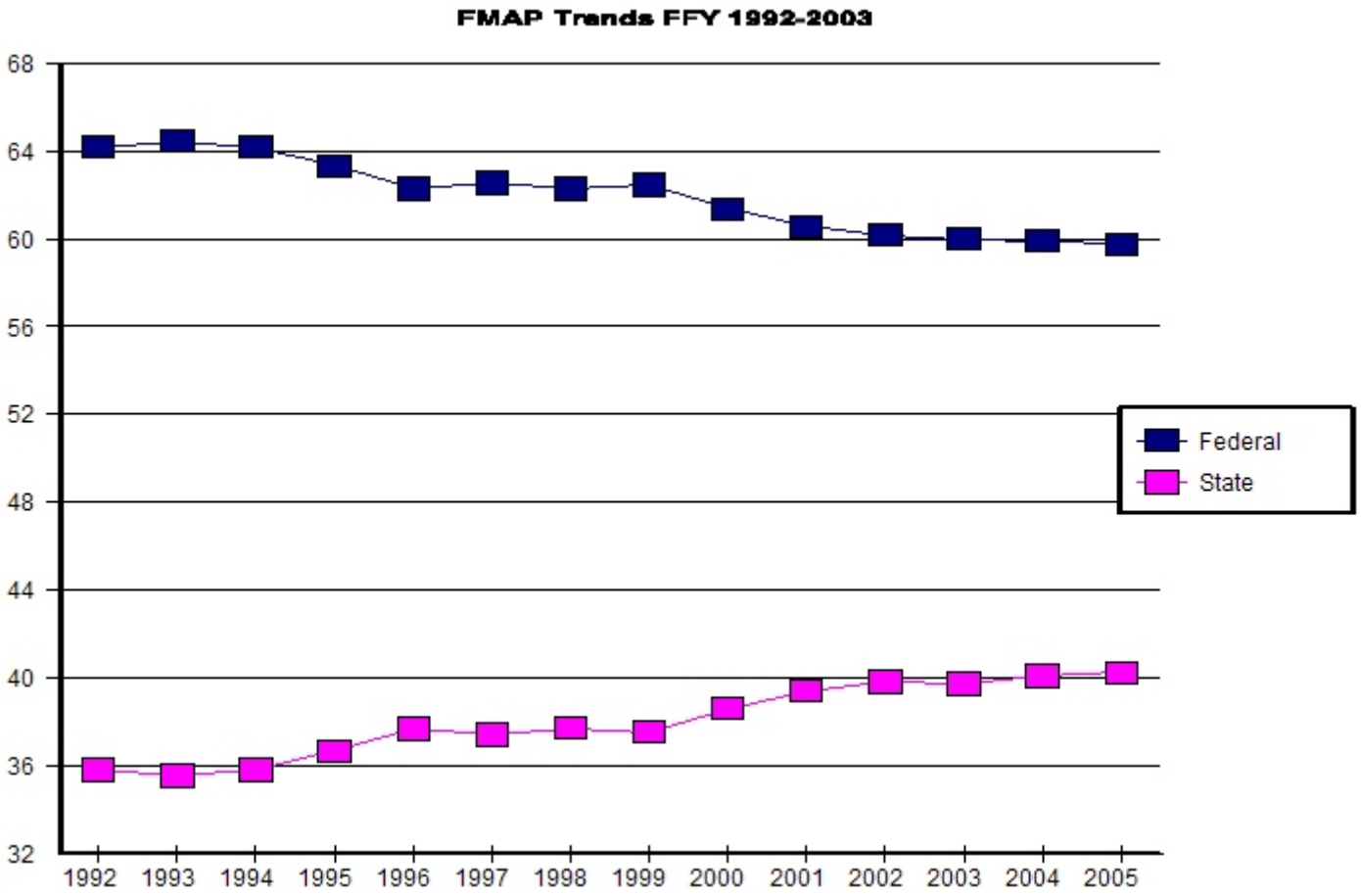
Appendix H*


Enrollment Process for TDMHMR Waivers
Make initial contact (facility visit/phone call)
Complete Service Coordination Evaluation
Does consumer want ICF/MR or TDMHMR waiver services?
ICF/MR
Complete Verification of Freedom of Choice Form
Fax TDMHMR Verification of Freedom of Choice Form
Verify Medicaid status
Verify LOC/LON or complete MR/RC
Refer to ICF/MR Providers (1180)
Change status on waiting list to withdrawn for waiver services (W21)
neither
Complete Verification of Freedom of Choice Form
Fax TDMHMR Verification of Freedom of Choice Form
Change status on waiting list to withdrawn for waiver services (W21)
Waiver services
Complete Verification of Freedom of Choice Form
Change waiting list status to pending for waiver services (W21)
Is there a DMR?
No
Schedule and complete DMR
Yes
Verify in consumer record Update diagnostic information, if necessary
Verify Medicaid (C63)
Complete Registration in CARE/L01 Waiver Enrollment
Give consumer/LAR provider list (C80)
Determine if previous LOC/LON is accurate (1168,1183)
Begin collecting information for PDP
Previous LOC/LON Accepted for fast-track enrollments
Complete ICAP (if necessary)
Complete Person Directed Plan initial interview(s)
Complete MR/RC and electronically submit, if necessary
Authorized?
No
Central Office generates letter denying eligibility to consumer/LAR
Yes
Draft of PDP Accepted for Fast-track enrollments
Complete Initial PDP document
Complete draft initial
Individual Plan of Care
Consumer/ Family selects provider
Provider Choice Form completed and signed
FAX copy of Provider Choice
Form to TDMHMR, Enrollment/Sanctions, Central Office
A



* Mental Health and Mental Retardation, 2002

Appendix I*



* Health and Human Services Commission, 2002

Appendix J

Thirty-three dental procedures with Legislative approved rate increases in FY 02.

Code*	Description
W-D0120	Periodic Oral Evaluation
W-D0140	Limited Oral Evaluation - Problem Focused
W-D0150	Comprehensive Oral Evaluation
W-D0210	Intraoral - Complete Series (including bitewings)
W-D0220	Intraoral - Periapical - First Film
W-D0230	Intraoral - Periapical - Each additional film
W-D0272	Bitewings - Two films
W-D0274	Bitewings - Four films
W-D0330	Panoramic Film
W-D1201	Topical Application of Fluoride (including prophylaxis - child)
W-D1205	Topical Application of Fluoride (including prophylaxis - adult)
W-D1351	Sealant
W-D2110	Amalgam - one surface, primary
W-D2120	Amalgam - two surfaces, primary
W-D2140	Amalgam - one surface, permanent
W-D2150	Amalgam - two surfaces, permanent
W-D2160	Amalgam - three surfaces, permanent
W-D2330	Resin - one surface, anterior
W-D2331	Resin - two surfaces, anterior
W-D2332	Resin - three surfaces, anterior
W-D2335	Resin - four or more surfaces or involving incisal angle (anterior)
W-D2380	Resin - on surface, posterior - primary
W-D2381	Resin - two surfaces, posterior - permanent
W-D2385	Resin - one surface, posterior - permanent

W-D2386	Resin - two surfaces, posterior - permanent
W-D2387	Resin - three or more surfaces, posterior - permanent
W-D2930	Prefabricated stainless steel crown - primary tooth
Code	Description
W-D3220	Therapeutic pulpotomy
W-D3240	Pulpal therapy
W-D3330	Three or more canals, molar (excluding final restoration)
W-D7110	Single tooth
W-D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
W-Z2013	Orthodontic adjustments, per month

* Health and Human Services Commission, 2002

Appendix K *

TEXAS NURSING FACILITY (NF) MEDICAID RATE SETS

EFFECTIVE 09/01/01

Rates effective September 1, 2001 will remain in effect until August 31, 2003. There will be no additional increase September 1, 2002. House Bill (HB) 154 requires the Health and Human Services Commission (HHSC) to ensure that the rate component derived

Nonparticipant - No liability insurance

TILE	Direc Care Staff	Other Resident Care	Dietary	General and Admin.	Fixed Capital	Total
201	$79.89	$29.28	$10.11	$19.55	$6.17	$145.00
202	$68.61	$25.15	$10.11	$19.55	$6.17	$129.59
203	$63.58	$23.31	$10.11	$19.55	$6.17	$122.72
204	$49.11	$18.00	$10.11	$19.55	$6.17	$102.94
205	$43.84	$16.07	$10.11	$19.55	$6.17	$95.74
206	$44.61	$16.35	$10.11	$19.55	$6.17	$96.79
207	$38.26	$14.02	$10.11	$19.55	$6.17	$88.11
208	$36.12	$13.24	$10.11	$19.55	$6.17	$85.19
209	$32.04	$11.74	$10.11	$19.55	$6.17	$79.61
210	$24.73	$9.06	$10.11	$19.55	$6.17	$69.62
211	$22.94	$8.41	$10.11	$19.55	$6.17	$67.18
212	$22.94	$8.41	$10.11	$19.55	$6.17	$67.18
Vent. - Cont.	$56.64	$20.76				$77.40
Vent. - < Cont	$22.66	$8.30				$30.96
Pediatric Tracl	$33.98	$12.46				$46.44

Participant - Level 0 - No liability insurance

TILE	Direc Care Staff	Other Resident Care	Dietary	General and Admin.	FixedCapital	Total
201	$83.53	$29.28	$10.11	$19.55	$6.17	$148.64
202	$71.73	$25.15	$10.11	$19.55	$6.17	$132.71
203	$66.48	$23.31	$10.11	$19.55	$6.17	$125.62
204	$51.34	$18.00	$10.11	$19.55	$6.17	$105.17
205	$45.84	$16.07	$10.11	$19.55	$6.17	$97.74
206	$46.65	$16.35	$10.11	$19.55	$6.17	$98.83
207	$40.00	$14.02	$10.11	$19.55	$6.17	$89.85
208	$37.76	$13.24	$10.11	$19.55	$6.17	$86.83
209	$33.49	$11.74	$10.11	$19.55	$6.17	$81.06
210	$25.85	$9.06	$10.11	$19.55	$6.17	$70.74
211	$23.98	$8.41	$10.11	$19.55	$6.17	$68.22
212	$23.98	$8.41	$10.11	$19.55	$6.17	$68.22
Vent. - Cont.	$59.22	$20.76				$79.98
Vent. - < Cont	$23.69	$8.30				$31.99
Pediatric Tracl	$35.53	$12.46				$47.99

* Health and Human Services Commission, 2002

Appendix L

COMMUNITY BASED ALTERNATIVES HOME AND COMMUNITY SUPPORT SERVICES (CBA HCSS) PAYMENT RATES EFFECTIVE SEPTEMBER 1, 2002 provided by HHSC	
SERVICE	PAYMENT RATE
CBA HCSS PAS	
Nursing Services:	
Registed Nurse (RN) per hour	$33.81
Licensed Vocational Nurse (LVN) per hour	$25.34
Physical Therapy (PT) per hour	$65.29
Occupational Therapy (OT) per hour	$62.28
Speech Pathology (SP) per hour	$61.22
Adult Foster Care (AFC) per day	
Level I	$18.92
Level II	$32.63
Level III	$66.25
AFC Out-of-Home Respite per day	
Level I	$32.81
Level II	$46.52
Level III	$80.15
In-Home Respite Care per day	$230.93
Administrative Expense Fee	
(Pre-Enrollment Home Health Assessment)	$130.70
Requisition Fees Adaptive Aids	
Under $500	10% of cost
$500 to $999.99	$54.03
$1,000 to $1,499.99	$92.85
$1,500 to $1,999.99	$105.66
$2,000 to $2,499.99	$118.86
$2,500 to $2,999.99	$134.21
$3,000 to $3,499.99	$140.81
$3,500 to $3,999.99	$147.02
$4,000 to $4,499.99	$153.62
$4,500 to $4,999.99	$160.22
$5,000 and over	$168.96
Minor Home Modifications	
under $500	10% of cost
$500 to $999.99	$80.04
$1,000 to $1,499.99	$118.86
$1,500 to $1,999.99	$131.67
$2,000 to $2,499.99	$163.89
$2,500 to $2,999.99	$196.50
$3,000 to $3,499.99	$227.19
$3,500 to $3,999.99	$258.27
$4,000 to $4,499.99	$284.28
$4,500 to $4,999.99	$309.90
$5,000 to $5,499.99	$335.91
$5,500 to $5,999.99	$361.92
$6,000 to $6,499.99	$395.15
$6,500 and over	$428.76

Appendix M

COMMUNITY BASED ALTERNATIVES HOME AND COMMUNITY SUPPORT SERVICES (CBA HCSS)

PERSONAL ASSISTANCE SERVICES (PAS)
PAYMENT RATE PER UNIT OF SERVICE
Effective September 1, 2002

Effective 9/1/02 to 8/31/03

	Attendant Cost Area	Administration and Facility Cost Area	Total
Nonparticipant	$7.17	$2.76	$9.93
Participant - Level 1	$7.22	$2.76	$9.98
Participant - Level 2	$7.27	$2.76	$10.03
Participant - Level 3	$7.32	$2.76	$10.08
Participant - Level 4	$7.37	$2.76	$10.13
Participant - Level 5	$7.42	$2.76	$10.18
Participant - Level 6	$7.47	$2.76	$10.23
Participant - Level 7	$7.52	$2.76	$10.28
Participant - Level 8	$7.57	$2.76	$10.33
Participant - Level 9	$7.62	$2.76	$10.38
Participant - Level 10	$7.67	$2.76	$10.43
Participant - Level 11	$7.72	$2.76	$10.48
Participant - Level 12	$7.77	$2.76	$10.53
Participant - Level 13	$7.82	$2.76	$10.58
Participant - Level 14	$7.87	$2.76	$10.63
Participant - Level 15	$7.92	$2.76	$10.68
Participant - Level 16	$7.97	$2.76	$10.73
Participant - Level 17	$8.02	$2.76	$10.78
Participant - Level 18	$8.07	$2.76	$10.83
Participant - Level 19	$8.12	$2.76	$10.88
Participant - Level 20	$8.17	$2.76	$10.93

* Health and Human Services Commission, 2002

Appendix N

COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES (CLASS)		
ADOPTED PAYMENT RATES		
EFFECTIVE SEPTEMBER 1, 2001 AND SEPTEMBER 1, 2002		
HHSC, 2002		
SERVICE	ADOPTED SFY 02 PAYMENT RATE	ADOPTED SYF 03 PAYMENT RATE
Case Management Services per month	$177.06	$177.06
Habilitation Services per hour (see attached chart)		
Registered Nurse (RN) Nursing Services per hour	$33.81	$33.81
Licensed Vocational Nurse (LVN) Nursing Services per ho	$25.34	$25.34
Physical Therapy (PT) per hour	$64.32	$65.29
Occupational Therapy (OT) per hour	$61.35	$62.28
Speech Pathology (SP) per hour	$61.22	$61.22
Psychological Services per hour	$69.72	$69.72
Respite Care / In-Home per day	$230.93	$230.93
Respite Care / Out-of-Home per day	$208.83	$208.83
Administrative Expense Fee	$456.85	$456.85
Requisition Fees-Adaptive Aids		
under $500	10% of cost	No adjustment to Adaptive Aid
$500 to $999.99	$54.03	Requisition Fee Schedule
$1,000 to $1,499.99	$92.85	
$1,500 to $1,999.99	$105.66	
$2,000 to $2,499.99	$118.86	
$2,500 to $2,999.99	$134.21	
$3,000 to $3,499.99	$140.81	
$3,500 to $3,999.99	$147.02	
$4,000 to $4,499.99	$153.62	
$4,500 to $4,999.99	$160.22	
$5,000 and over	$168.96	
Requisitions Fees-Minor Home Modifications		
under $500	10% of cost	No adjustment to Adaptive Aid
$500 to $999.99	$80.04	Requisition Fee Schedule
$1,000 to $1,499.99	$118.86	
$1,500 to $1,999.99	$131.67	
$2,000 to $2,499.99	$163.89	
$2,500 to $2,999.99	$196.50	
$3,000 to $3,499.99	$227.19	
$3,500 to $3,999.99	$258.27	
$4,000 to $4,499.99	$284.28	
$4,500 to $4,999.99	$309.90	
$5,000 to $5,499.99	$335.91	
$5,500 to $5,999.99	$361.92	
$6,000 to $6,499.99	$395.15	
$6,500 and over	$428.76	

Appendix O

DAY ACTIVITY AND HEALTH SERVICES

Payment Rate per Unit of Service
Effective September 1, 2002

Effective 9/1/02 to 8/31/03

	Attendant Cost Area	Other Direct Care Cost Area	Facility Cost Area	Administration/ Transportation Cost Area	Total
Nonparticipant	$2.45	$3.50	$2.36	$4.89	$13.20
Participant - Level 1	$2.50	$3.50	$2.36	$4.89	$13.25
Participant - Level 2	$2.55	$3.50	$2.36	$4.89	$13.30
Participant - Level 3	$2.60	$3.50	$2.36	$4.89	$13.35
Participant - Level 4	$2.65	$3.50	$2.36	$4.89	$13.40
Participant - Level 5	$2.70	$3.50	$2.36	$4.89	$13.45
Participant - Level 6	$2.75	$3.50	$2.36	$4.89	$13.50
Participant - Level 7	$2.80	$3.50	$2.36	$4.89	$13.55
Participant - Level 8	$2.85	$3.50	$2.36	$4.89	$13.60
Participant - Level 9	$2.90	$3.50	$2.36	$4.89	$13.65
Participant - Level 10	$2.95	$3.50	$2.36	$4.89	$13.70
Participant - Level 11	$3.00	$3.50	$2.36	$4.89	$13.75
Participant - Level 12	$3.05	$3.50	$2.36	$4.89	$13.80
Participant - Level 13	$3.10	$3.50	$2.36	$4.89	$13.85
Participant - Level 14	$3.15	$3.50	$2.36	$4.89	$13.90
Participant - Level 15	$3.20	$3.50	$2.36	$4.89	$13.95
Participant - Level 16	$3.25	$3.50	$2.36	$4.89	$14.00
Participant - Level 17	$3.30	$3.50	$2.36	$4.89	$14.05
Participant - Level 18	$3.35	$3.50	$2.36	$4.89	$14.10
Participant - Level 19	$3.40	$3.50	$2.36	$4.89	$14.15
Participant - Level 20	$3.45	$3.50	$2.36	$4.89	$14.20

Appendix P

PRIMARY HOME CARE AND FAMILY CARE

PRIORITY 1 PAYMENT RATE PER UNIT OF SERVICE
Effective September 1, 2002

Effictive 9/1/02 to 8/31/03

	Attendant Cost Area	Supervisor Cost Area	Administration and Facility Cost Area	Priority 1 Administration	Total
Nonparticipant	$7.59	$0.64	$1.51	$0.19	$9.93
Participant - Level 1	$7.64	$0.64	$1.51	$0.19	$9.98
Participant - Level 2	$7.69	$0.64	$1.51	$0.19	$10.03
Participant - Level 3	$7.74	$0.64	$1.51	$0.19	$10.08
Participant - Level 4	$7.79	$0.64	$1.51	$0.19	$10.13
Participant - Level 5	$7.84	$0.64	$1.51	$0.19	$10.18
Participant - Level 6	$7.89	$0.64	$1.51	$0.19	$10.23
Participant - Level 7	$7.94	$0.64	$1.51	$0.19	$10.28
Participant - Level 8	$7.99	$0.64	$1.51	$0.19	$10.33
Participant - Level 9	$8.04	$0.64	$1.51	$0.19	$10.38
Participant - Level 10	$8.09	$0.64	$1.51	$0.19	$10.43
Participant - Level 11	$8.14	$0.64	$1.51	$0.19	$10.48
Participant - Level 12	$8.19	$0.64	$1.51	$0.19	$10.53
Participant - Level 13	$8.24	$0.64	$1.51	$0.19	$10.58
Participant - Level 14	$8.29	$0.64	$1.51	$0.19	$10.63
Participant - Level 15	$8.34	$0.64	$1.51	$0.19	$10.68
Participant - Level 16	$8.39	$0.64	$1.51	$0.19	$10.73
Participant - Level 17	$8.44	$0.64	$1.51	$0.19	$10.78
Participant - Level 18	$8.49	$0.64	$1.51	$0.19	$10.83
Participant - Level 19	$8.54	$0.64	$1.51	$0.19	$10.88
Participant - Level 20	$8.59	$0.64	$1.51	$0.19	$10.93

VOUCHER

Vendor Fiscal Intermediary Payment Rate	$1.00
Consumer Payment Rate	$9.13
Total Payment Rate (= Participant - Level 4)	$10.13

Appendix Q

Texas Health and Human Services Commission Selected Non-Medicaid Rate Methodologies

INTERAGENCY COUNCIL ON EARLY CHILDHOOD INTERVENTION (ECI)		
Type of Rate: Comprehensive Services **Agency:** ECI	**Program Description:** Comprehensive services for children ages 0 to 3. This includes all services provided in accordance with the Individualized Family Service Plan (IFSP) developed by an interdisciplinary team that includes the child's family. This must include service coordination and may include, but is not limited to: assistive technology services and devices; audiology; family counseling; family education; home visits; health services necessary to enable the child to benefit from the other early intervention services; medical services only for diagnostic or evaluation purposes; nursing services; nutrition services; occupational therapy; physical therapy; psychological services; social work services; special instructional services/developmental rehabilitation services; speech/language therapy; transportation and related costs; and vision services. **Methodology:** ECI currently provides grants to 63 contractors statewide. These contractors provide services required in each child's individualized family service plan (IFSP) as described above. Because this is an entitlement program contracts are amended as necessary to meet the need for services. ECI has hired a contractor to study the feasibility of changing the reimbursement methodology from actual cost reimbursement to a fee for services system. **Rate Cycle:** Contracts are negotiated annually, but may be amended as necessary.	**Utilization:** 33,649 children received comprehensive ECI services in FY01. **Provider Base:** *63 contractors receive grants to provide comprehensive services. They subcontract as needed.*
Type of Rate: Eligibility Determination **Agency:** ECI	**Program Description:** Eligibility determination services for children ages 0 to 3. This includes all services that are provided prior to the point of IFSP development, excluding follow along services. Eligibility determination services include receiving referrals, conducting intake, providing service coordination, and conducting evaluation for eligibility determination. Eligibility determination is conducted annually. **Methodology:** ECI currently provides grants to 63 contractors statewide. These contractors provide eligibility determination services as described above. Because this is an entitlement program, contracts are amended as necessary to meet the need for services. ECI has hired a contractor to study the feasibility of changing the reimbursement methodology from actual cost reimbursement to a fee for services system. **Rate Cycle:** Contracts are negotiated annually, but may be amended as necessary.	**Utilization:** 47,033 children received eligibility determination services in FY01. **Provider Base:** 63 contractors receive grants to provide eligibility determination services. They subcontract as needed.
Type of Rate: Follow Along Services **Agency:** ECI	**Program Description:** Follow along services for children ages 0 to 3. These are services that are provided to children referred to ECI and determined ineligible for or decline comprehensive services, but by clinical opinion, may be at risk for developmental delay based on current ECI eligibility criteria. Follow along services include: (1) providing the age-appropriate developmental materials to every family whose child is eligible for follow along services so that the family can monitor their child's development and (2) contacting families at least every six months after the child enters follow along services to determine the child's developmental status.	**Utilization:** 4,360 children received follow along services in FY01. **Provider Base:** 63 contractors receive grants to provide follow along services. They subcontract as needed.

	Reimbursement: ECI currently provides grants to 63 contractors statewide. These contractors provide follow along services as described above. Because this is an entitlement program, contracts are amended as necessary to meet the need for services. ECI has hired a contractor to study the feasibility of changing the reimbursement methodology from actual cost reimbursement to a fee for services system. **Rate Cycle:** Contracts are negotiated annually, but may be amended as necessary.	
Type of Rate: Respite Care **Agency:** ECI	**Program Description:** Respite care for families with children enrolled in ECI comprehensive services. **Methodology:** Respite providers are reimbursed at an hourly rate based on the complexity of care needed by the child. Hourly rates, listed by complexity of care level, may not exceed: (1) basic - $7, (2) moderate - $12, and (3) intensive - $27. **Rate Cycle:** No specified cycle for adopting new rates.	Utilization: 921 children received respite services in FY01. **Provider Base:** 63 contractors receive grants to provider respite services.
TEXAS COMMISSION ON ALCOHOL AND DRUG ABUSE (TCADA)		
Type of Rate: Detoxification, Level I **Agency:** TCADA	**Program Description:** Level I residential detoxification services provide medication and nursing care to manage the client's withdrawal symptoms. **Methodology:** Unit Rate of $123 per day for adults; $132 per day for adolescents. **Rate Cycle:** Annual, September 1 – August 31.	**Utilization:** Approximately 8,200 clients per year. **Provider Base:** Services are provided by approximately 21 TCADA-funded substance abuse treatment providers. This includes primarily non-profit, governmental and quasi-governmental agencies and some for-profit.
Type of Rate: Residential, Levels II and III **Agency:** TCADA	**Program Description:** Level II residential services provide a minimum average of at least 20 hours of treatment services per week for each client, comprised of at least three hours of chemical dependency counseling and 17 hours of additional counseling, chemical dependency education, and/or life skills training. Level III residential services provide a minimum average of at least ten hours of treatment services per week for each client, comprised of at least two hours of chemical dependency counseling and eight hours of additional counseling, chemical dependency education, and/or life skills training. **Methodology:** Level II: unit rate of $64 per day for adult residential clients; $132 per day for adolescent residential clients; and $158 per day for adult/adolescent residential females with children. Level III: unit rate of $32 per day for adult residential clients; $46 per day for adult residential specialized female clients; and $90 per day for adolescent residential clients. **Rate Cycle:** Annual, September 1 – August 31.	**Utilization:** Approximately 13,500 Level II and 2,100 Level III clients per year. **Provider Base:** Services are provided by TCADA-funded substance abuse treatment providers: Level II, 69; Level III, 32. This includes primarily non-profit, governmental and quasi-governmental agencies and some for-profit.

Type of Rate: Outpatient, Levels II, III, IV **Agency:** TCADA	**Program Description: Level II** outpatient services provide a minimum average of at least 20 hours of treatment services per week for each client, comprised of at least three hours of chemical dependency counseling and 17 hours of additional counseling, chemical dependency education, and/or life skills training. **Level III** outpatient services provide a minimum average of at least 10 hours of treatment services per week for each client, comprised of at least two hours of chemical dependency counseling and eight hours of additional counseling, chemical dependency education, and/or life skills training. **Level IV** outpatient services provide a minimum average of at least two hours of counseling per week, including at least one hour of individual counseling per month. **Methodology:** Level II adolescent day treatment (outpatient) is $84 per day. All other adult and adolescent outpatient services are $47 per individual hour and $16 per group hour. Outpatient programs may not bill the Commission for more than: 29 hours per week for Level II services; 19 hours per week for Level III services; or 9 hours per week for Level IV services. **Rate Cycle:** Annual, September 1 – August 31.	**Utilization:** Approximately 800 Level II, 4,300 Level III, and 8,800 Level IV clients per year. **Provider Base:** Services are provided by TCADA-funded substance abuse treatment providers: Level II, 10; Level III, 66; Level IV, 106. This includes primarily non-profit, governmental and quasi-governmental agencies and some for-profit.
Type of Rate: Pharmacotherapy **Agency:** TCADA	**Program Description:** Pharmacotherapy services provide methadone and LAAM administration, as well as counseling, to clients who are addicted to opioids/narcotics. **Methodology:** Unit rate of $8 per day for methadone and $56 per week for LAAM. **Rate Cycle:** Annual, September 1 – August 31.	**Utilization:** Approximately 1,000 clients per year. **Provider Base:** Services are provided by approximately 10 TCADA-funded substance abuse treatment providers. This includes primarily non-profit, governmental and quasi-governmental agencies and some for-profit.
TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION (TDMHMR) **Note: As the provider of campus based mental health services for the state, TDMHMR establishes daily rates that are charged to the patients receiving those services in the state hospitals. Therefore, these rates are attached to the revenue the hospitals receive.**		
Type of Rate: Adult Psychiatric Services **Agency:** TDMHMR	**Program Description:** The Adult Psychiatric Service (APS) provides a continuum of care for adults with mental illness who have been referred by their local mental health authority (MHA) or by the court for inpatient psychiatric treatment. Patients are admitted from all of the 36 counties included in the Austin Sate Hospital service area. Services provided upon admission include initial psychiatric, medical, nursing, social, psychological, rehabilitation assessments, as well as other assessments and/or evaluations that may be needed. These initial assessments include: . Consideration of the presenting problems which made the patient's admission necessary, . Needs at the time of admission, . Assets and the liabilities; and . Criteria for the patient to return to the community or to a less restrictive treatment setting.	**Utilization:** 12,466 clients **Provider Base:** Nine Hospitals

	The Short-term Acute Care/Admission units provide essential diagnostic and intensive mental health care for patients in acute distress, including identification of underlying medical issues and medication management. The Longer-Term Care Program includes two units (one acute and one sub-acute) that provide a continuum of care for the psychiatrically hospitalized adult needing additional psycho-educational services and psychiatric treatment for successful transition to a less restrictive environment. Based upon a comprehensive assessment of the patient's needs, level of acuity, functional skills, and skill deficits assignments are made to either unit for sub-acute or acute level of care. **Methodology:** Facility Budget. Projected Expenses – projected operational number of beds – projected number of inpatient bed days. The charge is the projected actual cost of serving adult inpatients. **Rate Cycle:** Annual – October	
Type of Rate: Geriatric Psychiatric Services **Agency:** TDMHMR	**Program Description:** Geriatric Psychiatric Services is staffed by a treatment team including psychiatrists/physicians, nurses, mental health workers, psychologist, social workers, and rehabilitation staff, who are trained and qualified to provide services for the aging. These patients are diagnosed with major thought disorders, major affective disorders, major personality disorders, and organic disorders of various etiologies. An interdisciplinary team provides a bio-psycho-social assessment for each patient. This assessment addresses the physical, emotional, behavioral, social, recreational, legal, vocational, spiritual, and nutritional needs of the patients. Departmental standards require a physical, psychiatric, nursing, and social history, and rehabilitation assessment. Psychological, educational and vocational assessments, as well as special assessment for neurological deficits are provided as deemed necessary by the treatment team. Treatment planning is based on the assessment of identified needs and problems. Major treatment modalities include psychoactive medications, the full range of psychosocial intervention, and specialized interventions for physical and organic dysfunctions. Other services provided (e.g., vocational rehabilitation, recreational rehabilitation, chaplaincy, and patient education) are used to enhance and individualize the programs for geriatric patients. **Methodology:** Facility Budget. Projected Expenses – projected operational number of beds – projected number of inpatient bed days. The charge is the projected actual cost of serving geriatric inpatients. **Rate Cycle:** Annual – October	**Utilization:** 638 clients **Provider Base:** Seven Hospitals
Type of Rate: Adolescent Psychiatric Services **Agency:** TDMHMR	**Program Description:** Adolescent Psychiatric Services provide inpatient mental health services care to youth and their families. The programs are designed to provide psychiatric programming to ensure successful reintegration to the community, family, and school settings. The program focuses on timely assessments that include physical examination, psychiatric evaluation, medical history, intellectual functioning, educational level, interpersonal skill needs, social histories and assessment of family functioning. Treatment planning focuses on maximizing the earliest possible return of each patient to a less restrictive setting. Discharge and aftercare planning begins during the assessment phase. Liaison with follow-up services is established at admission, continued during the hospitalization, and followed after discharge. Discharge planning and aftercare referrals focus on all developmental needs. **Methodology:** Facility Budget. Projected Expenses – projected operational number of beds – projected number of inpatient bed days. The charge is the projected actual cost of serving adolescent inpatients.	**Utilization:** 2,055 clients **Provider Base:** Seven Hospitals

	Rate Cycle: Annual – October	
TEXAS COMMISSION FOR THE BLIND (TCB)		
Type of Rate: Inpatient Hospital **Agency:** TCB	**Program Description:** Rates are paid for medically necessary inpatient hospital admissions for TCB consumers. Covered services include semi-private accommodations, meals, nursing services, and all necessary ancillary services/supplies ordered by a physician. Private accommodations if required for medical reasons. Services can only be provided in relation to medically required services essential to the individual's vocational rehabilitation program. **Methodology:** Inpatient hospital services are paid based on contractual agreements between the Texas Rehabilitation Commission and the respective hospitals **Rate Cycle:** The entire Maximum Affordable Payment System (MAPS) system is reviewed annually.	**Utilization:** Approximately 850 cases with one or more admissions per year. **Provider Base:** Approximately 100 hospitals.
Type of Rate: Outpatient Hospital **Agency:** TCB	**Program Description:** Rates are paid for medically necessary eye diagnostics, surgery, and treatment performed in emergency room, outpatient hospital, and ambulatory surgery center settings. Outpatient hospital services are diagnostic, therapeutic, or rehabilitative services delivered by or under the direction of a physician in a licensed hospital setting. Services may be delivered in an emergency room, clinic setting or observation room of a hospital, ambulatory surgical center (ASC) or hospital outpatient setting. **Methodology**: TCB utilizes the Centers for Medicare and Medicaid Services (CMS) methodology of facility fee maximum payments, for eye services, with modification to a single statewide rate for each procedure done on an outpatient basis. TCB utilizes contractual agreements between the Texas Rehabilitation Commission and the respective hospitals for payment of outpatient hospital services not involving the eye. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Approximately 600 cases with one or more encounters per year. **Provider Base:** Approximately 100 hospitals and 100 ASCs.
Type of Rate: Physician Services **Agency:** TCB	**Program Description:** Rates are paid for medically necessary physician services. Services must be ordered and performed by a physician or under the personal supervision of a physician, and must be within the scope of practice of his/her profession as defined by state law. Services include office visits, diagnostics, surgery and treatment. Rates are also paid to optometrists for those services outlined in state law. **Methodology:** Payment is based on the CMS basic rate structure, specifically a modification of the relative value units adjusted by the Medicare conversion factor as applied to the Current Procedural Terminology. For eye related procedures, adjustments are made for co-managed care, global period, multiple procedures, as well as "non-facility" and "in-facility" payments. For non-eye related procedures, payment amounts to physicians are the CMS base structure, as modified by the Texas Rehabilitation Commission. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Approximately 6,200 cases per year, with one or more encounters. **Provider Base:** Approximately 1,000 qualified medical practitioners.

Type of Rate: Anesthesiology Services **Agency:** TCB	**Program Description:** Rates are paid for anesthesiology services essential to diagnostic and surgical procedures performed in relation to TCB consumer rehabilitation programs. **Methodology:** Payment is based on up to 50% of the amount paid to the surgeon. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Unknown, approximately 725 cases received Ancillary Surgery Services, which among other services, includes Anesthesiology. **Provider Base:** Approximately 125 vendors, including physicians, CRNAs, and groups
Type of Rate: Pathology/Lab/ Radiology **Agency:** TCB	**Program Description:** Rates are paid for services ancillary to diagnostic and surgical procedures performed in relation to TCB consumer rehabilitation program. **Methodology:** Payment is based on the CMS base payment structure, specifically as modified by the Texas Rehabilitation Commission and applied to the Current Procedural Terminology. Payment is distinguished for Technical, Professional and Total Service components. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Unknown, approximately 725 cases received Ancillary Surgery Services, which among other services, includes Pathology, Lab and Radiology. **Provider Base:** Approximately 100 vendors, including physicians or groups.
Type of Rate: Psychological Services **Agency:** TCB	**Program Description:** Rates are paid for assessment and counseling services performed by individuals meeting state criteria for psychological, neuropsychological services and counseling services. Specific training and experience are required for administration of the comprehensive instruments specific to individuals with vision loss. **Methodology:** Payment for assessment is based on the Medicare model, modified by the amount of time required to administer each tool to a person with vision loss. Level of payment for counseling depends on the vendor's academic credentials and the type of setting, individual or group. Individual counseling is paid at $73 for doctorate level, and $55 for master's level (Licensed Professional Counselor or Master's Social Worker). Group counseling is paid at $31 per hour for doctorate level and $23 for the master's level. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Approximately 120 cases with one or more encounters per year. **Provider Base:** Approximately 50 vendors, including psychiatrists, psychologists, and other licensed practitioners.

Type of Rate: Low Vision Services **Agency:** TCB	**Program Description:** Rates are paid for optical specialty services designed to maximize use of residual vision through optical devices. Services include professional services and supply of the optical devices. **Methodology:** Payment for glasses, prescriptions and optical devices are based on the CMS rates for eye prosthetics and supplies, as delineated in the national Level II V-codes. For optical devices not listed in the V-codes, payment is based on 4 representative national supplier's price lists. For components not found in an external system, rates are set internally based on the unique needs of persons with vision loss. **Rate Cycle:** The entire MAPS system is reviewed annually.	**Utilization:** Approximately 1,500 cases with one or more encounters or services per year. **Provider Base:** Approximately 150 vendors, including licensed medical practitioners, and equipment suppliers.
HEALTH AND HUMAN SERVICES COMMISSION (HHSC)		
Type of Rate: CHIP Managed Care Capitation Rates **Agency:** HHSC	**Program Description:** Children's Health Insurance Program - Provides health insurance for Children under 200% of the federal poverty level through participating HMOs. **Methodology:** The first year CHIP premium rates were determined using a bid process. HHSC specified a set of target premium rates, but HMOs were allowed to propose any rate they determined to be appropriate. The target rates were developed based on Medicaid experience. The initial rates covered the period May 1, 2000 through September 30, 2001. The second year CHIP premium rates are to cover the period October 1, 2001 through September 30, 2002. The rates were negotiated with each individual health plan based on the experience of the health plan. **Rate Cycle:** Annual rate adjustments are negotiated with HMOs.	**Utilization:** Approximately 496,000 clients were enrolled in CHIP at the end of FY01. **Provider Base:** 13 health plans participate in the CHIP program.
COMMISSION FOR THE DEAF AND HARD OF HEARING (TCDHH)		
Type of Rate: Interpreter Services **Agency:** TCDHH	**Program Description:** TCDHH adopts rates for interpreter services. **Methodology:** The rates are established as the best value through competitive bid on a biennial basis and may be reviewed and revised as deemed necessary by TCDHH. Rates for interpreter services are graduated to reflect the skill level of the interpreter. Rates apply only when the Commission determines that there is not sufficient competition among interpreter services within a particular region to provide interpreter services at a fair market price. The fee schedules adopted by TCDHH must be adopted by other state agencies that purchase interpreter services. **Rate Cycle:** Biennially.	**Utilization**: Approximately 1.9 million possible users statewide. **Provider Base:** 23 service providers contract with TCDHH throughout the state. Additional providers may contract with other state agencies, but they must comply with the rates for that region.

TEXAS DEPARTMENT ON AGING (TDoA) **Note: While the unit of service that is reimbursed is consistent across the state, the procurement methodology required by the federal regulations results in reimbursement rates being set at the local level.**		
Type of Rate: Adult Day Care **Agency:** TDoA	**Program Description:** An array of services provided in a congregate, non-residential setting to dependent older persons who need supervision but do not need institutionalization. These services may include any combination of social or recreational activities, health maintenance, transportation, meals and other supportive services. **Methodology:** Unit of Service: A Half-Day. Three hours but less than six hours of service provided by the facility shall constitute one unit of service. Six hours or more of service shall constitute two units of service. Time spent for transportation to and from day care, if provided by the facility, is included in calculating the amount of service provided. Less than three hours of service at any one time is not considered to be a unit of service **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 20,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Caregiver Respite Care In-Home **Agency:** TDoA	**Program Description:** Temporary relief for caregivers that includes an array of services provided to dependent older persons who need supervision. Services are provided in the client's home environment on a short-term, temporary basis while the primary caregiver is unavailable or needs relief. In addition to supervision, services may include meal preparation, housekeeping, assistance with personal care and/or social and recreational activities. **Methodology:** Unit of Service: One Hour. **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 33,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Congregate Meals and Home Delivered Meals **Agency:** TDoA	**Program Description:** A hot or other appropriate meat served to an eligible person which meets one-third (1/3) of the recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the National Academy of Sciences - National Research Council. There are two types of congregate and home delivered meals as follows: § Standard meal - the regular meal from the standard menu that is served to the majority or all of the participants. § Therapeutic meal or liquid supplement - a special meal or liquid supplement that has been prescribed by a physician and is planned specifically for the participant by a dietician, i.e., diabetic diet, renal diet, pureed diet, tube feeding. **Methodology:** One Meal **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 4 million congregate meals and 4 million home delivered meals per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Health Maintenance **Agency:** TDoA	**Program Description:** The provision of services, drugs, and/or equipment which will prevent, alleviate, and/or cure the onset of acute and/or chronic illness, increase awareness of special health needs, and/or improve the emotional well-being of an older individual. This includes the provision of services by a health professional other than "health screening/monitoring" or "mental health" services, and includes, but is not	**Utilization:** Approximately 30,000 units per year. **Provider Base:** No statewide database

	limited to, dental treatment, health education, home health services (nursing, physical, speech, or occupational therapy), or the provision of medications, glasses, dentures, or hearing aides. **Methodology:** One Contact. Record one contact each time a client receives a health service as described above. **Rate Cycle:** September 1 of each year.	of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Health Screening Monitoring **Agency:** TDoA	**Program Description:** Investigation or analysis by a medical or health professional to determine the need for a health service, including routine testing for blood pressure, hearing, vision, diabetes and anemia, or the periodic checking/monitoring of a known condition, such as monthly blood pressure checks for hypertension or hematocrit tests for anemia. This service should include appropriate referrals and follow-up when warranted. **Methodology:** One Contact. Record one contact each time a client receives a separate health screening or monitoring service. **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 5,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Homemaker **Agency:** TDoA	**Program Description:** A service provided by trained and supervised homemakers Involving the performance of housekeeping/home management, meal preparation and/or escort tasks and shopping assistance, provided to individuals who need assistance with these activities in their place of residence. The objective is to help the recipient sustain Independent living in a safe and healthful home environment. Does not include personal assistance services. **Methodology:** One Hour **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 200,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Hospice **Agency:** TDoA	**Program Description:** An array of services provided either in the home or in a residential setting to elderly persons suffering from a terminal illness. Services include medical care under the supervision of a physician, counseling for the person and the family members, and other supportive services. **Methodology:** One Contact **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 1,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Legal Assistance – 60 years and older **Agency:** TDoA	**Program Description:** Advice and representation by an attorney (including assistance by a paralegal or law student under the supervision of an attorney), or counseling or representation by a non-lawyer where permitted by law, to older individuals with economic and social needs. Legal assistance activities include the following: Advice/Counseling - a recommendation made to a client regarding a course of conduct, or how to proceed in a matter, given either on a brief or one-time basis, or on an ongoing basis, and given by telephone or in person.	**Utilization:** Approximately 128,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.

	Document Preparation - personal assistance given to a client which helps him in the preparation of necessary documents relating to public entitlements, health care/long term care, individual rights, planning/protection options, and housing and consumer needs. Representation - advocacy on behalf of a client in protesting or complaining against a procedure, or seeking special considerations appealing an administrative decision, or representation by an attorney of a client or class of clients in either the state or federal court systems. **Methodology:** One Hour **Rate Cycle:** September 1 of each year.	
Type of Rate: Personal Assistance **Agency:** TDoA	**Program Description:** Assisting another person with tasks that an individual would typically do if he were able. This covers hands-on assistance in all activities of daily living. **Methodology:** One Hour. Does not include travel time, unless it is directly related to the client's care plan. **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 90,000 units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
Type of Rate: Transportation – Demand/Response **Agency:** TDoA	**Program Description:** Taking an older person from one location to another. (This does not include any other activity.) There are two types of transportation service, as follows: Demand/Response-transportation designed to carry older persons from specific origin to specific destination upon request. Clients request the transportation service in advance of their need, usually twenty-four to forty-eight hours prior to trip. **Methodology:** Unit of Service – One, One-Way Trip. (i.e. one person traveling in one direction from one place to another.) **Rate Cycle:** September 1 of each year.	**Utilization:** Approximately 1.1 million units per year. **Provider Base:** No statewide database of providers. Area Agencies on Aging contract with local providers for service.
TEXAS DEPARTMENT OF PROTECTIVE AND REGULATORY SERVICES (PRS)		
Type of Rate: 24-Hour Residential Child-Care Services **Agency:** PRS	**Program Description:** PRS provides financial reimbursement for the cost of care and treatment of children who have been removed from their homes and placed in 24-hour child-care facilities, such as foster homes and residential care facilities, as a result of an allegation of abuse or neglect. Providers who care for children in PRS' conservatorship are provided a daily rate according to the level of care of the child that is generally assessed by an independent, third-party contractor. Services provided to children include basic maintenance (housing, food, transportation, clothing and miscellaneous); direct care and supervision; case management; treatment coordination; administration; overhead; and therapy, medical and dental costs not covered by Medicaid. **Methodology:** Statewide daily reimbursement rates for **foster homes** for level of care (LOC) 1 are based on data reported by the United States Department of Agriculture for middle income, dual parent households for	**Utilization:** Approximately 13,500 average monthly foster care clients, expressed as full-time equivalents, in 24-hour residential child-care. **Provider Base:** Approximately 6,173 providers of 24-hour residential child-care that includes 3,363 PRS foster homes, 2,639 Child-Placing Agencies and Homes, 111 Residential Care

	the "Urban South" excluding costs for healthcare and child care and education. Costs are inflated to the middle of the biennium using the Implicit Price Deflator-Personal Consumption Expenditures (IPD-PCE) Index. Two rates are established with an age differential from "0 to 11" years of age and "12 and up." Statewide daily reimbursement rates for **foster homes** for LOC 2 through 4 are based on a statistically valid sample of completed foster home cost surveys covering one month of service. Statewide daily reimbursement rates for **emergency shelters** are based on an annual cost report submitted every other year. Shelters must maintain at least a 30% occupancy rate to be included within the rate-setting population. Statewide daily reimbursement rates for **child-placing agencies** for levels of care 1 through 4 are based on annual cost reports submitted every other year. A rate-setting model is applied to cost reports within the rate-setting population for that level of care. Child-placing agencies must maintain at least 30% of their service days within a level of care to be included in the rate-setting population. Statewide daily reimbursement rates for **residential care facilities** for levels of care 1 and 2 are the same as the child-placing agency rate. Statewide daily reimbursement rates for **residential care facilities** for levels of care 3 through 6 are based on annual cost reports submitted every other year. A rate-setting model is applied to cost reports within the rate-setting population for that level of care. Residential care facilities must maintain at least a 50% occupancy rate and must maintain at least 30% of their service days within a level of care to be included in the rate-setting population. For levels of care 5 and 6 the residential care facility must provide at least 40% of state-placed services (versus private days) to be included in the rate-setting population. For all level of care rates, except LOC 1, total costs are divided by total days of care to calculate a daily rate for each provider in the rate-setting population. The total cost per day is inflated to the middle of the biennium using the IPD-PCE Index. The rate is established by the sample population's central tendency, which is defined as the average of the population after applying two standard deviations. Finally, all rates are equitably adjusted to the level of appropriations authorized by the legislature using the same assumptions regarding the number of full-time equivalent children at each level of care for setting rates as the legislature used to establish the appropriation. The PRS Board considers staff recommendations based on the described methodology, legislative direction, agency service demands, public testimony and the availability of appropriated revenue when adopting rates. **Rate Cycle:** Rates are updated at the beginning of each state biennium. Since increased funding was appropriated at a different percentage for each year of the FY 2002-2003 biennium, the rates will be set separately instead of establishing a biennial rate.	Facilities, and 60 Emergency Shelters (FY 2001 statistics).

TEXAS REHABILITATION COMMISSION (TRC)		
Type of Rate: Inpatient Hospital **Agency:** TRC	**Program Description:** Inpatient hospitalization is authorized when medically necessary and identified as a planned service to achieve a positive vocational outcome. Authorized services may be diagnostic, therapeutic, restorative or rehabilitative. Covered services include semi-private room, meals, nursing services, all necessary ancillary services/supplies ordered by the physician and any professional medical services provided by the facility. Private room may be authorized if the only room available or with physician orders confirming medical necessity. **Methodology:** Fee for service – based on established contract rates. All hospitals authorized to provide services must be identified by active contracts. Contracts are negotiated based on: · availability of qualified providers to provide assessment and treatment, · availability of qualified providers within a geographic distribution that mirrors client/claimant distribution, and · rates that represent best value, established based on factors that include reasonable and customary industry standards and Medicare cost factors when available. **Rate Cycle:** Less than 5 years.	**Utilization:** Fiscal Year 2001 1,782 admissions **Provider Base:** 396 contracted hospitals
Type of Rate: Outpatient Hospital **Agency:** TRC	**Program Description:** Outpatient hospitalization is authorized when medically necessary and identified as a planned service to achieve a positive vocational outcome. Authorized services may be diagnostic, therapeutic, restorative or rehabilitative. Covered services include nursing services, all necessary ancillary services/supplies ordered by the physician and any professional medical services provided by the facility. **Methodology:** Fee for service – based on established contract rates. All hospitals authorized to provide services must be identified by active contracts. Contracts are negotiated based on: · availability of qualified providers to provide assessment and treatment, · availability of qualified providers within a geographic distribution that mirrors client/claimant distribution, and · rates that represent best value, established based on factors that include reasonable and customary industry standards and Medicare cost factors when available. **Rate Cycle:** Less than 5 years.	**Utilization:** Fiscal Year 2001 7,263 services **Provider Base**: 396 contracted hospitals
TEXAS DEPARTMENT OF HEALTH (TDH)		
Type of Rate: Service Delivery Integration Project	**Program Description:** Service Delivery Integration (SDI) is not a program but an initiative, integrating several direct health care delivery programs' clinical and business functions. Programs currently included in the pilot of the initiative: Primary Health Care, Title V, Title XX, and Tuberculosis Elimination.	**Utilization:** In FY20'01, 7,905 unduplicated clients received medical services at the initiative pilot

Agency: TDH	**Methodology:** Fee-for-Service (FFS) through adoption of State Medicate Rates set using Texas Medicaid Reimbursement Methodology **Rate Cycle:** Rates change when State Medicaid rates change.	sites. **Provider Base:** Pilots are Denton County Health Department, Fayette Memorial Hospital, Smith County Public Health District, and Tarrant County Health Department.
Type of Rate: Medical benefit: Inpatient and Outpatient Facility Hemodialysis Treatments **Agency:** TDH	**Program Description:** The Kidney Health Care (KHC) program pays for medically necessary inpatient and outpatient hemodialysis treatments. **Methodology:** Rate was determined by using $117.00, which was the Medicare approved amount for unassigned freestanding dialysis facilities. Kidney Health Care (KHC) pays 60% of this rate. KHC pays a maximum of 14 treatments per month. Flat rate is $70.20 per treatment. **Rate Cycle:** This rate was established on 2/1/00 and there have been no changes since.	**Utilization:** Patients in their pre-Medicare period and patients who are not eligible for Medicare and/or Medicaid or private group health insurance coverage **Provider Base:** Approximately 292 outpatient dialysis centers and 84 hospitals for a total provider base of 376.
Type of Rate: Medical benefit: Peritoneal dialysis, including Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) **Agency:** TDH	**Program Description:** Kidney Health Care program pays for medically necessary peritoneal dialysis treatments, including CAPD and CCPD. **Methodology:** Rate was determined using the facility hemodialysis rate of $70.20 per treatment multiplied by 13 (number of treatments per month) multiplied by 12 (months per year) and divided by 365 (days per year) for a flat rate of $30.00 per day and the maximum number of days is 31 per month. **Rate Cycle:** This rate was established on 2/1/00 and there have been no changes since.	**Utilization:** Patients who are not eligible for Medicare and/or Medicaid or private group health insurance coverage **Provider Base:** Approximately 292 outpatient dialysis centers
Type of Rate: Medical benefit: Peritoneal dialysis training **Agency:** TDH	**Program Description:** The Kidney Health Care program pays for medically necessary peritoneal dialysis training. **Methodology:** Rate is based on $82.20 ($70.20 + $12 additional charge) multiplied by 13 (number of treatments per month) multiplied by 12 (months per year) and divided by 365 (days per year) for a flat rate of $35.13 per day and the maximum number of days per training is 14. **Rate Cycle:** This rate was established on 2/1/00 and there have been no changes since.	**Utilization:** Patients who are not eligible for Medicare coverage **Provider Base:** Approximately 292 outpatient dialysis centers
Type of Rate: Allowable access surgery procedures and hospitalization	**Program Description:** The Kidney Health Care program pays for medically necessary allowable access surgery procedures and hospitalization for access surgery. **Methodology:** Reimbursement for physician's services for access surgery is based on the effective Medicaid	**Utilization:** Patients in their pre-Medicare period and patients who are not eligible for Medicare coverage.

Agency: TDH	rate when procedure is added to program, and reimbursement for hospitalization services for access surgery is based on the ratio of cost to charges rate at the time the hospital is enrolled into the program. KHC established a maximum payment of $4,100 per hospital stay for access surgery. **Rate Cycle:** No rate cycle	**Provider Base:** Approximately 84 hospitals and 227 physicians for a total provider base of 311.
Type of Rate: Drugs **Agency:** TDH	**Program Description:** The Kidney Health Care program pays for allowable outpatient drugs and drug products. **Methodology:** The KHC allowable drug rate is the same as Medicaid drug rates. KHC changes rates when Medicaid drug rates change. KHC has a separate allowable drug list from Medicaid. **Rate Cycle:** As Medicaid rates change	**Utilization:** Patients who are not eligible for drug coverage under a private/group health insurance plan, or those receiving Medicaid unlimited prescription benefits. **Provider Base: There are 3,400** KHC participating pharmacies.
Type of Rate: Travel **Agency:** TDH	**Program Description:** The Kidney Health Care program pays for allowable patient travel. **Methodology:** The KHC rate for allowable travel is 13 cents per mile. There is a monthly cap of $200.00 per patient. Payment is made based on the number of trips up to a maximum of 13 per month and the established round trip mileage on file. **Rate Cycle:** None, based on budgetary limitations	**Utilization:** Patients who do not receive free travel or who are not eligible for transportation benefits under the Medicaid Transportation Program. **Provider Base:** None
Type of Rate: Blood product reimbursement **Agency:** TDH	**Program Description:** The Adult Hemophilia Assistance Program provides limited reimbursement for blood derivatives or manufactured pharmaceutical products for eligible persons with hemophilia (age 21 or older) who are uninsured or underinsured. Medicaid and Medicare clients are not eligible. List of covered products is reviewed and updated annually. **Methodology:** Based on Medicaid rates **Rate Cycle:** September 1 of each year	**Utilization:** 18 clients served in Fiscal Year 2001 **Provider Base:** 4 providers; pharmacy provider agreements required.
Type of Rate: Title V MCH Fee for Service (FFS) Direct Care **Agency:** TDH	**Program Description:** Title V Maternal & Child Health Direct Care for Prenatal, Infant/Child/Adolescent Health, Dysplasia, and Dental Services for Children/Adolescents ambulatory care through contracted Medicaid providers for delivery of routine and preventive care for income eligible clients. **Methodology:** Rates are based on 1996 Medicaid payments for bundled groups of common ambulatory care services, factored to account for estimated costs of services for an estimated percentage of clients and then augmented to allow for the recovery of administrative costs **Rate Cycle:** Publicly Issued Competitive Request for Proposal Process every 3 years.	**Utilization:** Texas residents earning less than 185% FPL but not eligible for Medicaid or CHIP (est. 94,000 unduplicated clients in FY 2000) **Provider Base:** 77 selected contractors distributed statewide (186 cos.), such as Local Health Departments, Community Health

		Center clinics, Public-Private & Teaching Hospitals, and private physician offices
Type of Rate: Fee for Service (FFS) Direct Care High Risk Case Management **Agency:** TDH	**Program Description:** Title V Maternal & Child Health Direct Care for High Risk Case Management Services to enable Title V eligible pregnant women and infants with high risk conditions to access health care resources. **Methodology:** Based on Medicaid rates in effect for the initial period of the contract term as defined in the Competitive Request for Proposal published each 3 years. **Rate Cycle:** Publicly Issued Competitive Request for Proposal Process each 3 years.	**Utilization:** Pregnant and Infant Texas residents earning less than 185% FPL but not eligible for Medicaid or CHIP with diagnoses of selected high risk conditions (est. 300 unduplicated clients in FY00) **Provider Base:** 41 qualifying contractors statewide (133 counties), such as Local Health Departments, Community Health Center clinics, Public – Private & Teaching Hospitals
Type of Rate: Fee for Service (FFS) Direct Care Family Planning Services **Agency:** TDH	**Program Description:** Title V Maternal & Child Health Direct Care for Family Planning Services for female clients including gynecologic care for infertile females and sterilization procedures for selected males. **Methodology:** Adoption of rates established by the TDH Associateship for Family Health Family Planning Division for the Title XX Program, which is based on Medicaid reimbursement rates. **Rate Cycle:** Annual re-assessment by the TDH Associateship for Family Health Family Planning Division for the Title XX Program.	**Utilization:** Texas residents earning less than 185% FPL but not eligible for Medicaid or CHIP who are females through age 44 or cessation of fertility; or males age 22+ seeking sterilization procedures (est. 54,000 unduplicated clients in FY00) **Provider Base:** 62 selected contractors distributed statewide (171 cos.), such as Local Health Departments, Community Health Center clinics, Public-Private & Teaching Hospitals, and private physician offices.
Type of Rate: Title V Genetic Fee for Service Agency: TDH	**Program Description: Title V Maternal and Child Health Genetics program rates are paid for medically necessary genetic services. Services must be ordered and performed by a geneticist or under the personal supervision of a geneticist, and must be within the scope of practice of his/her profession as defined by state law. Services include office visits, laboratory tests, diagnosis and treatment.** **Methodology:** Texas Medicaid rates for genetic services are used except for initial visit genetic services (including history, psychosocial evaluation and physical examination) and follow-up genetic physical	**Utilization:** $1.5 million was encumbered in FY2002 **Provider Base:** 9 Genetic Centers

	examinations. For the Texas Medicaid rated, a modified Resource Based Relative Value Scale (RBVS) fee schedule similar to Medicare is used, but it also includes over 800 "Access-Based Fees" (ABFs) which account for more than 50 percent of professional expenditures. The Texas Medicaid Reimbursement Methodology (TMRM) has no geographical or specialty differentiation. The conversion factor ($27.28) for non-anesthesiology services is multiplied by the appropriate Relative Value Unit to determine payment, or an ABF is applied. Most of the ABFs were developed specifically for Texas Medicaid because many obstetric and pediatric procedures were not appropriately considered in the Medicare system. ABFs have been implemented to assure adequate access for Texas Medicaid clients. The initial physical examination and psychosocial evaluation are based on Medicaid genetic services rates but are augmented by 23% for administrative case management. Follow-up visits were added with reimbursements depending on the complexity of the follow-up. **Rate Cycle:** Rates are updated when the Medicaid rates are updated.	
Type of Rate: screening and diagnostic procedures for breast and cervical cancer **Agency:** TDH	**Program Description:** Rates are paid on a fee-for-service basis for procedures performed under the Breast and Cervical Cancer Control Program. Procedures include office visits, mammograms, Pap smears, biopsies, ultrasounds, colposcopy, and anesthesia. **Methodology:** Reimbursement is based on the average Medicare rate for each CPT code approved by the program. The Medicare rates for Texas are averaged, with outliers being discarded. Medicare rates are required per federal legislation. **Rate Cycle:** September 1 of each year. Rates are re-calculated annually.	**Utilization:** Approximately 17,000 women served annually. **Provider Base:** Approximately 300 sites. Providers include community health centers, local health departments, public health regions, medical and professional schools, hospital districts, Planned Parenthood and other family planning agencies, and YWCAs.
Type of Rate: Family Planning **Agency:** TDH	**Program Description:** Facilitates statewide delivery of preventive, comprehensive health care services to low-income women and men in Texas in order to reduce unintended pregnancies, improve health status, and positively affect future pregnancy outcomes. The non-Medicaid family planning services are funded by Title X and Title XX. Family Planning contractors are awarded contracts to provide family planning services based on their applications and contracts with TDH. Title XX, Social Service Block Grant funds are awarded to contractors to support fee-based family planning services. Title X, Public Health Service Grant funds are awarded to family planning contractors to support the operational and infrastructure costs for service delivery. **Methodology:** Title XX family planning services are provided to eligible clients by TDH/FPD contractors using a fee schedule based on current Title XIX Family Planning Medicaid reimbursement rates. **Rate Cycle:** The fee schedule is not updated on a pre-determined cycle.	**Utilization:** During FY 01, Family Planning providers served 192,700 unduplicated clients for approximately 329,300 visits. **Provider Base:** Services were provided by 60 contractors and three of the Texas Department of Health's Regional Clinics.
Type of Rate: Emergency Dental Services for Texas school-children **Agency:** TDH	**Program Description:** Fee for Service Program provides emergency dental services for low-income Texas school children. Children are nominated by School Nurses. After approval by Regional Dental Director, participating dentist provides services up to $500 per year, per child. **Methodology:** Rates for services are the same as the rates set for the Children's Health Insurance Program (CHIP) dental services.	**Utilization:** During FY01, 1525 children received services at a cost of $280,024. **Provider Base:** Services are provided by approximately 610 dentists, who are licensed by the Texas State Board of

	Rate Cycle: Fee schedule not updated on a predetermined cycle.	Dental Examiners, and who have contracted with the program.
Type of Rate: Inpatient Hospital **Agency:** TDH	**Program Description**: Children with Special Health Care Needs (CSHCN) inpatient hospital services include medically necessary items and services ordinarily furnished by a hospital under the direction of a physician for the care and treatment of inpatient clients. Reimbursement to hospitals for inpatient services is limited to 60 days per calendar year of inpatient acute hospital care, and 90 days of inpatient rehabilitation, which may occur intermittently or consecutively. Once the maximum days of inpatient care have been provided, reimbursement for additional inpatient care is not considered until the next calendar year. Hospital services must be medically necessary, and are subject to the utilization review requirements of the Children with Special Health Care Needs (CSHCN) Program. **Methodology**: Inpatient hospital stays are reimbursed at 80% of the rate equivalent to the hospital's Medicaid interim rate [equivalent to the rate authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which is based on a percentage of the Medicaid hospital's standard charges derived from the Medicaid hospital's most recent tentative or final Medicaid cost report settlement. CSHCN does not have a separate cost settlement process. **Rate Cycle:** Follows Medicaid's rate cycle.	**Utilization:** In FY 00, total hospital days were 6,525 (data run 12/14/01); In FY 00, total inpatient hospital expenditures through 9/30/01 were $10.5 million, 605 persons received inpatient hospital services, with a cost per person served of $17,400. **Provider Base:** Medical professionals and facilities throughout the state that participate in the program must be Medicaid providers and enroll in CSHCN.
Type of Rate: Outpatient Hospital Services **Agency:** TDH	**Program Description**: CSHCN benefits include those diagnostic, therapeutic, rehabilitative or palliative items or services deemed medically necessary and provided by a CSHCN hospital or under the direction of a physician to an outpatient. Outpatient hospital services include those services performed in the emergency room or clinic setting of a hospital. This category also includes outpatient hospital ambulatory surgery facility charges. **Methodology:** Outpatient services are reimbursed at 80 percent of rate equivalent to the hospital's Medicaid interim rate [equivalent to the rate authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)], which is based on a percentage of the Medicaid hospital's most recent tentative or final Medicaid cost report settlement. Reimbursement of day surgeries is based on the CMS-approved Ambulatory Surgical Code Groupings payment schedule. **Rate Cycle:** Follows Medicaid's rate cycle.	**Utilization:** In FY 00, total outpatient hospital expenditures through 9/30/01 were $2.7 million; 2514 persons received outpatient hospital services, with a cost per person served of $1057. **Provider Base:** Medical professionals and facilities throughout the state that participate in the program must be Medicaid providers and enroll in CSHCN.
Type of Rate: Physician Services **Agency:** TDH	**Program Description**: CSHCN services include office visits, diagnosis, surgery and treatment. Services must be medically necessary and within the scope of practice of his/her profession as defined by state law. **Methodology:** The CSHCN program reimburses physicians based on the Texas Medicaid Reimbursement Methodology (TMRM) adopted by Medicaid. This method is used to reimburse physician services, services incidental to physician services, diagnostic tests (other than clinical laboratories) and radiology services. TMRM is based on Medicare's resource based relative value scale (RBRVS) with Medicaid modifications. Some of the differences include: access-based fee adjustments for specific services; a flat structure applicable on a statewide basis; no geographic or specialty differences. **Rate Cycle:** Follows Medicaid's rate cycle.	**Utilization:** In FY 00, total physician and professional service expenditures through 9/30/01 were $2.2 million; 3,462 persons received physician/professional services, with a cost per person served of $649. **Provider Base:** Medical professionals and facilities throughout the state that participate in the program must be Medicaid providers and enroll in CSHCN.

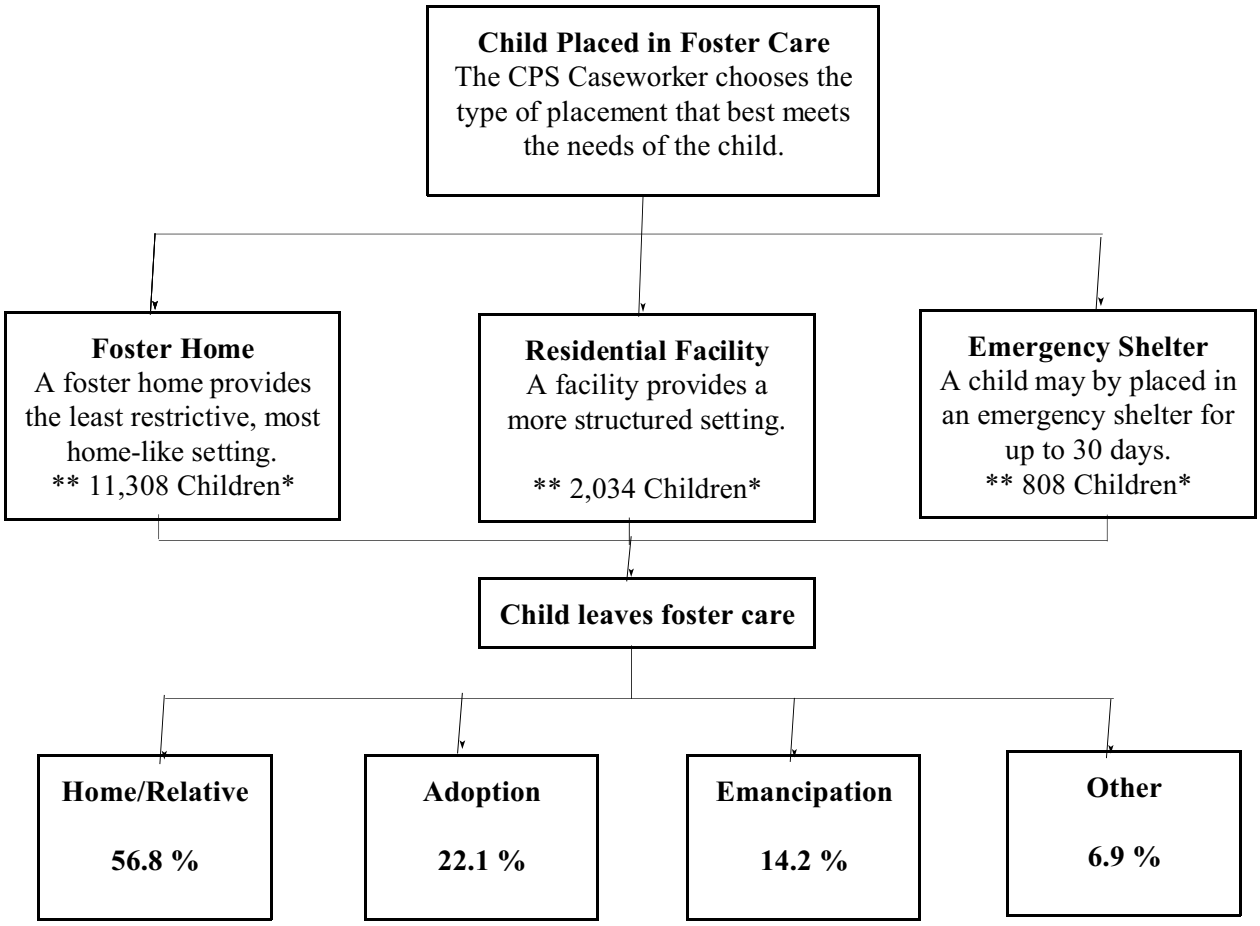
Type of Rate: Durable Medical Equipment **Agency:** TDH	**Program Description:** CSHCN provides medically necessary **d**urable medical equipment (DME) that is prescribed by a physician. **Methodology:** DME is reimbursed according to a fee schedule or a weighted discount methodology. Most DME rental or purchase is reimbursed according to the fee schedule using the HCPCS or Medicaid local codes. Purchase of standard or customized equipment including power equipment ordered from the manufacturer specifically for the client may be reimbursed at the manufacturer's suggested retail price minus 18 percent. **Rate Cycle:** Follows Medicaid's rate cycle.	**Utilization:** In FY 00, total expenditures for durable medical equipment (appliances) through 9/30/01 were $1.8 million; 564 persons received durable medical equipment, with a cost per person served of $3120. **Provider Base:** Medical professionals and facilities throughout the state that participate in the program must be Medicaid providers and enroll in CSHCN.
Type of Rate: Meals, Transportation, Lodging **Agency:** TDH	**Program Description:** The CSHCN Program covers transportation, meals and lodging expenses to enable clients to obtain medically necessary medical care away from their home- town. The program may cover the transportation cost for the remains of a client who expires in a CSHCN participating facility, while receiving CSHCN program services away from the client's hometown. The program will also cover the transportation cost of a parent or other person accompanying the remains. **Methodology:** MEALS: The program reimburses up to the amount specified in the current State of Texas Travel Allowance Guide as per diem meal expenses. LODGING: The program reimburses up to the amount contracted with the Texas Medicaid Medical Transportation Program (MTP), not to exceed the amount specified in the current State of Texas Travel Allowance Guide as per diem lodging expenses plus all applicable hotel occupancy taxes. MILEAGE: The program reimburses the distance and amount per mile as specified in the current State of Texas Travel Allowance Guide; the amount negotiated by the MTP with contractors such as intercity buses, vans, cabs or urban mass transit authorities; the air fare price reflecting the state discount if ordered by MTP, or the billed amount, if MTP had no opportunity to coordinate transportation in an emergency; and the billed cab fare amount or other transportation is unavailable, or the MTP is unable to coordinate transportation. The program also pays an administrative fee to social service organizations equal to the percentage of the charge for meals, lodging and transportation negotiated by the MTP with these entities. TRANSPORTATION OF REMAINS: a) first call: $75.00, b) embalming: $100.00, c) container: $75.00, d) mileage billed by funeral home: $1.00 per mile, e) air freight: billed amount. AMBULANCE SERVICES: the lower of the billed amount or the maximum charge allowed by the Texas Medicaid Program. **Rate Cycle:** Same as Medicaid, with the exception of Transportation of Remains (not a Medicaid covered service). Transportation of Remain rates are documented in rule.	**Utilization:** In FY 00, total expenditures for transportation through 9/30/01 were $.3 million, 995 persons received transportation services with a cost per person of $251. In FY 00, total expenditures for meals and lodging were $.2 million; 683 persons received meals and lodging, with a cost per person served of $310. **Provider Base:** Providers who are enrolled in the Medicaid Medical Transportation Program. Funeral Homes are enrolled only as needed.
Type of Rate:	**Program Description:** CSHCN provides medications and supplies that are medically necessary and	**Utilization:** In FY 00, total drug and

Drugs and Supplies **Agency:** TDH	prescribed by a physician. **Methodology:** OUTPATIENT MEDICATIONS: a) The program reimburses medications covered by Medicaid and billed by pharmacies using the same drug costs and dispensing fees allowed by the Texas Medicaid Vendor Drug Program, b) The program reimburses for medications not covered by the Medicaid program and billed by pharmacies the lower of the billed amount or the drug cost available through the database used by the Texas Medicaid Vendor Drug Program plus the same dispensing fees allowed by the Texas Medicaid Vendor Drug Program, c) The program reimburses Medicaid covered medications billed by hospitals the lower of the billed amount or the drug cost available through the database used by the Texas Medicaid Vendor Drug Program plus $2.28 divided by .970, and d) hemophilia blood factor products, the lower of the billed price or the United States Public Health Services (USPHS) price in effect on the date of service plus a dispensing fee of $.04 per unit of factor. SUPPLIES: The program reimburses the lower of the billed amount or the amount allowable by the United Stated Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if available, or by the Texas Medicaid Program. **Rate Cycle:** Same as Medicaid, with the exception of hemophilia product rates, which are revised quarterly.	supplies expenditures through 9/30/01 were $8.6 million; 3151 persons received drugs and supplies, with a cost per person served of $2726. **Provider Base: Pharmacies and other medical professionals across that state that participate in the program must be Medicaid providers and enrolled in CSHCN.**
Type of Rate: Medical care - County Indigent Health Care Program **Agency:** TDH	**Program Description:** The County Indigent Health Care Program (CIHCP) provides reimbursement to local counties for indigent health care. A full range of medical services are covered including: · Inpatient and outpatient hospital services · Physician services · Laboratory/ X-ray services · Rural Health Clinic services · Prescription drugs · Skilled nursing facilities · Family planning services · Primary and Preventive Care Counties may also choose to provide optional services such as nursing services, physician assistant services, ambulatory surgical centers, federally qualified health care centers, diabetic supplies, durable medical equipment, dental care, emergency medical devices, home and community health care, and vision care. **Methodology:** Rates are provided to counties based on Medicaid rates to the extent possible. **Rate Cycle:** Rates are updated annually to reflect the most recent Medicaid rates.	**Utilization:** In FY01, the program paid $9.6 million to participating counties for all covered medical services. **Provider Base:** Medical professionals and facilities throughout the state participate in the program.
TEXAS DEPARTMENT OF HUMAN SERVICES (DHS)		
Type of Rate: Primary Home Care – Family Care Services	**Program Description:** Primary Home Care (PHC) /Family Care (FC) services are available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living. PHC/FC is a non-skilled, non-technical service provided to eligible clients who are functionally limited in performing daily activities. PHC/FC services are provided by an attendant and do not require the supervision of a registered nurse. Services include: personal care, home management, and escort. PHC	**Utilization:** Approximately 8,654 Title XX FC clients per month for FY 2001. The average units per client, per month for FY 2001 are approximately 47.16 for FC.

Agency: DHS	provider agencies have the option of providing Family Care (FC) services. **Methodology:** Statewide unit rates are based on annual cost reports submitted by providers. Unit rates are determined based on the weighted median cost by cost center of all providers plus 4.4%. Providers have the option to participate in enhanced funding for attendant compensation. The attendant compensation cost center rate for non-participants is based on the 1997 data base inflated to SFY 2000 and the attendant compensation cost center rate for participants is based on a pro forma model. The attendant compensation cost center rate for participants will be retroactively adjusted in cases where providers fail to meet specific spending requirements. **Rate Cycle:** September 1.	**Provider Base:** Approximately 457 contracts with Home and Community Support Services Agencies (home health agencies). (Primary Home Care contracted providers providing Family Care services may also provide Primary Home Care services to Medicaid clients.)
Type of Rate: Day Activity and Health Services **Agency:** DHS	**Program Description:** Day Activity and Health Services facilities provide daytime services Monday through Friday to clients residing in the community in order to provide an alternative to placement in nursing homes or other institutions. Services are designed to address the physical, mental, medical, and social needs of clients. Services include nursing and personal care; physical rehabilitation; noon meal and snacks; transportation; and social, educational, and recreation activities. **Methodology:** Statewide unit rates are based on annual cost reports submitted by providers. Unit rates are determined based on the median cost by cost center of all providers plus 4.4%. Providers have the option to participate in enhanced funding for attendant compensation. The attendant compensation cost center rate for non-participants is based on the 1997 database inflated to FY 2000 and the attendant compensation cost center rate for participants is based on a pro forma model. The attendant compensation cost center rate for participants will be retroactively adjusted based upon failure to meet specific spending requirements. **Rate Cycle:** September 1.	**Utilization:** Approximately 682 Title XX clients per month estimated for FY 2001. The average units per client, per month for FY 2001 are approximately 31.31 for Title XX. **Provider Base:** Approximately 321 contracts with licensed adult day care facilities. (Day Activity and Health Services contracted providers may also provide Day Activity and Health Services to Medicaid clients.)
Type of Rate: Residential Care **Agency:** DHS	**Program Description:** The Residential Care (RC) program provides services to eligible adults who require access to care on a 24-hour basis but do not require daily nursing intervention. Services include but are not limited to personal care, home management, escort, 24-hour supervision, social and recreational activities, transportation, food and room. Services provided under the RC program are delivered through one of two arrangements: supervised living or emergency care. Emergency care is a living arrangement that provides services to eligible clients while caseworkers seek a permanent care arrangement. Services are provided in licensed assisted living facilities. **Methodology:** Statewide unit rates are based on annual cost reports submitted by providers. Unit rates are determined based on the weighted median cost by cost center of all providers plus 7%. Providers have the option to participate in enhanced funding for attendant compensation. The attendant compensation cost center rate for non-participants is based on the 1997 database inflated to FY 2000 and the attendant compensation cost center rate for participants is based on a pro forma model. The attendant compensation cost center rate for participants will be retroactively adjusted based upon failure to meet specific spending requirements. **Rate Cycle:** September 1.	**Utilization:** Approximately 328 apartment based and 458 non-apartment based Title XX clients per month estimated for FY 2001. The average units per client, per month for FY 2001 are approximately 29.38 for apartment based and 29.87 for non-apartment based clients for Title XX. **Provider Base:** Approximately 208 contracts with licensed assisted living facilities. (Some of these facilities also provide assisted living/residential care in the Medicaid Community Based Alternatives program.)

Appendix R

Foster Care for Children in PRS Conservatorship ***



* FTE children, defines as one child for complete month of service
** FY 2002 Projected Year End data from CAPS Reporting Database
*** Information Provided by Child Protective Services

Child's Need

The CPS Caseworker decides what type of services the child requires

Level of Care 1 * Child has routine needs and requires few professional services.

Level of Care 2 - 6* Child has need for additional services from professional staff. Third party provider determines the level of care of the child based on information from caseworker, therapist and foster parent.