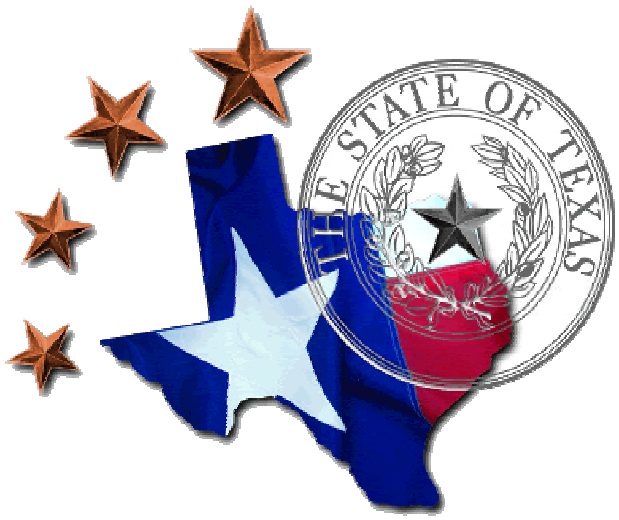
Review of the Children with Special Health Care Needs Program (CSHCN)



Prepared by the

Health and Human Services Commission

Don A. Gilbert, Commissioner

December 2001

Table of Contents

Table of Contents

Executive Summary

I. Executive Summary

The Children with Special Health Care Needs (CSHCN) program is projecting a funding shortfall in FY02-03. This has led to the implementation of a waiting list for medical and family support services. The Texas Department of Health (TDH) requested a program review from the Health and Human Services Commission (HHSC) for the purpose of addressing financial management issues and alleviating the shortfall. Commissioner Don Gilbert appointed a five-member review team from HHSC staff representing the Business Operations, Program Evaluation, and Fiscal Policy divisions.

The review team focused on verifying the shortfall data, examining specific areas of potential cost savings, and identifying program service priorities. Interviews were conducted with key central office staff, regional program staff, program contractors, and legislative offices.

This report presents 18 recommendations with a potential savings of $5.6 million in FY02 and $8.1 million in FY03. If implemented in a timely manner, these recommendations should eliminate the shortfall in FY02 and significantly reduce the waiting list. The recommendations are organized into the following categories: administrative functions, contracts and grants, medical services, financial management, and issues for further study. The table below summarizes these recommendations which have expected fiscal impacts.

Summary of Recommendations

	Savings	
Recommendation	**FY02**	**FY03**
Administrative Functions:		
1. Reduce Family Health support services administrative costs.	$100,000	$200,000
2. Reduce state office staffing.	$96,500	$193,000
3. Transfer primary eligibility determination responsibility to the regional offices.	$55,000	$110,000
4. Reorganize the central office.	$48,500	$97,000
5. Adjust salaries of Medical Doctors in managerial positions.	$30,000	$60,000
Subtotal, Administrative Functions	**$330,000**	**$660,000**

Recommendation	FY02	FY03
Contracts and Grants:		
6. Cancel, redirect the funding, and amend certain contracts.	$773,769	$718,152
Subtotal, Contracts and Grants	**$773,769**	**$718,152**
Medical Services:		
7. Allocate NHIC recoupments to the program.	$880,500	$0
8. Implement a comprehensive medical management process.	$1,400,000	$4,200,000
9. Suspend the service expansion as allowed by SB 374.	$400,000	$1,600,000
Subtotal, Medical Services	**$2,680,500**	**$5,800,000**
Financial Management:		
11. A. Continue to allocate Medicaid case management billings to staff employee benefits. B. Redirect any case management billings exceeding the cost of employee benefits to the program. C. Allocate anticipated drug rebates to the shortfall.	$600,000	$636,000
12. Reduce CSHCN Trust Account at NHIC.	$1,200,000	$0
10. Direct CSHCN Management Information System savings to the program.	$0	$249,000
Subtotal, Financial Management	**$1,800,000**	**$885,000**
GRAND TOTAL	**$5,584,269**	**$8,063,152**

Introduction

II. Introduction

PURPOSE

A projected budget shortfall in the Children with Special Health Care Needs program has led to the implementation of a waiting list for medical and family support services. Based on this projection, the Texas Department of Health (TDH) requested that the Health and Human Services Commission (HHSC) conduct a review of program operations for the purpose of alleviating the shortfall and improving program financial management. Commissioner Don Gilbert appointed a five-member team from HHSC staff representing the Fiscal Policy, Business Operations, and Program Evaluation divisions (Appendix A) to conduct a review and make recommendations to address the situation. TDH identified a 13-point scope of work for the program review (Appendix B).

PROGRAM HISTORY

Texas established the Crippled Children's Program in 1933. The program was renamed the Chronically Ill and Disabled Children's Program (CIDC) in 1989. The program is not an entitlement and was designed to be a payor of last resort for chronically ill and disabled children under the age of 21. (Adults, 21 years of age and older, with cystic fibrosis who meet financial and residency criteria are also eligible for services.) The program was originally diagnosis specific and funded with State General Revenue and federal Title V Maternal and Child Health funds. The federal government requires that 30 percent of Title V funds be expended on this program. With the enactment of SB 374, 76th Legislature, the program was renamed as the Children with Special Health Care Needs (CSHCN) effective on September 1, 1999. Other program changes created by SB 374 include:

- Redefinition of eligibility for the program from diagnosis specific services to a broader definition of a person younger than 21 who has a chronic physical or developmental condition or a person of any age with cystic fibrosis
- Requirement that the program provide access to a health benefit plan similar in scope to the Children's Health Insurance Plan (CHIP)
- Removal of the asset test from financial eligibility criteria and continuation of medical spend-down ability
- Allowing waiting lists to ensure the program is administered within appropriated levels
- Provision for development of family support services

An observation of the review team is that this program has drawn high interest from many influential quarters and program staff often find themselves under great outside pressure to direct resources into special areas. On occasion this has resulted in a reduction of the program resources directed towards direct medical services.

Table 1 provides historical data on program expenditures for the last two biennia.

Table 1

CHILDREN WITH SPECIAL HEALTH CARE NEEDS EXPENDITURES
Fiscal Year 98 thru Fiscal Year 2001

EXPENDTURES BY FUNCTION:	FY98 Expended	FY99 Expended	FY00 Projected	FY01 Projected
Administration				
Central Office Operations	$ 2,933,290	$ 3,258,516	$ 3,614,095	$ 4,207,951
Regional Operations (Eligibility Determination, Case Management)	4,310,609	4,313,152	4,297,815	4,394,605
Information Systems (IS)	211,193	543,487	761,043	546,701
NHIC Contract Costs	1,554,531	1,799,300	2,195,226	1,378,062
Subtotal	9,009,623	9,914,455	10,868,179	10,527,319
Grants and Contracts				
Grants to Local Agencies	2,245,687	2,104,205	2,242,991	2,951,620
Grants to Local Health Departments (Case Management and Other Contracts)	288,175	227,624	238,411	305,032
Subtotal	2,533,862	2,331,829	2,481,402	3,256,652
Direct Client Services	22,498,664	22,720,305	24,576,039	29,275,692
Total	**$ 34,042,150**	**$ 34,966,590**	**$ 37,925,621**	**$ 43,059,662**
METHOD OF FINANCE	-		-	-
General Revenue	$ 23,249,547	$ 23,977,978	$ 25,659,058	$ 27,345,453
Federal Funds - Title V	10,223,157	10,668,177	11,852,882	14,012,514
Federal Funds - Other Grants	353,575	307,276	235,485	540,814
Other Funds	215,870	13,159	178,196	1,160,882
Total, All Funds	**$ 34,042,149**	**$ 34,966,590**	**$ 37,925,621**	**$ 43,059,663**

Source: TDH, Financial Management Division

Notes: Medical claims from NHIC are based on claim date, not service date.

Appropriated as stated in ABEST plus $100 pay raise (FY98-01).

Expenditures do not include Employee Benefits/Indirect Costs.

General Revenue Expenditures do not include BRP.

Case management is reported under regional operations. However, it is a direct client service.

REVIEW PROCESS

The Department provided the review team with a detailed presentation of program operations, office space, and an extensive array of program documents, and data. The review team conducted interviews of key staff members in the central office and visited four regional offices in Arlington, Houston, San Antonio, and Temple, which included

interviews with eight contractors. All program personnel were readily accessible and forthcoming with requested information and data. Review team members also met with the CSHCN Advisory Committee to provide an overview of the study, and interviewed two committee officers and the program actuaries (see Appendix C for a complete list of interviews).

The review team sought to determine the specific requirements of the program and identify program service priorities. Everyone interviewed stated that the provision of medical services was the first and foremost priority. The goal of the review team was to search for actions that would alleviate the shortfall and address financial management issues.

This report presents recommendations designed to meet the objectives of the review. Additionally, issues for further study are presented because time constraints prevented a detailed analysis, but the review team identified these items as important to future program operations. The review team found that, in many respects, the CSHCN program is a microcosm of its parent agency as many of the findings of the *Business Practices Evaluation* by Elton Bomer are also reflected in this program.

The savings projected for each recommendation are estimates based on review team findings. The CSHCN program may or may not fully realize the savings upon consideration and implementation of the recommendations.

FY 2002-03 SHORTFALL PROJECTION

The CSHCN program is estimating a $5.9 million shortfall in the program for FY 2002 as indicated in Table 2. Should the Medicaid Cost Containment Provision (Section 33) develop increased savings to cover the share of the reduction allocated to CSHCN, the CSHCN shortfall could be reduced to $2.9 million.

An estimate of FY03 CSHCN projected expenditures has not been compiled to date. Known differences between FY02 and FY03 are:

- The Section 33 reduction is $10 million for FY03, compared to $3 million for FY02.
- SB1 transferred $7 million of CSHCN federal funds to the Interagency Council on Early Childhood Intervention only in FY02.

Total available funds for the program in FY03 is estimated at $39.6 million. This FY03 funding amount is slightly more than the estimated FY02 expenditure level. It appears that the imposition of the Section 33 reduction would determine whether there is an FY03 shortfall and the extent a waiting list continues.

Table 2

Summary of FY 2002 CSHCN Projected Expenditures
As of September 21, 2001

Expenditures		
Client Services		
Incurred FY 01 Services Paid in FY 02	$	3,378,000
Incurred FY 02 Services		28,389,000
New Services Pursuant to SB 374		1,626,000
Subtotal, Client Services	$	33,393,000
Administration/Case Management Services	$	15,587,614
Subtotal, CSHCN Program	**$**	**48,980,614**
Less:		
Implementation of Waiting List	$	(7,239,618)
Incurred FY 02 Services Paid in FY 03		(2,648,212)
Subtotal, Savings and Deferred Costs	$	(9,887,830)
Subtotal, CSHCN Program	**$**	**39,092,784**
Available Revenue	**$**	**36,242,696**
Difference: Surplus / (Shortfall)	**$**	**(2,850,088)**
Section 33 Reduction	**$**	**(3,000,000)**
Difference: Surplus / (Shortfall)	**$**	**(5,850,088)**

Source: CSHCN Program, October 19, 2001

The review of the shortfall projection found that almost all the budgetary elements comprising the FY2002 CSHCN shortfall are actuarial projections. The CSHCN program's contracted actuary is Rudd and Wisdom, which is also the contracted actuary for the Medicaid, CHIP and ERS programs. The actuarial projections consider the impact of the CHIP program.

Only the estimate of administrative/case management services was developed without the contracted actuary. The administrative/case management budget projection is a compilation of administrative salaries and related expenses, grants and contracts. TDH staff developed the forecast of the waiting list impact. However, the impact of the implementation of the waiting list ($7.2 million) is based on a methodology that was suggested and reviewed by the contracted actuary.

The estimate of the FY02 shortfall appears reasonable, but the estimate of providing new services pursuant to SB 374 includes only new services, and not newly covered diagnoses. For example, regional case workers stated that children with asthma, not previously covered, were now receiving CSHCN services. Since the actuarial projections are developed from previous claims, the shortfall projection may not be capturing the effect of providing services to children with newly covered conditions, and thus may be understated.

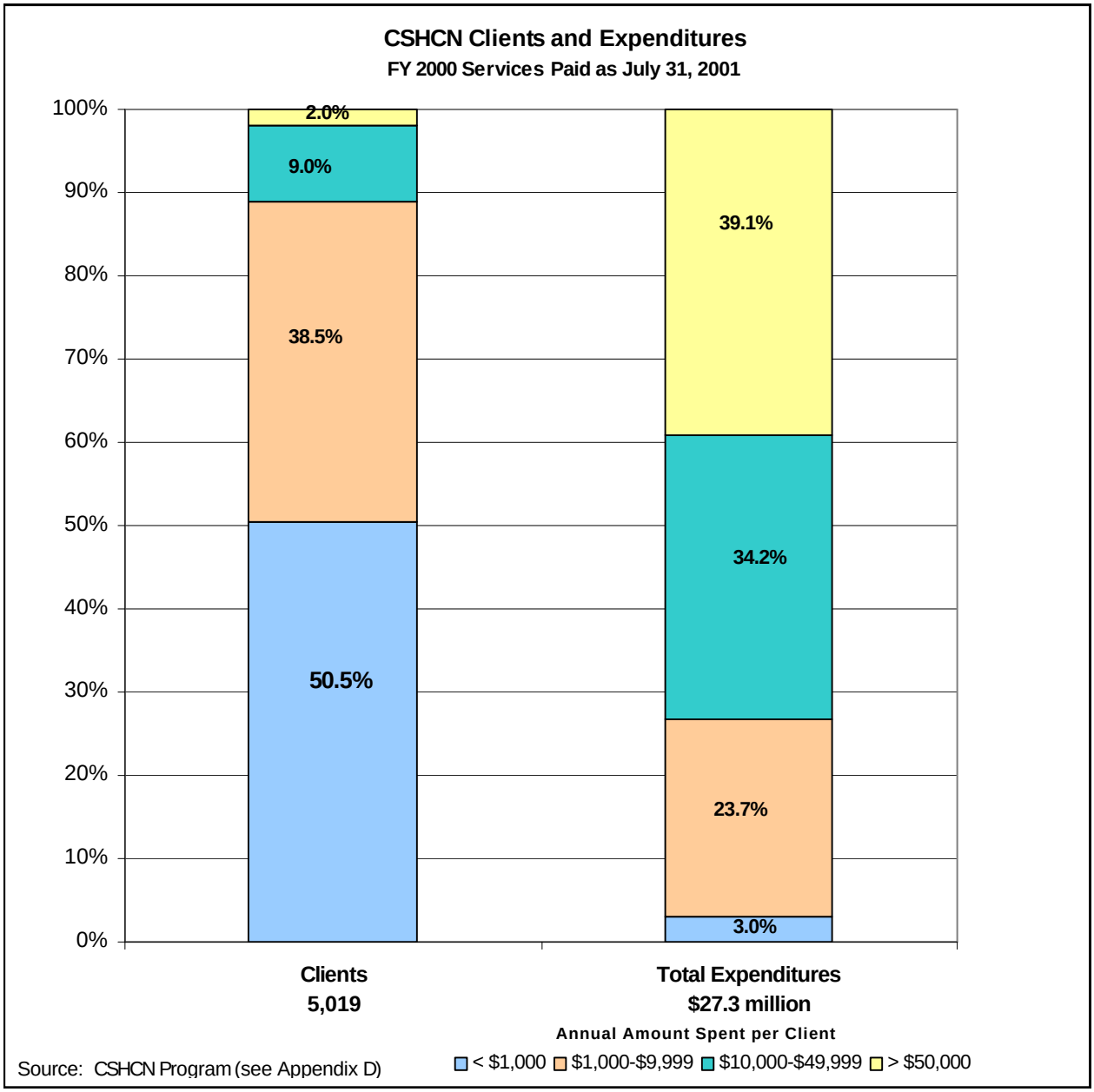
Currently, the program pays for the services when billed from the National Heritage Insurance Corp. (NHIC), the claims processor for CSCHN as well as the Medicaid program. The date billed from NHIC may not occur in the same fiscal year as the service was incurred. In Table 2, the program incurs the expense of FY01 services billed in FY02, estimated at $3.4 million and defers $2.6 million estimated to be billed in FY03.

Although the actuary accounts for the CHIP effect in the projections of claims, the CSHCN program has experienced difficulty in accounting for the effects of this program. Estimates of the effect of CHIP implementation on the CSHCN program have not come to fruition. The number of CSHCN children assumed to be CHIP eligible is less than what was projected. One factor is the number of CSCHN children who are Texas residents but have an undocumented status, and thus are ineligible for Medicaid or CHIP. The number of children enrolled in CSHCN during FY01, who were also enrolled in CHIP as of July 31, 2001, is 1,478.

According to the actuary, the data indicates that CSHCN children who have enrolled in CHIP tend to be the less expensive CSHCN children. Also the CSHCN program continues to provide wrap around services to CSHCN children enrolled in CHIP, such as transportation and lodging.

Another difficulty is projecting the breadth of services to be used by special needs children. As indicated in Figure 1, eleven percent of the 5,019 children served represented 73.3 percent of the medical expenditures in FY 2000, while over half of the children served represented only three percent of the total medical expenditures. Appendix D provides a more detailed account of CSHCN clients and expenditures.

Figure 1


CSHCN Clients and Expenditures
FY 2000 Services Paid as July 31, 2001
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2.0%
9.0%
38.5%
50.5%
39.1%
34.2%
23.7%
3.0%
Clients
5,019
Total Expenditures
$27.3 million
Annual Amount Spent per Client
< $1,000
$1,000-$9,999
$10,000-$49,999
> $50,000
Source: CSHCN Program (see Appendix D)

Recommendations

III. Recommendations

The review team presents 18 recommendations representing $5,584,269 in potential savings for FY02 and $8,063,152 for FY03. The recommendations are classified as Administrative Functions, Contracts and Grants, Medical Services, Financial Management, and Issues for Further Study.

ADMINISTRATIVE FUNCTIONS

There are five administrative recommendations with potential savings of $330,000 in FY02 and $660,000 in FY03. These recommendations address indirect salaries, central office reorganization and staffing, and eligibility processing procedures.

RECOMMENDATION 1: Reduce Family Health support services administrative costs paid by the CSHCN program

FINDINGS: Fifty-six state office positions (some are vacant) support the CSHCN program. In addition, there are 122 CSHCN regional staff positions, for a total of 178 positions. Currently, there are 20 Family Health support services administrative positions, at a cost of $850,240, which are indirectly charged to the CSHCN program. These positions include, among others, six automation staff, two research staff, three financial staff and various other professional and administrative support staff. They represent 26 percent of the state office positions funded by the CSHCN program.

Salaries associated with Family Health support services administrative positions charged to the CSHCN program are 40 percent of the state office salary dollars.

Family Health support services administrative costs borne by the CSHCN program are excessive. Without an empirical basis, such as a time and motion based cost allocation process, for determining true benefit to the program, it is left to the professional judgment of the review team to make such a determination. Given the current financial shortfall, particularly for medical services, a reduction in Family Health support services administrative costs is logical. Therefore, it is recommended that Family Health support services administrative costs be reduced, at a minimum, by 25 percent, which will result in an additional $100,000 (pro-rated for 6 remaining months in FY02) to be available to the program. (Actual saving could vary slightly, depending on the specific positions and associated salaries that are reduced.)

FISCAL IMPACT:

FY02: $100,000

FY03: $200,000

RECOMMENDATION 2: Reduce state office staffing associated with authorization and claims processing.

FINDINGS: The organization chart for the Authorization and Claims section within the Operations Unit shows a manager, two supervisors and eleven staff positions; six in Authorizations and Inquiry and five in Claims and Provider Enrollment. NHIC is now primarily responsible for these two functions. Within the CSHCN program, it had been planned to use these staff to:

1) Handle those authorizations and claims not administered by NHIC
2) Provide oversight to NHIC activities
3) Staff the hotline (used by clients and providers of multiple HHS programs)
4) Reallocate staff to other CSHCN program functions (e.g., quality assurance)

While some of these objectives have been partially accomplished, program staff have not been reduced in spite of diminished workloads.

Program staff estimated that three staff positions, not including supervisory positions, could be reassigned to other program functions. Although workload requirements for both sections are in transition, reductions of three to five staff could be realized. Consideration also should be given to reducing the number of supervisory positions from three to one.

These savings could be gained quickly by imposing a Reduction in Force (RIF) or more slowly through attrition. Savings as a result of imposing an immediate RIF of 7 positions (five staff and two supervisors) would be $96,500 (pro-rated for six remaining months in FY02). Savings achieved through attrition would be appreciably less in the short term but comparable over the longer term.

FISCAL IMPACT:

FY02: $96,500

FY03: $193,000

RECOMMENDATION 3: Implement new eligibility software and transfer primary eligibility determination responsibility to the regional offices.

FINDINGS: Twenty-three staff members perform eligibility functions and other duties in the regions. Regional eligibility staff are principally responsible for processing new applications and recertifications with the exception of “spend down” cases. Eligibility information is data entered into the automated eligibility determination system. In most instances, applicants do not provide all required information and documentation. Currently, regional staff members enter into the automated system what documents have not been provided and the relevant paragraphs that will be included in a letter sent, from the state office, to the applicant. Once all of the required documentation has been provided, and assuming the applicant meets the financial criteria, eligibility is approved.

With the exception of spend down cases, state office staff primarily perform tracking, technical assistance and quality control functions. It is anticipated that, with the implementation of the new eligibility system, work processes will be both simplified and automated. For example:

1) Regional staff are having to utilize "work arounds" to enter eligibility information required by new policy that is not yet accommodated by the current system.
2) Daily and weekly manual reports are sent from regional staff to the state office that will be automated in the near future.
3) Letters to applicants that are now partially automated will be completely computer generated.

Therefore, it is extremely important that all testing, modifications and implementation of the new system be comprehensively and properly completed as soon as possible (currently projected to be January 2002).

NOTE: In the future, responsibilities and workload of regional eligibility determination staff should be reviewed to ensure that the benefits associated with the new automated system are actually derived.

Furthermore, savings can be realized by removing certain responsibilities from state office staff. Examples include:

1) Having regional staff determine eligibility for all cases, including spend down cases
2) Reducing the number and type of quality control activities performed by state office staff and, where appropriate, assigning those responsibilities to regional managers
3) Issuing the long awaited policy manual thereby decreasing the number of questions that are addressed by state office staff
4) Sending and receiving eligibility related letters to applicants

These measures will facilitate the consolidation of the Eligibility Determination and Client Support Services sections' responsibilities and a concomitant reduction in staff.

Estimated saving associated with imposing an immediate RIF (two staff and two supervisory positions) as a result of this consolidation would be $55,000. Estimated savings achieved through attrition would be appreciably less in the short term but comparable over the longer term. In addition, program management should further review the functions, responsibilities and workload related to the Imaging Unit to determine if additional savings could be achieved.

FISCAL IMPACT:
FY02: $55,000
FY03: $110,000

RECOMMENDATION 4: Reorganize central office by combining the Health Care Policy, Program Evaluation and Analysis and Quality Improvement and Medical Management units and eliminating excessive layers of management. Prorate savings for FY 2002 for six months in order to allow sufficient time to implement changes.

FINDINGS: There are CSHCN functions in central office that overlap and could benefit from being combined. There is duplication of effort between the Health Care Policy and the Quality Improvement units, and they should be combined to more effectively use staff.

The Health Care Policy unit currently contains a manager who supervises three professional staff, totaling 2.25 FTEs (1.5 FTE funded by the CSHCN program and .75 FTE funded by another program), and two administrative technicians. The Quality Improvement and Medical Management unit contains an administrative technician, three filled and one vacant professional positions, including 1.75 FTEs funding by the CSHCN programs and 2 FTEs funded by another program. These units should be combined under one manager, with two administrative technicians and six professional FTEs. One existing manager position and one administrative technician would be reassigned outside the program for a reduction of two FTEs.

The Program Evaluation and Analysis unit is comprised of two staff. These staff and their functions should be moved into the combined Policy, Evaluation and Quality Improvement unit. Moving Program Evaluation and Analysis would improve organizational efficiency, though it would not result in any direct savings.

FISCAL IMPACT:
FY02: $37,000
FY03: $74,000

There is currently an administrative technician II and an administrative technician IV reporting directly to the division director. Consideration should be given to eliminating one of those positions.

FISCAL IMPACT:
FY02: $11,500
FY03: $23,000

RECOMMENDATION 5: Adjust the salaries of Medical Doctors in managerial positions to be commensurate with that of a manager unless the position specifically requires an

M.D. Prorate savings for FY 2002 for six months in order to allow sufficient time to implement changes.

FINDINGS: There are three physicians in the central office of CSHCN. Two are in management positions (the director of the CSHCN program and the manager of the systems development office) and one in a medical consultant position. The two physician FTEs in management positions appear to be performing administrative work but are being paid salaries much higher than comparable non-physician administrators. These positions should be reclassified to make their pay comparable to non-physicians performing similar functions. If managerial continuity considerations prevent those reductions in the near term, at a minimum, when vacancies occur in these positions, they should be reclassified to administrative or management positions, instead of physician classifications. The duties that require a physician to perform could then be reassigned to the medical consultant who reports to the division director. Reclassify the Program Director position from Physician IV (B21) to Director II (B18); reclassify the Systems Development Manager from Physician IV (B21) to Director I (B17).

NOTE: It is recognized that throughout TDH there are physicians performing administrative functions, and that this staffing is not unique to the CSHCN. Following this recommendation could have implications for staffing patterns that currently exist agency-wide.

FISCAL IMPACT:

FY02:	$30,000
FY03:	$60,000

Table 3 **Summary of Central Office Organizational Recommendations**

Current Organization	Current FTEs	Recommended Organization	Recommended FTEs	Projected FY02 Savings
Health Care Policy	4.25	Policy, Evaluation and Quality Improvement Reduce 2 FTEs	9.00	
Qualilty Improvement	4.75			
Program Evaluation	2.00			
Subtotal	11.00			$49,000
Program Operations-Authorizations and Inquiry and Claims and Provider Enrollment sections	14.00	Consolidate two sections and reduce 7 FTEs	7.00	$96,500
Program Operations-Eligibility Determination and Client Support Services sections	13.00	Consolidate two sections and reduce 4 FTEs	9.00	$37,000
Admin. Tech reporting to CSHCN Director	2.00	Reduce one FTE	1.00	$11,500
Physicians	3.00	Reclassify 2 physicians to directors	3.00	$30,000
Total for Affected Units	43.00		29.00	$224,000

CONTRACTS AND GRANTS

There is one recommendation concerning the cancellation of nine contracts, redirected funding of two contracts, and the amendment of two contracts resulting in a potential savings of $773,769 in FY02 and $718,152 in FY03.

RECOMMENDATION 6: Cancel nine contracts, redirect the funding of two contracts, and amend two service contracts.

FINDINGS: CSHCN issues service contracts to supplement the activities of the program. Currently, the program has 31 contracts totaling $3,905,898. Of these, 17 ($2,474,200) are classified as “Case Management and Community/Family Resources” contracts; two ($168,980) are “Safety Net Services (Outreach Clinics)”; six ($719,400) are “Miscellaneous” such as, actuarial services and support for the Genetics Division; and six ($543,318) are new contracts. Of the 31 contracts, 25 are ongoing and considered by the program to be re-occurring. The six new contracts for FY02 are four wellness centers ($324,321), one epilepsy direct services ($75,000), and one family-to-family/case management ($143,997).

One contract, issued to The House That Kerry Built, received an increase of 233.3 percent rising from $150,000 in FY01 to $500,000 in FY02. Rider 57 of the General Appropriations Act mandated this increase with no new funding and further directed that any funds not utilized in FY02 would be carried forward to FY03. This contract should be amended to provide the amount of $250,000 in each year of the biennium. This would provide consistent funding to the contractor in each year of the biennium and reduce the funding requirements of CSHCN in FY02. It should be noted that this contract would have been recommended for reduction to the FY01 level of $150,000 if funding had not been mandated by Rider 57.

It is recommended that the contract to the Harris County Hospital District also be amended. The FY02 amount for this contract is $218,386 and should be amended to $149,000, a savings of $79,386, because of low activity volume.

The Austin/Travis County MHMR assumed a contract upon the withdrawal of the original contractor, the Children's Partnership. The new contractor, however is not performing the contracted services at the required level and central office and regional staff assistance has not led to sufficient improvement. It is recommended that this contract be cancelled.

All contracts were reviewed to search for service duplications and the provision of mandated services. Most of the contracts involve case management that is a mandated service. Based upon the regional review, contracted case management contracts do not duplicate staff efforts but rather actively supplement and support the activities of the regional offices, especially in rural areas. Contracts issued for a combination of case management and community/family resources are particularly beneficial in supplementing regional activities. Contracts that address only community/family resources are not as useful because they provide only support services. All of the contracts perform services that are beneficial to the children and their families. There is a general consensus; however, that the provision of direct medical services to program clients is the first and foremost priority, especially in light of the current funding shortfall. Contracts that provide case management services are particularly important while contracts that provide support services are of less importance during periods of funding restrictions. With these elements in mind, the following table summarizes the recommendations concerning the current contracts.

Table 4 **Summary of Contract Recommendations**

Contract	FY02 Amount	Rec. Action	Finding	Projected FY02 Savings
Easter Seals Greater Northwest Texas	$75,000	Cancel	Support Services	$37,500
Trinity Clinic	$34,545	Cancel	Community Resources	$17,273
Austin/Travis County MHMR	$119,353	Cancel	Performance Problems	$59,676
El Paso Rehabilitation Center	$50,000	Cancel	Support Services	$25,000
El Paso Rehabilitation Center-Wellness Center	$62,900	Cancel	Support Services	$31,450
University of Houston	$143,997	Cancel	Duplicative Case Mgt.	$71,998
TX Children's Hosp.- Wellness Center.	$65,041	Cancel	Support Services	$32,521
Girls, Inc. – Wellness Center	$93,932	Cancel	Support Services	$46,966
YMCA of the Golden Crescent-Wellness Center	$102,448	Cancel	Support Services	$51,224
PKU-Genetics Div. Support	$35,950	Redirect	Identify new funding sources	$17,975
PKU-Genetics Div. - Foods	$105,600	Redirect	Identify new funding sources	$52,800
The House That Kerry Built	$500,000	Amend	TDH Rider 57, GAA	$250,000
Harris County Hospital District	$218,386	Amend	Low volume	$79,386
Totals	**$1,607,152**			**$773,769**

The program has the contractual power to terminate contracts because of funding restrictions. In addition, the PKU contracts are a result of TDH allocating funding for the Genetics Division to various agency programs. The CSHCN program should not be burdened with these internal requirements and this responsibility should be funded by other TDH resources.

Taking into account the administrative procedures that would be required to implement the recommended cancellations, it is reasonable to assume that one-half of the

cancelled contract amounts, with the exception of the amended contracts, could be saved during FY02 and the entire amount saved in FY03. The total amount recommended for cancellation and redirection in FY02 is $888,766 and one-half of this total is $444,383. The savings for FY03 from contract cancellations and redirections would be $888,766. The amendment of the contract to The House That Kerry Built would result in a savings of $250,000 during FY02 and a cost of $250,000 in FY03. The amendment of the contract to the Harris County Hospital District would result in savings of $79,386 in each year of the biennium.

FISCAL IMPACT:

FY02:	$773,769
FY03:	$718,152

MEDICAL SERVICES

There are four medical services recommendations with potential savings of up to $2,680,500 in FY02 and $5,800,000 in FY03. The recommendations address NHIC overpayment recoupments, the control of medical costs, and the temporary suspension of certain services. One recommendation addresses policy clarification with no fiscal impact determined.

RECOMMENDATION 7: Recouped funds realized as a result of overpayment of claims should be credited to the program.

FINDINGS: In the spring of 2001, overpayments by NHIC to hospitals for manually paid claims were identified and recoupment was requested. CSHCN staff estimate that NHIC made more than $900,000 in overpayments to hospitals over several years. The amount of $880,500 has been recouped. Those funds are in the trust account at NHIC and are available to pay claims. CSHCN staff should make every effort to recoup any additional outstanding overpayments that can be identified. According to CSHCN staff, the overpayments made by NHIC have not already been included in the budget projections. The amount already recovered, and any outstanding amount to be recovered, should be credited to the program to decrease the shortfall by the amount TDH has recouped. The recovered funds can be applied to the shortfall either as additional revenue or reduced claims.

FISCAL IMPACT:

FY02:	$880,500
FY03:	$0

RECOMMENDATION 8: Implement a comprehensive medical management process to control medical costs.

This initiative is currently under development by CSHCN staff and should be implemented immediately to achieve maximum savings and ensure appropriate use of limited program resources.

FINDINGS:

Since the transition of the utilization review function to NHIC in 1991, little oversight of medical utilization has been provided in the CSHCN program. Limited monitoring of medical claims paid through the contract with National Heritage Insurance Corporation (NHIC) has created a system of medical care that is not consistently managed to ensure that appropriate services are provided in the most cost effective manner. Therefore, it is necessary to strengthen the system of utilization review to improve program monitoring and allow for early intervention when costs or utilization increase significantly.

The total cost of medical services per client has increased 49 percent from FY1998 to FY2001, with inpatient costs increasing by 63 percent per client who received inpatient care and outpatient costs increasing by 37 percent per client who received outpatient care. (See Appendix E for a detailed breakdown of medical expenditures by category)

Table 5 **Medical Costs Per Client FY98-FY01**

	Total Costs	Total Clients Served	Total Cost per Client	Clients with Inpatient Costs	Inpatient Cost per Client	Clients with Outpatient Costs	Outpatient Cost per Client
FY98	$22,658,337	6,167	$3,674	561	$13,522	2,939	$742
FY99	$23,214,329	5,318	$4,365	526	$15,963	2,570	$923
FY00	$27,274,950	5,019	$5,434	603	$18,542	2,514	$1,119
FY01*	$20,924,287	3,818	$5,480	386	$22,010	1,731	$1,020

FY 98 data sources: FY 98 projections as of 7/31/01, Rider 8 report as of 8/31/00, and the Expenditures by ICD9 report as of 8/31/00.

FY 99, FY00 and FY01 data sources: Case Cost Report, VDP and MLT data as of 7/31/01.

***FY01 is an incomplete year; data as of 07/31/01.**

In the past, adequate data to evaluate the service delivery, outcomes, and costs of medical care has been lacking. However, the completion of the new CSHCN Management Information System, scheduled for January 2002, will provide improved data on medical treatment and costs for use by program staff. For example, the program has not collected data on critical indicators, such as inpatient days per 1000 enrollees or average length of stay. This information will be available when the new system is implemented.

NHIC plays a significant role in utilization review functions through prior authorization of claims and retrospective review of claims. TDH has responsibility for oversight of NHIC. However, TDH has not had a specific staff member assigned to oversight of the NHIC contract in several years. Additional program responsibilities for managing medical care include defining policy for utilization review, conducting performance reviews of the

contractor, assessing overall service expenses, and conducting assessments of specific areas of concern related to utilization of services and cost containment.

CSHCN is currently working to implement a medical management process to strengthen these functions. Priorities for initial development include:

- Improving and enhancing management reports
- Critical indicator reporting and corrective action
- Reviews of all manuals and process to assess opportunities for cost efficiencies
- Population analysis to assess areas needing further review, such as high cost, high volume services

One initial policy change recently adopted to improve medical management requires prior authorization for inpatient hospital stays, which account for approximately 40 percent of all medical costs. This policy will strengthen the program's ability to control costs for inpatient care.

CSHCN staff indicate that savings of up to 15 percent are possible with implementation of a medical management process that provides greater scrutiny of medical services authorizations. This new initiative can be implemented within existing resources, with the current program staff. Assuming 15 percent savings is achieved in four months, the program could save $1.4 million in FY02. In FY03, assuming the maximum savings of 15 percent, $4.2 million could be saved. Estimated savings for FY02 and FY03 do not assume the continuation of a waiting list. If the waiting list is continued, savings in FY02 decrease by approximately $360,000, and savings in FY03 decrease by approximately $1.1 million.

FISCAL IMPACT:

FY02: $1,400,000 (maximum estimated)
FY03: $4,200,000 (maximum estimated)

RECOMMENDATION 9: Suspend the service expansion authorized by SB 374 and revert to providing services covered prior to July 2001.

FINDINGS:

The expansion of services related to SB 374 implementation is estimated to increase costs for medical services by $1.6 million in FY02, and a similar amount in FY03. Given the fact that the program is facing a shortfall in FY02, any service expansion should be suspended until the budget shortfall is addressed.

Rules to implement SB 374 were adopted in July 2001. At that point the CSHCN program expanded eligibility for services and started covering a wider range of services for CSHCN clients.

New services covered include:

- Inpatient psychiatric care (benefit limited to five days emergency inpatient per year)
- Hospice
- Renal Dialysis
- In-home respiratory care
- Preventive check ups
- Outpatient behavioral health (limited to 30 outpatient visits per year)

Expansion of existing services include:

- Vision services
- Dental services
- Home health care

According to state law, the CSHCN program may discontinue, limit, or restrict services, reimbursement for services or types of services available to all clients to remain within available funding. This action requires adoption of rules by the Board.

Program staff estimate the cost of SB 374 implementation to be $1.6 million in FY02. Assuming the service expansion authorized by SB 374 is suspended by the TDH Board with one quarter of the year remaining, $400,000 could be saved in FY02.

FISCAL IMPACT:

FY02: $400,000
FY03: $1,600,000 estimated

RECOMMENDATION 10:

1. The Board of Health should establish a system of priorities relating to types of services provided and eligibility for services, which will govern any future instances in which budgetary limitations exist.
2. Clarify the waiting list policy as part of the Board's responsibility to prioritize services when budget limitations exist.

FINDINGS:

In addition to authorizing the establishment of a waiting list, Section 35.003(c) of the Health and Safety Code states:

> "If budgetary limitations exist, the board by rule shall establish a system of priorities relating to the types of services or the classes of persons eligible for the services."

While further legal review may be necessary to specifically determine the scope of the Board's responsibility in this area, the statute is clear that the Board should establish a process to manage services in situations where budgetary limitations exist.

In addition to establishing a system of priorities, the Board should work with program staff to modify the current waiting list policy in order to develop a fair method of considering clients' needs when determining who is to be removed from the waiting list. The current policy of "first come first served" removal from the waiting list does not take into account which clients have the most need, or which clients have other coverage, such as CHIP or Medicaid. This policy should be refined in conjunction with the system of priorities established by the Board.

FISCAL IMPACT: Undetermined.

FINANCIAL MANAGEMENT

There are five fiscal management recommendations with potential savings of $1.8 million in FY02 and $885,000 in FY03. These recommendations address the allocation of revenue collections and one-time savings. Two additional recommendations review forecasting methodologies and budget allocations to the regional offices with no determination of fiscal impacts.

ALLOCATION OF REVENUE COLLECTIONS

RECOMMENDATION 11:

1. Continue to allocate Medicaid case management billings for staff's employee benefits.
2. Inform program staff that Medicaid billings do indeed cover program costs and redirect any case management billings exceeding the cost of employee benefits to the program and not to the agency's central administration.
3. Anticipated CSHCN drug rebates should be counted toward reducing the shortfall.

FINDINGS:

Medicaid Billings

Regional CSHCN case managers are currently billing the Medicaid program for case management activities when appropriate. These billings are deposited as Earned Federal Funds and are indirectly being used in the program to pay for the employee benefits of the CSHCN staff. Regional staff could be more diligent in their billing if they knew that their efforts were actually benefiting themselves and covering the cost of the program. Employee benefits are a cost to the program and the estimated impact of Medicaid billings for FY02 is $200,000.

CSHCN Drug Rebates

The CSHCN program uses the Medicaid Vendor Drug Program to pay for pharmacy services for the children. Medicaid drug rebates are required for an open Medicaid formulary. Drug companies are not required to rebate the CSHCN program but some do so voluntarily.

In FY01, $473,818 was collected as voluntary rebates in the CSHCN program. Beginning in FY02, the rebates will be directed back to the program. Program staff apparently have not accounted for these rebates in the available revenue for FY02, estimated to be $600,000. Transfer authority may be required to redirect the rebates back to the program.

FISCAL IMPACT:

FY02: $600,000
FY03: $636,000

ONE-TIME SAVINGS

RECOMMENDATION 12: Reduce the CSHCN Trust Account at NHIC to reflect an amount approximately equal to the claims for a period of one month.

FINDINGS: Currently, NHIC maintains a CSHCN Trust Account in the amount of approximately $2.7 million *(See Appendix F).* As claims are processed, NHIC bills CSHCN monthly for the replenishment of the account thereby maintaining the account balance at the $2.7 million level. It is recommended that the contract be amended to change the payment of medical claims to effectively act more like a fiscal agent. NHIC would continue to submit the bills for claims on a monthly basis. A key component to allow for the continued payment of CSHCN medical claims without any delays would be the requirement for program staff to process invoices from NHIC in an expedited manner to replenish the CSHCN trust account. The trust account should be reduced from $2.7 million to $1.5 million, thereby freeing $1.2 million to be directed to the program shortfall.

FISCAL IMPACT:

FY02: $1,200,000
FY03: $0

RECOMMENDATION 13: Redirect funds saved from the completed development of the CSHCN Management Information System for FY 2003, estimated at $249,000.

FINDINGS:

The CSHCN program has been developing a new management information system. It is scheduled to be completed in FY02. The estimated cost of development that could be redirected into medical services is $249,000.

FISCAL IMPACT:
FY02: $0
FY03: $249,000

RECOMMENDATION 14:

1. Establish a forecasting methodology that projects program caseloads as well as program expenditures**.**
2. Require the contracted actuary to forecast a high and a low estimated expenditure in addition to the monthly number.
3. Realign payment of expenditures in the year incurred only after the shortfall and waiting list are eliminated.
4. Periodically bring in a secondary actuary to review the performance and methodology of the contracted actuary.

FINDINGS: The current program forecasting methodology projects fiscal year expenditures based on historical data. This concentration on expenditures limits the ability to project caseload trends that, in turn, affect expenditures. This practice is "traditional" within the program and it is recommended that this current forecasting methodology be supplemented with the addition of caseload projections.

This program has varied greatly in its ability to keep expenditures within appropriated levels over the last decade. The new comprehensive benefit package and expanded eligibility have further complicated the difficulties in forecasting the breadth and cost of needed services. The change in procedure to pay claims from the fiscal year that correlates with the NHIC billing date instead of the medical service date has impacted the program's projected expenditures. Given sufficient revenue, the program should reinstate a procedure to pay claims from the fiscal year of the claims' medical service date.

Additionally, forecasting a range of projected expenditures may provide greater credibility to volatile program expenditures.

FISCAL IMPACT: Undetermined.

RECOMMENDATION 15: Develop a system of budget allocation to the regions based on regional needs assessments and require associated performance expectations, rather than "historical" or "traditional" allocations.

FINDINGS: CSHCN currently budgets and allocates funds to the regions for CSHCN program activities and "core administration" based on previous years' budgets, "tradition" and regional directors' ability to make the case that they need more funding. As one regional director explained it, "I have to fight tooth and nail for every dollar I get."

Two regional directors were asked who has final approval of their annual budget, and they were not sure. Central office and regional staff confirm that a budget is not allocated on the basis of population in need, number of clients to be served, or other need indicators or performance expectations for case managers or eligibility workers. Staff have attempted in the past to develop need indicators for the state, but they were not adopted.

The U.S. Department of Health and Human Services estimates that nationwide, children with special health care needs constitute approximately 18 percent of all children, and projects that there are about 15 million children with conditions ranging from moderate health problems to severe disabilities. Because of limited funds, in FY 2000 Title V nationwide was able to serve fewer than 1 million (or about 6 percent) of these children.[1]

It is recommended that the CSHCN program use the U.S. Department of Health and Human Services need estimates to develop a budget allocation methodology which incorporates the need for each region (based simply on population of children in the target age cohort), and the expected performance level to be achieved by each region (percent and number of children determined eligible, percent and number of children provided case management, and any other performance indicators the program determines appropriate). This formula should be applied to all regions equally. In addition, case management and eligibility staff should be allocated based on a ratio to the general population or the population in need, so each region will have the resources to accomplish similar levels of performance. Performance should be tracked quarterly by central office staff and regions should be held accountable for managing budgets and performance.

FISCAL IMPACT: There is no direct fiscal impact for this recommendation. The impact will be improved budget allocation equity and performance accountability.

ISSUES FOR FURTHER STUDY

There are three issues identified for further study. These involve the policies related to residency requirements, undocumented clients, additional policy changes to reduce medical costs, and areas that were not addressed by the review team.

RECOMMENDATION 16: Review the policies on residency requirements and the provision of services to undocumented clients.

FINDINGS: CSHCN estimates that up to 25 percent of the medical service clients are classified as undocumented, and it is further estimated that these clients account for more than 25 percent of the medical services expenditures. This estimate is based on anecdotal knowledge because evidence of this situation is difficult to establish.

1 Title V Snapshot of Maternal and Child Health 2000, U.S. Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau

Currently, it is only required that a client be a resident of Texas with an intent to reside in the state. It is known, however, that citizens of Mexico travel to Texas for the sole purpose of acquiring medical treatment and, in another case, a Korean citizen traveled to Texas for the purpose of receiving a bone marrow transplant. An intent to reside in the state is usually documented by such things as an apartment lease or a utility bill, usually easy to obtain. Undocumented clients also tend to have the highest costs among program recipients because they tend not have private insurance and cannot qualify for Medicaid or CHIP. CSHCN, then, becomes the total payor rather than the payor of last resort as intended. Policy establishment and/or clarification are needed to assist program personnel in determining true eligibility.

FISCAL IMPACT: Undetermined.

RECOMMENDATION 17: The CSHCN program should consider addtional policy to reduce medical costs, if necessary.

FINDINGS:
Table 6 on the next page lists several policy options for reducing medical costs. These options should be considered if the program continues to project a shortfall.

RECOMMENDATION 18: TDH should continue to review the Scope of Work points numbered 9 to 13 (See Appendix B).

FINDINGS: TDH presented the review team with a 13-point Scope of Work (See Appendix B) as a guide for the program review. The review team was able to address several of the points in this document. However, time constraints prevented a thorough review of all points. The remaining issues should be studied by TDH in an ongoing analysis of the program.

Policy Options to Reduce Medical Costs

(Dollars in Millions)

Table 6

Policy Option	FY02 Impact	FY03 Impact	Assumptions
Place caps on individual expenditures	$1.1	$2.6	Assumes a cap of $50,000 per client. FY02 savings are based on five months.
Cap individual expenditures for durable medical equipment	0.08	0.1	Assumes cap of $10,000 a year. FY02 includes 9 months of savings.
Impose limits on expensive medications, procedures	Undetermined	Undetermined	Savings depends on the procedures, which are limited. Limiting high cost drugs, such a hemophilia factor, and procedures, such as bone marrow transplants, would produce the most savings.
Provide services up to age 19 (instead of age 21)	0.4	1.1	Assumes four months of savings in FY02.
Eliminate services for clients with cystic fibrosis over age 21	0.4	1.3	Assumes 5 months savings in FY02.
Decrease eligibility income limits from 200 percent FPL to 185 percent FPL	0.9	2.6	Assumes four months of savings in FY02
Charge co-pays for doctor visits and prescriptions drugs	Undetermined	Undetermined	Impact would be minimal considering $10 copay for doctor visits would produce less than $100,000 a year and a $5 copay for prescriptions would produce approximately $175,000 a year. Administrative costs and automated systems costs would be likely to negate any savings.

Note: Savings are not cumulative. The impact of each option was estimated based on current policy, without estimating the impact of adopting more than one of these policies at the same time.

Appendices

Appendix A

HHSC Review Team Members

Chester J. Dombrowski, Fiscal Policy Manager – *Team Leader*
Tracy Henderson, Fiscal Policy Manager
Jeff Kauffman, Director, Planning and Evaluation
David Kinsey, Fiscal Policy Manager
Joe Morganti, Manager, Business Process Improvement

Appendix B

Scope of Work for Children with Special Health Care Needs (CSHCN) Program Review

1. Determine specific business functions needed to support the delivery of medical/client services to CSHCN, i.e., eligibility determination, contract management, etc.
2. Determine number/level of staff (central and regional) needed to perform the needed business functions relating to the delivery of medical client services.
3. Identify other state and federal mandated services beyond those supporting medical/client services. Verify specific statutory or regulatory mandates for each.
4. Identify business functions needed to support other state and federally mandated services.
5. Determine number/level of staff (central and regional) needed to perform other state/federal-mandated services. Identify needs specific to each mandate.
6. Identify non-mandated program functions or activities, which could be eliminated or redirected to medical client services. Identify specific funding that could be redirected.
7. Evaluate and recommend changes as necessary to the CSHCN's organization chart (central and regional) to maximize and support providing cost-efficient services to CSHCN.
8. Review the financial processes and document how funds are allocated to functions or activities and how priorities are established.
9. Identify financial management system requirements/improvements to effectively monitor program budget and expenditures.
10. Identify and make recommendations to improve forecasting methodologies/protocols to accurately project client services and other necessary program expenditures with reasonable accuracy.
11. Evaluate the internal controls and accountability for the funds expended in the CSHCN program. Document the current system for reporting and monitoring the financial status and performance of objectives.
12. Prepare a report documenting the existing financial and management reporting system and recommending changes to enhance the system.
13. Coordinate with individuals involved in implementing PeopleSoft software to determine if the software can accommodate recommended changes in the financial and management reporting system. Identify gaps if necessary.

Appendix C

Summary of Interviews Conducted

Texas Department of Health, Austin

Charles Bell, M.D., Executive Deputy Commissioner
Gary Bego, Chief Operating Officer
Ben Delgado, Deputy Commissioner for Administration
Debra Stabeno, Deputy Commissioner for Programs
Debra Wanser, Title V Director[2]
L. Jann Melton-Kissel, Acting Chief, Bureau of Children's Health
Kathleen Barnett, Chief, Bureau of Budget and Revenue

CSHCN Central Office

Susan Penfield, M.D., Division Director, CSHCN
Franklin Jones, Unit Director, CSHCN Operations
Anita Freeman, Unit Director, Health Care Policy
Lesa Walker, M.D., Unit Director, Systems Development
Mary Noell, Unit Director, Quality Improvement and Medical Management
Duane Thomas, Manager II, Case Management
Lesa Walker, M.D., Unit Director, System Development Program
Ann Maire Mitchell, Program Specialist IV, Program Evaluation and Analysis
Amanda Nation, Accountant, TDH Fiscal Management Division
Gladys Padgett, Manager III, Financial Management Division,
Associateship for Family Health
Amanda Nation, Accountant IV, Financial Management Division,
Associateship for Family Health
Marjorie Doubleday, Program Specialist III, Contract Management Section,
Associateship for Family Health

Public Health Regions

Region 2/3 – Arlington
James Zoretic, M.D., Regional Director
Jan Havins, Director of Client Services
Bea Hilton, Program Administrator
Carol Sorich, Program Administrator
Crystal Womack, Program Administrator
Letty Cruz, Human Services Specialist
Mary Hamilton, Eligibility
Ana Kumpt, Eligibility
Tom Sanders, Human Services Specialist
Jan Washington, Human Services Specialist

Appendix C (Continued)

Region 6/5 South – Houston
Greta Etnyre, Deputy Regional Director
Raymond Turner, Director of Social Work Services
Entire CSHCN Regional Staff
Region 8 – San Antonio
Chip Riggins, M.D., Regional Director
Vicky Contreras, Region Social Work Director
Sonia Gomez, Social Worker, San Antonio
Julie Morquecho, Eligibility Supervisor
Lydia Medina, Eligibility Specialist
Sharlene Perez, Social Worker, Del Rio
Kay Roeh, Social Worker, Victoria

Region 7 – Temple
Leslie Anderson, Director Medicaid Programs and Social Work Service
Eileen Walker, Assistant Director Medicaid Programs and Social Work Service
Wanda Bernhardt, Eligibility and Support, Austin
Suzan Cooper, Case Management Coordinator
Yolanda Garcia, Eligibility and Support, Temple
Lisa Hodges, Eligibility and Support, Temple
Alice Watkins, Eligibility and Support, Temple

Contractors

Sylvia Cano, Social Work Services Director, Any Baby Can, San Antonio
Sara Dorsey, Harris County Hospital District
Phyllis Faukus-Dutton, Executive Director, Girls, Inc., Houston
Elaine Hime, University of Houston
Mia Jones, Harris County Hospital District
Lou Payne, Private Case Management Contractor, Temple
Marian Sokol, Director, Any Baby Can, San Antonio
Mary Faith Sterk, Director, Children's Special Needs Network, Temple
David Wilkes, Actuary, Rudd and Wisdom (telephone conversation)

CSHCN Advisory Committee

Robert W. Warren, M.D., Chair (telephone conversation)
Elaine Hime, Vice Chair

Legislative Offices

Karen Cheng, Senate Finance Committee
Gretchen Himsl, House Appropriations Committee
Leslie Lemon, Speaker's Office
Regina Martin, Legislative Budget Board
Paul Priest, Legislative Budget Board
Eileen Smith, House Appropriations Committee

CSHCN Expenditures by Amount Spent Per Client
FY Services Paid as of July 31, 2001

Amount Spent per Client	Number of Clients	Cumulative Clients	Percent of Clients	Cumulative Percent of Clients	Total Amount Spent[1]	Cumulative Amount	Percent of Total Spent	Cumulative Percent of Total Spent
< $100	724	724	14.4%	14.4%	$ 34,512	$ 34,512	0.1%	0.1%
$100 - $249	591	1,315	11.8%	26.2%	$ 97,456	$ 131,968	0.4%	0.5%
$250 - $499	560	1,875	11.2%	37.4%	$ 203,267	$ 335,235	0.7%	1.2%
$500 - $1,000	660	2,535	13.2%	50.5%	$ 478,299	$ 813,533	1.8%	3.0%
$1,000 - $1,999	711	3,246	14.2%	64.7%	$ 1,019,321	$ 1,832,855	3.7%	6.7%
$2,000 - $4,999	814	4,060	16.2%	80.9%	$ 2,532,897	$ 4,365,752	9.3%	16.0%
$5,000 - $9,999	407	4,467	8.1%	89.0%	$ 2,909,374	$ 7,275,126	10.7%	26.7%
$10,000 - $19,999	274	4,741	5.5%	94.5%	$ 3,875,136	$ 11,150,261	14.2%	40.9%
$20,000 - $29,999	95	4,836	1.9%	96.4%	$ 2,265,939	$ 13,416,200	8.3%	49.2%
$30,000 - $49,999	81	4,917	1.6%	98.0%	$ 3,191,740	$ 16,607,941	11.7%	60.9%
$50,000 - $99,999	65	4,982	1.3%	99.3%	$ 4,779,891	$ 21,387,831	17.5%	78.4%
> $100,000	37	5,019	0.7%	100.0%	$ 5,887,118	$ 27,274,950	21.6%	100.0%
	5,019		100.0%		$ 27,274,950		100.0%	

1. Expenditures include $3,673,348 in charges paid by the Vendor Drug Program and $106,229 in charges paid by the Medical Transportation Program.

Source: CSHCN Program, Texas Department of Health

Appendix E

CSHCN Medical Expenditures by Service Category FY 1997 - FY 2003

	FY 96	FY 97	FY 98	FY 99	FY 00	FY 01*	FY 02*	FY 03*
Inpatient Hospital	9,972,804	9,956,624	7,585,726	8,396,297	11,180,569	11,703,816	12,131,463	11,287,361
Other Hospital	2,684,438	2,518,608	2,180,906	2,372,253	2,814,365	2,635,925	2,804,434	2,777,222
Physician	3,321,577	2,902,894	2,459,999	2,402,703	2,382,390	2,020,506	2,020,506	2,020,506
Drugs & Supplies	4,273,338	4,326,954	4,373,800	4,605,203	4,796,575	4,594,960	4,870,657	5,162,897
Growth Hormone	485,209	513,325	375,515	232,365	377,589	359,978	395,975	435,573
Hemophilia Factor	4,091,205	3,079,562	3,363,742	2,804,541	2,971,285	3,471,059	3,375,475	3,375,475
Pulmozyne	388,054	306,864	280,702	333,800	334,634	263,405	276,575	290,404
DME	1,159,675	1,189,741	1,314,252	1,353,923	1,759,613	1,781,652	1,852,918	1,927,035
Home Health Care	24,110	28,121	22,690	26,081	16,517	14,505	14,505	14,505
Insurance Premiums	141,990	151,106	153,890	156,199	175,846	177,127	180,670	184,283
Meals, Lodging & Transportation	821,590	687,566	547,114	540,355	451,128	465,775	465,775	465,775
Total	27,363,990	25,661,365	22,658,336	23,223,720	27,260,511	27,488,708	28,388,953	27,941,036

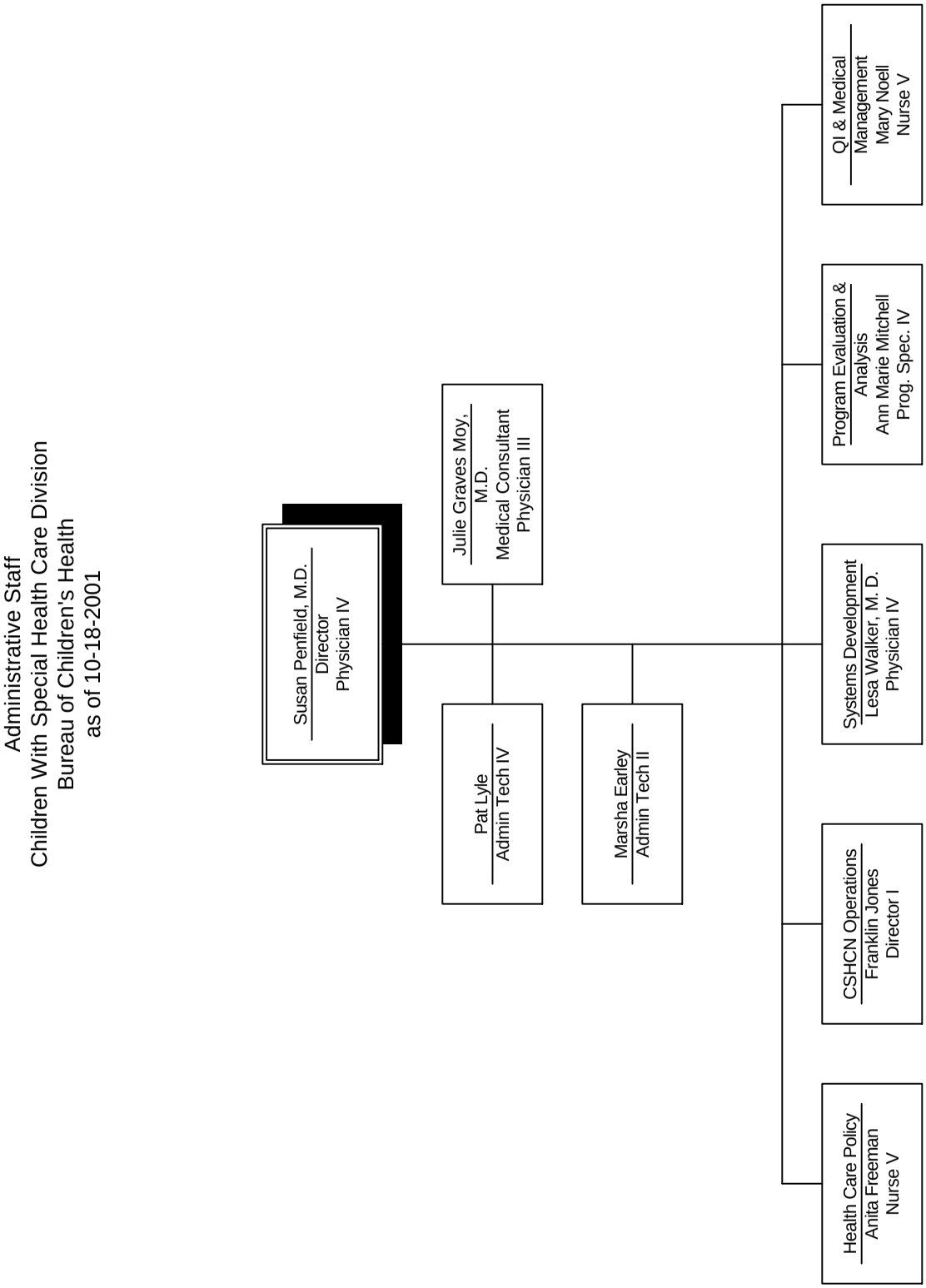
*FY 01 - FY 03 are projections. FY 01 - FY 03 projections do not include new services or new eligibility criteria, with the exception of FY 01 & 02 which included hospital reimbursement at 100% of TEFRA from July 01 - Nov 01.

Appendix F

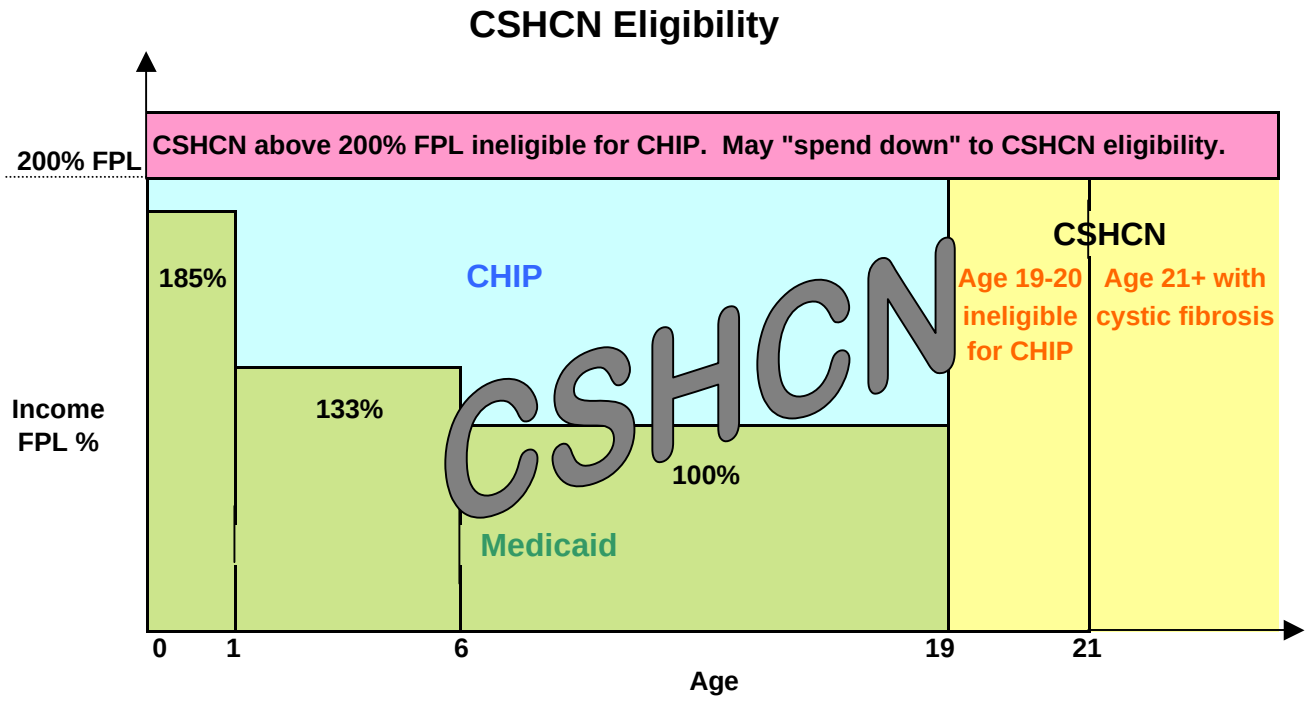
NHIC - CSHCN Trust Account
FY 2000 - FY 2002

Monthly	Beginning Balance	Checkwrite	Reissues	Recoupments	Interest Refund	Replenish Trust	Ending Balance
Sep-99	$ 2,027,577.24	$ (913,830.82)	$ 26.87	$ 9,662.70	$ 16,083.68	$ 2,105,071.65	$ 3,244,591.32
Oct-99	$ 3,244,591.32	$ (1,376,886.64)	$ -	$ 19,664.98	$ 14,253.87	$ -	$ 1,901,623.53
Nov-99	$ 1,901,623.53	$ (855,451.61)	$ -	$ 12,775.98	$ 10,747.90	$ 1,956,775.46	$ 3,026,471.26
Dec-99	$ 3,026,471.26	$ (1,225,745.06)	$ 16,765.60	$ 65,397.59	$ 14,828.54	$ -	$ 1,897,717.93
Jan-00	$ 1,897,717.93	$ (1,612,847.45)	$ 48.64	$ 12,942.32	$ 9,846.04	$ -	$ 307,707.48
Feb-00	$ 307,707.48	$ (1,284,826.25)	$ 4,620.84	$ 24,787.49	$ 3,807.92	$ 1,850,108.39	$ 906,205.87
Mar-00	$ 906,205.87	$ (1,660,317.03)	$ 613.54	$ 8,056.06	$ 705.64	$ 2,423,195.94	$ 1,678,460.02
Apr-00	$ 1,678,460.02	$ (1,632,542.37)	$ 19.35	$ 8,580.16	$ (139,568.31)	$ 2,757,243.26	$ 2,672,192.11
May-00	$ 2,672,192.11	$ (1,126,854.69)	$ 23.76	$ 2,775.16	$ (3,149.49)	$ 1,423,855.48	$ 2,968,842.33
Jun-00	$ 2,968,842.33	$ (1,480,264.44)	$ -	$ 6,423.61	$ (1,534.27)	$ 1,466,275.37	$ 2,959,742.60
Jul-00	$ 2,959,742.60	$ (960,524.24)	$ -	$ 7,907.21	$ (6,500.65)	$ 1,357,554.84	$ 3,358,179.76
Aug-00	$ 3,358,179.76	$ (1,716,815.43)	$ 1,240.10	$ 11,504.94	$ (9,865.11)	$ 1,429,553.03	$ 3,073,797.29
Sep-00	$ 3,073,797.29	$ (1,944,551.09)	$ -	$ 62,682.72	$ (3,701.11)	$ 1,476,925.38	$ 2,665,153.19
Oct-00	$ 2,665,153.19	$ (1,182,484.61)	$ -	$ 21,479.65	$ (3,091.64)	$ 1,401,915.75	$ 2,902,972.34
Nov-00	$ 2,902,972.34	$ (931,913.25)	$ 87.83	$ 13,256.95	$ (8,941.33)	$ 1,214,106.64	$ 3,189,569.18
Dec-00	$ 3,189,569.18	$ (1,692,265.93)	$ -	$ 22,597.00	$ (11,878.89)	$ 1,404,759.09	$ 2,912,780.45
Jan-01	$ 2,912,780.45	$ (792,848.47)	$ 444.89	$ 15,884.96	$ (9,336.79)	$ 1,376,813.13	$ 3,503,738.17
Feb-01	$ 3,503,738.17	$ (1,465,852.63)	$ -	$ 92,708.43	$ (10,283.39)	$ 1,334,986.00	$ 3,455,296.58
Mar-01	$ 3,455,296.58	$ (2,289,344.48)	$ -	$ 9,650.20	$ (10,425.68)	$ 1,392,451.56	$ 2,557,628.18
Apr-01	$ 2,557,628.18	$ (1,777,585.40)	$ -	$ 95,041.90	$ (6,165.87)	$ 1,491,635.03	$ 2,360,553.84
May-01	$ 2,360,553.84	$ (1,401,804.49)	$ -	$ 10,226.32	$ (3,782.38)	$ 1,569,950.23	$ 2,535,143.52
Jun-01	$ 2,535,143.52	$ (1,937,483.78)	$ 484.36	$ 8,741.02	$ (1,783.54)	$ 1,610,819.88	$ 2,215,921.46
Jul-01	$ 2,215,921.46	$ (1,293,652.84)	$ 44.95	$ 11,645.50	$ (2,024.05)	$ 1,694,287.27	$ 2,626,222.29
Aug-01	$ 2,626,222.29	$ (890,369.01)	$ 355.66	$ 234,526.63	$ (6,341.97)	$ 1,598,373.33	$ 3,562,766.93
Sep-01	$ 3,562,766.93	$ (1,571,814.88)	$ -	$ 650,851.97	$ (6,201.09)	$ 1,478,785.07	$ 4,114,388.00
Oct-01	$ 4,114,388.00	$ (1,617,767.70)	$ 670.01	$ 191,871.01	$ -	$ 1,452,148.78	$ 4,141,310.10

Appendix G


Administrative Staff
Children With Special Health Care Division
Bureau of Children's Health
as of 10-18-2001
Susan Penfield, M.D.
Director
Physician IV
Julie Graves Moy, M.D.
Medical Consultant
Physician III
Pat Lyle
Admin Tech IV
Marsha Earley
Admin Tech II
Systems Development
Lesa Walker, M. D.
Physician IV
Program Evaluation & Analysis
Ann Marie Mitchell
Prog. Spec. IV
QI & Medical Management
Mary Noell
Nurse V
CSHCN Operations
Franklin Jones
Director I
Health Care Policy
Anita Freeman
Nurse V

Appendix H



Note: CSHCN children ineligible for CHIP are those who:

* Have private insurance
* Are age 19-20
* Are age 21+ with cystic fibrosis
* Have income above 200% FPL
* Are undocumented

Source: CSHCN Program

CHILDREN WITH SPECIAL HEALTH CARE NEEDS EXPENDITURE PROJECTION FY02 AS OF 9/21/01			
Client Services Baseline	**Projected Expenditures***	**Assumptions and Background**	**Management Actions**
FY 01 Services Paid in FY 02	$3,378,000	Assumes that some FY 01 services will be paid in FY 02	Monitor cash flow as well as expenditures by service date monthly
FY 02 Services Incurred in FY 02	$28,389,000	Baseline costs for client services incurred in FY 02 for the CSHCN program projected to be $28.3M • Assumes no waiting list, no new services, no new diagnoses • Assumes 100% Medicaid hospital reimbursement for July-November 2001 • Projected by actuary with input from program and FMD • Includes trend analysis for drugs, hospitals, physicians, and other service categories • CHIP effect already reflected in the $28.3M projection, based on year's experience	• Monitor cash flow as well as expenditures by service date monthly • Monitor application, enrollment, and expenditure data monthly • Monthly update of projections (two sets—one based on client service date; one based on cash flow)
Client Services SubTotal	**$31,767,000**		
Projected Administrative Costs	**$15,587,614**	Includes traditional administration, NHIC contract, CSHCN public health activities, grants to local contractors, and regional infrastructure for CSHCN, including case management and eligibility determination activities.	Administrative review led by HHSC.
CSHCN Client Services and Admin SubTotal	**$47,354,614**		
New Services	**$1,626,000**	Assumes projected new services costs of approximately $1.63M (without waiting list) • Some new service projections based on Medicaid experience • Other new service projections are estimates • Assumes some clients with new diagnoses; (no changes to projections made on that basis to date) • Assumes new clients use services in similar manner as existing clients • Assumes no solid organ transplants (not added to policy at this time)	Estimates will be refined as CSHCN gains experience with new services • Monitor cash flow as well as expenditures by service date monthly • Monitor application, enrollment, and expenditure data for previously covered and new services monthly • Monthly update of projections (two sets—one based on client service date; one based on cash flow)

*The numbers projected in this document are estimates.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS EXPENDITURE PROJECTION FY02 AS OF 9/21/01			
Client Services Baseline	**Projected Expenditures***	**Assumptions and Background**	**Management Actions**
CSHCN with New Services SubTotal	**$48,980,614**		
Waiting List Impact	**($7,239,618)**	• Assumes that approximately 5,000 individuals will be enrolled in CSHCN on 10/5/01; no new clients added to the program after 10/5/01 except those with applications already received or postmarked before 10/5/01 • Assumes the expenditure patterns of the clients enrolled prior to the waiting list implementation will be similar to those of clients enrolled in CSHCN in FY 00 • Assumes the clients enrolled prior to the waiting list implementation will spend approximately 75.88% of the baseline client service dollars	• Monitor cash flow as well as expenditures by service date monthly • Monitor application, enrollment, clients served, clients on waiting list, and expenditure data for previously covered and new services monthly • Monthly update of projections (two sets—one based on client service date; one based on cash flow)
CSHCN with New Services and Waiting List SubTotal	**$41,740,996**		
FY 02 Services Incurred in FY 02, but paid in FY 03	($2,648,212)	Assumes that some FY 02 services will be paid in FY 03 • Estimated at $2.65M assuming a waiting list ($3.4M without a waiting list) • Will probably require change in Fiscal Agent RFP	Analyze financial feasibility of transitioning to service date reimbursement when funding allows.
Total Projected FY 02 Expenditures	**$39,092,874**		
Available Funds	$36,242,696	$32,742,696 in GR and Title V federal funds; $3.5M in additional Title V funds	
Projected Shortfall	($2,850,088)		
Section 33	($3,000,000)		
Net Projected Shortfall	**($5,850,088)**		