A Waiver Request

Submitted Under Authority of

Section 1115 of the Social Security Act

to

The Centers for Medicare and Medicaid Services

U.S. Department of Health and Human Services

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State of Texas
Rick Perry, Governor

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Texas Health Care Reform

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Executive Summary

There are 2.1 million low-income adults who lack insurance in Texas today. Most of these men and women work, yet they cannot afford to buy into their employer's health plan, or their job does not offer insurance. For these citizens, every health issue brings a choice: Try to get into a health clinic for the poor, pay for care out of meager wages, or wait and see if the condition gets worse. Waiting often wins.

When the working poor neglect their health care needs, we all pay a price. Health issues that could have been treated in a doctor's office can get worse and require more costly care later. Those without insurance do not have sufficient access to a regular doctor to help them manage chronic illnesses such as diabetes, asthma and heart disease. The result is crowded emergency rooms, skyrocketing uncompensated care charges, higher insurance premiums for other Texans and their employers, and poor health outcomes for those who are forced to make the difficult choice.

Senate Bill 10, passed by the 80th Texas Legislature and signed by Governor Rick Perry, gives Texas the tools to create new health coverage options for the working poor. In the future, low-income Texans will be able to use premium subsidies to choose from a range of affordable health plans or buy into employer-sponsored coverage. They will be able to choose their own doctor and have a medical home to manage their health issues in a more comfortable and less costly setting.

The Texas waiver request outlines a comprehensive package of health care reforms that will provide more people with insurance, reduce reliance on expensive emergency room visits for basic care, and make it easier for the working poor to buy into employer-sponsored health coverage. The reforms protect funding for our safety-net hospitals, reward innovative local efforts to reduce uncompensated care, and establish greater accountability and transparency in the reporting of uncompensated care costs. The Texas Legislature appropriated $150 million in additional state general revenue to serve as the financial catalyst for these reforms.

The goals of the Texas reform effort are to:

- Focus on keeping Texans healthy by providing premium subsidies for low-income uninsured citizens to buy in to employer-sponsored plans, or purchase market-based insurance or other coverage options. The state will emphasize providing people with easy access to primary and preventive care.
- Restructure current federal funding to gain flexibility in federal fund expenditures, optimize investments in health care, and reduce the number of uninsured Texans.

- Establish an improved, more integrated health care infrastructure to enhance quality and value with better data and information, increased coordination, better care management, and incentives to reduce uncompensated care and improve health care efficiency and effectiveness.

The challenge in Texas is big. Today, Texas has the highest uninsured rate in the nation. Compared to other states, Texas has lower wages, higher premiums, and fewer employers offering insurance. For a variety of reasons, Texas' current health care investment strategy too often focuses on uncoordinated care provided in the costliest settings, when undiagnosed diseases are more complicated and costly to treat. Uncompensated care costs in Texas are among the highest in the nation and lead to higher premiums for those with private insurance to help pay for the uninsured.[1]

The current system creates a costly self-perpetuating cycle that will not change until we change the system. When businesses drop group coverage because of rising costs, this means more uninsured people in our emergency rooms, which leads to even higher costs for those who can pay.

Working within the framework of Senate Bill 10 and federal policy objectives for health care financing, Texas proposes to transform its health care system. The cornerstone of the Texas plan is the creation of the Texas Health Opportunity Pool (HOP) trust fund that will serve as the funding source for targeted investments in our health care system.

The Health Opportunity Pool will be funded through a variety of federal and state sources and will be used to:

- Provide premium subsidies to low-income Texans.
- Develop a catastrophic coverage program for parents and caretakers.
- Reward hospitals for innovative efforts to reduce uncompensated care.
- Award grants to improve coordination, provide services and/or support the infrastructure for a more effective and efficient health care system.
- Increase family coverage by blending funds from the Medicaid Health Insurance Premium Payment (HIPP) program, HOP and the State Child Health Insurance Program (SCHIP) to enable families to buy into employer-sponsored coverage.[2]

Uncompensated care charges, as reported by Texas hospitals, went from $5.5 billion in 2001 to $11.6 billion in 2006. This trend will not change until we fundamentally reform the Texas health care system. Today, care for uninsured Texans too often takes place in hospitals and crowded emergency rooms – the most expensive points in the health care system.

With this waiver request, Texas is choosing to break this costly self-perpetuating cycle. The Texas plan redesigns the state's struggling health care system by reducing the reliance on expensive hospital-based care and making primary and preventive care affordable for all Texans.

[1] Institute of Medicine: Hidden Costs, Values Lost: Uninsurance in America. The National Academies Press, June 17, 2003. Uncompensated care funds are used to treat conditions that could have been treated earlier and more efficiently with primary and preventive care.
[2] See Section XII for additional details.

People who once relied on crowded emergency rooms for their care will be able to see doctors on a regular basis. Through the waiver, Texas is creating a more rational health care model that leads to better health outcomes and lower costs for all Texans.

Background

I. The Current Approach and the Need for Reform

The reform challenge in Texas is big. Texas has the highest uninsured rate in the nation, with one in four Texans without insurance. More than 25 percent of the population, or 5.5 million people, are uninsured. Twenty-nine states have total populations that are smaller than Texas' uninsured population.

Of Texas' total population, about 51 percent is privately insured;[3] 24 percent of the population is covered under publicly-funded programs; and the remaining 25 percent is uninsured. Looking solely at Texas' non-elderly population,[4] approximately 58 percent have private insurance; 15 percent are in publicly-funded programs, and 27 percent are uninsured. Table 1 compares Texas to national averages, showing a lower percentage of the non-elderly population with private insurance, about the same with publicly-funded insurance, and significantly higher percentage of uninsured.

Table 1
2006 Non-Elderly Population Only
Comparison of Texas and National Health Insurance Coverage
Percent of Population Distribution by Coverage Type

	Private Insurance	Publicly-funded Programs	Uninsured
United States[5]	**66.6%**	**15.8%**	**17.6%**
Texas	**58.1%**	**15.1%**	**26.8%**

Private insurance is typically accessed through employer plans or individual policies. Data generated through a Texas state planning grant awarded by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) program to the Texas Department of Insurance has documented that many working Texans either do not have access to employer-based coverage or do not enroll in it, primarily due to cost.

Fewer Texas employers offer insurance: 47 percent compared to the national rate of 54 percent, California's 49 percent or Massachusetts' 60 percent. Texas has a significantly lower rate of employer-sponsored health insurance coverage among small employers than the national average. Approximately 72 percent of all businesses in Texas are small businesses with fewer than 50 employees, and only 33.6 percent of these small businesses offer employer-sponsored

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[3] This includes both the elderly and non-elderly.
[4] The elderly are largely insured under Medicare.
[5] "Health Insurance Coverage in America," 2006 Data Update, October 2007, The Kaiser Commission on Medicaid and the Uninsured.

health insurance compared to the national average of 43 percent; in both California and Massachusetts the percent of small employers offering insurance exceed the national average.

There is also a significant gap in insurance coverage for large business employees when compared to the rest of the nation. While approximately 76 percent of all working Texans are employed by large business, Texas ranks 46th nationally in the percent of large businesses offering insurance. Table 2 provides relevant Texas and national comparative data on business health insurance coverage.

Table 2 **2005 Medical Expenditure Panel Survey (MEPS) Insurance Component**	**Texas**	**United States**	**Texas Rank**
Employees in small businesses[6]	1,976,805	31,274,563	3rd
Small businesses offering health insurance	33.6%	43.4%	40th
Employees in small businesses offering health insurance	49.8%	62.2%	42nd
Number of employees in large businesses	6,176,778	80,964,624	2nd
Percentage of employees in large businesses	75.8%	72.1%	2nd
Large businesses offering health insurance	93.4%	95.7%	46th
Number of employees in large businesses that offer health insurance	95.9%	96.4%	39th
Eligible employees who purchase insurance at large businesses offering insurance	77.0%	80.3%	44th

Cost is the primary issue that affects whether an employer offers coverage and whether employees take coverage that is offered. In a 2004 survey of Texas small employers, cost was cited by 65 percent of respondents as the primary reason for not offering health insurance. This is not surprising given that personal health care spending in Texas has increased an average of 9 percent annually since 1984. The average annual premiums for an individual enrolled in an employer-sponsored health benefit plan in Texas doubled between 1996 and 2004, from just more than $2,000 to more than $4,000. Premium trends make insurance too expensive for many individuals and businesses in Texas.

At the same time, Texas has a high number of low-income residents, and average wages in Texas are lower than wage rates nationally. Furthermore, as seen in Table 3, Texans also have higher premium costs than the national average.

Table 3 **2005 Medical Expenditure Panel Survey (MEPS) Insurance Component**	**Texas**	**United States**	**Texas Rank**
Average total annual single premium per enrolled employee	$4,108	$3,991	17th
Average total annual family premium per enrolled employee	$11,533	$10,728	5th

[6] In this table, small business refers to private-sector establishments with fewer than 50 employees. Large business refers to private-sector establishments with 50 or more employees.

Steep premium trends, lower average wages, higher poverty levels and higher average premiums contribute, among other factors, to Texans' challenges in accessing affordable health coverage. Yet the costs of not accessing health care are steep too.

A high rate of uninsured individuals leads to:

- Poorer health outcomes due to less access to primary and preventive care.[7]
- Increased costs of private insurance, as those with insurance subsidize the uninsured through higher premiums.[8]
- Over reliance on safety net providers, including hospitals and emergency rooms for care that is more expensive.[9]
- Crowded emergency rooms and costs for indigent care that outweigh available resources, stressing local, state, federal and safety net hospital resource and budget capacities.
- An increased likelihood of hospitalization for conditions that are avoidable, at an average cost of $3,300 per avoidable stay.[10]
- Increased mortality rates.[11]

A University of Texas School of Public Health study of 11 hospitals in Harris County illustrates how the state's high number of uninsured reduces access to primary and preventive care for the uninsured population and increases costs for hospitals and ultimately, taxpayers. A review of emergency room data for 2004 shows that nearly one-quarter of all emergency room visits were non-emergent in nature and that the uninsured accounted for 41 percent of these non-emergent episodes. The study also indicates that the uninsured accounted for nearly 38 percent of all primary care-sensitive visits (i.e., those that were either non-emergent or emergent but could have been prevented or avoided had proper primary care been provided).

Higher costs related to a high rate of uninsured generate insurance premium increases, threatening further erosion of individual, small group and employer-sponsored insurance coverage in a self-perpetuating cycle. Individual and family premiums in Texas in 2005 were 13 percent higher ($550 for an individual policy and $1,551 for a family policy) due to the costs of uncompensated care. By 2010, premiums in Texas are expected to be 14.4 percent

[7] Lack of insurance leads to poorer health because of less preventive care, diagnoses being made further in disease processes, and less access to therapeutic care. This leads to higher mortality rates for the uninsured: Institute of Medicine: Care Without Coverage – Too Little, Too Late, The National Academies Press, 2002.
[8] The impact of health care for the uninsured on premiums for private employer coverage in Texas in 2005 was $550 for individual and $1,551 for family coverage. This compared to national premium costs of $341 and $922 respectively. Only six other states had cost shifts at or above the level in Texas. Paying a Premium: The Added Cost of Care for the Uninsured, Families USA, June 2005.
[9] The uninsured are more likely to be hospitalized for avoidable conditions; and nationally, about 20 percent of the uninsured (vs. 3 percent of those with coverage) say their usual source of care is the emergency room. The Uninsured: A Primer, Key Facts About Americans without Health Insurance, January 2006, The Henry J. Kaiser Family Foundation.
[10] Institute of Medicine: Hidden Costs, Values Lost: Uninsurance in America. The National Academies Press, June 17, 2003.
[11] Dying for Coverage in Texas, Families USA, April, 2008.

higher ($922 and $2,786 respectively for individual and family premiums) due to uncompensated care.[12]

Higher costs of care, higher premiums and less access to care directly threaten the viability of employer-sponsored insurance, and indirectly present a significant risk for the entire Texas economy through poorer health status of the workforce, higher rates of absenteeism, and lower productivity.

In addition to having the highest rate of uninsured in the country, Texas' health system challenges are further exacerbated by Texas also having:

- The largest population growth of any state (absolute numbers).

- A significant portion of the population that is poor or low-income. In Texas, 43 percent of the population is below 200 percent Federal Poverty Level (FPL) compared to 36 percent nationally, 39 percent in California, 36 percent in Florida and 31 percent in Massachusetts. Twenty-one percent of all Texans have incomes below 100 percent FPL.

- The lowest annual household income (2004 – 2006: $43,425) compared to the national average of $46,071, California at $53,770, Florida at $44,448, and Massachusetts at $56,236. The combination of higher premiums and low incomes makes accessing health insurance even more challenging.

- One of the highest levels of uncompensated care in the country. Significant amounts of uncompensated care currently are provided where both acuity and costs are highest: hospital emergency rooms and inpatient services, which are overly costly and sometimes avoidable.

Taken together, these dynamics compound the challenge Texas faces today in a largely uncoordinated, but expansive collection of indigent care programs and responsibilities.

Some of the billions of dollars Texas spends for the uninsured are provided based on an historical and constitutional commitment to funding indigent care. Responsibility is shared through a statewide patchwork of local programs (with differing eligibility criteria) and federal and state funding. State law created county indigent health care programs, with requirements for counties, public hospitals and hospital districts to provide programs for low-income, uninsured Texans. Under these programs, public hospitals carry the largest burden of providing care. Approximately 150 public hospitals in Texas serve as the central and critical access points for uninsured persons seeking care. Sixty percent of the hospital cost for uninsured persons is covered by 45 of these public hospitals.

Many individuals rely on hospitals for care, in particular safety net hospitals, because they represent one guaranteed point of access in the health care system. The uninsured typically have to pay up front for primary and preventive services, and when they are unable to pay, can

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[12] Stoll et al., "Paying a Premium: The Added Cost of Care for the Uninsured", Families USA, 2005.

be turned away by many provider types.[13] Federal law requires that hospitals assess individuals seeking care through emergency rooms and prohibits hospitals from considering ability to pay as a criterion for providing emergency services. Safety net hospitals' historical missions to care for the indigent, as well as liability concerns, have also led to hospitals serving as a point of access to care.

At the federal level, health care financing has, in part, dictated health system policy. Texas' health system structure, in particular for the uninsured, reflects the federal funding flows with investments in hospitals as points of access for the uninsured. To address indigent care costs, the federal Medicaid Disproportionate Share Hospital (DSH) program requires payments to qualifying hospitals that provide uncompensated care. DSH regulations and rules relating to Medicaid rate setting create strong incentives for hospital-based care.

Specifically, the Texas DSH program provides supplemental payments to hospitals that serve large numbers of Medicaid beneficiaries and low-income or uninsured patients. DSH payments offset the costs not covered by payments from Medicaid, third-party reimbursement, and patient revenue collections. The state share of the Texas DSH program comprises a combination of funds from state-owned hospitals and intergovernmental transfers (IGTs) from nine hospital districts located in the state's largest metropolitan areas. This local funding mechanism coincides with historic precedent for local administration of care networks. With these funds, Texas draws down the available federal match (currently $901 million annually) for distribution to approximately 170 DSH-eligible hospitals across the state.

Even with DSH, due to the significant number of uninsured in Texas, unreimbursed hospital costs are growing with limited options for additional payments. Hospitals providing services to Medicaid patients are also eligible for supplemental payments available under the hospital upper payment limit (UPL) programs. Like the DSH program, Texas' hospital UPL payments are funded using local IGTs. The DSH and UPL supplemental payments illustrate that both state and federal rules, laws, and regulations reinforce a locally funded, hospital subsidy approach to address uncompensated care. While these funding streams can help offset indigent care costs, they do little to alter the underlying dynamic that creates these costs. By reimbursing hospital providers at the most expensive end of the care continuum, the state's current system fails to encourage the provision of primary and preventive care and other investments that are key to help moderate indigent care costs and growth.

A better investment strategy for Texas is to ensure that access to affordable primary and preventive care insurance and coverage is more broadly available. A broad array of state-specific health insurance survey and focus group data supports the need for and the value of primary care to low-income uninsured populations in Texas.

Texas received a five-year Health Resources and Services Administration (HRSA) State Planning Grant in 2001. Under this grant, the Texas Department of Insurance (TDI) gathered critical state insurance information and data, including insurance status, market and employer insurance data, and detailed employer and employee surveys and focus groups results. TDI also

[13] The Uninsured: A Primer, Key Facts About Americans without Health Insurance, January 2006, The Henry J. Kaiser Family Foundation.

received a State Planning Grant that assisted in the development of a Houston small employer pilot project. Other available Texas data includes meetings and interviews with the Service Employees International Union (which represents low-income employees), benefit preference data from the development of Texas multi-share programs including the University of Texas Medical Branch's program, and input received from our waiver stakeholder meetings and public input processes.

Some of the key points about the preferences of those low-income uninsured Texans whose opinions are reflected include:

- A preference for access to primary care. While affordable comprehensive care for all would be ideal, with limited funding, there is a preference for primary care. Lower income employees prefer access to primary care, and employers tend to prefer catastrophic care in order to protect their assets. Individuals without significant assets see more value in primary care services.

- The importance of first dollar coverage. Deductibles would present a significant barrier to individuals' ability to use insurance benefits, and would likely reduce take-up rates.

- A preference for point of service cost sharing versus premiums or enrollment fees. In developing a culture of insurance, the subsidy program will recognize current utilization, access and payment patterns, and transition to insurance approaches over time. Today, most uninsured seek care as it is needed, and pay point of service cost sharing in local programs or seek care in emergency rooms. For the low-income populations, paying for care when it is received makes more sense than spending scarce resources for a premium for care that may or may not be needed or accessed. Texas' approach starts with point of service cost sharing to begin fostering a culture of insurance.

Today, care for uninsured Texans too often takes place in hospitals and emergency rooms – the most expensive points in the health care system. The cost of that care is passed on to local governments and those with private insurance. When businesses drop group coverage because of rising costs, this means more uninsured people in our emergency rooms (or on Medicaid or other public programs), which leads to even higher costs for those who can pay.

The vision in Senate Bill 10 seeks to break this costly self-perpetuating cycle by improving our investments in health care, and providing low-income Texans with affordable insurance options to meet the needs of their families. To create a sound health care investment strategy, Texas' long-term goals are to reduce reliance on hospital-based care, create incentives for providing cost-effective care to indigent persons, slow the rate of growth in the cost of premiums for private health insurance, provide premium subsidies to improve access to affordable health insurance and coverage, encourage improved integration and coordination of local systems of care, and optimize the overall investment in Texas' health delivery system.

II. Legislative Authority

In June 2007, the 80th Texas Legislature passed and Governor Rick Perry signed Senate Bill 10, which created a foundation to transform the Texas health care system and increase the

number of Texans with access to primary and preventive care through health insurance coverage. The vision articulated in Senate Bill 10 provides a new investment strategy, provides the new funding, and provides the strategic vision to start the long-term system transformation needed to improve the health of Texans and their access to care.

The focus of Senate Bill 10 and the Texas health care reform efforts, which are consistent with the principles of the President's Affordable Choices Initiative and his policies to help make health care more affordable and accessible, include the following:

1. **Restructure current federal, state and local financing to gain flexibility, optimize investments in health care and reduce the number of uninsured Texans.**
   - Utilize new flexibility granted in the Texas Health Opportunity Pool (HOP) fund to provide premium subsidies to low-income, uninsured Texans to purchase basic, affordable market-based insurance and other coverage options.
   - Provide continued support for Texas' critical safety net providers, while ensuring that the hospital and public financing strategy supports policy objectives to improve health care and health outcomes.
2. **Promote consumer opportunities, choice and responsibility for health and health care with a focus on keeping Texans healthy.**
   - Focus on a sustainable market-driven approach.
   - Build on many of the concepts from the Deficit Reduction Act of 2005 including consumer responsibility through cost sharing and choice of health benefit plan options.
   - Emphasize primary and preventive health care, medical homes, and enhanced care management.
   - Initiate healthy lifestyle pilot programs and other incentives for positive health behaviors that improve health status.
   - Require that everyone contributes to the cost of care, either through sliding scale subsidies, point of service cost sharing or both.
3. **Promote public-private partnerships.**
   - Support and reinforce employer-sponsored insurance through the premium subsidy program, improvements to the Texas Medicaid Health Insurance Premium Payment (HIPP) program, request authority to implement a new CHIP Premium Assistance program for CHIP eligible children, and eventual blending of funds from various programs (e.g., Medicaid, CHIP, and HOP) for family coverage.
   - Encourage and build upon existing and proposed partnerships including multi-share programs.

- Provide grants to support innovation and best practice implementation in local and regional systems.

4. **Establish the infrastructure to enhance quality and value through better care management and performance improvement incentives.**

    - Implement new reporting requirements to support data-driven health policy. Hospital initiatives, such as reforms to hospital reporting for uncompensated care to create broader transparency and accountability, will strengthen the basis for future payment reforms, provide incentives to reduce the need for uncompensated care, and improve value.

    - Encourage medical efficiency and patient protection by promoting the development and use of electronic health information standards and electronic health records.

    - Provide HOP-funded grants to reduce uncompensated care and improve system efficiency, integration and coordination.

Summary of the Proposal

To transform its system of care, Texas seeks flexibility in funding and coverage under the authority of Section 1115 of the Social Security Act to create the Texas Health Opportunity Pool (HOP) trust fund as the funding source for targeted investments in Texas' health care system. Texas does not propose to include any existing Medicaid populations in the waiver.

Specifically, the state is requesting this waiver to allow Texas to:

- Achieve flexibility in regard to distribution and uses of DSH and UPL funds over the waiver period to create allocation methods under reform that are consistent with state and federal health policy goals and objectives.
- Recognize the HOP trust fund for the purposes identified in this waiver.
- Use recognized state and local expenditures as a state match for HOP funding.
- Provide grants for infrastructure improvements and innovative programs to reduce uncompensated care.
- Implement a health care subsidy program for uninsured Texan's at or below 200 percent FPL. Subsidies are initially planned to be offered to uninsured parents with incomes at or below 133 percent FPL, and to childless adults with incomes at or below 100 percent FPL.
- Have the flexibility to change the FPL eligibility levels based on available funding.
- Achieve flexibility in delivery systems, benefits and cost sharing requirements.
- Implement a limited catastrophic care spend-down benefit (inpatient and inpatient physician services) for parents and caretakers.
- Implement a new CHIP premium assistance program for CHIP-eligible children.
- Implement new blended funding options for the Medicaid HIPP and CHIP PA and HOP programs to facilitate family coverage under ESI.
- Achieve flexibility related to HOP eligibility and enrollment processes and procedures.

III. The Texas Health Opportunity Pool Trust Fund

The HOP will be funded with:

- Combined federal DSH and trended UPL funds based on UPL caps.
- State match for non-state DSH and UPL funds. This includes IGT funds.
- Federal Title XIX funding for state plan populations covered under the waiver. This includes HOP coverage for parents and caretakers with incomes at or below 200 percent FPL depending on available funding, and catastrophic care benefits for parents and caretakers established as a catastrophic care program with benefits provided under the authority of this waiver. Subsidies are initially planned to be offered to uninsured parents with incomes at or below 133 percent FPL, and to childless adults with incomes at or below 100 percent FPL. The state seeks flexibility to change the FPL levels based on available funding.
- State general revenue from funding sources allocated to the HOP. This includes revenues from House Bill 1751, 80th Legislature, Regular Session, 2007, and any other general revenue targeted to the HOP.
- State match recognized by the Centers for Medicare and Medicaid Services (CMS) for qualifying public expenditures for the uninsured. Public expenditures include state general revenue, local and other tax-based expenditures in unmatched programs providing health services to the uninsured.
- New IGT funds to pay for a portion of the state's share of the catastrophic care benefit to be offered in the HOP.

The 80th Legislature appropriated $150 million in additional general revenue to make funds available in the HOP. The appropriation was targeted to increased hospital rates, and the DSH previously used to pay for the Medicaid shortfall amounts will be allocated to the HOP for subsidies.

IV. HOP Fund Expenditures

Texas proposes to reallocate hospital DSH and UPL funding to alter uncompensated care financing, and invest those funds in premium subsidies, infrastructure development, and improved system coordination. Texas also seeks authority in the waiver to create the basis upon which current DSH and UPL funds are allocated to hospitals, in order to create allocation methods consistent with state and federal health policy goals and objectives, including supplemental payments to support delivery systems that have proven to be more efficient.

Funding from the HOP will be used to pay for:

- Health care coverage for target population groups, all of which include only citizens and legal permanent residents under 200 percent FPL. Under the waiver, Texas seeks authority to use HOP funds to pay for the following:
  - Full benefit costs for certain children up to age 19 not currently covered by private insurance who are not eligible for Medicaid, Medicare, or Texas SCHIP. These children will receive the current Texas CHIP benefit plan, though paid for with HOP funds, and will have benefits provided through managed care organizations currently providing coverage to CHIP enrollees. Coverage for this group will begin in waiver year one, with eligibility and enrollment managed through the same eligibility and enrollment process as current CHIP eligibles.
  - Full benefit costs for former foster care members who are 21 through 22 years of age and who have aged out of Medicaid and are enrolled in higher education. These individuals will receive the current Texas CHIP benefit plan, though paid for with HOP funds, and will have benefits provided by managed care organizations currently providing coverage to CHIP enrollees. Coverage for this group will begin in waiver year one, with eligibility and enrollment managed through the same eligibility and enrollment process as current CHIP eligibles.
- Sliding scale subsidies for adults, including parents of Medicaid and/or CHIP children, and other parents and childless adults. Coverage for this group will begin in waiver year three, paid for with HOP funds.
  - Eligibility and enrollment of this population will be managed through a vendor to be procured by the state.
  - HOP funds will be used to provide subsidies to these HOP enrollees, who will use them to buy market-based insurance or other coverage options.
  - HOP enrollees with access to ESI will be required to use their subsidies to enroll in ESI, provided the ESI meets state-identified qualifications such as affordability.
  - For those without access to qualifying ESI, benefits packages will be proposed by market-based insurers and other coverage options in the state (such as three share programs). The state will seek to include a manageable range of choices from which enrollees may choose; however, all eligibles will have a choice of at least one primary and preventive benefit package. The state will also seek to include options for catastrophic care packages, and more comprehensive packages from which individuals will choose.
- Administrative costs for HOP management and vendors.
- A catastrophic coverage program to be offered to parents and caretakers whose medical bills make them eligible for a medically needy program. The program will provide hospital

inpatient and hospital physician services. Coverage for this group will begin in waiver year one, paid for with HOP funds.

- New blended funding options for employer-sponsored insurance to provide family coverage opportunities (i.e., Health Insurance Premium Payment-Health Opportunity Pool or HIPP-HOP and Children's Health Insurance Premium Assistance-HOP or CHIP PA-HOP).

- Payments to public and private hospitals. Under reform, hospitals will continue to meet their current constitutional obligation to provide services to indigent groups that may include undocumented immigrants (only DSH funds will be used for services to this group), individuals who choose not to enroll in publicly-funded or HOP coverage, and individuals not eligible to be enrolled in HOP coverage. However, to qualify for receipt of HOP funds, hospitals will be subject to new requirements consistent with system reform. The state also seeks authority to alter the basis upon which current DSH and UPL funds are allocated to hospitals, in order to create allocation methods consistent with state and federal health policy goals and objectives, including supplemental payments to support delivery systems that have proven to be more efficient.

- Local and regional grants for infrastructure development and initiatives to improve health delivery system coordination, and reduce uncompensated care. Grants would be available to hospital and non-hospital organizations, as well as local units of government, 501(c)3 organizations, etc. Approved proposals will be required to document local community participation and show how they leverage existing resources and initiatives. Proposals must also document how they will achieve improved health system coordination and integration. Grants will be available in Years 1, 2 and 3 of the program.

Texas is also requesting authority under this waiver to:

- Use CHIP premiums to contribute to ESI for CHIP-eligible children. For families with members eligible for SCHIP, Medicaid and HOP, the state will seek to blend funds to enable the family to purchase available ESI. SCHIP funds will not be used for direct purchase of subsidies for adults.

- Cover target populations up to 200 percent FPL consistent with approved funding under the negotiated budget neutrality agreement, with actual FPL levels dependent on availability of funds.

- Implement an enrollment cap for covered adult populations and programs to ensure necessary control over the program budget.

V. Additional Reform Components

Texas will enhance the HOP reform activities implemented through the authority granted under the waiver with additional reform initiatives not requiring waiver authority. These complementary reform initiatives will include:

- Creation of a new Work Group on Uncompensated Hospital, and the development of new requirements to enable data-driven state health, uncompensated care, public health, and insurance policy development:
  - Development of new hospital uncompensated care cost and financing reporting requirements, to form the basis for uniform, reliable, and transparent uncompensated care reporting.
  - Creation of new uncompensated care claims submission requirements for all hospitals receiving DSH or UPL funds, as the basis for state and regional analysis of uncompensated care charges, utilization patterns, and disease conditions in the uncompensated care population.
- Development by the Texas Health and Human Services Commission (HHSC) and the Texas Department of Insurance of an analysis and recommendations for small employer premium assistance programs as required by Senate Bill 10.
- Identification of Texas health insurance market initiatives to lower state health care costs, improve health outcomes, and increase access to private coverage and market-based coverage options for the uninsured, based on a Texas Senate interim study of the Texas health insurance market's transparency and efficiency.
- Re-engineering of the state's HIPP and ESI administration capabilities to support Medicaid, CHIP, HOP and blended funding access to ESI programs.
- Development of local and regional multi-share programs to support affordable employer-based coverage, as authorized by Senate Bill 10.
- Implementation of disease management pilots that integrate state, local and private resources.
- The House Committee on Insurance will complete several studies related to potential health care reforms, such as:
  - Research and examination of other states that have transitioned from heavily regulated insurance markets to less regulated markets in order to assess the impact on market competition, pricing, consumer satisfaction and regulatory costs. Identification of current barriers and possible enhancements to flexibility in purchasing health insurance. Review and evaluation of state law and agency rules related to the use of health savings accounts and health reimbursement arrangements, particularly by small businesses. Review of possible tax incentives for purchase of private health insurance.
  - Study and recommendations concerning increased portability of health insurance.
  - Study and recommendations concerning the feasibility of establishing a "health insurance exchange" in Texas.

- Recommendations on potential alternatives to the Texas Health Insurance Risk Pool for providing private health insurance to otherwise uninsurable individuals.

VI. Target Population

Texas does not propose to include any existing Medicaid populations in the waiver. Under the authority of the 1115 Waiver, Texas will provide a benefit package or premium subsidies through the HOP to citizens or legal permanent residents (LPRs) who do not qualify for Medicaid, Medicare or SCHIP, with household incomes up to 200 percent of the FPL depending on available funding. Subsidies are initially planned to be offered to uninsured parents with incomes at or below 133 percent FPL, and to childless adults with incomes at or below 100 percent FPL. Table 4 provides more specific information on the maximum target population and implementation timeframes.

Table 4. Target Population Information at 200 percent FPL

Target Population	Est. # Eligibles	Eligibility & Enrollment	Coverage Options	Benefits and Cost Sharing
Waiver Year 1 (SFY 2009)				
1) Former foster care members who have aged out of Medicaid (age 21-22) and are enrolled in higher education.	450	Processed by the State's CHIP eligibility & enrollment contractor	Contracted CHIP health plans	CHIP benefit/Rx package, with CHIP cost sharing requirements
2) Certain children at or below 200% FPL who do not qualify for Medicaid, Medicare or Texas SCHIP, and who are not enrolled in private insurance. (Includes children of certain school employees, and legal immigrant children not eligible for SCHIP.)	30,120	Processed by the State's CHIP eligibility & enrollment contractor Note: Eligibility is determined annually, for a 12-month period.	Contracted CHIP health plans	CHIP benefit/Rx package, with CHIP cost sharing requirements
3) Uninsured parents and caretakers whose medical expenses are used as an offset to spend-down to the State's allowable medically needy levels (fixed amounts, which currently equate to between 17-19% FPL depending on household size)	16,820	Processed by the State's Medicaid eligibility support services contractor. Note: Eligibility is event/ time limited, and is determined after costs have been incurred to allow for spend-down to required FPL.	Limited catastrophic care benefit (inpatient and inpatient physician services)	Recipient is responsible for medical expenses incurred and used to spend-down to the required FPL level.
Waiver Year 3 (SFY 2011)				
Target Population	**Est. # Eligibles**	**Eligibility & Enrollment**	**Coverage Options**	**Benefits and Cost Sharing**
4) Uninsured parents and caretakers (including parents of Medicaid or CHIP enrolled children), at or below 200% FPL	965,150	Processed by a new HOP administrative services contractor, unless being enrolled into an ESI option through the State's	Market-based options, such as employer-sponsored insurance and	Market-based benefit options, such as: basic primary & preventive care, comprehensive coverage,

Table 4. Target Population Information at 200 percent FPL				
5) Uninsured childless adults, at or below 200% FPL	1,212,890	HIPP administrator. Note: Eligibility is determined annually, for a 12-month period.	other non-employer based health insurance options	catastrophic/HSA; cost sharing based on choice of benefit plans.

Table 5 summarizes Texas' uninsured population in relationship to the targeted adult population.

Table 5 2006 CPS Survey - Uninsured in Texas[14]	Number or percent of uninsured
Total number of uninsured	5,515,677
U.S. citizen and legal permanent residents (LPRs) as a percent of total uninsured (estimated)	88%
Uninsured adults age 19-64 (U.S. citizens and LPRs)	3,607,335
Uninsured adults age 19-64 (U.S. citizens and LPRs) with income at or under 200% of FPL	2,147,924
Uninsured adults 65 years of age and older (U.S. citizens and LPRs) with income at or under 200% of FPL	30,943

Table 6 describes the characteristics of 19-64 year old Texans who will comprise the majority of the target adult population.

Table 6. Description of Uninsured Texans Age 19-64: 2006 CPS Data[15]			
Population Characteristics			
Gender	Female	1,129,898	53%
	Male	1,018,026	47%
Race	Hispanic	1,187,584	55%
	White	591,564	28%
	Black	312,337	15%
	All Other	56,439	3%
Work Status	Employed	1,253,660	58%
	Unemployed	894,264	42%
Age	19 to 24	504,773	24%
	25 to 34	590,281	27%
	35 to 44	491,581	23%
	45 to 64	561,289	26%

[14] Source: U.S. Census Bureau, March 2006 Current Population Survey (Texas Sample)
[15] Source: U.S. Census Bureau, March 2006 Current Population Survey (Texas Sample)

Table 6. Description of Uninsured Texans Age 19-64: 2006 CPS Data[15]			
Population Characteristics			
Parental Status	Childless Adults	1,181,949	55%
	Parents	965,975	45%

Also included will be uninsured adults under 200 percent FPL over 64 years of age not eligible for Medicaid or Medicare (an estimated 31,000 individuals in Texas).

VII. Eligibility and Enrollment

Under the Section 1115 Waiver, the state will provide access to the Texas CHIP benefit package, provided by CHIP contracted health plans, for children and former foster care members covered under the HOP. Prior to the implementation of HOP for the adult population, the state will issue a competitive procurement for HOP administrative service functions. Once implemented, the state will offer the adult populations an array of market-based insurance and other coverage options.

A. Eligibility

Eligibility requirements will include those individuals who:

- Have incomes at or below 200 percent of the FPL. Subsidies are initially planned to be offered to uninsured parents with incomes at or below 133 percent FPL, and to childless adults with incomes at or below 100 percent FPL.
- Are Texas residents.
- Are U.S. citizens or LPRs.
- If eligible, apply for and accept coverage under an ESI policy, provided the ESI policy meets state qualifications.
- Are ineligible for Medicare, Medicaid or SCHIP.

The Section 1115 Waiver is designed to ensure the accessibility of more affordable health insurance products while avoiding crowding out current ESI markets. Adults seeking access to the subsidy program who have had health insurance coverage in the past six months will be ineligible for HOP subsidies unless insurance is lost for good cause, such as involuntary loss of insurance because the employer dropped the coverage.

All eligibility under the new Texas health care reform is based upon the availability of funding as determined by the Legislature and the Comptroller and in compliance with the budget neutrality agreement. The state seeks the authority to implement an enrollment cap for this waiver program to ensure necessary control over the program budget.

Marketing and Outreach

In addition to identifying potential eligibles through existing state systems for Medicaid, CHIP and Food Stamps, the state will develop a plan to effectively reach potential HOP-eligible individuals in their communities. The plan will include existing community infrastructures as well as providers and targeted programs such as Head-Start programs to reach parents and eligible children; school-based programs to reach educators, civic groups, children, and parents; faith-based and other community organizations to spread and reinforce the message about the importance of health coverage; and community chambers of commerce to reach small and medium sized businesses and employers.

Eligibility Period

- HOP subsidies will be offered with 12 months of continuous eligibility.
- Eligibility is prospective and begins on the 1st day of the month following enrollment. There is no retroactive eligibility, only prospective eligibility, once enrolled in a health plan.
- Eligibility may be lost during an active eligibility period for certain reasons, including the following:
    - The individual no longer resides in Texas.
    - The individual enrolls in Medicaid, SCHIP or Medicare.
    - Enrollment will be revoked should an individual fail to pay necessary premium contributions.
    - Death.
- Existing enrollees will be sent eligibility renewal information 3 months prior to the end of their current enrollment period to be completed and returned by a designated date.
- Eligibility information will be updated annually and an assessment of continued eligibility will be made.
    - If the enrollee is still HOP eligible, enrollment in the program will continue without a break in eligibility.
    - If the enrollee is no longer eligible for the program, enrollment will end on the last day of the month for the current enrollment period.
    - If the enrollee does not return the required information within the designated timeframe, a lapse in eligibility may occur.
- There is no default enrollment in a health plan or health insurance product. If an eligible consumer does not select a health plan within 45 days, program eligibility is lost or pended.

Eligibility for the catastrophic care benefit under the HOP will follow eligibility for the medically needy program. Eligibility will be determined on a month by month basis with provider funding reimbursed directly through the state claim payment administrator using HOP funds as the method of finance.

Eligibility for children and former foster children accessing benefits through the CHIP program will be consistent with CHIP eligibility process and timeframes.

B. Enrollment

For the initial implementation group (children, former foster care members, and uninsured parents and caretakers whose expenses are used as an offset to spend-down to the state's allowable medically needy levels), enrollment will be handled by the state's Medicaid and CHIP enrollment contractor. For the subsequent adult implementation group, enrollment into ESI coverage and non-ESI market-based health plan coverage options will be handled through an administrative contractor (see Attachment G for a diagram of the eligibility and enrollment process for adults). The contractor will provide eligibility and enrollment functions such as those now provided by the state's CHIP administrative contractor.

For those with access to qualifying ESI, the Section 1115 Waiver will require participation in employer-sponsored coverage as a requirement for eligibility. Any subsidy would then be available to offset the employee share of the costs. Those without access to acceptable and affordable ESI can apply the HOP subsidies to designated market-based insurance and other coverage options that manage and coordinate care and meet the state's qualifying criteria. Eligible consumers will be provided with plan comparison information and counseling, if needed, to assist them in making a selection.

Texas will have periodic open enrollment periods for individuals to apply for HOP subsidies based upon funding availability. Participation in the Texas Health Opportunity Pool will be voluntary.

VIII. Reforming Indigent Care Delivery and Reimbursement

Texas has an expansive but largely uncoordinated collection of indigent care programs and responsibilities. To improve coordination in the indigent health care delivery system and reduce the burden of uncompensated care, in particular for those without access to HOP subsidies, Texas reform seeks authority to award HOP-funded local and regional grants for infrastructure development and initiatives to reduce uncompensated care. Texas will also implement new requirements for hospital initiatives to reduce uncompensated care as a criterion for receipt of HOP funds.

A. Incentives and Funding for System Transformation

During the first three years of the waiver, the state's targeted efforts to reduce uncompensated care will include grants for local and regional community-based health care programs. These

grants will support local and regional innovative programs aimed at improving access to health care services, enhancing quality of care for the uninsured and some underinsured individuals, and improving coordination of indigent services provided locally and regionally. Grants would be available to hospital and non-hospital organizations, as well as local units of government, 501(c)3 organizations, etc. The grants are time limited and are not intended as an ongoing source of funding for programs.

Approved proposals will be required to document local community participation and show how they leverage existing resources and initiatives, and how and whether they will achieve improved health system coordination and integration. By partnering with local communities, the state will support programs that will continue into the future. By partnering with local communities, the state will also supplement the care of individuals, some of whom may eventually be enrolled in the HOP-funded premium assistance subsidy program.

Grants can be used to replicate initiatives that have been successful in Texas and other parts of the country, as well as new approaches that support the overall goals of reform. State grants will support a variety of approaches, some of which may include the following.

- Local service infrastructure integration and coordination.
- Case management for certain groups of individuals that benefit from access to this service.
- Multi-share coverage programs that increase access to health care.
- Electronic health information systems.

Programs will need to reflect local community participation and show how they leverage existing resources and initiatives, how they will continue when grant funding ceases, and how they will complement HOP subsidies when they are implemented. Technology solutions may include regional health information collaborative initiatives that focus on using health information technology to coordinate care for indigent persons across health care systems.

Texas already has models for innovative approaches to care improvement with best practices that can be leveraged. Below are some local and regional examples of such programs:

- University Health System's CareLink program in San Antonio offers a primary and preventive care network and discounted payment plans for the uninsured.[16]

- Project Access in Dallas coordinates voluntary services of physicians, pharmacies and labs, hospitals and other community providers; funds care managers to provide and coordinate care; improves quality of life; and saves the system and local community money in reduced emergency room visits and hospital costs.[17]

- Austin's Indigent Care Collaboration (ICC) is a regional, non-profit health coverage program provided by a consortium of local provider groups, hospitals, and public clinics. The ICC has developed an innovative community level infrastructure for a shared longitudinal electronic health records system for Austin's uninsured and other low-income patients. The system was

[16] http://www.universityhealthsystem.com/carelink/default.shtml
[17] https://www.projectaccess.info/html/about.html

designed to improve care continuity and delivery. It also saves the local indigent care system money by tracking tests and other medical information on patients who seek care from a variety of providers within the community.

- Harris County's Hospital District and local community have the largest CMS-sponsored Demonstration to Maintain Independence and Employment (DMIE) program in the country. By developing a public/private partnership to coordinate and provide comprehensive services for individuals with behavioral health needs who are at risk of losing employment and independence, the program is designed to improve health status, quality of life and employment success, and reduce health care costs in the community and at the state and federal levels.[18]

Key elements of most of these innovative programs are: 1) the community's recognition of the need to identify and coordinate existing resources and new resource options; 2) the development of integration and coordination approaches that leverage the community's potential; and 3) the existence of a local catalyst to create systems of care that build upon, but are greater than, the parts contributing to them.

These and other successful programs in Texas show the potential for coordinating community, regional and state resources to improve individual and public health and quality of life, and reduce health care costs through innovation, coordination and creative approaches and investment strategies. The grant programs authorized in Senate Bill 10 and the new requirements for receipt of DSH and UPL funds will provide incentives to develop new initiatives, replicate and improve on successful programs, and provide support to transform systems of care at the local levels where care is provided.

HOP participants who select primary and preventive care coverage will be able to locate additional services available in the community. Those who choose catastrophic coverage can identify affordable primary care services available locally. The state will work on establishing the framework to conduct pilot programs in selected areas of the state and in partnership with local communities to build a database of locally-driven health care programs and other services that could be used by the communities and individuals.

B. Supplemental Payments to Hospitals and Associated New Requirements

While hospital costs incurred in the delivery of services to the uninsured must be supported with a portion of HOP funding, DSH and UPL hospital payments made under the authority of this waiver will include payment requirements to achieve specific policy objectives with the ultimate goal of reducing uncompensated care. HOP-funded hospital reimbursement will focus on improving incentives for the provision of cost-effective and quality health care, strengthening hospital data reporting and collection, and supporting the development of innovative care models for providing services to indigent groups. By focusing payment incentives at the local level, the state will be able to leverage local and regional innovation to

[18] http://www.utexas.edu/research/cswr/nida/DMIE.htm
See also: http://www.cms.hhs.gov/TWWIIA/downloads/DMIEStateProjectSummaries.pdf

address issues unique to each area. Texas' diverse population and expansive geography demand a regionally diverse approach to complement and coordinate with statewide efforts.

Senate Bill 10 included new requirements that hospitals must meet to qualify to receive any DSH or UPL funds in the HOP. As a condition for receiving HOP funds for uncompensated care, hospitals must implement or maintain initiatives to reduce the need for uncompensated care. Examples include programs for emergency room diversion, improved primary and preventive care, healthy lifestyles, and other strategies to prevent unnecessary hospitalizations.

Senate Bill 10 also created a Hospital Uncompensated Care Workgroup, led by the Health and Human Services Commission and including representatives from Texas hospitals. Workgroup tasks include developing new requirements to enable data-driven state health, uncompensated care, public health, and insurance policy development.

- Development of new hospital uncompensated care cost and financing reporting requirements, to form the basis for uniform, reliable, and transparent uncompensated care reporting.

- Creation of new uncompensated care claims submission requirements for all hospitals receiving DSH or UPL funds, as the basis for state and regional analysis of uncompensated care charges, utilization patterns, and disease conditions in the uncompensated care population.

IX. Reform Principles Consistent with the Deficit Reduction Act of 2005

Texas analyzed options available under the Deficit Reduction Act (DRA). Due to the limited number of optional populations that Texas covers under its current program, there is limited opportunity to implement provisions of the DRA. However, many strategies supported by the DRA are consistent with Senate Bill 10 and will be incorporated into the Section 1115 Waiver, including the following:

- **New Options for Benefit Packages**

  The Section 1115 Waiver will provide access to basic health care services, as well as a manageable choice of additional benefit options such as catastrophic and comprehensive plans.

- **Employer-Sponsored Insurance Buy-In**

  The Section 1115 Waiver will require enrollment in employer-sponsored plans where available, acceptable and affordable (in accordance with minimum standards established by the state), as well as the possible pooling of HOP, Medicaid and SCHIP funds to support family coverage through employer-sponsored plans.

- **HOP Health Savings Account Plan Option**

The state will encourage market-based insurance to propose options for a high-deductible plan coupled with a health savings account.

Senate Bill 10 also includes multiple strategies supported by the DRA that will be incorporated into the Medicaid program. While Medicaid is the primary target for these initiatives, the policy objectives and resulting improved outcomes will also support the design of the Section 1115 Waiver subsidy program and the CHIP program. See Attachment B for a list of those strategies.

X. Benefits

Children and former foster care members covered under the HOP will receive the state's CHIP benefits, subject to CHIP cost sharing requirements. The state will not provide Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits, nor other wrap-around services to children covered under the HOP. Discussion of the adult benefits is included below. Uninsured parents and caretakers whose medical expenses are used as an offset to spend-down to the State's allowable medically needy levels (currently around 17-19 percent FPL), will be provided with a catastrophic care benefit. This benefit will cover hospital inpatient costs and costs for physicians services provided in an inpatient setting.

A. Benefits for Texas' Diverse Uninsured Populations

<u>Diversity and Choice</u>
The 5.5 million uninsured Texans are uninsured for a variety of reasons. Many do not have access to health insurance in the group or individual market. Some may have access, but find that the premiums are unaffordable. Some cannot find insurance at any price, because of pre-existing conditions. Still others, in particular the so-called "invincibles," are relatively young, often single individuals who choose not to buy a typical insurance package and do not anticipate the need for coverage.

To address Texas' focus on providing primary and preventive care while acknowledging the different causes for the state's uninsured rate, the waiver will provide sliding scale subsidies that can be used for enrollees' choices of benefit packages. Packages would be offered by the market to meet the different needs and preferences of currently uninsured Texans.

Consistent with the state's overall investment strategy of making primary and preventive care available, affordable primary and preventive care programs will be an option for all eligible uninsured Texans to purchase with their subsidies. Not only do these benefits make sense from a health care and social investment perspective, surveys, studies, interviews and focus groups reflect that low-income uninsured Texans prefer first dollar coverage (with low or no deductibles) to support access to primary care.

While primary and preventive care is preferred by many of the uninsured, others are more likely to prefer catastrophic only coverage. In Texas, 45 percent of young adults 18 – 24 and 36 percent of 25 – 34 year olds are uninsured. Of uninsured adults under 200 percent FPL, 51 percent are 19-34 years of age. Some of these are unable to afford insurance, and some choose

not to spend their income on traditional benefit packages. Under the waiver, Texas will include catastrophic plans, targeted to these "invincible" young, healthy, active, uninsured individuals, and to others who might choose this option. Still other uninsured Texans may want a mix of primary, preventive and some level of inpatient care.

Ensuring Value

To ensure that the enrollees as well as the state and federal governments are receiving appropriate value for the benefits and subsidies provided, the state will identify qualifying criteria for benefit packages, and solicit basic, comprehensive and catastrophic coverage options in regions throughout the state from which eligibles can choose. The state's goal will be to have sufficient carriers and benefits to provide enrollee choice without saturating the market and overwhelming enrollees with too many choices and options.

Additionally, the state will analyze the actuarial value of proposed benefit packages. It will require that subsidies paid will not exceed the actuarial value of the qualified benefit packages available for purchase with HOP subsidies.

Catastrophic Care

A catastrophic coverage benefit will be provided within the HOP for parents and caretakers whose medical bills make them eligible for a medically needy program. The catastrophic program will provide hospital inpatient and hospital physician services for qualifying HOP enrollees, and will help reduce the current burden of catastrophic care for consumers, providers and local governments. The state seeks authority under the waiver to use HOP funds to pay for the catastrophic care benefit.

XI. Cost Sharing

The Section 1115 Waiver will require cost sharing for all eligible enrollees. Sliding scale premium subsidies will be available, deductibles avoided or limited, and point of service cost sharing will be utilized. The maximum premium subsidy will be provided to the lowest income Texans. Children and former foster care members covered under the HOP will have the same cost sharing requirements as they would under the Texas SCHIP program. The following discusses cost sharing for the adult subsidy program.

While cost sharing specifics may vary by benefit plan and carrier, the following cost sharing principles will apply consistently:

- The program will promote personal responsibility, empowerment and a culture of insurance. Everyone will have some level and type of cost sharing.
- Cost sharing will be structured to promote the use of primary and preventive care and care sought in the most appropriate settings.
- The level of the premium subsidy provided will be related both to the income of the eligible individual and the value of the coverage selected.

With waiver authority, the state will use HOP subsidies to purchase employer-sponsored insurance, and market-based insurance and coverage options, for which out-of-pocket maximums may exceed DRA provisions. The state will allow the market to compete and enrollees to choose based on benefit value and out-of-pocket costs.

A. Subsidy Amounts

Under waiver authority, Texas will provide sliding scale subsidies to HOP-eligible individuals for the purchase of market-based insurance and other options. As part of its waiver development, to get a preliminary sense of the range of benefit offerings and the subsidies needed for affordable packages, the state met with insurance carriers. In addition, the state reviewed basic benefit packages offered in Texas and in other states, benefit proposals used by other states, Texas' consumer choice plans (which allow for waived coverage of some benefits otherwise mandated in Texas), and Texas-specific survey and focus group information about insurance coverage and preferences.

The state also developed a draft of a primary and preventive care package. The state developed an interactive actuarial model to show the effects of changing various parameters of an illustrative benefit package for the new adult population. Model variables included service types, dollar or service limits, cost sharing, and premium contributions. The model used Texas Temporary Assistance for Needy Families (TANF) Medicaid data and other Medicaid and commercial databases to predict utilization and costs. Take-up rates were estimated based on research and information on programs in other states and an assessment by the state's actuarial contractor. The model also provided an estimate of the degree to which the services provided would cover the needs of the target population, based on TANF claims data as a proxy for the new adult coverage population.

Over the course of several months of discussion and public input, the state developed the following draft benefit package to represent a primary and preventive package with the goal of balancing affordability with adequacy of primary care coverage. Under the benefit package illustrated below, the state estimated the proposed coverages would meet the annual needs of at least 90 percent of all enrollees for each service.

Table 7
Draft Primary And Preventive Care Benefit Package

Annual maximum benefit limit of $25,000 and the following benefits and co-payment amounts (for up to 150% and over 150% FPL)			
• Unlimited primary care visits	$5/$10	• 9 specialist visits (inpatient visits do not count against cap)	$10/$20
• $2,000 in other professional/ancillary	$0	• 5 preventive care physician visits	$0
• 18 mental health/substance abuse visits	$5/$10	• $2,500 outpatient surgery	$25/$50
• $1,250 in outpatient ER visits	$50/$75	• 3 days Inpatient coverage	$25/$100
• $2,500 other outpatient facility	$0	• Pharmacy 3 prescriptions/month (insulin, syringes family planning do not count against the 3 prescription cap)	$0-$5 (generic) 5-$10 (brand name)

Based in part on preliminary pricing associated with this model, the state's waiver financing data includes an estimated average subsidy amount of $180 per-member-per-month (pmpm) for parents and caretakers ($150 pmpm for childless adults) when the subsidies are available for the adult population in State Fiscal Year (SFY) 2011 or Demonstration Year 3. The state will work with the Texas Department of Insurance, and with insurance carriers, and will seek additional pricing information on benefit packages as development of the subsidy program proceeds. Final state subsidy amounts will be determined based on market rates and negotiated agreements with carriers.

Sliding scale subsidy amounts will also be determined based on assessments of affordability with higher enrollee contributions to premiums at higher income levels. Guidelines regarding affordability, premium subsidies and individual cost sharing will be developed prior to implementation of sliding scale subsidies in the waiver.

XII. Delivery System

The delivery system for the Section 1115 Waiver will leverage and build on the existing insurance market for both ESI and commercially available products. HHSC will coordinate with the Texas Department of Insurance to assess which qualifying plan options are available to waiver participants in each region of the state. The state will encourage a culture of insurance by enabling consumers to choose the plan that best meets their needs. The program will strive for administrative efficiency for the carriers, covered individuals, and program administration to maximize value for enrollees and the state. In addition, Texas will seek to leverage other system improvements through HOP coverage, such as disease management and case management for qualifying covered populations.

A. Texas Health Insurance Premium Payment (HIPP) Program

Senate Bill 10 includes a number of provisions that are intended to reinforce the Medicaid HIPP program to improve program administration and take-up rates. The bill specifically directs the state to make improvements to client referral and outreach practices, and minimize the financial burden to clients through streamlined and expedited client reimbursement processes.

The Texas HIPP program will undergo a number of changes over the next several months to improve HIPP ESI capabilities and to effectively position the state for successful implementation of ESI-related components of the HOP. In addition to improved outreach and identification of potential ESI participants and streamlining client reimbursement processes, Texas will develop more effective relationships with employers. Texas will also implement procedures to simplify the program so that it is more easily understood and accessed by enrollees and providers. Texas is in the process of enhancing automation and securing access to employer data systems, which will not only provide the state with more timely and comprehensive information on Medicaid recipients with access to ESI, it will also increase the state's ability to effectively track changes to health plan costs, benefits, and open enrollment periods.

Currently, the HIPP program serves over 8,000 Medicaid recipients each month. Texas believes that the program improvements that are planned will lead to an over 20 percent increase in Medicaid enrollees participating in the program. Texas will systematically review and make changes to strengthen the HIPP program and prepare for new opportunities to use blended funding sources to allow for coverage of more family members and to promote private market coverage options.

B. CHIP Premium Assistance Program

Texas is requesting authority under this waiver to implement a CHIP Premium Assistance Program for CHIP-eligible children with access to employer-sponsored insurance through a parent's employer.

Under this program, Texas will provide a monthly subsidy for an individual CHIP-eligible child not to exceed the amount the state would pay for that child if enrolled in one of the state's contracted CHIP health plans. Participation in the program will be voluntary for CHIP-eligible children.

Texas will set minimum standards for what is considered a qualifying and affordable health plan benefit package for this program. Employer health plans would be assessed, as is done in the state's HIPP program.

Cost sharing (point of service co-pays, deductibles and co-insurance) are the responsibility of the enrolled child's family. Cost sharing amounts will vary depending on the employer's health plan. If they are in excess of the minimum standards for affordability which have been set by the state, participation in the CHIP PA program will not be approved.

Texas will provide information and outreach to potential CHIP PA participants to explain participation considerations and potential for out of pocket expenditures for the family.

The program will be administered through the state's HIPP contractor.

C. New Opportunities for HIPP and CHIP PA

Under the waiver, the state will blend existing program funds in Medicaid HIPP, the CHIP premium assistance program requested in this waiver, and HOP subsidies to more fully support families in affording and buying into ESI. The following sections review the optional blending to support ESI.

New opportunities for participation in the HIPP Program authorized by Senate Bill 10 that will be covered under the Section 1115 Waiver include:

1. HIPP Plus Health Opportunity Pool Group

This option allows families to combine parents' and other qualifying family members' HOP subsidies with available Medicaid participant's HIPP premiums to more fully subsidize employer-sponsored insurance. This option will allow for payment of a HIPP participating Medicaid recipient's premium subsidy using Medicaid funding and wrapping an additional HOP subsidy. The HOP subsidy will pick up any additional premium cost, up to the HOP allowed amount, to cover additional uncovered HOP-eligible family members on the family's ESI health plan.

- Texas will provide a HOP subsidy to the parent(s) and other HOP-eligible persons in the family for coverage through an employer-sponsored health plan.
- Cost sharing for HOP participants (co-insurance, co-payments and deductibles) will be the responsibility of the individual(s).
- No wrap-around services will be provided to HOP participants. However, the state will continue to provide wrap services, including EPSDT as appropriate, for the participating HIPP individual.
- If the subsidized employer plan is determined to be unaffordable and/or non-qualifying based on the minimum standards established by the state, the individual(s) will have the option to use the HOP subsidy for approved basic HOP-funded coverage through market-based insurance and other coverage options.

2. CHIP Premium Assistance Program Plus Health Opportunity Pool Group

This option will allow families to combine parents' and other qualifying family members' HOP subsidies with available CHIP children's premiums to more fully subsidize ESI. In this option, CHIP funding will contribute a set premium contribution for each of the families' eligible CHIP child(ren), and HOP funding will pick up any remaining premium contribution for the families' HOP-eligible parents and other HOP-eligible family members, such as young adult children in the household.

- Cost sharing (co-insurance, co-payments, and deductibles) will be the responsibility of the HOP individual(s).
- No wrap-around services will be provided.
- If the subsidized employer-sponsored plan is determined to be unaffordable and/or non-qualifying, the individual will have the option to use the subsidy for approved basic HOP-funded market-based insurance and other coverage options.

This program is designed to provide a set subsidy to allow the family to purchase employer-sponsored coverage for CHIP eligible child(ren) as well as parents and other HOP-eligible family members who are ineligible for Medicaid or SCHIP.

XIII. Implementation Timeline

The following table illustrates the anticipated timeline for waiver and related reform component implementation:

Table 8. Anticipated Implementation Timeline by Waiver Year

	SFY 09 9/08 – 8/09 Waiver Year 1	SFY 10 9/09 – 8/10 Waiver Year 2	SFY11 9/10 – 8/11 Waiver Year 3	SFY 12 9/11 – 8/12 Waiver Year 4	SFY 13 9/12 – 8/13 Waiver Year 5
Catastrophic Care through HOP	●	—	—	—	→
Children's and Former Foster Care Member's Coverage	●	—	—	—	→
Grants	●	—	→		
Study with TDI and small employers	●	→			
Subsidy Program for Adults			●	—	→
Work Group on Uncompensated Care	●	—	→		
Uncompensated Care Claims	●	—	—	—	→
Updated Hospital Reporting		●	—	—	→
HIPP and ESI program improvements	●	—	—	—	→

Texas will implement the Section 1115 Waiver in state fiscal year 2009. In Waiver Year 1, the state will:

- Provide full health insurance subsidies to the initial implementation groups (certain children and former foster care members, as identified in Section VI, Target Populations, of the Waiver).
- Provide grants for innovative programs and strategies to reduce uncompensated care and improve health status.
- Establish new uniform cost and financial reporting requirements for hospitals providing uncompensated care.
- Establish claims reporting for uncompensated care.
- Establish a catastrophic care spend-down benefit (inpatient and inpatient physician services) for parents and caretakers.
- Implement health care reforms within the Medicaid program, such as a healthy behavior incentives pilot project.

- Implement HIPP program improvements to enroll more Medicaid recipients in employer-sponsored insurance.
- Establish new qualification standards for hospitals receiving DSH and UPL funds.
- Conduct a joint Health and Human Services Commission/Texas Department of Insurance study assessing and recommending small employer premium assistance programs for Texas.
- Obtain direction from the Texas Legislature concerning the establishment of an infrastructure and procurement of contractors to perform administrative functions, and to provide health care services for the HOP program.
- Identify waiver evaluation resources and establish baseline data.

In Waiver Year 2 (SFY 2010), the state will:

- Assess and refine uniform reporting requirements for hospitals providing uncompensated care.
- Assess and refine qualification standards for hospitals receiving DSH and UPL funding.
- Analyze data from uncompensated care reporting, claims submission and initial reports on grants. The state will use this information to inform program direction.
- Establish administrative structure for the subsidy program, procure administrative contractor(s) and select qualified market-based insurance and other coverage options eligible for subsidies.
- Continue providing infrastructure grants for innovative programs and strategies to reduce uncompensated care and improve health status.
- Implement the CHIP premium assistance option.

In Waiver Year 3 (SFY 2011), the state will:

- Expand the provision of health care subsidies to the adult target population (uninsured adults at or below 200 percent FPL, as identified in Section VI of the Waiver).
- Provide grants for innovative programs and strategies to reduce uncompensated care and improve health status.
- Implement options to provide blended funding for Medicaid, SCHIP and HOP participants to promote family coverage through qualifying and affordable employer-sponsored insurance.
- Assess and refine qualification standards for hospitals receiving DSH and UPL funding.

- Analyze data from uncompensated care reporting, claims submission and initial reports on grants. The state will use this information to inform program direction.
- Assess and refine uniform reporting requirements for hospitals providing uncompensated care.
- Continue analyzing data from uncompensated care reporting, claims submission and reports on grants.

In Waiver Year 4 (SFY 2012), the state will continue waiver activities.

In Waiver Year 5 (SFY 2013), the state will continue waiver activities and implement final evaluation.

XIV. Evaluation

The Section 1115 Waiver will significantly expand access to primary and preventive health care services for low-income, uninsured Texans. It represents the centerpiece of the transformation of the health care delivery system in Texas. As such, the state will evaluate the impact on consumers, providers, insurers, and the small business community. The state intends to use the information obtained through the evaluation as a means to inform programmatic and policy decisions in both the short- and long-term.

The state identified overall evaluation objectives, key research questions, hypotheses, data sources and methodologies to serve as a framework for evaluation. See Attachment C.

XV. Title XIX and XXI Waivers

The state requests that the federal Department of Health and Human Services Centers for Medicare and Medicaid Services grant a waiver of the Title XIX and XXI statutory provisions identified in Attachment D to effectively implement and administer the Section 1115 Waiver.

XVI. Current Medicaid Program Context for Waiver Financing

The Texas Medicaid program has implemented multiple initiatives that demonstrate that Texas can be a prudent purchaser of services with an emphasis on quality and value. See Attachment E for a list and description of those initiatives.

XVII. Waiver Financing

To finance this waiver, Senate Bill 10 established the Texas Health Opportunity Pool (HOP) trust fund and authorized the Executive Commissioner of the Health and Human Services Commission to seek a Section 1115 Waiver designed to use federal funds paid to Texas more efficiently and effectively to defray costs associated with providing uncompensated health

care. Texas seeks approval of a demonstration financing plan that will establish a defined federal budget allocation for both Medicaid DSH and UPL programs over the waiver demonstration period consistent with purposes identified in this waiver. The HOP will be funded with:

- Combined federal DSH and trended UPL funds based on UPL caps.
- State match for non-state DSH and UPL funds. This includes IGT funds.
- Federal Title XIX funding for state plan populations covered under the waiver. This includes HOP coverage for parents and caretakers with incomes at or below 200 percent FPL depending on available funding, and catastrophic care benefits for parents and caretakers established as a catastrophic care program with benefits provided under the authority of this waiver. Subsidies are initially planned to be offered to uninsured parents with incomes at or below 133 percent FPL, and to childless adults with incomes at or below 100 percent FPL. The state seeks flexibility to change the FPL levels based on available funding.
- State general revenue from funding sources allocated to the HOP. This includes revenues from House Bill 1751, 80th Legislature, Regular Session, 2007, and any other general revenue targeted to the HOP.
- State match recognized by the Centers for Medicare and Medicaid Services (CMS) for qualifying public expenditures for the uninsured. Public expenditures include state general revenue, local, and other tax-based expenditures in unmatched programs providing health services to the uninsured. The state seeks to establish a process for recognizing these qualifying expenditures.
- New IGT funds to pay for a portion of the state's share of the catastrophic care benefit to be offered in the HOP.

By granting the authority to create the HOP and develop a process for recognizing qualifying expenditures, Texas and the federal government are entering into a partnership to proactively meet the objectives of this Texas' reform proposal.

XVIII. Budget Neutrality

Without Waiver Projections

Under the current system, hospitals' uncompensated care costs are projected to continue on an upward trend. However, the fixed nature of the statewide DSH allotment provides only a limited source of offsetting revenue. Hospitals currently expect that UPL programs will provide the additional revenue necessary to support this growing pool of uncompensated costs.

Currently, UPL payments for private hospitals and state hospitals are below their respective allowable caps. However, local government and hospital districts have identified sufficient

local tax revenue to support payments up to the aggregate UPL limits and are prepared to fund these payments as costs rise to support such reimbursement. Texas is seeking the authority to create a more flexible, targeted and efficient mechanism to address these costs by funding the HOP using the total statewide DSH allotment and total aggregate UPL funding. Such flexibility will allow Texas to use this uncompensated care funding more efficiently to intervene earlier in the health care delivery process through increased levels of insurance and other health care coverage.

With Waiver Projections

HOP funding approved and certified under the auspices of this waiver will be expended in a manner consistent with the goal of reducing uncompensated care. As can be seen from Table 9, the first two years of the waiver establish a catastrophic benefit and provide grants to invest in improved health care delivery systems. These investments develop the infrastructure to support the success of the subsidy program, and begin the transformation of the current uncoordinated hospital-based approach to uninsured care to a more integrated system supporting primary and preventive care. Building upon this base, in Demonstration Year 3 the state will provide insurance subsidies targeted to low-income uninsured parents and childless adults as the major source of waiver expenditures.

Where hospital supplemental payments will still be required to support uncompensated hospital costs under this waiver, HHSC will implement new requirements to increase accountability, improve purchasing strategy and enhance access to primary care for uninsured persons receiving hospital care. In the first three years of the waiver, $75 million a year will be available for grant funding to projects designed to create the infrastructure, community coordination, services and systems that support the reduction of uncompensated care.

These grants will focus on regional coordination and integration of the currently fragmented local efforts (and expenditures) to reduce uncompensated care. The grants are time limited and are not intended as an ongoing source of funding for programs. As such, grant applications must reflect local community participation and show how the proposed programs leverage existing resources and initiatives to improve community coordination and service integration, how they will reduce uncompensated care, and how the program and outcomes will be evaluated.

Table 9: Projected HOP Expenditures (In Millions)

	DY1	DY2	DY3	DY4	DY5	Total
Pass Through Populations						
Catastrophic	$322	$351	$382	$417	$455	$1,927
Parents <=133% FPL			$401	$913	$1,220	$2,534
Parent Wrap			$273	$623	$833	$1,729
Combined DSH/UPL Expenditures	$3,732	$4,071	$4,248	$4,659	$5,143	$21,852
Expansion Population						
Certain Children <=200% FPL not SCHIP/Medicaid/Medicare Qualified	$50	$53	$56	$61	$64	$282

Childless Adults <=100% FPL			$260	$276	$292	$828
Grants	$75	$75	$75			$225
Designated State Health Programs	$27	$36	$222	$192	$214	$691
Total Expenditures	**$4,205**	**$4,585**	**$5,918**	**$7,140**	**$8,221**	**$30,068**

XIX. Public Stakeholder Input

There has been significant public involvement in the state's efforts to study health care coverage issues from the perspective of the uninsured, businesses, providers, insurers, stakeholders, and public programs like Medicaid and CHIP to develop a reform plan. HHSC has actively sought the involvement and input in the development of reform to the health care system of Texas and has held over 120 meetings, presentations and hearings on reform.

Stakeholder Meetings

To provide insights and input to the Medicaid Reform Project, HHSC conducted a series of meetings, many with conference call capabilities, open to the public and key stakeholder groups. HHSC hosted more than 25 public meetings during the previous 15 months related to health care reform in Texas. Additionally, HHSC staff held meetings with key stakeholder representatives, state provider associations, hospital executives, health care advocates, and other member organizations. State staff presented at various provider/association conferences and meetings. Continued involvement of these organizations is essential to the reform efforts in Texas.

See Attachment F for more detail on these meetings, which provided opportunities for discussion, information sharing, and for the state to hear the concerns and specific recommendations of these groups.

Legislative Briefings

HHSC presented to legislative committees and individual legislators on multiple occasions throughout the process of developing the Texas Health Care Reform plan. Senate Bill 10 also created the Medicaid Reform Legislative Oversight Committee. The Committee was created to facilitate:

- Medicaid reform.
- The process of addressing uncompensated hospital care.
- Establishment of programs addressing the uninsured.

The committee is comprised of four members from the Texas Senate and four members from the Texas House of Representatives. The committee held public hearings and received public testimony on December 6, 2007 and February 20, 2008.

Website

Public information and input have been key components of Texas Medicaid reform since the beginning of the legislative session that passed reform legislation. HHSC first created a reform website in January 2007 in anticipation of Medicaid and health care reform being a significant focus during the state's legislative session. The reform website is a comprehensive, informative, and user-friendly website devoted to health care reform in general and Medicaid reform in particular.

The website provides the public and stakeholders with updated information as the initiative progresses. The website serves as a communication medium to provide advanced notice of public meetings and makes available briefing materials and other information such as presentations, research papers, reports, timelines, and related documents. In addition, HHSC uses this website as a tool to continue to invite and obtain input from the public. An e-mail subscription list was created to notify stakeholders of any updates to the website. More than 2,100 stakeholders are included on the update distribution list.

Draft Section 1115 Waiver Concept Paper

To facilitate input on key components of the concept paper, a "Request for Public Input" document was published in late October 2007, outlining background information, key decision areas, decision principles, design questions and HHSC's preliminary assessment of those areas. The HHSC Council created a subcommittee on Medicaid reform and hospital financing, and received public testimony on the concept paper. The Legislative Oversight Committee also received public testimony on waiver development as the process moved forward. HHSC continues to meet with stakeholder groups, provides regular updates at bi-monthly HHSC Stakeholder meetings, and continues to meet with a large number of stakeholder groups, including reaching out to and updating representatives of the Alabama-Coushatta Tribe of Texas, Ysleta Del Sur Pueblo, and the Kickapoo Tribe of Texas.

XX. Related and Supporting Reforms

In addition to laying the foundation for transformational reform based upon the principles of personal responsibility, broader flexibility and improved purchasing strategy, the state's reform plan also provides opportunities for related and supporting reforms to reduce the cost of health care and to improve access to and the quality of health care.

Regional and Local Health Care Programs

Senate Bill 10 authorizes HHSC to develop a grant program to support the initial establishment and operation of regional and local health care programs for employees of small employers. A number of communities in Texas have been working to develop such programs, which also are known as "three-share" or "multi-share" programs because the cost of coverage often is shared between the employer, employee, and another entity, such as a local government. Through such programs, communities develop and offer affordable health care coverage for uninsured employees of small employers. HHSC will award $1 million in grants, and the Texas Department of Insurance plans to award additional grants to multi-share premium assistance programs.

HHSC and Texas Department of Insurance (TDI) Joint Study on Small Group Market

Senate Bill 10 also includes a provision for a joint study between HHSC and the Texas Department of Insurance regarding a small employer premium assistance program to assist small employers with purchasing a small group policy. The study will include options for HOP and other program funding, coordination with other premium assistance efforts, and a recommended program design.

Medicaid Billing Coordination System

Senate Bill 10 authorizes HHSC to implement an acute care Medicaid billing coordination system for the fee-for-service and primary care case management delivery models that will, upon entry in the claims system, identify within 24 hours whether another entity has primary responsibility for claim payment, and submit the claim to the primary payor as identified by the system. Senate Bill 10 also requires that an entity that holds a permit, license, or certificate of authority issued by a regulatory agency of the state must allow access to databases to allow for the identification of other payors. The billing coordination system is designed to move the majority of Texas Medicaid third-party recoveries from a post-payment "pay and chase" operation to a front-end cost avoidance model. The billing coordination system will provide increased access to other insurers' eligibility data, so the amount of cost-avoided claims is projected to increase.

Study Concerning Increased Use of Technology to Strengthen Fraud Detection and Deterrence and Implementation

Senate Bill 10 includes a provision for a joint feasibility study between the Office of Inspector General and HHSC to evaluate the potential benefits of using additional technology to reduce fraud and abuse in Medicaid, including verification of citizenship and eligibility and implementing any methods determined to be effective at strengthening fraud detection and deterrence.

Electronic Health Information

To complement a new managed health care delivery system for children in foster care, HHSC created a web-based electronic health information system that consolidates a child's medical information and makes it available to authorized providers, foster parents, and the Department of Family and Protective Services. The health passport contains such information as the name and addresses of the child's providers, a record of each visit to a provider including routine checkups, a record of immunizations, identification of the child's known health problems, and information on all prescriptions. The expectation is the health passport will improve a child's health care by better informing providers about a child's medical history. When children leave foster care, they will receive a copy of their health passport.

HHSC received a $4 million Transformation Grant under the Deficit Reduction Act of 2005 from CMS to support the implementation of the health passport. This funding will allow HHSC

to develop additional enhancements for the health passport, including interoperability between the health passport and existing electronic medical records of providers serving children in foster care.

The ability to share health information electronically has garnered the interest of the Texas Legislature and many others in Texas in a pursuit for better health care outcomes. In response to Senate Bill 10, HHSC is conducting a study to determine the feasibility of creating a health passport for all children in Medicaid and CHIP. HHSC anticipates a continued expansion of the use of electronic health information in the future.

XXI. Conclusion

This multidimensional approach to health care reform will provide the flexibility needed to make affordable health care coverage available and accessible to low-income, uninsured Texans. It is designed to promote more rational health care spending on the uninsured, decrease the number of uninsured Texans, improve access to individual and employer-sponsored private health insurance market, simplify funding streams, and increase overall system efficiency and effectiveness in reducing hospital uncompensated care.

With a timely review and approval of this proposal, the Texas Health Care Reform initiative can begin operations in State Fiscal Year 2009.

Attachment A
Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid

Approximately 2.8 million, or one in nine Texans, are eligible to receive medical and long-term services and supports through the Texas Medicaid program. Texas Medicaid covers all mandatory eligibility groups and categorically needy and medically needy pregnant women and infants up to 185% of the federal poverty level (FPL). Non-disabled children and pregnant women comprise approximately 75% of the Medicaid population, and the remaining 25% represent TANF adults and the aged, blind, and disabled. Coverage of benefits includes all mandatory services including acute health care (physician, inpatient, outpatient, pharmacy, lab, and x-ray services) and some optional services such as pharmacy and specified medical supplies and equipment. It also covers long-term services and supports for aged and disabled clients. Texas covers no non-disabled childless adults.

Like every other state in the nation, Texas has been challenged by increasing health care costs and, in response, implemented several initiatives designed to moderate cost trends while maintaining access to quality health care. Examples include the 1993 implementation and subsequent expansion of managed care, a primary care case management program, and a Preferred Drug List (PDL) with supplemental drug manufacturer rebates on drugs designated as preferred.

Texas Medicaid Caseload by Eligibility Category, September 2007			
General Category	**Eligible Category**	**FPL% or Income Limit**	**Percent of Medicaid Population**
Full Medicaid Beneficiaries, n = 2,878,261			
Families and Children (Non-TANF, Non-Disabled): 72% of total caseload (full Medicaid)	Pregnant Women	Up to 185%	5%
	Newborns (under age 1)	Up to 185%	9%
	Expansion Children (ages 1 - 5)	Up to 133%	25%
	Federal Mandated Children (ages 6 - 18)	Up to 100%	31%
	Medically Needy	*Up to $275/month	2%
Cash Assistance: 16% of total caseload (full Medicaid)	TANF Adult	*Up to $188/month	1%
	TANF Children (ages 0 - 18)	*Up to $188/month	5%
	SSI (Disability-Related) Adult	*Up to $637 /month	7%
	SSI (Disability-Related) Children	*Up to $637/month	3%
Aged: 12% of total caseload (full Medicaid)	Aged and Medicare Related	*Up to $637/month	12%

Attachment A

Medicaid and the Children's Health Insurance Program (CHIP)

CHIP

Texas CHIP covers low-income children from families below 200% of the federal poverty level (FPL) who are not eligible for Medicaid. CHIP recently expanded eligibility to provide perinatal services to pregnant women with income below 200% of the FPL and not eligible for Medicaid. CHIP currently provides coverage for a full range of health services including regular checkups, immunizations, prescription drugs, lab tests, x-rays, hospital visits and more to over 380,000 enrollees. All services are delivered by private managed care organizations (MCOs) selected by the State through a competitive procurement and enrollment is accomplished through an enrollment broker.

Attachment B

Senate Bill 10 Strategies for Medicaid Supported by the Deficit Reduction Act of 2005

- **Programs to promote healthy lifestyles**
  - Senate Bill 10 includes a provision to pilot a program under which Medicaid recipients are provided positive incentives to increase awareness of the importance of leading healthy lifestyles, including participating in health-related programs such as weight loss or smoking cessation programs, or engaging in health-conscious behaviors such as following disease management protocols to treat chronic conditions and improve health care outcomes.
  - These features are expected to encourage utilization of primary and preventive health care services.
  - The pilot program may include value-added services and individual health rewards accounts.
  - HHSC may also develop and implement an incentive program to encourage Medicaid recipients under the age of 21 to improve compliance with the periodicity screening schedule under the Early and Periodic Screening, Diagnosis, and Treatment Program.

- **New options for benefit packages**
  - HHSC will seek a federal Waiver to implement customized benefits tailored to meet the health care needs of children with special health care needs within the Medicaid population, and may assess the value of defining additional tailored benefit packages for other existing groups.
  - Future target populations may include adults with special health care needs, the elderly, and working-age parents and caretaker relatives.

- **Outcome-based performance measures for Health Maintenance Organizations (HMOs)**
  - HHSC will enhance current initiatives to include in all contracts with HMOs outcome-based performance measures.
  - The intent is to procure and manage the provision of heath care services to recipients under a value-based purchasing model and to facilitate and increase access.
  - HMO contract provisions may include provider network pay-for-performance opportunities that support quality improvements.

- **Regional or local health care programs for employees of small employers**
  - Establishes authority for regional or local entities to develop three-share programs; three-share refers to the fact that the employer, the employee and the regional or local entity share financing.
  - Permits local/regional entities to apply for Health Opportunity Pool (HOP) funding.
  - Allows an administering agency to use any individual, small group, or any other available product to extend coverage to eligible employees.

Attachment B

Senate Bill 10 Strategies for Medicaid Supported by the Deficit Reduction Act of 2005

- Permits insurers to sell group policies to the regional/local entities to cover all participating employees of small employers in the region.
- Creates a grant program for start-up costs associated with local/regional programs.
    - HHSC has awarded grants totaling $1 million to local coalitions to help develop health care programs for employees of small businesses. The grants include:
        - $700,000 for the Texas Communities Healthcare Coalition to develop multi-share programs in five areas. The coalition plans to implement programs in 2008 in Galveston and the Central Texas area, which includes Travis, Hays, Williamson, Burnet, Caldwell and Bastrop counties. In 2009, the coalition will develop programs in Houston, Dallas and El Paso. The coalition estimates it will enroll 45,000 people in its multi-share programs.
        - $300,000 for the Brazos Valley Council of Governments to implement a multi-share program that serves Brazos, Burleson, Grimes, Leon, Madison, Robertson and Washington counties. Brazos Valley plans to enroll 5,000 people in its program.

To be eligible to receive HOP funding for local/regional program, the programs must:

- Comply with requirements established in the Section 1115 Waiver; and
- Provide services to a person eligible for and receiving premium assistance through the reform.

Attachment C

Section 1115 Waiver Evaluation Objectives and Overview of Hypotheses and Approach to Research,

The state has identified overall evaluation objectives, key research questions, hypotheses, data sources and methodologies that can serve as a framework for evaluation. The state will provide a more detailed evaluation plan that includes specific hypotheses, research questions and data sources.

A. Evaluation Objectives

The Section 1115 Waiver provides the State and CMS with an opportunity to implement an innovative and market-driven approach to use Medicaid funds to increase access to private health insurance coverage. Through this process, the State expects to gain valuable information about the effects of the new model that infuses market-driven principles into a public healthcare insurance program.

The State has identified the following evaluation objectives:

1. To evaluate the extent to which availability of grants awarded to support innovative programs at the local level resulted in increased access to health care, better care coordination or improved quality of care.

2. To evaluate the extent to which availability of affordable health insurance results in a reduction in the number of uninsured.

3. To evaluate whether the availability of affordable health insurance, which provides coverage for primary and preventive health care, will reduce the need for inpatient or emergency care.

B. Overview of Hypotheses and Approach to Research

Several research projects would be conducted to evaluate the Section 1115 Waiver, including:

1. Improved Access to Local Health Care Programs

   The Section 1115 Waiver will evaluate the impact of the locally available programs, which would be funded during the first years of the demonstration. This evaluation would consider impacts for each of the grants based on the reports provided by the grantees. The state would also monitor whether services or activities established under grant funding would continue after the state ceases to provide funding for these grants.

2. Reduction in the Number of Uninsured

   The Section 1115 Waiver will assess the impact on the number and rate of persons without health insurance when affordable health insurance is made available.

This evaluation will examine insured/uninsured rates in general and more specifically by select population groups (e.g., income levels and race/ethnicity). Data collected by the U.S. Census Bureau's Current Population Survey will be analyzed to examine trends in the number and rate of persons without health insurance. Data from The American Community Survey will also be used when data collection regarding health insurance coverage is made available beginning in 2009.

3. Impact on Health Status and Utilization of Preventive Care

The Section 1115 Waiver will evaluate whether access to health insurance coverage that promotes preventive services improves health status and reliance on inpatient or emergency care.

This evaluation will be based on the analysis of uncompensated care data examining a series of preventative indicators in communities where initiatives have been implemented. These indicators will be examined statewide and at various sub-state geographic areas. For purposed of the evaluation, the Prevention Quality Indicators and the Pediatric Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ) will be used. These measures focus on hospital admissions for conditions that can be prevented with good outpatient care. Initiatives increasing access to or utilization of preventive care should result in lower hospitalization rates for these conditions.

4. Impact on Uncompensated Care

Lastly, the Section 1115 Waiver will assess the impact of increasing the number of persons who have access to affordable health insurance coverage on reducing reported hospital-based uncompensated care. The reduction in uncompensated care should increase hospital revenue due to commercial health insurance coverage, and decrease charity care and bad debt.

This evaluation project will examine the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Texas through the provision of subsidized premium assistance to access commercial health insurance plans or employer-subsidized insurance. The evaluation project will also examine the impact of the multi-faceted strategy of new requirements, incentives and reimbursement changes for hospitals and other locally or regionally administered programs to add capacity or implement programs that reduce uncompensated care costs.

Attachment D
Title XIX and Title XXI Waivers

Title XIX Waiver Authority

All requirements of the Medicaid program expressed in law, regulation, and policy, not expressly waived in this list, shall apply to the Demonstration beginning [insert date] through [insert date]

The following waivers shall enable Texas to effectively implement and administer the Texas Section 1115 Demonstration.

Title XIX Waivers

1. Statewideness/Uniformity — Section 1902(a)(1)

   To enable Texas to operate the demonstration and provide managed care plans or certain types of managed care plans only in certain geographical areas.

2. Hearing Rights — Section 1902(a)(3)

   Consistent with a market-based approach, to enable the state to have enrollees use the hearing rights provided to them as required of insurers and managed care organizations by the Texas Department of Insurance rather than using the Medicaid agency process.

   Complaints Concerning Health Services Matters Pursuant to Insurance Code

   A member, or a person acting on the member's behalf, or the member's physician or health care provider, may file a complaint about an adverse determination made by a health plan provider pursuant to the provisions of the Texas Insurance Code Chapter 843, subchapters G and H, and Chapter 4201. Such a complaint may lead to review by an independent external review organization formed pursuant to Chapter 4202 of the Texas Insurance Code.

3. Medicaid Eligibility & Quality Control — Section 1902(a)(4)(A)

   To enable Texas to use a system different from that required in Medicaid statute and regulation.

4. Amount, Duration and Scope — Section 1902(a)(10)(B)

   To permit Texas to modify the amount, duration and scope of the Medicaid benefits and services for the demonstration population, and allow for benefit packages that are comparable to private commercial health benefit plans, and to set annual benefit limits.

5. Timely Processing of Applications — Section 1902(a)(8)

   To enable Texas to implement an open enrollment period and cap enrollment to manage enrollment in a demonstration health care package.

Attachment D

Title XIX and Title XXI Waivers

6. Retroactive Eligibility — Section 1902(a)(34)

   To enable Texas to implement a prospective eligibility process for the demonstration population; no retroactive payments will be made for this population.[1]

7. Early and Periodic Screening, Diagnosis and Treatment Section — Section 1902(a)(43) 1905(a)(4)(B)

   To enable Texas to offer a health care service package that differs from the Medicaid package for individuals under the age of 21 in the demonstration population.

8. Eligibility Procedures — Section 1902(a)(10)(A) Section 1902(a)(10)(C)(1)-(111)

   To enable Texas to use streamlined eligibility procedures and different eligibility standards and requirements for the demonstration population.

9. Freedom of Choice — Section 1902(a)(23)

   To enable the state to restrict freedom of choice of providers.

10. Cost Sharing — Section 1902(a)(14)

    To enable the State to authorize coverage through private, commercial, individual insurance or employee-sponsored insurance that has cost sharing requirements in excess of the Medicaid limits for all individuals in the demonstration population, including those with incomes below 100% of the Federal Poverty Level.

11. Payment for Federally Qualified Health Centers and Rural Health Clinics Section — Section 1902(a)(15)

    To relieve Texas from making full-cost reimbursement payments to Federally Qualified Health Clinics since this demonstration focuses on subsidized premiums for private commercial plans.

12. Reimbursement — Section 1902(a)(32)

    To enable the State to provide a direct subsidy or reimbursement (including through the use of a voucher) to individuals in the demonstration population or their employer, not to exceed the established premium capped at total estimated Medicaid costs, so that low-income uninsured individuals can pay for their medical insurance premiums in an employer-sponsored insurance plan.

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[1] Individuals who qualify for the catastrophic care benefit under the HOP, consistent with Medically Needy spend down criteria are an exception to this.

13. Family Planning Services — Section 1905(a)(4)
Section 1915(b)

To enable Texas to require the use of network providers for family planning services.

14. Qualified Aliens — Section 1903(v)(1)

To enable Texas to provide coverage to qualified aliens under 19 who enter the United States on or after August 22, 1996, beginning on the date of the alien's entry into the United Sates.

15. Premiums and Deductibles — Section 1902(a)(14)
Insofar as it incorporates Section 1916

To the extent necessary to enable Texas to charge premiums and deductibles for the demonstration population.

16. Crowd-Out — Section 1902(a)(10)(B)

To enable Texas to impose a 6-month waiting period of uninsurance, for those over 21 who have terminated private health insurance coverage within 6 months prior to applying for coverage under the State's demonstration.

17. Using Gross Income to Determine Eligibility — Section 1902 (a)(17)

To enable Texas to use gross income in determining eligibility for certain individuals in the demonstration population.

18. Marketing — 42 CFR Section 1396u-2(d)(2)

To the extent necessary, enable Texas to waive some of the marketing restrictions to promote enrollment of the demonstration population in health coverage.

19. Disproportionate Share Hospital Payments — Section 1902(a)(13)(A)
Insofar as it incorporates Section 1923(c)(1)

To allow the diversion of DSH payments made to hospitals to cover the demonstration population.

20. Upper Payment Limit Payments

Waiver of the Medicaid upper payment limit provisions of the "Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) as incorporated in the

Consolidated Appropriations Act, 2001 (P.L. 106-554) and regulations promulgated pursuant to the BIPA."

Title XXI Waiver Authority

All requirements of the SCHIP program expressed in law, regulation, and policy, not expressly waived in this list, shall apply to the Demonstration beginning [insert date] through [insert date]

The following waivers shall enable Texas to effectively implement and administer the Texas Section 1115 Demonstration.

1. Cost Sharing — Section 2103(e)

   Rules governing cost sharing under Section 2103(e) shall not apply to the population to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored plans.

2. Benefit Package Requirements — Section 2103

   To permit the state to offer benefit packages that does not meet the requirements of Section 2103 of the Act and federal regulations at 42 CFR 457.401(b)(1) to the extent necessary to enable the State to impose cost sharing in private or employer-sponsored plans.

Expenditure Authority

Under the authority of 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures) under the State's Title XIX and XXI plans shall, for the period of this waiver, be regarded as expenditures.

1. The subsidy, reimbursement, or voucher, provided to individuals for their subsidized premium assistance for private commercial plans and employer-sponsored insurance.
2. Expenditures made by the State for costs related to providing health care services to uninsured individuals.
3. Expenditures made by the State for costs related to providing health care services to the following populations: Active Care and qualified aliens under the age of 19.
4. Expenditures to provide services not otherwise eligible under a state child health plan.
5. Expenditures that would not be payable because of the operation of the limitations at 2105(c)(2) because they are not targeted for low-income children.

Attachment E

Current Medicaid Program Context for Reform

The Texas Medicaid program has implemented or is in the process of implementing multiple initiatives that demonstrate that Texas is a prudent purchaser of services with an emphasis on quality and value.

A. **Managed Care** -- Texas' managed care program has an enrollment of more than 1.8 million people. Managed care in Texas includes a traditional managed care organization delivery system (the STAR Program) and a primary care case management program (PCCM). The STAR Program and PCCM include TANF and low-income children and families on a mandatory basis, and SSI and SSI-related clients under age 21 on a voluntary basis. The mandatory managed care program operates under a 1915(b) waiver.

   Texas' Medicaid managed care program is cost-effective, assures access to care, improves quality of care, and improves health care outcomes for Medicaid enrollees.

B. **Disease Managemen**t --Texas provides a disease management program to eligible Fee-for-Service, managed care, CHIP, and PCCM populations. The program includes activities designed to ensure a comprehensive approach to the management of certain chronic diseases (congestive heart failure, coronary artery disease, diabetes, asthma, and chronic obstructive pulmonary disease) including:

   - Identification and outreach to eligible beneficiaries;
   - Health assessment and risk stratification;
   - Enrollment and disenrollment of eligible/ineligible beneficiaries;
   - Education of beneficiaries and providers;
   - Quality assurance;
   - Care management; and
   - Outcomes measurement.

C. **Pharmacy Cost Containment** – Texas implemented an effective preferred drug list, which reduced costs while maintaining access to quality drugs.

D. **Case Management** - The Texas Legislature, recognizing the fragmentation of case management services, charged the Health and Human Services Commission (HHSC) with optimizing case management across the health and human services system in Texas. HHSC looked at best and promising practices in case management and conducted an analysis of programs providing case management services. Throughout the course of this effort, HHSC sought comments and feedback from external stakeholders-including consumers, providers, and advocates-through surveys, focus groups, opportunities to comment on draft reports, and public meetings. Using these findings and inputs, HHSC, in collaboration with the health and human services operating agencies, has developed recommendations to make case management more effective for consumers and more efficient for the health and human services system. Texas has been in contact with many other states in the course of this work, which are subsequently looking to Texas for its best practice approach to optimizing case management.

E. Value Based Purchasing - In September 2006, State Fiscal Year (SFY) 2007, Texas introduced Value-Based Purchasing and risk-based contracting for managed care organizations (MCOs) contracting with HHSC in both Medicaid and CHIP. The new MCO contracts identified areas of performance that would place a percentage of their capitation payments at risk and hold the MCOs accountable to meet certain standards for financial and non-financial incentives, rewards, and disincentives and sanctions. The annual 1% at-risk premium focuses on performance in clean claims payment, network composition and adequacy, and member and provider hotline utilization. Along with the at-risk performance measures, HHSC established an annual Performance Indicator Dashboard for Medicaid and CHIP MCOs, expanding the areas of performance monitored in access to care, ER/ED utilization, getting needed care, children's preventive health services, women's preventive and maternal health services, care for chronic illnesses, smoking prevention, member and provider complaints, and financial reporting and accountability. To further improve managed care within a specific service area or member population, HHSC included annual Performance Improvement Goals in the new contracts that would allow HHSC and the MCOs to negotiate areas of performance that could target the specific needs of members in geographic service areas. To incentivise the MCOs, HHSC established the Quality Challenge Pool to reward MCOs who demonstrated superior quality of care outcomes for certain clinical measures identified by HHSC on an annual basis.

F. STAR Health Program for Children in Foster Care – In April 2008, HHSC implemented STAR Health, a new health-care program to improve services and better coordinate care for children in foster care. Program components include:

- A Health Passport for each child in foster care, containing a claims-based summary of his or her medical information. The Health Passport is web-based and makes it easier for doctors and caregivers to get accurate medical information on each child.
- Expedited enrollment so children can begin receiving services as soon as they enter state conservatorship.
- Improved access to services through a network of providers.
- A medical home through a primary care doctor who coordinates care and promotes better preventive health practices.
- Service coordination to help children, caregivers and caseworkers get services and information.
- 24-hour nurse hotline for caregivers and caseworkers.
- Benefits that include:
  - Physical and behavioral health.
  - Vision services.
  - Dental services.
  - Service coordination.
  - Clinical service management and disease management.
  - Hotlines for member and provider assistance.

Attachment E

Current Medicaid Program Context for Reform

G. **STAR+PLUS** – This Medicaid managed care program is designed to integrate the delivery of Medicaid primary, acute and long term services and supports to better manage the care of aged, blind and disabled Medicaid recipients in certain areas of the state. The emphasis is on providing home and community based services to avoid the need for institutionalization.

H. **Integrated Care Management –** In February 2008, HHSC began providing services through Integrated Care Management (ICM), a non-capitated managed care delivery model that integrates acute care and long term care services for Medicaid clients in 13 Texas counties. The program, which serves clients with disabilities or who are 65 and older, aims to coordinate Medicaid benefits with long term care services in a managed care setting to provide better client care and assist clients in performing day-to-day activities.

I. ***Frew et al. v Hawkins et al.* Related Changes –** As the result of a children's Medicaid-related lawsuit, HHSC and its related operational health and human services agencies have implemented a number of strategic initiatives to increase the participation of children and health care providers in the Texas Medicaid Program. The initiatives include provider rate increases, efforts to encourage more comprehensive dental care for children, integrated mental health services in pediatric settings, payment to specialists for consultations with primary care providers, healthy lifestyle incentives, projects to identify children of migrant farm workers receiving Medicaid, and an interactive on-line provider directory.

J. **Medicaid Access Card –** In order to streamline provider access to Medicaid clients' eligibility and health information, HHSC plans to replace paper Medicaid identification cards with the Medicaid Access Card (MAC). The MAC, which will look like a credit card, will allow clients to quickly swipe the card at a provider's office to access Medicaid eligibility upon arrival to an appointment. The MAC will also connect to a system to retrieve other client information such as electronic health information, claims and encounter data, vendor drug information, and notification about needed periodic medical services.

K. **Tailored Benefits –** In response to guidance included in the Deficit Reduction Act of 2005 and legislation passed in 2007 during the 80th Texas Legislative Session, HHSC has begun researching and developing a Medicaid tailored benefit package that is customized for children with special health care needs. In addition to the tailored benefit package, children participating in the tailored benefit plan will remain eligible for the full set of standard Medicaid benefits.

L. **PCCM+PLUS -** In May 2008, HHSC will implement PCCM+PLUS, a program to provide coordination and assistance to some high-risk, high-cost aged, blind, and disabled Medicaid clients after they leave the hospital. The program will provide discharge planning to manage medical conditions and prevent readmission to the hospital while also aiming to reduce medically unnecessary emergency room visits. Some case management services provided through PCCM+PLUS will include making sure clients have set up necessary appointments after discharge, assistance with referrals and transportation, education on Medicaid benefits and other community supports, and telephone outreach to family members and caregivers.

Attachment F

Stakeholder Meetings

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Industry Stakeholders				
Texas Association for Healthcare Financial Management	4/14/2008	Various	Update on Medicaid Reform, Financing, and Waiver Status	In-person
Texas Council of Community MHMR Centers	3/24/2008	Various	Update on Medicaid Reform, Waiver Status, Financing and Benefit Model	In-person
Texas Association of Public and Nonprofit Hospitals	3/21/2008	Various	Waiver Status and Financing	In-person
Texas Medical Association	3/11/2008	Various	Benefit Model and Financing	Phone
Alabama-Coushatta Tribe of Texas	3/10/2008	Myra Sylestine	Update on Medicaid Reform Proposal & Timeline	In-person
Texas Medical Association	3/6/2008	Dr. William Hinchey	Benefit Model and Financing	In-person
Health Maintenance Organizations	2/27/2008	Various	Health Opportunity Pool Benefits	In-person
Urban Counties	2/25/2008	City of Dallas - Karen Rayzer	Federal Funds Matching Opportunities	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Spivey & Harris - Health Policy Group	2/25/2008	Mike Spivey, Jeff Harris	Update on Medicaid Reform Proposal and Financing	In-person
Harris County Healthcare Alliance	2/13/2008	Karen Love - Various	Update on Medicaid Reform Proposal - Presentation on Benefit Model and Financing	Phone
La Fe Policy Research Center	2/12/2008	Juan Flores, Amy Casso	Update on Medicaid Reform Proposal and Financing, Demographics, Outreach	In-person
Key Stakeholders, Advocacy Groups and Associations	2/11/2008	Public Meeting - Various	Medicaid Reform Informational Meeting and Update - Presentation on Benefit Model and Financing	Phone
Key Stakeholders, Advocacy Groups and Associations	2/8/2008	Public Meeting - Various	Medicaid Reform Informational Meeting and Update - Presentation on Benefit Model and Financing	In-person
Texas Medical Association	2/1/2008	TMA Medicaid Committee - Various	Update on Medicaid Reform Proposal, Financing & Other Senate Bill 10 Initiatives	In-person
Texas Hospital Association	1/18/2008	Various	Update on Medicaid Reform Proposal and Financing	In-person
Texas Organization of Rural and Community Hospitals	1/15/2008	Don McBeath	Update on Medicaid Reform Proposal and Financing	In-person
Health Maintenance Organizations	12/20/2007	Various	Update on Medicaid Reform and Healthy Lifestyle Initiative	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Ysleta del Sur Pueblo	12/10/2007	Dr. George Haddy	Update on Medicaid Reform & Timeline	In-person
Texas Association of Public and Nonprofit Hospitals	12/7/2007	Board Members - Various	Update on Medicaid Reform and Review of Draft Concept Paper	In-person
Kickapoo Tribe of Texas	12/4/2007	Nick Gonzalez	Update on Medicaid Reform & Timeline	In-person
Executive Directors' Consortium for Community MHMR Centers	11/1/2007	Various	Update on Medicaid Reform & Timeline - Presentation	In-person
Texas CHIP Coalition	10/26/2007	Various Stakeholder and Advocacy Groups	Update on Medicaid Reform & Timeline - Presentation	In-person
Urban Counties	10/25/2007	City of Houston - Elena Marks	Federal Funds Matching Opportunities	Phone
Texas Healthcare Association	10/25/2007	Various	Update on Reform Opportunities related to Long-Term Care	In-person
Texas Association of Community Healthcare Centers	10/22/2007	Jose Camacho, Various	Update on Medicaid Reform & Timeline - Presentation	In-person
Texas Medical Association	10/19/2007	TMA Medicaid Committee - Various	Update on Medicaid Reform & Timeline (HOP, Waiver Financing, and Three-Share) - Presentation	In-person
Pfizer	10/19/2007	Various	Smoking Cessation	Phone
Texas Association of Health Plans	10/18/2007	Jared Wolfe, Various	Medicaid Reform - Conference Roundtable Discussion	In-person
Private Providers Association of Texas	10/19/2007	Phil Haas, Various	Update on Medicaid Reform and Timeline - Presentation	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Texas Association of Voluntary Hospitals	10/9/2007	Various	Update on Medicaid Reform and Timeline - Presentation	In-person
Texas Communities Health Care Coalition	9/25/2007	Various	Discuss CHAT findings/Galveston	Phone
Amerigroup	9/24/2007	Meredith Delk	Medicaid Reform Informational Meeting - Texas Insurance Market	Phone
Texas Association of Public and Nonprofit Hospitals	9/24/2007	Steve Svadlenak	Medicaid Reform Informational Meeting - Hospital Financing Data	Phone
United	9/24/2007	Various	Medicaid Reform Informational Meeting - Texas Insurance Market	Phone
Center for Public Policy Priorities	9/24/2007	Anne Dunkelburg	Updated on Medicaid Reform and Timeline	In-person
Code Red	9/21/2007	Dr. Shine, G. Hernandez, Dr. E. Sanchez	Medicaid Reform Informational Meeting	In-person
Pfizer	9/21/2007	Various	Smoking Cessation	Phone
Texas Communities Health Care Coalition	9/13/2007	Ann Kitchen, Karen Love, Barbara Breier, Don Spies	Medicaid Reform - Informational Meeting on Three-Share	Phone
Urban Counties	9/10/2007	Michael Vaughan, Various	Informational Meeting - Technology	Phone
Key Stakeholders, Advocacy Groups and Associations	8/31/2007	Public Meeting - Various	Medicaid Reform Informational Meeting and Update - Presentation	Phone
Key Stakeholders, Advocacy Groups and Associations	8/30/2007	Public Meeting - Various	Medicaid Reform Informational Meeting and Update - Presentation	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Medicall	8/28/2007	Jack Vaughan	Medicaid Reform - Informational Meeting	In-person
Texas Association of Public & Nonprofit Hospitals	8/24/2007	Various	Update on Medicaid Reform (Waiver Financing) - Presentation	In-person
Pfizer	8/24/2007	Robert Jones	Smoking Cessation	In-person
Brazos Valley Council of Governments	8/23/2007	Herman Sustayta	Medicaid Reform - Informational Meeting	
Texas Association of Community Healthcare Centers	8/20/2007	Jose Camacho	Medicaid Reform - Informational Meeting	In-person
Texas Association of Health Plans	8/16/2007	Jared Wolfe	Medicaid Reform - Informational Meeting - Health Insurance	In-person
Urban Counties	8/16/2007	Various	Update on Medicaid Reform - Presentation	In-person
Texas Health Institute	8/5/2007	Camille Miller	Medicaid Reform - Informational Meeting	In-person
Texas Association of Health Plans	8/2/2007	Jared Wolfe	Medicaid Reform - Informational Meeting - Texas Insurance Market	In-person
Texas Association of Voluntary Not for Profit Hospitals	8/2/2007	Various	Update on Medicaid Reform - Presentation	In-person
Texas Hospital Association	8/2/2007	Richard Schirmer, John Hawkins	Medicaid Reform - Informational Meeting - Hospital Financing	In-person
Institute for Child Health Policy	8/1/2007	Dr. Betsy Shenkman	ICHIP Data	Phone
Indigent Health Care Program	7/27/2007	Byron Hale	Indigent Health Care	Phone
Texas Center for Infectious Disease	7/24/2007	Department of State Health Services	Medicaid Reform - Informational Meeting	Phone
South Texas Health Care System	7/19/2007	Various	Medicaid Reform - Informational Meeting	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
University of Texas Medical Branch	7/19/2007	Dr. Barbara Brier	Medicaid Reform - Informational Meeting - Reimbursement for Indigent Healthcare	Phone
Kidney Health Care	7/16/2007	Various	General Update on Medicaid Reform	Phone
Indigent Care Collaboration	7/13/2007	Ann Kitchen	General Update on Medicaid Reform	Phone
Health Maintenance Organizations	7/12/2007	Various	General Update on Medicaid Reform	In-person
Texas Association of Public & Nonprofit Hospitals	7/10/2007	Steve Svadlenak	General Update on Medicaid Reform	In-person
Texas Association of Health Plans	7/10/2007	Jared Wolfe	General Update on Medicaid Reform	In-person
Texas Association of Counties	7/10/2007	Donald Lee, Rick Thompson	General Update on Medicaid Reform	Phone
Spivey & Harris - Health Policy Group	7/9/2007	Mike Spivey, Jeff Harris	General Update on Medicaid Reform - Hospital Financing Data	In-person
University of Texas Medical Branch	7/9/2007	Barbara Brier	General Update on Medicaid Reform and Indigent Health Care	Phone
Center for Public Policy Priorities, AARP, Texas Medical Association, Indigent Care Collaboration	7/3/2007	Anne Dunkelberg, Helen Kent Davis, Nancy Walker, Ann Kitchen, Victoria Ford	General Update on Medicaid Reform - Three-Share, HOP and Senate Bill 10	In-person
HHSC Regional Advisory Committee	7/3/2007	Various	General Update on Medicaid Reform	In-person
Texas Association of Public & Nonprofit Hospitals	6/29/2007	Steve Svadlenak	General Update on Medicaid Reform - Hospital Financing	In-person
Stakeholder Teleconference	6/28/2007	Various Stakeholders	General Update on Medicaid Reform and Senate Bill 10	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Community First Health Plans	6/27/2007	Cindy Chase, Charles Kight	UHS Data	Phone
Texas Council for Developmental Disabilities	6/20/2007	Roger Webb, Angela Lello	General Update on Medicaid Reform and Senate Bill 10	In-person
Academy Health	6/19/2007	Brynnan Cox	SCI Connector	In-person
HMO Meeting	6/12/2007	Various	General Update on Medicaid Reform	In-person
Spivey & Harris - Health Policy Group	5/16/2007	Mike Spivey	Hospital Financing	Phone
Community First Health Plans and University Health System	5/16/2007	George Hernandez & Charles Kite	CFHP information, including UHS indigent care utilization, CareLink info, and possible unmatched USLF and fed funds	Phone
Texas Council of Community MHMR Centers	5/3/2007	Suzanne Elrod, Danette Castle, Susan Garnett, and Joe Lovelace	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Indigent Care Collaboration	5/1/2007	Ann Kitchen	ICC database	In-person
Texas Association of Community Health Centers	4/24/2007	Jose Comacho	Discussion of Senate Bill 10 and Medicaid Reform	Phone
Texas Conservative Coalition	4/20/2007	Various	Discussion of Senate Bill 10 and Medicaid Reform - Presentation	In-person
Spivey & Harris - Health Policy Group	4/13/2007	Mike Spivey, Jeff Harris	CNOM (costs not otherwise matched)	Phone
Community First Health Plans	4/12/2007	Charles Kight	Discussion of Senate Bill 10 and Medicaid Reform	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Texas Health Institute	4/5/2007	Camille Miller	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Association for Aging & Retired Persons	3/27/2007	Amanda McCloskey	Discussion of Senate Bill 10 and Medicaid Reform	Phone
The Arc of Texas	3/26/2007	Mike Bright, Amy Mizcles	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Association of Health Plans	3/21/2007	Jared Wolfe, Barbara Maxwell	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Disability Policy Consortium	3/19/2007	Geoff Miller, Bob Kafka, Colleen Horton	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Health Care Association	3/16/2007	Tim Graves, Coyle Kelly, Leticia Caballero	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Association of Home Care	3/13/2007	Heather Vasek, Rose Dunaway, Anita Bradberry	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Health Insurance Risk Pool	3/7/2007	Steve Browning	Discussion of Senate Bill 10 and Medicaid Reform - Risk Pool Presentation	Phone
Texas Association of Health Plans	2/26/2007	Jared Wolfe, Barbara Maxwell	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Hospital Association	2/26/2007	John Hawkins, Patricia Kolodzey, Charles Bailey, John Burta, Dan Stills	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Center for Public Policy Priorities	2/22/2007	Anne Dunkelberg	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Hospital Association	2/21/2007	Various	Discussion of Senate Bill 10 and Medicaid Reform	In-person
El Paso Community Scholars	2/21/2007	Various	Report on Analysis of Charity Care in El Paso	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Texas Public Policy Foundation	2/21/2007	Mary Katherine Stout	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Medical Association, Texas Academy of Family Physicians, Texas Pediatric Society	2/19/2007	Helen Kent Davis, Michelle Romano, Tom Banning, Carrie Kroll	Discussion of Senate Bill 10 and Medicaid Reform	In-person
Texas Association of Health Plans	2/14/2007	Various	Discussion of Senate Bill 10 and Medicaid Reform - Presentation Breakfast	In-person
Girling Health Care	2/13/2007	Renee Schmutz-Girling, Bob Donovan	Health Technology & Demo	In-person
Genworth Financial & Locke Liddell Strategies	12/6/2006	Bob Steil, Rod Perkins, Roy Coffee	Long Term Care Partnership	In-person
Legislative Presentations & Meetings				
Senate State Affairs Committee	3/26/2008	Public Hearing - Various	Medicaid Reform Update	In-person
Medicaid Reform Legislative Oversight Committee	2/20/2008	Public Hearing - Various	Medicaid Reform Update - Presentation on Financing and Benefit Model	In-person
House Public Health Committee	1/17/2008	Public Hearing - Various	Senate Bill 10 - Healthy Lifestyles Pilot	In-person
Medicaid Reform Legislative Oversight Committee	12/6/2007	Public Hearing - Various	Medicaid Reform Update - Presentation and Review of Draft Concept Paper	In-person
California Republican Caucus	10/15/2007	California Legislative Delegation	Medicaid Reform Update - Presentation	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
El Paso Community Delegation	10/4/2007	Thomason Board Members, El Paso City/County officials, Legislative Staff	Medicaid Reform Update - Presentation	In-person
House Appropriations Committee	4/27/2007	Public Hearing - Various	Medicaid Reform and Healthcare Financing - Presentation	In-person
House Public Health Committee	4/24/2007	Public Hearing - Various	Medicaid Reform - Presentation	In-person
House Appropriations Subcommittee on Health & Human Services	4/19/2007	Public Hearing - Various	Medicaid Reform - Medicaid Hospital Financing	In-person
Senate Health & Human Services Committee	3/23/2007	Public Hearing - Various	Medicaid Reform - DSH, UPL & Pool of Funds	In-person
House Appropriations Subcommittee on Health & Human Services	2/12/2007	Public Hearing - Various	Medicaid Reform - Presentation	In-person
House Public Health Committee	2/8/2007	Public Hearing - Various	Medicaid Reform - Presentation	In-person
Senate Finance Committee	2/7/2007	Public Hearing - Various	Medicaid Reform - Presentation	In-person
Legislative Budget Board	1/19/2007	LBB Staff	Medicaid Reform Briefing	In-person
Texas Medicaid Policy Summit	11/16/2006	Legislative Members and Staff	Medicaid Reform	In-person
Senate Finance Committee	10/10/2006	Public Hearing - Various	Uncompensated Care and Medicaid Hospital Reimbursement - Presentation	In-person
Senate Committee Health and Human Services	9/19/2006	Public Hearing - Various	Medicaid Reform in Texas - Presentation	In-person
Councils/Advisory Committees				

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
HHSC Council	4/10/2008	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
DSHS Council	4/10/2008	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Council	2/29/2008	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Council Subcommittee on Medicaid Reform and Hospital Financing	2/4/2008	Public Meeting - Various	Medicaid Reform Update and Benefit Model Presentation	In-person
HHSC Council Subcommittee on Medicaid Reform and Hospital Financing	10/30/2007	Public Meeting - Various	Medicaid Reform Update and Public Input	In-person
HHSC Council	8/6/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
Regional Advisory Committee	7/31/2007	Members	Medicaid Reform Update Presentation	In-person
Medical Care Advisory Committee	7/12/2007	Public Meeting of Various Stakeholder and Advocacy Groups	General Update on Medicaid Reform - Presentation	In-person
Hospital Payment Advisory Committee	6/13/2007	Various	Medicaid Reform Update Presentation	In-person
HHSC Council	3/29/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
DSHS Council	1/31/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
Public Forums				
HHSC Desktop Stakeholder Public Forum	3/12/2008	Public Meeting - Various	Medicaid Reform Update Presentation	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
HHSC Stakeholder Public Forum	3/10/2008	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	1/16/2008	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	1/14/2008	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	11/14/2007	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	11/12/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	9/12/2007	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	9/10/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	7/11/2007	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	7/9/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	5/16/2007	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	5/14/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
HHSC Desktop Stakeholder Public Forum	1/10/2007	Public Meeting - Various	Medicaid Reform Update Presentation	Phone
HHSC Stakeholder Public Forum	1/8/2007	Public Meeting - Various	Medicaid Reform Update Presentation	In-person
Long Term Care Health Policy Forum	11/10/2006	Various	Medicaid Reform - Long Term Care Presentation	In-person

Attachment G

Texas Health Opportunity Pool (HOP) Eligibility & Enrollment Processes for Adults

April 2008