



OFFICE OF THE GOVERNOR

December 5, 2007

RICK PERRY
GOVERNOR

The Honorable Michael O. Leavitt
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Leavitt:

I am pleased to present you with the Texas Health Care Reform proposal. The enclosed concept paper outlines my vision to provide more Texans with health insurance, reduce reliance on expensive emergency room visits for non-emergent care, and make it easier for the working poor to buy into employer-sponsored health coverage.

The challenge in Texas is great. More than 2 million low-income Texans are currently served through Medicaid and the Children's Health Insurance Program (CHIP). However, there are insufficient affordable insurance options for the 2.1 million adults in our state who earn less than 200 percent of the federal poverty level. Most of these citizens are working Texans whose jobs offer health care benefits they cannot afford, or no benefits at all. Through this reform effort, we seek to change the health care landscape in Texas by making health insurance a realistic option for these Texas families.

Below are the goals of the Texas reform effort, which build upon President Bush's Affordable Choices Initiative:

- We will focus on keeping Texans healthy by ensuring access to high quality care while reinforcing the importance of consumer choice and personal responsibility for health care and healthy lifestyles.
- We will seek approval to restructure federal Medicaid funding to gain flexibility, optimize investments in health care and reduce the number of uninsured Texans.
- We will establish the infrastructure to enhance the quality and value of health care through better care management and performance improvement incentives.

The cornerstone of our reform is an effort to lower the costs of the uninsured and uncompensated care by redirecting dollars to a funding pool to assist Texans, whose incomes are less than 200 percent of the federal poverty level, with purchasing insurance coverage. Our plan recognizes the long-term benefits of providing Texans preventative care through insurance instead of paying for costly emergency room visits. Patients once stuck in crowded emergency rooms will start seeing primary care physicians. Preventable conditions will be treated with less pain and at a lower cost.

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To achieve these results, Texas seeks flexibility in funding and coverage under the authority of Section 1115 of the Social Security Act. Using this flexibility, Texas will create the Texas Health Opportunity trust fund. The trust fund will allow us to provide premium subsidies for uninsured adults at or below 200 percent of the federal poverty level, or \$41,300 for a family of four. Cost sharing requirements will vary on a sliding scale based on the family's income.

The working poor who qualify for the subsidy will have a choice of health plans. For some this would help with the purchase of a catastrophic plan. For others it could make employer-sponsored coverage an affordable option when the state subsidy helps offset the employee's part of the premium.

Texas also proposes to strengthen and expand the existing Health Insurance Premium Payment Program, which helps low-income families purchase employer-sponsored health coverage. The Texas plan will supplement, rather than supplant, the employer-sponsored and individual insurance markets.

I look forward to working with you in the coming months as we seek approval to reform the Texas health care system. The chief point of contact for Texas will be Texas Health and Human Services Executive Commissioner Albert Hawkins.

The financial cost of our plan is modest, but the social benefit will be extraordinary. Our proposal will increase the number of Texans with health insurance coverage without expanding the rolls of government programs. We will make health insurance an affordable option for the working poor and emphasize the importance of regular and preventative health care. We can curb skyrocketing medical costs by transforming our system and creating the foundation for a healthier Texas.

Sincerely,

A handwritten signature in black ink that reads "Rick Perry". The signature is written in a cursive, slightly slanted style.

Rick Perry
Governor

RP:jop

Enclosure

cc: Mr. Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services
Mr. Dennis G. Smith, Director, Center for Medicaid and State Operations
Mr. Albert Hawkins, III, Executive Commissioner, HHSC
Texas Congressional Delegation

**Texas Health Care Reform
Draft Concept Paper for**

**A Waiver Request Submitted Under Authority of
Section 1115 of the Social Security Act to**

**The Centers for Medicare and Medicaid Services
US Department of Health and Human Services**

December 5, 2007

**State of Texas
Rick Perry, Governor**

**Albert Hawkins, Executive Commissioner
Texas Health and Human Services Commission
4900 North Lamar Boulevard
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Texas Health Care Reform

Outline of Provisions for a Section 1115 Waiver Request

I. Executive Summary

In June 2007, the 80th Texas Legislature passed and Governor Rick Perry signed Senate Bill (SB) 10, creating 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. This comprehensive legislation and the state's waiver proposal are based upon the principles of personal responsibility, broader flexibility and improved purchasing strategy.

The goals of the reform efforts authorized by SB10 include:

- Focus on keeping Texans healthy by ensuring access to high quality care, especially primary and preventive care, providing care management, and focusing on consumer choice and personal responsibility for health care and healthy lifestyles.
- Restructure current federal funding to gain flexibility, optimize investments in health care and reduce the number of uninsured Texans.
- Establish the infrastructure to enhance quality and value through better care management and performance improvement incentives.

These goals build upon President Bush's Affordable Choices Initiative, with a focus on reducing the number of uninsured by using innovation and efficiency. The plan transforms Texas' investments in health care by more directly supporting broader access to primary and preventive care through value-based competitive insurance and coverage models. Texas will more effectively drive quality and efficiency while improving access to health coverage, leading to better health outcomes for our citizens.

The challenge is big in Texas. Today, 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. This leads to poorer health status, higher cost-shifting, over-reliance on safety net providers for care, higher care costs once care is accessed, and increased demands on local health care systems to meet the needs of the uninsured.

These higher costs in turn 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 higher (\$922 and \$2,786 respectively for individual and family premiums) due to uncompensated care.¹

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

¹ Stoll et al., "Paying a Premium: The Added Cost of Care for the Uninsured", Families USA, 2005

economy through poorer health status of the workforce, higher rates of absenteeism, and lower productivity.

Working within the framework of Senate Bill 10 and federal policy objectives for public health care spending, Texas proposes to transform the health care system for the uninsured through targeted changes in both financing and the delivery of care.

The Texas proposal is a comprehensive, multidimensional plan that will result in:

- Improved access to basic health care services and health status for low-income, uninsured Texans.
- Strengthened access to and use of employer-sponsored insurance.
- Improved pricing and quality through performance-based purchasing and market-based competition.
- Increased consumer choice.
- Improved health investments by focusing investments in primary and preventive care, rather than more costly and unmanaged episodic care.
- Promotion of healthy lifestyles and chronic care management, as well as personal responsibility for health care and health care costs, such as consumer cost sharing.
- Over the long term, a significant reduction in the rate of growth of health care costs in Texas for low-income people and a reduction in the related increases in private sector health care premiums.

Summary of Proposal

To achieve these results, Texas seeks flexibility in funding and coverage under the authority of Section 1115 of the Social Security Act. Using this flexibility, Texas proposes to create the Texas Health Opportunity Pool (HOP) trust fund. By leveraging targeted investments from the HOP, Texas will transform access to health care for the uninsured from a heavy reliance on hospital-based care (fragmented and costly emergency and preventable inpatient care) to increased access to primary and preventive care. Texas will provide HOP premium subsidies for uninsured adults and older children (age 19-20) living in households with family income at or below 200 percent of the federal poverty level (FPL) -- approximately \$41,300 for a family of four. Cost sharing requirements will vary on a sliding scale based upon income to support access to affordable health insurance. Under the HOP, all consumers will be required to pay something toward the cost of their health care.

Consumers will be offered choice among health care coverage options with an emphasis on responsible consumer utilization of primary and preventive services through targeted cost sharing, medical homes and enhanced care management. Where affordable qualifying employer-sponsored insurance is available, subsidies will be used to access that coverage. Texas is also considering options to reduce the burden of catastrophic care for consumers and providers.

Health coverage secured under this reform is intended to promote a culture of insurance in place of episodic, uncompensated care for the uninsured. To enhance this transition, the program leverages employer-sponsored insurance. Consistent with the provisions of Senate Bill 10, Texas proposes under this Section 1115 Waiver to also strengthen and expand the existing Health Insurance Premium Payment (HIPP) Program. The bill includes significant new provisions that will assist in identifying potential HIPP enrollees and facilitate increased participation in the program. The state will also develop similar options for individuals eligible for HOP subsidies through which they can access available coverage for themselves and/or family members. With these enhanced administrative measures, this waiver and the related initiatives will supplement, rather than supplant, the employer-sponsored and individual insurance markets.

Parallel reform initiatives will address payment for uncompensated care by restructuring and redirecting federal and state funding in the HOP trust fund and by establishing financial incentives for hospitals, hospital districts, and other locally or regionally administered programs to implement strategies to reduce uncompensated care costs. Uncompensated care reductions will result as: (1) care is provided in a more rationally managed and less costly delivery system, reducing reliance on hospital-based care; (2) more people have health insurance thereby spreading and dispersing risk and cost burdens; and (3) hospitals implement strategies to reduce the cost of uncompensated care as provided for by Senate Bill 10. Strategies may include fostering improved access to primary care systems and medical homes or creating health care system efficiencies to reduce the need for uncompensated care.

II. The Current Approach and the Need for Reform

An overarching goal for reform is to optimize investments in health care to ensure more efficient use of available funding and best health outcomes for Texans. Nationally, about \$100 billion is spent annually to provide care for the uninsured. In Texas, even with an multi-billion dollar investment in publicly funded health-care, Texas has the highest rate of uninsured in the nation, and costs continue to outpace the rate of growth in personal income, wages and state revenues.

Current investments in uncompensated care often are used to treat conditions that could have been treated earlier and more efficiently with primary and preventive care.² A high rate of uninsured individuals leads to:

- Poorer health outcomes due to less access to primary and preventive care.³
- Increased costs of private insurance, as those with insurance subsidize the uninsured through higher premiums.⁴

² Institute of Medicine: Hidden Costs, Values Lost: Uninsurance in America. The National Academies Press, June 17, 2003.

³ 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.

⁴ 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.

- Over reliance on safety net providers, including hospitals and emergency rooms for care that is more expensive.⁵
- Crowded emergency rooms and costs for indigent care that outweigh available resources, stressing local, state, federal and safety net hospital capacities.
- An increased likelihood of hospitalization for conditions are avoidable, at an average cost of \$3,300 per avoidable stay.⁶

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 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).

To provide real and sustained relief to strained local, state, federal and private resources responsible for caring for the uninsured, Texas must improve the efficiency of existing investments in health care. Investments must target the core issues driving the state's high rate of uninsurance to achieve true health care reform.

For a variety of reasons, Texas' current approach to paying for indigent care includes investments in care for the uninsured at some of the most expensive points of access. Part of the billions of dollars Texas spends for the uninsured is provided based on a 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 healthcare programs, with requirements for counties, public hospitals and hospital districts to provide programs for 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 be turned away.⁷ Federal law requires that hospitals assess individuals seeking care through emergency rooms and prohibits hospitals from considering ability to pay as a criterion for

⁵ 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. Kaiser Family Foundation.

⁶ Institute of Medicine: Hidden Costs, Values Lost: Uninsurance in America. The National Academies Press, June 17, 2003.

⁷ The Uninsured: A Primer, Key Facts About Americans without Health Insurance, January 2006, The Henry. Kaiser Family Foundation.

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. Our 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 State 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 service 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 disproportionate share 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, hospital UPL payments are funded using local IGTs. Both 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.

However, while these funding streams can help offset indigent care costs, they now do little to alter the underlying dynamic which 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 that is key to help moderate indigent care costs and growth.

Pressure on safety net providers is further exacerbated as higher premium costs and reductions in employers offering insurance increase the state's dependence on the health-care safety net. Increasing insurance costs drive increases in the number of uninsured, which in turn lead to increased pressure on tax bases, increased costs for those left with private insurance, and increased need for indigent care services. As the number of uninsured grows, pressure on safety net systems increases. As critical providers of indigent care, safety net hospitals are overwhelmed by a need for care that outpaces hospitals' ability to pay for providing care. At the same time, increased funding using the current investment strategy will not address the core issues driving the costs.

Because of multiple factors, Texas' indigent care system is reliant on a hospital-based approach. Simply investing more in the current system will not address the core inefficiencies driving up

health-care costs in Texas. Options provided by the creation of the HOP will help target health-care spending, provide access to primary and preventive care through insurance and other coverage options, reduce the number of uninsured, and ensure a more effective investment of health-care dollars.

To address these issues, and create a sound health care investment strategy, Texas is seeking to reduce reliance on hospital-financed IGTs in an effort to improve the incentives for providing cost-effective care to indigent persons, slow the rate of growth in the cost of premiums for private health insurance, improve access to affordable health insurance and coverage, and rationalize the overall system of reimbursement for low-income uninsured Texans.

III. Legislative Authority

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 private health insurance for newly eligible uninsured Texans.
 - Provide continued support for Texas' critical safety net providers.
 - Ensure the financing strategy supports policy objectives to improve health care and health outcomes.
 - Improve access to coverage to reduce uncompensated care costs.

- 2. Promote consumer 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 including health savings accounts, if feasible, and other incentives for positive health behaviors that improve health status.
 - Implement standards for cost-sharing, including cost sharing for non-emergency use of the emergency room if cost effective.

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 (HIPPP) Program, and development of new employer-sponsored buy-in options.
- Encourage and build upon existing and proposed partnerships including multi-share programs.

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

- Implement new hospital initiatives, such as reforms to hospital reporting for uninsured care to create broader transparency and accountability, 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.
- Require the use of outcome-based performance measures and incentives in health maintenance organization (HMO) contracts to increase access to appropriate health care services.

IV. Health Insurance Market & Health Care Coverage

Of Texas' total population⁸, about 51 percent is privately insured; 24 percent of the population is covered under publicly funded programs; the remaining 25 percent is uninsured. Looking solely at Texas' non elderly population,⁹ almost 60 percent have private insurance; 15 percent are in publicly funded programs, and 27 percent are uninsured. Table one 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			
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 ¹⁰	66.6%	15.8%	17.6%
Texas	58.1%	15.1%	26.8%

Private insurance is typically accessed through employer plans or individual policies.

⁸ This includes both the elderly and non-elderly.

⁹ The elderly are largely insured under Medicare.

¹⁰ "Health Insurance Coverage in America," 2006 Data Update, October 2007, The Kaiser Commission on Medicaid and the Uninsured.

Data generated through a Texas state planning grant awarded by the U.S. Department of Health and Human Services' HRSA program 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.

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 health insurance.

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 Two below provides relevant Texas and national comparative data on business coverage.

Table 2 2005 Medical Expenditure Panel Survey (MEPS) Insurance Component	Texas	United States	Texas Rank
Employees in small businesses ¹¹	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
Employees in large businesses offering health insurance	95.9%	96.4%	39th
Employees eligible that are enrolled at large businesses offering	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 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 out of reach for many individuals and businesses in Texas.

At the same time, average wages in Texas are lower than wage rates nationally, and as seen in Table 3, Texans 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

¹¹ 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 and higher average premiums contribute, among other factors, to Texans' challenges in accessing affordable health coverage.

V. Target Population

Under the Section 1115 Waiver, Texas will provide premium subsidies through the Health Opportunity Pool (HOP) to uninsured individuals who do not qualify for Medicaid, Medicare or CHIP, with household incomes at or below 200 percent of the FPL. Of the 3.6 million uninsured adult citizens and qualified legal permanent residents of Texas, approximately 60 percent (2.1 million) have incomes at or below 200 percent of the FPL.

To facilitate implementation and make basic health care available to uninsured Texans as soon as possible, Texas plans to leverage its administrative capacity to identify low-income, uninsured Texans. Using existing data in the state's administrative management information systems will enable Texas to identify the following groups:

1. Uninsured parents of children in families whose income has been certified as being at or below 200 percent of the FPL. This would include approximately 480,000 uninsured parents.
2. Older siblings (up to 21 years of age) who reside in the same household with certified income at or below 200 percent FPL.

Texas will develop a separate infrastructure designed to support a phased implementation for those low-income, uninsured Texans not identified in the existing state administrative management information systems. This will include the following:

3. Uninsured children whose household income is at or below 200 percent FPL but do not qualify for Medicaid or CHIP.
4. Other parents and childless adults over 25 (an estimated 1.3 million individuals).
5. Childless adults age 19 through 25 (an estimated 368,000 individuals).

VI. Eligibility and Enrollment

Under the Section 1115 Waiver, the state will provide access to commercial health insurance plans and other health care coverage options for the eligible uninsured adults and eligible older children residing in the home with income at or below 200 percent of the FPL. Texas will leverage its existing infrastructure in the initial implementation phase to expedite access to HOP subsidies and basic health care coverage. Ultimately, administration of the Section 1115 Waiver requirements will be carried out by the state in coordination with a contracted administrative entity.

Eligibility - Eligibility requirements for the low-income, uninsured population will include those individuals who:

- Have incomes at or below 200 percent of the FPL.
- Are Texas residents.
- Are U.S. citizens or qualifying legal permanent residents.
- Apply for qualifying employer-sponsored insurance and accept coverage, if eligible and affordable.

In addition to meeting the eligibility requirements as stated above, the state will exclude potential enrollees who are eligible for Medicare, Medicaid or CHIP. The Section 1115 Waiver is designed to assure the accessibility of more affordable health insurance products without crowding out current employer-sponsored insurance markets. Individuals meeting any one of the following criteria will be determined ineligible:

- Eligible for Medicare, Medicaid or CHIP.
- Have had health insurance coverage in the past six months, unless insurance is lost for good cause, such as involuntary loss of insurance because the employer dropped the coverage.
- Eligible or enrolled in the proposed CHIP Premium Assistance waiver.

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.

Enrollment – Uninsured custodial parents in families whose income has been certified as being at or below 200 percent of the FPL and uninsured children up to 21 years of age who reside in the same household will be provided information regarding possible eligibility for basic HOP-coverage under the Section 1115 Waiver.

For those with access to qualifying employer-sponsored insurance, the Section 1115 Waiver will require application for 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 employer-sponsored insurance can apply the HOP subsidies to health insurance products that manage and coordinate care. Low-income, uninsured Texans not in the initial implementation group will be eligible for enrollment once the HOP administrator is operational.

Enrollment will be based on available program funding and on a first-come first-serve basis and will be capped with the potential to expand over time as funds become available. Texas will have

periodic open enrollment periods for individuals to apply for HOP subsidies based upon funding availability. Enrollment will be revoked should an individual fail to pay necessary cost sharing obligations. Failure to pay will result in six months of ineligibility for HOP-coverage. Participation in the Texas health care reform will be voluntary.

Texas Health Insurance Premium Payment (HIPP) Program

The provisions of Senate Bill 10 are intended to reinforce and support the employer-sponsored insurance market. Pursuant to the legislation, Texas is seeking authority under the Section 1115 Waiver to improve access to the Texas Health Insurance Premium Payment (HIPP) Program and create new opportunities for participation. Similar to all applicants and recipients of Medicaid, individuals within the targeted expansion population will be required to apply for employer-sponsored insurance as a condition of eligibility if they are eligible for such a plan, including the provision for family coverage when available, affordable and determined to be cost effective. Eligibility rules and provisions for coverage will vary by enrollment group.

Under the HIPP program, the following apply:

- Medicaid eligibles are required to enroll in available, cost effective employer-sponsored plans.
- The state reimburses the Medicaid eligibles for premiums and pays providers for other cost-sharing, including co-payments, co-insurance and deductibles.
- The state provides Medicaid-covered wrap-around services not covered by the employer-sponsored health plan.
- If cost-effective, the state can subsidize premiums for uninsured, related family members eligible for enrollment under the employer group health plan.
- Related family members are not eligible for cost sharing (co-payment, co-insurance and deductibles).

New opportunities for participation in the HIPP Program authorized by SB 10 to be covered under the Section 1115 Waiver include the following:

1. Existing Medicaid Eligibles With Access to Employer-Sponsored Insurance Determined to be Not Cost-Effective (Medicaid Opt-Out Group)

- This is a new eligibility group for HIPP, if determined feasible.
- A Medicaid eligible with access to employer-sponsored coverage is not required to enroll in an available employer plan when that plan has been determined to be not cost effective for traditional HIPP program participation.

- A Medicaid eligible individual may voluntarily choose to opt out of receiving health care services through Medicaid and elect to enroll in cost-ineffective employer-sponsored insurance.
- The state contribution to the cost-ineffective employer plan will be limited to the per member per month cost of providing services to that individual under Medicaid.
- Costs in excess of the maximum state contribution (cost sharing) will be the responsibility of the Medicaid eligible individual.
- The state will not provide coverage of Medicaid wrap-around services not covered by the employer health plan.
- The Medicaid eligible individual has the right to resume Medicaid coverage at any time.

2. HIPP Health Opportunity Pool Group

This option allows families to combine parents and other qualifying family members' HOP subsidies with available children's HIPP premiums to more fully subsidize employer-sponsored insurance.

- Texas will provide a HOP subsidy to the parent(s) and other 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.
- If the subsidized employer plan is determined to be unaffordable, the individual(s) will have the option to use the HOP subsidy for approved basic HOP-funded coverage through licensed commercial health insurance carriers

3. CHIP Premium Assistance Program¹² Health Opportunity Pool Group

This option allows families to combine parents and other qualifying family members' HOP subsidies with available CHIP children's premiums to more fully subsidize employer-sponsored insurance.

- Cost sharing (co-insurance, co-payments, and deductibles) will be the responsibility of the individual(s).
- No wrap-around services will be provided.

¹² Children's Health Insurance Premium Assistance (CHIP-PA) Program

- If the subsidized employer-sponsored plan is determined to be unaffordable, the individual will have the option to use the subsidy for approved basic HOP-funded coverage through licensed private health insurance carriers.

The CHIP Premium Assistance program is not yet operational. A waiver is pending with CMS. 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 family members who are not eligible for Medicaid or CHIP.

VII. Reforming Indigent Care Delivery and Reimbursement

In coordination with the HOP-funded premium subsidy initiative, the reform will include targeted efforts to reduce the costs of uncompensated care and transform the way uninsured individuals receive health-care services. The state intends to redirect some hospital supplemental payments to support premium subsidies, but hospitals and other providers will continue to incur significant costs for uninsured persons. Public hospitals and local units of government will maintain their current constitutional obligation to provide services to indigent groups that may include undocumented immigrants, individuals who choose not to enroll in publicly funded or HOP coverage, and individuals not currently eligible to be enrolled in HOP coverage.

While hospital costs incurred in the delivery of services to the uninsured must be supported with HOP funding, 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. Payments will be used to implement new requirements and reimbursement changes designed to reduce 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 collections 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 address issues unique to each area. Texas' diverse population and expansive geography demand a regionally diverse approach to complement and build upon statewide efforts.

Requirements

Under the reform, as a condition for receiving HOP funds for uncompensated care, hospitals will have new requirements to implement or maintain initiatives to reduce the need for uncompensated care. Examples include programs for emergency room diversion and improved primary and preventive care access to improve healthy lifestyles and prevent unnecessary hospitalizations.

Additional hospital reporting on uncompensated care will also be required to serve as the basis for the state's understanding and analysis of uncompensated care utilization and costs. This reporting will assist in evaluating the efficacy of programs implemented to reduce uncompensated care. This will include reviews of hospital uncompensated care reporting, may include claims reporting for hospitals that receive DSH or UPL and revised standardized cost

reporting to identify costs associated with specific populations, and will establish a basis for measurement of uncompensated care over time.

Incentives and Funding for System Transformation

HOP funds will also be used to support infrastructure development with the goal of reduced uncompensated care utilization and costs. These could include system improvements to enhance community-based capacity for providing primary and preventive care as well as information technology. 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.

Reimbursement Changes

Texas seeks under this Section 1115 Waiver to create improved payment methods for DSH and UPL funds to enhance current purchasing strategies and improve the delivery and reduce the cost of uncompensated care. Texas seeks flexibility to create payment methods which may include utilizing new claims data for the uninsured to modify DSH methods using DRG-priced claims. Using a claims grouper as the basis for the allocation of hospital uncompensated care reimbursement will implement incentives for coordinated, cost-effective and efficiently delivered care that do not exist in the current cost-based system. Texas' methodology will provide the foundation for quality-based and pay-for-performance reimbursement and strengthen the link between reimbursement streams and innovative, hospital-based programs developed to reduce the costs of care for the indigent population.

VIII. Deficit Reduction Act of 2005

Texas analyzed the 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.
 - To simplify the program for consumers, Texas is considering limiting the total number of plans that will be eligible for subsidies.
- Employer-Sponsored Insurance Buy-In
 - The Section 1115 Waiver will require enrollment in qualifying employer-sponsored plans where available, affordable and determined to be cost effective, as well as the possible pooling of HOP, Medicaid and CHIP funds to support family coverage through employer-sponsored plans.

- Cost Sharing Changes
 - The populations covered under the Section 1115 Waiver will be required to contribute to the cost of plan services at a rate that is comparable to commercial health benefit plans and compliant with federal requirements.
- HOP Health Savings Account Pilot Program
 - If determined to be feasible and cost effective, the Section 1115 Waiver will include a pilot program for a high deductible plan coupled with a health savings account.

Senate Bill 10 also includes multiple strategies supported by the DRA that are to be incorporated into the Medicaid program if determined to be cost effective and feasible. While Medicaid is the primary target for these initiatives, the policy objectives and resulting improved outcomes will spill over into the design of the Section 1115 Waiver expansion and the CHIP program. See Attachment B for a list of those strategies.

IX. Benefits

A. Basic Criteria

The Section 1115 Waiver will provide a choice of plans and benefits at an affordable cost. The following points apply to this population:

- Persons who qualify for the subsidy will select health-care services and benefits from a choice of insurance plans, carriers and other coverage options. Existing approved products that meet minimum benefit and cost sharing standards will be considered to cover basic health-care services.
- Health-care coverage will begin the first full month after eligibility is determined and plan enrollment is completed.
- Once enrolled, individuals will be locked-in for a 12-month period, except for cause (i.e., moves out of plan service area, lack of access to necessary services, failure to pay co-payments, etc.)

Initially, the state will extend coverage to individuals for whom the state has certified income information. These individuals would first be required to use their HOP subsidy to access qualifying and affordable employer-sponsored insurance if available. If not available, coverage would be provided through health insurance products that manage and coordinate care. The state will establish minimum standards and define a basic structure for the benefits to be offered. Benefits covered may include hospital inpatient and outpatient services, lab and X-ray, physician, and mental health and substance abuse services.

Once an independent administrative structure is developed, other low-income, uninsured Texans will have access to subsidies to apply to their choice of approved and qualifying insurance plans, carriers and other coverage options available in the market. Options will be available to best

meet the needs of Texas' diverse uninsured population without overwhelming individuals with too many choices.

B. Benefit Design Issues and Principles

Three considerations are instrumental in guiding the development of benefits and cost sharing for the Section 1115 Waiver:

- Encourage and promote primary and preventive care. This is best accomplished through providing access to health insurance or other coverage options designed to manage care.
- To minimize crowd-out from employers dropping coverage or from employees choosing the Section 1115 Waiver in place of existing coverage, Section 1115 Waiver benefits and cost sharing will be designed to be no richer or more attractive than private health insurance such as, existing employer-sponsored coverage, small employer group health benefit plans, or products available in the individual market.
- Benefits and cost sharing will be designed to meet the needs of the target population, while retaining an incentive to enroll in employer-sponsored plans if such coverage becomes available.

The 1115 Waiver also incorporated the following design principles:

- **Benefit Packages** – The Section 1115 Waiver will offer plans that cover basic health services promoting primary and preventive care, as well as a manageable choice of additional benefit options.
- **Access** – The Section 1115 Waiver will offer plans that emphasize primary and preventive care, enhanced care management, and consumer choice of an array of commercial health insurance plans and other coverages.
- **Affordability** – The scope of benefit coverage, premium subsidies, co-payments, and annual benefit limits are designed to insure the maximum number of Texas' uninsured citizens within available funding by designing the proposal to:
 - Focus on primary and preventive care most needed by the target population.
 - Encourage enrollment with sliding scale premium subsidies and/or cost sharing targeted to point of service.
 - Attract cost-effective market products through the use of annual benefit limits for some products to limit exposure for catastrophic care costs, to minimize risk, and to foster participation of competing plans.

- Administrative Simplicity – The Section 1115 Waiver will be structured so that consumers can understand their options and choices and enroll in an appropriate health insurance plan.
- Market Competition – The Section 1115 Waiver will leverage market competition to reduce costs, with insurers competing on the basis of value.

Additional design principles under consideration include Long Term Care Service Needs. Texas is also exploring options for the opportunity for low-income, uninsured Texans to begin saving for long-term care service needs.

X. Cost Sharing

The 1115 Waiver will require cost sharing for all eligible enrollees. Sliding scale premiums above 150 percent of the FPL as well as point of service cost-sharing will be utilized. In addressing the issue of cost sharing for the Section 1115 Waiver, several goals and strategies were explored in reviewing opportunities to:

- Align public coverage with private insurance to reduce the risk of crowding out employer-sponsored insurance. This includes provisions to:
 - Make the coverage and cost sharing more like commercial insurance products.
 - Supplement, not supplant, commercial employer-sponsored and individual markets.
- Utilize cost sharing to reduce costs by controlling inappropriate use of services and to promote access to services in the most appropriate setting.
- Offer cost sharing structures that meet the needs of the population.
- Provide access to primary and preventive care that is managed instead of fragmented and costly avoidable inpatient and emergency room care.
- Promote personal responsibility, empowerment and a culture of insurance.
- Promote prevention and improve healthy behaviors and health outcomes.

XI. Delivery System

The delivery system for the Section 1115 Waiver will consist of plans providing basic health care services and benefits designed to improve access to managed, primary and preventive care.

In addition, Texas will seek to leverage other system improvements through HOP coverage; e.g., negotiate with HOP vendors for improved after-hours access and expanded primary care capacity for both HOP and Medicaid/CHIP clients; and support improved quality through value-based contracting principles.

XII. Implementation Timeline

HHSC will begin implementing the Section 1115 Waiver in state fiscal year 2009.

To speed implementation, low-income, uninsured Texans for whom the state has certified income information will have access to premium subsidies and basic health care services and benefits through the existing state infrastructure. Ultimately, administration of the HOP program will be carried out by the state in coordination with a contracted administrative entity.

XIII. Evaluation

The Section 1115 Waiver will significantly expand access to primary and preventive health care services for low-income, uninsured Texans and represents the centerpiece of the transformation of the health-care delivery system in Texas. As such, the state is committed to evaluating 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 that can serve as a framework for evaluation. See Attachment C.

XIV. Title XIX Waivers

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

XV. 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.

XVI. 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. The legislation authorizes funds in the HOP to include Federal Disproportionate Share Hospital (DSH) funds, Hospital Upper Payment Limit (UPL) funds, and other federal and state funds.

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. The financing agreement under this waiver will establish new requirements to link the use of these funds with enrollment in subsidized insurance and health coverage products, and

development and implementation of hospital-based efforts to specifically reduce the costs of uncompensated care.

In conjunction with this allocation approach for funding uncompensated care, the state seeks federal authority to establish a new expenditure certification process for allowable public expenditures to provide a portion of the state share of waiver benefit costs. This waiver funding plan will be designed to provide greater accountability for program expenditures and outcomes and will allow the state to phase-out the use of intergovernmental transfers, which currently support hospital-only supplemental payments that are not linked to any measurable effort to reduce the number of uninsured or decrease uncompensated care costs. Expenditures eligible for federal matching funds through the HOP certification process will be required to meet the benefit and delivery system criteria established under provisions of the waiver.

By granting the authority to both create the HOP and develop the new HOP certification process, Texas and the federal government are entering into a partnership to proactively improve health care delivery for the uninsured, increase accountability related to hospital payments for uncompensated care, reduce the number of uninsured Texans and optimize the overall use of Medicaid and DSH funding.

XVII. Budget Neutrality

A. Without Waiver Projections

Under the current system, hospital 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, Texas does not make payments up to the UPL for either private hospitals or non-state, public hospitals. 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 mechanism to address these costs by funding the HOP using the total statewide DSH allotment and aggregate UPL funding. Such flexibility will allow Texas to use this uncompensated care funding more cost effectively to intervene earlier in the health care delivery process through improved levels of insurance and other health care coverage.

B. With Waiver Projections

Approved HOP funding will be expended in a manner consistent with the goal of reducing uncompensated care. Such efforts will include insurance subsidies targeted to low-income uninsured adults and a small group of uninsured children. Projected expenditures for these purposes under the waiver are detailed in the table presented below.

Where hospital supplemental payments will still be required to support uncompensated hospital costs under this waiver, HHSC is proposing to implement new payment requirements intended to

increase accountability, improve purchasing strategy and enhance access to primary care for uninsured persons receiving hospital care. Some hospitals have implemented programs that have significantly improved care coordination and actually resulted in a far greater level of personal financial responsibility than is otherwise generally achieved. HOP payments authorized under this waiver will be designed to support these efforts and create stronger incentives for other hospitals to implement similar programs.

XVIII. 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 and to develop a reform plan. HHSC has developed partnerships with and will seek ongoing input from key stakeholders as they continue to plan for ongoing and future reforms to the health care system in Texas.

A. Stakeholder Meetings

To provide insights and input to the Medicaid Reform Project, HHSC conducted a series of meetings, with conference call capabilities, open to the public and key stakeholder groups. 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.

B. Legislative Briefings

HHSC presented to legislative committees and individual legislators on multiple occasions throughout the process of developing the Medicaid Reform Project and the drafting of Senate Bill 10. As development of the provisions of Senate Bill 10 progresses, HHSC will continue to provide briefings and required reports for members of the State Legislature. 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 Senate and four members from the House.

C. Website

HHSC has a comprehensive, informative, and user-friendly website devoted to health care reform in general and the Medicaid Reform Project in particular. The website provides the public and stakeholders with up-to-date 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.

D. Draft Section 1115 Waiver Concept Paper

Public information and input have been key components of Texas Medicaid reform since the beginning of the legislative session that passed reform legislation. A reform website was created and background issues papers were published to help inform legislative deliberations. Medicaid reform and related presentations and reports are published as they are given and an e-mail subscription list was created to notify stakeholders of any updates to the website. More than 1,600 stakeholders are included on the update distribution list. After the Texas legislature passed reform legislation in Senate Bill 10, summaries were published.

To facilitate input on key components of the concept paper, a "Request for Public Input" document was published in late October, 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. That process will continue and the Texas Legislative Oversight Committee will also receive public testimony on waiver development as the process continues. HHSC has met with stakeholder groups, provided regular updates at bi-monthly HHSC Stakeholder meetings since the beginning of 2007, and continues to meet with groups, including reaching out and updating representatives of the Alabama-Coushatta Tribe of Texas, Ysleta Del Sur Pueblo, and the Kickapoo Tribe of Texas, receive input and make regular updates to the website.

XIX. 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.

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

SB 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

B. Electronic Communications

To the extent permitted under federal law, the HHSC may adopt rules to permit, facilitate and implement the use of health information technology for the Medicaid program to allow e-communication between HHSC, operating agencies and participating providers for:

- Eligibility, enrollment, verification procedures and prior authorization.
- Update of practice information.
- Exchange of health information: e-Prescribing and electronic health record.
- Requested documentation.
- Enhancement of clinical and drug information.

If HHSC determines that the technology is cost effective, HHSC will acquire and implement health information technology.

C. Health Passport Study

Senate Bill 10 includes a provision for a study of a health passport for Medicaid and CHIP children under 19 years of age to determine the fiscal impact and feasibility of providing health passports to help coordinate services.

D. 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 TDI regarding a small employer premium assistance program to assist small employers with purchasing a small group policy. The study will include options for program funding including those from the HOP, coordination with other premium assistance efforts, and a recommended program design.

XX. 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 Medicaid Reform initiative can be operational by state fiscal year 2009.

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

Medicaid

Approximately 2.7 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 stem the rate of growth of cost while maintaining access to quality health care. Examples include the 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, April 2007			
General Category	Eligible Category	FPL% or Income Limit	Percent of Medicaid Population
Full Medicaid Beneficiaries, n = 2,706,775			
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 300,000 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 health 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.

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

- 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.
- 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.

To be eligible to receive HOP funding for local/regional program, the program 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.
- Cost sharing changes
 - HHSC may implement emergency room co-payments for non-emergency services as specified in subsection 1916(e) of the DRA, if cost-effective and feasible.

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.

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 affordable health insurance results in a reduction in the number of uninsured.
2. To evaluate whether the availability of affordable health insurance, which provides coverage for primary and preventive health care and health and wellness activities, will increase healthy behaviors, improve health outcomes, and help consumers make prudent and informed decisions about their health care.
3. To evaluate the extent to which the HOP-covered individuals use hospital services less than similarly situated uninsured and incur lower hospital costs on a per admission basis.

B. Overview of Hypotheses and Approach to Research

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

1. Reduction in the Number of Uninsured

The Section 1115 Waiver will test the hypothesis that when affordable health insurance is made available, the uninsured population will decrease significantly.

This evaluation will examine insured/uninsured rates in general and more specifically by select population groups (e.g., income levels and race/ethnicity).

2. Impact on Healthy Behaviors and Health Outcomes

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

The Section 1115 Waiver will evaluate whether access to health insurance coverage that promotes preventive services, as well as health and wellness programs, increases healthy behaviors and improves health outcomes.

This evaluation will analyze selected indicators, such as measures of emergency room utilization rates, inpatient hospitalization rates, use of preventive services and health and wellness programs, and the extent to which participants report an increase in their overall health status.

3. Uncompensated Care Analysis

The Section 1115 Waiver tests the hypothesis that as more people receive health insurance coverage that emphasizes access to primary and preventive care with care management, combined with a range of hospital requirements and incentives to reduce uncompensated care and changes in hospital reimbursement, there will be a corresponding decrease in the demand for hospital-based care and uncompensated care for HOP-covered individuals and lower hospital costs on a per admission basis. The reduction in uncompensated care should increase hospital revenue due to commercial health insurance coverage and decrease 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.

4. Participant Views on the Effect of the Program on their Lives and Use of Health Care

The Section 1115 Waiver will evaluate whether access to a commercial primary and preventive health insurance benefit will encourage low-income, uninsured participants to more consistently use their coverage to maintain the basic health care needed to avoid more costly acute care services. For example, access to affordable prescription medications and routine physician services is expected to:

- Enable individuals to maintain their health
- Improve the quality of life
- Remove cost as a barrier to routine or chronic health services
- Decrease reliance on hospital-based care

Attachment D
Title XIX Waivers

The State will request that CMS grant a waiver of the Title XIX and Title XXI statutory provisions identified below in order to effectively implement and administer the Section 1115 Waiver.

A. Title XIX Waivers

1. Section 1902(a)(1), Statewide/Uniformity

This section requires that services provided under the plan be available in all political subdivisions of the State. Texas requests this provision be waived to enable the state to operate the demonstration and provide managed care plans or certain types of managed care plans only in certain geographical areas.

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

This section requires the State to provide for granting an opportunity for a fair hearing before the State agency to individuals whose claim for medical assistance is denied or not acted upon promptly. Texas requests that this provision be waived to eliminate the requirement for hearing rights before the Medicaid agency for service denied or approved other than as required by the Texas Department of Insurance.

3. Section 1902(a)(4)(a)

This section requires the Medicaid agency to utilize a Medicaid Eligibility and Quality Control system as defined in law and regulation. Texas requests this provision be waived to enable the State to use a system different from that required in Medicaid law and regulation for persons enrolled in private commercial individual insurance plans and employer-sponsored insurance.

4. Section 1902(a)(2)(10)(B), Amount, Duration and Scope/Comparability of Services

This section requires Medicaid to provide services in equal amount, duration and scope to all persons eligible under the plan. Texas requests that this section be waived for the following purposes:

- To permit the state to modify the Medicaid benefit package to allow for benefit packages comparable to private commercial health benefit plans such as ESI, offer differing benefits and benefits that vary in amount, duration and scope, and set annual benefit limits based on different private commercial plans;
- To permit coverage of benefits for the demonstration populations that is not covered for the non-demonstration population; and,

Attachment D
Title XIX Waivers

- To relieve the state of the requirement to wrap-around services for enrollees that access coverage under an employer-sponsored group health plan through this waiver. This does not apply to the current Health Insurance Premium Payment program

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

This section requires that applications for medical assistance be determined in a reasonable timeframe as defined in regulation. Texas proposes to waive this provision to allow eligibility determination contingent upon the individual selecting a health care plan within the timeframe specified by the State and the time required for enrollment in the selected plan. During the period, the individual will not be eligible for coverage.

6. Section 1902(a)(34)

This section requires that an individual determined eligible for Medicaid also be given eligibility for up to three months prior to the month of application if the individual received covered services during the period and was, or upon application would have been, eligible. Texas requests approval to implement a prospective eligibility process. Eligibility would begin on the first day of the month the beneficiary is determined eligible and enrolled in a health plan.

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

These sections require Medicaid coverage of early and periodic screening, diagnosis and treatment (EPSDT) services for children under the age of 21. Because the health care service package differs from the Medicaid service package, the State is requesting a waiver of EPSDT for participants under the age of 21 served under the waiver. (e.g. Older siblings [up to 21 years of age] who reside in the same household as CHIP or Medicaid enrollees and are not eligible for Medicaid.)

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

These sections require the eligibility determination process for all covered groups to be documented and set according to regulations. Texas requests a waiver of this provision to permit the state to use streamlined eligibility procedures and include eligibility standards and requirements that differ from those required by law.

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

Attachment D
Title XIX Waivers

This section requires the Medicaid agency to provide that any covered individual can receive services from any willing provider. Texas requests a waiver of this provision to enable the state to restrict freedom of choice of providers to be consistent with the networks provided by private health insurance plans and licensed managed care carriers eligible for subsidies.

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

This section establishes limits on the amount of cost sharing a state Medicaid agency may impose. Texas requests a waiver of this provision 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 expansion population, including those with incomes below 100% of the Federal Poverty Level.

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

This section requires Medicaid payment for Federally Qualified Health Centers and Rural Health Clinics to be consistent with the new prospective payment system described in Section 1902(aa) of the Social Security Act. Because this demonstration focuses on subsidized premiums for private commercial plans, the State is requesting to waive full cost reimbursement for services provided by these clinics.

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

To enable the State to provide a direct subsidy or reimbursement to enrollees (including through the use of a voucher), not to exceed the established premium capped at total estimated Medicaid costs, to enable low-income uninsured enrollees to pay for their share of medical insurance premiums when they elect enrollment in an available employer-sponsored insurance plan.

B. Costs Not Otherwise Matchable

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 Section 1903 shall, for the period of this waiver extension, be regarded as expenditures under the State's Title XIX Plan.

1. The subsidy, reimbursement, or voucher, provided to enrollees 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.

Attachment E

Current Medicaid Program Context for Waiver Financing

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 Management -- 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, is developing 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

Attachment E
Current Medicaid Program Context for Waiver Financing

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 will implement STAR Health, a new health-care program to improve services and better coordinate care for children in foster care. Program components will include:

- A Health Passport for each child in foster care, containing a summary of his or her medical information. The Health Passport will be available through the Internet and make 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.

Attachment E
Current Medicaid Program Context for Waiver Financing

- Clinical service management and disease management.
- Hotlines for member and provider assistance.

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.

Attachment F
Stakeholder Meetings

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
Industry Stakeholders				
Alabama-Coushatta Tribe of Texas	Scheduled 12/19/2007	Myra Sylestine	Update on Medicaid Reform & Timeline	In-person
Ysleta del Sur Pueblo	Scheduled 12/10/2007	Dr. George Haddy	Update on Medicaid Reform & Timeline	In-person
Kickapoo Tribe of Texas	Scheduled 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 Opportunies	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	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
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		Medicaid Reform Informational Meeting - Texas Insurance Market	Phone

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
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		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	Various	Medicaid Reform Informational Meeting and Update - Presentation	Phone
Key Stakeholders, Advocacy Groups and Associations	8/30/2007	Various	Medicaid Reform Informational Meeting and Update - Presentation	In-person
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
Indigent Health Care Program	7/27/2007	Byron Hale	Indigent Health Care	Phone
University of Texas Medical Branch	7/19/2007	Dr. Barbara Brier	Medicaid Reform - Informational Meeting - Reimbursement for Indigent Healthcare	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

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
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	7/9/2007	Rick Spivey	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
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
HMO Meeting	6/12/2007	Various	General Update on Medicaid Reform	In-person
Spivey & Harris	5/16/2007	Rick 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	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
Texas Health Institute	4/5/2007	Camille Miller	Discussion of Senate Bill 10 and Medicaid Reform	In-person

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
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
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				
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

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
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				
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	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 Forums				
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

Name of Organization	Meeting Date	In Attendance	Medicaid Reform Topic	Medium
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