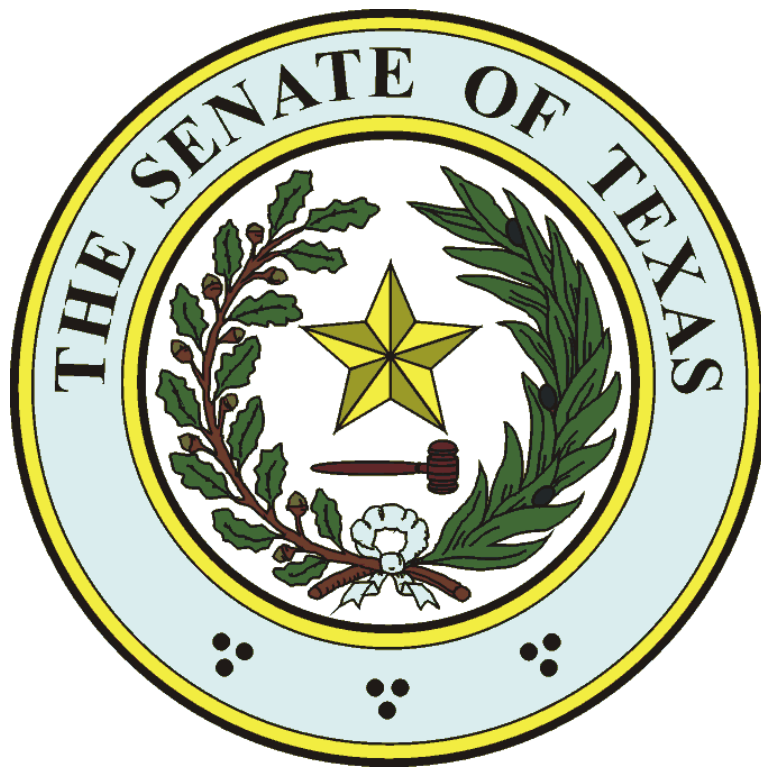


**TEXAS SENATE
COMMITTEE ON HEALTH
AND HUMAN SERVICES**



**INTERIM REPORT
TO THE
81ST LEGISLATURE**

January 2009

Please direct questions or comments to:

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THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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SENATOR JUDITH ZAFFIRINI

January 9, 2009

The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Governor Dewhurst:

The Senate Committee on Health and Human Services submits this report in response to the joint interim charge you have assigned to this Committee and the Senate Committee on Finance. The Committees met in a joint hearing on September 16, 2008 to discuss Medicaid provider reimbursement rate methodologies, hospital reimbursement, and uncompensated care. This report includes a review of these issues and makes recommendations related to the topics discussed.

The Committee has carefully considered all of the testimony received on this charge in order to provide you with these recommendations. We appreciate the leadership and foresight you have displayed in asking this Committee to monitor and seek remedies to these key issues, and we trust that the recommendations offered in this report will serve to improve health care and human services in Texas.

Respectfully submitted,

Senator Jane Nelson
Chair

Senator Bob Deuell
Vice-Chair

Senator Robert Nichols

Senator Dan Patrick

Senator Eliot Shapleigh

Senator Carlos Uresti

Senator Royce West

Senator Judith Zaffirini

Joint Report on Medicaid Provider Rate Reimbursement Methodologies, Hospital Reimbursement, and Uncompensated Care

Executive Summary

Health and human services expenditures continue to be among the largest drivers in our biennial state budget. For the 2008-09 Biennium, appropriations total \$53.0 billion in All Funds or 31.6 percent of all state appropriations, including \$21.4 billion in General Revenue (GR) funds and General Revenue-Dedicated funds. The various components of the Medicaid program account for \$15.4 billion in GR funding for the 2008-09 Biennium. On an All Funds basis, Medicaid accounts for \$39.6 billion, which is 75 percent of the Article II (Health and Human Services) budget and 24 percent of the total state budget. The Senate Committee on Health and Human Services, in conjunction with the Senate Committee on Finance, was given a specific charge regarding health care cost-related issues.

This report concerning that charge is divided into two chapters:

- Chapter 1: Uncompensated Care/Hospital Financing/Medicaid Reform
- Chapter 2: Medicaid Rates Reimbursement Methodologies

Summary of Recommendations to the 81st Legislature

1. Participating hospitals should be required to submit audited data to be eligible for Disproportionate-Share Hospital (DSH) & Upper Payment Limit (UPL) reimbursement. Via rider or statute, the Health and Human Services Commission (HHSC) should be provided the authority to withhold payment for a participating hospital's failure to comply with reporting requirements.

2. HHSC should implement a simpler and more standardized reporting methodology to calculate uncompensated care.
3. The Centers for Medicare & Medicaid Services (CMS) diagnosis related groups (DRGs) should be expanded to an "all patient" system for use in Medicaid to better measure severity of illness and differences in population, and to more accurately reflect each patient's needs.
4. Before any future rate increases are considered or approved, the Legislature and HHSC must understand how previous rate increases were implemented and what measurable results were obtained.

Procedural Background

The Senate Committee on Finance and the Senate Committee on Health and Human Services (the Committees) were charged with conducting a thorough and detailed study of the following issue, including state and federal requirements, and preparing recommendations to address problems or issues that were identified. The Committees met in accordance with the following interim charge as follows:

Review Medicaid provider reimbursement rate methodologies, including the impact of factors such as infrastructure concerns, federal minimum wage changes, and cost reports. Study the impact on access to care, quality of care, and value, and make recommendations for legislative changes, taking into account rate increases contained in the current budget.

The Committees met pursuant to the aforementioned interim charge in a public hearing in Austin, Texas on September 16, 2008, to consider invited testimony provided by HHSC and solicited public testimony. Both committees extend their thanks to those who participated in the hearing and assisted with or made presentations before the Committees.

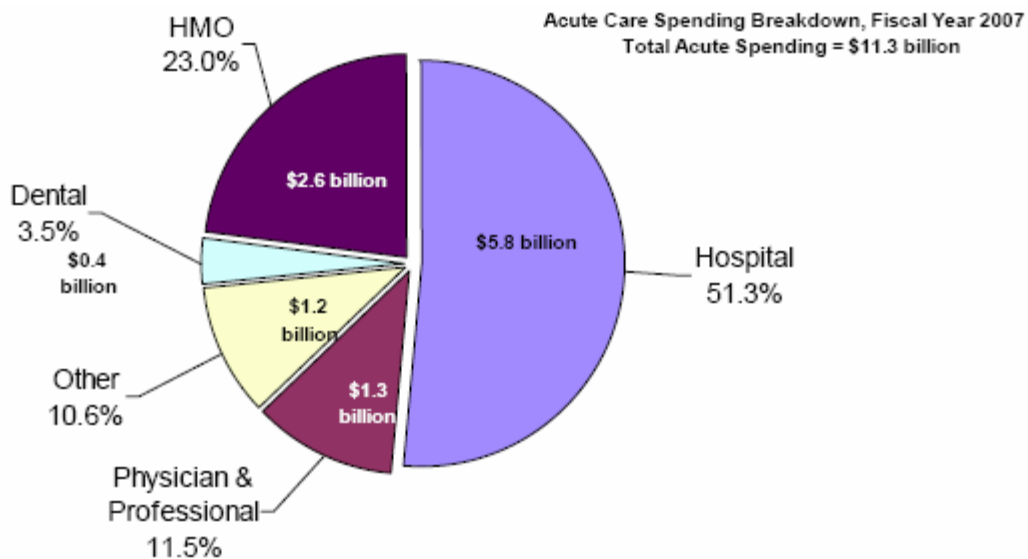
Chapter 1: Medicaid/Uncompensated Care Hospital

Financing

Background

Medicaid

According to the Legislative Budget Board's (LBB's) FY 2008-09 Fiscal Size Up, the various components of the Medicaid program account for \$15.4 billion in GR funding for the 2008-09 Biennium. This is 75 percent of the GR budget for Article II (Health and Human Services) of House Bill 1, 80th Legislature, 2007, and 19 percent of the total GR biennial budget for all articles. On an All Funds basis, Medicaid accounts for \$39.6 billion, which is again 75 percent of the Article II budget but 24 percent of the total state budget. Below is a chart prepared by HHSC relating to acute care (i.e. non-long term care) expenditures under the Texas Medicaid Program. It is based on FY 2007 data:



Uncompensated Care

Uncompensated care charges, according to Texas hospitals, went from \$5.5 billion in 2001 to \$11.6 billion in 2006. This clearly indicates the growing severity of the issue and the financial burden placed on federal, state, and local governments. Many times, the ultimate cost of uncompensated care lands on local property taxpayers who support county and other local facilities.

It is important to remember that several reimbursement sources and income enhancements should be factored in when determining a hospital's true cost of providing care to the underinsured. Applying such adjustments and income to the reported charges results in a much lower ultimate burden actually borne by hospitals. Using information supplied by HHSC, ultimate unreimbursed care is estimated to be between 5% and 25% of reported values for 2004, and between 3% and 22% for 2003. The difference between these estimates of ultimate burden and hospitals' self-reported charges leads to a great deal of confusion regarding the magnitude of the problem.¹

The 80th Legislature recognized the complexities of hospital uncompensated care and directed HHSC through Senate Bill 10 and HHSC Rider 44 to convene a hospital industry work group to study and advise HHSC on options to improve uncompensated care reporting, with the goal of streamlining definitions of uncompensated care.

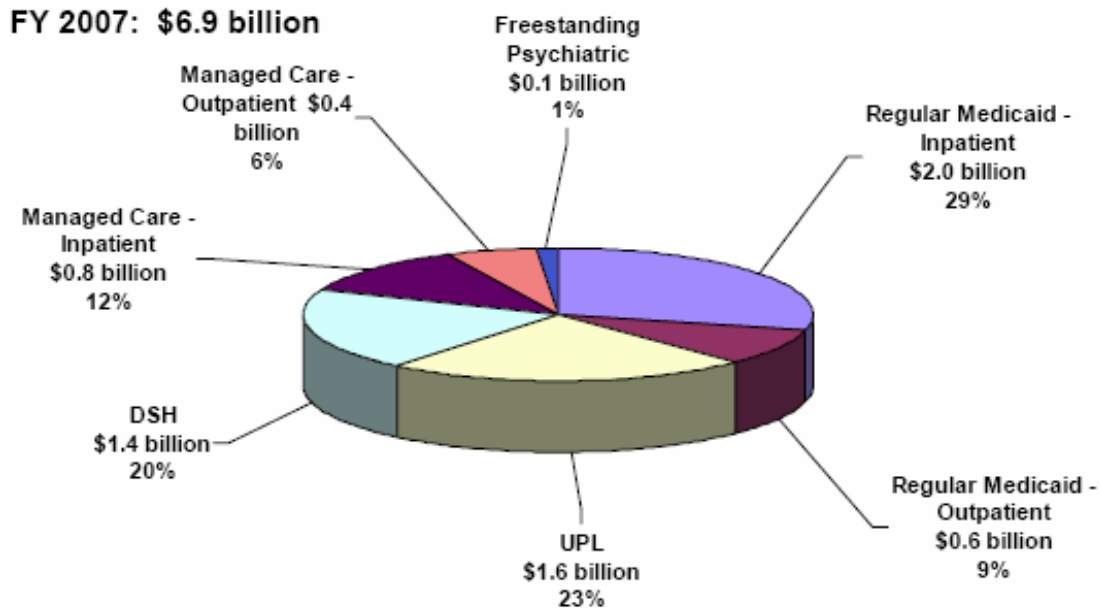
¹ Health and Human Services Commission, Rider 61 Texas Hospitals' Uncompensated Care Report, October 6, 2006.

The workgroup determined that the individual program definitions of uncompensated care were too unique to each program for a single definition to be workable in all cases. Instead, an overarching definition and methodology could clarify hospital uncompensated care reporting. This methodology should also account for offsetting funding sources provided by the legislature, federal, and local governments and measure the residual impact of uncompensated care on hospital costs.

Hospital Financing

Also of particular interest is hospital financing. A chart relating to sources of hospital income is included below:

TEXAS’ MEDICAID RELATED HOSPITAL PAYMENTS (ALL FUNDS)



Medicaid payments to hospitals for inpatient services are based on DRGs, which are comprised of a standard dollar amount (SDA) multiplied by a relative weight. The SDA is, in effect, a base rate that is unique to each hospital based on its costs. The relative weights are a measurement of severity of illness for the patients receiving treatment. Outpatient payments to hospitals are calculated differently; hospitals are provided a defined percentage of their allowable costs. High volume providers are reimbursed at 84.48 percent of their allowable costs while other hospitals are reimbursed at 80.30 percent of their allowable costs.

Effective October 1, 2007, CMS adopted a Medicare Severity-Diagnosis Related Groups (MS-DRG) classification system for the Medicare inpatient prospective payment program. Under this prospective payment program, hospitals are encouraged to use more cost-efficient medical care and are paid a pre-determined rate for each Medicare/Medicaid admission. HHSC also adopted the new MS-DRG listings for the state's Medicaid inpatient prospective payment system effective October 1, 2007. The previous version of the Medicare DRG listing had about 540 relative weights. The new MS-DRG has 745 relative weights.

CMS and HHSC adopted this expanded listing of weights to better recognize the severity of illness among patients whose care is reimbursed by the prospective payment system. This expansion focused more on the types of care provided to the older Medicare population, rather than the pregnant women and children who are the bulk of Medicaid clients. Even with this expanded number of DRGs, there are limitations on the completeness of this list since CMS based its system on the costs of its older Medicare population. HHSC is considering an "all patient" DRG methodology which will more appropriately categorize hospital costs for the

Medicaid population. A more accurate DRG system also paves the way for incorporating more quality data into payment systems.

Supplemental Hospital Payments (DSH and UPL)

In addition to regular payments for inpatient and outpatient care, the Medicaid program provides supplemental payment options. Two of the largest of these are the Disproportionate Share Hospital (DSH) program and the Upper Payment Limit (UPL) program.

The DSH program is for hospitals that qualify for participation based on the disproportionate number of Medicaid days and/or uninsured days provided. The program reimburses qualifying hospitals for the amount of their inpatient Medicaid shortfall costs (Medicaid costs not reimbursed by the DRG program) and the uncompensated care costs incurred by providing care to uninsured Texans. The current allocation formula pays state hospitals first for actual costs of uncompensated care and second, depending on the amount of DSH remaining, allocates the remainder of the federal DSH funds to all other qualifying hospitals. In 2008, the total amount of DSH funds available for allocation was approximately \$1.5 billion.

The UPL program is intended to reimburse participating hospitals for the difference between what Medicare would have paid for each Medicaid patient and what Medicaid actually did pay. This program is composed of three separate hospital classes: state hospitals, public hospitals, and private hospitals. Each class calculates its own UPL and a hospital cannot be in more than one class. Hospitals do not have to participate in the DSH program to be able to participate in

the UPL program; however, the formula used to calculate the payment to a hospital participating in DSH is different than what is used to calculate the UPL payment for a hospital that is not. As is the case for the DSH program, state hospitals fund the state share of their full UPL payments with GR funds, while public hospitals use Intergovernmental Transfers (IGTs) for their state match. The private hospital UPL program is unique in that private hospitals are unable to provide a match that is allowable under CMS rules (only governmental entities can provide such a match). In order for a private hospital to participate in the UPL program, a public hospital is required to supply the state match using allowable tax funds. This requirement leads to a need for an “affiliated agreement” between a private hospital and the public hospital providing the state match. The private hospital UPL program was temporarily on hold during the interim as CMS reviewed the permissibility of some non-federal matching funds. Private UPL program payments were restored beginning in August 2008 and will total \$575 million in All Funds for this year.

Nearly \$3 billion is paid to hospitals each year via the DSH and UPL programs, which make up about half of the total Medicaid funding provided to hospitals. These programs, initially intended as supplements and funding enhancements, now almost match traditional payments. However, there is very little accountability on how the funds are spent since the payments are not associated with specific patients or services.

Medicaid Reform

Texas has the largest uninsured population rate in the nation, with one in four or approximately

5.5 million Texans lacking insurance. Of these, 2.1 million are low-income adults.² The majority of these adults are employed but either cannot afford their employer's health plan or do not have access to a group insurance plan through their employer.

While most Texans are covered by health insurance, we all pay a price for the uninsured. Health conditions that could have been treated in a doctor's office often become more acute and require more costly treatment later. Chronic illnesses such as diabetes, asthma, and heart disease often are not treated in a proper manner. The result is overcrowded emergency rooms, rapidly growing uncompensated care charges, higher private insurance premiums for insured Texans and their employers, increased reliance on federal supplemental funding, and poor health outcomes for many.

The Texas Medicaid waiver request stipulated in SB 10, 80th Legislature, Regular Session, 2007, submitted in April 2008 and revised in October 2008, outlines a large series of health care reforms that are intended to assist more people with insurance, reduce reliance on high-cost emergency room visits for basic care, and make it easier for working individuals to participate in employer-sponsored health coverage.

Approval of the waiver would protect funding for our safety-net hospitals, establish greater transparency in the reporting of uncompensated care expenses, and support local efforts to reduce uncompensated care. If granted, the waiver could protect the allotment of UPL funds to Texas and allow for the development of a more cost-effective vehicle for providing care.

² Medicaid Reform Waiver Request, April 2008, Pages 3-5

The Texas Legislature appropriated \$150 million in additional GR to rebase hospital rates and provide a funding base for these reforms. Additional federal funds are expected from the "certification" of dollars already spent by the state and local governments on health care for Medicaid-eligible individuals. This money will flow into a Health Opportunity Pool (HOP), where it can be used to subsidize care for uninsured populations.

If the federal government does not approve the Medicaid Reform waiver, the state should still move forward with efforts to more effectively and efficiently use DSH funds. Funds might not simply be distributed to non-state DSH hospitals via the traditional formula, but could instead be leveraged to support disease management programs, for instance.

Participating hospitals should also be required to submit audited data to be eligible for these DSH & UPL payments. HHSC should be provided the authority to withhold payment for failure to comply with reporting requirements. Currently, most observers believe the state cannot address its problems relating to the uninsured unless the Texas health care system is reformed at its base. With Texas' Medicaid waiver request, the state is seeking to break this cycle.

Recommendations

The Senate Committee on Finance and the Senate Committee on Health and Human Services recommend that the 81st Legislature consider taking appropriate action to effectuate the following in regard to Medicaid/Uncompensated Care and Hospital Financing:

1. Participating hospitals should be required to submit audited data to be eligible for Disproportionate-Share Hospital (DSH) & Upper Payment Limit (UPL) reimbursement. Via rider or statute, HHSC should be provided the authority to withhold payment for participating hospitals failure to comply with reporting requirements.
2. HHSC should implement a more simple and standardized reporting methodology to calculate uncompensated care.
3. The Centers for Medicare & Medicaid Services (CMS) diagnosis related groups (DRGs) should be expanded to an "all patient" system for use in Medicaid to better measure severity of illness and differences in population to more accurately reflects a patient's needs.

Chapter 2: Medicaid Rate Reimbursement

Background

Methodology

HHSC develops more than 157,000 different reimbursement rates, primarily for the Medicaid program. Of these, 360 rates are for health maintenance organizations (HMOs), 955 are for nursing facilities, 28,000 for school health and related services (SHARS), 473 for inpatient hospital SDAs and 745 for inpatient hospital DRGs, 112,592 for physicians and other professionals, 1,991 for durable medical equipment, and 2,773 for Texas Health Steps providers.³

There are several major methodologies under which most of these reimbursement mechanisms can be grouped. Managed care rates are actuarially based, which include programs such as STAR, PACE, and CHIP. Other rates are cost report based, or prospective, which include nursing facilities, community care, rehabilitation services, and foster care. Cost-based reimbursement rates include children's hospitals, state schools, the state lab, outpatient hospital services, and SHARS.

In some cases, including DRGs, ambulance providers, and durable medical equipment, the state does not directly determine the rate methodology. Several major rate categories are influenced by federal Medicare policy. Furthermore, CMS mandates the methodology for the rate calculation. These include rates for hospice (both nursing facility and in-home), federally

³ Consolidated Budget, page 64.

qualified health centers (FQHCs), and rural health clinics. In general, most Medicaid services had rate increases effective September 1, 2007.⁴

Non-Hospital Items

In most cases, when the legislature approves increased funds for provider rates, state agencies responsible for the designated programs utilize stakeholder groups and other methods to determine reimbursement for each type of procedure. Rate increases can be targeted by appropriations rider and the legislature can review and modify instructions based on impact, fairness, or any other basis.

Appropriations to HHS agencies in FY 2008-09 for rate restorations, rate increases, and hospital rebasing are \$3.1 billion in All Funds, including \$1.2 billion in GR. A number of rate increases, especially those relating to community care and other providers which utilize lower-paid employees, were increased to compensate for the recent rise in the federal minimum wage. The appropriations include the following funding:⁵

- \$529.7 million in All Funds, including \$216.2 million in GR, for community care rate restorations and increases, Intermediate Care Facilities for the Mentally Retarded, and nursing facilities at the Department of Aging and Disability Services (DADS);
- \$39.0 million in All Funds, including \$13.4 million in GR, for foster care rate increases at the Department of Family and Protective Services (DFPS);

⁴ SFC presentation 9/16/2008, page 9.

⁵ FY 2008 - 2009 LBB Fiscal Size-Up, Page 136.

- \$3.1 million in GR for Children with Special Health Care Needs, Family Planning, and Women and Children’s Health rate restorations at the Department of State Health Services (DSHS);
- \$1.25 billion in All funds, including \$493.4 million in GR, for Medicaid and CHIP rate restorations and increases, and hospital rebasing at HHSC; and
- \$1.3 billion in All Funds, including \$511.7 million in GR, for rate increases related to the *Frew* expenditure plan at HHSC.

HHSC has recently published a rule making the allocation of \$150 million in GR for rate rebasing contingent upon approval of the pending Medicaid reform waiver. A table of recent rate adjustments is included below:

Providers	2002-2003	2004-2005	2006-2007	2008-2009
Hospitals - Inpatient	9/01/01 fully rebased acute care hospitals	9/1/03 rate decrease 2.5% 9/1/04 rate decrease of 5% (Implementation of UPL program begins in 2004)	9/1/06 rate decrease related to SSI patients in 8 specific Managed Care Organizations Service Delivery Areas 8%	Subject to Medicaid Reform Waiver approval - \$150 million (increases offset 5% rate decrease)
Hospitals - Outpatient	0%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate restoration 2.5%
Federally Qualified Health Centers (FQHC)	1/1/02 rate increase 3.8% 1/1/03 rate increase 4.5%	1/1/04 rate increase 4.4% 1/1/05 rate increase 4.8%	1/1/06 rate increase 4.3% 1/1/07 rate increase 3.6%	1/1/08 rate increase 3.3% 1/1/09 rate increase MEI + 1.5%
Rural Health Clinics (RHC)	1/1/02 rate increase 2.3% 1/1/03 rate increase 3.0%	1/1/04 rate increase 2.9% 1/1/05 rate increase 3.1%	1/1/06 rate increase 2.8% 1/1/07 rate increase 2.1%	1/1/08 rate increase 1.8% 1/1/09 rate increase MEI
Ambulance Providers	0%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate increase and rate restoration of 55.5%
Physicians and Certain Other Practitioners:				
<i>Children**</i>	0%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate increase and rate restoration of 27.5%
<i>Adults</i>	0%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate increase and rate restoration of 12.5%
Dentists**	1/1/02 rate increase of 13.5%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate increase and rate restoration of 52.5%
Vendor Drug (Dispensing Fee)	0%	9/1/03 rate decrease 2.5%	0%	9/1/07 rate increase and rate restoration of 44.8%

Providers	2002-2003	2004-2005	2006-2007	2008-2009
Nursing Facilities	9/1/01 rate increase of 8.8%	9/1/03 rate decrease of 1.75%	1/1/06 rate increase of 11.75%	9/1/07 rate increase of 3% 9/1/08 rate increase of 5%
Community Care - DADS (CBA, PHC, DAHS, CLASS, etc.)	9/1/01 rate increase varies from .04% to 2.2%	9/1/03 rate decrease of 1.1%	9/1/05 rate restoration increase of 1.10% 8/1/07 minimum wage increase - varies from 0% to 1.79%	9/1/07 rate increase - varies from 1.79% to 6.06% 8/1/08 minimum wage increase - varies from 2.45% to 14.29% 8/1/09 minimum wage increase - not yet determined
Community Care - DADS (HCS, TxHmL)	9/1/01 varies from rate decrease of 4.4% to rate increase of 3.23% depending on service	9/1/03 rate decrease of 1.1%	6/1/07 rate restoration increase of 1.1%	9/1/07 rate increase of 5%
Community Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	9/1/01 and 11/1/01 rate increase - varies from 10% to 13%	9/1/03 rate decrease of 1.75%	6/1/07 rate restoration increase of 1.75%	9/1/07 rate increase of 7.5%
Foster Care	9/1/01 rate increase of 3% 9/1/02 rate increase of 2%	9/1/03 rate decrease of 3.1%	9/1/05 rate increase of 2.78%	9/1/07 rate increase of 4.3%

Recommendations

The Senate Committee on Finance and the Senate Committee on Health and Human Services recommend that the 81st Legislature consider taking appropriate action to effectuate the following in regard to Medicaid Rate Reimbursement Methodology:

1. Before any future increases are approved, the Legislature and HHSC must understand how previous rate increases were implemented and what measurable results were obtained.

January 8, 2009

The Honorable Jane Nelson
Chairwoman
Senate Committee on Health & Human Services

The Honorable Steve Ogden
Chairman
Senate Committee on Finance

VIA HAND DELIVERY

RE: Joint Report on Medicaid Provider Rate Reimbursement Methodologies, Hospital Reimbursement, and Uncompensated Care

Dear Chairwoman Nelson & Chairman Ogden:

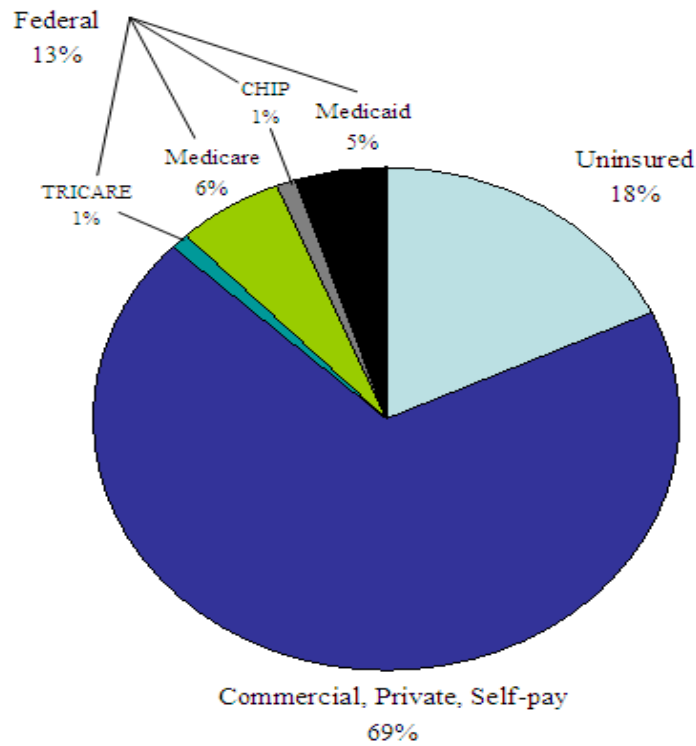
We appreciate your leadership and the Committees' work on the Joint Report on Medicaid Provider Rate Reimbursement Methodologies, Hospital Reimbursement, and Uncompensated Care for the 81st session of the Texas Legislature. I ask that you append this letter to the Joint Report.

Compounding the problem of the uninsured, Texas spends significantly less per capita for Medicaid acute care services delivered on the Border than in other geographic regions of the state. Payments to health care providers are among the lowest in the U.S., thereby perpetuating an already severe shortage of providers along the Border.¹ As a consequence, state provider rates are themselves a root cause for the lowest access to health care services for any major population base in the United States. Through abysmally low reimbursement rates, state policy creates a disincentive for providers to practice in Border counties.

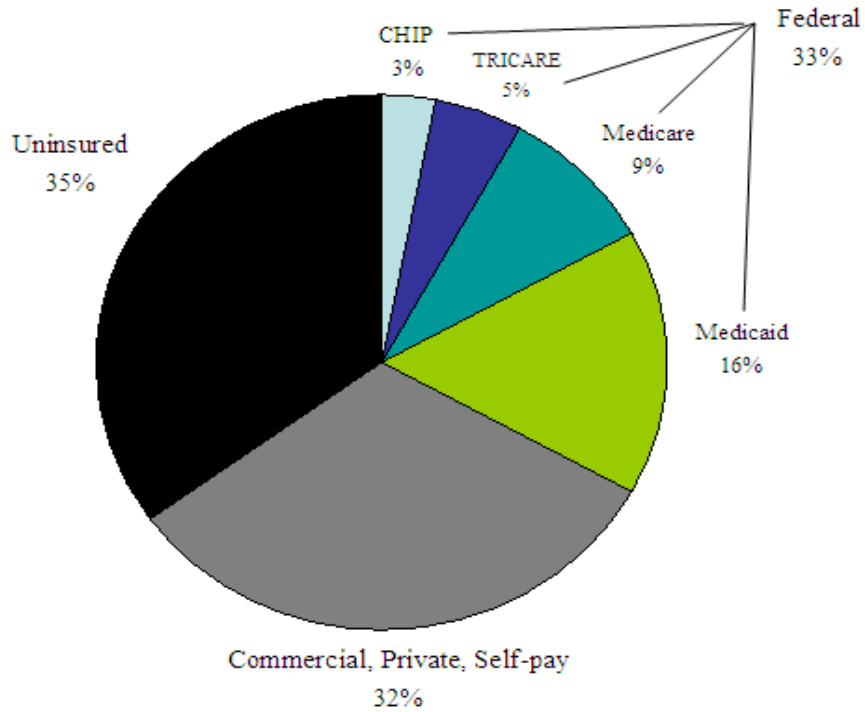
In the 43 counties of the Texas-Mexico Border, the mix of uninsured and insured is such that Medicaid and CHIP reimbursement rates control the market. Herein below are charts that demonstrate differences in the market share of Medicaid and CHIP in Travis County and El Paso County.

¹ Ralitsa B. Akins & Gilbert A. Handal, *Disparities in Children's Access to Healthcare in the Border Region: Issues, Solutions and Opportunities for Healthcare Policy Makers*, PUBLIC POLICY ISSUES RESEARCH TRENDS, Chapter 2, 2007.

Estimated 2000 Insurance Mix for Travis County



Estimated 2000 Insurance Mix for El Paso County



The reason the state has historically spent less per capita for Medicaid on the Border than in the rest of the state is because rates are based on historic utilization of health care services in a county. The Border has low utilization due primarily to the lack of health care providers and infrastructure. It is common knowledge that El Paso ranks near the bottom in comparison to the rest of the U.S. in terms of number of physicians, dentists, and every other type of provider.

Number of Health Professionals per 100,000 population (2007)

	El Paso County	State
Physicians	109	157
Physician Assistants	12	16
Dentists	17	37
Licensed Professional Counselors & Interns	34	59
Licensed Psychologists	5	15

Sources: Texas Medical Board (Aug. 2007); Texas State Board of Dental Examiners (Aug. 2007); Texas State Dept. of Health Services, Ctr. for Health Statistics, Health Professions Resource Ctr. (Oct. 2007); Texas State Board of Examiners of Psychologists (Aug. 2007).

Infrastructure is so poor that the number of hospital beds per capita in itself is a crisis. For every 317 people in Texas, on average, there is one hospital bed; in El Paso County, there is one bed for every 339 people.²

The Medicaid rates paid to physicians and dentists are woefully inadequate, particularly for a community like El Paso where Medicaid is a major payer for health care services. This problem is not limited to just the traditional Medicaid fee-for-service program. Under the Medicaid managed care program, the capitation rates paid to participating Health Maintenance Organizations (HMO) are set with the assumption that physicians will be paid the Medicaid fee-schedule. The chart *Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006* shows the wide variation in rates in cities throughout the state.

Adjusted Weighted Medicaid and CHIP Capitation Rate Disparities, 2006

Organized by HMOs in Selected Care Service Areas

	Bexar Superior	Dallas Parkland	Harris Amerigroup	Lubbock Firstcare	Tarrant Amerigroup	Travis Amerigroup	El Paso Superior
TANF Children (> 1 year)	\$81.18	\$86.51	\$75.28	\$77.51	\$74.73	\$73.69	\$83.04
TANF Adults	213.41	191.29	227.92	203.50	238.18	193.85	206.16
Pregnant Women	358.30	310.37	320.04	501.47	318.23	322.44	345.09
Newborns	563.36	622.35	678.97	340.97	465.19	520.87	495.48

² Texas Department of State Health Services

Expansion Children (> 1 year)	80.14	101.25	77.68	87.19	69.77	85.50	89.97
Federal Mandate Children	67.63	73.67	70.18	72.44	78.20	61.79	70.24
CHIP (ages 15-18)	87.15	119.94	83.64	94.53	101.71	n/a	96.06

Source: Texas Health and Human Services Commission

Capitation rates, or the fee per child, paid to managed care organizations participating in Medicaid are based on historic expenditures per capita. Cities like El Paso, which have always had disproportionately low Medicaid expenditures per capita, find themselves in a difficult situation. To achieve higher capitation rates, they must spend more per capita. But because the capitation rates are so low, it is impossible to spend more per capita. The disproportionately low per-capita expenditures, the low managed care capitation rates, and the wholly inadequate Medicaid fee schedules have forced health care providers to significantly limit their participation in Medicaid or leave the program altogether. All of these factors negatively impact Medicaid recipients' access to services.

We must develop a more objective methodology for determining reimbursement rates across the state.

With the inclusion of this letter, I sign the Committees' Joint Report to demonstrate that we stand together to work on important health-related issues in the 81st Session.

Very truly yours,



Eliot Shapleigh

cc: Lt. Gov. David Dewhurst, Members of Senate Committees on Finance and Health & Human Services

ES/sj