

# CHIP: A Texas 'Tragedy' on the Border



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*The Children Health Insurance Program is widely used in the El Paso region, which has the potential to grow even more and help uninsured children obtain insurance. In February of 2009, the Obama Administration and the U.S. Congress passed the Children’s Health Insurance Program Reauthorization Act. The legislation aims to increase the federal CHIP enrollment guideline—estimated to provide 4.1 million more children with health insurance. On the state level, Texas has the largest percentage of uninsured children in the nation. However, during the 81<sup>st</sup> Legislative Session, Texas legislators failed to pass a bill to meet new federal guidelines that would increase the amount of children enrolled in CHIP and help an estimated 80,000 uninsured Texas children. Lastly, the program relies on reimbursement and capitations rates that vary county to county. Community Scholars investigated these rates and their affect on the overall quality of healthcare for those insured through government programs, as well as what the Texas Legislature’s inaction will mean for the uninsured children of Texas.*

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The Children's Health Insurance Program (CHIP) is a state program regulated by the United States Department of Health and Human Services through the Centers For Medicare and Medicaid Services (CMS).<sup>1</sup> It is jointly funded by federal and state governments to provide health services at a subsidized cost to uninsured low-income children whose yearly family earnings are considered too high to qualify for Medicaid. Although the federal government distributes funds to the states, each state individually runs their CHIP program in accordance

CHIP was established by the Federal Budget Balanced Act (BBA) of 1997.<sup>2</sup> The purpose of BBA was to reduce the payments health-care providers would receive for Medicare and to encourage states to provide health insurance to uninsured children.<sup>3</sup> Congress agreed to the BBA with unanimous consent by the Senate and a House vote of 270-162.<sup>4</sup> President William J. Clinton (D) then signed CHIP into law on August 5, 1997.<sup>5</sup> CHIP was established as a block grant program, which will be discussed further in the *Funding* section.

Medicaid and CHIP are different government programs, even though they are sometimes combined together under state establishment. The differences between both programs are the eligibility income guidelines, their respective matching rate formula, point allotments, the number of patients insured and the patient payment plans they implement.

*(For further information regarding the difference between both programs: See Appendix A)*

CHIP covers children through the age of 18 as well as unborn children. CHIP does not cover parents or adults. A recipient's financial eligibility is determined by the income of his/her family.<sup>6</sup> The Federal Poverty Income Guidelines, informally known as the Federal Poverty Level (FPL), is determined by the U.S. Census Bureau and is a simplified definition of poverty thresholds.<sup>7</sup> Factors that determine the FPL are described in the *Enrollment* section, under the *Role of the FPL* sub section. Furthermore, the recipient cannot be enrolled in another health insurance plan, must be a U.S citizen or a legal immigrant and has to be a resident of the state that offers the CHIP program he/she is applying for.<sup>8</sup> Undocumented immigrants cannot receive coverage from federal programs like Medicaid or CHIP.<sup>9</sup>

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<sup>1</sup> First Step. No Date. "Glossary S." *U.S. Department of Health and Human Services*.  
<http://www.cms.hhs.gov/apps/firststep/content/glossarys.html> (July 27, 2009)

<sup>2</sup> U.S. Department of Health and Human Services. No Date. "Fiscal Year 2010 Budget in Brief."  
<http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbriefn.html> (July 1, 2009)

<sup>3</sup> Doherty, Eileen. 2002. "The Balanced Budget Act." January 1.  
<http://www.senioranswers.org/Pages/cgs.medbba.htm> (July 1, 2009)

<sup>4</sup> GovTrack. 1997-1998. "H.R. 2015: Balanced Budget Act of 1997."  
<http://www.govtrack.us/congress/bill.xpd?bill=h105-2015> (June 29, 2009)

<sup>5</sup> America's Agenda Health Care for Kids. No Date. "What is SCHIP-History?" <http://www.americasagenda-kidshealth.org/history.html> (July 1, 2009)

<sup>6</sup> Center for Children and Families. 2008. "About CHIP." *Georgetown University Health Policy Institute*.  
<http://ccf.georgetown.edu/index/eligibility-schip> (June 8, 2009)

<sup>7</sup> Institute for Research on Poverty. No Date. "What Are Poverty Thresholds and Poverty Guidelines?" *University of Wisconsin-Madison*. <http://www.irp.wisc.edu/faqs/faq1.htm> (July 9, 2009)

<sup>8</sup> *Center for Children and Families, "About CHIP."*

<sup>9</sup> Ambergalkal, Sonal. 2009. "Facts About New State Option to Provide Health Coverage to Immigrant Children and Pregnant Women." *National Immigration Law Center*. April.  
<http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA-facts-2009-04-01.pdf> (July 1, 2009)

Community Scholars gained information through internet research in addition to personal, phone and E-Mail interviews. The information collected was then compiled into this report. The following section will discuss the characteristics of a nursing home.

## **2009 Reauthorization**

The 1997 statute of CHIP provided U.S. states and territories a formula for the division of federal allotments. The calculation primarily consisted of the uninsured children population of each state. All states were given a three-year period to spend the allotments and unutilized state allotments were redistributed to states that demonstrated lack of funds.<sup>10</sup> The past system of fund distribution conveyed funding issues, as various states experienced budget shortfalls. The insufficiency caused states to reduce CHIP benefits and constrict the number of both eligible applicants and patients that needed to reenroll.<sup>11</sup>

The Children Health Insurance Program Reauthorization Act (CHIPRA) was passed by the 111<sup>th</sup> U.S. Congress and signed into law by President Barack Obama (D) on February 4, 2009, to subsidize health costs for low-income families. The \$33 billion fund under CHIPRA amends the federal allotment formula, CHIP enrollment qualifications and also encourages states to enroll more children through bonus grants.<sup>12</sup> The act is then expected to cover 4.1 million more uninsured children.<sup>13</sup> An amendment of the federal excise on tobacco products will help in implementing CHIPRA provisions. Its effect on CHIP funding for the 2009-2013 period is discussed in the following section.

## **Tobacco Tax Revision**

On February 4, 2009, Congress increased the federal taxation on all tobacco products. The tobacco tax went in effect on the April 1, 2009.<sup>14</sup> The increases are as follows.

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<sup>10</sup> Sullivan, Jennifer. 2009. "More Funding for CHIP, Different Rules: How Does CHIPRA Change CHIP Funding?" *Families USA*. <http://www.familiesusa.org/assets/pdfs/chipra/funding.pdf> (June 10, 2009)

<sup>11</sup> Park, Edwin. 2009. "Freezing SCHIP Funding In Coming Years Would Reverse Recent Gains In Children's Health Coverage." *Center on Budget and Policy Priorities*. June 5. <http://www.cbpp.org/cms/?fa=view&id=453> (June 25, 2009)

<sup>12</sup> Sullivan, Jennifer. 2009. "CHIPRA 101: Overview of the CHIP Reauthorization Legislation." *Families USA*. March. <http://www.familiesusa.org/assets/pdfs/chipra/chipra-101-overview.pdf> (June 17, 2009)

<sup>13</sup> Kaiser Family Foundation. 2009. "Children's Health Insurance Reauthorization Program (CHIPRA)." February. <http://www.kff.org/medicaid/upload/7863.pdf> (June 08, 2009)

<sup>14</sup> Alcohol and Tobacco Tax and Trade Bureau. 2009. "Federal Excise Tax Increase and Related Provisions." [http://www.ttb.gov/main\\_pages/schip-summary.shtml](http://www.ttb.gov/main_pages/schip-summary.shtml) (July 15, 2009)

**Table C.1: Proposed CHIPRA Effect on Federal Excise of Tobacco Products**

Product	Previous Law	With CHIPRA	Increase
<b>Pack of 20</b>			
Small Cigarettes	\$0.39	\$1.00	\$0.61
Small Cigars	\$0.04	\$1.00	\$0.96
<b>Large Cigars</b>			
Of Price	20.72%	52.75%	32.03%
Cap Per Cigar	\$0.05	\$0.40	\$0.35
<b>Products Sold Per Pound</b>			
Chewing Tobacco	\$0.20	\$0.50	\$0.30
Snuff	\$0.59	\$1.50	\$0.91
Pipe Tobacco	\$1.10	\$2.83	\$1.73
Roll-Your-Own	\$1.10	\$24.62	\$23.52

Source: U.S. House of Representatives Committee on Ways and Means

The tax increase on small cigarettes was 156 percent. Large cigars were affected by an increased cap price of \$0.40 on each individual cigar. The roll-your-own tobacco tax revision was the second highest with an increase of \$23.52 per pound. The greatest percentage increase was the tax on small cigars, at nearly 2,500 percent.

Funding CHIP with a federal tax on tobacco has caused conflict among tobacco users and businesses. One argument is the perception that the tax is a discriminatory action towards tobacco users and suggests that the federal government should compose a tax that would be collective by taxing products that are commonly utilized by many citizens. The contrary argument by non-tobacco users describes the tobacco tax as assistance in deterring youth and adults from buying and using tobacco products.<sup>15</sup>

### **Increasing Enrollment**

By simplifying the CHIP enrollment process, states may reach a greater number of eligible children through outreach programs. Under CHIPRA, the federal government allocates \$100 million to Medicaid and CHIP from 2009 to 2013 to fund enrollment activities that aim to decrease the number of uninsured children.

Outreach and Enrollment Grants The U.S. Department of Health and Human Services (HHS) will grant \$90 million to state and local entities such as schools, church groups and health clinics. Groups wanting the grant must go through an application process which is approved by the secretary of HHS. CHIPRA does not provide limits on the time or number/value of awards recipients may obtain. Outreach and enrollment grants focus on geographic regions that have a high number of eligible but not enrolled children.

National Enrollment Campaigns Using the remaining \$10 million, the secretary of HHS creates national campaigns that are in accordance with federal law. Partnerships with the secretary of

<sup>15</sup> Henchman, Joseph and Gerald Prante. 2009. "Funding S-CHIP with Federal Cigarette Tax Increase is Poor Tax Policy." *The Tax Foundation*. January 15. <http://www.taxfoundation.org/news/show/24208.html> (July 15, 2009)

education and the secretary of agriculture, along with the financial support of both public health campaigns and enrollment hotlines are acceptable.<sup>16</sup>

Federal Allotments Under CHIPRA, state allotments increase each year and are projected to be 110 percent higher than the allotments of the previous year. The next year's funds consist of the previous year's allotment plus the estimated expenses to meet a state's budget shortfall if it does occur. The timeframe that states have to spend annual allotments has been reduced to two years. Past year terms for the redistribution of unspent allotments still applies.<sup>17</sup> Federal allotment formulas will be discussed further in the *Funding* section.

To increase enrollment rates, CHIPRA provides states with increased funding: the performance bonus and the child enrollment contingency fund, two incentives that will be discussed in the following sections.<sup>18</sup> Enrollment target numbers are set each year by the federal government and exceeding the target allows states to be eligible for a grant.<sup>19</sup> The adjusted state policies are predicted to ease the enrollment process for new recipients and to efficiently cover already eligible customers when their CHIP coverage expires.<sup>20</sup>

Performance Bonus To qualify for this bonus, states must meet five of the eight policies stated below.<sup>21</sup>

- **12-month continuous coverage:** Children are guaranteed full CHIP or Medicaid coverage for 12 months despite a change in the family's financial status. The policy incites more people into the programs and reduces the cost of eliminating people and reprocessing them when eligible.
- **No asset test, simplified asset verification:** States may either ban the asset test or simplify it to lessen paperwork. Low-income families who may not have many assets are relieved from the strenuous verification process.
- **No face to face interview:** Federal law does not stress personal interviews for new applicants or those that are renewing their coverage. Elimination of the interview is to once again lessen and ease the enrollment process while preventing families from missing a day of work/school to apply for CHIP.
- **Express Lane eligibility:** States are allowed to use an applicant's information under another program (Food stamps, Head Start, WIC, free school lunch) to facilitate time spent on obtaining his/her documents.
- **Offer premium assistance option:** Federal government provides states with options that allow them to subsidize CHIP costs in covering employers.

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<sup>16</sup> Center for Children and Families. 2009. "The Children's Health Insurance Program Reauthorization Act of 2009." *Georgetown University Health Policy Institute*. March. <http://ccf.georgetown.edu/index/cms-filesystem-action?file=ccf%20publications/federal%20schip%20policy/chip%20summary%2003-09.pdf> (June 8, 2009)

<sup>17</sup> Kaiser Family Foundation. 2009. "CHIP Financing Structure." June. <http://www.kff.org/medicaid/upload/7910.pdf> (June 10, 2009)

<sup>18</sup> Kaiser Family Foundation, "Children's Health Insurance Reauthorization Program (CHIPRA)."

<sup>19</sup> Sullivan, "More Funding for CHIP, Different Rules: How Does CHIPRA Change CHIP Funding?"

<sup>20</sup> Kaiser Family Foundation, "Children's Health Insurance Reauthorization Program (CHIPRA)."

<sup>21</sup> Kaiser Family Foundation. 2009. "Medicaid Performance Bonus 5 Out of 8 Requirements." April. <http://www.kff.org/medicaid/upload/7885.pdf> (June 6, 2009)

- **Administrative renewals:** Administrative renewal is the process of renewing an applicant's coverage. States are allowed to obtain a recipient's already available information from databases or program records to determine eligibility. Furthermore, states may also send a pre-printed form to families to verify if their household size, income or home address has changed.<sup>22</sup>
- **Joint application for CHIP and Medicaid:** Applicants may use one form to apply for CHIP and Medicaid enrollment, a factor that assists families who are unsure of their eligibility for either program.
- **Presumptive eligibility:** States may allow CHIP enrollment fairs to be held at schools or other public sites to reach a large group of citizens that are possibly eligible but are not aware of the application process. Such an opportunity also provides temporary and immediate care (health screenings, vaccinations, check ups) to any child and his/her family

Child Enrollment Contingency Fund The fund provides money to states that meet a budget shortfall. Eligibility for the money depends on whether a state exceeds an enrollment target level.<sup>23</sup> The 2009 target level for the contingency enrollment children fund is the state's 2008 monthly average enrollment of children in CHIP plus a state's child population percentage increase plus one percentage point, as shown below.

*2009 Target Level for Contingency Fund:*

(State's 2008 Monthly Average Enrollment of Children) + [(State's Child Population Percentage Increase) + 1%]

For every child that is above the baseline, states receive a federal portion of the per capita cost of serving that child. Funds that a state receives from the contingency process will be included in the federal allotment of the following year.<sup>24</sup>

### **States' Effort**

At least thirteen states (Alaska, Arkansas, Colorado, Indiana, Iowa, Kansas, Montana, Nebraska, North Dakota, Oklahoma, Oregon, Washington and West Virginia) have expanded their CHIP programs within five months since the enactment of CHIPRA. These states invested more money into CHIP to cover 250,000 more children.

The remaining states failed to implement CHIPRA, because of depleting funds or simply legislative failure. An example of financial difficulty would be the enrollment freeze Californian legislators placed on CHIP to cope with the state's budget shortfall.<sup>25</sup> In Texas, the CHIP

<sup>22</sup> Families USA. 2009. "Covering More Children, Rewarding Success: State Performance Bonus." <http://www.familiesusa.org/assets/pdfs/chipra/state-performance-bonuses.pdf> (June 10, 2009)

<sup>23</sup> Sullivan, "More Funding for CHIP, Different Rules: How Does CHIPRA Change CHIP Funding?"

<sup>24</sup> Kaiser Family Foundation, "CHIP Financing Structure."

<sup>25</sup> Sack, Kevin. 2009. "Defying Slum, 13 States Insure More Children." *The New York Times*. July 18. [http://www.nytimes.com/2009/07/19/us/19chip.html?\\_r=2&pagewanted=all](http://www.nytimes.com/2009/07/19/us/19chip.html?_r=2&pagewanted=all) (July 29, 2009)

changes were not adopted during the regular legislative session, and were not included in the agenda for the special legislative session called in July 2009 by Governor Rick Perry (R).<sup>26</sup>

States wanting to expand their programs must comply with CHIPRA and prioritize health care despite the current recession that has put a strain on state budgets.<sup>27</sup> By August 31, 2009 and 2011, states should have submitted their request for an adjustment to their federal allotments of the next fiscal year.<sup>28</sup> Texas and other states will lose further funding if they do not meet these deadlines, which will affect future enrollment increases.

## **CHIP Enrollment**

The number of children insured in CHIP in the program's first three years (1998 – 2000), was an estimated 3.4 million. In 2001, the number increased by over a million children, due to high funding and support from both the House and Senate. CHIP premiums were raised, due to declining tax revenue; some states even took steps towards restricting eligibility and benefits offered.<sup>29</sup> As a result, CHIP enrollment slowed dramatically. By the end of 2002, the program had not reached an estimated 2.8 million eligible children it was intended to.

### **Texas**

The state reached a peak in enrollment rates in May 2002 with 529,211 children. Texas could have enrolled an estimated 80,000 children, if the state reauthorized CHIP. The graph below shows Texas' enrollment since 1998.

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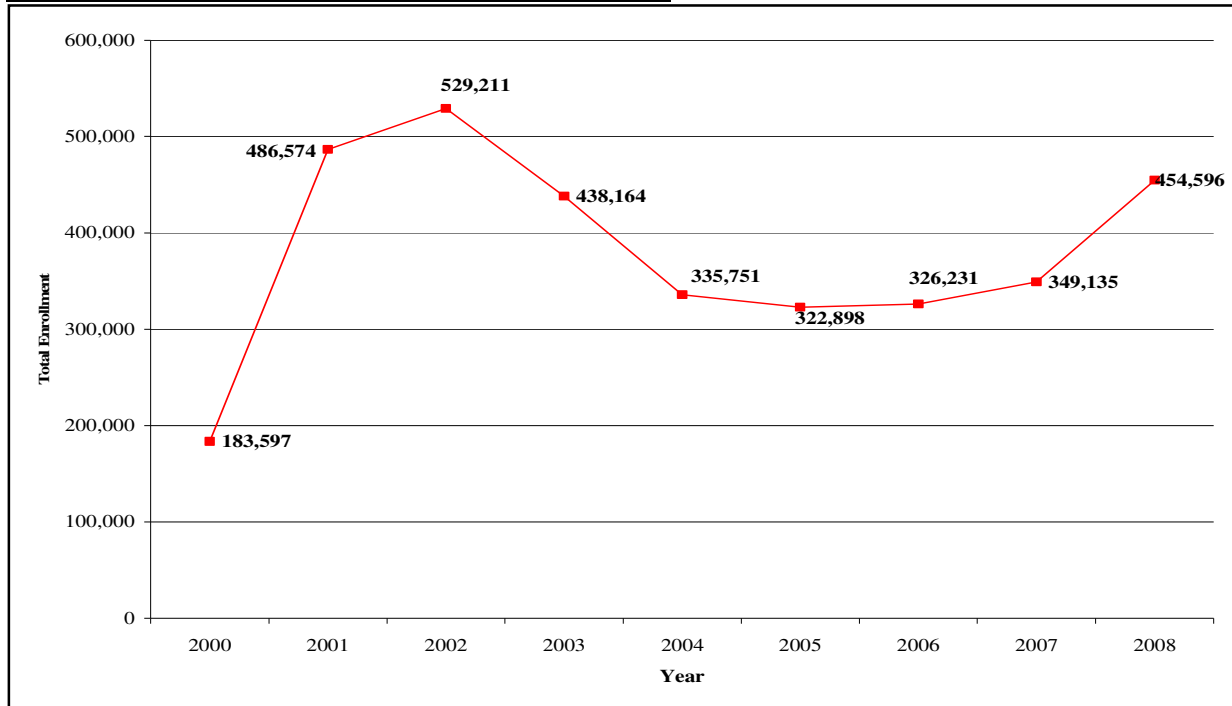
<sup>26</sup> Lee, Bryan. 2009. "Perry Ignores CHIP Plea." *The Daily Texan*. July 7. <http://www.dailytexanonline.com/state-local/perry-ignores-chip-plea-1.1772262> (July 29, 2009)

<sup>27</sup> Sack, "Defying Slum, 13 States Insure More Children."

<sup>28</sup> Center for Children and Families. No Date. "Implementation Dates of Key CHIPRA Provisions." *Georgetown University Health Policy Institute*. <http://ccf.georgetown.edu/index/cms-filessystemaction?file=policy/2009%20schip%20reauth/chip%20imp%20dates.pdf> (June 10, 2009)

<sup>29</sup> Maternal & Child Health Research Center. 2004. "SCHIP Programs More Likely to Increase Children's Cost Sharing than Reduce Their Eligibility or Benefits to Control Costs". [http://www.mchpolicy.org/documents/SCHIPFactSheetUpdate\\_000.pdf](http://www.mchpolicy.org/documents/SCHIPFactSheetUpdate_000.pdf) (June 17, 2009)

**Graph C.1: Texas CHIP Enrollment (2000-2008)**



Source: Texas Health and Human Services Commission

In 2003 Texas experienced a \$10 billion budget shortfall, forcing the state to make major budget cuts that affected CHIP enrollment drastically.<sup>30</sup> From 2003 to 2004, enrollment dropped by over 100,000 enrollees. Since then Texas has not seen drastic increases as before but Texas officials are trying to pass legislature to improve these rates.

With a national \$69.9 billion increase for CHIP funds in the next four years, Texas was estimated to receive \$4.87 billion in new federal funding for CHIP.<sup>31</sup> This money was estimated to enroll over four million children in CHIP, half of the estimated 8 million uninsured children nationwide. The funding also allows states to eliminate state enrollment roadblocks that have either discouraged or denied families coverage.<sup>32</sup>

## Border Counties

Border counties in Texas are known for having low enrollment rates in CHIP, because of utilization rates of the county. The utilization rates are factors that determine how much money each county receives from the state.<sup>33</sup> There is thought to be a discrepancy according to health-care professionals and some politicians, between big city counties and border counties. This is due to the amount of revenue in the healthcare industry the two receive. Despite the fact that

<sup>30</sup> Herrick, Devon M., and Chris Patterson. 2003. "Securing the Safety Net for Texas Children." *Texas Public Policy Foundation*. May 12. [http://www.texaspolicy.com/publications.php?report\\_year=2003](http://www.texaspolicy.com/publications.php?report_year=2003) (July 20, 2009)

<sup>31</sup> Families USA. No Date. "SCHIP Reauthorization: What's at Stake for Texas." <http://www.familiesusa.org/assets/pdfs/texas-schip.pdf> (June 10, 2009)

<sup>32</sup> *Center for Children and Families, "The Children's Health Insurance Program Reauthorization Act of 2009."*

<sup>33</sup> Law, Jon. Program Officer. *Paso del Norte Health Foundation*. Personal Interview. June 17, 2009

border counties are believed to be the main factors in what provides Texas with such a high matching rate from the federal government.<sup>34</sup>

Cameron, Webb, Val Verde and Presidio counties are all border counties, as noted by the B in the table below, and suffer from low reimbursement and utilization rates as El Paso. All five counties are thought to be medically underserved. Dallas, Tarrant, Travis, Harris and Bexar are counties in Texas that contain the big cities. Below is a comparison of border counties and the bigger dominant counties in Texas.

**Table C.2: Texas County Enrollment Post CHIPRA (2009)**

County	February	April	June	Increase
El Paso (B)	20,141	20,983	21,681	6.6%
Cameron (B)	11,324	11,701	11,845	3.9%
Webb (B)	6,748	6,932	7,160	5.7%
Val Verde (B)	941	930	970	4.5%
Presidio (B)	138	161	167	12.0%
Dallas	67,717	70,017	72,135	6.2%
Tarrant	44,414	46,150	47,689	7.1%
Travis	22,763	24,033	24,854	9.1%
Harris	123,790	129,357	134,901	8.1%
Bexar	38,386	39,815	41,103	6.4%

Source: Texas Health and Human Services Commission

Texas border communities are seeing an extremely small increase in CHIP enrollment for 2009, compared to the enrollment of Texas's larger counties. Presidio County has only seen a 29 enrollee increase from February to June of 2009, though it had a 12 percent increase which is due to the small amount of enrollees. Big city counties have percent increases similar to the border counties, but the enrollment numbers are much larger in the big city counties than those of border communities.

### Role of the Federal Poverty Line

There are two slightly different versions of the federal poverty measures: poverty thresholds and poverty guidelines. Thresholds are the original measurement for the poverty level, and are used specifically for statistical purposes. Poverty guidelines are used for administrative purposes for instances of determining financial eligibility for certain federally funded programs. The poverty thresholds change annually due to increases in population and unemployment rates.<sup>35</sup> The FPL does not take into account the different cost of living factors across the nation,

<sup>34</sup> Gutierrez, Carlos. Pediatrician. *Private Practice*. Personal Interview. July 2, 2009

<sup>35</sup> U.S. Census Bureau. 2004. "Difference; poverty Guidelines vs. Poverty Thresholds." [https://ask.census.gov/cgi-bin/askcensus.cfg/php/enduser/std\\_adp.php?p\\_faqid=94&p\\_created=1074807307&p\\_sid=EeKCi8Ej&p\\_accessibility=&p\\_lva=&p\\_sp=cF9zcmNoPSZwX3NvcnRfYnk9JnBfZ3JpZHNvcnQ9JnBfcm93X2NudD0mcF9wcm9kcz0mcF9jYXRzPSZwX3B2PSZwX2N2PSZwX3BhZ2U9MQ\\*\\*&p\\_li=&p\\_topview=1](https://ask.census.gov/cgi-bin/askcensus.cfg/php/enduser/std_adp.php?p_faqid=94&p_created=1074807307&p_sid=EeKCi8Ej&p_accessibility=&p_lva=&p_sp=cF9zcmNoPSZwX3NvcnRfYnk9JnBfZ3JpZHNvcnQ9JnBfcm93X2NudD0mcF9wcm9kcz0mcF9jYXRzPSZwX3B2PSZwX2N2PSZwX3BhZ2U9MQ**&p_li=&p_topview=1) (July 30, 2009)

nor does it take into account living or transportation expenses or that of child care costs, which have been drastically increasing.<sup>36</sup> The following table displays the 2009 FPL guidelines.

**Table C.3: 2009 Federal Poverty Guidelines**

Household Size	Poverty Guideline
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010
9 +	\$3,740/ person

Source: U.S. Department of Health and Human Services

The FPL does not directly determine a family's eligibility for CHIP coverage. Families eligible for CHIP are above the FPL, and depending on the state, may be up to 400 percent above the FPL. These rates vary from state to state and are outlined in the table below.

**Table C.4: Income Eligibility Percentage**

State	Percent Above FPL
California	250%
Connecticut	300%
Idaho	185%
Nevada	200%
New York	400%
New Jersey	350%
North Dakota	150%
Oregon	185%
Pennsylvania	300%
Texas	200%
Virginia	200%
Washington	300%

Source: Foundation for Health Coverage Education

The highest income eligibility for government-assisted health coverage is 400 percent in New York and New Hampshire. In New York, 16 percent of families enrolled in CHIP are above 200 percent of the FPL.<sup>37</sup> Currently, Texas has a limit of 200 percent (the federal guideline before CHIPRA) above the FPL, but Texas legislators have been trying to increase it to 300 percent.<sup>38</sup>

<sup>36</sup> Microfinance California. 2009. "Definitions." <http://www.microfinancecalifornia.org/conference-info/definitions.php> (June 24, 2009)

<sup>37</sup> Foundation for Health Coverage Education. 2008. "State Children's Health Insurance Program (CHIP) Income Eligibility." <http://www.coverageforall.org/pdf/SCHIPMap.pdf> (June 22, 2009)

<sup>38</sup> Houston Chronicle Staff. 2009. "CHIP Allies Demand Action from Perry." *Houston Chronicle*. June 24. [http://blogs.chron.com/texaspolitics/archives/2009/06/chip\\_allies\\_dem.html](http://blogs.chron.com/texaspolitics/archives/2009/06/chip_allies_dem.html) (July 22, 2009)

Using data from both tables, it can be estimated that a family of four persons living in Texas can have an annual household income of \$44,100 and qualify for CHIP. However, if that same family lived in the State of New York, their income could be as high as \$88,200 and they would still qualify for CHIP. Again, these are estimates that ultimately may be adjusted by local providers, which are discussed in the following section.

### Cost to Families

CHIP is not a free program, a co-payment is generally required. There are a small percentage of CHIP enrollees whose net income allows them to receive free CHIP coverage. With CHIP, the government has found a way to provide inexpensive healthcare that is comparable to the coverage of private insurers.

The divisions between families applying for CHIP occur due to differences in net income and number of household members (and their ages).<sup>39</sup> For example, a family with four children making only \$35,000 a year is in need of financial assistance more than a family making \$35,000 a year with only one child. The family with four children is making less money per family member. Although there are the federal poverty guidelines, the income eligibility for health care providers may vary between states and even counties. The table below shows El Paso First's income eligibility rates. Community Scholars chose to display the rates for El Paso First due to its leading enrollment figures for El Paso County.

**Table C.5: El Paso First's Eligibility Income Rates**

Household Size	Monthly	Annually
1	\$1,702	\$20,420
2	\$2,282	\$27,380
3	\$2,862	\$34,340
4	\$3,442	\$41,300
5	\$4,022	\$48,260
6	\$4,602	\$55,220
7	\$5,182	\$62,180

Source: El Paso First Health Plans, Inc.

The table explains that if a family makes below \$20,420 and has one child, their child will qualify for CHIP by El Paso First standards. These guidelines are due to change with other companies. Meaning throughout Texas, other health providers will have eligibility guidelines that may differ.

### Reenrollment

Reenrollment rates in CHIP have been steadily decreasing for the past years. Obstacles that CHIP applicants face could be:

- Families' lack of knowledge or perception of Medicaid and CHIP
- Administrative barriers to families completing the application process

<sup>39</sup> *Center for Children and Families, "About CHIP."*

- State challenges maintaining continuous enrollment for children
- Language and cultural barriers
- State response to budget pressures
- Uncertain federal funding and restrictions <sup>40</sup>

Reenrollment rates in border communities are much lower than those of big cities; this is due to the problems associated with border communities such as lack of permanent residence, no documentation, language barriers and a low-income population. According to Frank Dominguez, Director of Provider Relations and Contracting from El Paso First Health Plans, Inc., the problem with getting people to reenroll is that a lot of the enrollees change their address or move.<sup>41</sup> People may forget to notify health providers of the address change. This causes difficulty in the information reaching the right people.

Because of the problems associated with border communities, actual renewal rates and attempted renewal rates have decreased rapidly. The two tables below display a comparison of 2006 rates to current rates. The same border counties that were utilized in the previous tables are compared.

**Table C.6: Renewal Rates for Texas Border Cities (May 2006)**

County	Actual	Attempted
El Paso	62.70%	70.60%
Cameron	61.80%	71.50%
Webb	55.00%	66.60%
Val Verde	43.20%	52.80%
Presidio	75.00%	80.00%

Source: Texas Health and Human Services Commission

**Table C.7: Renewal Rates for Texas Border Cities (May 2009)**

County	Actual	Attempted
El Paso	52.20%	61.00%
Cameron	42.80%	51.00%
Webb	43.60%	53.50%
Val Verde	50.00%	52.60%
Presidio	50.00%	50.00%

Source: Texas Health and Human Services Commission

Generally speaking, 2009 renewal rates, both actual and attempted, are lower than in 2006. The only county to see an increase in actual renewal rates was Val Verde. Otherwise, El Paso County had both the highest attempted renewal rate at 61 percent and the highest actual renewal rate at 52.2 percent. The difference between the actual and attempted renewal rates decreased. The majority of the counties' renewal rates no longer fall above 50 percent

<sup>40</sup> Maximizing Enrollment for Kids. 2009. "Enrollment." <http://www.maxenroll.org/topic-areas/enrollment> (June 12, 2009)

<sup>41</sup> Dominguez, Frank. Director of Provider Relations and Contracting. *El Paso Health Plans, Inc.* Personal Interview. June 20, 2009

In El Paso, El Centro de Salud Familiar La Fe has had a big impact on the CHIP enrollment application. La Fe was involved in the development of the Spanish/English application. They ensured it was no longer than two pages and made the translation easier to understand. Another demand La Fe had was the elimination of face-to-face interviews, so the applicant does not feel any pressure or discomfort while applying.<sup>42</sup>

The health-care providers in El Paso have been working to remind people how important reenrollment is. El Paso First, a locally owned non-profit managed care organization (MCO), sends out reenrollment reminder postcards to their members two months before their membership expires. Health-care providers in El Paso County also use advertising as a way to attract attention. El Paso First seeks to ultimately develop name recognition in the community.<sup>43</sup> Keeping enrollment rates high for El Paso is important, because that is one of the main factors when determining funding.

## **Funding CHIP**

CHIP's funding is transferred from the federal government to the states' Health and Human Services Commissions, and then to local health providers. The money goes to health management organizations (HMOs) in their respective counties. The money is in the form of reimbursement and capitation rates (calculated on a per member per month basis). An HMO provides healthcare for an area in the form of hospitals, doctors and other providers that are under a contract with the HMO.

### **The Block Grant Program**

A block grant is money given to state and county governments by the federal government, with the provision that states spend it to meet federal goals. In this method of funding, the federal government has difficulty in tracking state expenditures and fund dispersion among counties, because the only strict mandate imposed on the state is the timetable for when the money needs to be spent.<sup>44</sup> Being a block grant program, CHIP differs from Medicaid when it comes to point of allotments. CHIP has a cap on the maximum amount of allotments the federal government can grant to states. The allotment level for all states must be adjusted yearly to account for health care inflation and child population of the states to provide an accurate distribution of funds.<sup>45</sup>

### **Funding Formulas and Contract Negotiations**

The Enhanced Federal Medical Assistance Percentage Formula (EFMAP) is used to determine CHIP matching rates for all 50 states, the District of Columbia and U.S. territories. This formula is designed so that states with the lower per capita income levels receive a higher federal reimbursement. The formula is as follows:

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<sup>42</sup> Salazar, Jorge. Administrator of Community Health Services. *Centro de Salud Familiar La Fe*. Personal Interview. June 23, 2009

<sup>43</sup> *Dominguez, Personal Interview*

<sup>44</sup> World Web Online. 2008. "Block Grant." <http://www.wordwebonline.com/en/BLOCKGRANT> (June 15, 2009)

<sup>45</sup> Peterson, Chris L. 2006. "SCHIP Original Allotments: Description and Analysis." *America's Health Insurance Plans*. October 31. <http://www.ahipresearch.org/PDFs/RL33366.pdf> (June 23, 2009)

*Enhanced Federal Medical Assistance Percentage Formula (EFMAP):*

$$1.00-[0.45(\text{State per capita income}/\text{National per capita income})^2] = \text{State matching rate}^{46}$$

This reimbursement is based on matching rates: for every dollar of its own money a state invests in CHIP, it receives a proportionate amount of federal money (see the formula above this paragraph).<sup>47</sup> The basis of why under-funded counties, like El Paso County, are under-funded lies not within the EFMAP formula, but within the method used by the states' health and human services commissions to determine where the money goes within the state.

The rates are determined through utilization, the reputation of a health plan, adjustments that were made to the provider reimbursement costs, adjustments made to investment income, adjustments made based on the "at risk" factor (this is covered more in detail in the *Expenditures* section) and the costs to pay the salaries of the staff and utility bills. Smaller, less affluent counties will receive much less, and will have a hard time strengthening their CHIP programs because of the lack of funding.

Jon Law, Program Officer of the Paso Del Norte Health Foundation, stated in an interview, "Although Medicaid is allocated to states based on the number of families below the federal poverty level, El Paso County's Medicaid reimbursement does not reflect the proportion of Medicaid-eligible families in the county; this disparity is due to 'utilization' formulas that penalize communities with less medical infrastructure."<sup>48</sup> Medicaid and CHIP funding structures are derived from the same principles. It is counties like El Paso (the smaller, lower-income counties) that lower Texas' state per capita to the level that gains the state the high matching rate.<sup>49</sup>

### **CHIPRA Reforms**

Before they reached their current funding levels, Texas and at least 17 other states were facing CHIP funding shortfalls.<sup>50</sup> The following table displays the vast differences in available funds for states that are geographically close to each other. Aside from Illinois and New York, which were included to show that physical size of a state does not determine how much funding it receives, California, Arizona, New Mexico and Texas are all in the same geographical area.

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<sup>46</sup> Community Scholars. 2004. *Texas CHIP and Medicaid Cuts: Is Texas in Need of a Band-Aid?* El Paso, Texas: Community Scholars

<sup>47</sup> Kaiser Family Foundation, "CHIP Financing Structure."

<sup>48</sup> Law, Jon. Program Officer. *Paso del Norte Health Foundation*. CHIP Presentation. May 15, 2009

<sup>49</sup> Gutierrez, *Personal Interview*

<sup>50</sup> Sullivan, Jennifer and Klein, Rachel. 2008. "Left Behind: Texas's Uninsured Children." *Families USA*. October. <http://www.familiesusa.org/assets/pdfs/uninsured-kids-2008/texas.pdf>. (June 26, 2009)

**Table C.8: CHIPRA Funding Changes FY2009 (In Millions)**

State	CHIP	CHIPRA
Texas	\$549.6	\$867.3
New Mexico	\$52.0	\$280.7
Arizona	\$149.1	\$171.1
California	\$799.2	\$1,552.9
New York	\$318.0	\$433.5
Illinois	\$198.7	\$344.6

Source: Georgetown University Health Policy Institute

On average, state allotments under CHIPRA will be 88 percent higher than before. All states receive greater allotments under CHIPRA, but some were increased by higher percentages than others. Texas' allotment would have been raised by a much lower percentage (58 percent) than its neighboring state of New Mexico (440 percent). However, since Texas did not reauthorize CHIP guidelines to 300 percent above the FPL, it will lose out on approximately \$400 million.

More Sources of Revenue Another change made under CHIPRA is an alternative source of revenue for CHIP. The new "buy-in" program means that higher income participants finance their own health insurance plans through a partial government subsidy.<sup>51</sup> It is also estimated that by increasing the tobacco tax (another revenue source for CHIP), available federal funding for CHIP will increase by \$32.8 billion over the 2009-2013 period.<sup>52</sup>

Allotment Distribution Changes Funds are annually allotted to states for CHIP. Before CHIPRA was passed, a state's CHIP allotment of funds would be determined by taking 70 percent of the state's FMAP rate for Medicaid, and then adding 30 percentage points.<sup>53</sup> They will now be distributed according to how much each state spends on CHIP in the previous fiscal year. For example, the FY2010 allotment for a state is based on that state's allotment in FY2009 (and that sum is adjusted for inflation and child population growth). The FY2011 allotment for a state is based on that state's spending in FY2010 (and that sum is also adjusted for inflation and child population growth).<sup>54</sup> This is to ensure that states failing to spend their allotted funds are not keeping that unused money from states that are spending their allotments successfully but may require more. Finally, states interested in expanding their CHIP program that calculate a need for even more funding can request that additional funding from the federal government.<sup>55</sup>

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<sup>51</sup> Development Disabilities Council. 2009. "H.B. No. 139 CHIP 'Buy-in' Option." *State of Delaware*. May 15. <http://ddc.delaware.gov/pdf/2009/hb139.pdf> (July 20, 2009)

<sup>52</sup> Dunbar, Sean, Grant Driessen, Kirsten Nelson, Robert Stewart, & Ellen Werble. 2009. "H.R. 2: Children's Health Insurance Program Reauthorization Act of 2009." *Congressional Budget Office*. 2009. <http://www.cbo.gov/ftpdocs/99xx/doc9985/hr2paygo.pdf> (July 2, 2009)

<sup>53</sup> National Conference of State Legislatures. 2007. "SCHIP FAQ: How is SCHIP Funded?" May. <http://www.ncsl.org/IssuesResearch/Health/SCHIPFAQ/tabid/14045/Default.aspx> (July 21, 2009)

<sup>54</sup> Eckstein, Kathy. Director of Public Policy. *Children's Hospital Association of Texas*. E-Mail Interview. June 30, 2009

<sup>55</sup> Sullivan, "CHIPRA 101: Overview of the CHIP Reauthorization Legislation."

## Expenditures

As enrollment numbers increase, so do expenditures. The more people a program serves, the more funds it needs to keep the program up to date and effectively running. If CHIP funding remains frozen at the current levels, it is estimated that that states will face a federal funding shortfall of \$13.4 billion over the next five years (FY 2008-2012). By 2012, it is estimated that 35 states would have inadequate federal CHIP funding to sustain their current programs.<sup>56</sup>

### Current Spending

The federal CHIP expenditures include data from the United States (50 states and the District of Columbia), Guam, Puerto Rico, the Virgin Islands, America Samoa and N. Marianas. The United States calculates expenditures over fiscal year time periods. Federal CHIP expenditures have sporadically grown over the past years. However, the same trend is not seen on the state level. Texas CHIP expenditures have fluctuated. In 2003, due to significant budgetary pressures, Texas was forced to scale back its CHIP program. This budgetary shortfall led to cuts in services and a decrease in enrollees. After the economic slump was over, Texas's legislation restored the program's benefits in late FY 2005.<sup>57</sup>

Table X below shows the top ten states ranked by total CHIP expenses for FY 2008. Because CHIP is a jointly funded program that receives revenue from both the federal and state governments, state and federal breakdown is illustrated below. The table shows how much the states rely on federal aid to fund their CHIP program. While Texas spent \$964 million on CHIP in total, the state spent \$266 million out of its own dollars and \$697 million of the federal government's.

**Table C.9: Top 10 CHIP Expenditures by Shares FY 2008 (In Millions)**

State	State Share	Federal Share	Total Expenditure
California	\$707.2	\$1,259.3	\$1,966.5
Texas	\$266.2	\$698.0	\$964.2
New York	\$176.0	\$326.9	\$502.9
New Jersey	\$173.9	\$323.1	\$497.0
Illinois	\$158.3	\$292.9	\$451.2
Massachusetts	\$141.5	\$259.3	\$400.8
Florida	\$117.7	\$272.3	\$390.0
North Carolina	\$89.8	\$237.7	\$327.5
Ohio	\$86.1	\$227.5	\$313.6
Georgia	\$78.0	\$225.0	\$303.0

Source: Henry J. Kaiser Family Foundation

<sup>56</sup> Broaddus, Matt & Edwin Park. 2007. "Senate Republican Leadership to Seek Reconsideration of SCHIP Plan That Would Fail to Make Progress in Covering Uninsured Children." *Center on Budget and Policy Priorities*. October 10. [https://www.cbpp.org/cms/index.cfm?fa=view&id=1261#\\_ftnref5](https://www.cbpp.org/cms/index.cfm?fa=view&id=1261#_ftnref5) (June 22, 2009)

<sup>57</sup> Southern Governors Association. 2007. "S-CHIP Fact Sheet: Texas' S-CHIP Program." <http://www.southerngovernors.org/Portals/0/pdffdocuments/TexasCHIPFactSheetFINAL.pdf> (June 29, 2009)

CHIP spending has experienced a sporadic growth in the past years. Current estimates project total CHIP expenditures will grow an approximated \$1.3 billion in FY 2009. That's more than double the amount spent in 2007, due to increased caseloads coming directly from the Texas House Bill 109. The bill mandated the insuring of 102,224 qualified children per month in Texas by the end of FY 2009, extending the period of eligibility to twelve months and eliminating a 90-day waiting period.<sup>58</sup> The implementation of CHIP prenatal programs is also expected to contribute to this.<sup>59</sup>

In FY 2008, El Paso County had an average monthly enrollment of 25,011 people, a health plan premium expense of \$22.1 million and a dental plan premium of \$1.9 million. Taken all these figures into consideration, the total CHIP expenditures add up to \$27.9 million.

The State of Texas utilizes CHIP percent matching rates using the FMAP formula that was previously discussed. Texas is not allowed to use federal funds, provider taxes or recipient's cost-sharing to make up its state share. The states are also not allowed to use CHIP funds to finance the state match for Medicaid. To receive these federal matching rates, Texas has to keep Medicaid eligibility levels at the minimum in place since June 1, 1997, and the same level of spending it had in 1996. These conditions are in place in order to ensure that the CHIP funds will cover the targeted population and so that the states do not transfer additional children to the program just to reap the higher federal matching rates.<sup>60</sup> Table C.10 below displays the matching rates for the past years and with projected years.

**Table C.10: CHIP Percent Matching Rate (FMAP)**

<b>Fiscal Year</b>	<b>Texas Percent</b>	<b>Federal Percent</b>
2003	28.01	71.99
2004	27.85	72.15
2005	27.39	72.61
2006	27.54	72.46
2007	27.45	72.55
2008	27.63	72.37
2009	28.39	71.61
2010	28.89	71.11

Source: Henry J. Kaiser Family Foundation

Table C.10 also shows that the lower the matching rate, the more the state of Texas spends out of its own budget to maintain its own program. A low matching rate results in the state having to provide more money out of the state budget, and less assistance from the federal government. In order to receive more federal aid, the state must invest more in its CHIP program. In the table above, the Texas percentage has fluctuated slightly. There is no existent pattern to this trend, except for the relation between the Texas percent and the federal percent, which decreases as the Texas percent increases. The only direct information Community Scholars can conclude, is that

<sup>58</sup> Texas House of Representatives. 2007. "House Overwhelmingly Passes HB 109 with 126 Votes." <http://www.house.state.tx.us/news/release.php?id=1942n> (June 15, 2009)

<sup>59</sup> Texas Health and Human Services Commission. 2007. "Chapter 7 Children's Health Insurance Program." <http://www.hhsc.state.tx.us/medicaid/reports/PB7/BookFiles/Chapter%207.pdf> (June 29, 2009)

<sup>60</sup> Task Force on Access to Health Care in Texas. 2008. "Code Red: The Critical Condition of Health in Texas-The Report." [http://www.coderedtx.org/files/Report\\_Chapter04.pdf](http://www.coderedtx.org/files/Report_Chapter04.pdf) (July 2, 2009)

the percent matching rates are not necessarily increasing or decreasing, but otherwise merely fluctuating. Also, the projected fiscal years show a higher Texas percentage than past years, but then again, this is projected data.

## Capitation Rates

Capitation rates can be considered an important factor to physicians; it affects their choice to operate in counties like El Paso. A low capitation rate does not cover the amount necessary to provide healthcare to patients, resulting in the physician losing money. If the capitation rate is not sufficient or adequate, the doctor assumes a financial risk. The following section will explain what a capitation is, an example of how it works and what its impact is on City of El Paso.

A capitation rate in relation to medical care is the system of payment for each customer served, rather than by service performed.<sup>61</sup> In simpler terms, a physician gets a pre-paid dollar figure for a given time period to provide for the healthcare needs of a set number of patients. The nature of a capitation rate transfers the financial risk from the health payer to the physician. The capitation risk is the risk that the capitation rate payment is less than the “cost” of providing service that can result in a net loss for a health provider.<sup>62</sup> This can best be understood through the following hypothetical scenario:

- This physician is an HMO provider and is paid a capitation rate of \$7.00 per member
- 250 people selected this physician to be their primary care physician (PCP)
- This physician gets paid \$7.00 for each of the 250 members (\$1,750/month)
- This physician is responsible for providing medical care to any of these 250 people with the capitation given.
- If the expenses are more than \$1,750, the physician must cover the difference out of his/her own pocket.<sup>63</sup>

A managed care organization (MCO) is an entity that provides or manages the coverage of specific health services for a fixed premium rate. MCOs are placed in an “at-risk” status for each capitation rate period, usually a fiscal year. “At-risk” status refers to the risk that unit costs, and/or utilization are substantially higher than average for that MCO.<sup>64</sup> The HHSC places the MCO at risk for 1% of the CHIP Capitation rate(s). HHSC has the option to vary the percentage of the capitation rate placed “at-risk” over a rate period. The HHSC then pays the MCO monthly

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<sup>61</sup> Policy Brief. 2008. " Executive Summary: Medicaid Payments for Interpreters." *Connecticut Health Foundation*. <http://www.cthealth.org/matriarch/documents/pb-medicaid-interpreters-executive-summary%283%29.pdf> (June 25, 2009)

<sup>62</sup> J.F. Walbridge FSA. 2001. "Capitation and Radiology: Ground Rules for Negotiating A Contract." *Internet Journal of Healthcare Administration*. [http://www.ispub.com/journal/the\\_internet\\_journal\\_of\\_healthcare\\_administration/volume\\_1\\_number\\_2\\_25/article/capitation\\_and\\_radiology\\_ground\\_rules\\_for\\_negotiating\\_a\\_contract.html](http://www.ispub.com/journal/the_internet_journal_of_healthcare_administration/volume_1_number_2_25/article/capitation_and_radiology_ground_rules_for_negotiating_a_contract.html) (June 22, 2009)

<sup>63</sup> Health Symphony. 2000. "Capitation Definition." <http://www.healthsymphony.com/capitation.htm> (June 22, 2009)

<sup>64</sup> California Department of Health Services. 2006. "Capitation Rate Development Process and Reimbursement Structure Review." [http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD\\_Fin\\_Rpts/RateMethodologyReport\\_FIN\\_AL.PDF](http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/RateMethodologyReport_FIN_AL.PDF) (June 22, 2009)

CHIP capitation payments based on the number of eligible and enrolled members. HHSC also calculates the monthly CHIP capitation payments by multiplying the number of member months times the applicable monthly capitation rate by the member rate cell.<sup>65</sup> The risk is highly associated with what a physician gets each month. If the region in which the physician is operating has a high “at-risk” factor, that region’s medical infrastructure is in worse shape than a region with a lower “at-risk” factor. The higher the “at-risk” factor is, the lower the capitation rate payment becomes.

The actual Texas capitation rate is \$25 per member per month (pmpm). This capitation is intended to provide for cost sharing obligations for dual eligible members in the state. This specific capitation rate was established based on an analysis of the following:

- The actual managed care experience for a large sample of dual eligible members
- Information in regards to current market cost-sharing arrangements for comparable health plans
- Information from other states regarding how they reimburse health plans for member cost-sharing
- Input from health plans that currently operate in the state of Texas<sup>66</sup>

Counties like El Paso, with disproportionately low CHIP expenditures per capita, find themselves aiming for higher capitation rates. In order to accomplish this, they must spend more money. However, if the capitation rate fails to provide enough revenue to serve the patients, physicians are losing money instead of spending it. The disproportionately low per capita expenditures, along with low managed rates and fee schedules have forced healthcare providers in lower-income regions to limit or terminate CHIP services.<sup>67</sup>

## Reimbursement Rates

A low reimbursement rate also presents the physicians with another monetary issue. Reimbursement rates are an important part of the health network. CHIP reimbursement rates are the rates that control the compensation a physician receives when he/she performs a medical service. The physician is reimbursed after filing a claim with the Health and Human Services Commission.<sup>68</sup> Once a claim is received, the HMOs are required, within the 30-day claim payment period, to pay the total amount of the claim, or part of the claim, in accordance with the contract. The HMOs are also required to notify the provider why a claim will not be paid should the claim be denied.<sup>69</sup> These rates are negotiated between state agencies and local health providers.

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<sup>65</sup> Texas Health and Human Services Commission. 2007. "Section 6: Premium Payment, Incentives & Disincentives." <http://www.hhsc.state.tx.us/contract/529080001/original/RFP/Section6.doc> (June 15, 2009)

<sup>66</sup> Centers for Medical & Medicaid Services. 2009. "Divisions of Medicaid & Children's Health, Region VI." [http://www.hhsc.state.tx.us/medicaid/StatePlanDocs/Amendments/08\\_001.pdf](http://www.hhsc.state.tx.us/medicaid/StatePlanDocs/Amendments/08_001.pdf) (June 25, 2009)

<sup>67</sup> Texas Senate Committee on Health and Human Services. 2009. "Health Care Professional Shortages." *Senator Eliot Shapleigh*. [http://shapleigh.org/system/reporting\\_document/file/322/Crisis\\_in\\_HC.pdf](http://shapleigh.org/system/reporting_document/file/322/Crisis_in_HC.pdf) (June 22, 2009)

<sup>68</sup> Ethical Health Partnerships. 2005. "Reimbursement, Physician Fees- What it all Means." <http://www.ethicalhealthpartnerships.org/reimbursement.html> (July 21, 2009)

<sup>69</sup> *Dominguez, Personal Interview*

The state HHSC negotiate contacts with local HMOS to reimburse the organization on a per-member-per-month (pmpm) basis.<sup>70</sup> The factors that these rates are based on are as follows:

- Utilization
- Historical experience of a plan
- Provider reimbursement adjustments
- Investment income adjustments
- Risk adjustments
- Administrative costs<sup>71</sup>

Based on this list, it can be seen that areas with the most hospitals, doctors, medical specialists and advanced facilities will receive the highest reimbursement rates. This is arguably a serious issue regarding equity of funding. At this time, less than half of Texas health care providers accept Medicaid and CHIP-enrolled children as patients due to low reimbursement rates.<sup>72</sup> The following table displays reimbursements rates for various counties across the State of Texas.

**Table C.11: Texas Counties Reimbursement Rates**

County (Major City)	Rate
El Paso (El Paso)	\$63.82
Lubbock (Lubbock)	\$69.91
Harris (Houston)	\$92.04
Travis (Austin)	\$94.81
Tarrant (Ft. Worth)	\$95.40

Source: Texas Health and Human Services Commission

El Paso County has a child population of 218,031. Travis County has a child population of 211,994, very close in size to El Paso.<sup>73</sup> Despite the similar child populations, their reimbursement rates are \$30.99 apart.

In an interview with Texas State Representative Joseph Moody (D-El Paso), he stated that varying reimbursements rates based on region are unfair. He added that should rates increase in El Paso, the area would attract more physicians as well as retain the ones that are already here. This alone would benefit the community greatly.<sup>74</sup> The current funding system was created at the same time the Texas CHIP program was, and the concept has not been altered since. Despite the problems presented with this system, the County of El Paso has taken proactive steps to increase its utilization rates through the new Paul L. Foster School of Medicine as well as the El Paso Children’s Hospital.<sup>75</sup> The coming years should undoubtedly see an increase in funding from the state due to higher utilization.

<sup>70</sup> Eckstein, E-Mail Interview

<sup>71</sup> Palmer, David. Chief Actuary. *Texas Health and Human Services Commission*. Phone Interview. June 26, 2009

<sup>72</sup> Texans Care for Children. 2009. "Increase CHIP and Medicaid Reimbursement Rates."  
[http://www.texanscareforchildren.org/files/CHIP\\_and\\_Medicaid\\_Reimbursements.pdf](http://www.texanscareforchildren.org/files/CHIP_and_Medicaid_Reimbursements.pdf) (June 24, 2009)

<sup>73</sup> State of Texas Children. 2007. "Travis County Data." *Center for Public Policy Priorities*.  
[http://www.cppp.org/factbook07/county\\_profile.php?fipse=48453](http://www.cppp.org/factbook07/county_profile.php?fipse=48453) (June 14, 2009)

<sup>74</sup> Moody, Joseph. State Representative. *Texas Legislature*. Personal Interview. July 13, 2009

<sup>75</sup> Gutierrez, Personal Interview

## Conclusions

1. **The reauthorization of CHIP includes more income levels and thus promotes more coverage of children and their families.** By allowing states to expand income eligibility to 300 percent of the Federal Poverty Line, CHIP may reach the supposed 4.1 million children that are uninsured. The country would be at a better status than previous years in improving the healthcare of children through a revised CHIP system.
2. **Texas is missing out on increased funding by not authorizing CHIPRA.** Current allotments for FY 2009 would have a 72 percent increase in Texas funding alone with the authorization of CHIPRA; the U.S. as a whole would have an 82 percent increase in allotments. With the increase funding states would be able to enroll more children.
3. **Reimbursement rates for border communities in Texas are too low.** Even if a certain border county has a similar population size to a non-border county, the reimbursement rates for the border county are still lower, and this can be interpreted as meaning an individual is worth less simply because they are living in a border community.
4. **Border communities will have difficulty improving their CHIP programs unless the reimbursement rates improve.** No amount of hard work and dedication can improve the lack of hospitals, physicians or medical specialists that border communities face. Increased reimbursement rates would attract more doctors to an area, and this would directly contribute to an area's utilization rates.
5. **Access to healthcare differs between counties due to utilization rates.** El Paso and other border counties do not receive a sufficient amount of money, because Texas disperses funds using utilization. With the creation of the Children's Hospital and Medical School, El Paso's utilization rates should rise in the coming years.
6. **Despite not benefiting from the utilization rate system the State of Texas employs, the El Paso area has begun to "play the game" of utilization.** The only option the area seems to have is to increase utilization rates through increased patronage of local healthcare infrastructure, as well as expanding it. The new medical school as well as the children's hospital may be seen as expansion of existing infrastructure.
7. **Border communities are stuck in a cycle of being medically underserved and having low reimbursement and capitation rates.** Border communities lack the facilities and personnel other large communities have. This leads to lower reimbursement and capitation rates.
8. **The 81<sup>st</sup> Texas Legislature failed to reauthorize CHIP due to political reasons.** Due to political "chubbing" that occurred during the 81st Texas Legislative Session, both CHIP bills failed to pass both chambers of Congress. Governor Perry then failed to add CHIP to the subsequent special session's agenda.

## Recommendations

1. **In the following Texas Legislative Session, Texas needs to raise the FPL guideline to 250 percent but authorize a buy-in program for those that fall in the 250 to 300 percent range.** Texas needs to concentrate on children that are currently uninsured and meet CHIP guidelines, before increasing the FPL guideline to 300 percent. At the same time, the area can focus on enrolling new children that fall between the 200 percent and 250 percent of the FPL, so Texas can receive additional funding from the federal government. The buy-in program can make insurance affordable for people that fall in between the 250-300 percent range, and also make more competition for insurance company's so they can lower their rates.
2. **Healthcare providers need to reach out to enroll children that are uninsured but meet current eligibility requirements.** Providers need to focus more on reaching the children who meet current guidelines rather than worrying about trying to change them to reach children who do not as of current guidelines meet eligibility. By creating a program designed specifically to target these children or having a division that looks up these children and reaches out to get them enrolled, doing so could eliminate a bug percentage of the estimated 8 million uninsured children in the U.S.
3. **Reimbursement rates should be the same for counties in participating states.** Because reimbursement rates are different in say El Paso and Dallas, physicians decide to leave cities like El Paso, just for the higher reimbursement rates. Creating one reimbursement rate for an entire state ensures the concept that no matter in which part of the state the physician serves, CHIP reimbursement is not going to be a factor for preference. This will allow doctors to stay in areas that currently have low reimbursement rates.
4. **The Health and Human Services for each state should have a report on exact expenses.** Information for exact dollar figures and reports is both outdated and not reported fully. Exact expenditures should be provided through the Health and Human Services for each provider. This information should be made accessible to the public.
5. **Texas should embrace the principle that all individuals living in Texas should have access to adequate levels of health care.** Texas has a large and diverse population of uninsured and underinsured individuals, 80 percent of whom work or have a working family member. Approximately 25 percent of Texans are uninsured, the highest percentage in the nation. The strength and productivity of the Texas workforce and student population depends on the good health of all of its residents.
6. **Increase community involvement in local issues through voting.** Voting turnout *must* improve in border communities if they are ever to have any clout when it comes to public policy. The numbers are there, but border communities historically have had very poor voting turnouts. This must change if the funding process is ever to be modified.

## Appendix A: CHIP and Medicaid Program Differences

The following section describes how Medicaid and CHIP are different government programs, even though they are sometimes combined together under state establishment.

### Income

Income eligibility differs for Medicaid and CHIP; CHIP covers those with an income that is considered too high to qualify for the Medicaid program.

**Table C.12: Annual Income Guidelines for Medicaid and CHIP**

Household Size	Medicaid	CHIP
1	\$10,830	\$21,660
2	\$14,570	\$29,140
3	\$18,310	\$36,620
4	\$22,050	\$44,100
5	\$25,790	\$51,580
6	\$29,530	\$59,060
7	\$33,270	\$66,540
8	\$37,010	\$74,020

Source: Texas Health and Human Services Commission

Alaska and Hawaii use different income guidelines because of the Office of Economic Opportunity administrative practice of noting the cost of living of these two states as higher than the other 48 states.<sup>76</sup> A family with a monthly or yearly income lower than the figures provided in the Medicaid section may be eligible for Medicaid. In some cases, families may qualify for CHIP even if their income is higher than the figures provided in the CHIP section.<sup>77</sup>

### Formula

Matching rates are used to calculate the federal government's portion of a state's Medicaid and CHIP expenditures. The matching rate allows CHIP expenses of states with a lower per capita income than the national per capita income to be paid mostly by the federal government.<sup>78</sup> The U.S Department of Health and Human Services is required by the Social Security Act to annually calculate and publish the federal matching rates for all states. The matching rate for Medicaid is known as the Federal Medical Assistance Percentage (FMAP) and is used in calculating the Enhanced Federal Medical Assistance Percentage (EFMAP), which applies to CHIP.<sup>79</sup>

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<sup>76</sup> U.S. Department of Health and Human Services. 2008. "Computations for the 2008 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia." February 15. <http://dhhs.nv.gov/Grants/Links/2008FedPovGuide.pdf> (July 14, 2009)

<sup>77</sup> CHIP | Children's Medicaid. No Date. "Income Guidelines For CHIP/Children's Medicaid." [http://www.chipmedicaid.org/english/chart\\_income\\_guidelines.htm](http://www.chipmedicaid.org/english/chart_income_guidelines.htm) (July 1, 2009)

<sup>78</sup> Congressional Research Reports for the People. 2009. "Medicaid: The Federal Medical Assistance Percentage." February 2. <http://openers.com/document/RL32950> (June 10, 2009)

<sup>79</sup> U.S. Department of Health and Human Services. 2009. "Federal Medical Assistance Percentage." <http://aspe.hhs.gov/health/fmap.htm> (June 6, 2009)

## Appendix B: CHIP Administration

Administrative overhead refers to the costs that are needed for operations and administration. It does not directly associate with providing healthcare, or its development. Administrative services include but are not limited to paperwork, salaries, and other services that are necessary for the establishment to work properly.

### Administrative Fees

The administrative cap has been reinforced, which has a ten percent limit on administration. There is also a limit on how much an HMO can gain in profit by administering the CHIP program. If too much profit is made, the money goes into redistribution funds.<sup>80</sup>

The rating method also has a specific provision for a health plan's administrative expenses. The amount allocated for administrative expenses is the greater amount of \$10.1025 pmpm plus 7.5 percent of gross premium and \$16.1025 pmpm plus 1.75 percent of gross premium. These values were meant to provide financially for all administrative related services that a health plan may engage in. These premium rates also incorporate a 2 percent gross premium risk margin.

### Unnecessary Expenses

Texas is taking progressive steps to oversee how providers spend the money allotted. The HMO's contracts have been shortened from 5-8 year contracts to 2-3 year contracts.<sup>81</sup> Under the HHSC, upon entering a contract, the MCOs comply with certain standards and regulations to ensure performance. If those standards are not met, HHSC is required by statute to declare and impose a sanction. Sanctions include any of the following contract violations:<sup>82</sup>

- Penalties
- Liquidated damages (Damages whose amount the parties designate during contract formation)<sup>83</sup>
- Consequential damages (Opposed to direct loss or damage, an indirect loss: can include lost profits)<sup>84</sup>
- Corrective action plan (A plan that addresses each audit finding included in the current year's auditor's report)<sup>85</sup>
- Debarment (A process in which a contractor is excluded from requesting or entering into contracts with the federal government.)<sup>86</sup>

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<sup>80</sup> *Dominguez, Personal Interview*

<sup>81</sup> *Dominguez, Personal Interview*

<sup>82</sup> Texas Health and Human Services Commission. 2008. "Managed Care Organization Sanctions." <http://www.hhsc.state.tx.us/medicaid/ContractorSanctions/index.html> (June 24, 2009)

<sup>83</sup> The Lectric Law Library's. No Date. "Liquidated Damages." <http://www.lectrlaw.com/def/1045.htm>. (July 14, 2009)

<sup>84</sup> Russo, Carmen A. and Garret Akerson. 2000. "21+ Useful Insurance Terms You Should Know." *Ezine Policy Articles*. September 1. <http://ezinearticles.com/?21+-Useful-Insurance-Terms-You-Should-Know&id=1198395> (June 22, 2009)

<sup>85</sup> Michigan Department of Human Services. 2007. "Accounting Auditing Definitions." *State of Michigan*. [http://www.michigan.gov/dhs/0,1607,7-124-5455\\_7199\\_8380-16669--,00.html](http://www.michigan.gov/dhs/0,1607,7-124-5455_7199_8380-16669--,00.html) (June 24, 2009)

- Suspension of contract or a portion of it
- Termination of contract
- Any other violation of non-compliance

Sanctions in that report did not include temporary delays in payment or agreed temporary remedial measures that were agreed upon to make contract compliance easier, as a threshold of a sanctions.

**Table C.13: Total Texas MCO Sanctions from FY 2008-FY2009**

Managed Care Organization	Total Sanctions Imposed
Evercare Integrated Care Management	\$632,033
Superior Health Plan	\$338,850
STAR Health Superior Health Plan Network	\$230,200
Evercare of Texas	\$192,935
Cook Children's Health Plan	\$117,550

Source: Texas Health and Human Services Commission

The table above displays the sanctions imposed on Texas MCOs. These MCOs' contracts were assessed liquidated damages in their respective amounts. These sanctions can be considered unnecessary expenses, since most of these sanctions were imposed for preventable issues of non-compliance. Issues include, but are not limited to, failing to:

- Complete reassessments
- Fill out certain paperwork requirements in a timely manner
- Meet deadlines and performance standards for deliverables
- Meet standards for member hotlines
- Add contract required components
- File paperwork correctly

If the states are facing budget shortfalls in coming years, money should be spent more efficiently. MCOs should adopt the responsibility of spending its money on the people it is trying to reach instead of paying off sanctions for repetitive mistakes.

Out of the nineteen MCOs who have recorded sanctions, El Paso First ranks eighteenth in expenses paid due to sanctions. Right in front of Seton Health Plan (\$353 sanction), El Paso First has two recorded sanctions. Sanction number 002 has the issue of non-compliance for the third quarter of State Fiscal Year 2008 in which El Paso First Health Plan submitted the original Provider Termination Report incorrect.<sup>87</sup> The maximum sanction the HHSC may fine is up to \$250 per calendar day if the report was late. The sanction imposed for this mishap cost El Paso First \$675 in what was labeled as liquidated damages. In a more recent occasion, El Paso First Health Plan's Primary Care Provider Network and Capacity Report for the CHIP program in the El Paso service area was received by the HHSC on January 19, 2009, when it was due on

<sup>86</sup> Department of General Services. 2005. "State Contracting Manual." [www.ols.dgs.ca.gov/Contract+Manual/GlossaryofTermsandIndex.htm](http://www.ols.dgs.ca.gov/Contract+Manual/GlossaryofTermsandIndex.htm) (June 24, 2009)

<sup>87</sup> Texas Health and Human Services Commission, "Managed Care Organization Sanctions."

December 31, 2008. This led to sanction 003 for the first quarter of State Fiscal Year 2009, in which the contractor was assessed \$425 in liquidation damages.<sup>88</sup>

## **Program Regulation**

CHIP is individually regulated in each state. A state is granted options for establishment, options in regards to what benefit package and what kind of administration fits their state best. States can obtain waivers to extend eligibility to some groups who are not eligible. Some states use waivers and some don't. Contract management varies in all states. In the following sections overall options and the way the State of Texas regulates the program will be explored.

State Regulation The states have options when it comes to the implementation of the program in their respective state. Each state is assigned a different match rate. CHIP grants the states three options for the establishment of the program:

- Use CHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program
- Design a separate children's health insurance program
- Combine both the Medicaid and separate program options.

Texas chooses to design and establish the CHIP program as a separate entity from Medicaid.<sup>89</sup> States are required to provide all mandatory benefits and optional services covered under the Medicaid State Plan. The Medicaid cost-sharing rules must also be implicated in the program. States that choose to employ a separate program have more options and leniency. Even though they abide by the set federal guidelines, they are allowed to determine their own CHIP benefit package.<sup>90</sup>

The states have the power to regulate the rate at which health service providers are reimbursed. Unlike the standard services covered by all states, provider reimbursement rates vary widely. In the majority of states, CHIP reimburses physicians at a much lower rate than private insurances do, which in large part is the reason why many doctors refuse to serve CHIP patients. The reimbursement rates for doctors under CHIP average about half of those credited to the private sector. In one survey conducted, one-third of all the physicians studied reported that they limit access of Medicaid/CHIP patients.<sup>91</sup> In other areas like El Paso, "El Paso clinics like La Fe must accept CHIP/Medicaid, but private doctors do have a choice. Doctors in the area rely on CHIP patients due to a lower number of commercial insurance patients. In fact one of our major problems is our severe shortage of Doctors – therefore, when one doctor does not accept CHIP, families lose the limited options for health care we have. When that Doctor is a specialist, CHIP loses value for those patients. Serving CHIP patients is what pays the bills," comments Jorge Salazar, Administrator of Community Health Services at Centro de Salud La Fe.<sup>92</sup>

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<sup>88</sup> Texas Health and Human Services Commission. 2008. "El Paso First Sanctions."

<http://www.hhsc.state.tx.us/medicaid/ContractorSanctions/MCOJuly2009/EIPasoFirst.xls> (June 24, 2009)

<sup>89</sup> *Southern Governors Association*, "S-CHIP Fact Sheet: Texas' S-CHIP Program."

<sup>90</sup> *Texas Health and Human Services Commission*, "Chapter 7 Children's Health Insurance Program."

<sup>91</sup> Gruber, John. 2005. *Public Finance and Public Policy*. New York: W. H. Freeman & Company

<sup>92</sup> Salazar, *Personal Interview*

Texas Contract Management In order to effectively provide coverage to eligible children, the state of Texas contracts fifteen Health Maintenance Organizations (HMOs).<sup>93</sup> The two local HMOs in the El Paso Region are El Paso First Health Plan and Superior Health Plan.<sup>94</sup> Eligible uninsured children living in the state's rural areas are taken care of through a single health plan. Texas, as a supplementary advantage, contracts with a dental health plan to provide dental services on the state level. The state is also given the responsibility of administering the Prescription Drug Program, which is the program that distributes drugs and prescriptions for children enrolled in CHIP.

Texas has also allowed the children of state employees and legal immigrants, who have been in the United States for less than five years, to be eligible for coverage. Since said groups are conveyed as ineligible for benefits provided through the federal portion of CHIP, Texas uses 100 percent of state funds to pay for these children. This financial responsibility costs the state approximately \$44.6 million annually.

In 2006, Texas implemented policies for contract management through a "value-based" purchasing approach to strengthen contract requirement and increase liability. "Value-base" includes:

- Establishment of annual goals for health plans
- Better tracking on leading indicators of performance
- Provider profiling and network management requirements to target poor performing providers and track the implementation of clinical guidelines
- Performance based incentives
- Liquidated damages for contract non-compliance<sup>95</sup>

This form of collaborative partnership with health plans and further accountability is projected to influence the healthcare system and benefit Texas recipients.

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<sup>93</sup> *Southern Governors Association, "S-CHIP Fact Sheet: Texas' S-CHIP Program."*

<sup>94</sup> Texas Health and Human Services Commission. No Date. "Joint Medicaid/CHIP HMO Request for Proposals RFP # 529-04-272." [http://www.hhsc.state.tx.us/contract/52904272/rfp\\_home.html](http://www.hhsc.state.tx.us/contract/52904272/rfp_home.html) (June 22, 2009)

<sup>95</sup> *Southern Governors Association, "S-CHIP Fact Sheet: Texas' S-CHIP Program."*

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