CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

Texas CHC Coalition
Meeting Minutes

March 24, 2017

Present:	Adriana Kohler, Texans Care for Children Clayton Travis, Texas Pediatric Society Kaitlyn Clifton, Texas Pediatric Society Anne Dunkelberg, Center for Public Policy Priorities Stacey Pogue, Center for Public Policy Priorities Leah Gonzales, Healthy Futures of Texas Alice Bufkin, Healthy Futures of Texas Helen Kent Davis, Texas Medical Association Mary Allen, Texas Association of Community Health Centers Patrick Bresette, Children's Defense Fund - Texas Kit Abney Spelce, Central Health Cheasty Anderson, Ken Martin, THEO Jeanne Stamp, THEO Sebastien Laroche, Methodist Healthcare Ministries Whitney Miller, Methodist Healthcare Ministries Veronica Brown, Lone Star Circle of Care
On the phone:	Kathy Eckstein, Children's Hospital Association of Texas Melissa McChesney, Center for Public Policy Priorities Sister JT Dwyer, Daughters of Charity Marilyn Barrera, Driscoll Health Plans Stephanie Stevens, Texas Hospital Association Frank Presley, Central Health Maureen Milligan, Teaching Hospitals of Texas
Chair:	Anne Dunkelberg, Center for Public Policy Priorities
Minutes Scribe:	Kamia Rathore, Center for Public Policy Priorities
Next meeting:	April 21, 2017

CHILDREN'S HEALTH COVERAGE COALITION
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I. Federal Reform Overview *(Anne Dunkelberg, CPPP)*

- *See slides below*
- **Anne**: One of the challenges on the state level has been talking about the revenue system and addressing a narrative that health care spending is 'crowding out' the rest of the budget. There have been continued reductions to state revenue adopted by the legislature and there are some resources here to help challenge that narrative with the facts. Data from the Legislative Budget Board indicates that general revenue spending on K-12 is substantially higher than that for Health and Human Services, and only with federal matching does the among exceed that for education. (*Refer to slide 11.)*
- **Anne:** If funding shifts to a block grant model, all previous guarantees are opened to no longer being guaranteed. EPSDT, which protects medically necessary care for children, would likely disappear under block grants and minimum benefits for adults are also likely be eliminated.
- **Anne:** Let's talk about the House's first version of its filed repeal bill: the CBO projects that 24 million fewer people will have insurance compared to current law over the span of 10 years. 14 million of that number will lose coverage in the first year (2018). Neither number has changed with revised CBO scores for different iterations of the bill. We would shift from 10 percent uninsured to 19 percent.
- **Patrick**: What's the reason for the dramatic decline in 2018?
- **Anne:** That's due to the individual mandate no longer being enforced and changes to tax credits—people who are buying insurance because they are required. Medicaid losses will start in 2020.
- An amendment on Monday on marginally improved the bill by reducing cuts to Medicaid from $880 million to $839 million, an estimate likely achieved from changing the per capita cap inflation adjustment to CPI + 1 for the Medicaid subgroup of older individuals and those with disabilities.
- Some big-picture concerns: there will be a large reduction in the adequacy of subsidies, which under current law are sensitive to age, income, and geography. This lack of sensitivity creates winners and losers, with winners being mostly younger adults. The plan also pushes high-deductible plans and promotes HSAs without providing help to pay these out-of-pocket costs. Overall, there is a 34% cut to ACA subsidies, and these credits don't go to the same people who used to receive them. Rural areas are hit much harder by premium increases, nearly twice as a high as urban areas due to subsidy cuts and a lack of insurers. The main problem is that the new structure does not adjust for the actual varying costs of care.
- **Anne:** The proposed Medicaid funding shift would launch in 2020, with new costs calculated for four groups and a potential expansion population group:
    - **1.** Children
    - **2.** Elderly
    - **3.** Disabled, which includes children eligible on the basis of disability
    - **4.** Non-expansion adults (pregnant women, former foster care youth, small number of parents)
    - **5.** Adults covered under Medicaid expansion
- Certain kinds of spending would be excluded from the formula. It's unclear how 1115 waiver funding would be incorporated. An amendment clarified that the funding could be rolled into Medicaid base funding, although it's largely used for uninsured costs and it's not clear how it would be used if rolled into the base. Also under Manager's amendments, two groups get CPI+1 adjustment – groups two and three – which reduces the cut to Medicaid.

- If a state spends more than cap established, the federal funds for the next year will be reduced to recoup the overage. It is expected that if Texas is in recoup mode, state funding will not increase to cover the costs.
- The use of 2016 as a base year for calculating per capita caps locks in certain decisions of the legislature that were not meant to be permanent—decisions that include cuts to provider rates, pediatric therapy cuts – and freezes permanently inadequate provider networks. Everything becomes a zero-sum; if the needs of one enrollment group become more intensive, the only way to meet those needs is to cut and allocate away funding from another group.
- **Anne:** Payments to Medicaid physicians have not been annually updated in over 20 years; since annual updates were frozen in 1993, there have been three legislative increases and four cuts. The effects of that trickle down to provider access and network adequacy. This is a long-standing challenge in Texas and a per capita cap system could make it even tougher by locking funding into a system not meant to be permanent.
- Prospects for expansion are unclear—federal advocacy groups are interpreting the proposal to say that expansion can happen for states that held off, but with regular federal matching rates. Funding for states who already expanded will be calculated through the fifth enrollment group. Two primary rules apply: enhanced matching falls off for beneficiaries after gaps in coverage of over one month and this population is required to renew coverage every six months rather than the current 12. This second rule is designed to induce 'churn' and effectively speed up the move of funding from the enhanced to regular rate for the expansion population.
- *Refer to slide 32 for overview of Manager's amendments*
- States could add work requirements to Medicaid, which may be similar to TANF. CMS has also indicated they are receptive to state proposals with work rules.
- States have the option to take funding as a block grant instead of a per capita cap system. This would be a lump-sum amount inflated by regular CPI rates. The block grant would not include seniors or individuals with disabilities, and could eliminate coverage of parents. EPSDT could be eliminated for children and minimum standards don't include primary or preventive care aside from a specific reference to prenatal care. If this bill passes, the challenge becomes to convince Texas legislators to choose per capita caps rather than a block grant

II. State Budget Discussion *(Kathy Eckstein, CHAT)*

- *Refer to budget overview attached below*
- **Kathy:** The House Supplemental Appropriation bill allocates funding for the Medicaid shortfall for FY 2017 and makes use of the Rainy Day Fund, which has been controversial this session. We're working on a one-pager to support use of the RDF in the budget and give an overview of the history of its use. For the supplemental bill, the RDF is used to cover shortfall, restore therapy rate cuts that were a part of the 2016-2017 cost containment rider, supplement DFPS, forensic bed capacity, and cover newborn screening at DSHS.
- The Senate's general budget bill, SB1, appropriates $106.3 billion in general revenue. It incorporates a cost containment rider for a reduction of $410 million in GR ($1 billion in all-funds) for 2018-2019,

with some directed reductions including managed care premium risk margin reductions, prescription drug changes, and savings related to waste, fraud, and abuse.

- Funding for the Healthy Texas Women program is reduced based on the assumption that the program will move to Medicaid and that HHSC will receive federal matching funds for 2019. They have accordingly reduced GR appropriations for the funding based on this assumption.
- **Kathy:** The House's general budget bill, HB1, has wrapped up its committee substitutes. Article II (Health and Human Services) appropriations have been reduced by $795 million GR ($2 billion AF) from the introduced bill, with HHSC appropriations being reduced by $966 million ($2.3 billion AF).
- A rider is also included that directs HHSC to evaluate and pursue flexibility from the federal government to reduce costs, which would waive or delay federal requirements. The cost-containment rider amount of reductions is also increased to $111 million GR.
- Article IX (General Provisions) includes a rider attempting to force the legislature to use the RDF in the Supplemental Bill. If the Supplemental Bill as passed does not include at least $2.47 billion in funding from the RDF, $4.6 billion in GR from the Appropriations bill will be reduced. The list of reductions includes health and human service programs with as long-term care, CHIP, CPS Critical Needs, Women's Health Programs, and Behavioral Health.
- **Helen**: These cuts aren't just for Medicaid, they're across HHSC. We're talking to the plans to see how this might affect services
- **Clayton**: Any reductions to MCOs run down and hit services because of prior authorizations or rate cuts.
- **Adriana**: It's hard to figure out what this means for general administration or clients, but it will all affect clients at the end of the day.
- **Anne**: With reductions that big, it will have to go to client services.
- **Kathy:** The agency is anxious about achieving this level of cuts, and it could just end up in the same place with a supplemental budget in two years.

IV. Update on Coalition Areas (*Multiple speakers)*

Early Childhood Intervention (Clayton Travis, Texas Pediatric Society)

- *Refer to ECI-Private Insurance one-pager below*
- **Clayton:** There's five million more in the budget for ECI services compared to the past biennium. The agency has also made an exceptional item request and acknowledged that it's not enough to address the needs of the program. The GEER also included two recommendations for cost reductions regarding ECI:
    - Eligibility could be cut to require a higher level of developmental delay to qualify
    - Create a state task force examining commercial payments because ECI bills all potential sources
- Hopefully this second option would provide another funding stream for ECI providers. There are a few bills regarding this recommendation, looking either for a task force or a mandate to commercial insurers.

- **Adriana:** Plans don't like this recommendation, but it does free up GR dollars.
- **Clayton**: The House also wants an interim discussion and study on ECI funding. We would have some parameters for an interim study, such as the fact that eligibility reduction is not on the table and the program would have to remain funded in the meantime.

Maternal and Child Health (Adriana Kohler, Texans Care for Children)

- *Refer to Maternal Depression Screening One-pager below*
- **Adriana:** We're supporting a bill to ensure mothers can be screened for depression as part of the well-baby visit. This would ensure that moms can get screened as part of the baby's coverage. The bills to watch are HB 2466 and the companion bill, SB1257.
- **Alice:** On the budget side, we have some specific concerns about the rider in Article IX that would cut funding to HHSC programs, including the women's health program**,** unless the RDF is used. The Senate budget also includes a reduction to funding for Healthy Texas Women based on the assumption that the state will received federal funds at the higher 90:10 rate. However, there's no guarantee this money will come through. The rider mentions that if federal funds aren't available, HHSC has to go to the LBB for direction before making reductions to benefits. Also, if the funding shifts to mostly federal, there are limits on what benefits can be covered and it's unclear if Texas would be able to maintain everything that it currently offers. This rider is only on the Senate side, which is encouraging.
- On other positive development it SB809 which would direct HHSC to expand auto-enrollment for Healthy Texas Women. Currently, pregnant women on Medicaid are automatically enrolled into HTW once their 60 days of post-partum coverage are up. This would expand HTW auto-enrollment to women in Medicaid or CHIP once they age out. The house also is considering a bill that would increase data collection on family planning providers by requiring a report to be produced.

Eligibility Renewal (Multiple speakers)

- *Refer to Eligibility Renewal handout below*
- **Anne**: When the kids in a family have different dates for renewal, this can dramatically increase the number of eligibility checks they have to comply with. For complicated family situations, having multiple eligibility checks increase the potential disruptions to care and effects continuity of care.
- **Clayton**: There are also fiscal impacts to dropping off in care. The savings that could be associated with continuous eligibility is avoiding denials for procedural reasons, and then having to retroactively cover ER costs.
- **Anne:** The coalition is still asking for data on how income checks effect children's coverage to determine how these checks may be procedurally denying potentially eligible children. It will also be a push we continue to make in the interim.

General updates

- **Anne:** There are also a couple of bills requesting interim studies to assess the impact of potential federal changes to Medicaid. One concern is that there may not be an adequate mechanism for

advocates to weigh in. Ideally, there will be a public process that goes around the state and asks for input for providers, consumers, and advocates. A letter to the sponsors suggesting a more inclusive process may be useful.

Diane Rhodes of Texas Dental Association will chair the April 21th meeting, which is an OTA meeting.

CENTER *for* PUBLIC POLICY PRIORITIES

Protect Our Health Care:

Real Threats to Health Insurance, Medicaid from Washington (& Austin)

Children's Health Coverage Coalition
March 24, 2017

ANNE DUNKELBERG, DUNKELBERG@CPPP.ORG
STACEY POGUE, POGUE@CPPP.ORG
MELISSA MCCHESNEY, MCCHESNEY@CPPP.ORG

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About CPPP:

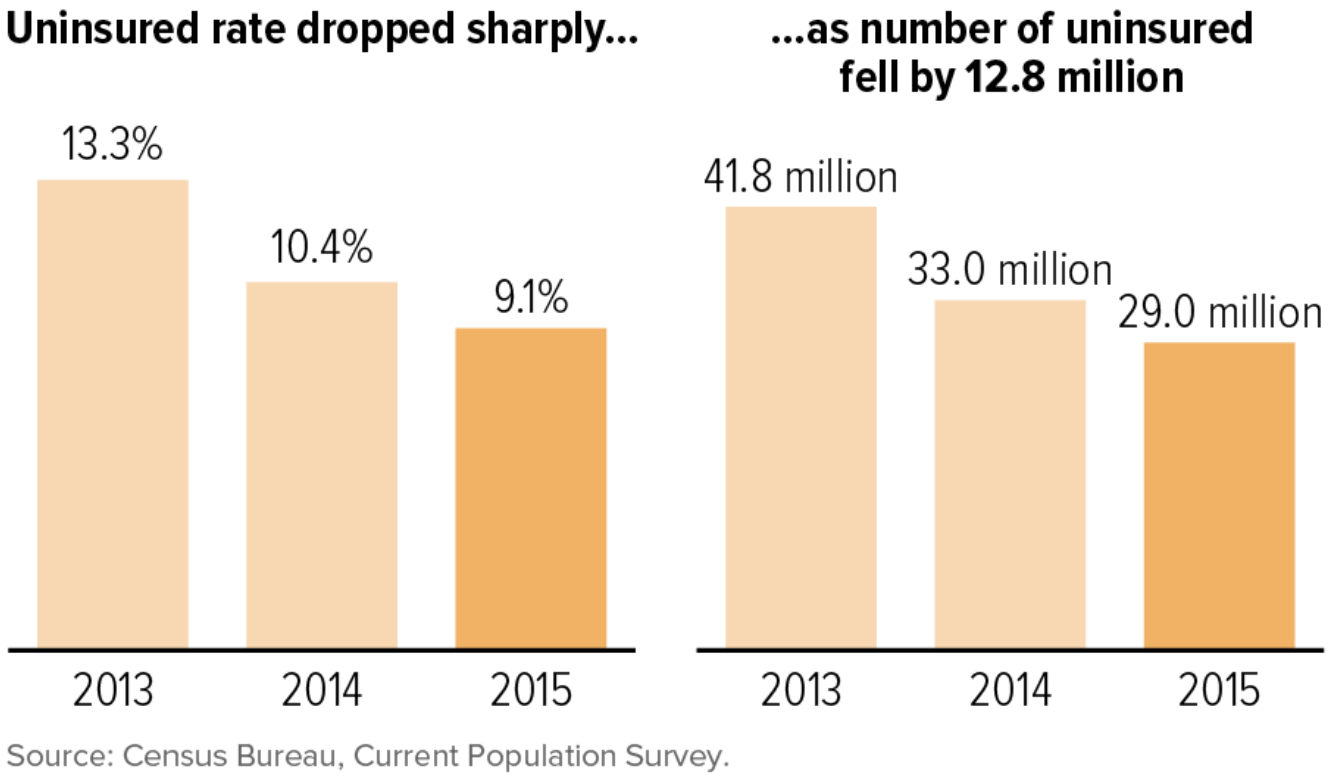
CPPP was born from faith and a vision of social justice in 1985 when a Congregation of Benedictine Sisters in Boerne, Texas, founded the center to improve health care access for the poor.

Historic Reduction in U.S. Uninsured with Affordable Care Act (a.k.a. ObamaCare)

2014 and 2015: the two largest single-year declines in the uninsured rate on record.

Substantial declines in the uninsured rate among all demographic groups.

Since 2010, 20 million fewer Americans are uninsured.



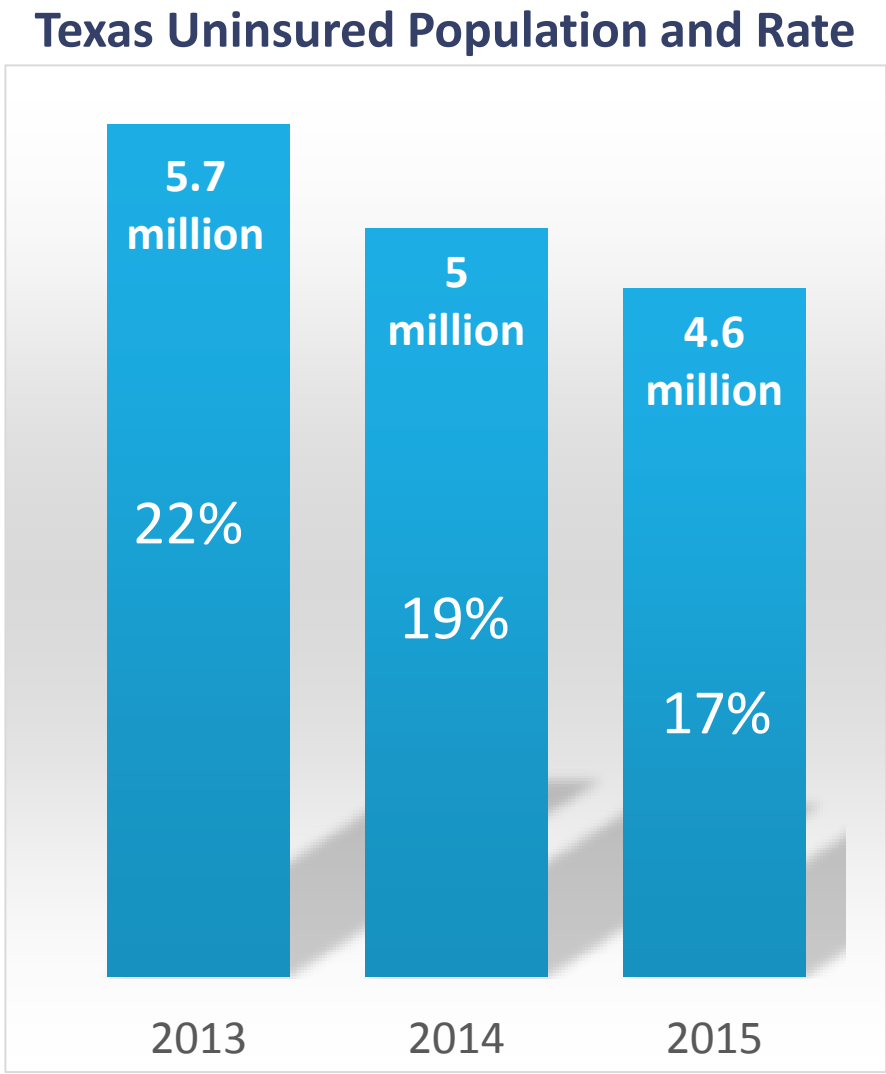
Source: Census Bureau, Current Population Survey.

ACA's Historic Reduction in Texas Uninsured

1.1 million fewer uninsured

5 percentage point drop in uninsured rate

Before ACA, Texas never had a one-year improvement of even a *single* percentage point



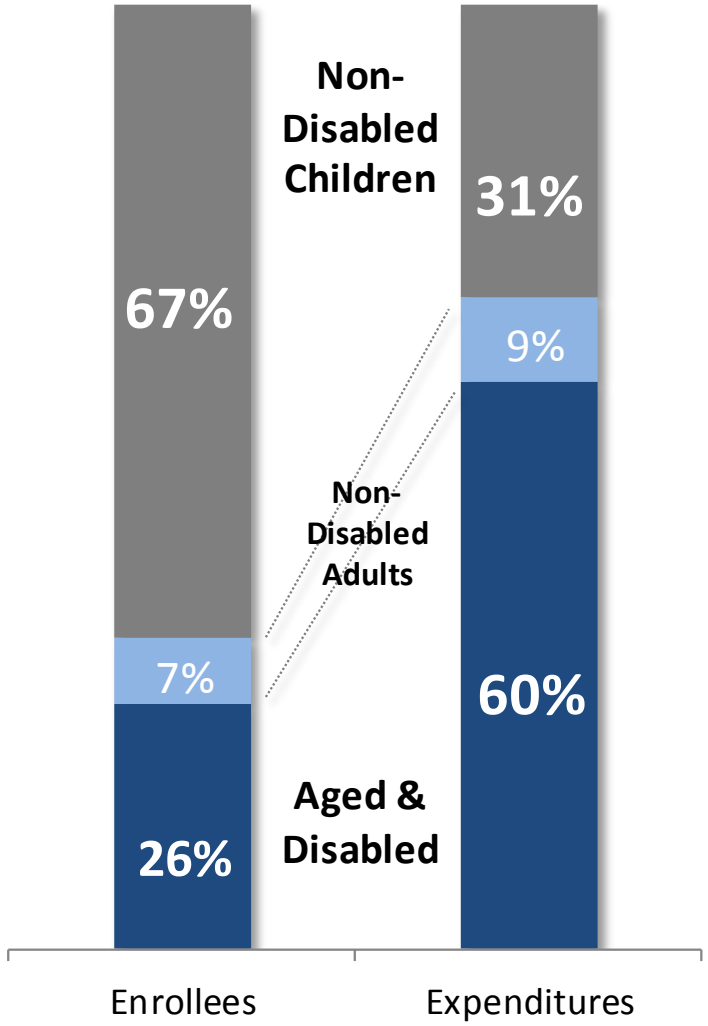
Center for Public Policy Priorities. 2015. "Census Data Reveal New Facts On Health Insurance." Austin, TX

Texas Medicaid Enrollment and Spending

KEY FACTS

- **4.3 M** enrollees
- **$36.1 B** total spending
  ($14.7 B state, $21.4 B federal)
- **56%** federal match rate

- **Non-Disabled Children** represent more than two-thirds of Texas Medicaid enrollees but less than one-third of spending
- **Aged and disabled** enrollees represent only a quarter of Medicaid enrollees but 60% of costs

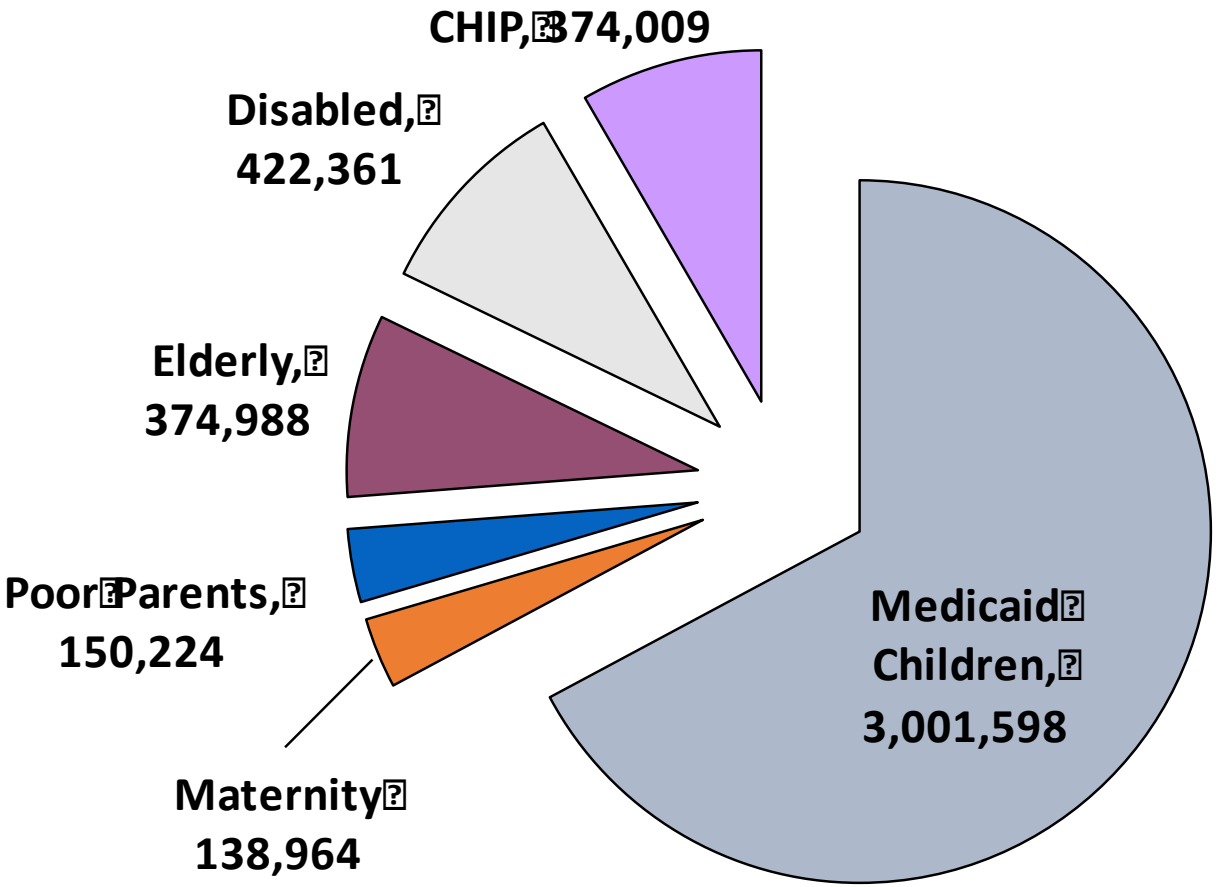


Sources: Robert Wood Johnson Foundation, "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States"; MACStats ; Texas Health & Human Services Commission, "Texas Medicaid and CHIP in Perspective," Feb. 2015.

manatt

Texas Medicaid/CHIP: Mostly Children

Plus Serious Disability, Poor Seniors, Pregnant Women



September 2016, HHSC data

Source: Center for Public Policy Priorities, HHSC data.

Total Enrolled:
(as of September 2016)

4.5 million Texans

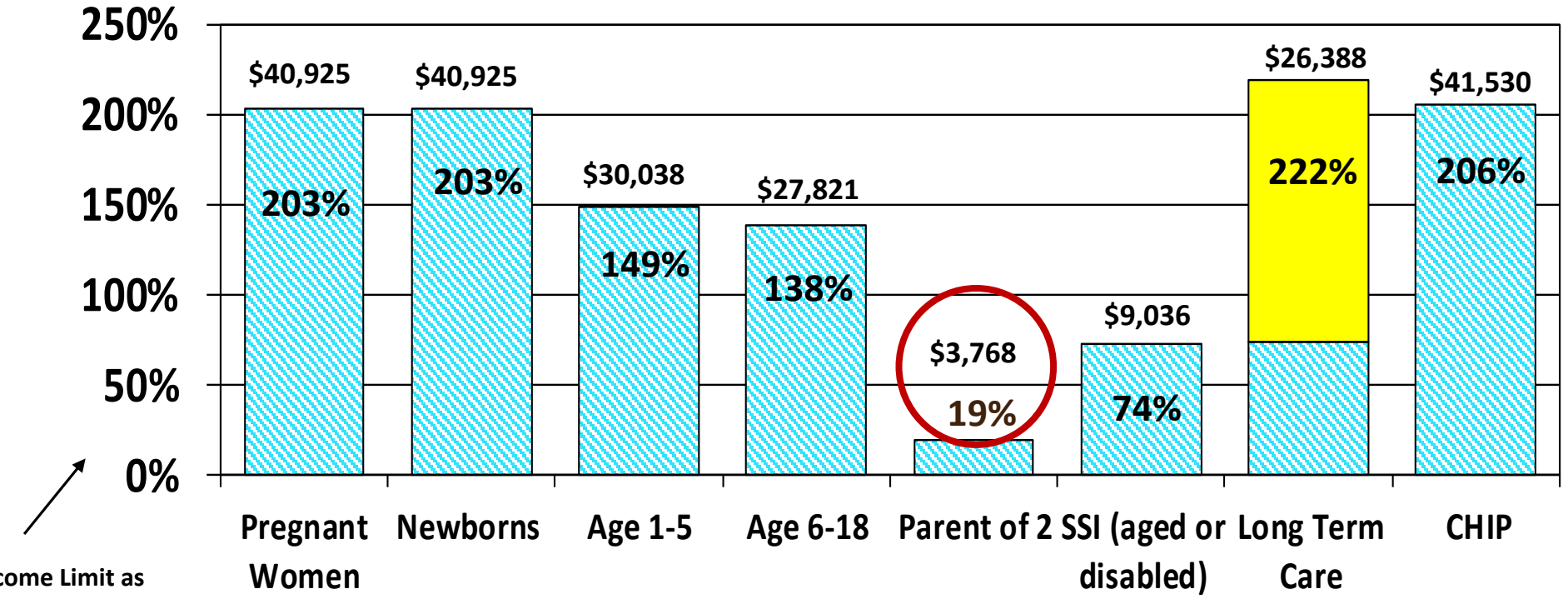
Of these,

3.4 million are children

(~45% of Texas kids)

Why 3 million children, only 150,000 Parents?

Income Caps for Texas Medicaid and CHIP, 2016



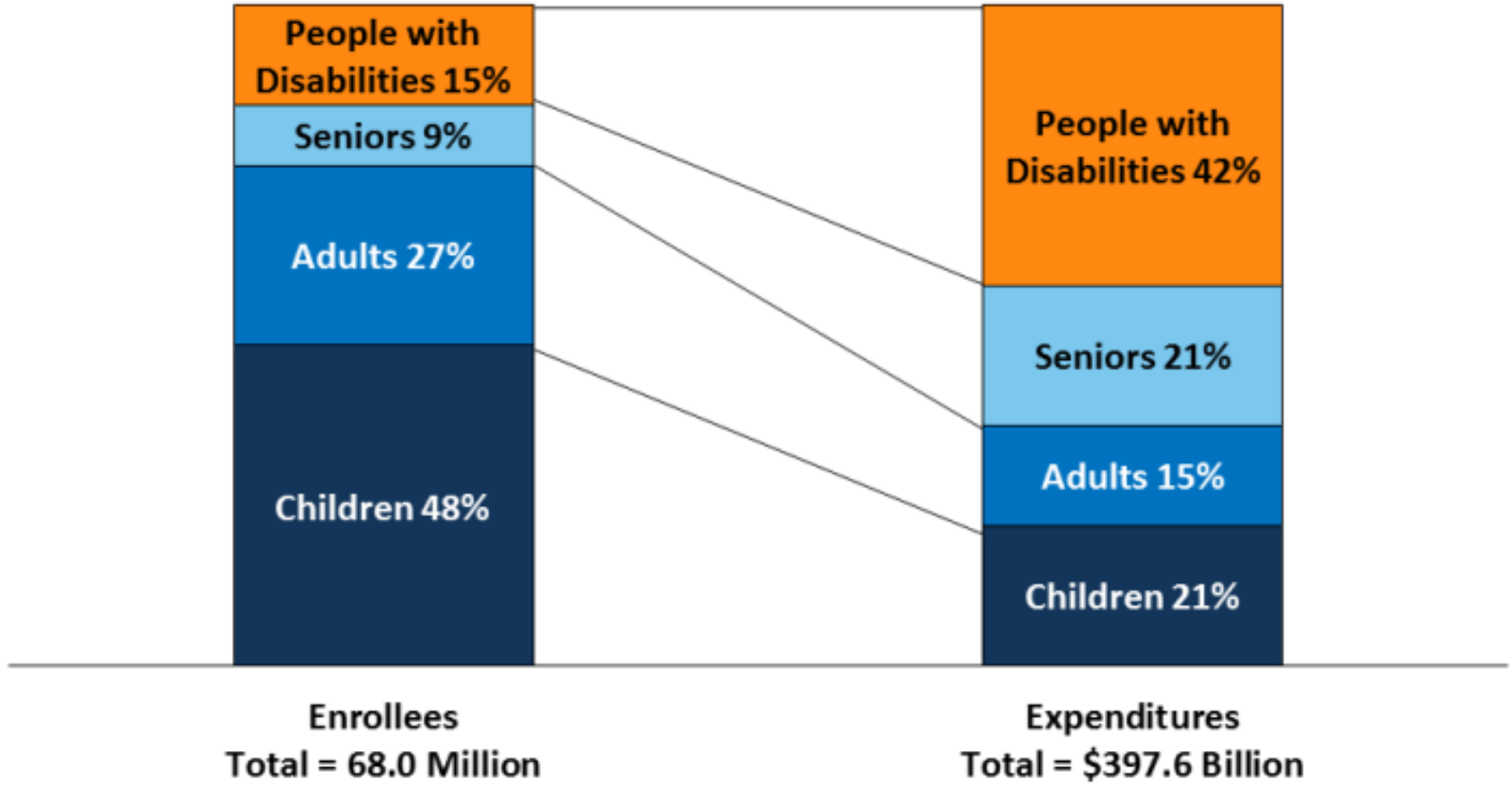
ACA Repeal May Change These!

Note: Annual income cap for a family of 3, except individual incomes shown for SSI and Long Term Care

Source: Center for Public Policy Priorities.

Figure 10

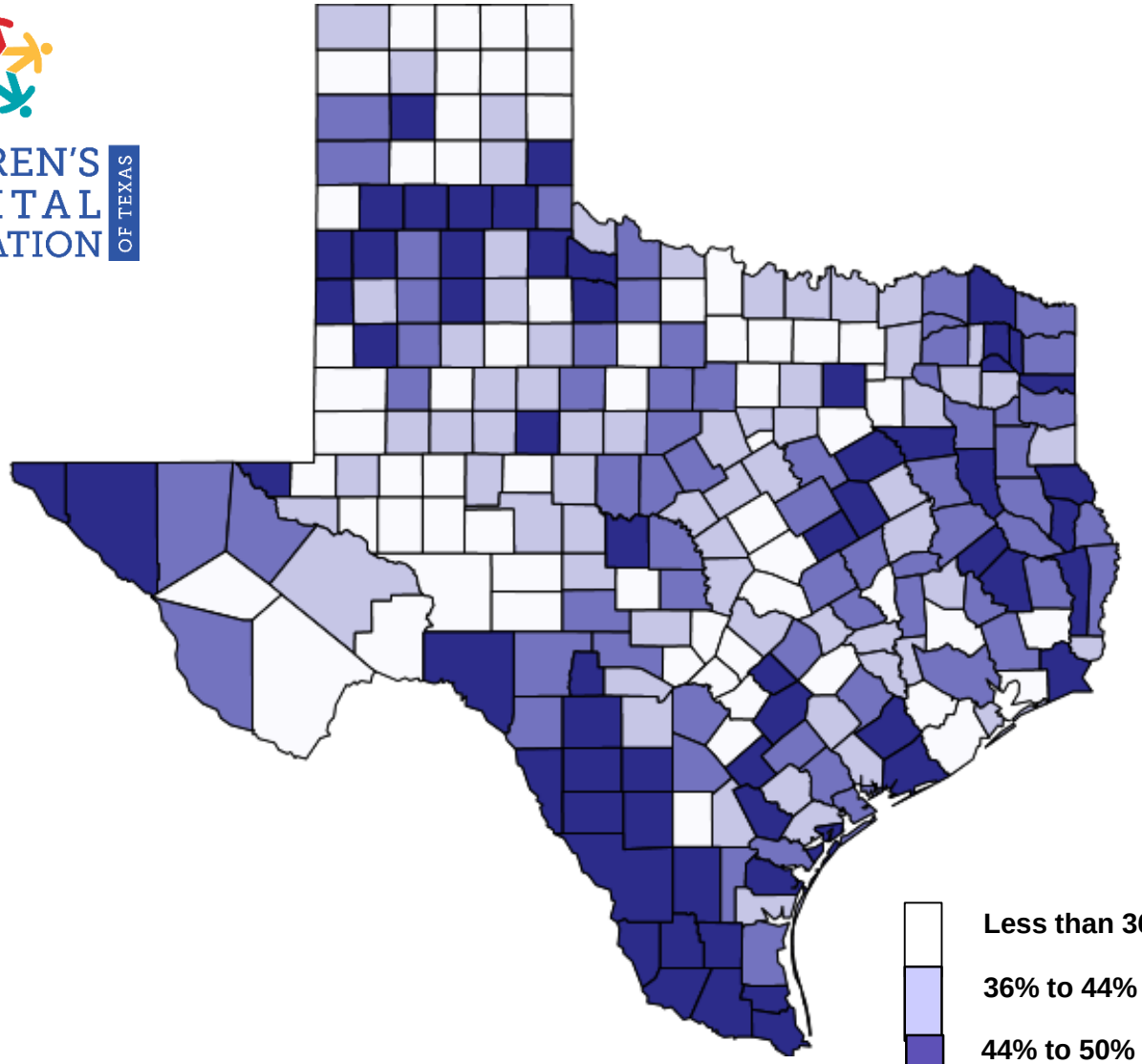
Medicaid enrollment and spending by coverage group, FY 2011



NOTE: People with disabilities include children and nonelderly adults. Includes both full and partial benefit enrollees. SOURCE: KFF/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, OK, TX, and UT, but adjusted to 2011 CMS-64.

Nearly half of Texas Children Were Enrolled in Medicaid or CHIP in March 2014,

From a high of 77% to a low of 10%

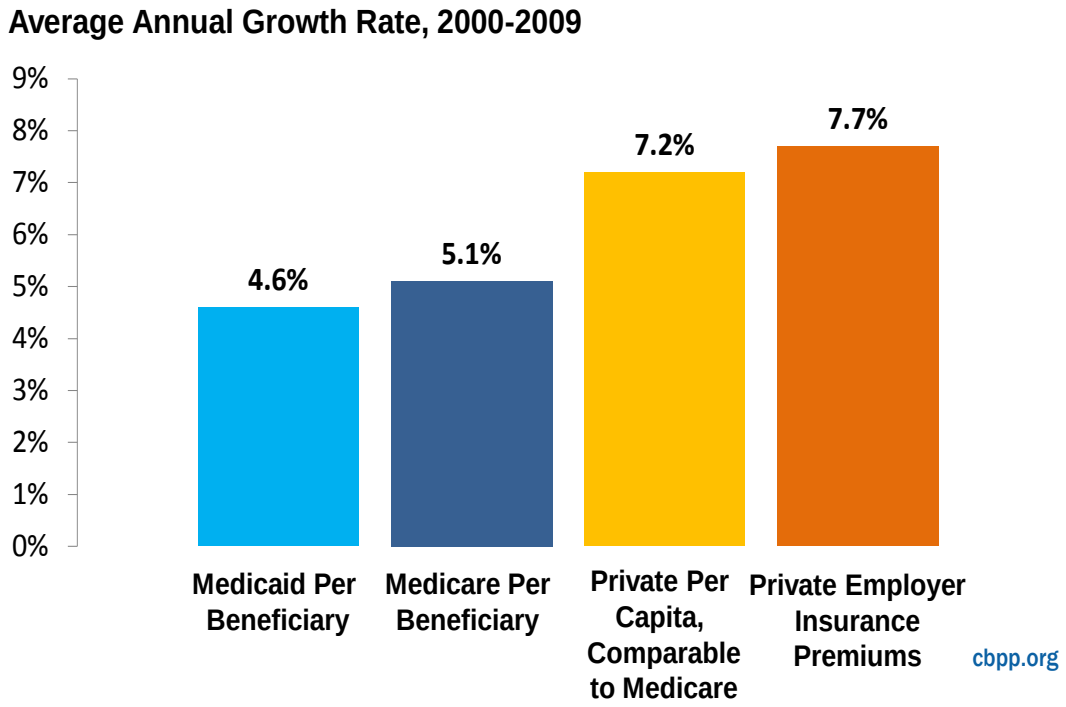


Analysis by Children's Hospital Association of Texas
Note: Includes children less than 19 years of age.
Sources: Medicaid: 8-Month Eligibility Databases, HHSC; CHIP: P10_dob_regular database , HHSC. Prepared by Data Quality & Dissemination, Strategic Decision Support, HHSC.
Children <19: Projections of the Population of Texas and Counties in Texas by Age, Sex and Race/Ethnicity for 2010-2050 (2000-2010 Migration (1.0) Scenario), UTSA, November 2014.

Medicaid Cost Growth Driven by Enrollment, Not Per-person Costs

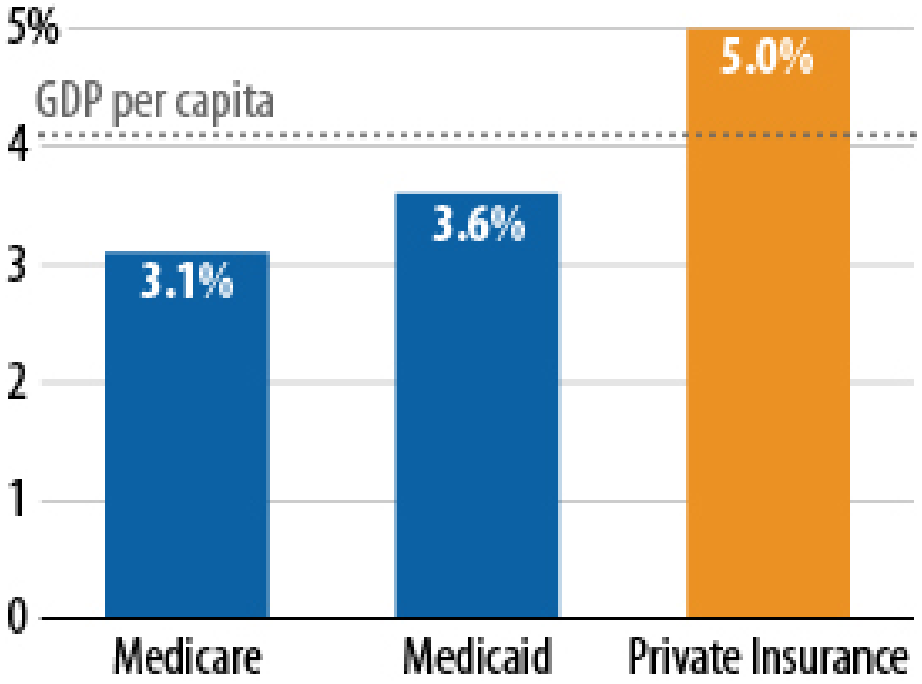
Center on Budget and Policy Priorities

Medicare and Medicaid Controlled Costs Better than Private Insurance Over the Last Decade



Medicare and Medicaid Spending per Beneficiary Is Projected to Grow Slower Than Private Insurance

Average annual growth rate per enrollee, 2012-2021



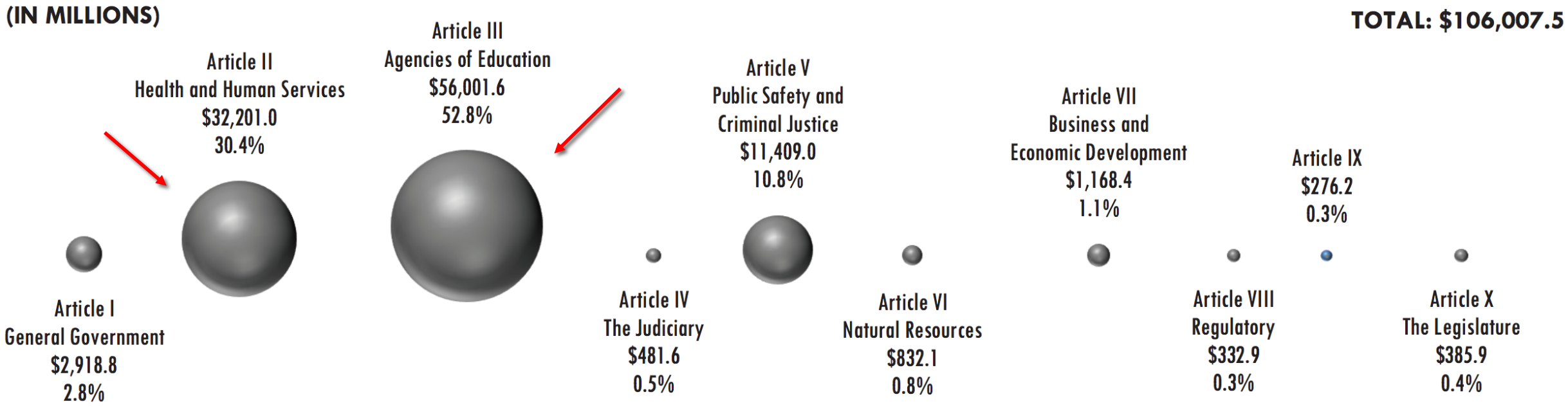
Source: Holahan and McMorrow, *New England Journal of Medicine*, August 2, 2012.

Center on Budget and Policy Priorities | cbpp.org

HHS as a share of Texas' State-Dollar Spending = 30.4%

Only with federal funds GAINED does HHS % exceed K-12 Public Education

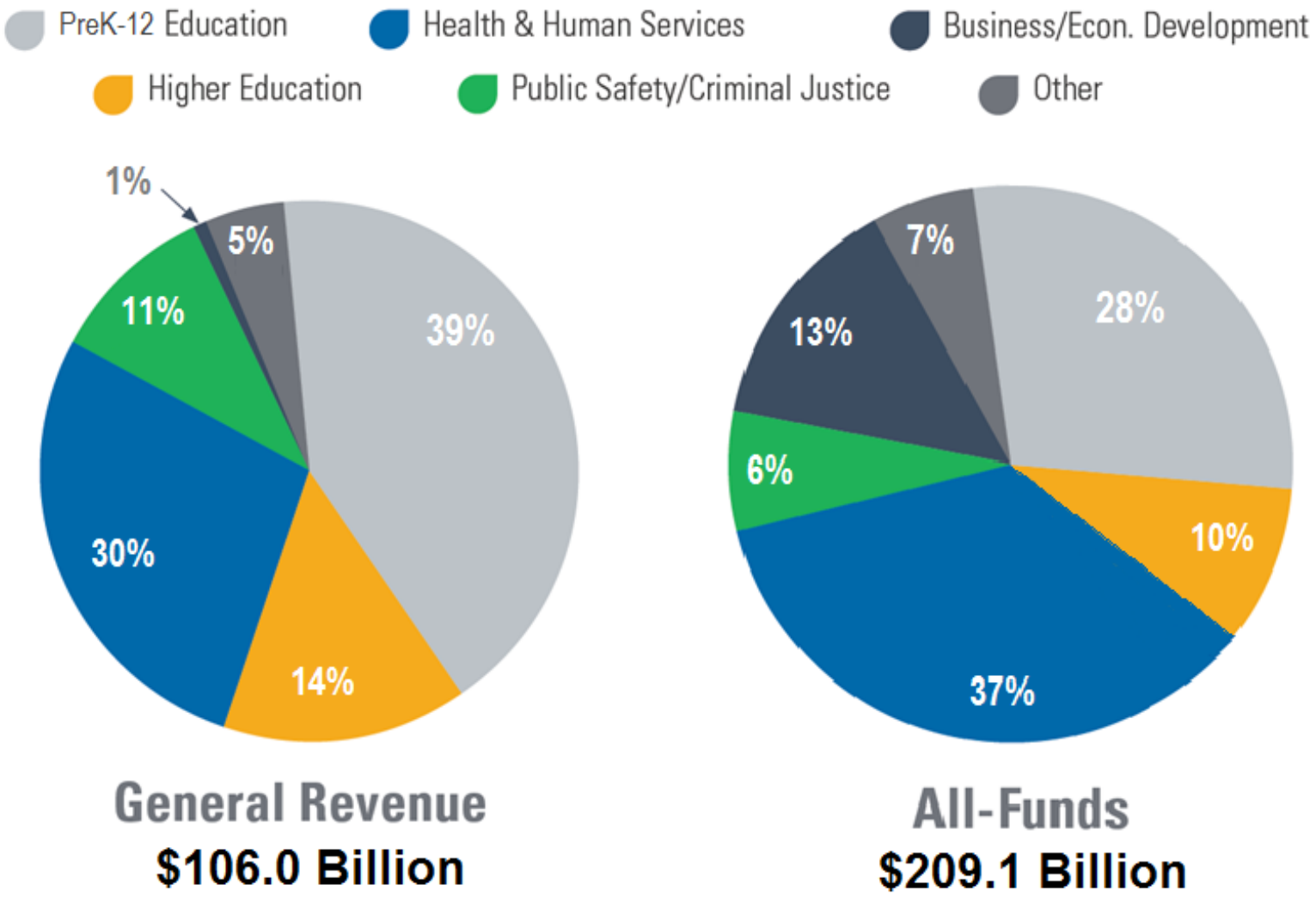
FIGURE 3
FUNDING BY ARTICLE, GENERAL REVENUE FUNDS



SOURCE: Legislative Budget Board.

2016-17 State Budget

Only with federal funds GAINED does HHS % exceed K-12 Public Education

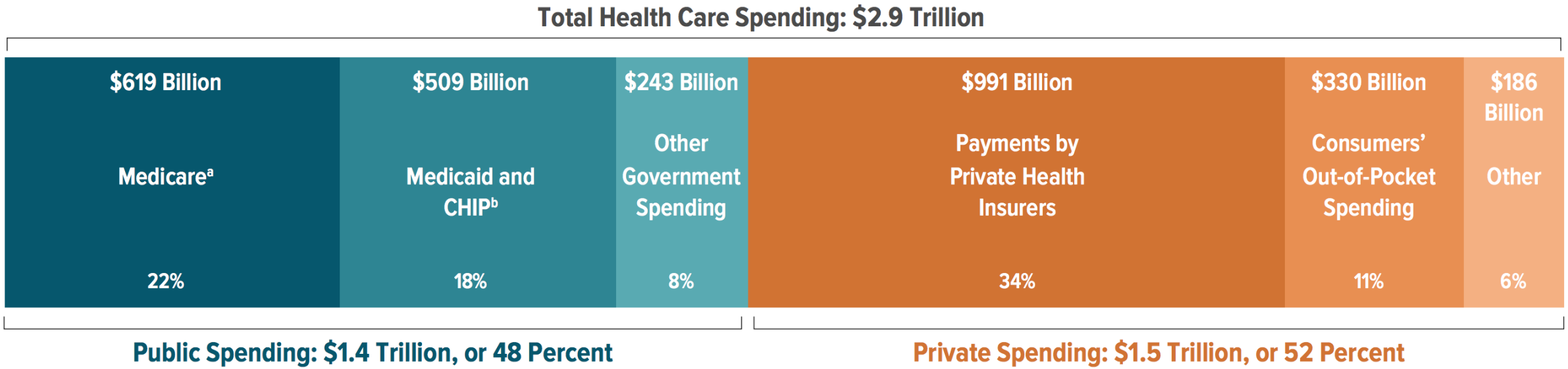


Source: Texas Legislative Budget Board, February 2016

Figure 3-1.

National Spending for Health Care, 2014

Total health care spending amounted to $2.9 trillion in calendar year 2014, about half of which was private spending. The federal government subsidizes a substantial part of that private spending, primarily through the tax exclusion for employment-based health insurance.



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

CHIP = Children's Health Insurance Program.

a. Refers to gross spending for Medicare, which does not account for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.

b. Includes federal and state spending.

What Can Change for Texans with a Medicaid Block Grant?

BENEFITS:

- Today kids can't be denied medically necessary care by Medicaid (no arbitrary limits, either).
- Adults are less protected under current law, but even these minimum benefits likely eliminated under BG.

AFFORDABILITY:

- Kids are exempt from co-payments, premiums, denial of care for non-payment in Medicaid TODAY.
- Adults today have upper limits on cost-sharing, plus no denial of care for non-payment in Medicaid below poverty (use of premiums, denial of care ONLY allowed in 1115 waivers). These limits likely eliminated under BG.

WHO IS COVERED:

- Current federal Medicaid law requires all kids to 138% FPL to get Medicaid (kids 138-206% FPL can get CHIP). Seniors and individuals with disabilities 75% FPL and lower incomes and pregnant women to 203% FPL covered.
- Eliminating entitlement for state and individuals likely; states can decide who to cover, have waiting lists.
- NO ability to improve coverage of Texans with disabilities on current wait lists for Long Term Services and Supports under Medicaid "waivers"

What Changes for Texans Under a Medicaid Block Grant?

RED TAPE:

- Current federal Medicaid law prevents states from cutting back on kid's coverage (income thresholds) or otherwise creating eligibility barriers.
- TODAY Medicaid Managed Care plans are subject to many consumer protections: network adequacy, due process, and more.

PROVIDER CHOICE AND PAYMENT:

- Freedom of Choice of Family Planning providers, Cost-based pay for Community Health Centers (FQHCs)

Per Capita Cap removes ONE harmful characteristic of the Block Grant: it allows funding for enrollment growth

With no federal "floor" in place, these and many other Medicaid standards may be eliminated.

AT RISK: ACA protections for all Texans with private insurance

- ✓ No copays for preventive care
- ✓ No annual or lifetime limits: won't "run out" of coverage if you get seriously ill
- ✓ Annual cap on out-of-pocket costs: protections from medical bankruptcy
- ~~✓ Young adults can stay on a parent's plan until age 26~~
- ✓ No waiting periods before insurance covers your pre-existing condition
- ✓ Right to appeal if insurer denies your care
- ✓ No skimpy plans that don't even cover hospitalization

AT RISK: More ACA protections

Small employer health plans and individual market insurance stand to lose:

- ✓ A guarantee of decent coverage: essential health benefits and mental health parity
- ✓ Fair premium prices
- ✓ Review of rate increases

Medicare enrollees stand to lose:

- ✓ No copays for preventive care (3.6 million Texans)
- ✓ Medicare more financially secure: the ACA extended the solvency of the Medicare Hospital Insurance trust fund by 11 years
- ✓ Help with costs for prescription drugs: prescription drug “donut hole” closed

AT RISK: ACA Medicaid innovations

- ✓Medicaid for Former Foster Youth to age 26;
- ✓Services for Texans with disabilities, (“Community First Choice”) and enhanced match
- ✓CHIP mega-enhanced match (92% federal)
- ✓Revamped Medicaid eligibility to make application and renewal simpler for families

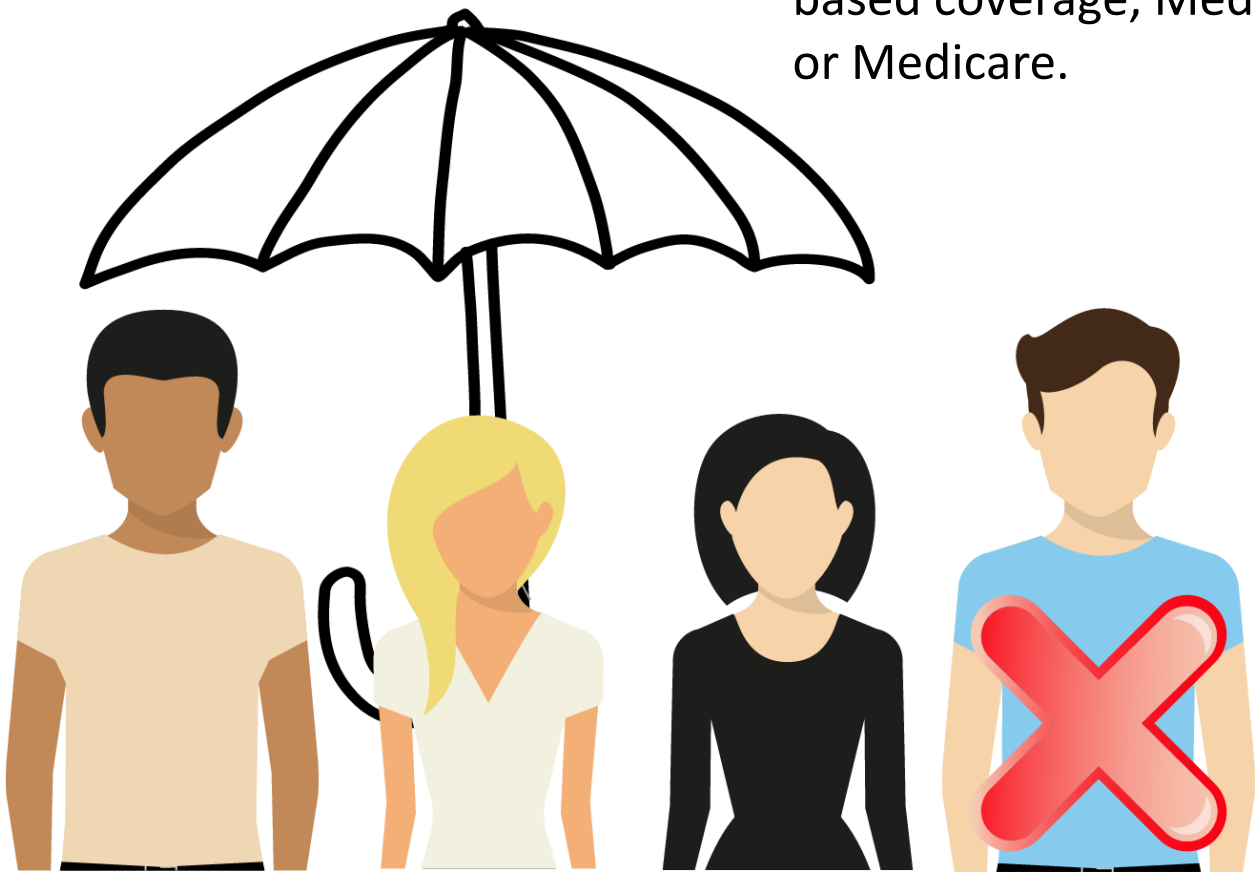
But Latest ACA Repeal Proposal:

- Cuts premium subsidies, no income adjusted subsidy; ends help with out-of-pocket costs.
- Allows adults 60+ to be charge 5X age 20

- So you can't be denied, but you likely can't afford coverage either.

27% of Non-elderly Texans Have a Pre-existing Condition

Many are protected today because they have job-based coverage, Medicaid, or Medicare.

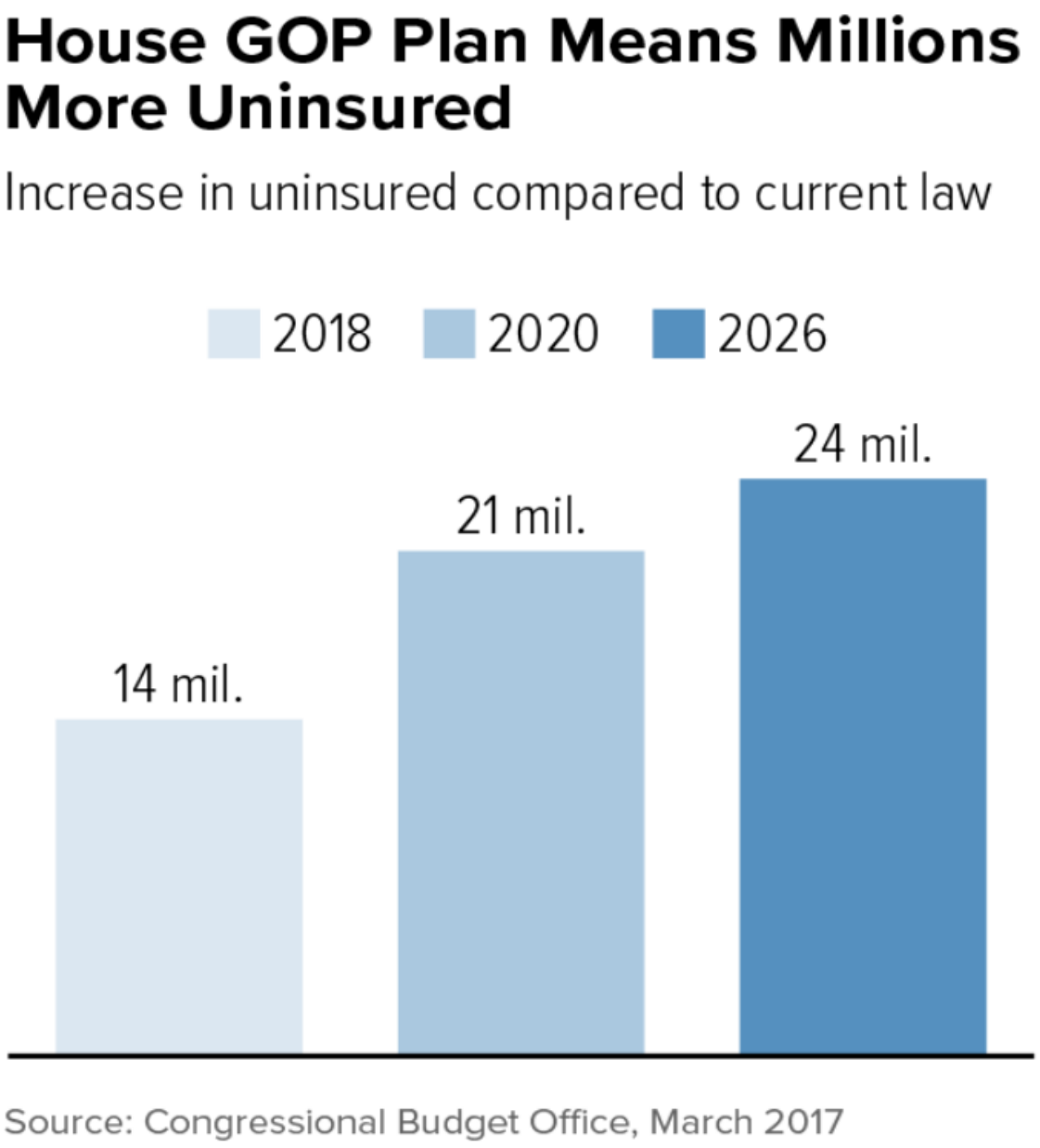


CBO Score:"AHCA" Repeal/Replace Bill, Medicaid

- The CBO's report shows:
  - 24 million more uninsured Americans by 2026, compared to current law.
    - 14 million more uninsured in 2018 (no change with Amendment)
  - By 2026 uninsured rate (under 65) grows from 10% percent today (where it is projected to remain if the ACA stays in place) to 19%.
  - People with lower incomes, ages 50-64, and rural residents hardest hit.
    - Funding that supports coverage for these groups today will be redirected primarily to large tax cuts that benefit wealthy households, as well as insurance companies and pharmaceutical companies.
  - Cuts Medicaid spending $880 billion/10 years; (18%) (Amendment: $839 Billion)
  - 14 million fewer people have Medicaid coverage nationwide by 2026, compared to current law. (no change)

High-Level Concerns: "AHCA" Repeal/Replace Bill, Medicaid

- Large reduction in subsidy adequacy for both premiums and out-of-pocket costs = Many will lose coverage
  - See KFF website tool: Lubbock , TX, Age 60, $30,000 income, subsidy drops from $10,600 to $4000 (63% reduction)
  - Family of 4 @ $25,000 gets same subsidy as family of 4 at $100,000
  - Family of 4 in Waco, TX gets same subsidy as family of 4 in San Francisco or Manhattan
- Pushing High deductible plans and HSAs but with no provisions for:
  - Sliding scale subsidies for the out-of-pocket costs , OR
  - Nor any way for poor and low-income families to get the money to fill the HSA and/or pay the deductible

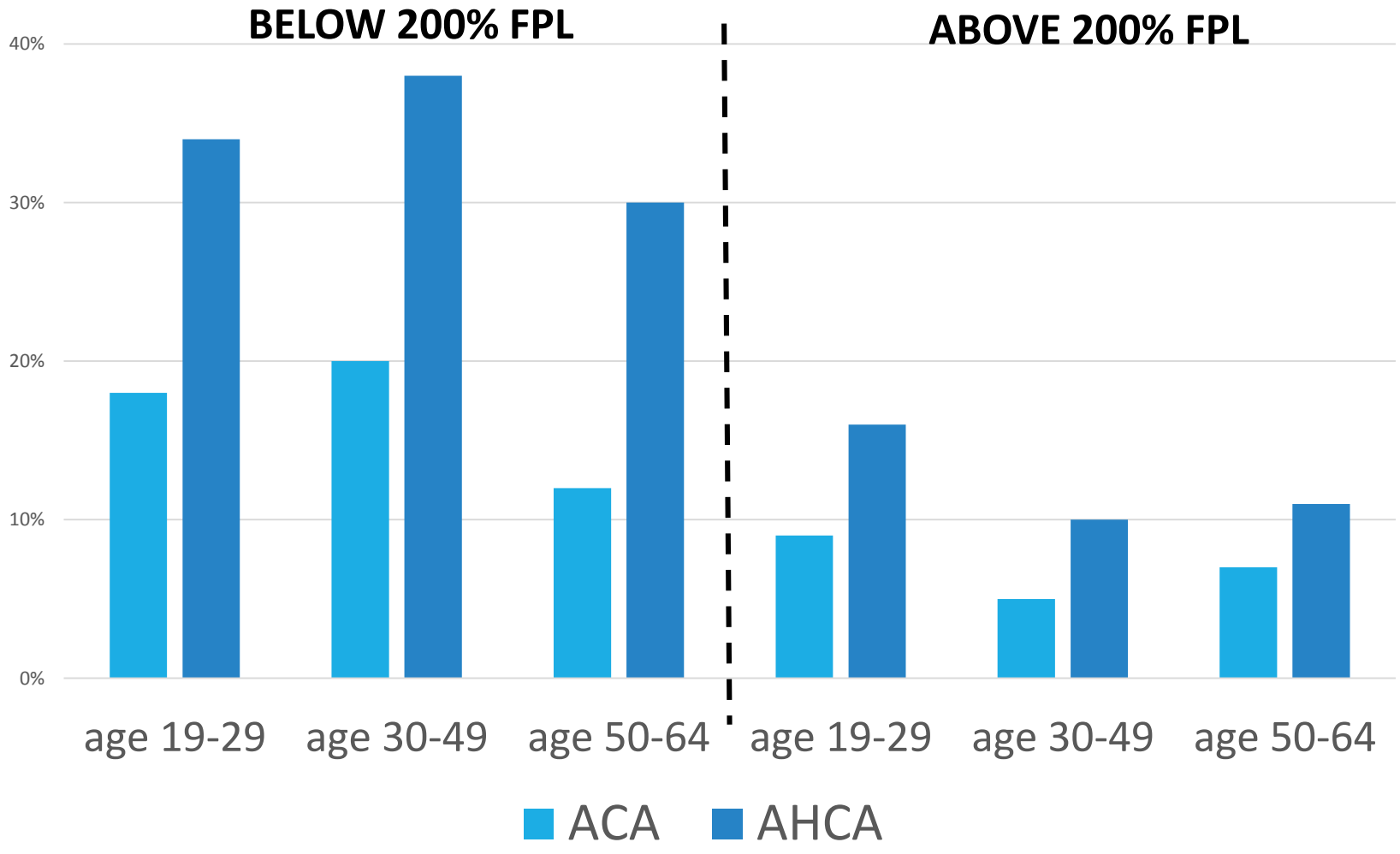


Person age 64 who earns $26,500 in 2026 would go from paying 6 percent of their income for premiums under the ACA

to paying more than half (55%) of their income for premiums under AHCA .

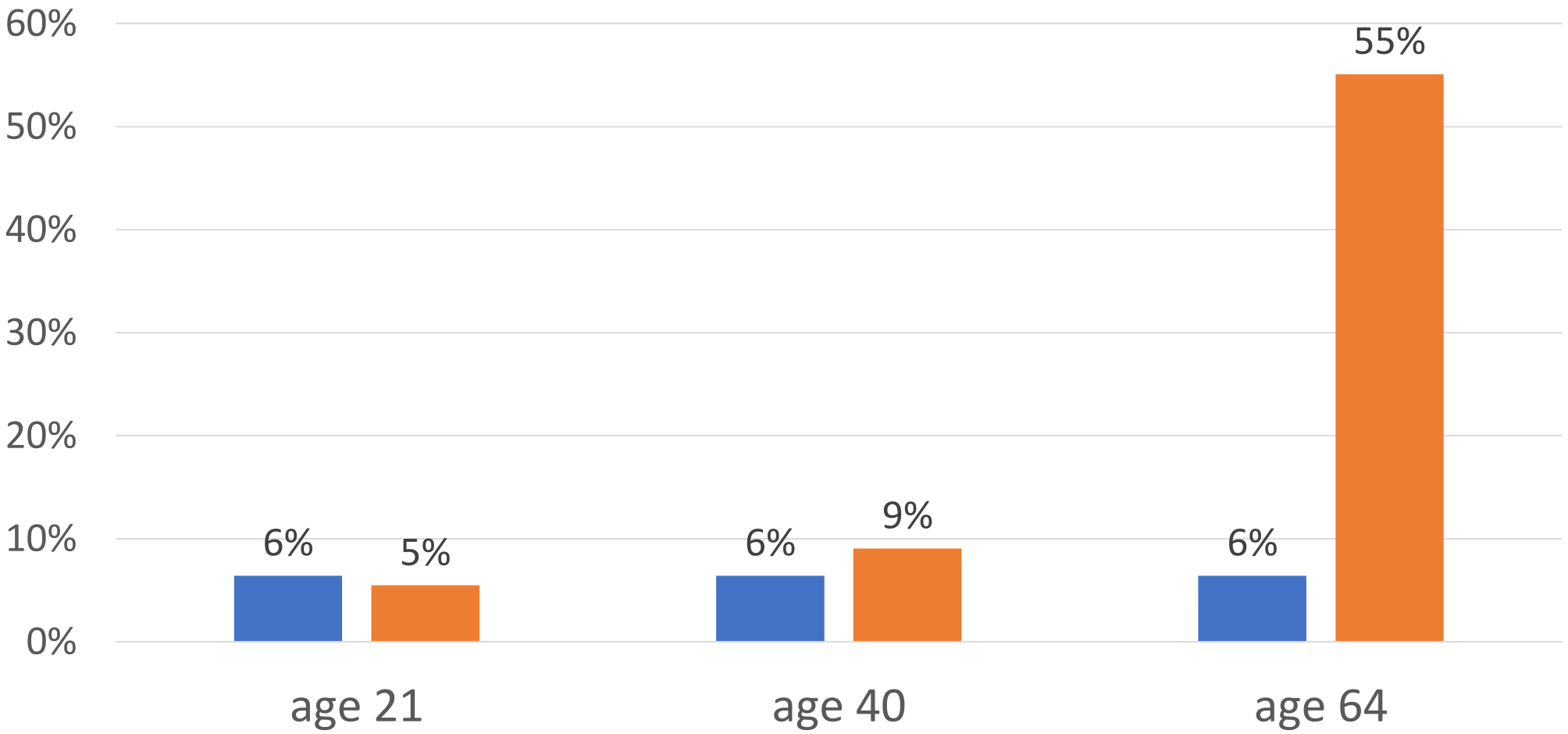
UPDATE: Even if $85 billion added for older Americans, average premium increase STILL more than 80% of the price hikes seen under the filed House bill.
US average 60-year-old with income of $22,000: premium increases six-fold, from $1,200 to $7,500.

ACHA Increases Uninsured Rates
Share of Nonelderly Uninsured Adults under ACA and AHCA, 2026



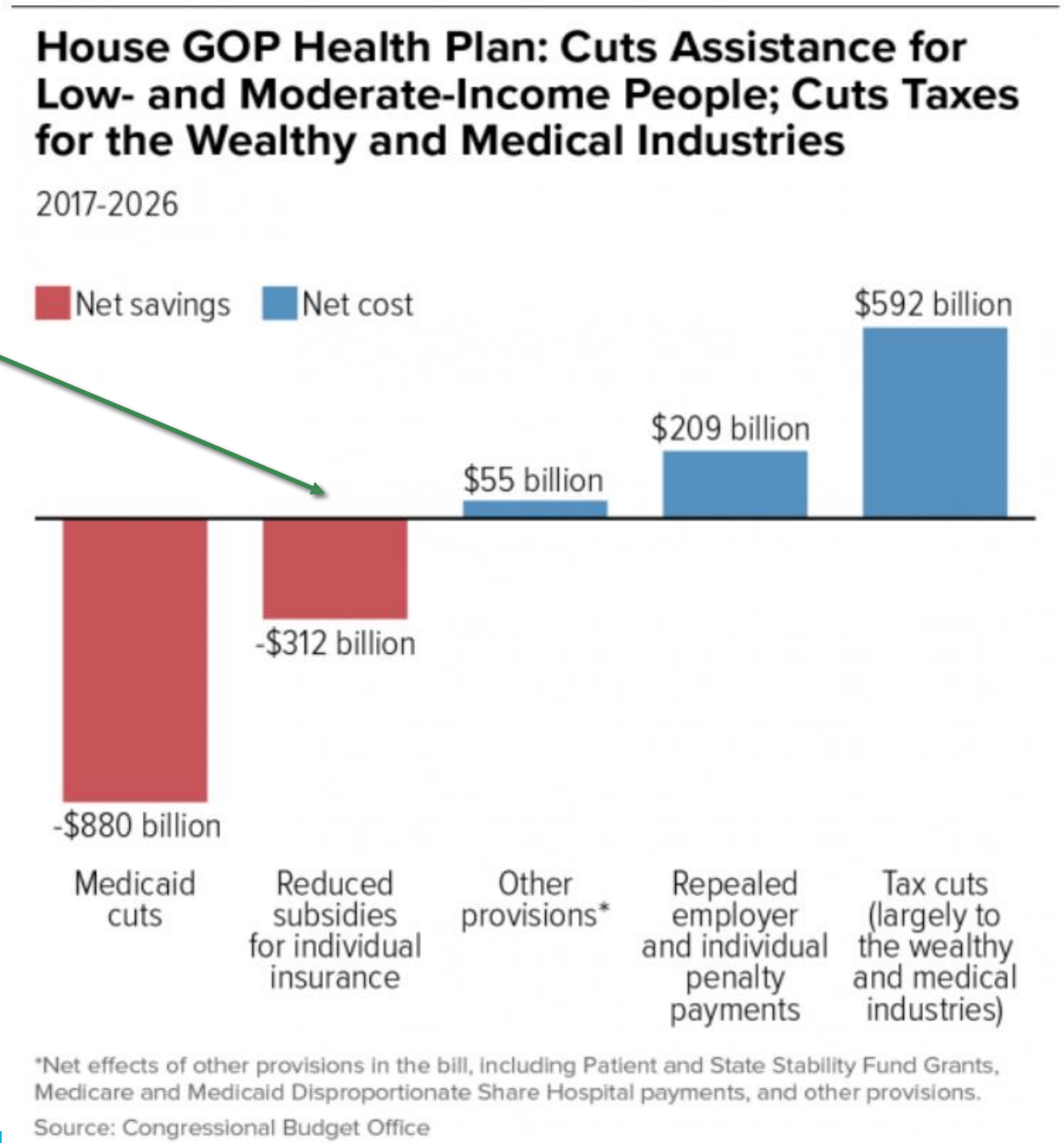
Net Premiums for Older and Poorer Skyrocket
Average projected share of annual income spent on net premiums (after tax credit applied) for individuals in 2026

Person making $26,500/year (175% of federal poverty level)



Subsidies cut from $673 billion ACA to $361 Repeal bill; 44% cut

- BUT the new $361 goes to different folks
- **Monday amendment** adds another $85 billion; **still a 34% cut**



Institute on Taxation and Economic Policy (ITEP) :

- 307,900 Texans get a tax break
- 74% of these are in the top 1% of incomes
- Average cut for top 1%ers is $4,350
- Texas tax cuts total $665 million

60 year-old Dallas county resident, $30,000 annual income

Loses 1/3 of ACA tax credit: drop from about $6,000 today under the ACA to a flat $4,000 under the House repeal bill.

Rural neighbors take a bigger hit: Same 60-year-old living in Cleburne, Bowie or Wichita Falls, where insurance prices are higher, would lose 2/3 or more of her subsidy

County	Credit ACA	Credit House Bill	Loss
Bexar (San Antonio)	$5,840	$4,000	-$1,840 (32%)
Guadalupe (Seguin)	$12,150	$4,000	-$8,150 (67%)
Dallas	$6,000	$4,000	-$2,000 (33%)
Wichita Falls	$15,300	$4,000	-$11,300 (74%)
Montague (Nocona)	$11,280	$4,000	-$7,280 (65%)
Travis (Austin)	$6,730	$4,000	-$2,730 (41%)
Brazos (College Station)	$11,870	$4,000	-$7,870 (66%)
Tom Green (San Angelo)	$14,390	$4,000	-$10,390 (72%)

Top Medicaid concerns with the repeal bill:

Medicaid Per Capita Cap funding: "Radical Restructuring"

- **New funding would launch in 2020.**
- Formula calculates average, per-enrollee cost in 2016 Texas Medicaid for each of four groups:

  (1) children;

  (2) elderly;

  (3) disabled (includes children eligible on basis of disability);

  (4) non-expansion adults (pregnant women, small number of parents in Texas, former foster care youth).

  (5) If Texas cover adults up to 133% under the Medicaid expansion option, a fifth group could be created, using same per-capita average cost as group (4) adults.

Top Medicaid concerns with the repeal bill:

Medicaid Per Capita Cap funding: "Radical Restructuring"

- Several kinds of 2016 state Medicaid spending NOT in the Per Capita Cap "buckets": Admin, DSH, Emergency Medicaid, FP Waivers, HIS, Medicare Savings, MBCC, CHIP, VFC

- Treatment of Texas 1115 waiver funds: **AMENDMENT** clarifies: *"funding for all non-DSH supplemental payments in 2016 is included under the allotment calculation."*

2016 costs per category get M-CPI updates (M-CPI + 1% for 2 & 3 under Manager's Amend.):

(per-enrollee cost in 2016 for each bucket) X (Actual number enrollees in that bucket)

Total of the above, for all 4/5 groups = aggregate state cap

- **IF STATE EXCEEDS CAP, FED FUNDS IN THE NEXT YEAR GET REDUCED TO RECOUP**

Top Medicaid concerns with the Per Capita Cap

- Under Per Capita Cap, if federal funds are inadequate, our Legislature's history indicates they will cut benefits, payment, or enrollment in response—not fill the gap with state funds—to pay for the federal recoupment of funds.
- Rigid use of a 2016 Medicaid spending for a "base year" will lock Texas and other states into permanent inadequate provider networks.
- If the make-up of Texas Medicaid enrollees in one of the four Per Capita Cap enrollment groups changes over time to have more intensive needs—e.g., for our elders or Texans with disabilities—we will be unable to meet their needs, and it will take an act of Congress to fix a too-low funding cap.
- Limits to 2016 **benefits** also make our Medicaid funding allocation too low to allow us to adopt best treatment practices and standards of care without first cutting elsewhere. (e.g., Hep C Rx; ABT for Autism, adult dental)

Medicaid Provider Payments

*Though many complain about Medi**care** physician payments, they are annually adjusted.*

Texas **Medicaid** physician payments have not had annual updates for over 20 years

- Annual updates frozen in 1993 and never resumed
- Since then, 3 legislative increases (99, 2001, 2007) and 4 cuts (2003, 2010, 2011, 2012)

Medicare Payment Advisory Commission estimates physician practice costs grow an average of 3% annually as a result of changes in practice expenses, such as salaries, rent, and other overhead costs.

Hospital payments are more complex, but like physician rates they stopped getting regular updates in the 1990s and pay far less than actual costs (average 55% for inpatient, 72% for outpatient).

Allowing provider rates to fall further and further behind actual costs of care has been a budget-balancing tool, which takes a toll on access to care.

Per Capita Cap formula Locks In all of Texas Medicaid reimbursement policies, AND turns any correction into a zero-sum fight: to fix one problem, you must cut elsewhere.

More Concerns: Repeal Bill Medicaid Restructuring

- Non-Medicaid expansion states like TX: new expansions only at "regular" match rate (not 90+% as in ACA)
  - **AMENDMENT**: No new expansion states until 2020.
- Texas would have gotten a net gain of fed Medicaid funds of $6 to $9 billion a year with Medicaid expansion
  - The "safety net fund" for non-expansion states is $2 billion a year SPLIT AMONG 19 STATES
- For Medicaid expansion states, phases down the enhanced match rate through
  1. No new folks get match after 12/31/2019, and
     a) **AMENDMENT**: No enhanced match in states that expand after 3/1/2017
  2. "Churn": Expansion adults must renew coverage every 6 months (down from 12)
  3. Gap in coverage of over 1 month drops that beneficiary down to "regular" match rate
- Minimum children's Medicaid coverage income threshold dropped to 100% FPL (from 133% FPL); states "may" move kids above poverty to CHIP.
- Lose enhanced match for Community First Choice; No way to add ~200,000 on waitlist for Long term services and supports in Texas Medicaid waivers

Monday Night "Manager's Amendment"

States could add **work requirements** to Medicaid for "nondisabled, nonelderly, non-pregnant adults" as a condition of receiving coverage under Medicaid.

States that pursue new Medicaid expansion will not get enhanced match at all.

State **option to take their Medicaid funding as a lump-sum block grant** rather than a per-capita capped allocation. (More specifics of the Block Grant structure, next slide)

New York County Spending Excluded. Would exclude from the Per Capita Cap formula Medicaid spending by New York county governments other than New York City.

Increases Medicaid Per Capita Cap inflation factor for the elderly and disabled: from CPI-U Medical to CPI-U Medical +1.

Adds funding, which MAY be used by Senate to boost tax credits for older Americans, estimated $85 billion. Still leaves the bill's net cut to ACA tax credit value at 34% (down from 44% in first draft), and does not address the lack of geographic or income adjustments at all.

Moves the repeal of Obamacare's tax increases by one year **earlier**.

Restricts rolling unused tax credit money into health savings accounts (to ease concerns of anti-abortion groups)

Monday Night "Manager's Amendment"

State **option to take their Medicaid funding as a lump-sum block grant** rather than a per-capita capped allocation.

- Option for Block Grant, 10-year increments, 2019 cost base, CPI-U
  - Can use CHIP match rate, but total fed dollars does not change**. THIS WOULD LOWER THE STATE'S CONTRIBUTION TO COVERAGE!!!!!**
- CANNOT include seniors or people with disabilities in Block Grant
- Can choose to Block Grant **children** and/or **pregnant women**
- Can choose to simply **eliminate coverage of parents**
- States only be subject to minimum income eligibility requirements for children and pregnant women (133% for 6-18; 133% for maternity)
- States could cut benefits for children, pregnant women, parents. (No EPSDT.) Minimum standards do not include primary or preventive, other than prenatal.
- States could also charge unlimited premiums, deductibles, and co-payments
- States likely could also deny coverage through enrollment caps or waiting lists

Thursday Night Changes

1 . Repeal Essential Health Benefits

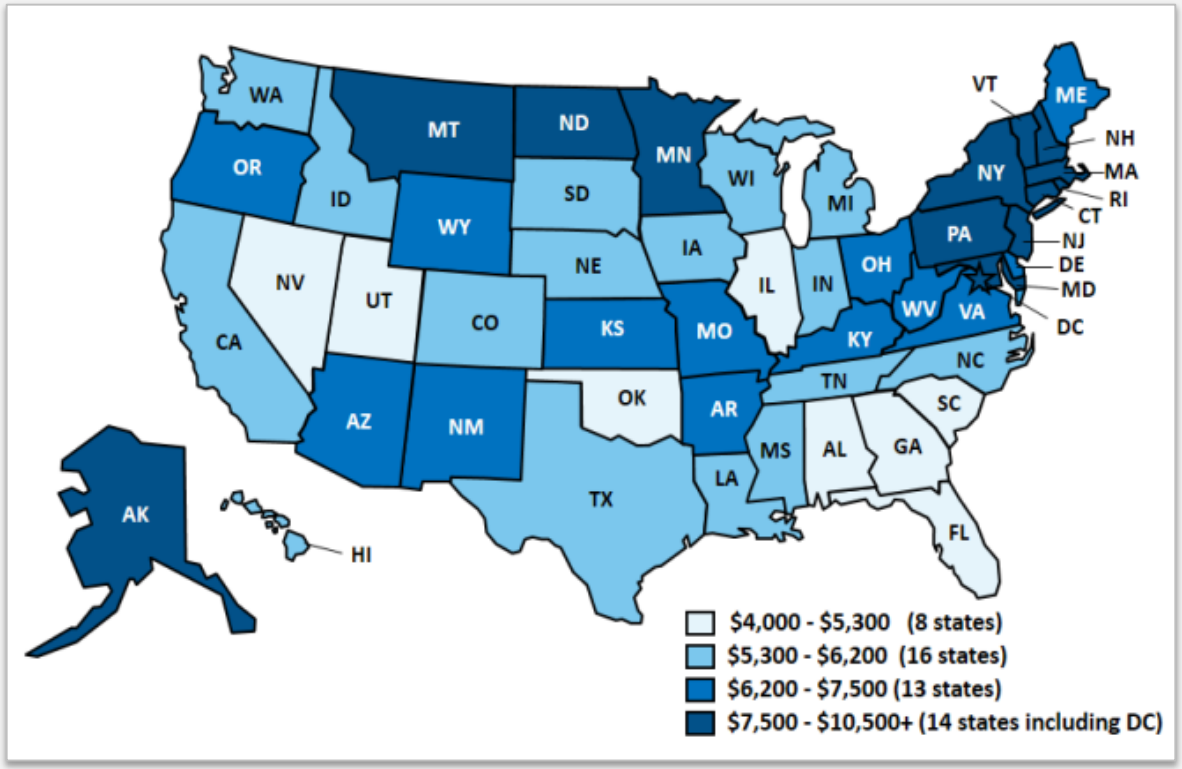
2. Add $15 billion to the stabilization fund, which Rep Murphy apparently is claiming as funding he obtained for mental health (despite the fact that repealing EHB will undermine mental health and substance use coverage)

3. Delay repeal of the Medicare high income tax by 6 years (presumably to pay for the repeal of EHB

Capped Funding: Locks in Disparities Across States

Capped funding freezes in historic differences in spending

Spending Per Full Medicaid Enrollee, FY 2011



Source: Rudowitz, R., Garfield, R., and Young, K., "Overview of Medicaid Per Capita Cap Proposals," Kaiser Family Foundation, June 2016. Available at: http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief

Texas Enrollee Medicaid Spending Varies by Category

State Ranking of Medicaid Spending (Federal and State) per Full Benefit Enrollee, FY 2011

#	Total		Children		Adults*		Disabled		Aged	
1	MA	$11,091	VT	$5,214	NM	$6,928	NY	$33,808	WY	$32,199
2	NY	$10,307	AK	$4,682	MT	$6,539	CT	$31,004	ND	$31,155
3	RI	$9,541	NM	$4,550	AK	$6,471	AK	$28,790	CT	$30,560
4	AK	$9,481	RI	$4,290	AZ	$6,460	ND	$28,692	NY	$28,336
5	DC	$9,083	MA	$4,173	VT	$6,062	DC	$28,604	DE	$27,666
11	MD	$7,878	**TX**	**$3,010**	KY	$5,055	OH	$21,892	MN	$25,030
22	VA	$6,477	MA	$2,528	**TX**	**$4,371**	VA	$18,952	MS	$18,592
26	KS	$6,267	TN	$2,470	OH	$4,225	**TX**	**$17,709**	KS	$18,328
36	**TX**	**$5,668**	IA	$2,116	WI	$3,765	MT	$16,352	TN	$15,745
40	HI	$5,506	LA	$2,082	OK	$3,551	LA	$15,099	**TX**	**$14,739**
47	AL	$4,976	NV	$1,940	FL	$2,993	MS	$12,960	CA	$12,019
48	FL	$4,893	MI	$1,926	CA	$2,855	KY	$12,856	UT	$11,763
49	IL	$4,682	IN	$1,858	NV	$2,367	SC	$12,830	IL	$11,431
50	GA	$4,245	FL	$1,707	ME	$2,194	GA	$10,639	NC	$10,518
51	NV	$4,010	WI	$1,656	IA	$2,056	AL	$10,142	NM	N/A
U.S. Average		**$6,502**		**$2,492**		**$4,141**		**$18,518**		**$17,522**

* Includes low-income parents and pregnant women.

- Texas' spending per enrollee was 36th overall, though spending per enrollee varied by eligibility category
- Texas spent more than most states on Children ($3,010 vs. US, $2,492)
- Texas spent less than most states on the Aged ($14,739 vs. US, $17,522)
- Texas' Adult and Disabled spending were on par with national averages

Source: Manatt analysis of Kaiser Family Foundation data. Available at: http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/
New Mexico's spending per aged enrollee was not available.

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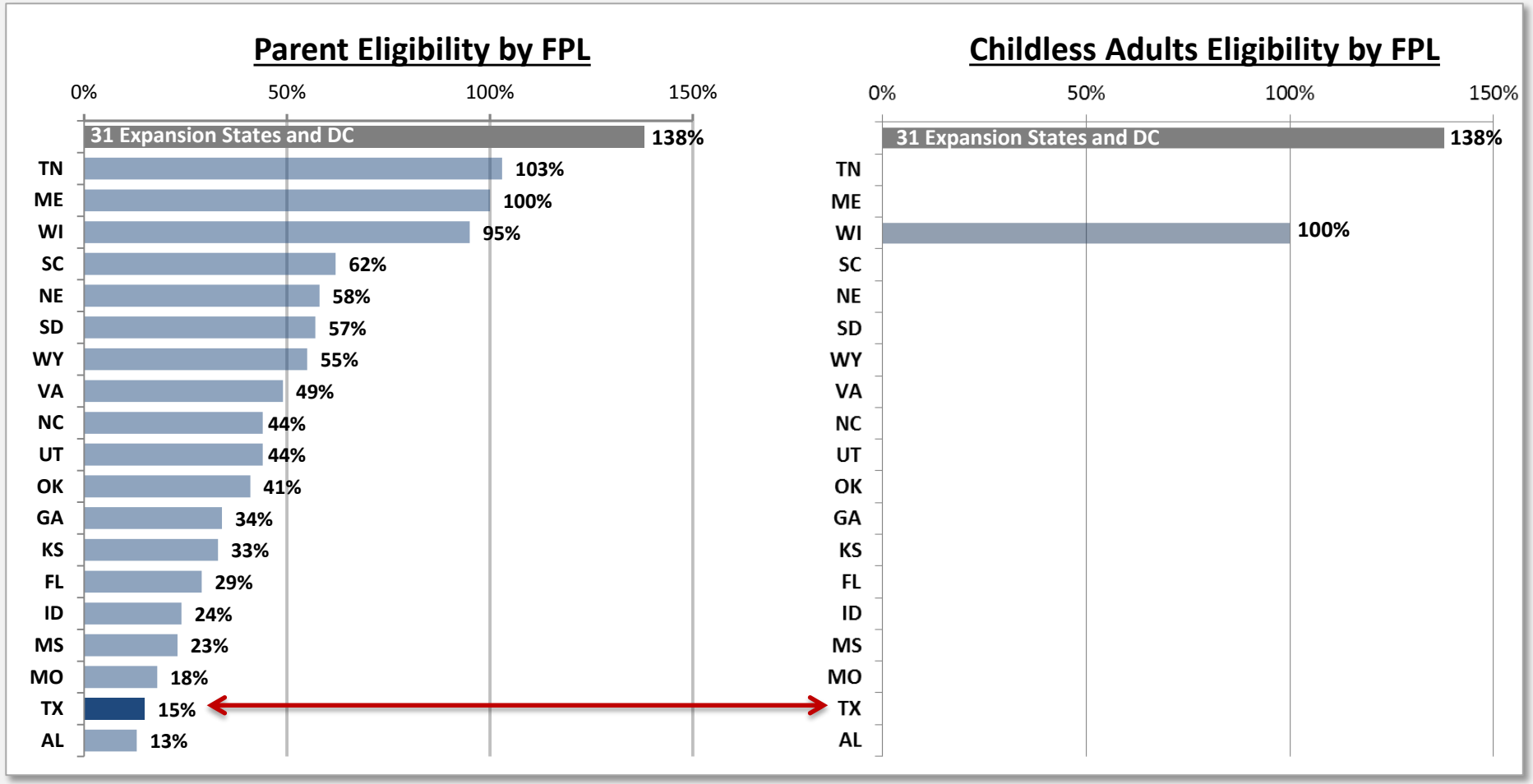
Texas Has the Second Lowest Eligibility Levels in U.S.

Medicaid Income Eligibility Levels Across States in 2017



Source: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html

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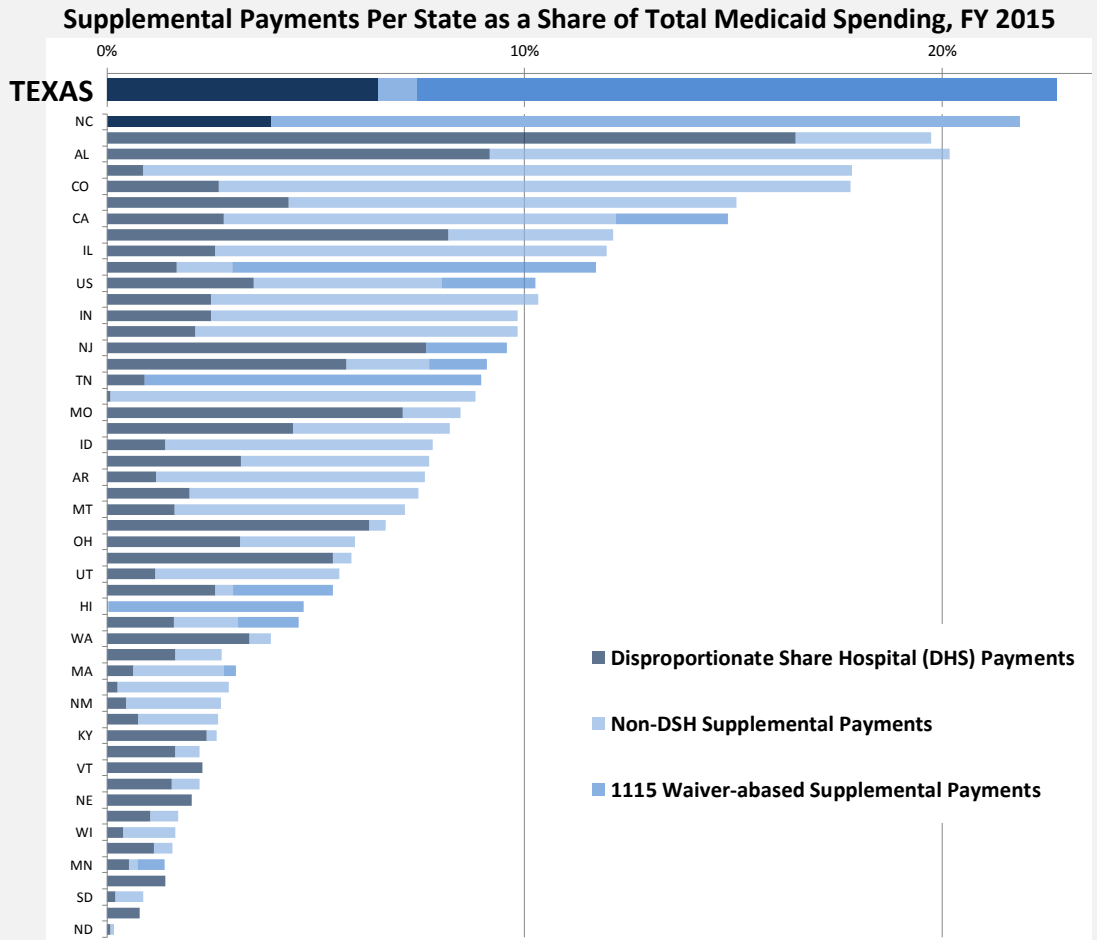
Capped Funding, Waivers, and Supplemental Payments

Supplemental payments are a major revenue source for Texas hospitals, but treatment of supplemental payments under funding caps is unclear



Texas spends the greatest percentage of total Medicaid dollars on supplemental payments and waiver funds of any state.

Supplemental Payments account for:

- **1 in 4** Medicaid dollars spent
- **53%** of Medicaid payments to hospitals participating in DSH and waiver programs

Source: Mann, C., Bachrach, B., Lam, A., and Codner, S., "Integrating Medicaid Supplemental Payments into Value-Based Purchasing," The Commonwealth Fund, November 2016. Available at: http://www.commonwealthfund.org/publications/fund-reports/2016/nov/medicaid-supplemental-payments. MACPAC, 2016, analysis of CMS-64 FMR net expenditure data as of May 24, 2016 and CMS-64 Schedule C waiver report data as of August 2, 2016.

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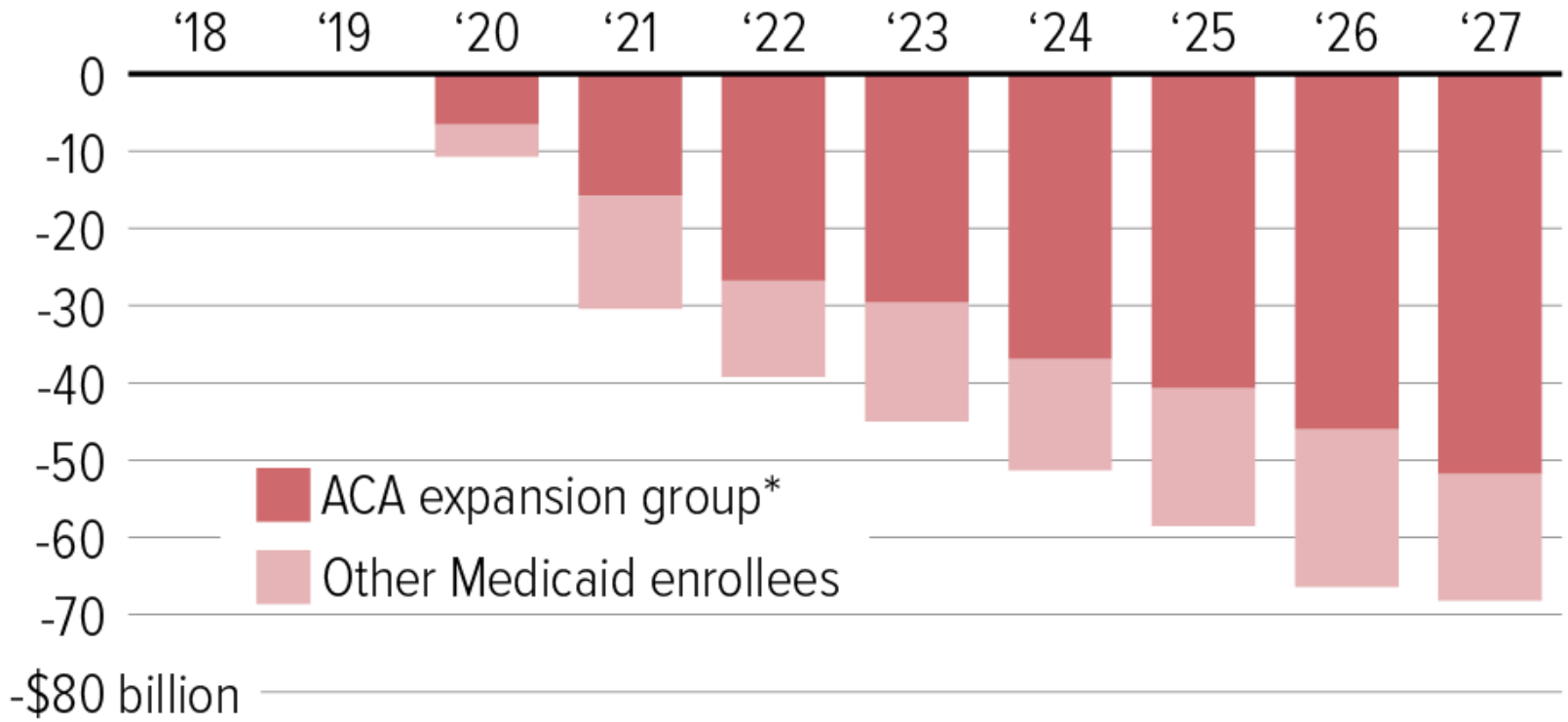
Medicaid Cost Shifts in House GOP Plan Would Total an Estimated $370 Billion Over 10 Years and Grow Over Time

Cost shifts to states, relative to current law



*Enrollees under the Affordable Care Act's Medicaid expansion

Source: CBPP analysis using Jan. 2017 Congressional Budget Office Medicaid baseline and inflation estimates from CBO and the Centers for Medicare and Medicaid Services

High-Level Concerns: "AHCA" Repeal/Replace Bill, Medicaid, New federal administration

Immigrant Access to Health Care in Texas

- Actual changes in lawfully present eligibility proposed in the AHCA bill
- Families that include undocumented members are frightened to access basic care as more stories of deportation circulate
- Even permanent residents frightened to use ACA coverage, Medicaid, CHIP:
  - *"consumers want to cancel their Marketplace plan, Medicaid, CHIP, SNAP because they heard that if they applied these benefit from government, they will be deported. And most of our consumers are legal immigrants (most of them are green card holders or waiting for their green card)."*
  - *"we have suddenly had an influx of calls and/or cancellation of appointments. This has been due to a concern that immigrants will be deported because their children are enrolled in Medicaid and/or that their citizenship application process will be terminated or denied because they are receiving Medicaid benefits."*
- 2.4 million Texas children (34%) live in a family with one or more non-US citizen parent (only 317,000 of these kids are themselves non-citizens)

High-Level Concerns: “AHCA” Repeal/Replace Bill, Medicaid, New federal administration

Immigrant Access to Health Care in Texas

- 20 years of federal standards and rights related to non-citizens may either be repealed or unenforced
- Resources are limited and dwindling to support outreach, education to immigrant communities

What to Do: Block Grant/Per Capita Cap/ACA Repeal

Watch for CPPP, Cover Texas Now emails (and others) for DETAILS on US House Medicaid, ACA Repeal/Replace proposals and Texas Impact.

Educate Texas Legislators, Mayors, County Judges on the expected impact of ACA repeal/replace, as well as Medicaid Block Grants or Per Capita Caps--past the talking points. Call on Texas lawmakers and staff to engage with our Congressional delegation to protect interests of Texans.

Others:

1. Call, meet with, email Texas US Senators and your Congressperson
2. Get on Cover Texas Now emails and web site to keep up with the latest
3. Follow NASW, too! And CPPP.org

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- **Connect**
- **Support**

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BUDGET UPATE

SUPPLEMENTAL APPROPRIATIONS BILL (HB 2)

House Appropriations considered a Supplemental Appropriations bill on March 16th to address shortfalls in fiscal year 2017 and some funding needs in the 2018-19 biennium.

- A total of $5.2 billion All Funds (AF) would be appropriated, $3 billion for 2017 and $2.3 billion for 2018-19.
- $2.5 billion is appropriated from the Economic Stabilization Fund (ESF or Rainy Day Fund), which is projected to grow to $12 billion by the 2018-19 biennium (if not tapped).
- The appropriations for 2017 would remain below the spending limit for the 2016-17 biennium.

Article II (Health and Human Services)

- $930 million ESF is appropriated for the Medicaid shortfall ($2.6 billion AF).
- $22 million ESF ($51 million AF) partially restores rate reductions for Medicaid therapy services assumed in the Cost Containment Rider for 2016-17.
- Critical needs at the Department of Family and Protective Services (DFPS) are funded with $181 million ESF for 2017, 2018 and 2019.
- $50 million ESF is appropriated for forensic bed capacity.
- $1.2 million ESF is available for newborn screening at the Department of State Health Services.

GENERAL APPROPRIATIONS ACT (GAA) FOR THE 2018-19 BIENNIUM

The Senate Finance Committee voted out the Committee Substitute for SB 1 on March 22nd, with a grand total of $106.3 billion General Revenue (GR) appropriated. The Senate Bill meets the "Pay-as-You Go" budget requirement and remains within the Biennial Revenue Estimate by delaying the transfer of $2.5 billion slated for the Highway Fund until September 2019. SB 1 is expected to be on the Senate floor on March 28th.

The House Appropriations Committee has wrapped up decisions for the Committee Substitute for the GAA, but has not yet voted the bill out of Committee.

Senate Finance Committee - Committee Substitute SB 1

- In total, $1.4 billion GR ($2.9 billion All Funds) has been added in Article II to the Senate's Introduced Bill.
- The Introduced Bill held the Medicaid caseload to the 2017 level.
- The Health and Human Services Commission (HHSC) requested $3.1 billion GR ($7.5 billion AF) to maintain Medicaid cost and caseload growth.
- The Committee Substitute adds $1.7 billion GR ($3.4 billion AF) for Medicaid acute and long-term care caseload growth; cost growth is not provided.
- A number of riders, however, reduce this appropriated amount.

- The Cost Containment Rider now includes a reduction of $410 million GR ($1 billion AF) for the biennium (see p. 42 in the link that follows for the text of the rider).
- There are new riders that direct reductions included in the $410 million:
    - Reduce the risk margin in managed care premiums from 2% to 1.5% ($105 million GR, $252 million AF for Medicaid and $0.8 million GR, $11 million AF for CHIP) (p. 44).
    - Assume prescription drug savings related to changes proposed in Senate Bill 1922 ($35.5 million GR, $120.8 million AF) (p. 48).
    - Assume savings for fraud, waste and abuse related to Senate Bill 1787 ($17 million GR, $39 million AF) (p. 63).
    - Improve managed care contract procurement (no dollar amount specified) (p. 48).
- Funding for the Healthy Texas Women program is reduced by $180 million GR, assuming HHSC will seek and receive federal matching funds at the 90: 10 federal : state ratio for the 2019 fiscal year (p. 50).
- No changes were made to the rider appropriating trauma funds for safety net hospitals.
- GR for Children with Special Health Care Needs is reduced by 10% ($1.4 million).
- GR for Early Childhood Intervention Services remains at the funding level in the Introduced Bill ($282 million AF, which reflects a $5 million increase related to projected caseload growth).
- For DFPS, CHAT's rider related to assigning Child Protective Services (CPS) caseworkers to children's hospitals or specialty clinics was adopted (p. 15).
- Other riders of significance:
    - Adds $2.5 million GR in 2018 and directs HHSC to establish a one-time grant program to expand targeted case management and rehabilitative services for children in foster care.
    - Directs HHSC to evaluate and pursue all available flexibility from the federal government to waive, receive exemptions from, or delay federal requirements that impose a significant financial burden on the state (p. 43).
    - Directs HHSC, in coordination with the Higher Education Coordinating Board, to determine the best method for enhancing funding for Graduate Medical Education through Medicaid (p. 52).
    - Directs HHSC to calculate the medical education add-on for hospital rates each fiscal year using the most recent indirect medical education adjustment factor finalized by CMS.
    - Directs HHSC to conduct an audit of administrative expenditures made by managed care organizations in Medicaid and CHIP (p. 45).
    - Directs HHSC to conduct a study of Medicaid managed care rate setting processes and methodologies in other states (p. 47).
    - Directs HHSC to review options for decreasing neonatal intensive care unit costs, increase prevention and reduce incidence of neonatal abstinence syndrome and evaluate options for reducing maternal mortality (refers to hospital level of care designations for neonatal and maternal care)(p. 54).
    - Directs HHSC to develop performance metrics to hold Medicaid managed care organizations accountable for the care of clients with serious mental illness and allows HHSC to develop and procure a separate managed care program in at least one service area aimed at serving individuals with serious mental illness (p. 69).
    - Directs HHSC to review policies and procedures related to coordination of services between dental maintenance organizations and managed care organizations (p. 55).
    - Directs HHSC to require all claims for therapy to include rendering providers national provider identification number (p. 61).

- Directs HHSC to review the coordination of services for children receiving therapy services from both school districts and other Medicaid providers (p. 56).
- Adds $5 million contingent on passage of SB 267 that creates a Hospital Perpetual Care Account for licensing and regulation of hospitals (p. 67).
- Requires DSHS to implement a program improvement process for the Vaccine for Children and the Adult Safety Net Programs.

- The Article IX provision in the Introduced Bill for a 1.5% reduction to GR across all agencies was deleted.
- Link to Article II riders: http://www.lbb.state.tx.us/Documents/Appropriations_Bills/85/Senate_Adopted/SFC_Article_II_Riders_Adopted.pdf

House Appropriations Committee- Committee Substitute HB 1

- In total, the Committee reduced appropriations for Article II by $795 million GR, $2 billion All Funds (AF), compared to the Introduced Bill. You may recall the House's Introduced Bill exceeded the Comptroller's Biennial Revenue Estimate by $4 billion.
- GR for DFPS increased by $172 million ($271 million AF), but funding to HHSC was reduced by $966 million ($2.3 billion) and funding to the Department of State Health Services (DSHS) by $1 million (GR/AF).
- A rider reduces funding for Medicaid by $1 billion GR ($2.4 billion AF) and directs HHSC to pursue flexibility from the federal government to reduce the cost of services (p. 8 of the rider package at the link for Article II that follows).
- The amount of reductions in the Cost Containment rider (p. 9) also increases by $11 million GR to $111 million GR for the biennium ($244 million AF), and actions to effect an increase in experience rebates has been added to the menu of cost containment options.
- Article IX (General Provisions) further decreases Medicaid funding, with a rider reducing appropriations by $500 million GR over the biennium for savings related to "Contract Cost Containment." There's a long list of reviews and procedures agencies must undertake. It means a $450 million GR reduction to HHSC (pp. 5-9).
- No changes were made to the rider appropriating trauma funds and GR for safety net hospitals (which fills in the gap in available trauma care funds).
- GR for Early Childhood Intervention Services remains at the funding level in the Introduced Bill ($282 million AF, which reflects a $5 million increase related to projected caseload growth).
- CHAT's rider related to CPS caseworkers in children's hospitals or clinics was adopted.
- Finally, in Article IX the Committee adopted a rider that attempts to force the Legislature to use the ESF for the Supplemental Bill.
  - If the Supplemental Bill does not include at least $2.47 billion from the ESF, certain GR appropriations for 2018-19 will be reduced.
  - The list totals $4.6 billion GR and covers critical health and human services programs, including:
    $1.4 billion for Long-term Care at HHSC
    $152 million for CHIP
    $263 million for CPS Critical Needs
    $261 million for Women's Health programs
    $63 million for Behavioral Health
  - The other significant items are $1.4 billion for the Foundation School Program, $900 million for Higher Ed Special Items, and $43 million at the Governor's Office (p. 4 in the following link).

- Link to the adopted riders for Article II: http://www.lbb.state.tx.us/Documents/Appropriations_Bills/85/Adopted_Decision/Art_II_Riders_Technical.pdf
- Link to the Article IX riders: http://www.lbb.state.tx.us/Documents/Appropriations_Bills/85/Adopted_Decision/HAC_Art_9.pdf