Children's Health Coverage Coalition Meeting Agenda
Friday, March 15th, 2019
11:00 A.M. – 1:00 P.M.

Present:

Anne Dunkelberg, CPPP
Laura Guerra-Cardus, CDF-TX
Clayton Travis, TPF
Ryan Lowery, TPF
Adriana Kohler, TCFC
Helen Kent Davis, TMA,
Cindy Ji, CDF-TX
Michelle Romero, TMA

On Conference Line:

Betsy Coats, Maximus,
Kate Hendrix, THA
Celia Kaye, LWVT
Christina Phamvu, MHM
Melissa McChesney, CPPP
Denise Gomez, Children's Health - Dallas
Stacey Wilson, CHAT
Jennifer Banda, THA

Meeting Chair: Christina Hoppe, CHAT

Meeting Scribe: Arinda Rodriguez, CPPP

I. Introductions (Christina Hoppe, 5 minutes)

II. Legislative Update (Clayton Travis, 15 minutes)

[Clayton Travis]

As a reminder, we are meeting every Thursday for Adriana's maternal and child health subgroup. Please email Adriana if you would like to be part of those meetings since this is where we go in depth for each piece of legislation.

[Anne Dunkelberg]

We are using a conference phone now so the quality of the calls has improved.

[Clayton Travis]

In terms of the Budget, we are focused mostly on ECIs, Medicaid and CHIP, and DSHS funding as it relates to women's health.

- On the Medicaid front, the supplemental bill is working its way through the process. Not much to report. Includes cost accumulation but not case load.
- For ECI, $7.2 billion additional dollars appropriated in the house budget, Chairman Davis has been a strong supporter of ECI and has been the one mainly ensuring those dollars are there.
- Senate conversations about Article 2 in the budget are happening, but we have very little information on them. In particular, I have no indication from Nelson and Kolkhorst on ECI. I have send information to assuage the concerns of these Senators regarding the problems they believe ECI has.
- DSHS: Full funding for maternal health exceptional items, on the House side. We don't know what the Senate has envisioned there. Women's Health programs have received over and about funding.

[Adriana Kohler]

There was an exceptional item for substance-use disorder funded through HHSC Exceptional Item 21, the ask is 45 million and in conversations with Article 2, that would get contractors about 75 percent of costs, so Davis made HHSC go back to tell her how much it would actually cost. As a result they increased the Exceptional Item, 51 million over exceptional item, from which a portion of that would go to women providers. We are making that push.

[Clayton Travis]

Regarding our Policy Priorities:

Children's health coverage bills: HB 342 and SB 637, Cortez and Zaffirini bills – The hearing went really well, many of the members noted support for the bills. There was an emphasis on the fact that children were being left without coverage due to 4,000 procedural reasons, and only 400 cases were about actual income.

We are meeting on Thursdays and Fridays to think about next steps and target members questioning the importance of the bill. Sen. Frank has stated he's not quite there, and that he will need more lobbying for convincing, he needs to be persuaded. Chairman Davis has signed on as joint author to the bill. Fiscal appropriations support for the bill are $5 million.

Email Laura Guerra-Cardus for information on the in-depth strategy meetings.

- Autoenrollment bills: Aimed at auto-enrolling young women into Healthy Texas Women.

There have been a lot of good meetings with public health members, this bill should be cost neutral, eventually it may have an initial cost due to more women joining the HTW, but a study showed that there could be $50 million in savings through this bill.

[Adriana Kohler]

We are still getting Republicans onboard; Davis's office is looking for additional support.

[Clayton Travis]

Have you talked to Kyler?

[Adriana Kohler]

Yes.

[Clayton Travis]

- Maternal health coverage: The idea is to ensure that women post-partum and pre partum have access to coverage but the main focus has been on the post-partum.

Is there a hearing coming up on health next Tuesday? HB 744 by Rose proposes a straight 12-month extension, that is something that we should be supporting.

[Adriana Kohler]

Are they looking for testimonies?

[Helen Kent Davis]

They reached out to TMA and we've been working on this.

[Clayton Travis]

Reach out to Rose's office is you wish to support that bill.

The senate has not given any indication that the 12-month extension is something that they want to do. There will be some negotiation there because the Senate is not quite there.

[Anne Dunkelberg]

HB 4204 was filed by Jessica Gonzales on Friday and it moves to end Texas current situation that does not extend coverage to legal permanent adults. The main group that would benefit would be pregnant women. I will send out more information for that. We will reach out when we need people.

[Clayton Travis]

- Medicaid Managed Care (MMC): There are many bills, about 52, that relate to MMC, we have sent out that list so you can track them yourself. They range on issues on consumer, fair hearings, specific populations, they're all over the place. We facilitated a quick meeting of advocates who are part of the MMC consumer protection work group to discuss all the bills. We focused on two bills, Rep. Frank and Kolkhorst bills. Ask me [Clayton Travis] for specific numbers. They are focused mostly on provider oriented improvements, to ensure that physicians and hospitals are not overburdened with red tape so they can come on board of providing services, but because it has focused on that summit it doesn't have all consumer facing reforms. Davis' and Watson's bills, HB 2453

and SB 1139, focus on the consumer-facing reforms. I would suggest that not everything on the bill is final and that many things can be added or removed, in case you are interested in a particular piece that you would like to dive into for that bill and provide feedback. The Raymond and Klick bill is also another bill to look into.

[Anne Dunkelberg]

My intention is to, a week from now, have a much better global understanding of the range of things that are in these bills and the priorities pertinent to my work, I will then be sharing.

[Helen Kent Davis]

We've been working with hospitals and providers on Frank's bill. Our organization has focused on improving care coordination. However, this bill is not meant to just be for providers, its open to anybody and can be open to amendments. Reducing red tape is huge reason why we're doing it, it's not exclusively for providers at all.

[Clayton Travis]

Also, 2 bills have been brought up during the Thursday meetings. HB 85, Romeo and Juliet laws as it relates to minors having relationships with non-minors. They are allowed to do it within 3 years apart, however they currently state that the relationship has to be different sex, and discriminates same-sex relationships. HB 85 aims at taking that provision out. It is also an ethical burden when it comes to reporting on behalf of children. The other bill is HB 937 and it relates to birth control.

III. Follow-up on Medicaid and CHIP caseload decline (30 minutes)

[Anne Dunkelberg]

We did get some of our data, but I don't think we got a chance to discuss it on this meeting. We've been discussing it, however, during our Thursday and Fridays

Big take-way: We have enough data to clarify the significant portion of kids who get terminated every month due to the periodic income checks. Of the kids who get terminated, 92 percent are due to procedural reasons and 8 percent due to actual income. We submitted questions to HHSC when we got the data, but we have not gotten answers yet. The presentation that Melissa did last month, we have used that information about the increased uninsured rate and the decline in Medicaid/CHIP enrollment, in our work for the children's health coverage bills as rationale for doing those bills.

[Melissa McChesney]

We got the new uninsured rate from the census data that shows a statistical increase in uninsured rate for children in the last decade and we now have the highest uninsured rate in the country. Keep in mind that these are conservative estimates.

Our partners at the Georgetown University Health Policy Institute Center for Children and Families, they have a good blog post that provides a national perspective on how in 2018 there was a drop in enrollment of children. We are probably going to continue seeing this drop when we get 2018 census data.

[Refer to Slide 5]

If you look at HHSC or CMS data, although it's not the same data, it is similar and both show a decline in 2018 on Medicaid enrollment, specifically on children enrollment.

Main take-away: We have seen a downward rate on Medicaid enrollment and the impact of this in Texas, but if you are interested in other eligibility groups, like pregnant women, they are also seeing a downward trend as well.

[Refer to Slide 19]

Left side shows Texas Medicaid based on income levels. While you do have these fluctuations on the application rates, overall the trend has gone down a little bit, but if you look at the number of renewals, the trend line is much more drastic in the decline. To us this is an indication we have number of people coming to the door, but we don't have the same number of children staying on the program. We're having a large amount of turn over for kids on Medicaid, because their 2nd 6 months-eligibility are not continuous. It is another indication of the anecdotal information we've received from the ground.

[Anne Dunkelberg]

Did it already occur to us to put a reference to decline data in the Q&A for Rep. Frank?

[Melissa McChesney]

Yes.

[Adriana Kohler]

The pushback that I get when we talk about the Medicaid enrollment decline is, a) that's a good thing, b) maybe that means that more parents are getting employer sponsored coverage. I know we can refute that with the rising uninsured rates, can we also refute that with employer sponsored coverage data?

[Anne Dunkelberg]

We can look and see, and it's worth checking in changes to ECI data.

[Christina Hoppe]

Since national trends are declining, I am wondering if there are other national trends that would also impact the rate of insurance?

[Melissa McChesney]

Anti-poverty program rhetoric and anti-immigrant could also be in the mix.

[Anne Dunkelberg]

Melissa's slide makes a reference to the extension of renewals in CHIP in relation to Harvey. That also hit at the same time when people thought CHIP was disappearing, that's the other factor I can think off. With over a quarter of our children in mixed status immigrant households, the potential of the chilling effect could be playing a role as well.

Also, we did make a note last month that we were going to ask if they would put former foster care and CHIP P data separately to make sure we have those numbers?

[Melissa McChesney]

There is some data on CHIP P, but it is an average over a fiscal year

[Anne Dunkelberg]

As we move ahead with our continuous flow of data requests with HHSC, we will add CHIP P and former foster care data.

IV. Budget Presentation from HHSC (Trey Wood, 30 minutes)

[Trey Woods]

A lot of what you are going to see is part of the presentations we've used in the Preparations and Appropriations Committee.

[Refer to Slide 3]

Below is a budget overview that speaks in particular to all funds expenditures and what we've requested.

Over 81 percent of our funding goes directly to Medicaid client services.

Very small percentage goes to the indirect administration.

Over 90 percent of the budget goes to client services.

[Refer to Slide 4]

In terms of supplemental needs, just for Medicaid and CHIP services, we are projecting 1.9 billion additional revenue.

[Refer to Slide 5]

Impact of HB 30 from the 2017 legislative session:

Scenario 1: Need to provide $565 million and $1.9 billion

CHILDREN'S HEALTH COVERAGE COALITION
FORMERLY THE CHIP COALITION

Scenario 2: We have to delay the MCO payment.

The difference between scenarios is the $780 million, and that is the rough amount of what we spend on MCO every month.

SB 500 and HB 4 include sufficient funding for HHSC. Supplemental appropriations include those funds, so we will probably be experiencing Scenario 1.

However, cash flow projections estimate that HHSC will not be able to make payments to Medicaid providers beginning May 2019. We may not have money to make payments by the end of May ~ early June.

Also, cost growth is not funded, so every time we get out of session we will be having some supplemental need. But there was an additional issue, $563 million were transferred and it impacted the agency, which is why it's included in our supplemental funding.

[Refer to Slide 6]

This slide is a comparison between our LAR, HB 1, and SB 1.

The biggest changes in the General Revenue between what we submitted in the LAR and the bills are the inclusion of FMAP

Regarding Medicaid recipients per month, we've included estimated caseloads. This is never about right or wrong, rather differences on time.

[Refer to Slide 7]

$110 million: We transferred money from Medicaid to other needs-based programs (cash-need response programs) assuming that it will be made whole once more through the supplemental funding.

Not included: Facilities short falls.

[Refer to Slide 8]

This is a high level overview of key budget drivers.

Cost growth has averaged a lower percentage than national trends. 1.5 percent on cost growth, trailing behind national trends

[Refer to Slide 9]

We see case load declines from Medicaid and CHIP programs, we did see people leaving. So we have children leaving Medicaid to CHIP, and then from CHIP leaving to Medicaid.

[Question]

Has HHSC identified any factors about why caseloads may be reduced?

[Trey Wood]

It's the economy, the Texas economy is doing extremely well, we have a historic low unemployment rate and that impacts enrollment rates.

[Laura Guerra-Cardus]

How does that align with the data we are seeing, that we are having rising child insurance rates, which seems to suggest that the lower case load may be causing/contributing to that rising number?

[Trey Wood]

There's certainly that potential, we've looked at the variables that we can look into. The problem is what the agency can do on that front, we can't make people apply. Medicaid looked at something, the number of people has not really changed but the renewals are declining. We attribute this to the economy.

[Anne Dunkelberg]

Our hypothesis is that the economy can be one of the factors, but we also hypothesize that the 6-month enrollment might also have something to do with it as well as the chilling effect of immigration rhetoric. We do feel that we need to have a conversation with the agency on their role in providing good information to families. 26 percent of kids have a non-citizen parent, so our hypothesis is reasonable

[Trey Wood]

As the budget guy, our perspective is more focused on numbers and those issues tend to focus more on the programs' issues of the agency.

[Helen Kent Davis]

We hear from providers that this is happening all over the state.

[Laura Guerra-Cardus]

The trick is that when we provide an explanation of why we are seeing these trends and we only mention the improving economy, without pointing out the HHSC data that indicates there are many children losing coverage due to procedural reasons. That can lead members with a very simpler explanation, disregarding those bigger picture variables.

[Trey Wood]

Periodic income checks have been going on since ACA. That data is already baked in, occurring, and normalized in the data, and now you see a change that may be independent of periodic income checks.

[Anne Dunkelberg]

Children's rates flatten out in 2014.

[Adriana Kohler]

I appreciate that this is an updated forecast. I wonder if you have a breakdown by population group in Medicaid that you can provide for us?

[Trey Wood]

Yes we can definitely do that.

[Refer to Slide 10]

A lot of what we are seeing is that FMAP is increasing in the state. However, other states are catching up with Texas. Texas is not necessary doing anything special

[Refer to Slide 11]

Decline in caseloads is what we are seeing now in 2018-19 and there's discussion on why it's happening. Again, we attribute it to the economy.

[Refer to Slide 12 and 13]

This is a high level overview of caseload and cost growth summary

Change in the CHIP FMAP is going down because the enhanced portion of that is going away, it will be cut in half in 2020, and the remainder is leaving in 2021. The state will be picking up a larger percentage of the tab.

[Adriana Kohler]

What's the percentage?

[Trey Wood]

I can send it to you.

The very last numbers at the bottom, you can see fairly low cost growth in the Medicaid program, about 1.5 percent case growth.

[Anne Dunkelberg]

My coworker Eva De Luna Castro has taken these charts and adjusted the per recipient expenditure for one of the inflation factors, and it does show a significant decline in spending per recipient. We point to that because that it is a sign that extreme measures have been taken to control the costs. I can send this to you.

[Trey Wood]

That is always good, to have to look at what is driving the increase in cost growths.

[Refer to Slide 14]

Good news, compared to national average we are lower on Medicaid program cost growth.

V. Medicaid Managed Care Update on Fair Hearing Reform (Anne Dunkelberg, Christina Hoppe, Adriana Kohler, 30 min)

[Adriana Kohler]

We touched on this a bit during the legislative update, the two bills that are more comprehensive and deal with MMC issues is the Frank and Davis bills. Both have pieces around fair hearing process but in different ways.

The Frank Bill requires clear explanation of an adverse decision made by a health plan and requires the client to get their rights on how to do a fair hearing process, doesn't necessarily change the process though.

The Davis Bill does make a change in reform to the fair hearing. It adds an additional layer of appeals. Changes the beneficiaries' rights and different processes they can take. Watson put forth a companion bill.

[Anne Dunkelberg]

It creates a new process. Nationwide the fair hearing process has never been adjusted. fair hearings are not about enrollment but rather about the rejection of services and that there's no clinical component when those decisions are made. The states that have a clinical component appear to be states that already had some sort of process. The states that I've talked to, New Jersey and Tennessee, didn't see it as a panacea to have that, but they think it is a good addition. And it seems that in both of those cases it is something similar to the sort of framework that Davis put out in the sense of creating a clinically competent alternative to what happens in the HMO. On our meeting on Monday, we spoke with partners advocating for disabilities rights. Their concern was that somehow, if I go through this 3rd party arbiter and they vote for the HMO, they will make my chances worse during a fair hearing.

[Helen Kent Davis]

A good suggestion might be that you make IRO process voluntary, and it'd be up to the patient/patient parent to share the decision with the fair hearing,

[Christina Hoppe]

So like, making it up to the patient to decide to opt into the IRO and about sharing the outcome?

[Helen Kent Davis]

Yes. We had talked about it before, if we get data on the HMO appeal process, and the number of appeals of the health plans, it is a high number of denials.

[Anne Dunkelberg]

Maybe this can incentivize better behavior from the plans if they know their information on the IRO process might be public. Also, transparency and accountability measures are included in Davis' bill, we have to make sure that those are priorities we advocate for in the final bills.

[Helen Kent Davis]

One of the things I heard yesterday, on the internal appeals side, one of the plans has a process where rather than denying request for services, it just goes to an automatic review. You don't want to create an incentive for putting this process on hold.

[Adriana Kohler]

In this coalition, one of our priorities is care coordination. The end of Davis's bill includes many pieces that mirror our lege agenda very closely. Now, I remember you mentioned that.

[Helen Kent Davis]

Yes that is a best practice and plans are employing a practice where they can have service coordinators every so often during the week to help with that. The challenge is that, physicians will be inclined to only contract with only 2 plans so they don't have to deal with multiple/many service coordinators in their practices.

We're also looking into developing virtual networks as best practices. It is one thing to promote common language, but the best practice is going to vary tremendously by provider and hospital.

Also, I just stumbled across this, in the Medicaid pink book they have comparisons of case providers, care coordination, service coordinators, but you still have to make it very transparent for patients and parents on how to get to service coordinators

[Christina Hoppe]

We've heard from our children's hospitals that they feel they are doing a lot of the care coordination.

[Helen Kent Davis]

North Carolina has done a really good job with their care coordination model.

[Christina Hoppe]

If you're looking at SB 1191 by West, it is a standalone bill that would require HHSC to have qualified nurses in the process.

[Anne Dunkelberg]

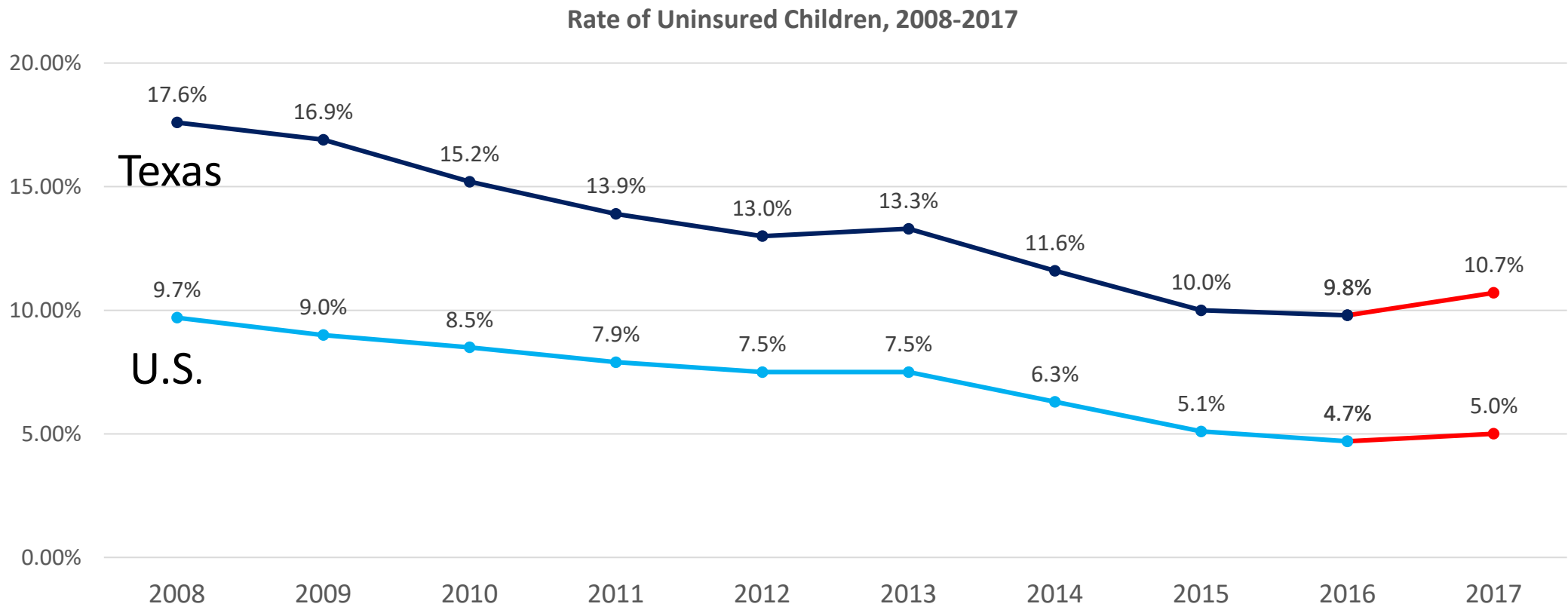
Watson also has a fair hearing bill, there's at least 5 bills focused on fair hearings.

As some better comparisons and announcements come up, we will be mindful to send them out through the list serv.

[Meeting adjourned at 12:37 pm]

Progress on Children's Health Coverage Reverses Course: Texas Worst in the Country

In 2017, for the first time since ACA was implemented, there was a significant increase in uninsured children.



~40% of uninsured kids in Texas are Eligible for Medicaid or CHIP

According to the US Census, in 2017 roughly 462,000 of our 835,000 uninsured kids are below 200% federal poverty income.

When we reduce that number to remove any immigrant children who are not eligible for Medicaid or CHIP, **an estimated 350,000 Texas kids are eligible but are not enrolled.**

Sources:

- https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html ; Table HI-10
- Number and Percent of Children Under 19 Below 200% of Poverty by Health Insurance Coverage and State: 2017
- https://www.migrationpolicy.org/data/state-profiles/state/demographics/TX
- https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/TX

CMS Enrollment Data
Dec 2017 – Oct 2018

All

State	State Expanded Medicaid	Total Medicaid and CHIP Enrollment, December 2017 (Preliminary)*	Total Medicaid and CHIP Enrollment, October 2018 (Preliminary)	% Change December 2017 to October 2018	Number Difference December 2017 to October 2018
Texas	N	4,446,935	4,333,994	**-3%**	**-112,941**

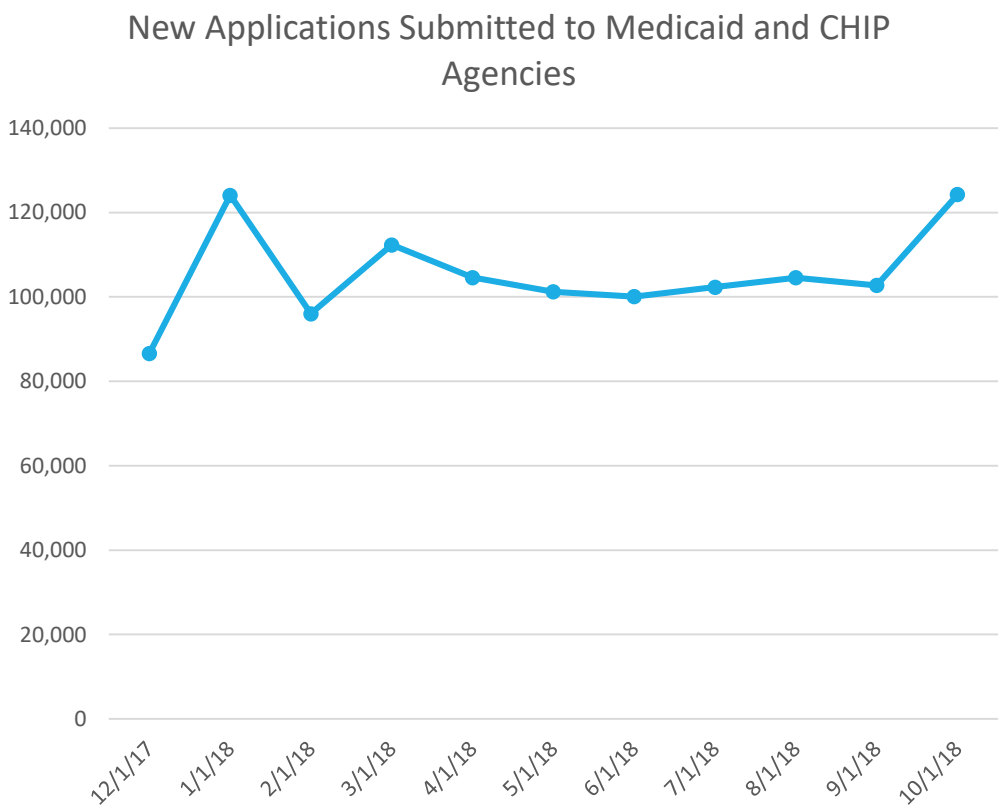
Children

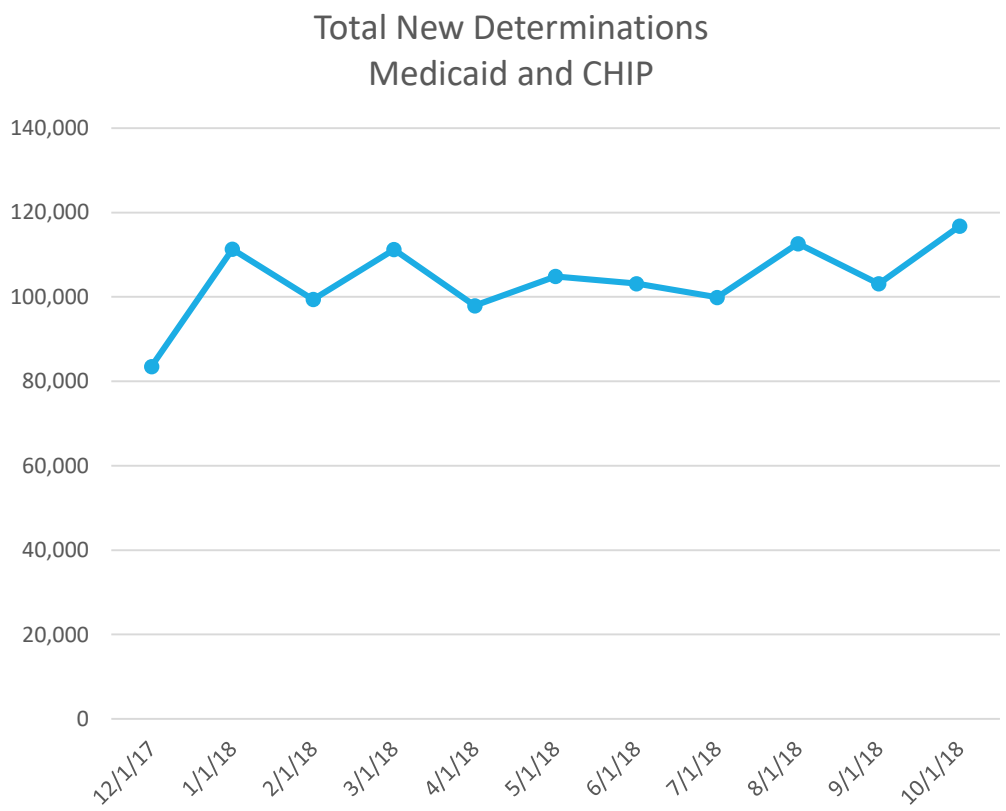
State	State Expanded Medicaid	Medicaid and CHIP Child Enrollment, December 2017 (Preliminary)	Medicaid and CHIP Child Enrollment, October 2018 (Preliminary)	% Change December 2017 to October 2018	Number Difference December 2017 to October 2018
Texas	N	3,529,641	3,422,390	**-3%**	**-107,251**

Texas' Enrollment in Medicaid and CHIP dropped for children and in the general population in 2018.

CMS Data on Incoming Application and New Determinations in Texas

(All ages. This should not include renewals.)





Based on this data, decline in enrollment would seem to be a result of fewer renewals not a reduction in applications.

HHSC Data
Dec 2017 – Oct 2018

All

Month	All Medicaid and CHIP Caseload	Change from Previous Month
Oct-18	4,376,573	5,723
Sep-18	4,370,851	(4,472)
Aug-18	4,375,322	(495)
Jul-18	4,375,817	413
Jun-18	4,375,404	(21,681)
May-18	4,397,086	(14,321)
Apr-18	4,411,407	(18,974)
Mar-18	4,430,381	(17,537)
Feb-18	4,447,918	(22,485)
Jan-18	4,470,403	(9,554)
Dec-17	4,479,957	

Overall
(103,384)
a decrease of 2.38%

Kids

Total CMA & CHIP	Change from Previous Month
3,306,443	5,442
3,301,001	-2,741
3,303,741	882
3,302,860	-3,022
3,305,882	-18,694
3,324,576	-13,396
3,337,972	-20,389
3,358,361	-14,105
3,372,466	-18,176
3,390,642	-13,979
3,404,621	

Overall
(98,178)
decrease of 2.88%

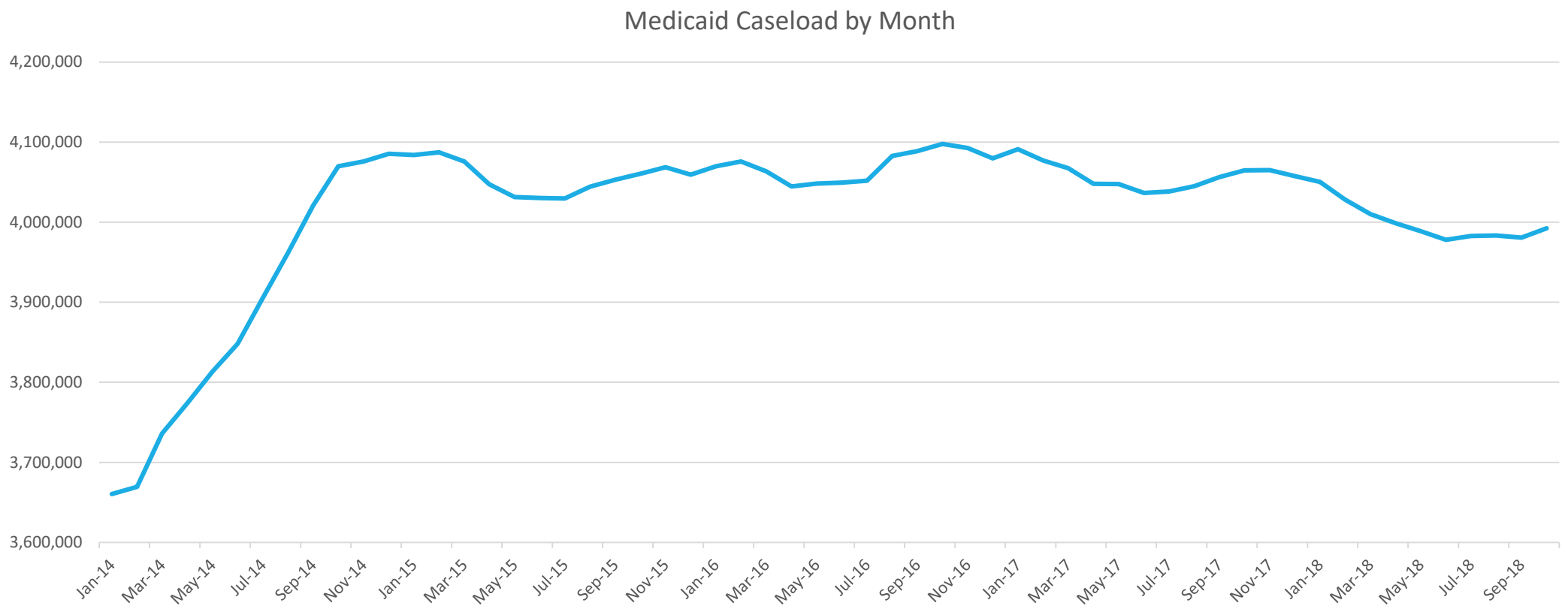
- While the enrollment data reported by CMS is not apples to apples with this data the numbers are close and the decline trend tracks with both data sets.
- HHSC data used for this presentation is available at: https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics

Main Takeaways – HHSC Data

1. Overall Medicaid caseload increased in 2014 due to ACA but has trended downward in recent years.
2. Due to income standard changes from the ACA **that shifted kids from CHIP to Medicaid,** CHIP enrollment dropped significantly in 2014 and has trended upward since.
   - Note: Postponement of renewals by HHSC in late 2017 (amid the federal CHIP funding fight) could mask any enrollment decline from 2017-2018.
3. Aged and Medicare-Related enrollment goes up and down throughout each year but overall does not seem to be trending downward.
4. Former foster-care youth and CHIP-P are not included in posted data.

HHSC – Entire Medicaid Caseload

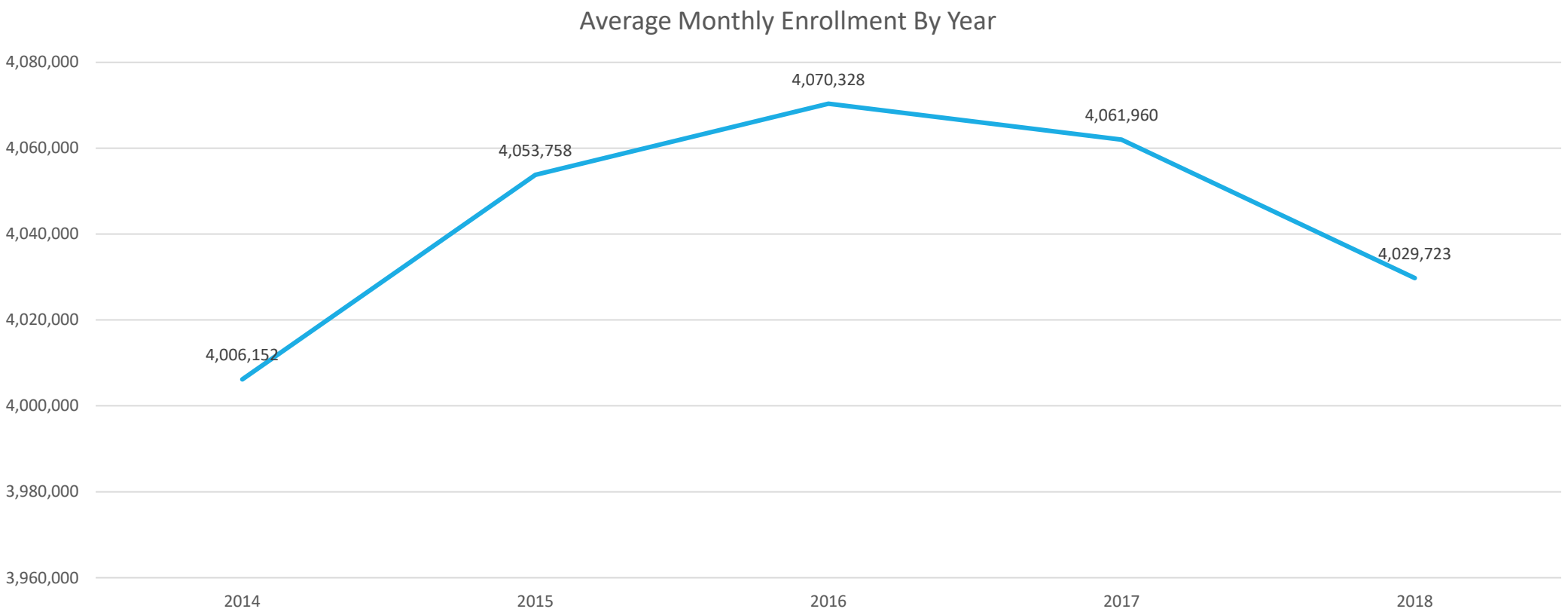
Monthly Enrollment Jan 2014 – Oct 2018



Overall Medicaid caseload increased in 2014 due to ACA but has trended downward in recent years.

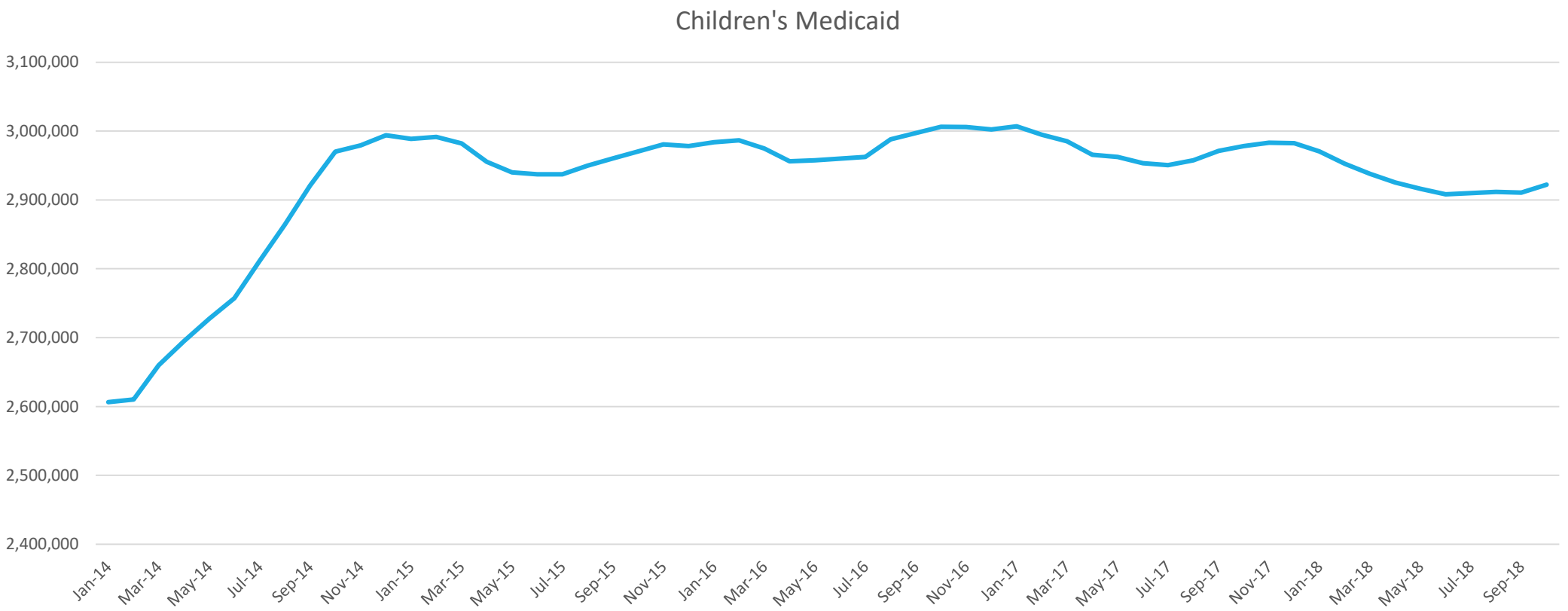
HHSC – Entire Medicaid Caseload

Average Monthly Enrollment for 2014 – 2018



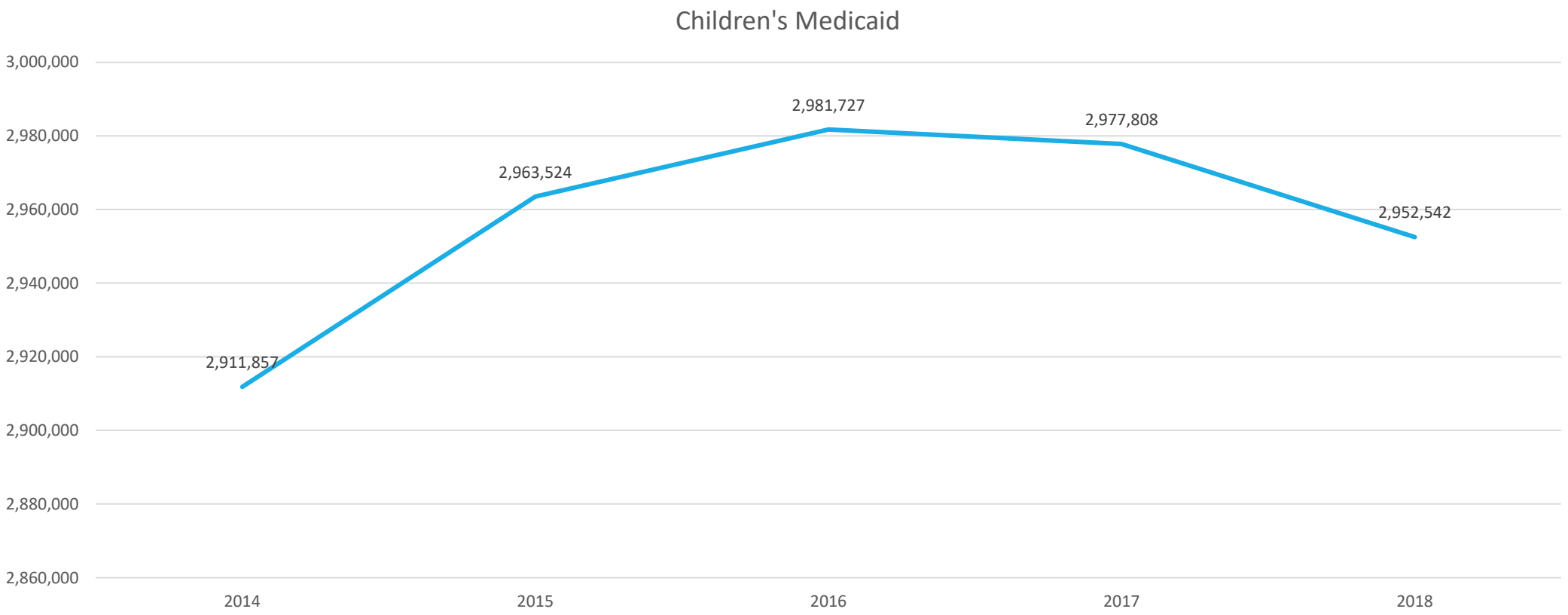
HHSC – Children's Medicaid

Monthly Enrollment Jan 2014 – Oct 2018



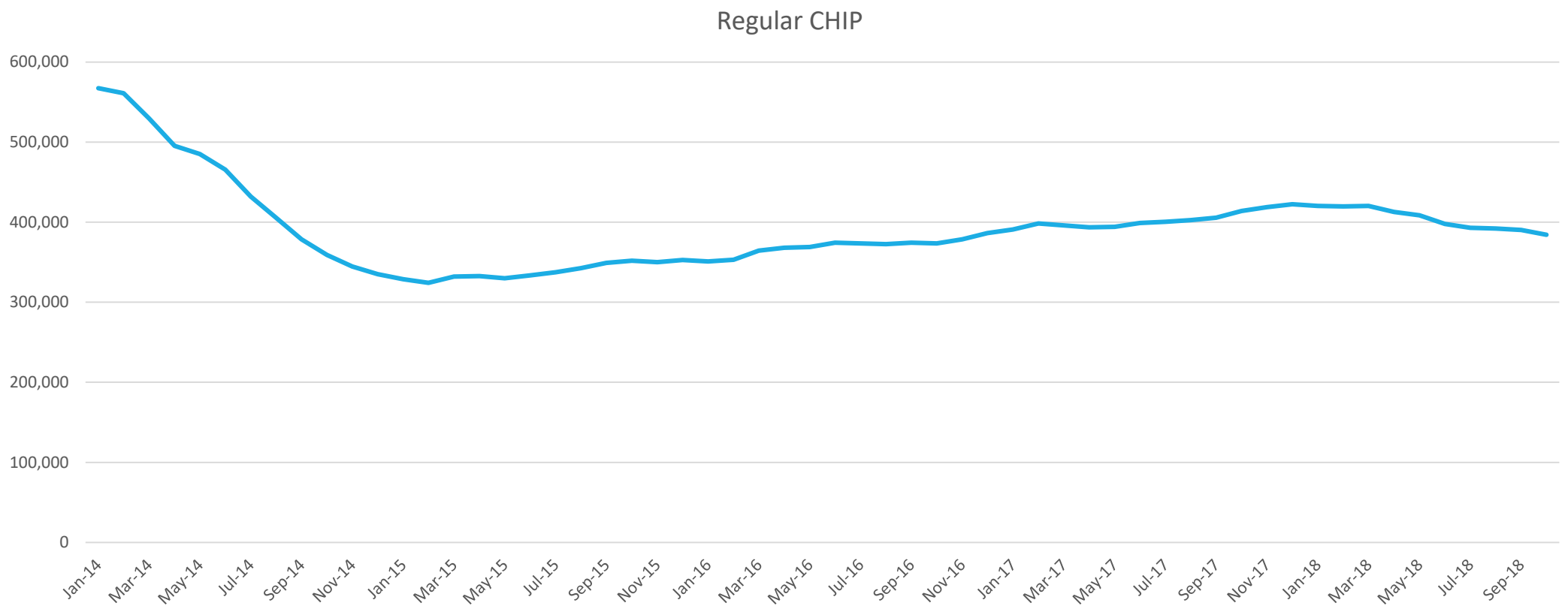
HHSC – Children's Medicaid by Year

Average Monthly Enrollment for 2014 – 2018



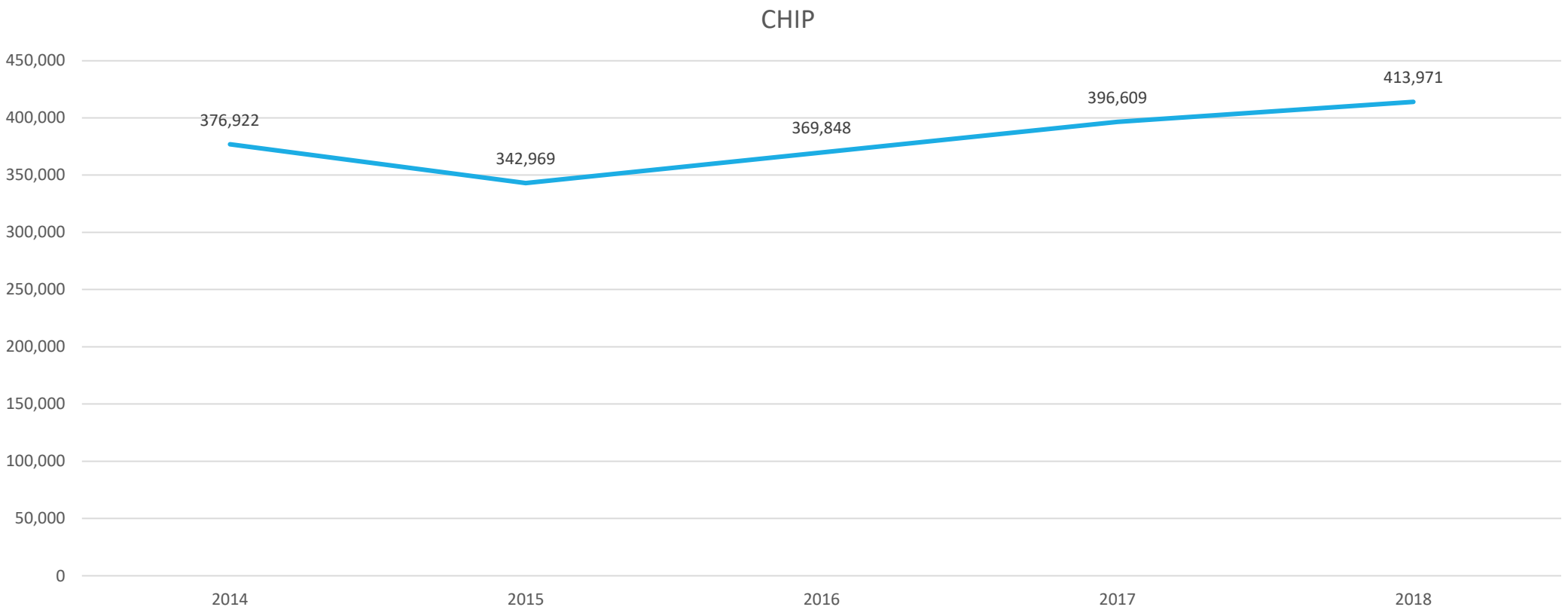
HHSC – Regular CHIP

Monthly Enrollment Jan 2014 – Oct 2018



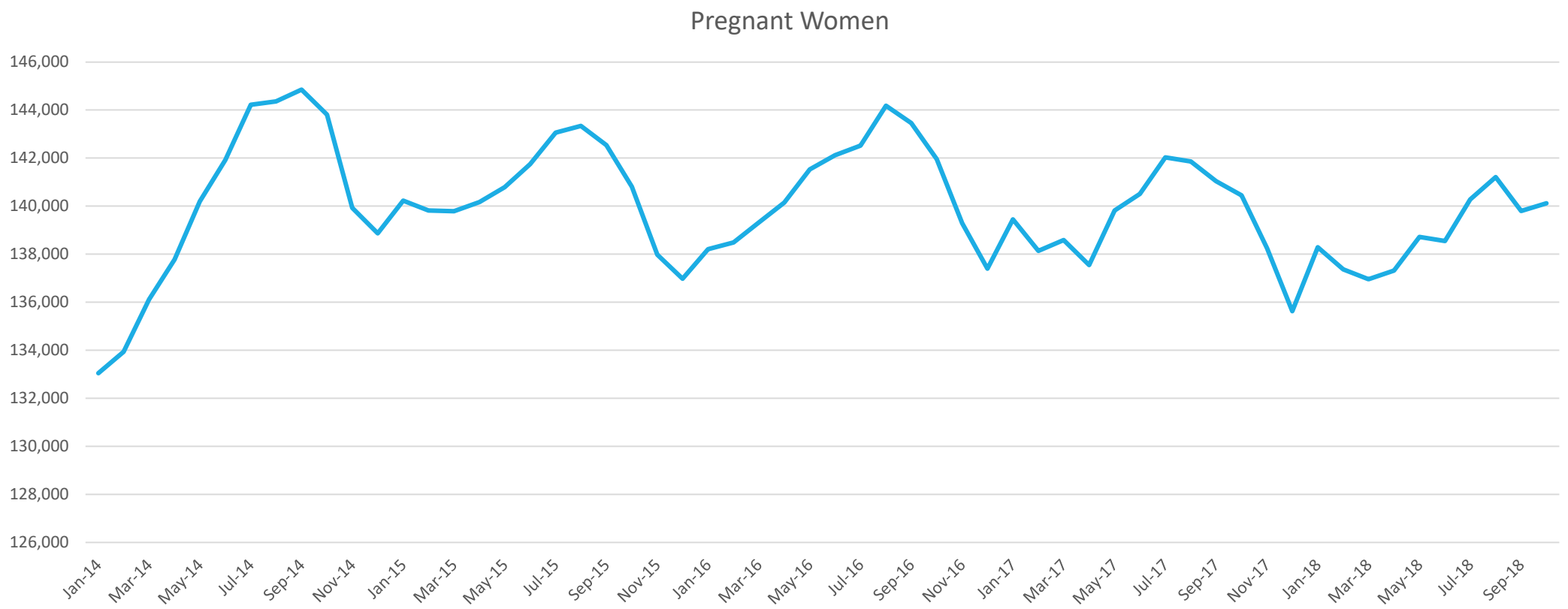
HHSC – Regular CHIP

Average Monthly Enrollment for 2014 – 2018



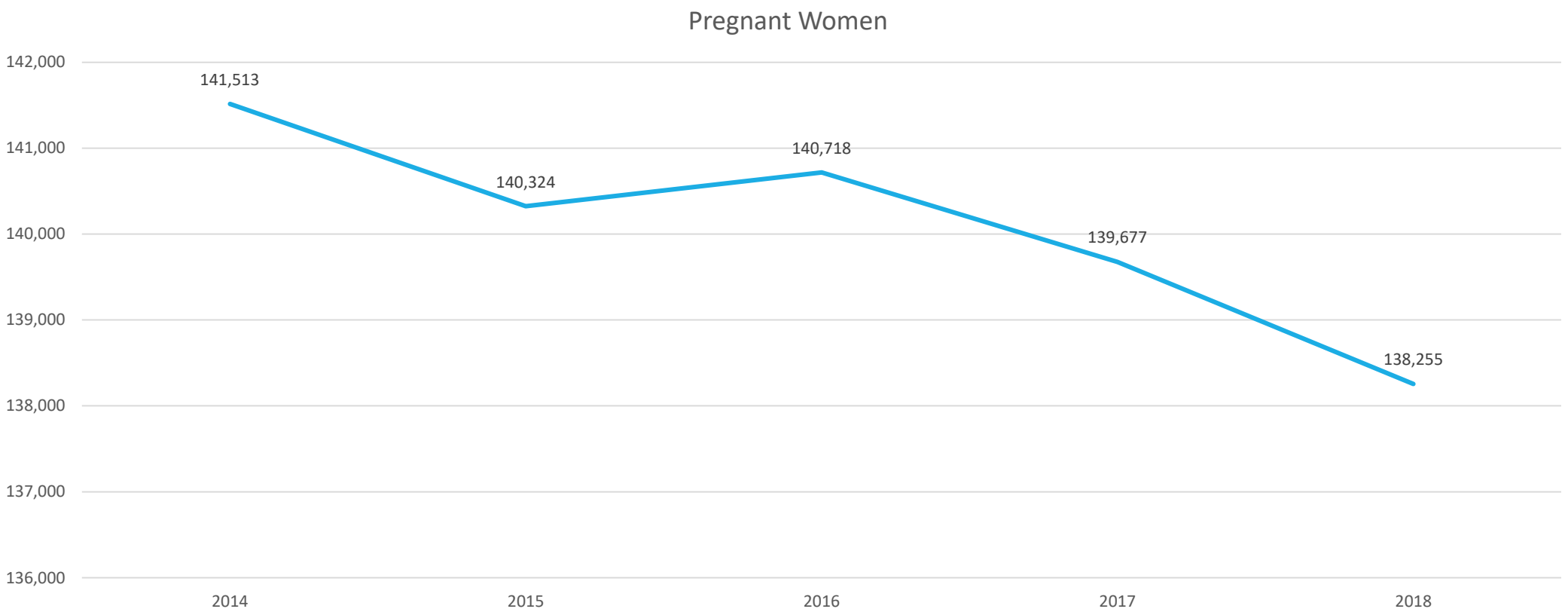
HHSC – Pregnant Women

Monthly Enrollment Jan 2014 – Oct 2018



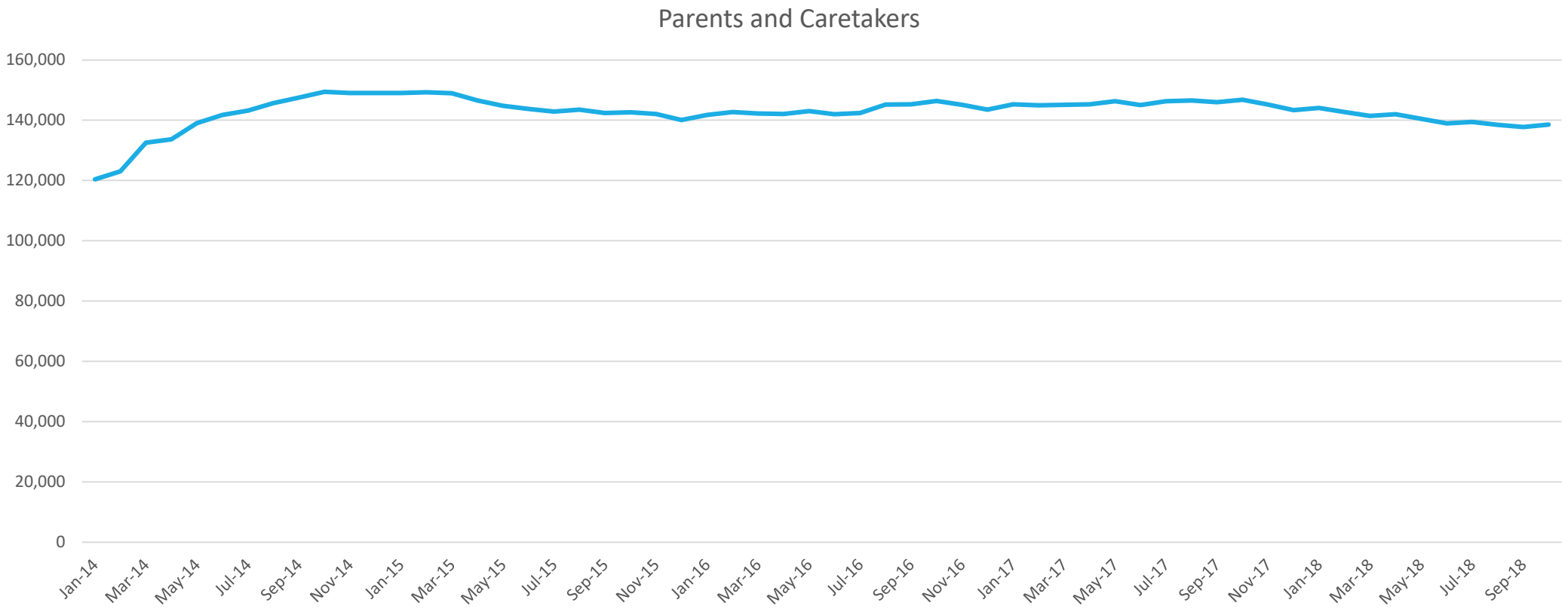
HHSC – Pregnant Women

Average Monthly Enrollment for 2014 – 2018



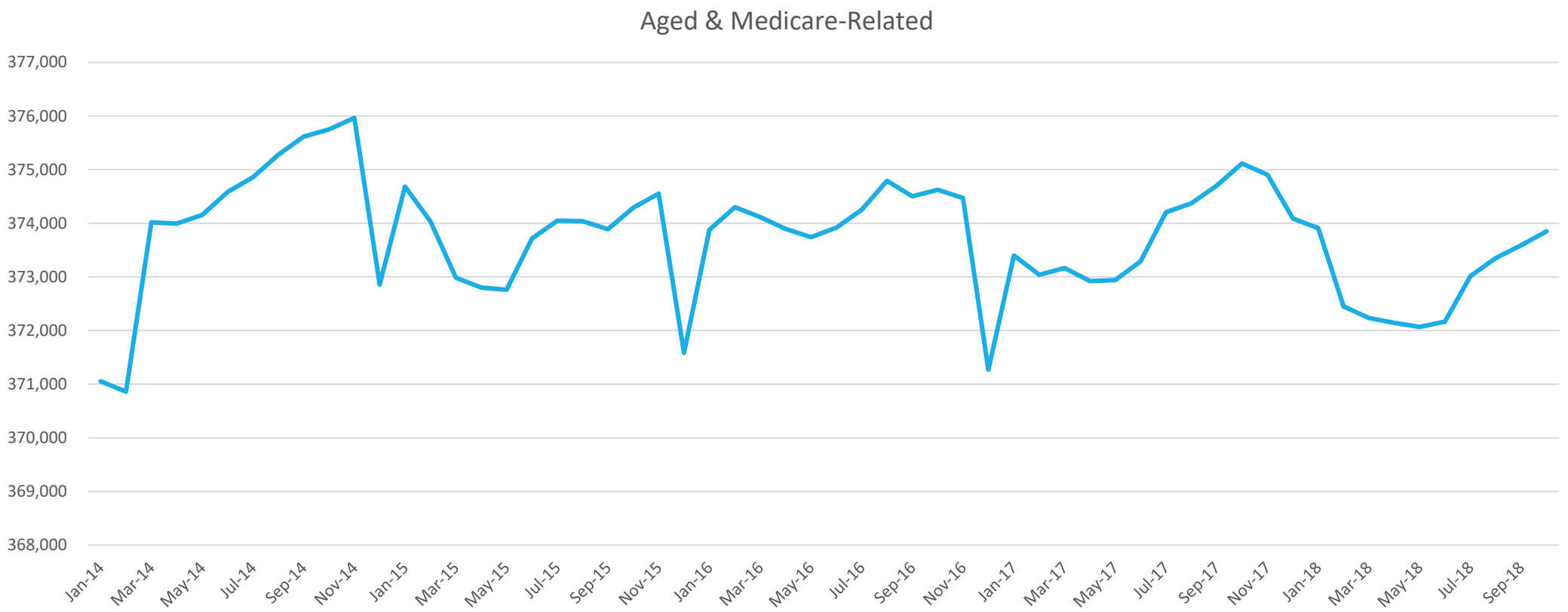
HHSC – Parents and Caretakers

Monthly Enrollment Jan 2014 – Oct 2018



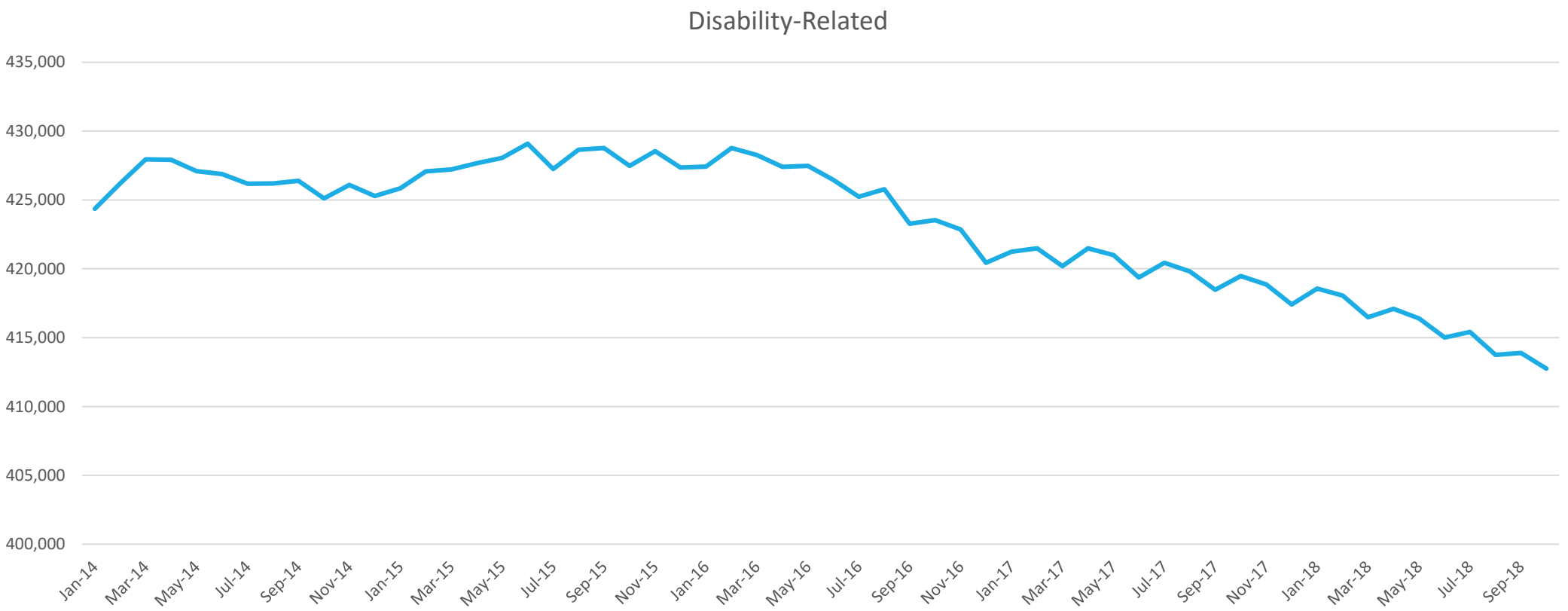
HHSC – Aged & Medicare-Related

Monthly Enrollment Jan 2014 – Oct 2018



HHSC – Disability-Related

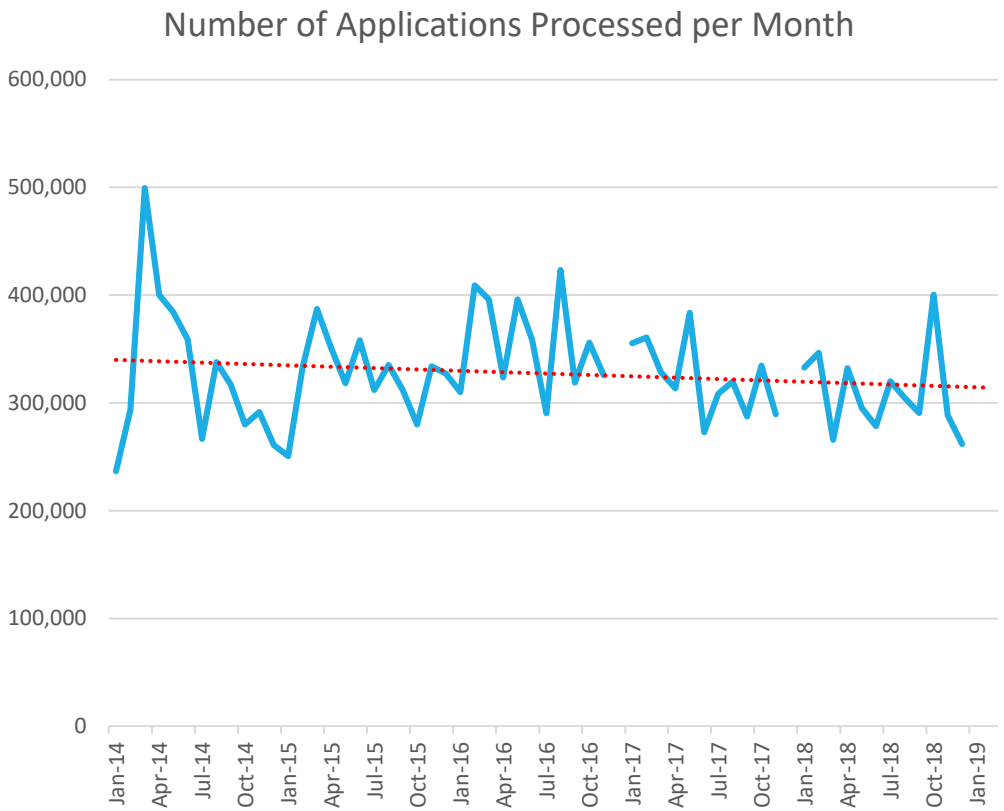
Monthly Enrollment Jan 2014 – Oct 2018

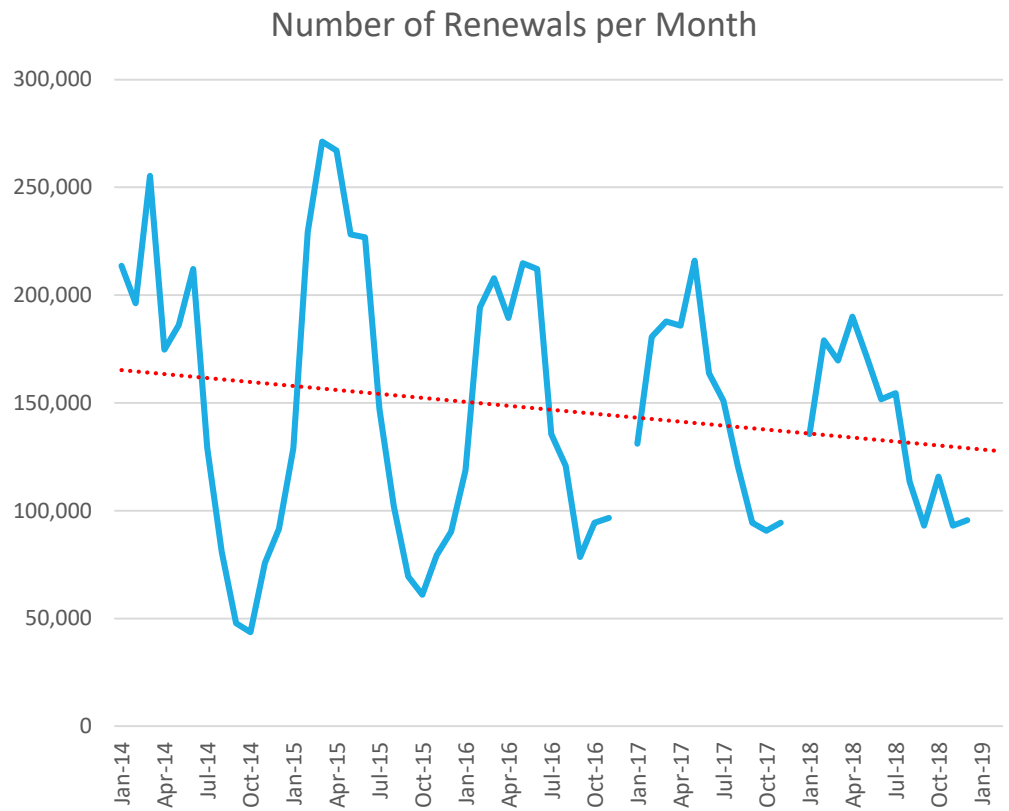


HHSC Data on Applications and Renewals*

Monthly 2014 – 2018

*Includes all programs except for MEPD.





The decline in enrollment would appear to be driven by a reduction in renewals as opposed to applications.

86th Session Budget Update

Trey Wood

Chief Financial Officer

March 15, 2019

TEXAS Health and Human Services

TEXAS
Health and Human Services

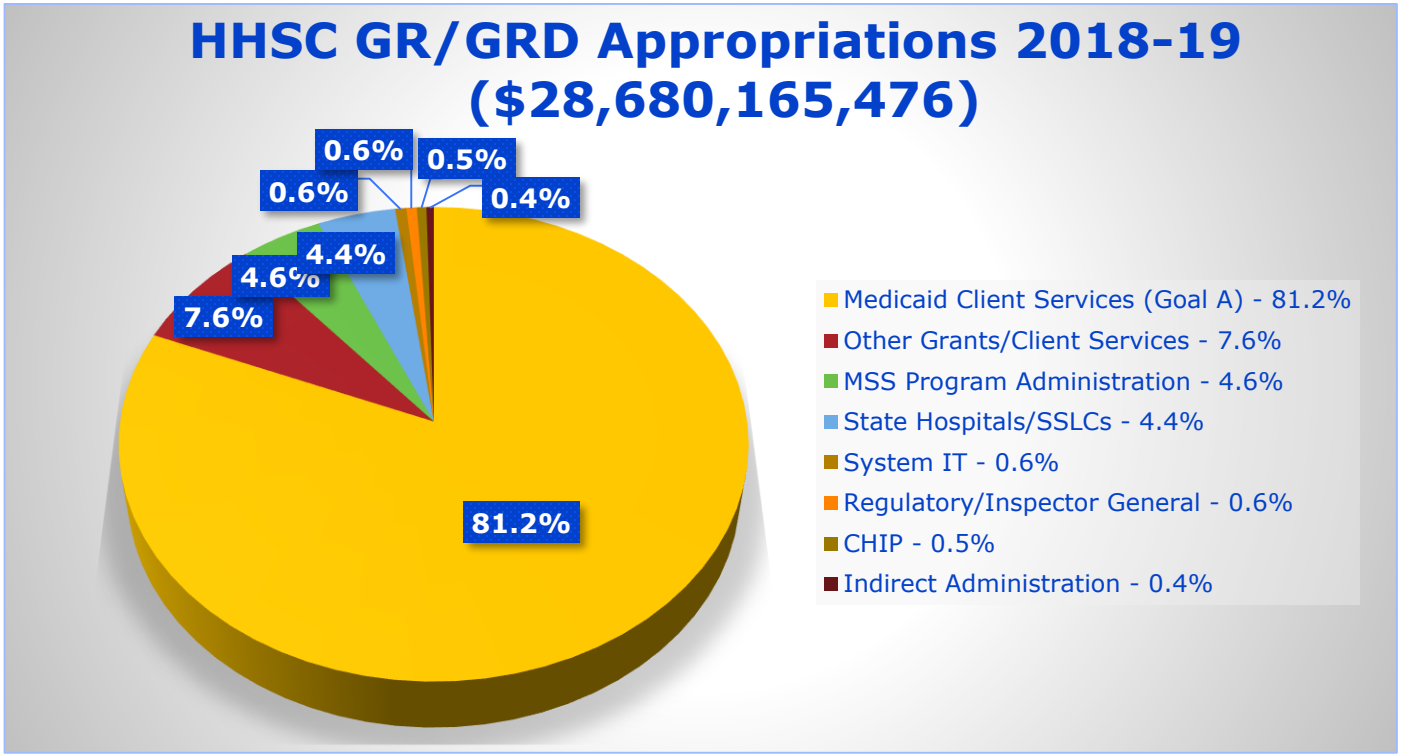
Presentation Overview

- Budget Overview
- Critical Budget Issues for FY 2019
- Summary of HB 1 and SB 1
- Supplemental Funding
- Key Budget Drivers
- Medicaid Caseload Trends
- Medicaid Federal Funds
- CHIP Caseload Trends
- CHIP Federal Funds
- Caseload and Cost Growth Summary
- Cost Growth Trends

TEXAS
Health and Human Services

Budget Overview

FY 2018-2019 Expended/Budgeted	FY 2020-2021 Requested
$77,508,766,079	$77,343,682,930



TEXAS
Health and Human Services

Critical Budget Issues for Fiscal Year 2019

HHSC projects a net supplemental appropriation need of approximately $1.9 billion in General Revenue

Supplemental Need	Fiscal Year (FY) 2018-19 (in millions)
Medicaid Acute Care for Full-Benefit Clients	($1,206.8)
Medicaid Long-Term Care Entitlement	($73.6)
Medicaid Long-Term Care Non-Entitlement	($19.9)
Medicaid Other Medical Services	($139.4)
Children's Health Insurance Program (CHIP)	$1.9
Hurricane Harvey	($110.0)
Other	($301.5)
Total Projected Need	**($1,849.3)**

Critical Budget Issues, Continued

Impact of H.B. 30, 85th Legislature, 1st Called Session, 2017

	Scenario 1	Scenario 2
Transfer to Teacher Retirement System & Texas Education Agency	($563.0)	($563.0)
MCO Payment Delay	$0.0	$780.0
House Bill 30 Impact	**($563.0)**	**$217.0**

Projected HHSC Supplemental Need for FY 2019

- Scenario 1: **($2,412.3)**
  OR
- Scenario 2: **($1,632.3)**

Cash flow projections estimate that HHSC will not be able to make payments to Medicaid providers beginning May 2019

Summary of HB 1 and SB 1

HHSC	LAR	House Bill 1	Senate Bill 1
Funding (AF)	$77.3 B	$77.4 B	$77.5 B
Funding (GR)	$30.4 B	$29.3 B	$29.4 B
FTEs	39,586.2	37,795.6	37,675.1

Adjustments include GR reductions associated with:

- Changes in Federal Medical Assistance Percentages (FMAP) (Goal A - Medicaid Client Services, State Supported Living Centers (SSLCs))
- Assumption of 1115 Waiver for Healthy Texas Women
- FTE reductions in the Integrated Eligibility and Enrollment (IEE) Appropriation

Medicaid Recipients Per Month included in HB 1 and SB 1:

- FY 2020: 4,026,358
- FY 2021: 4,094,589

Supplemental Funding

- House Bill 4:
  - $2.1 billion GR (Medicaid Shortfall)
  - $2.3 billion Federal Funds (Medicaid Shortfall)
  - $110 million ESF (Medicaid Client Services, resulting from Hurricane Harvey)
  - Expected to be voted out of HAC by 3/20/19
- Senate Bill 500:
  - $2.1 billion GR (Medicaid Shortfall)
  - $2.3 billion Federal Funds (Medicaid Shortfall)
  - $110 million ESF (Medicaid Client Services, resulting from Hurricane Harvey)
  - Voted out of the Senate on 3/13/19

Key Budget Drivers

- HHSC projects caseloads to increase by about 1 percent each year of the biennium for Medicaid and 4.5 percent for CHIP
- Medicaid cost growth ranges between 3.2 percent and 5.5 percent each year of the biennium
- Cost growth is impacted by:
  - Utilization trends
  - Benefit changes
  - Population acuity factors
  - Aging and births
  - Evolutionary and revolutionary advances in medicine
- Cost growth for Texas' Medicaid program has averaged a slower rate of increase when compared to national trends

Medicaid Caseload Trends

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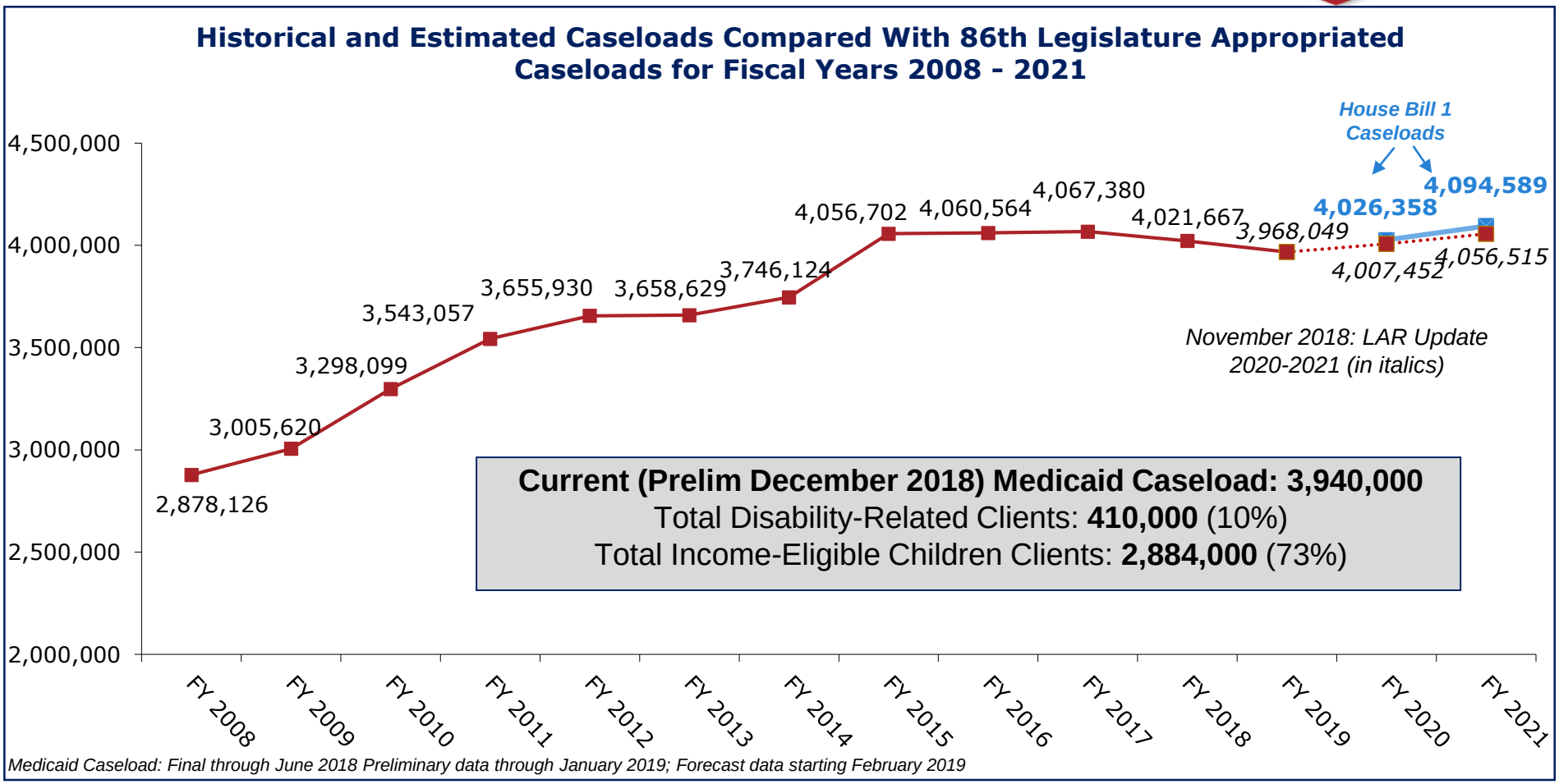

Medicaid Caseload: Final through June 2018 Preliminary data through January 2019; Forecast data starting February 2019

Medicaid Federal Funds

Medicaid is an entitlement program

There is no cap on federal funding to provide eligible services to eligible persons

- Federal Medical Assistance Percentage (FMAP) is derived from each state's average per capita income
- CMS updates the rate annually
- For federal fiscal year (FFY) 2019, Texas' Medicaid FMAP is 58.19 percent
  - The FFY is on a different calendar cycle than the state fiscal year (SFY)
  - The SFY FMAP rate is 58.08 percent (one of month the FFY 2018 rate of 56.88 and 11 months of FFY 2019 rate of 58.19 percent)

CHIP Caseload Trends

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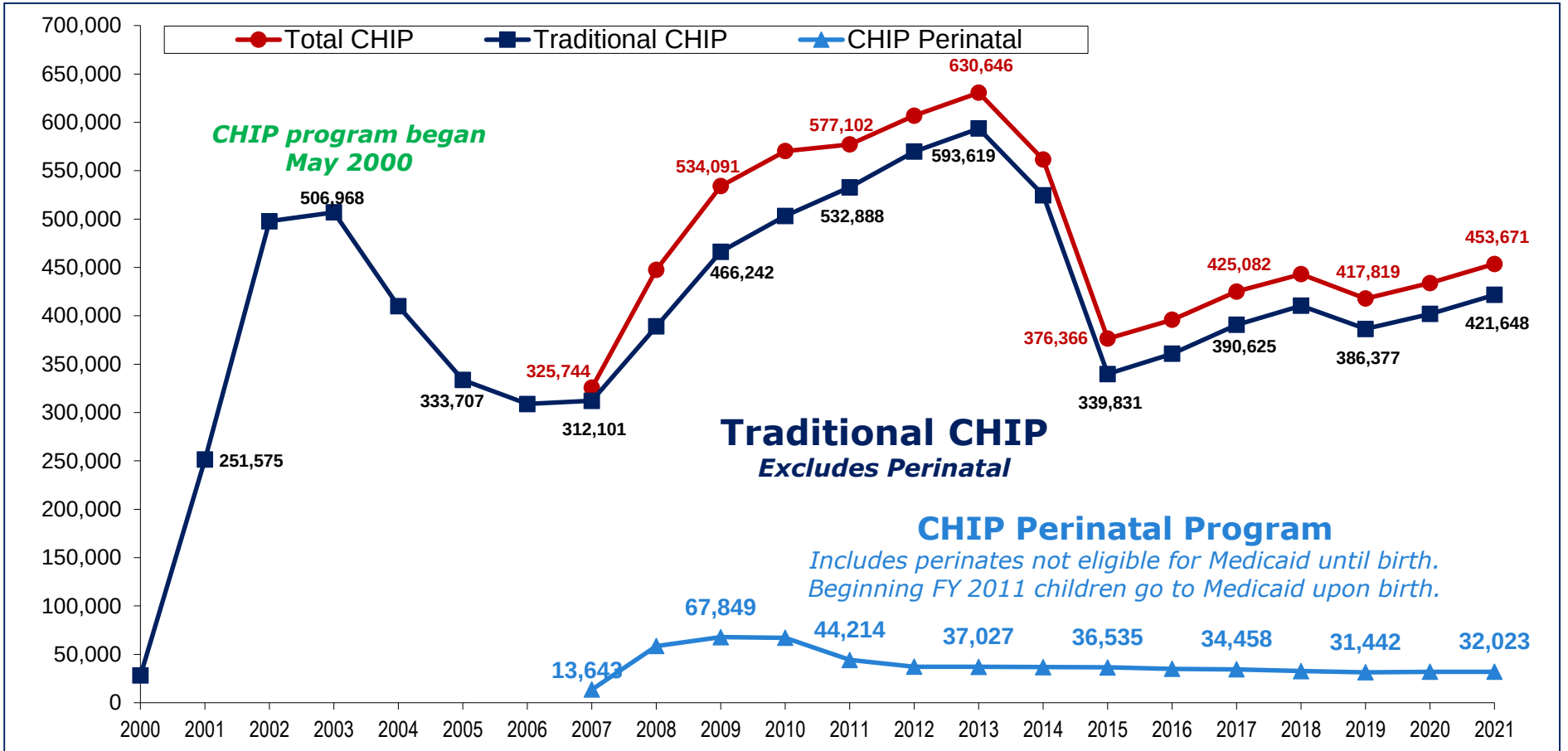

CHIP caseload: Data for FY 2018 is estimated; FY 2019-21 is projected based on November 2018 forecasts.

CHIP Federal Funds

CHIP is not an entitlement program

Federal funds are capped – when a state's CHIP funds are spent, no more are available

- Like Medicaid, the match rate is derived from each state's average per capita income and changes annually
- States are allotted a portion of the total federal funds based on a formula then receive federal matching funds up to that allotment
- CHIP has a more favorable match rate then Medicaid
- FFY 2019 match rate is 93.73 percent
- The Affordable Care Act increased the match rate for:
  - Oct. 2015 – Sept. 2019 by 23 percent
  - FFY 2020 by 11.5 percent
  - CHIP resumes its standard match rate in FFY 2021

Caseload and Cost Growth Summary

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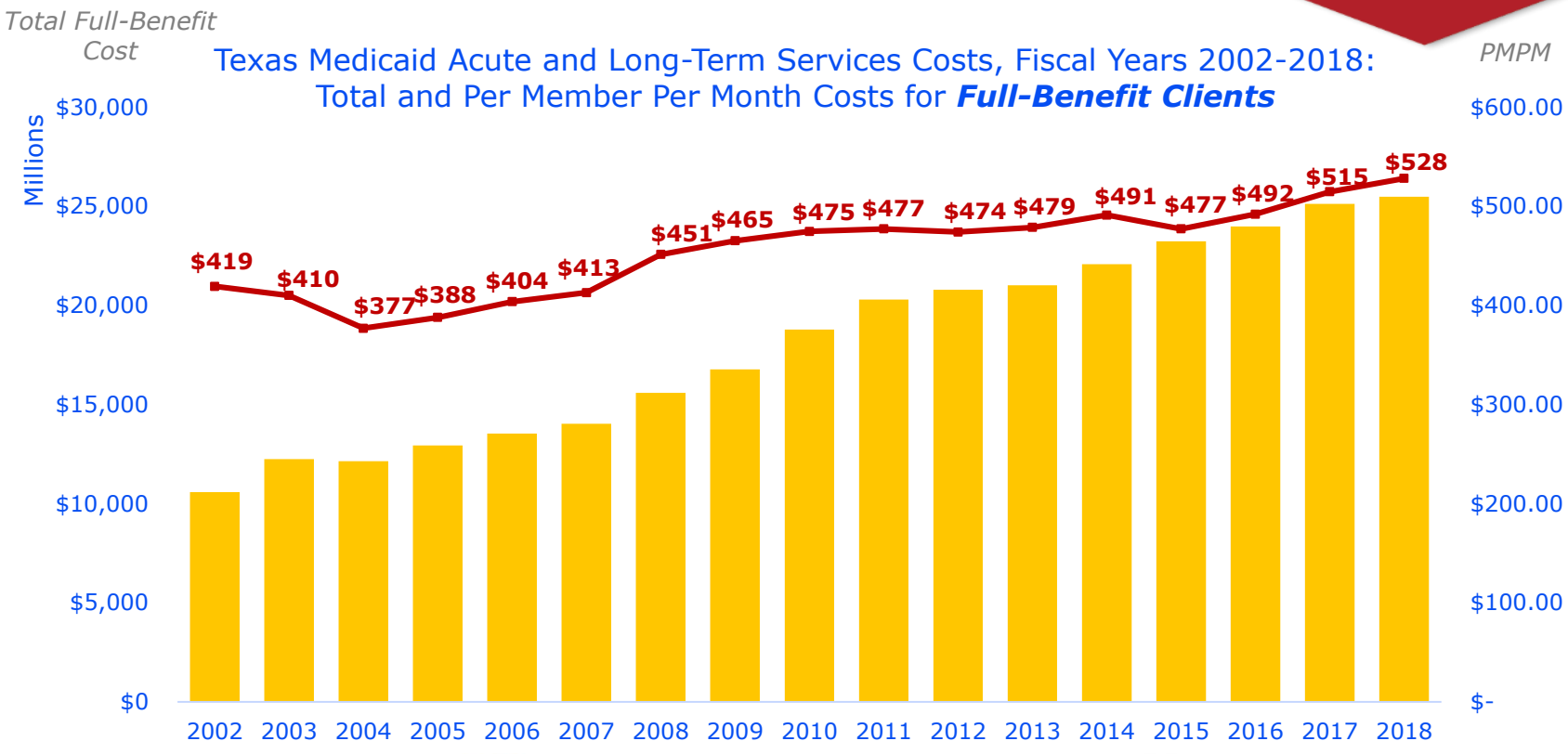


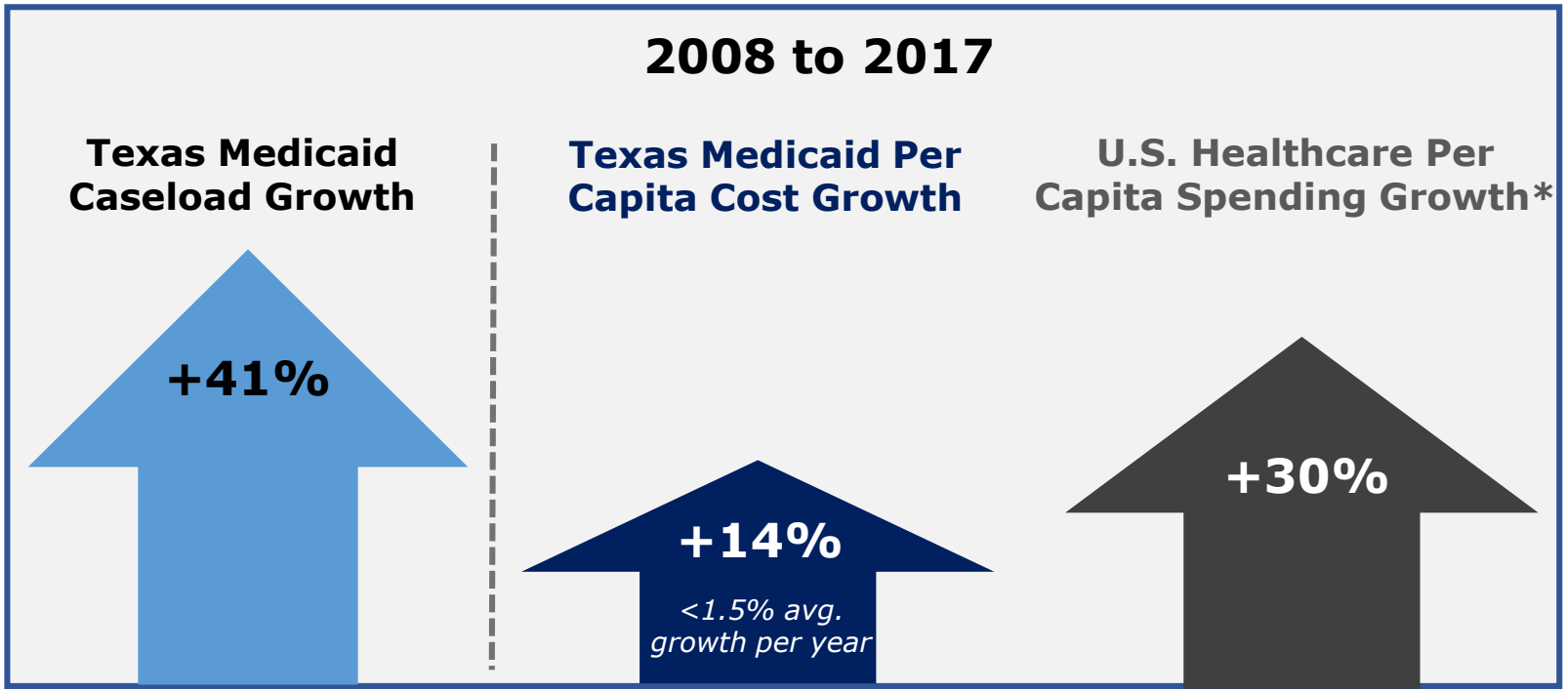
Medicaid Program Caseload - Recipient Months and Per Member Per Month Cost with Trends

	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
RMs	2,103,972	2,489,061	2,683,730	2,779,936	2,792,597	2,832,848	2,878,126	3,005,620	3,298,099	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702	4,060,564	4,067,380	4,021,935
RM Trend	*12%*	*18%*	*8%*	*4%*	*0%*	*1%*	*2%*	*4%*	*10%*	*7%*	*3%*	*0%*	*2%*	*8%*	*0%*	*0%*	*-1%*
PMPM	*$419*	*$410*	*$377*	*$388*	*$404*	*$413*	*$451*	*$465*	*$475*	*$477*	*$474*	*$479*	*$491*	*$477*	*$492*	*$515*	*$528*
trend	*4%*	*-2%*	*-8%*	*3%*	*4%*	*2%*	*9%*	*3%*	*2%*	*1%*	*-1%*	*1%*	*3%*	*-3%*	*3%*	*5%*	*3%*

Total Full-Benefit Cost Full-Benefit Per Member Per Month

Cost Growth Trends

Caseload is the primary drive of cost; however, despite caseload increases, Texas Medicaid cost per person cost growth is substantially lower than the national trend



*Data is for Calendar Year (CY) 2008 to CY 2016