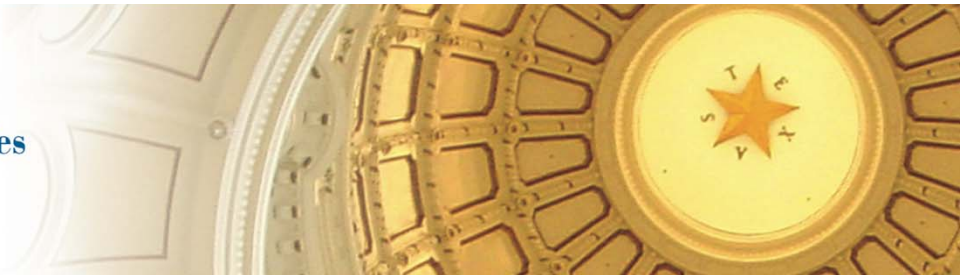




Center for Public Policy Priorities



Health Care Post-Session De-Brief & Next Steps Texas CHIP Coalition/Cover Texas Now Coalition

July 6, 2011

Thanks to Texas Hospital Association for hosting this meeting

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Health Care & Texas 2012-2013 Budget: Introduced Version

- Texas relied on billions \$ in ARRA (stimulus) funds to balance 2010-2011 budget; but extra Medicaid ARRA funding ended June 2011.
- With \$27 billion GR revenue gap to fund “current services” budget, introduced version of budget in January was \$18 billion (all funds) short of full funding for Medicaid:
 - about a one-third cut from what the program needed just to keep doing what it is currently doing.
 - To “save” \$7.6 billion state dollars (GR), Texas would lose another \$10.4 billion in federal matching dollars.
 - Assumed 10% across-the board cuts in provider fees (\$1.6 billion GR); no increases for caseload or inflation growth (\$1.7 billion), and no replacement of the ARRA funds used as state match (\$4.3 billion)
- Budget as introduced also:
 - Cut Mental health budgets by \$239 million (below 2010-2011)
 - Cut family planning by \$11.9 million

Health Care and Texas 2012-2013 Budget: **Adopted Version**

Rate Cuts	2010-2011	2012-2013
Nursing Homes	3%	0%
ICF-MR (not SSLC)	3%	2%
HCS Waiver	2%	1%
NF-related Hospice	2%	1%
Other Community Waivers	0%	\$12.5 million GR cut in in admin for agencies
Medicaid & CHIP physician, dentist, orthodontist	2%	0%
Medicaid Hospital	2%	8%
Medicaid DME & Labs	2%	10.5%
Other Medicaid Providers	2%	5%
Other CHIP Providers	2%	8%
Medicaid Pediatric private duty nursing & home health	2%	0%
Medicaid Managed Care premiums reduced to “average acuity”	n/a	\$169.3 million GR cut

Health Care and Texas 2012-2013 Budget: **Adopted Version**

Medicaid:

- **\$2 billion GR in specific cuts and “savings,”**
 - Provider rate/fee cuts (approx. \$805 billion GR);
 - Other benefit and spending cuts (approx. \$843 million GR); and
 - Managed care expansion spending reductions (approx. \$385.7 million GR per HHSC #51)
- **\$4.8 billion in Medicaid Shortfall**
 - \$1.7 billion GR for unfunded Medicaid cost and caseload growth, and
 - Roughly 2.25 billion more in GR shortfall from un-replaced federal stimulus aid (ARRA) that Texas used in 2010-2011 to fund Medicaid
 - Rider-directed additional savings, the sources of which are unspecified and/or as yet un-scored by LBB (approx. \$886 million GR)
 - \$700 million GR reduction “Federal Flexibility” rider (Art II SP rider 46); and
 - Unfunded portion per LBB of the “Medicaid Funding Reduction” rider : \$186 million GR out of the \$450 million nominal rider total.
 - Will these be IOU costs that get covered in 2013-- or cuts?
- **Texas Medicaid pays > \$2 billion/mo. health & long term care bills,**
 - about \$900 million/month is state dollars (GR); thus we are about 5 months short.
 - funds appropriated for Texas Medicaid program need to cover enough months bills to get us to Spring 2013, when the Legislature can appropriate more to fill the gap.

Health Care and Texas 2012-2013 Budget: **Adopted Version**

List of Cuts/Changes *(from Conf Cmte. decision docket)*

The adopted budget assumes an array of benefit and spending cuts, totaling approx. \$843 million GR.

- Reduced amount, duration, and scope of Community Services (\$31 million GR)
- Nursing Facility Cost Change (\$58 million GR)
- Prescription dispensing fee reductions (\$34.7 million GR)
- Community care wrap-around services (\$15 million GR)
- HHSC fee cuts (\$34.7 million GR)
- Reduced “optional” Medicaid benefits for adults (\$45 million GR)
- Reduced administrative spending at HHSC (\$38.2 million GR)
- **“Medicare Equalization:” Limiting payment for services to seniors and adults with disabilities enrolled in both Medicaid and Medicare to the Texas Medicaid fee schedule. (\$295.8 million GR)**
- Reduced Medicaid Managed Care administrative costs (\$27 million GR)
- Additional unduplicated savings indicated by LBB from “Medicaid Funding Reduction” rider (HHSC 61: \$264 million GR)

HHSC Rider 61: Medicaid Funding Reduction

Biennial reduction of \$450 million GR; LBB stated in Conf Cmte hearing that they scored the rider at \$264 million (i.e., \$186 million less than the \$450 mill. HHSC plan due by 12/1/2011.

May include any or all of the following initiatives:

- (1) Implementing payment reform and quality based payments in fee for service and managed care,
- (2) Increasing neonatal intensive care management,
- (3) Transitioning outpatient Medicaid payments to a fee schedule,
- (4) Developing more appropriate emergency department hospital rates for nonemergency related visits,
- (5) Maximizing co-payments in all Medicaid and non-Medicaid programs,
- (6) Maximizing federal matching funds through a combination of a Medicaid waiver, full-risk transportation broker pilots, and/or inclusion of transportation services in managed care organizations,
- (7) Reducing costs for durable medical equipment and laboratory services through rate reductions, utilization management and consolidation,
- (8) Statewide monitoring of community care through telephony in Medicaid fee-for-service and managed care,
- (9) Expanding billing coordination to all non-Medicaid programs,
- (10) Increasing utilization of over-the-counter medicines,
- (11) Renegotiating more efficient contracts,
- (12) Equalizing the prescription drug benefit statewide,
- (13) Allowing group billing for up to three children at one time in a foster care or home setting who receive private duty nursing services,
- (14) Achieving more competitive drug ingredient pricing,
- (15) Increasing generic prescription drug utilization,
- (16) Improving birth outcomes by reducing birth trauma and elective inductions,
- (17) Increasing competition and incentivizing quality outcomes through a statewide Standard Dollar Amount and applying an administrative cap,
- (18) Establishing a capitated rate to cover wrap-around services for individuals enrolled in a Medicare Advantage Plan,
- (19) Improving care coordination for Children with Disabilities in managed care,
- (20) Automatically enrolling clients into managed care plans,
- (21) Restricting payment of out-of-State Services to the Medicaid rate and only our border regions,
- (22) Increasing utilization management for provider-administered drugs,
- (23) Implementing the Medicare billing prohibition,
- (24) Increasing the assessment time line for private duty nursing,
- (25) Maximizing federal match for services currently paid for with 100 percent general revenue,
- (26) Adjusting amount, scope and duration for services,
- (27) Increasing fraud, waste and abuse detection and claims,
- (28) Strengthening prior authorization when efficient,
- (29) Paying more appropriately for outliers, and
- (30) Additional initiatives identified by the Health and Human Services Commission.

HHSC Rider 59: Federal Flexibility

\$700 million GR reduction: HHSC directed to seek federal waiver(s) that would permit the following:

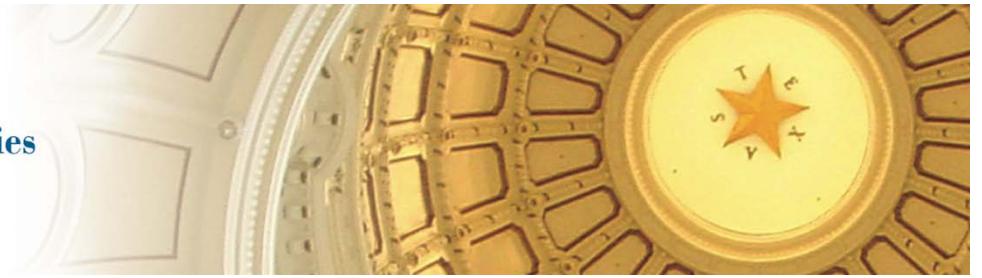
- a. greater flexibility in standards and levels of eligibility in Medicaid and CHIP programs;
- b. design and implement benefit packages that target the specific health needs and reflect the geographic and demographic needs of Texas;
- c. Texas Medicaid and CHIP programs foster a culture of individual responsibility through the appropriate use of co-payments;
- d. consolidate funding streams to increase accountability, transparency, and efficiency (consolidated funding streams should be considered for both hospital and long term care);
- e. federal government assume financial responsibility for 100 percent of the health care services provided to unauthorized immigrants; and
- f. that existing state and local expenditures be utilized to maximize federal matching funds.

Health Care and Texas 2012-2013 Budget: **Adopted Version**

- Mental health funding held at 2010-2011 level:
 - no growth or inflation, but a reprieve from proposed \$239 million cut
- Family Planning:
 - \$113.6 million 2010-11 funding level for block grant FP
 - Budget for 2012-2013 cuts \$72.9 million
 - Leaves just \$38 million, or a 66% reduction 2010-11 funds.
 - 284,000 fewer low-income women will receive birth control services, resulting in tens of thousands of unplanned pregnancies, and a projected \$98 million increase in Medicaid delivery costs
 - Medicaid family planning program provides services to another 110,000-120,000 adult women (no teens); budget “rider” may save this program.



Center for Public Policy Priorities



82nd Session Update: Private Health Insurance and ACA Implementation

July 6, 2011

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82nd Session Update: Private Coverage

- TDI Sunset bill (HB 1951) passed with 2 small but good amendments:
 - TDI can write “child-only” rules to increase availability
 - Improved notice of rate increase (was HB 2723)
- OPIC maintained as independent agency
- Exclusive provider organizations authorized (HB 1772)
- Under veto threat, no exchange bills passed
- No authority for TDI to enforce existing ACA protections (ex: no pre-ex for kids, dependent coverage to age 26).

Medicaid, CHIP & Medicare in the Crosshairs in D.C.

Sweeping Changes Proposed in DC (1)

Medicare

- U.S. House Budget Committee Chairman Paul Ryan's budget resolution—approved by the U.S. House but not the Senate—
 - would convert Medicare to a voucher program in which Medicare will pay less for care, but seniors would have to pay twice as much out of pocket to get the same coverage.
 - would also end today's sliding-scale help for very low income Medicare beneficiaries, & replace with new program that would leave average senior in poverty (less than \$10,890/yr.) with \$4,700 in annual out-of-pocket costs—43% of their income.

Medicaid

- Ryan budget plan would turn Texas Medicaid into a block grant that would:
 - By 2030, cut Medicaid funding in half,
 - Would lock in today's Texas Medicaid spending per enrollee at \$600 below the national average, and
 - end our current protection of increased federal support in disasters and recessions.

Sweeping Changes Proposed in DC (2)

CHIP Cut or Abolished, Too

- U.S. House Energy and Commerce Subcmte. on Health voted 5/2011 to repeal the federal stability protections (A.K.A. “maintenance-of-effort rules” or MOE) now keeping states from cutting Medicaid and CHIP coverage.
- CBO calculates that if MOE repealed, by 2013 states will drop Medicaid and CHIP coverage for about 400,000 people, about two-thirds of them children. CBO projects that three-quarters or 300,000 of those children and adults would become uninsured, and only a quarter would gain job-based coverage.
- Because the House/Ryan plan would repeal the ACA, it would also eliminate the CHIP program, because CHIP’s funding and authorization are part of the health reform law.

Sweeping Changes Proposed in DC (3)

Spending Caps Alone Can Cut Medicare and Medicaid Just as Deeply

- Several other proposals for hard caps on spending—whether for total federal spending, for Social Security, Medicare, and Medicaid, or just for federal health spending—**all have been calculated to cut Medicare and Medicaid just as deeply or even deeper than the Ryan plan.**
- These cap proposals and Balanced Budget Amendment (BBA) proposals are being pushed hard in the ongoing Congressional debate over deficit and debt reduction measures.

Balanced Budget Proposals: Even deeper cuts

- House Judiciary version of balanced budget amendment would bar federal spending from exceeding 18% of GDP in any year.
- Under Ryan budget, federal Medicaid funding in 2030 would be 49 percent lower;
- CBO says CBO says Ryan budget federal spending would be 20¼ percent of GDP in 2022 and 20¾ percent of GDP in 2030- or TOO HIGH for the BBA 18% cap—so under BBA far deeper cuts would be needed.

Obama Administration Proposals

Administration budget framework from April:

- Envisions at least \$100 billion in federal Medicaid savings over ten years.
- But ONLY in the context of a package that included savings from revenues.

\$100 billion in federal Medicaid savings over ten years:

- 1) Several measures to increase Medicaid efficiency/reduce costs for medical equipment, Rx, and other items, saving \$10 billion-\$15 billion;
- 2) Sharply restrict or bar states from raising Medicaid matching funds through health care provider taxes, saving \$25 -\$45 billion depending on how sweeping the proposal is; and
- 3) Blended-match-rate proposal.

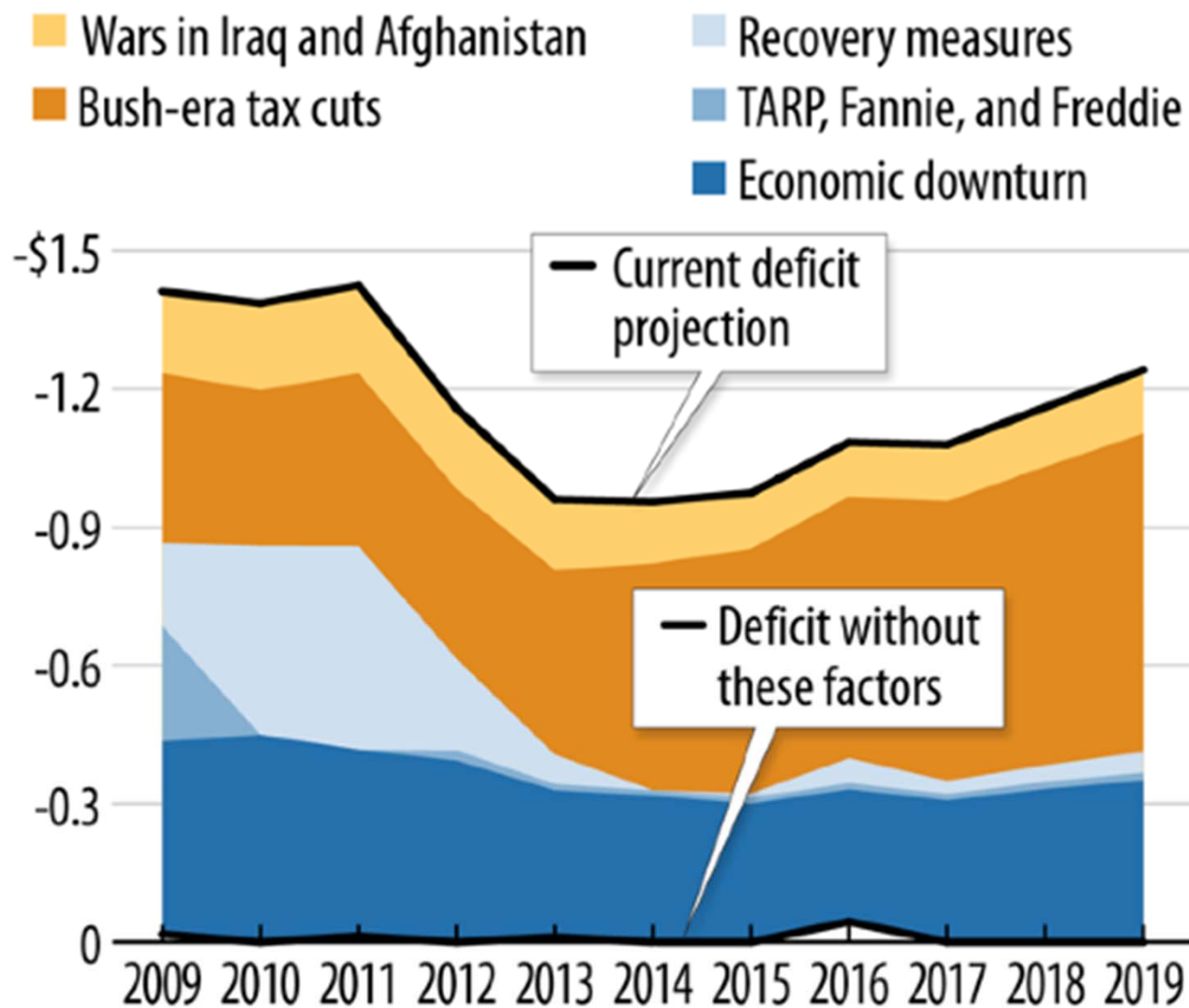
More from Administration and Congress:

The blended-rate proposal would replace today's Medicaid, CHIP and (future) ACA Medicaid match rates with a single matching rate for each state.

- **The blended rate would be set significantly below the combined effect of the various federal matching rates a state would otherwise receive.**
- This would save money for the federal government — the federal government would pay a lower percentage of overall Medicaid and CHIP costs than under current law, and states would bear a greater share.
- To compensate for the federal funding reductions, states would either have to:
 - contribute more of their own funds or, as is more likely,
 - shift costs to beneficiaries and health care providers by scaling back benefits and already-low payment rates.
- **NYT, 7/4/2011, reports lawmakers also “seriously considering”:**
 - gradual elimination of Medicare payments to hospitals to offset for bad debts when beneficiaries fail to pay deductibles and co-payments, and
 - reducing Medicare payments to teaching hospitals for the costs of training doctors, caring for sicker patients and providing specialized services like trauma care and organ transplants.

Economic Downturn and Legacy of Bush Policies Drive Record Deficits

Deficit, in trillions



Source: CBPP analysis based on Congressional Budget Office estimates.

Taming Health Spending Responsibly:

We can have Deficit Reduction without Gutting Medicaid, CHIP, & Medicare

- Controlling health care costs critical to reducing federal debt & deficit, but can be done with priority for protecting access and quality in Medicare and Medicaid, and without adding to the ranks of the uninsured.
- Just capping funding in a block grant does not control health care costs – it only shifts them to local governments, charities, and families.
- Real deficit reduction and health care spending control will require smart changes over the next two decades across our whole U.S. health care system: Medicare, Medicaid, and private insurance.
- Responsible deficit reduction by Congress calls for a balanced approach that includes revenues in the solution and does not rely on cuts alone.
 - The U.S. hands out over \$1 trillion in tax breaks every year—compared to a combined price tag for Medicare and Medicaid of \$719 billion
 - To put the importance of tax breaks to deficit control in perspective, every 36 hours the Bush tax cuts will add \$2.2 billion to the deficit: that is more than cutting the Medicaid-CHIP stability protections would save over 10 years!

More Deficit Reduction Facts:

- The House/Ryan budget plan takes two-thirds of its spending cuts from low-income programs, and then uses those cuts to offset the cost of making the Bush tax cuts permanent and prevent defense cuts, not to reduce the deficit.
- **Medicaid is NOT uniquely troubled by rising care costs:**
 - the CBO reports that growth rates for Medicare, Medicaid, and "All Other" U.S. health spending have out-stripped GDP growth consistently since 1975.
 - Medicare logged the highest cost growth in excess of GDP, and
 - Medicaid "tied" with All Other health spending over that entire period, despite having grown at a much slower rate than the rest of the system since 1990.
- Don't ask the poorest Americans to carry most of the load. Any "debt triggers" that would impose across-the-board cuts to keep federal spending growth under control must protect essential services for the poor including Medicaid.
- Americans agree: **Latest polls show a large majority of Americans oppose major cuts to Medicare and block-granting Medicaid to reduce federal deficits.**
 - 59 percent of Americans oppose any Medicare cuts at all;
 - 53 percent of Americans oppose any Medicaid cuts at all, and
 - 60 percent oppose making Medicaid a block grant.

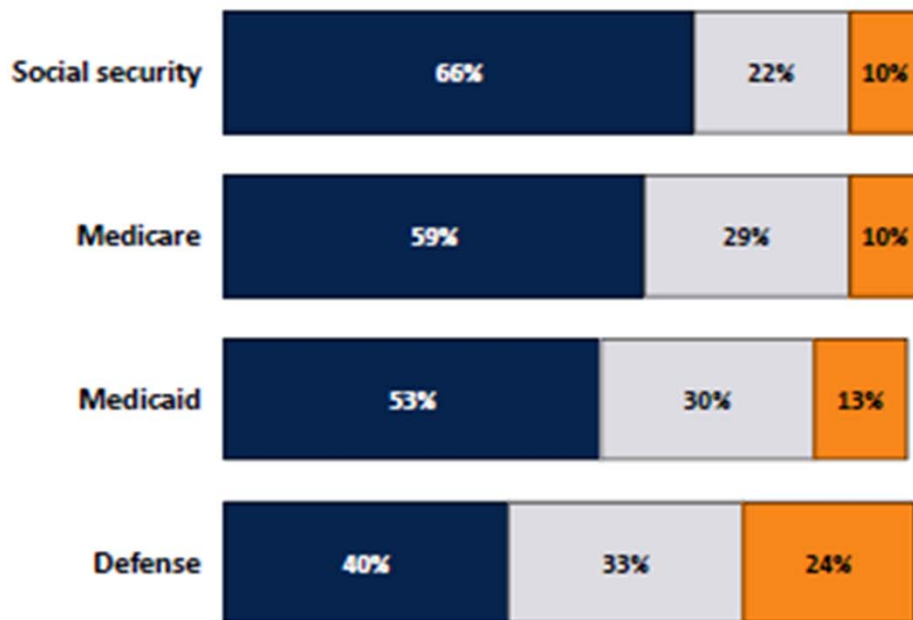
Responsible Deficit Reduction

- Bowles-Simpson deficit-reduction plan includes a principle to protect the disadvantaged.
- **The major deficit-reduction packages of 1990, 1993, and 1997 all generally protected programs for low-income Americans; those packages, in fact, reduced poverty and inequality even as they reduced deficits.**
- They did this thru substantial increases in EITC (1990, 1993) and food stamps (1993), and creation of CHIP (1997) package).
- This principle also reflected in the Gramm-Rudman-Hollings law, the Budget Enforcement Act of 1990, and last year's Pay-As-You-Go law — all of which exempted means-tested entitlement programs from automatic across-the-board cuts when deficit targets were missed or pay-as-you-go standards were violated.

Little Appetite for Spending Reductions to Reduce Deficit

For each area I name, please tell me if you would support major spending reductions, minor spending reductions or no reductions at all as a way to reduce the federal deficit.

■ NO reductions □ Support MINOR reductions ■ Support MAJOR reductions

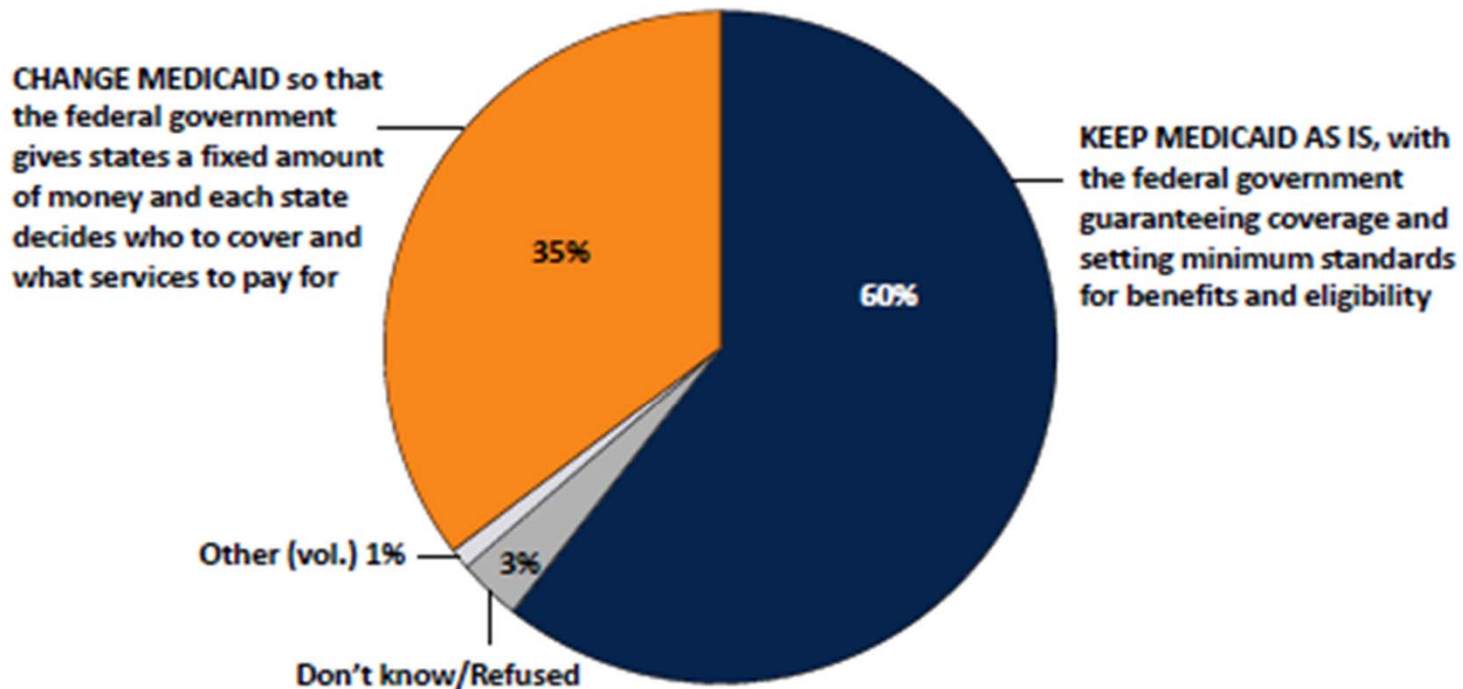



Note: Don't know/Refused answers not shown.

Source: Kaiser Family Foundation Health Tracking Poll (conducted May 12-17, 2011)

Reaction to Medicaid Block Grant Proposal

Under the current Medicaid program, the federal government guarantees health care coverage and long-term care for certain low-income people. The program is paid for by the federal and state governments. Each state administers its own Medicaid program with lots of state-to-state variation, but all states are required to provide coverage to anyone who meets minimum criteria set by the federal government. To reduce the budget deficit, some policymakers have suggested that the federal government reduce its Medicaid spending by giving each state a fixed amount of money and eliminating federal minimum standards for Medicaid. Which would you prefer:



The background of the slide is a photograph of the Texas State Capitol dome, showing its ornate architecture and the statue on top. To the right of the dome, the American flag and the Texas state flag are flying on a tall pole against a clear blue sky.

Texas Legislative Update

June 22, 2011

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Healthy Futures Alliance

*A Community Coalition to
Reduce Teen & Unplanned Pregnancy*



Pro-Life and Pro-Choice People
working together on Prevention



Texas Women's Health Program (WHP)

- Medicaid coverage of exams, screening, birth control - not abortion
- Women 18 - 44 (at/below 185% of Poverty)
- Saves over \$40 million per year
- Texas gets back \$10 for every \$1 it puts in
- About 120,000 women per year

LBB Texas State Government Effectiveness and Efficiency pp 259-266

HHSC Rider 64 Report, Oct 2010



Texas Women's Health Program (WHP)

In the 2011 Texas Legislature:

- NONE of the bills to Renew WHP passed...
- BUT a budget amendment (HHSC rider 62) renews the program
- Attorney General's opinion: Texas can exclude Planned Parenthood
 - PP provided over 40% of services in WHP
- Fewer providers means fewer patients will be served

Texas Family Planning Program

Preventive Care for Uninsured Women &

Family Planning Program Budget Cuts

DSHS Family Planning Program

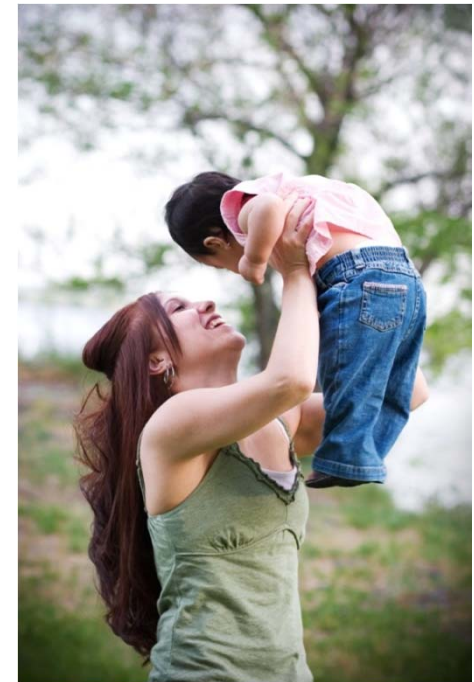
- Provides exam, screening, contraception, not abortion
- Fewer than 20% of women-in-need served

2010-2011 budget was over \$111 million;

- introduced 2012-2013 budget proposed \$98 million (\$11.9 million below 2010-2011)

Nearly \$62 million (of \$98 million) cut from the introduced budget:

- 284,000 fewer women will receive services
- More than 20,500 additional Medicaid-paid births
- More abortions
- Increase Texas tax costs of \$98 million



Family Planning Program Funding Restrictions



DSHS Rider 77: Funding Priorities

1. Public entities (state, county, local agencies, Federally Qualified Health Centers); Baylor Teen Clinic
2. Non-public entities that provide comprehensive care
3. Family planning clinics

SB 7 also includes family planning language:

- o **DSHS funds** -- tiered funding priority from public comprehensive primary care providers down to less comp. FP providers; “or as otherwise directed in the GAA (HB 1)”
- o **Medicaid**—ensure that FP funding in WHP or successor not used for perform/promote elective AB, or to contract with entities that “perform/promote” or affiliate with entities that “perform/promote” elective AB. (No change from current WHP law.)



Bills: Sex Education

HB 1624 /SB 852: “Education Works”

Sex education must be age-appropriate and, evidence-based;
Emphasize abstinence and to include methods to prevent STDs and pregnancy

HB 1255 /SB 585

Sex education must be evidence-based and medically accurate
Inform parents if Abstinence-Only or comprehensive

None got a Hearing