

August 8, 2013

Sizing Up the 2014-15 Texas Budget: Medicaid and CHIP

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While not as bad as the deep cuts, underfunding, and payment delays adopted in 2011, the state budget for 2014-2015 fails to undo the deepest cuts of 2011, and is marked by both new and ongoing austerity measures. Our state's inability to pay front-line health care workers a living wage, or keep other Texas Medicaid provider payments on par with Medicare, parallels our state's struggle to fund our education, water, and transportation needs. To support a 21st-century economy, Texas needs a solid public infrastructure—including education and health care—and that demands a 21st-century revenue system, not one based on the economic realities of the 1950s.

Most senseless of all, state leaders did not find a Texas Solution to draw down federal Medicaid funds to provide health care for our poorest uninsured. As a result, in January 2014, under the Affordable Care Act, Texas adults above the poverty line will qualify for publicly-funded sliding-scale help with health insurance, but Texans below poverty will qualify for nothing.

This policy brief highlights key budget and policy decisions on Medicaid and CHIP funding in the state budget for 2014-2015 (Senate Bill 1, as modified by HB 10 and HB 1025, the 2013 supplemental appropriations bills), and several additional health care issues.

Medicaid Big Picture: No Big IOU, but Most 2011 Cuts Remain

The legislature “made good” on its unprecedented Medicaid IOU in the 2012-2013 General Appropriations Act (totaling \$4.5 billion in General Revenue), with passage of the first supplemental appropriations bill (HB 10) in March. That bill included funding to fill a gap of about 5 months of Medicaid funding, to allow the program to meet its obligations through the end of fiscal year 2013. Though advocates worried in 2011 that lawmakers might try to make that massive funding reduction permanent in 2013, Texans were spared any direct effort to do so, partly because of the current federal administration's support for Medicaid and CHIP. Under different federal leadership, a major down-sizing of Medicaid would have been more politically viable. This was a critical juncture for Texas Medicaid's future, since the 2011 Texas legislature adopted provisions calling for creation of a Texas block grant for Medicaid, and possibly for most other federal health care funding streams, including Medicare ([read more](#), see page 4).

Costs of Some Mandatory ACA Medicaid Changes Not Included in Budget. While Texas Medicaid is not facing a giant IOU, the program is funded at nearly \$1.3 billion General Revenue (GR) below the projected need for 2014-2015. The biggest component of this is the legislature's decision not to allocate funding for an estimated \$760 million GR in increased Medicaid costs the Health and Human Services Commission (HHSC) projects will accompany ACA implementation in 2014. Increased costs result from changes that take effect in every state, regardless of whether or not they have implemented the ACA's adult Medicaid expansion, including:

- an extension of Medicaid coverage to former foster care youth until they reach the age of 26;
- the transition to Medicaid renewal periods that may not be more frequent than yearly (most Texas Medicaid kids and parents today must renew every 6 months), and elimination of asset limits for most Medicaid coverage; and
- increased “take-up” or participation rates—the percentage of qualified persons who actually enroll—by children and youth as the result of widespread outreach about and awareness of expanded coverage options under the ACA (sometimes called the “welcome mat effect”).

The other major Medicaid-CHIP underfunding in the 2014-15 budget stems from adoption of cost-per-client assumptions for both HHSC and the Department of Aging and Disability Services (DADS) that are lower than what the agencies and the Legislative Budget Board (LBB, the official “scorer” of the cost of Texas laws and programs) actually anticipate. LBB public working documents indicate the budget is short about \$487 million GR at HHSC and \$36 million GR at DADS for expected Medicaid cost growth needs.

Medicaid Under-Funding Choices are Not Necessarily Cuts. A critically important factor—as true for these 2013 session decisions as it has been in earlier state budgets going back nearly two decades—is that these particular decisions to underfund now and create the need for supplemental appropriations in the following session provide an alternative to deep program cuts today. As near as can be determined without a crystal ball, all of the Medicaid services and beneficiaries to which the \$1.3 billion GR in under-funding applies will still be fully provided by Texas Medicaid in 2014-2015.

“Real” Spending Cuts

Provider Payments: Plus and Minus. There were, however, additional actual cuts to Medicaid or CHIP approved for 2014-15. First, the 2013 Legislature made virtually no reversals of the benefit and payment cuts adopted for both programs in 2011. While fees for a set of specified Medicaid primary care services are increased in 2013 and 2014 with federal funds as part of the ACA, most of the significant Texas 2011 rate cuts still apply to non-physician providers, pharmacies, labs, hospitals, and others ([read more](#), see page 2).

On the positive side of the ledger, the ACA provides 100% federal funds to increase state Medicaid payments for specific primary care services provided by certain types of providers up to at least the Medicare level in 2013 and 2014. The Legislature added about \$44 million in GR to the state budget to extend those payments to OB-GYN doctors (not included in the federal policy) and to continue to replace the 2% cut from Texas Medicaid primary care rates in 2015, after the federal funding expires.

Rider 51: Medicaid Cuts Shopping List. In addition, a budget rider adopted in 2011 (then HHSC rider 61, now HHSC rider 51) was revised in the 2014-15 budget and requires HHSC to find \$400 million GR in Medicaid spending reductions, authorizing the agency to use “any or all” of 25 listed approaches to cuts, including a catch-all for “additional initiatives identified by the Health and Human Services Commission.”

Hospital analysts project that over half the spending reductions listed would come from reduced spending on hospital services; however, the scope of the language is quite broad and clearly will affect Medicaid clients and other provider types as well. One challenge faced by Texas Medicaid is to determine how Medicaid HMOs can be required to play a larger role in ensuring delivery of care in the best settings and avoiding hospitalizations when possible. Ensuring that the health plans and primary care providers have provided enrollees with timely access to urgent care and specialty care outside the E.R. is a key example of how responsibility for reducing E.R. and hospital use does not end at the hospital itself.

While the drive to improve quality and outcomes in ways that are cost effective is wholly supported by consumer advocates, history has shown that the lists of potential Medicaid cost savings approaches are often not fully analyzed and vetted. With so many potential surgical tools at HHSC’s disposal, advocates and stakeholders will have to monitor closely the resulting policy changes and cuts for future impact on consumers, and potential damage to the already-thin provider networks.

More Budget Additions and Reductions

The 2014-2015 Medicaid and CHIP appropriations include more than the usual share of complexity, some of which is related to the effects of two different 2013 supplemental appropriations bills (HB 10 and HB 1025). These provisions add to the uncertainty surrounding the ultimate size of Medicaid funding and cuts.

Rider 62 in Special Provisions Relating to All Health and Human Services Agencies assumes that \$254.5 million GR of the funds needed for Medicaid (\$218.3 million at HHSC and \$36.2 million at DADS) will come from carrying-forward unexpended balances from 2013. This rider tells the agencies that, to the extent that the supplemental bills provided more funding than was needed to cover 2013 costs, the balance will be put toward the 2014-15 budget. However, the agencies currently expect smaller unexpended balances than the amounts the rider

anticipates—in part due to uncertain size and timing of rebates from drug manufacturers and Medicaid HMOs—which could alter the size of the “baked-in” Medicaid shortfall.

Medicaid Savings from Family Planning Services. One major reversal of damaging 2011 budget decisions was the adoption of new funding for family planning services through the Department of State Health Services (DSHS) Family Planning and Primary Health Care programs. HHSC, DSHS, and the LBB all have calculated that the family planning cuts made in 2011 resulted in large increases in Medicaid costs resulting from unplanned pregnancies, and HHSC estimated 23,760 additional babies would be born under Medicaid in 2014-2015 at a cost of \$103 million GR for the biennium. With the addition of funding for Primary Health Care (60% of it is expected to go for family planning services), and replacement of Family Planning block grant money at DSHS, budget writers reduced the Medicaid GR allocation by \$132 million, banking on additional births from unintended pregnancies being avoided as family planning access is increased. Note: See upcoming CPPP brief for greater detail on family planning funding for 2014-2015.

Other Medicaid “Offsets.” Budget writers assumed additional Medicaid savings of \$10 million GR as the result of expanding the Youth Empowerment Service (YES) Waiver at the Department of State Health Services. With the federal match, this offsets the \$24.3 million needed to expand the YES waiver, which provides flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families. Another \$65 million in reduced Medicaid spending is assumed to be funded from increased fraud judgments and recoveries achieved by the Office of the Attorney General and from costs avoided through the HHSC Office of Inspector General activities (\$50 million GR for OAG, \$15 million GR for OIG).

Caseload Assumptions and Changes

The budget incorporates the Legislative Budget Board’s updated May 2013 forecasts of caseloads; federal Medicaid matching rates (FMAP) for 2015; enhanced federal match gains from the Balancing Incentives Program (certain activities promoting community-based care earn an extra 2 percentage points in federal match); prescription drug and HMO rebate revenues;

Caseloads in SB 1	FY 2013	FY 2014	FY 2015
Medicaid	3,666,216	3,860,020	4,193,348
CHIP	627,373	573,798	373,594

and any unexpended funds balance left over from FY 2013.

Sources: Texas HHSC, SB 1

CHIP caseloads will drop significantly in 2014 and 2015. Under the ACA, all children up to age 19 and in families with incomes up to 138% of the poverty line (\$32,499 for a family of 4 in 2013) will qualify for Medicaid—even in states like Texas that do not yet provide Medicaid for adults under the ACA. This means that Texas children enrolled in CHIP, ages six to eighteen, with family incomes between 100% and 138% of poverty, will move from CHIP to Medicaid. HHSC plans to handle this transition by sorting all newly enrolled children starting January 2014 according to the new income limits, and transitioning the currently enrolled children at their first scheduled renewal in 2014. Because not every health plan in every region serves both Medicaid and CHIP children, in some places a child may need to select a new health plan in 2014, unless HHSC and the affected plans revise their contract arrangements before then.

As of June 2013, children in this income range appear to account for well over a third of the more than 600,000 children in Texas CHIP, and possibly close to half ([see HHSC statistics](#)).

2014 Coverage Gap: No “Texas Solution” for Adults Leaves Poorest Uninsured without Options

A staggering missed opportunity was the failure of the Legislature and state leadership to move forward to accept billions in federal funds to insure Texas adults below 138% of poverty in 2014—either through Medicaid Managed Care contracts with HMOs or through private plans in the Health Insurance Marketplace. Congress did not intend for the role of expanded Medicaid in 2014 through the ACA to be optional, but last summer’s U.S. Supreme Court decision made it so when it eliminated any penalty for states that did not implement the coverage for adults in and near poverty. Because Congress intended that the poorest would get Medicaid, under the ACA, U.S. citizens below poverty are not eligible for sliding-scale help with premiums and out-of-pocket costs in the Marketplace. As a result, Texas’ decision means that in January 2014 Texas adults above the poverty line will begin to get publicly funded sliding-scale help with health insurance, but Texans below poverty will qualify for nothing.

Estimates of the number of uninsured Texas adults who will be left without a coverage option in the near term¹ range from around 935,000 (HHSC, out of 1.1 million below 138% of poverty) to as high as 1.3 million (Urban Institute/Kaiser Family Foundation, out of about 1.7 million below 138% of poverty).

Widespread Support, Executive Opposition. Statewide support for the Medicaid expansion is strong, with doctors, hospitals, county officials, chambers of commerce, and even the Texas Association of Business eventually supporting the coverage option. Polling by Texas and national firms found 58-59% of Texas voters support accepting federal ACA funds to cover the poorest uninsured adults. Twenty-two chambers of commerce have called on the state to accept this funding, and new chambers continue to add their names to the list.

Despite broad centrist support, the Legislature did not move forward with even the very-conservative, market-based “Texas Solution” alternative offered by Rep. John Zerwas in HB 3791. There was more than sufficient support by House members for Zerwas’ “Texas Solution” bill. But the Governor’s office began to communicate a veto threat, and House leaders decided not to bring the bill up for a vote in the chamber. Then, some of the most conservative members called for a non-binding “motion to instruct the conferees” on SB 1 not to authorize Medicaid expansion in any form, and a budget rider to create authority for a Texas Solution by Senate Finance Chair Tommy Williams was also deleted from the appropriations act conference committee report. A House floor amendment to SB 7 was approved that echoed the earlier budget instructions to conferees.

What’s Next for Adults in the Coverage Gap? Even if Texas does not have the political will or legal authority today to develop a Texas Solution to draw down new Medicaid dollars available under the ACA, we must begin now to make the case for action in 2015. But opposition by the Governor is currently the most critical obstacle to progress during the interim or in the 2015 session. The broad support among healthcare stakeholders is a good first step, but fixing the coverage gap in access to health care in Texas will require a strong, continued education effort to make many more Texans aware of the [unconscionable](#) and [wasteful](#) consequences of failing to draw down all available Medicaid dollars and address the gap.

What You Can Do. Individuals who want to help advocate for a Texas Medicaid expansion are encouraged to sign up for emails at texaswellandhealthy.org, and organizations are asked to consider joining the Cover Texas Now Coalition, covertexasnow.org.

Access to Community-Based Long-Term Care

Personal Attendant Care: Low Wages, No Benefits

Personal attendant care and home health aides help nearly 200,000 seniors and Texans with disabilities receive services that allow these Medicaid beneficiaries to live in the most integrated community settings possible, and to avoid more costly institutional care. The very low hourly rates paid for this care by Texas Medicaid make finding and keeping reliable attendant care an ongoing challenge, because it is so difficult for qualified workers to live on those wages. The Coalition of Texans with Disabilities reports that workers receive no paid sick leave, no paid vacation and no health insurance. The average worker today is a 55-year-old woman.

Wages. HHSC requested \$176 million GR as part of an “Enterprise Exceptional item” for DADS and HHSC programs, intended to fund a 50-cent per hour, across-the-board wage increase for all attendant workers. In the adopted 2014-2015 budget, the lowest-paid workers’ hourly wages will rise to \$7.50 an hour in 2014, and \$7.86 in 2015. This funding is just over half the agency-

requested amount, and leaves the lowest paid attendants earning 61 cents an hour above minimum wage.

Special Provisions Rider 52: Impact of ACA on Attendant Care, Nursing Facilities. Many attendant care workers are uninsured today, but given their very low wages many of them would qualify for coverage if Texas takes advantage of federal Medicaid funding to cover adults below 138% of the federal poverty line (\$15,856 a year for an individual, or \$26,951 for a family of 3 in 2013). Those above that income will qualify for sliding-scale premium assistance in the new Health Insurance Marketplace if their employers do not provide affordable health benefits.

Under the ACA and the recently announced one-year delay in employer penalties, starting in 2015 employers with more than 50 full-time-equivalent workers who choose not to provide health benefits can be assessed “shared responsibility” penalties if a full-time worker qualifies for taxpayer-funded sliding-scale help with coverage in the new Health Insurance Marketplace. However, employers will not be penalized when workers enroll in the expanded Medicaid for adults under the ACA.

There is some overlap between the Medicaid coverage group defined in the ACA (0-138% of the poverty line) and the population eligible for Marketplace sliding-scale subsidies (100%-400% of poverty). So, as long as Texas leadership fails to accept the available federal Medicaid funds and provide for our poorest uninsured, working-poor adults from 100% to 138% of the poverty line will have access to those subsidies—and that will increase the exposure of Texas employers to penalties. A March 2013 report from the Jackson-Hewitt Tax Service concludes that states that do not expand Medicaid will leave employers exposed to higher “shared responsibility” payments under the ACA, and projects that “the decision in Texas to forego the Medicaid expansion may increase federal tax penalties on Texas employers by \$299 to \$448 million each year.”²

Unless Texas Medicaid Pays, Direct Care Workers Increasingly Will Face Reduced Hours. Federal Medicaid law does not require states to pay Medicaid reimbursement rates sufficient to cover the new insurance costs of the agencies that hire personal attendants and home health care aides. This same dilemma is also present for most of Texas’ nursing home industry, where the majority of employees are also typically not provided health benefits.

The Texas Legislature and state agencies have neither debated nor taken action to address this ACA implementation issue. As a result, the businesses and nonprofits that hire attendants and aides face a dilemma: unless Texas Medicaid increases the rates it pays—to “pass through” the new business costs of workers’ health coverage (or penalties, which are significantly lower than the cost of health benefits)—more employers may choose to limit workers to 29 hours per week or less. Some Texas employers haven already taken this step, to avoid penalties which are only

triggered when full-time workers (defined in ACA as 30 or more hours per week) access the taxpayer-funded premium subsidies.

The adopted budget includes a rider (Special Provisions Relating to all Health and Human Services Agencies, section 52), which calls for HHSC and the Legislative Budget Board to calculate the fiscal impact of the employer responsibility penalties on Long-Term Care Medicaid Providers (i.e., both community-based and institutional), and report to the Governor and LBB by November 1, 2014. While a long way from resolving this serious systemic flaw, the rider represents a step in the direction of prudent planning and governance for these changes.

ACA-Funded Enhancements to Community-Based Care: CFC and BIP

The ACA includes several options for states to increase community living opportunities for the elderly and individuals with disabilities covered by Medicaid by providing increased federal Medicaid match rates for targeted community-based services and supports. The Legislature included state General Revenue to draw the enhanced federal match in several ways for 2014-2015.

Balancing Incentive Payments. Texas will receive increased federal match for selected Medicaid Home- and Community-Based Services (HCBS) costs under the Balancing Incentive Payments (BIP) provisions of ACA. Texas and other states with between 25 and 50 percent HCBS spending out of their total long-term care spending are eligible for a 2 percentage point federal matching rate increase. The BIP provisions of ACA require states to transform long-term care systems, create a more person-centered assessment and care plan, and improve quality measurement and oversight ([read more here](#)). The 2014-2015 Appropriations Act assumes that Texas activities and investments that will earn the enhanced match rate in the HHSC, DADS, and DSHS budgets will “free up” nearly \$220 million in state funds.

Community First Choice Option. The ACA established the Medicaid Community First Choice Option (CFC), available since 2011, which provides community-based attendant supports and services to individuals with disabilities whose incomes do not exceed 150 percent of the poverty line, or if their disability meets the state’s eligibility criteria for institutional services and their income level meets the state’s financial criteria for institutional care (in Texas, 300% of the federal SSI benefit rate). CFC provides a 6 percentage point increase in federal Medicaid match rates as a powerful fiscal incentive to offer services such as attendant care and habilitation services outside of the capped, wait-listed waiver programs. Nearly 12,000 additional Texans are projected to get these services in 2014-2015 with the implementation of this option.

Waiting Lists for Community-Based Care

Many of the special programs that help Texans with disabilities of all sorts and some seniors to live in community settings are Medicaid “waiver” programs at the Department of Aging and Disability Services (DADS), which have capped budgets and caseloads that result in waiting lists for interested participants.

DADS requested and received \$28.1 million for a package of “Promoting Independence” capacity increases for waiver programs, specifically designed to move Texans from institutions to community programs. An estimated 1,377 Texans will be able to leave or avoid institutional living because of this package of funding.

DADS also requested funding to serve 11,548 more Texans across six waiver programs and the STAR+PLUS Medicaid Managed Care program, but received funding for community “slots” for 5,846 individuals at a cost of \$64.9 million GR. This will serve about 5% to 6% of the total population waiting. As of April 30, 2013, 105,032 Texans with disabilities (unduplicated) were waiting on “interest lists” for the chance to get these services.

The Children with Special Health Care Needs program at the Department of State Health Services (DSHS) also historically has had children with significant health conditions waiting on lists for services: to fill in for what insurance will not cover and to provide medical services for children who cannot get coverage. The agency requested \$23.6 million to cover 802 more children per year, but the legislature allocated \$14 million to cover about 60% of that need, or about 476 additional children and teens.

Helping Infants, Children, and Adults with Developmental and Rehabilitative Services

Parents of infants and toddlers with developmental delays, and youth and adults recovering from illness and injury all turn to the Department of Assistive and Rehabilitative Services (DARS) for services to let them reach their maximum potential.

Funding cuts first adopted by the 2011 Legislature imposed more restrictive eligibility requirements for Early Childhood Intervention (ECI), and the program is still funded below 2011 levels. Though the final budget funded the DARS request to prevent even further cuts in services for the current, smaller pool of kids, Texas now serves a smaller pool of children in need—about 5,400 fewer than in 2011—and will still be about 2,100 below 2011 service levels in 2015.

Budget documents also show a small decrease in the number of adult Texans able to access Comprehensive Rehabilitation Services every month compared to 2012-13, and waiting lists for those needing rehab services will continue to grow.

The Big Picture and What's Next?

The LBB reported in 2011 that \$38.8 billion in All Funds (\$16.3 billion GR) was appropriated for Medicaid across all state agencies for the 2012–13 biennium, making up 70 percent of all funding for Article II Health and Human Services agencies. This number was, however, artificially low because of the large Medicaid IOU created by those appropriations, which started at about \$5.5 billion GR and was whittled down to \$4.5 billion GR (about \$11 billion All Funds) by subsequent budget adjustments. So, if the 2012-2013 Texas budget had not included the Medicaid IOU, the grand total of All Funds Medicaid appropriations would have been about \$50 billion.

For 2014-2015, \$58.2 billion in All Funds appropriations are included in the budget (rider 12, Special Provisions Relating to all HHS Agencies). The limited cost and caseload growth built into the 2014-2015 budget is not the only factor contributing to the gain. A greater share of state Medicaid matching dollars for the Disproportionate Share Hospital (DSH) payment program, and for payments to health care providers under Texas Medicaid's 1115 Transformation Waiver (formerly UPL payments)—both largely off-budget in the past—will be included in the budget going forward. Several different mechanisms will increase the state's role in using trauma funds, interagency contracts, and intergovernmental transfers to maximize the federal matching funds that can be raised under DSH and the 1115 waiver.

Another sweeping trend affecting Texas Medicaid will be the continued push to enroll nearly 100% of Texas Medicaid enrollees in “capitated,” risk-based HMOs. SB 7, SB 8, and SB 58 all establish new pathways to extend the reach of HMO-style Medicaid Managed Care. With an ever-larger share of the annual \$28+ billion Texas Medicaid program flowing through Medicaid Managed Care health plans every year, heightened oversight and engagement will be needed from consumer advocates and budget hawks alike.

Endnotes

¹ Uninsured U.S. citizen adults below 100% of the poverty line, 2014-2017.

² The Supreme Court's ACA Decision and Its Hidden Surprise for Employers: Without Medicaid Expansion, Employers Face Higher Tax Penalties Under ACA, Brian Haile, Jackson Hewitt Tax Service Inc., March 13, 2013; http://images.go.jacksonhewitt.com/Web/JacksonHewittTechnologyServicesLLC/%7b6effb4ab-9091-4659-a8a4-df8e5a759135%7d_Employer_Penalties_and_Medicaid_Expansion_%28Mar_2013%29_3-11-2013.pdf

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