



LEGISLATIVE BUDGET BOARD

Medicaid Overview

PRESENTED TO the House Committee on Appropriations

LEGISLATIVE BUDGET BOARD STAFF

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Overview

Medicaid is a jointly-funded State/Federal program providing health insurance primarily to low-income parents, non-disabled children, pregnant women, the elderly, and people with disabilities. As a requirement of participation, states must cover certain groups and have the option to cover additional groups.

The Health and Human Services Commission (HHSC) is the single state agency responsible for Texas's Medicaid program, but services are administered by a variety of state agencies.

Basic Federal Requirements

- **Entitlement:** any eligible person may enroll.
- **Statewideness:** states cannot limit available services to specific geographic locations.
- **Comparability:** same level of services available to all clients.
- **Freedom of Choice of Provider:** clients may see any Medicaid health care provider who meets program standards.

Waivers

The U.S. Secretary of Health and Human Services has broad authority to waive statutory and regulatory provisions, allowing states to test new ways of delivering and paying for services. For example:

- Section 1115 demonstrations do not require statewideness, comparability, or freedom of choice of provider; and
- 1915(c) waivers allow states to provide long-term-care services in home and community-based settings and may be implemented in limited geographic areas with comparability of services with non-waiver enrollees not required.

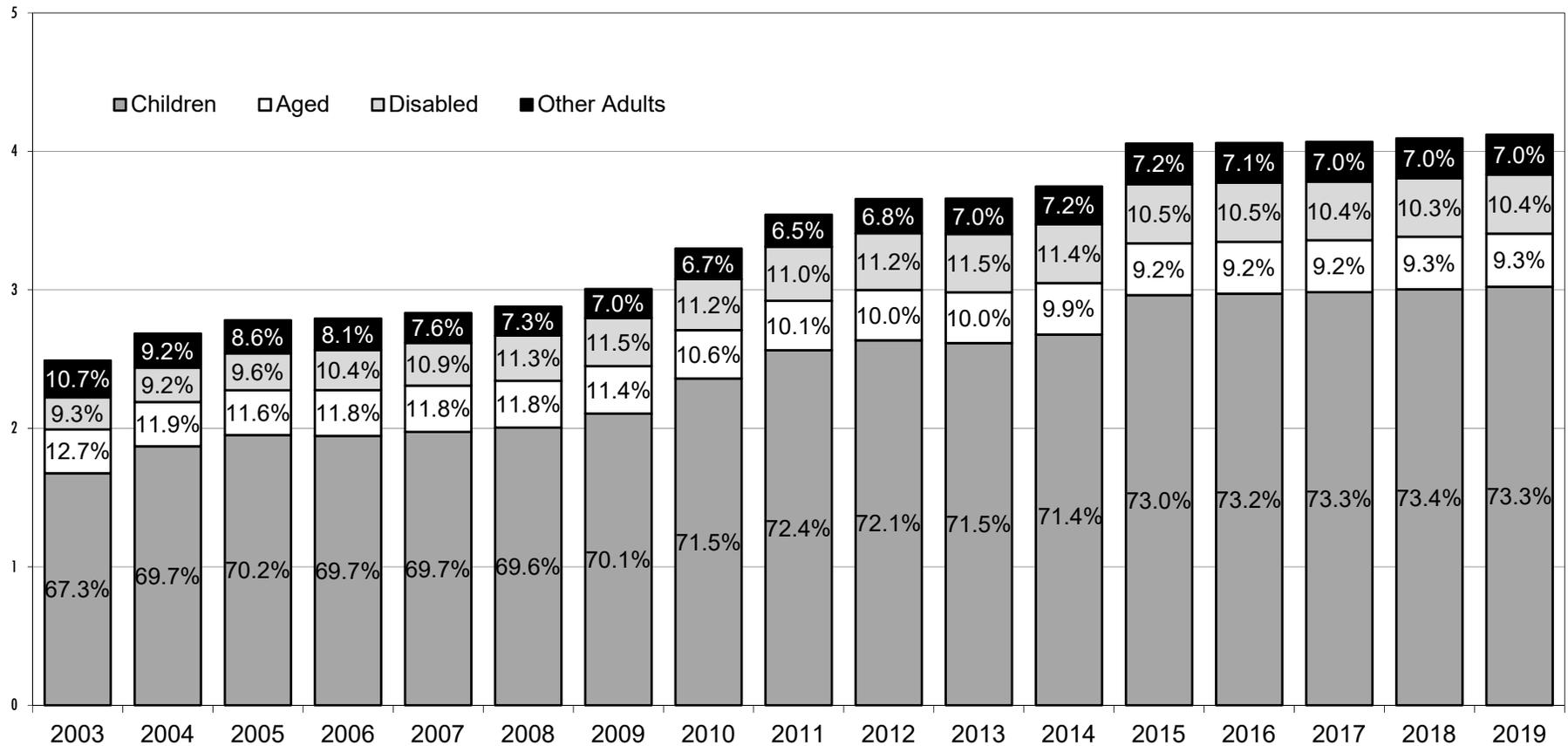
Budget Drivers: Caseload and Cost

Medicaid expenditures are primarily a function of two factors: caseload and cost.

- As caseloads increase or decrease (due to factors such as population growth, the economy, or policy changes), Medicaid expenditures fluctuate.
- Medicaid expenditures also fluctuate as a result of cost growth (tied to rate changes, medical inflation, utilization, and acuity), which can be negative or positive.

Medicaid Average Monthly Full-Benefit Caseload by Enrollment Group Fiscal Years 2003 to 2019

IN MILLIONS



NOTES:

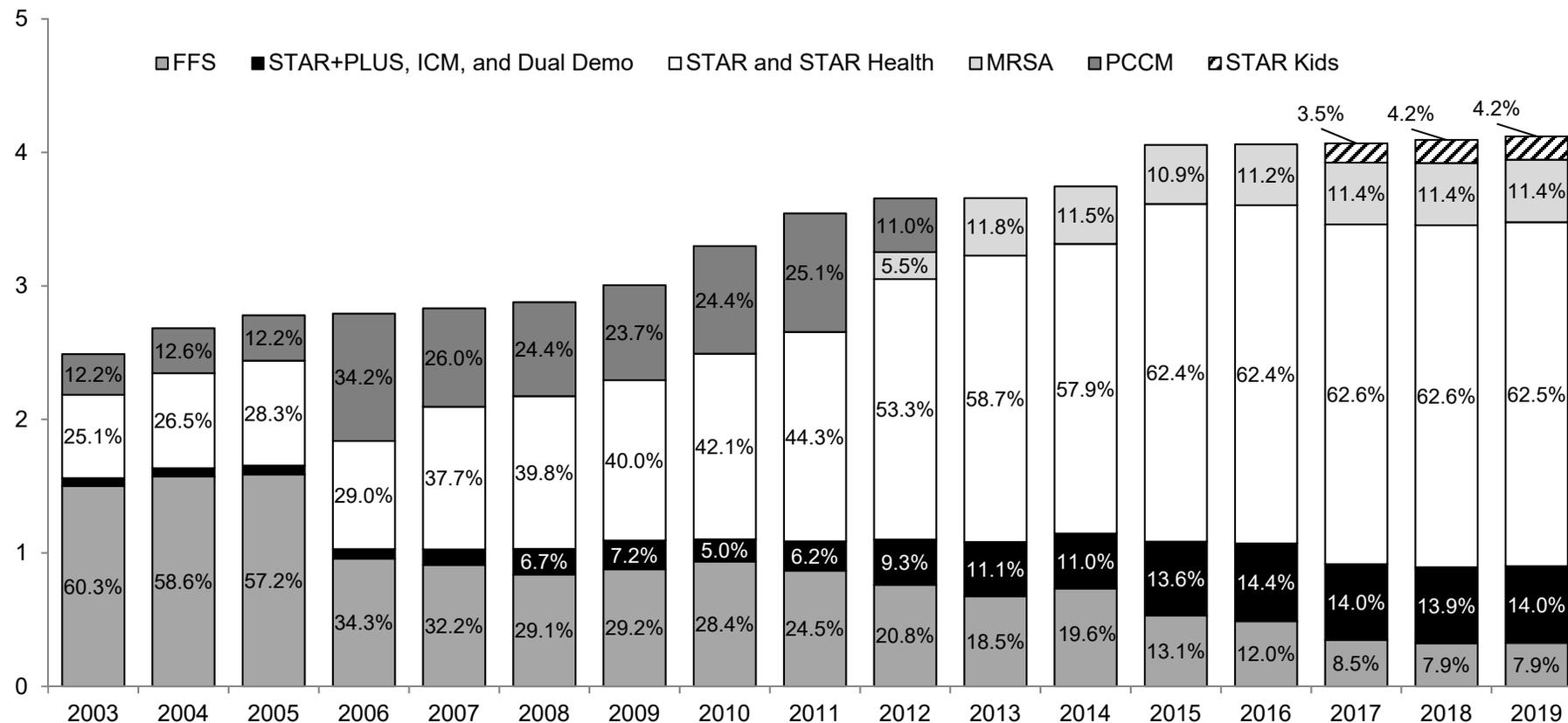
(1) Other adults includes TANF Adults, Pregnant Women, Medicaid for Breast and Cervical Cancer, and Medically Needy clients.

(2) Fiscal year 2016 is estimated; fiscal years 2017 through 2019 are the most recent Legislative Budget Board projections.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

Medicaid Average Monthly Full-Benefit Caseload by Delivery Model Fiscal Years 2003 to 2019

IN MILLIONS



NOTES:

(1) Represents average monthly number of clients receiving full-benefit Medicaid health insurance services. Managed Care delivery models include all but Fee-for-Service. The percent of clients receiving STAR+PLUS and ICM from 2003 to 2007 was between 2.3 and 4.1 percent.

(2) Fiscal year 2016 is estimated; fiscal years 2017 through 2019 are the most recent Legislative Budget Board projections.

SOURCES: Legislative Budget Board; Health and Human Services Commission.

Managed Care Delivery Models

Managed care is a system of delivering health care in which the state contracts with managed care organizations (MCOs) to provide services to Medicaid members and pays the MCOs a per member per month amount (premium or capitation payment).

Current Models

- STAR: Serves children, pregnant women, and certain other adults.
- STAR MRSA: STAR in the Medicaid Rural Service Area.
- STAR Kids: Serves children, under age 21, with disabilities.
- STAR+PLUS: Serves adults who are aged or disabled, integrating both acute and long-term care.
- STAR Health: Serves children in the conservatorship of the Department of Family and Protective Services and certain young adults in foster care or eligible as former foster care children pursuant to the Affordable Care Act (ACA).
- Dual Demonstration (Dual Demo): Operates in six counties (Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant), serving persons dually eligible for Medicare and Medicaid who were previously enrolled in separate coverage for each program.

Discontinued Models

- Integrated Care Management (ICM): Alternative to STAR+PLUS operating in Dallas from February 2008 through May 2009
- Primary Care Case Management (PCCM): Non-capitated model discontinued in March 2012

Caseload Growth

By fiscal year (FY) 2019, the Medicaid caseload is expected to have grown by more than 50 percent in the preceding fifteen years and will have more than doubled since FY 2001. Caseloads stabilized in FY 2016 and annual growth is projected to be less than one percent in FY 2017 through FY2019.

Recent events contributing to caseload growth include the following:

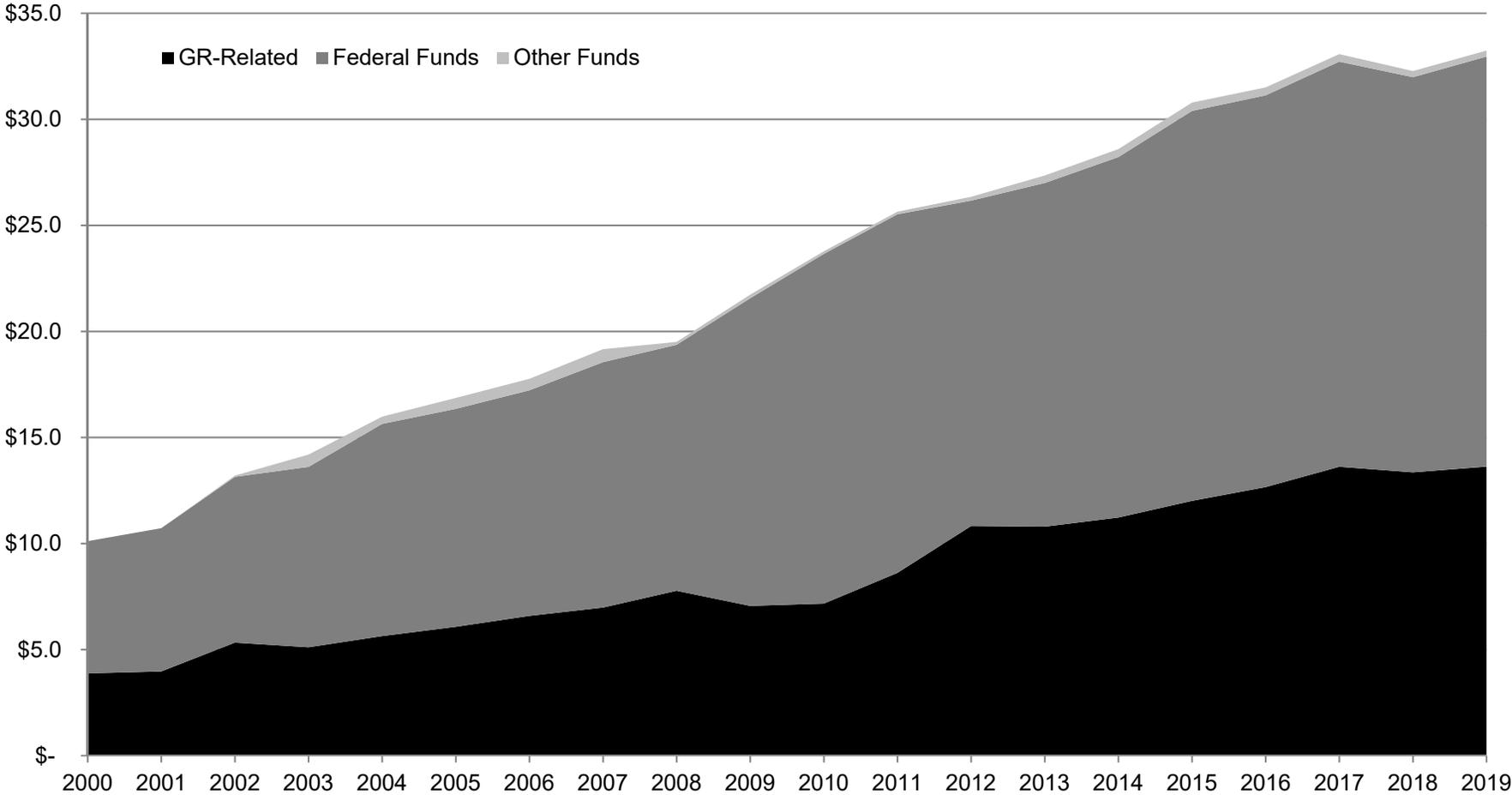
- **FY 2001 to FY 2003:** Nearly 50 percent growth in children enrolled from FY 2001 to FY 2003 due primarily to Senate Bill 43, Seventy-Seventh Legislature, which included Medicaid simplification provisions and six months continuous eligibility.
- **FY 2008 to FY 2011:** Caseloads grew 23 percent from FY2008 to FY2011, primarily due to the economic recession, with enrollment of children, people with disabilities, and other adults all growing more than 10 percent.
- **FY 2014 to FY 2015:** Pursuant to the ACA, children ages 6 to 18 with family incomes from 100 to 138 percent of the Federal Poverty Level (FPL) moved from the Children's Health Insurance Program (CHIP) to Medicaid beginning in early calendar year 2014, adding almost 300,000 children to Medicaid when the transition was complete. Growth in annual average monthly caseload for children is most apparent in FY2015, which increased more than 10 percent from FY 2014.
- **FY 2004 to FY 2019:** The population of Texas is projected to grow by 27 percent from calendar year 2004 to 2019.

Cost Growth

The primary factors contributing to cost growth include the following:

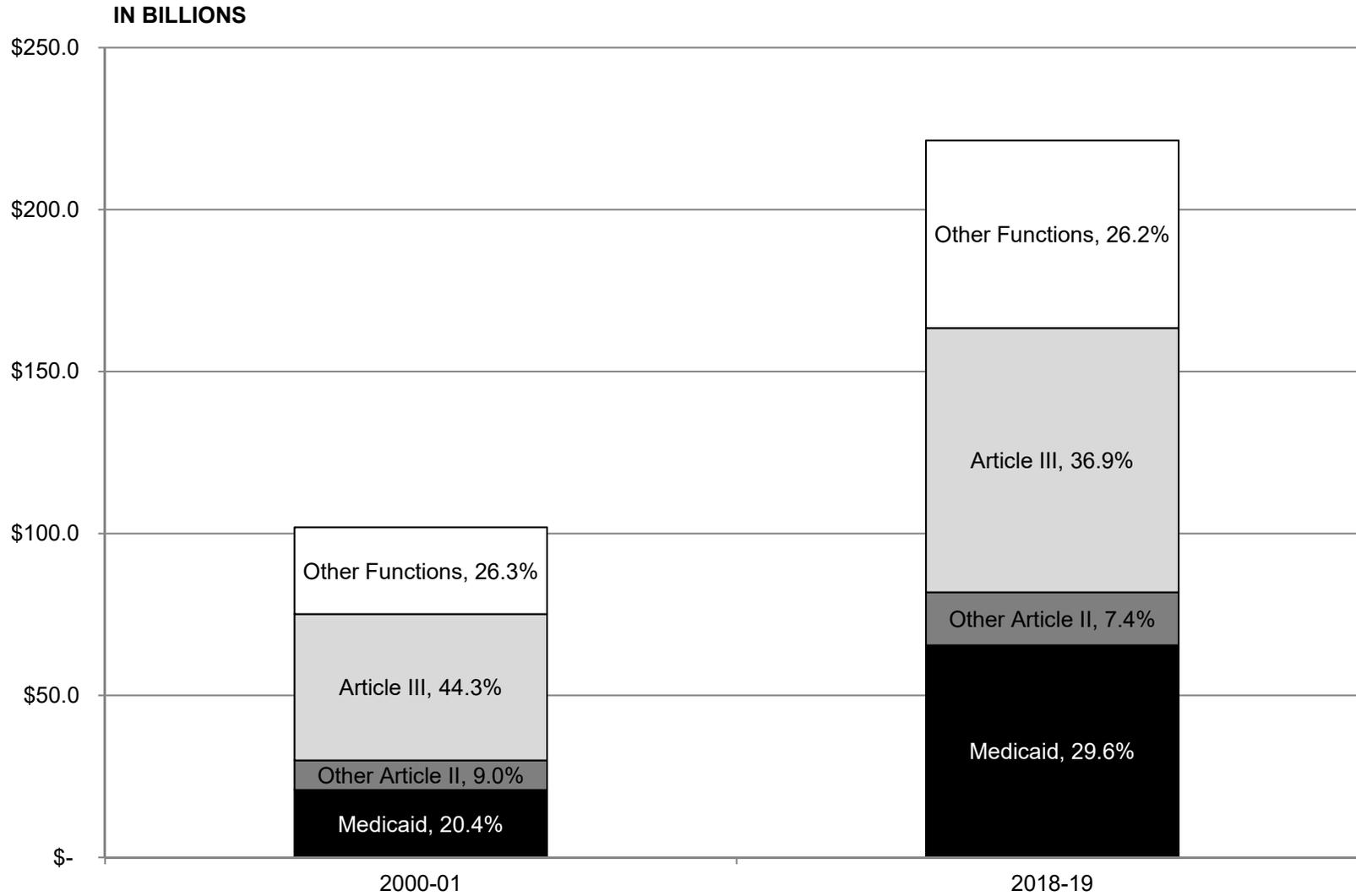
- **Rate Changes:** Adjustments to reimbursements to providers.
 - Recent rate changes include increases in 2016-17 for the Home and Community-based Services (HCS) waiver and non-state-owned intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).
 - Additionally, rates were increased in 2016-17 to accommodate community attendant wage increases.
- **Medical Inflation:** Growth in costs related to how health care is delivered and what services are available.
 - Technological and other medical advances.
 - Increases in the cost of prescription drugs.
- **Utilization:** Changes in how many services are accessed.
- **Acuity:** Relative health of persons enrolled in the program.

Medicaid Funding by Method of Finance Fiscal Years 2000 to 2019



NOTES:
 (1) Fiscal years 2000 to 2015 are expended, fiscal years 2016 through 2019 are amounts included in the Legislative Budget Estimates, House.
 SOURCE: Legislative Budget Board.

State All Funds Budget 2000-01 and 2018-19 Fiscal Biennia



Financing

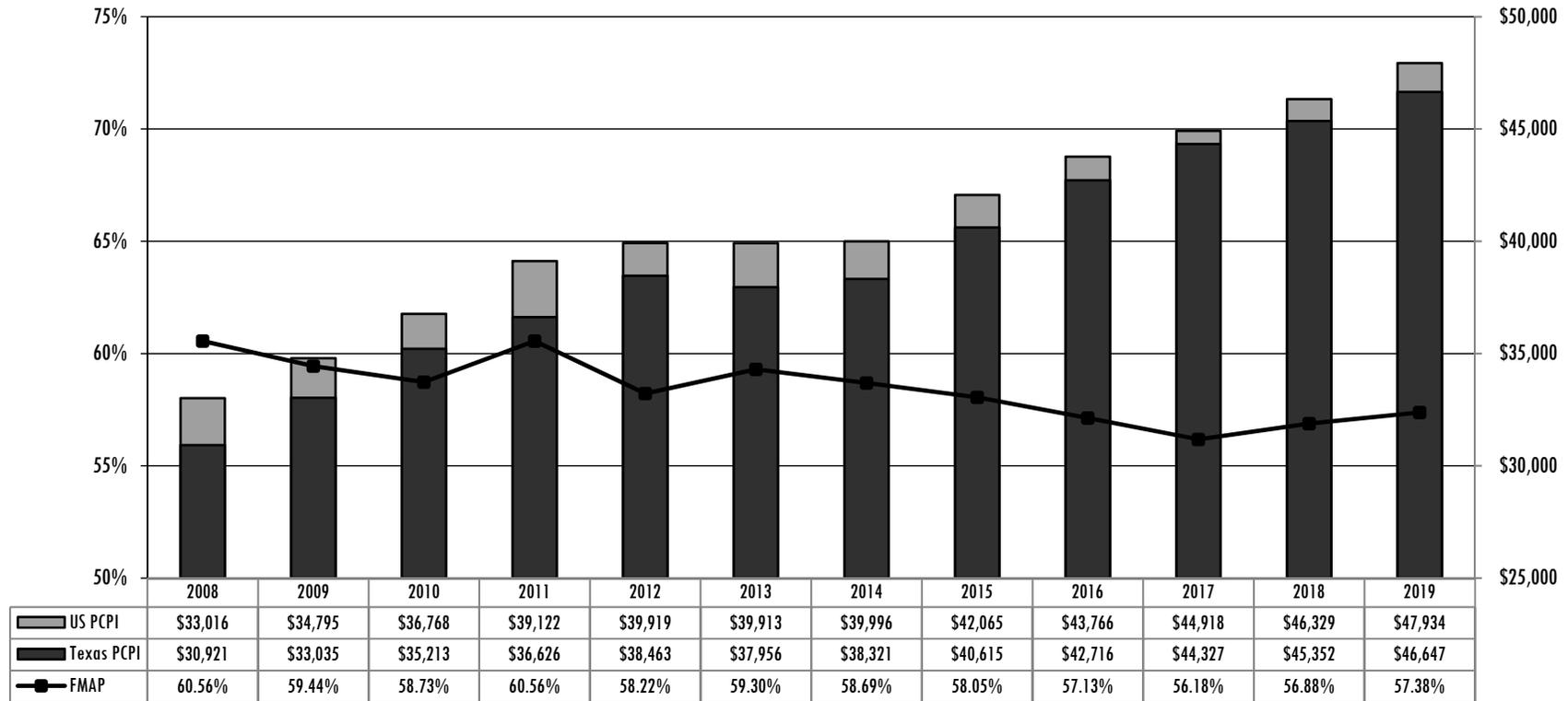
Financing of the Medicaid program is based on an array of matching rates that determine the amount of state funds (General Revenue, General Revenue-Dedicated, and Other Funds) and the amount of Federal Funds.

The primary matching rate for client services is the Federal Medical Assistance Percentage (FMAP).

- Each state has a different FMAP based on its per capita personal income (PCPI) relative to the nation's PCPI.
 - Federal Fiscal Year (FFY) FMAP is generally announced in November of the previous FFY.
 - FMAP is based on the three most recent years of income data available.
 - FFY 2018 FMAP was announced in November 2016 based on PCPI data for calendar years 2013 through 2015.
- State FMAPs can range from 50 to 83 percent.
 - Below 55 percent: states with PCPI higher than the national average.
 - Above 55 percent: states with PCPI below the national average.

FMAP and PCPI

Federal Fiscal Years 2008 to 2019



NOTES:

(1) FMAPs are for federal fiscal year (FFY) and do not reflect enhanced FMAPs related to the American Recovery and Reinvestment Act (ARRA) that applied from the first quarter of FFY 2009 until the third quarter of FFY 2011. Per capita personal income (PCPI) is the average of the most recent three years available at the time each FMAP was calculated and does not include any updates to the data made after that time. For example, FFY 2018 FMAP is based on the average of 2013 to 2015 PCPI as reported by the Bureau of Economic Analysis in September 2016.

(2) FFY 2008 FMAP reflects 0.03 percentage point increase related to the Deficit Reduction Act and Hurricane Katrina; PCPI is what was used to calculate initial FMAP without this adjustment.

SOURCES: Legislative Budget Board; U.S. Department of Health and Human Services; Bureau of Economic Analysis; U.S. Census Bureau.

Other Matching Rates

Higher matches are available for certain client services.

Examples include the following:

- Enhanced FMAP (EFMAP)
 - 30 percent reduction to the state share under FMAP
 - Applies to Medicaid for Breast and Cervical Cancer
- 23 percentage point increase to EFMAP
 - Applies to children previously eligible for CHIP
- 90/10
 - Applies to family planning services
- Community First Choice
 - 6 percentage point increase to FMAP
 - Applies to certain long-term-care services

Other Matching Rates (continued)

Matching rates for administrative services differ from those for client services, with most administrative services matched at 50 percent.

Examples of other administrative matching rates include the following:

- 90/10
 - Administration of family planning services
 - Design, development, or installation of an approved Medicaid Management Information System (MMIS) for claims and information processing
- 75/25
 - Operation of an approved MMIS for claims and information processing
 - Activities conducted by skilled medical professionals
 - Certain medical and utilization review activities
 - Certain external quality review activities
 - Operation of a state Medicaid fraud control unit

Medicaid Funding

in millions	FY 2016-17	FY 2018-19	Biennial Change	Percentage Change
General Revenue	\$26,104.1	\$26,814.5	\$710.4	2.7%
General Revenue-Dedicated	\$173.1	\$168.7	(\$4.4)	(2.6%)
Other Funds	\$724.8	\$575.4	\$(149.3)	(20.6%)
Federal Funds	\$37,564.1	\$37,970.3	\$406.1	1.1%
All Funds	\$64,566.1	\$65,528.9	\$962.8	1.5%

Total Medicaid funding in the 2016-17 adjusted base is \$26.3 billion in General Revenue-Related Funds and \$64.6 billion in All Funds.

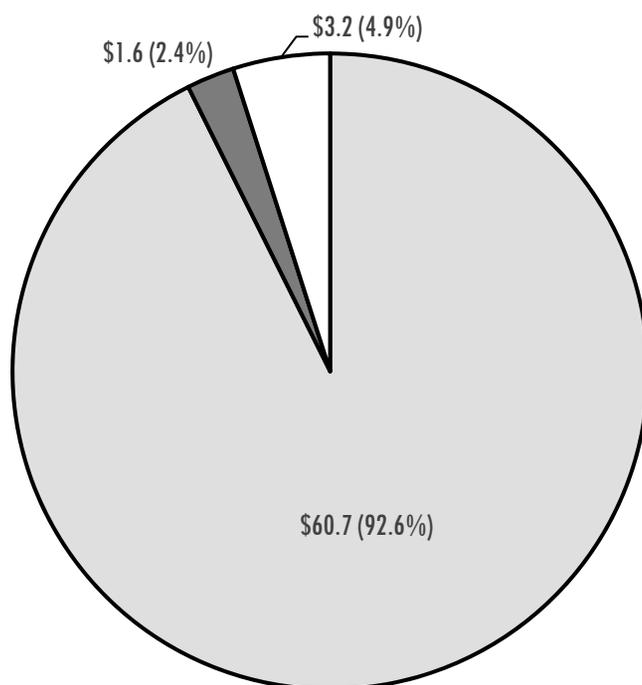
- This includes an estimated \$1.2 billion in General Revenue Funds above the 2016-17 General Appropriations Act to complete fiscal year 2017 expenditures, which includes revenue adjustments, transfers, and assumed supplemental funding.

House Bill 1, as introduced (HB1) includes \$27.0 billion in General Revenue-Related Funds and \$65.5 billion in All Funds for Medicaid in 2018-19.

- This is an increase of \$0.7 billion in General Revenue-Related Funds and \$1.0 billion in All Funds.

Medicaid Funding by Category 2018-19 Fiscal Biennia

IN BILLIONS



- Medicaid Program Client Services
- Other Programs Providing Client Services
- Administration

Medicaid funding supports three major functions.

- Medicaid program client services, which are funded in Goal A at HHSC
- Other programs providing client services where Medicaid is a source of funding
 - Examples include the Early Childhood Intervention (ECI) program and State Supported Living Centers (SSLCs)
- Administration of these programs including the following:
 - Direct administration of and contracts for the Medicaid program
 - Other administrative functions where Medicaid is a source of funding

Major Medicaid Increases and Decreases (Medicaid Program Client Services Only)

HB1 includes an increase of \$1.8 billion in All Funds, including \$0.7 billion in General Revenue-Related Funds, for the Medicaid program client services.

These amounts include funding for the following:

- Increases

- \$1,072.8 million GR for caseload growth, maintaining 2017 average costs for most services, and funding increases associated with average costs established by the federal government
- \$105.8 million GR to maintain 2016-17 hospital add-on payments with less funding from Trauma Facility and EMS Account No. 5111

- Decreases

- \$197.1 million GR for net more favorable matching rates
- \$93.2 million GR to transition additional services to cash accounting
- \$100.0 million GR for new cost-containment initiatives

An estimated \$1.4 billion in All Funds, including \$0.6 billion in General Revenue Funds, for cost growth is not included in HB1.



LEGISLATIVE BUDGET BOARD

Contact the LBB

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