LEGISLATIVE BUDGET BOARD

Medicaid Overview

PRESENTED TO the House Committee on Appropriations Subcommittee on Article II

LEGISLATIVE BUDGET BOARD STAFF **APRIL 2016**

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. States are required to 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:

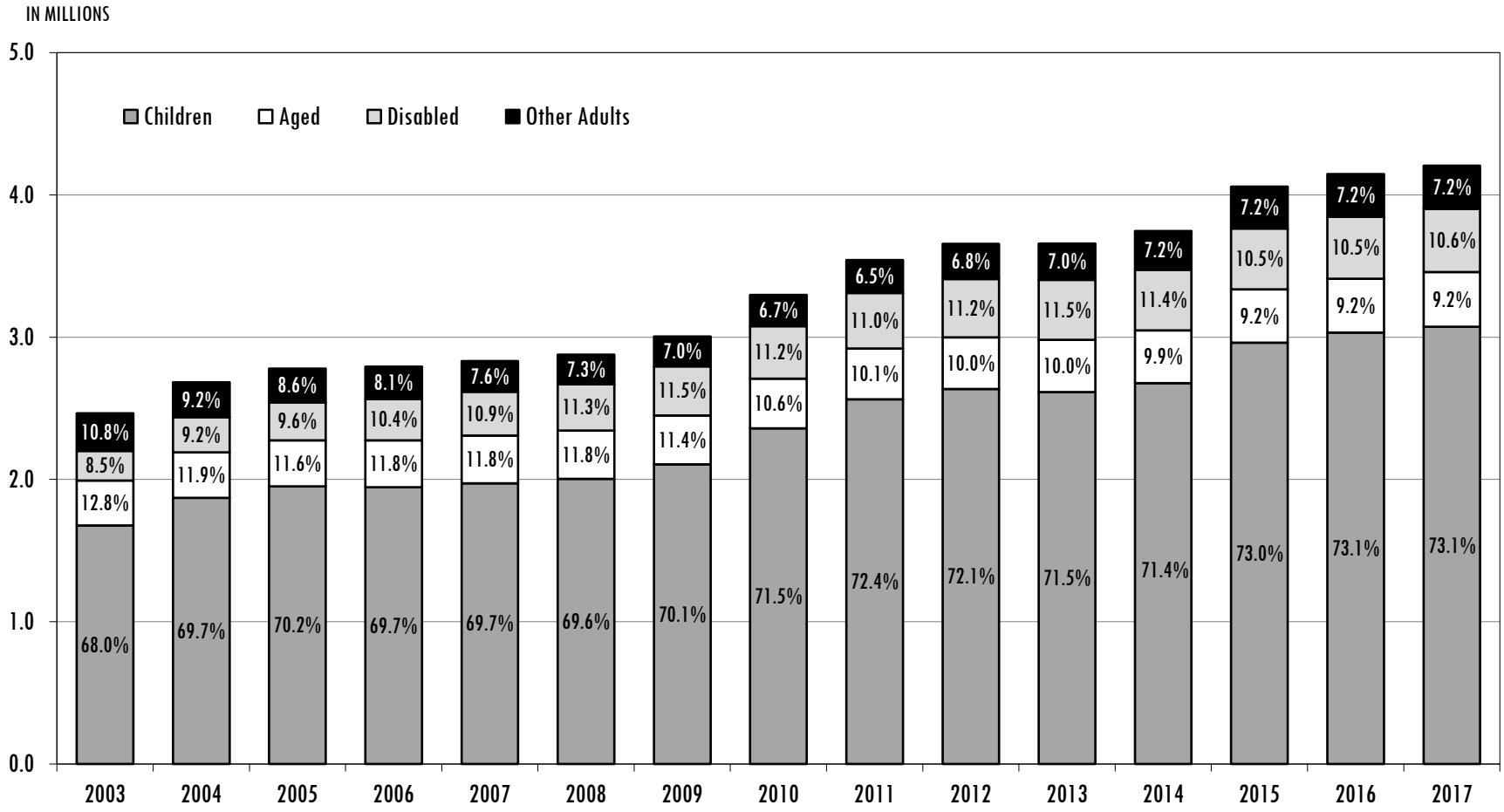
- Section 1115 demonstrations do not require statewideness, comparability, or freedom of choice of provider; and
- 1915(c) waivers allow states to provide long-term-care services in home and community-based settings and may be implemented in limited geographic areas with comparability of services with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

Budget Drivers: Caseload and Cost

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

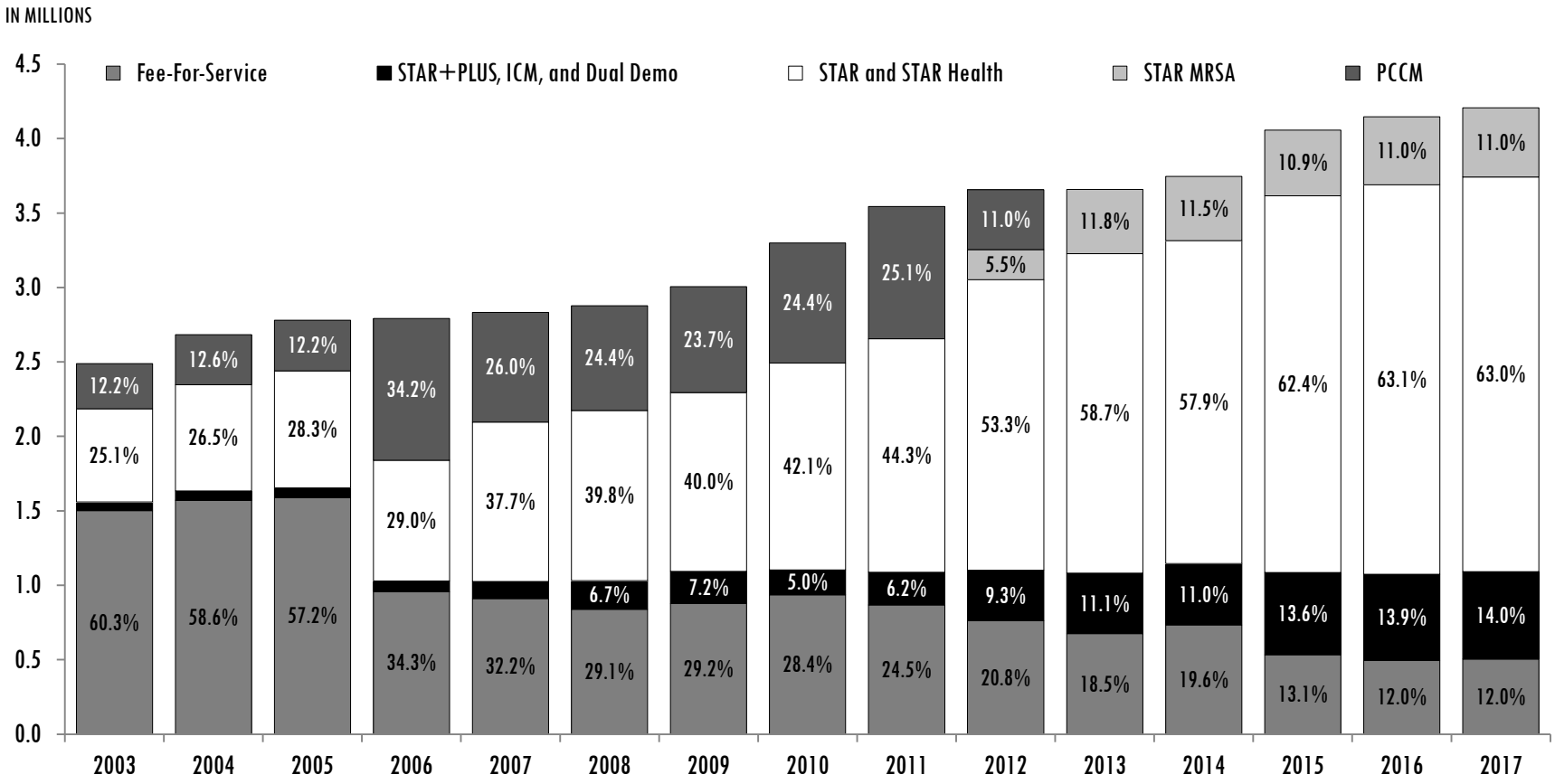
- As caseloads increase or decrease (due to factors such as population growth, economic factors, or policy changes), Medicaid expenditures fluctuate.
- Medicaid expenditures also fluctuate as a result of cost growth (tied to rate changes, medical inflation, utilization, and acuity), which can be negative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

Acute Care Medicaid Average Monthly Caseload by Enrollment Group Fiscal Years 2003 to 2017



NOTES:
(1) Other Adults includes TANF Adults, Pregnant Women, and Medically Needy clients.
(2) Fiscal year 2015 is estimated; fiscal years 2016 and 2017 are targets established in the General Appropriations Act.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

Acute Care Medicaid Average Monthly Caseload by Delivery Model Fiscal Years 2003 To 2017



NOTES:
(1) Represents average monthly number of clients receiving Medicaid acute care health insurance services through the Health and Human Services Commission. 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 2015 is estimated; fiscal years 2016 and 2017 are targets established in the General Appropriations Act.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

Managed Care Delivery Models

Current Models

- STAR: Serves children, pregnant women, and certain other adults.
- STAR MRSA : STAR in the Medicaid Rural Service Area.
- STAR+PLUS: Serves persons 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) 2017, the Medicaid caseload is expected to have grown by nearly 50 percent in the preceding ten years and will have more than doubled since FY 2002. Caseloads are expected to stabilize in 2016-17 with overall growth of 1 to 2 percent in each FY.

Recent events contributing to caseload growth include the following:

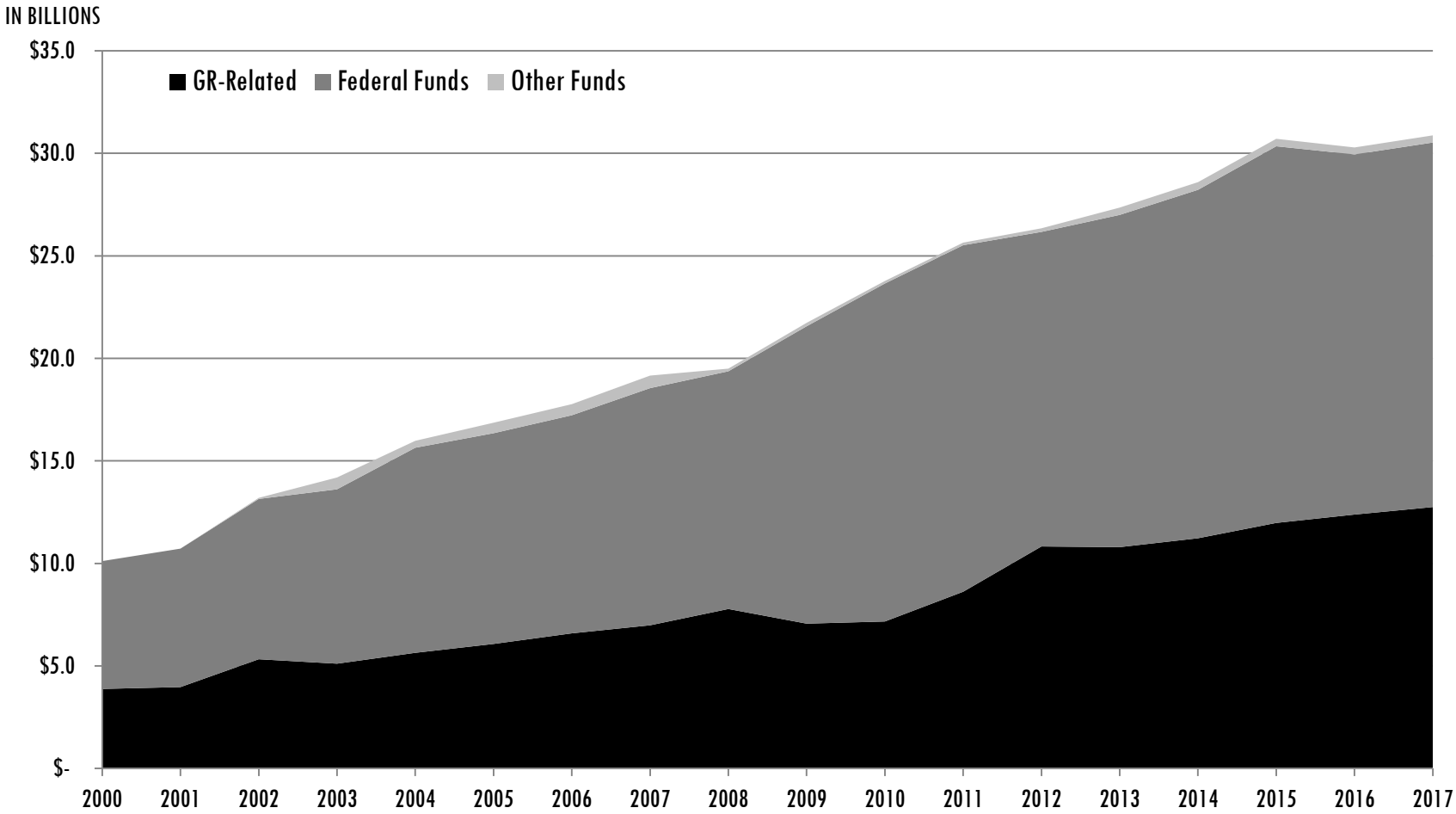
- **FY 2002 to FY 2003:** Nearly 50 percent growth in children enrolled from FY 2001 to FY 2003 due primarily to Senate Bill 43, Seventy-Seventh Legislature, which included Medicaid simplification provisions and six months continuous eligibility.
- **FY 2009 to FY 2011:** Caseloads grew 23 percent from 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 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 2002 to FY 2017:** The population of Texas is projected to grow by 28 percent from calendar year 2002 to 2017.

Cost Growth

The primary factors contributing to cost growth include the following:

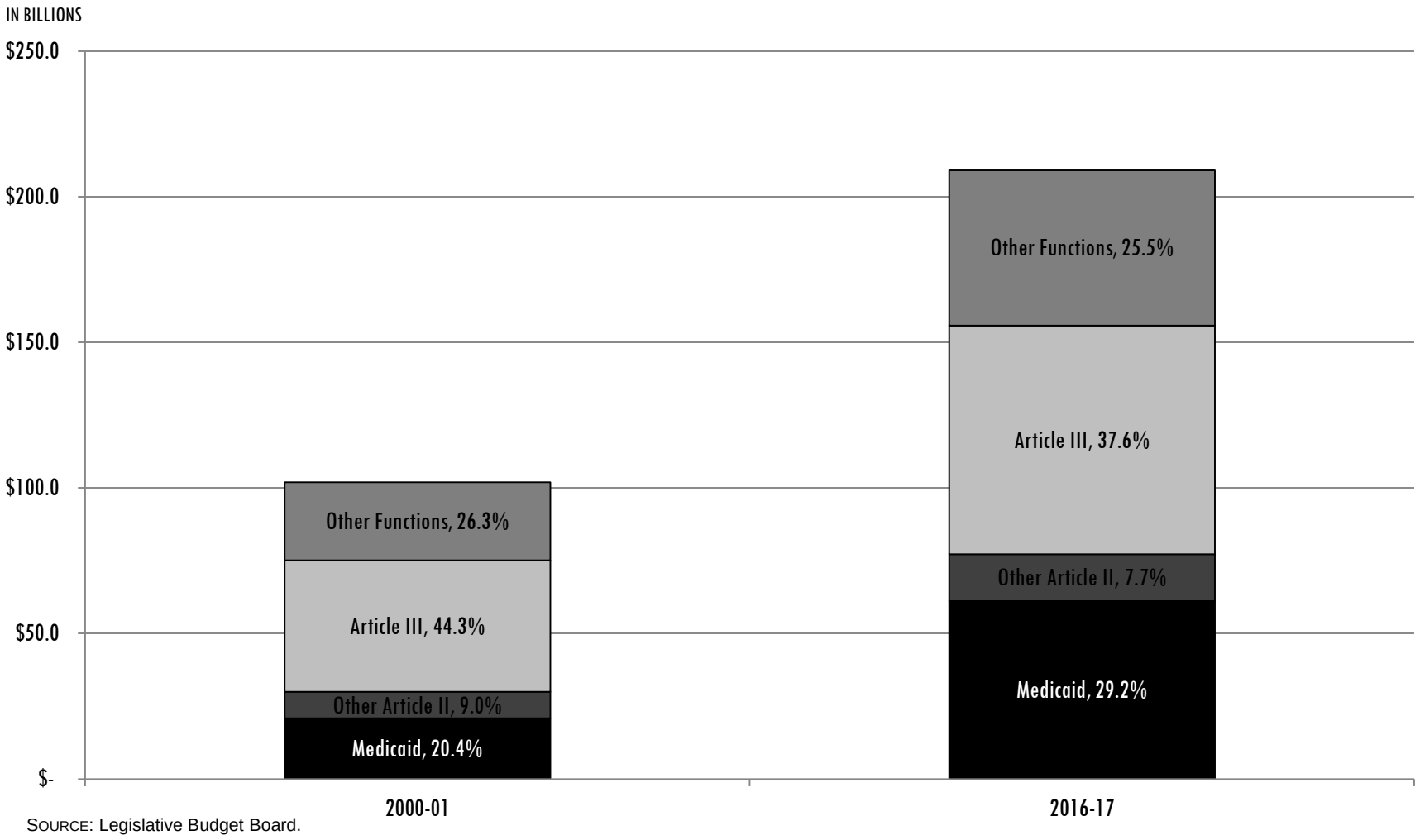
- **Rate Changes:** Adjustments to reimbursements to providers.
  - Recent rate changes include increases in 2016-17 for the Home and Community-based Services (HCS) waiver and non-state-owned intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).
  - Additionally, rates 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 2017



NOTES:
(1) Fiscal years 2000 to 2014 are expended, fiscal year 2015 is budgeted, and fiscal years 2016 and 2017 are amounts appropriated in the General Appropriations Act.
SOURCE: Legislative Budget Board.

State All Funds Budget
2000-01 and 2016-17 Fiscal Biennia



SOURCE: Legislative Budget Board.

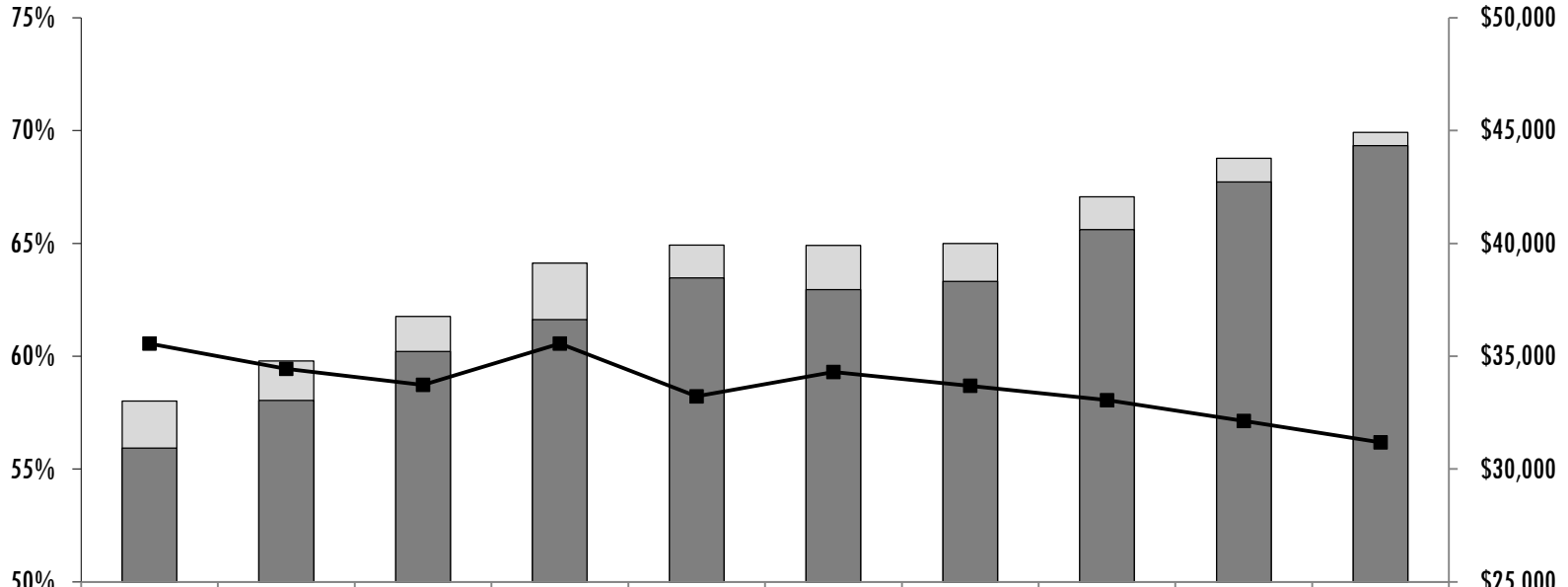
Financing

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 2017 FMAP was announced in November 2015 based on PCPI data for calendar years 2012 through 2014.
- 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 2017



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
US PCPI	$33,016	$34,795	$36,768	$39,122	$39,919	$39,913	$39,996	$42,065	$43,766	$44,918
Texas PCPI	$30,921	$33,035	$35,213	$36,626	$38,463	$37,956	$38,321	$40,615	$42,716	$44,327
Regular FMAP	60.56%	59.44%	58.73%	60.56%	58.22%	59.30%	58.69%	58.05%	57.13%	56.18%

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 2017 FMAP is based on the average of 2012 to 2014 PCPI as reported by the Bureau of Economic Analysis in September 2015.
(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.
(3) GAA assumed 56.67 percent in FFY 2017; figure reflects less favorable actual FMAP of 56.18 percent.
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

Comparison to Other States

Texas is the second largest state by total population and the largest state not expanding Medicaid pursuant to the ACA.

Of the 19 states with no current plan to expand Medicaid, there is no one state that is similar to Texas across a range of factors.

Texas has the highest Medicaid/CHIP enrollment among non-expansion states. Five other non-expansion states have Medicaid/CHIP enrollment exceeding 1,000,000 people: Florida, Georgia, North Carolina, Tennessee, and Wisconsin.

Of these six states, Texas has:

- The highest total population, Medicaid/CHIP enrollment, total Medicaid spending, percent of total population age 18 and under, and percent of Medicaid/CHIP enrollment age 18 and under.
- The lowest percent of population enrolled in Medicaid/CHIP and FMAP in FFY 2017.
- Mid-range per beneficiary Medicaid spending and population with income at or below 200 percent FPL.

Comparison to Other States (continued)

	2015 Population	Medicaid/CHIP Enrollment (Dec 2015)	Percent of Population Enrolled in Medicaid/CHIP	Medicaid Spending FFY 2014 (in billions)	Medicaid Spending per Full-Benefit Enrollee	FFY 2017 FMAP
Texas	**27,469,114**	**4,685,926**	**17.1%**	**$ 32.2**	**$ 5,668**	**56.18%**
Florida	20,271,272	3,576,023	17.6%	$ 20.4	$ 4,893	61.10%
Georgia	10,214,860	1,749,136	17.1%	$ 9.5	$ 4,245	67.89%
North Carolina	10,042,802	1,941,561	19.3%	$ 12.1	$ 5,450	66.88%
Tennessee	6,600,299	1,561,146	23.7%	$ 9.3	$ 5,607	64.96%
Wisconsin	5,771,337	1,044,478	18.1%	$ 7.5	$ 5,956	58.51%

Sources: United States Census Bureau, Centers for Medicare & Medicaid Services, Kaiser Family Foundation, United States Department of Health and Human Services.

Contact the LBB

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