CPPP Center for Public Policy Priorities | Policy Page

April 16, 2009 Contact: Anne Dunkelberg, dunkelberg@cppp.org No. 09-390

COMPARING MEDICAID AND CHIP PROVISIONS IN TEXAS HOUSE APPROPRIATIONS COMMITTEE AND SENATE BUDGET PROPOSALS

The Texas Senate approved its version of a 2010-2011 state budget bill, and the full House is expected to debate the House Appropriations Committee's version of the bill this Friday, April 17 (supplemental appropriations will be debated the day before). Complications caused by the recession and the federal recovery funding from the American Recovery and Reinvestment Act of 2009 (ARRA) compound the usual challenge of understanding the chambers' competing funding proposals for Medicaid, CHIP and other health care-related programs. This Policy Page highlights key differences between the chambers' Medicaid and CHIP proposals, plus selected other health care issues and items missing in both bills.

Medicaid & CHIP Funding in SB 1

Maintaining Medicaid

Continuing a 15-year trend, Medicaid is under-funded in the sense that the budget uses very low cost-per-client and caseload projections. However, this alone will not cause cuts in Medicaid services or programs, because the Texas Health and Human Services Commission (HHSC, the state agency that runs Medicaid and CHIP) must enroll eligible Texans in Medicaid and pay for actual health services delivered to them, regardless of the appropriated amounts. HHSC will track and keep state officials apprised of spending, and request supplemental appropriations as needed (and as usual) in January 2011. The ARRA FMAP assistance that will be applied to Texas' Medicaid spending above the appropriated amounts (described below) will help to reduce or avoid the need for Medicaid supplemental appropriations in 2011.

Medicaid Caseload and Cost Assumptions. The Texas budget often uses very low assumptions for Medicaid caseload, cost-per-client, or both in the appropriations act. This tactic allows the budget to be balanced at a lower state-dollar total, without imposing benefit or eligibility cuts. 1 In a program serving nearly 2.9 million Texans each month and spending nearly $20 billion a year on direct medical and long-term care, small differences or changes in caseload or cost can amount to billions of dollars. As a result, no state budget for two years can precisely project Medicaid spending.

If policymakers understand this budget tactic, this practice can be harmless. However, problems occurred when legislators proclaimed a Medicaid funding "crisis" when they came up short in the second budget year, even though they knowingly adopted low-ball caseload and enrollment assumptions. Today, most lawmakers in the budget process openly acknowledge this budgeting tactic.

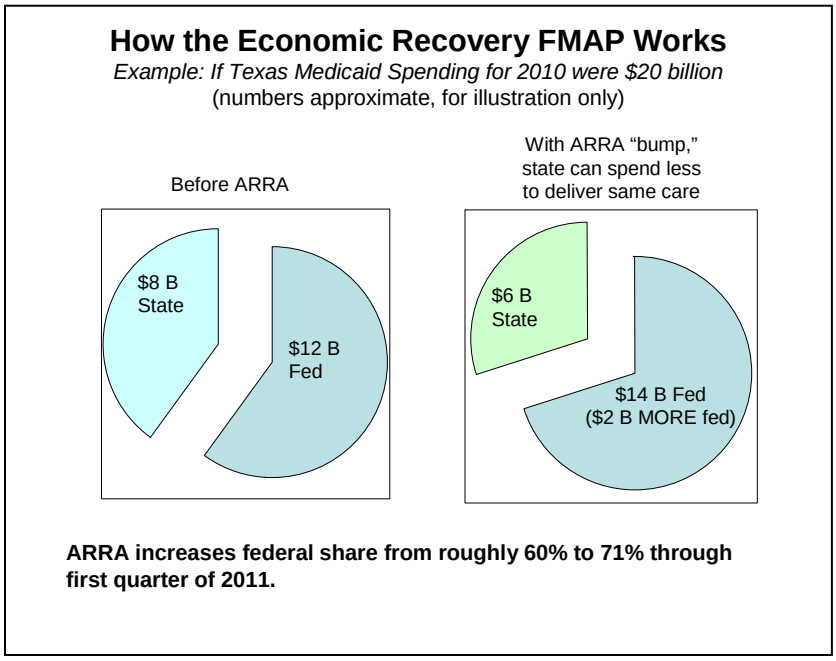
Low Estimates are Not a New Budget Tactic. As noted, in the last two decades, the Legislature often adjusted Medicaid caseload and cost assumptions to balance the budget. While this budgeting tool isn't recommended in any public finance textbook, state officials often rely on it to balance the budget without cuts to Medicaid eligibility or benefits, and also without having to identify new revenues to support enrollment growth and inflation. For example, in 2005, assumption changes reduced the state General Revenue (GR) price tag for Medicaid in the budget by nearly a billion dollars. And, in the 80th Legislative session, budget leaders acknowledged publicly their choice to under-fund Medicaid in the second year of the biennium, noting the difficulty of projecting costs for 2009 and that the Legislature could amend funding if needed through a

supplemental appropriations bill in that year. The final 2008-2009 budget allocated about $635 million GR less for Medicaid cost growth in 2009 than HHSC's estimated needs—even using the LBB's lower caseload assumption.

Medicaid Budget Math Basics and Economic Recovery Funds. The basic math in the Medicaid budget is:

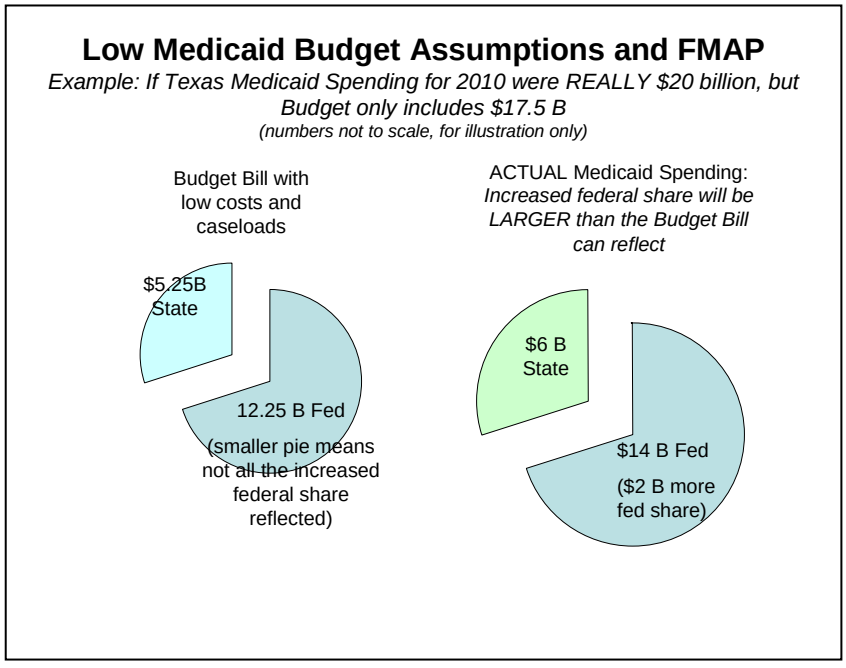
(Number Enrolled) X (Cost per Enrollee) = Total Cost

This helps explain how, given the enormous scale of Texas Medicaid, small variations in either enrollment or cost can have huge budget implications—and why using conservative estimates of both has become a popular budget tactic. Another critical math variable that drives the state budget impact is the share of Medicaid costs borne by the federal government (FMAP), which changes every year according to Congressional formula.



Under ARRA, the federal government will provide a much larger than normal share of Medicaid spending on health care through the first quarter of 2011 (instead of the usual 60 percent share, the federal contribution will range from about 68.7 percent to 70.9 percent). But, to the extent that the appropriations act under-estimates the true cost of operating Medicaid in 2010-2011, it cannot include the full benefits Texas will gain under the recovery act. This does not mean Texas will not get the ARRA Medicaid FMAP benefits, but it does mean the state budget will not fully reflect those benefits.

Senate and House: The Senate and House bills both account in Article 12 for a total of $4.153 billion in ARRA FMAP revenue: $1.64 billion for 2009 (informational item on supplemental appropriations); and $2.513 billion for 2010-2011. The U.S. GAO projects that Texas will earn another $1.297 billion in FMAP revenues, beyond what has been allocated in the budget bills thus far. **The exact amount is not certain because it will depend on several variables.** The first is the "basic Medicaid math" explained above: how many people enroll, and what health care services they use. Second, the size of the increased federal share will actually be updated quarterly, so that if Texas' unemployment rates worsen the federal FMAP benefits will increase in response. Whatever the exact size, the additional FMAP benefit to Texas could be used to fund



other budget initiatives (i.e., spending items added on the House floor or in the Conference Committee), or could simply be used to reduce the need for supplemental Medicaid appropriations in 2011.

Different HHSC and LBB Caseload and Cost Estimates. As has been typical in the last decade, HHSC and the Legislative Budget Board (LBB, the technical agency of the legislature in charge of crafting the budget and costing out its elements) began the budget process with very different projections of both Medicaid enrollment ("caseload") and cost per enrolled client. The table below shows the different caseload assumptions; at this time the caseloads assumed in both the House and Senate bills remain at the lower levels proposed by the LBB in the original filed budget.

Medicaid Caseload Assumptions (growth rate)	Actual 08	Budgeted 09	Fiscal 2010	Fiscal 2011
LBB (in SB 1, both House and Senate)	2,873,455	2,892,023	2,950,910	3,017,673
Growth trend		0.5%	2.0%	2.3%
HHSC Budget Request	2,877,285	2,926,238	3,005,563	3,093,784
Growth trend		1.7%	2.7%	2.9%
Difference			**54,653**	**76,111**

Sources: HHSC 2/09 and LBB 4/09; HHSC updated caseloads are expected soon.

Agencies must make most requests for funding above 2008-2009 levels as Exceptional Items (EIs). In the case of Medicaid, they may ask for caseload-related spending growth, but must assume no cost increases or inflation. The base budget—which begins the budget process—only allows for the LBB's caseload growth estimate, not the higher HHSC agency estimate. The HHSC and LBB also differ in their projections of the expected cost per Medicaid client in the upcoming biennium.[2] The combined impact of the caseload and cost differences were the subject of HHSC's Exceptional Item #1.

Major HHSC Budget Request Items in the Two Budget Bills

The table on page four shows the status of selected HHSC Exceptional Item requests for funding above 2008-2009 levels. Article XI in both versions is a "wish list;" items on this list are <u>not</u> actually funded at this time. Presumably, the House and Senate lists <u>may</u> indicate priorities for additional funding in the later stages of the budget process. Both chambers summarize how they allocated funding from the ARRA in Article XII, which, unlike Article XI, actually appropriates funds to the agencies.

Eligibility System Crisis. HHSC's Exceptional Items #2 and #3 are critical steps toward addressing the crisis that has hamstrung Texas' public benefits application and renewal system since 2006. The system remains badly under-staffed and over-worked, causing eligible Texans to wait months to begin receiving benefits, despite federal laws that require faster service. Current eligibility staffing is at about 8,000 workers despite authorized staffing levels at 9,039 for 2009, because working conditions in overwhelmed offices have become so poor that HHSC cannot recruit or retain enough workers to reach staffing targets.

HHSC maintained that the budget as filed did not include sufficient funding for the authorized FTEs, and that without more funding they would need to cut to 7,385 eligibility staff for 2010-2011, a 21-percent reduction in state staff at eligibility offices. In addition, in E.I. #3, HHSC requested 823 additional staff by 2011 to deal with anticipated caseload growth. It is important to note that **this request for caseload growth staffing was formulated before the depth of the economic downturn was understood, and before the degree of increased applications had been fully felt, so the request is conservative compared to the need**.

HHSC Exceptional Item Budget Requests in House Committee and Senate Budget Bills

Exceptional Item Description	HHSC Request ($GR, GR related millions)	Senate Bill (millions)	House Comte. (millions)
#1 Maintain Medicaid Current Services for Caseload and Cost Trends	$1,863.9	$750	*(Article XI only)*
#2 Maintain Funding for Current Eligibility Staff Authorized Levels (9,039 FTEs)	$74.97	*(Article XI only)*	$55 GR; $12 ARRA*
#3 Increase Eligibility Staff for Caseload Growth (up to 823 additional workers)	$56.7	*(Article XI);* Rider 55 allows HHSC to ask for more staff	*(Article XI);* Rider 60 allows HHSC to add staff up to 823
#4 Increase Capacity of HHS Community Services (DADS, DARS, DSHS, HHSC)	$223.3	$31.1 GR; $168.1 with S.P. Rider 48 (Rider 48 adds $200 million for community placements of State School residents)	$200.1 ($128.6 DADS, $8.3 DARS; $28.1 DSHS; $35.1 HHSC); see special provisions rider #51.
#10 Increase Family Violence Services	$2.48	$2.48 TANF-to-XX	$1.2 GR; $6.0 TANF-to-XX
#11 Increase 2-1-1-Funding	$0.982	$0.982 GR	$0.982 GR
#12 Critical Health & Family Services (Nurse-Family Partnership; Healthy Marriage; CRCG; TIFI; Raising Texas; Alternatives to Abortion)	$20.6	*(Article XI only)*	$3.5 ARRA; rider 64 NFP
#13 Medicaid Buy-In program for children with disabilities to 300% FPL	$22.48	*(Article XI only)*	0
#15 Premium Assistance: Local/Regional Subsidy (a.k.a. "Three-Share" programs)	$24.2	*(Article XI only)*	$24.2
#16 Replace Hospital Local IGT funds with GR	$63.3	0	0

**ARRA: American Recovery and Reinvestment Act of 2009 (federal economic recovery act)*

The **House** bill addresses the eligibility crisis in much stronger terms than the Senate. The House provides GR to ensure HHSC can add more than 1,000 workers they are authorized to hire, and rider #60 ensures that HHSC can hire additional workers as needed to respond to enrollment growth, up to the EI #3 level. The **Senate** bill includes no GR, its rider #55 authorizes no specific eligibility worker targets, and it only allows the addition of staff after an HHSC request has been reviewed by LBB staff and approved by Governor and LBB.

Another new rider of concern related to the eligibility system is **Senate HHSC #52, House HHSC #53,** which would require that the roughly 85 percent of Texans receiving Food Stamps or Medicaid now enrolled and tracked through the state's "legacy" computer system (SAVERR) be converted into the troubled replacement computer system, TIERS, by the end of fiscal 2011. The state launched a pilot of TIERS in five offices in Travis and Hays counties in July 2003, and planned to phase in statewide expansion by the end of that year. The system is so troubled that six years after its launch, the system is not statewide. Problems such as a lack of interoperability with other computer systems remain unresolved. As of September 2008, only 78.5 percent of TIERS applications were processed on time, compared to 92.7 percent of applications in SAVERR (the "old" system). **This rider should at best be eliminated, or at minimum be amended to allow the conversion to occur only if HHSC can certify timely and accurate processing throughout the entire eligibility system—both SAVERR and TIERS.**

12-Month Children's Medicaid. Neither the House Committee or Senate bill includes any provision for 12-month Medicaid for eligible children. However, House floor amendments will be offered when SB 1 is heard Friday, April 17, which would provide for funding of 12-month children's Medicaid eligibility using anticipated, unallocated ARRA Medicaid FMAP (Floor amendments page 73, page 93, and page 108 in the pre-debate packets). Contingency riders could also be added on the House floor or in conference committee (usually for bills that have passed from at least one chamber); this could allow for funding of 12-month children's Medicaid though bills such as SB 23 or 1252 by Zaffirini, SB 23 Zaffirini, SB 349 Shapleigh, HB 647 Dukes, HB 843 Martinez , HB 2199 Marquez, HB 2204 Gonzales, HB 584 Dukes, HB 1541 Turner, Sylvester, or HB 2962 Coleman. (For background see http://www.cppp.org/research.php?aid=836, Policy Page #09-376)

CHIP Funding. Funding for the current Texas CHIP programs in both bills appears adequate to maintain the program, and is supported by two important riders, **HHSC 34 and 35, in both House and Senate bills**. Rider 34 requires HHSC to request additional funding from the LBB in the event that appropriations are not sufficient to meet demand for CHIP enrollment. Rider 35 further directs that the traditional CHIP program for children shall take precedence over the perinatal program in the event of a federal CHIP funding shortfall. (It is important also to note that under the newly reauthorized CHIP Block Grant, states are unlikely to experience such shortfalls at all, because the funding stream is larger, grows every year, and is updated regularly to recognize state enrollment growth.)

The House bill also provides funding to extend the upper limit for affordable CHIP coverage from 200 percent of the FPL to 300 percent FPL (about $44,100 to $66,100 gross income for a family of four). **House HHSC rider #15** provides for $98.9 million in unspent CHIP funding to be carried forward for 2010 and 2011, and **HB 4586** (the supplemental appropriations bill which also includes the provisions of HB 6, the "Hurricane Ike Bill") "repays" HHSC for $47.4 million in CHIP funds it redirected to disaster relief. The House's **HHSC rider 59** specifically directs expenditure of available CHIP funds for eligibility to 300 percent FPL if legislation passes to authorize that change.

No explicit **Senate** funding or rider exists for extending CHIP coverage to 300 percent FPL. However, Sen. Averitt did submit a contingency rider for his SB 841 to the Senate Finance Committee.

***Frew* Medicaid Lawsuit Corrective Action Spending.** Both House and Senate Bills include riders related to the ongoing funding of corrective actions plans set in motion in the 2008-2009 budget and by agreement of the state and plaintiffs with the federal court's approval. However, neither HHSC agency nor LBB documents released so far have spelled out precisely what funding was included in the "base" budget as filed, or how funding in the supplemental appropriations act interacts with that funding and the budget riders in the chambers' bills.

With that caveat, the **House** bill includes **HHSC riders 54 and 55** related to *Frew*. The first makes clear that provider rate increases funded as part of the corrective action plan in 2008-2009 continue in the 2010-2011 budget; it also specifies that $75 million in GR is available for Frew Strategic Initiatives. In addition the **supplemental appropriations bill HB 4586**, appropriates $117.1 billion in unspent Frew Strategic Initiatives funding for spending on those programs in 2010. Rider 55 directs HHSC to develop and implement a plan to ensure that at least 85 percent of Frew Strategic Initiatives funding is spent during the 2010-2011 biennium, to serve children quickly, and avoid another large unspent balance and the controversy surrounding it. It is thought that the base budget also includes at least $45 million for Corrective Action Order compliance (the same amount budgeted in 2008-2009), but it is less clear whether the House bill also mirrors a full $150 million to match the 2008-2009 Strategic Initiatives funding, above and beyond the unspent $117.1 million.

The **Senate** bill includes **HHSC rider 53**, which, like the House's, continues the *Frew* provider rate increases from the last biennium. It also allocates the estimated $117 million unspent Frew Strategic Initiatives funding, designates $45 million for

Corrective Action Order compliance, and provides for HHSC to request staffing increases if needed to comply with corrective actions of Frew Strategic Initiatives. It is again unclear whether the $117 million is the full amount available for Frew Strategic Initiatives, or whether additional money (i.e., the $150 million) is available.

Frew Plaintiffs' attorneys appear to hold the view that appropriations related to *Frew* should include:

1. $45 million GR for compliance with the 2007 Corrective Action Order,
2. $150 million GR (2010-2011) for Frew Strategic Initiatives, and
3. $117 million unspent GR from 2008-2009.

It is not clear whether the Plaintiffs consider funding of the ongoing costs of Frew Strategic Initiatives that were begun in 2008-2009 (e.g., loan repayment programs for new doctors who serve children on Medicaid, first dental homes, fluoride varnish project) to be part of this package of funding, or in addition to it. Moreover, neither the HHSC or the LBB have produced a public accounting of the projected cost to the budget of continuing these already-launched Strategic Initiatives in 2010-2011.

Provider Payment Rates. Advocates for Medicaid worry about the need to increase rates (now still well below market and even below Medicare rates) so that Texans on Medicaid can find a doctor when they need one. Health care providers and the Frew Plaintiffs also worry about this issue.

The **Senate's** budget includes $309.5 million in GR to increase provider rates across four agencies. Rates would increase by differing amounts by program or provider type; Medicaid physicians would receive a three percent rate increase, as would most related programs housed at the Department of State Health Services. $129.5 million GR of the total would be dedicated to increasing the very low wages paid to attendants for the elderly and persons with disabilities, to $7.25 per hour in 2010 and $8.00 per hour in 2011 (see also **Senate rider HHS Special provisions #54**).

In the **House**, the Article XI "wish list" includes a placeholder (not actual funding) for reimbursement increases about half the size of the Senate's proposal.

Other Budget Issues and "Special Effects"

- **Senate** budget includes a place-holder for Senator Deuell's Medicaid buy-in for children with disabilities up to 300 percent FPL in Article XI (wish list); a very good program. A **House** floor amendment rider to fund this program will be offered on the floor tomorrow (page 72 of pre-debate Article II riders).
- **Senate** budget includes HHSC **rider 60 Medicaid Cost Savings** which assume savings to the agency budget of $107.1 million GR by implementing a list of policy changes:
    - Increase out-of-network discount from three percent to 10 percent in Medicaid Managed Care;
    - Market rating of plans;
    - Use Exclusive Provider Organization (EPO) in lieu of PCCM;
    - Tighten Administrative Risk Factor for HMOs;
    - Expand use of capitation in medical transportation;
    - Pay for Performance systems for hospitals and long-term care programs;
    - Ultra Sound Utilization Project to limit use based on practice guidelines; and

- Establish managed care for disabled children to "improve coordination of care and increase premium tax Revenue."

None of these proposals have been debated or explained in any budget hearings or documents, and a number of the provisions appears to be controversial and will be objectionable to various provider groups, as well as areas of Texas that do not want to roll out Medicaid Managed Care.

- **State School Reform**: Related to the intense activity around State School problems and legislation to reform and/or reduce State Schools for Texans with intellectual disabilities, the **Senate** has Article II **Special Provisions rider 53** allocating funding to support State School reform; **House** Article II **Special Provisions rider 49** provides for interagency systems to monitor and report on client abuse and neglect.

Floor Amendments. More than 100 amendments have been filed for Article II debate on the House floor, a few of special note (and not already mentioned above) are described below.

Family Planning Funding Reductions:

- page 54 (Isett): $6.5 million per year diverted to MH and MR Investigations
- page 57 (John Davis): $20 million per year diverted to Children's Mental Health
- page 58 (Laubenberg): $6.997 million per year diverted to Children with Special Needs
- page 77 (Hancock): $1.5 million per year diverted to Alternatives to Abortion
- page 64 (Chisum): Preferences for funding, which would mean thousands of women (possibly as many as 64,000 women) would not be served.

Family Planning for Teen Mothers. Pages 60 and 61 by Villareal would provide for teen mothers aged 16 and older (i.e., those who already have delivered babies under Medicaid) to consent to access to family planning.

Managed Care. Page 91 by Christian, would reduce Medicaid spending at HHSC in 2011 by $30.6 million related to expansion (unspecified) of Medicaid Managed Care and STAR+PLUS, also reducing the wait for community care waiver "slots" for seniors who would be served by STAR+PLUS instead.

Medicaid Medical Transportation. Page 98 directs HHSC to study contracting out transportation for Medicaid clients to private firm that would deliver services on a capitated, pre-paid basis.

No DSHS Birth Certificates for Some Children. Page 65 by Berman would deny birth certificates to children born to undocumented parents.

[1] The Legislature enacted a number of Medicaid cuts in 2003, and most but not all have been reversed. For example, Medically Needy coverage for parents in poverty has not been restored.

[2] HHSC details the differences in this presentation: http://www.hhsc.state.tx.us/news/presentations/HAC_Subcommittee_022609.pdf