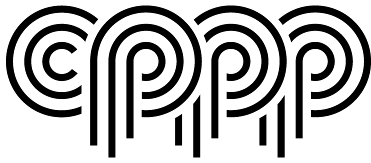

Center *for* Public Policy Priorities

THE POLICY PAGE

An Update on State and Federal Action

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July 16, 2001 No. 135

HIGHLIGHTS OF MEDICAID AND CHIP FUNDING IN SB 1, THE FINAL APPROPRIATIONS ACT

Policy Page 126 of April 20, 2001 described the respective Medicaid funding decisions made by the Texas House and Senate prior to production of the final appropriations bill adopted by the Legislature. At that time, a number of important questions about Medicaid funding were left unresolved by both houses. This Policy Page summarizes some of the major funding in the final state budget bill, reporting on state funding for Medicaid programs that is above the levels included in the original filed version of SB 1 (the "base budget" as drafted by the Legislative Budget Board according to the instructions of the Legislature's leadership). For a thumbnail background sketch on Texas Medicaid, see Policy Page 126.

Overview The Legislature appropriated $1.7 billion above 2000-2001 levels (14.5% increase) in state dollars (general revenue or GR) for all health and human services agencies, and Medicaid accounts for about 70% of all HHS spending. Increases were approved related to current-policy enrollment growth, inflation, rate increases, enrollment growth anticipated due to children's Medicaid simplification, modest expansions of eligibility and services, and increased access to community-based long-term care. On the other hand, many of the amounts allocated are far less than requested by agencies, and major reductions in funding (described below) are also laid out in the Appropriations Act. For example, $567 million GR was requested by the Texas Department of Health (TDH) for increased Medicaid costs, and $543 million GR was allocated. But one month's worth of nursing home payments and health care premiums ($153 million GR) are "put off" into the next budget period, and a budget "rider" reduces Medicaid GR funding by another $205 million. Doctors and hospitals asked for $165 million GR in rate increases, and got $85 million GR.

In all, the Legislature made commendable efforts to improve access to basic health care for low-income Texans and to maximize federal funding for that care. Still, the numbers suggest that finding enough funding for Medicaid may well become an issue in the second year of the biennium, and will certainly remain a challenge for the 78th Texas legislature. As the Center has often stressed, Texas' ability to maintain health and human services in the near term — much less make progress — depends on strengthening state government's revenue-generating capacity to match the needs of our growing population. *(See Policy Pages 110, 115, 117, and 129.)*

A REMINDER ABOUT THE BASE BUDGET

The Legislative Budget Board (LBB; the Lt. Governor, Speaker, and four members each from the Senate and House) creates rules that control how each state agency can request appropriations. In most cases, agencies were not allowed to request state funds above those used in the current 2000-2001 budget, except through the use of a separate listing of requests called "exceptional items." Medicaid programs were allowed to request funds in the base budget above the 2000-2001 funding level only to the extent that they are related to estimated caseload growth. No increases related to inflation, price increases, or higher utilization per client were allowed to be included in the base budget. The LBB does adjust the base budget periodically during the legislative session to reflect the newest Medicaid caseload estimates, so the amounts requested in January 2001 often differ from the amounts projected in April 2001 to be needed in 2002 and 2003.

The base budget did include costs to adjust for the shortages in the 2000-2001 budget addressed by the emergency appropriations bill (HB 1333), and to make up for the fact that the 2000-2001 budget included only 23 months of certain monthly Medicaid expenditures (nursing home payments and premiums paid to HMOs and NHIC). To correct for this, the base budget for 2002-2003 included 25 months worth of these expenses; but the final bill reduced these amounts to 24 months of costs (more detail below).

In the interest of brevity, Medicaid allocations listed below represent only state GR for Medicaid programs that are above the allocations included in the base budget filed in January. These amounts will draw a projected 60% federal match in

2002 and 2003 (for every dollar Texas spends, the federal government spends $1.50). The federal matching rate is adjusted annually to reflect changes in each state's average income per person compared to the average per capita income for the U.S. as a whole. Adjustments are expected to result in a lower federal match rate in 2002 and 2003, thanks to Texas relatively strong economy, requiring Texas to spend about $206 million GR more than would have been needed at 200-2001 match rates. This analysis attempts to identify major Medicaid funding decisions, and is not exhaustive.

SB 1156 and Medicaid Working Group Proposals The recommendations of the "Medicaid working group" composed of representatives Coleman, Eiland and Janek, and senators Zaffirini, Harris, and Duncan were largely laid out in SB 1156, which the Legislative Budget Board estimated would have saved the state $416.8 million in state dollars (general revenue or GR) over five years. SB 1156 authorized a list of policy changes aimed at cost savings or "budget certainty" (see *Policy Page* 132 for details). With Governor Perry's veto of SB 1156, it is not clear which, if any, of these cost-reduction strategies will be implemented. Also in anticipation of SB 1156, Medicaid premium payment allocations were moved from the budget of the Texas Department of Health (TDH) to the Texas Health and Human Services Commission's (HHSC) budget, though it is not entirely clear at this point whether these functions will be transferred in spite of the Governor's veto. Rider 34 under Special Provisions for Article II states that the Comptroller may refer any questions regarding allocation of Medicaid funds between TDH and HHSC to the LBB for clarification.

Medicaid inflation and increased utilization per client (acute care) TDH had requested $567 million in state GR above the base budget for Medicaid costs increases related to inflation, price increases, or higher utilization per client. The final budget includes $542.6 million GR and $58.2 million in drug rebates and premium credits (total $600.8 million) for this purpose.

No "catching up" on premiums and nursing home payments deferred in the 2000-2001 budget period The final budget actually includes $152.8 million GR less than was included in the January base budget for Medicaid premiums ($107.7 million GR) and nursing home payments ($53.6 million GR). This is because the base budget would have funded 25 months of those costs: not only the full 24 months of the 2002-2003 budget period, but also the 24th month of costs from the 2000-2001 budget which had been "deferred" by the last Legislature. Due to scarce revenues and a desire to fund important priorities (e.g., Medicaid simplification, provider rate increases, and public school health insurance), the decision was made to again defer the last month of payments into the next (i.e., 2004-2005) biennium, unless additional revenues become available. The budget sent by the House and Senate to the Governor included language ("riders" 53 and 34 in the HHSC and Department of Human Services budgets) which listed these deferred expenses among items to be funded should the Comptroller identify adequate revenues, subject to approval by the Governor and LBB. However, Governor Perry vetoed the sentences in the riders committing the state to giving priority to funding these deferred expenses. Also vetoed were references to funding these deferred costs in a separate section in the budget bill listing the order in which additional revenues identified would be spent. The veto message stated that the Governor wanted the "flexibility" to use any additional funds for other purposes.

Children's Medicaid simplification The HHSC was allocated $122.6 million GR (from Tobacco Settlement receipts) for increased children's Medicaid enrollment and related costs resulting from eligibility simplification under SB 43.

Medicaid rate increases for health care services of all kinds Most Medicaid outpatient and professional provider fees were frozen from 1992 until 2000, when they received a 2.7% increase. Another $197 million GR was allocated for a variety of provider rate increases:

- $50 million for physicians,
- $35 million for hospital outpatient costs ($165 million had been requested for these first 2 groups),
- $50 million for community care workers' wages ($149 million requested),
- $20 million for Texas Health Steps dentist fee increases ($27 million requested),
- $35 million for HMO premium increases ($42 million requested),
- $4.5 million for the StarPlus project ($5.6 million requested), and
- $2.5 million for Home and Community-based Services (HCS) waiver providers ($23.9 million requested). Of this amount $120 million was funded with tobacco settlement receipts.

Medicaid coverage expansions Treatment of breast and cervical cancer for low-income uninsured women (SB 532), and extension of coverage through age 21 for young adults "aging out" of Foster Care (SB 51), who currently become uninsured when they reach age 18. Riders in the budget (HHSC Rider 50 and Article IX Rider 11.25) allocate funding for these two groups.

Children's Health Insurance Program (CHIP) Because CHIP is not an entitlement program, agency officials were not allowed to request "base budget" funds for either enrollment growth above FY 2001 enrollment, or for inflation and cost increases. To allow for natural enrollment growth, inflation, and certain rate increases, HHSC requested CHIP funding of $79 million GR above the base budget amount as an "exceptional item." The final budget appropriated $65 million more in tobacco settlement dollars for CHIP than the base budget; these are state dollars that

can draw down the 72% federal match for CHIP ($2.57 in federal funds for every $1 in Texas spending).

Community and Long Term Care at Texas Department of Human Services (DHS) As with other Medicaid expenses, DHS' base budget for Medicaid community care and nursing home programs did not include cost increases related to inflation, price increases, or increased use of services per client (this last factor is sometimes referred to as increased "acuity"). Seventeen million dollars in GR above the base budget was allocated for community care client acuity increases.

The budget allocates funds to both DHS and Texas Department of Mental Health And Mental Retardation (MHMR) dedicated to reducing "interest lists" (a.k.a. waiting lists) for community care services. However, several variables must be sorted out before the number of new clients to be served will be known more precisely. First, since funds were directed to rate increases for these providers, the new rates will result in a new, higher cost-per-client and therefore a slightly lower number of new client slots. Second, decisions must be made regarding the number of new client placements that will be allocated to the Consolidated Waiver project (Texas' first attempt to create a community care program that is based on functional need, as opposed to diagnosis or condition); this will also reduce the numbers of new clients served in the separate programs. Finally, decisions remain to be made regarding what share of the new community care placements will be earmarked for persons leaving institutional settings (see DHS Rider 37, below). The following amounts were allocated for new community care clients in DHS programs; the estimated numbers of new clients are approximate and subject to change due to the factors just described. $30 million GR was provided to fund 2,500-2,700 new clients in the Community-Based Alternatives waiver. The Community Living Assistance and Support Services (CLASS) waiver will receive $11.2 million GR to add 435-492 new clients, and the Deaf-Blind waiver will use $863,000 GR to add about 27 clients. The Medically Dependent Children's Program waiver is allocated $1.9 million GR to fund about 145 more children. Increases were also directed to non-Medicaid funded community care ($10.4 million for about 820 new clients) and the In-home and Family Support program ($5 million for about 1,490 clients).

Funding for personal attendants' salaries received an additional $50 million GR ($90.9 million had been requested), and another $5 million GR was allocated for In-home and family support. Nursing home funding received an additional $15.3 million GR for client acuity increases, and $175 million GR for increases in nursing facility rates. Nursing home industry representatives had asked for $778 million GR: $210 million for increases in operating costs; $322 million to increase staffing, wages and benefits; and $246 million to deal with increasing liability insurance costs. They estimate the appropriated amount will increase Texas' Medicaid nursing home rates from 45th in the U.S. to 44th. The StarPlus waiver was allocated $400,000 GR above the 2000-2001 level in the final budget, which is $1.8 million less than in the base budget.

Texas Department of Mental Health and Mental Retardation (MHMR) The final budget included $7.2 million GR more than the base budget for Adult Mental Health Community Services: Assertive Community Treatment, Supported Employment and Housing, and New Generation Medications. Another $28.8 million GR in Tobacco Settlement funds is provided to pay for increased prescription drug costs and to increase rates paid for rehabilitation services. Five million dollars in GR above the base budget was provided for the Dallas-area NorthStar Behavioral Health Services waiver to help pay for increased prescription drug costs and to maintain caseloads at 2001 levels. Children's Mental Health Services got $4.1 million more than the base budget had allocated, to maintain caseloads at 2001 levels.

In the area of services for persons with mental retardation, $27.3 million GR above the base budget was allocated for the Home and Community-based Services waiver, to fund about 665 new placements. Budget committee discussions indicated these would be allocated to 130 community placements of persons leaving State Schools, 276 placements of persons leaving intermediate care facilities for mental retardation (ICFs/MR), and 259 placements for people on the MR community care waiting lists. However, the final allocations are subject to the same considerations described above under DHS Community Care.

ACRES OF FINE PRINT

This appropriations bill includes more than a hundred "riders" (numbered sections in the bill) which specify ways in which Medicaid funding will be directed. Many of these have been in several successive budget bills. Some of the new riders that may or will result in new Medicaid spending activities are listed below.

- **HHSC Rider 15** directs the agency to maximize use of federal "de-linking" funds set aside in the 1997 federal budget bill to help states break the historical linkage between Medicaid and cash assistance. Approaches listed include increased numbers of "out-stationed" eligibility workers, community-based outreach, and training for both health care providers and DHS eligibility workers.

- **HHSC Rider 19** authorizes the agency to contract with private consultants to identify cost-saving options for Texas Medicaid.

- **HHSC Riders 20-24** authorize HHSC to create Medicaid demonstration projects for women's health, mental health, HIV/AIDS services, workers with disabilities, and rural services. However, Rider 20 addressing women's health services is contingent on enactment of SB 1156, vetoed by Governor Perry. The others (21-24) are not contingent on legislation but are permissive, meaning HHSC may or may not implement them depending on funding, pressure from

the Legislature and/or the public, and the preferences of the Governor's office, to which the HHSC Commissioner reports.

- **HHSC Rider 26** directs the Commissioner to pursue enhanced matching funds rates for Medicaid services provided along the Texas-Mexico border. Though success in winning additional funds from Congress may be a long shot, this directive highlights the prominence in the 77th Legislature of concerns about rates paid by the state to Medicaid and CHIP HMOs (and by extension the rates those HMOs pay to doctors, clinics, hospitals, etc.) in the Texas-Mexico border region.

- **HHSC Rider 46** is a new informational rider which shows total Medicaid appropriations on an agency-by agency basis. This is a useful change in the budget bill, which would be even more useful if Medicaid spending funded with Tobacco Settlement dollars was included in the totals of the agencies where it will occur, rather than being aggregated into a distinct category. While a continued informational listing in the budget regarding uses of Tobacco Settlement funds could be helpful, it is confusing and inconsistent with the general appropriations bill format to have appropriations from a single source of funds (the Tobacco Settlement) listed in a separate Article of the bill, rather than being integrated into the bill patterns of the state agencies where they will be spent. Conversion of Article XII to an information-only section would simplify budget analysis.

- **HHSC Rider 51** directs HHSC to create a Medicaid asthma management program "as described in the Comptrollers e-Texas report issue HHS 11."

- **HHSC Rider 54** directs the Commission to direct some of the funds appropriated for physician and hospital outpatient fee increases to establish a methodology to recognize and reward "high-volume Medicaid providers, "especially those along the Texas-Mexico border and those in medically underserved inner-city areas." It is not yet known how this directive will be implemented.

- **DHS Rider 37** states that as Texans relocate from a Medicaid-funded nursing facility bed into a community-based long-term living arrangement, the appropriations related to their costs of community care will be re-allocated to the community care services portion of DHS' budget. This is a potentially important policy response to the U.S. Supreme Court *Olmstead vs. L.C.* decision, which ruled that states must take steps to ensure that Medicaid programs allow persons with functional disabilities to reside the "most integrated" possible setting (i.e., integrated into the community). It is not clear yet exactly how this provision will interact with the funding earmarked for serving additional clients in community care programs, described above, for DHS and MHMR programs.

- **DHS Rider 42** directs DHS to "notify" hospitals and clinics about the ability to access out-stationed Medicaid eligibility workers if the local entity can provide the matching dollars to pay half the worker's salary. Although the legislature <u>authorized</u> a substantial number of new locally-funded eligibility workers in the 1999 session, the majority of those positions remain unfilled. Outreach may help DHS to fill more of these potential positions.

- In the MHMR budget, a number of new riders were added that spell out in great detail how Medicaid funding is to be spent and accounted for; total riders for MHMR increased from 49 to 73. This is presumably a response to the agency's funding shortfall in the 2000-2001 biennium, which resulted in part from errors in classification of funds.

- **MHMR Rider 56, 57, and 60** direct the agency's spending on New Generation medications, requiring that practice guidelines be followed, and strictly limiting the amount of designated funding that can be used for medication support services (as contrasted with spending on the medications themselves). Funding for New Generation medications is found in at least five strategies (line items) of MHMR's budget, and additional funding is located in Article XII from Tobacco Settlement funds.

- **MHMR Rider 61** directs the agency to develop a "mid-range" waiver to serve persons with mental retardation who do not need out-of-home care, and thus have a lower cost per client than in many of the existing waivers.

- MHMR studies and plans:
    - **Rider 63** directs the agency to study and report on funding options for delivering mental health services to youth in the juvenile justice system.
    - **Rider 64** requires a study of funding and utilization of mental health services by "indigent" citizens, and to develop strategies to better serve those in the greatest need, and to develop performance measures for provision of indigent mental health to be incorporated into the agency's five-year strategic plan.
    - **Rider 65** requires a report to the Legislature comparing the per-client costs in the various community care waivers and the different types of institutional settings, including a comparison of state-owned and non-state operated facilities.
    - **Rider 66** requires MHMR to develop a plan and a system of care to provide enhanced care to persons with both mental health and mental retardation.
    - **Rider 70** requires an analysis of whether current systems to serve persons with mental retardation who have been referred through the criminal justice system are appropriate.

- The Texas Rehabilitation Commission (TRC) contracts with the federal Social Security Administration to perform disability reviews for persons seeking Social Security Disability Insurance (SSDI) or Supplemental Security

Income (SSI) benefits. Persons eligible for SSI are automatically enrolled in Medicaid in Texas. Although SSI and SSDI are federal benefits funded entirely with federal dollars, and should thus have consistent eligibility standards nationwide, Texas and TRC have the highest denial rate for disability claims in the U.S.. **TRC Rider 7** directs the agency to report quarterly to the LBB and Governor on Texas' rate of denials of initial claims for disability benefits, how that rate compares with national and regional rates, and rates of initial denials that are overturned on appeal, also compared to regional and national averages.

- **Special Provisions Rider 29** provides additional guidelines for the use of funds dedicated to increasing rates for medical professional services. Like HHSC Rider 54, it mentions targeting of providers along the Texas-Mexico border and those with a high volume of Medicaid patients, but this section also mentions rural providers. The rider also says that funds shall be used to increase fees for Texas Health Steps (EPSDT) screens, evaluation and management services (i.e., office visits that involve the time and attention of the physician), and primary care providers' fees generally. The rider states that the Legislature intends that these funds "go directly to providers"; that is, that the funds be applied entirely to fee increases and not be diverted into HMO administrative costs or profits.

- **Special Provisions Rider 30** similarly directs that funds for Medicaid dental fee increases must be targeted for dental exams and preventive care, enhanced rates for high-volume providers, and selected restorative services. As with the professional fees, funds are expected to make it into the hands of dentists.

- **And We Really Mean It: Special Provisions Rider 31** says that all funds earmarked for rate increases may only be used for that purpose.

- **The Budget Giveth, but also Taketh Away: Special Provisions Rider 33** reduces the overall Medicaid appropriations by $205 million GR — more than the amount allocated for professional and outpatient fee increases — and directs HHSC to achieve these savings through a variety of approaches including (but not limited to) the following cost-saving proposals (some of which were included in the vetoed SB 1156): statewide implementation of primary care case management (state-administered Medicaid Managed Care), mandatory Medicaid Managed Care participation by SSI clients, case management for medically complex clients, additional selective contracting for urban inpatient hospital care (a form of selective contracting has been in place since 1993), "best price" drug reimbursement for prescription drugs, supplemental drug manufacturers' rebates, reduced payments for high-cost "outlier" hospital stays, competitive pricing for medical equipment and supplies and vision care (no specifics given), greater use of employer-sponsored health benefits for Medicaid enrollees, use of co-payments, use of the Title XIX Trust Fund balance, increased utilization review for prescription drugs, a test of automatic drug dispensing machines in nursing homes, achieving savings through CHIP, "lowest contract price…for all retail purchases," and a demonstration project for psychiatric drugs. These reductions are reflected in the bottom line totals for Article II (but not in the agency totals).

- More reductions and additions: In Article IX, **Rider 10.82** reduces GR funds for Texas Health Steps Dental by $2 million to reflect projected savings from SB 1411, a bill aimed at improving oversight of Medicaid dental care practices to eliminate abuses that have been documented in recent years. **Rider 10.85** reduces Medicaid funding by $4.1 million GR to reflect savings anticipated from providing enhanced case management services for enrollees with catastrophic health conditions. **Rider 11.09** adds $5 million GR to DHS' budget to pay for new dental benefits for Medicaid nursing home residents (adults in Texas Medicaid have no routine dental benefits) as added by SB 34. **Rider 11.25** adds $1 million GR for the new coverage of treatment for breast or cervical cancer created by SB 532. Rider 11.27 adds $266,500 for a buy-in pilot for persons with disabilities, and another $826,200 in enrollee premium revenues.

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