



THE KAISER COMMISSION ON
Medicaid and the Uninsured

***Medicaid and State Budgets:
A Case Study of Texas***

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Introduction

Like most state governments, Texas has recently marked the end of several-year interlude during which slow Medicaid growth briefly suspended the program's image as a top state budget growth driver. Substantial caseload declines from 1996 to 2000 have now been replaced with a steady upward trend, matched with highly robust enrollment in the state's separate SCHIP program. With these trends afoot, it is helpful to pause and review Medicaid's place in Texas' state budget.

Medicaid accounts for 15% of total nonfederal appropriations in the state's most recent two-year budget act (2002-2003), and 72% of health and human services allocations. Some state budget practices in recent years have had the effect (presumably unintended) of both obscuring the true demand for spending growth, and exaggerating the perceived rate of program growth from one budget period to the next. For example, in recent years Medicaid agencies have not been allowed to reflect inflation or cost increases in their basic Medicaid budget requests. At the same time, deliberate deferrals of certain Medicaid costs into the next budget period have increased needed Medicaid funding in the subsequent budget period, adding to the sense of crisis.

With the economic downturn of 2001, Texas anticipates much slower state revenue growth in 2002 and 2003. If the state actually experiences zero growth, projected needs could outstrip revenues by several billion dollars as the state looks at a budget for 2004-2005. Analysts have noted a growing structural deficit — a mismatch between the ability of the state's tax system to generate revenues and the state government's need for revenues. Tax cuts enacted in 1999, while popular, have contributed to a reduction in tax revenues as a percentage of total state personal income, adding to the growing difficulty the Legislature faces in trying to maintain state government programs.

Driving the resumption of double-digit annual cost increases in Texas Medicaid are the commonly acknowledged factors of higher medical inflation (particularly for drug costs), higher cost-per-client for elder and disabled enrollees, increased demand for coverage in a slowing economy, and Medicaid eligibility policy reforms, as well as the less examined pressure of pent-up demand resulting from unmet needs and deferred costs. In Texas, this pent-up demand has resulted in part from provider reimbursement rates for many services that are not updated for inflation, and have lost more value over the last decade than they have gained through two modest legislative increases. Unmet need for community care for elders and Texans with disabilities, and for better access to and utilization of preventive care under EPSDT, both add sustained pressure on the Legislature to incrementally increase spending in those areas.

Texas Medicaid spending and policy decisions in recent years have reflected internal tensions between political and policy goals. Perhaps the most important is the ongoing tug-of-war between a majority political preference for avoiding obvious tax increases, and concurrent growing support for making visible progress toward meeting the health and long term care needs of Texans. This has resulted in adoption of legislation expanding services, reimbursement, and access, simultaneous with under-funding (and deferral of funding) of the program. Another struggle results from legislative budgeting policies which have eliminated virtually all areas of "slack" from Medicaid agencies' budgets (e.g., conservative caseload estimates, return of revenues to the General Fund), coupled with an unrealistic expectation that the resulting appropriations estimates for the \$11 billion-per-year program will be accurate and not fall short. Texas' historical reluctance to harness

Medicaid to provide health insurance for working poor parents has resulted in a direct shift of tax burden to local governments. As a result, Texas' use of disproportionate share reimbursement and recent proposals for upper payment limit mechanisms have been predominantly of benefit to local governments, rather than the state's General Fund. The large local tax base now supporting care for low-income uninsured, currently not matched with federal funds, may represent the most likely source of funding for any future expansion of coverage in the state.

The prospects for state Medicaid policy decisions in a time of declining revenues are mixed. Legislators are better educated than ever about the realities Medicaid faces. Increasingly, they recognize that the recent jump in medical inflation is not limited to Medicaid, as state employee health benefits demanded a hefty increase for the 2002-2003 budget. Attention to lack of inflation updates to fees for many services has brought the realization that payment cuts are not a promising source of program savings, but those few services which have historically received updates now expect that those adjustments are in jeopardy. Further expansion of managed care, a new focus on prescription drugs, and new enrollee cost-sharing are likely targets for program savings in the next two to four years, yet these are unlikely to yield major cost reductions. Meanwhile, steep growth in private sector insurance premiums is likely to cause more employers and workers to drop coverage. Higher unemployment rates and lower full-time employment will also erode private coverage rates and help sustain the upward trend in Medicaid enrollment — and put more pressure on local government indigent health care efforts. Texas' best chances for long-term stability in Medicaid funding are tied to increasing and rationalizing revenues for the program, through tax reforms to cure (or reduce) the state's structural deficit, and through harnessing existing local tax efforts to draw federal matching dollars — what one legislator has coined “homesick Texas dollars.”

I. The state, the state government, and the state government decision process

Relevant demographic and economic statistics

Texas was home in 2000 to 20.9 million persons, of whom 53% identified themselves as white, 32% as Hispanic, 12% as African American, and 3% as Asian. The 1999 average per capita personal income (PCPI) of \$26,834 was 94% of the national average for a ranking of 27th, and the average annual growth rate in Texas' PCPI over the last decade was 5.1%, compared to a the national growth rate of 4.4%¹. Because Federal Medical Assistance Percentages (FMAPs) are driven by this statistic, this improvement in per capita personal income has also meant a steady decline in Texas' federal share of funding for Medicaid. Some \$206 million in state general revenue Medicaid appropriations for the 2002-2003 budget period (about 2% of state Medicaid spending) are due strictly to the decline in FMAP compared to 2000-2001.

Structure of government

The Texas Legislature is composed of 31 State Senators and 150 Representatives. The House is presided over by a Speaker chosen by that body, while the Senate is led by the Lieutenant Governor. The legislature convenes in a regular session in January of every odd-numbered year. These biennial sessions are limited to 140 days' duration. The Governor's veto power includes line-item veto in the appropriations act. Currently, the Governor appoints the Commissioner of Health and Human Services. This agency is the "single state agency" for both Medicaid and SCHIP. The Commission does not have a public board, and the influence of the Governor's office on policy direction for both Medicaid and SCHIP can be considerable.

Description of the public health structure and its interaction with Medicaid

Texas state health and human services agencies are organized under the authority of the Texas Health and Human Services Commission (HHSC). HHSC's commissioner, appointed by the Governor, has hiring authority over agency executives and considerable authority over agency budgets and spending. Prior to September 2001, only a handful of Medicaid and SCHIP operations were located at HHSC. Under the recent reorganization, a major portion of Medicaid operations, and all SCHIP operations formerly administered by the Texas Department of Health (TDH) were relocated to HHSC. Major Medicaid programs and expenditures are now operated by: HHSC (most basic medical and Medicaid Managed Care functions), TDH (family planning, EPSDT, medical transportation), Texas Department of Mental Health and Mental Retardation (ICF-MR and waiver services, other ambulatory services for mental illness and mental retardation), Texas Department of Human Services (DHS: eligibility services, MMIS, long-term care). Smaller Medicaid programs and their funding are located in seven other state agencies.

Unlike many states, Texas does not incorporate county governments into the state-administered public health or public assistance delivery systems. Cities and counties are not required to operate health departments, and the nature and scope of services delivered by these entities varies considerably. In some smaller cities and towns, local health departments play a major role in providing care, though they are not arms of the TDH. Texas' largest metropolitan areas² are covered by county-wide hospital districts: taxing jurisdictions which may levy property and sales taxes to support the provision of health care to "needy residents." In these major cities, hospital district-operated programs of subsidized care for the uninsured are generally much broader in scope than those operated by metropolitan health departments. In this patchy network, federally qualified health centers, rural health clinics, independent non-profit clinics, and city, county, and nonprofit hospitals all play critical roles in providing care to low-income uninsured.

Medicaid and the State Budget

Medicaid appropriations for the 2002-2003 biennium total roughly \$10 billion in state general revenue (\$25 billion in funds from all sources). This amounts to 15% of total state general revenue spending, and 72% of health and human services allocations. Due to Texas' biennial budgeting cycle HHSC and Medicaid operating agencies must begin to project in the spring of every even-numbered year, the Medicaid budget requests for the biennium beginning 18 months later, in the following even-numbered state fiscal year (SFY).³ Because of the substantial potential for unpredictable changes in enrollment, medical inflation and FMAP, Medicaid-related budget request items are typically updated at least quarterly. HHSC has intensified enforcement of coordination of Medicaid budget forecasting assumptions across the operating agencies in recent years.

Texas' evolving budgeting procedures have made it difficult in recent years to easily follow Medicaid program growth and demand. Since 1995, state agencies have not been allowed to request funding for "current services" needs (i.e., the funding and staffing levels needed to provide the same level of services to the same numbers of people). In the last 3 budget cycles, state agencies have been required to limit their requests for most programs and functions to amounts appropriated in the previous two-year budget. Since 1999, Medicaid programs have been allowed to request funding increases related to enrollment growth projections, but not increases related to medical inflation, rate increases, or other increases in cost-per-client (such as increased per capita consumption of certain services). Agencies must request funds needed to cover inflation and increased consumption per client in the form of "exceptional items." The exceptional item lists must also be used to request any growth in demand or need for non-entitlement public health needs, or program expansions of any kind. One result of these budget instructions is that a concise record of Medicaid program need and growth is not generated.

Since the adoption of this budget request approach, the “base” appropriations bill filed early in the legislative session has not included any funding for Medicaid-related “exceptional items.” This has helped to create the sense that appropriating funds to cover Medicaid cost-per-client growth is discretionary, or even expansionary. In the 2001 legislative session, new spending needed to maintain Medicaid appeared larger because of the previous legislature’s deliberate under-funding of Medicaid (i.e., deferring one month’s nursing facility, managed care, and acute care insurance payments into the next budget cycle), as well as shortfalls related to inaccurate projections of enrollment trends, FMAP, and cost-per-client. The under-funding obscured the true baseline for needed Medicaid spending. Lawmakers faced the need not only to fill in the resulting gap, but also to fund projected caseload growth and increased costs per client.

During the legislative session, opportunities for public testimony on Medicaid funding proposals are limited to four: hearings on the filed budget by the House and Senate budget committees very early in the process, and hearings in those same committees on the conference committee’s budget late in the session. Many decisions about Medicaid funding are made behind closed doors in settings that are not subject to the state’s open meetings laws.

II. Fiscal history of the state in the last five years

Overall changes in the economy

During the past five years the Texas economy grew faster than the national average, with job growth exceeding the nation’s rate in every year. Statewide, non-farm employment grew by 3.3% per year during this time, significantly faster than the national average of 2.1%. However, great regional disparities exist within the state’s economy. The fastest-growing of Texas’ metropolitan areas, Austin-San Marcos, added jobs at a rate of 5.0 % annually over five years (April 1996 to April 2001), while jobs in El Paso—the slowest-growing major area—grew at only a 1.9% annual rate over the same period.

Personal income growth in Texas also outpaced the nation’s. Unadjusted for inflation, total personal income in Texas increased by an average 7.6% annually from 1996 to 2000, compared to 6.1% for the U.S. Per capita personal income in Texas is projected to have grown at a rate of 5.7% annually in nominal terms from 1996 to 2000, compared to 5.2% for the nation as a whole. However, Texas’ economic regions experienced different trends in personal income. South Texas maintained a per-capita income level in the 1990s that was about 79% of the state average, while the Upper Rio Grande region (El Paso) actually lost ground, with its per-capita personal income falling from about 69% of the state average in 1989 to less than 65% percent in 1998. The Gulf Coast (Houston-Galveston-Brazoria) and Metroplex (Dallas-Fort Worth) continued to fare better than the state overall throughout the 1990s, with regional per capita personal incomes that were almost 20% higher than the Texas average.

The structure of the state economy continued to change. The mining sector (primarily oil and gas production) barely increased employment over the past five years and currently employs only 2% of the Texas workforce. Most Texans work in the service sectors, which account for 29% of all jobs, or in trade, which is responsible for another 24%. Most service jobs are in business and health services, while trade jobs involve eating and drinking places and wholesale trade. The service sectors were also among the fastest growing parts of the state economy, growing by 5.0% a year, second only to construction, which added jobs at a 6.0% annual rate.

With the diminished role of the oil and gas sector, the Texas economy resembles the national economy now more than in the past, and the state is likely to suffer along with the rest of the nation during any prolonged economic downturn. The state comptroller's office currently forecasts slower employment growth over the next two years (increasing about 2.4% annually in 2002 and 2003), although this forecast may be revised shortly to reflect recent developments.

Fiscal health

In October 2000, Texas' Aa1 rating from Moody's for general obligation bonds was second only to that of the 10 states with Aaa ratings. This rating is primarily a reflection of the state's historically conservative revenue estimates and a low level of indebtedness. General bonded debt per capita was only \$252 in 2000, down from \$260 in 1996. Debt service as a percent of all state spending hit a 10-year low in 2000, at only 1.14%.

Another contributor to the state's favorable short-term financial picture is a greatly increased balance in its Economic Stabilization Fund, commonly known as the Rainy Day Fund. Mandatory transfers of revenue from natural gas taxes, combined with legislative decisions not to tap the fund for the 2002-03 budget, will increase the fund's balance from less than \$10 million in fiscal 1996 to \$881 million by the end of fiscal 2003.⁴ At this higher level, the fund would represent about 2.7% of the state's current non-federal spending for one year.

The long-term fiscal condition of the state is not as healthy. Texas was one of the states identified in a 1998 report by the National Education Association as having a general structural deficit (i.e., not just for public education), because its current revenue system will be unable to generate enough funding to cover the cost of current programs in the long term (eight years). Texas' projected shortfall was the eleventh largest of all states, and second largest among the 10 most populous states, among which only Florida had a larger shortfall.

Major sources of state government revenue

The State of Texas relies on tax revenue for more than half of its total income — \$54.5 billion of an anticipated total income of \$106.8 billion in the 2002-2003 budget period (see Chart 1). (Texas is one of only seven states with a biennial legislative session and a biennial budget.)

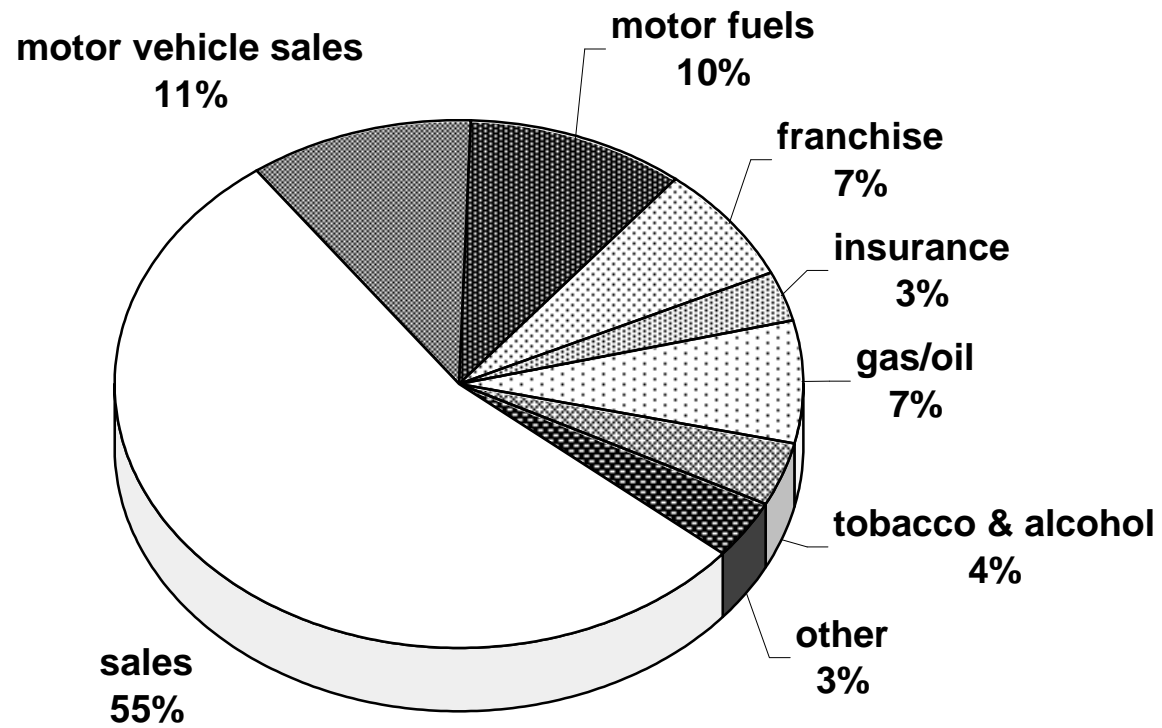
The sales tax (\$14.0 billion in SFY 2000) is the mainstay of the state revenue system, accounting for 55% of estimated tax revenue and 28% of all state revenue. A similar proportion of state revenue came from the federal government (\$14.8 billion), primarily for Medicaid, public education, and state highways.

Other major taxes are the motor vehicle sales tax (\$2.8 billion) and the motor-fuels tax (\$2.7 billion), each of which contributed roughly 5.5% of all state revenue in fiscal 2000, and the corporate franchise tax (\$2.1 billion), which provided 4% of total revenue. (See Chart 2.)

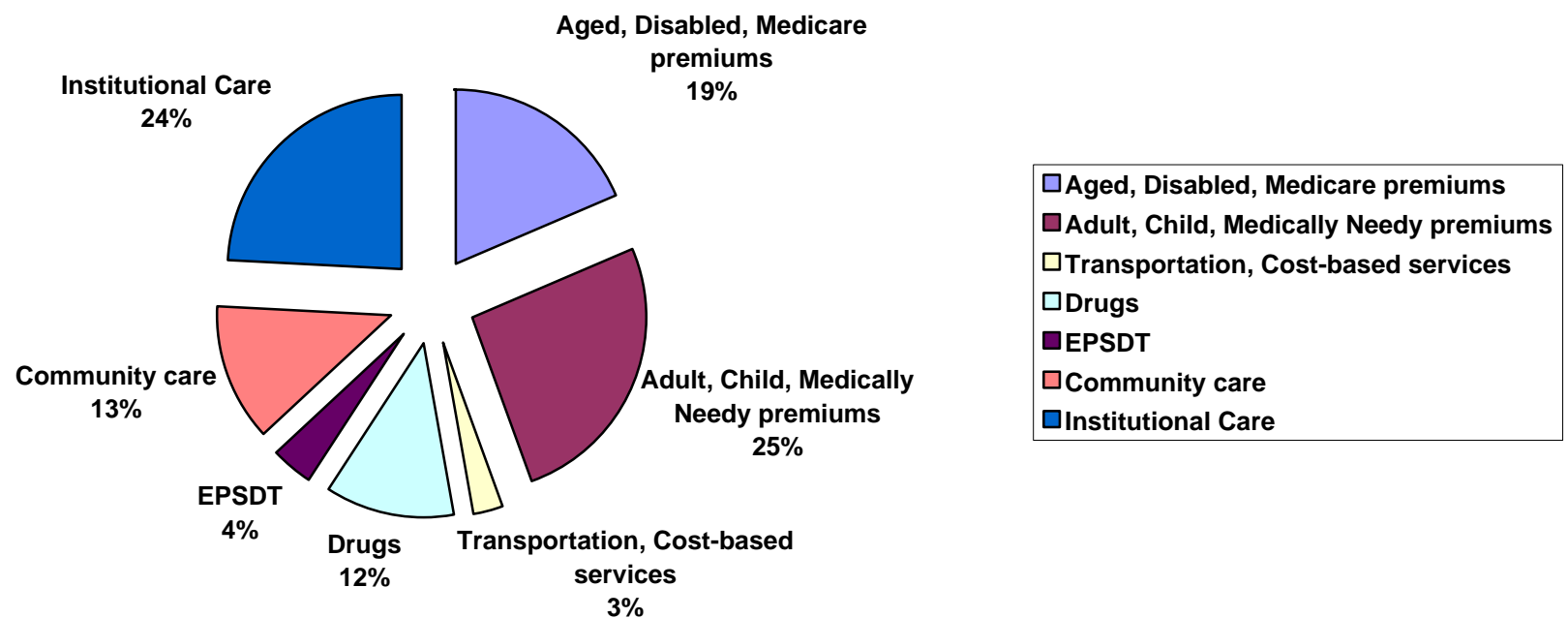
Major non-tax sources in fiscal 2000 include a category of licenses, fees, fines, and penalties (\$4.2 billion), which accounted for 8.5% of state revenue; and interest and investment income (\$1.9 billion). The state lottery (\$1.3 billion) generated only 2.6% of state revenue.

State proceeds from the tobacco settlement were primarily used to create endowments for higher education institutions in the 2000-2001 biennium, in addition to funding the Children's Health Insurance Program (CHIP) and other Medicaid and health-related programs. Allocations for SCHIP, look-alike coverage for children of state employees and so-called "Medicaid spillover"

Chart 2:
What Taxes Does the State Collect?



**Chart 3:
Texas Medicaid Spending, 2000**



(child Medicaid enrollment growth projected to result from SCHIP outreach) made up 10% of Tobacco Settlement allocations in the 2000-2001 appropriations act. Another 4.5% went to expansions of Medicaid community care waivers and a variety of unmatched spending on direct health care services. The bulk (83%) of the \$1.8 billion 2000-2001 Tobacco Settlement allocations went to the creation of permanent endowment funds for a variety of purposes, including funds for Children and Public Health, Tobacco Education, Trauma Care Systems, and Rural and Small-city hospitals. Endowments for higher education funds (including \$665 million for medical education funds) totaled more than \$1 billion, or 56% of the \$1.8 billion allocated.

Tobacco Settlement allocations in the 2002-2003 appropriations act totaled \$925 million (excluding appropriated earnings from the endowment funds), all of which was for direct health-related spending. Programs receiving Tobacco Settlement funds again included SCHIP (and related look-alikes), community care waivers, unmatched direct state health care spending, plus funds for Medicaid provider rate increases and child Medicaid enrollment growth related to eligibility procedure simplification.

Recent tax changes, type and size

The past three legislative sessions — in 1997, 1999, and 2001 — have each seen major tax cuts. In 1997, the primary beneficiaries were homeowners. The homestead exemption from school property taxes was tripled, and the rate at which the taxable value of homes could increase was capped, with the state making up the reduced local revenue via larger general revenue appropriations for public education. In 1999, consumers gained from a sales tax exemption for over-the-counter drugs and the introduction of a two-day summer sales-tax holiday for clothing and footwear. However, businesses gained even more, from a small business exemption and tax breaks for research and development, capital investment, and job creation. In 2001, a major tax abatement program for large new corporate investments was approved.

As a result of the 1997 and 1999 changes, the amount available for the Legislature to appropriate for the 2002-03 state budget was reduced by \$2.6 billion. The costs of the new tax abatement program are deferred, but are expected to total \$1.6 billion in 2007-11.

Expenditure issues

Compared to other states, Texas has historically spent very little per capita at the state government level. The most recent Census Bureau data (SFY 1998) rank the state dead last in spending per capita, with \$2,584 in state government expenditures per resident compared to a national average of \$3,447. When state and local government spending per capita is the basis of comparison, Texas remains near the bottom, in 46th place (with \$4,125 in direct spending per resident in 1998).

All-funds spending by state government in SFY 2000 reached \$45 billion, with the largest functional areas being health and human services (HHS: \$17.9 billion), public K-12 and higher education (\$14.7 billion), transportation (\$4.6 billion), and public safety/corrections (\$3.6 billion). Of these, public safety/corrections grew most rapidly in the last five years, with an average annual nominal growth rate of 7.2%, compared to 4.6% annual growth in state spending overall. Transportation grew at a 6.9% annual rate, followed by 5.6% growth for education and 2.5% growth for health and human services.

With federal funds removed from the picture, state expenditure trends look a bit different. This is because federal dollars are 30% of all state spending, but a much higher share of certain functions,

such as HHS (56% in fiscal 2000) or transportation (40% federally funded). Unadjusted for inflation, nonfederal state spending increased at an average annual rate of 3.8 % from 1996 to 2000, with public safety/corrections again showing the largest increase (6.4% annually) among the major spending areas. The next-fastest growth took place in education (5.3% annually), followed by 4.5% for transportation. HHS nonfederal spending (72% of which is Medicaid) actually decreased over this time period on average by 0.1% annually. Examining the year-by-year changes more closely, one sees that HHS nonfederal spending was highest in 1996 at \$7.98 billion, then dropped to \$6.92 billion in 1998, then began rising again to its SFY 2000 level of \$7.94 billion. The short period of decreased state revenue spending was due in large part to caseload declines in Medicaid and TANF-related programs (see pages 6 and 7), and to substitution of federal TANF funds for HHS functions previously funded with state revenues.

Growth areas

Although Texas prisons underwent their fastest growth in the early 1990s — more than doubling from 49,600 inmates in 1991 to almost 127,600 in 1995 — continued growth in the following five years put additional pressure on state budget-writers. In the latter half of the 1990s, the adult prison system added 23,500 inmates, for a total inmate count of 151,100 in 2000. Juvenile prisons have also increased rapidly, with Texas Youth Commission institutional populations increasing from 2,200 in 1996 to almost 4,100 in 2000.

Texas has one of the highest adult incarceration rates among the states, second only to Louisiana. State prison expenditures (about \$2 billion annually) are thus quite high, although much lower than they would be if the state were to invest more in health care and education per inmate or address the issue of severe understaffing. In 1998, Texas' daily incarceration costs per inmate (\$39) were less than 70% of the national average (\$56).

In addition to K-12 education, discussed below, higher education has been another important growth area in the state budget. Public two-year college enrollment grew by 1.4 percent annually in the last five years, reaching 439,150 in 2000. General four-year academic enrollment peaked in 1992 at 410,700 and then declined steadily to 396,300 in 1997. It then began increasing rapidly again, exceeding 409,000 by 2000. Combined, these trends gave four-year academic institutions an average annual growth rate of 0.7% from 1996-2000. Health-related institutions experienced an enrollment drop in this period of about 4.5% annually, bottoming out at 12,800 in 2000, after which enrollment is expected to increase.

Medicaid and SCHIP growth

Texas Medicaid monthly caseloads dropped 13% overall from January 1996 to December 2000, with modest growth in aged and disabled clients masking a steeper 17% decline for the remainder of the population. Almost two-thirds of the caseload decline was due to decreased coverage of children (see Table 1).⁵ Despite the caseload decline, from FY1996 to FY2000 non-DSH state (non-federal) Medicaid spending grew by \$816 million (nominal dollars), a 26% increase. However, this growth was dramatically lower than the \$1.7 billion (118%) non-DSH state spending increase from 1991 to 1996, when caseloads were climbing. The caseload decline gave the Legislature several years of relatively modest Medicaid cost growth. Caseloads ceased their decline in early 2000 and slow, steady enrollment growth since is one factor behind steeper projected Medicaid spending projections for 2000-2003. Texas projects 13% growth in Medicaid state spending from 2000-2001 and 17% from 2001-2002,⁶ the largest annual increases since 1994 (see Table 2).

Table 1:

Texas Medicaid Monthly Average Enrollment, 1996-2001

	Jan. 1996	Jan. 1997	Jan. 1998	Jan. 1999	Jan. 2000	Jan. 2001	Sept. 2001	Change 1/96-9/01
Aged & Medicare Related	298,142	304,836	303,712	309,555	307,703	310,180	313,164	5.0%
Disabled & Blind	190,469	192,518	196,475	201,743	182,168	185,620	188,814	-0.9%
TANF Adult	215,098	197,046	164,297	123,789	108,230	106,902	108,874	-49.4%
Pregnant Women	83,661	83,338	81,757	80,088	81,564	87,914	96,788	15.7%
Medically Needy	18,683	18,277	18,191	17,454	20,838	25,650	28,968	55.1%
Children	1,287,828	1,228,050	1,138,836	1,111,106	1,096,710	1,137,425	1,171,899	-9.0%
total	2,093,881	2,024,065	1,903,268	1,843,735	1,797,213	1,853,691	1,908,509	-8.9%

Source: Texas Health and Human Services Commission. September 2001 figures preliminary.

Table 2:

**Total Texas Medicaid State Non-DSH Spending,
1991-2001 Actual, 2001 Estimated**

1991	\$1,424,386,399	
1992	\$1,724,429,072	
1993	\$2,082,715,764	
1994	\$2,526,666,323	
1995	\$2,807,741,801	
1996	\$3,098,816,127	
1997	\$3,216,166,410	
1998	\$3,394,639,465	
1999	\$3,606,248,118	
2000	\$3,914,868,199	
2001, estd.	\$4,421,319,707	
Change, 91-96	\$1,674,429,728	117.6%
Change, 96-00	\$816,052,072	26.3%

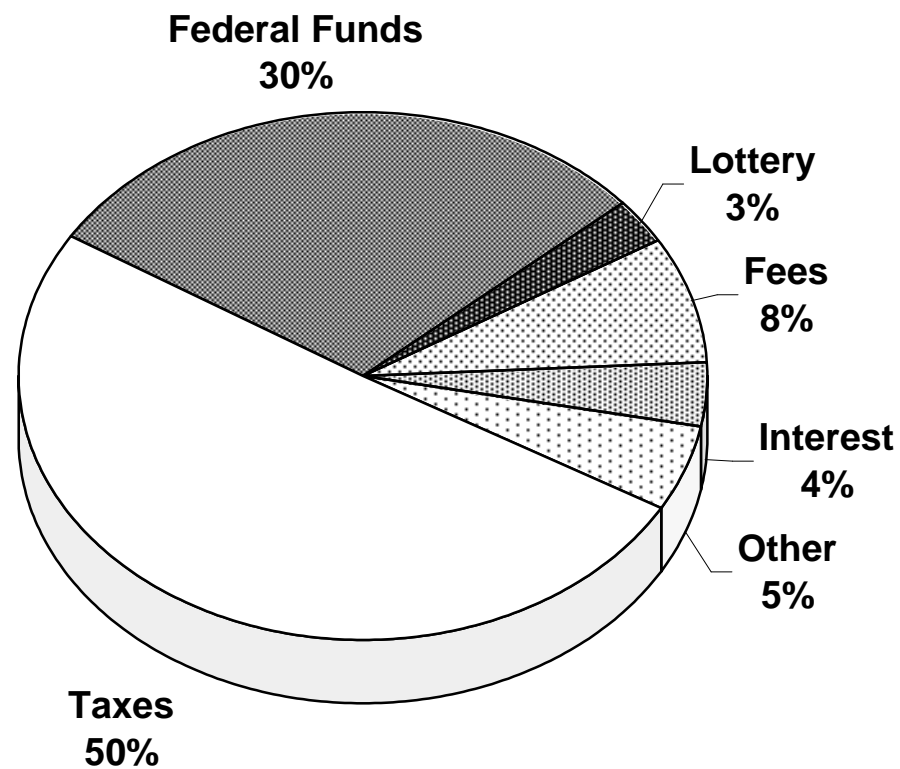
Source: Texas Department of Human Services, Title XIX Expenditure History List, CMS-37 federal funds request 8/15/01 Submission

Table 3: Texas Medicaid Budget Trends, 1996-2000 actual, All Funds (Source: Legislative Budget Estimates)

	1996	2000	Increase 96 to 00	rate	distribution
TDH/HHSC					
Aged and Disabled	\$1,204,192,768	\$1,317,129,330	\$112,936,562	9.4%	6.5%
TANF adults and children	\$806,495,106	\$555,588,365	-\$250,906,741	-31.1%	-14.4%
Pregnant women	\$495,574,202	\$496,524,945	\$950,743	0.2%	0.1%
Children and Medically Needy	\$1,166,984,622	\$1,370,604,838	\$203,620,216	17.4%	11.7%
Medicare cost-sharing	\$372,605,042	\$443,671,145	\$71,066,103	19.1%	4.1%
EPSDT Services, above premium	\$177,834,526	\$165,837,438	-\$11,997,088	-6.7%	-0.7%
Cost- Reimbursed Services	\$140,752,163	\$230,594,234	\$89,842,071	63.8%	5.1%
Prescription Drugs	\$663,225,225	\$1,126,293,372	\$463,068,147	69.8%	26.5%
TDH					
Medical Transportation	\$19,677,834	\$35,119,462	\$15,441,628	78.5%	0.9%
EPSDT Screens & Admin	\$65,702,837	\$72,470,118	\$6,767,281	10.3%	0.4%
EPSDT Dental	\$106,568,988	\$138,553,210	\$31,984,222	30.0%	1.8%
DHS					
Community Care for Aged	\$484,644,849	\$861,955,262	\$377,310,413	77.9%	21.6%
Long Term Care eligibility	\$83,512,545	\$105,375,452	\$21,862,907	26.2%	1.3%
Nursing Facilities & Hospice	\$1,323,904,523	\$1,640,777,455	\$316,872,932	23.9%	18.1%
MHMR					
Community Care Waiver, MR	\$77,157,997	\$236,117,431	\$158,959,434	206.0%	9.1%
ICF-MR	\$242,046,446	\$364,557,420	\$122,510,974	50.6%	7.0%
State Schools, MR	\$260,134,682	\$276,303,836	\$16,169,154	6.2%	0.9%
			1,746,458,958		100.0%

NOT exhaustive of all Medicaid spending; small amounts exist in other line items.

Chart 1:
Where Does the State Get Its Money?



Medicaid program line items that not only showed very high rates of increased spending from 1996 to 2000, but also accounted for a large share of the increase in Medicaid spending included prescription drug coverage (70%) community-based long term care (78%), consistent with national trends. Very substantial growth is seen in community care waivers and intermediate care facilities (ICF-MR) for persons with mental retardation, reflecting both a major shift from large state-operated institutions (“state schools”) and net increases in community care capacity. Medical transportation and EPSDT dental services also showed very high rates of increase due to intensive state efforts to improve access in response to a federal class-action lawsuit over access to EPSDT services. However, growth in these services still only accounted for 3.1% of total program growth. Services accounting for the largest dollar amounts of new spending were prescription drugs, community care, nursing home care, with children’s Medicaid a distant fourth place. (See Table 3 and Chart 3.)

While spending trends for 1996 to 2000 represent actual experience, the trends for 2000-2003 are based on appropriated amounts. Because appropriated amounts were not only subject to pressures to achieve a balanced budget, but also were calculated before the economic downturn (and the expected resulting increase in caseload growth rates) was clear, the 2000-2003 projections are subject to a wide margin of error. Based on appropriations, growth in Medicaid line items is projected to remain high from 2000-2003. Costs for SSI recipients (aged or disabled), children, and TANF recipients are expected to grow at higher rates than they did in the previous five years. The state is predicting that the average Medicaid monthly caseload for SFY 2003 will be 220,000 higher than in April 2001 (12% growth), with most of this growth consisting of higher numbers of children.

Texas’ separate state SCHIP program began covering children in May 2000, and has been funded entirely from Tobacco Settlement proceeds. Due to robust enrollment (over 477,000 as of November 5, 2001), strong pressure from health plans for premium increases, and appropriations that were lower than the amounts requested by HHSC, a funding shortfall is expected in the 2002-2003 biennium.

Declining areas

Plummeting caseloads in TANF (Temporary Assistance for Needy Families) cash assistance are partly responsible for a brief decline in Texas’ nonfederal HHS spending in 1996-2000. Food Stamp caseloads fell from about 2.4 million in 1996 to 1.4 million in 2000. The number of TANF grant recipients fell by about 51 percent, to about 341,500, with total grant spending falling from \$481 million in 1996 to \$259 million in 2000. In 1999, some of the state and federal dollars freed up by the TANF caseload decline were used to raise the grant (but not the eligibility threshold) for families for the first time since 1985 (from \$188 to \$197 monthly for a family of 3, pegged thereafter at 17% of the FPL) and to reinstate a per-TANF child annual payment of \$60. An even larger portion of the freed-up funds, however, were used to supplant and expand funding for other HHS programs such as child protective services, foster care funding, and child care subsidies.

Functional shifts between state and local governments

The largest state or local government program in Texas is public K-12 education, which is controlled by independently elected school boards in more than 1,000 school districts. School districts are supported by local property taxes and by state aid, which is funded by general tax revenue and by the state lottery. Average daily attendance was about 3.7 million in SFY 2000, up from 3.4 million in 1996 (an annual increase of 1.9%).

The share of support for public education provided by the state steadily declined over the past five years, from 47.1 percent of state and local revenue to an estimated 42 percent in 2001. The increased local share reflects both rapidly increasing local property values, which reduces matching state aid, and increased tax rates, as local school boards struggle to provide desired salaries and facilities.

Texas' 1995 state welfare reform law moved a number of workforce functions from state agencies to 28 local boards. Administration of subsidized child care was included among the devolved services. No major health or Medicaid functions have shifted to the local level during this period.

III. Overall impact of the federal government

Impact of PRWORA and Immigration Law Changes

Though Congress intended in 1996 for the de-linking of TANF and Medicaid to prevent the loss of coverage by persons who remained poor enough to qualify for cash assistance, Medicaid coverage in Texas dropped sharply in Texas from 1996 to 2000. This decline was not offset by a corresponding increase in private insurance. The state's "leaver" studies found that few former cash assistance recipients obtained health insurance benefits, and average wages achieved were less than \$7.00 per hour. From January 1995 through December 1999, only 21% of persons leaving TANF due to increased earning received Transitional Medical Assistance (TMA). Over 253,000 children left TANF from January 1996 to November 1999, and child Medicaid enrollment dropped by over 220,000 because so few children were transferred to either TMA or the income-related child Medicaid categories. State legislation in 1999 directed additional resources to informing TANF clients about the availability of ongoing Medicaid coverage for parents and children, and both child and adult enrollment began to increase early in 2000. A HCFA review of states' implementation of de-linking recommended in early 2001 that Texas should take a number of corrective actions to improve access and customer service. However, it is not clear whether or how the newly-reorganized CMS will pursue these recommendations.

Restrictions on legal immigrants' eligibility and fears about the possible impact of benefit use on family members' ability to gain legal status have depressed Medicaid take-up rates for some populations. Improved enrollment in Medicaid by "qualified alien" children and U.S. citizen children with non-citizen parents has been a focus of recent state policy activities. Both Medicaid and SCHIP application and outreach materials now include reassuring information about "public charge" issues and confidentiality. However, despite federal and state efforts to reduce fears about "public charge" and confidentiality issues, barriers remain. Questions about the financial liability of immigrant sponsors for properly-received Medicaid benefits are unresolved. Also, parents who are undocumented immigrants can find the task of proving their income in order to enroll their U.S. citizen children daunting. Some immigration attorneys continue to discourage parents who hope to gain permanent resident status from enrolling their children.

EPSDT Lawsuit

Texas Medicaid was named as defendant in a federal class-action lawsuit filed in 1993, alleging that the state had failed to provide children with access to care as required under federal Medicaid law. A consent decree between the state and plaintiffs was approved by the court in 1996. As previously noted, spending on certain EPSDT-related program areas has increased faster than overall Medicaid spending as the state has attempted to improve screening rates and provider participation. However, key legislators have expressed resistance to court-directed spending, and EPSDT needs have often been funded below requested levels. Unfortunately, despite apparent improvement for several

years, Texas' most recent EPSDT participant ratios seem to have declined (it is unclear how much of this is due to poor encounter in Medicaid Managed Care). In November 1998, plaintiff's attorneys alleged that Texas was not living up to some terms of the consent decree. The District Court agreed in August 2000 that the state had not complied in some areas, but the state is appealing that ruling and has been granted a stay of the District Court's order to propose a plan of corrective action pending resolution of the state's appeal.

Despite the unresolved status of this dispute, significantly increased 2002-2003 appropriations were granted for dental care and medical transportation — two of the primary areas of the most recent dispute. Also, 62% of funds allocated for Medicaid physician fee increases in 2002-2003 will go to increasing the EPSDT medical screening fee from \$49 to \$70. The EPSDT lawsuit has clearly brought increased investment — in transportation, dental services, medical screening fees and “comprehensive care” services — yet spending data suggest that it has not been a program cost driver of a comparable magnitude to services for aged or disabled clients, or prescription drugs.

Olmstead Decision

Language in Texas' 2002-2003 appropriations act 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. While unmet demand and substantial waiting lists remain for all of Texas Medicaid's community care waiver programs, the Legislature authorized significant additional funds (over \$280 million state dollars above the previous budget, to fund about 3,700 new community placements and better wages for attendant care) for all these programs — another indicator of the influence of *Olmstead* on policy and budget decisions.

III. Description of Medicaid program

Eligibility, service structures

Texas Medicaid eligibility standards include the following general categories:

Children: Infants up to age one up to 185% of the federal poverty level (FPL); ages 1 to 6 up to 133% FPL; and 6 to 19 up to 100% of the FPL.

Pregnant Women: Coverage for women up to 185% of the FPL.

Families with Dependent Children: Coverage for families with countable incomes at or below 17% of the FPL (Section 1931).

Transitional Medical Assistance: for families leaving Section 1931 coverage or TANF. Under an AFDC waiver, Texas has not required documentation for months six through twelve of TMA benefits, and has offered 18 months of TMA for TANF clients who volunteer for job training.

Medically Needy: available only to families with dependent children (no aged or disabled coverage). Income eligibility (after medical bills) is pegged at 133% of Texas' very low Section 1931 income threshold and subject to asset limits.

SSI-related: Texas does not supplement SSI payments. All SSI beneficiaries are automatically enrolled in Medicaid.

Special Income Limit for Long-Term Care: Persons with incomes up to 3 times the SSI limit (about 220% FPL) may access Nursing Facility or ICF-MR services if medically necessary. This income threshold is also applied to a number of community care waivers which serve children and adults (including persons with mental retardation). This income cap is also applied to the so-called “Frail Elderly” program, which provides non-medical home care services to persons of any age at risk of declining to require nursing home care.⁷

Medicare-related costs: Texas provides Medicaid financing of these costs for low-income Medicare recipients as required by federal law (QMB, SLMB, Q1, Q2, QWDI).

Foster Care Transition: coverage for children aging out of Foster Care through age 21.

Authorized but not yet implemented: Coverage for women with breast or cervical cancer; Implementation has been delayed due to funding issues, discussed later in this paper.

Service Delivery

Texas began implementing Medicaid Managed Care in 1993, and as of September 2001 600,559 Medicaid recipients (one-third of the total) were enrolled in either HMO-based care or Primary Care Case Management (PCCM). All of the state’s largest metropolitan areas now mandate that income-related clients participate in managed care, and Harris county (Houston) is home to the StarPlus waiver, which provides both acute and long-term care (primarily community-based) to over 56,000 elderly and disabled clients via managed care plans. State plans for managed care expansions in the near term are described later in this paper.

Uninsured Rate

Texas has, among the states, had for more than a decade one of the highest percentages of residents who lack health insurance. The latest U.S. Census three-year average estimate (1998-2000) ranks Texas just ahead of New Mexico with 22.2% of all Texans uninsured. Analysis of 1999 CPS data found Texas had 4.6 million uninsured residents (24.1% of all ages, or 25.8% of Texans under 65).⁸ As with economic statistics described earlier, uninsured rates vary dramatically across the state, directly tracking unemployment rates, poverty rates, and lower average per capita incomes. Low rates of coverage are attributed to low levels of industrial employment and unionization, high concentrations of employment in retail and service jobs, high proportions of poor and low-income residents, and very low income caps on adult Medicaid eligibility. Census data for 2000 reflected the second year of slight improvement in coverage rates for the state, consistent with (and slightly stronger than) the modest improvement recorded for the U.S. as a whole. Texas’ upturn in 1999 was most likely attributable to marginally improved private coverage rates from a then-robust economy. The up-trend in Texas Medicaid enrollment and the rapid enrollment of children in SCHIP began in 2000, and thus may have contributed to the continued upward trend seen in the March 2001 CPS data. Similarly, impact of the recent economic downturn on the small gains in private coverage is not likely to be reflected until 2002.

Enrollment trends

As described before, Texas Medicaid rolls declined precipitously from 1996 through late 1999. Monthly total caseloads dropped 15% from January 1996 to December 1999, from 2,093,881 to 1,776,201. This drop of 317,680 included 208,518 children. Expansion of coverage (and associated outreach) to teenagers below poverty beginning in July 1998 helped prevent an even steeper decline. First-time efforts at outreach and informing of Medicaid clients⁹ (and eligibility workers) about the de-linking of Medicaid and TANF in fall 1999 contributed to reversal of the decline. Outreach efforts related to SCHIP implementation began in March 2000, and this new

application pathway has also added to caseload growth. As of September 2001, total monthly average caseload had climbed to 1,908,076, still below the 1996 level (See Table 1).

Prior to SCHIP implementation, Texas' 1.4 million uninsured children were estimated (based on income alone) to include 600,000 children eligible for, but not enrolled in Medicaid. About 136,000 Texas children now enrolled in SCHIP (31% of the total) have reduced that estimate, as they are in families with incomes at Medicaid levels who qualify for SCHIP only because of Medicaid limits on family assets. Parents of children referred to Medicaid via Texas' SCHIP application process to date have been required to complete a face-to-face interview requiring extensive additional documentation at a Department of Human Services (DHS) eligibility office, and this unpopular requirement has resulted in 58% of applicants referred to Medicaid thus far not completing the enrollment process, leaving their children ineligible for either Medicaid or SCHIP.¹⁰ Despite this high attrition rate, between December 1999 and September 2001, Medicaid enrollment grew by over 91,000 children, about half of whom applied via the SCHIP "TexCare Partnership" process.¹¹ A new state law adopted in 2001 will allow application and re-certification for children's Medicaid by mail and provide a 6-month period of continuous eligibility for most children beginning January 2002.¹² Other provisions in the legislation, which require parents to receive an initial orientation and to keep their children current with EPSDT check-ups as a condition of accessing simplified eligibility, may have some dampening effect on enrollment growth. Still, the simplified eligibility policies are expected to further increase children's participation in Medicaid, which was the goal of the legislation.

The enrollment upturn is not limited to children; caseloads for elders, disabled, maternity coverage, and medically needy have also increased since December 1999. The overall increase has been 3.5%. The state implemented expedited and simpler processes for enrollment of pregnant women in 2000. Also, families eligible under Section 1931 (and who do not receive TANF) are carried in the Medically Needy category, due to MIS limitations, so part of the growth in that group is likely due to increased awareness about Section 1931 among community-based agencies and health care providers, as well as better training of DHS eligibility workers.

SSI disability-related Medicaid remains at lower levels than in January 1996. The most likely cause is the substantially more restrictive definition of disability for children imposed by PRWORA. However, Texas has also been shown to have the highest overall rate of SSI disability denials in the U.S. This will be the subject of a Legislative study in 2002.

Optional Benefits Offered

Optional services Texas provides to adult Medicaid enrollees include:

Advanced Practice Nurses;
Ambulatory surgery;
Birthing center services (limited);
Case management for people with chronic mental illness, women with high risk pregnancies and infants, and persons with mental retardation and related conditions;
Certified Registered Nurse
Anesthetists or Anesthesiologist;
Chiropractic (limited);
Christian Science Sanitarium;
Day activities and health services;

Emergency medical services;
Licensed Professional Counselors;
Licensed Masters of Social Work/Advanced Clinical Practitioners;
Hearing aids and related audiologists' services;
Home and Community-based services;
Hospice care;
Intermediate care facilities for persons with mental retardation or developmental disabilities;

Maternity care clinics (limited);
Medically needed oral surgery and dentistry (not routine dentistry);
Optometry and eyeglasses;
Personal care services in the home;
Physical therapy;
Podiatry;
Prescription drugs (three per month in Texas; all drugs for nursing home residents are covered. Currently managed care participants not subject to limit.);

Psychologist's services (limited);
Rehabilitation services: chronic
mental illness, chronic medical
conditions;

Respiratory care in the home;
School Health and Related
Services;
Telemedicine; and

Tube feeding in the home (total
parenteral hyperalimentation).

Provider Payments

Comparative Medicaid reimbursement rate data across states is not readily available. Also, managed care obscures the rates providers receive, since each HMO may negotiate its own rates for most services. In Texas, the Medicaid program holds these negotiated rates to be “proprietary information” not available to the taxpayer. As an exception to this general rule, the legislature by statute has required that certain EPSDT fee increases be “passed through” to health care providers.

Most Texas Medicaid outpatient and professional provider fees were frozen from 1992 until 2000, when they received a 2.7% increase. For the 2002-2003 budget, Texas lawmakers allocated \$197 million state general revenue (GR) 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 had been requested), \$20 million for Texas Health Steps dentist fee increases (\$27 million had been requested), \$35 million for HMO premium increases (\$42 million had been 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.

To allow for natural enrollment growth, inflation, and certain rate increases, HHSC requested SCHIP 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 SCHIP than the base budget. Some of this amount was to pay for a 10% increase in SCHIP health plan premiums. However, most SCHIP health plans reported significant losses on their SCHIP business, and the state ultimately offered a larger premium increase (19.7%) than provided for in appropriations. The state is proposing policy changes including increased co-payments (e.g., for legend drugs, emergency room visits, inpatient admissions) and somewhat less aggressive outreach in order to afford these higher premiums (i.e., reducing the number of follow-up calls and letters to non-responding parents).

Funding for personal attendants' salaries received an additional \$50 million GR (\$90.9 million had been requested). Nursing Home funding received an additional \$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.

Source of state match

The bulk of Texas Medicaid spending is financed with state general revenue (GR). A portion of Tobacco Settlement receipts have been used for Medicaid and SCHIP state matching funds in the previous (2000-2001) and current (2002-2003) budget periods. State matching funds for Medicaid (\$453.4 million) and SCHIP (354.7 million) account for more than half the of Tobacco Settlement receipts allocated in the current budget. The only use to which settlement receipts are dedicated under state law is for SCHIP match, and these receipts fund the entire state match for that program, as well as the full cost of the state's “look-alike” coverage for legal immigrant children during their

5-year bar from Medicaid and SCHIP, and for children of low-income state employees. In contrast, the settlement receipts make up less than 5% of the state's matching funds for Medicaid.

Local funds are used in Texas Medicaid in two ways. The most significant is for the state's matching requirements for the disproportionate share hospital reimbursement program, which is described briefly later in this paper. The state also uses local funds provided by hospitals and some Federally Qualified Health Centers (FQHCs) to pay for the state's share of outstationed eligibility workers. The state's ability to use donated funds in this way was established in federal courts over two decades ago, and was the impetus for some of the first regulations regarding the use of donated funds. The state finances its share of a single outstationed worker in each DSH hospital, but hospitals desiring additional workers must fund the state's 50% share of those workers (some of the largest hospitals employ as many as 40). Similarly, the state has provided the matching funds for a single worker at some of the state's highest-volume FQHCs, but requires the FQHCs to fund the state match where volume is considered too low. The state is currently in discussions with the FQHCs regarding the appropriate level of state-funded staffing levels of these workers, based on a January 2001 HCFA letter to State Medicaid Directors. Texas Medicaid has also recently begun using the PRWORA-authorized "de-linking" enhanced matching funds to establish outstationed workers in new rural sites.

Other Texas safety net mechanisms

The major role of hospital districts in the provision of health care to uninsured Texans was described earlier in this paper. County and city programs to serve the uninsured, as well as contributions of care by certain non-profit clinics and hospitals provide what limited safety net Texas has to serve those lacking public or private health benefits, or the means to pay out of pocket for care. Many smaller counties are subject to the County Indigent Health Care and Treatment Act, but this only requires the provision of care to uninsured persons at or below 21% FPL. Uninsured people with higher incomes in these counties must look to the generosity of individual health care providers in their area, as no formal public program is in place to help them. With increasing frequency, low-income uninsured Texans in need of care are assuming financially crippling medical debts. The hospital districts in larger counties typically provide subsidized care to a higher income threshold, ranging from 100%-200% of the FPL; they are not subject to a statutory requirement. The districts have no legal obligation to provide care (beyond emergency care) to the residents of other counties, so low-income uninsured Texans in small counties have far less of a safety net to rely on than urban residents. If they travel to another county for care at an urban public hospital, they are likely to get treatment, but will be held financially liable for the bill.¹³

Of special concern in Texas is access to care for undocumented residents. The Urban Institute has recently estimated that Texas is home to about 1.2 million such persons.¹⁴ While most Texas county programs have historically served the uninsured based on need and residence (rather than citizenship), a recent state Attorney General's Opinion has created confusion among local governments about continued provision of such services. Most large urban counties continue to provide care, and health care providers hope to enact state or federal legislation to eliminate any ambiguity about provision of medically necessary care to the undocumented.

IV. Financing mechanisms

Disproportionate Share Hospital Reimbursement

Texas has had a disproportionate share hospital reimbursement (DSH) program since 1987, and has used local funding in a variety of ways to support DSH since 1991. Program rules have been

modified several times over the years to accommodate changes in federal law intended to limit abuses of DSH. A major shift was in response to the 1993 federal law which limited hospital payments to actual unreimbursed costs, bringing an end to the practice of funding the entire budget of some state-owned hospitals with DSH. This change resulted in making more DSH funds available to the non-state-owned hospitals, reducing DSH payments to state-owned hospitals from about half the statewide total to less than one-third.¹⁵ Balanced Budget Act provisions reducing amounts states may pay to state-owned psychiatric hospitals are resulting in another, smaller shift of available DSH funds to non-state-owned hospitals, at the same time that overall DSH funding for Texas is reduced. Like most states with substantial DSH funding at stake, Texas has lobbied vigorously to minimize DSH reductions whenever they have been contemplated.

Texas' current DSH program has two components: one program for state-owned hospitals, and another for all other public and private hospitals. State-owned hospitals include ten psychiatric hospitals, two hospitals operated by the TDH (founded as tuberculosis hospitals, now serving broader public health needs), the M.D. Anderson Cancer Center, and two state-owned teaching hospitals. Methodologies for paying these hospitals are designed to ensure that the state makes the highest DSH payment allowable under federal guidelines, and the remainder of the federal DSH allocation is then available for the non-state-owned hospital program. The state puts up its own general revenue to draw the federal share for the state-owned hospitals. Only the federal DSH matching funds directly related to these state-owned hospitals are retained by the state. All of the federal funds related to the intergovernmental transfers from the DSH program for non-state-owned hospitals (described below) are redistributed to those local public and private hospitals.

The DSH program for hospitals not owned by the state is funded entirely by intergovernmental transfers from nine public hospitals or hospital districts in Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston, Lubbock, Midland-Odessa, and San Antonio. With the federal matching funds, DSH funds are then distributed to these nine, plus another 121 Texas hospitals. The state has just published proposed rules that would allow a small number of additional hospitals in counties of 250,000 or less to qualify for DSH payments in 2002. In state fiscal year 2000¹⁶ non-state-owned hospitals received 62% of total Texas DSH payments. Reductions in the federal DSH allocation increase the state-owned hospitals' percentage of the total, as the state continues to maximize payments to those facilities. Texas FFY 2001 federal DSH allocation was \$765 million, for total aggregate DSH payments of \$1.263 billion.

Texas Medicaid adopted rules in 1993 which included "conditions of participation" for non-state-owned hospitals receiving DSH payments. These rules do not create rigid requirements for expenditure of DSH funds, but they do make several requirements of hospitals. Hospitals must report their charity care criteria to the state, meet a minimum standard ratio of charity care charges to DSH payments, inform patients about the availability of charity care, report annually on DSH expenditures, report on availability of primary care alternatives to the emergency room, and conduct and report annually on community health care needs. DSH hospitals must participate in regional trauma system development, and public hospitals with 250 beds or more must ensure that local revenues for support of the hospital are not reduced. On occasion, a hospital's DSH payments are withheld for non-compliance with these conditions; payments generally can be received once a hospital comes into compliance. The state also monitors compliance with the federal requirement that DSH hospitals have at least 2 physicians accepting Medicaid obstetrical patients (a challenge for some small rural facilities), and will withhold DSH payments if the standard is not met.

It is generally agreed that in Texas DSH has helped large urban public hospitals avoid having to seek (or has reduced in size) direct property and sales tax increases. Since urban property tax

burdens in Texas are already high, the likelihood of passing a tax increase is always uncertain, so DSH is generally also credited for maintaining services levels to uninsured residents. Texas' DSH allocation formula includes payments to several dozen small rural hospitals, helping them to continue operations during a period in which Medicare payments have been significantly reduced.

Upper Payment Limit Financing Mechanisms

Texas has not yet implemented upper payment limit (UPL) financing mechanisms, but proposed rules have been drafted which would create "supplemental payments" for inpatient and outpatient services at the same nine non-state-owned public hospitals which now fund the statewide DSH program. These hospital districts will provide the state's share to fund the supplemental payments via intergovernmental transfers. An official projection of the benefit to these hospitals has not been published, but discussions have suggested total annual reimbursements (including federal and local shares) of \$100-150 million. The largest portion of the federal funds from this mechanism will benefit the donating county health care financing jurisdictions. Another portion reportedly will be used to fund updates to Texas Medicaid's graduate medical education payments, which are supposed to track Medicare policy but have lagged behind. This will extend the benefits of the UPL funding to several dozen additional hospitals with residency programs. Creation of a separate UPL methodology funded by intergovernmental transfers from rural public hospitals is under consideration for the future. As currently configured, there is no "rake-off" of UPL matching funds for the Texas treasury; all funds are distributed to hospitals. However, the mandate (described below, Actions in 2001) to reduce Medicaid nonfederal spending for 2002-2003 by \$205 million has raised the possibility that (subject to federal approval) UPL payments may be revisited to play a role in filling that funding gap.

V. Recent changes in Medicaid

Program Reductions

Despite the tighter revenue position faced by state government in the 2001 legislative session, no substantial Medicaid program benefit or eligibility reductions were considered. No major roll-backs have been publicly discussed since the Medicaid enrollment boom years of the early 1990s. However, a broad array of cost containment measures have been adopted in recent years, are underway, or are under consideration. For example, tighter pre-authorization standards for private duty nursing care in the homes of medically complex children have reduced the numbers of hours of care delivered in recent years. Texas' implementation (beginning in 1993) of managed care for many enrollees was largely motivated by the legislature's desire to contain or slow Medicaid cost growth, although the documented cost savings have been modest.¹⁷

The legislature has mandated major reductions in eligibility workers since 1996 (Texas eligibility workers provide Medicaid, TANF and Food Stamp eligibility services). Rates of application for benefits have not dropped along with caseloads since welfare reform. Comparing 1996 to 2000, applications for Food Stamps dropped by 12% and TANF by 37%, but Medicaid applications increased by 18%. Because Food Stamp and Medicaid caseloads are so much larger than TANF, there was a net increase in total applications of almost 1%. There is also evidence that the amount of caseworker time required per client has nearly doubled in this time frame. Despite the intensified workload and the slight increase in applications, the legislature cut DHS eligibility workers by 18% from 1996 to 2001: by 1,274 in 1998 and 1999 alone, and another 679 positions in 2000 and 2001. In the face of widespread complaints about customer services and recent lawsuits over failures to meet timeliness and other federal standards, the Legislature has mandated further cuts (450

positions in 2002, and 300 more in 2003), based on their assumption that simplification of child Medicaid eligibility processes will reduce workloads accordingly.

Supplemental appropriations: 2001

Legislative appropriations for Texas Medicaid for the 2000-2001 biennial budget fell short of actual needs for several reasons. According to HHSC, nearly half of the shortfall was due to the upturn in caseloads in 2000, after five years of decline. The Legislative Budget Board (LBB), which makes ultimate decisions regarding budget assumptions, had projected a reduced rate of caseload decline during 2000-2001 compared to the previous biennium, but failed to project the actual upturn that occurred. Medical inflation and increases in “intensity” of utilization (i.e., higher service consumption per client) were responsible for about a quarter of the shortfall, and increases in prescription drug spending about one-sixth. Finally, mistaken FMAP assumptions accounted for about 10% of the appropriations gap. While LBB used FFIS projections of FMAP for 2000, they assumed no decrease in the federal match share for 2001, which proved to be unduly optimistic. To address the shortfall, the supplemental appropriations bill appropriated \$489.9 million (total funds) for Medicaid, and transferred another \$105.3 million (total funds) of existing authorized appropriations from other state agencies, for a total of \$595.2 million.¹⁸ After the supplemental appropriations bill was passed, it was determined that a shortfall of approximately \$240 million (total funds; \$75.5 million GR) remained, and these funds were transferred from lapsing funds in other HHS agencies’ 2000-2001 budgets.¹⁹ With this addition, the total Medicaid shortfall for the 2000-2001 biennium came to \$835 million (total funds). This biennial (not annual) shortfall amount represents just under 4% of the roughly \$21.3 billion in non-DSH spending for Texas Medicaid in 2000 and 2001.

Program Expansions Considered or Adopted

Despite revenue forecasts unfavorable to full funding of desired policy changes, the Texas Legislature enacted in 2001 a number of measures to improve access to Medicaid and to provide additional services to new populations. Legislation to simplify child Medicaid eligibility procedures was adopted, which will allow application and re-certification for Medicaid without a face-to-face interview, change to a simple, self-declared assets test, and phased-in continuous eligibility for children through age 19, with six months continuous eligibility by February 2002, and 12 months continuous eligibility no later than June 2003 (this schedule makes it possible for the next Legislature to pre-empt the transition to 12 months coverage). 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. Previously described were Medicaid provider rate increases totaling over \$420 million GR, critical to maintaining an increasingly discontented provider base. Rate increases for SCHIP health plans are being negotiated, and are expected to fall between \$30 and \$60 million GR for the 2-year period. Over \$70 million GR was provided to increase community care placements. Coverage for young adults aging out of foster care was approved, with projected GR costs of less than \$1 million.

Funding for several Medicaid initiatives adopted by the 2001 legislature is referenced in the Appropriations Act for 2002-2003 in a distinct listing of contingency priorities which are only to be implemented and funded if the Comptroller later certifies higher revenues than were projected at the time the Act was adopted (May 2001). This approach to contingency funding has not been used in previous budget bills. Among the affected expansions are Medicaid coverage for treatment of breast or cervical cancer (requiring \$1 million GR), a limited preventive dental benefit for nursing home residents (\$5 million GR), and legislation creating a modest prescription drug assistance

program.²⁰ The latter program would provide up to three prescriptions per “Qualified Medicare Beneficiary” per month, at a cost of \$35 million GR for 2002-2003. This program will also be expanded if Congress should authorize “immediate helping hand” funds for low-income Medicare prescription assistance. At this time, while drafting of rules and Amendments is underway for some of these initiatives, state agency staff have been told that that implementation will proceed no further unless and until additional funds are identified. At this time, the small amount (about \$10 million) in available revenues above appropriations will be allocated to other needs which were granted higher priority in the Appropriations Act.

A number of other proposed service expansions or pilots were included in a large omnibus bill which was passed, but vetoed by the Governor.²¹ Included in the bill was a provision to exercise Texas’ option to provide Medicaid benefits to legal immigrants who entered the U.S. on or after PRWORA enactment, after completion of a 5-year bar on federal funding. A waiver for the provision of preventive health screening and family planning to low-income uninsured women was also in the vetoed bill. These first two proposals are under consideration for implementation despite the veto.

The fate of the following vetoed items is even less certain. A demonstration project for low-income uninsured adults would have created projects to serve low-income uninsured adults (i.e., below 200% of the poverty income), using local government funds to pay the state's share of Medicaid. Another demonstration project for psychiatric medications and related services would have created a limited-enrollment program to provide medications to low-income Texans with major psychiatric diagnoses who do not now qualify for Medicaid and lack coverage for those medications. A limited-enrollment program in 2 counties would have provided a targeted array of services to low-income persons with HIV who do not now qualify for Medicaid and lack adequate private insurance coverage. The counties selected would provide the state's share of Medicaid matching funds for the project. A pilot program in one county would have provided case management services to homeless persons who are eligible for Medicaid and have chronic illnesses.

Actions in 2001, and prospect that supplemental appropriations may again be necessary

Several aspects of Texas Medicaid appropriations demonstrate that a significant shortfall can be expected in the 2003 fiscal year. As previously noted, SCHIP appropriations were below requested levels, and premium increases above those projected for appropriations were agreed to in October 2001, to avoid losing health plan coverage in some regions of the state. These factors combined with robust enrollment growth make funding pressures on SCHIP seem inevitable, though it is too early to have a clear sense of how re-enrollment rates will affect the caseload. The program has formally proposed increased co-payments, and has begun trimming back aggressive follow-up procedures with parents as a means of slowing enrollment growth by dampening re-enrollment rates. Imposition of open and closed enrollment periods for SCHIP is under consideration for the future, but no final decision has been made. Implementation of simplified child Medicaid eligibility procedures is expected to result in a strong upward enrollment trend, despite measures included in law to moderate that impact. Also, provider participation in Medicaid is showing some signs of erosion, and it is not clear yet whether the fee increases authorized will be sufficient to prevent further deterioration.

The final budget was reduced by \$161.3 million state general revenue (GR) for Medicaid premiums (\$107.7 million GR) and nursing home payments (\$53.6 million GR) “deferred” to 2003-2004, just as was done by the last Legislature. The decision to again defer the last month of payments into the next (i.e., 2004-2005) biennium unless additional revenues become available was made because,

despite scarce revenues, legislators wanted to authorize important policy priorities (e.g., Medicaid simplification, provider rate increases, and public school health insurance). The budget sent by the House and Senate to the Governor included language which listed these deferred expenses among items to be funded should the Comptroller identify adequate revenues. However, the Governor vetoed this language.

While the nursing home and premium payments can be deferred to 2004-2005, other costs cannot. The Appropriations Act directs HHSC to achieve savings of \$205 million GR (about 1.9% of total projected state Medicaid spending). These savings would occur through a variety of approaches including (but not limited to) the following cost-saving proposals: statewide implementation of primary care case management (PCCM), 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 certain escrowed Medicaid funds, 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.

In response to the reduction mandate, the state announced a plan to extend PCCM statewide by April of 2002, and was discussing mandating certain SSI recipients into PCCM (requiring a federal waiver) by summer of 2002. This would nearly double the number of Medicaid enrollees in managed care statewide. However, strong negative response from hospitals and physicians in parts of the state not currently involved in Medicaid Managed Care has resulted in an indefinite postponement of these plans. The HHSC also recently proposed reducing inpatient hospital payments across the board by \$48.5 million GR during the 2002-2003 biennium, through formula reductions and the elimination of annual prospective payment inflation adjustments. Action on this proposal has been postponed to give hospitals time to propose an alternative approach to achieving the savings. There are strong indications that the state will pursue additional prescription drugs savings initiatives, but no specific changes have been announced. It is not yet clear what savings may be projected or achieved from these policy changes, nor what additional policy changes may have to be pursued to reach the savings target.

Damage to the Houston area by tropical storm Allison in June 2001 made it necessary for the state to provide matching funds for federal FEMA family assistance grants. In SFY 2001, Texas provided \$46.8 million in FEMA match, all of which came from lapsing appropriations at the Department of Human Services. Since the claims process is still underway, the ultimate state share is not yet clear, but is projected to reach as much as \$66 million. This match is being transferred from other health and human service agency allocations, which may include Medicaid, in the near term. While this does not represent a Medicaid expenditure, it will add to the total size of supplemental appropriations likely to be needed to complete SFY 2003.

V. Medicaid and federalism

Overall expectations for the future

In addition to tax cuts taken in 1999 and 1997 (described earlier), the Legislature in 2001 reinstated a policy of replacing with state public education funds any local revenue lost due to public school district corporate abatements. This is expected to increase state public education spending by 2004.

State appropriations for all health-related expenses are expected to climb significantly in the near term. Appropriations for state employee and retiree health benefits in 2003 are 57% above the 2000 level, despite declining numbers of active employees and dependents and a proportional shift toward retiree coverage which is much less costly than full coverage (due to the contribution of Medicare). This is a steeper increase than is projected for any area of state Medicaid spending (except for the injection of funds for the Medical Transportation program in response to the EPSDT lawsuit). The legislature made a major new commitment to help fund health insurance for public school employees across the state, which is expected to require \$1.86 billion GR in 2002-2003, and to climb to \$2.9 billion in the next biennium.²² The state's comptroller (an elected official) has noted that projected growth in public school health insurance and Medicaid costs, if coupled with low or zero growth in state revenues above 2002-2003 levels and no cash balances remaining at the end of SFY 2003 (\$2.9 billion in cash balance was available on September 1, 2001 for use in certifying the 2002-2003 budget), could leave the legislature facing a \$5 billion revenue shortfall for funding state government in 2004-2005. However, this scenario depends on a very gloomy zero-growth revenue forecast. The Comptroller herself currently projects a 3% growth in state revenues, down from an actual growth of 10% during 2000-2001. With so much uncertainty about the impact of the current economic downturn on state revenues, the only safe prediction is that a revenue shortfall is a real possibility.

The Texas legislature today is much better informed about Medicaid than in the budget crunch years of the early 1990s. Many influential officials now understand that rapid health care inflation is a problem for all health programs, and is not uniquely associated with Medicaid. The meagerness of Medicaid provider payments is also widely understood, which helps to discredit the notion that easy cost-cutting solutions exist. A special Joint Interim Committee on Health Services has been appointed to monitor and analyze Medicaid and SCHIP costs throughout until the 2003 legislative session. Another joint committee will monitor long-term care. The House Appropriations and Insurance Committees are jointly charged with assessing the "reasonableness" of health insurance costs from Medicaid to state employee health benefits. Still, Medicaid is likely to once again be viewed as Texas' biggest budget problem, and pressure to find ways to cut costs will continue to be strong.

Need for future tax increases or other revenue enhancements

As noted before, Texas has been identified as having a structural deficit. Texas' state and local tax revenue has not kept up with personal income growth. In the early 1990s, after the tax-rate increases forced by difficult economic conditions, state and local tax revenue equaled a fairly constant 9.6 percent of personal income. But since 1994, tax revenue has fallen steadily as a percentage of personal income. By 2003, state and local taxes are projected to equal only 8.35 percent of personal income — only 7/8 of the relative income of 10 years earlier. If state tax revenue had remained at the same percentage of personal income as in 1994, state budget-writers would have had an additional \$9.8 billion available to appropriate in the 2002-03 budget. Another \$11.2 billion would have been available in 1995-2001.

In response to the seemingly inevitable revenue shortfall facing the state, two interim studies have been mandated for the interim period before the 2003 legislative session. A joint select committee of House and Senate members will study the public school finance system in Texas. The Senate Finance committee will also survey and assess Texas' current tax system, including taxation authority given to units of local government, and the economic value associated with all current taxes, as well as current exemptions and abatements. The House Ways and Means committee will review a variety of tax issues including property appraisal practices, local dedicated sales taxes,

internet sales taxation, and the impact of franchise tax credits passed in 1999. Serious as the problem is, most political observers think it unlikely that the state will succeed in passing major tax reform legislation in 2003.

Impact of federal actions -- tax cut, possible Medicare expansion, coverage of the uninsured

Since Texas has no personal income tax, the primary impact of recent federal tax cut provisions will be to reduce estate tax receipts. The state comptroller estimates the lost revenue for the 2002-2003 biennium at about \$81 million, \$250 million for 2004-2005, reaching estimated annual losses of about \$300 million when fully phased in.

Given the steady growth of Medicaid and SCHIP caseloads, higher medical inflation, reduced state revenues and a structural revenue deficit, pressures to reduce or control spending in these and other health care programs is sure to continue. These pressures, along with a strong conservative legislative contingent, may create an atmosphere favorable to the consideration of policy initiatives that reduce benefits for some populations, or that introduce or increase cost-sharing. The recent Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative waiver processes announced by the Centers for Medicaid and Medicare Services (CMS: formerly HCFA) potentially create the possibility for changes in this direction, and may even allow for enrollment caps.

However, other pressures will also be at work. As this paper reflects, local governments in Texas bear the biggest share of the burden of providing care for the uninsured. A number of major urban areas are eager to explore federal waivers to provide public insurance to broader groups of low-income uninsured, possibly using local tax revenues to fund the state share of a Medicaid or SCHIP expansion. One concern of national health policy experts raised by HIFA is that states may curtail benefits or increase cost-sharing without reinvesting savings in health care access. In Texas, the demand from local governments to take steps to reduce local tax burdens by qualifying more currently-uninsured Texans for federal matching funds will create pressure for re-investment in expanded coverage. Additionally, public hospitals will resist efforts to reduce benefits in any way that is likely to simply shift costs to local taxpayers. Still, the budget-neutrality requirement of HIFA — essentially, that no additional federal resources will be available to address the problem of the uninsured — clearly means the initiative cannot hope to make a more than a marginal contribution to reducing Texas' staggering health care access challenge.

Notes:

- ¹ Bureau of Economic Analysis.
- ² The exception is Travis county, where the state capital Austin is located.
- ³ Texas' fiscal year begins September 1, ends August 31.
- ⁴ House Research Organization, Texas Budget Highlights: Fiscal 2002-2003, September 2001, p. 7.
- ⁵ Texas Health and Human Services Commission, Quarterly Caseload forecasting reports.
- ⁶ Federal fiscal year, from TDHS 8/15/01 update to Title XIX Expenditure History List, (report based on historical data from HCFA/CMS-37 requests and state agency projections for future requests).
- ⁷ Also known as 1929(b) eligibility, in reference to the Social Security Act.
- ⁸ U.S. Census, Health Insurance Coverage, 1999, September 2000; Employee Benefits Research Institute, Sources of Health Insurance and Characteristics of the Uninsured, December 2000.
- ⁹ HB 820, 76th Texas Legislature, mandated new outreach and informing of Medicaid clients. Outreach was also extended to families that had left AFDC and TANF since 1995.
- ¹⁰ Texas Health and Human Services Commission; www.hhsc.state.tx.us.
- ¹¹ Texas Health and Human Services Commission, Medicaid and CHIP enrollment data.
- ¹² SB 43, 77th Texas Legislature.
- ¹³ Two recent reports describe the legal framework for Texas' health care safety net, and an examination of safety nets and their shortcomings in smaller Texas communities. Providing Health Care to the Uninsured in Texas: A Guide for County Officials, and Random Access: Holes in the Texas Health Care Safety Net, both available at www.accessproject.org.
- ¹⁴ Unpublished estimates, Jeffrey S. Passel, Immigration Studies Program, Population Studies Center, Urban Institute, Washington, D.C.
- ¹⁵ THHSC, Texas Medicaid in Perspective, third edition, pp. 65-66.
- ¹⁶ Texas' state fiscal year begins September 1.
- ¹⁷ See Texas Medicaid Managed Care Report, November 2000, www.hhsc.state.tx.us.
- ¹⁸ Fiscal Note, HB 1333, enrolled version; www.capitol.state.tx.us.
- ¹⁹ House Appropriations Committee staff communication with CPPP.
- ²⁰ SB 532, SB 34, HB 1094, 77th Texas Legislature.
- ²¹ SB 1156, 77th Texas Legislature.
- ²² HB 3343, 77th Texas Legislature.