

## Repeal Bill Threatens Texas Medicaid

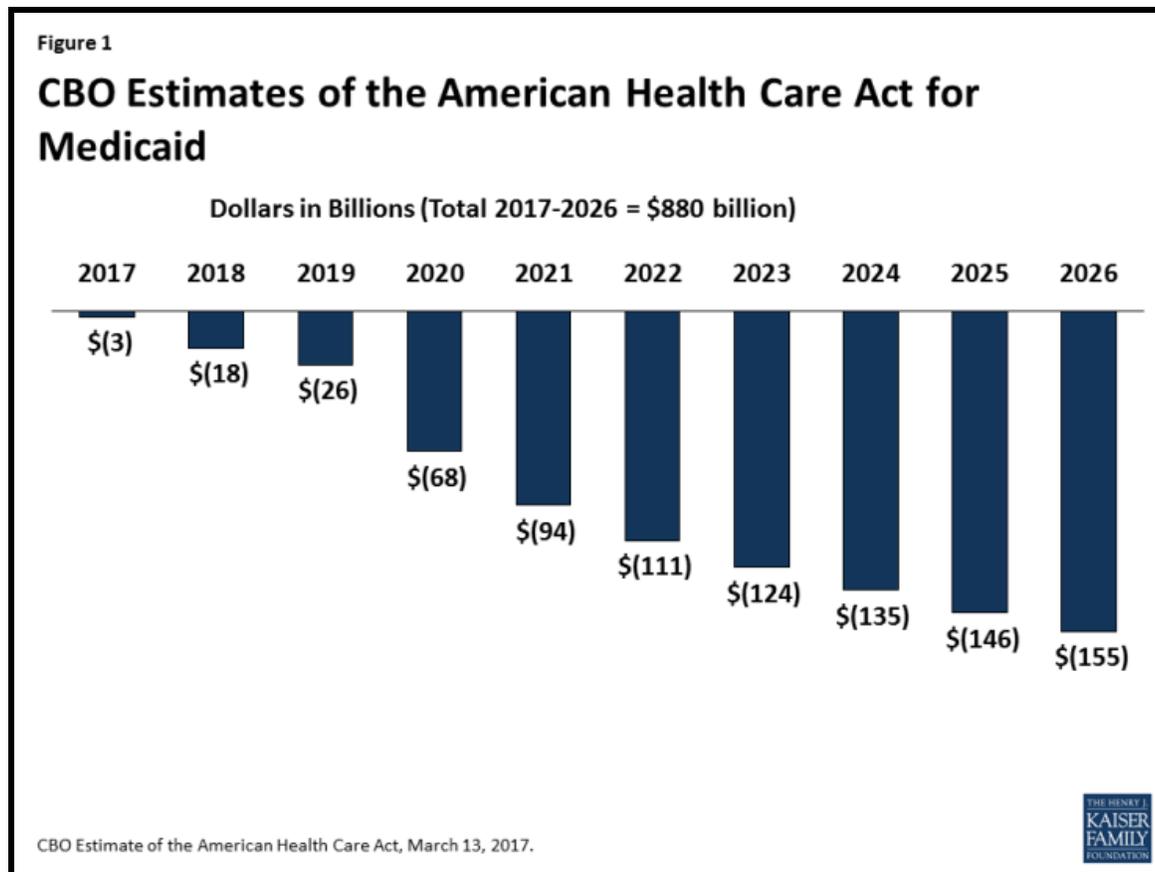
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### Repeal Bill Threatens Texas Medicaid

*NOTE: An UPDATE on the latest changes to the House Repeal bill (as of 3/21/2017) is provided at the END of this brief. The changes overall make the bill worse for consumers, and the Medicaid changes are particularly bad.*

The non-partisan Congressional Budget Office has released its detailed “score” for the U.S. House Republican proposal to repeal the ACA and radically reduce federal support to states for Medicaid (the repeal bill), and estimates that if passed, the number of U.S. uninsured will immediately jump up by 14 million in 2018, growing to 24 more uninsured in 2026 than would have been covered under the Affordable Care Act. Of the 26 million, about 14 million fewer will be covered by Medicaid than under the ACA.

The House Republicans’ repeal bill cuts federal Medicaid funds to states by \$880 billion over the decade, accounting for more than half of the bill’s “savings” (most of the remainder results from cutting the ACA’s health insurance tax credit subsidies).



Expert estimates of state-by-state impact will become available in the near future. While we wait for that helpful information, this brief reviews key cuts and changes to Medicaid proposed in the AHCA bill itself, adding a Texas perspective where possible.

- **Planned Parenthood One-Year Freeze-Out:** For one year from passage of the bill, Planned Parenthood could no longer provide services (like birth control, well-woman check-ups, cancer and STD screening) in Medicaid. The House repeal bill would also cut off Planned Parenthood funding from CHIP, the Maternal and Child Health block grant (Title V), and the Social Services block grant (Title XX). For that year, CBO estimates direct payments to Planned Parenthood drop by \$178 million, partially offset by \$21 million increased Medicaid spending for additional births.
- **Medicaid expansion roll-back begins in 31 expansion states.** The bill would phase out through attrition the high federal match rate for the newly-covered adults. Any adult covered under the ACA Medicaid expansion as of 12/31/2019, who has a gap in coverage of more than one month after 1/1/2020, will drop back down to the traditional Medicaid match rate (e.g., 56% for Texas in 2017) from the much higher 90% rate that would have been in effect under the ACA.
- **Requires the 31 Medicaid expansion states to re-determine eligibility for Medicaid every six months.** The ACA currently prohibits states from requiring renewal more often than once a year.

By requiring renewal twice a year starting October 2017, the bill would speed up the rate with which Medicaid expansion adults will experience gaps in coverage of more than one month, which beginning January 2020 will cause the federal funding match rate for that individual to drop from 90% to the state's regular match rate (e.g., 56% in Texas 2017). States would get a 26-month window with enhanced federal support (5 percentage points) for the system changes required.

Going from 12 to 6 months can be a surprisingly powerful tool for driving down enrollment. When the Texas legislature cut CHIP eligibility from 12 to 6 months in 2003, CHIP enrollment dropped by 40%, with 200,000 fewer children covered after 18 months. CBO estimates that fewer than 5 percent of Medicaid expansion enrollees would qualify for the higher federal matching rate by the end of 2024.

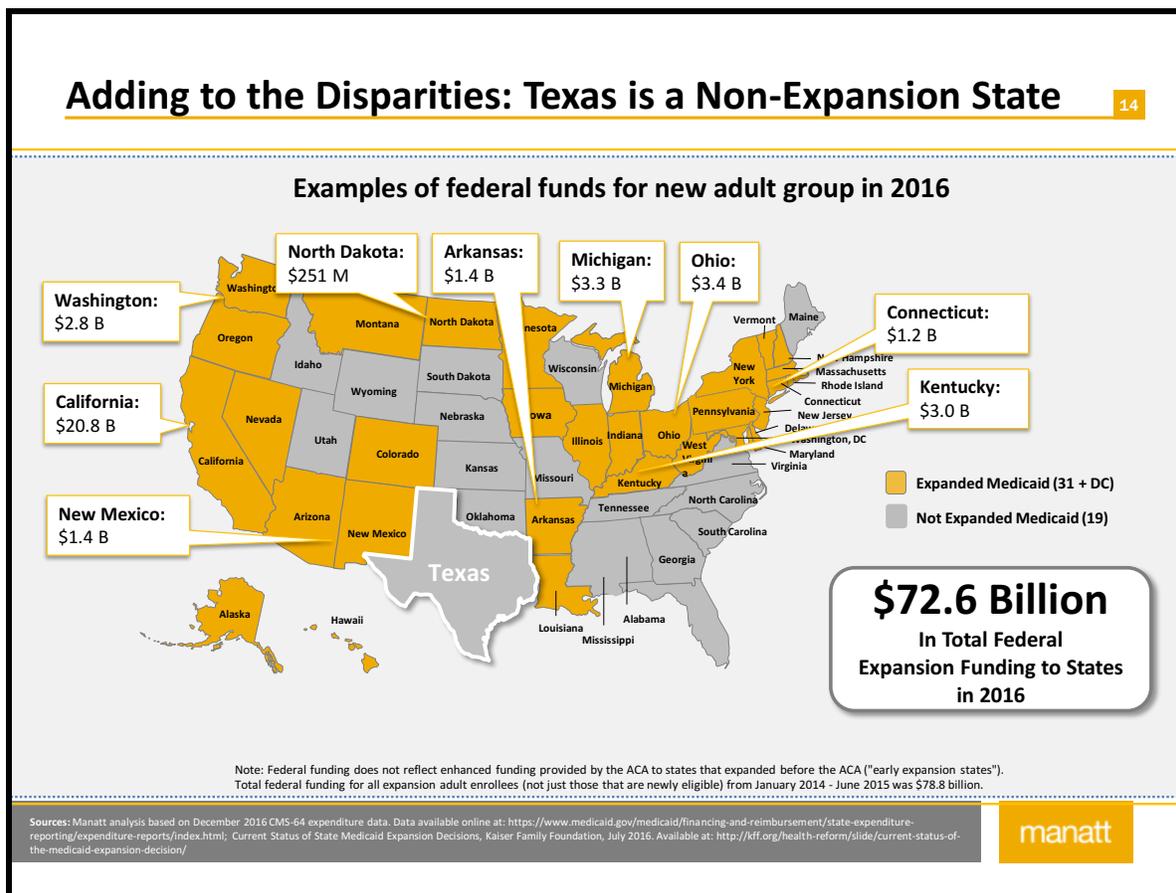
- **States (like Texas) among the 19 non-expansion states could still expand coverage for adults in 2017-2019, and:**
  - Would be subject to the same phase-out of the enhanced federal match for enrollees who sign up before 2020;
  - New enrollees 1/1/2020 and later would be matched only at the traditional Medicaid match rate; and
  - Under the complex new per-capita cap formula, the average costs of newly-eligible adults would be assumed to be the same as for the adults covered in the state in 2016 (in Texas, that group includes a small number of very poor parents, pregnant women, and young adults who phased out of the foster care system.)
  - Unless Texas takes action to create coverage for the working poor by 2019, the repeal bill would leave us with no way to cover poor and near-poor adults. Medicaid could not be expanded in 2020 or later, and large cut in subsidies for market-based coverage would make it impossible for low-income families and workers to purchase coverage. Even at the lower match rate, Medicaid expansion states would have a tremendous fiscal advantage.
- **Ends Hospital-based Presumptive Eligibility,** established under the ACA, which allowed hospitals to be paid for care provided to patients while their application was still in process. Texas Medicaid officials imposed such strict limits on this option that it was used very little.

- **Cancels the ACA’s scheduled Disproportionate Care Hospital (DSH) payment reductions for non-expansion states.** ACA’s scheduled cuts to Medicaid payments to hospitals serving a Disproportionate Share of Medicaid and uninsured patients had not begun. Along with the much-larger Texas Medicaid 1115 waiver, DSH helps make up for inadequate Medicaid hospital payment rates, using almost 100% local taxpayer matching funds rather than state-budget dollars. The House repeal bill would cancel the cut for the states without Medicaid expansion; any state that expands between now and 2020 would become subject to the cuts again.
- **Drops the “floor” for covering children in Medicaid to 100% FPL** from 133% under the ACA. States that wanted to shrink Medicaid coverage for children could do that.
- **Ends the higher federal match rate for Personal Attendant Services under the ACA’s Community First Choice option.** Texas has enjoyed a 6-percentage point increase in federal matching funds for these services provided both in STAR+Plus and through waivers. HHSC reports savings of \$35 million in 2016 from the enhanced federal match rate for Community First Choice.
- **Ends retroactive eligibility (sometimes called “three months prior”) for new Medicaid enrollees.** Under this long-standing Medicaid policy (i.e., decades before the ACA), a new Medicaid enrollee who had unpaid medical bills could have those covered for up to three months prior to the date on which her/his application was filed. This is enormously beneficial not only to Medicaid recipients who would otherwise owe large debts to hospitals and other health care providers, but also to the care providers themselves. The House repeal bill would limit coverage to care delivered in the month in which the application was filed. **Retroactive coverage also provides a level of protection for both Medicaid beneficiaries and care providers when state Medicaid eligibility systems are underfunded, create onerous red tape barriers, or fail outright.** Even when a state falls weeks or months behind in processing applications and renewals, patients’ bills are eventually paid. Texas Medicaid’s eligibility system is performing well today, but it has experienced all of the aforementioned problems in the last 25 years.
- **Ends “Reasonable Opportunity” period for Medicaid applicants to establish U.S. citizenship or eligible immigration status.** States are currently required to provide applicants with time to provide documentation of citizenship or immigration status, beginning Medicaid benefits based on their self-attestation during that period. The House repeal bill would prohibit Medicaid coverage from starting until proof has been provided. (Exceptions are provided for applicants whose status has already been established in another federal program including SSI, SSDI, federally funded adoption assistance or foster care, and most U.S. newborns.)
- **Lowers the cap on the value of home equity that can be excluded when calculating eligibility for Medicaid long term services and supports, whether in community or a nursing facility.** The House repeal bill would start this policy six months after the bill became law.
- **“Safety Net Fund for Non-Expansion States” would net Texas far less federal support than Medicaid Expansion; and is also too small to allow for correction of currently inadequate provider rates.** The repeal bill would establish a fund that would distribute at total of \$2 billion each year, divided across all the non-expansion states (currently numbering 19). In contrast, projections of net federal funding (i.e., net gain after any state matching funds are subtracted) for Texas under Medicaid expansion have ranged from \$6 to \$10 billion a year.<sup>1</sup> The proposed fund clearly would not offset the federal Medicaid expansion funding Texas has left on the table.

The bill states that this small fund can be used to adjust payment rates for safety net providers (not to exceed actual costs). As explained further below, the formula for the repeal bill’s proposed reduction in

federal Medicaid support to states would lock in per capita costs of Texas Medicaid beneficiaries based on 2016 spending. Texas Medicaid provider rates for 2016 included a number of problematic features, like therapy rate cuts for high-needs children; inadequate wages for personal attendants who care for our seniors and disabled persons; and physician and other professional fees that have not had regular updates since 1993. They become even more problematic when frozen into a zero-sum formula that presumes the 2016 funding level was adequate.

Texas Medicaid pays hospitals, physicians and professionals over \$14 billion a year in direct fees; the scope of adjustments needed in our state could not be supported by this modest fund.



**Per Capita Allotment Restructuring of Medicaid: Locks in 2016 Texas Medicaid policies and spending; makes future improvements difficult; leaves state exposed to costs above new cap.**

Many critiques of the risks to states in accepting capped federal Medicaid funding have noted these high-level problems for states, but a walk through the proposed formula for funding helps explain the specific reasons that the capping will be problematic for Texas, as well as areas in which the filed Repeal bill is unclear or ambiguous.

- **Use of the per capita formula for federal share of Medicaid funding would launch in 2020.**
- **The formula would calculate an average, per-enrollee cost in 2016 Texas Medicaid for each of four groups: (1) children; (2) elderly; (3) disabled (includes children eligible on basis of disability); (4) non-expansion adults (pregnant women, small number of parents in Texas, former foster care youth).** If Texas chooses to create coverage for adults up to 133% under the Medicaid expansion option in 2018 or 2019, a fifth group

could be created, and lacking 2016 experience data would be assumed to have the same per-capita average cost as group (4) non-expansion adults.

- **A list of certain 2016 state Medicaid spending types is NOT included in the calculations of per capita cost by group:**
  - Vaccines for children;
  - Children’s Health Insurance Program enrollees (CHIP);
  - Medicaid for breast and cervical cancer treatment;
  - Medicare cost-sharing enrollees (Medicaid pays Medicare out-of-pocket costs to varying degrees based on very low incomes);
  - Indian Health Services;
  - Medicaid Family Planning waivers;
  - Emergency Medicaid services to lawfully present and undocumented immigrants;
  - Disproportionate Share Hospital (DSH) reimbursements;
  - Medicaid administration costs. (The filed bill does not list administrative spending as exempt, but the committee’s official summary does. Clarification is expected. In 2016, Texas received about \$1 billion in federal Medicaid administration funding.

**(These excluded Medicaid costs are NOT being eliminated from federal support; they appear to continue without being subject to a cap.)**

- **The big ambiguity: treatment of Medicaid 1115 supplemental payments for Uncompensated Care and Delivery System Reform Incentive Payments (UC and DSRIP).** A number of national experts have described as ambiguous the language about how supplemental payments like Texas’ Medicaid 1115 Transformation waiver will be treated in this formula. In 2016, Texas’ federal funding from the waiver topped \$3.5 billion (and leveraged another \$2.7 billion in local tax revenues). The Repeal bill language related to “non-DSH supplemental payments” including 1115 waiver DSRIP and UC pools includes contradictory statements which appear at one point to exclude that spending from the formula for the spending base, and in another place to define terms for their inclusion in the 2019 funding base. Experts indicate that the problem is under discussion in Congress, and may be corrected soon in the process. The ideal outcome for Texas on this specific point (if the bill were passed into law) is of course to ensure that the funds continue to be available, as they account for such a large share of total Texas Medicaid hospital reimbursement. If no part of the waiver funds could ever be built into the Medicaid program, e.g., via increasing hospital rates to Medicare levels, or by building successful DSRIP policies into Medicaid benefits and delivery models, Texas would be locked into awkward policies and funding that were never intended to be permanent.
- **2016 costs for each group would be totaled, and then divided by the number of full-year equivalent enrollees in that specific group in Texas in 2016.**
- **Each group’s 2016 per-capita cost would be trended forward to 2019 using the medical component of the Consumer Price Index (M-CPI).** As the [Kaiser Family Foundation’s analysis of the CBO score](#) notes, Medicaid per-enrollee growth constrained to CPI-M (3.7% over the 2017-2026 period) would be lower than the U.S. average annual rate of 4.4 percent projected under current law.

- **An aggregate total Texas target Medicaid expenditure would be calculated for year 2020**, using the 2019 per-enrollee average cost for each group, inflated by M-CPI plus 1 percentage point (this is the only year for which the additional percentage point is added to M-CPI). Those 2020 amounts will be multiplied by the actual 2020 enrollment in each of the four (or five) groups to arrive at Texas' 2020 Target Medicaid expenditure.
- **If Texas' 2020 spending on enrollees (excluding the above-listed categories) exceeded that target amount, federal Medicaid allocations to Texas in 2021 would be reduced to recoup the overage.**

## **Top Concerns for Texas Medicaid under Per Capita Cap/Allotment**

CPPP has reviewed the [substantial list of risk and issues](#) for Texas if Medicaid is converted from the current federal partnership to a per-capita cap on federal matching funds (see pp. 7-8). To recap the top concerns:

- (1) If Texas makes errors in predicting Medicaid spending in an upcoming year and our federal funds are inadequate, our Legislature's history indicates they will cut benefits, payment, or enrollment in response, to pay for the federal recoupment of funds.**
- (2) Rigid use of a retrospective base year will lock Texas and other states into permanent inadequate provider networks.**
- (3) If the make-up of enrollees in one of the four (or five) enrollment groups changes over time to have more intensive needs—e.g., among elders or Texans with disabilities—we will be unable to meet their needs, and it will take an act of Congress to correct the problem.**
- (4) Limits to 2016 benefits also make our Medicaid funding allocation too low to allow us to adopt best treatment practices and standards of care without first cutting elsewhere.**
  - Capping spending for broad categories of Medicaid enrollees based on 2016 spending locks Texas into a long list of Legislative policy choices that were made when there was no threat whatsoever that they would be made permanent.
  - **Many Texas Medicaid providers are paid rates that have gone without regular inflation updates for decades, and as a result some are paid well below their costs.** Unfortunately, the top examples are medical and mental health professionals, and personal attendants who care for our seniors and disabled persons. Access to these providers is critical to providing the most basic health care that can prevent hospitalizations, incarcerations, disability, and developmental delays.

In contrast, systems have evolved that allow other players in Texas Medicaid to gain large profits; for example, Texas Medicaid Managed Care plans net large profits after paying Texas "experience rebates." This did not result from a thoughtful planning or deliberate choices, but the repeal bill formula would nevertheless create a situation in which we can only correct inadequate rates for one provider type by cutting rates for another provider (or cutting benefits for enrollees).

- **Locking in 2016 spending also locks in inadequate health benefits.** For example, 2016 spending "bakes in" the widely-criticized 2015 cuts to pediatric therapy rates that have caused multiple Early Childhood Intervention providers to shut their doors. Other examples: 2016 Texas Medicaid spending will not reflect costs of life-saving Hepatitis C cure medication; dental care for adults in Texas Medicaid (especially short-sighted for pregnant women); or the current U.S. standard of treatment for many children on the autism spectrum.

## Update: Manager's Amendment added Monday night (3/20/2017) by US House Committees on Energy & Commerce and Ways & Means

The changes reported are mostly negative for consumers.

<https://rules.house.gov/sites/republicans.rules.house.gov/files/115/PDF/115-AHCA-SxS-MNGR-Policy.pdf>

The major changes to the bill are:

- **States could add work requirements to Medicaid.** Amendment to Social Security Act would give States the option to add a work requirement in Medicaid for “nondisabled, nonelderly, non-pregnant adults” as a condition of receiving coverage under Medicaid. Based on H.R. 1381 by Griffith, uses TANF “countable activities” and exemptions in current law. States could begin using this new option on October 1, 2017. States would get a 5% administrative FMAP bump if they implement a work requirement.
- **States that pursue new Medicaid expansion will not get enhanced match at all.** (Original bill treated all states the same regardless of when they expanded.)
- **State option to take their Medicaid funding as a lump-sum block grant rather than a per-capita capped allocation.** Provides specifics of the Block Grant structure, to be outlined in a separate blog post.
- **New York County Spending Excluded.** Would exclude from the Per Capita Cap formula Medicaid spending by New York county governments other than New York City. Written in a way that appears to NOT affect Texas Medicaid county government contributions—though questions about Texas 1115 waiver described above are still unanswered.)
- **Increases Medicaid Per Capita Cap inflation factor for the elderly and disabled:** Increases the annual inflation factor for the elderly and disabled from CPI-U Medical to CPI-U Medical +1.

Non-Medicaid provisions:

- A change in the tax deductibility of medical expenses that the Senate could harness to boost tax credits for older Americans, to the tune of an estimated \$85 billion. This change still leaves the bill's net cut to ACA tax credit value at 34% (down from 44% in first draft) and [does not address the lack of geographic or income adjustments](#) at all.
- Moves the repeal of Obamacare's tax increases by one year (earlier).
- Restricts rolling unused tax credit money into health savings accounts (apparently to ease concerns of anti-abortion groups)

To [quote Vox's Ezra Klein](#): “None of these provisions meaningfully change the underlying legislation, nor any of its flaws. These are mostly tweaks meant to win over hardcore conservatives and Congress members from New York.”

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For more information or to request an interview, please contact Oliver Bernstein at [bernstein@cphp.org](mailto:bernstein@cphp.org) or 512.823.2875.

### About CPHP

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<sup>i</sup> <http://www.urban.org/sites/default/files/publication/49881/2009209-Medicaid-Expansion-Health-Coverage-and-Spending.pdf>; [http://tools.forabettertexas.org/healthwealth/images/Statewide\\_Coverage\\_Gap.pdf](http://tools.forabettertexas.org/healthwealth/images/Statewide_Coverage_Gap.pdf) and [http://tools.forabettertexas.org/healthwealth/data\\_source.php](http://tools.forabettertexas.org/healthwealth/data_source.php)