

JOINT REPORT OF COUNCIL ON SOCIOECONOMICS AND SELECT COMMITTEE ON
MEDICAID, CHIP, AND THE UNINSURED

CSE and SC-MCU Report 6-A-17

Subject: Federal Medicaid Reform and Implications for Texas

Presented by: John Carlo, MD, Chair, Council on Socioeconomics
Ryan Van Ramshorst, MD, Chair, Select Committee on Medicaid, CHIP, and the
Uninsured

Referred to: Reference Committee on Socioeconomics

1 **Background**

2 On March 6, 2017, House Speaker Paul Ryan introduced the American Health Care Act to repeal and
3 replace the Affordable Care Act. By March 24, the bill was dead, pulled down without a House vote due
4 to insufficient support. Despite its quick death, efforts to revive the legislation continue, with
5 congressional leaders vowing to reconsider AHCA — or its successor — in May. Though the legislation
6 will undergo some revision to accommodate dissenters' concerns, it undoubtedly will have significant
7 implications for Texas' health care delivery system, particularly its safety net. Provisions in the bill would
8 not only terminate enhanced Medicaid funding for states to use to expand health insurance coverage to
9 low-income patients but also upend the programs' entire financing and benefit structures, ending a 50-
10 year commitment of guaranteed funding and minimum benefits for poor and low-income patients. (The
11 AHCA also would have substantial implications for the commercial health insurance market, but this
12 report focuses only on the Medicaid provisions).

13
14 While the AHCA contains numerous Medicaid provisions, of particular concern are two:

- 15
16 1) *Eliminating the 90 percent federal matching rate for Medicaid expansion.* As a result of the
17 Affordable Care Act, states have the option to expand Medicaid coverage for parents and
18 childless adults up to 138 percent of federal poverty using either the state's current Medicaid
19 delivery system or a state-designed model that enrolls patients in private health insurance or
20 mimics key elements of the private sector. To date, 31 states have done so, including more than a
21 half-dozen Republican led ones. Texas has not. The AHCA forecloses the option.
22
23 2) *Eliminating Medicaid's guaranteed, open-ended financing mechanism,* replacing it with one of
24 two capped federal funding options — a per-capita cap or block grant — in exchange for granting
25 states greater flexibility to determine Medicaid benefits, services, and payments. However,
26 through Medicaid waivers, states already have considerable latitude to reshape Medicaid. This
27 provision is inarguably the most alarming since it would mean Texas receiving less money for
28 doing what it already does.
29

30 Texas physicians strongly support prudent reforms to simplify Medicaid administrative requirements for
31 physicians, patients, and the state as well as ongoing, thoughtful efforts to curtail costs. Like all payers,
32 Medicaid costs are rising, and limited state tax dollars must be diligently managed. But Medicaid costs
33 are driven primarily by caseload growth, not per-person expenditures. Texas is the fastest growing state in
34 the country. Enactment of capped funding would tie the state's hands, not only preventing it from

1 enacting broader coverage but also limiting its ability to address current health care disparities and
2 inequities, including inadequate Medicaid physician payments.

3
4 **Medicaid Basics: Current Texas Medicaid Financing, Eligibility and Coverage**

5
6 ➤ Financing

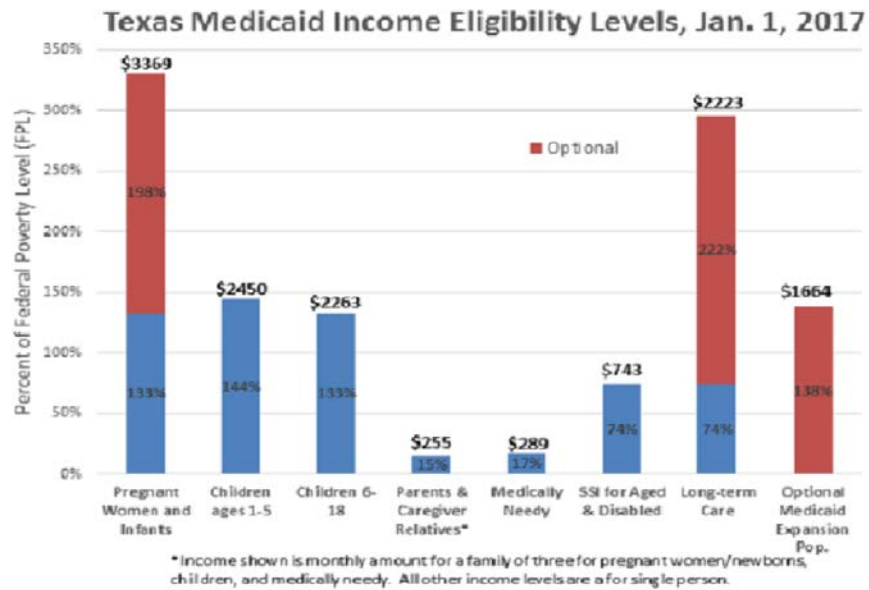
7 Under current federal law, Medicaid is financed jointly by the states and the federal government.
8 Minimally, states receive a 50/50 match. The U.S. Department of Health and Human Services sets
9 matching rates annually based, in part, on a state's economic health relative to other states. For fiscal year
10 2018, Texas' federal matching rate will be 56.88 percent, meaning for every dollar spent by Texas
11 Medicaid nearly 57 percent of the costs will be paid by the federal government. In 2015, Texas received
12 \$21.4 billion in federal Medicaid matching funds for Texas' \$14.8 billion in state spending

13
14 Historically, Texas' matching rate has fluctuated between 58 percent and 60 percent, but if Medicaid
15 spending increases due to a recession, natural disaster, public health emergency, or new medical or
16 pharmaceutical innovations that intensify Medicaid spending, the federal government guarantees to match
17 it so long as the state complies with federal minimum eligibility and benefit standards. According to the
18 Kaiser Family Foundation, during the 2008-2011 recession, Texas' unemployed rate soared to 8.4
19 percent, resulting in 475,900 more people enrolling in Medicaid. Federal matching funds grew to
20 accommodate the new enrollees. Under a block grant formula, a state's federal Medicaid allotment would
21 not change, regardless of any pressures to serve more patients.

22
23 Texas receives supplemental Medicaid funding via hospital disproportionate share funds (DSH) and the
24 1115 Medicaid Transformation Waiver. Under the latter, local taxing authorities – mostly hospital
25 districts but also rural and border counties – provide the state's share of matching funds to draw down
26 additional federal funds. Under Texas' current Medicaid 1115 waiver, which began in 2011 and has been
27 extended at least through the end of this year, Texas receives more than \$3 billion per year in additional
28 federal dollars to offset hospital uncompensated care and to fund innovative projects at the community-
29 level to expand access to and quality of services for Medicaid and uninsured patients. While the waiver
30 has drawbacks, including inadequate community physician input and participation, without it many
31 safety-net providers would cease to operate or limit their services. Late last year, HHSC submitted a letter
32 to the Centers for Medicare and Medicaid Services requesting a 21-month waiver extension, which would
33 provide additional dollars through Sept. 30, 2019 if approved.

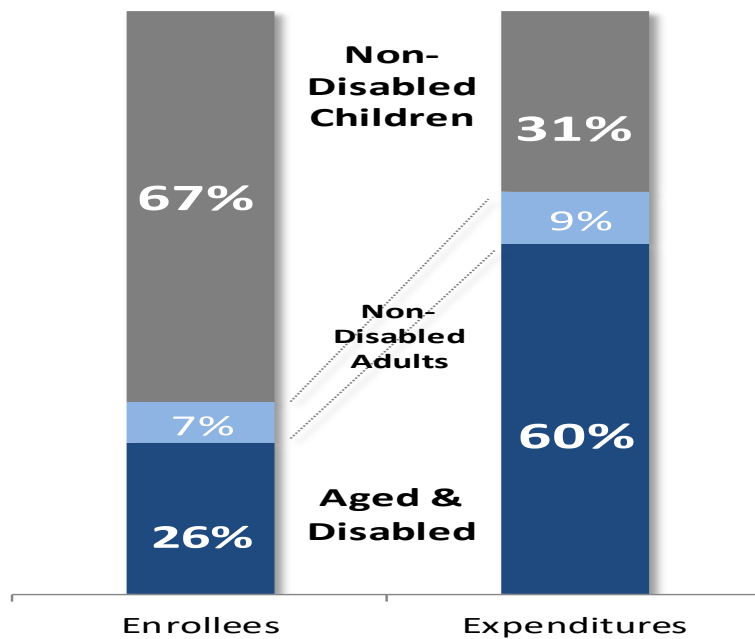
34
35 ➤ Eligibility

36 Federal law establishes mandatory Medicaid populations — children, pregnant women, poor parents,
37 patients with disabilities, and seniors — and the minimum eligibility levels for each. For each mandatory
38 population, states have the option to expand coverage above the federal minimum. Texas Medicaid
39 eligibility adheres strictly to the federal minimum standards for all populations except two: pregnant
40 women/newborns and patients needing long-term care services.



Source: Texas Health and Human Services Commission

More than 4 million Texans currently obtain health care coverage via Medicaid, 67 percent of whom are children. Indeed, Medicaid plays a vital role in children’s coverage. Some forty percent of all Texas children are insured via the program, including all children in foster care.



Source: Texas HHSC

Medicaid provides children benefits tailored to their particular needs. Through a provision in federal law known as the Early Periodic Diagnosis Screening and Treatment (EPSDT) Act, states must provide children all medically necessary services, including preventive, primary, and specialty physician services, behavioral health, hospital care, and dental and vision services. EPSDT also ensures children with special health care needs receive necessary ancillary services, such as durable medical equipment, physical,

1 speech, and occupational therapy, and community-based long-term care, making Medicaid the single
2 largest provider of services for children with disabilities.

3
4 Medicaid is the largest payer of maternity care. It pays for 52 percent of all Texas births, though that
5 number is substantially higher in rural, urban, and border communities. Additionally, the program serves
6 as a critical stakeholder in improving birth outcomes, pushing quality improvement measures to reduce
7 rates of prematurity and low-birth weight babies, as well as promoting early entry prenatal care.

8
9 According to the Medicaid and CHIP Payment Advisory Commission, Medicaid is the single largest
10 payer for behavioral health services in the U.S., covering everything from autism spectrum disorders to
11 severe and persistent mental illness to dementia. Among adults enrolled in Medicaid (excluding dually
12 eligible patients), almost half of those who enroll on the basis of a disability have a mental illness. For
13 children in foster care, these services are particularly important since children with a history of physical
14 or mental trauma often need more intensive behavioral health interventions.

15
16 For seniors, Medicaid is vitally important, covering not only long-term care services and supports but also
17 Medicare cost-sharing for those poor enough to qualify for both Medicaid and Medicare. Seventy percent
18 of nursing home care is paid by Medicaid. Medicaid also pays for less expensive community-based
19 services to help keep seniors and people with disabilities in their homes instead of institutions.

20
21 From a population health perspective, Medicaid plays a critical role, funding vaccines for children,
22 championing initiatives to promote better birth outcomes, and screening eligible patients for a wide range
23 of infectious diseases, including Zika and tuberculosis, that could harm the general public if left
24 undetected and untreated.

25
26 At the same time, contrary to popular opinion, being poor does not necessarily qualify a person for
27 Medicaid. Patients must meet Medicaid income and categorical coverage requirements. Very few low-
28 income parents actually qualify. For example, women qualify for Medicaid while pregnant and for two-
29 months postpartum, but after that time, they no longer qualify for coverage unless their income is at or
30 below 15 percent of poverty, the eligibility rate for Texas parents. Parents earning more than \$3,200
31 annually are not eligible. (Only Alabama has lower income level eligibility rate for parents — 13 percent
32 of poverty). In addition to income and categorical requirements, patients must be Texas residents and U.S.
33 citizens, though for emergency services, including labor and delivery, undocumented immigrants are
34 eligible so long as they meet all other Medicaid eligibility requirements.

35 **AHCA Medicaid Reform Provisions**

36 The AHCA contains two broad provisions designed to fundamentally restructure Medicaid:
37

38
39 *1) Eliminate the 90 percent federal matching funds for states to pursue Medicaid expansion.*

40 As a result of the Affordable Care Act, states have the option to expand Medicaid coverage for
41 parents and childless adults up to 138 percent of federal poverty (\$16,587 for a single adult) using
42 either a state's current Medicaid delivery system or a state-designed model that enrolls patients in
43 private health insurance or mimics key elements of the private sector. To date, 31 states have
44 expanded coverage, including a dozen Republican led ones. Texas has not. The AHCA forecloses
45 the option.

46
47 An estimated 1 million uninsured, working-age Texans would potentially gain coverage via
48 Medicaid expansion. **In 2013, the TMA House of Delegates adopted policy 190.032 Medicaid**

1 **Coverage and Reform encouraging state legislative leaders to draw down all available**
 2 **federal funding to expand access to health care for poor Texans.**
 3

4 If enacted, the AHCA would eliminate the enhanced federal matching funds to expand Medicaid.
 5 Instead, it would create a \$10 billion safety-net pool apportioned among the 19 non-expansion
 6 states over five years based on each state's low-income population. Texas' estimated portion
 7 would be \$500 million annually to be shared among physicians and providers. Under current law,
 8 if Texas expanded Medicaid coverage in accordance with TMA policy, the federal government
 9 would pay 90 percent of the costs from 2020 on resulting in up to \$10 billion annually for the
 10 state. That is a 20-fold differential. (The ACA provided states 100-percent federal funding for
 11 Medicaid expansion from 2014-2016, gradually tapering down to down to 90 percent by 2020
 12 on).

13
 14 2) *Eliminate Medicaid's guaranteed, open-ended financing mechanism, replacing it with one of two*
 15 *capped federal funding options: a per-capita cap or block grant.*

16 As described above, capped federal funding would give states a fixed annual sum plus a nominal
 17 growth factor, such as general or medical inflation, but less than estimated cost growth over a 10-
 18 year period. For both a block grant and per-capita cap, a state's allotment would be based on its
 19 historical level of spending. In the case of the AHCA, each state's base allotment would be built
 20 on 2016 expenditures. This means Texas' previous decisions to fund — or not fund — services or
 21 benefits would be locked into its base funding formula as would low physician payment rates.
 22 Texas physician payments stopped receiving annual inflation updates in 1993. Since then, rates
 23 have mostly stagnated or declined, with the exception of rate increases for children's preventive
 24 care and a temporary Medicaid to Medicare parity adjustment for select primary care physician
 25 services in 2013 and 2014 funded by the Affordable Care Act.

26
 27 Even though the per-capita grant would grow with population, neither a block grant nor per-
 28 capita cap would adjust if the state's costs increased due to changes in medical costs from new
 29 technology or pharmaceutical innovations or due to a public health emergency or catastrophic
 30 event. Had capped funding been in place in 2015 when new Hepatitis C drugs were approved by
 31 the FDA, the cost of the new drugs would not be reflected in Texas' federal matching funds just
 32 as a capped funding formula would not be adjusted to reflect higher-than-anticipated Zika-related
 33 expenditures for prenatal laboratory testing, neonatal intensive care services, or follow up
 34 services.

35
 36 Summary of major AHCA Medicaid provisions:
 37

- 38 • Reduce Medicaid federal funding by an estimated \$880 billion over ten years, approximately 25
 39 percent less than projected under current law (source: Congressional Budget Office; AHCA as filed);
 40 Conservatively, Texas' share of the reduction would total \$15 billion (source: Urban Institute)
 41
- 42 • Beginning in 2020, for each of five patient categories — children, blind and disabled, elderly, other
 43 adults (including pregnant women and poor parents), and expansion adults — states would receive a
 44 fixed per capita cap (PCC) amount based on the state's *average* per person spending amount in 2016
 45 trended forward to 2019 by medical Consumer Price Index. Certain expenditures and populations
 46 would be outside the adjusted per-capita cap, including vaccines for children, women with breast or
 47 cervical cancer services, and dual eligible. The per-capita cap funding level would increase annually
 48 based on the medical Consumer Price Index but less than the Congressional Budget Office's
 49 projected Medicaid growth projections, shifting the higher costs to the states.

- 1
- 2 • The per-capita cap formula accounts for caseload growth, but not for other unexpected Medicaid
- 3 costs, including an infectious disease outbreak such as Zika or other public health emergency, such as
- 4 the opioid addiction crisis, the advent of new, costly life changing medical interventions or
- 5 medications, including those to treat Hepatitis C or muscular dystrophy, a surge in demand following
- 6 a natural disaster, or new medical technology, such as telemedicine.
- 7
- 8 • The proposed bill bases Medicaid capped funding on 2016 expenditures trended forward to 2019
- 9 using medical CPI. Effectively, this will lock in perpetuity Texas' low rates of physician payments,
- 10 including the cuts enacted in 2012 for dual eligible cost sharing and in 2015 for children's services
- 11 because Texas will not be able gain matching dollars for new investments in payments or services.
- 12
- 13 • If a state's Medicaid expenditures exceed its per-capita cap target amount within a fiscal year, then it
- 14 will have its payments reduced in the following fiscal year by the amount of the excess payments.
- 15
- 16 • Eliminates scheduled cuts in hospital disproportionate share (DSH) funds to mitigate increases in the
- 17 number of uninsured; however, it remained unclear whether the bill's base-level funding formula
- 18 fully accounted for supplemental Medicaid funds, including Texas' 1115 Medicaid transformation
- 19 waiver, and how such funding would trend forward.
- 20
- 21 • A last minute manager's amendment provided states the option to establish a block grant for children,
- 22 pregnant women, or both, with an annual growth factor pegged to the consumer price index +1. States
- 23 selecting the option would be locked into that decision through 2020. As previously noted, Texas'
- 24 Medicaid costs are driven primarily by caseload, not per-person costs, so the purchasing power of a
- 25 10-year block grant without caseload growth would quickly erode, leaving Texas with unpalatable
- 26 choices to make up the difference — either increasing state spending or making reductions in
- 27 services, eligibility, and/or physician payments. To entice states to adopt the block grant, the bill
- 28 would reduce *state* contributions to obtain the federal funds for this population, resulting in even a
- 29 deeper funding cut for the block grant population. Other populations would be subject to per-capita
- 30 caps.
- 31
- 32 • Under the block grant option, minimum federal eligibility and benefit standards would be eliminated,
- 33 including EPSDT protections for children.
- 34

35 The following table summarizes the key differences among the current Medicaid funding system, block
 36 grants, and the per-capita cap.

	Current Medicaid Funding	Block Grants	Per-Capita Cap
Federal Funding	Open ended	Aggregate cap	Per-enrollee cap (by eligibility group)

37

	Current Medicaid Funding	Block Grants	Per-Capita Cap
Risk	Federal government and state share enrollment and spending risk	States bear risk of both higher enrollment and health care costs	States bears spending risk of higher health care costs
Annual Trend	Determined by health care costs in the state and individual state spending decisions	National trend rate	National trend rate
Ability to Accommodate Increase Costs due to Medical Advances or Public Health Crises	Federal payments automatically increase as state costs rise	Federal payments fixed – no additional funding for public health emergencies or new medical technology	Federal payments fixed – no additional funding for public health emergencies or new medical technology
Spending Higher than Cap	N/A	States responsible for higher than anticipated costs, including caseload growth	Provides additional funding for caseload but spending higher than cap responsibility of state; if state outspends annual spending limit, federal funds reduced following year
State Flexibility	States must adhere to federal minimum standards, but Section 1115 waivers provide additional flexibility and innovation	Increased flexibility; unknown whether minimum federal standards will apply. Flexibility must be achieved within the funding level	Increased flexibility, but could set some minimal standards and accountability
Benefits	Federal minimum standards, including special protections for children via EPSDT	Likely no federal minimum standards; benefits and services determined by the state	Unclear whether states will continue to be required to adhere to federal minimum benefits

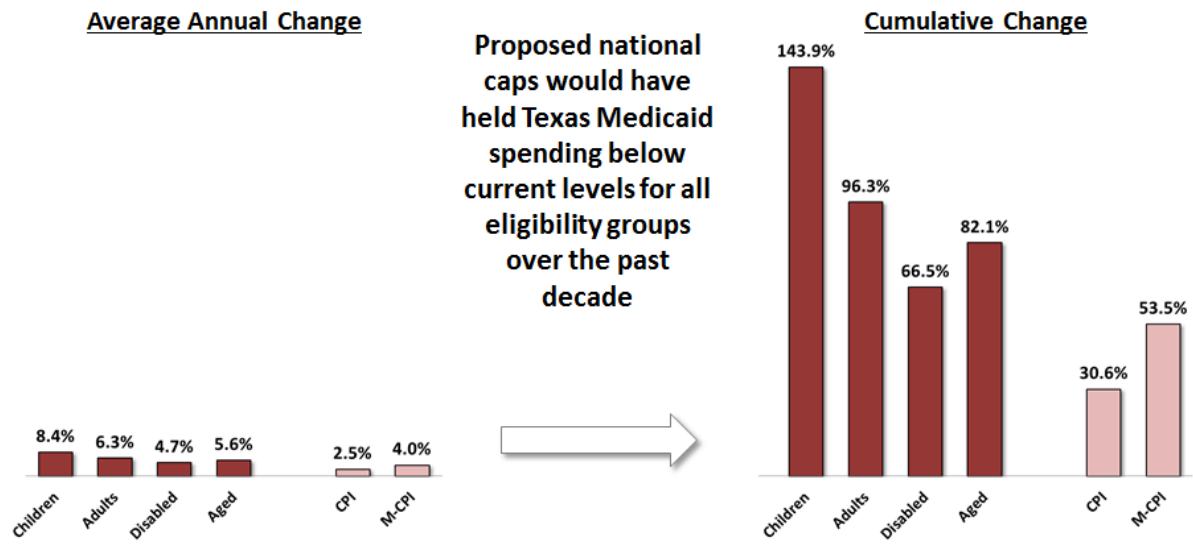
	Current Medicaid Funding	Block Grants	Per-Capita Cap
Physician Payments	Federal standards regarding access, but rates determined by state; increased funding for payments will be matched by federal funds	Rates determined by state; if rates increased after state's base allotment is determined, higher costs not included in block grant base	Rates determined by state; if rates increased after state's base allotment is determined, higher costs not included in block grant base
Supplemental Funding	Funded via Medicaid 1115 waivers	Appears to be funded in base funding	Appears to be funded in base funding

1 Source: Manatt Health, TMA

2
 3 Without a doubt, capped Medicaid funding will have enormous implications for patients, physicians,
 4 providers — and the state. **According to the Kaiser Family Foundation, if a Medicaid per-capita cap**
 5 **funding formula had been in place from 2000-2011 and per-enrollee growth had been limited to the**
 6 **Consumer Price Index-Medical — the same growth factor envisioned by the AHCA — federal**
 7 **funding would have been \$128 billion (7 percent) less nationally, costing Texas \$13 billion (11**
 8 **percent) in federal funds.** Of Texas' losses, \$9.9 billion (24 percent) would have come from the child-
 9 enrollee group.

10
 11

Texas Medicaid Spending per Full-Benefit Enrollee Relative to National Benchmarks (FYs 2000 – 2011)



<https://www.bea.gov/national/index.htm#drg>

<https://data.bls.gov/cgi-bin/survey/most?cu>

<http://www.statenetwork.org/resource/data-points-to-consider-when-assessing-proposals-to-cap-federal-medicaid-funding-a-toolkit-for-states/>

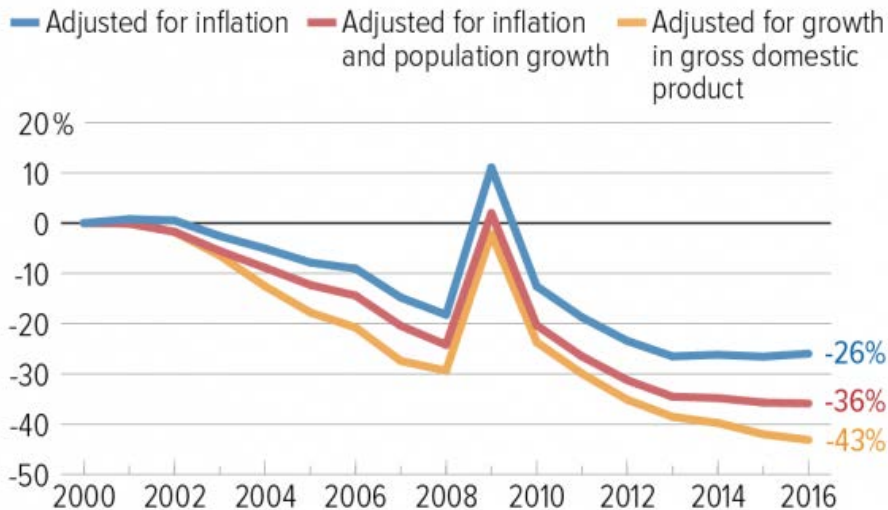
Source: Manatt

Texas is grappling with formidable health issues. Cuts in federal funding will hamper our ability to respond. Beyond continuing to be the nation’s uninsured capital, 21 percent of Texas children live in poverty, a known risk factor for short- and long-term behavioral and physical health disorders; 34 percent of adults are considered obese, contributing to high rates of chronic health conditions, including diabetes and heart disease; and opioid addictions continue to escalate. Alarming, Texas also has one of the highest rates of maternal mortality and morbidity, doubling from 18 per 100,000 births to 36 per 100,000 births from 2010 to 2012. While the factors contributing to maternal death and illness are complex and varied, lack of access to care in the 12 months following delivery is one of them. Without coverage, women with chronic conditions, such as hypertension, diabetes, or perinatal depression, often go without care, with results to match. If Texas were to draw down the federal funds to enhance coverage, it could devise a benefit package to ensure women at risk of postpartum mortality or complications receive the services they need.

If history provides a guide, capped federal funding will not grow over the decade but decline. A 2016 analysis conducted by the national Center on Budget and Policy Priorities of 13 federal housing, health, and social policy block grants found that funding for 11 of the 13, including the Temporary Assistance to Needy Families (TANF), failed to keep pace with inflation and dropped significantly over time. According to the study, the median funding change was a decline of about 26 percent. For four of the block grants, funding plunged by significantly more than half.

Changes in Overall Funding for Housing, Health, and Human Services Block Grants

Change relative to 2000 funding level



Source: CBPP based on Office of Management and Budget data. Figures generally reflect obligations, which are the amounts distributed as grants during the year. Inflation adjustments use CPI-U.

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

1
2
3 Additionally, according to an Urban Institute analysis, a 2012 House Medicaid block grant proposal
4 would have cut Texas Medicaid funding by 32 percent over 10 years. For Texas to avoid steep enrollment
5 cuts, it would have needed to increase spending by 46 percent to 78 percent. Nationally, the same analysis
6 found that over 10 years, 14 million Americans would have lost coverage and provider payments
7 (primarily among hospitals and nursing homes) would have declined some 30 percent. While the AHCA
8 provisions are not identical, the analysis of the 2012 legislation is instructive because as of this writing,
9 the Congressional Budget Office had not published state-by-state analyses of the AHCA .

10
11 **It also should be noted that without the Medicaid entitlement, federal funding would be**
12 **appropriated annually, forcing states to lobby Congress every year to retain their federal**
13 **commitment,** much like physicians were forced to do each year for more than a decade to prevent SGR-
14 triggered Medicare payment cuts.

15
16 While the capped funding discussion often gets discussed in the same context as repeal of Medicaid
17 expansion, **a per-capita cap or block grant, as envisioned by the AHCA, would apply to all Medicaid**
18 **enrollees – the current federally mandated populations (low-income pregnant women, parents,**
19 **children, patients with disabilities and seniors)** as well as higher income enrollees eligible for ACA
20 Medicaid expansion. A block grant would end guaranteed Medicaid coverage for the poorest Texans, with
21 the likely impact being a large increase in Texans without coverage and a concomitant increase in
22 uncompensated care for physicians and hospitals.

23
24 **Undoubtedly, Medicaid has its limitations, beginning with too many paperwork headaches and too**
25 **little payment. But Medicaid is the keystone to Texas' safety net system.** Funding cuts to the program

1 will harm not only patients enrolled in the program and physicians who treat them, but also the entire
2 health care system. Nearly every hospital in Texas receives supplemental Medicaid funding to offset
3 uncompensated care. Cuts in funding would jeopardize their ability to provide services, including
4 maternity and trauma services, for all Texans and make it increasingly difficult for remaining
5 participating physicians and providers to deliver even basic health care services. In some communities,
6 the loss of funding would shutter hospital doors. **Further, Texas counties are constitutionally required**
7 **to provide indigent care. If the federal government shifts costs to the states, Texas will shift costs to**
8 **counties, which in turn will increase property taxes and/or reduce services to compensate.**
9

10 Policy Implications and Recommendations

11 In January, TMA's Select Committee on Medicaid, CHIP and the Uninsured held two meetings to discuss
12 implications of a Medicaid capped-funding formula and how to respond. From those discussions, it
13 developed key policy questions to ask about any legislation.
14

15 Capped Funding Policy Questions

- 16 • How will the block grant and/or per-capita cap base year be calculated?
- 17 • Will new financing include growth for medical inflation as well account for innovations in
18 medical care? Caseload growth? Recession? Natural disaster? Public health emergency?
- 19 • Will the funding be periodically rebased over time?
- 20 • Would states be required to continue matching payments to receive federal funds?
- 21 • Will supplemental payments, including the state's 1115 Medicaid waiver funding, be
22 incorporated into a block grant, limited, or carved out?
- 23 • How will the proposal avoid financially penalizing Texas, which already has low per-person costs
24 as a result of low provider payments and aggressive cost-containment initiatives?
- 25 • Will Texas receive additional dollars to account for its Medicaid expansion population?
- 26 • Will the block grant or per-capita cap discontinue EPSDT protections for children?
- 27 • Will existing federal minimum patient and provider protections remain in place, including
28 minimum standards for eligibility, benefits, and services?
- 29 • Could Texas achieve "flexibility" without a wholesale change in Medicaid financing? What key
30 issues require additional flexibility? Cost-sharing? Work requirements? Administrative
31 processes? Other?
- 32 • Will the reforms establish minimum federal eligibility and coverage standards, including
33 maintenance of effort for existing mandatory populations?
- 34 • Will a block grant or per-capita cap apply to all Medicaid populations and services or exclude
35 some? (E.g. carve out nursing homes and long-term care)?
- 36 • Will CMS maintain federal minimum standards for Medicaid managed care regarding network
37 adequacy, benefits, quality improvement, etc.?
- 38 • Will states lose funding for emergency Medicaid, which offsets costs of uncompensated care
39 provided to immigrants ineligible for coverage?
- 40 • Will federal rebates for prescription drugs end?
- 41 • How will capped funding impact long-term care services, including community-based services?
42 Would it preclude moving patients from waiting lists?
- 43 • Poverty is a key driver of health care costs. Will states with high poverty rates, particularly
44 among children, receive additional dollars to address social determinants of health?
- 45 • Will the funding formula be adjusted to account for Texas' low physician payment rates and other
46 funding disparities?

1 Concurrently, in January, TMA and the Texas Hospital Association formed a joint, 14-person Block
2 Grant Task Force, chaired by TMA's Board of Trustees Chair Doug Curran, MD, to develop joint
3 principles to guide both organizations' evaluation of federal block grant legislation and to communicate to
4 Texas' congressional and state legislative leadership reform priorities for physicians and hospitals. The
5 task force convened twice, culminating in a letter to Texas' congressional delegation outlining TMA's
6 and THA's strong concerns about the AHCA's per-capita cap scheme (see Appendix 1 for letter and task
7 force roster).

8
9 Many state lawmakers argue in favor of capping federal Medicaid funding in exchange for greater
10 programmatic flexibility. But lawmakers already have tremendous latitude in designing Medicaid,
11 ranging from the amounts the state pays physicians and providers to services covered by the Medicaid
12 delivery system. For other issues, such as experimenting with Medicaid cost-sharing or testing innovative
13 models of care, states can seek federal waivers. Flexibility and capped funding are not inherently linked
14 — states can pursue greater federal flexibility without upending Medicaid financing by reducing federal
15 funds. Low-spending states like Texas might find their ability to implement additional services, such as
16 enhancing opioid addiction treatment, or covering more people, diminished.

17
18 If federal strings go away, it is likely the Texas Legislature will push for additional cuts. In 2011, Texas
19 reduced funding for preventive women's health services. The result was an increase in Medicaid births
20 and a significant cost increase to the program far above the savings achieved. In 2015, lawmakers cut
21 \$350 million in Medicaid therapy services, resulting in reduced access to these services for Texans with
22 disabilities and low-income Medicaid beneficiaries.

23
24 **Beyond the potential to jeopardize patient care, capped funding likely also would increase**
25 **physician uncompensated care substantially.** According to the Texas Comptroller and Texas Health
26 and Human Services Commission, caseload is the primary driver of Medicaid costs, not per-person
27 spending. Texas legislators have squeezed the program significantly over the past decade. Ninety-two
28 percent of Medicaid patients are now enrolled in managed care, and physician Medicaid payments
29 average roughly 73 percent of Medicare's. Each session, lawmakers squeeze Medicaid even further,
30 establishing more and more unrealistic cost-containment goals. There really are no additional realistic
31 options for Texas to curtail costs under a capped-funding scheme except to reduce benefits, eligibility,
32 and payments.

33
34 While the AHCA's final form is unknown, it is clear that congressional efforts to fundamentally alter
35 Medicaid will persist. Given the sweeping implications of capped funding for patients, physicians, and
36 Texas' health care safety net system, the council and committee recommend a path that would not
37 irreparably harm the existing system. Instead the focus should be on maintaining uncapped federal
38 Medicaid funding, preserving minimum Medicaid benefit and eligibility protections for the lowest income
39 Texans, including EPSDT for children, and pursuing initiatives to expand health care coverage to low-
40 income Texans using private-sector solutions. Furthermore, TMA also should collaborate with state
41 legislative leadership to pursue federal reforms to streamline federal administrative processes that impose
42 undue burdens on patients, physicians, and the state.

43 44 **Recommendations:**

45
46 **Recommendation 1:** That TMA vigorously advocate to preserve guaranteed, uncapped federal Medicaid
47 funding for at least all Texas Medicaid populations covered by the program as of Jan. 1, 2017.

48
49

1 **Recommendation 2:** That TMA strongly advocate maintaining mandated minimum services, benefits
2 and cost-sharing requirements for pregnant women and children, including protecting the Early Periodic
3 Screening Diagnosis and Treatment (EPSDT) program to ensure Medicaid-enrolled children retain access
4 to all medically necessary services, and maternal health services to promote healthy pregnancies and birth
5 outcomes.

6
7 **Recommendation 3:** That TMA strongly reiterate its support for measures that promote continuity of
8 care and the patient-centered medical home, including maintaining 12-month continuous coverage for
9 children enrolled in the Children’s Health Insurance Program and advocating for the same policy for
10 children’s Medicaid, and preserve measures to simplify and streamline Medicaid and CHIP enrollment
11 processes so that children and other enrollees do not lose coverage due to red-tape and bureaucracy.

12
13 **Recommendation 4:** That TMA reiterate its commitment to implementing a comprehensive initiative to
14 expand health care coverage to low-income Texans using federal funding and private sector solutions.

15
16 **Recommendation 5:** That TMA evaluate the feasibility of piloting a capped Medicaid funding scheme
17 for Medicaid expansion population should Texas implement a coverage option for low-income Texans, so
18 long as the initiative provides patients meaningful coverage as devised by an advisory panel of primary
19 and specialty care physicians and does not increase uncompensated care for physicians.

20
21 **Recommendation 6:** That TMA advocate strongly to stand against any federal or state reform measure,
22 including block grants, that will diminish patient access to services or increase physicians’
23 uncompensated care.

24
25 **Recommendation 7:** That TMA collaborate with state legislative leadership to seek relief from federal
26 administrative requirements that impose undue costs and paperwork on patients, physicians, and the state
27 without improving patient care or outcomes.
28