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TEXAS HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS

PANEL DISCUSSION
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House Appropriations Committee

Charles Smith
Executive Commissioner

Jami Snyder
Associate Commissioner for Medicaid and CHIP Services

TEXAS Health and Human Services

Impact of ACA to the Health and Human Services System

TEXAS
Health and Human Services

ACA Overview

- The Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010
- Most Medicaid and CHIP changes were implemented in January 2014
- Key provisions of ACA as it relates to the Health and Human Services System:
  - 12-Month Certification Period
  - Presumptive Eligibility
  - Eliminates Asset Tests
  - Modified Adjusted Gross Income (MAGI)
  - Medicaid Income Limits
  - Former Foster Care Youth
  - Prevention and Public Health Fund
  - Department of Family and Protective Services' home visiting programs

Cost Impacts of ACA

Level of Implementation	FY2018		FY 2019		Biennium	
	GR	*All Funds*	*GR*	*All Funds*	*GR*	*All Funds*
Impacts to Caseload						
SHIFT: CHIP to Medicaid	***$4,261,329***	***$59,021,174***	***$4,537,560***	***$66,145,188***	***$8,798,889***	***$125,166,362***
Additional Clients						
-- Foster Care to 26	$4,263,414	$9,873,584	$4,518,466	$10,591,811	$8,781,880	$20,465,395
--12 Month Recertification	$103,061,124	$238,677,915	$108,947,510	$255,385,632	$212,008,634	$494,063,546
-- MAGI / Previously Eligible Newly Enrolled	$163,660,197	$379,018,519	$173,062,825	$405,679,383	$336,723,021	$784,697,902
-- Hospital Presumptive Eligibility	$ -	$ -	$ -	$ -	$ -	$ -
Total Additional Client Costs	***$270,984,734***	***$627,570,018***	***$286,528,802***	***$671,656,826***	***$557,513,536***	***$1,299,226,843***
Impacts to Cost						
-- Community First Choice	$63,086,430	$288,225,811	$65,783,035	$307,750,225	$128,869,464	$595,976,036
-- ACA Health Insurance Issuer Fee			$104,448,479	$262,522,442	$104,448,479	$262,522,442
-- Federal Income Tax			$56,241,489	$141,358,238	$56,241,489	$141,358,238
Total Cost Impact	***$63,086,430***	***$288,225,811***	***$226,473,002***	***$711,630,904***	***$289,559,432***	***$999,856,715***
Federal Match Rate Impacts						
--Savings due to +23% Enhanced Match	($247,599,060)		($266,217,090)		($513,816,150)	
--Federal Match for SKIP Children	($12,573,181)		($13,398,383)		($25,935,564)	
Overall ACA Cost Impact	**$78,160,252**	**$974,817,003**	**$237,923,891**	**$1,449,432,918**	**$316,120,143**	**$2,424,249,920**

The total costs for ACA cost and caseload impacts are additive. However, assumptions regarding savings need to consider that changes to one area will impact the savings (or cost) in another.

Costs for administrative and eligibility changes are not included in this estimate. Any savings for undoing all or part of ACA must consider the costs for IT changes and staffing needs, as well as the timetable for completion.

ACA cost impacts above include full cost/caseload growth; these are not base funding estimates (without cost growth).

Other optional ACA estimates for the Balancing Incentives Program (BIP) ended September 2015, estimates for historical BIP freed up General Revenue will be provided for HHSC and DADS Legacy.

Community First Choice (CFC) is a state option directed by the legislature.

Impacts above represent estimated costs as a result of ACA. Potential savings resulting from a repeal of ACA are not estimated due to the many unknowns resulting from that change.

Texas Health Care Transformation and Quality Improvement Program 1115 Waiver

TEXAS
Health and Human Services

1115 Waiver Overview

- The 1115 Waiver was originally approved for five-years (2011–2016)
- The Waiver allows Texas to expand Medicaid managed care while preserving federal hospital funding historically received as Upper Payment Limit (UPL) funding
- The Waiver also provides new means, through regional collaboration and coordination, for local entities to access additional federal matching funds

TEXAS
Health and Human Services

1115 Waiver Overview

- Under the 1115 waiver, hospitals and other providers earn historical UPL and new funds through two pools
- Uncompensated Care (UC) Pool
  - Replaces UPL
  - Costs for care provided to individuals who do not have third-party coverage for hospital and other services and Medicaid shortfall
- Delivery System Reform Incentive Payment (DSRIP) Pool
  - Incentive program to support coordinated care and quality improvements through 20 Regional Healthcare Partnerships (RHPs)
  - Goals: transform delivery systems to improve care for individuals, improve health for the population, and lower costs through efficiencies and improvements
  - Targets Medicaid recipients and low income uninsured individuals
  - There are currently 1,340 projects and 296 providers, totaling $10.7 billion in DSRIP payments as of July 2017

UC and DSRIP Pool Funding Distribution (All Funds)

Type of Pool	DY1 FFY 2012	DY2 FFY 2013	DY3 FFY 2014	DY4 FFY 2015	DY5 FFY 2016	DY6 FFY 2017	Extension Partial DY7 Oct-Dec 2017
UC	$3.7 billion	$3.9 billion	$3.5 billion	$3.3 billion	$3.1 billion	$3.1 billion	$775 million
DSRIP	$500 million	$2.3 billion	$2.7 billion	$2.8 billion	$3.1 billion	$3.1 billion	$775 million
Total	***$4.2 billion***	***$6.2 billion***	***$6.2 billion***	***$6.2 billion***	***$6.2 billion***	***$6.2 billion***	***$1.6 billion***
% UC	88%	63%	57%	54%	50%	50%	50%
% DSRIP	12%	37%	43%	46%	50%	50%	50%

1115 Waiver Extension

- In September 2015, HHSC submitted a request to CMS to extend the 1115 Waiver for five additional years
- CMS approved a 15-month extension in October 2016
  - This extension maintains current funding levels for both UC and DSRIP through December 2017
- In January 2017, HHSC submitted a request to CMS for a 21 month extension of the Waiver for DYs 7-8, with level funding for each funding pool
- As part of the 1115 Waiver renewal, CMS determines each state's waiver budget neutrality cap – spending under the waiver must not exceed costs without the waiver
- Negotiations with CMS are ongoing

CHIP Reauthorization

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Health and Human Services

CHIP Overview

- The Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP)
  - Jointly funded state-federal program that enables states to initiate and expand healthcare to uninsured, low-income children
  - Covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance
- Texas implemented CHIP in 1998
- CHIP serves approximately 380,000 Texas children

CHIP Eligibility

- To qualify for CHIP, a child must be:
  - A U.S. citizen or legal permanent resident
  - A Texas resident
  - Under age 19
  - Uninsured for at least 90 days
  - Living in a family whose income is at or below 201 percent FPL

TEXAS
Health and Human Services

CHIP Services

- Federal regulations afford states flexibility to tailor their benefit package to meet the unique needs of the population served
- CHIP services include:
  - Primary health care
  - Inpatient and outpatient behavioral health services
  - Vision exams and corrective lenses
  - Hearing exams and hearing aids
  - Physical, occupational, and speech therapy
  - Durable medical equipment
  - Dental benefits

TEXAS
Health and Human Services

CHIP Delivery Model

- CHIP services are delivered through a managed care model
- Most families in CHIP pay an annual enrollment fee to cover all children in the family
- All families make co-payments for office visits, prescription medications, inpatient hospital care, and non-emergent care provided in an emergency room setting
- CHIP annual enrollment fees and co-payments vary based on family income

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Health and Human Services

Benefits of CHIP

- CHIP affords Texas the freedom to design a system that aligns with the state's goals of good stewardship of public funds and increasing personal responsibility for program participants
- Since CHIP was implemented, Texas has seen a reduction in the overall rate of uninsured children below 200 percent of FPL, from approximately 18 percent in 1998 to 6 percent in 2015
- CHIP provides medical and dental benefits to the covered population at a rate of $156 per member per month, which is $67 less on a per member basis than the cost of coverage for the state's children Medicaid population

TEXAS
Health and Human Services

Reauthorizing CHIP

- Congress may elect to reauthorize CHIP but at a lower federal matching rate
- Texas assumed continued funding for CHIP for fiscal years 2018 and 2019 at the *super* enhanced federal matching rate
  - Current federal match – 93 percent
  - 23 percentage point increase above standard enhanced federal matching rate for CHIP of 70 percent
- Returning to the standard enhanced federal matching rate (70 percent) would result in a loss of $800 million in federal funding over the biennium
- Currently, as mandated by ACA, the state would also be expected to continue adherence to Maintenance of Effort requirements

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July 7, 2017

Honorable John Cornyn
Hart Senate Office Bldg 517
Washington, DC 20510

Dear Senator Cornyn:

Thank you for meeting with members of the Texas Hospital Association and Texas Medical Association earlier this week to discuss the Senate's health care reform legislation. We appreciated being able to share our concerns about the Better Care Reconciliation Act.

From the hospital perspective, we believe it is important to reiterate our opposition to the conversion of the Medicaid program from an entitlement to one of fixed federal funding. As we have stated before, the proposed per capita cap methodology will disadvantage Texas because it memorializes low hospital and physician reimbursement rates and is based on historical spending that Texas has kept low through managed care efficiencies. Also, states (including Texas) with a greater reliance on supplemental payments will be disadvantaged when setting the cap under the BCRA's methodology [see attachment from Manatt Health]. In addition, the proposed inflation factors will be insufficient to keep up with spending growth and do not account for public health emergencies, natural disasters or medical breakthroughs.

The financial impact of BCRA's Medicaid coverage provisions are expected to cost Texas more than $57 billion from 2018-2026, according to an analysis by the American Hospital Association. Ultimately, the state will have to make choices about whether to cut services, eligibility and enrollment, or provider reimbursement rates because federal funding will be inadequate. Rather than artificial funding limits to the Medicaid program, we support allowing states to work through the 1115 waiver process to institute reforms.

While numerous sources confirm the harmful impact of the BCRA to Texas, several changes to the legislation could help mitigate the negative consequences:

- Specifically increase the DSH allotment for all states that did not expand Medicaid and do not use a national average.
- Ensure that the per capita cap calculation accounts for all supplemental payments and includes an adequate growth factor to better meets the state's need for funding.
- Increase the safety-net fund for non-expansion states and eliminate the requirement for state matching funds.
- Preserve retroactive eligibility for enrollment in Medicaid.
- Maintain the Medicaid provider tax threshold at current law.
- Eliminate all Medicaid and Medicare hospital funding cuts from the Affordable Care Act.

We also continue to be greatly concerned about the impact of BCRA on the number of uninsured in the state. The AHA estimates that 1.8 million more Texans will be uninsured by 2018 and 2.8 million by 2026 if the BCRA is enacted compared to current law. While increased funding to the long-term state stabilization fund is intended to help reduce the number of uninsured, we remain concerned the financial support will not be enough to address myriad needs in Texas. Hospitals will continue to comply with the

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federal mandate to provide emergency care regardless of an individual's ability to pay; however, a growing amount of uncompensated care coupled with low reimbursement rates and a rising number of under/uninsured will create the perfect storm. If the impact of the BCRA on coverage is anywhere close to the estimates by the Congressional Budget Office, the health care infrastructure in Texas will be in serious jeopardy.

As a high growth, high need state, Texas will be significantly harmed by many of the provisions in the BCRA.

Thank you again for your time this week and ongoing attention to our concerns. I and my staff are available at any time to answer questions or provide additional information.

Sincerely,

Ted Shaw
President/CEO
Texas Hospital Association

Impact of Non-DSH Supplemental Payments in Formula

Non-DSH supplemental payments* are excluded from FY 2019 spending, but then added based on ratio of FY 2016 supplemental payments to FY 2016 total spending to calculate cap. However, this does not result in a directly proportionate increase in the cap. States with greater reliance on supplemental payments in FY 2016 will see a greater disparity.

Supplemental Payment Adjustment

Non-DSH Supplemental Payments = 5% of total Medicaid spending ($1 billion out of $20 billion total)

$$\left(1 + \frac{\text{FY 2016 Supp. Payments} = \$1\text{ B}}{\text{FY 2016 Total Spending} = \$20\text{ B}}\right) \times \text{FY 2019 Total Spending – Supp. Payments } \$20\text{ B} - \$1\text{ B} = \$19\text{ B}$$

$$=$$

$19.95 B Cap

0.25% less than if adjustment fully accounted for supplemental payments

Supplemental Payment Adjustment

Non-DSH Supplemental Payments = 20% of total Medicaid spending ($4 billion out of $20 billion total)

$$\left(1 + \frac{\text{FY 2016 Supp. Payments} = \$4\text{ B}}{\text{FY 2016 Total Spending} = \$20\text{ B}}\right) \times \text{FY 2019 Total Spending – Supp. Payments } \$20\text{ B} - \$4\text{ B} = \$16\text{ B}$$

$$=$$

$19.2 B Cap

4% less than if adjustment fully accounted for supplemental payments

*Includes UPL and 1115 waiver payments, including Uncompensated Care Pools, DSRIP and DSHP

Testimony of the Children's Hospital Association of Texas
Stacy E. Wilson, President
House Appropriations Committee, July 25, 2017

On behalf of the eight non-profit hospital and health system members of the Children's Hospital Association of Texas (CHAT), I appreciate the opportunity to testify today about the sweeping changes being discussed by the federal government that would fundamentally restructure the Medicaid program.

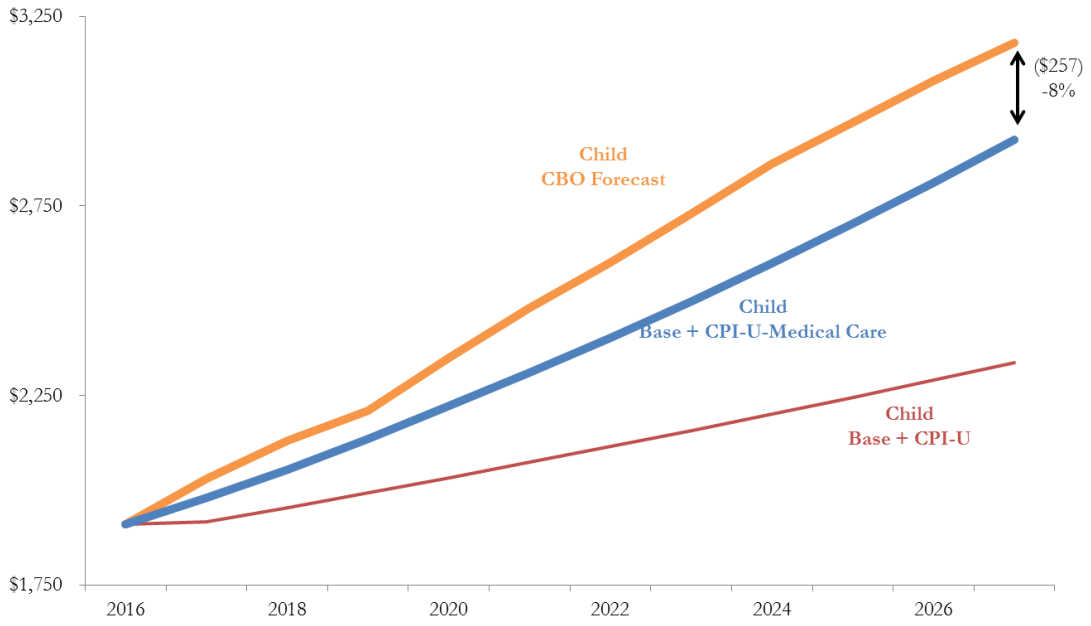
Children's hospitals and health systems are very concerned about the proposed changes to the Medicaid program, especially the federal government's capping its investment in Medicaid through per capita caps (also known as per beneficiary allotments) and block grants. This limited federal investment shifts the funding risk to the state and, unless the state makes up the difference in reduced federal funding, fewer services will be available and fewer children are likely to be covered. This result is probable because more expensive populations like the elderly and disabled will use up all the available funding. Below is a summary of the options under discussion:

Current Model	Block Grant	Per Beneficiary Allotment
• Federal and state share in increasing cost	• Federal funding capped on a state or aggregate basis	• Federal funding fixed on a per person basis
• Open-ended entitlement with comprehensive services, some not covered by private insurance	• Does not limit spending, but reduces federal obligation	• Does not limit spending, but provides predictability on federal spending
• Accounts for changes in population and cost of care	• Could penalize state with increasing populations	• More reflective of changes in population or services
• Limited state accountability in overall spending	• Could negatively impact states with efficient programs	• Challenge determining funding amounts and populations

Regardless of changes at the federal level, children in Texas will continue to need care. New therapies and drugs that are curative but expensive as well as public health emergencies and rising healthcare costs will still exist. With capped federal funding, the state will be faced with a Hobson's choice: use limited state dollars to continue current levels of service and eligibility or cut services and/or change eligibility requirements to reduce the number of individuals covered by Medicaid to stay within the limited federal funds. States may also be forced to make extremely difficult choices among different vulnerable populations and decide whether and how to respond to public health emergencies, new therapies and drugs, and rising healthcare costs.

While per capita caps at least address caseload growth, block grants do not. Block grants remain a funding option for pregnant women. Ensuring that babies get their best start in life and do not need expensive neonatal intensive care services are achieved through appropriate pre-natal care and care during after delivery. These services may be jeopardized under a block grant, especially considering that Medicaid covered over half of the births in the state in state fiscal year 2015 and has done so since 2007.

The inflators that have been proposed, especially by the U.S. Senate under the Better Care Reconciliation Act (BCRA), will not keep pace with cost growth over time. Under the BCRA, the inflator for the per capita caps would lower to the Consumer Price Index-Urban in 2025, or standard inflation. As is shown below, the Consumer Price Index-Medical, which is what has been proposed in the House repeal and replace bill, results in a deficit for the Medicaid program across the country over time when compared with the Congressional Budget Office's projected cost growth. The CPI-U is a much more drastic reduction in federal funding for children.



Source: Children's Hospital Association

In addition to the fundamental restructuring of the Medicaid program, there are other proposed changes to the Medicaid program that are troublesome, including repeal of the three-month Medicaid eligibility lookback period and the ability of hospitals to make presumptive eligibility determinations. Both of these programs help ensure that children can access care, and providers can receive payment, for services received during a limited period prior to the actual Medicaid enrollment date. Eliminating these provisions will likely result in either children not having access to needed care or in additional uncompensated care being borne by hospitals.

Some children will also be harmed by a repeal of the Patient Protection and Affordable Care Act (ACA) without an adequate replacement. While children were not the main focus of the ACA, in addition to the general provisions that impact everyone; *e.g.*, marketplace coverage and overall private insurance market and delivery system reforms, there were a few provisions that did benefit children:

- The ability of young adults to remain on their parents' insurance plan until age 26.
- Required coverage of pediatric and habilitative services by plans in the individual and small group markets. Habilitative services are services that help a child keep, learn, or improve skills and functioning, such as therapy for a child who is not walking or talking at the expected age
- Maintenance-of-effort requirements in Medicaid and CHIP, which prevent states from rolling back the eligibility standards, methodologies and procedures they had in place for children's coverage as of March 23, 2010.
- An enhanced federal CHIP matching rate, which has helped states continue coverage for children and address budgetary shortfalls.
- Expansion of 340B Drug Pricing Program eligibility to children's hospitals so they can provide reduced-price drugs to patients, expand comprehensive health services, and continue to serve patients who cannot pay.

A straight repeal of the ACA would eliminate these benefits for children. In Texas, more than 132,000 children are enrolled in marketplace coverage as of January 21, 2017, the largest number of children in any state.

Children's hospitals in Texas are disproportionately reliant on Medicaid due to the large number of children who are enrolled in Medicaid – 70% of all enrollees and over 3 million children – almost half of the child population in Texas. Children's hospitals consistently are among the top hospitals with the greatest percentage of Medicaid inpatient days of all hospitals as is demonstrated by the chart below. Children's hospitals also have very little Medicare revenue, about 1%, compared with adult hospitals that receive about 40% of their revenue from Medicare. Thus these severe Medicaid reductions will disproportionately impact children's providers, including children's hospitals.

FACILITY	COUNTY	CITY	2015 Total Medicaid Days	2015 Total Inpatient Days	Percent Medicaid
Children's Hospital of San Antonio	BEXAR	San Antonio	25,129	31,682	79.3%
Driscoll Children's Hospital	NUECES	Corpus Christi	21,587	28,627	75.4%
Starr County Memorial Hospital	STARR	Rio Grande City	32,999	44,029	74.9%
El Paso Children's Hospital	EL PASO	El Paso	16,241	22,063	73.6%
Children's Health	DALLAS	Dallas	70,127	101,533	69.1%
McCamey Hospital	UPTON	McCamey	5,626	8,377	67.2%
Healthbridge Children's Hospital	HARRIS	Houston	6,425	10,353	62.1%
Cook Children's Medical Center	TARRANT	Fort Worth	40,974	71,801	57.1%
Covenant Children's Hospital	LUBBOCK	Lubbock	9,188	16,302	56.4%
Our Children's House	DALLAS	Dallas	4,670	8,461	55.2%
Dell Children's Medical Center	TRAVIS	Austin	23,304	42,529	54.8%
HopeBridge Hospital	HARRIS	Houston	10,586	20,170	52.5%
Texas Children's Hospital	HARRIS	Houston	101,003	198,933	50.8%
Edinburg Regional Medical Center	HIDALGO	Edinburg	61,898	125,573	49.3%
Parkland Memorial Hospital	DALLAS	Dallas	103,466	225,608	45.9%
Texas Scottish Rite Hospital for Children	DALLAS	Dallas	2,200	4,872	45.2%

* Includes all Medicaid inpatient days, both children and adults.
Source: 2015 Cooperative DSHS/AHA/THA Annual Survey of Hospitals, State Center for Health Statistics, DSHS.

Children's hospitals in Texas recognize the need to improve quality of care and reduce costs. Two examples of how they have addressed these challenges are: (1) Solutions for Patient Safety (SPS); and (2) CHAT quality collaboratives. SPS is a national effort in which over 130 children's hospitals are working toward eliminating all serious harm to children in children's hospitals. That effort has saved hundreds of millions of dollars and thousands of lives since its inception in 2012. Additionally, the CHAT member hospitals have undertaken several quality collaboratives in which they address identified conditions (asthma, sepsis, and bronchiolitis to date) and share knowledge, data, and best practices to improve care and lower costs. The state is interested in achieving the Institute for Healthcare Improvement triple aim of improving the patient experience, improving population health, and lowering the cost of care. Children's hospitals are interested in partnering with the state to achieve this triple aim through incentivizing these provider-driven quality efforts.

TEXAS RURAL HOSPITALS
AND
THE 1115 WAIVER

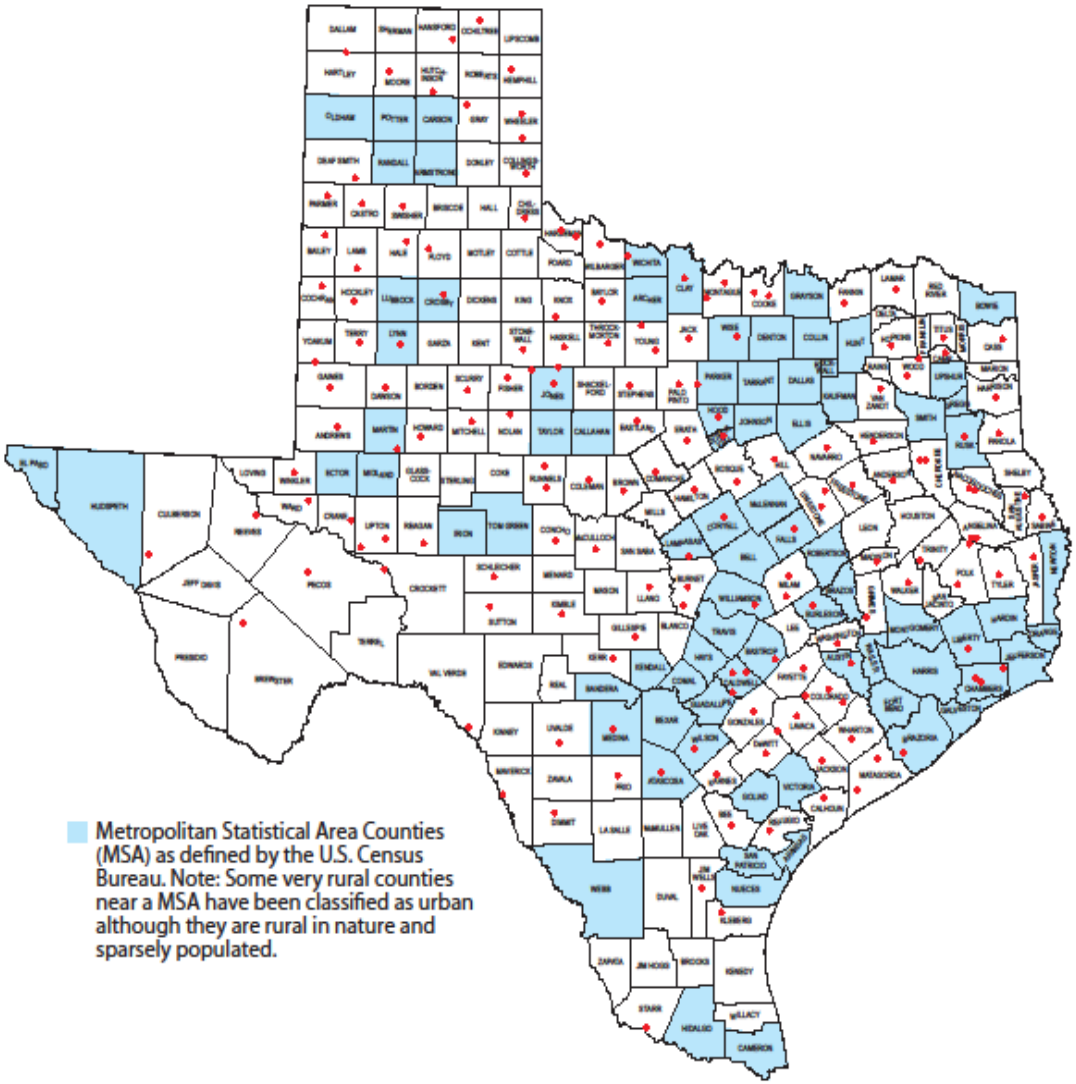
Presentation to the Texas House Committee on Appropriations

Don McBeath
Director of Government Relations
Texas Organization of Rural & Community Hospitals
(TORCH)

July 25, 2017

TEXAS MAP OF RURAL HOSPITALS

(164 Rural Hospitals)



Metropolitan Statistical Area Counties (MSA) as defined by the U.S. Census Bureau. Note: Some very rural counties near a MSA have been classified as urban although they are rural in nature and sparsely populated.

Rural hospital defined by Medicare as Critical Access Hospital, Sole Community Hospital, Rural Referral Center, hospital in a non-MSA, or other designation as rural/defined by Texas Medicaid as CAH, SCH, RRC in a non-MSA, RRC in a MSA but 100 or less beds, or in county of 60,000 population or less. TORCH does not consider urban/MSA located RRCs as rural for purposes of this map.

TEXAS RURAL HOSPITAL SNAPSHOT

- There are 164 rural hospitals in Texas (using the definitions of rural hospitals in Medicare and Medicaid, but not including rural referral center hospitals in urban metropolitan areas).
- Rural hospitals are closing in near record numbers across Texas primarily because of Medicare and Medicaid payment cuts along with continuing high levels of uninsured.
- 18 Texas rural hospitals have closed permanently or temporarily since the beginning of 2013 (last 4 ½ years) – this is 8% of the rural hospitals in Texas.
- The hospital in Crocket closed on June 30 and the hospital in Trinity is scheduled to close on July 31.
- Several more Texas rural hospitals are in financial distress, bankruptcy, and on the brink of closure.
- Of the 18 closures, 4 have reopened, 1 is planned to reopen in several months, and 3 are now an emergency or urgent care center only.
- The upswing in Texas closures is mostly driven by $50 million a year in Medicare cuts to Texas rural hospitals starting in 2013 as well as a $60 million dollar a year underpayment by Texas Medicaid to rural hospitals.
- Many more Texas rural hospitals would have closed if not for the inflow of supplemental dollars from the 1115 waiver, mostly UC.

TEXAS RURAL HOSPITAL OPERATING DYNAMICS

- Rural hospitals operate very differently than urban hospitals.
- They are NOT small urban hospitals.
- Rural hospitals care for older and poorer patients which results in higher percentages of Medicare and Medicaid, as opposed to urban hospitals which tend to treat a higher percentage of insured patients which can offset losses in other areas.
- Rural hospitals deal with higher levels of uninsured patients – Texas now averages around 17% uninsured but many rural counties are much higher - (Presidio 34%, Starr 34%, Hudspeth 32%, Culberson 29%, Reeves 28%, Foard 27%, Val Verde 27%, Castro 26%, Collingsworth 24%).
- Rural hospitals experience wide swings in patient volume (2 patients on one day, 15 patients the next day, and back down to 2) versus urban hospitals which are usually consistently full – this poses a staffing efficiency challenge.
- Rural hospitals do not provide more profitable services such as advanced cardiac care and orthopedic care.
- Rural hospitals do provide services which tend to be less profitable or often come at a financial loss to the hospital – obstetrical services (mostly Medicaid), caring for the elderly, and operating an emergency room around the clock which often doesn't see a patient but must be standing by.
- Rural hospitals are more challenged to recruit and maintain appropriate and qualified health care workforce
- Rural hospitals have a narrower financial bottom line than urban hospitals – they are often in the red and rely upon the 1115 waiver payments, local taxes, and other outside support to stay open.

IMPACT OF THE 1115 WAIVER ON RURAL HOSPITALS

- The Waiver has helped many rural hospitals keep their doors open.
- It has allowed rural hospitals as a whole to keep supplemental payments that would have been lost with the ending of the Texas Upper Payment Limit system when Texas converted its Medicaid program to a private insurance, managed care program.
- Supplemental payments from the Waiver and related Disproportionate Share (DSH) program help urban hospitals provide services – in rural hospitals they make the difference in whether the hospital stays open.
- Many rural hospitals report that between 25 and 33% of their income now comes from one or both of these programs.
- The waiver is allowing some rural hospitals to participate in new and innovative health programs that they would not otherwise have been able to participant in
- The waiver has strengthened communications, patient care coordination and collaboration between many rural hospitals and with the larger medical centers in their region.
- A downside is that the decreasing federal portion of dollars in the Waiver from the declining FMAP mean that MORE local tax dollars much be contributed by hospitals to net same level of payments.

1115 WAIVER AND UNCOMPENSATED CARE

- The Uncompensated Care payments continue to fall short of covering the actual uncompensated care services provided by rural hospitals.

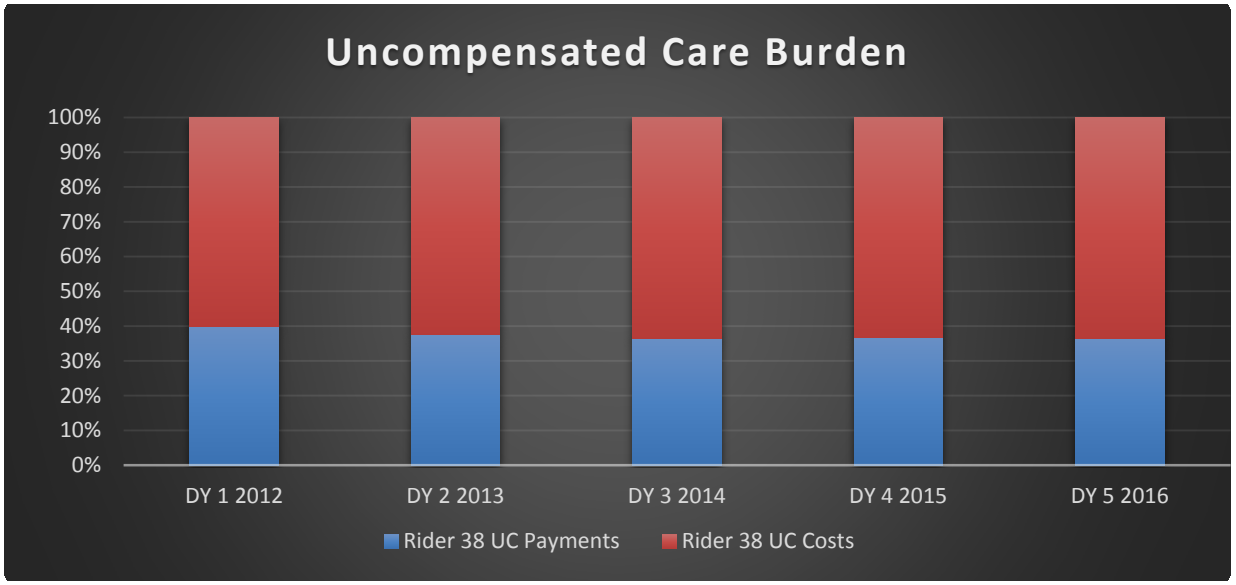


Chart shows uncompensated care payments compared to uncompensated care cost for rural hospitals. Compiled from HHSC data.

*1115 IMPACT ON RURAL TEXAS**

	2012 1115 YEAR 1	2013 1115 YEAR 2	2014 1115 YEAR 3	2015 1115 YEAR 4	2016 1115 YEAR 5
FMAP%*	58.22	59.30	58.69	58.05	57.13
UC Payments					
RURAL HOSPITALS	254,453,293	313,322,795	316,962,045	385,321,320	337,769,327
ALL UC PAYMENTS	3,540,204,109	3,788,090,055	3,236,545,377	3,056,160,568	2,764,923,238
DSRIP Payments					
RURAL HOSPITALS	28,747,757	122,044,502	186,002,370	192,406,115	151,124,411
ALL DSRIP PAYMENTS	453,986,513	1,920,741,185	2,538,485,007	2,656,329,553	2,326,174,604
TOTAL RURAL PAYMENTS	283,201,049	435,367,297	502,964,415	577,727,435	488,893,738
TOTAL PAYMENTS	3,994,190,622	5,708,831,241	5,775,030,384	5,712,490,121	5,091,097,842
NET TOTAL PAYMENTS*	2,325,417,780	3,385,336,926	3,389,365,333	3,316,100,515	2,908,544,197
NET RURAL HOSPITALS*	***164,879,651***	***258,172,807***	***295,189,815***	***335,370,776***	***279,304,992***

Rural payments estimated from HHSC data. Some payments may have been made in the year after project year.
FMAP is ratio of federal to state/local dollars. Declining federal share (FMAP) requires increasing local property tax dollars (IGT) to maintain the same net payment levels.

*** Net payment received by hospitals is new federal dollars after subtracting the IGT (local tax money) provided by hospitals to draw down federal funds.***

RURAL HOSPITAL SUCCESS STORIES FROM THE WAIVER

- 87 rural hospital projects are associated with primary care
- 20 (approximately) rural hospital projects are associated with telemedicine
- 20 rural hospital projects are associated with specialty care

Here are some examples of how some Texas rural hospitals have carried out DSRIP projects:

CHILDRESS REGIONAL MEDICAL CENTER *(Childress)* - NAIP Telemedicine

- A middle of the night flight transfer for a 6 day old infant with severe kidney problems was avoided with the use of a telemedicine consult to Children's Medical Center in Dallas. It was followed-up with a scheduled urgent visit to the specialist several days later.
- A 10 year old was taken to Dallas several days away for dialysis under the supervision of a pediatric nephrologist. Childress Regional could provide dialysis but is without the specialist. With telemedicine, the dialysis now takes place in the child's home town. The child is back in school, and the father is back at work instead of being a full time driver.

HEART OF TEXAS MEMORIAL (*Brady*) – Healthy Eating Education

- Students at risk of childhood obesity are educated about health eating with the Coordinated Approach to Child Health (CATCH) program to students in the schools. This includes the growing of healthy vegetables that are served in the cafeteria.

ELECTRA MEMORIAL HOSPITAL (*Electra*) – Increased access with primary care clinics.

- This included the opening of a new clinic in Iowa Park, Texas were there was no primary care and expanded hours at the clinic in Electra. Coordination with the United Regional Health Care System in Wichita Falls allowed for access to some specialty care in the clinics. A specially care coordination program was put in place for rural providers to provide testing prior to their specialist visit in order to avoid duplication of services and speed specialist office visit time.

OLNEY HAMILTON HOSPITAL (*Olney*) – Increased primary care access

- Opened a rural health clinic in Archer City to provide additional primary care access and opened a Wellness Center in Olney that includes access to Health Coaches – the Center is open to the public

NORTH TEXAS MEDICAL CENTER (*Gainesville*) - Increased primary and behavioral care

- Opened a new behavioral health clinic offering evening and weekend hours and expanded primary care access with additional hours and on-site providers

NACOGDOCHES MEMORIAL HOSPITAL (*Nacogdoches*) – Patient self-health management project

- Implemented an evidence-based self-management program to improve primary and preventative care to the Medicaid and underserved populations

HOPKINS COUNTY HOSPITAL (*Sulphur Springs*) – Reduction of congestive heart failure effects

- Developed and implemented standardized clinical protocols and evidence based care delivery model to improve care transitions focusing on the congestive heart failure patients

EAST TEXAS MEDICAL CENTER (*Carthage*) – Primary care access project

- Increased access to healthcare through extended clinic hours on nights and weekends, recruited a family practice physician and a physician assistant, and added support staff.

FRIO REGIONAL HOSPITAL (*Pearsall*) – Cardiac telemedicine

- Implemented telemedicine to provide patient consultations by a cardiologist for inpatient, outpatient and emergent situations

STARR COUNTY MEMORIAL HOSPITAL (*Rio Grande City*) – Enhanced prenatal care

- Obtained family practice physician with an OB background to provide services in the Rural Health Clinic as well as complete rounds at SCMH and integrate diabetes education in a group setting and optional one-on-one for diabetic, pregnant women, in an effort to promote a healthy pregnancy and decrease complications.

NONE OF THESE RURAL DSRIP PROGRAMS WOULD HAVE OCCURRED IF NOT FOR THE 1115 WAIVER DSRIP FUNDING!

TEACHING HOSPITALS of TEXAS

House Appropriations Committee Chairman John Zerwas

Tuesday, July 25, 2017

Key Points:

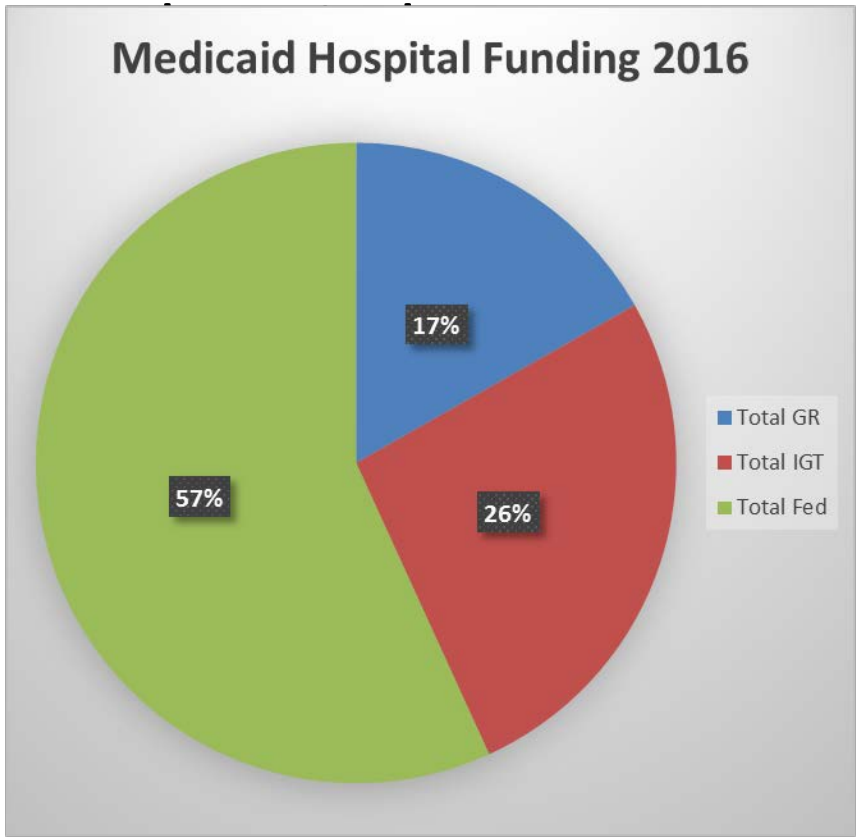
- *Scope of federal Medicaid funding*
- *Related Federal Risks*
- *Medicaid Rates; IGT Dependence & Risk*

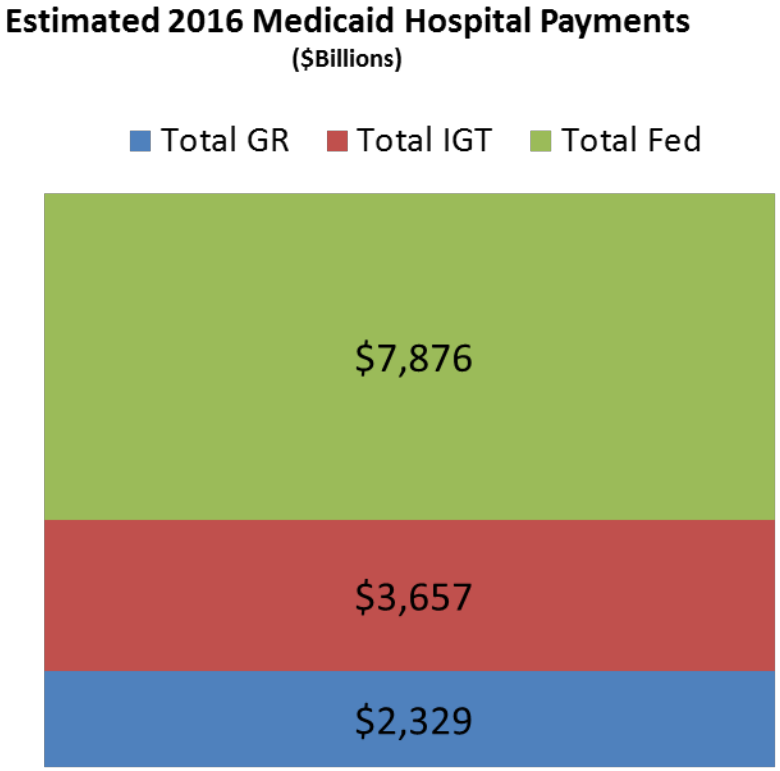
Teaching Hospitals of Texas

Maureen Milligan, President & CEO

Federal Funding – Majority of Texas Medicaid Financing

- Federal Funding - 57% of Medicaid and Uninsured





Included Medicaid base payments plus the UC program and Delivery System Incentive Payment Program (DSRIP) under the 1115 waiver, the DSH program and the Network Adequacy Incentive Payment (NAIP) program payments.

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Federal & State Health Risks

- Adverse impacts to TX:
  - Reductions in federal Medicaid funding (Caps)
  - Policy changes increasing the uninsured
  - Increasing underinsurance (too high deductibles, uncovered costs, etc.)
  - Unfavorable CMS Waiver Funding Decisions (UC/DSRIP)
  - TX property tax caps

Source is HMA analysis of Texas Uncompensated care including provider payments as a percentage of costs.

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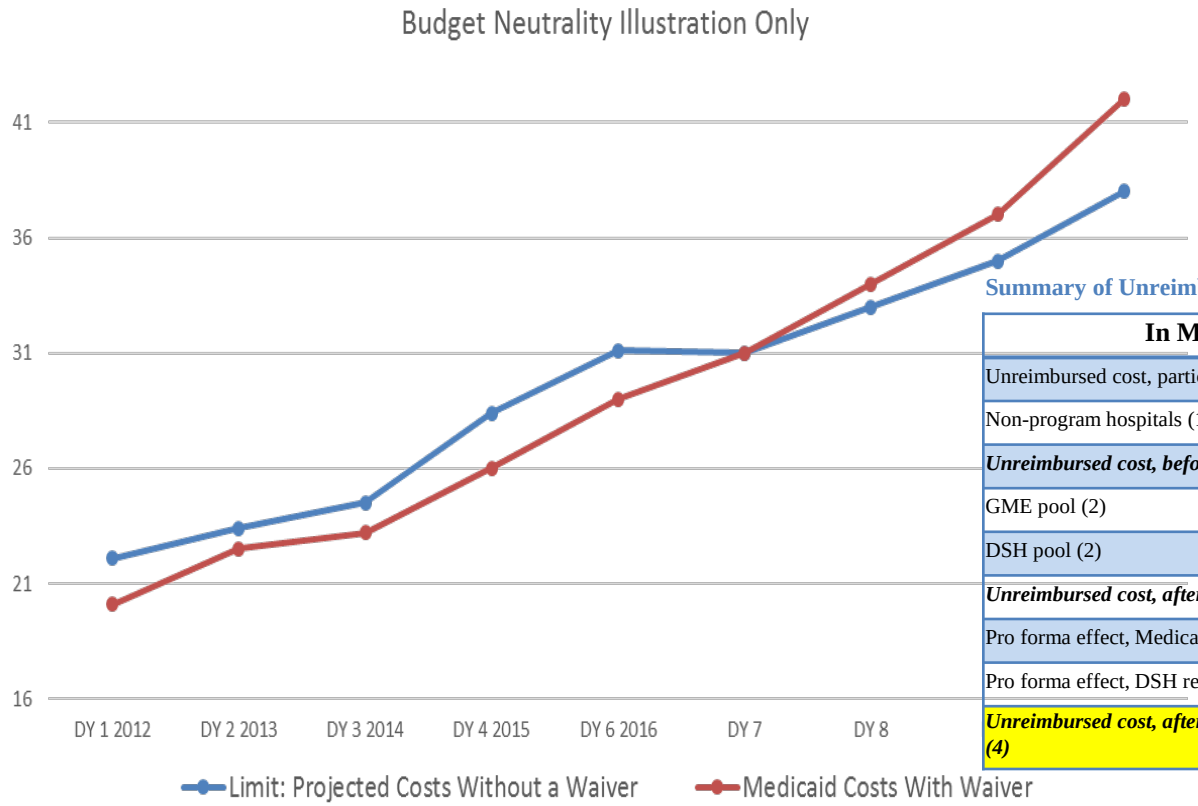
Waiver Risks - Illustration

- Budget Neutrality: Functions as a CAP freezing underfunded Medicaid & uninsured programs.



Summary of Unreimbursed Costs, FY 2017 Pro Forma

In Millions	Medicaid	Uninsured	Total
Unreimbursed cost, participating hospitals (1)	($3,804)	($5,517)	($9,321)
Non-program hospitals (1)	($63)	($221)	($284)
Unreimbursed cost, before supplemental payments	***($3,867)***	***($5,737)***	***($9,605)***
GME pool (2)	$31	$0	$31
DSH pool (2)	$560	$1,162	$1,722
Unreimbursed cost, after supplemental payments	***($3,277)***	***($4,575)***	***($7,852)***
Pro forma effect, Medicaid expansion	$0	$0	$0
Pro forma effect, DSH reductions (3)	$0	($749)	($749)
Unreimbursed cost, after pro forma adjustments (4)	***($3,277)***	***($5,324)***	***($8,601)***

- Already limiting TX' ability to make payments - UHRIP.

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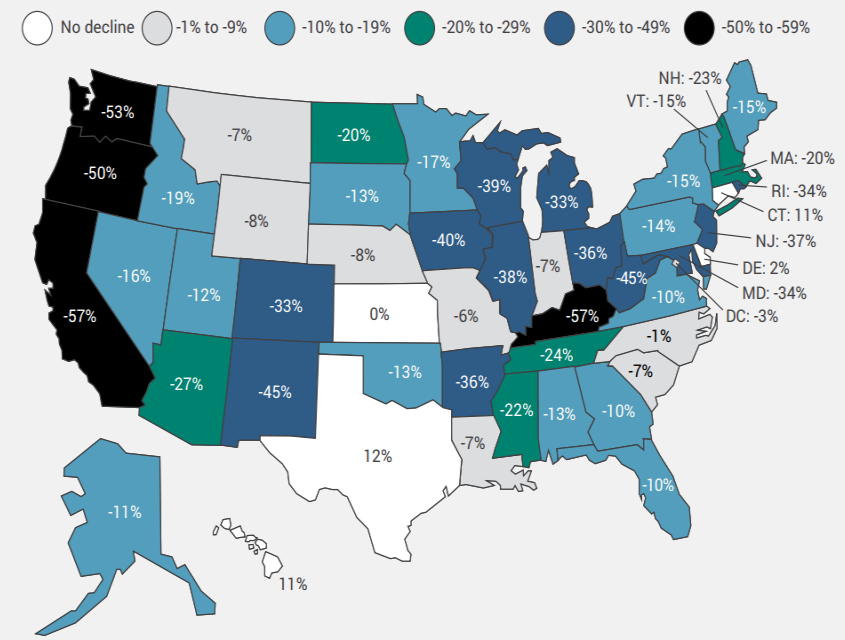
Waiver Risks

- Budget Neutrality
- Higher uncompensated care & Texas uninsured rates – TX demographics
- DSRIP – Phase down & uninsured %
- Waiver Method of Finance – possible federal disallowance
- Provider budget cycles and funding instability
- Uncertainty at the federal level overshadows this discussion & highlights the need for as much stability as possible at the state and local levels.

FIGURE 2-2. Percent Decline in Uncompensated Care as a Share of Hospital Operating Expenses by State, 2013–2014



Note: Medicare cost reports define uncompensated care as charity care and bad debt.

Source: MACPAC, 2017, analysis of Medicare cost reports.

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Considering Flexibility

- Waiver funding today – critical, but if there is insufficient budget neutrality or flexibility and elimination of DSRIP:
- Should TX consider a different path? E.g., hospital carve out to improve ability to manage & fund Medicaid & uninsured?
  - Need transition for provider funding and stability.
  - Need options for uninsured.
  - Self-funded rate increases? UPL?
  - Not limited by rules disallowing directed payments to providers?
  - More flexibility for value-based payment methodologies with providers?
  - Providers directly manage costs & innovation as in DSRIP?

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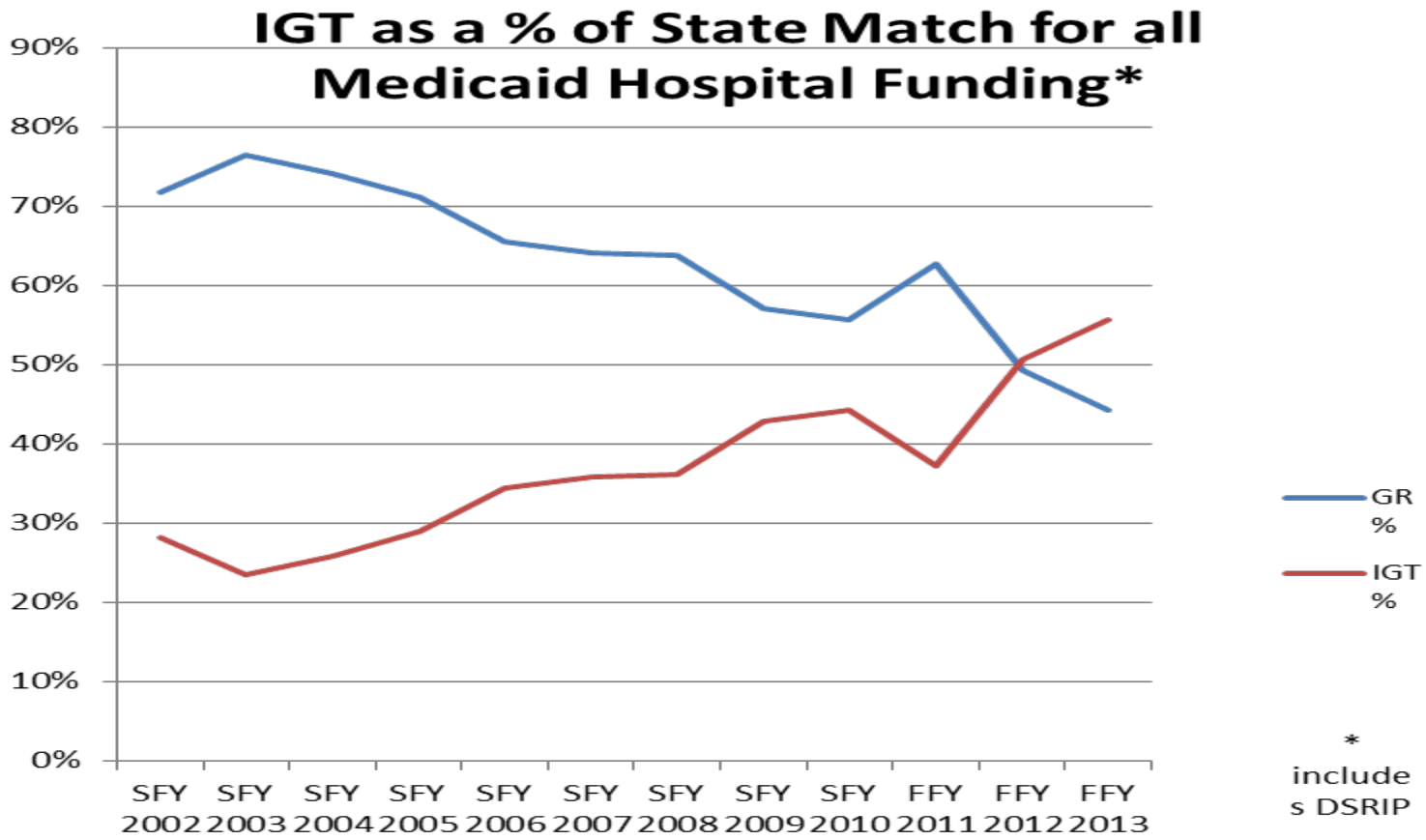
IGT & Counties: Substantial Medicaid Hospital Payers



Only six counties provide the bulk of IGT match funding for the Medicaid Hospital payments to all TX hospitals: (DSH, Waiver UC and Waiver DSRIP): Bexar, Dallas, El Paso, Harris, Tarrant and Travis

Texas Hospital Losses At Current State & Federal Funding Levels

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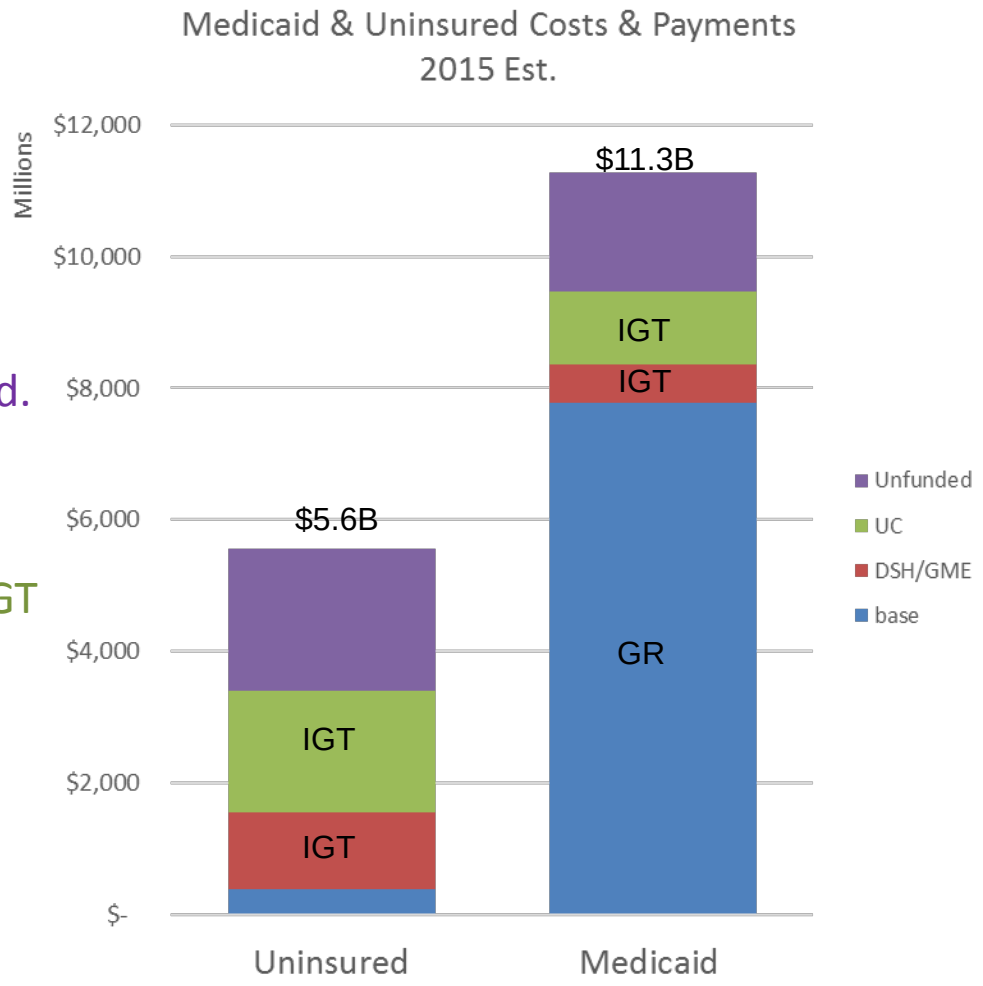
Medicaid

- GR –funded rates pay only 68% of Medicaid costs.
- Supplemental funding (largely property taxes / IGT) supports 15% of Medicaid costs
- 16% of Medicaid costs are unfunded.

Uninsured costs @ hospitals:

- 54% unfunded
- 39% supported with property tax/IGT
- 7% other funding

Hosp. Costs for:	Uninsured	Medicaid
	$5,563,230,520	$11,286,783,508
Funding:		
GR Base Rates	$388,999,991	$7,767,426,386
DSH/GME (IGT)	$1,162,344,913	$590,739,310
UC (IGT)	$1,839,581,802	$1,107,539,283
Unfunded	$2,172,303,814	$1,821,078,529



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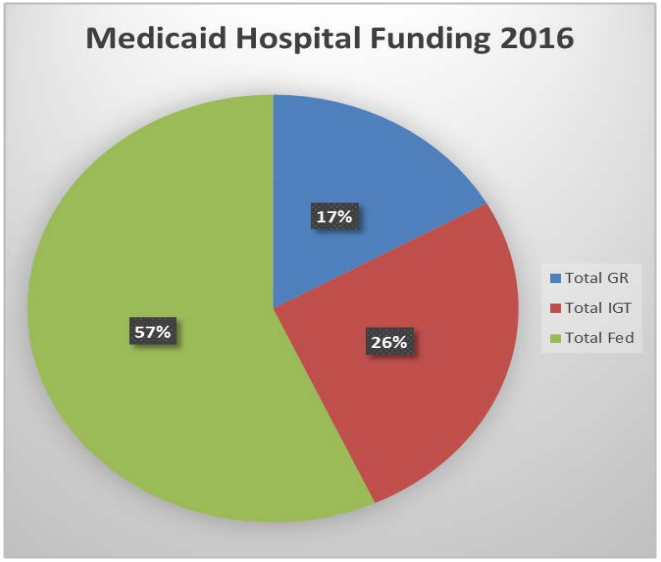
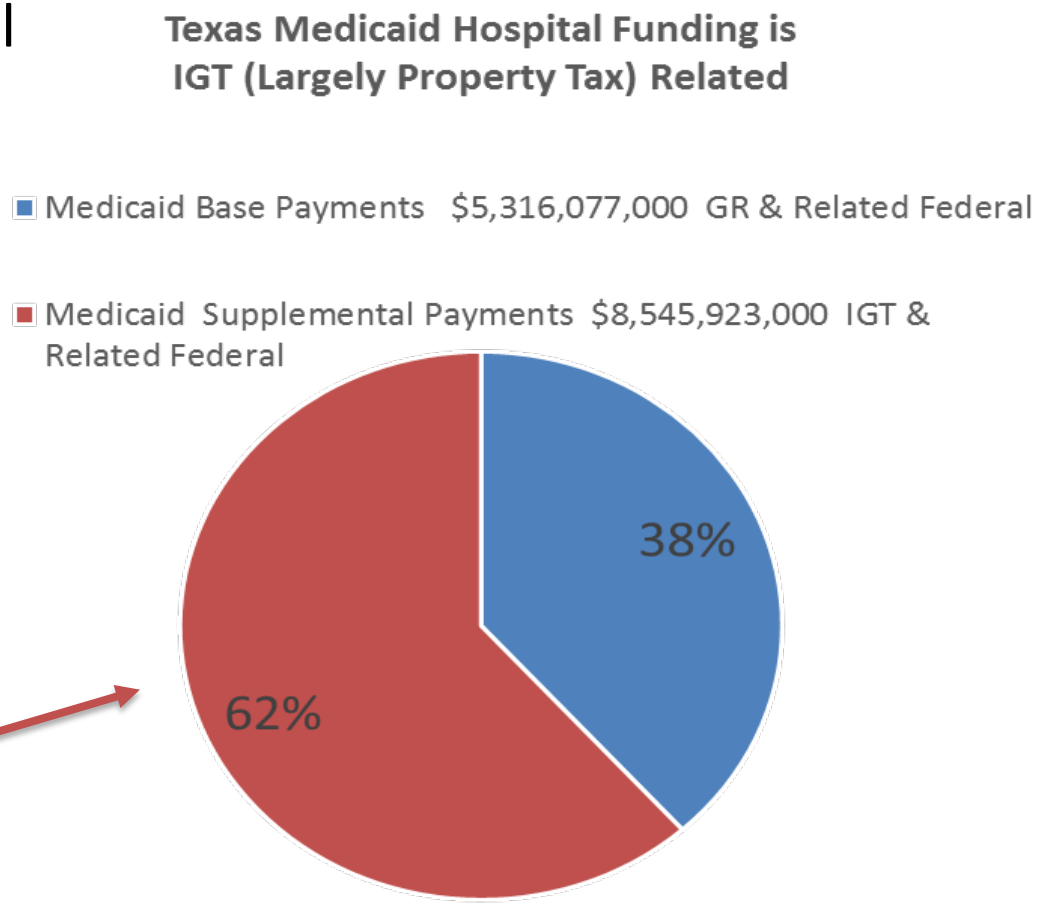
Medicaid Hospital Funding is Largely IGT (Property Tax) Financed

(rather than GR Financed)

- IGT + Federal > GR + Federal





- IGT Primarily from just 6 Texas Counties:

  Bexar, Dallas, El Paso, Harris, Tarrant and Travis

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Your Hospital Districts Provide Essential Healthcare for all Texans

- Significant coverage for uninsured Texans and those on Medicaid
- Complex and life saving trauma and tertiary care
- Training our doctors and health care providers, including Graduate Medical Education (GME) residencies
- Significant levels of outpatient care – because that's most cost-effective
- 1115 Transformation Waiver leadership, funding, and innovation
- 11 of the State's 20 Anchors are THOT members including the large urban transferring hospitals
- Support for 62% of Medicaid funding for uninsured and for Medicaid hospital payments through IGT and supplemental payments

Many of these services funded locally – underfunded by Medicaid and Feds

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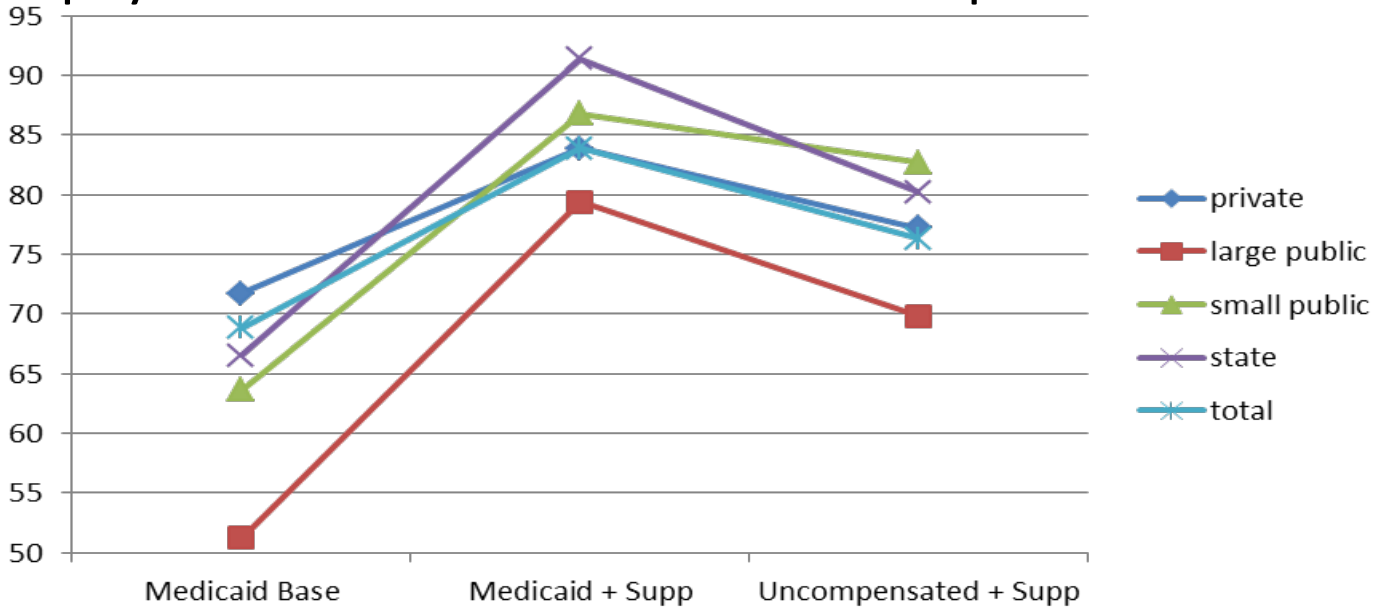
IGT Partners are Critical But Paid Less by Medicaid

- Biggest six hospital districts fund most IGT but receive less in Medicaid payments than other Medicaid hospitals.



2015 Medicaid Hospital Payments as a % of Costs	Number of Hospitals	Medicaid Base Payments only	Medicaid with Supplemental Pools	Uncompensated Care and Supplemental Pools
Private	230	71.7%	83.9%	77.2%
Large Public	6	51.2%	79.4%	69.8%
Small Public	102	63.6%	86.8%	82.7%
State	18	66.5%	91.4%	80.2%
Total	***356***	***68.8%***	***83.9%***	***76.3%***

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Seek support for GR-Neutral Flexibility

- Biggest six hospital districts and Medicaid funders receive less (% of cost) in Medicaid payments than other groups of Medicaid hospitals.
- To support system stability & IGT capacity by allowing these systems to address inequity by self-matching existing unfunded costs, e.g.,
  - Uniform Hospital Rate Enhancement (self funded rate increase that benefits all participating hospitals – public, private, urban, rural).
  - Unfunded GME: IGT for a share of the estimated $417 M in unfunded hospital GME costs (2015 est.)

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Appendix

THOT: What We Do Together

We are 4% of Texas Hospitals and represent 16% patient days; but provide:

- 21% of Medicaid Patient Days
- 30% of outpatient care at Texas Hospitals
- 36% of unfunded (including uninsured) care
- 58% of Level I trauma centers and nearly 50% of unfunded trauma care
- 63% of Hospital Based GME Residencies in TX

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THOT: One Shared Mission Based on Three Shared Commitments

- Supporting access to care for all in our communities with a special focus on vulnerable populations;
- Providing and coordinating essential community health systems, such as trauma and disaster management;
- Preparing for the future by training tomorrow's healthcare providers and supporting health research and healthcare transformation.

TEACHING HOSPITALS of TEXAS

Contact Information

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House Appropriations Committee Hearing

KEVIN WARREN

PRESIDENT/CEO

TEXAS HEALTH CARE ASSOCIATION

JULY 25, 2017

THCA
Texas Health Care Association

Texas Medicaid and Better Care Reconciliation Act (BCRA)

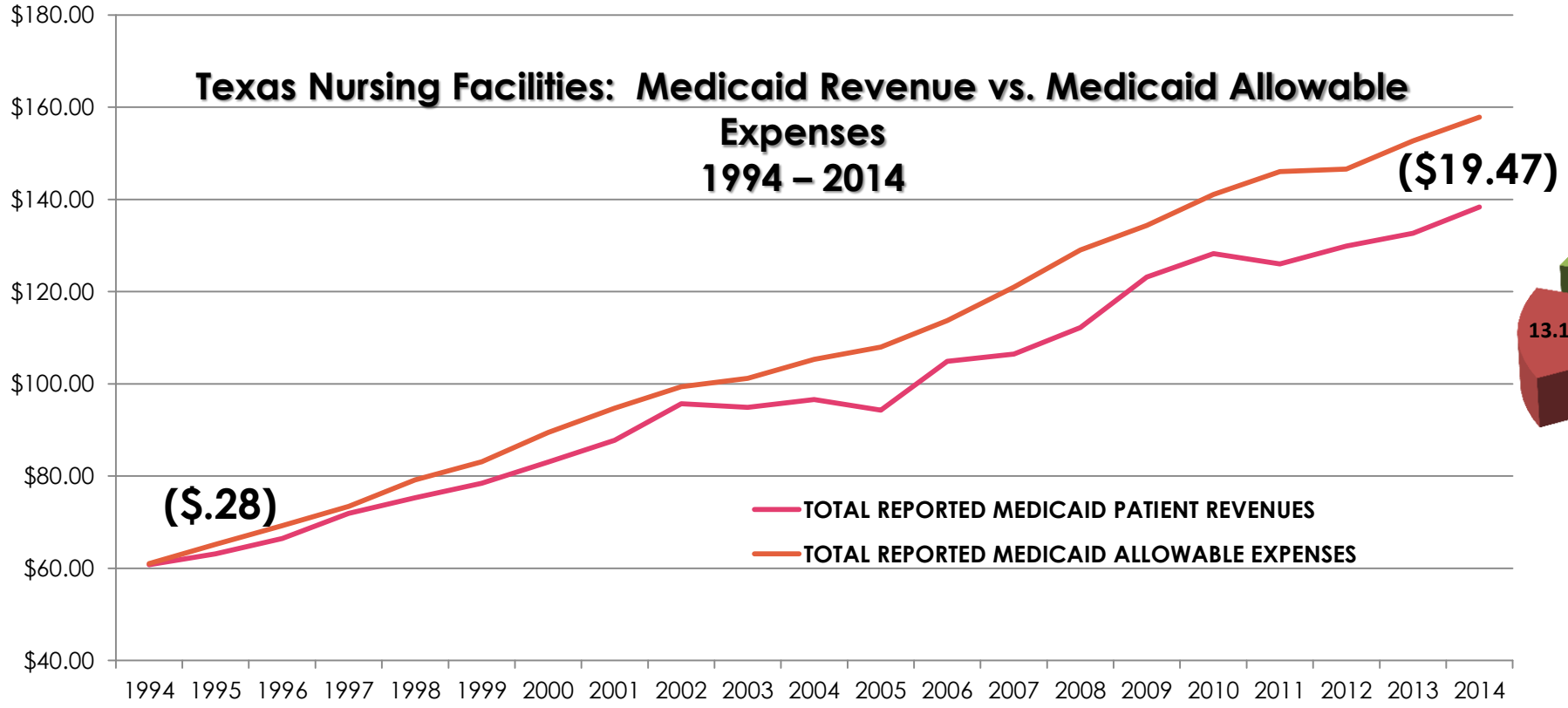
- The Medicaid growth rate for aged and disabled populations is reduced beginning in 2025.
- Reduction to CPI-U in 2025 estimated as a 20% reduction to providers.
- Texas Long Term Care Impact (FFS data only)*
  - Estimated Reduction from CPI-U drawdown: **$71,399,906**
  - Amount reduction per Building: **($58,333)**

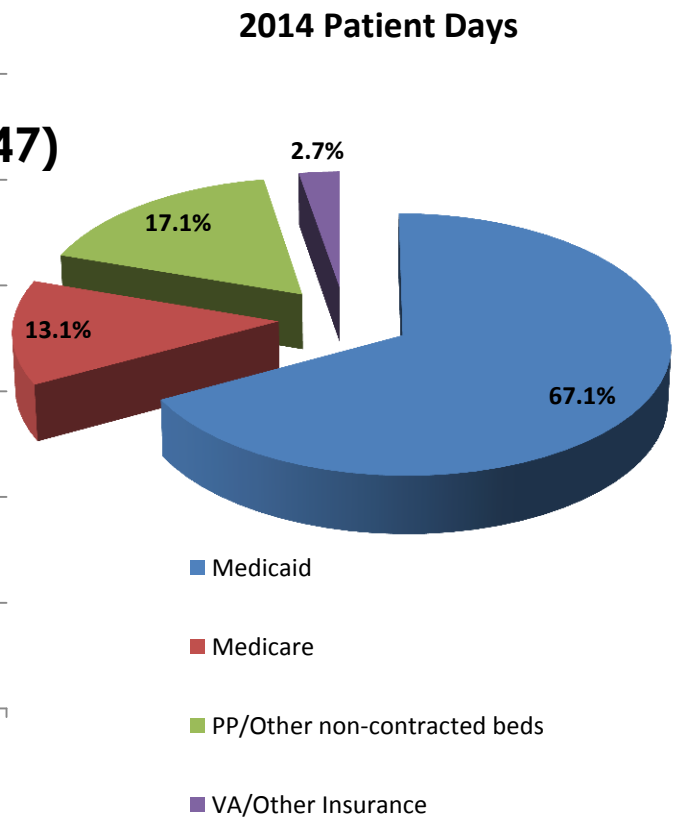
- **Impact: Increased uncompensated care for providers, potential reduced economic activity and negative impact on job growth** *(source: Avalere presentation to the NGA)*

**Spending and related cuts are understated in states with Medicaid managed long term care and Dual Demonstration Programs*

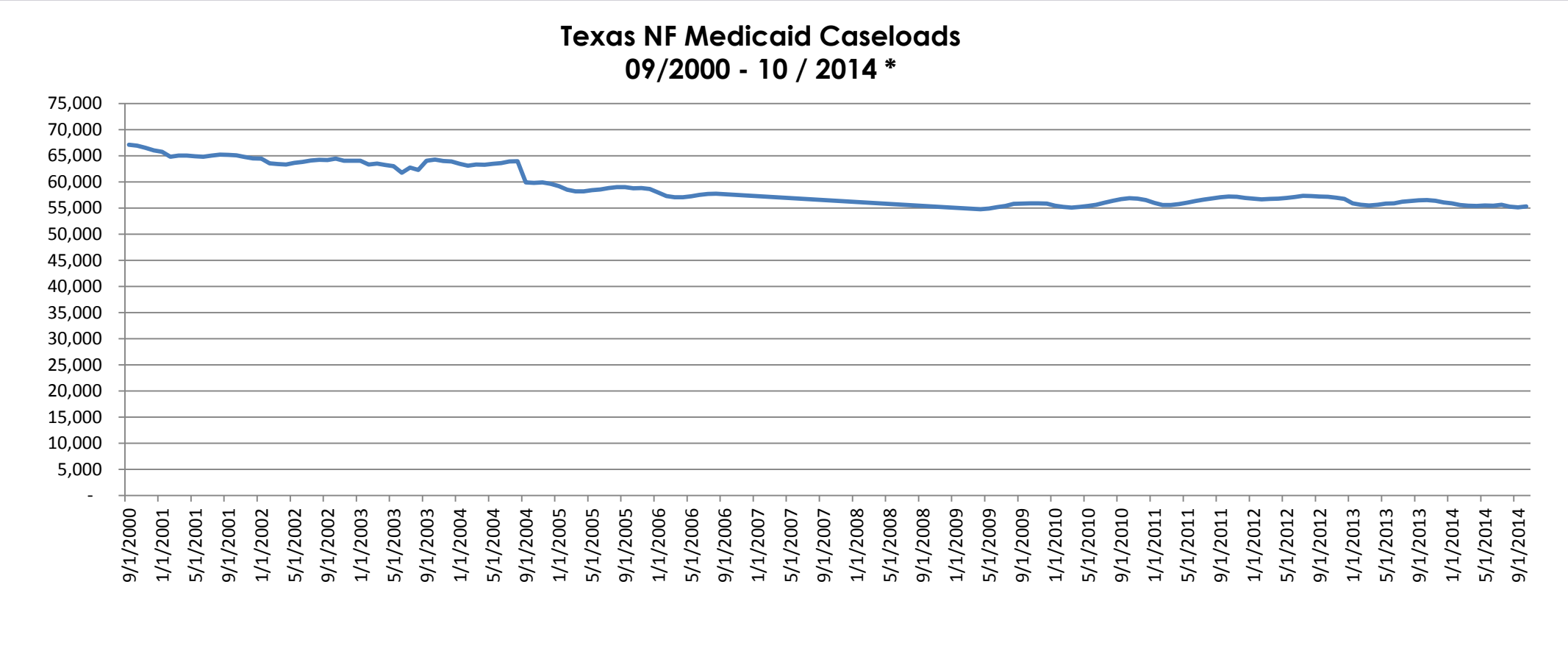
Source: American Health Care Association (AHCA)

Texas Medicaid and Long Term Care





Medicaid Caseload Growth in Long Term Care



Uncompensated Care and Cost Shifting

HHSC Consolidated Budget	Average Medicaid Rate	Average Private Pay	% Medicaid to Avg Private Pay
CB 2014-2015 (FY 2010 CR Data)	$127.80	$133.57	95.68%
CB 2016-2017 (FY 2012 CR Data)	$129.63	$147.79	87.71%
CB Request 2018-2019 (FY 2014 CR Data)	$138.44	$159.80	86.63%
% Inc. 2010 vs 2014	8.33%	19.64%	

Based upon HHSC Consolidated Budget, the private pay daily rate has increased 19.64% from FY 2010 to FY 2014 compared to 8.33% for Medicaid over the same timeframe.

§19.504 Equal Access to Quality Care in Medicaid-Certified Facilities

(a) A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services…for all individuals regardless of source of payment

1115 Waiver (Supplemental Payments) Quality Incentive Payment Program (QIPP)

- QIPP encourages nursing facilities to improve the quality and innovation of their services, using the CMS 5-star rating system as its measure of success for the following 4 measures: High-risk long-stay residents with pressure ulcers
  - Long-stay residents who received an antipsychotic medication
  - Long-stay residents experiencing one or more falls with major injury
  - Long-stay residents who were restrained
- Program allocation:
  - January 2017 - $664M
  - March 2017 - $400M (reduction attributed to budget neutrality concerns)
- To be implemented September 2017

Source: HHSC

House Appropriations Committee Hearing
Medicaid and ACA
by
Amanda Fredriksen
July 25, 2017

My name is Amanda Fredriksen and I am Associate State Director for Advocacy and Outreach with AARP. I appreciate the opportunity to share AARP's perspective on potential impacts related to federal action to Medicaid and the Affordable Care Act. Although my comments today will focus on long term care, Medicaid is our nation's health and long term care safety net. As a result, it plays a vital role in providing health and long term care to many vulnerable individuals with nowhere else to turn.

Unpaid Family Caregivers Provide More Long Term Care than all of Medicaid Funding

As you look to a growing need for long term services and supports, at AARP we think it is important to acknowledge the role of unpaid family caregivers and consider what can be done to help unpaid family caregivers continue caring for their loved ones. There are more than 3.4 million Texans who care for a family member or loved one, helping to keep that individual at home and out of a costly institution. We know that once someone enters a nursing facility, even as private pay, most eventually spend down their assets and eventually need help from Medicaid.

Unpaid family caregivers provide an estimated 3.2 billion hours of care annually – about $34 billion dollars' worth of care, if the state and federal government were paying for it. The care they provide, all $34 billion dollars' worth, is priceless. They provide this care because it's what families do for each other. Yet these unpaid caregivers are also making great sacrifice to keep their loved ones out of costly institutions. Some family caregivers must leave their jobs, they sacrifice their own financial security, and often their own health.

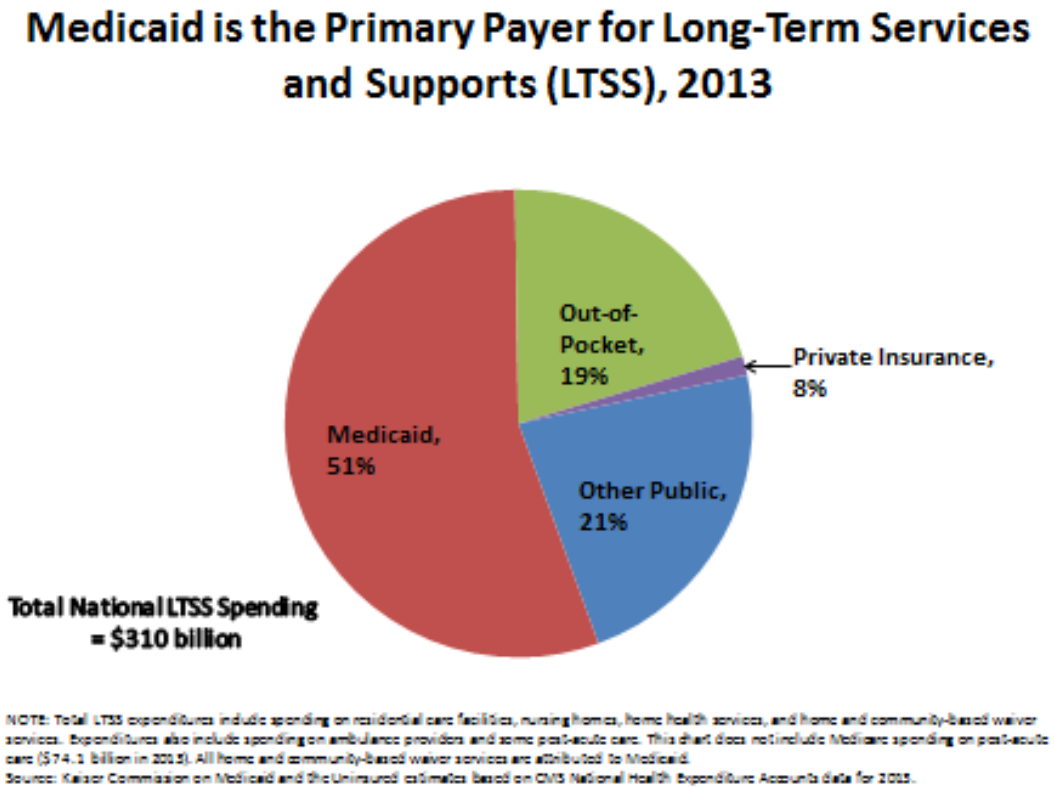
It is much more cost effective for the state to help unpaid family caregivers keep doing what they are doing for their loved ones, by offering respite care, encouraging employers to offer caregiver leave, or other supports that help keep these caregiving going.

Who pays for long term services and supports.

- Long term care is expensive. The average private pay cost for a semi-private room in a Texas nursing home is $4,502 per month ($54,000 annually) and $5,931 per month for a private room ($71,000 annually).

- Medicare does not pay for long term services and supports. Medicare pays for limited skilled nursing facility care and home health care generally tied to an acute care hospital stay. Medicare covers up to a maximum of 100 days of skilled nursing care after a hospital stay. Medicare coverage of home health care must be medical in nature and ordered by a physician. Medicare does not cover ongoing personal care or help with activities of daily living (eating, bathing, dressing, toileting, meal prep).

- Few people have private insurance for long term care. Many consumers find they are unable to sustain the costs of long term care insurance long enough to benefit from the policy. Long term care insurance is generally purchased when an individual is in their 50s or 60s and the services are not accessed for 20, 30 or even 40 years. During those years, the policyholder must continue to pay premiums and premiums often increase at a time when the policy holder's income is flat or declining due to retirement. As a result, many people who purchase the policies ultimately drop the policy before they receive any benefit.



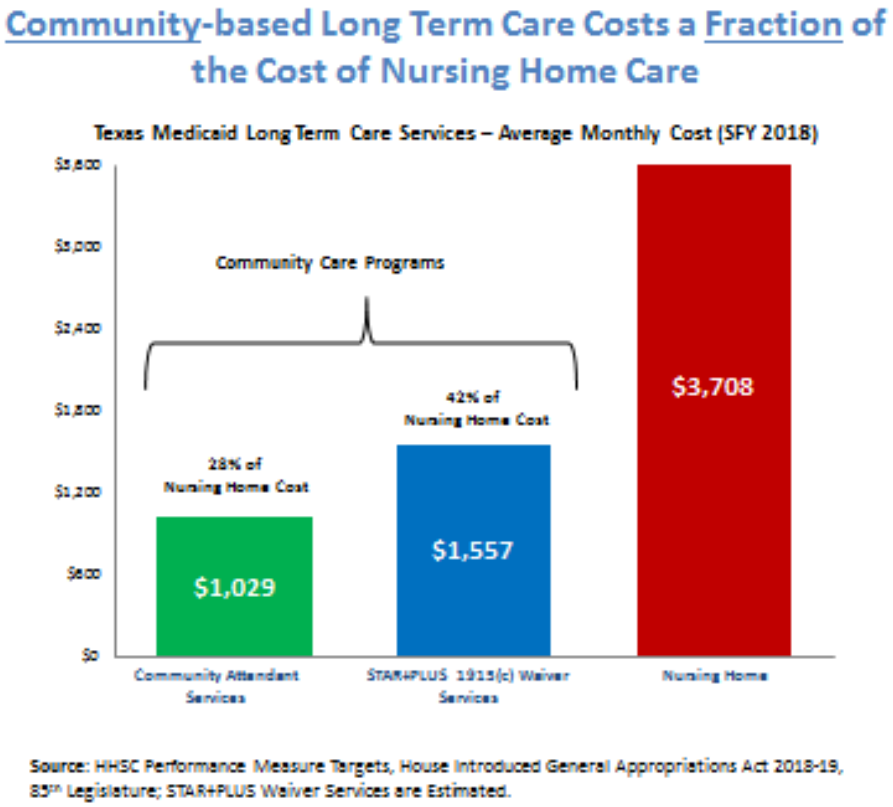
Medicaid Is the middle class long term care insurance program.

- Nationwide, Medicaid is the largest payer of long term care services and supports, paying for just over 50 percent. Medicaid helps seniors and others who need nursing home care or care at home when they have exhausted their savings and their income doesn't cover the cost of their care.

- Medicaid helps pay for LTSS but so do consumers. Seniors who get help from Medicaid for long term services and supports are making substantial contributions to the cost of their care. Nursing home residents on Medicaid contribute all monthly income, except for $60, toward the cost of their nursing home care. Their copay equals all of their income, every month. Medicaid pays the difference between the individual's monthly income and the Medicaid payment rate. When Medicaid nursing home and community care clients die, Medicaid can place on a lien on their property to recoup the state's costs through the Medicaid Estate Recovery program.

Texas Medicaid has done a good job promoting cost effective community care.

Texas Medicaid nursing home resident census has stayed relatively flat in spite of the growth in the 65+ population. This flat growth in Medicaid nursing home residents is at least partly due to the fact that Texas has been a leader in promoting community based care, an optional Medicaid service. Community care is a win for the state because it costs a fraction of nursing home care and it is a win for the consumer because it reflects their preference to remain in the community.



Source: HHSC Performance Measure Targets, House Introduced General Appropriations Act 2018-19, 85th Legislature; STAR+PLUS Waiver Services are Estimated.

1

There are opportunities to stretch Medicaid dollars that make more sense than cutting people off from services they need.

Proposals to change Medicaid to a block grant or per capita caps are focused on meeting a budget target not designing cost effective programs that meet the needs of our most vulnerable. These proposals raise more questions than they answer, while shifting more financial burden to the states under the guise of flexibility. How would the state address care for people needing long term services and supports, but unable to pay the cost? Is it realistic to ask seniors to contribute more toward the cost of their care? Does it make sense to offer less community care, given how cost effective it is relative to nursing home care?

- Block Grants do not account for changes in Medicaid enrollment. Block grants would provide states a fixed amount of federal funds that would not change based on enrollment. Under a block grant, states would likely have discretion to determine which populations and services they cover. States would be at risk for covering expenses that exceed block grant funds. This puts Texas at risk in the event of an economic downturn or other cause of higher-than-anticipated enrollment, for example, the economic downturn associated with the great recession that began in June 2008 and ran through June 2010.

- Per capita caps would likely not meet the needs of Texans receiving Medicaid. Medicaid provides health and LTSS to a broad range of populations, including low-income seniors and children and adults with disabilities. In addition, the care needs of Medicaid enrollees can also vary significantly. As a result, it would be difficult to set a per capita cap that would appropriately serve Texans who rely on Medicaid to meet their health care and LTSS needs. Because per capita caps are based on historical spending on Medicaid, such caps would also likely lock in the current variation of federal dollars sent to the states indefinitely—even with health care costs consistently rising faster than inflation.

- Repeal of the ACA would jeopardize funding for cost-effective programs like Community First Choice. The ACA provides enhanced matching dollars for states that expanded access to community care through the Community First Choice Program. If the ACA is repealed, presumably the authority for Community First Choice and the enhanced match go away.

- HHSC could do more to hold Star+Plus MCOs accountable through performance measures and contracts to make sure the state is getting what it is paying for. Poor quality of care drives costs up elsewhere, including more hospital stays. A recent AARP Long Term Services and Supports Score Card ranked Texas 46th in the number of long-stay nursing home residents with a hospitalization and 49th on home health patients with a hospitalization. High rates of

hospitalizations are a reflection of poor quality care because they suggest that resident care needs are not being identified early and addressed.

- HHSC and MCOs can do more to divert people from nursing homes and access more cost effective care in the community.

    - The same LTSS Score Card ranked Texas 49th in percent of new nursing home stays lasting 100 days or more (24.7 percent). After 100 days, these stays are either private pay or Medicaid stay. Doing more to help consumers locate services in the community rather than transitioning to a long-stay nursing home stay is highly cost effective for the state and the consumer.

    - The state could also do more to encourage assisted living as an alternative to nursing homes, particularly for nursing home residents who are identified as having low care needs. The AARP LTSS Score card identified about 12 percent of Texas nursing home residents as having low care needs. Keeping in mind the goal of caregiving for individuals in the least restrictive setting possible, many of these low care needs individuals may be better served in the community or in assisted living. The state and the Star+Plus managed care plans have done very little to develop assisted living as a true option for Medicaid long term care clients. Assisted living costs substantially less than nursing home care and provides consumers with a community centered environment. HHSC could be doing more to encourage Star+Plus MCOs to utilize assisted living where appropriate for the consumer.

Thank you for the opportunity to testify. AARP would welcome the opportunity to discuss these issues in more detail.

For More Information, Contact:
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ADAPT of Texas

Testimony to House Appropriations

Tuesday, July 25, 2017

Good Morning. My name is Bob Kafka. I am an Organizer for ADAPT of Texas.

ADAPT is a statewide activist disability rights organization committed to the integration of people with disabilities into all Texas communities.

My testimony will focus on Medicaid and its critical role it plays in implementing the goals of the Americans with Disabilities Act. Tomorrow is the 27th anniversary of the ADA signed by President George HW Bush. ADA is our civil rights bill.

Community integration of people with disabilities is the goal of the ADA.

We believe Health Care is a Right NOT a Privilege.

We have heard the argument that the federal government is too involved in the provision of health care looking at the expenditures of Medicaid and Medicare.

If proponents of this free market model in health care were consistent they would be advocating for the elimination of the the VA health care system. A true model of socialized medicine. They aren't!

This is personal for me. I spent a year of my life in the Bronx VA after breaking my neck. I owe my life to the government run health care system.

Back to Medicaid:

You may ask how does Medicaid a funding source for healthcare relate to the ADA, a civil rights bill.

Along with funding of our acute medical needs it funds our long term services and support needs. Almost 150,000 people with disabilities and seniors use Medicaid funding for support services to live in the community, age in place. We believe living and receiving services and supports in the most integrated setting is a civil rights issue.

Texas under the current Medicaid funding model is already under funding Medicaid approximately $1billion dollars. We have long waiting lists for all our current Medicaid waivers like StarPlus, HCS, CLASS etc.

Since all in home services (HCBS) are optional and institutional services are mandatory these Congressional proposals have a massive institutional bias.

We have crisis in Recruiting and Retaining Community Attendants. Finding Community Attendant at a base rate of $8 an hour will be impossible and cause unnecessary institutionalization.

- Provider rates are already some of the lowest in the country making access to services problematic.

Though new Congressional legislation is supposed to be proposed today in DC , we know many of the principles that it will have by looking at previous proposals:

Reduce Medicaid funding between $700 - $850 billion over 10 years;

Per capita caps harm Texans because it harms our future health care needs by freezing inequities forever. Looks a lot like a Block Grant.

Waivers to eliminate some of the essential health benefits like mental health services;

Allowing waivers to not serve some pre existing conditions;

Allowing high risk pools however premiums and copays would be so high most folks won't be able to afford it.

Sunsets the Community First Choice Option which has kept many people with disabilities and seniors out of nursing facilities and other institutions;

Ah you say what about new flexibility which will save money. All calculations done show that any savings made will never offset the draconian cuts proposed in this legislation and lets not forget the additional $600 Billion reduction in Medicaid funding in President Trump's budget.

Medicaid is already flexible. Each Medicaid Program around the country is different. The National Association of Medicaid Directors as has every national trade association like the AMA have been against these proposals.

Let me now talk about what ADAPT thinks should be done to improve our current Medicaid LTSS system:

ADAPT supports the continued expansion of StarPlus with the caveat that Community Integration Performance Indicators be created and enforced. Use the Ronald Reagan quote: “Trust BUT Verify” We think a truly integrated delivery system can save money however without accountability “Power Corrupts Absolute Power Corrupts Absolutely”

The MCO's have enormous market power over our lives. We have for almost a decade asked HHSC to implement these Performance Indicators nothing has been done.

Provide incentives to promote Consumer Directed Services. StarPlus has an abysmal record in providing CDS. This can save administrative dollars. We also believe a vibrant agency model should be funded.

There is a crisis in Recruiting and Retaining Community Attendants. This is another issue HHSC has known about but has done almost nothing. We know that if a person can keep a Community Attendant for a long time it will avoid that person getting secondary medical conditions like decubiti.

Lastly I want to close on a problem many in the advocacy community have recently experienced. I have been on many advisory committees and know the role we play. We get to make recommendations based on info given to us and the agency folk accept or reject our recommendations. Now HHSC gives us information on policies the staff has already made decisions on. I recently resigned from the PIAC Committee because I felt we were being tokenized by the leadership of HHSC.

Maybe direction from y'all to HHSC would send a message that consumer input is critical in developing important policies that effect our lives.

Again thank you for the opportunity to testify.

For an Institution and Barrier Free Texas

Bob Kafka for the

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The Potential Impact of the Better Care Reconciliation Act on Home and Community-Based Services Spending

H. Stephen Kaye, Ph.D.

Executive Summary

The second "Discussion Draft" of the Senate's Better Care Reconciliation Act (BCRA), released on July 13, 2017, retains provisions contained in the prior version that would cap Federal Medicaid reimbursements to the states on a per-enrollee basis. The caps would be based largely on 2016 spending, adjusted for inflation, and would go into effect in 2020. The amount of the cap would increase each subsequent year, at first keeping pace with inflation in healthcare costs and then, beginning in 2025, increasing more slowly than the rise in healthcare costs.

Added to the second version of the bill is a new home and community-based services (HCBS) demonstration program that would allow states to apply for additional funding, with a total budget of $8 billion over four years. As in the prior version, the bill would end the enhanced Federal reimbursement rate for the Community First Choice Option, a new HCBS program introduced in the Affordable Care Act.

Because HCBS are not a mandated part of each state's Medicaid program, it is likely that these services would be among the first to be cut if caps were to be imposed. In this report, we estimate the extent to which per-enrollee caps on Medicaid reimbursements would likely have influenced state HCBS spending, had such caps been imposed during the decade of the 2000s.

We find that:

- Caps would have caused HCBS spending on people with physical disabilities, seniors, and others with non-developmental disabilities to have been reduced by between 23 and 30 percent after 9 years.
- Caps would have caused states to reduce spending on HCBS for people with intellectual and developmental disabilities by an initial 11 percent, rising to as much as 16 percent after 9 years.
- If caps had been imposed in 2005, annual HCBS spending on all populations would have been reduced below actual spending by as much as $18 billion by 2013. Adjusting for inflation in healthcare costs, which typically double over a 15-year period, these reductions are projected to be as much as $36 billion per year in 2028 dollars.
- Over the nine years of caps, total HCBS spending would have been reduced below actual by between $72 and $98 billion. Adjusting for inflation to 2020-28 dollars, **reductions would total between $149 and $202 billion.**
- A new HCBS demonstration program budgeted at $8 billion total would replace only about 4 percent of the potential $202 billion in reduced expenditures.
- The 8 states offering a Community First Choice program in 2015 received $453 million through an enhanced Federal match of their program spending. Eliminating the enhanced match would reduce Federal HCBS spending by a minimum of $5.5 billion over 10 years, adjusted for inflation. The Congressional Budget Office, assuming substantial growth in the program because of the enhanced match, estimates a $19 billion reduction in Federal HCBS spending through the elimination of the match.

Background

The decade of the 2000s saw rapid growth in state Medicaid spending on home and community-based services. Part of the growth was due to increased numbers of beneficiaries receiving such services, and part was due to increased spending per enrollee, due to both program changes and inflation in healthcare and social service costs. Nearly all states increased HCBS spending during the period, and many did so rapidly over a few years, as they developed new programs, made infrastructure investments, or offered a more robust package of benefits to serve people with higher levels of need. As a result, there were growth spurts in HCBS spending in many states, with per-enrollee amounts increasing by about 50 percent or more over a one- or two-year period, followed by a longer period of stability or modest growth. When state budgets became tight beginning in 2009, as a result of the Great Recession, the growth in HCBS spending slowed considerably.

The Better Care Reconciliation Act proposes to cap Federal Medicaid reimbursements to the states on a per-enrollee basis, effectively limiting growth to a rate that at first only modestly exceeds the rate of inflation and then falls below inflation. The cap would be set according to each state's 2016 per-enrollee spending, inflation-adjusted for each subsequent year. Caps would take effect in 2020. The inflation adjustment for 2016 to 2019 is the consumer price index for medical care (CPI-MC) for all types of enrollees, including people with disabilities and seniors who receive HCBS. Between 2020 and 2024, adjustments depend on enrollment category: the adjustment for people with disabilities and seniors is set at CPI-MC plus 1 percentage point, and the adjustment for other enrollment categories is CPI-MC. Beginning in 2025, the inflation adjustment is greatly reduced to the Consumer Price Index for all items, which does not take into account the higher growth rate of healthcare costs. Over the past ten years, the growth in the Consumer Price Index for all items averaged 1.8 percent per year, and the CPI-MC increased by an average of 3.3 percent per year.

For most people who receive HCBS, it is by far the largest component of their Medicaid spending. If the BCRA were to be enacted, it is reasonable to assume that most states would limit HCBS spending to the per-enrollee cap amount; otherwise, any excess comes entirely out of the state budget.

Methods

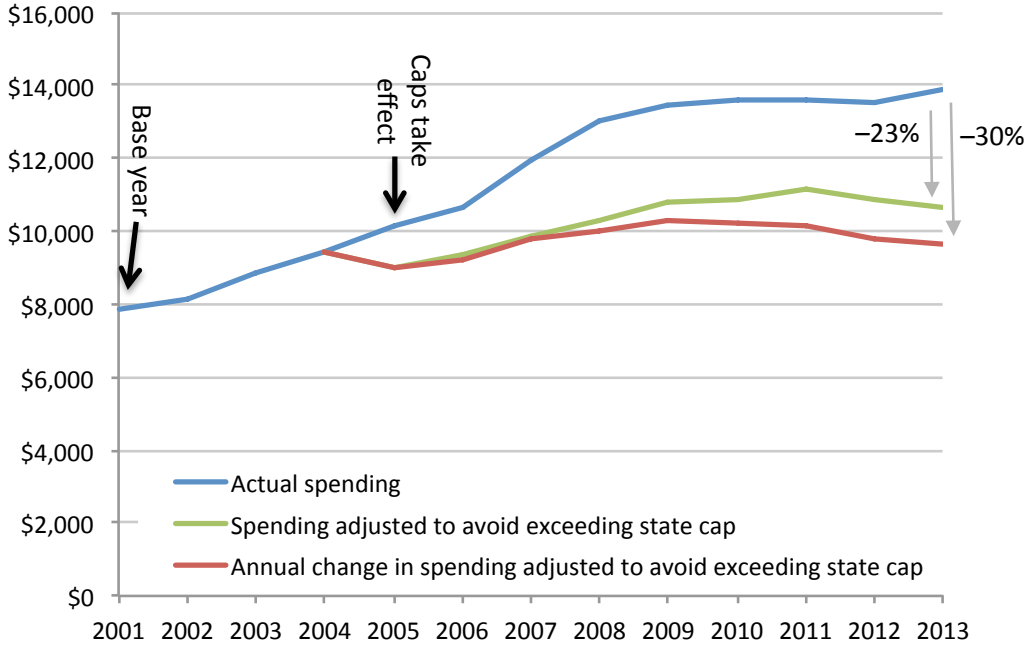
For this analysis, we used all publicly available data for 2001–2013 on state per-enrollee spending on 1915(c) waiver programs and state plan personal care services programs. Expenditure data come from the annual Truven Health Analytics reports,[1] and number of participants in the two programs comes from the Kaiser Family Foundation and the University of California San Francisco.[2]

Spending was analyzed separately for enrollees with and without intellectual or developmental disabilities (I/DD). The analysis for enrollees without I/DD includes all state spending on personal care services programs and 1915(c) waiver programs other than for people with I/DD. The analysis for enrollees with I/DD is of 1915(c) waiver programs specifically targeted to that population.

Because of data limitations, other HCBS programs are not included; data for a few states include extrapolated numbers in the final years of the time period, due to shifting of participants to a managed care or Community First Choice program. Data from all states and the District of Columbia were used, except for those states with unavailable or inconsistent data due to the use of managed care arrangements (Arizona, Rhode Island, and Vermont; Hawaii, Minnesota, and Wisconsin were also excluded from the non-I/DD analysis).

We developed two scenarios of the impact that hypothetical BCRA-like reimbursement caps might have had on Medicaid spending, under the assumption that states would not exceed their per-enrollee cap. In both scenarios, we treated 2001 as the baseline year (equivalent to 2016 in the BCRA), and 2005 as the year that caps would have been implemented (equivalent to 2020). Following the procedure proposed in the BCRA, caps were inflation-adjusted using the

Figure 1. Average annual HCBS spending per non-I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



CPI-MC of the data years (i.e., we applied CPI-MC to the base-year spending for 2002-04, CPI-MC plus 1 percentage point for 2005–09, and CPI all items to 2010–13).

In Scenario 1, per-enrollee spending in any year is the lower of actual spending or the cap amount. The impact of the cap is therefore assumed to be limited to the years in which the actual spending exceeded the cap.

In Scenario 2, each state's actual, year-to-year percent increase (or decrease) in per-enrollee spending is applied to the prior year's spending, unless that change would have caused the per-enrollee spending to exceed the cap. In that case, per-enrollee spending is set to the cap level, and the following year's percent increase (or decrease) is applied to that amount. Thus, the impact of the cap extends to future years, because increases that were limited by the cap are not made up by additional increases in subsequent years.

Results

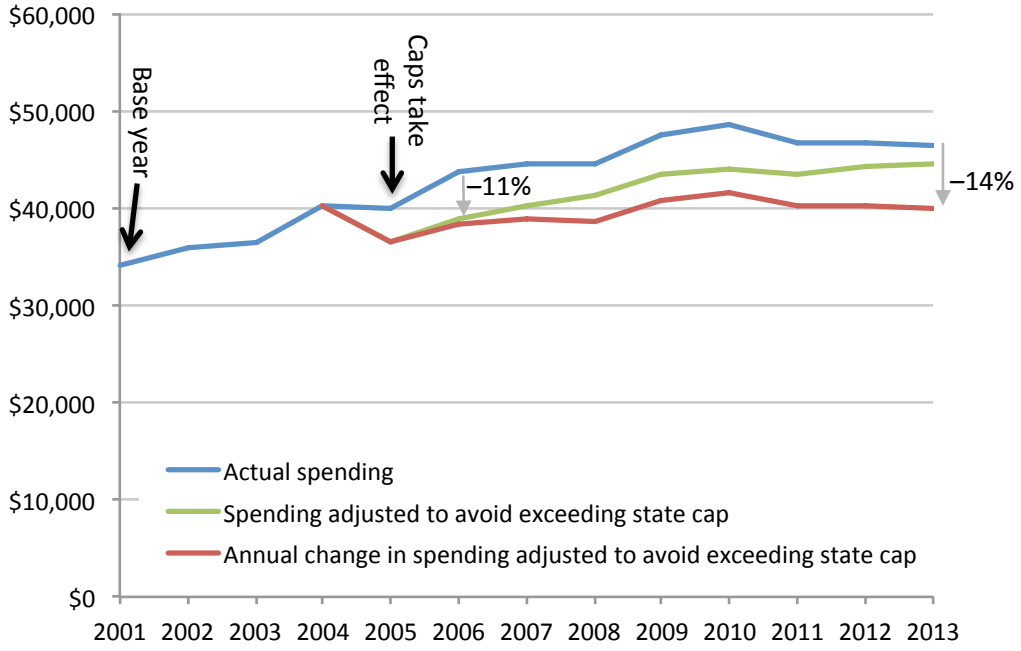
In spending for non-I/DD beneficiaries, 38 out of the 49 states with full or partial data (including DC as a "state") exceeded the hypothetical cap in at least one year between 2005 and 2013; 33 exceeded the cap in 6 or more of those years (see Table 1). Initially low-spending states are especially subject to seeing growth impacted by the caps. The five states with the least amount of per-enrollee spending in 2001 (DC, SD, OK, MI, and MO) all exceeded the cap amount over the entire period.

The blue line in Figure 1 shows the average national per-enrollee HCBS spending for programs targeted to people without I/DD. As caps take effect, spending in both scenarios begins to diverge substantially from actual spending. By 2013, spending under Scenario 1 (green line) is 23 percent less than actual spending. Spending under Scenario 2 (red line) is 30 percent less.

Using the 2013 figure for U.S. non-I/DD HCBS expenditures ($44.4 billion[1]), a 23- to 30-percent reduction translates to between $10.3 and $13.5 billion less spending over a single year.

With respect to I/DD spending, most states (32 of the 49 with full or partial data) had per-enrollee spending above the hypothetical cap in one or more years, as indicated in Table 1. Once again, the states spending the least per enrollee in the "base year" of 2001 (DC, MS, FL, NV, GA) would have been particularly hard hit by

Figure 2. Average annual HCBS spending per I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



the caps, exceeding them in all or nearly all years and by quite substantial amounts.

Figure 2 shows national per-enrollee spending data for I/DD beneficiaries. With fewer growth spurts among these more established programs, the impact of caps is somewhat less dramatic but still substantial. Both scenarios diverge from actual spending as soon as the hypothetical caps take effect, with spending at 11 percent less by the second year. Spending under Scenario 1 begins to catch up to actual spending by 2013. Scenario 2, in contrast, remains low, with 2013 spending at 16 percent below actual.

With I/DD spending at $30.7 billion[1] in 2013, a reduction of between 4 and 14 percent would mean between $1.3 and $4.2 billion less spent on I/DD services.

Altogether, annual HCBS spending for all populations would have been reduced by between $11.6 and $17.7 billion, in 2015 dollars. Across all nine years of the hypothetical caps, total HCBS expenditures would have been reduced by between $72.3 (Scenario 1) and $98.3 billion (Scenario 2).

Conclusions

If per-enrollee caps like those proposed in the Better Care Reconciliation Act had been imposed in the mid-2000s, they would likely have caused many states to restrict HCBS spending to amounts far lower than spending under existing Medicaid reimbursement rules. States spending the lowest amounts initially—those likely most in need of improvement—would have been among the hardest hit, either in terms of reduced Federal reimbursements or having to abandon plans for building a more robust HCBS system.

Indeed, states that invested heavily in HCBS infrastructure, expanded benefits to serve people with higher needs, or created new HCBS programs would probably have become far less ambitious had Federal match been capped. A capped reimbursement would have discouraged states, especially laggard states, from innovating in delivering the types and amounts of services that could meet people's needs.

The consequences would have been readily apparent: Without their long-term services and supports needs met, more people would have been institutionalized, and those remaining in

their homes would have been more isolated, experienced worse health, and been prevented from participating in their communities. The great success of HCBS program expansion in enabling people to continue living at home and promoting successful community integration would have been seriously jeopardized.

References

1. Eiken S, Sredl K, Burwell B et al. Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015. Cambridge, MA: Truven Health Analytics, 2017.

2. Ng T, Harrington C, Musumeci M et al. Medicaid Home and Community-Based Service Programs: 2013 Data update. Issue Paper. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2016.

Funding

The Community Living Policy Center is funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (grant 90RT5026) and the Administration for Community Living, U.S. Department of Health and Human Services. Opinions are those of the author and not the funders.

Table 1. Maximum amount and number of years during which state HCBS expenditures exceeded hypothetical AHCA-like cap, 2005–13

	Non-I/DD expenditures		I/DD expenditures	
	Max. % > cap	Years > cap	Max. % > cap	Years > cap
Alabama	21.6	7	30.8	9
Alaska	45.9	9	—	—
Arkansas	22.5	8	25.4	9
California	24.5	7	—	—
Colorado	22.4	9	—	—
Connecticut	38.8	9	49.0	4
Delaware	—	—	14.1	8
District of Columbia	97.0	9	96.3	9
Florida	55.6	7	29.6	9
Georgia	27.7	6	32.3	7
Hawaii*	7.7	1	30.8	9
Idaho	28.3	3	—	—
Illinois	36.1	9	4.2	1
Indiana	7.0	1	—	—
Iowa	34.5	9	8.8	9
Kansas	—	—	—	—
Kentucky	31.9	6	4.7	1
Louisiana	23.9	3	26.6	5
Maine	55.0	9	23.2	2
Maryland	38.4	9	10.1	2
Massachusetts	—	—	22.4	7
Michigan	16.0	9	—	—
Minnesota	31.2	9	21.8	9
Mississippi	45.1	9	55.8	9
Missouri	26.6	9	26.1	9
Montana	—	—	—	—
Nebraska	10.3	4	—	—
Nevada	17.8	7	46.2	9
New Hampshire	9.2	9	17.0	1
New Jersey	—	—	40.1	9
New Mexico	1.9	1	—	—
New York	40.6	9	19.8	8
North Carolina	—	—	—	—
North Dakota	—	—	2.7	1
Ohio	—	—	—	—
Oklahoma	43.0	9	—	—
Oregon	23.1	8	—	—
Pennsylvania	40.4	9	0.3	1
Rhode Island*	—	—	25.9	4
South Carolina	21.2	6	21.8	8
South Dakota	48.8	9	0.5	1
Tennessee	56.6	6	42.3	9
Texas	53.7	9	—	—
Utah	57.3	6	1.4	2
Virginia	30.4	9	13.2	8
Washington	—	—	26.4	9
West Virginia	25.8	6	8.8	2
Wisconsin	—	—	—	—
Wyoming	33.8	9	—	—

*Analysis includes 2005–08 only.
Consistent data not available for Arizona or Vermont.

The Potential Impact of the Medicaid Caps on Home and Community-Based Services Spending in Texas

H. Stephen Kaye, Ph.D.

Community Living Policy Center

Executive Summary

Medicaid caps would severely impact spending on home and community-based services in Texas, where more than 120,000 people rely on these services to remain in their homes, avoid institutionalization, and participate in their communities.

- If Medicaid caps similar to those in the Republican healthcare bill had been enacted in the decade of the 2000s, Texas would have seen annual Federal reimbursements reduced by about 54 percent after 9 years, or about $1.5 billion per year.
- The total drop in Federal Medicaid reimbursements over the 9-year period would have been nearly $8 billion.
- If Texas had limited HCBS spending to the amount allowed under the cap, per-enrollee spending would have dropped by $11,000 after 9 years.
- In addition to the reductions due to Medicaid caps, the legislation proposes to eliminate enhanced Federal reimbursement for the Community First Choice Option. This change would have cost Texas $21 million in Federal reimbursements 2015.

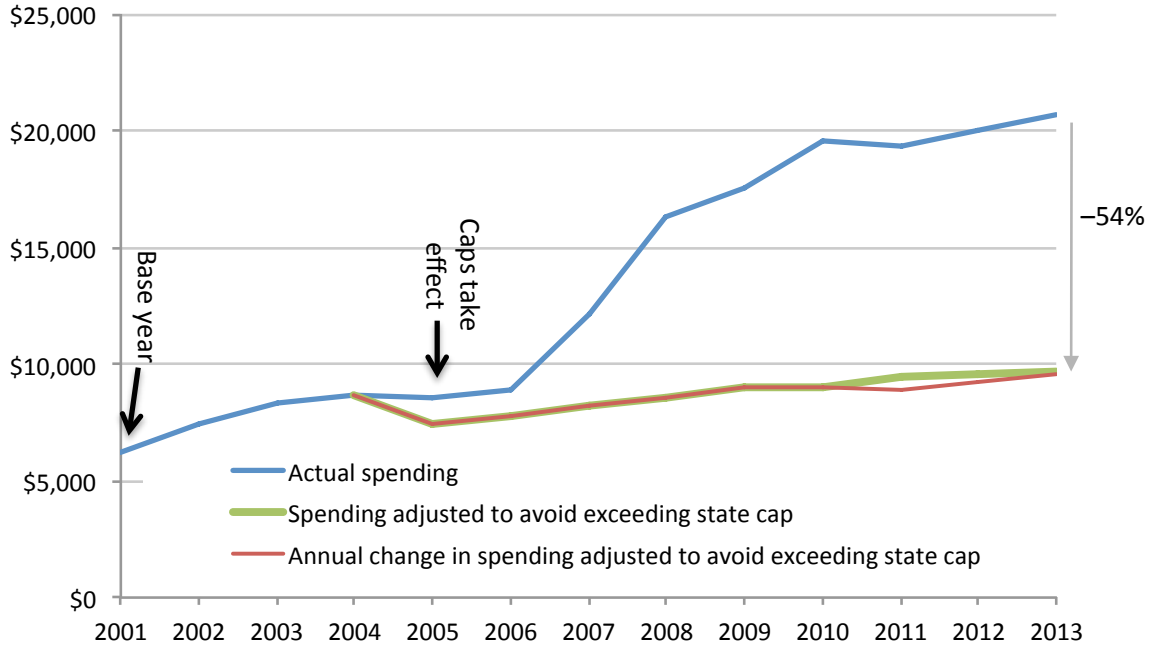
Background

The decade of the 2000s saw rapid growth in state Medicaid spending on home and community-based services (HCBS). Part of the growth was due to increased numbers of beneficiaries receiving such services, and part was due to increased spending per enrollee, due to both program changes and inflation in healthcare and social service costs. Nearly all states increased HCBS spending during the period, and many did so rapidly over a few years, as they developed new programs, made infrastructure investments, or offered a more robust package of benefits to serve people with higher levels of need. As a result, there were large growth spurts in HCBS spending in Texas and many other states, with per-enrollee amounts increasing by about 50 percent or more over a short period.

The Better Care Reconciliation Act (BCRA) proposes to cap Federal Medicaid reimbursements to the states on a per-enrollee basis, effectively limiting growth to a rate that at first only modestly exceeds the rate of inflation and then falls below inflation. The cap would be set according to each state's 2016 per-enrollee spending, inflation-adjusted for each subsequent year. Caps would take effect in 2020. The inflation adjustment for 2016 to 2019 is the consumer price index for medical care (CPI-MC) for all types of enrollees, including people with disabilities and seniors who receive HCBS. Between 2020 and 2024, adjustments depend on enrollment category: the adjustment for people with disabilities and seniors is set at CPI-MC plus 1 percentage point, and the adjustment for other enrollment categories is CPI-MC. Beginning in 2025, the inflation adjustment is greatly reduced to the Consumer Price Index for all items, which does not take into account the higher growth rate of healthcare costs.[1] Over the past ten years, the growth in the Consumer Price

[1] This procedure reflects the author's understanding of the provisions of the Senate "Discussion Draft" of the BCRA, released June 22, 2017.

Figure 1. Average annual HCBS spending per Texas non-I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



Index for all items averaged 1.8 percent per year, and the CPI-MC increased by an average of 3.3 percent per year.

For most people who receive HCBS, it is by far the largest component of their Medicaid spending. If the BCRA were to be enacted, it is reasonable to assume that most states would limit HCBS spending to the per-enrollee cap amount; otherwise, any excess comes entirely out of the state budget.

Methods

For this analysis, we used all publicly available data for 2001–2013 on state per-enrollee spending on 1915(c) waiver programs and state plan personal care services programs. Expenditure data come from the annual Truven Health Analytics reports,[1] and number of participants in the two programs comes from the Kaiser Family Foundation and the University of California San Francisco.[2] The analysis includes all state spending on personal care services programs and 1915(c) waiver programs other than for people with intellectual or other developmental disabilities (I/DD).

We developed two scenarios of the impact that hypothetical BCRA-like reimbursement caps might have had on Medicaid spending, under the assumption that states would not exceed their per-enrollee cap. In both scenarios, we treated 2001 as the baseline year (equivalent to 2016 in the BCRA), and 2005 as the year that caps would have been implemented (equivalent to 2020). Following the procedure proposed in the BCRA, caps were inflation-adjusted using the CPI-MC of the data years (i.e., we applied CPI-MC to the base-year spending for 2002-04, CPI-MC plus 1 percentage point for 2005–09, and CPI all items to 2010–13).

In Scenario 1, per-enrollee spending in any year is the lower of actual spending or the cap amount. The impact of the cap is therefore assumed to be limited to the years in which the actual spending exceeded the cap.

In Scenario 2, each state's actual, year-to-year percent increase (or decrease) in per-enrollee spending is applied to the prior year's spending, unless that change would have caused the per-enrollee spending to exceed the cap. In that case, per-enrollee spending is set to the cap level, and the following year's percent increase (or decrease) is applied to that amount. Thus, the impact of the cap extends to future years, because increases that were limited by the cap

are not made up by additional increases in subsequent years.

Results

Texas HCBS spending exceeded the hypothetical cap by a large amount in every year. An immediate 13 percent reduction in expenditures would have been necessary (or the state would have had to make up the difference) in the first year of the caps, with the gap between actual and capped spending widening in subsequent years. By 2010, actual spending was more than double the amount that would have been reimbursable under the cap.

The blue line in Figure 1 shows Texas per-enrollee HCBS spending, excluding I/DD programs. On average, spending on each enrollee more than doubled between 2006 and 2010, compared to an increase in the cap of only 16 percent. By 2013, spending under Scenario 1 (green line) is 53 percent less than actual spending. Spending under Scenario 2 (red line) is 54 percent less. This is among the largest gaps seen in any state.

Conclusions

If per-enrollee caps like those proposed in the Better Care Reconciliation Act had been imposed in the mid-2000s, they would likely have caused Texas, as well as many other states, to restrict HCBS spending to amounts far lower than spending under existing Medicaid reimbursement rules. States like Texas that invested heavily in HCBS infrastructure, expanded benefits to serve people with higher needs, or created new HCBS programs would probably have become far less ambitious had Federal match been capped. A capped reimbursement would have discouraged states, from innovating in delivering the types and amounts of services that could meet people's needs.

The consequences would have been readily apparent: Without their long-term services and supports needs met, more people would have been institutionalized, and those remaining in their homes would have been more isolated, experienced worse health, and prevented from participating in their communities. The great success of HCBS program expansion in enabling people to continue living at home and promoting successful community integration would have been seriously jeopardized.

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Funding

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The Potential Impact of the Better Care Reconciliation Act on Home and Community-Based Services Spending

Community Living Policy Center

H. Stephen Kaye, Ph.D.

The decade of the 2000s saw rapid growth in state Medicaid spending on home and community-based services (HCBS). Part of the growth was due to increased numbers of beneficiaries receiving such services, and part was due to increased spending per enrollee, due to both program changes and inflation in healthcare and social service costs. Nearly all states increased HCBS spending during the period, and many did so rapidly over a few years, as they developed new programs, made infrastructure investments, or offered a more robust package of benefits to serve people with higher levels of need. As a result, there were growth spurts in HCBS spending in many states, with per-enrollee amounts increasing by about 50 percent or more over a one- or two-year period, followed by a longer period of stability or modest growth. When state budgets became tight beginning in 2009, as a result of the Great Recession, the growth in HCBS spending slowed considerably.

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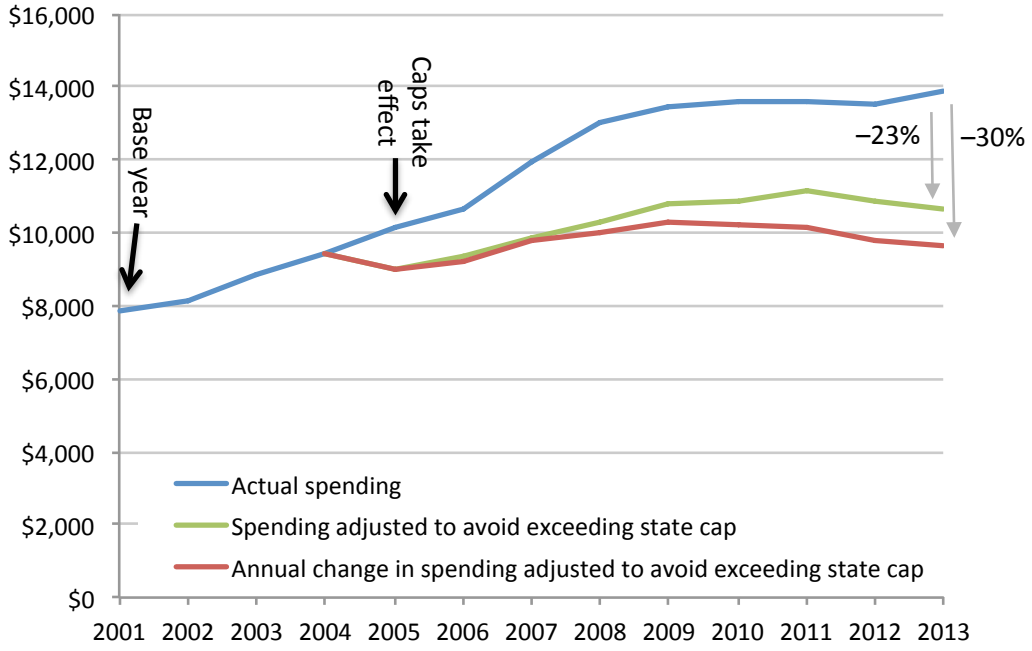
[1] This procedure reflects the author's understanding of the provisions of the Senate "Discussion Draft" of the BCRA, released June 22, 2017.

Figure 1. Average annual HCBS spending per non-I/DD enrollee, 2001–13, actual and reduced as if BCRA caps had been in place



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In Scenario 2, each state's actual, year-to-year percent increase (or decrease) in per-enrollee spending is applied to the prior year's spending, unless that change would have caused the per-enrollee spending to exceed the cap. In that case, per-enrollee spending is set to the cap level, and the following year's percent increase (or decrease) is applied to that amount. Thus, the impact of the cap extends to future years, because increases that were limited by the cap are not made up by additional increases in subsequent years.

Results

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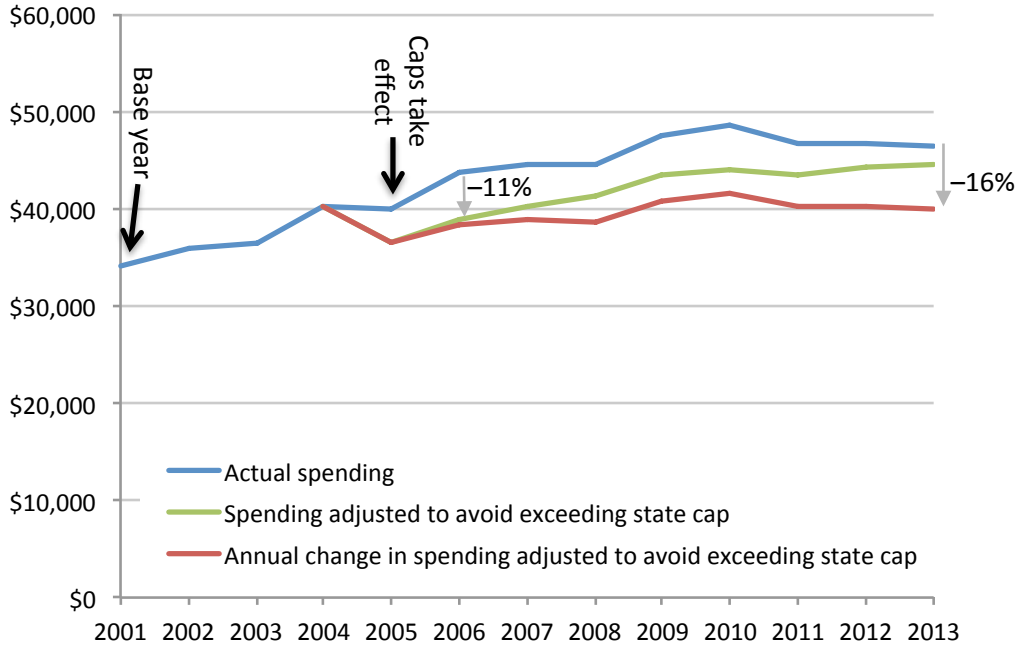

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With respect to I/DD spending, most states (32 of the 49 with full or partial data) had per-enrollee spending above the hypothetical cap in one or more years, as indicated in Table 1. Once again, the states spending the least per enrollee in the "base year" of 2001 (DC, MS, FL, NV, GA) would have been particularly hard hit by the caps, exceeding them in all or nearly all years and by quite substantial amounts.

Figure 2 shows national per-enrollee spending data for I/DD beneficiaries. With fewer growth spurts among these more established programs, the impact of caps is somewhat less dramatic but still substantial. Both scenarios diverge from actual spending as soon as the hypothetical caps take effect, with spending at 11 percent less by the second year. Spending under Scenario 1 begins to catch up to actual spending by 2013. Scenario 2, in contrast, remains low, with 2013 spending at 16 percent below actual.

Conclusions

If per-enrollee caps like those proposed in the Better Care Reconciliation Act had been imposed in the mid-2000s, they would likely have caused many states to restrict HCBS spending to amounts far lower than spending under existing Medicaid reimbursement rules. States spending the lowest amounts initially—those likely most in need of improvement—would have been among the hardest hit, either in terms of reduced Federal reimbursements or having to abandon plans for building a more robust HCBS system.

Indeed, states that invested heavily in HCBS infrastructure, expanded benefits to serve people with higher needs, or created new HCBS

programs would probably have become far less ambitious had Federal match been capped. A capped reimbursement would have discouraged states, especially laggard states, from innovating in delivering the types and amounts of services that could meet people's needs.

The consequences would have been readily apparent: Without their long-term services and supports needs met, more people would have been institutionalized, and those remaining in their homes would have been more isolated, experienced worse health, and prevented from participating in their communities. The great success of HCBS program expansion in enabling people to continue living at home and promoting successful community integration would have been seriously jeopardized.

References

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Table 1. Maximum amount and number of years during which state HCBS expenditures exceeded hypothetical AHCA-like cap, 2005–13

	Non-I/DD expenditures		I/DD expenditures	
	Max. % > cap	Years > cap	Max. % > cap	Years > cap
Alabama	21.6	7	30.8	9
Alaska	45.9	9	—	—
Arkansas	22.5	8	25.4	9
California	24.5	7	—	—
Colorado	22.4	9	—	—
Connecticut	38.8	9	49.0	4
Delaware	—	—	14.1	8
District of Columbia	97.0	9	96.3	9
Florida	55.6	7	29.6	9
Georgia	27.7	6	32.3	7
Hawaii*	7.7	1	30.8	9
Idaho	28.3	3	—	—
Illinois	36.1	9	4.2	1
Indiana	7.0	1	—	—
Iowa	34.5	9	8.8	9
Kansas	—	—	—	—
Kentucky	31.9	6	4.7	1
Louisiana	23.9	3	26.6	5
Maine	55.0	9	23.2	2
Maryland	38.4	9	10.1	2
Massachusetts	—	—	22.4	7
Michigan	16.0	9	—	—
Minnesota	31.2	9	21.8	9
Mississippi	45.1	9	55.8	9
Missouri	26.6	9	26.1	9
Montana	—	—	—	—
Nebraska	10.3	4	—	—
Nevada	17.8	7	46.2	9
New Hampshire	9.2	9	17.0	1
New Jersey	—	—	40.1	9
New Mexico	1.9	1	—	—
New York	40.6	9	19.8	8
North Carolina	—	—	—	—
North Dakota	—	—	2.7	1
Ohio	—	—	—	—
Oklahoma	43.0	9	—	—
Oregon	23.1	8	—	—
Pennsylvania	40.4	9	0.3	1
Rhode Island*	—	—	25.9	4
South Carolina	21.2	6	21.8	8
South Dakota	48.8	9	0.5	1
Tennessee	56.6	6	42.3	9
Texas	53.7	9	—	—
Utah	57.3	6	1.4	2
Virginia	30.4	9	13.2	8
Washington	—	—	26.4	9
West Virginia	25.8	6	8.8	2
Wisconsin	—	—	—	—
Wyoming	33.8	9	—	—

*Analysis includes 2005–08 only.
Consistent data not available for Arizona or Vermont.

Medicaid Per Capita Caps:

A Cut in Sheep's Clothing

By: Jennifer Lav

Introduction

For more than 50 years, Medicaid has efficiently provided health care to low income individuals and families through a unique federal-state partnership, with the federal government contributing a guaranteed amount of each dollar a state spends on Medicaid.[1] On June 22, 2017, Republicans released the Senate version of their health care bill, called the Better Care Reconciliation Act of 2017 ("BCRA"). BCRA, like the House's American Health Care Act ("AHCA"), proposes to terminate this open-ended federal-state partnership through the use of the use of per capita caps ("caps").[2] Medicaid caps divorce funding from states' actual expenditures, replacing a funding guarantee with an artificial cap, and forcing states to massively cut health care. While full analysis of BCRA's economic impact on states is not yet available, BCRA's cuts to Medicaid will be deeper than AHCA's in the long run.[3]

Medicaid caps, like the one in BCRA, have been repeatedly dangled in front of federal legislators as a way to slash funding to states under the guise of giving states more flexibility without being upfront about the true costs.[4] Yet fundamentally altering the funding structure of Medicaid to a per capita cap will forever put states at risk for severe cuts and substantial inequities. **The evidence is unmistakable: While BCRA and other per capita cap proposals put forward in recent years differ in details, they all led to same result — a gargantuan cut in federal money to states and arbitrary funding inequities between states.**

Republicans have tried to impose caps before: in 2016, they attempted to impose a cap through a proposal called "A Better Way" ("ABW"). Design differences among these proposals do not change their devastating outcomes. Regardless of the base year or inflation index picked, Medicaid caps like BCRA, AHCA, and ABW permanently codify massive and inequitable cuts in federal funding. Once such fundamental changes are enacted, Medicaid will always be vulnerable: Congress can continually adjust the growth rate to impose even bigger cuts.[5]

I. Medicaid Caps Slash Funding for States

AHCA cuts a colossal $834 billion in federal funding to states by both imposing caps and functionally eliminating Medicaid expansion.[6] Although the Congressional Budget Office's analysis is not yet available for BCRA, it is likely that the Medicaid cuts will be even deeper. Cuts are par for the course for Medicaid cap proposals. A conservative estimate found ABW would cut $841 billion to states.[7] Finessing the details of per capita caps by using different rates of inflation does not change the fundamental fact that caps lead to cuts.

To put these cuts in perspective, under AHCA, twelve states would have to increase their current state Medicaid spending by 25% or more to make up for the losses. West Virginia would have to increase spending by $4 billion – a 34% increase.[8] BCRA's cuts are expected to be even bigger. Many states – including West Virginia – are *already* dealing with severe budget crises. Adding historic Medicaid cuts onto those deficits will be cataclysmic.

The proposed growth index in BCRA and prior proposals have all been lower than historic Medicaid growth rates. Using a growth index tied to the Consumer Price Index (ABW), a combination of CPI and CPI-Medical for different groups of beneficiaries (AHCA), or the CPI-Medical for a set number of years and then dropping down to CPI for perpetuity (BCRA) artificially ties growth to consumer spending rather than to actual health care costs. Further, limits on growth rates put states at risk for 100% of any new costs not included in the baseline year. These new costs can arise from the development of new vaccines, prescription drugs, or treatments; from epidemics or the outbreak of new diseases or illnesses; from an aging population; from natural disasters; and from states' up-front investments in technology or infrastructure intended to improve care delivery or save money in the long run.

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II. Medicaid Caps Impose Disproportionate and Inequitable Cuts on States

The massive cuts under BCRA and AHCA **will hurt <u>all</u> states**. The pain, however, is not distributed equally; some states will lose more than others. This is because caps:

- lock in historic spending patterns;
- fail to account for variability in state growth rates;
- do not compensate for increased need in traditionally low-income states; and
- fail to compensate states that have relied on increased funds from Medicaid expansion.

Under AHCA, the following states will suffer more than their fair share of the inequitable cuts: **Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New**

Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, and Washington.[9]

a. Per Capita Caps Harm States by Ignoring States' Future Needs and Permanently Freezing Spending Patterns

Caps harms states by locking them into a one-time "snapshot" of their spending – freezing inequities in spending, and thereby federal reimbursement, for perpetuity.

Medicaid is an extremely flexible and state-specific program. Some states traditionally spend less on Medicaid. In some cases, this is because of differences between state programs, such as increased efficiency and innovation, slimmer optional benefit packages, or simply because the cost-of-living is lower than average, and therefore the cost of providing health care is less in that state.[10] In other cases, differences in Medicaid spending are simply a function of annual fluctuations. A state may spend a little less in one year due to a state budget shortfall and then increase funding in the next year due to political changes or increased revenues.

States that have lower than average spending in the cap's "base year" risk being frozen at low spending levels forever, without any flexibility to choose to offer more benefits or reinvest savings gained through efficiency or innovation. Proposals have been floated to choose a new base year every few years. This "rebasing," however, is not the "reset button" it is made out to be. Once a cap is implemented, states have heavy incentives to underspend the ceiling every year. Resetting new ceilings based on post-cap spending levels could lead to even more restrictive caps and increasing cuts in federal support. In this way, rebasing creates the risk of a "one-way ratchet" instead of a safety valve.

To implement a cap, Congress must pick a base year from which to calculate growth. AHCA will freeze spending in 2016, while ABW would have frozen funding in 2019. BCRA lets a state choose a time period to freeze it at some point between 2014 and 2017, by allowing states to pick eight consecutive quarters from which to calculate future spending. The base year influences *which* states will lose the most, but any caps based on a snapshot in time will cause *all* states to permanently and substantially lose out on the opportunity for more funding. Caps turn short-term state budget spending decisions into permanent long-term spending ceilings.

This kind of "snapshot" of spending increases inequities across states, because Medicaid spending varies dramatically among states. Total federal Medicaid expenditures per enrollee by eligibility group vary across states by a factor of at least 2 to 1. Spending on subgroups of beneficiaries varies even more between states, which is significant because BCRA, AHCA and other cap proposals apply different growth indexes to different subpopulations.[11]

Medicaid expenditures for the aged span from a high of $44,752 per person in Delaware, to a low of $8,623 in South Carolina. Under a cap, South Carolina would be stuck forever at its relatively low spending level, even as its older adult population continues to age and needs more services. Similarly, per capita spending for a child in Vermont is $4,612, but only $2,984 in New Hampshire. If a cap like AHCA were imposed, a child in Vermont would forever get almost twice as much allotted to the state for her care than her neighbor living across the border in New Hampshire, irrespective of what either state needs to meet future needs.[12]

b. Caps Harm States By Ignoring Variability in the Growth of Costs

Not only does a cap lock states into a one-time snapshot of spending, but it also fails to account for the fluctuations across states in the rate that Medicaid costs grow ("growth rate"). The effect of growth rate variations across states can be dramatic. For example, if a Medicaid cap like AHCA's had been in place from 2001-2011, more than half of the states would see a funding drop in federal Medicaid funds of more than 10%. At least four states would have faced cuts of 20% or more.[13] Furthermore, the risk to the states is asymmetrical: if the state spends less under the cap in one year, the state does not get extra funds to roll over to the following year. Even a state that, on average, matched the growth index for the cap over a ten year span would lose funding in some years, because the growth in annual Medicaid costs fluctuate by year.[14]

Some cost drivers are relatively predictable. As one example, HIV/AIDS rates of diagnoses are growing most rapidly in Nevada, the southeast United States, and some states with large urban populations. Providing health care for individuals with HIV/AIDS is expensive.[15] It is predictable that Medicaid spending associated with HIV/AIDS treatment will rise in **Florida, Georgia, Louisiana, Maryland, Mississippi, Nevada, New Jersey, New York, North Carolina, South Carolina, Texas, and the District of Columbia,** compounding the harm caused by AHCA's unprecedented cuts.[16]

Other cost drivers are completely unpredictable. The 2001 attack on the World Trade Center led to an increased need for mental health and medical care in its aftermath, which New York quickly addressed through a new Medicaid waiver.[17] The opioid overdose epidemic has led to a 20% increase in overdoses in 2016, increasing the need for overdose-reversal medication like naloxone, and the need for medication-assisted treatment like Buprenorphine as well as an overall increased need for substance use disorder treatment. In West Virginia, Medicaid pays for 45% of all buprenorphine prescriptions in the state. If an exigent need forces a state to spend more on health care than is permitted by the cap, that state is on its own; no federal assistance will be available once the state hits its cap. States experiencing emergencies lose the opportunity for potentially hundreds of millions or billions of dollars in federal assistance.

Some fluctuations have more mundane causes. Costs rise when a state increases provider payment rates necessary to attract sufficient qualified providers. The impact, however, is the same: Medicaid caps fail to account for increases in spending that are not related to increased enrollment, and they harm states by not accounting for these fluctuations.

Not only do growth rates fluctuate over time, buy it's typical that a state that spends less than average one year tends to spend more (grow a bit faster) in the following years.[18] This tendency is important because if a state happens to be in the low-spending part of the cycle in

the selected base year, it is more likely to be hurt by the cap. Medicaid caps will hit these states twice, first by having their spending frozen at historically low levels, and then by being forced to live under a growth index that is less likely to keep pace with actual growth. If a cap like the one under AHCA had been imposed from 2001-2011, states with below-median per beneficiary costs would have been forced to absorb 85% of estimated federal spending reductions.[19] States with the lowest current spending, and therefore more likely to require faster growth in the future, include **Alabama, Georgia, South Carolina, Florida, Illinois, Oklahoma, Utah, and Nevada**.[20]

c. AHCA Penalizes Poorer States That Expanded Medicaid

Medicaid, by design, gives poorer states more federal assistance. The federal share of Medicaid costs is based on a state's per capita income so the poorer the state, the higher the federal matching rate, also known as Federal Medical Assistance Percentages (FMAP).[21] States that expanded Medicaid also get a higher FMAP for that population as an incentive to expand coverage. A low-income state with both a high FMAP for its regular Medicaid population and the enhanced FMAP for newly eligible adults faces a disproportionate reduction in federal funds under AHCA.

Table 1 Expansion States with Low FMAPs Harmed by Caps[22]

State	FMAP	Percentage of increase needed in state spending to make up for AHCA funding gap.	Percentage of Increase needed in State Spending to Make up for funding gap caused by A Better Way
National	N/A	16%	30%
New Mexico	71%	55%	82%
Kentucky	70%	52%	82%
Oregon	64%	48%	71%
Nevada	65%	38%	58%
West Virginia	72%	34%	62%
Montana	66%	34%	62%
Arizona	69%	30%	49%

Because BCRA and AHCA both impose a cap and eliminate expansion funding, all states will face massive federal cuts that will be impossible to fill (even if they did not expand), but low income states that have also expanded Medicaid will be hurt the most, as they will be forced to increase state spending even more to fill federal funding gaps. These low income expansion

states include: **New Mexico, Kentucky, Oregon, Nevada, West Virginia, Montana, and Arizona.**

d. Medicaid Caps Harm Other States that Expanded Medicaid

AHCA also harms states that, due to expansion, successfully enrolled new Medicaid beneficiaries but still otherwise have a low FMAP for the non-expansion population. These states will experience a dramatic decrease in the reimbursement rate for their expansion population. For example, Alaska's FMAP for its expansion adults would decrease by 44%. By comparison, for the same population, Kentucky's reimbursement rate would only decrease by 22%, since Kentucky's FMAP for the non-expansion population is higher than Alaska's.[23] The same concept applies to all Medicaid cap proposals. Due to their successful implementation of Medicaid expansion, **Colorado, New Jersey, and Washington** would all experience a federal cut of 20% or more under AHCA. The same states would be harmed under ABW, with overall cuts of 25% or more. Under these two proposals, using different base years and growth indexes, these same states are harmed by the combination of imposing caps and eliminating Medicaid expansion. These states will be forced to choose between cutting health care for large numbers of individuals, or absorbing a huge loss of federal funding.

Table 1 Expansion States with Low FMAPs Harmed by Caps[24]

State	FMAP	AHCA: Percent decrease of federal funding	ABW: Percent decrease of federal funding
National	N/A	10%	18%
Colorado	50%	20%	27%
New Jersey	50%	21%	28%
Washington	50%	20%	27%

III. Conclusion

Medicaid caps have been repeatedly proposed, most recently in BCRA. Significantly, the details of the base year or growth index used under various Medicaid cap proposals do not meaningfully change the outcome. Proposed caps all lead to massive cuts in funding, and substantial inequities between states. Caps turn short-term state budget decisions into permanent ceilings without regard for a state's future needs. Caps also cannot accommodate the widely variable growth rates among different subpopulations in different states. Last, caps impose the biggest burdens on low income states and states that relied on federal incentives to expand Medicaid. Medicaid caps are not a new or innovative idea; they are a recycled gimmick that will slash funding to states and dismantle the 50-year partnership that has successfully provided health care to so many Americans.

ENDNOTES

[1] *See generally* Teresa A. Coughlin, et al., Kaiser Family Found., What Difference Does Medicaid Make? Assessing the Cost Effectiveness, Access, and Financial Protection Under Medicaid for Low-Income Adults (May 2013) (comparing cost of low income beneficiaries in Medicaid compared to their expected costs in private insurance); Medicaid and CHIP Payment and Access Comm'n. (MACPAC), Report to Congress on Medicaid and Chip at xiii (June 2016) ("Medicaid spending overall is expected to grow at a slower rate than Medicare and private insurance—growth in spending per enrollee has been lower than or comparable to Medicare and private insurance since the early 1990s.").
[2] American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017).
[3] Office of the Speaker of the House, A Better Way: Report from the Health Care Reform Task Force (June 22, 2016) at 26 (proposing a growth index of CPI, and a base year of 2019); American Health Care Act of 2017, H.R. 1628, 115th Cong. (2017) (proposing a growth index of the Consumer Price Index for Medical Care (CPI-M) for all beneficiaries for the first three years, then CPI-M for adults and children, and CPI-M +1% for people with disabilities and the aged, and a base year of 2016). BCRA proposes of CPI-M + 1% for people with disabilities and the aged for 2020 to 2024, and CPI-M for kids, adults, and the expansion population for 2020 to 2024. After 2024, the growth index drops to CPI for all beneficiary categories.
[4] Per capita caps proposals have been proposed and defeated numerous times. *See e.g.* Medicaid Accountability and Care Act of 2012. H.R. 5979, 112th Cong (2012); Rep. Fred Upton and Sen. Orrin Hatch, Making Medicaid Work (May 1, 2013).
[5] Kelly Whitener, Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, *Dialing for Dollars*, Say Ahhh! Blog (May 18, 2017).
[6] *Id.* at 8; Cong. Budget Office, Cost Estimate, H.R. 1628 American Health Care Act of 2017, As passed by the House of Representatives on May 4, 2017, at 13 (May 24, 2017).
[7] John Holahan, *et al*., Urban Inst., The Impact of Per Capita Caps on Federal and State Medicaid Spending (March 2017) at 8.
[8] *Id*.
[9] *Id.* at 15-16. This analysis is based on Urban Institute's analysis of the projected percentage change in total spending under each proposal. It does not take into account harm caused by state-specific lost opportunities, health risks, or other factors. For a more detailed analysis of states' risk factors under caps, see Robin Rudowitz, et al., Kaiser Family Found., Factors Affecting States' Ability to Respond to Medicaid Cuts and Caps: Which States are Most at Risk? (June 2017).
[10] As the Congressional Budget Office noted, an unintended consequence of per capita caps may be that efficient states are harmed more by per capita caps than inefficient states. Cong. Budget Office, Options for Reducing the Deficit at 225 (Dec. 2016) ("[S]tates that have made efforts to operate their programs efficiently to keep costs low would receive caps that reflected that efficiency and were, all else equal, lower than the caps of states with inefficient programs. Therefore, those efficient states would have less flexibility to reduce spending to comply with the caps while inefficient states would have more flexibility.").
[11] John Holahan and Matthew Buettgens, Urban Inst., Block Grants and Per Capita Caps The Problem of Funding Disparities among State at 8, table 2 (Sept. 2016).
[12] Kaiser Family Found., Data Note: Variation in Per Enrollee Medicaid Spending (June 2017).
[13] Rachel Garfield, et al., the Kaiser Family Found., Data Note: What if Per Enrollee Medicaid Spending Growth Had Been Limited to CPI-M from 2001-2011? at 4 (March 2017).
[14] Loren Adler, *et al.*, Brookings, Effects of the Medicaid Per Capita Cap Included in the House-Passed American Health Care Act at 8 (May 2017).
[15] Ctrs. for Disease Control & Prevention, HIV in the United States by Geographic Distribution (March 7, 2017); Kaiser Family Found., Medicaid and HIV at 3 (Oct. 2016) (in 2011, annual per capita spending on HIV positive beneficiaries was almost 5 times that of Medicaid beneficiaries overall).
[16] Kaiser Family Found., Factors Affecting States' Ability to Respond to Federal Medicaid Cuts and Caps, Table 5.
[17] Jocelyn Guyer and David Rosales, Manatt Health, Medicaid's Role in Public Emergencies and Health Crises at 2 (April 2017).
[18] Adler, *et al.*, *supra* note 14.
[19] *Id.* at 2.
[20] Katherine Young, *et al*., Kaiser Family Found., Medicaid Per Enrollee Spending: Variation Across States (Jan. 2015).

[21] Every state has an FMAP assigned to it. This rate is the percentage of each dollar a state spends on Medicaid that the federal government contributes. This rate is generally calculated on a formula that is based on the state's per capita income. The poorer a state's residents, the more help the state receives from the federal government for each dollar spent on Medicaid. *See generally* Kaiser Family Found., Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (Sept. 2012).
[22] Kaiser Family Found., Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier for FY 2017 (June 2, 2017); Holahan *et al.* at 12-13 (table 5).
[23]Alaska receives at least a 90% FMAP for the expansion population. For other populations, the FMAP is 50%. The change from 90% to 50% represents a 44% decrease in funding (the decrease in funding is derived by dividing the amount of decrease divided by the original FMAP. Kentucky, like Alaska, receives at least a 90% FMAP for the expansion population. However, Kentucky's FMAP for other populations is 70%. The reduction of 90% to 70% represents a 22% decrease in funding for that population.
[24] Kaiser Family Found., Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier for FY 2017 (June 2, 2017); Holahan *et al.* at 10-11 (table 4).

June 2017

Summary of the Better Care Reconciliation Act of 2017

This summary describes key provisions of H.R. 1628, the Better Care Reconciliation Act of 2017, an amendment in the nature of a substitute proposed in the Senate on June 22, 2017, as a plan to repeal and replace the Affordable Care Act (ACA) and make fundamental changes to Medicaid financing through the Fiscal Year 2017 budget reconciliation process.

	Better Care Reconciliation Act of 2017 H.R. 1628
Date plan announced	Discussion draft proposed in Senate June 22, 2017
Overall approach	• **Repeal ACA mandates (2016), and cost sharing subsidies (2020).** • **Modify ACA premium tax credits starting in 2020**. Extend eligibility to individuals with income under 100% FPL, end eligibility for income above 350% FPL. Tie subsidy level to a less expensive benchmark plan with 58% actuarial value (AV) and change required individual contributions at income levels above 150% FPL so younger people pay less toward subsidized coverage and older adults pay more. • **Retain private market rules,** including requirement to guarantee issue coverage, set premiums based on modified community rating, prohibition on pre-existing condition exclusions, requirement to extend dependent coverage to age 26. Modify age rating limit to permit variation of 5:1, unless states adopt different ratios, effective 2019. Retain essential health benefits requirement, although bill makes it easier for states to waive it. • **Create new association health plan option for small employers** (called "small business health plans") established in the large group market where community rating and essential health benefits requirements do not apply. • **Retain health insurance marketplaces, annual Open Enrollment periods (OE),** and special enrollment periods (SEPs). • **Establish State Stability and Innovation Program** with federal funding of $112 billion over 9 years. Program divided into short-term and long-term funding. Short-term funding of $50 billion, to be used for reinsurance program for calendar years 2018-2021, administered by CMS. Insurers in every state are eligible to participate. Long-term program with funding of $62 billion from 2019-2026 is available for states to use for 4 purposes (state reinsurance programs, high-risk pools, cost sharing subsidies, and direct payments to providers), though a minimum portion of total funding must be used for reinsurance. State matching funding is required for long-term program beginning in 2022. • **Encourage use of Health Savings Accounts** by increasing annual tax free contribution limit and through other changes. • **Phase out enhanced FMAP for Medicaid expansion to states that adopted the expansion as of March 1, 2017 from 90% in 2020 to traditional state match by 2024.** • **Convert federal Medicaid funding to a per capita allotment** and limit growth in federal Medicaid spending beginning in 2020. State per enrollee amounts for 5 groups would increase at a rate of medical CPI for children and adults and medical CPI plus one percentage point for the elderly and disabled for 2020 – 2024 and then by

	CPI-U for 2025 and beyond; provide state option to receive a block grant for certain adults. • **Add state option to require work as a condition of eligibility for nonelderly Medicaid adults who are not disabled or pregnant.** • **Prohibit federal Medicaid funding for Planned Parenthood clinics for one year.** • **Appropriate $2 billion for FY 2018 for grants to states to support substance use disorder treatment and recovery support services.** Eliminate funding for Prevention and Public Health Fund. Provide supplemental funding for community health centers of $422 million for FY 2017. • **No change to Medicare benefit enhancements or provider/Medicare Advantage plan payment savings.** • **Repeal Medicare HI tax increase and other ACA revenue provisions.**
Individual mandate	• Tax penalty for not having minimum essential coverage is eliminated effective January 1, 2016
Premium subsidies to individuals	• For 2018-2019, ACA premium tax credit formula and eligibility standards are unchanged, except – For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply; and penalty for erroneous claim of premium tax credit is increased to 25%. – Tax credits cannot be used for plans that cover abortion, effective 2018. • Starting in 2020, modify ACA income-based tax credits as follows: – Income eligibility for the credit is 0% FPL to 350% FPL – The tax credit amount is tied to the median priced marketplace plan with actuarial value of 58% – The required individual contribution amount is changed for people with income above 150% FPL. The contribution amount is reduced for younger individuals and increased for older individuals at the same income level. For example, at 350% FPL, a 29-year old is required to contribute 6.4% of income toward the premium while a 60-year-old is required to contribute 16.2% of income. – Current law requires reduction of tax credit amounts if aggregate subsidy costs exceed 0.504% of GDP for the preceding year; the bill lowers this threshold to 0.4% – In general, individuals who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credits. – Individuals who are offered any employer sponsored health plan (regardless of affordability or minimum value) are not eligible for tax credits – Eligibility for noncitizens is restricted. Currently, individuals lawfully present in the U.S. are eligible; the bill restricts eligibility to “qualified aliens,” a narrower category that would exclude, for example, individuals in the U.S. on worker visas or student visas. • Taxpayers who are also enrolled in qualified small employer health reimbursement arrangements (HRA) that apply to non-group coverage will have tax credit reduced, but not below zero, by the amount of the HRA benefit. • Premium tax credit can be applied to any eligible individual health insurance policy sold on the exchange. Eligible policies do not include those for which substantially all coverage is for excepted benefits; policies that cover abortion (with Hyde exceptions) are not eligible policies.
Cost sharing subsidies to individuals	▪ Funds (such sums as necessary) are appropriated to reimburse health insurers for cost sharing reductions effective on the date of enactment through the end of 2019. ▪ ACA cost sharing subsidies are repealed effective January 1, 2020.

Individual health insurance market rules	• Require guaranteed issue of all non-group health plans during annual open enrollment. Insurers also must offer 60-day special enrollment periods (SEP) for individuals after qualifying events. Short-term non-renewable policies can continue to be sold using medical underwriting. • Continue ACA rating rules, except age rating of 5:1 is permitted starting January 1, 2019, unless states adopt a different ratio. Short-term non-renewable policies can continue to set premiums based on health status. • Prohibition on pre-existing condition exclusion periods is not changed. Short term non-renewable policies can continue to exclude pre-existing conditions
Benefit design	• ACA requirement to cover 10 essential health benefit categories is not changed; however, the 1332 waiver authority is amended to make it easier for states to eliminate or change the essential health benefits standard for health insurance coverage offered in the individual or small group market. • ACA requirement for maximum out-of-pocket limit on cost sharing is not changed; however, the 1332 waiver authority is amended to make it easier for states to eliminate or change the maximum out-of-pocket limit on cost sharing. • ACA requirement for plans to be offered at specified actuarial values/metal levels is not changed, however, the 1332 waiver authority is amended to make it easier for states to eliminate or change this requirement. • Prohibition on lifetime and annual dollar limits is not changed; however, the prohibition applies to limits on essential health benefits, which can be changed under 1332 waiver authority • Requirement for individual and group plans to cover preventive benefits with no cost sharing is not changed. • Requirement for all plans to apply in-network level of cost sharing for out-of-network emergency services is not changed • Prohibit abortion coverage from being required. Federal premium tax credits cannot be applied to plans that cover abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment). Nothing prevents an insurer from offering or an individual from buying separate policies to cover abortion as long as no premium tax credits are applied.
Women's health	• ACA essential health benefit requirement for individual and small group health insurance policies is not changed, including requirement to cover maternity care as an essential health benefit; however, the 1332 waiver authority is amended to make it easier for states to change this requirement. • Requirement for individual and group plans to cover preventive benefits, such as contraception and cancer screenings, with no cost sharing is not changed. • Prohibition on gender rating is not changed • Prohibition on pre-existing conditions exclusions, including for pregnancy, prior C-section, and history of domestic violence, is not changed. • Prohibit federal Medicaid funding for Planned Parenthood clinics for one year, effective upon date of enactment. Specifies that federal funds to states including those used by managed care organizations under state contract are prohibited from going to such entity. • Redefine qualified health plans eligible for tax credits to exclude any plan that covers abortion services, beyond those for saving the life of the woman or in cases of rape or incest (Hyde amendment), effective in 2018 • Disqualify small employers from receiving tax credits if their plans include abortion coverage beyond Hyde limitations, effective in 2018. Insurance issuers that cover abortion beyond Hyde limitations in any of their plans are not eligible for short-term assistance funds made available under the State Stability and Innovation Program.
Health Savings Accounts (HSAs)	• Modify certain rules for HSAs, changes take effect January 1, 2018 unless otherwise noted: – Increase annual tax free contribution limit to equal the limit on out-of-pocket cost sharing under qualified high deductible health plans ($6,550 for self only coverage, $13,100 for family coverage in 2017, indexed for inflation).

	– Additional catch up contribution of up to $1,000 may be made by persons over age 55. Both spouses can make catch up contributions to the same HSA. – Amounts withdrawn for qualified medical expenses are not subject to income tax. Qualified medical expense definition expanded to include over-the-counter medications and expenses incurred up to 60 days prior to date HSA was established – Tax penalty for HSA withdrawals used for non-qualified expenses is reduced from 20% to 10%, effective January 1, 2017.
High-risk pools	• States may use State Stability and Innovation Program grants to fund high-risk pools, and for other purposes
Selling insurance across state lines	• No provision
Exchanges/ Insurance through associations	• State exchanges continue. Under Section 1332 waiver authority, states can waive requirements or operations of exchanges, including to allow premium tax credits to be applied to plans sold outside of exchanges. • Single risk pool rating requirement for plans first sold on or after January 1, 2014 is not changed, though requirement can be changed or waived under Section 1332 waivers. • The bill authorizes establishment and federal certification of small group association health plans, called "small business health plans" (see employer section below)
Dependent coverage to age 26	• Requirement to provide dependent coverage for children up to age 26 for all individual and group policies is not changed.
Other private insurance standards	• Minimum medical loss ratio standards for all health plans sunset for plan years beginning in 2019. Thereafter, States shall establish minimum medical loss ratios for group and non-group policies and rules governing annual rebates to enrollees • Requirement for all health plans to offer independent external review is not changed. • Requirements for all plans to report transparency data, and to provide standard, easy-to-read summary of benefits and coverage are not changed.
Employer requirements and provisions	• Tax penalty for large employers that do not provide health benefits is reduced to zero, retroactive to January 1, 2016 • Wellness incentives permitted under the ACA are not changed • Repeal tax credits for low-wage small employers, effective January 1, 2020. Prohibit small business tax credits from being used to purchase plans that cover abortions beyond Hyde limitations, effective in 2018 • Establish authority for new small business association plans, called "small business health plans" (SBHP). SBHPs must be fully insured health plans offered in the large group market, where modified community rating and essential health benefits are not required. The Secretary of Labor will certify SBHPs, under an expedited process of 90 days or less, and state laws precluding insurers from offering SBHPs are preempted. Federal certification requirements relate to governance, standards for membership in the association, forms filing and notice rules. Secretary of Labor may conduct oversight of SBHPs. SBHPs are prohibited from discriminating against employees and employers eligible to participate; nondiscrimination standard are satisfied if the SBHP provides appropriate notice of all coverage options it offers. A SBHP must be domiciled in a single state but can offer coverage to employers in other states
Medicaid	*Financing* • Limit and phase down the enhanced match rate for the Medicaid expansion for states that adopted the expansion as of March 1, 2017 to 90% in CY 2020 (same as current law), 85% in 2021, 80% in 2022, 75% in 2023 and then to the regular state match rate in 2024 and beyond. – Eliminate option to extend coverage to adults above 133% FPL effective December 31, 2017

- Limit the "expansion state" enhanced match rate transition percentage to CY 2017 levels of 80% (instead of phasing up the match to equal the ACA enhanced match rate by 2020).

- Convert federal Medicaid financing to a per capita cap beginning in FY 2020.
  - Set total medical assistance expenditures for a state as the sum of the per enrollee amounts for 5 groups - elderly, blind and disabled, children, expansion adults, and other adults – multiplied by the number of enrollees in each group. (For states opting to adopt the Medicaid expansion after FY 2016, the per enrollee amount for this group would be the same as the other adult group under the per capita cap).
  - The base year for per enrollee amounts is determined using state-selected 8 consecutive quarters of expenditure data from FY 2014 through the third quarter of FY 2017 for enrollees subject to the per capita caps. Secretary has discretion to adjust data as deemed appropriate. Base year amounts are inflated to 2019 by medical CPI. The target expenditures in 2020 are calculated based on the 2019 per enrollee amounts for each enrollment group adjusted to maintain the ratio of non-DSH supplemental payments to total payments and multiplied by the number of enrollees in each group. Expenditures exclude administrative costs, DSH, Medicare cost-sharing, and safety net provider payment adjustments in non-expansion states. Certain categories of individuals, including CHIP, those receiving services through Indian Health Services, those eligible for Breast and Cervical Cancer services, partial-benefit enrollees (including partial duals), and children who qualify on the basis of being blind or disabled are excluded.
  - Increase per enrollee amounts by medical CPI for adults and children and medical CPI plus one percentage point for the elderly and disabled for 2020 through 2024. For FY 2025 and beyond, increase per enrollee amounts by CPI-U.
  - Direct the Secretary to calculate and apply per capita cap payment provisions for categories that were not satisfactorily submitted as if they were a single 1903A enrollee category and the growth factor otherwise applied shall be decreased by one percentage point.
  - Direct the Secretary to adjust target per enrollee amounts by .5% to 2% for states spending 25% or more above and below the mean per capita expenditures to be closer to the mean beginning in 2020. (Adjustments applied in aggregate and not for each enrollee group in 2020 and 2021). Adjustments are to be budget neutral to the federal government and excludes adjustments to certain low-density states (Alaska, Montana, North Dakota, South Dakota and Wyoming). Any adjustment made will be disregarded when determining the target medical assistance expenditures for state and category for the succeeding year.
  - States with medical assistance expenditures exceeding the target amount for a fiscal year will have payments in the following fiscal year reduced by the amount of the excess payments.

- Decrease per capita cap target medical assistance expenditures by the amount of certain expenditures required by political subdivisions of certain states that are unreimbursed by the state beginning in FY 2020 – as written appears to apply only to New York.[1]

- Add state option to elect Medicaid block grant instead of per capita cap for non-disabled, non-expansion adults for a period of 5 fiscal years, beginning in FY 2020, through the Medicaid Flexibility Program.
  - States are required to provide for eligibility for mandatory adults (including adults receiving cash assistance, pregnant women with incomes up to 133% FPL and foster care children up to age 26).

- States must provide, as targeted health assistance, hospital care, lab and x-ray services, nursing facility services, physician services, home health care, rural health clinic and federally-qualified health center services, family planning services, pregnancy-related services including nurse midwife and freestanding birth center services. The targeted health assistance must have an actuarial value of 95% of Medicaid benchmark coverage and must include mental health and substance use disorder services on parity with physical health services. States may impose cost sharing on enrollees up to 5% of family income annually.
- The block grant amount for the initial fiscal year a state elects the block grant is based on the state's target per capita medical assistance expenditures for the fiscal year multiplied by the number adult enrollees (adults in the base period increased by population growth plus three percentage points) and the federal average medical assistance matching rate for the state for the fiscal year. In subsequent fiscal years, the block grant amount is increased by annual CPI-U.
- States have a maintenance of effort (MOE) requirement state share of the CHIP enhanced FMAP. States can rollover unused block grant funds into the next fiscal year as long as they continue to elect the block grant option and meet the MOE. States may use rollover funds for other purposes that are consistent with quality standards established by the Secretary, or to finance the state share.
- States must submit an application that includes a description of the program, including the conditions of eligibility for program enrollees, the amount, duration and scope of services, and covered benefits; a certification that the state will meet requirements related to data and program evaluations; and a statement of program goals related to quality, access, growth rate targets, consumer satisfaction, and outcomes. The application is subject to state and federal notice and comment periods.

- Provide 100% FMAP for MMIS and eligibility systems for FY 2018 and FY 2019 and increase other administrative matching to 60% for expenses related to implementing new data requirements.
- Exempt non-expansion states from DSH cuts. Provide an increase in the FY 2020 DSH allotment for non-expansion states where the 2016 DSH allotment divided by the number of individuals enrolled in the state plan is below the national average in an amount that would increase the ratio up to the national average ratio. These increases would not be applicable to determining the DSH allotment in 2024 and beyond.
- Provide $10 billion over 5 years (FY2018 – FY 2022) to non-expansion states for safety-net funding (applies to states not adopting the expansion by July 1 of the previous year). Allotments based on the number of individuals in the State with income below 138% of FPL in 2015 relative to the total number of individuals with income below 138% of FPL for all the non-expansion States in 2015. Payments 100% funded by the federal government in FY 2018-2021 and 95% in FY 2022. Payments to providers may not exceed providers' costs in providing health care services to Medicaid and uninsured patients. States receiving these funds in a year in which they also adopt expansion shall no longer be eligible to receive these funds in any subsequent year.
- Phase down the safe harbor threshold for provider taxes from 6.0% to 5.8% in FY 2021; 5.6% in 2022; 5.4% in 2023; 5.2% in 2024; and 5% in 2025 and beyond.
- Provide $8 billion for FY 2023-2026 for quality performance bonus payments to states that have lower than expected medical assistance expenditures and meet quality performance or improvement for certain measures defined by the Secretary with state consultation. Payments provided to states as an increase in FMAP.

Other Changes

	• Create state option to conduct eligibility redeterminations every 6 months (or more frequently) for expansion enrollees beginning October 1, 2017; increase the state administrative match rate by 5 percentage points from October 1, 2017 through December 31, 2019 for administering more frequent redeterminations.
	• Eliminate 3-month retroactive coverage requirement (start eligibility "in or after" the month of application) beginning October 1, 2017
	• Create state option to require work as a condition of eligibility for nondisabled, nonelderly Medicaid enrollees as of October 1, 2017, by participating in work activities as defined in the TANF program[2] for a period of time as determined by the state and as directed and administered by the state.
	  – Exempts pregnant women through 60-days post-partum, children under 19, individuals who are the only parent/caretaker relative in family of child under age 6 or child with disability, and individuals under age 20 who are married or head of household and maintain satisfactory attendance at secondary school or equivalent or participate in education directly related to employment.
	  – Provides 5 percentage point increase in the federal administration matching rate to implement the work requirement.
	• Require states to report on qualified expenditures for IMDs (inpatient psychiatric hospital services) within 60 days post enactment and to report on children with complex medical conditions by January 1, 2020.
	• Grandfather certain managed care waivers (those renewed at least 1 time) to continue without application. Modifications would require an application, but would be deemed approved unless the Secretary issues a denial or request for additional information within 90 days of application. Also requires the Secretary to implement procedures to encourage states to adopt or extend HCBS waivers.
	• Provide state option to cover qualified psychiatric hospital (IMD) services for adults ages 21-65 beginning in FY 2019. Services for individuals limited to up to 30 consecutive days and up to 90 days in a calendar year. To receive federal matching rate of 50% for these services, states must maintain the number of licensed IMD beds and the state funding for IMD services and psychiatric outpatient care as of enactment of provision or, if higher, as of date of application to provide coverage.
	• Repeal the essential health benefits requirement for those receiving alternative benefit packages, including the expansion group, as of December 31, 2019.
	• Repeal increase in Medicaid eligibility to 138% FPL for children ages 6-19 as of December 31, 2019. The minimum federal income eligibility limit for these children will revert to 100% FPL.
	• Repeal hospital presumptive eligibility provisions and presumptive eligibility for expansion adults, effective January 1, 2020
	• Repeal enhanced FMAP for the Community First Choice Option to provide attendant care services effective January 1, 2020
	• Prohibit federal Medicaid funding for Planned Parenthood for one year, effective upon date of enactment
	• Require Secretary to coordinate with states on a regular and ongoing basis with regard to rules and implementation of provisions in the bill.

Medicare	*Revenues* • Repeal the HI payroll tax on high earners, beginning after December 31, 2022 • Repeal the annual fee paid by branded prescription drug manufacturers, beginning after December 31, 2017 • Reinstate the tax deduction for employers who receive Part D retiree drug subsidy (RDS) payments to provide creditable prescription drug coverage to Medicare beneficiaries, beginning after December 31, 2016

	Coverage enhancements ▪ ACA benefit enhancements (no-cost preventive benefits; phased-in coverage in the Part D coverage gap) are not changed *Reductions to provider and plan payments* ▪ ACA reductions to Medicare provider payments and Medicare Advantage payments are not changed *Other ACA provisions related to Medicare are not changed, including:* ▪ Increase Medicare premiums (Parts B and D) for higher income beneficiaries (those with incomes above $85,000/individual and $170,000/couple). ▪ Authorize an Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the rate of growth in Medicare spending exceeds a target growth rate. ▪ Establish various quality, payment and delivery system changes, including a new Center for Medicare and Medicaid Innovation to test, evaluate, and expand methods to control costs and promote quality of care; Medicare Shared Savings Accountable Care Organizations; and penalty programs for hospital readmissions and hospital-acquired conditions.
State role	• States may determine age rating ratio; otherwise federal standard of 5:1 applies, beginning in 2019. • Establish new State Stability and Innovation Program within Title XXI of the Social Security Act (so Hyde restrictions on spending for abortion apply). Short-term and long-term assistance is provided under the Program – For short-term program, $50 billion is authorized and appropriated for 4 calendar years ($15 billion for each of calendar years 2018 and 2019, $10 billion for each of calendar years 2020 and 2021.) Short-term funding will be used for reinsurance. CMS will administer reinsurance program and make payments directly to health insurers. The CMS Administrator appears to have authority to design reinsurance program features (such as attachment point, coinsurance rates, etc.) as the bill does not specify these details. Insurers will notify CMS of their intent to participate in reinsurance program (within 35 days of date of enactment for calendar year 2018; and for later years, by March 31 of previous year.) No state matching funds are required for short term reinsurance program. – A separate long-term program is authorized for 2019 through 2026. The bill appropriates $62 billion for 8 years ($8 billion for calendar year 2019, $14 billion for each of calendar years 2020 and 2021, $6 billion for each of calendar years 2022 and 2023, $5 billion for each of calendar years 2024 and 2025, and $4 billion for calendar year 2026). States must apply for funding for a year no later than March 31 of the prior year. – Long-term funding can be used for one or more of four specified purposes: for financial help for high-risk individuals, to stabilize private insurance premiums, to provide cost sharing subsidies, or to make direct payments to health care providers. However, for 2019, 2020, and 2021, at least $5 billion of the amounts appropriated for each year must be used for state reinsurance programs. – Long-term funding will be allocated among states based on a methodology to be developed by CMS. Any unallocated funds will be distributed to other states with an approved application. – For long-term program, state matching funding of 7% is required starting in 2022, phasing up to 35% in 2026. • State option to establish a state based health insurance exchange remains, but states can apply, under Section 1332 waivers, to change or eliminate exchanges or to make

premium subsidies available for plans sold outside of exchanges, effective January 1, 2018.

- Amend state waiver authority under Section 1332 of the ACA, effective on date of enactment:
  - As under current law, States may apply to waive the following requirements:
    - Standards for qualified health plans, including requirements to cover essential health benefits, to apply a maximum annual out of pocket limit on cost sharing, to offer plans at different metal levels;
    - Standards for state health insurance exchanges, including requirements to establish individual and SHOP exchanges, offer annual open enrollment periods, operate web sites, provide navigators, and other exchange requirements, and the requirement that Members of Congress must obtain health coverage through the Exchange;
    - Requirement to provide cost sharing subsidies; and
    - Requirement to provide premium tax credits.
  - The bill repeals the following standards for granting 1332 waivers:
    - Requirement that coverage under the waiver program will be at least as comprehensive as the ACA would otherwise provide;
    - Requirement that coverage and cost sharing protections are at least as affordable as the ACA would otherwise provide; and
    - Requirement that at least as many state residents will be insured
  - The bill retains the current law requirement that 1332 waivers cannot result in an increase in the federal deficit.
  - The bill eliminates the Secretary's discretion to disapprove; it requires that waivers shall be approved unless they increase the federal deficit. The Secretary shall establish an expedited application and approval process for 1332 waiver applications that respond to urgent or emergency situations in a state.
  - State waiver applications must explain the provision(s) to be waived, what will take the place of waived requirements, and how the waiver will provide alternative ways to promote access to coverage, affordability, and enrollment.
  - 1332 waivers will be in effect for 8 years unless State requests a shorter duration; waivers may be renewed for an unlimited number of times.
  - Any 1332 waivers already approved as of the date of enactment continue to be subject to 1332 requirements under current law; waivers submitted but not yet approved as of the date enactment can be governed by current law standards or new standards, at the State's option.
  - For FY 2017, $2 billion is authorized and appropriated for grants to states to develop 1332 waiver applications and implement waiver plans. Funding will remain available through the end of FY 2019. States may also use funds from the Long-term State Innovation and Stability allotment to implement a waiver plan.
- Appropriate $2 billion in FY 2018 for grants to states to support substance use disorder treatment and recovery support services.
- State consumer assistance/ombudsman program is not changed, and is not funded.
- State option to establish a Basic Health Program (BHP) is retained, though federal subsidy funding that would flow through BHP would be reduced.
- States continue to administer the Medicaid program with Federal matching funds available up to the federal per capita cap with the option of a block grant for certain populations.

Financing	• ACA taxes repealed, effective January 1, 2018, except where otherwise noted: – Tax penalties associated with individual and large employer mandate, reduced to zero effective on January 1, 2016 – Cadillac tax on high-cost employer-sponsored group health plans is suspended for tax years 2020 through 2025, no revenues shall be collected during this period – Increase in Medicare payroll tax (HI) rate on wages for high-wage individuals, effective January 1, 2023; also 3.8% net investment income tax on unearned income for high-income taxpayers, effective January 1, 2017 – Tax on tanning beds, effective for services received after September 30, 2017 – Tax on health insurers – Tax on pharmaceutical manufacturers – Excise tax on sale of medical devices – Provision excluding costs for over-the-counter drugs from being reimbursed through a tax preferred health savings account (HSA) – Provision increasing the tax (from 10% to 20%) on HSA distributions that are not used for qualified medical expenses, effective January 1, 2017. – Annual limit on contributions to Flexible Spending Accounts (FSAs) repealed – Annual limit on deduction for salary in excess of $1 million paid to employees of publicly held corporations repealed – Income threshold for medical expense deduction reduced from 10% to 7.5%, effective January 1, 2017 • Cap federal Medicaid funding, effective FY 2020; enhanced match for Medicaid expansion population phased out beginning January 1, 2020 • Appropriate $500 million for federal administration of the premium tax credit changes, State Stability and Innovation Program, Medicaid changes, and other implementation responsibilities.
Endnotes	[1] State must have had FY 2016 DSH allotment more than six times the national average. Contributions required by the state from political subdivisions that, as of the 1st day of the CY in which the FY begins, has a population of more than 5,000,000 and imposes a local income tax and those for administrative expenses if required as of January 1, 2107 are included. [2] Work activities under the TANF program include unsubsidized employment, subsidized private sector employment, subsidized public sector employment, work experience (including refurbishing publicly assisted housing) if sufficient private sector employment is not available, on-the-job training, job search and job readiness assistance, community service programs, vocational educational training (not to exceed 12 months for any individual), job skills training directly related to employment, education directly related to employment for those who have not received a high school diploma or certificate of high school equivalency, satisfactory attendance at secondary school or in a general equivalency certificate course for those who have not already completed, and provision of child care services to an individual participating in a community service program.
Sources of information	https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf

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June 14, 2017

Oppose the American Health Care Act (H.R. 1628)
Oppose Repeal of the Affordable Care Act; Medicaid Block Grants/Per Capita Caps; and Defunding of Planned Parenthood

Dear Senator:

On behalf of The Leadership Conference on Civil and Human Rights, the National Health Law Program, the National Partnership for Women & Families, and the undersigned 158 organizations, we urge you to oppose any attempt to repeal the Affordable Care Act (ACA); slash federal funding and transform Medicaid into a block grant or per capita cap; eliminate the Medicaid expansion; and defund Planned Parenthood health centers.

Repealing the ACA, and restructuring and reducing the financing and coverage of Medicaid as proposed by the American Health Care Act (AHCA), would leave at least 23 million people in the United States, particularly people of color and underserved populations, significantly worse off than under current law. The ACA and Medicaid are critical sources of health coverage for America's traditionally underserved communities, which our organizations represent. This includes individuals and families living in poverty, people of color, women, immigrants, LGBTQ individuals, individuals with disabilities, seniors, and individuals with limited English proficiency.

The ACA has reduced the number of people without insurance to historic lows, including a reduction of 39 percent of the lowest income individuals.[i] The gains are particularly noteworthy for Latinos, African Americans, and Native Americans. Asian Americans, Native Hawaiians and Pacific Islanders have seen the largest gains in coverage. The nation and our communities cannot afford to go back to a time when they did not have access to comprehensive, affordable coverage. Further, due to the intersectionality between factors, such as race and disability, or sexual orientation and uninsurance, and issues faced by women of color, many individuals may face additional discrimination and barriers to obtaining coverage. Proposals to replace the ACA with high-risk pools, Health Savings Accounts, or "cheaper" insurance plans that do not offer comprehensive, affordable benefits are unacceptable.

Medicaid is also critically important as it insures one of every five individuals in the United States, including one of every three children and 10 million people with disabilities. Medicaid coverage, including the Medicaid expansion, is particularly critical for underserved individuals and especially people of color, because they are more likely to be living with certain chronic health conditions, such as diabetes, which require ongoing screening and services. People of color represent 58 percent of non-elderly Medicaid enrollees.[ii] According to the Kaiser Family Foundation, African Americans comprise 22 percent of Medicaid enrollment, and Hispanics comprise 25 percent.[iii] They are more likely than White non-Hispanics to lack insurance coverage and are more likely to live in families with low incomes and fall in the Medicaid gap.[iv] As a result, the lack of expansion disproportionately affects these communities, as well as women, who make up the majority of poor uninsured

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adults in states that did not expand Medicaid. For people of color who experienced some of the largest gains in health coverage, this could mean vastly reduced access to needed health care, increased medical debt, and persistent racial disparities in mortality rates.[v] Further, Medicaid provides home and community-based services enabling people with disabilities to live, work, attend school, and participate in their communities. The proposed cuts would decimate the very services that are cost-effective and keep individuals out of nursing homes and institutions. Finally, one in five people with Medicare rely on Medicaid to cover vital long-term home care and nursing home services, to help afford their Medicare premiums and cost-sharing, and more.

Despite the common myth that all low-income people could enroll in Medicaid, the Medicaid program has only been available to certain categories of individuals (e.g., children, pregnant women, seniors, people with disabilities) and had little to no savings or assets. Parents of children and childless adults were often excluded from Medicaid or only the lowest income individuals in these categories were eligible. For example, the Medicaid expansion greatly expanded coverage for LGBTQ individuals who previously did not fit into a traditional Medicaid eligibility category and for working people struggling in jobs that do not offer health insurance and pay at or near the minimum wage.

The CBO estimated that under the AHCA, as initially proposed, 14 million people would lose their Medicaid coverage by 2026, a reduction of about 17 percent relative to the comparable number under current law.[vi] The AHCA would end the higher federal matching rate for people newly enrolled through the Medicaid expansion and transform the financing from an entitlement program based on the number of persons enrolled to a more limited per capita-based cap or block grant. CBO estimates that by 2026, Medicaid spending would be reduced by $834 billion or 25 percent less than estimated under current law.[vii] This dramatic reduction in funding to the states is likely to result in more people losing coverage and/or needed services, particularly those optional services needed by people with disabilities.

Further, we are very concerned about the possibility of giving states an option under the Medicaid program to impose a work requirement as a condition of eligibility for the first time. Such a requirement not only fails to further the purpose of providing health care but also undermines this objective. Among adults with Medicaid coverage, nearly 8 in 10 live in working families and a majority are working themselves.[viii]

In addition, the AHCA would single out Planned Parenthood and block federal Medicaid funds for care at its health centers. The “defunding” of Planned Parenthood would prevent more than half of its patients from getting affordable preventive care, including birth control, testing and treatment for sexually transmitted diseases, breast and cervical cancer screenings, and well-women exams at Planned Parenthood health centers, often the only care option in their area. This loss of funds will have a disproportionate effect on poor families and people of color who make up 40 percent of Planned Parenthood patients.[ix] Seventy-five percent of Planned Parenthood patients are at or below 150 percent of the federal poverty level and half of their health centers are in rural or underserved areas.[x]

We are seriously concerned about the lack of transparency of the discussions taking place to develop this legislation. After more than seven years and 60 votes to repeal the ACA, there is no excuse for forcing consideration of this bill without adequate time for analysis, hearings, and discussion of a CBO score, providing ample opportunity for the public to understand the proposed legislation and participate in this discussion in which their very access to health care for themselves and their families is at stake.

We urge you to oppose any repeal of the Affordable Care Act, attempts to change Medicaid's open-ended funding guarantee into a block grant or per capita caps, and any attempts to defund Planned Parenthood. If you have any questions, please feel free to contact Leadership Conference Health Care Task Force Co-chairs Judith Lichtman at the National Partnership for Women & Families (jllichtman@nationalpartnership.org), Mara Youdelman at the National Health Law Program (youdelman@healthlaw.org), or June Zeitlin at The Leadership Conference (zeitlin@civilrights.org).

Sincerely,

The Leadership Conference on Civil and Human Rights
National Health Law Program (NHeLP)
National Partnership for Women & Families
ACCESS
Access Living
ADAP Advocacy Association (aaa+)
Advocates for Youth
AFL-CIO
AFSCME
AIDS Foundation of Chicago
American Academy of Nursing
American Association of Colleges of Pharmacy
American Association of People with Disabilities (AAPD)
American Association of University Women (AAUW)
American Civil Liberties Union
American Federation of Teachers
American Nurses Association
American-Arab Anti-Discrimination Committee
Amida Care
Amnesty International USA
APLA Health
Asian & Pacific Islander American Health Forum
Asian & Pacific Islander Caucus for Public Health (APIC)
Association of Asian Pacific Community Health Organizations (AAPCHO)
Association of Programs for Rural Independent Living
Association of Reproductive Health Professionals
Association of University Centers on Disabilities
Autistic Self Advocacy Network
Bazelon Center for Mental Health Law
Bend the Arc Jewish Action
Black Women's Health Imperative
Black Women's Roundtable, National Coalition on Black Civic Participation
Breast Cancer Action
Center for Community Change Action
Center for Law and Social Policy (CLASP)
Center for Medicare Advocacy
Center for Reproductive Rights
Children's Health Fund

The Leadership Conference

Coalition for Disability Health Equity
Coalition of Labor Union Women
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)
Commission on the Public's Health System
CommonHealth ACTION
Community Access National Network (CANN)
Crescent City Media Group
Disability Rights Education and Defense Fund
EMILY's List
Equal Justice Society
Equal Rights Advocates
Equality California
Equality Federation
Families USA
Family Equality Council
Family Voices
Farmworker Justice
Feminist Majority
GLMA: Health Professionals Advancing LGBT Equality
Health & Medicine Policy Research Group
Health Care for America Now (HCAN)
Health Justice Project
Hispanic Health Network
HIV Medicine Association
Human Rights Campaign
Human Rights Watch
Illinois Public Health Association
Indivisible
International Association of Official Human Rights Agencies
International Association of Women in Radio and Television, USA
Jewish Council for Public Affairs
Jewish Women International
Justice in Aging
Korean Community Services of Metropolitan NY
Lambda Legal
Latino Commission on AIDS
Latinos in the Deep South
Lawyers' Committee for Civil Rights Under Law
LBGT PA Caucus of the American Academy of Physician Assistants, Inc.
League of United Latin American Citizens
League of Women Voters of the United States
LEAnet, a national coalition of local education agencies
LPAC
Main Street Alliance
Medicare Rights Center
Movement Advancement Project
MoveOn.org Civic Action
NAACP

The Leadership Conference

NAPAFASA
NASTAD
National African American Drug Policy Coalition Inc.
National Association of County Behavioral Health and Developmental Disability Directors & National Association for Rural Mental Health
National Association of Human Rights Workers
National Association of Social Workers
National Black Justice Coalition
National Center for Learning Disabilities
National Center for Lesbian Rights
National Center for Transgender Equality
National Collaborative for Health Equity
National Council of Asian Pacific Americans (NCAPA)
National Council of Churches
National Council of Jewish Women
National Council of La Raza
National Council on Independent Living
National Disability Rights Network
National Domestic Workers Alliance
National Education Association
National Employment Law Project
National Family Planning & Reproductive Health Association
National Hispanic Medical Association
National Immigration Law Center
National Institute for Reproductive Health
National Latina Institute for Reproductive Health
National LGBTQ Task Force Action Fund
National Low Income Housing Coalition
National Network for Arab American Communities (NNAAC)
National Organization for Women
National Urban League
National Women's Health Network
National Women's Law Center
National Women's Political Caucus
NETWORK Lobby for Catholic Social Justice
NOBCO: National Organization of Black County Officials
OCA - Asian Pacific American Advocates
OneAmerica
Organizing for Action-Springfield
Out2Enroll
People For the American Way
Philadelphia Unemployment Project
Planned Parenthood Federation of America
PolicyLink
Population Institute
Positive Women's Network - USA
Presbyterians Affirming Reproductive Options (PARO)
Prevention Institute

The Leadership Conference

Progressive Leadership Alliance of Nevada
Raising Women's Voices for the Health Care We Need
Resource Center
San Francisco AIDS Foundation
Service Employees International Union (SEIU)
Sexuality Information and Education Council of the U.S. (SIECUS)
SisterSong: National Women of Color Reproductive Justice Collective
SiX Action
TASH
The AIDS Institute
The Arc of the United States
The National Campaign to Prevent Teen and Unplanned Pregnancy
The Trevor Project
The United Methodist Church – General Board of Church and Society
Trust for America's Health
UCHAPS: Urban Coalition for HIV/AIDS Prevention Services
Union for Reform Judaism
United Church of Christ, Justice and Witness Ministries
URGE: Unite for Reproductive & Gender Equity
Voices for Progress
Wisconsin Alliance for Women's Health
Women Employed
Women's Action Movement
Women's Intercultural Network (WIN)
Women's Media Center
Women's Missionary Society African Methodist Episcopal Church
Young Invincibles
YWCA USA

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[i] U.S. Department of Health and Human Services, Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage, pp. 2, 4 (Sept. 29, 2016), available at https://aspe.hhs.gov/sites/default/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf.
[ii] Kaiser Family Foundation, Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity: 2015, available at http://kff.org/medicaid/state-indicator/rate-by-raceethnicity-3/?currentTimeframe=0.
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[iv] Kaiser Family Foundation, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, http://kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/
[v] Center on Budget and Policy Priorities, African Americans Have Much to Lose Under House GOP Health Plan, available at http://www.cbpp.org/blog/african-americans-have-much-to-lose-under-house-gop-health-plan.
[vi] Congressional Budget Office Estimate, American Health Care Act (March 13, 2017) available at https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/costestimate/americanhealthcareact_0.pdf.
[vii] Congressional Budget Office Estimate, American Health Care Act (May 24, 2017) available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.
[viii] Kaiser Family Foundation, Understanding the Intersection of Medicaid and Work, available at http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work
[ix] Planned Parenthood, This is Who We Are, (July 11, 2016), available at https://www.plannedparenthood.org/files/6814/6833/9709/20160711_FS_General_d1.pdf
[x] Planned Parenthood, The Urgent Need for Planned Parenthood Health Centers (Dec. 7, 2016), available at https://www.plannedparenthood.org/files/4314/8183/5009/20161207_Defunding_fs_d01_1.pdf

CENTER *for* PUBLIC POLICY PRIORITIES

CPPP PERSPECTIVE:

Texas Impact of proposed federal roll-back of Medicaid and the ACA

House Appropriations Committee
Tuesday, July 25, 2017

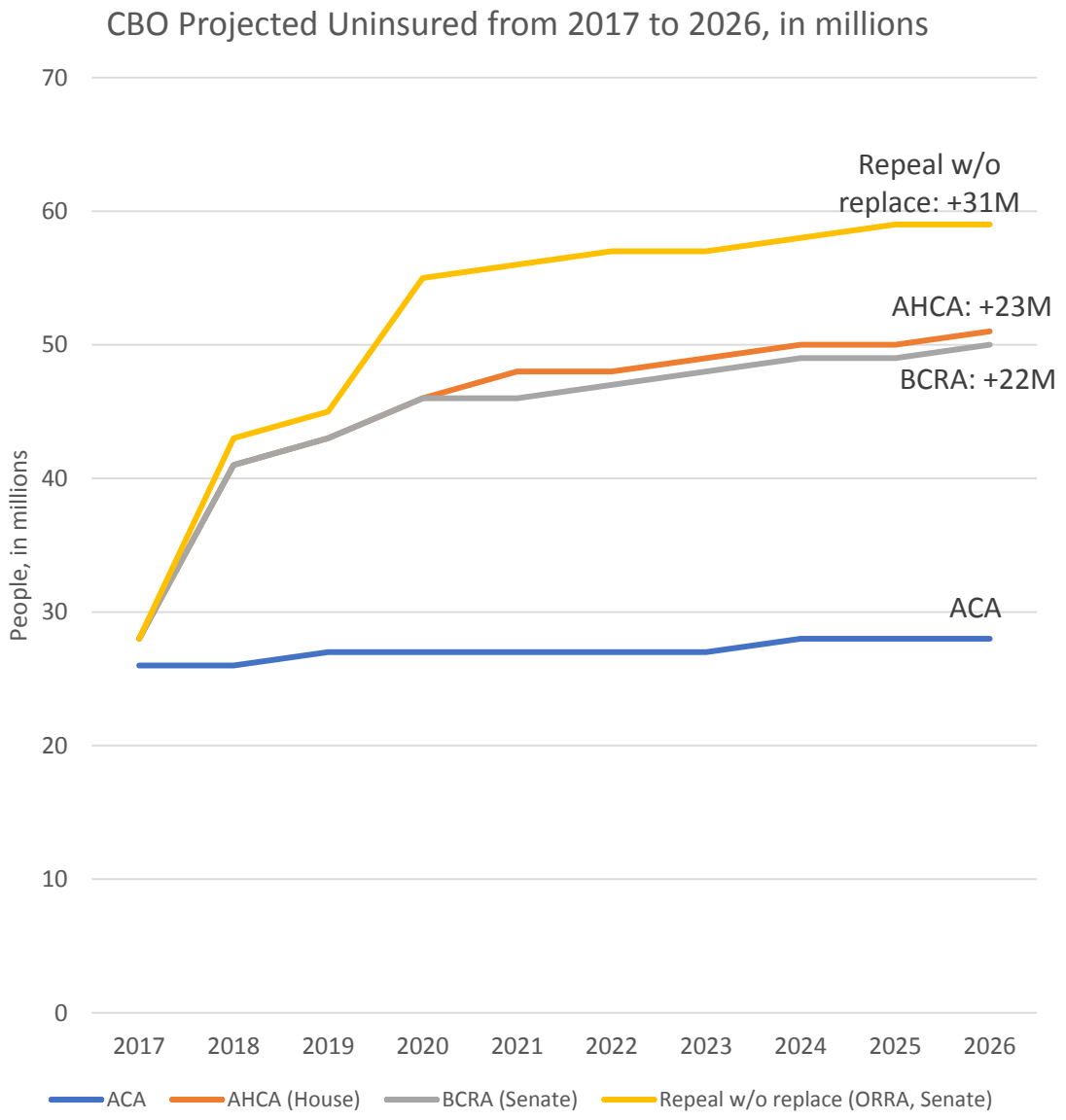
ANNE DUNKELBERG

CPPP ASSOCIATE DIRECTOR, DUNKELBERG@CPPP.ORG

About CPPP:

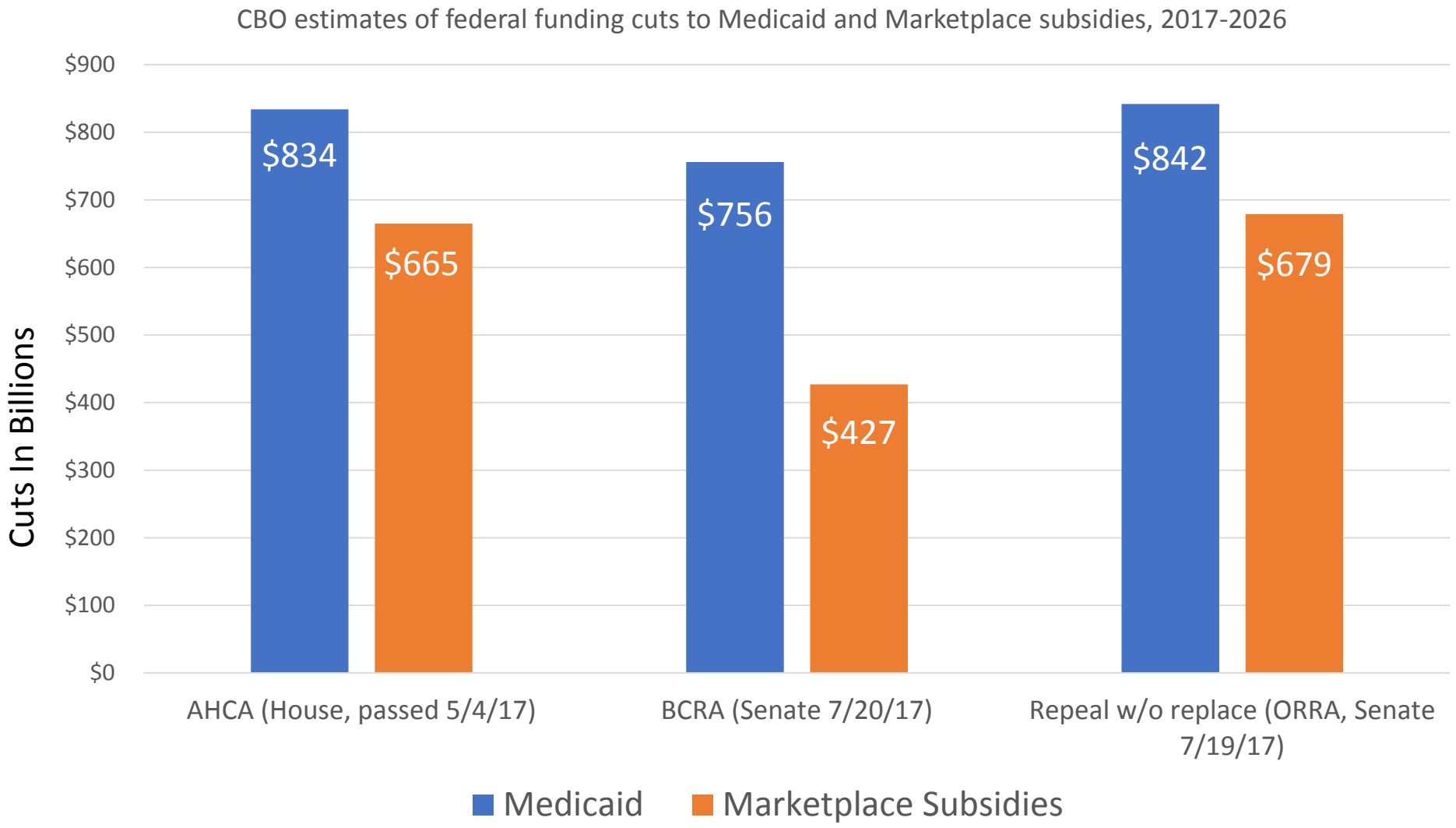
CPPP was born from faith and a vision of social justice in 1985 when a Congregation of Benedictine Sisters in Boerne, Texas, founded the center to improve health care access for the poor.

All ACA Repeal Bills in Congress Cause 22 Million Or More People to Lose Coverage



Source: Congressional Budget Office

All Repeal Bills Contain Massive Cuts to Programs That Make Coverage Affordable for Low- and Moderate-Income People

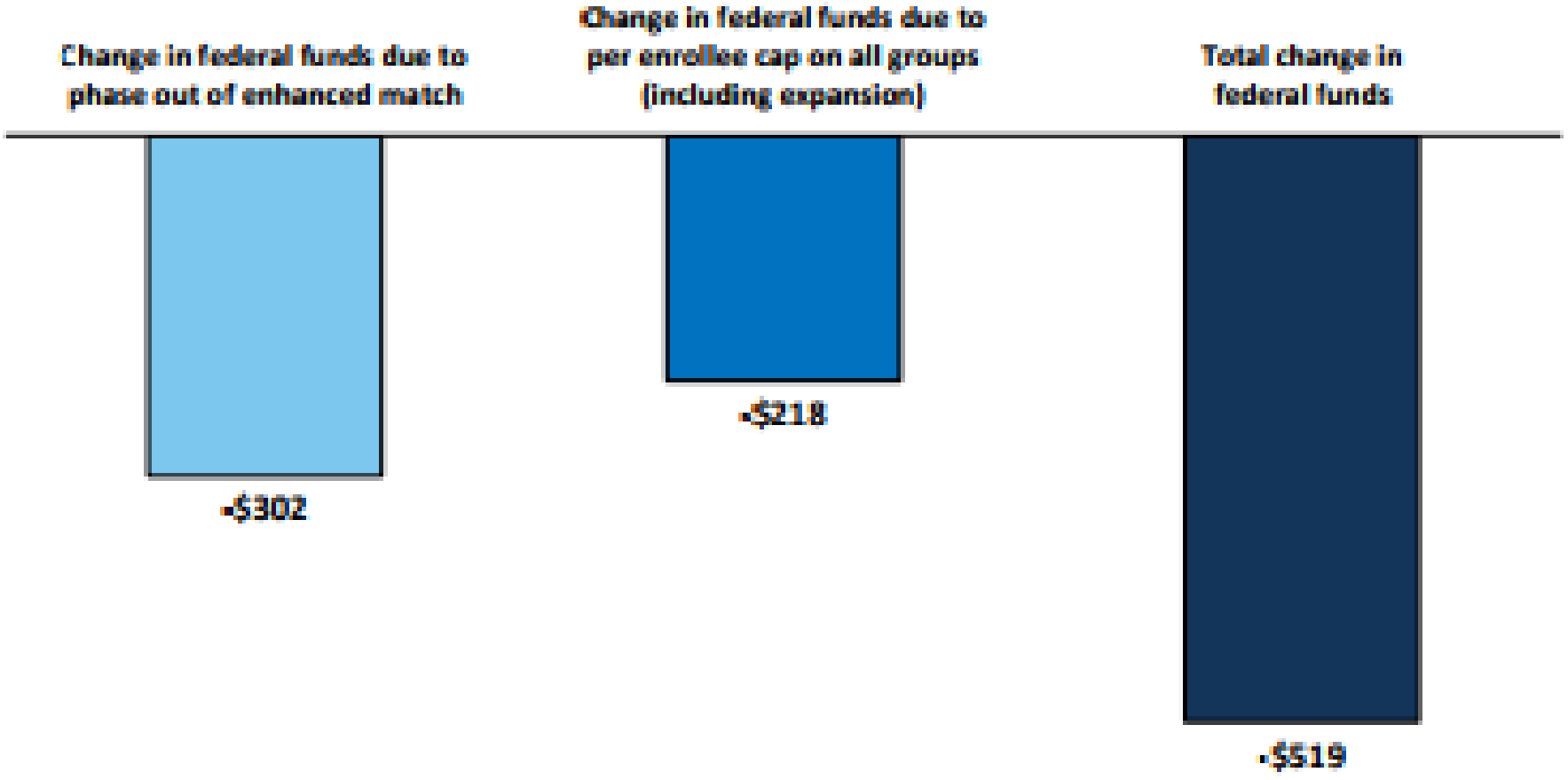


Source: Congressional Budget Office

Figure 1

Estimated Change in Federal Medicaid Spending under the BCRA, 2020-2029 (in billions)

Assumes States Fill in Loss of Federal $



SOURCE: Kaiser Family Foundation estimates, July 2017.

Medicaid Cuts are NOT limited to Medicaid expansion:

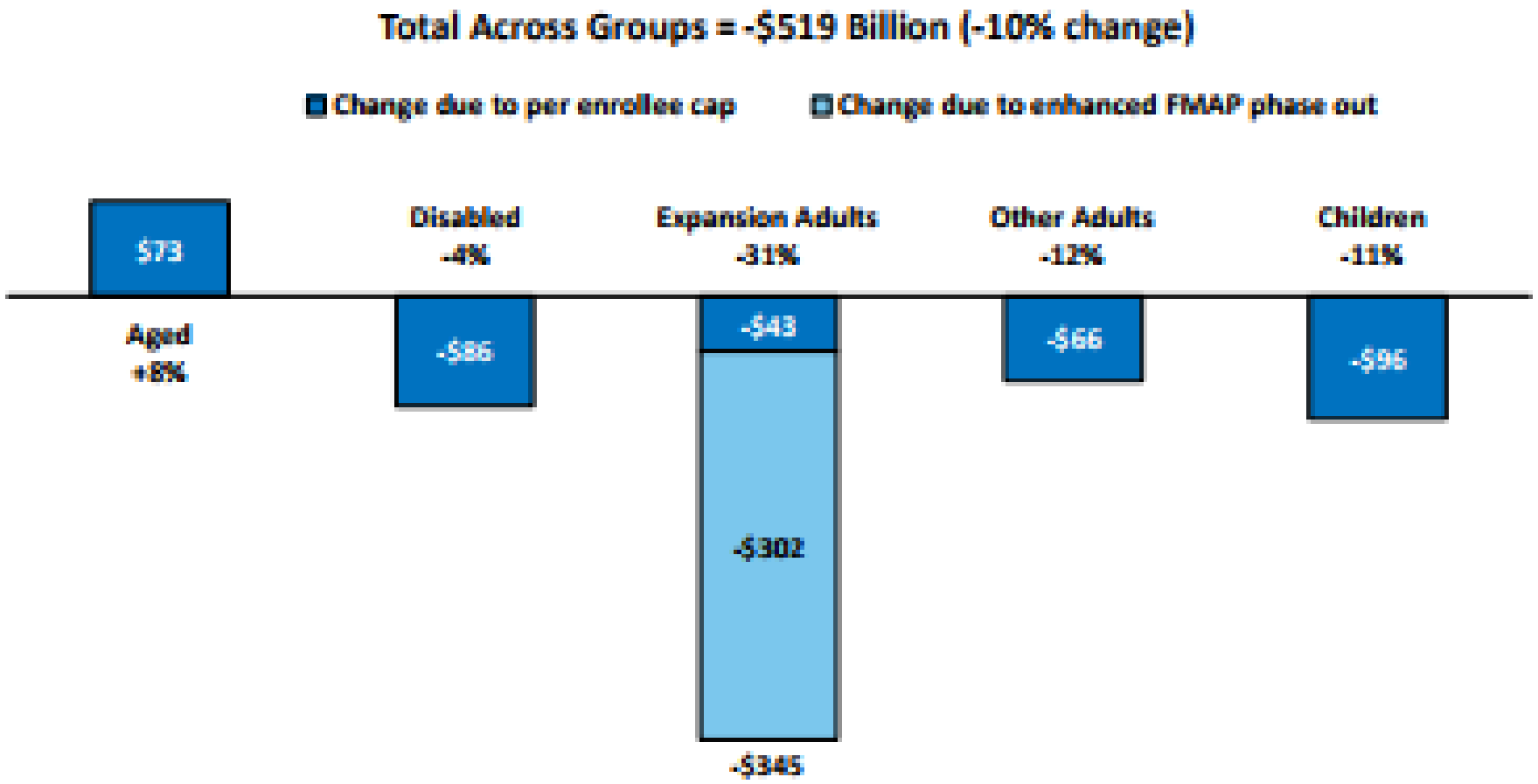
42% of Senate BCRA cuts 2020-2029 are due to Per Capita Cap

http://files.kff.org/attachment/Issue-Brief-BCRA-State-by-State-Estimates-of-Reductions-in-Federal-Medicaid-Funding

Figure 3

Estimated Change in Federal Medicaid Spending under the BCRA, 2020-2029 (in billions)

Assumes States Fill in Loss of Federal $



SOURCE: Kaiser Family Foundation estimates, July 2017.

Senate bill delays a big Medicaid cut to 2025 to push major impact into the second decade.

Supplemental CBO (6/29) report:

- **National Medicaid spending cut to 26% lower in 2026 than under current law.**
- **Deeper cuts in the next decade cause the reduction to the Medicaid to grow to 35% in 2036.**

Impact on Texas Medicaid and Private Insurance (1)

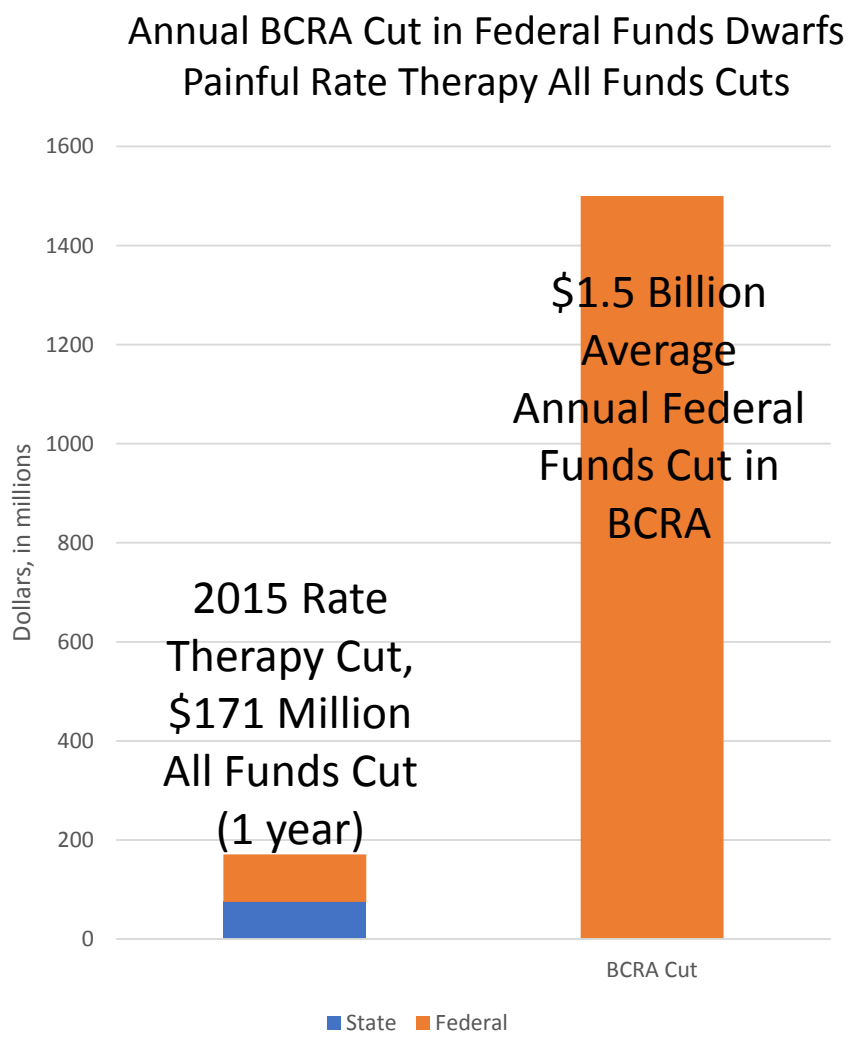
- CBO scores are nationwide
- Estimates of state impact from Robert Wood Johnson and Kaiser Family Foundations, Urban Institute, and Manatt Health.
- Urban Institute:
  - In 2022 over a million fewer Texans have coverage under **Senate** bill, including:
    - 440,000 Texans with employer-sponsored insurance and
    - 768,000 Texans with individual market insurance. (page 13 report)
    - 295,000 more Texas children will be uninsured, compared to current law (Table 1.B)
  - Urban's **House** bill analysis estimated 224,000 fewer Texans would be covered by Medicaid in 2022 (page 23 of the report).

Impact on Texas Medicaid and Private Insurance (2)

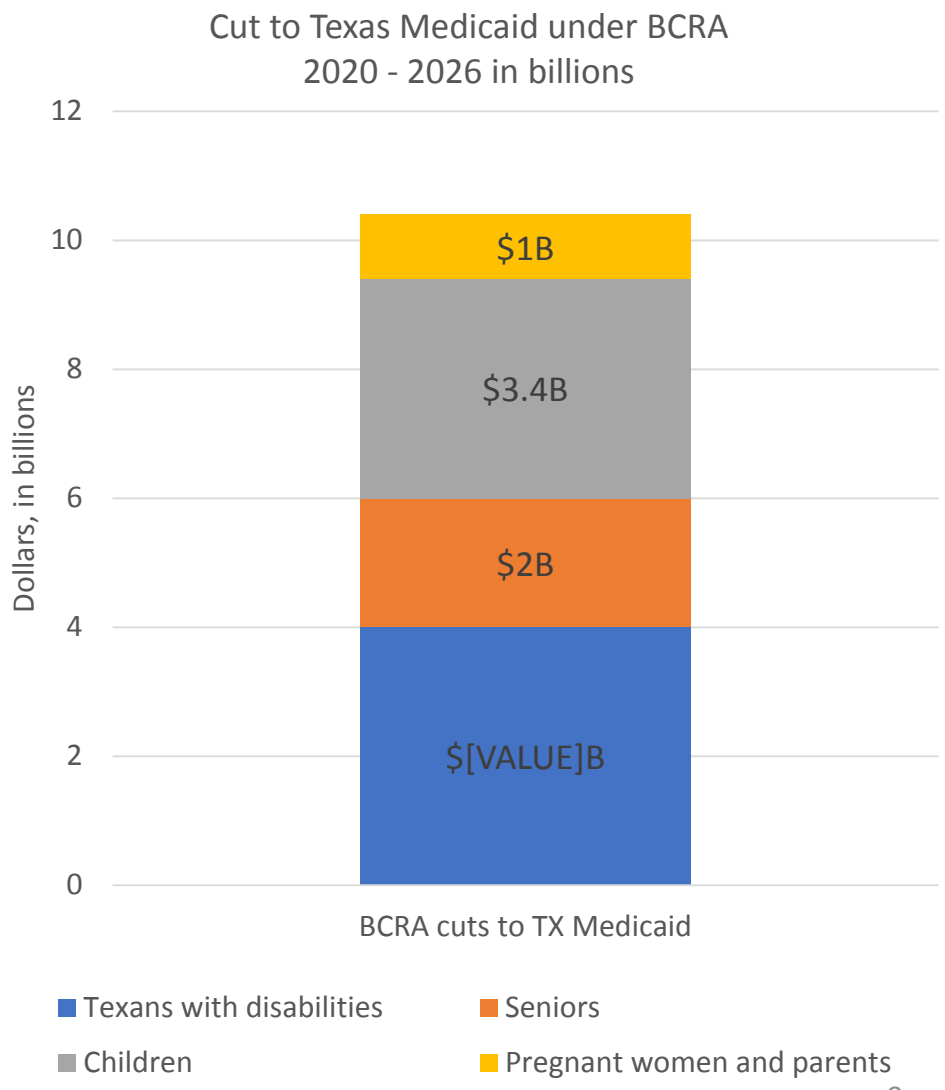
- Manatt Health, for the Robert Wood Johnson Foundation.
  - 19 non-Medicaid expansion states lose $53 billion from 2020 to 2026 in federal Medicaid dollars, due to per capita cap that launches in 2020.
  - Cuts to the existing (pre-ACA expansion) Medicaid program will hit people with disabilities the hardest, with seniors, children, and pregnant women following behind.
  - Texas would lose $10.5 billion in federal Medicaid dollars for our current (unexpanded) Medicaid program between 2020 and 2026. That's about $1.5 billion a year.
  - Of this loss, $4 billion would be for care for Texans with disabilities, $2 billion for seniors, $3.4 billion for children, and $1 billion for pregnant women and the small number of parents who qualify for Texas Medicaid.

BCRA Cuts Billions of Federal Dollars From Texas Medicaid

One Year Snapshot



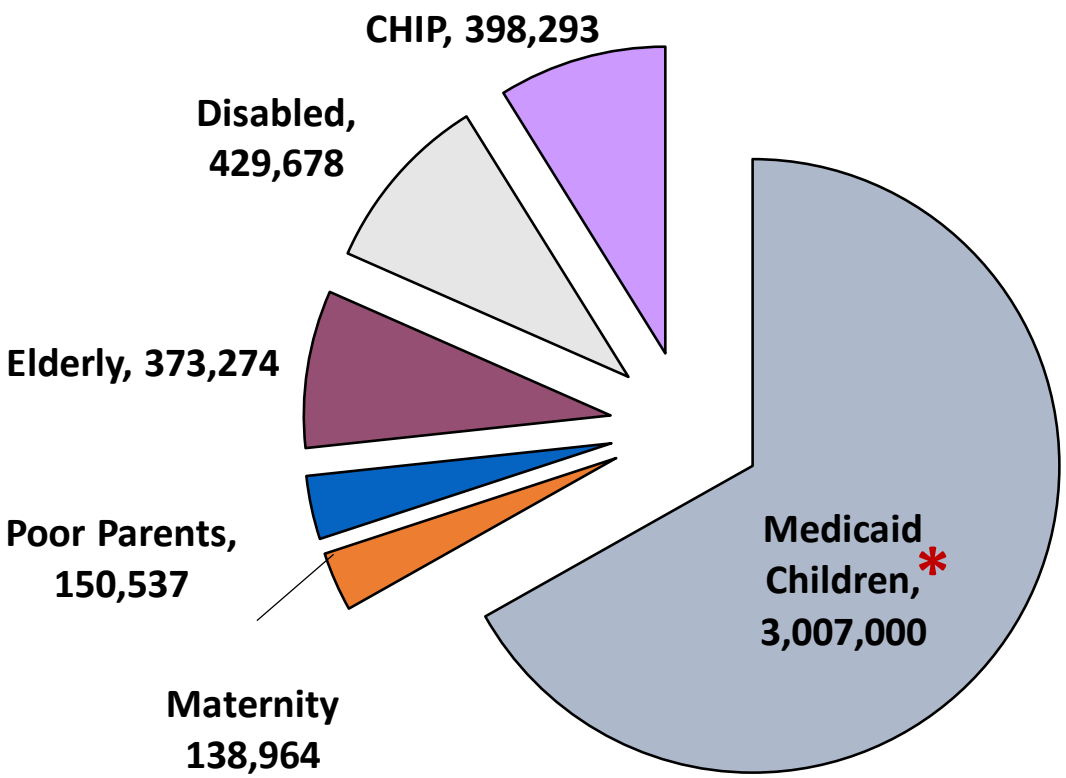
Seven Year Total, $10.5B Cut



Source: Manatt Health, http://www.statenetwork.org/resource/understanding-the-senates-better-care-reconciliation-act-of-2017-bcra-key-implications-for-medicaid/

Texas Medicaid/CHIP: What's at Stake in Congress

Children, Texans with Serious Disability, Poor Seniors, Pregnant Women



* ~ 197,000 more under-21 are in disability, maternity or parent category

Total Enrolled:

(as of February 2017)

4.5 million Texans

Of these,

3.4 million are children

(that's ~45% of Texas kids)

February 2017, HHSC data

Source: Center for Public Policy Priorities, HHSC data.

Senate Bill Doesn't Help People In Medicaid Coverage Gap

- Premium subsidies would be available to people in poverty (low-income consumers would need to pay 2 percent of their incomes in premiums),
- **But,** plans will have deductibles averaging $6,100, or *more than half* the income of someone at the poverty line ($12,060 in 2017).
- So, enrolling in the coverage available under the Senate bill would leave low-income people with an insurance card they couldn't use.
- Because of this, the CBO predicts that very few low-income consumers would purchase coverage.

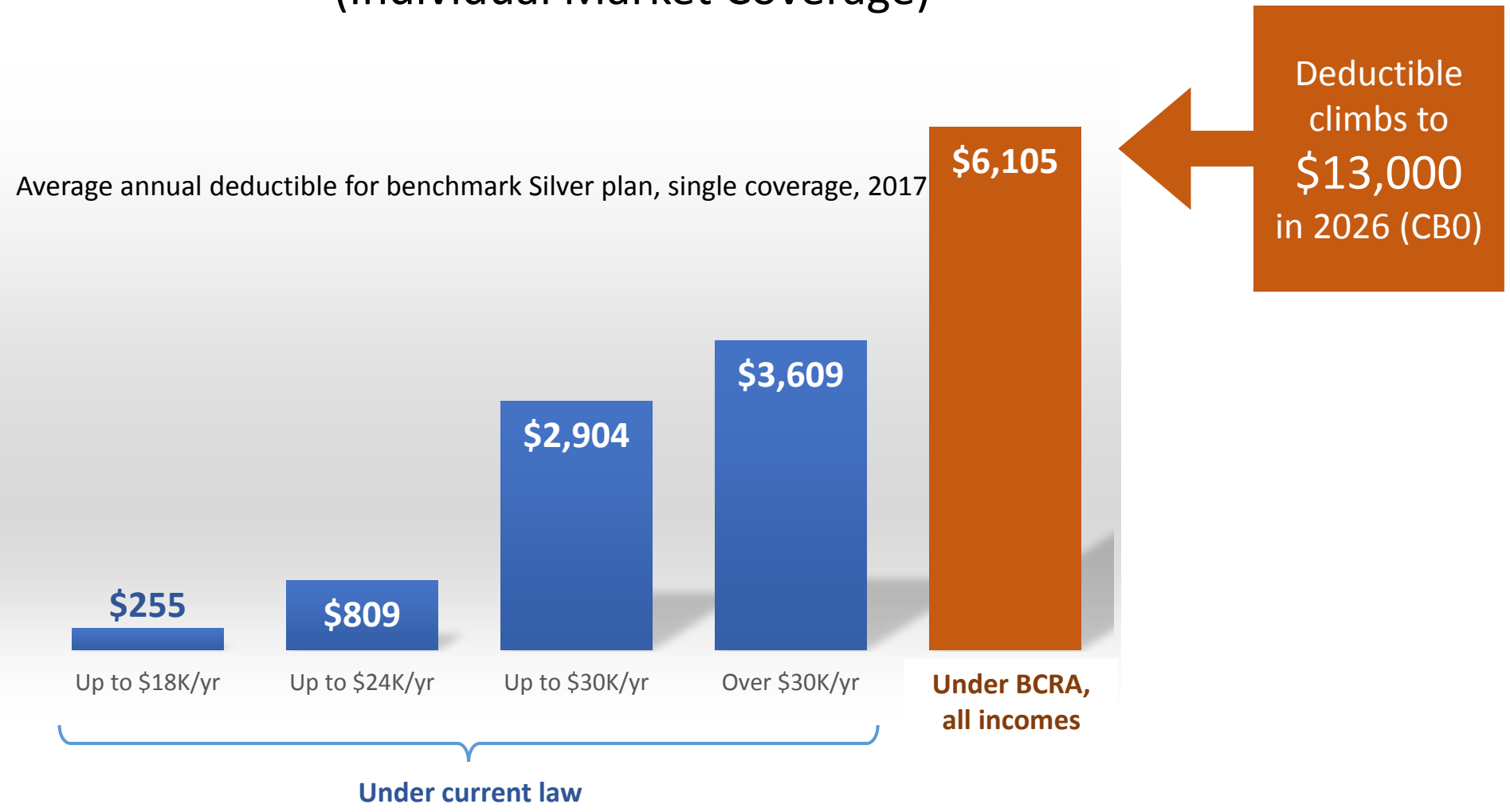
Example: BCRA Increase in Net Premium (after subsidy) for Silver Plan in 2020

Some of Hardest Hit by Repeal Bill Marketplace Subsidy Changes are Lower-Income Texans, Texans Age 50+, and Texans in Rural Areas

Individual Age 60 Earning $30,000/year
Net Premium Increase of $1,360 - $7,360

BCRA 6/22/17
Source: Kaiser Family Foundation

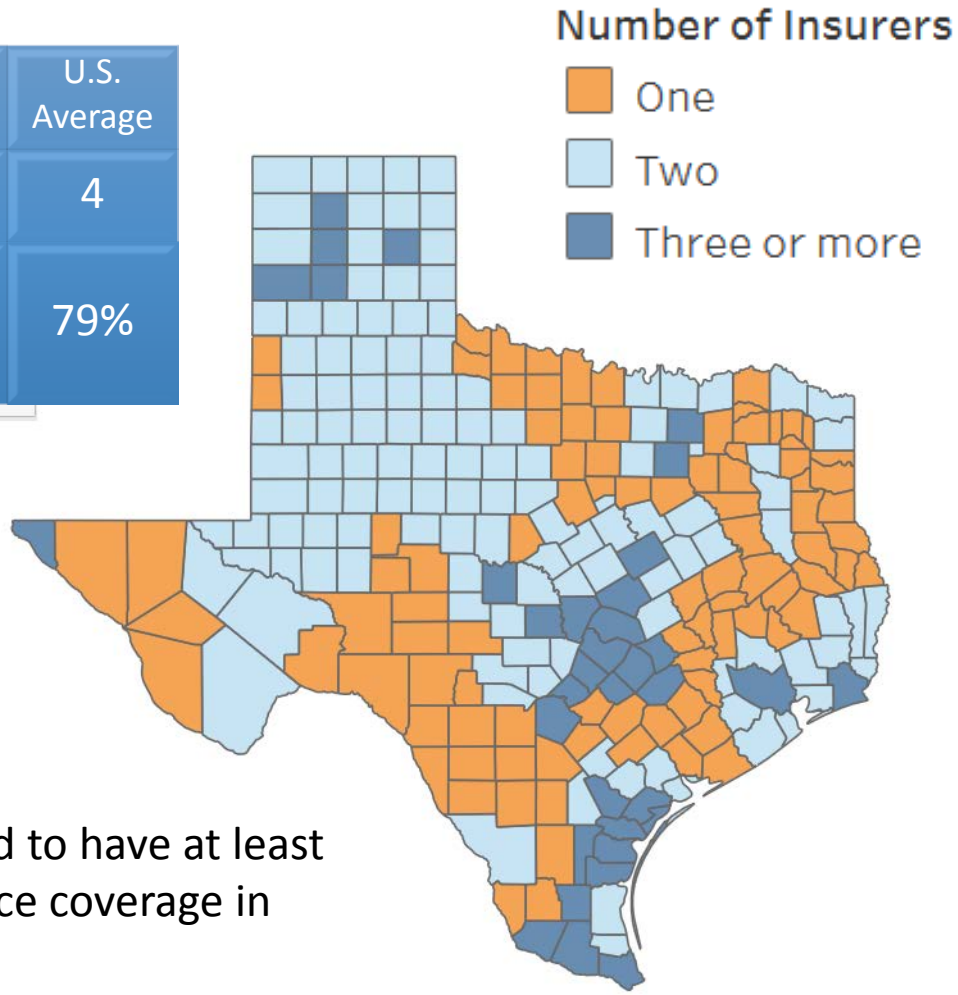
Deductibles Soar Under Senate Health Repeal Plan (Individual Market Coverage)

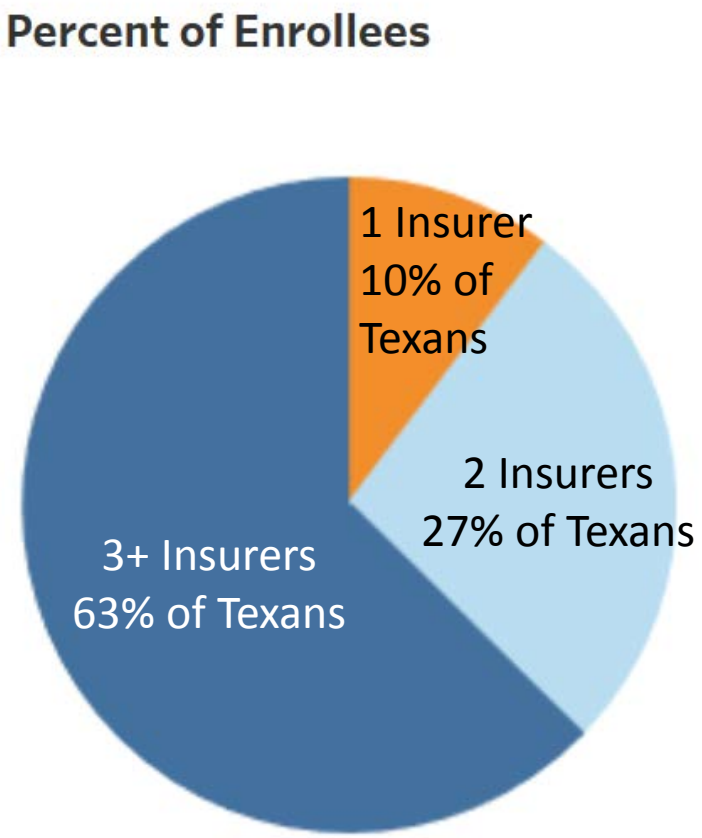


Source: Kaiser Family Foundation analysis, https://twitter.com/larry_levitt/status/878605553705943040

Texas Marketplace Insurer Participation, 2017

	Texas	U.S. Average
# of Marketplace Insurers, 2017	10	4
% of population with choice of 2 or more insurers, 2017	90%	79%





All Texas counties are expected to have at least one insurer writing Marketplace coverage in 2018, as of now.

Source: Kaiser Family Foundation

How Senate Repeal of Subsidies for "Cost Sharing" Would Gut Affordability

- In 2017 (under ACA), the average deductible for a silver plan was $3,609 and $6,105 for a bronze plan
  - people making between 100 – 150% of poverty enrolled in a silver plan on healthcare.gov had an average deductible of $255;
  - incomes between 150 – 200% of poverty had an average deductible of $809;
  - incomes between 200 – 250% of poverty had deductibles averaging $2,904

- Without the sliding-scale "CSR" subsidies, high deductibles and co-pays will make care unaffordable and make insurance worthless.

Recap:

- House, Senate, and Repeal-without-replace bills all result in large increase in uninsured Texans.
- Reduced federal Medicaid funds for states include Texas -- cuts are NOT limited to Medicaid expansion states.
- CBO provides US totals; estimates of Texas' share show deep fiscal losses, more uninsured with fewer covered in employer plans, individual market, and Medicaid.
- Capping Medicaid with Per Capita Cap below historical trends means Texas must either cut back, or replace federal dollars.
- Senate bill drives up premiums and deductibles, but takes away any help with deductibles. This will drive off current low-income Texans and wipe out potential benefits from "offering" Marketplace coverage to Texas adults below poverty (Coverage Gap).

We believe in a Texas

that offers everyone the chance
to compete and succeed in life.

We envision a Texas

where everyone is healthy,
well-educated, and financially secure.

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LEGISLATIVE BUDGET BOARD

Overview of the Texas Healthcare 1115 Transformation Waiver

PRESENTED TO THE HOUSE APPROPRIATIONS COMMITTEE

LEGISLATIVE BUDGET BOARD STAFF

JULY 2017

1115 Texas Healthcare Transformation Waiver

The 1115 Texas Healthcare Transformation Waiver is a five-year Medicaid demonstration waiver that created both the Delivery System Reform Incentive Payment and Uncompensated Care funding pools, and allowed for statewide managed care expansion.

The initial five-year proposal was approved by CMS on December 12, 2011, running through September 2016. This allowed the state to expand Medicaid managed care while preserving federal hospital funding historically received as Upper Payment Limit payments.

HHSC submitted a request to CMS for a 15-month waiver extension in April 2016. The 15-month extension was approved on May 1, 2016 and maintained the size of both pools at Demonstration Year 5 level funding (approximately $7.8 billion total). The approval letter from CMS stated that CMS and HHSC must agree on the size of the UC pool and DSRIP structure by December 31, 2017.

HHSC submitted an additional 21-month extension at current funding levels for UC and DSRIP on January 26, 2017 for a period ending September 30, 2019. This extension is still pending CMS approval.

Funding authorized for both pools in the first five-years of the waiver totals $29.0 billion.

Funding Pools

Uncompensated Care (UC) Pool

- Cost-based
- Offset the costs of uncompensated care provided by hospitals and other providers.
- Payments are based on each provider's uncompensated care costs as reported on an application for UC funding.
- The state uses local or state intergovernmental transfer (IGT) funds from hospital districts, counties, and certain state-owned entities to fund the state match on all UC and DSRIP payments.
- UC payments totaled approximately $3.3 billion in federal fiscal year 2015. $3.1 billion is available for distribution through the UC pool in federal fiscal year 2016.

Delivery System Reform Incentive Payment Pool (DSRIP)

- Providers undertake projects from a menu of projects agreed upon by CMS and HHSC in the Regional Healthcare Partnership Planning Protocol.
- Funds cannot be used to maintain existing initiatives or continue existing services. Funds must be used to enhance an existing initiative or expand services provided.
- Projects come from several different categories including infrastructure development, program innovation, quality improvements, and population-focused improvements.
- As of the end of fiscal year 2016, there were 1,451 approved and active DSRIP projects. Providers report twice annually on achievement of project metrics and milestones in order to earn DSRIP payments. As of April 2016, DSRIP providers have earned approximately $7.1 billion for reaching project-specific milestones since the inception of the waiver.

Regional Healthcare Partnerships

- Eligibility to receive UC or DSRIP payments require participation in one of 20 Regional Healthcare Partnerships (RHPs)
- Activities in each RHP are coordinated by an Anchoring Entity, which is a public hospital or other local governmental entity within each RHP with authority to provide Intergovernmental Transfer (IGT) funds.
- The Anchoring Entity collaborates with regional providers to develop an RHP Plan that includes a regional mission, projects that relate to specific community needs as identified by the RHP, and mechanisms for performance evaluation and reporting.

LEGISLATIVE BUDGET BOARD

Contact the LBB

Legislative Budget Board
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