LEGISLATIVE BUDGET BOARD

Medicaid Overview

PRESENTED TO HOUSE COMMITTEE ON APPROPRIATIONS

LEGISLATIVE BUDGET BOARD STAFF **FEBRUARY 2023**

Medicaid Overview

Medicaid is a jointly funded State-Federal program providing health coverage and services to low-income children and their families, pregnant women, seniors, and people with disabilities. As a requirement of participation, states must cover certain groups and have the option to cover additional groups.

Basic Federal Requirements of Medicaid

Entitlement	Statewideness	Comparability	Freedom of Choice
Any person eligible may in enroll.	Services cannot be limited to certain geographic locations.	The same level of services must be available to all clients.	Clients may see any Medicaid health care provider who meets program standards.

Service Delivery Models

There are two service delivery models for Medicaid:

- **Fee-for-Service** (3.0 percent of clients) – payments are made directly to hospitals, providers, physicians, pharmacists, and other medical practitioners for services rendered.
- **Medicaid Managed Care** (97.0 percent of clients) – a health care delivery system where the state Medicaid agency, the Health and Human Services Commission (HHSC), enters into contractual agreements with managed care organizations (MCOs) to deliver services to clients through negotiated contracts with various service providers.

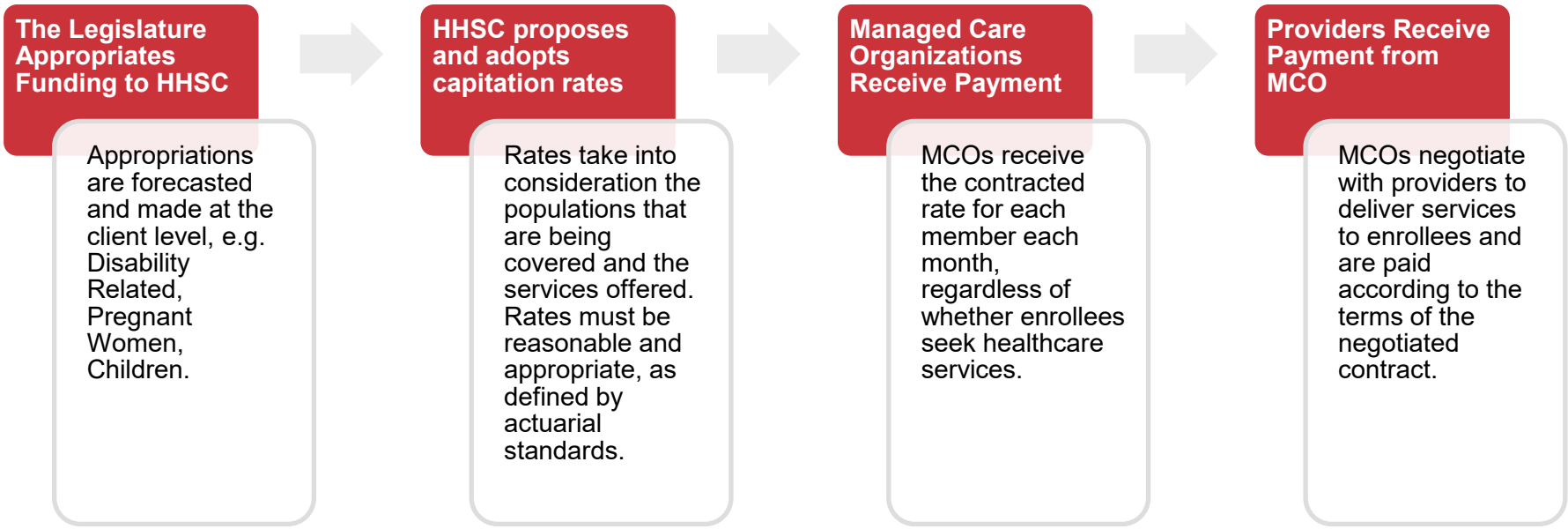
Medicaid Managed Care

Over the last 20 years, HHSC has transitioned most clients away from the fee-for-service payment model.

HHSC now contracts with 17 managed care organizations, and three dental maintenance organizations, to coordinate care for Texas Medicaid and Children's Health Insurance Program (CHIP) Beneficiaries.

Funding Managed Care

In a managed care system, HHSC pays a capitated rate, or fixed amount of money, per member per month to MCOs. This amount is fixed for 12 months but may be modified to account for new or developing situations, such as COVID-19.



Waivers

The U.S. Secretary of Health and Human Services has broad authority to waive statutory and regulatory provisions, allowing states to test new ways of delivering and paying for services. For example:

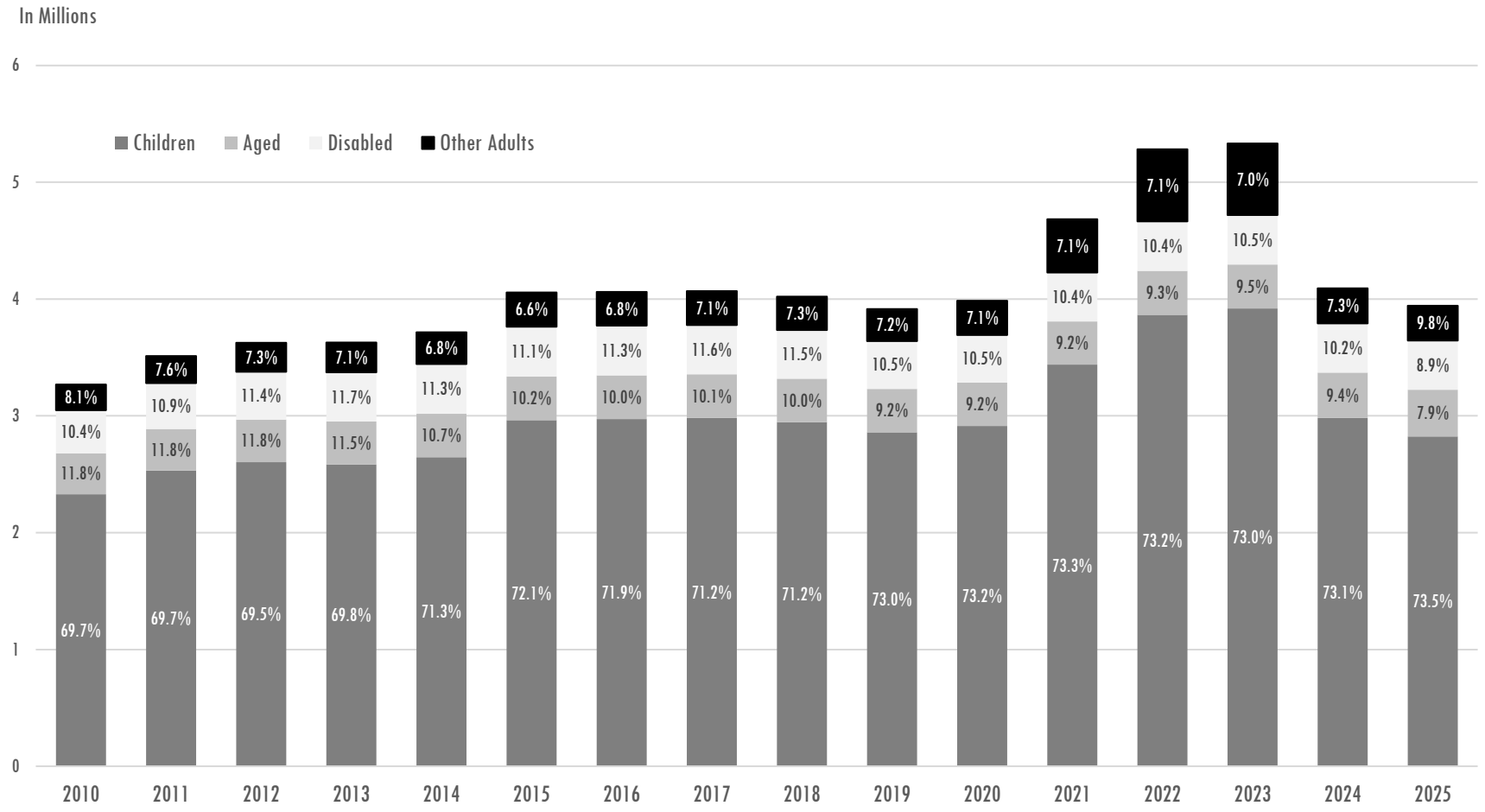
- **Section 1115 demonstrations** do not require statewideness, comparability, or freedom of choice of provider; and
- **1915(c) waivers** allow states to provide long-term-care services in home and community-based settings and may be implemented in limited geographic areas with comparability of services with non-waiver enrollees not required.

Budget Drivers: Caseload and Cost

Medicaid expenditures are primarily a function of two factors: caseload and cost.

- As caseloads increase or decrease (due to factors such as population growth, the economy, or policy changes), Medicaid expenditures fluctuate.
- Medicaid expenditures also fluctuate as a result of cost growth (tied to rate changes, medical inflation, utilization, and acuity), which can be negative or positive.

Medicaid Average Monthly Full-Benefit Caseload by Enrollment Group Fiscal Years 2010 to 2025



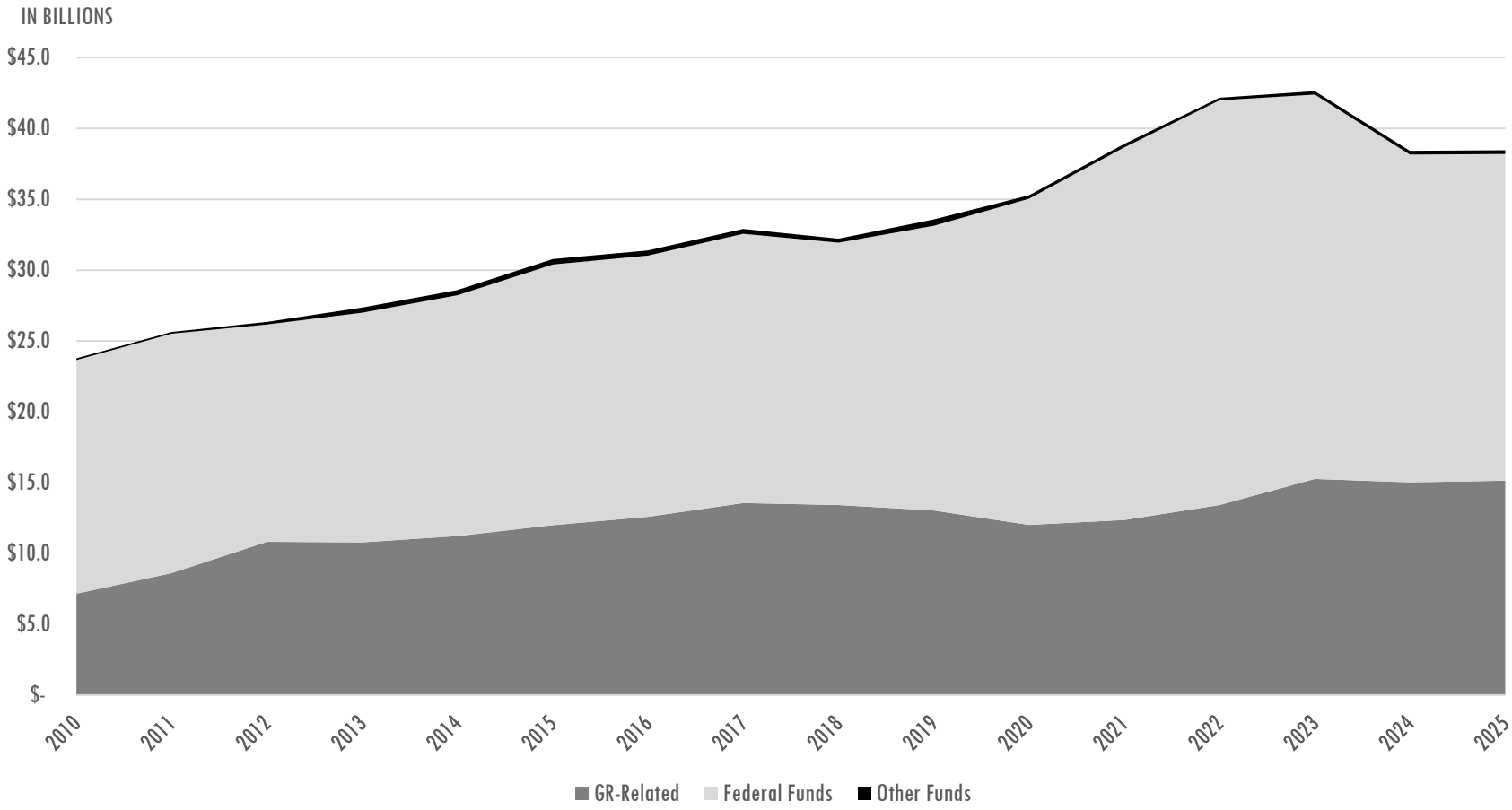
NOTES:
(1) Other adults includes TANF Adults, Pregnant Women, Medicaid for Breast and Cervical Cancer, and Medically Needy clients.
(2) Actual caseloads as reported by Health and Human Services Commission through May 2022, with LBB projected caseloads through 2025.
SOURCES: Legislative Budget Board; Health and Human Services Commission.

Cost Growth

The primary factors contributing to cost growth include the following:

- **Rate Changes:** Adjustments to reimbursements to providers.
- **Medical Inflation:** Growth in costs related to how health care is delivered and what services are available.
    - Technological and other medical advances.
    - Increases in the cost of prescription drugs.
- **Utilization:** Changes in how many services are accessed.
- **Acuity:** Relative health of persons enrolled in the program.

Medicaid Funding by Method of Finance
Fiscal Years 2000 to 2025



NOTES:
(1) Fiscal years 2010 to 2021 are expended, fiscal years 2022 to 2025 are amounts included in the Legislative Budget Estimates, House for all Medicaid funding in Article II.
SOURCE: Legislative Budget Board.

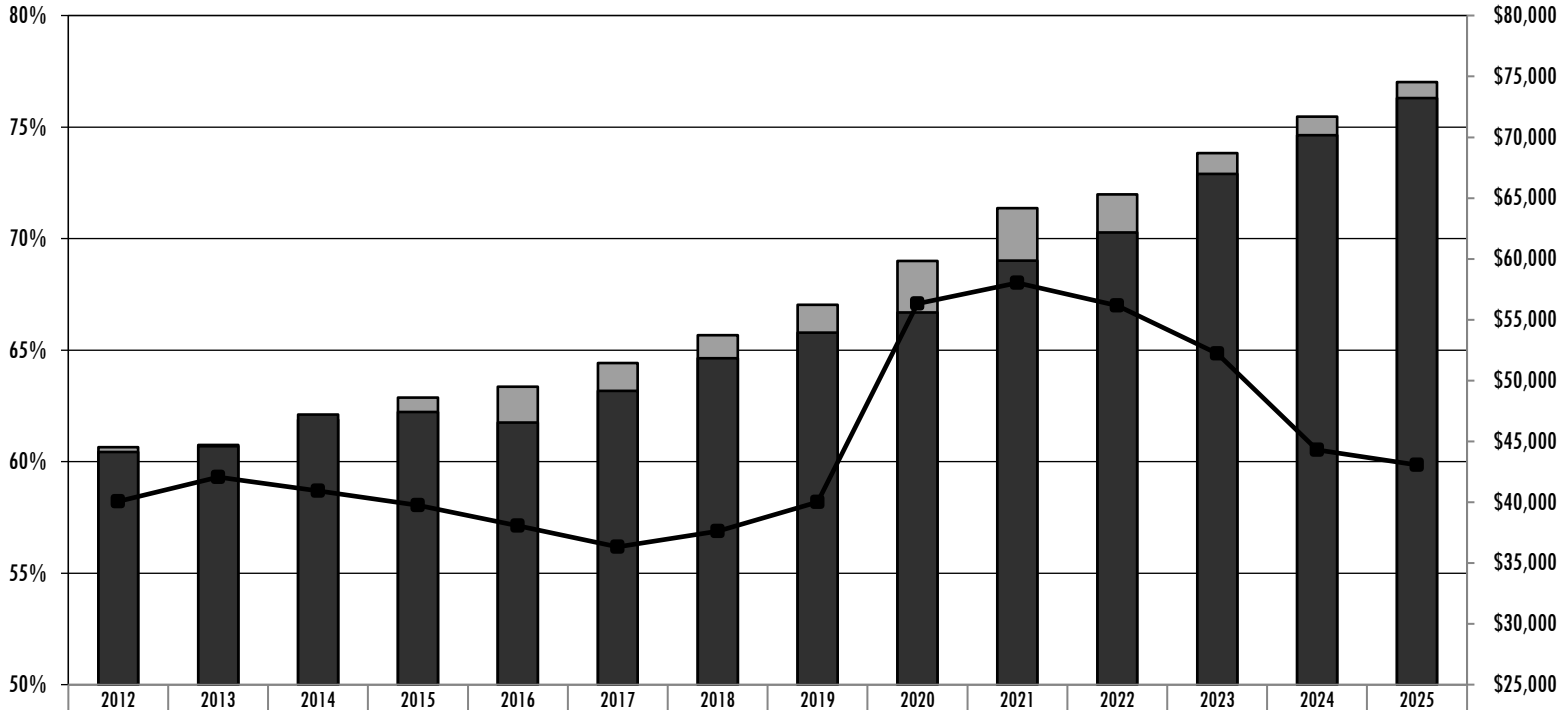
Financing

Financing of the Medicaid program is based on an array of matching rates that determine the amount of state funds (General Revenue, General Revenue-Dedicated, and Other Funds) and the amount of Federal Funds.

The primary matching rate for client services is the Federal Medical Assistance Percentage (FMAP).

- Each state has a different FMAP based on its per capita personal income (PCPI) relative to the nation's PCPI.
    - Federal Fiscal Year (FFY) FMAP is generally announced in November of the previous FFY.
    - FMAP is based on the three most recent years of income data available.
- State FMAPs can range from 50 to 83 percent.
    - Below 55 percent: states with PCPI higher than the national average.
    - Above 55 percent: states with PCPI below the national average.

FMAP and PCPI
Federal Fiscal Years 2012 to 2025



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
US PCPI	$44,528	$44,706	$46,772	$48,592	$49,498	$51,444	$53,725	$56,228	$59,826	$64,162	$65,296	$68,690	$71,702	$74,547
Texas PCPI	$44,136	$44,608	$47,206	$47,409	$46,556	$49,147	$51,836	$53,938	$55,601	$59,865	$62,178	$66,987	$70,178	$73,212
FMAP	58.22%	59.30%	58.69%	58.05%	57.13%	56.18%	56.88%	58.19%	67.09%	68.01%	67.00%	64.85%	60.53%	59.85%

NOTES:
(1) FMAPs are for federal fiscal year (FFY) and reflect increased FMAPs related to the Families First Coronavirus Response Act. The FMAP has been updated here due to the passage of the CAA, 2023, which will phase out the increased FMAP through the first fiscal quarter of state fiscal year 2024.
(2) FFY 2025 FMAP and 2023-25 PCPIs are projected.

SOURCES: Legislative Budget Board; U.S. Department of Health and Human Services; Bureau of Economic Analysis; U.S. Census Bureau.

Unwinding Continuous Medicaid Coverage and the Increased FMAP

- March 2020 - the Families First Coronavirus Response Act (FFCRA) provided a 6.2 percentage point increase in FMAP under the condition that states provide continuous Medicaid coverage.
    - The FFCRA made the 6.2 percentage point increase available from January 1, 2020, through the last day of the federal fiscal quarter in which the public health emergency (PHE).
- December 2022 - Congress passed H.R. 2617, the Consolidated Appropriations Act, 2023, (CAA, 2023) which unlinked the increased FMAP from the PHE and phases out the increase through the end of this year:
    - Beginning April 1, 2023, states will receive a 5.0 percentage point increase to the FMAP through June 30 (compared to the 6.2 percent).
    - For July 1 to September 30 the increase drops to 2.5 percentage points.
    - From October 1 to December 31 the increase drops to 1.5 percentage points.
- States will have 12 months to initiate eligibility redeterminations for every client on Medicaid.
- Disenrollments can begin April 2023.

Other Matching Rates

Certain Client Services

Higher matching rates are available for certain client services. Examples include:

- Enhanced FMAP (EFMAP)
    - 30 percent reduction to the state share under FMAP
    - Applies to Medicaid for Breast and Cervical Cancer
- 90/10 - Family planning services
- Community First Choice
    - 6 percentage point increase to FMAP
    - Applies to certain long-term-care services

Administration

Most administrative services are matched at 50 percent. Examples of other administrative matching rates include:

- 90/10 - Design, development, or installation of an approved Medicaid Management Information System (MMIS) for claims and information processing
- 75/25
    - Operation of an approved MMIS for claims and information processing
    - Activities conducted by skilled medical professionals
    - Certain medical and utilization review activities
    - Certain external quality review activities
    - Operation of a state Medicaid fraud control unit

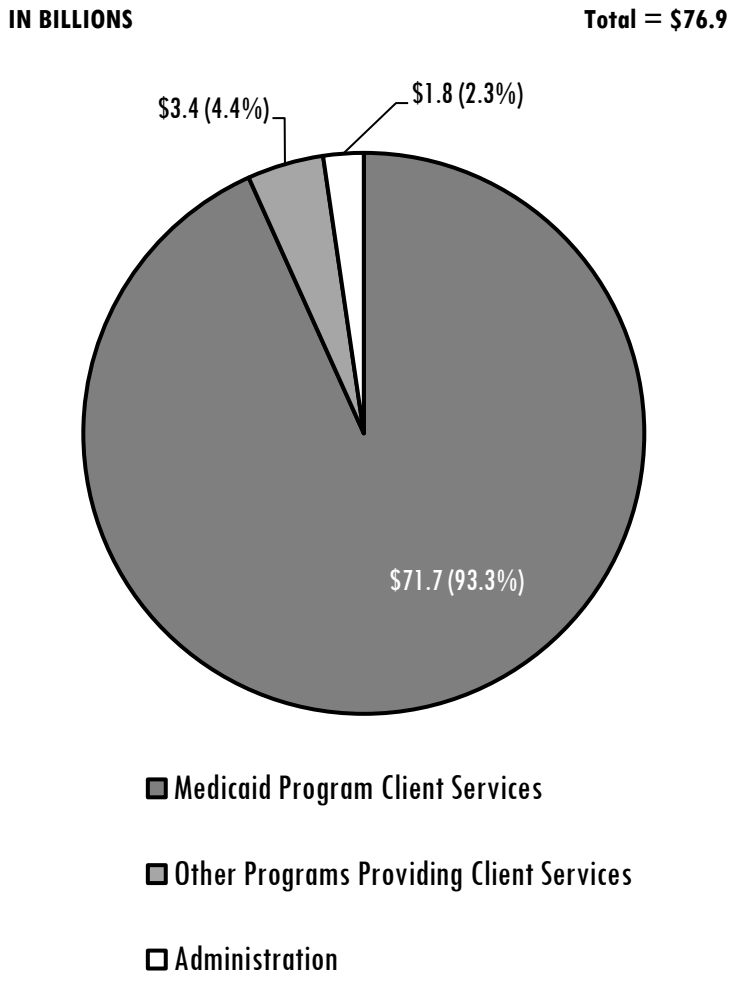
Medicaid Funding

In Millions	2022-23	2024-25	Biennial Change	Percentage Change
General Revenue	$28,564.0	$30,026.1	$1,462.0	5.1%
General Revenue-Dedicated	$114.1	$123.5	$9.4	8.3%
Other Funds	$410.2	$531.4	$121.2	29.5%
Federal Funds	$55,709.2	$46,193.6	($9,515.7)	(17.1%)
All Funds	**$84,797.6**	**$76,874.5**	**($7,923.0)**	**(9.3%)**

Less favorable FMAPs result in a lower proportion of the program being funded with Federal Funds.

The 2022-23 base, shown above, includes $3.4 billion in General Revenue Funds above the 2022-23 General Appropriations Act and reflects revenue adjustments, transfers, and assumed supplemental funding.

Medicaid Funding by Category
2024-25 Biennium



Medicaid funding supports three major functions across Article II.

- Medicaid program client services, which are funded in Goal A at HHSC
- Other programs providing client services where Medicaid is a source of funding
    - Examples include the Healthy Texas Women (HTW) program, the Early Childhood Intervention (ECI) program and State Supported Living Centers (SSLCs)
- Administration of these programs including the following:
    - Direct administration of and contracts for the Medicaid program
    - Other administrative function where Medicaid is a source of funding

Contact the LBB

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