Texas Public Policy Foundation

Save Texas Medicaid:
A Proposal for Fundamental Reform

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Save Texas Medicaid: A Proposal for Fundamental Reform

Executive Summary

Texas' Medicaid program is in need of fundamental reform. The current system leaves enrollees with inadequate access to providers and delivers poor health outcomes. Nearly 70 percent of Texas physicians will not accept new Medicaid patients, who are often forced to seek primary care in hospital emergency rooms. Numerous studies have demonstrated that those on Medicaid have worse outcomes than those with private health insurance.

Moreover, Medicaid spending is on an unsustainable trajectory. Medicaid expenditures in Texas now consume more than 25 percent of the state budget—an estimated $28 billion in 2012—and are expected to increase in the current biennium. Rising enrollment due to a slowly recovering economy and rising health care costs, exacerbated by the implementation of the Patient Protection and Affordable Care Act (ACA), necessitate fundamental reform of the program.

This paper proposes such reform in the context of a federal block grant of Medicaid funds to the state. With a defined contribution of federal funding, along with broad flexibility to redesign its Medicaid program, Texas could implement market-based reforms that would lower costs and improve patient choice.

The proposals outlined below are the culmination of more than three years of research by the Texas Public Policy Foundation (TPPF). A 2010 report[1] by TPPF modeled the long-term costs of Medicaid, both with and without expansion, and found that under the ACA expansion the program would consume 33 percent of the General Revenue (GR) budget and 49.4 percent of the All Funds (AF) budget by 2040.

A pair of studies published by TPPF in 2011[2] and 2012[3] examined the acute and long-term care sides of Medicaid, respectively, and proposed systematic reforms that laid the foundation for a patient-centered, market-driven Medicaid program for Texas. Among the findings of the 2011 study was that given the flexibility, Texas could design a Medicaid program that covers the current Medicaid population for less than current program costs. The 2012 study, published in December, found that if long-term care cost growth was limited to 4 percent per year, savings would build over time, and by 2020 the state would be spending $6 billion less than it would if the program remained unreformed.

The findings of these three studies form the basis for the recommendations set forth in this paper. By making program enrollees cost-conscious participants in their care and by transitioning from a "defined benefits" model to a "defined contribution model" for most Medicaid eligibility groups, Texas can ensure the long-term sustainability of its Medicaid program and improve health outcomes for those who rely on it for coverage.

Introduction

Rapid cost escalation in the Medicaid program is creating immense pressure in the federal and state budgets, displacing other important spending priorities. Despite efforts to control costs over the past decade, Medicaid spending has continued to rise at both the federal and state level. Federal Medicaid spending has more than quadrupled over the past forty years, increasing from $25.4 billion in 1972 to $282 billion in 2011 (measured in constant 2012 dollars).

On the state level, Medicaid spending continues to consume an ever larger share of state budgets. Even if Texas does not expand Medicaid as called for in the ACA, the state's program costs will continue to diminish funding available for other budget areas. The rapid growth of the cost of entitlement programs like Medicaid has meant that even states with a relatively strong economy, like Texas, have experienced difficulty meeting their entitlement obligations. A budget gap in 2011 left a $4.5 billion shortfall in Texas' current Medicaid budget, which lawmakers must backfill before they approve a budget for the 2014-15 biennium.

The intermingling of state and federal finances through the federal matching program splits political accountability for expenditures, creates instability in state budgets, and incentivizes states to spend more, not less, in order to pull down more federal dollars.

In anticipation of rising enrollment and cost, the State Texas House of Representatives has recommended a 4.2 percent increase ($1.2 billion) in GR general revenue funds for Medicaid in the upcoming biennium, the vast majority of which will pay for caseload growth. Beyond this, there is little room to infuse more state funds into the Medicaid program without raising taxes, making cuts elsewhere in the budget, or both.

For all the spending growth, the program's quality and provider access falls short of what is needed for people dependent on it for health care. The network of providers serving Medicaid patients overlaps less and less with the mainstream provider community. In Texas, only about one-third of all physicians will accept new Medicaid patients, down from 67 percent in 2000. This is primarily due to declining reimbursement rates from the state. Under the current structure, federal rules and regulations provide states few options for controlling Medicaid costs aside from cutting provider payments, with the result that more providers are opting out of the program entirely and leaving enrollees with declining access to care.

The root cause of this problem is the funding structure of the program. The intermingling of state and federal finances through the federal matching program splits political accountability for expenditures, creates instability in state budgets, and incentivizes states to spend more, not less, in order to pull down more federal dollars. The federal government pays states Medicaid matching funds according to a Federal Medical Assistance Percentage (FMAP), calculated based on a state's per capita income. Minor fluctuations in the FMAP have a significant impact on state budgets. For Texas, a one-tenth percent decline in the FMAP shifts approximately $25 million in Medicaid costs from the federal budget into the Texas general revenue fund.

This approach makes cost control difficult. In 2012, the federal government paid 58.22 percent of all Texas Medicaid costs, making cuts to the program's budget an unattractive and politically difficult proposition for state lawmakers. The national average FMAP rate is 60 percent, which means states keep only $1 for every $2.50 they cut. Given these perverse incentives, it is little wonder that legislators are loath to cut the Medicaid budget.

To solve this problem, state funding for Medicaid should not be determined based on the amount of federal funding, nor should federal funding be dependent on state decisions regarding eligibility, benefits, and provider payments. Federal funding should be fixed at a certain amount and given to states in the form of a block grant. In return, states should be given the flexibility to implement more cost-efficient programs while also being held accountable for outcomes, such as health status indicators of low-income residents and insurance coverage trends.

Converting Medicaid funding to a block grant program has clear advantages for states and the federal government alike. By funding state Medicaid programs with a block grant, the federal government would gain budgetary stability; funding would no longer be subject to state spending patterns and schemes to pull down ever-more federal funds. Likewise, states could rely on a fixed amount for Medicaid in their budgets and avoid chronic issues of underfunding and backfilling program budget shortfalls. Such an approach would incentivize states to control costs, as they would have clear budget limits and no unlimited entitlement to matching federal funds.

A block grant would also give states near total control over program design, eliminating the need for federal waivers and approval of state plan amendments. Authority to design and run the program would rest entirely with the states, as would political accountability for outcomes and performance. With greater control, states would have flexibility to innovate in their Medicaid program implementation and improve both quality and access to care for those who rely on it. Research by the Texas Public Policy Foundation has shown that Texas could provide higher quality care to a greater number of Medicaid recipients for only 95 percent of the aggregated amount of current funding, resulting in a budget surplus for both federal and state governments.

Beyond cost considerations, a block grant would allow Texas to pursue patient-centered, market-driven reforms that allow Medicaid enrollees to be active, decision-making participants in their own care.

With greater control, states would have flexibility to innovate in their Medicaid program implementation and improve both quality and access to care for those who rely on it.

Such reforms would be consistent with a broad effort aimed at expanding access to quality healthcare while reducing its costs.

Part I: The Federal Block Grant

Any block grant proposal must answer two central questions: 1) what will be the basis for calculating the state block grant amounts, initially and in future years, and 2) what are the accountability rules for federal funding?

The Basis of the Federal Block Grant Amounts

Determining the amount of the block grant based on historical funding presents a number of inequalities. Medicaid programs vary between the states, such that states with higher health care costs get more federal funding. In addition, some states have negotiated more favorable waiver arrangements than others, and Disproportionate Share Hospital (DSH) payments reflect historical use rather than rational policy choices.

Nonetheless, basing the initial block grant amount on historical spending is the most acceptable method because it represents the political status quo. The basic formula should be structured as follows:

- Examine the three most recent years of spending (inflating years one and two using the state's 10-year average Medicaid growth rate). Emergency Medicaid funds, as well as DSH, Uncompensated Care, Upper Payment Limit, etc., will be included in this total.

- Subtract from the three-year amounts the expenditures for the covered populations whose incomes are above 100 percent of the Federal Poverty Level (FPL) and who will be covered through the federal exchange. The amount subtracted from the block grant will not include the groups defined in the "state accountability" section with incomes at about 100 percent FPL, who will be required to be covered under the block grant for a period of three years.

- Inflate the resulting three-year average by the 10-year average rate of growth to get the state's funding in year one.

- After the first year, the block grant amount should be adjusted as follows:

  - For inflation (by the Medical CPI)

  - For changes in the number of persons in the state with income below 100 percent of the FPL relative to the number in year one, as measured by a data survey that is mutually agreed upon by the federal and state governments (the block grant would be multiplied by the ratio of the population in year X divided by the number in year one).

State Accountability

If the federal government provides funding through a block grant, metrics for state accountability will be needed to ensure federal taxpayer funds are used efficiently to meet the national objective of ensuring a safety net for access to health care.

Upon accepting a block grant, the state will agree to various conditions in order to ensure accountability, eligibility, and quality outcomes. Utilizing the funding and flexibility available to it under the block grant, the state will commit to decrease the number of uninsured residents with incomes below 100 percent FPL within the first five years of the program, while assuring equal or better quality of care and equal or better access to providers.

In determining eligibility, the state will grandfather the current eligible and enrolled population for a period of 3 years. An individual eligible for and receiving benefits under the Texas state plan as of December 31, 2013, will remain eligible to receive benefits offered to the comparable population under the Texas block grant program provided the individual remains continuously eligible and enrolled under the state plan provisions in effect on December 31, 2013.

For new applicants, the state will provide coverage to all individuals who:

- are pregnant women whose family income does not exceed 133 percent of the federal poverty level;

- are infants and children under the age of 19 whose family income does not exceed 133 percent of the federal poverty level;

- are parents and caretaker relatives meeting the requirements of Section 1931 of title XIX;

- receive supplemental security income (SSI) benefits, or are mandated to be covered under the Act as of December 31, 2013;

- are receiving foster care or adoption assistance under part E of title IV (including individuals eligible under this title by reason of section 473(b));

- are recipients of Refugee Cash Assistance;

- are qualified Medicare beneficiaries as defined in 1905(p)(1) eligible for Medicare cost-sharing or are mandated to be covered for Medicare cost sharing coverage as of December 31, 2013.

In order to achieve improved quality of coverage, the state will also ensure that the scope of the health benefits under the block grant is sufficient to provide adequate medical care to populations being served by the program, and assure that there are adequate providers of services for the populations covered. For those who require long term care services and supports (LTCSS), the state will assure that they will have the means to obtain the services necessary to meet these needs in a community or, if necessary, in an institutional setting.

The following provisions of law shall apply to the block grant:

- The Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.);
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);
- The Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.);
- Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.);
- Health Insurance Portability and Accountability Act of 1996 (HIPAA; Pub.L. 104-191, 110 Stat. 1936, enacted August 21, 1996).

In addition, the state will:

- Maintain a Tribal consultation process to ensure meaningful and timely input by Tribal officials in the development of policies that have Tribal implications;
- Follow the federal requirements for state residency;
- Comply with the Hyde Amendment regarding abortion-related services for all grandfathered, mandated, and state approved populations (no block grant funding, or state funding used in the Medicaid program, can be used in violation of the Hyde Amendment);
- Agree to certain specific administrative responsibilities as outlined in section 6 below.

Nothing in this plan would prevent the state from utilizing the most efficient method of determining eligibility and other state administrative responsibilities.

State Authority

The state will retain authority in all areas not explicitly identified as reserved to the federal government. For example, income and resource methodologies for grandfathered and mandated groups are determined by the state. For populations the state chooses to cover beyond the grandfathered and mandated populations, the definition of the groups, resource and income standards and methodologies, benefits, cost-sharing, effective dates, etc. are all determined by the state.

For all eligibility groups, services are delivered to eligible recipients as determined by the state. Nothing in the act creating the block grant will prohibit the state from providing care through a fee-for-service delivery system, a managed care contract, premium support through commercial plans, health savings accounts, or other methods determined by the state to be the most cost effective approach to assuring access to covered benefits for the populations covered. In addition, if it so chooses, the state will have authority to allow premiums to be eligible for payment from health savings accounts notwithstanding other provisions of federal law.

For all eligibility groups, services are delivered to eligible recipients as determined by the state.

For any groups receiving care through a fee-for-service system, the methods for determining amounts of provider reimbursement are determined by the state. In addition, the state is not required to comply with 1917(d)(4)(B) of the Act (Miller Trusts) for mandated or state optional populations.

The Centers for Medicare and Medicaid Services (CMS) will retain the waiver authority to contract with the state to provide coordinated services to individuals who are dually eligible for Medicare and Medicaid Services.

State Administrative Requirements

Although the block grant will afford the state ample flexibility with regard to implementation and program design, a number of administrative require-

The federal government will review and comment on the state plan, but will not approve or disapprove of individual components of the plan unless there is a direct violation of the terms of the block grant as set forth in statute.

ments must be fulfilled by the state as a condition of receiving the block grant. These requirements include the following:

1. Provide a plan of the program and notice of significant revisions to the plan prior to expenditure by the state of payments made with block grant funds for any fiscal year. The plan will include the intended use of the payments the state is to receive under the block grant, including information on the types of activities to be supported, the categories or characteristics of individuals to be served, the benefits to be provided, how the benefits will be provided, the objective criteria for the determination of eligibility and for fair and equitable treatment, including an explanation of how the state will provide opportunities for recipients who have been adversely affected to be heard in a state administrative or appeal process;

2. Provide for adequate public consultation on the plan with local governments and private sector organizations;

3. Provide protections against program fraud and abuse, including standards and procedures concerning nepotism, conflicts of interest among individuals responsible for the administration and supervision of the state program, kickbacks, and the use of political patronage;

4. Submit reports containing information, as the Secretary may from time to time require, to ensure compliance with the program's federal requirements and to allow HHS compliance with its reporting requirements to Congress on Texas program expenditures and other program components, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

5. Comply with Section 1921 of the Social Security Act concerning sanctions taken by state licensing authorities against health care practitioners and providers;

6. Provide that Texas Medicaid will not be secondary payer to Indian Health Services and 638 facilities, Title V, and IDEA;

7. Comply with 1902(a)(9) of the Social Security Act regarding the establishment and maintenance of health standards for institutions in which recipients may receive care, laboratory requirements, and the creation and maintenance of a consumer-oriented website providing useful information regarding all skilled nursing facilities and all nursing facilities in the state;

8. Include a state program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes.

Federal Responsibility, Authority and Limitations

Any block grant will require some reasonable level of federal oversight to ensure compliance with the terms of the grant. The federal government will therefore review and comment on the state plan, but will not approve or disapprove of individual components of the plan unless there is a direct violation of the terms of the block grant as set forth in statute.

To ensure accountability, the federal government will report biannually to Congress on a description of the state's program (including populations covered, benefits provided, delivery system components, etc.),

compliance with the conditions of the block grant, adherence to state assurances; and overall expenditures under the block grant. The HHS Secretary and other relevant agencies will work cooperatively with the state to obtain the information necessary to provide the information for the report to Congress.

The federal government will likewise ensure the state is complying with all block grant requirements and assurances and take any corrective actions necessary, including sanctions. The Secretary can impose penalties for violations of the terms of the block grant, including failure to provide required levels of coverage to mandated populations and submitting required reports. Types of penalties and procedural requirements would be structured similar to those outlined in the Temporary Assistance for Needy Families (TANF) block grant in Title IV of the Social Security Act. Audits of the state's program will continue under chapter 75 of title 31, United States Code.

However, the state is to be granted broad authority and flexibility to design and implement its program. The federal government may provide advice and guidance on matters as requested by the state but will take no adverse actions not explicitly authorized in federal law under the terms of the block grant. Because the state's program will replace the Medicaid State Plan, all active waivers of Medicaid law and regulation will sunset on December 31, 2013.

In addition, the state has the right to advance notice of any federal sanction and a right to appeal to the Departmental Appeals Board (DAB) established in the Department of Health and Human Services, and the state may obtain judicial review of the final DAB decision.

Concerning courts of jurisdiction, the state must provide a state right of action, but there is no federal right of action for individuals or providers who assert that the state is violating Medicaid laws. Sole access to federal court is the right to petition the U.S. Supreme Court for review of a decision of the Texas Supreme Court.

Exit

The state may opt out of the block grant by providing the Secretary six months advance notice of its intent to discontinue its block grant funding, an approvable Medicaid State Plan (if it intends to opt into the Medicaid program), and an approvable transition plan for the populations being covered under the block grant.

Part II: The State Plan

With a federal Medicaid block grant secured, Texas will fundamentally reform Medicaid at the state level, transforming it from a defined benefit program to a defined contribution program for most eligibility groups. Beneficiaries not enrolled in managed care or in need of nursing home care will receive a subsidy on a sliding scale based on income and assets and be able to purchase insurance on the private market.

With a federal Medicaid block grant secured, Texas will fundamentally reform Medicaid at the state level, transforming it from a defined benefit program to a defined contribution program for most eligibility groups.

The state will determine eligibility, subsidy amounts, and offer counseling to beneficiaries seeking to purchase private health insurance. To administer subsidies and manage applications, the state will build a centralized web portal/single point of entry for applicants. Subsidies will go into individualized accounts funded annually, from which premium payments can be transmitted directly to the Medicaid enrollee's chosen insurance plan.

Acute Care Eligibility and Subsidies

Under the current Texas Medicaid program, individuals qualify for benefits based on age, disability, pregnancy, and an income and assets test. The State Plan could simplify these income eligibility requirements in order to lower the cost of administering subsidies. For example, all applicants under a certain threshold of the Federal Poverty Level (FPL) would qualify for a sliding scale subsidy to purchase health insurance. The subsidy amount could be based on average premiums in the market, with an enhancement for eligible enrollees who choose a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). The state might also choose to make counselors available to enrollees receiving a subsidy to advise them on selecting a health insurance plan that meets their needs.

For lower income applicants, the state could opt to enroll them in a state-administered, risk-based Medicaid managed care program, along with children receiving SSI. The state would have flexibility and authority to determine eligibility requirements for subsidies, enrollment in managed care, or any combination thereof. Applicants who earn more than 100 percent FPL will be referred to the federal health insurance exchange established by the PPACA (until such time when that law is modified or replaced).

Any difference between the premium costs of the selected plan and the amount of the subsidy will be covered by the individual beneficiary. The individual beneficiary will be responsible for paying any premium amount not covered by the subsidy, as well as co-payments to the extent required by the selected health insurance plan. This structure will provide strong incentives to the enrolled population to purchase low premium, high value plans. Beneficiaries selecting coverage that costs less than their premium support entitlement would be allowed to deposit the difference in an HSA.

The following are some special considerations that need to be taken into account when designing the acute care program:

1. **Cost-Sharing Support.** The state will further subsidize the cost-sharing requirements for the lowest income populations on the program to ensure access to care is not compromised even as incentives for appropriate use of services are retained. Subsidy amounts could be administered through deposits in prefunded health care accounts. Funds in the account would be available only for health care-related services that count towards insurance cost-sharing.

2. **Maternity Benefits.** The state program will ensure that insurance plans offered to Medicaid-eligible enrollees provide appropriate maternity care, in recognition of the fact that the state is currently financing a large percentage of statewide maternity costs.

3. **Foster Care.** The state plan will ensure full, no-cost coverage for all children in foster care up to age 18.

4. **Reinsurance.** To encourage the development of a robust insurance marketplace for Medicaid beneficiaries, the state will consider a reinsurance program (perhaps on a temporary basis) which would partially protect the participating insurers from very high cost insurance claims.

Long-Term Care Supports and Services

Long-term care under Medicaid must be addressed in any reform proposal. However, the savings to be achieved by reform can be both short term through incremental reforms and long term through fundamental structural reforms. Each of these is addressed separately below.

Incremental Reforms

In order to contain Medicaid program costs in the near term, the following reforms to long-term care supports and services could be implemented in tandem with or in advance of comprehensive long-term care reform. These incremental measures have potential for immediate budget relief.

1. **Tighten Estate Recovery Processes.** Texas has several policy options it could utilize to increase the efficacy of its estate recovery program, including various definitions of “estate” and other services that

are subject to recovery. Currently, the state recovers only about two-tenths of a percent of the Texas nursing home budget. A reexamination of the estate recovery program design could yield a substantially greater recovery rate than the state currently has.

2. **Eliminate or Reform Qualified Income Trusts (QITs or Miller Trusts).** Texas is required to allow the use of Miller Trusts because it has no medically needy program for those in need of institutionalization. The income limit is set at 300 percent of the SSI payment level, but the allowance of Miller Trusts means there is effectively no upper income limit on eligibility for institutional care. Texas could consider tightening restrictions on exempt assets, capping the amount of income that can be diverted into a Miller Trust equal to the average cost of nursing home care, or setting a harder income limit anywhere between 100 percent and 300 percent of SSI.

The allowance of Miller Trusts means there is effectively no upper income limit on eligibility for institutional care.

3. **Include Nursing Home, 1915(c) Waiver, and Other Long-Term Care Populations in the Dual Eligible Integrated Care Demonstration Project.** While most dually eligible persons in Texas Medicaid and Medicare are enrolled in the state's STAR+PLUS program/a Medicare Advantage or Special Needs plan (MA/SNP), only a small percentage are enrolled in the same MCO for both Medicaid STAR+PLUS and the Medicare plan. Having one plan manage medical care and another manage long-term care is not efficient or well-coordinated. The dual eligible integrated care demonstration project (application submitted to CMS by Health and Human Services Commission May 2012) would combine Medicaid and Medicare funding streams into one capitated payment to select plans that cover medical care, LTCSS, and prescription drugs. The proposal excludes those in nursing facilities, Intermediate Care Facilities for Persons with Intellectual and Developmental Disability (ICF/IDD), and residents of Institutions of Mental Diseases or State Hospitals, as well as those enrolled in 1915(c) programs.

4. **Enroll SSI Children into Risk-Based Managed Care.** The state does not require children age 20 or under to enroll in its STAR+PLUS programs, although the state has ample experience using managed care for less acute populations and some experience with the adult population with disabilities. Voluntary enrollment for SSI children is currently allowed; mandating enrollment could increase coordination of care and result in savings over the long term.

5. **Financial Contributions from Parents.** Under federal law, parents' income and assets cannot be considered as part of an eligibility determination for children in need of institutionalization. States must either choose community or institutional deeming rules, which means considering all non-exempt parental income or nothing—an all-or-nothing approach that leaves little room for a middle ground. The state could implement a parental fee program, although under federal maintenance of effort rules (MOE) it could not deny services because of a failure to pay, but the state may take other measures to ensure payment. The collection of this fee would not be part of the child's eligibility determination, and the amount could be determined on a sliding scale based on the care setting, with a higher amount for institutional care and a lower amount for care in the home setting.

6. **Filial Responsibility.** Currently, 29 states have filial responsibility laws, but Texas is not among them. The state could impose an assessment on the recipients of the beneficiary's prior transfer beyond the five-year look-back period. Another approach would be to establish a sliding scale fee schedule based on the income and assets of children whose indigent parents are receiving institutional or community-based care.

7. **Partial Entitlement to Benefits.** A full benefits package is not always necessary, or wanted, by those who qualify to remain in community settings rather than institutional ones. One way to control over-utilization of this sort would be to eliminate the full entitlement to services in a benefits package and enable individuals to self-direct their care. Qualified services and a customized benefits package could be determined through an individualized needs assessment administered at a single point of entry into the system.

Community-based settings are less costly than institutional ones, and efforts should be made to expand community care.

8. **Different Approaches to Providing Community Care.** Community-based settings are less costly than institutional ones, and efforts should be made to expand community care. Current federal HCBS guidelines do not allow for the payment of housing. With more flexibility, Texas could pay for assisted living or other living arrangements for some individuals eligible for nursing home care.

9. **Nursing Home Competitive Bidding.** Texas reimburses nursing homes on a Fee-For-Service (FFS) basis, resulting in little price competition among nursing homes, many of which have low occupancy rates. Consolidation of nursing homes and an increase in the census of existing nursing homes might result from a competitive bidding process with the state. Alternatively, the state could direct more patients to facilities that win contracts by providing high quality, lower cost services.

Long-Term Care Supports and Services: Fundamental Reform

The systematic restructuring of Medicaid LTCSS under a block grant will adhere to the same principles outlined above in the section on acute care reform. The state will establish a defined contribution payment model based on an assessment of existing usage of services by the current LTCSS population, with the option of creating a single estimate for all applicants or multiple estimates based on subcategories (elderly, non-elderly disabled, and disabled children). Those eligible for subsidies to purchase private insurance or other acute care services will obtain it through the program structure as outlined in the above section on acute care.

Eligibility

This process will require a disability acuity assessment for all current enrollees and all new applicants. The state will contract with an independent medical evaluator to assess the relative acuity of functional impairments of all applicants and enrollees. These assessments would occur independently of budgetary pressures and be based solely on the evidence of disability and functional impairment. In addition, the state will also conduct a financial assessment, including an evaluation of resources available to the applicant and the applicant's family. These two assessments together will determine the amount of defined contribution financial support to which the beneficiary will be entitled.

Accessing Care

The state will provide a pre-determined level of financial support directly to those eligible by establishing and funding an account on each beneficiary's behalf that can be used to make payments to approved vendors for services provided by the program. The state shall make available to beneficiaries a list of approved vendors for various Medicaid LTCSS. Beneficiaries will be allowed to retain resources not used in one month for later use, and in this way "save" resources in their accounts for the purchase of future services.

Nursing Home Exception

The above reforms are focused on keeping beneficiaries, as much as possible and consistent with appropriate clinical care, out of nursing home care. Nursing home care is significantly more expensive than home and community-based care, and the defined contribution payment model would apply only to non-nursing home LTCSS expenses and be available

only to beneficiaries not residing in a nursing home. Applicants found to need nursing home care would be taken out of the defined contribution program and their care would be financed through the traditional Medicaid structure. In addition, the Program of All-Inclusive Care for the Elderly (PACE) programs throughout the state (and all future PACE programs) would also qualify for this nursing home exception.

However, the defined contribution payment system would encourage community-based services and likely reduce nursing home utilization and increase the number of beneficiaries in alternative settings, which would create significant savings for the state. In order to "rebalance" the LTCSS population, the state will establish a separate application for nursing home services with strict criteria to ensure only those who cannot be cared for in community settings receive nursing home care.

Budgetary Control for LTCSS

To ensure that the state does not exceed the Medicaid budget, which is the sum of the federal block grant amount and the funding voluntarily provided by the state, and to ensure that services and contributions to beneficiaries are adequately funded, the maximum defined contribution amounts should be set to grow at the same rate as the federal block grant, as outlined above. This measure would not guarantee that Medicaid spending would remain within the budgeted amount, given the possible increase of program applicants or an unexpected rise in the cost of nursing home care. Therefore, the program should include measures to adjust spending as necessary to stay within budgeted amounts. Such adjustments could include:

- A uniform benefit reduction applied to all defined contribution payments automatically triggered and enforced by the state Medicaid office based on actual expenditures;
- Elimination of the lowest acuity beneficiaries from eligibility for the program;
- Reduced benefits for those closest to the income eligibility cut-off;
- Some combination of all or some of the above.

Conclusion

The time has come for fundamental Medicaid reform. In light of the program's growing costs, Texas cannot afford to delay. Medicaid enrollees should not be asked to remain in a program that gives them increasingly poor health outcomes and a declining access to care. States, not the federal government, are best-suited to design and implement reforms that will control costs and improve outcomes.

The proposals outlined in this paper provide a clear pathway to achieving these goals. It is vital and imperative that Texas ensure quality, affordable health care for its low-income and disabled residents. A federal block grant of Medicaid funds, combined with ambitious, innovative reforms to the Texas Medicaid program, will control Medicaid costs for states and the federal government and improve care for those who need it most. ✯

Endnotes

[1] Jagadeesh Gokhale, "Final Notice: Medicaid Crisis, A Forecast of Texas' Medicaid Expenditures Growth," Texas Public Policy Foundation (Dec. 2010).

[2] Spencer Harris, Arlene Wohlgemuth, and Brittani Harris, "Medicaid Reform: Constructive Alternatives to a Failed Program," Texas Public Policy Foundation (Feb. 2011).

[3] James C. Capretta, "Assuring a Future for Long-Term Care Services and Supports in Texas," Texas Public Policy Foundation (Dec. 2012).

About the Authors

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The Honorable Arlene Wohlgemuth Executive Director and director of the Foundation's Center for Health Care Policy. She served 10 years as a state representative for district 58. During the 77th legislative session, she served as chairman of Appropriations Article II Subcommittee (Health and Human Services), vice-chairman of Calendars, CBO for Human Services, and member of the Select Committee for Health Care Expenditures. Wohlgemuth authored HB 2292, the sweeping reform of Health and Human Services which improved service delivery for the recipients, saving taxpayers more than $3.7B during its first five years.

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