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Capped Federal Medicaid Funding: Implications for Texas

Prepared by Manatt Health for the Texas Alliance for Health Care

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Executive Summary

Since its inception, Medicaid has been financed jointly by the federal and state governments. There are no caps on the federal government's financial obligations; federal funding is guaranteed as a share (known as a "match") of all state expenditures that follow federal rules. Today, this open-ended funding model is being called into question. Republican congressional leadership and President Trump are seeking to replace the current matching system with a fixed allocation of federal dollars paid through block grants or per capita caps.

Drawing on proposals advanced in recent years, this paper examines the factors that go into calculating the amount of federal dollars that would be allocated to each state in a capped funding model and considers how they might play out for the State of Texas. Because capped funding proposals generally provide states with greater flexibility than the current Medicaid funding model, the paper also reviews the type of flexibilities that might be available to Texas under such proposals.

I. Medicaid Financing Models

Under the current system, the federal government matches state spending on Medicaid so long as the state follows federal Medicaid rules, including terms and conditions authorized by section 1115 waivers. Texas's federal matching rate for 2017 is 56%—meaning that the federal government generally pays 56% of all allowable Medicaid expenditures.

By contrast, under capped funding, the amount of federal dollars is set in advance and does not increase when the state's healthcare costs increase beyond the preset amount. The base funding amount is trended annually generally using a national trend rate set below the rate of medical inflation. And, at least to date, all such proposals both cap and reduce the amount of federal dollars available to states.

Two types of capped models have been advanced:

- **Block grants** impose an aggregate cap on federal funding for each state. If costs are above the federal caps—due to enrollment or rising healthcare costs—states would bear all of those costs.
- **Per capita caps** limit federal funds on a per enrollee basis. Unlike a block grant, federal payments would rise with enrollment (that is, the state is paid per enrollee up to the cap), but like a block grant, federal payments would not vary based on healthcare costs. Notably, a per capita cap could also include a state or national spending cap, placing states at risk for increasing enrollment and rising healthcare costs in much the same way as a block grant.

II. Key Features of Capped Funding Models and Considerations for Texas

To evaluate the potential impact of capped funding, Texas will want to review key elements that affect the amount of federal Medicaid dollars it will receive—the base funding, trend rate, and the treatment of supplemental payments and waivers—and consider how Texas fares relative to current law and other states. In some cases, the implications for Texas depend on whether capped funding is structured as a block grant or a per capita cap. The financial impact of capped funding will also be affected by the flexibility provided, which is considered below.

Base Funding. The proposals typically set initial state allotments based on each state's historic federal payments. Block grants are generally based on a state's total federal Medicaid payments during a base year, while per capita caps would be based on historic spending during a base year for specific populations, such as children, adults, the elderly, or people with disabilities. In doing so, capped funding models essentially lock in prior state decisions with respect to eligibility levels, covered benefits, and payment rates. Texas will likely have additional programmatic flexibility to change some or all of its earlier programmatic decisions, but the state's previous decisions, which are reflected in its base payments, will largely determine the funding available to make any future changes.

- **Eligibility.** In a block grant context, relatively low eligibility levels will translate into relatively low base payments. The eligibility issue that has garnered the most attention in connection with proposals to cap federal Medicaid funding relates to whether a state has elected to expand Medicaid under the Affordable Care Act. The 31 states plus the District of Columbia that expanded Medicaid received an additional $72.6 billion in federal funding in 2016—funding that did not flow to the 19 non-expansion states, including Texas. (Texas would have received about $10 billion in 2016 had it expanded Medicaid.) A critical question for Texas is whether in setting the caps Congress will address the disparities between expansion and non-expansion states.
- **Benefits and payment rates.** State decisions on covered benefits and plan and provider rates likewise drive its Medicaid expenditures and therefore the historical base on which the capped funding is calculated. While eligibility levels affect base funding decisions with respect to block grants, benefit and rate decisions affect the base amount with respect to both block grants and per capita caps because they drive both total state spending as well as per enrollee spending.

Texas's relatively low eligibility levels will mean that it has a smaller base upon which block grant payments will be set; those eligibility levels are less informative in the context of a per capita cap. A comparison of Medicaid spending per enrollee provides further insight into how Texas would fare under both types of capped funding models as compared to other states and whether it would have a relatively robust base payment available to underwrite future costs. The most recent data available for all states is 2011; in that year Texas spent more per enrollee than most states on children, but

considerably less on elderly and disabled beneficiaries, ranking 40th and 26th in the nation, respectively. With the elderly population (and particularly the 85 plus population) expected to grow in every state, this will disadvantage Texas under most capped funding proposals. Ironically, Texas may also be disadvantaged by having made greater strides than many other states on lowering its spending on long-term services and supports, by prioritizing less costly home and community-based services.

Trend Rate. As important as the base payment is in determining the amount of federal dollars that a state will receive, the trend rate is likewise important—particularly over time. The trend rates in recent proposals are tied to a national, not a state-specific, indicator—usually the Consumer Price Index (CPI) or Gross Domestic Product (GDP) plus one. These trend rates are projected to grow more slowly than overall healthcare costs or Medicaid spending (this is one of the ways federal savings are achieved). States might be able to lower program costs, but to the extent these trend rates do not keep up with actual costs, states will bear these added costs. From 2000 to 2011, Texas's average annual growth in spending for children was 8.4%; for elderly adults it was 5.6%; and, for disabled individuals it was 4.7%. During that same period of time, GDP grew at 2.9% and the CPI grew at 2.5%. In a block grant context, the trend rate implications for Texas are especially concerning, as Texas is projected to be one of the fastest growing states in the nation, but the trend rate is also a concern to Texas in a per capita cap context particularly when considered in combination with the low base rate for elderly enrollees and the expected rise in the elderly population.

Supplemental Payments and Waivers. Virtually every state relies on some form of supplemental payment or waiver funding, but it is not clear from most of the proposals whether these funds would be built into the base payment or continue to be available to states as a separate stream of funding. These issues are of particular importance to Texas which receives a greater percentage of total Medicaid dollars through supplemental payments and waiver funds than any other state in the nation.

State Share. While the federal government, on average, covers 62 percent of the cost of Medicaid nationally and 56 percent in Texas, state spending in the program is significant. Texas will want to look closely at a number of features relating to state share:

- **State spending requirement.** Many of the proposals are unclear as to whether states would have to spend their own funds as a condition of receiving capped federal funds. If a state-matching requirement remains and the federal funds that states can draw down are themselves reduced, Texas's state-spending requirement will also be reduced given that Texas law limits state spending for Medicaid to those expenditures that will qualify for federal matching payments. This would mean that total reductions in program spending would be much higher than the federal spending reductions—unless Texas law was changed so that it would absorb program costs above the federal caps with state-only funds.
- **Matching rate.** Assuming state spending is required, the capped funding proposals generally do not address the federal match rates that would be applied, nor whether higher matching rates currently available for certain populations and services would continue. Texas currently receives enhanced matching funds for its IT and eligibility systems and certain program integrity initiatives. Texas also was the 5th state in the nation to take advantage

of the Community First Choice federal option, which provides enhanced federal matching payments (a six percentage point increase) for the home and community-based services provided through the program.

- **Changes in how states can raise their nonfederal share.** State spending (and therefore total program spending) could also be affected if the rules relating to how states can raise their nonfederal share are changed. Some proposals are silent on this question but a few would limit state reliance on intergovernmental transfers (IGTs) or provider taxes. Texas currently relies heavily on both IGTs and provider taxes to fund the nonfederal share of Medicaid costs.

III. Flexibility

Capped funding is typically coupled with additional state flexibility. While states generally welcome more flexibility, when that flexibility is linked to a reduction of and cap on federal Medicaid funding, states will want to consider the flexibility they are looking for and the extent to which it will help them manage program costs with less federal funding. In addition, states will want to consider whether that flexibility is available today through waivers or administrative changes as well as the downstream implications for new flexibility on local governments, providers, health plans and consumers.

The three big drivers of spending in Medicaid are eligibility, benefits, and provider payment rates. With the exception of children and pregnant women, Texas's eligibility rules are set at the federal minimums today; it is unclear if Texas would have the flexibility to set lower eligibility levels or if it did, whether it would choose to take up that flexibility. Texas might gain additional flexibility to condition coverage on work or job training requirements or payment of a monthly premium, but the majority of program enrollees are children and the majority of program spending is for low-income elderly and people with disabilities. Given the population Texas Medicaid covers today, Texas will want to consider whether it would impose such requirements, how much savings it would achieve, and whether it could secure the authority to do so through a waiver today.

Similar questions arise with respect to benefits—which benefits would Texas choose to drop if it had the flexibility to do so? Notably, certain mental health services as well as substance abuse and pharmacy are optional benefits today, and Texas has determined to cover them. Finally, while Texas has considerable flexibility to set plan and provider payment rates today, it might be able to reduce rates even further and with fewer constraints in a capped funding model. Again, Texas will want to consider the impact both on access to care as well as the sustainability of its providers, most particularly rural providers.

IV. Conclusion

By design, capped funding proposals shift the risks of any Medicaid costs above the federal caps to states. States will seek to ensure that any capped funding program that is considered by Congress protects them to the greatest extent possible; that is, that decisions on base year costs, out-year trend rates, state share obligations, and the treatment of supplemental and waiver payments are fair to the state, its residents, and its healthcare providers. And each state will have different priorities; accommodating all of them would be complicated and not likely given Congress's interest in reducing federal Medicaid expenditures.

Texas comes to the capped funding discussion with a number of fiscal challenges—most notably its historically low investment in Medicaid relative to other states, its relatively low spending per enrollee for the elderly, its growing population, and its high reliance on supplemental and waiver funding. New flexibility could help Texas structure its program in less costly ways, but given its spending levels and the fact that most of the spending is driven by the needs of high cost, high-needs disabled and elderly enrollees, it is unclear how much Texas can save through any new flexibility. Texas will want to carefully consider all these factors as it evaluates the potential impact of capped funding on its budget, its residents, and its healthcare providers.

Capped Federal Medicaid Funding: Implications for Texas

Republican congressional leadership and President Donald Trump have called for a restructuring of how the federal government funds Medicaid—going well beyond repealing and replacing the Affordable Care Act. Since its inception in 1965, Medicaid has been financed jointly by the federal and state governments with the federal government providing funds to match all state expenditures made pursuant to federal Medicaid law. There are no caps or limits on the federal government's financial obligations for the program, as long as state expenditures follow federal law.[1] Replacing this matching system with a fixed allocation of federal dollars, likely coupled with fewer federal requirements, has major implications for states, healthcare providers, and consumers.

Under a capped financing system, Congress predetermines the maximum amount each state receives typically based on historic state enrollment and spending and adjusted yearly by a national trend rate. While additional adjustments could be added (for example, an adjustment for population growth), under all of the capped funding proposals federal payments to states are divorced from actual costs. At the same time, the proposals offer states new programmatic flexibility, although the proposals provide little detail on the new flexibility that would be permitted. States will want to evaluate whether the additional flexibility is a good trade-off for the risk they must assume under a capped financing system.[2]

This brief looks at capped funding proposals drawn from federal capped programs already in place as well as recent proposals relating to Medicaid. It focuses on how the caps and trend rates are designed, and the implications for Texas. Details do matter; since many important details are missing from the recently advanced proposals, this brief does not purport to calculate the impact of capped funding on Texas or anticipate with precision how new programmatic flexibility might impact the Texas Medicaid program under a capped funding structure. Instead, this brief offers a preliminary framing of the key issues related to setting funding caps and expanding state flexibility. Further discussion will be needed as new details on capped funding proposals emerge.

I. Overview of Models for Funding Medicaid

Financing Medicaid Today

States and the federal government share responsibility for funding the Medicaid program, with each covering a share of all permitted Medicaid expenditures. Federal contributions match state expenditures with no upper limit[3] on the total Medicaid expenditures.[4] As a result, as state Medicaid spending rises, so do federal expenditures. State decisions about the populations and benefits to cover and the amount they pay for services are the principal drivers of the level of federal funding a state receives.

The current model affords states significant but not unfettered flexibility to tailor their Medicaid programs to address shifting social, economic, and clinical imperatives. States can manage spending—and consequently their share of the costs—through a number of levers, most significantly through the choices they make on covering optional populations and benefits, designing their delivery system (e.g., managed care versus fee-for-service), setting plan/provider payment rates, ensuring appropriate utilization of services, as well as engaging in population health and valued-based payment arrangements. However, states operate under certain federal constraints, including minimum standards relating to benefits and requirements that payments to plans be "actuarially sound." And like all healthcare payers, states face costs that are often beyond their control. The current financing model helps states absorb these unanticipated or hard-to-control costs. States receive more federal dollars when Medicaid enrollment rises, as often occurs when the economy falters. Federal support also automatically adjusts when state costs rise due to a public health crisis such as the opioid epidemic or Zika or emerging new technologies and cures. The added federal support generally does not relieve the state of its share of rising costs,[5] but it does assure that added costs are fully shared by both levels of government (in Texas at a 56/44 split). Since federal spending rises and falls based on state spending, some proponents of capped federal funding cite the fact that the federal government lacks year-to-year certainty on Medicaid costs as an important reason for implementing caps.[6]

Texas Medicaid Today

- **4.3 M** enrollees
- **$36.1 B** total spending ($14.7 B state, $21.4 B federal)
- **56%** federal match rate

Sources: Robert Wood Johnson Foundation, "Data Points to Consider When Assessing Proposals to Cap Federal Medicaid Funding: A Toolkit for States"; MACStats

Capped Funding Proposals

Two different types of capped funding models are under consideration: block grants and per capita caps. The models differ in several key respects, but in both states are no longer guaranteed federal funding for the actual costs of their Medicaid programs. In addition and significantly, to date all such proposals contemplate reducing federal funding to states, through the way base payments are set or by imposing a national—rather than state-specific—year-to-year growth rate that is below the rate of medical inflation and the projected growth in Medicaid program costs.

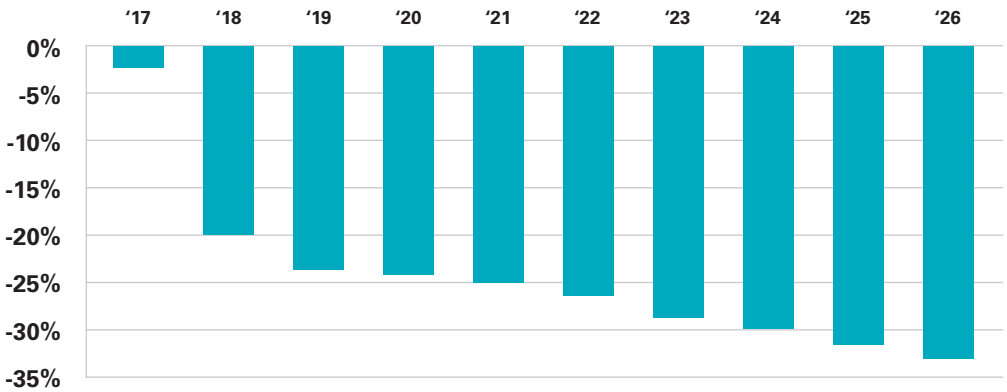
1115 Waiver Caps

States operating 1115 waivers are subject to per capita caps on federal spending to enforce the federal policy that waivers be budget neutral to the federal government. The caps in 1115 waivers differ from the proposed per capita caps in several key respects. Budget neutrality caps apply only to the population and services that are subject to the waiver, and they are negotiated based on expected growth in the state's Medicaid program to ensure that the growth under the waiver is no greater than it would have been without the waiver. In contrast, current capped funding proposals are designed to reduce federal spending, and they would be imposed by federal law program wide. Additionally, waiver caps apply over the life of the waiver, allowing savings in one year to offset overages in another. Finally, waivers are voluntary and the caps are negotiated by states.

Block grants impose an aggregate cap on federal Medicaid funding for each state. Funding under block grants is fixed and does not increase in response to a state's growth in enrollment or healthcare expenditures. Block grant proposals differ with respect to the states' obligation to match federal expenditures, and most include some additional state flexibility in designing and administering their Medicaid programs.[7] The details will matter—there might be population or other adjusters in the block grant formula —but, by design, capped federal funding shifts all costs above the caps to the states. States might have greater flexibility to reduce costs, but if capped federal funding ultimately falls short of actual costs, states must either invest additional state dollars or make further changes to eligibility, benefits, or payment rates.

Per capita caps impose a cap on federal funds on a per enrollee basis. Base payments are set for each group of enrollees (e.g., children, people with disabilities) and, like a block grant, these base payments would likely rise each year by a national trend rate. In contrast to a block grant, under a per capita cap, total federal payments would rise with enrollment (that is, the state is paid for each enrollee up to the cap), but like a block grant, federal payments would not vary based on states' decisions regarding covered

Figure A: Percent Cut in Federal Medicaid and CHIP Funds House FY 2017 Plan Relative to Current Law



benefits, provider payments, or healthcare costs. In other words, states are at cost risk, but not at enrollment risk. Because total funding fluctuates with enrollment, states operating under a per capita can be more certain that their Medicaid programs will be able to respond to financial downturns or population changes. Notably, however, some per capita cap proposals also include a national aggregate cap,[8] placing states at risk for increasing enrollment and rising healthcare costs in much the same way as a block grant. Like block grants, state matching requirements vary under different per capita cap proposals, though most proposals appear to assume states would continue to have a state match requirement.

Recent capped funding proposals split on whether they propose block grants or per capita caps (or, in some cases, give states the option). However, they all are explicitly designed to reduce federal Medicaid spending; this is largely accomplished by setting a national trend rate for the capped payments below the level of growth that is projected under current law. For example, the House Budget Committee's proposal for the FY 2017 Budget ("House Budget proposal") would reduce federal Medicaid spending by almost one trillion dollars over ten years as compared to projected spending under current law.[9] See Figure A.[10]

II. Key Features of Capped Funding Models and Considerations for Texas

Any change to federal Medicaid financing and program rules would have significant implications for Texas. Figure B shows the role that state and federal Medicaid funds play in Texas's budget.[11]

Medicaid accounts for a large share of spending of State funds—20 percent in State fiscal year 2015.[12]

But it is also the single largest source of federal funding for Texas, representing just over 50 percent of all of the federal funds available to the State. By comparison, the next largest source of federal funds—for primary and secondary education—is just under 12 percent. Proposals to cap federal Medicaid funding alter this source of federal funding for the State.

All capped funding models shift risk to the states. The magnitude of risk shifted depends on the funding levels: the lower the base funding levels and applicable trend rates, the greater the level of risk shifted to the states. We therefore begin this section of the paper by reviewing four key elements that affect the amount of the cap—the base funding, trend rate, state spending requirements, and supplemental payments and waivers—and describe how different factors work to advantage or disadvantage Texas relative to other states.[13] In some cases, the implications for Texas depend on whether the capped funding is structured as a block grant or a per capita cap. In the final section, the paper compares the flexibility that might be coupled with capped federal financing to the flexibility available under current law.

1. Base Funding

In setting initial allotments for any capped funding model, proposals typically use each state's historic Medicaid spending. Block grants are

Figure B: Medicaid's Role in Texas's Budget

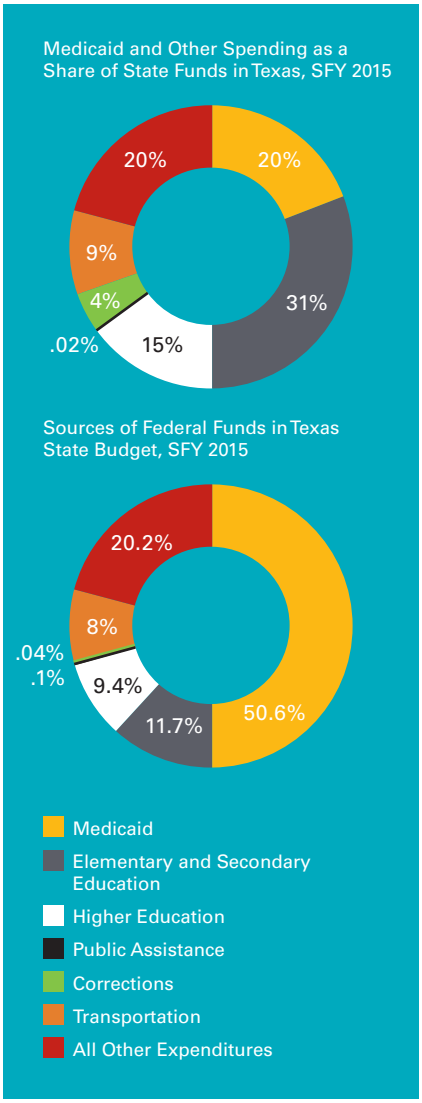
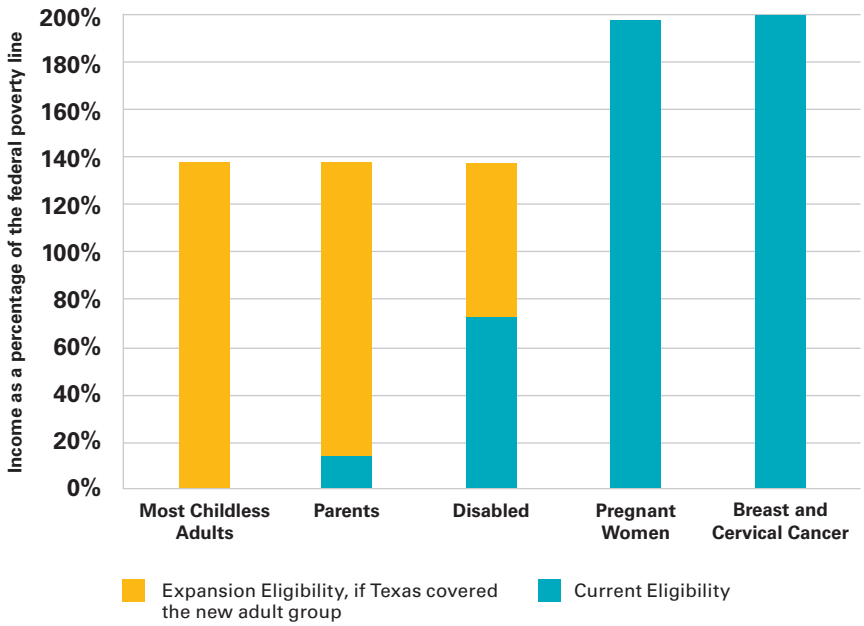


Figure C: Comparison of Current Eligibility Levels in Texas to Eligibility Levels under Expansion



generally based on a state's total federal Medicaid payments during a base year, while per capita caps would be based on historic spending during a base year for specific populations, such as children, adults, the elderly, or people with disabilities. (Note that an important question for Texas is whether the base payments incorporate spending on supplemental payments and waiver spending; that issue is discussed in section 4 below.) In doing so, all capped funding models essentially lock in prior state decisions with respect to **eligibility levels**, **covered benefits** and **payment rates**. In addition, the greater a state's matching rate, the greater the cap will be for a given state's spending level. At any given spending level, a state with a 70% match will have a higher federal cap than a state with a 50% match.

The base payments will likely be subject to a national trend rate, and states will likely have the programmatic flexibility to change those decisions (both issues are discussed below). But their previous decisions, which are reflected in their base payments, will largely determine the funding available to make any future changes. States with higher base payments will have more federal dollars available, affording them a relatively broader array of options for running their Medicaid programs in the future.

Eligibility Levels

The eligibility issue that has garnered the most attention in the current block grant debates relates to whether a state has elected to expand Medicaid

under the Affordable Care Act. Thirty-one states (plus Washington DC) have expanded Medicaid; nineteen states, including Texas, have not. Figure C[14] compares Texas's current eligibility levels to eligibility levels under expansion.

The 31 expansion states plus D.C. received $72.6 billion additional federal dollars in 2016.[15] (For Texas, this would represent an additional 10 billion federal dollars.) It is unclear whether these funds will survive an ACA repeal effort. Assuming they do, the expansion states will want them folded into their capped payments as these dollars are now "baked" into those states' budgets. Resolving the disparity between the expansion and non-expansion states will be one of the thornier issues Congress will navigate if it moves ahead with a block grant proposal.

Texas is further disadvantaged under a block grant structure because it has relatively low eligibility levels as compared to other non-expansion states. Today, Texas does not cover childless adults at any income level (unless disabled, pregnant or elderly) and covers parents with incomes below 15 percent of the federal poverty level. Of the 19 states that have not expanded Medicaid, most do not cover childless adults but only one state—Alabama— has lower eligibility levels for parents than Texas.[16] Figure D[17] compares parent eligibility levels in Texas relative to eligibility levels for the other non-expansion states.

States with lower eligibility levels have lower aggregate spending relative to the size of their low-income populations, resulting in a lower base payment in a block grant structure as compared to other states with higher eligibility levels. A lower base payment, in turn, will put greater fiscal pressure on Texas, making it difficult to make future changes in the program, whether those changes might involve covering more people, addressing

Figure D: Comparison of Eligibility Levels for Parents Among Non-Expansion States

Rank	State	Parent/Caretaker Eligibility Level
1	Tennessee	103%
2	Maine	100%
3	Wisconsin	95%
4	South Carolina	62%
5	Nebraska	58%
6	South Dakota	57%
7	Wyoming	55%
8	Virginia	49%
9	Utah	44%
10	North Carolina	44%
11	Oklahoma	41%
12	Georgia	34%
13	Kansas	33%
14	Florida	29%
15	Idaho	24%
16	Mississippi	23%
17	Missouri	18%
18	**Texas**	**15%**
19	Alabama	13%

Table E: State Ranking of Medicaid Spending per Full Benefit Enrollee, FY 2011

#	Aged	Adults	Children	Disabilities
U.S.	**$17,522**	**$4,141**	**$2,492**	**$18,518**
1	WY ($32,199)	NM ($6,928)	VT ($5,214)	NY ($33,808)
2	ND ($31,155)	MT ($6,539)	AK ($4,682)	CT ($31,004)
3	CT ($30,560)	AK ($6,471)	NM ($4,550)	AK ($28,790)
4	NY ($28,336)	AZ ($6,471)	RI ($4,290)	ND ($28,790)
5	DE ($27,666)	VT ($6,062)	MA ($4,173)	DC ($28,604)
6	OH ($27,494)	RI ($5,778)	MN ($3,461)	MN ($26,890)
7	DC ($27,336)	OR ($5,631)	NH ($3,241)	WY ($25,346)
8	MA ($27,205)	DE ($5,430)	PA ($3,194)	MD ($23,798)
9	NH ($26,794)	MD ($5,385)	CT ($3,158)	DE ($22,972)
10	MT ($26,704)	NY ($5,339)	AZ ($3,052)	AZ ($22,040)
11	MN ($25,030)	KY ($5,055)	**TX ($3,010)**	OH ($21,892)
12	AK ($24,288)	ID ($4,878)	MO ($2,978)	ID ($21,781)
13	OR ($24,253)	TN ($4,852)	DE ($2,942)	NH ($21,545)
14	MD ($23,491)	VA ($4,781)	MT ($2,919)	RI ($21,417)
15	WV ($23,243)	WA ($4,756)	KY ($2,911)	IA ($20,242)
16	PA ($21,372)	NJ ($4,648)	DC ($2,820)	CA ($20,080)
17	IN ($21,269)	PA ($4,631)	MD ($2,765)	NJ ($19,951)
18	IA ($21,163)	CT ($4,538)	NY ($2,707)	UT ($19,718)
19	AR ($20,484)	MA ($4,496)	VA ($2,696)	CO ($19,718)
20	ME ($19,881)	SC ($4,449)	NJ ($2,616)	IN ($19,488)
21	NJ ($19,160)	DC ($4,446)	ND ($2,531)	SD ($19,156)
22	MS ($18,592)	**TX ($4,371)**	ME ($2,528)	VA ($18,952)
23	CO ($18,478)	NC ($4,360)	WV ($2,506)	NM ($18,500)
24	AL ($18,473)	SD ($4,356)	SD ($2,503)	OR ($18,255)
25	HI ($18,328)	WV ($4,284)	CA ($2,475)	VT ($17,789)
26	KS ($18,328)	OH ($4,225)	TN ($2,470)	**TX ($17,709)**

#	Aged	Adults	Children	Disabilities
27	MI ($17,599)	GA ($4,215)	OK ($2,461)	MO ($17,481)
28	MO ($17,020)	LA ($4,168)	AR ($2,458)	NE ($17,449)
29	RI ($16,998)	MO ($4,122)	MS ($2,403)	KS ($17,153)
30	SD ($16,374)	NE ($4,015)	NC ($2,355)	HI ($17,035)
31	VA ($16,367)	WY ($3,986)	UT ($2,260)	MA ($16,927)
32	WI ($16,344)	MS ($3,983)	CO ($2,241)	ME ($16,920)
33	WA ($16,183)	MI ($3,913)	KS ($2,186)	IL ($16,689)
34	AZ ($16,145)	AL ($3,899)	AL ($2,156)	WI ($16,599)
35	KY ($15,757)	MN ($3,863)	IL ($2,123)	PA ($16,441)
36	TN ($15,745)	HI ($3,765)	IA ($2,116)	MT ($16,352)
37	ID ($15,558)	KS ($3,762)	WA ($2,111)	WA ($16,208)
38	LA ($15,491)	NH ($3,652)	OH ($2,110)	NV ($15,706)
39	NE ($14,997)	ND ($3,652)	OR ($2,085)	MI ($15,109)
40	**TX ($14,739)**	OK ($3,551)	LA ($2,082)	LA ($15,099)
41	VT ($14,258)	CO ($3,469)	HI ($2,062)	NC ($15,060)
42	FL ($14,253)	UT ($3,326)	NE ($2,041)	OK ($15,010)
43	GA ($14,142)	AR ($3,198)	GA ($2,023)	FL ($15,005)
44	NV ($13,226)	IN ($3,198)	ID ($2,023)	TN ($14,680)
45	OK ($12,315)	IL ($3,184)	SC ($2,008)	AR ($14,023)
46	SC ($12,256)	WI ($3,170)	WY ($1,967)	WV ($12,993)
47	CA ($12,019)	FL ($2,993)	NV ($1,940)	MS ($12,960)
48	UT ($11,763)	CA ($2,855)	MI ($1,926)	KY ($12,856)
49	IL ($11,431)	NV ($2,367)	IN ($1,858)	SC ($12,830)
50	NC ($10,518)	ME ($2,194)	FL ($1,707)	GA (10,639)
51	NM (N/A)	IA ($2,056)	WI ($1,656)	AL ($10,142)

Source: Manatt analysis of Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2011 MSIS and CMS-64 reports.

provider payment rates, or just keeping up with costs not accommodated by the trend rate.

Benefits and Provider Rates

Eligibility levels are not the only factor that shapes capped funding calculations: state decisions on covered benefits and plan and provider rates likewise drive a state's Medicaid expenditures and therefore the historical base on which the capped funding is calculated. While eligibility levels affect base funding decisions with respect to block grants, benefit and rate decisions affect the base amount with respect to both block grants and per capita caps because they drive both total state spending as well as per enrollee spending. States with more comprehensive benefit packages or higher payment rates—or both—will tend to have higher per enrollee spending and will draw down more federal dollars on both an individual and aggregate basis.

As Table E shows, Texas's spending per enrollee group relative to other states varies based on eligibility category, with the State spending more than most states with respect to children ($3,010 compared to $2,492 for the US average). However it spends considerably less than most states or the US average on the more costly elderly beneficiaries, spending just under $15,000 a year per elderly beneficiary, with the three highest spending states (Wyoming, North Dakota and Connecticut) spending more than twice as much per elderly beneficiary. With respect to other adults and people with disabilities, Texas spending is about in the middle of states.[18] These spending figures suggest that Texas will be at a significant disadvantage in terms of federal funding levels under both a block grant and a per capita cap with respect to spending for the elderly, which along with the disabled, are the two highest cost enrollee groups covered under Medicaid. With the elderly population (and particularly the 85 plus population) expected to grow in every state, this will significantly disadvantage Texas under most capped funding formulas.

Ironically, states that have taken steps to add more cost-effective benefits to their Medicaid programs may also be at a disadvantage under capped funding formulas. In particular, given the high cost of long-term care and services to the program, states that have successfully shifted more of their long-term services and supports from higher-cost institutional settings to lower-cost community-based settings will have lower caps for elderly and disabled populations (or lower overall block grant caps) than those states that have not done so. States with limited use of community-based long-term care will have higher caps, and they may also be able to manage spending within caps more easily by shifting care from institutional to community-based settings once the caps are in effect.

Texas has made important strides with respect to providing more home and community-based services. It is ranked 13th in terms of the percentage of long-term care provided in home and community settings, placing it well ahead of most states.[19] Texas's success in implementing community-based care no doubt contributes to its lower spending on elderly and to a lesser extent disabled enrollees. While generally this would be considered a good thing, in the context of a fixed block grant or per enrollee cap, Texas may find that future options with respect to payment rates and benefits for these populations are constrained.

All of these factors—eligibility levels, payment rates, and benefits, as well as whether a state has been a good manager of limited resources—will determine a state's base payment rate under most capped funding proposals.

Alternate Approaches

Although most capped funding proposals allocate dollars based on a state's historic spending, two proposals take alternative approaches—each with implications for Texas. The Patient CARE Act, for example, proposes to allocate national federal Medicaid spending across states based on each state's number of low-income enrollees. Texas has the second largest number of low-income residents in the nation, behind California,[20] meaning that Texas would fare better under this model than if the dollars were allocated based on state-historic Medicaid spending. This ranking includes undocumented immigrants, but it is unclear whether the Patient CARE Act's proposed allocation of federal dollars would count undocumented immigrants in calculating a state's number of low-income residents since such individuals are not currently Medicaid eligible. Last year's House Budget proposal takes an entirely different approach, basing the initial cap on national average spending per Medicaid enrollee, rather than state-historic spending. Texas would have higher caps for the elderly, but lower caps for children, if national rather than state-specific average expenditures were used. Using a national average advantages states that have lower spending and disadvantages states that spend above the national average, making any movement toward a national average disruptive and difficult to achieve.

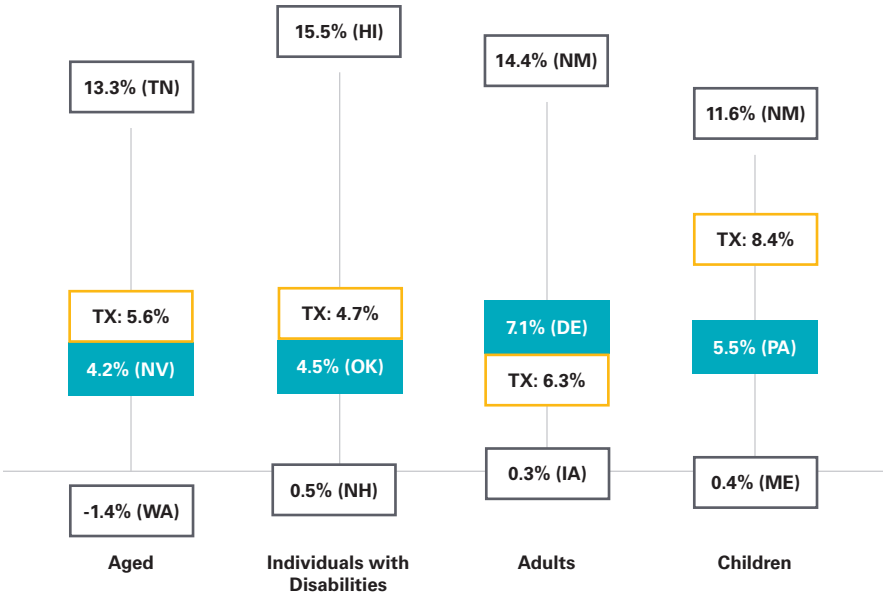
2. Trend Rate

As important as the base payment is in determining the amount of federal dollars that a state will receive, the trend rate is likewise important—particularly over time. Consider a block grant or a per capita cap that sets the base rate at the level of federal payments the State received in 2016. The trend rate will determine whether that payment is frozen over time or whether it grows year-by-year and, if so, by how much. Like other states, Texas will want to consider whether there is a prescribed trend rate and if so what that growth rate will be.

All recent proposals to cap Medicaid funding have included a trend rate that would grow the base payments year to year. This is critical; a capped proposal without a growth rate will lose value relative to the cost of healthcare. Two examples of federal block grant proposals where the base amounts do not automatically grow are the Social Services Block Grant and the Temporary Assistance for Needy Families (TANF).

While the proposals to cap federal Medicaid funding have contemplated that the base payments would be adjusted annually, the trend rates in these proposals would be tied to a national, not a state-specific indicator, and one that is projected to grow more slowly than overall healthcare

Figure F: Comparison of Growth Rates by Eligibility Category, FY 2000-2011



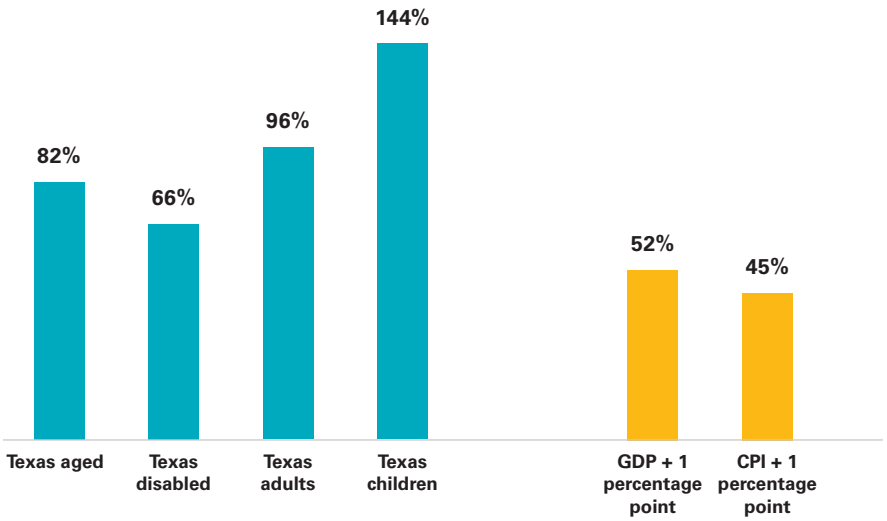
costs or Medicaid spending. For example, the Patient CARE Act uses CPI + 1 percentage point,[21] while the HAEL Act would use GDP + 1 percentage point.[22]

None of the recent Medicaid proposals to cap funding trend the initial capped payments based on state, or even the national, growth in healthcare costs. Medical inflation has outstripped general inflation factors, like changes in CPI or GDP, in recent years, with overall medical inflation averaging 3.21% over the past ten years, nearly twice as high as general inflation, which averaged 1.82% over the same period. And growth rates vary considerably across eligibility groups. Figure F[23] shows the different average trend rates across eligibility groups, underscoring that a single national trend factor might not account for variation in spending growth across different eligibility categories. Caps based on general inflation factors are therefore likely to fall short of Medicaid spending over time, at least in the absence of significant reductions in program costs. Figure G[24] illustrates the gap between the cumulative change in Texas's Medicaid spending compared to the trend factors proposed in the HAEL Act and the Patient CARE Act over the time period between 2000-2011.

The trend rates identified in the Medicaid capped funding proposals address, to a limited degree, the issue of rising healthcare costs, but they do not address enrollment growth. None of the Medicaid block grant proposals or any of the existing federal block grant programs adjusts for enrollment, or even population growth. By contrast, a per capita cap model would accommodate enrollment growth (subject of course to the limits of the base payment), so long as the model does not also include a national spending cap. Because Texas is the third fastest growing state in the nation,[25] it will be particularly disadvantaged by any capped funding approach that does not adjust for enrollment. Because of the combination of a low base rate for elderly enrollees and the expected rise in the elderly population—Texas's growth in terms of population age sixty-five or older is projected to grow 45% between 2015–2025, compared to 36% for the nation[26]—Texas is at risk under a per capita cap, too. If Texas is unable to keep costs under its per capita cap for elderly enrollees, the losses will mount with each new elderly enrollee.

One issue with applying multiple adjusters is that the more meaningful they are to a larger number of states the more they will add federal costs, unless there would also be an allowance for downward adjustment (e.g., to reflect an increase in the average health of an enrollee population in a state that scales back eligibility for long-term care or makes other changes that substantially

Figure G: Cumulative Growth in Texas Medicaid Spending per Full-Benefit Enrollee Relative to Benchmarks, 2000-2011



change its enrollee mix). In addition, while improvements are being made, the federal government currently lacks reliable, timely data for all states that can ensure an adjustment is applied appropriately and in real time. The HAEL Act would adjust per capita caps to account for "new instances of communicable diseases or other public health hazards," but the proposal calls for the adjustments to be budget neutral in the aggregate. In other words, caps could be adjusted to account for a regional health crisis, but other states' caps would need to be reduced to account for the increased federal spending. The Patient CARE Act would be adjusted to "reflect demographic and population changes," though the proposal provides few details on how those adjustments would be made.

3. State Share

While the federal government, on average, covers 62 percent of the cost of Medicaid nationally and 56 percent in Texas,[27] state spending in the program is significant. Several proposals to cap federal Medicaid funding appear to modify or eliminate the requirement that states spend their own funds as a condition of receiving capped federal payments. Speaker Ryan's Better Way proposal, for example, appears to require a state match for states operating under per capita caps but not for states opting for a block grant. (The Ryan proposal would give states a choice of a block grant or a per capita cap.) Eliminating or reducing state-match requirements could add state-spending reductions to the projected federal funding reductions, further reducing the overall funding available for the program. Or, the elimination or reduction of a federal requirement for states to spend their own funds could be illusory. Even without a federal obligation, states may determine that they have to continue to spend their own dollars—and perhaps more of their own dollars— if federal Medicaid funds were reduced and capped.

Even if a state-matching requirement remains in place, if the federal funds that Texas can draw down are themselves reduced then its state-spending requirement will also be reduced. Currently, Texas law limits state spending for Medicaid to those expenditures that will qualify for federal matching payments.[28] If that law (common to many states) remains in place and Texas was to see a 10 or 20 percent reduction in available federal payments due to federal caps, the program would experience a commensurate reduction in state payments for Medicaid coverage and services.

In addition, capped funding proposals generally do not address whether the enhanced federal match rates that are currently available for certain populations and certain services for everything ranging from health homes (for which states receive a 90 percent federal match for two years) to the cost of new IT investments (90 percent match) to the operation of eligibility systems (75 percent match) will remain in place. Texas currently receives enhanced matching funds for its IT systems (claims and eligibility systems and staffing relating to those systems) and certain program integrity initiatives.[29] Texas also was the 5th state in the nation to take advantage of the Community First Choice federal option, which provides enhanced federal matching payments (a six percentage point increase) for the home and community-based services provided through the program.

State spending could also be affected if the rules are changed with respect to how states can raise their nonfederal share. Proposals also vary on whether they would make changes to how a state is permitted to raise its nonfederal share. The HAEL Act, for example, would end state reliance on funding from intergovernmental transfers (IGTs). The House Budget Proposal, by contrast, would

reduce the effective cap on provider taxes to 5.5 percent of net patient revenues, down from the current 6 percent cap. Most other proposals do not speak to this issue.

Texas currently relies heavily on both IGTs and provider taxes to fund the nonfederal share of Medicaid costs, and thus any changes to how states may use IGTs and provider taxes would have significant implications for Texas. In total, IGTs account for roughly half of the nonfederal share for payments to hospitals. If IGTs are no longer allowed to be used to fund the nonfederal share, Texas may struggle to raise the funds required to draw down available federal dollars.[30] Texas also uses provider tax revenue to fund the nonfederal share. Texas currently has no taxes above 5.5 percent of net patient revenue, meaning that Texas's provider tax structure would not be affected by current proposals.[31]

4. Supplemental Payments and Waivers

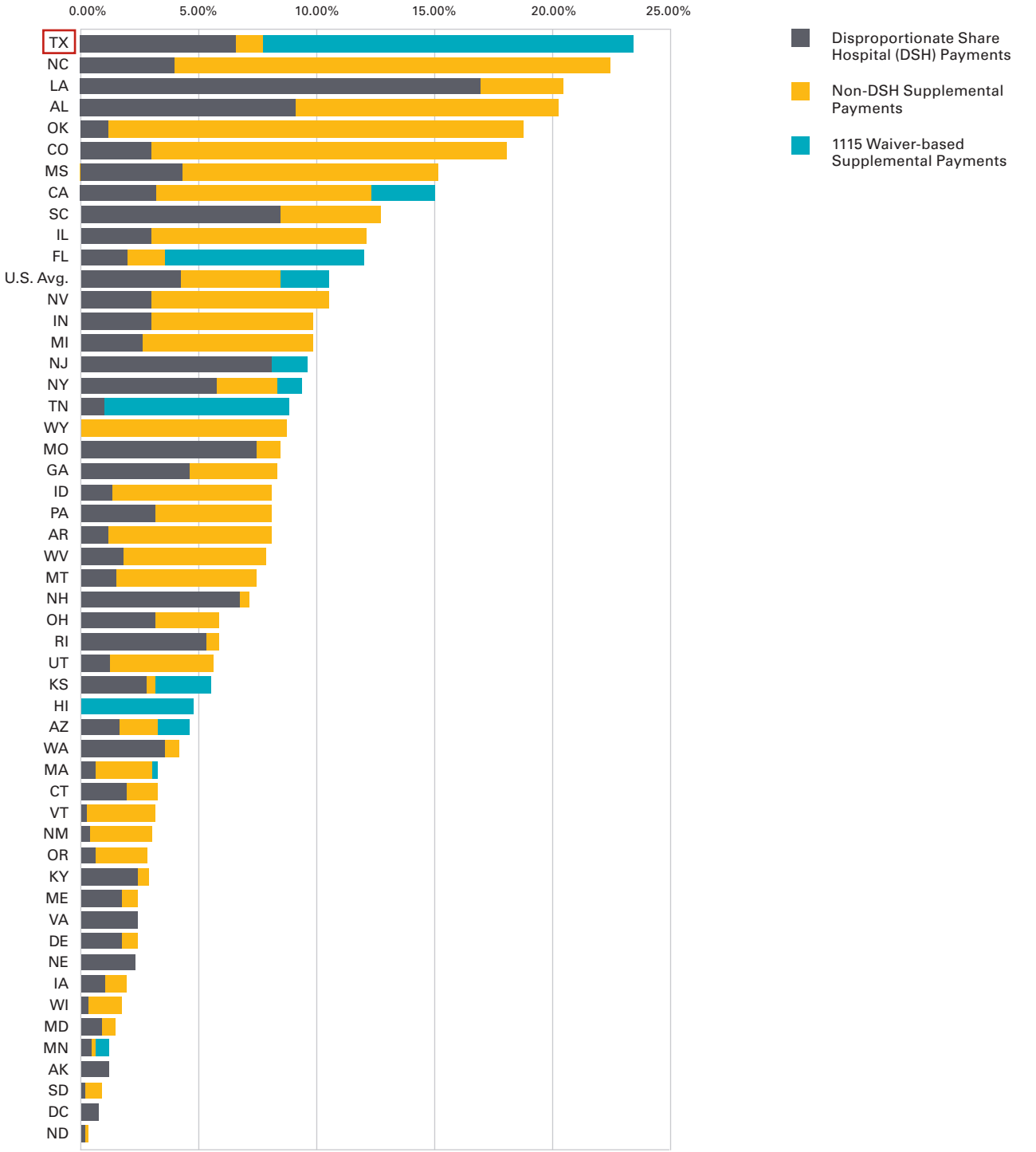
Virtually every state relies on some form of supplemental payment (Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments and Upper Payment Limit payments) or waiver funding, and many states, including Texas, rely on both. In moving to a capped funding model, several questions arise. First, how will Congress treat such spending in calculating each state's base payment? Second, will such funding be permitted outside the cap going forward? Finally, will states continue to be permitted to finance the nonfederal share of supplemental payments or waiver funds through the same mechanisms currently deployed—provider and health plan assessments, intergovernmental transfers, and with respect to waivers, "costs not otherwise matchable." Recent proposals, for the most part, do not have sufficient details to answer any of these questions. The one exception is Speaker Ryan's Better Way proposal that explicitly limits the Secretary of Health and Human Services' ability to approve certain types of new waiver funds, though it provides few details on how existing waiver funds would be handled under capped funding. It also provides that DSH and GME payments would not be included in calculating a state's funding cap; i.e., a state could maintain such funding streams outside its capped federal funding allocation. The HAEL Act, by contrast, would include DSH and GME payments under caps.

No state spends a greater percentage of total Medicaid dollars on supplemental payments and waiver funds than Texas (Figure H). Supplemental payments, most of which have been converted in Texas to waiver payments, account for nearly 1 out of 4 dollars spent in the Texas Medicaid program and for more than half (53 percent) of all Medicaid payments to hospitals participating in the DSH and waiver programs.[32] Thus, how these payments are handled under any capped funding proposal will be especially important to Texas. In addition, because Texas relies on provider and health plan assessments, as well as IGTs, to fund the nonfederal share of these payments, the State will want to track closely any proposals to eliminate or constrain these financing options.

5. The Tradeoff: Flexibility

As noted at the outset, capped funding is generally coupled with additional flexibility for states in administering their programs. More flexibility is almost always appealing to states. However, when that flexibility is linked to a reduction of and cap on federal Medicaid funding, Texas will want to evaluate carefully the added flexibility it seeks and whether that flexibility might be available today through waivers. Additionally, the State will want to consider how it might exercise that flexibility and any downstream implications for local governments, providers, health plans and consumers.

Figure H: FFY 2015 Supplemental Payments as a Share of Total Medicaid Spending



The proposals advanced to date have little detail on the scope of flexibility that would be permitted relative to current law. Whether Congress adopted a block grant or a per capita cap, billions of federal funds would not flow to states without some federal oversight and related audit and reporting requirements and perhaps new quality or outcome measures. In addition, it should be anticipated that any capped funding proposals will include some minimal requirements on eligibility levels and benefits, though current proposals have provided few details on what benefits and populations must be covered. States would have flexibility over and above those minimums. Today, Texas covers no childless adults and covers parents to 15 percent of the FPL and elderly and disabled adults to 75 percent of the FPL. These are the lowest levels permitted under current law,[33] and it may be unlikely that lower eligibility levels would be permitted for these groups. Texas covers pregnant women to 198 percent of the FPL. If Texas were to reduce eligibility, the State must consider who will bear the costs of the additional uninsured: consumers? hospitals? counties? Texas may be able to reduce the benefits it covers, but notably in three areas where benefits are optional under current law—namely, certain mental health services, substance abuse services, and pharmacy—Texas has opted to cover these benefits in part because they tend to reduce spending in other parts of the program (e.g., emergency room and inpatient hospital costs). Texas will need to consider whether there are benefits (or more to the point, costly benefits) it would like to eliminate or reduce that the state is constrained from doing under current law. Further, the State will need to evaluate the potential impact on other program costs, like emergency room and inpatient hospital care, as well as other stakeholders.

States could also gain flexibility with respect to payments to plans and providers, although this is an area where states already have significant flexibility. Federal rules require that payments to health plans be actuarially sound leaving states significant discretion to set those rates. Probably the most burdensome part of these rules for states is the process they must go through with the federal government to assure that the rates are actuarially sound. It is not clear whether even if the federal rules no longer required actuarially sound rates that Texas would change its practice in this regard; it is, however, likely that some of these process requirements would be ended or reduced under a capped funding structure.

Additionally, States could gain flexibility in administering their managed care programs. Federal rules related to network adequacy, for example, may no longer apply, enabling plans to contract with fewer hospitals with patients traveling longer distances to obtain care. Texas will want to consider the impact of such changes on hospitals, especially rural hospitals, and the communities they serve.

One of the more important set of federal rules that is less likely to be dropped in a capped funding environment has to do with how states raise their nonfederal share, assuming a nonfederal share is still required. States have discretion to use intergovernmental transfers and provider taxes to help finance their nonfederal share of costs and Texas, like most other states, rely heavily on these sources of funds. Given longstanding congressional concern about these sources of financing, it is not at all certain that new flexibility will be permitted with respect to these rules. In fact, some of the capped funding proposals would reduce state flexibility in this area.[34]

In short, Texas will want to consider whether the additional flexibility that may come with the reduction in federal funds will be sufficient to enable the state to manage coverage and care for its lowest income residents—

including children, and elderly and disabled adults—with a fixed and reduced sum of money.

Texas will also want to consider whether the additional flexibilities it seeks are available already under section 1115 of the Social Security Act. For example, several states have already secured waivers to allow them to collect premiums, apply higher co-pays, and remove non-emergency transportation and retroactive coverage from their benefit package, with respect to expansion adults. Several expansion states have likewise sought to condition coverage for the expansion adults on work or job training requirements. While such waivers have been denied in the past, these waivers and others could well be granted by the new Administration. In Texas, however, the majority of program enrollees are children and the majority of program spending is for low-income elderly and people with disabilities, likely reducing the impact of work requirements on Medicaid spending.

Thus, Texas will want to evaluate whether the flexibility the State seeks will permit it to take actions it would choose to take to manage costs and whether, at least in critical respects, such flexibility is already available under existing law and under the current open-ended financing structure.

With respect to the administrative burden imposed on states by the current Medicaid structure, it should be noted that CMS could expedite and streamline the review process for both State Plan Amendments and waivers without a change in law, or with changes in law that are not accompanied by capped funding. And, while the reporting and audit requirements might be somewhat less in connection with a capped allocation of federal Medicaid dollars, they will certainly continue given the size of even a reduced Medicaid program.

III. Conclusion

Capped Medicaid financing shifts the risk of any costs above the federal caps to the states. Particularly when capped funding is coupled with the goal of reducing federal Medicaid spending, the risk of a significant cost shift is great. If a proposal to cap funding—either through a block grant or a per capita cap—is proposed in the 115th Congress, all states will seek to ensure that any capped proposals protect their states to the greatest extent possible. But in the context of fixed and reduced federal funding, resolving issues favorably for one set of states inevitably creates issues for other states. As this paper describes, Texas comes to the capped funding discussion with a number of fiscal disadvantages—most notably its historically low investments in Medicaid relative to its low-income population, its growing population, its relatively low spending levels for the elderly and its high reliance on supplemental and waiver funding. States with higher funding caps will have the same flexibility as Texas to modify eligibility, benefits and payments, but that same flexibility will be coupled with more federal dollars to invest in their Medicaid programs. Texas will want to consider all these factors as it evaluates the potential impact of capped funding on its budget, its residents, and its healthcare providers.

Appendix A: Overview of Capped Funding Proposals

Feature	A Better Way (Ryan)	Patient CARE Act (Hatch/Upton/Burr)	FY17 House Budget Comm. Budget Resolution (Price)	HAEL Act of 2016 (Sessions/Cassidy)
Type	State option for block grant or per capita cap	Per capita cap	State option for block grant or per capita cap	Per capita cap
State Match Required	✔ (per capita cap) ✘ (block grant)	✔	✘	✔
National aggregate cap	✘	✔	✔	✘
Different caps for populations	✔	✔	?	✔
Populations covered	All	All, except acute care of elderly & disabled	All	All
Base amount	Average Medicaid spend in state during base year	Nat'l Medicaid spend allocated based on state population with income < 100% FPL	Unclear	Average Federal Medicaid spend during base year
Treatment of supplemental payments	DSH and GME payments excluded from per capita caps and paid through current match process; unclear for other waiver payments	Included in cap	DSH would be excluded from caps and transitioned to separate pool	Included in cap
Changes to financing nonfederal share	None	None	Would reduce maximum provider taxes to 5.5%	Would prohibit intergovernmental transfers and certified public expenditures
Trend rate	Unclear	CPI + 1	Unclear	GDP +1

[1] Some streams of funding in the Medicaid program (for example, disproportionate share hospital payments) are subject to caps or limitations. The basic financing of program services, however, is not subject to a cap or overall limit.

[2] In a letter to House leadership, the National Governors Association addressed the potential for capped funding to shift risk to the states. The letter urged Congress to "maintain a meaningful federal role in the [Medicaid] partnership and . . . not shift costs to the states . . . [but to] protect states from unforeseen financial risks." National Governors Association, Letter to Rep. Kevin McCarthy, January 24, 2017, available at https://www.nga.org/cms/home/federal-relations/nga-letters/health--human-services-committee/col2-content/main-content-list/health-care-reform.html.

[3] Certain types of payments, such as supplemental payments are subject to limits. See Social Security Act § 1903(i) for examples of limits on what expenditures qualify for federal match. In addition, while different from a cap on federal funding, federal law imposes certain constraints on states' use of federal funds by defining the services and populations that may be covered with federal funds. With billions of federal dollars at stake, it is likely that even under capped funding some definitional constraints would continue to operate.

[4] The federal government's share of nearly all Medicaid expenditures is determined by each state's federal medical assistance percentage (FMAP). By statute, states' FMAPs range from 50-83%, meaning that the federal government pays for between 50% and 83% of the costs of the state's Medicaid program. States with higher per capita incomes have lower federal matching rates, and states with lower per capita incomes have higher federal matching rates.

[5] At times, federal law has been changed to relieve states of some of their financing obligations; most recently during the Great Recession, states were relieved of some of their state financing responsibilities through a temporary increase in the federal matching rate for all states.

[6] See, for example, Rep. Paul Ryan's *Better Way* proposal available online at: http://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf.

[7] Cindy Mann, Deborah Bachrach, et al, Capping Federal Medicaid Funding: Key Financing Issues for States, Robert Wood Johnson Foundation, December 2016, available at: http://statenetwork.org/wp-content/uploads/2016/12/State-Network-Manatt-Capping-Federal-Medicaid-Funding-Key-Financing-Issues-for-States-December-2016.pdf.

[8] Both the House Budget Committee, FY 2017 Budget Proposal and the HAEL Act include a national cap.

[9] House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4, Available online at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf.

[10] Source for Figure A: House Budget Committee, FY 2017 Budget Proposal, Appendix IV, Table S-4, available at: http://budget.house.gov/uploadedfiles/fy2017_a_balanced_budget_for_a_stronger_america.pdf.

[11] Source for Figure B: Manatt analysis of National Association of State Budget Officers (NASBO) State Expenditure Report, 2016.

[12] The 20% figure depicts the direct impact of Medicaid spending on the State's own revenue—it does not include the federal dollars allocated to the Medicaid program through the State budget or other federal revenues received by the state for other purposes.

[13] The Texas Hospital Association cited similar issues in its letter to Governor Greg Abbott dated Jan. 9, 2017.

[14] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[15] Manatt analysis using enrollment estimates from The Urban Institute, What if More States Expanded Medicaid in 2017? Changes in Eligibility, Enrollment, and the Uninsured and the Office of the Actuary's 2015 Actuarial Report estimate for average newly eligible adult costs of $5,910 for 2016.

[16] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[17] Centers for Medicare and Medicaid Services, Medicaid and CHIP Eligibility Levels as of June 1, 2016, available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html.

[18] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000912-Block-Grants-and-Per-Capita-Caps-the-Problem-of-Funding-Disparities-among-States.pdf.

[19] Truven Health Analytics, Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2014, available at https://www.medicaid.gov/medicaid/ltss/downloads/ltss-expenditures-2014.pdf.

[20] United States Census Bureau, Small Area Income and Poverty Estimates, 2014 available at: http://www.census.gov/did/www/saipe/data/interactive/saipe.html?s_appName=saipe&menu=grid_proxy&s_inclUsTot=n&s_state=56,01,02,04,05,06,08,09,10,11,12,13,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,44,45,46,47,48,49,50,51,53,54,55&s_inclStTot=y&s_USStOnly=y&s_year=2014

[21] The Patient Choice, Affordability, Responsibility, and Empowerment Act (Senator Orrin Hatch, Senator Richard Burr, Representative Fred Upton), https://murphy.house.gov/uploads/FINAL%20Patient%20CARE%20Act%20Plan.pdf.

[22] Healthcare Accessibility, Empowerment, and Liberty Act of 2016 (Representative Pete Sessions and Senator Bill Cassidy), http://www.goodmaninstitute.org/wp-content/uploads/2016/05/SESSIO_007_xml.pdf.

[23] Rudowitz, R., Garfield, R., and Young, K., "Overview of Medicaid Per Capita Cap Proposals," Kaiser Family Foundation, June 2016. Available at: http://kff.org/report-section/overview-of-medicaid-per-capita-cap-proposals-issue-brief/.

[24] Sources for GDP per Capita, Manatt analysis of National Health Expenditure Accounts (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip), for CPI Medical, BLS CPI Medical (https://data.bls.gov/cgi-bin/surveymost?cu), and for Texas Population Groups, Kaiser Family Foundation Data, (http://kff.org/medicaid/issue-brief/medicaid-per-enrollee-spending-variation-across-states/).

[25] Census Bureau, Cumulative Estimates of Resident Population Change for the United States, Regions, States, and Puerto Rico, and Region and State Rankings: April 1, 2010 to July 1, 2016.

[26] Manatt analysis of U.S.Census Bureau, Population Division, Interim State Population Projections, 2005, Table B1, https://www.census.gov/population/projections/data/state/projectionsagesex.html.

[27] MACStats December 2016, Exhibit 6.

[28] See Tex. Hum. Res. Code Ann. § 32.024.

[29] See State of Texas, Advance Planning Document Updated, March 2014, available at https://assets.documentcloud.org/documents/1357133/oig-graph-pattern-analysis-apd-uv16.pdf.

[30] Texas Health and Human Services Commission, Evaluation of Uncompensated Care and Medicaid Payments in Texas Hospitals and the Role of Texas's Uncompensated Care Pool, September 13, 2015, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-uncomp-care-eval-rpt-sept-2016-update.pdf.

[31] Kaiser Family Foundation, State and Medicaid Provider Taxes or Fees, 2016, available at http://kff.org/medicaid/fact-sheet/states-and-medicaid-provider-taxes-or-fees/.

[32] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-uncomp-care-eval-rpt-sept-2016-update.pdf. The HMA analysis included the 356 hospitals that participated in the Texas Medicaid DSH/UC Pool program in FY 2015. These hospitals account for more than 98% of Medicaid payments to hospitals.

[33] Parents must be covered up to the maximum income to qualify for the state's Aid to Families with Dependent Children (AFDC) program in 1996. Alabama's income limits to qualify for AFDC at that time were lower than Texas's income limits, and thus their eligibility for parents is slightly lower in terms of a percentage of the federal poverty level.

[34] The HAEL Act would prohibit the use of intergovernmental transfers. The House Budget Committee FY 2017 proposal would reduce the implicit cap on provider taxes from 6% to 5.5%.

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