Overview of Medicaid Funding in Texas:
Unraveling the Rapidly Changing Funding and Program Dynamics

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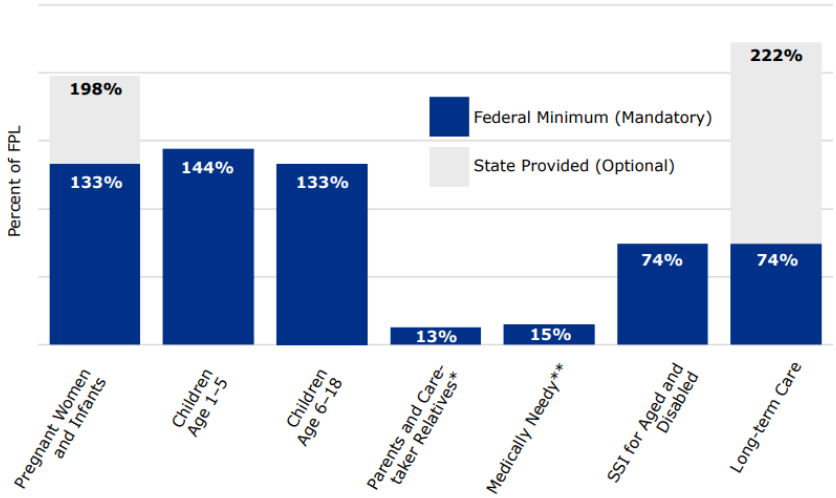
Background

Medicaid is a joint state and federal program[1] that provides health care coverage to individuals meeting program eligibility. The federal government provides a portion of the funding (Federal Medical Assistance Percentage, or FMAP) and sets the program guidelines. While the federal match may vary slightly from year-to-year, and for certain programs or populations, the federal match for Texas is generally around 60 percent, meaning that for each dollar spent on Texas Medicaid client services, the state pays 40 cents and the federal government funds the remaining 60 cents.

Beyond the mandatory eligibility and service requirements, states may also cover optional populations, and/or provide optional services. The table[2] below provides current Texas Medicaid eligibility levels.

Texas Medicaid Income Eligibility Levels for Selected Programs, March 2022 (as a Percent of the FPL)



*For Parents and Caretaker Relatives, maximum monthly income limit in SFY22 was $230 for a family of three, or about 13 percent of the FPL.
**For Medically Needy pregnant women and children, the maximum monthly income limit in SFY22 was $275 for a family of three, or about 15 percent of the FPL.

[1] Medicaid Program | Benefits.gov
[2] texas-medicaid-chip-reference-guide-14th-edition.pdf

Acute care, including hospitalization, physician visits, and prescription drugs, as well as long-term services and supports (LTSS) and behavioral health services, are provided to eligible clients in Medicaid, with the state having discretion to offer additional optional services. For full list of mandatory and optional Medicaid services see the *Texas Medicaid and CHIP Reference Guide*, *14th Edition*, Chapter 2, and Appendix B, page 146.

As of December 2022, almost 5.8 million clients[3] were enrolled in Medicaid, with a monthly average of 5.3 million for fiscal year (FY) 2022. This number is significantly higher than is typical and is a result of the maintenance of effort (MOE) requirement for receiving additional federal matching funds during the federal COVID-19 Public Health Emergency (PHE)[4]. The MOE requires that all Medicaid enrollees as of January 2020 must remain in the program through the end of the PHE. As the PHE expires May 11, 2023, the increased FMAP will be reduced and ultimately discontinued, with caseload MOE winding down simultaneously.[5]

Given this backdrop, this paper will provide information based on the most recent full year of data (FY 2022), which includes increased caseload and increased FMAP. However, while it is important to understand the effects of the PHE requirements on both caseloads and costs, it is also critical to examine historical data on the dynamics of the Medicaid program, and the growth of Medicaid in Texas during the past two decades.

The focus of this paper is the changing landscape of Medicaid in Texas and how that changing landscape – including Medicaid enrollees, and the interaction of complex policy and funding dynamics- has important implications for future policies and decisions that will impact the balance of the system for decades to come.

Medicaid Clients

Medicaid has two primary categories of clients. The first, full-benefit clients, shown in the eligibility categories above, are the primary recipients of Medicaid, and may receive acute and/or LTSS benefits. The second, non-full benefit clients receive only partial benefits, or benefits from a specific program. For example, persons who are dually-eligible for Medicaid and Medicare can be both full-benefit clients and receive Medicaid for services not paid by Medicare, or partial-benefit and have only their Part A or Part B Medicare premiums paid. Additionally, federal Medicaid law provides that individuals not eligible for Medicaid due to citizenship status, including some legal permanent residents as well as undocumented persons, receive services for any condition considered to be emergent (which includes childbirth, as well as any life-threatening emergency), which results in a payment to the hospital or physician.

Both full and non-full benefit clients comprise the Medicaid Client Services component, but when costs and caseload are discussed, it is for full-benefit clients only, as those are the clients who are enrolled and can be measured in terms of a per member per month cost. Full-benefit costs comprise more than 80 percent of the Medicaid expenditures paid through the General Appropriations Act (discussed in greater detail below) and remain the largest portion of Medicaid payments.

[3] Healthcare Statistics | Texas Health and Human Services
[4] Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch | KFF
[5] SHO-23-002 (medicaid.gov)

Medicaid Payments

Client Services and Supplemental Payments

As recently as 2012, the definition of Medicaid client service payments was straightforward, and cost per client (per member per month, or pmpm) could be validly and reliably calculated on an annual basis. Under this scenario the pmpm was determined by dividing payments made for the care of the (full-benefit) client, by the number of clients.

Even still, the Medicaid pmpm did not capture everything. Some providers, typically hospitals, received supplemental payments through federal funding sources known as the Disproportionate Share Hospital and the Upper Payment Limit programs. The Disproportionate Share Hospital (DSH) program provides funds to help make up for "Medicaid shortfall," which is the deficit when the Medicaid payment does not meet the actual costs for serving the client, and for serving low-income uninsured clients. The Upper Payment Limit (UPL) program existed to help make up the difference between what Medicaid paid and what Medicare would have paid for that service. UPL is a large component of the initial waiver pool and was a driving factor in how the initial waiver was established, as discussed below.

During the past decade, the structure and flow of Medicaid payments has changed dramatically, to the point that payments no longer necessarily fall into clean and distinct categories, rendering the pmpm less straightforward. There are several reasons for this – including changes due to the Affordable Care Act (ACA); increased American Rescue and Recovery Act (ARRA) funding due to the recession in the late 2000's; and increased funding due to COVID-19. However, the primary cause is the Texas Healthcare Transformation and Quality Improvement Program, also known as the 1115 Transformation Waiver, or simply, "the waiver." As a result of the waiver, Medicaid payments have evolved considerably to include more provider payments, particularly to hospitals, that fall outside the General Appropriations Act and are referred to as Supplemental Payments. These fall outside the GAA because the source of funding for the non-federal share, essentially what is used to draw down federal dollars, are not state general revenue funds, but rather intergovernmental transfers (IGT) from local hospital districts or governments (e.g., counties) to the Texas Comptroller of Public Accounts. Waiver supplemental funds are not the only supplemental funds flowing through the system, but in the past few years have become the largest component of supplemental funding.

One consequence of the increased use of supplemental funds is that payments are not always directly tied to a Medicaid client and their costs. This makes identifying, understanding, and describing the factors that underlie cost growth difficult, and not as readily accessible as a per member per month cost, which is based on utilization parameters and treatment or services.

Texas Transformation Waiver

The initial iteration of the waiver was approved by the Centers for Medicare and Medicaid (CMS) on December 12, 2011, with a five-year extension approved in December 2017, and an additional 10-year extension ultimately approved through September 30, 2030. More on the waiver and its impact follows, but for comparison, the data tables below for federal fiscal years 2002, 2012, 2021 and 2022 show the significant changes in Medicaid spending over the last two decades.

A caveat to the tables – FFY 2022 data, from the CMS-37 report, is based on cash payments, not accruals, and due to waiver negotiations some 2021 payments were delayed. Therefore, the cash flow for 2022 is higher than typical due to the size of the increased PHE-related caseloads.

Federal Fiscal Years 2002, 2012, 2021, and 2022 Medicaid Payments[6]:

Total Medicaid, FFY 2002	**$**	**14,269,608,618**	***% of Total***
Full-benefit	$	10,580,000,000	74%
Caseload		*2,103,972*	
pmpm	$	419	
Non-full benefit	$	1,359,646,809	10%
Administration	*$*	*738,782,267*	5%
Supplemental	$	1,591,179,542	11%

Total Medicaid, FFY 2021	**$**	**48,217,963,939**	***% of Total***
Full-benefit	$	30,200,000,000	63%
Caseload		*4,682,819*	
pmpm	$	537	
Non-full benefit	$	4,050,859,429	8%
Administration	*$*	*1,625,375,878*	3%
Supplemental	$	12,341,728,631	26%

Total Medicaid, FFY 2012	**$**	**29,348,165,839**	***% of Total***
Full-benefit	$	20,550,000,000	70%
Caseload		*3,655,930*	
pmpm	$	468	
Non-full benefit	$	3,447,017,815	12%
Administration	*$*	*1,440,692,506*	5%
Supplemental	$	3,910,455,518	13%

Total Medicaid, FFY 2022	**$**	**58,365,391,076**	***% of Total***
Full-benefit	$	34,000,000,000	58%
Caseload		*5,312,573*	
pmpm	$	533	
Non-full benefit	$	4,446,396,678	8%
Administration	*$*	*1,659,874,696*	3%
Supplemental	$	18,259,119,702	31%

Key points from the tables show that:

- Total Medicaid spending has grown just slightly more than 300 percent from 2002 to 2022, and approximately 250 percent from 2002 to 2021.
- The proportion of total Medicaid spending made up of supplemental funding has grown substantially, to the point that the 2022 the supplemental amount is larger than total Medicaid (Base+Supplemental) spending was in 2002.
- Caseload has grown substantially as well – to the point that it had almost doubled from 2002 through the time just prior to the impact of the MOE/PHE. Caseload is anticipated to settle back in to just above 4 million full-benefit clients, although that could take some time.

The impetus for the waiver, in large part, was the increasing desire to expand managed care to provide coordinated care to the Medicaid population without unnecessary or duplicative services, enabling successful management of chronic conditions, and to establish defined metrics for quality of care, which are often disjointed in a fee-for-service (FFS) system. Although the State determined that managed care would result in increased savings and client outcomes, federal regulations did not allow UPL funds to be paid within a capitated (i.e., managed care) arrangement. Therefore, expansion of Medicaid managed care would have resulted in a significant reduction in UPL funding which, at the time, was one of the primary funding sources

[6] CMS-37 Medicaid History, November 2022, Health and Human Services Commission, Office of the CFO

(non-GAA) for hospitals. To address this issue, HHSC was directed to expand managed care but seek a means to preserve UPL funding for hospitals by pursuing an 1115 waiver (Senate Bill 7, 82nd Legislature, First Called Session).

Managed care in Medicaid requires CMS approval through a waiver, but an 1115 Waiver operates differently than other Medicaid waiver options. Section 1115 of the Social Security Act provides authority for demonstration programs with relatively broad flexibility, allowing states to improve their Medicaid programs without adhering to all of the traditional federal requirements.[7] These demonstrations must be "budget-neutral" and not cost the federal government more than the program would have cost without the demonstration. This is achieved by comparing the projected costs 'without waiver' (WOW) to those 'with waiver' (WW). The difference between these two components forms the pool of funds used to meet the original objective of preserving UPL hospital funding, as well as providing funding for programs that further the objectives of the Medicaid program. Importantly, CMS policy requires the budget ceiling to be "rebased" with more recent cost data and growth trends each time the waiver is granted an extension and can limit carry-forward of accumulated savings from one extension approval to the next. The waiver is currently being rebased for this most recent (10-year) extension, using data from October 2021 through September 2022.

The original pool of waiver funding was built with the UPL funds that would have been forfeited by moving to managed care without the waiver (including a component already forfeited during the prior managed care rollout), plus savings generated by transitioning from FFS Medicaid to managed care. These cost savings were derived from increased utilization management, improved service coordination that better identified needs, and a more intense focus on medical home and preventative care available in the managed care model. These cost savings are well documented[8] and it is this component of managed care – the management and coordination – that allows the waiver savings pool to grow. This mechanism – generating a pool of funds using the differential between growth with a waiver versus without – is followed closely by HHSC to ensure that the funds are and remain available for use. But the role of managed care savings – and managed care oversight of services and utilization – cannot be underscored enough in ensuring that the WW piece remains cost efficient. Cost efficiency requires not only containing costs through coordination, but also through quality-driven care and a focus on treating and stabilizing chronic conditions.

Supplemental Programs – Basic Descriptions[9]

Listed below are the supplemental programs that are currently or have been part of the Medicaid program over the past two decades, followed by a timeline showing some of the major milestones as the 1115 waiver and funding have evolved over time. Lastly, a broader picture of Medicaid funding shows the growth of total funding, with state and federal client funding, and the combined federal and local supplemental funding, that is driving the overall increase in Medicaid dollars.

[7] https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[8] TCCRI MMC Cost Containment FINAL.docx (wixstatic.com); Healthcare Reform Presentation (texas.gov)
[9] Sources include the 14th Edition of the Texas Medicaid Reference Guide ("Pink Book"), January 2023, Reference Guide | Texas Health and Human Services; CMS-37 Medicaid History Report, November 2022; Medicaid Supplemental & Directed Payment Programs, Presentation by HHSC, April 30, 2020.

The tables below show both current and discontinued supplemental programs, with a brief description of each. More detailed information on each program may be found in the Texas Medicaid and CHIP Reference Guide (aka, "pink book") as well as on the HHSC website: Medicaid Supplemental Payment & Directed Payment Programs | Texas Health and Human Services.

Non-Waiver Supplemental Programs	Acronym	Description	Begin Date
Disproportionate Share Hospital	***DSH***	*Payments to hospitals with a large (disproportionate) number of Medicaid and Low-Income Uninsured. DSH funds are not tied to specific services [1].*	*Pre-1990*
Hospital Augmented Reimbursement Program	***HARP***	*Payments to public hospitals to offset Medicaid FFS losses, using the Medicare -Medicaid rate difference (similar to UPL)*	*2023*
Intermediate Care Facilities-Upper Payment Limit	***ICF-UPL***	*Public intermediate care facilities for intellectual / developmental delay conditions (IID). Payments based on the Medicare-Medicaid reimbursement differential.*	*2016*
Graduate Medical Education	***GME***	*Payments to public teaching hospitals for residents training and costs*	*2014*
School Health and Related Services	***SHARS***	*Payments for direct services to students with special needs, provided in a school setting using certified public expenditures as non-federal share*	*2014*

[1] *DSH allocation (federal) will be reduced beginning in 2024, with an overall reduction of $8 billion nationwide . DSH began federally in 1981.*

Supplemental Waiver - Waiver Pool Payments	Acronym	Description	Begin Date
Uncompensated Care	***UC***	*Created with the 1115 waiver from the UPL amounts forfeited when moving to managed care, UC is based on Medicaid shortfall and uninsurance provided, but allocated based on charity care (a change made Oct 1, 2019)*	*2012*
Public Health Provider Charity Care Pool	***PHP-CCP***	*Created with the 1115 waiver extension (2021) provides public mental health and community health providers for uncompensated care (charity care only, beginning 2023)*	*2022*

Supplemental Waiver - Delivery System and Provider Payment Initiatives, Network Access Improvement	Acronym	Description	Begin Date
Network Access Improvement Program	***NAIP***	*Pass-through to Health Related Institutions and Public Hospitals for network access to primary and specialty care. Will sunset in 2027, per federal law.*	*2015*
Quality Incentive Payment Program	***QIPP***	*QIPP is a directed payment program focused on improving quality of care throught innovative practices in nursing facilities. Providers must meet outcome measures on four components to receive full payment, and must serve primarily Medicaid residents.*	*2018*
Comprehensive Hospital Increase Reimbursement Program	***CHIRP***	*DPP for hospitals with clients in STAR and STAR+Plus. CHIRP reduces Medicaid shortfall and has a UHRIP component and an incentive component.*	*2022*
Texas Incentives for Physician and Professional Services	***TIPPS***	*DPP for physician groups providing services to managed care clients in STAR, STAR+Plus and STARKids.*	*2022*
Rural Access to Primary and Preventive Services	***RAPPS***	*DPP for rural access clinics (RACs) providing primary and long-term services to Medicaid managed care members in STAR, STAR+Plus, and STARKids. Includes hospital-based and free-standing RHCs.*	*2022*
Directed Payment Program for Behavioral Health Services	***DPP-BHS***	*DPP for community mental health centers and local behavioral health authorities to improve access to behavioral health care, including care coordination and transition.*	*2022*

Discontinued Programs	Acronym	Description	Dates
Upper Payment Limit	***UPL***	*Payments to hospitals for the difference between Medicaid and Medicare - ended with 1115 Waiver*	*2002 to 2012*
Delivery System Reform Incentive Payments	***DSRIP***	*Incentive payment program for providers, focusing on quality, coordination and population health with a goal of transforming service delivery. DSRIP was always intended to phase out and transition to the most effective*	*2013 to 2023*
Minimum Payment Amount Program	***MPAP***	*Payment to Nursing Facilities in STAR+PLUS - revised to QIPP to include a quality focus.*	*2015 to 2018*
Uniform Hospital Reform Incentive Payment	***UHRIP***	*Increases reimbursement rates to hospitals for inpatient and outpatient Medicaid patients in managed care (directed payment); CHIRP replaces in 2022*	*2018 to 2022*

These programs now contribute to the overall Medicaid funding, which, as noted in the program descriptions, may not be a program that provides funding to Medicaid clients directly, or indirectly (such as Uncompensated Care, which funds charity care clients only), but can impact funding for other Medicaid programs. Historically, the DSH and UPL programs were the primary sources of supplemental funds. DSH remains a key supplemental program (outside the waiver), providing stability by compensating for services to low-income uninsured clients, as well as "Medicaid shortfall" (the portion of costs not fully paid by Medicaid). The UPL program, which was replaced by Uncompensated Care (UC), was directly tied to Medicaid. Payments such as GME and NAIP, while not directly tied to Medicaid clients per se, provide resources to all hospital clients in a public hospital or health-related institution.

This plethora of programs directed at specific needs and/or providers illustrates the convolution in determining cost growth in the Medicaid program overall. More importantly, this continued growth and complexity in funding streams illustrates the pressure and difficulty that state leaders will face to continue to sustain the program should the waiver not be renewed beyond the current extension to 2030, or if the sources of non-federal share funding are reduced or restructured based on federal guidance or statutory changes. Given the magnitude and recency of growth in supplemental funding and the number of programs, maintaining the stability and equilibrium to sustain a statewide Medicaid program with non-federal matching funds made up largely from local tax dollars or provider fees is a delicate balance, particularly in ensuring that the program continues to serve as a safety net.

Lawmakers face an almost constant onslaught of requests for additional funding for various components of the Medicaid program, particularly in the area of provider payments. And while many Medicaid reimbursement rates, particularly for primary or specialty physician services, may be below commercial or Medicare levels, it is imperative that state policymakers have a clear picture of all the funds flowing "off-budget" to hospitals and other providers. The charts below provide an abbreviated timeline for the waiver (and non-waiver) supplemental programs, as well as a matrix listing of where the supplemental funds go (and how they are paid).

Total Medicaid Payments *(In billions)*

$14.3	$29.5	$37.0	$40.0	$42.6	$44.3	$48.2	$58.4
Base Medicaid							
$12.7	$25.6	$27.5	$29.7	$30.3	$31.4	$35.9	$40.1
2002	**2013**	**2015**	**2018**	**2019**	**2020**	**2021**	**2022**
Supplemental Payments, Percent of Total, Programs							
$1.6 11%	$3.9 13%	$9.5 26%	$10.3 26%	$12.3 29%	$12.9 29%	$12.3 26%	$18.3 31%
DSH *UPL*	*DSH* *UPL* (final year) *UC** *DSRIP**	*DSH* *SHARS* *GME* *UC** *DSRIP** *NAIP** *MPAP**	*DSH* *ICF UPL* *SHARS* *GME* *UC** *DSRIP** *NAIP** *MPAP** (final year) *QIPP** *UHRIP**	*DSH* *ICF UPL* *SHARS* *GME* *UC** *DSRIP** *NAIP** *QIPP** *UHRIP**	*DSH* *ICF UPL* *SHARS* *GME* *UC** *DSRIP** *NAIP** *QIPP** *UHRIP**	*DSH* *ICF UPL* *SHARS* *GME* *UC** *DSRIP** *NAIP** *QIPP** *UHRIP**	*DSH* *ICF UPL* *SHARS* *GME* *UC-PHP-CCP* *UC** *DSRIP** *NAIP** *QIPP** *UHRIP** (final year) *CHIRP** *DPP BHS** *TIPPS** *RAPPS**

** Denotes Waiver Supplemental*

All numbers are in billions

The timeline above raises the question of where the funds for these programs go – and how they are funded (in terms of the non-federal share). The matrix below provides a picture of the funding sources and beneficiaries. A caution – one picture cannot capture in full the complexities and nuances of the funding dynamics – but this provides at least a beginning to the discussion.

Supplemental Payment Programs: Primary Beneficiaries and Funding Sources

Funding Source						
Non-Waiver (1115) Supplemental Programs	DSH	■	☼			
	HARP	●				
	ICF-UPL					●
	GME	●				
	SHARS				●	
Waiver-Based Supplemental Programs	UC	●	●			?
	UC-PHPCCP					●
	DSRIP[1]	●	●			
	UHRIP[2]	●	●			
	NAIP[3]	●				
	CHIRP	●	●			
	TIPPS[4]	●	●[4]			?
	RAPPS	●	●			●
	DPP BHS					●
	QIPP[5]	■		×		
		Public[6] Hospital / Health-Related Institution	***Private Hospital / Health-Related Institution***	***Nursing Facility***	***School District***	***Other Provider***

Legend:

■	Receives, IGTs self/others
●	Receives, IGTs
☼	Receives, does not IGT
×	Receives, Managing Entity Only
?	Receives, IGT mixed

[1] *DSRIP discontinued with waiver extension (2022)*

[2] *UHRIP discontinued with waiver extension (2022)*

[3] *NAIP will discontinue approximately FY 2027*

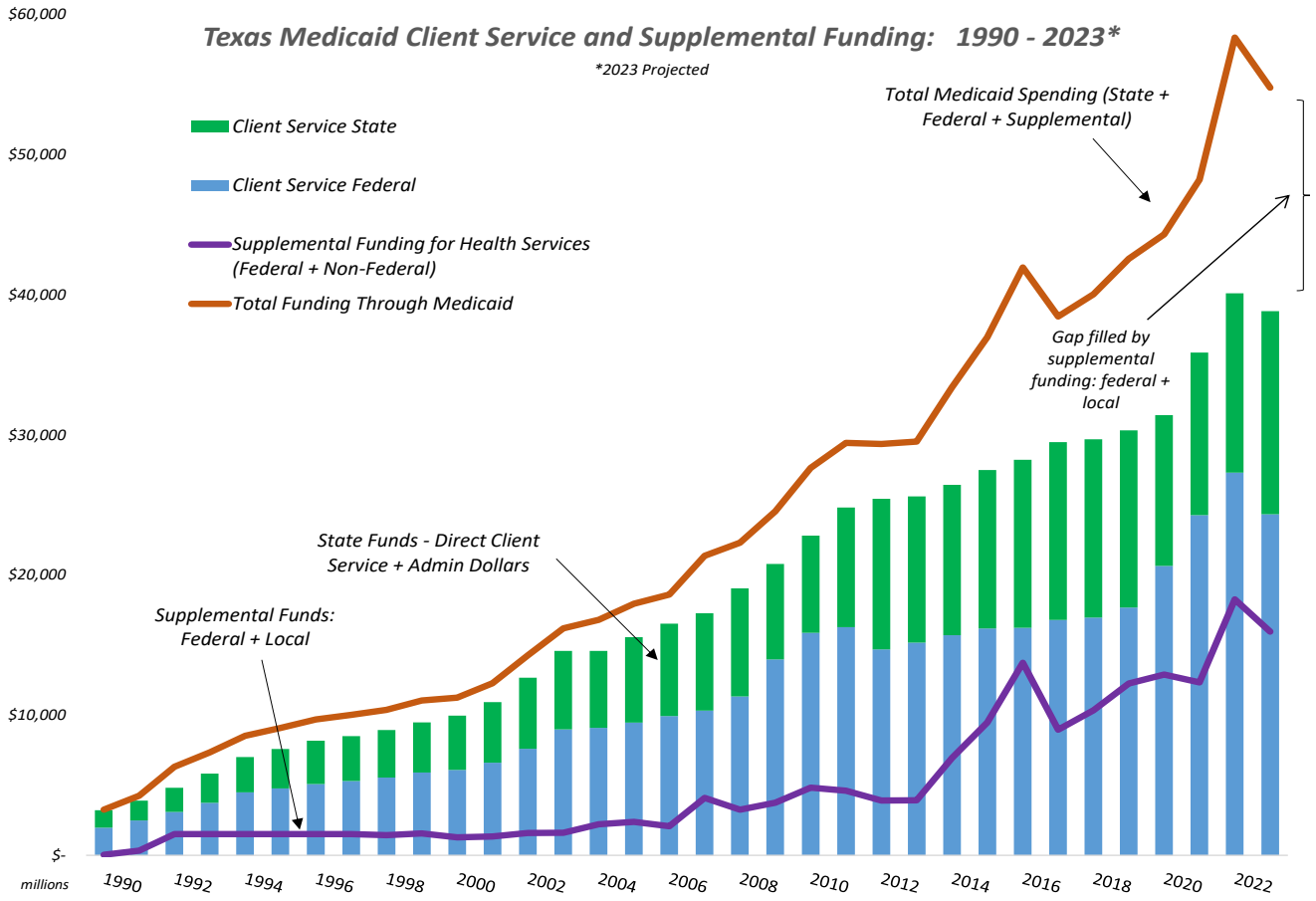
[4] *TIPPS includes three components, and an entity may receive all three but only IGT for part (not component 3, which is up to 10% of the payment)*

[5] *Nursing Facility payments were originally the nursing facility minimum payment program (MPAP) which provided enhanced rates to qualified skilled nursing facilities*

[6] *Public hospital includes the hospital district. For QIPP, these may be the non-state government owned (NSGO) nursing facilities managed and operated by private providers .*

As the timeline illustrates, although Texas received its initial waiver approval in December 2011 (fiscal year 2012), the Uncompensated Care and DSRIP waiver funding was received in fiscal year 2013 (calendar year 2012), but even in fiscal year 2013 supplemental funds were only 13 percent of overall funding. By 2015, more supplemental programs had come online (not all waiver programs), and supplemental funding had more than doubled in just two years – comprising 26 percent of overall funding at just under $10 billion. By 2022, more than a dozen supplemental programs existed and accounted for approximately 30 percent of overall Medicaid funding. Up until the last decade, supplemental payments comprised around 15 percent of the total Medicaid budget. Currently, supplemental payments – including the category of directed payments, or DPPs, discussed in the tables on pages six and eight – now comprise up to 30 percent of the total Medicaid budget, and often more than half of hospital funding.

The chart below provides an overview of this growth from a global perspective, as well as the growth in client service funds (even with lower state funds due to temporarily increased federal matching dollars) during COVID.



Conclusion

Medicaid, originally established to provide essential health care coverage and services to the most vulnerable, has grown over the decades, covering not only Texas' increasing population, but also additional caseload categories including children, newborns, pregnant women, and women needing treatment for breast or cervical cancer. Medicaid currently covers more than half the children in Texas and is often the primary resource for persons who are elderly or have a disabling condition that necessitates treatment in their homes, or in a facility. While the number of Texans receiving services funded through base payments for the state-federal Medicaid program has grown with population size, cost growth for Medicaid remained mostly steady – growing at a rate 13 percentage points lower than the overall U.S., in large part attributed to "improved preventative care within managed care.[10]" But, given an ever-growing supplemental funding pool that includes non-Medicaid clients, and/or funding that is not client-specific or "off budget," true cost growth, utilization, and impact remains unknown. State leaders are forced to continue to make overarching policy decisions without this vital information. Whether funds are state, federal, or local, the Medicaid program is ultimately administered by the state – and the overall health of the program itself is the responsibility of state leaders. Good decisions require good information – and complete information.

[10] Healthcare Reform Presentation (texas.gov), see page 35

About the Author

Lisa Carruth specializes in financial and policy analysis in the health care sector, with an emphasis on Medicaid, hospital reimbursement, and managed care. Lisa's 30-year public-sector career doing research, forecasts, and fiscal impacts to inform policy and program decisions provide her with a strong foundation to understand the complexities of health care finance. Lisa ended her public-sector career as Chief Financial Officer of the Texas Health and Human Services Commission (HHSC), and has spent her time as a consultant assisting provider groups with strategy and analytics to understand the funding picture from all perspectives. Lisa holds a Bachelor's degree from Texas A&M University, and a Master's degree from Louisiana State University.