POLICY PAGE

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A Fist Full of Dollars or A *Frew* Dollars More?

Wild rumors are circulating about the cost of complying with the settlement Texas agreed to in *Frew v Hawkins* in 1995. Some are saying *Frew* will require the state to identify and enroll every eligible Texas child in Medicaid (not true), or require the state to spend as much as $5 billion more annually on children in Medicaid (also not true). This *Policy Page* provides a brief summary of key facts about *Frew* and the upcoming April hearing.

What Does Federal Law Require? Federal Medicaid law requires that states provide comprehensive health benefits to all Medicaid clients under the age of 21. The children's provisions are titled Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), known here as Texas Health Steps. Under federal law, states can't place any arbitrary limits on the "amount, duration or scope" of coverage such as X days coverage of hospital care, or Y doctor visits, or Z prescriptions per month. Instead, children are to receive whatever level of care is medically necessary.

In addition, states must take steps to ensure that enrolled children get all the check-ups, immunizations and dental check-ups recommended by a professionally recognized schedule, and Texas uses the American Academy of Pediatrics and American Academy of Pediatric dentistry standards. States also must make sure these children get needed diagnosis and treatment for their medical conditions. In order to make these things happen, states are required to do "outreach and informing" to educate parents of enrolled children about the need for check-ups, help them find doctors and dentists, and help them access transportation to the doctor if necessary. Federal Medicaid rules set a goal for states to make sure that at least 80% of children get at least one exam per year (though children are supposed to get 10 check-ups between birth and their second birthday).

What is *Frew* About? The *Frew* case was filed in 1993, alleging that Texas Medicaid was failing to ensure access to check-ups as well as to medically needed follow-up care. In 1994, the court certified the case as a class action composed of all children enrolled in Texas Medicaid. The case has raised issues about adequate children's access to providers of check-ups, specialty care, transportation, dentistry, and medical case management.

Contrary to recent rumors, the Frew suit relates only to access to care for children already enrolled in Medicaid. It in no way addresses children who may be eligible for Medicaid but are not enrolled, and includes no provisions whatsoever to compel the state to enroll more children.

What Did Texas Agree to do in the 1995 Settlement? The state and the plaintiffs' attorneys agreed on a settlement that was approved by the federal district court as its "Consent Decree" in February 1996. The 75-page decree (see full decree at www.cppp.org) requires Texas Medicaid officials to increase substantially the number and proportion of children receiving all recommended check-ups through training, outreach, provider recruitment, and increased check-up fees. Medicaid officials are also to ensure access to diagnosis and treatment (i.e., not just check-ups), and to ensure that Medicaid Managed Care also meets these standards. The decree paid special attention to improved access to dentistry, medical transportation, and case management. The decree also established reporting requirements for check-ups, outreach, and health outcomes for children in Texas Medicaid.

What has Happened in the Courts Since 1995? In November 1998, plaintiff's attorneys filed a motion to enforce the Consent Decree,

claiming that Texas Medicaid officials were not living up to the terms of the agreement. After a hearing in March 2000, the district court ruled in August 2000 that the state was not complying with much of the agreement, and ordered the state to propose Corrective Action Plans (CAPs). The state appealed this decision to the Fifth Circuit Court of Appeals, which granted a stay of the order to produce the CAPs. Then in July 2002, the Fifth Circuit ruled that the district court could not enforce the decree, citing the 11th Amendment. The plaintiffs appealed to the U.S. Supreme Court in October 2002, which agreed in March 2003 to hear the case.

In January 2004, the U.S. Supreme Court overruled the Fifth Circuit, and returned the case to the appeals court for further proceedings. In July 2004, the Fifth Circuit determined that it should not rule on the interpretation of the consent decree, but should return the case to the district court.

Once back in the district court, Texas officials filed a motion to dissolve the Consent Decree, while plaintiffs' attorneys moved for entry of CAPs. The district court held a hearing in June 2005 and ruled in August 2005 that the state had not proven that conditions had improved enough to justify terminating the settlement, but did not rule on the plaintiffs' motion. (CPPP staff provided expert testimony at this hearing on behalf of the plaintiffs.)

The state appealed this decision to the Fifth Circuit, which upheld the district court in September 2006. The Texas Attorney General then requested that the U.S. Supreme Court review the case a second time, but the U.S. Supreme Court denied further review in January 2007.

What will Happen at the April 2007 Hearing? The upcoming hearing will address the plaintiff's still-pending 2005 motion for entry of CAPS. Plaintiffs have asked the court to direct Texas Medicaid officials to take remedial actions to bring them into compliance with the settlement. Both sides have filed proposed corrective action plans, which the court will consider in an April hearing before ruling on what the actual Corrective Action Plan will be. There is no fixed deadline for this ruling, which could come several months later.

What is the Plaintiffs' Corrective Action Plan? Plaintiffs have filed 11 CAPs:

(1) Training for health care providers;
(2) Reporting on check-up rates and plans to improve those rates in lagging counties;
(3) Improving check-up completeness;
(4) Access to medications, medical equipment and supplies;
(5) Toll-free number performance;
(6) Medical transportation;
(7) Health outcomes measures and dental assessment (e.g., immunization, lead screening, hearing screens, vision, mental health, etc.);
(8) Outreach and informing and reporting;
(9) Case management;
(10) Special issues in Medicaid Managed Care (e.g., monitoring frequency and completeness of check-ups, and reporting what percentage of children enrolled in Medicaid Managed Care get no health care during a 12 month period); and
(11) Adequate supply of health care providers (standards for travel distance, time to wait for appointments, accurate information on provider availability, adequate reimbursement to meet these standards). (You can review the plaintiffs' CAPs at www.cppp.org.)

What are the Cost Implications of these CAPs? It is not known which elements (if any) of the plaintiffs' proposed CAPS will be actually ordered by the court, nor is it possible to predict what the court's precise interpretation of key elements will be, so it is also not possible to currently estimate what compliance will cost. Three proposals in the proposed CAPs call for additional spending in a general way, but do not prescribe the exact degree or manner of the increase.

Perhaps the most significant of these is the proposal related to adequacy of provider networks, which says that Medicaid payment rates must be adequate to support a provider supply sufficient to meet standards for proximity to doctors and waiting times to get an appointment. The CAP does not specify any size or method of increase—only adequate rates—and proposes evaluation of reimbursement to determine if future increases are needed.

While each of the provisions of the CAPs—if implemented—clearly would have cost impacts, the

directives are too general to be credibly scored at the billions of dollars some have suggested.

- **To put the potential cost in context, the cost of serving all the children in Texas Medicaid is less than $5 billion (All Funds) per year, of which the state's share is less than $2 billion. Even a very ambitious and aggressive remediation order by the court, while it could require significant spending, would not plausibly double the cost of Texas children's Medicaid.**
- **Improving availability of doctors for children's services would not require rate changes for services to adults, or for every category of Texas Medicaid services. To illustrate, HHSC estimates that bringing all hospital and doctors' fees up to actual cost would require about $1.5 billion GR for the 2-year budget, but 70% of that spending or more would be for adults, and thus not required by *Frew*.**
- **In short, while compliance with whatever corrective action plan the court ultimately requires will undoubtedly require significant new state spending, nothing supports projections of multiple billions in annual costs.**

What improvements Have Been Made for Children on Texas Medicaid Since 1993? While the state has taken significant steps to better serve children, much work remains. Since 1993, Texas Medicaid has implemented systems designed to provide outreach and information to parents, and invested more in medical transportation, dentistry, and check-ups. The fees paid for the comprehensive Texas Health Steps check-ups were increased from $49 to $70 in 2002, bringing those fees much closer to Medicare rates (i.e., to a range from 60% to 90% of Medicare) than for adult Texas Medicaid fees in general. On the other hand, though check-up rates according to the official federal scoring method improved significantly from 1993 to 1998, they have failed to improve since then, and in fact have gotten a little worse. The number of children enrolled in Medicaid who received no medical or dental check-up during a year continues to grow.

Was the 1995 Consent Decree too Generous? Though the *Frew* lawsuit has been a topic of discussion and a budget issue in every session since 1995, the current session is the first time that any one has implied that the Texas Attorney General did not cut a reasonable or fair deal for the state. The plain truth is that Texas was not in compliance with the law in 1995; the attorney general could not have won the case in court; and the settlement was a reasonable resolution.

In any event, it really doesn't matter now whether the state could have done slightly better through litigation or not. The state agreed to a settlement in 1995, has tried through the courts to renege, and has been told by the U.S. Supreme Court that it can't renege. Texas must now fully implement the settlement and live up to its word.

Since 1995, the consent decree has produced results that have improved care for Texas children, but we remain well short of full compliance with our agreement.

One way to compare access to care among states is to look at a state's federal score on check-up participation. In 1993, Texas EPSDT's federal score was abysmal. As noted above, while it improved at first, it has stagnated since 1998, and in fact, is currently below the 1998 level.

As for comparing spending, according to the American Academy of Pediatrics, Texas Medicaid spending per enrollee under age 18 in 2003 was $1,795, compared to $1,856 per child for the U.S. average.

What Does *Frew* Mean for the Rest of the Budget? To comply with federal law, we need to spend more money on children's Medicaid. Some of that money has already been requested by the Health and Human Services Commission in its exceptional items, particularly to increase provider rates. While *Frew* will cost the state more, the state can afford to comply with *Frew* and still meet other critical needs. Nothing about *Frew* argues for shorting other programs or services.