POLICY PAGE

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Devil's in the Details: Six Essential Things Medicaid Reform Should Not Do

Several bills aimed at changing the Texas Medicaid program are scheduled for hearings this week. While the bills as a group do include concepts with merit, they also include provisions which raise grave concerns from the perspectives of both client advocacy and fiscal responsibility. There are still opportunities to revise these bills to preserve and protect both client access to care as well as prudent stewardship of Texas taxpayer dollars. This *Policy Page* identifies the major themes in the bills needing revision to protect the interests of Medicaid recipients and taxpayers, and makes the following recommendations:

1. Every bill proposing or requiring an 1115 Medicaid waiver should specifically state that no waiver of children's comprehensive health care under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) will be sought.
2. Every bill proposing or requiring Tailored Benefit Plans should specifically state that the plans must enhance, not reduce, benefits for any Medicaid recipient population.
3. Every bill proposing Health Savings Accounts, Premium Assistance, Health Insurance Premium Payment (HIPP) programs, or "Opt-Out" programs must (1) include a provision requiring that HHSC determine that it is cost effective; (2) either exempt recipients under age 21 or explicitly require that the program be designed to protect and promote children's access to preventive care and medical treatments; and (3) guarantee that recipient participation is voluntary, and that a prompt return to regular Medicaid coverage is allowed on request of the recipient.
4. SB 10 provisions related to cost-sharing should be modified to limit the language to non-emergent ER use co-payments, and to delete the open-ended HHSC authority to impose additional cost-sharing policies in Medicaid.
5. Each of the bills proposing incentives for health behaviors should explicitly state that it is authorizing only positive rewards, and not punitive incentives.
6. SB 10 (or any similar bill) provisions related to pooling of disproportionate share hospital (DSH) and upper payment limit (UPL) funds should require that any such pool include inflation and population growth factors.

What Bills are Under Consideration?

Chairman Jane Nelson of the Senate Committee on Health and Human Services filed **SB 10**, an "omnibus" bill of roughly 30 pages, which aggregates a number of different proposals for changes and pilot programs. The bill as filed is likely to be replaced with a committee substitute which is not yet available, but it is likely that most of the major themes in the filed version will be reflected in the substitute. On the House side, a number of bills have been filed whose language is identical or very similar to sections of the Senate bill, including **HB 2539** by Rep. Carl Isett; **HB 3284** by Rep. Jodie Laubenberg; **HB 3466** by Chairman Dianne Delisi; **HB 3733** by Rep. Myra Crownover et al.; and **HB 3792** by Rep. John Davis.

In the sections below, the key issues of concern to CPPP in these bills are identified.

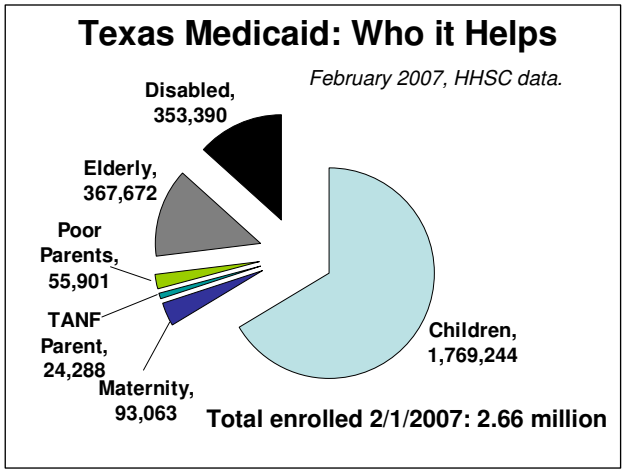
Protect Comprehensive Care for Children in Medicaid, Now Guaranteed in Federal Law. Federal Medicaid law requires states to provide comprehensive health benefits to all clients under age 21. The children's provisions are titled Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), known here 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 care is medically necessary.

SB 10 and several of the House bills (HB 2539, HB 3733, HB 3792) call for (or would require under federal law) the Texas Health and Human Services Commission (HHSC) to request a "waiver" of unspecified provisions of federal Medicaid laws under authority of Section 1115 of the Social Security Act.

Recommendation: To clearly demonstrate that lawmakers do not intend to reduce the coverage of medically needed care, preventive care, and dental care for children in Medicaid now afforded by EPSDT, every bill proposing or requiring an 1115 waiver should specifically state that no waiver of EPSDT can be sought.

"Tailored Benefit Plans:" Better Coverage, or Less Coverage? Both **HB 3792** and **SB 10** call for HHSC to seek an 1115 waiver to implement Tailored Benefit Plans, in which different benefits would be offered to different Medicaid "populations," recipients with disabilities or special health care needs, the elderly, children, and parents (fewer than 80,000 parents receive Medicaid in Texas). The bills direct that these plans are to improve health outcomes and access to services, but also to "achieve cost savings."

The great majority of kids and parents in Texas Medicaid are already enrolled in HMO care, which provides a benchmark package for children; HHSC provides services that "wrap around" the HMO package to provide comprehensive EPSDT services as required by federal law.



Children, parents, seniors and adults with disabilities already receive significantly different Medicaid benefits in Texas, and neither bill spells out what, if any additional advantage this option offers Texas. If Tailored Benefit Plans were used to offer more case management, care coordination, easier access to community care supports, or even check-ups for adults (Texas Medicaid currently does not cover adult check-ups) then they could be quite beneficial. But as drafted, these bills could be used as the basis for cutting benefits.

Recommendation: Every bill proposing or requiring Tailored Benefit Plans should clearly state that the plans are intended to enhance, not reduce, benefits for any Medicaid recipient population.

Experimental Medicaid Delivery Models Must be Optional, Cost-Effective, and Protect Children's Access to Preventive Care and Treatment. Experiments with Health Savings Accounts, Premium Assistance, Health Insurance Premium Payment (HIPP) programs, or "Opt-Out" programs (the last two use public Medicaid dollars to subsidize employer coverage or other private plans) are proposed in **SB 10, HB 2539,** and **HB 3733.** These proposals must meet three tests to be good for clients and Texas taxpayers.

First, they should be cost-effective; that is, if they cost more than regular Medicaid, they should not be allowed. The Congressional Budget Office (CBO) has scored the "Health Opportunity Accounts" authorized by the federal Deficit Reduction Act (DRA) as costing more

than current Medicaid. Premium assistance, "Opt-Out" experiments, or HIPP programs that allow Medicaid dollars to be used to buy employer or other private coverage should not be allowed to exceed the current cost of Medicaid coverage.

Second, of even greater concern is whether coverage of children under either a Medicaid savings account model, a premium assistance program, and "Opt-Out" experiment, or a Health Insurance Premium Payment program, can ensure that children retain access to the preventive care and treatment they are now guaranteed under federal law.

Under a Health Savings Account model, will incentives be designed to provide incentives for parents to take their children for check-ups and immunizations, and not create incentives to "save" by skipping preventive care? Will the higher co-payments and out-of-pocket costs allowed under premium assistance, "Opt-Out" experiments, or HIPP programs create barriers to preventive care for children? What will be the administrative cost of HHSC determining the limits of thousands of different private health plans, so the agency can provide wrap-around services for children? Unless they are deliberately and carefully designed to protect children's access to preventive care and treatments, these models are likely to undermine the EPSDT standard. None of the bills containing these provisions exempts children (who make up more than one-third of Medicaid clients), so these questions are important.

Third, all of these approaches should be voluntary, both when a Medicaid recipient chooses to begin participation in the program, and when a client determines that the experimental model is not appropriate for them and wishes to return to "regular" or comprehensive Medicaid. In other words, recipients must be explicitly allowed not just to "opt out," but also to "opt back in" to Medicaid.

Recommendation: Every bill proposing Health Savings Accounts, Premium Assistance, Health Insurance Premium Payment (HIPP) programs, or "Opt-Out" programs must (1) include a provision requiring that HHSC determine that it is cost effective; (2) either exempt recipients under age 21 or explicitly require that the program be designed to protect and promote children's access to preventive care and medical treatments; and (3) guarantee that recipient participation is voluntary, and that a prompt return to regular Medicaid coverage is allowed on request of the recipient.

Bills Increasing Cost Sharing for Children Should Be Specific in Describing Scope. The DRA now allows for children on Medicaid—who are otherwise virtually exempt from cost-sharing—as well as adults to be charged nominal co-payments for use of the emergency room for non-emergency services. Such co-payments can be imposed only if the recipient has access to care in an alternative setting (e.g., a physician's office, urgent care clinic, or community health center), and if the hospital provides the recipient with both the name and location of the alternative provider and a referral to coordinate scheduling of an appointment. While HB 3284 is limited exclusively to this provision, SB 10 as filed also includes an open-ended authorization for the HHSC commissioner to impose cost sharing for other services. This could open the door, for example, for prescription drug co-payments for children and adults.

Recommendation: SB 10 provisions related to cost-sharing should be modified to limit the language to non-emergent ER use co-payments, and to delete the open-ended HHSC authority to impose additional cost-sharing policies in Medicaid.

Positive incentives for Healthy Behavior, Not Denials of Benefits. Several bills propose to offer bonus benefits or other rewards for recipients who engage in health activities (unspecified in the bills). This practice could yield useful results, such as enabling HHSC to explore ways to promote better uptake of preventive care. However, SB 10, HB 3466, and HB 3284 all contain broad language that could be used as the basis for negative actions against recipients who "fail" to engage in healthy behaviors. There is no indication that any of the authors intend to promote punitive incentives.

West Virginia has been criticized not because its program rewards healthy behavior, but for its denial of benefits to children when their parents do not comply with the healthy goals. As a matter of public policy, children should not be punished for their parents' shortcomings—e.g., the parent, not the child chooses to use the ER for urgent care. No child should lose medical benefits for parental actions. Since two-thirds of Texas' 2.7 million Medicaid clients are children, and only 80,000 parents are covered, these policies should be seen as primarily affecting children (and after that, disabled adults). Negative sanctions can also put physicians in the counter-therapeutic position of being "enforcers."

Recommendation: Each of the bills proposing incentives for health behaviors should explicitly state that it is authorizing only positive rewards, and not punitive incentives.

Don't Let the Feds off the Hook: Texas Should Not Accept an Artificial Cap on Hospital Payments. A key element of the filed version of SB 10 proposes to pool special Medicaid hospital payment funds to create more coverage for the uninsured under a Medicaid waiver. The bill says that the state "might" try to negotiate an annual inflation and population growth factor for the portion of the pool derived from "upper payment limit" (UPL) supplemental payments. The other fund, disproportionate share hospital (DSH) reimbursement, is already capped under federal law. However, UPL funds are simply based on every state's right under current federal law to pay up to (but not over) what Medicare would pay for the same service. Texas' nine UPL programs depend on the fact that local governments and public entities provide the "state share" of these Medicaid payments from local tax revenues.

Federal Medicaid law entails **two** forms of entitlement: the entitlement of eligible persons to enroll, and the states' entitlement to federal matching funds. Texas is entitled to receive up to the Medicare limit in Medicaid payments for hospital care. **Accepting a cap on UPL is the same as saying we are willing to accept in perpetuity the 2006 amount of federal matching funds for Medicaid hospital care, even though population, Medicaid enrollment, and medical inflation will continue to grow.**

The only threat to our current UPL system is through federal attempts to rein in local government contributions to UPL programs. If the state were to allocate state budget funds for UPL, it could raise all Medicaid hospital payments up to the Medicare limit today, and there would be no threat to the program at all.

The taxpayers of Texas are entitled to these federal matching funds, and any deal to pool DSH and UPL funds to create a pool to address some of the costs of the uninsured must not bargain away those funds.

Recommendation: SB 10 (or any similar bill) provisions related to pooling of DSH and UPL funds should require that any such pool must include inflation and population growth factors.

Equity is About More Than Schools: Remember Who Could Be Left Out of Premium Assistance and Three-Share Programs. SB 10 also includes provisions for the promotion of local and regional premium assistance programs and so-called "three-share" programs, which typically include contributions from a worker, his employer, and some public source. While these programs have merit and could help reduce the number of uninsured Texans, two caveats related to potential for inequity should be noted. The first is that there is a potential for wealthier parts of the state to have broader options for coverage than poorer parts of the state with less tax revenues. The second is that programs depending on a voluntary employer contribution will disadvantage workers whose employer is not willing to contribute. Thus, two families with the same take-home income and the same willingness to pay out of pocket will not have access to the same coverage.

While these concerns do not call for outright opposition to these programs, state programs must be equitably designed, and premium assistance and three-share programs need to consider how they might mitigate the impact of local wealth and employer motivation.