CPPP Center for Public Policy Priorities | Comments

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CPPP COMMENTS ON TEXAS HHSC DRAFT MEDICAID 1115 WAIVER CONCEPT PAPER: SUBMITTED TO CMS 12/5/07

The Center for Public Policy Priorities (CPPP) appreciates the opportunity to comment on the draft concept paper which has been submitted to CMS. We summarize key concerns below and list relevant page and section references parenthetically. We also refer you to our comments submitted to HHSC in November 2007, posted at http://www.cppp.org/research.php?aid=727.

General Comment

CPPP has long supported rationalizing the financing of health care for low-income Texans by redirecting currently unmatched public expenditures on the uninsured to the Medicaid program. For over two decades, Texans have pursued Medicaid maximizing policies designed to improve the return for Texas taxpayers by drawing a substantial federal match, while also improving access to primary and preventive care and health outcomes, and reducing costs that result from neglected health. The center strongly supports the high-level goal of using Title XIX funds to provide health coverage for low-income Texas adults currently not covered by Medicaid or any other public insurance. For the vast majority Texans below 100% of the federal poverty income level (FPL)—even those working full time—no purely market-driven solution exists that can overcome the prohibitive cost of health care in relation to their household incomes. And, while adults from 100-200% FPL are somewhat better situated to access coverage as their incomes increase, it is clear that a meaningful role for government is still needed to ensure affordable access to decent health care and to allow these low-income adults to participate in the health care marketplace. CPPP sincerely hopes to be able to support HHSC in designing a program that can bridge the large gap which the private health insurance marketplace and public programs currently leave unfilled for low-income Texas adults.

However, the draft concept paper as submitted on December 5, 2007 leaves so many critical elements undefined and key questions unanswered that it is impossible to make a more specific statement of support for the document or the HHSC effort at this point in development. As the comments below describe, an acceptable waiver would have to:

(1) provide an adequate minimum standard for health benefits,

(2) be affordable at all income levels served;

(3) provide for the higher-level needs of those in the demonstration population with acute or chronic conditions;

(4) incorporate special protections for Texans below 100% FPL;

(5) be available statewide;

(6) incorporate measures to address the lack of provider capacity to serve the demonstration population

(7) protect ongoing ability of safety net hospitals and FQHCs to serve remaining uninsured Texans (numbering 5.7 million at present) ; and

(8) be scalable to meet the needs of all (or most) eligible uninsured Texans in the demonstration population's income range. A symbolic program that serves few and stands in the way of solutions that could reach all low-income uninsured Texans is not acceptable.

Summary of Key Concerns

Setting an adequate floor for minimum acceptable benefits for HOP coverage statewide and for "acceptable," "qualifying" ESI, and any other coverage funded thru title XIX 1115 waiver funds such as hospital district or multi-share is critical.

Despite questions raised in the November 2007 comment period, the term "basic" coverage remains undefined, as are "qualifying" and "affordable" coverage (see section V p.12).

CPPP believes that "basic" or floor overage must be available statewide from the HOP. Severe inpatient limits are unacceptable, and the basic benefit floor must include prescription drug coverage, mental health services, and routine preventive care. Without these the program will not be cost-effective, nor will it live up to the draft's promise of focusing on primary and preventive care.

Given that a large proportion of the demonstration population will have income below the federal poverty income level (100% FPL), some provision for including coverage of non-emergency transportation in the basic floor coverage should be considered when prescribed by a physician (e.g., for persons whose injuries or illness creates unusual barriers to medical transportation).

To the extent that successful existing programs—such as those operated by large urban hospital districts—are treated as programs eligible for HOP (and thus Title XIX) funding, or new models such as multi-shares or Medical Savings Accounts (section VIII p. 17) are tested with these funds, HOP coverage providing the basic floor benefits should be available as an alternative to any program that fails to meet the basic floor benefit standard. This approach will allow local programs to choose whether to meet the floor standard, without allowing inequitable access standards in different parts of the state. The CHIP "benchmark" approach to creating a meaningful floor for benefits may provide a good general framework for setting and protecting a basic floor for HOP benefits.

The demonstration population will inevitably include a significant sub-population of adults who have chronic or acute care needs that fall just below the functional needs test thresholds for SSI or Medicaid community care coverage. Some demonstration population members will also, after their enrollment, sustain injuries or develop illnesses which escalate their medical needs above the levels of support provided by basic floor coverage. The concept paper should acknowledge this, and include a proposal for assessing and meeting the needs of the acutely ill, chronically ill, mentally ill, and just-below-disability standard members enrolled in the "basic" benefit plans.

The proposal to include annual benefit limits of unknown adequacy (section IX, p. 18) also points to a need for systematic advance planning regarding how demonstration population members who exceed the annual limits will receive care.

HHSC should work with the Texas Department of Insurance to obtain accurate information regarding the Texas health insurance marketplace. For example, the private marketplace almost never provides care management, despite the statement in the concept paper (**page 4**) that care management is supposed to be a focus of the waiver program. In addition, many ESI plans do not cover preventive care for adults.

Setting appropriate cost sharing limits (premiums and POS, including the "affordable" definition) for HOP coverage, and for subsidized ESI and other waiver-supported coverage is critical.

We applaud the reference (**Section X, page 19**) to collection of premiums beginning above 150% FPL. However, little more is described suggesting how affordability will be determined or POS cost sharing will be set.

Affordability standards for families above 150% FPL subject to premiums or ESI buy-in (see for e.g. p. 12) should look to existing benchmarks such as the federal law prohibition on CHIP cost sharing (premiums plus POS) not exceeding 5% of family income, and the Texas law exempting families from waiting periods if they spend more than 10% of income of health insurance. See also *The Uninsured And The Affordability Of Health Insurance Coverage*, by Lisa Dubay, John Holahan and Allison Cook, Health Affairs, 26, no. 1 (2007): w22-w30 doi: 10.1377/hlthaff.26.1.w22.

We oppose the request to waive Cost Sharing protections for clients under 100% FPL (**see section VIII p. 17, and Attachment D, p. 3, #10**). The waiver has said no premiums will be charged to this groups, and the DRA provides ample latitude to set affordable co-payments for the below-poverty adults.

If HHSC's intent is to use this waiver only for demonstration population members opting to access ESI without benefit wrap-around and without cost-sharing limits, then the waiver request needs to specifically say so. However, CPPP would oppose such experimentation unless demonstration population members can choose between ESI and the basic floor HOP coverage (i.e., the latter with a benefit floor and a cost ceiling).

If HHSC's intent is to use this waiver for core Medicaid population adult members opting to access ESI without benefit wrap-around and without cost-sharing limits, then the waiver request needs to specifically acknowledge that SB 10 requires that participation in such experiments must be voluntary and include the right to return to traditional Medicaid on request.

We oppose allowing denial of care for demonstration population members below 100% FPL for inability to make a POS co-payment denial. The great majority of such persons would be eligible for traditional Medicaid in many other states, and therefore entitled to the protections under current federal law for the core Medicaid population. The federal law rationale for these protections is equally applicable to the proposed demonstration population. (**The draft concept paper is silent on this issue.**)

Termination of coverage for non-payment of premium (**Section VI, p. 13**)should include a reasonable grace period (e.g., the commercial world typically provides 30-60 days). We object to the proposal to freeze demonstration population members out for 6 months for late payment, as this policy is unheard of in the private marketplace. Private insurers typically reinstate coverage as soon as payment is received. The proposed policies appear to be much harsher than the private market.

Opposition to Waivers of Federal Medicaid protections for demonstration population under 100% FPL

The **Attachment D** waiver requests need to specify in each item which are being requested for the demonstration population only, and which are for our current ("core") Medicaid population.

Attachment D and the concept paper also should clearly describe how they will comply with the SB 10 requirements regarding no reductions in benefits for core population, no involuntary participation in HSAs or substandard ESI, the right to return to traditional Medicaid, *et cetera*.

No waivers for recipients under 100% FPL should be allowed for:

EPSDT for demonstration population members aged 19-21. This principle is critical to federal Medicaid law and Congress has chosen to extend protections through age 21. There is no need to waive comprehensive coverage for this age group. (**p. 2, #7**)

Fair hearing rights: (**p. 1, #2**) demonstration population applicants and enrollees in poverty need access to appeals for both eligibility and benefit denials or reductions. The latter should be as robust as current state and federal law requires for Medicaid managed care clients.

Comparability: (**p.1, #4**) the concept paper must make clearer what is to be waived. Demonstration population members below poverty should be guaranteed floor benefits via HOP coverage and not required to accept ESI coverage that fails that standard or costs more. Current core Medicaid population members are guaranteed under SB 10 that their participation in ESI without wrap-around must be voluntary; this concept paper should also make that clear.

Eligibility Timeliness: (**p. 2, #5**) Demonstration population members below poverty should retain the protection (guaranteed to current Texas Medicaid enrollees) of an eligibility determination within 45 days. Exceptions should be allowed only in cases of health plan selection delays by the demonstration population member.

Cost sharing: (**p. 3, #10**) As stated above, the statutory DRA limits provide all the flexibility that is needed for enrollees below 100% FPL with regard to POS cost sharing. Any "opt-out" to ESI coverage with no cost share limits and/or substandard benefits should be voluntary, and with a right to return to HOP coverage for below-poverty demonstration population members (or to traditional Medicaid for core population members per SB 10).

3 months prior: (**p. 2, #6**) Texas would be wise to retain this for the below-poverty group and pay unpaid bills (just as they do now for the core Medicaid population) via the Fee for Service system. Recall, the core population of parents now cuts off at 13%-22% FPL. To waive this would forego federal participation in payment for care to the ill and injured that would have been covered under the Medically Needy program cut by the Texas legislature in 2003, and in doing so will hurt Texas safety net providers.

Other Appendix D Waiver Concerns:

Pregnant Women: Demonstration population Waiver enrollees <185% FPL who become pregnant should receive Medicaid coverage, or benefits at least as comprehensive as that coverage.

"**Statewideness:**" (**p. 1, #1**) For the entire demonstration population (i.e., not just those below 100% FPL), a reasonable phase-in period during which coverage is not statewide is acceptable, but long-term geographic inequity is not. Access to an adequate (floor) HOP benefit package statewide should be assured.

"**Eligibility Procedures:**" (**p. 1, #3 and p. 2, #8**) It is unclear what is being waived here, and why. A separate enrollment system for this waiver is acceptable (though it is unclear why HHSC would not wish to use the general eligibility system framework in which it is currently investing), but no matter what system is used, it should still be subject to documented rules and performance standards.

Freedom of choice: (**p. 2, #9**) Choice among plans in urban areas should be the standard, just as it is in traditional Medicaid Managed Care. Provider panel sizes large enough for meaningful PCP choice within plans should also be required.

FQHCs provide richer benefits than a "basic" package, and need their cost-based reimbursement to cover those costs. HHSC should preserve this guarantee, at least for the below-poverty population (**p. 3, #11**).

Reimbursement (**p. 3, #12**); a model involving reimbursements to enrollees for their contributions to the ESI is probably not wise for much of this population.

Adequacy of Public Input:

While the list of public presentations & meetings appended to the concept paper is long, there is a sense that communication at the great majority of these events was largely one-way, e.g., consisting of brief high-level overview PowerPoint presentations which were not designed to solicit input. The timing of this current comment period on the draft concept paper (three weeks

and 2 days, including the Christmas holiday) is less than ideal. The waiver development process needs to move rapidly to a more robustly collegial model if Texas is to build a successful waiver model that earns widespread public support.

Unanswered Questions Regarding Waiver Financing

Because the aggregate amount of state and federal funds to be available for funding this waiver is far from clear at this time and is highly dependent on CMS approval, it is likewise unclear whether this program will serve a significant number of the potentially eligible 2.1 million uninsured Texas adults described in the concept paper. This raises several concerns:

Will an under-funded program that serves few simply stand in the way of solutions that could truly reach all low-income uninsured Texans? As stated above, this outcome is not acceptable.

Will safety net hospitals get enough relief of uncompensated care to really offset reductions in their UPL or DSH support? Will the numbers covered be so small that there is no noticeable impact on the number of uninsured requiring their care?

Will all risks and costs be borne by local government? Will the state government and budget make any significant contribution to financing?

The concept paper fails to mention or propose solutions to address severe issues related to capacity of Texas' health care workforce to serve more insured patients. Moreover, there are legitimate concerns about the viability of a model that is based on current adult Medicaid provider payment rates in terms of its ability to attract providers.

Other Comments

Section V, p. 11: We support the general target population structure proposed, with one exception. We believe that the #3 group, Uninsured children below 200% FPL but not CHIP or Medicaid eligible, should instead be retained in CHIP. This could be done via either eliminating the CHIP asset test (only one other state has a CHIP asset test), or by charging a higher premium rate to children under 200% but over the current asset limit (neither would technically require legislative authority, since state law permits but does not require a CHIP asset test, though leadership approval and LBB expenditure authority would be needed). In this way, children will be retained in a benefit package appropriate to their needs.

Section VI, p. 12: crowd out prevention (6 month wait) exceptions should use Texas CHIP law exceptions as a model.

Section VI, p. 14, #2 HIPP HOP group: ESI plans should have to meet a minimum benefit floor standard as well (not just affordable), or else demonstration population member should have choice to access HOP instead of ESI. Same should be true of CHIP premium assistance group under #3.

Thank you for considering our comments. If you have questions or would like additional information, please contact Anne Dunkelberg at CPPP, Dunkelberg@cppp.org, or (512) 320-0222, extension 102.