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HHSC'S PROPOSED MEDICAID WAIVER

"Affordable" Coverage Should Not Come from Shrinking Benefits

Americans are increasingly concerned about access to affordable, comprehensive health care. Living in the state with the highest rate of uninsured citizens, which undermines the cost and quality of everyone's health care, Texans are particularly concerned. As one step to decrease the number of uninsured, in 2007, the Texas Legislature directed the Texas Health and Human Services Commission to request a "waiver" of federal Medicaid laws to allow Texas to use federal Medicaid dollars to fund a health care coverage program that would be allowed to operate in ways not normally allowed under federal law. In developing a waiver, HHSC must balance keeping the cost per person low against the need to provide a decent and affordable standard of care. Top concerns for the low-income uninsured Texas adults who might be served are (1) a package with "bare-bones" benefits; (2) co-payments that are too high for the poorest parents; and (3) no clear policy on whether parents whose benefits run out will be in debt for the additional care they need. Achieving "affordable" care by cutting benefits dramatically (instead of finding a way to provide an acceptable standard of care) raises serious concerns. An overarching concern for all Texans is whether the financing of the proposed program will hurt our safety net hospitals, which are the backbone of the trauma system for every Texan—rich or poor. Finally, the amount of funding available for the new program is uncertain, and so the number of adults who will be able to enroll is also unknown. This policy page makes recommendations for improving the state's waiver proposal and explains how you can voice your concern to state officials.

How to Fix It

1. **Add a program component to ensure that seriously ill or injured Texans who need more than the limited coverage both (1) get the care they need and (2) are not left financially devastated when their benefits run out.**

2. **Revise Co-payment Structure to treat the mother of two earning $450 per month differently from the mother of two earning $1,450.**

Background on the SB 10 1115 Waiver

SB 10, passed by the Texas Legislature in 2007, directs HHSC to request a "waiver" of federal Medicaid laws to allow Texas to use federal Medicaid dollars to fund a health care coverage program that would be allowed to operate in ways not normally allowed under Federal law. HHSC proposes to cover adults under 200% FPL (whose children already qualify for Medicaid or CHIP), starting with coverage of parents of children enrolled in Medicaid or CHIP (most of these parents could be covered under federal law without a waiver, but Texas has chosen to cover very few parents in Medicaid).

The proposal is based on a very limited benefit package, with the most recent models (see: http://www.hhs.state.tx.us/medicaid/reform.shtml) covering three days of hospital care, three prescriptions per month, and a $25,000 annual maximum benefit. The concept depends on conversion of some hospital payments—designed to offset the costs of the uninsured and the inadequacy of Medicaid payment rates—into direct health benefits for uninsured adults. HHSC proposes that these reductions would be offset by higher Medicaid hospital rates, and reduced numbers of uninsured patients.

Hospitals have questioned whether they will really break even, much less benefit from the scheme, and are negotiating with HHSC to see if they can agree on changes to ensure hospitals would not be adversely affected. Advocates wonder what will happen to parents after their benefits run out: will they get the care they need, and will they be protected from overwhelming debt and bankruptcy?

Add a Program to Meet Needs, Cover Costs of the Sick and the Injured

Many low-income Texans (38% of Texans, and 47% of Texas children live below 200% FPL today—less than $42,400 annual pre-tax income for a family of 4) *would* enroll in the limited coverage proposed, and that would in fact improve those individuals' access to routine health care. Unfortunately, the 20% of uninsured Texans whose health conditions drive 80% of total health care spending will be the ones who find their needs for care unmet by the current waiver plan. Those with chronic illness who need more than two or three prescriptions a month to avoid hospitalization, those who are injured, or those fighting cancer or another serious acute illness will not know whether they will get the care they need, or whether they will be financially liable for those costs.

38% of all Texans and 47% of Texas children live below 200% of the federal poverty line. For a family of four that is less than $42,400 in annual pre-tax income.

Of course, health care providers are also uncertain about their legal and ethical obligation to provide care after the benefits run out, when they cannot expect to be paid under the current plan. CPPP proposes that HHSC create a formal program component under which all uninsured adults in the waiver who exceed the modest Rx limits, diagnosis, and hospital limits are referred by their physician to a linked program of benefits and intensive care management, which will cover the additional drugs, tests, treatments, and hospitalization needed by the Texans whose needs are the real cost drivers in the uncompensated care population today. Project Access in Dallas and other Texas cities offers a helpful model, and has produced data that show this effort will reduce ER use and avoidable hospital care. Only in this way can the waiver truly address the benefits of improved primary care access, directly attack the cost drivers of the 20% of patients who drive 80% of the costs, and meaningfully reduce the uncompensated care burdens of our public and safety net hospitals.

Medically Needy as Fix?

One idea under consideration is to restore the Medicaid "Medically Needy" coverage for parents, which was eliminated by the Legislature in 2003. Restoring the Medically Needy program (MN) would be beneficial to some low-income parents and to safety net health care providers, but it is not certain that the MN program can prevent gaps in health care or protect waiver parents from major financial liability.

Major concerns include: (1) a *complete* MN program is needed, not one that only covers inpatient hospital care. For example, a MN program that only covers inpatient hospital stays would not help a person who needs cancer treatment, kidney dialysis, major rehab after injury, or costly drug therapies—*unless* HHSC carefully and deliberately crafts the program to make sure those gaps and needs are filled. (2) MN coverage has never been used in this way (that is, as a catastrophic back-up to a limited benefit plan), and federal authorities will have to approve allowing parents to transition from waiver coverage to MN. (3) MN coverage, as part of the traditional Medicaid program, does not cover childless adults, and thus would not be available to the childless adults HHSC proposes to cover in the second phase of the waiver (which the state would pursue only if enough state dollars were available to enroll beyond the initial low-income parent group).

Adjust Cost Sharing for the Poorest Uninsured Adults

The latest HHSC proposals would expect a mother of two children who earns *$450* per month (who now earns "too much" to qualify for traditional Texas Medicaid) to pay exactly the same co-payment amounts as a mother of two earning *$1,450* per

month. CPPP raised this issue early with HHSC staff, and the latest benefit scenario does include a reduction in the hospital co-payment for the <150% FPL group, but no reduction in any of the other costs.

The cost sharing scheme must be constructed in a manner that is consistent with the expanded co-payment standards created under the 2005 Deficit Reduction Act (DRA), including the DRA requirement that out-of-pocket costs must not exceed 5% of family income for this group. This is the cap allowed under federal CHIP law for the total out-of-pocket costs for the children in a low-income family, and also the cap imposed by CMS on cost-sharing in the recently-approved Indiana 1115 waiver. Even with this limit, a family might be at risk for up to 10% of their income, as they would have a 5% limit for children's CHIP costs, and *another* 5% for those of the parents under the waiver. This "fair share approach" is one which CPPP could support, and it will require HHSC to construct a model that creates smaller ranges of costs (e.g., for less than 50% FPL, 51-100% FPL, and 100-150% FPL).

The experience of 1115 waivers in other states has shown that point-of-service co-payments that are too high can essentially create a program that is biased in favor of higher-income enrollees who can afford the co-payments, while lower-income enrollees go without the care they need because of costs that are too high for their family. For example, in Utah, over 75% of adults enrolled reported needing services beyond the waiver benefits, and a third reported going without care or delaying care due to cost share. It is also notable that *no* state has ever been allowed to charge a co-payment for emergency care in a waiver.

Eligibility System Must Be Functional to Achieve the Goals of the Waiver

HHSC proposes to "piggy-back" parents' waiver enrollment on the systems that support their children's Medicaid and CHIP coverage (1.8 million children in Medicaid, 358,000 in CHIP in February). Currently, the state's eligibility system remains severely distressed, with fewer than 65% of Medicaid applications processed within the 45-day federal law limit in Travis County, for example. An equally low percentage of children in the TIERS computer system statewide are processed on time. In fact, in November 2007, HHSC sent formal guidance to eligibility staff on how to process children's Medicaid applications and renewals which have sat unprocessed for 90 days—*twice* what the federal law allows. CPPP agrees with the Texas Medical Association and Texas Hospital Association that Texas must put this system back on its feet before the state creates another major new program whose success depends on it functioning promptly and accurately.

The Real Goal: Comprehensive Affordable Care for all Uninsured Texans

CPPP is committed to a vision of affordable health care for every Texan. One concern raised by this waiver proposal is that the capped funding, "first-come, first-served" approach may create the *illusion* that the issues of the uninsured target population below 200% FPL have been addressed, while in reality the funding caps result in only a fortunate few actually improving their access to care. For example, the Utah 1115 waiver created under then-Governor Leavitt enrolls some 17,000 adults below 150% FPL today, but another 122,000 Utah adults below 150% of FPL remain uninsured. The capped approach raises equity issues for the hundreds of thousands in Texas who would not have a "waiver slot" for their care. A critical concern would be the continued disadvantages faced by rural and small-town Texans where there is no hospital district to provide the care they need.

What You Can Do:

Please contact the state elected officials who have oversight responsibility for this waiver, and tell them the waiver must include:

(1) A program component to ensure that sick or injured Texans who need more than the limited coverage *both* get the care they need and are not financially devastated when their benefits run out. If a Medically Needy program is used to solve this problem, it must cover all needed medical care, not just hospital bills.

(2) A revised co-payment structure that complies with the DRA and recognizes the different ability to pay between a mother of 2 earning $450 per month, and a mother of 2 earning $1,450 a month.

All contact information for the officials listed below can be found at: http://www.capitol.state.tx.us/

Joint Committee on Oversight of Medicaid Reform Chair: Sen. Jane Nelson; Members: Rep. John Davis, Rep. Dawnna Dukes, Sen. Robert Duncan, Sen. Kyle Janek, Rep. Dianne White Delisi, Sen. Judith Zaffirini ,Rep. John Zerwas.

Governor Rick Perry Staff contact: Jessica Olson
Lt. Governor David Dewhurst Staff contact: Jamie Dudensing, Senior Policy Analyst for Health and Human Services
Speaker Tom Craddick Staff contact: Troy Alexander

Email a copy of your comments to federal and state Medicaid officials at: Dennis.Smith@cms.hhs.gov; Kerry.Weems@CMS.hhs.gov; and medreform@hhsc.state.tx.us.

Proposed Waiver Benefit Package (annual limits):

The benefit package under discussion is *not* final, but here is a recent version:

Inpatient Hospital .....3 days
Outpatient Surgery.....$2,500 per year
Outpatient Emergency Room.....$1,250 per year
Other Outpatient Facility.....$2,500 per year
Mental Health/Substance Abuse Visits.....18
PCP – Preventive Visits.....5
PCP – Other Visits.....no limit
Specialty CP – Other Visits.....9
Other Professional/Ancillary .....$2,500 per year
Pharmacy.....30 prescriptions per year*
Annual Maximum .....$25,000 total benefits

*36 prescriptions also being discussed. Diabetic supplies, family planning and vaccines do *not* count toward limit; will use Texas Medicaid Preferred Drug List