

November 15, 2012

The Honorable David Dewhurst  
Lieutenant Governor of Texas  
P.O. Box 12068  
Austin, Texas 78711

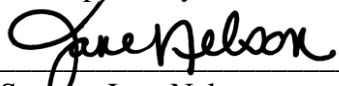
The Honorable Joe Straus  
Speaker, Texas House of Representatives  
P.O. Box 2910  
Austin, Texas 78768

Dear Lieutenant Governor Dewhurst and Speaker Straus:

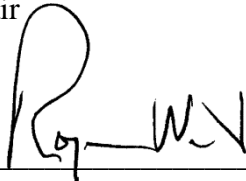
Senate Bill 7, passed by the 82<sup>nd</sup> Legislature during the First Called Session, established the Medicaid Reform Waiver Legislative Oversight Committee. The Committee submits this report in accordance with SB 7.

The Committee has carefully considered all of the testimony received on this issue and looks forward to continued discussions during the 83<sup>rd</sup> legislative session.

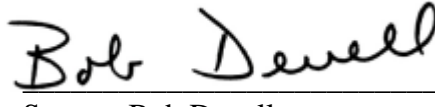
Respectfully submitted,



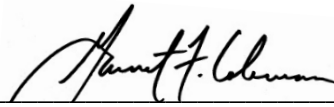
Senator Jane Nelson  
Chair



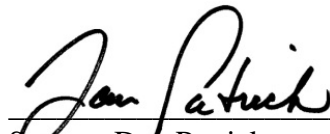
Senator Royce West



Senator Bob Deuell



Representative Garnet Coleman



Senator Dan Patrick



Representative John Zerwas

Representative Lois Kolkhorst

Representative Brandon Creighton

## **Section I. Background**

Medicaid is a jointly funded state-federal health care program that primarily serves low-income children, families, pregnant women, the elderly, and individuals with disabilities.<sup>1</sup>

For eligible individuals, Medicaid pays for acute care services such as physician visits, inpatient hospital stays, outpatient services, pharmacy benefits, lab services, and x-ray services. For individuals who meet financial and functional eligibility criteria, Medicaid pays for long-term care services and supports such as home and community based services, nursing facility services, and services provided in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).<sup>2</sup>

Texas Medicaid currently covers approximately 3.5 million<sup>3</sup> Texans and comprises a quarter of the state budget.<sup>4</sup> As Medicaid continues to grow as a percent of states' budgets, state lawmakers are increasingly searching for ways to make the program more efficient and curb unsustainable cost growth. One of the biggest challenges facing states attempting to reform their Medicaid programs has been limited state flexibility due to federal regulations.

### **Medicaid 1115 Waivers**

Section 1115 of the federal Social Security Act allows states to request waivers from the federal government of certain federal requirements to test new or existing approaches to financing and delivering Medicaid and Children's Health Insurance Program (CHIP) services. While these waivers, typically referred to as "1115 waivers" or "demonstration waivers," provide certain flexibilities many federal requirements cannot be waived, and flexibilities allowed by the federal government under these waivers can typically only be applied to higher income populations within the Medicaid program. Additionally, Medicaid 1115 waivers must:

- be budget neutral to the federal government;
- include stakeholder input; and
- comply with federal maintenance of effort (MOE) requirements designed to maintain coverage levels until January 2014 (for adults) and October 2019 (for children).<sup>5</sup>

There is no standard process or application for a state to apply to the federal government for an 1115 waiver. States work with the federal Centers for Medicare and Medicaid Services (CMS) to submit an informal concept paper and develop a proposal. An 1115 waiver proposal typically discusses the environment, administration, eligibility, coverage and benefits, delivery system, access, quality, financing issues, systems support, implementation timeframes, and evaluation and reporting of the demonstration project. There is also no specific timeframe for the federal government to approve, deny, or request additional information on a state's proposal. As a result, it can take years to negotiate an 1115 waiver. Medicaid 1115 waivers are generally approved for a five-year period, but can be renewed, generally for three years, to continue the program beyond the initial five-year period.<sup>6</sup>

### **Medicaid 1115 Waiver vs. Block Grant**

An 1115 waiver is not the same as a Medicaid "block grant." An 1115 waiver is approved at the discretion of the federal Secretary of Health and Human Services through negotiations between the state and CMS, while a Medicaid block grant would require action by the United States Congress. Additionally, an 1115 waiver only exempts states from *specific* federal requirements.

The program remains an entitlement, and the state must still follow federal requirements not included in the waiver. In contrast, a Medicaid block grant would give the federal portion of Medicaid funds directly to the state and give the state autonomy in how the program is operated.

As described below, the Medicaid Reform Waiver Legislative Oversight Committee was required to specifically assist in the request of a Medicaid 1115 waiver, thus this report focuses on opportunities for reform the state can achieve through the 1115 waiver process, not a Medicaid block grant. However, certain state flexibilities discussed in this report would be appropriate for reform under both the 1115 waiver and a block grant.

### **Texas Medicaid Reform Waiver**

Senate Bill 7 by Senator Jane Nelson, passed by the 82<sup>nd</sup> Legislature during the First Called Session, directed the Texas Health and Human Services Commission (HHSC) to seek an 1115 Medicaid waiver designed to achieve the following objectives regarding the Medicaid program and alternatives to the program:

- 1) provide flexibility to determine Medicaid eligibility categories and income levels;
- 2) provide flexibility to design Medicaid benefits that meet the demographic, public health, clinical, and cultural needs of this state or regions within this state;
- 3) encourage use of the private health benefits coverage market rather than public benefits systems;
- 4) encourage people who have access to private employer-based health benefits to obtain or maintain those benefits;
- 5) create a culture of shared financial responsibility, accountability, and participation in the Medicaid program by:
  - o establishing and enforcing copayment requirements similar to private sector principles for all eligibility groups;
  - o promoting the use of health savings accounts to influence a culture of individual responsibility; and
  - o promoting the use of vouchers for consumer-directed services in which consumers manage and pay for health-related services provided to them using program vouchers;
- 6) consolidate federal funding streams, including funds from the disproportionate share hospitals and upper payment limit supplemental payment programs and other federal Medicaid funds, to ensure the most effective and efficient use of those funding streams;
- 7) allow flexibility in the use of state funds used to obtain federal matching funds, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other funds and funding mechanisms to obtain federal matching funds;
- 8) empower individuals who are uninsured to acquire health benefits coverage through the promotion of cost-effective coverage models that provide access to affordable primary, preventive, and other health care on a sliding scale, with fees paid at the point of service; and
- 9) allow for the redesign of long-term care services and supports to increase access to patient-centered care in the most cost-effective manner.<sup>7</sup>

To facilitate the design and development of the 1115 Medicaid Reform Waiver, Senate Bill 7 also established the Medicaid Reform Waiver Legislative Oversight Committee. The Committee is comprised of eight members – four members of the Senate appointed by the Lieutenant Governor and four members of the House of Representatives appointed by the Speaker of the House of Representatives. Senate Bill 7 directed the Governor to appoint a member of the Committee to serve as the presiding officer.<sup>8</sup>

On January 20, 2012, Lieutenant Governor Dewhurst appointed Senators Jane Nelson, Bob Deuell, Dan Patrick, and Royce West to the Committee. On February 1, 2012, Speaker Joe Straus appointed Representatives Garnet Coleman, Brandon Creighton, Lois Kolkhorst, and John Zerwas to the Committee. On February 2, 2012, Governor Perry appointed Senator Jane Nelson Chair of the Medicaid Reform Waiver Legislative Oversight Committee.

The Committee held a hearing on February 29, 2012. HHSC and the Department of Aging Disability Services (DADS) presented the Committee with opportunities for Medicaid reform. The Committee also allowed for public testimony. An archived video of the hearing and written testimony from HHSC and DADS are available on the Texas Legislature webpage at: <http://www.senate.state.tx.us/75r/senate/commit/c885/c885.htm>.

HHSC has also established a public e-mailbox for questions and comments related to the 1115 Medicaid Reform Waiver: [MedicaidProgramInnovation@hhsc.state.tx.us](mailto:MedicaidProgramInnovation@hhsc.state.tx.us).

## **Section II. Analysis**

### **Current Medicaid Environment**

The concept of Medicaid reform is not novel in Texas. For years, Texas policymakers have attempted to gain greater flexibilities within the Medicaid program. Last session the Legislature approved a number of Medicaid reforms that are currently being implemented. Additionally several other factors could potentially impact the Medicaid environment, including the recent Supreme Court ruling on the Affordable Care Act (ACA) and efforts pursued by the 83<sup>rd</sup> Legislature to reform the Medicaid program.

### **Managed Care Expansions**

In order to better coordinate care and provide greater efficiencies within the Medicaid program, the 82<sup>nd</sup> Legislature directed HHSC to enact several major expansions of managed care:

- STAR and STAR+PLUS expansion to counties adjacent to existing managed care services areas;
- STAR+PLUS expansion to El Paso and Lubbock;
- STAR+PLUS and STAR expansion to the Hidalgo Service Area;
- STAR expansion to the Medicaid Rural Service Area;
- Carve-in of prescription drug benefits;
- Dental managed care model for Medicaid; and
- Carve-in of inpatient hospital services in STAR+PLUS.

The STAR and STAR+PLUS expansion to adjacent counties went into effect on September 1, 2011, while the remaining expansions went into effect March 1, 2012.<sup>9</sup>

Senate Bill 56 (Nelson, 83R) and Senate Bill 57 (Nelson, 83R), would expand upon these efforts by carving non-emergency medical transportation services (currently provided under the Medical Transportation Program) into managed care, expanding STAR+PLUS statewide, and carving nursing facility services into STAR+PLUS.

#### Medicaid 1115 Transformation Waiver

On December 12, 2011, CMS approved Texas' request for an 1115 waiver request, commonly referred to as the "Transformation Waiver," that allows HHSC to move forward with the carve-in of inpatient hospital services into STAR+PLUS managed care while preserving federal hospital funding historically received as Upper Payment Limit (UPL) supplemental payments.<sup>10</sup>

Although the Transformation Waiver was initially pursued as a way to preserve hospital supplemental funding, the waiver will also provide incentive funding to regional health partnerships for projects that improve health services and access to care in the region.<sup>11</sup> The Transformation Waiver represents a new opportunity for hospitals, counties, and communities to work together to address issues in their region such as access to primary care, workforce shortages, behavioral health crisis stabilization, and integration of primary and behavioral health care services.

It is still premature to determine the impact the Transformation Waiver will have on Medicaid, the uninsured, and the broader Texas health care delivery system.

#### U.S. Supreme Court Ruling on the Affordable Care Act

On June 28, 2012, the Supreme Court ruled that the federal government cannot deny existing Medicaid funds to states that opt not to expand their Medicaid program eligibility to 133 percent of the federal poverty level (FPL) as required by the ACA. This ruling rendered the provision, originally mandatory, voluntary for states. Some states have discussed using the voluntary nature of the expansion to leverage additional federal flexibility for existing and expansion Medicaid populations.

Ultimately, the decision of whether to expand Medicaid will be made by the Legislature. These decisions will impact the development and negotiation of the Medicaid Reform Waiver. Many of the reform opportunities presented to the Committee would have an increased likelihood of approval by CMS for the expansion Medicaid population (able-bodied, childless adults) rather than the current Medicaid population (pregnant women, children, elderly, and individuals with disabilities).

#### Dual Eligible Shared Savings Project

In July 2011, CMS presented states with an opportunity to develop demonstration projects to integrate Medicare and Medicaid services for dual eligible individuals (Dual Eligibles Integrated Care Project). For individuals eligible for both Medicare and Medicaid, Medicare predominately pays for acute care services while Medicaid covers long-term care services and supports. As a result, any savings in acute care services due to improvements in Medicaid long-term care accrue to Medicare, not the state.

The goal of this demonstration project is to achieve savings and employ cost avoidance strategies through integrated and improved care management for dual eligibles. Participating states will get to keep a portion of the cost-savings.<sup>12</sup> HHSC has included a placeholder in its FY 2014-2015 Legislative Appropriations Request (LAR) exceptional item list for savings resulting from the Dual Eligibles Integrated Care Project.<sup>13</sup> HHSC anticipates significant savings from this initiative. HHSC is still working to develop a cost-savings estimate, but expects to have an estimate closer to the 83rd legislative session.

HHSC submitted an application for the Dual Eligibles Integrated Care Project to CMS on May 31, 2012.<sup>14</sup> At the time of report publication, CMS had not issued a decision on the Texas application.

#### Long-Term Redesign Efforts

Efforts are currently underway to improve the quality and efficiency of the Medicaid long-term care service and supports system during the 83rd legislative session. SB 57 (Nelson 83R) would redesign the Medicaid long-term care services and supports system to improve quality through the increased coordination of acute and long-term care services, provide services in a manner that better meets the needs of individuals with intellectual and developmental disabilities, and ensure that state resources are used in the most cost-effective manner to increase access to long-term care services and supports.

Some of the reforms under SB 57 may also require an 1115 waiver to implement.

#### **Request for New 1115 Waiver**

In light of the current Medicaid environment addressed above, uncertainties surrounding the impact of the ACA, and the need for the 83rd Legislature to meet and determine the direction of the Texas Medicaid program, a new Medicaid 1115 waiver request would be premature at this time.

When the state does apply for the Medicaid Reform Waiver, the request should be submitted in accordance with legislative direction from the 83<sup>rd</sup> Legislature. In addition, HHSC should continue to explore opportunities to better leverage concepts and innovations commonly used in the private health insurance market such as wellness programs, increased personal responsibility, and premium assistance to connect Medicaid-eligible individuals to private health insurance when feasible and cost-effective.

Several ideas to achieve these goals were discussed at the committee's hearing. These included greater use of the existing Health Insurance Premium Payment (HIPP) program, incentive programs for healthy behaviors, and Medicaid cost-sharing.

#### Health Insurance Premium Payment Program

Federal law provides states with options for establishing premium assistance programs for individuals eligible for Medicaid or CHIP. Premium assistance programs use state and federal Medicaid and/or CHIP funds to help subsidize the purchase of private group health insurance coverage for Medicaid and/or CHIP eligible individuals.

Under this federal option, Texas has operated a Medicaid premium assistance program called the Health Insurance Premium Payment (HIPP) program since 1994. To qualify for HIPP, the cost of the private plan premium (and other cost sharing) must be less than the cost of enrolling the individual into Medicaid. Federal law requires that Medicaid provide all Medicaid covered services not offered by the employer-sponsored insurance plan through wrap-around coverage.<sup>15</sup>

HHSC is currently reviewing the HIPP program in light of ACA changes to the requirements for state premium assistance programs. HHSC is also exploring opportunities for more effectively utilizing HIPP, including the possibility of a premium assistance program for CHIP and opportunities to blend funding methodologies to help increase the use of private market coverage for families whose eligibility may cross over multiple programs (e.g., Medicaid, CHIP, private insurance premium subsidies under the ACA). Depending on the results of HHSC's review, changes to HIPP could require statutory change and/or a waiver.<sup>16</sup>

#### Incentives for Healthy Behaviors

The federal government recently made grants available to states in order to implement initiatives that involve providing incentives to Medicaid beneficiaries for participating in health improvement programs and demonstrating health improvements through participation in such programs. Texas was one of ten states to receive a grant, totaling \$2.7 million in the first year. The project serves individuals with severe mental illness and individuals with other disabilities that co-occur with mental illness or substance abuse disorders. The program provides \$1150 a year for participating individuals through a wellness account (much like a health savings account) that finances specific health goals defined by the individual.<sup>17</sup>

The results of this grant project could help inform future opportunities for Texas to expand incentive based wellness programs more broadly within the Medicaid program. Expansion of this concept to other Medicaid populations would require additional flexibility, likely through an 1115 waiver.

#### Medicaid Cost-Sharing

Texas currently does not have cost sharing in Medicaid. SB 7 required HHSC to implement Medicaid cost sharing that encourages personal accountability and appropriate utilization of health care services, including cost sharing for recipients who receive non-emergency medical services through a hospital emergency department.<sup>18</sup> HHSC is requesting flexibility to implement this copayment for non-emergency use of the emergency room through an amendment to the existing Transformation Waiver.

In addition to implementing cost sharing for non-emergent use of the emergency department, the state could consider implementing copayments for prescription drugs and a missed appointment fee. However, in order to achieve certain efficiencies relating to cost-sharing not currently available, Texas would need to request a waiver from the federal requirement that states track cost-sharing charges to ensure they do not exceed five percent of income. Waiver of this requirement would allow Medicaid clients to track their own copayments similar to the successful tracking mechanism used in CHIP.

### **Section III. Conclusion**

In light of the current Medicaid environment, including ongoing implementation of initiatives passed by the 82<sup>nd</sup> Legislature, uncertainties still surrounding the impact of the ACA ruling, and the need for the 83rd Legislature to meet and determine the direction of the Texas Medicaid program, a new Medicaid 1115 waiver request would be premature at this time.

Because of the necessary delay in requesting the waiver, it would also be premature at this time to address the SB 7 requirements specifically relating to the Committee's report. However, the Committee will continue to work with HHSC to develop the Medicaid waiver request once the 83<sup>rd</sup> Legislature has provided legislative direction necessary to move forward.

In the meantime, HHSC should continue to explore opportunities to better leverage concepts and innovations commonly used in the private health insurance market such as wellness programs, increased personal responsibility, and premium assistance to connect Medicaid-eligible individuals to private health insurance when feasible and cost-effective.



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<sup>1</sup> Texas Medicaid in Perspective Eighth Edition, January 2011, *Chapter 1 Texas Medicaid in Perspective*, p 2-3.

<sup>2</sup> *Id.*

<sup>3</sup> Presentation by the Health and Human Services Commission and Department of Aging and Disability Services to the Medicaid Reform Waiver Legislative Oversight Committee, February 29, 2012, p6.

<sup>4</sup> Texas Medicaid in Perspective Eighth Edition, January 2011, *The Medicaid Numbers*.

<sup>5</sup> *Supra* note 3 at p4.

<sup>6</sup> Health and Human Services Commission background document, *Key Features of an 1115 Demonstration Waiver*, February 2012.

<sup>7</sup> Senate Bill 7 by Senator Jane Nelson (82nd Legislature, 1st Called Session), Section 13.01.

<sup>8</sup> Senate Bill 7 by Senator Jane Nelson (82nd Legislature, 1st Called Session), Section 13.03.

<sup>9</sup> Health and Human Services Commission, *Medicaid Managed Care Initiatives*, <http://www.hhsc.state.tx.us/medicaid/MMC.shtml>. Accessed November 14, 2012.

<sup>10</sup> Health and Human Services Commission, *Waiver Overview*, <http://www.hhsc.state.tx.us/1115-Waiver-Overview.shtml>. Accessed November 14, 2012.

<sup>11</sup> *Id.*

<sup>12</sup> Health and Human Services Commission, *Texas Dual Eligible Integrated Care Project*, <http://www.hhsc.state.tx.us/medicaid/dep/index.shtml>. Accessed November 14, 2012.

<sup>13</sup> Presentation by the Health and Human Services Commission to the Legislative Budget Board and Governor's Office of Budget Planning and Policy, September 21, 2012, p 51.

<sup>14</sup> *Supra* note 12.

<sup>15</sup> Health and Human Services Commission background document, *Health Insurance Premium Payment Program*, November 2012.

<sup>16</sup> *Supra* note 3 at p19.

<sup>17</sup> Health and Human Services Commission background document, *Incentives Based Wellness Programs*, February 2012.

<sup>18</sup> Senate Bill 7 by Senator Jane Nelson (82nd Legislature, 1st Called Session), Section 1.09.

STATE of TEXAS  
HOUSE of REPRESENTATIVES



GARNET F. COLEMAN

STATE REPRESENTATIVE  
DISTRICT 147

November 28, 2012

Re: Medicaid Reform Waiver Legislative Oversight Committee Report

I first want to express what an honor it was to serve on the Medicaid Reform Waiver Oversight Committee, and I look forward to continue working with my fellow members to ensure that we do what is best for the people of Texas. I will attach my signature to the Committee's Report, but I disagree with some of the language in the report and want to ensure that my signature is not construed to be an endorsement of that language.

Primarily, I disagree with the idea that block grants should be part of any Medicaid solution in Texas. Research shows that block grants are not the answer, primarily because they reduce the amount of funding the state receives from the federal government. Even if the amount contained in the block grant were keyed to population growth and inflation, medical costs historically rise at a rate far greater than that of nominal inflation. Therefore, with each passing year, Texas would receive fewer federal dollars to pay for growing Medicaid needs. Further reducing funding outweighs any benefit – to the extent there are any – of the “increased flexibility” Texas would receive by block granting Medicaid.

Further, I have concerns about the flexibility sought by a block grant. Most of the flexibility sought by states that is not allowed by the already-existing 1115 Waiver process involves reducing coverage or services, which I oppose.

I do, however, agree that there is room for improvement in the state Medicaid system, and I want to thank Chairwoman Nelson for her hard work and willingness to look at new and innovative ways to improve healthcare quality across Texas. I look forward to working with Chairwoman Nelson and all other members so that we can do what is best for our state.

Sincerely,

A handwritten signature in cursive script that reads "Garnet F. Coleman".

Garnet F. Coleman  
District 147