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Federal approval of Medicaid waiver allows revisions to program in Texas

Federal approval of a five-year Medicaid waiver proposal from Texas has jumpstarted an overhaul of how much pharmacies are reimbursed for filling Medicaid prescriptions and how hospitals in the state are reimbursed for treating the uninsured.

Certain kinds of waivers, including the Texas waiver, grant states permission to deviate from Medicaid requirements if the state's proposal is approved by the federal Centers for Medicare and Medicaid Services (CMS). The recently approved Texas waiver gives the state flexibility to test new ideas for its Medicaid program.

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Approved by CMS on December 12, the Texas waiver is a wide-ranging proposal from the state's Health and Human Services Commission (HHSC) to revamp the state Medicaid program based on the managed care model. Unlike the fee-for-service model, which pays providers separately for each service performed, the managed care system provides a fixed monthly "capitation" payment to a managed care organization that contracts with providers and hospitals. Advocates for managed care say it saves the state money by ensuring more cost predictability and control (*see page 2*). The Texas waiver's plan contains multiple ways to expand managed care and may help prepare the state for 2014, when certain provisions of the federal Patient Protection and Affordable Care Act (PPACA) are scheduled to kick in to make more people eligible for Medicaid.

Under PPACA, nearly all individuals under age 65 earning up to 133 percent of the federal poverty level, about $15,000 for one person, will become eligible for Medicaid in 2014. In Texas, Medicaid now is generally limited to low-income children, seniors, the disabled, and pregnant women, and more than two-thirds of Texas Medicaid recipients are children. Under the state's current eligibility criteria, a working parent of two children would have to earn less than $4,000 a year to qualify even if his or her children are eligible. Under PPACA, a working parent of two children earning about $25,000 a year would be eligible, as would a childless adult earning about $15,000. The Texas Medicaid program is expected to add about 2 million new enrollees by 2019, according to the Kaiser Commission on Medicaid and the Uninsured, nearly halving the percentage of uninsured adults in the state.

Two aspects of the health care system in Texas that the newly approved waiver is expected to affect are the Medicaid vendor drug plan and the supplemental federal funding that hospitals have received for treating the indigent.

Medicaid vendor drug program

Federal approval of the Medicaid waiver formalizes Texas' plan to shift the Medicaid vendor drug program into managed care in March of 2012. Currently, through the vendor drug program, HHSC directly contracts with more than 4,200 pharmacies to provide prescription drugs to Medicaid enrollees on a fee-for-service basis. In fiscal 2009, the state paid $2.1 billion for more than 28 million prescriptions at an average cost of about $74 per prescription, according to HHSC. Under the managed care model, the prescription drug benefits of Medicaid's more than 3 million recipients will be administered by pharmacy benefit managers acting as subcontractors for managed care organizations instead of directly by the state.

Supporters of the new managed care system say it will save Texas about $100 million over the fiscal biennium by making Medicaid prescription dispensing more closely resemble the commercial market. This is necessary, they say, to increase efficiency and rein in Medicaid drug costs. They say the dispensing fee for filling a non-Medicaid, commercial prescription ranges from $1.25 to $2, lower than the fixed amount of $6.50 the state pays pharmacists as part of the dispensing fee for filling a Medicaid prescription under the traditional vendor drug program.

Before the waiver's approval, pharmacy benefit manager Navitus Health Solutions notified pharmacists that it would pay them a nonnegotiable prescription dispensing fee of $1.35 once the managed care system assumed control of the vendor drug program, which critics say would be an 80 percent decrease in the fixed amount paid to pharmacists. Critics also point to a study conducted by the University of Texas at Austin on behalf of HHSC, which randomly surveyed about 1,000 pharmacies that contracted with the Medicaid vendor drug program in 2007. Based on responses from roughly 800 pharmacies, the study found that the mean cost of dispensing a prescription was $11.17.

Critics further claim that comparing the vendor drug program to the commercial market is inappropriate because of their different reimbursement methodologies. They have expressed alarm about the power of pharmacy benefit managers to reduce reimbursement rates to pharmacists, who have questioned their ability to participate in Medicaid or to continue operating under the new system. Smaller, independent pharmacies rely more heavily on the dispensing fee reimbursement to pay operating costs than do larger chain pharmacies

What is Medicaid managed care?

Texas is among many states moving to a managed care system to control Medicaid costs. The state began pilot programs for managed care in the early 1990s and has increased them county by county since then. Most urban areas in Texas now operate under a managed care model. The Texas waiver recently approved by the federal Centers for Medicare and Medicaid services will extend managed care into many rural areas and the Rio Grande Valley and will transition about 1 million Medicaid enrollees into privately run managed care plans. Under a managed care system, managed care organizations contract with providers and hospitals to form a network. The state pays the managed care organization an established monthly amount, rather than paying each provider for each individual service, as in the fee-for-service model. The managed care organization then sets rates and distributes reimbursements to providers.

Supporters of managed care say it controls costs by giving providers a financial incentive to minimize services while maximizing quality and to focus more on preventive care and coordinated patient management. Each Medicaid client is assigned to a primary care provider who oversees the patient's treatment, a scenario intended to enhance the quality of care while improving efficiency. Supporters say managed care also provides budget certainty for the state by setting a fixed monthly price, as opposed to a fee-for-service system in which providers and clients are more likely to accumulate charges.

Critics of managed care say it is overly restrictive and provides a mechanism for capping medical services regardless of actual need. Non-Medicaid clients are not subjected to such rigidity, they say, so the state should not impose it on Medicaid clients. Critics of managed care say providers should be free to select appropriate care whether or not a patient receives Medicaid. They also caution against allowing "middlemen," such as managed care organizations and pharmacy benefit managers, to set reimbursement rates. They say low reimbursement rates force many providers out of Medicaid, threatening patient access to care, especially in rural areas.

with a greater volume of prescriptions. For some pharmacies, especially in the Rio Grande Valley, Medicaid recipients constitute up to 90 percent of the customer base. The lower South Texas region has one of the highest Medicaid enrollment rates in the state, and the loss of a single pharmacy in a rural area could inhibit a client's ability to access prescription drugs. Closed pharmacies could eliminate jobs and hurt the economy, critics say, and threaten the health of vulnerable patients. An economic analysis conducted for the Pharmacy Choice and Access Now coalition by the Perryman Group estimated that the managed care switch would cause the loss of more than 770 pharmacies and tens of thousands of jobs. Some pharmacists have floated the option of reducing pharmacy hours as an alternative to closing down, but say this also would affect patient access.

The Medicaid waiver also creates a way to protect certain federal funding that hospitals receive for treating the uninsured.

Supporters of moving the vendor drug program into managed care contend that the state's requirement that each managed care organization demonstrate "network adequacy," a term used to describe the ability to serve the expected number of enrollees, will guarantee continued access to services. Each managed care organization must prove that it has attempted to include current Medicaid pharmacy providers in its network and must verify that its network is sufficiently comprehensive so that patients' access to providers and services is not impeded. They also say that the decrease is not as sharp as critics claim because the dispensing fee paid to pharmacists is only a small portion of the entire reimbursement arrangement, most of which is based on the actual costs of the drug.

Supplemental funding for hospitals

The Medicaid waiver also creates a way to protect certain federal funding that hospitals receive for treating the uninsured that otherwise would have been lost with the expansion of managed care. Hospitals historically have received supplemental funding from the federal government through what is known as the upper payment limit (UPL) program, which has been used to cover some of the expenses of caring for uninsured patients. UPL payments to Texas hospitals amounted to nearly $3 billion in fiscal 2011, according to the Texas Hospital Association.

Under federal law, any state that transitions its Medicaid program from a fee-for-service to managed care system loses access to a substantial portion of supplemental UPL hospital funding unless the state obtains a waiver. Texas was positioned to lose funds without the approval of the waiver after SB 7 by Nelson was enacted by the 82nd Legislature in its first called session in 2011, directing HHSC to expand the use of managed care for Medicaid statewide.

HB 1 by Pitts, the fiscal 2012-13 general appropriations act enacted by the Texas Legislature in 2011, specified that unless this supplemental hospital funding was preserved, the state would have to omit hospitals from the managed care expansion and achieve those cost savings elsewhere, such as by further reducing reimbursement rates to hospitals. It also specified that unless the federal government approved continuation of hospital UPL payments, HHSC could not expand STAR, Texas' primary managed care program, which serves about 1.5 million enrollees. The Medicaid waiver addresses this problem, using "funding pools" as a mechanism to protect the funding. Approval of the waiver ensures that the expansion of STAR may move forward.

Funding pools. Using the federal money that otherwise would be lost under the managed care expansion, as well as savings generated by the expansion, the waiver establishes two new pools of funding for public, private, and state-run hospitals.

Uncompensated care pool. The uncompensated care pool will help defray hospitals' costs of providing care for uninsured individuals. This uncompensated care totaled $15.1 billion in Texas in 2009, according to HHSC, with hospitals bearing the brunt of this burden. The uncompensated care pool will reimburse hospitals based on the actual costs of services provided, rather than on charges, which was the basis for reimbursing hospitals before the waiver.

Supporters of the new method say it will better direct the funding to hospitals that perform more uncompensated care and will more narrowly restrict use of the dollars, ensuring that they truly are spent on caring for the poor. Others have expressed concern that this will overly restrict use of the funding and give an unfair advantage to public hospitals by expanding their share of the payments, while hurting the private hospitals that benefited from the former system by shrinking their share. This shift is expected because private hospitals no longer will be reimbursed based on their charges but on their actual costs, which may be lower than what they charge. About 39 percent of the hospitals in Texas are for-profit entities, compared with a nationwide average of about 20 percent.

Delivery System Reform Incentive Payment pool. Another new funding pool will support the Delivery System Reform Incentive Payment (DSRIP) program. Hospitals will be able to participate in the program through regional health care partnerships led by public hospitals and local governments, which will provide the non-federal share of payments designed to encourage hospitals to implement system reform. DSRIP will finance health care system improvement projects to develop infrastructure, design innovative programs, and implement measures to improve patients' experiences and quality of care.

In order to give hospitals time to adjust to the new payment structures, the uncompensated care pool will receive most of the funding in the first two years, after which the resources gradually will shift to something closer to an even split between the pools in the fifth year. According to HHSC, the changes to hospital funding under the waiver will affect more than 300 Texas hospitals that historically have received supplemental funding.

— by Elizabeth Paukstis

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