President's Page

Can a confusing federal waiver SAVE MEDICAID?

With the latest extension of the Texas Medicaid Section 1115 waiver through September 2022, the state will bring in about $25 billion to the Texas budget for health care for the poor and disabled population. The influx of these funds provides critical support to the two main programs in this waiver: Uncompensated Care (UC), which funds hospitals for the care they directly provide to the poor, and the Delivery System Reform Incentive Payment (DSRIP), a pool of funds to encourage innovation and cost reduction by hospitals.

With the current and potential changes in the Affordable Care Act, this funding is critical for Texas. This extension did not come easily.

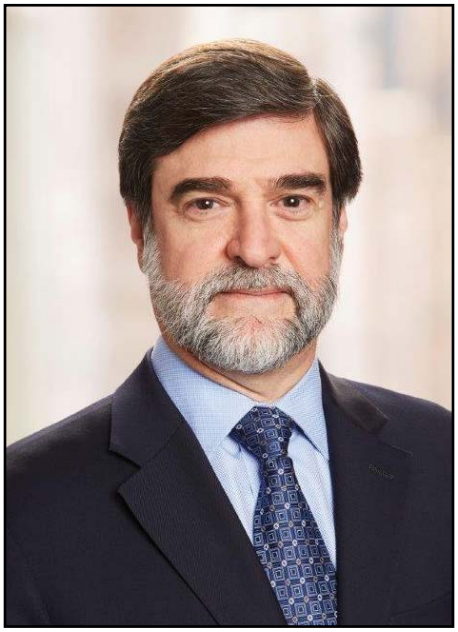
The Centers for Medicare and Medicaid Services (CMS) initially approved the Texas waiver program to run December 2011 through September 2016. This waiver was needed because Texas legislators voted to transition Medicaid from fee-for-service to a managed care system. The managed care companies promised the state savings. Recent estimates indicate that the change may have reduced Medicaid costs by more than $1 billion in those five years.

But during this initial period, CMS had many concerns, and the state's request for renewal was delayed. A 15-month temporary extension was granted, but cash flow to hospitals became a serious issue as CMS negotiated with the state. Eventually, the waiver was approved, but with several severe changes which I will discuss.

BACKGROUND

If you're like I am, you've been confused about the "Texas Healthcare Transformation Quality Improvement Program Waiver" and what has happened in the last several years. Let us visit the history of this program of the Centers for Medicare and Medicaid Services.

The 1115 Waiver Program is not new to CMS. Back in the 1960s, Section 1115 was added to the Social Security Act and the Medicaid law. As we know, Medicaid was created to provide health care to poor patients and to those with disabilities. Section 1115 gave permission to the secretary of the Department of Health and Human Services to waive certain prohibitions and rules as part of a demonstration project to provide new approaches to Medicaid and CHIP programs to improve care and efficiency, possibly decreasing costs. These waivers can expand services typically not covered, expand eligibility to patients being covered, and look at options — such as managed care — to provide care to this vulnerable population.



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USES OF WAIVER FUNDS

Many states have used these waivers as an opportunity to expand care to patients who require increased care or who have increased needs. Many of the waivers have been used to improve and expand service, particularly to increase funding for treatment of behavioral health and substance use, support the move from Medicaid to managed care, expand eligibility of certain individuals, and add funds to programs that would meet the unique needs of the Medicaid population that would have remained unmet under the current federal rules.

These goals are a step in the right direction toward reforming the healthcare delivery system for this population. Many states have applied for more than one waiver using Section 1115. The CMS website says that waiver funding should propose new ways to improve access to high-quality services, promote efficiencies in the system, and improve coordinated care and an enhanced alignment in healthcare providers. This sounds good on the surface.

As we all know, although such waivers also support the state's hospital safety-net programs, the new extension of the Texas waiver comes with many caveats, lessening the confidence that future cash coming into the state will remain at current funding levels. For example, the DSRIP funding will be stable for the first two years of this extension, but will start declining in years three and four, and this pool of funds will end by year five. The UC funding will be decreased significantly after the first two years of this extension. The new payment prohibitions that CMS requires likely will reduce UC funding after the first two years. So, the future of this $25 billion cash flow is unknown. That is no small margin of error.

ELEPHANT-SIZED CONCERNS

We have two elephants in the room: the broken Medicaid program, in which the vast majority of physicians decline to participate, and now the unstable 1115 waiver program, which provides hospitals the backup funds needed to care for the underserved population. If the estimates are correct and Medicaid expenses have been reduced by more than $1 billion — required by federal statute to be budget neutral — where have these savings been used? Have they been applied to improve uncompensated care or achieve appropriate reimbursement for needed services and clinical care? I do not know the answer to this. At whose expense have these Medicaid savings come? Is necessary care being limited? Is reimbursement being cut for needed services?

The next big question related to the Texas 1115 Waiver program is the role of physicians. Current rules and laws prohibit these waiver funds from being shared with physicians. This must change. It is well-known that the fee schedule for physicians is unacceptable. The Legislature has not sufficiently addressed Medicaid reimbursement for decades, resulting in Texas physicians leaving the Medicaid program. This leaves unaddressed the healthcare needs of the vulnerable population.

Is the 1115 waiver the answer to the low Medicaid fee schedule and the unmet needs of the poor and disabled population? Many observers consider the 1115 waiver program too "hospital-centric." As important as all of the hospitals are for delivering care to the Medicaid population, nothing indicates that significant changes will be made to improve the reimbursement to community doctors who also directly treat these patients.

If Medicaid expenses have been reduced by more than $1 billion, where have these savings been used?

As I have stated before, together, we can travel far. It is time to look at the Medicaid program and the 1115 waiver program in a different light and to include more people at the table.

This all reminds me of the quotation credited to Albert Einstein about insanity: "Insanity is doing the same thing over and over again and expecting different results."

We have been there and done that! Is it time to do this in a different way? **DMJ**