



Dually Eligible Individuals Enrolled in Medicaid Managed Care – Supplemental Report

**As Required by
Section 12, House Bill 2658, 87th
Legislature, Regular Session, 2021**

**Texas Health and Human Services
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Executive Summary

Section 12, House Bill (H.B.) 2658, 87th Legislature, Regular Session, 2021, requires the Health and Human Services Commission (HHSC) to conduct a study on dually eligible people in Medicaid managed care including:

- Current Medicare cost-sharing requirements for this population,
- The cost-effectiveness of transitioning Medicaid services not covered under Medicare (“Medicaid-only services”) into Medicaid managed care and requiring cost-sharing for those services, and
- The impact the transition would have on providers and dually eligible people.

A summary of HHSC’s study findings and a recommendation as to whether the transition should be implemented was due to the legislature on September 1, 2022.

On September 1, 2022, HHSC submitted the Dually Eligible Individuals Enrolled in Medicaid Managed Care report (September 2022 Duals Report¹) to the legislature which included current Medicare cost-sharing requirements for dually eligible people and the programmatic impacts from transitioning Medicaid-only services into managed care and charging cost-sharing for those services. This supplemental report provides HHSC’s findings regarding the cost-effectiveness of transitioning Medicaid-only services for dually eligible people into Medicaid managed care and requiring cost-sharing for those services, considerations of the operational and system costs, and a recommendation regarding implementation of these changes.

HHSC conducted a cost-effectiveness analysis of transitioning Medicaid-only services into managed care for dually eligible adults enrolled in managed care and requiring cost-sharing for these services. Using state fiscal year 2019 data, HHSC found that transitioning Medicaid-only services into Medicaid managed care for dually eligible adults is cost neutral. This transition may result in costs for one-time MCO system updates and minimal to no costs for HHSC FFS Medicaid claims administrator system changes. However, the cost-effectiveness of providing these services in managed care, the more streamlined claims process, and improved service coordination outweigh these costs.

¹ <https://www.hhs.texas.gov/sites/default/files/documents/dually-eligible-individuals-enrolled-medicare-managed-care.pdf>

Based solely on cost-sharing estimates, HHSC's Medicaid-only service expenditures would only be offset minimally by requiring copayments for Medicaid-only services. Implementing cost-sharing would also require complicated operational and system updates which would likely result in costs that exceed the revenue generated from the copayments. Imposing cost-sharing on dually eligible people may result in them foregoing needed health care services. Therefore, HHSC recommends transitioning Medicaid-only services without imposing cost-sharing on dually eligible people.

1. Introduction

As required by Section 12, H.B. 2658, 87th Legislature, Regular Session, 2021, this supplemental report provides HHSC's findings regarding the cost-effectiveness of transitioning Medicaid-only services into Medicaid managed care and requiring cost-sharing for those services, considerations of the costs associated with the operational and systems changes needed to implement the transition, and a recommendation as to whether the transition should be implemented.

2. Background

Dually eligible people have health coverage through both Medicare and Medicaid. In general, this population has limited income and resources and is comprised of people who are either age 65 or older, under 65 with certain disabilities, or any age with end-stage renal disease. “Full duals” are Medicare beneficiaries eligible to receive the full array of Medicaid benefits, including assistance for payment of their Medicare Part A and/or B premiums, and cost-sharing expenses. “Partial duals” are Medicare beneficiaries who are not eligible to receive the full array of Medicaid benefits but may receive Medicaid assistance for payment of their Medicare Part A and/or B premiums, and cost-sharing expenses.

For dually eligible people, Medicare is the primary payer for acute and post-acute care services. Medicaid reimburses for services after other insurance has been used, including Medicare. Medicaid also covers necessary home and community-based waiver services, state plan long-term services and supports (LTSS), and other state plan benefits not covered by Medicare (Medicaid-only).²

With the changes explored in this study, the responsibility for covering Medicaid-only services would shift from HHSC’s fee for services (FFS) Medicaid claims administrator to Medicaid MCOs,³ and providers would bill an MCO directly for Medicaid-only services instead of HHSC’s FFS Medicaid claims administrator. The study also explores whether dually eligible people should be required to pay cost-sharing for services HHSC does not impose cost-sharing on today.

² Examples of the Medicaid-only services described by H.B. 2658 are included in HHSC September 2022 Duals Report.

³ The Dual Demonstration is not included as its members already receive all Medicare and Medicaid services through a single health plan.

3. Transitioning Medicaid-only Services into Medicaid Managed Care

Transitioning Medicaid-only services into Medicaid managed care for dually eligible individuals would transfer responsibility for covering additional services to MCOs. MCO capitation payments would need to be adjusted to account for the coverage of Medicaid-only services for dually eligible members.

The September 2022 Duals Report describes the contractual, rule and state plan amendments that may be needed, which could take up to a year to finalize, although some could be completed concurrently.⁴ Additionally, HHSC's and its FFS Medicaid claims administrator's systems would require updates to ensure claims for Medicaid-only services for dually eligible people in Medicaid managed care are automatically denied and routed to the appropriate MCO. The current FFS Medicaid claims administrator contract is under re-procurement. Therefore, the transition of Medicaid-only services in managed care would likely need to take place upon receiving approval from the Centers for Medicare and Medicaid Services (CMS) of the Medicaid state-plan amendments and when the new Medicaid claims processing contract is in place. If it is implemented after the new Medicaid claims processing contract is operational, HHSC would incur minimal to no additional costs related to the new Medicaid claims processing contract.

Due to the complexity of the Medicare claim process, HHSC's FFS Medicaid claims administrator does not currently provide a comprehensive list of Medicaid-only services to providers or MCOs. Although Medicare does not ever cover some Medicaid services, other services become Medicaid-only services because Medicare does not cover them in certain situations. For example, Medicare may cover a service only when a specific diagnosis is involved. Numerous exceptions like these rely on multiple variables (of which diagnosis is only one) making it challenging to pull and maintain a comprehensive list. HHSC's FFS Medicaid claims administrator maintains business rules to identify all Medicaid-only services, including those covered on a situational basis. If these Medicaid-only services transition to Medicaid managed care, HHSC would need to ensure MCOs have the necessary information to establish and maintain their own business rules that identify, and process claims for Medicaid-only services. MCOs would need to update systems to incorporate this new process and may request an increase in their administrative cap of their

⁴ <https://www.hhs.texas.gov/sites/default/files/documents/dually-eligible-individuals-enrolled-medicaid-managed-care.pdf>

capitation payment to account for costs associated with these system changes. HHSC would need to regularly update MCOs about HHSC policy changes regarding the Medicaid-only managed care services covered for dually eligible individuals. HHSC receives annual Healthcare Common Procedure Coding System (HCPCS) files from CMS with Medicare coverage information. The file is used to identify changes in the services covered by Medicare and is shared with the MCOs internally on a quarterly and annual basis. This information allows MCOs to update their claims system accordingly. Please note that these files include proprietary information and code descriptions. They are intended for MCO internal use only and must not be distributed publicly.⁵

In addition, HHSC's FFS Medicaid claims administrator currently releases a HCPCS bulletin annually and quarterly listing updated codes Texas Medicaid covers. With the transition, HHSC would share an initial list of Medicaid-only services with the MCOs. However, after that list is incorporated into the MCOs' systems, the MCOs would be required to use the quarterly and annual HCPCS files HHSC shares with them and the quarterly and annual HCPCS bulletins published by HHSC's FFS Medicaid claims administrator to determine which Medicaid-only services they are responsible to cover. These files include proprietary information and code descriptions. As mentioned above, these files are intended for MCO internal use only and must not be distributed publicly.⁶

HHSC would also need to work with its FFS Medicaid claims administrator, Medicare Advantage Plans (MAPs), and MCOs to ensure the transition is seamless and member materials are informative, so members and providers are clear on any new requirements.

⁵ CMS has agreements with the American Medical Association (AMA) and American Dental Association (ADA) to use their code sets. CMS is restricted from posting the Current Procedural Terminology (CPT) code descriptions for the public due to AMA copyright laws. MCOs should review the AMA Terms and Conditions and the ADA Terms and Conditions prior to code use.

⁶ Ibid.

4. Cost-Sharing Requirements for Dually Eligible People

HHSC's September 2022 Duals Report described HHSC's current obligation to cover Medicare cost-sharing for certain duals, federal regulations related to Medicaid cost-sharing, Medicaid cost-sharing imposed in other states, and the steps to implement cost-sharing.⁷ This supplemental report reviews some information related to Medicaid cost-sharing and adds a high-level cost estimate for the system updates needed to implement co-payments on the Medicaid-only services, if these services were transitioned into managed care for full duals in Medicaid managed care.

Cost-sharing is the share of costs for services covered by a person's health insurance for which that person is responsible to pay out-of-pocket. Cost-sharing includes deductibles, coinsurance, and co-payments. At the time of this report, HHSC does not impose cost-sharing on Medicaid recipients for Medicaid services, including dually eligible people.

Medicaid Cost-Sharing

The Code of Federal Regulations (CFR) at 42 CFR §447.52 allows states to impose cost-sharing on Medicaid state plan services, with several limitations. States cannot impose cost-sharing for preventive services for children under 18, emergency services, pregnancy-related services, and family planning services.⁸ Certain groups of Medicaid beneficiaries are exempt from cost-sharing based on income level and the Medicaid services they receive, such as a person receiving Medicaid hospice services.⁹ States also have the option to impose "targeted cost-sharing" to certain Medicaid recipient groups, such as dually eligible people, as long as their income is above 100 percent federal poverty level (FPL). If CMS considers implementing cost-sharing for dually eligible people in Medicaid managed care to be targeted cost-sharing, HHSC would need to obtain CMS approval to also apply such cost-sharing. Although other states have received CMS approval to implement cost sharing, it's unclear whether they have approved targeted cost-sharing for dually eligible people with income below 100 percent of FPL. Cost-sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the

⁷ <https://www.hhs.texas.gov/sites/default/files/documents/dually-eligible-individuals-enrolled-medicaid-managed-care.pdf>

⁸ See 42 CFR §447.56(a)(2)

⁹ See 42 CFR §447.56(a)(1)

family's income.¹⁰ Further, states that impose cost-sharing that could place a person at risk of reaching the aggregate family limit, must describe in the state plan a process for tracking each family's cost-sharing that does not rely on the beneficiary to document their cost-sharing payments.¹¹

In accordance with 42 CFR §447.52(e), HHSC may allow providers to deny the provision of Medicaid-only services for nonpayment of cost-sharing obligations to non-exempt dually eligible people whose family income is above 100 percent FPL.

Cost-Sharing in Other States

The September 2022 Duals Report noted that several states require cost-sharing from their Medicaid recipients.¹² However, most states don't require cost-sharing for the Medicaid-only services.

Steps to Implement Cost-Sharing

In addition to the policy and programmatic changes reported in the September 2022 Duals Report needed for implementing cost-sharing on Medicaid-only services for dually eligible people in Medicaid managed care, HHSC has identified other considerations and operational system changes.¹³

Since the cost-sharing being considered in this study is for Medicaid-only services in managed care, HHSC would not be able to charge cost-sharing to the subset of dually eligible adults age 21 and over who receive intellectual and developmental disability services and are excluded from Medicaid managed care.¹⁴ Additionally, CMS may raise concerns about maintenance of effort related to the American Rescue Plan Act, which aims to expand access to high-quality home and community-based services to improve outcomes for people with LTSS needs.¹⁵ CMS may consider some Medicaid-only services, such as disposable medical supplies for incontinence, as long-term services and thus, might be reluctant to allow Texas to impose cost-sharing on those services as cost-sharing could create access barriers.

¹⁰ See 42 CFR §447.56(f)

¹¹ See 42 CFR 447.56(f)(2)

¹² <https://www.hhs.texas.gov/sites/default/files/documents/dually-eligible-individuals-enrolled-medicaid-managed-care.pdf>

¹³ Ibid

¹⁴ Dually eligible adults age 21 and over who receive IDD waiver services or ICF/IID services are not enrolled in Medicaid managed care.

¹⁵ Under a maintenance of effort provision, a state is required, as a condition of eligibility for federal funding, to maintain its financial contribution to a program at not less than the amount of its contribution for some prior time period.

States are obligated to comply with the maintenance of effort requirements from April 1, 2021 through August 2023.

Implementing cost-sharing on Medicaid-only services for dually eligible members in managed care would require operational changes. For example, HHSC would need to build systematic processes to regularly share with providers and MCOs updated information about Medicaid-only services that require cost-sharing and the respective amounts. HHSC would also need to develop systematic operational oversight to identify and share with MCOs and providers the members that are exempt from cost-sharing or who have met their cost-sharing limit. HHSC must develop a systematic process to identify dually eligible people according to their income in relation to FPL, which would be contingent on reliable, up-to-date income information.

One option to meet federal Medicaid cost-sharing tracking requirements is to leverage some of the current infrastructure used to implement cost-sharing in the Children's Health Insurance Program (CHIP) today. In this process, a member tracks, reports, and provides verification to the state's enrollment broker vendor when they reach their cost-share limit. However, HHSC must obtain CMS permission to allow member tracking of their cost-sharing payments as it does not align with the requirements in 42 CFR §447.56(a)(2). It is unclear whether CMS has approved states to require Medicaid recipients to track their cost-sharing. The regulation requires that states that impose cost-sharing describe in their state plan a process to track each family's cost-sharing without relying on beneficiary documentation of cost-sharing payments. Under a member tracking process, the enrollment broker would confirm the member met their cost-share limit and send that updated cost-share designation to the MCOs through a systems interface. A process and system change to share these updates with HHSC's Texas Integrated Eligibility Redesign System (TIERS) would be needed. HHSC would incur an estimated one-time cost of \$210,000 in all funds to make a TIERS system interface update. The MCOs would then use this information to ensure the member is no longer charged a co-pay. To implement such a solution for cost-sharing for dually eligible people, there would be an initial one-time system and operational costs of at least \$2 million in all funds for member mailings and necessary technology updates, and ongoing costs of at least \$2 million in all funds per year for staff and additional mailings. There may be additional systems costs to implement due to the system complexity.

HHSC could explore other options to establish a cost-sharing tracking process. For example, HHSC could require MCOs and providers to track and report member cost-sharing. When the member reaches their cost-share limit, the MCO would inform

HHSC's enrollment broker using a new interface specifically for reporting that the member met their cost-share limit. The enrollment broker would then update the member's managed care enrollment record to reflect the member met their cost-sharing limit, which could be shared with the necessary entities so the member would no longer be charged a copay. This would require MCO, provider, and HHSC system updates and interface changes. HHSC would also set up required reporting and quality metrics to support the changes for this option.

With any solution, having access to cost-sharing information may require additional updates to MCO and provider systems. These system changes would help prevent members from being charged more than the cost-sharing maximum.

Updates to HHSC's FFS Medicaid claims administrator's claims processing system would be needed to ensure Medicaid-only service cost-sharing claims for dually eligible people responsible for cost-sharing are automatically denied and routed to the appropriate MCO. If these changes are completed when HHSC's new FFS Medicaid claims processing contract is in place, these changes would incur minimal to no costs. MCOs would be responsible for notifying providers when they can charge a member.

Completing all necessary system changes for HHSC's enrollment broker and FFS Medicaid claims administrator, MCOs, and possibly even provider systems, may take twelve to eighteen months to implement.

Dually eligible people tend to have complex and costly health care needs. Imposing cost-sharing for Medicaid-only services could add an increased financial burden to these households and interrupt access to care. Proactive and ongoing communication with providers, MCOs, and members would be critical to ensure impacted members continue to receive needed services.

5. Cost-Effectiveness Analysis

HHSC compared the costs of providing state plan acute care Medicaid-only services in FFS to dually eligible adults who are enrolled in Medicaid managed care¹⁶ to the costs of providing these same services to non-dually eligible individuals in STAR+PLUS Medicaid managed care.

HHSC used a subset of Medicaid-only procedure codes processed in state fiscal year 2019 by HHSC's FFS Medicaid claims administrator. The subset of Medicaid-only procedure codes consisted of 97 percent of the total cost paid for FFS Medicaid-only procedure codes by HHSC's FFS Medicaid claims administrator. These services mostly consisted of incontinence DME and supplies such as adult diapers and bed liners. Comparing these FFS costs to state fiscal year 2019 managed care encounter data costs for these same services provided to non-dually eligible STAR+PLUS members, HHSC found that on average MCOs pay less than FFS for the subset of codes reviewed. Based on state fiscal year 2019 data, expenditures for these services would total \$93.4 million in all funds if provided in managed care. Compared to the costs for covering these services in FFS (\$98.7 million), it is 5.3 percent less costly or an estimated \$5.2 million in all funds savings (\$2.2 million in general revenue savings) to cover them in managed care, making the transition cost neutral.

HHSC applied the maximum allowable copayments on fiscal year 2019 Medicaid-only services for eligible populations based on CMS guidelines to assess the cost-effectiveness of requiring cost-sharing for these services. This analysis accounts for the federal five percent aggregate cost-sharing limit for Medicaid services. The findings reflect an estimated \$1.9 million in all funds (approximately \$800,000 in general revenue funds) or less than two percent of expenditures for Medicaid-only services could be offset by the new cost-sharing requirement, if CMS permitted HHSC to apply copayments for these state plan acute care Medicaid-only services to all dually eligible STAR+PLUS members including those with incomes lower than 100 percent of the FPL. If CMS only permitted HHSC to apply cost-sharing to dually eligible STAR+PLUS members with incomes above 100 percent of FPL, the estimated savings would be lower, about one percent or \$1.2 million in all funds savings (approximately \$500,000 in general revenue funds). These findings suggest that the addition of copayments has very little impact on offsetting expenditures for

¹⁶ Dually eligible adults age 21 and over who receive IDD waiver services or ICF/IID services are not enrolled in Medicaid managed care and were not included in this analysis.

Medicaid-only services. These estimates do not account for necessary cost-sharing operational and system changes.

Based on the study's findings, HHSC determines transitioning Medicaid-only services into Medicaid managed care for dually eligible people is cost neutral to the state.¹⁷ In addition, HHSC's expenditures for Medicaid-only services are only offset minimally by requiring cost-sharing for Medicaid-only services.

¹⁷ This analysis is based on state fiscal year 2019 data. Differences between fee-schedule rates and negotiated rates between MCOs and providers may change, which could impact future savings.

6. Recommendation

HHSC recommends transitioning payment for Medicaid-only services provided to dual eligible people enrolled in managed care to the MCOs without implementing cost-sharing for these services.

As noted in the September 2022 Duals Report, HHSC recognizes the administrative burden providers experience billing for Medicaid-only services and the limitations MCOs experience with coordinating Medicaid-only services today.¹⁸ The transition of these services into managed care would streamline the claims process and address the confusion around billing for these services that providers experience today. At the same time, the transition would ensure that MCOs can coordinate needed services for dually eligible members. Based on HHSC's review of Medicaid-only services paid for by HHSC's FFS Medicaid claims administrator from fiscal year 2019, transitioning Medicaid-only services into managed care is estimated to be cost neutral, even without imposing cost-sharing on dually eligible people. HHSC and its FFS Medicaid claims administrator's system updates could be deployed once the new FFS Medicaid claims administrator contract is in place incurring minimal to no costs. MCO capitation payments would need to be adjusted to account for the coverage of Medicaid-only services for dually eligible members. HHSC recommends transitioning these services into managed care because the cost-effectiveness of providing these services in managed care and the programmatic benefits from a more streamlined claims process and improved service coordination outweigh possible minimal one-time costs.

HHSC is uncertain that CMS would approve imposing cost-sharing on dually eligible people enrolled in managed care for Medicaid-only services. As noted in the September 2022 Duals Report, several of the states HHSC examined require cost-sharing from Medicaid recipients, most do not require cost-sharing for the Medicaid-only services described in H.B. 2658.¹⁹ Navigating between Medicare and Medicaid coverage is complicated for dually eligible people without accounting for copays, coinsurance, and deductibles for certain Medicaid services. Cost-sharing could add barriers for this population in accessing needed services and could lead to negative health and financial outcomes. Additionally, cost-sharing would result in HHSC

¹⁸ <https://www.hhs.texas.gov/sites/default/files/documents/dually-eligible-individuals-enrolled-medicare-managed-care.pdf>

¹⁹ Ibid

treating dually eligible people differently than Medicaid recipients who do not have Medicare and dually eligible people who are in Medicaid FFS.

HHSC's cost-effectiveness analysis found that expenditures for Medicaid-only services are only offset minimally by requiring cost-sharing for those services. Implementing cost-sharing would require programmatic and operational changes such as CMS approval, system changes, and policy updates, and would require frequent and clear communication with MCOs, providers, and members. There is expected to be costs for updates to enrollment broker systems, eligibility systems, MCO and provider systems, which would only increase the costs with implementing copayments. Therefore, the costs to implement copayments would likely exceed the revenue generated from the copayments. Additionally, if charging copayments results in a decrease in service utilization, revenue would be further reduced, and more importantly it could result in members not getting needed care. Taken together, because the minimal impact on offsetting expenditures, complicated operational and system updates, and potential negative impact on members not accessing needed care, HHSC does not recommend charging cost-sharing for Medicaid-only services provided to dual eligible people enrolled in managed care.

List of Acronyms

Acronym	Full Name
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
D-SNP	Dual-Eligible Special Needs Plan
FFS	Fee-for-Service
FPL	Federal Poverty Level
H.B.	House Bill
HHSC	Health and Human Services Commission
HCPCS	Healthcare Common Procedure Coding System
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions Program
IDD	Intellectual/Developmental Disability
KFF	Kaiser Family Foundation
LTSS	Long-Term Services and Supports
MAP	Medicare Advantage Plan
MCO	Managed Care Organization
MMP	Medicare-Medicaid Plan
PMPM	Per-Member-Per-Month
QMB	Qualified Medicare Beneficiary
TIERS	Texas Integrated Eligibility Redesign System