



Dually Eligible Individuals Enrolled in Medicaid Managed Care

**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, which must include:

- 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 is due to the legislature by September 1, 2022.

Dually eligible people are Medicare beneficiaries who are also eligible for Medicaid. Generally, dually eligible people have limited income and resources, are older adults age 65 and over, or are people under age 65 who have a disability. For dually eligible people, Medicare is the primary payer for most acute and post-acute care services, while Medicaid is the primary payer for most Long-Term Services and Supports (LTSS) and some other services not covered by Medicare.

For dually eligible people enrolled in managed care, HHSC currently covers Medicare cost-sharing and Medicaid-only state plan acute services through a Medicaid fee-for-service (FFS) delivery system and LTSS and home and community-based services (HCBS) through managed care. Cost-sharing includes deductibles, coinsurance, and co-payments. When a person is dually eligible, Medicaid may help cover Medicare cost-sharing obligations, depending on the type of Medicaid the person receives. HHSC does not impose cost-sharing on Medicaid-only services for Medicaid recipients, including dually eligible people.

H.B. 2658 requires HHSC to study the cost-effectiveness and impacts of transitioning Medicaid-only services for dually eligible people into Medicaid managed care and requiring cost-sharing for these services. Under such a transition, reimbursement of these services would shift from HHSC to Medicaid managed care organizations (MCOs), dually eligible people would be required to pay cost-sharing for these services, and providers would be responsible for collecting cost-sharing payment for these services from dually eligible members.

This report describes the Medicare cost-sharing requirements, and the programmatic impacts on dually eligible people and Medicaid providers from transitioning Medicaid-only services into managed care and charging cost-sharing for those services. HHSC will submit an addendum to this report with the required cost-effectiveness analysis of these changes by October 1, 2022.

1. Introduction

HHSC submits the Dually Eligible Individuals Enrolled in Medicaid Managed Care report in compliance with Section 12, H.B. 2658, 87th Legislature, Regular Session, 2021. H.B. 2658 requires HHSC to conduct a study regarding dually eligible people enrolled in Medicaid managed care. The study must include:

- The Medicare cost-sharing requirements for dually eligible people,
- The cost-effectiveness for a Medicaid MCO to provide all Medicaid-only services and require cost-sharing for those services, and
- The impact on dually eligible people and Medicaid providers that would result from the implementation of MCOs providing those services and requiring cost-sharing for the services.

By September 1, 2022, HHSC must provide the legislature a summary of the study's findings and a recommendation as to whether HHSC should implement the transition of Medicaid-only services into Medicaid managed care and require cost-sharing for those services. This report describes Medicare cost-sharing requirements, and the programmatic impacts on dually eligible people and Medicaid providers from transitioning Medicaid-only services into managed care and charging cost-sharing for those services. HHSC will submit an addendum to this report with the required cost-effectiveness analysis of these changes by October 1, 2022.

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. HHSC does not impose cost-sharing on members for any Medicaid state plan services.

For dually eligible people, Medicare is the primary payer for acute and post-acute care services. Medicaid is the payer of last resort, reimbursing for services after other insurance has been used, including Medicare. Medicaid helps dually eligible people pay their Medicare premiums and Medicare cost-sharing obligations,¹ and covers necessary home and community-based waiver services, state plan LTSS, and other state plan benefits not covered by Medicare (Medicaid-only). Dually eligible people have access to benefits depending on whether they are a full dual or partial dual.

Examples of the Medicaid-only services described by H.B. 2658 include:

- Targeted case management and mental health rehabilitation;
- Substance use disorder treatment services provided in a chemical dependency treatment facility;
- Routine podiatry;
- Hearing aids and fitting exams;
- Most disposable medical supplies such as those for incontinence and tube feeding;

¹ Cost-sharing obligations include a dually eligible person's Medicare Part A and B deductibles, coinsurance, and copayments. Cost-sharing obligations do not include coinsurance for Part A services provided during an HHSC-contracted Medicare Advantage Plan's dual eligible member's Medicare-covered stay in a nursing facility when the member is also enrolled in STAR+PLUS for their Medicaid services, or wrap-around services covered by Medicaid.

- Vision services (e.g., routine eye exams and eyeglasses); and
- Long term care (e.g., custodial nursing facility long term stays for dually eligible people age 20 and younger).

Currently for full duals enrolled in managed care, HHSC's FFS Medicaid claims administrator processes claims for Medicaid-only state plan acute care services, while MCOs cover and process claims for LTSS. Because Medicaid-only state plan acute care services are reimbursed in FFS, providers must maintain information regarding the services processed by the FFS Medicaid claims administrator versus the Medicaid MCO, which adds complexity and can be administratively burdensome. Additionally, Medicaid MCOs note that the separate processes complicate their ability to confirm and track all services a member receives which can affect a dually eligible person's service coordination.

With the changes explored through this study, the responsibility for covering Medicaid-only services would shift from HHSC's FFS Medicaid claims administrator to Medicaid MCOs.² This means providers would bill an MCO directly for Medicaid-only services instead of billing HHSC's FFS Medicaid claims administrator. There would also be a new requirement for dually eligible people to pay cost-sharing for these services. H.B. 2658 only directs HHSC to study the transition of Medicaid-only services into managed care and not also other services provided to dually eligible people for which providers would still bill HHSC's FFS Medicaid claims administrator. This means that providers would bill the MCO directly for Medicaid-only services and HHSC's FFS Medicaid claims administrator for:

- Medicare-covered services that become a Medicaid expense when a dually eligible person has reached the Medicare benefit limitation, and
- Medicare Part A and B coinsurance (except Medicare Part A skilled nursing facility coinsurance currently covered by Medicaid MCOs).³

In state fiscal year 2021 full duals who were age 20 and younger represented 0.3 percent of the average monthly enrollment of all full duals of any age. Given the small proportion of dually eligible youth, HHSC is focusing this study and report on dually eligible people who are age 21 and over.⁴

² The Dual Demonstration is not included as its members already receive all Medicare and Medicaid services through a single health plan.

³ Section 8.2.13., Medicaid Wrap-Around Services, of the *Uniform Managed Care Contract*.

⁴ In state fiscal year 2021, the monthly average of full duals who were age 20 and younger was 1,108 as compared to 368,049 full duals age 21 and older.

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. Instead of billing HHSC's Medicaid claims administrator, providers would bill the MCO directly. MCO capitation payments would need to be adjusted to account for the coverage of Medicaid-only services for dually eligible members.

To transition Medicaid-only services into Medicaid managed care, HHSC would need to amend current Medicaid managed care contracts, Medicare-Medicaid coordination rules,⁵ and the Medicaid state plan.⁶ Each amendment could take up to a year to finalize, although some could be completed concurrently. Additionally, HHSC's and its 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 providers are notified to submit these claims to the person's Medicaid MCO. MCOs may request an increase in their administrative cap of their capitation payment to account for costs associated with these system changes.

Due to the complexity of the Medicare claim process, HHSC's Medicaid claims administrator does not currently provide a comprehensive list of Medicaid-only services to providers. Most Medicaid-only services are services that are never covered by Medicare. However, some services become Medicaid-only services because Medicare does not cover them in certain situations. For example, there are instances in which Medicare will cover a service only when a specific diagnosis is involved. There are numerous exceptions like these that rely on a variety of variables (of which diagnosis is only one) making it challenging to pull and maintain a comprehensive list. HHSC's Medicaid claims administrator maintains business rules set to identify all Medicaid-only services, including those covered on a situational basis. HHSC would need to provide MCOs with similar business rules to identify and process claims for Medicaid-only services. MCOs would need to incorporate these business rules into their systematic processes.

HHSC would need to work with its Medicaid claims administrator, Medicare Advantage Plans (MAPs), and MCOs to ensure the transition is seamless and

⁵ See 1 Tex. Admin. Code §354.1143

⁶ See 42 CFR §447.52(i)

member materials are informative, so members and providers are clear on the new payment requirements.

4. Cost-Sharing Requirements for Dually Eligible People

H.B. 2658 directs HHSC to evaluate applying cost-sharing to the Medicaid-only services provided to full duals. At the time of this report, HHSC does not impose cost-sharing on Medicaid recipients for Medicaid services, including dually eligible people.

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. When a person is dually eligible, Medicaid may help cover the cost-sharing obligations for the person's Medicare coverage, depending on the type of Medicaid the person receives.

Medicare Cost-Sharing

HHSC is federally required to cover Medicare cost-sharing for full duals and partial duals in the Qualified Medicare Beneficiary (QMB) Program.⁷ The QMB program pays for Medicare premiums and cost-sharing for Medicare beneficiaries that meet the program's financial and resource requirements. A Medicare Advantage managed care health plan covers Medicare Part C services for people eligible for Medicare. Dual-Eligible Special Needs Plans (D-SNPs) and Dual Demonstration Medicare-Medicaid Plans (MMPs) are types of MAPs. MAPs and D-SNPs can partner with HHSC to further assist dually eligible people through capitated contracts under which the MAP is responsible for providing coverage of Medicare cost-sharing for certain members.⁸ MAPs and D-SNPs that do not contract with HHSC may provide Medicare services to dually eligible people but would not be responsible for covering cost-sharing. Instead, cost-sharing claims for dually eligible people enrolled in FFS Medicare or in a MAP that is not contracted with HHSC are processed by HHSC's FFS Medicaid claims administrator. HHSC-contracted MAPs pay providers directly for cost-sharing claims for their members.

A brief description of each type of MAP that HHSC contracts with is outlined below.

- MAPs serve Medicare-only, partial, and full duals, and provide Medicare services to their members. HHSC pays contracted MAPs a per-member-per-month

⁷ Section 1902(a)(10)(E) of the Social Security Act.

⁸ MMPs are all HHSC-contracted.

(PMPM) capitation payment to cover HHSC’s Medicare cost-sharing obligations⁹ for partial duals in the QMB Program and full duals.¹⁰

- D-SNPs serve partial or full duals and provide Medicare services for their members. HHSC pays contracted D-SNPs a PMPM capitation payment to coordinate the delivery of Medicaid services and cover HHSC’s Medicare cost-sharing obligations for full duals and partial duals in the QMB Program.
- MMPs serve full duals and are responsible for the provision of the full array of Medicare and STAR+PLUS Medicaid services, including Medicaid-only acute care services. MMPs also cover HHSC’s Medicare cost-sharing obligations for their members. HHSC and the Centers for Medicare and Medicaid Services (CMS) pay MMPs a PMPM capitation payment for the provision of Medicare and Medicaid services. HHSC’s PMPM portion is also for MMPs to cover HHSC’s Medicare cost-sharing obligations for full duals and partial duals in the QMB Program.

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.¹¹ 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.¹² States 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). Cost-sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family’s income.¹³ Further, states that impose cost-sharing that could place a person at risk of reaching the aggregate family limit, must describe in the

⁹ Cost-sharing obligations include a member’s Medicare Part A and B deductibles, coinsurance, and copayments. Cost-sharing obligations do not include coinsurance for Part A services provided during a HHSC-contracted MAP or D-SNP’s dual eligible member’s Medicare-covered stay in a nursing facility when the member is also enrolled in STAR+PLUS for their Medicaid services, or wrap-around services covered by Medicaid.

¹⁰ See Section II, Scope, of Attachment 4.19-B, of the State Plan and Article I, Background, of the MAP contracts between HHSC and a MAP.

¹¹ See 42 CFR §447.56(a)(2)

¹² See 42 CFR §447.56(a)(1)

¹³ See 42 CFR §447.56(f)

state plan a process for tracking each family's cost-sharing that does not rely on the beneficiary to document their cost-sharing payments.¹⁴

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

Several states require cost-sharing from their Medicaid recipients. However, most states don't require cost-sharing for the Medicaid-only services described in H.B. 2658.

The most common types of cost-sharing imposed by states are for prescription drugs, non-emergency services when rendered in an emergency department, physician office, and outpatient hospital (non-emergency department) visits.¹⁵ As of January 1, 2020, 22 states impose cost-sharing on Medicaid services such as non-preventative physician visits, non-emergency use of the emergency department, and inpatient hospital visits.¹⁶ Montana and North Dakota imposed cost-sharing requirements on Medicaid services at one point but later eliminated those requirements. In 2019, North Dakota eliminated Medicaid cost-sharing completely due to their inability to track cost-sharing and ensure the cost-sharing five percent aggregate cap was not exceeded.¹⁷ In 2020, Montana eliminated Medicaid cost-sharing completely to comply with new legislation passed in the state prohibiting cost-sharing to meet a deductible amount for any covered service.¹⁸

Arkansas and Maine impose cost-sharing on Medicaid-only services. Arkansas requires cost-sharing for adults with income above 100 percent FPL on specific services such as podiatry (\$10 per visit), targeted case management (10 percent of Medicaid max allowable rate per unit), and DME (20 percent of the Medicaid max

¹⁴ [See 42 CFR 447.56\(f\)\(2\)](#)

¹⁵ <https://www.kff.org/health-reform/state-indicator/premium-and-cost-sharing-requirements-for-selected-services-for-medicaid-expansion-adults/view/print/?currentTimeframe=0&print=true&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-1>

¹⁶ <https://www.kff.org/health-reform/state-indicator/premium-and-cost-sharing-requirements-for-selected-services-for-medicaid-expansion-adults/view/print/?currentTimeframe=0&print=true&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

¹⁷ [ND-19-0016.pdf \(medicaid.gov\)](#)

¹⁸ [MT-20-0012.pdf \(medicaid.gov\)](#)

allowable amount).¹⁹ Maine requires cost-sharing for non-exempt Medicaid recipients without specifying income limits, on Medicaid-only services such as DME (\$3 per day max, \$30 per month max) and podiatry (\$2 per day max, \$20 per month max).

Steps to Implement Cost-Sharing

To require cost-sharing for Medicaid-only services for dually eligible people, HHSC would need to implement several policy changes:

- Receive approval from CMS for an amendment to the Texas Healthcare Transformation and Quality Improvement Program (1115 waiver) to reflect new cost-sharing requirements;
- Amend current Medicaid managed care contracts;
- Create Medicaid cost-sharing policy and make corresponding system changes;
- Update Medicare-Medicaid coordination rules;²⁰ and
- Adjust MCO capitation rates.

HHSC anticipates the above changes would take at least a year to complete, with some steps being completed concurrently. Medicaid managed care contracts are amended annually. Medicaid rule amendments and waiver amendments can take up to twelve months to complete. It is important to note CMS is not required to approve or deny 1115 waivers or amendments requests within a defined timeframe. HHSC must pursue an 1115 waiver amendment rather than a state plan amendment because CMS is unlikely to allow a state plan amendment unless it applies to all dually eligible individuals. 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.²¹ Additionally, CMS may raise concerns about maintenance of effort related to the American Rescue Plan Act because CMS may consider some Medicaid-only services, such as disposable medical supplies for incontinence, as long-term services.

¹⁹ See Attachment 2.6-A, pages 12p-1 and 12p-2 for a full list of services and their respective co-payments

²⁰ See 1 Tex. Admin. Code §354.1143

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

Implementing cost-sharing on Medicaid-only services for dually eligible members in managed care would require operational system 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. To meet federal Medicaid cost-sharing tracking requirements, HHSC could require MCOs and providers to track and report member cost-sharing to HHSC's enrollment broker, which would potentially require MCO and provider system updates. HHSC's enrollment broker system must be updated to update the member's enrollment record when the member reaches their limit. MCOs and providers could use this cost-sharing information found in the member's enrollment record to confirm whether cost-sharing needs to be collected at the time of service or if the member has met their cost-sharing limit. Having access to these records may require additional updates to MCO and provider systems. These system changes will help prevent members from being charged more than the cost-sharing maximum for a particular service and ensure that the cost-sharing incurred by all dually eligible members in the household does not exceed an aggregate limit of five percent of the family's monthly or quarterly income. System changes may take several months or years to implement.

If HHSC were directed to implement targeted cost-sharing to non-exempt individuals above 100 percent of FPL, HHSC would need to make additional operational changes. HHSC must develop a systematic process to identify dually eligible people who are above 100 percent FPL, which would be contingent on reliable, up-to-date income information. Updates to HHSC's Medicaid claims administrator's claims processing system would be needed to ensure cost-sharing claims for the target group of dually eligible people are automatically denied and providers are notified to charge the member.

Because Medicare and Medicaid coverage changes frequently, regular communication between MCOs, providers, and members would be needed to ensure members and providers understand which Medicaid-only services members will be charged cost-sharing for at the time of service, as well as the amounts due for each service. Dually eligible people also 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. Impact on Dually Eligible People and Medicaid Providers

HHSC anticipates dually eligible people and Medicaid providers would be impacted by a transition of Medicaid-only services into Medicaid managed care and the imposition of cost-sharing for these services.

Transition of Medicaid-only Services to Managed Care: Impact on Providers

Medicaid is the payer of last resort when a Medicaid recipient has other types of health insurance such as Medicare. Therefore, providers are required to bill Medicare first for Medicare-covered services.²² Medicaid-only services never covered by Medicare are not billed to Medicare. HHSC does not require a Medicare denial or explanation of benefits for Medicaid-only services for dually eligible people before reimbursing for services. Providers often experience operational and administrative challenges in billing for dually eligible people. For example, if a person is retroactively found eligible for Medicare it can result in the Medicaid MCO recouping Medicaid reimbursements for services covered by Medicare, which then requires the provider to bill Medicare. Additionally, it is difficult for providers to know which entity to bill for specific services. If a provider bills Medicare for a service in error, delays in claim processing and adjudication may occur. Processing Medicaid-only service claims through the MCO could mitigate provider challenges as the claims process would be streamlined.

Simplifying the claims process for Medicaid-only services only addresses one category of services which providers currently bill to HHSC's Medicaid claims administrator for dual eligible people. Two categories not addressed are Medicare services that become a Medicaid expense due to a Medicare benefit limitation, and Medicare coinsurance claims. For dually eligible people enrolled in an HHSC-contracted MAP, providers would still bill the MAP for these services as well.

²² See 1 Tex. Admin. Code. §354.1143

Transition of Medicaid-only Services to Managed Care: Impact on Dually Eligible People

Because MCOs do not have access to HHSC's Medicaid claims administrator's system, MCOs do not know when a claim or prior authorization request for a dually eligible member is submitted, including claims or prior authorization requests for Medicaid-only services. MCOs report the lack of access to HHSC's Medicaid claims administrator's system negatively impacts their ability to coordinate care for their dually eligible members and to ensure that there are no gaps in care. This includes MCOs' ability to coordinate services which the MCO is not responsible for covering, such as Medicaid-only services. If MCOs were to pay claims for Medicaid-only services for dual eligible people, MCOs would be processing these claims and thus have timely access to information about services received by their members, which could improve their ability to coordinate services for their dually eligible members. Enhanced coordination could improve the care provided to dually eligible people and could result in more timely receipt of these services.

Cost-sharing: Impact on Providers

While provider billing processes for Medicaid-only services would be streamlined with the transition, imposing cost-sharing on dually eligible people for these services means providers would now have the responsibility of collecting co-payments and coinsurance from dually eligible people, and reporting the information on claims to MCOs. This process could add a level of complexity to the provider's billing processes, especially since the cost-sharing would only apply to dually eligible people and not Medicaid recipients who do not have Medicare. It could also lead to provider concerns about reimbursement since federal cost-sharing regulations prohibit providers from denying services to Medicaid recipients on account of the person's inability to pay the cost-sharing, with a few exceptions. Exceptions to this regulation are when:

- The person does not fall under one of the groups exempted from cost-sharing,²³ and

²³ See 42 CFR §447.56(a)

- For cost-sharing imposed for non-emergency services provided in an emergency department, only when certain conditions have been satisfied.²⁴

H.B. 2658 focuses on the impacts of Medicaid recipients and Medicaid providers. However, research conducted by Kaiser Family Foundation (KFF) suggests applying cost-sharing may also increase pressures on safety net providers such as community health centers and hospitals, especially when a Medicaid recipient cannot afford to use their Medicaid benefits.²⁵

Cost-sharing: Impact on Dually Eligible People

HHSC does not currently require Medicaid recipients, including dually eligible people, to pay cost-sharing for Medicaid-only services. By imposing cost-sharing on Medicaid-only services for dually eligible people in Medicaid managed care, Texas Medicaid would be treating this population differently than dually eligible people in Medicaid FFS such as dually eligible adults age 21 and over who receive Intellectual/Developmental Disability (IDD) waiver services or Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) program services, dually eligible people pending enrollment into managed care, and Medicaid recipients who do not have Medicare.

All full duals have limited incomes (at or below 300 percent of FPL) and resources. Imposing cost-sharing for Medicaid-only services on dually eligible people could limit access to care. It would be critical for members to be informed on an ongoing basis of the Medicaid services for which cost-sharing is required. Even with clear communication, imposing cost-sharing for these services means dually eligible people would be responsible for paying co-payments and coinsurance on services for which they, nor any other Medicaid recipient, are responsible for paying today. Unintended barriers to care may be introduced if cost-sharing were implemented because dually eligible people with limited incomes may not be able to afford cost-sharing, even of minimal amounts. This could lead to dually eligible people not seeking health care when needed.

The KFF study found that the implementation of cost-sharing may result in increased barriers to coverage and care, greater unmet health needs, and increased

²⁴ See 42 CRF §447.54(d)

²⁵ https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-issue-brief/#endnote_link_220856-4

financial burdens for families.²⁶ KFF concluded even small levels of cost-sharing in the range from \$1 to \$5 are associated with reduced use of necessary care partially due to the increased financial burden. KFF also suggests these requirements can have unintended consequences, such as increased use of other costly services like emergency room visits, resulting from lower service utilization.

²⁶ https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-issue-brief/#endnote_link_220856-4

6. Conclusion

HHSC recognizes the providers' administrative burden billing for Medicaid-only services and the MCOs' limitations coordinating Medicaid-only services.

Transitioning Medicaid-only services into Medicaid managed care for dually eligible people could resolve some of the administrative burden providers face today while improving an MCO's ability to coordinate needed services for their dually eligible members.

Imposing cost-sharing for these services on this population, however, means dually eligible people would be treated differently than Medicaid recipients who do not have Medicare. HHSC would need CMS approval to impose cost-sharing on Medicaid-only services for non-exempt dually eligible people in Medicaid managed care through amendments to the Texas Healthcare Transformation and Quality Improvement Program (1115 Transformation) waiver. It is unknown if CMS would approve imposing cost-sharing on dually eligible people enrolled in managed care for Medicaid-only services. Although 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. Additionally, CMS may raise concerns about maintenance of effort related to the American Rescue Plan Act because CMS may consider some Medicaid-only services, such as disposable medical supplies for incontinence, as long-term services. This could put HHSC's American Rescue Plan Act funding at risk.

Navigating between Medicare and Medicaid coverage is complicated for dually eligible people without accounting for copays, coinsurance, and deductibles for certain Medicaid services. Because dually eligible people have low incomes and are often medically fragile, requiring cost-sharing for certain services may cause individuals to forego needed care, which could lead to negative health outcomes. Additionally, providers may be adversely impacted if members are unable pay their cost-sharing. 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.

The addendum to this report will build from the information in this report to provide the findings from HHSC's cost-effectiveness analysis study and recommendations. The addendum will be submitted no later than October 1, 2022.

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
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