



*The National Association of Community Health Centers, Inc.*

**Emerging Issues in Medicaid and SCHIP #2:  
Medicaid Reform: Privatization and Health Savings Accounts  
July 2005**

Rising Medicaid expenses continue to create major budget problems for states. Health care inflation is growing at least twice the rate of general inflation.<sup>1</sup> State governors agree that Medicaid needs reform however, states differ in their approach. Medicaid funding is vital to the operation of health centers, at over 35% of health center budgets on average, and therefore, any changes to the structure, reimbursement or coverage policies within Medicaid, could potentially have a huge impact on the operation and thus the mission of health centers. Florida, South Carolina, New Hampshire and a number of other states are currently developing Medicaid reform plans that incorporate some form of health savings accounts.<sup>2</sup>

**What is a Health Savings Account?**

Health Saving Accounts (HSAs), as part of Medicaid reform proposals, differ from private market HSAs. Medicaid associated HSAs are funded by state contributions, rather than by individuals. Beneficiaries then use the state funds to enroll in health plans or to pay for medical services. In some proposals, unspent funds in the accounts roll over to the following year, while in other proposals unspent funds can be withdrawn in cash or as a voucher. Unlike the federal plans, individuals do not get a tax break. Conceptually, however, state financed HSAs share a similar philosophy with federal accounts. HSA proponents maintain that these accounts promote personal accountability and incorporate market competition to control costs. They also believe that HSAs increase patient satisfaction because more health care choices are available.<sup>3</sup>

HSA detractors point out that because the accounts have a finite sum, people (particularly low income) will delay care, providers will detect problems at a later stage, and medical costs will subsequently increase. Critics also note the main reason health care costs are sky rocketing has less to do with irresponsible spending and more to do with underlying costs such as prescription drug benefits, provider reimbursements, and the expense of caring for a relatively small group of people with major health problems (the elderly and those with chronic medical conditions).<sup>4</sup> These critics also point out that Medicaid patients have an advantage in that the state negotiates payments with providers, consequently the state pays less for Medicaid services than a patient would be able to negotiate on his or her own. Beneficiaries may lose this advantage when they use HSA funds to pay for services.<sup>5</sup> Particularly important, HSAs can undermine the entitlement aspect of the Medicaid program which guarantees beneficiaries key services when they are determined to be medically necessary.

Under current Medicaid law, states wishing to institute HSAs must apply for a waiver from the Centers for Medicare and Medicaid Services (CMS) and commit to such

waiver being “budget neutral” meaning, the federal government will not spend more money with a new waiver than it would have spent had there been no waiver.<sup>6</sup>

In terms of health centers and HSAs, it is important to understand reimbursement issues. In 2000, Congress underscored the importance of adequate Medicaid reimbursement to health centers by creating a FQHC prospective payment system (PPS), ensuring access to primary care services for Medicaid and uninsured patients, while simultaneously ensuring that neither Medicaid nor the federal Health Centers grant program is forced to subsidize care for the other program’s beneficiaries. At the same time, a wrap-around payment was legislated which requires states to pay health centers the difference between what MCOs pay and PPS. The concern with HSAs therefore is that beneficiaries may decide not to seek services from health centers—even if they have been patients of the center for many years—since the center’s PPS visit rate may exceed what other providers would charge them. However, if the center charges the patient less than its PPS rate, it is not at all clear that the state would make a “wrap-around” payment to the health center.

### **Medicaid: The whole picture**

Although state governors often quote worrisome statistics on the percentage of state budgetary spending on Medicaid, it is important to remember that 50-77% of state Medicaid expenditures for services are financed by the federal government and not states. Medicaid is more cost effective than private plans whose premiums are growing much faster than Medicaid costs. On an individual basis, Medicaid insures adults for 30% less and 10% less for children than do private plans. During times of economic crises, Medicaid is designed to expand and increase enrollment to compensate for those who lose jobs and subsequently their employer based health coverage. Unfortunately, policy makers may perceive the model as a further drain on the system in tough economic times rather than as a critical safety net until people are able to secure new employment.<sup>7</sup>

### **Analysis of the State Plans**

Even as this issue brief is being written, an increasing number of states are proposing, or at least considering, various forms of HSAs as part of their overall “Medicaid reform”. Each week concept papers are released from yet another state and/or earlier state proposals undergo revisions. Consequently, it is difficult to compose an issue brief that is current on each HSA proposal that is being floated by various states. Instead, this issue brief highlights three state HSA proposals, as they appeared as of July, 2005. While even these three states may have since revised or elaborated further on their proposals, we believe the summaries below provide a good overview of the direction states are attempting to go with regard to HSAs.

#### **A. FLORIDA: Empowered Care**

*Proposal:* Florida’s plan to reform Medicaid is entitled Empowered Care. The proposal will model private insurance with an overall limit on state expenditures as well as a cap on the amount of money a beneficiary is allotted for medical services. Under the state’s proposal, it will pay a risk-adjusted premium for each enrollee. The premium amount is a vital number and will influence available patient services.<sup>8</sup> Vendors will

develop a variety of health care plans with unique sets of covered services to compete for enrollment.<sup>9</sup> Florida proposes that Medicaid recipients, with the help of counselors, will use their state supplied premium to purchase a health care plan or “opt-out” of Medicaid and use their premium to purchase private insurance, and enroll in a flexible spending account. The proposed health care structure will include comprehensive care, enhanced benefits, and catastrophic coverage up to a yet to be determined amount.<sup>10</sup>

The state will allow various health care plans to determine the benefit packages they will offer beneficiaries.<sup>11</sup> This is major alteration of the usual state Medicaid managed care arrangement, in which the state usually contracts with managed care organizations (MCOs) for specific services which are itemized in the state-MCO agreement. One critical observer of the proposal has stated “HMOs and private insurers will have the opportunity to profit from Medicaid enrollees without having to guarantee access to key services.”<sup>12</sup>

*Impact on Health Centers:* The Florida plan, particularly if and when it expands beyond the two initial demonstration counties may be problematic for health centers, as it does not appear to define a specific role for them in the reform package. There does not appear to be a requirement that MCOs offer federally qualified health center (FQHC) services or contract with FQHCs, nor does there appear to be a mechanism proposed to assure or at least enhance the ability of centers to retain their current Medicaid patients. Equally important, if the state’s program does not provide recipients with sufficient funds to purchase adequate low-deductible insurance coverage, many of these patients are likely to go to centers when they have exhausted their coverage or if they are unable to meet the cost-sharing requirements of their plans. Thus, health centers could lose their current Medicaid patients but then get them and others back essentially as uninsured patients.

*Status:* The Florida legislature passed and Governor Bush signed into law, a plan to implement a pilot project in two counties (Duval and Broward) that includes HSAs for Medicaid patients. Prior to implementation, the state has to have this demonstration program approved by CMS as a Section 1115 waiver, and pursuant to the state law, the final version of the waiver program could not be implemented without approval once again from the state legislature. After the pilot, the program can be rolled out to the rest of the state pending legislative approval. The state is currently drafting the waiver application.

#### B. NEW HAMPSHIRE: GraniteCare

*Proposal:* New Hampshire proposed to offer all non-disabled Medicaid consumers with incomes between 133% and 300% FPL (pregnant women and children) a preventive and non-emergent *Health Service Account*. In promoting this proposal, the state emphasizes that its key elements would include an individual budget for each recipient, a medical home for the recipient, provision of a specific schedule of prevention services, availability of disease management and utilization of primary care case management. The state’s proposal would consist of three benefit components: prevention services and major medical care, both of which would be paid by the state; and acute care

services, payment for which would come out of the recipient's HSA. The proposal also envisions an incentive system that rewards the recipient for adhering to an individual prevention services schedule and for effective management of his/her HSA. The funding put into the recipient's HSA would be for use in non-emergency care such as office visits and hospital outpatient visits.

A number of concerns have been raised about New Hampshire's HSA proposal. For example:

1. It contains little detail about the plan's potential to expand services and how to ensure provider support of the new payment rates.
2. It creates limits on services for a group that is not that expensive to cover: children and pregnant women.
3. Limiting services may cause people to delay care and has the potential to drive up health care costs.
4. Prior-authorization--which can potentially be used to deny services to a beneficiary-- is a component of the HSA proposal, but prior authorization guidelines are not put forth in the proposal.
5. The plan is not clear on managing and standardizing the process for physicians to waive patients with high health care costs into the "major medical pool" or what will happen to these patients if this pool is depleted.<sup>13</sup>

*Impact on Health Centers:* Finally, as with the Florida proposal, the state's plan appears to have the potential for adversely impacting FQHCs. When a patient has exhausted his/her HSA account, he or she may then visit the health center as an uninsured patient. It is not clear-- given Medicaid and Bureau of Primary Health Care (BPHC) grant requirements-- whether the center can then charge the patient for the service, and how much it can charge (full pay, sliding scale, etc).

*Status:* While the state legislature gave the NH Department of Health and Human Services legislative approval to pursue necessary waivers related to long-term care, care management, mental health integration, transportation, and IT infrastructure, the HSA proposal was not approved by the Legislature. The HSA proposal has, however, been retained in a legislative committee.

### C. SOUTH CAROLINA: South Carolina Medicaid Choice

*Proposal:* South Carolina submitted a waiver in June 2005 to reform Medicaid using Private Health Accounts (PHA) to pay health care costs for Medicaid beneficiaries. Under its pending proposal, the South Carolina Department of Health and Human Services (SCDHHS) would fund risk adjusted accounts and pay premiums to various health care plans. Enrollees can choose between self directed plans, private insurance, a Medical Home Network (the primary care provider acts as the gatekeeper), or alternative

coverage (group-based insurance). The waiver permits different benefit packages and cost sharing requirements. All the plans require catastrophic coverage, however, those enrollees with high health care costs must enroll in a managed care plan.

Proposed incentives would reward beneficiaries and care networks. The state would issue reward cards for those who meet health outcomes documented by a physician. Enrollees with third party coverage would receive an additional \$2/month in their PHA. Managed care plans would retain any savings if costs are lower than the monthly capitated rate. The managed care plans would bear any excess costs to treat those enrollees with chronic illnesses and those with acute care crises (i.e. “high utilizers”). SCDHHS maintains that its goal is to “encourage” aggressive case management for these patients.

*Impact on Health Centers:* Detrimental to health centers are the state’s reimbursement proposals, at least as they are articulated in the state’s June 2005 proposal. While reimbursement differs among the four types of coverage, the state has asked CMS to waive supplemental (wrap-around) payments to FQHCs and rural health clinics (RHCs). In short, under this proposal SCDHHS would not make additional payments to FQHCs for services provided to beneficiaries enrolled in capitated programs. In order to serve certain enrollees, FQHCs will have to join the provider network under the managed care plans and negotiate their reimbursement rates. While the state proposal does not specifically seek a waiver of FQHC services, it is unclear in the South Carolina proposal how and if health center services would remain a service available to Medicaid recipients. There appears to be no provision in the program that would require that centers be contracted by MCOs, or integrated into self-directed plans or offered as a service by insurance plans, etc. And, as with the Florida and New Hampshire proposals, health centers may get these same patients back when they have exhausted their PHA benefits, that is, they may be seeing them as uninsured patients.

Other concerns, that are not FQHC specific: beneficiaries in the self directed plans who exhaust their PHA funds will have to pay future fees as any other private-pay patient or choose not to seek additional care. The waiver also would allow providers to deny services to beneficiaries who can not make their co-pay. The proposed co-pays may be prohibitive to some patients (\$100 for inpatient services and \$25 for outpatient procedures) and decrease patients’ access to needed services.

*Status:* An application is currently pending at CMS. Despite the negative language regarding FQHC reimbursement in the June proposal, the SC Primary Care Association (PCA) has received assurance from the state that FQHC reimbursement will not change and secured language in the July version stating, “the state intends to work with them (RHCs and FQHCs) to develop alternate delivery models including participation with the approved plans under privately negotiated terms.”

## **Conclusion**

What is clear from the three proposals discussed above is that the states have not identified a clearly defined role for health centers and in some cases, whether intentional or not, have proposed changes that may be harmful to health centers. When states are

weighing HSAs for Medicaid populations, health centers and PCAs, need to work with the state to make sure the following questions have been considered:

1. Has an adequate payment rate been determined for beneficiaries at health centers using HSA funds?
2. Are health centers adequately included in provider networks and eligible to serve the Medicaid population being transferred to HSAs?
3. Are health centers protected from absorbing the costs if the state or beneficiaries exceed their cap and the number of uninsured increases?
4. Are eligibility and benefits protected for existing enrollees?
5. What is the potential impact of the proposed changes on health centers and their patients?

**For More Information:**

Current Medicaid 1115 waiver concept papers and applications for the states discussed above and many others can be found on NACHC's State Policy webpage at:

<http://www.nachc.com/advocacy/state-policy.asp>

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<sup>1</sup> <http://www.statecoverage.net/stateside0205.htm>

<sup>2</sup> [www.healthdistrict.org](http://www.healthdistrict.org)

<sup>3</sup> [http://www.managedcaremag.com/archives/0011/0011.peer\\_msa.html](http://www.managedcaremag.com/archives/0011/0011.peer_msa.html)

<sup>4</sup> *State Coverage Initiatives* Sept. 2004 Vol. V, No. 3

<sup>5</sup> "GraniteCare: Some Questions and Answers", Doug Hall, NH Center for Public Policy Studies, 2/05.

<sup>6</sup> <http://wphf.org/access/pubs/Medicaid.pdf>

<sup>7</sup> Jones.ihcrp.georgetown.edu

<sup>8</sup> hospitalconnect.com

<sup>9</sup> [www.aif.com](http://www.aif.com)

<sup>10</sup> <http://www.statecoverage.net/stateside0205.htm>

<sup>11</sup> [www.aif.com](http://www.aif.com)

<sup>12</sup> [www.wphf.org](http://www.wphf.org)

<sup>13</sup> NACHC Letter to Bi-State Primary Care Association 11/8/04