TEXAS
Health and Human
Services Commission

Presentation to Senate Health and Human Services Committee – Charge #2

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Overview

- Medicaid Trends in Expenditures and Caseload
- Cost Containment Initiatives
- Next Steps

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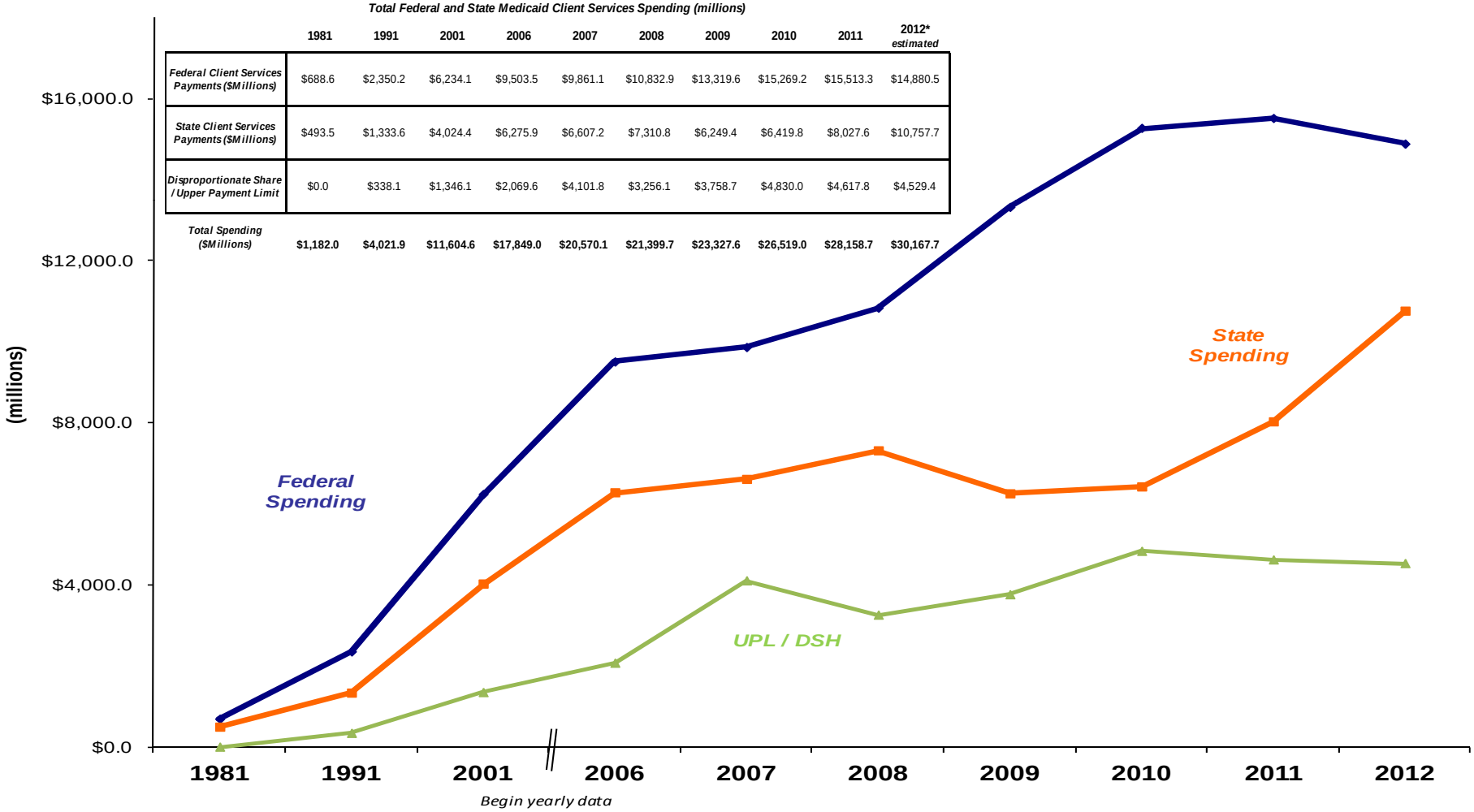
Medicaid Trends:
Historical State & Federal Medicaid Spending

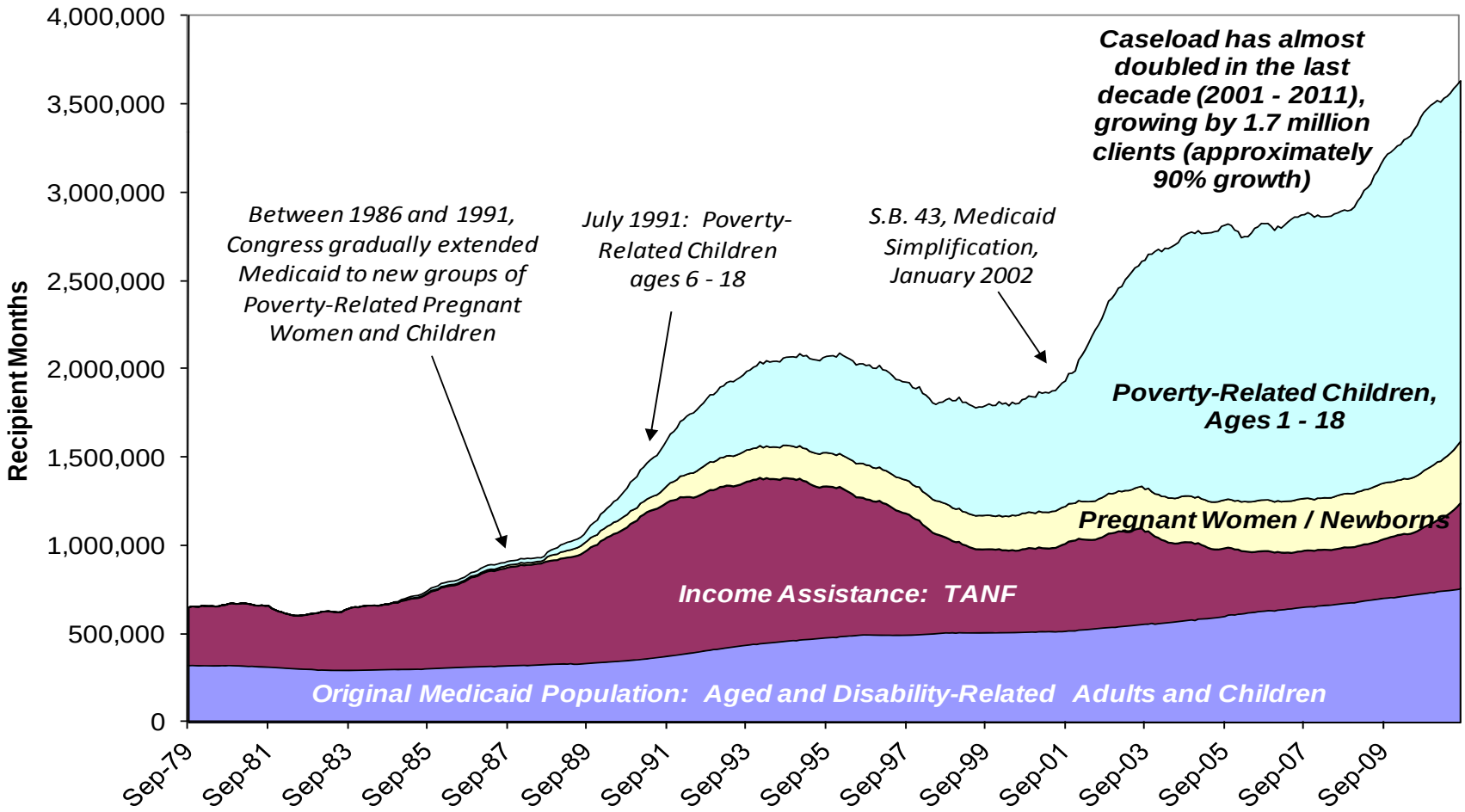
Total Federal and State Medicaid Client Services Spending (millions)

	1981	1991	2001	2006	2007	2008	2009	2010	2011	2012* estimated
Federal Client Services Payments ($Millions)	$688.6	$2,350.2	$6,234.1	$9,503.5	$9,861.1	$10,832.9	$13,319.6	$15,269.2	$15,513.3	$14,880.5
State Client Services Payments ($Millions)	$493.5	$1,333.6	$4,024.4	$6,275.9	$6,607.2	$7,310.8	$6,249.4	$6,419.8	$8,027.6	$10,757.7
Disproportionate Share / Upper Payment Limit	$0.0	$338.1	$1,346.1	$2,069.6	$4,101.8	$3,256.1	$3,758.7	$4,830.0	$4,617.8	$4,529.4
Total Spending ($Millions)	**$1,182.0**	**$4,021.9**	**$11,604.6**	**$17,849.0**	**$20,570.1**	**$21,399.7**	**$23,327.6**	**$26,519.0**	**$28,158.7**	**$30,167.7**

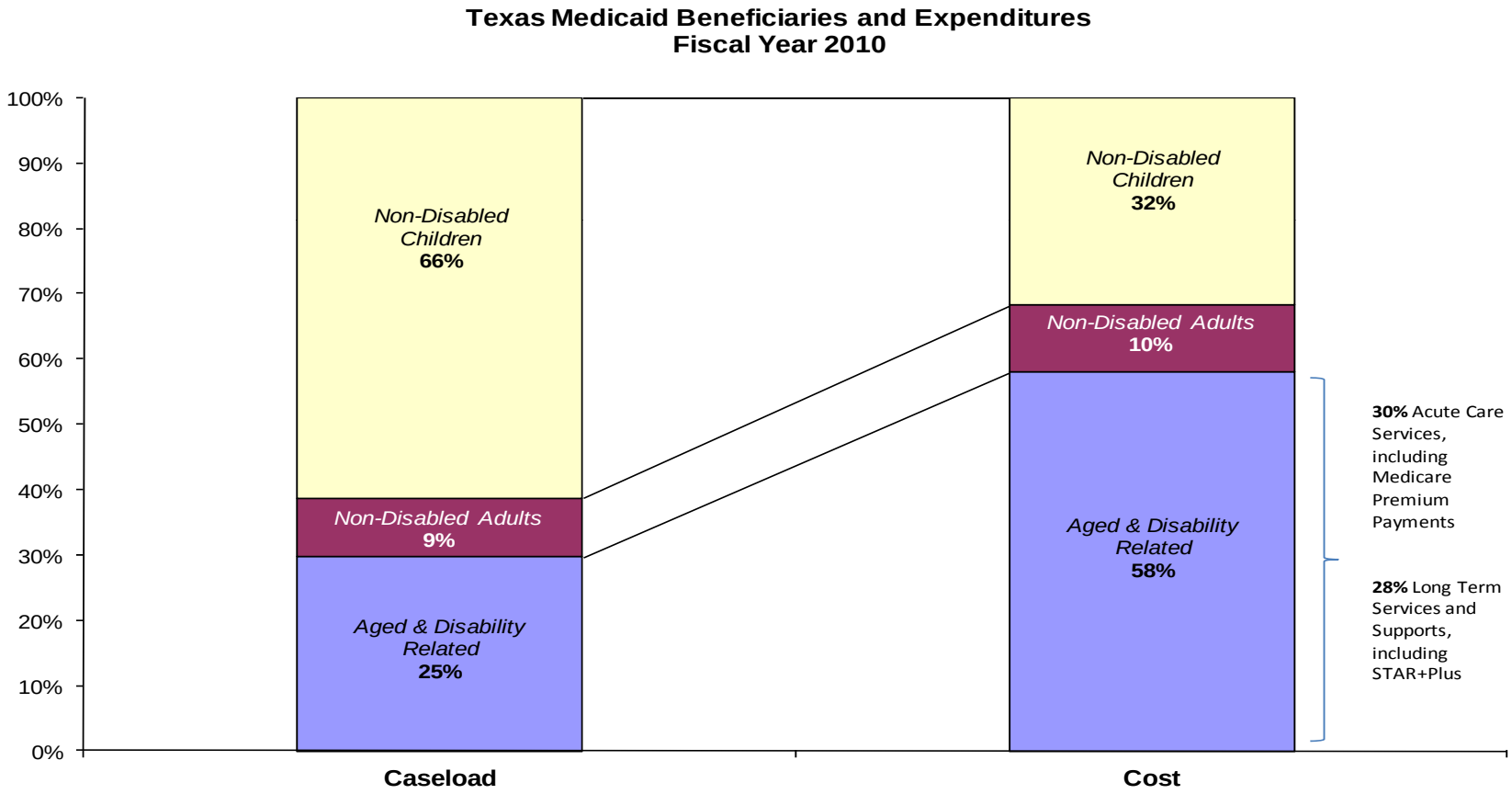


Medicaid Caseload Trends: Who Does Medicaid Serve?

Texas Medicaid Caseload by Group, September 1979 - August 2011

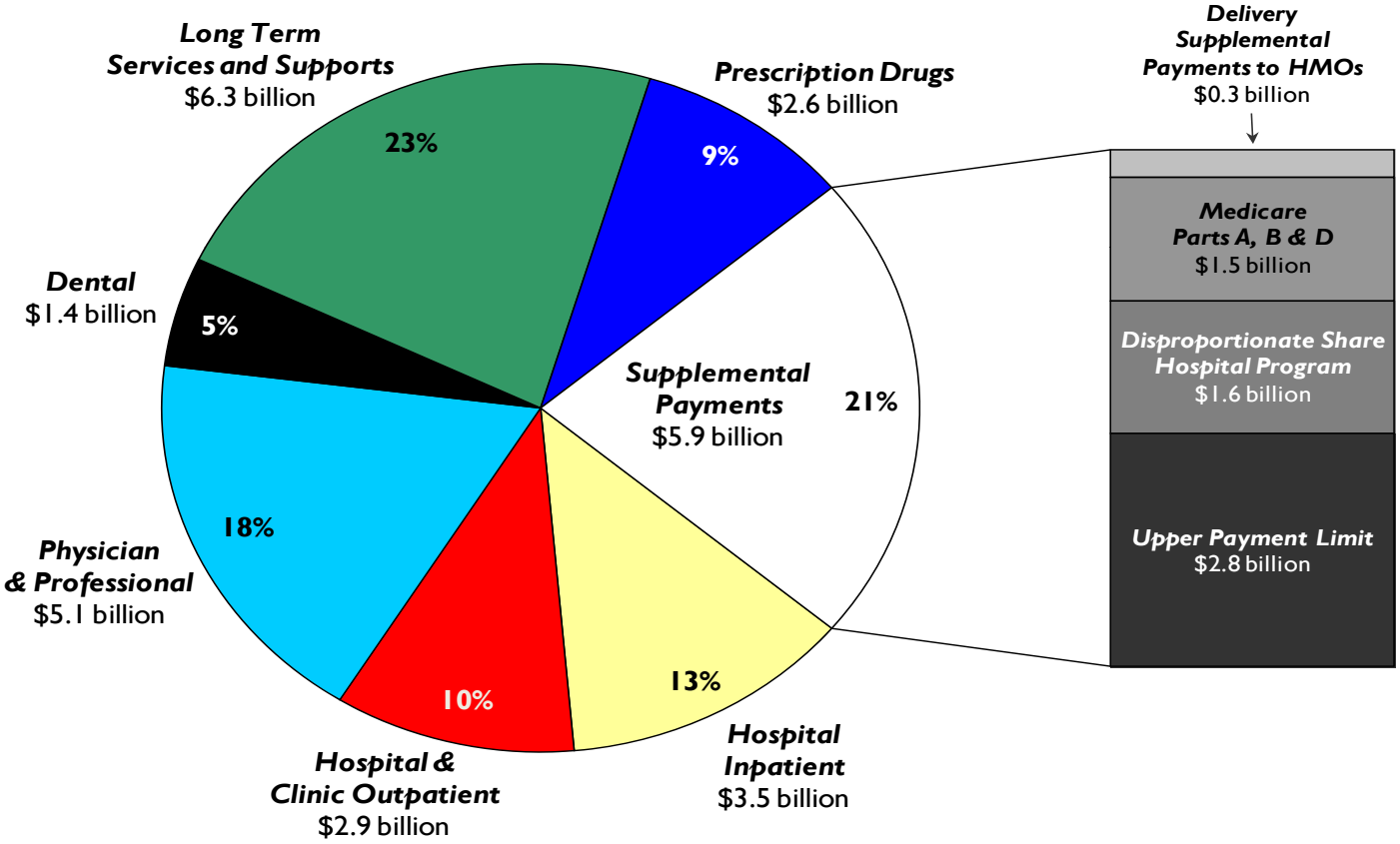


Medicaid Caseload and Cost: Who Does Medicaid Serve at What Cost?



Source: HHS Financial Services, 2010 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Care. Costs and caseload for all Medicaid payments for full and non-full beneficiaries (Women's Health Waiver, Emergency Services for Non-Citizens, Medicare payments) are included. Children are all Poverty-Level Children, including TANF. Disability Related Children (under age 21) are in the Aged & Disability-Related Group.

Texas Medicaid Expenditures, SFY 2011* by Service Type — Total $28 billion



* Source: *Medicaid Management Information System (MMIS).*
Prepared By: *Strategic Decision Support, Texas Health and Human Services Commission, April 2012.*
Note: *Due to rounding, totals may not add up exactly.*

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Cost Containment: Overview

HHS Cost Containment Initiatives
2012-13 General Appropriations Act, H.B. 1
General Revenue ($ in mil.)

Cost Containment Initiative	H.B. 1 Target
HHSC Rider 61: Medicaid Funding Reduction	$450.0
Special Provisions, Section 16: Provider Rates	$571.3
Special Provisions, Section 17: Additional Cost Containment Initiatives	$705.0
HHSC Rider 51: Managed Care Expansion	$385.7
Other Initiatives	$85.6
Total, Cost Containment Initiatives	**$2,197.6**
Estimated Premium Tax from Managed Care Expansion	$238.0
HHSC Rider 59: Federal Flexibility	$700.0
Total, Cost Containment Initiatives, Premium Tax, and HHSC Rider 59	**$3,135.6**

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Cost Containment: Overview

- Based on current estimates 88% of the savings for cost containment initiatives will be achieved, including:
  - 89% of Rider 61 Medicaid cost containment target
    - Rider 61 includes 30 initiatives with a focus on improving quality of care and health outcomes
  - 85% of Section 16 rate reduction target
    - All rates effective September 2011, with reductions ranging from 1% to 10.5%
  - 82% of Section 17 additional cost containment target
    - Section 17 includes 14 initiatives affecting DADS, DSHS, and HHSC, including Medicare equalization

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Medicaid Managed Care Status

- March 1, 2012, HHSC implemented statewide Medicaid managed care.
  - 3 million covered people in capitated managed care.
  - Major expansion in Hidalgo Service Area (HSA) and rural areas.
  - Administration of Medicaid and CHIP prescription drug benefit added to managed care model.
  - Implementation of a statewide, risk-based dental managed care model to 2.5 million children.
  - Coverage of in-patient hospital services added to STAR+PLUS managed care model.

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Managed Care Statewide Monitoring

- Pharmacy
  - HHSC is tracking:
    - Prescription drug information daily
    - Claims paid and rejected
    - Ingredient Costs versus Dispensing Fees
    - Brand verses Generic
    - Client and provider calls
- Client and Provider Complaints
- Dental
  - HHSC is tracking:
    - Client and provider Calls
    - Dental and orthodontic Claims
    - Prior authorizations

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Improved Birth Outcomes

- H.B. 1983 requires HHSC to achieve cost savings by adopting and implementing qualifying initiatives to reduce the number of elective non-medically indicated induced deliveries or cesarean sections before 39 weeks gestation.
  - Effective October 1, 2011, Medicaid eliminated reimbursement for non-medically necessary early childbirth inductions.
  - Anecdotal reports indicate a decrease in NICU utilization.
  - Other insurers adopting policy.
  - 12 months post implementation HHSC will analyze policy impacts on provider practices and birth outcomes.

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Improved Birth Outcomes

- Council to Study Neonatal Intensive Care Units (NICU):
  - H.B. 2636, 82nd Legislature, Regular Session, established a council to recommend operating standards improvements and changes to Medicaid NICU care reimbursement.

- May 14, 2012 – second meeting of the NICU council.

- NICU Council is working with the Department of State Health Services (DSHS) to gather survey information on NICU and obstetrics quality of care services.

- NICU Council will incorporate findings into the development of a NICU accreditation process.

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Electronic Visit Verification (EVV)

- EVV is a telephone and computer-based system that electronically verifies that home health visits actually occur and documents the duration of the visit to ensure proper payment.

- October – December 2010 – A request for proposals was released and an award of a contract to Sandata Technologies was made for a mandatory EVV System pilot in DADS Region 9 (with an option to go statewide).

- March 2011 - Pilot was fully operational in Region 9 (West Texas).

- February 2012 – Pilot expanded and was fully operational in Regions 2 (Northwest Texas) and 4 (Upper East Texas).

- August 2012 – Pilot expected to be fully operational in Regions 3 (Metroplex) and 7 (Central Texas).

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Electronic Visit Verification (EVV)

- April 2013 – Pilot expected to be fully operational in the remaining regions (Regions 1, 5, 6, 8, 10 and 11).

- EVV challenges
  - Flexible scheduling for attendants and clients
  - System not currently ADA accessible/ADA compliant
  - Improved training needed to assist consumers and home health agencies

- Implementing provider compliance plan for home health agencies
  - Establishing contract requirements to ensure proper use of the EVV system
  - Establishing liquidated damages when out of compliance

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Maximizing Co-Payments

- Effective March 1, 2012, CHIP copays increased.
- S.B. 7 requires HHSC to implement Medicaid copayments, including copays for nonemergent ED use.
  - Federal regulations will cause implementation of nonemergent ED copays to be complex and costly.
  - In February 2012, HHSC presented options to the Medicaid Reform Waiver Legislative Oversight Committee regarding options to reduce administrative costs through flexibility in co-payment implementation including:
    - Request exemption from requirements to reduce provider payments by the cost sharing amount required of individuals.
    - Request exemption from requirements for states to track all cost sharing collected at the individual level (and instead using the CHIP individual self-reporting method).

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Increasing Fraud, Waste, and Abuse Detection and Claims

New Investigative Strategy

- OIG' investigation time has been reduced from 42 months to 2 months, allowing for more investigations to be conducted.

Reorganization of Enforcement Assets

- OIG has implemented a triage system that prioritizes high-dollar investigations with a high likelihood of recoupment.

Advanced Data Analysis and Pattern Recognition Technology

- New technology allows OIG to analyze data to identify patterns and relationships.
- OIG can monitor service utilization, access to care, and quality of care.
- HHSC can use this data to evaluate and update the capitation payment rates paid to MCO's.
- Helps OIG monitor each MCO and their provider contract performance, and manage and enforce managed care contracts.

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Fraud, Waste, and Abuse: Orthodontic Enforcement

- Since July 2011, the Office of the Inspector General (OIG) has verified credible allegations of fraud against 21 orthodontic providers and suspended payments to those providers.
- OIG has also notified the dental maintenance organizations of the payment suspensions.
- Federal regulations prohibit payment of federal financial participation if states fail to suspend provider payments upon verifying a credible allegation of fraud by that provider.

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Fraud, Waste, and Abuse: Orthodontic Enforcement

- HHSC's fiscal agent is holding $7 million in suspended payments while the orthodontic investigations and administrative proceedings cases remain are in progress.

- OIG issued final notices of overpayments and assessments of penalties to 2 providers totaling $19.1 million.

- OIG issued potential notices of overpayments and assessments of penalties to 4 providers totaling $ 40.6 million.

Independent Assessments: Private Duty Nursing

- S.B. 7 directs HHSC, if cost effective, to develop an objective assessment process for determining need for Medicaid acute nursing services.
- HHSC is partnering with Texas A&M to develop the assessment tool.
- A standardized assessment tool is expected in April 2013.
  - Cost effectiveness will be determined at that time.
- HHSC will work with providers to assure use of the assessment.

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Medicare Equalization

- The 2012-2013 G.A.A directed HHSC to implement Medicare Equalization on January 1, 2012.
- The policy limits payment of Medicare Part B deductibles and coinsurance for dual eligible clients (clients who receive Medicaid and Medicare) to no more than what Medicaid would have paid for the same service.
- HHSC estimates that Medicare Equalization will save over $450 million (GR) for the biennium.
- HHSC continues to evaluate feedback from many providers on the policy and continues to monitor the impact on access to care.

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Medicare Equalization

- Upon gathering provider feedback and analyzing impact on specific services, HHSC has made the following adjustments related to the policy:

  - Cost sharing for renal dialysis for dual eligible clients is paid 5 percent less than the Medicare rate (effective January 1, 2012).

  - Cost sharing for psychiatrists, psychologists, licensed clinical social workers, and two portable x-ray transportation codes are paid at the Medicare rate (effective May 1, 2012).

  - HHSC increased its overall Medicaid rates for cancer medications to 100 percent of the current Medicare rate (effective April 1, 2012).

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Amount, Duration, and Scope

- 2012-13 G.A.A. assumed $45 million in general revenue (GR) savings resulting from changes in the amount, duration, and scope of certain Medicaid benefits.
- Implemented adjustments:
  - Effective January 1, 2012, renal dialysis can be administered on an outpatient basis and no longer requires hospital admission.
    - Estimated biennial savings - $8.7 million in GR.
  - Effective February 1, 2012, reimbursement for infant cranial helmets is limited to cases of medical necessity.
    - Estimated biennial savings - $1.5 million in GR.
- Adjustments in progress:
  - In May 2012, porcelain crowns will be limited to front, permanent teeth.
  - Estimated biennial savings - $2.41 million in GR.

Medical Transportation Program (MTP)

Medical Transportation Program

- Effective April 2011, Federal funds leveraged with approved federal waiver.
- Per Rider 55, S.B. 1, 81st Legislature, the Full-Risk Broker Pilot was implemented in two areas:
  - Houston/Beaumont in March 2012
  - Dallas/Ft. Worth in April 2012
- Strategic redesign of the program is under development.

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Emergency Department (ED) Reductions

- ED Reimbursement Reduction:
  - As of September 1, 2011, 40% reduction applied to Medicaid reimbursement for hospital facility charges for nonemergency ED services.
  - Definition of a nonemergent service is now based on the way the physician codes the visit and allows treating physician to assess the severity of the patient's condition.
  - In May 2012, HHSC will analyze the initial data to evaluate the results of the reduction.

Early Childhood Intervention (ECI) Cost Containment Strategies

- DARS narrowed ECI eligibility criteria. The current criteria are:
  - Has a delay of at least 25% in one or more areas of development (motor, communication, cognition, social-emotional or self-help) or a 33% delay in expressive language only
  - Has a qualifying medically diagnosed condition
  - Has an auditory or visual impairment

  In addition, DARS adopted a single evaluation tool, the Battelle Developmental Inventory II, to ensure consistent determination of eligibility for children with developmental delays.
- DARS revised the ECI family cost share requirements. Changes included:
  - Increasing fees on the family cost share sliding fee scale
  - Requiring families to sign an attestation of family income to ensure consistency in determining ability to pay
  - Requiring families at or above 200% of the FPL to participate (Proposed rule will require participation at 100% of FPL, effective 7/1/12)
  - Requiring families to allow use of their private insurance or pay the maximum monthly fee
- DARS required ECI contractors to directly bill either TMHP or a managed care company for Medicaid covered services. This change transferred the responsibility for collections of Medicaid payments from DARS to ECI contractors.

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Immunizations

- DSHS manages and distributes federal vaccines, recruits and supports children vaccine providers, administers an adult safety net program, and maintains the immunization registry.
- DSHS includes 165 Health Service Regions, 118 Central Offices and 350 Local Health Departments.
- The following populations are eligible for DSHS immunization programs:
  - Medicaid and CHIP, Native American, un- and underinsured children;
  - Uninsured adults (for tetanus,diphtheria,pertussis; hepatitis B; and measles,mumps,rubella).
- DSHS has access to federal contract pricing for vaccine purchases.
- Where vaccines are not available through federal pricing, DSHS uses the state contract price.
  - Vaccine worth $342 million purchased with federal funds is made available to immunizations
  - $36 million in CHIP vaccine funding
  - $6.3 million in General Revenue

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Cost Containment: Hospital Reimbursement

- 8% reduction
- Statewide standard dollar amount (SDA) with add-ons to recognize high-cost circumstances (wage index, trauma, teaching hospitals)
  - For FY 2012 only, $20 million general revenue appropriated to provide a transition for the most affected hospitals
- Outlier payments reduced 10%
- Reduction in payments for non-emergency services provided in hospital emergency departments
- Medical imaging fee schedule (outpatient hospital services)

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Cost Containment: Hospital Outlier Payments

- HHSC adjusts inpatient reimbursement to diagnosis-related group (DRG)hospitals for admissions that meet the criteria for exceptionally high costs (cost outlier) or exceptionally long lengths of stay (day outlier) for clients younger than 21 years of age as of the date of the inpatient admission.

- Effective September 1, 2011, the reimbursement percentage for cost and day outliers changed from 70 percent to 60 percent for Medicaid inpatient hospital admissions.

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Cost Containment: Standard Dollar Amount (SDA) Changes

- Prior to September 1, 2011, Texas Medicaid reimbursed each general acute care hospital based on its costs to provide services (cost-based SDA) and its mix of clients (case mix).

- This cost-based methodology had the potential to reward inefficient and high-cost hospitals and resulted in significant disparities in payments to hospitals for the same services.

- Effective September 1, 2011, Texas Medicaid pays each general acute care hospital a statewide SDA in accordance with Rider 61, plus add-ons for geographical wage variances, teaching programs, and trauma designation.

- A statewide base SDA is intended to eliminate the significant disparities in payment to hospitals for the same services.

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Future Opportunities for Cost Containment

- Medical Transportation Program (MTP):
  - Include administration of MTP in Medicaid managed care contracts, or
  - Implement a statewide full-risk broker model

- Expand STAR+PLUS to the Medicaid Rural Service Area (MRSA):
  - In MRSA, replaces existing STAR program for SSI adults.
  - Replace Community Based Alternatives waiver program operated by DADS.

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Future Opportunities for Cost Containment

- SB 7 – Medicaid Reform:
  - SB 7, Article 13, 82nd Legislature, First Called Session, 2011 directs HHSC to pursue a Medicaid Reform Waiver.
  - This waiver would allow Texas to implement reforms to eligibility, benefits, and long-term care services and implement copayments.

- Dual enrollees savings project:
  - Texas has applied to CMS for a demonstration project to reduce costs through integrated and improved care management of Medicaid/Medicare services for dual eligibles.
  - If awarded, Texas will share the resulting savings with CMS.

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Future Opportunities for Cost Containment

- Adjustments to amount, duration, and scope:
  - Several changes to the administration of physical and occupational therapy services are under consideration including:
    - Prior authorization to verify medical necessity; reduced benefit periods, and changes to how services are evaluated.