



Presentation to the House Appropriations Subcommittee on Article II: Cost Containment Initiatives

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Presentation Overview

- I. Historical Overview of Cost Containment and Durable Medical Equipment
- II. Update on Rider 51, S.B. 1, 83rd Legislature (2013)
- III. Medication Adherence

Historical Overview

- Over the past decade, HHSC has developed and implemented new policies and initiatives to control spending growth in Medicaid and other health and human services programs.
- Since FY 2002, cost containment projects identified by the Legislature and implemented by HHS agencies are estimated to have reduced general revenue spending by over \$4 billion.
- Most recently, the 83rd Legislature directed HHSC to achieve \$400 million in general revenue savings in FY 2014-15 through the implementation of 25 Medicaid cost containment initiatives.
- Current cost containment efforts build upon initiatives implemented in previous biennia.

Historical Overview

Recent HHS Cost Containment Initiatives FY 2010 - 2013 General Revenue Savings (\$ in mil.)

FY 2010-11	
HHSC Rider 59: Medicaid Cost Savings	\$76.5
5% Budget Reduction FY 2010-11	\$205.0
2.5% Budget Reduction FY 2011	\$85.0
Total, FY 2010-11 Cost Containment Initiatives	\$366.5
FY 2012-13	
HHSC Rider 61: Medicaid Funding Reduction	\$355.0
HHSC Rider 51: Managed Care Expansion	\$263.3
Special Provisions, Section 16: Provider Rates	\$486.6
Special Provisions, Section 17: Additional Cost Containment Initiatives	\$576.0
Other Cost Containment Initiatives in H.B. 1	\$80.6
Budget Reduction FY 2012-13	\$207.0
Total, FY 2012-13 Cost Containment Initiatives	\$1,968.5

Historical Overview

DME Cost Containment

HHSC Rider 80 - DME Cost Containment Initiatives FY 2012-13 General Revenue (\$ in mil.)

DME Policy and Rate Changes	GR Savings	Effective Date
Incontinence Supplies – Reduce Quantity Limitations	\$18.2	April 1, 2011
Diabetic Equipment & Supplies – Reduce Quantity Limitations	\$10.9	September 1, 2011
Targeted Rate Reductions	\$25.0	September 1, 2011
Other Rate Reductions (6.5%)	\$34.6	September 1, 2011
Additional Incontinence Supplies (establish a maximum fee and quantity limitation for barrier cream)	\$0.9	January 1, 2012
Subtotal	\$89.7	
DME Adjustments		
Incontinence and Nutrition Supply and other DME rate changes	-\$4.7	March 1, 2012
Subtotal	-\$4.7	
Total, FY 2012-13 DME Cost Savings	\$84.9	

Update on Rider 51

FY 2014 – 2015

- S.B. 1, HHSC Rider 51, 83rd Legislature (2013) requires HHSC to achieve Medicaid savings of \$400 million in general revenue from 25 cost containment initiatives.
- These efforts focus on payment reforms, service delivery and quality improvements, and reduction of fraud and waste.
- A total of 21 initiatives have been fully or partially implemented.
- General revenue cost savings resulting from these initiatives are currently estimated to meet the Rider 51 target of \$400 million.

Update on Rider 51 Managed Care Initiatives

Initiative: Improve care coordination through a capitated managed care program for remaining fee-for-service populations.

- STAR+PLUS will expand to the Medicaid Rural Service Area (MRSA) on September 1, 2014, integrating acute and long-term care services.
- Adults with intellectual and developmental disabilities will begin receiving acute care services through STAR+PLUS on September 1, 2014.
- Mental health rehabilitation and mental health targeted case management services will be carved into managed care (STAR and STAR+PLUS) by September 1, 2014.

Update on Rider 51 Managed Care Initiatives

Initiative: Increase efficiency and reduce fraud in Medicaid transportation service through the most appropriate transportation model, including the transfer of transportation for dialysis patients to the Medical Transportation Program and non-emergency ambulance services.

- The medical transportation program (MTP) currently operates on a fee-for-service basis except in the Dallas/Fort Worth and Houston/Beaumont service delivery areas. MTP services in each of these areas are managed by a non-emergency medical transportation full-risk broker.
- SB 8, 83rd Legislature, directs HHSC to transition MTP into a capitated model beginning September 1, 2014 with services provided on a regional basis through contracted “managed transportation organizations” (MTOs).
- Tentative awards were announced in early April 2014 and contracts are expected to be in place by July 2014 so the new MTOs can begin serving clients in the remainder of the state by September 1, 2014.

Update on Rider 51

Appropriate Utilization

Initiative: Implement statewide monitoring of community care and home health through electronic visit verification in Medicaid FFS and managed care.

- As a result of cost containment efforts by the 82nd Legislature (2011), DADS has implemented electronic visit verification (EVV) for attendant services in select regions.
- Through this new initiative, DADS will expand EVV to remaining regions, and HHSC will implement EVV statewide for attendant services, acute care nursing services, and personal care services (PCS).

Initiative: Strengthen prior authorization requirements.

- HHSC's Managed Care Orthodontia Policy includes benefit limitations on appliances and brackets and requires more in-depth documentation of medical necessity for orthodontia (radiographs, photographs, diagnostic models).

Update on Rider 51 Vendor Drug Program

Initiative: Increase efficiencies in the Vendor Drug Program.

- HHSC has a number of cost containment initiatives related to the Vendor Drug Program (VDP) that are in progress and at various stages of implementation.
- General cost savings initiatives:
 - Develop a new FFS pharmacy reimbursement methodology, resulting in a more competitive ingredient cost;
 - Increase rebate revenues for clinician-administered drugs;
 - Reduce narcotic drug utilization in FFS Medicaid; and
 - Discontinue coverage of barbiturates and benzodiazepines for dual eligible clients.
- Preferred Drug List (PDL) cost savings initiatives:
 - Reduce or eliminate Vendor Drug grandfathering program;
 - Limit the number of preferred drugs in a class on the PDL;
 - Increase compliance in FFS with PDL approval criteria;
 - Require additional clinical prior authorizations in FFS for Attention Deficit Hyperactivity Disorder (ADHD) medications; and
 - Add additional drug classes for review for the PDL.

Update on Rider 51

Improve Birth Outcomes

Initiative: Improve birth outcomes, including access to information and payment reform.

- HHSC will provide Medicaid MCOs with birth record and historical claims data for all women entering the Pregnant Women’s Medicaid Program.
 - This initiative focuses on early identification of mothers at risk for a pre-term birth.
 - The data sharing will allow MCOs to identify members who have had a previous pre-term birth so that timely, targeted care (e.g., 17P drug therapy) can be provided to mothers at risk for repeat pre-term births.
 - The project is entering the final testing phase and is expected to be operational by the end of July 2014.

Update on Rider 51 Quality-Based Payments

Initiative: Implement payment reforms and quality-based payment adjustments in fee-for-service and managed care premiums.

- Potentially Preventable Readmission (PPR) and Potentially Preventable Complication (PPC) Hospital Reimbursement:
 - HHSC applies FFS reimbursement adjustments to hospitals based on PPRs and PPCs.
 - MCO capitation rates are also adjusted based on in-network hospital performance on PPR and PPC rates.
- Pay-for-Quality Program (P4Q):
 - Effective January 2014, 4% of the MCOs' capitation, which is placed at-risk, can be earned back or increased based on performance on quality-based measures including PPRs, potentially preventable emergency department visits (PPVs), and potentially preventable hospital admissions (PPAs).

Update on Rider 51 Quality-Based Payments

Initiative: Implement dually eligible Medicare/Medicaid integrated care model and long-term services and supports quality payment initiative.

- HHSC has received approval from CMS for a fully integrated, capitated approach that involves a three-party agreement between an MCO with an existing STAR+PLUS contract, the state, and CMS for the full array of Medicaid and Medicare services.
- The initiative will test an innovative payment and service delivery model to alleviate the fragmentation and improve coordination of Medicare and Medicaid services for dual eligibles, enhance quality of care and reduce costs for both the state and the federal government.
- The demonstration will be implemented in six counties and is scheduled to begin March 1, 2015 and continue until December 31, 2018.

Update on Rider 51

Appropriate Reimbursement

Initiative: Continue to adjust outpatient Medicaid payments to a fee schedule that is a prospective payment system and that maximizes bundling of outpatient services, including hospital imaging rates.

- HHSC is in the process of implementing an Enhanced Ambulatory Patient Grouping (EAPG) patient classification system which will allow bundled payments and reduce incentives for overutilization found in the cost-based reimbursement methodology.
- HHSC will begin reimbursing MCOs for outpatient hospital payments based on EAPGs by September 1, 2014.

Initiative: Expand efforts to develop more appropriate emergency department hospital rates for non-emergency related visits.

- Beginning September 1, 2013:
 - MCO premiums were reduced to reflect non-payment when a Medicaid client returns to the emergency department for a non-emergency within 36 hours; HHSC is still developing the best approach to implementing this policy in FFS.
 - HHSC implemented a flat rate (125% of physician office visit) for non-urgent emergency department visits for both FFS and managed care.

Update on Rider 51

Appropriate Reimbursement

Initiative: Implement the 30-day inpatient spell of illness in STAR+PLUS.

- MCO contracts have been amended to restore the 30-day spell of illness in STAR+PLUS beginning September 1, 2013.
- Medicaid payment is not made for inpatient services after a client has had 30-days of aggregate inpatient care. The 30-day limit starts over when the client has been out of the hospital 60 consecutive days. The 30-day limit does not apply to children or to inpatient stays related to most transplants.

Initiative: Expand initiatives to pay more appropriately for outlier payments.

- Outlier payments are adjustments made to claims for certain children's inpatient hospital stays that result in extraordinarily high costs or extended lengths of stay.
- FFS and MCO rate reductions of 10% were implemented effective September 1, 2013.

Initiative: Phase down Medicaid rates which are above Medicare rates.

- Rate reductions were implemented for FFS and managed care on September 1, 2013.

Update on Rider 51

Appropriate Reimbursement

Initiative: Develop a more appropriate fee schedule for therapy services, requiring providers to submit the National Provider Identification (NPI) on each claim.

- Beginning September 1, 2013, rates for all acute care therapy services, excluding evaluations and re-evaluations were reduced as follows:
 - 1.5% reduction for services provided in a client's home by either a home health agency or independent provider; and
 - 2.5% reduction for services provided in an office or clinic by either a Comprehensive Outpatient Rehabilitation Center (CORF), Outpatient Rehabilitation Center (ORF) or independent provider.
- HHSC has contracted with Texas A&M to perform an independent review comparing Texas Medicaid's authorization policies, rates, and utilization patterns for pediatric acute therapy (physical, occupational, and speech) to those in other state Medicaid programs and commercial insurance plans. Findings are expected this fall.
- HHSC is developing an interim process regarding NPI submission for therapy providers.

Update on Rider 51 Appropriate Reimbursement

Initiative: Align Texas Home Living with Home and Community-based Services (HCS) rates.

- Texas Home Living and HCS are both FFS programs administered by DADS.
- Beginning September 1, 2013, Texas Home Living rates were reduced to be equal to HCS rates.

Initiative: Enforce appropriate payment practices for non-physician services.

- As recommend by the LBB, HHSC has implemented system changes needed to enforce appropriate payments for physician assistant and nurse practitioner rates at 92% of the physician rate when billing under their Texas Health Steps provider number or as an individually enrolled family planning provider effective January 1, 2014.
- HHSC is also pursuing system changes that will enforce the 92% payment for all advanced practice registered nurses and physician assistants performing under a physician's supervision effective January 1, 2015.

Update on Rider 51 Fraud, Waste, and Abuse

Initiative: Increase fraud, waste, and abuse prevention and detection.

- The Office of Inspector General (OIG) has deployed an advanced graph pattern analysis technology (LYNXeon):
 - Used to increase the detection of Medicaid fraud, waste, and abuse.
 - Utilizes direct data feeds from the Medicaid Management Information System (MMIS). HHSC has ingested over 76 months of data (January 1, 2008 through April 30, 2014).
- OIG has 6 FTEs in its Data Analytics and Fraud Detection Unit.
- LYNXeon cases:
 - Speech therapy
 - Ambulance (Houston area)
 - Ambulance overpayments (phantom runs and emergency up-coding)

Update on Rider 51 Fraud, Waste, and Abuse

- Additional OIG staff authorized by the 83rd Legislature (2013) will allow OIG to:
 - Reduce case backlog;
 - Increase utilization review (UR) nurse positions to conduct UR of hospital and nursing facility services; and
 - Increase third party liability positions to ensure private insurance benefits, rather than Medicaid benefits, are utilized when available.
- Other OIG initiatives include:
 - Coordinating with MCOs on Lock-In program referrals to prevent abuse and overutilization of prescription benefits; and
 - Audits of home health providers to ensure adequate documentation is in place for Medically Dependent Children and Comprehensive Care programs.

Medication Adherence Medication Therapy Management

- H.B. 1, HHSC Rider 49, 82nd Legislature (2011) required HHSC to implement a medication therapy management (MTM) pilot program aimed at reducing adverse drug events and medical costs for high-risk Texas Medicaid FFS clients with a hypertension diagnosis who are on four or more chronic medications. Services were provided April 2012 through December 2013.
- S.B. 1, HHSC Rider 45, 83rd Legislature (2013) expanded MTM services to FFS patients with high risk asthma or chronic obstructive pulmonary disease (COPD). Services will be provided January 2014 through December 2014.
- Through MTM, clients receive at least 5 consultations with a pharmacist, who coordinates with physicians to adjust clients' medications.
- Early results from the first pilot show an estimated cost savings and return on investment. A final report will be produced later in 2014.

Medication Adherence Drug Utilization Review

- Federal law requires states to operate a prospective and retrospective drug utilization review (DUR) program to help improve quality of patient care, medication adherence, and promote cost effectiveness in overall Medicaid health care expenditures.
- For prospective DUR, VDP reviews and implements prior authorization criteria for both clinical appropriateness and cost effectiveness of prescriptions.
- For retrospective DUR, VDP's contractor sends educational letters to practitioners whose prescribing patterns fall outside the normal and nationally accepted practice guidelines.
- MCOs must have a process in place to conduct prospective and retrospective utilization reviews.
- The Drug Utilization Review Board provides guidance and consultation to VDP and approves proposed prospective and retrospective criteria.

Medication Adherence Initiatives in Managed Care

- Medication adherence initiatives currently underway within the Medicaid and CHIP managed care plans include:
 - Medication therapy management (MTM);
 - Prospective and retrospective drug utilization review (DUR);
 - Provider notifications for missed chronic medication refills;
 - RN care coordination for chronic conditions, recent hospital stays, and pregnant women;
 - Psychotropic drug monitoring;
 - Member education;
 - Creation of self-management plans with patients; and
 - Patient refill alerts.
- Future initiatives under consideration by MCOs include diabetes management, incentives for asthma adherence, and partnerships between care management and local pharmacies.