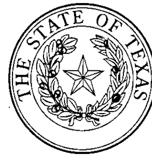
The Modernization of the Texas Medicaid Program

Medicaid Reform Workgroup

Final Report

March 2005



OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

March 11, 2005

The Modernization of the Texas Medicaid Program
Governor's Medicaid Reform Workgroup Final Report

Dear Workgroup Members:

Let me first thank you for your contribution to the development of *The Modernization of the Texas Medicaid Program,* the Medicaid Reform Workgroup's final report. You reviewed and seriously considered more than 340 proposed changes to the Medicaid program, and the dedication with which you worked is truly admirable. This report will provide strong guidance for the future development and improvement of Medicaid in Texas.

As you all learned, many of the Medicaid reforms that were passed by the 78th Texas Legislature have helped to control costs in Medicaid. The new preferred drug list and prior authorization process implemented by Medicaid have generated an estimated $140 million in general revenue for Fiscal Year 2004-2005. Additionally, the creation of the Office of Inspector General and the improvement of fraud and abuse collection efforts generated an estimated $22.4 million in general revenue for Fiscal Year 2004-2005. However, we need to continue this progress, as the rate of growth in the Medicaid program is expected to increase by a projected average of 7 percent for each of the next five years.

This report builds on those programmatic changes. It identifies how Medicaid needs to evolve and improve its operations, suggests new mechanisms for the improvement of care, and guides the future development of the program. Taken as a whole, given the proposals' inherent assumptions, it is estimated that $341 million in gross savings will be generated over the next five years. Net savings will be an estimated $262 million, taking into account the costs associated with certain proposals.

Included in the report is a proposal for a comprehensive review and reevaluation of all the financing mechanisms and funding formulas in Medicaid to determine if they are cost effective for the state and if they promote positive health outcomes. As part of the review of hospital financing mechanisms, the Texas Health and Human Services Commission (HHSC) should evaluate the cost effectiveness of developing a fee schedule, implementing a prospective payment system rate, changing the current percent for outlier payments, or implementing

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Medicare payment policies, rather than the current discount pricing system. Additionally, HHSC should consider uncompensated care as a criterion for Disproportionate Share Hospital funds distribution to hospitals. HHSC should also consider whether an administrative cap for health maintenance organizations that make exceptions for certain quality of care efforts, such as improving client management, would create an incentive for service innovation and improved health outcomes. Finally, HHSC should consider the use of reasonable co-payments for Medicaid for emergency room use as a means to discourage inappropriate use of emergency rooms.

While I believe that the reforms made in this report will move this state a long way toward modernization of the Medicaid program, the reality is that without significant reform in administration and service delivery at the federal level, Texas cannot make more significant reforms of our program. For true modernization of the Medicaid program, Congress should consider proposals that allow state governments to operate their Medicaid programs more like private health insurance plans and allow for innovations like health savings accounts. Ultimately, such reforms should not only be applicable to optional populations, as the expense of this program's mandatory population will bankrupt state budgets.

I look forward to working with each of you to best serve the citizens of this great state.

Sincerely,

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Acronyms Used Throughout the Report

AAA	Area Agencies on Aging
AAP	American Academy of Pediatrics
ABF	Access-Based Fees
ACT	Assistive Community Treatment
AHEC	Area Health Education Centers
AHRQ	Agency for Healthcare Research and Quality
ASO	Administrative Services Only
AWP	Average Wholesale Price
BBA	Balanced Budget Act
BIPA	Benefits Improvement and Protection Act
CBA	Community Based Alternatives
CDS	Consumer Directed Services
CHIP	Children's Health Insurance Program
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare and Medicaid Services
CPOE	Computerized Physician Order Entry
CORF	Comprehensive Outpatient Rehabilitation Facility
CSHCN	Children with Special Health Care Needs
CWP	Consolidated Waiver Pilot
DADS	Department of Aging and Disability Services
DARS	Department of Assistive and Rehabilitative Services
DBMD	Deaf-Blind with Multiple Disabilities
DFPS	Department of Family and Protective Services
DHHS	U.S. Department of Health and Human Services
DM	Disease Management
DME	Durable Medical Equipment
DSH	Disproportionate Share Hospital
DRG	Diagnosis Related Group
DSS	Decision Support System
DUA	Data Use Agreement
EDB	Electronic Database
E-ICU	Electronic Intensive Care Unit Monitoring Program
EMTALA	Emergency Medical Treatment and Active Labor Act
EPO	Exclusive Provider Organization
EQRO	External Quality Review Organization
ER	Emergency Room
ERS	Employees Retirement System
ESRD	End Stage Renal Disease
FFS	Fee-for-Service
FMAP	Federal Matching Assistance Program
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent
FY	Fiscal Year
GME	Graduate Medical Education

GI	General Investigations
HHS	Health and Human Services (Enterprise)
HHSC	Health and Human Services Commission
HIPAA	Health Improvement Performance and Accountability Act
HMO	Health Maintenance Organization
HRSA	Health Resource and Services Administration
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
ICMS	Integrated Case Management System
ICU	Intensive Care Unit
IGT	Intergovernmental Transfers
IMD	Institutions of Mental Disease
IME	Incurred Medical Expense
IVR	Integrated Voice Recognition
MCO	Managed Care Organization
MDCP	Medically Dependent Children's Program
MDS	Minimum Data Set
MHMR	Mental Health and Mental Retardation
MMIS	Medicaid Management Information System
MPI	Medicaid Program Integrity
MOU	Memorandum of Understanding
MTP	Medical Transportation Program
OB/GYN	Obstetrical and Gynecological
OIG	Office of Inspector General
OON	Out-of-Network
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PIP	Performance Improvement Plan
PPS	Prospective Payment System
QR	Quality Review
RBVS	Resource-Based Relative Value Scale
RFP	Request for Proposals
R&S	Remittance and Status Report
RVU	Relative Value Unit
SDA	Standard Dollar Amount
SIU	Special Investigations Units
SSI	Supplemental Security Income
STAR	State of Texas Access Reform Program
STAR+PLUS	Enhanced State of Texas Access Reform Program
TACHC	Texas Association of Community Health Centers
TANF	Temporary Assistance for Needy Families
TDI	Texas Department of Insurance
TEA	Texas Education Agency
THSteps	Texas Health Steps Program
TILE	Texas Index of Level of Effort
TMA	Texas Medical Association
TMHP	Texas Medicaid and Healthcare Partnership
TMPPM	Texas Medicaid Provider Procedures Manual

TRS	Teacher's Retirement System
TxDot	Texas Department of Transportation
TXPEC	Texas Partnership for End-of-Life Care
UM	Utilization Management
USC	Universal Services Card
UPL	Upper Payment Limit
WIC	Women, Infants, and Children Program

Executive Summary

Charge to the Medicaid Program Reform Workgroup

On October 20, 2003, Governor Rick Perry invited the Texas Hospital Association, the Texas Medical Association, the Texas Association of Health Plans, and others to participate in a Medicaid program reform workgroup. The workgroup was charged to examine the Medicaid program's design, utilization, and reimbursement methodologies and to outline possible cost containment and reform recommendations. The workgroup was also asked to consider the current fiscal challenges facing the State and to consider the need for greater budget certainty. Governor Perry outlined the following fundamental principles for consideration in this review process.

- *Quality*: The Medicaid program should maintain an adequate and diverse network of providers, and clients should have access to quality primary and specialty health care services. Clients should have a "medical home" to provide them with assistance in making responsible and informed health care decisions.

- *Accountability*: Texas taxpayers and Medicaid program participants should be assured accountability among all elements of the Medicaid system. Additionally, any incentives within the program should promote accountability among providers, vendors and recipients.

- *Balance*: The Medicaid program serves many different types of clients with a variety of needs through a diverse provider base. The program should be developed in a way that takes into account the impact of changes on all parties involved in order to successfully maintain balance between competing interests.

- *Efficiency*: The Medicaid program should have efficient and cost effective operations while promoting improved health care quality. Regulatory requirements should be simplified and the program should ensure cost-effective, proactive, and appropriate use of medical services.

- *Opportunity*: Texas should optimize the use of federal funding opportunities as well as encourage innovative collaborations between the public and private sectors to address shared health goals.

The Process

The workgroup began their work on November 6, 2003. The workgroup was briefed with the most current research and information regarding reforms of other Medicaid programs across the country (see Table 1).

Table 1
Additional Resources for Medicaid Policy Research

- **State Actions to Control Health Care Costs,** National Governor's Association, Center for Best Practices, Contacts Brendan Krause, November 2003.
http://www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_6125,00.html
- **Medicaid Reform Proposal, Draft**, National Conference of State Legislatures.
http://www.ncsl.org/statefed/health/MARefProp.htm
- **Why Are States' Medicaid Expenditures Riding**, Leighton Ku and Matthew Broaddus, Center on Budget and Policy Priorities, January 13, 2003.
http://www.cbpp.org/1-13-03health.pdf
- **Medicaid and Other State Healthcare Issues: Current Trends**, June 2003, National Association of State Budget Officers. www.NASBO.org
- **State Health Care Cost Containment Ideas,** prepared by the Standing Committee on Health, National Conference of State Legislatures. July 2003.

However, it became immediately apparent that the efforts of the workgroup were going to be on the cutting edge of Medicaid reforms. An overview of the research showed that of the top 10 reform proposals for Medicaid, Texas had already implemented or was in the process of implementing them (see Table 2).

Facing the challenge of breaking new ground on reform policies, the workgroup issued an informal "request for reform proposals." These proposals could be submitted by any citizen, group, provider, advocate, agency, or other interested party. The proposals had to be submitted on a one-page work sheet for consideration to the Office of the Governor by January 16, 2004. The workgroup received over 340 proposals for consideration. Anonymous proposals were accepted.

The proposals were grouped into the following categories for consideration at a series of six public meetings of the workgroup:

- Medicaid program administration;
- Medicaid financing;
- Medicaid long term care;
- Medicaid managed care;
- Federal issues, women's health, expand services, other Medicaid issues, and non-Medicaid issues; and
- Mental health, ER utilization, patient education, and research.

Table 2
Medicaid: 10 Fixes That Work

1. Reform Long Term Care
2. Focus on the Sickest People
3. Emphasize Prevention
4. Reduce Prescription Drug Costs
5. Investigate Fraud and Abuse
6. Use Electronic Records
7. Get the Most Out of Federal Funding
8. Leverage Federal Flexibility
9. Evaluate the Program
10. Make Medicaid the Payer of Last Resort

Source: King, Martha and Dianna Gordon, March 2004. *Medicaid: 10 Fixes that Work of all the Reforms States Have Tried, These Are The Ones That Hold The Most Promise,"* State Legislatures, pages 14-18.

For each category, a briefing document was prepared which included the proposals for consideration and a one-page summary of the proposal. The summaries were prepared by Medicaid program staff and other agency staff and contained additional information regarding the proposal.

At each of the six public meetings the staff of the Health and Human Services Commission (HHSC) and other agencies interpreted the intended meaning of the proposals submitted; provided a current status of the proposal being considered; and provided a preliminary estimate of cost savings for each proposal. Public input on the proposals was presented at the end of each meeting and the workgroup members were then asked to vote in favor of, against, or for no action on each proposal.

The deliberations regarding the proposals and results of the voting are provided throughout this report. Those proposals supported by the workgroup comprise the major chapters of this report and have been used as guidance and direction for recommendation development. A list of unsupported proposals by the workgroup is included in Appendix 2. A list of proposals the workgroup decided not to consider favorably or unfavorably is included in Appendix 3. A list of proposed issues supported by the workgroup but not directly related to the Medicaid program is included in Appendix 4.

Several proposals recommending the expansion of Medicaid services were submitted. These proposals were considered through the same process as the other proposals. Instead of voting for or against them, the workgroup members were asked to rank these proposals in order of priority. A table ordering these proposals by priority ranking is included in Appendix 5.

In addition to the formal review of the Medicaid program, the workgroup also spent one meeting considering broad-based health policy issues. The Texas Department of Insurance briefed the workgroup on the current status of their research and efforts to quantify and develop solutions to the problem of the uninsured in Texas. They also considered how the state might develop a long-term mechanism for developing a more comprehensive health care policy agenda.

The workgroup members discussed these issues at length. There was general agreement that without longer-term visions for health care policy in this state permanent solutions to the challenges facing the health care system would be difficult to identify and implement. However, there was not agreement on how to develop that vision. Strong differences of opinion surfaced as the scope of the state's authority and responsibility for the health care system's problems was discussed. Additionally, there was little consensus on how such a vision for health policy could be developed in a way that takes into account the varied and diverse interests of all stakeholders in the system.

Issues

This report describes the most consistent themes identified by the workgroup's efforts, which were grouped into the following eight issues:

Issue I: Federal Mandates, Funding, and Innovation

Reduce federal mandates and cost shifts that limit Texas' ability to serve its citizens and support flexibility, innovation and overall funding levels that more accurately reflect the state's population.

Proposals approved by the workgroup include working with Congress to update the federal funding formula to more accurately reflect the needs and conditions of Texas's Medicaid population; working through the Texas Office of State Federal Relations to seek reform of the Emergency Treatment and Active Labor Act (EMTALA) to more appropriately regulate emergency department use; working with Congress and the Centers for Medicare and Medicaid Services (CMS) on key implementation issues for the new federal Medicare prescription drug law; working with CMS to eliminate Medicare's three-day hospital stay requirement prior to nursing home placement; and automating the survey and complaint deficiencies system for nursing homes to more efficiently use complaint information for follow-up.

Issue II: Financing

The Medicaid program financing system should be revised to ensure the efficient and effective use of state funds and allow for additional federal funds matching.

The workgroup heard about several inefficiencies in the current Medicaid financing formulas. These inefficiencies have both positive and negative impacts on various provider groups, as well as the Medicaid program. There was consensus on the need to make funding mechanisms more efficient and reflect more accurately the costs borne by all program participants.

Issue III: Managed Care

Managed care in the Medicaid program should be as efficient as possible and provide effective and appropriate care.

The proposals approved by the workgroup regarding Medicaid managed care recommendations focus on two primary areas: 1) improving how the state administers managed care programs and 2) improving the delivery of health care services to Medicaid patients enrolled in managed care plans.

Issue IV: Long-Term Care

The Medicaid long-term care system should provide the broadest array of choices possible for consumers, while ensuring that services are delivered in a way that is cost-effective and make the best use of available funds.

The workgroup heard a number of concerns of fragmentation in the long-term care delivery system and that costs within the program are not well managed. Considering the need to prepare the Medicaid long-term care system for the aging of Texas, it will be critical for the state to develop mechanisms to ensure services are delivered efficiently while offering a continuum of services that allow for consumer choices.

Issue V: Education

Necessary information regarding the appropriate use of Medicaid by all participants in the program including clients, providers, community partners, and administrative partners should be more widely available in a consistent format that is comprehensive and understandable so that the clients and partners are able to identify their appropriate roles in the program and optimize the programs' resources more efficiently.

The workgroup received many proposals that called for the education of every partner in the Medicaid program about the appropriate utilization of the programs' resources. It was suggested that clients receive more education on appropriate emergency room utilization, prenatal care, and available services. It was also suggested that providers should receive additional education on evidence-based care management practices and on appropriate use of program services. The workgroup was recommended community partners and providers for these educational efforts and to take advantage of other existing efforts to educate all Texans on positive health outcomes. Additionally, it was also suggested to the workgroup that the administrative partners should be encouraged to develop more effective educational material for clients and providers, and work with local communities in this effort.

Issue VI: Administrative Burdens

The administrative burdens placed on clients, providers, and other partners in the Medicaid program should be significantly reduced. Medicaid should take advantage of every opportunity to use technology and efficient business practices to decrease the administrative burdens borne by all partners in the program.

The workgroup heard many complaints about the administrative burdens that clients, providers, and other Medicaid partners face in the program. The workgroup also received information on how the use of technology can create efficiencies and improve quality in the Medicaid program.

Issue VII: Utilization Management Services

The medical and case management provided to Medicaid clients should be more effectively coordinated to eliminate duplication, eliminate barriers to services, and to ensure the most appropriate utilization of services.

Throughout the public meeting process, the workgroup consistently heard about significant inefficiencies in the case management, care coordination, and the medical management of clients. These inefficiencies create duplication of services, present barriers to accessing other services, and encourage inappropriate utilization. Such problems have developed over time, as multiple programs and systems were created to address particular issues that were identified and solutions implemented in a piecemeal fashion. The need for a consistent mechanism for coordination of these services was evident to the workgroup.

Issue VIII: Data Analysis and Policy Information

Medicaid data should be analyzed and utilized more effectively to ensure more informed decisions are made regarding program structure and service provision, and to enhance the quality and effectiveness of the program.

The workgroup learned that the Medicaid program collects data and information regarding clients, providers, health plans, claims paid, services provided, and systems used. However, the workgroup also learned that there are limited mechanisms through which this information can consistently and effectively be analyzed and then recycled back through the program's decision-making processes.

Conclusions

The issues and recommendations identified in this report describe Medicaid reforms that can be achieved within the next two to five years. Upon implementation of this plan, the Texas Medicaid program will operate as effectively as possible, will be significantly more efficient, and will provide better health outcomes for clients in the program.

Issue I: Federal Mandates, Funding, and Innovation

Reduce federal mandates and cost shifts that limit Texas' ability to serve its citizens and support flexibility, innovation and overall funding levels that more accurately reflect the state's population.

Proposals approved by the workgroup include working with Congress to update the federal funding formula to more accurately reflect the needs and conditions of Texas's Medicaid population; working through the Texas Office of State Federal Relations to seek reform of the Emergency Treatment and Active Labor Act (EMTALA) to more appropriately regulate emergency department use; working with Congress and the Centers for Medicare and Medicaid Services (CMS) on key implementation issues for the new federal Medicare prescription drug law; working with CMS to eliminate Medicare's three-day hospital stay requirement prior to nursing home placement; and automating the survey and complaint deficiencies system for nursing homes to more efficiently use complaint information for follow-up.

WORKGROUP RECOMMENED HEALTH CARE REFORMS:

→ Update the Federal Medicaid Assistance Percentage (FMAP) Formula

Most federal requirements related to Medicaid specify the people who must be served and the amount of cost-sharing the federal government will provide each state. At the heart of cost-sharing is the federal medical assistance percentage (FMAP) formula, which drives the amount of matching funds the state must provide to serve its Medicaid population and draw federal Medicaid funds.

The current FMAP formula is based on the state's *per capita* personal income, measured against the national *per capita* personal income from a three-year rolling average. The way the formula is set up means that it cannot reflect changes in the state's economic circumstances when they occur. For example, when the economy was slowing down in the 2001-2002 period and many people were losing jobs, the state's FMAP formula reflected a three-year prior period when personal income in the state was growing. Thus, the FMAP reflected an outdated time period and provided inadequate support to the state.

1. Base the FMAP formula on the rate of poverty, not *per capita* personal income, to increase the amount of federal cost sharing and reduce the amount of state match required to pay for Medicaid health care services.

The rate of poverty represents the percent of the population living below the official poverty line. Between 1998 and 2000, Texas had the seventh-highest rate of poverty among the 50 states and the second-largest poverty population in the nation. More than 40 states had lower poverty rates than Texas, yet roughly 20 states had FMAPs higher than Texas because of the formula based on *per capita* income.

Even minor changes in the FMAP formula can significantly increase the level of federal funding to Texas. In the spring of 2003, the United States Congress passed the Jobs and Growth Tax Relief Reconciliation Act of 2003, which temporarily increased the FMAP rate for all states, recognizing the impact of the economic downturn on states' budgets and the effect it was having on Medicaid programs across the country. The temporary fiscal relief added 2.95 percentage points to each state's FMAP for the last two quarters of federal fiscal year 2003 and the first three quarters of federal fiscal year 2004. This increased FMAP translated to an additional $524.6 million in federal Medicaid funds over that five-quarter period.

FMAP Action Plan

Step 1: Continue to build coalitions in support of changes to the current FMAP formula so that it more accurately reflects currents needs, economic conditions, and demographics.

→ Reform the Emergency Medical Treatment and Active Labor Act (EMTALA)

The federal law that affects the way that Medicaid is implemented in hospital emergency departments is the Emergency Management Treatment and Labor Act (EMTALA). The law was promulgated to combat the discriminatory practice of some hospitals transferring, discharging, or refusing to treat indigent patients coming to emergency departments because of the high cost associated with diagnosing and treating these patients with emergency medical conditions. The law applies to all Medicare participating hospitals and physicians who work in those hospitals, but it protects anyone who goes to a hospital seeking emergency services. EMTALA requires that hospitals provide a medical screening exam to anyone who comes to an emergency department for medical assistance in order to determine if an emergency condition exists.

Although a hospital is not required to provide care if an initial exam does not prove an emergency condition, most hospitals still provide care to non-emergency patients in their emergency departments. In these cases, the screening exam is a major step in providing treatment for the condition. Hospitals are also concerned about litigation from patients and penalties and fines under EMTALA.

1. Clarify EMTALA to allow more effective triage utilization in emergency departments to send non-emergency patients to clinics for care. This action

would provide relief for emergency departments, allowing them to concentrate on patients truly needing emergency attention.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) addresses some issues related to the implementation of EMTALA. One improvement requires emergency services provided to screen and stabilize a Medicare beneficiary furnished after January 1, 2004, be evaluated by the U.S. Secretary of Health and Human Services for Medicare's "reasonable and necessary" requirement on the basis of information available to the treating physician and practitioner at the time services are ordered. (This includes the patient's presenting symptoms or complaint and not the patient's principle diagnosis.) This means that in the case of an EMTALA investigation, the actions of the treating physician and hospital would be considered based on the existing medical condition of the patient and expressed reason for the visit to determine whether the patient had an emergency for which treatment was necessary.

Another improvement in the law is the establishment of a 19-member technical advisory group under specified requirements to review issues related to EMTALA. The advisory group includes Centers for Medicare and Medicaid Services (CMS) staff, the Department of Health and Human Services (DHHS) Inspector General, hospital representatives who have EMTALA experience, practicing physicians, and patient representatives. The advisory group will review EMTALA regulations; provide advice and recommendations to the Secretary; solicit public comments from interested parties; and disseminate information on the application of the EMTALA regulations. This advisory group is a useful agent to bring forward recommendations at the federal level.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 also includes the modification of requirements for medical screening exams, notification to providers when an EMTALA investigation is closed, provision for the federal government to cover a portion of un-reimbursed costs of emergency medical care for illegal aliens, and adds a prior review by peer review organizations in EMTALA cases before termination of a hospital's Medicare participation.

EMTALA Action Plan

Step 1: Monitor federal legislation.

Step 2: Engage an EMTALA Advisory Group on issues impacting Texas hospitals.

Step 3: Monitor implementation of federal payments to Texas providers for un-reimbursed costs of emergency medical care for illegal aliens.

→ Amend Provisions in Medicaid-Medicare Dual-Eligible Coverage

Medicare is the federal health insurance program for people age 65 or older, certain people under 65 who have disabilities, and people with end-stage renal disease. Like Medicaid, it is a major payer of hospital care. For eligible low-income people over age 65, the Medicaid program pays for Medicare premiums and cost-sharing. These individuals are referred to as Medicaid-Medicare dual-eligibles.

Texas' dual eligibles are 12 percent of the Texas Medicaid population and almost 36 percent of the state Medicaid program expenditures. The cost to the state for prescription drugs for dual-eligible beneficiaries alone totaled $724 million in 2002. The state cost for Medicare premiums, prescription drugs, medical transportation, and long-term care and other services for dual-eligibles, was $4.019 billion in 2002.

Medicare Part D Prescription Drug Benefit

The Medicare Prescription Drug bill signed into law in 2003 creates a new voluntary prescription drug program for Medicare beneficiaries beginning on January 1, 2006, including those eligible for Medicaid. Prescription drug coverage will be provided through private plans, whether through drug-only plans or as part of Medicare managed care.

In exchange for the inclusion of dual-eligibles in the Medicare prescription drug program, states will be required to pay the federal government a “clawback” amount on a monthly basis based on a number of factors. Although Texas could realize savings over the ten-year life of the program, the impact is variable based on the data used to calculate the federal clawback. Potential savings may not be realized if Texas faces additional dual-eligible caseload growth as a result of the desirability of the new drug benefit and from administration costs related to outreach and enrollment activities to educate beneficiaries and encourage them to enroll in the new program. Texas’ 2006 clawback amount per dual-eligible will be determined in 2005.

Beginning January 1, 2006, the state will no longer be permitted to draw federal matching dollars for Part D covered drugs for full dual-eligibles who currently receive drug coverage through Medicaid (approximately 316,000 as of January 1, 2005). Medicaid drug coverage for these 316,000 full dual-eligibles will be turned-off effective midnight, December 31, 2005. CMS is required to auto-enroll this population into an appropriate Part D plan and subsidize their premiums and cost-sharing requirements. These clients will be enrolled and subsidized for coverage in the lowest cost plans. Other dual-eligibles who do not currently receive the Medicaid drug benefit (approximately 163,000 other dual-eligibles) will be deemed eligible for the low-income subsidy under Medicare Part D, but must select and enroll in a plan (i.e., they will not be auto-enrolled).

Key issues for Texas include:

- Providing flexibility in the mechanism ("clawback") to fund part of Medicare drug benefit costs for recipients eligible for Medicaid and Medicare services ("dual eligibles"); allowing states the option to use a base year later than 2003 if it would better reflect cost savings implemented by Texas and other states;
- Clarifying the federal-state roles and responsibilities in providing eligibility determination for subsidies that will assist low-income persons with the new coverage. States should be allowed to choose one of two options -- performing the eligibility determinations or relying on the federal Social Security Administration; and
- Additional costs related to administration and outreach.

Medicare Part D Prescription Drug Benefit Action Plan

Step 1: Monitor implementation of the Medicare Prescription Drug Bill and continue to educate the Texas Congressional Delegation and CMS on key Texas issues identified above through HHSC and the Texas Office of State-Federal Relations.

Step 2: Continue to build coalitions with other states.

Step 3: Develop a state outreach and communications plan for dual-eligibles and other affected populations.

HHSC staff are currently developing an outreach plan to help those transitioning from Medicaid prescription drug coverage to Medicare Part D better understand how to access their new coverage and assist other low-income individuals affected by the creation of Part D. Outreach activities will be focused on three distinct populations:

A. **Full dual-eligibles**, i.e., those individuals who get their drugs from Medicaid today and will be getting their drugs from Medicare starting in 2006. This group will be auto-enrolled by CMS by January 1, 2006, if they do not choose a plan. The key message for this group is informing them of the changes in their Medicaid coverage and their options for changing plans if they are not happy with the plan into which they were auto-enrolled.

B. **Other dual-eligibles**, i.e., those individuals who have Medicare and some attachment to Medicaid, but are not getting Medicaid drug coverage. These individuals will be deemed eligible for the Part D low-income subsidy. One key effort for this group will be informing them of access to this new drug benefit. Because Texas Medicaid shares their incurred health and long term care costs, access to the new drug benefit has the potential to reduce Medicaid health and long-term care expenditures.

C. **State-Funded pharmacy programs**: For Medicare-only clients who receive assistance with medications through state-funded programs such as Kidney Health and new generation medications, the key is informing them of the new benefit and assisting them in completing the application for the low-income subsidy.

Step 4: Explore support for additional administrative funding from CMS for outreach.

CMS has not provided any designated outreach funding for dual-eligible clients. Any outreach activities to dual-eligible clients (full and other dual-eligible individuals) are considered administrative activities and eligible for federal matching dollars at the administrative rate (50 federal/50 state). No additional dollars designated for outreach are anticipated.

CMS is providing funds for outreach to state pharmacy assistance programs. In October 2004, CMS announced it would provide transition grants to states with existing pharmacy assistance programs, such as Texas' Kidney Health program. Grants can be used to provide technical assistance, phone support, and counseling to assist clients with selecting and enrolling in Part D plans. The Kidney Health program will receive about $900,000 in fiscal year 2005 and an additional $900,000 in fiscal year 2006 for outreach activities associated with their clients. The use of these funds is strictly limited to outreach activities associated with the pharmacy assistance program and its clients.

The staff working on outreach will coordinate messages, material development, and other activities across the Medicaid population and the state pharmacy assistance program population.

Nursing Facility Care

Although all medical services for dual-eligibles are covered by Medicare, there are certain policies that shift costs back to the Medicaid program. An example of this cost-shift is the Medicare program's requirement for a person to have a three-day hospital stay immediately before nursing facility admission for that person to be eligible for Medicare coverage. If a dual-eligible individual stays in the hospital less than three days, the
Medicaid program is responsible for all nursing facility costs.

1. Eliminate Medicare's three-day hospital stay requirement before admitting a dual-eligible individual to a nursing facility.

Making this change would mean that Medicare would pay for nursing home care up to the first 100 days, the limit on the Medicare benefit, which would delay nursing home costs for the Medicaid program until after the first 100 days.

Dual-Eligible Nursing Facility Coverage Action Plan

Step 1: Contact CMS about removing or altering the federal regulation. (Timeline: 1 month)

→ Regulate Nursing Facilities

CMS is working to automate the process that nursing facilities use to respond to the surveys and complaint deficiency with their plans of correction. While state law requires that every effort be made to get a complainant's name and contact information, an individual has the right to make an anonymous complaint. Federal law also requires that the state make every effort to protect the complainant's anonymity and privacy and requires that the state review all allegations regardless of source.

At the state level, complaints are ranked in priority, so those that are not high priority may not be investigated immediately. There may, however, be additional steps in the desk review process that can be implemented that would eliminate the unnecessary use of Medicaid funds and investigators' time on an invalid complaint. Complaints that may be the result of retaliation are considered in that context, such as the example of a nursing facility employee who has been fired and files a false complaint of abuse against his former employer in retaliation for the firing.

1. Automate nursing home surveys and complaint deficiencies.

Automating Nursing Facility Surveys and Complaints Action Plan

Step 1: Assess CMS's January 14, 2005, clarification letter regarding the electronic format to be used in issuing the Statement of Deficiencies Report to providers. (Timeline: 1-2 months)

Step 2: Identify automation issues. (Timeline: 3-4 months)

Step 3: Implement the use of the electronic Statement of Deficiencies Report in limited scope to enable identification and address issues that center on the ability of the provider to alter information in the "Summary Statement of Deficiencies" column on the report. (Timeline: 6-8 months)

Step 4: Implement an electronic format statewide (always at the optional choice of the provider). (Timeline: 8-10 months).

2. Require more identifying information for follow-up on complaints.

Identifying Information Action Plan

Step 1: Identify any additional steps in the desk review process that can be implemented that would eliminate the unnecessary use of Medicaid funds and investigators' time on an invalid complaint. (Timeline: 9-10 months)

Step 2: Develop policies and procedures to implement new processes in conjunction with input from stakeholders. (Timeline: 11-12 months)

Step 3: Train staff on new procedures. (Timeline: 1-2 months)

→ Encourage Medicaid Program Innovation

Texas strongly believes that the federal government should grant states a high degree of flexibility in administering assistance to their citizens through programs such as Medicaid. Greater flexibility will allow essential services to be provided within realistic state and federal resources, with the state and federal governments both benefiting from potential fiscal efficiencies. Examples of program innovation include flexible benefit packages and the ability to subsidize employer insurance when cost effective. States should be allowed to seek federal approval through state plan amendments in lieu of more cumbersome waiver applications.

1. Continue to seek federal authority for states to creatively design and manage their Medicaid programs.

State Program Design and Management Action Plan

Step 1: Continue to work with Congress to authorize CMS to approve program innovation through Medicaid state plan amendments. (Timeline: Ongoing)

Step 2: Continue to work with coalitions, such as other states, to demonstrate the need for a more sustainable long-term Medicaid program through more flexible state innovations. (Timeline: Ongoing)

Fiscal Implications

The proposals recommended in this chapter require advocating at the federal level for changes to federal rules that would more favorably affect the state Medicaid program. If these rule changes are successfully implemented, there could be significant savings to the state from increased federal participation. For example, changing the FMAP and making changes to the EMTALA program would positively impact the state Medicaid program. However, without knowing more specifically what kinds of reforms might occur, it is impossible to predict actual savings. With specific regard to

Medicare Part D policies, it is difficult to predict what savings may be possible within this part of the program for the state because of the changing federal environment regarding federal policies.

Issue II: Financing

The Medicaid program financing system should be revised to ensure the efficient and effective use of state funds and allow for additional federal funds matching.

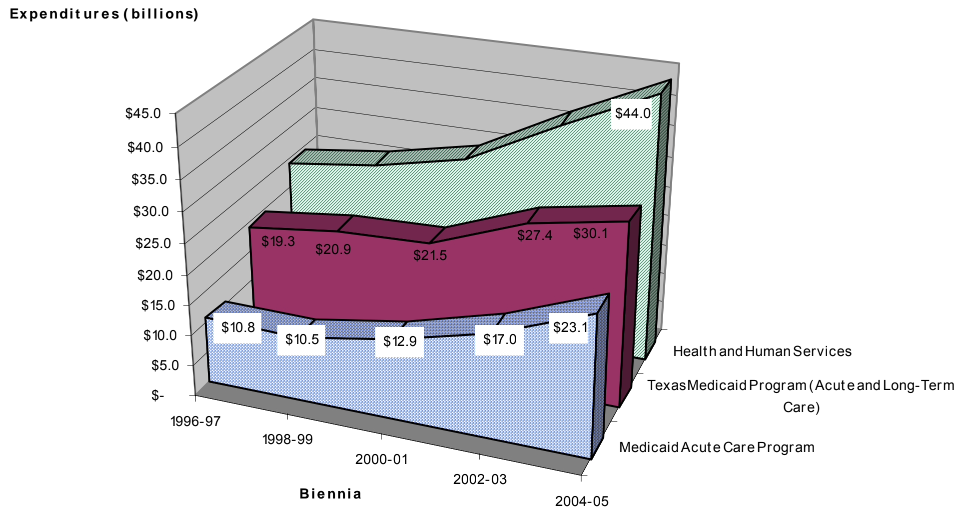
The workgroup heard about several inefficiencies in the current Medicaid financing formula. These inefficiencies have both positive and negative impacts on various provider groups, as well as the Medicaid program. There was consensus on the need to make funding mechanisms more efficient and reflect more accurately the costs borne by all program participants. It was clear that relevant and affected stakeholders should be included in any process developed to change the payment system, however, the process for reforming the finance system should include stakeholder input without being dependent upon complete stakeholder agreement for adoption of changes.

Ultimately, the state must balance the necessity of being a good steward of public money with the goal of the Medicaid program to provide health care services to the poorest and most vulnerable portion of the population. Total state and federal expenditures for the Texas Medicaid program have increased by one-half from $19.2 billion to $30.1 billion in the ten-year period between 1996 and 2005 (see Figure 1).

To be a good steward, the workgroup felt that the state should reconsider the financing mechanisms currently used in the Medicaid program to purchase services. The proposals supported by the workgroup suggest that financing mechanisms should be designed to promote state goals in the Medicaid program. The finance mechanisms should more accurately reflect the costs of services, and should promote and support practices in the program that are the most cost effective and appropriate. For example, the state could better utilize Medicaid program funds if it created incentives through new payment mechanisms for behaviors it wants to encourage, like appropriate primary care visits versus emergency room visits and other less expensive, preventive procedures. Additionally, the state could encourage doctors to utilize lower cost procedures and treatments when appropriate. Encouraging these changes can make a meaningful difference toward enhancing health outcomes and ensuring better state funds utilization.

Figure 1

Comparison of Medicaid Acute Care, Texas Medicaid, and Total Health and Human Services Expenditures (All Funds), 1996-2005



Source: Legislative Budget Board, Legislative Budget Estimates (1998-99 biennium, 2000-01 biennium, 2002-03 biennium, 2004-05 biennium, 2006-07 biennium).

Assessing Current Hospital Reimbursement Methodologies: An Overview

Many of the proposals relating to hospital payments cannot be considered independently of each other. Because of the relationship among these payment sources, increasing one can impact the amount that a hospital is eligible to receive from another source. For example, increasing inpatient or outpatient reimbursements could decrease the amount of Disproportionate Share Hospital (DSH) or Upper Payment Level (UPL) funding a hospital can receive. Altering hospital payment methodologies can also shift payments from one group of hospitals to another. Hospital funding methodologies include inpatient and outpatient reimbursements as well as UPL funding, graduate medical education (GME) funding, and DSH funding. However, not every hospital is eligible for all of the different funding sources beyond Medicaid inpatient and outpatient reimbursements for providing medical care to Medicaid clients. UPL, GME, and DSH are hospital-specific funding sources granted to hospitals that meet specific eligibility criteria.

Inpatient Hospital Reimbursement Rates

General acute care hospital reimbursement rates for non-managed care and fee-for-service (FFS) beneficiaries are set using a prospective payment system (PPS) based upon Medicare's diagnosis related groups (DRG). DRG payments consist of three main components: the standard dollar amount (SDA), the DRG case weight, and outliers.

- The SDA approximates a hospital's standardized average cost of treating a Medicaid inpatient admission and is specific to each hospital. A hospital's Medicaid claims and audit cost reports are used to set the SDA for the base year.
- The case weight represents the average resources required to care for cases in a particular DRG relative to the average hospital resource expenditures for all Texas Medicaid DRGs.
- Outlier payments are payments made in addition to the base DRG payment for clients under age 21 whose treatments are exceptionally costly, or who have long lengths of stay.

Outpatient Hospital Reimbursement Rates

Outpatient hospital reimbursement rates for non-managed care and FFS beneficiaries are determined retrospectively on a cost-based system. An interim payment rate is used, subject to cost settlement at year-end. There is a discount factor applied to each outpatient payment and then the final rate is determined. New outpatient hospital rates were implemented for "high volume providers" on October 1, 2001, increasing the amount of allowable costs paid to these providers from 80.3 percent to 84.48 percent. The 77th legislature appropriated for the 2002-2003 biennium $35 million in general revenue funds to support this change. Providers not designated as "high volume" Medicaid providers are still reimbursed at 80.3 percent of their allowable Medicaid outpatient costs.

Upper Payment Limit

States have broad flexibility in setting the Medicaid rates that are paid to hospitals and other providers. Federal Medicaid rules, however, specify that state Medicaid payments to state-owned facilities and all other providers cannot exceed the amount Medicare would have paid for the same services. These rules are known as the "upper payment limit" (UPL). These rules also specify that states cannot pay individual hospitals more than the amount of their aggregate charges for providing services to Medicaid beneficiaries.

States typically make UPL payments to publicly owned providers using intergovernmental transfers (IGTs) from local governmental entities to provide the state share of UPL funding to draw down federal funding. Texas uses IGTs from local governmental entities, generated through ad valorem taxes, to provide the state share for federal match. HHSC calculates the gross UPL permitted to the state based on a

formula set in state regulations. The state calculates these payments on an annual basis, but hospitals receive funds on a quarterly basis.

UPL eligibility correlates to a hospital having a difference between Medicaid costs and Medicaid charges. The maximum UPL funding that a hospital may receive is limited to the aggregate total of Medicaid charges. For cases in which Medicaid charges exceed the total costs of providing services to Medicaid, plus indigent, clients, the UPL for reimbursements from all Medicaid sources is these total costs. Examples of these UPL limits are shown in Figures 2 and 3.

Figure 2: Medicaid Charges > Medicaid & Indigent Costs
In this example, UPL reimbursement is limited to the total Medicaid and indigent care costs borne by the hospital, not its charges which are higher than its actual costs.

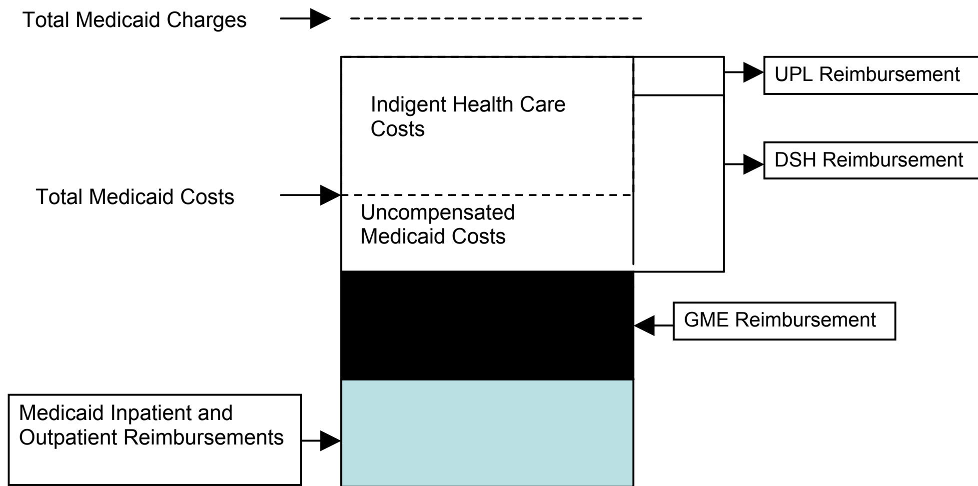
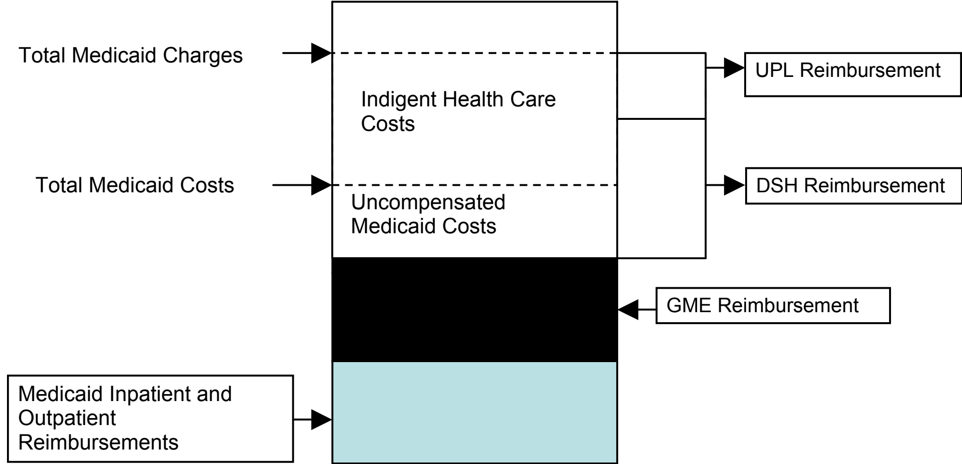


Figure 3: Medicaid Charges < Medicaid & Indigent Costs
In this example, total Medicaid and indigent care costs borne by the hospital are more than its Medicaid charges. UPL reimbursement is limited to its charges, not costs.



In 2001, HHSC adopted rules for a UPL payment methodology for two categories of non-state public hospitals: 1) large urban public hospitals; and 2) rural hospitals. Approximately 100 rural hospitals throughout the state received gross payments of $23 million in fiscal year 2002 and $35 million in fiscal year 2003. In fiscal year 2005, there is funding to cover UPL funding for an additional 47 non-state, non-public urban hospitals.

Graduate Medical Education

Teaching hospitals that operate approved medical residency training programs incur higher expenses than hospitals without teaching programs. The Medicaid share of these higher costs is covered by payments made directly to teaching facilities to cover the costs of residents' and teaching physicians' salaries and fringe benefits, program administrative staff, and allocated facility overhead costs.

During the 2003 session, the 78th Legislature changed statute to limit the availability of GME funding to the amount appropriated. No funds were appropriated for the 2004-05 biennium, but the 2003 General Appropriations Act included a rider that allows the use of up to $40 million of unclaimed lottery proceeds if these funds become available. In August 2004, there were $20 million of unclaimed lottery proceeds available which, when matched to federal funds, made $51 million available to disburse to hospitals eligible for GME payments in fiscal year 2005. Approximately 52 teaching hospitals in Texas with inpatient GME are eligible to receive Medicaid GME reimbursement.

Disproportionate Share Hospital Program

The DSH program is a state-federal matching program that provides payments to qualifying hospitals serving large numbers of Medicaid beneficiaries, uninsured patients, and patients with no means to pay for care. DSH funds differ from other Medicaid payments because they are not tied to specific services for Medicaid-eligible beneficiaries. The total amount of funding available for each state's DSH program varies within federal limits, based on the amount of the federal share and the state's Medicaid matching rate. This combination of federal and state funds is known as the DSH allotment.

In federal fiscal year 2004, Texas's DSH allotment was $1.496 billion. The federal share was $901 million, and the state share was $595 million. The state share of Texas's DSH program funds is contributed by state-owned hospitals and the nine largest public hospitals in the state. In state fiscal year 2004, 178 hospitals qualified for DSH reimbursement, with other facilities awaiting determination of eligibility. The projected Texas DSH allotment in federal fiscal year 2005 is $1.479 billion.

Federal law requires states to classify certain hospitals as DSH-eligible based on a facility's Medicaid inpatient utilization rate or "low-income utilization rate." Hospitals must also meet the following federal statutory conditions to qualify for the DSH program: 1) at least one percent of a facility's total inpatient days must be attributable to Medicaid patients; and 2) the hospital must provide at least two obstetricians with staff privileges who agree to serve

Medicaid beneficiaries if the hospital offers obstetrical services. All 400 Medicaid-participating hospitals in Texas are eligible for DSH funding, but in any given year about 165 non-public hospitals and 14 public hospitals are eligible to receive DSH funding based on these federal requirements.

Additionally, there are two federal caps on the amount of DSH payments that can be made to hospitals:

- Texas's DSH spending on Institutions of Mental Disease (IMD) is limited to the lower of the amount spent in federal fiscal year 1995, or 33 percent of the DSH allotment. In federal fiscal year 2000, Texas's DSH spending on IMDs was limited to 19.3 percent of the total allotment.

- The amount an individual hospital can receive under DSH cannot exceed the sum of the hospital's non-reimbursed Medicaid costs and the hospital's uncompensated care costs.

The Medicare, Medicaid, and state Children's Health Insurance Program Benefits Improvement and Protection Act (BIPA) of 2000 provided relief to state DSH programs from the reductions mandated by the Balanced Budget Act (BBA) of 1997 through a temporary increase in the DSH reimbursement rate from 100 to 175 percent of uncompensated care costs for fiscal year 2003 and fiscal year 2004. The increased reimbursement rate applies to all public hospitals, including those owned or operated by the state.

Assessing Current Physician and Other Provider Reimbursement Methodologies: An Overview

Physician participation in the Medicaid program is necessary to ensure Medicaid clients have access to medical care from general practitioners and specialists around the state. Ensuring adequate physician reimbursement is an important aspect of ensuring sufficient physician participation in the program. The 2003 General Appropriations Act required a reimbursement rate reduction to all Medicaid providers, including high-volume providers, for the 2004-05 biennium. The maximum rate reduction for any provider group is five percent. However, Governor Perry and the Legislative Budget Board approved use of federal fiscal relief funds provided to all states in 2003 to reduce the rate reduction for fiscal year 2004 by half for all providers. These same funds were used to maintain fiscal year 2005 rates at the fiscal year 2004 level for all providers, except hospitals making the effective rate reduction to physicians two and one half percent in both fiscal years 2004 and 2005.

Fee-for-Service (FFS)

In the case of the direct state-provider relationship in the FFS methodology, professional fees are determined using a Resource-Based Relative Value Scale (RBVS) fee schedule similar to the Medicare fee schedule. The Texas RBVS has no geographical or specialty differentiation. The conversion factor of $27.276 is multiplied by its appropriate Relative Value Unit (RVU) to determine payment. There

are also approximately 800 Access-Based Fees (ABFs) that were developed specifically for Texas Medicaid because many obstetric and pediatric procedures were not appropriately considered in the Medicare fee schedule system. The majority of the codes used in Medicare are for elderly populations, not children and pregnant women as in Medicaid. ABFs have been implemented for procedures used by these populations.

All FFS professional reimbursement rates are the same for physicians, regardless of geographic location or medical specialty, with the exception of the high-volume provider increase authorized by the 77th Legislature. A high-volume primary care practitioner (PCP) is defined as a primary care physician, advanced practice nurse, or certified nurse midwife who averages at least 300 Medicaid paid units of professional services per month over a twelve-month qualification period. High-volume PCPs receive an additional 1.9 percent add-on to their Medicaid payments. High-volume specialists are defined as physicians who provide the top-50 percent of services within their specialty. High-volume specialists receive an additional 6.1 percent add-on to their Medicaid payments.

Proposed Recommendations:

- Update the Resource-Based Relative Value (RBVS) fee schedule on an annual basis or rebase all physician rates.
- Fully fund Medicaid payments made to state-owned hospitals. This initiative could increase DSH funds available to non-state hospitals and increase inpatient, outpatient, and GME expenditures by $22-25 million in all funds.

Primary Care Case Management

Under the Primary Care Case Management (PCCM) program, the state pays providers the current FFS rates through the state claims processor. If a PCCM provider is a patient's designated primary care provider (PCP), the provider will receive an additional $3 per member per month. The PCP serves as the client's medical home and is responsible for 24-hour coverage when a beneficiary requires access to medical services or care coordination. The PCP is responsible for referral and authorization of specialty physician care and non-emergent inpatient hospital services. Authorization is required for a specialist to receive payment for services.

Managed Care Organizations

Under the contract terms between HHSC and managed care organizations (MCO), HHSC does not currently have access to the rates negotiated between MCOs and their providers. However, HHSC does review the adequacy of a MCO's provider network when considering contracting with that MCO for a service delivery area. It is the responsibility of MCOs to provide sufficient reimbursement and other contract terms to their contracted physicians to ensure the adequacy of their network in each of their service delivery areas. For MCOs, maintaining adequate network participation correlates to paying providers sufficient rates.

Durable Medical Equipment

Durable medical equipment (DME) and expendable supplies, including nutritional products, are provided either under home health services [1 TAC §355.8021(b)-(c)] or under Texas Health Steps (THSteps) [1 TAC §355.8441(4)-(5)]. Fees for DME and expendable supplies, excluding nutritional products, are based on Medicare fees in effect at the time of the implementation of the fee or, if there is no Medicare fee or the Medicare fee is not appropriate for the Medicaid population since the Medicare population is primarily elderly, the fee is based on the manufacturer's suggested retail price (MSRP) less 18 percent. Fees for nutritional products are primarily based on the average wholesale price (AWP) less 10.5 percent.

Home Health

The reimbursement methodology for professional services delivered by home health agencies are statewide visit rates that were calculated in accordance with 1 TAC §355.8021(a) effective November 1, 2002. Until the statewide visit rates are implemented, home health agencies continue to be reimbursed in accordance with a reasonable cost methodology, with interim payments being a percentage of billed charges based on each provider's most recent cost report desk audit. It is anticipated that the statewide visit rates will be implemented during 2005. Home health agencies are reimbursed for durable medical equipment and expendable supplies as noted above. Home health agencies are reimbursed for private duty nursing services in accordance with the fee schedule for those services.

Dental

The Medicaid rates for dentists are calculated as access-based fees in accordance with 1 TAC §355.8085. The fees are based upon a percentage of billed charges (i.e., the usual-and-customary fees charged to non-Medicaid clients) reported on Medicaid dental claims for each dental service, excluding billed charges that are less than or equal to the maximum Medicaid fee for that service. The fees are reviewed at least every two years. A high-volume dentist is defined as a dentist that averages at least 300 paid Medicaid units of service over a 12-month qualification period. High-volume dentists receive an add-on of 3.7 percent to their Medicaid payments. Payments to dentists have been reduced by 2.5 percent during state fiscal years 2003 and 2004.

Prescription Drug Services

Medicaid reimbursement for pharmacy providers includes payment for the cost of the drug plus payment of a dispensing fee. HHSC estimates the acquisition cost of the drug utilizing techniques that differ depending upon how the drug was obtained by the pharmacist, whether purchased from a wholesaler, purchased direct from the manufacturer, or obtained from a warehouse or at warehouse prices. The dispensing fee includes an amount for the cost of dispensing, presently $5.14, plus an inventory management factor that is presently 1.95 percent.

Table 3
List of Recommended Reimbursement Strategies For Consideration

1. Devise a more equitable distribution of DSH, UPL, and GME formulas.
2. Develop a way to use trauma funds to draw down additional federal matching funds.
3. Implement an inpatient reimbursement methodology that recognizes and rewards/reimburses hospitals based on efficiency and good business practices.
4. Require non-profit hospitals not meeting their charity service provision requirements to contribute to the state budget as state matching funds for the Medicaid program.
5. Develop selective contracting for DME, home health, or any other non-hospital or physician providers.
6. Increase access to care by increasing the rate advanced practice nurses are reimbursed for services.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Review and Re-Evaluate Medicaid Funding Mechanisms and Formulas

The proposals supported in this chapter by the workgroup recommend various changes to funding formulas and purchasing methods used in Medicaid. The re-evaluations are recommended because all of the formulas and mechanisms in the state Medicaid program are intertwined in an effort to avoid unintended and negative consequences.

The overall finance recommendation is for HHSC to establish a process to review all funding formulas and purchasing mechanisms to determine which of these are the most cost effective for the state and promote positive health outcomes. Further, HHSC should consider hospital financing, physician and other provider financing, as well as new and innovative funding mechanisms to help the state benefit from additional federal funds.

The workgroup recommended many proposals ranging from provider reimbursement increases to changing the funding formula for the disproportionate share hospital program. The general themes reflected in these proposals are the efficient use of state funds and optimization of federal Medicaid dollars. Additionally, the proposals recommended that the reimbursements to providers, especially hospitals, should be based on a measurement of good business practices and efficiency in their treatment and administrative systems.

The workgroup also recommended several creative finance reform options to use existing expenditures from state and local programs that provide health care to low-

income populations as match to draw additional federal Medicaid dollars to Texas. Other proposals focused on developing more 1115 waivers, or research and demonstration waivers, to expand the state's ability to match federal funds. Finally, the workgroup recommended proposals to develop new funding mechanisms to fund the core Medicaid program as well as expand eligibility.

The workgroup noted that the goals of the finance system should be to:

a. Optimize federal funds to the state;
b. Create incentives for providers to use preventive care;
c. Increase and encourage use of less expensive and appropriate treatments to keep providers in the system to maintain an adequate provider network;
d. More accurately reflect the costs borne by providers; and
e. Encourage best practices and quality care.

The workgroup also supported proposals that would recommend the following finance options.

1. Include Comprehensive Outpatient Rehabilitation Facilities (CORF) in Prospective Payment Systems (PPS) methodology.

2. Consider developing 1115 waivers for:
   a) Inter-governmental transfers from local entities similar to those outlined in H.B. 3122, 78th Legislature, Regular Session, 2003;
   b) Women's health care servcies waiver; and
   c) Increasing insurance coverage under the Medicaid and Children's Health Insurance Program (CHIP) up to 200 percent of the Federal Poverty Level (FPL) using existing state Medicaid and CHIP resources with buy-in ability from local government entities as well as private employers.

Proposed Recommendation: Texas Medicaid should consider utilizing a prospective payment system for comprehensive outpatient rehabilitation facilities (CORFs) to ensure greater budget certainty for the state. Such a system could save the state $7.5 million in general revenue.

For 1115 waiver proposals to be successful, federal issues on the use of employer contributions and use of donations would have to be overcome. In addition, submissions for 1115 waivers must demonstrate federal budget neutrality based on a state's existing Medicaid program and its expenditures.

3. Consider using employer contributions and donations to expand Medicaid and CHIP eligibility and funding.

There currently exists another proposal to use an employer fee and participant cost-sharing to expand the Medicaid and CHIP programs to include participants up to 200 percent of FPL under an 1115 waiver. This proposal follows an 1115 waiver request by the state of Arkansas.

4. Consider using existing state expenditures on health-related programs as match for federal Medicaid funds. Two examples of possible existing state expenditures are the County Indigent Health Care Program, which reimburses counties that spend in excess of eight percent of their gross tax levy on health care services for very low-income people; and the Area Health Education Centers (AHEC) around the state, which provide services for disadvantaged Texans.

Using some of these existing expenditures will be easier than others. For the state to use the existing county expenditures from the County Indigent Health Care Program to match federal Medicaid funds, the federal government would have to amend the law that governs Medicaid eligibility. A household is eligible for the program if its monthly net income does not exceed 21 percent of the federal poverty limit. Counties may choose to increase the monthly income standard to a maximum of 50 percent of the federal poverty limit and still qualify to apply for state assistance funds. However, because these expenditures are not for Medicaid eligible individuals, the state could not draw additional federal funds. On the other hand, designating the eligible portions of expenditures at AHECs for Medicaid administrative cost match would not require revisions to the federal law but would require AHECs to revise accounting and auditing systems to ensure that the correct time spent on eligible tasks is recorded and reported.

Proposed Recommendations:

- Designate eligible general revenue funds currently appropriated in AHEC activities into Medicaid administration in order to draw down federal matching funds.
- Apply for a federal waiver to raise the income eligibility level for family planning, reproductive services, and women's preventive health screening services.

5. Consider a tax incentive for employers, especially small businesses, to be able to afford premium costs. The tax credit could be applied to the ad valorem, franchise, or sales tax paid by employers.

6. Consider a quality assurance fee on nursing facilities that could be used to match additional federal Medicaid funds. From this funding stream, money can be used to offset state money necessary to fund increases in the nursing facility
costs, such as direct care staff costs.

By federal regulation, however, all nursing facilities would be subject to the fee, even those that serve no Medicaid clients and are not Medicaid contracted. Therefore, these facilities would have to pay the fee but would not receive any of the benefit of the use of these funds to enhance the Medicaid rate.

7. Consider taxes on alcohol and tobacco products to finance the Medicaid program. Texas is in the middle to lower range of tax rates on these products compared to other states.

Because all Medicaid finance formulas and mechanisms impact each other, it is not feasible to choose one or two proposals without understanding the impacts of those changes on the rest of the program.

Therefore, the workgroup proposal is to direct HHSC to review and re-evaluate all finance mechanisms within the Medicaid program. HHSC should establish a review schedule that starts with hospital reimbursements, then other providers and also includes a review of new and alternative financing mechanisms. The review process should consider all of the alternative mechanisms outlined in this report as well as any other finance mechanisms that could support the goals of the Medicaid program. Following this review, HHSC should adopt new rules, state plans, or follow other procedures as necessary to implement the new funding mechanisms.

Review and Re-Evaluate the Medicaid Finance System Action Plan

Below is a general work plan to make reimbursement rates more effective and efficient and to more accurately reflect the Medicaid program's funding priorities.

Step 1: Analyze rate setting best practices in other states and determine applicability to Texas providers while considering the goals above. HHSC staff would gather information and thoroughly review different rate methodologies in other states. This phase would take six to 12 months.

Step 2: Work with the legislature to determine the most effective rate methodologies for the state. This phase would take up to three years, with results in the 2007 legislative session.

Step 3: Plan data system improvements that are necessary for the new system and increase automation of financial information received from providers and processed by the state. Stakeholder input would be important to this aspect of rate setting evaluation design. This phase would take one to two years.

Step 4: Implement updated rate methodologies for physicians, hospitals, and HMOs. This phase will take one to two years depending on the system priorities at HHSC.

Following Step 1, HHSC would seek stakeholder input on the rate methodologies that could be used in Texas and use this information when working with the 80th Legislature in 2007. As mentioned above in Step 3, stakeholder input would be important to designing the new rate methodology system and improving the automation of the financial information system that providers will be required to use.

A) **Hospital Rates**: In order to improve hospital reimbursement rates, HHSC should evaluate the following:
   - Encourage more equitable distribution of funds.

- Encourage more accountability and cost-based reimbursement.
- Tie payments to providers to more effective business practices and better health outcomes.
- Require all cost reports be submitted to HHSC electronically.
- Re-evaluate the cost report information that is required from hospitals and consider reducing the data elements that need to be reported by the hospital.
- Use same-year data to set all hospital rates (even though the data may be unauditable and incomplete) rather than using two to three-year old data to set certain rates, such as DSH and inpatient rates.
- After developing more effective hospital inpatient and outpatient reimbursement rates, revising DHS, GME, and UPL methodologies would be considered.

B) **Provider Rates**: During Step 1, HHSC would evaluate:

- Updating the Relative Value Units (RVUs) in Texas based on Medicare's most recent RVU values. HHSC expects this activity to take up to six months.
- The feasibility of paying providers on another Prospective Payment System (PPS).
- Setting provider rates based on percent of costs or usual and customary charges.
- Incorporating payment incentives for high-volume providers.

During Step 1, HHSC would improve oversight of durable medical equipment (DME) price setting. This process will evaluate manufacturer retail price for DME and determine if the state is paying a reasonable markup on DME items. In Step 2, HHSC will explore the use of selective contracting, including an evaluation of the barriers to access similar to those considered in hospital selective contracting.

Additionally during Step 1, HHSC would consider the cost-effectiveness of a PPS system for all home health providers or selective contracting for home health services through a competitive procurement.

HHSC has made significant strides in the past few years to use each HMO's encounter data to set a market rate in each service delivery area rather than using outdated FFS data. HHSC is taking the following steps to improve HMO rate methodology to more accurately reimburse the HMO based on the acuity of their clients:

- Working with the HMOs to improve data reporting to the state via improved encounter data fields. This activity can be completed in three to four months.
- Using encounter data (with some of the Financial Statistical Reporting to validate encounter data) to set a market rate per service delivery area. This activity can be completed in five months.
- Using risk adjusted rates to adequately reimburse HMOs with higher acuity levels. This activity can be completed in six to 12 months.

C) HHSC will then evaluate other funding mechanisms to more effectively utilize local funding, optimize federal funding, and consider new resources like:
   - Waiver options;
   - Local funding options;
   - Employer contributions and donations;
   - Employer tax incentives;
   - Quality assurance fees; and
   - Taxes on alcohol and tobacco products.

Fiscal Implications

This chapter recommends the establishment of a review process through which HHSC will examine and re-evaluate financing formulas and mechanisms currently used in the Medicaid program, and determine whether those formulas are in the best interest of the Medicaid program. The goal is to ensure that these funding formulas provide the state with the best opportunity to promote appropriate utilization within the Medicaid program and to get the most out of each dollar spent.

HHSC will consider a significant number of financing changes and depending on which of those changes are adopted, the savings derived from this chapter will vary. The workgroup recommended considering a variety of finance reform proposals. Some of those proposals, especially regarding hospital financing through DSH and UPL, may not accrue savings to the state, but would re-distribute funds in a more equitable way among facilities receiving those funds. Other proposals for consideration include activities such as collecting a nursing facility quality assurance fee that is estimated to generate $310.9 million GR in the 2006-2007 biennium under the waiver option currently under consideration. Implementing selective contacting for the purchase of certain services, like durable medical equipment, could generate immediate savings of $12.8 million GR for 2006-2007 if the DME payments were reduced by five percent. Other fee-related proposals would increase available general revenue in the program. For example, if statewide prospective payment system visit rate payments for professional services delivered by home health agencies were reduced by five percent for the 2006-2007 biennium, this would result in savings of $3.2 million in GR. A portion of these savings would be necessary to cover the cost of the review of the financing formula.

Issue III: Managed Care

Managed care in the Medicaid program should be as efficient as possible and provide effective and appropriate care.

The proposals approved by the workgroup regarding Medicaid managed care recommendations focus on two primary areas: 1) improving how the state administers managed care programs and 2) improving the delivery of health care services to Medicaid patients enrolled in managed care plans.

Currently the Medicaid program operates managed care for acute care services through two models primarily in the major metropolitan areas of the state. One model contracts for services to health maintenance organizations (HMO) and the second, the Primary Care Case Management (PCCM) model, pays an additional fee to primary care providers for providing Medicaid patients with a medical home. HMOs are fully "at risk," that is, they receive a fixed premium payment for each client and are responsible for all Medicaid covered services for that client. In the PCCM model, the state bears the risk of financial loss.

For persons who require long-term care under Medicaid, the state uses a managed care model called STAR+PLUS. The STAR+PLUS model was implemented in Harris County in 1998 and is slated for expansion to all major urban areas of the state by September 2005. The program integrates acute and long-term services into a single delivery system for the disabled and chronically ill Medicaid population. Several independent evaluations of the program have demonstrated improved outcomes for people enrolled in STAR+PLUS, a high level of member satisfaction, and reduced cost for the state.

In late 2003 at the request of the legislature via H.B.2292, 78th Legislature, Regular Session, 2003, HHSC contracted for an independent evaluation of the cost-effectiveness of each model of service delivery in Medicaid. A recent analysis performed by The Lewin Group found the state could achieve twice the cost savings for the aged and disabled populations if long-term care services were included with acute care services in the Health Maintenance Organization (HMO) model. The results of The Lewin Group analysis, coupled with the quality of care studies performed by the External Quality Review Organization (EQRO), convinced HHSC the STAR+PLUS model should be expanded.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Medicaid Managed Care

The workgroup heard significant testimony regarding both the benefits and the challenges experienced by all partners in the Medicaid managed care program. While it was shown that the state benefits from the use of certain managed care models because of the budget certainty the model offers, there were allegations that provider network inadequacies create barriers to access to care by clients. The workgroup believed that while savings is an important component of managed care expansion, it should not the sole criterion with which to base policy decisions.

Due to the difficulty of balancing these benefits and challenges, the workgroup members were unable to come to consensus on whether, or which, models to recommend for expansion of Medicaid managed care. However, there was consensus and a recommendation supported by the workgroup that an "appropriate" service delivery model should be used on each service delivery area; where the workgroup differed was on the definition of "appropriate."

Therefore, the workgroup does not have recommendations regarding whether to expand the use of managed care in Medicaid. However, if managed care is expanded, this chapter presents many recommendations for improvement to that system. Additionally, the workgroup recommends that when policy makers make decisions about whether to move forward with managed care in Medicaid that additional criteria beyond just savings be used to determine which models would be "appropriate." Recommended criteria for consideration include:

- Network adequacy and the ability of the program to maintain access to both primary care and specialty services;
- Accountability with the assurance the state delivery model will provide cost-effective care using best practices in patient care and administration; and
- Innovations in the marketplace may also be used for the Medicaid program.

→ Improve the Delivery of Health Care Services to Clients Enrolled in Managed Care

Another focus of the workgroup was on improving the care and services received by clients enrolled in managed care. The workgroup recommendations range from increasing the availability of immunizations through the program, to increasing the use and access to nurse triage lines, to more effectively enforcing restrictions on persons who inappropriately use services. The workgroup recommends adding a contract requirement to the health plans in Medicaid managed care that immunizations be provided to Medicaid clients. This is currently a requirement for health plans enrolled in Medicaid managed care. These proposals echo the same concerns outlined earlier in this report regarding the appropriate coordination of care provided to clients and the education of clients and providers regarding the appropriation use of the health care system and the Medicaid program specifically. These recommendations should be taken in coordination and conjunction with the earlier recommendations.

1. Add a contract requirement to the health plans in Medicaid managed care that immunizations are provided to Medicaid clients.

HMOs are required to provide immunizations to Medicaid clients under the current contract with HHSC.

H.B.1921, 78th Legislature, Regular Session, 2003, provided health plans with the statutory authority to provide information to, and access information from, the state's immunization registry. The Department of State Health Services is currently working with the health plans to implement that provision early in 2005.

2. Allow HMOs access to previous claims history for new enrollees maintained by the claims administrator for former FFS/PCCM Medicaid enrollees.

Access to this information will allow HMOs to better provide care to newly enrolled members. This information should be incorporated as the program implements more effective care coordination systems as proposed earlier in this report. Since this information is confidential under state and federal law, sufficient safeguards will need to be established to ensure confidentiality and protect patient privacy. This can be addressed by ensuring that the data and data transfer procedures are HIPAA-compliant. Entities that share patient health information have to ensure the confidentiality and integrity of the data they receive, maintain, or transmit. To achieve this, the federal HIPAA rules require entities to have security management processes (including workforce security), information access management policies and procedures, security incident procedures, facility access controls, workstation security, device and media controls, and audit controls.

HMO Access to Previous Claims History Action Plan

Step 1: Research and analyze state and federal regulations pertaining to enrollee privacy protections that may impact the ability of HMOs to gain access to previous claims history for FFS and PCCM enrollees. (Timeline: 1 month)

Step 2: Determine:
a) Which vendors and state stakeholders would be affected by the implementation of a process to allow HMOs to obtain electronic access to previous claims history for FFS and PCCM enrollees;
b) The management information system (MIS) modifications required for data exchange; and
c) Any costs for data system modifications. (Timeline: 3-6 months)

Step 3: Develop and execute vendor and HMO contract amendments to implement this initiative. (Timeline: 12-18 months)

3. Encourage the operation of nurse triage lines by the health plans, and then more effectively notify clients that the lines exist and how to access those lines.

Encourage the Operation of Nurse Triage Lines by the Health Plans Action Plan

Step 1: Convene a workgroup of contracted health maintenance organizations (HMOs), physicians and advocates to share any concerns, best practices and innovations in the use of nurse triage lines within an HMO. (Timeline: 3-5 months)

Step 2: Share information with the Texas Medical Association, the Texas Association of Health Plans and other associations to:
a) Achieve buy-in to the concept;
b) Promote the use of nurse triage lines; and
c) Inform as to which HMOs provide this service to members. (Timeline: 1 month)

Step 3: Facilitate the coordination and implementation of a communications campaign to educate and inform beneficiaries and physicians of the availability and benefits associated with the use of nurse triage lines within participating HMOs. (Timeline: 6-8 months)

4. Create tougher managed care health plan contract standards to ensure that children have actual alternatives to the emergency room outside of regular office hours.

This should include requiring access to daytime walk-in sick care and after-hours care. Currently, in order to decrease emergency department use, several HMOs have developed contractual arrangements with after-hours and acute care clinics. Establishing this as a contract requirement will likely increase costs to the program. Effective with the re-procurement, HHSC developed a monitoring mechanism that includes use of the emergency department by clients and will establish limits on emergency department out-of-network utilization. This approach should encourage HMOs to better manage emergency department utilization without incurring additional costs to the state.

Current state Medicaid policy does not provide an incentive for physicians to expand their office hours. When a physician extends their office hours beyond the normal workday, the state considers those hours to be part of the physician's normal office hours. This precludes the physician from being able to bill and be compensated specifically for after-hours services. HMOs are subject to the same restrictions in their physician contracts.

The Texas Medicaid Provider Procedures Manual (TMPPM, section 34.3.4.6) contains specific physician after hours procedure codes and describes the policy to be applied when a physician renders after-hours care. Use of the codes allows the physician be eligible for an extra payment (around $13) in addition to the payment for the office visit.

However, under current TMPPM policies, if a physician establishes regular office hours that are earlier than 7:00 a.m. and later than 7:00 p.m., the after-hours code and claim for service will be denied. So, for example, a physician with office hours between 6:00 a.m. and 8:00 p.m. who submitted an after-hours claim for seeing a Medicaid client at 7:30 p.m. would not be reimbursed the extra $13. In addition, to be eligible for this *de minimis* payment, the physician either must have had to leave his or her home to see the client in the emergency room, or left his or her home to see the client in the office.

HHSC will consider revising policy so that regular office hours are 8:00 a.m. to 5:00 p.m. and that when a physician provides services to a Medicaid client before or after those hours, those services will be eligible for the after-hours payment.

Create Tougher Managed Care Health Plan Contract Standards Action Plan

Step 1: HHSC incorporated the consultant's recommendations relating to network access and adequacy into Request for Proposal to procure services for Medicaid managed care expansion. (Completed in July 2004).

Step 2: Analyze feasibility of incorporating into managed care health plan contracts the requirement to provide additional reimbursement to physicians for the provision of after-hours services to Medicaid clients

in the physician's office. The analysis should:

a) Determine which vendors and state stakeholders would be affected by the implementation of this requirement;
b) Determine any management information system (MIS) modifications required; and
c) Determine any costs associated with the requirement. (Timeline: 3-6 months)

Step 3: Develop and execute vendor and HMO contract amendments to implement this initiative. (Timeline: 12-18 months)

5. Develop more effective mechanisms to control utilization of the program by clients who abuse the services of the program.

HHSC will consider revisions to its current "lock in" program in fee-for-service. However, the mechanism used by the "lock in" program is to assign the beneficiary to a primary care provider (PCP). With the possible expansion of Medicaid managed care, this would become less of a problem since each beneficiary would be assigned a PCP.

Develop More Efficient Mechanisms to Control Program Utilization Action Plan

Step 1: HHSC Incorporated into Medicaid health maintenance organization (HMO) contracts requirements relating to fraud, abuse and waste in health care, including the creation of special investigation units (SIU) as mandated by H.B. 2292, 78th Legislature, Regular Session, 2003. (Completed in September 2004)

Step 2: HHSC established quarterly meetings between the HHSC Office of the Inspector General (OIG) and contracted HMOs to discuss SIU findings and to continue to identify more efficient mechanisms to control utilization of the program by beneficiaries who abuse the services of the program. (Completed in November 2004)

Step 3: HHSC established a website within the OIG Compliance Division to facilitate communication with HMO SIUs. HMO SIUs are able to submit questions directly to the appropriate OIG division/section, including Quality Review (QR), Medicaid Provider Integrity (MPI) and General Investigations (GI) through a web-based secured email system. (February 2005)

6. Study the impact of high-use and abusive clients and incorporate the most effective ways to curtail that activity while assuring that those clients receive adequate health services.

In general, service utilization is driven by an individual's health status. The less healthy the individual is, the more likely they are to need and use health care services. Medicaid managed care clients are, for the most part, children and pregnant women. Most children in Medicaid managed care (80% -85%) are healthy and use few services, except for preventive care. A small percentage of children have chronic conditions or special health care needs, like leukemia, cystic fibrosis, cerebral palsy, and spina bifida. These children require and use health care services intensively.

Pregnant women sometimes enter the Medicaid managed care system late in their pregnancies. In such cases, the managed care organization may not have had an opportunity to assist the mother in obtaining comprehensive prenatal care services. Lack of access to prenatal care can contribute to complications during pregnancy and may also place the newborn at risk. These situations may also require extensive use of medical services.

Studies of service utilization need to take into account the health status and morbidity profile of the user. The HHSC external quality review organization can analyze patient-level encounter data using case-mix adjustment software to generate these kinds of studies.

Other issues raised by the workgroup will be addressed with the implementation of the new Integrated Eligibility system. This new system will replace the current operating system for eligibility and enrollment of clients, offering real-time capability to report data and make data corrections or changes in a more-timely manner.

The Medicaid program has committed to work with the stakeholders to accomplish the remaining issues of concern through an open process as the state continues to operate and expand the use of Medicaid managed care.

One area in particular where managed care presents a problem both for the state and providers is Medicaid client utilization of out-of-network services. Because of this concern, the workgroup recommended that limits be placed on the use of out-of-network services in the program.

In September 2004, HHSC began to make changes based upon recommendations regarding utilization standards and MCO reporting requirements made in a Lewin Group report titled *Assessment and Recommendations Regarding Out-of-Network Reimbursement, Usage Standards and Resolution Processes*. The report's recommendations were refined by the HHSC Executive Commissioner and were incorporated into proposed rules presented to the Medical Care Advisory Committee on March 10, 2005. These rules were also presented to, and modified by comments from, provider associations and MCOs. Following publication in the Texas Register, public comment, and public hearing, HHSC expects final rules to be published in August 2005 and implemented in September 2005.

→ Improve Managed Care Administration

These proposals focus on actions the state might take to improve program administration of Medicaid through managed care. The workgroup's focus regarding the administration of managed care was to achieve greater efficiencies in the operation of Medicaid managed care, and also to improve the services provided through this delivery model.

1. Ensure the Medicaid program has appropriate expertise and qualified staff to effectively manage Medicaid managed care plans.

The workgroup found that Medicaid should hire additional staff with managed care experience and expertise in order to maximize savings from Medicaid managed care and to promote continued quality of care. During the last year the Medicaid/CHIP Division has been successful in recruiting staff with commercial managed care, insurance, and financial management skills.

On a contingency fee basis:

2. Evaluate Medicaid payment recovery options from contracted Medicaid Health Maintenance Organizations (HMOs) due to death, incarceration or multiple state program enrollment of managed care enrollees.

Evaluate Medicaid Payment Recovery Options Action Plan

Step 1: Convene an HHSC workgroup to identify any issues with current rules, laws and contract provisions, including the need to establish or revise current administrative rules. (Timeline: 2 months)

Step 2: Gather input from stakeholders, including contracted HMOs, other Texas state agencies, as well as other Medicaid agencies in other states. (Timeline: 1-2 months)

Step 3: Develop and present recommendations to HHSC leadership. (Timeline: 2 months)

3. Engage expertise to assist in the recovery of payments from health plans and capitation payments from persons who leave the program to optimize Medicaid payment recovery options.

The following are specific recommendations for methods to decrease these burdens:

- Decrease the burden of duplication of administrative reporting requirements by the health plans, such as submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports.
- Allow the Medicaid/STAR health plans to provide updated address information directly back to HHSC for correction in the state system.
- Allow the health plans to be responsible for assignments of primary care providers (PCP) and maintain PCP assignments.
- Permit STAR HMOs to process claims for their voluntary supplemental security income (SSI) members.
- Require consistency and uniformity among Medicaid HMO policies (authorization process, length of stay, filing deadlines, levels of care, case management, etc.).
- Review appropriateness of PCCM requirements in the admission/clinical criteria process, including separate cover sheets for all communications – for handwritten communication instead of electronic or typed review processes - and admitting patients listed on separate notifications (previously one fax listed several patients). Reviews should be electronic, legible and timely.

Engage Expertise To Assist in the Recovery of Payments Action Plan

Step 1: Develop Request for Proposals (RFP) for development. (Timeline: 3-6 months)

Step 2: Issue RFPs and award contracts for this initiative. (Timeline: 12-18 months)

Step 3: Publish and adopt any rules necessary to implement changes in Medicaid payment recoveries (Timeline: 9-12 months).

Step 4: Determine impact on HMO and other vendor management information and claims processing systems and develop implementation timeline to coincide with rule effective date. (Timeline: 1 month)

Step 5: Develop, test, implement and evaluate operations policy and Contracting monitoring tools necessary to support this initiative. (Timeline: 3-6 months)

Step 6: Develop and execute HMO and other vendor contract amendments necessary to implement this initiative. (Timeline: 2-3 months)

In 2004 the Medicaid program issued a new Request for Proposals (RFP) to re-bid and expand the implementation of Medicaid managed care. Effective with the planned HMO re-procurement, many administrative requirements have already been significantly reduced.

4. Regulate the Exclusive Provider Organization (EPO) model currently used by the Children's Health Insurance Program and PCCM with the Texas Department of Insurance in a manner similar to the way HMOs are regulated.

The workgroup believes such regulation is necessary to help minimize state exposure to financial, legal, and quality risks.

The Texas Department of Insurance (TDI) currently has rules in place regulating the EPO delivery system. The CHIP EPO contract was recently re-procured and the HHSC contract requirements associated with the EPO reflect TDI requirements. (The PCCM model is not a financial risk-bearing entity and not subject to TDI regulation. However, the PCCM model is subject to federally established Medicaid managed care requirements related to enrollee rights and protections, access standards, structure and operation, program integrity and sanctions.)

5. Study whether the state is currently at risk of exposure to the aforementioned risks and then determine whether additional regulation by TDI is necessary.

Any additional regulation should not be designed to create any unnecessary new burdens or duplication of administrative effort on behalf of providers or health plans.

6. Revisit use of the $3 case management fee in the PCCM program.

7. Establish a sliding scale fee for providers based on primary care provider performance.

Proposed Recommendation:
Tie some preventive health performance measures to the $3 per member per month fee paid to physicians under the PCCM model. Additionally, index payments to less than, or equal to, $3 per member per month based upon preventive health performance.

Currently primary care providers enrolled in the PCCM program are paid a case management fee of $3 per member per month (PMPM). Workgroup concerns focused on ensuring that the state is getting the best value for the case management fee and that the fee be designed to provide incentives to the providers and patients for the most appropriate and cost effective methods of medical management. Considering this concern, and those raised regarding the effective management of patient care in

the program, a more comprehensive look at the PCCM model may be more appropriate than just evaluating the case management fee.

8. Ensure the PCCM program is operated efficiently, provides the most effective care and case management, and provides for the best health outcomes.

9. Reconsider the mechanism used for hospitals to participate in the PCCM program.

The workgroup approved proposals requiring hospitals to sign up with the PCCM network or to implement a selective contracting system in order for them to participate in the PCCM program. The most effective mechanism for hospital contracting should be incorporated into any reform of the PCCM program.

10. Require HMOs to utilize Advanced Practice Nurses as primary care providers to increase the availability of primary care providers in the program.

While current law allows for the use of advance practice nurses, the workgroup felt that requiring the plans to use these providers would address the significant problem of inadequate primary care provider access. These changes are scheduled for implemented in 2006.

Fiscal Implications

The proposals recommended in this chapter require increased coordination between the state Medicaid program, health maintenance organizations, and providers in an effort to increase efficiencies and ultimately savings to the state Medicaid program. For example, building systems to allow HMO access to claims history of clients would allow health plans to make more effective health care decisions because health plans would have more up-to-date and accurate information regarding clients. The proposals also recommend the development of a system to identify clients who utilize the Medicaid program at high or abusive rates, so that health plans can more effectively coordinate the services those clients receive.

While these changes may present some costs to implement, the proposals will result in savings from more effective program utilization, such as decreasing emergency room use. For example, the average cost of a Medicaid HMO's reimbursement for emergency room facility and physician charges for a TANF or TANF-related clients (e.g., Expansion children, Federal Mandate children, newborns, and pregnant women) is roughly $145 more than the cost of an average physician office visit for the same client. A 40 to 50 percent shift from inappropriate emergency room use to physician office visits among TANF or TANF-related HMO members alone could yield savings of between $7 and $9 million per year. This does not include additional savings potential from decreased inpatient stays by promoting the use of outpatient services when appropriate. Allowing HMOs to use advance practice nurses as primary care providers could also yield savings to the state by lowering premiums to HMOs.

Proposals to encourage increased utilization of nurse triage lines will also generate savings by allowing clients to be directed to the most appropriate care.

Issue IV: Long-Term Care

The Medicaid long-term care system should provide the broadest array of choices possible for consumers, while ensuring that services are delivered in a way that is cost-effective and make the best use of available funds.

The workgroup heard a number of concerns that the long-term care delivery system is fragmented. Considering the need to prepare the Medicaid long-term care system for the aging of Baby Boomers, it will be critical for the state to develop mechanisms to make sure that services are delivered efficiently while offering a continuum of services that allow for consumer choices.

The Department of Aging and Disability Services (DADS) has been designed to integrate the long-term care services system and to offer its clients a full range of services, both institutional and community-based. Long-term care programs have historically been administered at the Department of Human Services and the Department of Mental Health and Mental Retardation, with additional programs for the elderly administered through the Department on Aging and the local area agencies on aging. In addition to having duplicative administration, this three-part system meant that a single consumer might have to go to three different offices to receive services. Offering services and supports at the local level through a single office is intended to make access to services easier for consumers. The location of all these programs in a single agency provides the state with previously unavailable opportunities to examine the way services are delivered across programs and promote changes that allow for more choices for consumers.

The Consumer Directed Services (CDS) model allows consumers, their guardians, or designated representatives to be legal employers of record for their personal attendants. Legal employer of record means they can hire, fire, train and supervise personal attendants, and they assume fiscal and personnel responsibilities as well. H.B. 2292, 78th Legislature, Regular Session, 2003, required HHSC to establish CDS in the following Medicaid waiver programs: Community Based Alternatives (CBA); Community Living Assistance and Support Services (CLASS); Deaf-blind/multiple disabilities (DBMD); Consolidated Waiver Pilot (CWP); and Medically Dependent Children's Program (MDCP). A 2004 HHSC cost-effectiveness study showed the CDS option to cost an average of $161.39 more per month than non-CDS services (which cost an average of $2532.27), although there were savings in acute care service and vendor drug costs. Studies in other states have shown that increased costs resulted from an increase in use of authorized hours.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Expand DADS Care Options

A number of the proposals cited the need for improvements in the existing Consumer Directed Services (CDS) program that would allow more choices for consumers, and also examined workforce issues related to long-term care. The workgroup also recommends consolidating community mental health and mental retardation centers and local authorities to assure more effective service delivery management. The workgroup received a specific proposal about improving care for those with end-stage renal disease. While the workgroup did not choose to endorse that specific recommendation, it was recognized that the choice of palliative care (hospice) versus curative care is an individual's care decision; the state cannot mandate that a person end curative interventions. The workgroup also recommends the development of protocols for appropriate transfer of nursing facility residents to hospitals to help decrease the number of inappropriate transfers. The workgroup also recommends the provision of speech pathology services, intravenous therapy and chemotherapy treatments as a Medicaid home health benefit. The workgroup recommends that the state explore either grants or private funding to support care-giving efforts, considering the predicted growth in the Alzheimer's population for Texas over the next 30 years. The workgroup also recommendations that state school rehabilitation services be made available to qualifying individuals in the community. The workgroup recommends that the state improve administrative and regulatory processes in nursing homes.

1. Expand the CDS provider base by encouraging organizations such as Agencies on Aging (AAAs), Independent Living Centers, and other entities to become providers through contracts with DADS.

Expanding the provider base would offer more options for individuals seeking to exert control over their services and will not require a statutory change. CDS is a model the state is actively encouraging and HHSC conducts an on-going workgroup to improve the process and explore other areas/services to use the model.

Expanding the CDS Provider Base Action Plan

Step 1: Present concept to CDS Workgroup for their recommendation. (Timeline: 3-4 months)

Step 2: Convene a DADS workgroup to develop amendments to current rules, if necessary, and to develop policies and procedures to make the concept operational. (Timeline: 6-8 months)

Step 3: Submit appropriate waiver and state plan amendments. (Timeline: 6-8 months)

Step 4: Provide training to staff and providers. (Timeline: 2-3 months)

Step 5: Enroll additional providers. (Timeline: Ongoing)

2. Consolidate community Mental Health and Mental Retardation (MHMR) centers and local authorities to assure a more effective system of service delivery management.

Consolidating community MHMR centers and local authorities will increase access to services and quality of care for Medicaid clients by establishing statewide standards for mental health and mental retardation services. Additionally, allowing local communities to develop their own systems to more accurately meet the needs of their population will ensure that clients receive appropriate services.

Proposal Recommendations:

- Consolidate community MHMR centers and local authorities to assure a more effective system of service delivery management.
- Consolidate mental health authorities down to 4-6 Super Regional Authorities.

3. Provide all nursing facility residents with information about end-of-life care options and the importance of planning for end of life care.

Currently, the federal Patient Self-Determination Act requires nursing facilities to inquire upon admission whether individuals have an advance directive and to provide them with information about advance directives. Additionally, the Texas Partnership for End-of-Life Care (TXPEC), a broad-based advocacy organization, is addressing end-of-life education across all care settings. This could be an opportunity for the state to work with TXPEC to disseminate information.

Provide End-of-Life Education Action Plan

Step 1: Partner with the Texas Partnership for End-of-Life Care (TXPEC), a broad-based end-of-life advocacy organization, to develop end-of-life educational materials appropriate for use within nursing facilities. (Timeline: 3-5 months)

Step 2: Provide additional training to nursing facilities in partnership with both the Texas Health Care Association and the Texas Association of Home and Services for the Aging. (Timeline: 2-3 months)

Step 3: Post materials on the DADS website and inform nursing facilities about their availability. (Timeline: 1-2 months)

4. Provide an appropriate continuum of care for residents of nursing facilities. Encourage treatment at nursing facilities whenever possible, rather than disrupting residents' lives by making them undergo the trauma of being transferred to a hospital for care.

Provide Continuum of Care Action Plan

Step 1: Convene a workgroup of physicians, nursing facility providers, and advocates to develop protocols for determining when transfer is appropriate and what care can reasonably be provided at nursing facilities. (Timeline: 3-5 months)

Step 2: Share information with the Texas Medical Association and the Texas Medical Director's Association to achieve buy-in to the concept and to provide appropriate training. (Timeline: 1 month)

Step 3: Disseminate protocols to nursing facilities through the Quality Monitors and to long-term care physicians via the Texas Medical Director's Association. (Timeline: 1 month)

5. Expand access to speech pathology services, intravenous therapy, and chemotherapy treatments as a Medicaid home health benefit.

The issue is not whether an individual receives these services, but whether they can receive these services at home. Such program expansion will reduce the provision of these services in more expensive environments. Eliminating the need for medical transportation and a physician's office visit will also decrease costs as well. Additionally, providing these services in home settings requires less disruption to clients, thereby potentially improving health outcomes. The workgroup believes that delivering these services at home would provide a continuum of care in the most appropriate setting.

With specific regard to speech pathology, it is important to note that physical therapy and occupational therapy are currently home health benefits. Under the current system, a client recovering from a stroke could conceivably receive physical and occupational therapy in their home, but be required to go to a speech pathologist's office for speech therapy. Adding a third and complementary home health benefit contributes to the continuum of care for clients in need of these services.

Proposed Recommendation:
Begin a program through the Area Agencies on Aging (AAA) or the retired senior volunteer programs to have volunteers call to check on older adults that live alone and do not get out often.

Expand Home Health Benefits Action Plan

Step 1: Develop fiscal note with HHSC fiscal department. (Timeline: 1 month)

Step 2: Request appropriate approvals from the Legislative Budget Board. (Timeline: 1-2 months)

Step 3: Promulgate necessary rules or develop policy changes. (Timeline: 6-9 months)

Step 4: Submit appropriate state plan amendments to CMS. (Timeline: 3-4 months)

Step 5: Initiate necessary automation changes via the Texas Medicaid and Healthcare Partnership. (Timeline: 8-10 months)

Step 6: Share information with providers and implement services. (Timeline: 1 month)

6. Provide support services to individuals providing day-to-day assistance to persons with Alzheimer's disease/dementia to reduce caregiver "burn-out."

These services allow caregivers to continue to provide support to their loved ones, allowing them to stay home and not be institutionalized, keeping the caregivers physically and mentally healthy.

Provide Caregiver Support Services Action Plan

Step 1: Establish program rules, criteria, and service array. (Timeline: 6-8 months)

Step 2: Establish provider base and rate structure. (Timeline: 6-8 months)

Step 3: Create necessary automation program changes to existing systems. (Timeline: 6-9 months)

Step 4: Provide necessary training, information, and implement service delivery. (Timeline: 2-4 months)

7. Educate stakeholders on caregiver issues.

Provide Stakeholder Education on Caregiver Issues Action Plan

Step 1: Designate a portion of continuing education and training for contract providers to include issues facing caregiver population. (Timeline: 1 month)

Step 2: Provide caregiver education to all who provide information, referral, and case management services to consumers at state and local levels. (Timeline: Ongoing)

Step 3: Develop and implement certification program to train consumers, informal caregivers, and kinship caregivers on how to provide quality care. (Timeline: 12 months)

Step 4: Develop and implement a statewide communications campaign to educate and inform the general public about caregiver needs, experiences, and available support services. (Timeline: 6-8 months)

Step 5: Develop and implement a statewide communications campaign to educate and inform businesses about the needs and experiences of employees who are caregivers. (Timeline: 6-8 months)

8. Develop a new system for opening state school facilities to clients who are living in the community and determine how to make the funding for community-based services pay for the services from the state school.

If an individual lives in a community setting rather than an institution, the state's cost for caring for that person is generally lower. However, in some communities there are limited resources available in the community to support some persons with disabilities. Sheltered workshops, some habilitative therapies, orthotics, or other services are currently provided in all state schools. If a person who lives in the community could take advantage of the resources available in the state school, the overall cost for caring for that person could decrease. The state schools should also consider whether they need to become Medicare providers to serve those individuals who have Medicare coverage. Additionally, the state should consider in which communities this option would be most appropriate, as making this service available would put state schools in direct competition with current private community service providers of these services. The state schools could then fill in the gaps in the continuum of care and allow persons who would otherwise not be able to, to continue to live in the community.

Expand State School Facilities Action Plan

Step 1: Convene a DADS workgroup to develop parameters for these services and identify any issues with current rules or laws. (Timeline: 2 months)

Step 2: Gather input from stakeholders. (Timeline: 1-2 months)

Step 3: Identify appropriate state schools to implement this process. (Timeline: 3-4 months)

Step 4: Determine the need for the state school to become a Medicaid/Medicare provider and whether any amendments to waivers/state plan amendments are required. (Timeline: 1-2 months)

Step 5: Review with DADS Executive Committee and Advisory Council. (Timeline: 3 months)

Step 6: Finalize policies and draft legislation/riders as needed. (Timeline: 6-8 months)

9. The state should simplify administrative procedures for the regulation of nursing homes.

Simplify Nursing Home Regulation Action Plan

Step 1: Convene an internal workgroup to review current administrative procedures for the regulation of nursing facilities and to identify more time and cost-efficient methods of regulation. (Timeline: 2-3 months)

Step 2: Convene a stakeholder's workgroup to review proposals to simplify the process. (Timeline: 1-2 months)

Step 3: Develop and implement new procedures and, as necessary, promulgate new rules. (Timeline: 6-8 months)

10. Improve collection of information on nursing home clients that would support community placement efforts.

These efforts would be cost-neutral to the state and beneficial to the provider community. For example, the state has already implemented a rule to extend the time between Texas Index of Level of Effort (TILE) reviews for nursing facilities with good track records. One specific recommendation suggested that entities merely change the manner in which they own a licensed nursing facility, without changing the underlying ownership, to be exempt from an initial licensure survey. For example, a sole proprietorship forms a corporation to hold the license and the sole proprietors own the shares. Such a change would permit DADS to utilize limited resources, primarily survey staff, more efficiently without inhibiting their ability to protect residents. In fact, it would permit DADS to enhance its ability to protect residents by permitting surveyors to focus on more critical activities, such as complaint investigations or deficiency follow-ups. Federal Medicare and Medicaid certification rules do not require change of ownership surveys; however, state licensure statutes require them. Therefore, this proposal would require a statutory change and related licensure rules changes.

> ***Proposed Recommendation:***
> Extend the TILE review process for nursing facilities with good track records. Additionally, provide notice to these facilities before reviews instead of making unannounced visits.

Improve Collection of Nursing Home Client Information Action Plan

Step 1: Develop and promulgate a nursing facility rule, which requires nursing facilities to provide to residents, who indicate a desire to return to the community on the Minimum Data Set (MDS) assessment, information about local centers for independent living, Promoting Independence and Rider 28. (Timeline: 6-8 months)

Step 2: Ensure that the state's current data use agreement (DUA) allows for the sharing of Q1a information (a question that asks if a resident expresses or indicates a preference to return to the community) from the MDS. (Timeline: 1-2 months)

Step 3: Ensure that all the appropriate HIPAA requirements have been met. (Timeline: 1 month)

Step 4: Implement the appropriate automation changes, if required. Appropriate automation changes may include ancillary changes required to extract Q1a data and format it to become a usable public communications product. (Timeline: 8-12 months)

Step 5: Provide information on new rule and policies to staff and all interested stakeholders. (Timeline: 1-2 months)

Step 6: Implement new rule and procedures. (Timeline: 10-12 months)

→ Achieve Cost Efficiencies

The workgroup strongly recommends that the state implement utilization review processes for certain programs and services to ensure appropriate use of services and appropriate payment for these services. The workgroup recommends establishing a system for private contractors to secure/coordinate the collection of Medicare funds for dual-eligibles. The workgroup recommends creation of additional partnerships with drug companies to get discounted prescription drugs for Medicaid clients. Finally the workgroup recommended auditing Medicaid Hospice in LTC facilities for correct billing of drug costs.

1. Use fee schedules, prior approval processes, and alternative service delivery options to ensure appropriate utilization and payment for services.

Ensure Appropriate Utilization and Payment for Services Action Plan

Step 1: Develop appropriate fee schedules for services that currently do not have them. This may require several workgroups that are service-specific. (Timeline: 6-8 months)

Step 2: Establish prior approval processes for specific high-end products. (Timeline: 6-8 months)

Step 3: Establish utilization review procedures for all community based programs. (Timeline: 3-5 months)

Step 4: Ensure that all contract management activities include measures other than process review. (Timeline: 3-5 months)

2. Establish a fee schedule for incurred medical expense (IME) for dental services controlled in long-term care facilities.

Long-term care facility residents that have applied income (AI) can pay for dental expenses as an incurred medical expense (IME); residents with supplemental security income (SSI) do not have this option. Any AI funds used for IME are deducted from a resident's contribution to their long-term care and must be made up by the state's Medicaid program. Containing costs in this area is important to the overall Medicaid budget and will also help protect clients from unnecessary dental care.

DADS and HHSC recently implemented a new procedure for dental IME, which involves DADS's regional nurse approval for certain services in an attempt to address fraud and abuse. HHSC has plans to convene a group of dentists, advocates, and nursing facility providers to explore the possibility of a fee schedule and the appropriateness of certain procedures.

Implement a Dental Services Fee Schedule Action Plan

Step 1: Convene a workgroup of providers, long-term care dentists and advocates to develop a fee schedule for incurred medical expensed dental services. (Timeline: 6 months)

Step 2: Develop related rules, policies and procedures systems. (Timeline: 6-8 months)

Step 3: Implement automation changes, if necessary. (Timeline: 10-12 months)

Step 4: Provide training on the fee schedule to staff, providers and long-term care dentists. (Timeline: 2 months)

Step 5: Implement fee schedule. (Timeline: 18 months)

3. Implement a fee schedule for allowable incurred medical expenses (IME) for durable medical equipment (DME) in nursing facilities and Intermediate Care Facilities for Persons with Mental Retardation (ICF-MR).

Currently, the ICF- MR program has a rule (Title 1 TAC 355.455) under which facilities are responsible for the first $1,000 of the cost of DME and the rest of the cost (up to $5,000) is reimbursed through a voucher system by the state. The state may need to explore a similar system for nursing facilities and create a related fee schedule. Any such system would also include appropriate assessments by professionals to document the medical necessity for such equipment.

Implement a Durable Medical Equipment Fee Schedule Action Plan

Step 1: Convene a workgroup of nursing facility, ICF-MR, and durable medical equipment providers and advocates to develop a fee schedule. (Timeline: 6-8 months)

Step 2: Develop related rules, policies and procedure systems. (Timeline: 6-8 months)

Step 3: Implement automation changes, if necessary. (Timeline: 10-12 months)

Step 4: Provide training on the fee schedule to staff and providers of long-term care durable medical equipment. (Timeline: 2 months)

Step 5: Implement the fee schedule. (Timeline: 18 months)

4. Establish a system for private contractors to secure and coordinate the collection of Medicare funds for dual-eligibles.

Texas already employs private contractors to coordinate the collection of Medicare funds for dual-eligibles. The Claims Administrator Primary Care Case Management contract is the primary contributor to this effort. Under this contract, provider claims edits are in place to ensure Medicaid remains the payer of last resort. When there is retroactive coverage, or Medicare recoupment, the Post Payment Recovery Activity group recoups provider claims to bill Medicare.

Secure Collection of Medicare Funds for Dual-Eligibles Action Plan

Step 1: Identify Medicaid recipients with Medicare coverage not previously identified by the state utilizing the Medicare Enrollment Database. (Timeline: 6 months)

Step 2: Manage and utilize the CMS-supported electronic database (EDB) exchange to enhance the identification of dually-eligible Medicaid recipients by September 1, 2005. This process provides Texas with the ability to exchange data with CMS in order to identify additional Medicare coverage. This process includes:

- Exchanging data with CMS;
- Verifying the quality of results;
- Comparing match results to State Known Medicare (i.e., Medicare coverage that is already known by the state); and
- Identifying new policies. (Timeline: 6-8 months)

Step 3: Initiate recovery for claims previously paid by Medicaid where new Medicare coverage has been identified, or where no recovery was made. (Timeline: 6-8 months)

5. Create additional partnerships with drug companies to get discounted prescription drugs for Medicaid clients.

The state implemented a new preferred drug list (PDL) program beginning in February 2004. Under this program, manufacturers who provide a supplemental rebate, above the rebate required by law, have their drugs put on a preferred drug list. Before a drug that is not listed on the PDL is dispensed to a Medicaid client, it must go through a prior authorization process. Savings of approximately $150 million in general revenue are projected for the 2004-2005 biennium. The extent to which this program is successful in negotiating rebates in the future is likely to be affected by the removal of dual-eligibles from the Medicaid Vendor Drug Program.

These partnerships are currently in effect:

a. The Medicaid PDL is in its second year of negotiations with drug companies. Aggressive negotiation in the second year is producing even better discounts (rebates) for preferred drugs.
b. Implementation of a preferred drug status for generic drugs is resulting in more movement to these "premium preferred generics."
c. Clinical edits that encourage movement to generic drug categories when appropriate have also been implemented.

Establish Additional Partnerships with Drug Companies Action Plan

Step 1: Investigate multi-state pooling. (Timeline: 12 months)

6. Audit Medicaid Hospice in long-term care facilities for correct billing of drug costs.

Beginning in January 2006, drug costs for most hospice clients will be subsumed by Medicare because most Texas Medicaid hospice clients are dually-eligible for Medicare and Medicaid. With a small number of Medicaid-only clients remaining, it is unlikely this proposal will generate sufficient savings to make it cost-effective in the long-term, but some short-term cost savings could be achieved through ensuring that drug costs are billed to the correct program.

Ensure Correct Billing of Drug Costs Action Plan

Step 1: Hire or contract with staff to review drug claims for hospice recipients in nursing facilities by January 1, 2006.

Step 2: Implement necessary automation edits by January 1, 2006.

Step 3: Run drug utilization reports for hospice recipients to compare to drugs appropriate to treat terminal conditions by January 1, 2006.

Step 4: Develop recoupment processes by January 1, 2006.

Fiscal Implications

The proposals recommended in this chapter seek to enhance the efficient and appropriate utilization of long-term care services in the state Medicaid program. Savings would be generated from more appropriate utilization of services, like increasing the use of hospice care when appropriate rather than providing more expensive facility-based care. Increasing utilization review would also create savings by assuring more appropriate use of services. Allowing an increase in home-delivered services for certain services provided currently in facility-based settings would accrue savings in the program. Additionally, an estimated savings on inpatient expenses is expected between fiscal years 2008 and 2010 from the development of more appropriate nursing facility transfer protocols that would ensure more services are performed in nursing facilities instead of at hospitals. These changes, along with expanding home health benefits for certain services could yield an estimated savings of $6 million between fiscal years 2008 and 2010.

Issue V: Education

Necessary information regarding the appropriate use of Medicaid by all participants in the program including clients, providers, community partners, and administrative partners should be more widely available in a consistent format that is comprehensive and understandable so that the clients and partners are able to identify their appropriate roles in the program and optimize the program's resources more efficiently.

The workgroup received many proposals that called for the education of every partner in the Medicaid program about the appropriate utilization of the program's resources. It was suggested that clients receive more education on appropriate emergency room utilization, prenatal care, and available services. It was also suggested that providers should receive additional education on evidence-based care management practices and on appropriate use of program services. The workgroup recommended community partners and providers for these educational efforts and to take advantage of other existing efforts to educate all Texans on positive health outcomes. Additionally, it was also suggested to the workgroup that the administrative partners should be encouraged to develop more effective educational material for clients and providers, and work with local communities in this effort.

Currently, Medicaid patients and their families receive education about the Medicaid program through different sources, including HHSC (through direct communication and via an updated Consumer Guide), the Department of State Health Services (DSHS) THSteps program, the Medicaid enrollment broker, Medicaid managed care plans, the TexCare Partnership and community-based organizations. Providers receive education through the Medicaid claims administrator, the Texas Medicaid and Healthcare Partnership (TMHP) and through the Medicaid managed care plans with which they have contracts. The workgroup heard a critical review of these outreach and education efforts of the Medicaid program and the workgroup suggested these efforts be continued only if they are proven to be effective.

The majority of the proposals submitted to the workgroup regarding provider education focused on the need to educate providers about appropriate utilization of things such as DME and pharmaceuticals and how, if fraud and abuse are suspected, to report it to Medicaid. Currently, the TMHP and the Medicaid managed care organizations educate providers on reporting possible fraud – both provider and client. This effort needs to be combined into a comprehensive educational message and curriculum so that providers receive standardized information on how to appropriately use Medicaid resources as well as report fraud and abuse.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Develop an Education Campaign

The workgroup recommends implementation of a clearly defined education effort, with a core curriculum of information about the appropriate use of the Medicaid program that could then be adapted for use with patients, providers, community partners and administrative partners, and involve local partners in the development and dissemination of the educational information. To direct clients to physicians and clinics, the education program should be continuously active with a component developed with a coordinated effort of internal, agency, and external administrative stakeholders familiar with the Medicaid population.

The workgroup suggested that patient education efforts focus on three to four components of patient care and behavior, and use a targeted message to reinforce the use of positive behavior. The areas of highest need are emergency room, non-emergent care, and women's health. The state should also examine ways to identify those specific patients most in need of education and target programs for those patients.

1. The information needs to be made demographically relevant and appropriate for each partner and population. If the state could achieve more effective coordination of resources for education and outreach, and make the information more accessible to clients and providers, it would produce long-term cost savings to the program.

2. This educational program should also target certain households, like the Head Start households being targeted with intensive children's health care education in the Johnson & Johnson funded pilot through the University of California at Los Angeles.

3. The workgroup recommends any current funds spent on education efforts be coordinated into an integrated education initiative.

4. Enlist the help of stakeholders such as the Area Health Education Centers (AHEC), who use public funds to educate clients and providers about the Texas health care system. When used as partners in the Medicaid program, AHECs should qualify to draw down additional federal funding for administrative costs to the program dealing with Medicaid related activities. This increases the efficiency of all state dollars for the coordinated purpose of educating clients and providers about how to access Medicaid health care services. Federally Qualified Health Centers (FQHC) are also well positioned to do community-level education because of the federal requirements tied to their funding that mandate significant community involvement and oversight of their operations.

5. Other state agencies that work with Medicaid clients, as well as the administrative partners who work on enrollment, eligibility and service provision, should follow the same curriculum for client and provider education.

6. Community-based health workers, health educators, state eligibility workers stationed in hospitals and other provider locations, as well as *promotoras*, should also be used in this effort.

7. Participants in this process should include TMHP, the enrollment broker (MAXIMUS, Inc), the managed care organizations, and any private companies that may have contracts to provide eligibility services.

8. There should be a standardized and simplified process for providers regardless of the service delivery system in which they provide services. (The appropriate use of prescription drugs was a core concern voiced by the workgroup. The Vendor Drug Program currently sends letters to physicians whose patients are taking over nine outpatient prescription drugs at the same time and seek assistance with identification of possible inappropriate drug utilization.) One component of this educational effort needs to focus entirely on pharmaceutical utilizations both in acute care and in long-term care.

9. Providing polypharmacy education and review of drug information for patients in nursing homes was specifically recommended.

10. Routine educational activities such as newsletters, health fairs, and emergency department staff are necessary tools for this education effort to begin to change the pattern of accessing care for many clients.

11. The education effort should focus on encouraging clients to keep and use a "medical home" and reduce the utilization of high-cost emergency department services for conditions that can be treated by the client's primary care physician.

> ***Proposed Recommendation:***
> Improve utilization of "medical homes" and relationships with primary care physicians.

12. The workgroup recognized that any increases in provider reimbursement rates should be targeted to physicians serving medically underserved areas, or who see a high volume of Medicaid patients, and who provide care that is an alternative to emergency department use.

Educating clients about the appropriate use of the emergency department for emergent care, and how to access care for non-emergency conditions, will reduce emergency department utilization and therefore program costs. With the expansion of managed care statewide, health plans contracting with HHSC, as well as the PCCM administrator, must focus their attention on the appropriate utilization of emergency departments. Table 4 outlines additional recommendations for conducting outreach and education for emergency department consumers.

Table 4
Recommendations for Outreach and Education for Emergency Department Consumers

1. More effectively advertise existing nurse triage call lines, and develop a statewide strategy to ensure there is an available number in every part of the state.
2. Develop educational modules on a wide variety of topics to help break myths and barriers about illness, and promote understandings of child development, child nutrition, and health.
3. Use existing outreach networks to distribute consistent messages about health care utilization.
4. Insert educational messages about sick-care into the context of THSteps checkups.
5. Train caseworkers to deliver these same educational messages.
6. Create partnerships with health care providers and their professional organizations to disseminate educational and informational messages.

Source: SETON Healthcare Network, July 2002. Selected recommendations from *Out of the Emergency Room, Communicating Healthcare Options to Low-Income Texans,* page v.

Education Campaign Action Plan

FOR CONSUMERS:

1. Direct Mail

a. **Strategy:** Produce direct mail campaigns for Medicaid households, consisting of two to four pieces, which deliver specific utilization messages. Focus on the benefits of having a "medical home," exercising preventive measures, reserving the emergency department for emergencies, and utilizing nurse triage call lines. (Timeline: 8-12 months)

2. Earned Media (Media Relations and Free Media Placement)

a. **Strategy:** Develop 60-second radio public service announcements with features focused on specific prevention care measures and emphasizing the overall benefit of using prevention to avoid illness. (Timeline: 8-12 months)

b. **Strategy:** Develop a series of prevention-focused newspaper Op-Eds In English and Spanish, which local organizations can adapt to their local needs. (Timeline: 8-12 months)

3. **Collateral**

a. **Strategy:** Update all collateral to reflect new messaging. (Timeline: 8-12 months)

b. **Strategy:** Review materials sent by HHS programs to make recommendations to ensure consistent messaging on utilization. (Timeline: 8-12 months)

FOR PROVIDERS:

1. **Health Plans**

a. **Strategy:** Send all Medicaid enrollees a notice about the importance of scheduling an initial appointment with a doctor. (Timeline: 8-12 months)

b. **Strategy:** Encourage health plans to distribute a quarterly preventive care newsletter to enrollees. (Timeline: 8-12 months)

c. **Strategy:** Encourage health plans to more effectively advertise their nurse triage lines.

2. **Primary Care Provider Offices**

a. **Strategy:** Send an initial appointment letter or post card to notify parents who have either chosen, or have been assigned to, a primary care physician (PCP) of the need to arrange for an initial appointment. (Timeline: 8-12 months)

b. **Strategy:** Produce a preventive care toolkit for physicians' offices that include client education materials focused on preventive care. (Timeline: 8-12 months)

FOR PARTNERS:

1. **Provider Associations**

a. **Strategy:** Develop a series of newspaper articles which provider associations can adapt to their members' needs and run in their publications. (Timeline: 8-12 months)

b. **Strategy:** Develop a presentation on best practices and present at provider associations' annual meetings. (Timeline: 8-12 months)

2. Claims Administration Contractor

a. **Strategy:** Review materials and training developed to make recommendations to ensure consistent messaging on utilization and medical practices. (Timeline: 8-12 months)

Fiscal Implications

The education campaign proposed in this chapter would require modest up front costs to develop curriculum and establish an education network. However, it is expected that future savings would eventually offset this initial investment by as much as $20 million between fiscal years 2007 and 2010. Furthermore, using these initial resources to develop effective messages about appropriate and efficient Medicaid program utilization may yield savings and other benefits well beyond the $20 million projected for the five-year period.

Issue VI: Administrative Burdens

The administrative and paperwork burdens placed on clients, providers, and all other partners in the Medicaid program should be significantly reduced. Medicaid should take advantage of every opportunity to use technology and efficient business practices to decrease the administrative burdens borne by all partners in the program.

The workgroup heard many complaints about the administrative burdens that clients, providers, and other Medicaid partners face in the program. The workgroup also received information on how the use of technology can create efficiencies and improve quality in the Medicaid program. The proposals and concerns raised in the workgroup focused around finding as many administrative efficiencies in the program as possible, thereby reducing any unnecessary burden on the Medicaid provider community.

The program should be able to determine and verify eligibility as early and as efficiently as possible. The workgroup also supported a proposal for integrating a client's medical records into a universal services card, to ensure providers have the most accurate and up-to-date information about clients' medical history.

Business processes, such as applying to be a Medicaid provider or filing a claim, should be electronic and as efficient as possible. If implemented, these goals should effectively integrate various components of the system, eliminate duplication, decrease paperwork hassles, and improve the quality of the program.

Current Administrative Improvement Initiatives

Integrated Eligibility

House Bill 2292, 78th Legislature, Regular Session, 2003, requires HHSC to examine ways to streamline the process used to determine if a person qualifies for health and human services programs. The current system of eligibility determination was designed in the late 1960s and has not incorporated modernized business processing and new technology to make it more effective. HHSC conducted an in-depth examination of the current system and found that it places burdens and barriers on applicants for health and human services programs, including:

- Applicants usually make multiple visits to a local office for eligibility determination. For many applicants this requires taking time off from

work, arranging for childcare, or taking children out of childcare, as well as transportation challenges.

- In 72 percent of the face-to-face cases observed by HHSC discovery teams, eligibility was not determined during the initial interview and the cases were pended for additional verification.
- Applicants may receive numerous pages of notices, some 15 to 20 pages in length, when applying for multiple programs.

Before developing a new model for eligibility determination, HHSC conducted an in-depth examination of the current systems. As required by H.B. 2292, HHSC also conducted extensive analysis and research that concluded with a Business Case for Integrated Eligibility and a new model for eligibility determination.

Table 5
HHSC Eligibility System Research and Findings

The workgroup recommended the Texas program mirror other states' best practices to the greatest extent possible. An HHSC research team was established to review eligibility initiatives in other states to determine best practices. Information was obtained from 29 states around the country. At the conclusion of the research and in developing our own State's eligibility initiative, HHSC believes the Texas Integrated Eligibility initiative exceeds other programs researched because:

1. The Texas system will integrate eligibility for TANF, Food Stamps, CHIP, Medicaid, and long-term care services and will provide seamless integration with managed care enrollment for CHIP and Medicaid clients.
2. The Texas system will support self-service through the web and call center integrated voice recognition (IVR) - some states offer one, but not the other.
3. The Texas system will collect client information at a single point of contact and will share with other systems (e.g. MAXIMUS, Inc. – the Texas enrollment broker, THSteps, TMHP – the Texas claims administrator, and other trading partners outside the health and human services enterprise), and will be scalable to allow expansion to other programs.
4. Channels of Access - the Texas system will offer more channels of access not offered in other states: web, IVR, mail, fax, face-to-face, community based organizations, out-stationed workers, and traveling units.
5. The Texas system will be rules-based - some of the other states do not have a rules-based system.
6. The technology being considered in Texas is more recent than technology used in other states.
7. Texas will roll out to all the state's 254 counties in a 10-month period. Some states, California among them, have had systems in development for over six years and are now expanding from just six counties to 37.

The new model offers clients multiple and new channels to submit applications: in person, through the Internet, over the phone, by fax, or mail. The new model also proves that eligibility determination that incorporates call centers is cost-effective and will yield significant savings to the state.

The benefits of an integrated eligibility determination system include:

- **Convenient access for consumers.** Applicants will not have to take time off from work, pay for transportation, or arrange childcare to apply for services.
- **Benefit Issuance Centers.** The state will locate benefit issuance centers across the state for those who wish to apply in person. Enrollment broker staff will be available at the benefit issuance centers to assist applicants with managed care options and THSteps information.
- **Customized single application**. Applicants will be able to access a variety of services, and the system allows for customized applications. Increased integration will mean clients will be able to access a variety of services – even across agency lines – with one application.
- **Net savings** of at least $300 million over a 60-month period. HHSC anticipates additional savings will be achieved by streamlining central office administration, information system support, other eligibility support functions, and implementing new initiatives, such as the Universal Services Card.

The integrated eligibility model is fundamentally different from the current system because it is designed around the consumer's needs and uses technology to streamline processes. The biggest advantage of the integrated eligibility model is the improved access to state services for working Texans, for people who lack transportation or live in remote areas, and for others who have difficulty traveling.

Universal Services Card

Another effort supported by the workgroup, on which HHSC is already working, is for the development of a Universal Services Card (USC) that would utilize a single card to provide a standardized delivery platform for multiple programs. HHSC is currently investigating the feasibility of pursuing the USC concept and will identify implementation alternatives. HHSC anticipates that this concept will be introduced in fiscal year 2006, with a phased-in implementation over four years.

A key component of the USC concept is the establishment of centralized card management. Card management functions include creating and maintaining standards for cards and readers, development and distribution of cards, providing help desk assistance to clients and providers, and replacement of lost or stolen cards. A centralized card management model would dramatically reduce the administrative overhead that would normally be required if each individual program was required to provide these services.

Medicaid providers will benefit from the introduction of the USC. Presentation of the card will eliminate confusion that currently exists when a client presents in a provider's office for the first time without knowing their appropriate payer of services, either fee-for-service or a health plan. This card will decrease the administrative burdens on providers to obtain that information about the client and improve the services clients receive. Other expected benefits of a USC include improving service to clients by providing a single card for access to all applicable program benefits and services; improving the delivery of services through the standardization of cards and simplification of processes; and improving service provider participation and decreased provider administrative costs through simplified processes, and improved payment cycles. Several tangible benefits are anticipated to result from the implementation of a USC as a result of reduced administrative costs associated with combined USC card production, distribution, and operation.

HHSC's current feasibility study will determine the most efficient and cost-effective way to implement the common card concept and identify and prioritize applicable programs that will use the card. Initial programs that have been identified include TANF, Food Stamps, the Women Infants and Children (WIC) program, and Medicaid.

The move to a USC would create some immediate savings by decreasing certain administrative burdens, such as costs associated with the production of currently utilized paper Medicaid identification, which are $9 million per year. A portion, or all, of this money can be deferred to pay for the cost associated with the USC card production, distribution, and operation. Operational cost-savings associated with the USC will include a reduction in mailing and production expenses; fewer maintenance activities for multiple systems; reductions in paper processes, and procurement discounts associated with increased consolidated purchases and increased volumes. All of these improvements will result in less waste and improve provider access to eligibility information.

Electronic Remittance and Status Reports

Electronic Remittance and Status (R&S) reports indicating which claims are to be paid each week have already alleviated some of the provider burdens associated with traditional paper generated reports. Providers who choose to receive their payments via electronic funds transfer are afforded more expeditious payments.

The workgroup heard a great amount of information regarding the burdens faced by providers working with multiple health plans. While it was not a workgroup proposal, one option would be to consider a single clearinghouse for submission of Medicaid claims. By using a single clearinghouse, providers would only need to submit their claims to a single claims administrator that would be responsible for determining the appropriate payer for services provided based on the patient's eligibility and enrollment status. This eliminates the need for providers to know in advance of service delivery which entity would pay the claim. The Medicaid claims administrator, TMHP, has the most prevalent source of Medicaid patient and provider data in the state and has the systems and infrastructure in place to quickly migrate to a single clearinghouse design. For example, TMHP could take all provider claims, determine the payer of record related to that patient's eligibility using the new USC or other interim means, and process the claim accordingly. For managed care entities, these claims would transmit directly to them, eliminating the need for the provider to first submit to the plan (or all plans as is the current practice), receive either payment or denial, and in the case of the latter, re-submit to the claims administrator for payment.

Benefits to providers of using a single clearinghouse include:

- *Centralized encounter and other claims data-capture and reporting;*
- *Improved cycle times for payment;*
- *Alleviated burden in determining which claims administrator to utilize;*
- *Increased focus on quality patient care; and*
- *Expedited claim payments.*

The USC would compliment the single clearinghouse model, as data would transmit directly to the clearinghouse. This would result in the elimination of redundant systems and less 'touching' of the claim itself. This process could also reduce duplicate submissions. Presently, 30 percent of all claims adjustments (appeals for reconsideration of prior decisions) are duplicates.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Improve Business Processes

Proposals supported by the workgroup encouraged the use of technology and innovation to ease administrative burdens in the Medicaid program, with a specific focus on filing claims and complying with current administrative processes. Suggested solutions included exploring the use of technology initiatives, consistency in coding, and the elimination of redundant or conflicting rules or regulations across programs. The workgroup also recommended increased coordination with federal partners to draw down federal funds for technology innovations and improvements.

1. Expand electronic claims payment system utilization.

An electronic claims payment system is a natural enhancement to the single clearinghouse and is currently utilized in the current claims administrator contract. Expanding this service to the majority of providers would eliminate the cost of, and need for, paper checks and postage. Further, such expansion would:

- Ensure TMHP accountability for claim payment errors and recoupments;
- Provide cost-savings to the state; and
- Expedite payments of Medicaid funds to providers.

2. Develop a web portal system for prior authorization requests.

The current prior authorization process is paper and labor intensive for both vendors and providers because requests are made via paper, fax, or telephone. Failure to submit the appropriate documentation when requesting prior authorization for services can result in patient care delays. Additionally, if further information is required in order to approve a prior authorization request, the provider may be contacted multiple times by phone and mail within a 21-day timeframe in order to fully process the request.

Implementing an electronic system that providers directly interact with would:

- Eliminate the need for providers to submit prior approval requests;
- Provide immediate feedback on whether additional information may be required;
- Indicate immediately if requested services are not allowable; and
- Provide affirmative responses so that services can be rendered immediately.

3. Encourage Medicaid providers to submit their program participation applications electronically.

Currently, the Texas Board of Medical Examiners takes license applications for physicians in Texas through *Texas OnLine,* a web-based system operated by the state of Texas. A link from *Texas OnLine* to the Medicaid program provider application could be established, with the capability of auto-filling common information.

4. Ensure the Medicaid provider application is easy to locate on the Internet so that providers can conveniently apply to the program.

5. Work with federal partners to take advantage of every opportunity at the federal level to draw down funding for technology in the Medicaid program.

In April 2004, President Bush issued an Executive Order calling for widespread adoption of an interoperable Electronic Health Record within 10 years. The Medicaid program should be a participating partner with the National Coordinator for Health Information Technology as this initiative moves forward.

6. Encourage the increased use of medical technology by providers.

The workgroup received a number of proposals focusing on the use of technology. The most significant was a report titled, *Advanced Technologies to Lower Health Care Costs and Improve Quality*, which was written and issued by the Massachusetts Technology Collaborative. The report outlines many ways that cost savings in the health care system can be achieved through the use of technology. Table 6 outlines some of the recommendations of the report. While many of these technologies have significant up-front costs that may make them cost-prohibitive for implementation, the Texas Medicaid program should take advantage of as many opportunities for expanding the use of technology as possible. Texas should also look to other states and emulate successful programs using technology.

Table 6
Advanced Technologies to Lower Health Care Costs and Improve Quality

1. **Electronic communication between patients and their physicians** has been shown to measurably decrease overall claims costs while improving patient access and communication and enhancing practice efficiency.
2. **Electronic prescribing** tools that provide up-to-date payer formulary information at the time a physician writes a prescription, and that support the electronic transmission of that legible prescription to a pharmacy, can markedly reduce drug costs and improve patient safety associated with the prescription process.
3. **Ambulatory computerized physician order entry (CPOE)** systems that facilitate physician orders at the point-of-care for medications, laboratory, and radiology tests provide significant opportunities for improving quality while reducing costs.
4. **Inpatient CPOE** can reduce errors, improve health care quality, and lower costs in the hospital setting.
5. **Regional data sharing** can coordinate patient care across a community when patients are seen at multiple provider organizations.
6. **E-ICU** technology allows physicians to fully monitor patients remotely, thereby reducing costs by expanding the ability of one intensivist to cover multiple ICUs using remote monitoring.
7. **Disease management** has been shown to increase patient involvement and therefore satisfaction with overall care while effectively improving the quality of care and reducing costs to treat patients.

Source: Massachusetts Technology Collaborative, 2003. *Advanced Technologies to Lower Health Care Costs and Improve Quality,* pages 5-6.

Florida identified 1,000 physicians who wrote the most Medicaid prescriptions and provided them with handheld devices (at no cost to the provider) that allow physicians to access the Medicaid Preferred Drug List (PDL); obtain a 60-day patient-specific prescription history; and browse clinical information for drug products and drug interactions. The device makes it easier for physicians to prescribe medications from the PDL, and it helped to reduce polypharmacy (duplicative prescriptions), and inappropriate drug use, while alerting physicians to potential adverse drug interactions and patient drug allergies. Successful expansion of the program is being paid for with the savings.

Improve Business Processes Action Plan

Step 1: Determine which vendors and state stakeholders would be affected by the implementation of (1) expansion of an electronic claims payment utilization system and (2) development of a web portal system for prior authorization requests. (Timeline: 3-6 months)

Proposed Recommendation:
To save State funds, utilize National Drug Codes for outpatient injectable drugs.

Step 2: Develop Requests for Proposals (RFP) for development of (1) expansion of an electronic claims payment utilization system and (2) development of a web portal system for prior authorization requests. (Timeline: 3-6 months)

Step 3: Issue RFPs and award contracts for the three initiatives. (Timeline: 12-18 months)

All of the technology improvements outlined above would require a minimum of 12 months to design, develop, implement and staff to monitor. There are multiple vendors and state stakeholders who are affected in some form or another by technology enhancements.

The use of telemedicine and telehealth holds tremendous opportunity for the Medicaid program to more efficiently and effectively deliver services to Medicaid clients located in rural or underserved areas. Currently, the Medicaid program reimburses for covered services (which include evaluation and management, consultation, and teleradiology and telepathology services) provided to eligible Medicaid clients using telemedicine technology. Texas Medicaid has the authority to use telemedicine and telehealth technology to deliver any service provided that can be shown to be both cost-effective and clinically appropriate. Advances in technology now allow providers to interact and provide follow-up visits with homebound patients through home telemonitoring, which could produce savings both in home health and medical transportation costs. The use of telemedicine allows for increased access to medical services for Medicaid clients living in rural or underserved areas while also allowing for savings in travel time and expense for the program. HHSC is exploring the use of telemedicine and telehealth for home health and other services in the Medicaid program where these options can increase access to care and decrease the cost of providing services.

→ Ensure Program Integrity

The workgroup supported proposals to increase the accountability of the Medicaid program's payment systems, with particular concern that appropriate payment for services is rendered. The workgroup wanted to ensure that providers meet established quality and efficiency standards, and that the program is effectively managed by the state. Further, the workgroup recommended that various changes to the THSteps program be made and that these changes be put on a priority schedule with deliverable timelines for completion.

1. Audit Medicaid program utilization.

To ensure accurate and appropriate provider payments are made, the workgroup recommended establishing Medicaid audit teams to review claims. The HHSC Office of Inspector General (OIG) currently performs this function as an after-payment review. However, the workgroup encouraged OIG to establish relationships with the Medicaid/CHIP division's claims administrator contract management department, in order to develop a thorough understanding of how claims are processed, and ultimately paid, according to current state policy. This will afford the OIG and associated audit teams an opportunity to integrate their understanding of state policy as it relates to operational performance to support the goal of performing proactive

audits of claims and provider payments, rather than recouping monies already expended.

In addition to OIG claims review, the workgroup also recommended that a process be developed by Medicaid/CHIP to regularly examine available utilization data to identify and report potentially inappropriate use of services and eligibility.

Evaluate Medicaid Program Utilization Action Plan

Step 1: Complete full assessment of OIG claims review process; schedule an ongoing series of meetings between claims administrator contract management staff and OIG to establish roles, responsibilities, system to be used, and anticipated outcomes. (Timeline: 2-3 months)

Step 2: Identify Medicaid audit teams, prospective staff participants, charter, roles, and responsibilities. (Timeline: Concurrent with Step 1)

Step 3: Determine system and/or reporting functionality required to provide proactive audits of claims to be paid. (Timeline: 5-7 months)

Step 4: Incorporate prospective review of claims to be processed into existing OIG retrospective audits to prevent provider overpayments and provide assurance of accurate payments made by the claims administrator vendor. (Timeline: 2-3 months)

Step 5: Revise policies and procedures to reflect actions necessary to the performance of the audit function; incorporate into claims administrator contract management department operating policies. (Timeline: 3-5 months)

Step 6: Evaluate the ongoing system for reporting utilization patterns by random selection of providers who have been identified for recoupment actions; determine best practices related to identifying inappropriate use of services and/or eligibility; create reporting requirements; determine the most appropriate entity to be accountable for the production and evaluation of the data; implement accordingly. (Timeline: 6 months)

2. Ensure appropriate HHSC oversight of the Medical Transportation Program.

In March 2004, the administration of the Medical Transportation Program (MTP) was transferred from the Texas Department of Health to HHSC. In September 2004, the administration of the program transferred from HHSC to the Texas Department of Transportation (TxDOT). However, HHSC serves as the single state agency for federal communication, thereby ensuring program compliance with federal and state requirements. TxDOT maintains responsibility for daily program operations. Currently, HHSC is developing a risk management plan to review TxDOT policies

and procedures to ensure program services are compliant and appropriately delivered to clients.

3. Perform a quality review assessment of the Medicaid Medical Transportation Program.

Currently, the MTP program is regionally based; dependent on multiple carriers throughout the state; and uses varying systems and administrative resources to provide services. The program hopes to transition to an automated system that would centralize service request and dispatch by utilizing existing 211 telephone capabilities. For example, the new system would allow providers or patients to access a newly designed 'tree' off the 211 phone system that would allow them to request a new MTP service, identify the date, time and place of pick-up and delivery, and route the request to the region-specific provider via email, phone, or in some cases, a printed letter may be inevitable for rural or smaller MTP carriers. Further, the USC reader could be installed in transportation vehicles so that eligibility can be readily established and payment requests authorized. With the help of the proposed single clearinghouse concept, faster payments could be rendered to MTP service providers.

Because so many changes are occurring and planned for MTP, a quality review assessment of the program is essential to ensure appropriate program administration.

The quality review assessment should:

- Evaluate program efficiency;
- Assess the quality of services provided to program beneficiaries;
- Evaluate the cost-effectiveness of vendors; and
- Identify potential overpayments to providers, thereby supporting state efforts to pursue potential fraud cases.

Review and Assess the Quality of the Medical Transportation Program Action Plan

Step 1: Further refine the areas of responsibilities for HHSC, TxDot, and DSHS as appropriate. (Timeline: 2-3 months)

Step 2: Clarify the Memorandum of Understanding (MOU) between the three agencies, as appropriate, clearly laying out job responsibilities. (Timeline: 2 months)

Step 3: In defining job responsibilities, clearly outline financial and program responsibilities related to the annual quality review assessment required of the MTP program. (Timeline: 1-2 months)

Step 4: Complete the annual quality review (may contract out with an outside vendor or public university) assessment and recommend options for improving the MTP program. (Timeline: 5-7 months)

4. Utilize the THSteps Performance Improvement Plan to guide changes and improvements to the program.

HHSC and the DSHS, the agency that implements the THSteps program, participated in the Texas Health Steps performance improvement plan (PIP) with program stakeholders in 2002 and 2003. That process developed a report and recommendations for improvements to the program. The report can be viewed at http://www.hhsc.state.tx.us/medicaid/programs/thsteps/0303_StatusRpt_Intro.html However, many factors - including important legal considerations - must be taken into consideration in order to properly plan and implement changes in the THSteps program. All new initiatives or program revisions must be coordinated between DSHS, HHSC, and the Office of the Attorney General.

The improvement plan makes several kinds of recommendations for program improvements that are at various stages of implementation. The first activity proposed by the improvement plan is to merge the Texas Medicaid Provider Procedure Manual with the THSteps Manual. A single manual will make it easier for providers to participate in THSteps as well as provide acute care Medicaid services. This projected was completed in January 2005.

HHSC has already merged the applications for THSteps with the Medicaid provider application. The Medicaid provider enrollment application was modified to require providers to “opt out” as a THSteps provider rather than affirmatively indicate a wish to be a THSteps provider. This application change results in less documentation and fewer requirements, should the provider choose to provide THSteps medical check-ups at a later date.

a. The improvement plan also proposed that THSteps pay claims for children ages two to 21 years in a manner similar to that for those aged birth to two years, which allows a total number of visits over a range of ages, instead of the current requirement for the older children that their visits coordinate with their date of birth.

The additional flexibility will accommodate the needs of families and providers and help ensure greater compliance in the program. The contractor, Texas Medicaid Healthcare Partnership (TMHP), will need to revise the current claims systems edits and audits to complete implementation of this recommendation. The system changes are part of a large number of changes awaiting implementation as the result of HIPAA and change of contractors. The order in which systems changes are addressed and given to the contractor for implementation is prioritized by HHSC, with input from state stakeholders. Consideration is given to all other projects that are pending and critical to the claims processing system. Currently, this change is ranked as a medium priority with an anticipated completion date of fall 2008; an elevation on the priority listing could result in completion date of fall 2005.

b. The improvement plan also proposes that the program develop more effective mechanisms of collecting information regarding THSteps visits for children in managed care plans. A current HHSC initiative

will develop a fully functional Medicaid managed care encounter data system that will provide timely and accurate information about a child's use of services. Implementation of HIPAA has aided in this process by allowing the plans to use the standardized codes utilized by the private insurance industry to submit claims. Completion of this initiative is anticipated in fall 2005.

c. The PIP also focused on improving training for those individuals who participate in the THSteps program. The program will continue to seek input from provider and professional organizations to develop consistent content for provider and office manager training for the program.

5. Develop a quality assurance system for the THSteps program.

The THSteps program currently utilizes the American Academy of Pediatric (AAP) Recommendations for Preventive Pediatric Health Care. The AAP Recommendations for Preventive Health Care are nationally recognized and were adopted as an outcome of the THSteps Process Improvement Plan (PIP). THSteps has modified these only as needed to meet federal regulations or to coordinate the timing of some procedures with other programs, such as WIC, which serve the same population.

However, workgroup proposals suggest these standards may not be appropriate for Texas children and that independent standards should be developed. The proposed quality assurance system should re-evaluate these standards to ensure and enhance prevention services, and ensure the program is designed adequately so that the appropriate services are provided.

6. HHSC and DSHS should continue to coordinate efforts to obtain approval from the CMS for prenatal and family planning exams to count as THSteps medical exams.

Differences in federal regulations regarding confidentiality, parental consent and involvement, and providers' relationships to managed care plans create the need for careful coordination between HHSC and THSteps.

7. Develop mechanisms that would help increase compliance with THSteps' check-up and immunization schedules.

Increasing compliance in these preventive health areas could also decrease emergency room use.

8. Encourage enhanced coordination and communication between THSteps' check-up providers and PCPs, which are the children's medical home.

As a starting point, language was placed in the Texas Medicaid Provider Procedure Manual –THSteps to inform medical check-up providers of the responsibility to send the results of the check-up to the medical home.

9. Facilitate the integration of THSteps services and the medical home.

The goal is to encourage the medical home to provide medical check-ups as often as possible. The "opt-out" application is a first step in the process of eliminating additional paperwork and encouraging the medical home to also be a THSteps provider. HHSC continues to coordinate with professional organizations to meet this goal. The Medicaid/CHIP Medical Director participates in the Texas Medical Association's (TMA) Ad Hoc Committee on Medicaid and meets regularly with the medical directors of the Medicaid MCOs where topics such as participation in THSteps, promotion of the medical home concept, and communication and coordination among providers are discussed.

The workgroup supports these initiatives and the development of a stronger timeline for implementation. Additionally, DSHS and HHSC are committed to continued improvements and enhancements to the THSteps program; responsiveness to provider concerns and complaints; and stakeholder input regarding potential changes.

Enhance the Texas Health Steps Program Action Plan

Step 1: Re-convene a limited sub-group of the original THSteps Process Improvement Plan (PIP) Workgroup to re-evaluate status of original policy recommendation in each of the four main areas of focus:

- Simplify the administrative requirements for providers (including physicians and health plans);
- Simplify data issues to improve program performance and accountability;
- Improve THSteps client access to care and strengthen provider/client education; and
- Improve coordination of THSteps among all health and human services operating agencies. (Timeline: 3-4 months)

Step 2: Identify a specific agency lead for each of the outstanding policy recommendations as appropriate with particular focus on the following items:

- Simplification of provider manuals;
- Altering of payment of THSteps visits for children ages 0-2 years old in the TMHP claims system;
- Assisting with HHSC contractor work related to improvements in the encounter data project;
- Developing consistent messages for all provider organizations treating Medicaid clients;
- Re-evaluate the use of the AAP recommendations for preventive pediatric health care as the source for setting the THSteps periodicity schedule;
- Work with CMS to consider counting pre-natal and family planning visits as THSteps exams;

- Develop specific plans of action for increased compliance with THSteps check-up and immunization schedules; and
- Increase the coordination and further development of a medical home for all THSteps clients. (Timeline: 4-5 months)

Step 3: Work with the respective HHS agency legal and financial departments to further clarify the legal and financial implications for the specific items above. (Timeline: 1-2 months)

Step 4: Re-convene external stakeholders formally on the workgroup such as the TMA, Texas Pediatric Association, Texas Association of Community Health Centers (TACHC), etc. to discuss any updated or revised recommendations. (Timeline: 1-3 months)

Step 5: Revise any recommendations based on input from external stakeholders. (Timeline:1 month)

Step 6: Implement THSteps revised PIP recommendations as appropriate. (Timeline: 6-8 months)

Fiscal Implications

Increasing the use of technology in the Medicaid program is an expensive endeavor, however, if all of stakeholders and partners in the program work together the state and health care providers can take advantage of every funding opportunity to cover these costs. For example, the U.S. Department for Health and Human Service's Agency for Health Research Quality has federal funds available to help states increase the development and use of electronic medical records. Additionally, when private entities transition to electronic billing or medical records, the state could partner with those entities and benefit from their transition. Expanding the electronic claims payment system could also yield cost savings to the state, as could physicians' use of handheld devices to access the Medicaid PDL.

Issue VII: Utilization Management Systems

The medical and case management provided to Medicaid clients should be more effectively coordinated to eliminate duplication, eliminate barriers to services, and ensure the most appropriate utilization of services.

Throughout the public meeting process, the workgroup consistently heard about significant inefficiencies in the case management, care coordination, and the medical management of clients. These inefficiencies create duplication of services, present barriers to accessing other services, and encourage inappropriate utilization. Such problems have developed over time, as multiple programs and systems were created to address particular issues that were identified and solutions implemented in a piecemeal fashion. The need for a consistent mechanism for coordination of these services was evident to the workgroup.

The concerns in this area on both acute and long-term care service provisions. Regarding acute care, concerns were raised about the management of certain chronic conditions, as well as certain high risk and high utilizing clients. Acute care services permit varied case management, but those services are provided with varying levels of consistency and competence.

Additional concerns were raised about the case management, medical management and care coordination for persons receiving long-term care services. Medicaid pays for different levels of case management through various programs, and a Medicaid recipient may receive these services from more than one program. This duplication is wasteful and might create conflicting service provision to clients. Case management services for the Children with Special Health Care Needs (CSHCN) program also need to be coordinated across multiple state and federal programs to improve services and eliminate duplication.

- *Neonatal Intensive Care Unit babies are an example of one population that could be better managed.*
- *Clients who use very expensive durable medical equipment or other high-cost services are another example.*
- *Clients with high drug utilization also need to be better managed, including those in nursing homes.*
- *Providers need to be better educated about the cost and use of prescription drugs.*

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Develop Utilization Management Systems (UMS): Acute and Long-Term Care

Acute Care-UMS

The workgroup recommends that the Medicaid program develop a comprehensive acute care utilization management system that would provide care coordination, medical management, and standardized case management to clients.

1. The Acute Care-UMS should be developed to prioritize populations identified through data analysis as needing additional assistance. For example, studies have shown that focused interventions for pregnant women or children with asthma are successful at improving health outcomes, controlling costs, and ensuring that care is managed for high-cost clients, regardless of their diagnosis.

2. Additionally, the Acute Care-UMS should include a mechanism to identify those clients who reach a certain level of expense, and then require additional interventions.

3. Because the Texas Medicaid program has several kinds of service delivery modalities, the development of the Acute Care-UMS must appropriately acknowledge variations in these delivery methods while at the same time providing a consistent platform to leverage development efforts. For example, dental services would need to be explored for inclusion in this care coordination system. Current practices are fragmented, there are fewer dental providers in the state, and initiatives to retain and recruit additional providers need to be considered.

4. An Acute Care-UMS should include care coordination, case management, disease management, supportive services, utilization management, etc. into one complete system rather than fragmenting the services provided. Some vendor systems have targets included in the clinical, operational, and financial aspects of the system that will trigger when a client is having some type of difficulty with their care, both from a quality and cost perspective.

5. The Acute Care-UMS should be combined with "predictive modeling" applications that use health risk assessments and claims data to identify clients with utilization patterns or complex health conditions that may likely generate sizable health care costs in the future. Predictive modeling allows for the identification of high-risk clients prospectively in order to lower future health care costs through avoiding delays in needed care, coordinating health care delivery, eliminating redundant care, and promoting self-management of health conditions.

6. Targeted case management programs can be developed to aid in "filling in the gaps" by serving those clients with complex conditions that are not addressed through existing treatment protocols and standardized care plans.

Fee-For-Service

Texas should use its existing data resources to identify the greatest opportunities for improvement in the coordination of care and medical management of the fee-for-service (FFS) population. An integrated analysis of medical claims data, pharmacy data, and behavioral health data would be performed to identify the key cost and quality drivers within the population. Once identified, these drivers would be prioritized based on the greatest return on investment in terms of cost savings, improved patient outcomes, and barriers to implementation. The Medicaid program would coordinate the use of medical management, operations, and data analysis tools to achieve target improvements based on the opportunities identified through the data analysis. This strategy should be used for the entire FFS population resulting in improved coordination of care and improved financial and clinical outcomes. Specific programs and interventions should also be developed for clients with unique sets of needs, such as foster children in the Child Protective Services system who receive their health benefits through Medicaid.

Primary Care Case Management (PCCM)

The data analysis process described under the FFS delivery system can also be replicated in the PCCM environment. Specific opportunities would be identified to enhance the managed care techniques already utilized in Texas Medicaid's PCCM program. The targeted approach would ensure the implementation of enhancements targeted on the delivery system and populations currently served. This will ensure a greater likelihood for improved coordination of care, cost effective program management, and improved member and provider satisfaction. Since clients in PCCM may already be enrolled in disease management initiatives, an initial program for this population would need to be directed at those clients who are not enrolled in a disease-specific (for example, asthma or diabetes) disease management program.

7. Develop a tiered Acute Care-UMS for providers to give incentives and rewards to primary care providers based on the overall cost-effectiveness of the program and individual provider's performance. A provider profiling tool could be used to monitor, measure, and report performance results at individual provider and health plan levels. Financial incentives such as an increased case management fee or enhancements to the fee schedule could be considered, and could be funded specifically through cost savings achieved by the program.

Medicaid Managed Care

Currently the Medicaid managed care plans have contract provisions regarding the provision of care management and disease management for clients.

8. The burden on the health plans could be reduced through the collaborative identification of opportunities to improve the coordination of care, cost effective program management, and improved clinical outcomes. Texas Medicaid can utilize the encounter data already provided by the MCOs to perform the analysis similar to that being done for the PCCM and FFS populations. Working in collaboration with the MCOs and providers, opportunities for streamlining case management, disease management, and care coordination activities can be identified and implemented.
9. Current programs or protocols not achieving desired cost savings and quality outcomes can either be enhanced or replaced with targeted strategies that have demonstrated success in improving coordination of care and cost savings within similar Medicaid populations.
10. Combine services under a federal waiver, either a 1915(b) waiver (managed care) or an 1115 waiver (research and demonstration).

Proposed Recommendation:

HHSC should consider contracting with a pharmacy benefits manager to bring the most advanced cost management techniques to the Texas Medicaid Vendor Drug Program.

The Medicaid Vendor Drug Program currently works with an outside contractor, Heritage Information Systems, to monitor prescribing patterns and engage in provider education with physicians treating Medicaid recipients in order to achieve prescription drug cost savings and quality improvement. The program begins with a complex analysis of the prescribing patterns of physicians who treat Medicaid recipients. Physicians whose prescribing patterns greatly deviate from general patterns will receive educational mailings and visits from clinical pharmacists who will teach preferred ways of prescribing. The program promotes best-in-class prescribing, which will address problems of under-use, misuse, and over-use of prescription drugs. Heritage has made seven major interventions with outlier physician providers regarding their prescription practices and has been able to show over $5 million in savings for FY2003.

Acute Care-UMS Action Plan

Step 1: Develop an HHS interagency workgroup to include representatives from the HHSC Medicaid/CHIP Division, Department of Family and Protective Services (DFPS), DADS, DSHS, and the Department of Assistive and Rehabilitation Services (DARS), to review and define the specific needs of Medicaid clients related to case management, care management, medical management, disease management, and utilization management using FFS, PCCM, and managed care data as

appropriate. Data regarding these programs should also be considered from the HHS agencies. (Timeline: 2-5 months)

Step 2: Research best practices in other states related to case management, care management, medical management, disease management, and utilization management, and incorporate into information gathered from the interagency workgroup outlined above. (Timeline: 1-2 months)

Step 3: The interagency workgroup should develop a plan for implementing a utilization management system (UMS) or a similar program as defined by Steps 1 and 2 above that includes the following elements:

- A standardized definition of case management, care coordination, medical management, and disease management.
- "Triggers" for these services that may be based on the cost, or conditions, related to clients.
- The UMS should be consistent with similar quality indicators across all Medicaid health delivery systems including FFS, PCCM, and Medicaid managed care.
- Develop a coordinated data management system for clients' medical, prescription drug, and behavioral health information.
- Develop a tiered system to reward, or provide an incentive to health care providers to administer the benefits developed by this interagency workgroup. (Timeline: 6-8 months)

Step 4: Meet with relevant stakeholders to discuss options developed by the health and human services interagency workgroup. (Timeline: 2-3 months)

Step 5: Begin discussions with health and human services agencies and CMS partners, such as the Health Resources and Services Administration (HRSA), to discuss options for blending federal and state funds to achieve the interagency workgroup recommendations. (Timeline: 3-5 months)

Step 6: Develop waiver or state plan amendment changes as required (Timeline: 5-9 months)

State Medicaid programs and the federal Medicare program have begun to take steps toward electronic transmission of prescriptions (e-prescribing), and a recent "best practices" document released by CMS encourages more states to consider disease management and e-prescribing initiatives. Physicians and pharmacists are increasingly accepting of e-prescribing and medication management as effective ways to promote patient safety while also saving money. Florida provides a potentially useful model to emulate.

Long-Term Care-UMS

The workgroup recommends that Medicaid develop a Long-Term Care-UMS in addition to the Acute Care-UMS for persons who are elderly, persons with disabilities, persons with developmental disabilities, persons who have behavioral health needs in addition to long-term care needs, and residents of nursing facilities, in order to coordinate care, authorize appropriate levels of care, and provide relocation assistance to those in nursing homes statewide.

A utilization management system for the Medicaid long-term care (LTC) population would provide basic case management to its clients; provide more sophisticated care management of clients with higher needs, and finally target the most high-risk and high-need clients with a sophisticated management system that could ensure better health outcomes. The system will ensure services are not duplicated and that services are also delivered in a pro-active and cost-effective manner. These principles have been used with LTC populations in other states with considerable success, including increases in members residing in community-based settings, lower hospitalization rates, and high levels of member satisfaction.

Additionally, data from the STAR+PLUS pilot indicates that a positive role exists for care coordination that results in increased quality of care and decreased costs for the state. While STAR+PLUS is a program provided in a managed care environment, there may be lessons to be learned in providing some aspects of the care coordination model and integrating overall service delivery even in a FFS environment. The utilization management system for LTC should ensure that the same principles are followed in managed and non-managed care environments. Services should be combined under an 1915(b)/1915(c) waiver combination such as STAR+PLUS, or under an 1115 research and demonstration waiver.

Long-Term Care-UMS Action Plan

Step 1: Review current case management models across all Medicaid waiver and state plan amendment programs. (Timeline: 3-4 months)

Step 2: Review other states' case management systems. (Timeline: 3-4 months)

Step 3: Develop a common definition of case management for all Medicaid waiver and state plan amendment programs, concentrating particularly on the STAR+PLUS care coordination function and lessons learned from it. (Timeline: 2 months)

Step 4: Add case management, using common protocols, to all Medicaid waiver and state plan amendment programs (or replace current case management within certain programs with the new model of case management). Hire and train staff as appropriate. (Timeline: 6-9 months)

Step 5: Amend state plan or waivers as needed. (Timeline: 10-12 months)

→ Enhance the Disease Management Program

The workgroup was presented a great deal of information about the need for, and the effectiveness of, disease management. HHSC rolled out its disease management initiative in November 2004. The disease management program targets eligible FFS Medicaid recipients with five common chronic heart and respiratory diseases. The program includes an outreach and education component for clients and providers, as well as health assessment and care coordination. The disease management initiative will improve the overall quality of care these medically needy patients require while holding clients and providers accountable for better and efficient use of current medical resources.

In managed care, disease management for clients is built on the existing health plans' case management programs. HHSC is in the process of reviewing current initiatives and has included disease management as a program requirement in the health maintenance organization (HMO) procurement currently underway.

1. The workgroup recommends that the disease management program should also include persons with end stage renal disease (ESRD), home health services for children with chronic conditions beyond the five disease management conditions, and the use of schools and school nurses as an asset with the management of chronic diseases for children.

As one component of a utilization management system, a disease management system should be designed as effectively as possible and would be one tool for the most effective client management. As such, disease management services provided to clients should be transparently provided no matter which program enrolls the client. Consistent provision of these services across programs will improve client outcomes for clients who may shift from FFS to managed care, or those who may move from one part of the state to another.

Enhanced Disease Management Program Action Plan

Phase I: **Evaluate potential for including persons with ESRD in DM program.**

Step 1: HHSC Disease Management (DM) program staff begin research and data analysis on the prevalence and cost-savings potential of non dual-eligible Medicaid recipients with ESRD diagnoses. (Timeline: 1 month)

Step 2: Present staff recommendation on procurement of ESRD DM program to HHSC leadership. (Timeline: 2 weeks)

Step 3: Executive Commissioner reviews and approves staff recommendations. (Timeline: 2 weeks)

Step 4: Develop and post Requests for Proposal (RFP) for ESRD program intervention. (Timeline: 3 months)

Step 5: Complete procurement process and award. (Timeline: 3 months)

Step 6: Complete contract negotiation. (Timeline: 1 month)

Step 7: Internal/vendor pre-implementation phase. (Timeline: 2 months)

Step 8: HHSC launches ESRD program. (Timeline: 1 week)

Phase II: **Evaluate home health services by children as an indicator for enrollment in DM.**

Step 1: Staff reviews claims, prior approval (PA) history, procedure codes and diagnosis of children receiving home health services to determine prevalent categories of chronic disease. (Timeline: 1-2 months)

Step 2: Staff meets with stakeholder groups to present initial findings and obtain feedback on analysis and strategies for integration into the current DM program. (Timeline: 1 month)

Step 3: Staff meets with disease management vendor/DM actuary to determine impact and required modifications to current DM program design. (Timeline: 1 month)

Step 4: Staff identifies impacts on internal infrastructures and contract deliverables. (Timeline: 2 weeks)

Step 5: Staff develops analysis, presents recommendations, and obtains Executive Commissioner approval. (Timeline: 1 month)

Step 6: HHSC infrastructure and contract revisions are completed. (Timeline: 1 month)

Step 7: Home Health Care children identified for new DM program services begin receiving DM interventions. (Timeline: 2 weeks)

Phase III: **Evaluate the current and potential role of schools and school nurses in the management of chronic diseases in children.**

Step 1: HHSC conducts data research and analysis to identify number of Medicaid/CHIP school-age enrollees with diagnosis of chronic disease. (Timeline: 1-2 months)

Step 2: Staff conduct meetings with DSHS School Health Services program to identify and develop potential role of schools/school nurses in the

assistance of management of chronic diseases. (Timeline: 3 months)

Step 3: Staff meets with DM vendor to develop strategies to utilize school health services/nurses in the current DM program. (Timeline: 3 weeks)

Step 4: Staff develops recommendations on program/cost impact/contract amendment for utilization of school health services/nurses. (Timeline: 3 weeks)

Step 5: Staff develops and presents recommendations and obtain Executive Commissioner approval. (Timeline: 1 month)

Step 6: Potential contract revisions are completed. (Timeline: 2 months)

Step 7: Utilization of school health services/nurses begins. (Timeline: 1-3 months)

Challenges

Through the *Overview of Case Management Programs and Service Definitions Throughout Texas Health and Human Services Agencies* study that was performed in August 2003, HHSC has identified that one of the barriers to more effective and efficient care coordination is federal limitation on the state's ability to blend funds to provide a utilization management system. The study found that while the state has the ability to standardize definitions of care and coordination, the funding streams still remain separate and cannot be combined, as they are tied to various federal funding entities. With this maze of complex federal laws and regulation, the workgroup recommends the development of a federal reform agenda.

Another idea that may assist clients in community-based waiver programs is separating case management services that may currently be provided by the client's home health agency. Through the existing CDS program discussed in the long-term care chapter, consumers could be given the choice to "purchase" their case management for long-term care from the same funding sources that may be providing complementary services, either through acute care funding, community based organizations, or general revenue funded programs.

Fiscal Implications

Implementing the Acute-Care and Long-Term Care Utilization Management Systems is expected to save the state an estimated $24 million over the next five years. This section will require the health plans to improve utilization management of client services with the goal to decrease duplication of services and encourage better management of clients for more effective health outcomes and cost savings. Additionally, this proposal would require the development of a utilization management system for clients who are not in managed care plans. Initial costs may accrue during the implementation for hiring additional staff to analyze data, creating

systems to expedite analysis, and hiring case managers. However, it is expected these costs will be offset by savings. Expanding disease management initiatives is also expected to yield savings to the Medicaid program over time.

Issue VIII: Data Analysis and Policy Information

Medicaid data should be analyzed and utilized more effectively to ensure more informed decisions are made regarding program structure and service provision, and to enhance the quality and effectiveness of the program.

The workgroup learned that the Medicaid program collects data and information regarding clients, providers, health plans, claims paid, services provided, and systems used. However, the workgroup also learned that there are limited mechanisms through which this information can consistently and effectively be analyzed and then recycled back through the program's decision-making processes. While HHSC conducts research and can produce reports on demand, it does not methodically evaluate and analyze the volumes of data at its disposal. Without policies and procedures in place to ensure data is regularly analyzed, this resource cannot be used to guide and direct more effective program and policy development.

Another concern heard often by the workgroup was that the program does not effectively monitor utilization patterns of clients or providers and then use that information to ensure that policies are developed to encourage appropriate utilization of the program. The workgroup heard about providers and clients who manipulate the program either to acquire additional resources, or because they are not aware of the most effective means to use program resources.

Current Medicaid Program Data Collection Resources

Health and Human Services Commission Data

HHSC has been developing enhanced systems for collecting data, including the establishment of two projects enabled under H.B. 2292, 78th Legislature, Regular Session, 2003.

The first project is the HHSC OIG's partnership with the University of Texas at Dallas. In early 2004, OIG entered into a partnership with the School of Social Sciences, University of Texas at Dallas, to create a data resource from the Medicaid Management Information System (MMIS) administrative records. Claims data will be matched with U.S. Census data so provider and client activity can be monitored down to the zip code level. This will be useful for examining, for example, the way a change in the eligibility for services for pregnant women has impacted utilization of those services at the local level. The system will also have the ability to trend data across a number of criteria, including looking at changes in services provided over time by different areas of the state, and by different population groups within Medicaid. The state will then have the ability to examine trends in utilization, and to monitor the use of services before and after a policy change is implemented.

Properly leveraged, this information can then be used by state and local policymakers when making policy decisions. This data resource will facilitate measurement of numerous social services phenomena and the scientific study of those phenomena by social scientists and policy makers. In particular, the data resource will enable social scientists to apply advanced research methodologies and theories to understand behaviors, procedures, and policies that result in excessive abuse, waste, and/or fraud of HHSC funds. Several research datasets that will be created from this data can be used to answer social science research questions. In addition to providing a new resource to combat fraud and waste, this data source will also provide state policymakers with a unique opportunity to look at the way policy changes in Medicaid are affected at state, regional, and local levels.

The second project HHSC has been developing is the HHSC Center for Strategic Decision Support. The Center for Strategic Decision Support provides health and human services leadership and enterprise programs with information, analysis, planning, and evaluation to support effective decision-making and identify optimal outcomes for clients. This is achieved through:

- Research, evaluation, and demonstration activities;
- Economic and demographic analysis; and
- The provision of program data analyses and reports to the health and human services enterprise, state and federal entities, stakeholders, and constituents. Examples of work done by the Center to support the Medicaid program specifically include:

    - Analyzing databases for programs such as Medicaid, CHIP, mental health and mental retardation;
    - Coordinating with HHS agencies and contractors to ensure data quality and integrity, such as Medicaid/CHIP enrollment, medical encounters, providers, and cost databases;
    - Providing consistent demographic, socioeconomic, and program data and analysis to inform caseload forecasting, strategic and program planning, budgeting, and program performance and evaluation across the HHS system;
    - Performing evaluation studies to assess HHS programs and special projects, including large-scale studies that gather and analyze data over extended periods of time and short-term initiatives in response to executive information requests; and
    - Producing Medicaid/CHIP cost information analyses – including response to ad hoc requests from the legislature or executive leadership - ensuring that consistent information is released externally.

The center also has the ability to provide analytical reviews of programs, functions, or operations throughout the HHS enterprise. The team analyzes existing business practices and develops recommendations for improvements in business processes, policies, or practices in program and administrative operations to reduce waste and improve productivity, while maximizing services to internal and external customers.

Currently, the center is implementing a Decision Support System (DSS) to allow management access to critical information and data to facilitate decision-making. This decision support system is being designed specifically for data analysis and reporting, and it will use a data warehouse to compile data from multiple sources. The system is currently being built using the Cognos Business Intelligence Suite and is incorporating CHIP enrollment, Medicaid enrollment, Vendor Drug Utilization, and Adult Protective Services investigations data. It is envisioned that this system will be used to analyze and report data for programs across the enterprise.

Texas Medicaid & Healthcare Partnership Data

Through the Texas Medicaid claims administrator contract signed in 2002 with the Texas Medicaid Healthcare Partnership (TMHP), a tremendous amount of information is available for policy analysis and decision-making purposes.

- **Claims History** - Data includes all claims irrespective of status for the prior 72 months and provides information on amounts billed, paid, and adjusted per procedure code, per provider type, per program type, as well as hospital payments. This information is available for the following types of claims:
    - **Tort Claims** - For services that are the result of a possible accident, thus funds might be available for payment (as Medicaid is payer of last resort);
    - **Vendor Drug** - The vendor drug program forwards claims data to TMHP for inclusion in Vision 21;
    - **Claims Management System for Long Term Care** - As with acute care claims, long term care claims through the Claims Management System;
    - **Encounter Data** - From managed care organizations. This data is similar to acute care fee-for-service data and is collected from those HMOs who submit it.
- **Client Eligibility** - Client eligibility records by program type acquired from the eligibility files from DSHS;
- **Provider History** - Includes all provider history, including any negative actions, provider type and subtypes, application information such as change of addresses, different practice locations, and professional license information;
- **Texas Automated Recovery/Other Insurance Cash/Financial**- Data related to claims; and
- **Authorizations** – Data includes prior approvals information for medically necessary services, including the date the service was authorized, related diagnosis, and the specific set of services given approval.

All of the above data exists within the Compass21 claims payment system and the Vision21 data warehouse at TMHP, creating the most comprehensive data system for Medicaid programs.

Current Medicaid Program Decision-Making Processes

Currently, policy decisions in Medicaid are made through a variety of mechanisms (see Table 7).

Table 7
Methods of Decision Making in Texas Medicaid

- Statutory changes and legislative direction
- HHSC priority directives
- Internal problem solving
- External problem solving
- CMS and other federal directives
- Funding availability

While all these methods of decision-making take advantage of the current research and data capabilities, very often the decisions that are made are not considered for systemic impacts on the program. For example, a particular problem will be addressed by the decision, but without reviewing the systemic impacts: Over time, a new problem's solution may conflict with that previous solution. Ultimately both problems and solutions were viable and important, but because the decisions were made in separate and different times, new challenges are created.

WORKGROUP RECOMMENDED MEDICAID REFORMS:

→ Improve Data Analysis and Policy Development

The workgroup recommends that the Medicaid program utilize the Decision Support System (DSS) in the HHSC Center for Strategic Support to more systematically and effectively use the data the program currently collects for program evaluation and policy development.

1. The DSS should incorporate enrollment, utilization and provider data that are already being collected.

2. The DSS should allow available data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program. The DSS should ensure the ability to obtain consistent and accurate answers to questions.

3. The DSS should be designed to allow for analysis of multiple issues within the Medicaid program to determine whether any programmatic or policy issues overlap or are in conflict with each other.

4. There should be sufficient, and consistent, opportunity for stakeholder input into the creation of, or modification to, the DSS. This could be accomplished through existing mechanisms (e.g., Regional Advisory Committees, Public Forums, etc.), as well as meetings for state partners within the state's health and human services system.

5. The DSS should also include predefined data reports on utilization of high-cost services that would allow program management to “drill down” and determine why utilization has increased or decreased and immediately proceed with policy changes, if appropriate.

Develop Decision Support System Action Plan

Step 1 Procure and install Cognos Business Intelligence Software Suite system. Obtain necessary hardware infrastructures (e.g., servers, database programs, etc.). (Timeline: 2-3 months)

Step 2 Identify relevant subject areas for inclusion in the DSS. Develop a series of business questions and user requirements for subject area. (Timeline: 1 month)

Step 3 Obtain access to relevant data and/or data systems. Ensure business questions and user requirements can be addressed by available and collected data. (Timeline: 2 months)

Step 4 Develop business plan for development and roll-out of DSS for each subject area. (Timeline: 2 months).

Step 5 Develop prototype DSS for each subject area. (Concurrent with Step 4).

Step 6 Conduct user testing and training for appropriate staff for each subject area. Modify DSS based on feedback received during user testing. (Timeline: 2 months)

Step 7 Implement DSS for each subject area. (Timeline 1 month)

→ Create an Office of Community Collaboration

Many of the challenges the workgroup heard about not only impact the Texas Medicaid program, they also confront every participant in the health care system. Every heath care system, program, provider and advocacy group faces the same challenges of rising health care costs, increased demand, and a lack of information and data on the health care system.

1. Create an Office of Community Collaboration.

This office should be designed to share best practices, resources and other information regarding improvements to the health care system. For instance, if a local community created a public education awareness campaign on health literacy, this program could coordinate with the Medicaid program and share the Medicaid program’s educational

materials with the participants in that local community's program. This would benefit the local community, the Medicaid program, and the individual who was educated.

In addition, many large private health care systems or management practices are moving toward implementation of certain technology initiatives. If the Medicaid program was aware of these efforts, then a partnership may prove mutually beneficial to both the Medicaid program and the private provider. The Office of Community Collaboration can also work with local hospital districts that conduct special projects or apply for federal Medicaid waivers.

2. Optimize the resources of our federal partners for the Office of Community Collaboration and the DSS in the Center for Strategic Decision Support.

CMS is just one strong partner in the Medicaid program. There are other divisions of the United States Department of Health and Human Services with resources for the improvement of the health care system and health care programs. One agency, the Agency for Healthcare Research and Quality (AHRQ), is currently funding projects in four states that use a data-driven model to support policy-making decisions related to the health care safety net. AHRQ has established a model for the use of data that takes into account a number of factors: stakeholder input, funding, political feasibility, and timing[1]. The Texas Medicaid program should be apprised of the process of these projects and working with AHRQ in an effort to bring some federal resources to Texas for this purpose. Texas Medicaid should take advantage of the lessons learned by the federal, local and private partners in the health care system so that the evolution of the Texas Medicaid program is innovative, effective, and constantly enhancing the quality of the services it provides.

Office of Community Collaboration Action Plan

Step 1 With input from senior management, program staff and stakeholders, define scope and responsibilities for the office. (Timeline: 3 months).

Step 2 Identify key programs and staff from within the HHS system whose roles are similar to those defined for the office. (Timeline: 1 month)

Step 3 With input from management, program staff and stakeholders, begin to develop operating plan for creation of the office. Identify key external partners with which to collaborate. (Timeline: 2 months)

Step 4 Determine organization placement and staffing for the Office. (Timeline: 3 months)

Step 5 Provide draft operating plan to senior staff, program and HHS system staff, and stakeholders and identified partners. Conduct public forum

[1] Weinick, Robin M and Peter W Shin, April 2004. *Developing Data-Driven Capabilities to Support Policymaking.* Agency for Healthcare Research and Quality, page 10.

to gather additional information from stakeholders. (Timeline: 3-4 months)

Step 6 Modify the operating plan and prepare to implement office. (Timeline: 2 months)

Fiscal Implications

The Decision Support System will enhance HHSC's ability to make informed and prudent choices about how Medicaid services should be provided. Additionally, the Office of Community Collaboration will ensure that Medicaid will be able to work in partnership with local communities to take advantage of new, innovative, and more effective changes in the health care delivery system. Once fully implemented, both initiatives have the potential to save the Medicaid program $6 million dollars between fiscal years 2008 and 2010.

Appendix 1
Fiscal Estimates of All Funds Costs and (Savings) of Action Plans

	FY 06	FY 07	FY 08	FY 09	FY 10
Issue I: Federal Mandates, Funding, and Innovation (Savings estimates attributable to obtaining a more favorable FMAP.)	$0 M	$0 M	($100 M)	($100 M)	($100 M)
Issue II: Financing (Estimated costs to fund rate studies and develop systems for rate data.)	$5 M	$5 M	$15 M	$15 M	($50 M)
Issue III: Managed Care (Estimated costs attributable to obtaining access to previous claims history, additional staff for payment recoveries and increasing out-of-network services.)	$4 M	$2 M	($8 M)	($8 M)	($8 M)
Issue IV: Long-Term Care (Estimated costs attributable to securing resources to ensure appropriate utilization and payment for services. Estimated savings attributable to increasing clients' choice of hospice and reducing transfers to hospitals.)	$5 M	$0 M	($2 M)	($2 M)	($2 M)
Issue V: Education (Estimated costs attributable to curriculum development and establishing an education network.)	$3 M	($5 M)	($5 M)	($5 M)	($5 M)
Issue VI: Administrative Burdens (Estimated costs attributable to development of a web-based provider enrollment application and development of an accountability system for claims accuracy and utilization. Additional costs for increasing THSteps utilization.)	$6 M	$34 M	$18 M	$18 M	$18 M
Issue VII: Utilization Management Systems (Estimated costs attributable to the development of utilization management systems and expanding disease management.)	$10 M	$10 M	($8 M)	($8 M)	($8 M)
Issue VIII: Data Analysis and Policy Information (Estimated costs attributable to hiring additional staff, creating systems, and setting up the Office of Community Collaboration.)	$0.2 M	$0.2 M	($2 M)	($2 M)	($2 M)
Total All Initiatives	**$33.2 M**	**$46.2 M**	**($92 M)**	**($92 M)**	**($157 M)**

Appendix 2
List of Unsupported Proposals by the Workgroup

MEDICAID LONG-TERM CARE

Proposal	Summary	Fiscal Impact	Current Status
17	Expand the ICF/MR surrogate Decision-Making Program to HCS	Negative Fiscal impact	The current program would have to be expanded and would require additional funds.
19	Allow persons choosing ICF/MR the same right to be placed on the HCS waiting list, and then move them into the community.	Negative Fiscal Impact	Current policy allows these persons to be put on the community waiting list. Moving them into the community beyond any currently funded slots, would require additional funding.
337	Add a counseling component to the existing consumer-directed services model.	Negative fiscal impact	The existing CDS model does not include funds to pay for additional counseling services for consumers that choose to participate.
24a	Expansion of the Rider 28 provisions (Money follows the client) to ICF/MR.	Negative fiscal impact	Currently, Rider 28 allows nursing facility residents to transfer into the community but does not cover ICF/MR.
26	Establish a statewide system to provide relocation services for persons transferring from an institutional settings; broaden Rider 28 to cover all populations in all settings.	Negative fiscal impact.	Same as 24a.
28	Expand Rider 28 provisions for the developmentally disabled population.	Negative Fiscal impact	Same as 24a.
36b	Evaluate the degree to which Medicaid case management funds could pay for inter-disciplinary teams	Negative fiscal impact.	DFPS currently has a permanency planning team meeting every six months – an inter-disciplinary team would be more costly and may not be allowable under federal program rules.
36e	Access Family Preservation funds to help families avoid abandoning their child with disabilities in order to get support.	Negative fiscal impact	Funds are not currently targeted to families of children with disabilities who may be at risk of abandonment. Prioritizing this population would delay services to other eligible children.

Proposal	Summary	Fiscal Impact	Current Status
117	Eliminate TDH Connect. Go to third party for claims (eye care)	Since TDH Connect is currently administered by the Texas Medicaid and Healthcare Partnership, there could be some potential increased costs associated with transitioning services to a different third party.	HHS currently does not have a third party for claims filing.
118	Eliminate TDH Connect. Go to debit card for routine eye care and glasses. Simplify claims. Save money.	Unknown. System changes would require significant capital expenditures.	HHSC is not currently using debit cards for eye care.
38	Allow for community-based services in lieu of institutionalization.	Significant negative fiscal impact	HHSC is currently studying this issue through the STAR+PLUS expansion.
1	Transfer Medicaid dollars used for vocational services to the Texas Department of Assistive and Rehabilitative Services (DARS)	N/A	Rehab funds are currently used in several agencies for vocational services because these dollars are optimized for federal match.
31	CLASS program eligibility criteria should be revised to only allow physically disabled young adults at least 16 years of age who are at high risk of institutionalization.	Significant negative fiscal impact	The CLASS program is open to all ages—there is currently a large interest list associated with this program
2	Change Mentally Retarded (MR) designation to Developmentally Disabled (DD)	N/A	MR and DD designation are both used in federal regulations. MR is a diagnosis not a designation.

MEDICAID PROGRAM ADMINISTRATION

Proposal	Summary	Fiscal Impact	Current Status
121	Medicaid should recognize case management for chronic diseases as reimbursable service. HHSC should reinstate case management for pregnant women.	Negative fiscal impact.	Case management for pregnant women was not eliminated. Rather, it was renamed "Case Management for Children and Pregnant Women."
122	Reimburse physicians for telephone calls with disease management companies related to patient care.	Unknown	Medicaid does not cover calls as a paid service. The Medicaid managed care plans and current disease management efforts may cover this service.
123	Limit mastectomy, breast reconstruction, and breast reduction surgery to breast cancer diagnosis.	Unknown	Breast reduction is covered only if medically necessary, but does not require a breast cancer diagnosis.
279	Eliminate cranial molding helmets as a Medicaid benefit	Possible savings.	Cranial molding devices are only a benefit through the THSteps CCP program and must be prior authorized.
88	Require providers in ERS or TRS health insurance network to also be Medicaid providers.	N/A	HHSC is currently not doing this activity.
89	Consider requiring all newly licensed physicians to participate in the Medicaid program for a period of five years.	N/A	HHSC is currently not doing this activity.
101	Give practicing physicians who elect to participate in the Medicaid Reform Program a discount on their annual Medical License Renewal Fee (currently $334)	N/A for Medicaid. Negative impact to general revenue through the Board of Medical Examiners.	HHSC is currently not doing this activity.

MEDICAID FINANCE

Proposal	Summary	Fiscal Impact	Current Status
73	Implement a competitive selective contracting program that rewards facilities providing high quality, low cost services.	State savings of $12 to $60 million total funds annually, depending on method used. Hospital impact varies on method used.	HHSC is currently operating two selective contracting programs, Lone Star I and Lone Star II.
137	Implement a competitive selective contracting program with adequate reimbursement for the Medicaid program. A provider would need to have at least 20 percent Medicaid utilization in order to participate.	State savings of $12 to $60 million total funds annually. depending on method used. Hospital impact varies on method used.	HHSC currently operating two selective contracting programs, Lone Star I and Lone Star II.
347	Texas Medicaid should direct all DSH funding to public hospitals rather than distributing DSH funds to private and non-profit hospitals.	State: None. Hospitals: Individual hospital DSH amounts may shift.	State is currently not doing this activity.
131	Texas should place a cap on high dollar cases.	None.	The state is currently doing this activity.
134	Require legislative approval for increases of the SDA in the hospital payment methodology.	Unknown.	Yes, in accordance with HB 1, 7th Legislative Session, Regular Session, rider 46.
143	Allow hospitals to collect actual charges from illegal immigrants and use emergency Medicaid as a safety net for hospitals and providers.	Cost savings if providers collected payment and do not bill Medicaid. If the intent is to give hospitals and providers dollars currently spent on emergency Medicaid, there will be no savings.	The state is currently not doing this activity.

Proposal	Summary	Fiscal Impact	Current Status
346	Texas Medicaid could reduce outlier payments on inpatient services by decreasing the outlier payment percentage.	State: $3 million savings to general revenue. Hospitals: Would reduce the outlier payments to hosp-ital reimbursements in accordance with DRG payment methodology. Certain hospitals would not be affected.	The state is currently not doing this activity.
349	Texas Medicaid should consider a change to a prospective payment system for reimbursement of inpatient services provided by Children's Hospitals.	Children's Hospitals' PPS at current fund in level. May ensure long term budget certainty.	The state is currently not doing this activity.
133	Eliminate the cost based reimbursement methodology for outpatient services.	Unknown. Implemented to ensure budget certainty.	The state is currently not doing this activity.
160	Reimburse outpatient hospital diagnostic services under a fee schedule. Eliminate the cost-based reimbursement methodology for outpatient services.	Unknown. Depends on how state implements.	The state is currently not doing this activity.
141	Increase inpatient and outpatient hospital rates 16% for border areas uncompensated care.	A 16% increase for the 43 counties in the Texas-Mexico border region as specified in HB 501, 76th Legislature, Regular Session, would require an additional $287 million (all funds).	The state is currently not doing this activity.
343	HMO capitation rates should have administrative costs that are no more than 10% of total medical costs.	May or may not achieve savings. The average HMO administration is about 13%. However, allowance must be made for a 1.75% premium tax and a possible risk margin.	The state is currently not doing this activity.

Proposal	Summary	Fiscal Impact	Current Status
136	Implement co-pays for emergency room non-emergent care and pharmacy as proposed in 2002.	ER co-pays: $400,000 in GR due to reduction in inappropriate use of emergency services. Pharmacy co-pays: $3.4 million GR per FY until January 2006 when savings will decrease by $1.2 million due to Medicare Prescription Drug Bill.	HHSC Medicaid/CHIP staff is currently evaluating Medicaid cost sharing policies are directed in HB 2292, 78th Legislature, Regular Session.
140	Implement monthly co-pay for each Medicaid client based on the number of health care visits per month and with collection by the state.	$4.3 million with a 50% collection rate. $0.9 million with a 10% collection rate.	HHSC Medicaid/CHIP staff is currently evaluating Medicaid cost sharing policies as directed by HB 2292, 78th Legislature, Regular Session.
176	Implement $2.00 member co-pay for brand name prescription drugs.	State: $3.4 million per FY until January 2006 when savings will decrease by $1.2 million due to the impact of the Medicare Prescription Drug Benefit.	HHSC Medicaid/CHIP staff is currently evaluating Medicaid cost sharing policies as directed by HB 2292, 78th Legislature, Regular Session.
179	Implement an annual enrollment fee for Medicaid patients.	$226,000 GR with a 10% collection rate. Unknown administrative and system change costs.	HHSC Medicaid/CHIP staff is currently evaluating Medicaid cost sharing policies as directed by HB 2292, 78th Legislature, Regular Session.
139	Establish a new system for setting rates for rehabilitative services.	Negative fiscal impact.	The state is currently not doing this activity.
153	Reduce Financial Reporting and Fiscal Accountability with financial rewards for higher levels of compliance.	There is no fiscal impact to revise/redesign the cost report and instructions.	HHSC has reviewed.

Proposal	Summary	Fiscal Impact	Current Status
23	Expand the staffing enhancement program for nursing facilities so that a larger percentage of Medicaid funding is tied directly to staffing levels.	The fiscal impact is contingent on the extent to which direct care staff hours and/or compensation are increased. The fiscal impact would be significant.	The state is currently doing this proposal that has been in effect since May 1, 2000.
34	Revisit the decision to reduce the spending requirement for attendant compensation in the Attendant Compensation Rate Enhancement for DHS community programs.	No fiscal impact.	The spending limit was reduced because state budget limitations resulted in a reduction of reimbursement rates for DSH community based programs. The reduction of the spending requirement allows participating providers more flexibility in spending across cost areas and will assist providers in covering their non-attendant costs as they adjust to the cost reduction.
44	Examine the benefits of using the Minimum Data Set (MDS) system to replace the 3652 resident assessment form.	There will be a large fiscal impact to implement this change if nursing facilities lose revenue due to changing their systems. However, they would be held harmless and their losses would be reimbursed.	The state is currently evaluating the feasibility of implementing this proposal.

MENTAL HEALTH, ER UTILIZATION, PATIENT EDUCATION, RESEARCH

Proposal	Summary	Fiscal Impact	Current Status
190	Recommend FFS utilization management (UM) by a Quality Improvement Organization as a mechanism to realize cost containment and improve the quality of care in medical and behavioral health services, such as the Arkansas UM for adult outpatient behavioral health services for Medicaid clients.	Unknown.	This proposal may be duplicative of the Resiliency and Disease Management initiative.
191	Recommend FFS utilization management (UM) by a Quality Improvement Organization as a mechanism to realize cost containment and improve the quality of care in medical and behavioral health services, such as the Alaska care coordination program for behavioral health treatment	Unknown.	The state may cover this type of activity under the Resiliency and Disease Management initiative.
192	Recommend FFS utilization management (UM) by a Quality Improvement Organization as a mechanism to realize cost containment and improve the quality of care in medical and behavioral health services, such as Arkansas' UM program for children's outpatient behavioral health services provided to Medicaid clients	Unknown.	This proposal may be duplicative of the Resiliency and Disease Management initiative.

Proposal	Summary	Fiscal Impact	Current Status
193	Recommend FFS utilization management (UM) by a Quality Improvement Organization as a mechanism to realize cost containment and improve the quality of care in medical and behavioral health services, such as Florida's statewide UM system for Medicaid funded behavioral health care	Unknown.	This proposal may be duplicative of the Resiliency and Disease Management initiative.
180	Refrain from instituting policies that implement false savings, such as requiring prior authorization for mental health drugs.	Negative fiscal impact.	HHSC utilizes a preferred drug list, which includes atypical antipsychotic and antidepressants.
181	Allow private providers to directly bill Medicaid for rehabilitative services.	There may be a negative fiscal impact due to fraud or inappropriate utilization of services.	Currently mental health authorities are the authorized submittal point for rehabilitative services claims.
182a	Make Assertive Community Treatment (ACT) a covered service under Medicaid.	N/A	The state currently covers similar services to ACT as well as care coordination.
182b	Provide care coordination for Medicaid recipients with mental illness.	N/A	The state currently covers similar services to ACT as well as care coordination.
182d	Establish a mechanism for appealing reductions in Medicaid service.	N/A	Clients who have had their services reduced are not eligible to receive a fair hearing since the reduction is a result of clinical decision and not a result of state action.
201	Lack of a valid address should cause suspension of Medicaid eligibility until a valid address is determined.	No fiscal impact	The client is currently denied if they do not provide a new mailing address.

Proposal	Summary	Fiscal Impact	Current Status
132	Analyze and compare methodologies and actual payments made to hospitals and compare those to what other states pay in their Medicaid FFS programs.	Unknown, but potential for significant increased cost to the state.	The state is currently not doing this activity.

FEDERAL ISSUES, WOMEN'S HEALTH, NON-MEDICAID, AND OTHER MEDICAID

Proposal	Summary	Fiscal Impact	Current Status
304	Extend limited mental health care benefits to undocumented aliens.	Significant additional costs to the state. Long term savings unknown.	Currently not doing this.
3	Presumptive eligibility for persons seeking community services.	Increased state GR cost for those clients found not to be Medicaid eligible.	Currently not doing this for community services.
233	Establishment of demonstration project to evaluate costs/effects of CHIP benefit reductions, including impact on local health care delivery systems.	Additional state or contractor resources may be required.	Currently not doing this.
90	Review policies defining "independent child" status for children placed at Cal Farley's Boys Ranch to access Medicaid.	There would be a fiscal impact if more children became eligible for Medicaid.	Currently, DADS eligibility staff evaluates status on a case-by-case basis.
272	Provide more door-to-door transportation for older adults and encourage more services that come to the elderly and persons with disabilities such as doctors, vets, and delivery of prescription drugs.	Additional state funds would be required to expand services.	Texas provides transportation services through the Texas Department of Transportation and the AAAs.

Proposal	Summary	Fiscal Impact	Current Status
298	Require school districts to report to TEA the type of health insurance students have. Designate school and district uninsured rates as standard performance measure.	May be an additional cost to the school districts to develop this new report.	Currently not doing this.
174	Consider implementation of a broad based provider tax to fund UPL or DSH payments	Budget neutral since the programs would remain and only the method of finance for these programs would differ.	Currently not doing this.

MANAGED CARE PROPOSALS

Proposal	Summary	Fiscal Impact	Current Status
50/59/61/77	Maximize savings from managed care by using HMOs in the urban areas and use PCCM in the rural areas of the state. The state can also maximize savings by placing a cap on the PCCM enrollment in urban areas to get more savings from the HMO model.	The Lewin Groups estimates about $72.7 million savings for all Medicaid managed care expansion.	HHSC is currently working on expanding Medicaid managed care statewide.
51/57	Expand STAR+PLUS to other urban areas of the state.	The Lewin Group estimates about $72.7 million savings for all Medicaid expansion.	STAR+PLUS expansion in urban areas is part of the managed care expansion plan.
60	Allow HMOs currently contracted to the state to compete as ASO contractor to provide management services to the state for the PCCM model.	May render cost savings of $36 million per year if integrate with requirements of the Claims and PCCM administrative contracts.	The state does not currently allow the HMOs to compete for the ASO contractor since it may be a conflict of interest.

Proposal	Summary	Fiscal Impact	Current Status
66	Require hospitals to report Medicaid eligible newborns within two days of birth or risk nonpayment for services. Untimely reporting results in the state paying FFS rather than managed care rates for care.	Unknown.	The state is currently not doing this activity.
78	Limit physical therapy services to annual max of 35 visits.	Unknown.	HHSC is currently not doing this activity. There are limitations for the length therapy is provided without authorization.
79	Eliminate cochlear implants as a covered benefit.	Unknown.	HHSC is currently not doing this activity. Most cochlear implants are provided to children and the benefit would be required if deemed medically necessary.

Appendix 3
List of Proposals the Workgroup Decided Not to Consider Favorably or Unfavorably

Proposal	Summary	Fiscal Impact	Current Status
18	To better serve and fund beds for behaviorally challenged individuals sent through the court system to state schools.	N/A	TDMHMR worked with leadership to ensure these beds are managed as effectively as possible. Per Rider 55 from 77th Legislative Session.
335	Review and expand Consolidated Waiver pilot project.	Unknown.	The state currently has a pilot project that is studying the effectiveness of this model in Bexar County.
24c	Expand consumer directed services in waiver programs.	Negative fiscal impact if new services are added.	The state currently has a consumer directed services activity in its primary home care and waiver services.
115	Provide reimbursement for self-management training and case management of diabetes.	N/A	Self-management training and case management of diabetes are included in HHSC's disease management initiative.
33	Have Medicare stop covering air conditioners, heaters, ovens, refrigerators, and washers and dryers.	N/A to state Medicaid program.	Federal issue.
296	Implement meaningful injury prevention for Texas pediatric population.	New programs would require additional state resources. Long-term savings are possible.	DSHS implements injury prevention programs through THSteps, Title V, and Traffic Safety.

Appendix 4
List of Proposals Supported by the Workgroup, But Not Directly Related to the Medicaid Program

The workgroup received several proposals that did not directly relate to the Medicaid program. The proposals outlined below were recommended by the workgroup. Each recommendation would require direction from the Texas Legislature for implementation.

Local Administrative Reforms

The workgroup recommended two proposals for the consolidation of 41 existing local mental health and mental retardation authorities into a smaller number of "super-regional" authorities to take advantage of economies of scale in administrative and service delivery functions, saving money that can be used for client services. Local authorities are created by statute, so the creation of super-regional authorities would have to be determined by the Texas Legislature. With the consolidation and restructuring of the health and human services program operations under House Bill 2292, 78th Legislature, Regular Session, the consolidation of local mental health and mental retardation authorities is a logical step in the movement to streamline processes to ensure more money is available for services.

Organ Donation

Since 1997, the organ donor option on the Texas driver's license has not existed. This option was removed by the legislature because the technology did not exist to document an individual's wish to donate organs. The only way individuals can indicate their wish to donate organs has been to fill out a donor card. These donor cards are not linked to a registry. Furthermore, if an individual does not have the card available in the event of an accidental death, then the wish to donate organs will not be known, for it is rare that family members know an individual's wishes for organ donation.

The Living Bank proposes that it be designated the state's official organ donor registry. The registry would be based on the information downloaded from the Texas Department of Public Safety (DPS) drivers' license records of people who affirmatively indicate that they would like to donate their organs. The Living Bank would donate its infrastructure to the state, thus the cost to the state would be minimal for downloading and maintaining records from the DPS system. These costs could potentially be supported by donations from a one-dollar check-off for organ donation on the driver's license renewal form. In the long run, ensuring the more donor organs are available could save on long-term health care costs for individuals who need an organ donation. For example, care for a kidney patient with renal failure over five years is about $400,000, while the cost of a kidney transplant with follow-up medication is $130,000.

Wellness in Schools

Another proposal recommended by the workgroup is to tie public school funding to the implementation of wellness programs in the schools. Attention has been focused on the increase in childhood obesity and the growth in the number of children with

health conditions, such as Type II diabetes, that are a result of overweight and obesity. Agriculture Commissioner Susan Combs developed the Texas Public School Nutrition Policy, which became effective on August 1, 2004. The policy requires that no foods competing with foods served by the school food service department be made available in elementary schools with the exception of food for student birthday parties. Parents are allowed to provide food for a child's birthday celebration, but the celebration must occur after lunch to prevent birthday party food from replacing a nutritious lunch. The policy includes direction on food and beverages sold for school fundraising activities. For a strategy to achieve overall wellness to be implemented successfully, measures of preventing and reducing overweight and obesity among children through increasing physical activity in Texas schools would have to be developed by the legislature.

State Contracting

The workgroup recommended the state change statutes that guide contracting for services to include a provision that vendors who contract with the state must provide health insurance to all of their employees. The implementation of this provision could encourage more employers to provide health care coverage to their employees, reducing the number of uninsured and possibly reducing the number Medicaid recipients.

Appendix 5
List of Proposals To Expand Medicaid Services, by Priority

Priority	Proposal	Summary	Fiscal Impact	Current Status
1	305	Restore eligibility cuts to the adult medically needy spend down and pregnant women programs.	Increased state costs to restore eligibility to these groups. Pregnant women – Additional $20.3 million general revenue for fiscal year 2005.	Currently not doing this.
2	310 312	Restore Children's Health Insurance Program (CHIP) eligibility criteria to the criteria that existed before the 78th Legislative Session. Study the local impact and costs of the CHIP changes.	$92.8 million general revenue in fiscal year 2005 for a larger CHIP caseload based on eligibility changes.	Currently not doing this.
3	311 149	Restore the Medicaid eligibility level for pregnant women to 185 percent federal poverty level.	Increased state cost of $20.3 million general revenue in fiscal year 2005.	The current eligibility level for women age 19 and older was reduced from 185 percent of the federal poverty level to 158 percent of the federal poverty level. Eligibility for women under age 19 was maintained at 185 percent of the federal poverty level.
4	135	Pay for all items that are considered a standard of care for cancer patients, including intensity modulated radiation therapy (IMRT) and positron emission tomography (PET) scans.	Increased state costs.	Medicaid does not currently cover these items. However, the Medicaid Benefits Management Workgroup has reviewed some of these procedures to recommend additions to the program.

Priority	Proposal	Summary	Fiscal Impact	Current Status
4	309	Exempt newborns from the 90-day delay in coverage upon enrollment in CHIP.	Increased state costs to provide services to newborns during CHIP 90-day waiting period. Long-term cost-savings unknown	Currently not doing this.
5	308 307	Reinstate continuous coverage at 12 months for infants and children in Medicaid to reduce state administrative expense. Ensure continuous eligibility, preferably 12-month coverage for CHIP and Medicaid to minimize state administrative expense.	Increased state costs for caseload increase.	Currently not doing this Six-months continuous eligibility was maintained for children's Medicaid eligibility. CHIP coverage was reduced from 12 months to 6 months, but will resume 12-month continuous eligibility on September 1, 2005, pursuant to H.B. 2292.
6	35	Cover Inpatient Rehabilitation Services for Medicaid Patients in the state of Texas.	Unknown.	Inpatient rehabilitation services are covered in general acute care hospital settings with an acute condition or an acute exacerbation of a chronic illness in which rehabilitation services are medically necessary.
7	187 182c 183 184 185 186 188	Restore behavioral health counseling services, podiatry, eyeglasses, and hearing aids for Medicaid clients age 21 years and older. Restore maternity services. Reinstate Medicaid counseling and rehabilitation services for adults.	Increased state costs to restore services. Increased state costs to restore services.	Currently not doing this. Currently not doing this.

Priority	Proposal	Summary	Fiscal Impact	Current Status
	306	Restore podiatry services for Medicaid recipients age 21 years and older.	Increased state costs to restore services.	Currently not doing this.
	189	Reinstate behavioral health counseling services for Medicaid Beneficiaries 21 years or age and older by Licensed Professional Counselors (LPCs).	Increased state costs to restore services.	Currently not doing this.
8	259	Review current policies concerning bilateral tubal ligation (BTL) to be sure that women who desire permanent sterilization have access to that option.	Unknown.	Texas Medicaid follows federal guidelines that require a 30-day wait period once the Medicaid client has signed the sterilization consent form.
9	45	Restore the cuts to optional services to Medicaid nursing home residents.	Increased state costs to restore services.	Currently not doing this.

Appendix 6
Participation Invitation Letter to Mr. Richard Bettis, President and CEO of the Texas Hospital Association

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

October 20, 2003

Richard Bettis, CAE
President and CEO
Texas Hospital Association
P.O. Box 15587
Austin, Texas 78761-5587

Dear Mr. Bettis:

As you know, Texas is at a critical point in the development of our health care system. Health care costs and utilization of services are both increasing, and the system is increasingly inefficient. At the same time, the resources which pay for these services are decreasing. During this past legislative session, I promoted two methods of supporting the health care system. The first was to increase the availability of health insurance and, through SB 10 and SB 541, I believe that employers will have more opportunities to purchase more affordable health insurance. Then, for those individuals who do not have access to health insurance, I created a program to promote the creation of Federally Qualified Health Centers to provide increased access to cost effective and preventative health care services.

During this interim, I want to continue to build on these successes. I am asking for the medical and hospital industries' assistance in undertaking a serious, concentrated examination of the Texas Medicaid program in an effort to find reforms that will help us increase the effectiveness and efficiency of the program.

I am creating a Medicaid Reform Workgroup to study and develop these reforms. Could you work with the various interests within the hospital industry and provide me with a balanced list of up to 10 individuals with program, finance, and policy backgrounds to provide their expertise to this project? We will also have physicians and allied health care professionals represented in the workgroup. Our first meeting will be November 6, 2003, at 2:30 p.m. in the Governor's Press Conference Room. I look forward to working with you on this important endeavor.

Sincerely,

Rick Perry

Rick Perry
Governor

RP:vfp

cc: Mr. Jared Wolfe, Office of the Lieutenant Governor
Mr. Troy Alexander, Office of the Speaker of the House
Mr. Albert Hawkins, III, Commissioner, Texas Health and Human Services Commission

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Appendix 7
Participation Invitation Letter to Mr. Lou Goodman, President and CEO of the Texas Medical Association

OFFICE OF THE GOVERNOR

RICK PERRY
GOVERNOR

October 20, 2003

Mr. Lou Goodman
President and CEO
Texas Medical Association
401 West 15th Street
Austin, TX 78701

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Sincerely,

Rick Perry
Governor

RP:vfp

cc: Mr. Jared Wolfe, Office of the Lieutenant Governor
Mr. Troy Alexander, Office of the Speaker of the House
Mr. Albert Hawkins, III, Commissioner, Texas Health and Human Services Commission

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