TAHP
The Texas Association of Health Plans

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October 1, 2021

RE: HHSC Cost Containment Recommendations

On behalf of our member managed care organizations (MCOs) we would like to thank you for the opportunity to provide cost containment recommendations and would ask that the agency work closely with the MCOs as decisions are made to implement any cost containment initiative, or policy or rate change. Additionally, we think it is very important that HHSC review cost drivers in the Medicaid program to target specific areas for cost containment initiatives.

Before Texas moved most of its Medicaid clients into a managed care model, it was necessary for the state to find areas for cost containment. Over the years, HHSC Budget Riders directed the agency to find savings through making policy changes to therapy and durable medical equipment (DME) services; exploring other payment models; strengthening fraud, waste, and abuse (FWA) prevention; strengthening prior authorization requirements; increasing private duty nursing assessments; reducing payment for non-emergent ER visits; reducing providers' FFS rates; implementing value-based payments; changing neonatal payment coding; improving birth outcomes; increasing efficiencies in the vendor drug pharmacy; and carving more services into managed care. Given all these efforts and the movement to the more efficient managed care model, there are fewer areas for the state to find savings in the administration of Medicaid.

We can continue to reform the system, increase efficiency, and control costs by embracing the innovation and efficiency of the private market. As HHSC looks for ways to contain costs, we encourage the state to continue embracing the proven managed care model and to continue moving away from paying for the volume of services delivered. Instead, we should focus on paying for quality of care. To that end, we offer the following areas for additional efficiency and cost-containment for your consideration.

1. Encourage preferred provider arrangements. Health care experts generally agree that FFS payment models incentivize volume without necessarily promoting quality. Therefore, current healthcare quality strategy moves away from evaluating and compensating providers based on volume and instead bases compensation on the value of care provided. Implementation of these value-based contracting arrangements, also known as alternative payment models (APMs), encourages innovation that can help sustain the Medicaid program by focusing the entire system on quality and efficiency. Consequently, the state's contract requires MCOs and dental maintenance organizations to transition a percentage (which increases each year) of payments to

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their contracted providers into APMs. The goal is to reward providers for focusing on the quality of the care they deliver — not on volume.

A type of APM used in the private market, Medicare, and Medicaid programs is called a preferred provider arrangement, which is the use of high-value providers who have a track record of providing high-quality, cost-efficient care to patients. These arrangements are critical for MCOs to further improve quality, contain costs, and increase efficiencies in Texas. Relying on provider performance data, health plans can identify providers who deliver high-quality, efficient health care and implement strategies to direct care to those providers. Arrangements with DME suppliers are among the most common types of preferred arrangements used by Medicaid programs and commercial insurers across the country. These arrangements ensure clients use the appropriate product, which increases their quality of life and decreases other health complications such as falls, ulcers, and other common conditions that result in more costly care.

APMs help achieve many of the goals previous cost containment riders set forth — incentivizing quality care, reducing FWA, and reducing administrative burdens — without affecting client services or provider payment rates. APMs also encourage the use of higher-value services such as evidence-based preventive care while limiting unnecessary services. A study of a high-value network in California found that preferred provider arrangements resulted in 20% lower health care costs and 20% higher quality.[1] In a 2016 pilot program in Texas, one health plan entered into a preferred provider arrangement with a DME company for incontinence supplies and saw a 59.4% reduction in admissions for treatment of ulcers while reducing waste by identifying 675 patients receiving supplies at an old address.[2] The 1% Steps for health care reform also cites preferred pharmacy networks as a way to reduce spending: *In the Medicare Part D market, plans with preferred pharmacy networks reduce spending on prescription drugs by approximately 2%. While around 95% of Medicare Part D insurers use preferred pharmacy networks, only half of employers are using narrow or preferred pharmacy networks.*[3]

APMs reward high-quality providers by incentivizing MCOs to waive certain administrative requirements those physicians consider burdensome. Performance-based payments also incentivize providers to improve their performance to become eligible for these types of arrangements in the future.

Recommendation: Texas currently has barriers to using preferred provider arrangements in the Medicaid program. TAHP recommends HHSC change policies to encourage and allow MCOs to use these arrangements to contain costs and improve quality of care.

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[1] High Value Provider Networks. Milliman, July 2014.
[2] UnitedHealthcare and Longhorn Health Solutions Incontinence Supplies Capitation Program. December 2016.
[3] https://onepercentsteps.com/policy-briefs/promoting-preferred-pharmacy-networks/

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2. Improve PCP assignment processes. Recognizing the importance of primary care, every Medicaid client is required to have an assigned primary care physician (PCP). Today, this assignment takes place through a third party - Maximus. A client is given the choice of PCPs, but if a client does not select a PCP, the third party makes an assignment. Currently in the CHIP program, the MCO, not a third party, makes the assignment. Because the PCP assignment is currently made by a third party instead of the MCO, the existing process is in conflict with Texas Government Code 533.005(a)(26), which requires MCOs to make initial and subsequent primary care provider assignments and changes. Requiring the client's MCO to make the PCP assignment allows the health plan to work directly with their client to find an in-network, high-quality provider. Health plans have methodology in their systems to help assign clients to a provider that is located near them, is high quality, and honors existing or previous client-physician relationships.

Allowing MCOs to make the PCP assignment also creates efficiencies in the program and moves the state closer to allowing clients to go directly into managed care rather than wait in the fee-for-service program while the PCP assignment is being made by a third party. Most other states require the MCO to make the assignment as it is more efficient and is a step in developing the relationship between the client and their health plan.

Recommendation: TAHP recommends HHSC align Medicaid and CHIP processes and honor existing statutory requirements to allow MCOs to make primary care physician assignments. This change should reduce costs paid to the Enrollment Broker to perform this function.

3. Improve the coordination of benefits for Medicaid and Medicare dual eligible clients. MCOs are required by contract to coordinate benefits for STAR+PLUS clients who receive both Medicaid and Medicare coverage (called "dual eligible" clients). The MCOs are also federally required to ensure Medicaid does not pay for certain services that Medicare should cover. As part of the benefit coordination process, MCOs cannot pay for the Medicare-covered service until Medicare denies the service. While MCOs go to extensive efforts to coordinate the delivery of these services, the process is complicated and often delayed due to the majority of dual eligible clients receiving their Medicaid and Medicare services from different health plans or from Medicaid FFS. Medicaid MCOs are dependent on the cooperation of an external Medicare payer or provider (often not in network with the STAR+PLUS plan) to coordinate and provide ongoing status and supporting information to the MCO with no incentive. In some cases, per HHSC direction, when Medicare does not pay for the service or fully cover a needed treatment (called "wrap coverage"), TMHP — not the MCO — is responsible for paying for the service.

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Recommendation: HHSC should move responsibility for payment of wrap coverage for dual clients from TMHP to MCOs to further align accountability, enable better coordination of services for clients, and streamline processes and payment for providers. Having a single entity responsible for payment of all Medicaid services simplifies processes for providers and further reduces costs at TMHP while improving access to care for members.

4. Address private duty nursing (PDN) costs by aligning personal care services (PCS) and PDN services. PDN is one of the biggest cost drivers in the Medicaid program. In many cases, clients could use PCS, also known as attendant services, instead of more expensive PDN services. Current policy states that if a client does not meet medical necessity for PDN, then PCS can be offered instead. PDN is individualized, continuous, skilled nursing care in the home whereas PCS are home care benefits that assist with activities of daily living such as bathing, eating, and dressing. MCOs actively refer clients to these services; however, there are barriers that limit the ability to interchange the services when appropriate. The PCS agencies often have no nurse on staff, which means the PCS attendant is not supervised by a licensed professional. PDN is often used in place of PCS because families and medical providers are not comfortable not having a nurse overseeing the care. If the licensing of PCS services could be modified to require a nurse on staff who has the authority to delegate and supervise the attendees, it would reduce the reliance on PDN and be a cost savings to the state.

Effective November 2016 Prescribed Pediatric Extended Care Centers (PPECCs) became a Medicaid benefit in Texas. PPECs allow minors from birth through age 20 with medically complex conditions to receive daily medical care in a non-residential setting. The Legislature authorized the use of PPECS to help address PDN costs. For clients in which it is appropriate, these centers provide a more cost effective way for clients to access PDN and other therapy services. Due to over burdensome regulatory requirements there are only 7 PPECs licensed in Texas. To provide greater access and help reduce overall costs with PDN, we recommend HHSC review licensing requirements and other policies to find ways to encourage greater access to these centers in Texas.

Recommendation: **Since PDN is one of the largest cost drivers in the Medicaid program, HHSC should review the option of joining the PCS and PDN benefits instead of allowing them to operate in parallel and review any additional policy changes that could help address PDN costs.**

5. Review DME fee-for-service rates. The managed care system allows health plans to negotiate private market reimbursement rates which has resulted in taxpayer savings. One area where MCOs have seen a larger discrepancy between market rates and the Medicaid fee-for-service (FFS) fee schedule is for certain DME supplies. While the majority of clients are

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enrolled in managed care, there are still clients that receive services through the FFS system and a review of the fee schedule for common DME products could result in savings for the state.

Recommendation: TAHP recommends HHSC conduct a review of the DME FFS fee schedule to determine if there are areas for cost containment for the state.

6. Improve the Vendor Drug Program. We appreciate the collaboration between HHSC and the MCO pharmacy teams to continue to improve the Medicaid vendor drug program but we believe there are additional areas where we can work together to contain costs. Pharmacy is a major cost driver in the Medicaid program making it a prime focus to find cost containment initiatives.

- **Biosimilars.** Research indicates that the use of biosimilars can generate savings in the Medicaid program.[4] In 2017 and 2018, twelve states enacted legislation requiring biosimilar substitution (Iowa, Kansas, Maryland, Minnesota, Montana, Nebraska, Nevada, New Mexico, New York, Ohio, and South Carolina, and South Dakota). **TAHP recommends that HHSC adopt policies allowing and encouraging the use of biosimilars when appropriate. Biosimilars, especially the new insulin biosimilars and clinician administered biosimilars for concologic and immunologic agents, could decrease cost in the Medicaid program.**

- **Over the Counter Drugs**. In the past MCOs had been allowed to offer OTC drugs as a value added benefit (VAB). Today, common OTC items, such as acetaminophen (Tylenol), ibuprofen (Advil/Motrin), topical antifungal creams like OTC terbinafine (Lamisil AF), etc, are not allowed by VDP to be listed on a VAS because those items are available to members with a prescription from a provider. While providers can prescribe OTC items there are many times that members could obtain the OTC instead of making a medical appointment or going to an emergency room for treatment of a simple condition such as athletes foot, or minor allergies or other conditions where OTC products are the standard of care. We realize that CMS has restrictions related to allowing a VAS if it is a covered Medicaid benefit but we think HHSC should work with CMS to explore greater flexibility considering other factors such as provider access, member transportation, and other barriers that our members face. Plans that operate in other states maintain VAS OTCs. Texas should review and reconsider the current limitation in light of allowances in other states. **TAHP recommends that HHSC review the OTC and VAS policy and explore opportunities for MCOs to provide OTCs, either as a VAS or through another authority.**

[4] Andrew Mulcahy, Zachary Predmore, and Soeren Mattke, "The Cost Savings Potential of Biosimilar Drugs in the United States," Rand and Corporation, 2014),

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- **Clinician administered drugs**. Clinician-administered drugs are one of the largest cost drivers in the pharmacy benefit and the Medicaid program as a whole. We believe there is cost-savings to be recognized by allowing clinician administered drugs to be adjudicated at the lowest cost channel, whether that be under the pharmacy benefit or the medical benefit. We also recommend that clinical edits be permitted on these drugs to ensure that they are being used appropriately and in the confines of evidence-based medical care. Further, for drugs available under both the pharmacy and medical benefit, we recommend that the clinical edit criteria is in alignment across benefits to provide for consistent coverage and discourage inappropriate utilization. Specialty pharmacy network narrowing may also be an avenue by which to get the best cost for these drugs which we know have very hefty price tags associated with them. **TAHP recommends HHSC review options to reduce the costs associated with clinician-administered drugs.**

- **Drug Growth Caps.** One idea currently being tested in New York is the use of a spending growth cap for Medicaid prescription drugs, under which the state targets drugs with high or quickly-growing costs for additional supplemental rebates or strict utilization review. If total Medicaid drug spending in a year is projected to exceed the growth target, the NY Commissioner of Health may identify specific drugs for referral to the DUR Board13 and can implement additional utilization controls. NY's DUR Board considers a variety of factors about the specified drugs, such as the cost of the drug including rebates, its impact on the drug spending growth target, and its value to Medicaid beneficiaries. If the department is unable to obtain the desired additional supplementary rebates, the manufacturer must provide information to the department on the drug in question including the cost of development and manufacturing, R&D costs, advertising costs, utilization, prices charged outside the U.S., average rebates, and average profit margin. **Texas should explore options to allow the agency and MCOs to target certain drugs with growing costs in any given year and explore options to allow flexibility for the MCO to adopt additional utilization controls for targeted drugs.**

7. Fully carve all nursing facility (NF) payment and administration processes into managed care. STAR+PLUS MCOs are committed to continuing to find areas for improvement and ways to increase administrative efficiency in the program, but the only way we are going to further reform the system is to stop trying to fit the managed care program into the FFS infrastructure. Payment and administration of Medicaid NF services straddle both FFS and managed care and involve multiple, confusing, and inefficient processes. For example, NFs submit admission and discharge notices to HHSC instead of to the MCO, which can delay the initiation of MCO

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service coordination. Also, the process for developing NF payments rates involves HHSC, TMHP (Medicaid FFS), and the MCOs and is extremely cumbersome.

HHSC's rate methodology uses a complicated set of rules that generates *over 1,000* different NF payment combinations based on the client's level of need, which can change daily, resulting in a constantly adjusting rate, and MCOs must rely on information from TMHP for that rate. This process creates administrative complexity and budgeting challenges for NFs that are compounded by frequent retroactive payment adjustments based on the constant changing rate and conflicts between TMHP, MCO, and HHSC files and systems. The volume of retroactive adjustments is much higher in Texas' STAR+PLUS program than in other managed care programs because of these frequently changing rates. Frequent retroactive payment adjustments and inefficient processes result in NFs, HHSC, and MCOs spending countless hours on claims payments, adjustments, and reconciliations. NFs bill anywhere from 300,000 to 350,000 claims per month with over 125,000 of those resulting in payment adjustments. One STAR+PLUS plan analyzed its claims to demonstrate the administrative burden and found that on average, it processed 46,000 NF room/board claims in a given month with 37% of those claims needing to be adjusted, compared to 15% in other markets. And 54% of those adjustments yielded a payment difference of just $10 or less. This example from just one plan demonstrates MCOs' and NFs' complaints and concerns with the current processes.

Almost every other state has adopted simpler NF payment methodologies. HHSC also understands the importance of adopting a simplified payment methodology, and the agency created a workgroup to review what Medicare and other states have adopted and to develop recommendations for a new payment methodology.

Recommendation: TAHP recommends HHSC adopt a new, simpler, more transparent payment model that leverages best practices from other state Medicaid programs, rewards quality, and achieves administrative simplification for NFs, HHSC, and STAR+PLUS MCOs and removes payment processes from TMHP.

Thank you for the opportunity to provide these recommendations. If you need additional information or would like to meet and discuss cost drivers in the Medicaid program and identify solutions to continue to contain costs please feel free to contact us.

Sincerely,

Jamie Dudensing
CEO