Texas Health and Human Services Commission (HHSC)

Approach to Rider 60 and Rider 61
Rider 60: Prescription Drug Benefit Administration in Medicaid, CHIP & Other Health-Related Services

Rider 60 requires HHSC to study potential cost savings in the administration of prescription drug benefits by transitioning from managed care and administering them as fee-for-service (FFS). Key changes to be considered in the analysis include the impact from moving to a single, state-wide claims processor, eliminating certain components of pharmacy capitation payments to managed care organizations (MCOs), and transitioning to a pricing model based on National Average Drug Acquisition Costs (NADAC) with a dispensing fee commensurate with the most recent study commissioned by HHSC.

Illustration of Approach to Quantifying Potential Costs or Savings under Rider 60(1)

Current State Costs (not to scale)

Future State Costs (not to scale)

POTENTIAL SAVINGS OR LOSSES

- Claims previously from managed care populations, priced using NADAC plus a professional dispensing fee

Non-risk claims for previous managed care populations

Administrative costs for FFS program

Pharmacy claims paid under HHSC’s current FFS program

Combined rebate offset across all pharmacy programs

ACM Health Insurance Providers Fee

Pharmacy Capitation Payments to MCOs

State Premium Tax

Risk Margin

MCO/ PBM Administrative Costs

Projected incurred pharmacy claims at risk for managed care population

Non-risk claims for managed care populations

Administrative costs for FFS program

Pharmacy claims paid under HHSC’s current FFS program

Combined rebate offset across all pharmacy programs

(1) The graphic is for illustrative purposes only and is meant to capture some of the high-level changes that may occur in this model; other qualitative and quantitative impacts not reflected herein will also be considered and incorporated in the Rider 60 study

(2) While premium tax is embedded in MCO capitation payments, it is later reimbursed by MCOs to the State

(3) HHSC currently negotiates and collects rebates for all Texas pharmacy programs
Rider 61(a): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care System

Rider 61(a) requires HHSC to evaluate the performance of Managed Care throughout Medicaid and Children’s Health Insurance Program (CHIP). Aspects of the evaluation include review of historical data and trends including enrollment, cost, quality, access, and CAHPS (Consumer Assessment of Healthcare Providers and Systems) surveys, as well as estimating the cost savings attributed to Managed Care and summarizing potential opportunities for Texas.

**Approach**

**Gather and Review Materials**
Gather and analyze existing documentation to understand the current program, including its design, successes, and challenges

**Analyze and Understand Data**
Work with HHSC to fully understand the summarized data needed to conduct the assessment. Conduct interviews with key personnel across HHSC to supplement insights gained from the data and documentation

**Perform Analysis**
Leverage the materials collected, the data provided, industry sources, and interviews to analyze trends, caseload growth, and savings realized within the managed care program

**Compare to Other States**
Leverage experience in working with other state Medicaid and CHIP programs and use nationally available data sources and industry benchmarks. Compile a summary of managed care program outcomes (cost savings, trends, and caseload changes) and initiatives states have used to contain costs and improve program effectiveness
Rider 61(a): Evaluation of Medicaid and CHIP Managed Care – Review of Managed Care System (continued)

Rider 61(a) requires HHSC to evaluate the performance of Medicaid managed Care, including estimating cost savings from Medicaid managed Care. The methodology used to identify cost savings from Medicaid managed care is summarized below.

**Managed Care Cost Savings: High Level Methodology**

1. **Baseline**: Starting point for comparison is FY2009 MC PMPM.
2. **Managed Care Experience Trend**: Based on actual managed care expenditures.
3. **Estimated FFS Trend**: Based on Texas historical and industry FFS trends applied to FY2009 baseline.
4. **National Medicaid Trend**: Based on nationwide Medicaid trends applied to FY2009 baseline.
5. **Program Changes**: Changes to the Medicaid program will be considered for each of the comparison trend lines (#3 and #4 above).
6. **Caseload and Case Mix Changes**: Changes in both caseload and case mix will be assessed and evaluated at the rate cohort level. Impact of caseload and case mix changes on the managed care trend will be assessed and, as appropriate, may be incorporated into comparison trend lines.
7. **Managed Care Savings**: Medicaid managed care experience trend (#2 above) will be compared to both the estimated FFS trend and national trend (#3 and #4 above) to evaluate Medicaid managed care savings. Medicaid managed care savings within and prior to baseline year will be noted and estimated by reviewing the rate certifications pre-FY2009.
Rider 61(b): Evaluation of Medicaid and CHIP Managed Care - Review of Managed Care Contract Review & Oversight Function

Rider 61(b) requires HHSC to conduct a review of the agency’s contract management and oversight function for Medicaid and Children’s Health Insurance Program (CHIP) managed care contracts. The review framework includes eight functional areas from the CMS Medicaid and CHIP Managed Care Final Rule that align with the scope of review stated in Rider 61b. In addition, the ninth domain, Contract Amendment and Procurements, is defined in the Rider 61 as an additional group of functions to review.

**Medicaid and CHIP Managed Care Oversight and Contract Management Assessment Framework**

<table>
<thead>
<tr>
<th>Understand Goals &amp; Objectives:</th>
<th>Goals and Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct visioning interviews with HHSC leaders to understand goals and objectives of the Texas’ Medicaid and CHIP managed care contract review and oversight function</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review Operating Model:</th>
<th>Operating Divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate sessions with sections / offices staff to assess the maturity stages for the 9 Managed Care Contract Review and Oversight functional domains, as well as to clarify questions results from the document review and analysis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assess the Managed Care Oversight Functions:</th>
<th>Managed Care Contract Review and Oversight Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop preliminary findings as related to the contracting and oversight responsibilities in each of the functional domains. The review includes identifying leading practices from other states and where relevant, benchmarks from other Medicaid state programs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Analyze State’s Environment:</th>
<th>Texas’ Medicaid and CHIP Managed Care Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze multiple documents to inform assessment of HHSC’s contract management and oversight function for the Medicaid and CHIP managed care program</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Monitoring Standards</th>
<th>Quality of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grievances and Appeals</td>
<td>Program Integrity</td>
</tr>
<tr>
<td>Contract Amendments and Procurements</td>
<td>Rate Development Standards</td>
</tr>
<tr>
<td>Network Adequacy and Access to Care</td>
<td></td>
</tr>
<tr>
<td>Marketing Activities</td>
<td></td>
</tr>
<tr>
<td>Enrollment / Disenrollment</td>
<td></td>
</tr>
<tr>
<td>State Infrastructure and Capacity</td>
<td></td>
</tr>
<tr>
<td>Current State Processes and Procedures</td>
<td></td>
</tr>
<tr>
<td>Tools and Technology</td>
<td></td>
</tr>
</tbody>
</table>
Rider 61(c) requires HHSC to provide an overview of the Medicaid managed care rate setting methodology for Texas and compare Texas’s rate setting methodology to other states. In addition to rate setting, HHSC will provide an overview and comparison of states’ funding and MCO procurement methods, including competitive bidding procedures.

1. **Managed Care Rate Setting Methodology**
   - **Gather Information**: Collect publicly available rate development documentation for states selected for comparison
   - **Compare Rate Setting Methodologies**: Leverage rate setting experience across the country, knowledge of the current Texas MCO environment, and prior experience in program evaluation support, to summarize and document procedures for developing, adjusting, and applying the various components of capitation rates, highlighting potential areas of opportunity for Texas

2. **MCO Selection**
   - **Gather Information**: Collect publicly available MCO procurement information for states identified as comparable to Texas. Analyze responses from “Managed Care Pricing Models” RFI released by HHSC to the Texas MCOs
   - **Summarize MCO Selection Processes**: Consolidate data and document state MCO selection processes including, competitive bid arrangements, variation in selection process by Medicaid population, contracting requirements, and competition requirements

3. **Funding Methods**
   - **Gather Information**: Collect data for funding methods used in comparable states through interviews, subscription services (e.g. HealthLeaders Interstudy), and publicly available information
   - **Document Other States’ Funding Methods**: Document inventory of funding methods used in other states, accounting for insured, self-insured, and hybrid funding models
Rider 61(d): Evaluation of Medicaid and CHIP Managed Care – Managed Care Administrative Expenditure Audit

Rider 61(d) requires HHSC to review Texas Medicaid and CHIP MCOs’ administrative costs including developing a survey for each MCO to determine the nature and scale of administrative resources devoted to the Texas Medicaid and CHIP Programs and the identification of cost reduction opportunities.

Gather and review existing data
- Examine key national administrative expense trends and changes required by the 2016 final CMS managed care regulations (MLR)
- Analyze Financial Statistical Reports (FSRs) from SFY 2016 and SFY 2017
  - Conduct comparative MCO analysis, with consideration to membership size and programs served
  - Examine Quality Improvement (QI) expenditures in SFY 2017, the first year QI was fully reflected as a medical cost per the final CMS managed care regulation

Develop and release MCO survey
- Develop and release survey, pursuant to Rider requirement, to each Texas Medicaid and CHIP MCO to collect additional information regarding:
  - Number of staff supporting Texas Medicaid and CHIP program
  - Additional detail on certain FSR components to better understand cost drivers
  - MCO perspective on current administrative challenges and opportunities for new efficiencies and cost savings

Analyze and document findings
- Analyze the survey data, identifying trends and information to understand major administrative expenditures
- Summarize and report on cost trends and potential efficiency opportunities

MCO Administrative Expenditure Survey Topics
- Number of FTE Resources by Functional Component
- Corporate Allocations
- Outsourced Services
- HHSC Reporting Requirement Expenditures
- Clarification on Specific Reported FSR Expenditures
- Cost Allocation Methodologies
- SFY 2016 to SFY 2017 Administrative Expenditure Changes
- Areas of Opportunity