



Presentation to the House Public Health Committee: HHSC Overview

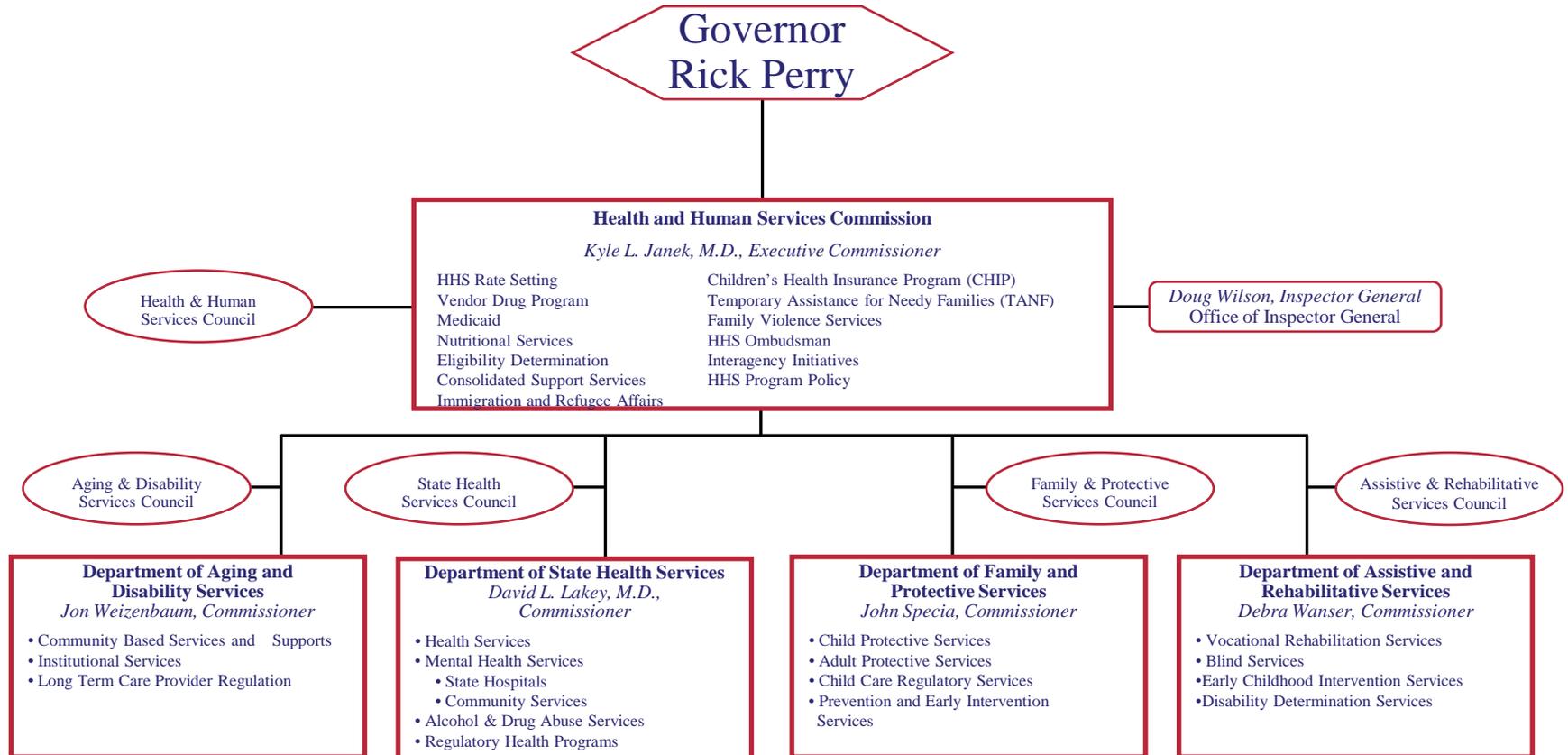
Kyle L. Janek, M.D., Executive Commissioner
Chris Traylor, Chief Deputy Commissioner

February 13, 2013

Texas HHS Overview

- The Texas health and human services system includes five agencies, four of which operate under the oversight of the Health and Human Services Commission
- Together, these five agencies administer more than 200 programs ranging from Medicaid to Child Protective Services to regulatory and licensing functions

HHS Organization



HHSC Mission Statement and Key Functions

“The mission of the health and human service agencies in Texas is to develop and administer an accessible, effective, and efficient health and human services delivery system that is beneficial and responsive to the people of Texas.”

Operations

- *Medicaid*
- *CHIP*
- *TANF Cash Assistance*
- *Eligibility Determination*
- *Disaster Assistance*
- *Family Violence*

HHS System Oversight

- *Consolidated Administrative Supports*
- *HHS Program Policy and Coordination*
- *Interagency Initiatives*

Office of Inspector General



TEXAS

Health and Human
Services Commission

Texas Medicaid Program Overview

Medicaid Overview

Medicaid is a jointly funded state-federal program that provides health coverage to low income and disabled people

- At the federal level, Medicaid is administered by the Centers for Medicare and Medicaid Services (CMS) within the U. S. Department of Health and Human Services
- At the state level Medicaid is administered by the Health and Human Services Commission (HHSC)
- Federal laws and regulations
 - Require coverage of certain populations and services
 - Allows states to cover additional populations and services
- Medicaid is an entitlement program, meaning:
 - Guaranteed coverage for eligible services to eligible persons
 - Open-ended federal funding based on the actual costs to provide eligible services to eligible persons

Medicaid Overview: Who Does Medicaid Serve?

- Texas Medicaid serves:
 - Low-income families
 - Children
 - Pregnant women
 - Elders
 - People with disabilities
 - Effective January 1, 2014, the ACA expands Medicaid to individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care
- Texas Medicaid does not serve:
 - Non-disabled, childless adults under the age of 65

Medicaid Overview: Who Does Medicaid Serve?

- Eligibility criteria includes:
 - Residency in Texas
 - U.S. citizenship or certain qualified aliens
 - Income and resource limits
 - Applicants for long-term services and supports may be required to meet certain functional or medical criteria
 - Most child applicants must be under age 19

Medicaid Overview: Who Does Medicaid Serve?

Medicaid eligibility is financial and categorical

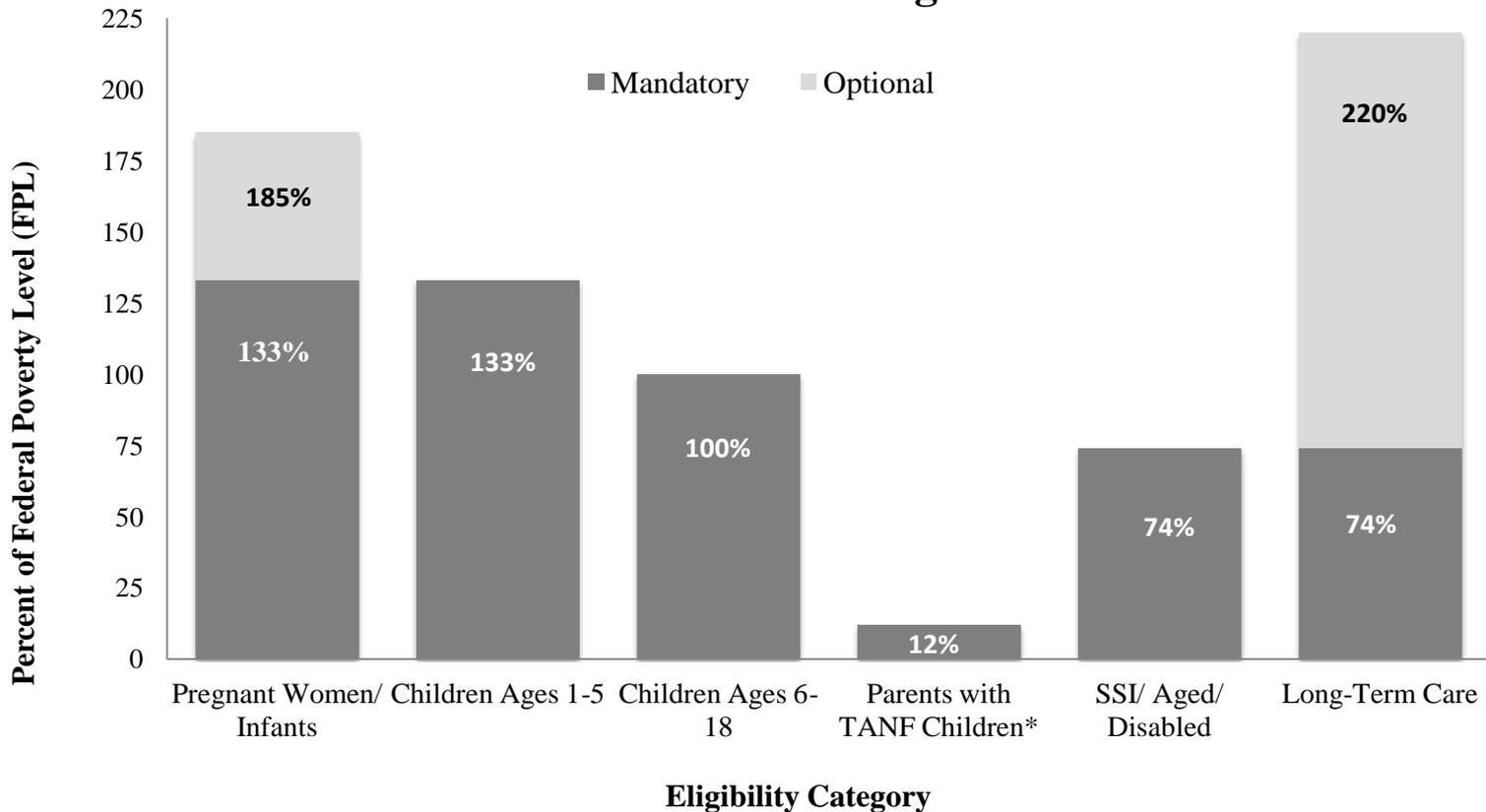
- Low income alone does not constitute eligibility for Medicaid
- Eligibility factors include:
 - Family income;
 - Age; and
 - Other factors such as being pregnant or disabled or receiving TANF
- Individuals receiving SSI cash assistance are automatically eligible for Medicaid

In general, our clients:

- 55% are female
- Children and persons 65 and older make up 83% of clients
- 55.9% of births in Texas are paid by Medicaid

Medicaid Overview: Who Does Medicaid Currently Serve?

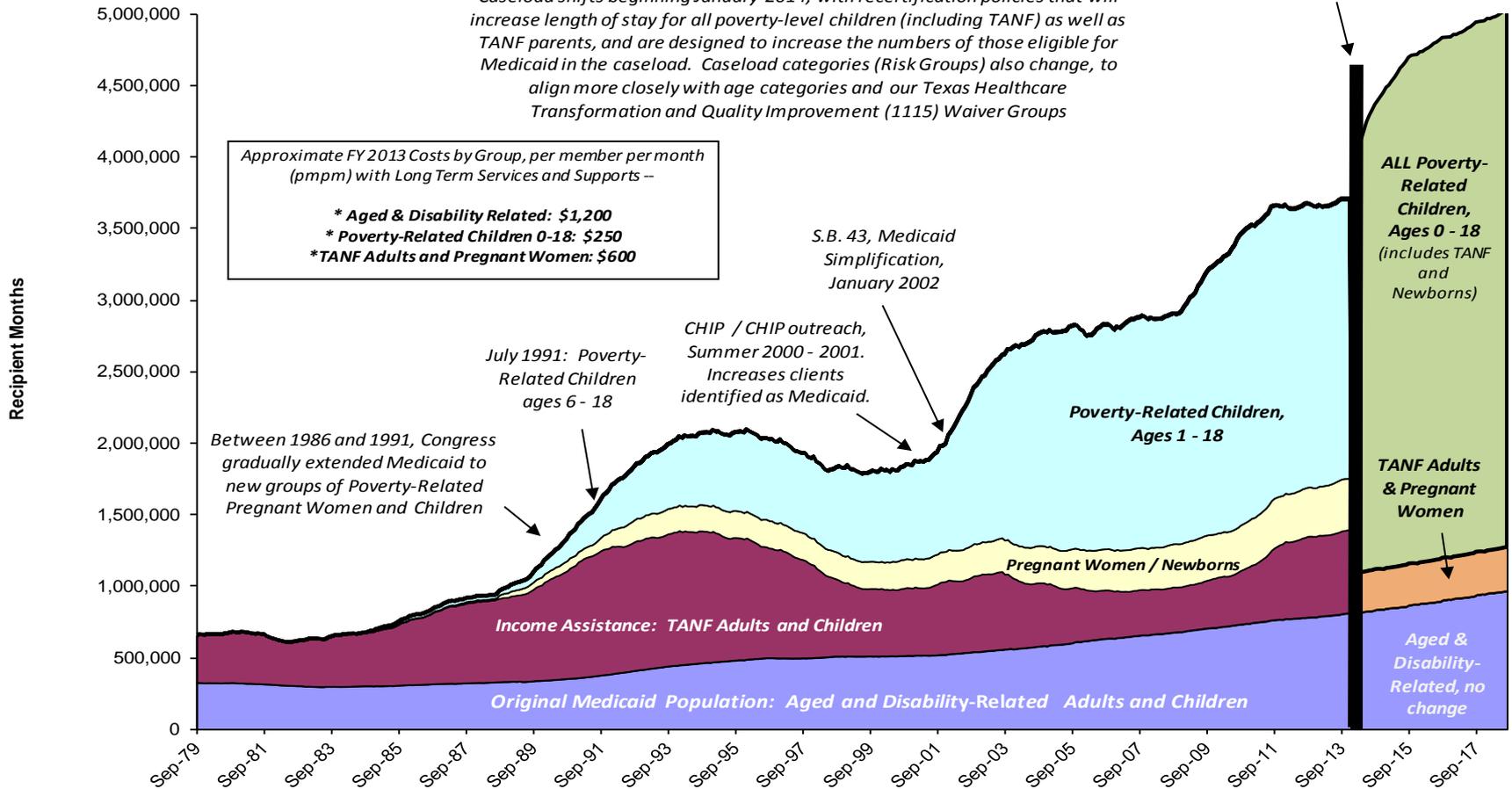
**Texas Medicaid Income Eligibility Levels
for Selected Programs**



Where Texas Spends Medicaid Dollars – Caseload

Texas Medicaid Caseload by Group, September 1979 - August 2018
Forecast December 2012 - August 2018 showing ACA Policy Changes

Caseload shifts beginning January 2014, with recertification policies that will increase length of stay for all poverty-level children (including TANF) as well as TANF parents, and are designed to increase the numbers of those eligible for Medicaid in the caseload. Caseload categories (Risk Groups) also change, to align more closely with age categories and our Texas Healthcare Transformation and Quality Improvement (1115) Waiver Groups



Mandatory Services

- Federal law requires that all state Medicaid programs pay for certain services to Medicaid clients. The following are mandatory Medicaid services:
 - Early Periodic Screening, Diagnosis and Treatment (EPSDT) also known as Texas Health Steps for children under age 21
 - Check-ups include medical history, complete physical exam, assessment of nutritional, developmental and behavioral needs, lab tests, immunizations, health education, vision and hearing screening, referrals to other providers as needed
 - Access to Federally Qualified Health Centers (FQHCs) and Rural Health Centers
 - Home health care
 - Inpatient and outpatient hospital
 - Family planning

Mandatory Services

- Mandatory Services (continued):
 - Lab and X-ray
 - Nursing facility care
 - Pregnancy-related services
 - Physician services
 - Certified Nurse Midwife services
 - Certified Pediatric and Family Nurse Practitioner services

Optional Services

- The state may choose to provide some, all, or no optional services specified under federal law. Optional services provided in Texas include services such as:
 - Prescription drugs
 - Physical therapy
 - Occupational therapy
 - Targeted Case Management
 - Some rehabilitation services
 - Certified Registered Nurse Anesthetist
 - Eyeglasses/contact lenses
 - Hearing aids
 - Services provided by podiatrists
 - Certain mental health provider types

Medicaid Overview: How are Services Provided?

Medicaid services are delivered *by* certain provider types *through* certain delivery models

The following providers deliver Medicaid services:

- Health professionals - doctors, nurses, physical therapists, dentists, psychologists, etc.
- Health facilities - hospitals, nursing homes, institutions and homes for persons with Intellectual and Developmental Disability (IDD), clinics, community health centers, school districts
- Providers of other critical services like pharmaceuticals or drugs, medical supplies and equipment, medical transportation

Medicaid Overview: How are Services Provided?

The Texas Medicaid program provides services to Medicaid eligibles through different “delivery models”

- Fee for Service (Traditional Medicaid)
- Managed Care:
 - **Managed Care Programs in Texas:**
 - STAR (State of Texas Access Reform) – Acute Care HMO
 - STAR+PLUS – Acute & Long-Term Services and Supports HMO
 - NorthSTAR – Behavioral Health Care HMO
 - STAR Health – Comprehensive managed care program for children in Foster Care
 - Dental Maintenance Organizations provide dental care for the Medicaid/CHIP populations as of March 1, 2012

Program Administration: Medicaid State Plan

- Each state has a State Plan that constitutes that state's agreement with the federal government on:
 - Who will receive Medicaid services – all mandatory and any optional eligibles
 - What services will be provided– all mandatory and any optional services;
 - How the program will be administered
 - Financial administration of the program
 - Other program requirements
- State Plan Amendment (SPA):
 - Required to change existing optional coverages or other components of the program
 - Must be submitted to CMS for approval
 - Must be approved by CMS to ensure the federal matching funds will be provided to the program

Program Administration: Waivers

- Waivers provide states with options for their Medicaid programs
- Federal law allows states to apply to CMS for permission to deviate from certain Medicaid program requirements through waiver applications
- States typically seek waivers to:
 - Provide different kinds of services
 - Provide Medicaid to new groups
 - Target certain services to certain groups
 - Test new service delivery and management models



TEXAS

Health and Human
Services Commission

Texas CHIP Program Overview

CHIP Overview

- CHIP is a joint state-federal program that provides health coverage to eligible children up to age 19, who are not already insured
- Federal law and regulations:
 - Requires each state to set eligibility guidelines, service levels, and delivery systems
 - Requires each state to operate a state plan listing these elements
- CHIP is not an entitlement program

CHIP Eligibility

- CHIP serves:
 - Uninsured children under age 19
 - Net income up to 200 percent FPL
 - U.S. citizens or legal permanent residents
 - Not eligible for Medicaid
- Families with income above 150 percent FPL must meet assets criteria:
 - Assets below \$10,000
 - One vehicle is exempt up to \$18,000; additional vehicles are exempt up to \$7,550
- Eligibility is determined for a 12-month period; income verification at six months for families at 185 percent FPL and above
- There were 563,740 children in CHIP in FY 2012

CHIP Cost Sharing

- CHIP has annual enrollment fee and co-payment requirements for most clients which vary based on family income levels
 - The annual enrollment for families from 150% - 185% FPL is \$35
 - The annual enrollment fee for families from 185% - 200% FPL is \$50
 - Based on family income, co-pays for office visits range from \$3 up to \$25; co-pays for non-emergency emergency room visits range from \$3 up to \$75; and co-pays for drugs range from \$0 for certain generic drugs to \$35 for some brand-name drugs



Texas Healthcare Transformation and Quality Improvement Program Waiver

Kyle L. Janek, M.D., Executive Commissioner

Chris Traylor, Chief Deputy Commissioner

Lisa Kirsch, Deputy Medicaid Director, Healthcare Transformation Waiver

Transformation Waiver Overview

- Managed care expansion
 - Allows statewide Medicaid managed care services while preserving historical upper payment limit (UPL) funding
 - Includes legislatively mandated pharmacy carve-in and dental managed care
- Hospital financing component
 - Preserves UPL hospital funding under a new methodology
 - Creates Regional Healthcare Partnerships (RHPs)
- Five Year Waiver 2011 – 2016

UC and DSRIP

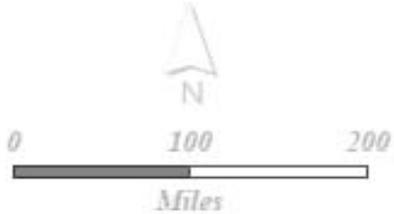
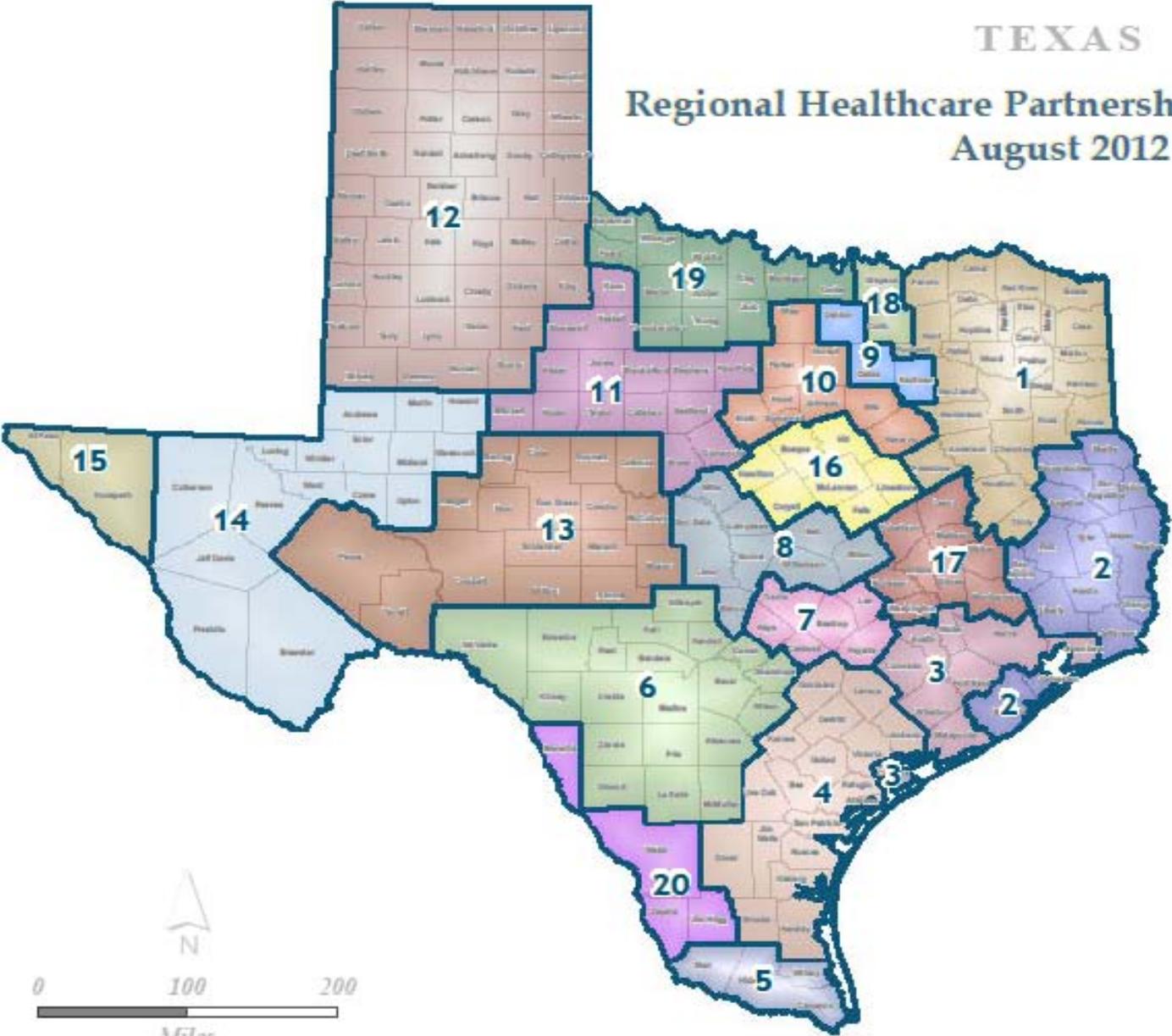
- Under the waiver, historic UPL funds and new funds are distributed to hospitals and other providers through two pools:
 - **Uncompensated Care (UC) Pool**
 - Replaces UPL
 - Costs for care provided to individuals who have no third party coverage for hospital and other services
 - **Delivery System Reform Incentive Payments (DSRIP) Pool**
 - New program to support coordinated care and quality improvements through RHPs
 - Transform delivery systems to improve care for individuals (including access, quality, and health outcomes), improve health for the population, and lower costs through efficiencies and improvements

Regional Healthcare Partnerships

- In May 2012, HHSC established 20 RHPs:
 - Each RHP is anchored by a public hospital or other public entity
 - Each RHP has submitted its RHP Plan that outlines priority community needs and DSRIP projects to improve regional health care delivery
- Hospitals and other providers must participate in an RHP to access UC and DSRIP funds

TEXAS

Regional Healthcare Partnership (RHP) Regions August 2012



Map Prepared by: Strategic Decision Support Department,
Texas Health and Human Services Commission,
August 2012

Transformation Waiver: RHP Status

- 20 RHPs
 - 1,335 DSRIP projects proposed (\$9.9 billion all funds)
 - Projects received from 224 hospitals, 38 community mental health centers, 20 local health departments, and 18 physician practices (included 12 affiliated with academic health science centers)
 - Projects include infrastructure (e.g. expand primary/specialty care capacity) and innovation (e.g. patient navigation, chronic care management)
 - Over 27% of projects proposed relate to behavioral healthcare (\$2.1 billion all funds over four years)

Transformation Waiver: DSRIP and UC Status

- DSRIP Status
 - Formal HHSC feedback to RHPs began in early February
 - Submit RHP plans to CMS by March
 - May 1, 2013 is target for federal approval
- UC Status
 - HHSC is processing UC applications for Demonstration Year 1 and plans to make UC payments around late April 2013



Affordable Care Act

Kyle L. Janek, M.D., Executive Commissioner
Chris Traylor, Chief Deputy Commissioner

Affordable Care Act

- The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act collectively are known as the Affordable Care Act (ACA)
- HHSC began implementation for certain mandatory provisions not related to the litigation filed by 26 state attorneys general and the National Federation of Independent Business that challenged, among other things:
 - The constitutionality of the law's individual mandate to purchase health insurance, and
 - Whether the Medicaid expansion was unconstitutionally coercive for states

Key ACA Provisions

- Some key ACA provisions include:
 - All U.S. citizens and legal residents must obtain health coverage that meets federal standards (individual mandate)
 - Eliminates lifetime and annual benefit limits/restrictions
 - Prohibits pre-existing conditions exclusions
 - Extends dependent coverage up to age 26
 - Expands Medicaid to individuals under age 26, who aged out of foster care in the state and who were enrolled in Medicaid while in foster care
 - Eliminates out-of-pocket expenses for preventive services
 - Creates Health Benefit Exchanges to serve as marketplaces for individuals and small business employees to compare and purchase health coverage
- Medicaid Expansion
 - The Court upheld the Medicaid expansion up to 138* percent of the Federal Poverty Limit (FPL), with limitations, effectively making it optional for states to implement
 - If a state decides not to participate in the Medicaid expansion, the state can continue receiving funds for its existing Medicaid program

*Eligibility determination for the ACA Medicaid Expansion population includes a 5 percentage point income disregard, effectively bring the eligibility limit to 138 percent FPL.

ACA Provisions Implemented to Date

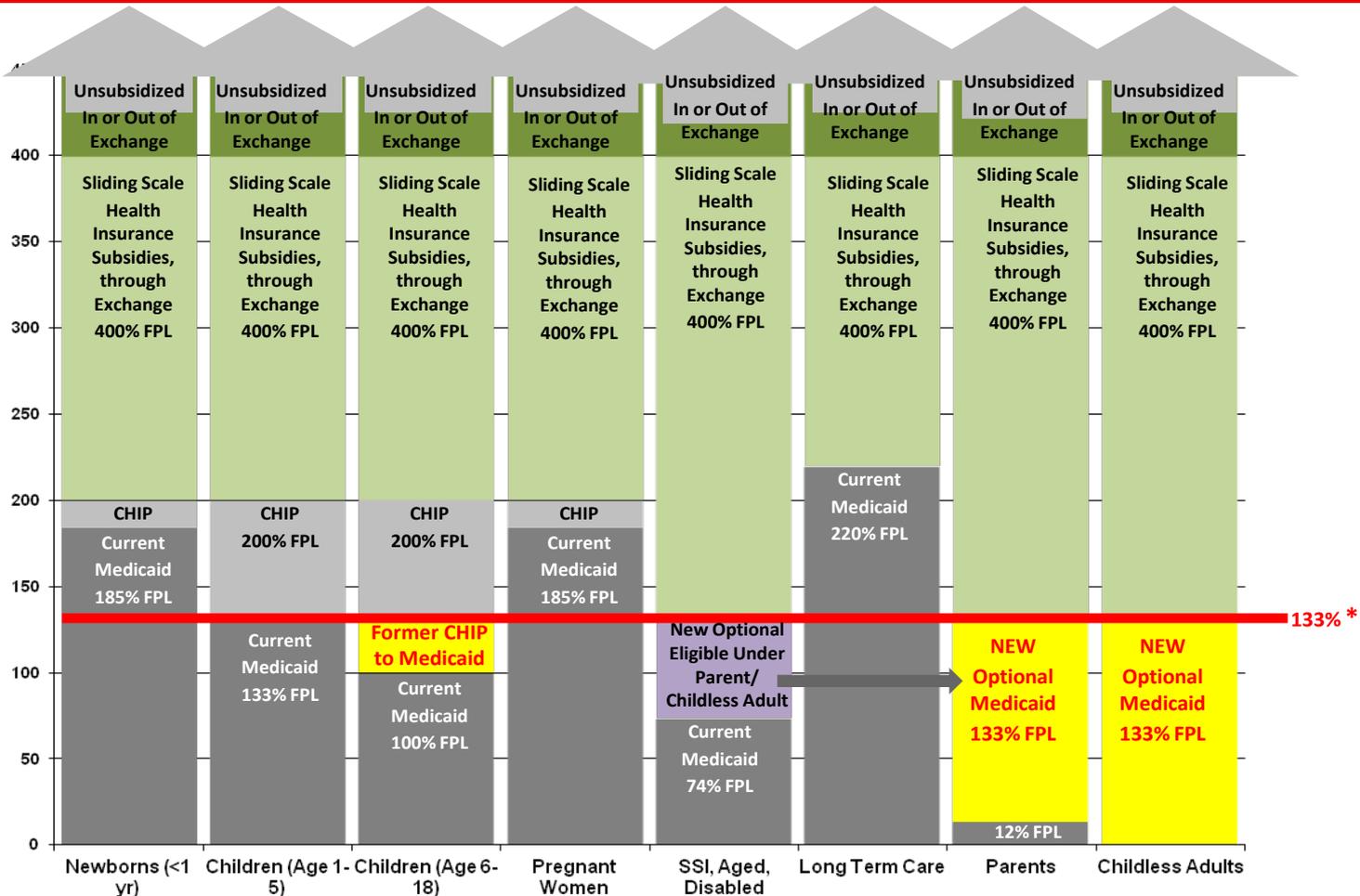
- Allow children enrolled in Medicaid and CHIP to elect hospice care without waiving their rights to treatment for their terminal illness
- Made freestanding birthing centers eligible for Medicaid reimbursement
- Claim federal matching funds for school and state employees' children enrolled in CHIP
- Added tobacco cessation counseling as a Medicaid benefit for pregnant women
- Made drug rebate formulary changes to collect additional rebates when pharmacy benefits were added to managed care
 - Increased the federal rebate amounts drug manufacturers had to pay
 - Federal government could claw back increased rebates
- Several program integrity provisions

ACA Provisions in Progress (cont'd)

- Long Term Services & Supports (LTSS) Balancing Incentives Payment Program Option (10/1/12)
- Temporary Primary Care Provider Rate Increases (1/1/13 – 12/31/14)
- Dual Eligibles (Medicare/Medicaid) Integrated Care Demonstration Project shared savings initiative (TBD)
- Beginning January 1, 2014, states must determine financial eligibility for Medicaid and CHIP based on Modified Adjusted Gross Income (MAGI)
 - Applies to pregnant women, children and families, but does not apply to individuals who are elderly or who have disabilities
 - Tax filing rules are used to determine income and household composition
 - Assets tests and most income disregards are prohibited, but a 5 percentage point across-the-board income disregard is applied
- Disproportionate Share Hospital Reductions (1/1/14)
- Health Insurance Issuer Tax(9/1/2014)

Medicaid Cost Drivers:

Who Medicaid Currently Serves and ACA Requirements



* Eligibility determination for the ACA Medicaid Expansion population includes a 5 percentage point income disregard, effectively bringing the eligibility limit to 138% FPL.



Medicaid Orthodontia

Kyle L. Janek, M.D., Executive Commissioner

Chris Traylor, Chief Deputy Commissioner

Douglas Wilson, Inspector General

Medicaid Orthodontia: Background

- Concerns raised about high utilization of Texas Medicaid orthodontia services
- Allegations about Medicaid policies and management of the prior authorization process by Texas Medicaid & Healthcare Partnership (TMHP)
- Medicaid fee-for-service (FFS) policy limits orthodontic services (including braces) to treatment of medically necessary cases:
 - Children ages 13 and older with severe handicapping malocclusion (a misalignment of teeth that causes the upper and lower teeth not to fit together correctly)
 - Children under 21 years of age with cleft palate or other special medically necessary circumstances
- Medicaid policy does not allow orthodontia for cosmetic reasons

Medicaid Orthodontia: Prior Authorization Management

- HHSC contracts with TMHP for Medicaid claims administration activities (including processing claims and enrolling providers)
- HHSC reviewed TMHP's prior authorization evaluation process and identified areas where improvement was necessary:
 - Review and retention of clinical information
 - Collection of additional clinical information
 - Employment of sufficient and qualified staff

Medicaid Orthodontia: Fee-For-Service Policy Changes

- Effective October 1, 2011, submission of diagnostic models and radiographs (x-rays) were required for comprehensive orthodontic treatment and cross-bite therapy
- On January 1, 2012, HHSC added language to allow substitution of photographs for diagnostic models, in some cases
- In March 2012, HHSC included the following changes:
 - Increased age requirement from 12 to 13 years of age for comprehensive orthodontia treatment
 - Updated the criteria for prior authorizing the premature removal of orthodontia
 - Clarified the diagnostic tool criteria
- HHSC is planning to offer comprehensive rates that includes all services related to the orthodontia service

Medicaid Orthodontia: Dental Managed Care

- On March 1, 2012, children's Medicaid dental services (including orthodontic services) were transitioned into managed care
- Dental managed care contracts include quality improvement and utilization review requirements
 - Quality improvement - continuously examine, monitor, and revise processes and systems to improve administrative and clinical functions
 - Utilization review - retroactive, prospective, or concurrent reviews of the appropriateness of dental services provided
- The state required dental plans to submit their prior authorization policies for review with the goal of ensuring medically necessary orthodontic service delivery
- Dental plans conduct provider profiling to identify unusual service delivery trends
- Special investigative units track, trend, and report possible fraud, waste, and abuse
- Since the implementation of dental managed care, there has been a significant decrease in the number of orthodontic prior authorization requests and approvals

Medicaid Orthodontia: Next Steps

- Redefine Orthodontic Medical Necessity as “Malocclusion that requires surgery to correct”
- Recruit new orthodontic providers in potential low access-to-care areas
- Encourage current providers to continue client treatment
- Encourage new providers to accept transfer cases:
 - Developed payment option (CDT code D8999)
 - Streamline transfer of client care authorizations to ensure care continuation

OIG: Medicaid Orthodontia Claims

- HHSC-OIG data analysis has identified more than 50 probable overutilizers of orthodontia services.
- Analysis by experts indicates orthodontic overutilization rates range from 39 percent to 100 percent with an average error rate of 93 percent.
- HHSC-OIG has completed more than 36 investigations with over \$303,000,000 in identified potential overpayments and has placed 28 orthodontic providers on payment hold based upon credible allegations of fraud.

OIG: Medicaid Non-Orthodontia Claims

- HHSC-OIG data analysis has identified 89 probable overutilizers of non-orthodontic dental services.
- Analysis by experts suggests error rates ranging from 25 percent to 99 percent, averaging 55 percent, and resulting in identified potential overpayments of \$154,000,000.
- Special emphasis on transportation and injury cases.
- OIG continues to work with MCD to identify systemic or process flaws that can lead to overutilization of dental services.

OIG: Medicaid Dental Claims

- At the end of September, HHSC-OIG received formal approval from the Centers for Medicare & Medicaid Services (CMS) to purchase and implement a comprehensive revision of HHSC-OIG's analytics and case management system.
 - Approval came with significant financial support
 - Implementation began October 1, 2012. Deployment began in December 2012.
 - With the most advanced and comprehensive data analysis system in the country, future widespread overpayments within an industry such as those in orthodontics become unlikely.

OIG: TMHP Performance Audit

- TMHP Performance Audit Report was issued August 28, 2008 and significant findings included:
 - An opportunity for improvement exists in the orthodontic prior authorization requests process
 - Prior authorization staff approved prior authorization requests that were not in compliance with the Texas Medicaid Providers Procedures Manual

OIG: Follow-Up Audit

- Follow-up audit of TMHP was conducted in conjunction with the U.S. Department of Health and Human Services' review
- Internal Control Report was issued August 1, 2012, and significant findings included:
 - TMHP is not hiring medically knowledgeable personnel to process dental prior authorization requests as contractually required
 - The dental director is not approving all orthodontic prior authorization requests
 - TMHP's Quality Assurance Review tool does not address medical necessity
 - TMHP is approving multiple prior authorization requests for the same client and the same service

OIG: Next Steps

- Federal OIG has pulled its sample. OIG is awaiting the sample.
 - Federal OIG has began to mail letters to providers requesting documentation
 - Orthodontists will contract with HHSC
 - HHSC-OIG will conduct a review of the records
 - Results will be extrapolated to the entire state