Dual Eligible Medicare/Medicaid Fee Reductions

To help close a $27 billion budget deficit, the 82nd Texas legislature directed the Health and Human Services Commission to implement a multitude of new initiatives aimed at trimming Medicaid expenditures by some $2 billion (general revenue) within the 2012-13 biennium.

The bulk of savings – more than $1 billion -- will be achieved through provider and health plan rate reductions. Additional savings will come from expanding the Medicaid HMO model statewide, reducing benefits and services, intensifying utilization management, and increasing fraud and abuse investigations (a summary of major cost-containment initiatives is provided below).

Physicians were spared reductions in Medicaid/CHIP payments through a fee schedule adjustment. The legislature rejected a proposal to cut the physician fee schedule by 10 percent fearing that such a deep cut would destabilize the Medicaid/CHIP physician network and potentially violate the *Frew* consent decree (which the state settled in 2007 to resolve a class action lawsuit in which a federal court determined that children in Texas Medicaid were not able to timely access needed medical and dental services).

In lieu of reducing Medicaid/CHIP physician fee schedule, the legislature instructed HHSC to eliminate Medicare Part B coinsurance and deductible payments for dually-eligible patients if the payment would exceed the Medicaid allowable. (Texas previously implemented the same policy for Medicare Part A services). The federal Balanced Budget Act of 1997 expressly authorizes this policy – thus a federal waiver is *not* necessary for implementation. To date, 18 states have implemented it with more considering the change given their ongoing Medicaid budget challenges. HHSC estimated that the policy change would save nearly $300 million (general revenue).

TMA, AARP, and other provider organizations opposed the reduction, but given the magnitude of the savings and that only Medicaid rate reductions would achieve similar savings, the legislature included the change as a rider in the budget (House Bill 1, Article II, HHSC Special Provision 17c(3)). This legislatively directed change will affect all providers who are paid under Medicare Part B who care for dually-eligible patients, though the legislature did instruct HHSC to limit the policy change to a 5 percent reduction for renal-dialysis centers.

The HHS Council considered the rules at its September meeting, where TMA again testified against the change. Several council members expressed concerns about the impact of the rules, but the rules were approved. HHSC will publish the rules in the *Texas Register* in October for formal public comment. HHSC now estimates the new policy, scheduled to take effect January 1, 2012, will save more than $400 million over the biennium. Without legislative intervention, HHSC *must* implement the new policy.

Appendix 1
Medicaid Cost-Containment Initiatives

- **Medicaid HMO Expansion**
  $385 million in savings plus $240 million in additional premium tax
  Phase I: implemented Sept. 1, 2011
  Phase II: begins March 1, 2012

- **Reduce Provider Rates**
  Total savings more than $1 billion (reductions listed below are in addition to payment cuts enacted during the 2010-11 biennium)
  - Hospital inpatient and outpatient services: -8%
    (excludes inpatient services for children's hospitals and rural hospitals)
  - Physicians: 0%
  - Dentists: 0%
  - Nursing homes: 0%
  - Home/Community Based Services: -1%
  - Other Medicaid providers: -5%
  - Other CHIP providers -8%
  - Durable Medical Equipment: -10.5%
  - Lab: -10.5%
  - ICF/MR: -2%
  - New medical imaging fee schedule
  - Reduce HMO administrative payments
  - Reduce pharmacy dispensing fee and PCCM payment

  Effective 9/1/2011

  - Eliminate Medicare Part B coinsurance/deductible payments for dually-eligible patients if payment would exceed the Medicaid allowable (effective Jan. 2012)
    (revised HHSC savings estimate equals more than $400 m in GR)

- **Reduce Non-Emergent Use of Emergency Rooms**
  No savings target specifically identified, though the Legislative Budget Board estimated that diverting patients from the ER to their PCP or an urgent care clinic could save up to $75 million annually (general revenue)
  Directs HHSC to implement measures to reduce non-emergent use of the emergency room in the Medicaid program, including evaluating whether the cost of the physician incentive programs implemented by Medicaid HMOs has been offset by reduced use of the emergency room; determining the feasibility of permitting freestanding urgent care centers to enroll as Medicaid providers; and using financial incentives and disincentives to encourage the HMOs to reduce non-emergent use of the ER among their enrollees. Financial incentives and disincentives may include adding a performance indicator that measures non-emergent use of the ER.

  On Sept. 1, 2011, HHSC implemented new rules reducing hospital emergency room payments by 40 percent for services that are non-urgent.

- **Implement Statewide Hospital Standard Dollar Amount**
  $30.9 million savings
  Directs HHSC to establish a statewide standard dollar amount (SDA) for hospitals. In establishing the statewide formula, HHSC may consider high-cost hospital functions and services, including regional differences

  Effective Sept. 1, 2011

- **Reduce Inappropriate Utilization of Physician Services**
  No savings target identified
  Requires HHSC to establish a committee of physicians and HHSC representatives to determine the ten most overused services performed by physicians in Texas Medicaid, using national guidelines related to unnecessary medical procedures as the basis for this determination, then based on the determinations, decrease Medicaid payments for those services that should not be provided.

  HHSC will appoint committee by mid December

- **Implement Higher CHIP Copayment Amounts**
  Up to $8 million
  Effective March 1, 2012

- **Miscellaneous Initiatives**
  - Reduce amount, duration and scope of optional benefits: -$45 m
  - Adjust HMO Premiums to "Average Acuity": -$169 m
  - Reduce incidence of elective inductions and C-Sections: -$2 to $4 million (Effective 10/1/2011)
  - Expand use of telemedicine
  - Reduce hospital payments for potentially preventable readmissions (implement in 2013)
  - Implement Three-Prescription Drug Limit – no longer being pursued; HHSC will evaluate other drug utilization controls to help lower costs
  - Increase use of generic and over-the-counter drugs
  - Achieve more competitive drug ingredient pricing
  - Improve care coordination for children with disabilities in managed care
  - Automatically enrolling clients into managed care plans
  - Restricting payment of out-of-state services to the Medicaid rate and only our border regions
  - Increasing utilization management for provider-administered drugs
  - Increase neonatal intensive care unit management
  - Increasing fraud, waste and abuse detection and claims
  - Automatically enrolling patients in an HMO
  - Additional initiatives identified by HHSC

- **Federal Flexibility Waiver**
  Assumes $700 million in savings

  Authorizes HHSC to pursue a federal Medicaid waiver to restructure and simplify Medicaid services, benefits, eligibility, and financing. Specifically, the waiver must do the following 1) achieve flexibility regarding Medicaid eligibility, income levels, and benefit design; 2) encourage the use of private health insurance in lieu of public coverage; 3) encourage people who have access to employer-based health benefits to obtain or maintain that coverage; 4) promote personal responsibility and accountability for Medicaid patients by implementing copayments, health savings accounts or vouchers; 4) consolidate federal funding streams, including for disproportionate share and upper payment limit programs, to promote greater efficiency; 5) allow flexibility in the use of state funds used to obtain federal matching funds, including allowing the use of intergovernmental transfers, certified public expenditures, costs not otherwise matchable, or other funds and funding mechanisms to obtain federal matching funds; 6) empower individuals who are uninsured to acquire health benefits coverage through the promotion of cost-effective coverage models that provide access to affordable primary, preventive, and other health care on a sliding scale, with fees paid at the point of service; and 7) allow for the redesign of long-term care services and supports to increase access to patient-centered care. (Note: Rider 59, HB 1 contains similar language to that in SB 7 and assumes $700 million in savings from implementation of the waiver).

- Instructs HHSC to pursue modification of Texas' Federal Medical Assistance Percentage (FMAP) formula so that it accounts for Texas' high rates of poverty, undocumented immigrants, and high rate of population growth. Further, HHSC must the commission pursue additional federal funding for Medicaid services provided to undocumented immigrants.

Prepared by: Helen Kent Davis, Director, Governmental Affairs