Tennessee’s Experience in Controlling Medicaid Costs

Darin Gordon, TennCare Director
Common Issues in Medicaid

- Fragmentation of care
  - Fee-for-service (FFS) programs
  - Mixture of FFS, PCCM & managed care programs
  - Service carve-outs

- Misaligned incentives
  - Payment systems do not reward efficiency
  - Often pays for quantity not quality of care
TennCare’s Managed Care Model

Brief Historical Overview of TennCare Managed Care

- TennCare addressed issues of fragmentation and misalignment of incentives by enrolling all Medicaid members into managed care.

- As a revolutionary model, this approach brought about some challenges.

- The lessons learned from these challenges allowed TennCare to evolve into a program that is able to contain costs while providing high-quality care to its members.

Integration of Medicaid Populations

While many Medicaid agencies do enroll some populations into managed care, TennCare is the only Medicaid agency in the U.S. to enroll its entire population into managed care. This occurred in 1994. Prior to 1994, TennCare was entirely fee-for-service.

Integration of Services

Over the years, TennCare experienced many different service integration models. TennCare began with a relatively integrated model, then carved out selected services over time. Today, TennCare integrates physical, behavioral, and long-term care services.
Managed Care and Quality

Though some skeptics said otherwise, TennCare has seen a significant increase in quality since moving to managed care.

Well Child Screening Rates

2011 Member Satisfaction Survey

The 2011 HEDIS results showed over the last 5 years (2007-2011):

- Improvement in nearly all child health measures including: well-child visits, access to primary care practitioners and immunizations
- Improvement in 7 of 8 adult diabetic measures including: HbA1c testing, retinal eye exams and LDL-C screening and control
- Improvement in management of cardiovascular conditions including: cholesterol screening, cholesterol management and control of high blood pressure
Managed Care and Cost Containment

U.S. Expenditure on Health Care Per Capita Vs. Comparable TennCare Per Member Cost

TennCare Medical Inflation Trend

Actual Expenditures vs. McKinsey and Co.’s Best Case Scenario Estimates

TennCare trend remains below national Medicaid trends even as many other states have made significant program reductions.

*The 2009 figure was calculated by continuing the 2006-2008 trend.

*Source: OMB 2012; Kaiser 2013
**Source: PricewaterhouseCoopers
Managed Care Lessons Learned

**On Effective Contracting**

1. The MCO procurement process must be well thought out.
2. Contracts with MCOs must be detailed, with each requirement carefully defined, and with appropriate reporting and monitoring processes to ensure compliance.
3. New skill sets are required of staff as you shift from FFS to managed care – more of a regulator function.
4. Whenever possible, developing requirements in partnership with the MCOs helps to ensure they are understood and can be operationalized.
5. Contracts should be routinely reviewed and amended – continuous improvement.
6. Thorough readiness review processes are critical prior to any program implementation.
7. Program leaders must be willing to hold the MCOs accountable. There must be different types and levels of incentives and sanctions which are used when necessary to ensure compliance. Automated systems for tracking deliverables is recommended.
8. Program leaders should be respectful of their MCO partners and willing to take a look at issues when circumstances arise that could not have been foreseen.

**On Cost Containment**

1. Aligning financial incentives is key.
2. MCOs need multiple tools to manage benefits and cost.

**On Quality**

1. Quality of care is improved when coordination of care is enhanced.
2. High quality care is more cost-effective care.
3. Collection and analysis of reliable encounter data is a critical foundation for quality monitoring.
4. A comprehensive approach is needed to assure quality and track improvement over time.
5. Standardized evidence-based outcome measures are essential.

**On Integration of Care**

1. Integration of benefits results in improved coordination of care and reduces potential for duplicative services and/or cost shifting.
2. The MCO must be the single entity responsible for needs assessment and case management activities, and for ensuring timely access to quality services.
3. NF services must remain carved in with the MCO at risk.
Managed Care Model in Action

Analysis of Cost Drivers

Pharmacy Spend

HH/PDN Spend

Quality Improvement and Utilization Management Strategies

Pharmacy

- Prescription Limits
- Point of Sale Edits
- Preferred Drug List/Drug Rebates/Generics
- Narcotic Controls
- Pharmacy Lock-in

Medical

- Benefit redesign
- Outlier Monitoring
- Prior authorization
- Medical Home
- Network Consolidation
- Disease Management
- Case Management
TennCare CHOICES in Long-Term Care (LTC) allows the state to use existing dollars to offer more options to those in need of LTC.

**Program Overview**

- TennCare CHOICES in Long-Term Care integrates TennCare nursing facility (NF) services and Home and Community Based Services (HCBS) for the elderly and adults with physical disabilities into the existing managed care system offering more options for individuals in need of LTC.
- This better prepares the program to adapt to the state’s growing aging population in the years to come.
- CHOICES was implemented statewide in August of 2010 and there has already been a noticeable shift in LTC enrollment – from NF enrollment to HCBS enrollment.

**Cost Savings**

- Often times the home is the most appropriate and cost effective setting to receive LTC services.
- The CHOICES program design allows more people to be served with existing funding so long as it can be done safely and cost effectively.
  - $19,000 (average annual cost HCBS) vs. $55,000 (average annual cost level 1 NF)
### Addressing the Immediate Problem

#### Benefit Changes
- Review coverage of optional benefits
- Benefit redesign (pharmacy, home health, PDN)
- Modify level of care criteria

#### Changes in Provider Reimbursement & Contracting Strategies
- Limits on payments to hospitals and ED physicians for non-emergent ED visits
- Single rate for vaginal vs. C-section birth
- Non payment for hospital preventable conditions
- Changes in crossover reimbursement methodology
- Provider network redesign

#### Pharmacy Controls
- Suboxone dosage limits
- Exclusion of acne products and prescription strength allergy products for adults
- More aggressive generic pricing and limiting reimbursement to $4 for drugs that are widely accessible for $4 on commercial formularies
- Enhanced pharmacy TPL recovery systems

#### Fraud Control
- Implementation of electronic visit verification
- Deployment of recovery audit contract services
Dual Integration:

- Duals would receive their Medicare benefits from the same MCOs that provide their Medicaid/TennCare services
- MCOs would be at full risk for Medicare services, as well as TennCare services
- With savings achieved from Medicare/Medicaid integration, TennCare would begin offering care coordination services to duals

Multi-Payer Partnerships:

- Identify commercial payers to partner on targeted initiatives
- Joint focus on incentivizing the improvement of select health care indicators

Alternative Payment Methodologies:

- Alignment of incentives at provider level
- Reward quality
- Further promote integration at provider level