

# MRT Initiative 24 (Phase II) Coverage for Enteral Formula

May 18<sup>th</sup>, 2012

Division of OHIP Operations  
Office of Health Insurance Programs

# Division of OHIP Operations

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# Webinar Objectives

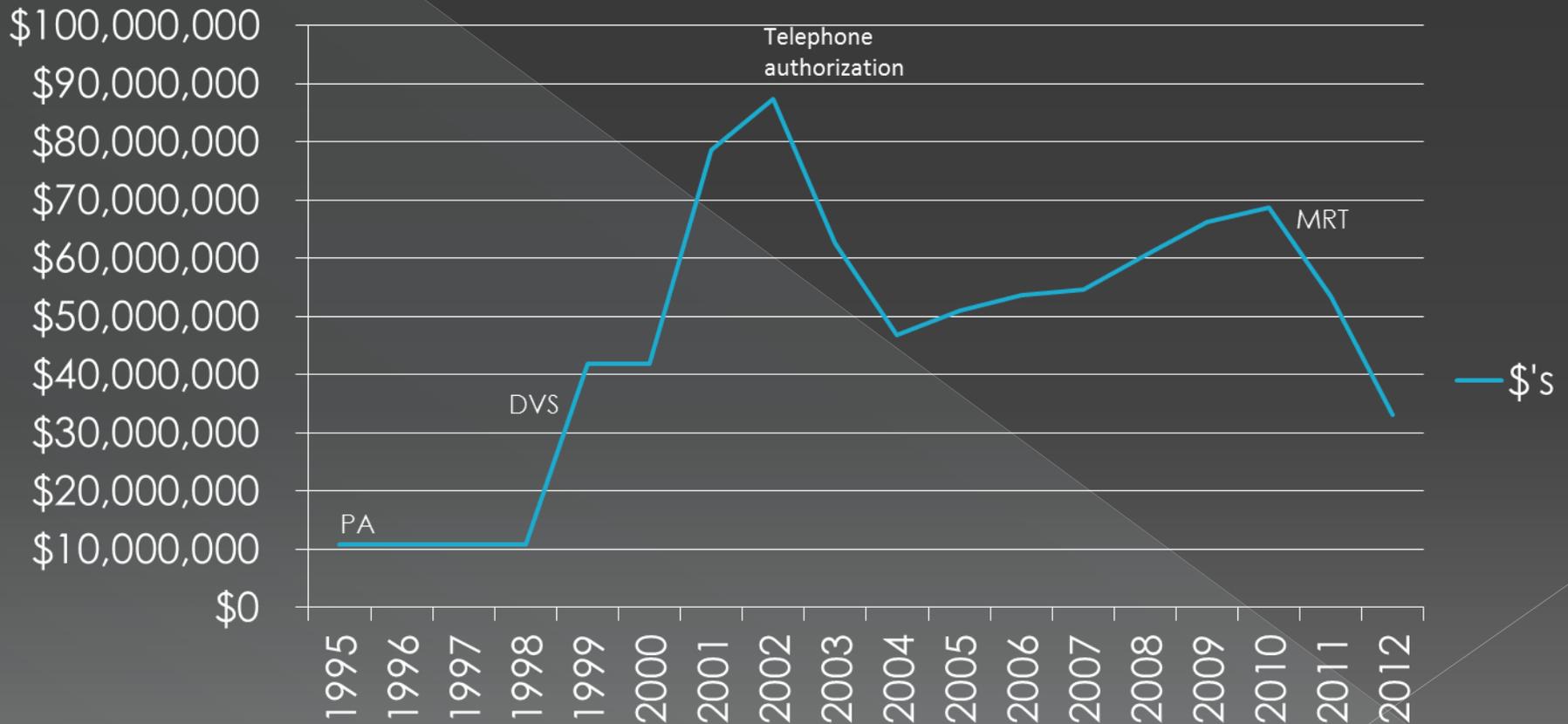
- Background on Medicaid enteral formula benefit and utilization
- 2012-13 changes to Social Services Law
- Overview of options for proposed regulation changes and utilization management
- Stakeholder feedback

# Enteral Utilization Management History

- Prior approved with documentation of medical necessity until 1999
- DVS/electronic prior authorization 1999-2003 using system verified service limits with prior approval override with medical necessity
- Automated electronic telephone prior authorization 2003 to present

# Utilization Trends

1995-2012



# Enteral Benefit Pre MRT 24

- Tube fed individuals
- Treatment of an inborn metabolic disorder
- Oral administration for adults and children when caloric and dietary nutrients from foods cannot be absorbed or metabolized

# April 2011 Social Service Law Changes-MRT 24

- Tube fed individuals
- Treatment of an inborn metabolic disorder
- Oral administration for children when caloric and dietary nutrients from foods cannot be absorbed or metabolized

# 2012-2013 Budget

- **Changes previous SSL language to read:**  
“enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children,”.
- **Adds:** “or, **subject to standards established by the commissioner**, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions”

# What Does The 2012-13 Budget Language Mean?

- Grants the Commissioner of the Department of Health the authority to make changes to the coverage of enteral formula and nutritional supplements
- No specific funding was allocated to fund changes to expand the benefit

# DOH Is Currently

- Evaluating the fiscal impact of expanding coverage
- Exploring regulation and utilization management change options available for enteral coverage

# Current Review Procedures

In 2009, began random review of automated phone authorizations, requiring the prescriber to submit medical documentation for review

- 257,212 authorizations issued
- 514 records were selected
- 6% of records were submitted
- Of these, 40% had documentation consistent with coverage criteria

# Current Review Procedures (cont.)

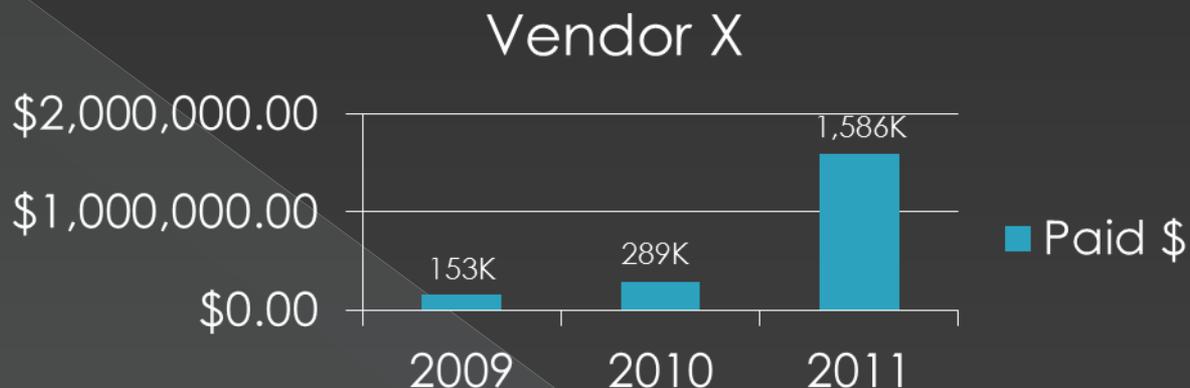
19 prescribers are required to submit all requests using paper prior authorization process for reasons including:

- Prescribers ordering same products and/or quantities for all beneficiaries
- Oral fed beneficiaries becoming suddenly tube fed, after SSL change without related supporting evidence
- Beneficiary's BMI suddenly changed after utilization management changes
- Of the 19 prescribers, 1 submitted requests for paper prior approval. All 69 paper authorizations were submitted without supporting documentation with no responses received to a request for the documentation

# Case Sample 1 (Prescriber Z\*)

- 103 authorizations obtained for 2000 calories/day when BMI over 18.5
- Represented 92% of prescriber Z's authorizations
- Only 2.6% of all authorizations were for individuals with a BMI under 18.5
- 95% of the authorizations were for maximum calories allowed

# Case Sample 2 (Vendor X)



- Targeted review revealed a spike in the vendors' billing of one specific code over a 3 year period
- Department acted by placing the vendor on a Pre-Payment review edit
- Additional review revealed atypical spikes in billing for other codes resulting in additional oversight
- Additional investigation determined the vendor was inappropriately obtaining authorizations for the prescribing practitioner(s), at times in excess of the intended ordered quantity

# Case Sample 3 (13 year old)

- Enteral support starting 2005
- BMI reported btw 19 and 30
- Average of 1800 calories per authorization
- Approx 60% of authorizations were for 2000 calories
- No reduction in prescribed calories with increasing BMI

# Case Sample 4 (48 year old)

- Enteral user since 2004
- BMI 24-29
- Increased to 2000 calories from 750/day in 2007 without evidence of weight loss
- Oral feeding reported until criteria changed in 2011. First authorization after coverage change indicated beneficiary as being tube fed.
- No evidence of tube placement or related supplies

# Goals For Revised Enteral Coverage

- Expand coverage for the most medically fragile beneficiaries
- Maintain program cost to be consistent with adopted 2012-2013 budget
- Enhance utilization management functions to balance cost of expanded coverage

# Change Options Identified

- Regulation change to add coverage for underweight adults\* who require enteral formula orally
  - Primary goal is to provide short term nutritional support
  - Estimated cost of 4.5 million annually (State/local share)
  - Would require additional measures to offset added cost
  - Applicable to both FFS and MMC

# Change Options Identified (cont.)

- Expand FFS utilization management functions for defined group of children taking enteral formula orally\*
  - Would allow the Department to ensure that coverage requirements are being met
  - Achieve cost savings for individuals who do not qualify based on the coverage language to partially offset cost of expanding coverage for adults

\*Children 10 to 20 years old with a BMI greater than 18.5

# Change Options Identified (cont.)

- Utilize 3 month authorization periods for underweight adults and children with a BMI over 18.5 taking enterals orally\*

- Allow up to 2 authorizations via the telephone authorization system in a year. Additional authorizations would require a paper prior approval

- Encourages more frequent assessment of the beneficiary's medical/nutritional status and plan of care as related to the short term need for enteral formula support

- Provides the Department the ability to oversee the provision of enteral formula nutrition when indicated for a longer course of treatment

\*Compared to current 6 month authorization.

# Change Options Identified (cont.)

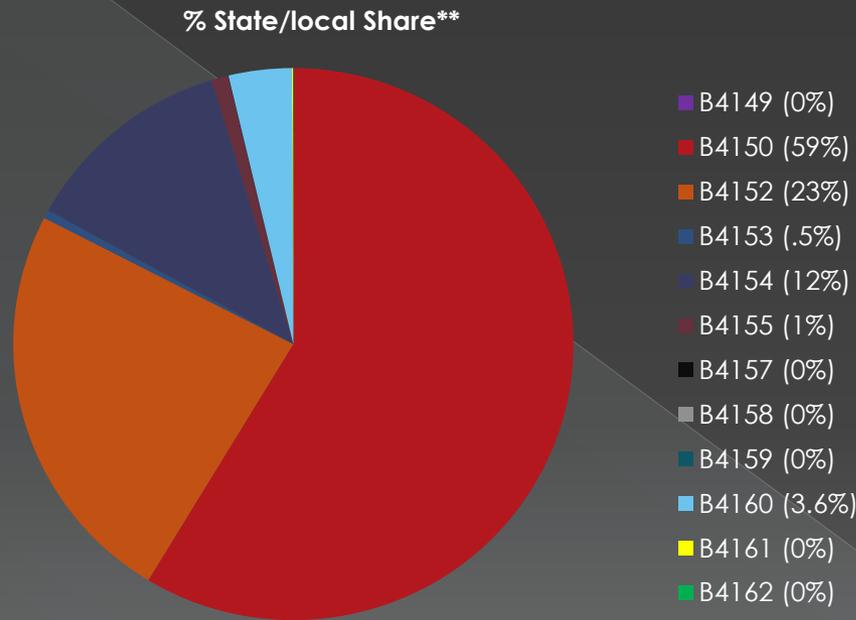
- Limit authorizations for oral supplemental enteral support to up to 1,000 calories/day
  - Regulation change for adults
  - Children would require a paper authorization with supporting medical documentation to receive approval for greater than 1,000 calories/day
  - Benefit would provide beneficiaries with the necessary supplemental enteral support as part of their comprehensive nutrition care plan

# Change Options Identified (cont.)

- Exception, allow coverage for adults with structural/mechanical\* limitations when:
  - The condition prevents the beneficiary from consuming food (including softened, pureed, etc.) resulting in an inability to meet nutritional needs, and
  - Placement of a feeding tube is medically contraindicated
  - Minimal fiscal impact anticipated
  - 1,000 calories/day benefit limit would not apply to this group

# Change Options Identified (cont.)

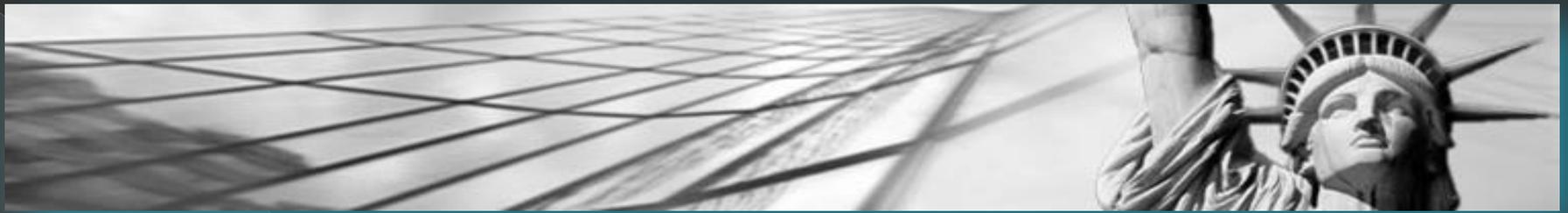
- Enhance utilization management controls for higher cost HCPCS codes\*



-98% of spending is already for lower cost code categories, therefore resulting savings would be minimal

# Questions/Comments

- Provide written comments or questions to:  
[OHIPMedPA@health.state.ny.us](mailto:OHIPMedPA@health.state.ny.us)
- Next steps: Evaluate feedback



# MRT: Additional Information

- ◉ MRT Website:  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/)
- ◉ Sign up for email updates:  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/lis\\_tserv.htm](http://www.health.ny.gov/health_care/medicaid/redesign/lis_tserv.htm)
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