The Future of Medicaid

Collaborative Connections -- Impacting Care

Andy Vasquez, Deputy Associate Commissioner Quality & Program Improvement

February 23, 2017
Agenda

• Network Adequacy Standards
• Provider Re-Enrollment
• Pay for Quality (P4Q) Program Redesign
• Healthcare Quality Strategic Plan
HHS System Transformation

“My industry has probably transformed again just since we started the session.”
HHS System Transformation

FY16 HHS System (5 agencies)
- DSHS
- HHSC
- DADS
- DARS
- DFPS

FY18 HHS System (3 agencies)
- DSHS: Public Health Programs
- HHSC: DADS
- DARS: DSHS
- DFPS: Protective and Preventative Services

- HHSC: Client Services
- Facilities
- Regulatory Programs
- DADS: Regulatory Programs
- DFPS
HHSC shall establish minimum provider access standards for the provider networks of managed care organizations (MCOs).

- Ensure access to:
  - Different types of care (preventive, specialty, primary)
  - Timeliness (routine vs. urgent) including after-hours care
  - Types of services (long term services, nursing facilities)

- Distinguish settings
  - Rural vs. urban standards for service delivery area
Network Adequacy Standards
- Managed Care Final Rule

States will develop and implement time and distance standards for:

- Primary care - adult and pediatric
- OB/GYN
- Behavioral health - adult and pediatric
- Specialist - adult and pediatric
- Hospital
- Pharmacy
- Pediatric dental
- Long-term services and supports
- Additional provider types as needed

States must be compliant by September 1, 2018
Network Adequacy Standards
- Current Contract

Current MCO contract requirement states that members must have access to a hospital within 30 miles.

• Contract amendment in March to add time standard.
• At present, MCOs regularly provide HHSC with data demonstrating compliance.
• Once the March 2017 contract amendment goes into effect, reporting will be conducted by Medicaid & CHIP Data Analytics Team.
• HHSC will examine data on a more granular level (county) and share information with MCOs.
Network Adequacy Standards  
- Contract Effective March 1, 2017

Travel time and mileage standards for Acute Care Hospitals

• Distance in Miles: 30 Miles
• Travel time in Minutes: 45 minutes

Standards apply for all counties (Metro, Micro, and Rural)
## Time & Distance Standards
### Effective March 1, 2017

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Current Managed Care Contracts</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Distance in Miles</td>
<td>Travel Time</td>
</tr>
<tr>
<td></td>
<td>Metro</td>
<td>Micro</td>
</tr>
<tr>
<td>Behavioral Health-outpatient</td>
<td>30 urban</td>
<td>75 rural</td>
</tr>
<tr>
<td><strong>Hospital- Acute Care</strong></td>
<td>30 none</td>
<td>30</td>
</tr>
<tr>
<td>Prenatal</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>30 none</td>
<td>30</td>
</tr>
<tr>
<td>Specialty Care Provider</td>
<td>Cardiovascular Disease</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>ENT (otolaryngology)</td>
<td>75 none</td>
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<tr>
<td></td>
<td>General Surgeon</td>
<td>75 none</td>
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<tr>
<td></td>
<td>OB/GYN (non-PCP)</td>
<td>75 none</td>
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<tr>
<td></td>
<td>Ophthalmologist</td>
<td>75 none</td>
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<tr>
<td></td>
<td>Orthopedist</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>Pediatrician</td>
<td>75 none</td>
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<tr>
<td></td>
<td>Psychiatrist</td>
<td>75 none</td>
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<tr>
<td></td>
<td>Urologist</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>Other Physician Specialties</td>
<td>75 none</td>
</tr>
<tr>
<td>Occupational, Physical, or Speech Therapy</td>
<td>75 none</td>
<td>30</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>75 none</td>
<td>75</td>
</tr>
<tr>
<td>Main Dentist (general or pediatric)</td>
<td>30 urban</td>
<td>75 rural</td>
</tr>
<tr>
<td>Dental Specialists</td>
<td>Pediatric Dental</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>Endodontist, Periodontist, and Prosthodontist</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>Orthodontist</td>
<td>75 none</td>
</tr>
<tr>
<td></td>
<td>Oral Surgeons</td>
<td>75 none</td>
</tr>
</tbody>
</table>
Provider Re-Enrollment
Next Steps
Provider Re-Enrollment Next Steps

- Patient Protection and Affordable Care Act (PPACA) deadline has passed.
- Dis-enrollment from Texas Medicaid occurred on February 1, 2017 with an end date of January 31, 2017.
- 28,850 providers were dis-enrolled
  - Out of 298,000 providers
- Of those dis-enrolled providers, only 6,903 had submitted claims in the past six months.
Provider Re-Enrollment Next Steps

• Claims submitted for dates of service on or after February 1, 2017, using dis-enrolled provider numbers will not be reimbursed for Texas Medicaid.
Provider Re-Enrollment Next Steps

Initiatives in Progress:

• Additional streamlining of the provider enrollment process (e.g. shorter application, staggering of re-enrollment, implement provider notification system for re-validation, improve provider enrollment deficiency notification and communication)

• Providers who do not bill Medicaid but who order, prescribe or refer Medicaid clients will need to be screened by October 2017

• CHIP providers who are not enrolled in Medicaid need to be screened by January 2018
Provider Re-Enrollment Next Steps

Providers with questions are encouraged to call the

**TMHP Contact Center** at

1-800-925-9126
Medical and Dental Pay for Quality (P4Q) Program Redesign
P4Q Program Redesign

Considerations in Program Redesign:

• The Executive Commissioner's vision for P4Q
• Legislative mandates and constraints related to P4Q
• Literature review findings on the effectiveness of pay for performance programs and other states’ programs
• Stakeholder input: Health plans, Providers, and Associations
Considerations in Program Redesign (cont.)

- Department of State Health Services' (DSHS) initiatives and priorities
- Opinions from HHSC clinical staff, subject matter experts, external quality review organization
- Lessons learned from implementation of the current P4Q program
P4Q Program Redesign

Goals for the Redesigned Program

• Simpler and easier to understand
• Allows plans to track their performance and predict losses, to the degree possible
• Rewards high performance and improvement
• Promotes transformation and innovation leading to better health outcomes
P4Q Program Redesign

Features of the Redesigned Program

• Incentivizes plans to improve performance:
  • Against national and state benchmarks
  • Against their own performance in prior year
  • On bonus measures

• Selected areas of focus:
  • Prevention
  • Chronic Disease Management, including Behavioral Health
  • Maternal and Infant Health
P4Q Program Redesign

Quality-Based Alternative Payment Models (APMs)

• Not part of P4Q program, but related
• HHSC is planning to revise contractual requirements for MCOs related to APMs
  • Example: Require that a percentage of payments to providers are governed by an Alternative Payment Model
  • Annual percentage increases
• The requirement will allow flexibility so MCOs can meet providers where they are in regard to interest and aptitude
• Align with national priorities of tying provider payments to quality or value.
The Future of Texas Medicaid
The Future of Medicaid

Key Medicaid Numbers - Fiscal Year 2015

• $38.0 billion: Texas Medicaid spending, including Supplemental Health Care Payments
• $ 2.7 billion: Texas Medicaid payments to nursing homes
• $ 3.7 billion: Texas Medicaid prescription drug expenditures
• 78 percent: Texas Medicaid clients under age 21
• 45 percent: Texas children covered by Medicaid or CHIP
• 52.2 percent: Births covered by Texas Medicaid
Texas Medicaid Beneficiaries and Expenditures

State Fiscal Year 2015

- **Non-Disabled Children**: 69%
- **Non-Disabled Adults**: 7%
- **Aged & Disability Related**: 24%
- **Non-Disabled Children**: 32%
- **Non-Disabled Adults**: 9%
- **Aged & Disability Related**: 59%

**Caseload**

**Expenditures**

Source: FY 2015 Medicaid Expenditures, including Acute Care, Vendor Drug, and Long-Term Services and Supports. Expenditures are for Medicaid Clients only, and do not include any payments for DSH or Uncompensated Care Costs. Costs include all Medicaid beneficiaries, including Emergency Services for Non-Citizens, School-Health and Related Services, and Medicare payments for partial dual eligibles. Children include all Poverty-Level Children ages 0-19. Disability Related Children are included in Aged & Disability Related.

Texas Health and Human Services Commission: June 2016
The Future of Medicaid

• Block Grants – the future of Medicaid financing?
  • Too early to speculate
  • NAMD Paper: *Technical Considerations on ACA Repeal & Replace*

• 85th Texas Legislature
  • Focus on value in healthcare
  • See Texas Comptroller’s *Health Care Spending Report*
# Healthcare Quality Strategic Plan

## CMS National Healthcare Quality Strategy

<table>
<thead>
<tr>
<th>Three Aims</th>
<th>Six Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Better Care:</strong> Improve the overall quality of care by making healthcare more person-centered, reliable, accessible, and safe.</td>
<td><strong>1.</strong> Make Care Safer by Reducing Harm Caused in the Delivery of Care</td>
</tr>
<tr>
<td><strong>2. Healthier People, Healthier Communities:</strong> Improve the health of Americans by supporting proven interventions to address behavioral, social, and environmental determinants of health, and deliver higher-quality care.</td>
<td><strong>2.</strong> Strengthen Person and Family Engagement as Partners in Their Care</td>
</tr>
<tr>
<td><strong>3. Smarter Spending:</strong> Reduce the cost of quality healthcare for individuals, families, employers, government, and communities.</td>
<td><strong>3.</strong> Promote Effective Communication and Coordination of Care</td>
</tr>
<tr>
<td></td>
<td><strong>4.</strong> Promote Effective Prevention and Treatment of Chronic Disease</td>
</tr>
<tr>
<td></td>
<td><strong>5.</strong> Work with Communities to Promote Best Practices of Healthy Living</td>
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<tr>
<td></td>
<td><strong>6.</strong> Make Care Affordable</td>
</tr>
</tbody>
</table>

Don Berwick, Tom Nolan, and John Whittington are credited with first describing the Triple Aim in 2008 for the Institute of Healthcare Improvement (IHI).

**The IHI Triple Aim**

- **Health of a Population**
- **Experience of Care**
  - Safe
  - Effective
  - Patient centered
  - Efficient
  - Timely
  - Equitable
- **Per Capita Cost**

*Better care for individuals, better health for populations, lower per capita costs*
Draft Healthcare Quality Strategic Plan

Texas Healthcare Quality Strategy - Priorities

• Keeping Texans well throughout their lifespan
• Serving individuals in the least restrictive setting
• Keeping patients safe and free from harms caused in the delivery of care
• Promoting the most effective practices to improve outcomes for individuals with chronic diseases
• Attracting and retaining world class providers and other health care professionals
Draft Healthcare Quality Strategic Plan

Texas Healthcare Quality Strategy - Subpopulations

• Individuals with complex health care needs
• Individuals eligible for long term services and supports
• Individuals with mental health and/or substance use disorders
• Individuals age 65 years and over
• Pregnant women and mothers
• Newborns and children
• Uninsured
• All Texans
The Future of Medicaid

• Links at HHS.Texas.Gov:
  • Quality Improvement
  • 1115 Transformation Waiver
  • Uniform Hospital Rate Increase Program (UHRIP)
  • MCO Pay for Quality (P4Q)
  • LTC Quality
  • QIPP

• DSRIP Questions:
  TXHealthcareTransformation@hhsc.state.tx.us
Questions & Open Discussion

Andy Vasquez, Deputy Associate Commissioner
MCS, Quality & Program Improvement Section
Thank you

E-Mail: Andy.Vasquez@hhsc.state.tx.us