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
“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
- DADS
- DARS
- DSHS
- DFPS
- Regulatory Programs
- Client Services
- Facilities
- Regulatory Programs
Network Adequacy Standards
Network Adequacy Standards
- SB 760

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
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 in Minutes</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</td>
<td>none</td>
</tr>
<tr>
<td>Prenatal</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Primary Care Provider</td>
<td>30</td>
<td>none</td>
</tr>
</tbody>
</table>

**Specialty Care Provider**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>ENT (otolaryngology)</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>OB/GYN (non-PCP)</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Orthopedist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Urologist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Other Physician Specialties</td>
<td>75</td>
<td>none</td>
</tr>
</tbody>
</table>

**Occupational, Physical, or Speech Therapy**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>none</td>
<td>30</td>
</tr>
</tbody>
</table>

**Nursing Facility**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td>none</td>
<td>75</td>
</tr>
</tbody>
</table>

**Main Dentist (general or pediatric)**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 urban</td>
<td>75 rural</td>
<td>none</td>
</tr>
</tbody>
</table>

**Dental Specialists**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Distance in Miles</th>
<th>Travel Time in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Dental</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Endodontist, Periodontist, and Prosthodontist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Orthodontist</td>
<td>75</td>
<td>none</td>
</tr>
<tr>
<td>Oral Surgeons</td>
<td>75</td>
<td>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
P4Q Program Redesign

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
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. Make Care Safer by Reducing Harm Caused in the Delivery of Care</strong></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. Strengthen Person and Family Engagement as Partners in Their Care</strong></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. Promote Effective Communication and Coordination of Care</strong></td>
</tr>
<tr>
<td></td>
<td><strong>4. Promote Effective Prevention and Treatment of Chronic Disease</strong></td>
</tr>
<tr>
<td></td>
<td><strong>5. Work with Communities to Promote Best Practices of Healthy Living</strong></td>
</tr>
<tr>
<td></td>
<td><strong>6. Make Care Affordable</strong></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*

- Safe
- Effective
- Patient centered
- Efficient
- Timely
- Equitable

*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
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