



Presentation to Senate Health and Human Services Committee on Medicaid Quality and Efficiency Initiatives

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Overview

- **Acute Care Quality Initiatives in Medicaid and CHIP**
 - Quality-Based Payment Advisory Committee
 - Hospital Quality-Based Payment Reforms
- **Long-Term Care Quality Initiatives in Medicaid**
 - Nursing Facility Initiatives
 - Community-Based Services and Supports
 - Managed Care Initiatives

Medicaid/CHIP Quality-Based Payment Advisory Committee

S.B. 7 requires the following of HHSC:

- In consultation with committee, HHSC shall develop quality-based outcome and performance measures for Medicaid/CHIP that:
 - Promote efficient, quality healthcare
 - Includes fee for service and managed care
 - Consider measures addressing potentially preventable events
 - Take into account patient risk factors
 - Are similar to those used in private sector, as appropriate

- In consultation with committee, HHSC shall use the outcome and performance measures to:
 - Align payment incentives with high quality and cost effective care
 - Incentivize best practices
 - Promote coordinated care and collaboration
 - Promote effective delivery models and payment systems
 - Coordinate with other HHSC initiatives (EDW, MITA, ICD-10)



Quality-Based Payment Advisory Committee: HHSC Responsibilities

- At least once each 2-year period, HHSC shall evaluate outcomes and cost effectiveness of any quality based payment initiative that is implemented from committee's recommendations.
- HHSC shall submit an annual report to the legislature regarding:
 - Quality-based outcome and process measures developed; and
 - Progress of the implementation of quality-based payment systems and other payment initiatives implemented under this chapter.
- HHSC shall report outcome and process measures under by health care service region and service delivery model.



Mary Dale Peterson, MD, Chair
Medicaid/CHIP Quality-Based Payment Advisory Committee

- First meeting held February 29, 2012
 - Decision to focus work through three subcommittee areas based on highest cost groups, greatest member volume; and understanding rate setting as a way to effect payment incentives. The three subcommittees will focus on:
 - Populations who are Aged and Disabled
 - Children and Pregnant Women
 - Managed Care Organization Payment Structures
 - Each subcommittee has had an initial meeting

Patient Centered Medical Homes

- SB 7 contained a provision on Patient Centered Medical Homes (PCMH):
 - Encourage Managed Care Organizations (MCOs) to promote (PCMH)
- In development:
 - Research and identification of best practices
 - 2012 Texas Medicaid/CHIP Annual Managed Care Quality Forum – April 19, 2012
 - National experts discussed models for MCO development of PCMH

Hospital Payment Reform: Quality-Based Payments

Pay for Quality – P4Q Adjustment

- Adjusts payments by linking quality to payment.
- Removes incentives that reward poor quality by adjusting claim reimbursement or overall hospital reimbursement.
- Encourages hospitals to focus on quality outcomes rather than volume.

Hospital-Acquired Conditions

- Using present on admission (POA) indicators, adjust payment for inpatient stays for hospital-acquired conditions effective September 1, 2010.
- Currently applied to hospitals prospectively reimbursed under the Diagnosis Related Group (DRG) method by determining the DRG without the inclusion of the hospital-acquired condition.
- HHSC will apply to all inpatient hospital services, including TEFRA cost reimbursed inpatient services, effective September 1, 2013.

Hospital Payment Reform: Quality-Based Payments

Potentially Preventable Events (PPE)

- Potentially Preventable Readmissions (PPR)
- Potentially Preventable Complications (PPC)
- Potentially Preventable Admissions (PPA)
- Potentially Preventable Emergency Room Visits (PPV)
- Potentially Preventable Ancillary Services (PPS)

Hospital Payment Reform: Quality-Based Payments

Potentially Preventable Events (PPE)

- HHSC will begin adjusting hospital payments based on PPRs in September 2012 and based on PPCs in September 2013.
- Potentially preventable events (PPR and PPC) are not based on individual instances of a hospital stay, but on overall rates of such events compared to other hospitals.
- PPR and PPC will be implemented as an overall hospital percentage reimbursement adjustment applied to each hospital claim.
- Hospital adjustment will be implemented as an “end of the payment” adjustment (not to the hospital standard dollar amount).

Hospital Payment Reform: Quality-Based Payments

Inpatient Hospital Conversion from MS-DRG to APR-DRG

- HHSC will transition from Medicare Severity Diagnosis Related Grouping (MS-DRG) to the All Patient Refined Diagnosis Related Grouping (APR-DRG) effective September 1, 2012.
- The MS-DRG has limitations related to an under-65 population which may not result in an equitable payment system addressing the Medicaid population.
- The APR-DRG is an expansion of the basic DRG concept to better reflect the attributes of non-Medicare populations to include newborn birth weight, pediatric illnesses, and high-risk pregnancies.

Hospital Payment Reform: Quality-Based Payments

- All Patient Refined Diagnosis Related Grouping (APR-DRG)
 - A clinical model for different types of patients that has been extensively refined with historical data.
 - Offers enhanced equity in determining prospective payments and a bridge to other pay-for-performance efforts like Potentially Preventable Readmissions (PPR) and Potentially Preventable Complications (PPC).
 - Provides for severity adjustments in numerous quality assessment initiatives.

Nursing Facility Pay for Performance Incentives

- The 2010-11 General Appropriations Act and H.B. 1218 authorized and set aside \$2.5 million in general revenue funds to develop a pay for performance system.
 - February 2010 budget reduction options called for elimination of funds set aside for this system.
- S.B. 7, 82nd Legislature, First Called Session, 2011, authorized the executive commissioner to establish an incentive payment program for nursing facilities, if feasible.

Nursing Facility Direct Care Staff Rate Enhancement

- The 2000-01 General Appropriations Act and S.B. 1839 (77th Legislature) established the nursing facility direct care staff rate enhancement that incentivizes increased direct care staffing and direct care wages and benefits in nursing homes.
- Nursing facilities may choose to maintain a certain staffing level in return for increased direct care staff reimbursement rates.
 - The rate enhancement currently has twenty-seven levels.
 - Each level adds an additional \$0.38 per hour to the base per diem rate.
- Currently, approximately 88% of Texas' Medicaid-contracted nursing facilities participate in the direct care staff rate enhancement.

Improving Quality and Efficiency in Nursing Facilities

- **Quality Monitoring (QM) program**
 - In 2001, S.B. 1839 created the QM program to make visits to Medicaid certified nursing facilities in Texas to help them improve the quality of life and quality of care for individuals in nursing facilities.

- **Improved quality outcomes in areas targeted by the QM program**
 - Decreased incidence of mechanical restraint use from 19.1% in March 2002 to 1.9% in July 2010;
 - Decreased use of indwelling bladder catheters from 7.8% in March 2002 to 6.4% in July 2010;
 - Increased incidences of influenza vaccinations from 59% in 2004 to 76% in 2009;
 - Increased incidences of pneumococcal vaccinations from 27% in 2004 to 71% in 2009; and
 - Overall decrease in the usage of antipsychotics from 25% in June 2002 to 19.9% in July 2010.

Financial Feasibility for Program Improvements

- Opportunities to improve nursing facility performance
 - Nursing facility providers could accept an additional payment on an “at-risk” basis – guaranteeing savings through decreased acute care costs.
 - Centers for Medicare and Medicaid Services (CMS) is encouraging states to participate in a new demonstration program to provide more integrated health services to dual Medicare and Medicaid enrollees.
 - The state and CMS would negotiate an agreement in which each would share a portion of the savings achieved through improved coordination of benefits and alignment of goals.
 - Civil Monetary Penalties – To assist in funding small house and other culture change models.
 - Arkansas – three grants (two nursing facilities and one assisted living facility) for a total of \$1,225,000.
 - Center for Medicare & Medicaid Innovation Grants – CMS Health Care Innovation Challenge Grant.
 - Funded compelling new models of service delivery and payment.
 - Cooperative agreement for three years. Award \$1 million to \$30 million.
 - CMS Initiative to Reduce Avoidable Hospitalizations.

Community-based Services and Supports

- The 2000-01 General Appropriations Act established the attendant compensation rate enhancement by making certain funding contingent upon HHSC adopting agency rules to incentivize increased compensation to attendants.
- Initially, the attendant compensation rate enhancement only applied to Primary Home Care (PHC), Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Adult Day Care and Deaf Blind with Multiple Disabilities (DMBD). It was expanded to include ICF, Home and Community-based Services and Texas Home Living effective September 1, 2011.
 - The rate enhancement currently has twenty-five levels.
 - Each level adds an additional \$0.05 to the base rate (typically the base rate is an hourly rate).
- Currently, approximately 71 percent of eligible providers participate in the attendant compensation rate enhancement.

Community-based Services and Supports

Opportunities for outcome based payments:

- Texas could develop quality payments to community providers based on measurable acute care outcomes. For example:
 - TMF Health Quality Institute CMS Care Transitions Project
 - Goal of the project was to reduce 30-day rehospitalizations by a minimum of 2% through improved quality of patient transitions.
 - Included 14 communities in the U.S. including Harlingen Hospital Referral Region, including Cameron, Hidalgo, and Willacy counties.
 - Included six hospitals and numerous other providers including 16 skilled nursing facilities, 50 home health agencies and 3 inpatient rehabilitation facilities.
 - Outcomes:
 - Rehospitalizations from home health agencies decreased from 16.5% to 12.5%.
 - Rehospitalizations from skilled nursing facilities decreased from 29% to 23.8%.
 - Rehospitalizations from inpatient rehabilitation facilities decreased from 16.7% to 16.3% .

MCO Performance Requirements

STAR+PLUS provides acute and long term services and supports to aged, blind, and disabled adults:

- MCOs must have a Quality Assurance Program and Quality Goals .
- MCOs must conduct annual Performance Improvement Projects.
- 5 % of the Monthly Per Member Per Month payment is “at-risk” for achievement of specific performance measures.
- Recoupment of “at-risk” funds can be used to reward MCOs that achieve high results on health outcome measures.
- HHSC uses a Performance Indicator “Dashboard” to compare performance across MCOs.

MCO Performance Requirements

- STAR+PLUS overarching goals:
 - Improve member understanding and utilization of service coordination.
 - Reduce nursing facility admission rates.
- Each MCO is required to implement three Performance Improvement Projects per year.
- These Projects are part of each MCO's Quality Assurance Program Annual Plan.
- Projects are specific and measurable and reflect opportunities for performance improvement.

Member Experiences with Medical Homes

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey about medical homes:
 - Getting needed care and information
 - Getting care quickly
 - Doctor communication
 - Office staff
 - Family-centered care
 - Shared decision-making
 - Care coordination
- The survey is administered to the STAR+PLUS population annually.

Dual Eligible STAR+PLUS Focus Study

- To assess the unique needs of this population, HHSC's External Quality Review Organization (EQRO) is conducting a two-year focus study to:
 - Examine physical and mental health status for STAR+PLUS beneficiaries using self-report measures.
 - Evaluate key aspects of health care quality including:
 - Aspirin use and discussion.
 - Medical assistance with smoking and tobacco cessation.
 - Flu shots for older adults using the CAHPS survey tool.
 - Work with CMS to obtain Medicare claims for the STAR+PLUS population and link these claims to the Medicaid claims/encounter data.

External Quality Review Organization

- HHSC contracts with the Institute for Child Health Policy (ICHP) to independently review the quality outcomes, timeliness of, and access to services provided by Medicaid MCOs.
- CMS requires the EQRO to perform:
 - Validation of performance improvement projects and measures.
 - A review to determine MCO compliance with certain federal Medicaid managed care regulations.

EQRO Reports

- Annual Quality of Care Report for each Texas Medicaid managed care program using:
 - Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures.
 - Rates of inpatient and emergency department services for ambulatory care sensitive conditions (ACSCs).
 - The Agency for Healthcare Research and Quality Pediatric Indicators (PDIs) and Prevention Quality Indicators (PQIs).
- Consumer Assessment of Health Plan Satisfaction (CAHPS) Surveys:
 - Designed for Medicaid clients to report on and evaluate their health care experiences.

Other Opportunities for Quality Improvements

- Medicaid Incentives for Prevention of Chronic Disease (MIPCD) Project
 - A five-year grant to fund interventions to help prevent chronic disease among STAR+PLUS Medicaid-only members with behavioral health conditions.
 - DSHS has project oversight.
 - Employs person-centered incentives to empower participants to take charge of their health.
 - Goals include:
 - Improved health self-management
 - Increased use of preventive services
 - More appropriate use of health care services
 - Greater satisfaction with health care and with personal progress toward wellness