TAHP

The Texas Association of Health Plans

# Senate Committee on Health and Human Services Interim Charge on Long-Term Care Quality and Oversight

February 18, 2016

JAMIE DUDENSING, CEO

# The Texas Association of Health Plans

**The Texas Association of Health Plans (TAHP) is the statewide trade association representing private health insurers, health maintenance organizations, and other related health care entities operating in Texas.**

- Health Plans - Employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid
- 28 Health Plan Members, including the 20 Medicaid Health Plans
- 2 Dental Medicaid Managed Care Organizations
- TAHP advocates for public and private health care solutions that improve the affordability, access and accountability of health care for many Texans

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# The Role of Medicaid Managed Care

- **Improving Quality and Provider Oversight**
  - State uses contracting, licensure and regulation
  - Health plans use care management and contracting/credentialing – increased focus on outcomes
- **Goal of Managed Care: To better manage care to improve access, quality, and outcomes while ensuring appropriate utilization and containing costs**
  - Full-risk, capitated model
    - Medicaid managed care organizations (MCOs) at full-risk for costs and outcomes
    - Encourages appropriate utilization and coordination of services
    - Promotes quality improvement
  - Integrated managed care model
    - Builds on the managed care model by integrating acute care and long-term care services and supports (LTSS)
    - STAR+PLUS Program (and STAR Kids beginning Fall 2016)

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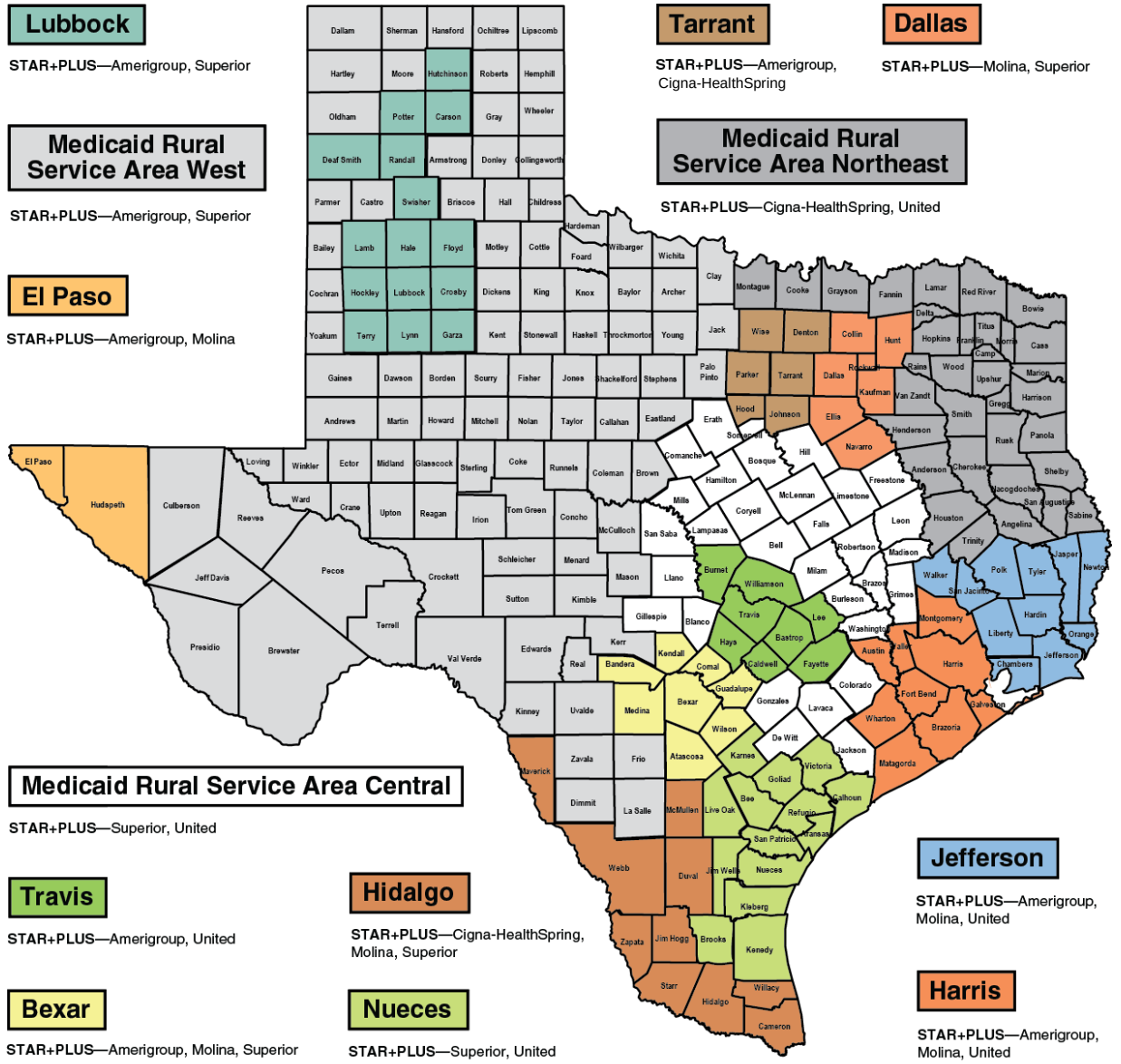
# STAR+PLUS

- **Primary health care delivery model for individuals age 65 or older and individuals with disabilities in Medicaid**
- **First STAR+PLUS pilot initiated in 1998**
- **Statewide as of Sept. 1, 2014**
- **Acute care for adults with IDD carved-in Sept. 1, 2014**
- **Nursing homes carved-in March 1, 2015**
- **Community First Choice implemented June 1, 2015**
- **Future integration of acute care and LTSS for individuals with IDD through STAR+PLUS/STAR KIDS**
- **Key Features:**
  - Integrates acute care and long-term care to promote quality and access to care in the least restrictive, most appropriate setting
  - Service coordinators
  - Value-added benefits



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# What Integrated Care Looks Like

## Acute Care

(non-exhaustive list)

- Emergency & Non-emergency Ambulance Services
- Behavioral Health Services
- Outpatient Mental Health Services
- Psychiatry Services
- Substance Use Disorder Treatment Services
- Chiropractic Services
- Durable Medical Equipment
- Hospital Services (Inpatient and Outpatient)
- Laboratory
- Podiatry
- Primary Care Services
- Specialty Physician Services
- Radiology
- Therapies (Physical, Occupational, Speech)
- Prescription Drugs

## SERVICE COORDINATION

**Service Coordination = Specialized care management service that is performed by a Service Coordinator, and includes (but not limited to):**

- Identification of needs
- Development of a Plan of Care
- Assistance to ensure timely and coordinated access to an array of providers and covered services
- Coordination of covered services with services outside the benefit plan

**Service Coordination is an integral service and the main feature of the STAR+PLUS program.**

## Long-Term Care Services & Supports

(non-exhaustive list)

- Nursing Facility Services
- Personal Assistance Services (PAS)
- Community First Choice (CFC)
- Day Activity & Health Services (DAHS)
- STAR+PLUS HCBS Waiver (CBA waiver in Traditional Medicaid):
  - Assisted Living
  - Adaptive Aids
  - Minor Home Modifications
  - Personal Assistance Services
  - Respite Care
  - Emergency Response
  - Transition Assistance Services
  - Home Delivered Meals
  - Nursing Services
  - Medical Supplies
  - Adult Foster Care
  - Dental
  - Therapies
  - Financial Management Services
  - Cognitive Rehabilitation Therapy
  - Supported Employment & Employment Assistance

# Improving Quality: MCO Oversight Tools

- **Credentialing**
  - Verifying a provider's professional qualifications (e.g., licensure, certification, training, academic background) and professional competence and conduct
  - Vetting providers for safety and quality issues prior to contracting with the provider
  - Continued monitoring through recredentialing process
- **Contracting**
  - Negotiating rates and terms and conditions, including value-based purchasing arrangements
  - MCO provider networks must meet state-specified standards to ensure access to care
  - Contracting gives MCOs the mechanism to:
    - Shift toward paying for value rather than volume to reward providers for performance
    - Hold their network providers accountable – including terminating providers who fail to meet program requirements (weed out "bad actors")
- **Service Coordination Visits**
- **Complaint Monitoring**

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# Integration of Care Produced Savings and Quality: Produced Early Results

## REDUCING THE HIGHEST COST DRIVERS IN MEDICAID

**28%** Reduction in independent hospitalization

**40%** Reduction in emergency room visits

## KEEPING PEOPLE IN THEIR COMMUNITIES

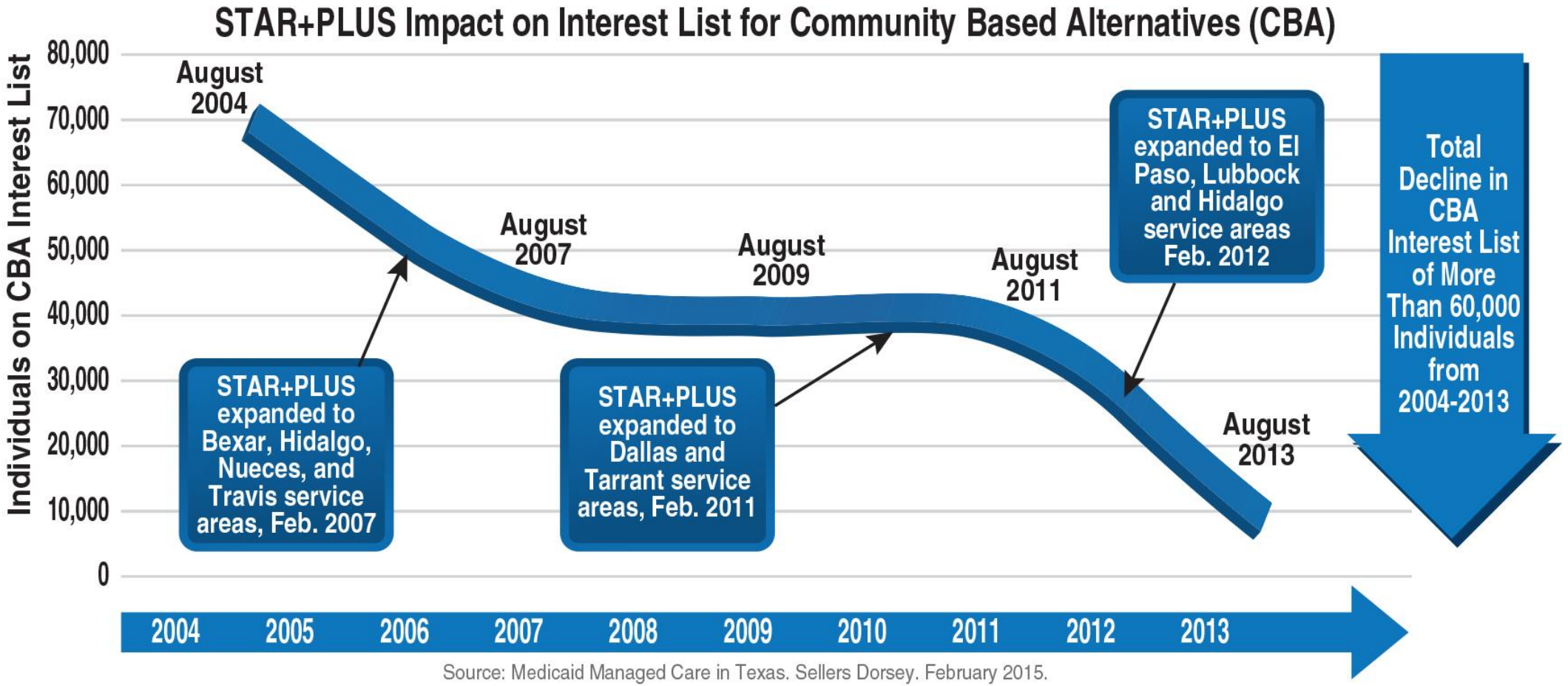
**70%** Increase in the use of community based services

**38%** Increase in the use of adult day care services



Source: Institute for Child Health Policy. The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Enrollees. November 2003.

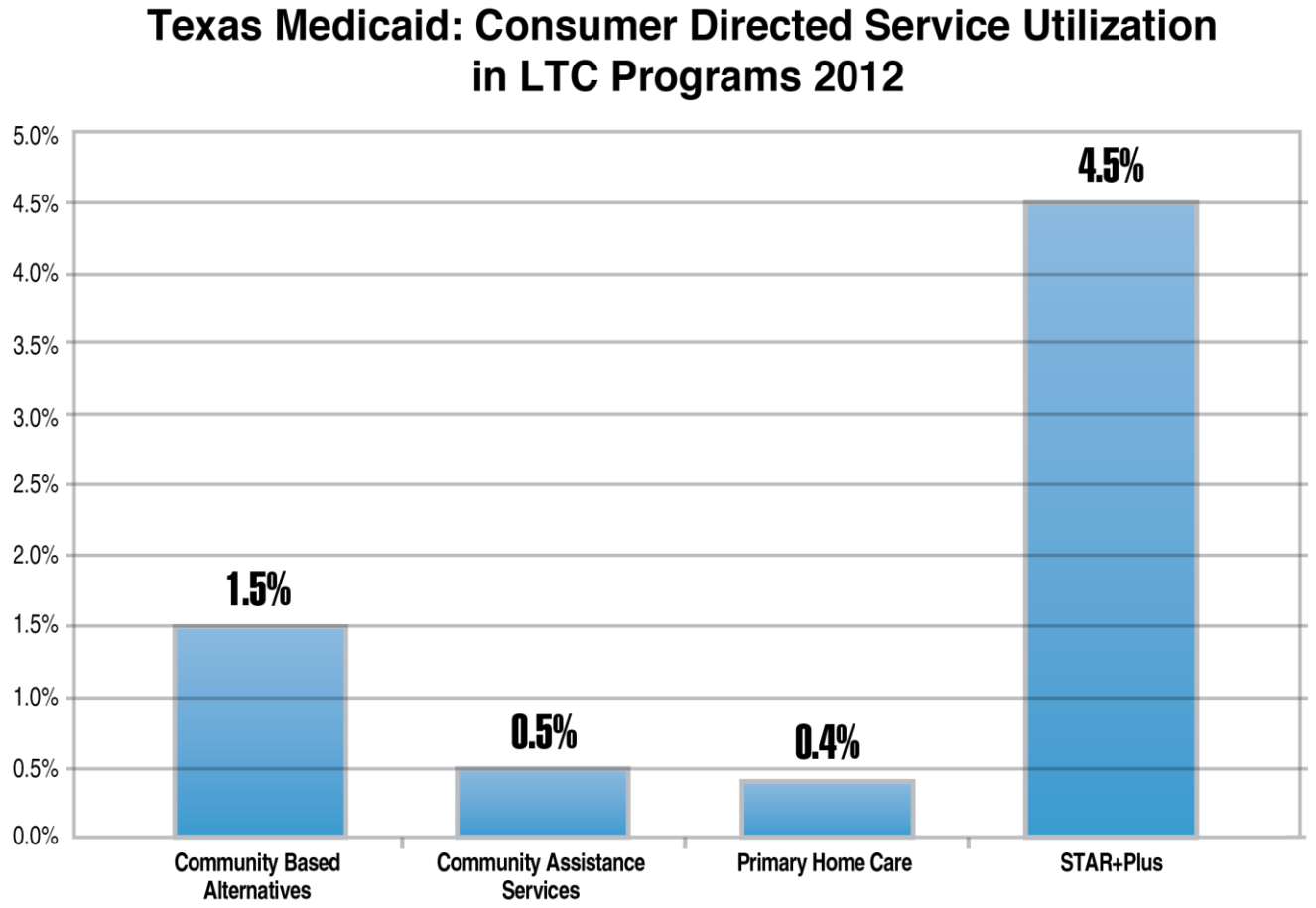
# STAR+PLUS: Increased Access to Community Care




Source: Medicaid Managed Care in Texas. Sellers Dorsey. February 2015.

# STAR+PLUS: Increased Focus On Community Care and Maintaining Independence

- **Community care has increased significantly at no additional cost to the state, while nursing home caseloads have stayed relatively flat**
- **Nursing home caseloads:**
  - 2003: 60K
  - 2013: 56K
- **Consumer directed services (CDS) has increased under managed care**
  - Allows individuals to directly hire and manage the people who provide their services
- **Focus on community care through STAR+PLUS has helped Texas address growing needs, without substantially adding new costs**






Source: Medicaid Managed Care in Texas. Sellers Dorsey. February 2015.

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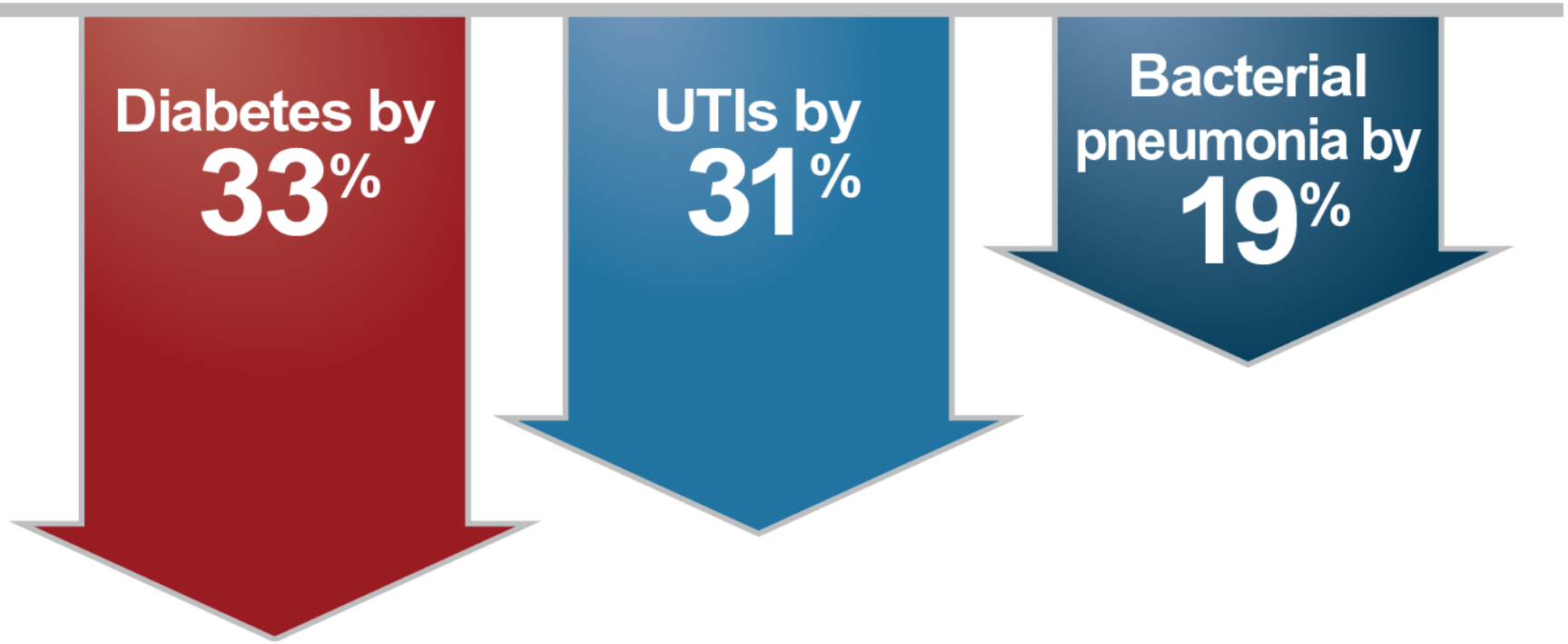
# STAR+PLUS Improved Quality of Care

## Between 2009 and 2011, STAR+PLUS plans reduced hospital admissions for:





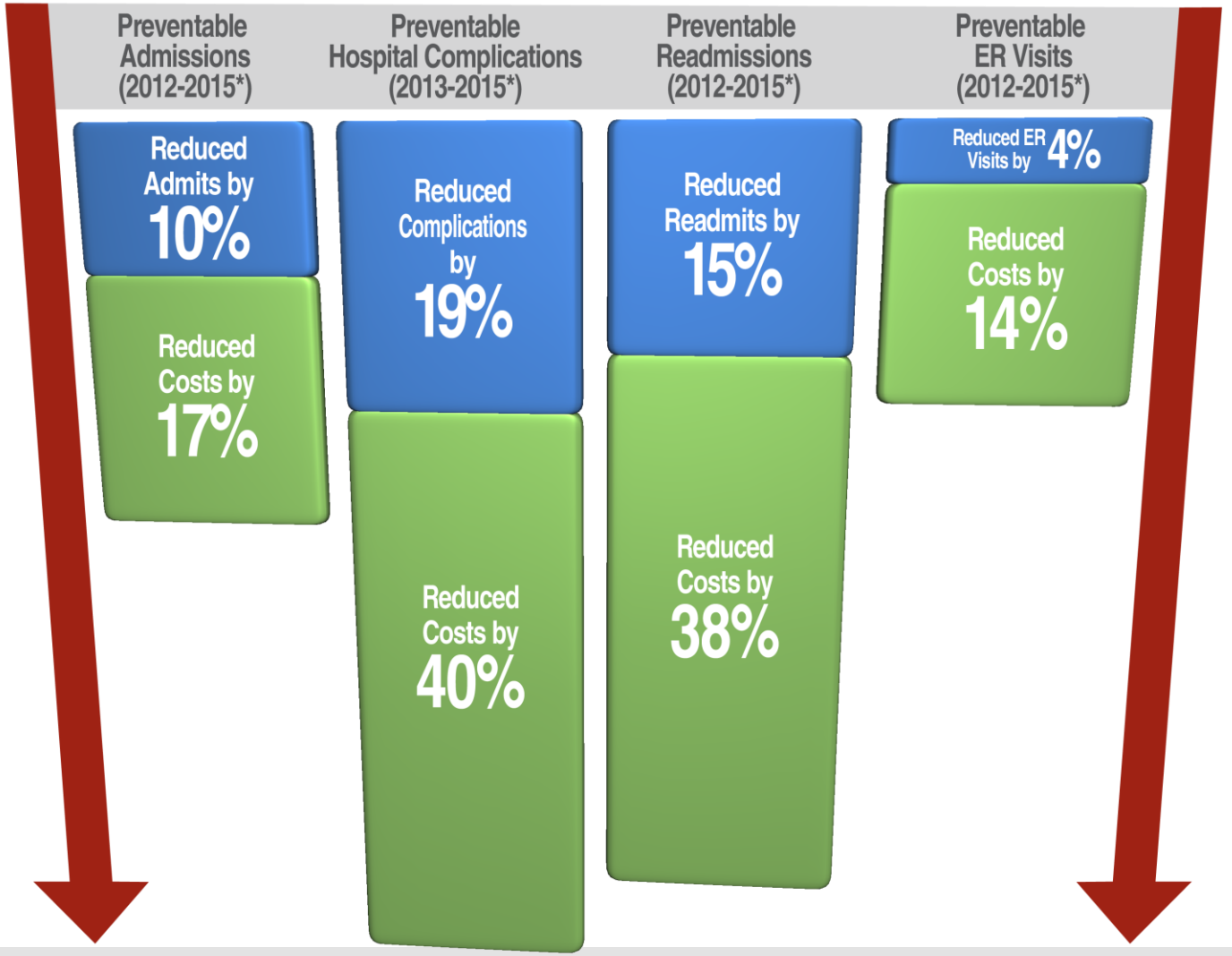

Source: Medicaid Managed Care in Texas. Sellers Dorsey. February 2015.

# Texas Medicaid Managed Care: Pay-for-Quality (P4Q)

## P4Q Program:

- Focuses on outcomes
- 4% of MCO premium payments at-risk for quality
- Focus on reducing Potentially Preventable Events (PPEs)

## STAR+PLUS Plans Reduced Potentially Preventable Events




Source: HHSC Interactive MCO PPE Report CY 12- CY 15.

*2015 includes data through November 2015

# Other Managed Care Quality Initiatives

- **External Quality Review Organization (EQRO)**
  - Contracted by HHSC to provide an external independent review of quality outcomes, timeliness of services, and access to services provided by MCOs
- **MCO Performance Indicator Dashboards**
  - Includes MCO performance on PPEs, access to care, member satisfaction with care, population-specific preventive health, care for certain chronic conditions
  - Specific LTSS and NF measures added to MCO dashboards for CY 2015
- **MCO Report Cards**
  - Allow members to easily compare the MCOs on specific quality measures
- **Member Surveys**
  - Conducted by state's EQRO using validated and nationally accepted survey instruments

# Other Managed Care Quality Initiatives

- **Performance Improvement Projects (PIPs)**
  - Topics recommended by EQRO and based on MCO performance
- **Dual Demonstration**
  - Six county pilot program
  - Integrates Medicare acute care and Medicaid LTSS to better coordinate services
  - Shared savings between federal government and state
- **HB 1, HHSC Rider 67**
  - HHSC will evaluate how Texas Medicaid providers and MCOs use existing pay for quality measures to improve health care delivery and impact of these initiatives on quality of care and improved outcomes

# STAR+PLUS NF Carve-In (March 1, 2015)

- **Nursing Facility Access Standard –** STAR+PLUS MCOs must ensure access to a Nursing Facility in the Provider Network within 75 miles of the Member's residence
- **Significant Traditional Provider (STP)/Any Willing Provider**
  - STAR+PLUS MCOs must contract with any NF that is a STP (as of Sept. 1, 2013), and any other NF that is willing to agree to the MCO's contract rates and terms (expires Feb. 28, 2018)
  - MCOs must use state identified credentialing criteria (NF must hold a valid certification and license and contract with DADS)
- **HHSC sets minimum reimbursement rate paid to NFs under STAR+PLUS (until September 1, 2021)**

# NF Quality Initiatives

- **Nursing Facility Incentives**
  - STAR+PLUS MCOs are required to implement a NF incentive program, based on guidelines determined by HHSC
  - Goals:
    - Reduce potentially preventable events (PPEs), including admissions, readmissions, unnecessary institutionalization, and acute care costs
    - Encourage NF culture change
- **Quality Improvement Payment Program (QIPP)**
  - Shifts traditional NF Upper Payment Limit (UPL) program (based on utilization), to payments based on quality improvements and innovation

# Recommendations

- **Focus on measures that exist and have been vetted**
- **Focus on outcome measures rather than prescriptive process measures**
  - Outcome measures allow for flexible and innovative improvements
  - Process measures can drive up services (and costs) without corresponding improvements in outcomes
- **Limit "Any Willing Provider" requirements which require MCOs to contract with providers without having an opportunity to fully vet for quality and safety issues**
- **Experience Rebates - Use these funds to provide incentives to health plans to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce potentially preventable events (as permitted by SB 7, 83R)**