



Presentation to House Committee on Public Health

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House Bill 300

- The bill delineates responsibilities and prohibitions associated with handling protected health information and establishes enhanced penalties for existing acts or offenses associated with misuse of information when those acts or offenses include medical information
- Several sections of the bill require implementation by other agencies or state agencies generally, or impose requirements on “covered entities”
- HHSC is examining policies and procedures and working with other state agencies to coordinate efforts to implement the bill
- The bill is effective September 1 2012

Senate Bill 7 (Quality Provisions)

- The bill establishes a Quality Based Payment Advisory Committee and directs HHSC to work with the committee on new payment methodologies that produce quality health outcomes and cost savings
- HHSC is required to submit an annual legislative report regarding quality-based outcome and process measures developed and implementation of quality-based payment systems
- Council members have been appointed the Executive Commissioner and notification letters are being sent



Healthcare Transformation Waiver: Background

- Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver:
 - **Managed care expansion**
 - Allows statewide Medicaid managed care services
 - Includes legislatively mandated pharmacy carve-in and dental managed care
 - **Hospital financing component**
 - Preserves upper payment limit (UPL) hospital funding under a new methodology
 - Creates Regional Healthcare Partnerships (RHP)



Healthcare Transformation Waiver: Purpose

- Protect hospital supplemental payments (i.e., UPL)
- Develop Regional Healthcare Partnerships (RHPs)
- Expand range of reimbursement eligible uncompensated care services
- Develop delivery system improvements incentives

Healthcare Transformation Waiver: Changes to UPL

- Under the Healthcare Transformation waiver, funding is redirected to:
 - Uncompensated Medicaid and indigent care
 - Redesign investments to:
 - Improve care
 - Support creation of a coordinated health system
 - Contain costs
- Hospitals would submit uncompensated care documentation to HHSC
- Uncompensated care payments limited to actual costs

Healthcare Transformation Waiver: Waiver Pools

Under the waiver, trended historic UPL funds and additional new funds are distributed to hospitals through two pools:

- **Uncompensated Care (UC) Pool**
 - Costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers (beginning in first year)
- **Delivery System Reform Incentive Payments (DSRIP)**
 - Support coordinated care and quality improvements through RHPs to transform care delivery systems (beginning in later waiver years)



Healthcare Transformation Waiver: Uncompensated Care Pool Funds

- Hospitals must:
 - Provide non-federal share of the match via IGT
 - Submit a waiver application and uncompensated care certification report to HHSC
- Uncompensated care amounts will be based on:
 - Shortfalls not paid by disproportionate share hospitals (DSH)
 - Uncompensated care costs and uninsured patients costs not covered by DSH
 - Medicaid non-hospital uncompensated care costs (such as clinic and pharmacy settings)



Healthcare Transformation Waiver: DSRIP Pool

- The Delivery System Reform Incentive Payment (DSRIP) pool consists of regional health partnerships (RHPs)
- RHPs help hospitals and local entities:
 - Secure federal supplemental hospital funding
 - Develop local planning and system redesign
 - Identify the state share necessary to fund payments from the DSRIP pool



Healthcare Transformation Waiver: Pool Funding Distribution

Type of Pool	DY 1 (2011-2012)	DY 2 (2012- 2013)	DY 3 (2013- 2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Totals
UC	3,700,000,000	3,900,000,000	3,534,000,000	3,348,000,000	3,100,000,000	\$17,582,000,000
DSRIP	500,000,000	2,300,000,000	2,666,000,000	2,852,000,000	3,100,000,000	\$11,418,000,000
Total/DY	4,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	6,200,000,000	\$29,000,000,000
% UC	88%	63%	57%	54%	50%	60%
% DSRIP	12%	37%	43%	46%	50%	40%

Healthcare Transformation Waiver: RHP Principles

- RHPs are formed around the hospitals that today are currently receiving UPL, and one of these would serve as an anchor
- Anchors serve as the single point of contact and coordinate RHP activities
- Develop plans to address local delivery system concerns with a focus on improved access, quality, cost-effectiveness, and coordination
- RHP should reflect delivery systems and geographic proximity
- UC and DSRIP pools are dependent on RHP plan participation



Healthcare Transformation Waiver: RHP Stakeholder Participation

- RHPs shall provide opportunities for public input in plan development and review
- HHSC is seeking broad local plan engagement including:
 - County medical associations/societies
 - Local government partners
 - Other key stakeholders



Healthcare Transformation Waiver: RHPs and DSRIP

- Anchors will bring RHP participants and stakeholders together to develop plans for public input and review
- Participants will select incentive projects and identify hospitals to receive payments based on incentive projects
- Participating hospitals will report performance metrics and receive state incentives if metrics are reached

Healthcare Transformation Waiver: RHPs and DSRIP (continued)

- RHP Plans include:
 - Regional health assessments
 - Participating local public entities
 - Hospitals receiving incentives and yearly performance measures
 - Incentive projects by DSRIP categories
- RHPs and RHP plans do not:
 - Require four-year local funding commitments
 - Determine health policy, Medicaid program policy, regional reimbursement, or managed care requirements



Healthcare Transformation Waiver: DSRIP Category 1

- Infrastructure Development
 - Expand primary and specialty care access
 - Increase behavioral health care access
 - Improve performance and reporting capacity
 - Develop and expand telemedicine use
 - Increase prenatal and healthy birth care access
 - Enhance health promotion and disease prevention

Healthcare Transformation Waiver: DSRIP Category 2

- Program Innovation and Redesign to Create and Implement:
 - Disease registry management
 - Medical Home Models and Care Coordination Initiatives
 - Innovations in pregnant women care and infant delivery
 - Health promotion and disease prevention improvements
 - Appointment redesign and referral processes
 - Post-discharge coordination models
 - Reduce inappropriate ER use
 - Alternative financing models



Healthcare Transformation Waiver: DSRIP Category 3

- Quality Improvements in Prevention and Management of:
 - Diabetes
 - Asthma
 - Congestive heart failure
 - HIV care
 - Hypertension
 - Obesity
 - Stroke/chest pain
 - Medication management
- Reduction in:
 - Surgical site infections and birth trauma rates
 - Behavioral health inpatient admissions



Healthcare Transformation Waiver: DSRIP Category 4

- Population-focused Improvement:
 - Patient/care giver experience
 - Care coordination
 - Preventative health
 - At-risk populations



Healthcare Transformation Waiver: Under Development

- Determination of statewide requirements for UC and DSRIP allocations within RHPs
- Project values (incentive payments within plans)
- Roles and potential IGT/General Revenue of Health Science Centers
- Other possibilities - IGT/General Revenue full waiver pools



Healthcare Transformation Waiver: Stakeholder Outreach

HHSC has conducted meetings and presentations to inform stakeholders about the waiver. These meetings include, but are not limited to, the following:

- July 21, 2011 – Regional Advisory Committee waiver summary
- September 15, 2011 – House County Affairs Interim Committee Hearing
- October 11, 2011 – Texas Teaching Hospital law seminar presentation
- October 20, 2011 – Regional Advisory Committee waiver update
- October 21, 2011 – CHIP coalition meeting and presentation to the Texas Medical Association
- October 25, 2011 – Healthcare Financial Management Association presentation
- November 21, 2011 – STAR+PLUS stakeholders quarterly meeting presentation
- December 2, 2011 – Community mental health association member webinar



Healthcare Transformation Waiver: Stakeholder Outreach (continued)

- Through the Executive Waiver Advisory Committee, HHSC is working with hospitals and local and county officials to share information and seek input on the implementation of the waiver
- HHSC created a rural Texas workgroup on to identify waiver implications for rural areas and to assist in outreach coordination and RHP development
 - Workgroup consists of associations representing counties, rural hospitals, and county commissioners and judges
 - Four meetings held since September 2011



Healthcare Transformation Waiver: Next Steps

- February 2012 - Establish preliminary RHP areas and participants
 - Rural and South Texas - Continue planning discussions and outreach with:
 - IGT transferring entities
 - Texas Organization of Rural and Community Hospitals
 - Texas Association of Counties
 - County Judge and Commissioners Association of Texas

Healthcare Transformation Waiver: Next Steps (continued)

- March 1, 2012 - UC protocol submitted to CMS
 - HHSC working with Deloitte and hospital representatives
- August 31, 2012 – Due to CMS:
 - Finalized RHP regions
 - DSRIP menu of projects and payment protocol
- October 31, 2012 - Final RHP plans due to CMS

Medicaid Orthodontia Claims: Background

- Concerns have been raised about the high utilization of Texas Medicaid orthodontia services
- Allegations have been about both Medicaid policies and management of the prior authorization process by Texas Medicaid & Healthcare Partnership (TMHP)

Medicaid Orthodontia Claims: Policy

- Medicaid policy limits orthodontic services (including braces) to treatment of medically necessary cases:
 - Children ages 12 and older with severe handicapping malocclusion (a misalignment of teeth that causes the upper and lower teeth not to fit together correctly)
 - Children ages birth through 20 with cleft palate or other special medically necessary circumstances
- Medicaid policy does not allow orthodontia for cosmetic reasons

Medicaid Orthodontia Claims: Expenditure Increases

- In response to *Frew v. Suehs*, the 2007 Legislature appropriated \$1.8 billion to expand access to preventative services in children's Medicaid including medical and dental checkups and services
- HHSC significantly increased outreach and dental reimbursement rates (including orthodontia) with the intent of increasing utilization
- From 2008 to 2010, Medicaid expenditures for orthodontic care increased from \$102 million to \$185 million
 - In 2007, 38.5 percent (1.1 million) children with Medicaid received dental services
 - In 2010, 51.6 percent (1.6 million) children with Medicaid received dental services

Medicaid Orthodontia Claims: Prior Authorization Management

- HHSC contracts with TMHP for Medicaid claims administration activities (including processing claims, enrolling providers, etc.)
- HHSC reviewed TMHP's prior authorization evaluation process and identified areas where improvement was necessary:
 - review and retention of clinical information
 - collection of additional clinical information
 - employment of sufficient and qualified staff

Medicaid Orthodontia Claims: Prior Authorization Management

- TMHP has already made staffing changes
 - In September 2011, TMHP terminated the former Dental Director
 - TMHP hired a new Dental Director, four orthodontists, and additional staff within the dental prior authorization unit
- HHSC is addressing performance issues through contract requirements

Medicaid Orthodontia Claims: Contract Quality Assurance

- The contract quality assurance process has been revised to include additional factors including staff qualifications, volume, and accuracy
- Staff qualification metrics will ensure staff with the correct knowledge review prior authorization requests, if staff volume is reasonable given the number of PA requests, and a quality component has been added
- Each quarter, a random sample of TMHP-approved orthodontia prior authorizations will be used to assess approval process accuracy
- HHSC is in the process of hiring a full-time Medicaid and CHIP Dental Director



Medicaid Orthodontia Claims: Audit Activities

- The federal and HHSC OIG are auditing the TMHP orthodontia prior authorization process
- Both audits are expected to be completed in the next 6 to 12 months
- If the TMHP approved services do not meet state criteria, HHSC will recover service costs from TMHP
- If the audit finds a dentist submitted incorrect information to get services approved, HHSC will seek provider reimbursement
- Any cases involving suspected fraud will be referred to the Office of the Attorney General for handling

Medicaid Orthodontia Claims: Policy Review

- HHSC determined Medicaid orthodontia reimbursement policy allowed for unlimited visits for maintenance of orthodontic devices, which could provide an incentive for more visits than necessary
 - Average number of visits for a child receiving orthodontia services exceeded 22 per year, while typically 12 visits per year is expected
- HHSC is revising this policy to allow for global orthodontia payments
 - Payments will be based on the level of severity as well as several other changes to strengthen policy weaknesses

Medicaid Orthodontia Claims: Policy Changes

- Effective October 1, 2011, dentists must submit full-cast dental models with all orthodontia requests. This is in addition to the radiographs, photos, and other documentation already required.
- Performance of Medicaid orthodontic services will soon be limited only by board certified orthodontists, pediatric dentists, or general dentists with 200 hours of continuing dental education in orthodontics
- HHSC is planning to offer a bundled rate for orthodontic services that includes all services related to the orthodontia service

Medicaid Orthodontia Claims: Implementing Dental Managed Care

- The state required the dental plans to submit their Prior Authorization policies for review and approval with the goal of ensuring Orthodontic Services delivered are medically necessary
- Dental plans conduct provider profiling and look for unusual trends in service delivery
- Special Investigative Units track, trend, and report possible fraud, waste, and abuse
- Dental plans are required to follow Medicaid/CHIP dental policies

Medicaid Orthodontia Claims: OIG Review Systems

- Surveillance and Utilization Review System (SURS)
 - Dental services (including orthodontia) are included in the federally required SURS claims processing system component
 - There are no unique SURS line items for orthodontia specific services since the prior authorization process is the front-end utilization review for these services
- The Medicaid Fraud and Abuse Detection System (MFADS) has several dental targeted queries that include orthodontia services billed outside of published policy
 - MFADS also has a dental model that includes orthodontic providers
 - The billing patterns for this provider group are fairly consistent among the specialty