TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

October 25, 2011

Maureen Milligan, Deputy Commissioner
Texas Health and Human Services Commission
Brown-Heatly Building
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Austin, TX 78751-2316

Sent via email: Maureen.milligan@hhsc.state.tx.us

Dear Ms. Milligan:

On behalf of the Texas Medical Association, thank you for the opportunity to provide input regarding the initiatives that will be funded via the new Delivery System Reform Incentive Payment (DSRIP) program that Texas will establish as part of the state's soon-to-be-approved federal Medicaid 1115 waiver restructuring Texas' Upper Payment Limit (UPL) program.

According to the waiver application submitted by the Health and Human Services Commission (HHSC) to the Center for Medicare and Medicaid Services, the waiver is designed to

> *.... redesign health care delivery in Texas consistent with the CMS triple aim to improve the experience of care, improve the health of populations, and to reduce the cost of health care without compromising quality.*

The waiver will, among other things, create a new DSRIP funding pool from which hospital districts and counties providing Texas' state share of Medicaid waiver matching dollars will be eligible to obtain funding to implement projects to improve health care outcomes of the Medicaid and uninsured populations within their communities. HHSC will develop a list of DSRIP projects designed to improve access and quality for eligible populations. From this list, hospitals districts and counties, which will form new Regional Health Partnerships to implement the changes, will be required to implement some projects but allowed to choose others. Participating RHPs will be required to develop a five-year plan outlining the local projects that will be implemented.

Over the last 10 days, the association solicited feedback about potential DSRIP initiatives from members of the TMA Select Committee on Medicaid, CHIP and the Uninsured as well as leaders of county medical and specialty societies. Most of our members are learning about the waiver at the same time TMA is seeking input on the projects that should be funded. It is a challenge to obtain input on the design of a program the physicians are only beginning to understand. As such, in the coming weeks, as we further educate our members about the waiver, we may suggest additional project ideas.

From the comments obtained thus far, it is imperative that the menu of initiatives ultimately adopted by HHSC reflect of the range of populations eligible for coverage under Texas Medicaid. Further, each regional 5-year plan should be required to include initiatives designed to address the care of patients across the life span: neonatal, pediatric, obstetric, adult, and geriatric. For example, the California DSRIP program, on which the Texas Medicaid DSRIP program is modeled, does not appear to include initiatives specifically designed to improve health outcomes of children or pregnant women, an enormous oversight given that children and pregnant women comprise the majority of the Medicaid population.

Further, we believe that HHSC needs to align, to the extent possible, the waiver quality improvement initiatives with those that will be implemented by 1) the Medicaid HMOs as part of the their contractual obligations; and 2) initiated as a result of the Medicaid quality-based payment improvement process outlined in Senate Bill 7. Local health care delivery systems are stretched thin trying to provide appropriate care for growing Medicaid and uninsured populations. If the hospital districts/counties, Medicaid HMOs and the HHSC quality-based payment process each adopt different quality-improvement activities, we do not believe it will be possible for physicians, hospitals, and providers to implement them all given the finite human and financial resources needed to successfully launch and maintain quality-improvement projects.

Below are the specific projects we recommend HHSC consider including in the DSRIP program.

Category 1: Infrastructure Development

- Expand and strengthen primary and specialty care capacity by supporting:
  - Graduate Medical Education
  - Primary care preceptorships
  - Loan repayment programs
- Provide resources to sustain regional Health Information Exchanges (HIEs), which will give physicians, hospitals and health care providers the necessary tools to better manage and coordinate patient care as well as to foster improved clinical collaboration;
- Support expansion of telemedicine for services not readily available within a community, such as mental health care or subspecialty services;
- Support training to promote team-based models of care, such as by educating physicians about how to effectively incorporate nurse practitioners and physician assistants into their practices;
- Develop disease and population registries to help physicians and providers better identify patients who might benefit from chronic care management;
- Implement initiatives and appropriate reimbursement to help improve the sustainability, effectiveness and efficiency of primary care practices, including implementing same-day scheduling, incorporating group visits for preventive health services, such as prenatal care or diabetes education, improving patient compliance, providing telephone consultations, and reducing ER utilization;
- Collaborate with practicing physicians to develop and disseminate evidence-based referral guidelines for specialty services (HHSC developed pediatric referral guidelines as a *Frew* initiative; we recommend a similar process for adult specialty services and to update/expand those initiatives for children)

Category 2: Program Innovation and Redesign

- Support implementation of medical homes for adult and pediatric populations;
- Support local implementation and/or expansion of Project Access initiatives. Project Access links uninsured patients with community physicians to provide, coordinate and manage their care. Studies show that Project Access reduces costs for enrolled populations by reducing ER visits and inpatient hospitalizations. Multiple county medical societies have established a Project Access; others are interested in implementing the model locally, but lack the necessary resources (an overview of the Dallas County Medical Society initiative will be sent under separate cover later this week);
- Contract with privately practicing physicians in underserved urban and rural communities, instead of constructing new clinics, to provide Medicaid and uninsured patients access to after-hours/urgent care, care coordination, or other initiatives aimed at lowering health care costs by moving care out of more expensive hospital inpatient units and into the community;
- Support nurse educators, "grand aides" or other initiatives aimed at reducing repeat emergency room or hospital inpatient admissions for premature babies or patients with chronic conditions, such as asthma or diabetes;
- Support integration of physical and mental health services for adult and pediatric populations in order to improve the detection, treatment and ongoing management of mental illness;

- Implement initiatives that reduce waiting times in emergency rooms and decrease "boarding" of patients in the ER;
- Support programs to improve palliative care;
- Test innovative initiatives aimed at reducing rates of childhood obesity

Category 3: Quality Improvements

- Reduce preventable hospitalizations by improving availability of physician and other community-resources;
- Reduce hospital inpatient and emergency room preventable admission rates for ambulatory sensitive conditions identified by AHRQ;
- Reduce hospital inpatient and emergency room readmission rates;
- Reduce rates of central-line associated blood stream infections;
- Reduce rates of surgical site infections;
- Reduce rates of birth trauma

Category 4: Population-Focused Improvements

- Improve the health of mothers and babies by adopting programs that
    - Improve birth spacing
    - Decrease rates of teen pregnancy
    - Reduce use of Neonatal Intensive Care Units
    - Reduce low birth weight babies
    - Reduce prematurity rates, including initiatives that eliminate elective inductions and C-Sections prior to 39 weeks gestation
    - Promote early prenatal care
- Implement prevention programs aimed at reducing chronic diseases or conditions prevalent throughout Texas, including
    - Diabetes
    - Asthma
    - Cancer
    - Pediatric and adult trauma
- Support programs aimed at reducing smoking rates.

In addition to the above recommendations, we want to reiterate comments made at the September 15, 2011 County Affairs committee hearing (and in recent meetings with HHSC officials) regarding the need for active, ongoing practicing physician involvement in Regional Health Partnerships (RHPs) and in the identification and selection of DSRIP projects. Specifically, we endorse the following:

- The formation of a statewide clinical advisory committee composed of practicing primary and subspecialty physicians to provide HHSC and RHPs advice on which incentive program projects to include in the DSRIP. A clinical advisory committee is essential to ensuring that the measures selected are clinically sound, reliable, meaningful and achievable.

- A requirement that each entity anchoring an RHP be required to appoint a physician advisory committee composed of county medical society physician representatives and practicing community and academic physicians (to the extent the latter are located within the region) to ensure that physicians are actively involved in the development and implementation of the five-year regional health plans required by the waiver.

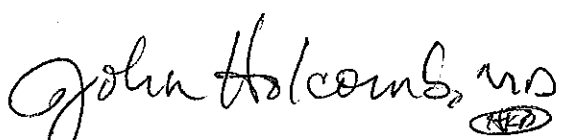
Today's health care environment is highly competitive, a situation that tends to foment distrust among physicians, hospitals and other key stakeholders. Given the demanding goals and timetable set by the waiver, and the large number of dollars at stake, the waiver could inadvertently further strain local

relationships if the state does not establish a clear expectation that the success of the project depends on collaboration and transparency. Any sense among physicians that they have been systematically excluded from the process may further fuel the exodus of community-based physicians from Medicaid at a time the state will need more physicians practicing in the program, not less. We are encouraged that several hospital districts have contacted their local county medical societies asking for their input into the formation of the RHP and five-year plan. However, there is no requirement for hospital districts – or counties – to do this. Our goal is ensure uniform expectations. Physicians recognize the enormous opportunity the waiver presents to improve care for Texas' most vulnerable populations and they want to be active partners in achieving that goal.

Lastly, we also strongly encourage HHSC to implement rules specifying that hospitals and counties must actively engage the public in the development and implementation of the regional health plans, including conducting public hearings to solicit input on the plans and to keep the community informed on efforts to achieve the goals set out in each RHP's 5-year plan. The success of the Regional Health Partnerships – and the waiver itself -- will depend on collaboration and cooperation with local physicians and other key stakeholders.

Thank you again for the opportunity to provide input. TMA looks forward to working closely with HHSC to successfully implement the waiver.

Sincerely,



Bruce Malone, MD, President
Texas Medical Association

John Holcomb, MD, Chair
Select Committee on Medicaid, CHIP, and the Uninsured

cc: Tom Suehs, HHSC Commissioner
Billy Millwee, Deputy Executive Commissioner for the Office of Health Services
Gary Young, Senior Policy Advisor