



**House Committee on Public Health and  
Appropriations Subcommittees on Health & Human  
Services and General Government**

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**Executive Commissioner Thomas M. Suehs**

**May 10, 2010**

# Health Care Cost Trends and Variations

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There are multiple factors that impact health care cost trends and regional variations in the Medicaid program.

Total caseload and cost per client are the primary cost drivers in the Medicaid Program.

- **Caseload** - Since January of 2009, Medicaid caseload has increased, on average, by 28,000 clients per month, and is growing at an annual rate of 11 percent. In May 2010, there are approximately 3.4 million Medicaid clients, compared to 3.05 million in May 2009, and 2.9 million in May 2008. Caseload factors that impact cost trends include:
  - Type of client (Child, Pregnant Woman, Aged and Disabled)
  - Volume
- **Cost per Client** – The cost of providing services to a client depends on several factors, including:
  - Managed Care Rates
  - Procedure Rates
  - Service Utilization
  - Technology Improvements

# Health Care Cost Trends and Regional Variations

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**Regional Variations in Cost Data** – Fiscal Year 2009 Medicaid spending data shows marked regional variability across health and human services (HHS) regions. HHSC is currently examining these patterns to more fully understand the underlying reasons for this variability.

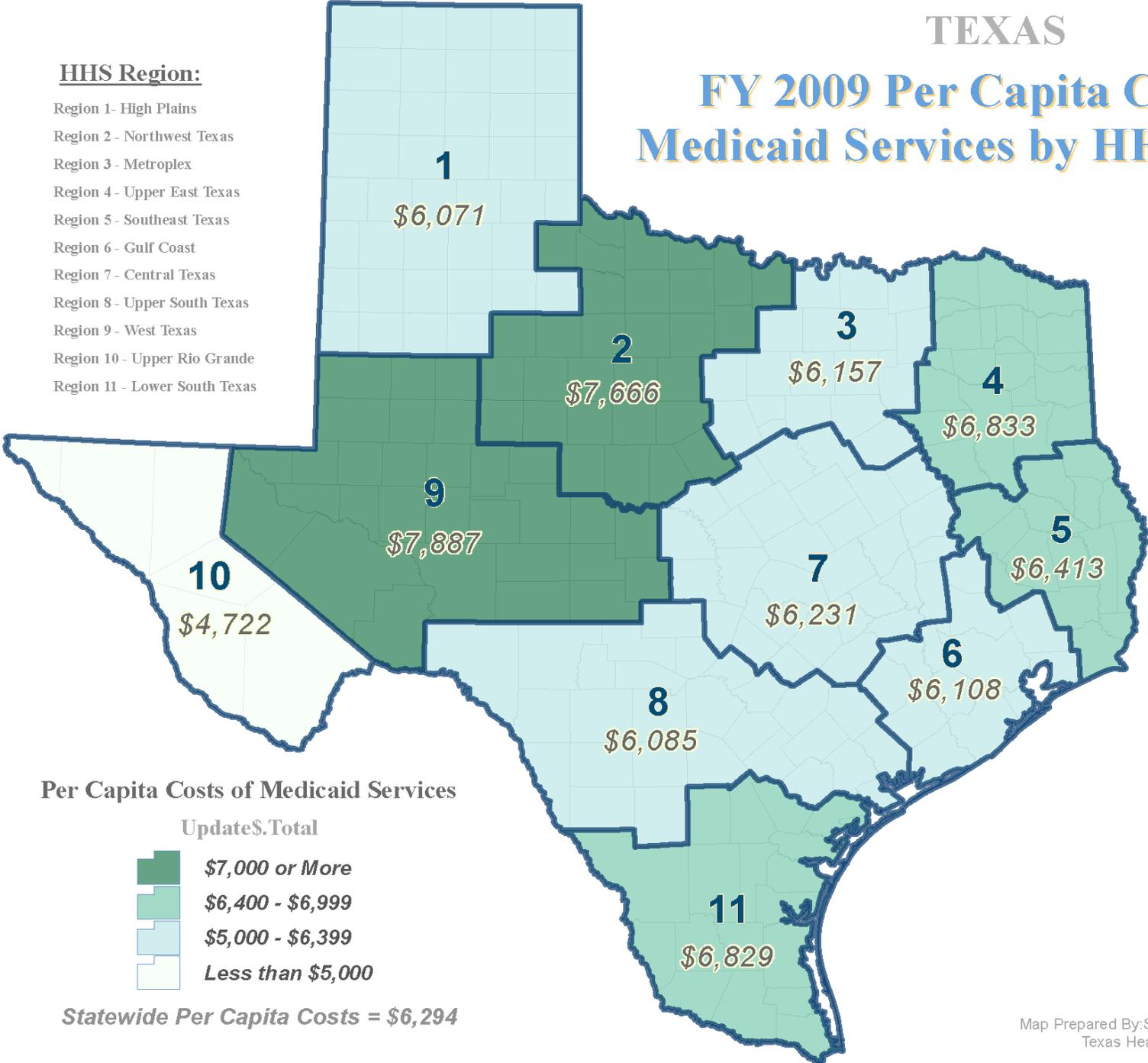
- **Contributing factors that could explain regional variation in per capita spending include:**
  - Availability of providers
  - Presence of adequate primary care
  - Transportation and distance requirements
  - Client composition of the regions
  - Presence of Managed Care

# TEXAS

## FY 2009 Per Capita Costs of Medicaid Services by HHS Region

**HHS Region:**

- Region 1- High Plains
- Region 2 - Northwest Texas
- Region 3 - Metroplex
- Region 4 - Upper East Texas
- Region 5 - Southeast Texas
- Region 6 - Gulf Coast
- Region 7 - Central Texas
- Region 8 - Upper South Texas
- Region 9 - West Texas
- Region 10 - Upper Rio Grande
- Region 11 - Lower South Texas



**Per Capita Costs of Medicaid Services**



**Statewide Per Capita Costs = \$6,294**



Map Prepared By: Strategic Decision Support Department  
 Texas Health and Human Services Commission.  
 May 5, 2010

# Cost Containment Initiatives

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HHSC has implemented, and is in the process of exploring, various initiatives to help contain costs in the Medicaid program

- Implemented Cost Containment Initiatives:
  - Increase efficiencies and reduce cost for Managed Care Organizations (MCOs)
    - Increase third-party recovery requirements
    - Reduce administrative cost component in rates
  - High cost imaging management
    - Requires prior authorization (PA) for high cost imaging services
  - New Drug Classes added to Preferred Drug List (PDL)
    - Effective July 2009, Medicaid cough and cold products were added to the PDL
  - Billing Coordination System (BCS) Expanded to Pharmacy Claims
    - Identifies other insurance and defers Medicaid payment
  - Women's Health Program
    - Reduced pregnancies and associated costs

# Cost Containment Initiatives

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## Cost Containment Initiatives under development:

- **National Corrective Coding Initiative (NCCI)**
  - Implement standard codes for claims payment to more closely align the Texas Medicaid claims adjudication rules with those enforced by Medicare and private sector payers
- **Diagnosis Related Group (DRG) Recovery**
  - Ensure the diagnosis and procedure codes that generate the DRGs, and thus the hospital invoice, are accurate, valid and sequenced in accordance with national coding standards
- **Ultrasound Utilization Project**
  - Obstetric ultrasounds for a pregnancy would be limited to no more than 3 per client, unless medical necessity is provided under prior authorization
- **Enhanced Third Party Recovery Efforts**
- **Additional Administration Cost Containment Initiatives including:**
  - Discontinue mailing paper Medicaid bulletins
  - Discontinue printing of remittance and status reports

# Quality Improvement Initiatives

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- Over the past few legislative sessions, a number of bills have been passed that are directed at increasing the quality of healthcare.
- In addition to working toward the implementation of these legislative initiatives, HHSC has been exploring other policies that could help produce healthier outcomes for Medicaid and CHIP recipients and lead to the long term reduction of some high cost healthcare expenditures.



# Quality Improvement Initiatives: Preventable Adverse Events Reporting

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- Senate Bill 288, 80<sup>th</sup> Legislature
  - Directed the Department of State Health Services (DSHS) to develop the Healthcare-Associated Infections (HAI) Reporting System and established the HAI Advisory Panel
  - Required DSHS to publish summaries by facility
  - The HAI reporting component is under development and will be in 2011
- Senate Bill 203, 81<sup>st</sup> Legislature
  - Expanded reporting to include Preventable Adverse Events
  - Added PAE responsibilities and two additional members to the HAI Advisory Panel
  - DSHS is planning expansion of the HAI reporting initiative to include reporting of PAEs. Reportable PAEs will include 28 events identified by the National Quality Forum
- This information will be used by both facilities and patients to improve the quality of care and allow consumers to make informed choices about where they receive care
- DSHS is working closely with stakeholders in developing the HAI/PAE Reporting System

## Quality Improvement Initiatives: Medicaid Payment Reduction for PAE's

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- Senate Bill 203, 81st Legislature, directs HHSC to reduce or deny reimbursements to hospitals for preventable adverse events
  - A preventable adverse event (PAE) is when a medical intervention causes an injury or other harm to a patient. It includes any unintentional harm to a patient arising from any aspect of healthcare management.
  - Target implementation date is September 1, 2010
  - HHSC will follow Medicare policy
- Medicare denies all payments, including those to physicians, for the following surgical procedures:
  - Incorrect (i.e. unintended) surgical procedure
  - Surgical procedure on the wrong side of the body or on the wrong body part
  - Surgical procedure on the wrong patient
- In addition to the above procedures, there are 10 categories of hospital acquired conditions for which Medicare reduces reimbursement if they were not present on admission

# Quality Improvement Initiatives: Potentially Preventable Readmissions

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- House Bill 1218, 81<sup>st</sup> Legislature, requires HHSC to adopt rules to:
  - Identify potentially preventable readmissions (PPR) of Medicaid recipients
  - Exchange confidential data with hospitals regarding their performance with respect to PPRs
- A PPR is a readmission into a hospital that may have resulted from either the:
  - Process of care and treatment during the prior admission (e.g., readmission for a surgical wound infection), or
  - Lack of post-admission follow up care (e.g., lack of follow-up arrangements with a primary care physician).
- The likelihood of a PPR is dependent on severity of illness, extremes of age, and the presence of mental health diagnoses.



# Quality Improvement Initiatives: Potentially Preventable Readmissions

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- Medicaid claims data will be used to identify hospital readmissions
- Analysis will determine whether the reason for readmission is clinically related to a prior admission
- HHSC will provide hospitals with data to help improve performance in serving the Medicaid population
- Target implementation date of January 1, 2011



# Quality Improvement Initiatives: Nursing Facility Incentive Payment Program

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- Department of Aging and Disability Services (DADS) Rider 45 of the General Appropriations Act (81st Legislature, Regular Session, 2009) and H.B. 1218, 81<sup>st</sup> Session, establish a quality of care health information exchange with certain nursing facilities designed to improve the quality of care and services provided to Medicaid recipients.
- DADS has issued a request for proposal (RFP) to assist in the development and implementation of an incentive payment program for nursing facilities in Texas that demonstrate superior performance.
  - The RFP was released on February 16, 2010. Vendor proposals were due April 9, 2010 and a vendor is expected to be announced in May.

# Quality Improvement Initiatives: Frew Strategic Initiatives

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- **Improvements in Dental Health and Screenings**
    - **First Dental Home**
      - Provides oral health education to families and fluoride varnish to Medicaid children under age 3
      - Educates general dentists on treating pediatric patients
      - Began March 1, 2008
    - **Oral Evaluation and Fluoride Varnish in the Medical Home**
      - Provides education and reimbursement for physicians to provide oral evaluations, fluoride varnish and oral health guidance for Medicaid children under the age of 3 during medical checkups
      - Began September 1, 2008
    - **Assists in preventing early dental disease and more costly long-term restorative dental care**
  - **Health Home Pilot Project**
    - **HHSC will fund up to 8 pilot projects that will focus on comprehensive health home models for children enrolled in Medicaid under the age of 21**
    - **RFP has been issued and responses are due back to HHSC in July**

# Quality Improvement Initiatives: Frew Strategic Initiatives

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- Promotores(as) Outreach in Emergency Rooms
  - Promotores are stationed in emergency rooms to assist and educate families of Medicaid children who are seeking non-emergent care
  - Aimed at educating families in seeking better quality, less costly primary care for non-emergent situations
  - Pilot began March 1, 2010
- Integrated Pediatric and Mental Health Program
  - Places behavioral health specialists in pediatric practices to integrate appropriate screening and assessment to identify mental health and behavioral health symptoms as they are developing
  - The goal is to manage and/or treat these symptoms early on achieve better health outcomes for the Medicaid client and lessen the need for more costly care in the future
  - Began September 1, 2008



# Quality Improvement Initiatives: Under Development

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HHSC is developing additional initiatives to improve quality and gain efficiencies

- All Patient Refined Diagnosis Related Groups (APR-DRG)
  - APR-DRG is a refined classification system to support targeted quality initiatives and operational improvements
  - APR-DRG establishes the foundation for quality-based payment initiatives, such as a bundled payment system
- Health Information Technology
  - Medicaid Eligibility and Health Information System (MEHIS)
  - Provider Electronic Health Record Incentive Payments

# Patient Protection and Affordable Care Act State Pilots & Policy Options

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**In addition to the various initiatives that HHSC is currently exploring, there are some options aimed at quality improvement available to states under the Patient Protection and Affordable Care Act (PPACA).**

## **Medicaid Global Payment System Demonstration Project**

- Up to five states could create a global capitated, bundled payment system for a large safety-net hospital system to evaluate changes in health care spending and outcomes. Under a global payment option, no matter how long the service, what is provided, or number of encounters, only one rate is paid.
  - The intent is to improve care and save money through reduction in duplicative services, use of more cost-effective services and providers, and the elimination of potentially preventable costly services.
- The demonstration will operate from 2010 - 2012.

## **Health Homes for Enrollees with Chronic Conditions**

- Allows states to provide health home services under a Medicaid state plan to eligible individuals with chronic conditions.
  - Health home services include care management, care coordination and health promotion, transitional care, patient and family support, referrals to support services, and the use of health information technology.
- Beginning January 2011, states must submit a Medicaid state plan amendment for this option.

# Patient Protection and Affordable Care Act State Pilots & Policy Options

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## **Pediatric Accountable Care Organization (ACO) Demonstration Project**

- Establishes a demonstration project that allows qualified pediatric medical providers to be recognized and receive incentive payments as Accountable Care Organizations (ACOs).
  - ACOs are composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to accept responsibility for all or most of the care that enrollees need.
- Effective January 2012 through December 2016. CMS has not yet issued guidance to states on how to apply.

## **Demonstration Project to Evaluate Integrated Care Around a Hospitalization**

- Establishes a bundled payment demonstration project under Medicaid in up to 8 states. States may target certain beneficiaries or geographic areas of state.
  - Bundled payments apply to an episode of care which includes a hospital stay and concurrent physician services provided during hospitalization.
- Effective January 2012 through December 2016. CMS has not yet issued guidance on how states will be selected to participate.