Texas Medicaid and Texas Diabetes Council Coordination Report

As Required by

2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 25)

Health and Human Services Commission

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Executive Summary

The 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 25) directs HHSC to identify efficiencies across agencies to integrate systems of care and work jointly with the Texas Diabetes Council (TDC) to:

1. improve screening rates for Medicaid patients at risk for diabetes; and
2. increase enrollment in diabetes self-management education (DSME) programs for those Medicaid patients diagnosed with diabetes.

To fulfill the requirements of the rider, HHSC Medicaid and CHIP Services formed a workgroup with TDC to respond to the legislative request to identify efficiencies across agencies. The workgroup implemented a resource website for diabetes self-management targeted at Medicaid and CHIP recipients and providers based on market research conducted by the Department of State Health Services (DSHS). The site, called Diabetes Self-Management Education, is hosted on the HHSC website.[1]

This report provides a description of the resource website and identifies some next steps that could be implemented for individuals with diabetes enrolled in Medicaid. While these project ideas are discussed in the report, the workgroup's efforts over the interim focused on developing the resource website, which could be accomplished with existing resources. The report also provides a summary of current Texas Medicaid efforts related to diabetes, particularly quality monitoring of screenings and DSME.

[1] https://hhs.texas.gov/services/health/prevention/diabetes-self-management-education

1. Introduction

Rider 25 directs HHSC to develop a report in consultation with TDC, including the results from the joint efforts of the agency and the council, a summary of previously submitted related reports, limitations, improvements made, and recommendations on the two issues identified in the rider. The report must be submitted to the Legislature and Governor by August 31, 2018.

TDC, established under Health and Safety Code, Chapter 103, is a health promotion and advisory body to the Texas Legislature concerning education and healthcare for persons with diabetes.[2] TDC members include physicians, nurses, dieticians, policy experts, members of relevant professional associations and advocacy groups, and interested members of the public. The Council is supported by the staff from DSHS, and certain representatives of state agencies also participate in a non-voting capacity, including HHSC.

HHSC works closely with the TDC by participating in quarterly meetings and workgroups, collaborating regularly to address questions from the council, and developing new initiatives.

[2] https://www.dshs.texas.gov/diabetes/tdcmembr.shtm

2. Background

Diabetes is a group of diseases marked by high levels of blood glucose (sugar) resulting from defects in insulin production, insulin action, or both. According to DSHS, as of 2012, 2.5 million Texans had diabetes, of which 457,819 were estimated to be undiagnosed. In Texas, the percentage of adults living with diabetes for that same year was 10.6 percent. Data from DSHS and the federal Centers for Disease Control and Prevention indicate that the prevalence of diabetes in Texas increased almost 50 percent from 2002 to 2012.

Prediabetes is when a person's blood glucose (sugar) levels are higher than normal but not high enough for a diagnosis of type 2 diabetes. Average blood glucose levels are measured by a test called the A1C. A person with prediabetes has an A1C between 5.7 percent to 6.4 percent (a normal A1C is less than 5.7 percent). People with prediabetes are at increased risk of cardiovascular disease. Most people with prediabetes develop type 2 diabetes within two to ten years, unless they modify their lifestyle. A person is diagnosed with diabetes when he or she has an A1C of 6.5 percent or higher.

According to the American Diabetes Association, the total estimated cost of diagnosed diabetes in the United States (U.S.) in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in reduced productivity. People with diagnosed diabetes incur average medical expenditures of about $13,700 per year, of which about $7,900 is attributed to diabetes. People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes. Care for people with diagnosed diabetes accounts for more than one in five health care dollars in the U.S., and more than half of that expenditure is directly attributable to diabetes.

In 2015, the U.S. Preventive Services Task Force (USPSTF) recommended screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. The USPSTF further recommends that clinicians refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. This recommendation is the result of strong evidence for the effectiveness of lifestyle interventions in delaying or preventing the onset of diabetes. Referral to intensive behavioral interventions is key, as screening for abnormal glucose identifies patients in need of lifestyle interventions. Part of the USPSTF's intent is to

get physicians and others to think about lifestyle intervention more, and to make effective lifestyle programs more available.

3. Diabetes-Related Medicaid Landscape

Diabetes Screening and Treatment

Diabetes screenings and treatments are available for adults and children through both Medicaid fee-for-service (FFS) and managed care as medically indicated. Currently Medicaid provides the following benefits related to diabetes: labs for diagnosis and monitoring of diabetes, diabetes equipment and supplies for monitoring and treatment, continuous glucose monitoring, and prediabetes and DSME.

Education and other related services for children and eligible adult clients with diabetes are provided through regular physician/client consultation.

Pregnant women enrolled in Medicaid who have gestational diabetes are eligible to receive both telemedicine (physician-directed) and telehealth (non-physician directed) services.[3] Women with gestational diabetes also qualify for telemonitoring services. Telemonitoring services involve transmitting clinical data to a remote provider to allow for quick intervention in disease exacerbations. These services are limited by statute to certain diagnoses and conditions including gestational diabetes, unlike telemedicine and telehealth services, which have no diagnosis or condition restrictions.

Group clinical visits for educational counseling are a Texas Medicaid benefit for clients with diabetes and pregnant clients. Group clinical education must include a nationally approved curriculum and must promote self-management of diabetes. Groups must have a minimum of 2 clients and a maximum of 20 clients. Diabetes self-management education must address nutrition, exercise and physical activity, preventing acute and chronic complications, monitoring and medication.

The data show that, of the individuals receiving Medicaid with a primary diagnosis of diabetes, 8,700 individuals also had inpatient hospital claims, 88,988 had outpatient hospital claims, and 206,806 had professional claims in either fee-for-service or managed care. See Appendix B for additional information.

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[3] Telemedicine services are available to all Medicaid recipients. However, this section of the report is focusing on ways pregnant women with gestational diabetes can be treated.

Medicaid Managed Care Quality

The movement of Texas Medicaid to a managed care delivery model has coincided with the expansion and adoption of Medicaid performance and quality measures. These measures are tracked by HHSC for each MCO by both program and service area. The managed care contracts hold MCOs accountable to the measures through the Pay-for-Quality program, and other quality initiatives. HHSC tracks Agency for Healthcare Research and Quality (AHRQ) pediatric quality indicators (PDIs), AHRQ prevention quality indicators (PQIs), 3M Potentially Preventable Events, and Healthcare Effectiveness Data and Information Set (HEDIS®) hybrid quality of care measure. Appendix A contains a comprehensive list of diabetes measures HHSC tracks. Performance data on these measures are available on the Texas Healthcare Learning Collaborative Portal thlcportal.com.

Table 1: Diabetes-related 2017 Pay-for-Quality At-Risk Measures

Measure	Measure Description	STAR	STAR+PLUS	CHIP
HbA1C Control <8	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1C control <8.		X	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotics	Percentage of members 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test.		X	
Potentially Preventable Emergency Room Visits	Hospital emergency room or freestanding emergency medical care facility treatment provided for a condition that could be provided in a nonemergency setting. This measure is not specific to diabetes but does include complications from diabetes as a possible reason for a PPV.	X	X	X

Measure	Measure Description	STAR	STAR+PLUS	CHIP
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition or physical activity.			X

Among other quality initiatives, MCOs are required to conduct performance improvement projects (PIPs). HHSC, in consultation with Texas' external quality review organization (EQRO), assigns topics for PIPs based on MCO performance, HHSC priorities, and the number of members affected by the issue. These projects are ongoing interventions and measurements designed to achieve significant, sustainable improvement in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction. Diabetes Control was a 2017 PIP topic for plans in STAR+PLUS (Amerigroup, Cigna Healthspring, Molina) and STAR (Driscoll). The EQRO evaluates the PIPs in accordance with the Centers for Medicare and Medicaid Services (CMS) EQRO Protocols.

1115 Transformation Waiver Diabetes Prevention and Control

CMS has approved Texas' 1115 Healthcare Transformation waiver for an additional five years, fiscal year 2018 through fiscal year 2022, referred to as Demonstration Years (DYs) 7 through 11. Funding for the Delivery System Reform Incentive Payment (DSRIP) program continues only through DY 10. HHSC is planning for later years of DSRIP as funding decreases, and conducting transition planning for after DSRIP.

Although there was not a specific project type for diabetes prevention and control, many DSRIP projects during DYs 2 through 6 focused on treatment or improving diabetes-related outcomes. The measure bundles and measures on which DSRIP providers will report reflect a continued emphasis on diabetes prevention and treatment in DYs 7 and 8.

Other Diabetes-Related Policies

HHSC has shared in TDC meetings and formal reports that one of the most common complaints from providers of individuals with diabetes is the complexity of the DME/Medical Supplies Physician Order Form (Title XIX Form). The Title XIX Form is used by providers to request prior authorization for diabetic equipment and supplies. However, Texas Medicaid allows the substitution of a detailed written order for the Title XIX form for the dispensation of diabetic equipment and supplies. The written order must contain the client's name, date of the order, description of items to be provided quantity to dispense, and a diagnosis code or description supporting the medical necessity.

4. Recent Initiatives

Diabetes Self-Management Education Website

The joint HHSC and TDC workgroup implemented a resource website targeted at Medicaid and CHIP recipients and providers regarding diabetes self-management and based in part on market research conducted by DSHS. The site is called Diabetes Self-Management Education and is hosted on the HHSC website.[4] The website allows Medicaid providers and recipients to easily find local DSME. In addition to the website, the workgroup members considered other possible projects. However, these projects would have a fiscal impact, which has not been assessed. Ideas considered by the workgroup include:

- adding a Medicaid benefit for targeted, individualized DSME by phone
- delivering DSME via a home health agency in individuals' homes
- establishing focus groups to determine a short-list of questions for providers to ask patients and publishing the list as a checklist under Texas Medicaid provider materials
- developing and implementing an interface for TDC or Texas Medicaid to conduct claims-driven outreach or intervention
- developing and implementing an interface for Texas Medicaid and MCOs to electronically complete and share Title XIX forms for diabetes medical supplies
- establishing and measuring new quality metrics in Texas Medicaid for post-partum diabetes education, tracking and reporting of DSME in the community,
- implementing provider training requirements (many primary care providers offer diabetes counseling to patients)
- developing and implementing a Texas Medicaid benefit for community health workers to deliver DSME

The workgroup ultimately elected to focus attention on a no-cost solution and implemented the resource website.

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[4] https://hhs.texas.gov/services/health/prevention/diabetes-self-management-education

CMS Technical Assistance

HHSC applied for and CMS approved Texas participation in a technical assistance opportunity in 2016 to promote effective prevention and treatment of chronic disease. HHSC staff participated in CMS' Diabetes Prevention and Management Affinity Group to share lessons learned regarding diabetes treatment and prevention. The focus was to learn from other states about the current best practices for MCO-managed DSME and related quality metrics. The models used by other states would have fiscal impacts HHSC would need to assess.

1115 Transformation Waiver Diabetes Prevention and Control

Hospitals and physician practices participating in the DSRIP program will report on measure bundles, which are sets of indicators that share a unified theme, apply to a similar population, and are impacted by similar activities.

There are two measure bundles specific to diabetes care: Improved Chronic Disease Management: Diabetes Care with six measures for adults; and Pediatric Chronic Disease Management: Diabetes with three measures for children. In addition, there are several diabetes-related measures in other measure bundles and on the measure lists for local health departments and community mental health centers.

HHSC will continue to make available information on DSRIP providers' achievement on diabetes-related outcome measures to the TDC. There will also be opportunities for stakeholder input on refreshing the measure bundles and lists of measures for DYs 9 and 10.

Providers will report baselines for their measures beginning in October 2018 and achievement of measures beginning in April 2019. HHSC can make available data on DSRIP providers' achievement on diabetes-related outcomes to the TDC.

Next Steps

As a result of the work done through the workgroup and the development of the website, HHSC will explore the following:

1. Develop a follow-up survey to the MCOs on DSME that was initially completed as part of implementation of 2016-2017 General Appropriations

Act, House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, HHSC, Rider 84).

2. Work with TDC members to develop a short list of questions for providers to ask patients and publish the checklist on the Medicaid diabetes website.
3. Continue to monitor the Medicaid diabetes website. Seek TDC input on any updates to existing links or information currently hosted on the webpage as well as additional resources to be added.

5. Conclusion

HHSC formed a workgroup of individuals from the TDC and Medicaid and CHIP Services. The workgroup implemented a resource website targeted at Medicaid and CHIP recipients and providers regarding diabetes self-management. To build on this work, HHSC identified next steps and will explore implementation with existing resources.

List of Acronyms

Acronym	Full Name
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control
CMS	Centers for Medicare and Medicaid Services
DME	durable medical equipment
DSHS	Texas Department of State Health Services
DSME	diabetes self-management education
DSRIP	Delivery System Reform Incentive Payment
EQRO	External Quality Review Organization
FFS	fee-for-service
HEDIS®	Healthcare effectiveness data and information set
HHSC	Health and Human Services Commission
MCO	managed care organization
PDI	pediatric quality indicators
PIP	Performance Improvement Project
PQI	AHRQ prevention quality indicators

Acronym	Full Name
TDC	Texas Diabetes Council
USPSTF	U.S. Preventive Services Taskforce

Appendix A. Medicaid Performance and Quality Measures

Agency for Healthcare Research and Quality (AHRQ) pediatric quality indicators (PDIs)

- Diabetes short-term complications admission rate (PDI 15)

AHRQ prevention quality indicators (PQIs)

- Diabetes short-term complications admission rate (PQI 1)
- Diabetes long-term complications admission rate (PQI 3)
- Uncontrolled diabetes admission rate (PQI 14)
- Rate of lower-extremity amputation among patients with diabetes (PQI 16)

3M Potentially Preventable Events (PPEs) - these measures are not specific to diabetes, but do include reasons related to diabetes

- Potentially Preventable ED Visits (PPVs)
- Potentially Preventable Admissions (PPAs)
- Potentially Preventable Readmissions (PPRs)

Healthcare effectiveness data and information set (HEDIS®) quality of care measures

- Comprehensive diabetes care (Sub measures: HbA1C testing, HbA1C adequate control (<8), blood pressure control (<140/90), eye exam, and monitoring for nephropathy.
- Statin therapy for patients with diabetes
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotics
- Diabetes monitoring for people with cardiovascular disease and schizophrenia
- Metabolic Monitoring for Children and Adolescents on Antipsychotics
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Appendix B. Medicaid Expenditures Related to Diabetes

Table 2: Medicaid Clients with Claims Related to Diabetes (Fiscal Year 2017)

Demographic Indicator	Number of Clients with Inpatient Hospital Claims	Number of Clients Outpatient Hospital Claims	Number of Clients Professional Claims
Sex			
Female	4,673	56,072	132,802
Male	4,028	32,908	74,180
Unknown	0	22	51
Race/Ethnicity			
White	1,756	18,262	43,782
Black or African American	1,526	13,049	30,549
Hispanic	3,723	39,095	87,966
Other	102	1,655	7,257
Unknown or Not Reported	1,593	16,927	37,252
Age			
0-17	1,054	4,681	8,094

Demographic Indicator	Number of Clients with Inpatient Hospital Claims	Number of Clients Outpatient Hospital Claims	Number of Clients Professional Claims
18-29	630	2,670	7,219
30-44	1,399	9,083	21,829
45-64	3,581	36,240	81,788
65+	2,069	37,260	91,077
Unduplicated Total	**8,700**	**88,988**	**206,806**

Table 3: Medicaid Expenditures Related to Diabetes (Fiscal Year 2017)

Type of Claim	Total Expenditure	Number of Claims	Number of Clients	Average Expenditure per Claim	Average Expenditure per Client	Percent Clients with Repeat Visits
Inpatient Hospital[5]	$49,608,465	11,882	8,700	$4,175	$5,702	20.5%
Outpatient Hospital	$22,517,685	259,126	88,988	$86.90	$253	60.0%

[5] Average length of stay for inpatient hospital is 6.51 days

Type of Claim	Total Expenditure	Number of Claims	Number of Clients	Average Expenditure per Claim	Average Expenditure per Client	Percent Clients with Repeat Visits
Professional	$50,477,127	1,139,184	206,806	$44.31	$244	75.6%
Total	**$122,603,279**	**1,410,192**	**222,390**	**$86.94**	**$551**	**78.9%**

Table 4: Medicaid Clients with Claims Related to Diabetes (Fiscal Year 2016)

Demographic Indicator	Number of Clients with Inpatient Hospital Claims	Number of Clients Outpatient Hospital Claims	Number of Clients Professional Claims
Sex			
Female	4,132	56,126	134,951
Male	3,412	31,613	73,536
Unknown	1	16	49
Race/Ethnicity			
White	1,581	18,995	46,165
Black or African American	1,297	12,949	31,693

Demographic Indicator	Number of Clients with Inpatient Hospital Claims	Number of Clients Outpatient Hospital Claims	Number of Clients Professional Claims
Hispanic	3,200	37,100	85,825
Other	75	1,799	7,312
Unknown or Not Reported	1,392	16,905	37,495
Age			
0-17	994	4,539	7,823
18-29	563	2,672	7,235
30-44	1,314	8,665	21,776
45-64	3,082	35,072	82,573
65+	1,637	37,752	92,561
Unduplicated Total	**7,545**	**87,748**	**208,490**

Table 5: Medicaid Expenditures Related to Diabetes (Fiscal Year 2017)

	Total Expenditure	Number of Claims	Number of Clients	Average Expenditure per Claim	Average Expenditure per Client	Percent Clients with Repeat Visits
Inpatient Hospital[6]	$42,638,077	10,235	7,545	$4,166	$5,651	19.6%
Outpatient Hospital	$19,432,049	253,018	87,748	$77	$221	60.4%
Professional	$47,738,178	1,143,827	208,490	$42	$229	76.5%
All Acute Care	$109,808,304	1,407,080	223,389	$78	$492	79.3%

Source: AHQP Claims Universe, TMHP; Enc_Best Picture Universe, TMHP; 8 month eligibility database, HHSC
Prepared by Data Quality & Dissemination, Center for Analytics and Decision Support, HHSC. May 2018.
Filename: TX Medicaid Reimbursement for Diabetes Summary FY16_FY17_final.xlsx

Data Notes:

- For this report, race group 'Unknown' consists of clients with missing race information and clients with the code for 'UNKNOWN OR NOT REPORTED' race. Previous reports may have included only clients with missing race information in this category.
- Data include Fee-For-Service (FFS), MMP, STAR, STAR Kids, STAR Health and STAR Plus programs (MCO). The STAR, STAR Kids, STAR Health and STAR Plus health plans are paid on a capitation basis. Texas Medicaid does not reimburse individual providers under contract with the health plans.

[6] Average length of stay for inpatient hospital is 6.53 days

- The MMP program began in April 2015.
- Managed care encounters did not include long term supports and services.
- Diabetes is defined as ICD-10 primary diagnosis like E10-E14 stating on 10/1/2015, and ICD-9 primary diagnosis like 250% before that date.
- Other race includes Alaskan Native, Asian, Native American, and other.
- Average reimbursement amount is the amount paid divided by the number of claims.
- Average Expenditure per Client is the amount paid divided by the number of clients.
- Percentage of repeat visits represents the percentage of clients who had more than 1 claim with a diabetes diagnosis.
- Counts and percentages may not add up to the total because a client may be in more than one age, race, or sex category.
- Length of stay was calculated using To and From Dates of Service. In cases where more than one claim was submitted for a single inpatient hospital stay, the number of hospital stays is overestimated and the average length of stay is underestimated. Claims with To and From Dates of Service on the same day have a length of stay of 1 day.
- Diabetes summary tabs include other/unknown diabetes, as well as Type I and Type II.