Texas Medicaid Diabetes Treatment and Prevention Report

As Required By
S.B. 796, 82nd Legislature, Regular Session, 2011

Health and Human Services Commission
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Executive Summary

Senate Bill 796, 82nd Legislature, Regular Session, 2011, directed the Texas Health and Human Services Commission (HHSC) to coordinate with the Texas Diabetes Council (TDC) to develop three reports on the prevention and treatment of diabetes in Texas.

This report addresses the first requirement of S.B. 796: a biennial report, to be submitted not later than December 1 of each even-numbered year, which identifies HHSC's priorities for addressing diabetes within the Medicaid population.

Diabetes is a group of diseases marked by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. According to the Texas Department of State Health Services (DSHS), as of 2012, 2.5 million Texans had diabetes. Of these, 457,819 incidents were estimated to be undiagnosed.[1] In Texas, the percentage of adults living with diabetes for that same year was 10.6 percent. Data from DSHS and the Centers for Disease Control (CDC) indicate that the prevalence of diabetes in Texas increased almost 50 percent from 2002 to 2012.[2]

Texas Medicaid implemented the 1115 demonstration waiver in 2011 with authorization from the Centers for Medicare & Medicaid Services (CMS). The waiver leverages savings from managed care expansion to reimburse providers for uncompensated care costs and to establish the Delivery System Reform Incentive Payment (DSRIP) program, which provides incentive payments to health care providers that implement delivery system reforms.

At least 128 of the almost 1,500 DSRIP projects approved as of July 2014 reference persons with diabetes as a target population or have a goal related to preventing or managing diabetes as a chronic health condition. Examples of DSRIP-funded projects include hiring individual endocrinologists, increasing case management services, establishing team-based clinics, and increasing disease self-management education. The maximum incentive funding available for diabetes-related DSRIP projects is about $821 million all funds (AF) over four years.

A majority of Texas Medicaid clients with diabetes receive care from a Medicaid managed care organization (MCO). Texas has requirements for MCOs to implement diabetes-related performance improvement projects and disease management programs. MCOs also are subject to a number of diabetes-related performance and outcome measures and may receive incentives or penalties based on their performance on these measures. The comprehensive set of performance and outcome measures in Medicaid managed care help to inform the Medicaid diabetes priorities addressed in this report.

[1] Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, DSHS. (Undiagnosed diabetes estimate based on 2003 -2006 NHANES age-adjusted prevalence estimate of 2.5 percent for persons twenty years of age and older).

[2] *Gestational Diabetes in Medicaid: Prevalence, Outcomes, and Costs,* HHSC. Accessed November 2014 at: http://www.hhsc.state.tx.us/reports/2014/SB1-Gestaional-Diabetes.pdf

Texas Medicaid Diabetes Treatment and Prevention Priorities

1. *Texas Medicaid provides coverage for quality screening and treatment services to identify and treat patients with diabetes.*

Prevention, timely diagnosis, and treatment are critical in patients with diabetes mellitus. Quality screening and treatment of the complications of diabetes mellitus have the potential to improve quality of life and increase life expectancy.[3] Diabetes screenings and treatments are available for adults and children in Texas Medicaid as medically indicated.

2. *Texas Medicaid provides coverage for pre-diabetes and diabetes disease self-management education.*

The overall objectives of diabetes self-management education (DSME) are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.[4]

Texas Medicaid provides eligible children and adults with diabetes with self-management education and other related services through regular physician/client consultation. Additionally, the Texas Medicaid Wellness Program provides comprehensive care management services for high-cost/high-risk fee-for-service (FFS) clients. The Wellness Program offers ten hours of diabetes self-management training (DSMT) and three hours of nutritional counseling to patients with diabetes.

3. *Texas Medicaid provides coverage for gestational diabetes screenings.*

Numerous national and international medical organizations, along with expert panels and working groups, have issued specific guidelines with recommendations for screening and diagnosing Gestational Diabetes Mellitus (GDM). Gestational diabetes screening is currently available to pregnant women in Medicaid and the Children's Health Insurance Program (CHIP), as medically necessary. During fiscal year 2012, 40 to 50 percent of the women participating in Medicaid or the CHIP Perinatal program were screened for GDM.[5]

4. *Texas Medicaid will continue to dialogue with advisory bodies and external stakeholders to inform the development and improvement of Medicaid diabetes programming and benefits.*

HHSC is committed to providing services to individuals with pre-diabetes or diabetes in an effective and evidence-based manner that is responsive to their needs. HHSC will continue to

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[3] *Diabetes Mellitus: Diagnosis and Screening* Patel, P., MD, and Macerollo, A., MD. American Family Physician. 2010 Apr 1; 81(7): 863-870. Accessed November 2014 at: http://www.aafp.org/afp/2010/0401/p863.html

[4] Diabetes Care, January 2008 vol. 31 no. Supplement 1 **S97-S104.** Accessed November 2014 at: http://care.diabetesjournals.org/content/31/Supplement_1/S97.full?sid=9b759fa8-b450-4639-ba77-9a4c82390f1d

[5] *Report on Direct and Indirect Costs of Diabetes in Texas.* HHSC. Accessed November 2014 at: http://www.hhsc.state.tx.us/reports/2012/direct-indirect-costs-diabetes-texas.pdf

work with parties interested in Texas Medicaid diabetes services, including the Texas Diabetes Council, in support of that goal.

Introduction

S.B. 796, 82nd Legislature, Regular Session, 2011, requires HHSC to coordinate with the Texas Diabetes Council (TDC) to develop three reports on the prevention and treatment of diabetes in Texas. The three reports, taken together, provide the legislature, relevant state agencies, and the general public with information regarding the impact of diabetes on the state while clarifying the present scope of services available statewide, both public and private. Ensuring this information is readily available will help the state and interested stakeholders identify potential areas of improvement for diabetes-related services.

This report addresses the first requirement of S.B. 796: a biennial report identifies HHSC's priorities for addressing diabetes within the Medicaid population.

Diabetes is a group of diseases marked by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. This report provides four priorities for HHSC focused on the treatment and prevention of diabetes among Medicaid participants. Those priorities include the provision of: quality screening and treatment services to identify and treat patients with diabetes; pre-diabetes and diabetes disease self-management education; and gestational diabetes screening as medically indicated. A final critical priority is for HHSC to continue to dialogue with advisory bodies and external stakeholders to inform the development and improvement of Medicaid diabetes programming and benefits.

These priorities and the efforts HHSC staff make in support of them are detailed below.

Background on Diabetes

Diabetes is a group of diseases marked by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. According to DSHS, as of 2012, 2.5 million Texans had diabetes; 457,819 of which were estimated to be undiagnosed.[6] In Texas the percentage of adults living with diabetes for that same year was 10.6 percent. Data from DSHS and the Centers for Disease Control (CDC) indicate that the prevalence of diabetes in Texas increased almost 50 percent from 2002 to 2012.

Although diabetes is less prevalent among individuals younger than 20 years of age, its diagnosis among children, adolescents, and teens does occur. The CDC stated in 2012 that about 208,000 young people in the U.S. were diagnosed with diabetes, or about 0.25 percent of that age group.[7]

[6] Texas Behavioral Risk Factor Surveillance System, Center for Health Statistics, DSHS (* Undiagnosed diabetes estimate based on 2003-2006 NHANES age-adjusted prevalence estimate of 2.5% for persons twenty years of age and older).

[7] *National Diabetes Statistics Report, 2014*. CDC. Accessed November 2014 at: http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

Diabetes can lead to serious complications and premature death, but people with diabetes, working together with their support network and their health care providers, can take steps to control the disease and lower the risk of complications.

Type 1 Diabetes

Previously called insulin-dependent diabetes mellitus (IDDM) or juvenile-onset diabetes.

Type 1 diabetes develops when the body's immune system destroys pancreatic beta cells, the only cells in the body that make the hormone insulin that regulates blood glucose. To survive, people with type 1 diabetes must have insulin delivered by injection or a pump. This form of diabetes usually strikes children and young adults, although disease onset can occur at any age. In adults, type 1 diabetes accounts for approximately five percent of all diagnosed cases of diabetes. Risk factors for type 1 diabetes may be autoimmune, genetic, or environmental. There is no known way to prevent type 1 diabetes.

Type 2 Diabetes

Previously called non–insulin-dependent diabetes mellitus (NIDDM) or adult-onset diabetes.

In adults, type 2 diabetes accounts for about 90 to 95 percent of all diagnosed cases of diabetes. It usually begins as insulin resistance, a disorder in which the cells do not use insulin properly. As the need for insulin rises, the pancreas gradually loses its ability to produce it. Type 2 diabetes is associated with older age, obesity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians or other Pacific Islanders are at particularly high risk for type 2 diabetes and its complications. Type 2 diabetes in children and adolescents, although still rare, is being diagnosed more frequently among American Indians, African Americans, Hispanic/Latino Americans, and Asians/Pacific Islanders.[8]

Gestational Diabetes

Gestational diabetes is diabetes that first occurs during pregnancy. When women are pregnant, their need for insulin appears to increase, and many can develop gestational diabetes during the late stages of pregnancy. Gestational diabetes occurs more frequently among African Americans, Hispanic/Latino Americans, and American Indians. It is also more common among obese women and women with a family history of diabetes. During pregnancy, gestational diabetes requires treatment to optimize maternal blood glucose levels to lessen the risk of complications in the infant.[9]

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[8] *National Diabetes Factsheet, 2011.* CDC. Accessed November 2014 at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

[9] *National Diabetes Factsheet, 2011.* CDC. Accessed November 2014 at: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

Pre-diabetes

Pre-diabetes is when a person's blood glucose levels are higher than normal but not high enough for a diagnosis of type 2 diabetes. Studies have shown that 15 to 30 percent of people with pre-diabetes will develop type 2 diabetes within five years, unless they lose 5 to 7 percent of their body weight—about 10 to 15 pounds for someone who weighs 200 pounds—by making changes in their diet and level of physical activity.[10] People with pre-diabetes also are at increased risk of developing cardiovascular disease.

Texas Medicaid and Diabetes

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by HHSC. In October 2013, almost one in seven Texans (3.7 million of the 26.7 million) relied on Medicaid for health coverage or long-term services and supports.

Medicaid pays for acute health care (physician, inpatient, outpatient, pharmacy, lab, and X-ray services) and long-term services and supports (home and community-based services, nursing facility services, and services provided in Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)) for people ages 65 and older or who have disabilities. Medicaid serves primarily low-income families, non-disabled children, related caretakers of dependent children, pregnant women, people age 65 and older, and people with disabilities.

During fiscal year 2013, 277,424 individuals received one or more Medicaid services for a primary diagnosis of diabetes. The diabetes-related service costs for these clients was $279.1 million. Of these totals, 96,601 individuals received services under the STAR or STAR+PLUS Medicaid managed care program at a total cost of $243.4 million. Under fee-for-service (FFS) and Primary Care Case Management (PCCM) models, 180,823 individuals received services at a cost of $35.7 million. The fee-for-service (FFS) and Primary Care Case Management (PCCM) numbers also include clients with claims with Medicare as the primary payer while Medicaid pays any coinsurance. The FFS and PCCM numbers include clients with claims with Medicare as the primary payer while Medicaid pays any coinsurance.

Delivery System Reform Incentive Payment projects

Texas Medicaid implemented the 1115 demonstration waiver in 2011 with authorization from the Centers for Medicare & Medicaid Services (CMS). The waiver leverages savings from managed care expansion to reimburse providers for uncompensated care costs and to establish the Delivery System Reform Incentive Payment (DSRIP) program, which provides incentive payments to health care providers that implement delivery system reforms.

At least 128 of the almost 1,500 DSRIP projects approved as of July 2014 reference persons with diabetes as a target population or have a goal related to preventing or managing diabetes as a chronic health condition. Examples of DSRIP-funded projects include hiring endocrinologists,

[10] Diabetes Home. CDC. Accessed November 2014 at: http://www.cdc.gov/diabetes/basics/prediabetes.html

increasing case management services, establishing team-based clinics, and increasing disease self-management education. The maximum incentive funding available for diabetes-related DSRIP projects is about $821 million all funds (AF) over four years. A list of approved Delivery System Reform Incentive Payment projects can be found at: http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

Medicaid Managed Care Initiatives

Because of recent Medicaid managed care expansions, a majority of Texas Medicaid clients with diabetes now receive care from a Medicaid managed care organization (MCO). Texas has requirements for MCOs to implement diabetes-related performance improvement projects and disease management programs. MCOs also are subject to a number of diabetes-related performance and outcome measures. The Uniform Managed Care Contract promotes health plan adherence to the measures through means that include financial incentives based on plan performance.

Medicaid Managed Care Quality Standards and Outcome Measures

Informing each of the Medicaid diabetes priorities addressed in this report is a comprehensive set of performance and outcome measures required in Medicaid managed care. The Medicaid performance measures and standards related to diabetes are listed below[11]. These measures are tracked by HHSC for each MCO by both program and service area.

[11] Uniform Managed Care Contract Terms and Conditions, Version 2.12, Chapter 10.1.7. Accessed November 2014 at: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf

Table 1: Medicaid Managed Care Performance Measures and Standards Related to Diabetes[12]

STAR Diabetes 2014 Performance Standards for clients 18 years of age and older:		
• *Diabetes short-term complications admission rate standard is 24 per 100,000 members*		
• *Diabetes long-term complications admission rated standard is 11 per 100,000 members*		
• *Uncontrolled diabetes admission rate standard is 3 per 100,000 members.*		
• *Rate of admission for lower extremity amputation among patients with uncontrolled diabetes is 0 per 100,000 members.*		
STAR+PLUS Diabetes Performance Standards for clients 18 years of age and older:		
• *Diabetes short-term complications admission rate standard is 230 per 100,000 members*		
• *Diabetes long-term complications admission rated standard is 409 per 100,000 members*		
• *Uncontrolled diabetes admission rate standard is 40 per 100,000 members.*		
• *Rate of admission for lower extremity amputation among patients with uncontrolled diabetes is 37 per 100,000 members.*		
STAR and STAR+PLUS Diabetes Performance Standards for client 18 years of age and older:		
	STAR	STAR+PLUS
• *HbA1c tested standard*	*83%*[13]	*83%*
• *Poor HbA1c control standard*	*48%*	*48%*
• *Diabetic eye exam standard*	*53%*	*53%*
• *LDL-C screened standard*	*76%*	*80%*
• *LDL-C controlled standard*	*37%*	*37%*
• *Nephropathy monitored*	*79 %*	*80%*

Performance Based At-Risk Capitation and Quality Challenge Award

[12] Data taken from the 2014 Calendar Year 2014 HHSC MCO Quality Performance Indicators dashboard. Accessed November 2014 at: http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/Chp10/10_1_7.pdf

[13] The simple percentages given refer to the percent of members receiving a service. The standards in the dashboard are the performance benchmarks that HHSC sets for the MCOs. This is typically a measure of access to and quality of care.

In the At-Risk/Quality Challenge program, which ended December 31, 2013, each managed care organization had the opportunity to achieve performance levels that enabled it to receive the full at-risk amount. However, should a managed care organization not achieve those performance levels, HHSC would recoup a portion of the five percent at-risk amount. HHSC reallocated any unearned funds from the performance-based, at-risk portion of a managed care organization's capitation rate to the managed care organization program's Quality Challenge Award. HHSC used these funds to reward managed care organizations that demonstrated superior clinical quality, service delivery, access to care, or member satisfaction. Final payment or recoupment based on performance in this program will be made in the fall of 2014.

Table 2. Diabetes-Specific 2013 At Risk Measures

Measure	Measure Description	STAR	STAR+PLUS
HbA1c Testing	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.		x

Table 3. Diabetes-Specific 2013 Quality Challenge Measures (2013)

Measure	Measure Description	STAR	STAR+PLUS
Member using Inpatient Services for ACSC (AHRQ-Pediatric Quality Indicators (PDI)	Pediatric Quality Indicators (PDIs) for child members: Diabetes Short-Term Complications	x	
Member using inpatient services for ACSC (AHRQ- Prevention Quality Indicators (PQIs)	Prevention Quality Indicators (PQIs) for adult members: • *Diabetes Short-Term Complications* • *Diabetes Long-Term Complications* • *Uncontrolled Diabetes* • *Rate of Lower Extremity Amputation among Patients*		x
Diabetic Eye Exam	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam.		x

Pay-for-Quality Program

The new Pay-for-Quality Program uses an incremental improvement approach that provides financial incentives and disincentives to managed care organizations based on year-to-year

incremental improvement on pre-specified quality goals. The quality of care measures used in this initiative are a combination of process and outcome measures which include select potentially preventable events as well as other measures specific to the program's enrolled populations.

The Pay-for-Quality Program includes an at-risk pool that is four percent of the managed care organization capitation rate. In the Pay-for-Quality Program, points are assigned to each plan based on incremental performance on each quality measure, with positive points assigned for year-to-year improvements over a minimum baseline. Negative points are assigned for most year-to-year declines, with the exception of modest decreases of plans whose performance is already performing within a specified range of the attainment goal rate. Rewards and penalties are based on rates of improvement or decline over the baseline. All funds recouped from managed care organizations through the assignment of negative points are redistributed to managed care organizations through the rewarding of positive points.

Table 4. Diabetes-Specific 2014 Pay-for-Quality Measure

Measure	Measure Description	STAR	STAR+PLUS
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

Disease Management Programs

To ensure Medicaid managed care organizations are meeting all state and federal requirements related to providing care to Medicaid members, the external quality review organization conducts managed care organization administrative interviews and on-site visits to assess multiple domains, including MCO care coordination and disease management programs. HHSC requires that all managed care organizations participating in STAR, STAR+PLUS, and CHIP provide disease management services covering diabetes.

Managed care organizations are evaluated by the external quality review organization (EQRO) on components of their disease management programs through the EQRO Administrative Interview process. Managed care organizations complete the administrative interview tool online and are required to provide supporting documentation. For example, when describing disease management programs, the managed care organization must provide copies of all evidenced-based guidelines used in providing care to members. The EQRO analyzes all responses and documents and generates follow-up questions for each managed care organization, which are administered during in-person site visits and conference calls.

Performance Improvement Projects

The external quality review organization recommends topics for performance improvement projects based on managed care organization performance results, data from member surveys,

administrative and encounter files, medical records, and the immunization registry. HHSC selects two of these goals, which become projects that enable each managed care organizations to target specific areas for improvement that will affect the greatest numbers of members. These projects are specified and measurable, and reflect areas that present significant opportunities for performance improvement for each managed care organization. A potential topic for STAR and STAR+PLUS 2014 performance improvement projects was Comprehensive Diabetes Care.

Texas Medicaid Diabetes Treatment and Prevention Priorities

1. *Texas Medicaid provides coverage for quality screening and treatment services to identify and treat patients with diabetes.*

Prevention, timely diagnosis, and treatment are critical in patients with diabetes mellitus. Many of the complications associated with diabetes, such as nephropathy, retinopathy, neuropathy, cardiovascular disease, stroke, and death, can be delayed or prevented with appropriate treatment of elevated blood pressure, lipids, and blood glucose. Quality screening and treatment of the complications of diabetes mellitus have the potential to improve quality of life and increase life expectancy.[2]

Diabetes Screening and Treatment in Texas Medicaid

Diabetes screenings and treatments are available for adults and children through Medicaid Fee-for-Service (FFS) and Managed Care Health Plans as medically indicated.

Currently Medicaid FFS 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.

Medicaid MCOs are responsible for providing all services and benefits available to Medicaid FFS clients to the MCO's Medicaid members, with the exception of non-capitated services (non-capitated services are those services that are unavailable through a managed care client's health plan, but are available for that client as FFS).[14] Medicaid MCOs must provide the services and benefits described in the most recent *Texas Medicaid Provider Procedures Manual* and in updates to the manual provided through *Texas Medicaid Bulletins*.[15]

2. *Texas Medicaid provides coverage for pre-diabetes and diabetes disease self-management education.*

As stated by the American Diabetes Association (ADA), diabetes self-management education (DSME) is the ongoing process of facilitating the knowledge, skill, and ability necessary for

[14] Uniform Managed Care Contract Terms and Conditions, Version 2.2, Section 8.2.2.8. Accessed November 2014 at: http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf
[15] Uniform Managed Care Contract Terms and Conditions, Version 2.2, Section 8.1.2. Accessed November 2014 at: http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf

diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. [3]

Pre-Diabetes, Diabetes Disease Self-Management Education and Texas Medicaid

Currently self-management education and other related services for children and eligible adult clients with diabetes are provided through regular physician/client consultation for clients enrolled in the Medicaid FFS program, as well as through the Texas Medicaid Wellness Program.

The Texas Medicaid Wellness Program replaced the Disease Management program that was mandated by Human Resources Code 32.057 & 059, and provides comprehensive care management services for high-cost/high-risk fee-for-service clients. The Wellness Program includes a diabetes self-management training (DSMT) component and offers ten hours of DSMT plus three hours of nutritional counseling to all patients who have diabetes.

3. Texas Medicaid provides coverage for gestational diabetes screenings.

Numerous national and international medical organizations, along with expert panels and working groups, have issued specific guidelines with recommendations for screening and diagnosing Gestational Diabetes Mellitus (GDM). In 2001, the American College of Obstetricians and Gynecologists recommended that all pregnant women should be screened for GDM, whether by patient history, clinical risk factors, or laboratory testing.

Gestational Diabetes Screenings and Texas Medicaid

Gestational diabetes screening is currently available through Pregnant Women's Medicaid, CHIP, and Managed Care as medically necessary.

4. Dialogue with advisory bodies and external stakeholders to inform the development and improvement of Medicaid diabetes programming and benefits

HHSC has worked with the TDC and other stakeholders in the development of this report. HHSC is committed to providing individuals with pre-diabetes or diabetes in an effective and evidence-based manner that is responsive to their needs. Stakeholder involvement is critical to that goal and HHSC will continue to incorporate stakeholder feedback into its diabetes policies whenever possible.

Conclusion

S.B. 796, 82nd Legislature, Regular Session, 2011, requires HHSC to coordinate with the Texas Diabetes Council to develop three reports on the prevention and treatment of diabetes in Texas. This report provides four priorities for HHSC focused on the treatment and prevention of diabetes among Medicaid participants. These priorities include the provision of: quality

screening and treatment services to identify and treat patients with diabetes; pre-diabetes and diabetes disease self-management education; and gestational diabetes screening as medically indicated. A final critical priority is for HHSC to continue to dialogue with advisory bodies and external stakeholders to inform the development and improvement of Medicaid diabetes programming and benefits. Ensuring the information provided by this report and the two other reports required by S.B. 796 is readily available will help the state and interested stakeholders identify potential areas of improvement for diabetes-related services.

Appendix: Medicaid Expenditures Related to Diabetes

Table 1. Medicaid Expenditures for Diabetes-related Claims, fiscal years 2010-2013 (FFS and PCCM)

	Total FFS and PCCM clients	Percent of Clients with Diabetes Claims[1]	Number of Diabetes Clients	Number of Diabetes Claims	Claims per Client	Amount Paid	Amount Paid per Client	Amount Paid per Claim
FY2010								
Age < 21	2,550,641	0.2%	6,348	43,076	7	$9,763,858.79	$1,538.10	$226.67
Age >= 21	1,201,933	17.4%	209,244	1,652,806	8	$91,750,229.10	$438.48	$55.51
Total[2]	3,731,908	5.8%	215,459	1,695,882	8	$101,514,087.89	$471.15	$59.86
FY2011								
Age < 21	2,567,083	0.3%	6,428	46,299	7.20	$10,190,266.60	$1,585.29	$220.10
Age >= 21	1,284,688	16.6%	213,090	1,599,892	7.51	$89,990,127.77	$422.31	$56.25
Total[2]	3,828,800	5.7%	219,375	1,646,191	7.50	$100,180,394.37	$456.66	$60.86
FY2012								
Age < 21	2,403,880	0.2%	5,142	34,202	6.65	$8,179,448.82	$1,590.71	$239.15
Age >= 21	1,260,586	16.0%	201,875	1,370,039	6.79	$51,332,151.71	$254.28	$37.47
Total[2]	3,644,796	5.7%	206,929	1,404,241	6.79	$59,511,600.53	$287.59	$42.38
FY2013								
Age < 21	1,551,320	0.2%	3,450	25,195	7.30	$6,390,669.26	$1,852.37	$253.65
Age >= 21	1,255,843	14.1%	177,443	1,141,900	6.44	$29,304,154.02	$165.15	$25.66
Total[2]	2,526,535	7.2%	180,823	1,167,095	6.45	$35,694,823.28	$197.40	$30.58

[1]Diabetes Related Claims is defined as claims with primary diagnosis of ICD-9-CM 250. Claim Types included are Physician, Outpatient and Inpatient Hospital. Crossover claims,

which are those with Medicare as the primary payer while Medicaid pays any coinsurance, are included.

[2]Unduplicated Number of Eligibles and Diabetes Clients.
Age is based on the age of the client on the date of service.

Data Source: FFS and PCCM data were selected from the Texas Medicaid and Health Partnership (TMHP) Ad Hoc Query Platform (AHQP) Claims Universe.

Prepared By: Research Team, Strategic Decision Support, Texas Health and Human Services Commission, Feb, 2014.(wl)

Table 2. Medicaid Expenditures for Diabetes-related Encounters, fiscal years 2010-2013 (STAR and STAR+PLUS)

	Eligible STAR/ STAR+PLUS Clients	Percentage of Clients with Service	Number of Diabetes Clients	Number of Diabetes Encounters[1]	Encounters per Client	Amount Paid[2]	Amount Paid per Client	Amount Paid per Encounter[2]
FY2010								
STAR Age < 21	1,975,623	0.3%	5,223	29,100	5.57	$6,633,570.42	$1,270.07	$227.96
STAR Age >= 21	210,418	1.9%	4,007	16,338	4.08	$2,431,188.93	$606.74	$148.81
Total[3]	2,179,317	0.4%	9,200	45,438	4.94	$9,064,759.35	$985.30	$199.50
STAR+PLUS Age < 21	10,167	1.2%	127	967	7.61	$118,203.03	$930.73	$122.24
STAR+PLUS Age >= 21	180,363	15.3%	27,613	352,508	12.77	$98,827,343.40	$3,579.02	$280.35
Total[3]	190,147	14.6%	27,732	353,475	12.75	$98,945,546.43	$3,567.92	$279.92
FY2011								
STAR Age < 21	2,142,487	0.3%	5,390	33,144	6.13	$7,598,833.45	$1,405.11	$229.27
STAR Age >= 21	224,715	2.4%	5,408	22,059	2.06	$3,332,312.00	$310.47	$151.06
Total[3]	2,360,287	0.5%	10,733	55,203	5.14	$10,931,145.45	$1,018.46	$198.02
STAR+PLUS Age < 21	11,082	1.5%	163	1,112	6.82	$163,531.86	$1,003.26	$147.06
STAR+PLUS Age >= 21	275,017	13.7%	37,714	433,637	11.50	$117,374,647.26	$3,112.23	$270.67
Total[3]	285,605	13.3%	37,867	434,749	11.48	$117,538,179.12	$3,103.97	$270.36

FY2012								
STAR Age < 21	3,109,979	0.2%	6,756	40,931	2.19	$8,845,542.86	$473.25	$216.11
STAR Age >= 21	387,413	4.8%	18,691	75,910	2.99	$10,176,453.08	$400.27	$134.06
Total[3]	3,487,859	0.7%	25,424	116,841	4.60	$19,021,995.94	$748.19	$162.80
STAR+PLUS Age < 21	23,734	1.2%	296	2,104	7.11	$382,393.18	$1,291.87	$181.75
STAR+PLUS Age >= 21	422,864	14.5%	61,237	654,161	10.68	$183,141,626.91	$2,990.70	$279.96
Total[3]	445,896	13.8%	61,522	656,265	10.67	$183,524,020.09	$2,983.06	$279.65
FY2013								
STAR Age < 21	3,112,050	0.2%	6,936	48,704	2.14	$10,289,013.10	$452.30	$211.26
STAR Age >= 21	400,593	5.7%	22,748	129,188	4.36	$17,073,657.18	$575.65	$132.16
Total[3]	3,503,120	0.8%	29,660	177,892	6.00	$27,362,670.28	$922.54	$153.82
STAR+PLUS Age < 21	22,620	1.4%	314	2,512	8.00	$430,805.93	$1,371.99	$171.50
STAR+PLUS Age >= 21	425,614	15.7%	66,639	770,214	11.56	$215,572,183.87	$3,234.93	$279.89
Total[3]	447,588	15.0%	66,941	772,726	11.54	$216,002,989.80	$3,226.77	$279.53

Notes:

[1] Diabetes Related Encounters is defined as encounters with primary diagnosis of ICD-9-CM 250.

[2] Health Maintenance Organizations participating in Medicaid Managed Care in Texas are paid on a capitation basis, and not on a fee-for-service basis. Therefore, any dollar amounts provided for Managed Care are estimates only and reflect amounts paid by the health plans.

[3]Unduplicated Number of Eligibles and Diabetes Clients.

Age is based on the age of the client on the date of service.

Data Source: STAR and STAR+PLUS data were selected from Enc_Best Picture Universe, TMHP.

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