



HHSC Regional Healthcare Partnership Planning Summit

Dr. Ben Raimer, Presiding Officer
The Texas Institute of Health Care Quality
and Efficiency
Board of Directors
August 7, 2012



The Texas Perspective

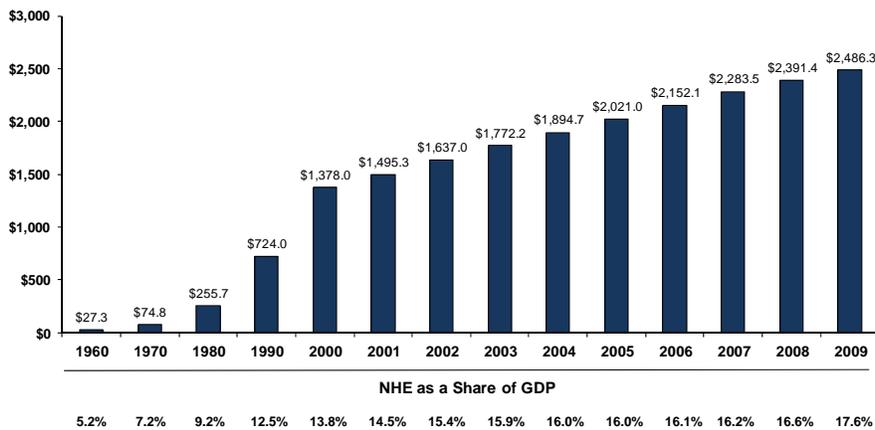
- Among fastest-growing populations in U.S.
- Highest uninsured rate in the nation
- 2 million more Texans will be newly insured over next 10 years
 - Enrollment will require major investments in people, new technologies
- Significant shortage/mal-distribution of health professionals
 - 42nd in percentage of doctors to population
 - 47th in percentage of nurses to population
 - No increase in GME slots in 10 years;
 - Half who leave for GME never return; 80% who do residency in state stay
 - Scope-of-practice issues
- Reimbursement a disincentive to provider participation
- Dead last (#51) in all major health rankings nationally in 2012!

Hallmarks of a Rescue Care System

- Infant mortality rate of 6.7 per 1,000 live births places U.S. in 4 highest among 34 industrialized countries
- Life expectancy at birth of 78.2 years places U.S. 8th lowest among 34 industrialized countries
- 1 in 2 Americans (133M) has a chronic condition; number will rise to 157M by 2020
 - 4 out of 5 U.S. health care dollars (78%) are spent on people with chronic conditions

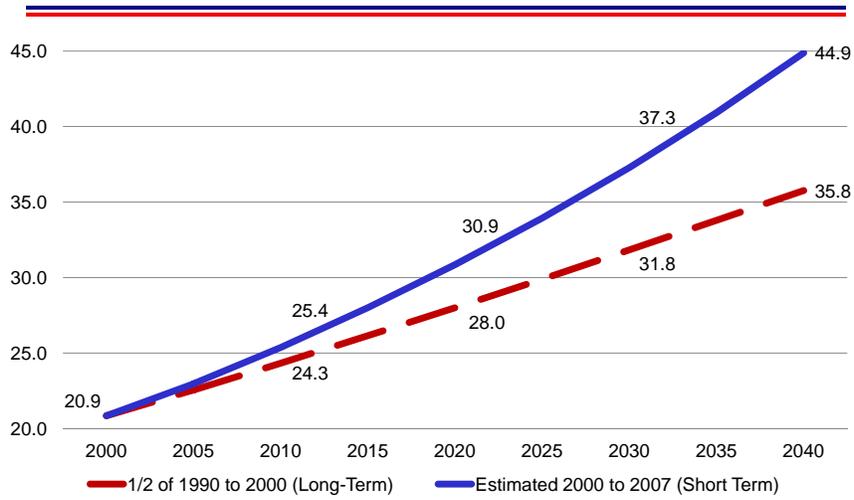
Sources: Infant mortality and life expectancy, Organization for Economic Co-operation and Development, 2008 (OECD Health Data 2011); The Growing Burden of Chronic Disease in America, Public Health Reports, May/June 2004

National Health Expenditures as Share of GDP



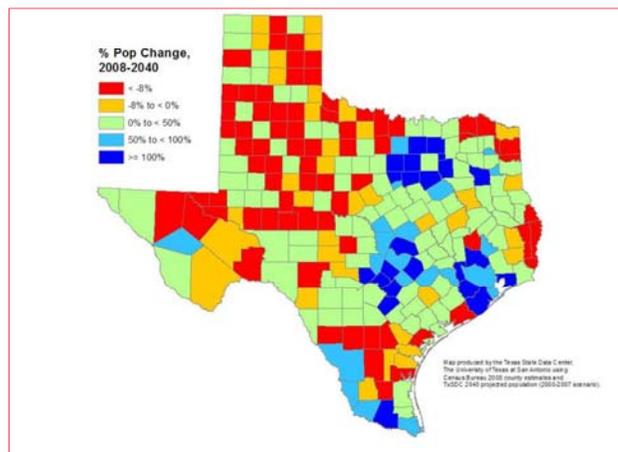
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

Projected Population of Texas



Source: Texas State Data Center Population Projections

Projected Percent Change in Total Population Texas Counties (2008-2040)





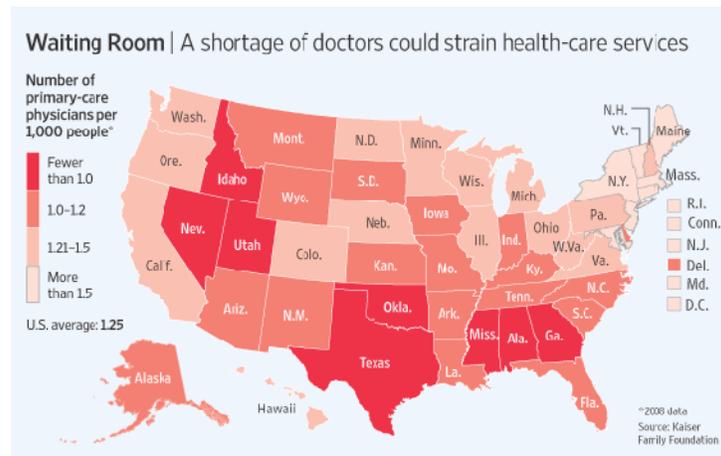
Workforce Shortages and Maldistribution

- There is a shortage of all health professions in Texas with the exception of LVNs
- Physicians, registered nurses, physical therapists, clinical laboratory scientists, occupational therapists, dentists, audiologists, and other health care professionals all number LESS per 100,000 population than the national averages
- In addition, the supply of health professionals in rural and border areas is even far LESS than it is in urban and non-border areas
- 73 percent of the counties in Texas are designated Health Professions Shortage Areas
- The most severe shortages in the health professions are in the area of mental health services

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Primary Care Physician Shortages



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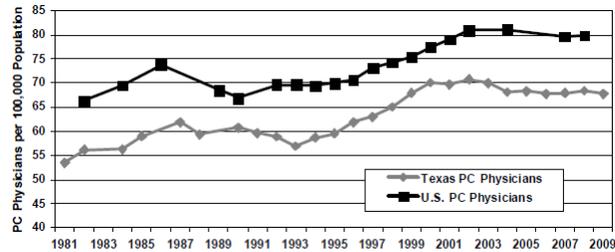
Primary Care Physicians

2009 Texas PC Physician Facts:

Total: 16,830

White 58.2%
 Black 6.1%
 Hispanic 14.4%
 Other 21.1%
 Male 64.9%
 Female 35.1%

Median Age Male 52
 Median Age Female 43



Providers/100,000 Population

Border Metropolitan 51.4
 Non-Border Metropolitan 71.9
 Border Non-Metropolitan 35.5
 Non-Border Non-Metropolitan 54.7

Physician Distribution – A Type of Shortage!

As of April 2009 there were 118 Whole County Health Profession Shortage Areas (HPSAs) for primary care, and 109 sub-county geographic or special population HPSAs in Texas.

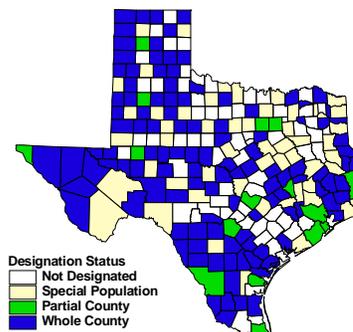
Whole county HPSAs are predominately in rural counties and sub-county HPSAs are predominately in urban counties.

5,245,681 people lived in HPSAs.

More people live in Partial County HPSAs than Whole County HPSAs

It was estimated that 542 primary care physicians would have been needed to alleviate the mal-distribution.

Federally Designated Health Professional Shortage Areas (HPSAs) Texas April 2009

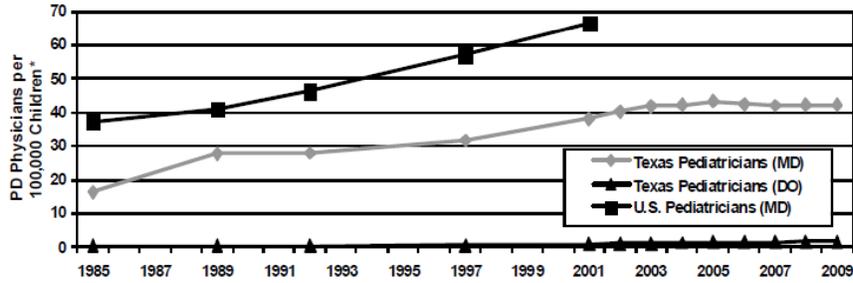


Designation Status
 Not Designated
 Special Population
 Partial County
 Whole County

Ratio needed to qualify – 3,500:1
 Texas 2009 ratio – 1,478:1

2009 Harris Ratio with 3,059 physicians = 1,313:1
 # Physicians for 3,500:1 ratio = 1,146
 Harris could lose 1,913 physicians and not qualify as shortage area

Pediatric Workforce



While the Texas general pediatrician to pediatric population ratio increased by 65% between 1996 and 2008, it consistently remains lower than the national average.

Psychiatrists

2009 Texas Psychiatrist Facts:

Total: 19,579

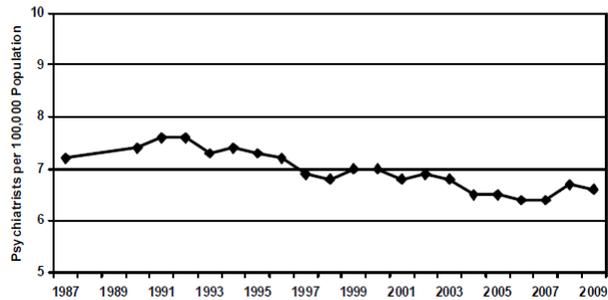
White 64.0%
 Black 3.5%
 Hispanic 12.4%
 Other 20.1%

Male 63.9%
 Female 36.1%

Median Age Male 57
 Median Age Female 50

Providers/100,000 Population

Border Metropolitan 2.8
 Non-Border Metropolitan 7.6
 Border Non-Metropolitan .8
 Non-Border Non-Metropolitan 3.0





Health Care Reform: The Pressing Issues

- Access
- Capacity of workforce to meet increased demand
- Funding for “safety net” role of academic health centers
- Capacity of hospitals to provide services for newly and remaining insured
- Reimbursement for services at fair rate
- Cost of expanding federal programs, particularly in highly populated states
- Need for new delivery models (efficiency, effectiveness, cost)
- Better use of health information technology
- Funding for GME

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Institute for Healthcare Quality and Efficiency

Structure and Administration of the Institute:

- Established by Article 3 of S.B. 7 (82nd Regular Legislature, First Called Session, 2011)
- Governed by a board of 15 directors appointed by the Governor
- The Board includes ex officio, nonvoting board members representing state agencies.

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Institute for Healthcare Quality and Efficiency

General Responsibilities of the Institute:

- Institute is charged with issuing recommendations in three general areas:
 - Improving the quality and efficiency of health care delivery
 - Improving the reporting, organization, and transparency of health care information
 - Supporting the implementation of innovative health care collaborative payment delivery systems

Institute for Healthcare Quality and Efficiency

Institute Work Plan:

- Appointments to the Board of Directors were made in March 2012
- Initial meeting of the Institute Board in Austin, May 24, 2012 and continue monthly
- Aggressive initial work plan to complete required reports and recommendations for consideration during the 83th Legislative session



Institute for Healthcare Quality and Efficiency Initial Deliverables

1. Maximizing benefits from the current health data and information infrastructure

- Assess all health-related data collected by the state, its availability, and its benefit
- Develop a plan for consolidating and enhancing reporting from existing data with the goal of improving the transparency of health care services delivered in the state
- Conduct the assessment in collaboration with DSHS
- Issue a report with recommendations to the Legislature by December 2012

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Institute for Healthcare Quality and Efficiency Initial Deliverables

2. Building the next generation health data and information infrastructure

- Study the feasibility and desirability of establishing a centralized database of healthcare claims across all payors, known as an all payor claims database
- Consider other additional collection of healthcare information not required under current law
- Consult with DSHS and TDI
- Issue a report with recommendations to the Legislature by December 2012

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Institute for Healthcare Quality and Efficiency Initial Deliverables

3. Promoting an efficient and accountable health care system

- Evaluate options for the Legislature to consider to promote a consumer driven health care system
- Examine the issue of providers charging different payors different amounts for the same or similar services (price discrimination)
- Coordinate with TDI to issue a report with recommendations by January 2013

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Institute for Healthcare Quality and Efficiency Initial Deliverables

4. Measuring and reporting health care quality and efficiency

- The Institute is charged with determining outcome measures and developing recommendations for measuring quality and cost effectiveness
- Under this charge, the Institute will collaborate with DSHS, with DSHS acting as the lead, on the following projects:
 - Public reporting on potentially preventable readmissions and complications for Texas hospitals
 - Identification of potentially preventable health conditions that occur in long-term care facilities
 - Development of a program to recognize exemplary health care facilities for superior quality performance (recommendations due December 2012)

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SB 7 related HHSC Medicaid quality initiatives

- Patient-Centered Medical Homes
 - Report due December 1, 2013 on promoting and providing incentives for Medicaid HMOs
- Physician Incentive Programs
 - Report due August 31, 2012 on physician incentive programs used in HMOs to reduce ED use for non-emergency visits
- Implement 1115 waiver for HMO expansion and UPL funds (Texas Transformation waiver)
 - Includes Delivery System Reform Incentive Payments



Medicaid/CHIP Quality-Based Payment Advisory Committee

S.B. 7 requires the following of HHSC:

- In consultation with committee, HHSC shall develop quality-based outcome and performance measures for Medicaid/CHIP that:
 - Promote efficient, quality healthcare
 - Includes fee for service and managed care
 - Consider measures addressing potentially preventable events
 - Take into account patient risk factors
 - Are similar to those used in private sector, as appropriate
- In consultation with committee, HHSC shall use the outcome and performance measures to:
 - Align payment incentives with high quality and cost effective care
 - Incentivize best practices
 - Promote coordinated care and collaboration
 - Promote effective delivery models and payment systems
 - Coordinate with other HHSC initiatives (EDW, MITA, ICD-10)

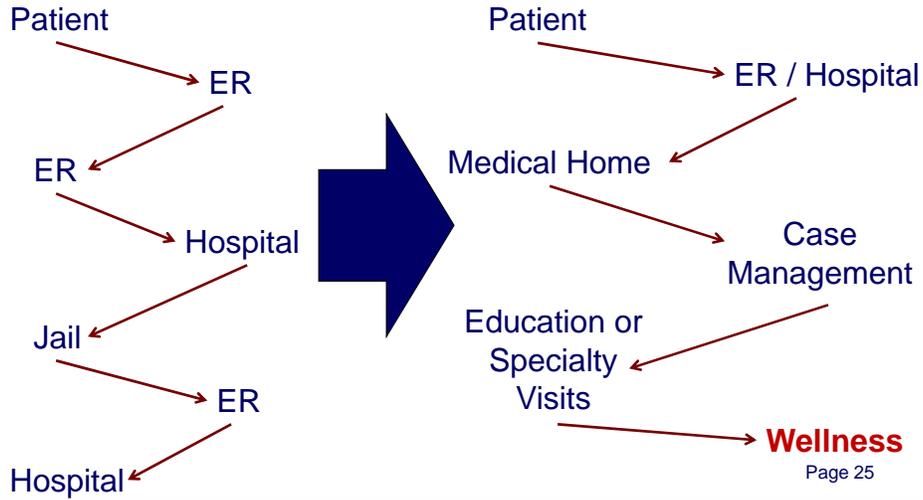
Related Advisory Committees/Councils

- Physician Payment Quality Committee – Rider 68
 - Determine the ten most overused services performed by physicians in Texas Medicaid. No timeline in rider; goal to identify prior to next session
 - HHSC shall decrease Medicaid payments for those services that should not be provided
- NICU Council – HB 2636
 - Develop standards for operating a NICU in the state
 - Develop accreditation process for NICUs to receive Medicaid reimbursement
 - Study and make recommendations regarding best practices and protocols to lower NICU admissions
 - Report by January 1, 2013 its findings and recommendations

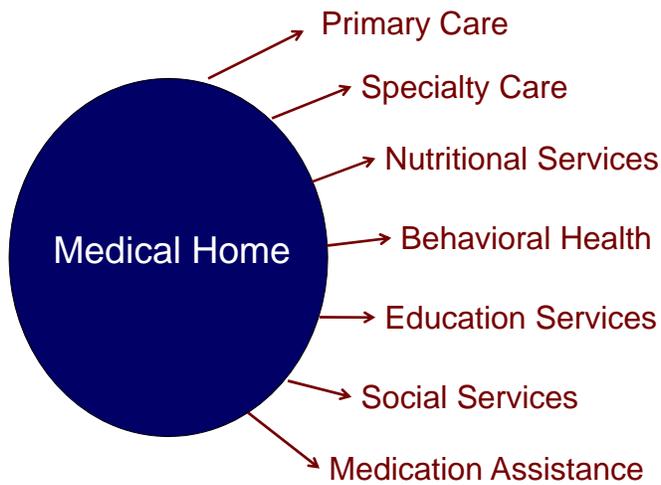
Reducing non-medically necessary induced Deliveries or C-sections – HB 1983

- Starting October 1, 2011, Medicaid implemented non-payment for elective inductions prior to 39 weeks gestational age
- Claims submitted for payment must have certain modifiers to indicate one of the following three conditions:
 - Delivery was at 39 weeks gestation or later
 - Delivery was prior to 39 weeks of gestation and medically necessary
 - Delivery was prior to 39 weeks of gestation and not medically necessary
- No payment is made for non-medically necessary delivery prior to 39 weeks
- HHSC uses a retrospective review process based on modifiers and review of medical records

Changing the Patient Experience



Integrate Resource Management





Building the New Health Care Delivery Model

Required Resources:

- Information Technology / Information Systems
- Electronic Health Records
- Case Management Systems
- Community Health Workers
- Telemedicine
- Quality and Effectiveness Data
- Business Intelligence Systems
- Culturally competent health professions workforce

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Vision for the Future

- Texans should enjoy access to the highest quality and most efficient health care in the world
- All Texans should have access to information necessary to make informed decisions regarding their health care
- Health Education and Prevention Programs should be readily available to all Texans

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Thank You



Ben G. Raimer, MD

Presiding Officer for The
Texas Institute of Health
Care Quality and Efficiency
Board of Directors

Email: bgraimer@utmb.edu

Web: www.utmb.edu/hpla

Blog: <http://blog1.utmb.edu/hpla>