Texas Leadership Roundtable Series on Healthcare

Number of Covered Lives Task Force

Principles and Recommendations for Improving Health Outcomes & Lowering Healthcare Costs:

Principle: Ensure that individuals, whether insured or uninsured, have access to and are connected to care. Ongoing development of provider capacity and delivery system innovation is important for addressing health care needs and challenges.

Recommendations:

1. Increase primary care capacity by:

    a. Creating primary care residency positions to match the number of Texas medical school graduates that will enter that respective field.

    b. Restoring funding for the Physician Education Loan Repayment Program, for physicians that agree to practice in health profession shortage areas. Also restore funding for Family Practice Residency Programs and the Texas Statewide Family Medicine Preceptorship Program.

    c. Developing public-private partnerships in order to increase general medical education slots.

    d. Strengthening the primary care infrastructure with nurse practitioners and physician assistants, who practice in association with physicians. Some of Texas' innovative models for scaling up the primary care infrastructure include school-based health clinics and convenient-care clinics.

2. Decrease fragmentation in service delivery and program funding. Consolidate funding for public health coverage in order to decrease funding fragmentation.

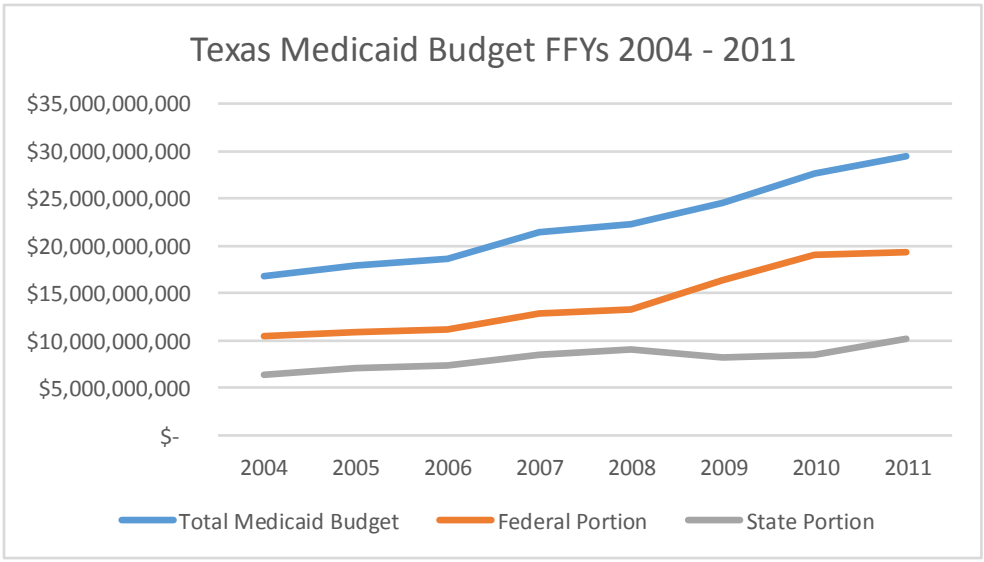
3. Pilot innovative payment strategies to incentivize integration of care within and across provider organizations for episodes of care, as opposed to incentivizing greater volumes of services.

4. Increase the utilization of patient-centered medical homes. Pilot innovative payment strategies to incentivize the creation and maintenance of patient-centered medical homes.

5. Strategically target high healthcare utilizing patients for intervention and closer management.

BACKGROUND:

In Texas fiscal year 2011 there was a monthly average of approximately 4 million Medicaid recipient months, which when compared to a 2004 average of 3,093,092 represents an increase of 33% in the monthly caseload.[1] Total Texas Medicaid spending in 2004 was approximately $16.8 billion of which $6.3 billion was state funding. Total funding in 2011 grew to $29.4 billion ($10.1 billion in state funding).[2] While the monthly caseload grew by 33% from 2004 to 2011, total Medicaid funding grew by almost 75%.



The growth in Medicaid funding is partially related to the increase in Medicaid recipients for children, which in 2011 represented 66% of Medicaid recipients but only 33% of expenditures. The Aged (65+) and Disability-Related eligibility groups accounted for a disproportionately large amount of Texas Medicaid spending. Only 25% of Texas Medicaid clients were in these two groups but they

accounted for 58% of Medicaid program spending.[3] The disproportionate growth in funding relative to recipient months represents an increase in the more expensive Aged and Disability-Related eligibility groups in the Texas Medicaid program.

While high healthcare costs contain elements of waste, fraud and inappropriate hospital and emergency room use, as mentioned above, a significant cause of the increase over the years is the growth in caseload for the high cost Medicaid eligibility groups. Yet, the rate of increase in cost per Medicaid enrollee is actually lower than for commercial insurance. There are several reasons for this but a major one which is relevant to the issue of accessible medical coverage for Medicaid recipients, is the way that Texas pays for Medicaid. For example, Medicaid inpatient care in Texas is provided through a DRGs (Diagnostic Related Groups) payment methodology that prospectively relates hospital payment to the cost of the patient's diagnosis. In Texas DRG payments to hospitals are roughly matched at a 60%/40% rate, with the state putting up 40% of the DRG payment and the Center for Medicare and Medicaid Services (CMS) providing the 60%. Texas uses general revenue (GR) as the state share of this 60/40 match. However, to reduce the cost to the state, Texas only pays approximately 58% of the allowed Medicaid costs to hospitals, which means that hospitals treating Medicaid patients, (which in Texas are largely private hospitals), have approximately 42% of their cost unpaid. Texas can "underpay" the Medicaid cost because it essentially shifts the other 42% of the cost to two Medicaid supplemental payment pools where Texas' share of the 60/40 match is funded by local communities and not by state GR. This cost shifting essentially reduces the amount of GR needed to fund Medicaid inpatient costs however, it creates a significant burden on local communities.

While the state's cost shifting to local communities has been going on for years, primarily through the Medicaid Disproportionate Share Hospital (DSH) supplemental payment program, and more recently through the Medicaid 1115 waiver's Uncompensated Care Pool, the ability to continue this cost shifting strategy is being called into question.[4] Because CMS rules prevent private hospitals from providing the state match, a relatively small number of public hospitals provide the match for not just themselves but also for the private hospitals. However, these public hospitals' ability and willingness to continue with this match is fading, and the result is that the inpatient and outpatient coverage provided by private hospitals is being threatened.

In Texas there is a need for greater education on public policy and a clearer understanding of healthcare cost dynamics. Other factors also impact the cost of care. For example, the data show that areas with higher rates of the uninsured have higher healthcare costs as illustrated in the map and table below.[5,6] For example, the impact of the uninsured on healthcare costs or methodologies to control the cost of high service utilizers. With more individuals covered by Medicaid, and a potential Medicaid expansion, the primary care infrastructure needs to be strengthened. This effort would require conversations about the number of medical schools, how to attract healthcare providers, and establishing community clinics. The primary care capacity issue needs to be clearly articulated, with examples of how to define primary care gaps, how to identify high utilizers, and how to find an increase in capacity. Today, 22.1% of the Texas state population lives in a Primary Care Health Professional Shortage Area (HPSA), with a population to primary care physician ratio of ≥3,500:1.[7] With currently 25,060 professionally active primary care physicians, Texas needs 1,523 additional primary care practitioners to achieve the Health Resources and Service Administration's target ratio of 2,000:1.[8] As mental health services are a central aspect of primary care, there is also an acute shortage of mental health care professionals – 68% of the Texas population lives in a HPSA for mental health.[9] The primary care and mental health healthcare professional shortages occur in both rural and urban areas.

Healthcare Referral Region (Dartmouth Atlas)	Total Medicare Reimbursements Per Enrollee	% Uninsured
McAllen	$15,695	34%
Harlingen	$13,531	30.60%
Corpus Christi	$11,068	22%
Houston	$10,503	30.80%
Dallas	$10,430	33.10%
Victoria	$10,248	23.80%
Odessa	$9,747	26.30%
Fort Worth	$9,670	24.80%
Wichita Falls	$9,448	20.60%
San Antonio	$9,188	22.40%
San Angelo	$9,174	21%
Amarillo	$9,062	22.80%
Austin	$8,794	23%
Bryan	$8,788	21.20%
El Paso	$8,353	28%
Abilene	$8,277	18.50%

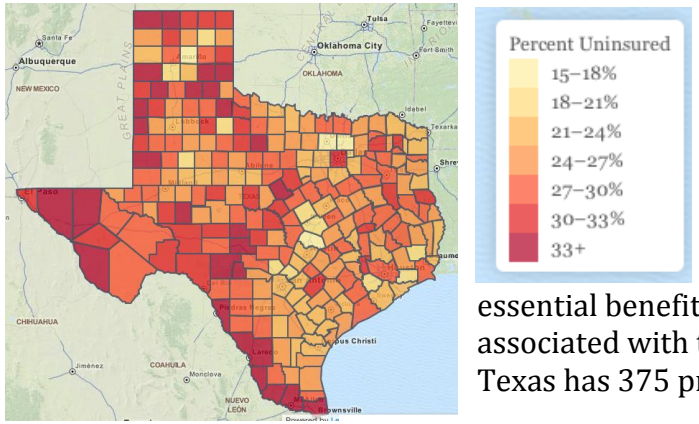
Source: Dartmouth Atlas & U.S. Census Report

The Medical Group Management Association reports that primary care physicians receive a 55% lower total median annual compensation than physicians practicing in subspecialties.[10] At the same time, following training, new physicians face an average of $157,944 in educational debt, making primary care positions less attractive.[11] In order to achieve a physician population with 40% practicing primary care, experts say their average income should be at least 70% of the income of other physicians.[12] For physicians in training, if additional first-year residency positions are not added, 180 Texas medical school graduates will be unable to enter a Texas residency program by 2016. This problem corresponds to a $30.2 million loss on investment, with the State investing $168,000 educating each medical graduate.[13] Texas needs to increase the number of residency positions to have 10% more than the total number of Texas medical student graduates.

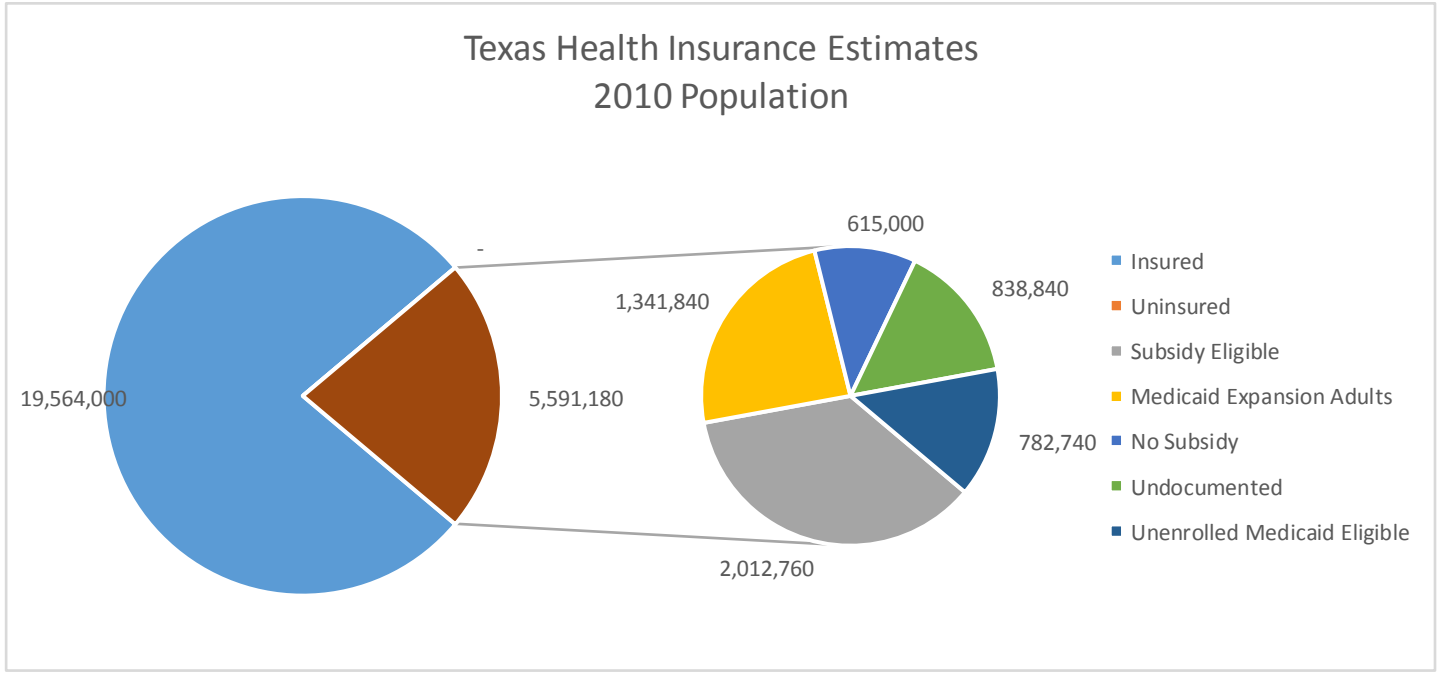
The primary care infrastructure can also be strengthened for example with Nurse Practitioners and Physician Assistants, who practice in association with physicians. These healthcare professionals are cost effective because while the quality of their primary care services is on par with that of physicians.

Uninsured & the Affordable Care Act

Uninsured Texans lack access to preventative care nor can they afford access to primary care. As a result they typically access hospital emergency departments when their illnesses have become more severe than they may otherwise need to be. This treatment pattern for the uninsured increases the cost of healthcare and while creating substantial inefficiencies in the delivery system.



From the graph below it can be seen that of the 25 million Texans in 2010 approximately 5.6 million were uninsured, and of these, just over 2 million (34% of the uninsured) are eligible for tax subsidies under the Affordable Care Act (ACA) while another 1.3 million (23%) are eligible for Texas Medicaid under the expanded eligibility criteria.[14] The map at the left shows the distribution of the uninsured throughout the state. During the first ACA open enrollment, it was estimated that approximately 700,000 to 800,000 Texans signed up for insurance. While ACA presents opportunities for Texans to be insured, and eligible for the essential benefits that qualified health plans must offer, it also tends to exacerbate issues associated with the shortage of primary care practitioners. According to Kaiser's analysis, in 2014, Texas has 375 primary care HPSA designations with only 71% of these areas having their need for primary care physicians met if the minimum definition of 1 practitioner per 3,500 population is used as opposed to the target ratio of 1 to 2000.[15] However, this picture is made more complex when one considers the type of payor. Texas, as discussed previously,



significantly underpays Medicaid providers, with the state relying on supplemental payment methodologies to bring payments closer to costs. As the uninsured continue to enroll in the insurance Marketplace there will be a greater discrepancy between Medicaid and commercial insurance in provider payments.

"An adequate physician supply is important for the effective and efficient delivery of health care services and therefore, for population health and the cost and quality of health care. Assessments of the adequacy of physician supply often focus on three dimensions of the physician population: its size; its composition, (e.g., the mix between primary care and specialty physicians); and its geographic distribution."[16] While the passage of ACA will surely "…affect the demand for physician services, (i.e., physician supply), it also includes provisions that may affect the size, composition and geographic distribution of the physician population by supporting changes to physician training, compensation, and practice."[17] With respect to size, the ACA authorizes $230 million to increase the number of medical residents as well as funding to increase the number of nurse practitioners and physician assistants trained in primary care. The ACA also created the Teaching Health Center Program to move primary care training into community-based settings to support training of over 600 new primary care physician and dental residents by 2015. To encourage more medical residents to pursue careers in primary care, the ACA redistributed unused residency positions and directed those slots for the training of primary care physicians.[18]

While the ACA identifies multiple strategies for encouraging the growth in primary care, how CMS develops the methodologies for implementation can shape the impact of these initiatives on Texas. For example, according to the Texas Medical Association (TMA), the redistribution of residency slots has had a negative impact on Texas.[19] Apparently CMS's methodology resulted in Texas losing 50 direct graduate medical education slots and 40 indirect medical education positions from 21 hospitals.

Texas' 83rd Legislature appropriated $2 million toward funding psychiatric residency slots at both state psychiatric hospitals and local mental health community centers. The hospitals will partner with colleges and universities that are accredited by the Accreditation Council for Graduate Medical Education. The Department of State Health Services' Texas Primary Health Care Office oversees cooperative agreement funding from the U.S. Department of Health and Human Services, Health Resources and Services Administration to support recruitment and retention of health professionals across the state. DSHS also oversees Texas' Conrad 30 program, which places foreign physicians in medically underserved areas.[20]

Another Texas program that is has potential for increasing access to primary care practitioners is the Texas Medicaid 1115 waiver. Over the five years of the waiver (October 2011 to September 2016) the Delivery System Reform Incentive Pool (DSRIP) has almost $12 billion to fund 1,500 projects throughout the state. While there are variations in the type of project, the most frequent project type is access to primary care and many of these DSRIP projects involve hiring primary care practitioners.

Other Considerations

As the primary care workforce is expanded, fragmentation of the Texas healthcare system—both in service delivery and in program funding—must also be reduced. Service delivery fragmentation is not unique to the Medicaid: patients across all types of insurance coverage often must navigate multiple different types of healthcare providers in several different care settings, resulting in costly inefficiencies such as duplicate testing, preventable hospital admissions and readmissions, and other medical errors and waste. For the low-income population, the problem of service delivery fragmentation is compounded by funding fragmentation and non-uniform eligibility guidelines for various programs. The fragmentation of the healthcare system also impact providers with delays in reimbursement and higher administrative costs.

For example, Medicaid alone has seven different eligibility groups, with six different income-based eligibility limits. In addition to general health benefits coverage, Medicaid also includes programs such as Medicaid for Breast and Cervical Cancer and the Women's Health Program. Because many uninsured, low-income groups, such as uninsured adults and parents making over 26% of the Federal Poverty Level (about $6,000 a year for a family of four) are not eligible for Medicaid, the program must be supplemented by additional programs and funding sources.

These disparate sources include, but are not limited to:

- County property taxes for indigent care programs;
- State supplemental funds for counties that exceed 8% of their budget on indigent care spending;
- Local property taxes for hospital districts;
- Local property taxes for local mental health authorities (LMHMRAs);
- State funds for LMHMRAs;
- State mental health hospitals and other state mental health programs;
- Local and state dollars for mental health care provided in the criminal justice system;
- Higher charges from hospitals to commercial insurers and self-funded employers to cover the cost of uncompensated care in emergency rooms;
- Community benefit dollars expended by non-profit hospitals for care for low income uninsured;
- Charitable/philanthropic dollars to charity clinics, Federally Qualified Health Centers, hospitals;
- Specified federal grants for kidney disease, HIV/AIDS, family planning, etc.;
- In-kind donations and pro bono services by many physicians;
- Supplemental Disproportionate Share and Upper Payment Limit/Uncompensated Care payments to hospitals via funds and intergovernmental transfers.

Two scenarios are presented below for identical patients, an uninsured pregnant woman experiencing diabetes and later post-partum depression. One illustrates the patient experience that occurs in the current highly fragmented Texas healthcare system. The second patient experience demonstrates the potential of patient-centered medical homes to meet expanded healthcare needs through optimized delivery. In the traditional medical system example, the patient potentially interacts with at least five different agencies, all with different funding mechanisms and different restrictions on eligibility and access. When patients cycle in and out of various

programs and facilities, continuity of care is difficult to maintain. Not only can this fragmentation be confusing for the patient, it can become dangerous when continuity of care is disrupted. The disruptions are both inefficient and costly, and are financially unsustainable. However, in the patient-centered medical home model, the individual receives continuous, comprehensive, coordinated, and convenient care, ultimately resulting in better health outcomes and lower healthcare costs. Fundamentally, primary care capacity and the fragmentation in service delivery and program delivery must be addressed simultaneously to achieve both quality and cost effectiveness in this growing industry.

Lone Star Circle of Care's (LSCC) Patient Centered Medical Home Model	**Traditional Medical System**
Patient: Uninsured pregnant woman with diabetes that later experiences post-partum depression, without access to a medical home	
• The patient calls **LSCC's Member Navigation Center**, where a patient service representative schedules a provider and program registration appointment. Before the appointments, the **LSCC Program Advisor** calls the patient for a program registration interview, and reminds her to bring the proper documents. • The patient has her 1st prenatal appointment with an LSCC provider, and immediately after works with the **LSCC Benefit Specialist** to complete CHIP perinatal application and is assigned to a sliding scale fee for all non-covered services provided. • The patient receives CHIP Perinatal coverage and has 10 – 14 prenatal visits (*Note – Even if patient did not qualify for CHIP, they would have the have the same number of visits). • The designated **LSCC care team** delivers the patient's baby in hospital and the **LSCC outreach team** goes to the hospital to schedule both the follow-up appointments for the mother and child. • The family is rescreened once the baby is born to cover the child under Medicaid/CHIP and the mom is placed on a sliding fee scale. • **OUTCOME:** The mother attends a post-partum visit where she is screened for and diagnosed with post-partum depression. She is provided with affordable behavioral healthcare within LSCC on a sliding fee scale based on Federal Poverty Limit (FPL). The mother's **LSCC family practice and behavioral health providers** coordinate a patient care plan. In addition, discounted prescription	• The patient visits a **charity clinic**, applies for and receives Medicaid. She chooses a private doctor and obstetrician. • The doctors cease being able to help the patient control her diabetes after the delivery of her baby, at which time she loses Medicaid eligibility. • The patient begins to suffer from post-partum depression and is unable to properly care for her diabetes. • She experiences a diabetic emergency and goes to the **county hospital emergency room**. There her post-partum depression is diagnosed, and she is referred to the local mental health authority. • However, the **mental health authority** only treats three diagnoses: severe major depression, schizophrenia, and bipolar disorder. The women's post-partum depression is not severe enough to qualify. • Although she is referred to **other mental health programs**, she has trouble accessing care due to long wait times, confusing eligibility guidelines and her worsening depression. • **OUTCOME:** Finally her condition progresses to severe major depression, and the patient is accepted by the **Mental Health and Mental Retardation Authority (MHMRA).** After some treatment she is transferred to the county psychiatric facility. Meanwhile, other public welfare programs must care for her baby.

medications are obtained at LSCC's in-house Class A pharmacy, if needed.	

Attachment: Case Studies

Today there are many new delivery models and funding mechanisms that are being tested in the market. Texas has the potential to benefit from adapting and implementing these best practices to its unique healthcare environment. The following matrix provides a selection of case-study initiatives that have addressed cost drivers with proven costs savings, and could feasibly be replicated in Texas.

Case Study	Description	Outcomes	Cost Driver	Strategy
Lone Star Circle of Care (LSCC) Amerigroup Medicaid Health Plan Patients	• 1,490 individuals enrolled in the Amerigroup Medicaid health plan list Lone Star Circle of Care as their primary care provider. • With access to a primary care medical home, 94% of these individuals have had at least one office visit between January 1, 2011 and August 31, 2012.	• Receiving primary care during an office visit was associated with fewer visits to the Emergency Department and fewer hospitalizations. o The 94% that had an LSCC office visit were 1.2 times less likely to have gone to the Emergency Department than individuals without any office visits. o The 94% that had an LSCC office visit were 1.3 times less likely to have at least one in-patient hospitalization than health plan patients without any office visits. • Through additional strong outreach and getting the remaining 6% of individuals to make office visits, $24,188 can be saved per year in ER diversion. • In other plans with greater overall enrollment, annual ER diversion costs savings would be approximately $357,284.	• Emergency room and in-patient hospital utilization	• ER Diversion • Patient-Centered Medical Homes
Medical University of South Carolina	• Medical, nursing, pharmacy and health administration students have a semester class where they work as		• A weak primary care capacity that is	• Using integrated care delivery

	a team to solve patient events.[21] • Many medical practices and healthcare systems have begun using integrated care delivery, where teams of practitioners from different levels coordinate to most effectively and efficiently serve their patients. • Graduate health programs have responded by starting inter-professional training models.		insufficient to serve the expanding Medicaid population	teams to enhance access to care
Texas Tech University Health Science Center	• Schools like the Texas Tech University Health Sciences Center have started an innovative Family Medicine Accelerated Track in 2011, where students can enter the workforce earlier by completing the training curriculum in three years.		• A weak primary care capacity that is insufficient to serve the expanding Medicaid population	• Scaling up the primary care practitioner population
University of Texas Health Science Center School of Nursing (UTHSCSA)	• With 85 to 90% of all nurse practitioners entering primary care, and 85% remaining in Texas to practice, nurse practitioners as well as physician assistants and certified nurse midwives are a cost-effective resource to help fill the primary care gap through inter-professional patient care.	• There are 250 nurse-managed health centers in the U.S., and in 2011 - 2012 the UTHSCSA nurse-led clinics had over 15,000 total visits.	• A weak primary care capacity that is insufficient to serve the expanding Medicaid population	• Scaling up the primary care practitioner population

[1] Texas Health and Human Services Commission, in its Preliminary Medicaid Enrollment by Month report, estimates the Medicaid enrollment in August 2011 at 3.7 million. This differs from the case load numbers used in the diagram. Not sure of the reason for the differences, perhaps it is related to the use of "member months". HHSC Medicaid member months search. http://www.hhsc.state.tx.us.

[2] Texas Health and Human Services Commission. Pink Book, Appendix $: Medicaid Expenditure History (FFYs 1987 – 2011).

[3] Texas Health and Human Services Commission. Pink Book

[4] Until 2012 Texas funded hospital costs through the Upper Payment Limit (UPL) supplemental program in addition to the DSH program. UPL, like DSH supplemented the limited DRG payments. However, with the implementation of the Texas Medicaid 1115 waiver, the UPL program was terminated and replaced, in part, by the waiver's UC Pool.

[5] U.S. Census Bureau and Centers for Disease Control and Prevention. Small Area Health Insurance Estimates. SAHIE/State and County by Demographic and Incomes Characteristics 2010. http://www.census.gov/did/www/sahie/

[6] The Dartmouth Atlas of Health Care. Medicare Spending – Total Medicare Reimbursements Per Enrollee, 2007. http://www.dartmouthatlas.org/data/region/

[7] Salinsky E. Health Care Shortage Designations: HPSA, MUA, and TBD. Background Paper No. 75. National Health Policy Forum. June 24, 2010. Available at: http://www.nhpf.org/library/background-papers/BP75_HPSA-MUA_06-04-2010.pdf. Accessed July 10, 2012.

[8] Kaiser Family Foundation. State Health Facts 2012. Available at: http://www.statehealthfacts.org/. Accessed July 10, 2012.

[9] Hogg Foundation for Mental Health and Methodist Healthcare Ministries. Crisis Point: Mental Health Workforce Shortages in Texas. March 2011. Accessed January 22, 2013. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf

[10] Council on Graduate Medical Education. Twentieth Report – Advancing Primary Care. December 2010. Available at: http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf.

[11] American Medical Association. Background, Student Debt Statistics. Available at: http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/medical-student-section/advocacy-policy/medical-student-debt/background.page. Accessed July 13, 2012.

[12] Council on Graduate Medical Education. Twentieth Report – Advancing Primary Care. December 2010. Available at: http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf.

[13] Texas Higher Education Coordinating Board. Graduate Medical Education Report. 82nd Legislature. Regular Session, House Bill 2908. April 2012.

[14] Thomas Suehs: Presentation to the Senate health & Human Services Senate State Affairs Committees on the Affordable are Act, August 2012

[15] Kaiser Family Foundation: Primary Care Health Professional Shortage Areas (HPSAs), April 2014.

[16] Elayne J. Heisler: Physician Supply and the Affordable Care Act. Congressional Research Service, January 2013.

[17] Elayne J. Heisler: Physician Supply and the Affordable Care Act. Congressional Research Service, January 2013

[18] CMS; Creating Jobs by Addressing Primary Care workforce Needs, June 2013.

[19] TMA: Texas Suffers in GME Redistribution, February 202.

[20] Health & Human Services Commission: Strategic Plan 2015-2019, October 2014.

[21] Krupa C. Med Schools Shift Focus to Team-Based Care. American Medical News. March 19, 2012. http://www.ama-assn.org/amednews/2012/03/19/prl20319.htm