



Medicaid Super-Utilizers:
1% of Members = 25% of Costs

Opportunities for Improvement

Presenter: James A. Cooley
Texas Health and Human Services
Commission (HHSC) Medicaid/CHIP
Super-Utilizers Program

October 13, 2015

Texas Medicaid Program

- Jointly funded state-federal program, with approximately 60 percent of costs covered by the federal government and 40 percent of costs covered by state for most services.
- Provides health coverage to more than four million Texans who are low income or have disabilities; 82% are under age 21 (State Fiscal Year 2013)
- In Fiscal Year 2015, Medicaid-CHIP had an all-funds cost of \$25.7 billion

CMS: 1% of Medicaid = 25% of costs

CMCS Informational Bulletin

DATE: July 24, 2013

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality**

“A disproportionate share of health care spending in the United States is used to provide care to a relatively small group of patients, with 1% of the population accounting for 22 percent of total health care expenditures annually. The distribution of spending is even more uneven within Medicaid, with just 5 percent of Medicaid beneficiaries accounting for 54 percent of total Medicaid expenditures and 1 percent of Medicaid beneficiaries accounting for 25 percent of total Medicaid expenditures. Among this top 1 percent, 83 percent have at least three chronic conditions and more than 60 percent have five or more chronic conditions.”

<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf>

What is a super-utilizer? It can vary.

- Can look at high-costs, high inpatient and/or emergency department (ED) utilization, or other metrics (prescriptions, ambulance use, etc.)
- Super-utilizers can have a major event and then regress to the mean, cycle up and down, or stay at high-utilization levels for years
- Super-utilizers are not all the same. There are distinct sub-populations and not one-size-fits all. Study your population and dive deep into the data!

A way to look at risk factors: four chair legs

‘Legs’ of a super-utilizer chair:

1. Chronic conditions
2. Mental illness
3. Addiction
4. Social factors

A chair can have a broken leg and still stay upright. Each new damaged leg lowers stability. If all four fail, so does the chair. Focusing on one leg won't get it upright.



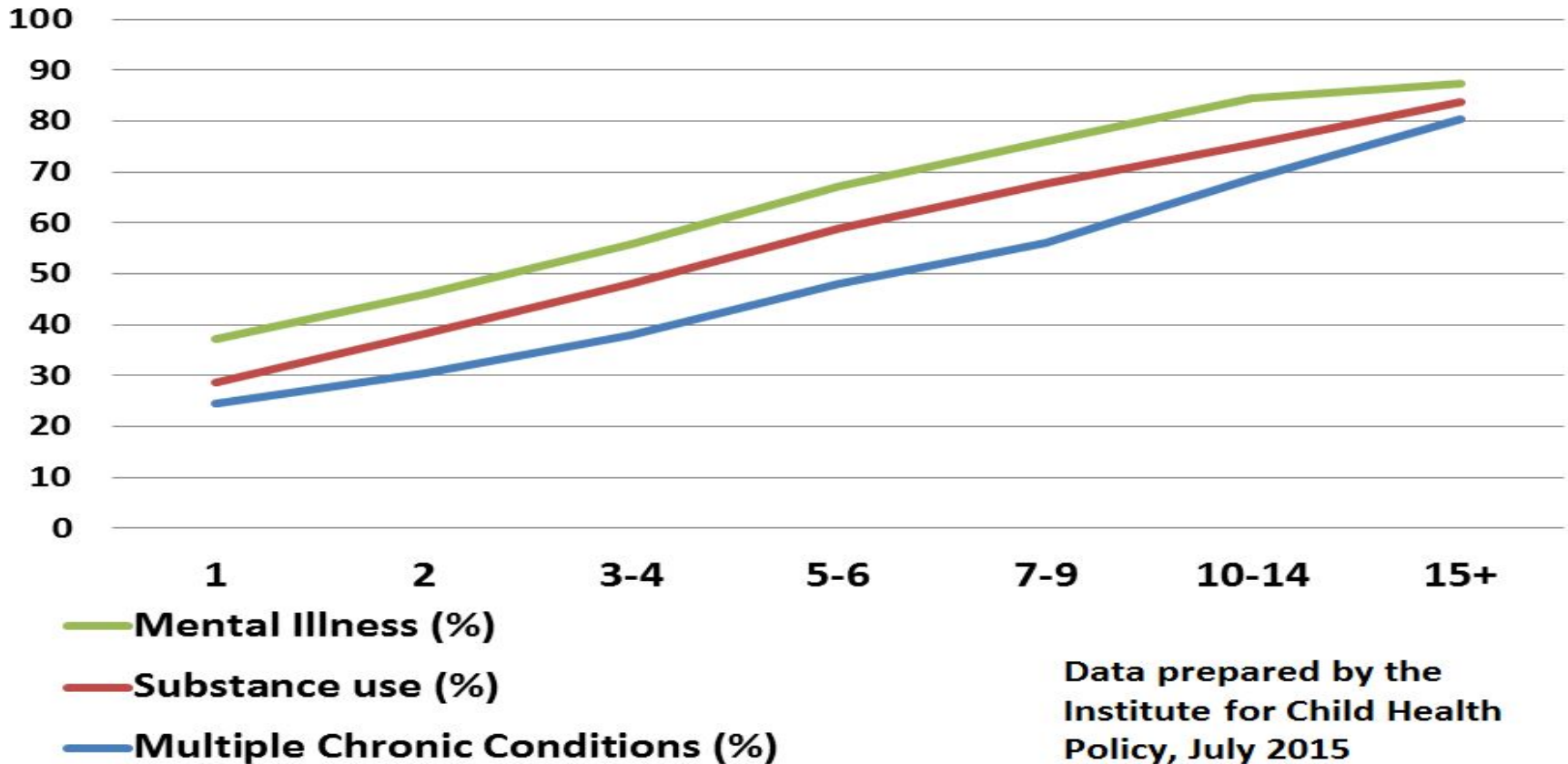
Texas Medicaid ED data shows risk factors

Number of ED Visits in 2013	1	2	3-4	5-6	7-9	10-14	15+
Number of Patients (age 18-62)	168,088	72,354	54,463	17,825	9,429	4,548	3,058
Percent of Patient (among those with at least one ED)	50.97	21.94	16.52	5.41	2.86	1.38	0.93
Any Chronic Condition (%)	43.03	50.95	59.75	70.05	77.33	85.84	92.54
Number of Chronic Conditions	1.06	1.33	1.66	2.13	2.51	3.12	3.96
Multiple Chronic Conditions (%)	24.64	30.56	37.93	48.04	56.20	68.78	80.35
Substance Use (%)	28.68	38.21	48.16	58.87	67.81	75.57	83.88
Mental Illness (%)	37.21	46.04	55.88	67.18	76.10	84.52	87.44
Schizophrenia (%)	5.15	6.74	9.09	12.40	15.66	20.73	27.01
Bipolar disorder (%)	9.55	13.27	18.53	24.74	31.48	38.65	46.04
Depressive Psychosis	9.60	12.57	16.88	22.31	27.60	34.70	40.52
Charlson Comorbidity Index	1.15	1.43	1.79	2.26	2.7	3.36	4.41

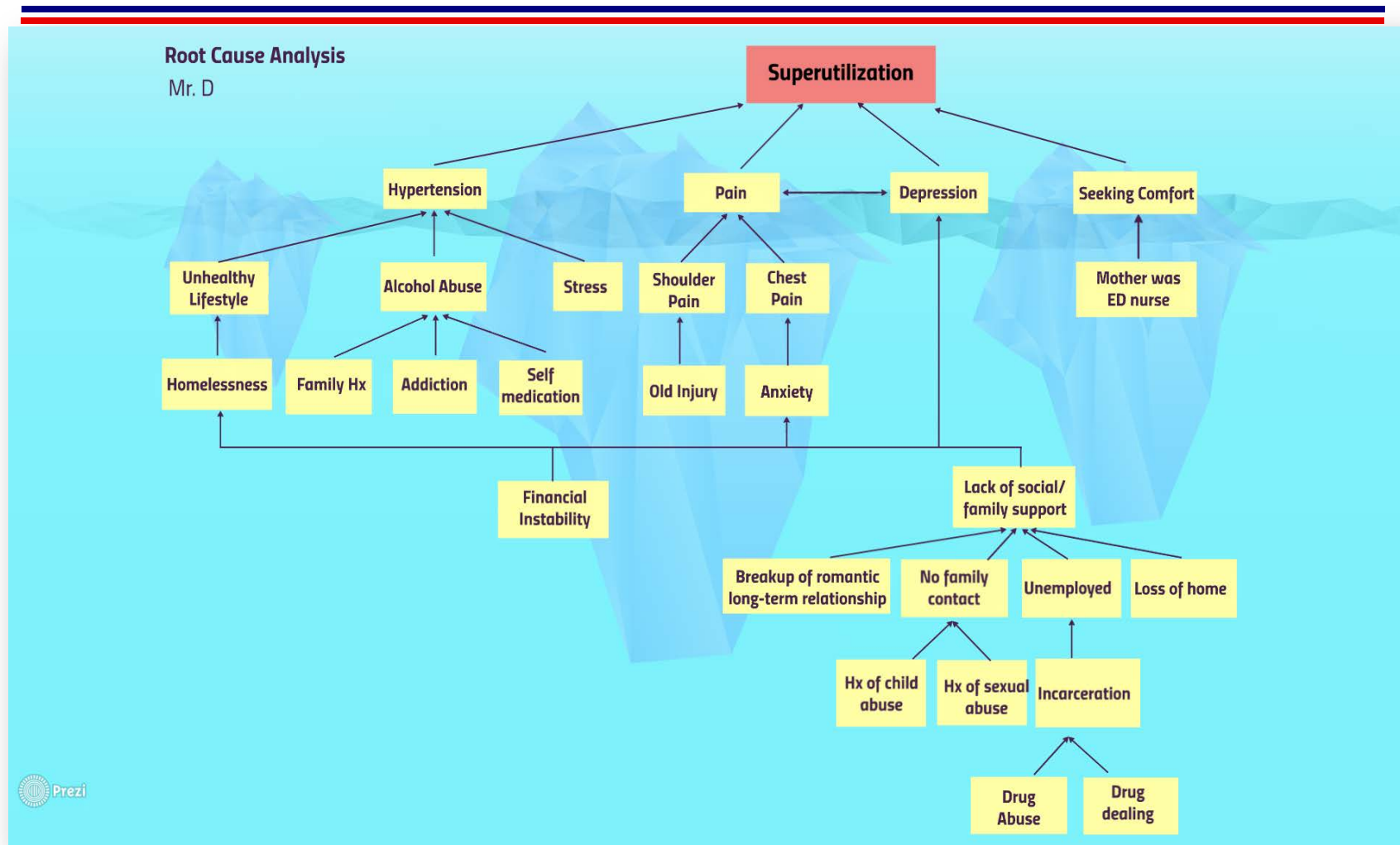
Data prepared by the Institute for Child Health Policy, July 2015

Comorbidity rises as ED use increases (ages 18-62)

Patient characteristics as number of Medicaid ED visits increases (2013 data)



Super-utilizer root cause analysis



Strategic considerations: fit the population

- Most health care is designed for the generally healthy or to treat an acute episode or manageable chronic condition. Think of it as serving round pegs and round holes; it mostly works OK
- Super-utilizers are not round pegs - they are square ones and unlikely to become rounded
- Adopt a strategic approach to create some square holes into the health care system

Problem: This is hard on the pegs and holes



This won't work to solve it



Super-utilizers represent an opportunity

- A small population with high utilization/costs may present more opportunity than a large population with low utilization/costs. Even marginal improvements in high-cost populations can add up
- Think of them as customers whose needs are not met with existing offerings and then build around their specialty requirements
- Meets “triple aim” of better patient experience, improved population health, and lower costs

What seems to work with Super-utilizers

- Hands-on approach with face-to-face outreach (contract requirement for our MCOs); integrate services to work on all four legs at once – to include social needs
- Build an intervention model around these patients and their complex needs. Make your new model fit them instead of trying to make them fit the status quo (hammers won't work!)
- Persistence and patience are key; don't give up

Medicaid-CHIP Super-utilizer program

Special Populations/Super-utilizers Health Plan Contract Provision (UMCM Section 8.1.14.1) (PDF)

The state's contract with health plans requires each plan to have a program for targeting, outreach, education and intervention for members who have high utilization patterns that indicate typical disease management approaches are not effective. **A summary of 2014 special populations plans received (PDF).**

- **May 27, 2014 webinar: How Can Health Plans Be Effective Partners on Super-Utilizer Management?**
- **May 27 webinar slides (PDF)**
- **August 6, 2014 webinar: Behavioral Health Super-Utilizers Program in Bexar County (WMV)**
- **August 6 webinar slides (PDF)**
- **December 2, 2014 webinar: Specialized Program for High Utilizers in One Hospital Network (WMV)**
- **December 2 webinar slides (PDF)**
- **July 10, 2015 webinar (PDF): Restoring Lives and Cutting Costs, The Cigna-HealthSpring Intensive Behavioral Health Program**

Note: For an accessible version, please email your request to **HHSC Quality**.

Other HHSC efforts on Super-utilizers

- Dedicated research by our external quality review organization (EQRO) with a multi-year scope
 - Developing a predictive model for super-utilizers to target earlier interventions
 - Working on a multi-state project with New York and Florida
 - Evaluation of Texas super-utilizer projects to ascertain Medicaid impact on quality and cost
- Multi-state project with CMS targeting beneficiaries with complex needs and high costs

HHSC DSRIP targets Super-utilizers

- Delivery System Reform Incentive Payment (DSRIP) program provides incentive payments to hospitals and other providers to transform their service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.
- Most projects are working toward improving access to care and value of care and decreasing inappropriate utilization, particularly in the EDs

HHSC DSRIP projects continued

- There are 47 DSRIP projects that directly target frequent utilizers of Emergency Departments
 - 31 of the projects provide navigation services to patients to get services at the most appropriate place and time
 - Medicaid-CHIP MCOs are working on collaborative efforts with DSRIP projects
- There are 13 projects that address enhancing care for patients with complex behavioral health needs, such as serious mental illness

EDEN system: statewide admission – discharge – transfer (ADT) feed

- Emergency Department (ED) Event Notification System (EDEN)
 - Proposed system detects Medicaid patients entering ED
 - Alert sent to Health Plans for coordination of care, forwarded to care team members
 - Can lower ED over-utilization, as seen in other states
 - Provides for better patient care through many use cases, such as alerting primary care physician to a need for follow-up with patient to prevent readmission to ED

EDEN system continued

- EDEN continued:
 - Similar private systems have been created within a few regional HIEs and hospital systems
 - This system would bring statewide event notification service; initially only for Medicaid patients
 - Project approved by HHSC and CMS, implementation begins Fall of 2015
 - Utilizes hospital Health Level 7 ADT feeds to detect admissions
 - Similar to syndromic surveillance and can use the same connection

Cigna-HealthSpring Behavioral Health Outpatient program

- Started in STAR+PLUS Hidalgo Area; expanded to Fort Worth
- Removed boundaries between areas of member need. Member needs may extend across physical health, behavioral health, and socioeconomic domains
- Redefined the home health model of care
 - Home Health vendor to spend as much time as necessary and to visit the member as frequently as needed to comprehensively address all of the member's needs
 - Removal of authorization limits with the close consultation and guidance of the plan Medical Director
 - Empower the nurse: “Do whatever it takes to keep the member living as independently as possible in the community”

Cigna-HealthSpring Behavioral Health Outpatient Program results

Sustainability: 2013 Pre Enrollment Compared to 2014 Post Enrollment

Top 10 Most Frequently Admitted Members	Total Admissions Pre-Enrollment	Medical Loss Ratio Pre-Enrollment	Total Admissions Post-Enrollment	Medical Loss Ratio Post-Enrollment
1	26	481.60%	2	187.08%
2	22	2348.05%	9	773.97%
3	21	907.70%	15	466.36%
4	19	816.05%	18	637.83%
5	13	536.55%	5	242.44%
6	12	227.56%	8	137.25%
7	11	568.88%	11	482.52%
8	11	176.66%	2	195.01%
9	11	670.77%	1	704.55%
10	10	316.25%	2	104.82%
	156		73	

Cigna-HealthSpring Behavioral Health Outpatient Program case studies

- **A male member with schizophrenia who lived under a bridge was reunited with his family, became medication compliant, and had a reduction in his medical loss ratio from 513% to 289%.**
- **A female with schizophrenia was previously alienated from her family. Her psychosis had invaded her ability to maintain a healthy relationship with her children. With assistance from the program, she was court committed to a psychiatric facility. That court commitment was then modified to the outpatient setting. With mandated compliance by the court, monitored by the nurses of the program, the member's psychosis was controlled. The member's family saw such improvement that she was allowed to attend her oldest son's graduation from a military boot camp and her youngest son's graduation from high school.**
- **A male member with methamphetamine addiction and a cardiac ejection fraction of 20% was relocated from a crack house to an assisted living facility. The change in living conditions improved his medication compliance and sobriety. His medical loss ratio was reduced from 462% to 300%.**
- **A homeless female member with chronic psychosis was taken off the streets and reunited with her family. Her primary psychosis was controlled. Her medical loss ratio was reduced from 513% to 250%.**
- **A female with histrionic personality traits had twice a month psychiatric hospitalizations for years. After enrollment in the program, her admittance rate declined to two times in the last year.**

CHCS (Bexar) behavioral health super-utilizer program

Standard Approach	Integrated Care
Assume Quadrant Model (Hi Med/Hi Psychiatric)	Complex Psychosocial Needs; Trauma history; Axis II/Personality Disorders
Silo'd Providers and Care System	Integrated; Multidisciplinary; Community Coordinated
Focus on Pathology	Strengths-Based/Recovery Model
Driven by contract requirements/revenue	Driven by needs of the person served
Setting-determined/limited	Person-centered/<i>in vivo</i>
Non-compliance/exclusion	Engagement/inclusion
System-driven/productivity goals	Person-centered/quality outcomes
Individual Professional Services	Groups; Peer Services
Re-traumatizing	Trauma-Informed

Brackenridge (Austin) High-Alert Program

- Program Created by Dr. Chris Ziebell for Brackenridge Hospital ED after a serious incident
- Case Management System
 - Identifies Patients with Complex Needs
 - Identifies Patients with Numerous ED Visits
 - Organizes Clinical Information
 - Creates a Plan for Future Patient Encounters
- Adds an alert to patient labels and wristbands
- Flags patients with a care plan on file, self-harm risk, or potentially dangerous

Brackenridge High-Alert Program results

- 48% reduction in number of total ED visits in High-Alert Program population
- Working locally to coordinate care plans across multiple hospital systems
- Dr. Ziebell's ED medical group (Emergency Services Partners) staffs ~30 hospitals throughout Texas and adopted High-Alert at roughly half of their sites; HCA has adopted it at Austin hospitals and is planning to take it nationwide

Conclusions

- Super-utilizers are an opportunity; look at your data and learn their unique needs
- Focus on care models with an evidence base of effectiveness (add square holes)
- Patience and persistence; don't give up

Remember: super-utilizers have names; these are people in your community

Contact for Questions

Contact: James A. Cooley

Healthcare Quality Analytics, Research and
Coordination Support

512-380-4376

James.cooley@hhsc.state.tx.us

HHSC quality website:

http://www.hhsc.state.tx.us/hhsc_projects/ECI/index.shtml