Medicaid
Solutions for High-Need, High-Cost Enrollees
NATIONAL CONFERENCE of STATE LEGISLATURES

INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

Five percent of patients account for about half of the nation's health care expenditures.[1] The same is true of the Medicaid program, with 5 percent of enrollees accounting for over half (54 percent) of Medicaid expenditures. Further, 1 percent of beneficiaries with complex care needs account for one-quarter of all Medicaid expenditures, according to the Centers for Medicare and Medicaid Services (CMS).[2] Due to the complexity of their illnesses or conditions, these "high-need" patients are the most costly, relative to healthier groups.[3]

The Commonwealth Fund, a nonprofit private foundation, defines "high-need" patients as those having two or more chronic medical conditions and physical or cognitive limitations. A 2017 National Academy of Medicine report finds that high-need patients:

- Are often seniors and younger adults with disabilities, chronic mental illness and/or substance abuse disorders.

- Have short-term needs, such as those following a complex surgery, or long-term needs related to multiple chronic conditions.

- Are more likely than others not defined as high-need to have public insurance (83 percent have Medicare, Medicaid or both), report being in fair to poor health, and have a behavioral or substance abuse condition.[4]

High-need adults also are more likely than other adults to have unmet emotional and social needs, such as social isolation or emotional distress (e.g., caused by inability to pay the rent or utility bill). These circumstances can compound their medical condition and increase public health care spending.[5,6] Researchers found one in 20 adults (5 percent) age 18 and older who live in the United States, or about 12 million people, met this definition of high need. Young people with complex medical conditions represent 0.4 to 0.7 percent of all U.S. children, or between 320,000 to 560,000 individuals, and account for about one-third (34 percent) of all Medicaid spending on children.

According to the Commonwealth Fund, high-need patients are a growing population that could benefit from coordinated health services. A 2016 survey administered by the foundation found that the health care system fails to meet the complex needs of these patients. The study's authors concluded that "with better access to care and good patient–provider communication, high-need patients are less likely to delay essential care and less likely to go to the emergency department for nonurgent care, and thus less likely to accrue avoidable costs."[7]
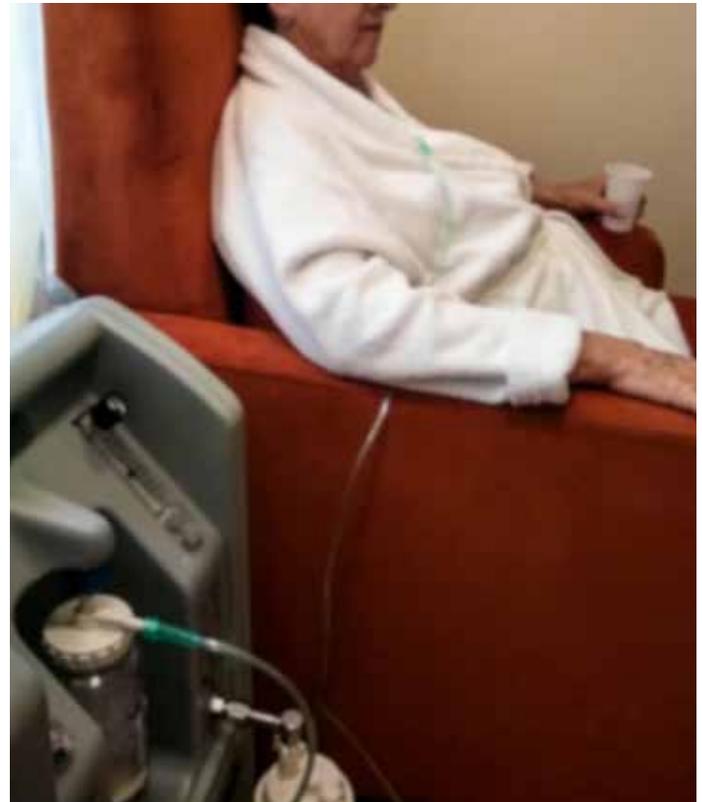
This report looks at state efforts to improve high-need patients' health and lower the costs to taxpayers.

Best and Promising Practices to Improve Outcomes for High-Need, High-Cost Groups

Across the country, states fund and implement care coordination models, or care management programs, that improve outcomes for people with complex needs. The programs are designed to decrease costly and unnecessary treatments and avoid preventable hospital and emergency room visits. While many of these programs offer the potential to reduce costs while improving patients' health, evidence is scarce and few have demonstrated net cost savings to date. Cost savings analysis is difficult to demonstrate when the programs are embedded in a fee-for-service care system. A team of researchers at the Commonwealth Fund state that "incentives created by accountable care and other value-based purchasing initiatives

may strengthen the business case for adopting carefully designed and well-executed care coordination models."[8] Research shows that the most effective models include the elements outlined below.

Several care coordination models have shown promise for high-need, high-cost patients, including:[9]

- Interdisciplinary primary care (coordination of preventive, primary, acute and long-term care services)

- Enhancements to primary care (including care and case management, disease management, preventive home visits, geriatric evaluation and management, chronic disease self-management and more)

- Transitional care (improved discharge transitions from hospital to home)

- Acute care in patients' homes (programs that substitute care in the patient's home instead of in a hospital)

- Team care in nursing homes

- Comprehensive care in hospitals

The evaluation of these models shows positive results in areas related to quality of care or a patient's quality of life. Most models reduced hospital stays, though the evidence was mixed. Three models—interdisciplinary primary care for heart failure patients, transitional care from hospital to home and "hospital-at-home" programs—showed evidence of lower cost.[10]

State Examples

States are taking various steps to coordinate care for Medicaid beneficiaries with complex health and social service needs. As described in the companion brief on Medicaid payment models, states are adopting payment and delivery reforms, including through health homes and accountable care organizations. Their goals are to encourage collaboration and care coordination among different providers, reduce spending on unnecessary services and reward providers for delivering higher-quality care. States are adopting the following strategies to improve outcomes and control spending for this population.

TARGETING SERVICES TO HIGH-NEED ENROLLEES

CMS in 2017 approved a five-year extension to **Utah's** Section 1115 Primary Care Network demonstration. The extension adds covered benefits for, and continues providing health coverage to, vulnerable populations, some of whom are not eligible for Medicaid under the state plan. The approval authorizes Utah to provide benefits to "targeted adults" to improve their health outcomes. These include individuals without dependent children earning up to 5 percent of the federal poverty level and who are chronically homeless, and adults who need substance use or mental health treatment, including those involved in the criminal justice system.[11]

COORDINATING CARE AND FINANCING FOR DUAL-ELIGIBLE ENROLLEES

States are addressing the high cost of caring for individuals who are eligible for both Medicare and Medicaid, also known as "dual-eligible" patients. State efforts emphasize coordinated care in a patient's home or in the community, which could bring substantial savings by lowering the rate of emergency room use, reducing hospital admissions and readmissions, and decreasing reliance on long-term care facilities. For example:

- **Massachusetts'** One Care Program is the first Section 1115 demonstration focusing exclusively on the dual-eligible population younger than age 65. Under the demonstration, participating health plans receive capitated Medicare and Medicaid payments to provide medical, behavioral health, and long-term services and supports. The One Care model involves interdisciplinary care teams whose members work with patients to identify and address their unmet needs.[12] One study of Care One found a 7.5 percent reduction in hospital admissions and a 6.4 percent drop in emergency department visits for enrollees after 12 months of participation. Studies also pointed out that the program incurred more costs in the first year, stemming from up-front expenses for developing provider networks, meeting the needs of patients with substance use disorders, and managing care transitions.[13]

As of 2018, 31 states operated the Program of All-Inclusive Care for the Elderly (PACE) as a strategy for helping frail, elderly patients with functional limitations stay in their homes.[14] PACE pools funding from Medicare and Medicaid to offer a comprehensive set of services to enrollees, most of whom are eligible for Medicare and Medicaid benefits. A literature review on the PACE program found mixed results on enrollee use of acute and long-term care services. PACE enrollees had fewer hospitalizations than individuals in fee-for-service Medicare, but higher rates of nursing home admission. The study found that the program increased Medicaid expenditures and had a neutral effect on Medicare costs.

USING DATA TO IDENTIFY AND SUPPORT HIGH-NEED PATIENTS

States are improving their capacity to use data to identify and support beneficiaries with complex care needs. For example:

- **New Jersey's** "hot-spotting" initiative, under the Camden Coalition of Healthcare Providers, tracks "super-utilizers." The coalition identifies "hot spots" in the community that have a high concentration of high-need health patients to improve their care and reduce costs. AmeriCorps volunteers help connect super-utilizers to outpatient resources and accompany patients to appointments, coordinate medications, determine benefit eligibility and offer emotional support. The coalition's founder, Dr. Jeffrey Brenner, reported a 50 percent drop in avoidable hospitalizations among patients helped by the coalition.

- **Washington** state developed the Predictive Risk Intelligence System (PRISM) to identify and support care management for high-risk Medicaid patients. The tool identifies clients in need of comprehensive care coordination based on their risk scores, which reflect a variety of factors, including outpatient and in-patient services, medications, and emergency room and office visits.[15] PRISM integrates patient data from medical, social service, behavioral health and long-term care data systems, and displays client data for clinicians and care managers who can use it for a variety of purposes, such as to monitor patients' medication use or identify potential barriers to care.[16,17]

- According to the Washington Department of Social and Health Services, early results from the Chronic Care Management (CCM) program showed net savings of $27 per member per month. They also found increased patient satisfaction and reduced mortality for individuals enrolled in CCM pilots relative to a control group.[18] Despite its small sample size and other limitations, the study's authors noted "promising potential to improve health outcomes and control costs for patients with high medical risk and major functional limitations."[19]

  Moreover, a 2015 article published by the Deloitte consulting firm finds that "by moving data and information management to the front end of the work so it becomes a day-to-day tool for decision-making rather than a back-end tool for accountability, states are working toward redefining the business model for health and human services."[20] The authors go on to note that such tools can identify which interventions work and which blend of services can help each client.

DEVELOPING AND REPLICATING APPROACHES

CMS in 2015 selected the District of Columbia and four states—New Jersey, Oregon, Texas and Virginia—to participate in a multi-state Medicaid Innovation Accelerator Program, which focused on improving care for beneficiaries with complex care needs and high costs.[21] The program worked with state Medicaid programs to design, plan and implement strategies to improve care coordination for high-need beneficiaries. For example:

- **New Jersey** focused on substance use services for young adults dependent on opiates using 1115 waiver demonstration authority. According to New Jersey's Section 1115 waiver renewal application, the state sought technical assistance through CMS' Substance Use Disorder (SUD) and Beneficiaries with Complex Needs accelerator programs. The programs helped the state identify a value-based reimbursement method that offers incentives for better health outcomes and develop data analytic capabilities to share enrollee information across state agencies.[22] The state's work in these programs informed its 2017 Section 1115 waiver,[23] which created an SUD continuum of care that uses Medicaid and state funds to provide comprehensive and coordinated benefits to adults and children.[24]

High Need, High Cost Enrollees: State Policy Options and Considerations

- Explore policies that offer incentives to use best practices and evidence-based care coordination models, such as those highlighted in the Institute for Healthcare Improvement's Better Care Playbook or the Commonwealth Fund's synthesis of evidence.
- Examine the cost analysis and return on investment for programs that not only save the state resources, but also improve quality of care or a patient's quality of life. The Commonwealth Fund developed a financial tool that calculates the return on investment from integrating social services with medical care.
- Explore payment policies that offer incentives for quality and efficiency and/or disincentives for ineffective care or uncontrolled costs.
- Establish Medicaid subcommittees, task forces or work groups to address program design and implementation. Cost-saving programs include those that address the needs of "super utilizers." It is important to consider the relative cost and benefit of building and maintaining the data systems that track the expenses of these patients.
- Examine opportunities to integrate social services and health care, including integration of Medicare and Medicaid funding for dual-eligible enrollees.
- Consider opportunities to develop and foster data-sharing across agencies, payers and provider networks.

- **Oregon** engaged with the accelerator program to evaluate the use of health services and quality of care being provided to the dually eligible Medicare and Medicaid population under the state's Coordinated Care Organization (CCO) model."[25] Oregon joined the program to support its efforts to bring together "All Payer All Claims" data and Medicaid data to inform a statewide evaluation of dually eligible beneficiaries in coordinated care.[26] As a result, according to the Section 1115 waiver renewal, the Oregon Health Authority (OHA) anticipated "having better data integration to allow us to take a deeper dive into duals' work and help inform legislative and policy initiatives going forward."[27] The 2016 program evaluation published by OHA and the Oregon Health and Science University found that Medicaid's transformation to coordinated care organizations "improved quality of care for dual-eligibles to some degree, but did not lead to any meaningful improvement in health service use."

Notes

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