Preserving the Community Safety Net

10 Imperatives for Designing a Sustainable Medicaid Strategy
1. Current State of the Safety Net

2. Preserving the Community Safety Net

3. Our Mission Imperative
Medicaid Steps Back Into the Spotlight

A Tumultuous Year for Medicaid

**The New York Times**

“G.O.P Health Plan is Really a Rollback of Medicaid”

*June, 2017*

**Forbes**

“House G.O.P.’s Medicaid Plan Will Mean More Flexibility, Less Money, and Worse Care for Seniors”

*July, 2017*

**KHN**

“Repeal-Only Bills’ Estimated Impact: 32 Million More Uninsured; 25 Percent Premium Spikes”

*July, 2017*

**Modern Healthcare**

“Analysts Predict Drop in Provider Net Revenue Under BCRA”

*July, 2017*

**BECKER'S Hospital Review**

“Uncompensated Care Costs Could Rise 78% at Hospitals in Medicaid Expansion States Under AHCA”

*June, 2017*

**THE WALL STREET JOURNAL**

“G.O.P. Ramps Up Effort to Transform Medicaid Into Block Grants”

*February, 2017*

Source: Health Care Advisory Board interviews and analysis.
Medicaid Expansion (Mostly) Good for Finances

Absent Shift to Block Grants, a Seemingly Rosy Picture for Medicaid

31 States and DC Have Approved Expansion

![Map of the United States showing states that have approved Medicaid expansion](image)

- **Participating**
- **Not Currently Participating**

<table>
<thead>
<tr>
<th>Enrollment increase</th>
<th>Coverage Expansion Put More Dollars into Safety Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.3%</td>
<td>$68B Federal spending on Medicaid expansion population, FY2015</td>
</tr>
<tr>
<td>3.9%</td>
<td>$4.3B State spending on Medicaid expansion population, FY2015</td>
</tr>
<tr>
<td></td>
<td>$6.2B In savings for hospitals in expansion states through reduced uncompensated care, 2013-2015</td>
</tr>
</tbody>
</table>

Nearly one in four U.S. residents covered by Medicaid

Expansion Only One Piece of a Much Bigger Picture

Focus on Uncompensated Care Reductions Obscures Other Threats

Three Major Forces Eroding Safety Net Economics

**Shifting Population Dynamics**
- Decreasing proportion of children and pregnant women in Medicaid
- Dual-eligible beneficiaries aging
- Higher-spending groups outgrowing lower-spending groups

**Changing Utilization Patterns**
- Growing need for Long-term Services and Supports
- Opioid epidemic driving inpatient and ED volumes

**Increasing Reimbursement Pressures**
- Declining enhanced federal match for the expansion population
- Impending cuts to and increased scrutiny of supplemental payments

**Deteriorating Economics of the Safety Net**
- Disproportionate burden of uninsured falls on safety-net providers, minimizing opportunities to cross-subsidize
- Safety-net hospitals heavily dependent on threatened supplemental payments
Meet the New Medicaid Population

Expansion, Population Aging Increasing Per-Capita Medicaid Costs

**Expansion Redistributed Low- to High-Spend Categories**

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td>8.6%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Adults</td>
<td>6.6%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Disabled</td>
<td>14.6%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Aged</td>
<td>24.4%</td>
<td>31.1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>45.8%</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

**Aging Population will Further Exacerbate Trend**

- **Projected growth in 65+ population by 2050**, making it the fastest growing age group
- **Times higher spending per full-year equivalent for aged beneficiary than adult**
- **Projected annual growth in Medicaid spending due to growing aged and disabled population**

19% Reduction in proportion of women of reproductive age between 2009 and 2014

6% Reduction in proportion of children enrolled between 2011 and 2014


1) FY 2014 Data.
Need for Costly Services on the Rise

New Pressures Demanding Increased Spending in Medicaid

Aging Population Grows Need for Long-term Services and Supports

4.8M → 5.2M
Increase in number of people receiving Medicaid-funded LTSS, 2011-2013

363%
Increase in total Medicaid LTSS expenditures, 2006-2010

Opioid Epidemic Driving Increased Medicaid Spending on Addiction Treatment

2x
Greater chance a Medicaid enrollee will be prescribed opioids than those with private insurance

45%
Of total overdose deaths accounted for by Medicaid enrollees in 2014

$9.4B
Medicaid program spending on opioid-related treatment in 2013

Medicaid Pricing Likely at Its Peak

Multiple Forms of Downwards Pressures on Reimbursement

**Economy Currently at Relative High**

- **7.2% → 4.2%**
  - Change in unemployment rate 2013-2017

- **1.68 → 2.6%**
  - Change in GDP growth 2013-2017

**Enhanced Match for Expansion Phasing Down**

- 2016: 100%
- 2017: 95%
- 2018: 94%
- 2019: 93%
- 2020: 90%

**Diminishing Reliability of Supplemental Payments**

- $1.6B cut in 340B payments
- New limits on pass-through payments
- Increased scrutiny of provider taxes

**Impending DSH Payment Cuts**

- Cut to federal Medicaid DSH payments, 2018-2026
- $43B
- 20 states have projected cuts that surpass decline in uncompensated care

**Potential Shift to Block Grants**


---

1) Data for September 2013 and September 2017.
2) Q2 data.
3) Between 2013 and 2014.
Safety Net Hospitals Particularly Vulnerable

Price Cuts, Loss of Supplemental Payments Hit Safety Net First

Breakdown of Medicaid Payments to Hospitals

- Non-DSH Supplemental Payments: 56%
- DSH Supplemental Payments: 27%
- Base Payment: 17%

Operating Margins of a Safety Net Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>With DSH</th>
<th>Without DSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>-3.20%</td>
<td>-12.50%</td>
</tr>
<tr>
<td>2014</td>
<td>0.00%</td>
<td>-6.20%</td>
</tr>
<tr>
<td>2015</td>
<td>3.20%</td>
<td>-3.60%</td>
</tr>
</tbody>
</table>

DSH respondents reported using 340B benefit to provide more services despite low Medicaid payments in 2017

DSH Status Closely Tied with 340B Benefit

Margin Pressures Not Unique to Safety Net Providers

Hospital Pricing Challenged Across All Payer, Provider Segments

Hospital Price Growth Low Despite Rebound
Annualized Hospital Price Growth, Jan. 2010-May 2017

Current Strategies Further Erode Safety Net Stability

As Margins Deteriorate, Reactive Strategies Compromise the Safety Net

The Status Quo Health System’s Approach to Medicaid

| Deflect Medicaid volumes to safety net hospitals | Siphon off select few lucrative Medicaid volumes (e.g., L&D, neonatal) | Compete for Medicare and commercial patients |

Safety-Net Providers Forced to Close

- Of the 195 hospital closures in the U.S. between 2003 and 2011 were in urban areas: 70%
- Increase in number of rural hospitals vulnerable to closure between 2013 and 2015: 138%

Direct Impact on Remaining Hospitals

- Increase in local unemployment rate when a critical access hospital closes: 1.6%
- Increase in uncompensated care at neighboring hospitals when an average county hospital closes: 10%


1) At risk for unprofitability, equity decline, insolvency, and closure.
Significant Downstream Impact of Safety Net Closures

Closures Create Substantial Challenges for Those Left Standing

St. Vincent’s Closure Increases Burden on Remaining Hospitals

After years of serving Medicaid and indigent patients, permanently closed with $1B in debt

Increase in ED volumes across the 4 remaining hospitals in the area: 10-30%

Impact on Remaining Hospitals

- Increased demand for staffing and hours
- Increased emergent psychiatric patients
- Increased overcrowding compromised patient privacy

Case in Brief: St. Vincent’s Hospital

- Not-for-profit, Level 1 trauma safety net hospital in lower Manhattan, NY
- Handled 62,000 ED visits, 22,000 admissions, and 1,800 births annually
- Permanently ceased all operations after negotiations for new ownership failed in 2010
- Closure drove surge in patient volume, particularly in ED, across remaining four hospitals in the area

Seemingly Pulled in Two Directions

Mission and Margin Seem in Conflict

On many Medicaid services, there is no longer any contribution margin. If we were in any other business, now would be the time to walk away. But we can’t.

Executive Planning Officer
ACADEMIC MEDICAL CENTER IN MIDWEST

Boosting Margin

- Target advantageous payer mix geographies
- Terminate MCO contracts
- Benefit from tax exemption through provision of “community benefits” programs
- Charge competitive rates

Advancing Mission

- Expand direct network access to vulnerable patients
- Improve health outcomes in communities
- Deliver compassionate care and service

Source: Health Care Advisory Board interviews and analysis.
Recognizing a False Choice

Two Potential Paths Forward

**Margin Deterioration Compromises Access, Fuels High-Cost Utilization**

- Margin deterioration forces providers to limit access for safety net population
- Inappropriate ED and IP utilization increase, further eroding margins
- Caught in vicious cycle that deteriorates both margins and access

**Margin Improvement Funds Access Expansion, Right-Sizing Utilization**

- Margin improvement fuels access expansion
- Expanded network enables providers to shift patients out of unnecessary, high-cost settings
- Further improvements to margin enable additional investments in community

*Source: Health Care Advisory Board interviews and analysis.*
Clarifying Our Ambition

Striking a Balance Across Conflicting Priorities

Protect Margins

- Mitigate losses under FFS
- Evaluate potential to transform reimbursement model

Enhance Access

- Maintain ability to provide crucial services
- Expand access by filling network gaps

Preserve Stability of the Community Safety Net

- Refrain from strategies that actively harm safety-net counterparts
- Engage in partnerships to preserve, enhance market stability

Source: Health Care Advisory Board interviews and analysis.
Designing a Sustainable Medicaid Strategy

Three Steps to Establishing a Sustainable Medicaid Strategy

1. Addressing Avoidable Low-Margin Utilization Flashpoints
2. Extending Risk Strategy into Medicaid
3. Succeeding Under Medicaid Risk

Source: Health Care Advisory Board interviews and analysis.
Preserving the Community Safety Net

10 Imperatives for Designing a Sustainable Medicaid Strategy

Stabilize Under Current Economics

1. Addressing Avoidable Low-Margin Utilization Flashpoints

Deploy Targeted Strategy for Highest Utilizers

1. Stratify super-utilizers to customize level of intervention

Fill Highest-Need Network Gaps

2. Minimize high-acuity mental health needs through crisis management

3. Establish bidirectional community clinic partnerships

4. Address most prevalent non-clinical drivers of inappropriate utilization

Transform Business Model

2. Extending Risk Strategy into Medicaid

5. Predicate transition to Medicaid risk on care management capabilities

6. Target manageable entry point to establish baseline experience

7. Capitalize on emerging opportunities to rapidly expand risk strategy

3. Succeeding Under Medicaid Risk

8. Augment staffing model to include non-clinical roles

9. Hone risk stratification methodology with social determinants of health

10. Recruit patients to care management system

Special Report:
Confronting the Opioid Epidemic

Source: Health Care Advisory Board interviews and analysis.
1. Current State of the Safety Net

2. Preserving the Community Safety Net

3. Our Mission Imperative
Special Report: Confronting the Opioid Epidemic
Safety Net Bearing the Brunt of the Opioid Crisis

Medicaid Beneficiaries Disproportionately Affected

U.S. National Opioid-Related Emergency Department Visits by Expected Payer

- **44%** of opioid-related ED visits
- **2x** Greater chance a Medicaid enrollee will be prescribed opioids than those with private insurance
- **45%** Of total overdose deaths accounted for by Medicaid enrollees in 2014
- **$9.4B** Medicaid program spending on opioid-related treatment in 2013

Prescribing Patterns a Clear Contributor

Acknowledging Health Systems’ Role

Opioid Prescriptions Undeniably Part of the Problem

17%
Of surgical patients who were prescribed opioids were still using them three to six months later

5%
Of opioid-naïve patients who received a prescription became addicted

10%
Of opioid-naïve patients who filled a second prescription refill became addicted

Driven by Misconceptions of Necessity and Impact

The Joint Commission classified pain as the “fifth vital sign”\(^1\) indicating patient well-being

CMS used to include pain management in HCAHP\(^2\) scoring, impacting provider reimbursement

$600M
Purdue Pharma penalty for contending that OxyContin had a lower risk of addiction, misuses than other pain killers

1) In addition to temperature, pulse rate, breathing rate, and blood pressure.
2) Hospital Consumer Assessment of Healthcare Providers and Systems.

Providers a Vital Part of the Solution

Health System Responses Must Target Two Goals

Prevent Addiction

- Standardize clinician education to prevent and mitigate unintentional harms
- Strive for addiction-free prescribing through targeted protocols that include accountability mechanisms
- Empower patients to be part of the solution with resources, education, and accountability

Treat Addiction

- Begin treatment in the hospital to capture high-impact opportunity
- Expand treatment options to offer sufficient capacity and flexibility
- Connect community caregivers to ensure post-discharge wrap-around services

Source: Health Care Advisory Board interviews and analysis.
Provide Resources, Guidelines to Prevent Addiction

Health Systems Must Support Clinicians, Patients to Change Behavior

Three Steps to Safe Opioid Prescribing Practices

1. Standardize Clinician Education
   - Provide physicians with baseline education to prevent, mitigate unintentional harms

2. Strive for Addiction-Free Prescribing
   - Create specific goals to reduce prescriptions
   - Implement targeted protocols to guide, support physician behavior
   - Embed accountability mechanisms to ensure compliance

3. Empower Patients to Be Part of the Solution
   - Provide patients with resources, education, accountability to drive safe behavior

Source: Health Care Advisory Board interviews and analysis.
## Overcoming Our Fear of Feedback

### Physician Misconceptions Encourage Unsafe Opioid Prescribing

<table>
<thead>
<tr>
<th>Misconception</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids lead to better long-term pain relief than alternatives</td>
<td>No studies have confirmed opioids are most effective long-term pain treatment</td>
</tr>
<tr>
<td>Curbing opioid prescriptions will bring down HCAHP scores</td>
<td>Opioid prescriptions have not been correlated with increased HCAHPs</td>
</tr>
<tr>
<td>The patient receiving the prescription is the only individual likely to abuse it</td>
<td>54% of individuals taking illegal opioids acquire them through a relative or friend</td>
</tr>
</tbody>
</table>

### Components of Successful Physician Education

- **Outlines potential pitfalls of current prescribing patterns**
- **Demonstrates efficacy and safety of alternative treatments**
- **Uses real life and patient scenarios, case examples**
- **Mandates attendance of all prescribing physicians**

Set Clear, System-Wide Goals

Intermountan’s Initiative Aligns Service Line Interventions

System-Wide Opioid Reduction Pathway

- Surgical service line leadership conducted a survey of 7K patients; learned 40% of pills go unused
- CEO established opioid reduction as a cross-system priority
- System leadership teams determined goal to reduce opioid prescription by 40% across acute conditions by 2019
- Analytics team took four months to build a cross-system opioid prescription-tracking dashboard
- Service line leaders tasked with developing team-specific protocols for prescription reduction

Case in Brief: Intermountain Health Care

- 22-hospital health system based in Salt Lake City, UT
- Recognized that Utah consistently has one of the highest rates of opioid-related overdose in the country
- Pursuing a cross-system goal to reduce opioid prescriptions across acute conditions by 40% by the end of 2018

Promising Early Results

- 10% Reduction in tablets prescribed in primary care
- 32% Reduction in tablets prescribed in women’s, newborn’s care

Source: Health Care Advisory Board interviews and analysis.
Establish Protocols to Achieve Reduction Goals

Gundersen Sought Input, Offered Resources to Ensure Clinician Buy-in

Assemble Multi-Disciplinary Protocol Development Team

Opioid Safety Committee

Includes medical and non-medical staff, such as:
- Nursing
- Pharmacy
- Service line leaders
- IT and analytics
- Emergency response
- Legal

Provide Clinicians with Clear Guidelines Across Care Continuum

- Patient presents with pain
- Consult PDMP\(^1\) to screen for pill shoppers
- Screen for opioid abuse risk factors (anxiety, depression, substance abuse)
- Explain and complete opioid use contract to hold patient accountable
- Educate patients on opioid risks, handling, safe use, disposal
- Follow up to address any suspected misuse or abuse


\(^1\) Prescription Drug Monitoring Program: electronic database that tracks controlled substance prescriptions in a state.
Establish Protocols to Achieve Reduction Goals

Continued

Case in Brief: Gundersen Health System

• Five-hospital health care system based in La Crosse, WI
• Identified over-prescription of opioids as a source of rising incidence of opioid misuse
• Pain clinic established committee to spearhead opioid management efforts, but eventually included other departments, such as nursing, legal, quality, patient education
• Committee representatives from across the organization obtained executive and physician buy-in from their respective departments to develop prescription protocols and create an opioid patient registry
• System provided prescribers with standard operating procedure as well as a screening checklist for visits with opioid patients to ensure comprehensive pain management care across the system

Accountability a Key Driver of Behavior Change

Pair Broad-Based Transparency with Targeted Interventions for Outliers

Geisinger Uses Data Transparency, Provider Education to Facilitate Culture Change

1. Track provider prescription patterns in data dashboard visible to all system clinicians

2. Identify clinicians with high incidence of opioid prescriptions

3. Send Pharmacy Outcomes team to educate outlier clinicians on pain management alternatives

4. Have clinical service line leaders use data transparency, individual follow-up to ensure compliance

Case in Brief: Geisinger Health System

- 12-hospital system based in Danville, PA
- Identified pain management prescriptions as a driver of opioid misuse and poor patient satisfaction
- Created a dashboard to track cross-system opioid prescriptions visible to all system clinicians; use targeted interventions, offer resources to address outlier physicians

Source: Health Care Advisory Board interviews and analysis.
Engaging Patients the Final Step

Create Guidelines, Support Structures to Drive Safe Patient Behavior

Gundersen Health Instituted Opioid Use Contracts

Established Patient Expectations

Patients required to sign contract before receiving opioid treatment

Key Contract Components:

- Treatment goals
- Medication use, refill guidelines
- Consequences of breaking contract

Ensured Consequences of Non-Compliance

Providers empowered to change treatment if patients fail to meet expectations

Case in Brief: Gundersen Health System

- Five-hospital health care system based in La Crosse, WI
- Identified over-preservation of opioids as a source of rising incidence of opioid misuse
- System provided prescribers with patient chronic pain management contract to hold patients accountable and establish mechanism to change treatment should patients begin to show signs of opioid abuse or addiction

Ensure Patients Have Tools for Success

Provide Community Options for Safe Excess Drug Disposal

Intermountain Introduced Speak Out, Opt Out, Throw Out Initiative

Case in Brief: Intermountain Health Care

- 22-hospital health system based in Salt Lake City, UT; also owns SelectHealth insurance plan
- Recognized that Utah consistently has one of the highest rates of opioid-related overdose in the country
- Pursuing a cross-system goal to reduce opioid prescriptions, including educating community members and encouraging safe drug disposal

Funded Drop Boxes
Established 25 secure opioid drop boxes in Intermountain pharmacies; funded drop boxes for six non-profit clinical partners

Developing Disposal Bags
Bags will be distributed to patients and include instructions on how to dispose of excess opioids and a map of drop box locations

15K Pounds of medication dropped, 2015-2017

7K Opioid Pill Bottle Chandelier

Source: Health Care Advisory Board interviews and analysis.
Providers a Vital Part of the Solution

Health System Responses Must Target Two Goals

Prevent Addiction

Standardize clinician education to prevent and mitigate unintentional harms

Strive for addiction-free prescribing through targeted protocols that include accountability mechanisms

Empower patients to be part of the solution with resources, education, and accountability

Treat Addiction

Begin treatment in the hospital to capture high-impact opportunity

Expand treatment options to offer sufficient capacity and flexibility

Connect community caregivers to ensure post-discharge wrap-around services

Source: Health Care Advisory Board interviews and analysis.
Medication-Assisted Treatment the Gold Standard in Treating Addiction

From Prevention to Treatment

Medication-Assisted Treatment in Brief

- The use of medications such as methadone or buprenorphine to wean patients off of more potent painkillers
- **Benefits:**
  - Has reduced mortality among addiction patients by more than half
  - Eliminates withdrawal symptoms
  - Does not induce euphoria; less attractive for abuse
  - Does not reduce functionality
- **Considerations:**
  - Frequently highly regulated
  - Overdose and abuse still possible
  - Cautious prescription practices still necessary

Health Systems Positioned to Help

**Begin treatment in the hospital**
with enhanced system inpatient MAT\(^1\) treatment options

**Expand outpatient treatment options**
by increasing community MAT\(^1\) resources and capitalizing on external funding to fill market gaps

**Connect community caregivers**
across the care continuum to ensure post-discharge wrap-around services

---

1) Medication-Assisted Treatment.

Source: Lopex, G., “There’s a highly successful treatment for opioid addiction. But stigma is holding it back,” Vox, July 20, 2017; Health Care Advisory Board interviews and analysis.
Leveraging a Critical Inpatient Opportunity

OHSU\textsuperscript{1} Begins Addiction Treatment in the Hospital

1. Recognized hospitalization is a reachable moment to initiate and coordinate addiction care

2. Developed capacity to begin treatment in hospital through an inter-professional hospital addictions team in collaboration with community partners

System Implemented IMPACT\textsuperscript{2} Model

- Assembled an inter-professional team including peers with lived experience in recovery (2), social workers (2), a nurse practitioner, and physicians (1.5 FTE)
- Treat 10-15 hospitalized adults at any time focusing on patients admitted to medical and surgical services with substance use disorder

IMPACT Model Improving Patient Outcomes and Engagement

- 521 of 600 Patients seen from July 2015-September 2017 engaged with IMPACT in the hospital
- 61% Of patients initiated medications for addiction treatment in the hospital
- 68% Of patients were referred to addiction treatment in the community post-discharge
- Hospital staff reported improved morale, disease understanding, and patient care experience

Source: Englander, H. et al., “Planning and designing the Improving Addiction Care Team (IMPACT) for hospitalized adults with substance use disorder,” *Journal of Hospital Medicine*, May 2017; Health Care Advisory Board interviews and analysis.
Leveraging a Critical Inpatient Opportunity

Continued

Case in Brief: Oregon Health & Science University

• Three-hospital academic medical center based in Portland, OR
• Identified unique opportunity to reach patients with substance use disorder, improve care quality and provider experience, and reduce costs by beginning treatment during hospitalization
• Launched Improving Addiction Care Team (IMPACT) model in July 2015
Incorporate MAT\(^1\) into Existing Outpatient Assets

Mobilize Existing System Resources to Treat Opioid Addiction

Geisinger Upskilling Existing Clinical Pharmacists

- Trained **pharmacists embedded in primary care clinics** on pain management and recognition for risk of addiction
- Now have **nine pharmacist pain-management specialists** able manage patient cases collaboratively with primary care and specialty physicians
- Fewer ER visits over 12 months from patients working with a trained pharmacist **20\%**

Lapis Health\(^2\) Building Out Staffing at Current Community Clinics

- In the past year, **staffed community addiction specialists** at local health centers and school-based clinics
- Now able to **transition stable patients back to the community** expanding capacity at the hospital’s central treatment center

Case in Brief: Geisinger Health System

- 12-hospital system based in Danville, PA, with 58 existing pharmacists embedded in primary care clinics
- Implemented pharmacist pain-management training program

Case in Brief: Lapis Health

- Integrated delivery system in the West
- Staffed certified addiction counselors in four community health centers and social workers with addiction specialties in six school-based clinics

Source: Health Care Advisory Board interviews and analysis.

---

1) Medication Assisted Treatment
2) Pseudonym
Introducing a Different-In-Kind Clinic

Fill Clear Market Gaps with Financial Support

Boston Medical Center Established Opioid Urgent Care with State Grant Funding

Case in Brief: Boston Medical Center

- 496-bed hospital based in Boston, MA
- Launched the Faster Paths to Treatment Opioid Urgent Care in August, 2016
- Staffed with seven MA-licensed alcohol and drug counselors, five X-waivered addiction physician specialists, three fellows, and one nurse addiction specialist
- Counselors conduct psych-social exams to place patients in appropriate treatment

Source: Health Care Advisory Board interviews and analysis.
Unprecedented Funding for Large-Scale Initiatives

Working with State Administration Key to Success

Providers Have Variety of Funding Options

Solicit Philanthropic Dollars
Donors interested in philanthropy with clear impacts or newsworthy topics will eagerly contribute to this cause.

Negotiate with Commercial Payers
Providers may be able to secure flexible funding from insurers eager to confront this issue directly.

Engage with State Agencies to Capture State, Federal Funding
State governments have emergency funding resources as well as access to federal public health grants.

States Already Offering Grants, Applying for Federal Dollars

$500K
Arizona tapped emergency fund to increase state education, prevention, treatment options.

$4M
Alaska applying for two-year, federal grant to increase MAT\(^1\) availability.

$15M
Alabama applying for two-year federal grant to create comprehensive opioid response plan.

---

1) Medication-Assisted Treatment.

Health Systems Can’t Solve Addiction Alone

Drive Holistic Change with Community Engagement, Education

<table>
<thead>
<tr>
<th>Key Stakeholders</th>
<th>Upskill Local Providers</th>
<th>Gain Broad Community Buy-in</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency services</td>
<td>Local primary, behavioral, specialist clinicians</td>
<td>Government officials, agencies</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>Dentists</td>
<td>Law enforcement, drug courts, DEA¹</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample Tactics</th>
<th>In-person workshops</th>
<th>Online seminars</th>
<th>Toolkits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional summits</td>
<td>Community coalitions</td>
<td>Brochures, advertising</td>
<td></td>
</tr>
</tbody>
</table>

UC Davis Online Education Program Results

<table>
<thead>
<tr>
<th>Case Example</th>
<th>59%</th>
<th>66%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are less likely to prescribe opioids</td>
<td>Are working to taper patients off opioids</td>
<td></td>
</tr>
</tbody>
</table>

Columbia Pacific CCO’s Summits²

- Launched annual community-wide educational meetings in 2016
- One county voted to open a needle exchange; four clinics now interested in offering MAT³

Source: “UC Davis ECHO Pain Management TeleMentoring,” UC Davis Health Center for Advancing Pain Relief, Health Care Advisory Board interviews and analysis.

1) Drug Enforcement Administration.
2) Entity owned by CareOregon, Portland, OR.
3) Medication-Assisted Treatment.

©2017 Advisory Board • All Rights Reserved • advisory.com • 35577B
Uniquely Positioned to Serve as Conveners

Health Systems Leading Change Across a Spectrum of Initiatives

Beyond the Hospital Walls

Community Care of North Carolina (NC):
- Held community coalition meetings to mitigate community stigma toward addiction in 74/100 NC counties
- Succeeded in encouraging several counties to allow police to carry overdose rescue medication

Mercy Hospital of Portland (ME):
- Established a regional leadership team of local stakeholders
- Constructing an integrated cross-community, data platform for data integration, real-time alerts, reporting, treatment standardization, and predictive analytics

Intermountain Health Care (UT):
- Contributed $3.5M to general community efforts, 2015-2017
- Committed additional $2M in 2018 for provider education and public awareness

Community Hospital of the Monterey Peninsula (CA):
- Convened 17 clinical and non-clinical organization leaders
- Developed community opioid mitigation efforts
- Saw 59% reduction in county-wide recurrent opioid-related ED visits

Comprehensive Ownership of Community Response

1) With assistance from Open Lattice, a technology public benefit company from CA.
2) Including: implementing county-wide opioid prescription protocols, community education, safe disposal sites, increased access to pain management services.

Source: “Prescribe Safe Monterey County,” Community Hospital of Monterey Peninsula, 2017; Health Care Advisory Board interviews and analysis.
Key Takeaways

Confronting the Opioid Epidemic

1. Every provider organization should have a strategy for preventing new cases of addiction

   Prescribing patterns have been a crucial driver of the opioid crisis; health systems have an obligation to work with clinicians to change their approach to pain management.

2. Existing inpatient and outpatient capabilities and resources present a unique opportunity for systems to expand addiction treatment

   Health systems should mobilize current resources and expertise to confront opioid addiction presenting internally; for the most part, existing assets provide clear channels for advancing and expanding treatment options.

3. Health systems should take advantage of state, federal, and philanthropic grants to construct a comprehensive opioid response

   Systems cannot solve the opioid crisis alone; however, providers are uniquely positioned to capitalize on new funding opportunities and convene community stakeholders to develop new clinical capabilities, fund local programs, and increase community interconnectivity.

4. The opioid crisis is not only a Medicaid problem, but it has disproportionately impacted the Medicaid population

   Systems must address the opioid epidemic not just as a part of their overall strategy, but specifically as a component of their journey to build a financially viable community safety net.

Related Resource: Reducing Opioid Misuse and Abuse

Dive deeper into building your response to the opioid epidemic with this white paper detailing three imperatives for provider organizations.
Addressing Avoidable Low-Margin Utilization Flashpoints

1. Stratify super-utilizers to customize level of intervention
2. Minimize high-acuity mental health needs through crisis management
3. Establish bidirectional community clinic partnerships
4. Address most prevalent non-clinical drivers of inappropriate utilization
ED Utilization a Ubiquitous Challenge

Low-Margin Medicaid ED Volumes Only Growing with Time

Rate of ED Utilization Increasing
Annual Rate of ED Visits, in Millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits, in Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>118</td>
</tr>
<tr>
<td>2008</td>
<td>127</td>
</tr>
<tr>
<td>2010</td>
<td>136</td>
</tr>
</tbody>
</table>

Proportion of Medicaid Patients in ED Rising Over Time

- 23% of ED patients on Medicaid, 2006
- 32% of ED patients on Medicaid, 2014

$54.4B
Total cost of ED use by Medicaid patients, 2014

(36%)
Average profit margin from Medicaid ED visits

27%
Proportion of ED visits that could likely be treated in a non-emergency setting

Source:
Inpatient Volumes Increasingly Non-Accretive

Financial Impact of Hospitalizations Depends on Reimbursement, Capacity

Inpatient Volumes Decreasing, But Not For Medicaid Patients

- **2.4 M**
  - *Decrease* in total number of inpatient stays, 2005-2014

- **15.7%**
  - *Increase* in proportion of inpatient stays covered by Medicaid, 2005-2014

Many Leading Causes of Medicaid Hospitalization Potentially Avoidable

- **Leading Diagnoses for Medicaid Hospitalizations:**
  - Mood Disorders
  - Pneumonia
  - Psychotic disorder
  - Asthma
  - Septicemia
  - Skin infection
  - Diabetes complications
  - Epilepsy, convulsions
  - Acute bronchitis
  - COPD

- **6 of 10**
  - Conditions preventable through outpatient care

- **16%**
  - of all Medicaid hospitalizations caused by these six conditions

---

1) Excludes septicemia as a result of labor and delivery.
2) Excludes maternal and neonatal hospitalizations.

### Three Critical Drivers of Preventable Utilization

#### Current Models for Behavioral, Physical, Non-Clinical Needs Falling Short

<table>
<thead>
<tr>
<th>Unmanaged Behavioral Health Issues</th>
<th>Lack of Access to Lower-Acuity Care Sites</th>
<th>Prevalence of Non-Clinical Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% of Medicaid population with one or more behavioral health conditions</td>
<td>25% of adult enrollees using ED because other sites aren’t open</td>
<td>22% of ED frequent-users(^1) report being homeless during the previous year</td>
</tr>
<tr>
<td>48% of total Medicaid spending attributable to those with one or more behavioral health conditions</td>
<td>34% of adult enrollees report barriers finding a doctor or delays in getting needed care</td>
<td>61% of dual-eligibles require help with daily self-care activities (eating, bathing, dressing)</td>
</tr>
</tbody>
</table>

### Small Group of Medicaid “Super-Utilizers” Driving Outsized Spending

| 5% of total Medicaid population | 55% of total annual Medicaid spend | 4% of total Medicaid population | 19% of total Medicaid ED charges |

---

\(^1\) “Frequent Users” here defined as individuals with 4+ ED visits in the previous 12 month period.

Four Priorities to Reduce Preventable Volumes

1. Stratify super-utilizers to customize level of intervention
2. Minimize high-acuity mental health needs through crisis management
3. Establish bidirectional community clinic partnerships
4. Address most prevalent non-clinical drivers of inappropriate utilization

Deploy Targeted Strategy for Highest Utilizers

Fill Highest-Need Network Gaps

Source: Health Care Advisory Board interviews and analysis.
A Comprehensive Approach to Managing the Top 5%

Further Stratify Highest Utilizers to Determine Appropriate Strategy

Intensity of Intervention Varies Based on Frequency of Visits

1. Stratify super-utilizers to customize level of intervention

High Utilizers:
5% of patients; often with co-occurring physical and behavioral health conditions and non-clinical barriers to care

- Top <50 patients
- 30+ annual ED visits
- 10+ annual ED visits

Proactive, high-touch, intensely personalized care management services
Proactive care management engagement to prevent future inappropriate use
Care management resources when they next appear in the ED

Source: Health Care Advisory Board interviews and analysis.
Embed Resources in ED for Broadest Reach

CRMC Flags High-Utilizers, Demonstrates Potential ROI to Engage Stakeholders

1. **Mine Data to Identify Frequent Users**
   - Pulled data from ED’s EMR
   - Found 575 patients with 9+ ED visits in 12-month period; 8,897 visits total

2. **Present Findings to Generate Buy-In**
   - Program coordinator met with hospital board and community stakeholders
   - Calculated cost and ROI projections

3. **Hardwire Referral Process**
   - ED social work staff fill out referral form
   - ED social worker emails or faxes form to Community Connections team

4. **Program Staff Deliver Services**
   - Community Connections staff meet with referred patient
   - In first two years, staff conducted 1,204 face-to-face contacts

**Case in Brief: Community Regional Medical Center**

- 626-bed community hospital in Fresno, CA
- In 2009, created Community Connections, a frequent-user program that expands beyond the scope of the ED to provide outreach, engagement, and case management

**An Immediate Impact**

*Participant utilization six months post-intervention*

- **52%** Decrease in ED visits
- **58%** Decrease in IP admissions

Source: Health Care Advisory Board interviews and analysis.
Deploy Proactive Outreach for Smaller Subset

Super-Utilizers Targeted for Intensive Needs Assessment

Carolinas Stratifies ED Users Into Cohort Suitable For Intervention

Data-Mining-Identified Super-Utilizer Cohort:
- 158 Patients
- 7,000 Total visits
- $22M Total charges

Care Management Team Contacts Super-Utilizers, Creates Personal Care Plans

Nurse, Community Health Worker, Behavioral Health Specialist team reach out to Super-Utilizers via phone or in-person visit

Patients connected to PCPs, community clinics, social work, supportive resources as needed

Reduction in ED use among Super-Utilizer cohort six months post-intervention

Source: Health Care Advisory Board interviews and analysis.
Deploy Proactive Outreach for Smaller Subset

Continued

Case in Brief: Carolinas Healthcare System

• 47-hospital system based in Charlotte, NC

• Avoidable ED utilization a statewide issue, with 53% of ED visits classified as “non-emergent”

• Stratified patient utilization data to identify frequent users (10+ ED visits), which returned an unmanageably high number of patients

• Stratified to identify super-utilizers (30+ ED visits), which returned a manageable cohort of 158 individuals

• Care managers reached out to super-utilizers for personal care planning that addressed clinical and non-clinical needs
Invest in Personal Touch For Highest-Use Patients

Peninsula Regional Provides Super High Utilizers with Hands-On Support

High-Touch Navigation Reduces Readmission Risk for Top 25 Patients

- Team of nurse and community health workers meet patient at time of discharge and review discharge instructions together
- Drive patient home to build personal connection, rapport
- Follow-up with patient at home to ensure adherence to discharge instructions for three months post-discharge

Case in Brief: Peninsula Regional Medical Center

- 289-bed community hospital located in Salisbury, MD; subsidiary of Peninsula Regional Health System
- Collaborated with Lower Shore Clinic, a community-based outpatient clinic offering behavioral health and primary care services, to launch the CareWrap care management program targeting 20-30 chronically ill super-utilizers

66% Reduction in hospitalizations within two years

$10K Average cost to readmit patient

$5-6K Average cost to engage in CareWrap

1) FY2016.

Source: Health Care Advisory Board interviews and analysis.
Four Priorities to Reduce Preventable Volumes

1. Stratify super-utilizers to customize level of intervention

2. Minimize high-acuity mental health needs through crisis management

3. Establish bidirectional community clinic partnerships

4. Address most prevalent non-clinical drivers of inappropriate utilization

Source: Health Care Advisory Board interviews and analysis.
Start with Most Pressing Gap to Goal

Medicaid Behavioral Health Needs Cross the Acuity Spectrum

Medicaid Patients Present with Wide Range of Behavioral Health Needs

LOW
E.g., children who need screening, referral, and treatment for attention deficit hyperactivity disorder

MODERATE
E.g., chronically-ill adults with co-morbid physical and behavioral health conditions

HIGH
E.g. adults with disabilities or substantial psychosocial limitations and severe psychoses

Comprehensive Approach Spans Care Continuum

Improve Access to Preventive Services for Low-to-Moderate Acuity Patients

Deploy Crisis Management for Moderate-to-High Acuity Patients in the ED

Source: Health Care Advisory Board interviews and analysis.
Ensure Effective Navigation of Existing Assets

Training Community Paramedics to Assess, Treat, and Triage

Case In Brief: Wake County Emergency Medical Services

- EMS organization in Wake County, NC
- In 2009, Community Care of Wake and Johnson Counties (CCWJC) initiated a multi-stakeholder collaboration with the Wake County community paramedicine program to reduce inappropriate ED utilization by frequent utilizers
- 16 advanced practice paramedics (APPs) provide a range of home-based services including assessment of mental health, injury risk, and chronic condition management, and also divert mental health patients away from medical EDs based on screening protocol

Paramedics Train to Expand Responsibilities

Paramedics receive 200 hours of didactic and clinical training prior to serving as an APP

Program Impact for Duke-Raleigh Hospital

$325K Estimated cost savings due to a 34% reduction in ED visits from 2012 to 2014 for a sample of 25 patients

Source: Health Care Advisory Board interviews and analysis.
Maximize Community Resources Through Technology

Telepsychiatry Positions Services at Right Place and Right Time

Telepsychiatry Program Details

- Connects 17 community-based, outpatient mental health centers with over 20 hospital EDs across the state
- Service is available 16 hours per day, with psychiatrists from the South Carolina DMH offering rotating coverage
- Program is funded by grants from The Duke Endowment; participating hospitals also pay subscription fee

Program Outcomes

- Participating patients diverted from an inpatient admission: 43%
- Reduction in overall length of stay for participating hospitals: 53%
- Estimated cost savings for the hospital per episode of care: $1,400+

Case in Brief: South Carolina Department of Mental Health (DMH)

- State-operated system of 17 community-based, outpatient mental health centers, each with clinics and satellite offices, which serve all 46 counties in the state
- Operates statewide telepsychiatry network available for all hospitals in state operating EDs

Source: Health Care Advisory Board interviews and analysis.
Share the Investment Cost of New Network Assets

Unity Center Coordinates Services, Reduces Loss Through Four-System Partnership

**Legacy Health**
donated real estate, covered costs of remodeling, and licenses the PES unit as an ED; takes on 40% of profits and losses

**Kaiser Permanente**
provided strategic planning expertise, takes on 20% of profits and losses

**OHSU**
contributes provider recruitment, medical staffing, and residents; takes on 20% of profits and losses

**Adventist Health**
transferred psychiatric beds to Unity Center; takes on 20% of profits and losses

24-hour behavioral health services center providing outpatient psychiatric emergency services, several inpatient units, and ongoing support

**Source:** Health Care Advisory Board interviews and analysis.

---

1) Temporary status for a health care facility in which it informs local emergency medical services and ambulances that its beds are full and it cannot take new patients.
Case in Brief: Unity Center for Behavioral Health

- 102-bed inpatient behavioral health facility and psychiatric ED in Portland, OR
- Legacy Health, Kaiser Permanente, Adventist Health, and Oregon Health & Science University established a partnership to address market-wide shortage of appropriate psychiatric treatment services
- Creation of Unity Center decreased volume of psychiatric patients presenting in hospital EDs, increased connections with community support services
Taking a More Proactive Approach

Comprehensive Strategy Reaches into Ambulatory Space

Three Steps to Developing a Proactive Approach to Behavioral Health Management

1. Screen for behavioral health needs in the primary care setting
2. Use care transitions to detect and support behavioral health
3. Collaborate with other providers to build a robust behavioral health continuum

Study in Brief: Proactive Behavioral Health Management
Download this briefing for three steps to building a robust behavioral health continuum.

Source: Health Care Advisory Board interviews and analysis.
Four Priorities to Reduce Preventable Volumes

1. **Stratify super-utilizers to customize level of intervention**

2. **Minimize high-acuity mental health needs through crisis management**

3. **Establish bidirectional community clinic partnerships**

4. **Address most prevalent non-clinical drivers of inappropriate utilization**

**Deploy Targeted Strategy for Highest Utilizers**

**Fill Highest-Need Network Gaps**

Source: Health Care Advisory Board interviews and analysis.
Ensure Access to Lower-Cost Alternatives

Falling Short in Primary and Specialty Care Needs

Chronic Disease, Maternity Care Two Major Drivers of Utilization in Medicaid

- Of non-dual Medicaid beneficiaries have 4+ chronic conditions: 33%
- Of maternal and neonatal ED visits are covered by Medicaid: 58%

Three Major Low-Acuity Access Needs:

- Primary Care
- Prenatal Care
- Specialty Care

In Search of an Access Partner

Community Clinics Better Positioned to Serve Needs of Medicaid Population

Community Clinics Combine Critical Clinical and Social Services

- Primary Care Clinic
- Pediatric Dental Clinic
- Laboratory Services
- Community Resource Specialist
- Social Work Coordinator
- Enrollment Specialist

Playing a Crucial Role in the Safety Net

1,128
Federally Qualified Health Centers

20 M
Patients served annually by FQHCs and “look-alikes”

85%
of patients at FQHC and look-alike clinic have Medicaid or no insurance

1) Health centers that function similarly to FQHCs, but without federal designation and eligibility for Section 330 grant support.

Mutual Support Required for Long-Term Sustainability

Moving Beyond a Simple Redirection Relationship

- **Expand and Improve Clinical Capabilities**: Support partner to offer specialty care on-site
- **Solidify Clinician Relationships to Ensure Referrals**: Ensure alignment of partnership value-add across all stakeholders
- **Provide Direct Support to Increase Capacity**: Address potential financial, material challenges in offering new partnership services
- **Identify a Best-in-Class Partner**: Carefully assess strengths and needs of community partner, beginning relationship with clear expectations

Source: Health Care Advisory Board interviews and analysis.
Critically Assess Partnership Opportunities

High-Value Relationships a Two-Way Street, Success Not Guaranteed

**Community Partner Checklist:**

- Provides high quality services valuable to Medicaid population
- Conveniently located near crowded, high-Medicaid system EDs
- Articulates clear value to system, with demonstrable ROI
- Maintains open, transparent communication channels
- Willing to meet clinical standardization expectations
- Willing to progress toward risk-based arrangements

**Hallmarks of Effective Relationships**

- Enthusiastic buy-in from leadership and frontline staff
- Sustainable infrastructure for stakeholder engagement, feedback
- Clear metrics for measuring ROI, transparency, accountability
- Aligned back office capabilities for data transparency, continuity
- Shared mission and culture

Source: Health Care Advisory Board interviews and analysis.
Financial Support Vital to Expanding Capacity

Funding for Uninsured Referrals Ensures Continued Viability

**Case in Brief: Dignity Health AZ**

- Seven-hospital system based in Phoenix, AZ
- Established partnership with local free clinic Mission of Mercy to divert ED volumes to more appropriate site of care; Mission proposed regular financial support
- Dignity agreed to cover first-year startup costs, annual support based on number of “patient slots” allotted for referrals

Dignity Provides Per-Patient Funding to Local Community Clinic to Divert Non-Acute ED Volumes

- Mission of Mercy’s average patient encounter cost: $200
- Number of “patient slots” allotted for Dignity referrals: 1,240
- Cost to Mission of Mercy: $250K
- Annual operational support from Dignity to offset costs: $125K

**Financial Support Only Scratching the Surface**

- Donated facilities, capital
- Subsidized grant writing
- Leadership training
- Clinical development
- Shared technology
- Coordinated marketing
- Coordinated advocacy
- Shared recruitment
- EHR platforms
- Pharmacy distribution

Source: Advisory Board Company, “Meet Your Community Partner in Improving Population Health,” 2016; Health Care Advisory Board interviews and analysis.
Physician Relationships Solidify Partnerships

Ambassadors Ensure Timely Referrals Between Hospital and FQHC

Unfamiliar with Community Resources, Hospitalists Delay Discharge

- Highly complex and time-consuming care planning
- Uncertain volumes for FQHCs
- Longer LOS for complex patients

Ambassador Program Solidifies Professional, Personal Trust

- Face-to-face meetings increase familiarity, collaboration
- Patients consistently referred to FQHC for follow-up
- Care is delivered at appropriate, lower-cost site

Case in Brief: Lapis Health

1. Integrated delivery system in the West
2. Operates Medicaid managed care plan
3. Hospitalists unfamiliar with community resources uncomfortable discharging complex patients
4. Ambassador Program encourages partners to communicate, better understand programs and support services available to patients after hospital discharge

Source: Health Care Advisory Board interviews and analysis.
Extend Specialty Assets to Primary Care Partners

OB/GYN a Clear Opportunity to Enhance Community Clinic Capabilities

Building a Quality Obstetrics Care Pathway

CHC PCP
Evaluates patients and refers to OB

Mercy OB/GYN
Treats patients part-time at CHC

Mercy MFM\(^1\) Specialist
Provides care to high-risk patients at CHC one day per week

Mercy Hospital Springfield
OB delivers CHC patients at Mercy

Other Mercy Specialists
Connected as deemed necessary by OB/GYN

Case in Brief: Mercy Hospital Springfield and Jordan Valley CHC

- 562-bed hospital member of Mercy Health System; seven-clinic FQHC based in Springfield, MO
- Partnered to provide prenatal care to low-income expectant mothers, providing OB/GYN and specialist access to promote healthier pregnancies and safer deliveries


1) Maternal fetal medicine.
2) Neonatal intensive care unit.
E-Consults Expand Range of Shareable Specialties

Connecticut Becomes First State to Secure Medicaid Reimbursement

CHC Pilots E-Consults For High-Demand Specialties, Secures CMS Reimbursement

- PCP submits referral to cardiologist, endocrinologist, or nephrologist (high Medicaid demand services)
- Specialist accesses PCP notes, patient records
- Clinician confirms care plan or advises follow-up
- E-Consults reimbursed by CMS beginning in 2016

Case in Brief: Community Health Center

- Non-profit primary care network with 200 locations across Connecticut
- Created an online consultation platform in partnership with community-based research center The Weitzman Institute and CA-based care coordination tool developer Safety Net Connect
- CMS approved the program for Medicaid reimbursement in 2016

70%
Of PCP referrals are resolved without need for a specialist appointment

Source: Wicklund E., “Telehealth Tackles Medicaid’s Challenges with eConsult Program,” mHealthIntelligence, May 2017; Health Care Advisory Board interviews and analysis.
Four Priorities to Reduce Preventable Volumes

1. Stratify super-utilizers to customize level of intervention
2. Minimize high-acuity mental health needs through crisis management
3. Establish bidirectional community clinic partnerships
4. Address most prevalent non-clinical drivers of inappropriate utilization

Source: Health Care Advisory Board interviews and analysis.
Non-Clinical Interventions Warrant Due Diligence

Current Strategies Failing to Achieve Sustainable Impact

Three Predominant Issues Prevent Systems from Achieving Long-Term Goals

An Overwhelming Set of Opportunities to Pursue
System investment in interventions is haphazard, based on pick-and-choose of myriad options

Current Efforts Ad-Hoc Passion Projects
Passion projects are steered by individual stakeholders rather than data-informed approach

Funding Precludes Comprehensive Approach
Even the most thoughtfully-designed programs struggle with inconsistent funding

Targeted, High-Value Interventions
System investments in addressing non-clinical drivers of poor health, inappropriate utilization show clear ROI

Source: Health Care Advisory Board interviews and analysis.
Home in on Most Pressing Community Needs

Keren Health’s Multi-Stage Analysis Isolates Opportunities for High-Impact Intervention

1. Identify hospital EDs with the highest utilization rates
   - Three local EDs crowded with repeat utilizers

2. Break down most prevalent diagnoses for frequent utilizers
   - High frequency of asthma, respiratory distress

3. Layer in claims, demographic data to identify common factors
   - Patients’ ZIP codes have housing sanitation violations

4. Create targeted intervention for affected population
   - Contract with exterminator to clean out homes

Case in Brief: Keren Health

- Large integrated system in the Northeast
- Applying analytics to identify trends, potentially inflectable underlying causes of high utilization
- Early results have identified non-clinical intervention opportunities with greater ROI than standard clinical responses
Don’t Hesitate to Sunset Programs if Ineffective

Limited Resources Necessitate Regular Evaluation of ROI

Annual Review Process Checks Programs Against Four Key Metrics

Case in Brief: Lehigh Valley Health Network

- Eight-campus health system based in Allentown and northeast PA
- Department of Community Health (DCH) maintains a diverse portfolio of outreach, education, and health improvement programs and uses collaborative cycles of improvement
- DCH leadership conducts annual sustainability review of every current project, determines which programs will be scaled up, continued, or discontinued

Source: Health Care Advisory Board interviews and analysis.
Introducing Your Population Health Advisor

Explore In-Depth Research to Guide Effective Interventions

Addressing Avoidable ED Utilization: Primer Series
Explore the reasons patients seek care in the ED, the business case for intervening, and solutions for reducing unnecessary ED use

Building the Business Case for Community Partnership
Four steps for building effective community partnerships to extend care team reach, engage consumers, and improve cost and quality

Closing the Housing Gap through Strategic Partnerships
A blueprint for reducing housing insecurity and improving community health outcomes

FOR MORE RESOURCES on this topic, visit advisory.com

Source: Health Care Advisory Board interviews and analysis.
Key Takeaways

Addressing Avoidable Low-Margin Utilization Flashpoints

1. Every health system should have a dedicated super-utilizer strategy
   Curbing utilization among the highest utilizers of the ED presents the biggest near-term opportunity to improve Medicaid margins.

2. Delivering appropriate care to the Medicaid population requires fundamentally different access strategies
   Simply increasing the number of access points is not enough to inflect Medicaid utilization patterns. Systems must improve ease of access by expanding existing services, with high-need services prioritized.

3. Health systems should not try to be all things for Medicaid patients; optimize the delivery network through partnership rather than ownership where possible
   Most systems do not possess the full set of assets that make up a Medicaid-tailored delivery network. Rather than building them out alone, prioritize a partnership that supports an existing provider’s ability to better meet Medicaid needs.

4. Providers must apply the same rigor to evaluating community health interventions as they do any other system investment
   Initiatives targeting the safety-net population are particularly prone to be borne of individual passion projects. With limited resources, however, any intervention must be backed up by real evidence of ROI.

Source: Health Care Advisory Board interviews and analysis.
Extending Risk Strategy into Medicaid

5. Predicate transition to Medicaid risk on care management capabilities
6. Target manageable entry point to establish baseline experience
7. Capitalize on emerging opportunities to rapidly expand risk strategy
Navigating the Path Forward

An Economic Incentive to Change the Reimbursement Model

Three Potential Responses to Medicaid Cuts

1. Advocate for Increased Medicaid Reimbursement
   - **$75M** Montana’s 2017 budget shortfall due to Medicaid
   - **11%** Texas’ proposed decrease to Medicaid reimbursement rates

2. Terminate Existing Medicaid Contracts
   - “DMH, HSHS no longer accepting Molina Medicaid”
   - “University of Chicago Medicine severs ties with Medicaid insurer IlliniCare”

3. Transform Payment Model by Taking on Medicaid Risk
   - **8.3%** Of 936 total ACOs hold a Medicaid risk contract
   - “Our risk-based population health strategy is our growth strategy.”
   - SVP Population Health, Hospital in the Midwest


1) According to the Leavitt Partners Database.
States Pushing Providers Toward Risk

Private Payers Beginning to Follow Suit

State-Based Medicaid Accountable Care Organizations
Active or Proposed Models, June 2017

- **States with active or proposed Medicaid ACO programs**: 23
- **Increase in active or proposed Medicaid ACO programs, 2015-2017**: 35%

**Confronting Our Fear**

“We’re afraid to take on Medicare or commercial risk because we know payers will insist we take risk for our Medicaid contract and we’re just not ready to manage that population yet.”

*SVP Population Health, Health System in the Northeast*

Source: Center for Health Care Strategy, “Medicaid Accountable Care Organizations: State Update,” June 2017; Health Care Advisory Board interviews and analysis.
But Undeniable Challenges Accompany Medicaid Risk

- Lower reimbursement rates than any other payer
- Complex patient population with **significant** non-clinical needs
- Intricate contracting environment with no established path and significant regulatory oversight

**New Economic Model Brings New Benefits and Challenges**

**Flexible Funding Advances Overall Organizational Goals**

1. **Advance Mission**
   - Reorient toward prevention rather than treatment

2. **Boost Margin**
   - Capitalize on risk-based incentive structures

Source: Health Care Advisory Board interviews and analysis.
Extending Risk Strategy into Medicaid

Three Key Questions to Guide an Intentional Medicaid Risk Strategy

**Making the Go, No-Go Decision**

*Do we have the necessary clinical infrastructure and risk experience to succeed under Medicaid risk?*

**Developing an Entry Strategy**

*What should we prioritize for our first Medicaid risk contract?*

**Ensuring Long-Term Success**

*How do we evolve our Medicaid risk strategy over the long term?*

1. Predicate transition to Medicaid risk on care management capabilities
2. Target manageable entry point to establish baseline experience
3. Capitalize on emerging opportunities to rapidly expand risk strategy

Source: Health Care Advisory Board interviews and analysis.
5. Predicate transition to Medicaid risk on care management capabilities

Evaluating Existing Capabilities the First Step

Medicaid Requires Additional Care Management Investment

**Foundational Investments for Any Risk Contract**

- Nurse Care Managers
- Telehealth
- Risk Stratification Analytics
- Preferred Post-Acute Partner Network
- Medical Homes
- Patient Engagement Tools

**Additional Investments for Medicaid Risk**

- Community Health Workers
- Community Resource Inventory
- Social Workers
- Health Literacy Resources
- Behavioral Health Specialists
- Social Determinants of Health Screening Tools
- Medical Homes

Source: Health Care Advisory Board interviews and analysis.
Staging Your Entry Into Risk

Risk in Other Segments Prepared Summit for Managing Medicaid

Sample of Summit’s Step-Wise Journey in Tennessee

- **2012**: Entered Medicare Advantage (MA)\(^1\) Upside-Only Risk
- **2015**: Entered Medicaid Upside-Only Risk
- **2016**: Entered Medicare Advantage (MA), Commercial Downside Risk
- **2017**: Contract with State for Medicaid Patient-Centered Medical Home (PCMH)

19,000 Medicaid patients now attributed to Summit

**Potential for Downside Medicaid Risk**

**Clinical Infrastructure Development**
- Built robust annual wellness visit program capturing 85% of Medicare beneficiaries

**Enhanced Population Health Management**
- Expanded wellness visits to commercial and Medicaid

**Targeted Intervention Development**
- Developing process to capture social determinants of health; analyzing drivers of ED overutilization

Source: Health Care Advisory Board interviews and analysis.

---

1) Medicare Advantage.
Case in Brief: Summit Medical Group

- Physician-owned primary care group with 55 office locations based in Knoxville, TN
- Currently holds one Medicare Advantage contract, two commercial risk contracts, and recently entered an upside-only agreement with three Medicaid ACOs; 14 Summit sites are participating in CPC+
Assessing Your Medicaid Risk Readiness

Three Potential Paths Forward

Large safety-net population?

- YES
  - Invested in clinical care management?
    - NO
      - Experience in other risk models?
        - NO
          - NO
        - YES
          - YES
    - YES
      - In a favorable contracting environment?
        - NO
          - NO
        - YES
          - YES

Evaluate Large-Scale Medicaid Risk

Stage Entry into Medicaid Risk

Build Experience in Other Risk Models

Source: Health Care Advisory Board interviews and analysis.
Medicare Risk Provides Foundational Experience

Those Unready for Medicaid Risk Should Explore Other Risk Options

Three Steps to Establishing a Sustainable Medicare Risk Strategy

1. Redefine Path to Risk for Traditional Medicare
   - Set foundation for overall Medicare strategy by determining appropriate level of risk, considering implications of physician strategy on MACRA response

2. Expand Into Medicare Advantage Market
   - Complement traditional Medicare strategy with customized approach to MA contracting based on organizational, market readiness

3. Ensure Longevity of Medicare Risk Strategy
   - Engage partners and patients to ensure maximal financial performance over time

Related Resource: Medicare Risk Strategy
Imperatives to guide the creation of your intentional Medicare risk strategy

Source: Health Care Advisory Board interviews and analysis.
Extending Risk Strategy into Medicaid

Three Key Questions to Guide an Intentional Medicaid Risk Strategy

Making the Go, No-Go Decision

Predicate transition to Medicaid risk on care management capabilities

Do we have the necessary clinical infrastructure and risk experience to succeed under Medicaid risk?

Developing an Entry Strategy

What should we prioritize for our first Medicaid risk contract?

Target manageable entry point to establish baseline experience

Ensuring Long-Term Success

How do we evolve our Medicaid risk strategy over the long-term?

Capitalize on emerging opportunities to rapidly expand risk strategy

Source: Health Care Advisory Board interviews and analysis.
Array of Entry Points

Opportunities Vary by Region

Providers Confronted with Three Major Options

<table>
<thead>
<tr>
<th>Contracting with the State</th>
<th>Contracting with an MCO</th>
<th>Launching an MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Option Exists if:</strong></td>
<td><strong>State does not have mandatory managed care</strong></td>
<td><strong>State allows MCOs</strong></td>
</tr>
<tr>
<td><strong>Pros:</strong></td>
<td><strong>State has unique flexibility, control over policy and budgetary decisions</strong></td>
<td><strong>MCOs have flexibility to evolve contract quickly</strong></td>
</tr>
<tr>
<td><strong>Cons:</strong></td>
<td><strong>State programs often inflexible once set</strong></td>
<td><strong>MCOs payments, structure must align with state policy decisions</strong></td>
</tr>
</tbody>
</table>

---

1) Per-member, per-month payment.

Source: Health Care Advisory Board interviews and analysis.
Identify Targeted Entry Point for Risk

Critically Deliberate System Capabilities, Market Offerings

1. Evaluate if there is a clear opportunity to take on risk for a specific population

   - Do we have the necessary clinical infrastructure and patient volumes to succeed?
   - Is there a regional payer willing to offer a population-specific contract?

2. Identify mechanisms to narrow scope of initial risk contracts

   - What level of risk can we take on?
   - How many patients can we manage at once?
   - What services are we comfortable managing?

Source: Health Care Advisory Board interviews and analysis.
Pediatric ACOs an Increasingly Popular Strategy
For Those With Substantial Pediatric Capabilities, a Natural Starting Point

Pediatric ACOs Growing in Prevalence
Representative Sample Organizations

Examples of Achieved Cost Savings

<table>
<thead>
<tr>
<th>Provider</th>
<th>Population Served</th>
<th>% Reduction or $ Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Children’s Hospital</td>
<td>CSHCN¹: 67% Medicaid, 33% Commercial</td>
<td>Hospital Admissions: 40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Per Child Cost: 30%</td>
</tr>
<tr>
<td>Colorado Medical Homes for Children</td>
<td>Medicaid/CHIP</td>
<td>Hospital Admissions: 18%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Savings per patient: $169-$530</td>
</tr>
<tr>
<td>St. Joseph’s Children’s (Tampa)</td>
<td>CSHCN¹: 85% Medicaid, 15% Commercial, Self-pay</td>
<td>Hospital Days: 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ER Visits: 33%</td>
</tr>
</tbody>
</table>

¹) Children with Special Healthcare Needs.

Clear Pathways to Risk for Dual-Eligible Population

Several Opportunities to Build on Medicare Risk Capabilities

Payer-Led Option

Dual Eligible Special Needs Plan (D-SNP)

29 States with D-SNP participation option

• Program details: Insurance Plan specifically targeted at dual-eligible enrollees in which the state helps cover some Medicare costs

• Sample organizations: WellCare Health Plans, Health Net, Signature Advantage

Provider-Led Option

Program for All-Inclusive Care for the Elderly (PACE)

33 States with PACE participation option

• Program details: Providers are responsible for covering all services in the home, community, and PACE center in exchange for a PMPM; only covers those eligible for nursing home-level care

• Sample organizations: Trinity Health, CarePartners, Cheyenne Regional Medical Center

Assess Readiness Before Taking Next Steps

Trinity Health Cautiously Launches New PACE Programs

Launching PACE Program Dependent on System, Market Features

- Existing clinical experience, infrastructure
- PACE eligible individuals present in selected market
- >2K
- $5-7M

Upkeep Requires Ongoing Recruitment

- 35-40 New people that must be reasonably expected to join program annually to maintain average target of ~200 patients
- “Our job is to keep people out of nursing homes and we succeed 90% of the time.”
  - John Capasso
  - EVP, Continuing Care

Case in Brief: Trinity Health

- Cross-state health system operating 93 hospitals and 121 continuing care locations
- Formed in 2013, when Trinity Health and Catholic Health East merged
- Operates 14 PACE programs across the country

1) 55+, dual-eligible, nursing home eligible.

Source: Health Care Advisory Board interviews and analysis.
Don’t Overestimate the Benefits of Scale

No Matter the Path, Start Small

Three Critical Considerations for Any Initial Risk Model

1. Level of Risk
   - **Upside-Only:** shared savings, pay-for-performance
   - **Upside-Downside:** shared savings/losses, percent of premium
   - **Full Capitation:** PMPM payments, total cost of care management

2. Number of Lives
   - **Attributed Patients:** capped PCP patient panels, limited clinician availability
   - **Risk Contracts:** risk contract restricted to patients of payer partners

3. Scope of Services
   - **Specific Services:** emergency care, designated specialists
   - **Out-of-Network Utilization:** external clinicians, pharmaceutical costs

Source: Health Care Advisory Board interviews and analysis.
Extending Risk Strategy into Medicaid

Three Key Questions to Guide an Intentional Medicaid Risk Strategy

<table>
<thead>
<tr>
<th>Making the Go, No-Go Decision</th>
<th>Developing an Entry Strategy</th>
<th>Ensuring Long-Term Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do we have the necessary clinical infrastructure and risk experience to succeed under Medicaid risk?</td>
<td>What should we prioritize for our first Medicaid risk contract?</td>
<td>How do we evolve our Medicaid risk strategy over the long-term?</td>
</tr>
<tr>
<td>Predicate transition to Medicaid risk on care management capabilities</td>
<td>Target manageable entry point to establish baseline experience</td>
<td>Capitalize on emerging opportunities to rapidly expand risk strategy</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Market Shifts Provide Opportunities for Acceleration

Stay on the Lookout for Changing State Policies, Payment Models

Areas to Watch for Potential Opportunities to Expedite Risk Strategy Development

State Policy Changes
- Medicaid expansion
- Waiver-enabled changes (e.g. All-Payer, ACOs)
- Introduction of MCOs or switch to mandatory managed care
- Mandated minimum targets for value-based contracts

New Funding Sources
- DSRIP\(^1\) funding
- Novel state grant funding
- New funding directed at specific initiatives (e.g. opioid use reduction, natural disaster relief)

Changes in Leadership
- State and federal executive, legislative elections
- Administrative leadership transitions

---

\(^1\) Delivery System Reform Incentive Payment Program.
Evolving to a Global Risk Arrangement

Reliant Increasing Scope of Risk Contract Under Massachusetts' New Waiver

100% risk on clinician fees
50% risk on hospital expenses

Massachusetts received a $52.5B **five-year waiver** in 2017 to restructure the state Medicaid program to transition toward ACO models.

Case in Brief: Reliant Medical Group

- 500-provider group practice headquartered in Worcester, MA
- Held contract for 100% risk on professional fees and 50/50 risk on hospital expenses since 2000
- Capitalizing on DSRIP funding to enhance infrastructure to manage total cost of care of 30K Medicaid patients

100% risk for total cost of care for 30K Medicaid patients

Source: Health Care Advisory Board interviews and analysis.
Key Takeaways

Extending Risk Strategy into Medicaid

1. Medicaid risk is not the right starting point for most; only those with existing clinical care management capabilities should consider Medicaid risk.

Due to poor reimbursement, a complicated contracting environment, and a more complex population, success under Medicaid risk is even more difficult than under risk with other payers. Ensure organizational competencies are in place before jumping into risk.

2. Systems new to Medicaid risk should start small; scale is less critical in Medicaid risk than in Medicare and commercial risk.

Systems should construct initial Medicaid risk contracts that focus on a specific subpopulation (pediatrics, dual-eligibles) or limit contract terms based on level of risk, population size, or scope of services. No matter the specific path, systems should work to harmonize terms across all risk contracts to minimize administrative, clinical burdens.

3. Providers must be prepared to capitalize on fortuitous state and federal policy changes to radically advance their Medicaid risk strategies.

State, federal funding, policy, and leadership changes all represent fleeting, potential opportunities to gain new support and enter previously unavailable risk contracts. Systems should be prepared to capitalize when these chances arise.

Source: Health Care Advisory Board interviews and analysis.
Succeeding Under Medicaid Risk

8. Augment staffing model to include non-clinical roles
9. Hone risk stratification methodology with social determinants of health
10. Recruit patients to care management system
Medicaid Risk Requires Expanded Set of Capabilities

Care Management Needs Higher in Medicaid Population

**Foundational Investments for Any Risk Contract**

- Nurse Care Managers
- Risk Stratification Analytics
- Telehealth
- Preferred Post-Acute Partner Network
- Patient Engagement Tools

**Additional Investments for Medicaid Risk**

- Community Health Workers
- Community Resource Inventory
- Social Workers
- Health Literacy Resources
- Behavioral Health Specialists
- Social Determinants of Health Screening Tools
- Medical Homes
- Patient Engagement Tools

Source: Health Care Advisory Board interviews and analysis.
The More Complex Patient

Clinical, Non-Clinical Factors Complicate Treatment Plans for Medicaid

Common Clinical and Non-Clinical Factors Among Medicaid Population

Clinical Needs

- 46% of Medicaid adults have a functional limitation
- 35% of Medicaid adults have two or more chronic conditions
- 26% of Medicaid adults in fair/poor health
- 10% of Medicaid adults in serious psychological distress

Non-Clinical Needs

- Fluctuating eligibility
- Inconsistent employment
- Food insecurity
- Unstable housing
- Unreliable transportation
- Multiple caregiver responsibilities

Extending Reach into the Community

Representative Community Health Initiatives

<table>
<thead>
<tr>
<th>Montefiore School Health Program</th>
<th>Enos Park Access to Care Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>partners with local schools to provide health education (including nutrition and exercise) and access to primary care, oral health, mental health, and community health</td>
<td>is a collective made up of three providers that implemented a multi-part initiative in a specific neighborhood to improve access to care through a holistic approach</td>
</tr>
</tbody>
</table>

Targeted Continuum of Initiatives Broad-based

| University of Vermont Medical Center reimburses partners for beds and case management across a range of affordable housing programs matched to patient acuity; saved $500,000 annually for permanently housed patients | Ballad Health is a new system comprised of two previously competing health systems that promises to improve 28 access and 25 population health metrics for the region under state oversight for accountability and transparency |

Three Near-Term Care Management Priorities

Expanding Care Management Capabilities to Address Unique Medicaid Challenges

- **Ensure Patient Engagement**
  - Recruit patients to care management system (10)

- **Adapt Existing Infrastructure**
  - Hone risk stratification methodology with social determinants of health (9)

- **Maintain Foundational Investments**
  - Augment staffing model to include non-clinical roles (8)

Source: Health Care Advisory Board interviews and analysis.
Meet the Medicaid Care Management Team

<table>
<thead>
<tr>
<th>Role</th>
<th>Main Tasks</th>
<th>Education &amp; Training</th>
<th>Median Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Care Manager</td>
<td>Central contact and care coordinator for medically complex patients; located in clinical setting</td>
<td>Registered Nurse; many years of experience</td>
<td>$68,450 per year</td>
</tr>
<tr>
<td></td>
<td>• Manages patients with multiple chronic conditions post-discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provides ongoing support to more fragile patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Coordinates across sites of care and manages referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>Counsels patients to cope with clinical, non-clinical stresses; located in clinical setting</td>
<td>Bachelor’s or Master’s; several years experience</td>
<td>$46,890 per year</td>
</tr>
<tr>
<td></td>
<td>• Assists patients through poverty, abuse, addiction, physical illness, divorce, bereavement, disability, and mental illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provides community resource referrals and legal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>Assists patients with non-clinical components of health; typically goes out into the home, community</td>
<td>High school diploma; receives on-the-job training</td>
<td>$37,330 per year</td>
</tr>
<tr>
<td></td>
<td>• Connects patients with community resources; serves as liaison between clinical and non-clinical organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assists patients with navigating health care expenses, coverage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Non-Clinical Staff Step Into Leading Role

Main Point of Contact Assigned Based on Main Utilization Drivers

Partners’ Integrated Care Management Program

Full model following transition to Medicaid Risk

<table>
<thead>
<tr>
<th>Main Risk Factor</th>
<th>Model under Medicare risk</th>
<th>Additions to care team following transition to Medicaid risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Medical Issue</td>
<td>Nurse 180-200 patients</td>
<td>Social Worker 80-100 patients CHW 30 patients</td>
</tr>
<tr>
<td>Behavioral Health Issue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Support Issue</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Support staff for all patients: Pharmacists and Community Resource Specialist

Case in Brief: Partners HealthCare

- Eight-hospital health system in Boston, MA
- 500,000+ patients in some form of risk contract; 30,000 of which are Medicaid
- After expanding to Medicaid risk, adapted Integrated Care Management Program to address social determinants

1) Specifically charged with helping patient navigate financial or coverage issues.

Source: Health Care Advisory Board interviews and analysis.
The Case for Non-Clinical Staff

Community Health Workers Deliver Clear ROI

University of New Mexico, Molina Healthcare, and Hidalgo Medical Services CHW¹ Pilot Program

Background

Team of 10, including six CHWs, assigned to 448 high utilizer Medicaid managed care patients

Results

Program Costs vs. Savings

<table>
<thead>
<tr>
<th>Costs</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$521K</td>
<td>$2M</td>
</tr>
</tbody>
</table>

ROI: 4:1

Fewer inpatient admissions³

83%

Impact

Model has since been expanded to all 13 counties in New Mexico and replicated in 12 states

Case in Brief: Centennial Care

• Medicaid program of New Mexico since January 2014; BlueCross BlueShield, Molina Healthcare, Presbyterian, and UnitedHealthcare operate MCOs² for the program

• Expanded on a CHW pilot originally conducted by University of New Mexico, Molina Healthcare, and Hidalgo Health Center deploying community health workers to establish trusting relationships with high-risk enrollees and significantly reduce caseload for traditional case managers

Source: Johnson, D. et al, “Community Health Workers and Medicaid Managed Care in New Mexico,” Journal of Community Health, June 2012; Health Care Advisory Board interviews and analysis.

¹ Community health worker.
² Managed Care Organization.
³ Control group not managed by CHWs had 53% fewer inpatient admissions.
New Staff Model Requires New Analytic Model

Non-Clinical Data Crucial for Connecting Patients to the Right Intervention

Multiple Dimensions of Risk Provide Additional Analytic Advantages

<table>
<thead>
<tr>
<th>Risk Type</th>
<th>Data Elements</th>
<th>Advantage Gained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Risk</td>
<td>• Age, gender&lt;br&gt;• Level of social support&lt;br&gt;• Home environment&lt;br&gt;• Social relationships</td>
<td>Allows clinician to identify culturally competent wraparound support services for individual patient</td>
</tr>
<tr>
<td>Geographic Risk</td>
<td>• Average income&lt;br&gt;• Housing value&lt;br&gt;• Distance from health care services</td>
<td>Quantifies community-level risk factors, prioritizes patients and community-level interventions</td>
</tr>
<tr>
<td>Behavioral Risk</td>
<td>• Anxiety&lt;br&gt;• Depression&lt;br&gt;• Stress&lt;br&gt;• Mental health symptoms</td>
<td>Alerts clinician to prioritize behavioral health interventions</td>
</tr>
<tr>
<td>Patient Activation</td>
<td>• Health understanding&lt;br&gt;• Health literacy&lt;br&gt;• Engagement&lt;br&gt;• Confidence</td>
<td>Provides guidance on intensity and approach to behavior change management</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Make the Most of the Primary Care Visit

Incorporate Simple Data Collection into Clinical Visits

Expanding Risk Stratification to Include Social Determinants of Health

1. Housing Insecurity
2. Social Isolation
3. Stress, Depression
4. Making Ends Meet
5. Transportation
6. Food Insecurity
7. Child Care
8. Legal Issues
9. Intimate Partner Violence
10. Substance Abuse
11. Health Literacy

Case in Brief: Lapis Health

- Integrated delivery system in the West
- Operates Medicaid managed care plan
- To enhance risk stratification methodology, embedded screening for social determinants of health into primary care visit workflow

• Questions curated from several national social determinant surveys
• Simple screening is easily embedded into primary care visit workflow

Source: Health Care Advisory Board interviews and analysis.
Efficiently Connecting Patients to the Right Resources

Technology Platforms Centralize and Expedite Process

Screening and Resource Connection Process

Screening
- Patient fills out survey during visit to identify potential health-related social needs

Resource Identification
- Technology platform\(^1\) produces a printout of community resources for patients that identify needs

Navigation
- Navigators made available to provide additional support

Case in Brief: Allina Health
- 12-hospital system based in Minneapolis, MN
- Cares for at risk Medicaid patients through the state Integrated Health Partnership model
- Implemented a pilot to test a screening, referral, and limited navigation process for their Medicaid patients

Initial Pilot Results
- 39% of screened patients identified at least one need
- 35% of patients called in follow up used the resources provided

\(^1\) Allina uses NowPow, a community resource database and referral tool.

Source: Health Care Advisory Board interviews and analysis.
Designing Distinct Prioritization Scores for Subgroups

CCNC\(^1\) Applies Dedicated Methodologies to Target Impactable Costs in Three Areas

<table>
<thead>
<tr>
<th>Complex Patients Score</th>
<th>Transitional Care Score</th>
<th>Maternal and Infant Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Predicts</em> efficacy of complex care management program</td>
<td><em>Predicts</em> efficacy of care management of hospital to home care episode</td>
<td><em>Predicts</em> efficacy of care management of prenatal care episode</td>
</tr>
<tr>
<td><em>Impacts</em> total cost of care through reduced inpatient and ER visits</td>
<td><em>Impacts</em> total cost of care through reduced readmissions</td>
<td><em>Impacts</em> total cost of care through reduction in low birth weight (or preterm) deliveries</td>
</tr>
</tbody>
</table>

Case in Brief: Community Care of North Carolina

- Public-private partnership based in Raleigh, NC that provides case management, data analysis, quality improvement, and training activities for primary care practices
- Patient-centered care model includes 5,000 providers and 1.6 million patients
- Developed Impactability Score program which combines utilization, clinical risk, and social determinant data along with care management intervention results to identify opportunities to lower total cost of care and improve quality measures

Download *How to Prioritize Population Health Interventions*, on advisory.com

---

1) Community Care of North Carolina.

©2017 Advisory Board • All Rights Reserved • advisory.com • 35577B

Source: Health Care Advisory Board interviews and analysis.
The Virtuous Care Management Cycle

Cautiously Applying Lessons Across Populations

Medicare Care Management Focus

Non-Clinical Expertise
- Community Health Workers
- Social Determinants of Health Screening Tools
- Community Resources Inventory

Clinical Expertise
- Nurse care managers
- Preferred post-acute partner network
- Patient-centered medical home
- Disease management

The Virtuous Care Management Cycle

Medicaid Care Management Focus

Source: Health Care Advisory Board interviews and analysis.
Three Near-Term Care Management Priorities

Expanding Care Management Capabilities to Address Unique Medicaid Challenges

1. Adapt Existing Infrastructure
2. Maintain Foundational Investments
3. Hone risk stratification methodology with social determinants of health
4. Augment staffing model to include non-clinical roles
5. Recruit patients to care management system

Source: Health Care Advisory Board interviews and analysis.
Hard to Reach, Hard to Engage

Overcoming the Perennial Medicaid Challenge

Recruitment Complexities

40% of low-income adults likely to experience a change in eligibility status within 12 months

15-20% average appointment no-show rate in underserved populations

Four Steps of Engagement

- Proactive Insurance Enrollment
- Systematic New Enrollee Onboarding
- High-Risk Patient Engagement
- Disconnected Low-Risk Patient Engagement

Proactively Enroll High-Utilizing Uninsured Groups

Targeting a Clear Opportunity for Inflection

Initiating Relationship With High-Utilizers Improves Coverage, Coordination

PA-led Street Medicine team visits homeless individuals on-site to provide basic care

Social workers assist with Medicaid enrollment, coordinated connections to community resources and health care

2015-2017 Results

24% → 74%
Increase in Medicaid enrollment

204 → 55
Decrease in ED utilization rate

$4.3M
Downstream revenue attributed to Street Medicine Program enrollment

Case in Brief: Lehigh Valley Health Network

• Eight-campus health system based in Allentown and northeast PA
• Identified group of uninsured homeless individuals who only interacted with the network through ED and inpatient stays
• Launched Street Medicine pilot to bring basic care to homeless individuals, connect with resources

1) Physician Assistant.
2) Two-year longitudinal performance (n = 1,300).
3) ED utilization rate per 100 patients within same cohort for those whose care originated in street/shelter clinic (n=901).

Source: Health Care Advisory Board interviews and analysis.
Systematic New Enrollee Onboarding

Onboard New Enrollees to System

Pilot Tests Proactive Onboarding for Medicaid Population

Ensuring Appropriate Engagement From the Outset

Navigators conduct telephonic outreach to all new Medicaid members for onboarding

Case in Brief: Ebbit Medical Group

- Independent medical group with risk-based Medicaid contract in the Northeast
- Piloting Medicaid-specific onboarding protocol for portion of the managed care population

New Medicaid Patient Onboarding Agenda

- Assign a primary care physician
- Assess care needs (e.g., pregnancy, immediate acute needs) and schedule appointments
- Ensure successful medication transfer

Potential Follow-Ups

- Patient attends scheduled primary care, specialty visits
- Complex patients connected with high-risk care manager

1) Pseudonym.

Source: Health Care Advisory Board interviews and analysis.
Warm Handoff to Care Management a Must

Build on Existing Relationships to Increase Engagement

Outreach Roadmap for Complex Managed Medicaid Patients

Initial Outreach
- Risk management system flags patient to case managers
- Invitation letter sent from case manager

Follow-Up Outreach
- Phone call from physician
- 2-3 calls by case manager over several weeks

Enrollment
- Stop outreach after 3 calls
- Patient comes in for a “super visit” with physician and case manager

Case in Brief: Henry Ford Health System
- 1,679-bed, not-for-profit system with five hospitals in the Midwest
- 650,000 members in their subsidiary Health Alliance Plan; ~100,000 are in Medicaid
- Employed introduction from physicians to initiate patient engagement with care management program

Keys to Success
- Market care management program as a free resource
- Case managers embedded in physician office and maintain patient relationship over time

Source: Population Health Advisor, “Care Management Enrollment for Complex Managed Medicaid Patients,” Advisory Board, 2015; Health Care Advisory Board interviews and analysis.
Disconnected Low-Risk Patient Engagement

Replicating the Medicare Wellness Visit

Summit Medical Group Targeted Patients Not Seen for Two Years to Build Relationship

Outreach Approach

1. Seven practices piloting HealthGrid platform to automate text- and phone-based outreach
2. Remaining practices conduct outreach manually through receptionists
3. Health plan partners also deploy staff to conduct outreach

Annual Wellness Visit

- Occur in primary care office or at health fairs
- Covers required and recommended screenings, diagnostics, and immunizations based on age

Case in Brief: Summit Medical Group

- 55-practice primary care group based in Knoxville, TN
- Upside-only risk agreements with three Medicaid Managed Care Organizations
- Applied their Medicare Annual Wellness Visit process to their less complex Medicaid patients in order to establish and maintain relationships

Source: Health Care Advisory Board interviews and analysis.
Tracking Down “Unreachable” Patients

Deploy Specialized Staff to Track Current and Potential Patients

Three Outreach Tactics

Dedicated Research Team

Track down phone numbers that are reachable

Consistent Presence in Community

Use social workers and CHWs\(^1\) in the field who have built trust with a patient peer group

Leverage Utilization Points

Track utilization of potential beneficiaries in primary care, inpatient, or pharmacological settings

Percentage of “Unreachable” Potential Beneficiaries

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>43%</td>
</tr>
<tr>
<td>2017</td>
<td>32%</td>
</tr>
</tbody>
</table>

Case in Brief: Commonwealth Care Alliance

- Not-for-profit, community-based health plan based in Boston, MA
- Created two D-SNPs\(^2\) that serve individuals with complex care needs who are dually eligible for Medicaid and Medicare
- Deployed a research team to track down potential clients because so many were considered “unreachable”

---

1) Community health worker.
2) Dual-Eligible Special Needs Plans.

Source: Health Care Advisory Board interviews and analysis.
Key Takeaways

Succeeding Under Medicaid Risk

1. Nurse-led care management models addressing medical complexity are necessary but insufficient under Medicaid risk. Compounding non-clinical issues make Medicaid care management particularly challenging. Organizations must modify both their care management staffing models and analytics platforms to address social determinants of health.

2. Medicaid care management systems must include strategies to proactively recruit patients to the system. Low levels of health literacy and transience among certain segments of the Medicaid population present unique challenges. Proactive enrollment and onboarding strategies, in addition to warm handoffs to care management are crucial to ensuring desired levels of engagement.

3. Care management investments made for the Medicaid population can be scaled across all populations under risk. While Medicaid warrants outsized focus on social determinants of health, patients across all payer segments present with non-clinical needs. While Medicaid risk may provide the financial incentive to address these issues, solutions should be scaled across the broader population.

Source: Health Care Advisory Board interviews and analysis.
1. Current State of the Safety Net

2. Preserving the Community Safety Net

3. Our Mission Imperative
Preserving the Community Safety Net

10 Imperatives for Designing a Sustainable Medicaid Strategy

Stabilize Under Current Economics

1. **Addressing Avoidable Low-Margin Utilization Flashpoints**
   - Deploy Targeted Strategy for Highest Utilizers
     - Stratify super-utilizers to customize level of intervention
   - Fill Highest-Need Network Gaps
     - Minimize high-acuity mental health needs through crisis management
     - Establish bidirectional community clinic partnerships
     - Address most prevalent non-clinical drivers of inappropriate utilization

Transform Business Model

2. **Extending Risk Strategy into Medicaid**
   - Predicate transition to Medicaid risk on care management capabilities
   - Target manageable entry point to establish baseline experience
   - Capitalize on emerging opportunities to rapidly expand risk strategy

3. **Succeeding Under Medicaid Risk**
   - Augment staffing model to include non-clinical roles
   - Hone risk stratification methodology with social determinants of health
   - Recruit patients to care management system

Special Report:

Confronting the Opioid Epidemic

Source: Health Care Advisory Board interviews and analysis.
Embracing Our Ambition

Striking a Balance Across Conflicting Priorities

Protect Margins

- Mitigate losses under FFS
- Evaluate potential to transform reimbursement model

Enhance Access

- Maintain ability to provide crucial services
- Expand access by filling network gaps

Preserve Stability of the Community Safety Net

- Refrain from strategies that actively harm safety-net counterparts
- Engage in partnerships to preserve, enhance market stability

Source: Health Care Advisory Board interviews and analysis.
All In This Together

Safety Net Strategy a Multi-Stakeholder Effort

Expanding Our Community Impact

Scope

Health System

Holistic care that connects to community resources

Neighborhood

Provider-provider partnerships to expand access and address community-wide challenges

Region

Multi-market reach to impact more complex, long-term determinants of health

Source: Health Care Advisory Board interviews and analysis.