Medicaid Innovation Accelerator Program
Beneficiaries with Complex Care Needs and High Costs (BCN)

Identification and Stratification of Medicaid Beneficiaries with Complex Needs and High Costs

IAP BCN National Dissemination Webinar

October 31, 2016
2:00 PM – 3:30 PM ET

Logistics for the Webinar

- All participant lines will be muted automatically during today's webinar.
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in "full screen" mode
  - Please exit out of "full screen" mode to participate in polling questions
- Moderated Q&A will be held during the webinar:
  - To verbally ask a question, dial *1. You will be connected to the webinar operator, who will connect your line so that you can ask your question.
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience.

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Poll #1

- Please select the type of organization you are representing.
  - State Medicaid Agency
  - State Agency other than Medicaid Agency
  - Managed Care Organization
  - Healthcare Provider
  - Consultant
  - Other

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Agenda and Background

Karen LLanos

Medicaid Innovation
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Agenda

- Background
  - Karen Llanos, Director, Medicaid IAP Centers for Medicare & Medicaid Services

- Key Learnings about BCN Identification & Stratification
  - Juan Montanez, Principal, Health Management Associates

- Perspectives from the Field
  - Tracy Johnson, Director, Health Care Reform Initiatives, Denver Health
  - Ruben Amarasingham, President and CEO, Parkland Center for Clinical Innovation, Pieces Technologies, Inc.

- Reflections from BCN Initiative States

- Topic Wrap Up and Closing Remarks

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Background

- BCN track of IAP has worked with five states over ten months on issues such as:
  - Identifying and stratifying BCN target populations
  - Incorporating social determinants of health into targeting and program design activities
  - Designing effective care management strategies
  - Designing Alternative Payment Methodologies
- This is the first of a series of four national dissemination webinars for the IAP Beneficiaries with Complex Care Needs & High Costs program area
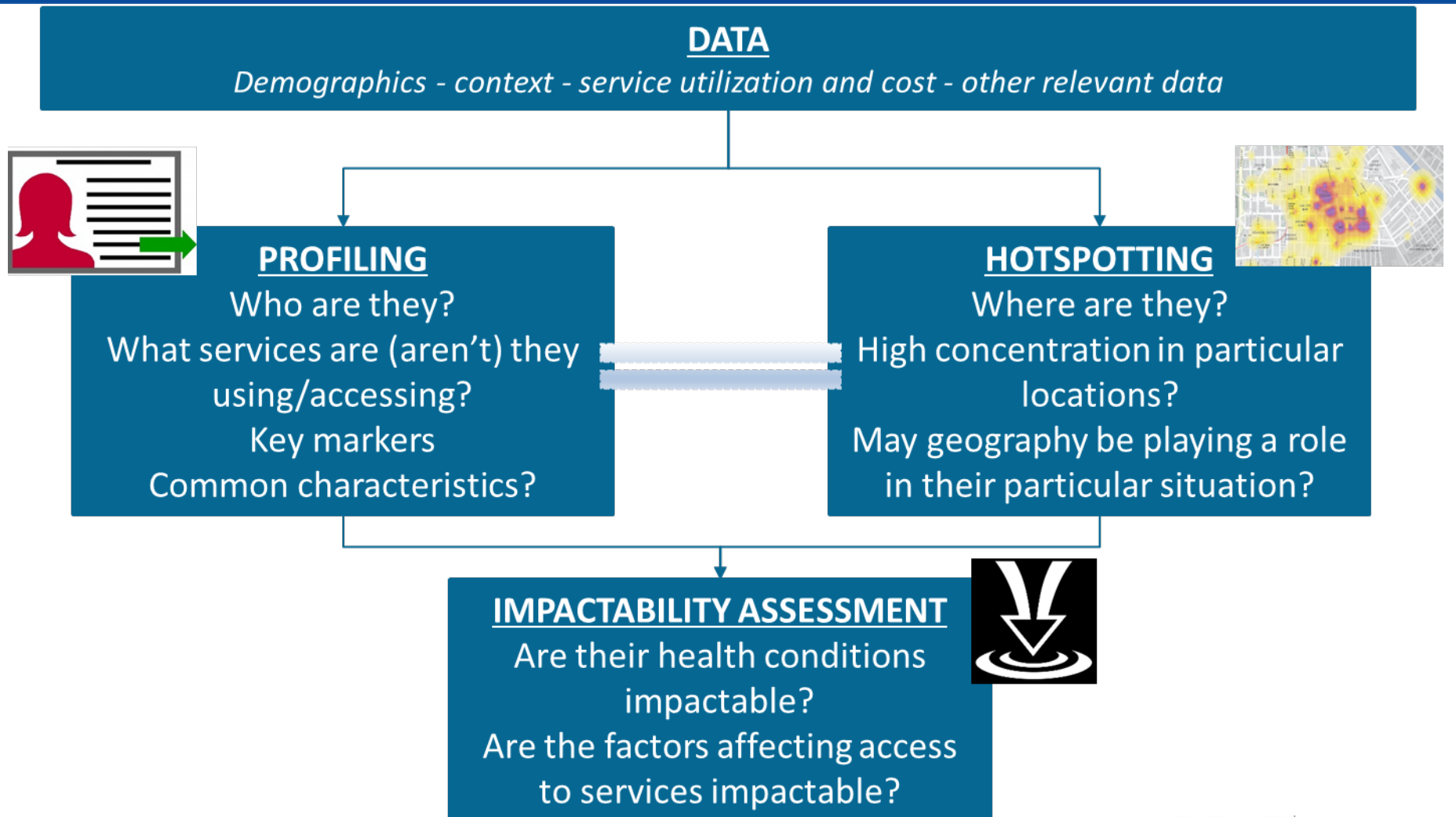- Today's focus-- Identifying and stratifying BCN target populations

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IAP BCN Participating State Teams

- District of Columbia
- New Jersey
- Oregon
- Texas
- Virginia

Learnings about BCN Identification and Stratification

Juan Montanez

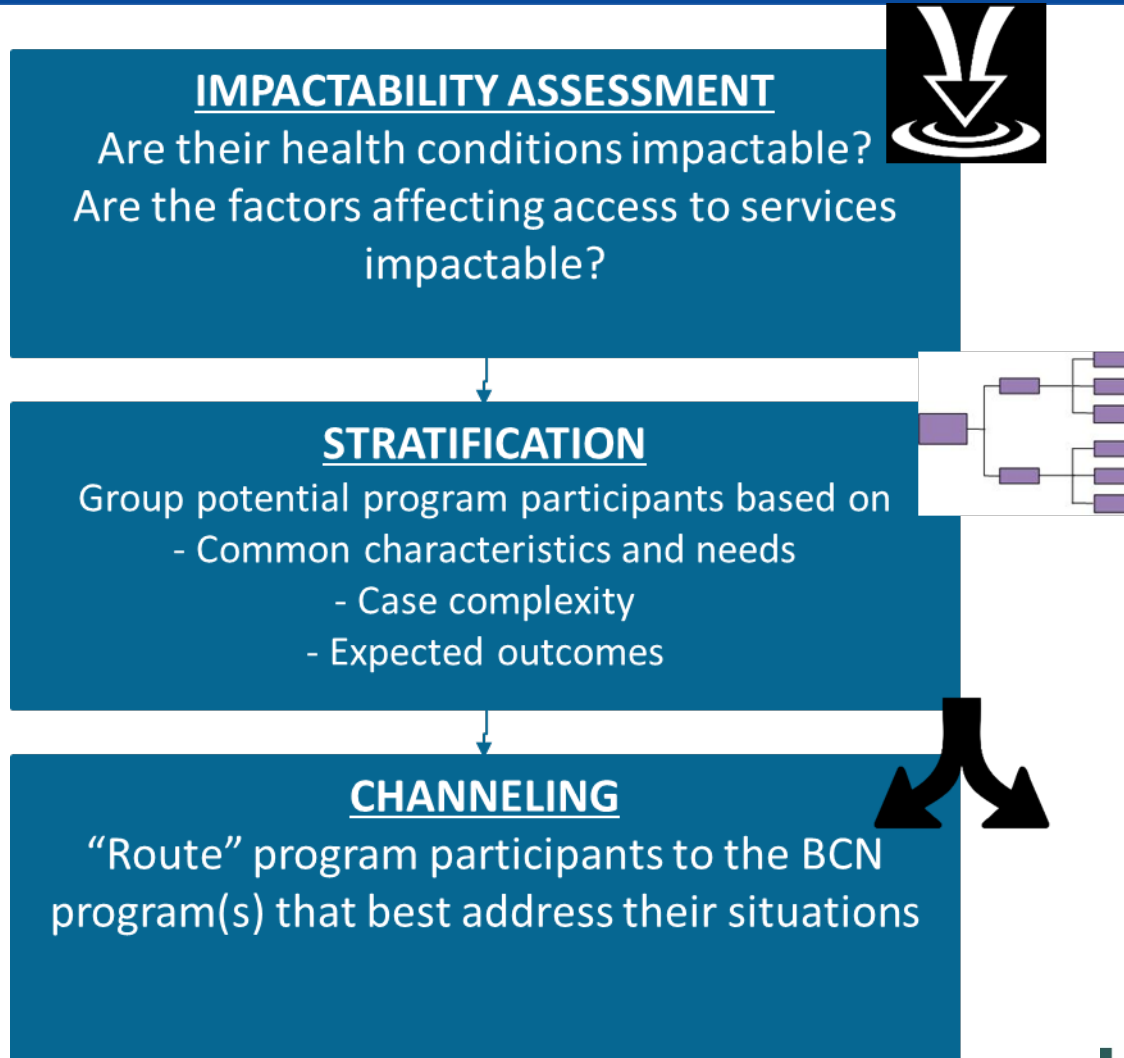IAP | Medicaid Innovation Accelerator Program

Premise

- Innovative models and systems of care (ACOs, health homes, etc.) are being implemented across the country with the goals of improving the health and containing the health care costs of Medicaid beneficiaries with complex needs (BCNs).

- BCNs manifest **poorly managed yet impactable health conditions** that result in high utilization and costs.

- Addressing these conditions calls for coordinated physical health, behavioral health and social services that attend to health risks, gaps in care and barriers to accessing needed health care services.

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What is Targeting?

DATA
Demographics - context - service utilization and cost - other relevant data

PROFILING
Who are they?
What services are (aren't) they using/accessing?
Key markers
Common characteristics?

HOTSPOTTING
Where are they?
High concentration in particular locations?
May geography be playing a role in their particular situation?

IMPACTABILITY ASSESSMENT
Are their health conditions impactable?
Are the factors affecting access to services impactable?

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What is Targeting? (cont'd)

IMPACTABILITY ASSESSMENT
Are their health conditions impactable?
Are the factors affecting access to services impactable?

STRATIFICATION
Group potential program participants based on
- Common characteristics and needs
- Case complexity
- Expected outcomes

CHANNELING
"Route" program participants to the BCN program(s) that best address their situations

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The Universe of BCN program participants: *Results from Systematic Activities*

- After Completing…

PROFILING/ HOTSPOTTING

IMPACTABILITY ASSESSMENT

STRATIFICATION AND CHANNELING
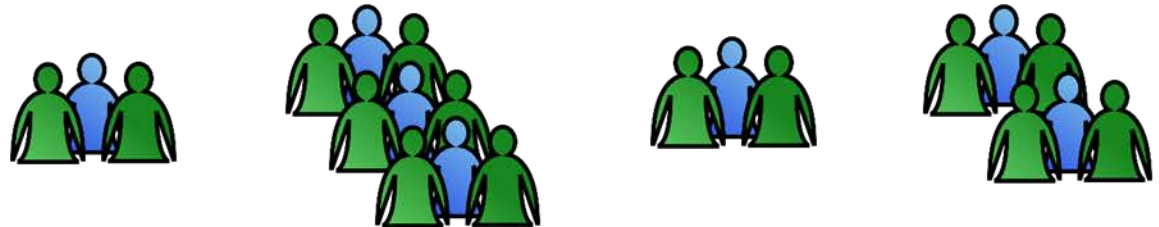
| NO BCN PROGRAM WARRANTED | BCN PROGRAM A TIER 1 | BCN PROGRAM A TIER 2 | BCN PROGRAM B |

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Macro vs. Micro Targeting

- **Macro**
    - Occurs at the state/region/local level
    - More reliant on higher-order, more aggregated, historical data
    - More reliant on encounter/claims and program participation data
    - Ultimately leads to channeling individuals to specific BCN programs but <u>not</u> to the development of case/care/service plans
    - Occurs prior to "enrollment" in a BCN program

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Macro vs. Micro Targeting (cont'd)

- **Micro**
  - Occurs at the program/service provider level
  - Pulls more "real-time" information, such as facts garnered from observations/assessments, into evaluation and decision making
  - Leads to development of individualized case/care/service plan and assignment to a specific care manager and care team

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What Data Do States and BCN Providers Need for these Activities?

Key Learnings from Engagement with IAP BCN State Participants

Area	Examples	Observations
Use of algorithms for BCN targeting and risk stratification/scoring	- CDPS - PRISM (WA State) - Elixhauser comorbidity index	- Important to incorporate social determinants to the degree that is feasible - Means to an end…
Use of academic institutions and Medicaid EQRO in support of analytics activities	- Oregon (OSHU) - Texas (ICHP – U. of Florida)	- Many capable institutions - Important that this is not treated mainly as academic or research exercise
Overcoming the challenge of data aggregation and harmonization	- Data warehouses/marts - Decision support systems	- Leverage data "standards" (HIPAA, NIEM, HL7, QRDA, etc.) - Ability to "drill down" and "roll up" is critical

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Key Learnings from Engagement with IAP BCN State Participants

Area	Examples	Observations
Overcoming challenges of sharing/exchanging data - Across agencies - With and among MCOs	- Data sharing/ exchange use cases - Data use agreements (DUAs)	- Must understand real constraints to, and enablers of, data sharing/exchange - Ability to regulate access based on laws/regs, consents, user roles - Importance of well structured DUAs - Importance of data governance
Linking measurement strategies to targeted populations	- Leveraging claims data (VT) - Going beyond claims data to harness data from risk assessments (WA)	- Strategies depend on available data and analytics resources - Important to leverage current quality/performance initiatives but not overburden data collection/reporting capacities - Importance of alignment across state, other payers and providers - Challenges to harness social determinant data

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Perspectives from the Field

Tracy Johnson, PhD, MA

Director

Health Care Reform Initiatives Denver Health

Ruben Amarasingham, MD, MBA President and CEO

Parkland Center for Clinical Innovation. Pieces Technologies, Inc.

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Macro and Micro Targeting for Population Health Management

Tracy Johnson, PhD, MA

Director, Health Care Reform Initiatives

Denver Health

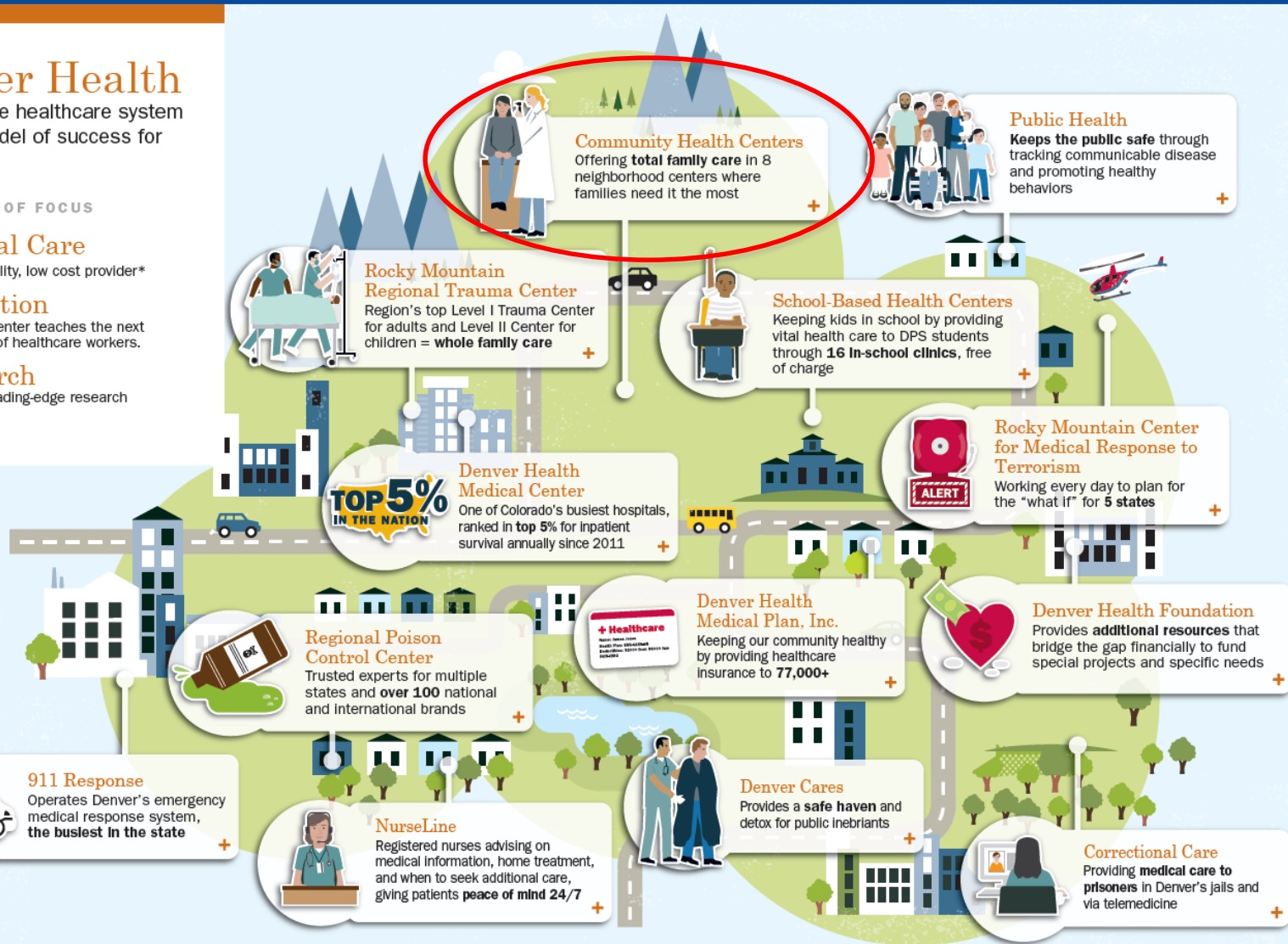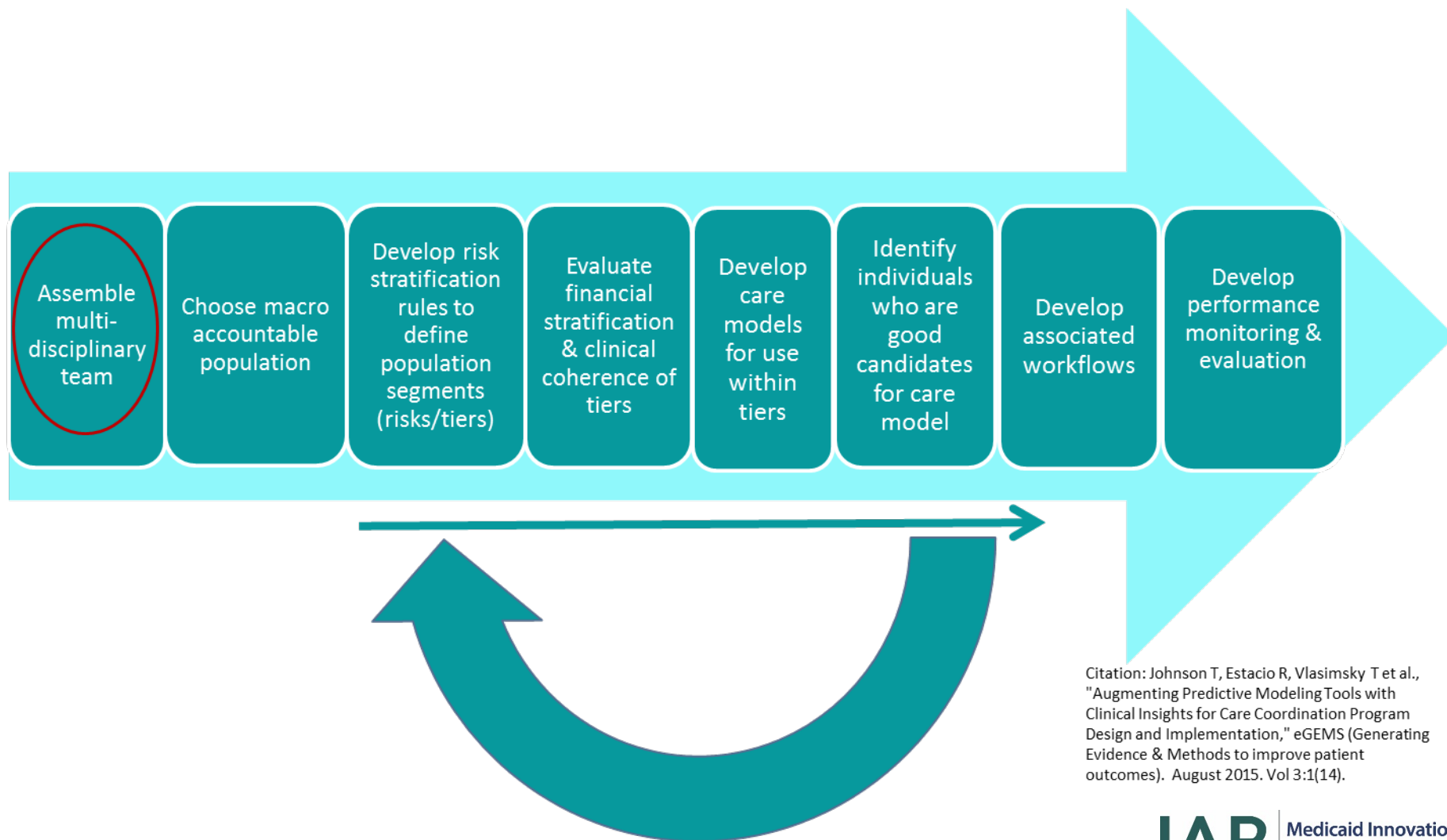Australian-American Health Policy Research Fellow (2016-17)

DENVER HEALTH
Level One Care for ALL

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Denver Health and Hospital Authority

Iterate to optimize population segmentation & patient identification

Assemble multi-disciplinary team

Choose macro accountable population

Develop risk stratification rules to define population segments (risks/tiers)

Evaluate financial stratification & clinical coherence of tiers

Develop care models for use within tiers

Identify individuals who are good candidates for care model

Develop associated workflows

Develop performance monitoring & evaluation

Citation: Johnson T, Estacio R, Vlasimsky T et al., "Augmenting Predictive Modeling Tools with Clinical Insights for Care Coordination Program Design and Implementation," eGEMS (Generating Evidence & Methods to improve patient outcomes). August 2015. Vol 3:1(14).

Inspired by Institute for Healthcare Improvement (IHI) BHLC Collaborative

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21st Century Care: Population Health "Tiered" Delivery of Enhanced Care Management Services

Patients MMs — **Baseline PMPMs** — **Staffing Model** — **Enhanced Clinical & HIT Services**

Tier 4 — 10,087 Adult 73%, Peds 27%
Tier 3 — 31,372 Adult 80%, Peds 20%
Tier 2 — 397,463 Adult 82%, Peds 18%
Tier 1 — 640,933 Adult 27%, Peds 73%

$6,919 Adults: $7,801 Peds: $4,552
$3,035 Adults: $3,449 Peds: $1,410
$560 Adults: $614 Peds: $314
$93 Adults: $137 Peds: $76

Multidisciplinary High Risk Health Teams
PN, RN CC, PharmD, BHC, HIT
PN BHC HIT
HIT

High Intensity Treatment Clinics
Complex Case Management (High Risk Care Coordination)
Chronic Disease Management
- Panel Management
- eTouch Programs

Notes: Baseline period is July 2010 through June 2011. This initial "proof of concept" tiering algorithm was implemented by Milliman using CDPS predictive modeling tool thresholds to define tiers. Tier sizes were pre-determined according to estimated resource capacity. The attributed managed care population was identified through membership files, whereas the fee-for-service population was selected at a single point in time at the beginning of the time period and fixed for the duration. All attributed individuals were tiered. MM: Member months, PMPMs: Per member per month, PN: Patient Navigator, RN CC: Nurse Care Coordinators, PharmD: Clinical Pharmacist, eTouch: Health Text Messages Programs. Grant tiers (Beta version).
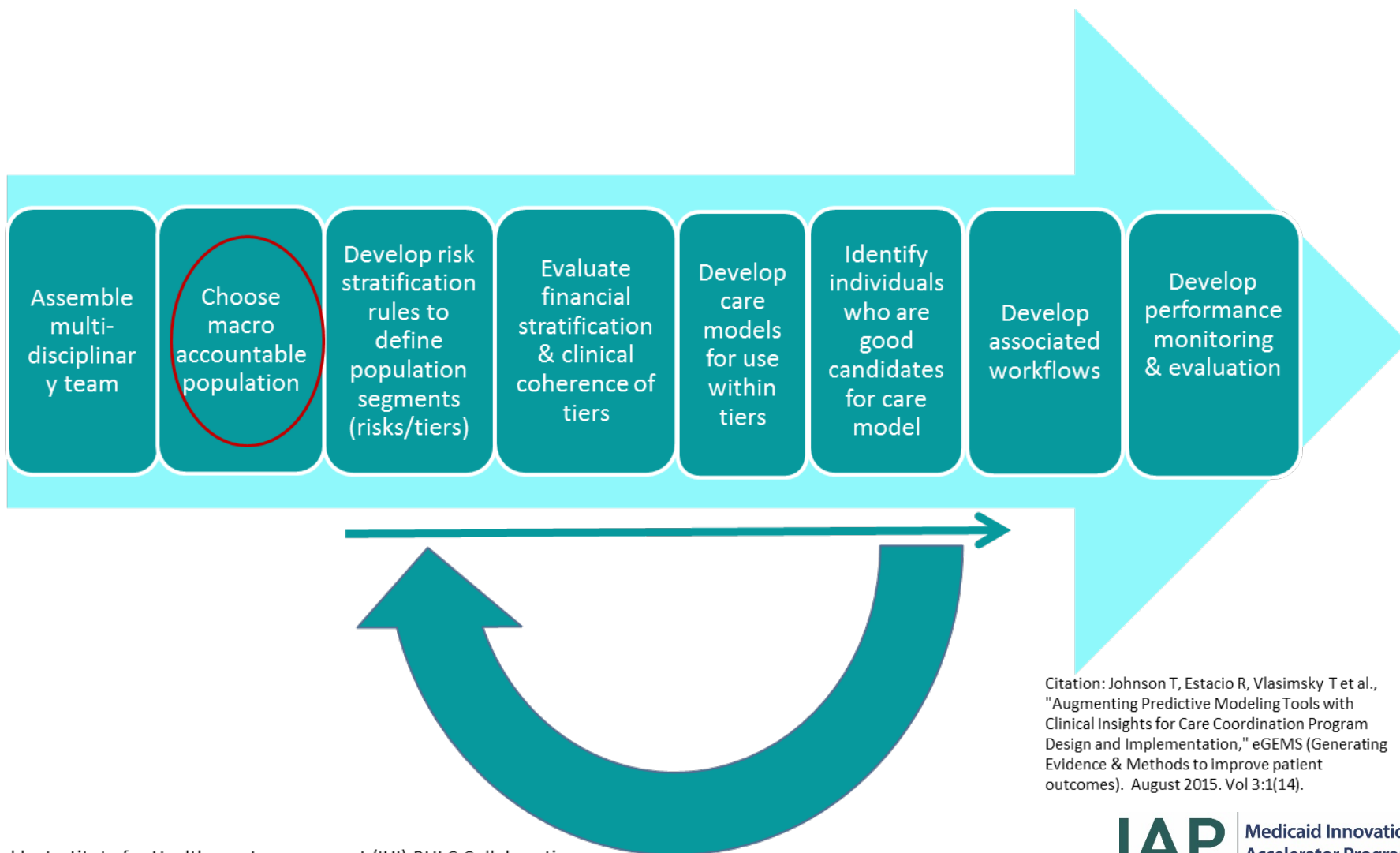
Citation: Johnson T, Estacio R, Vlasimsky T et al., "Augmenting Predictive Modeling Tools with Clinical Insights for Care Coordination Program Design and Implementation," eGEMS (Generating Evidence & Methods to improve patient outcomes). 2015 (In press.) Graphic developed by. Susan Moore, Kathy Thompson and Sarah Sabalot.
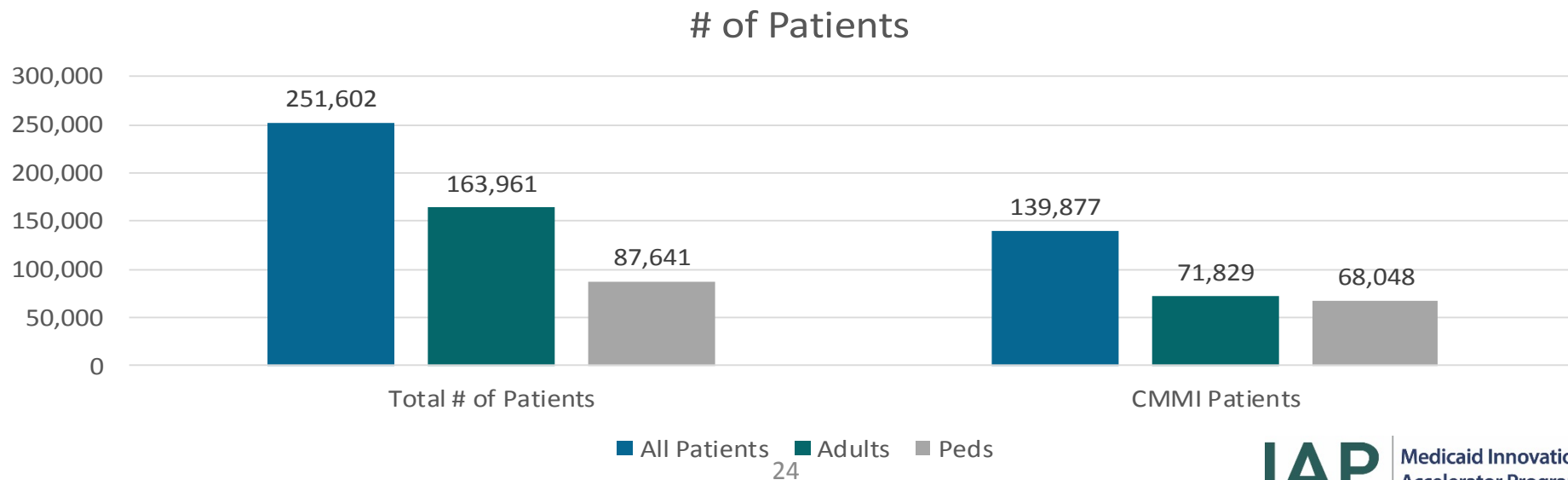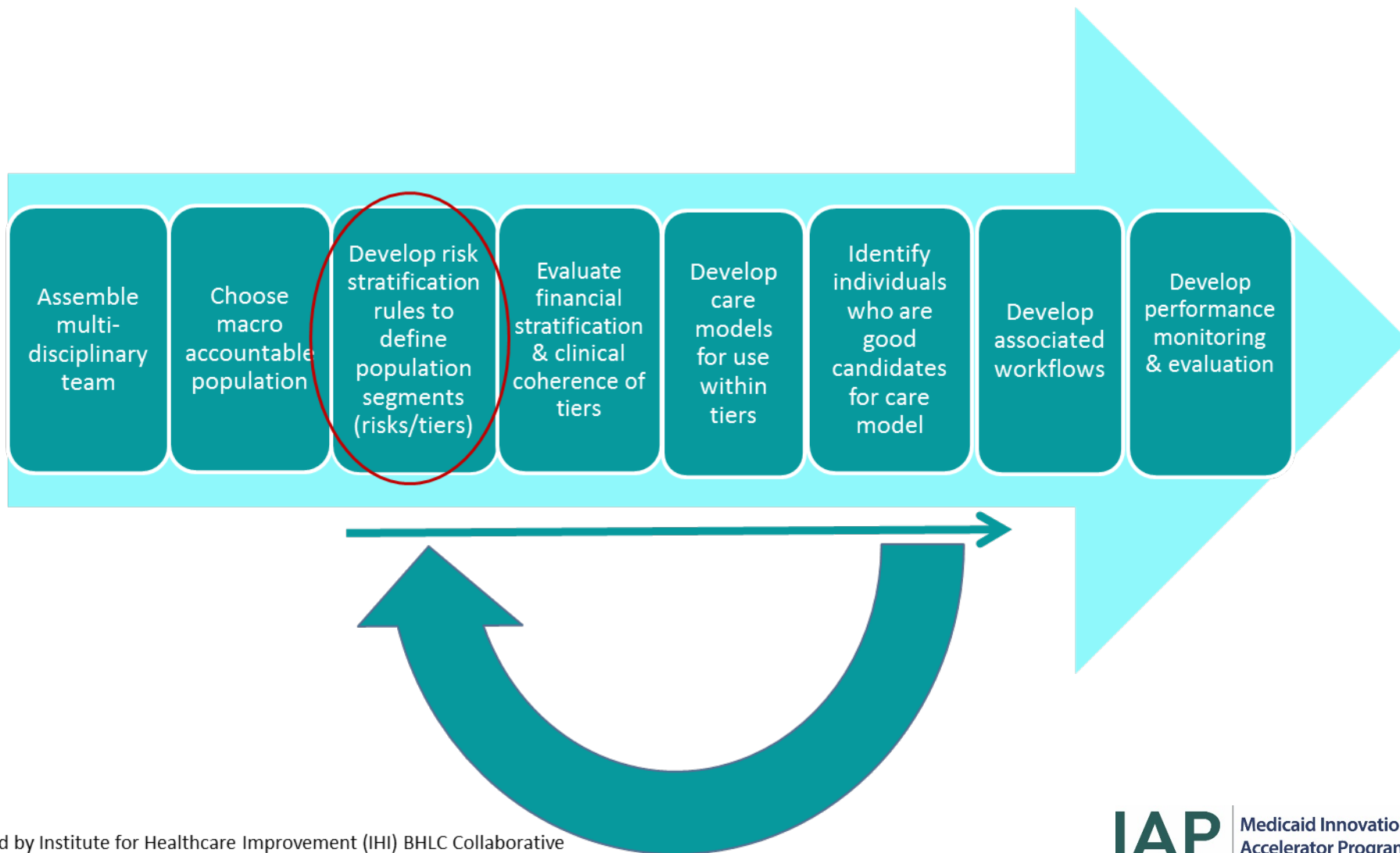
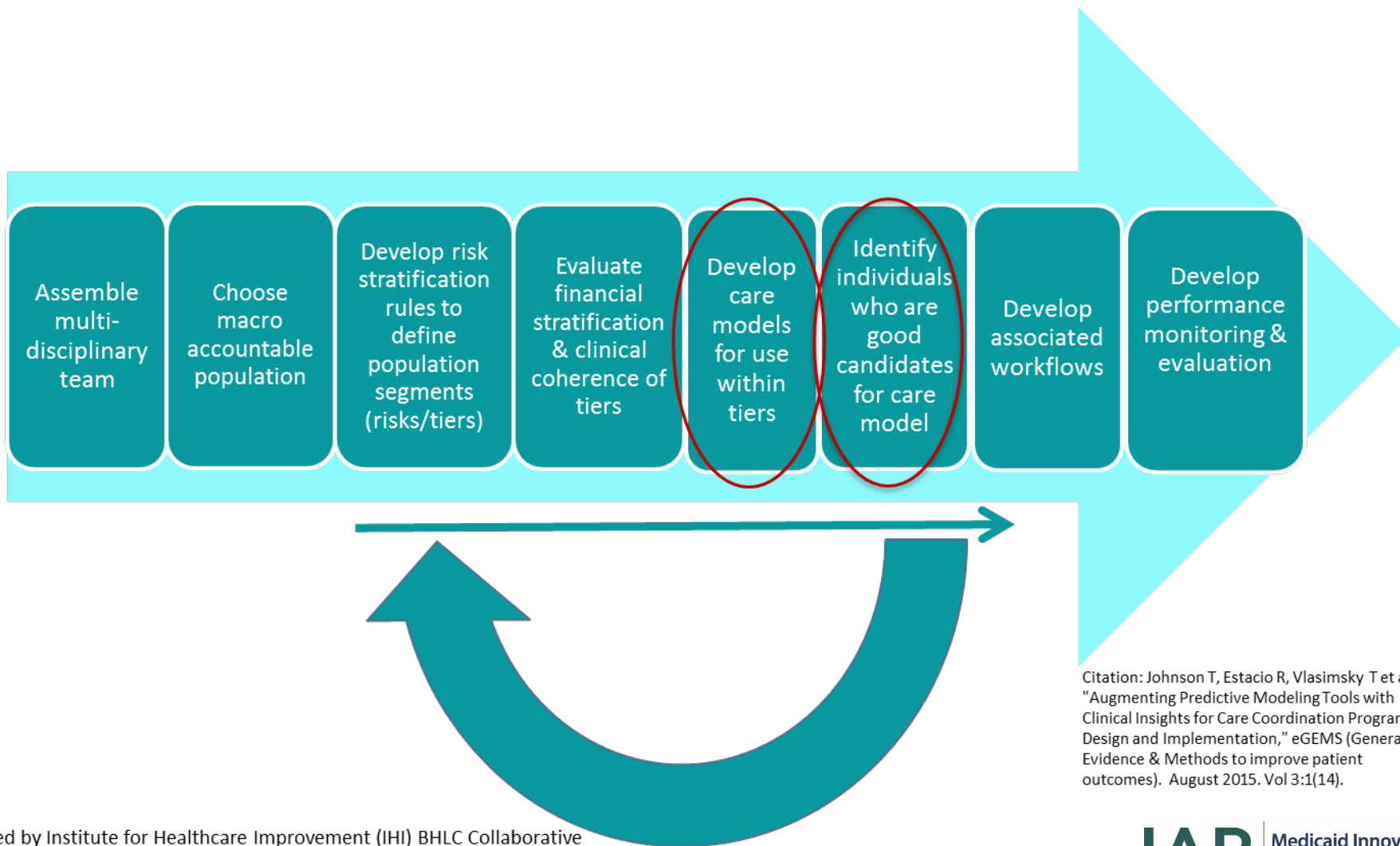# Iterate to optimize population segmentation & patient identification

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Inspired by Institute for Healthcare Improvement (IHI) BHLC Collaborative

Who Do We Tier?

- All patients who have had a visit to a Denver Health facility in the previous 18 months (includes clinic visits, hospital, ED, urgent care, public health visits, etc.)

- Medicaid, Medicare, CHP Managed Care patients, regardless of whether they have been to DH or not

- Run daily, with full population refreshes monthly

of Patients

	Total # of Patients	CMMI Patients
All Patients	251,602	139,877
Adults	163,961	71,829
Peds	87,641	68,048

Legend: ■ All Patients ■ Adults ■ Peds

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CRG Status

CRG Status is a primary building block for constructing DH's tiered population

CMMI Adults by CRG Status
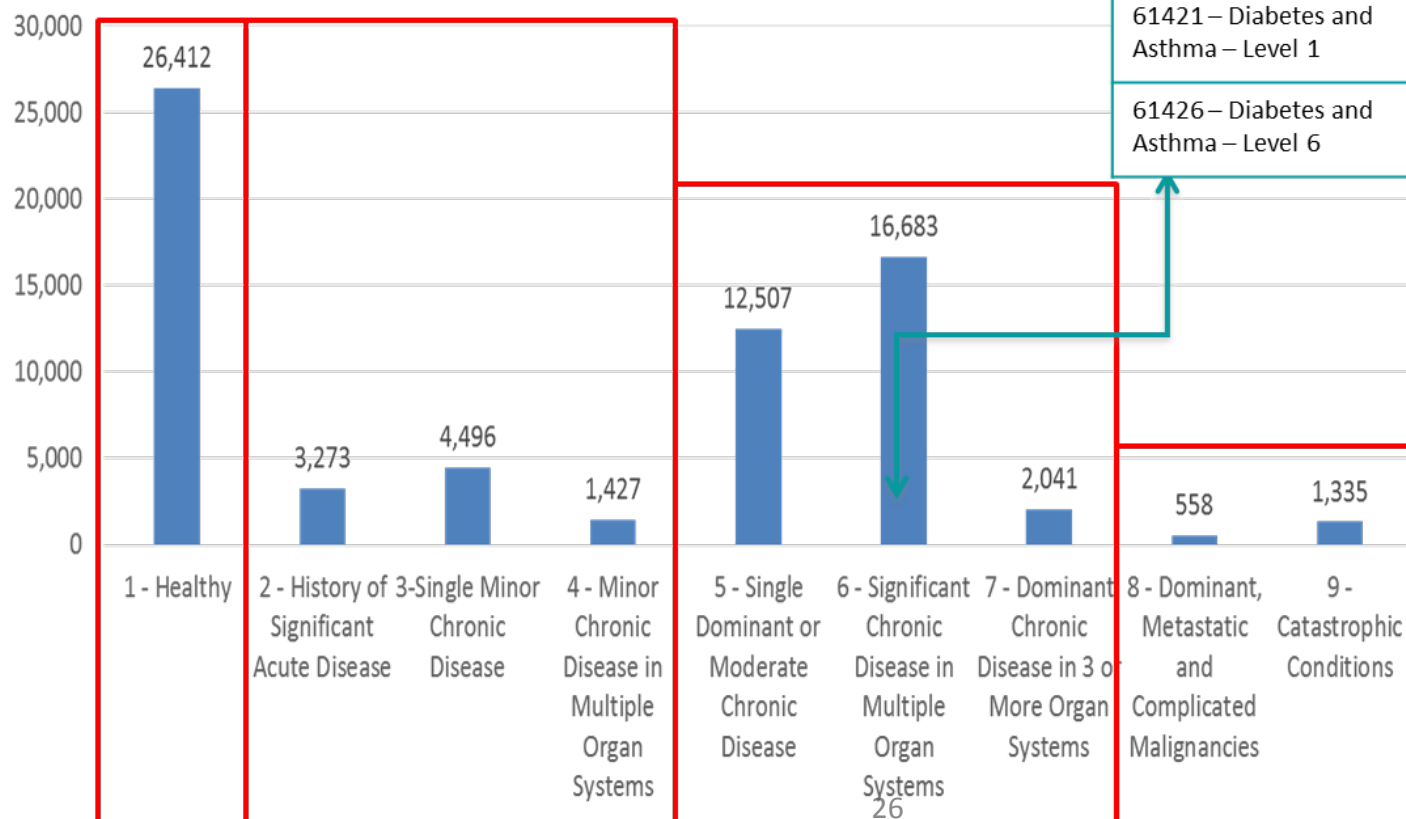
Full CRG Description	Avg. Charges
61421 – Diabetes and Asthma – Level 1	$5,815
61426 – Diabetes and Asthma – Level 6	$41,346

Chart values:
- 1 - Healthy: 26,412
- 2 - History of Significant Acute Disease: 3,273
- 3 - Single Minor Chronic Disease: 4,496
- 4 - Minor Chronic Disease in Multiple Organ Systems: 1,427
- 5 - Single Dominant or Moderate Chronic Disease: 12,507
- 6 - Significant Chronic Disease in Multiple Organ Systems: 16,683
- 7 - Dominant Chronic Disease in 3 or More Organ Systems: 2,041
- 8 - Dominant, Metastatic and Complicated Malignancies: 558
- 9 - Catastrophic Conditions: 1,335

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Adult Risk Stratification Using Predictive Risk Model and Recent Use

CRGs are primary basis for tier assignment

Utilization may override CRG-assigned Tier
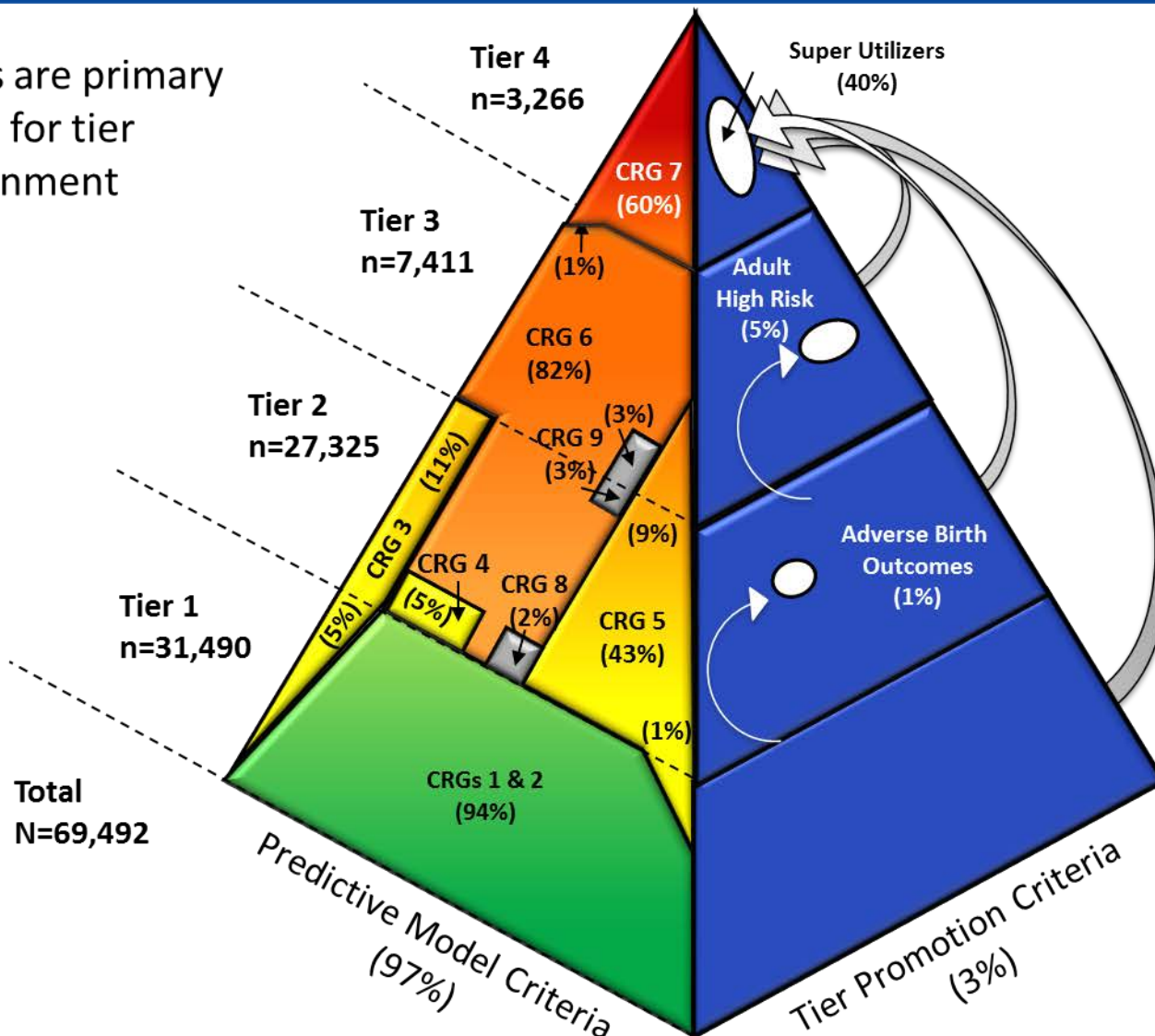
Tier 4 n=3,266

Tier 3 n=7,411

Tier 2 n=27,325

Tier 1 n=31,490

Total N=69,492

Super Utilizers (40%)

CRG 7 (60%)

(1%)

Adult High Risk (5%)

CRG 6 (82%)

(3%)

CRG 9 (3%)

(9%)

Adverse Birth Outcomes (1%)

CRG 3 (11%)

CRG 4 (5%)

CRG 8 (2%)

(5%)

CRG 5 (43%)

(1%)

CRGs 1 & 2 (94%)

Predictive Model Criteria (97%)

Tier Promotion Criteria (3%)

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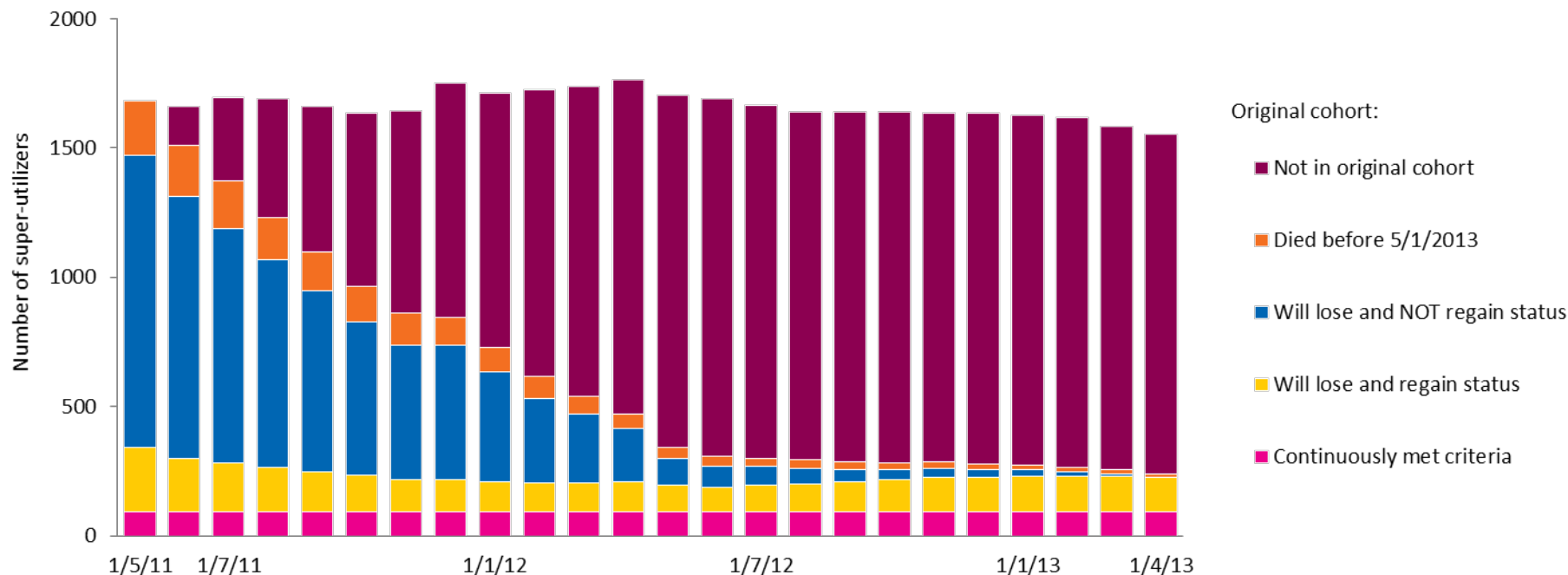
Citation: Johnson T, Estacio R, Vlasimsky T et al., "Augmenting Predictive Modeling Tools with Clinical Insights for Care Coordination Program Design and Implementation," eGEMS (Generating Evidence & Methods to improve patient outcomes). August 2015. Vol 3:1(14).
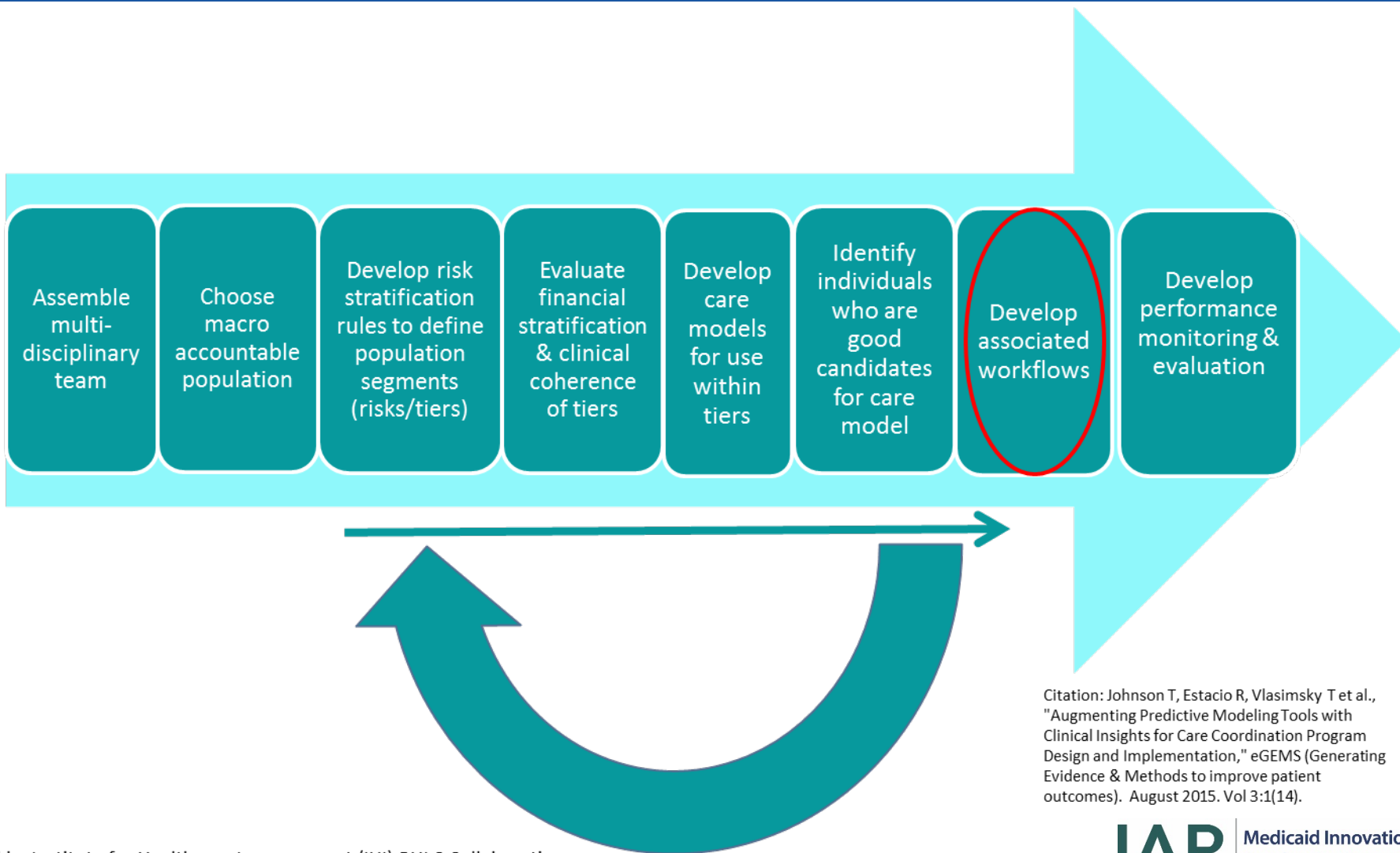
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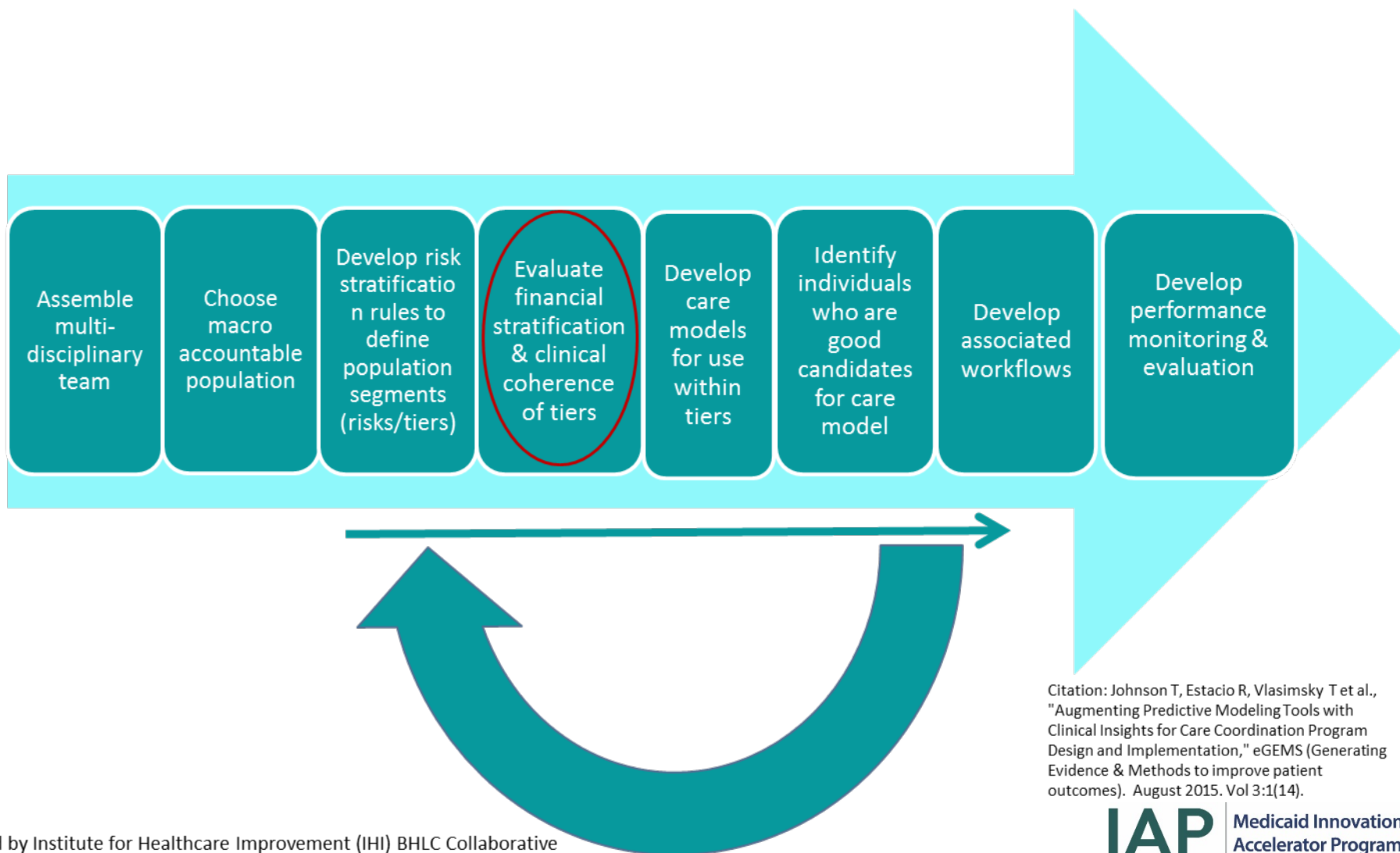
CRGs Provide Financial Stratification with Clinical Meaning

CRG* Status	2012 Cohort average charges	2013 Cohort average charges	2014 Cohort average charges
1 - Healthy	$2859	$3,058	$1,940
2 - Acute Only	$5686	$5,820	$3,450
3 – Single Minor Chronic	$5243	$5,843	$3,213
4 – Multiple Minor Chronic Disease	$6572	$7,055	$4,346
5 – Moderate Chronic Disease	$7474	$7,571	$4,084
6 - Significant Multiple Chronic	$17,413	$18,437	$9,909
7 – Dominant Multiple Chronic	$45,277	$42,380	$29,353
8 - Cancer	$39,243	$48,771	$34,689
9 - Catastrophic	$81,538	$87,993	$48,372

Citation: Johnson T, Estacio R, Vlasimsky T et al., "Augmenting Predictive Modeling Tools with Clinical Insights for Care Coordination Program Design and Implementation," eGEMS (Generating Evidence & Methods to improve patient outcomes). August 2015. Vol 3:1(14)

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Inspired by Institute for Healthcare Improvement (IHI) BHLC Collaborative

Adult Risk Stratification Using Predictive Modeling and Clinical

CRGs are primary basis for tier assignment
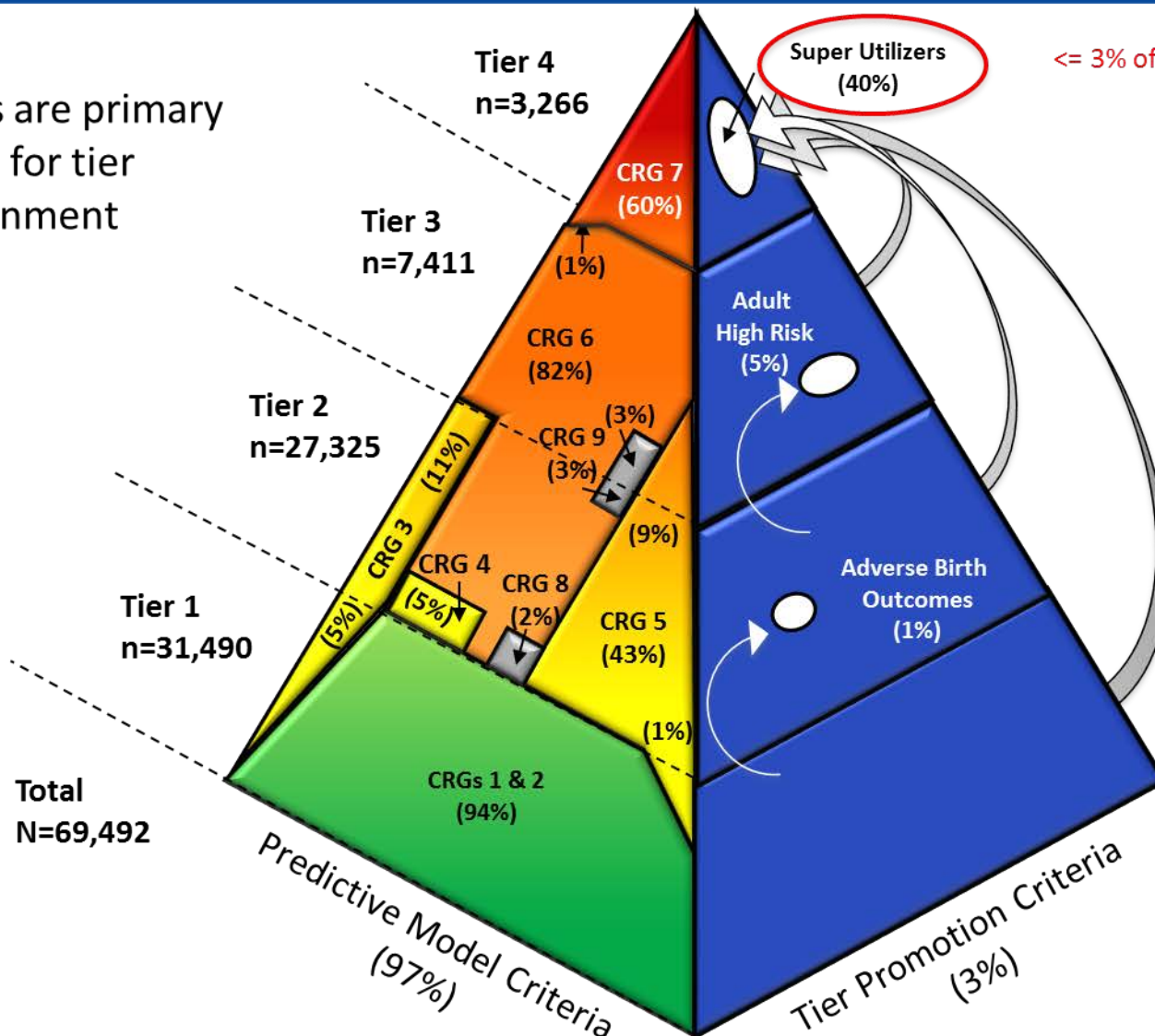
Utilization overrides CRG-assigned tier

Super Utilizers (40%)

<= 3% of adults; 30% of facility costs

Tier 4 n=3,266

Tier 3 n=7,411

Tier 2 n=27,325

Tier 1 n=31,490

Total N=69,492

CRG 7 (60%)
CRG 6 (82%)
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(3%)
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(1%)
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"Super-Utilizers" are Stable in Number, BUT Individual Turn-Over is High

Population And Individual-Level Analyses of Adult Super-Utilizers in Denver County, Colorado, May 1, 2011–April 30, 2013

Original cohort:
- Not in original cohort
- Died before 5/1/2013
- Will lose and NOT regain status
- Will lose and regain status
- Continuously met criteria

DATA NOTES: Authors' analysis of data from the data warehouse of Denver Health. NOTES "Not in original cohort" is people who became super-utilizers after the study period began (members of all other categories were in the original cohort). "Will die" is people from the original cohort who died during the study period; some people who died also permanently or temporarily lost super-utilizer status. "Will lose and not regain status" is people from the original cohort who stopped being super-utilizers and did not regain that status during the study period. "Will lose and regain status" is people from the original cohort who stopped being super-utilizers and did regain that status during the study period. "Continuously met criteria" is people who met the criteria for super-utilizers throughout the study period. Some people classified as "not in original cohort" also died, permanently or temporarily lost super-utilizer status, or both during the study period. However, these super-utilizer status changes were not tracked. Only status changes affecting the original cohort are shown in the exhibit.

Iterate to optimize population segmentation & patient identification

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Inspired by Institute for Healthcare Improvement (IHI) BHLC Collaborative

Develop Work Flows:
Daily Intensive Outpatient Clinic List

Iterate to optimize population segmentation & patient identification

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Cost Savings Analysis

Why can't we simply compare utilization/costs of before and after program enrollment?

"INTERVENTION"
Labeled certain patients "Super-Utilizers"

Charges reduced 44% & admissions reduced 53%, but NO clinical intervention was provided!

$114K
4.25 Admits / person

Utilization

$63 K

1.98 Admits / person

Utilization

05/2010   05/2011   05/2012
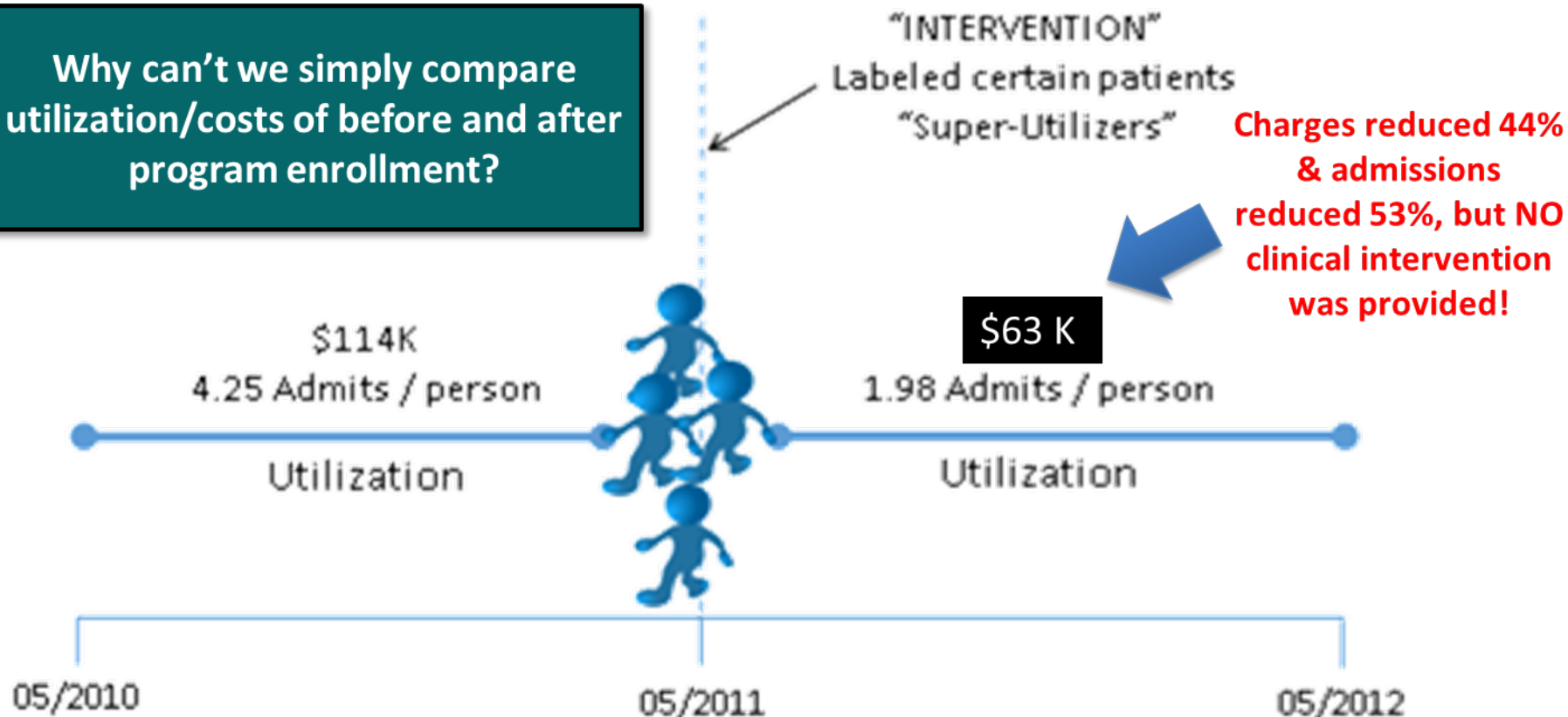
This natural tendency for high-utilizing patients to become less high-utilizing over time is known as "regression to the mean".

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Evaluation: Total Cost of Care Analysis Sample ("Mocked-Up") Data
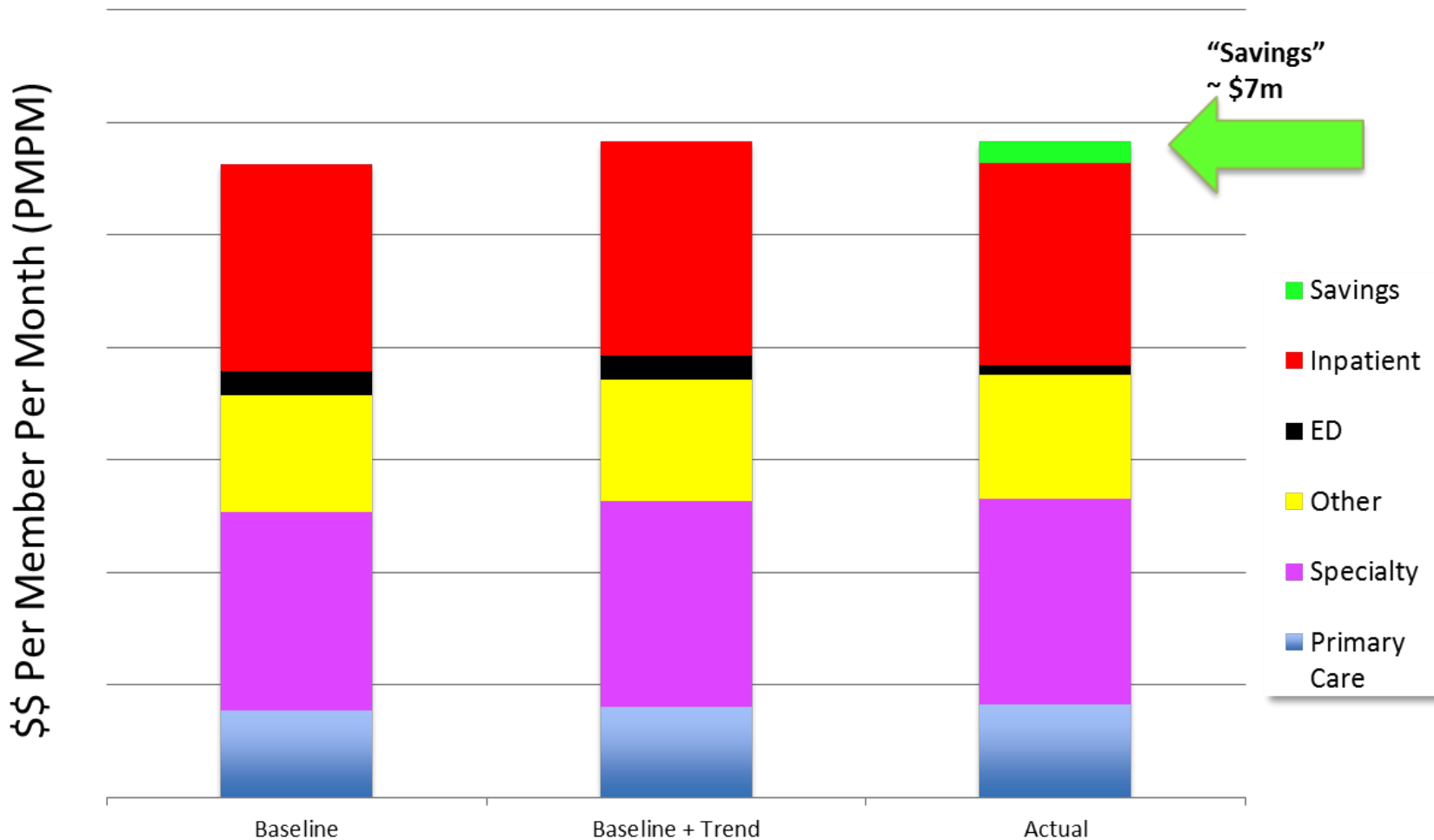
Macro-Targeting Lessons Learned

- Gaining clinician buy-in
  - Transparency
  - Focus on avoidable hospitalizations
  - Clinical design control
- Identifying target population
  - Claims data useful for population analysis
  - Provide real-time (not claims) data for clinical action
  - Balance predictive analytics & clinical insight
  - Balance short-term & long-term goals
- Payment model/perverse incentives
  - Modified productivity standards

Micro-Targeting Lessons Learned Super-Utilizer Program Implications

- Real-time identification is critical
  - Billing data is helpful for descriptive analysis but "too old" for program identification
  - Window of opportunity may be short
- Where, when, how to intervene must be matched to the target population
  - Subpopulations differ by primary care use, reasons for utilization, and cost trajectory
  - Non-target populations are likely to be identified
  - Many super-utilizers are not currently engaged in primary care

State Medicaid Opportunities

- Regulatory approach
  - Process vs. outcomes orientation
  - Flexibility vs. standardization
- Data analytics
  - Facilitate access to real-time data on high-risk patients
  - Obtain clinical input to define what is a "high risk" patient
  - Facilitate access to raw data (for further analysis at clinical sites)
- Payment model
  - Advanced systems will want capitation/global payment ASAP
  - Managed FFS (PMPM care coordination payments) should focus on outcomes (less on qualified providers, workflow)

Acknowledgements and Disclaimers

- Core Team, Clinical Teams, IT Team, Evaluation Team, ACS and Executive Leadership (past and present)

- Denver Health's 21st Century Care project is supported by Grant Number 1C1CMS331064 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

- The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

- The analysis presented was conducted by the awardee. Findings may or may not be consistent with or confirmed by the findings of the independent evaluation contractor.

- The Colorado Multiple Institutional Review Board determined this project to be Quality Assurance, Not Human Subject Research.

Contact Information

- Thank you!

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  - Tracy Johnson, PhD, MA
    - Tracy.Johnson@dhha.org
    - Co-PI, Evaluation Lead

Mobilizing Social Determinants Data to Target BCN Interventions and Improve Health Outcomes

Ruben Amarasingham, MD, MBA

President and CEO

PCCI & Pieces Technologies, Inc.

Dallas, Texas

Medicaid Innovation Accelerator Program

Who We Are
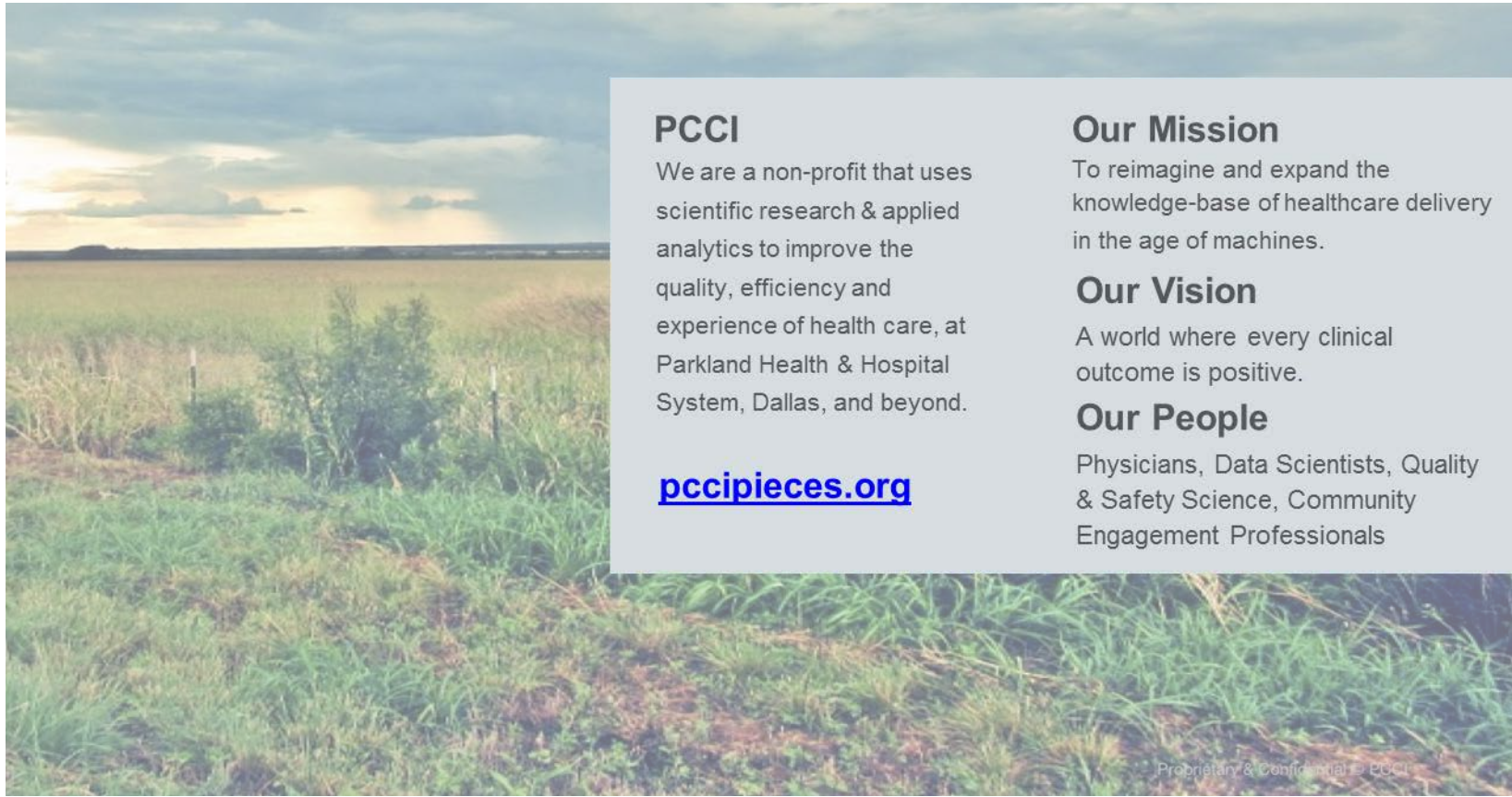
PCCI

We are a non-profit that uses scientific research & applied analytics to improve the quality, efficiency and experience of health care, at Parkland Health & Hospital System, Dallas, and beyond.

pccipieces.org

Our Mission

To reimagine and expand the knowledge-base of healthcare delivery in the age of machines.

Our Vision

A world where every clinical outcome is positive.

Our People

Physicians, Data Scientists, Quality & Safety Science, Community Engagement Professionals

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The Role of Social Determinants in Health

Health Behaviors 30%

Clinical Care 20%

Social, Economic, Environmental 50%
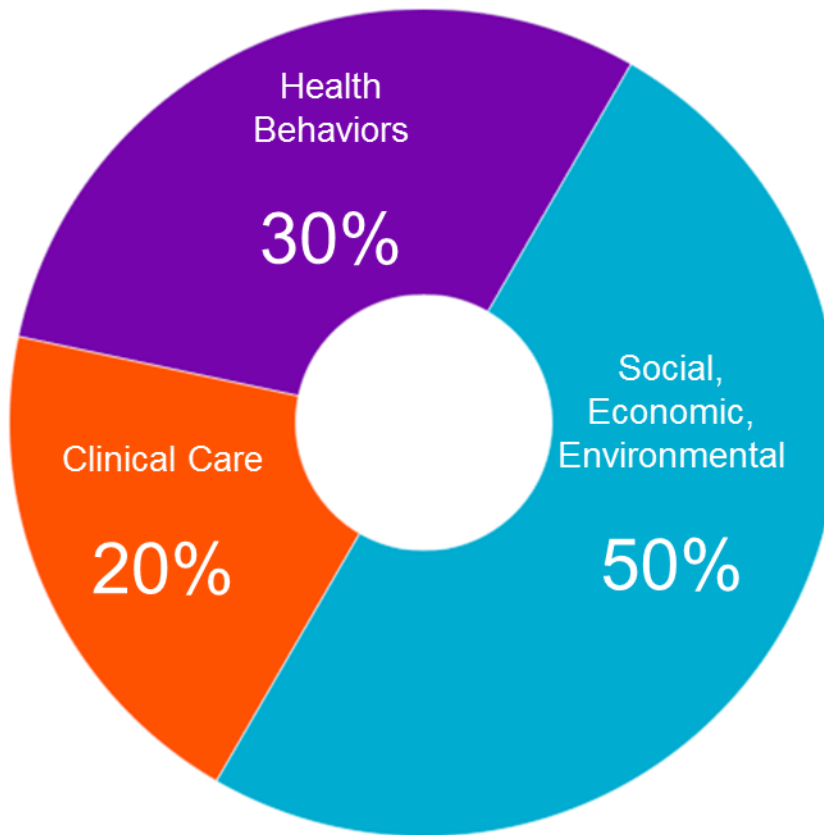
Adapted From: Booske, B.C., Athens, J.K., Kindig, D.A., Park, H., & Remington, P.L. (2010). County Health Rankings [www.countyhealthrankings.org]

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Our Approach: Modeling Adverse Events Across a Time Scale
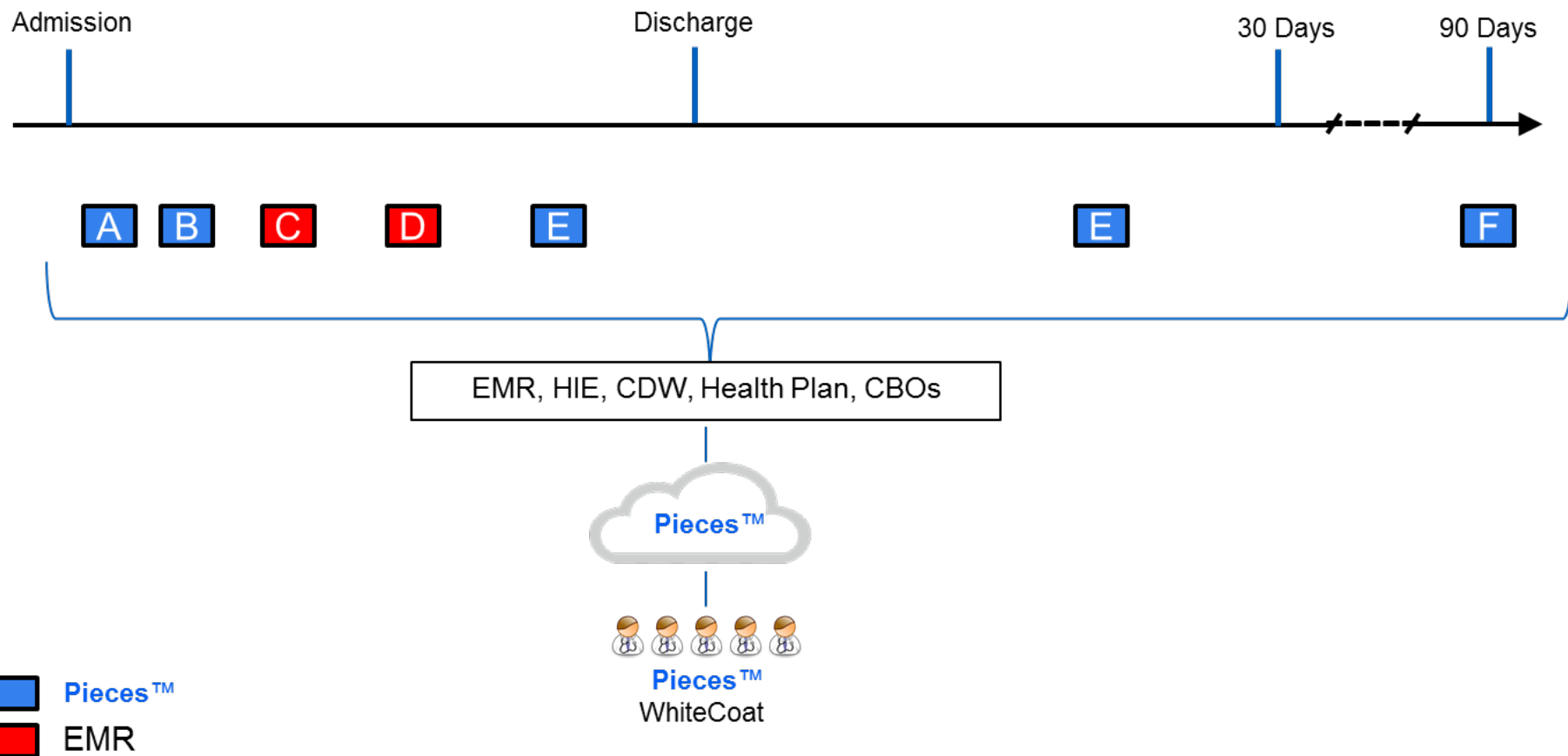
Our Approach: Modeling Adverse Events Across the Time Scale
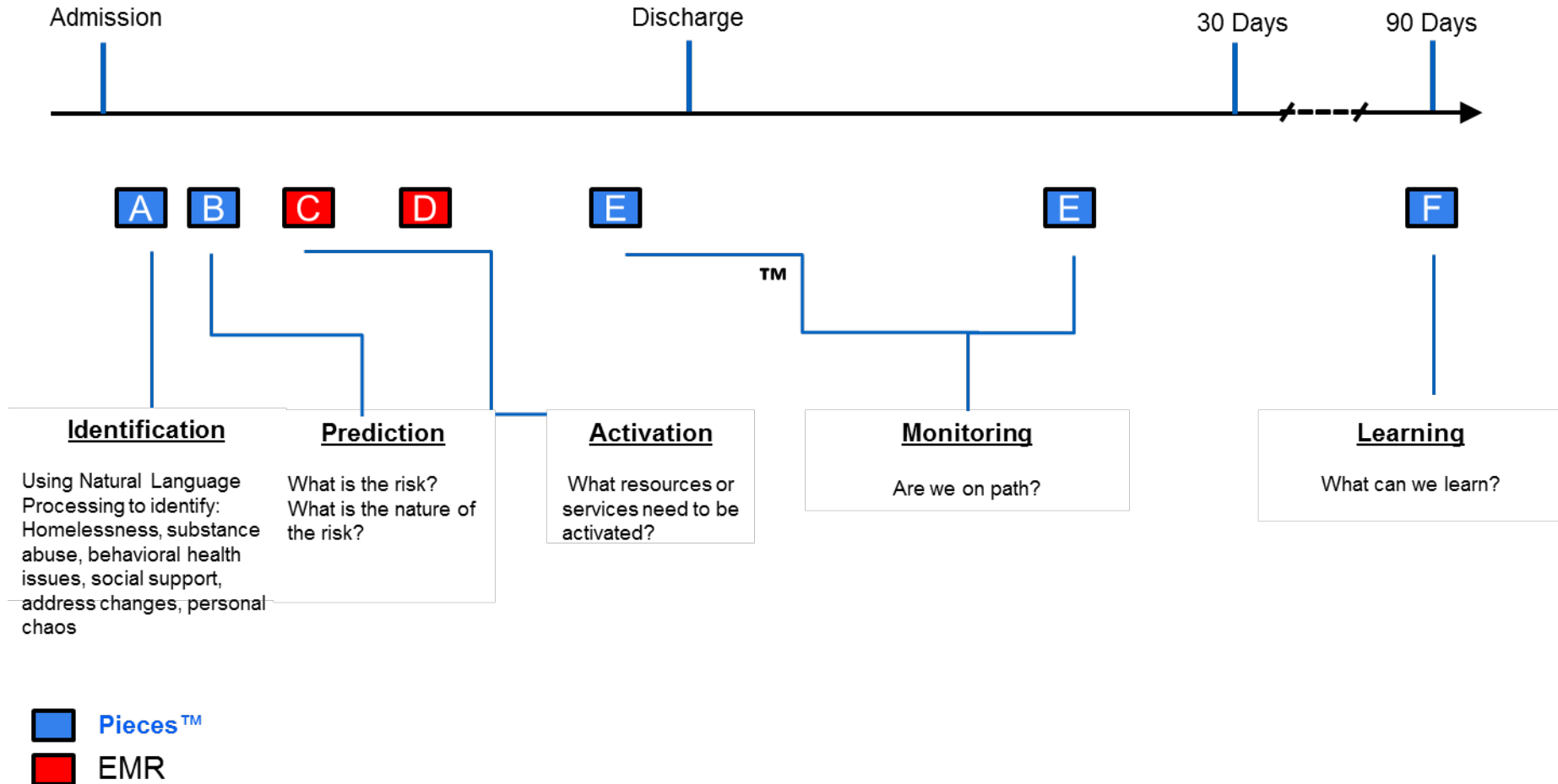
Modeling Use Cases

Emergency	Hospital Operations	Population Health	Medical / Surgical	Oncology	Medication Administration	Infectious Disease	Perinatal	Social Factors
• ED complex case management • **Preventable ED utilization** • **High utilizer identification**	• **Real-time discharge modeling (Fall 2016)** • **High bed capacity days (Summer 2016)** • **Patient flow (Fall 2016)** • **ICU modeling (Fall 2014)** • OR modeling • Chart reviews for QI and Federal reporting	• **Readmissions suite v 2.0 with context** • **Avoidable Hospitalization** • **CKD progression** • **Diabetes Management** • HTN Management	• **Inpatient Deterioration (Fall 2014)** • Burn Sepsis • Slow-healing wounds • Complications from Procedures • Surgical Failure to Rescue • SSI • Blood incompatibility • Manifestations of poor glycemic control • DVT and PE • VAP • Rapid Mortality Analysis	• **Avoidable hospital** • **Advanced Care Planning** • Appropriate diagnostic and procedure utilization E.g: ■ Imaging ■ Chemo duration ■ Chemo selection ■ Radiation	• **Medication non-compliance** • **Complex medications or medication list** • Abx Stewardship through ID of false allergies • Opioid Abuse	• Appropriate treatment based on condition • Treatment adherence • Self administered outpatient antibiotics • **Sepsis POA** • **Sepsis non-POA**	• Neonatal blood stream infection • Newborn care-associated infection • Late sepsis • Meningitis • C-section SSI • Pre-term Delivery Prediction	• Access to care barriers • **Homelessness** • **Substance abuse** • Environmental stressors • Community Based Referral prediction

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Complexities of Predictive Modeling in Healthcare

By Ruben Amarasingham, Rachel E. Patzer, Marco Huesch, Nam Q. Nguyen, and Bin Xie

Implementing Electronic Health Care Predictive Analytics: Considerations And Challenges

Ruben Amarasingham (ruben
.amarasingham@phhs.org) is
president and CEO of PCCI, a
nonprofit research and
development corporation and
an associate professor in the
Departments of Internal

ABSTRACT The use of predictive modeling for real-time clinical decision making is increasingly recognized as a way to achieve the Triple Aim of improving outcomes, enhancing patients' experiences, and reducing health care costs. The development and validation of predictive models

By I. Glenn Cohen, Ruben Amarasingham, Anand Shah, Bin Xie, and Bernard Lo

The Legal And Ethical Concerns That Arise From Using Complex Predictive Analytics In Health Care

I. Glenn Cohen (igcohen@law
.harvard.edu) is a professor of
law and director of the Petrie-
Flom Center for Health Law

ABSTRACT Predictive analytics, or the use of electronic algorithms to forecast future events in real time, makes it possible to harness the power

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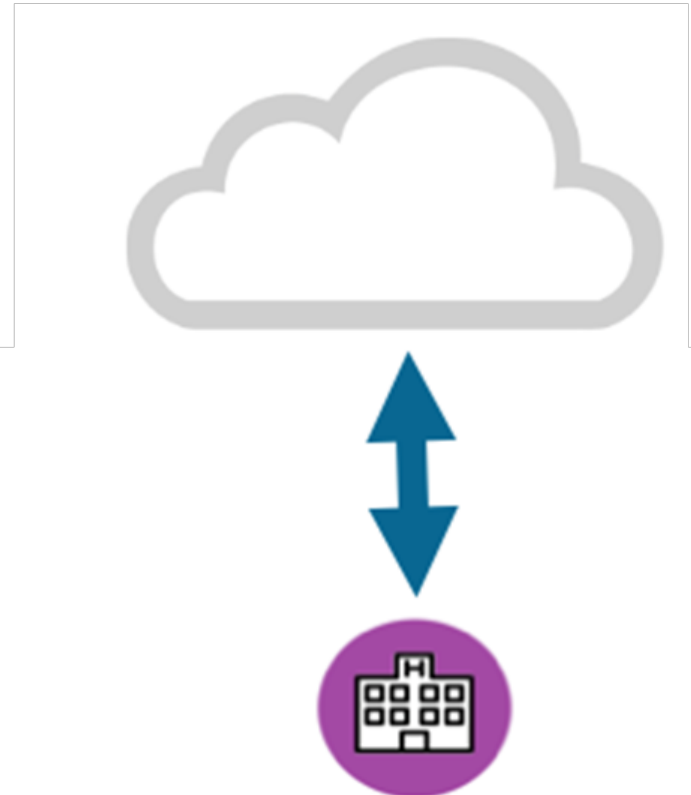IAP Medicaid Innovation Accelerator Program

It's not enough to quantify risk: the intervention must match the need
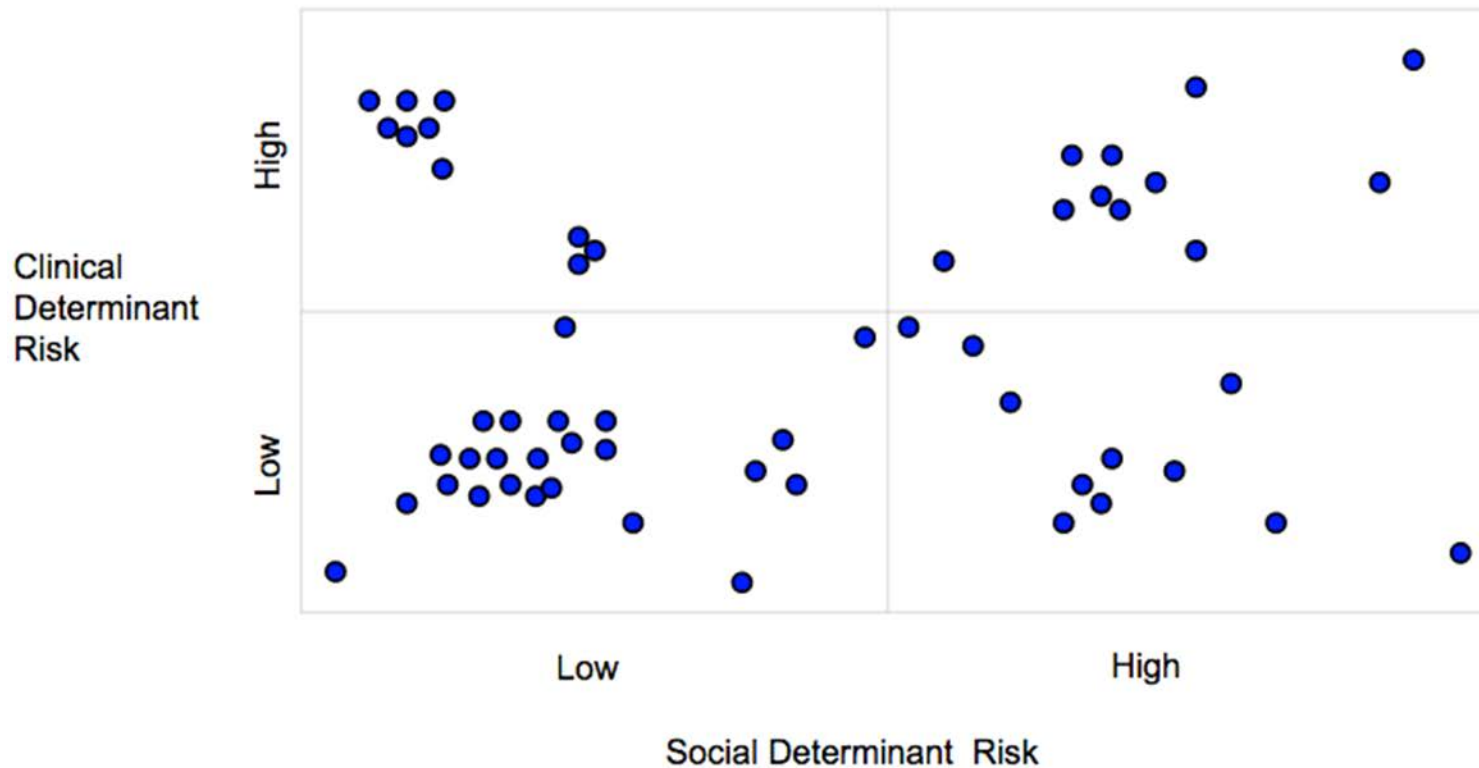
Impacting Clinical
Decision Making and Utilization

However..

Population health is often impacted by social determinants outside of a health system's walls.

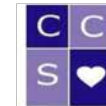pcci

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# Community Based Organizations (CBO) Address These Social Determinants of Health

CBOs

- Crisis and Emergency
- Food
- Transportation
- Housing and Utilities
- Health and Hospice
- Human Trafficking
- Jobs and Support
- Legal
- Special Needs
- Youth Counseling
- Seniors

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..But CBOs are Fragmented, Technology Scarce, and Disconnected from Health Systems

CBOs
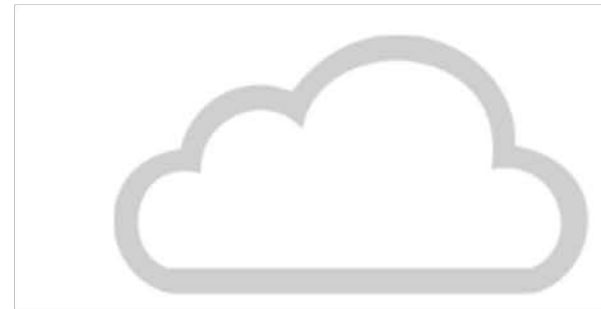
Critical Technology Needs to Connect the Care Continuum

Connecting all Community Partners.

Pieces Iris™

Pieces Iris™

Behavioral Health Facilities

Local Health Information Exchanges

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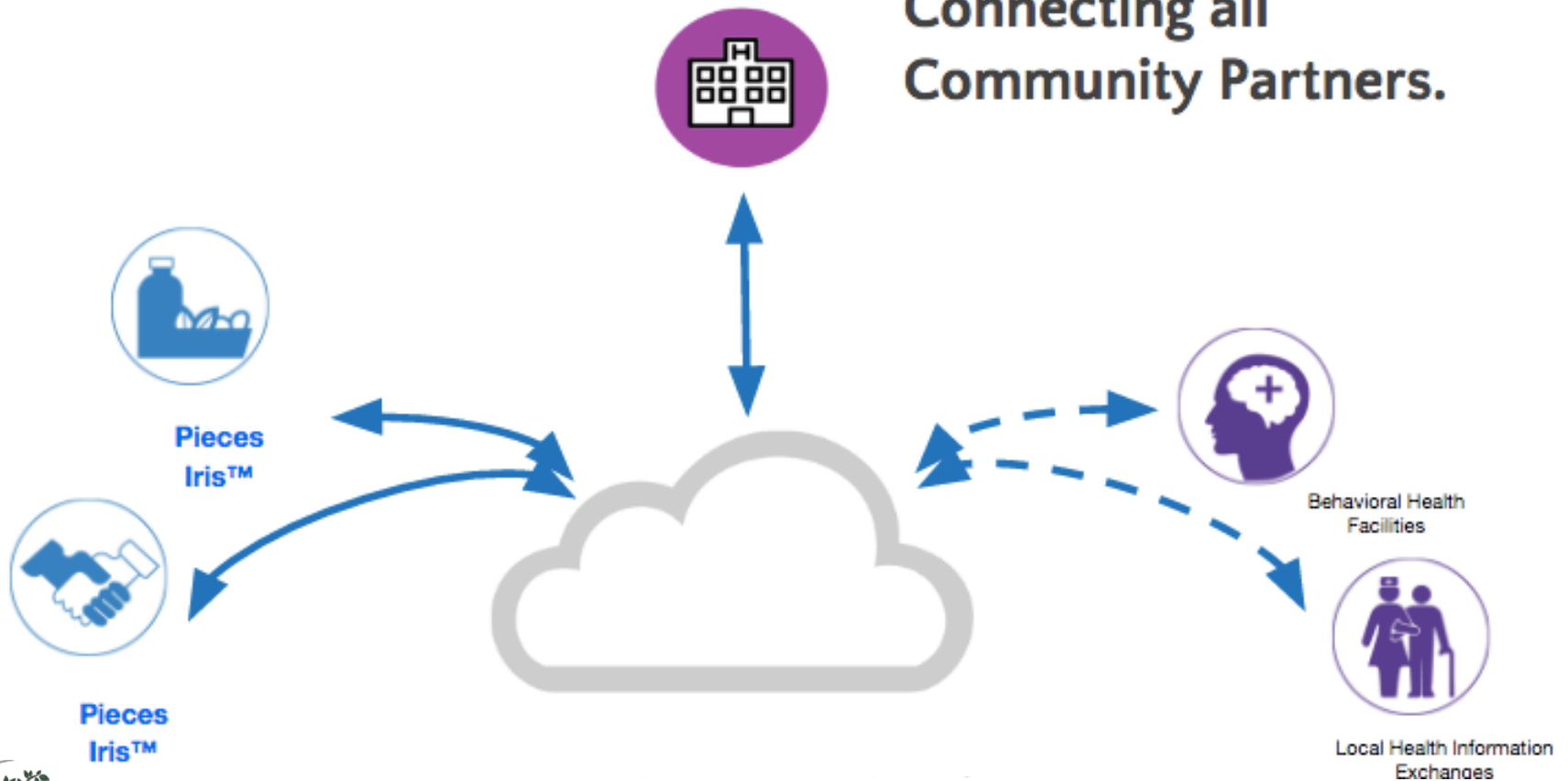
Tracking & Coordinating Across the Continuum of Care

LONGITUDINAL PATIENT TRACKING

We envision a connected community – Iris connects patients and service providers to support continuous information and a continuum of care.

CBO

HOSPITALS

CBO

FOODBANKS

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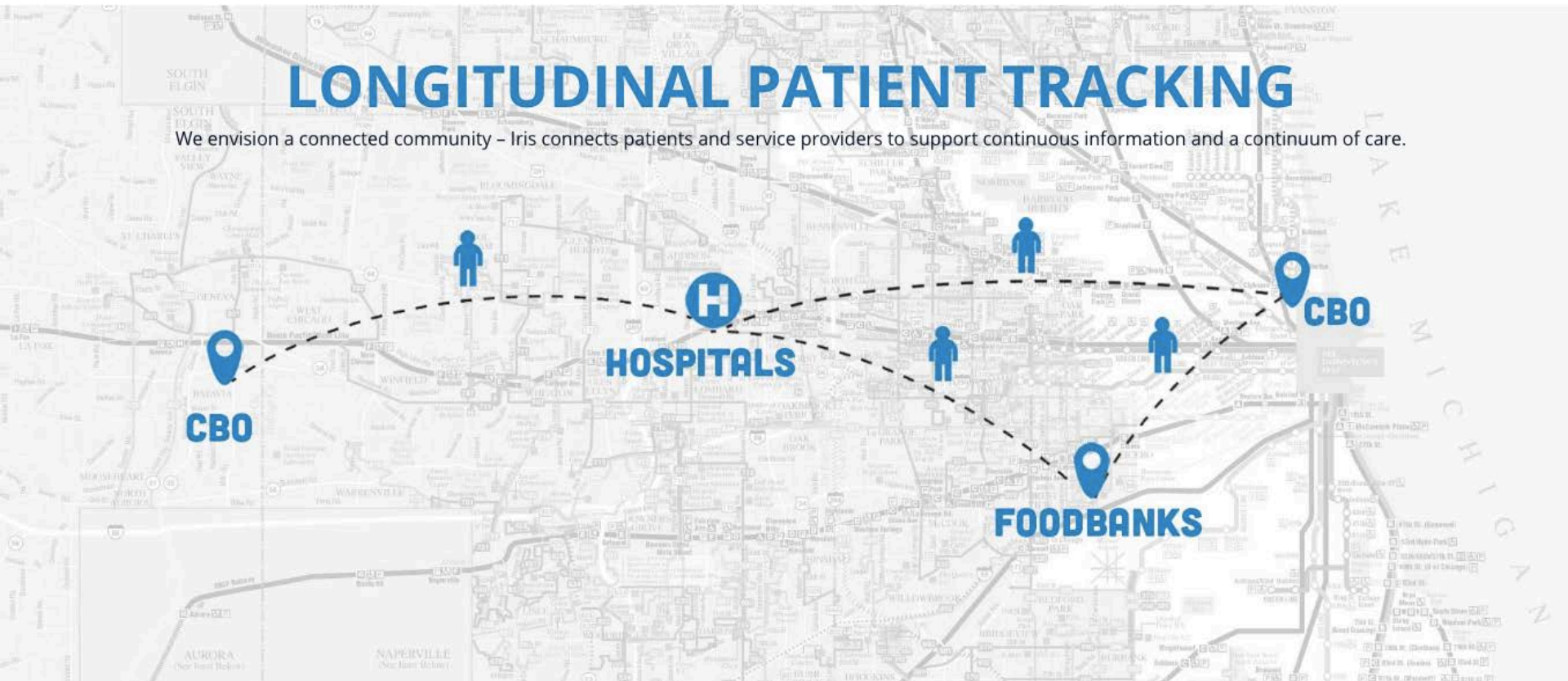
PCCI Related Work:
The Dallas Information Exchange Portal
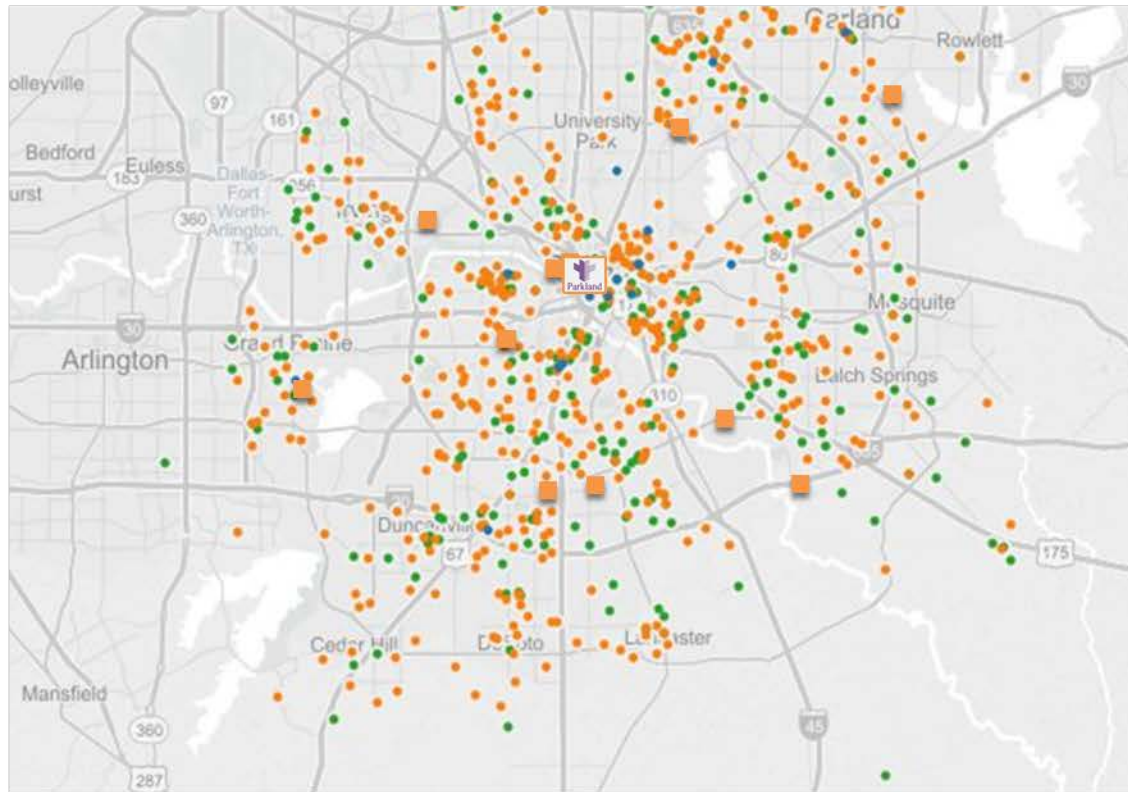
Legend:
- North Texas Food Bank programs (654 Impacted Programs)
- NTFB Partner Agencies (316 Piece Iris™ Implementations)
- MDHA Projects (28-47 Pieces Iris™ Implementations)
- Parkland Community Oriented Primary Care Clinics

Some of our current and future partners

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PCCI's work in this area is available for Download

PCCI's playbook & environmental scan report and the playbook are available for download at:

PCCI[1]

http://www.pccipieces.org/environmental-scan/

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Contact PCCI:

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District of Columbia

Joe Weissfeld, MPP

Department of Health Care Finance

Government of the District of Columbia

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Proposed My Health GPS Overview

- **Target population:** ~25,000 beneficiaries (primarily fee-for-service)

- **Eligibility:** 3 or more chronic conditions

- **Enrollment**: Patients will be assigned to a My Health GPS provider through an opt-out, with utilization trigger process. Patient attribution to My Health GPS provider will be based on a prior provider/patient relationship (up to a 2 year look-back), geography, provider capacity

- **Target Start Date:** April '17

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Identification of My Health GPS Target Population

- **Population Profiling and Analytics**
  - Necessary Data
    - Claims data
      - To target populations/conditions
      - To determine eligibility
      - To tier by acuity
      - To identify potential providers
      - To provide "mock attributions"
      - To attribute to providers
    - Medicare data for dual eligibles
    - Historical, national Medicaid data for a risk assessment tool

- **Incentive Payment Structure**
  - Care Plan Incentive and P4P

Top 5 Data and Data Analytics Challenges

1. Lack of cohesive data compatibility and data sharing across District agencies as well as across District service providers

2. Lack of access to timely, high-quality historical claims data for our beneficiaries and/or a business analytics or risk assessment tool (however, we are in the process of launching a Data Warehouse)

3. Lack of internal data analytics capacity and expertise

4. Difficulty operationalizing a sensitive, responsive tool that is will be utilized by end-users

5. Difficulty balancing the powerful opportunity with CMS-Implementation Advanced Planning Document funds and the unpredictable nature of receiving approvals

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Oregon

Jennifer Valentine, MSPH
Dual Eligibles/Medicare Medicaid
Health Services Division
Oregon Health Authority

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Oregon Project Overview

- Initial focus on dual eligible beneficiaries as population with high prevalence of complex chronic and behavioral health conditions compared to the overall Medicaid population

- Expanded focus to complete a deeper dive on Oregon's Medicaid super utilizer population

- Brought diverse data sets together:
  - Medicare data from Oregon's All-Payer All-Claim Database (APAC) including Medicare Advantage
  - Oregon's Medicaid data
  - Medicare FFS data files from RESDAC

- Two-Phased Approach
  - Phase 1: Population Profile
  - Phase 2: Regression Analysis

https://www.oregon.gov/oha/analytics/Pages/All-Payer-All-Claims.aspx

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Methodology

- After numerous conversations, we decided to take a two-phased approach to defining Oregon's super-utilizer population

- Because no standard definition of super-utilization currently exists, we drew on a review of published literature, conversations with other BCN IAP teams, and discussions with the Oregon Health Authority's Office of Health Analytics team to define super-utilizers.

- Since our project started as a look at Oregon Dual Eligibles, we decided to incorporate dual eligibles into our superutilizer analysis.

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Phase I - Definitions

- **Several themes emerged from background work**
  1. *High users that can be targeted for intervention.* Large numbers of visits for any reason put strain on the healthcare system, but high numbers of preventable ED visits are a clear target for interventions.

  2. *Repeated vs. time-limited high use.* Interventions for patients with repeated high utilization can differ from those for patients with time-limited high utilization.

  3. *Role of mental health*. Discussion with Oregon Health Authority staff suggested that this may be an important factor related to high utilization in Oregon.

  4. *Medicaid expansion.* Discussion with Oregon Health Authority staff revealed that the Medicaid expansion population was a topic of interest.

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Accomplishments: Phase 1

- Themes from background work:
  - Focus on high users that can be targeted for intervention. Repeated vs. time-limited high use.
  - Role of mental health.
  - Medicaid expansion.

- We stratified 9 groups of high ED Users

ED VISIT PATTERN	Traditional Medicaid Population		Medicaid Expansion Population (2014 only)
	Temporary (2013 only)	Persistent (2013 & 2014)	
4+ ED visits of any kind per year	Group 1	Group 4	Group 7
4+ avoidable ED visits per year	Group 2	Group 5	Group 8
4+ ED visits for mental health conditions per year	Group 3	Group 6	Group 9

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Question and Answer

Juan Montanez, Facilitator

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To Ask a Question or Make a Comment

- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in "full screen" mode
  - Please exit out of "full screen" mode to participate in polling questions
- Ask a question verbally by dialing *1. You will be connected to the webinar operator, who will connect your line so that you can ask your question.

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Topic Wrap Up

Juan Montanez

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Key Takeaways

1. Incorporating medical health, behavioral health and social/human needs data in the methodology/algorithm for targeting and stratification is ideal, and becoming more doable as information systems become more interoperable and data exchange standards become more prevalent.

2. Building a *continuum* of BCN data that supports targeting, stratification, care plan development <u>and</u> measurement is ideal, and also becoming more doable as advancements in information technology and exchange take hold and greater collaboration across data stewards occurs.

3. States should dedicate efforts to develop a feasible strategy for obtaining and using data from an expanded set of sources including non-clinical sources.

4. A better understanding of the federal and state laws and regulations that govern information access, use and exchange is critical to the success of any BCN initiative.

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Closing Remarks

Karen LLanos

Medicaid Innovation
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Closing Remarks

- National Dissemination Series continues:
  - December 12, 2016: Factoring Social Determinants into Strategies for BCNs
  - January 9, 2017: Effective Care Management Strategies for BCNs
  - February 27, 2017: Employing Alternate Payment Strategies for BCNs
  - All sessions are scheduled for 2:00 p.m.-3:30 p.m. ET

- Resources
  - Data Privacy, Data Use and Data Use Agreements Resource Paper will be posted soon to the updated IAP BCN webpage at: http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html
  - Upcoming T-MSIS based tools for states from IAP Data Analytics
  - CMS's State Data Resource Center for Medicaid agencies interested in Medicare data access

- Please complete the post webinar evaluation

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