Delivering Care to Special Populations

Meg Murray, CEO, ACAP
NAMD Fall Conference
November 4, 2014
About ACAP

**Mission**: To strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower-income and vulnerable populations

**Membership**: 58 Safety Net Health Plans in 24 states, collectively covering more than 11 million people enrolled in Medicaid, CHIP, Medicare and other publicly-sponsored programs
ACAP Plans: Recognized Nationally

4 of the 5 top Medicaid plans in the U.S. are ACAP-member Safety Net Health Plans

- Network Health (Mass.) - #1 overall
- Neighborhood Health Plan (Mass.) – #3
- Boston Medical Center HealthNet Plan (Mass.) – #4
- Neighborhood Health Plan of Rhode Island – #5

Four others are top-ranked in their state:
- Passport Health Plan (Ky.), MDwise (Ind.), CalOptima (Calif.), CareSource (Ohio)

Source: NCQA Health Insurance Plan Rankings 2014-15 (Medicaid)
Policymakers Think Medicaid Is This…

Medicaid
…But It’s Really This.
Tools Safety Net Health Plans Use to Reach Special Populations

- Addressing social determinants of health
- Integrating behavioral and physical health care
- Intensive care management for high-risk members
- Improving Care for Dual Eligible Members
Leading Determinants of Health

Genetic: 30%
Behavior: 40%
Health Care: 10%
Social: 15%
Environment: 5%

McGinnis, JM et al Health Affairs, April 2002; Kaiser Permanente 2010 Community Benefit Annual Report
Housing as Health Care: UPMC’s
Cultivating Health for Success
Chronic Medical Illness and the Homeless

- Among people experiencing homelessness:
  - 31% to 46% report having a chronic medical problem.
  - High prevalence of HIV, CVD, diabetes, latent TB infection
  - Substance abuse estimated to affect 40% to 60% of the population.
  - Homeless adults are hospitalized 4 to 5 times the rate of the general population, and inpatient stays are generally longer.
  - Homeless patients, particularly those with substance use disorders, are more likely to frequently utilize the emergency department.

- Despite the high use of medical services by people experiencing homelessness, they have poor health outcomes.
  - Mortality rates 3x-4x higher than the general population.
  - Earlier mortality for those with severe mental illness (SMI), multiple co-morbidities.
Cultivating Health for Success: The Partners

- **The member:** Medicaid or D-SNP member; disabled, as determined by the PCP; lengthy history of repeated inpatient hospitals stays and ED visits; homeless/unstable permanent housing situation (as defined by HUD)

- **Metro Family Practice:** a primary care practice committed to working with people with psychosocial challenges

- **Allegheny County Housing Authority** (local HUD)

- Housing support agency: **Community Human Services**

- **UPMC for You Health Plan**
Cultivating Health for Success: The Process

- Conduct member assessments and obtain member consents (program agreement; release of PH/BH PHI)
- PCP initial appointment and care plan development
- Assist member in finding fair market housing (1 BR)
- Assist member in obtaining transportation assistance
- Medication reconciliation; review/address barriers to adherence
- Follow-up after emergency room visits
- Visit member during inpatient hospitalization for care coordination; assist member in scheduling follow-up visits
Cost of Care

- Post enrollment data shows a decrease of 8.3% for average PMPM expenses (medical and pharmacy)

### Average Expenses PMPM by Period

<table>
<thead>
<tr>
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<th>Pre</th>
<th>Post</th>
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<tbody>
<tr>
<td>Average PMPM Medical PMPM</td>
<td>$2,231</td>
<td>$2,001</td>
</tr>
<tr>
<td>Average Unplanned Care Costs PMPM</td>
<td>$1,349</td>
<td>$1,132</td>
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<tr>
<td>Average RX PMPM</td>
<td>$456</td>
<td>$481</td>
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<tr>
<td>Average RX and Medical PMPM</td>
<td>$2,687</td>
<td>$2,482</td>
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Data courtesy UPMC for You
Bridging the Physical/Behavioral Health Care Gap: MDwise
Bridging the Physical/Behavioral Health Care Gap: MDWise

• A pilot project encouraged community mental health centers to identify patients without recent physical health care and refer them to primary care providers.

• Emphasizes well-care visits for children/adolescents; care for adults with BH issues and diabetes; tobacco cessation

• Part of a greater effort to share case management, claims data between the health plan and CMHCs.

• Expanding to ten additional centers in 2015, resulting in the participation of more than half of the state’s 26 CMHCs.
CareOregon’s Health Resilience Program
CareOregon’s Health Resilience Program: Targeting High-Acuity, High-Cost Members

- Generally older, more likely to be female, more likely to have a high level of disease burden
- Nearly 3 in 4 report depression
- 6 in 10 report substance use disorder
- Nearly 1 in 4 report substance use disorder PLUS a complex behavioral health condition
What Health Resilience Specialists **DO** when meeting with their clients

- *Info Gathering*: 15%
- *Regular Check In w/ Client*: 14%
- *Skills / Problem Solving Training*: 10%
- *Motivational Interviewing*: 8%
- *Goals Setting / Review*: 8%
- *Community Resources Education*: 7%
- *Advocacy*: 6%
- *Health Promo Activities*: 5%
- *Health Education / Health Literacy*: 5%
- *Rx Adherence & Support*: 4%
- *Physical Assessment*: 4%
- *Side by Side Coordination*: 3%
- *Multidisciplinary Assessment*: 3%
- *Follow-Up After ED or Inpt Admit*: 2%
- *Insurance Advocacy*: 1%
- *Other*: 5%
<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medical office</td>
<td>52%</td>
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<tr>
<td>Client's home</td>
<td>21%</td>
</tr>
<tr>
<td>Community site</td>
<td>15%</td>
</tr>
<tr>
<td>Hospital</td>
<td>5%</td>
</tr>
<tr>
<td>SNF/Adult Foster Care</td>
<td>3%</td>
</tr>
<tr>
<td>Mental Health or Addictions Site</td>
<td>2%</td>
</tr>
<tr>
<td>Emergency Dept</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
</tr>
</tbody>
</table>
HRP Successes: **Emergency Dept. Visit Rate**

**Visit Rate for 222 Members**
Engaged AT LEAST One time for 3+ months (on or Before June 30th, 2013)

**ED Visits**
per member per year

**Preliminary Findings**
Amy Vance, Health Resilience Specialist (center): 2014 Making a Difference Award Winner
What ACAP Plans Have Learned So Far from the Duals Demonstrations and Member Outreach

- 17 ACAP plans participate in duals demos (or are preparing to do so).
- Participation is voluntary, but some states use passive enrollment
  - Calif. uses passive enrollment exclusively in some counties
  - Member engagement is key
Lessons Learned: Challenges

- Many members have incomplete/incorrect contact information. Plans had to dedicate significant resources to finding and contacting new members.
- HRA is required in first 90 days; new strategies needed to engage enrollees with behavioral health conditions to raise HRA completion rates
- Being “person-centered” not always consistent with timelines
- Vendor management: if subcontracting the assessments, performance metrics must be determined early on.
- Higher staff capacity to anticipate, respond to changing needs for high-risk populations key.
- There is unmet need especially in the behavioral health area
- In-home assessments are finding unsafe conditions, scarcity of food and other challenges which affect health, but are not health care
Lessons Learned: Solutions

- **Leverage partnerships** with providers and community organizations.
- **Develop dedicated outreach teams.** Set aside specific resources and training for enrollment and engagement.
- **Develop multiple points of engagement** for enrollees (phone, during HRA) to integrate, coordinate information and build trust.
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