CMCS Informational Bulletin

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FROM:   Cindy Mann, Director
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SUBJECT:   Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality

The Medicaid program serves as the county’s largest insurer, covering over 62 million Americans. The Center for Medicaid and CHIP Services (CMCS) is committed to supporting innovative care delivery models with potential to improve care, improve health, and reduce costs.

Programs that target “super-utilizers” – beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers – demonstrate early promise of realizing these goals for Medicaid populations. CMCS is issuing this Informational Bulletin to share details of care delivery and payment models to help states and Medicaid providers better meet the complex needs of the highest utilizers of acute care in Medicaid populations.

Section I of this Bulletin describes the key policy decisions that states and providers with existing super-utilizer programs under Medicaid have considered in designing and implementing their programs. It presents a spectrum of possible approaches to address each policy decision based on interviews with state Medicaid officials and providers leading ten super-utilizer programs across the country. Section II provides details of existing Medicaid funding mechanisms and policies that can support super-utilizer programs.

As noted, this informational bulletin is based on interviews with ten super-utilizer programs, including six described in detail in the appendix. CMCS identified these programs based on conversations with CMS and HHS staff, program leaders, foundations, state Medicaid agencies, and outside experts. We appreciate that there are other programs and successful models and invite others to share their experiences and insights with us.

The case studies identified in this round of conversations were primarily oriented towards acute care. Most are not in capitated arrangements, although several programs have some intersection with managed care. We believe that super-utilizer programs also hold strong promise to address the needs of complex Medicaid beneficiaries in long term care settings and in managed care...
settings, but this informational bulletin summarizes our learning to date. We will continue to refine and develop the lessons on these issues and welcome feedback.

Interest in super-utilizer programs is increasing across the public and private sectors, creating new funding opportunities to support these programs. The Center for Medicare and Medicaid Innovation (CMMI) awarded Health Care Innovation Awards to two initiatives targeting Medicaid super-utilizers. Cooper University Hospital in New Jersey was awarded $2.8 million to expand the Camden Coalition super-utilizer program to serve over 1200 patients with estimated 3-year cost savings of $6.2 million. Rutgers, the State University of New Jersey, was awarded $14.4 million to test community-based super-utilizer models led by safety-net provider organizations in Pennsylvania, Colorado, Missouri, and California with estimated 3-year cost savings of $67.7 million. The first annual report for these CMMI awards will be in 2014. In addition, the Robert Wood Johnson Foundation is funding super-utilizer programs in six communities in New Jersey, Ohio, Maine, California, Massachusetts, and Michigan. These programs include community-based super-utilizer teams that focus on the highest utilizers in a specific geographic area and super-utilizer clinics/ambulatory Intensive Care Units (ICU) that care for patients with the highest utilization.

We look forward to continuing to work with states, providers, and other stakeholders to provide further assistance in developing new care models to improve quality and decrease costs for complex Medicaid beneficiaries. Please contact Stephen Cha, Chief Medical Officer at CMCS, at stephen.cha@cms.hhs.gov for questions about this Bulletin or to suggest additional resources or care models.

**Background**

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

This concentration of spending is expected. Individuals who suffer an acute illness or trauma or who have serious chronic conditions will have higher utilization and incur greater medical expenses compared to the rest of the population. However, there is growing evidence that some of these high-cost patients are not receiving coordinated care, preventive care or care in the most appropriate settings. “Super-utilizers” is the term used to refer to patients who accumulate large numbers of emergency department visits and hospital admissions which might have been prevented by relatively inexpensive early interventions and primary care.v,vi
Not surprisingly, many of the same patients continue to generate high costs every year, which provides further support for the value of intervention. The majority (nearly 60 percent) of Medicaid beneficiaries who were among the most expensive 10 percent in one year remained among the top 10 percent in two subsequent years. These patients may continue to generate high utilization because they receive fragmented care in more expensive acute care settings while lacking access to coordinated care in lower-cost primary care settings. In addition, they may have behavioral health conditions, including mental illness and substance use disorders, or face social barriers such as homelessness, which exacerbate their chronic medical illnesses.

Some state Medicaid agencies and provider organizations have implemented super-utilizer programs to better address the needs of this population, often by building on existing care management programs and working in close partnerships with primary care providers. By integrating treatment for mental illness and substance use disorders with social supports, programs are addressing the non-medical factors that may be driving high utilization in Medicaid populations. When effectively designed and implemented, these programs can greatly improve the lives of their patients while dramatically reducing their hospitalization and emergency department (ED) visit rates, and thus total medical spending.

SECTION I: KEY POLICY DECISIONS

The following set of key policy questions are presented for review by states and providers interested in launching super-utilizer programs. The state Medicaid officials, Medicaid managed care organizations, and providers leading super-utilizer programs interviewed by CMCS staff identified these as questions they needed to address in order to move forward with their programs.

This list is not meant to be comprehensive, but it provides a high-level overview that may be useful for planning purposes. Several approaches are presented as options for addressing each key policy question based on the experiences of the programs selected as case studies. For more information on any of these approaches, please read the case studies in the Appendix, which include state-level programs underway in Maine, North Carolina, and Vermont, as well as local programs led by CareOregon, Hennepin Health, and Spectrum Health.

1. Should we pursue a super-utilizer program in our state?

Naturally, a state should first consider the fundamental question of whether a super-utilizer program in their state is likely to be successful in improving beneficiary outcomes and reducing unnecessary spending. The core analysis involved in this decision involves (1) identifying the major super-utilizer subpopulations within the state; (2) identifying a provisional set of factors driving high-utilization among these populations; (3) assessing the feasibility of eliminating unnecessary utilization through a set of targeted interventions to address those factors; and
(4) estimating both the potential cost and savings associated with a program that is able to address those drivers and reduce unnecessary utilization.

States can begin this exercise by analyzing their claims data to identify the potential super-utilizer population—in particular, focusing on beneficiary subpopulations that may have higher-than-expected levels of acute care utilization given their diseases or conditions. By analyzing claims data, states can analyze the total costs of care and common diagnoses and treatments for super-utilizers in their state and start to quantify the number and cost of super-utilizers to the state Medicaid program. State Medicaid staff can also talk with providers, payers, and community organizations about the situations of the patients they have encountered to determine what features and patterns to look for, and then confirm these with analysis.

The state can then consider whether these super-utilizer populations represent “impactable” costs. Some people who may fall within a “super-utilizer” group by looking solely at expenditures, simply require expensive treatments that are unavoidable, such as certain traumatic injuries, or patients with cancer or other medical conditions that are costly to treat effectively. In contrast, “impactable” patients typically have a constellation of chronic medical illness, and sometimes, in addition, mental illness or substance use disorders, as well as social barriers driving high preventable utilization of care in acute care settings. A typical “impactable” patient may have multiple ED visits for mental illness or substance use disorders and/or multiple preventable admissions for poorly controlled chronic conditions (such as diabetes complications or heart failure exacerbations).

Given the nature of the “impactable” beneficiary populations, the state can then begin to identify the types of interventions that would be necessary to address the needs of these populations. Finally, the state can estimate the initial and recurring cost of establishing a program that is able to deliver these interventions, and compare that to the potential savings to the state in reduced utilization. A simple sensitivity analysis—comparing low, medium, and high estimates of both cost and potential savings can be performed to understand the general scenarios in which the program will be cost-saving.

Once a state decides to move forward with a super-utilizer intervention, it will need to invest significant resources up-front to build the necessary analytic infrastructure to support an effective, data-driven intervention. This infrastructure includes:

1. **Web-Based Provider Portals with Patient Data:** Allow providers and programs to sort their patients by the number of recent hospitalizations and ED visits so they can consider their patients with respect to their utilization patterns (primarily ED versus primarily inpatient) and develop interventions to meet their needs.
2. **Real-time Utilization Data:** A state health information exchange (HIE) delivers real-time data to programs on a daily basis. HIEs can include utilization data such as ED visits and inpatient admissions as well as clinical data such as discharge summaries, prescriptions filled, and laboratory and radiology results. By aggregating utilization data across hospitals, HIEs can create daily reports of current hospital inpatients classified as super-utilizers. Programs can use these daily reports to identify and engage potential clients during ED visits and hospitalizations, when they are most receptive to the intervention. Another option is for hospitals to provide daily ED and inpatient admission data to a centralized state database through admission/data/transfer feeds.

3. **Decision Support Tools:** Decision support tools can help care managers use these data to identify and prioritize high risk individuals. Some tools identify high risk individuals based on patterns such as frequent hospitalizations. Other tools can identify individuals with gaps in care, such as severe asthma without a controller medicine like inhaled corticosteroids.

2. **What payers are involved?**

Payers typically “own” the financial risk of the patient and are a natural place for states and providers to look for interest and partnership when establishing a super-utilizer program. The case studies in this Bulletin tended to involve primarily Medicaid populations only. However, Medicare, other commercial payers, large public or private organizations that serve as health care purchasers for employees, and even hospitals with large uncompensated care populations have also pursued these types of programs.

Developing a super-utilizer program focused on Medicaid populations offers the advantages of allowing states and managed care organizations to use existing Medicaid data systems and analytic tools and to design targeted services that meet the unique needs of Medicaid super-utilizers.

Partnering with other payers such as commercial insurers and Medicare may provide greater incentives to providers to refer to and partner with the super-utilizer program because more payers in the market are participating. States can seek opportunities to partner with similar initiatives and demonstrations targeting “super-utilizers” in Medicare and commercial markets. Collaborations with commercial insurers and Medicare can provide additional funding opportunities because improvements in care that reduce utilization for program clients will typically translate directly to savings to the payers. However, a super-utilizer program involving multiple payers may create data challenges in assembling an all-payer claims data base and logistical challenges in adapting program services to the different needs of different populations.

3. **Who provides the services and what is their relationship to primary care providers?**
One of the central questions to address is if the program will work in close partnership with primary care providers to enhance their capacity to care for people who are super-utilizers and provide alternative intensive services, or if the program will transfer these patients from primary care to a specialized care setting. Programs partnering closely with primary care practices use several approaches along a spectrum from highly centralized within the primary care practice to decentralized and based in the community. 

Some programs establish intensive services separate from the providers, although with close interactions:

1. **Centralized**: Care managers or outreach workers employed or contracted by the state or the Medicaid managed care organization are embedded in primary care practices. Primary care practices are selected either because they serve a high volume of Medicaid patients or they are high-performing patient-centered medical homes with the infrastructure to work closely with the additional staff to address the needs of their most complex patients. (For examples, see the Vermont or CareOregon cases included in the Appendix.)

2. **Supportive Networks**: Not-for-profit, community-based organizations provide care managers to support a network of primary care practices in their region. The care managers travel between primary care practices and build capacity within multiple practices in their network to address the needs of their highest utilizers. (For an example, see the North Carolina case included in the Appendix.)

3. **Community-Based Care Teams**: Interdisciplinary teams including nurse care managers, social workers, and behavioral health workers based in communities visit patients in their homes and community settings. These teams target the highest utilizers in a geographic region but work with the primary care practices to identify referrals and coordinate care for patients. These teams may be organized by home health agencies, community-based organizations, or large community-based primary care practices such as federally-qualified health centers. (For an example, see the Maine case included in the Appendix.)

Other programs offer more comprehensive services in specialized care settings known as “ambulatory intensive care units.” These separate complex care clinics focus all their attention and resources on a small panel of high-utilizing patients. Programs can provide short-term interventions or take over care of the patients permanently:

1. **Short-Term Intervention in Super-utilizer Clinic**: Provides comprehensive medical, mental health, addiction treatment, and social services for a limited duration (typically 6 to 9 months). After identifying and treating triggers of high utilization and successfully decreasing utilization of unnecessary or avoidable care, this clinic sends patients back to their primary care and specialty care providers with individualized care plans. (For an example, see the Spectrum Health case included in the Appendix.)
2. **Permanent Ambulatory ICU**: Takes over care of patients when their primary care providers agree that the patients have complex needs beyond the capacity of traditional primary care. This specialized super-utilizer clinic has an interdisciplinary staff including physicians, nurse care managers, social workers, pharmacists and behavioral health specialists with extensive experience caring for medically and socially complex patients. The clinic provides comprehensive and intensive services at a much lower provider to patient ratio than traditional primary care. (For an example, see the Hennepin Health case included in the Appendix.)

**4. What is the targeting strategy?**

A critical element of any super-utilizer program is how it identifies potential patients. Existing programs employ a broad spectrum of approaches ranging from quantitative analysis of claims data and predictive modeling to referrals from providers supplemented by in-person screening interviews. Through its targeting strategy, a successful program will identify candidate patients that are both likely to experience high levels of costly but preventable utilization in the future and likely to be “impactable” – capable of being helped by the specific capabilities of the super-utilizer program.

Specific targeting approaches include:

1. **Targeting based on high observed-to-expected costs**: States or vendors may use home-grown or vendor provided risk-adjustment algorithms or “grouper” programs to analyze Medicaid claims data and identify expected costs for each patient in the eligible population. Patients with actual costs significantly higher than expected costs may be targeted on the theory that higher-than-expected costs are likely to be a marker for a failure to provide fully adequate care, and are thus an opportunity to eliminate unnecessary and preventable utilization through an appropriate intervention.

2. **Targeting specific patterns of care**: States may review historical claims data or real-time data from providers (available through a Health Information Exchange or other arrangement) to identify specific care patterns that indicate fragmented care, such as high utilization of EDs and high volume of preventable admissions combined with no primary care visits or visiting multiple primary care and specialty care providers over a relatively short time period.

3. **Targeting very high levels of utilization**: States may use historical or real-time data to identify patients just based on a high volume of inpatient admissions and/or ED visits over the course of the last six to 18 months. The number of ED visits and/or admissions used as the selection threshold differs widely depending on the size and complexity of the eligible population. Different thresholds can yield significantly different types of patients. Criteria based on a high volume of ED visits alone may identify patients with more severe co-existing
behavioral health conditions including substance use disorders, chronic pain, addiction, and mental illness. Including patients with multiple inpatient admissions may yield more patients with severe chronic medical illnesses.

Some programs have found that targeting based on high levels of spending alone is often a flawed approach. High levels of spending in the absence of excessively high rates of inpatient or outpatient care is often simply a marker of legitimate and necessary medical treatment for a high-cost condition, making it a poor targeting criterion (by itself) for super-utilizer programs aiming to reduce unnecessary use of medical resources.

4. **Targeting based on referrals and follow-up investigation:** Programs may accept referrals of potential patients from local providers – such as ED staff or primary care providers – or other community resources – such as social workers. Data sharing must meet state and federal confidentiality requirements. Once the program identifies potential patients, they often collect additional data by delving into the electronic medical record (EMRs). Some specialty providers in mental health and long-term care settings may not have the capacity to conduct deep data dives because they lack EMRs. Complementary or alternative approaches are for program staff to discuss potential participants with their primary care providers and to conduct in-depth interviews with clients. Some of these interviews can be quite extensive and systematic, lasting for several hours. This large up-front investment in time is seen as appropriate given the potential cost of on-boarding and dedicating significant program resources on a client that is ultimately not “impactable.”

5. **Excluding candidate clients with medical conditions associated with high but non-preventable costs:** A complement to several of the previous targeting strategies, used by several programs to avoid “false-positives” when identifying candidate patients, is to exclude beneficiaries with a history of specific medical conditions known to require costly medical treatment, such as cancer or acute trauma.

6. **Targeting by presence of risk factors associated with high, preventable costs:** Conversely, programs may target patients with a history of high cost and utilization that are also known to have psychosocial risk factors such as substance use disorders, homelessness, and mental illness.

7. **Targeting by community:** Targeting underserved areas can be an important factor to consider, since high utilization may be due to inadequate systems of care across a community, particularly with regard to primary care and behavioral health.

5. **What services are provided?**
The selection of services should be guided by the needs of the individuals selected for the program and access to primary care and behavioral health in the community. Effective super-utilizer programs excel in matching program services to the patient’s needs.

Existing programs described in the case studies included in the Appendix offer an array of services in several categories: care coordination, in-person medical care, in-person behavioral health care, assistance with social needs, and health coaching. Care coordination refers to scheduling appointments and coordinating primary and specialty care. In-person medical care includes disease and medication management and in-person behavioral health care includes treatment of mental illness and substance use disorders. Assistance with social needs encompasses help obtaining housing, transportation, and food as well as financial assistance for medication co-pays. Health coaching includes self-management support and teaching clients how to navigate the health system.

Segmenting individuals into subpopulations (e.g., primarily ED versus primarily inpatient) allows programs to tailor their services to the individual’s particular needs. Programs can develop different intervention pathways based on the utilization profile and needs of their patients. An intervention that emphasizes social services and behavioral health treatment may be ideal for individuals with high ED visit rates but without many inpatient admissions because individuals who are ED “super-utilizers” may have more addiction and substance use disorders and mental illness diagnoses. In contrast, an intervention emphasizing coordination of medical care and disease management might be best for people with low ED visit rates but a large number of inpatient admissions because individuals who are inpatient “super-utilizers” may be older with greater medical complexity and multiple poorly-controlled chronic medical conditions.

Traditional care management approaches that rely primarily on claims data that provides information on historical utilization and telephonic outreach and support have had limited success in addressing the needs for many super-utilizer populations. Effective super-utilizer programs use real-time data to identify potential patients, engage them while they are still at the hospital or in the ED, and follow-up with existing clients enrolled in the program in a timely way when they are hospitalized or visit an ED. Programs obtain real-time data either through HIEs or admission/discharge/transfer feeds from partnering hospitals. Program staff review real-time data on a daily basis, sending care managers to meet potential and existing clients while they are hospitalized and responding quickly to existing emergent needs.

Telephonic case management alone has had limited success, perhaps because people may be difficult to reach by phone and require more intensive, in-person interventions to build trust and provide needed supports. Many super-utilizer programs field interdisciplinary care management teams that create personalized care plans, engage in frequent, in-person outreach to clients, and connect clients with behavioral health and social services. Team members may need
to meet with a potential client multiple times in-person in their home or community settings in order to build trust and establish a relationship with a client.

The capacity and infrastructure of primary care and behavioral health services in a community are key determinants of the scope of services provided by a super-utilizer program. A program in an impoverished community with a severe shortage of primary care and behavioral health providers may need to deliver intensive in-person medical and behavioral health care because patients have no other options for obtaining this care. At the other end of the spectrum, a program in a community with high-performing patient-centered medical homes and rich behavioral health resources can focus on providing comprehensive care coordination and health coaching.

The physical location where people will receive services is also an important element. For example, providing a range of services within the same physical facility such as an “ambulatory intensive care unit” reduces the need to make separate referrals and appointments, reducing the chance that patients miss important services. Deploying community-based outreach workers or teams who visit patients in their homes and community settings may allow a program to reach high risk individuals who are marginally housed, lack phones, and do not have established relationships with primary care providers. Outreach workers can use home-based models for adults with serious mental illness such as Assertive Community Treatment.xiv

After the program identifies the core services, it will need to carefully consider the type of staff (including training, skill set, and experience) who will be able to provide these services to patients most effectively. Programs can include a spectrum from care managers or community health workers only to a multi-disciplinary team that includes a combination of providers (doctors, nurse practitioners, and/or physician assistants), nurses, pharmacists, social workers, behavioral health specialists (psychiatrists, psychologists, mental health counselors, chemical dependency counselors, and/or peer specialists), care managers, health coaches, and/or community health workers. One key feature of successful programs is that they recruit staff with many years of experience working in the field with very vulnerable and complex patients.

Another key function for any super-utilizer program is establishing feedback loops, based on both quantitative data such as dashboards; and qualitative data, such as patient surveys to determine whether their needs are being better met. These kinds of feedback systems are essential to the rapid cycle improvement model that forms the core of successful super-utilizer interventions.

6. How is the program funded?

States should consider how to pay super-utilizer programs for services provided directly to Medicaid patients and how to fund other essential program components such as program
planning, management and evaluation. The way in which care team organizations are paid can create powerful incentives, and should be considered carefully. The potential savings to the organizations that currently bear the risk for patients should be considered when developing the program payment structure as a way to achieve long-term sustainability. Aligned payers and providers are a potential source of funding because programs that improve care and reduce utilization for program clients will typically generate savings for the payers, but care must be taken to avoid duplication of funding streams.

Existing programs that serve Medicaid beneficiaries use several different payment mechanisms:

1. **Medicaid Case Management Payment**: Use fixed per-member-per-month (PMPM) Primary Care Case Management or other care coordination fee to fund care managers supporting primary care practices. (For examples, see the North Carolina and Vermont cases included in the Appendix.)

2. **Multi-Payer Case Management Payment**: The program receives Medicaid Health Home PMPM payments for Medicaid beneficiaries, Medicare PMPM payments from the Multi-Payer Advanced Primary Care Practice Demonstration and federally qualified health center (FQHC) Advanced Primary Care Practice Demonstration for Medicare beneficiaries, and PMPM payments from commercial insurers for privately insured individuals. The PMPM payments fund Community Care Teams working in partnership with Medicaid Health Homes, Advanced Primary Care Practices, and FQHCs. (For an example, see the Maine case included in the Appendix.)

3. **Per-Episode of Care Payment for Program Services**: The program receives a single payment for each episode for each insured individual from payors (including Medicaid managed care organizations). This payment covers all program costs for the specific duration and can be adjusted up or down based on the complexity of the individual’s condition(s) as represented by a risk score of some sort – for example, the cumulative number of medical, psychosocial, and behavioral conditions of the individual. (For an example, see the Spectrum Health case included in the Appendix.)

4. **Per-Member Per-Month Payment to Managed Care Organization (MCO)**: The state Medicaid agency provides a risk-based capitation payment for each Medicaid client enrolled in an MCO which is part of a larger integrated delivery system. The MCO uses that payment to cover the costs of providing both medical and behavioral health services as well as the data analytics and care interventions for super-utilizer programs. (For an example, see the Hennepin Health case included in the Appendix.)

5. **Shared Savings for Total Cost of Care**: Similar in some respects to a fully capitated model, the state Medicaid agency enters into a partial risk-sharing arrangement with the care team
organization, providing a negotiated share of the savings if program clients incur lower-than-expected costs over a fixed time period (and perhaps penalizing the care team organization if clients incur higher-than-expected costs). For example, Minnesota’s Integrated Care Model will implement Medicaid shared savings to hold providers accountable for care delivered by sharing in savings and losses for the total cost of care.

SECTION II: HOW MEDICAID CAN SUPPORT SUPER-UTILIZER PROGRAMS

Medicaid has a variety of existing authorities that can provide sustainable support to super-utilizer programs. An essential step is identifying the best funding pathway to support the design and development of the necessary statewide data and analytic infrastructure. Improving the interface of a state’s Medicaid Management Information Systems (MMIS) (MMIS, which primarily contains Medicaid claims data) with a statewide HIE with robust Medicaid functionality is one method a state may use to develop an effective statewide super-utilizers program. States can either focusing on enhancing MMIS functionality on the Medicaid side or on building Medicaid functionality on the HIE side.

States committed to developing MMIS functionality should consider pursuing the enhanced 90 percent federal matching payment for Design, Development, and Implementation of MMIS. These enhanced federal payments can support the design and development of real-time admission/discharge/transfer (ADT) data feeds, data analytic tools, and MMIS decision support systems.

States interested in enhancing Medicaid functionality on the HIE side should consider pursuing the enhanced 90 percent federal matching payment available to cover Medicaid’s “fair share” of design, development, and implementation costs associated with the HIE’s ability to help providers achieve the requirements for Meaningful Use. The Health Information Technology (HITECH) funding under the Recovery Act can also support on-boarding costs charged to Medicaid EHR Incentive Program providers and hospitals through subsidies.

An additional option, administrative contracts, can support utilization review and data analysis to identify the “impactable” population of individuals who are super-utilizers.

Medicaid Health Homes and Integrated Care Models can support a variety of components that are central to successful super-utilizer programs such as interdisciplinary care teams and comprehensive care coordination services while providing flexibility for states to develop tiered rate methodologies. Targeted Case Management can enhance other models such as Health Homes or traditional managed care because states can target intensive case management services to specific complex populations.

Finally, CMS has worked to enhance data resources for states that are focused on Medicare-Medicaid enrollees.

States that modify their MMIS to support real-time data analytics for super-utilizer programs can receive an enhanced 90 percent federal matching payment under section 1903(a)(3) of the Social Security Act (the Act) for design, development, and installation of the new MMIS subsystem or component. Enhancements such as upgrading or augmenting MMIS or MMIS decision support systems or adding MMIS components including a data warehouse, advanced query and report tools, and power programmers can qualify for the enhanced 90 percent federal matching payment. These enhancements must be under the state Medicaid agency and integral to an approved MMIS system that has been certified by CMS. The 90 percent federal matching payment also applies to all staff or contractors directly involved in the design and installation of the MMIS or its subsystem.

MMIS funding can support the data infrastructure for super-utilizer programs by developing admission/data/transfer feeds that are delivered to providers and programs in real-time or via batch transfers every 24 hours. States could also add analytic tools to MMIS that enable providers to better understand and characterize their Medicaid super-utilizer populations.

For continuing operations and maintenance of MMIS, states can receive a 75 percent federal matching payment. All professional staff or contractors directly involved in operating and maintaining the MMIS or its subsystem can qualify for the 75 percent matching payment (including systems managers, programmers, and other IT staff) under section 1903(a)(3) of the Act.

Medicaid staff who use the MMIS data and reports to operate and manage super-utilizer programs can receive the 50 percent federal match for Administrative Contracts described below. One exception is for power programmers who write the code that is used to execute the reports in the system. Because they are considered to be directly developing, operating, and maintaining the system, power programmers qualify for enhanced MMIS funding (90 percent federal match during design and installation phases and 75 percent federal match during maintenance and operations phase). If staff are both developing the reports and using them in a program management function, their costs should be allocated according to the percent of time spent on MMIS development work versus program management functions.

An advantage of obtaining the enhanced MMIS funding to develop the data infrastructure for super-utilizer programs is that states can obtain 75 percent Federal Financial Participation (FFP) for ongoing maintenance and operations (M&O). In addition, states can integrate real-time utilization data with the Medicaid claims data in their MMIS and develop robust analytic tools focused on the Medicaid super-utilizer population. This pathway may be optimal for super-utilizer programs focused on Medicaid fee-for-service populations.

In order to be eligible for the enhanced federal match rate, a state’s MMIS must comply with the seven standards and conditions listed in the Federal Register, Vol. 76, No. 75, dated April 19,
2011. States must submit an Advanced Planning Document to CMS for review and prior approval in order to receive this funding.

2. **Enhanced Federal Match for Health Information Exchanges**

State Medicaid agencies can receive enhanced 90 percent FFP for their administration and oversight of the Medicaid EHR incentive program, including reasonable administrative expenses related to their efforts to promote the adoption of HIE, under the HITECH Act. A State Medicaid Director’s (SMD) Letter on August 17, 2010, clarified that states can receive the enhanced 90 percent FFP for Medicaid’s fair share of the costs to design, develop and implement statewide Health Information Exchanges. It also describes CMS’ expectations of state Medicaid agencies’ roles in promoting and participating in HIEs. xv

Please note that the participation of the state Medicaid agency in a state-designated or private HIE, as well as the decision to apply for this enhanced FFP, is optional and at the discretion of the state.

States could use the enhanced 90 percent federal match for Medicaid “fair share of costs” to build functionality into their HIE. As outlined in a second SMD Letter on May 18, 2011, that provides additional guidance on state expenditures related to the development and sustaining of HIEs, “funding from Medicaid should be part of an overall financial plan that leverages multiple funding sources to develop and maintain HIEs between hospitals, health systems, and individual practices.” xvi

States must work with commercial payers, sister agencies, and health systems to pay their fair share of costs to design and develop the HIE, if they, too, will benefit from the development of the functionality.

An advantage of obtaining the HITECH funding to support the enhancement of a HIE to support a super-utilizers program is that the 90 percent FFP may be used to subsidize the on-boarding costs of eligible providers and eligible hospitals participating in the Medicaid EHR incentive program on a time limited basis. An HIE is only robust if many providers are participating, and this is especially important for identifying super-utilizers, who often access multiple care settings across a region. This funding can provide incentives that helps an HIE reach the “tipping point”, generating more comprehensive utilization data to identify and engage super-utilizers. In addition, the HIE is ideal for a multi-payer super-utilizer program because it is not limited to Medicaid and can also identify super-utilizers in the commercially insured and Medicare populations.

It is important to note that the 90 percent enhanced federal match under HITECH funding is only meant to support time-limited activities such as HIE design, development, and implementation (DDI). Once the HIE moves to maintenance and operations, it will need to sustain itself without
this additional federal funding. A sustainability model is required by CMS before Medicaid HITECH funds can be approved for disbursement.

States are required to submit Advanced Planning Documents and state Medicaid HIT Plans to CMS that clearly describe vision and direction of the state in regard to HIE, along with their funding requests, their cost allocation, measurable milestones, any MOUs to other agencies, and documented agreements with other payers to pay their share. Additionally, any request for proposal (RFP) or contract issued from this funding requires federal approval as well. States are encouraged to consult with CMS before submitting these plans to obtain technical assistance regarding the funding options and to identify whether certain components are more appropriate to receive MMIS funding and/or HITECH funding.

3. Administrative Contracts

States could expand their existing contracts to conduct ongoing utilization review and data analysis to support super-utilizer programs through an Administrative Contract under Section 1903(a)(7) of the Act and receive a 50 percent federal matching payment. These costs must be “necessary for the proper and efficient administration of the state plan” in accordance with section 1903(a)(7). These administrative costs cannot duplicate costs that are paid through any source and must not duplicate activities that are already offered through other programs or entities.

Only state Medicaid agencies are allowed to claim the matching payment for Administrative Claims from CMS. Therefore, a non-profit organization that leads a community-based super-utilizer program would need to partner with their state Medicaid agency in a contractual arrangement to become a vendor of the state in order to assist with data analysis and utilization review activities. A contract would need to clearly state the specific data collection, analytic, and utilization review activities performed by the organization that are not duplicative of existing efforts being conducted by the state Medicaid agency and meet the requirements for the proper and efficient administration of the Medicaid program.

4. Medicaid Health Homes

Health Homes authorized under section 2703 of the Affordable Care Act are a promising option to support super-utilizer programs because they support interdisciplinary care teams and a comprehensive set of services including many of the core components of super-utilizer programs. States receive an enhanced 90 percent federal matching payment for the first eight quarters of operation of the Medicaid Health Home. The enhanced matching payment is tied to the Health Home’s operation, not to individual beneficiaries. After the first eight quarters, Health Homes receive the state’s regular federal matching payment.

Health Home payments can support care delivered by interdisciplinary teams with members including physicians, nurse care coordinators, nutritionists, social workers, behavioral health
professionals, or other professionals designated by the state and approved by the Secretary. Health Home services include comprehensive care management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings, individual and family support, referral to community and social support services and health information technology.\textsuperscript{xvii}

Under section 1945(h)(2) of the Act, a state can select a Health Home population that has one persistent and persistent mental health condition, two or more chronic conditions, or one chronic condition and is at risk for a second. The chronic conditions specified in section 1945(h)(2) include a mental health condition, a substance use disorder, asthma, diabetes, heart disease, HIV/AIDS and BMI $> 25$. The Secretary has flexibility to expand the list of chronic conditions.

States may target the highest cost beneficiaries with the most severe conditions in the Health Home population under CMS interpretation of current statute. According to the CMS letter to state Medicaid directors on November, 16, 2010: "The State may elect in its State plan to provide Health Home services to individuals eligible to receive Health Home services based on all the chronic conditions listed in the statute, or provide Health Home services to individuals with particular chronic conditions. While all individuals served must meet the minimum statutory criteria, States may elect to target the population to individuals with higher numbers or severity of chronic or mental health conditions."\textsuperscript{xviii}

A state could select a population for its Health Homes that includes the majority of the individuals fitting its definition of super-utilizers after it determines which chronic and mental health conditions are most prevalent among its most expensive beneficiaries, and which conditions are most impactable. States have already obtained Health Home state plan amendments (SPAs) that include target populations with high cost conditions such as developmental disabilities and intellectual disabilities.\textsuperscript{xix} Once a state obtains approval for its Health Home SPA, the state could enroll its highest cost, highest need beneficiaries with the most severe conditions into its Health Homes first. States are not required to actively assign all eligible individuals who meet their criteria to Health Homes but they cannot limit Health Homes to only the highest cost beneficiaries with the most severe conditions. The state would need to ensure that the Health Home is available to all eligible individuals who are referred to or interested in receiving Health Home services.

States can also structure payment methodologies that incentivize Health Homes to deliver more intensive care management services to the most complex patients who have the greatest need.\textsuperscript{xx} The CMS letter to state Medicaid directors on November 16, 2010, states, "section 1945(c)(2)(A) of the Act expressly permits states to structure a tiered payment methodology that accounts for the severity of each individual’s chronic conditions and the “capabilities” of the designated provider, the team of health care professionals operating with the designated provider, or the health team."
States have developed different approaches to make Health Home payments for eligible beneficiaries enrolled in Medicaid managed care. Two states are currently making payments to the managed care plans, and two states pay the providers directly for providing Health Home services.\textsuperscript{xxi}

5. \textit{Integrated Care Models}

Integrated Care Models (ICMs) are care delivery and payment models that reward coordinated, high quality care. ICMs can include patient-centered medical homes, accountable care organizations, or other models that emphasize person-centered, continuous, coordinated, and comprehensive care. CMCS released guidance on how states can implement ICMs in a Medicaid fee-for-service environment, including a new state plan amendment option that allows states to move more quickly.\textsuperscript{xxii} Future guidance is forthcoming on how to implement ICMs for Medicaid managed care populations.

ICMs provide an avenue for states to develop payment mechanisms that support intensive care interventions and reward providers who lower costs and improve quality for their highest utilizers. Section 1905(t) of the Act authorizes coordinating, locating and monitoring activities that may support Integrated Care Models (ICMs). Under the Medicaid state plan, ICM activities must be available to all eligible individuals; however, states could have a tiered reimbursement structure that pays providers more for caring for beneficiaries with complex conditions and care needs. According to the State Medicaid Director’s Letter released on July 10, 2011, “states may vary payments to providers based on the level of activity/service that will occur within a quarter and/or variations in the costs of delivering the care coordination activities.” The letter clarifies that “a state could implement a tiered rate methodology that pays one rate for providers who maintain a staff of care coordinators.”\textsuperscript{xxiii}

A state that implements an ICM could also develop a shared savings methodology that calculates the total cost of care associated with super-utilizers and incentivizes providers to reduce population cost (and increase quality) specifically for the super-utilizers within the state. For a state to employ this option under the Medicaid state plan, it must offer and reimburse coordinating, locating and monitoring services for all individuals eligible under the state plan. States that wish to target ICM activities to specific populations or within limited geographic regions would need to use section 1915(b) or 1115(a) authority to waive state plan requirements. States could use this authority to target services to individuals with high needs who have characteristics typically associated with super-utilizers or focus on a locality with a high prevalence of Medicaid utilization.

6. \textit{Targeted Case Management}

Under Section 1915(g) of the Act, states could add an optional Targeted Case Management (TCM) service to the state plan to support care managers that address the needs of super-
utilizers. Under Section 1915(g), “the State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness.” TCM could be used to assist super-utilizers with mental health, substance use disorders, and/or developmental disabilities gain access to needed medical, social, educational, and other services. Case managers assess individuals’ needs, develop person-centered care plans, refer individuals to services, and monitor receipt of services and the need for care plan changes.

Targeted case management services may employ a multi-disciplinary team approach to serve super-utilizers. Case managers coordinate the team’s resources and expertise to inform a comprehensive, medical, educational, and social assessment as well as to create and implement a comprehensive plan of care. States may develop differential rates based on case or task complexity to reflect the need to draw on additional resources to develop and implement comprehensive assessments, care plans, and follow through activities.

TCM adds value to other models such as Health Homes or traditional managed care models. As a stand-alone service, it would be difficult to achieve the efficiencies of managed care or to take advantage of shared savings available under ICMs. TCM services are reimbursed at the traditional state-specific FMAP rate, which is less generous than the enhanced 90 percent federal matching payment available for the first eight quarters of operation of Medicaid Health Homes. After the first eight quarters, Health Homes are reimbursed at the same state-specific federal medical assistance percentage rate that states receive for TCM. One advantage of TCM is that the authority for states to target case management activities to specific populations or within limited geographic regions is built into the statutory provision so there is no need for the state to obtain a section 1915(b) waiver.

7. **Medicare Data Access and Assistance**

For states designing initiatives focused on Medicare-Medicaid enrollees, the Medicare Medicaid Coordination Office (MMCO) provides both access and no-fee assistance with Medicare Parts A, B, and D data for the support of care coordination efforts. MMCO’s State Data Resource Center (SDRC) provides state Medicaid agency staff direct access to Medicare data experts, who can assist in requesting and using Medicare data as part of those agencies’ care coordination activities. The State Data Resource Center (SDRC) established a SDRC website: [www.statedataresourcecenter.com](http://www.statedataresourcecenter.com). The website houses a range of information on the Medicare data available to agencies, the no-fee process for requesting that data, frequently asked questions about the data, and use restrictions.

Assistance from a team of Medicare data experts through SDRC is currently available. States may visit the SDRC Website at [www.statedataresourcecenter.com](http://www.statedataresourcecenter.com) for assistance with:

- Understanding Medicare data and its applicability to an agency’s proposed intended use for care coordination;
• Obtaining Medicare data from CMS, including gaining an approved Data Use Agreement or addenda;
• Linking databases and creating analytic databases;
• Addressing anomalies within CMS data—including assisting agencies who may or may not be familiar with the data available at CMS and its use; and
• Using available data, based on an agency’s priorities for care coordination.

States may also find the following specialized data useful:
• Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) is a suite of 2006-2009 linked data files for Medicare-Medicaid eligibility, enrollment, utilization, and expenditure data. This data source includes health care information for all dually eligible Medicare-Medicaid enrollees, and, for comparison purposes, all Medicare-only beneficiaries and Medicaid-only beneficiaries with disabilities. This is available by request through the SDRC.

• Chronic Condition Data Warehouse (CCW) clinical condition indicators, or “flags”, have been developed from the claims data for 27 chronic conditions that were deemed to be relevant to the study of Medicare-only beneficiaries. The CCW is CMS’s database to facilitate research on chronic illness in the Medicare population and ultimately improve the quality of care and reduce program spending. With the assistance of subject matter experts, MMCO developed and made available additional CCW flags for 8 mental health conditions, tobacco use, and 14 conditions related to intellectual, developmental, and physical disability. More information on these flags is available at: www.ccwdata.org.

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Centers for Medicare and Medicaid Services. Use of administrative funds to support health information exchange as part of the Medicaid EHR Incentive Program. May 18, 2011. Available from


Rhode Island has obtained a Health Home SPA for a target population of children with a diagnosis of serious mental illness or severe emotional disturbance, or two chronic conditions. Chronic conditions includes mental health conditions, Down Syndrome, developmental disabilities, intellectual disabilities, seizure disorder, asthma, and diabetes. Available at http://www.chcs.org/usr_doc/Rhode_Island_1-CEDARR_Family_Center_Health_Homes.pdf

New York adjusts their monthly payments, which range from $75 to $390 PMPM based on geography and patient-case mix. National Academy for State Health Policy. Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues. July 2012

Missouri is making payments directly to the providers for managed care enrollees to avoid the delay of renegotiating managed care contracts. The SPA does not change managed care rates. Oregon is paying the entire care management fee to the managed care plans and does not require the plans to pass the entire fee onto the providers. However, any money retained by the plans must be used to carry out functions related to the state’s Health Home program. New York is amending their managed care contracts to address the potential payment duplication of managed care capitation and Health Home payments. A small portion of the New York payment may be retained by managed care plans to support administration of the program. Managed care plans are expected to pay the same rates to contracted Health Homes as the state. National Academy for State Health Policy. Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues. July 2012.