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Super-Utilizer Summit

Common Themes from Innovative Complex Care Management Programs

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In Brief: In many regions across the country, robust "super-utilizer" programs providing intensive outpatient care management to high-need, high-cost patients are beginning to emerge. The term "super-utilizer" describes individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization—all costly, chaotic, and ineffective ways to provide care and improve patient outcomes.

To explore how Medicaid could best advance models for this high-need group of patients, the Center for Health Care Strategies (CHCS), in partnership with the National Governors Association, hosted a *Super-Utilizer Summit* on February 11 and 12, 2013. The *Summit* brought together leaders from super-utilizer programs across the country, states, the Centers for Medicare & Medicaid Services, the Robert Wood Johnson Foundation (RWJF) *Aligning Forces for Quality* (AF4Q) alliances, health plans, and other key stakeholders to share strategies for changing how our health care system interacts with these high-need, high-cost patients. The meeting was made possible through the generous support of RWJF and The Atlantic Philanthropies.

This report presents the *Summit's* common themes and key recommendations for building better systems of care for high utilizers. The appendices also include materials related to existing complex care management programs that can be educational resources for states and policy-makers considering ways to implement, spread, and sustain such programs.

Introduction

As health care costs continue to consume an increasingly large proportion of state and federal budgets, payers, providers, and policy-makers—particularly those focused on Medicaid, the newly eligible expansion population, and the uninsured—are developing "super-utilizer" programs with a greater sense of urgency.

Super-utilizer programs provide intensive outpatient care management to patient subpopulations with very complex physical, behavioral, and social needs. Because of these needs and a lack of coordinated care, these individuals have very high health care costs from avoidable utilization of inpatient care and emergency room services. Lacking a medical "home," super-utilizers typically bounce between emergency departments, inpatient admissions/readmissions, nursing homes and back again—all costly, chaotic, and ineffective ways to give and receive care.

Many super-utilizers either receive insurance through Medicaid or are uninsured. Many super-utilizers have disabilities that prevent them from working and are unlikely to have coverage through an employer. Many are single, childless adults and, as such, have been uninsured in states that have not expanded Medicaid coverage in the past. With the implementation of the Affordable Care Act (ACA), many more of them will become eligible for Medicaid coverage on January 1, 2014.

In Medicaid overall, approximately five percent of beneficiaries drive more than 50 percent of total spending.[1] Eighty percent of high-cost beneficiaries have three or more chronic conditions, and 60 percent have five or more chronic conditions.[2] Many of these high-cost, complex beneficiaries are super-utilizers. In addition, super-utilizers may face an array of complex social challenges—joblessness, homelessness, substance abuse, etc.—and unstable or chaotic living conditions.

The term super-utilizer became part of the common vernacular in the last few years in part through a groundbreaking article by Dr. Atul Gawande on the Camden Coalition of Health Care Providers.[3] Dr. Gawande wrote about Dr. Jeff Brenner's "hot-spotting" work in Camden, New Jersey—how he used data to map neighborhoods of high-cost and high-utilization of medical services. With support from local hospitals, Dr. Brenner would mine claims and other data to identify super-utilizers and provide high-touch complex care management with his team. By helping manage the social, behavioral, and medical needs of these individuals, the Coalition has been successful in breaking the harmful and costly cycle of inappropriate and costly emergency department (ED) or inpatient admissions. The Coalition's work in finding a more effective way to manage the care of the super-utilizers is not only a more patient-centered approach to health care, but it provides better quality care and promises to bend the cost trend. It leverages community supports and institutions, such as churches and faith-based organizations, as part of the solution. The value placed by the Coalition on investment in human relationships with patients fundamentally changes and challenges the common construct of how we think about health care, wellness, and how people become healed.

Across the country, other states and regions are looking to learn from Camden's super-utilizer approach in order to develop new programs to manage care and control costs for high-need populations. This concept of complex care management for high-cost, high-need individuals

is not new—programs like the Commonwealth Care Alliance in Massachusetts have been doing this for many years, and the Center for Health Care Strategies (CHCS) has been working with innovative states and delivery system partners to develop these models over much of the last decade. However, the dire budgetary situation has heightened interest in super-utilizer programs.

A number of such efforts are emerging across the county, and they are creating a growing body of evidence around effective strategies. To capture and spread lessons from existing programs, the Robert Wood Johnson Foundation (RWJF) and The Atlantic Philanthropies supported a national *Super-Utilizer Summit* on February 11 and 12, 2013 in Alexandria, Virginia. The *Summit* brought together a diverse mix of leaders from 14 states, super-utilizer programs across the country, the Centers for Medicare & Medicaid Services (CMS), several RWJF *Aligning Forces for Quality* (AF4Q) alliances, pilots from CHCS' *Rethinking Care Program* funded by Kaiser Permanente, health plans, and other key stakeholders.

This report captures themes discussed at the meeting and highlights innovative strategies used by the super-utilizer programs that presented at the *Summit*. It groups strategies shared during the *Summit* into three areas:

1. Data collection and analysis strategies to identify the eligible population and target patient subgroups that are most likely to be impacted by complex care management;

2. Care teams and care management interventions; and

3. Integration, replication, and sustainability of super-utilizer programs in the delivery system.

The report includes several appendices:

- Appendix A lists the participants and organizations that attended the *Summit*;

- Appendix B provides examples of key state and federal legislative language supporting delivery system and payment reform efforts that facilitate complex care management programs;

- Appendix C provides examples of resources and tools from existing super-utilizer programs and complex care management programs; and

- Appendix D provides a bibliography of relevant legislative and programmatic references and resource documents.

Appendices B and C have been organized into the same three areas created during the *Summit*: data collection and analysis strategies; care teams and interventions; and integration/replication/sustainability of programs. The materials in the appendices are intended as an educational

resource for states and policy-makers considering ways to implement, spread, and sustain complex care management programs in their communities.

Data Collection and Analysis to Identify Impactable Subpopulations

The *Summit* participants unanimously agreed that access to real-time information—such as notifications of ED visits or inpatient admissions—and a strong analytics team provide a critical foundation for super-utilizer programs. One leader referred to data as "oxygen for our program." Programs place a high priority on developing a robust data repository that can be mined to identify groups of patients that might respond well to complex care management. Following are the common themes and strategies from the meeting related to data analytics.

Types of Data

The *Summit* participants are consistently creative about the types of data they pursue to understand their population and build their programs. Following is a discussion of the ways the participants are using data.

Claims Data

The programs represented at the *Summit* generally use historical claims data as a foundation to understand the size and scope of super-utilization. Claims analysis is an iterative process and includes identifying areas of high cost and high utilization, and/or identifying groups of recipients with a high number of diagnoses. With this initial broad brush information, programs are able to further shape and define the target population. For example, Community Care of North Carolina (CCNC), which includes 14 regional networks that manage the care of Medicaid beneficiaries, will analyze at least 12 months of data in order to understand which chronic illness and mental health indicators are contributing to a high number of ED visits.

Participating super-utilizer programs reported a high prevalence of behavioral health diagnoses in high-utilizers through claims data. Indeed per capita Medicaid costs increase significantly with the addition of a mental health diagnosis, substance abuse diagnosis, or mental health plus substance abuse diagnosis, as noted in Exhibit 1.

Alternative Data Sources

Beyond claims data, super-utilizer programs that participated in the *Summit* use a wide range of data to inform program design and patient interventions. R. Corey Waller, MD, the program director for a super-utilizer program at Spectrum Health Medical Group's Center for Integrated Medicine in West Michigan, noted the danger of relying on only one

Exhibit 1: Per Capita Medicaid Costs: Implications of Behavioral Health Comorbidity[4]
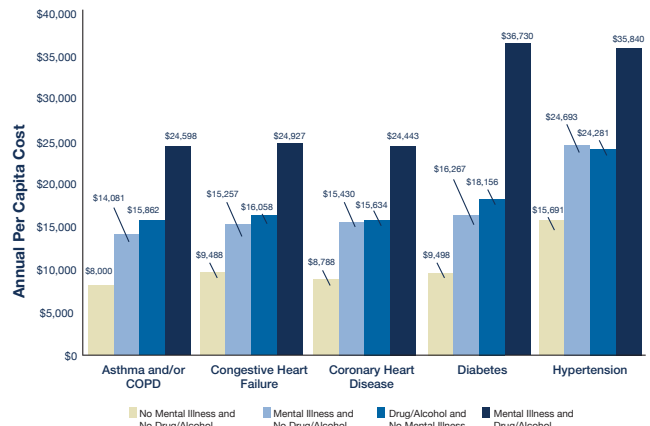
type of data—like claims or diagnosis—because it might not provide an accurate picture of the patient's situation. Experience has taught him that "relying only on one type of data makes you more vulnerable to inaccuracies." As an emergency room physician, Dr. Waller noted that the chaotic conditions of the ED and the frequent lack of historical patient information can lead to inaccurate or missed diagnoses.

Examples of alternative data sources include real-time notification of inpatient admissions, patient demographic files, patient assessments, data from electronic health records (EHRs), information from conversations with patients and families, and information gathered from the care team. The Camden Coalition and two local hospitals developed an arrangement whereby the Coalition receives an email of a daily list or "snapshot" of patients currently in the hospital with two or more inpatient admissions and/or six or more ED visits in the last six months. The Coalition team reviews the cases captured in this daily admission list to identify potential participants to recruit to its care management program. The Coalition also has access to the EHRs of one of the hospitals, and as such, can gather additional information about identified patients.

Programs also use assessments to gather invaluable information from patients. Assessments collect a range of information including the patient's social supports, food needs, and jobs and housing situations, substance abuse habits, partners and living situation. This information helps the team paint a much more complete picture of the target subpopulations, their needs, and the opportunities to impact their care.

Predictive Modeling

Predictive modeling is a common tool used by super-utilizer programs to identify who might be at risk for

super-utilizing in the future. One program said they use predictive modeling so that they are not "held hostage waiting for claims to come down the road." Washington State uses predictive modeling to begin to identify the target populations. Using its Health Service Encounter algorithm, the state examines 15 months of integrated health care claims to determine future medical costs and inpatient risk scores. The state has found that conditions such as diabetes, cardiovascular disease, mental health and substance abuse are common among the super-utilizing subset of patients. It uses different approaches to further stratify subgroups for complex care management including identifying individuals with extreme ED utilization (e.g., approximately 80 to 130 ED visits in 15 months), high expected future medical costs (predicted by high utilization and costs in the past), high prospective inpatient risk scores, and significant gaps in care and quality indicators.

Defining Subgroups

Through data analysis, *Summit* participants discovered that super-utilizers are incredibly heterogeneous—there is not one single profile for a super-utilizer but rather many different subgroups. Programs use a variety of different definitions for super-utilizers, although common characteristics include high ED use, inpatient admissions, readmissions, and poly-pharmacy.

Washington's Health Service Encounter Risk Criteria

Predictive modeling

- Past 15 months of integrated health care claims determine future medical cost and inpatient risk scores
- High frequency conditions: mental health and substance abuse, diabetes, cardiovascular
- Minimum risk score in top 20% of expected future medical cost for Social Security Income (SSI)-related population

Criteria based on long-term care assessment data

- Client lives alone
- High risk moods/behaviors
- Medication management risk
- Self-reported health rating is "fair" or "poor"

Source: February 11, 2013 presentation by D. Mancuso

The Camden Coalition conducts a cluster analysis to identify the various subpopulations. This involves sorting cases (usually by patient utilization history) into groups, or clusters, so that the degree of association is strong between people in the same cluster, and weak between members in different ones. Some programs stratify the typologies by the different social needs faced by the patients such as homelessness, joblessness, and language preference—further indicating what interventions would be the most effective.

Although the super-utilizer population is heterogeneous, the pilot programs did note a common thread across the subpopulations: the prevalence of childhood trauma. Many care management teams were working to understand and address the impact of early childhood trauma.

Stratification of Eligible Populations

Once the eligible subpopulations are identified, the programs identify which subgroups have the greatest potential to achieve improved health outcomes and reductions in high-cost utilization from care management interventions. A program must generate a positive return on investment in order to be sustainable, which means that limited resources must be targeted to individuals who offer the best chance of reducing their super-utilization behavior. Programs participating at the *Summit* stressed the importance of carefully choosing "who's in and who's out." Examples of exclusion or "rule out" criteria include:

- Inpatient admissions related to pregnancy, oncology, trauma, or a surgical procedure for an acute condition;
- Advanced age (e.g., greater than 80 years of age) and a dementia diagnosis; or
- Someone declining to participate in the super-utilizer program.

Patient inclusion or exclusion criteria may also take into account the skill set and experience of the care team. Finally, programs incorporate a "readiness to change" factor at an individual patient level, recognizing that there is a great likelihood of impact when the patient is willing to make some changes. The Patient Activation Measure© (PAM)[5] is one example of a tool that can be used to help teams segment the patient population into levels of activation in order to target limited outreach and engagement resources.

An Iterative Process

The *Summit* participants stressed that assessing the eligible patient population is an iterative process—the care team has to keep revisiting the patients' risk factors, which are dynamic and likely to change over time. Continuously gathering information can help programs achieve greater levels of accuracy in their targeting and exclusion criteria.

New York State Health Home Analytical Tools

Medicaid health homes, Section 2703 of the Affordable Care Act (ACA), give states the ability to pay for complex care management/care transitions services for populations with multiple chronic conditions and complex physical, behavioral health and social needs. Health homes can be vehicles for super-utilizer programs.

New York Medicaid is using its health home program to better manage the care of its super-utilizers. New York's Medicaid beneficiaries who are eligible for health homes are identified and assigned using a variety of analytical tools:

- **Clinical Risk Groups (CRG)-Based Attribution**—*Used for cohort selection;*
- **CRG-Based Acuity**—*Used for determining payment tiers;*
- **Predictive Model**—*Used for predicting future negative events;*
- **Ambulatory Connectivity Measure**—*Used for assigning priority;*
- **Provider Loyalty Model**—*Used for matching to appropriate health home and to guide outreach activity.*

Source: February 12, 2013 presentation by G. Allen

One program has a detailed system for tracking care management team activities and their impact on the patient's social situation in its data warehouse. The program tracks how much of the care manager's time is spent making calls, referrals, attending appointments, etc., for each individual patient. This information is then assessed in relation to whether or not there was a successful outcome, e.g., the patient ultimately got the job, or housing, or child care. Essentially, the data is used to answer the question: what exactly does it take for the care team to make a difference in one person, and will that effort ultimately generate a positive return on investment (ROI), in terms of both the care team's time and financial resources?

Care Management Teams and Successful Interventions

If data is considered oxygen for super-utilizer programs, the care management team and its interventions are considered the "secret sauce," as described by many of the *Summit* participants. Determining the right dose of the right intervention with the right individual at the right time in the right location is at the heart of successful super-utilizer programs. Following are themes gleaned from the *Summit* participants regarding care management teams and intervention design.

Care Team Structure

The programs noted that the care teams "reside" in different locations. Some are embedded with a large integrated system or hospital, such as Spectrum Health Medical Group's Center for Integrated Medicine. Others, although working with specific practices and/or hospitals, may be unaffiliated or independent, with a home-base office, like the Camden Coalition. Other teams are located within the health plan or at the state. All care teams spend significant time working in the community.

The care teams have several common features. Most include some combination of nursing, social work, and community outreach expertise. Team members pride themselves in being persistent in trying to engage patients. They learn to keep their door open even when they "frequently get fired" by patients who may be unresponsive to support, or not interested in having their care managed. The care teams recognize that patients may need time to become accepting of and ready for change, and that different patients may require different engagement strategies, interventions, etc. Although care team composition varies across programs, team member roles tend to remain fairly consistent and well-structured within an individual program.

Care Team Interventions

Although super-utilizer programs come in many shapes and sizes, they share a common portfolio of interventions. These interventions typically include:

- Extensive outreach and engagement strategies;
- 24-hour on-call system;
- Frequent contacts with patients with priority placed on face-to-face contact;

Nurse Care Manager to Client Ratios

Nurse care manager to patient ratios are low but vary across programs. Washington State uses a 1:50 ratio and relies heavily on face-to-face interaction with the patient, with phone support only as needed.

Source: February 11, 2013 presentation by D. Mancuso

San Francisco Health Plan

This Medicaid health plan has adapted its care management strategy to better manage the care of its super-utilizers. The plan used to provide phone-based management of high-risk members (identified via a phone survey) using two care coordinators, one registered nurse (RN), and one individual with a master of social work, but found the phone-based process less than effective in engaging with patients.

Now, the plan identifies patients via prior utilization and provider referrals. The plan's care management team includes four care coordinators, two social workers, and one RN. The team is expanding its presence in the community, in patients' homes, and in health care settings, and doing more outreach to community partners.

Source: February 12, 2013 presentation by M. Raven, MD

- Comprehensive medication reconciliation and management;
- Patient-caregiver self-management education;
- Timely outpatient follow-up post-discharge;
- Linkage to a primary care provider/medical home;
- Goal setting and care plan development;
- Health education and health coaching;
- Pain management;
- Management of chronic conditions (e.g., diabetes, asthma);
- Preparation for provider visits; and
- Linkages to housing, substance abuse treatment and other community resources.

"Front-Loading" Social Needs

The care teams prioritize the interventions that impact the person's basic needs—housing, jobs, child care, and food insecurity must be addressed before physical health can be impacted. As a result, the programs "front-load social services" and typically use non-clinicians and non-traditional providers such as social workers and community health workers to address gaps in and needs for social services. Case managers, social workers, or community health workers often make the first connection with the patient, even before the patient sees a clinician. They strive to understand and address the root cause determinants of health in the specific high-risk subgroup.

Identifying the Right Intervention at the Right Time

The care teams unanimously note that one size does not fit all in super-utilizer programs. The trick is to figure out which patients need which interventions in which setting by which provider—this complex equation was noted as the "holy grail" by one *Summit* participant. While there is a growing body of evidence around super-utilizer programs, *Summit* participants stated that they were very much still figuring out the holy grail. For example, many programs noted that subpopulations respond better to bedside outreach and engagement in the hospital while others are more responsive during the first home visit within 24-48 hours of discharge from the hospital. Programs universally noted that medication management is a critical task that must be done in the patient's home to be most effective in really seeing how the patient takes his/her medicine. Another area of agreement was the tremendous opportunity to impact care when the patient is being transitioned from the hospital to his/her home.

Care Team Engagement Strategies

Care teams noted similar challenges when outreaching to and managing the care of super-utilizers. Many teams referred to the investment in building human relationships, while acknowledging the inherent "messiness" and lack of certainty of this work. The transient nature of the patient population can make it difficult to locate, talk with, and re-engage with the person over the course of time. Explaining the goals of the super-utilizer program and gaining patient consent may also be challenging. The obstacles faced by the patients can seem insurmountable, and care teams face burn out if unable to create boundaries between themselves and their patients. Several programs noted the importance of around-the-clock availability of care managers, particularly related to programs addressing behavioral health conditions. The demand to be "on call" can place significant strain on care teams.

Participants all agreed that super-utilizer programs must prioritize face-to-face interventions whenever possible within the patient's community. These programs invest

North Carolina's Transitional Care Team for Diabetic High-Utilizers

The team includes: (1) an RN case manager and health educator who visit the patient's home two days after discharge; (2) a health educator and registered dietician who conduct a follow-up visit; and (3) a CCNC network pharmacist who provides consultation on medications.

Source: February 11, 2013 presentation by L. A. Dobson, MD

heavily in "boots on the ground"—in the patient's home, church, doctor's office, hospital, rehabilitation office, community centers, nursing home, etc. Phone-based care management systems are less-than-effective in super-utilizer programs. Health Quality Partners (HQP) in Pennsylvania, one of the most successful Medicare Coordinated Care Demonstrations, stated that of all the contacts made by its care managers, 62 percent were in-person, and of those, 38 percent were in the person's home.

External Relationship Building to Support Care Management Goals

In addition to investing in patient relationships, the programs that participated in the *Summit* invest significant time and effort building relationships external to their organization. Because super-utilizer programs are so focused on creating connections that will support the individual patients, *Summit* participants repeatedly used the phrase "It takes a village to do this work effectively." The *village* includes not only state agencies, health plans,

health systems, and mainstream medical providers (hospitals, primary care practices, specialists), but also social services organizations (housing, jobs, child care, education, etc.), and other critical community partners (e.g., schools, churches, faith-based organizations, corrections facilities, etc.) Care managers come to be viewed within the community as the "main connector" because they may have the only comprehensive view of the needs of the patients.

Best Practices for Connecting with Providers

The programs represented at the *Summit* noted that establishing a connection and relationship with primary care practices and physicians is particularly critical as these providers will become central to the patients' ongoing care upon "graduation" from the super-utilizer program. Some care management teams affiliate themselves with a few primary care practices and serve as the practices' "reinforcements" when a patient needs enhanced or wrap around care management or care coordination, particularly around social services and supports. In some programs, like Maine's, the patient-centered medical home (PCMH) receives a payment for managing the care of the individual, while the community care team receives an additional payment for providing intensive wrap around supports and services to the patient that the PCMH is unable to provide.

One program stated that it invests significant time fostering relationships with nursing homes since these facilities may lack the supports and knowledge of how to effectively manage challenging patients, particularly those with behavioral health needs. When nursing homes are unable to manage a non-compliant and potentially disruptive patient, they may call 911, which only perpetuates the cycle of fragmented, costly, and unnecessary care.

Health Quality Partners stressed the importance of information management in communicating with other providers. For example, care management teams need to be

disciplined and reliable in sharing timely information with providers. This information also needs to be "high-value" to the physician as care teams will have a limited window of opportunity to get the attention of the physician. While email is a common means of communication, HQP noted that some primary care providers continue to rely on phones and faxes to receive information, even in this digital age. HQP also found that although EHRs are spreading throughout the delivery system, this technology is best used for non-urgent communications. Face-to-face meetings between the care team and external providers are valuable, but should be used judiciously and ideally linked to addressing issues around the flow of care.

Implementing, Paying for and Sustaining Super-Utilizer Programs

The role that states, CMS, and philanthropies can play in terms of paying for, advocating for and evaluating super-utilizer programs is the third critical focus area addressed at the *Summit*.

Sustaining Super-Utilizer Programs Through Financial Support

States can pay for super-utilizer programs via Medicaid using a range of payment models. CMS recently released a helpful informational bulletin on caring for super-utilizers that outlined existing authorities to provide sustainable support to these programs. In addition, the bulletin provides other valuable information including case studies of programs. The bulletin can be found at http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf.[6]

Some Medicaid programs have embedded super-utilizer programs within a primary care case management (PCCM)

delivery system (e.g., Vermont's Chronic Care Initiative). In Maine, qualified PCCM providers can receive additional payment to be part of a health home team, which includes a community health team (CHT) that manages the care of the PCP's most costly and complex patients.

States can consider how other existing care management programs—e.g., targeted case management, Programs of Assertive Community Treatment (PACT) services, Ryan White Care Act programs, and Programs of All-Inclusive Care for the Elderly (PACE) programs—can support or spread a super-utilizer pilot. Other super-utilizer programs are funded by innovative health plans within Medicaid managed care delivery system (e.g., San Francisco Health Plan). Some pilots are funded through time-limited grants or demonstrations (Camden Coalition and Health Quality Partners).[7] Pilots funded by time-limited grants may be particularly concerned about securing ongoing reimbursement for services.

The Affordable Care Act offers new financing vehicles for super-utilizer programs through Medicaid health homes (Section 2703 of ACA). Through health homes, CMS offers states a way to pay care teams to manage the complex medical, behavioral, social needs of eligible Medicaid beneficiaries. If a state chooses to reimburse care teams using a per member per month (PMPM) payment, as opposed to a fee-for-service (FFS) reimbursement, the care team has greater flexibility to use the funds to "do what it takes" to reach and engage with the individual (not otherwise a service reimbursed by Medicaid) and to do so using non-traditional workers not typically part of the Medicaid provider network (e.g., community health workers, promotores, etc.).

Programs need flexibility in funding, including access to up-front funding for start-up costs and infrastructure. Up-front costs include hiring and ramp-up of the care team and other staff, data infrastructure and equipment, legal expertise, and team training, among other costs. Medicaid is limited in its ability to pay up-front infrastructure costs since the program traditionally reimburses for services rendered. Even if the state reimburses using a more flexible global PMPM, the super-utilizer program will not get reimbursed until a team has been hired and services have been rendered. As a result, it can be difficult to find enough resources to hire a team. Many programs start small and build over time. Some rely on philanthropic or grant funding to cover initial costs.

Innovative Funding Strategies

Programs that have more experience under their belts are exploring shared savings arrangements, and there are ongoing discussions between Medicaid and CMS about how to make this a reality. For most super-utilizer programs, shared savings is not yet possible. However, the

Hennepin County, Minnesota, model, which is structured as an accountable care organization (ACO), includes shared risks and gains by the partners in its financial model. The Hennepin County program, which was launched in January 2012, set outcomes goals for the first two years of the program including a 10 percent decrease in admissions and readmissions; a 10 percent reduction in ED visits; and an increase of five percent in primary care "touches." As of October 2012, admissions were on a downward trend; readmissions decreased by two to five percent; ED use decreased by 35 percent; and primary care increased by 23 percent.

Sustaining Programs Through Broad-Based Leadership and Political Support

In addition to a sustained funding stream, super-utilizer programs noted the importance of strong executive level and political support for spread and sustainability. Super-utilizer programs are positioned to fundamentally change how care for complex and high cost beneficiaries is managed and delivered in this country. One program said that super-utilizer programs "exemplify disruptive innovation" because they place value on building one-on-one relationships with patients, and seek to eradicate fragmented, costly, and ineffective medical care. The goal is to keep people out of hospitals, nursing homes, and other costly institutions, which in turn will eliminate a substantial revenue source for these providers. Since super-utilizer programs are essentially creating a new alternative to traditional care delivery systems, these new programs need strong leaders to "go to bat" for them over the long-haul.

State Medicaid Leadership

Medicaid leadership is vital to create, support, and sustain super-utilizer programs. Through their contracting efforts, Medicaid agencies can direct health plans to partner with super-utilizer programs, develop super-utilizer

approaches within health plans, or use care managers differently, e.g., deploy more care managers into the community and reduce less-than-effective phone-based care management activities.

Participants also noted that states play a critical leadership role in facilitating access to data and driving data sharing agreements across providers. For programs that are not affiliated with a clinical site, accessing data may be particularly challenging, and state (or health plan) support may be important to get data. Also, states and counties are well-positioned to create linkages between Medicaid and other state and local agencies and social services providers to create a more holistic approach to patient care that is so critical to super-utilizer programs. For example, Minnesota's Hennepin County is working with local corrections partners to manage the care of formerly incarcerated individuals. Medicaid leadership can convene plans, providers and payers who might otherwise be competitive and help address anti-trust concerns.

Summit participants noted that states can use super-utilizer programs as a testing ground for policy issues, such as workforce development. For example, states can use super-utilizer programs to explore ways to incorporate and fund non-traditional health care workers such as community health workers or promotores. *Summit* participants suggested that Medicaid could give providers the flexibility to use and test different payment methodologies in different regions of the state.

Support in Addressing Larger System Failures

To help super-utilizer programs proliferate, state policy-makers need to address larger existing system failures simultaneously. These system failures include inefficiencies such as:

- Patients losing insurance coverage or eligibility;

- The lack of adequate and timely information to providers;

- The misuse of crisis care venues and the absence of a less costly, more appropriate venue to address patient needs; and

- The lack of transitional housing or vocational services, among other issues.

Hennepin Health is investing in some of these system changes by creating a Sobering Center where intoxicated individuals can "dry out" and be connected to community-based treatment services in a safe and cost-effective venue, as opposed to being treated in the ED. The state estimates an 80 percent return on investment from reductions in the ED as a result of the recently established Sobering Center. The state is also investing in transitional housing—one month of housing is less costly than two days of hospitalization. The state is addressing the lack of access to psychiatric services by implementing a psychiatric consult model, which gives non-behavioral health care providers much needed access to psychiatric expertise. Only by addressing these larger systematic issues can super-utilizer programs thrive.

Leadership From the Governor's Office

The governor's office can also use its bully-pulpit to provide political support to sustain and spread super-utilizer programs. One program director noted that when he told one governor about the opportunity presented by super-utilizer programs, the governor had an "a-ha" moment: the governor realized that rather than participate in "one more ribbon-cutting ceremony for another new hospital," he could instead support implementation of a super-utilizer program that could actually keep people out of hospitals.

Federal Leadership

Lastly, beyond states, CMS is playing a strong leadership role in supporting and advancing super-utilizer programs. Initiatives funded through the Centers for Medicare and Medicaid Innovation (CMMI), through the Multi-Payer Advanced Primary Care Program (MAPCP), chronic care demonstrations, and the Center for Medicaid and CHIP Services' (CMCS) support for health homes are all examples of federal policy promoting these programs. Again, in July 2013, CMS released an information bulletin on super-utilizer programs in Medicaid, including key policy decisions states should consider when designing a program, different payment mechanisms available to Medicaid programs, and case studies of existing models. Through this bulletin, CMS substantially elevated the level of attention and discussion around this model, both within and outside of Medicaid.

Evaluating Program Impact and Building the Evidence Base

Super-utilizer programs need ongoing support from funders to evaluate and demonstrate the impact of complex care management and to build the evidence base of what works, for whom, when, etc. Demonstrating a positive return on investment is the primary sustainability strategy for super-utilizer programs. While the evidence base regarding the right interventions for various subpopulations is evolving,[8, 9] both public and private funders can give the programs much-needed resources to build initial infrastructure and greater flexibility in finding the best way to use funding.

All of the programs represented at the *Summit* are striving to prove that savings from reductions in inappropriate utilization outweigh program costs. However, many of them noted that it takes a long lead-time to demonstrate this impact for a variety of reasons including that:

- It takes a long time enroll a sufficient number of patients in the program;

- Patients are not only difficult to get engaged but to *keep* engaged;

- Changes to behavior and utilization do not happen over night; and

- Utilization and costs often increase in the beginning of the care management program because the patient engages with the system and finally gets the treatment he/she needs.

Through a combination of the above factors, many programs do not begin to show impact until 18, 24 or more months into the intervention. And, as noted above, some programs actually note initial cost increases as patients begin to access services that were previously underutilized.

Finally, program participants called for creation and support of an ongoing learning network for super-utilizer programs. Such a learning network would be a vehicle for building and spreading evidence and best practices for programs and demonstrating impact. One participant noted that the *Summit* was the first time he had the opportunity to meet with so many "like-minded" leaders in complex care management and he was grateful for the "fellowship" the *Summit* created. Through meeting regularly, super-utilizer programs can learn from, inspire, and support each other in this very challenging ground-breaking work. Private funders could play a critical role in supporting such a network in the future.

Two related efforts have been recently launched: the National Governors Association recently convened its

Policy Academy with seven states that are developing action plans for delivering and financing the care of super-utilizers. CHCS also launched its *Complex Care Innovation Lab*, a new initiative that brings together leading innovators in complex care to collaboratively problem-solve and develop new approaches to improve the quality and cost-effectiveness of health care for Medicaid super-utilizers.

Challenges Before Us

Targeting complex care management services and supports to high-cost, complex patients is an increasingly well-recognized best practice in health care; however, this approach is still no "slam dunk." The discussion at the *Summit* identified larger societal obstacles that need to be grappled with before super-utilizer programs can become common practice:

- **Overcoming society's cognitive bias that more— more medical care, more expensive medical care, more high-tech medical care—is better.** Our health care system values (i.e., pays more for) high-tech, complex medical and specialty services. However, if there is a secret sauce in successful super-utilizer programs, it is the dogged (and decidedly "unsexy") investment in human-to-human relationships between the patient and the care team. Super-utilizer programs seek to fully understand why the patient is stuck and in crisis and identify strategies to get them unstuck and on their way to higher functioning. This process is inherently messy—it is rarely a direct path. If the industry embraces complex care management as an effective strategy to purchase greater value, this shift will impact our current delivery system and will create new challenges as a result.

- **Taking a highly individualized, highly unique program to scale.** As noted in the previous bullet, super-utilizer programs are effective because they invest resources in making an impact one patient at a time. Each patient has very complex and specific medical, behavioral, and social needs that require creativity, flexibility, and patience on the part of the care team. Our current health care system is not designed to flexibly and creatively address the complexity and uniqueness of each super-utilizer. The challenge therefore is how to take super-utilizer programs to scale within our health care system.

- **Shifting the role of hospitals from treating people who are sick to keeping more people healthy.** Hospitals have a lot to lose financially from reduced admissions, readmissions, and ED visits. Hospitals are also a primary source of good jobs in many communities and regions. If hospitals face reduced revenue, local jobs can be impacted. The question is whether hospitals can change their business model and role in a community.

- **Rethinking the health care team and workforce team.** If we expand the concept of health from delivering medical care to creating healthy populations and communities, we also need to expand our concept of the health care team. For example, social workers, care managers, and non-traditional providers such as community health workers must be included as part of the core care team as a necessity. Not only can they provide a release valve for over-burdened primary care providers, but in many cases non-traditional providers can be much more effective in outreaching to and forming relationships with patients. The expansion of the health care team and workforce requires a cultural shift for providers, particularly for the medical community. Developing, training and paying for the unique skill set that non-traditional providers bring in managing the care of complex and costly patients will be important.

- **Creating a linkage between traditional medical medicine and population health.** Addressing the social determinants of health is not a new concept; however, creating healthy communities (e.g., jobs, education, housing, food, parks, etc.) as a core responsibility of the health care industry *is*. A starting point is convening regional multi-stakeholder discussions to identify strategies to create linkages between traditional medicine and community health. Linking health care data and information about the health of our communities is another strategy. Initiatives such as CMMI's State Innovation Model (SIM) grants are attempting to address this disconnect.

Endnotes

1. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. *5 Key Questions About Medicaid and Its Role In State/Federal Budgets & Health Reform*. May 2012.

2. R.G. Kronick, M. Bella, and T.P. Gilmer. *The Faces of Medicaid II: Recognizing the Care Needs of People with Multiple Chronic Conditions.* Center for Health Care Strategies, Inc., October 2007.

3. A. Gawande. "The Hot Spotters," The New Yorker, January 17, 2011. Available at http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande.

4. C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin. *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations.* Center for Health Care Strategies, December 2010.

5. For more information about the PAM tool, see http://www.insigniahealth.com/solutions/patient-activation-measure.

6. http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-07-24-2013.pdf.

7. Medicare provides funding through the Advanced Primary Care Practice PMPM program.

8. For information about the evaluation of the *Rethinking Care Program,* see http://www.mathematica-mpr.com/health/rethinking_care.asp and http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=676169.

9. For information about the evaluation of the Medicare Chronic Care Demonstration, see http://www.mathematica-mpr.com/health/mccd.asp.

Appendix A

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Appendix B

Key Legislative Language Authorizing and Supporting Delivery System and Payment Reform Efforts Supporting Complex Care Management Programs

This appendix includes legislation that has been proposed or passed in states related to super-utilizer programs specifically or to delivery system and payment reform more generally that support super-utilizer programs. The legislative examples are organized in four categories: 1) Legislative language authorizing Super-Utilizer or Relevant Delivery System and Payment Reforms; 2) Legislative language addressing Data Collection, Analytics, and Use; 3) Legislative language related to Care Management and Care Coordination; and 4) Legislative language related to Spreading and Sustaining Super-Utilizer Programs. The last three categories (2, 3 and 4) reflect the categories used to organize the common themes and strategies in the *Summit* report.

Note, **this information was assembled prior to July 2013** and is not exhaustive, but includes many examples from innovative programs from across the country. The examples are intended purely as an educational resource to states and policy-makers considering ways to implement, spread, and sustain complex care management programs in their communities and are not endorsed as policies that should be adopted.

Authorization of Super-Utilizer Programs or Relevant Delivery System and Payment Reforms

Example 1: New Jersey. § 30:4D-8.1. Findings, declarations relative to a Medicaid Accountable Care Organization Demonstration Project.[1]

1. The Legislature finds and declares that:

a. *The current health care delivery and payment system often fails to provide high quality, cost-effective health care to the most vulnerable patients residing in New Jersey, many of whom have limited access to coordinated and primary care services and, therefore, tend to delay care, underutilize preventive care, seek care in hospital emergency departments or be admitted to hospitals for preventable problems;*

b. *The Accountable Care Organization (ACO) model has gained recognition as a mechanism that can be used to improve health care quality and health outcomes, while lowering the overall costs of medical care by providing incentives to coordinate care among providers throughout a region. Coordination is achieved through initiatives such as creation of patient-centered medical homes, sharing of patient health information among providers, and implementation of care management programs designed to facilitate best practices and improve communication among providers and social services agencies throughout the community;*

c. *Providers participating in the ACO are supported in their efforts to share accountability for the overall quality and cost of care rendered to patients. The ACO provides support for coordination, identification of improvements in health outcomes, quality, and cost savings, and the distribution of any overall cost savings achieved, often referred to as "gainsharing," to the ACO participants in a manner that furthers the goals of the ACO to improve quality and accessibility while reducing or stabilizing the costs of medical care throughout a region;…*

f. *It is, therefore, in the public interest to establish a Medicaid ACO demonstration project whereby providers can continue to receive Medicaid payments from managed care organizations, and, in the case of individuals not enrolled in managed care, directly from the Medicaid program, while simultaneously participating in a certified Medicaid ACO designed to improve health outcomes, quality, and access to care through regional collaboration and shared accountability, and while reducing the costs of medical care throughout a region; and*

g. *The Legislature, therefore, intends to exempt activities undertaken pursuant to the Medicaid ACO Demonstration Project that might otherwise be constrained by State antitrust laws and to provide immunity for such activities from federal antitrust laws through the state action immunity doctrine; however, notwithstanding this subsection, the Legislature does not intend to allow and does not authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of State or federal antitrust laws.[2]*

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Example 2: Maryland. Health-General § 20-1402.[3]

(a) The purpose of establishing Health Enterprise Zones is to target State resources to reduce health disparities, improve health outcomes, and reduce health costs and hospital admissions and readmissions in specific areas of the State.

(b)(1) The Secretary, in consultation with the Commission, may adopt regulations to carry out the provisions of this subtitle and to specify eligibility criteria and application,

approval, and monitoring processes for the benefits under this subtitle.

(2) The Secretary shall consult with the Office of Minority Health and Health Disparities in implementing the provisions of this subtitle.[4]

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Example 3: Texas. § 531.0861. Physician Incentive Program to Reduce Hospital Emergency Room Use for Non-Emergency Conditions.[5]

(a) If cost-effective, the executive commissioner by rule shall establish a physician incentive program designed to reduce the use of hospital emergency room services for non-emergent conditions by recipients under the medical assistance program.

(b) In establishing the physician incentive program under Subsection (a), the executive commissioner may include only the program components identified as cost-effective in the study conducted under Section 531.086.

(c) If the physician incentive program includes the payment of an enhanced reimbursement rate for routine after-hours appointments, the executive commissioner shall implement controls to ensure that the after-hours services billed are actually being provided outside of normal business hours.[6]

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Data Collection, Analytics and Use

Example 1: New Jersey. § 30:4D-8.5. Eligibility to receive, distribute gainsharing payments.[7]

b. The department, with input from the Department of Health and Senior Services and utilizing outcome evaluation data provided by the Rutgers Center for State Health Policy, shall approve only those gainsharing plans that promote: improvements in health outcomes and quality of care, as measured by objective benchmarks as well as patient experience of care; expanded access to primary and behavioral health care services; and the reduction of unnecessary and inefficient costs associated with care rendered to Medicaid recipients residing in the ACO's designated area. The department and the Department of Health and Senior Services shall provide all data necessary to the Rutgers Center for State Health Policy for analysis in support of the department's review of gainsharing plans.[8]

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Example 2: Oregon. § 414.679. Use and Disclosure of Member Information; Access by member to Personal Health Information.[9]

(1) The Oregon Health Authority shall ensure the appropriate use of member information by coordinated care organizations, including the use of electronic health information and administrative data that is available when and where the data is needed to improve health and health care through a secure, confidential health information exchange.

(2) A member of a coordinated care organization must have access to the member's personal health information in the manner provided in 45 C.F.R. 164.524 so the member can share the information with others involved in the member's care and make better health care and lifestyle choices.

(3) Notwithstanding ORS 179.505, a coordinated care organization, its provider network and programs administered by the Department of Human Services for seniors and persons with disabilities shall use and disclose member information for purposes of service and care delivery, coordination, service planning, transitional services and reimbursement, in order to improve the safety and quality of care, lower the cost of care and improve the health and well-being of the organization's members.

(4) A coordinated care organization and its provider network shall use and disclose sensitive diagnosis information including HIV and other health and mental health diagnoses, within the coordinated care organization for the purpose of providing whole-person care. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.529 and applicable federal privacy requirements. Redisclosure of individually identifiable information outside of the coordinated care organization and the organization's providers for purposes unrelated to this section or the requirements of section 4, 5, 6, 7, 8 or 10 of this 2011 Act remains subject to any applicable federal or state privacy requirements.

(5) This section does not prohibit the disclosure of information between a coordinated care organization and the organization's provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the laws of Oregon.

(6) The Health Information Technology Oversight Council shall develop readily available informational materials that can be used by coordinated care organizations and providers to inform all participants in the health care workforce about the appropriate uses and limitations on disclosure of electronic health records, including need-based access and privacy mandates.[10]

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Care Management and Care Coordination

Example 1: New Jersey. § 30:4D-8.1. Findings, declarations relative to a Medicaid Accountable Care Organization Demonstration Project.[11]

d. *The ACO model can facilitate improvements in health outcomes, quality, and access, and stabilize or reduce the rate of health care inflation while permitting patients to maintain their current health care relationships. The Medicaid ACO Demonstration Project to be established pursuant to this act is specifically intended to:* (1) *increase access to primary care, behavioral health care, pharmaceuticals, and dental care by Medicaid recipients residing in defined regions;* (2) *improve health outcomes and quality as measured by objective metrics and patient experience of care; and* (3) *reduce unnecessary and inefficient care without interfering with patients' access to their health care providers or the providers' access to existing Medicaid reimbursement systems. The Medicaid ACO Demonstration Project may provide a model for achievement of improved health outcomes, quality, and decreased costs that can be replicated in other settings to the benefit of patients and payers throughout New Jersey, but is not intended to inhibit, prevent, or limit development or implementation of alternative ACO models;*

e. *The Medicaid ACO Demonstration Project seeks to address a variety of access, health outcomes, coordination, and service utilization problems that lead to increased health costs. One major goal is to reduce the inappropriate utilization of high-cost emergency care by Medicaid recipients and others, especially where an individual's need is more properly addressed through non-emergency primary care treatment. The Medicaid ACOs shall develop relationships with primary care, behavioral health, dental, pharmacy, and other health care providers to develop strategies to:* (1) *engage these individuals in treatment;* (2) *promote medication adherence and use of medication therapy management, and healthy lifestyles, including, but not limited to, prevention and wellness activities, smoking cessation, reducing substance use, and improving nutrition;* (3) *develop skills in help-seeking behavior, including self-management and illness management;* (4) *improve access to services for primary care and behavioral health care needs through home-based services and telephonic and web-based communication, via culturally and linguistically appropriate means; and* (5) *improve service coordination to ensure integrated care for primary care, behavioral health care, dental care, and other health care needs, including prescription drugs;*[12]

[Link to Full Text](#)

Example 2: Oregon. § 414.625. Coordinated care organizations; rules.[13]

SECTION 4. Coordinated care organizations.

(1) *The Oregon Health Authority shall adopt by rule the criteria for a coordinated care organization and shall integrate the criteria into each contract with a coordinated care organization. Coordinated care organizations may be local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two. Coordinated care organizations may contract with counties or with other public or private entities to provide services to members. The authority may not contract with only one statewide organization. A coordinated care organization may be a single corporate structure or a network of providers organized through contractual relationships. The criteria adopted by the authority under this section must be designed so that:*

    (a) *Each member of the coordinated care organization receives integrated person centered care and services designed to provide choice, independence and dignity.*

    (b) *Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery.*

    (c) *The supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient centered primary care homes and individualized care plans to the extent feasible.*

    (d) *Members receive comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.*

    (e) *Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, as defined in ORS 409.615, community health workers and personal health navigators who meet competency standards established by the authority under section 11 of this 2011 Act or who are certified by the Home Care Commission under ORS 410.604.*

    (f) *Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.*

    (g) *Each coordinated care organization uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable.*

(h) Each coordinated care organization complies with the safeguards for members described in section 8 of this 2011 Act.

(i) Each coordinated care organization convenes a community advisory council that includes representatives of the community and of county government, but with consumers making up a majority of the membership, and that meets regularly to ensure that the health care needs of the consumers and the community are being addressed.

(j) Each coordinated care organization prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable emergency room visits and hospital admissions.

(k) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization:

(A) Work together to develop best practices for care and service delivery to reduce waste and improve the health and well being of members.

(B) Are educated about the integrated approach and how to access and communicate within the integrated system about a patient's treatment plan and health history.

(C) Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication.

(D) Are permitted to participate in the networks of multiple coordinated care organizations.

(E) Include providers of specialty care.

(F) Are selected by coordinated care organizations using universal application and credentialing procedures, objective quality information and are removed if the providers fail to meet objective quality standards.

(G) Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.

(l)(sic) Each coordinated care organization reports on outcome and quality measures identified by the authority under section 10 of this 2011 Act and participates in the health care data reporting system established in ORS 442.464 and 442.466.

(m) Each coordinated care organization uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.

(n) Each coordinated care organization participates in the learning collaborative described in ORS 442.210 (3).

(o) Each coordinated care organization has a governance structure that includes:

(A) A majority interest consisting of the persons that share in the financial risk of the organization;

(B) The major components of the health care delivery system; and

(C) The community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community.

(2) The authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of coordinated care organizations.

(3) On or before July 1, 2014, each coordinated care organization must have a formal contractual relationship with any dental care organization that serves members of the coordinated care organization in the area where they reside.[14]

Link to Full Text

Example 3: Federal Government. Affordable Care Act, § 2703(a); 42 U.S.C. 1296w-4(e). State Option to Provide Health Homes for [Medicaid] Enrollees with Chronic Conditions.[15]

COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(3) HEALTH HOME—The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services.

(4) HEALTH HOME SERVICES— (A) IN GENERAL.— The term 'health home services' means comprehensive and timely high-quality services de- scribed in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) SERVICES DESCRIBED—The services described in this subparagraph are—(i) comprehensive care management; "(ii) care coordination and health promotion; (iii)

comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; (iv) patient and family support (including authorized representatives); (v) referral to community and social support services, if relevant; and (vi) use of health information technology to link services, as feasible and appropriate."[16]

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Spreading and Sustaining Super-Utilizer Programs

Example 1: New Jersey. § 30:4D-8.14 Report to Governor, Legislature.[17]

14. Upon completion of the demonstration project, the Commissioners of Human Services and Health and Senior Services shall report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), on the demonstration project, and include in the report the findings of the evaluation carried out pursuant to section 9 of this act. The commissioners shall make such recommendations as they deem appropriate.

If, after three years following enactment of this act, the commissioners find the demonstration project was successful in reducing costs and improving health outcomes and the quality of care for Medicaid recipients, the commissioners may recommend that Medicaid ACOs be established on a permanent basis and in additional communities in which Medicaid recipients reside.[18]

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Example 2: Maryland. Health-General § 20–1406.[19]

(a) There is a Health Enterprise Zone Reserve Fund.

(b) The Fund is a special, nonlapsing fund that is not subject to § 7–302 of the State Finance and Procurement Article.

(c)(1) The State Treasurer shall invest the money of the Fund in the same manner as other State money may be invested.

(2) Any investment earnings of the Fund shall be credited to the General Fund of the State.

(d) The money in the Fund shall be used for:

(1) Any activity authorized under this subtitle; and

(2) The State income tax credit authorized under § 10–731 of the Tax--General Article.

(e) The Commission shall administer the Fund and provide funding in accordance with the designation by the Secretary of a Health Enterprise Zone under this subtitle.[20]

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Example 3: Minnesota. § 26B.0755 Health Care Delivery Systems Demonstration Project.[21]

Subd. 7.Expansion.

The commissioner shall explore the expansion of the demonstration project to include additional medical assistance and MinnesotaCare enrollees, and shall seek participation of Medicare in demonstration projects. The commissioner shall seek to include participation of privately insured persons and Medicare recipients in the health care delivery demonstration.[22]

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Example 4: Federal Government. Affordable Care Act. State Option to Provide Health Homes for [Medicaid] Enrollees with Chronic Conditions.[23]

42 U.S.C. 1296w-4(a) "IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary deter- mines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider (as described under subsection (h)(5)), a team of health care professionals (as described under subsection (h)(6)) operating with such a provider, or a health team (as described under sub- section (h)(7)) as the individual's health home for purposes of pro- viding the individual with health home services."[24]

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Endnotes

1. N.J. STAT. ANN. § 30:4D-8.1 (2013).

2. *Id.*

3. MD CODE ANN., HEALTH–GEN. § 20-1402 (2013).

4. *Id.*

5. TX GOV'T. CODE ANN. § 531.0861 (2013).

6. *Id.*

7. N.J. STAT. ANN. § 30:4D-8.5.

8. *Id.*

9. OR. REV. STAT. § 414.679 (2013).

10. *Id.*

11. N.J. STAT. ANN. § 30:4D-8.1.

12. *Id.*

13. OR. REV. STAT. § 414.625.

14. *Id.*

15. Patient Protection and Affordable Care Act (ACA) § 2703(a) (codified at 42 U.S.C. 1296w-4(e)).

16. *Id.*

17. N.J. STAT. ANN. § 30:4D-8.14.

18. *Id.*

19. MD CODE ANN., HEALTH–GEN. § 20–1406.

20. *Id.*

21. MINN. STAT. § 26B.0755 (2013).

22. *Id.*

23. ACA § 2703 (codified at 42 U.S.C. 1296w-4(a)).

24. *Id.*

Appendix C

Relevant Resources and Tools from Super-Utilizer Programs

This appendix includes helpful resources and tools that Medicaid programs could adopt and adapt in developing a super-utilizer program. These tools are mostly foundational —that is, Requests for Proposals (RFPs), contracts, and Letters of Agreement (LOAs)/Memorandums of Understanding (MOUs) to help establish a super-utilizer program. The resources and tools are grouped into the three categories used to organize the common themes and strategies in the *Summit* report: **1)** Data Collection, Analytics, and Use; **2)** Care Management and Care Coordination; and **3)** Spreading and Sustaining Super-Utilizer Programs.

This information was assembled prior to July 2013 and is not exhaustive, but includes many examples from innovative programs from across the country. The examples are intended purely as an educational resource to states and policy-makers considering ways to implement, spread, and sustain complex care management programs in their communities and are not endorsed as policies that should be adopted.

Data Collection, Analytics, and Use

Description of issue: Access to real-time data and strong analytic capabilities are essential to the successful administration of super-utilizer programs. Aspiring super-utilizer programs must consider the following issues when designing their programs: **(1)** data privacy & security laws that govern disclosure and use of data; **(2)** data types & sources; and **(3)** data analytics.

1. Data Privacy & Security Laws

Prior to collecting data, super-utilizers will need to identify and comply with the numerous federal and state laws and regulations that govern data privacy and security. Relevant federal laws and regulations include HIPAA (which governs the use and disclosure of "Protected Health Information" by "Covered Entities"),[1] FERPA (which governs the disclosure of education records, including health information within these records),[2] and 42 C.F.R. Part 2 (which governs the use and disclosure of substance abuse treatment records). [3] These laws generally serve as the legal and regulatory "floor" for data privacy and security. Many states have enacted stricter protections, particularly related to mental health and HIV/AIDs information.[4] One common permitted disclosure under all of these legal frameworks, federal and state, is disclosure to the individual patient or their designee. However, given the variation in state laws, it is difficult to identify a uniform model consent form that would work in all settings and all states. Aspiring super-utilizer programs may refer to the Health Information Security and Privacy Collaboration's work on ["Harmonizing State Privacy Law"](#)[5] for detailed information on state privacy laws and the various mechanisms for obtaining consent which include: **(1)** No consent; **(2)** Opt-out; **(3)** Opt-out with exceptions; **(4)** Opt-in; and **(5)** Opt-in with restrictions.[6] Choosing among the consent mechanisms will require states to make a policy decision in favor of greater access to data (no consent), greater privacy protection (opt-in), or a balance of these interests (opt-in, opt-out with restrictions).[7]

Compliance with federal and state privacy and security laws and regulations will also likely necessitate super-utilizers to enter into "data use agreements" that include contractually binding terms related to the disclosure and use of data such as the one required by Oregon's CCO project (See Example 6).

2. Data Types and Sources

Super-utilizer programs may obtain data from a variety of sources including "Medicaid health plans, hospitals, providers, and patient surveys, census data, birth and death certificates, and agencies such as state and local public health departments."[8] State sponsored programs may access Medicare data through the [State Data Resource Center](#) (SDRC). [9] Available data includes "eligibility, enrollment, utilization, and expenditure data" from the "Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS)." Super-Utilizer Programs may also find the Chronic Condition Data Warehouse ([CCW](#)) clinical condition indicators pertaining to 27 chronic conditions, 8 mental health conditions, and 14 "intellectual, developmental, and physical disability conditions" [to be] of interest.[10]

3. Data Analysis

Data analysis is the key to identifying super-utilizers, designing interventions, and assessing program success. Methods for targeting super-utilizers include: **(1)** "Targeting based on high observed-to-expected costs;" **(2)** "Targeting specific patterns of care;" **(3)** "Targeting very high levels of utilization;" **(4)** "Targeting based on referrals and follow-up investigation;" **(5)** "Excluding candidate clients with medical conditions associated with high but non- preventable costs;" **(6)** "Targeting by presence of risk

factors associated with high, preventable costs;" and (7) "Targeting by community:"[11]

Example 1: Massachusetts. Comprehensive Primary Care Payment Reform Request for Information.

Summary: Massachusetts is developing a Comprehensive Primary Care Payment Reform pursuant to S.B. 2400 (2011-2012) "An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation."[12] This document "describes a proposed Comprehensive Primary Care Payment Reform model across six dimensions: finance, quality, clinical delivery model, eligibility and application processes, data sharing, and member protections, and seeks broad input from all stakeholders."[13]

Text/Language: *MassHealth recognizes that to effectively coordinate care across settings, Participants need accessible, timely, and accurate data. To that end, there are several data streams MassHealth anticipates that Participants would receive.*

- *Timely notification of [Emergency Department ("ED")] visits and hospital admissions/discharges. Timely notification of acute care events can be essential to primary care practices pursuing appropriate follow up procedures. In the PCC plan, hospitals are currently required to notify [Primary Care Clinician ("PCCs")] when their patients are seen in the ED or admitted in a timely fashion. However, there is little infrastructure to support hospitals in communicating this information to PCCs in a standardized, automated fashion. The health information exchange may provide a medium term solution to this problem, but may not suffice in the near term. MassHealth is open to exploring multiple approaches to ensuring timely notification of ED visits and hospital admissions/discharges, including potentially having hospitals relay information on a daily basis to a central repository, which then transfers information out to practices. MassHealth is particularly interested in stakeholder feedback in this area.*

- *Access to claims-based data and analysis. Claims data can help practices track utilization of patients, to help meet cost and quality targets. MassHealth may pursue a path of offering both access to raw data and providing some aggregated reports based off that data. MassHealth envisions a common approach to claims and encounter data across the PCC and MCO plans, with the understanding that individual MCOs may produce supplemental reports and data. MassHealth is particularly interested in stakeholder feedback regarding the content and supporting technology for such reports.*

- *Patient panel information. Participants would need to receive regular reports from payors of the complete list of patients on their panel, potentially with risk stratification analyses from the payors. Again, this could be done either through detailed specifications to ensure standardization across payors, or through a centralized mechanism.*[14]

Example 2: New York. Request for Proposals for Chronic Illness Demonstration Projects.

Summary: New York issued an RFP for providers to develop chronic illness demonstration projects (CIDPs) that "will result in improved health outcomes, appropriate utilization of health care services and a more cost-effective use of Medicaid funds."[15]

Text/Language: *Data Exchange Application: The selected contractor will be required to complete, and have approved, a New York State Data Exchange Application and Agreement (DEAA) prior to being allowed access to Medicaid confidential data. Bidders may request an electronic copy of the DEAA for review.*[16]

Data Management Systems and Reporting: Describe the bidder's status and capacity to:

- *Utilize Health Information Technology.*

- *Collect and track data on all demonstration activities.*

- *Communicate with, track and share data within the integrated health care system and community network.*

- *Data transfer capability.*

- *Provide on-line access to DOH to monitor program activities.*

- *Meet DOH reporting requirements.*[17]

Example 3: Louisiana. Coordinated Care Networks-Shared Model (CCN-S) Request for Proposals.

Summary: The Louisiana Department of Health and Hospitals (DHH) released an RFP for "[qualified] entities to serve as a Shared Savings Coordinated Care Network (CCN-S) in one or more of the three Geographic Service Areas (GSAs) within the State."[18] CCNs functions will include improving care coordination, reducing avoidable hospital stays, and improving health outcomes.[19]

Text/Language: Coordinated Care Network Providers. Predictive Modeling.

The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP. The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually thereafter, and prior to any changes. These specifications shall include but are not limited to: [1] A brief history of the tool's development and historical and current uses; [2] Medicaid

data elements to be used for predictors and dependent measure(s); [3] Assessments of data reliability and model validity; [4] A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and [5] A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.[20]

Example 4: Humboldt County (California) Care Transitions Program.

Summary: The Humboldt County Care Transitions Program uses the following language to obtain individuals' consent to disclose their health information.

Text/Language: Humboldt County Care Transitions Program. Consent to Exchange Information.

Authorization for Release of Information: To assure appropriate services, I authorize any physician, hospital, service agency or other professionals involved in my care to disclose all medical records including those for treatment of mental illness, substance or alcohol abuse, Acquired Immune Deficiency Syndrome or Human Immunodeficiency Virus and any other diseases, hospital, vocational, financial, or related information to Care Transitions Program team members on my behalf. I also authorize any information about me held by the Department of Health and Human Services and/or the Humboldt/Del Norte Independent Practice Association—Priority Care to be shared with the Care Transitions Program as requested.

I authorize that the information, as described above, may be shared with other professional or agencies who may be involved in the provision of necessary services, with the exception of those agencies or individuals that I have indicated below. I understand that each agency involved in my care has access to specific data, on a need to know basis, to provide services to me.

I understand that Care Transitions Program is required by law to report certain events to appropriate governmental agencies such as law enforcement and public health agencies. Mandatory reporting obligations include but are not limited to instances of child and /or elder abuse, information relating to homicidal intent or any other event required by law whereby my welfare or another individual is compromised. I understand that my Protected Health Information (PHI), including but not limited to my HIV status, will not be disclosed unless otherwise required by law.[21]

Example 5: Camden Coalition of Healthcare Providers.

Summary: The Camden Coalition of Healthcare Providers uses the following language to obtain consent to access individuals' information on the Camden Health Information Exchange.

Text/Language: Consent for My Healthcare Provider to View My Health Information in the Camden Health Information Exchange.

Healthcare Provider(s): _____

This Consent form allows you to permit the above-named healthcare provider(s) ("Provider") to view and access your health information through a computerized system called the Camden Health Information Exchange ("Camden HIE").

The Camden HIE collects health information from the places where you receive medical treatment and makes it available electronically to the Provider listed above. Your health information in the Camden HIE is used by the Provider for your medical treatment and to coordinate your medical care with other healthcare providers.

If you give your consent, the Provider will be able to view all of your health information in the Camden HIE for this episode of care.

You can give Consent or deny Consent. Your Provider cannot tell you that you must give Consent in order to receive medical treatment. You may stop the Provider from viewing your health information through the Camden HIE at any time.

How your health information will be used:

Your health information will be used by your Provider to:

- Provide you with medical treatment and related services
- Coordinate your medical care with other healthcare providers
- Improve the quality of medical care you receive

What types of information about you are included:

Your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications you have taken. This includes information created before and after the date of this Consent Form. Sensitive health conditions may also be included, such as:

- Alcohol or drug use problems
- Birth control, abortion, family planning
- Genetic (inherited) diseases or tests
- HIV/AIDS
- Mental health conditions
- Sexually transmitted diseases

Where health information about you comes from:

Health information about you comes from places that have provided you with medical care. These include: hospitals, physicians, pharmacies, laboratories, the Medicaid program,

nursing care services, emergency medical services, and other health organizations that provide information to the Camden HIE. The Camden Coalition of Healthcare Providers (www.camdenhealth.org) can provide you with a complete list of organizations that send health information to the Camden HIE.

Who may access information about you, if you give Consent:

Only authorized people that work for the Provider may access information about you through the Camden HIE. These include, but are not limited to:

- Doctors and other medical and non-medical staff directly involved in your medical care

- Doctors and other medical and non-medical staff on call or covering for your doctor and directly involved in your medical care

Penalties for improper use or access of your health information:

There are penalties for wrongful access to or use of your health information through the Camden HIE. If at any time you suspect that someone who should not have seen or gotten access to your health information has done so, contact the Provider listed on this form or the Camden Coalition of Healthcare Providers (856-365-9510) immediately.

Re-disclosure of information:

Health information about you may be re-disclosed by the Provider to others only to the extent permitted by state and federal laws and regulations. The Camden Coalition and healthcare providers who access this information through the Camden HIE must comply with these regulations.

Effective period:

This Consent Form will remain in effect for this episode of your medical care.

Withdrawing your consent: You may withdraw your consent at any time by signing a new Consent Form. Providers that have accessed your health information through the Camden HIE while your consent was in effect may copy or include your health information in their own medical records. If you decide to withdraw your consent, those providers are not required to return or remove your health information from their records.

Copy of Consent Form. You are entitled to get a copy of this Consent Form after you sign it.[22]

Example 6: Oregon Coordinated Care Organizations.

Summary: Oregon requires Coordinated Care Organization (CCO) Applicants to execute the following "data use agreement."

Text/Language: Applicant CCOs must acknowledge understanding of the data use agreement found with the

CCO web portal terms and conditions in order to receive these datasets. This agreement requires that the applicant is responsible for maintaining the security and privacy of all OHA obtained, "Data" includes all copies of the Data and any document that uses or is derived from any part of the Data. Applicant understands that OHA will provide access to Data and that these Data are provided to Applicant solely for the purposes of the administration of the medical assistance program and implementation of state laws established the Oregon Integrated and Coordinated Health Care Delivery System by the use of Coordinated Care Organizations.

Applicant warrants that:

- The confidentiality of all Data will be protected as mandated by state and federal laws and regulations, including HIPAA Privacy and Security Rules;

- The Data will not be used for any other purposes than those related to this RFA and Application unless prior written authorization is obtained from an authorized OHA representative;

- No findings, listing or information derived from the Data will be released or disclosed to other parties with or without identifiers, if such findings, listings, reports or information contain any combination of Data elements that might allow the deduction of a patient's identification;

- Access to the Data will be limited to those individuals directly involved in the Applicant's Application to the extent necessary to achieve the purposes of the RFA response, and that access will be limited to the minimum amount of Data necessary to achieve the purposes stated above;

- Applicant will report to OHA any breach of security or violations of this Agreement as soon as the Applicant becomes aware of the violation;

- Applicant will apply appropriate administrative, technical and physical safeguards so that the Data will be protected to prevent unauthorized use;

- Applicant will grant OHA authorized representatives access upon request to review Applicant's security arrangements;

- If the Applicant ceases to participate in the RFA for any reason (including but not limited to the withdrawal of its Application, OHA's denial of certification, or OHA's not awarding a Contract to Applicant), Applicant will return to OHA or destroy all of the Data and not later than 60 days after the participation ceases will provide to OHA an attestation that all the Data have been returned to OHA or destroyed, unless written agreement

between OHA and the Applicant establishes another method for the Data to be handled;

- *Applicant will enter into written agreements with any other persons who assist Applicant with the Data or otherwise obtain or use the Data obtained by the Applicant, binding such person to all of the terms in this Agreement. Applicant will disclose such written agreements to the OHA upon request; and*

- *Applicant will be responsible for any use by any person of the Data.[23]*

Care Management & Care Coordination

Description of issue: Matching individuals with the proper care management intervention is vital to the success of super-utilizer programs. Although super-utilizer programs generally prioritize face-to-face interventions, there is no one size fits all approach to care management interventions or teams; rather programs employ a variety of approaches including, for example, substance abuse treatment, medical home support, and care planning.

Example 1: Oregon Coordinated Care Organization Request For Applications.

Summary: Oregon released an RFA for entities become certified as Coordinated Care Organizations (CCOs). Once certified, CCOs will be "accountable for care management and [the] provision of integrated and coordinated health care for each of their Members, including Members who are dually eligible for Medicare and Medicaid services, managed within a global budget."[24]

Text/Language: *In order to carry out the Triple Aim, it will be important for [Coordinated Care Organizations] to develop meaningful relationship with social and support services in the services area. Describe how the Applicant has established and will maintain relationships with social and support services in the service area, such as:*

- *DHS Children's Adults and Families field offices in the service area*

- *Oregon Youth Authority (OYA) and Juvenile Departments in the service area*

- *Department of Corrections and local community corrections and law enforcement, local court system, problem solving courts (drug courts/mental health courts) in the service area, including for individuals with mental illness and substance abuse disorders*

- *School districts, education service districts that may be involved with students having special needs, and higher education in the service area*

- *Developmental disabilities programs*

- *Tribes, tribal organizations, urban Indian organizations, Indian Health Services and services provided for the benefit of Native Americans and Alaska Natives*

- *Housing*

- *Community-based family and peer support organization*

- *Other social and support services important to communities served[25]*

Example 2: New York Chronic Illness Demonstration Projects.

Summary: New York issued an RFP for providers to develop chronic illness demonstration projects (CIDPs) that "will result in improved health outcomes, appropriate utilization of health care services and a more cost-effective use of Medicaid funds."[26]

Text/Language: *[New York State Department of Health ("DOH")] is seeking demonstration projects that will propose comprehensive care management strategies for the targeted patient group. Bidders are expected to define care coordination models that include an integrated health care delivery network, including community providers, which ensure beneficiaries appropriate access to the continuum of medical, mental health, chemical dependence, rehabilitative care and social services required to meet the complex needs of this population.*

The demonstrations will be responsible to provide care coordination for high need, high cost beneficiaries with multi-faceted interventions that include at a minimum core elements, including:

- *Comprehensive health assessments that identify medical, mental health, chemical dependence treatment and social service needs*

- *Individualized patient-centered care plans to address those needs with periodic reassessments;*

- *Integration of medical, mental health, chemical dependence and social service needs in care planning and coordination activities;*

- *Care coordination to ensure access to all needed services, including referral for services and follow up;*

- *Provider engagement strategies to assure these disenfranchised patients are appropriately served;*

- *Patient self-management/activation interventions to improve patients' motivation to achieve health goals and education to enhance their independent use of the health care delivery system; and*

- *Caregiver/Family support/involvement.[27]*

Example 3: Minnesota Hennepin Health ACO.

Summary: The following language comes from Hennepin County's application to participate in the Hennepin Health ACO pilot project.

Text/Language: *Care Team*

Each enrollee will be served by an integrated team of medical professionals, behavioral health providers, human services and public health staff, and community health workers.

Team Composition:

- *Physician or Advanced Nurse Practitioner*
  - *Role: Oversight of enrollee care and medical issues management*
- *Care Coordinators*
  - *1-2 specialists assigned to enrollee team, dependent upon needs, one lead assigned based on dominant treatment area*
    - *Nursing*
      - » *Role: medical needs assessment/ management*
    - *Behavioral Health Specialists*
      - » *Role: mental health/ chemical health needs assessment/management*
    - *Human Services Specialist*
      - » *Role: coordination of the vast array of human service needs*
- *Pharmacist*
  - *Role: Medication education and management*
- *Community Health Worker*
  - *Role: enrollment, outreach, engagement/follow-up, education, information-gathering, reporting of barriers to treatment, and support for success of enrollee in meeting treatment goals*
- *Extended team members*
  - *Role: Specialized needs. Examples include housing specialists, medical specialists, and employment specialists*

Team composition will be determined at intake and will be driven by enrollee needs. The team will be adjusted based on new needs and/or successful goal composition. Staffing ratios are dependent upon tiering levels (higher and lower intervention needs)…

The lead coordinator, as the primary contact for the patient, is charged with ensuring communications to the entire team on status and needs. The lead coordinator will respond to service access issues and work with the enrollee on crisis prevention and planning. Hennepin Health is developing protocols for addressing key issues (e.g. what does each partner do with an enrollee who is a substance abuse, overusing ED, drug seeking, medication noncompliant, etc.?) The protocols will be measured for compliance and effectiveness.

Care Transitions will be proactively managed by the lead coordinator to ensure collaborative planning, communications, and efficient warm hand-off's occur among systems with the ultimate goal of community care via the Patient centered medical home…

Team location will be based upon enrollee preference and needs. Teams may be located in hospital-based outpatient clinics, neighborhood-based FQHC's, other community clinics, shelter-based clinics, and behavioral health centers. The pilot will continuously re-evaluate geographic location and barriers to access to make certain that Hennepin Health is meeting the enrollee's needs.[28]

Example 4: Minnesota Health Care Delivery Systems (HCDS) Demonstration Request for Proposals.

Summary: Minnesota released an RFP to "test alternative and innovative health care delivery systems serving MHCP patients."[29]

Text/Language: *To be considered eligible to participate as an HCDS for the purposes of responding to this RFP, a successful Responder must meet the following criteria:*

- a. *Deliver the full scope of primary care services and directly deliver or demonstrate the ability to coordinate with specialty providers and hospitals. For the purposes of this RFP, "primary care" is defined as overall and ongoing medical responsibility for a patient's comprehensive care for preventive care and a full range of acute and chronic conditions.*

- b. *All providers included in the HCDS demonstration payment model must be enrolled MHCP providers.*

- c. *Demonstrate, through the care delivery model, how the HCDS will affect the total cost of care of its MHCP participants regardless of whether the services are delivered by the HCDS.*

- d. *Demonstrate how formal and informal partnerships with community organizations, social service agencies, counties, etc. are included in the care delivery model. Responders are encouraged to propose mechanisms to incorporate these organizations directly into the payment model.*

- e. *Demonstrate how the HCDS will meaningfully engage patients and families as partners in the care they receive, as well as in organizational quality improvement activities and leadership roles.*

- f. *Nothing in the contract agreement will obviate all providers included in the HCDS from meeting all MHCP fee-for-service and/or managed care organization (MCO) requirements including, but not limited to enrollment, reporting, claims submission, and quality measures.*

The State may change requirements or impose additional requirements for participation as an HCDS as required through the federal approval process with the Centers for Medicare and Medicaid Services.

HCDS' will not administer the MHCP benefit set or pay claims under the demonstration or be required to contract for additional services outside of the services delivered by the HCDS.[30]

Spreading and Sustaining Super-Utilizer Programs

Description of issue: Aspiring super-utilizer programs must identify the means to fund and sustain their programs. Many states have enacted payment and delivery reform legislation that will help fund super-utilizer programs (e.g. ACOs, demonstration projects, grants) while the Affordable Care Act's Medicaid Health Home and Accountable Care Organization provisions offer states an opportunity to establish federally assisted super-utilizer programs. Additional funding may also be available from the Center for Medicare and Medicaid Innovation (CMMI).[31]

Sustaining a successful super-utilizer program will require a sound business plan that accurately accounts for items such as costs and revenue streams. Interested parties may refer to the New Jersey Medicaid Accountable Care Organization Business Planning Toolkit for additional information on business considerations including a template business plan.[32]

Example 1: Maryland. Health Enterprise Zones ("HEZs").

Summary: Maryland solicits applications from entities interested in receiving HEZ designation. Successful Applicants will receive funding to reduce health disparities and improve health outcomes within a specified geographic area.

Text/Language: *HEZ designation will be for a four-year period and applications for HEZ designation should reflect a four-year period of activities. Designations made by the Secretary will be for the duration of the four-year program. Applicants should submit a detailed work-plan and evaluation plan with specific activities, objectives, milestones, and deliverables for each year of the potential four-year program. In order to receive funding in years two, three, and four of the designation, HEZ Coordinating Organizations will need to meet the terms and conditions of the designation award, namely submitting the required reporting documents on a quarterly basis. In addition, Coordinating Organizations must demonstrate progress in terms of meeting performance measures developed by the Coordinating Organization and CHRC. HEZs that fail to comply with the reporting requirements or do not demonstrate performance in year one may be subject to revocation of designation status, and would no longer have access to benefits and incentives under the HEZ Act. The*

CHRC retains the right to "claw-back" funds distributed to the Zones or revoke the designation award if the Coordinating Organization is not compliant under the terms and conditions of the designation or does not meet performance measures during implementation.[33]

Example 2: Oregon Coordinated Care Organizations (CCO)

Summary: The following language is from the Umpqua Health Alliance's CCO application.

Text/Language:

SECTION 5—Payment Methodologies that Support the Triple Aim

A.5.1. The OHP managed care contractors in Douglas County have a long history of innovative payment practices that support the triple aim, including but not limited to:

- *Primary care case management fees paid by DCIPA since the mid 90's are a precursor to Patient Centered Primary Care homes. We anticipate further expansion of our PCPCH model with the goal of high tier PCPCH in many of our practices.*

- *DCIPA has contracted with a geriatrician to provide the bulk of nursing home services to our dual eligible providers in LTC.*

- *Hospital capitation payments focus on the provision of quality care rather than volume of services.*

- *Risk pools in hospital contracts focus on outcomes rather than the volume of services.*

- *Risk pools in mental health contracts focus on outcomes.*

- *Dental capitation payments focus on preventive dental care.*

- *Extra payments to providers for performing comprehensive assessments of those who are dual eligible.*

- *Special programs to align financial incentives for those who work with the Medicare Advantage STARS program.*

Under the CCO model, we anticipate that we will be able to better share information and pool dollars across mental, dental and physical health. Projects under discussion include:

- *Decrease ED utilization for acute dental pain and mental health issues*

- *Decrease OR utilization for extensive dental reconstructions in children*

- *A quality project between mental and physical health to share medical and drug utilization[34]*

Example 3: Oregon Coordinated Care Organization Request For Application.

Summary: Oregon released an RFA for entities to become certified as Coordinated Care Organizations (CCOs). Once certified, CCOs will be "accountable for care management and [the] provision of integrated and coordinated health care for each of their Members, including Members who are dually eligible for Medicare and Medicaid services, managed within a global budget."[35]

Text/Language: *Demonstration of Financial Solvency*

The following standard applies as of the COO's Medicaid effective date and/or the CCO's Medicare/Medicaid Alignment Demonstration effective date:

The Applicant shall provide evidence of solvency, incorporate specific provisions against insolvency, commensurate with enrollment (both Medicaid and Medicare) and level of risk assumed; demonstrate financial management ability; and generate periodic financial reports and make them available to OHA for review by DCBS and OHA.

The specific measurements enumerated below are not intended to be considered in isolation from each other or to be comprehensive. When considered as a whole (and with additional information, as appropriate,) they provide a basis for demonstrating general financial solvency and identifying changes to be addressed….

E.2.1. Measurement Standard–Applies to MCOs converting to CCO and newly formed CCO

To identify in an entity can demonstrate the necessary financial solvency and ability to manage a plan financially, an entity must show that sufficient financial resources are available to provide the needed developmental and operational capital and that an adequate staffing plan is in place to operate the plan effectively.

Financial Solvency Minimum Standard

E.2.1.a. *Applicant shall establish and maintain restricted reserve funds per OAR 410-141-3350(A). The restricted reserves must be in place before terminating the Applicant's current MCO contract to begin operations as a CCO (restricted reserves previously held by an MCO may, with the consent of OHA, be transferred to the CCO), and*

E.2.1.b. *Applicant shall maintain, at all times, a level of net worth, per OAR 410-141-3350(B) and (C). If the Applicant has a net worth less than the calculated minimum requirement, the Applicant's net worth must be increased to an amount greater than or equal to the minimum requirement prior to the award of a Contract under this RFA.*

E.2.1.c. *An Applicant must also have sufficient working capital above the minimum, as required by OAR 410-141-3350(D), in order to maintain the minimum net work requirement at all times.*[36]

Example 4: Center for Medicaid and CHIP Services (CMCS) "Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality.

Summary: The CMCS Informational Bulletin provides an overview of the policy decisions associated with creating a super-utilizer program, discusses the ways in which super-utilizer programs may receive Medicaid support, and offers case studies of existing super-utilizer programs.

Text/Language: *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. 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.[37]

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.[38]

Endnotes

1. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 139 (1996) (codified as amended in scattered sections of 42 U.S.C.).

2. Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g.

3. Confidentiality of Alcohol and Drug Abuse Records, 42 C.F.R. Part 2 (2013).

4. *See* Health Information & the Law, Privacy and Confidentiality, http://www.healthinfolaw.org/topics/63 (last visited Aug. 2, 2013).

5. Health Information Security and Privacy Collaboration, HealthIT.gov, http://www.healthit.gov/policy-researchers-implementers/harmonizing-state-privacy-law (last visited Aug. 2, 2013).

6. Melissa M. Goldstein, Jd. & Alison L. Rein, MS Consumer Consent Options for Electronic Health Information Exchange: Policy Considerations and Analysis 5-7 (2010).

7. *Id.*

8. Rob Houston et. al., Center for Health Care Strategies, Inc., The New Jersey Medicaid Accountable Care Organization: Business Planning Toolkit 32 (2013) [hereinafter ACO Toolkit].

9. Cindy Mann, Center for Medicaid and CHIP Services, Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality 18 (2013) [hereinafter CMCS Report].

10. *Id.* at 19.

11. *Id.* at 7-8.

12. S.B. 2400, Gen. Ct. (Mass 2012).

13. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Comprehensive Primary Care Payment Reform: Request for Information 2 (2012).

14. *Id.* at 8-9.

15. New York Department of Health, Request for Proposals for Chronic Illness Demonstration Projects 4 (2008) [hereinafter NY RFA].

16. *Id.* at 10.

17. *Id.* at 17.

18. Louisiana Department of Health and Hospitals, Coordinated Care Networks- Shared Model, Request for Proposals 1 (2011).

19. *Id.* at 1-2.

20. *Id.* at 115-16.

21. St. Joseph Health System, Humboldt County, Care Transitions Program, Consent to Exchange Information.

22. Camden Coalition of Healthcare Providers, Consent for My Healthcare Provider to View My Health Information in the Camden Health Information Exchange.

23. Tri-County Medicaid Collaborative, CCO Application, 81 (2012).

24. Oregon Health Authority, Request for Applications for Coordinated Care Organizations (CCOs) 5 (2012) [hereinafter OR RFA].

25. *Id.* at 55.

26. NY RFA *at.* 4.

27. *Id.* at 8.

28. Hennepin Health, A Social Disparities Approach to Health & Health Care 7-8 (2011).

29. Minnesota Department of Human Services, Request for Proposals For A Qualified Grantee(S) To Provide Health Care Services to Medical Assistance (MA) and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Health Care Delivery Systems (HCDS) Demonstration 3 (2011) [hereinafter Minnesota RFP].

30. *Id.* at 5.

31. CMMI awarded Healthcare Innovation Challenge Awards to Care Oregon and Denver Health to help fund their super-utilizer programs. CMCS Report *at* 21-22; Health Care Innovation Awards: Colorado, CMS.gov, http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Colorado.html (last visited Aug. 3, 2013).

32. ACO Toolkit at. 84.

33. Maryland Community Health Resources Commission, Health Enterprise Zone Call for Proposals 7-8 (2012).

34. Umpqua Health Alliance, CCO Application 60 (2012).

35. OR RFA at. *5.*

36. OR RFA *at.* 80.

37. S*ee* Peikes D, et. al.. *How changes in Washington University's Medicare coordinated care demonstration pilot ultimately achieved savings,* 31 (6) Health Aff. 1216-26 (2012).

38. CMCS Report *at.* 17.

Appendix D

Bibliography of Legislative and Programmatic Reference and Resource Documents

This appendix provides a bibliography of legislative and programmatic reference and resource documents from Appendices B and C of the *Super-Utilizer Summit Report*. Note, the **resources were assembled prior to July 2013** and the list of materials is not exhaustive, but includes many examples from innovative programs from across the country. The examples are intended purely as an educational resource to states and policy-makers considering ways to implement, spread, and sustain complex care management programs in their communities and are not endorsed as policies that should be adopted.

Requests for Applications (RFA), Information (RFI), & Proposals (RFP)

- *New York State Department of Health. Chronic Illness Demonstration Project RFP.* The RFP solicits proposals for projects that will improve the health of persons with chronic illness while reducing medical costs. Available at http://www.health.ny.gov/funding/rfp/inactive/0801031003/0801031003.pdf.

- *Missouri. Health Home Service Provider Status RFA.* The RFA solicits applications from providers to serve as Health Homes for MO Healthnet participants. Available at: http://dss.mo.gov/mhd/cs/health-homes/pdf/hhapp.pdf.

- *Louisiana. Coordinated Care Networks RFPs.* Louisiana solicited proposals from entities interested in serving as a Coordinated Care Network (CCN) or providing Medicaid services through a CCN. Louisiana accepted applications for both a "Prepaid Model" and a "Shared Savings Model."

- *Maryland. Health Enterprise Zones Call for Proposals.* Available at: http://dhmh.maryland.gov/healthenterprisezones/Documents/Health%20Enterprise%20Zone%20Call%20for%20Proposals,%20October%205,%202012.pdf.

- *Oregon. Coordinated Care Organizations RFA.* The RFA solicits applications from entities interested in obtaining certification as a "Coordinated Care Organization." Available at: https://cco.health.oregon.gov/RFA/Pages/Download-the-RFA.aspx.

Applications

- *Oregon. Tri-County Medicaid Collaborative Coordinated Care Organization Application.* Available at: http://www.oregon.gov/oha/OHPB/Documents/tricounty-medicaid-collabtricounty-medicaid-collab.pdf.

- *Oregon. "Umpqua Health Alliance" Coordinated Care Organization Application.* Available at: http://www.oregon.gov/oha/OHPB/Documents/dcipa-umpqua.pdf.

Letters of Agreement (LOA)/ Memorandum of Understanding (MOU)

- *Michigan. Priority Health and Spectrum Health Medical Group Center for Integrative Medicine LOA.* The LOA establishes reimbursement terms for Priority Health patients seen by the Center for Integrated Medicine. [on file with authors].

Program Documents (Consent Forms, Assessments, Etc.)

- *Camden County. Health Information Exchange Opt Out Form.* [on file with authors]

- *Camden Coalition of Health Care Providers. Consent for My Healthcare Provider to View My Health Information in the Camden Health Information Exchange.* [on file with authors. Spanish version available].

- *California. Humboldt County. Agreement Regarding Confidential or Proprietary Information.* [on file with authors]

- *California. Humboldt County. Super Utilizer Program-Initial Assessment.* [on file with authors]

- *California. Humboldt County. Consent to Exchange Information.* [on file with authors]

- *North Carolina. CCNC. Transitional Care Process.* The document summarizes CCNC's transitional care process and model. Available at: https://www.communitycarenc.org/media/related-downloads/transitional-care-process-and-model.pdf.

- *Ohio. MetroHealth RCC Daily Worksheet.* Template to record incoming and outgoing phone calls, office visits, home visits, ED visits, inpatient visits, and additional activities. [on file with authors].

- *Vermont. Vermont Chronic Care Initiative Referral Form.* The form allows providers to refer patients with high ER utilization to the Vermont Chronic

Care Initiative. Reasons for referral include the client's need for education, care coordination, and medication reinforcement. Available at: www.vtccmp. com/files/VT_ProviderReferralForm.pdf.

Toolkits/Reports

- *CMCS Informational Bulletin. Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality.* CMCS report provides strategies for targeting Medicaid super-utilizers and case studies for existing super-utilizer programs. Available at: http://www. medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html.

- *Center for Health Care Strategies (CHCS). "The New Jersey Medicaid Accountable Care Organization: Business Planning Toolkit."* CHCS Toolkit provides prospective New Jersey ACOs with "useful tool and resources" to begin their venture. Available at: http:// www.chcs.org/usr_doc/New_Jersey_Medicaid_ ACO_Business_Planning_Toolkit_Final4.pdf.

- UC Berkeley, School of Public Health. "Safety Net Accountable Care Organization (ACO) Readiness Assessment Tool." Available at: http://www.law. berkeley.edu/files/bclbe/Mar6_FINAL_combined.pdf.

Legislation

- *California.* WELF. & INST. CODE §§ 14016.5(c), 14092.25 give Medicaid enrollees the option to either (1) maintain an existing relationship with their health care provider; or (2) enroll in a managed care plan or pilot program. However, California may require enrollees that opt to maintain their provider relationship to enroll in managed care or a pilot program if the enrollee proceeds to rely on emergency departments for non-emergency care.

- *Colorado.* § 25.5-5-415. Colorado establishes a pilot program that will allow for testing of various payment models within the state's Medicaid coordinated care system.

- *Connecticut.* § 19a-724. Connecticut has established the Office of Health Reform and Innovation to oversee state health reform efforts. The Office's broad statutory authority should allow for the creation of super-utilizer programs.

- *Louisiana.* § 46-978.3. Louisiana passed health care reform legislation that will provide medical home services to Medicaid recipients.

- *Maryland.* HEALTH–GEN. §§ 20-1405, 20-1407. Maryland authorizes the creation of "Health Enterprise Zones" as a means of reducing health

disparities, improving health outcomes, and reducing health care costs.

- *Minnesota.* § 256B.0755. Minnesota has authorized a demonstration project that will test various health care delivery models, including Accountable Care Organizations.

- *Nebraska.* § 68-960. Nebraska established a Medical Home Pilot Program as a means of improving access to care and health outcomes while reducing the costs of the Nebraska medical assistance program. Functions of Nebraska's medical homes include coordinating care, providing appropriate referrals, and encouraging appropriate use of emergency departments.

- *New Jersey.* § 30:4D-8.1. New Jersey has authorized the formation of Accountable Care Organizations as a means to improve health, reduce costs, and address super-utilizers.

- *New York.* Pub. Health § 2999-p. New York has passed legislation authorizing the creation of ACOs.

- *Oregon.* H.B. 3650 (2011). Oregon authorized the creation of Coordinated Care Organizations (CCOs) as part of their 2011 "Health System Transformation" Bill. CCOs will work to reduce unnecessary emergency department utilization.

- *Texas.* GOV'T. CODE ANN. § 531.0861. If cost effective, Texas has the authority to establish a program that will provide incentives to physicians that reduce emergency department utilization for non-emergency care.

- *Utah.* § 26-10b-102. Utah has established a pilot program that provides funding to nonprofit entities that serve medically underserved populations. The legislative language is broad enough to support a super-utilizer program.

- *Vermont.* Act 191. Vermont established a chronic care management program as part of their comprehensive 2006 health reform legislation.

CHCS Center for
Health Care Strategies, Inc.