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CMS Gives States Much-Needed Guidance To Target 'Super Utilizers'

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CMS last week provided states examples of programs they can use to control spending on “super utilizers” -- the small population of Medicaid beneficiaries that wrack up most of the costs. States have been reinventing the wheel each time they wanted to target super utilizers and had no way to track what other states were doing to control costs, state officials said.

CMS interviewed ten super-utilizer programs that deliver acute care, and CMS said in the July 24 bulletin that these programs “hold strong promise to address the needs of complex Medicaid beneficiaries in long term setting and in managed care settings.”

The document lays out what states and counties should consider, including setting up a web-based provider portal with patient data, determining what payers are involved, determining who will provide services and if they are centralized or community-based care teams, what the targeting strategy will be and what strategies will be provided.

Jennifer DeCubellis, area director of human services at the Public Health Department of Hennepin County in Minneapolis, Minnesota, said “the more we can learn instead of reinventing the wheel is a good thing,” and the bulletin gives much-needed information to states and counties beginning to develop programs to target the population of super utilizers. DeCubellis said the county frequently receives calls from other health departments that have concerns about the cost of expanding Medicaid or that want to know how to contain costs.

Minnesota expanded Medicaid to low-income childless adults under a state plan amendment in 2010 that set up an accountable care organization. The state receives federal Medicaid matching funds to cover adults ages 21 to 64 years old with incomes up to 75 percent of the federal poverty level. While implementing the new health care delivery system, Hennepin Health found that 5 percent of Medicaid beneficiaries account for 64 percent of Medicaid spending. DeCubellis said it was cheaper to offer Medicaid to more people because otherwise the county pays for their through emergency room visits and other uncompensated care costs.

“Giving benefits didn't cost us more, it gave us the opportunity to manage their care,” she said.

She notes that although many public health efforts have been effective, many people do not know when to seek primary care or who to go to.

The experience of Minnesota’s population is not isolated: a disproportionate share of health care spending is used to provide care to a relatively small group of patients, with 1 percent of the population accounting for 22 percent of total national health care expenditures annually. The distribution of spending is even more uneven within Medicaid, with just 5 percent of Medicaid beneficiaries accounting for 54 percent of total Medicaid expenditures and 1 percent of Medicaid beneficiaries accounting for 25 percent of total Medicaid expenditures. Among this top 1 percent, 83 percent of beneficiaries have at least three chronic conditions and more than 60 percent have five or more chronic conditions.

Those numbers, which are becoming increasingly important with the push to contain health expenditures, prompted the Center for Medicare and Medicaid Innovation to award Health Care Innovation Awards in 2012 to Cooper University Hospital in New Jersey for $2.8 million to expand the Camden Coalition super-utilizer program. The grant program is set to serve more than 1,200 patients with estimated three-year cost savings of $6.2 million. Another award went to State University of New Jersey at Rutgers, which received $14.4 million to test community-based models led by safety-net provider organizations in Pennsylvania, Colorado, Missouri, and California with estimated three-year cost savings of $67.7 million. The first annual report for these awards will be in 2014.

The private sector is also looking at solutions: the Robert Wood Johnson Foundation is funding super-utilizer programs in six communities in New Jersey, Ohio, Maine, California, Massachusetts, and Michigan. These programs include community-based

super-utilizer teams that focus on the highest utilizers in a specific geographic area and super-utilizer clinics/ambulatory intensive care units that care for patients with the highest utilization.

Allison Hamblin, director of complex populations at the Center for Health Care Strategies, said until the CMMI and Robert Wood Johnson initiatives, there were not clear path to start a pilot in regional areas, and CMS' bulletin could make it easier to implement the other models it highlighted across states.

“What's most helpful is highlighting that CMS sees this as a priority for states to invest in, and clearly announcing that it's there to support states efforts to identify regulatory pathways to support and sustain these models,” Hamblin said.

Some states are already building the framework for such programs through Medicaid state plan amendments to develop care management programs, such as health homes, to provide services to individuals with super-utilizer profiles.

The bulletin could also recognize that most people in the hospital industry see a coming change in the way care is paid for, and “this is an important tool in that environment,” said Annette DuBard, director of informatics, quality and evaluation at highlighted Community Care of North Carolina, a statewide program established in 1998 by the North Carolina Department of Health and Human Services to provide population health management for Medicaid beneficiaries. The program provides a fixed per-member per-month fee between $2.50 and $5 to primary care providers to serve as medical homes, with requirements that they offer 24-hours-a-day/7-days-a-week availability and coordinate with program staff. Primary care providers participating in CCNC deliver about 90 percent of North Carolina’s Medicaid primary care.

“I think CMS is trying to highlight that the state Medicaid agency can have an instrumental role in implementing these kind of models -- in every case, it's the Medicaid agency recognizing that there is a role to play beyond playing claims, but enabling better care with better tools,” DuBard said.

Maine Quality Counts, another highlighted program, which coordinates efforts between Maine’s Patient-Centered Medical Home Pilot and Community Care Teams and other regional groups, started in 2012. The CCT program builds on the earlier CMS Multi-Payer Advanced Primary Care Practice demonstration project, with 10 CCTs currently active and supporting the most complex and highest-need patient populations of the 75 primary care practices participating in the Maine PCMH Pilot and MAPCP initiative, representing just over 25 percent of the state’s population.

The business case has been slowly building for super-utilizer programs, which can cost money to implement upfront but produces savings for states.

“We and others would be the first to admit that we don't have the answers, but we do recognize that the current health care system in the fee-for-service, one patient at a time, is not the right thing, and that's what this is trying to recognize,” said Lisa M. Letourneau, executive director of MQC. – *Lisa Gillespie* (*lgillespie@iwpnews.com*)