

# Medicaid Demonstration Project Planning Update

Grant Coalition for Health Improvement  
10/10/2017 Meeting

# Goals

- Presentation goals
  - Review 6 selected Demonstration projects
  - Revisit data on healthcare and social needs in our region
  - Think about potential priority populations for Medicaid Demonstration projects
  - Share any concerns and recommendations
- What will happen with your feedback?
  - Will be shared with regional project workgroups and Governing Board
  - Will inform projects, including selected approach and priority populations

# Projects and general target populations

Bi-Directional Integration	
Objective	Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers. Will support bringing together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.
General target population (as defined by HCA)	All Medicaid beneficiaries (children and adults) particularly those with or at-risk for behavioral health conditions, including mental illness and/or substance use disorder (SUD).

# Projects and general target populations

## Community-Based Care Coordination (aka HUB)

Objective	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with one or more chronic disease or condition (such as, arthritis, cancer, chronic respiratory disease [asthma], diabetes, heart disease, obesity and stroke), <b>or</b> mental illness/depressive disorders, <b>or</b> moderate to severe substance use disorder and at least one risk factor (e.g., unstable housing, food insecurity, high EMS utilization).

# Projects and general target populations

## Transitional Care

Objective	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place.
General target population (as defined by HCA)	Medicaid beneficiaries in transition from intensive settings of care or institutional settings, including beneficiaries discharged from acute care to home or to supportive housing, and beneficiaries with SMI discharged from inpatient care, <b>or</b> client returning to the community from prison or jail.

# Projects and general target populations

## Diversion Interventions

Objective

Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations.

General target population (as defined by HCA)

Medicaid beneficiaries presenting at the ED for non-acute conditions, Medicaid beneficiaries who access the EMS system for a non-emergent condition, and Medicaid beneficiaries with mental health and/or substance use conditions coming into contact with law enforcement.

# Projects and general target populations

## Addressing the Opioid Use Public Health Crisis

Objective	Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.
General target population (as defined by HCA)	Medicaid beneficiaries, including youth, who use, misuse, or abuse, prescription opioids and/or heroin.

# Projects and general target populations

Chronic Disease Prevention and Control	
Objective	Integrate health system and community approaches to improve chronic disease management and control.
General target population (as defined by HCA)	Medicaid beneficiaries (adults and children) with, or at risk for, arthritis, cancer, chronic respiratory disease (asthma), diabetes, heart disease, obesity and stroke, with a focus on those populations experiencing the greatest burden of chronic disease(s) in the region.



# Overall Population Demographics

Grant County (N=93,930)

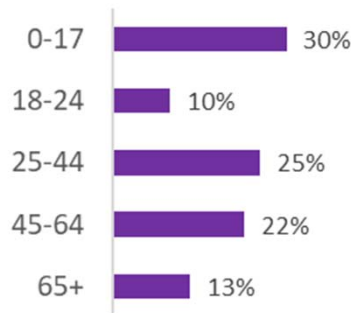
## Gender



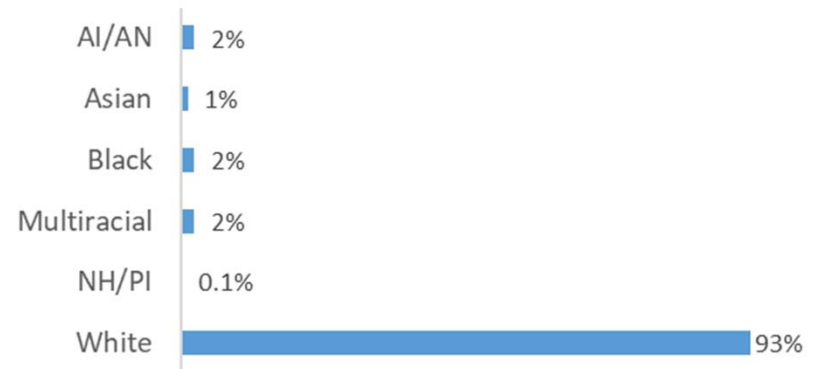
## Ethnicity



## Age



## Race



Source: Office of Financial Management (Measurement period = 2015)

# Medicaid Population Demographics

**Grant County (N=37,345)**

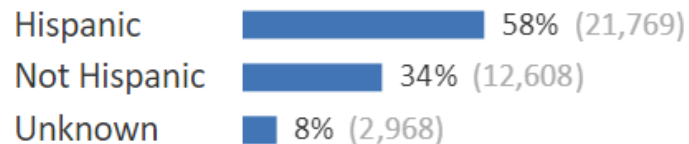
## Age Group



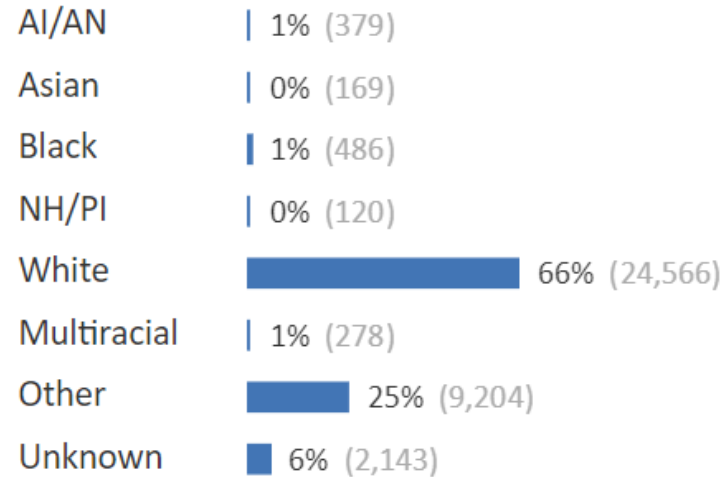
## Gender



## Ethnicity



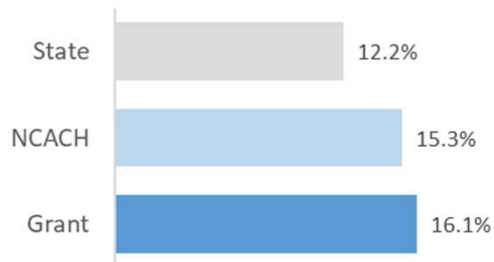
## Race



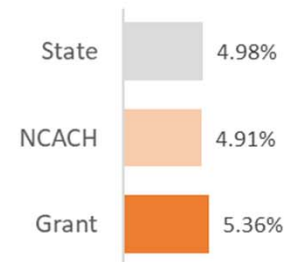
Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)

# Social & Environmental Determinants of Health

## Percent of People Living in Poverty



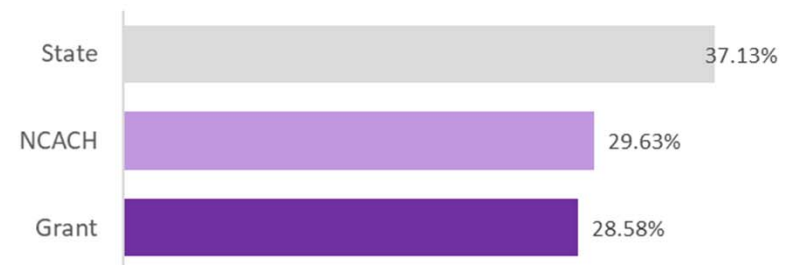
## Unemployment Rate



## Estimated Median Household Income



## Unaffordable Housing



Source: Health Care Authority Starter Kit, drawn from U.S. Census Bureau, Employment Security Department and Washington Tracking Network

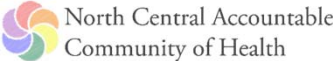
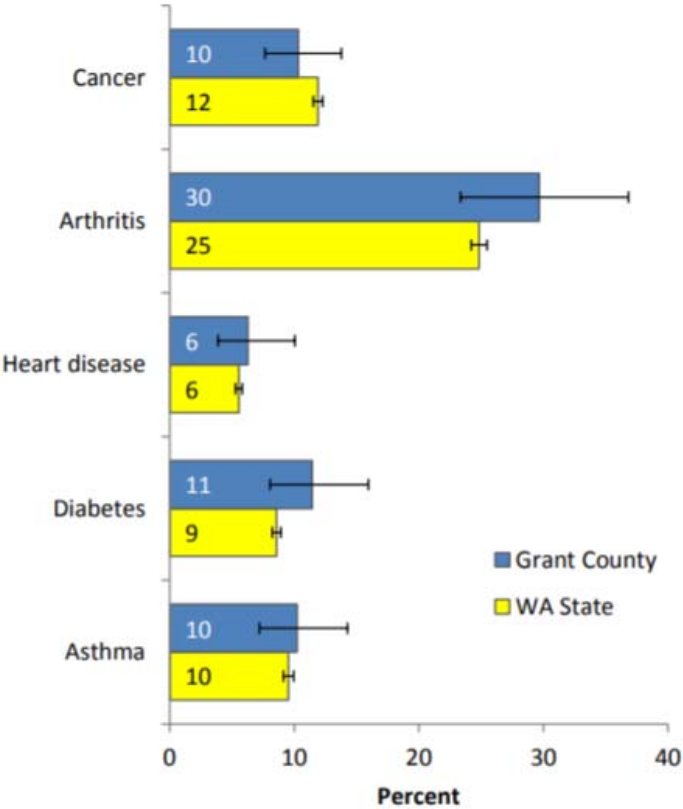
# Top Ten Most Common Causes of Acute Hospitalizations Among Medicaid Recipients

Rank	Cause of Acute Hospitalization	Count	%	State Rank
1	Injury and Poisoning	266	12.1	2 (9.4%)
2	Mental and Behavioral Disorders	171	7.8	1 (18.2%)
3	Diseases of Heart	135	6.1	4 (5.7%)
4	Respiratory Infections	132	6.0	9 (3.6%)
5	Diseases of the Musculoskeletal System and Connective Tissue	115	5.2	5 (4.5%)
6	Substance Use Disorder	105	4.8	6 (4.6%)
7	Septicemia	105	4.8	3 (7.4%)
8	Cancer/Malignancies	102	4.6	8 (3.6%)
9	Diabetes	94	4.3	
10	Diseases of Liver, Biliary Tract, and Pancreas	84	3.8	7 (3.7%)

Data for North Central ACH, Excluding Pregnancy and Child Delivery Related Hospitalizations (Jan 1, 2015 - Oct 31, 2015)  
 Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System

# Adult (18+) Chronic Diseases

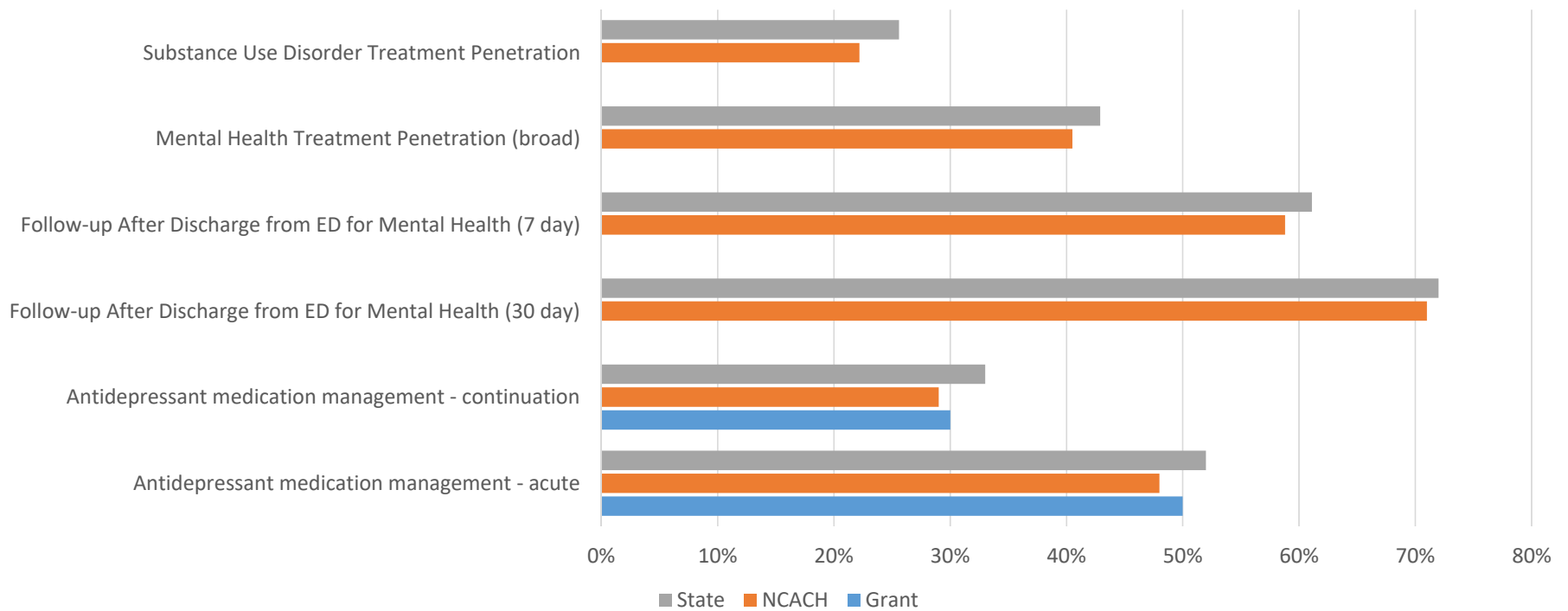
## Grant County



Source: Washington Dept. of Health Chronic Disease Profiles (2017), drawing from Washington Behavioral Risk Factor Surveillance System 2013-2015

# Behavioral Health

## *Behavioral Health Measures Where NCACH Below State Average*



Data for North Central ACH from Health Care Authority – based on demonstration measures

# Risk Factors for Arrests

**5-6 times more likely** to exhibit one of these risk factors

- Substance abuse (not including alcohol)
- SUD treatment need
- Co-occurring mental illness/substance use disorder

# Risk Factors for Homelessness

**3-4 times more likely** to exhibit one of these risk factors

- SUD treatment need
- Co-occurring mental illness/substance use disorder
- Substance abuse (not including alcohol)
- Psychiatric (bipolar)



# Risk Factors for ED Utilization

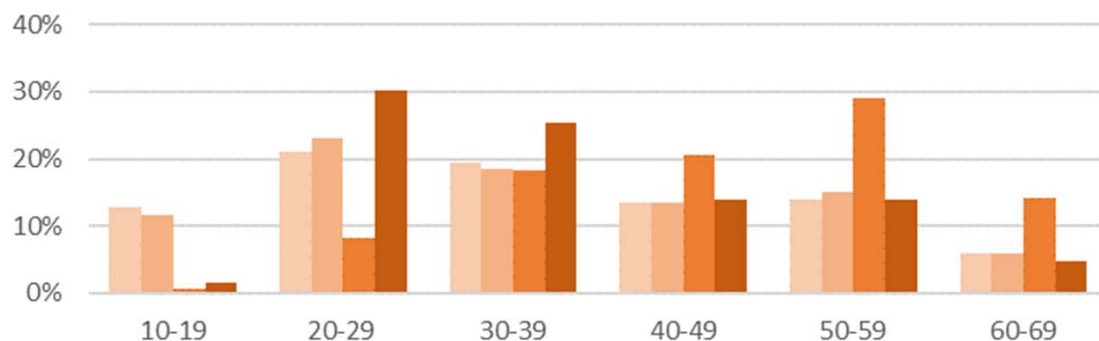
**5-7 times more likely** to exhibit one of these risk factors, if have 3+ ED visits

- Type 1 diabetes
- Pulmonary
- Cardiovascular
- Renal
- Liver disease
- Co-occurring mental illness/substance use disorder
- Substance abuse (low)

# Opioid Use

## Opioid Use by Age (NCACH Region)

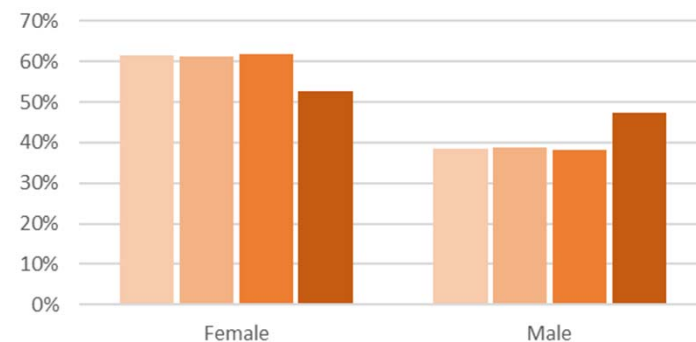
- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



Source: Health Care Authority drawn from fiscal year 2016 claims data and ICD coding Medicaid only population with full medical eligibility

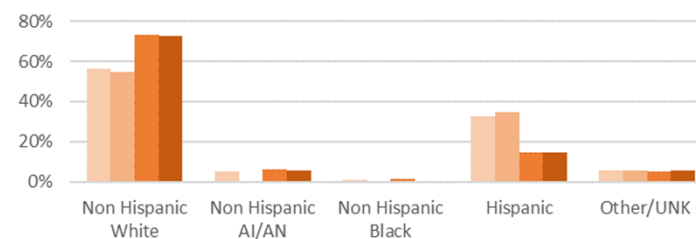
## Opioid Use by Gender (NCACH Region)

- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



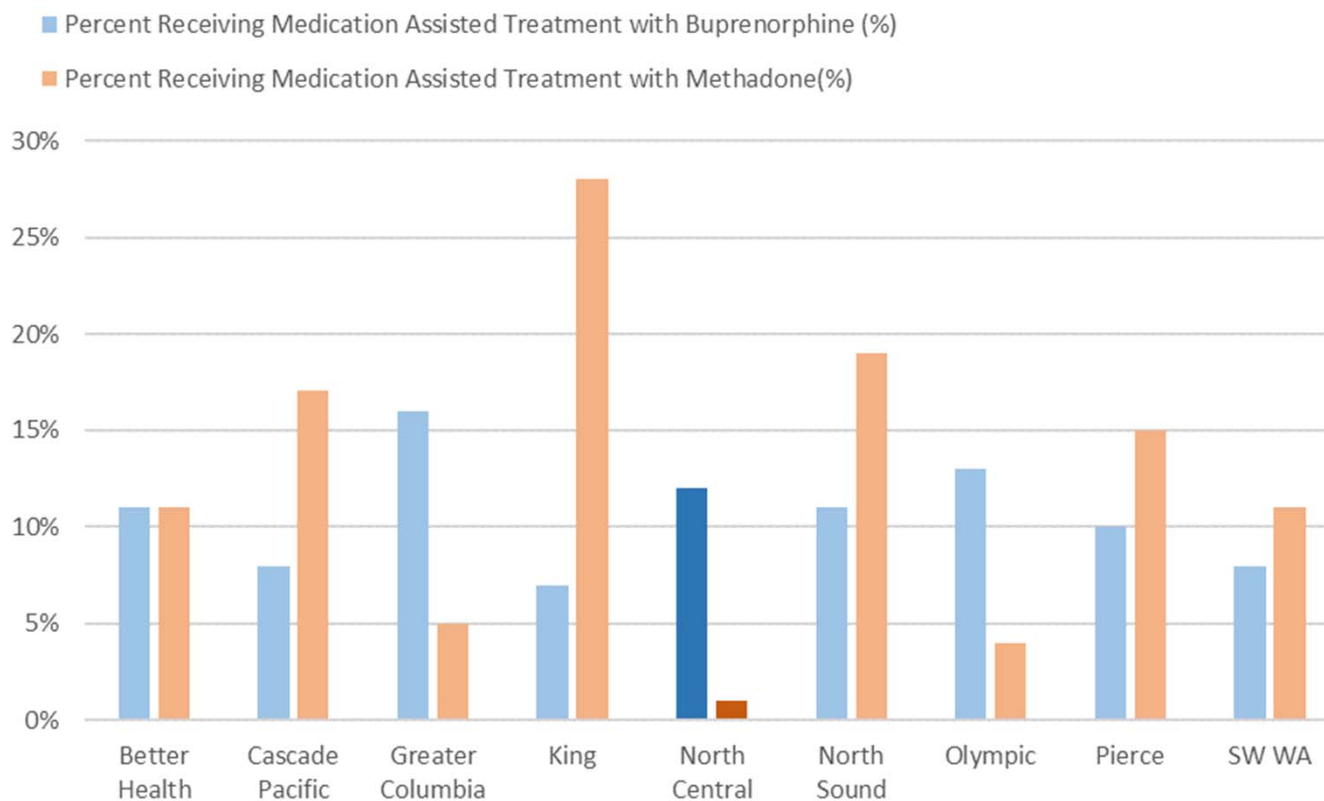
## Opioid Use by Race/Ethnicity (NCACH Region)

- % Opioid Users with no Cancer Diagnosis history (N = 9,764)
- % Heavy Opioid Users with no Cancer Diagnosis History (N = 1,742)
- % Chronic Opioid Users with no Cancer Diagnosis History (N = 1,815)
- % Diagnosis History of Opioid Abuse/Dependence (N = 1,359)



# Opioid Treatment

## Medication Assisted Treatment Across ACHs



Source: Health Care Authority

# Project Performance Measures

- Antidepressant Medication Management\*
- Child and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care: Eye Exam (retinal) performed
- Comprehensive Diabetes Care: Hemoglobin A1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Follow-up After Discharge from ED for Mental Health
- Follow-up After Discharge from ED for Alcohol or Other Drug Dependence
- Follow-up After Hospitalization for Mental Illness
- Inpatient Hospital Utilization
- Medication Management for People with Asthma (5 – 64 Years)\*
- Mental Health Treatment Penetration (Broad Version)
- Outpatient ED Visits per 1000 Member Months
- Plan All-Cause Readmission Rate (30 Days)
- Substance Use Disorder Treatment Penetration
- Percent Homeless (Narrow definition)
- Percent Arrested
- Medication Assisted Therapy (MAT): With Buprenorphine or Methadone\*
- Patients on high-dose chronic opioid therapy by varying thresholds
- Patients with concurrent sedatives prescriptions
- Substance Use Disorder Treatment Penetration (opioid)
- Statin Therapy for Patients with Cardiovascular Disease (Prescribed)\*

*Demonstration Measures across 6 projects – red indicates measures where ACH is below state average (\* indicates where we are lowest performing ACH)  
Measurement periods vary across measures (2015, FY 2016, or Oct 2015-Sep 2016)*

# High- Performance Measures

<b>Metric</b>	<b>2A: Integration</b>	<b>2B: Pathways</b>	<b>2C: Transitional</b>	<b>2D: Diversion</b>	<b>3A: Opioid</b>	<b>3D: Chronic</b>	<b>Demonstration Projects</b>
Outpatient Emergency Department Visits per 1000 Member Months	1	1	1	1	1	1	6
Inpatient Hospital Utilization	1	1	1		1	1	5
Follow-up After Discharge from ED for Mental Health, Alcohol or Other Drug Dependence	1	1	1				3
Follow-up After Hospitalization for Mental Illness	1	1	1				3
Percent Homeless (Narrow Definition)		1	1	1			3
Plan All-Cause Readmission Rate (30 Days)	1	1	1				3
Substance Use Disorder Treatment Penetration	1	1					2
Mental Health Treatment Penetration (Broad Version)	1	1					2
Child and Adolescents' Access to Primary Care Practitioners	1					1	2
Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	1					1	2
Comprehensive Diabetes Care: Hemoglobin A1c Testing	1					1	2
Comprehensive Diabetes Care: Medical Attention for Nephropathy	1					1	2
Medication Management for People with Asthma (5-64 years)	1					1	2

# Discussion Questions

As our project workgroups work on recommending evidence-based approaches and priority populations...

- What potential populations do you recommend they target?
- What populations/issues should they look further into?
  - e.g. gender, race/ethnicity, age, specific health conditions
- What questions and data gaps should they dig into?
- Any other takeaways you want us to relay to workgroups?