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

<table>
<thead>
<tr>
<th>Bi-Directional Integration</th>
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</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
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</tbody>
</table>
# Projects and general target populations

<table>
<thead>
<tr>
<th>Community-Based Care Coordination (aka HUB)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
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<td><strong>General target population (as defined by HCA)</strong></td>
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<tr>
<td><strong>Transitional Care</strong></td>
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Projects and general target populations

<table>
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<tr>
<th>Diversion Interventions</th>
</tr>
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<tbody>
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<td><strong>Objective</strong></td>
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<td><strong>General target population (as defined by HCA)</strong></td>
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</table>
## Projects and general target populations

<table>
<thead>
<tr>
<th>Addressing the Opioid Use Public Health Crisis</th>
</tr>
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<td><strong>Objective</strong></td>
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<td><strong>General target population (as defined by HCA)</strong></td>
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Projects and general target populations

<table>
<thead>
<tr>
<th>Chronic Disease Prevention and Control</th>
</tr>
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<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>General target population (as defined by HCA)</strong></td>
</tr>
</tbody>
</table>
Overall Population Demographics

Grant County (N=93,930)

**Gender**
- Female: 49%
- Male: 51%

**Ethnicity**
- Hispanic: 41%
- Not Hispanic: 59%

**Age**
- 0-17: 30%
- 18-24: 10%
- 25-44: 25%
- 45-64: 22%
- 65+: 13%

**Race**
- AI/AN: 2%
- Asian: 1%
- Black: 2%
- Multiracial: 2%
- NH/PI: 0.1%
- White: 93%

*Source: Office of Financial Management (Measurement period = 2015)*
Medicaid Population Demographics

Grant County (N=37,345)

Age Group
- Adult (19+): 41% (15,273)
- Child (<19): 59% (22,072)

Gender
- Female: 53% (19,961)
- Male: 47% (17,384)

Ethnicity
- Hispanic: 58% (21,769)
- Not Hispanic: 34% (12,608)
- Unknown: 8% (2,968)

Race
- AI/AN: 1% (379)
- Asian: 0% (169)
- Black: 1% (486)
- NH/PI: 0% (120)
- White: 66% (24,566)
- Multiracial: 1% (278)
- Other: 25% (9,204)
- Unknown: 6% (2,143)

Source: Healthier Washington Dashboard (Measurement period = 10/1/2015 – 9/30/2016)
Social & Environmental Determinants of Health

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

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


Source: Health Care Authority Starter Kit, determined by primary diagnosis field in HCA ProviderOne Medicaid Data System
Adult (18+) Chronic Diseases

Grant County

Behavioral Health

Behavioral Health Measures Where NCACH Below State Average

- Substance Use Disorder Treatment Penetration
- Mental Health Treatment Penetration (broad)
- Follow-up After Discharge from ED for Mental Health (7 day)
- Follow-up After Discharge from ED for Mental Health (30 day)
- Antidepressant medication management - continuation
- Antidepressant medication management - acute

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

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members in NCACH region
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)

Source: DSHS Research and Data Analysis cross-system outcome measures
Date specific to Medicaid members in NCACH region
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 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

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