Medicaid Quality Strategy: Opportunities to Further Align Managed Care and DSRIP

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Texas External Quality Review Organization
September 2014
Overview

• US Population Health
• What is an External Quality Review Organization (EQRO)?
• DSRIP and Medicaid Performance Improvement Projects (PIPs)
• Potentially Preventable Events (PPEs)
  • What are they?
  • What are the results in Medicaid for Calendar Year (CY) 2014
• Who are the super-utilizers?
• Next steps
The Price Paid for Not Preventing Disease

• Between 2005 and 2030 the number of individuals with chronic disease is expected to increase from 133M to 171M.
• 38% of all deaths in the US are attributable to: smoking, unhealthy diet, physical activity, & problem drinking.
• Intensive lifestyle changes can be effective – ex. In diabetes, reduced cost by $44 PMPM.
• 75% of US health spending (total of $2.6 trillion in 2010) is for chronic illness.
BEST CARE AT LOWER COST

The Path to Continuously Learning Health Care in America

Institute of Medicine Study Released September 2012
Commercial Data But Same Pattern Seen in Medicaid

Wellness/Illness Burden Pyramid

- Catastrophic Conditions
  - Band 1
- Multiple Chronic Conditions
  - Band 2
- At Risk for Multiple Chronic Conditions
  - Band 3
- Stable
  - Band 4
- Healthy
  - Band 5

### Percent of Population
- Catastrophic Conditions: 2%
- Multiple Chronic Conditions: 8%
- At Risk for Multiple Chronic Conditions: 20%
- Stable: 20%
- Healthy: 50%

### Percent of Cost
- Catastrophic Conditions: 32%
- Multiple Chronic Conditions: 28%
- At Risk for Multiple Chronic Conditions: 24%
- Stable: 10%
- Healthy: 6%
IOM Recommendations 2012

• Improve capacity to capture clinical, care delivery process, and financial data

• Accelerate creation and adoption of decision support tools

• Improve coordination within and across organizations

• Increase transparency and health care system performance, including quality, prices, and costs
Sec. 536.003 requires HHSC to develop quality-based outcome and process measures used in quality-based payments for acute and long-term care services across all child health plan and Medicaid program delivery models and payment systems.

Measures addressing potentially preventable events (PPEs) must be considered.

The measures can be aligned with the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), or other federal agency requirements.
What is the External Quality Review Organization?
EQRO and QI are Federal Requirements

**MEDICAID**
Balanced Budget Act of 1997 (BBA)

- Requires State Medicaid agencies to develop a State quality assessment and improvement strategy
- Requires independent, external reviews of the quality and timeliness of, and access to, care and services provided to Medicaid beneficiaries by Medicaid MCOs and prepaid inpatient health plans

**CHIP**
Reauthorization Act of 2009

- Requires CHIP managed care plans to participate in external quality review
- Requires each State to annually report on its child health quality measures and other State-specific information collected through EQROs
Enrollee Characteristics
Age, Race/Ethnicity, Health Status, Gender, Health Literacy, Self-Efficacy

Environmental Characteristics
Poverty, Urban/Rural, Health Care Provider Shortage Areas

Outcomes
• Improved Patient Reported Outcomes
• Improved Clinical Indicators
• Reduction in Potentially Preventable Events
• Better Adherence to Treatment Recommendations

Processes
• Evidenced-Based Care
• Individualized Service Plans
• Risk Assessments
• Care Coordinators

Structure
• Health Care Delivery System
• Health Plan Organization
• Practice Characteristics
• Disease Management

Health and Human Services Commission
Assessment of MCO Compliance and Quality

- MCO compliance with state and federal requirements
  - Administrator Interview Tool
- Performance Measurement
  - Electronic Data Validation, Surveys, Quality of Care Measures
- Performance Improvement
  - PIPs and PIP implementations
- Special studies/focused studies
  - Super-utilizers
Performance Improvement Projects
PIPs
PIPs and Federal Regulations

BBA 1997 requires all states with Medicaid managed care to ensure MCOs conduct PIPs (per 42 CFR 438.240)

Projects must be designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and nonclinical care areas that have a favorable effect on health outcomes and enrollee satisfaction.
Key Questions for Developing a PIP

• What is the problem and who is affected?

• What causes the problem?

• How will the health plan address the root causes of the problem?

• How will you know if the intervention worked?

• What will you do if it works? If it doesn’t?
Components of a PIP

1. Select the study topic
2. Define the study questions
3. Select study indicators
4. Use a representative and generalizable study population
5. Use sound sampling techniques (if sampling)
6. Collect reliable and valid data
7. Implement interventions and improvement strategies
8. Analyze data and interpret study results
9. Plan for real improvement
10. Achieve sustained improvement
Possibilities to Align DSRIP and PIPs
## Summary of PIPs Aligned with DSRIP Initiatives

<table>
<thead>
<tr>
<th>DSRIP Initiative</th>
<th>MCO</th>
<th>DSRIP RHPs Involved</th>
<th>PIP Topic</th>
<th>PIP Interventions</th>
<th>Key Health Issues Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2 Increase training of Primary Care workforce</td>
<td>Amerigroup</td>
<td>1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19</td>
<td>Controlling High Blood Pressure</td>
<td>Employ Practice Management Consultants to train/education provider office staff and providers</td>
<td>Chronic Conditions</td>
</tr>
<tr>
<td>1.8 Increase, expand, and enhance dental services</td>
<td>MCNA Dental</td>
<td>Statewide</td>
<td>Annual Dental Visit - Timeliness of Care</td>
<td>Home visits with children of migrant farmworkers to identify as a migrant farmworker and assist with dental accelerated services</td>
<td>Lack of utilization of care</td>
</tr>
<tr>
<td>2.11 Conduct Medication Management</td>
<td>Superior</td>
<td>1-20</td>
<td>Asthma Management</td>
<td>Established partnerships with the providers to conduct provider-initiated member outreach to members identified as not having the appropriate asthma medications. Additionally, members are sent asthma-related educational materials and an asthma action plan and instructed to complete it with their PCP.</td>
<td>Chronic Conditions, Lack of patient education on self-managing their health conditions</td>
</tr>
<tr>
<td>2.12 Implement/expand care transitions programs</td>
<td>UnitedHealthcare</td>
<td>1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19, 20</td>
<td>Reduce PPRs with a focus on COPD</td>
<td>Employ Service Coordinators who work with members discharged from an inpatient stay to provide intensive care and service coordination. The service coordinators will work with the members to identify and schedule a visit with a specialist, identify and address barriers to care, and manage medications, among other services.</td>
<td>Chronic Conditions, Care Transitions, PPRs due to Chronic Conditions</td>
</tr>
<tr>
<td>2.17 Establish improvement in care transition from the inpatient setting for individuals with mental health and/or substance abuse disorders</td>
<td>ValueOptions</td>
<td>9, 10, 18</td>
<td>Follow-up after BH Hospitalization</td>
<td>Collaborate with a BH facility to establish a care coordination and discharge planning program</td>
<td>Care coordination</td>
</tr>
</tbody>
</table>
## Summary of PIPs Aligned with DSRIP Initiatives

<table>
<thead>
<tr>
<th>DSRIP Initiative</th>
<th>MCO</th>
<th>DSRIP RHPs Involved</th>
<th>MCO Program</th>
<th>Key Health Issues Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.8 Increase, expand, and enhance dental services</td>
<td>Driscoll</td>
<td>3, 4, 5, 6, 20</td>
<td>Oral Health Initiative - recruits new providers of the Oral Evaluation and Fluoride Varnish services in the Primary Care office, increasing the number of fluoride varnish applications, and ultimately decreasing the number of dental surgeries in the under 5 year old population</td>
<td>Lack of access to and utilization of needed health care services</td>
</tr>
<tr>
<td>1.13 Develop behavioral health crisis stabilization services as alternatives to hospitalization</td>
<td>ValueOptions</td>
<td>9, 10, 18</td>
<td>Mobile Crisis Unit - provides both telephonic and onsite crisis services 24/7/365</td>
<td>High rates of PPEs, specifically hospitalizations</td>
</tr>
</tbody>
</table>
2014 Collaborative PIP Topics

• Adolescent Well Care
• Asthma
• Potentially Preventable Readmissions
## Collaborative PIP Partnerships

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE AREA</th>
<th>HEALTH PLANS</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP</td>
<td>HARRIS, JEFFERSON</td>
<td>JEFFERSON CHC, TCHP</td>
<td>AWC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HARRIS CHC, TCHP, MOLINA</td>
<td></td>
</tr>
<tr>
<td>CHIP</td>
<td>TRAVIS</td>
<td>BCBS, SENDERO, SETON</td>
<td>AWC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR</td>
<td>DALLAS</td>
<td>AG, PARKLAND</td>
<td>ASTHMA</td>
</tr>
<tr>
<td>STAR</td>
<td>HARRIS</td>
<td>AG, CHC, MOLINA, TCHP</td>
<td>ASTHMA</td>
</tr>
<tr>
<td>STAR</td>
<td>JEFFERSON</td>
<td>CHC, TCHP</td>
<td>ASTHMA</td>
</tr>
<tr>
<td>STAR</td>
<td>NUECES</td>
<td>CHRISTUS, DRISCOLL</td>
<td>ASTHMA</td>
</tr>
<tr>
<td>STAR</td>
<td>TRAVIS</td>
<td>BCBS, SENDERO, SETON</td>
<td>ASTHMA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAR+PLUS</td>
<td>HARRIS, TRAVIS,</td>
<td>HARRIS UHC, MOLINA</td>
<td>PPR</td>
</tr>
<tr>
<td></td>
<td>HIDALGO</td>
<td>TRAVIS UHC, AG</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HIDALGO HS</td>
<td></td>
</tr>
</tbody>
</table>
Potentially Preventable Events
PPEs
PPE Calculations

• Potentially Preventable Admissions (PPAs), Readmissions (PPRs), Emergency Department Visits (PPVs)
• Calculated at the Provider Level
• Calculated for STAR, STAR+PLUS and CHIP
• Will be calculated for RHPs
• Using the 3M™ Population Focused Preventable software and methodology (Core Grouping software 2014.0.1; Population-Focused Preventable Grouper Version 29.0)
PPAs: Definition

- Facility admissions that may have resulted from the lack of adequate access to care or ambulatory care coordination.
- The occurrence of high rates of PPAs may represent a failure of the ambulatory care provided to the patient. In addition to a significant quality problem, excess PPAs result in unnecessary increases in cost.
PPAs: Calculation

• Assignment of APR-DRG to inpatient admissions. Based on the reason for admission, an initial preventable status is set.

• Modification can be made for admissions from nursing or residential care.

• Health status (Clinical Risk Groups), determined from encounter data for the year prior to the measurement year, is used to exclude certain patients from being at risk for PPAs
  • Malignancy
  • Catastrophic conditions
  • Less than 3 months enrollment
PPAs: Calculation

- Relative weights are assigned to each admission at risk for PPA assignment by APR-DRG.
  - Based on resource utilization from Texas Medicaid data.
- High resource PPA weigh more in the PPA rate than lower resource PPA so that a calculated excess in the PPA rate reflects potential waste more accurately.
- PPAs are risk adjusted using the Clinical Risk Groups (CRGs).
## Sample Provider Level Report: PPAs

### PPA Rates

<table>
<thead>
<tr>
<th></th>
<th>Total Admissions at Risk for PPA</th>
<th>Actual Number of PPAs</th>
<th>PPA Rate (weighted)</th>
<th>Expected Number of PPAs</th>
<th>Expected PPA Rate (weighted)</th>
<th>Actual-to-Expected Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Results</td>
<td>6284</td>
<td>950</td>
<td>15.46%</td>
<td>1296.08</td>
<td>19.10%</td>
<td>0.81</td>
</tr>
</tbody>
</table>

### PPA Expenditures

<table>
<thead>
<tr>
<th></th>
<th>Members with PPAs</th>
<th>Actual PPA Expenditures</th>
<th>Expected PPA Expenditures</th>
<th>Actual-to-Expected Ratio for PPA Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Results</td>
<td>802</td>
<td>$4,008,854.00</td>
<td>$6,956,080.33</td>
<td>0.58</td>
</tr>
</tbody>
</table>

### State-Wide PPA Rate

<table>
<thead>
<tr>
<th></th>
<th>State Norm</th>
<th>25&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>50&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPA Rate (weighted)</td>
<td>18.48%</td>
<td>25.79%</td>
<td>19.19%</td>
<td>11.54%</td>
</tr>
</tbody>
</table>
### Sample Provider Level Report: PPAs

#### State-Wide Provider Distributions

<table>
<thead>
<tr>
<th></th>
<th>25&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>50&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
<th>90&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Admissions at Risk for PPA</td>
<td>156</td>
<td>416</td>
<td>2,184</td>
</tr>
<tr>
<td>Actual Number of PPAs</td>
<td>31.0</td>
<td>77.0</td>
<td>362.0</td>
</tr>
<tr>
<td>Members with PPAs</td>
<td>26</td>
<td>65</td>
<td>318</td>
</tr>
<tr>
<td>Category</td>
<td>Number of PPAs</td>
<td>PPA Category Rate (weighted) per 1,000 Resource Unit</td>
<td>State Percentile of PPA Rate (weighted) per 1,000 Resource Unit</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------</td>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>CHF (Congestive Heart Failure)</td>
<td>34</td>
<td>8.9</td>
<td>17.77 9.65 0.00</td>
</tr>
<tr>
<td>DM (Diabetes)</td>
<td>65</td>
<td>11.2</td>
<td>14.99 8.26 0.00</td>
</tr>
<tr>
<td>BH/SA (Behavioral Health or Substance Abuse)</td>
<td>10</td>
<td>1.2</td>
<td>1.16 0.00 0.00</td>
</tr>
<tr>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
<td>71</td>
<td>12.8</td>
<td>25.67 13.15 0.00</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>22</td>
<td>2.4</td>
<td>2.46 0.29 0.00</td>
</tr>
<tr>
<td>Pediatric Asthma</td>
<td>126</td>
<td>10.8</td>
<td>15.14 4.99 0.00</td>
</tr>
<tr>
<td>CP &amp; CAD (Angina and Coronary Artery Disease)</td>
<td>33</td>
<td>4.9</td>
<td>6.91 3.18 0.00</td>
</tr>
<tr>
<td>HTN (Hypertension)</td>
<td>8</td>
<td>1.3</td>
<td>1.85 0.00 0.00</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>124</td>
<td>16.7</td>
<td>24.16 15.53 0.00</td>
</tr>
<tr>
<td>Bacterial PNA (Respiratory Infection)</td>
<td>129</td>
<td>20.3</td>
<td>53.94 33.19 0.00</td>
</tr>
<tr>
<td>PE &amp; RF (Pulmonary Edema and Respiratory Failure)</td>
<td>2</td>
<td>0.9</td>
<td>0.00 0.00 0.00</td>
</tr>
<tr>
<td>Others</td>
<td>326</td>
<td>63.3</td>
<td>86.96 60.77 0.40</td>
</tr>
</tbody>
</table>
STAR Program PPAs Statewide

- Total admissions at risk: 156,190
- Actual PPAs: 21,553
- PPA expenditures total: $95,502,090
- PPA expenditures per 1,000 member months: $3,586
STAR Top PPA Reasons

753 | BIPOLAR DISORDERS
751 | MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES
463 | KIDNEY & URINARY TRACT INFECTIONS
420 | DIABETES
383 | CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS
249 | NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING
141 | ASTHMA
139 | OTHER PNEUMONIA
113 | INFECTIONS OF UPPER RESPIRATORY TRACT
053 | SEIZURE
PPRs: Definition

• A PPR is a readmission (return hospitalization within the specified readmission time interval) that is clinically related to the initial hospital admission. “Clinically related” is defined as a requirement that the underlying reason for readmission is related to the reason for the initial admission.

• *Global PPR exclusions*
  - Certain Malignancies,
  - HIV patients,
  - Palliative care,
  - Discharge status of “left against medical advice”.
PPRs: Severity Adjustment

• Since a hospital PPR rate can be influenced by a hospital’s mix of patient types and patient severity of illness during the Initial Admission, PPR rates are adjusted for case mix and severity of illness.

• Higher than expected readmission rates can be an indicator of quality of care problems during the initial hospital stay or with the coordination of care between the inpatient and outpatient setting.
### Provider Level PPR Example

#### PPR Rates

<table>
<thead>
<tr>
<th></th>
<th>Total Admissions at Risk for PPR</th>
<th>Actual Number of PPR Chains</th>
<th>PPR Rate</th>
<th>Expected Number of PPR Chains</th>
<th>Expected PPR Rate</th>
<th>Actual-to-Expected Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Results</td>
<td>2802</td>
<td>145</td>
<td>5.17%</td>
<td>177.36</td>
<td>6.33%</td>
<td>0.82</td>
</tr>
</tbody>
</table>

#### PPR Expenditures

<table>
<thead>
<tr>
<th></th>
<th>Members with PPRs</th>
<th>Number of PPR Events</th>
<th>Actual PPR Expenditures</th>
<th>Expected PPR Expenditures</th>
<th>Actual-to-Expected Ratio for PPR Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Results</td>
<td>132</td>
<td>191</td>
<td>$912,199.16</td>
<td>$1,616,313.99</td>
<td>0.56</td>
</tr>
</tbody>
</table>

#### State-Wide PPR Rate

<table>
<thead>
<tr>
<th></th>
<th>State Norm</th>
<th>25th Percentile</th>
<th>50th Percentile</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPR Rate</td>
<td>5.03%</td>
<td>7.14%</td>
<td>4.45%</td>
<td>2.30%</td>
</tr>
</tbody>
</table>
## PPR Results by Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Admissions at Risk for PPR</th>
<th>PPR Rate</th>
<th>State Percentiles</th>
<th>PPR Expenditures</th>
<th>Fraction of PPR Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF (Congestive Heart Failure)</td>
<td>18</td>
<td>11.11%</td>
<td>21.43% 8.70% 0.00%</td>
<td>$13,720.25</td>
<td>1.50%</td>
</tr>
<tr>
<td>DM (Diabetes)</td>
<td>14</td>
<td>21.43%</td>
<td>20.00% 0.00% 0.00%</td>
<td>$29,615.50</td>
<td>3.25%</td>
</tr>
<tr>
<td>BH/SA (Behavioral Health or Substance Abuse)</td>
<td>593</td>
<td>10.12%</td>
<td>16.49% 5.75% 0.00%</td>
<td>$358,175.39</td>
<td>39.27%</td>
</tr>
<tr>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
<td>31</td>
<td>16.13%</td>
<td>17.95% 5.56% 0.00%</td>
<td>$48,203.61</td>
<td>5.28%</td>
</tr>
<tr>
<td>CVA (Cerebrovascular Accident)</td>
<td>21</td>
<td>14.29%</td>
<td>10.20% 0.00% 0.00%</td>
<td>$13,260.69</td>
<td>1.45%</td>
</tr>
<tr>
<td>Adult Asthma</td>
<td>3</td>
<td>33.33%</td>
<td>0.00% 0.00% 0.00%</td>
<td>$3,081.44</td>
<td>0.34%</td>
</tr>
<tr>
<td>Pediatric Asthma</td>
<td>41</td>
<td>7.32%</td>
<td>0.00% 0.00% 0.00%</td>
<td>$6,411.03</td>
<td>0.70%</td>
</tr>
<tr>
<td>AMI (Acute Myocardial Infarction)</td>
<td>0</td>
<td>0.00%</td>
<td>0.00% 0.00% 0.00%</td>
<td>$0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>CP &amp; CAD (Angina and Coronary Artery Disease)</td>
<td>14</td>
<td>14.29%</td>
<td>7.69% 0.00% 0.00%</td>
<td>$12,824.16</td>
<td>1.41%</td>
</tr>
<tr>
<td>HTN (Hypertension)</td>
<td>13</td>
<td>15.38%</td>
<td>0.00% 0.00% 0.00%</td>
<td>$7,737.08</td>
<td>0.85%</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>72</td>
<td>0.00%</td>
<td>7.14% 0.00% 0.00%</td>
<td>$0.00</td>
<td>0.00%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>20</td>
<td>10.00%</td>
<td>14.29% 0.00% 0.00%</td>
<td>$19,074.64</td>
<td>2.09%</td>
</tr>
<tr>
<td>C Section (Cesarean delivery)</td>
<td>447</td>
<td>2.24%</td>
<td>1.82% 0.92% 0.00%</td>
<td>$26,301.44</td>
<td>2.88%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>10</td>
<td>20.00%</td>
<td>14.29% 0.00% 0.00%</td>
<td>$9,954.60</td>
<td>1.09%</td>
</tr>
<tr>
<td>Others</td>
<td>1505</td>
<td>3.32%</td>
<td>4.65% 3.25% 0.00%</td>
<td>$363,829.33</td>
<td>39.88%</td>
</tr>
</tbody>
</table>
STAR Program PPRs Statewide

- Total Readmissions: 306,784
- Readmissions at Risk: 5,629
- PPR expenditures: $45,197,455.20
How are Super-Utilizers Defined?
What does a Medicaid “Super-Utilizer” look like?

Top 10 most frequent ED utilizers in WA State in past 15 months:

1. ED visits in past 15 months range from 78 to 134
2. IP admissions range from 0 to 22 (average of 7)
3. 9 out of 10 have an indication of a current substance abuse problem
4. 10 of 10 have an indication of mental illness
5. 2 of 10 are currently homeless
6. 3 of 10 are currently or have recently been living in a group care setting
7. 1 of 10 is currently receiving in-home personal care
Centers for Medicare and Medicaid Services Super-Utilizer Guidance

• Identifying those with conditions that CMS calls “impactable”, defined as “multiple mental illness or substance use disorders (SUD) and/or multiple preventable admissions for poorly controlled chronic conditions (such as diabetes complications or heart failure exacerbations).”

Current Project

- Texas, Florida, New York Medicaid
- Define super-utilizers using different definitions
  - ED use and expenditures
  - Inpatient use and expenditures
  - Pharmacy
  - Mode of transportation to ED
- Include
  - Adults
  - Children
- Include all conditions
Provider Level Example: Possible Targets Related to Super-Utilizers

**PPR Results by Category**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Admissions at Risk for PPR</th>
<th>PPR Rate</th>
<th>State Percentiles</th>
<th>PPR Expenditures</th>
<th>Fraction of PPR Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF (Congestive Heart Failure)</td>
<td>18</td>
<td>11.11%</td>
<td>21.43% 8.70% 0.00%</td>
<td>$13,720.25</td>
<td>1.50%</td>
</tr>
<tr>
<td>DM (Diabetes)</td>
<td>14</td>
<td>21.43%</td>
<td>20.00% 0.00% 0.00%</td>
<td>$29,615.50</td>
<td>3.25%</td>
</tr>
<tr>
<td>BH/SA (Behavioral Health or Substance Abuse)</td>
<td>593</td>
<td>10.12%</td>
<td>16.49% 5.75% 0.00%</td>
<td>$358,175.39</td>
<td>39.27%</td>
</tr>
<tr>
<td>COPD (Chronic Obstructive Pulmonary Disease)</td>
<td>31</td>
<td>16.13%</td>
<td>17.95% 5.56% 0.00%</td>
<td>$48,203.61</td>
<td>5.28%</td>
</tr>
<tr>
<td>CVA (Cerebrovascular Accident)</td>
<td>21</td>
<td>14.29%</td>
<td>10.20% 0.00% 0.00%</td>
<td>$13,260.69</td>
<td>1.45%</td>
</tr>
</tbody>
</table>
State Medicaid agency role

- Work collaboratively with plans and providers to build shared commitment to improve outcomes for at-risk patients
- Support multi-system data integration and analytics
- Recognize impact of social and behavioral risk on medical utilization
Questions and Thank You