MCO Special Populations (Super-Utilizers) Program
Initial Evaluation – March 2014
Updated – December 2014

Introduction

A recent provision in the Texas Health and Human Services Commission (HHSC) Uniform Managed Care Contract requires each managed care organization (MCO) to have a specialized program for targeting, outreach, education and intervention for "super-utilizer" members. This "special population" is defined as members who have excessive utilization patterns that indicate typical disease management approaches are not effective. HHSC will evaluate each MCO plan and conduct interviews with MCO staff. HHSC intends to hold quarterly collaborative calls and/or webinars with its MCOs to discuss plan implementation, barriers, successful strategies, etc. This is a long-range quality improvement project being done as a partnership with our MCOs.

Preliminary Results

- All 19 MCOs have turned in their plans and each met the required submission guidelines.
- While there was a great deal of variation between MCOs, there were several common elements.
- Each plan was looking at emergency department (ED) overutilization. This was typically coupled with looks at inpatient use, readmissions, and other high-cost utilization.
- All plans met a new HHSC requirement for the option of face-to-face visits with super-utilizers.
- The various health plans use a number of analytics tools to flag and track super-utilizers. Typical flags looked at the presence of certain chronic diseases and patterns of utilization. Some plans are further ahead than others in regard to the sophistication of their data strategies.
- There is no single shared definition of what is considered a "super-utilizer" across all MCOs. The lack of a common benchmark to establish baseline levels and measure improvement is spurring HHSC to consider development of a basic framework for defining super-utilizers. Such a framework would facilitate "apples-to-apples" views of super-utilizer prevalence across Medicaid-CHIP and permit program-wide progress improvement measurement.

Anticipated benefits

Super-utilizers are known to be costly. National estimates are that 1 percent of the Medicaid population is responsible for about 25 percent of costs. The super-utilizer initiative at HHSC should lead to better focus on this expensive sub-population. Specific benefits may include:

- Closer coordination of physical and behavioral health services. Super-utilizers generally have both chronic physical health diseases and a comorbid behavioral health condition.
- Better communication between Medicaid-CHIP MCOs and social services providers and agencies. Super-utilizers often have a need for other social services. Their medical utilization will often improve as their social circumstances stabilize.
- Better health outcomes and an improved quality of life for Medicaid-CHIP clients.
- While the number of super-utilizers is small, their cost impact is disproportionately large. It is anticipated that a sustained effort to address this subpopulation will yield a return on investment for Medicaid-CHIP.

MCO Interventions

The MCOs outlined a number of similar interventions in their super-utilizer strategies. These include:

- Flagging two or more non-emergency ED visits for a referral to case management. Both member and provider notified via mail of two ED visits within 6 months. Night clinic use may be encouraged if it is available.
- Home visits by case managers and/or Physician/Nurse Practitioner and/or enrollment into intense management.
- Contracts with specialized vendors, to include home health agencies and predictive modeling data tools.
- Creating an Interdisciplinary Care Team (ICT). This team may include the following: Physicians, Case Managers, Licensed Social Workers, Medicare Coordinators, Pharmacists, Disease Management & Behavioral Health Case Managers and others.
- Referrals to substance abuse/behavioral health services, community providers/resources, supportive therapy, housing assist & crisis intervention.

MCO Evaluation Plans

The MCOs use a variety of methods and metrics to track progress in better super-utilizer management. While there are various unique elements for specific plans, there are certain common elements. These include:

- Evaluation of key metrics such as overall medical costs, ED visits, admissions/readmissions, and gaps in care.
- Clinical outcomes improvement using metrics and measures from national health care quality organizations and evidence-based practice guidelines.
- Member satisfaction surveys and feedback from primary care physicians.

Outreach Calls and emails

Follow up calls with MCOs are being made to reinforce the overarching goals of this contract provision and to discuss MCO ongoing plans for fiscal year 14 and for fiscal year 15 (new populations and services). Initial calls were made in the first quarter of 2014 to discuss each plan's submission. Topics for the calls and follow-up emails included success stories, barriers, and next steps.

Barriers and Challenges

A major discussion topic during the initial calls was barriers and challenges MCOs encountered while developing and implementing special populations programs. These include:

- Every plan mentioned as a barrier being supplied erroneous or incomplete contact information on plan members. A great deal of time and effort may be expended simply trying to find good contact information on the client. Once the correct information was obtained, plans pointed to difficulties in getting the correct information incorporated into the master contact information maintained by the Medicaid-CHIP program.
- Plans noted the contact information situation could be improved by diligently collecting and updating alternative contact information such as email addresses, cellphone numbers, and whether the client would accept text messages.
- Plans noted barriers to wider use of text messaging due to the process required to obtained client communication material approvals by the Medicaid-CHIP program. Efforts to streamline the approval process were welcomed by the plans.

- Plans noted problems with super-utilizer clients switching primacy care providers or health plans to evade efforts to curtail excessive utilization. This was an issue that might accompany drug-seeking behavior. Suggestions were made to enhance the Limited Program to allow it to "lock in" a client with a specific primary care provider and health plan.
- Plans noted the extra time and effort required to perform intense case management and face-to-face work with a super-utilizer needed to be considered by the Medicaid-CHIP program. UPDATE: Several plans offered feedback that complex case and disease management are considered administrative expenses and not counted toward their medical loss ratio. It was suggested HHSC review costs that might be more appropriate as medical expenses. HHSC agreed and is examining whether certain disease and case management costs may be counted as medical expenses by MCOs.
- Plans noted they often lack information on a new client that would enable them to flag them as a super-utilizer and be better prepared. Ongoing efforts by HHSC to increase the amount of historic information available to health plans were seen as helpful.
- Plans noted that effective super-utilizer program typically require a high degree of integration and cooperation across a community. Efforts to spur closer collaboration between Medicaid providers, the behavioral health system, social services providers, community-based organization, and other stakeholders were seen as beneficial when working with very complex cases. UPDATE: HHSC has been acting upon this suggestion by looking for successful super-utilizer efforts run by providers and highlighting them. A goal is to build closer ties between provider-based programs and MCOs.

Other HHSC Activities This Fiscal Year

HHSC is actively researching advances in super-utilizer management, outlier populations, regional variations, and "hotspots" of health care costs, utilization, and chronic conditions. This information is being shared with our MCOs and will be the topic of conference calls and web events. National subject matter experts in these topics are being invited to present on emerging best-practices.

In addition, HHSC is ramping up its analytics functions in these areas and working on appropriate measures to establish the scope of the problem and track improvement progress.

UPDATE: HHSC initiated an educational webinar series for health plans and stakeholders on super-utilizer management. Three webinars on the topic were held in 2014 and more are planned for 2015. The presentations and rebroadcast links are posted on the HHSC quality initiatives website.

UPDATE: Success Stories

New contract language was added to the Special Populations requirement to request that MCOs include what they consider a success story. Several plans submitted member case studies that detailed the overutilization and specific strategies used to improve it. These case studies are being reviewed to discern common elements that may be considered as best practices. One shared thread running through the various case studies is the high degree of personal interaction required for these interventions to be successful.

HHSC Future Opportunities

- HHSC will use the first year of the new special populations management requirement to evaluate best-practices.
- The lessons learned from the first year might be reflected in revised MCO requirements in future years.