Data Snapshot: A Descriptive Analysis of District of Columbia My Health GPS Medicaid Health Home Enrollees with Multiple Chronic Conditions

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Summary

The District of Columbia offers the My Health GPS health home program that provides comprehensive care management for Medicaid beneficiaries with three or more chronic conditions. This data snapshot examines the demographic characteristics and health care service utilization patterns among a baseline cohort of approximately 3,000 program enrollees, prior to and during their enrollment in the program. The purpose of the snapshot is to provide an early look at the program's initial impact and to establish baseline data and metrics that will be used in future to evaluate improvements in care and outcomes across the My Health GPS program.

KEY FINDINGS

- On average, 60% of beneficiaries in the My Health GPS baseline cohort had five or more chronic conditions.
- Compared to other Medicaid adults who are not eligible for My Health GPS or any long-term care program, beneficiaries in the baseline cohort are older and account for higher per-person spending, with higher rates of prescription drug utilization and potentially avoidable hospital admissions and re-admissions.
- Nearly all (94%) of beneficiaries in the baseline cohort of enrolled beneficiaries had a primary care visit with their assigned My Health GPS provider, suggesting that, despite having a relationship with primary care providers, these individuals have high utilization of services and may benefit from care coordination.

Background

On July 1, 2017, the District of Columbia Department of Health Care Finance (DHCF) launched the My Health GPS (MHGPS) program, a Health Home program under Section 2703 of the Affordable Care Act that provides reimbursement for comprehensive care management to provide care for the "whole person" for Medicaid beneficiaries with three or more chronic conditions. Beneficiaries must meet clinical criteria, not be enrolled in a home- and community-based waiver and opt to participate to be considered enrolled. Once a beneficiary is determined eligible, s/he is assigned to one of twelve My Health GPS providers. Beneficiary assignment to a provider is based on a hierarchical process that incorporates historical relationships with participating providers, beneficiary Ward of residence in proximity to a provider, and a match between the beneficiary's chronic condition profile and a provider's area of specialization.

Each beneficiary's health home consists of a multi-disciplinary team within the primary care setting to coordinate care across medical, behavioral, and social service systems. Covered health home services include:

- care coordination,
- comprehensive case management (CCM),
- health promotion,
- comprehensive transitional care,
- individual and family support services, and
- referrals to community and social support services.

All participating providers are also required to have certified EHR technology and health information exchange services needed to support population health management.

Since July 2017, approximately 45,000 beneficiaries have been determined eligible for My Health GPS and assigned to one of 12 approved My Health GPS entities, including a mix of Federally Qualified Health Centers (FQHCs), hospital systems, and physician group practices. Of these 45,000 beneficiaries, nearly 4,600 had effectuated their My Health GPS enrollment by completing a person-centered care plan with a My Health GPS provider as of August 2018. Of the 4,600 beneficiaries with a completed care plan, approximately 4,100 remained enrolled in the program as of September 2018, with the remainder having opted out of the program. A review of federal reporting on states' experience with enrolling eligible beneficiaries in health homes programs found that the ten percent uptake rate for My Health GPS is higher than

the uptake rates for certain states, and lower than others, for states reporting this data.[1] Additionally, many states reported low initial enrollment rates following the launch of their health homes programs, due to challenges with eligibility determination and referral processes.[2]

Methodology

This data snapshot provides an analysis of a cohort of beneficiaries (n=3,167) who were enrolled in My Health GPS between July and October 2017. This group represents nearly 70 percent of total current My Health GPS enrollees (as of September 2018).

From July through October 2017, providers were given a one-time, enhanced payment from DHCF if they executed a person-centered care plan for the attributed beneficiary. This payment was created to incent providers to enroll beneficiaries in the My Health GPS program. Structuring the My Health GPS baseline cohort to align with this timeframe enables DHCF to use this group to serve as the study group for this snapshot and subsequent program evaluation.

DHCF used claims extracted from the District of Columbia Medicaid Management Information System (MMIS) with dates of service in fiscal year 2016, which was the most recent fiscal year before the launch of the My Health GPS program, for the baseline findings reported in this snapshot. DHCF identified chronic conditions among the study group and comparison groups using the Agency for Healthcare Quality and Research (AHRQ) Chronic Condition Indicator (CCI) algorithm, which is based on ICD-9 and ICD-10 diagnosis codes.

In order to understand the demographic and utilization characteristics for the baseline cohort in context, DHCF compared the My Health GPS baseline cohort's experience to a comparison group consisting of Medicaid adults (ages 21 and older) with continuous eligibility in fiscal year 2016 who are residing in the community. Like the My Health GPS eligible group, the comparison group of Medicaid adults is not enrolled in a home- and community-based waiver or DHCF's My DC Health Home program for beneficiaries with serious mental illness.

DHCF also compared results for the My Health GPS baseline cohort and Medicaid adult comparison group from three established quality measures the agency uses as proxy indicators for avoidable care: 1) low-acuity, non-emergent (LANE) emergency department visits; 2) 30-day, all-cause hospital readmissions; and 3) potentially preventable hospital admissions.

Results

DEMOGRAPHIC CHARACTERISTICS
Compared to other Medicaid adults who are not eligible for My Health GPS or any long-term care program, beneficiaries in the baseline cohort are older and account for higher per-person spending, with higher rates of prescription drug utilization and potentially avoidable hospital admissions and re-admissions. On average, beneficiaries in the My Health GPS baseline cohort were likely to reside in Wards 7 and 8 (19% and 18%, respectively), be female (60%), African-American (83%), and have an average age of 53 years. Nearly all beneficiaries (99.9%) were enrolled for at least three continuous months in fiscal year 2016, a standard measure for continuous enrollment that indicates a sustained need for regular and frequent health care services.

PRE-ENROLLMENT UTILIZATION AND SPENDING PATTERNS
DHCF reviewed claims for the baseline cohort in fiscal year 2016 to determine their utilization patterns before they enrolled in My Health GPS. The five most common chronic conditions among this group were hypertension (86% of all beneficiaries in the cohort), hyperlipidemia (66%), diabetes (57%), obesity (53%), and asthma (47%). Among this cohort,

more than half (60%) of beneficiaries in the cohort had five or more chronic conditions. A total of 545 (17%) of cohort beneficiaries had a diagnosis indicating substance use disorder (SUD).

Compared to other Medicaid adults not enrolled in My Health GPS or any long-term care program, beneficiaries in the baseline cohort are older and account for higher per-person spending, with higher rates of emergency room visits, hospital admissions, and prescription drugs (See Table 1, below).

Table 1: Demographic and Utilization Characteristics Among Baseline Cohort and Comparison Group, FY2016

Measure	MHGPS Baseline Cohort (n=3,167)	Other Medicaid Adults (n=86,151)
Average age as of 9/30/16	53 years	39 years
Per-member cost*	$17,975	$7,171
Average hospital admissions**	2.4	1.5
Average emergency room visits**	2.9	1.2
Mean medications per person	14.8	3.2
Percent with substance use disorder (SUD)	17%	2%
Percent living in Wards 7 or 8	37%	39%
Low-acuity, non-emergent (LANE) visits	55%	62%
30-day, all-cause hospital readmissions	17%	11%
Potentially preventable admissions	12%	3%

*Excludes long-term care spending

**Restricted to beneficiaries with at least one claim for this service

Prior to enrollment in the program, 98% of beneficiaries in the baseline cohort had a primary care visit in fiscal year 2016, which is twice the primary care utilization rates for Medicaid adults in the comparison group (49%). In addition, an average of 94% of beneficiaries in the baseline cohort were attributed to their My Health GPS provider based on a historical primary care visit, and beneficiaries in the cohort had an average of 9.4 primary care visits in FY2016. These findings suggest that beneficiaries in the baseline cohort were actively engaged in primary care prior to their enrollment in the program.

Lastly, DHCF examined rates of potentially avoidable care and found that while the Medicaid adult comparison group had slightly higher rates of LANE visits (62% vs. 55%), the My Health GPS baseline cohort had higher rates of 30-day hospital readmissions (17% vs. 11% for Medicaid adults) and potentially preventable hospital admissions (12% vs. 3% for Medicaid adults). This suggests that the baseline cohort was more likely to receive costly, avoidable care before entering the program.

POST-ENROLLMENT UTILIZATION PATTERNS

DHCF has collected preliminary data findings on the utilization of care for the baseline cohort to understand their level of engagement with the My Health GPS program. On average, 71% of beneficiaries in the baseline cohort have had at least two visits with their My Health GPS provider since enrolling in the program, which served as a proxy for program engagement. However, these program engagement rates varied greatly, from as low as 20% of beneficiaries enrolled with certain providers up to 95% of beneficiaries enrolled with others. Additional findings on post-enrollment experience for the baseline cohort will be forthcoming in FY2019.

Implications for Medicaid Program

This data snapshot is intended to provide a baseline understanding of who is enrolled in the My Health GPS program, and an overview of their utilization and care patterns prior to entry, with the underlying goal of using these analytical

measures to periodically monitor and evaluate the impact of program enrollment on these outcomes and to document changes over time. DHCF will also be monitoring these outcomes for all My Health GPS enrollees in order to compare the experiences between the My Health GPS baseline cohort and those enrolled during a later period. DHCF will also be comparing characteristics of the My Health GPS baseline cohort with beneficiaries who have been determined eligible for the program and assigned to one of the participating providers, but not yet enrolled, to inform beneficiary recruitment practices and how best to engage beneficiaries most in need of comprehensive care coordination.

Nearly all (94%) beneficiaries in the baseline cohort had a historical relationship with their assigned My Health GPS provider prior to entry into the program. In future research, DHCF will seek to understand whether the characteristics of these early enrollees – high per-member cost, extensive use of primary care, but high rates of potentially avoidable hospital care as well – have implications for recruitment efforts. In addition, future research will focus on the concurrent use of primary care and avoidable hospital-based care among this cohort to explore the efficacy of consistent preventive care in managing the needs of beneficiaries with complex health needs.

For additional future research, DHCF plans to conduct short- and long-term evaluations of the impact of the My Health GPS program on several key domains, including provider capacity, quality of care, and health expenditures, and whether the use of population health management tools reduces rates of avoidable and costly care and helps improve health outcomes for District Medicaid beneficiaries with multiple chronic conditions.

Conclusion

On average, 60% of beneficiaries in the My Health GPS baseline cohort had five or more chronic conditions. Compared to other Medicaid adults not enrolled in My Health GPS or any long-term care program, beneficiaries in the baseline cohort are older and account for higher per-person spending, with higher rates of prescription drug utilization and potentially avoidable hospital admissions and re-admissions. Nearly all (94%) of beneficiaries in the baseline cohort had a primary care visit with their assigned My Health GPS provider, suggesting that, despite having a relationship with primary care providers, these individuals have high utilization of services and may benefit from enhanced care coordination.

Notes: The data shown here are drawn from enrollment and claims data in the District's Medicaid Management Information System (MMIS) The data provided here were compiled by staff in the Division of Analytics and Policy Research, Health Care Policy and Research Administration, DC Department of Health Care Finance. MMIS data were extracted in June 2018. For more information, contact DHCF at 202-442-5988.

References

1. Spillman BC, Richardson E, Spencer A, Allen E. Urban Institute. Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report – Year Two. June 2014. Office of the Assistant Secretary for Planning and Evaluation. Available at: https://aspe.hhs.gov/basic-report/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-annual-report-year-two#execsum
2. Spillman BC, Richardson E, Spencer A, Allen E. Urban Institute. Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report – Year Three. July 2015. Office of the Assistant Secretary for Planning and Evaluation. Available at: https://aspe.hhs.gov/system/files/pdf/163041/HHOption3.pdf
3. DHCF utilized a methodology developed by Mercer which identifies the percentage of Emergency Room (ER) visits that are considered Low Acuity Non-Emergent (LANE) visits. Based on industry best practices and supporting literature, Mercer developed a data-analytic procedure to identify low to moderate acuity diagnosis codes that could potentially be avoided. Some examples of conditions included in this type of analysis are fever, headache, cough, rash, and removal of sutures.
4. DHCF utilized a methodology developed by the Agency for Healthcare Research and Quality (AHRQ) that measures Prevention Quality Indicators (PQIs), which are a set of measures that can be used with hospital inpatient discharge data to identify conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent compilations or more severe disease.

5. DHCF utilized methodology developed by the National Committee for Quality Assurance (NCQA) which assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. As well as reporting observed rates, NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors.
6. My Health GPS State Plan Amendment (SPA), Approved February 2017. Available at: https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Health%20Home%20%2528My%20Health%20GPS%2529%20%281%29_0.pdf