WHITEPAPER

Collective Medical for Medicaid

Medicaid covers 70.9 million—or about one in five—individuals in the United States, including many patient populations with complex care needs, such as those with disabilities or serious mental illness.[1,2]

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In order to meet the needs of Medicaid patients, Collective Medical has partnered with several state Medicaid agencies and health information exchanges. By empowering physicians, nurses, and other care team members through actionable alerts, Collective Medical helps care teams identify at-risk patients and address their needs at the point of care—receiving a five out of five star rating in an overall assessment for Medicaid effectiveness by the Medicaid Black Book, published by Mostly Medicaid.[3,4]

The following are six success stories discussing how real-time notifications—powered by advanced analytics based on patient care histories, admission, discharge, and transfer (ADT) information, Continuity of Care Documents (CCDs), collaborative care plans, and other data sources—have helped care teams across the nation better care for vulnerable Medicaid patient populations with complex needs.

Washington

In 2012, the Washington State American College of Emergency Physicians, the Washington State Hospital Associations, and the Washington State Medical Association created the "ER is for Emergencies" program due to concerns surrounding the costs associated with frequent emergency department (ED) utilization—particularly among the state's Medicaid patient population.

This collaborative effort is aimed at redirecting acute care to more appropriate settings and decreasing unnecessary utilization through seven best practices:

1. Adopt an electronic emergency department information system
2. Implement patient education efforts

3. Identify patients with patterns of high utilization
4. Develop care plans for those with frequent utilization
5. Implement narcotic guidelines
6. Track patients being prescribed controlled substances by enrolling in the state's Prescription Monitoring Program (PMP)
7. Review reports and ensure interventions are working

Collective serves as the technical backbone for the ER is for Emergencies Medicaid Hospital Incentive program by Washington Healthcare Authority. Collective also supports Washington Medicaid providers in achieving quality metrics such as the ED Medicaid Quality Incentive, for management of patients that have been to the same ED five or more times.

Washington Outcomes

According to The Brookings Institution, in a review of Washington State's ER is for Emergencies program, use of Collective as part of the program resulted in the following:[5]

- 9.9 percent overall reduction in Medicaid-related ED encounters
- 24 percent decrease in opioid prescriptions written in the ED
- 14.2 percent reduction in low-acuity ED visits
- 10.7 percent decrease in ED visits among high utilizers
- $34 million in savings during the program's first year of operation

Oregon

Collective has been a technology partner to the Oregon Health Authority (OHA) since 2015. Collaboration between Coordinated Care Organizations, HIT Commons, Medicaid CCO payers, plans, public health entities, and health care providers across Oregon has facilitated better quality care and improved patient outcomes, particularly focused on the state's over a million Medicaid members.

Additionally, OHA has partnered with Collective to support patients in several programs, such as Dual Eligible Special Needs Plans. The Collective platform is used by providers caring for dual-eligible patients to hold virtual "stand ups"—in which primary care and behavioral health providers, hospitals, and health plans discuss patient follow-ups, and update care guidelines following patient admissions or in advance of discharges or transfers.

This collaboration supports OHA and Medicaid providers in achieving quality metrics and Medicaid Incentive Measures, such as the ED Disparity measure and the Transitions of Care measure.

Oregon Outcomes

Sharing patient information across the care continuum, and ensuring that providers have access to the insights they need to make more informed care decisions, has helped decrease potentially unnecessary ED utilization in Oregon. Through collaboration managed by HIT Commons, potentially avoidable **ED visits from patients with patterns of high utilization decreased 10.9 percent** from 2017 to 2019.[6]

Care collaboration has also led to faster patient follow-up after discharge. One organization, which historically had difficulty getting timely notifications when mental health clients were discharged from the hospital, was able to successfully implement a workflow that resulted in **almost all of its patients receiving follow-up care within seven days of discharge**.[7]

Massachusetts

Medicaid is the single largest payer for mental health services in the US.[8] In Massachusetts, the Medicaid system—known as MassHealth—provides care for 25 percent of the state at a cost of over 40 percent of the state budget. With many of these Medicaid patients requiring significant mental, behavioral, and physical health care, roughly 5 percent of the state's patient population accounts for 50 percent of the entire MassHealth budget.

Massachusetts-based Aspire Health Alliance focuses on the importance of behavioral health integration and the role technology plays as part of a Medicaid accountable care organization (ACO) program delivered by MassHealth—the Massachusetts Medicaid healthcare system—which provides care for a quarter of the state's population.

Aspire partnered with Spectrum Health Systems to form the South Shore Community Partnership, using Collective's platform to successfully implement the Behavioral Health Community Partner (BHCP) program. This partnership and program cares for MassHealth beneficiaries—many of whom don't have accurate contact information, making it difficult to provide necessary support.

Using the Collective platform has helped case managers identify and track patients, enabling them to reach out in moments of crisis. Deborah Jean Parsons, Ph.D., Director of Integrated Care at Aspire Health Alliance explains:

"Aspire participates in MassHealth, our state's Medicaid system, and we were under some pressure to improve patient outcomes and to reduce our overall costs as part of MassHealth's plan to streamline patient care. Real-time notifications are so important to help you find and engage with all of your patients—even those with social determinants of health like transient populations or the homeless."

Massachusetts Outcomes

Armed with real-time information, Aspire case managers have been able to successfully track at-risk patients and schedule necessary follow-up appointments, ultimately contributing to a **150 percent increase in patient engagement** within the BHCP program.[9]

Virginia

In 2017, the General Assembly established the Emergency Department Care Coordination (EDCC) program through the Virginia Department of Health (VDH) to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to faciliitate real-time communications and collaboration among healthcare providers for the purpose of improving the quality of patient care services. VDH contracts with Virginia Health Information (VHI) to administer the program and Collective was chosen as the technology partner to support this program.

Through a phased approach, all Virginia hospital emergency departments and Medicaid Managed Care Organizations (MCOs) onboarded to the Collwective network in 2018, followed by Commercial and Medicare payers in 2019. ACOs, downstream, and post-acute providers have also been onboarding through the EDCC program.

After onboarding, Virginia MCOs quickly began using specific criteria to help identify at-risk patients and those who qualify for community resources and programs. For example, the "Healthy Heartbeats" program provides additional case management and assistance for new and high-risk mothers.

Another initiative provides much-needed support for patients with behavioral health conditions or substance use disorders (BH/SUD). Within 48 hours of an acute encounter, patients are called and referred to a local BH/SUD provider to decrease the likelihood of another acute episode or opioid overdose.

Another example includes enrolling members in chronic case management programs after a new diagnosis, such as diabetes, and automatically authorizing a glucometer kit at no additional cost to help the member manage their condition. Real-time encounter and collaboration technology allows payers to intervene before a hospital admission or readmission is needed.

Virginia Outcomes

With updated demographic information and real-time notifications, member engagement improved across all MCOs. For UnitedHealthcare of Virginia, Medicaid member **engagement rates increased from 30 percent to 70 percent.**

New Mexico

Nationwide, one in eight emergency department visits involves mental illness, behavioral health, or substance use disorder.[10] However, one third of ED visits for New Mexico Medicaid members were related to behavioral health and/or substance use disorder.

Blue Cross and Blue Shield of New Mexico started its peer support program in 2017 to stop the cycle of members being discharged without adequate plans or referrals for follow-up care—which would soon lead to another crisis and another ED visit. With 20 recovery support specialists statewide and Collective's real-time notifications, Blue Cross and Blue Shield of New Mexico has been able to track and support Medicaid members struggling with behavioral health conditions.

New Mexico Outcomes

By engaging members in moments of crisis, peer support specialists can help guide members towards long-term solutions. This support has led to a **70 percent decrease in ED visits** and a **50 percent decrease in 30-day readmission rates** among members participating in the program.[11]

California

In the US, one-fifth of healthcare spending is attributed to just one percent of patients.[12] And nearly half of all healthcare spending can be attributed to just five percent of patients. Collective has partnered with a number of key Medicaid—known as Medi-Cal in California—plans to support member population management, with a focus on high-risk individuals in the top 3 to 5 percent of population in terms of utilization under the Medi-Cal Health Homes initiative.

Key partnerships between Collective and Medi-Cal plans—including L.A. Care, San Francisco Health Plan, and Anthem Blue Cross—connect hospitals, health plans, and community-based care-management entities (CB-CMEs).

Collective's platform enables CB-CMEs to receive real-time notifications when eligible or enrolled members visit a hospital, and communicate key care plan information to hospitals—enabling frontline hospital providers to connect the patient back to the health home or to referral destinations, such as medical respite.

California Outcomes

According to a Collective Medical analysis of California patients, individuals with 10-20 visits in a year with care plan content in the Collective platform have **8 percent fewer ED visits** in the following year and have a shorter length of stay.

About Collective Medical

Collective Medical provides the nation's largest and most effective network for care collaboration. Our risk-adjusted event notification and care collaboration platform spans across all points of care—including emergency departments, hospitals, payers, behavioral and physical ambulatory, and post-acute settings. This technology integrates seamlessly with existing workflows and allows payers and providers to identify and support at-risk patients in real time—avoiding preventable admissions and utilization and providing better care.

Learn more at collectivemedical.com

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