

# Managing High Risk Medicaid Populations: Success in Texas

## CLIENT

Texas Health and Human Services Commission (HHSC).

## ISSUE

High risk Medicaid patients in Texas needed care management, better education on self-management techniques, access to locally available resources, and improved engagement from statewide Medicaid providers.

## SOLUTION

AxisPoint Health placed regionally-based care teams throughout Texas to provide one-on-one counseling, assessment, case management, and personal care planning, while coordinating with providers and community resources to support and educate Medicaid patients.

According to the Kaiser Family Foundation, half of Medicaid beneficiaries are enrolled in MCOs nationally. However, only 20% of Medicaid payment for services is made to MCOs. Disabled and elderly beneficiaries can be found mostly in fee-for-service (FFS) programs, and it is this group which accounts for the largest portion of Medicaid spending.<sup>1</sup>

Since 2004, the Texas Health and Human Services Commission (HHSC) and AxisPoint Health have partnered to provide disease management programs helping high cost, high risk Medicaid patients better manage their health. Through the programs, community-based care teams deliver one-on-one patient counseling, health assessments, and personalized care plans to help patients better self-manage their conditions.

This partnership has proven highly successful in generating significant financial savings for the State of Texas, while improving quality of care, engaging providers, delivering innovative solutions, and increasing patient and provider satisfaction.

## SIGNIFICANT FINANCIAL SAVINGS

As patients learned and applied self-management techniques, and were thus better able to control their chronic conditions, the financial savings increased in each successive year of the program. During the original 6 year contract, the Texas Medicaid Enhanced Care Program generated more than **\$95.8 million in total net savings**<sup>2</sup> (savings after fees paid) for the State of Texas, by improving care for over 168,000 patients with ischemic heart disease, diabetes, COPD, asthma, and heart failure.

After the original 6 year HHSC contract, the State put the program out for bid in 2009; AxisPoint Health won the contract again. Launched in 2011, the new program was renamed the Texas Medicaid Wellness Program and the primary focus shifted to wellness, enrolling those at risk of developing chronic conditions, as well as those who are currently at high risk with all conditions.

Because of the state's shift to managed care, the program now focuses primarily on the disabled pediatric population, and many in the population have a diagnosis of developmental disability, ADHD, asthma, depression, or bipolar disorder as their main condition.

In the most recent program year, the program has achieved a **3.95:1 ROI and a 16.77% net savings**<sup>2</sup>. Currently in Year 6, the program has generated **\$209 million in total net savings in the first 5 years**<sup>2</sup>. Enrollment has increased by 50% over the first year.

Among pediatric patients with asthma, from March 1, 2014 to February 28, 2015, AxisPoint Health's analysis of self reported metrics demonstrates a 66% increase in the number of patients with a written action plan; a 93% increase in the number of patients using a daily inhaled corticosteroid (controller medication); and a 12% increase in the number of patients who have filled a prescription for an inhaled short-acting beta 2-agonist (rescue medication).

### COMMUNITY-BASED TEAMS – “FEET ON THE STREET”

The program supports eligible patients with 24 regional care teams across the state, which include registered nurses, social workers, behavioral health workers and promotoras/community health workers. By design, these multidisciplinary care team members live in their patients' communities and

reflect the diversity of Texas. This strategy provides the benefit of patient access to regionally-based resources who help generate and work from personalized care plans, manage follow-up appointments, obtain equipment and medications, and arrange transportation to appointments. Using evidence-based clinical guidelines, these teams coordinate care with the patients' physicians and treatment teams to work collaboratively on patients' behalf.

Through this model, the program has achieved positive clinical outcomes for managed patients, including<sup>2</sup>:

- + 36% average relative improvement across 10 HEDIS and similar measures, including visit compliance, medication adherence, and influenza vaccinations
- + 14% reduction in ED visits and 53% reduction in inpatient admissions among pediatric patients with asthma
- + 31% decrease in inpatient admissions for short-term complications among diabetic patients

### IMPROVED CARE THROUGH INNOVATIVE SOLUTIONS

Over the life of the programs, several inventive pilots have been launched:

- + Beginning in February 2014, the Innovative Funds pilot program was launched, placing a dedicated RN in high volume clinics to assist with coordination of care for eligible patients.
- + A 2011 diabetes self-management training pilot identified patients with diabetes and provided targeted diabetes self-management training and nutritional counseling. Results showed positive trends in several areas, including increases in the the number of

HbA1c tests performed, improved self-care and glucose control among those receiving the educational training, and increases in flu vaccination rates.

- + A telemonitoring program for patients with diabetes on a prescribed plan of oral medication for blood sugar control was piloted from November 2009 to October 2010. Patients enrolled in the pilot program were given a glucometer connection device for tracking blood sugar monitoring information, and those results were recorded and shared with the patient's provider and program nurses. The pilot was a success in identifying best practices, including a streamlined enrollment process and appealing incentives.
- + A Six Sigma® pilot to reduce avoidable pneumonia inpatient admissions was tested from October 2007 to May 2008. Participating patients received a specialized mailing on the pneumococcal vaccine, with providers receiving literature on guidelines and indications for pneumococcal vaccination. Based on results measured by AxisPoint Health, this pilot resulted in a 23% decrease in inpatient admissions for pneumonia among participants, a 31% reduction in inpatient pneumonia spend, and a 9% reduction in pneumonia-related average length of stay.

## PROVIDER PARTNERSHIP & ENGAGEMENT

The programs strive to promote improved health outcomes by supporting and sustaining the provider-patient relationship and building connections between HHSC, providers, patients, and community resources. A focused Provider Outreach Plan informs providers of services available through the program, provides practice

support, and enables collaboration among providers and regional care teams. Provider outreach efforts conducted by locally-based staff can include onsite meetings, relationship building with professional associations and state agencies, and attending and exhibiting at major stakeholder medical conferences and meetings.

In the first year of the Wellness Program, the provider outreach team made 3,184 total visits to physicians, and has made **7,616 total provider visits** over the first 5 years of the program.

Another component of the program is a Program Advisory Board, consisting of physicians and members of numerous state professional associations. This team meets to exchange information, share program performance results, and gather feedback regarding program initiatives and outcomes. Across the state, the Wellness Program supports provider education and clinic transformation to Patient Centered Medical Homes (PCMHs), and our Practice Support Facilitators coach providers through PCMH standards for NCQA recognition.

## PATIENT & PROVIDER SATISFACTION

In a recent third-party survey of 131 providers familiar with the program, **82% agreed that the program helps patients take better care of themselves**, 88% would recommend that eligible patients participate in the program, and 84% reported strong overall satisfaction with the program.

Another third-party survey of 4,448 participating program enrollees conducted in 2015 found that 96% expressed satisfaction with the program and **95% reported that the program has been helpful in the management of their condition.**

“ *This program really opened up lines of communication for me. The nurses pushed me to see the right doctors, get the best meds for my condition and learn more about little [health] signs that tell me I need to get help before things turn bad. The education alone has made it all worthwhile.*”

— TEXAS MEDICAID ENHANCED CARE PROGRAM PARTICIPANT

## OUTSTANDING COLLABORATIVE CARE AWARD

In September 2011, HHSC and AxisPoint Health received the Outstanding Collaborative Care Award from the Care Continuum Alliance (now the Population Health Alliance) for “demonstrating the powerful, positive effects a well-designed, evidence-based chronic care program can have on the health of a population.” Recognition of this magnitude is a testament to the impact that an innovative and focused care management program can make.



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<sup>1</sup>Kaiser Family Foundation. Medicaid Managed Care: Key Data, Trends, and Issues; February 2012

<sup>2</sup>Calculated on HHSC's behalf by third party actuarial contractor, Mercer Government Human Services Consulting