Medicaid Strategies: Data Sharing

Sarah Gallagher, Director of Strategic Initiatives
Why do we want to share data to target frequent users?

Types of data driven targeting

Review of practical considerations in sharing data
- Data needed
- Data flow
- PHI
- Partnership tools
- The process of data sharing

Case Study in Data Sharing - Connecticut
Why Share Data to Target Frequent Users?

**Invisible Chronic Homelessness with High Costs**
- Subset of homeless individuals who cycle between multiple crisis systems and are systematically excluded from interventions that may benefit them.
- Poor outcomes for individuals... multiple arrests, risky behaviors, unmanaged chronic conditions
- High costs with little positive results

**Opportunity for Coordinated Service Delivery System**
- Population demands a more comprehensive intervention: targeted housing, enhanced outreach and engagement, intensive case management, and access to health care than is currently available
- Use data to identify and target cohort
- Builds integration with health care improving health access and outcomes while lowering costs

**Blue Print for Systems Change and Scaling**
- Develop a services financing model that benefits all systems
- Diversify funding for services and reinvest savings from health/CJ system into housing and/or housing based services
- Increase capacity of housing and health services interventions
Setting a path to ending and preventig cronic homelessness
Potential Partners in Data Sharing and Care Coordination
2 types of data driven targeting....

- **Match identified administrative data from HMIS and health system (Medicaid/hospital) to generate list of priority individuals**
  - Flag individuals in a system (HMIS, hospital) for referral
  - Partner with service providers, care coordinators, or outreach teams to find eligible members in the community (MOU needed)
  - Assertive outreach to engaged only those on the list who meet threshold criteria
  - Criteria can be adjusted based on local characteristics and need

- **Use de-identified administrative data to develop predictive algorithms**
  - Able to identify and engage high utilizers in multiple systems (hospitals) and make direct referrals to housing
  - In LA, the 10th Decile Triage tool is used in 14 hospital systems
## Basic Data Needed

<table>
<thead>
<tr>
<th>HMIS</th>
<th>Health System</th>
<th>Jail Data</th>
<th>Other Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dates in shelter</td>
<td>Utilization type and dates</td>
<td>Booking date</td>
<td>Mental health</td>
</tr>
<tr>
<td>Services used</td>
<td>Cost (if needed)</td>
<td>Release date</td>
<td>Substance use services</td>
</tr>
<tr>
<td>Location of last service</td>
<td>Location</td>
<td>Arresting/charging agency</td>
<td>Child welfare involvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit/bed type</td>
<td>Benefits access</td>
</tr>
</tbody>
</table>

*Source: CSH*
Questions to Ask in Your Community

- **Where is the best data in terms of quality?**

- **Are there existing “frequent user” analysis that you can work with?**
  - Top 100 longest shelter stayers
  - ER/hospital “frequent flyers”
  - Jail “superusers”

- **Where is the analytical capability?**
  - Staff who can receive data from other systems and conduct match and analysis
  - External researcher/organization (can cost $)
  - Government superstructure with data matching responsibility

- **Are there existing data sharing agreements?**
Data Sharing Flow for Matching

Least restrictive

Corrections data

HMIS/Shelter data

Health-Hospital/MCO

Mental health/ Substance use data

Most restrictive
Partnership Tools

- **Written Authorization – Beneficiary Level**
  - Special legally-sufficient authorization is needed from individuals before their PHI may be used or disclosed for any purpose not specifically permitted by HIPAA

- **Business Associate Agreements**
  - HIPAA “business associates” provide services, for or on behalf of covered entities, which involve HIPAA-protected information
  - Can allow use of data by the business associate agency

- **Memoranda of Understanding (MOU)**
  - The MOU is a renewable agreement that is entered into for a set period of time and formalizes and supports the partnership by outlining the key responsibilities and expectations of both partners.
  - It is also the operating document that explicitly sets the expectation for all of the partners related to data use, training, screening, patient, clinic, and population health interventions.
Case Study

Using cross systems data to drive housing and health care solutions for vulnerable populations in Connecticut
Preliminary Medicaid/HMIS Data Match

- Data set consisted of 8,132 clients from HMIS
- 4,193 adults were matched to State Medicaid data
1,340 adult Medicaid beneficiaries identified as homeless and accrued $20,000 annually:

- 51% > 31 days in shelter
- 32% > 61 days in shelter
- 78% had 3+ ED visits
- 49% had 6+ ED visits
- 52% had any chronic condition
- 47% had 3+ inpatient visits

1,340 Cohort accrued more than $67 million in annualized costs!
Cost and Service Usage for Homeless High Cost Utilizers in CT

- Acute Inpatient: 49%
- Drugs: 11%
- ED Visits: 10%
- SNF: 7%
- BH Outpatient: 5%
- Home Health: 4%
- OP Medical Services: 3%
- Med Transport: 3%
- State: 2%
- IP Behavioral Health: 2%
- Other: 2%
- Labs: 2%
- Dental: 1%

Cost of Homeless High Cost Utilizers in Connecticut:

- Acute Inpatient Services
- Behavioral Health Outpatient
- Home Health Services
- Acute Care Hospitalization
Who Are We Reaching through SIF?

~$76,000 Medicaid Benefits previous 12 months

- 77% are age 45 and over
- 80% Have any chronic condition
  - 60% Hypertension
  - 49% Diabetes
  - 35% Asthma
- 67% have 2 or more CHC
- 83% Major Mental Health Diagnosis
- 65% Alcohol Use
- 88% Drug Use
- Concurrent involvement in the criminal justice system
  - 82% had at least one arrest
  - 45% had 6 or more arrests
  - 51% had 6 or more convictions
General health status questions indicates severe needs...

- 51% extremely bothered by medical problems in past month
- 38% experience medical problems daily in past month
- 26% report difficulty dressing or bathing

*SIF clients reported more negative general and mental health indicators than a national sample of homeless and non-homeless adults*

<table>
<thead>
<tr>
<th>Fair/poor self-rated health</th>
<th>Difficulty walking/climbing stairs - Activity restrictions in past month</th>
<th>Regular psych vists/any psych hospitalizations - Any treatment for mental health issues in past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>63</td>
<td>52</td>
<td>36</td>
</tr>
<tr>
<td>63</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>59</td>
<td>40</td>
<td>21</td>
</tr>
</tbody>
</table>
Limited access to successful care

- 31% report ED as main source of care
- 40% had difficulty finding a doctor
- 55% needed but unable to find a dentist

*SIF clients were more frequent utilizers of hospital services than a national sample of homeless and non-homeless adults*\(^1\)

<table>
<thead>
<tr>
<th>Category</th>
<th>31%</th>
<th>40%</th>
<th>55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER is usual source of care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any ER visits in past 12 months</td>
<td>31</td>
<td>59</td>
<td>41</td>
</tr>
<tr>
<td>4+ ER visits in past 12 months</td>
<td>21</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Any overnight hospitalizations in past 12 months</td>
<td>23</td>
<td>23</td>
<td>18</td>
</tr>
</tbody>
</table>
Seeing improved outcomes for tenants

- **Significant, observable impact on tenants outcomes, Emergency Department utilization and hospitalization**
  - Capacity to meet presenting needs (symptomatic health/mental health, active substance use, wound care, medication adherence, open warrants)
  - Immediate changes in types of services utilized (from crisis services to medications/outpatient) ... costs slower to decline
  - Overcoming modest barriers have had enormous consequences

*Scotty in LA reduced his annual number of hospital visits from 52 to 3 over a 12 month period once he was placed in supportive housing.*
The Blueprint

Data-Driven Problem-Solving
- Cross-system data match to identify frequent users
- Track implementation progress
- Measure outcomes/impact and cost-effectiveness

Policy and Systems Reform
- Convene interagency and multi-sector working group
- Troubleshoot barriers to housing placement and retention
- Enlist policymakers to bring FUSE to scale

Targeted Housing and Services
- Create supportive housing and develop assertive recruitment process
- Recruit and place clients into housing, and stabilize with services
- Expand model and house additional clients
### The Potential Impact of Supportive Housing on Medicaid

<table>
<thead>
<tr>
<th></th>
<th>Top 10%</th>
<th>Top 20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per person Medicaid costs for homeless, high-cost utilizers</td>
<td>$67,987</td>
<td>$47,796</td>
</tr>
<tr>
<td>Potential % Medicaid cost offsets from supportive housing</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Potential per person Medicaid cost reductions from supportive housing</td>
<td>$27,875</td>
<td>$19,596</td>
</tr>
<tr>
<td>Annual average per person cost of supportive housing</td>
<td>$19,500</td>
<td>$19,500</td>
</tr>
<tr>
<td>Potential annual per person savings</td>
<td>$8,374.67</td>
<td>$96.36</td>
</tr>
<tr>
<td><strong>Potential annual savings for 200 high utilizers</strong></td>
<td><strong>$1,674,934</strong></td>
<td><strong>$19,272</strong></td>
</tr>
</tbody>
</table>

% reductions needed to break-even with cost of supportive housing

- Top 10%: 28.7%
- Top 20%: 40.8%