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Accountable care act

# Risk sharing grows in the Medicaid space

By Jordan Bazinsky

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If implemented strategically, alternative care delivery models such as accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and integrated delivery networks can improve patient outcomes while reducing costs. Until now, these models have made the greatest inroads into commercial and Medicare populations, but increasingly, they're being employed within the Medicaid space.

While forming risk-based entities among Medicaid providers could be an effective way to better manage the care of low-income populations, the risk of unintended consequences cannot be ignored. A key hedge against these consequences is better use of patient data.

**Payment and delivery reform in the safety net**

One of the most important provisions of the Affordable Care Act has been the expansion of health coverage to low-income families through the Medicaid program. As a result, some 29 states, as well as the District of Columbia, have grown their Medicaid programs. Not surprisingly, alternative delivery models are beginning to penetrate the expanded Medicaid marketplace in the form of PCMHs, Medicaid health homes, and Medicaid ACOs.

Many patients seeking medical care from safety net providers have complex medical and social needs, low levels of health literacy, and priorities—like housing and food—that compete with taking care of their health. And because Medicaid populations often have heavy burdens of physical and mental illness, these alternative delivery models could have a dramatic impact on healthcare cost and quality.

Already, there are some notable examples of these experiments, including one of the first Medicaid ACOs in the country—the three-year-old Federally Qualified Health Center Urban Health Network (FUHN). FUHN is a coalition of 10 federally-qualified health centers operating at 40 sites across Minneapolis and St. Paul, Minnesota. Its adult patients have chronic disease burdens that are typical for a Medicaid population—with 26% suffering from a depressive condition, 17% with asthma, and 12% with diabetes.

**The opportunity for Medicaid ACOs**

Like other models of alternative care delivery, FUHN hopes to recoup savings and improve health through better coordination of services for a population whose healthcare has traditionally been very fragmented. Medicaid ACOs enable providers in different settings to share data to gain a more holistic view of patients. This enables them, for example, to counsel high utilizers of the emergency room on what constitutes a true emergency versus a better way to manage chronic disease. In its first two years of operations, FUHN reduced its costs by $9.4 million.

Medicaid ACOs also have a tremendous opportunity to deliver non-core, health-related services that are often not easily accessed by low-income patients, including transportation to doctor appointments, nutritious food, child care, translation services, and general case management assistance with things like housing and food stamps.

While some of these services are arguably outside the purview of a healthcare provider and issues of reimburse-

ment are best left to policymakers, there is a strong argument to be made that they could drive improved health outcomes while ultimately lowering costs.

**Concerns for safety net facilities in payment and delivery reform**

Safety net facilities already operate on slim margins, so is the ACO model too risky? While better care coordination should result in some cost savings, will those savings be enough to offset additional care management costs—like infrastructure and personnel—especially if the ACO takes on additional non-healthcare responsibilities? There is also the danger that Medicaid ACOs could become all things to all people, saddled with delivering a much broader range of services to an expanded population. Failing to scale, these experiments could end up undermining the care to medically needy populations.

And more broadly, with all the mergers and acquisitions occurring in the healthcare space, will Medicaid organizations, with their less attractive financials, be left behind by mergers? As they grow more slowly relative to other large provider organizations, they will be the ones with less clout to negotiate contracts with payers. That could work against them in the long run, as they won't have the resources to invest.

**Better data to the rescue**

Given these challenges, how can the healthcare system ensure that Medicaid populations reap the same benefits from ACOs and new delivery and payment models as their Medicare and commercial peers? There is no single answer. Things like higher reimbursements and greater parity for behavioral health needs, both issues for policymakers, are important pieces of the puzzle.

But one solution that the healthcare system itself could readily deliver on is better use of data. We need to tell a more nuanced story with data—one that describes the distinct needs of these patients and where their care is breaking down, both on the individual and the population level. On the individual level, robust data gives caregivers access to a 360 degree view of the patient experience and his or her encounters with the healthcare system, in order to target opportunities to improve outcomes and contain costs.

On a population level, good data can segment populations by risk to prioritize interventions, and also identify which high-cost—or future high-cost—patients have utilization patterns that are modifiable.

Better data and analytics has been the linchpin of the Federally Qualified Health Center Urban Health Network, according to FUHN board chair Jaeson Fournier, who is also the CEO of one of the member clinics. "We use data now to make decisions about where we should be focusing our efforts and one of our mantras is data is only useful if it's actionable," said Fournier.

ER utilization has been one actionable cost center identified through analytics. In the pre-FUHN days, caregivers would often not know their patients had been to the ER unless the patient mentioned it during an appointment, according to Fournier.

One homeless patient, they discovered, had been to the ER 78 times over the course of 12 months. "Armed with that insight, we could then focus our efforts on connecting with the patient to understand the reasons for the frequent ER use," explained Fournier. "Was it because it's a warm place where you can get a meal in the winter? We're reaching out to establish a stronger clinical relationship with her." FUHN's efforts have paid off: ER use has dropped by 18% in three years.

**Data feeds of the future**

The healthcare industry is still far behind other industries in using data to better serve its customers. But the day may come in the not-too-distant future when payers and providers use patient data such as diet, exercise regimens, life stressors—perhaps gleaned from sources such as patients' social media activities—to more precisely predict health risks and ways to mitigate them. These new data streams could be especially helpful for Medicaid ACOs.

Better data could also help identify barriers to care. For example, a geographic registry of patient cohorts, with the aid of analytics, could throw into sharp relief things like distances between patients and pharmacies, primary care practices, or grocery stores with fresh fruit and vegetables. These are factors that would affect compliance with demands, such as meeting yearly checkup recommendations and complying with outpatient treatment regimens.

These new types of data and analyses will not happen tomorrow. But in the meantime, in order for alternative delivery models to fulfill the promise of better quality, lower costs, and improved patient experience, they must be informed by the best data and analytics available today.

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