Accountable Care Communities

Department of Transportation

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Kevin Moore, UnitedHealthcare
John Cowley, Anthem
10/9/2018
NC Institute of Medicine

- Quasi-state agency chartered in 1983 by the NC General Assembly to:
  - Be concerned with the health of the people of North Carolina
  - Monitor and study health matters
  - Respond authoritatively when found advisable
  - Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions

*NCGS §90-470*
• 78 (4) – Accountable Care Communities: Connecting Communities and Health Care
  • Hennepin Health
  • Mission Health Partners
  • Roanoke Valley
  • Community Partnerships
  • Rural
  • Work Force
  • Business
Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

* 2012.
### Exhibit 9. Select Population Health Outcomes and Risk Factors

<table>
<thead>
<tr>
<th>Country</th>
<th>Life exp. at birth, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Infant mortality, per 1,000 live births, 2013&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Percent of pop. age 65+ with two or more chronic conditions, 2014&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Obesity rate (BMI&gt;30), 2013&lt;sup&gt;a,c&lt;/sup&gt;</th>
<th>Percent of pop. (age 15+) who are daily smokers, 2013&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Percent of pop. age 65+</th>
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<tbody>
<tr>
<td>Australia</td>
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<td>3.6</td>
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<tr>
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<td>4.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>56</td>
<td>25.8</td>
<td>14.9</td>
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<td>Denmark</td>
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<td>—</td>
<td>14.2</td>
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<td>—</td>
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<td>37</td>
<td>30.6</td>
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<tr>
<td>Norway</td>
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<td>43</td>
<td>10.0&lt;sup&gt;d&lt;/sup&gt;</td>
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<td>11.7</td>
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<tr>
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<td>44</td>
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<td>20.4&lt;sup&gt;d&lt;/sup&gt;</td>
<td>17.3</td>
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<td>17.1</td>
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<td>35.3&lt;sup&gt;d&lt;/sup&gt;</td>
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<td>14.1</td>
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<tr>
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<td>3.5</td>
<td>—</td>
<td>28.3&lt;sup&gt;e&lt;/sup&gt;</td>
<td>18.9</td>
<td>17.0</td>
</tr>
</tbody>
</table>

<sup>a</sup> Source: OECD Health Data 2015.
<sup>b</sup> Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
<sup>c</sup> DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
<sup>d</sup> 2012.  <sup>e</sup> 2011.
Exhibit 8. Health and Social Care Spending as a Percentage of GDP

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Care</th>
<th>Social Care</th>
</tr>
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<tbody>
<tr>
<td>FR</td>
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<td>19</td>
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<tr>
<td>SWE</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>SWIZ</td>
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<tr>
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<tr>
<td>NETH</td>
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</tr>
<tr>
<td>US</td>
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<td>16</td>
</tr>
<tr>
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<td>9</td>
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<tr>
<td>AUS</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>

Notes: GDP refers to gross domestic product.
Accountable Care Communities

- Accountable Care Communities include partnerships between health systems/providers and social/human service organizations.
- These partnerships work best when risk and reward are shared.
- An ACC encourages aligned investments to improve health such as housing for people with unstable CHF or food security for people with insulin dependent diabetes.
- We often think of an ACC as an opportunity to invest in social determinants of health.
Determinants of Health

Centers for Disease Control and Prevention:
https://www.cdc.gov/nchhstp/socialdeterminants/faq.html
Accountable Care Communities

- ACCs across the country have begun to address:
  - Food security
  - Housing
  - Transportation
  - Employment
  - Education
  - Child Care
  - Caregiving
  - Poverty
  - Health Equity
Hennepin Health

• Key levers of success
  • Shared electronic health record
  • Collaborative decision-making
  • Data and service integration
  • Measuring impact
  • Defining success in community health terms

• Transformed from FFS to VBP (total-cost of care)
• Aligned incentives
• Reinvestment of savings
• Flexibility in investments
Sample outcomes

- ED Diversion -9% ED, -45% inpatient
- **Housing initiative** -55% ED, -72% inpatient
- **Employment initiative** -60%
- Access clinic initiative -32%
- Chronic inebrietes diversion team -50%
- Withdrawal management -60% (projected)
Why transportation?

• Think about what you are doing right now in your community and with whom in the health space you have contracts.
• Publicly insured clients? Privately insured clients? Uninsured clients?
• Healthcare and ‘non-healthcare’?
• Acute, urgent, routine?
• Behavioral health?
Medicaid

• Most communities have contracts with transportation providers for routine follow up (24 hours notice is typical).

• Access to out of county services is often limited.

• Access to urgent transportation is often limited. Do you have 24 hours of notice when you are going to be sick? This leaves many people dependent on EMS services for sick transport---a far more expensive option---or they wait until they are sicker---can be costly and dangerous.

• Behavioral health crisis transportation is often limited to the Emergency Room.
What about ‘non-health’ services?

• Many activities important for health require transportation (supermarket, community center, gym, etc).

• Securing and maintaining employment also requires transportation. Ultimately this is one of the most important predictors of health. Requires a system and infrastructure approach---but has a big payoff for health.
Hertford County

• Transportation pilot to serve low income, rural population.
• Grant funded. Total cost $2650. Cost per transit $55.
• 33 clients enrolled.
• Broad variety of services (outpatient and hospital-based, substance use treatment, food access, prescription pick up, wellness center).
• 88% reduction in ED utilization. Improvements in chronic disease metrics.
Framing

• Kevin Moore and John Crowley, on the panel, are health insurance executives with UnitedHealthcare and Anthem—part of the BCBS family that helps manage Medicaid managed care.

• They both have extensive experience with Medicaid managed care in other states.

• With transition to managed imminent for NC Medicaid, we asked them to share their experience in addressing transportation needs in other states.

• After brief presentations, we will have a chance to ask them questions and they can pose questions to you.
For More Information on Accountable Care Communities

• Websites:  www.nciom.org
  www.ncmedicaljournal.com

• Key Contacts:
  • Adam Zolotor, MD, DrPH, President & CEO, NCIOM
    919-445-6150 or adam_zolotor@nciom.org
  • Berkeley Yorkery, MPP, Associate Director
    919-445-6155 or berkeley_yorkery@nciom.org
Non-Emergency Medical Transportation
What is it?

• The Medicaid NEMT benefit is authorized under the Social Security Act section 1902(a)(70) and 42 CFR section 440.170.

• Medicaid NEMT is transportation for eligible Medicaid beneficiaries to and from appointments and services for those who have a legitimate need for the services.

• Under 42 CFR 440.1701, “Travel expenses” include¹
  - The cost of transportation for the beneficiary by ambulance, taxicab, common carrier, or other appropriate means;
  - The cost of meals and lodging en route to and from medical care, and while receiving medical care; and
  - The cost of an attendant to accompany the beneficiary, if necessary, and the cost of the attendant's transportation, meals, lodging, and, if the attendant is not a member of the beneficiary's family, salary.

Non-Emergency Medical Transportation Delivery Models

• Fee-for-Service
  - North Carolina (current)

• Managed Care “Carve-In”
  - Virginia, Florida, North Carolina (future)

• Broker Model
  - Regional
    Michigan
  - Statewide
    Wisconsin

• Hybrid
  - Populations
NC Medicaid Transformation and Non-Emergency Medical Transportation

- The Prepaid Health Plan (PHP) shall provide non-emergency medical transportation (NEMT) services to ensure that Members\(^1\) have coordinated, timely, safe, clean, reliable, medically necessary transportation to and from North Carolina Medicaid and NC Health Choice-enrolled providers.
- The PHP shall furnish NEMT services in an amount, duration and scope no less than the amount, duration, and scope for the same services furnished to beneficiaries under the Medicaid Fee-for-Service program.
- The PHP shall provide non-emergency medical transportation (NEMT) services for all enrolled Members:
  - By the least expensive mode available and appropriate for the Member;
  - To the nearest appropriate medical providers; and
  - For a Medicaid-covered service, including services carved out of Medicaid Managed Care, provided by a NC-enrolled Medicaid provider.

\(^1\) NEMT is not a covered benefit for North Carolina Health Choice Members (unless added as a “value-added benefit” and Members in nursing homes (facility is responsible for patient transportation) [https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf](https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf)
Transportation-Health Care Connection
Member and Provider Focused...
Technology Powered
Thank you

Kevin Moore
Kevin.Moore@uhc.com
Transportation Solutions
TRANSPORTATION: INFLUENCE ON HEALTHCARE

3.6M
Americans forgo or delay care because of a transportation problem\(^1\)

$150 B
Cost to providers of missed appointments\(^2\)

$2.7B
Federal Government spends on non-emergency medical transportation (NEMT)\(^3\)

51%
Of parents who had missed appointments for their children identified transportation as the main barrier\(^4\)

38%
Members using Medicaid NEMT to access behavioral health services\(^5\)

68%
Disease risk driven by access to care and individual circumstances\(^6\)

Typically, our Medicaid states offer non emergent transportation (NET) to all members, with few exceptions. Generally, routine trips (No trip limits, but health plan approval for trips that exceed a certain distance) are covered under the “standard” NET benefit. These include:

- Transport to and from member’s home to covered Medicaid medical doctor appointments, urgent care, dialysis, lab, dental and vision services
- Transport to member’s home after discharge from Hospital or SNF
- Meals and lodging when allowed by state contract

Transportation methods include: Wheelchair vans, Ambulatory vehicles (including taxis where allowed by the state), Mileage reimbursement, Public transportation (bus passes, trains and in some instances commercial air), Volunteer drivers (in some cases), and Lyft (where allowed by the state)

In some states we offer a value-add benefit (VAB), such as gas cards and gift cards to allow members flexibility and in some markets other trip/ride types have been implemented, such as: Community events, DMV, Grocery stores, Health education programs, Lamaze or birthing classes, Pharmacy, Self-help meetings (AA meetings, NA meetings, Al Anon, Eating Disorder support groups, Grief Support Groups, Cancer/Disease Support Groups), and Wellness activities and events
WHAT IS OUR STRATEGY/PHILOSOPHY?

We are looking for a differentiated user experience and increased network efficiency

We need to be innovative in our solutions because our members expect the same service from us as consumers in the digital world

The healthcare transportation market is ripe for change due to the following:
  • Service level dissatisfaction which leads to complaints and grievances
  • Costs associated with missed appointments that lead to unmet health needs, delays in receiving appropriate care, inability to get preventive services, hospitalizations that could have been prevented
  • Lack of transparency regarding visibility into ride scheduling, vehicle matching, arrival times
Successful solutions will look and feel very different from what we see today

- On-demand ridesharing is growing more and more important as a ride option
- Focus on provider and consumer as users vs. states and call centers
- New technology will facilitate rapid scale replacement of manual processes
- New market opportunities accompany patient transport (e.g. products, unique messaging)

Proactively exploring novel solutions to address better transportation while ensuring regulatory compliance

- Collaborate with providers and community resources to help identify and manage high-risk individuals
- Partner with brokers (vendors) and transportation providers (TPs) to facilitate better access for our members who need travel support
- Pilot new models to enhance user experience and drive efficiency in transportation management