IAP Medicaid Innovation Accelerator Program

Medicaid Innovation Accelerator Program

Beneficiaries with Complex Care Needs and High Costs (BCN)

Effective Care Management Strategies for Medicaid Beneficiaries with Complex Care Needs and High Costs

IAP BCN National Dissemination Webinar

January 9, 2017
2:00 PM – 3:30 PM (ET)

Logistics for the Webinar

- All participant lines will be muted automatically during today's webinar
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in "full screen" mode
  - Please exit out of "full screen" mode to participate in polling questions
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Welcome

Karen LLanos

Poll #1

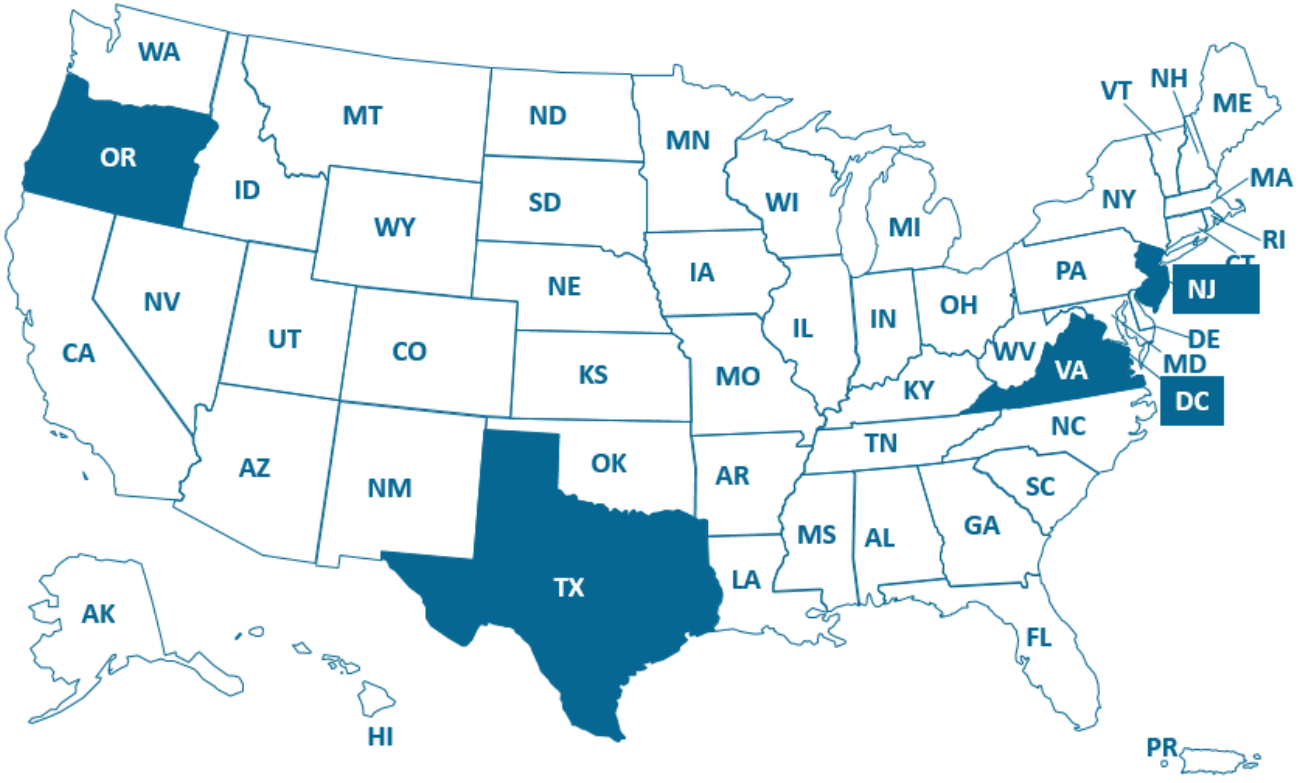
- Please select the type of organization you are representing.
  - State Medicaid Agency
  - State Agency other than Medicaid Agency
  - Managed Care Organization
  - Healthcare Provider
  - Consultant
  - Other

Welcome

- BCN track of IAP has worked with five states since Oct 2015 on issues such as:
  - Identification and stratification of Medicaid BCNs
  - **Effective care management strategies for Medicaid BCNs**
  - Factoring social determinants of health into strategies that impact Medicaid BCNs
  - Applying alternative payment strategies for Medicaid BCNs

IAP BCN Participating State Teams

- District of Columbia
- New Jersey
- Oregon
- Texas
- Virginia



IAP Medicaid Innovation Accelerator Program

Today's Agenda

- Overview: Care Management and Implications for Targeted BCN efforts
  - Lynn Dierker, BSN, RN, PCMH CCE, Health Management Associates
- Perspectives from the Field
  - Art Jones, MD, HMA, CMO Medical Home Network, former CEO Lawndale Christian Health Center
  - Tom Curtis, Director, MI SIM Project, Michigan Department of Community Health
- Reflections from an IAP BCN State
  - Leslie Clement, Director of Health Policy and Analytics, Oregon Health Authority
- Q&A
- Wrap Up and Closing Remarks

Overview: Care Management for Beneficiaries with Complex Care Needs and High Costs

Lynn Dierker

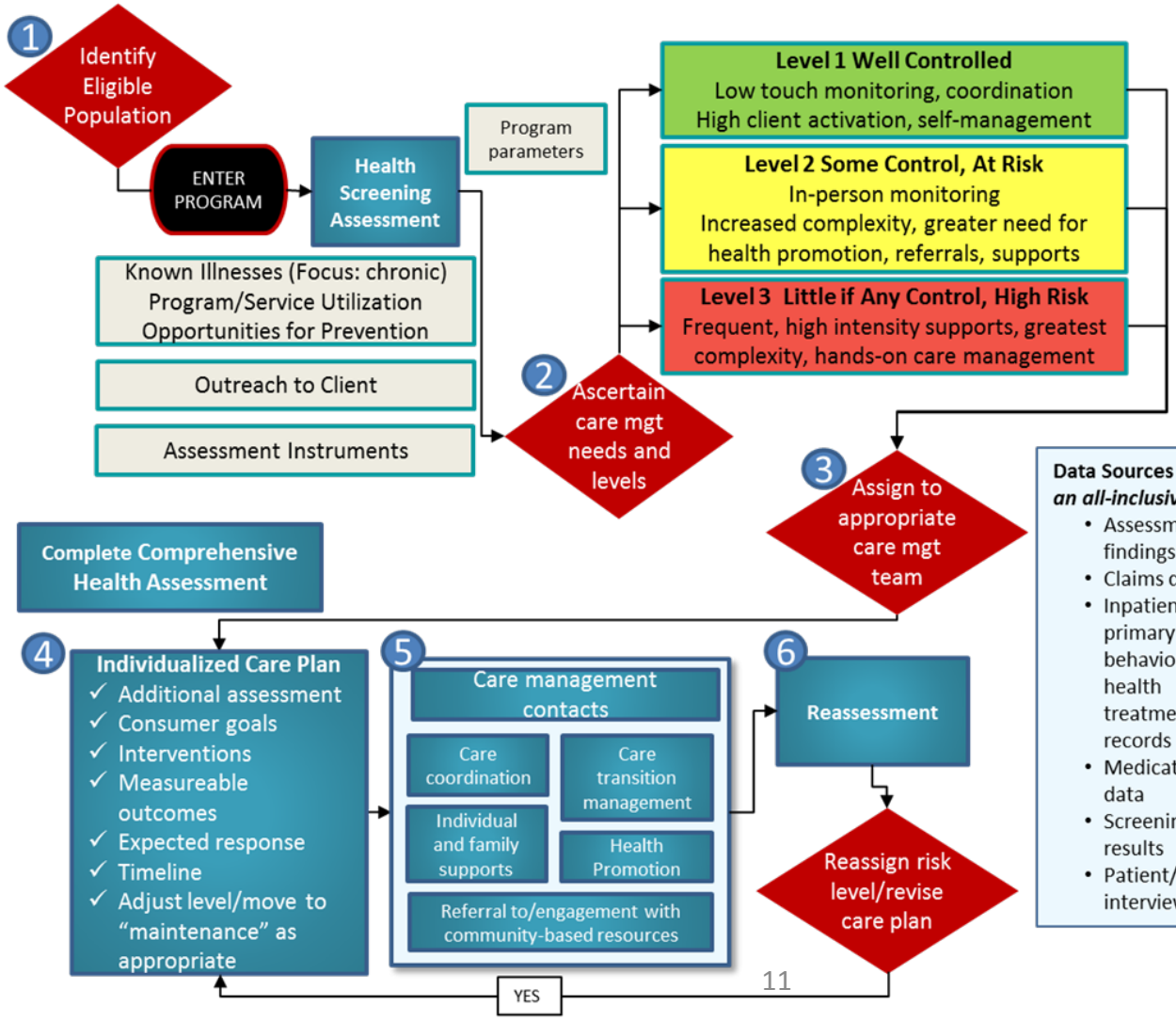
Review of the Evidence about Care Models: Attributes of Effective Care Management

- **Target patients** likely to benefit from the intervention;
- **Complete a comprehensive assessment** of the patient's health conditions, treatments, behaviors, risks, supports, resources, values, needs and preferences;
- **Use evidence-based care planning and monitoring** to meet the patient's health-related needs and preferences;
- Promote **patient and family active engagement** in self-care;
- **Encourage coordination and communication** among all the professionals engaged in a patient's care, especially to facilitate transitions from the hospital, referrals to community resources and appropriate care in accordance with patients' preferences.

Core PCMH Principles as Foundation for Primary Care/Care Management Programs

- **Data driven**
  - Profile relative health risks and needs of patient panel
  - Use registry to monitor key variables to assess progress and adjust care
  - Support shared, single care plan among primary/specialty care via Health IT
- **Establish and maintain individual provider-patient relationship**
  - Attribution or “assignment”
  - Support personalized care planning, care management, shared decision-making
- **Utilize team-based care model**
  - Designed roles for care management, care coordination
  - Multi-disciplinary identification of a team organized around the patient
- **Incorporate physical-behavioral health integration**
- **Focus on care coordination**

Comprehensive Care Management Illustrated



Risk Factors *not an all-inclusive list*

- Age
- Gender
- Presence of specific chronic illnesses and levels of control
  - Asthma
  - Diabetes
  - Respiratory disease
  - Cardiac disease
  - Sickle cell disease
  - Seizure
  - Neurological disease
- Developmental disability
- Serious mental illness
- Substance use disorder
- Utilization
  - # ER visits over period
  - # ER visits for a specific chronic illness/condition
  - # hospitalizations over period
  - # hospitalizations for a specific chronic illness/condition
- Payer/financial class
- Family income
- Homelessness
- Other social or environmental

Data Sources *not an all-inclusive list*

- Assessment findings
- Claims data
- Inpatient primary care, behavioral health treatment records
- Medication data
- Screening results
- Patient/family interviews

The Assessment

- Standardized instruments
- Motivational interviewing
- History and Physical

BCN Care Management Programs: Multi-level Profiling and Interventions Required

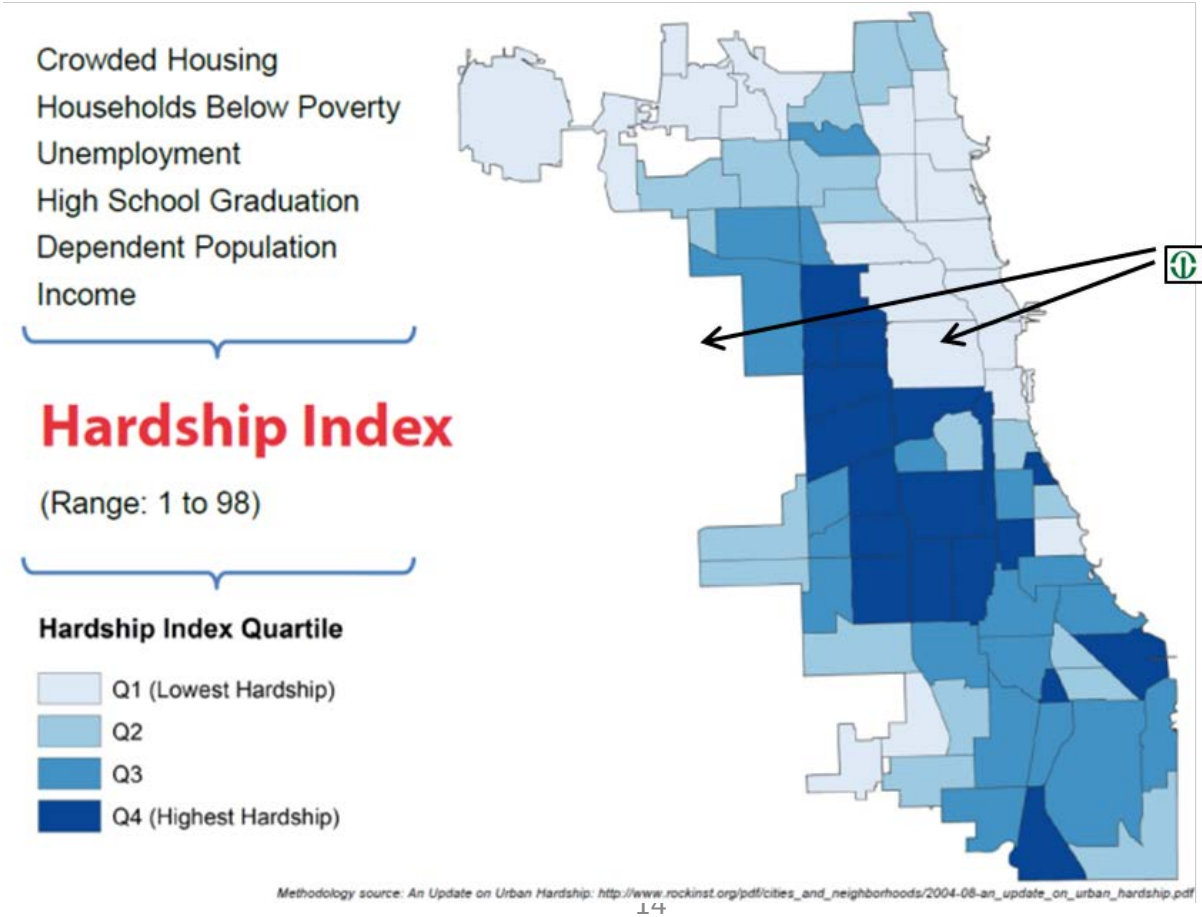
- Limits of only relying on initial targeting of BCN population based on costs/ED/Hospitalization
  - Case in point: Denver Health analysis of clinic-enrolled high risk population found selective enrollment of some patient profiles and not others (i.e., screening out young, homeless, alcoholic adults because they were not yet medically complex). (Johnson)
- Critical importance of provider level data analysis to design care pathways based on patient profiles
  - Case in point: Australian analysis of the sequence of primary care utilization before and after hospitalization illustrates importance of not just relying on primary care visits as interventions, but also considering the intensity and reorganization of services needed to address emerging risk (Comino).
- Fidelity to care planning processes i.e., prevalence and sequence of steps in care management progress, significantly impacts outcomes
  - Case in point: Reaching and getting patients to a primary care visit within 1 week of hospitalization is the biggest opportunity to prevent 30-day readmissions. However, just establishing care doesn't make a difference; active review of the care plan did (Everhart).

Care Management for BCN Populations: A Provider Perspective

Art Jones, MD

On the Ground Considerations for What Constitutes Primary Care Management

Community Areas Experience High Hardship



Local Realities: Safety Net Delivery System and Provider Affiliations

Medical Home Network

Partnerships Driving Transformation

MHN ACO Population

	Medicaid Members	ACO % of Total
ACA	24,347	30%
FHP	55,170	68%
SPD	1,589	2%
Total	81,106	100%

MHN ACO Providers

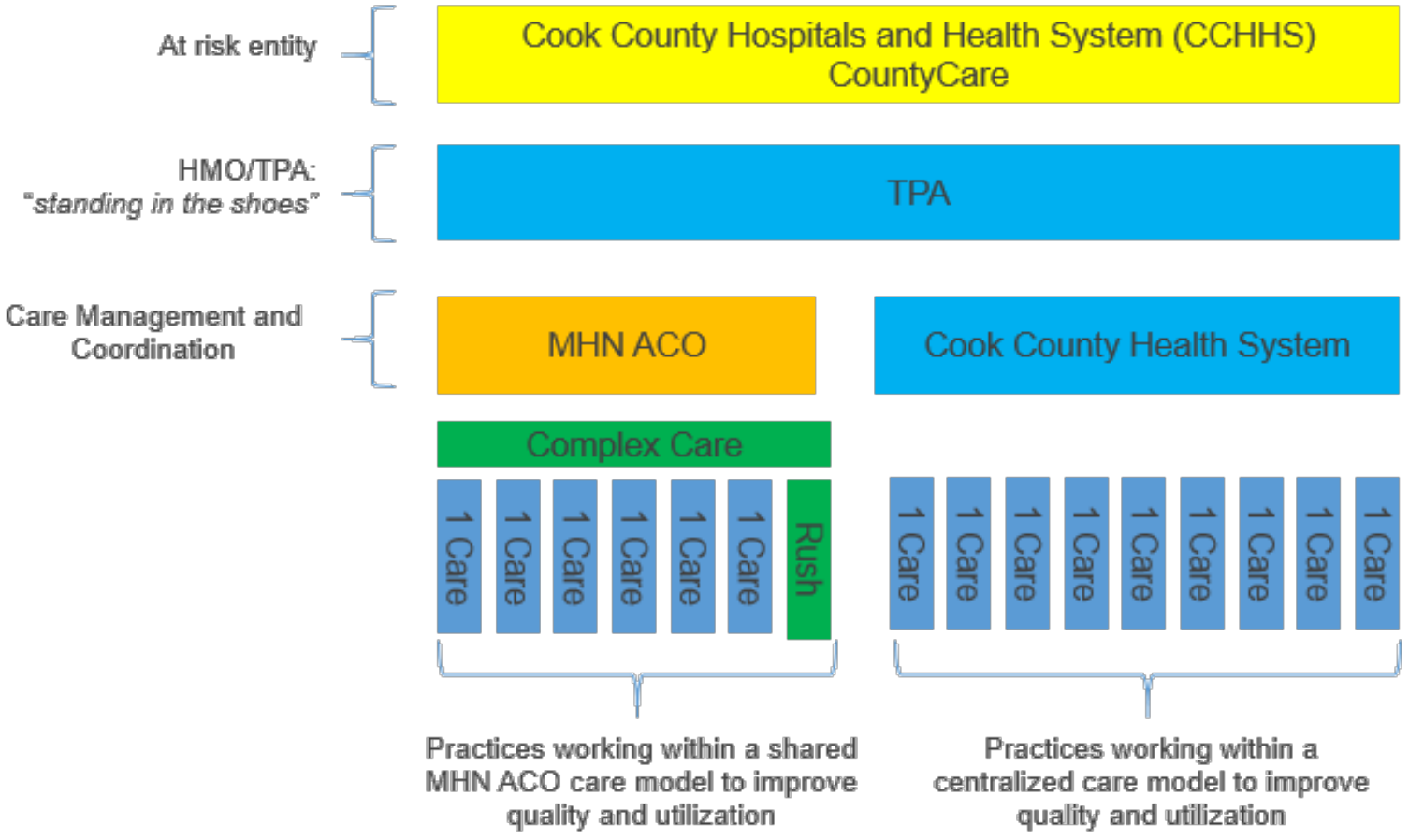
9 FQHCs
3 Hospital Systems

86 Medical Homes
375 PCPs
150 Care Managers
1,200 Specialists
5 Hospitals

MHN Geography

Taking into Account Complex Care Management Pathways

Centralized vs. Practice Level Care Management



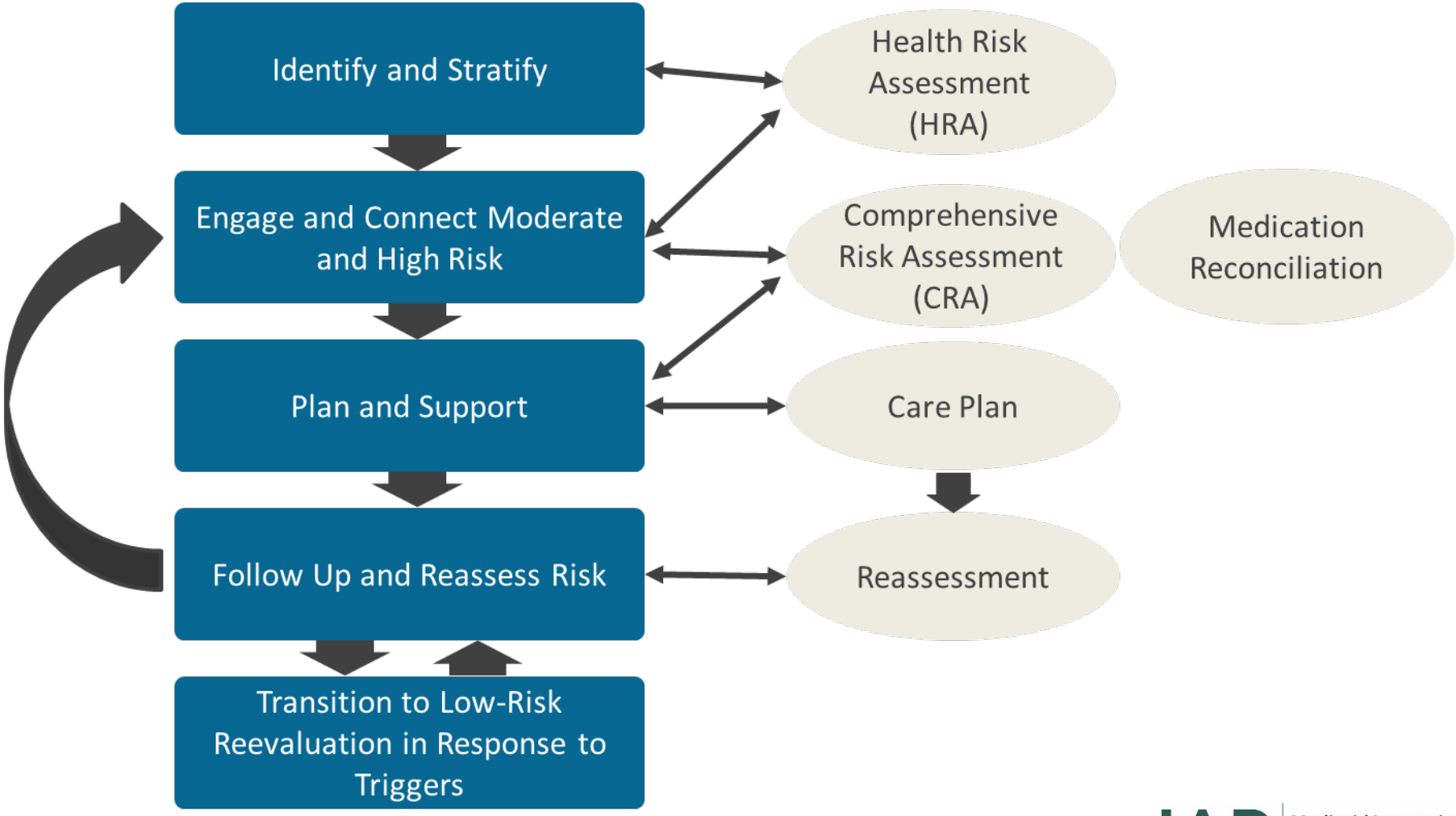
Provider Level CM Implementation Challenges

- Imbedding the care manager as part of the care team
- Create a common, structured approach to care management with tools, processes, staffing and sharing of care plans
- Create a model with a positive return on investment
- Improve on current risk stratification methodology by adding addressable barriers to treatment plan adherence to the usual claims-based diagnosis, utilization and cost factors
- Inform care management staff with real time information placed in historical context
- Follow task completion, lead and lag metrics aimed at improved utilization and cost across the full continuum of care

Implications for Working with Payer/Accountable Care Organization Context

- Payers depend on effective care management to handle financial risk; don't expect delegation without assuming some of the latter
- Delegate care management responsibilities based on strengths and competencies
- Meet NCQA and any state specific care management delegation requirements
- Agree to clear deliverables, metrics and targets
- Negotiate a value-based payment that recognizes upfront investment but is ultimately supported by savings from improved management of the full continuum of care
- Pursue multi-payer contracts with aligned expectations

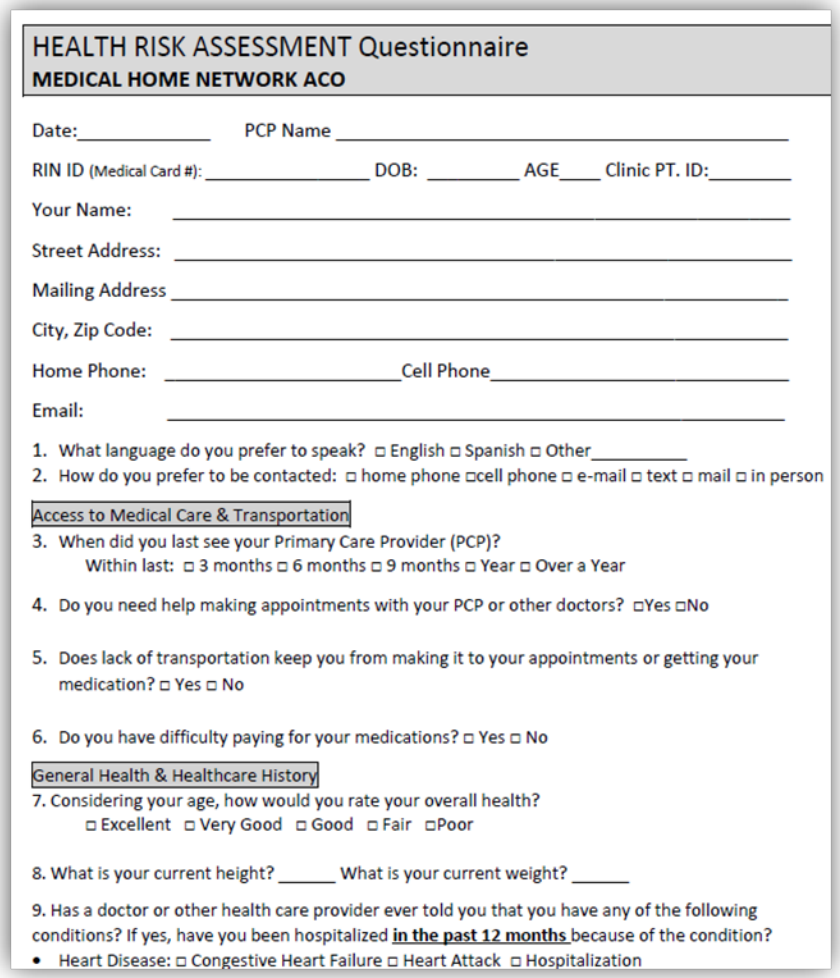
MHN Model of Care:
Driving Care Transformation via Risk-Focused Patient Management



Medical Home Network Care Management Tool - Health Risk Assessment

Topics Covered:

- Responses stratify patients into 3 risk categories
- 20 questions take 5-7 minutes to complete
- Adult & Pediatric HRA
- Addresses:
  - Hospitalization/Emergency Department usage
  - Barriers to care (transportation, $$ for meds)
  - Health risk factors: BMI, smoking, alcohol/drugs
  - Social Determinates of health: Housing/food/clothing
  - Depression



HEALTH RISK ASSESSMENT Questionnaire
MEDICAL HOME NETWORK ACO

Date:_____ PCP Name _____

RIN ID (Medical Card #): _____ DOB: _____ AGE____ Clinic PT. ID:_____

Your Name: _____

Street Address: _____

Mailing Address _____

City, Zip Code: _____

Home Phone: _____Cell Phone_____

Email: _____

1. What language do you prefer to speak? □ English □ Spanish □ Other_____
2. How do you prefer to be contacted: □ home phone □cell phone □ e-mail □ text □ mail □ in person

Access to Medical Care & Transportation

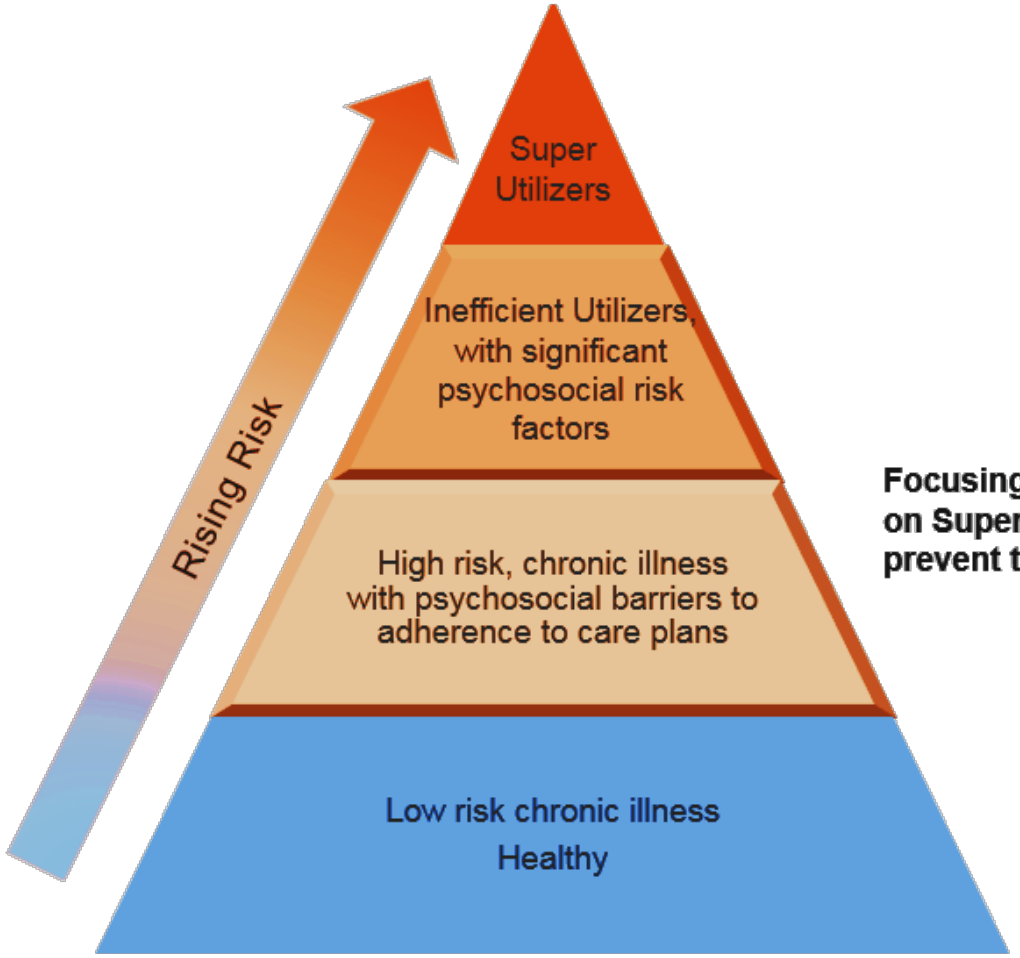
3. When did you last see your Primary Care Provider (PCP)?
   Within last: □ 3 months □ 6 months □ 9 months □ Year □ Over a Year
4. Do you need help making appointments with your PCP or other doctors? □Yes □No
5. Does lack of transportation keep you from making it to your appointments or getting your medication? □ Yes □ No
6. Do you have difficulty paying for your medications? □ Yes □ No

General Health & Healthcare History

7. Considering your age, how would you rate your overall health?
   □ Excellent □ Very Good □ Good □ Fair □Poor
8. What is your current height? _____ What is your current weight? _____
9. Has a doctor or other health care provider ever told you that you have any of the following conditions? If yes, have you been hospitalized **in the past 12 months** because of the condition?
   - Heart Disease: □ Congestive Heart Failure □ Heart Attack □ Hospitalization

Medical Home Network Model of Care

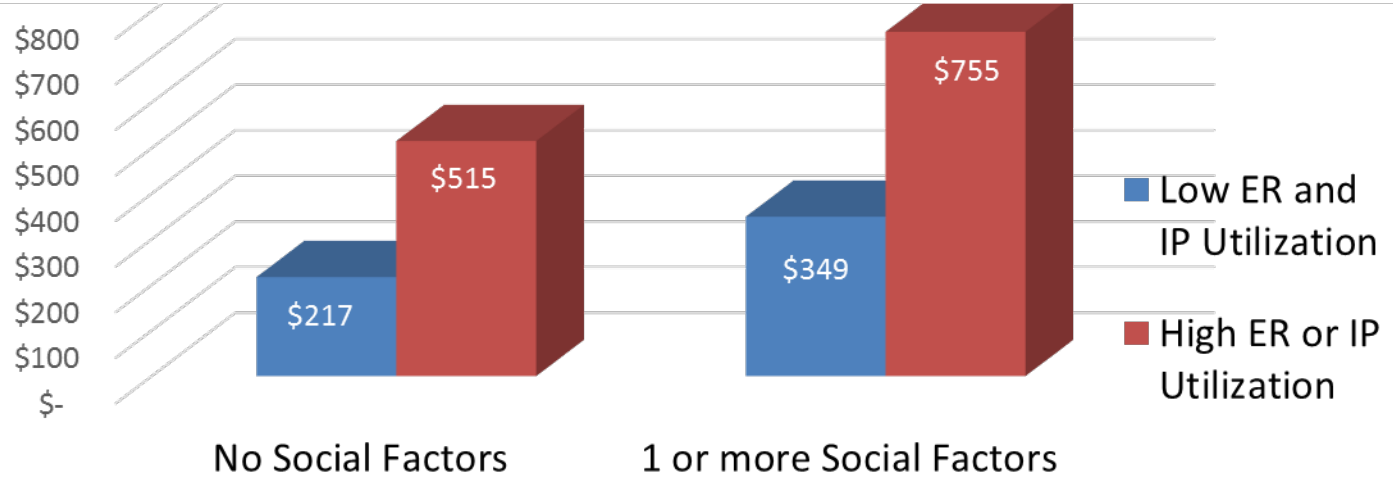
Addressing Rising Risk by Identifying Barriers to Patient Compliance



Focusing exclusively on Super Utilizers doesn't prevent them in the first place*

Predictive Value of Addressable Barriers to Compliance with Treatment Plans

PMPM Total Cost of Care for a Medicaid Expansion Population Subsequent 12 Months



- High ER utilization is defined as members who self-reported having 3 or more ER visits in the last 6 months, while low ER utilization is defined as members who denied having ER utilization at this level.
- High IP utilization is defined as members who self-reported either (a) having 1 or more hospitalizations for ambulatory-sensitive chronic conditions (e.g. heart failure, asthma, diabetes) OR (b) self- reported having 2 or more hospitalizations in past 12 months for any other condition. Low IP utilization is defined as members who denied having IP utilization at this level.

Medical Home Network Addressable Risk Prediction

Medicaid Expansion Population

PROSPECTIVE ANALYSIS FINDINGS

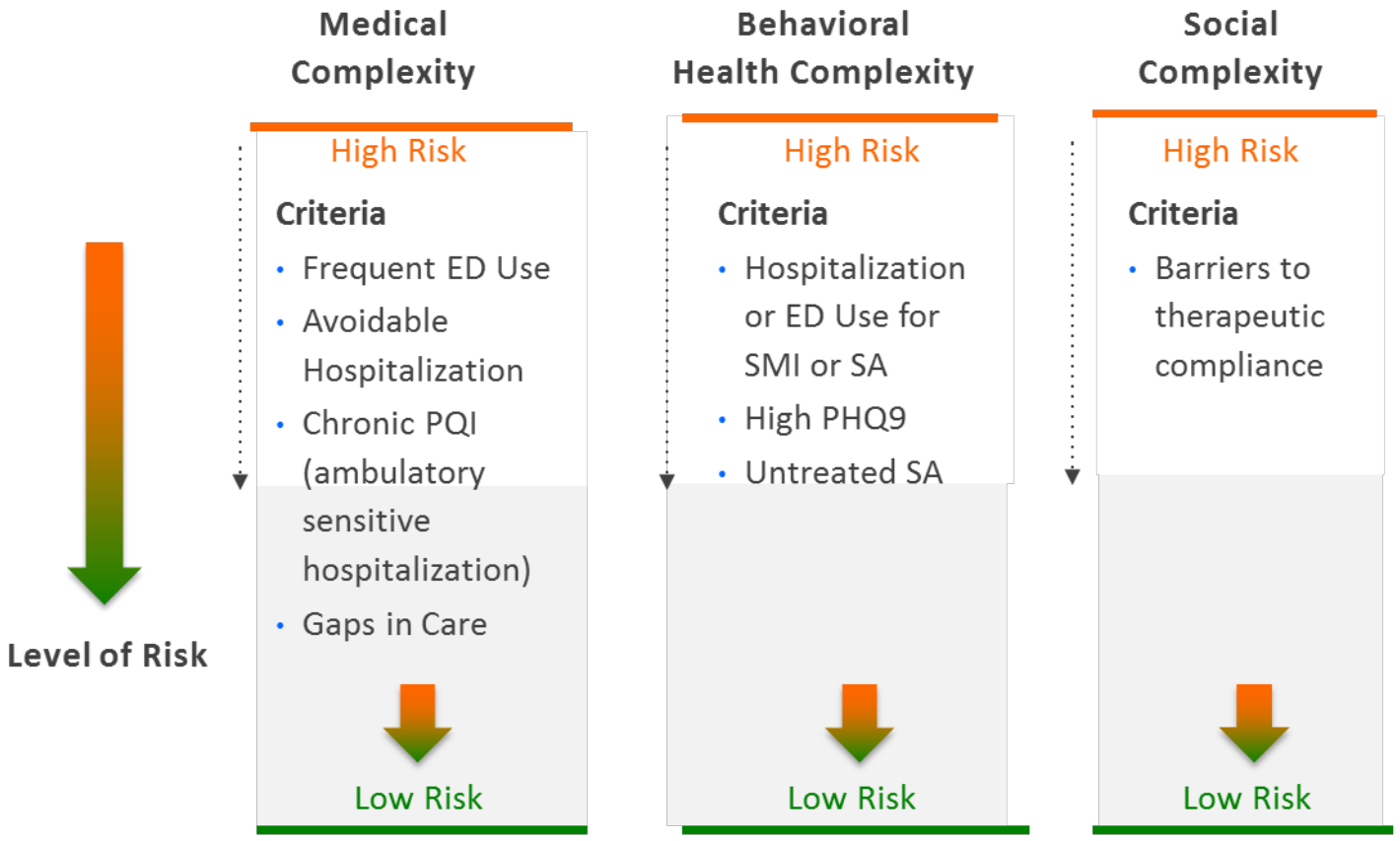
1. MHN's risk stratification algorithm accurately correlates with subsequent cost of care
2. Presence of addressable risk factors even in the absence of historical high inpatient or emergency room utilization increases subsequent hospital utilization and total cost of care.

HRA Risk Profile	Count	ER Visits /1000	Inpatient Admits /1000	Medical & RX Cost
Low by Utilization without any Addressable Risk Factors	1,606	---	---	---
Low by Addressable Risk Factors	4,181	↑	↑	↑
Medium by Addressable Risk Factors	663	↑↑	↑↑	↑↑
Medium by Utilization +/- Addressable Risk factors	320	↑↑↑	↑↑	↑↑
High by Addressable Risk Factors	127	↑↑	↑↑	↑↑
High by Utilization +/- Addressable Risk Factors	865	↑↑↑	↑↑↑	↑↑↑
Total	7,762	758	165	---

Source: MHNConnect & CountyCare Claims Data

MHN: Driving Effective Care Management

Judge effective care management by its ability to lower patient risk

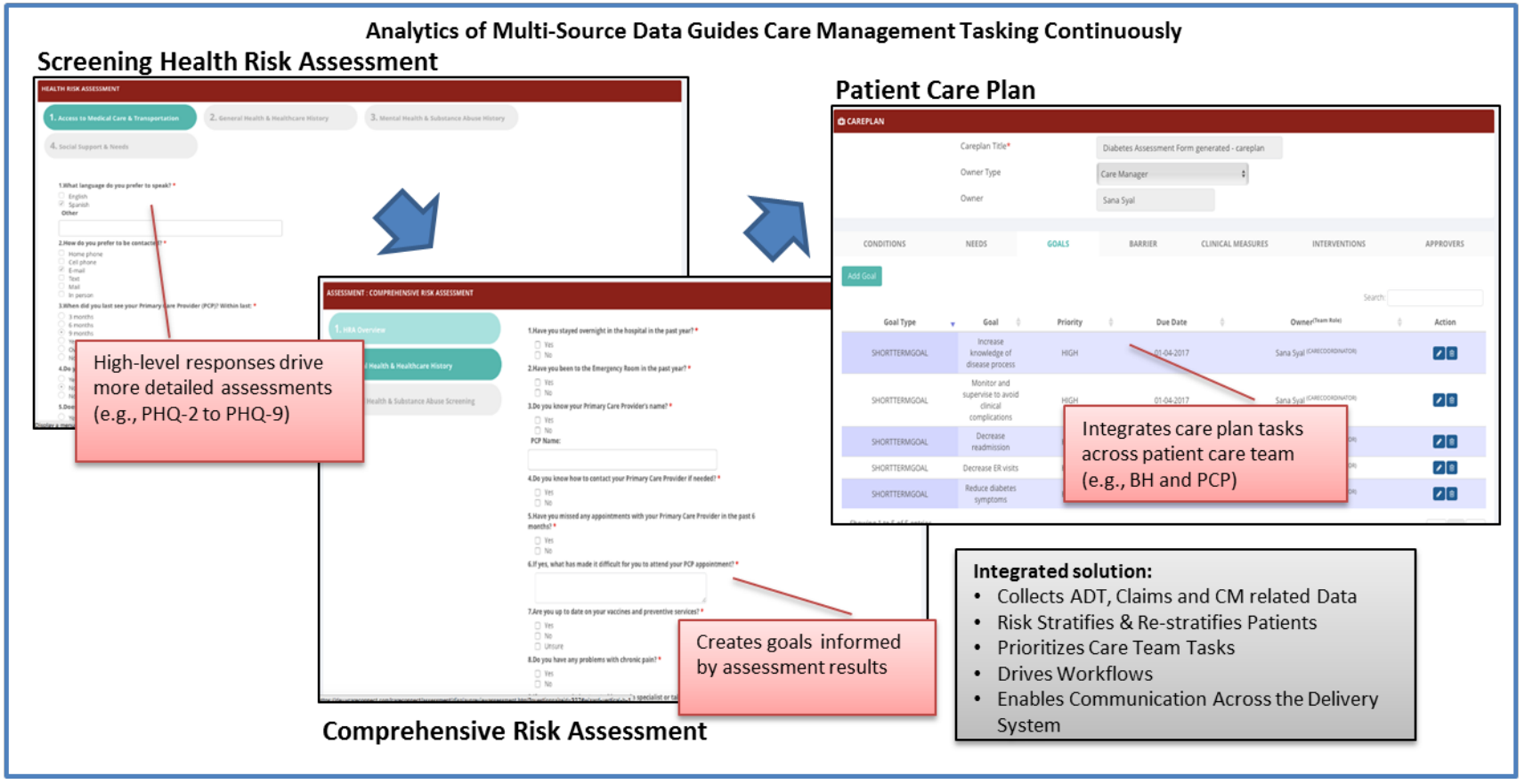


PQI = Prevention Quality Indicators

PHQ9 = Patient Health Questionnaire 9 (Depression Module)

Texture Health

Brings structure to Care Management Processes



Medical Home Network Clinical Integration Dashboard

MHN ACO- Current Members - Current Risk Level

Counts current member current risk level only

Ranking

ON PATH - goal achieved for reporting period.

OFF PATH - goal not met, but at or within 20% of goal

BELOW - performance is 20% or more below goal

Weekly Completion

What we are measuring.....	Completion Counts	ACO Average	Reported
HRA Count	1560	130	12/01/16-12/15/16
CRA Count	125	10	12/01/16-12/15/16
Care Plan Count	107	9	12/01/16-12/15/16

Care Management Process	*What we are measuring.....*	MHN ACO: Current Member Count	MHN ACO: Completion Count Over Time	MHN ACO: Rate Over Time	MHN ACO: Goal	MHN ACO: Ranking	Data Period Reported (Over Time)
Initial HRA Completion Rate	**All Products Combined**	66,669	54,288	81.4%	70%		7/1/14-12/22/16
	Timely Completion *(New members as of 10/1/16)*	660	376	57.0%	70%		10/1/16-11/30/16
Initial CRA Completion Rate	**All Products Combined**	5,336	3,481	65.2%			7/1/14-12/22/16
	High Intensity	2,140	1,484	69.3%	75%		7/1/14-12/22/16
	Medium Intensity	3,196	1,997	62.5%	50%		7/1/14-12/22/16
	ACA Members						
	High Intensity	1,045	749	71.7%	75%		7/1/14-12/22/16
	Medium Intensity	1,243	816	65.6%	50%		7/1/14-12/22/16

Addressing Social Determinants of Health as part of Comprehensive Care Management

A Community Centered Health Home Approach in North Lawndale

- The role of local churches
- Community health center
- Community Development Organization
- Legal assistance
- Housing rehab and affordable new housing
- After-school and summer programs for youth
- Pre-school
- Escaping street violence lifestyle
- Job training and employment opportunities
- Peer counselling and centering programs
- Gyms and fitness center
- Nutrition classes
- Healthy food options
- Police relations

27

Medical Home Network Medicaid Results

Impact on Cost, Outcomes & Engagement

Patient Engagement - ACO

MHN's engagement efforts reach over 2½ times as many patients as other IL Medicaid providers/plans.

MHN ACO: 79% COMPLETE

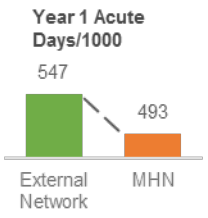
Period: July 1, 2014 – May 19, 2015

Total Cost of Care - ACO

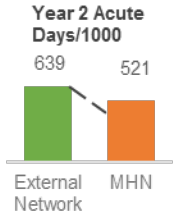
Contract Year 1	Contract Year 2 Q1
$17.7m	$6.6m
SAVINGS	SAVINGS
+12.1% variance from target	+18% variance from target

ACA Utilization - ACO

Inpatient Days/1000



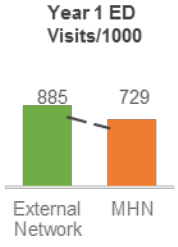
YEAR 1 Jul14–Jun15
10% BETTER OUTCOME



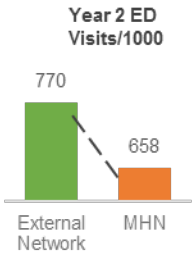
YEAR 2 Jul15– Mar16
18% BETTER OUTCOME

ACA Utilization - ACO

ED Visits/1000



YEAR 1 Jul14–Jun15
18% BETTER OUTCOME



YEAR 2 Jul15–Mar16
15% BETTER OUTCOME

Care Management for BCN Populations: Insights from Michigan

Tom Curtis

Michigan Agenda

- Michigan Medicaid Managed Care Contract
  - Physical/Behavioral Health Integration
  - Patient Centered Medical Home
  - Population Health Management
- Michigan State Innovation Model (SIM) Project
  - Structured community collaboration between health care partners across sectors
  - Address social determinants, population health management priorities
  - Model for care coordination

Care Management Policy Levers: Michigan's Medicaid Managed Care Contract

- Physical/Behavioral Health Integration via collaboration between Medical Services and Behavioral Health Administrations
  - Shared care management processes/protocols
    - Risk stratification
    - Care management standards
    - Document/track shared care plan
  - Shared care management metrics
    - Jointly develop and implement performance improvement projects
      - Shared metrics
      - Shared incentives

Physical/Behavioral Health Integration

- Medicaid managed care performance bonus
  - Implementation of Joint Care Management Processes
    - Managed care plans and Pre-paid Inpatient Hospital Plans (PIHPs) will demonstrate that joint care plans exist for members with appropriate severity/risk that have been identified as receiving services from both entities
    - Provide documentation of joint monthly care management meetings
  - Follow-up after hospitalization for Mental Illness within 30 days
    - MDHHS will define specifications for minimum standard and eligible population
    - Measurement period July 1, 2016 to June 30, 2017
    - Performance rate will be Medicaid health plan/PIHP combined

Care Management Policy Levers: Michigan's Medicaid Managed Care Contract

- Patient-Centered Medical Home
  - Report and expand model
  - Accept accreditations as designated by MDHHS
  - Participation in MDHHS-defined policies
    - Eligible provider types
    - Payment parameters
    - Care coordination measures
    - Care coordinator types

Patient Centered Medical Home

- Compliance review requirements to report number and percentage of enrollees receiving care from PCMH designated practices
  - Designation agnostic
  - State Innovation Model (SIM) defined PCMH program requirements in partnership with Managed care plans
- Contract requirement to coordinate health plan care management activities with care managers embedded in primary care practices

Community Integration Policy Levers: Michigan's Medicaid Managed Care Contract

- Population Health Management
  - Incorporate social determinants of health into interventions (Community Health Workers)
  - Begin developing partnerships with community-based organizations
  - Participate in State Innovation Model (SIM) Pilot efforts
    - Local, collaborative infrastructure
    - Clinical-community linkage partnerships
    - Data collection and decision-making

Community Integration: Medicaid Managed Care Performance Bonus

- Population Health Management
  - Submit and annually update multi-year plan to meet all Population Health Management contractual requirements
    - Incorporate social determinants of health data into analysis and intervention design
    - Address health disparities through services beyond telephonic and mail-based care management
  - Pursue community-based approaches to care coordination, health promotion, and disease management where applicable
- Community Health Workers (CHWs)
  - Contract defines CHWs, responsibilities, and education/training requirements
  - Contract defines minimum CHW ratio 1 FTE per 20,000 managed care enrollees
- Community Collaboration Project
  - Report participation in MDHHS-approved community-led project to improve population health in each service area
  - Describe activities, timelines, and updates relative to new initiatives

Community Integration: State Innovation Model (SIM) efforts

- Pilot local, multi-sector collaborative infrastructure to support Medicaid managed care plans in coordination to address social and behavioral health determinants
  - Governance to include providers, physician/hospital organizations, Medicaid managed care plans, and behavioral health entities
  - Requirement to implement clinical-community linkage partnerships to impact social/behavioral determinants of community-defined ED utilization issue

Community Integration: State Innovation Model (SIM) efforts (con't)

- Leveraging **Michigan Pathways to Better Health (MPBH) Demonstration**
  - CMMI Health Care Innovation Award (HCIA) project led by the Michigan Public Health Institute (MPHI) and Michigan Department of Health and Human Services (MDHHS)
- Piloted Pathways **Community Hub model**
  - Coordinated community care and leveraged data to inform collaborative decision making
  - Community Health Workers employed by designated Pathways organization
  - Used quality assurance/data collection tools called Pathways to address other determinants of health outcomes
- **Local variation/choices** determined targeted issues, business processes, and partnership roles/responsibilities

Community Integration: State Innovation Model (SIM) efforts (con't)

- Support Medicaid managed care plan adoption of new contract requirements
  - Consider partnerships with community-based community health workers as augmentation of plan-based CHWs and care management services
  - Collect social determinant of health data for incorporation into health plan intervention design and implementation
  - Identification of community-based partners for coordination, health promotion, and disease prevention/management
  - Participation in broad community collaboration project

Perspectives from a BCN State: Oregon's Experience and Commentary

Leslie Clement

Oregon's Coordinated Care Model

Care Management Strategies

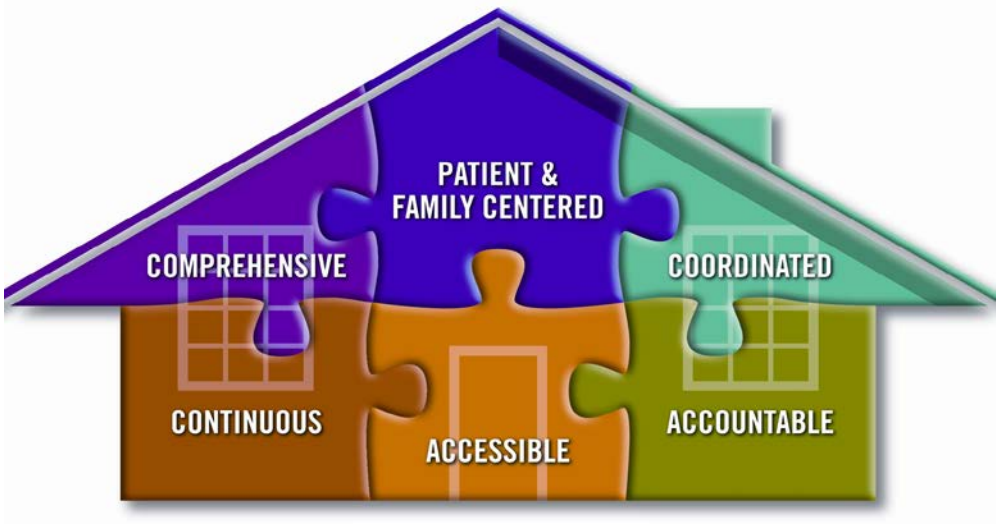
Patient Centered Primary Care Model (PCPCH)

State-based Levers to Encourage Effective Care Management Strategies

- **CCO Incentive Measures**
  - Annual assessment of CCO performance on 17 measures.
  - Quality pool paid to CCOs meeting performance goals.
- **EHR/HIE Development/Incentives**
  - EDIE (Emergency Dept. Information Exchange)
  - Clinical Metrics Registry
- **Public-Private initiatives**
  - Example: Multi-payer Primary Care Payment Reform Collaborative
    - Alignment on payment recommendations that promote care management

State-based Levers to Encourage Effective Care Management Strategies (Cont.)

- **Patient-centered Primary Care Home (PCPCH) Program**
- Certification program for Oregon's "medical homes"
  - Increases in: team-based care, culture of continuous improvement, patient-centered lens
  - Organizational culture shifts => care coordination, shared decision-making, use of data, population-based strategies



Primary Care Supports the Triple Aim

- OHA's PCPCH program:
  - ~$240M savings first three years
  - 4.2% reduction expenditures per person
  - 13:1 ROI
- National CMS Comprehensive Primary Care Initiative (CPCI)
  - 65 Oregon clinics saved $12.8 million in Medicare costs
  - All clinics met quality metric benchmarks, qualifying for shared savings payments totaling $1 million (2015)

CPC+: Advancing Care Delivery and Payment

Fee-for-Service Primary Care

- Focus on volume
- High-cost services
- In-person encounters
- Fragmented care
- Provider burnout
- Payer segregation
- Little attention to social determinants of health

Practice Transformation

- Actionable milestones to deliver high quality, whole-person, patient-centered care
- Effective use of health information technology (HIT) and data analytics
- Practice learning networks

Payment Redesign

- Non-visit based care management fees
- Regional shared savings opportunity

Comprehensive Primary Care

- Focus on efficient, high quality care
- High-value utilization
- Population-based care delivery
- Engaged patients, caregivers, and families
- Multi-payer support
- Coordination across the medical neighborhood and community services

Lessons Learned/Key Takeaways

- Set broad vision/goals at state level
- Allow for ownership/experimentation at local level
  - Foster local leadership (e.g., quality improvement training)
- Incorporate financial incentives
  - Incentive measures drive behavior change
- Seek payment alignment across the delivery system
  - Value-based payment alignment key

Questions?

Leslie M. Clement
Director of Health Policy & Analytics
Oregon Health Authority

Leslie.m.clement@state.or.us

Q & A: Discussion

Key Takeaways

- **States play a pivotal role to set standards and drive the uptake of effective care management models for BCN populations**
  - Various policy levers to advance health care transformation
  - Strategy alignment is key
- **Fidelity to evidence-based care models can be balanced with care management programs that accommodate local, regional and statewide health care landscapes and diverse populations**
  - Consider the characteristics of BCN sub-populations and provider/health system characteristics/capacity
- **Information and data analytics supports are critical at both state and provider levels in order to develop and support effective care management for BCN subpopulations**
  - State risk stratification/population health management for value based health care strategies
  - Provider risk stratification, registries and data driven care management

Closing Remarks

Karen LLanos

Closing Remarks

- National Dissemination Series continues:
  - February 27, 2017: Factoring Social Determinants into Strategies for BCNs
  - March 27, 2017: Employing Alternative Payment Strategies for BCNs
  - All sessions are scheduled for 2:00 p.m.-3:30 p.m. ET
- Please complete the post webinar evaluation