Pursuing Value in Medicaid

States Taking a Lead in Health Care Transformation

#ValueinMedicaid
@HCTTF @ModernMedicaid

Modern Medicaid ALLIANCE

HCTTF.org

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HEALTH CARE TRANSFORMATION TASK FORCE

Jeff Micklos
Executive Director,
Health Care Transformation Task Force

Established in 2014, the **Health Care Transformation Task Force** is a multi-sector industry consortium comprised of

Providers

Payers

Purchasers

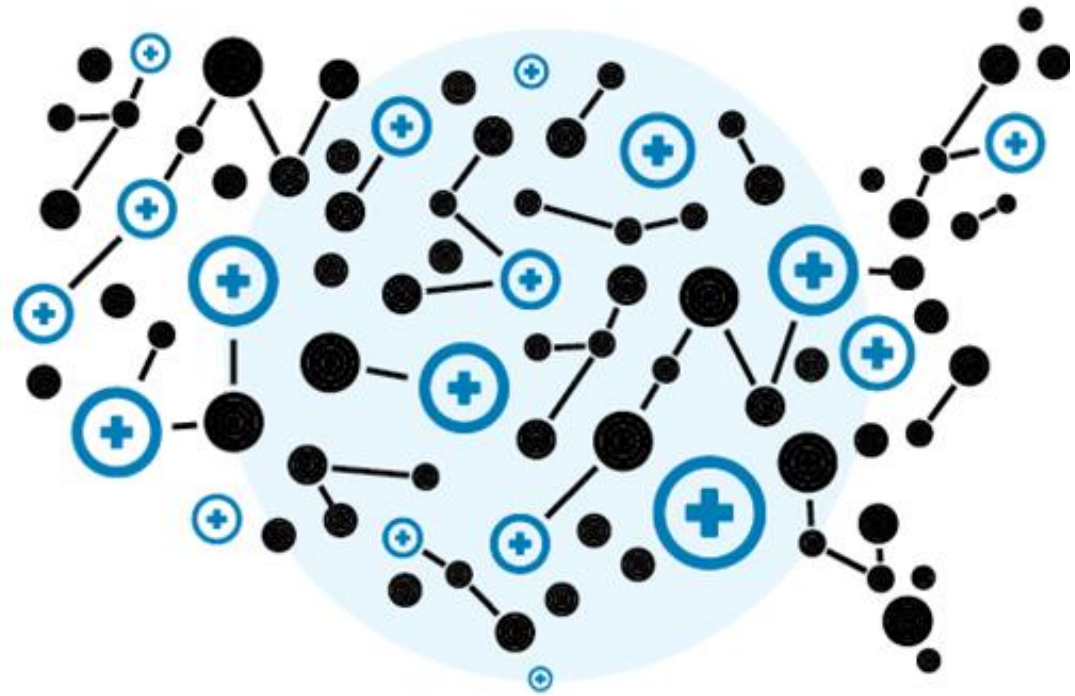
Patients

committed to advancing delivery system transformation.

Our members aspire to have 75% of their respective businesses operating under **value-based payment arrangements** by the end of 2020.

HCTTF Transformation Progress

Medicaid is a cornerstone of the American health care system. Since it began, it's helped improve the health and financial security of millions of Americans.



Medicaid Facts

Covers **over 76 million** low-income Americans, including those with disabilities, children, the elderly, and veterans.

- **Medicaid** was enacted as part of the same legislation that created Medicare.
- **Medicaid** is a joint federal-state program.
- States establish their own **Medicaid** eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines.
- **Medicaid** provides benefits not typically covered by other insurers, including long-term services and supports.
- **Medicaid** pays for Medicare premiums and cost sharing for more than 10 million people who are enrolled in both programs.

Alternative Payment Model Framework

SOURCE: Health Care Payment Learning and Action Network (2017): Alternative Payment Model (APM) Framework White Paper

APM MEASUREMENT EFFORT

Public and private health plans, managed Medicaid FFS states, and Medicare FFS voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN's goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

In **2017,**

34% of U.S. health care payments, representing approximately **226.3 million** Americans and **77%** of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:

COMMERCIAL

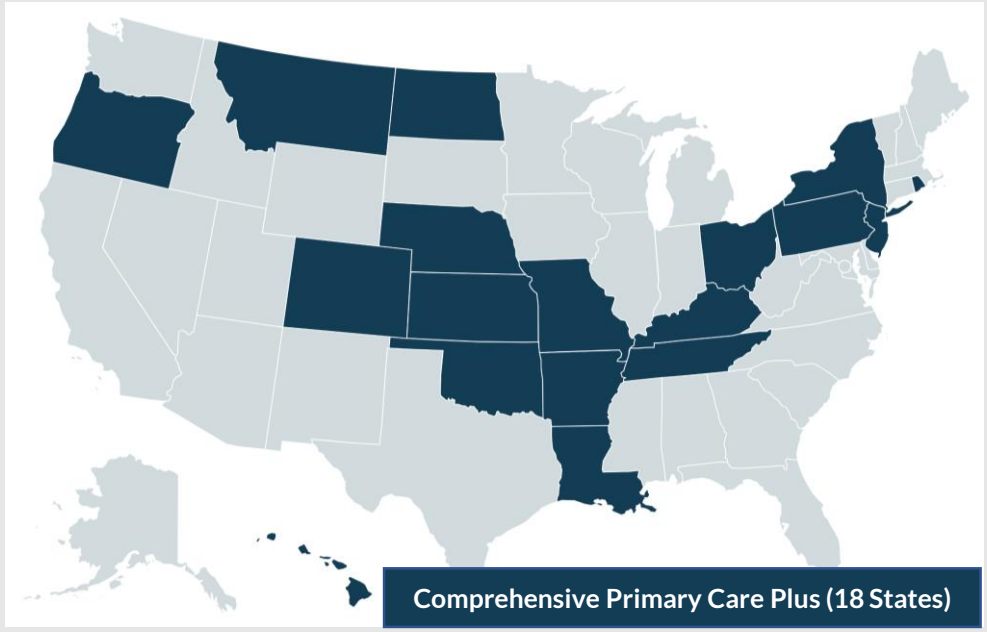
MEDICARE ADVANTAGE

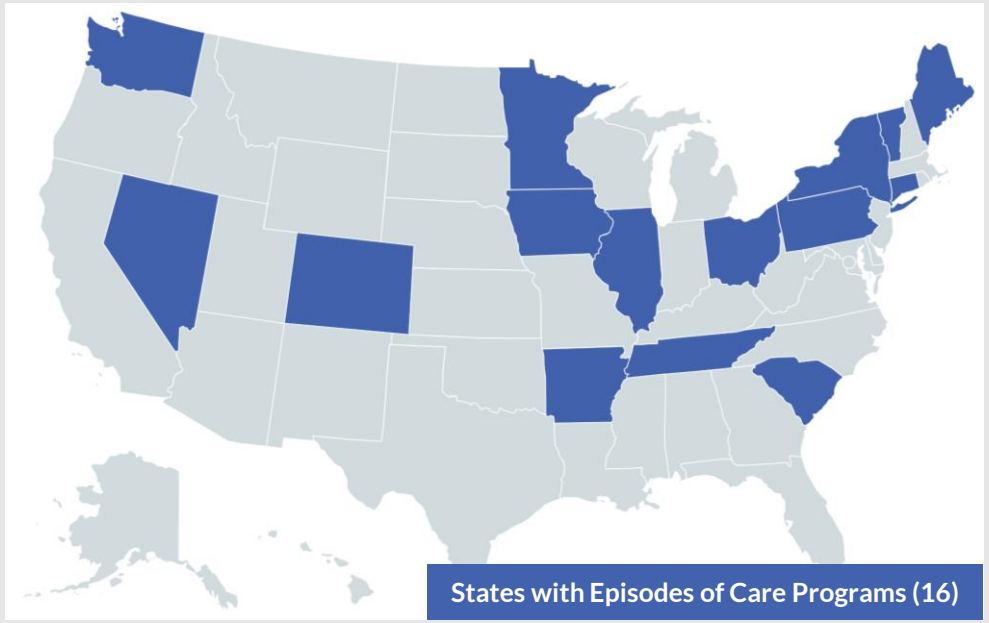
MEDICARE FFS

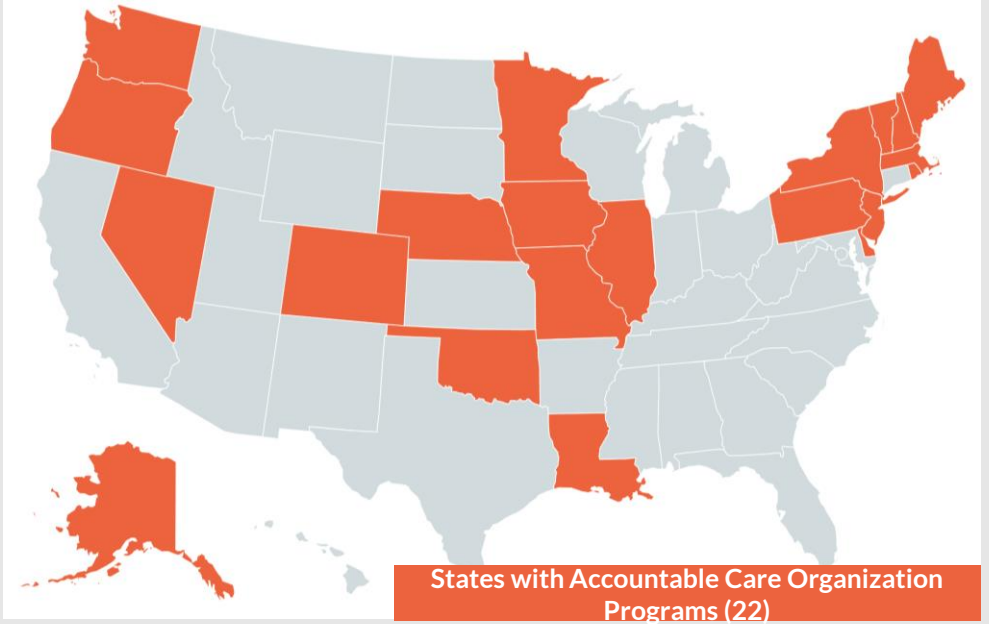
MEDICAID

Representativeness of covered lives:
Commercial - 63%
Medicare Advantage - 70%
Medicare FFS - 100%
Medicaid - 50%

HCP LAN
Health Care Payment Learning & Action Network







SOURCE: Change Healthcare (2019): *Value-Based Care in America: State-by-State*

Medicaid Innovation

1. **Should** create the opportunity for states to implement public policies supporting better health, better care, and lower costs
2. **Should** invest in delivery system innovations that emphasize care coordination and drive better health outcomes
3. **Should** advance cross-payer initiatives across Medicaid, Medicare, and private payers for greatest effectiveness
4. **Should not** create new barriers to coverage and care

Speakers

Sue Birch, MBA, BSN, RN
Director, Washington State Health Care Authority

Esther Kim, ScD
Program Director, Partners HealthCare

Kristen Mucitelli-Heath
Administrator, St. Joseph's Health (a Trinity Health member)

Ann Hwang, MD
Director, CCEHI

Sue Birch, MBA, BSN, RN

Director, Washington State Health Care Authority

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Esther Kim, ScD
Program Director,
Partners HealthCare

PARTNERS
HEALTHCARE

MassHealth ACO at Partners HealthCare

Esther Kim, ScD, Program Director

June 12, 2019

What is Partners HealthCare?

BWH

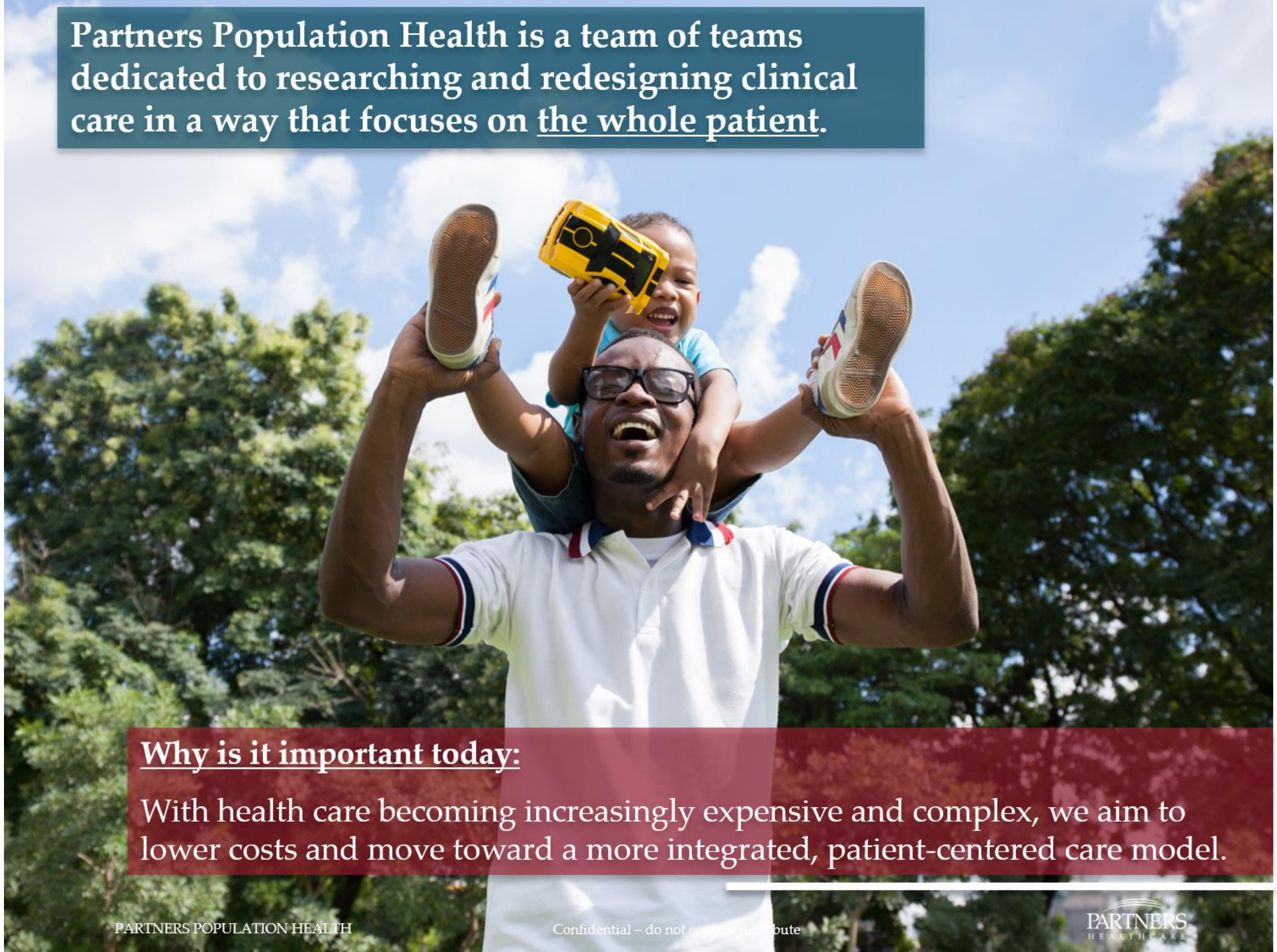
MGH

Partners HealthCare is an integrated health care system founded in 1994 by Brigham and Women's Hospital and Massachusetts General Hospital, teaching affiliates of Harvard Medical School.

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

In addition to its two academic medical centers, the Partners HealthCare System includes community and specialty hospitals, a managed care organization, community health centers, a physician network, home health and long-term care services, and other health-related entities.

Who We Are



Partners Population Health is a team of teams dedicated to researching and redesigning clinical care in a way that focuses on the whole patient.

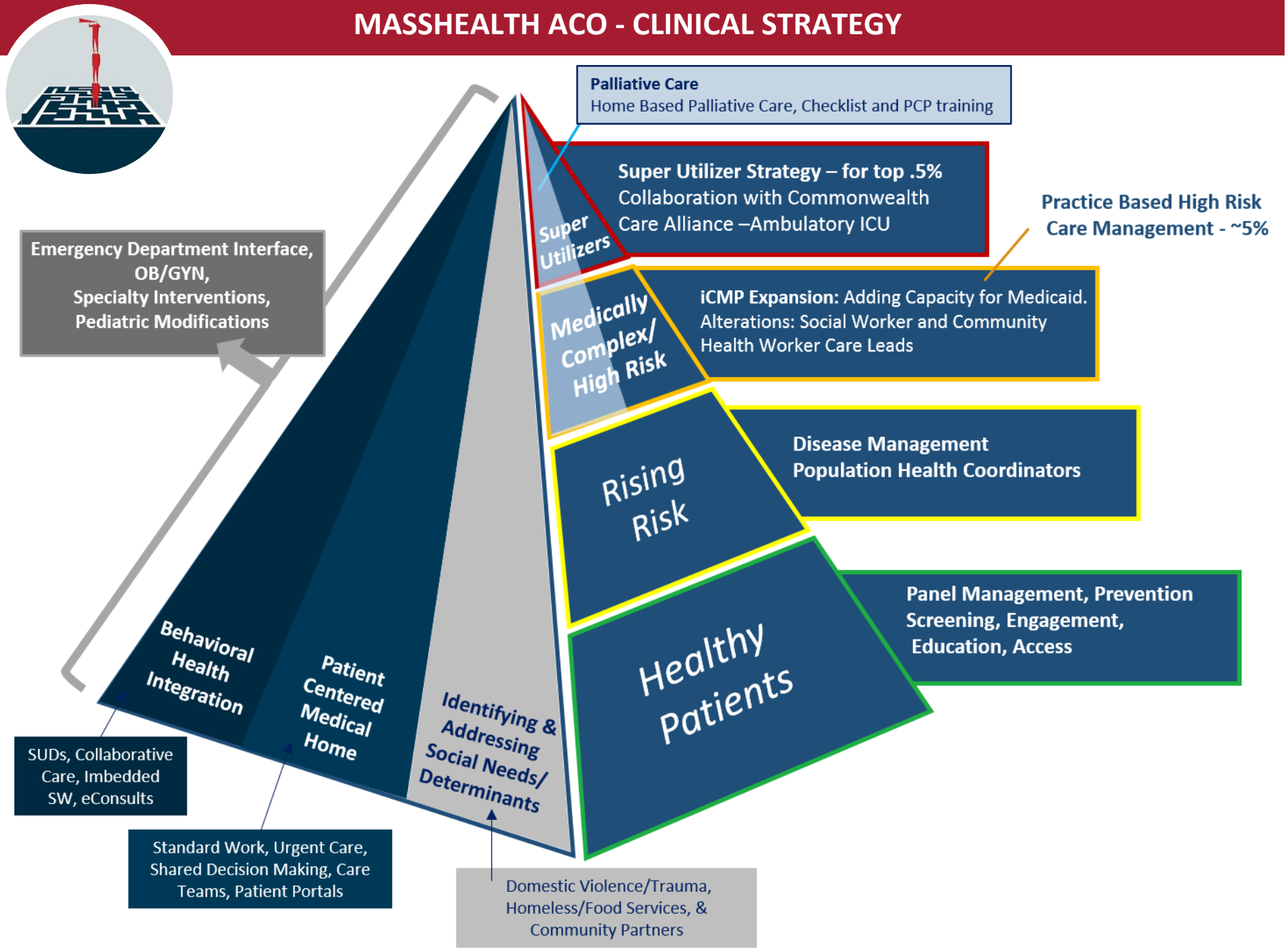
Why is it important today:

With health care becoming increasingly expensive and complex, we aim to lower costs and move toward a more integrated, patient-centered care model.

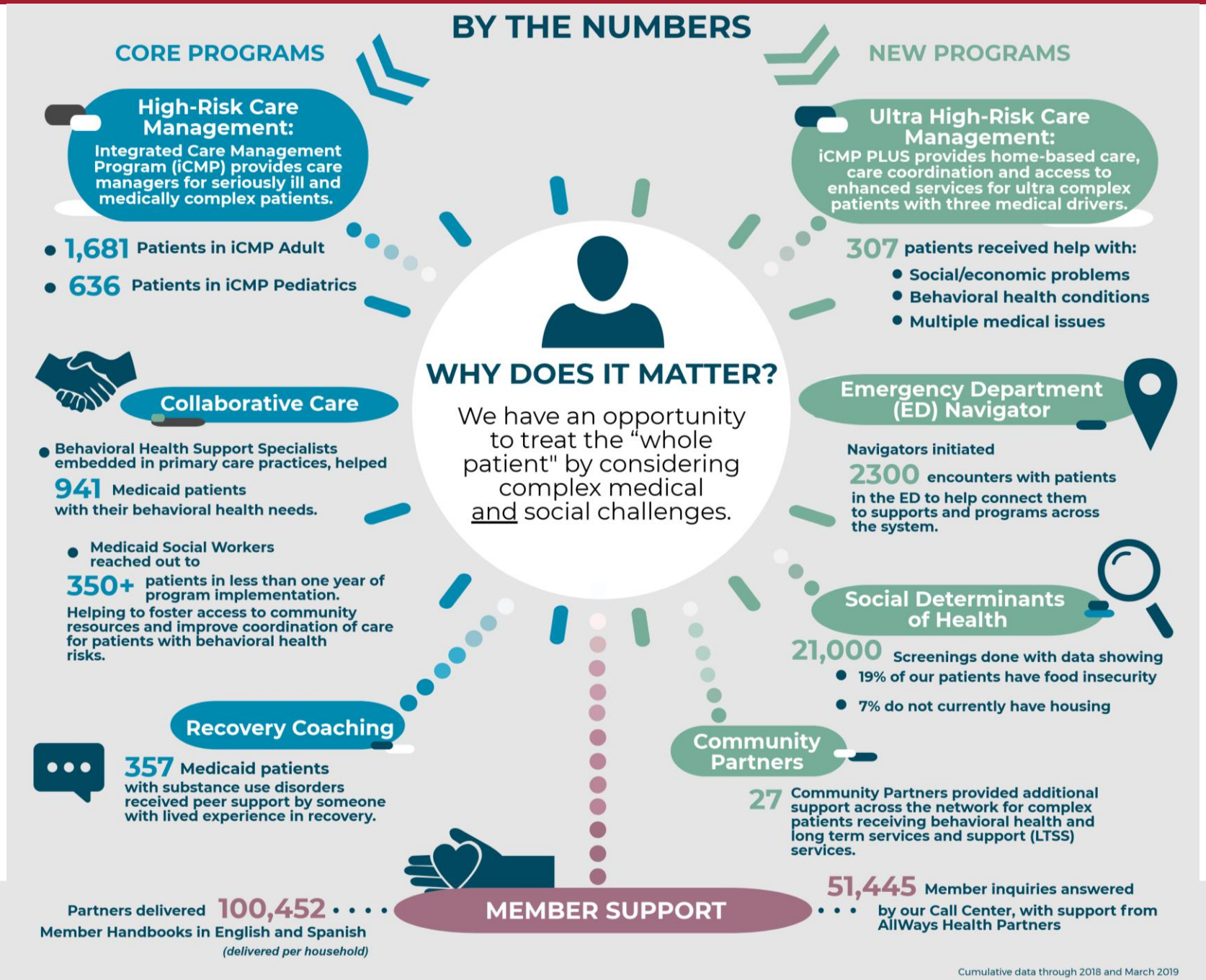
Partners Population Health: Performance by the Numbers

300k Commercial Patients Covered	**100k** Medicaid Patients Covered	**90k** Medicare Patients Covered	**100k** Partners Employee Patients
$50M Commercial Shared Savings	**$23M** Medicare Shared Savings	**2%** Under 2017 State Spending Benchmark	**96%** 2017 Medicare Quality Score

MASSHEALTH ACO - CLINICAL STRATEGY

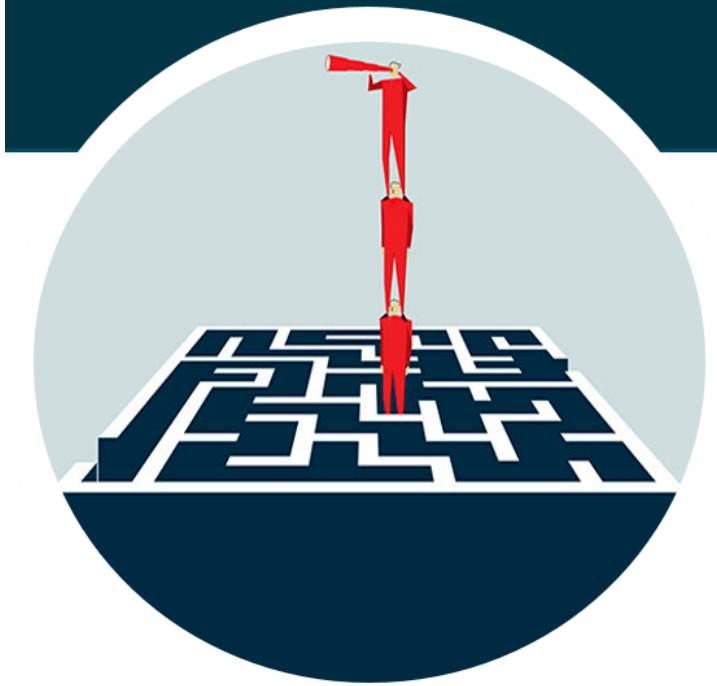


MASSHEALTH ACO - YEAR ONE REVIEW



High-Risk Care Management

Integrated Care Management Program (iCMP) Care Management Team



- Helps patients stay healthier longer by providing the specialized care and services they need to prevent complications and avoid hospitalizations.
- Matches high-risk adult patients with a nurse, social worker, or community health worker care coordinator based on the unique need of the patient.
- Care coordinators work closely with patients and their families
  - Develops a customized care plan to address their specific needs
  - Monitors the patients during their office appointments, and after the visit when a patient is at home
  - Serve as liaisons between the patient and other members of the care team and helps coordinate services such as diagnostic tests, transportation, social services, and specialist services.

- When the CHW functions as a lead, results include a:
  - $664 larger PMPM reduction in total medical expense and an 11 percent larger reduction in ED visits compared to the control group.
- When the CHW functions as a part of the care team, results include a:
  - $635 larger PMPM increase in total medical expense. However, patients with a CHW team member had a 28 percent larger reduction in ED visits, and an 11 percent larger decrease in office no-show rates compared to the control group.

Behavioral Health and Substance Use

Supports for Patients

- **Partners Collaborative Care Team:** Non-clinical workforce who collaborate with clinicians to deliver suite of behavioral health interventions in a primary care setting.
- **Substance Use Screening:** Screening for substance use; targeted education, and referral (as appropriate) to treatment.
- **Virtual Cognitive Behavioral Therapy:** Online self-directed therapy course offered to patients with low to moderate levels of depression, anxiety and related conditions.
- **Resource Finding:** Support for patients seeking local community-based mental health specialists and programs.
- **Recovery Coaching:** Peer support specialists, with lived experience in recovery, mentor patients to facilitate a pathway to recovery.

Integrated Care Teams

- **BHSS:** Bachelors level patient and practice support. Assists primary care in managing patients appropriate for primary care.
- **LICSW:** Support to patients with BH conditions too complex for BHSS, provides support and consultation to BHSS as well.
- **Psychiatrist:** Provides structured, population health approach to case review, makes recommendations to primary care on treatment.
- **Recovery coach:** Peer support for patients with SUD
- **Primary Care Team:** Manages the treatment of patients with support form above team

Kristen Mucitelli-Heath

Administrator, St. Joseph's Health
(a Trinity Health member)

ST. JOSEPH'S HEALTH

Medicaid Innovation and System Transformation at St. Joseph's Health- Syracuse, NY

Medicaid Health Homes
Medicaid Value Based Payment Pilot
DSRIP
Accountable Health Communities Cooperative Agreement
June 2019

SJH Stats: (FY 2017)

- 451 Beds in Syracuse, NY
- 9,000 inpatient surgeries
- 5,000 outpatient surgeries
- 66,000 emergency room visits
- 26,000 inpatient visits.
- 400,000 primary care visits
- 83,000 outpatient psych visits
- 121,000 visits through St. Joseph's Certified Home Health Care Program

Medicaid Health Homes

Quick Info

- *Alabama*
- *California*
- *Connecticut*
- *District of Columbia*
- *Illinois*
- *Iowa*
- *Maine*
- *Maryland*
- *Michigan*
- *Minnesota*
- *Missouri*
- *New Jersey*
- *New Mexico*
- *New York*
- *North Carolina*
- *Oklahoma*
- *Rhoda Island*
- *South Dakota*
- *Tennessee*
- *Vermont*
- *Washington*
- *West Virginia*
- *Wisconsin*

- **Affordable Care Act of 2010, Section 2703 (1945 of the Social Security Act), created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions.**

- **As of January 2019, 22 states and the District of Columbia have approved SPAs, with some states submitting multiple SPAs to target different populations or phase-in regional implementation (resulting in 37 unique models).**

- States must submit a Medicaid state plan amendment (SPA) to CMS to create a health home program.

- More than one million Medicaid beneficiaries have been enrolled in health homes to date, Nearly a half-dozen other states are planning health home models.

- CMS expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the whole person.

Source: Center for Health Care Strategies and Mathematica Policy Research

Medicaid Health Hom

St. Joseph's Care Coordination Network

- Program launched in 2014 (0 patients) – has grown to over 4,000 patients in 6 NYS counties
- Patient success stories are profound – touching families, enabling recovery and improving health
- Community Based Organizations participate in the healthcare system

WHY IT WORKS–THE MODEL:

PROGRAM IS COMMUNITY BASED

Care Managers meet the patient where they are or where they need them to be – community, home, shelter, clinics, social services – face to face engagement by staff with the client is required as much as possible.

COMPREHENSIVE ASSESSMENT

That extensively explores clinical history inclusive of mental health and social determinants of health. Buildout of this assessment in EPIC (took time but worth it and necessary!)

PATIENT CENTERED CARE PLAN

Patient Centered Care Plan is created from the comprehensive assessment and mandated to be updated annually. Goals, timelines are self identified by the patient and progress against the care plan is monitored/audited

PROGRAM IS VOLUNTARY

Patient is participative because they want to be, or see a benefit. This drives engagement and productivity

DOCUMENTATION DIRECTLY IN THE EHR (EPIC)

By care managers AND subcontracted care management partners

CBOS ARE PART OF THE TEAM

Program subcontracts with community based organizations (CBOs) to care manage specific populations or needs. Medicaid billing is conducted and submitted on their behalf.

OPPORTUNITY FOR CLIENT/PATIENT SUPPORT IS EXTREMELY BROAD

Includes opportunities to support in almost all needs related to social determinants (employment, transportation, housing, access to food, etc).

EMBEDDED IN A HOSPITAL HEALTH SYSTEM

A community based program embedded in a health system allows for greater fluidity of team across care settings and care transitions.

Medicaid Health Homes

St. Joseph's Care Coordination Network

CLINICAL IMPACTS:

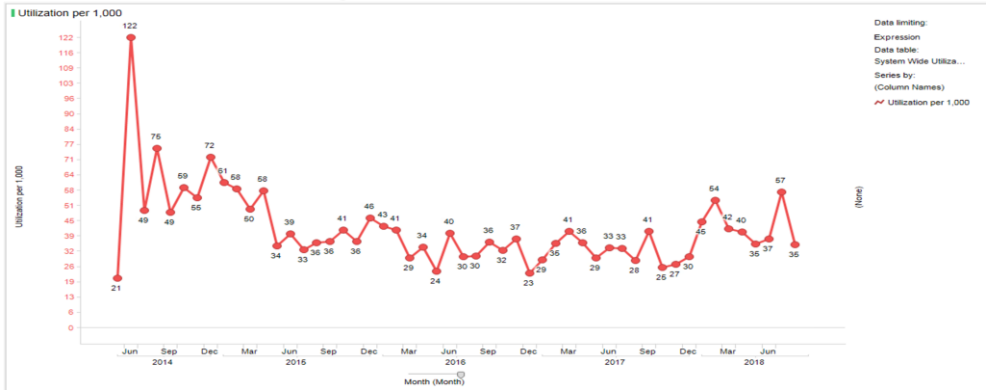
Some stats on enrolled population (per 1000 per member per month):

- 58% reduction in inpatient utilization
- 53% reduction in emergency department utilization
- 80% reduction in psychiatric emergency visits

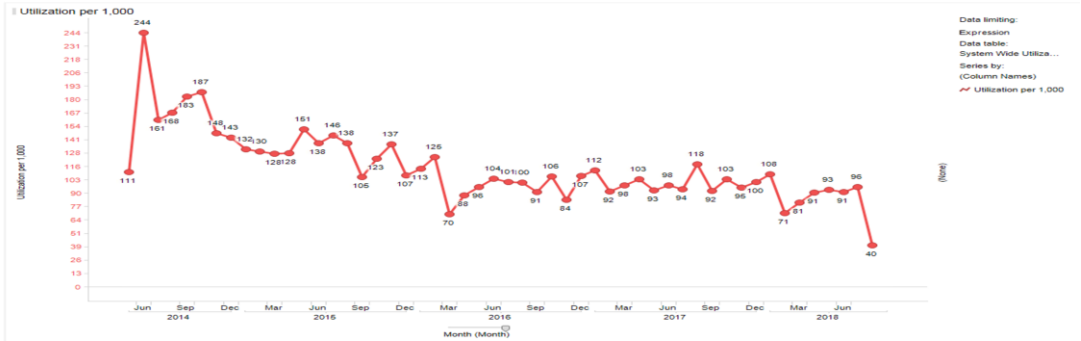
ADDITIONAL IMPACTS/HEALTH SYSTEM OPERATIONS:

- Significant decrease in total healthcare charges
- Significant reductions in readmissions
- Length of Stay Reduction
- Supports Medicaid VBP Performance
- Supports our Track 3 ACO performance (dual eligible)

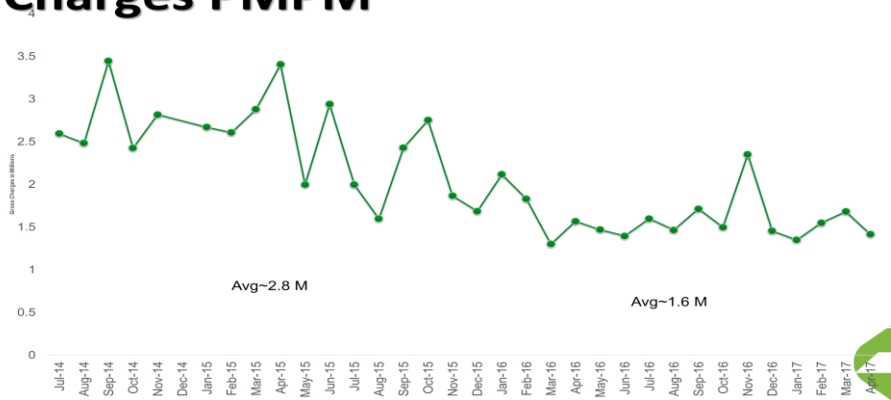
Health Home Inpatient Admissions PMPM



Health Home ED Visits PMPM



Charges PMPM



Medicaid Value Based Payment Pilot

St. Joseph's Medicaid VBP

- 2014 NYS 115 Waiver
  - Required definition of a NYS Value Based Payment Roadmap
  - Enabled support to move willing and advanced health systems into Value Based Payment Models with MCOs

- SJH Began work in 2016 with NYS, entered into two year Medicaid VBP Pilot in 2017
  - 2017/Year 1 – upside only (no risk), 2018/Year 2 – risk based

- NYS Medicaid VBP Pilot provided:
  - technical support and assistance from NYS re: contracting, data
  - moderate financial support scaled to # of lives attributed to agreements with MCOs
  - Incentive for health system to move towards VBP in Medicaid (overcome hesitation)

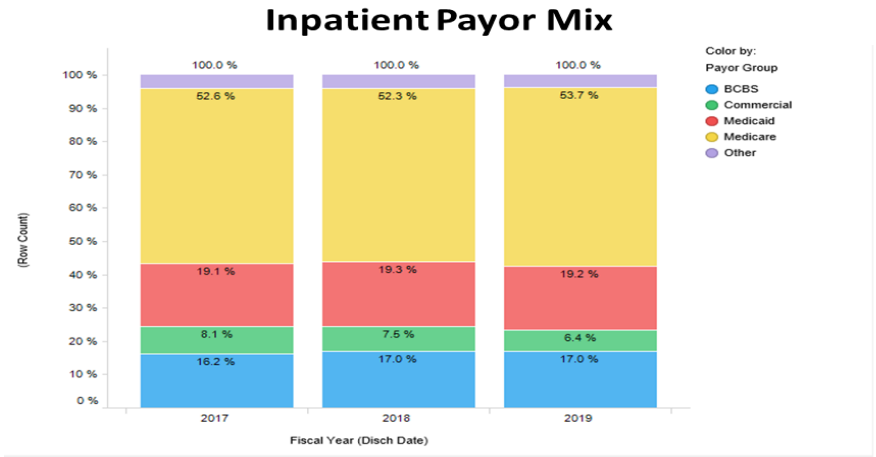
- Latest snapshot – VBP CAN work in Medicaid
  - performance is positive (final performance reconciliation pending) – in line for gainshare
  - Initial performance reports indicate over $5M in savings on Medicaid VBP population (~23,000 patients)

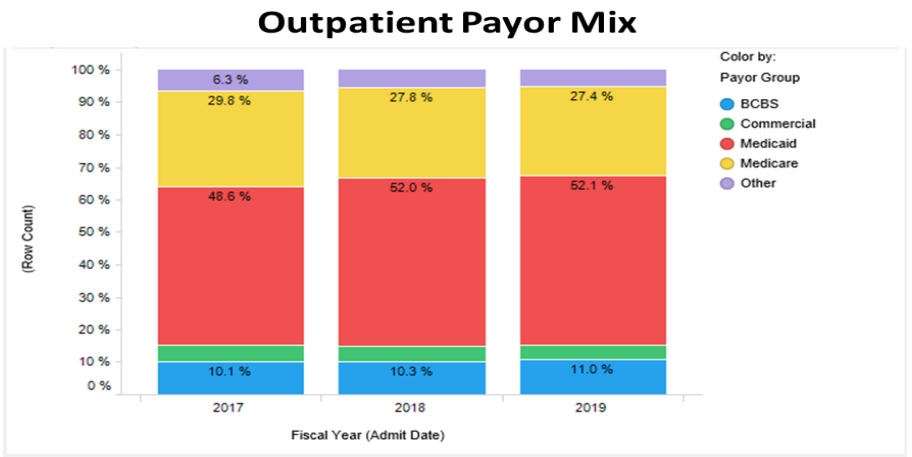
St. Joseph's Health APM Agreements

Approximately 90,000 patients representing ~$600,000,000 in total medical spend

Agreement	Payer	Model	Attribution	Risk Level	Entity
Medicare BPCI (Model 2)	CMS	Category 3B APM (4 Bundles) *(Episode-based built on FFS Architecture)*	n/a (1700)	Upside/Downside	SJH
Medicare MSSP (Track 3)	CMS	Category 3B APM *(Total Cost, Total Population built on FFS Architecture)*	~25,000	Upside/Downside	THIC (ACO)
Excellus BCBS ACQA	Commercial	Category 3B APM *(Total Cost, Total Population built on FFS Architecture)*	~40,000	Upside/Downside	CNY AIM (CIN)
Medicaid VBP (Fideliscare-Centene/Molina)	Medicaid	Category 3B APM *(Total Cost, Total Population built on FFS Architecture)*	~23,000	Level 2 (Upside/Downside)	SJH

St. Joseph's Health Payor Mix –Significant Government Payor Volume (like most Upstate NY Systems)





NYS DSRIP AND OTHER BENEFITS OF MEDICAID INNOVATION

Transformational System Design and Support

NYS DSRIP funding Enabled transformational system development:

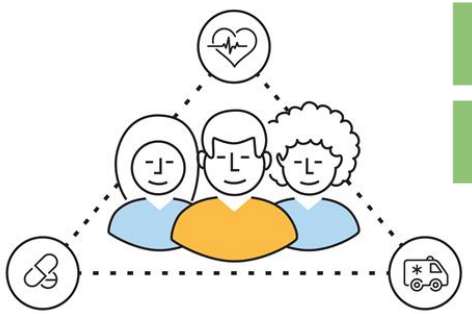
- Health Systems straddling FFS and Value Based Care NEED support to make the transition
- DSRIP grants and $$ through DSRIP PPS enabled:
  - **Transition Nurse and Physical Therapist Team (TNT Team):** Team assesses patient while "in house"/on inpatient unit to define optimal discharge plan/"next level of care".
  - **Mobile Integrated Service Team (MIST):** Mobile "health home" team utilizing a combination of resources (telemonitoring and NP home visits) to connect dual-eligible beneficiaries to reduce unnecessary/avoidable utilization.
  - **Network Care Coordination Team (NCCT):** multi-disciplinary care team focusing on "super-utilizers" to address the medical, social and psychological drivers of utilization including social determinants of health

CMMI: Accountable Health Communities

- 5 year cooperative agreement.
- Study to test the effectiveness of screening all patients for the social determinants of health across clinical care sites, connecting them to community resources and supporting them in the community through care management,
- SJH AHC: An expansion of the St. Joseph's Medicaid Health Home (SJCCN) - provides care management to address the social determinants of health for **Medicare** beneficiaries with chronic conditions.

Ann Hwang, MD
Director, CCEHI

CENTER FOR CONSUMER ENGAGEMENT *in health innovation*
A better way to better health. For everyone.



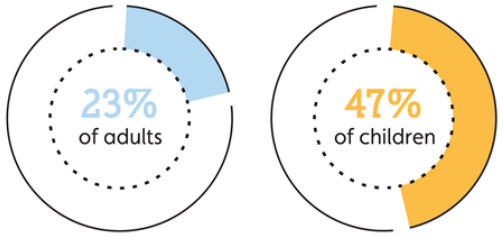
Medicaid delivers high-quality care.

Thanks to Medicaid and CHIP, **just 4.8 percent of American children are uninsured** – down from 67.9 percent in 1997.

About half of adults with disabilities covered by Medicaid live below the federal poverty level (about 3.5 million Americans), leaving them with limited resources to pay for health care and support services.

Medicaid covers approximately 875,000, or 10% of, veterans aged 19-64, ensuring they receive health care when and where they need it.

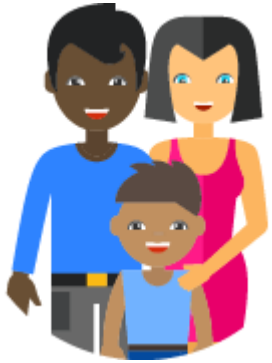
Medicaid provides needed coverage for about 23% of adults and 47% of children in rural areas.



Questions & Answer

Partners in Promoting Value



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