Pursuing Value in Medicaid

States Taking a Lead in Health Care Transformation

#ValueinMedicaid
@HCTTF @ModernMedicaid

HCTTF.org
ModernMedicaid.org
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

HCTTF members continue to progress towards our goal of 75% of business in value-based payment arrangements by the end of 2020.
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 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


<table>
<thead>
<tr>
<th>CATEGORY 1</th>
<th>CATEGORY 2</th>
<th>CATEGORY 3</th>
<th>CATEGORY 4</th>
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</thead>
<tbody>
<tr>
<td><strong>FEES FOR SERVICE - NO LINK TO QUALITY &amp; VALUE</strong></td>
<td><strong>FEES FOR SERVICE - LINK TO QUALITY &amp; VALUE</strong></td>
<td><strong>APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE</strong></td>
<td><strong>POPULATION - BASED PAYMENT</strong></td>
</tr>
<tr>
<td><strong>A</strong> Foundational Payments for Infrastructure &amp; Operations</td>
<td><strong>A</strong> APMs with Shared Savings</td>
<td><strong>A</strong> Condition-Specific Population-Based Payment</td>
<td><strong>A</strong> Integrated Finance &amp; Delivery System</td>
</tr>
<tr>
<td>(e.g., care coordination fees and payments for HIT investments)</td>
<td>(e.g., shared savings with upside risk only)</td>
<td>(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)</td>
<td>(e.g., global budgets or full/percent of premium payments in integrated systems)</td>
</tr>
<tr>
<td><strong>B</strong> Pay for Reporting</td>
<td><strong>B</strong> APMs with Shared Savings and Downside Risk</td>
<td><strong>B</strong> Comprehensive Population-Based Payment</td>
<td><strong>B</strong> Risk Based Payments NOT Linked to Quality</td>
</tr>
<tr>
<td>(e.g., bonuses for reporting data or penalties for not reporting data)</td>
<td>(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)</td>
<td>(e.g., global budgets or full/percent of premium payments)</td>
<td><strong>C</strong> Capitated Payments NOT Linked to Quality</td>
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<td><strong>C</strong> Pay-for-Performance</td>
<td><strong>C</strong></td>
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<tr>
<td>(e.g., bonuses for quality performance)</td>
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**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: 28.3%
- Medicare Advantage: 49.5%
- Medicare FFS: 38.3%
- Medicaid: 25%

Representativeness of covered lives:
- Commercial: 69%
- Medicare Advantage: 70%
- Medicare FFS: 100%
- Medicaid: 50%

HCP LAN
Health Care Payment Learning & Action Network
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
Esther Kim, ScD
Program Director,
Partners HealthCare
MassHealth ACO at Partners HealthCare

Esther Kim, ScD, Program Director

June 12, 2019
What is Partners HealthCare?

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.

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.
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.
<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>Commercial Patients Covered</td>
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<tr>
<td>Medicaid Patients Covered</td>
<td>100k</td>
</tr>
<tr>
<td>Medicare Patients Covered</td>
<td>90k</td>
</tr>
<tr>
<td>Partners Employee Patients</td>
<td>100k</td>
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<tr>
<td>Commercial Shared Savings</td>
<td>$50M</td>
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<tr>
<td>Medicare Shared Savings</td>
<td>$23M</td>
</tr>
<tr>
<td>Under 2017 State Spending Benchmark</td>
<td>2%</td>
</tr>
<tr>
<td>2017 Medicare Quality Score</td>
<td>96%</td>
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</tbody>
</table>
MASSHEALTH ACO - YEAR ONE REVIEW

**CORE PROGRAMS**

- **High-Risk Care Management:** Integrated Care Management Program (iCMP) provides care managers for seriously ill and medically complex patients.
  - 1,681 Patients in iCMP Adult
  - 636 Patients in iCMP Pediatrics

- **Collaborative Care**
  - Behavioral Health Support Specialists embedded in primary care practices, helped 941 Medicaid patients with their behavioral health needs.
  - Medicaid Social Workers reached out to 350+ patients in less than one year of program implementation. Helping to foster access to community resources and improve coordination of care for patients with behavioral health risks.

- **Recovery Coaching**
  - 357 Medicaid patients with substance use disorders received peer support by someone with lived experience in recovery.

**NEW PROGRAMS**

- **Ultra High-Risk Care Management:** iCMP PLUS provides home-based care, care coordination and access to enhanced services for ultra complex patients with three medical drivers.
  - 307 patients received help with:
    - Social/economic problems
    - Behavioral health conditions
    - Multiple medical issues

- **Emergency Department (ED) Navigator**
  - Navigators initiated 2,300 encounters with patients in the ED to help connect them to supports and programs across the system.

- **Social Determinants of Health**
  - 21,000 Screenings done with data showing:
    - 19% of our patients have food insecurity
    - 7% do not currently have housing

- **Community Partners**
  - 27 Community Partners provided additional support across the network for complex patients receiving behavioral health and long term services and support (LTSS) services.

**MEMBER SUPPORT**

- Partners delivered 100,452
  - Member Handbooks in English and Spanish (delivered per household)

- 51,445 Member inquiries answered by our Call Center, with support from AllWays Health Partners

**WHY DOES IT MATTER?**

We have an opportunity to treat the "whole patient" by considering complex medical and social challenges.
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.
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 from above team.
Kristen Mucitelli-Heath
Administrator, St. Joseph’s Health
(a Trinity Health member)
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

- 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 Home
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)
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

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Payer</th>
<th>Model</th>
<th>Attribution</th>
<th>Risk Level</th>
<th>Entity</th>
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<tbody>
<tr>
<td>Medicare BPCI</td>
<td>CMS</td>
<td>Category 3B APM (4 Bundles) (Episode-based built on FFS Architecture)</td>
<td>n/a (1700)</td>
<td>Upside/Downside</td>
<td>SJH</td>
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<tr>
<td>Medicare MSSP (Track 3)</td>
<td>CMS</td>
<td>Category 3B APM (Total Cost, Total Population built on FFS Architecture)</td>
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<td>THIC (ACO)</td>
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<td>Excellus BCBS ACQA</td>
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<td>Category 3B APM (Total Cost, Total Population built on FFS Architecture)</td>
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<td>Medicaid VBP (Fideliscare-Centene/Molina)</td>
<td>Medicaid</td>
<td>Category 3B APM (Total Cost, Total Population built on FFS Architecture)</td>
<td>~23,000</td>
<td>Level 2 (Upside/Downside)</td>
<td>SJH</td>
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### St. Joseph’s Health Payor Mix –Significant Government Payor Volume (like most Upstate NY Systems)

**Inpatient Payor Mix**

- **2017 (Fiscal Year (Disch Date))**: 52.6% BCBS, 18.1% Commercial, 17.0% Medicaid, 10.2% Medicare, 10.7% Other
- **2018 (Fiscal Year (Disch Date))**: 52.3% BCBS, 19.3% Commercial, 17.0% Medicaid, 11.7% Medicare, 10.4% Other
- **2019 (Fiscal Year (Disch Date))**: 63.7% BCBS, 10.8% Commercial, 17.6% Medicaid, 10.2% Medicare, 10.7% Other

**Outpatient Payor Mix**

- **2017 (Fiscal Year (Admit Date))**: 6.3% BCBS, 28.5% Commercial, 27.8% Medicaid, 27.4% Medicare, 10.1% Other
- **2018 (Fiscal Year (Admit Date))**: 6.1% BCBS, 28.6% Commercial, 27.9% Medicaid, 27.1% Medicare, 10.3% Other
- **2019 (Fiscal Year (Admit Date))**: 6.1% BCBS, 28.6% Commercial, 27.9% Medicaid, 27.1% Medicare, 11.6% Other
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
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