MEDICAID PAYMENT POLICIES AND CARE COORDINATION WORKGROUP

Meeting 3

December 17, 2020

Meeting Agenda

- Welcome and Introductions
- Review of Strategies to Address ED Utilization and Hospital Readmission
- Virginia Efforts to Reduce Unnecessary ER Utilization and Hospital Readmissions: A New Collaborative Approach is Needed
- Group Discussion
- Homework
- Adjourn

Disclaimer

The primary goal of this workgroup is to provide a report to the General Assembly highlighting data, findings, and recommendations in the areas of emergency room utilization and hospital readmissions. As a reminder, this meeting is open to the public and all information shared and presented during workgroup activities, may be made public and/or included in this public report to the Virginia General Assembly.

Public Comment

Public comments should be submitted to Rusty Walker (rusty.walker@dmas.virginia.gov) and will be collected for distribution to workgroup members.

MERCER

Medicaid Payment Policies and Care Coordination Workgroup

Review of Strategies to Address ED Utilization and Hospital Readmissions

Mercer Government
Ready for next. Together.

Jennie Echols, PhD, MSN, RN
Principal
Wendy Woske, RN, BSN, MHA
Principal

Commonwealth of Virginia
December 17, 2020

Agenda

1

Reengineering the System
- Impact on Preventable and Avoidable Emergency Department Visits and Hospital Readmissions
- Systemic View

2

Potentially Preventable and Avoidable Emergency Department Utilization
- Drivers
- Solution Types
- Example Strategies

3

Potentially Preventable Hospital Readmissions
- Drivers
- Solution Types
- Example Strategies

4

Conclusion and Considerations

What is the most important solution to impact Potentially Preventable and Avoidable ED Visits and Hospital Readmissions?

Healthcare Ecosystem

Solution Type

Provider Access & Availability	Communication	Programs & Process	TOC & Community Re-Integration	Technology	Financial

Model Approaches

Reducing Potentially Preventable and Avoidable ED Visits

Drivers

Solution Type

Provider Access & Availability

Initiator

- Medicaid Agency ED Diversion Grant PA (Access 1)
- Medicaid Agency ED Diversion Grant NJ (Access 2)
- Medicaid Agency KY (Access 3)
- Community OK (Access 4)
- National Priorities Partnership Convened by National Quality Forum (Access 5)
- Community TX (Access 6)
- Hospital OK (Access 7)

Initiative

- Increased hours
- ER Navigators - finding medical home
- Community collaborations
- FQHC as medical home with 24/7access
- Bundled services:
  - Medication education
  - Transportation
  - Triage/Nurse Lines
  - Telehealth
- CHC as regular source of care
- Workflows re-designed to address EMTALA

Results

- ED decreased by almost 40%
- ED transports decreased 56%

Communication

Initiator

- Medicaid Agency and Providers KY (Communication 1)
- Medicaid Agency OR (Communication 2
- Medicaid Agency WA (Process/Management 1)

Initiative

- PCP, hospital and Medicaid Agency collaboration
- Staff training
- Care coordination
- Peer consultation
- Health information technology
- Communication plans via HIE

Results

- No results reported

Programs & Process

Initiator

- Medicaid Agency WA (Program & Process 1)
- Medicaid Agency Partnership for EDCC MI (Program & Process 2)
- Health Plan CA (Program & Process 3)
- Health Plan OH (Program & Process 4)
- Medicaid Agency OR (Program & Process 5)

Initiative

- Care management for ED frequent users
- Health literacy
- Expanding transition of care
- Identification of at-risk populations
- Self-management skills
- Medication management
- Primary care re-engagement
- Health Engagement Team (MD, RN, SW, CHWs)
- 24/7 nurse advice line

Results

- 49% reduction in ED visits
- 56% ED diversion saving of $1.7 million

TOC & Community Re-Integration

Initiator

- Medicaid Agency WA (TOC & Community Re-integration 1)
- Medicaid Agency KY (TOC & Community Re-integration 2)
- Health Plan CA (Program & Process 3)

Initiative

- PCP, hospital and Medicaid Agency collaboration
- MCO member education and follow-up
- Patient navigators
- High-risk member follow-up by Care Coordinators, 2, 7 days, then 7 days later and again 14 days later

Results

- Case managers evaluate stability and continued need for follow-up beyond 30 days
- ED visits declined by 9.9% and the rate of visits by frequent users fell by 10.7%.
- $33.6 million in savings
- ED visits decrease

Technology

Initiator

- Medicaid Agency OR (Technology 1)
- Medicaid Agency WA (Technology 2)
- Military Health System (Technology 3
- Study by Eastern Virginia Medical School (Technology 4)
- Study by Medical University of South Carolina (Technology 5)

Initiative

- EDIE, High Utilizer/Complex
- E-info between hospitals and providers
- Secure messaging, Nurse Advice Line (NAL), patient portal, mobile apps, virtual primary care visits, and telehealth to monitor patients in remote area
- Video after-hours telehealth calls
- School-based telehealth for children with asthma in a rural areas of SC
- School nurses, connect with providers, via a telehealth cart

Results

- PPV by high utilizers decreased by 10.9%
- Frequent user ED fell by 10.7%
- Reduced from > 3ER visits/1000 in 2012 to < 2.5 visits/1000
- 21% reduction in asthma ED visits with access to school-based telehealth

Financial

Initiator

- Medicaid Agency OR (Finance 1)
- Medicaid Agency WA (Finance 2)
- Medicaid Agency MN (Finance 3)
- Medicaid Agency WY (Finance 4)
- Medicaid Agency PA Integrated Care Program (Finance 5)

Initiative

- Uses “bonus quality pool” to reward Coordinated Care Organizations for quality
- One metric is ED utilization among beneficiaries with mental illness
- Hospitals can earn a 1% incentive payment under the Medicaid Quality Incentive Program for reduced ED
- Managed Care Withhold
- Performance Payment Targets
- Provider VBP

Results

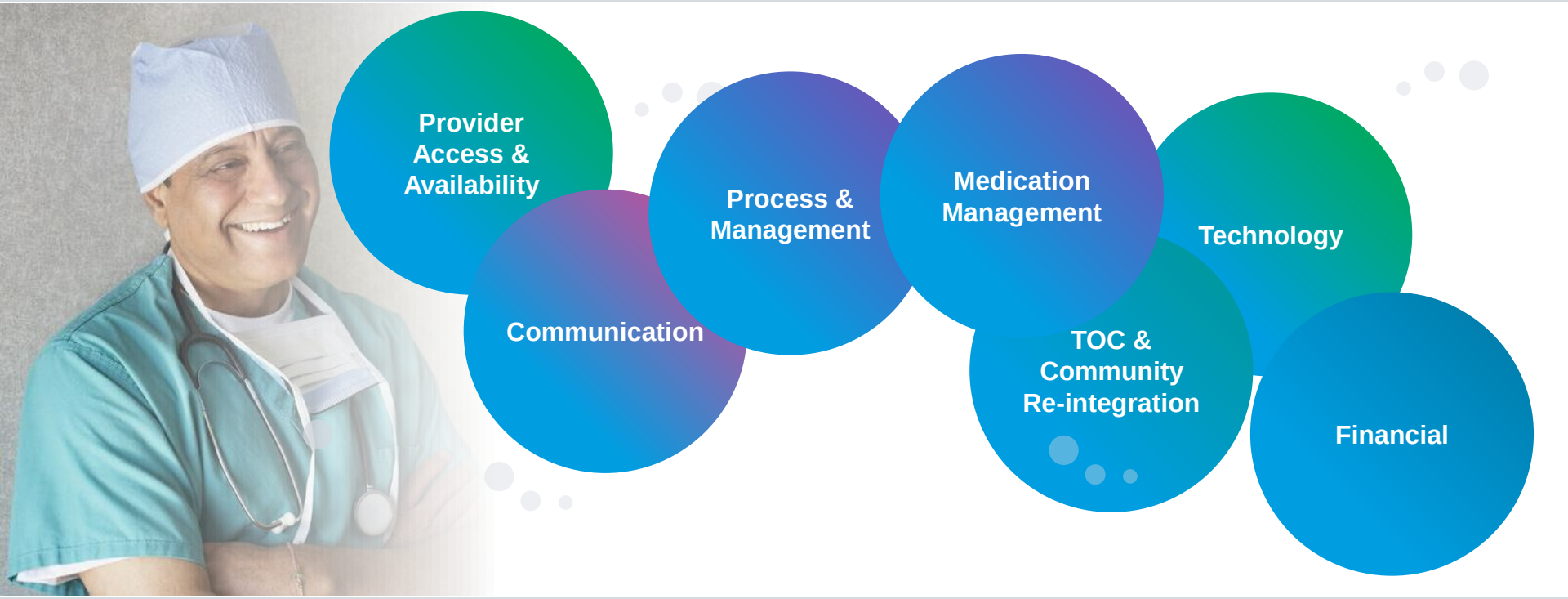
- ED visits decreased by 13%

Model Approaches

Reducing Potentially Preventable Hospital Readmissions

Drivers

Solution Type



Provider Access & Availability

Initiator

- Study – Weill Cornell Medical College (Access 1)
- Informational article - National Health Center Week (Access 2)
- Article – ACP Hospitalist (Access 3)

Initiative

- Early primary care follow-up
- FQHCs reduce health disparities, effectively manage chronic diseases
- Access in high-need areas
- Risk factor identification to target for follow-up

Results

- Lower 30 day readmission rate
- 5.8 fewer preventable hospitalizations per 1,000

Communication

Initiator

- Hospital CA (Communication 1)

Initiative

- Multidisciplinary collaborative team to coordinate discharge and transition of care

Results

- 30 day readmission rate reduced to 5.27% compared to 19.6% in preceding period

MERCER

Process & Management

Initiator

- Health Plan CA (Program & Process 1)
- Hospital NY (Program & Process 2)
- Hospital MA (Program & Process 3)
- Study – University of North Carolina Dept of Medicine and Pediatrics (Program & Process 4)
- Hospital VA and National (Program & Process 5)
- Hospital VA – VHHA “Home is the Hub” Initiative (Program & Process 6)
- Study – Siouxland Medical Education Foundation (Program & Process 7)

Initiative

- Chronic care management and psychosocial needs
- TOC visits by team (care coordinator, RN and SW
- Re-focused inpatient discharge process
- Member Education
- Care coordination
- Post-discharge follow-up clinic visits and phone calls
- Education
- Discharge bundle
  - Medication review, discharge education and follow-up appointments)
- TOC Coach roles
- BOOST
- Medication reconciliation
- Pharmacist follow-up OP visits
- RED with 12 components

Results

- 30 day readmissions reduced to 5.27% from 19.6%
- 60 day readmissions reduced to 17.6% from 26.3% in control group
- 11.1% decrease in 30 day readmissions

Medication Management

Initiator

- Pharmacy Study (Siouxland Medical Education Foundation, IA (Medication Management 1)
- Hospital – Study Value Institute, Christiana Care Health System, Newark, DE (Medication Management 2)

Initiative

- OP pharmacist visit
- DPP – Patients are able to pick up filled medications as part of discharge process

Results

- Participation in the DPP decreased odds of 7-day readmission by 20% and of 30-day readmission by 16%
- Resulted in 30-day readmission of 9.2% from 19.4%
- Decreased odds of 7-day readmission by 20% and of 30-day readmission by 16%

TOC & Community Re-Integration

Initiator

- Study - CMS Submitted study from Vanderbilt University, TN (TOC & Community Re-Integration 1)
- Informational Article, News Medical and Life Sciences (TOC & Community Re-Integration 2)
- Study – Patient-Centered Outcomes Research Institute (TOC & Community Re-Integration 3)
- Study – University of Pennsylvania School of Nursing (TOC & Community Re-Integration 4)
- Study – University of Florida (TOC & Community Re-Integration 5)

Initiative

- Bundled Interventions
  - Pre-discharge interventions
  - Post-discharge interventions
  - Bridging interventions
- Coleman Care Transition Interventions
- Peer support
- Naylor Transitional Care Model
- Interprofessional Transition of Care Clinic

Results

- Reduced patient visits to specialists by 24%, ED visits by 13% and hospitalizations by 39%
- 22% reduction in likelihood of readmission
- 34% reduction in average number of readmissions
- $4,500 savings per patient
- 60% reduced odds of 90 day readmissions

Technology

Initiator

- Health Plan – Multistate (Geisinger Center for Health Research) (Technology 1)
- Study – Canada (SMART Program) (Technology 2)

Initiative

- Interactive voice response protocol with post-hospital discharge tele-monitoring system
- Remote monitoring medical devices automatically sends results to home health care professional

Results

- 44% reduction in 30-day readmissions
- 35% reduction in hospitalizations

Financial

Initiator

- CMS National (Finance 1)
- Medicaid Agency OH (Finance 2)
- Medicaid Agency MN (Finance 3)
- Medicaid Agency PA (Finance 4)

Initiative

- HRRP – Hospitals are financially penalized for higher 30-day readmission rates for acute myocardial infarction, heart failure and pneumonia
- CCTP – To test models for improving care transitions and reducing readmissions
- Used 3M software to identify potentially preventable admissions and determine if future rewards or penalties will occur
- Provider APM
- MCO Withholds
- Payment Incentives

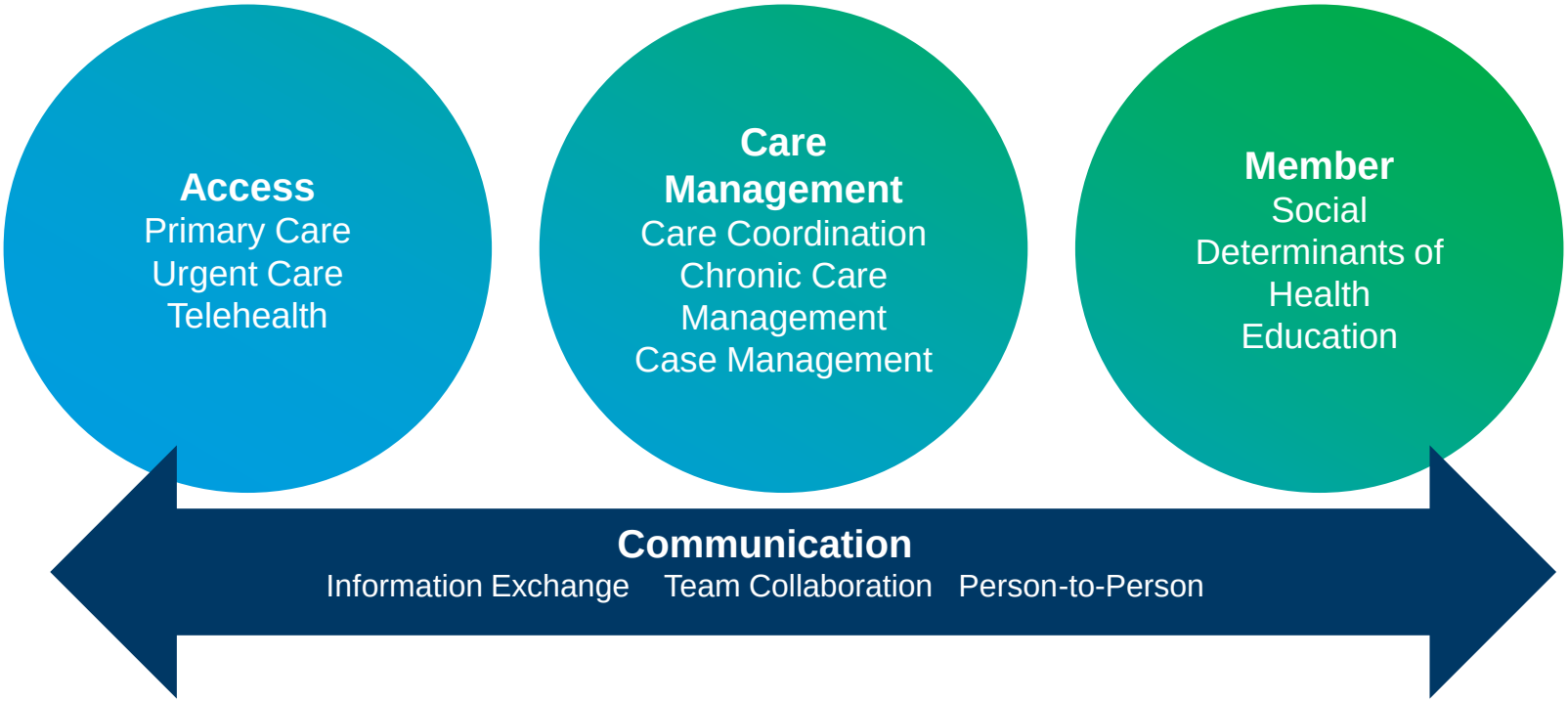
Results

- All-cause 30-day readmission rate fell from 19.5% in 2011 to 17.5% in 2013

Model Approaches

Conclusions and Considerations

Conclusions



Key Considerations

State

- Defining progressive results
- Legislation and authorities
- Data analytics
- Reporting
- Continued stakeholder input
- Readiness of Market

MCO

- Resources
- Data analytics
- Paradigm shift
- Reporting
- Network design and contracting
- Care management
- Provider transformation

Hospital and Providers

- Resources
- Paradigm shift
- Communication technology
- Analytics and reporting abilities
- Reporting
- Modified workflows
- Need streamlined interface

Questions

Making a difference in people's lives

MERCER

Acronyms

Behavioral Health	BH
Better Outcomes for Older Adults through Safe Transitions	BOOST
Centers for Medicare & Medicaid Services	CMS
Community-Based Care Transitions Program	CCTP
Community Health Center	CHC
Discharge Prescription Program	DPP
Electronic Health Record	EHR
Emergency Department	ED
Emergency Department Care Coordination	EDCC
Emergency Department Information Exchange	EDIE
Emergency Room	ER
Emergency Telehealth and Navigation	ETHAN
Emergency Medical Treatment and Labor Act	EMTALA
Federally Qualified Health Care	FQHC
Geisinger Monitoring Program	GMP
Health Engagement Teams	HET
Health Care Financing and Organization	HCFO
Health Information Exchange	HIE
Hospital Readmission Reduction Program	HRRP
Managed Care Organization	MCO
Patient Centered Medical Home	PCMH
Primary Care Provider	PCP
Registered Nurse	RN
Re-Engineered Discharge	RED
Return on Investment	ROI
Skilled Nursing Facility	SNF
Subject Matter Expert	SME
Transition of Care	TOC
Value-Based Purchasing	VBP
Virginia Hospital and Healthcare Association	VHHA


MERCER

Virginia Efforts to Reduce Unnecessary ER Utilization and Hospital Readmissions: A New Collaborative Approach is Needed

VIRGINIA CENTER FOR HEALTH INNOVATION

No Shortage of Promising Programs

- Mercer report reviews numerous national, state and local programs, featuring a wide variety in the entity offering the program:
  - Hospital-based initiatives
  - Health plan departmental initiatives
  - Community-based initiatives
  - Urgent care and primary care based initiatives

  And the type of approach employed:

  - Education
  - Case management
  - Disease management
  - Care coordination
  - Pharmacological

Virginia Research Yields Similar Findings

- In follow-up to the hospital and health plan presentations we heard at our last meeting, VCHI identified six additional programs that appear to have yielded positive results.
- These are:
  - Bay Area Agency on Aging: *VAAA Cares*
  - Patient First: *ConnectVA*
  - UVA Health: *Population Health and Interactive Home Monitoring from the Emergency Department for COVID patients*
  - UVA Health: *Home Team Program*
  - Virginia Health Care Foundation: *Taking Aim, Improving Health*
  - Walgreens: *Specialty Pharmacy Extended Prescription Fill Program*

Brief Program Descriptions

ConnectVA Utilization	Information obtained as a part of payer value-based care programs is fundamental to transitions of care programs focusing on reducing inpatient readmissions and unnecessary bounce-backs to the ER (or potentially an avoidable admission). Attributed patient lists provided by payers are fed into ConnectVA to receive near-real-time updates as to when patients are admitted or discharged from the hospital or ER. This enables rapid outreach from nurse care managers to connect with patients and facilitate a timely transition of care, assist with follow-up care guidance, or partnering with them for a care plan. There has been a notable increase in the level of patient engagement since working with ConnectVA due to the expedited turnaround time of communication from the hospital to NCM staff.
Extended Prescription Fill Program	This year, Walgreen's 4 Specialty Pharmacy locations within hospital systems have focused on educating teams on the floor to prescribe 90 day versus 30 day upon discharge, thereby providing the coordination of care team more time to follow up with patients for their PCP follow up and to reduce readmissions. This program is also supported through the Bedside Delivery program and Medication Synchronization program.
Home Team Program	An extremely small number of patients (1%) considered to be high utilizers are more likely to have mental health or substance use disorders in addition to complex chronic medical illnesses. After conducting patient interviews to understand these patients' experiences in care and exploring best practices, longitudinal, multidisciplinary individualized care plans (ICP) were developed. These ICPs are published in EMR for frontline providers to access from any point of care. 12 months post intervention demonstrated meaningful reductions in 30-day readmissions, admission, hospital bed days, and total costs. Also, patients praised the improved consistency in their care, and providers expressed appreciation of effectiveness of ICPs in facilitating care.

Brief Program Descriptions Continued

Population Health and Interactive Home Monitoring from the ED for COVID Patients	Remote in-home monitoring technology has become an increasingly important means to conserve hospital and ED capacity while providing observation and care for high-risk patients with milder symptoms during the COVID-19 pandemic. UVA aimed to evaluate the safety of introducing an Interactive Home Monitoring program (IHM) for high-risk patients discharged from the emergency department (ED) with suspected or confirmed COVID-19 who without remote monitoring would have required admission to the hospital.
Taking Aim, Improving Health	VHCF awarded six grants to stimulate and/or strengthen collaboration between hospitals and their local primary care health safety net organizations (free clinics and community health centers) to reduce avoidable hospital admissions and Emergency Department visits by uninsured patients via population health initiatives. The six grantees used differing approaches to intervene with a total of 1,095 high-cost charity care patients during the 18-month grant period.
VAAA Cares	VAAACares is a statewide one-stop-shop collaborative performing hospital to home interventions and services addressing non-medical risk factors shown to improve health outcomes and reduce the cost of care. Services delivered in the home and community that address transportation issues, manage chronic disease, address food insecurities, prevent falls, reduce social isolation, and more, are proven supports that maximize independence and functioning.

With So Many Good Ideas – Why Do We Have Such a Problem?

- First, current data and limited previous evaluation efforts make it difficult to effectively review many of the interventions.
- But even for programs with rigorous evaluation data and demonstrated positive returns on investment, we still struggle to take them to scale and sustain them.
- Consider the case of VAAA Cares.

VAAACares®

Care Transitions Intervention Model

VAAACares® - Virginia's Area Agencies on Aging Caring for the Commonwealth

- Statewide collaborative performs hospital to home care transitions intervention (CTI) wherein health coaches go to the home within 48 hours +/- of discharge from acute care to prevent unnecessary 30 day readmission. They:
    - Review patient's health acumen with instructions and medications, make sure patient has meds and knows how to take them, knows warning signs of need to call doctor, and has follow up care in place with transportation to get there.
    - Teaches chronic disease self-management, fall prevention, depression interventions, etc., as necessary
    - Arranges for needs from Social Determinants of Health

Outstanding Performance — Reductions in 30 Day readmissions and emergency department visits

- Performance reports show a 66% decrease in Medicare hospital readmission and a 60% decrease in Medicaid readmission.
- One demonstration involving hospital extremely high utilizers resulted in nearly half of the participants having no ED utilization and another group had a 56% decrease in utilization of EDs in the several months following the CTI intervention.

Budgets — Revenues stay in Virginia

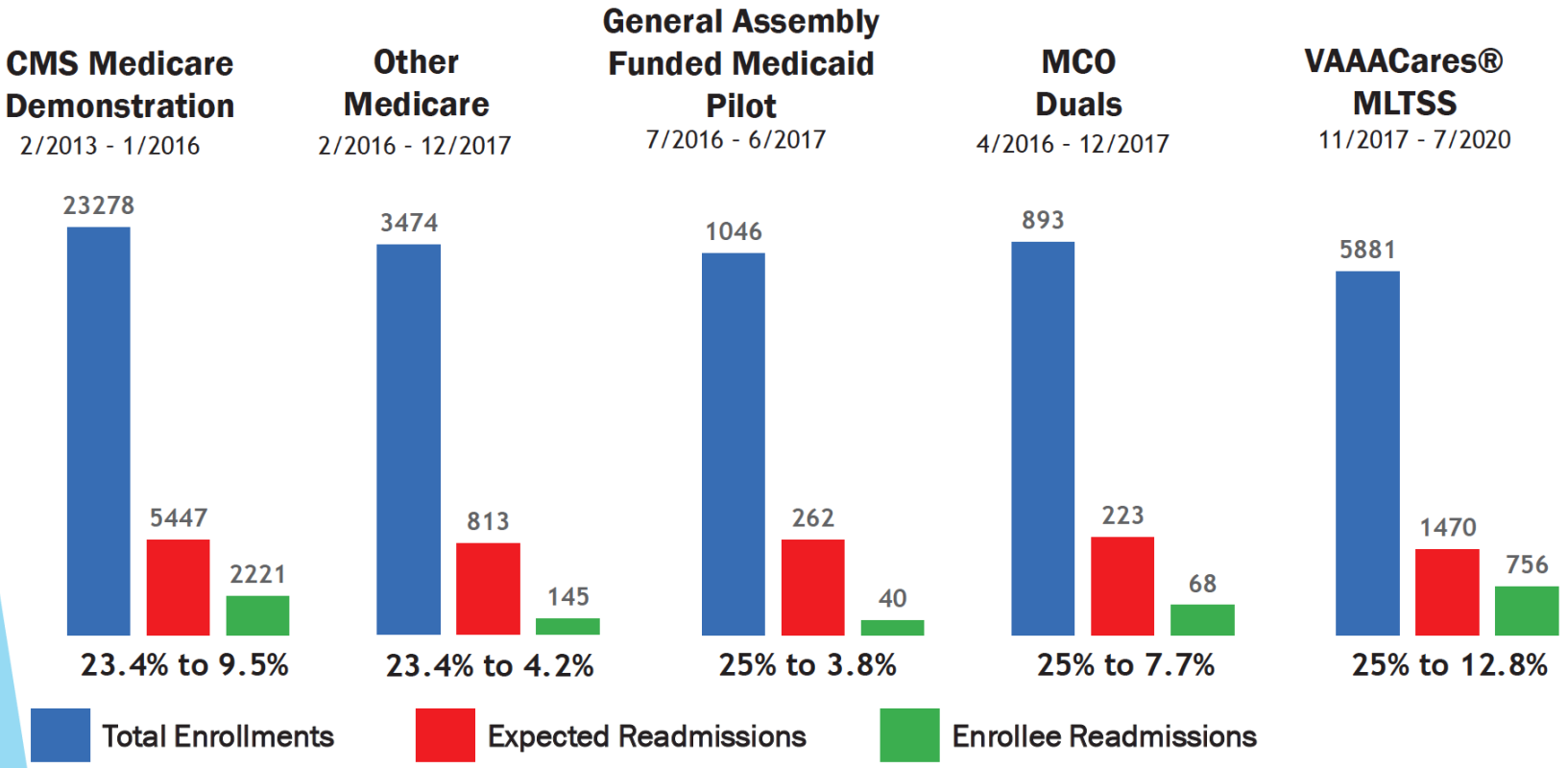
- Costs are nominal, ranging from $356 per intervention to $450 if RN services are needed.
- Nonetheless VAAACares® realizes modest net revenue from these programs when sufficient referral volume occurs from payers (health systems or health plans). In turn, these funds are reinvested directly into local communities, off-setting costs of increasing needs of services for older citizens.

National Awards –

- VAAACares® is recognized as the premier leader in forming the first statewide collaborative for business with MCOs. In January 2020, it was heralded as the #1 program in the U.S. by the Administration for Community Living based on:
    - $6.4 million in savings due to decrease in hospital readmissions
    - 48% had no ER visits in 4 months following intervention
    - Performed 26,000 home visits over 3 years
    - VAAACares® has done presentations for Ohio, Indiana and Colorado about their business model, and these states are requiring MCOs to contract with AAAs for assessments, care transitions, and/or care coordination

Care Transitions Intervention Outcomes

Readmission Reduction Rates



Care Transitions Reduction Pilot - Highest Utilizers

Outcomes for 89 Enrollees (Medicaid & Medicare)

43 of the 89 Enrollees had 100% Decrease Utilization

Prior to Enrollment		Post Enrollment
63 ED Visits	→	0 ED Visits
35 Hospital Admissions	→	0 Hospital Admissions

35 Enrollees Reduced Utilization by 56.1%
With no 30-Day Readmissions

11 Enrollees Readmitted Within 30-Days of Discharge

So What's The Problem?

- Why have VAAA Cares and other seemingly successful initiatives not seen wider scale adoption?
- Virginia isn't the only state wrestling with this challenge
- The Trusted Broker Model may be a solution

Collaborative Approach to Public Good Investments (CAPGI):

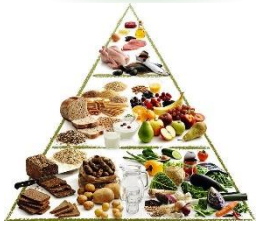
A Sustainable Financing Tool For *Communities*

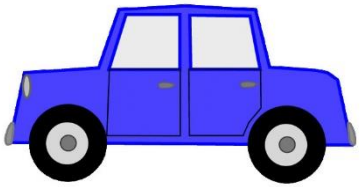
Len M. Nichols, Ph.D.

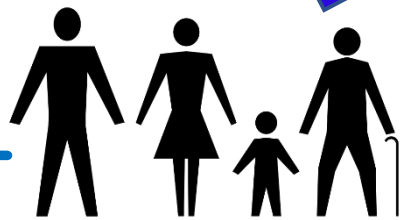
Urban Institute

December 17, 2020

Value Creation from Upstream Interventions



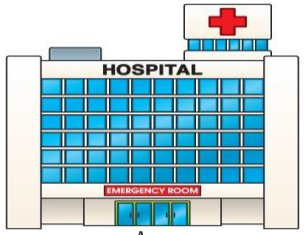


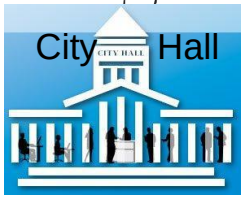


Improved Health And well being

Stronger Community

Lower Costs, Or Mission-Consistent Value





How Long?

COMMUNITY HEALTH

By Len M. Nichols and Lauren A. Taylor

DOI: 10.1377/hlthaff.2018.0039
HEALTH AFFAIRS 37,
NO. 8 (2018): 1223–1230

POLICY INSIGHT

Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039

CAPGI Helps Stakeholders Find Fair and Effective Prices to Pay for Intervention

- Private Solutions to "Free-Rider" problem possible under 2 conditions
  - Operational local stakeholder coalition
  - "Trusted Broker"
- Those conditions are widespread today
- Key elements of CAPGI model:
  - Reveal willingness to pay to the trusted broker *only*
  - If aggregate value > cost, we help TB assign fair prices so that surplus is shared
  - Contributions and Sustainability are based on enlightened self-interest

Example of Pricing for Upstream Investments

Cost: $180 for Complex Case Management by CHWs and Social Workers

Value Expressed

Insurers — Initial Bid: $110

Hospitals — Initial Bid: $50

Non-Vendor CBOs — Initial Bid: $40

= $200

Sum of Bids (Collective Valuation) = $110 + $50 + 40 = $200

But We only Need $180 to Cover the Cost

so

We need 90% (180/200) of Total

We can allow 10% "Discount" to All Bidders

Note: **Fairness Constraints** *Satisfied*!!

Prices Assigned

Insurers — Price Charged: $99 ($11 less than Bid)

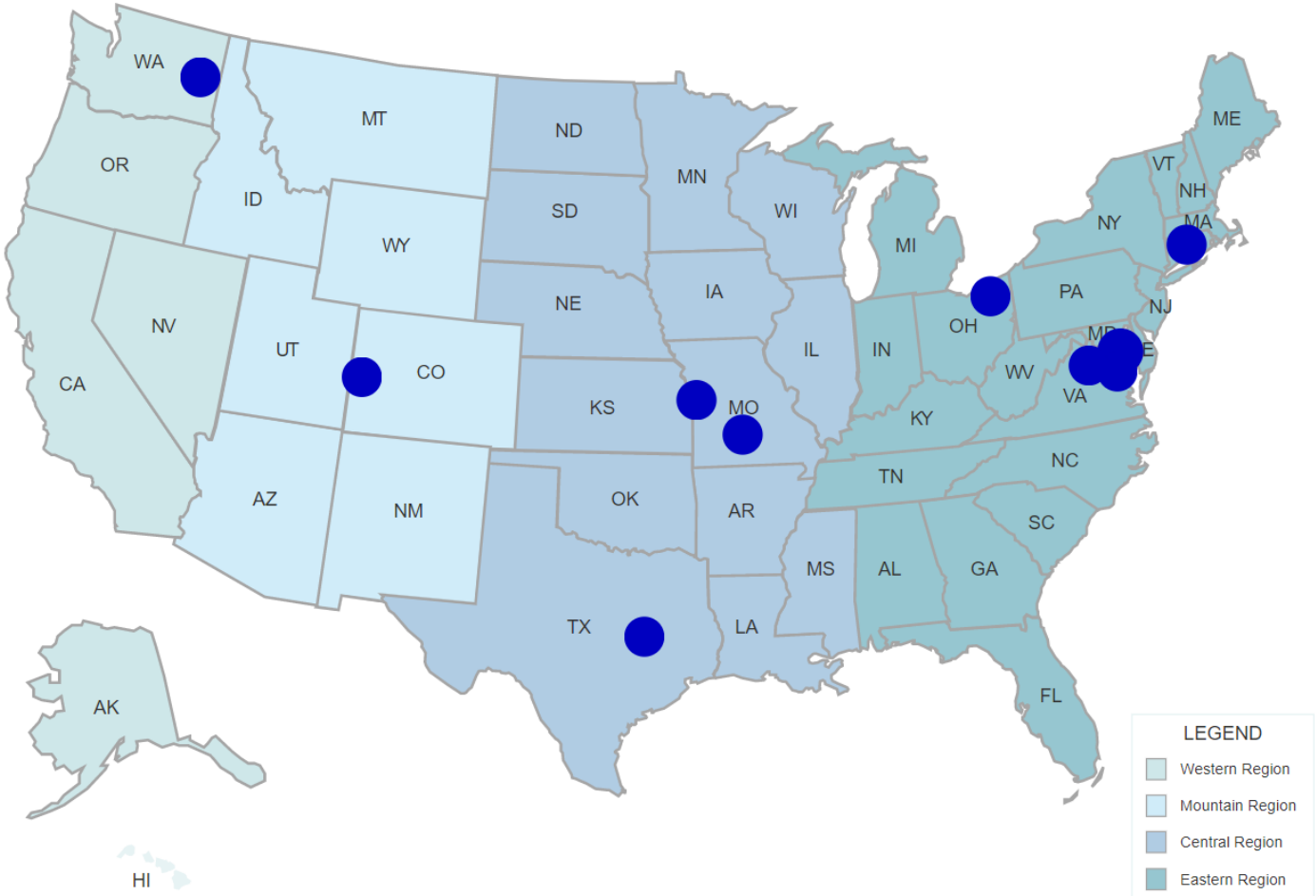
Hospitals — Price Charged: $45 ($5 less than bid)

Non-Vendor CBOs — Price Charged: $36 ($4 less than bid)

= $180

Total Collected = $180 = Cost of Intervention = $180, but *VALUE delivered = $200*

Communities Participating in CAPGI 2020



CAPGI Locations and SDOH Foci

- Spokane, WA----------
- Grand Junction, CO----------
- Waco, TX----------
- Anne Arundel County, MD----------
- Kansas City, KS/MO----------
- Springfield, MO----------
- Cleveland, OH----------
- DC----------
- Hartford, CT----------
- Eastern Virginia----------

- Permanent Supportive Housing (PSH)
- Case Mgt. for SI older adults in Section 8 housing
- CHW services for those w/ Behavioral Health Risk
- Tiny Houses for the Homeless
- Upstream for high-risk of re-admission
- Family Connect
- Medically Tailored Meals for SI older adults
- Navigation redesign to improve BRCA outcomes
- Improving parents' ability to manage asthmatic children
- Reduce readmissions

Challenges So Far

- COVID-19
- Health care sector generally wary of “charity” requests
- Most SDOH interventions likely require Medicaid “permission”
  - Definitions of *in lieu of* or *value added*
  - Value based pricing initiatives
  - Conditional increases in allowed profit rates
- Novel interventions have less compelling evidence of impact

QUESTIONS?

lnichols@urban.org

Next Meeting and Timelines

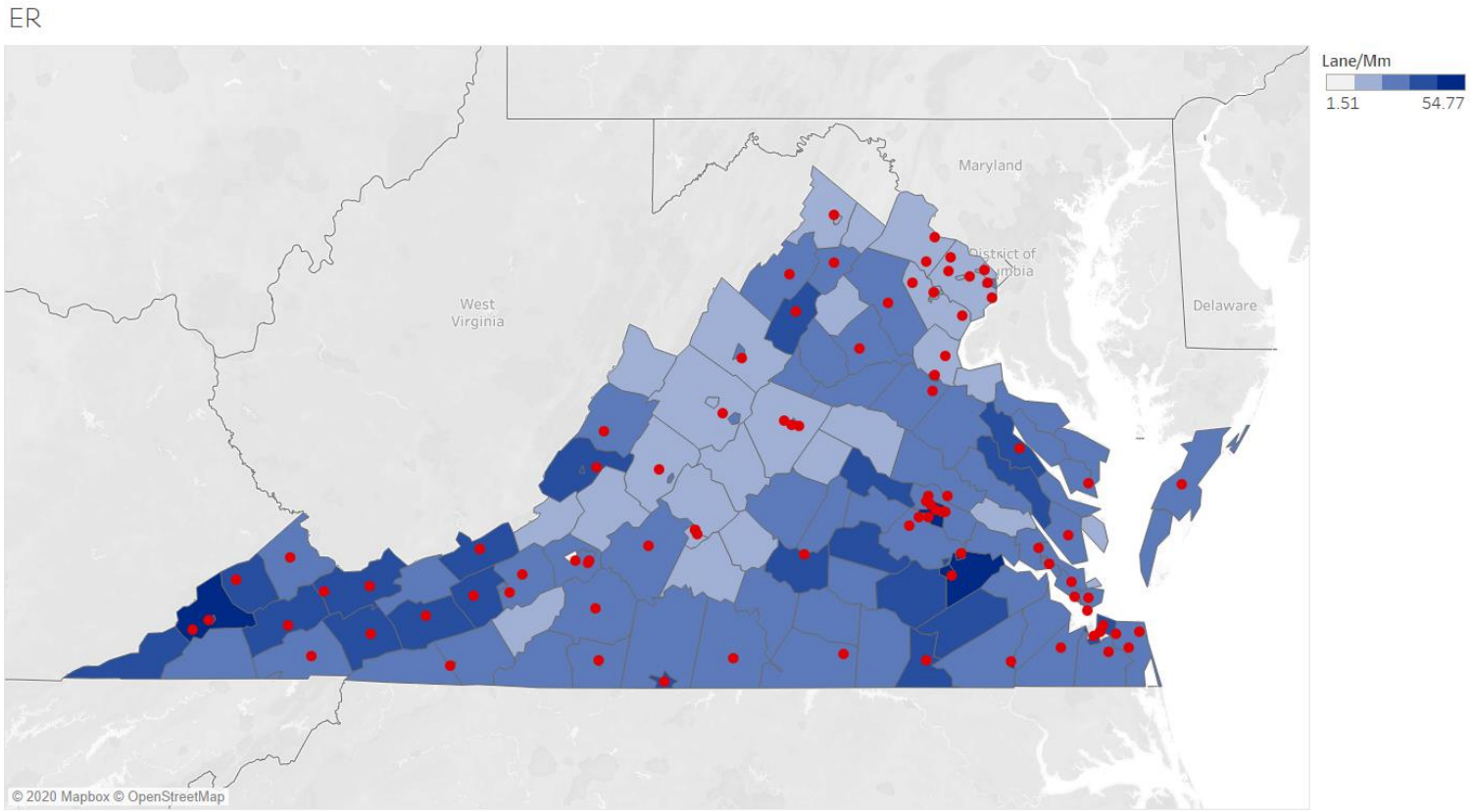
- ✓ **Next Draft Review:**
  - DMAS will send a second draft in early January for workgroup members to review and provide input by January 29, 2021.
    - The draft will include a revised ED/Readmissions section, and new sections incorporating the care coordination and discharge planning content from meeting 2.
- ✓ **Next Meeting:**
  - **March 18, 2021**, 3:00-5:00 p.m.

ADDENDUM 1: READMISSIONS AND POTENTIALLY PREVENTABLE ER VISIT MAPS

Maps for Potentially Preventable ER Visits and Hospital Readmissions

- ✓ In Meeting 1, workgroup members requested to 1) see potentially avoidable ER visits and hospital readmissions by county and 2) those same measures with hospital locations.
- ✓ The following slides show the results from the DMAS clinical efficiency measures on potentially preventable ER visits and hospital readmissions by county with hospital locations.
  - A darker shade indicates a higher rate.
  - For both measures, a lower rate is the optimal outcome.

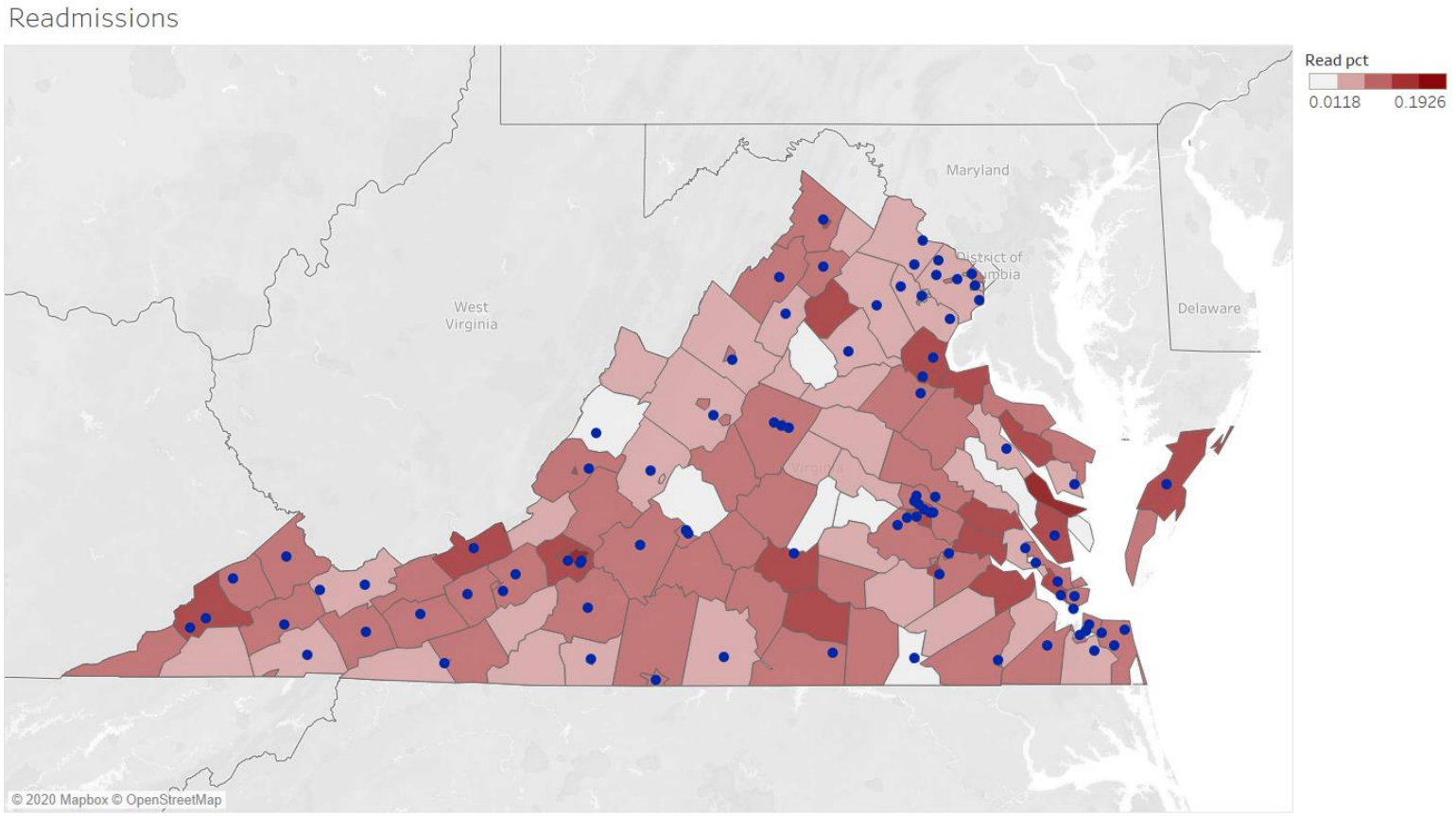
Potentially Preventable ER Visit Map



Map based on Longitude (generated) and Longitude (generated) and Latitude (generated). For pane Longitude (generated): Color shows Lane/Mm as an attribute. Details are shown for FIPS code and County name. For pane Longitude (generated) (2): Details are shown for Facility Name, Latitude and Longitude.

- ✓ Counties are shaded blue based on the rate of potentially preventable ER Visits per 1000 member months. Darker blue indicates a higher rate of potentially preventable ER Visits. For more information on the DMAS clinical efficiency measures, visit www.dmas.virginia.gov/#/valuebasedpurchasing
- ✓ The red dots represent hospitals across the Commonwealth based on VHHA data on hospital location.

Hospital Readmissions



Map based on Longitude (generated) and Longitude (generated) and Latitude (generated). For pane Longitude (generated): Color shows sum of Read pct. Details are shown for FIPS code and County name. For pane Longitude (generated) (2): Details are shown for Facility Name, Latitude and Longitude.

- ✓ Counties are shaded red based on the rate of hospital readmissions (readmissions out of total admissions). Darker red indicates a higher readmissions rate. For more information on the DMAS clinical efficiency measures, visit www.dmas.virginia.gov/#/valuebasedpurchasing
- ✓ The blue dots represent hospitals across the Commonwealth based on VHHA data on hospital location.