March 18, 2020
3:00 – 5:00 P.M. EST
WebEx: link
Meeting 4

Agenda

3:00 – 3:05 p.m.	**Welcome/Roll Call**	**Ellen Montz** **Chief Deputy, DMAS**
3:05 – 4:45 p.m.	**Discuss Potential Policy Options**	**Ellen Montz** **Chief Deputy, DMAS**
3:45 – 4:55 p.m.	**Workgroup Extension**	**Ellen Montz** **Chief Deputy, DMAS**
4:55 – 5:00 p.m.	**Closing**	**All**

MEDICAID PAYMENT POLICIES AND CARE COORDINATION WORKGROUP

Meeting 4

March 18, 2021

Meeting Agenda

❑ Welcome

❑ Review and Discussion of Potential Policy Options

❑ Workgroup Extension

❑ 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.

Policy Options from the Draft Report

✓ Review and discuss 13 policy options.

  ▪ Policy options were developed based on presentations, handouts, and discussions from meetings 1-3

✓ Policy options are categorized as they appear in the current workgroup report draft (shared with workgroup members prior to the meeting). Some policy options may be applicable to multiple categories (e.g. care coordination, lower-acuity settings, and value-based purchasing)

POLICY OPTIONS: CARE COORDINATION

Policy Option 1a— Targeted Focus on Care Coordination Responsibility and Resources Across the Commonwealth

The frequent duplication of efforts and barriers to data and information sharing that exist in the care coordination processes around a patient require specific focus. These problems are complex and go beyond the administration of financial incentives, often dealing with significant issues around administrative burden, the complexities of health care data exchange, and the cost of establishing systems to enhance and streamline the care coordination process. In an effort to focus specifically on such issues, VCHI, as an objective, non-governmental third party, should convene MCOs, hospitals, primary care providers, and DMAS stakeholders to develop a set of best practices focused specifically on synchronizing care coordination resources to avoid duplication of efforts, allow more effective data sharing, and ensure clarity of communication to Medicaid members discharged from an inpatient hospital or ED setting of care. This group may include additional stakeholders at its discretion.

Policy Option 1b—Explore an Embedded Care Coordination Model for Behavioral Health

As part of the care coordination effort outlined in Policy Option 1a, VCHI and the workgroup should explore the feasibility of adopting an embedded care coordination model in hospitals with high volume of Medicaid members, particularly with demonstrated behavioral health needs. Such work should evaluate how to avoid overlap of such efforts from multiple MCOs, criteria for identifying participating hospitals, the anticipated cost of such a model, and funding options.

POLICY OPTIONS: DATA EXCHANGE

Policy Option 2a—Fund Expansion and Adoption of EDCC among Downstream Providers

The General Assembly could provide VHI with direction and funding to address barriers to on-boarding downstream, non-acute providers to the EDCC. This charge should also support creating a functionality that notifies downstream providers when their patients had an ED visit and relevant information from the visit. Such efforts could include, but are not limited to, allowing additional customization of the amount and type of data a provider is able to receive, streamlining legal and administrative requirements to accessing such data, and the flexibility necessary to undertake additional efforts to appropriately expand EDCC access to providers with a member care business case for such access.

Policy Option 2b—Expand Care Insights

VHI could continue and expand efforts to increase the percentage of members with high ED utilization who have a Care Insight included in their EDCC records. Care Insights are additional context included by the ED providers on a member and the circumstances around their ED visit. This work should include efforts from DMAS, Medicaid MCOs, Hospitals, and EDs to encourage the same. Workgroup members highlighted that they see a significant decrease in ED visits for patients whose EDCC record includes Care Insights information.

Policy Option 2c—Align Measurement Efforts

DMAS could work with VHI and VHHA to craft a uniform definition of ED "super-utilizer" to align performance measurement efforts for Medicaid members across the state. VHI and VHHA both currently track such measures of ED utilization and DMAS and MCOs could streamline efforts by developing/adopting similar measurement capacity to track MCO performance.

POLICY OPTIONS: LOWER-ACUITY SITES OF CARE

Policy Option 4a—Increase Primary Care Rates to Promote Increased Non-Traditional Access

Currently, Medicaid pays primary care providers approximately 76% of Medicare rates. The General Assembly could consider bringing payment for PCPs more in line with Medicare through a non-fee-for-service-based payment structure, such as a per-member-per-month model, and accompanied by the expectation of the adoption of certain practice features meant to facilitate broader or more convenient access for Medicaid members. Examples of such features include guaranteed access during expanded night and weekend hours, 24/7 access to consultation for urgent needs with an individual who has access to the patients EMR data, and/or provider enrollment in the EDCC program. Additionally, such payments could be linked to performance on designated health outcomes influenced by the provision of high-quality primary care, such as ED visits.

Policy Option 4b—Include Coverage of Additional Care Management Services

The General Assembly could consider more completely funding chronic care management activities in lower-acuity settings to align payment levels with the extent of activities and services necessary by downstream providers, like PCPs, to reduce avoidable/preventable utilization in the ED and hospital. To accomplish this, the General Assembly could direct DMAS to cover CPT 99491, which covers each additional 30 minutes of physician or other qualified health professional time per calendar month used to establish, implement, revise, monitor a comprehensive care plan for members with two or more chronic conditions expected to last at least 12 months that also put the member at risk of death or acute exacerbation. Additionally, the General Assembly could approve funding for and direct DMAS to cover complex chronic care management codes, such as 99487 and 99489. CPT 99487 covers the same chronic care management activities but for cases with moderate or high complexity in medical decision making, and 99489 covers each additional 30 minutes per month for those activities.

Policy Option 4c—Targeted Increased Payment Rates for Access-Promoting Services

The General Assembly could direct DMAS to increase the payments for CPT codes associated with extended hours access to services such as nights, evenings, weekends, and holidays. Increasing payment for services provider outside of normal business hours (9 a.m. – 5 p.m.) may increase office hours, access to services for Medicaid members, and potentially reduce avoidable and unnecessary ED utilization.

POLICY OPTIONS: HEALTH RELATED SOCIAL NEEDS

Policy Option 5a—Fund Direct Connection between MCOs and Unite Us

The General Assembly could fund access to Unite Us for Medicaid MCOs as a critical partner in care coordination for Medicaid members HRSNs. MCO care coordinators access to Unite Us would enable them to make referrals to needed services for Medicaid members through the platform, much like other stakeholders with access, and for MCO care coordinators to follow up with members who have referrals from other Unite Us users.

Policy Option 5b—Move Toward Population-Based Payments

DMAS could encourage MCOs and providers to pursue financial structures that move away from volume based financial incentives and increase financial alignment with a population health focus. This effort could include development of a statewide program to encourage the adoption of Medicaid accountable care organizations, whereby entities comprised of health care payers and/or providers take on accountability for the cost and quality of care furnished to a defined Medicaid population. In establishing this program, DMAS should work with providers, MCOs, and other health care stakeholders to identify the barriers to more holistic member care and establish a model that removes such barriers to promote provider care and financial flexibility in exchange for significant accountability for member costs and health outcomes.

Policy Option 5c—Medicaid Pilot of Trusted Broker

The General Assembly could provide funding and authority for DMAS to test the Trusted Broker Model on a defined intervention targeting Medicaid member HRSN in a specific area. This effort should focus on an area likely to have significant impact on reducing members' utilization of the ED or hospital readmissions. DMAS should research a range of options for this intervention and report recommendations to the General Assembly no later than 6 months after the enactment of this provision. Additionally, the funding to implement this pilot project should fund an evaluation of said project to address the effectiveness of the intervention, as well as provide information on how DMAS could pursue expansion of the pilot if it is deemed to be effective.

POLICY OPTIONS: VALUE BASED PURCHASING

Policy Option 6a—Increase Emphasis on VBP Adoption in Managed Care

DMAS currently includes VBP penetration targets in its managed care contracts. DMAS could increase the emphasis on VBP adoption within the Medicaid market by setting multi-year targets to increase VBP adoption and incorporating VBP targets as a measure under the PWP. These targets could be set to prioritize the adoption of Category 3 and 4 models in future years.

Policy Option 6b—Add Upside Incentives to Hospital Payment Policy

The General Assembly could fund and authorize the creation of a Medicaid hospital VBP program which provides upside financial incentives for hospitals to achieve reductions in potentially preventable, avoidable, and/or unnecessary ED visits and includes enhanced requirements around the hospital's use of the EDCC and accountability for designated performance metrics (e.g. PCP follow-up).

Bring Your Own Policy Options

✓ Open discussion for workgroup members to suggest additional policy options for group consideration.

Workgroup Extension

The workgroup timeline is very likely to be extended to November 1, 2021.

- ✓ **Collect Feedback on Draft Report:**
  - ■ Workgroup members should provider written feedback on the draft workgroup report to DMAS (rusty.walker@dmas.Virginia.gov) by March 31, 2021.
- ✓ **Select One Area for Additional Research, Analysis, and Expanded Discussion of Policy Options:**
  - ■ With the workgroup extension, we will convene two additional meetings in May and July. Workgroup members will select one policy are they would like to devote additional time to develop.

DMAS