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

Agenda

3:00 – 3:05 p.m.	**Welcome/Roll Call**	**Ellen Montz,** **Chief Deputy, DMAS**
3:05 – 3:30 p.m.	**Discuss Additional Policy Options from Workgroup Members**	**Rusty Walker** **Director, VBP, DMAS**
3:30 – 4:10 p.m.	**CBC Solutions: Complex Care Management Presentation and Discussion**	**Enrique Enguidanos (MD,FACEP, MBA)** **CEO/Founder, CBCS**
4:10 – 4:55 p.m.	**Refine EDCC Policy Options**	**Melissa Mannon,** **VBP, DMAS** **Kyle Russell,** **Director of Strategy and Analytics, VHI**
4:55 – 5:00 p.m.	**Closing**	**All**

MEDICAID PAYMENT POLICY AND CARE COORDINATION WORKGROUP

Meeting 5

May 19, 2021

Meeting Agenda

- Welcome
- Review of Workgroup Member Policy Options
- Community Based Coordination (CBC) Solutions Presentation on Complex Care Management
- Refine EDCC Recommendation(s)

Disclaimer

The primary goal of this workgroup is to provide a report to the General Assembly highlighting data, findings, and policy options 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 Workgroup Members

Policy Option: Convene a Medicaid Member Focus Group

Incorporate the “Voice of the Member” by convening a focus group comprised of Medicaid Members to provide the member perspective related to Emergency Department utilization and associated recommendations, access to lower-acuity sites of care, behavioral health resources, and care coordination.

Policy Option: Increase Rates for Behavioral Health Providers

The General Assembly should direct DMAS to increase payment rates for behavioral health providers to expand the network of providers accepting Medicaid and reduce wait times for post-discharge behavioral health appointments.

Policy Option: Eliminate Emergency Department Utilization Policy Under Item 313 AAAAA

Eliminate Item 313 AAAAA in the budget that down-codes hospital and emergency physician services provided in an emergency department based on the final principal diagnosis code listed on the Medicaid claim.

Policy Option: Modify the Readmission Program under Item 313 BBBBB

Replace the current reimbursement reductions under Item 313 BBBBB with an approach that aligns with the Hospital Readmission Reductions Program under Medicare by:

- ✓ Measuring a hospital's performance relative to other hospitals with similar patient populations.
- ✓ Risk-adjust or otherwise account for select social risk factors.
- ✓ Target condition/procedure-specific measures with the highest risk for Medicaid (e.g. the CMS Medicare Hospital Readmissions Reduction Program [HRRP] targets AMI, COPD, Heart Failure, Pneumonia, CABG, and elective primary total hip arthroplasty and/or total knee arthroplasty).
- ✓ Limit payment reductions (e.g. HHRP limits reductions to no more than 3%).

CBC Solutions: Complex Care Coordination

CBC SOLUTIONS

COMMUNITY BASED COORDINATION

Introduction to CBCS: Virginia Medicaid Care Coordination and Payment Policy Workgroup

ENRIQUE ENGUIDANOS, MD, FACEP, MBA

CEO/FOUNDER CBCS

CBCS – What We Do…..

Community coordination of resources and care for complex patients

How?

Direct Patient Engagement With 24/7 availability	Developing Personal Connections With Community Resources	Removing barriers between care silos

CBCS Track Record in "CM States"

Washington

- 2012 "7 Best Practices"
  - Year 1 state-wide data
    - 15% reduction in utilization
    - 10% reduction opioid Rxs
    - $34 million Year 1 saving
  - Year 1 CC-region data
    - 50% reduction in utilization
    - 30% reduction opioid Rxs
    - 40% costs savings/enrollee

Alaska

- 2017 MSHF HUMS Program
  - Year 1 state-wide data
    - No reductions in utilization
    - 10% reductions opioid Rxs
    - No cost savings identified
  - Year 1 HUMS data
    - 60% reduction in utilization
    - 50% reduction in opioid Rxs
    - >$40,000 savings/enrollee

CBCS Key Performance Indicators

- Emergency Department visit reductions
- Hospital Admissions reductions
- Decreased out-patient no-show rates
- Decreased emergent community resource use (EMS and Law Enforcement calls)
- Increased satisfaction (patient/provider/resource)
- Decreased controlled substance use
- Decreased homelessness
- Costs

3 Tools that maximize CBCS's efforts

- Health Information Exchange (HIE)
  Collective Medical (EDIE/PreManage)
- Community Information Exchange (CIE)
  Aunt Bertha
  UniteUs
- Immediate Access Fund

CBCS Catalyst Programs

DIRECT PATIENT ENGAGEMENT

COMMUNITY RESOURCE ENGAGEMENT

CUSTOMIZED CARE PLANS

COMMUNITY MULTI-DISCIPLINARY TEAM

CONTROL SUBSTANCE PROGRAM

CBCS Patient Engagement Program

Staff

- Community Workers
  - Lived-experience
  - Local
  - Field-based
- Coordinate with existing resources
  - Providers
  - Coordinators

Engagement

- Intake assessment
  - Validated risk tools
- Customized care plans
- 24/7 patient access
- Immediate Access Fund
- Resource coordination/navigation
- Immediate follow-up
  - After ED/PCP visits

Outcomes

- Achieved within months
- 20% reduction in expenditures
  - Reduced ED use
  - Reduced hospitalizations
- Additional KPIs
  - Decrease opioid Rxs
  - Decrease EMS/LE calls
  - Community Engagement

Mary's Story

Immediate opportunity (achievable within 1 year)

Improved Care

- Decreased Opioid Use
- Improved Prevention Care
  - Decreased Crisis Events
- Increased PCP Engagement
- Increased Resource Access

Better Coordination

- Decreased Duplication
- Common Care Plan Use
- Increased coordination btw EDs + PCPs
- Improved communications amongst all resources

Outcomes

- Decreased ED Utilization
- Decreased Hospital Admissions
- Decreased LE/EMS Calls
- Decreased PCP "No Shows"
- Decreased Opioid Prescriptions
- Financial Savings

Virginia data (07/19 - 06/20)

(Source – Virginia Dept Health All Payer Claim Database) Obtained via VHI

1.5 Million Medicaid patients

17,700 patients with 10+ ED visits

- 70% have behavioral health diagnosis
- 282,000 Total ED visits
- 36,000 Total Inpatient visits

$1.1 Billion annual expenditure

One possible approach….

- 1,000 enrollees/year
- Annual "at-cost" program = $1.8 million
  - Staffing
  - Resources
- Annual savings (35%) = $21 million
  - Target-based incentives

CBCS adapts to local needs

Turn-Key Model

- CBCS staff
  - Community Workers
  - Lived Experience
- On-going
- Contracting options
  - PMPM
  - Incentive-Based

Consult Model

- CBCS program with local staff
  - CBCS protocols
  - CBCS oversight
- Yearly contracting fee
  - On-site monthly
  - Virtual meetings weekly
  - 24/7 availability

Short-Term Training

- Focus on specific CBCS catalysts
- Several packages
  - Hand-in-Hand
  - Hybrid
  - Virtual
  - Lectures
- Typically, over few months

Virginia MCCPPW and Complex Care

MISSED OPPORTUNITIES DAILY

WHERE DO YOU WANT TO BE?

BY WHEN?

CBCS CAN HELP

NEXT STEPS?

Additional Discussion of EDCC Optimization

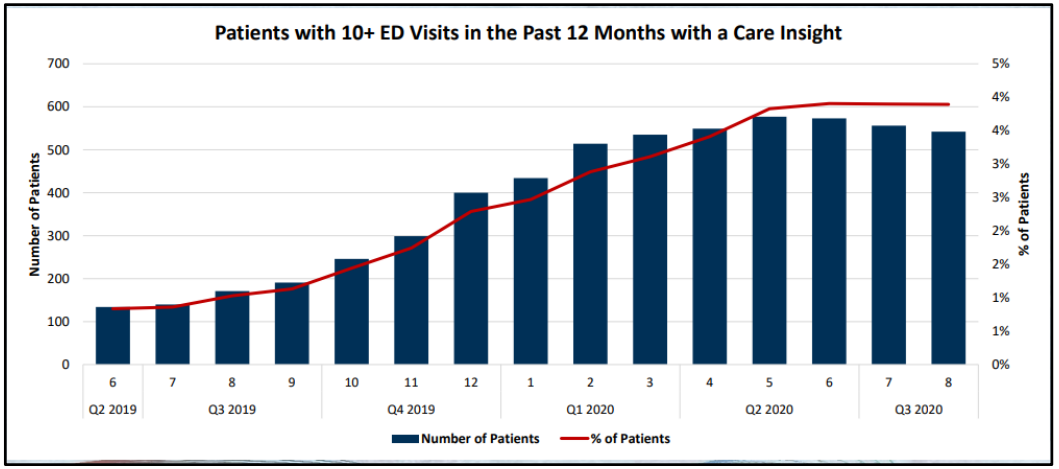
Policy Option 2b—Expand Care Insights

The group provided verbal and written feedback on policy options; the most common comment was that the policy options need to be more specific.

Policy Option Discussed in Meeting 4	High Level Feedback from the Group
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. This work should include efforts from DMAS, Medicaid MCOs, Hospitals, and EDs to encourage the same.	• General support/ consensus that increasing care insights is beneficial. • Clarity needed on *who* is responsible for adding care insights, and *who* is the user of the care insights. • Policy option should specify goals/targets for completing care insights. • Outstanding question on *how* to build accountability (e.g. incentives, contract requirements, etc.)

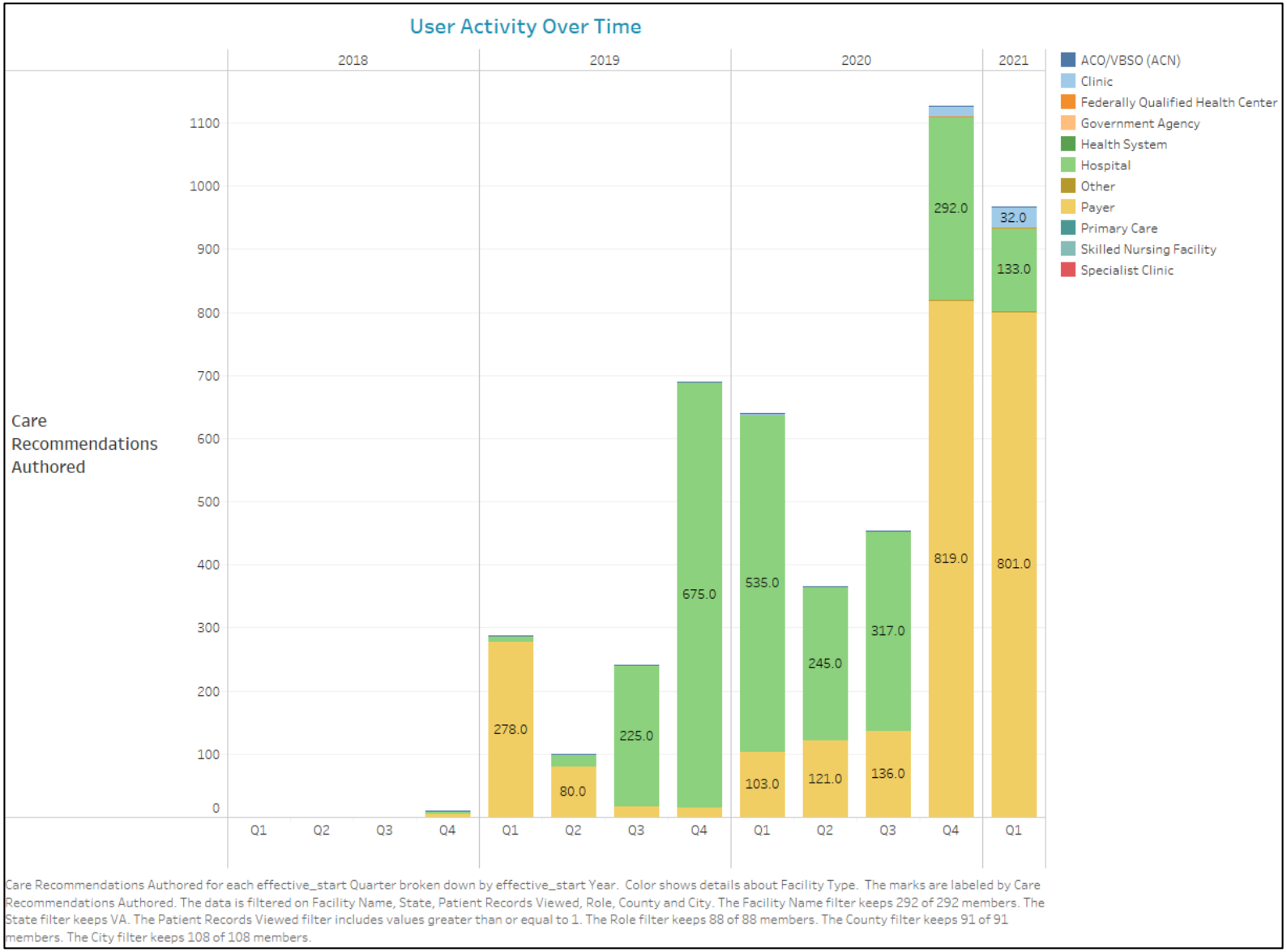
Review of Care Insights Information from Past Meetings

- ✓ About 4-5% of patients with 10+ ED visits in 12 months had a care insight.
- ✓ Among patients with 100+ ED visits, **less than half** have and care insight.



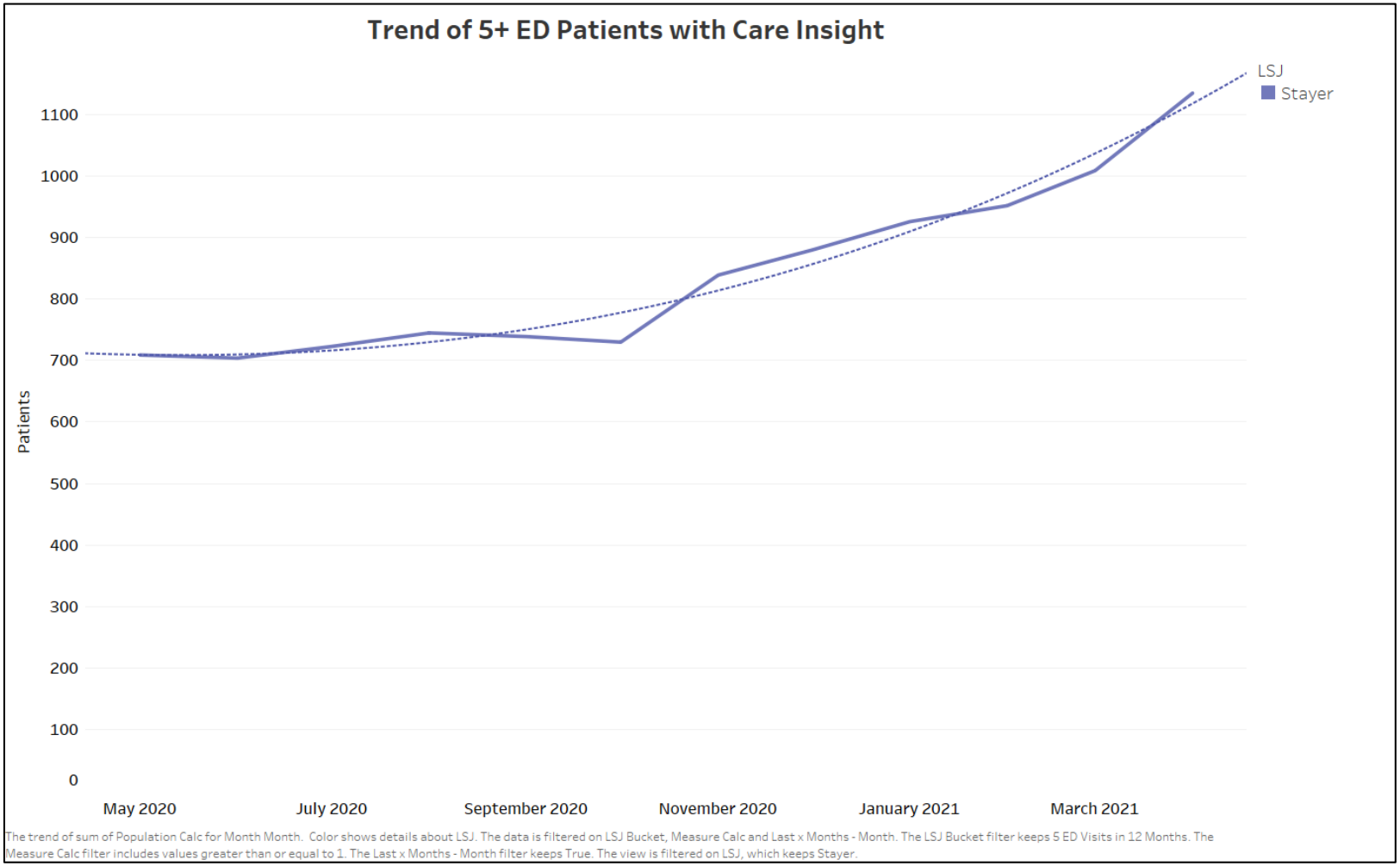
Collective Utilization Category	Visit Count in 12 Months	Number of Patients	Total ED Visit	Percent with Care Insight
Rising Risk	10 - 14	10,297	117,641	4.4%
	15 - 19	2,743	45,515	8.3%
High Utilization	20 - 29	1,693	39,670	13.7%
	30 - 49	699	25,836	18.2%
Super Utilization	50 - 74	184	10,852	29.3%
	75 - 99	59	5,023	40.7%
Extreme Utilization	100 +	59	8,531	44.1%
Grand Total		15,734	253,068	7.3%

Author(s) of Care Insights (VHI)

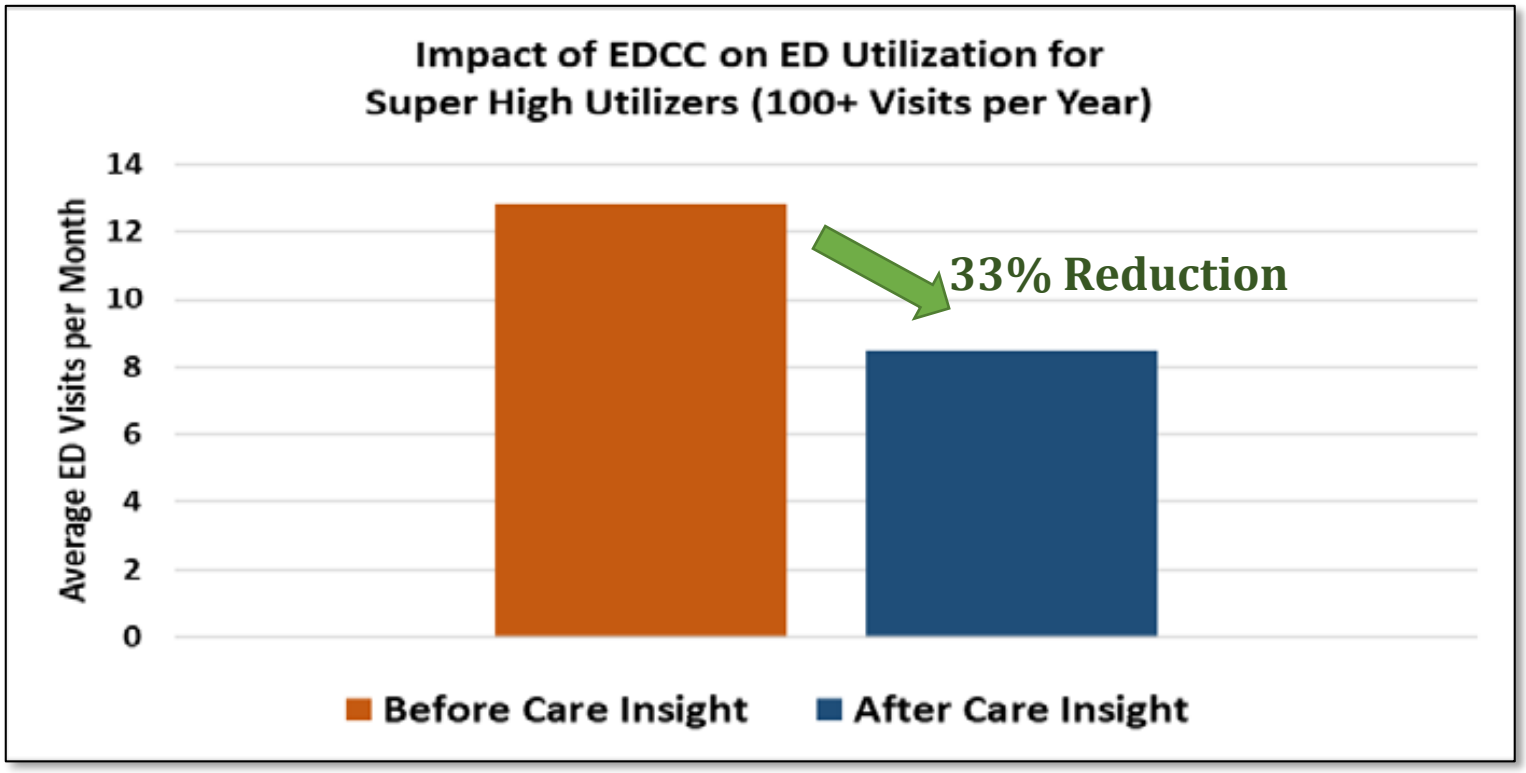


Care Recommendations Authored for each effective_start Quarter broken down by effective_start Year. Color shows details about Facility Type. The marks are labeled by Care Recommendations Authored. The data is filtered on Facility Name, State, Patient Records Viewed, Role, County and City. The Facility Name filter keeps 292 of 292 members. The State filter keeps VA. The Patient Records Viewed filter includes values greater than or equal to 1. The Role filter keeps 88 of 88 members. The County filter keeps 91 of 91 members. The City filter keeps 108 of 108 members.

Growth in Care Insights (VHI)



Impact of Care Insights (VHI)



20% decrease for patients with 10+ visits as well!

Workgroup Discussion of Care Insight Policy Option

- ✓ How might the group further specify the policy option to address the group feedback, such as identifying:
  - The target population(s) for care insights,
  - A reasonable/ achievable target for improvement,
  - Who should complete the care insights, and
  - Incentives, contract requirements, or other tools to consider to support the policy.
- ✓ Are there elements that make a care insight more or less useful?

Policy Option 2c—Align Definitions

The group provided verbal and written feedback on policy options; the most common comment for this option was support for how the Collective Medical/ EDCC platform categorizes utilization.

Policy Option Discussed in Meeting 4	High Level Feedback from the Group
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.	• Group sentiment was to align with Collective Medical/ EDCC platform. • Some referenced the alert for a person who has 5+ ED visits in 12 months (which is not the Collective Medical/ EDCC definition)

Review of Definitions from Collective Medical/ EDCC

- ✓ The EDCC platform does “flag” patients with 5+ visits to the ED within in 12 months.
- ✓ The EDCC platform defines “Super-Utilization” as 50-99 ED visits in 12 months.

Collective Utilization Category	Visit Count in 12 Months
Rising Risk	10 - 14
	15 - 19
High Utilization	20 - 29
	30 - 49
Super Utilization	50 - 74
	75 - 99
Extreme Utilization	100 +

Workgroup Discussion of Aligning Definitions

- ✓ Should the workgroup adopt the Collective Medical / EDCC definitions for the utilization categories for the report and policy options?
  - **Rising Risk**: 10-19
  - **High Utilization**: 20-49
  - **Super Utilization**: 50-99
  - **Extreme Utilization**: 100+

Policy Option 2a—Increase Downstream Provider Use of EDCC

The group provided verbal and written feedback on policy options; the feedback on this option was mixed on whether or not action is needed.

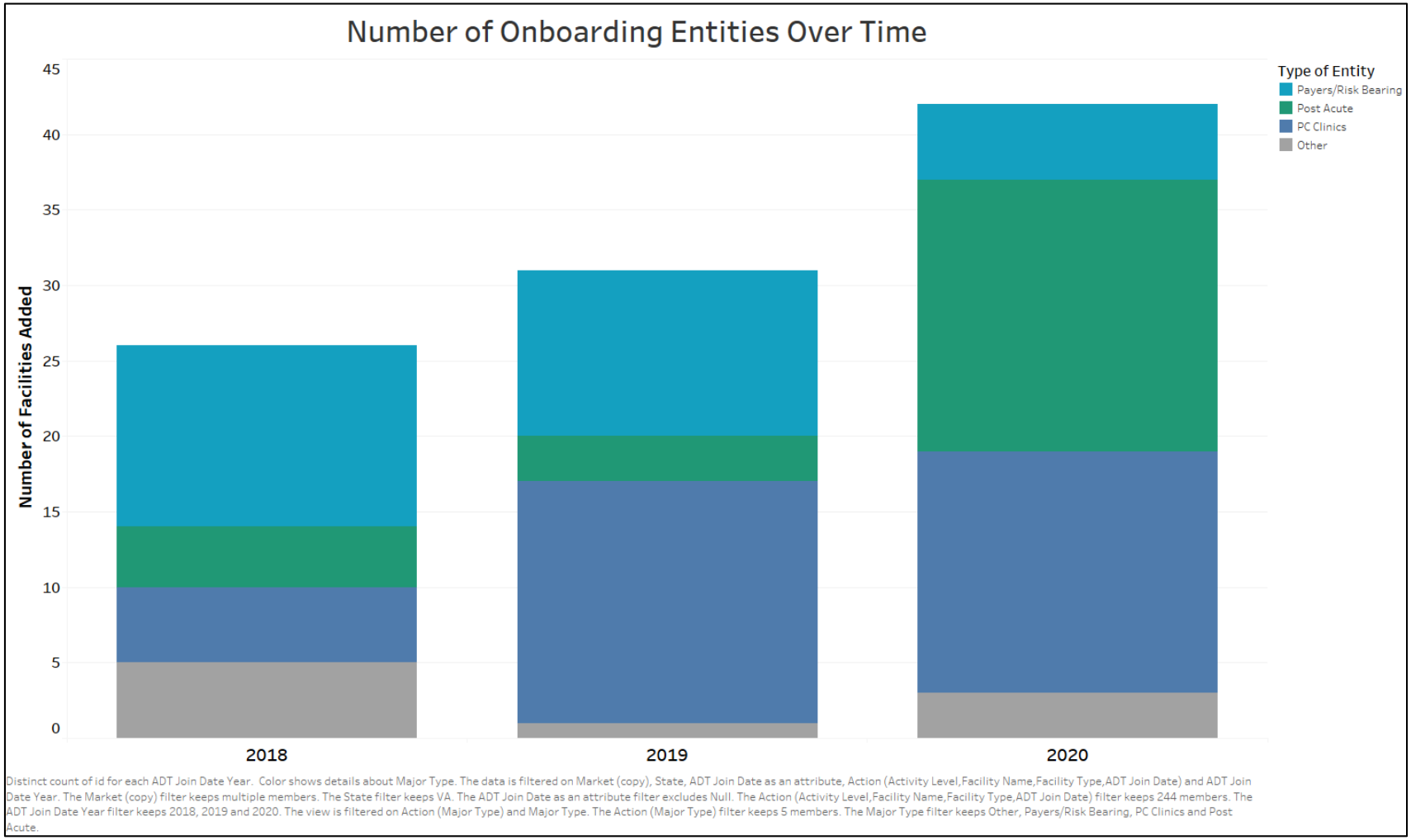
Policy Option Discussed in Meeting 4

Increase Downstream Provider Use of EDCC: 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.

High Level Feedback from the Group

- General support, consensus that it would be a positive outcome to have more downstream providers engaged with EDCC.
- Differing views on whether adoption/expansion would occur with time or there needs to be policy to spur and/or expedite.

EDCC Onboarding Update (VHI)



Distinct count of id for each ADT Join Date Year. Color shows details about Major Type. The data is filtered on Market (copy), State, ADT Join Date as an attribute, Action (Activity Level,Facility Name,Facility Type,ADT Join Date) and ADT Join Date Year. The Market (copy) filter keeps multiple members. The State filter keeps VA. The ADT Join Date as an attribute filter excludes Null. The Action (Activity Level,Facility Name,Facility Type,ADT Join Date) filter keeps 244 members. The ADT Join Date Year filter keeps 2018, 2019 and 2020. The view is filtered on Action (Major Type) and Major Type. The Action (Major Type) filter keeps 5 members. The Major Type filter keeps Other, Payers/Risk Bearing, PC Clinics and Post Acute.

Growth of Downstream Network: Currently in IT Implementation (VHI)

Workgroup Discussion of Increasing Downstream Provider Use of EDCC

- ✓ Should the workgroup continue to consider this policy option to increase use of the EDCC among downstream providers?
- ✓ If yes, how might the workgroup make the policy option more specific? For example,
  - Prioritize certain downstream providers with most ability to impact future ED utilization,
  - Define an improvement target and reasonable timeframe,
  - Identify how to support this policy, like funding for VHI, provider contracts, etc.

Next Meeting and Timelines

- ✓ **Meeting 6: June 16, 2021**, 3:00-5:00 p.m.
  - Behavioral Health Focus
- ✓ **Meeting 7: July 9, 2021,** 3:00 – 5:00 p.m.
  - Final voting on policy options by workgroup members
  - Updated report will be provided in advance of this meeting
- ✓ **August:** Incorporate final input & complete drafting
- ✓ **September & October:** Department & Administration Review
- ✓ **November 1, 2021:** Report Due to the General Assembly