Medicaid Care Management Strategies

Interim Health Care Committee | November 1, 2023 | Sarah Aker

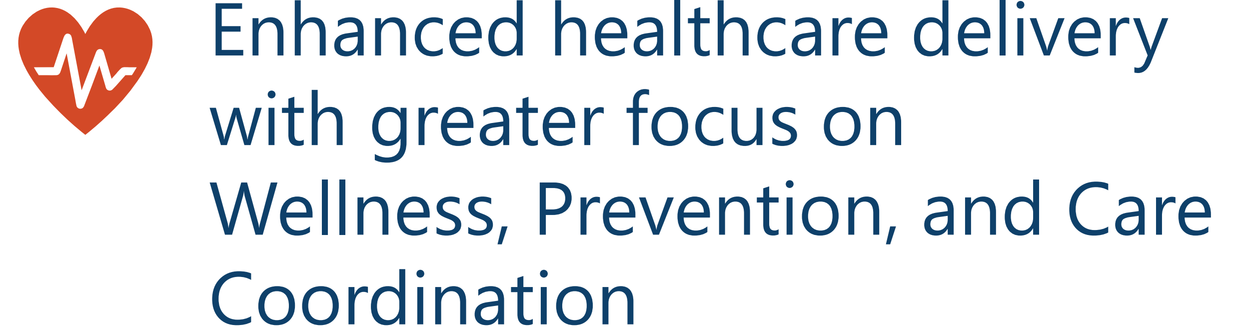
Senator Davison, Chair

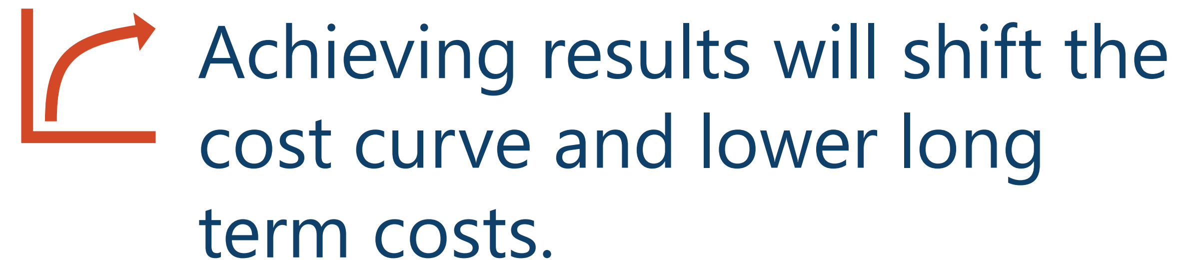
Health & Human Services

Agenda

- Review ND Medicaid Value Based Care Strategies
- Care Management Options in Medicaid
- Future Considerations

Why Value-Based Care?





Health System Value Based Care

- Puts a portion of hospital payments at risk for performance on a set of quality measures.
- If health systems fail to hit the targets, up to 4% of Medicaid revenue for a subset of services and population returns to the state.
  - Systems are given an opportunity to earn back funds through performance on measures in comparison to their peers.
- To support systems in being successful, the Department is working to provide regular access to data analytics that highlight gaps in care and performance on measures.

Updates on Health System Value Based Care

- State Plan Amendment submitted to Centers for Medicare and Medicaid Services (CMS) for approval.
- Performance Dashboards have been shared with health systems.
- Additional resources documents are available for health systems and stakeholders:
  - Model Overview
  - Quality Measure Specifications
  - Performance Comparison Resource

Medicaid Care Management Strategies & Best Practices

What is Care Management?

Care management is a collaborative approach to healthcare that focuses on coordinating and managing services to ensure that individuals receive appropriate care in the appropriate setting.

Care Management Best Practices

- Stratification and triage by risk/need
- Integrated Care, Designated "Care Home" and patient-centered care plan
- Patient and Provider Engagement
- Information Exchange
- Performance measurement & accountability
- Align Financial incentives

Stratification and Triage

Why stratify and triage?

- Health care costs are generally highly concentrated in a very small patient subpopulation.
- Identify patients with highest needs and costs who are most likely to benefit from care management.
- Immediate outreach and intervention to avoid unnecessary costs.

- What does stratification look like?
  - Claims Data:
    - High medical expenditures;
    - High inpatient or emergency department use;
    - Diagnosis history.
  - Health Screens & Assessments:
    - Clinical Needs
    - Health Related Social Needs

Example: Medicaid Health Home Option

Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for Medicaid members with chronic conditions.

20 States have elected the Health Home State Plan Option.

Federal regulation requires stratification for the Health Home population. Individuals must:

- Have two or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions may be considered by CMS for approval.

Integrated Care, Care Home, & Person-Centered Care Plans

- Effective Care Management generally includes care coordination across and beyond traditional health care delivery.
- Centralized care homes coordinate physical, behavioral, and health related social needs.
  - Creates one go-to person for the patient to develop a relationship and trust.

- **Person-Centered Care Plans:**
  - Maps out needs across physical, behavioral and health-related social needs.
  - Engages the patient in the plan and helps set attainable and compelling goals.

Engaging Patients & Providers

Patient engagement is key to successful behavior changes to reduce long term costs. Many programs utilize strategies like motivational interviewing to engage patients in setting and reaching goals related to behavior change.

- Successful care management programs integrate with care delivery teams and embed care managers with the primary care team.
- Providers are more engaged with care management programs when they have input in program development, can refer individuals into the program, and have access to additional clinical information about patients.

Example: Enhanced Primary Care Case Management (PCCM) Models

Some states have built enhanced PCCM programs focused on integrated care, patient-centered medical homes, patient engagement and provider participation.

Many states also offer non-financial supports such as technical assistance, data analytics, and other organizational support to providers.

- **Idaho:** Established a 4-tier PCCM program that rewards providers for increasing their patient-centered medical home capabilities.
- **Colorado:** Operated an enhanced primary care medical provider which rewarded providers who adopted practices like extended hours, data use, behavioral health integration & screening, follow-up, and patient-centered care plans.
- **Oklahoma:** Only pays PCCM providers that have established care with a patient.

Information Exchange

- Effective care coordination requires that all members of a care team are communicating and working on the same set of goals in the care plan and interventions.
- May include alerts about gaps in care and real-time notifications for critical events like ED use or hospitalization to ensure coordinated discharge planning.

Example: Pennsylvania

- Integrated health profiles are developed and shared with all members of a care team. Members of the care team can access and update information electronically.

Example: South Dakota

- Use Health Information Exchange and caseload data to notify care managers of each emergency department and inpatient hospital admission for Health Home population.

Performance Measurement & Accountability through Aligned Financial Incentives

Linking performance measures with financial incentives can align states and providers to common goals and outcomes.

- Performance Measure Best Practices:
  - Quality and usefulness of measures
  - Balance of process and outcome measures
  - Source & feasibility of data collection
  - Potential for improvement
- Financial incentives can take a variety of forms:
  - Payments for Incremental Progress
  - Shared Savings Approach
  - Total Cost of Care Targets
  - Risk Based Payments
  - Alternative Payment Models

Example: Alternative Payment Models

Some states are starting to transition to alternative payment models to align accountability for performance to outcomes.

North Dakota's Value Based Purchasing program for Health Systems is a good example of aligning financial incentives with performance measurement and accountability.

- **South Dakota:** Rewards high performing Health Home providers with a quality incentive payment if the state achieves a savings threshold.
- **Colorado:** Using an alternative payment model for primary care providers that changes the amount of the FFS payment based on the provider's performance on 10 quality measures.
- **Idaho:** Launched Healthy Connections Value Care program where providers select a risk or shared savings option. Incentivizes providers to move towards PCMH model.

Future Considerations

- Explore Care management models and applicability to North Dakota
- Engage providers in care management program design
- Look for ways to complement current infrastructure and programs

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