Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

Pediatric and Medicaid Payment Models that Support Sustainable Care Delivery Models

Welcome

Ellen-Marie Whelan (CMS)

Senior Advisor at the Center for Medicare and Medicaid Innovation (CMMI)

Today's Panel

Emily Loman

Medicaid Policy Initiatives Advisor, Wisconsin Department of Heath Services

Andrew Hertz

Vice-President of the Rainbow Primary Care Institute at University Hospitals

Mary Ehlenbach

Medical Director, Pediatric Complex Care Program

Brynne Potter

Associate Professor of Pediatrics; Chief, Division of General Pediatrics & Adolescent Medicine; and Director, TIKES Center

Molly Siegel

Executive Director at University of Illinois at Chicago

Timothy E. Corden

Medical Director, Division of Special Needs, Department of Pediatrics

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Coordination of Healthcare for Complex Kids

LAN Summit

October 30, 2017

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PRESENTATION OBJECTIVES

1) Learn about a unique program, funded by CMMI which identifies and addresses gaps in care for children and young adults with chronic diseases
2) Learn the outcomes and successes of the CHECK program
3) Learn about the process, and the challenges associated with designing and implementing a payment model that is aligned with service delivery

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CHECK'S MISSION AND GOALS

Improve the coordination of health care for children and young adults with chronic conditions by engaging and collaborating with them, THEIR families and THEIR communities to provide tailored disease specific programs and to reduce their barriers to accessing medical, behavioral, and social services.

1. Reduce Costs
2. Reduce School Absenteeism
3. Increase Patient Engagement

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CHECK PROGRAM ELIGIBILITY

- Birth to 25 years of age
- Enrolled in Medicaid (traditional or MCO) in Cook County
- Diagnosis of a chronic disease(s):
  - Asthma
  - Diabetes
  - Sickle Cell Disease
  - Prematurity
  - Other chronic illnesses may also qualify for eligibility into the CHECK program
- Elevated healthcare utilization

The CHECK project was supported by Grant Number 1C1CMS331342 from the Department of Health and Human Services, a Health Care Innovation Award from the Centers for Medicare and Medicaid Innovation

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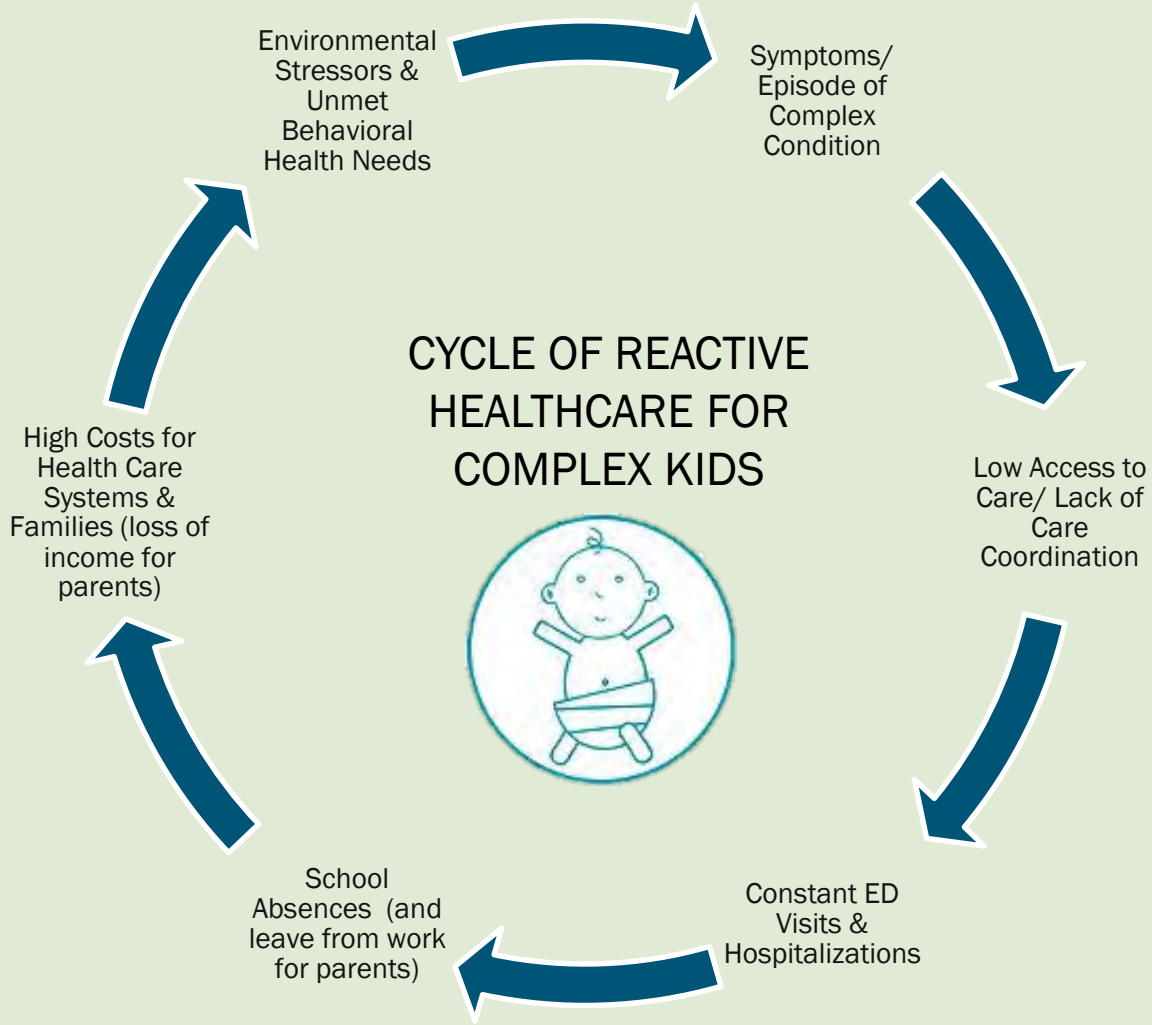
CHECK RESPONDS TO THE "REACTIVE CARE"



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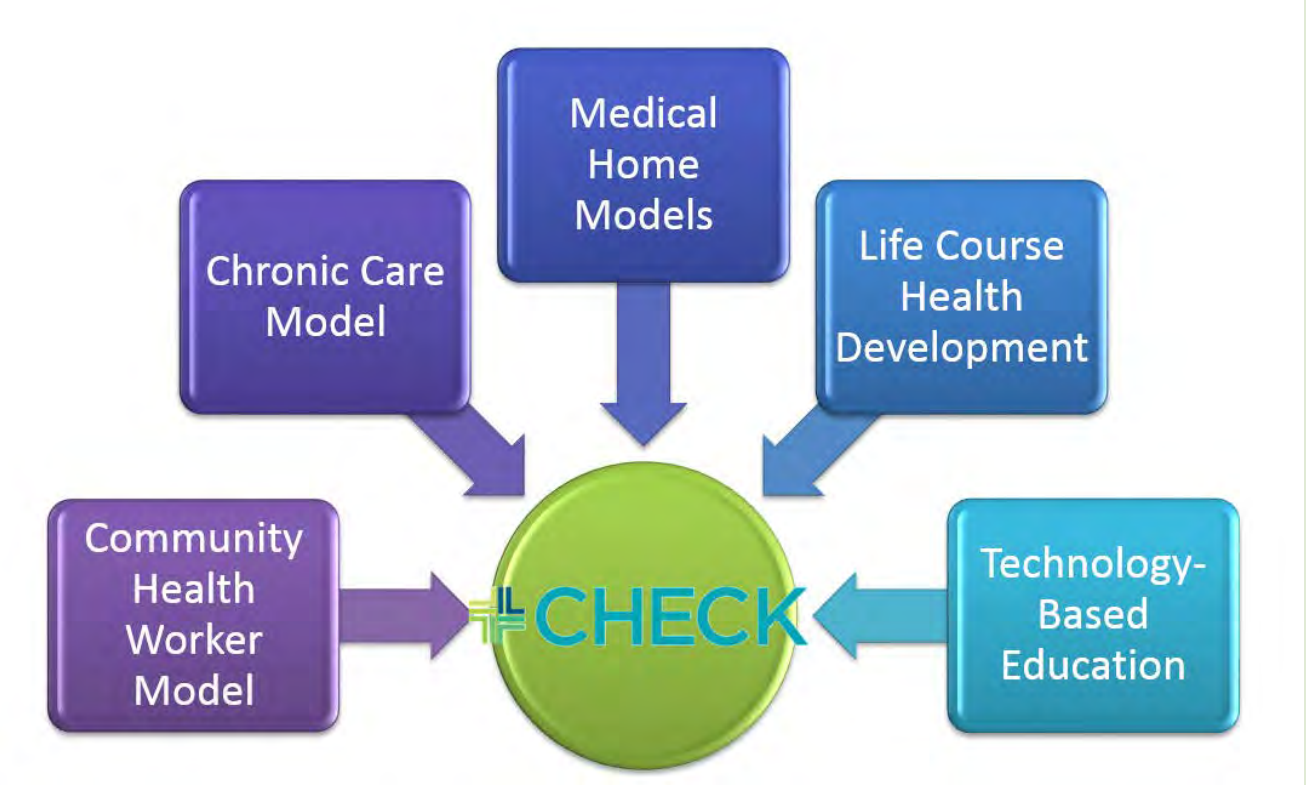
HEALTH SERVICES MODELS INTEGRATED INTO CHECK TO ADDRESS "REACTIVE CARE"



Patient-Centered Primary Care Collaborative, 2015; PCMH Congress, 2015; Coleman et al., 2009; United Voices, 2015 & APHA, 2016

HEALTH SERVICES MODELS ORGANIZED INTO CHECK "INTERVENTIONS" FOR COST EFFECTIVE DELIVERY

- **Enhanced Care Coordination** – *Population health management through Community Health Workers (CHWs) & Care Coordinators*
- **Mental Health Promotion** – *Promotion, skill building, coaching, direct interventions, and referrals*
- **Technology & Innovation** – *Online education, text messaging, use of predictive analysis, and virtual care*
- **Community Medical Neighborhood** – *Needed clinical and social services are available and promoted through 50 partnerships where CHECK families reside*
- **Medical-Legal Services –** *Screening for health harming legal needs and connection to on-staff legal team to those in need*

Interventions based on Chronic Care Model, Lifecourse Health Model, Health Technology

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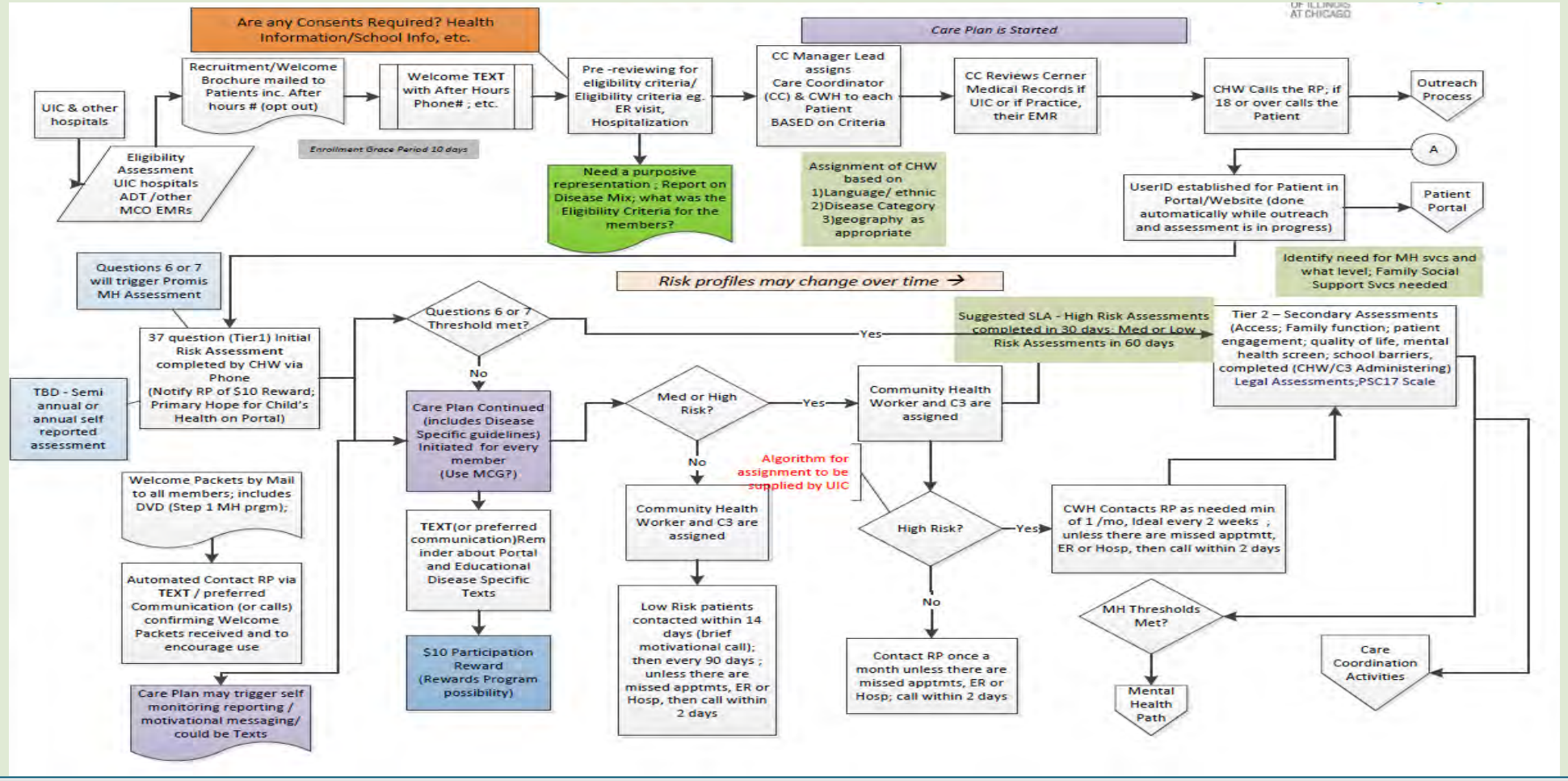
TECHNOLOGY- THE FOUNDATION OF COST-EFFECTIVE AND SEAMLESS INTERVENTION DELIVERY



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CHECK "INTERVENTIONS" COHERENTLY ORGANIZED AROUND PATIENT –SEAMLESS PATIENT EXPERIENCE

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CHECK "INTERVENTIONS" SYSTEMATICALLY "TACKLE" DRIVERS OF "REACTIVE" CARE

Care Coordination Services

- CHWs worked with 16 year old patient suffering from Asthma
- While treating patient, CHWs enlisted the help of CHECK Legal Services to help family relocate from homeless shelter

Legal Services

- Legal Services helped patient transition into new school & discovered patient needed severe mental health treatment
- Enlisted the help of the Mental Health Team to address Mental Health

Mental Health Services

- The Mental Health Team contacted SASS and discovered that patient services were not provided as planned
- With the help of our MHPT, the patient was also connected with Catholic Charities, a member of our Medical Based Community Neighborhood

Medical Based Community Neighborhood

- Catholic Charities worked to ensure that the family continued receiving additional resources

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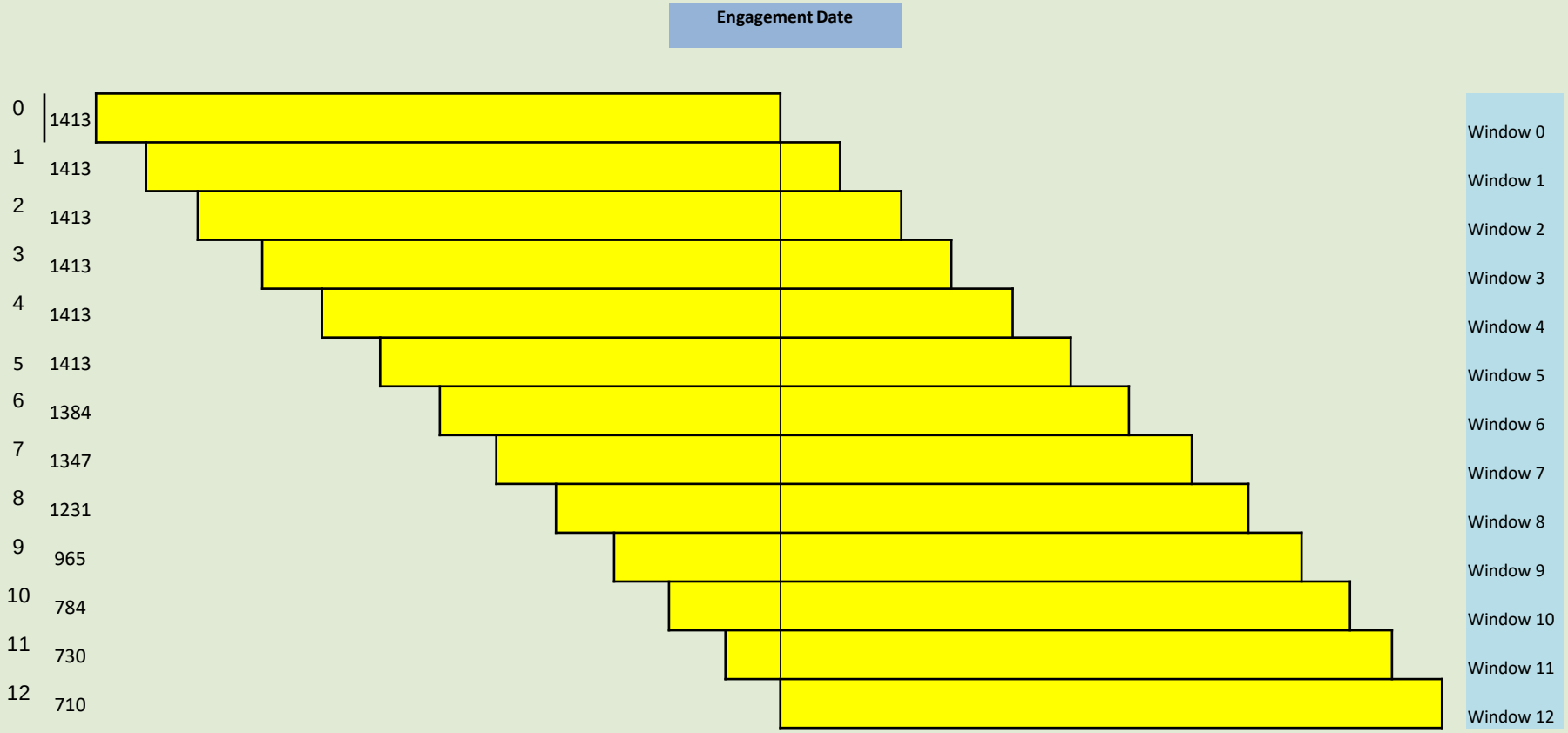
PRELIMINARY OUTCOMES

AIM # 1 : REDUCE HEALTHCARE COSTS

Sliding Window Calculation



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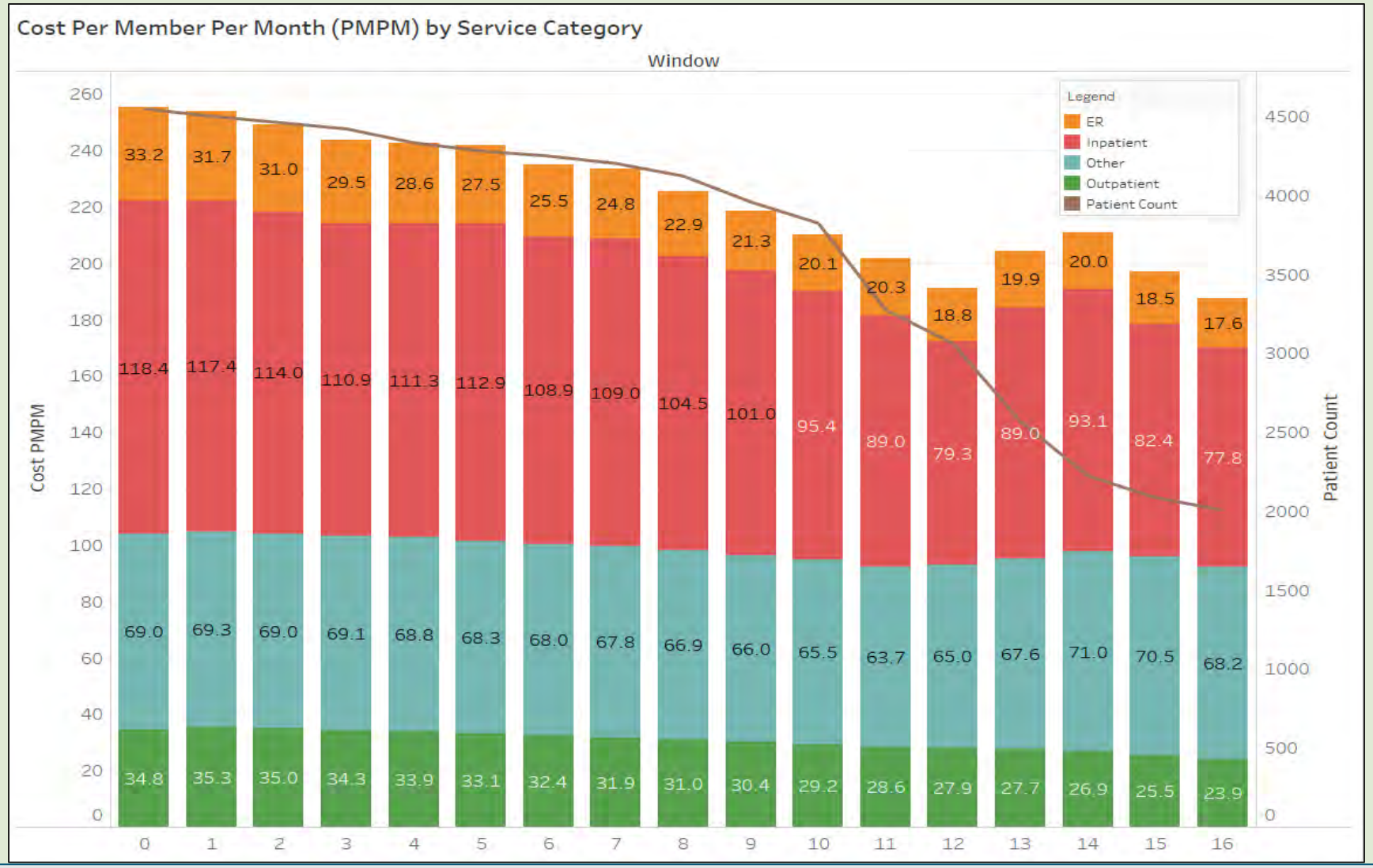
AIM # 1 : REDUCE HEALTHCARE COSTS



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AIM # 1 : REDUCE HEALTHCARE COSTS

	N	Pre-Intervention (2014-15)		Post-Intervention (2015-2016)		
		Total Cost	PMPM	Total Cost	PMPM	Percent Change
Total CHECK Enrolled	16206	$57,457,193	$295.45	$46,296,425	$238.06	**-19**
Total CHECK Engaged	2058	$9,305,098	$376.79	$4,971,289	$201.30	**-47**

Excludes pharmacy costs and participants with no claims; includes participants with 12 months of claims

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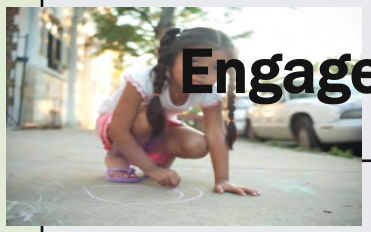
AIM # 2: REDUCE SCHOOL ABSENTEEISM



Attendance Mean (SD)		Mean Difference (95% CI)	P-value
Engaged	Enrolled		
91.0% (2.2%)	89.1% (2.6%)	1.9 (1.85%, 1.95%)	< 0.0014

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AIM # 3: IMPROVE PATIENT & FAMILY ENGAGEMENT

Psychosocial Measures among CHECK engaged

		Baseline Score			6-Month Score			
	N	Mean	SD	SE	Mean	SD	SE	p-value
Parent Measures								
Anxiety (PROMIS)	445	49.04	10.02	0.47	47.36	8.69	0.41	0.0004
Depression (PROMIS)	476	47.83	8.94	0.41	46.44	7.87	0.36	<0.001
Quality of Life (PROMIS)	447	57.03	9.26	0.44	58.87	9.75	0.46	0.0001
Family Function	437	18.84	3.32	0.16	19.82	2.96	0.14	<.0001
Child Measures								
PSC-17	366	6.80	6.56	0.34	3.76	5.15	0.27	<.0001
PHQ-A	189	4.59	4.40	0.32	2.68	2.97	0.22	<.0001
PHQ-9	219	7.13	5.99	0.41	4.89	4.96	0.34	<.0001
CHAOS (Home)	471	18.83	3.29	0.15	19.83	2.89	0.13	<.0001

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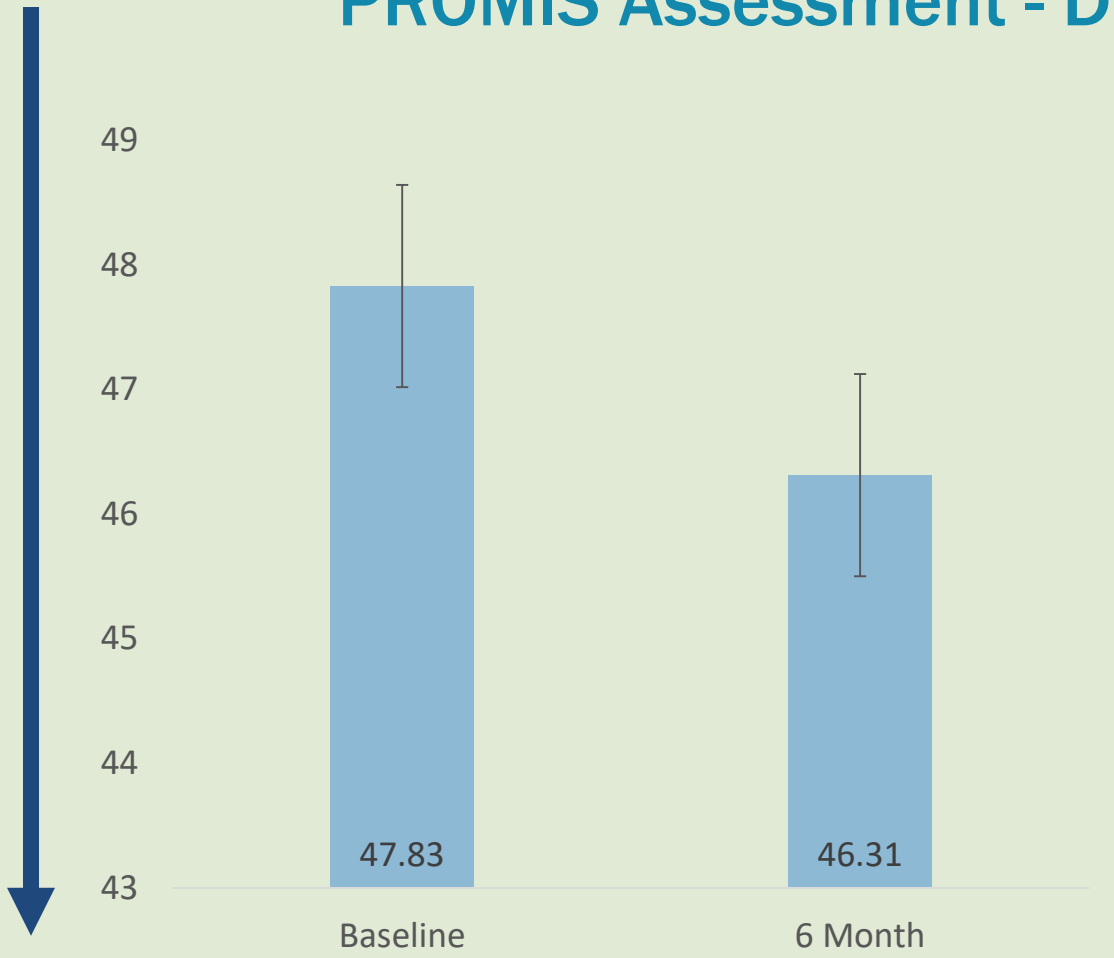
Aim # 3: Improve Patient & Family Engagement

PROMIS Assessment - Depression



Questions:

1. I felt worthless…
2. I felt helpless…
3. I felt depressed…
4. I felt hopeless…

Question Choices:
1, Never | 2, Rarely | 3, Sometimes | 4, Often | 5, Always

N = 476
Baseline Mean = 47.83
Reassessment Mean = 46.31
p = .0002 w/ two tailed paired t-test

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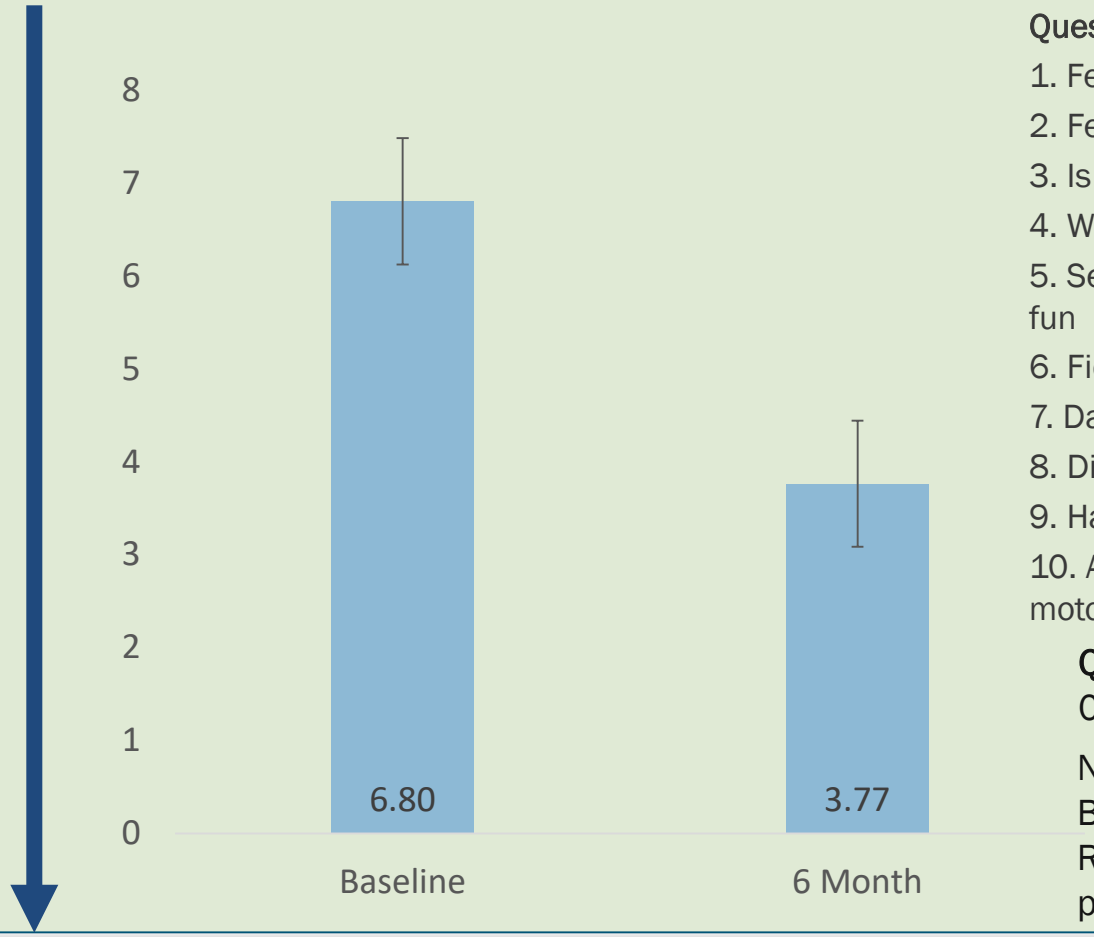
Aim # 3: Improve Patient & Family Engagement

PSC-17 (Pediatric Symptom Checklist 17) Assessment



Questions:

1. Feels sad, unhappy
2. Feels hopeless
3. Is down on self
4. Worries a lot
5. Seems to be having less fun
6. Fidgety, unable to sit still
7. Daydreams too much
8. Distracted easily
9. Has trouble concentrating
10. Acts as if driven by a motor
11. Fights with other children
12. Does not listen to rules
13. Does not understand other people's feelings
14. Teases others
15. Blames others for his/her troubles
16. Refuses to share
17. Takes things that do not belong to him/her

Question Choices:
0, Never | 1, Sometimes | 2, Often

N = 366
Baseline Mean = 6.80
Reassessment Mean = 3.77
p = <.0001 w/ two tailed paired t-test

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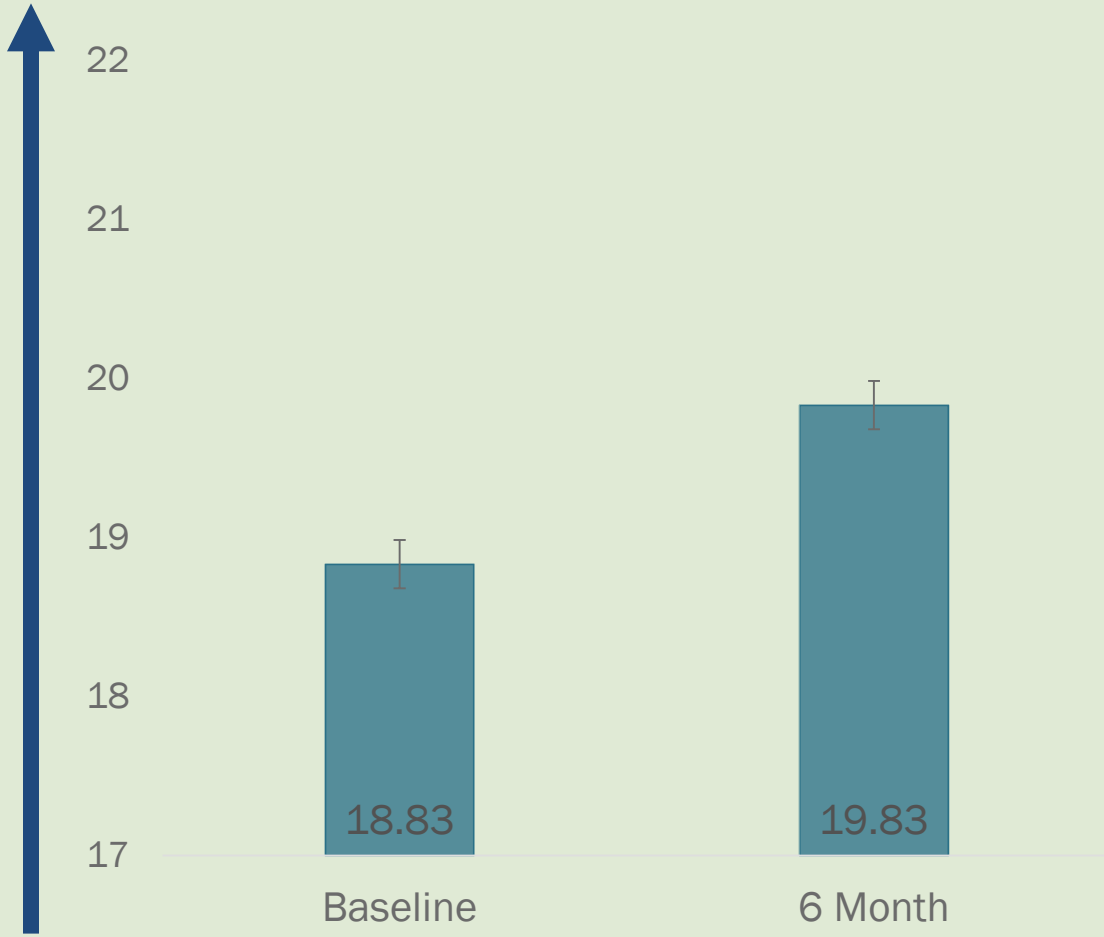
Aim # 3: Improve Patient & Family Engagement

CHAOS (Confusion, Hubbub, and Order) Assessment



Questions:

1. I have a regular morning routine
2. You can't hear yourself think in our home
3. It's a real zoo in our home
4. We are usually able to stay on top of things
5. There is usually a television turned on somewhere in our home
6. The atmosphere in our house is calm

Question Choices:

Very much like your own home | Somewhat like your own home | A little bit like your own home | Not at all like your own home (graded based on negative or positive)

N = 471
Baseline Mean = 18.83
6 Month Mean = 19.83
$p < .0001$ w/ two tailed paired t-test

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THE CHALLENGE

Aligning Payment Model and Service Delivery

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LINKING SERVICE NEEDS TO PAYMENT

- Community health workers billing for services
- Reimbursement for non-traditional mental health services (prevention and promotion)
- Care coordination reimbursement for children
- Payment to address social determinants of health

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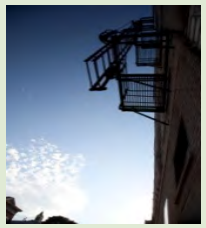
POTENTIAL PAYERS FOR CHECK



- Managed care organizations
- Hospitals and health systems
- Public schools
- Philanthropic organizations
- Federally qualified health centers

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BENEFITS TO THE PATIENT AND FAMILY

- Trust in the community – CHWs work in communities where they live
- Disease specific interventions and education
- Leveraging data to focus interventions and minimize cost
- Technology to augment front line staff
- Universal screening and early intervention for mental health
- Medical oversight between visits

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TRANSLATING BENEFIT INTO A PAYMENT MODEL

Value based payment versus PMPM:

- Value based payment = flexibility with dollars, payment for quality
- PMPM = Predictable to manage operating costs, ideal for a new program

The complexity of calculating the PMPM:

1. Costs to operating the program, and savings (if available)
2. Quality measures and prevention (HEDIS)
3. Patient volume– this will impact the amount charged

Public private partnerships:

- Private capital needed to develop technology and geographic spread

LINKING TOTAL HEALTH CARE COSTS TO PAYMENT MODEL

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Total CHECK Enrolled	16206	$57,457,193	$295.45	$46,296,425	$238.06	-19
Total CHECK Engaged	2058	$9,305,098	$376.79	$4,971,289	$201.30	-47

Excludes pharmacy costs and participants with no claims; includes participants with 12 months of claims

- **State capitation rate to MCOs: $197**
- **CHECK is achieving savings for the MCOs**
- **Suggested PMPM: $20-40**

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TRANSITIONING TO VALUE BASED PAYMENT

Determining how to share accountability in a fee-for-service environment

Leveraging data to quantify savings and demonstrate outcomes to payers

Establishing a product (not a pilot) whose measurable value is directly linked to accountability and outcomes

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THANK YOU!

Visit Our Website To Learn More!

www.mycheck.uic.edu

We're On Social Media!
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A special thank you to CMS and CMMI for the opportunity to build this program, and to the CHECK Program staff for their dedication to wellness, community and ensuring health equity.

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CHECK ESTABLISHES PARTNERSHIPS

Community Medical Neighborhood

LEGAL COUNCIL
FOR HEALTH JUSTICE

MOBILE CARE CHICAGO
CHILDREN'S MEDICAL CARE
Asthma Dental Allergy

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

CHICAGO PUBLIC SCHOOLS | CPS

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Implementing Pediatric Alternative Payment Models in an Adult World

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Medical Director, Rainbow Care Connection
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University Hospitals
Cleveland | Ohio

Rainbow Babies
& Children's Hospital

Objectives

1. Understand our CMMI HCIA award care delivery model and high-level outcomes
2. Understand our challenges with developing a sustainable model and how we eventually succeeded
3. Identify opportunities for CMS to help pediatric APM succeed

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UH Rainbow Care Connection

- $12.8 million over 3 3/4 years from CMMI
- Service delivery began January 1, 2013
- 164 pediatric providers, 40% not system employees
- Based on ***Physician Extension Team*** model

Funding ended March 31, 2016

Rainbow Care Connection

Activity	*Milestones (internal UH data)*
Quality / Practice-Tailored Facilitation	• 15 quality improvement programs implemented
Children with Medical Complexity	• 25% decrease in hospitalizations • 34% decrease in average length of stay
Integrated Behavioral Health	• 57% decrease in hospitalizations • 15% decrease in managed care behavioral health cost of care
ED Alternatives / Education / Outreach	• 22% decrease in avoidable ED visits
Well-Visit Promotion	• 7.8% increase in well visits
Value-Based Payment	• All 5 Medicaid managed care plans

5.6% decrease in total cost of care to Medicaid over 2 years as evaluated in a case study by Mercer

Objectives

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Proposed Sustainability Plan

Alternative Payment Models with 5 Medicaid MCPs

1. Care Coordination Fee – Per Member Per Month (PMPM)
2. Quality PMPM Incentive Payments
3. Shared Savings

UH provides Population Health Services for more than **325,000** patients, of all ages, since 2010

Medicaid Managed Care Members	Commercially & Self-Insured Members	Medicare Advantage Members	Medicare Shared Savings Program Beneficiaries
70,000	**168,000**	**30,000**	**60,000**

Networks

University Hospitals
Accountable Care Organization
Provider Network

University Hospitals
Coordinated Care Organization
Provider Network

University Hospitals
Rainbow Care Connection
Pediatric Network

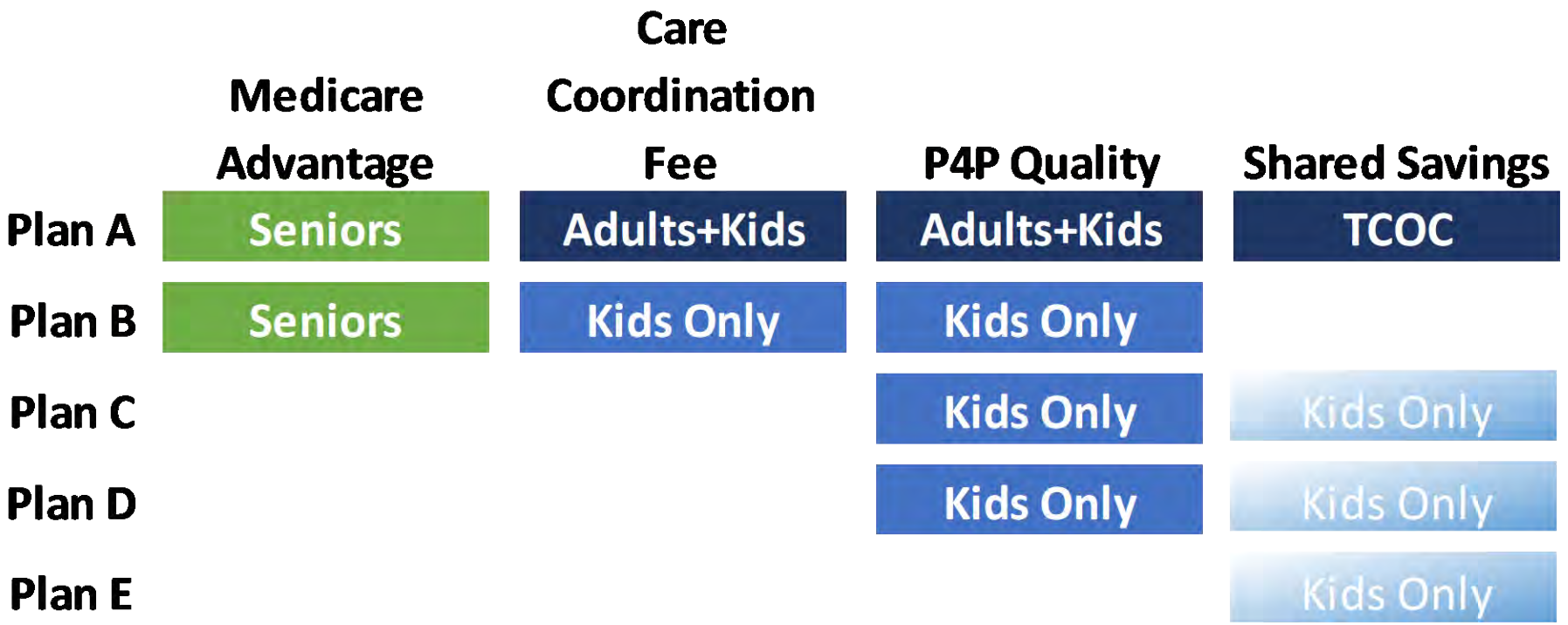
Partners in Lifelong Health
Post-Acute Network

Quality Care Network

Road to Success = Engaging Payers

- Ohio Medicaid support
  - Medicaid data
  - Advocate for alternative payment models
- Independent actuarial evaluation
- Ohio Medicaid Managed Care Plans
  - Engagement critical to success
  - Success with leveraging Medicare Advantage
  - Eventual APM arrangements

Current Medicaid Alternative Payment Models



TCOC = total cost of care

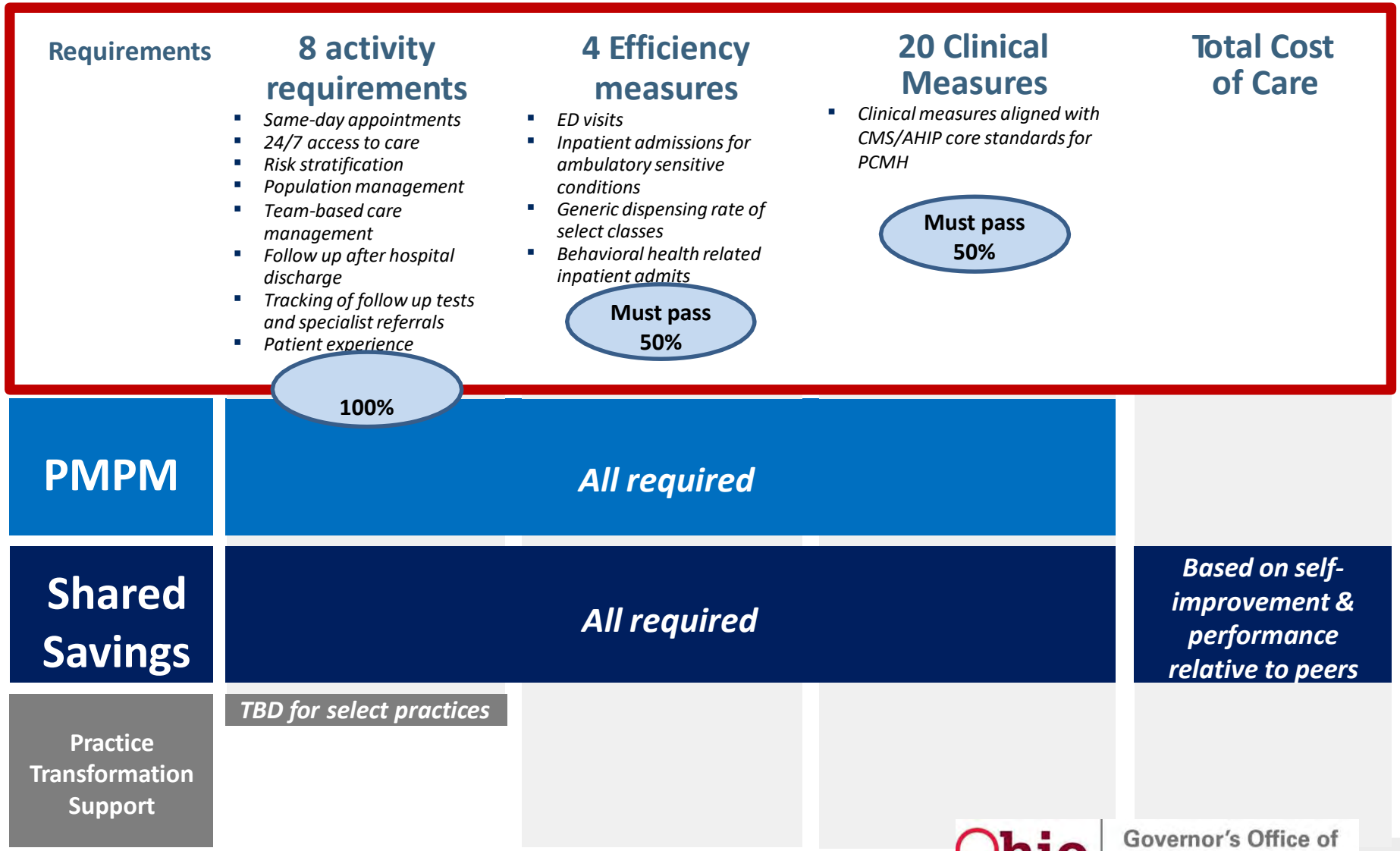
Challenges

1. No pediatric thresholds for value-based payments
2. Multiple APM – different with each payer
3. Variation in pediatric models challenges
   - common data infrastructure
   - commercial vendor support

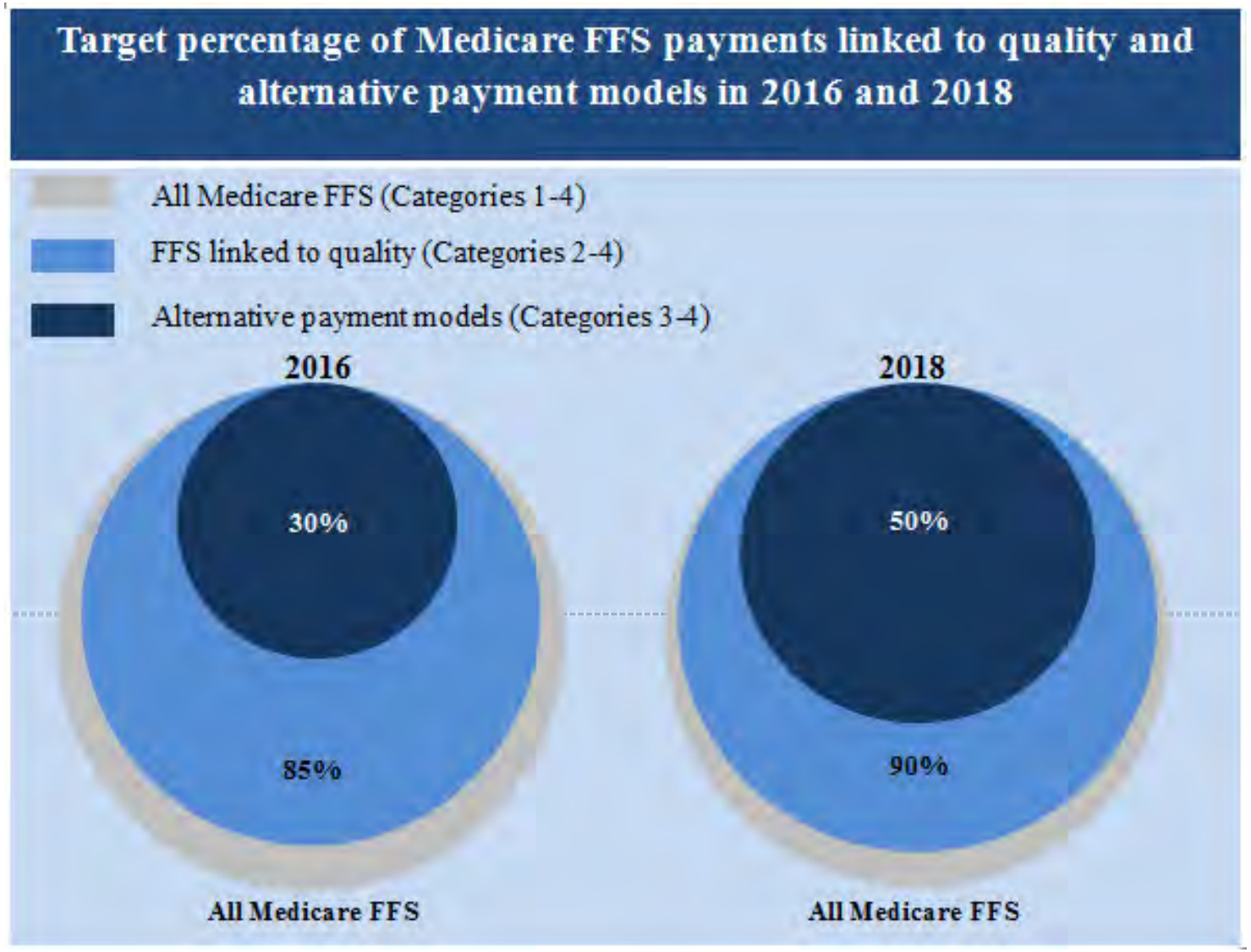
Objectives

1. Understand our CMMI HCIA award care delivery model and high-level outcomes
2. Understand our challenges with developing a sustainable model and how we eventually succeeded
3. Identify opportunities for CMS to help pediatric APM succeed

Ohio Comprehensive Primary Care (CPC) Program Requirements and Payment Streams



CMS Goals


Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018
All Medicare FFS (Categories 1-4)
FFS linked to quality (Categories 2-4)
Alternative payment models (Categories 3-4)
2016
30%
85%
All Medicare FFS
2018
50%
90%
All Medicare FFS

Opportunities for CMS Support of Pediatric APM

1. Create a goal for state Medicaid payments in APM by category – Children, Adults, ABD, Duals
2. Develop standard Medicaid APM such that goals are standardized
3. Continue CMS support of standard Medicaid claims AND quality reporting formats

Disclaimer

- *The project described is supported, in part, by Funding Opportunity Number CMS-1C1-12-0001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.*

- *The data presented has not been audited or verified by CMMI.*

Thank You!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Cleveland | Ohio


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Special Needs Program for Children with Medical Complexity: The Wisconsin Idea

Mary Ehlenbach, MD

Emily Loman, JD

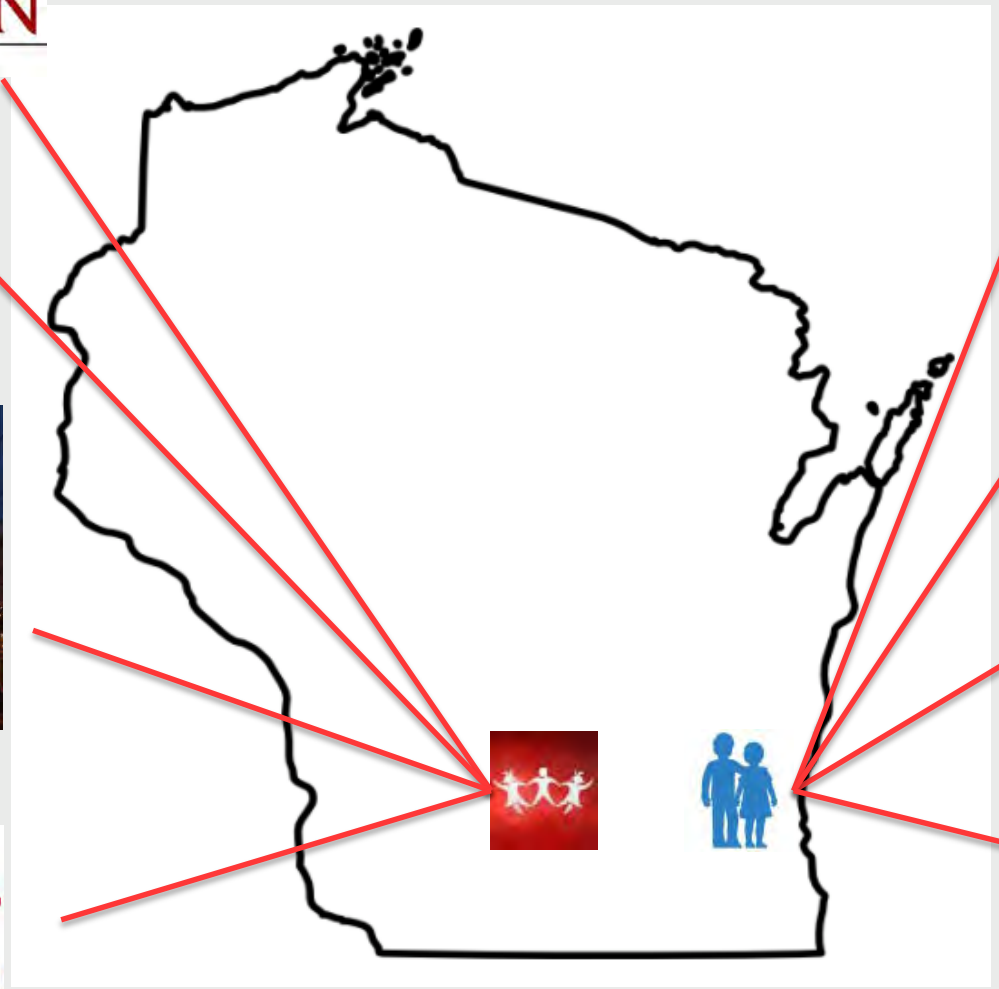
Tim Corden, MD

UW Health

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

THE UNIVERSITY of WISCONSIN MADISON

Epic



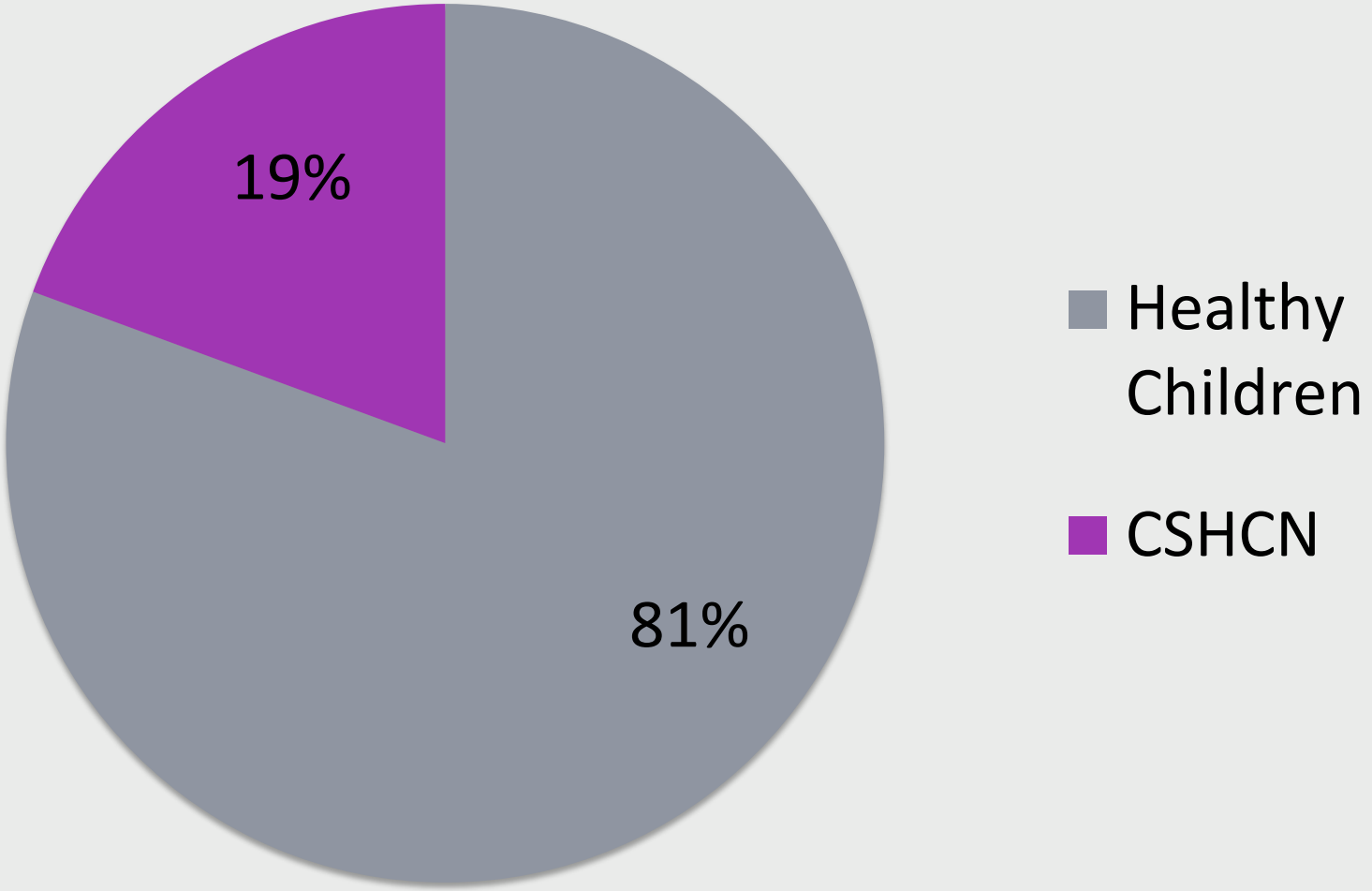
Miller HIGH LIFE

Milwaukee Brewers

UW Health
American Family Children's Hospital

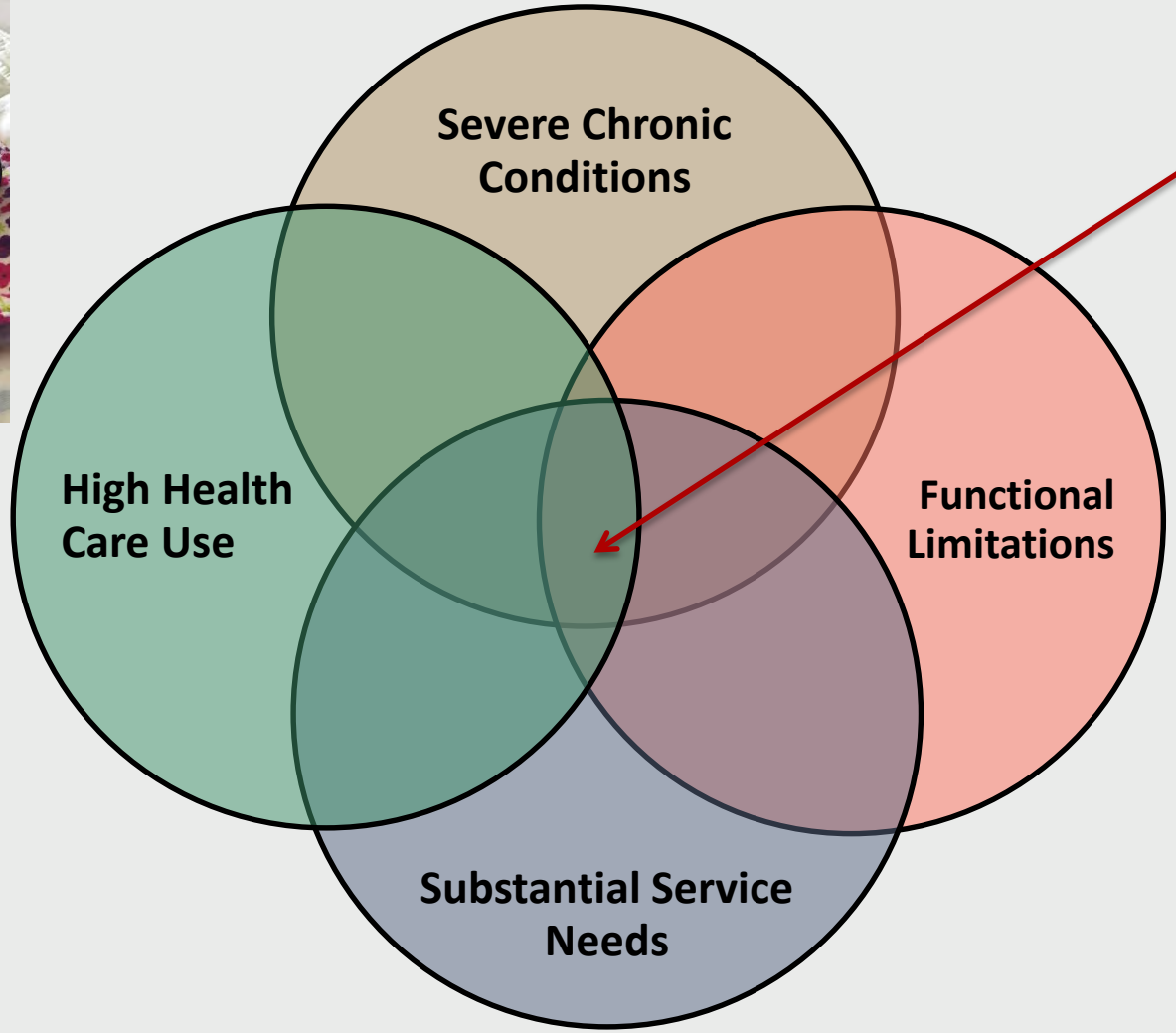
Children's Hospital of Wisconsin

CMC 101



National Survey of Children with Special Health Care Needs. NS-CSHCN 2016. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 9/6/17 from www.childhealthdata.org.

CMC are a Subset of CSHCN

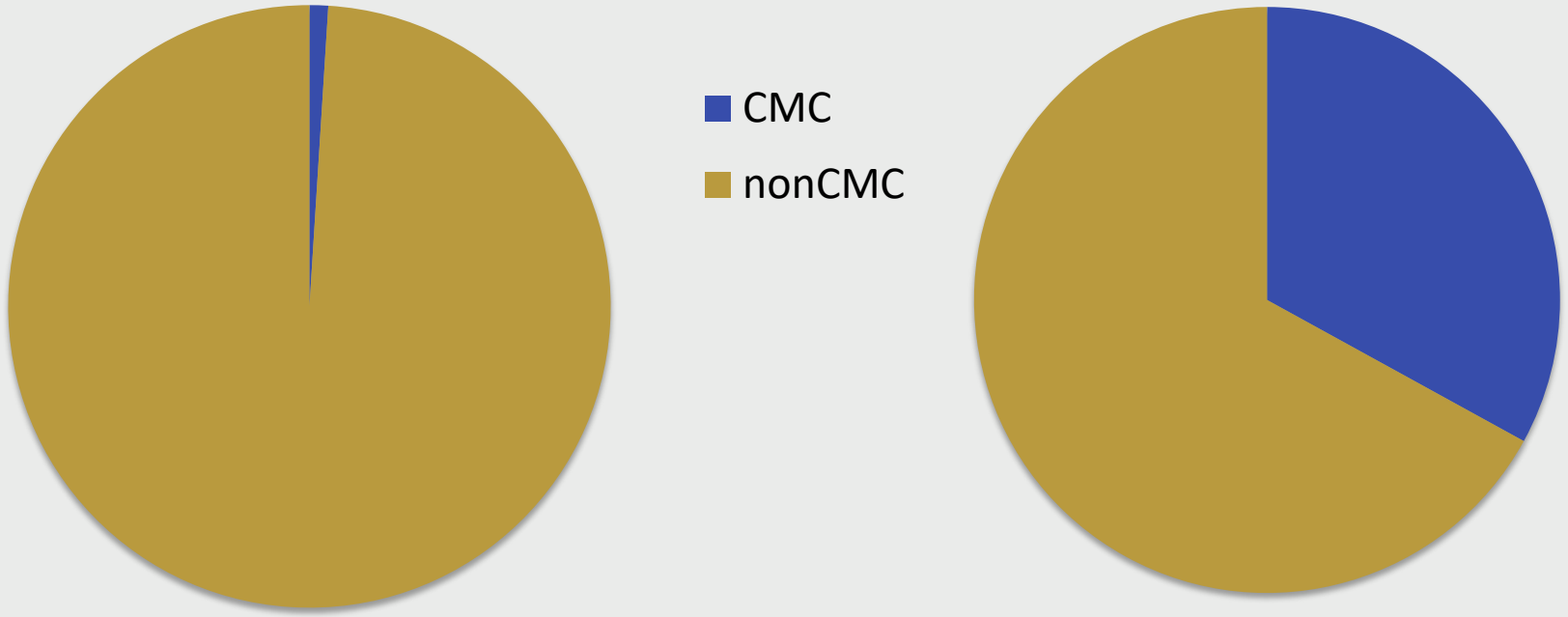


Cohen, et al. Children With Medical Complexity: An Emerging Population for Clinical and Research Initiatives. *Pediatrics*. 2011:127:529.

Small but Mighty

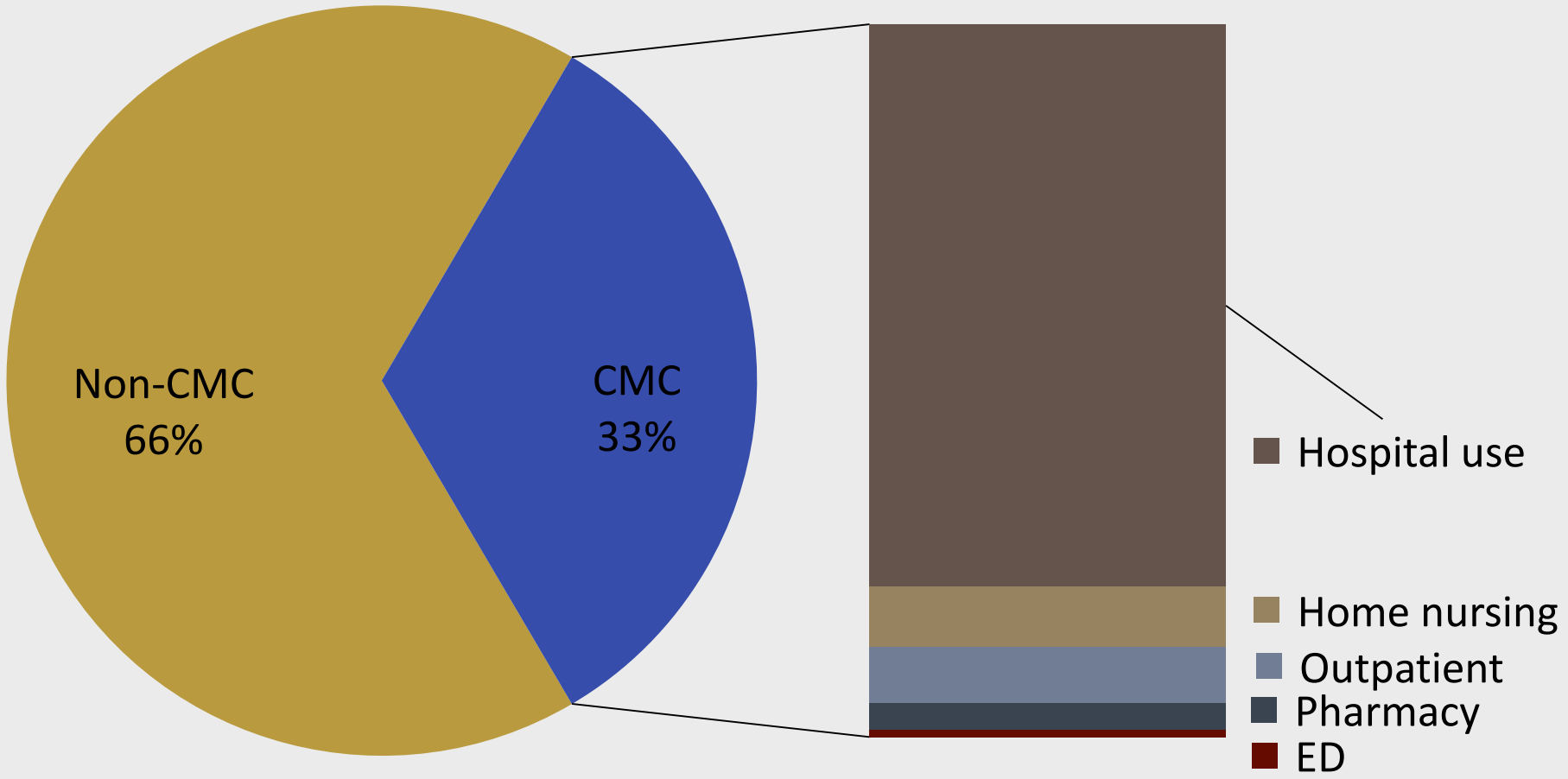
<1% of children

~33% of healthcare spending on children



Cohen E, et al. Patterns and costs of health care use of children with medical complexity. *Pediatrics*. 2012.
Neff JM, et al. Identifying and classifying children with chronic conditions using administrative data with the clinical risk group classification system. *Ambulatory Pediatrics.* 2002.

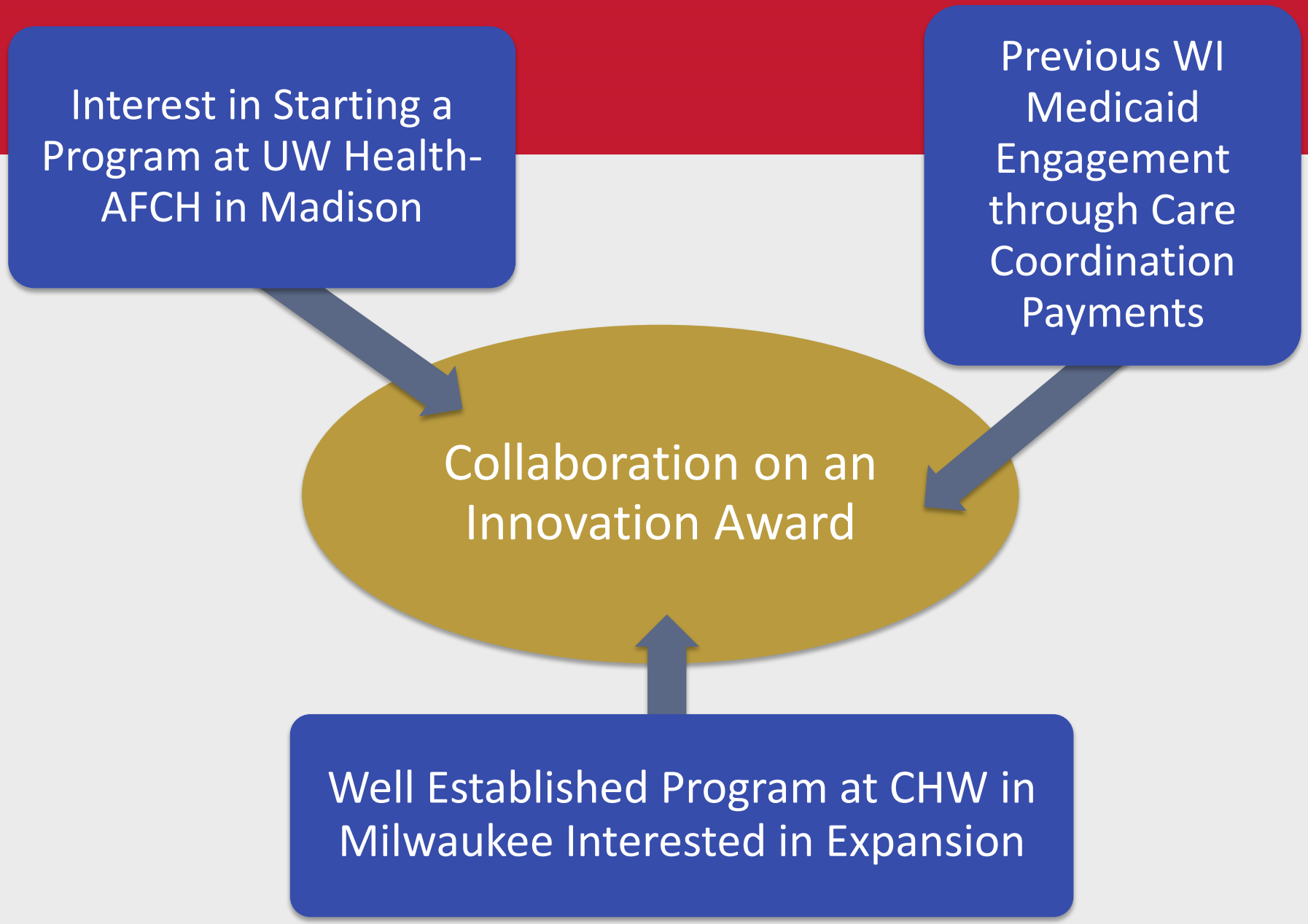
Child Health Spending and CMC



Slide courtesy of Ryan Coller, MD MPH.

Cohen E, et al. Patterns and Costs of health care use of children with medical complexity. *Pediatrics*. 2012

Neff J, et al. Profile of medical charges for children by health status group and severity level in a Washington State Health Plan. *Health Services Research*. 2004


Interest in Starting a Program at UW Health-AFCH in Madison
Previous WI Medicaid Engagement through Care Coordination Payments
Collaboration on an Innovation Award
Well Established Program at CHW in Milwaukee Interested in Expansion

What Do We Do?

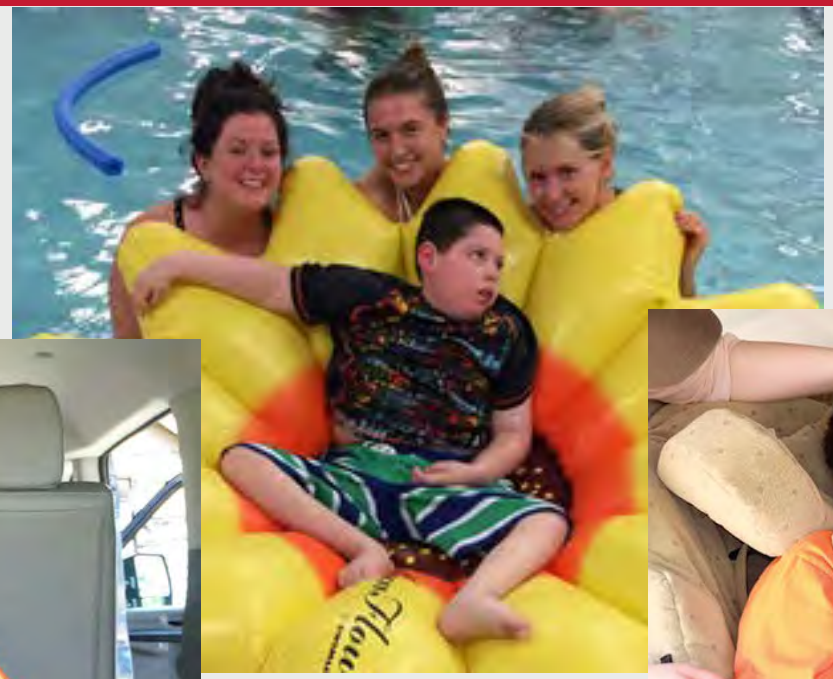
Medical co-management and care coordination for CMC with…

- 3 or more affected organ systems affected *and*
- 3 or more medical or surgical specialists *and*
- 5 or more hospital days *or* 10 or more clinic visits in the previous year

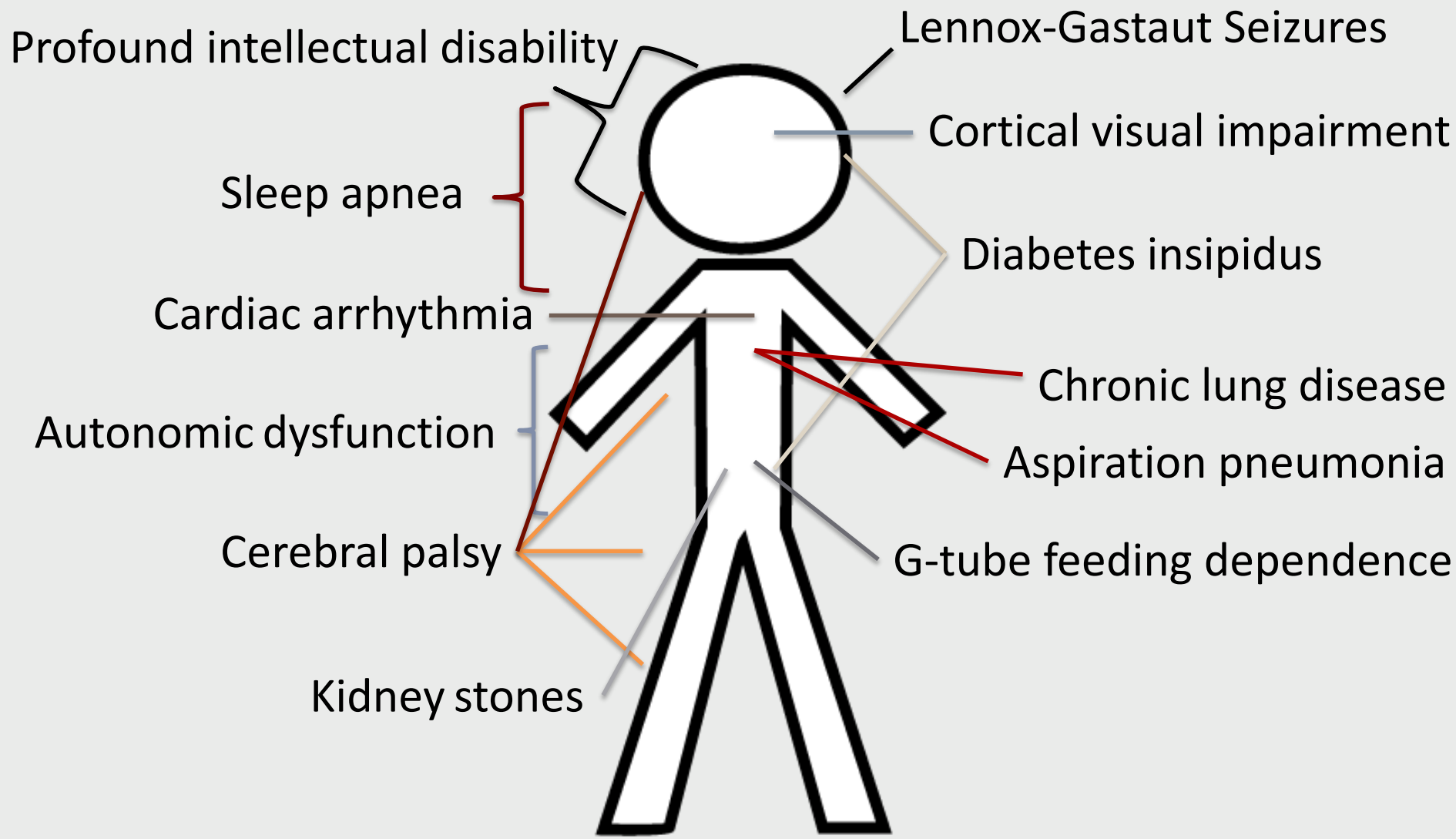
UW Health

School of Medicine and Public Health
UNIVERSITY OF WISCONSIN–MADISON

Liam’s Story



Medical Issues at Enrollment



In the words of Liam's mom…

"The Complex Care team functions…as the 'CEO' of [Liam's] health…Every health issue that Liam has is cloaked under the Complex Care team…"

"If…Complex Care did not exist…

- Liam would have **more ER visits** that would lead to more admissions.
- Liam would spend **less time in school…**
- I would spend **more time contacting** multiple **subspecialists…**trying to arrange doctors' appointments, x-rays, and lab draws."

UW Health

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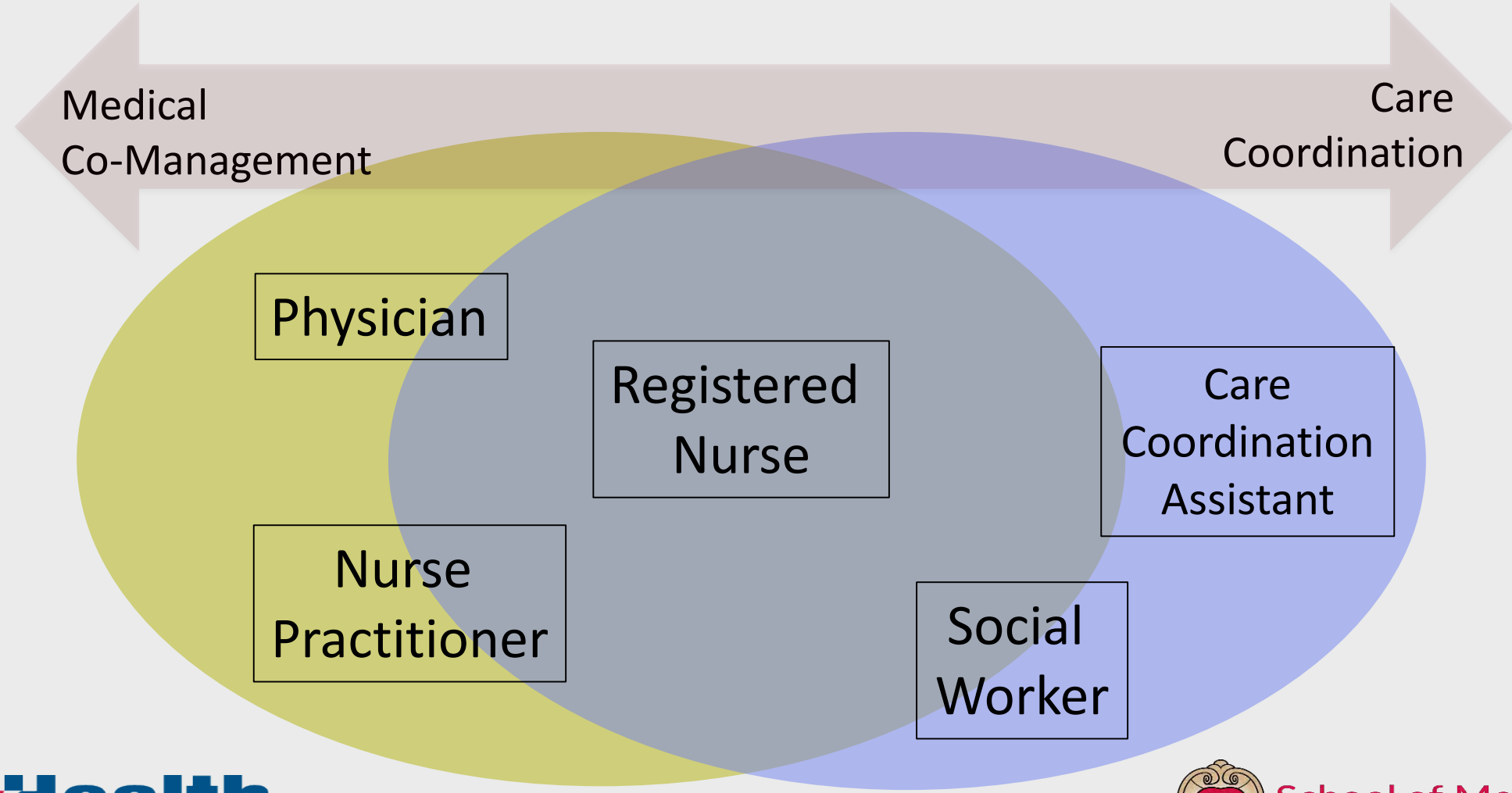
Interprofessional Team



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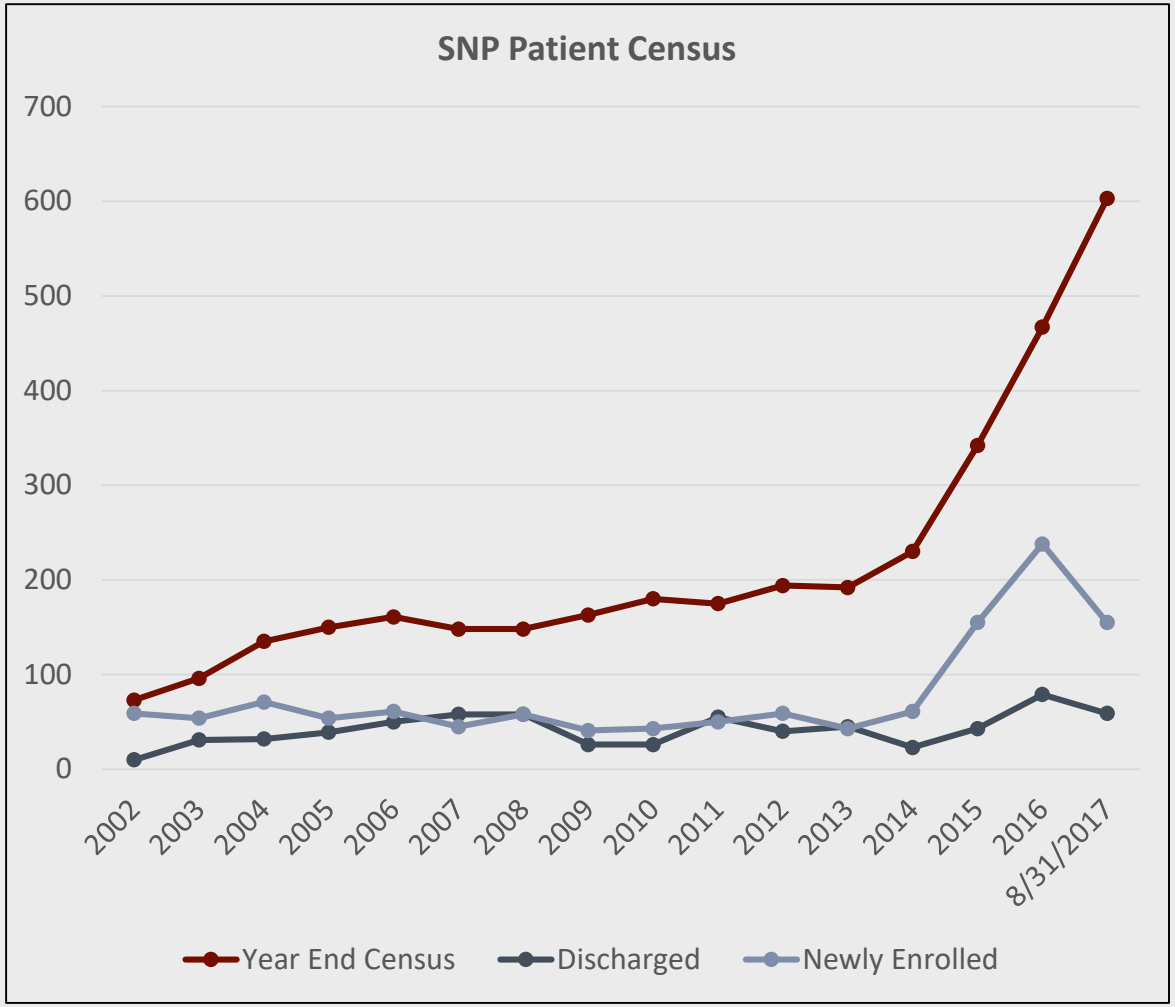
Complex Care Quality Initiatives

All about the team, and the bigger team

- Efficiency – cost of care
  - Pre-Post data (claims payment data)
  - Change in length of stay – DRG related savings
- Family and provider satisfaction with program
- Medication project with inpatient and outpatient pharmacy
  - Error reduction in Px, call out drug interactions, optimize medication delivery
- Note project --- how to better ”push” information to colleagues
- Intranet resources – practice, family, program
- Peri-op service with orthopedics, neurosurgery, hospitalist sx
  - Upcoming nutritional support evaluation with GI

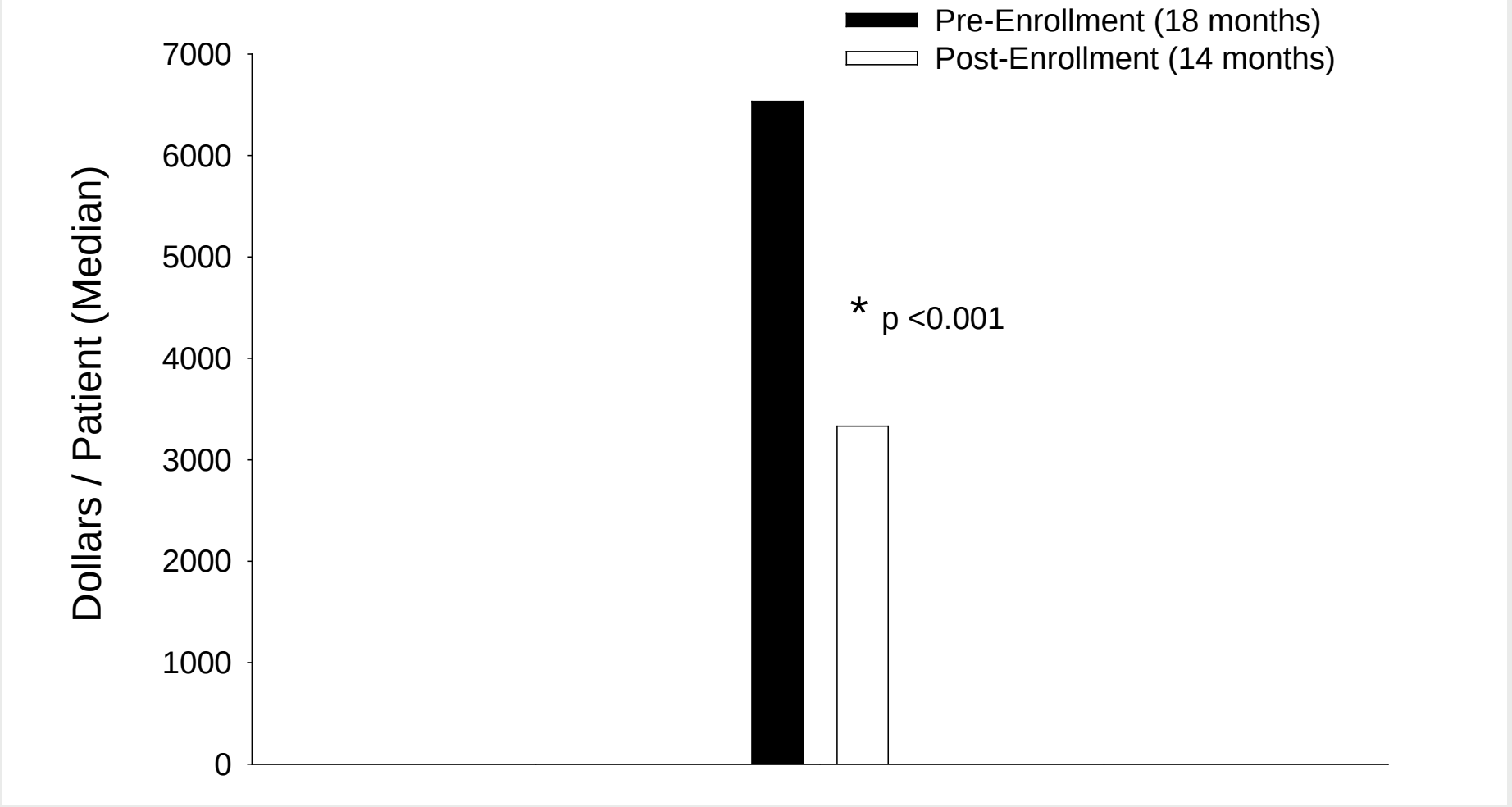
SNP Growth 2002-2017

Date	Staff	Total FTE
1/2002	2.5 RN, .5 MD	3
1/2003	3.5 RN, .5 MD	4
1/2004	3.5 RN, 1.5 MD	5
1/2005	4.5 RN, 1.5 MD	6
7/2006	4.5 RN, 1.5 MD	6
7/2007	4.5 RN, 2.5 MD	7
7/2008	4.5 RN, 3 MD	7.5
7/2009	4.5 RN, 1 MD	5.5
7/2010	4.5 RN, 1 MD, 1.2 PNP	6.7
7/2011	4.5 RN, 1 MD, 1.2 PNP	6.7
7/2012	5 RN, 3 MD, 2.2 PNP	10.2
7/2013	5 RN, 3 MD, 2.2 PNP	10.2
9/2014	3.8 RN, 1 MD, 3.2 PNP, 0.8 CCA	8.8
9/2016	9 RN, 3.8 MD, 6.7 PNP, 6 CCA, 0.6 SW	26.1
9/2017	8 RN, 2.75 MD, 6.7 PNP, 8 CCA, 1 SW	26.5



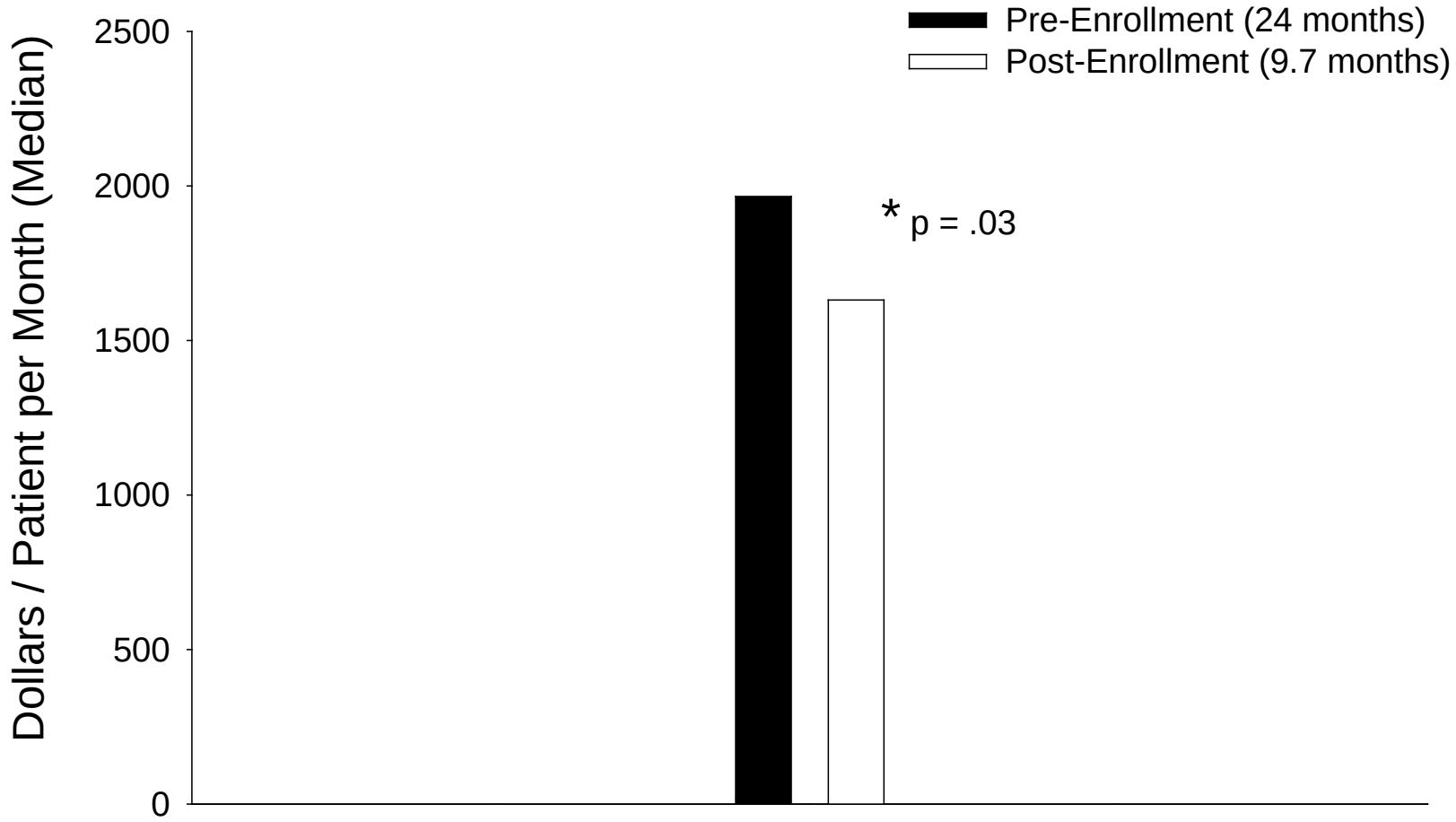
Pre - and Post - Enrollment Medicaid Costs for CMC With Very High Pre-Enrollment Resource Use

(n = 161)

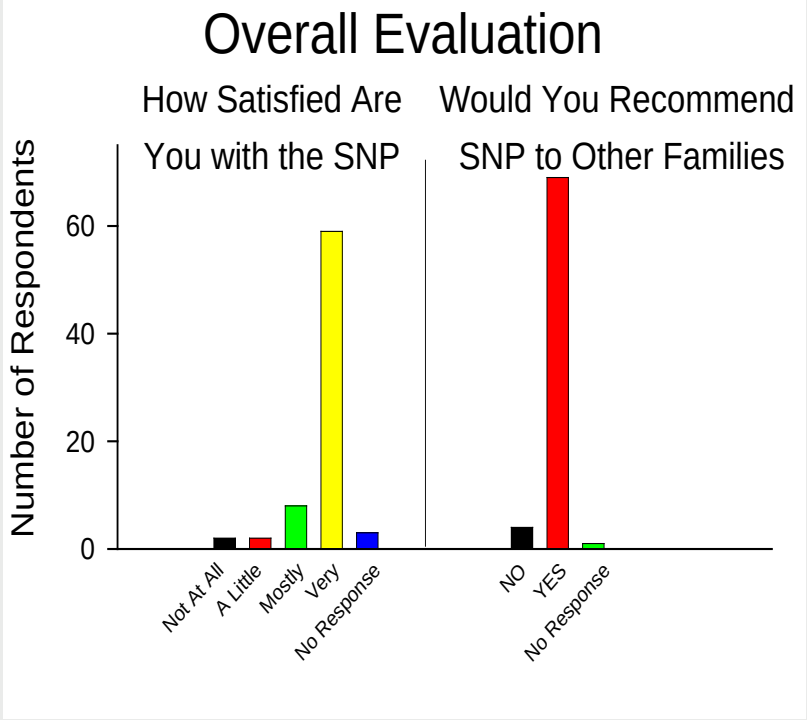


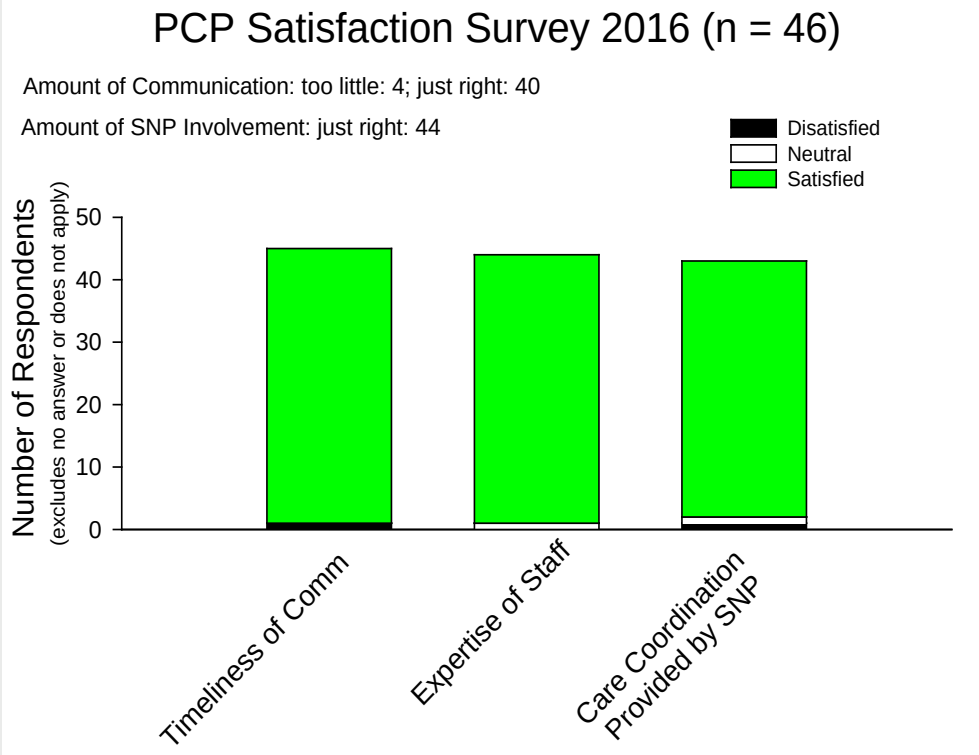
Pre - and Post - Enrollment Medicaid Costs for CMC With Moderately High Pre-Enrollment Resource Use

(n = 120)



CHW SNP Satisfaction Data 2015-16





Assure the “Near Medical”, Compliance

- Medical literacy
  - Diagnosis – specialty care
  - Medications – what is it, how to give, how to store, home visits
- Nutrition
- Medical Equipment
- Appointments
- Transportation
- Housing --- work with landlords, utility company, modification, nursing, respite
- School communication

Medicaid Payment Model for Targeted Case Management (TCM) for Children with Medical Complexity (CMC)

Mary Ehlenbach, M.D.
Emily Loman, J.D.
Tim Corden, M.D.

Wisconsin Department of Health Services

State Plan Authority

- The Department of Health Services (DHS) considered:
  - Section 1945 (2703 ACA) Health Home.
  - Section 1905 Targeted Case Management (TCM).
- DHS selected Section 1905 TCM.

Targeted Case Management

TCM is comprised of the following:

- Comprehensive assessment and periodic reassessment of individual needs
- Development of a specific plan of care
- Referral and related activities
- Monitoring and follow-up activities

TCM Procedure Codes

DHS plans to use two procedure codes for reimbursement:

- Enrollment (G0506)—one-time fee for comprehensive assessment and completion of care plan
- Ongoing care coordination (T2023)—monthly fee for referral, monitoring, and follow-up activities

TCM Reimbursement Rate Development Timeline

- DHS, with the assistance of the State's actuary, has completed development of proposed rates for TCM services for high cost children with medical complexity.
- DHS is awaiting approval from CMS for the State Plan Amendment (SPA) we submitted earlier this month.
- Effective date of the SPA is expected to be September 1, 2017.

TCM Reimbursement Rate Development Data

Children's Hospital of Wisconsin (CHW) and American Family Children's Hospital (AFCH) provided data for the first quarter of 2017 to develop reimbursement rates.

- Monthly time-tracking data
- Monthly invoices
- Monthly enrollment files
- Estimated enrollment at full capacity

Rate Methodology

The following factors were considered when developing the rates:

- Time study data
- Service count for each procedure code
- Historical invoice costs
- Rates for each code
- Adjustments

1. Time Study Data

- Exclusions
  - Time recorded as “billable”
  - Time spent with non-Medicaid patients
  - Time spent with patients who were referred but not enrolled in the program

1. Time Study Data (cont.)

- Reclassified minutes
  - Any patient time up until two weeks after enrollment date is treated as enrollment.
  - Any time after two-week period is treated as ongoing care.
- Time study minutes by staff position and activity

  Summarized total minutes by staff position and activity for Q1 2017

Time Study Minutes

Time Study Minutes January 2017 through March 2017 Both Hospitals					
Staff Position	Enrollment G0506	Ongoing Care T2023	Non-Patient Specific but Program Related	Other*	Total
CCA	22,331	144,545	68,333	58,049	293,258
Program Manager	890	2,855	32,290	33,999	70,034
Physician	5,906	37,459	50,245	37,341	130,951
Nurse Practitioner	17,701	128,712	43,685	89,930	280,028
Registered Nurse	19,965	194,827	64,995	69,041	348,828
Social Worker	3,705	24,380	9,615	18,650	56,350
Administrative	638	245	65,148	39,321	105,352
Total Minutes	71,136	533,023	334,311	346,331	1,284,801
% of Total Minutes	5.5%	41.5%	26.0%	27.0%	100.0%

**Includes non-program related minutes and time spent with patients who were referred but not enrolled.*

2. Count Services for Each Procedure Code

- Time study data was used to calculate service counts for each procedure code.
- Hospitals will bill DHS for ongoing care coordination on a monthly basis per patient each time staff has “contact” with the child.

3. Historical Invoice Costs

- Hospitals provided salaries and benefits by staff position.
- Invoice costs by provider type and activity were allocated based on the distribution of minutes in the time study.

4. Rates

- Historical invoice costs for each procedure code / # of services provided during Q1 = initial cost per service
- Initial cost per service x number of services = invoices paid by DHS

5. Adjustments

- Capacity adjustment

  Actual Medicaid enrollment during Q1 2017 / projected enrollment in 12-18 months

- Target funding level

  Actual Medicaid enrollment is about 85 percent of total program enrollment

Observations

- The one-time enrollment fee is about three times higher than the rate for ongoing care coordination activities.
- Fixed costs (invoice costs not related to direct patient care) represent a significant portion of expenses.

Cost Savings?

- Initial data suggests costs savings for the Medicaid program.
- Additional data and analysis is needed to confirm it is due to program enrollment versus other factors.

Potential Cost Gap

- Hospitals may experience a gap between program costs and Medicaid reimbursement.
- Net savings may be realized through avoiding hospitalizations.
- Addressing overstaffing should reduce any gap.

Next Steps

- Begin reimbursement for TCM services on September 1, 2017.
- Review Mathematica's cost-benefit analysis in 2018.
- Review program sustainability after two years.

Thank You!

Thank you to our CMS partners and LAN participants!

LAN Resources

https://hcp-lan.org/resources/

Contact Us

We want to hear from you!

www.hcp-lan.org

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