Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

# Engaging Payers to Support Innovative Care Delivery Models

# Engaging payers to support innovative care delivery models

## Pediatric Partners in Care: Payment Model Update

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# Disclosures

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- The contents of this presentation are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies
- The presenter has no financial relationships or conflicts to disclose

# Context: SSI recipients represent a sub-group of children with medical complexity

- Children with medical complexity have chronic physical, developmental, behavioral or emotional
- These children comprise ~6% of population and 40% of the spend
- Care is often highly fragmented and complicated by significant social complexity (poverty, mental health, etc.)
- Require highly specialized care coordination and multi-disciplinary approach to optimize quality
- Children are eligible for SSI if they are blind or disabled with severe functional limitations, and meet certain income and resource requirements.

# Pediatric Partners in Care: Overview

**Description**

Pediatric Partners in Care (PPIC) is a collaborative, innovative, community-based care management model targeted to improve the health care and health outcomes for children with disabling conditions who receive Supplemental Security Income (SSI) and are covered by Medicaid

**Eligible population**

Approximately 4,000 SSI children and adolescents in King and Snohomish counties (Washington State) under the age of 18. Payer participants agree to carve out these patients for care management.

**Goals**

- Improve the health outcomes of disabled children covered by SSI
- Reduce medical costs by eliminating unnecessary, redundant, and ineffective treatments, and substituting more effective, patient-centered, and less costly care
- Develop a scalable, community-based care management model that supports and optimizes the existing care delivery infrastructure

**Award**

CMMI award runs from 9/14 -9/17; award funding for Year 3 is $1.75M. Awardee is Seattle Children's, a pediatric health system serving the Pacific Northwest

**Payer Partners**

Molina, Community of Health Plan of Washington, Coordinated Care, Amerigroup

**Care Team**

4 RN Care Managers, 4 Care Coordinators, 1 Program Manager, 1 Data Analyst

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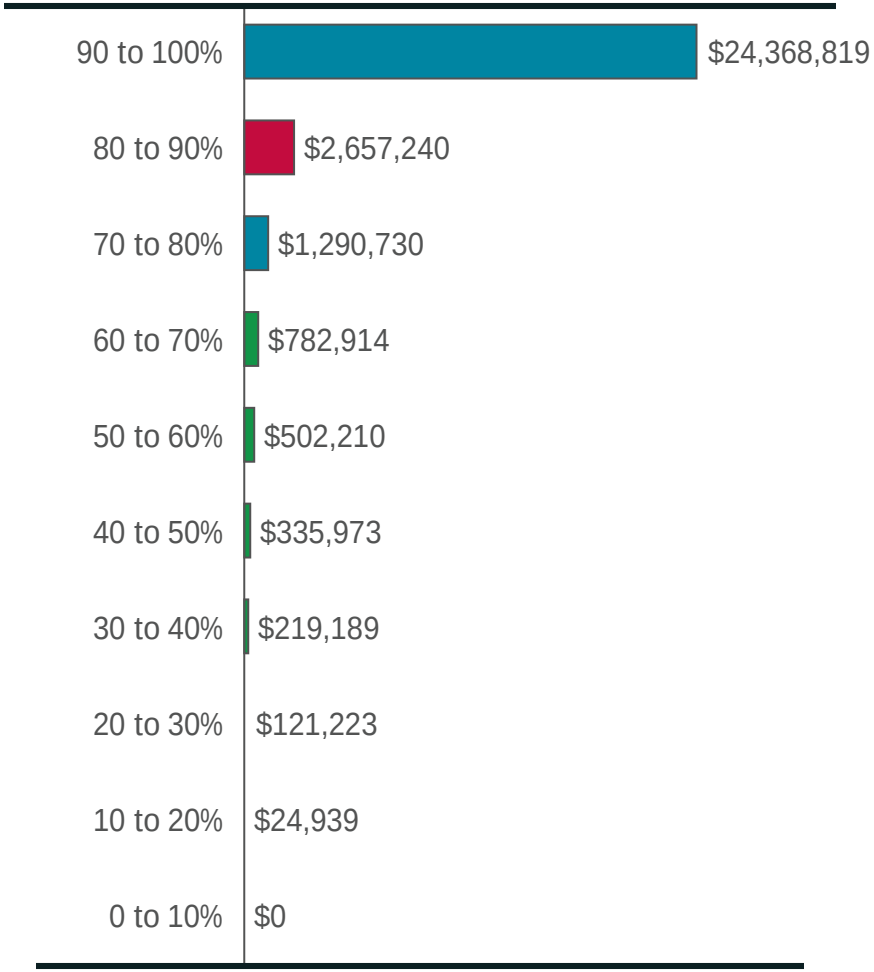
# Actuarial Analysis: 10% of the SSI Children on Medicaid Account for 80% of the Cost




| Deciles | Total Cost | Percent of the Total Cost | Unique Members | Avg. Paid Claims per Member |
|---|---|---|---|---|
| 90 to 100% | $24,368,819 | **80.4%** | **360** | $**67,691** |
| 80 to 90% | $2,657,240 | 8.8% | 360 | $7,381 |
| 70 to 80% | $1,290,730 | 4.3% | 360 | $3,585 |
| 60 to 70% | $782,914 | 2.6% | 360 | $2,175 |
| 50 to 60% | $502,210 | 1.7% | 360 | $1,395 |
| 40 to 50% | $335,973 | 1.1% | 360 | $933 |
| 30 to 40% | $219,189 | 0.7% | 360 | $609 |
| 20 to 30% | $121,223 | 0.4% | 360 | $337 |
| 10 to 20% | $24,939 | 0.1% | 360 | $69 |
| 0 to 10% | $0 | 0.1% | 360 | $0 |
| | **$30 ,303,238** | | **3,600** | **$8,418** |

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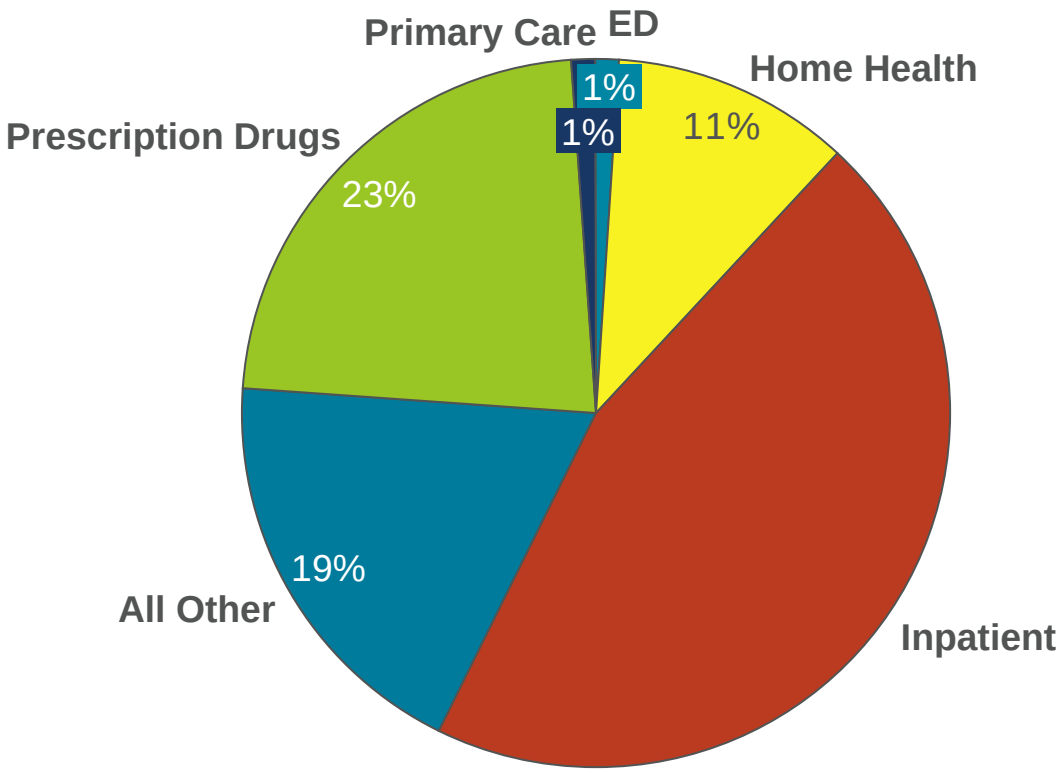
Source: Milliman and Associates

# Almost 50% of Costs Among Top 10% of Children Are in Inpatient Care

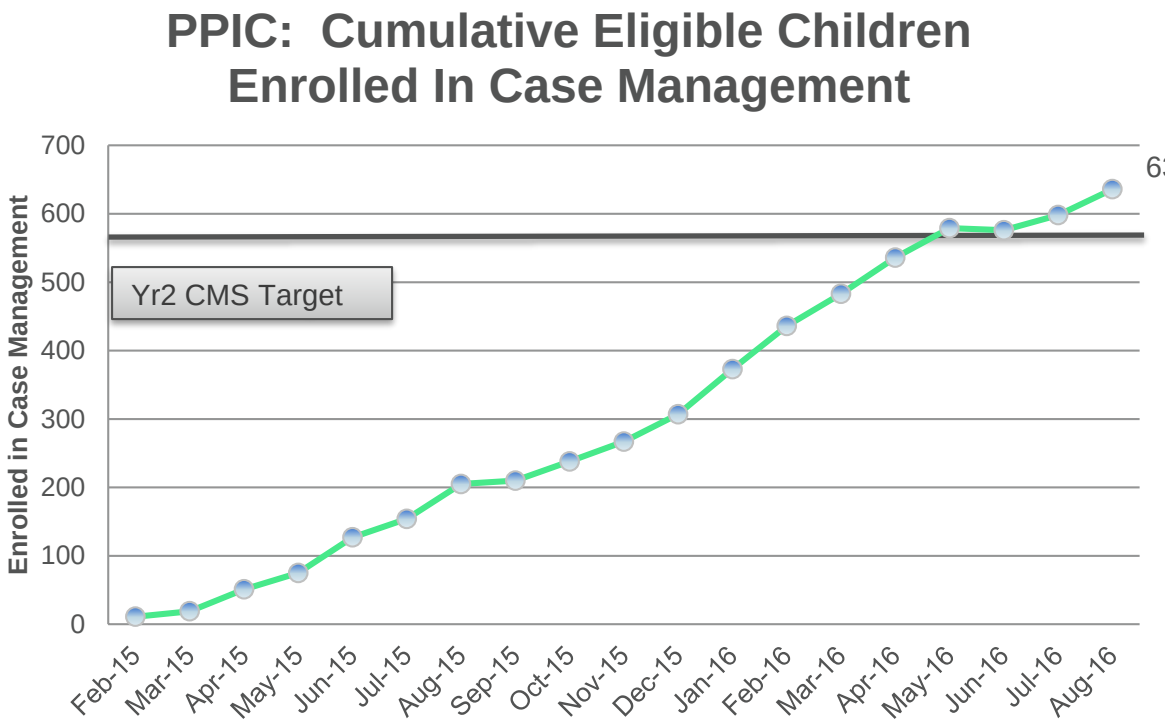
**90 – 100% Decile**




Source: Milliman and Associates based on 2010 data from Washington Health Care Authority

# PPIC Intervention: Care Management

Target: Enroll at least 50% of all eligible clients with a Prism score >=1.0




**Care Management Interventions**:

- Comprehensive (social determinants and clinical) Assessment and Plan of Care
- ED/IP Episode of Care follow up
- School advocacy
- 30 or 60 day check in when stabilized

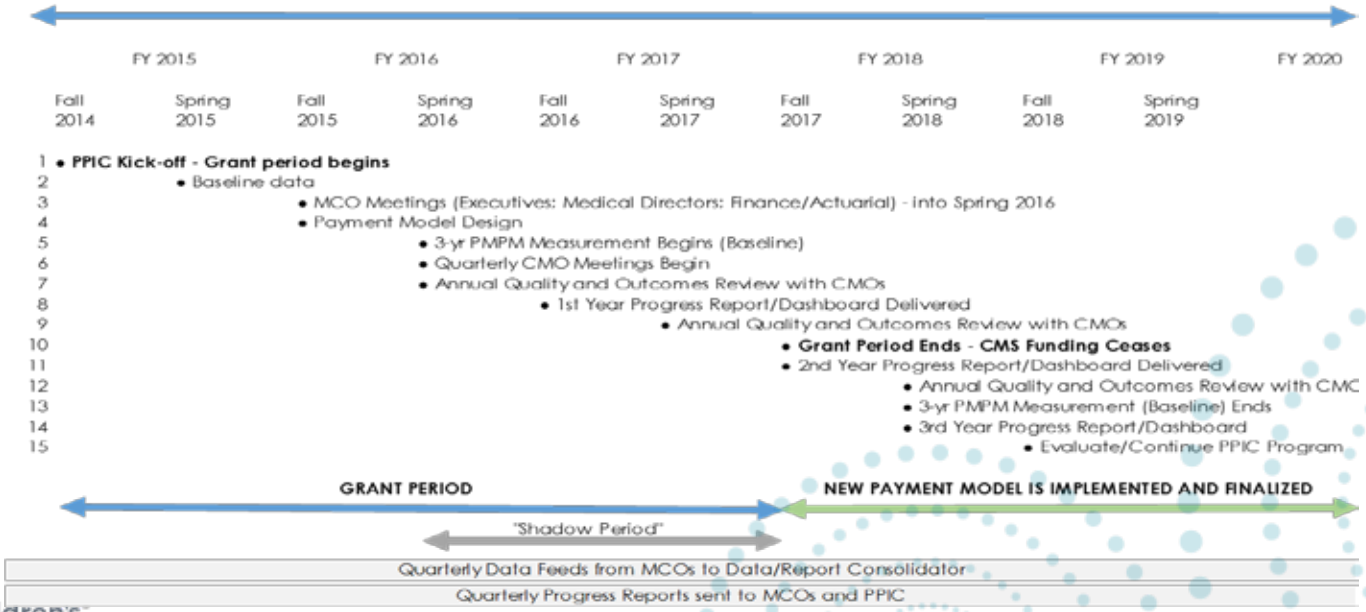
PRISM s a Washington State DSHS risk stratification method to describe utilization and is derived from dx, meds, and utilization history

# PPIC Interventions Focus on Care Management and Support of PCPs

- Care Management
  - Assess for Social Complexity (Safety, Food, PCP)
  - Patient-Centered Shared Care Plan
  - Environmental Assessment/Mitigation for Asthma Patients
  - Focus on optimizing CM model of care – enrollment, maintenance, and graduation
  - IT : Communication and analytics support using Wellcentive
- Clinical interventions to support PCPs
  - Training for management of most common problems - autism, seizures, G-tubes, asthma
  - Practice based care coordination training monthly
  - PCP-Centered Complex Patient Plan of Care
  - Focus on specialists (endocrine, neurology, pulmonary - developing school and PCP co-management plan

# Development of the Payment Model: MCO Engagement

- Discussion of the PPIC program with MCO teams
- Initial data analytics to characterize the population
- Creation of initial strawman payment model design
- Developed consensus on the structure of the proposed payment model
- Reviewed and agree on timeline



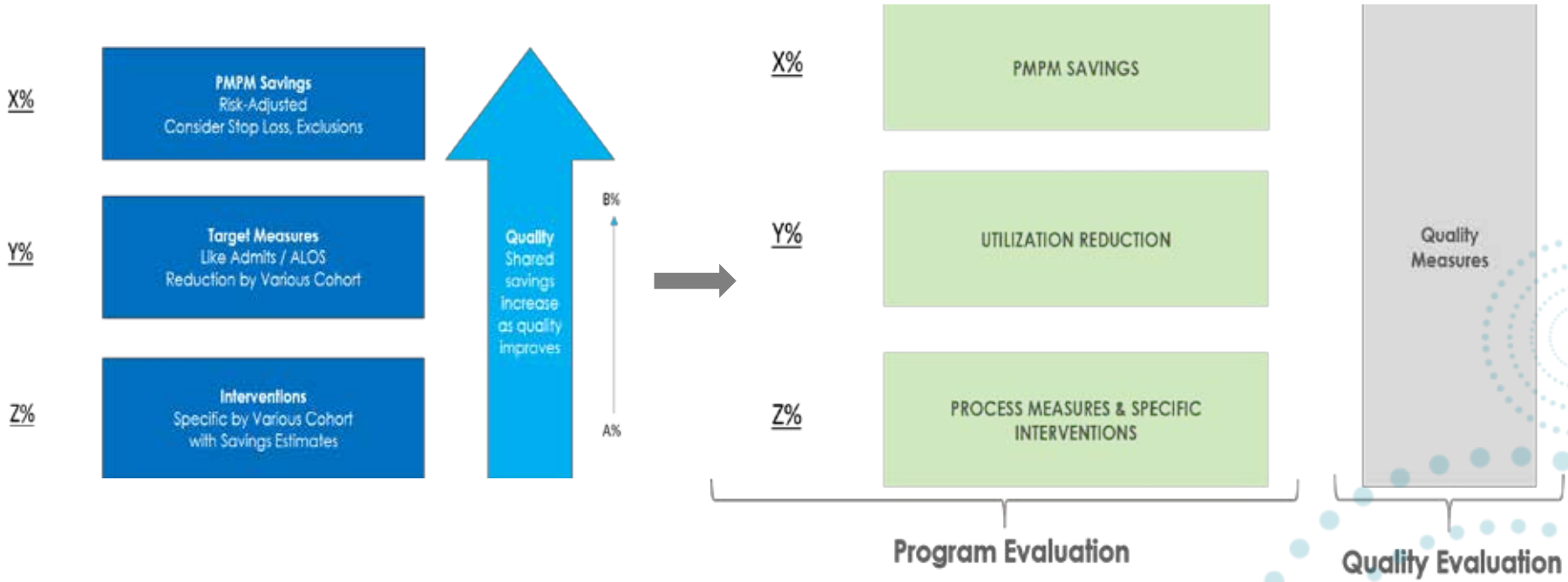
# Initial data analytics were developed to characterize the population

- Worked with actuaries (Axene Health Partners) to develop detailed medical claims, pharmacy claims, and eligibility from information secured from each MCO
  - BAAs directly between AHP and MCOs
  - Recognize need to maintain confidentiality of MCO negotiated arrangements with other providers
- Actuary partners developed an analytics package for each MCO to facilitate discussion of key issues in building a payment model for this population
  - PMPM and member-months by year
  - Examination of high-cost claimants by year
  - Predictability of high-cost patients
  - Adequacy of CDPS and PRISM as risk scoring tools
  - Churn analysis
  - Volatility of cohort-specific utilization
- **What makes this population different?**

# Key lessons learned: What makes this population different?

- **Volume**: Sample size of the population is small (low-n). Overall population is volatile; MCO-based measures approach randomness.
- **Outliers**: In this high-risk, SSI population of children, everyone has the potential to be an outlier, but the number of actual outliers, if defined as $100K+ in spend in a year, is quite small. A very small number of patients are driving the majority of spend; however, predicting these members is difficult.
- **Risk adjustment:** Standard models are generally not sensitive enough for a pediatric program of this nature. CDPS and PRISM by themselves are not sensitive enough, but PRISM-squared showed promise in better predicting the high-cost "tail."
- **Program participation and cohorts:** Program may have significant variability in participation from year to year (turnover). MCO-specific churn results suggest that eligibility may need to be monitored closely.
- **Care management:** It is not yet clear where payer and provider responsibilities lie.
- **Control:** Effective transition of care may be hampered by psychosocial and socioeconomic issues.

# Early versions of the payment model structure were developed and reviewed



# PPIC Payment Model: “Shadow” Year

| | Payment Model Components | Metrics | Weight |
|---|---|---|---|
| PROGRAM EVALUATION | PMPM Savings | • PMPM (3-year rolling) Risk adjusted | 35% |
| | Utilization Reduction | • Readmission rate<br>• ER utilization rate<br>• IP utilization rate | 20% |
| | Process Measures & Specific Interventions | • % Enrolled in care management (Care coordination assessment, care management plan, at least monthly outreach)<br>• % of episodes of care in which care manager has contact within 72 hours<br>• % seizure patients with a current seizure plan<br>• % of asthmatics with at least two office visits for asthma in the last year | 25% |
| | Patient/Caregiver Experience and Outcomes | • Family Experience with Care Coordination 8 Measures (survey)<br>• Peds QL | 20% |
| | **TOTAL** | | **100%** |
| | **QUALITY EVALUATION** | | |
| | Quality Measures (gate) | • % patients ages 3-21 with at least one WCC visit per year<br>• Ambulatory Sensitive Inpatient Stay | 75% for baseline, 100% for 5% improvement |

# Payor Engagement: Focusing financial and actuarial teams on methodological details

- Engaged financial and actuarial teams to explore the detailed methodology and technical requirements to support the payment model structure
  - Standardize data requirements
  - Come to consensus on methodological steps for metrics – especially PMPM
  - Recognize that other metrics require care management/clinical input
- New data analytics to support evaluation of specific methodologies
- Development of comprehensive draft methodology document to generate feedback and move toward consensus
- Current status: "Exposure period" for the current draft document, securing feedback through multiple channels