CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

# Centerpiece of Medicaid Transformation: Care Management

Kelly Crosbie, MSW, LCSW, DHB-DHHS
Danika Mills MSW, LCSW, MPS, LCAT, CCM, CCNC
Andrew Clendenin, MSW, CCNC

COLLABORATING *for* CHANGE

# Medicaid Transformation:

# Care Management & The Advanced Medical Home (AMH) Program

**Kelly Crosbie, MSW, LCSW**
**Senior Program Manager, Health Transformation**
**Project Lead, Quality & Population Health**

**Division of Health Benefits**

# Population Health: Care Management

**Under managed care, PHPs (plans) will have responsibility for the care management of enrollees.**

***The PHP contract will define standardized PHP care management responsibilities***

***Priority Populations***

***LTSS Needs***
***High Unmet Resource Needs***
***Special Healthcare Needs***
***Rising Risk***
***High Risk Pregnancy***
***At-Risk Children***
***Transitional Care***

**PHP Care Management Responsibilities**


***Under the AMH program, primary responsibility for comprehensive assessment and care management passes from PHP to practices when practices certify into higher AMH "tiers" (see next slides)***

# Advanced Medical Home Overview*

- The **Advanced Medical Home (AMH) program** will:
  - Build on the strengths of today's North Carolina's primary care infrastructure as the State transitions to managed care
  - Offer a range of participation options for providers
  - Emphasize local delivery of care management
  - Offer the opportunity for providers to be rewarded for high quality care by aligning payment to value

- **Care management will be a shared responsibility of practices and PHPs, with division of responsibility varying by AMH "Tier"**
- **The AMH Program will launch concurrently with managed care, with a State attestation process for practices launching in Summer/Fall 2018**

***AMH focus today is on Standard Plans. Details for AMH in Tailored Plans is TBD.***

# Four “Tiers” in the AMH Program

- **Practices will apply to DHHS to participate in the AMH program, and practices’ AMH Tier status will be recognized by all PHPs .**

| AMH Tier | Summary |
|---|---|
| 1 | • Based on Carolina ACCESS I standards<br>• **Will phase out after 2 years** |
| 2 | • Based on Carolina ACCESS II standards |
| 3 | • Based on Carolina ACCESS II standards **PLUS demonstrated care management capabilities at practice or system level to serve all Medicaid beneficiaries**<br>• PHPs must contract with a substantial proportion *(% to be set by state)* of certified Tier 3 practices in each region in which they operate |
| 4 | • **Will launch in Year 3 of managed care**<br>• Care management capabilities as in Tier 3<br>• Will capture “advanced” alternative payment arrangements |

# Certification/Attestation Requirements by Tier

- Practices will be eligible to participate in AMH if they meet current requirements for Carolina ACCESS.
- Practices will be required to choose between Tier 1, 2 or 3 and attest accordingly.
- The **Tier 3** practice attestation process will assess practices' readiness to perform care management functions at the site or system level:
  - Risk stratifying all patients in their panel;
  - Providing targeted, proactive, relationship-based care management to all higher-risk patients;
  - Providing short-term or transitional care management;
  - Providing medication reconciliation support to targeted higher-risk patients;
  - Ensuring patients with emergency department visits receive a follow-up interaction within one week of discharge; and
  - Contacting a high % of patients who were hospitalized in target hospitals, within two business days.

# Four AMH Payment Types

| Payment Type | Description |
|---|---|
| **Clinical Services Payments** | • Fee-for-Service |
| **Medical Home Fees** | • Payment for coordination with PHPs, similar to today's Carolina ACCESS fees<br>• Will be set at Carolina ACCESS levels for 2 years |
| **Care Management Fees** | • Payments available to Tier 3 practices for assuming significant care management responsibilities<br>• Fee levels negotiated between PHPs and practices |
| **Performance-Based Payments** | • Payments based on performance against AMH measures |

# Payment Model by Tier

**DHHS will require PHPs to adhere to standard payment models by Tier**

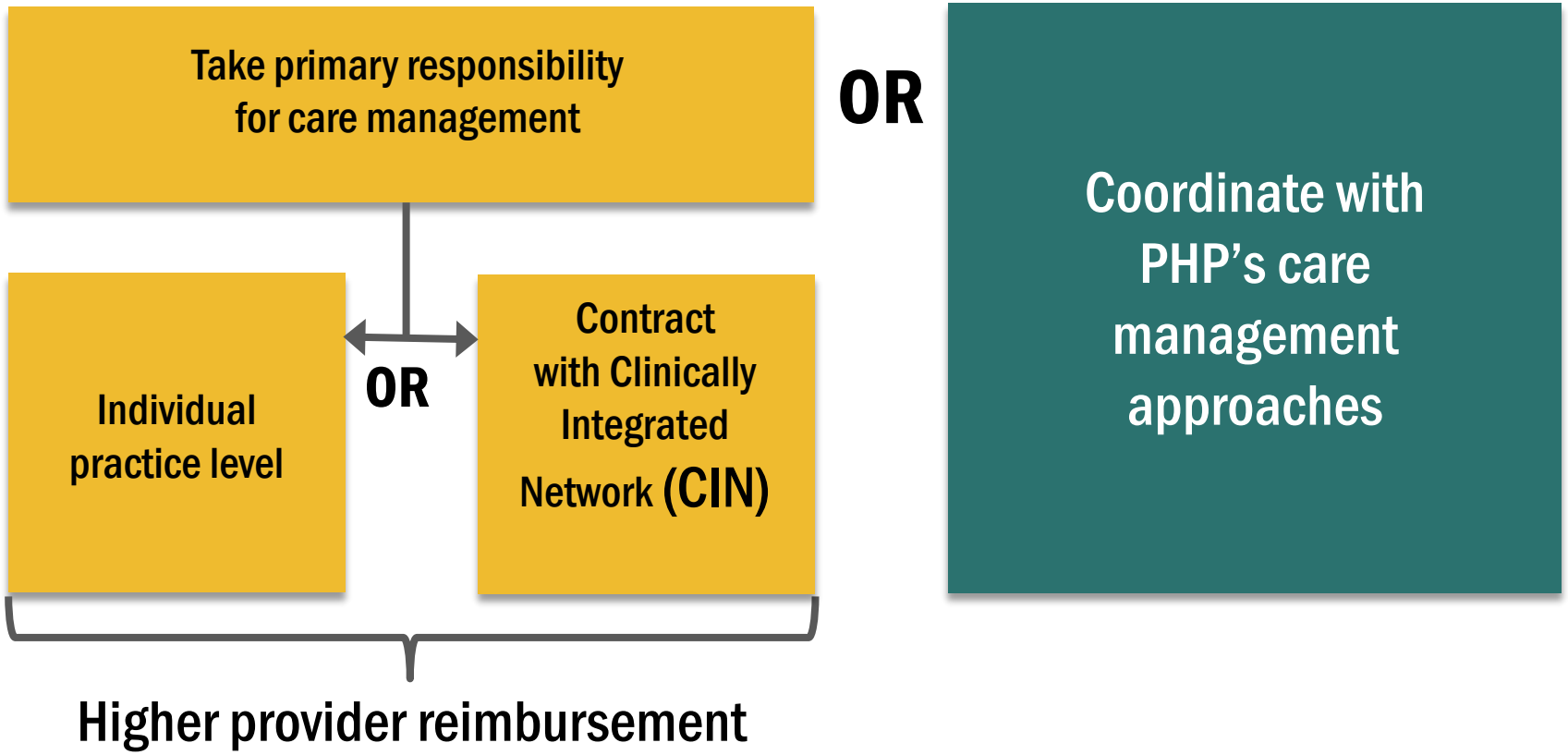
| AMH Tier | "Clinical Services Payments" (FFS) | Medical Home Fee | Care Management Fee | Performance Based Payments in Years 1-2 |
|---|---|---|---|---|
| 1 | ✓ | ✓ - CA I | N/A | Optional |
| 2 | ✓ | ✓ - CA II | N/A | Optional |
| 3 | ✓ | ✓ - CA II | ✓ - Negotiated between each AMH/CIN and PHP | ✓ |
| 4 (Year 3 +) | *Alternative Payment arrangements may change the balance or merge the components of the payment components, including by decreasing FFS* | | | ✓ |

# AMHs and Clinically Integrated Networks (CINs)

- **AMH practices can perform all care management functions on their own.**
- **AMH practices may also contract with a Clinically Integrated Network (CIN) for care management & analytic support.**
- **DHHS is using the term "CIN" to refer to an entity with whom the AMH practice voluntarily contracts to share responsibility for data sharing/analytics and care management. Could be:**
  - **a hospital or health system**
  - **an independent non-profit organization;**
  - **third-party population-health company.**

# Provider Determines Care Management Role

**Advanced Medical Home (AMH) program is a framework to help providers choose:**



# AMHs and Clinically Integrated Networks (CINs)

- **DHHS will certify AMH practices who apply to the program**
- **DHHS will not separately certify CINs**
- **DHHS intends to allow providers flexibility in how they decide to meet AMH Tier 3 and 4 care management requirements**
- **DHHS expects there will be multiple CINs offering services to support AMHs, and providers are free to choose any CIN**
- **AMHs may choose to affiliate with more than one CIN and may change their affiliation over time**

# AMH Quality Measures

- DHHS will require PHPs to monitor the performance of AMHs in all tiers
- DHHS will develop a set of Core AMH quality performance measures aligned with North Carolina's Quality Strategy and varied by population (Pediatric, Family Practice, Internal Medicine)

https://files.nc.gov/ncdhhs/documents/DRAFT_QualityStrategy_20180320.pdf

- The core measure set will include (at a minimum) measures in the following categories:
  - Measures tied to Quality Strategy objectives
  - Total Cost of Care
  - Key Performance Indicators
- PHPs will be responsible for monitoring the performance of AMHs in all tiers
- PHPs will be responsible for using the core measure set to design performance-based programs and payments

# AMH Data Sharing

**To ensure that AMHs have sufficient data to support their care management efforts, PHPs will be required to share data on attributed enrollees*:**

**All AMH Tiers**

- Assignment/attribution files;
- Results of PHPs' risk stratification
- Initial enrollee-level care needs screening data;
- Practice-level quality measure performance information

**AMH Tier 3 and 4**

- Timely enrollee level claims & encounter data feeds (DHHS to standardize format(s))

*To receive feeds, Tier 3 and 4 AMHs will need to demonstrate:*

- Appropriate health information technology
- Data privacy and security processes

*DHHS will publish a policy paper on AMH Data-Sharing Requirements in Summer 2018


To share comments, email: Medicaid.Transformation@dhhs.nc.gov

For NC Medicaid managed care information and documents:
www.ncdhhs.gov/nc-medicaid-transformation

https://files.nc.gov/ncdhhs/documents/CareMgmt-AMH_ConceptPaper_FINAL_20180309.pdf


# Centerpiece of Medicaid Transformation: Care Management

**April 10, 2018**

**Danika Mills MSW, LCSW, MPS, LCAT, CCM**
**Andrew Clendenin, MSW**

# Objectives

- Identify the components of the Carolina Access/CCNC model
- Review the role of care managers for individuals with mild-to-moderate and more intensive BH/I-DD needs

# Community Care of North Carolina

Community Care of North Carolina (CCNC) is an organization providing complex care management and population health management.

Our core values include:

- Promoting the medical home model, providing supports to providers;
- Providing quality care by offering holistic, care coordination of services for clients within the community setting;
- Containing costs by targeting prevention of hospital readmissions and non-emergent Emergency Department (ED) utilization; and
- Empowering recipients through disease and utilization education.

# CCNC Footprint Statewide

- **5,000 primary care providers**
  - 1,800 Practices
  - 90% of PCPs in NC

- **1.5 million Medicaid Patients**
  - 1 million children
  - 500,000 adults
  - 300,000 Aged, Blind, Disabled
  - 150,000 Dually Eligible

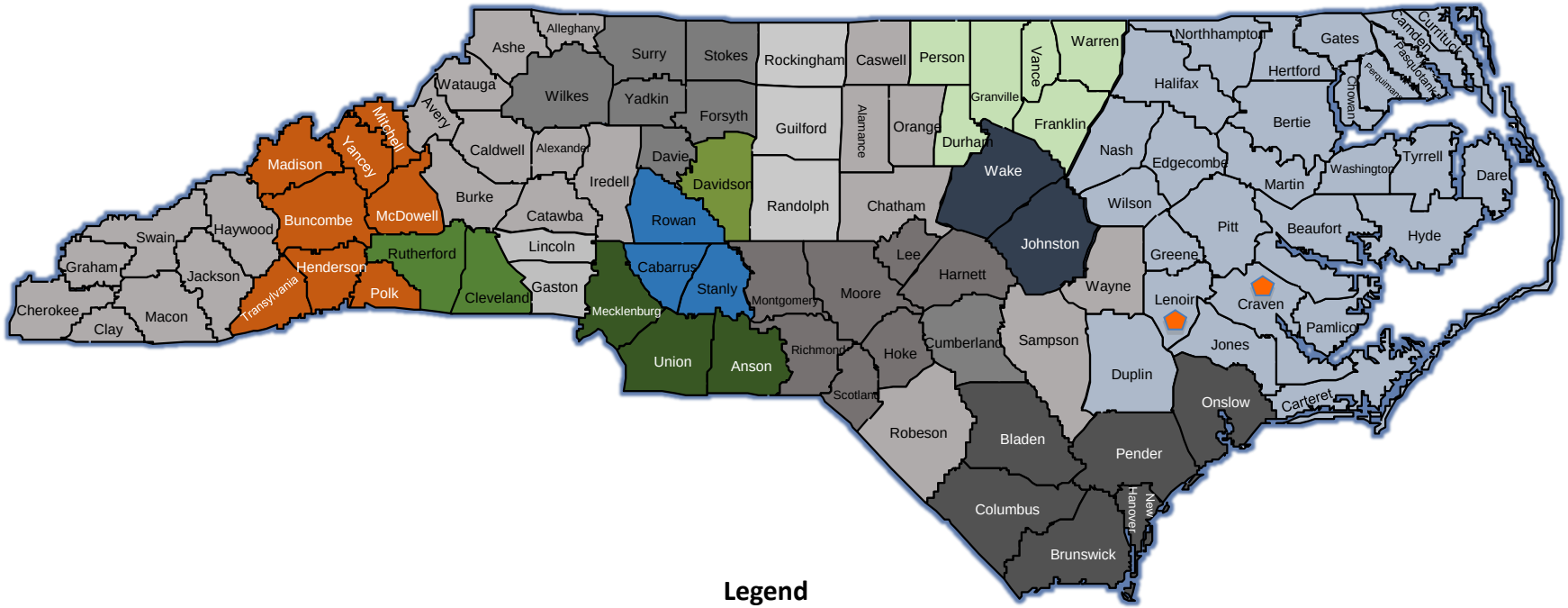
## All 100 NC Counties


## 14 Networks

**Each network averages:**

- 1.4 Medical Directors, 1.0 Psychiatrist
- 42.8 Local Care Managers
- 1.8 Pharmacists
- Multiple disciplines: RN, LCSW, RD, …

# Network Regions

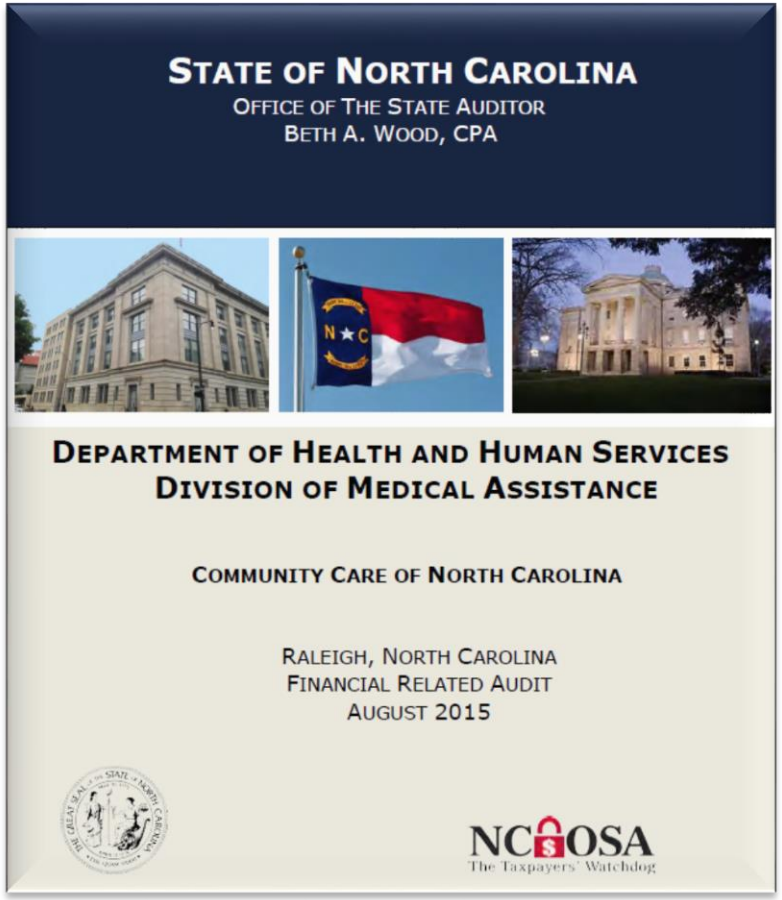



**Legend**

- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Carolina Community Health Partnership
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care
- Partnership for Community Care
- Community Care of the Sandhills
- Community Care of Southern Piedmont

# External Evaluation: Bending the cost curve

- 2015 report from the Office of the State Auditor, analysis conducted by Harvard health economist, Dr. Michael Chernew
- Every dollar invested in CCNC has generated over $3 in savings to the state
- Total net savings $312 per member per year (9% of Medicaid costs)
- Savings driven by 25% reduction in inpatient admissions



# CCNC Complex Care Management Model

The Complex Care Management model is evidence-based built on standards of practice and quality guidelines from nationally recognized models and industry leaders, including:

- Chronic Care Model by Ed Wagner
- The Care Transitions Program by Eric Coleman
- The Transitional Care Model by Mary Naylor
- Case Management Society of America (CMSA)
- Commission for Case Manager Certification (CCMC)
- National Committee for Quality Assurance (NCQA)

# CCNC Complex Care Management Model

**A Care Team** includes many disciplines as part of the delivery model, unique to each person's needs:

- Care Manager—(RN, Social Worker)
- PCP and Specialty Care
- Patient Coordinator
- Pharmacists
- Community Providers

**Motivational Interviewing** incorporated throughout our programs

**The Fifth and Sixth Vital Signs**– All programs support the evaluation of Chronic Pain needs and BH needs

**"Real Time" Data—Accessible i**ncludes Admission/Discharge/Transfer (ADT), Pharmacy Home, etc.

# Complex Care Management Model

**Data Driven – due to Impactability ™** scores for Complex Care Management and Transitional Care.

- Claims
- EHR
- Labs
- Pharmacy

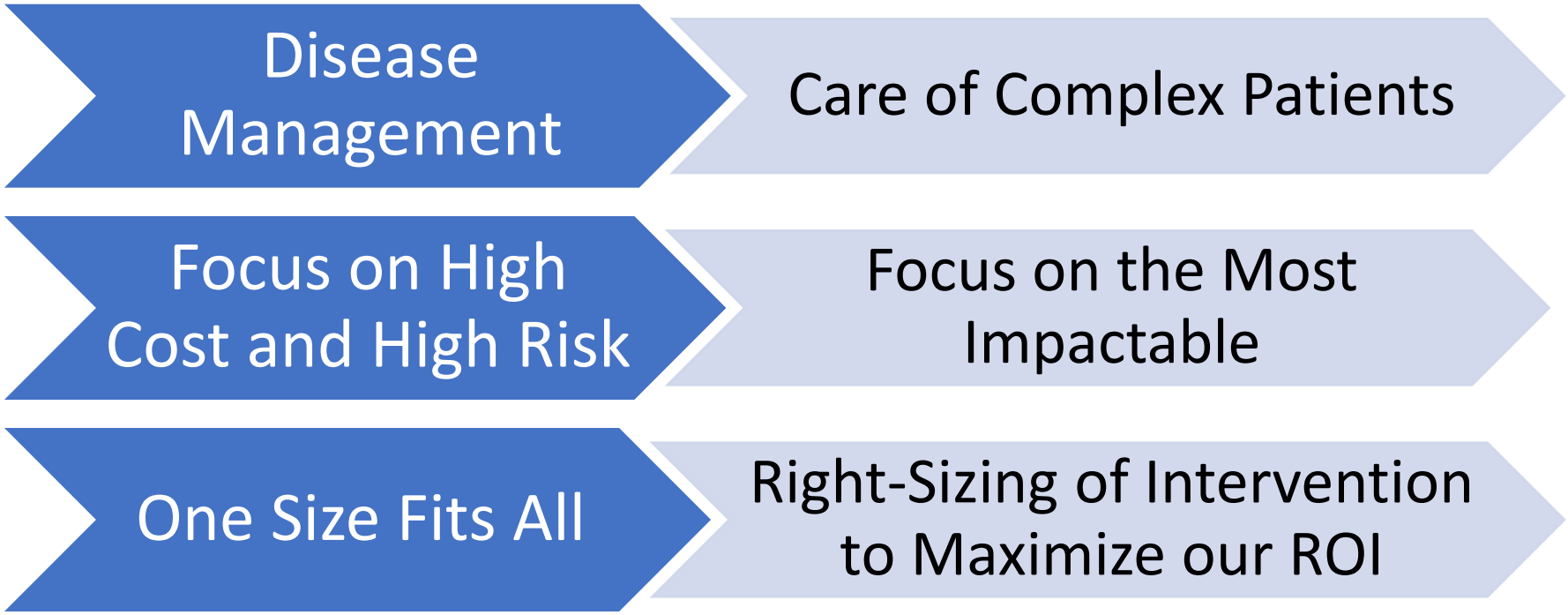
**Targeted Interventions**

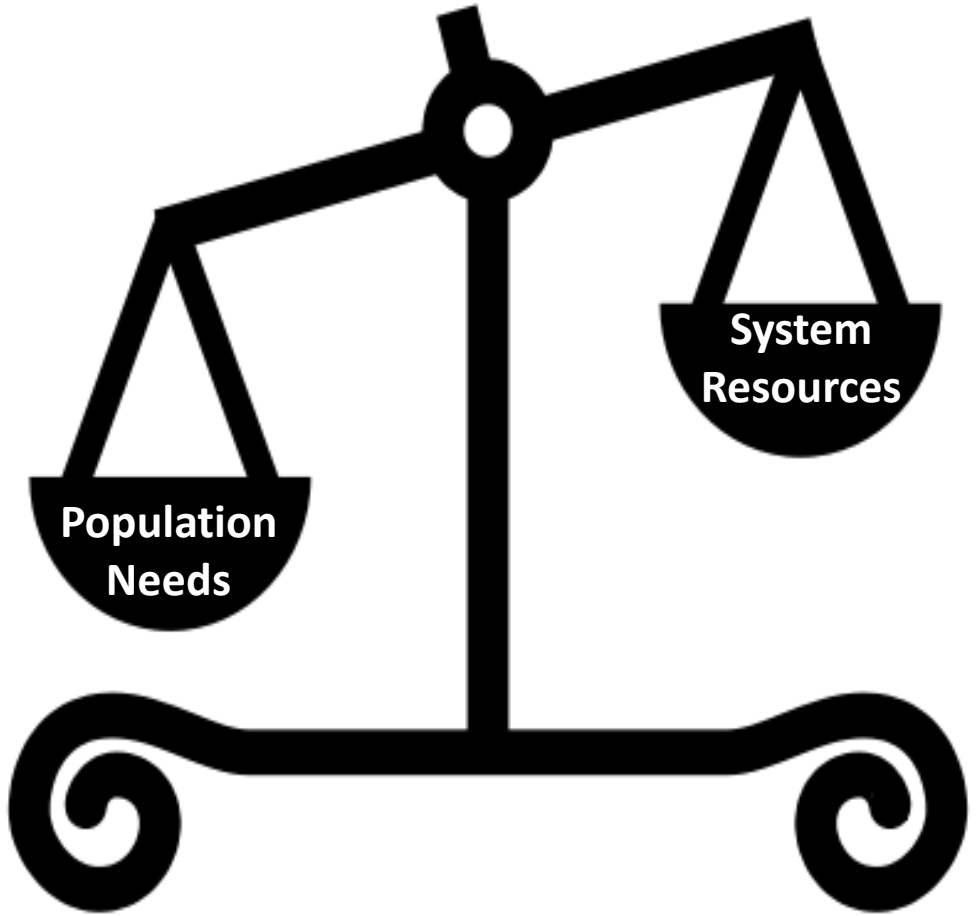
- With the right patient
- At the right time
- In the right environment

**Fully Integrated** with Primary Care, Behavioral Health and Pharmacy

# Building Blocks for CCNC's Health Care Analytics

# The Evolution of CCNC Care Management




System
Resources
Population
Needs

# Social Determinants and the need for the Community Based Care Team

**88% of "impactable" patients have at least one of the following social risk factors in addition to their medical conditions:**

- 77% have mental illness
- 30% lack adequate support system
- 29% lack adequate transportation
- 18% have unstable housing
- 17% have experienced trauma or abuse
- 17% have substance abuse problems
- 16% have unmet nutritional needs
- 14% are illiterate

➢ **58% have more than one of these**

➢ **21% have at least 4 or these**

**The most "impactable" patients (score ≥ 500) visit an average of**

- ❖ **14 different billing providers during any given year**
- ❖ **2.5 different hospitals for acute events in a 12 month period.**
  - **70% use more than one hospital**
  - **20% use 4 or more hospitals**

# Intervention Strategies

- Provide assistance, statewide, to practices implementing:
  - Routine behavioral health screening
  - Interventions to address mild/moderate behavioral health conditions
  - Evidence-based models of integrated care (SBIRT, Collaborative Care, PCBH)
  - Referral pathways to specialty mental health/substance use /IDD providers
- Increase return on investment for practices
- Improve access to behavioral health treatment for patients with mild to moderate behavioral health conditions
  - Reduce unnecessary utilization and total cost of care for patients with mild to moderate behavioral health conditions.
  - Improve overall quality of care for patients with mild to moderate behavioral health conditions

# Behavioral Health Integration: Value-Add

- **Integrated primary care practices will be accountable for medical and behavioral health outcomes. We must assist practices to learn, master, and implement the changes needed to achieve these outcomes.**

- **Our efforts will advance health care in North Carolina and help us achieve the goals of the "quadruple aim" to better experience of care, better health in our community, improve provider engagement and support, and lower per capita cost.**

# Where we took it from there…

## Risk Scores

- Designed to predict events and outcomes in the absence of intervention.  The dependent variable in the predictive models are typically events (e.g., hospital utilization) or costs.

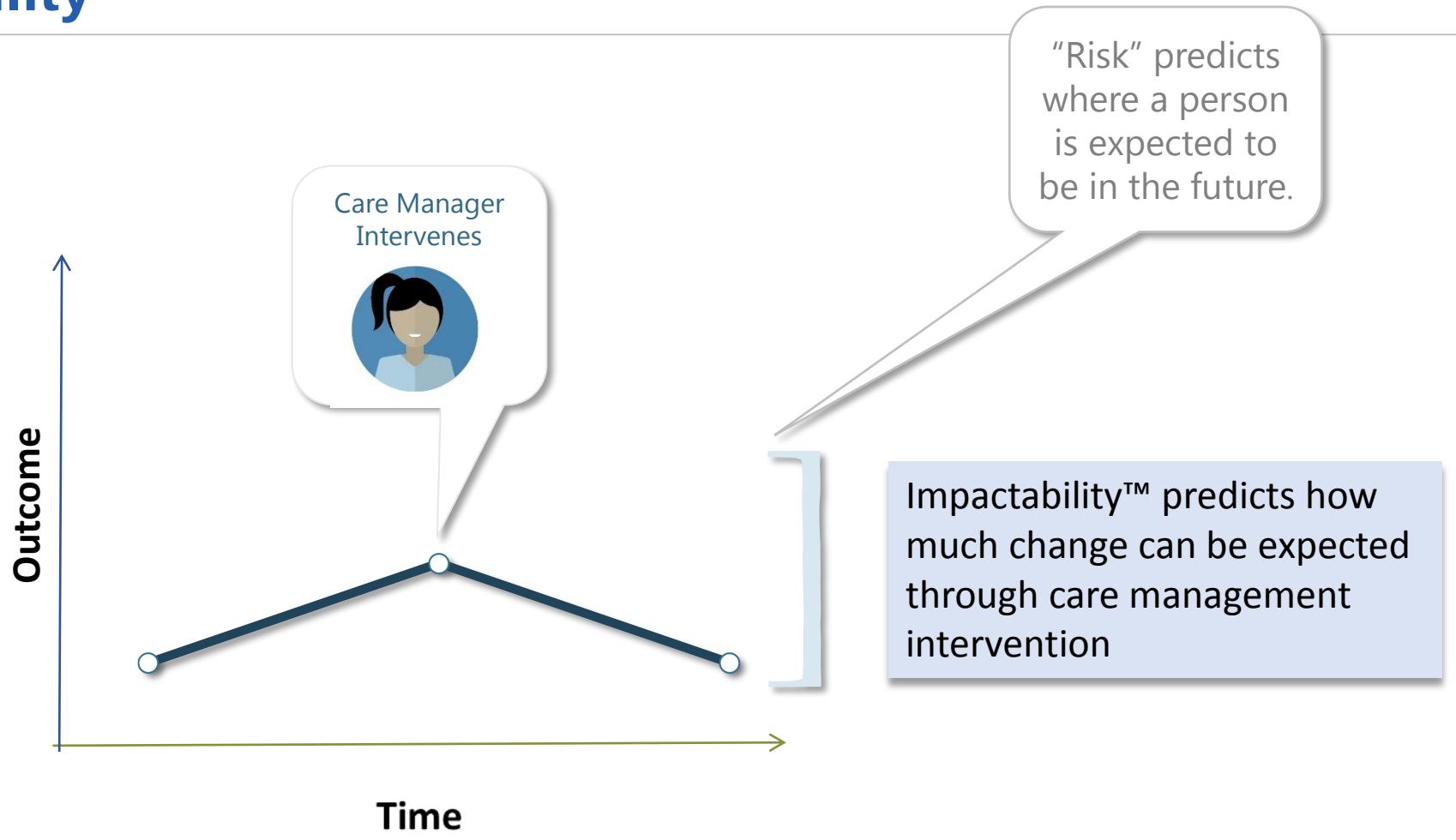
## Impactability Scores ™

- Designed to identify members, who will benefit the most from a given intervention. The dependent variable in the predictive models are the estimated savings from care management interventions, based on rigorous, controlled real-world evaluations.

## Evidence-based Care Guidance

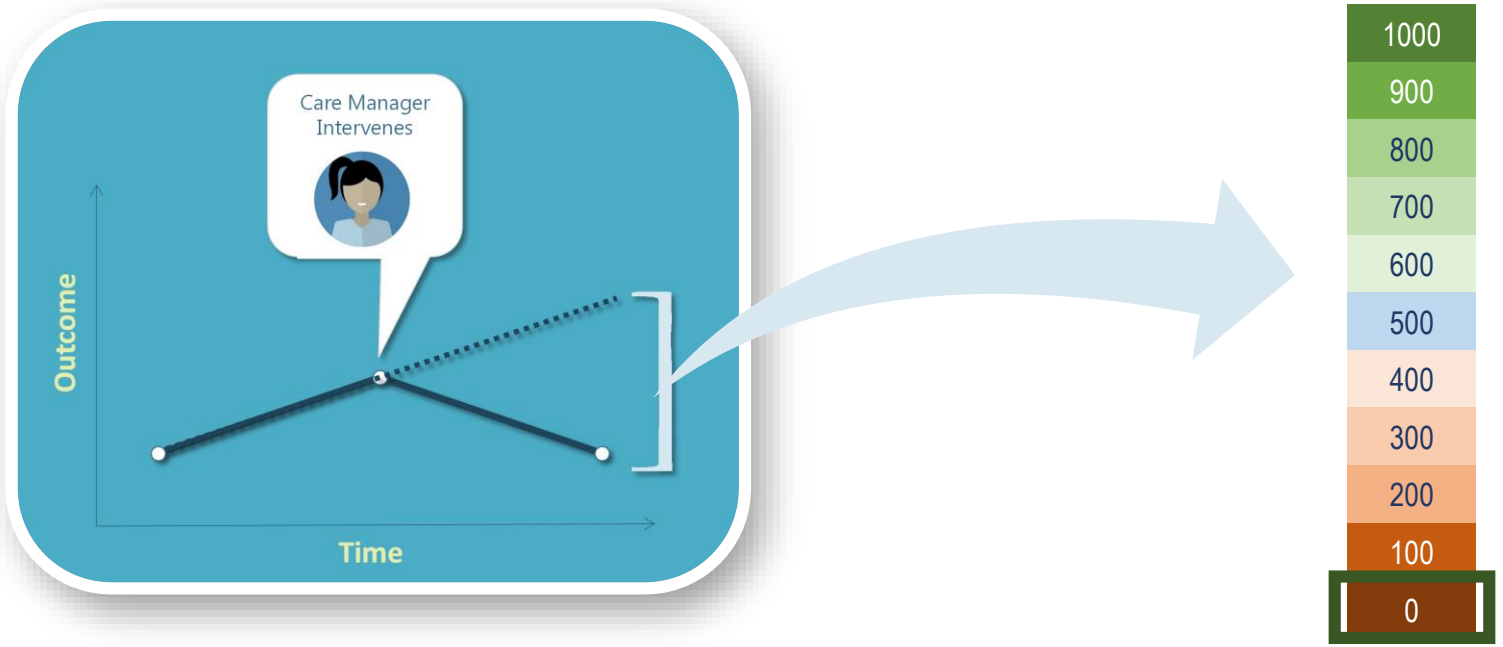
- What interventions make the most difference…. for which patients, by whom and when?

# The Sweet Spot: Optimizing ROI Requires a Focus on Impactability™

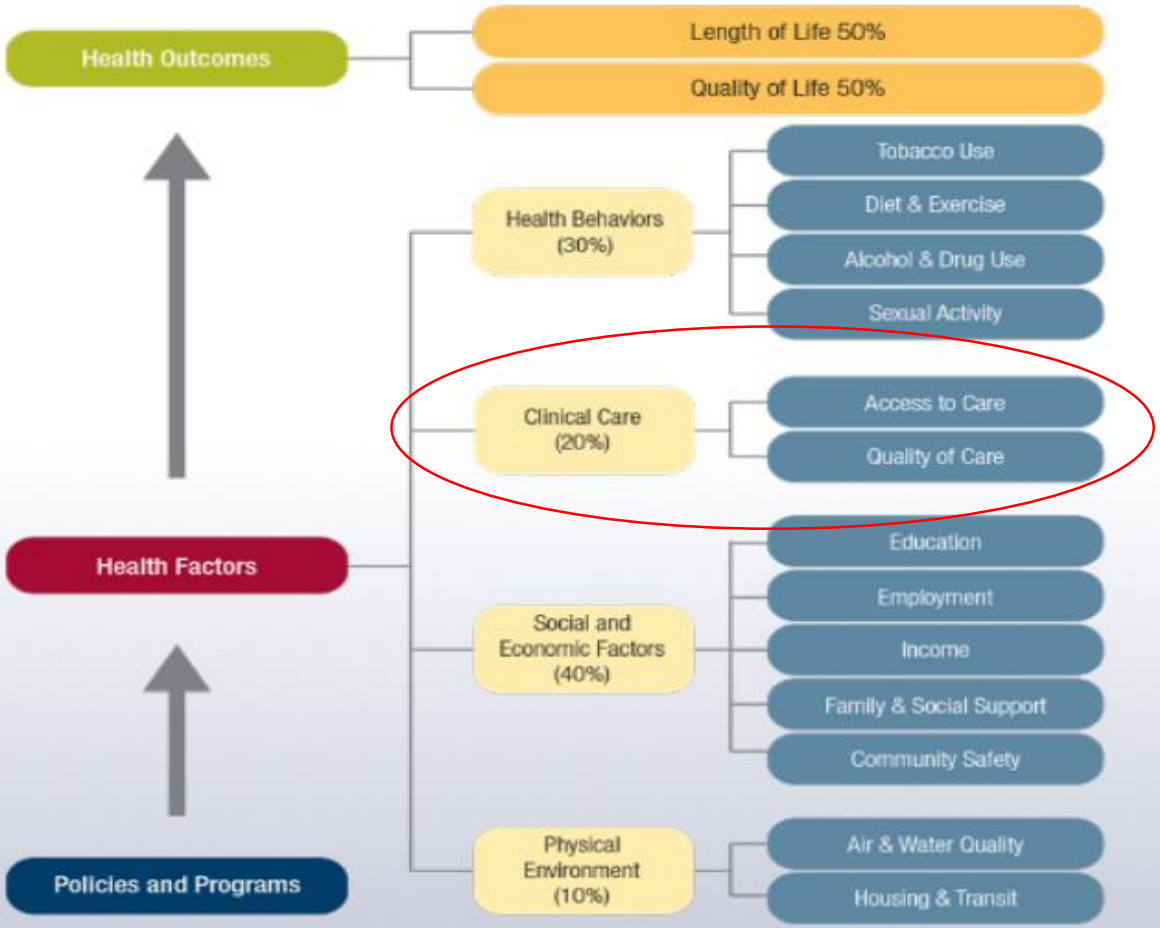


# Complex Care Management (CCM) Impactability Score

| Score | How Defined? | What it means? |
|---|---|---|
| **Complex Care Management Impactability Score™** | A score from 0-1,000 reflecting likely cost saving, per month (over 6 months following care management);<br><br>CCNC prioritizes patients with a CCM Impactability Score above 200 | Clinical characteristics and utilization patterns indicate a high likelihood of benefitting from care management. Prioritizing patients with a score of 200-1,000 flags less than 1% of the Medicaid population, but for these patients, we are confident that we can expect an average savings of $1,200 - $6,000 per patient receiving care management. |



# Why Do We Right-Size Our Interventions?




## It Translates into Better Health Outcomes!

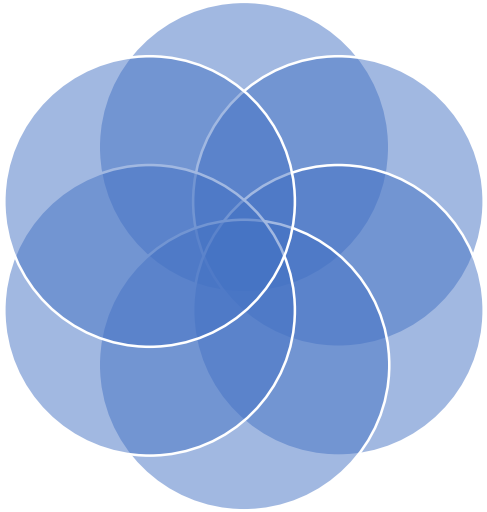
**Sources:**

- Rask, February 2017
- Robert Wood Johnson Foundation – Health County Ranking http://http://www.countyhealthrankings.org/

# Core Components: CCNC Care Management Benefits

Enhanced risk stratification - Impactability Scores™

Linkage to Medical Home



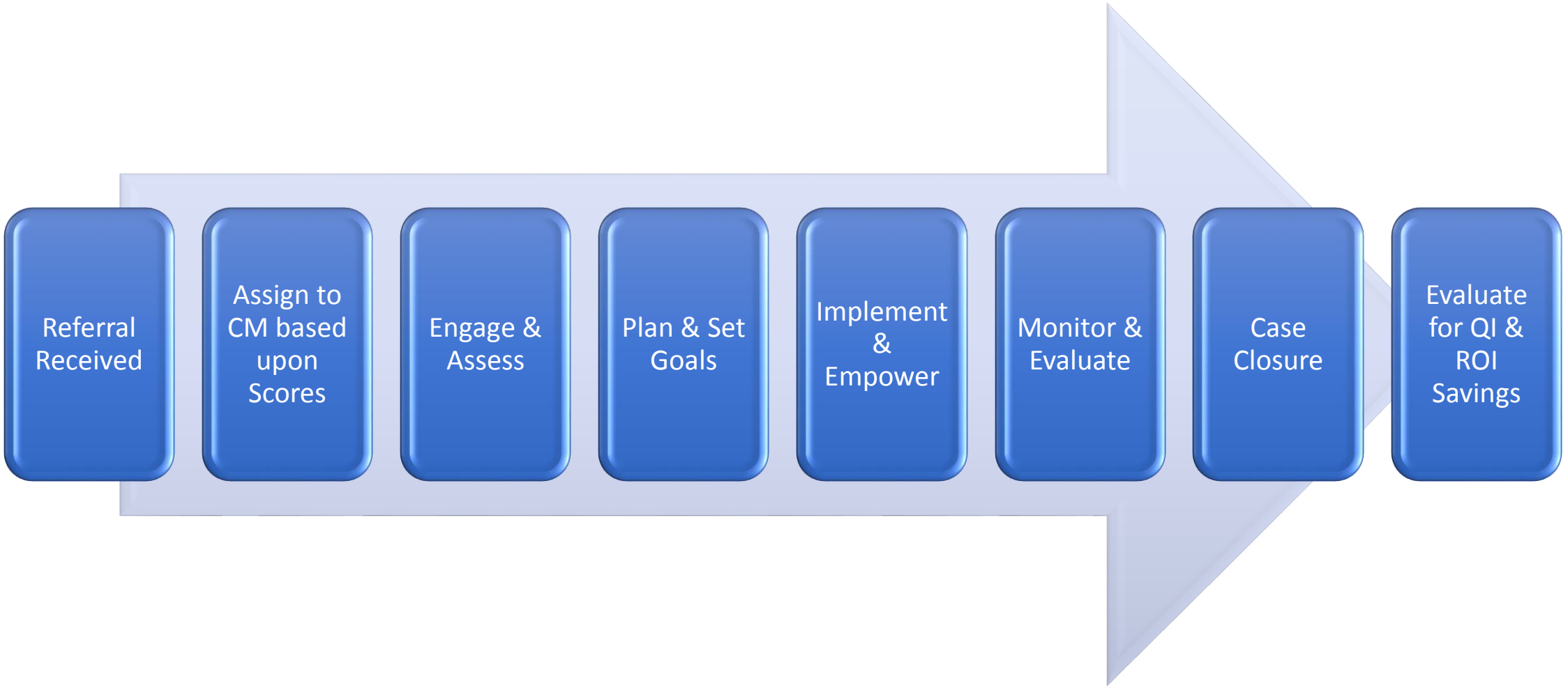
Multi-disciplinary team- Clinical and Non-clinical staff

Motivational Interviewing to increase engagement, identify needs & empower

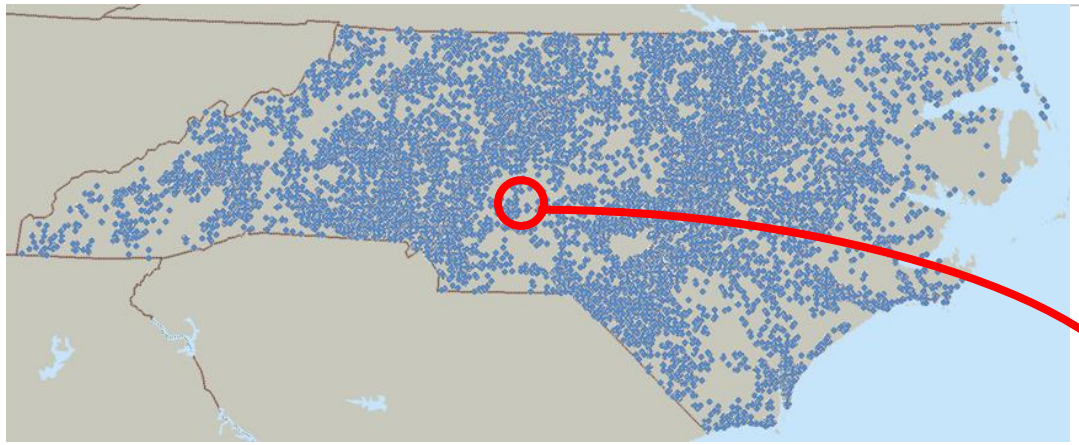
Medication management incorporating pharmacy support (internal and external)

Targeting appropriate interventions based upon QI and ROI (Face-to-face and telephonic interventions)

# CCNC's Integration of the Essential Components within the Care Management Process



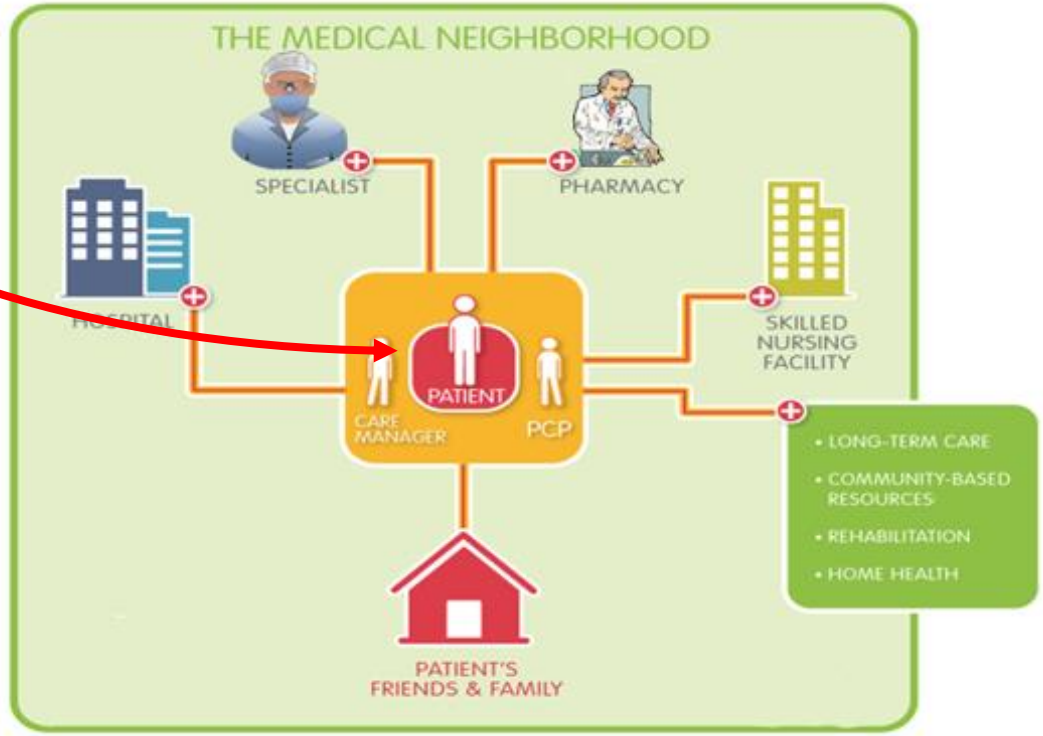
# When We Remove the Barriers to Care, We Improve the Impact of Care.



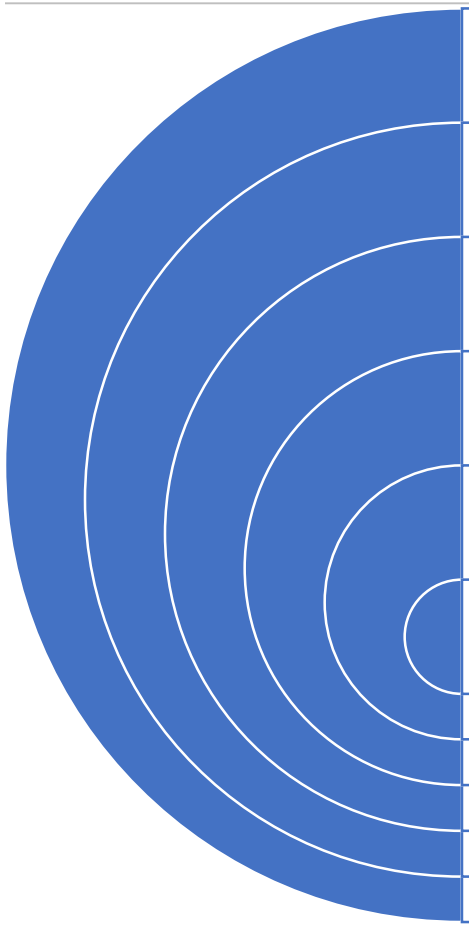
- ✓ Community-based multidisciplinary care team
- ✓ Connecting the dots with PCMH and other providers
- ✓ Comprehensive medication management
- ✓ Goal setting and care plan
- ✓ Education and self-management support
- ✓ Linkage to community resources

## >32,000 Individuals received CCNC Transitional Care Support in 2015

**Targeted from among 146,000 patients with 190,000 hospitalizations**
**Out of 1.4 million enrolled in Medicaid primary care medical home program**



# Takeaways



| |
|---|
| Even though we have served hundreds of thousands, there are opportunities to improve the way we deliver care |
| Integrated Care Team is essential, as is face to face and home visits, collaboration (providers, plan LME MCOs, community providers) with BH providers |
| Right-sizing into opportunities to serve in the future - Peer support, human-centered design, members and families drive our interventions to understand what is important. |
| There is so much work left to do – collaboration rather than competition |
| Let's realize future opportunities – there is enough work for everyone. |
| We can't blame it on the system. Collectively, we are the system |
| |
| |
| |
| |
| |

# References


- CCNC: Community Care of North Carolina. www.communitycarenc.org
- County Health Rankings & Roadmaps. www.countyhealthrankings.org/
- Jackson, CT., DuBard, CA. (October 2015). *Identifying Highest Yield Transitional Care Opportunities*. CCNC Data Brief, No. 5, Community Care of North Carolina, Inc.: Raleigh, NC.
- Jackson, CT., Kasper, EW., DuBard, CA., (October 2015). *Incremental Benefit of a Home Visit following Discharge for Patients with Multiple Chronic Conditions*. Population Health Management.
- Jackson, CT., Trystad, TK., DeWalt, DA., DuBard, CA. (August 2013). *Transitional Care Cut Hospital Readmissions for North Carolina Medicaid Patients with Complex Chronic Conditions.* Health Affairs. Vol 32, No 8., www.healthaffairs.org
- Jackson, CT., Shahsahebi, M., Wedlake, T., & DuBard, CA. (March/April 2015). Timeliness of Outpatient Follow-up: an Evidence Based Approach for Post-Discharge Planning. Annals of Family Medicine. Vol 13(2); 115-122. http://www.annfammed.org/
- Rask, K (February 2017). Paying for Quality Healthcare across the Continuum. Alliant Quality.
- Wood, BA, (August 2015). Department of Health & Human Services-Division of Medical Assistance-Community Care of North Carolina. NC Office of the State Auditor, Summary Report: FCA-2014-4445. http://www.ncauditor.net/pub42/AllReportsList.aspx

# *Thank you*