Accountable Care Collaborative Program Improvement Advisory Committee

Medicaid Director Update

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August 18, 2021

Department Update
Tracy Johnson
15 minutes

Discussion
All
15 minutes

Present complex definition update

Population Health Strategy: Right care, right time, right place

A core principle of health equity is to recognize that members have different needs and to match the service to the need. Complex members can benefit from higher level interventions and resource allocation.

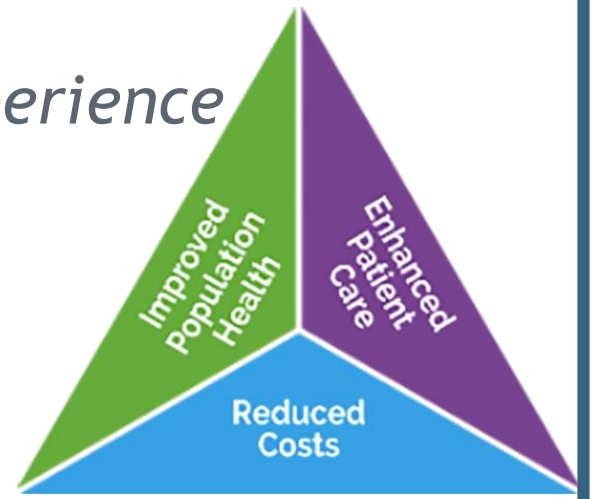
Current Expectations of RAEs

- Stratify your population based on health risk
- Place additional focus on population health interventions for complex members
- At a minimum, use care coordination to support complex members
- Allocate a greater portion of administrative payments to providers who see more complex members.

Why Care Coordination?

Triple Aim: Improving health care requires simultaneous pursuit of:

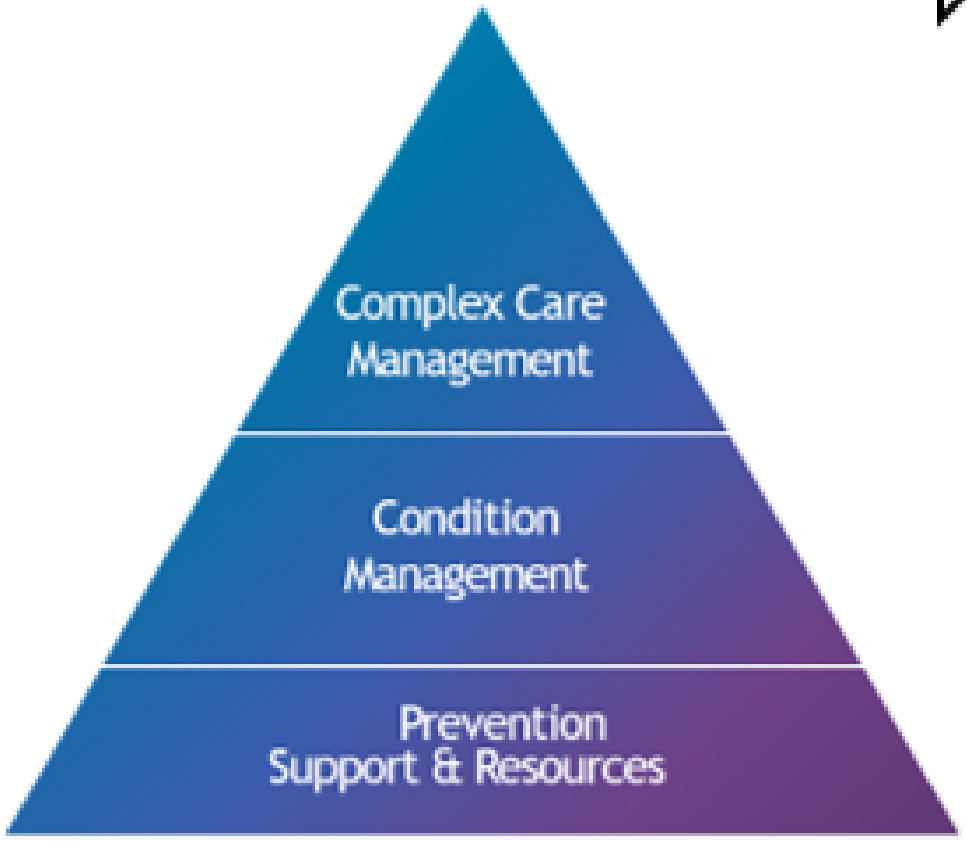
- *Improved population health*
- *Enhanced patient experience*
- *Reduced Costs*



The Agency for Healthcare Research and Quality defines care coordination as "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer, more effective care." This includes determining the patient's needs and preferences and communicating them "at the right time to the right people."

ACC Population Health Framework

STRATIFICATION → DELIVERABLES → OUTCOMES



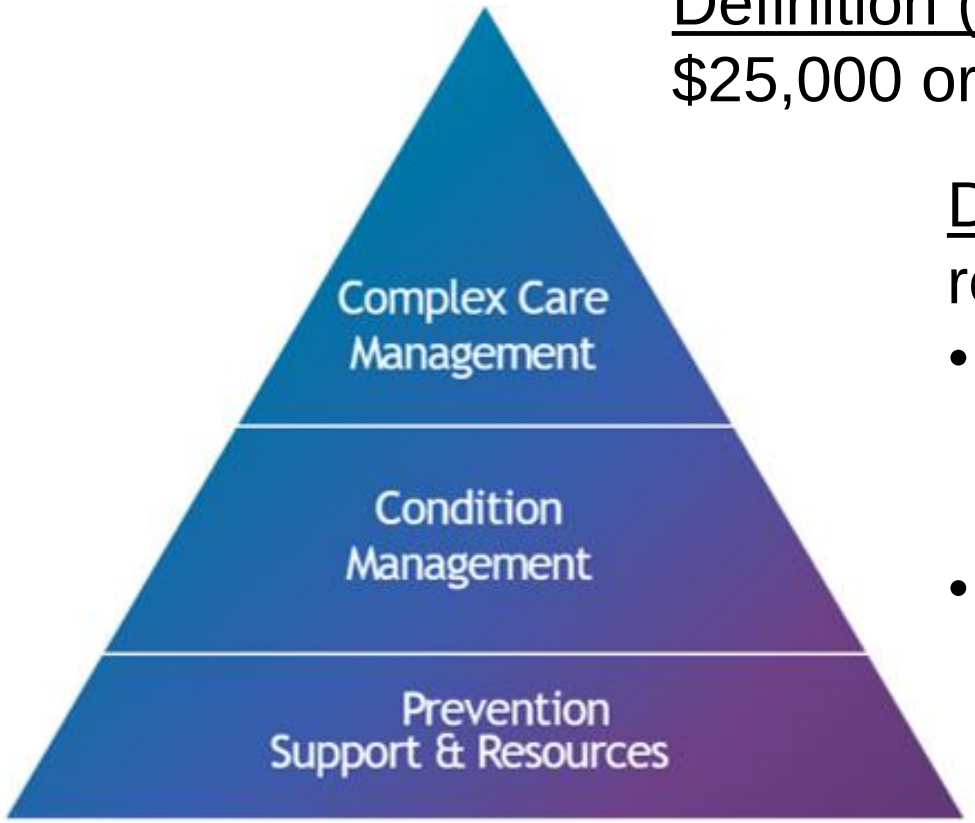
Population Management Strategic Plan

- Complex Care Coordination Report
- Condition Management Report
- Prevention and Member Engagement Report

- Health Neighborhood Report
- Practice Support Plan
- Administrative Payment Report
- Financial Deliverable

- Key Performance Indicators
- Performance Pool
- Behavioral Health Incentive Measures
- MLR Measures
- Clinical Dashboard

Complex Members Defined



Definition (SFY20-21): Members with annual costs of $25,000 or greater

Definition (SFY21-22): Definition will vary by RAE region

- HCPF default definition: Children and youth with annual costs of $25,000 or greater and adults with four or more chronic conditions
- RAEs have until 10/1/2021 to propose an alternate definition using predictive risk models or other evidence-based methodologies

Stratification by Cost: Less Than Ideal

- **Regression to the Mean**: individuals identified by their high cost will likely show decreased cost without an intervention upon re-measurement
- **Actionable Costs**: high costs may be due to necessary drugs or procedures, one-time events such as accidents, or other events not well-suited for care coordination
- **Miss People Who are Underserved:** underserved complex members may be low cost in the short-term

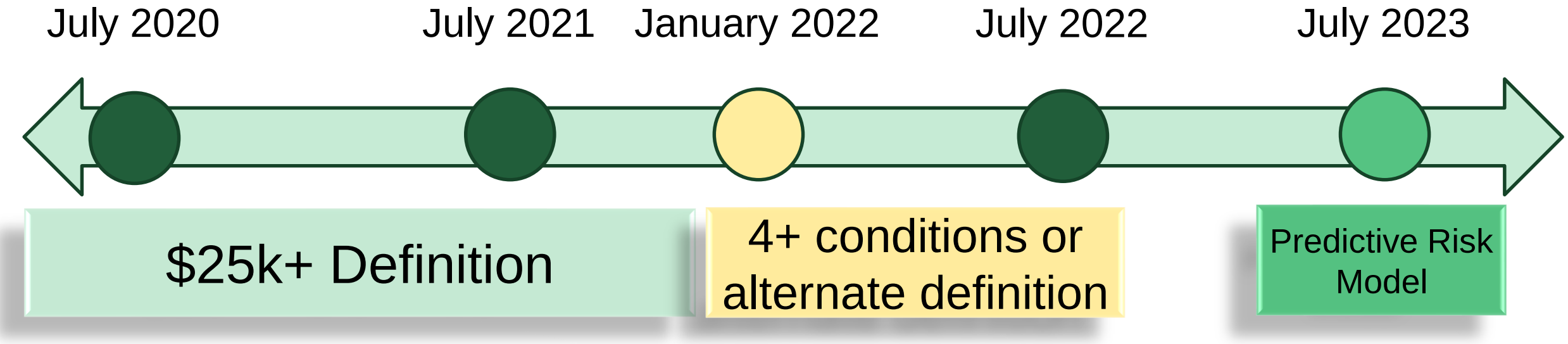
Linden, A. Assessing regression to the mean effects in health care initiatives. *BMC Med Res Methodol* **13,** 119 (2013). https://doi.org/10.1186/1471-2288-13-119

Members with Chronic Conditions

- 6.9% of adult members have four or more chronic conditions
- Early and effective outreach and care coordination is an effective, evidence-based approach
- More stability in complex status, less coming on/off the list

Maternity	Diabetes	Hypertension	Heart Failure/ Cardiovascular Disease	Asthma
COPD	Depression	Anxiety	Chronic Pain	SUD

Complex Members: Timeline



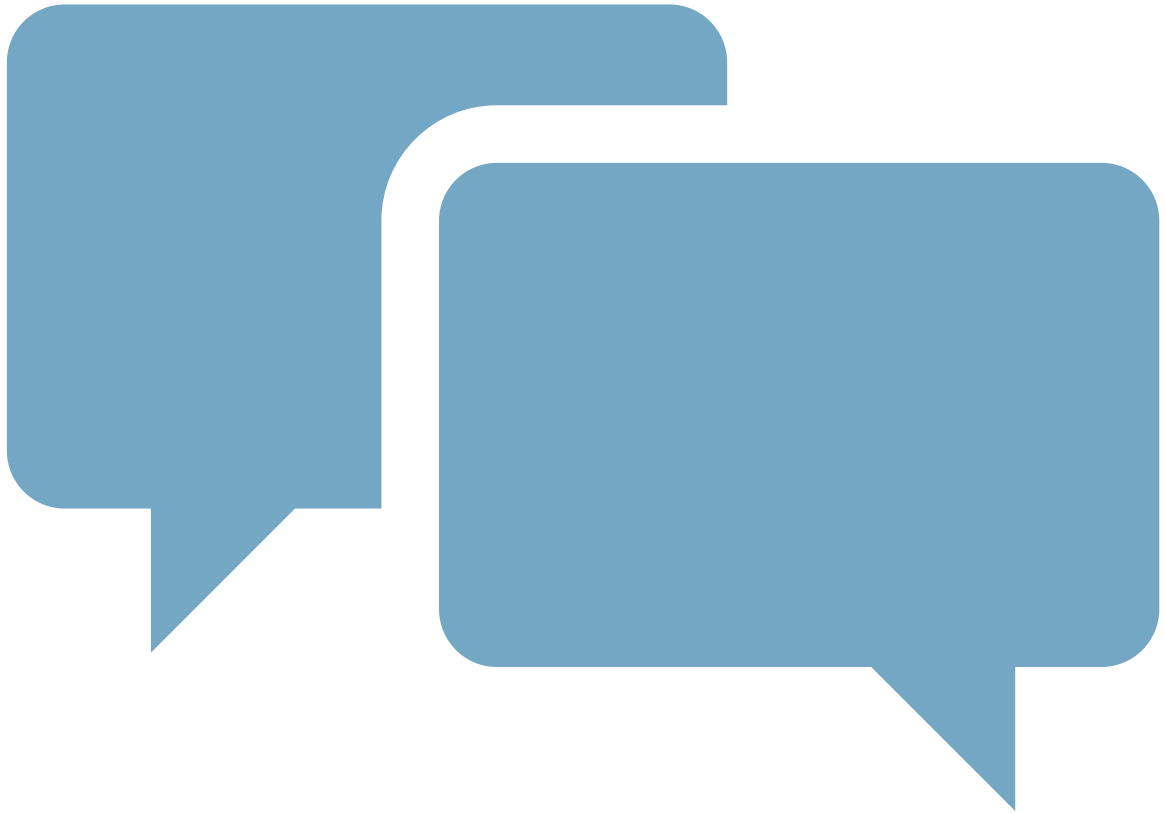
Complex Members: Incentive Payments

Performance Pool Metric: Percentage of complex members who received extended care coordination (ECC)

- Results will not be comparable across RAEs due to variations in definitions
- ECC: robust care plan within the first 3 months and at least quarterly monitoring
- Encourages early outreach to complex members and allows flexibility for assessments on the front & back end

Where We're Heading

- Implement an improved definition for complex pediatrics (date TBD)
- Trial different regional approaches and learn from them to develop a predictive risk model all RAEs can use (ideally by July 2023)
- Improve consistency in care coordination offerings and data across regions (Fall 2022)
- Collaborate with OCL and stakeholders to develop improved practices for team-based care coordination with ARPA funding (SFY21-22)



Discussion

Thank you!