Managing Medicaid in Era of Value-Based Care

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Agenda

• TennCare Overview
• TN Health Care Innovation Initiative
  – Ohio SIM
• Managing Medicaid
  – Challenges
  – Strategies
Welcome Back to Tennessee

- Served as Chief Medical Officer, Summit Medical Group (2008-2013)
- Developed first NCQA recognized PCMH in TN (2010) - also 3rd largest PCMH group in US at the time

TennCare: TN’s Managed Care Medicaid Program (2016)

- Enrollment: ~1.5 million
- Provides health coverage for:
  - 20% of TN residents
  - 50% of TN children
- Annual Budget: $10.5 billion
- Only state that enrolls entire Medicaid population into managed care
TennCare Snapshot

- 2,347,500 Outpatient visits
- 564,900 Children dental check-ups
- 310,200 Receive Medicare assistance
- 2,250 Prosthetics
- 2,534,700 Mental health & substance abuse counseling visits
- 762,900 Inpatient days
- 453,000 Well-child visits
- 41,400 Treated for cancer
- 78 Transplants

TennCare Quality Strategy

- Goal 1: Assure appropriate access to care.
- Goal 2: Provide quality care.
- Goal 3: Assure satisfaction with services.
- Goal 4: Improve health care.
- Goal 5: Provide cost effective care.

From TennCare 2016 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY
Tennessee Health Care Innovation Initiative

- Primary Care Transformation
- Episodes of Care

TennCare PCMH

- Meet NCQA PCMH criteria
- Compensation
  - Transformation Support
  - Activity support (risk adjusted pmpm)
  - Outcome payments
- Similar programs throughout US
Episodes of Care

Episodes of Care will be designed and implemented over 5 years.

Design year & episode

2015
1
Premature

2016
2
COPD acute exacerbation

2017
3
GI hemorrhage

2018
4
CHF acute exacerbation

2019
5
Breast cancer, metastatic

Ski and soft tissue infections
Neonatal (Age 31 weeks or less)
Neonatal (Age 22 to 36 weeks)
Neonatal (Age 37 weeks or greater)
Poly/pancreatic diabetes and other endocrinology
Skeletal fractures
Knee, ankle sprains, strains, and fractures
Knee sprains, strains, and fractures
Shoulder sprains, strains, and fractures
Shoulder sprains, strains, and fractures
Back pain
Depression - acute exacerbation
Lung cancer (multiple)
Penile/gynecomastia cancers
Other major bowel (multiple)
PTSD
Head/face trauma
Bipolar disorder
Bipolar - acute exacerbation
Chronic prostatitis
Benign prostatic hyperplasia
Hypertension/hypertensive disease
Kidney cancer
Other respiratory infection
Dermatitis/dermatosis

https://www.tn.gov/hcfa/topic/episodes-of-care
Ohio State Innovation Model (SIM)

- Comprehensive Primary Care (CPC+)
  - Pmpm (to support activities)
  - Shared savings
  - Ohio CPC+ (CareSource requires participation in their value-based contracts)

- Episode-Based payments
Sample Report

Managing Vulnerable Populations
Factors Influencing Health Status

- Environment
- Behavior
- Genetics
- Social status
- Health care services


Why is Pop Health so Hard?

- Different definitions of “population”
- Type of health services offered
- Operationalization/Integration
What is Population Health?

• “The health outcomes of a group of individuals, including the distribution of such outcomes within the group”


What is Population Health?

• Current enrollees or covered lives
• Providers panel of patients
• Broad group of people united by geography (not provider)
Types of Services

- Tradition (covered) services in provider offices: insufficient for continuum
- “beyond the walls”: inconsistent coverage and evidence
  - Evisits
  - Home visits
  - Care coordination
  - Electronic monitoring

Poorly Integrated Care
## Challenges for Managing Vulnerability

- Medicaid vs Medicare
  - More mental health
  - Substance use
  - Social Isolation
  - Poor/inconsistent access to resources

## Management Strategies

- Assessment of 14 high-utilizing Medicaid Patient engagement programs
- Virtually all a mix of different models of care
- 10 key factors that emerged as themes for success
Categories of Complex Care Mgmt Programs

- Health Plan Model
- Primary Care Model
- aICU/extensivist
- Hospital Discharge
- ED Model
- Home Based
- Housing First
- Community-based

High-Utilizer Programs: Reflections

- Can impact hospital admits, hospital days, ED visits, and total cost of care
- No “pure models”- all programs were hybrids of more than one model
High-Utilizer Programs Reflections:
Assessment and Care Plans

- Careful initial assessment
- Develop Care Plan
- Regular follow-up by care mgmt team
- Many included home visits

High-Utilizer Programs Reflections:
Patient Engagement

- Coaching rather than rescuing philosophy
- Coaching to understand medications and to become more medication adherent is essential feature of all programs
High-Utilizer Programs Reflections:

Care Management Teams

- No standard composition (core usually RN and SW)
- Case loads vary with team size, composition, and patient complexity
  - RN: 40-50 patients
  - RN/SW: 100 patients
  - “complex team” (RN/SW/CHF): 200+
- Some allowed 24/7 access, others did not

High-Utilizer Programs Reflections:

PCP vs aICU

- Big differences between aICU and PCP model
  - Resources
  - Patient volume
  - Compensation
- Not possible, given data, to say which model is superior
High-Utilizer Programs Reflections:
Homelessness

- For homeless or precariously homeless, housing + case mgmt (no medical staff) appears most powerful way to reduce costly utilization

Pop Health: Impact on Physicians

- Financial incentives tied heavily to:
  - Cost management of populations/care transitions
  - Attaining performance measures
- Engagement in complex/integrated data resources
- Era of persuasion
  - Other physicians
  - Patients (who are not “locked in” as they were in HMO)
Essential Skill Sets: Aligning with Value Proposition

- Marked transition from “fee-for-service”
- Poorly correlates with physician culture of autonomy and professionalism
- Mastering more than “medical intelligence” (disease, pathophysiology, etc)
- Must engage utilization and population health to greater degree
- Will be impossible without aligned incentives

Change Management

- How do we prepare physicians to meet these new challenges and acquire new skills?
  - Create a shared vision
  - Communicate/educate
  - Create aligned incentives
  - Adequate transition period
  - Acknowledging and managing Physician Burnout
The True Challenges

- Kindling Physician Leadership while transforming the role of physicians
- Aligning pace of provider and patients exposure to value-based pricing/compensation changes

Summary

- Value-based population management is ubiquitous and (likely) here to stay
- Care models have delivered impact
- If you have seen one model, you have seen one model
- Patient engagement = coaching
- Providers will likely need as much help in this transformation as patients