



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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MEMORANDUM

TO: The Honorable Mark D. Sickles
Chair, Joint Subcommittee for Health and Human Resources Oversight

The Honorable George L. Barker
Vice Chair, Joint Subcommittee for Health and Human Resources Oversight

FROM: Karen Kimsey
Director, Virginia Department of Medical Assistance Services

SUBJECT: Medicaid Payment Policy and Care Coordination Workgroup Report due November 1, 2021 This report is submitted in compliance with Item 313 YY of the 2021 Appropriation Act, which states:

The Department of Medical Assistance Services shall convene a workgroup to evaluate and develop strategies and recommendations to improve payment policies and coordination of care in the Medicaid program to encourage the effective and efficient provision of care by providers and health care systems serving Medicaid members. The workgroup shall include representatives from the Virginia Hospital and Healthcare Association, hospitals, the Virginia Association of Health Plans, managed care organizations, emergency department and primary care physicians, and other stakeholders deemed necessary by the department. The workgroup shall: (i) evaluate the appropriate coordination of services and cooperation among Medicaid managed care organizations (MCOs), hospitals, physicians, social services organizations, and nonprofit organizations to achieve a reduction in hospital readmissions, improved health outcomes, and reduced overall costs of care for conditions with high rates of hospital readmission in the Medicaid program; (ii) examine the role of hospital discharge planning and MCO care coordinators in assisting Medicaid beneficiaries with access to appropriate care and services post-discharge and other factors that may contribute to higher rates of readmission such as social determinants of health that could impact a patient's readmission status; (iii) assess the effectiveness of past and current mechanisms to improve outcomes and readmission rates by hospitals and health care systems and best practices and models from federal programs and other states; (iv) assess how to prevent inappropriate utilization of emergency department services; (v) examine the role of MCO care coordinators in assisting Medicaid beneficiaries access to appropriate care, including Medicaid beneficiary access to and the availability and use of alternative non-emergency care options, adequacy of MCO provider networks and reimbursement for primary care and alternative non-emergency care options, and the effectiveness of past and current mechanisms to improve the use of alternative non-emergent care by Medicaid beneficiaries; (vi) evaluate the impact of freestanding emergency departments and hospital emergency department marketing on emergency

department utilization along with lower-cost options for triage of non-emergency cases to alternative settings; (vii) consider other states efforts to address emergency department utilization, including the use of medical and health homes, alternative primary care sites, and programs to coordinate the health needs of "super-utilizers"; and (viii) consider strategies to engage in value-based payment arrangements and other forms of financial incentives to encourage appropriate utilization of services and cooperation by health care providers and systems in improving health care outcomes, including a review of designated Performance Withhold Program measures, Clinical Efficiency measures, and other existing or potential programs. The department shall provide data on emergency room utilization and hospital readmissions of Medicaid beneficiaries to the workgroup to assist in its evaluation and analysis. The department shall report on the workgroup's findings and recommendations to the Joint Subcommittee for Health and Human Resources Oversight by November 1, 2021.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

KEK/
Enclosure

pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Medicaid Payment Policy and Care Coordination Workgroup Report

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Executive Summary

[Chapter 1290, item 313YY](#) of the 2020 Appropriations Act (the Act) outlines a Workgroup on Medicaid Payment Policies and Care Coordination ([see Appendix I for language](#)), which consists of health care stakeholders and is convened by the Department of Medical Assistance Services (DMAS). The Act directed the workgroup to evaluate and develop strategies to encourage effective and efficient provision of care for Medicaid members. The Act specifies that the workgroup should:

- 1) examine the role of hospital discharge planning and Managed Care Organization (MCO) care coordination and factors that may contribute to hospital readmissions,
- 2) assess the effectiveness of past and current activities to improve hospital readmissions,
- 3) assess how to prevent inappropriate emergency department utilization,
- 4) examine the role of MCO care coordinators in assisting Medicaid members in accessing appropriate sites of care,
- 5) evaluate the impact of freestanding emergency departments on utilization,
- 6) consider other state and federal efforts to address inappropriate emergency department utilization, and
- 7) consider strategies to engage in value-base purchasing arrangements to encourage the effective and efficient provision of care.

The content required of the workgroup spans complex and interconnected issues within health care delivery and financing. The workgroup focused on areas with trusted data and the greatest opportunity or need by the Medicaid population.

The Act outlines six required stakeholders—the Virginia Hospital and Healthcare Association (VHHA), Hospitals, Virginia Association of Health Plans (VAHP), Managed Care Organizations (MCO), Emergency Department (ED) Physicians, and Primary Care Physicians (PCP)—and gives DMAS the authority to include other stakeholders, as necessary. DMAS included Virginia Health Information (VHI) and the Virginia Center for Health Innovation (VCHI) as additional workgroup members ([See Appendix II](#) for full list of Workgroup Participants). DMAS assembled the workgroup members for seven meetings in October, November, and December of 2020 and March, May, June, and July of 2021.

The report below seeks to summarize a large amount of data and information developed, presented, and discussed by the workgroup. While the content of this report does not necessarily reflect the views of DMAS or of any individual workgroup participant, this report does reflect and summarize key themes, policy options, and considerations discussed by the group. The report presents potential policy options for the Administration and General Assembly to consider which address the issues discussed by the group. This report outlines policy options that received consensus support from workgroup members, including options that received both support and abstention among the workgroup members. Policy options that did not receive consensus support are discussed with relevant context and listed in the appendix. As the convener of the workgroup, DMAS did not vote on the policy options. To review materials presented to the workgroup, please visit the Value-Based Purchasing section of the DMAS website at <https://www.dmas.virginia.gov/about-us/value-based-purchasing/>.

Policy Options

The workgroup members proposed for discussion a range of policy options for consideration by the General Assembly to address the areas outlined in chapter 1290, item 313YY of the 2020 Appropriations Act. Eleven policy options received consensus support, in addition to six non-consensus options. Both are listed below with summarized voting results for non-consensus options. The full list of the 17 policy options considered by the workgroup are also included in the appendix ([Appendix III](#)). The 11 consensus recommendations are included throughout the report with the supporting discussion and data the workgroup members presented, reviewed, and considered related to each policy option. Non-consensus options are also discussed throughout the report and *underlined and italicized* for easier identification.

Consensus Policy Options

- 1) **Increase Primary Care Rates to Promote Increased Access to Care:** Currently, Medicaid pays primary care providers approximately 76% of Medicare rates¹. To increase access to providers and care that could help reduce inappropriate ER utilization and avoidable hospital readmissions, the General Assembly could consider bringing payment for PCPs more in line with Medicare, including Medicare's regional variation in rates, to improve the financial viability of practices serving Medicaid members. ([Page 21](#))
- 2) **Include Coverage of Complex Chronic Care Management Services:** Fund chronic care management activities in lower-acuity settings to align payment levels with the extent of activities and services provided by eligible downstream providers, like PCPs, to reduce avoidable/preventable utilization in the ED and hospital. Coverage for these services could initially target complex care management services for specific conditions with the highest rates of ED utilization and hospital readmissions. ([Page 21](#))
- 3) **Targeted Increased Payment Rates for Access-Promoting Services:** Fund an increase for CPT codes associated with extended hours access to services such as nights, evenings, weekends, and holidays. Increasing payment for services provided outside of normal business hours (weekdays 9 a.m. – 5 p.m.) may increase access to services for Medicaid members, and potentially reduce avoidable and unnecessary ED utilization. Targeted interventions to increase access to primary care services, particularly outside of business hours, is consistent with CMS guidance on reducing inappropriate utilization of emergency rooms². ([Page 22](#))
- 4) **Support Expansion and Adoption of EDCC among Downstream Providers:** Provide VHI with support to address barriers to onboarding downstream, non-acute providers to the Emergency Department Care Coordination platform (EDCC). Onboarding efforts could focus on providers with large Medicaid patient panels to prioritize access to the real-time notification to providers that treat higher volumes of Medicaid members. Such efforts could include, but are not limited to, funding to support additional staffing and contract resources for provider outreach and streamlining legal and administrative requirements for onboarding to the EDCC. ([Page 24](#))
- 5) **Expand Care Insights for Medicaid Members with Frequent ED Utilization (10+ ED Visits in 12 Months):** VHI should continue and expand efforts to increase the use of Care Insight in their EDCC records among members with 10 or more ED Visits in 12 months. The percentage with Care Insights could be increased from 7% to 50%. DMAS could set an improvement target for MCOs to double the percentage of Medicaid members with 10+ ED visits in 12 months that have a Care Insight annually, until the target of 50% is reached. After achievement of the

¹ This estimate of Medicare parity is based on the utilization of ~300 primary care related service codes and associated total costs under Medicaid and Medicare.

² CMS. Reducing Non-urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 16, 2014 ([link](#)).

initial target, DMAS can work with MCOs and VHI to set a future benchmark and/or improvement targets. ([Page 24](#))

- 6) **Align Definitions for Emergency Department (ED) Utilization:** DMAS, VHI, VHHA, MCOs, and other stakeholders should adopt unified definitions for ED categories in order to better describe, analyze, and report ED utilization. An aligned, unified language will provide enhanced discussion, analysis, policy development, and assessment of strategies in this area. ([Page 24](#))
- 7) **Develop an Embedded Care Coordination Model in Areas with High Behavioral Health Needs:** DMAS could implement an integrated treatment model within high volume Medicaid outpatient centers of behavioral health. The goal would be to target individuals with chronic medical conditions and co-occurring mental health disorders to increase continuity of care. This model would embed a physical health practitioner in high-volume outpatient behavioral health provider/therapy practices and Community Service Boards to connect with members who have a history of being difficult to engage, low acuity non-emergent ER utilization, potentially preventable inpatient admissions, appointment/medication non-adherence, and/or identified gaps in care for their medical conditions to include preventative health screenings. The physical health practitioner would provide education on physical health diagnosis and management, referrals/appointments for PCP/specialist intervention and follow-up, basic health screenings (i.e. in-house lab work, diabetic screenings, monitor blood pressure, weight checks, drug screenings, etc.), and work closely with the behavioral health provider(s) to integrate medical needs into a comprehensive integrated treatment plan to address whole-person health. Both the behavioral health and physical health practitioner would collaborate closely with the MCO care coordinator as part of an interdisciplinary care team. The care coordinator would assist practitioners in locating in-network providers, obtaining durable medical equipment, assist with medication pre-authorizations, schedule transportation, and collaborate around ED and IP admissions and discharges. (Page 25)
- 8) **Access to Providers in the Behavioral Health Continuum:** Fund and support the adoption of evidence-based practices and training for existing behavioral health providers consistent with the continuum of behavioral health services outlined in Project BRAVO, and provide funding to expand the licensed mental health provider workforce to meet the behavioral health needs of the population. ([Page 26](#))
- 9) **Encourage Emergency Departments to Implement a Bridge Program:** Encourage Emergency Departments and health systems to implement a Bridge Program to screen patients, offer treatment (buprenorphine) in the ED, and refer individuals with substance-use disorder for outpatient follow-up at an office-based opioid treatment through grants to support training and implementation. The program could prioritize EDs with high prevalence of behavioral health and substance use disorders and access to appropriate outpatient office-based care in the community. ([Page 27](#))
- 10) **Fund Direct Connection between MCOs and a Community Based Organization Network Coordinator:** Fund access to a community based organization network coordinator for Medicaid MCOs as a critical partner in care coordination for Medicaid member health related social needs (HRSNs). Access to a community based organization (CBO) network coordinator would facilitate referrals to needed services for Medicaid members through the platform. ([Page 28](#))
- 11) **Comprehensive Primary Care Value-Based Purchasing Payment Model:** Develop a comprehensive primary care value-based payment model that increases members' access to lower-acuity settings, preventive care, and chronic disease management in order to reduce potentially avoidable and preventable ED and hospital utilization. This recommendation will require new general funds to support increased Medicaid primary care

payment so that it is comparable with Medicare payment and supports coverage of complex care management services and access-promoting services. The funding increase would be made through value-based, as opposed to volume-based, payments specifically designed to meet set goals. A primary care VBP model could accomplish the policy goals of 1, 2, and 3 listed above as well as provide the flexibility for primary care providers to financially support other interventions not specifically paid under a fee-for-service structure that would reduce potentially avoidable utilization. (Page 34)

Non-Consensus Policy Options

- 12) **Medicaid Pilot of Trusted Broker Model:** Fund VCHI to explore the Trusted Broker Model with stakeholders and define a business case for such a model to target Medicaid member health related social needs in a specific area. This effort should identify an area of focus likely to have significant impact on reducing members' utilization of the ED or hospital readmissions. (Generally Support: 3, Generally Do Not Support: 4, Abstention: 1) (Page 29)
- 13) **Update VBP Targets in MCO Contracts to Emphasize More Advanced Alternative Payment Models:** DMAS currently includes VBP targets in its managed care contracts requiring MCOs to have a percentage of relevant spending by MCOs to be in VBP arrangements (e.g. HCPLAN Categories 2-4) and must assure annual improvement until the target is achieved (Medallion 4.0 25%, CCC+ 10%). DMAS could increase the emphasis on VBP adoption within the Medicaid market by setting multi-year targets to increase VBP adoption and incorporating achievement of the VBP targets as a measure under the PWP. These targets could be set to prioritize the adoption of more advanced payment models (e.g. HCPLAN category 3 and 4) in future years. (Generally Support: 5, Generally Do Not Support: 2, Abstention: 1) (Page 31)
- 14) **Modify Existing Hospital Readmission Payment Policy to include an Upside Performance Incentive (313 BBBBB):** Fund and authorize the creation of a Medicaid hospital VBP program to add an upside financial incentive for hospitals that achieve reductions in potentially preventable, avoidable, and/or unnecessary hospital readmissions. (Generally Support: 3, Generally Do Not Support: 3, Abstention: 2) (Page 32)
- 15) **Modify Existing Emergency Department Policy (313 AAAAA) to include an Upside Performance Incentive:** Fund and authorize the creation of a Medicaid hospital VBP program to add an upside incentive to reward hospitals that successfully reduce potentially avoidable and unnecessary ED utilization in the future. (Generally Support: 3, Generally Do Not Support: 4, Abstention: 1) (Page 33)
- 16) **Modify the Existing Hospital Readmission Payment Policy to Align with Medicare Hospital Readmissions Reductions Program (313 BBBBB):** Modify item 313 BBBBB with an approach that aligns with the Hospital Readmission Reductions Program (HRRP) under Medicare to align priorities across programs for hospitals. A modified version of 313 BBBBB could include aspects from the Medicare HRRP such as, measuring hospital performance relative to other hospitals with similar patient populations, risk adjusting performance, target condition- and procedure-specific measures with highest risk or utilization in Medicaid, and limit payment reductions similar HRRP. (Generally Support: 4, Generally Do Not Support: 2, Abstention: 2) (Page 33)
- 17) **Remove the Payment Down-Code for the Emergency Department Policy (313 AAAAA):** Repeal item 313 AAAAA, which down-codes emergency department visits based on principal diagnosis. (Generally Support: 4, Generally Do Not Support: 2, Abstention: 2) (Page 33)

Emergency Department and Hospital Readmissions Trends in Virginia

To assess the ED utilization and hospital readmissions in the Commonwealth, DMAS, Virginia Health Information (VHI), and the VHHA provided data to the workgroup highlighting trends in Medicaid, Commercial, and Medicare populations. The workgroup reviewed this information to establish a baseline understanding for relevant utilization and trends and identify additional foundational analyses to inform the workgroup.

Emergency Department (ED) Utilization

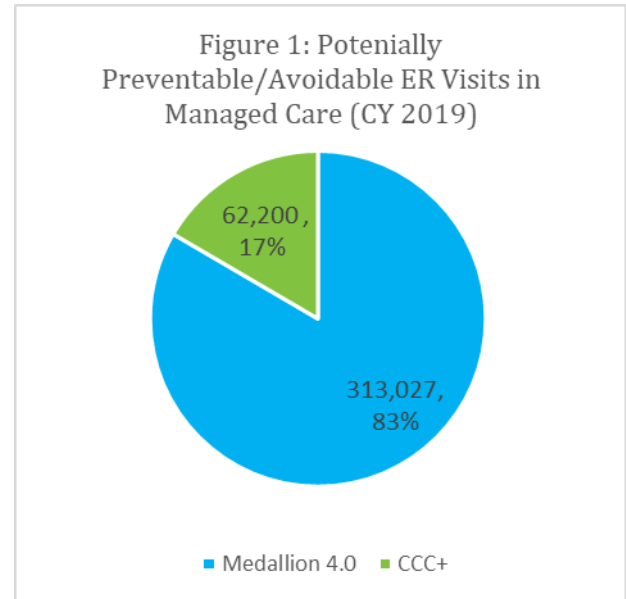
EDs are an important part of the health care system, treating people suffering from serious, acute problems that need immediate care. However, many people use EDs for health problems that can safely and effectively be treated in a PCP's office or urgent care clinic for a fraction of the cost.

Additionally, many ED visits are avoidable through more proactive and effective management of member conditions.

Many more emergent manifestations of illnesses and/or chronic conditions can be appropriately treated through routine care in lower acuity settings to avoid the need for an ED level of care.

Recognizing that only a portion of ED visits are potentially preventable and/or avoidable, DMAS and Mercer (DMAS Actuary) created a clinical efficiency (CE) measure for MCOs to focus on ED visits that research indicates can be avoided and/or prevented through the provision of consistent, evidence-based primary care, proactive care management, and/or member health education.

Although the CE measure for potentially preventable and/or avoidable ED visits captures a broad list of diagnoses, it is not exhaustive and does not include behavioral health related diagnoses, which can also result in significantly higher rates of ED utilization.



To measure MCO performance, DMAS presents the rate of potentially preventable/avoidable ED visits per 1,000 member months (MM). This rate allows for comparisons among MCOs, regions, age groups, and programs in a way that adjusts for varying levels of enrollment. These analyses are not intended to imply that members did not need or should have been denied access to care in the ED. Instead, the analyses reflect the objective that more effective, efficient and innovative managed care could have prevented or preempted the need for some members to seek care in the ED.

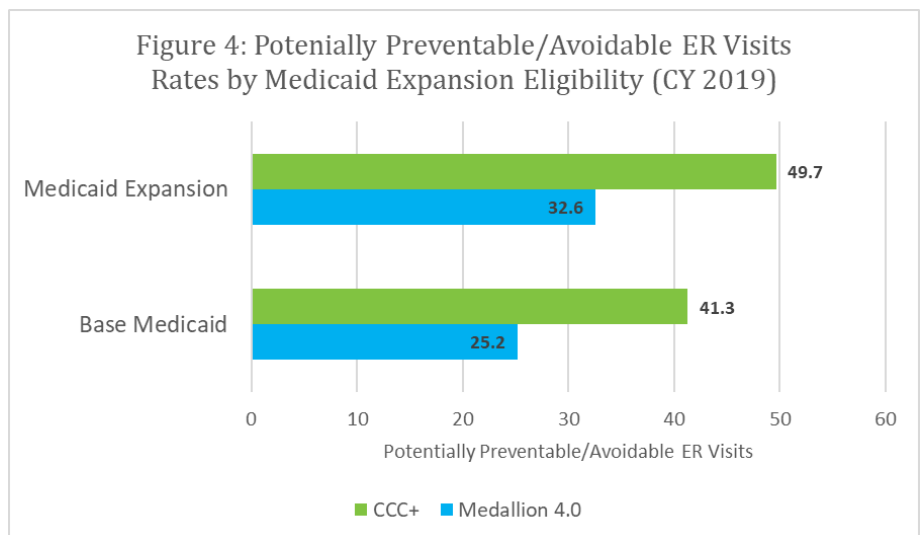
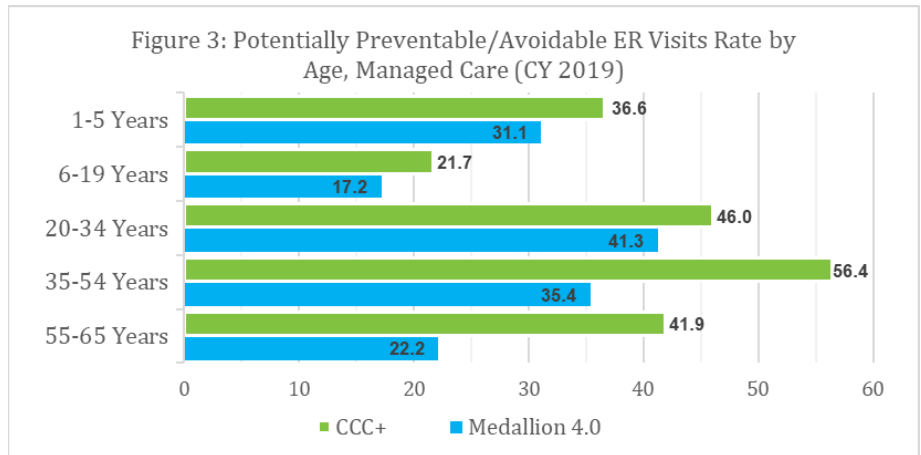
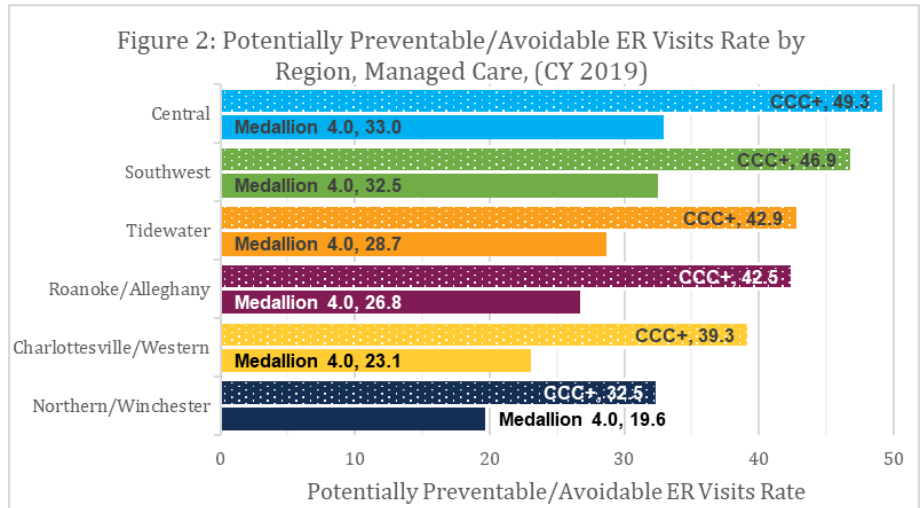
In calendar year (CY) 2019, DMAS identified approximately 375,227 potentially preventable/avoidable ED visits in Medicaid managed care through the ED CE Measure, as compared to over a million total ED visits in CY 2019 under Virginia Medicaid. Of those 375,227 potentially preventable/avoidable ED visits, 83% were in Medallion 4.0 and 17% were in CCC+ (Figure 1). Most of these visits occur in the Medallion 4.0 program because Medallion enrollment is about eight times larger in than CCC+. The CCC+ program experienced a rate of 43.1 potentially preventable/avoidable ED visits per 1,000 MM compared to 27.0 in the Medallion 4.0. Although Medallion 4.0 has more total visits, the relatively higher level of medical complexity for members in CCC+ contributes to this program having a higher relative rate of potentially preventable/avoidable ED visits.

Total and Potentially Preventable/Avoidable ED Rates by Region, Age, and Medicaid Expansion

As illustrated in Figures 2 and 3, ED CE rates tend to vary across region and age group, with the membership in both Medallion and CCC+ experiencing the same regional variation patterns.

When looking across the six regions, potentially preventable/avoidable ED visit rates are highest in Central and Southwest Virginia and lowest in the Charlottesville/Western and Northern/Winchester regions for both Medallion 4.0 and CCC+. Rate patterns vary by age groups across both programs, with the highest concentration of any group occurring in CCC+ members age 35-54 years, and members age 20-34 years experiencing the highest rates in Medallion 4.0 (Figure 3).

As illustrated in Figure 4, the ED CE rate also varies between Medicaid expansion and base Medicaid members, with expansion members experiencing higher relative rates under both Medallion 4.0 and CCC+. CY 2019 represents the first year of expansion, introducing a new population of Virginians into the Medicaid program. Differences between the Medicaid expansion population and the base population are expected due to the differences in health care risk and needs among the two populations (e.g., the base population includes children), as well as the likely lower familiarity with health insurance than the base population in the first year of expansion.



While the DMAS ED CE measure targets a certain slice of ED utilization, VHHA provided data illustrating trends in total ED visit patterns. Figure 5 depicts VHHA's measure of total Medicaid ED visits by zip code and shows the higher volume of total ED visits clustered around more densely populated areas. One notable exception here is the lower relative volume of ED visits in the northern Virginia area. Similarly, Figure 6 shows the DMAS' ED CE measure by county, depicting a similar pattern to the VHHA data with higher volume adjusted rates in certain urban areas. In addition to higher volumes around some more densely populated areas, Figure 6 also illustrates higher relative ED CE rates in certain rural areas of the state after adjusting for member volume. The red dots in Figure 6 depict hospital locations.

Figure 5. Total Medicaid ED Visits by Zip Code

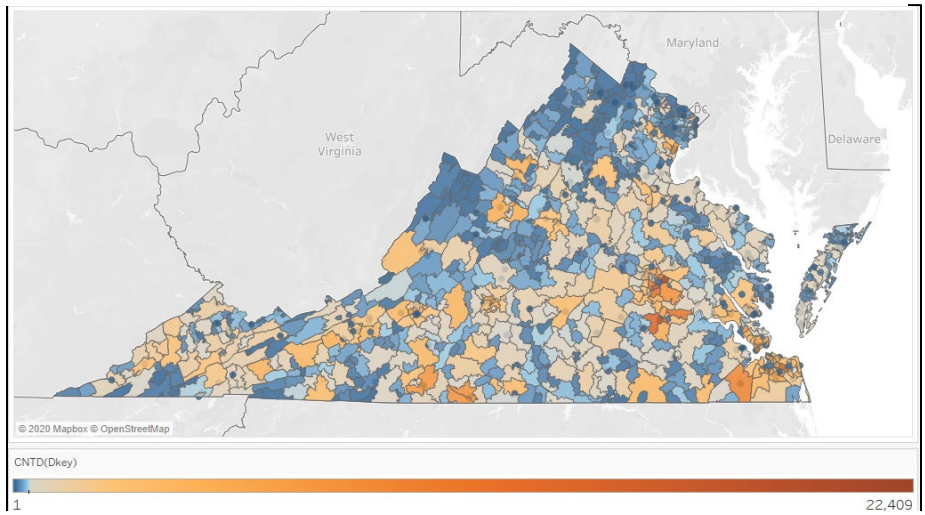
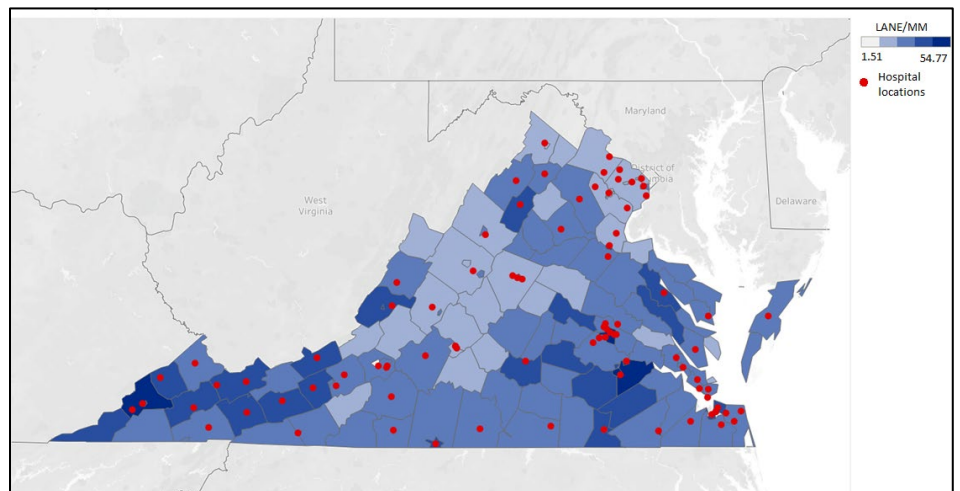


Figure 6. Potentially Preventable ED Visits by County, with Hospital Locations



ED Utilization Measures by Diagnosis and Chronic Condition

Below are the top 10 diagnosis codes associated with DMAS' ED CE measure, out of a possible 790 diagnosis codes considered in the measure as potentially preventable, avoidable, and/or medically unnecessary with proactive and effective management of member conditions. The top 10 diagnosis codes account for 35% of potentially preventable/avoidable ED visits in Medallion 4.0 and 32% in CCC+. This measure does not include ED visits related to behavioral health.

Table 1. Top Ten Diagnoses for Potentially Preventable/Avoidable ED Visits in Medallion 4.0 and CCC+, CY 2019

Medallion 4.0		CCC+	
Diagnosis	# of potentially preventable/avoidable ED Visits	Diagnosis	# of potentially preventable/avoidable ED Visits
Acute upper respiratory infection, unspecified	31,290	Acute upper respiratory infection, unspecified	3,169
Acute pharyngitis, unspecified	13,317	Urinary tract infection, site not specified	2,654
Urinary tract infection, site not specified	10,907	Headache	2,406

Medallion 4.0		CCC+	
Headache	9,707	Low back pain	2,284
Streptococcal pharyngitis	8,891	Acute bronchitis, unspecified	1,952
Nausea with vomiting, unspecified	8,710	Chronic obstructive pulmonary disease with (acute) exacerbation	1,719
Influenza due to other identified influenza virus with other respiratory manifestations	7,443	Nausea with vomiting, unspecified	1,673
Acute bronchitis, unspecified	6,729	Unspecified abdominal pain	1,550
Cough	6,598	Acute pharyngitis, unspecified	1,212
Low back pain	5,944	Type 2 diabetes mellitus with hyperglycemia	1,203
Percentage of all potentially preventable/avoidable ED Visits	35%	Percentage of all potentially preventable/avoidable ED Visits	32%

Table 1 Note: These analyses are not intended to imply that members did not need or should have been denied access to EDs. Instead, the analyses are designed to reflect the objective that more effective, efficient, and innovative managed care could have prevented or preempted the need for some members to seek care in the ED. This analysis identifies visits that could have occurred in a lower acuity setting or been avoided through the provision of consistent, evidence-based, primary care, proactive care management, and health education.

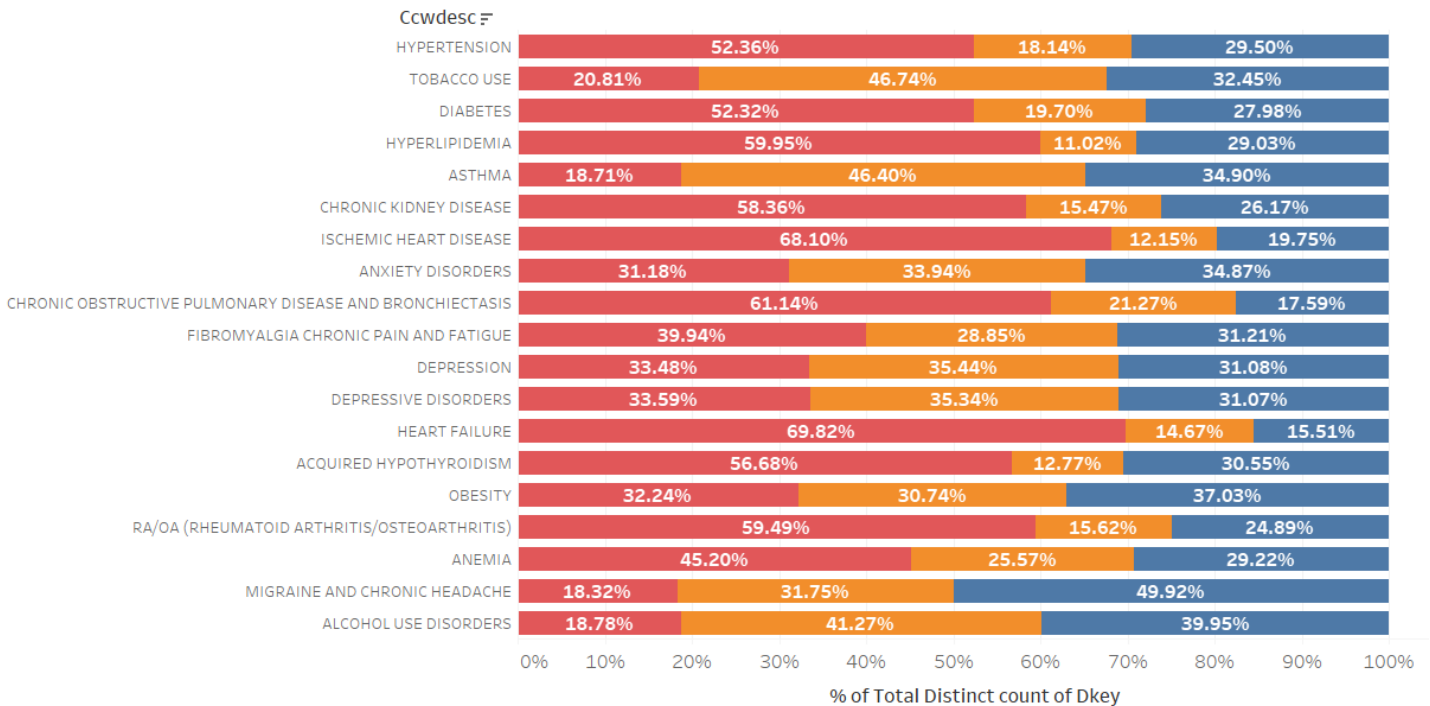
Data from the Emergency Department Care Coordination (EDCC) tool provided by VHI, shows 71% of patients with 10 or more ED visits also have a behavioral health diagnosis (Figure 7). Although the EDCC data includes all patients, it does illustrate the concentration of behavioral health among high- ED utilizers in the Virginia. VHHA conducted additional analyses observing total volumes associated with the top 20 chronic conditions for ED visits and top 20 primary diagnoses by payer (Figures 8 & 9); depicting Medicaid, Medicare, and Commercial ED visits. This data illustrates a broader picture of ED visits by volume and demonstrates the prevalence of behavioral conditions such as anxiety disorders, depression, depressive disorders, and alcohol use in total ED visits across all payers—including Medicaid (Figure 8).

The broader view of total volume provided by VHHA offers additional insight into other areas of ED utilization. Although behavioral health, alcohol, and substance use disorder diagnoses are not included in DMAS' CE measure, they remain important conditions to consider in evaluating underlying drivers for ED use among Medicaid members. Nearly half of ED visits for Tobacco Use and Asthma were for Medicaid members, and about a third of visits for anxiety and depression were for Medicaid members (Figures 8 and 9).

Figure 7. Patterns Associated with High ED utilization in Virginia (VHI)

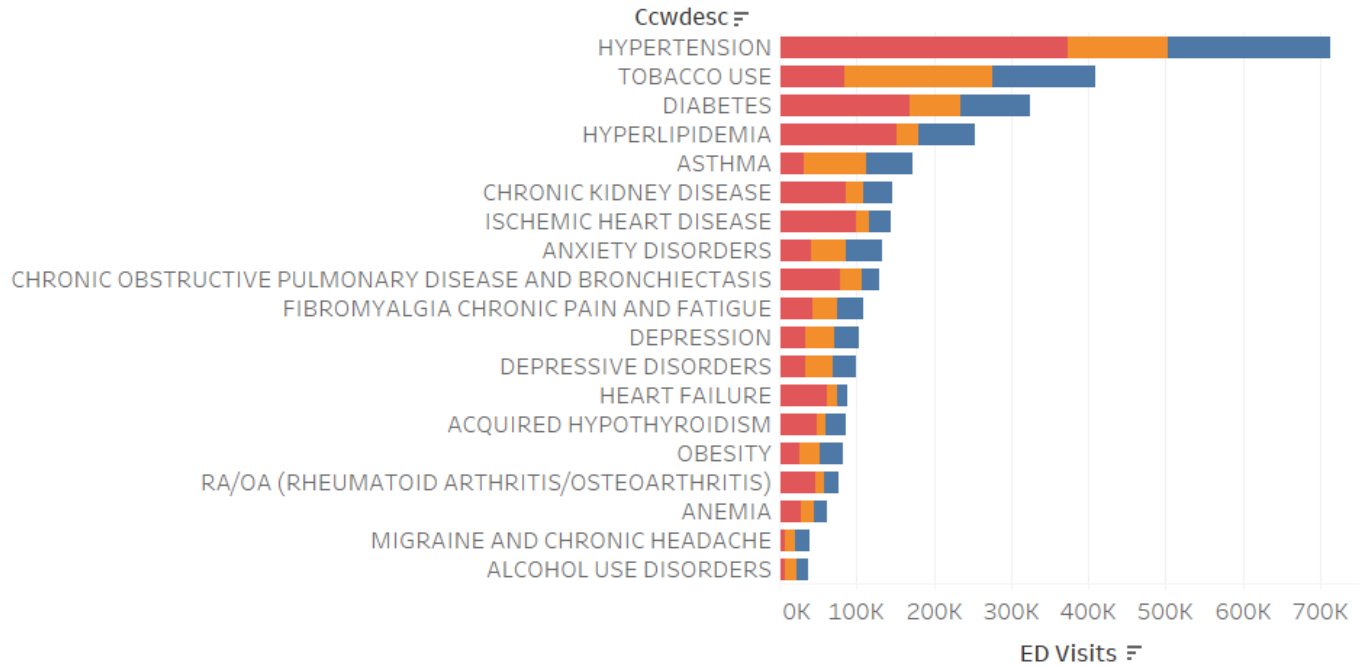
Collective Utilization Category	Visit Count in 12 Months	Number of Patients	Total ED Visits	Median ED Visits	Total Inpatient Admissions	Median Inpatient Admissions	Average Length of Stay (Days)	Percent with a Behavioral Health Diagnosis	Percent that are Suspected Homeless	Percent with Care Insight
Rising Risk	10 - 14	10,297	117,641	11	18,409	1	4.0	66.2%	0.3%	4.4%
	15 - 19	2,743	45,515	16	6,535	1	3.7	75.3%	0.5%	8.3%
High Utilization	20 - 29	1,693	39,670	23	5,369	1	3.4	82.9%	0.5%	13.7%
	30 - 49	699	25,836	36	2,715	2	3.6	87.7%	1.1%	18.2%
Super Utilization	50 - 74	184	10,852	58	967	3	2.7	90.2%	0.0%	29.3%
	75 - 99	59	5,023	85	322	3	3.0	93.2%	0.0%	40.7%
Extreme Utilization	100 +	59	8,531	128	255	2	4.0	96.6%	0.0%	44.1%
Grand Total		15,734	253,068	12	34,572	1	3.8	71.0%	0.4%	7.3%

Figure 8. Percentage of ED Visits by Top Chronic Conditions, Q2 2019 – Q1 2020 (VHHA)



Payer Category
■ Medicare ■ Medicaid ■ Commercial

Figure 9. ED Visits by Top 20 Primary Diagnoses and Payer (VHHA)



Payer Category

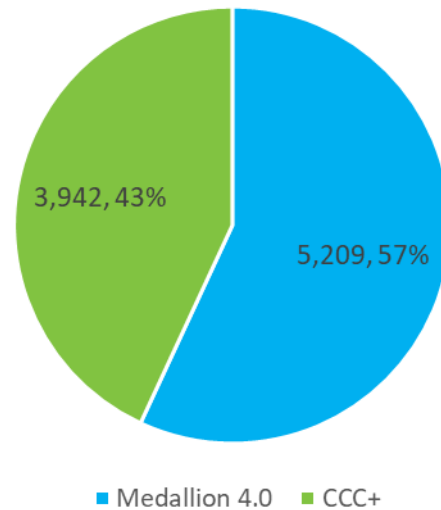
■ Medicare
 ■ Medicaid
 ■ Commercial

Hospital Readmissions

In CY 2019, DMAS identified 9,151 potentially preventable hospital readmissions in Medicaid managed care through the hospital readmissions CE Measure³. Improved patient follow up, care coordination, and discharge planning can help reduce and prevent the occurrence of hospital readmissions⁴. In 2019, 43% of the readmissions were in CCC+ and 57% were in Medallion 4.0 (Figure 10).

The hospital readmission rate for CY 2019 was 18.8% in CCC+ and 6.4% in Medallion 4.0. For the sake of comparison, VHI analysis indicates that the commercial market in the Commonwealth experienced a quarterly hospital readmission rate of 7.8% in CY 2018 and CY 2019 when using the same methodology as DMAS. The overall quarterly rate of hospital readmissions in the Commonwealth—including Medicaid, Commercial, and Medicare—ranges from 12.8% to 13.3% in 2018 and 2019, according to VHI.

Figure 10: Hospital Readmissions in Managed Care (CY 2019)

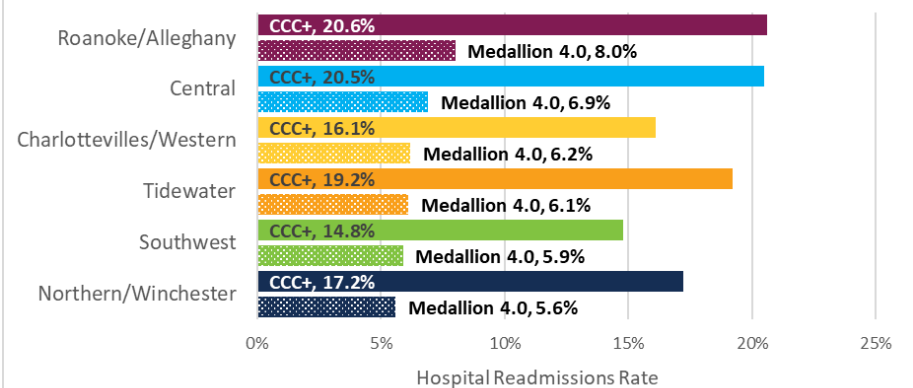


Hospital Readmission Rates by Region, Age, and Medicaid Expansion

As illustrated in Figures 11 and 12, hospital readmission rates tend to vary across region and age group, with the membership in both Medallion and CCC+ experiencing regional variation patterns.

When looking across the six regions, hospital readmission rates appear highest in Roanoke/Alleghany and lowest in the Southwest region, though it is noteworthy that Northern/Winchester has the lowest rate in Medallion. Despite the relatively low

Figure 11: Hospital Readmission Rate by Region, Managed Care (CY 2019)



³ The DMAS Clinical Efficiency (CE) Measures are performance accountability measures for Managed Care Organizations (MCOs) designed to improve health outcomes of Medicaid members. The Hospital Readmissions measure identifies hospital readmissions in Medicaid managed care that could have potentially preventable or avoidable through improved patient follow up, care coordination, and discharge planning. For more information on the DMAS CE Measures, please visit (<https://www.dmas.virginia.gov/about-us/value-based-purchasing>/<https://www.dmas.virginia.gov/#/valuebasedpurchasing>) for the full measure technical specification found on the Value Based Purchasing page of the DMAS website.

⁴ Agency for Healthcare Research and Quality. The Issue: Effective Communication and Care Coordination. June 2016. <https://www.ahrq.gov/sites/default/files/wysiwyg/workingforquality/nqs-priority-focus-carecoordination.pdf>

hospital readmission rate for Medallion 4.0 (6.4%), there remain pockets of opportunity to reduce the number of readmissions.

The highest hospital readmission rates occur in adults in both Medallion 4.0 and CCC+ (Figure 12). In Medallion 4.0, adults 35-54 and 55-65 had the highest hospital readmission rates. In CCC+, approximately one in every five adults age 20 to 54 admitted to a hospital will have a readmission within 30 days. Higher rates of readmissions may be expected in CCC+ given the higher degree of medical complexity of CCC+ members; however, CCC+ still has significant opportunity to reduce readmissions and improve member care and outcomes.

Hospital readmission rates also vary by Medicaid Expansion eligibility (Figure 13). In CCC+, the hospital readmission rate is higher for base Medicaid members compared to the Medicaid Expansion group, but both groups have rates of hospital readmissions nearing 20%. The hospital readmission rate for Medicaid Expansion members in Medallion 4.0 is significantly greater than the rate for Medallion 4.0 overall. While the larger number and proportion of relatively younger members in Medallion 4.0 keeps the overall readmissions rate relatively low, the higher readmission levels observed in older Medallion members (i.e., expansion members) highlight that there are pockets of opportunity to improve quality and care outcomes even with strong performance in the program overall.

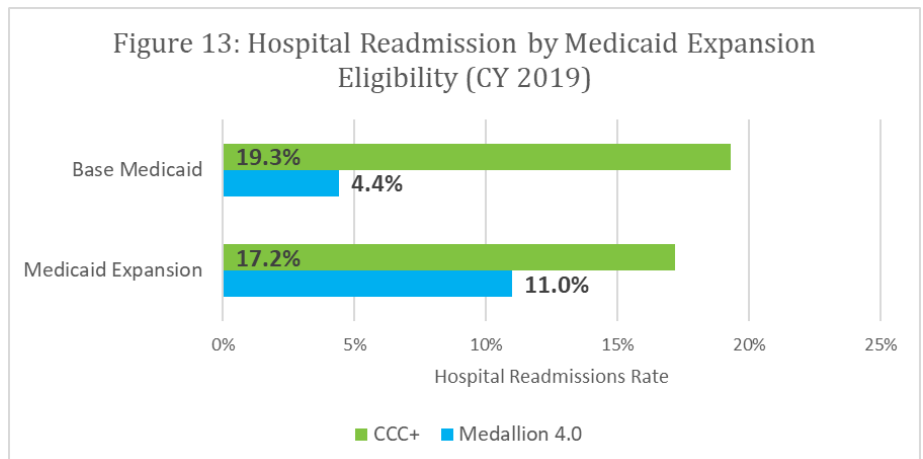
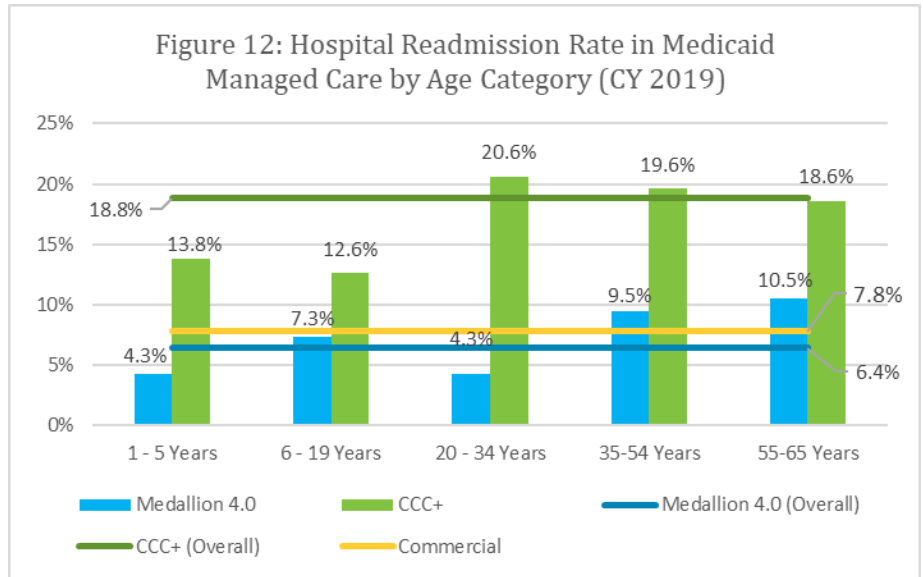
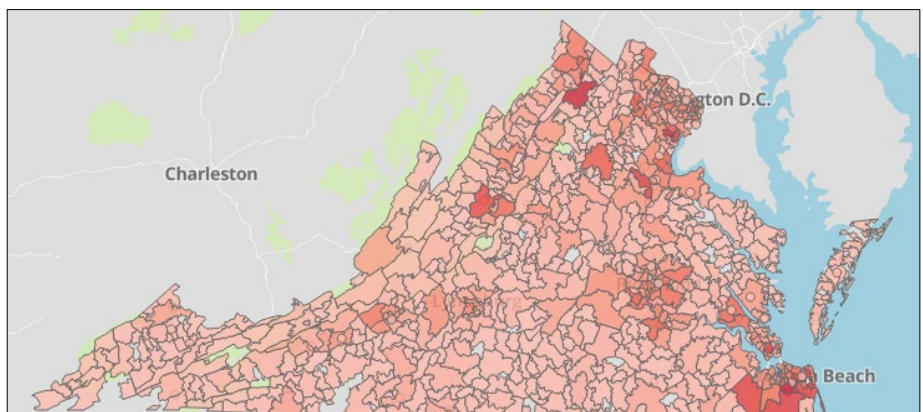


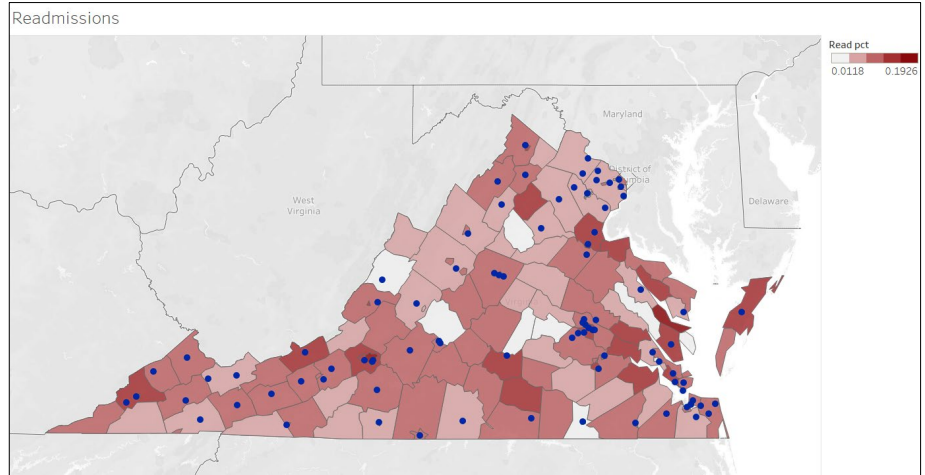
Figure 14. Total 30-Day Hospital Readmissions in Medicaid by Zip Code (3 years)



As illustrated by Figure 14, provided by VHHA, higher volumes of hospital readmissions tend to cluster around more densely populated areas when reviewing the total count of Medicaid 30-day readmissions by zip code over the last three year.

However, when we adjust for population, we see a somewhat different pattern. Figure 15 depicts the 30-day Hospital readmissions rate—or the total readmissions over total admissions—by county based on the hospital admission CE measure. Blue dots depict the locations of inpatient hospitals. Evaluating the rate of readmission shows that, although the volume of total readmissions is higher in more urban areas, there are opportunities to reduce hospital readmissions across the Commonwealth.

Figure 15. 30-Day Hospital Readmission Rate in Medicaid by County, with Hospital Locations



Hospital Readmission Rates by Diagnoses

When looking specifically at readmissions drivers in Medicaid Managed Care, four out of the top five diagnoses for hospital readmissions are behavioral health related, compared to just one out of the top five diagnoses in the Commercial market, as illustrated by data provided by VHI. In Medallion 4.0, six out of the top 10 diagnoses for hospital readmissions are behavioral health related and account for a third of the total hospital readmissions. In CCC+, five out of the top 10 diagnoses are behavioral health related and account for 25% of the total hospital readmissions in CCC+ (Table 2). The CCC+ population includes members with serious mental illness. The high concentration of behavioral health diagnoses in Medicaid hospital readmissions indicates that there is a need for a targeted behavioral health focus to reduce hospital readmissions in the Medicaid program.

After behavioral health diagnoses, the remaining diagnoses related to hospital readmissions in Medicaid are primarily chronic conditions, such as diabetes, hypertension, and chronic kidney disease.

Table 2: Top Ten Diagnoses for DMAS Hospital Readmissions in Medallion 4.0 and CCC+, CY 2019

Medallion 4.0 Diagnosis	# of Hospital Readmissions	CCC+ Diagnosis	# of Hospital Readmissions
Major depressive disorder, recurrent	462	Schizoaffective disorders	549
Bipolar affective disorder	202	MDD recurrent moderate	411
Alcohol related disorders	199	Bipolar affective disorder	337
Type 1 diabetes mellitus	158	Other Sepsis	286
Persistent mood [affective] disorders	148	Alcohol abuse, uncomplicated	204
Major depressive disorder, single episode	147	Schizophrenia	179
Schizoaffective disorders	128	Hypertensive heart and chronic kidney disease	171
Other Sepsis	110	Type 1 diabetes mellitus	162
Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth and the puerperium	91	Type 2 diabetes mellitus	125
Complications of procedures, not elsewhere classified	89	Respiratory Failure	114
Percentage of Total Hospital Readmissions	44%	Percentage of Total Hospital Readmissions	49%

For additional detail on readmissions and all DMAS CE measures, including technical specifications and program level output, please see the Value-Based Purchasing section of the DMAS website at <https://www.dmas.virginia.gov/about-us/value-based-purchasing/>.

Care Coordination and Discharge Planning

With the establishment of certain baseline data and trends to anchor ongoing discussions, the workgroup began a discussion of the wide array of care coordination and ED and hospital discharge management activities engaged in by the various stakeholders. As part of these efforts, each participant presented how care coordination works to improve member care outcomes, with a focus on reducing hospital readmissions and preventing or avoiding ED visits. These presentations highlight that the goal of effective care coordination and discharge planning is to coordinate needed medical, social, and other support services for the member so they can successfully follow their care plan and attain the best possible health outcomes.

The Agency for Healthcare Research and Quality (AHRQ) describes 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 and more effective care⁵. Care coordination activities occur across a variety of settings: during an ED visit or inpatient hospital stay, where care coordination is often accomplished as part of the discharge planning process; during post discharge follow-up by a member’s managed care plan, where MCO care coordinators ensure members have what they need to follow their care plan; or by the exchange of member’s health information from a hospital stay or ED visit with a member’s primary care provider. In recent years, care coordination has also evolved to a more holistic patient care

⁵ AHRQ. National Center for Excellence in Primary care Research: Care Coordination. Page last updated: August 2018 ([link](#)).

function that can include addressing social and wellness aspects of a member’s life outside of the traditional health care system, such as access to healthy food, safe housing, employment and working conditions.

With care coordination activities occurring across the health care system, Medicaid members encounter many staff providing care coordination and discharge planning support and resources to address their care needs. MCOs and hospitals are often the health care stakeholders that devote the most significant resources to member care coordination, primarily due to their responsibilities to the member, regulatory or contractual requirements, and access to more significant resources than smaller provider types or groups. Additionally, ED and primary care representatives on the workgroup presented the important roles of each group in the care coordination process.

Managed Care Organizations

MCO care coordination staff have a range of responsibilities, both within and without the health plan, including completing member assessments, benefits education, troubleshooting access barriers, assisting with medication and pharmacy access and instruction, assisting members with compliance with treatment plans, and securing necessary medical equipment. MCO care coordinators also work with utilization management staff and data to monitor appropriate levels of care and share such information as part of the collaboration with health care providers in an effort to improve member care.

Members may interact with their MCO care coordination team in a variety of clinical settings, including the hospital, ED, or outpatient office setting. However, not all members will have, or necessarily require, a designated care coordinator. Care coordinators are assigned for a variety of reasons. Medicaid MCOs provide care coordination to members in both CCC+ and Medallion 4.0, but the level of member engagement varies based on the member’s needs. All CCC+ members have a care coordinator and their level of engagement with members is dependent on the acuity and care needs of the member. Not all members in Medallion 4.0 are assigned or necessarily need a care coordinator. In the Medallion 4.0 program, members are assigned a care coordinator based on physical and/or behavioral health factors, such as multiple ED visits, a provider or member referral for care coordination, and/or a behavioral health related ED visits or hospital admissions. Each MCO may approach care coordination differently and have variation in the eligibility factors in Medallion 4.0. Table 3 illustrates some of the typical factors that can result in assignment of a designated care coordinator by an MCO under the Medallion program.

Table 3: Care Coordinator Eligibility for Medallion 4.0

Domain	Physical Health	Behavioral health
Referral	<ul style="list-style-type: none"> Utilization Manager Provider Member 	<ul style="list-style-type: none"> Provider Member
Emergency Room Utilization	<ul style="list-style-type: none"> Members with 3 or more ED visits in 90 days 10 or more ED visits within a year 4 or more Low-acuity, non-emergent ED visits in a year 	<ul style="list-style-type: none"> 3 ED visits in 90 days Behavioral health ED visits
Inpatient Utilization	<ul style="list-style-type: none"> Inpatient daily census 	<ul style="list-style-type: none"> Behavioral health hospital admission
Other	<ul style="list-style-type: none"> n/a 	<ul style="list-style-type: none"> Member with acute needs Observed need in program review data Residential treatment program step down

MCO care coordinators also follow-up with members within 24 hours of discharge from a hospital inpatient admission, within 24 hours of an ED visit for a CCC+ member, and within 48 hours of an ED visit for a Medallion member. If the care

coordinator was involved in the discharge process, they will be informed of the plan and can use that time to trouble shoot issues for the member and ensure the discharge plan is followed. However, if care coordinators are not involved, that initial follow up can be less effective, efficient, and productive.

Inpatient Hospitals

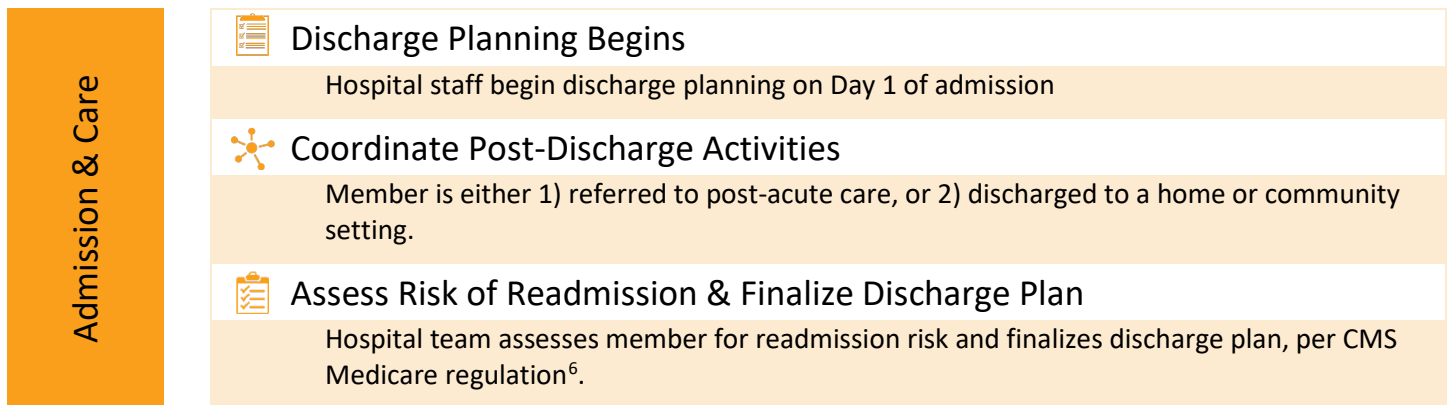
In addition to support from MCOs, members may also encounter care coordination staff during a hospital admission. Members may interact with a range of care coordination functions in hospitals, including case managers coordinating with the provider team and social workers that assist with psychosocial needs and connect members to community resources. VHHA highlighted a range of care coordination activities hospital staff conduct to support successful discharge, including:

- Assessments of patient physical and psychosocial needs,
- Arrangement of treatment and services necessary post-discharge (including connection with both physical and behavioral health providers),
- Evaluating member risk of readmissions,
- Sharing patient data with other providers caring for the member,
- Coordinating such efforts with the patient’s family,
- Ensuring members have appropriate medications and guidance, and
- Formalizing a member’s post-discharge plan.

These efforts can all be part of a hospital’s development of the member discharge plan following an admission. However, because these resources are expensive and often not directly reimbursed by payers, the extent to which such staff are available can vary considerably based on available facility resources. Additionally, while an ED discharge can be less extensive than what a member would experience during a hospital discharge, the hospital/ED still strives to make many of the same efforts to ensure the member is discharged with an appropriate treatment plan, necessary medications, and follow-up activities.

Figure 16 outlines the hospital discharge planning process as described by the workgroup members. Discharge planning is a critical component to the hospital’s role in coordinating member care and begins on the first day of an admission.

Figure 16. Hospital Discharge Planning Process



⁶ CMS. Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care. September 30, 2019 ([link](#)).



Discharge

Hospital provides a patient-friendly post-discharge plan (per CMS Medicare regulation) and provides information to the next clinical care provider(s)⁷.



Follow-Up Post-Discharge

MCO Care Coordinators follow up with member within 24 to 48 hours of discharge.

Hospitals can also provide an array of post-discharge care management services. Several services discussed with the workgroup include:

- A care management continuum integration center that allows for 24-7 access to nurses, social work, and other clinical staff to avoid hospital readmissions or ED bounce back
- A home-based medication program for high-risk patients or patients with high-risk medications that focuses on medication reconciliation, education, and management
- Utilization of patient identification and risk stratification tools embedded in hospital EHRs to assess a patient's risk for readmissions
 - The example risk stratification tool discussed, LACE+, specifically evaluated a patient's length of stay, acute/emergent admission, Charlson Comorbidity Index, and number of ED visits in the last 6 months to assign a LACE risk score to the patient. LACE stands for: length of stay, acuity, co-morbidities, and number of ED visits in the last 6 months. Both hospital and ED representatives indicated that a higher LACE+ score will trigger increasingly robust care coordination and follow-up for a member.
- Maintaining a hospital readmissions steering committee to focus on institutional efforts and key areas of care necessary to positively influence hospital readmissions.

When the necessary resources are present, efforts such as these serve to provide targeted assistance to members at heightened risk of repeat ED visits and hospital readmissions. However, it should be noted that workgroup members highlighted that such resources are highly variable across providers and frequently unavailable in hospitals with more significant resource limitations.

Emergency Departments

When a patient presents at the ED a number of protocols are immediately triggered, including triage, a medical screening exam, and commencing any care necessary to stabilize the patient. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to apply the prudent layperson standard and provide those services to all persons that present themselves in the ED for care, regardless of the patient's final diagnosis and regardless of the patient's ability to pay. At the ED, providers and staff often have access to a range of information on the patient, better informing them of their history, clinical risk, and potentially readmissions risk and social needs. While the process for patient intake and stabilization in an ED is relatively uniform, care coordination activities are variable and depend on the resources available to the ED for such tasks. In larger medical centers, a member may encounter care coordination staff in the ED, though the level of engagement or even the presence of such staff are not consistently available across EDs due to the resources necessary for such positions.

When the resources for ED care coordination exist, it often resembles those discussed at the MCO and hospital levels, where dedicated staff work to coordinate necessary follow-up care, access to medications, or address social needs or identified barriers to care. Often times the goal of care coordination in the ED is to achieve a "warm hand-off" when transitioning a stabilized patient to the next setting or level of care that is appropriate for the patient. EDs also teach patients ED avoidance measures, like how to handle the circumstances that contributed to their ED visit if they should

⁷ See footnote 5.

arise again in the future. However, positions addressing care coordination in the ED setting are in short supply and smaller EDs and hospitals are less likely to employ dedicated staff.

Care Coordination Summary

The entities providing care coordination and discharge planning for Medicaid members invest significant resources in these efforts. However, the range of coordination supports within segments of the health care system are often disjointed from each other, creating an opportunity to better align the efforts and resources to improve member care and care transitions, reduce duplication, and promote efficiency. A central theme highlighted across workgroup stakeholders is that successful care coordination requires communication of a member's medical and social needs and a treatment plan that addresses those circumstances. While there are many examples of effective and robust care coordination and information sharing efforts in this area, it is also common for such efforts to be under-adopted and underfunded, and to suffer from communication gaps among staff and across stakeholders. This creates a situation where disjointed, less effective, and potentially more costly care can be common across the system. Even successful examples face challenges in securing funding or scaling to serve a large population.

Lower-Acuity Sites of Care

Stakeholders viewed access to lower-acuity sites of care as a priority in preventing avoidable ED visits or hospital readmissions and as a more appropriate site of care when those cases were non-emergent. Such settings typically include, but are not necessarily limited to, primary care providers, FQHCs, urgent care clinics, and non-acute specialty care providers. The Workgroup discussed barriers and limitations to member access to such settings of care in a variety of forms. For example, there may be socio-economic reasons that Medicaid members choose the ED for care over a lower acuity setting, including inability to secure transportation on short notice or that the ED is more accessible, particularly after traditional office hours. Workgroup members also indicated experience with patients who visit the ED to obtain over the counter medications they cannot otherwise afford to purchase. While these are only two examples, they illustrate that there can be a number of medical, social, and economic reasons that present barriers to Medicaid members accessing lower-acuity sites of care.

Stakeholders use a wide range of tools to improve member education on, and improve access to, lower acuity sites of care, including nurse help lines, telehealth services and consultations, personalized patient engagement tools and health record portals, and, for more complex patients, patient navigators and enhanced care coordinator interaction to proactively engage patients to better facilitate access and follow-up on necessary routine care. Additionally, many EDs promote different ways of notifying patients' PCPs when they visit the ED and connect these patients with PCP, non-acute, or other follow-up resources as part of the patient's ED visit. Much of this work focuses on getting the member to the appropriate setting of care, however, even when the member is able to coordinate getting to this site of care, there is the question of whether a provider or practice is accepting new patients or has available appointments in a timely manner. Broader access to primary care settings is a key to expanding access to care in a way that reduces ED use and requires not just strong network adequacy, but also facilitating timely and convenient access.

MCO presentations highlighted how the plans evaluate how increased utilization in these lower-acuity settings can influence use of higher-acuity settings of care. For example, monitoring increases in PCP and specialty visits, prescription drug fills, and follow-up after ED and hospital discharge are paired with measures evaluating decreases in ED visits and inpatient admissions. DMAS MCO-related performance incentive programs seek to encourage this type of measurement and targeting of performance improvement efforts through measures in both the Performance Withhold Program (PWP) and Clinical Efficiency (CE) Program. As mentioned previously, the CE Program holds MCOs accountable for the volume of potentially preventable and/or medically unnecessary utilization of their assigned patients in the ED and hospital settings. Additionally, the PWP evaluates measures such as *Follow-up after ED Visits*, *Child and Adolescent Well-Care Visits*, *Prenatal and Postpartum Care*, and *Comprehensive Diabetes Care Management* as examples of tracking levels of

positive utilization. The rationale for this measurement on the part of both DMAS and the MCOs is to encourage effective care management, a component of which is ensuring members are receiving the care they need at the appropriate sites of care.

Representatives from MCOs, VHHA, ED, and PCPs all highlighted increased access to primary care services as a tool to improve care coordination, reduce readmissions, and prevent ED visits. A common sentiment among the workgroup members is that the solution to reducing such negative care events resides upstream—or before the event occurs. Workgroup members have emphasized the integral role of primary care in preventing avoidable utilization through health maintenance, chronic disease management, and preventive services. Increasing access to and utilization of the necessary primary care services to improve member health and reduce preventable utilization will require a multifaceted approach, time, and resources to achieve. DMAS' actuary, Mercer, presented research indicating that expanded provider access and availability often had significant impact on ED visits, emergency transports, and hospital readmissions. Such efforts included a number of solutions already referenced here or currently in practice, to some extent, by providers throughout the state, and included expanded hours, ED care navigators, and community collaborations to address member care needs.

There are several consensus policy options related to primary care which could impact both ED and hospital utilization, the options are presented below. In an a la carte approach, these options are increasing payment in a fee-for-service system, which rewards higher-volume and without a direct link to quality for the member. A VBP approach to primary care can encompass these options in a more comprehensive non-volume based model that aligns payment with value rather than volume; a comprehensive primary VBP policy option that would increase payment with added flexibility to support effective, efficient, and innovative primary care also received consensus support (page 32).

Consensus Policy Option 1— Increase Primary Care Rates to Promote Increased Access to Care:

Currently, Medicaid pays primary care providers approximately 76% of Medicare rates⁸. To increase access to providers and care that could help reduce inappropriate ER utilization and avoidable hospital readmissions, the General Assembly could consider bringing payment for PCPs more in line with Medicare, including Medicare's regional variation in rates, to improve the financial viability of practices serving Medicaid members.

Consensus Policy Option 2—Include Coverage of Complex Care Management Services:

Fund chronic care management activities in lower-acuity settings to align payment levels with the extent of activities and services provided by eligible downstream providers, like PCPs, to reduce avoidable/preventable utilization in the ED and hospital. Coverage for these services could initially target complex care management services for specific conditions with the highest rates of ED utilization and hospital readmissions. To accomplish this, the General Assembly could direct DMAS to cover CPT 99491, which covers each additional 30 minutes of physician or other qualified health professional time per calendar month used to establish, implement, revise, monitor a comprehensive care plan for members with two or more chronic conditions expected to last at least 12 months that also put the member at risk of death or acute exacerbation. Additionally, the General Assembly could approve funding for and direct DMAS to cover complex chronic care management codes, such as 99487 and 99489. CPT 99487 covers the same chronic care management activities but for cases with moderate or high complexity in medical decision making, and 99489 covers each additional 30 minutes per month for those activities. Coverage for these services could initially be targeted to specific conditions with the highest rates of ED utilization and hospital readmissions.

⁸ This estimate of Medicare parity is based on the utilization of ~300 primary care related service codes and associated total costs under Medicaid and Medicare.

Another potential obstacle is member access to PCPs after business hours. According to the Centers for Medicare and Medicaid Services (CMS), two-thirds of ED visits occur after business hours (9 a.m. – 5 p.m.)⁹, with only 44% of PCPs in VA offering evening and weekend hours according to a VCU report on Primary Care¹⁰. A lack of access to primary care services after business hours may be a factor in members seeking care at the ED for lower acuity conditions or visits. While Medicaid MCOs currently cover services furnished outside of regular office hours, utilization of these services among primary care providers remains low.

Consensus Policy Option 3—Targeted Increased Payment Rates for Access-Promoting Services:

The General Assembly should fund and direct DMAS to increase the payments for CPT codes associated with extended hours access to services such as nights, evenings, weekends, and holidays. Increasing payment for services provider outside of normal business hours (9 a.m. – 5 p.m.) may increase office hours, access to services for Medicaid members, and potentially reduce avoidable and unnecessary ED utilization. Targeted interventions to increase access to primary care services, particularly outside of business hours (weekdays 9 a.m. to 5 p.m.) is consistent with CMS guidance on reducing inappropriate utilization of emergency rooms¹¹.

PCPs and their associated care coordination efforts are diverse. While some practices may employ dedicated staff to address care coordination efforts, clinical staff are often responsible for these activities on top of their existing workloads. Practices also have varying levels of sophistication with regards to data and information exchange capabilities. While some practices have electronic health record (EHR) platforms that help to risk stratify patients, and allow for tracking member cost and utilization, others still operate on predominantly paper-based systems that do not facilitate the same types of population management as more sophisticated systems.

One obstacle identified by workgroup members is that many members do not have a relationship with a PCP. After an ED visit, hospital admission, or hospital readmission those members do not have an established PCP to follow up with for post-discharge care. Additionally, as mentioned above, PCPs have varying ability to receive information on a member following such a discharge, and when this information is received, there can be gaps in that information.

The primary care workgroup representative raised the possibility of a non-branded, statewide “Call us First” initiative that would make non-branded cards, pamphlets, and other resources available to providers to help educate members on appropriate use of EDs. A statewide campaign with downloadable resources would be of particular help to small and non-affiliated practices that may not have the resources to create materials on their own.

Data Exchange and the Emergency Department Care Coordination Tool

Robust data on a member’s health and health care is a key feature to successful care coordination and member care management. Workgroup stakeholders continuously highlighted the need for a robust data exchange and access to the full picture of a member’s health care utilization as critical to providing the care and follow-up a member needs to avoid negative care events such as avoidable/preventable ED visits or hospital readmissions. One tool that offers significant promise in this space is the Emergency Department Care Coordination (EDCC) platform—a single, statewide technology solution that connects all hospital EDs in the Commonwealth to facilitate real-time communication and collaboration among health care providers. The EDCC will notify other users, like primary care providers and MCO care coordinators,

⁹ CMS. Reducing Non-urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 16, 2014 ([link](#)).

¹⁰ VCU. Primary Care in Virginia: A Report on Providers’ Perspectives Prior to Medicaid Expansion. November 2019 ([link](#)).

¹¹ CMS. Reducing Non-urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 16, 2014 ([link](#)).

of an ED visit for a patient in their care. The EDCC offers a powerful tool to share member information around an ED visit that a patient's care team can leverage to facilitate better coordination of their care around an ED discharge.

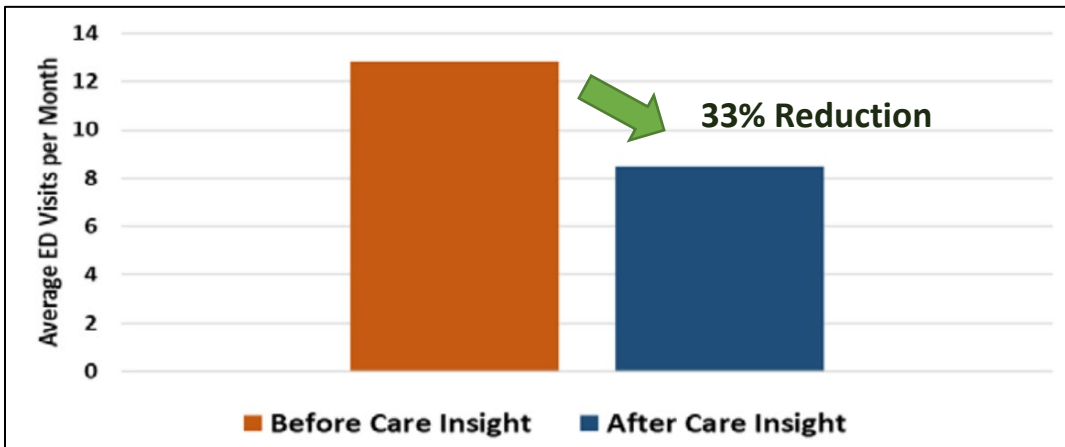
As of October 2020, 106 hospital EDs, all six Medicaid MCOs, the state employee health plan, Medicare, and commercial health plans operating in Virginia participate in the EDCC program. Connect Virginia continues efforts to onboard downstream providers such as primary care providers, FQHCs, nursing facilities, and external rehabilitation facilities to the EDCC. VHI shared that approximately 80 clinics, offices, FQHCs, and Community Service Boards that care for roughly 500,000 patients have adopted the EDCC as downstream providers; however, according to a VCU report prepared for DMAS on provider perspectives prior to Medicaid Expansion, there are 1,622 adult primary care practices in the state¹². This indicates that there are still significant growth opportunities to onboard downstream, non-acute providers with access to EDCC data. While efforts to onboard downstream providers proceed in 2021, the need for seamless notification of ED utilization to downstream providers continues. Downstream provider access to the EDCC and the real-time notifications available from the tool, particularly among primary care providers, FQHCs, and other providers furnishing more routine care and care management services to members, are necessary for successful care coordination that ultimately can improve health outcomes and prevent avoidable utilization. This type of follow-up is important for all Medicaid members, but particularly for members who may not fall into a category assigned to an MCO care coordinator.

Within the EDCC, care team members, including clinical providers and care coordinators, can add Care Insights. These are, ideally, brief notes about the members' care plan or relevant pieces of information that can help inform a treating provider, such as an Emergency Department physician, about the member and their needs. In Figure 17, data from VHI shows an observed 33% reduction in average ED visits per month after a Care Insight for people with 100+ ED visits in 12 months. Among all patients with 10 or more visits in 12 months, those with Care Insights have an observed 20% reduction in utilization. Only 7.3% of all patients with 10 or more ED visits in 12 months had a Care Insight, according to data in Figure 7 provided by VHI. Workgroup members highlighted an observed reduction in ED visits of over 20% for patients with 10+ annual ED visits after their EDCC record includes Care Insight information. Expanding Care Insights for members with a higher frequency of ED visits is consistent with guidance to focus on frequent ED users from CMS on reducing inappropriate emergency room utilization¹³.

¹² VCU. Primary Care in Virginia: A Report on Providers' Perspectives Prior to Medicaid Expansion. November 2019 ([link](#))

¹³ CMS. Reducing Non-urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 16, 2014 ([link](#)).

Figure 17. Impact of Care Insights in EDCC on ED Utilization for Extreme Utilization (100+ visits in 12 Months)



Consensus Policy Option 4—Support Expansion and Adoption of EDCC among Downstream Providers:

Provide VHI with support to address barriers to onboarding downstream, non-acute providers to the Emergency Department Care Coordination platform (EDCC). Onboarding efforts could focus on providers with large Medicaid patient panels to prioritize access to the real-time notification to providers that treat higher volumes of Medicaid members. Such efforts could include, but are not limited to, funding to support additional staffing and contract resources for provider outreach and streamlining legal and administrative requirements for onboarding to the EDCC.

Consensus Policy Option 5—Expand Care Insights for Medicaid Members with Frequent ED Utilization (10+ ED Visits in 12 Months):

VHI should continue and expand efforts to increase the use of Care Insight in their EDCC records among members with 10 or more ED Visits in 12 months. The percentage with Care Insights could be increased from 7% to 50%. DMAS could set an improvement target for MCOs to double the percentage of Medicaid members with 10+ ED visits in 12 months that have a Care Insight annually, until the target of 50% is reached. After achievement of the initial target, DMAS can work with MCOs and VHI to set a future benchmark and/or improvement targets.

Consensus Policy Option 6—Align Definitions for Emergency Department Utilization:

DMAS, VHI, VHHA, MCOs, and other stakeholders should adopt unified definitions for ED categories in order to better describe, analyze, and report ED utilization. An aligned, unified language will provide enhanced discussion, analysis, policy development, and assessment of strategies in this area.

Behavioral Health

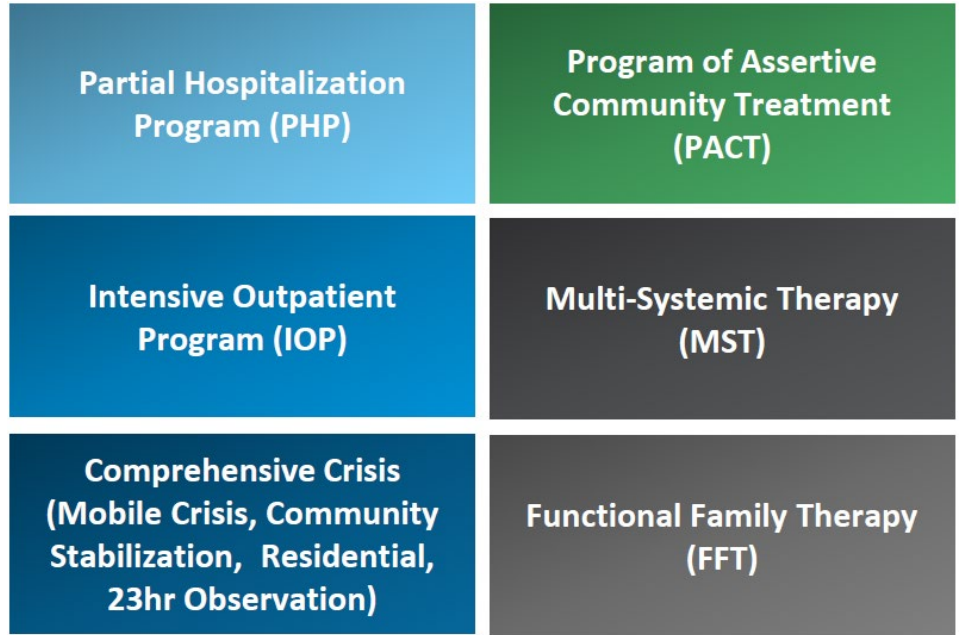
Addressing the needs of Medicaid members with behavioral health diagnoses is essential. Workgroup members consistently highlighted patients' behavioral health conditions as significant contributors to higher levels of ED visits and hospital readmissions among Medicaid members.

All CCC+ members in Medicaid have a care coordinator. In Medallion 4.0, a member receives a care coordinator for a specific set of reasons, including if the member has a hospital admission or ED visit with a behavioral health diagnosis. Despite access to care coordinators in both programs, behavioral health diagnoses remain a significant driver of hospital readmissions and ED visits for Medicaid members. Innovative approaches are necessary to address the unique behavioral health needs

that contribute to higher levels of high-acuity care utilization in Medicaid. One such approach discussed by MCO representatives outlined a model where MCO care coordination staff are embedded on-site with inpatient and outpatient provider groups experiencing a high volume of behavioral health-related cases. This allows the care coordinators to work alongside both behavioral and physical health providers to better facilitate the care necessary for these more complex members. This effort not only serves as an opportunity for coordinators to work closely with clinical staff seeing the member, thus allowing for more effective data sharing and better integration into the discharge planning process for the MCO, but also help the MCO access high-needs members that have otherwise been difficult to contact.

Medicaid is the largest payer for behavioral health services in the Commonwealth, with nearly a third of all Medicaid members having some form of behavioral health diagnosis. Despite the prevalence of behavioral health conditions, their association with significantly higher health care expenditures, and role as a primary driver of Medicaid hospital readmissions, Medicaid-covered behavioral health services are often reactive, with an overreliance on intensive treatment services and underdeveloped opportunities for prevention and early intervention. DMAS is currently working to address this issue by expanding access to and funding for services that emphasize lower-intensity and community-based intervention for behavioral health issues. This Project BRAVO, as the effort is known, focuses on increasing the provision of the services listed below, which are currently either not covered by Medicaid or are underfunded (Figure 17).

Figure 17. Six Settings of Care Included in Behavioral Health Enhancement



Consensus Policy Option 7—Develop an Embedded Care Coordination Model in Areas with High Behavioral Health Needs:

DMAS could implement an integrated treatment model within high volume Medicaid outpatient centers of behavioral health. The goal would be to target individuals with chronic medical conditions and co-occurring mental health disorders to increase continuity of care. This model would embed a physical health practitioner in

high-volume outpatient behavioral health provider/therapy practices and Community Service Boards to connect with members who have a history of being difficult to engage, low acuity non-emergent ER utilization, potentially preventable inpatient admissions, appointment/medication non-adherence, and/or identified gaps in care for their medical conditions to include preventative health screenings. The physical health practitioner would provide education on physical health diagnosis and management, referrals/appointments for PCP/specialist intervention and follow-up, basic health screenings (i.e. in-house lab work, diabetic screenings, monitor blood pressure, weight checks, drug screenings, etc.), and work closely with the behavioral health provider(s) to integrate medical needs into a comprehensive integrated treatment plan to address whole-person health. Both the behavioral health and physical health practitioner would collaborate closely with the MCO care coordinator as part of an interdisciplinary care team. The care coordinator would assist practitioners in locating in-network providers, obtaining durable medical equipment, assist with medication pre-authorizations, schedule transportation, and collaborate around ED and IP admissions and discharges.

Consensus Policy Option 7 received consensus support from seven workgroup members, with one workgroup member abstaining from voting on this option.

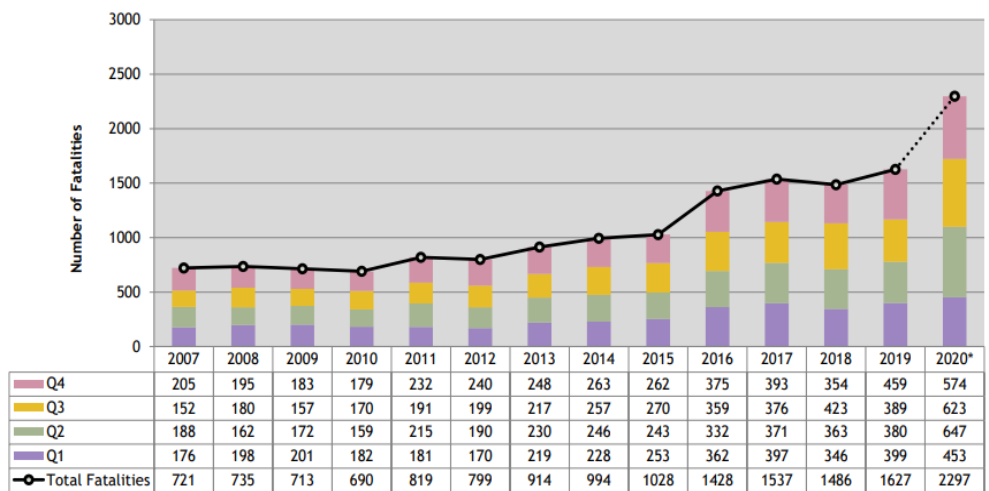
The General Assembly’s recent inclusion of funding for Project BRAVO is a significant step towards expanding access to these necessary services. There are additional steps that can be taken to further strengthen this infrastructure of lower-acuity and community-based behavioral health interventions.

Consensus Policy Option 8—Access to Providers in the Behavioral Health Continuum:

The General Assembly should fund support for the adoption of evidence-based practices and training for existing behavioral health providers consistent with the continuum of behavioral health services outlined in Project BRAVO, and provide funding to expand the licensed mental health provider workforce to meet the behavioral health needs of the population.

Treatment for substance use disorders is an important piece of behavioral health. In 2020, fatal drug overdoses in the Commonwealth have increased by 42% (figure 18). Thirty-seven percent of people that have a fatal overdose had a touchpoint with 1) opioid detoxification, 2) non-fatal opioid overdose, 3) injection-related infections, and 4) release from incarceration¹⁴. Experiencing a non-fatal overdose is independently associated with a subsequent fatal overdose¹⁵. A randomized control

Figure 18. Fatal Drug Overdose Trends (Updated April 2021)



¹⁴ Larochelle, M. et. Al. Touchpoints – Opportunities to predict and prevent opioid overdose: A cohort study. Drug and Alcohol Dependence, V. 204., November 2019. <https://www.sciencedirect.com/science/article/abs/pii/S0376871619302960>

¹⁵ Larochelle, M. et. Al. Touchpoints – Opportunities to predict and prevent opioid overdose: A cohort study. Drug and Alcohol Dependence, V. 204., November 2019. <https://www.sciencedirect.com/science/article/abs/pii/S0376871619302960>

trial testing buprenorphine initiation, brief intervention and referral, and referral alone found that initiating buprenorphine in the ED increased the likelihood of the patient entering outpatient treatment by 74%^{16,17,18}. In Virginia, there are currently two hospitals—Virginia Commonwealth University Hospital and Carilion Clinic—that initiate treatment for patients who enter the ED with substance use disorder or an overdose emergency and transition them to community-based addiction and recovery services. Comparing the year prior to introducing the medication-assisted treatment (MAT) in the ED versus one year after introduction of MAT in the ED, Carilion found a 40% reduction in ED utilization¹⁹. In year one, 82% of patients seen and treated in the ED successfully “crossed the bridge” to the office-based opioid treatment.²⁰

Consensus Policy Option 9—Encourage Emergency Departments to Implement a Bridge Program:

The General Assembly should encourage Emergency Departments and health systems to implement a Bridge Program to screen patients, offer treatment (buprenorphine) in the ED, and refer individuals with substance-use disorder for outpatient follow-up at an office-based opioid treatment through grants to support training and implementation. The program could prioritize EDs with high prevalence of behavioral health and substance use disorders and access to appropriate outpatient office-based care in the community.

Policy Option 9 received consensus support from seven workgroup members, with one workgroup member abstaining from voting on this option.

Addressing Member Health Related Social Needs

Another theme that permeated much of the group’s discussion on the topic of care coordination, as well as a significant driver of potentially preventable or avoidable ED visits and hospital readmissions, was the need to address members’ social needs, frequently referred to as social determinants of health (SDOH) or HRSNs. Members’ HRSNs can have a profound effect on their health and health care utilization, with figures indicating that 80% of factors influencing a person’s health are due to socioeconomic, environmental, and behavioral factors.²¹ While such factors often have a significant influence on a member’s health, they are frequently outside the ability or resources of stakeholders within the health care system to address. Each of the group’s medical stakeholders indicated they devote resources to addressing members HRSNs, most commonly in the form of social workers, case managers, or strategic partnerships working to connect a member with the right benefits or community resources for their needs. Presentations from VHHA, hospitals, and Emergency Room Physicians highlighted the need to address social needs to improve member health outcomes—including social and structural factors such as housing, food access, and education, environment, and employment opportunities that influence the health and well-being of a person.

¹⁶ Liebschutz JM et al. Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients: A Randomized Clinical Trial. *JAMA IM* 2014.

¹⁷ D’Onofrio G et al. Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. *JGIM* 2017.

¹⁸ Caudarella A, Dong H, Milloy MJ, Kerr T, Wood E, Hayashi K. Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. *Drug Alcohol Depend*. 2016;162:51-55. doi:10.1016/j.drugalcdep.2016.02.024

¹⁹ Carilion presentation to the workgroup during the 6th meeting on June 16, 2021.

²⁰ Carilion presentation to the workgroup during the 6th meeting on June 16, 2021.

²¹ Olson, Douglas, et al., Health Affairs, Standardizing Social Determinants of Health Assessments, March 18, 2019 ([link](#)) and Robert Wood Johnson Foundation, Medicaid’s Role in Addressing Social Determinants of Health, February 1, 2019 ([link](#)).

To better connect individuals with various community-based support resources, the Virginia Department of Health, in collaboration with VHHA, is working to launch a technology solution called Unite Us in 2021. Unite Us is a referral system to connect health providers with community-based organizations to meet the social needs of community members and track outcomes, essentially a closed loop referral system for HRSNs. Currently, \$10 million in CARES Act funds will provide access to the platform for public agencies, community-based organizations, and the Commonwealth's providers²². Continued support for such connection between providers, agencies, and community-based organizations is essential for coordinating the interconnected social and medical needs of Virginians. The agreement, however, does not currently cover private entities contracted with state agencies, which excludes Medicaid MCOs.

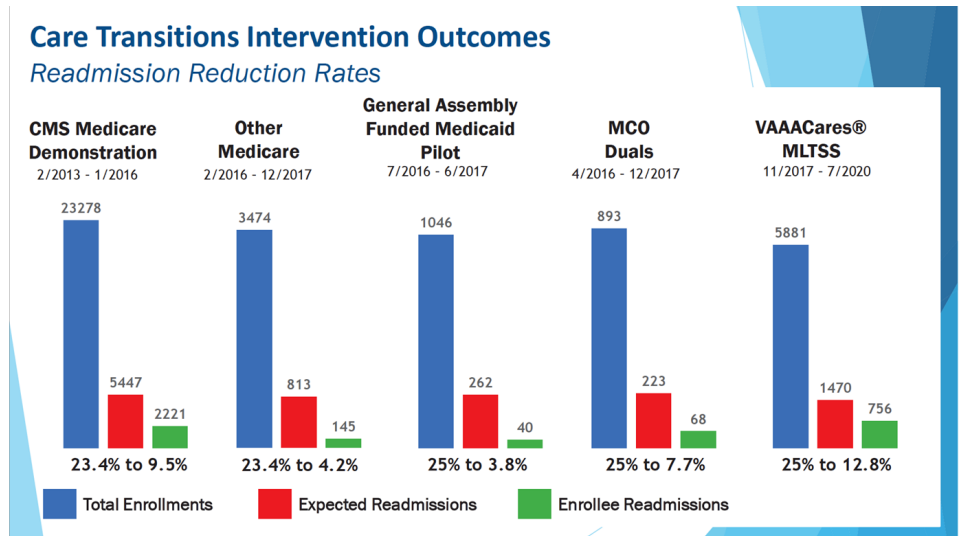
Consensus Policy Option 10—Fund Direct Connection between MCOs and a CBO Network

Coordinator:

The General Assembly should fund access to a community based organization network coordinator for Medicaid MCOs as a critical partner in care coordination for Medicaid member health related social needs (HRSNs). Access to a community based organization (CBO) network coordinator would facilitate referrals to needed services for Medicaid members through the platform.

While providers within the health care system often make significant efforts to assist members with HRSNs, provider payment structures do not compensate them for doing so. Payment to health care providers and systems is connected to the provision of medical services and treatment, predominantly on a volume driven, fee-for-service basis. While investments to address a member's HRSNs are likely to improve their health, such investments are not currently part of the reimbursement structures that govern health care. VCHI presented on one such effort to braid non-medical services and HRSN intervention for patients discharging from the hospital by the Virginia Area Agencies on Aging Caring for the Commonwealth's (VAAACares®) Care Transitions Intervention Model. This statewide collaborative works with hospitals to perform home care transition interventions wherein health coaches go to a patient's home within 48 hours of discharge to evaluate and execute on clinical education and HRSN interventions necessary to avoid readmissions (figure 19). Interventions include assistance such as addressing transportation issues, education and assistance on managing chronic disease, addressing food insecurity, fall prevention, or efforts to reduce social isolation. While the evidence presented by VCHI shows this effort significantly decreases Medicare and Medicaid hospital readmissions, funding remains an issue as much of the support provided by VAAACares® does not narrowly qualify as reimbursable medical services.

Figure 19. Care Transitions Intervention Outcomes



²² Governor of Virginia. Virginia to Partner with Unite us to Create Statewide Infrastructure Connecting Health and Social Services: Integrated e-referral system will support ongoing COVID-19 response and recovery efforts, advance health equity. December 18, 2020. ([link](#))

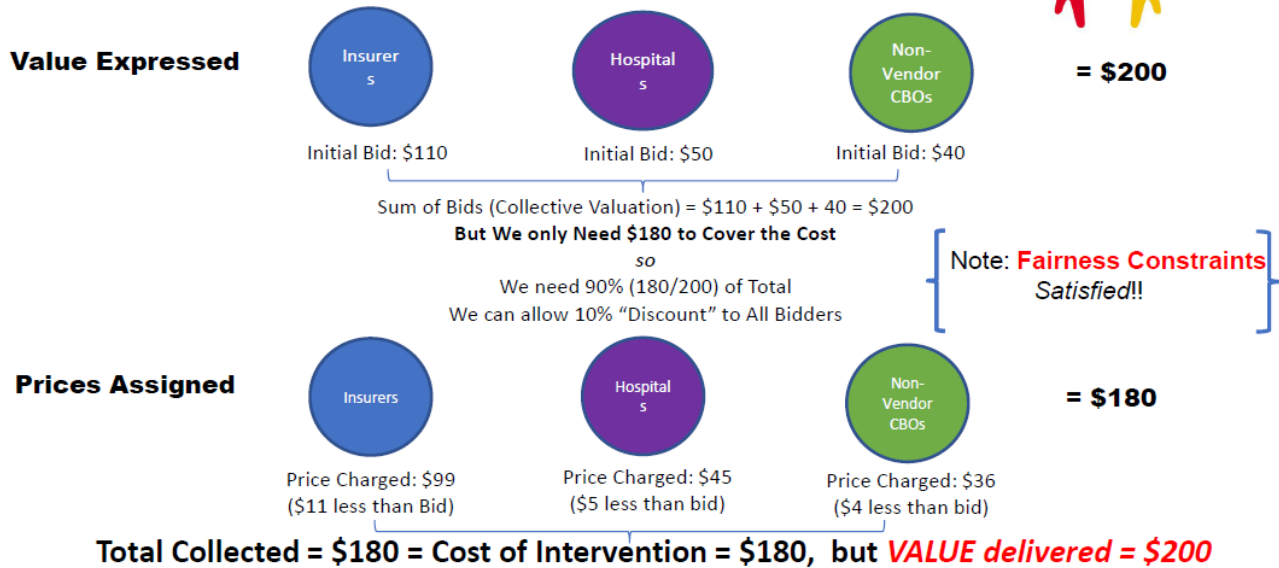
Virginia is not alone in struggling for a large-scale approach on how to effectively and efficiently fund targeted HRSN or other non-medical interventions that improve member care outcomes. To explore one proposed approach to addressing this issue, VCHI brought in a guest speaker from the Urban Institute²³ to discuss the Trusted Broker Model as a potential solution. The Trusted Broker Model utilizes a collaborative approach to public good investments (CAPGI), which can help markets get past funding issues stemming from the “free-rider” problem, whereby investors cannot easily prevent non-payers from benefiting from and thereby capturing some of the benefits of the investments of another party.²⁴ Under a Trusted Broker Model, a non-governmental third party assigns fair prices to each entity for receiving the good or service so that the benefits are shared among the entities collectively. This creates a structure that has the potential to overcome the “free-rider” problem by funding the collectively used good or service consistent with each entity’s willingness to pay, when the value of that good or service is higher than the collection of the entities’ bids (Figure 20).

Figure 20. Example of Pricing for Upstream Investments in CAPGI (Provided by Dr. Len Nichols, Urban Institute)

Such a model could have potential for funding select non-medical or HRSN related services and interventions, such as the care transitions assistance or select HRSN intervention projects.

Example of Pricing for Upstream Investments

Cost: \$180 for Complex Case Management by CHWs and Social Workers



²³Dr. Len M. Nichols, PhD, is a health economist and non-resident Fellow of the Health Policy Center of the Urban Institute and Professor Emeritus of Health Policy at George Mason University. Dr. Nichols has been intimately involved in health reform debates, policy development, and communication with the media and policy makers for 25+ years, after he was Senior Advisor for Health Policy at the Office of Management and Budget (OMB) in the Clinton Administration. ([link](#))

²⁴ Nichols, Len M. and Lauren A. Taylor, Social Determinants As Public Goods: A New Approach to Financing Key Investments In Healthy Communities, Health Affairs 37, No. 8 (2018), pgs. 1223-1230 ([link](#))

The workgroup considered a policy option (non-consensus) to fund the exploration of the Trusted Broker Model with stakeholders and to define a business case for such a model, targeting Medicaid member health related social needs in a specific area. This effort would identify an area of focus likely to have significant impact on reducing members' utilization of the ED or hospital readmissions. However, only three workgroup members generally supported the option, four members voted not to support the option, and one workgroup member abstained. The general feedback from workgroup members on this option indicated a need for more study before further consideration. The Trusted Broker model policy option did not reach consensus support. The Trusted Broker model is underway in other parts of the country, so perhaps with data and evidence from other applications this model could be considered in the future.

Value-Based Payment and Financial Incentives

Value-based payment and value-based purchasing (VBP) arrangements use varying forms of financial incentives to encourage the provision of high-quality, efficient care that supports positive health outcomes. In such arrangements, health care stakeholders, including varying types of providers and MCOs, have accountability for defined performance outcomes within a predetermined incentive structure. These structures can take many forms, but generally follow a quality continuum that evolves from measures of care processes to measures of care outcomes, and financial accountability structures that range from bonus or upside-only arrangements to agreements where entities take on significant financial risk for the cost and quality of care provided to a designated population. Within VBP arrangements, the reduction of ED visits and hospital readmissions are often prioritized as more outcome-focused performance measures due to their associated cost, utilization of a high acuity setting of care, indication of a negative care event, and potential to be avoided or prevented by a number of lower-cost and lower-acuity interventions involving care coordination, member education, effective care management, and more frequent access to lower-acuity sites of care that are often indicative of proactive, high-quality, member-focused care. While financial incentives for strong or improved performance in these areas are helpful, they must be coupled with other supports to achieve their goals. Such supports have been discussed above, and include, but are not limited to, data on patient health (e.g. conditions, family and medical history, and HRSNs) and health utilization (e.g. ED visits, PCP visits, medication fills), convenient access to non-emergent care settings for more routine and non-complex care, and interaction with the entities providing their health care, both providers and MCOs.

In recent years, the Commonwealth and stakeholders that serve Virginia's Medicaid members have made progress in many of these areas, but these initiatives are in the early stages. As mentioned previously, establishment of the EDCC provided a powerful tool with significant opportunities to expand provider access to critical data necessary to better manage members, particularly those with high ED utilization. Expanding access to and utilization of this critical data exchange will be an important part of any efforts to reduce preventable and/or avoidable ED utilization.

DMAS has also taken meaningful steps to enhance MCO accountability through its PWP (Figure 21) and CE Programs. These programs place significant financial accountability on Medicaid MCOs to improve, or maintain strong performance in, areas of importance to the Medallion and CCC+ populations. Additionally, the CE Program holds MCOs accountable for targeted reductions in potentially preventable and/or medically unnecessary ED visits, hospital admissions, and hospital readmissions. The incentives under these two programs represent 1.25% of MCO's Medicaid capitation rates, accounting for over \$100 million in MCO payment based solely on performance achievement.

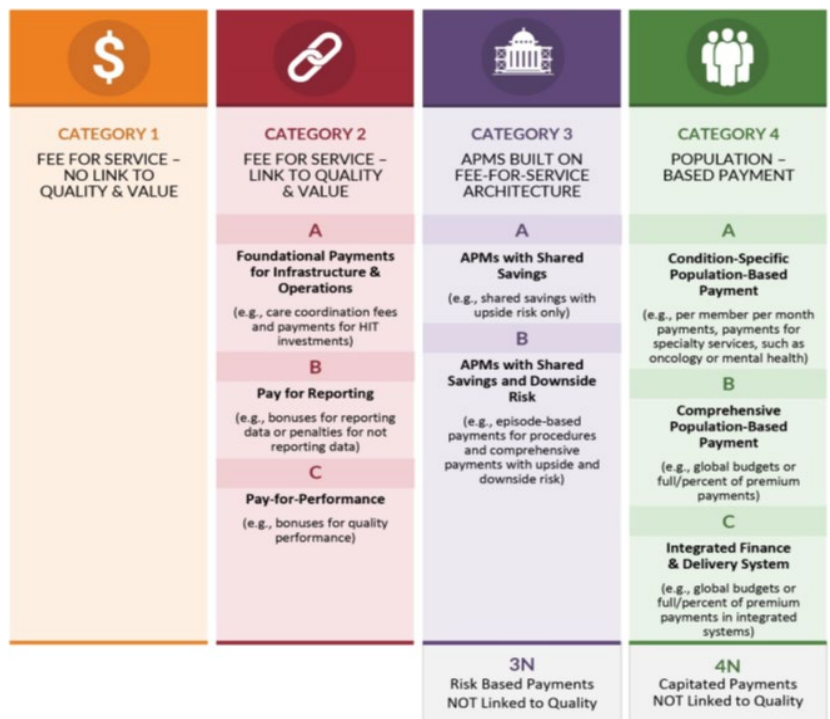
Figure 21. Performance Withhold Program Measures

Performance Withhold Program Measures	
CCC Plus	Medallion 4
Follow-up After ED Visit Alcohol or Other Drug Dependence	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Heart Failure Admission Rate	
	Prenatal and Postpartum Care
	Childhood Immunization Status
	Child and Adolescent Well-Care Visits
	Follow-up After ED Visit for Mental Illness
	COPD and/or Asthma Admission Rate
	Comprehensive Diabetes Care

MCOs and providers caring for Medicaid members have also worked together to increase the portion of health care dollars governed under VBP arrangements that introduce financial accountability for the provision of high-quality, efficient care at the provider level. Currently, MCO VBP arrangements cover over 25% of total medical spending in Medicaid managed care in Virginia. Both MCOs and providers continue to work together to expand on the number, size, and sophistication of these arrangements as they gain experience in caring for Medicaid members under a VBP environment.

The Health Care Payment Learning and Action Network (HCLPLAN) publishes a framework for evaluating provider VBP arrangements (Figure 22).²⁵ As payment models progress along the continuum from Category 1 (fee-for-service) to Category 4 (population-based payments) providers take on increasing accountability for the quality and cost of care furnished to a defined population of patients. DMAS encourages growth in both the scope and sophistication of VBP arrangements between Medicaid MCOs and providers serving Medicaid members. Growth in these more advanced VBP arrangements (i.e. Category 3 & 4 models) is critical to improving member care as these arrangements often provide the additional flexibility and support providers need to adjust practice patterns and invest in enhancements

Figure 22. HCLPLAN Alternate Payment Model Framework



²⁵ Health Care Payment Learning & Action Network, Advanced Payment Model (APM) Framework, July 2011, 2017 ([link](#))

necessary to focus on population health management, while also providing more substantive, non-volume-driven financial incentives for improving and maintaining the health and health outcomes of Medicaid members. These more advanced Category 3 and 4 VBP models currently account for approximately half of all VBP-related spending in Medicaid managed care in Virginia.

The workgroup considered a policy option (non-consensus) to update VBP targets in MCO contracts to emphasize more advanced alternative payment models. DMAS currently includes VBP targets in its managed care contracts requiring MCOs to have a percentage of relevant spending in VBP arrangements (e.g. HCPLAN Categories 2-4) and must assure annual improvement until the target is achieved (Medallion 4.0 25%, CCC+ 10%). The policy option considered by the workgroup would increase the emphasis on VBP adoption within the Medicaid market by setting multi-year targets in MCO contracts to increase VBP adoption and incorporating achievement of the VBP targets as a measure under the PWP. These targets could be set to prioritize the adoption of Category 3 and 4 models in future years. This option received a majority of support, but did not reach consensus: 5 members generally supported the option, 2 members did not support the option, and 1 member abstained from voting on this option.

Hospitals also face enhanced financial accountability to avoid readmissions following enactment of a budget policy instructing DMAS to reduce hospital payment for a readmission by 50% when that readmission is to the same hospital for the same or a similar diagnosis between 5 and 30 days and a policy that down-codes hospital emergency department services based on principal diagnosis code.²⁶ Under Virginia Medicaid regulation, a hospital readmission within 5 days of discharge is currently considered to be a continuation of the original admission. Other states have crafted upside incentive programs to spur strong hospital performance in targeted utilization areas.

The workgroup considered a policy option (non-consensus) to modify the existing hospital readmission payment policy (Appropriations Act Item 313 BBBB) in the budget language passed by the 2020 General Assembly, signed by the Governor, and implemented by DMAS to include an upside performance incentive. For the option, the General Assembly could fund and authorize the creation of a Medicaid hospital VBP program to add an upside incentive to reward hospitals that successfully reduce potentially avoidable and unnecessary ED utilization in the future. This option did not receive consensus support from the workgroup: 3 members generally supported, 3 members did not support, and 2 member abstained.

Washington State has a Medicaid Quality Incentive Program that rewards hospitals for activities that reduce future ED utilization. This program provides hospitals with the ability to earn a 1% incentive payment through activities to reduce future unnecessary ED utilization in Medicaid. Through this program, Washington established an ED technology—similar to the EDCC in Virginia and administered by the same company (Collective Medical)—to track ED visits and identify frequent users of EDs. Hospitals then target patient education efforts, redirect care to the most appropriate setting, institute care management for frequent ED users, and facilitate the required follow up with primary care with 72 hours of the ED visit. The program also instituted narcotic guidelines and tracked patients prescribed controlled substances through the state's prescription monitoring program. This EDCC-like software in Washington calculates the number of members with 5 or more ED visits at the same facility in the last year without a care guideline—meaning a provider interacting with the software and notating care items—out of the total number of members without a care guideline

²⁶ 2020 Special Session I, Virginia Acts of Assembly, Chapter 56, Item 313 BBBB ([link](#))

with five or more ED visits at the same facility. The performance on these measures corresponds to different levels of the potential reward payment for the hospital.

Within the first year, ED visits declined by 9.9% and the rate of visits by frequent users declined by 10.7% and the savings accrued from reductions in unnecessary ED utilization in 2013 was \$33.6 million^{27,28,29}. These tools already exist in Virginia and could serve as the basis for supporting a hospital-focused rewards program for achieving reductions in ED utilization. A similar incentive to reward hospitals for activities that successfully reduce future potentially avoidable and unnecessary ED utilization could be created in Virginia.

The workgroup considered a policy option (non-consensus) to modify the existing Emergency Department Policy (Appropriations Act Item 313 AAAAA) in budget language passed by the 2020 General Assembly, signed by the Governor and implemented by DMAS to include an upside performance incentive, funded and authorized by the General Assembly, to reward emergency departments that successfully reduce unnecessary ED utilization. Workgroup members generally did not support this option: 3 members generally supported, 4 members generally did not support, and 1 member abstained.

Additionally, the workgroup considered a policy option (non-consensus) to amend the financial incentives put in place by budget item 313 BBBB passed by the 2020 General Assembly and signed by the Governor. The workgroup considered an option to modify the existing hospital readmission payment policy (313 BBBB) to align with the Medicare Hospital Readmissions Reductions Program. This aligned 313 BBBB with the Hospital Readmission Reductions Program (HRRP) under Medicare to align priorities across programs for hospitals. A modified version of 313 BBBB could include aspects from the Medicare HRRP such as measuring hospital performance relative to other hospitals with similar patient populations, risk adjusting performance, target condition- and procedure-specific measures with highest risk or utilization in Medicaid, and limit payment reductions similar HRRP. This option did receive majority support among members who voted on this option, but this option did not receive consensus support: 4 members generally supported, 2 members generally did not support, and 2 abstained.

Workgroup members representing primary care, EDs, and Hospitals raised objections to the ED budget language passed by the 2020 General Assembly and signed by the Governor, which directs DMAS to reduce ED visits payments with a potentially preventable or avoidable diagnosis that could be avoided with appropriate primary care and care management. Workgroup members cited the need for investment in upstream interventions to address potentially preventable and avoidable ED utilization. A CMS bulletin urges states that pursue payment strategies to “demonstrate sufficient access to services outside of the ED and consider expanding care through medical homes or other arrangements that improve linkages between patients and providers.”³⁰ These workgroup members expressed concerns that reductions in reimbursement for ED visits based on a final diagnosis code is a barrier to hospital’s efforts to provide

²⁷ Washington Hospital Association. ER is for Emergencies Medicaid Quality Initiative (MQI) Training Webinar. July 9, 2020. http://www.wsha.org/wp-content/uploads/FINAL_Washington-State-Hospital-Association-Collective-MQI-Training-7.9.2020-1.pdf

²⁸ Washington State Health Care Authority. Health Care Authority says Emergency Department Partnership is Improving Care and Saving Medicaid Funds. March 20, 2014. <https://www.acep.org/globalassets/uploads/uploaded-files/acep/advocacy/state-issues/wa-hca-er-update-report-for-legislature-3-20-14.pdf>

²⁹ Center for Health Policy at Brookings. Washington State Medicaid: Implementation and Impact of “ER is for Emergencies” Program. May 4, 2015. <https://www.brookings.edu/wp-content/uploads/2016/07/050415emermedcasestudywash.pdf>

³⁰ CMCS Informational Bulletin. Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 2014. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/CIB-01-16-14_20.pdf

robust services, which can be critical when a patient presents with behavioral health and substance use disorder conditions.

The workgroup considered a policy option (non-consensus) to recommend that General Assembly remove the payment down-code for emergency departments based on principal diagnosis (313 AAAAA) from budget language passed by the 2020 General Assembly and signed by the Governor. This option received majority support among the members, but did not reach consensus: 4 members generally supported, 2 members generally did not support, and 2 members abstained.

While the Commonwealth is engaged in many of the efforts necessary to improve member care and care outcomes to reduce preventable, avoidable, or unnecessary ED visits and hospital readmissions, including the care coordination, data, and VBP resources referenced above, many of these efforts are still in the early stages or working independently of each other. The Commonwealth's health care data exchange and VBP efforts need time and support to mature to a level where more providers have significant financial incentives to more holistically manage member care and convenient access to the member data necessary to do so. This must also include care coordination that encourages the various resources from MCOs, hospitals, and outpatient providers to work more collaboratively. While there are significant pockets of such collaboration, there currently appears to be significant duplication and discontinuity in these efforts, contributing to less effective and inefficient deployment of these resources.

One potential pathway to support more care coordination, care management of chronic conditions, and improve access to lower acuity sites of care to reduce unnecessary and potentially avoidable utilization in EDs and hospitals is a comprehensive VBP program in primary care. The workgroup discussions continually returned to the need to invest in care upstream to prevent negative care events like an ED visit, hospital admission, or a hospital readmission through the provision of consistent, evidence-based, proactive care management, health education, and primary care. The workgroup supported a policy option to develop a comprehensive primary care VBP model (option 11).

Policy Option 11— Comprehensive Primary Care Value-Based Purchasing Payment Model:

Develop a comprehensive primary care value-based payment model that increases members' access to lower-acuity settings, preventive care, and chronic disease management in order to reduce potentially avoidable and preventable ED and hospital utilization. This recommendation will require new general funds to support increased Medicaid primary care payment so that it is comparable with Medicare payment and supports coverage of complex care management services and access-promoting services. The funding increase would be made through value-based, as opposed to volume-based, payments specifically designed to meet set goals. A primary care VBP model could accomplish the policy goals of 1, 2, and 3 listed above as well as provide the flexibility for primary care providers to financially support other interventions not specifically paid under a fee-for-service structure that would reduce potentially avoidable utilization.

Approaching primary care through a value-based payment model requires new general fund spending to increase reimbursement rates in primary care. Increased payment could expand access to primary care services for members and introduce necessary flexibility for primary care providers—both financially and programmatically—to deliver the necessary and appropriate care and support members' needs. With enhanced funding and flexibility, there is also opportunity to introduce expectations of practice features and effective, efficient and innovative primary care for improved quality and outcomes for Medicaid members.

This recommendation would provide value-based payments to primary care in an amount that would bring successful practices in line with Medicare payment rates. This option would increase members' access to lower-acuity settings, preventive care, and chronic disease management in order to reduce potentially avoidable and preventable ED and hospital utilization as well as support coverage of complex care management services and access-promoting services. Non-volume based payments provide flexibility in time and resources to perform activities and services that improve the health and wellbeing of members that are not typically reimbursed under fee-for-service or volume based payments. This option received consensus support: 7 members generally supported, and 1 member abstained.

Conclusion

The workgroup reviewed and assessed a large amount of data, information, and examples from stakeholders related to emergency department and hospital utilization and the requisite coordination of care. From the seven meetings, the workgroup considered, discussed and voted on 17 policy options and found consensus support for 11. [Appendix III](#) lists all policy options and the detailed voting results from workgroup members.

Next Steps

In prioritizing content, there are aspects to care coordination, emergency department utilization, and hospital readmissions not addressed by the workgroup. For example, in the case of freestanding emergency departments, the data was insufficient to thoroughly examine and discuss the topic. This group is dedicated to reconvening to review data on free-standing EDs and the impact they may have on utilization and costs trends once reliable data is available. DMAS has the authority to collect information on whether services were rendered in a free-standing ED under Appropriations Act Item 313 HHHHHH.

Throughout the workgroup discussions, members raised the relationship between social needs (i.e. housing, transportation, food, etc.) and utilization of health care services—particularly higher-acuity services such as ED visits, hospitalizations, and readmissions. This group is interested in tracking and supporting the implementation of DMAS' 1115 waiver for high-needs support services in 2022 for housing and employment support services.

Appendix

I. Chapter 1290, Item 313YY of the 2020 Appropriations Act.

The Department of Medical Assistance Services shall convene a workgroup to evaluate and develop strategies and recommendations to improve payment policies and coordination of care in the Medicaid program to encourage the effective and efficient provision of care by providers and health care systems serving Medicaid members. The workgroup shall include representatives from the Virginia Hospital and Healthcare Association, hospitals, the Virginia Association of Health Plans, managed care organizations, emergency department and primary care physicians, and other stakeholders deemed necessary by the department. The workgroup shall: (i) evaluate the appropriate coordination of services and cooperation among Medicaid managed care organizations (MCOs), hospitals, physicians, social services organizations, and nonprofit organizations to achieve a reduction in hospital readmissions, improved health outcomes, and reduced overall costs of care for conditions with high rates of hospital readmission in the Medicaid program; (ii) examine the role of hospital discharge planning and MCO care coordinators in assisting Medicaid beneficiaries with access to appropriate care and services post-discharge and other factors that may contribute to higher rates of readmission such as social determinants of health that could impact a patient's readmission status; (iii) assess the effectiveness of past and current mechanisms to improve outcomes and readmission rates by hospitals and health care systems and best practices and models from federal programs and other states; (iv) assess how to prevent inappropriate utilization of emergency department services; (v) examine the role of MCO care coordinators in assisting Medicaid beneficiaries access to appropriate care, including Medicaid beneficiary access to and the availability and use of alternative non-emergency care options, adequacy of MCO provider networks and reimbursement for primary care and alternative non-emergency care options, and the effectiveness of past and current mechanisms to improve the use of alternative non-emergent care by Medicaid beneficiaries; (vi) evaluate the impact of freestanding emergency departments and hospital emergency department marketing on emergency department utilization along with lower-cost options for triage of non-emergency cases to alternative settings; (vii) consider other states efforts to address emergency department utilization, including the use of medical and health homes, alternative primary care sites, and programs to coordinate the health needs of "super-utilizers"; and (viii) consider strategies to engage in value-based payment arrangements and other forms of financial incentives to encourage appropriate utilization of services and cooperation by health care providers and systems in improving health care outcomes, including a review of designated Performance Withhold Program measures, Clinical Efficiency measures, and other existing or potential programs. The department shall provide data on emergency room utilization and hospital readmissions of Medicaid beneficiaries to the workgroup to assist in its evaluation and analysis. The department shall report on the workgroup's findings and recommendations to the Joint Subcommittee for Health and Human Resources Oversight by December 15, 2020.

Note that in the 2021 Special Session, Chapter 520, Item 313YY the report date was updated to November 1, 2021.

II. Workgroup Members

Workgroup Member	Organization
Dr. Ellen Montz	DMAS
Beth Bortz	Virginia Center for Health Information
Dr. Charles Frazier	Riverside Health System, Virginia Academy of Family Physicians
Doug Gray	Virginia Association of Health Plans
Melinda Hancock	Sentara Healthcare
Dr. Todd Parker	Riverside Health System,
Jennie Reynolds	Anthem HealthKeepers Plus
Kyle Russell	Virginia Health Information
Lanette Walker	Virginia Health and Hospital Association

III. Full List of Policy Options Considered and Workgroup Voting Results

Policy Option	Voting Results
<p>Increase Primary Care Rates to Promote Increased Access to Care: Currently, Medicaid pays primary care providers approximately 76% of Medicare rates. To increase access to providers and care that could help reduce inappropriate ER utilization and avoidable hospital readmissions, the General Assembly could consider bringing payment for PCPs more in line with Medicare, including Medicare’s regional variation in rates, to improve the financial viability of practices serving Medicaid members.</p>	<p>Consensus Support</p>
<p>Fund chronic care management activities in lower-acuity settings to align payment levels with the extent of activities and services provided by eligible downstream providers, like PCPs, to reduce avoidable/preventable utilization in the ED and hospital. Coverage for these services could initially target complex care management services for specific conditions with the highest rates of ED utilization and hospital readmissions.</p>	<p>Consensus Support</p>
<p>Targeted Increased Payment Rates for Access-Promoting Services: Fund an increase for CPT codes associated with extended hours access to services such as nights, evenings, weekends, and holidays. Increasing payment for services provided outside of normal business hours (weekdays 9 a.m. – 5 p.m.) may increase access to services for Medicaid members, and potentially reduce avoidable and unnecessary ED utilization. Targeted interventions to increase access to primary care services, particularly outside of business hours, is consistent with CMS guidance on reducing inappropriate utilization of emergency rooms³¹.</p>	<p>Consensus Support</p>
<p>Support and Fund Expansion and Adoption of EDCC among Downstream Providers: Provide VHI with support to address barriers to onboarding downstream, non-acute providers to the Emergency Department Care Coordination platform (EDCC). Onboarding efforts could focus on providers with large Medicaid patient panels to prioritize access to the real-time notification to providers that treat higher volumes of Medicaid members. Such efforts could include, but are not limited to, funding to support additional staffing and contract resources for provider outreach and streamlining legal and administrative requirements for onboarding to the EDCC.</p>	<p>Consensus Support</p>
<p>Expand Care Insights for Medicaid Members with Frequent ED Utilization (10+ ED Visits in 12 Months): VHI should continue and expand efforts to increase the use of Care Insight in their EDCC records among members with 10 or more ED Visits in 12 months. The percentage with Care Insights could be increased from 7% to 50%. DMAS could set an improvement target for MCOs to double the percentage of Medicaid members with 10+ ED visits in 12 months that have a Care Insight annually, until the target of 50% is reached. After achievement of the initial target, DMAS can work with MCOs and VHI to set a future benchmark and/or improvement targets.</p>	<p>Consensus Support</p>

³¹ CMS. Reducing Non-urgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. January 16, 2014 (link).

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<p>Align Measurement efforts: DMAS, VHI, VHHA, MCOs, and other stakeholders should adopt unified definitions for ED categories in order to better describe, analyze, and report ED utilization. An aligned, unified language will provide enhanced discussion, analysis, policy development, and assessment of strategies in this area.</p>	<p>Consensus Support</p>
<p>Develop an Embedded Care Coordination Model for Behavioral Health: DMAS could implement an integrated treatment model within high volume Medicaid outpatient centers of behavioral health. The goal would be to target individuals with chronic medical conditions and co-occurring mental health disorders to increase continuity of care. This model would embed a physical health practitioner in high-volume outpatient behavioral health provider/therapy practices and Community Service Boards to connect with members who have a history of being difficult to engage, low acuity non-emergent ER utilization, potentially preventable inpatient admissions, appointment/medication non-adherence, and/or identified gaps in care for their medical conditions to include preventative health screenings. The physical health practitioner would provide education on physical health diagnosis and management, referrals/appointments for PCP/specialist intervention and follow-up, basic health screenings (i.e. in-house lab work, diabetic screenings, monitor blood pressure, weight checks, drug screenings, etc.), and work closely with the behavioral health provider(s) to integrate medical needs into a comprehensive integrated treatment plan to address whole-person health. Both the behavioral health and physical health practitioner would collaborate closely with the MCO care coordinator as part of an interdisciplinary care team. The care coordinator would assist practitioners in locating in-network providers, obtaining durable medical equipment, assist with medication pre-authorizations, schedule transportation, and collaborate around ED and IP admissions and discharges.</p>	<p>Consensus Support Among Workgroup Members that Voted.</p> <p>Abstention (1): Beth Bortz (VCHI)</p>
<p>Access to Providers in the Behavioral Health Continuum: Fund and support the adoption of evidence-based practices and training for existing behavioral health providers consistent with the continuum of behavioral health services outlined in Project BRAVO, and provide funding to expand the licensed mental health provider workforce to meet the behavioral health needs of the population.</p>	<p>Consensus Support</p>
<p>Encourage Emergency Departments to Implement a Bridge Program: Encourage Emergency Departments and health systems to implement a Bridge Program to screen patients, offer treatment (buprenorphine) in the ED, and refer individuals with substance-use disorder for outpatient follow-up at an office-based opioid treatment through grants to support training and implementation. The program could prioritize EDs with high prevalence of behavioral health and substance use disorders and access to appropriate outpatient office-based care in the community.</p>	<p>Consensus Support Among Workgroup Members that Voted.</p> <p>Abstention (1): Beth Bortz (VCHI)</p>
<p>Fund Direct Connection between MCOs and a CBO Network Coordinator: Fund access to a community based organization network coordinator for Medicaid MCOs as a critical partner in care coordination for Medicaid member health related social needs (HRSNs). Access to a community based</p>	<p>Consensus Support</p>

Policy Option	Voting Results
<p>organization (CBO) network coordinator would facilitate referrals to needed services for Medicaid members through the platform.</p>	
<p>Comprehensive Primary Care Value-Based Purchasing Payment Model: Develop a comprehensive primary care value-based payment model that increases members’ access to lower-acuity settings, preventive care, and chronic disease management in order to reduce potentially avoidable and preventable ED and hospital utilization. This recommendation will require new general funds to support increased Medicaid primary care payment so that it is comparable with Medicare payment and supports coverage of complex care management services and access-promoting services. The funding increase would be made through value-based, as opposed to volume-based, payments specifically designed to meet set goals. A primary care VBP model could accomplish the policy goals of 1, 2, and 3 listed above as well as provide the flexibility for primary care providers to financially support other interventions not specifically paid under a fee-for-service structure that would reduce potentially avoidable utilization.</p>	<p>Consensus Support Among Workgroup Members that Voted.</p> <p>Generally Support (7): Lanette Walker (VHHA), Melinda Hancock (Sentara Healthcare), Charlie Frazier (VAFP), Doug Gray (VAHP), Jennie Reynolds (Anthem Healthkeepers), Beth Bortz (VCHI), Kyle Russell (VHI)</p> <p>Generally Do Not Support (0):</p> <p>Abstention (1): Todd Parker (VACEP)</p>
<p>Medicaid Pilot of Trusted Broker Model: Fund VCHI to explore the Trusted Broker Model with stakeholders and define a business case for such a model to target Medicaid member health related social needs in a specific area. This effort should identify an area of focus likely to have significant impact on reducing members’ utilization of the ED or hospital readmissions.</p>	<p>Generally Support (3): Melinda Hancock (Sentara Healthcare), Kyle Russell (VHI), Beth Bortz (VCHI)</p> <p>Generally Do Not Support (4): Lanette Walker (VHHA), Todd Parker (VACEP), Doug Gray (VAHP), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Abstention (1): Charlie Frazier (VAFP)</p>
<p>Update VBP Targets in MCO Contracts to Emphasize more Advanced Alternative Payment Models: DMAS currently includes VBP targets in its managed care contracts requiring MCOs to have a percentage of relevant spending by MCOs to be in VBP arrangements (e.g. HCPLAN Categories 2-4) and must assure annual improvement until the target is achieved (Medallion 4.0 25%, CCC+ 10%). DMAS could increase the emphasis on VBP adoption within the Medicaid market by setting multi-year targets to increase VBP adoption and incorporating achievement of the VBP targets as a measure under the PWP. These targets could be set to prioritize the adoption of more advanced payment models (e.g. HCPLAN category 3 and 4) in future years.</p>	<p>Generally Support (5): Doug Gray (VAHP), Melinda Hancock (Sentara Healthcare), Kyle Russell (VHI), Beth Bortz (VCHI), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Generally Do Not Support (2): Lanette Walker (VHHA), Todd Parker (VACEP)</p> <p>Abstention (1): Charlie Frazier (VAFP)</p>

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Policy Option	Voting Results
<p>Modify Existing Hospital Readmission Payment Policy to include an Upside Performance Incentive (313 BBBB): Fund and authorize the creation a Medicaid hospital VBP program to add an upside financial incentive for hospitals that achieve reductions in potentially preventable, avoidable, and/or unnecessary hospital readmissions.</p>	<p>Generally Support (3): Lanette Walker (VHHA), Charlie Frazier (VAFP), Beth Bortz (VCHI)</p> <p>Generally Do Not Support (3): Doug Gray (VAHP), Melinda Hancock (Sentara Healthcare), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Abstention (2): Todd Parker (VACEP), Kyle Russell (VHI)</p>
<p>Modify Existing Emergency Department Policy (313 AAAAA) to include an Upside Performance Incentive: Fund and authorize the creation of a Medicaid hospital VBP program to add an upside incentive to reward hospitals that successfully reduce potentially avoidable and unnecessary ED utilization in the future.</p>	<p>Generally Support (3): Doug Gray (VAHP), Charlie Frazier (VAFP), Beth Bortz (VCHI)</p> <p>Generally Do Not Support (4): Lanette Walker (VHHA), Todd Parker (VACEP), Melinda Hancock (Sentara Healthcare), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Abstention (1): Kyle Russell (VHI)</p>
<p>Modify the Existing Hospital Readmission Payment Policy to Align with Medicare Hospital Readmissions Reductions Program (313 BBBB): Modify item 313 BBBB with an approach that aligns with the Hospital Readmission Reductions Program (HRRP) under Medicare to align priorities across programs for hospitals. A modified version of 313 BBBB could include aspects from the Medicare HRRP such as, measuring hospital performance relative to other hospitals with similar patient populations, risk adjusting performance, target condition- and procedure-specific measures with highest risk or utilization in Medicaid, and limit payment reductions similar HRRP.</p>	<p>Generally Support (4): Lanette Walker (VHHA), Todd Parker (VACEP), Melinda Hancock (Sentara Healthcare), Charlie Frazier (VAFP)</p> <p>Generally Do Not Support (2): Doug Gray (VAHP), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Abstention (2): Beth Bortz (VCHI), Kyle Russell (VHI)</p>
<p>Remove the Payment Down-code for the Emergency Department Policy (313 AAAAA): Repeal item 313, which down-codes emergency department visits based on principal diagnosis.</p>	<p>Generally Support (4): Lanette Walker (VHHA), Todd Parker (VACEP), Melinda Hancock (Sentara Healthcare), Charlie Frazier (VAFP)</p>

Policy Option	Voting Results
	<p>Generally Do Not Support (2): Doug Gray (VAHP), Jennie Reynolds (Anthem Healthkeepers)</p> <p>Abstention (2): Beth Bortz (VCHI), Kyle Russell (VHI)</p>