



# MEDICAID PAYMENT POLICY AND CARE COORDINATION WORKGROUP

Meeting 7

# Agenda

- ❑ Welcome
- ❑ Review and Discuss of Policy Options from Workgroup Members
- ❑ Review and Discuss Policy Options in Draft Report
- ❑ Voting Overview
- ❑ Closing

# Policy Options from Workgroup Members

# Workgroup Should Support the Parameters and Goals of the Virginia High Needs Support Services

- ✓ The High-Needs Supports benefit begins in July 2022 and include housing and employment services for members with at least 1 health needs based criteria and at least on housing or employment risk factor.

# Require MCOs to Contract with a Vendor that Provides a CBO Network

- ✓ Requires MCOs to have CBO networks to meet member needs.
- ✓ Prioritizes making referrals to CBOs in the CBOs preferred system.

# Rebalance the Medicaid Fee Schedule to Support Appropriate Care

- ✓ Adopt site-neutral rates for services, or adjust fees to increase rates in lower-cost settings, like primary care, and decrease rates in higher cost settings.
- ✓ Consider fee schedule rates that adjust for potential regional variation.
- ✓ Increase rates for after-hours primary care, or for longer hours to offer greater flexibility for members to access care.

# DMAS should study the Impact of Free- Standing EDs

- ✓ Assessment of common diagnosis codes for Medicaid members treated in freestanding ERs,
- ✓ Evaluation of the cost structure for freestanding ERs, and
- ✓ Explore policy options to prevent inappropriate development of freestanding ERs in place of lower cost, lower acuity facilities of comparable quality.
- ✓ Note: DMAS already has the authority to collect information on free-standing EDs (313 HHHHHH)

# Policy Options from Report Draft



# Policy Option 1 – Increase Primary Care Rates to Promote Access to Care

Currently, Medicaid pays primary care providers approximately 76% of Medicare rates . The General Assembly could consider bringing payment for PCPs more in line with Medicare to improve the financial viability of practices to see Medicaid members.

## Policy Option 2 – Include Coverage for Complex Chronic Care Management

Provide additional funding for chronic care management activities in lower-acuity settings to align payment levels to support qualified health professional time to establish, implement, revise, and monitor a comprehensive health plan to reduce avoidable/preventable utilization in the ED and hospital.

## Policy Option 3 - Targeted Payment Increases for Access-Promoting Services

The General Assembly could direct DMAS to increase the payments for CPT codes associated with extended access to services such as nights, evenings, weekends, and holidays to expand non-acute access to services for Medicaid Members.

# Policy Option 4 - Support and Fund Expansion and Adoption of EDCC among Downstream Providers

The General Assembly could provide VHI with direction and funding to address barriers to on-boarding downstream, non-acute providers to the EDCC. Onboarding efforts should focus on providers with large Medicaid patient panels to prioritize access to real-time notification to providers that treat high volumes of Medicaid members. Such efforts could include but, are not limited to, allowing additional customization of the amount and type of data a provider is able to receive, streamlining legal and administrative requirements to accessing such data, and the flexibility necessary to undertake additional efforts to appropriately expand EDCC access to providers with a member care business case for such access.

# Policy Option 4 - Support and Fund Expansion and Adoption of EDCC among Downstream Providers

Provide VHI with direction and funding to address barriers to on-boarding downstream, non-acute providers to the EDCC. Onboarding efforts should focus on providers with large Medicaid patient panels to prioritize access to real-time notification to providers that treat high volumes of Medicaid members. Such efforts could include but, are not limited to, allowing additional customization of the amount and type of data a provider is able to receive, streamlining legal and administrative requirements to accessing such data, and the flexibility necessary to undertake additional efforts to appropriately expand EDCC access to providers with a member care business case for such access.

## **Policy Option 5 - Expand Care Insights for Medicaid Members with Frequent ED Utilization (10+ ED Visits in 12 Months)**

VHI should set a target to increase the percentage of people with 10+ ED Visits in 12 months that have a Care Insight from about 7% to 50% over the course of one year.

DMAS should set targets for MCOs to ensure that at least 50% of members with 10+ ED visits in 12 months have a Care Insight.

# Policy Option 6 - Align Definitions for Emergency Department (ED) Utilization

DMAS, VHI, VHHA, MCOs and other stakeholders should adopt the categories of ED utilization from the Emergency Department Care Coordination tool (EDCC) for describing, analyzing, and reporting ED utilization. The categories are:

- ✓ rising risk (10-19 ED visits/12 months),
- ✓ high utilization (20-49 ED visits/12 months),
- ✓ super utilization (50-99 ED visits/12 months), and
- ✓ extreme utilization (100+ ED visits/12 months).

A unified and consistent language will enable better discussion, analysis, and communication of policy development in this area.

# Policy Option 7 - Develop an Embedded Care Coordination Model in Areas with High Behavioral Health Needs

The General Assembly could direct DMAS to develop an embedded care coordination model with high-volume Medicaid outpatient centers for behavioral health. The model could embed an MCO care coordinator in high-volume behavioral health outpatient settings to connect with hard to reach members, provide education on both physical and behavioral health benefits, encourage and aid in preventative care, assist in selecting a primary care provider, provide necessary referrals, assist with obtaining durable medical equipment, assist with medication pre-authorizations, schedule transportation, and visit members in the hospital prior to discharge.



## Policy Option 8 - Access to Providers in the Behavioral Health Continuum

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

# Policy Option 9 - Encourage Emergency Departments to Implement a Bridge Program

The General Assembly could require 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.

# Policy Option 10 - Fund Direct Connection between MCOs and Unite Us

The General Assembly could fund access to Unite Us for Medicaid MCOs as a critical partner in care coordination of medical and health related social needs for Medicaid Members.

**Break**

# Policy Option 11 - Medicaid Pilot of Trusted Broker Model

The General Assembly could provide funding and authority for DMAS to test the Trusted Broker Model on a defined intervention targeting Medicaid member health related social needs. This effort should focus on an area likely to have significant impact on reducing members' utilization of the ED or hospital readmissions.

## **Policy Option 12 - Update VBP Targets in MCO Contracts to Emphasized More Advanced Alternative Payment Models**

DMAS could update MCO VBP Targets to specify the expectations to transition payment arrangements to more advanced alternative payment models to support high-quality care and improved outcomes for members.

## **Policy Option 13 - Modify Existing Hospital Readmission Payment Policy to include an Upside Performance Incentive (313 BBBB)**

The General Assembly could fund and authorize the creation a Medicaid hospital VBP program which provides upside financial incentives for hospitals to achieve reductions in potentially preventable, avoidable, and/or unnecessary ED visits and include enhanced requirements around the hospital's use of the EDCC and accountability for designated performance metrics (e.g. PCP follow-up).

## **Policy Option 14 - Modify Existing Emergency Department Policy (313 AAAAA) to include an Upside Performance Incentive:**

The General Assembly could fund and authorize the creation of a Medicaid hospital VBP program to add an upside incentive—similar to the Washington example—to reward hospitals that successfully reduce unnecessary ED utilization.



# **Policy Option 15 - Modify the Existing Hospital Readmission Payment Policy to Align with Medicare Hospital Readmissions Reductions Program (313 BBBBB)**

The General Assembly could 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.

# **Policy Option 16 - Remove the Payment Down-code for the Emergency Department Policy (313 AAAAA)**

The General Assembly could repeal item 313 AAAAA, which down-codes Medicaid emergency department visits based on principal diagnosis.

# Policy Option 17 – Develop a Primary Care VBP Model

DMAS should develop a comprehensive VBP payment model –encompassing policy options 3, 4, and 5—to shift payment from volume to value and increase members’ access to lower-acuity settings, preventive, and chronic disease management to reduce potentially avoidable and preventable ED and hospital utilization.

# Workgroup Voting

# Workgroup Voting Details

- ✓ DMAS will make final refinements based on today's conversation and send out an excel sheet (**by 7/14**) with each option.
- ✓ Workgroup members will document their vote in the excel sheet and submit to Melissa Mannon ([Melissa.Mannon@dmas.Virginia.gov](mailto:Melissa.Mannon@dmas.Virginia.gov)) **by 7/21**.
- ✓ Voting options:
  - Generally Support
  - Generally do NOT Support
  - Abstain
- ✓ If DMAS does not receive your vote sheet by 7/21, DMAS will assume that is an abstention.

# Next Meeting and Timelines

- ✓ **August:** DMAS to incorporate final input, votes, and complete drafting
- ✓ **September & October:** Department & administration review
- ✓ **November 1, 2021:** Report due to the General Assembly