MEDICAID PAYMENT POLICIES AND CARE COORDINATION WORKGROUP

Meeting 3

December 17, 2020
Meeting Agenda

- Welcome and Introductions
- Review of Strategies to Address ED Utilization and Hospital Readmission
- Virginia Efforts to Reduce Unnecessary ER Utilization and Hospital Readmissions: A New Collaborative Approach is Needed
- Group Discussion
- Homework
- Adjourn
Disclaimer

The primary goal of this workgroup is to provide a report to the General Assembly highlighting data, findings, and recommendations in the areas of emergency room utilization and hospital readmissions. As a reminder, this meeting is open to the public and all information shared and presented during workgroup activities, may be made public and/or included in this public report to the Virginia General Assembly.
Public Comment

Public comments should be submitted to Rusty Walker (rusty.walker@dmas.virginia.gov) and will be collected for distribution to workgroup members.
Medicaid Payment Policies and Care Coordination Workgroup

Review of Strategies to Address ED Utilization and Hospital Readmissions

Jennie Echols, PhD, MSN, RN
Principal
Commonwealth of Virginia
December 17, 2020
Agenda

1. Reengineering the System
   - Impact on Preventable and Avoidable Emergency Department Visits and Hospital Readmissions
   - Systemic View

2. Potentially Preventable and Avoidable Emergency Department Utilization
   - Drivers
   - Solution Types
   - Example Strategies

3. Potentially Preventable Hospital Readmissions
   - Drivers
   - Solution Types
   - Example Strategies

4. Conclusion and Considerations
What is the most important solution to impact Potentially Preventable and Avoidable ED Visits and Hospital Readmissions?

1. Provider Access and availability to primary care
2. Communication between hospital and providers
3. Programs and Process
   - Care management
   - Addressing SDOH
4. TOC and Community Re-Integration
5. Technology and telehealth
6. Payer financing models
# Healthcare Ecosystem

<table>
<thead>
<tr>
<th>Member</th>
<th>Medicaid Agency</th>
<th>Health Plan</th>
<th>Hospital</th>
<th>Health Providers</th>
<th>Community</th>
<th>Pharmacies</th>
</tr>
</thead>
</table>

## Solution Type

<table>
<thead>
<tr>
<th>Provider Access &amp; Availability</th>
<th>Communication</th>
<th>Programs &amp; Process</th>
<th>TOC &amp; Community Re-Integration</th>
<th>Technology</th>
<th>Financial</th>
</tr>
</thead>
</table>
Model Approaches
Reducing Potentially Preventable and Avoidable ED Visits
Drivers

Provider Communication

Convenience

Medication Access

Primary Care Access & Availability

Member Knowledge & Health Literacy

High-Risk & Chronic Conditions

Behavior Health Conditions

Social Determinants of Health

Member Knowledge & Health Literacy
Solution Type
Provider Access & Availability

**Initiator**
- Medicaid Agency ED Diversion Grant PA (Access 1)
- Medicaid Agency ED Diversion Grant NJ (Access 2)
- Medicaid Agency KY (Access 3)
- Community OK (Access 4)
- National Priorities Partnership Convened by National Quality Forum (Access 5)
- Community TX (Access 6)
- Hospital OK (Access 7)

**Initiative**
- Increased hours
- ER Navigators - finding medical home
- Community collaborations
- FQHC as medical home with 24/7 access
- Bundled services:
  - Medication education
  - Transportation
  - Triage/Nurse Lines
  - Telehealth
- CHC as regular source of care
- Workflows re-designed to address EMTALA

**Results**
- ED decreased by almost 40%
- ED transports decreased 56%
Communication

**Initiator**
- Medicaid Agency and Providers KY (Communication 1)
- Medicaid Agency OR (Communication 2)
- Medicaid Agency WA (Process/Management 1)

**Initiative**
- PCP, hospital and Medicaid Agency collaboration
- Staff training
- Care coordination
- Peer consultation
- Health information technology
- Communication plans via HIE

**Results**
- No results reported
Programs & Process

Initiator

• Medicaid Agency WA (Program & Process 1)
• Medicaid Agency Partnership for EDCC MI (Program & Process 2)
• Health Plan CA (Program & Process 3)
• Health Plan OH (Program & Process 4)
• Medicaid Agency OR (Program & Process 5)

Initiative

• Care management for ED frequent users
• Health literacy
• Expanding transition of care
• Identification of at-risk populations
• Self-management skills
• Medication management
• Primary care re-engagement
• Health Engagement Team (MD, RN, SW, CHWs)
• 24/7 nurse advice line

Results

• 49% reduction in ED visits
• 56% ED diversion saving of $1.7 million
TOC & Community Re-Integration

**Initiator**
- Medicaid Agency WA (TOC & Community Re-integration 1)
- Medicaid Agency KY (TOC & Community Re-integration 2)
- Health Plan CA (Program & Process 3)

**Initiative**
- PCP, hospital and Medicaid Agency collaboration
- MCO member education and follow-up
- Patient navigators
- High-risk member follow-up by Care Coordinators, 2, 7 days, then 7 days later and again 14 days later

**Results**
- Case managers evaluate stability and continued need for follow-up beyond 30 days
- ED visits declined by 9.9% and the rate of visits by frequent users fell by 10.7%.
- $33.6 million in savings
- ED visits decrease
Technology

**Initiator**
- Medicaid Agency OR (Technology 1)
- Medicaid Agency WA (Technology 2)
- Military Health System (Technology 3)
- Study by Eastern Virginia Medical School (Technology 4)
- Study by Medical University of South Carolina (Technology 5)

**Initiative**
- EDIE, High Utilizer/Complex
- E-info between hospitals and providers
- Secure messaging, Nurse Advice Line (NAL), patient portal, mobile apps, virtual primary care visits, and telehealth to monitor patients in remote area
- Video after-hours telehealth calls
- School-based telehealth for children with asthma in a rural areas of SC
- School nurses, connect with providers, via a telehealth cart

**Results**
- PPV by high utilizers decreased by 10.9%
- Frequent user ED fell by 10.7%
- Reduced from > 3ER visits/1000 in 2012 to < 2.5 visits/1000
- 21% reduction in asthma ED visits with access to school-based telehealth
Financial

Initiator
- Medicaid Agency OR (Finance 1)
- Medicaid Agency WA (Finance 2)
- Medicaid Agency MN (Finance 3)
- Medicaid Agency WY (Finance 4)
- Medicaid Agency PA Integrated Care Program (Finance 5)

Initiative
- Uses “bonus quality pool” to reward Coordinated Care Organizations for quality
- One metric is ED utilization among beneficiaries with mental illness
- Hospitals can earn a 1% incentive payment under the Medicaid Quality Incentive Program for reduced ED
- Managed Care Withhold
- Performance Payment Targets
- Provider VBP

Results
- ED visits decreased by 13%
Model Approaches

Reducing Potentially Preventable Hospital Readmissions
Drivers

01 Readmission Risk
02 Caregiver Support
03 Primary Care Access & Availability
04 High-Risk & Chronic Conditions
05 Social Determinants of Health
06 Behavior Health Conditions
07 Member Knowledge & Health Literacy
08 Medication Management
Solution Type

- Provider Access & Availability
- Process & Management
- Medication Management
- TOC & Community Re-integration
- Technology
- Financial
- Communication
Provider Access & Availability

**Initiator**
- Study – Weill Cornell Medical College (Access 1)
- Informational article - National Health Center Week (Access 2)
- Article – ACP Hospitalist (Access 3)

**Initiative**
- Early primary care follow-up
- FQHCs reduce health disparities, effectively manage chronic diseases
- Access in high-need areas
- Risk factor identification to target for follow-up

**Results**
- Lower 30 day readmission rate
- 5.8 fewer preventable hospitalizations per 1,000
Communication

Initiator

• Hospital CA (Communication 1)

Initiative

• Multidisciplinary collaborative team to coordinate discharge and transition of care

Results

• 30 day readmission rate reduced to 5.27% compared to 19.6% in preceding period
Process & Management

Initiator

- Health Plan CA (Program & Process 1)
- Hospital NY (Program & Process 2)
- Hospital MA (Program & Process 3)
- Study – University of North Carolina Dept of Medicine and Pediatrics (Program & Process 4)
- Hospital VA and National (Program & Process 5)
- Hospital VA – VHHA “Home is the Hub” Initiative (Program & Process 6)
- Study – Siouxland Medical Education Foundation (Program & Process 7)

Initiative

- Chronic care management and psychosocial needs
- TOC visits by team (care coordinator, RN and SW)
- Re-focused inpatient discharge process
- Member Education
- Care coordination
- Post-discharge follow-up clinic visits and phone calls
- Education
- Discharge bundle
  - Medication review, discharge education and follow-up appointments
- TOC Coach roles
- BOOST
- Medication reconciliation
- Pharmacist follow-up OP visits
- RED with 12 components

Results

- 30 day readmissions reduced to 5.27% from 19.6%
- 60 day readmissions reduced to 17.6% from 26.3% in control group
- 11.1% decrease in 30 day readmissions
Medication Management

Initiator

- Pharmacy Study (Siouxland Medical Education Foundation, IA (Medication Management 1)
- Hospital – Study Value Institute, Christiana Care Health System, Newark, DE (Medication Management 2)

Initiative

- OP pharmacist visit
- DPP – Patients are able to pick up filled medications as part of discharge process

Results

- Participation in the DPP decreased odds of 7-day readmission by 20% and of 30-day readmission by 16%
- Resulted in 30-day readmission of 9.2% from 19.4%
- Decreased odds of 7-day readmission by 20% and of 30-day readmission by 16%
**TOC & Community Re-Integration**

**Initiator**
- Study - CMS Submitted study from Vanderbilt University, TN (TOC & Community Re-Integration 1)
- Informational Article, News Medical and Life Sciences (TOC & Community Re-Integration 2)
- Study – Patient-Centered Outcomes Research Institute (TOC & Community Re-Integration 3)
- Study – University of Pennsylvania School of Nursing (TOC & Community Re-Integration 4)
- Study – University of Florida (TOC & Community Re-Integration 5)

**Initiative**
- Bundled Interventions
  - Pre-discharge interventions
  - Post-discharge interventions
  - Bridging interventions
- Coleman Care Transition Interventions
- Peer support
- Naylor Transitional Care Model
- Interprofessional Transition of Care Clinic

**Results**
- Reduced patient visits to specialists by 24%, ED visits by 13% and hospitalizations by 39%
- 22% reduction in likelihood of readmission
- 34% reduction in average number of readmissions
- $4,500 savings per patient
- 60% reduced odds of 90 day readmissions
Technology

**Initiator**
- Health Plan – Multistate (Geisinger Center for Health Research) (Technology 1)
- Study – Canada (SMART Program) (Technology 2)

**Initiative**
- Interactive voice response protocol with post-hospital discharge tele-monitoring system
- Remote monitoring medical devices automatically sends results to home health care professional

**Results**
- 44% reduction in 30-day readmissions
- 35% reduction in hospitalizations
Financial

**Initiator**
- CMS National (Finance 1)
- Medicaid Agency OH (Finance 2)
- Medicaid Agency MN (Finance 3)
- Medicaid Agency PA (Finance 4)

**Initiative**
- HRRP – Hospitals are financially penalized for higher 30-day readmission rates for acute myocardial infarction, heart failure and pneumonia
- CCTP – To test models for improving care transitions and reducing readmissions
- Used 3M software to identify potentially preventable admissions and determine if future rewards or penalties will occur
- Provider APM
- MCO Withholds
- Payment Incentives

**Results**
- All-cause 30-day readmission rate fell from 19.5% in 2011 to 17.5% in 2013
Model Approaches
Conclusions and Considerations
Conclusions

Access
Primary Care
Urgent Care
Telehealth

Care Management
Care Coordination
Chronic Care Management
Case Management

Member
Social Determinants of Health
Education

Communication
Information Exchange
Team Collaboration
Person-to-Person

Copyright © 2020 Mercer (US) Inc. All rights reserved.
Key Considerations

State
- Defining progressive results
- Legislation and authorities
- Data analytics
- Reporting
- Continued stakeholder input
- Readiness of Market

MCO
- Resources
- Data analytics
- Paradigm shift
- Reporting
- Network design and contracting
- Care management
- Provider transformation

Hospital and Providers
- Resources
- Paradigm shift
- Communication technology
- Analytics and reporting abilities
- Reporting
- Modified workflows
- Need streamlined interface
Questions

Making a difference in people’s lives
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>BOOST</td>
<td>Better Outcomes for Older Adults through Safe Transitions</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CCTP</td>
<td>Community-Based Care Transitions Program</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>DPP</td>
<td>Discharge Prescription Program</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EDCC</td>
<td>Emergency Department Care Coordination</td>
</tr>
<tr>
<td>EDIE</td>
<td>Emergency Department Information Exchange</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>ETHAN</td>
<td>Emergency Telehealth and Navigation</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Labor Act</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Care</td>
</tr>
<tr>
<td>GMP</td>
<td>Geisinger Monitoring Program</td>
</tr>
<tr>
<td>HET</td>
<td>Health Engagement Teams</td>
</tr>
<tr>
<td>HCFO</td>
<td>Health Care Financing and Organization</td>
</tr>
<tr>
<td>HIE</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>HRRP</td>
<td>Hospital Readmission Reduction Program</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>PCMH</td>
<td>Patient Centered Medical Home</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>RED</td>
<td>Re-Engineered Discharge</td>
</tr>
<tr>
<td>ROI</td>
<td>Return on Investment</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>SME</td>
<td>Subject Matter Expert</td>
</tr>
<tr>
<td>TOC</td>
<td>Transition of Care</td>
</tr>
<tr>
<td>VBP</td>
<td>Value-Based Purchasing</td>
</tr>
<tr>
<td>VHHA</td>
<td>Virginia Hospital and Healthcare Association</td>
</tr>
</tbody>
</table>
Virginia Efforts to Reduce Unnecessary ER Utilization and Hospital Readmissions: A New Collaborative Approach is Needed
• Mercer report reviews numerous national, state and local programs, featuring a wide variety in the entity offering the program:

  • Hospital-based initiatives
  • Health plan departmental initiatives
  • Community-based initiatives
  • Urgent care and primary care based initiatives

And the type of approach employed:

  • Education
  • Case management
  • Disease management
  • Care coordination
  • Pharmacological
Virginia Research Yields Similar Findings

• In follow-up to the hospital and health plan presentations we heard at our last meeting, VCHI identified six additional programs that appear to have yielded positive results.

• These are:
  • Bay Area Agency on Aging: VAAA Cares
  • Patient First: ConnectVA
  • UVA Health: Population Health and Interactive Home Monitoring from the Emergency Department for COVID patients
  • UVA Health: Home Team Program
  • Virginia Health Care Foundation: Taking Aim, Improving Health
  • Walgreens: Specialty Pharmacy Extended Prescription Fill Program
<table>
<thead>
<tr>
<th>Brief Program Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ConnectVA Utilization</strong></td>
</tr>
<tr>
<td><strong>Extended Prescription Fill Program</strong></td>
</tr>
<tr>
<td><strong>Home Team Program</strong></td>
</tr>
</tbody>
</table>
### Brief Program Descriptions Continued

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health and Interactive Home Monitoring from the ED for COVID Patients</td>
<td>Remote in-home monitoring technology has become an increasingly important means to conserve hospital and ED capacity while providing observation and care for high-risk patients with milder symptoms during the COVID-19 pandemic. UVA aimed to evaluate the safety of introducing an Interactive Home Monitoring program (IHM) for high-risk patients discharged from the emergency department (ED) with suspected or confirmed COVID-19 who without remote monitoring would have required admission to the hospital.</td>
</tr>
<tr>
<td>Taking Aim, Improving Health</td>
<td>VHCF awarded six grants to stimulate and/or strengthen collaboration between hospitals and their local primary care health safety net organizations (free clinics and community health centers) to reduce avoidable hospital admissions and Emergency Department visits by uninsured patients via population health initiatives. The six grantees used differing approaches to intervene with a total of 1,095 high-cost charity care patients during the 18-month grant period.</td>
</tr>
<tr>
<td>VAAA Cares</td>
<td>VAAACares is a statewide one-stop-shop collaborative performing hospital to home interventions and services addressing non-medical risk factors shown to improve health outcomes and reduce the cost of care. Services delivered in the home and community that address transportation issues, manage chronic disease, address food insecurities, prevent falls, reduce social isolation, and more, are proven supports that maximize independence and functioning.</td>
</tr>
</tbody>
</table>
With So Many Good Ideas – Why Do We Have Such a Problem?

• First, current data and limited previous evaluation efforts make it difficult to effectively review many of the interventions.

• But even for programs with rigorous evaluation data and demonstrated positive returns on investment, we still struggle to take them to scale and sustain them.

• Consider the case of VAAA Cares.
VAAACares® - Virginia’s Area Agencies on Aging Caring for the Commonwealth

- Statewide collaborative performs hospital to home care transitions intervention (CTI) wherein health coaches go to the home within 48 hours +/- of discharge from acute care to prevent unnecessary 30 day readmission. They:
  
  * Review patient’s health acumen with instructions and medications, make sure patient has meds and knows how to take them, knows warning signs of need to call doctor, and has follow up care in place with transportation to get there.
  
  * Teaches chronic disease self-management, fall prevention, depression interventions, etc., as necessary
  
  * Arranges for needs from Social Determinants of Health
Outstanding Performance — Reductions in 30 Day readmissions and emergency department visits

- Performance reports show a 66% decrease in Medicare hospital readmission and a 60% decrease in Medicaid readmission.
- One demonstration involving hospital extremely high utilizers resulted in nearly half of the participants having no ED utilization and another group had a 56% decrease in utilization of EDs in the several months following the CTI intervention.

Budgets — Revenues stay in Virginia

- Costs are nominal, ranging from $356 per intervention to $450 if RN services are needed.
- Nonetheless VAAACares® realizes modest net revenue from these programs when sufficient referral volume occurs from payers (health systems or health plans). In turn, these funds are reinvested directly into local communities, off-setting costs of increasing needs of services for older citizens.
**National Awards –**

- VAAACares® is recognized as the premier leader in forming the first statewide collaborative for business with MCOs. In January 2020, it was heralded as the #1 program in the U.S. by the Administration for Community Living based on:
  - $6.4 million in savings due to decrease in hospital readmissions
  - 48% had no ER visits in 4 months following intervention
  - Performed 26,000 home visits over 3 years
  - VAAACares® has done presentations for Ohio, Indiana and Colorado about their business model, and these states are requiring MCOs to contract with AAAs for assessments, care transitions, and/or care coordination
Care Transitions Intervention Outcomes

Readmission Reduction Rates

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Enrollments</th>
<th>Expected Readmissions</th>
<th>Enrollee Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Medicare Demonstration 2/2013 - 1/2016</td>
<td>23278</td>
<td>5447</td>
<td>2221</td>
</tr>
<tr>
<td>Other Medicare 2/2016 - 12/2017</td>
<td>3474</td>
<td>813</td>
<td>145</td>
</tr>
<tr>
<td>General Assembly Funded Medicaid Pilot 7/2016 - 6/2017</td>
<td>1046</td>
<td>262</td>
<td>40</td>
</tr>
<tr>
<td>MCO Duals 4/2016 - 12/2017</td>
<td>893</td>
<td>223</td>
<td>68</td>
</tr>
<tr>
<td>VAAACares® MLTSS 11/2017 - 7/2020</td>
<td>5881</td>
<td>1470</td>
<td>756</td>
</tr>
</tbody>
</table>

Readmission Reduction Rates:
- CMS Medicare Demonstration: 23.4% to 9.5%
- Other Medicare: 23.4% to 4.2%
- General Assembly Funded Medicaid Pilot: 25% to 3.8%
- MCO Duals: 25% to 7.7%
- VAAACares® MLTSS: 25% to 12.8%
Care Transitions Reduction Pilot - Highest Utilizers

Outcomes for 89 Enrollees (Medicaid & Medicare)

43 of the 89 Enrollees had 100% Decrease Utilization

Prior to Enrollment
63 ED Visits
35 Hospital Admissions

Post Enrollment
0 ED Visits
0 Hospital Admissions

35 Enrollees Reduced Utilization by 56.1%
With no 30-Day Readmissions

11 Enrollees Readmitted Within 30-Days of Discharge
So What’s The Problem?

• Why have VAAA Cares and other seemingly successful initiatives not seen wider scale adoption?

• Virginia isn’t the only state wrestling with this challenge

• The Trusted Broker Model may be a solution
Collaborative Approach to Public Good Investments (CAPGI):
A Sustainable Financing Tool For Communities

Len M. Nichols, Ph.D.
Urban Institute
December 17, 2020
Value Creation from Upstream Interventions

- Improved Health and well-being
- Stronger Community
- Lower Costs, or Mission-Consistent Value

How Long?

City Hall

Value Creation from Upstream Interventions

- Improved Health and well-being
- Stronger Community
- Lower Costs, or Mission-Consistent Value

How Long?

City Hall
Social Determinants As Public Goods: A New Approach To Financing Key Investments In Healthy Communities

CAPGI Helps Stakeholders Find Fair and Effective Prices to Pay for Intervention

• Private Solutions to “Free-Rider” problem possible under 2 conditions
  o Operational local stakeholder coalition
  o “Trusted Broker”

• Those conditions are widespread today

• Key elements of CAPGI model:
  o Reveal willingness to pay to the trusted broker only
  o If aggregate value > cost, we help TB assign fair prices so that surplus is shared
  o Contributions and Sustainability are based on enlightened self-interest
Example of Pricing for Upstream Investments

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

Value Expressed

- Insurers
  - Initial Bid: $110
- Hospitals
  - Initial Bid: $50
- Non-Vendor CBOs
  - Initial Bid: $40

Sum of Bids (Collective Valuation) = $110 + $50 + $40 = $200

But We only Need $180 to Cover the Cost

so

We need 90% (180/200) of Total
We can allow 10% “Discount” to All Bidders

Note: Fairness Constraints Satisfied!!

Prices Assigned

- Insurers
  - Price Charged: $99
    ($11 less than Bid)
- Hospitals
  - Price Charged: $45
    ($5 less than bid)
- Non-Vendor CBOs
  - Price Charged: $36
    ($4 less than bid)

Total Collected = $180 = Cost of Intervention = $180, but **VALUE delivered = $200**
CAPGI Locations and SDOH Foci

- Spokane, WA
- Grand Junction, CO
- Waco, TX
- Anne Arundel County, MD
- Kansas City, KS/MO
- Springfield, MO
- Cleveland, OH
- DC
- Hartford, CT
- Eastern Virginia

- Permanent Supportive Housing (PSH)
- Case Mgt. for SI older adults in Section 8 housing
- CHW services for those w/ Behavioral Health Risk
- Tiny Houses for the Homeless
- Upstream for high-risk of re-admission
- Family Connect
- Medically Tailored Meals for SI older adults
- Navigation redesign to improve BRCA outcomes
- Improving parents’ ability to manage asthmatic children
- Reduce readmissions
Challenges So Far

• COVID-19

• Health care sector generally wary of “charity” requests

• Most SDOH interventions likely require Medicaid “permission”
  • Definitions of *in lieu of* or *value added*
  • Value based pricing initiatives
  • Conditional increases in allowed profit rates

• Novel interventions have less compelling evidence of impact
QUESTIONS?

lnichols@urban.org
Next Meeting and Timelines

✔ Next Draft Review:
  - DMAS will send a second draft in early January for workgroup members to review and provide input by January 29, 2021.
    - The draft will include a revised ED/Readmissions section, and new sections incorporating the care coordination and discharge planning content from meeting 2.

✔ Next Meeting:
  - March 26, 2020, 3:00-5:00 p.m.
ADDENDUM 1: READMISSIONS AND POTENTIALLY PREVENTABLE ER VISIT MAPS
Maps for Potentially Preventable ER Visits and Hospital Readmissions

- In Meeting 1, workgroup members requested to 1) see potentially avoidable ER visits and hospital readmissions by county and 2) those same measures with hospital locations.
- The following slides show the results from the DMAS clinical efficiency measures on potentially preventable ER visits and hospital readmissions by county with hospital locations.
  - A darker shade indicates a higher rate.
  - For both measures, a lower rate is the optimal outcome.
Counties are shaded blue based on the rate of potentially preventable ER Visits per 1000 member months. Darker blue indicates a higher rate of potentially preventable ER Visits. For more information on the DMAS clinical efficiency measures, visit [www.dmas.virginia.gov/#/valuebasedpurchasing](http://www.dmas.virginia.gov/#/valuebasedpurchasing)

The red dots represent hospitals across the Commonwealth based on VHHA data on hospital location.
 Counties are shaded red based on the rate of potentially preventable ER Visits per 1000 member months. Darker red indicates a higher rate of potentially preventable ER Visits. For more information on the DMAS clinical efficiency measures, visit [www.dmas.virginia.gov/#/valuebasedpurchasing](http://www.dmas.virginia.gov/#/valuebasedpurchasing)

-The blue dots represent hospitals across the Commonwealth based on VHHA [data](http://www.dmas.virginia.gov/#/valuebasedpurchasing) on hospital location.