Providing High-Value Care for High-Risk Members of Medicaid ACOs

Chad Boult, MD, MPH, MBA

Faculty, Boise State University

Former Professor, Johns Hopkins School of Public Health

Optimizing “Value” (Quality/Cost) for High-Risk Members of Medicaid ACOs

Presentation

- Factors that affect ACOs “shared savings” and “shared losses”
- Care models that reduce costs and optimize quality of care for high-risk members
- Enhanced Primary Care: structure, function and effects on costs and quality
- How Enhanced Primary Care is likely to affect ACOs’ financial performance
- Facilitators and barriers to ACOs’ adoption of Enhanced Primary Care models

Questions & Comments

Health Care Payment Learning & Action Network (HCP-LAN)

A collaboration of public and private health care leaders of

- State Medicaid agencies
- Commercial health plans
- Medicare Advantage plans
- Traditional Medicare

Since 2015, the LAN has tracked the total annual healthcare dollars that flowed through Value-Based Payment (VBP) plans:

- Types 3A (“shared savings”) and 3B (“two-sided risk”)
- Type 4 (“capitation”)

Line of Business Results – Medicaid: 2021

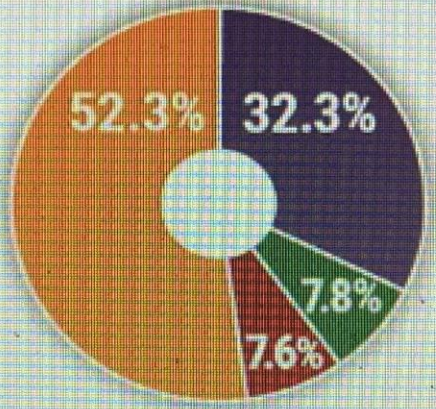
CATEGORY 1: *FEE-FOR-SERVICE – NO LINK TO QUALITY & VALUE*

52.3%

CATEGORY 2: *FEE-FOR-SERVICE – LINK TO QUALITY & VALUE*

A	B	C
0.2%	0.0%	7.4%

MEDICAID



Representativeness of Covered Lives: Medicaid (MCOs and state Medicaid Agencies) - 62%

CATEGORY 3: *APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE*

A	B
23.5%	8.8%

CATEGORY 4: *POPULATION-BASED PAYMENT*

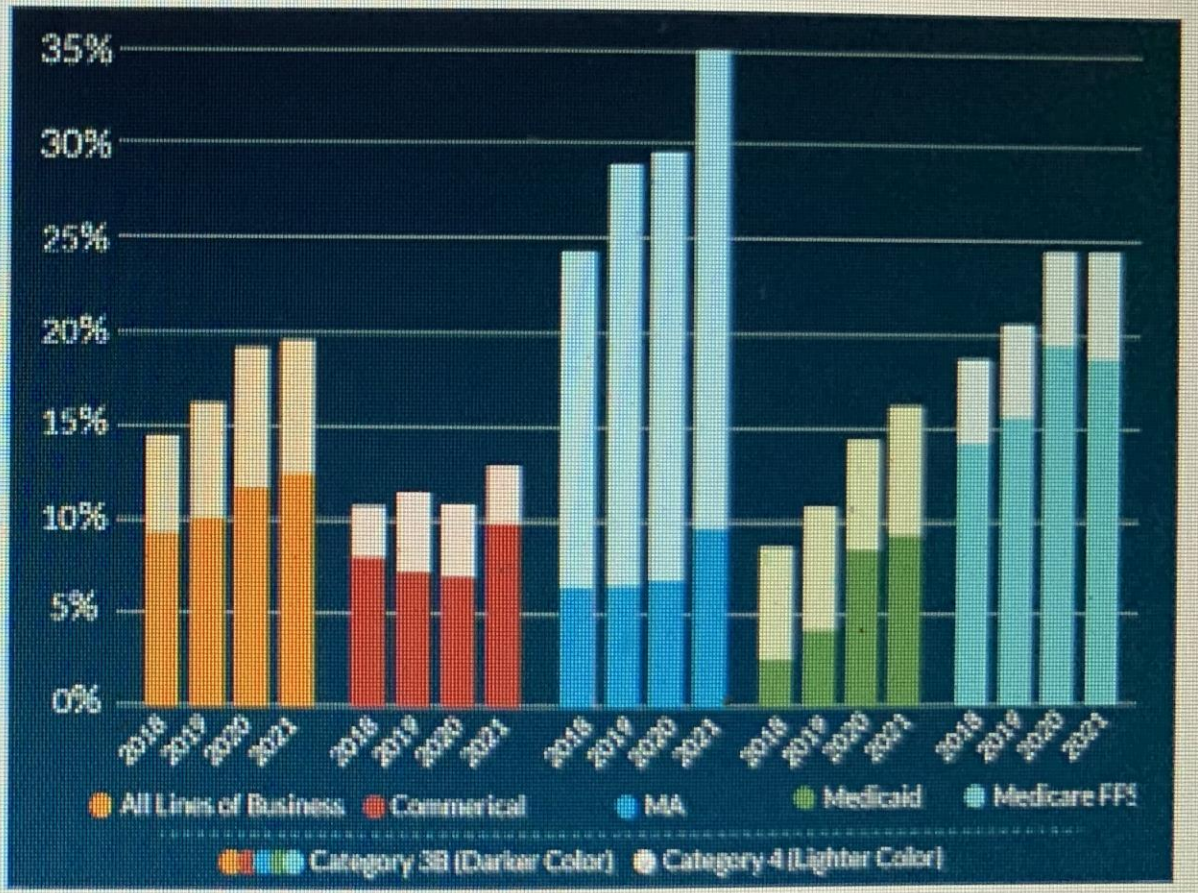
A	B	C
1.6%	4.4%	1.8%

16.6% *Combination of Categories 3B, 4A, 4B, & 4C Represents Two-Sided Risk APMs.*

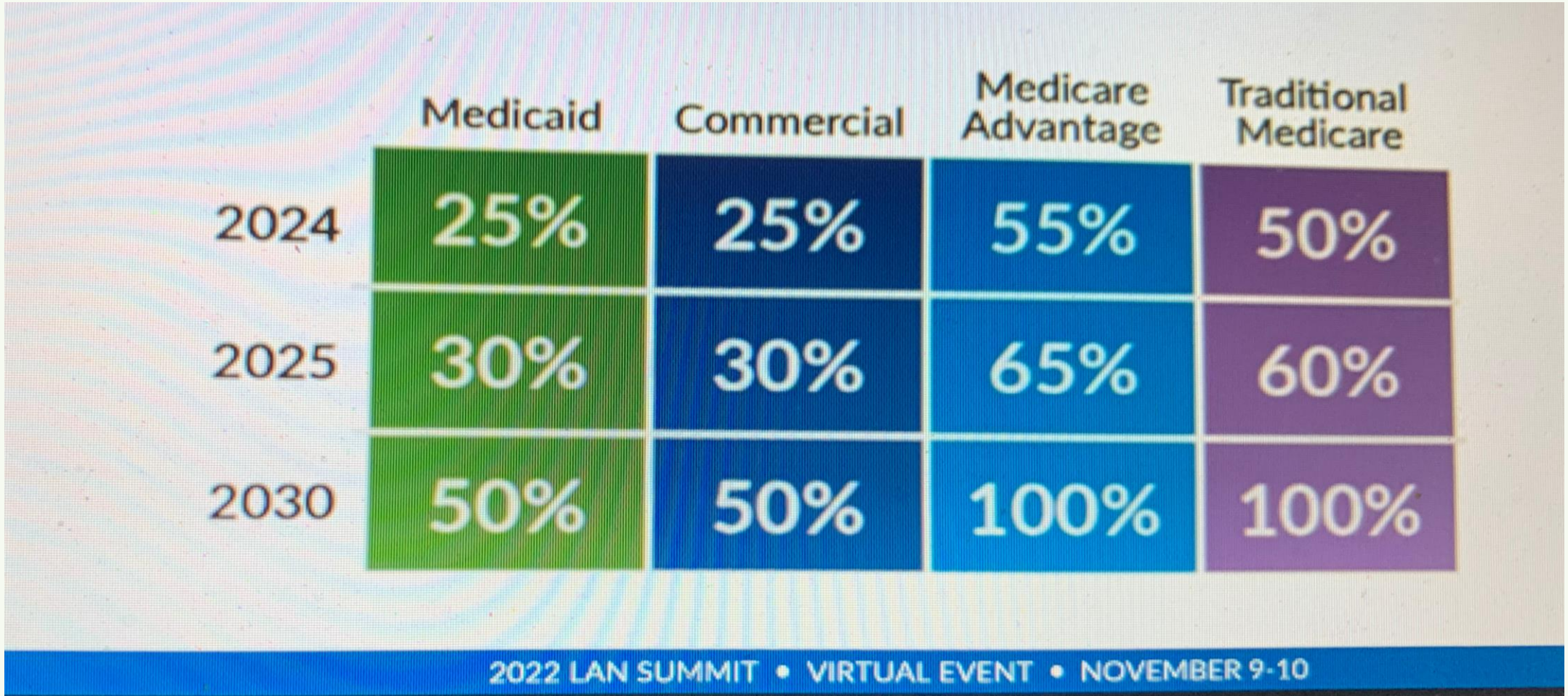
APM Trends

Categories 3-4 Spending By Year and by Line of Business: Data Years 2015-2021

Categories 3B-4 Spending By Year and Line of Business: Data Years 2018-2021



LAN Goals for VBP Categories 3B and 4



What do LAN Payers Think about the Future?

What is the future of VBP in U.S. healthcare?

- 83% think that VBPs will increase
- 13% think that VBPs will stay the same
- 0% think VBPs will decrease

Which categories of VBP plans will increase the most?

- 34% think Category 3B plans will increase the most
- 24% think Category 3A plans will increase the most

Payments to ACOs

“Savings” (or “Loss”) payments

- Risk scores -> “benchmark”
- [Benchmark] – [**Payer’s costs for care**] = “savings” or “losses” (shared between payer and ACO, if quality standards are met)

“Quality” is measured by:

- Care processes: rates of screening, monitoring
- Members’ experience of care: H/CAHPS
- 30-day re-admissions

Capitation payments (Category 4 ACOs)

- Member demographics, diagnoses, SDOH -> risk scores -> capitation payments

To Earn “Shared Savings”

Contain the payer’s total costs of care for both segments of the ACO’s aligned population, which include:

A. Low- to average-risk members
   - This 80% of the population accounts for only ~20% of its total healthcare costs

B. High-risk members
   - This 20% of the population accounts for ~80% of its total healthcare costs

The healthcare costs of both groups can be contained, but the potential savings are much greater among the high-risk group

Containing All Members' Costs

Keep members as healthy as possible!

Provide easy access to care for acute problems:

- 24/7 hot-line to healthcare professionals with access to EHR
- Weekend and evening appointments
- Mobile vans in underserved neighborhoods

Enhance communication with members:

- Telehealth, portals, digital monitors, reminders for preventive care

Address Social Determinants of Health (SDOH):

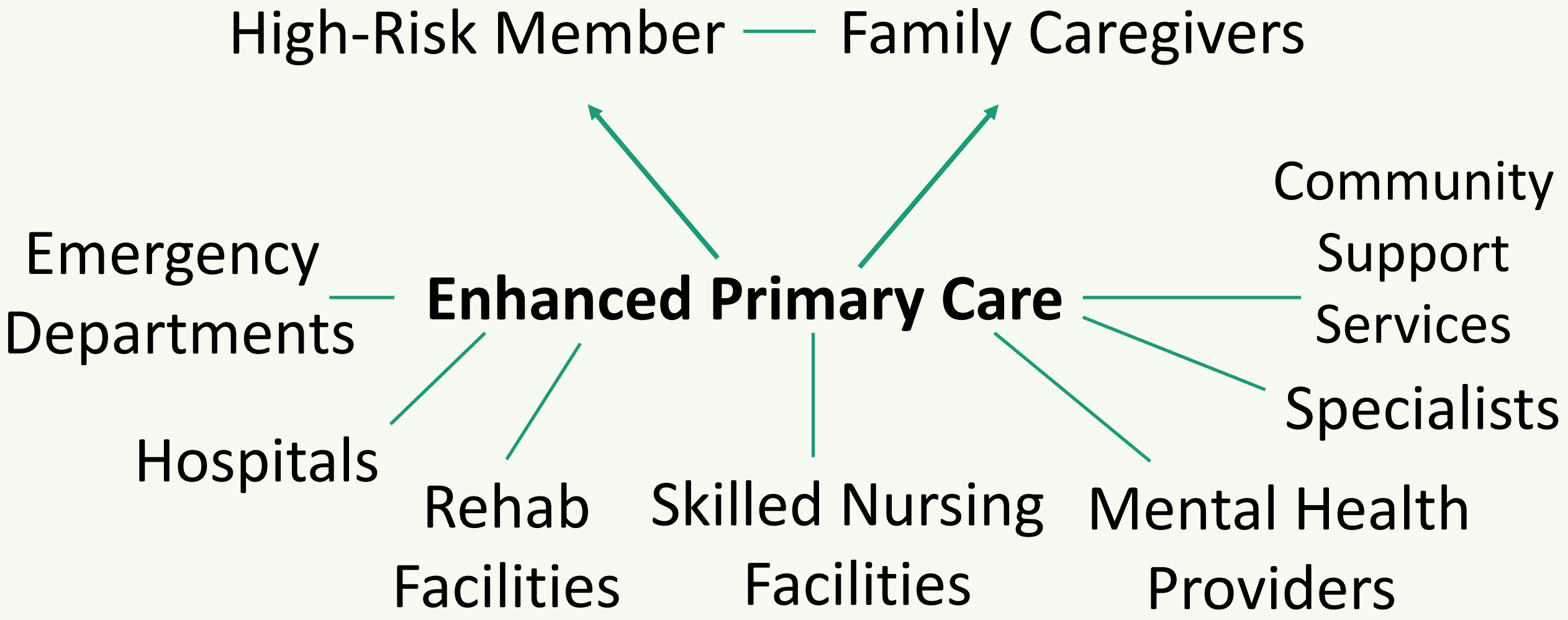
- Collaborate with agencies that provide transportation, food, housing, clothing, safety

Containing High-Risk Members' Costs

Additionally...devote extra resources to the primary care of high-risk members to enable:

- Close monitoring of high-risk members' clinical status
- Coaching members in self-care: meds, diet, exercise, self-monitoring
- Supporting family caregivers
- Customizing advance directives
- Coordinating all the care provided by hospitals, emergency departments, and other medical and mental health providers

Coordination of Care



Strategy: "Enhance" the Primary Care of High-Risk Members

Budget supplemental funds to enhance the primary care of members who are at high risk for high healthcare costs in the near future

Use these funds to provide all high-risk members with specific care processes that have been proven to:

- Reduce the use of expensive emergency, inpatient and post-acute care
- Produce high "quality" ratings

Reduce the total care costs for the ACO's aligned population (with high quality and equity ratings)

Maximize "shared savings"

Proven Successful Models for Providing "Enhanced Primary Care"

Two types

A. Members are transferred to new PCPs who take over their care:
   - Home-Based Primary Care – for members who are travel-limited
   - PACE (Program for the All-inclusive Care of the Elderly) – for members whose disabilities quality them for care in nursing homes

B. Members receive enhanced care through their established PCPs:
   - GRACE (Geriatrics Resources for Assessment and Care of Elders)
   - Guided Care

The Guided Care Model

- The ACO identifies the high-risk members of its aligned population
- A *specially-trained* RN is integrated into each primary care team.
- The Guided Care nurse (GCN) collaborates with 3-4 PCPs in caring for 80-100 high-risk patients with chronic conditions and complex needs.
- The GCN provides eight services to guide the high-risk patients and caregivers longitudinally.

Boyd CM et al. *Gerontologist*

The Guided Care Nurse Partners with the patient's PCP to:

- Assess patients' needs and preferences at home
- Create evidence-based "Care Guides" and "Action Plans"
- Monitor patients proactively
- Coach patients in self-management
- Smooth patients' transitions between sites of care
- Coordinate all other providers:
  - ✓Hospitals, EDs, specialists, rehab facilities, home care, hospice programs
- Educate and support family caregivers
- Facilitate access to community services: meals, transportation, repairs, etc.

Making Guided Care Equitable

To provide Guided Care *equitably* to all high-risk members of their aligned, under-served populations, ACOs will also need to implement methods for:

- Identifying the *rarely-seen*, high-risk members of their aligned populations perhaps, for example, by telephonic administration of health risk assessments that include the social determinants of health
- Preparing and equipping GCNs to engage productively with *diverse* high-risk ACO members of different races, religions, educational levels, linguistic abilities, sexual orientations and socio-economic statuses

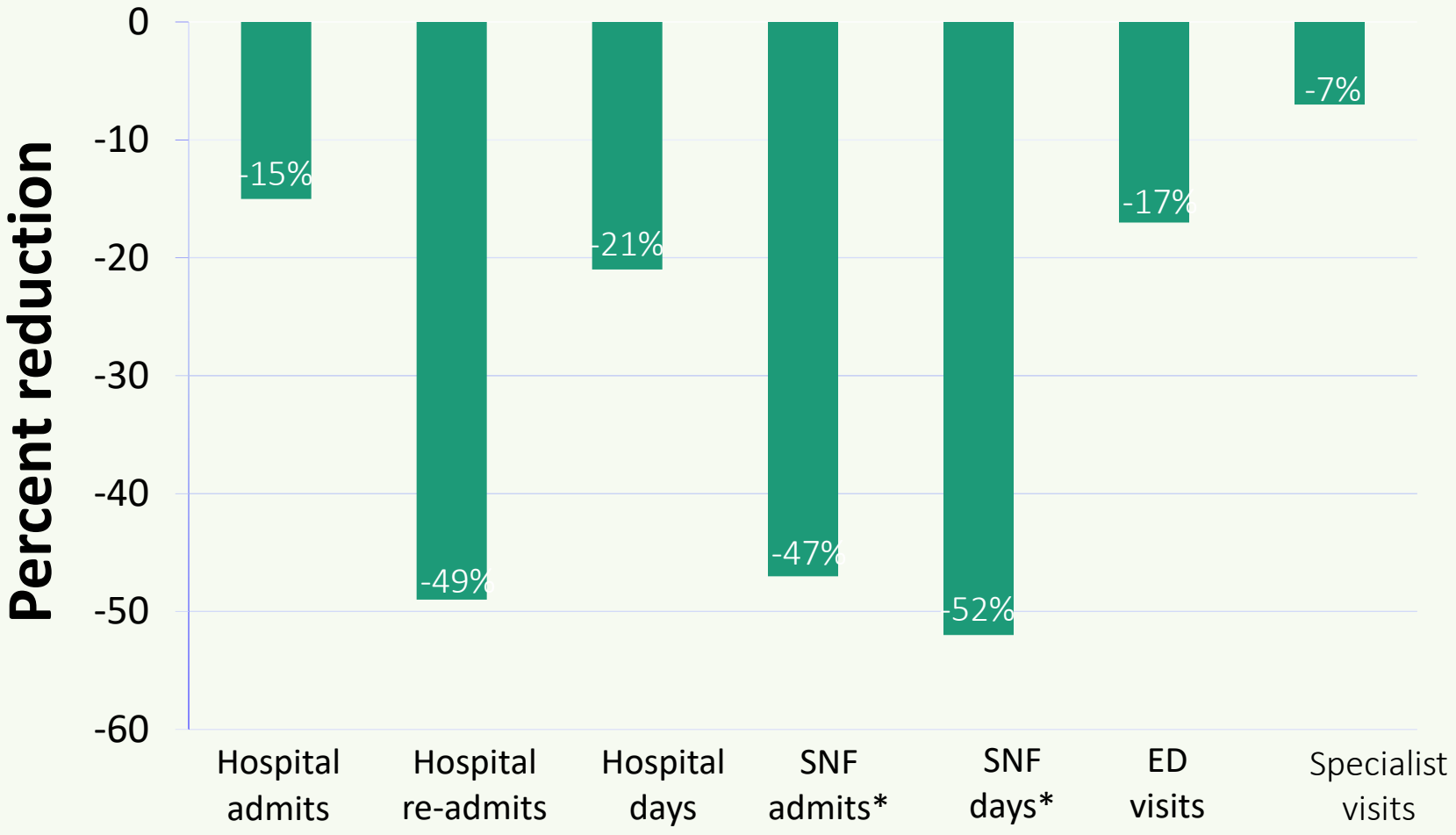
Proven Effects of Guided Care

A three-year, NIH/AHRQ/Foundation-funded, randomized trial:

- 904 high-risk older patients of 14 primary care teams (49 physicians)
  - ❖ Six teams paid via VBPs (Kaiser Permanente)
  - ❖Eight teams paid via FFS (Medicare)
- The 6 teams in KP and the 8 other teams were randomly assigned to provide either “Guided Care” or “usual care” to their high-risk patients
- Analyses compared the patient outcomes of “Guided Care” vs. “Usual Care”

Boult C et al. *J Gerontol*

Reduction in Use of Services (KP)

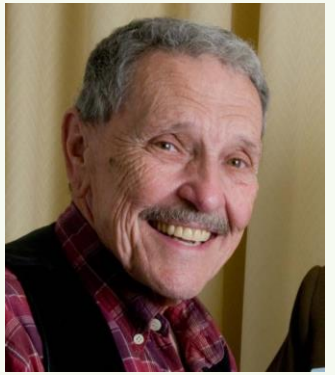


* Statistically significant

Boult C et al. *Arch Intern. Med*

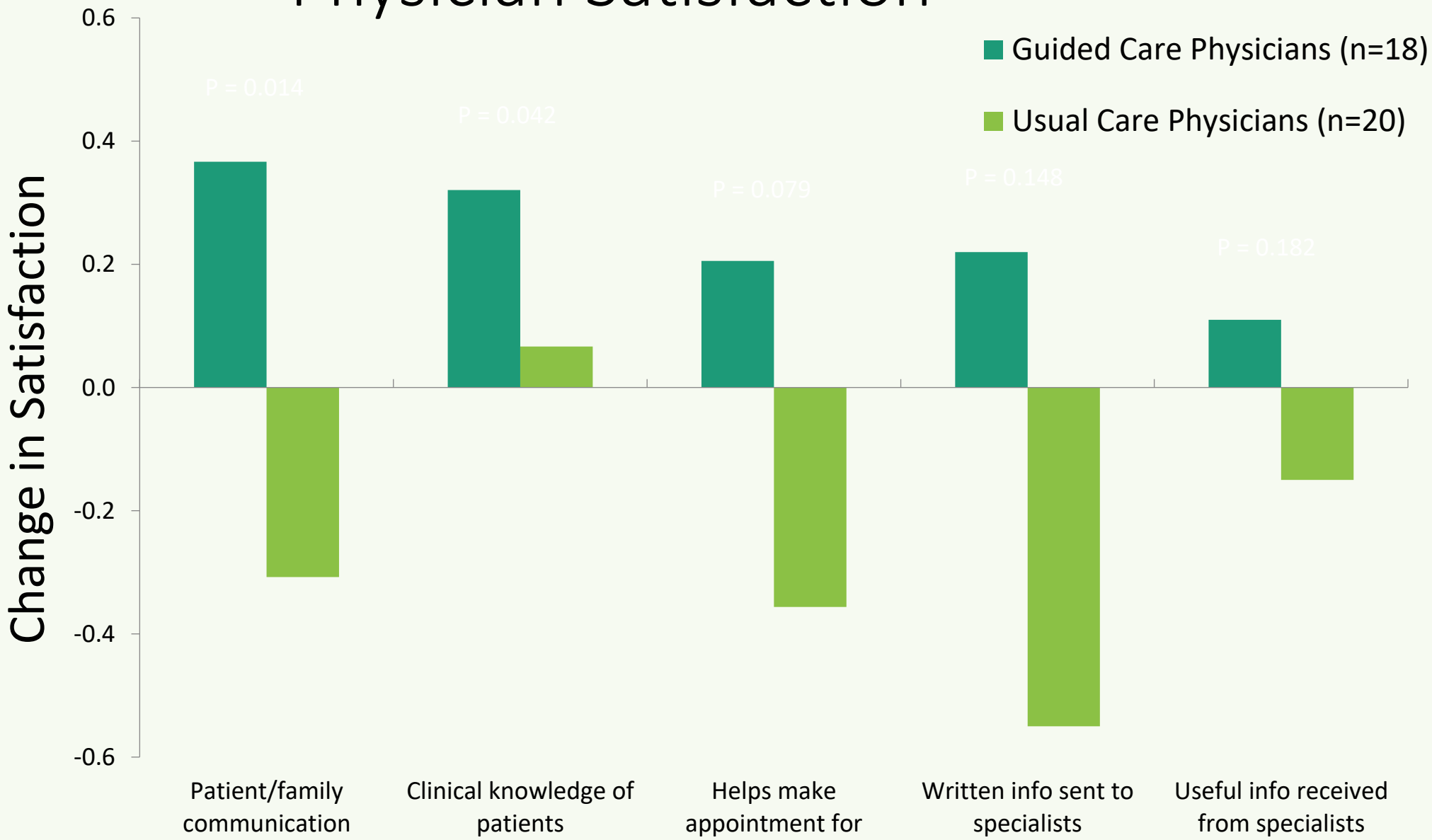
Improved Quality of Care

- After 18 months, patients were surveyed using the Patient Assessment of Chronic Illness Care (PACIC) scale.
- Guided Care recipients were twice as likely the controls to rate the quality of their care in the highest category.



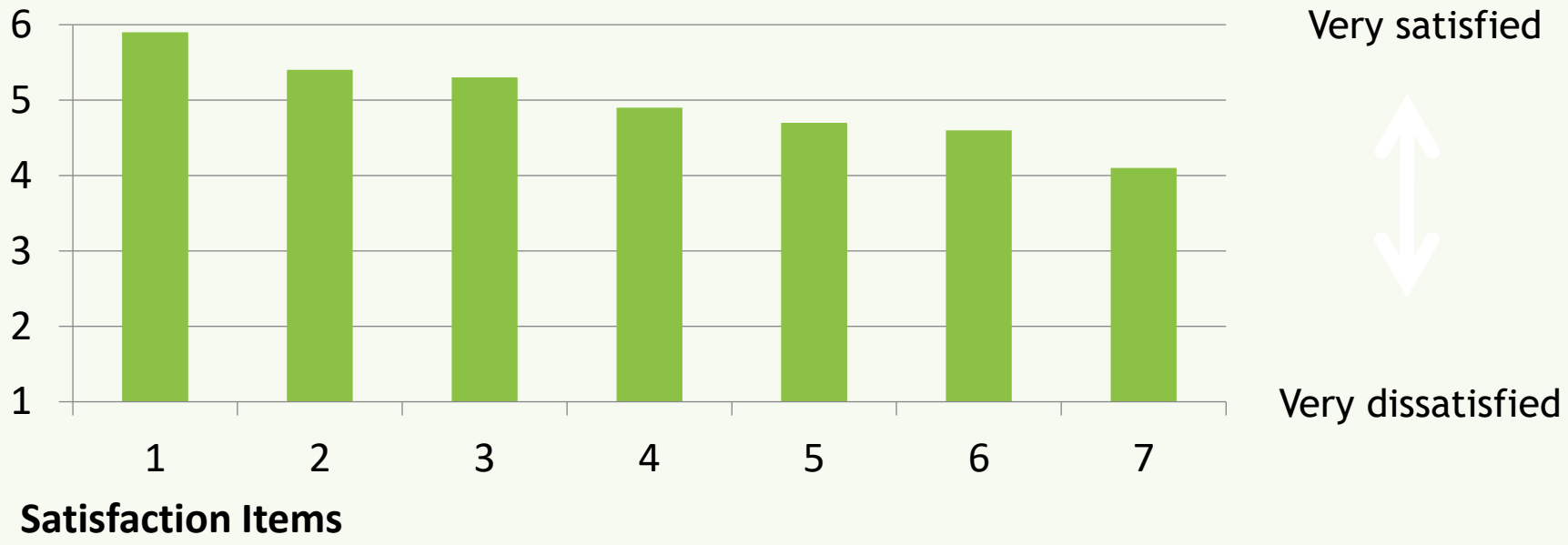
Boyd CM et al. *J Gen Intern Med*

Physician Satisfaction



Marsteller JA et al. *Ann Fam Med*

Nurse Job Satisfaction



1 Familiarity with patients
2 Stability of patient relationships
3 Communicating w/patients; availability of clinical info; continuity of care for patients
4 Efficiency of office visits; access to evidence-based guidelines
5 Monitoring patients; communicating w/caregivers; efficiency of primary care team
6 Coordinating care; referring to community resources; educating caregivers
7 Motivating patients for self management

Boult C et al. *J Gerontol*

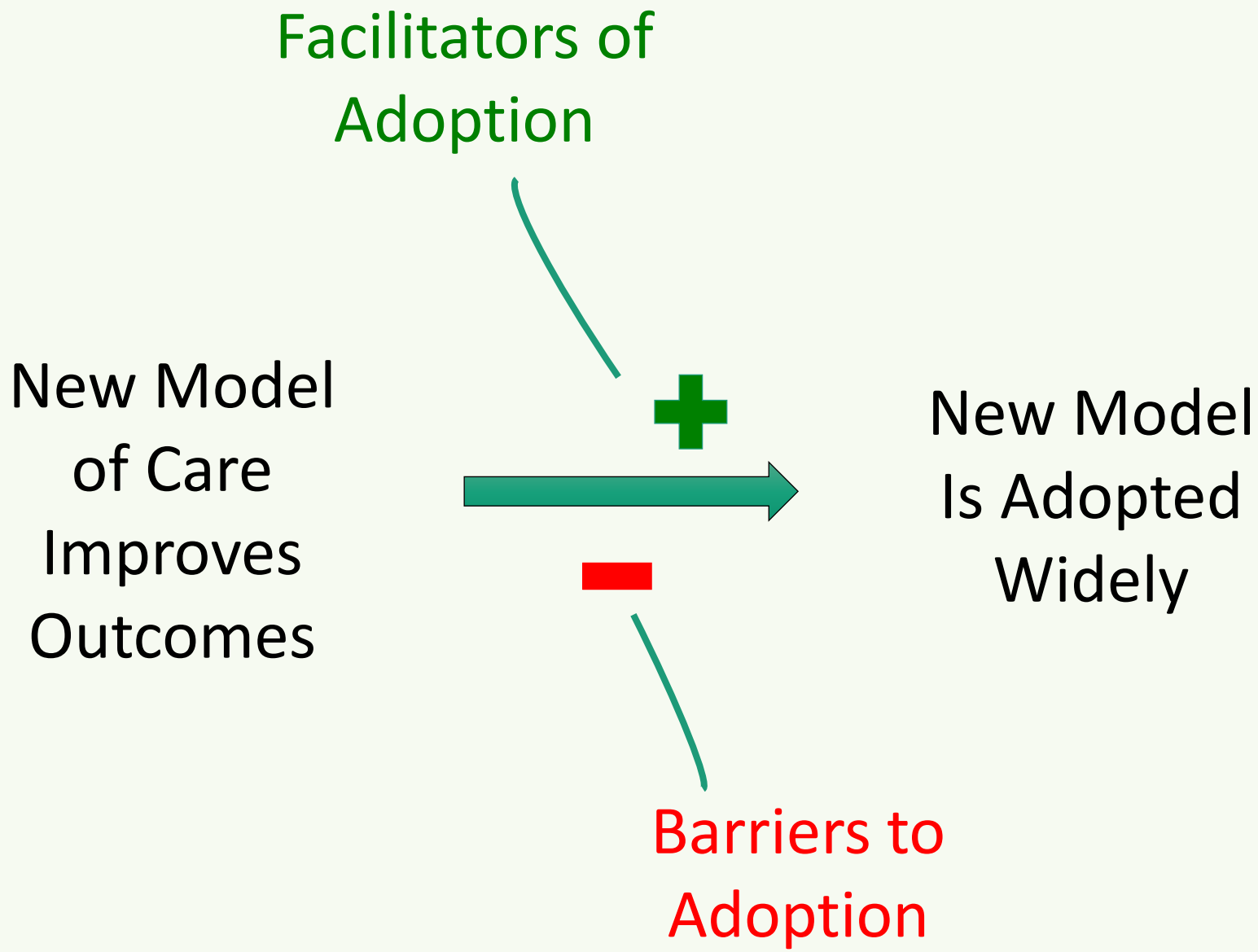
Likely Effects of Guided Care on Financial Success among ACOs

1. By reducing high-risk members' use of hospitals, emergency departments and nursing homes, Guided Care is likely to reduce payers' costs, thereby generating "savings" that will be shared by ACOs
2. By generating high "quality" scores, Guided Care is likely to ensure that ACOs qualify to share the savings that they produce
3. By improving the job satisfaction of PCPs and GCNs, Guided Care is likely to reduce job burnout and expensive staff turnover
4. By conducting thorough member assessments, GCNs are likely to ensure that members' "risk scores" (which determine capitation rates and spending benchmarks) accurately reflect members' true needs and risks

Adoption of Guided Care

Guided Care has been adopted by value-based healthcare systems in:

- U.S.
- Italy
- Canada


Facilitators of Adoption
New Model of Care Improves Outcomes
New Model Is Adopted Widely
Barriers to Adoption

Barriers to ACOs' Adoption of Guided Care

- Challenges of identifying and engaging with diverse high-risk patients and caregivers
- Cost of GCNs
- Resistance to changes in the roles and relationships of PCPs and RNs
- Misunderstanding the functions of "external" care managers
- Uncertainty about financial risk in future VBP contracts
- Uncertainty about the future availability of GCNs

Facilitators of ACOs' Adoption of Guided Care

- Demonstrated improvements in value (cost and quality of care)
- Potential for financial success
- Popularity with patients, caregivers
- Satisfaction among PCPs and GCNs
- Assistance available for implementation:
  - "Patient risk" estimators
  - Tools for implementing Guided Care

Tools for Adopting Guided Care

- A 180-page implementation manual: “Guided Care: A New Nurse-Physician Partnership in Chronic Care” (Springer Publishing Co.)
- A 20-module online course for RNs: “Guided Care Nursing” (Inst for JH Nursing, updated in 2022)
- A Guided Care orientation book for patients and families
- Templates used by GCNs for comprehensive patient assessment and care planning and coordination (jhu.technologypublisher.com/technology/45019)

“GRACE Team Care”

- Developed for low-income, high-risk, older patients
- NP/SW “support team” collaborates with 100 patients’ regular PCPs
  - Assessments and interventions are similar to those of Guided Care Nurses
  - Care planning is assisted by interdisciplinary team (geriatrician, pharmacist, PT, mental health SW)

“Grace Team Care”

Two-year RCT with 951 patients showed that GRACE:

- Enhanced patients’ health and function
- Reduced patients’ ED visits, hospital admissions and acute care costs

Indiana University provides tools for implementation of “GRACE Team Care”

- Training, manuals, assessments of organizational readiness and the “business case”
- University, community, VA, Medicare Advantage, ACO and other healthcare systems have adopted the GRACE Team Care model

Summary

"Enhanced primary care" models have been shown to optimize the "value" of care for high-risk populations

Tools are available to facilitate ACOs' adoption of the "Guided Care" and "GRACE Team Care" models

Long-term ACO success will require the adoption of effective clinical care models to provide high-value care for the high-risk members of their aligned populations

Questions?

Comments?