Medicaid Delivery System Reform and Payment Innovation: Role of Safety Net Plans in System Reform

ACAP Leadership Academy

October 07, 2020

3:30-5:00 pm ET/12:30-2:00 pm PT

ACAP Leadership Academy

Housekeeping Items

- Sessions are being recorded
- This call, like all ACAP calls, is being conducted in accordance with our antitrust guidelines which can be found on the ACAP website at www.communityplans.net

You can visit our dedicated webpage to review a list of resources! https://www.communityplans.net/event/leadership-academy-resources/ *Password: 'academy'*

If you have any collateral you want to share, feel free to email us!

ACAP Leadership Academy

Participant Instructions for Zoom

You'll see this control panel at the bottom of your screen

- **Mute** / **Unmute yourself:** Touching/clicking on the icon mutes and unmutes yourself. Please mute yourself during presentations, but feel free to unmute yourself if you have a comment or question to share.
  - Audio Controls (click the **^** arrow next to **Mute** / **Unmute**): Allows you to change the microphone and speaker that Zoom is currently using on your computer.
- **Start Video** / **Stop Video**: Touching/clicking on the icon turns your camera on or off.
  - Video Controls (click the ^ arrow next to **Start Video** / **Stop Video**): Change cameras if you have multiple cameras, select a virtual background (if enabled).
- **Participants**: You can click on this icon to view a list of all call participants
- **Chat**: Use this to ask the group a question.

ACAP Leadership Academy

About ACAP

- **Our mission** is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health and well-being of lower-income people and/or people with significant health needs.

- **Our vision** is a country with accessible, affordable, high-quality care, regardless of income, provided through coordinated care entities.

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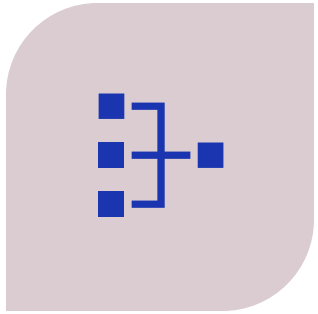
Today's Agenda

WELCOME, EVALUATIONS, AND CHIEF'S MEETING INFORMATION



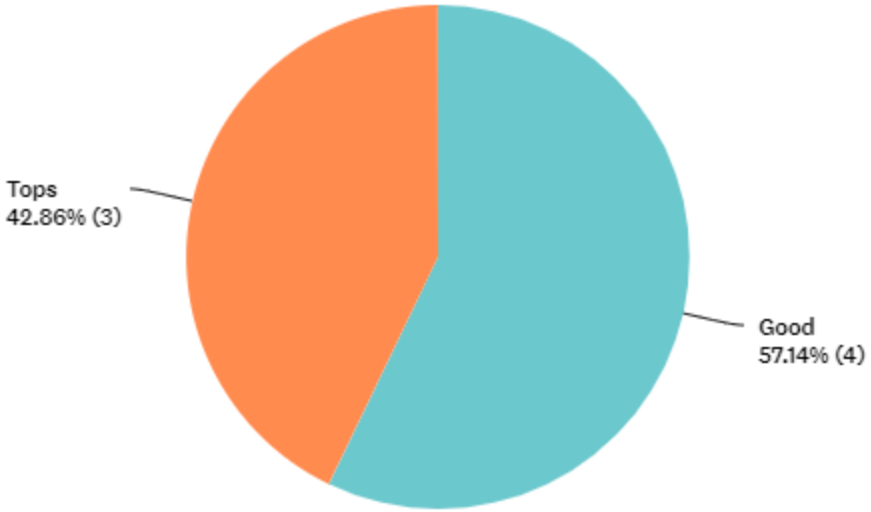
INTRODUCTION TO MEDICAID DELIVERY SYSTEM REFORM AND INNOVATION

CASE STUDY PRESENTATIONS

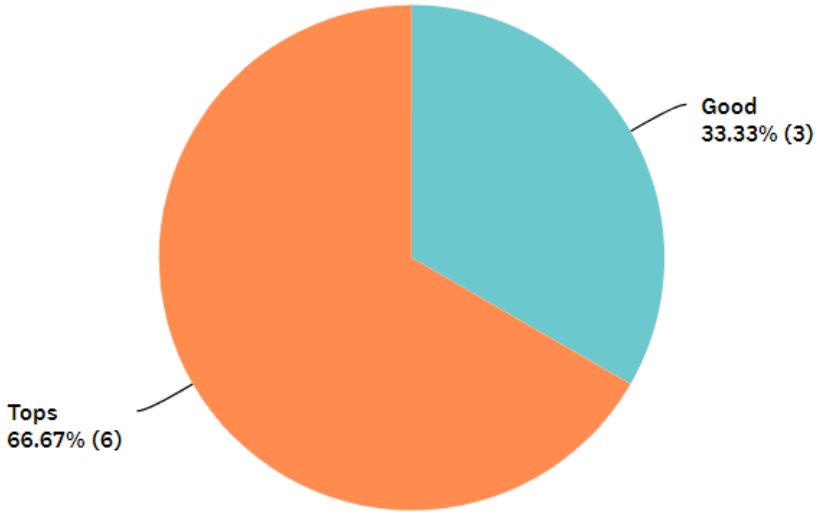
BREAKOUT GROUPS

July Webinar and Leadership Workshop Evaluations

July Webinar on Racial and Ethnic Disparities



Leadership Workshop with Ed O'Neil



Key Takeaways!

- Racial and Ethnic Disparities:
  - The importance of data in combating disparity
  - Unconscious bias
  - Continue to review outcomes based on race/ethnicity for health challenges by certain
  - Questions for employee survey to change plan culture
  - Be creative, think outside the box in developing solutions
- Leadership Workshop:
  - Model for influence - Up, Down, & Out
  - Knowing yourself and your boss – key
  - Learning more about management vs. leadership
  - How to improve your relationship with your supervisor
  - Framing a conversation

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November Webinar and 2020 Fall Meeting

- **Monthly webinar**: Health Plan Operations: Nov 10: 3:30-5:00 ET/ 12:30-2:00 PT
- Our Fall Meetings will take place virtually
  - Chiefs Meeting: Nov 11-13
  - CMO/Quality Meeting: Nov 16-17
- Virtual Chiefs meetings will include a dedicated ancillary hour with COOs, CIOs, and CFOs only for Leadership Academy participants.
- This hour will feature conversations with chiefs on their work experience and leadership strategies.

Medicaid Delivery System Reform and Payment Innovation: Role of Safety Net Plans in System Reform

ACAP Leadership Academy

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Why Payment and Delivery System Reform?

- Historically fee-for-service payments tied to health care providers and volume of services provided
  - Uneven care, excessive services, health care inflation
  - Treatment of diseases and injuries as they occur
  - Roadblock to more "whole-person" care approach
- New payment models link providers' reimbursement to the value of the services they provide, both to individual patients and broader patient populations
  - Identification of conditions at early stages to reduce the cost of treatment
  - Monetary benefits are persistently aligned with the delivery of coordinated and quality care at the best price – the Triple Aim

Current Priorities for Delivery System Reform

- Access challenges and intrinsic bias of the health care system
  - Where you live matters
  - Who you are matters
- Cracks in system made worst by COVID-19 pandemic
- Better preparation to handle similarly disruptive events in the future
- Moving states away from less sophisticated payment systems to ones based on the value of care provided.
- Aligning VBP initiatives among multiple payers

POLL: Attributes of High Performing Health Care Delivery System

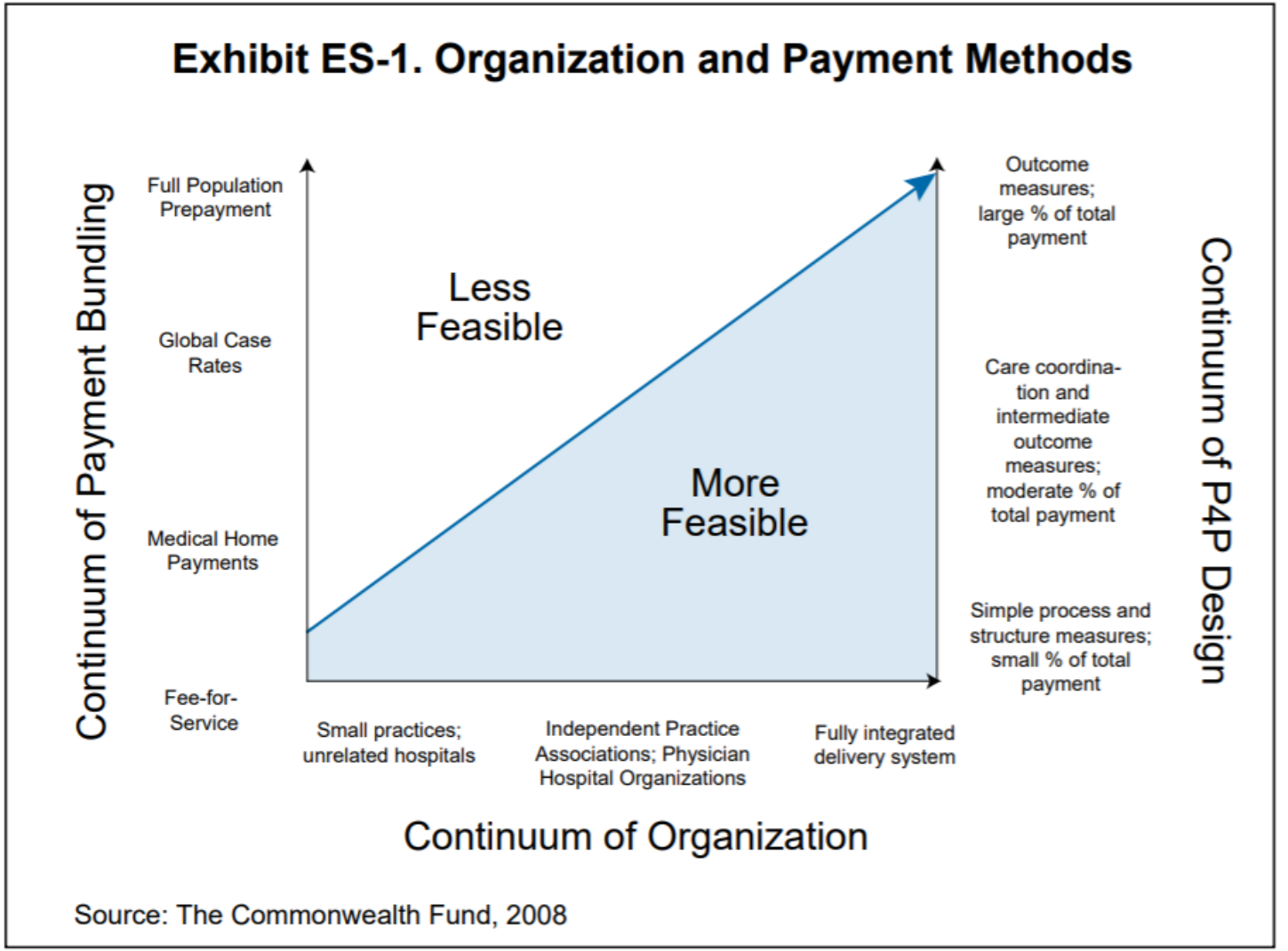
- Please answer the poll question on your screen.
- This question allows for multiple choices – choose all that apply!

Attributes of High Performing Health Care Delivery System

- Clinical information available to providers at the point of care and to patients through electronic health record systems
- Care coordinated across providers, transitions between care settings are actively managed
- Providers accountable to each other and collaborate to deliver high quality and value care
- Patients access appropriate and culturally competent care and information, including after hours
- Clear accountability for total care of patients
- System continuously innovating and improving quality, value, and patient experience

Source: The Commonwealth Fund, Organizing the U.S. Health Care Delivery System for High Performance, Aug. 1, 2008, accessed at https://www.commonwealthfund.org/publications/fund-reports/2008/aug/organizing-us-health-care-delivery-system-high-performance

Organizing the U.S. Health Care Delivery System for High Performance



What is Value-Based Payment (VBP)?

The goal is to incentivize quality, positive health outcomes and value over volume to achieve better care, smarter spending and healthier populations.

How? Provide incentives for providers to delivery efficient, coordinated care centered on the needs of the patient.

Use performance measures to drive improvement in patient care and outcomes.

Replace fragmented, fee-for-service based care with comprehensive, coordinated care using payment that holds providers accountable for cost control and quality gains.

Health Care Payment Learning & Action Network (LAN) Alternative Payment Methodologies (APM) Framework

Category 1

FEE FOR SERVICE – No link to Quality & Value

Category 2

FEE FOR SERVICE – Link to Quality & Value

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

Pay-for-Performance

(e.g., bonuses for quality performance)

Category 3

APMs BUILT ON FEE-FOR-SERVICE ARCHITECTURE

APMs with Shared Savings

(e.g., shared savings with upside risk only)

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

Category 4

POPULATION-BASED PAYMENT

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services)

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

Medicaid Transformation Landscapes Vary

- Patient-Centered Medical Homes (PCMH)
  - PCP focused with multi-disciplinary team support.
- Health Homes
  - Builds on PCMH, but for complex populations.
- Episodes of Care/Bundled Payments
  - Condition-focused lump-sum payments.
- Accountable Care Organizations (ACOs)
  - Providers responsible for defined patient population.
- Accountable Care Communities (CMMI)/Accountable Communities of Health (WA)

Recent Federal Support for State Delivery System Reform

- Center for Medicare and Medicaid Innovation (CMMI) State Innovation Models (SIM) Initiative
  - Provided financial and TA support for developing and testing state-led, multi-payer health care payment and service delivery outcomes
- Medicaid Delivery System Reform Incentive Program (DSRIP)
  - Requires Section 1115 waiver and budget neutrality
- Innovation Accelerator Program
  - TA to states for delivery system reform

POLL: Which of the following models does your plan participate in?

- Please answer the poll question on your screen.
- This question allows for multiple choices – choose all that apply!

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Which of the following models does your plan participate in?

- Medical Homes
- Health Homes for Complex Patients
- Accountable Care Organizations (ACOs)
- Accountable Care Communities
- Bundled Payments
- Other - Please let us know in the chat!

New CMS Guidance: State Delivery System Reform

- September 15th State Medicaid Director's Letter road map for adoption of Medicaid VBP
- Stresses multi-payer alignment – Medicare, Medicaid and commercial insurance
- Builds on models tested for the Medicare program that build on:
  - Fee for service architecture
  - Episodes of care payment
  - Payments involving total cost of care accountability
- Targets state and MCO VBP opportunities

Types of State Approaches to Promote Payment Reform in Managed Care – VBP Models

- Require MCOs to:
  - Adopt a standardized VBP model (TN, MN)
  - Make a specific percentage of provider payments through approved VBP arrangements (SC, AZ, PA)
  - Move toward implementation of more sophisticated VBP approaches over the life of the contract (NY)
  - Actively participate in a multi-payer payment alignment initiative (TN)
  - Launch payment model pilot projects subject to state approval (NM, MN)

POLL: Why is this important to understand?

- Please answer the poll question on your screen.
- This question allows for multiple choices – choose all that apply!

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Why is this important to understand?

- Future leaders of managed care plans will need to understand these concepts and approaches as states and plans try new models.
- Plans' finances will be dependent on the models states and plans implement – payments will be tied to plans' success in implementing these models.
- Leaders will be required to know how these models can be implemented and operationalized.
- Leaders' knowledge will need to evolve as delivery and payment reform models continue to emerge as there is more innovation and evaluation.

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Questions for you…

- What delivery system and payment reform models is your plan (or state) developing or implementing in your market(s)?
- Do you see an evolution in what your plan (or state) is attempting? What goals is your plan (or state) trying to achieve now and over time?
- How does and will this impact your day-to-day work and responsibilities?
- What can you do as a leader to contribute to your plan's success in developing and operating these models?

Questions?

UPMC HEALTH PLAN

ACAP Leadership Academy

UPMC *for You* Innovations on Value-Based Payments – OB Care Bundle

October 7, 2020

HERE'S THE PLAN

PRESENTER

Teodoro Norman

AVP Medicaid Clinical Operations

Johanna Vidal-Phelan, MD, MBA, FAAP

Senior Medical Director-Pediatrics

UMPC Insurance Services Division

AGENDA

01 UPMC Health Plan OB Bundle

02 Pennsylvania Department of Human Services OB Bundle

03 UPMC Health Plan Maternity Care Management Program

01 UPMC Health Plan OB Bundle

UPMC Health Plan OB Bundle

Alternative payment model

Goals

1. Enhance patient education and communication with providers, create a superior birth experience, improve outcomes, and reduce costs related to obstetrical care
2. Improve maternity quality metrics
3. Optimize C-section rate
4. Attract and retain employers and providers seeking payers with value-based models of care

UPMC Health Plan OB Bundle

Development and timeline

2016

Medicaid data showed substantial variation in cost, quality, and C-section rates

OB bundle development began with multiple integrated delivery and finance system (IDFS) work groups

- Create standardization and efficiency of practice (improve quality, lower cost)
- OB dashboard developed to track monthly quality, procedures, complications, LOS, costs

2017

Shadow bundle started with UPMC Magee-Womens Hospital

UPMC HEALTH PLAN

UPMC Health Plan OB Bundle

Development and timeline

2019

OB P4P program implemented across the entire UPMC OB network to incentivize and reinforce metrics:

- First trimester prenatal care visit
- Postpartum care visit
- Two well-child visits in the first 30 days postpartum
- C-section rate

January 2020

OB bundle started

June 2020

DHS announces OB bundle for inclusion in MCO 2021 contracts

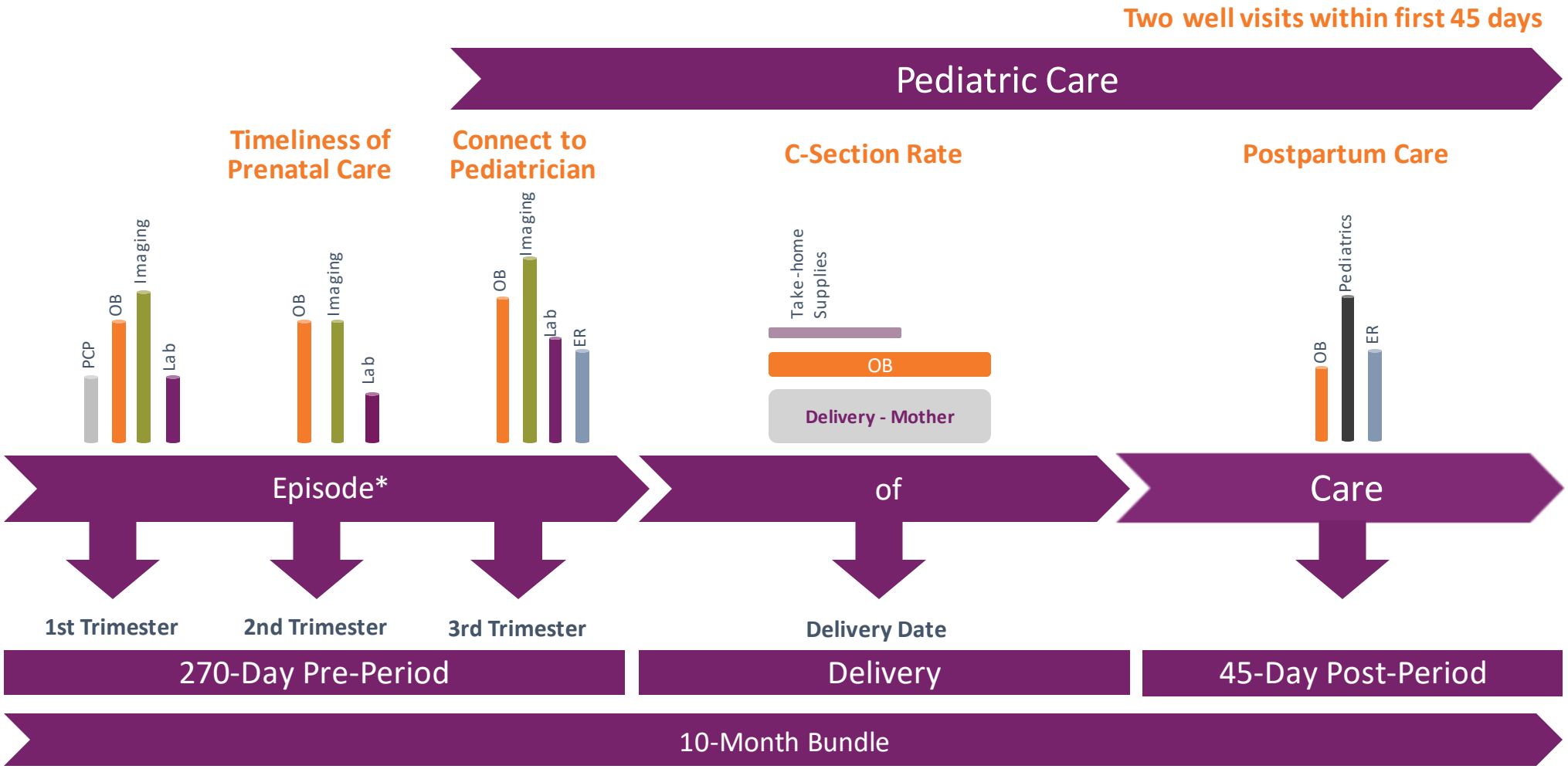
UPMC Health Plan OB Bundle

Program overview

UPMC HP OB Bundle Contract Proposal

- Began January 2020
- No risk — continue to pay all providers on an FFS basis with settle up at end of contract year
- Mother only – Medicaid and Commercial products
- Covers entire episode = Prenatal + Labor & Delivery + Postpartum Services (facility and professional claims; total cost of care)
- Shadow reporting for newborn and NICU in 2020

UPMC Health Plan OB Bundle



*Notified of active pregnancy through our enhanced ONAF procedure

UPMC HEALTH PLAN

UPMC Health Plan OB Bundle

Quality metrics

Five quality metrics are being measured as part of program

The percentage of target savings paid to provider will now be based on number of quality metrics met.

Medicaid
2 of 5 metrics **100%** of target savings
1 of 5 metrics **80%** of target savings

Medicaid C-Section Incentive
If provider meets none of the five quality metrics but reduces C-section rate by 1%, health plan will pay 60% target savings

Medicaid
Quality Metric
C-Section Rate
Prenatal
Postpartum
Postpartum Depression
Well Child Visits

UPMC Health Plan OB Bundle

Leveraging technology

Pregnancy visit populates field in EPIC

Health Plan collects clinical/quality data using bundle logic

OB Bundle Dashboard

Implemented January 1, 2020

IDFS tool

- Built by Clinical Analytics team using Health Plan and EPIC data

Multiple Tabs

- Delivery volumes and procedures
- C-section rates
- Average claims/spend by episode
- Spend by trimester, delivery, and postpartum period
- OB bundle quality metrics

02 Pennsylvania Department of Human Services OB Bundle

PA Perinatal Quality Collaborative and Alternative Payment Models

1st Advisory Council 11/16/2018 – Launched 4/2019

Goals

1. Reduce maternal mortality
2. Improve pregnant/postpartum care for OUD
3. Improve care for opioid-exposed newborns

Methods

1. **PQC Learning Collaborative**
   - Sharing best practices
   - Developing VBP bundles
2. **Maternity Review Committee**

Maternity Bundles: Reinvesting in what matters: Guaranteed price and quality

Prenatal Services	Labor and Birth	Postpartum Services: Mother-Infant Dyad
• Visits OB-GYN, midwives, doulas, specialists • Lab tests and ultrasound • Assessments and risk stratification; high-risk condition management • Transportation • Childbirth classes and parental training	• Inductions • Pain/labor management • Episiotomies • Vaginal deliveries, C-sections, VBACs	• Rooming-in model — NICU • Provider visits; home care (in-home) visits; breastfeeding support • Transportation • Birth-to-pediatric care transition

Alternative payment meets DHS requirements and enables IDFS innovation/savings

UPMC Health Plan OB Bundle

Pennsylvania Department of Human Services OB bundle characteristics

Providers/facilities must have >10 births per year and:

- At least one physician who can provide high-risk pregnancy care
- One hospital with capability to perform C-sections
- One individual to coordinate care (could be a doula, CHW, or peer recovery specialist)

Pricing based on trimester, historical spend, and a blend of vaginal births, C-sections, and newborn care services up to 60 days postpartum

Prospective target price minus actual FFS payments = $ shared savings pool

UPMC Health Plan

UPMC Health Plan OB Bundle

Pennsylvania Department of Human Services OB bundle characteristics

Percentage of shared savings will depend on quality performance

- SDOH, initiation of alcohol and other drug abuse or dependence treatment, timeliness of prenatal/postpartum care, prenatal/postpartum depression screening and follow-up, prenatal immunization status, well child visits (two or more WCV with a primary care provider within the first 60 days after birth)
- Points based on achieving 50th, 75th, 90th percentile and Health Equity Score

Stop-loss mechanism is built in

At least 80% of shared savings must go to the providers delivering the care

UPMC Health Plan

03 UPMC Health Plan Maternity Care Management Program

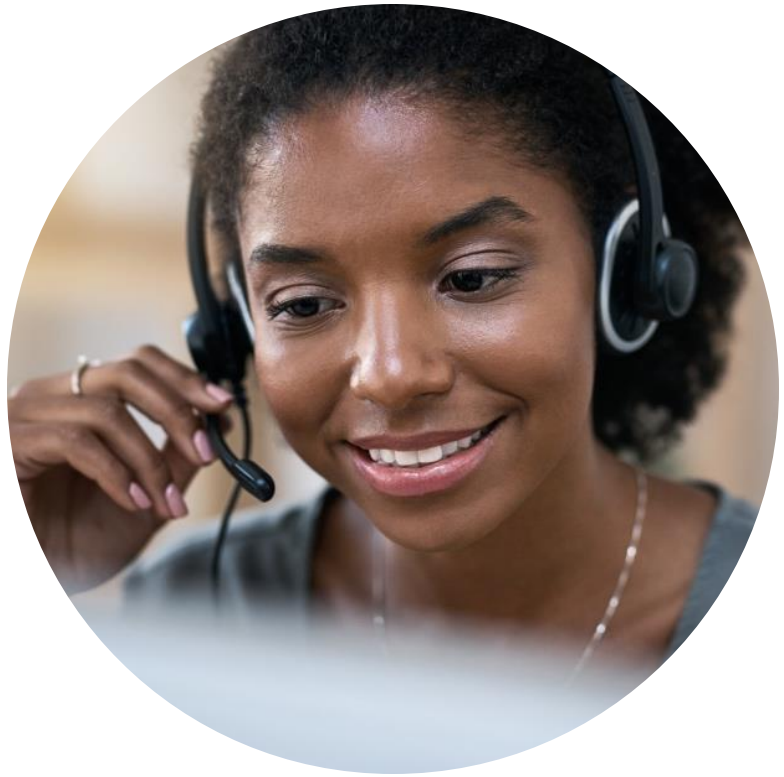
UPMC Health Plan Maternity Care Management Program

Healthy pregnancy, healthy baby

The UPMC Health Plan Maternity Program is a maternity care management program offered to women enrolled in all applicable UPMC Health Plan insurance products

- **An experienced maternity nurse serves as a health coach** throughout the continuum of a woman's pregnancy, including the postpartum period

The maternity health coach completes comprehensive assessments that include SDOH and links the member with appropriate community resources to support mom and baby in the postpartum period (e.g., breastfeeding support, identification and referral for postpartum depression treatment, plans for well-baby care)



UPMC HEALTH PLAN

Maternity Care Management

Maternity model of care

The UPMC Health Plan Maternity Program

Comprehensive, holistic, team approach

- Telephonic and mobile staff, focused on optimizing health and enhancing pregnancy outcomes
- Geographically assigned RN/social worker teams
- Transition to Pediatric First Steps program after delivery for ongoing care management support
- Complex Care team established (NICU, shift care)

Maternity Care Management

Maternity model of care

Subpopulations of Interest

- High-risk pregnancy
- First-time mothers
- Black mothers
- Neonatal Abstinence Syndrome
- NICU (preterm, low birth weight)
- Shift care (private duty nursing)

Maternity Care Management

Maternity model of care

Maternal/child home visiting program

- Mobile maternity and pediatric teams
- First-time moms and families at risk for adverse outcomes
- Care management engagement during pregnancy and through 18 months of age

Partnerships with other community-based organizations

- Evidence-based home visiting programs (Early Head Start, Parents as Teachers, Healthy Families America)
- Birth Circle Doulas

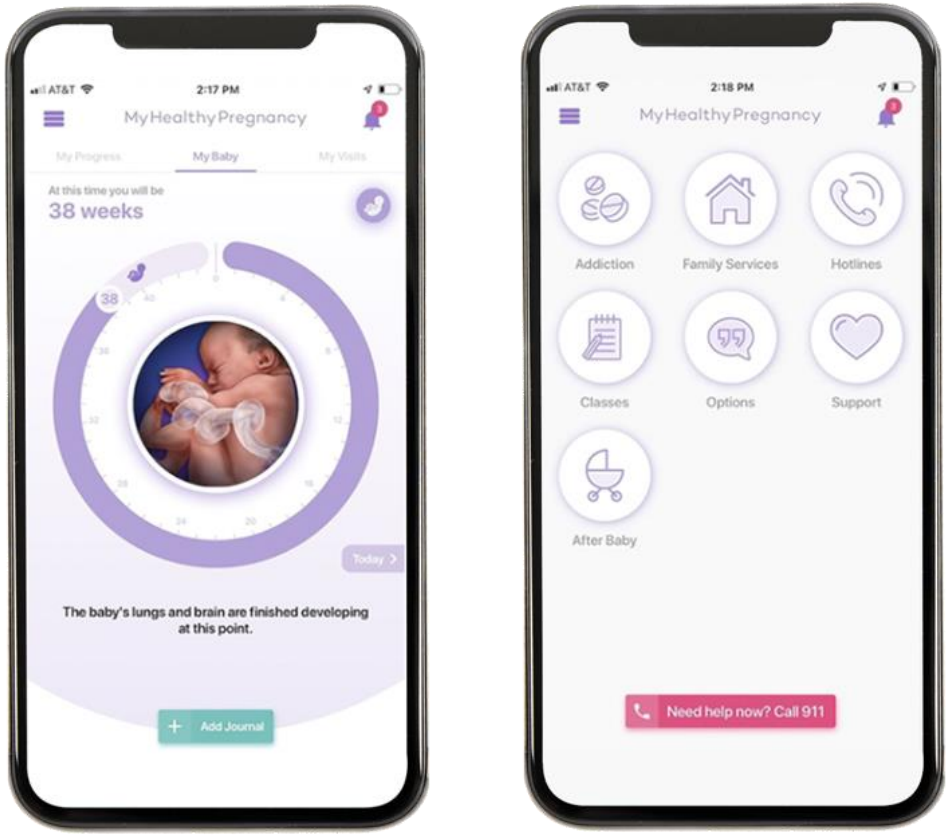
Maternity Care Management

Innovation

- Dashboard development
- **MyHealthyPregnancy app**
  - Magee launched in 2019
  - Developed and designed to support OB bundle care
  - Focus on pregnancy education, behavioral nudges, resources, feedback, personalized risk predictions
- Telehealth visits
  - OB-GYN and pediatric providers
- **UPMC AnywhereCare** platform mobile maternity team pilot, launched August 2020

Maternity Resources

Technology and innovation



MyHealthyPregnancy (MHP) is a maternal mobile health platform, integrated with the health system, that identifies and communicates actionable risks from a variety of clinical and psychosocial risk factors, enabling real-time interventions with the goal of improving patient outcomes and reducing health care costs.

UPMC Health Plan

UPMC Health Plan OB Bundle

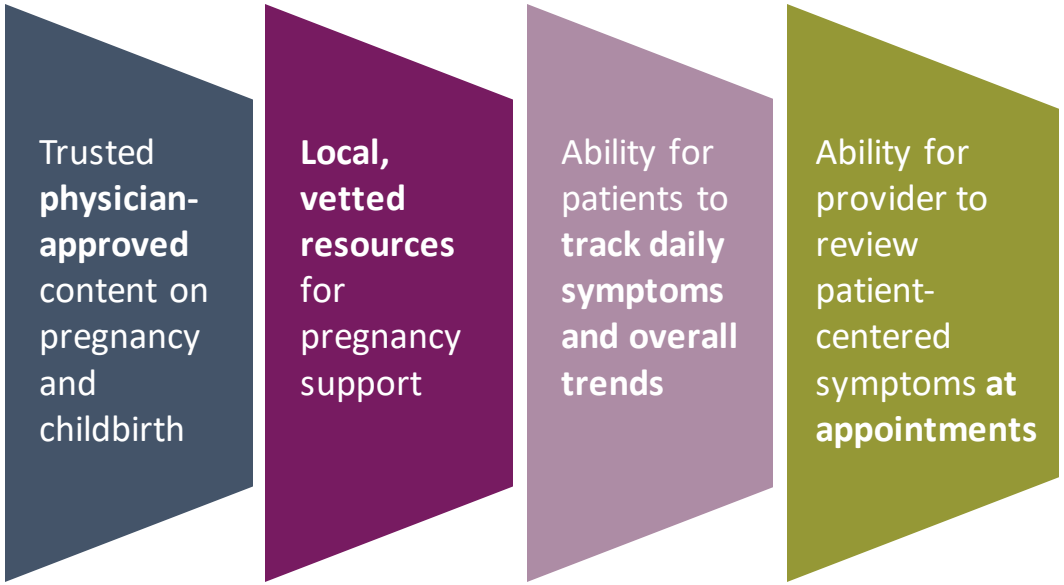
Future considerations

Collaborative IDFS Labor Support Programming

- Magee doulas and mobile maternity care managers

Health Disparities – IDFS Opportunities/Tactics

- Timeliness/frequency of engagement in prenatal care and postpartum care
- Intensive identification and population dissemination of high-value clinical interventions related to adverse neonatal outcome in at-risk women
- Longitudinal/comprehensive screening for depression and intimate partner violence in pregnancy, matched with integrated clinical and community-based interventions



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Thank You

UPMC Health Plan

Accountable Entity Program

Rhode Island Medicaid Delivery Reform

Presentation by Edward Curis

Neighborhood Health Plan OF RHODE ISLAND™

Leadership VALUES

As leaders, we are examples for the rest of the organization. We hold ourselves to a consistent standard and expect that we all act in accordance with our values, even when no one is looking. These values are agreed upon expectations the Leadership Team has made of themselves and of each other. The Leadership Team seeks being held accountable to these values and the associated behaviors.

Honesty • Integrity • Ethics • Trustworthiness
We are trustworthy and honest in everything we do. Integrity and ethics is at the forefront of our decisions, interactions, and relationships.

Accountability
We are accountable- individually and in teams/groups- for our behavior, actions and results.

Commitment • Loyalty
We respect and support each other as individuals, as members of the organization's Leadership Team and move forward with 'one voice'.

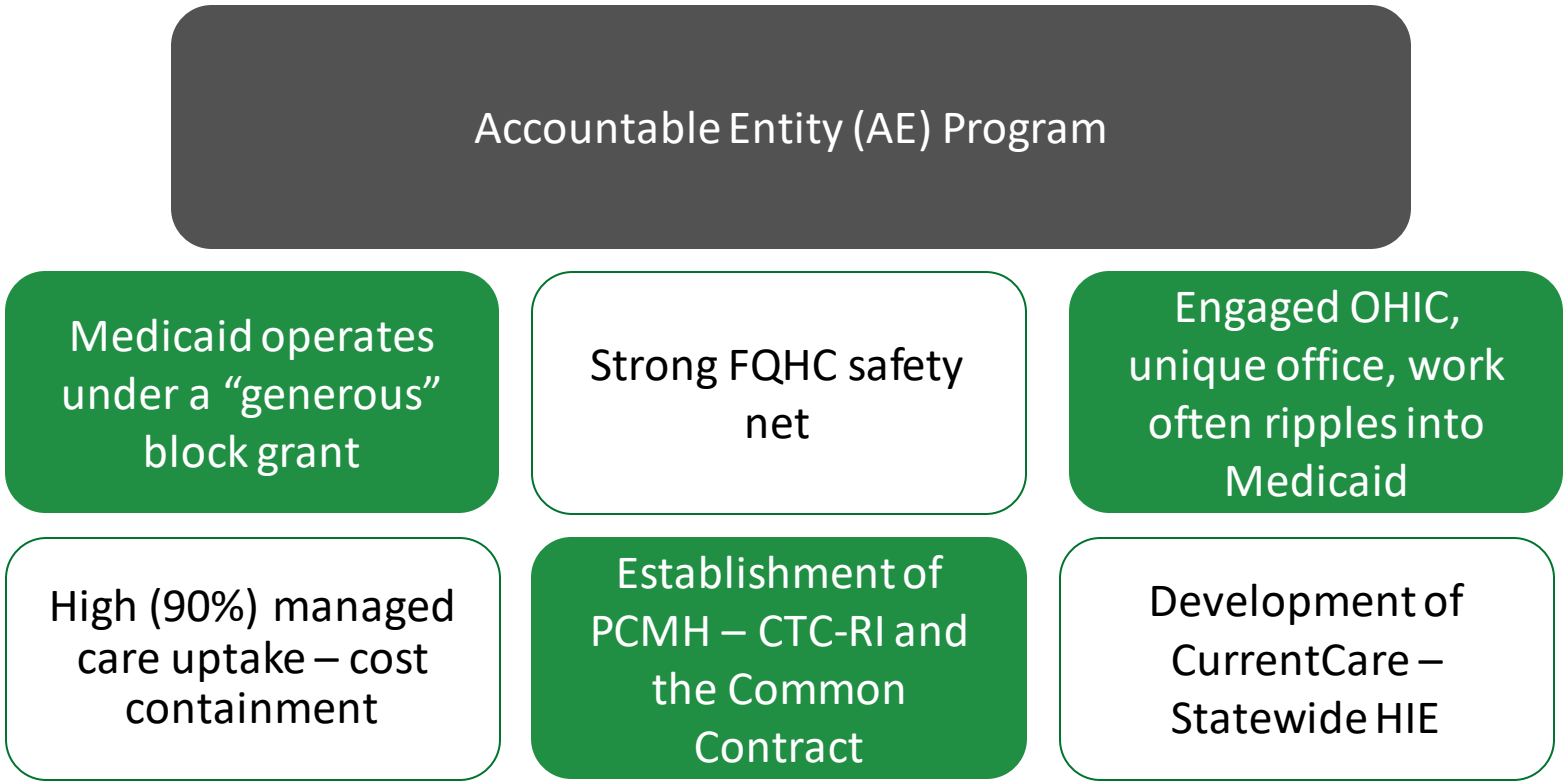
Collaboration • Teamwork
We work closely together to improve the way we do business every day.

Innovation • Think Differently and Creatively
We are committed to continuous improvement and finding new solutions, and will embrace change.

Discussion Topics

1	Payment and Delivery Reform in RI
2	What is an Accountable Entity?
3	Program Foundations
4	Program Progression
5	Results to Date
5	What's Next
6	Challenges
7	Questions?

Payment and Delivery Reform in RI



What is an Accountable Entity?

- AN ACO by any other name
- *"Provider organization is accountable for quality health care, outcomes and the total cost of care of its population."*
- A Value Based Contract, with shared budget responsibility between MCO and provider
- Incentive Funding to further develop infrastructure to manage high-cost, high-risk populations
- Application of data to create provider change
- Improve health equity and outcomes for vulnerable populations
- Share savings and risk as part of a Total Cost of Care Model
- EOHHS has the role of certifying the AE's through certification requirements

Program Foundations

- Focal point of Governor's "Reinventing Medicaid" program
- Supported by Designated State Health Programs Funding
- Leverages the DSRIP Program
- Amendment to waiver brought just under $130M (2016-2020)
- Medicaid Infrastructure Incentive Program (MIIP) provides Incentive Funding
- Two year pilot program followed by 5 Program Years (currently in Program Year 3)
- Six total AE's: 2 CHC stand alone AEs, One aggregated AE (comprised of multiple CHCs), two hospital based A and one non-CHC provider organization AE
- Total earnable incentive pool available to AE and MCO
- Embedded in MCO contract with EOHHS
- Separate MCO contracts with AEs that wrap over standard agreements

Program Progression

Timetable

2016
- EOHHS piloted Medicaid AE program (7/1/16 – 6/30/18)
- EOHHS received system transformation funding from CMS (approximately $260M)

2018
- Launched revised AE program in SFY 18

2020
- Currently in SFY 20 or Program Year (PY) 3

2020+
- AE program funding expected to last until SFY 24 (PY 5)

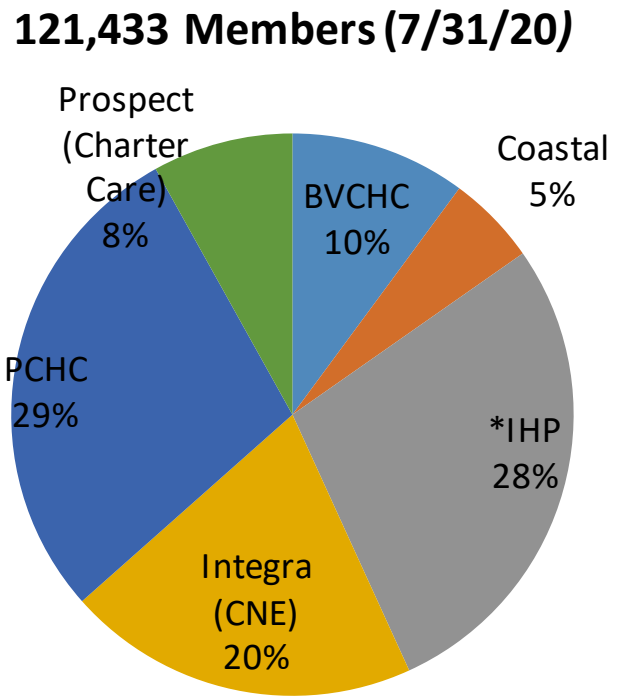
Programmatic Actions

MCO
- Interpretation of EOHHS highly prescriptive guidance
- Adjust internal processes
- Create helpful tools- move towards actionable data, SDOH, claims

AE
- Texting platform for patients
- Gap Analysis
- Population Health Management Tools
- Universal Screenings
- Care Team additions
- New Relationships- family service agencies, BH Providers,

Results to Date

Membership



Outcomes

- Greater sharing of information between MCO's and AE's
- 2 out of 5 AE's achieved shared savings, 4 out of 6 close to hitting spend targets
- High quality scores
- Projected $34M in earned revenue reinvested into program for AE's
- Slight decreases in ER and admissions

What's Next?

State Plans

- AE Roadmaps
- 2019 Proposed new strategic goals for Managed Care and AE's
- Pilot a specialized AE for the MMP population – designed to avoid institutional LTSS (Summer 2022)
- Specialized AE,s may not use TOCC
- Community referral program for SDOH
- Considering SDOH investments considered in medical loss ratio
- Considering shifting towards primary care capitation

AE Activities

- Further data enhancements
- Member engagement
- Better accounting for items outside of AE control
- Pilot "in-lieu of" value add services

Challenges

- Highly prescriptive nature of guidance
- Engaging in new environments with providers not accustomed to APMs
- Low hanging fruit remaining in cost contained market
- Small populations (especially in specialized)
- Highly fragmented delivery systems
- Pace of change/risk adoption
- Political uncertainty – changes in Medicaid financing, stability of ACA

Questions?


Neighborhood
data
success
AEs
population
accountable
EOHHS
quality
Entity
incentives
reporting
SDOH
savings
care
Medicaid
costs
changes
target
claims
MCO
rate
Care
risk
Accountable
Program
Shared
increases
TCOC
Neighborhood's

Health Homes Program: A Year in Review

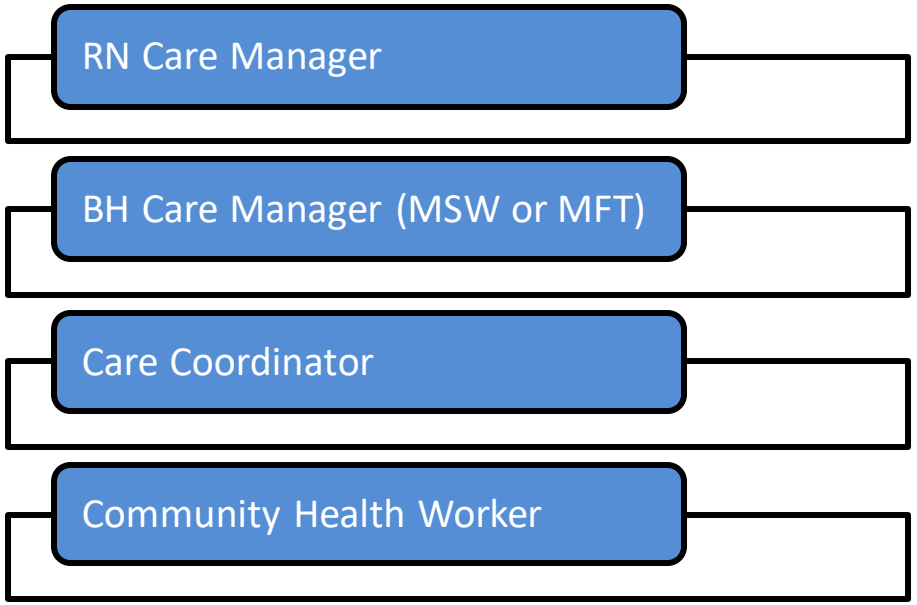
Juan Ortega, MHCM

Director Delegation Oversight

What is the HHP?

- The Health Home Program (HHP) is a DHCS Medi-Cal benefit providing comprehensive care management and whole person care to eligible patients with chronic conditions and a certain level of acuity.
- January 1, 2019 launch for Members with qualifying physical conditions and substance use disorders (SUD)
- July 1, 2019 launch for Members with severe mental illness (SMI)
- HHP services are delivered through Community Based-Care Management Entities (CB-CMEs) referred to as “Care Teams”

HHP Model of Care: Care Team Composition



HHP Core Services

- Comprehensive Care management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to community and social support services

Care Team Model Types

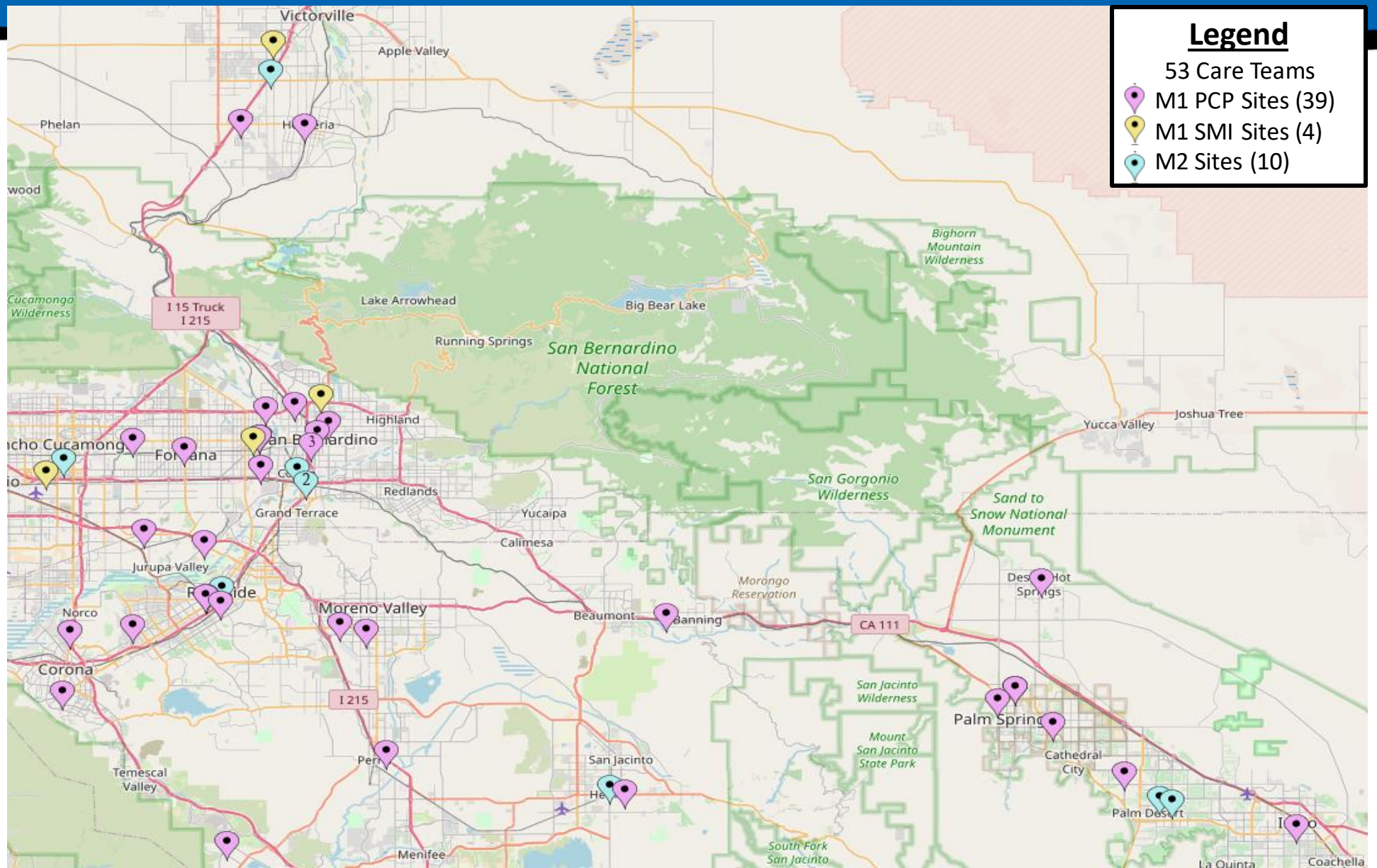
Model 1 Care Teams

Provider-based Care Teams Embedded Onsite at Practices

Model 2 Care Teams

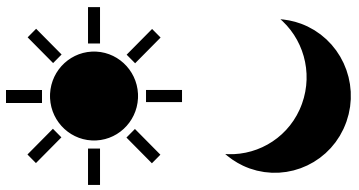
IEHP Regional Care Teams

IEHP HHP Care Team Network Map

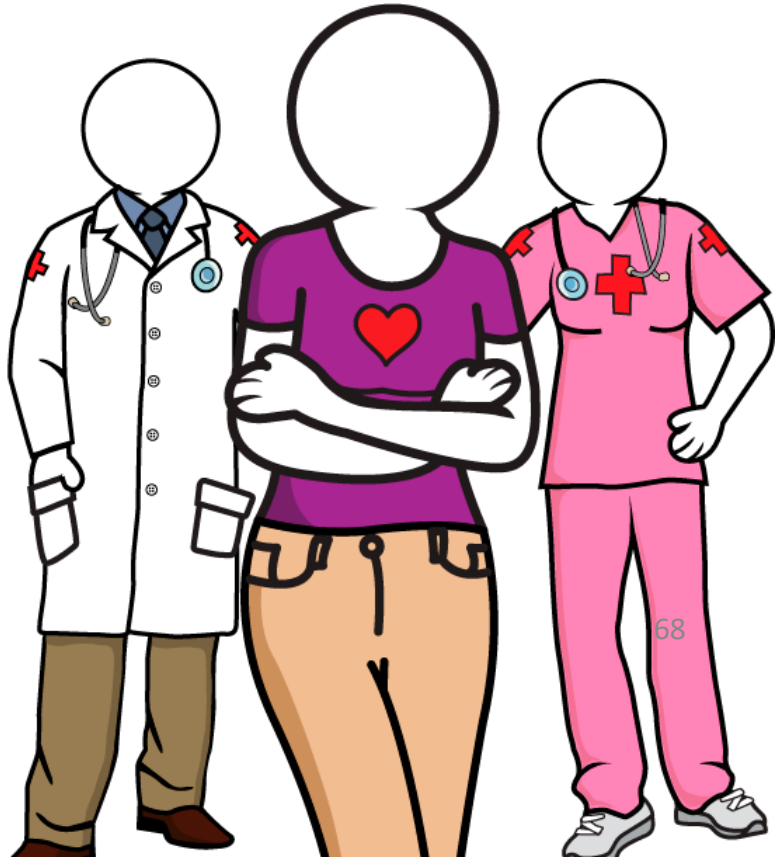


Enrollment Numbers

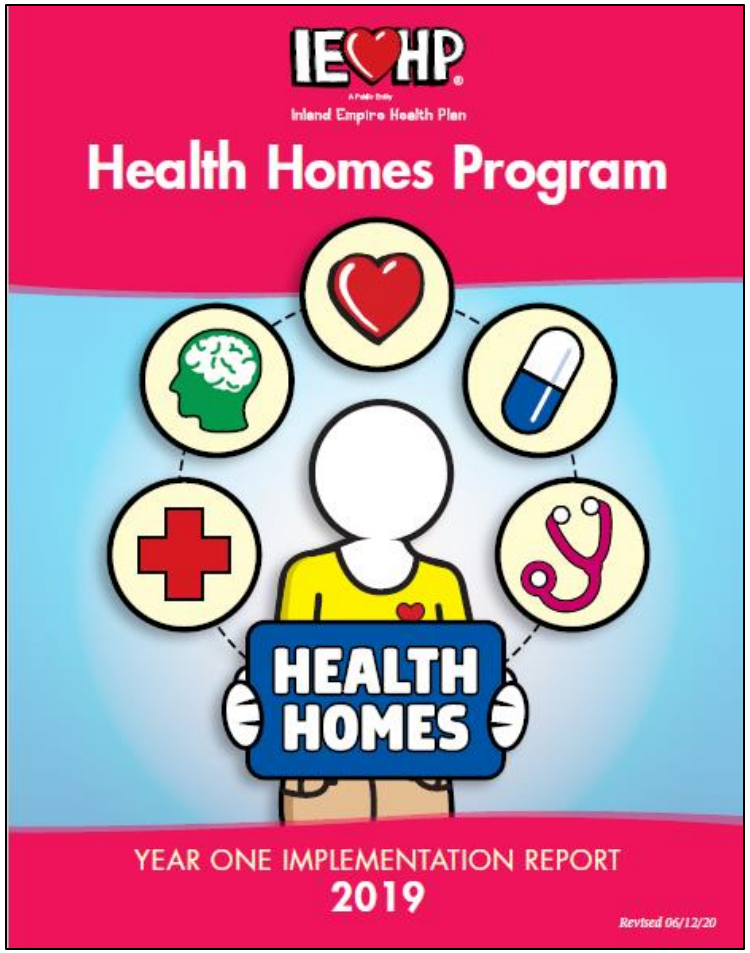
7,560 Patients Enrolled



Patients Enrolled for
216 Days on Average

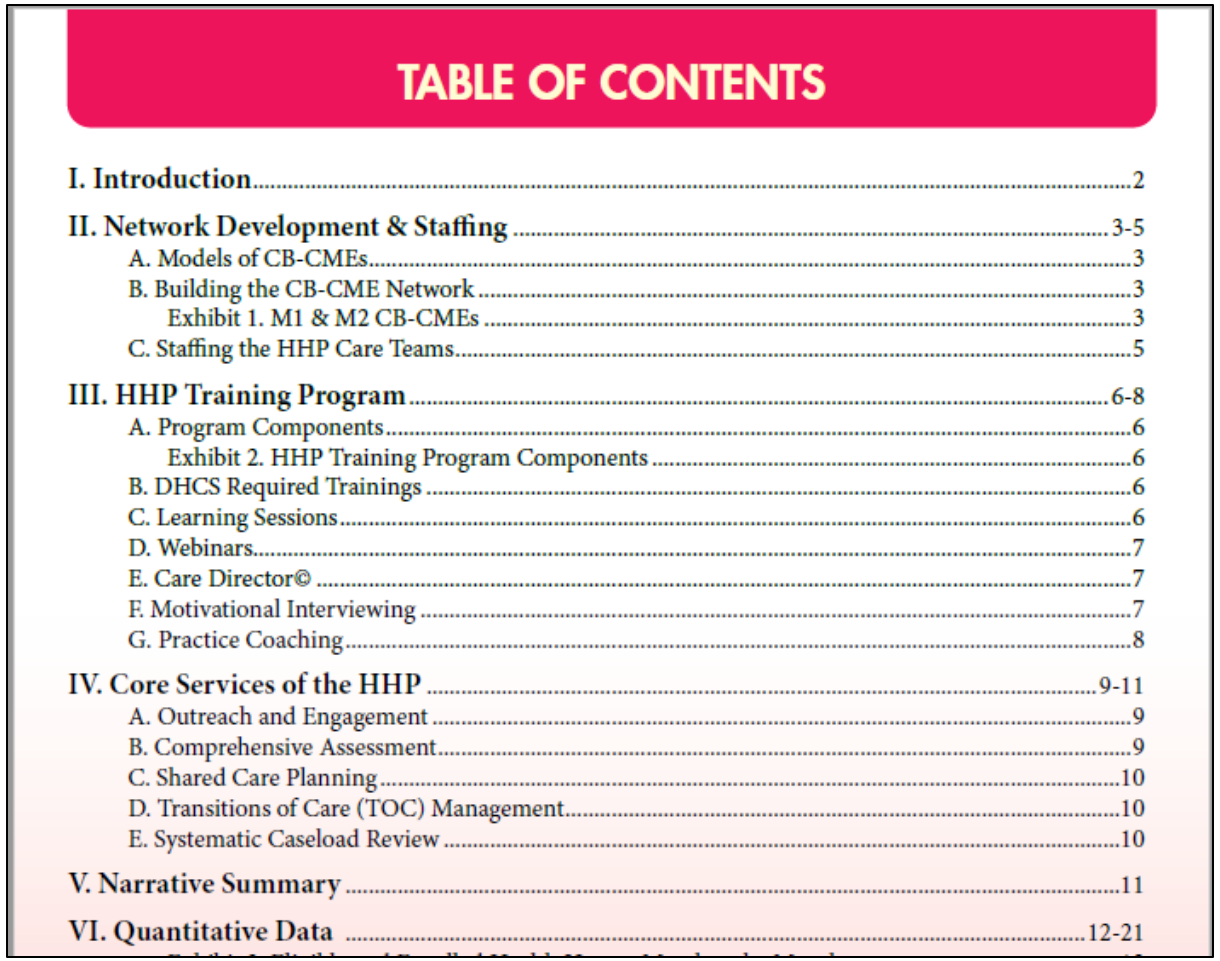


HHP Year 1 Implementation Report



Overview of Report Contents

- Describes the year one implementation and outcomes of IEHP's Health Homes Program (HHP)



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Clinical Outcomes

Outcome Measure	Average Baseline Score	Current Average Score
Systolic Blood Pressure	156	142*
Hemoglobin A1c	10.7%	9.4%*
Patient Health Questionnaire -9	16	13*

** Conducted t-test for significance between baseline and follow-up measurement*
** $p < 0.001$*
From page 20 in the Year One Implementation Report

Significant Utilization Changes

	TOTAL MEMBERS	PER MEMBER PER MONTH MEAN	PTMPY[1]
Primary Care Provider Visits			
Enrolled Membership	3503	0.69	8,253.25*
Matched Eligible but not Enrolled Membership	2633	0.32	3,841.67
HHP enrolled Members had a statistically significant higher rate of PCP visits compared to the control group.			
Emergency Department Visits			
Enrolled Membership	1810	0.21	2,523.15*
Matched Eligible but not Enrolled Membership	1758	0.23	2,816.53
HHP enrolled Members had a statistically significant lower rate of Emergency Department visits compared to the control group.			

[1] *PTMPY (per thousand Members per year)*

From page 19 in the Year One Implementation Report

Significant Utilization Changes

	TOTAL MEMBERS	PER MEMBER PER MONTH MEAN	PTMPY[1]
Total Cost ($)			
Enrolled Membership	3802	616.46	7,397,568.54*
Matched Eligible but not Enrolled Membership	3649	371.70	4,460,457.64
HHP enrolled Members had a statistically significant higher mean cost compared to the control group. The costs accounted for in this calculation include medical and pharmacy costs and do not include capitation or other HHP-related payments.			

[1] *PTMPY (per thousand Members per year)*

From page 19 in the Year One Implementation Report

Other Utilization Changes

	TOTAL MEMBERS	PER MEMBER PER MONTH MEAN	PTMPY[1]
Inpatient Admissions			
Enrolled Membership	281	0.33	3,907.14
Matched Eligible but not Enrolled Membership	278	0.34	4,100.90
Although not statistically significant, HHP enrolled Members had fewer admissions on average compared to the control group.			
Bed Days			
Enrolled Membership	790	0.49	5,903.86
Matched Eligible but not Enrolled Membership	800	0.54	6,478.61
Although not statistically significant, HHP enrolled Members had fewer bed days on average compared to the control group.			
Urgent Care Visits			
Enrolled Membership	1101	0.20	2,437.09
Matched Eligible but not Enrolled Membership	953	0.21	2,498.29
Although not statistically significant, HHP enrolled Members had fewer urgent care visits on average compared to the control group.			

[1] *PTMPY (per thousand Members per year)*

From page 19 in the Year One Implementation Report

Testimonial

- In a patient's own words...

The Future HHP Payment Structure

- HHP Year 1 & 2 – Incentivized volume enrolled
- HHP Year 3 – Incentivize volume AND **value**
  - Rewards CB-CMEs who meet performance standards in key quality performance areas:
    - Care Planning
    - Blood Pressure (BP)
    - Depression

HHP Payment Structure - Value-based Payment

Level Determination for VBP Measures

VBP Measure	Level 1	Level 2	Level 3
Care Plan (% initiated or updated)	20-45.99%	46-84.99%	85-100%
Blood Pressure (% documentation or control)	80% Documentation	80% Documentation + 35-84.99% Control	80% Documentation + 85-100% Control
Depression (% documentation or monitored)	80% Documentation	80% Documentation + 46-84.99% Control	80% Documentation + 85-100% Control

Breakout Groups

Break-out #1

- Cortney Ware – *Discussion Leader*
- Kiesha Smith – *Note-taker/Reporter*
- Elliot Clark
- Julie Antholine
- Juan Ortega
- Amy Turnipseed

Break-out #2

- Tracey Saucier – *Discussion Leader*
- Sarah Spiekermeier – *Note-taker/Reporter*
- Edward Curis
- Katie Domalakes
- Toni Jones

Break-out #3

- Victoria Hurtado – *Discussion Leader*
- Katie-Elyse Turner – *Note-taker/Reporter*
- Johanna Vidal-Phelan
- Felecia Garner
- Tricia Grayson

Questions to Discuss

Q1: What delivery system reform(s) did your plan implement?

Q2: What challenges did it present to the plan, including operational, organization, partnering, and financial?

Q3: If you have them, what have the results of the delivery system reform been? Do you think they were worth it?

Q4: Were there lessons learned?

Discussion and Report Out

Take our Evaluation Survey!

Tell us how we did! You can take the survey at the link below or scan the QR code:

https://www.surveymonkey.com/r/acapleadershipacademy107

ACAP Leadership Academy

Looking Ahead

- **November Webinar: Health Plan Operations**
  - **DATE**: Tuesday, November 10, 2020
  - **TIME**: 3:30-5:00 pm ET/ 12:30-2:00 pm PT

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