3M Proposed Medicaid Transformation Project
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Contact Information	**Jack Ijams Program Manager, State Initiatives, 3M Health Information Systems, jhijams56@mmm.com** *Which organizations were involved in developing this project suggestion?* *Answer:* **3M Health Information Systems and our experience achieving results with other states and their partners engaged in CMS-funded delivery system reform.**
Project Title	**Deploy Value Based Payment Tools with Demonstrated success in driving Successful Delivery System Reform**

Rationale for the Project

- *Problem statement – why this project is needed:*

Achieving the (4) key goals of the waiver proposal, most specifically a Medicaid per capita cost growth that is 2% below national trend, will have the greatest opportunity for success with the WA Health Care Authority mandating certain reform elements the most critical of which are: 1) effective payment incentives that align all health payment and delivery constituents in value-based payment arrangements[1] that improve quality outcomes and lowers costs and establishing and managing in a 'total cost of care' framework.[2]

Supporting research (evidence-based and promising practices) for the value of the proposed project.

Published multi-year savings from 6 states in generating savings from aligning incentives around lowering the key cost drivers of preventable hospital admissions, ED visits, hospital readmissions, complications and unnecessary use of outpatient services.

- *Relationship to federal objectives for Medicaid[i] with particular attention to how this project benefits Medicaid beneficiaries.*

The incentives to lower the key cost drivers and manage total cost of care also explicitly establishes a firm foundation for statewide value based care where costs are reduced and quality of care increases. More specifically, the critical ingredients for delivery system reform of improved coordination and integration of care and achieving whole person care result from adoption of the noted incentives that have shown to be effective in other states.

Project Description

Which Medicaid Transformation Goals[ii] are supported by this project/intervention? Check box(es)

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ✓ Accelerate transition to value-based payment
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved? Check box(es)

- ☐ Health Systems Capacity Building
- ✓ Care Delivery Redesign
- ✓ Population Health Improvement – prevention activities

Describe:

- *Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).*
- *Relationship to Washington's Medicaid Transformation goals.*
- *Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.*

- *Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.*
- *Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project.*

See attached page for input on each of these topics.

Core Investment Components

Describe:

- *Proposed activities and cost estimates ("order of magnitude") for the project.* ***Activities as noted elsewhere in this response can include a range of approaches from an opportunity assessment to a full scale engagement including data intake, enrichment with 3M value based payment tools, incentive payment design and results/dashboard reporting.***
- *Best estimate (or ballpark if unknown) for:*
  - How many people you expect to serve, on a monthly or annual basis, when fully implemented. ***Depends on the scope of the approach undertaken.***
  - How much you expect the program to cost per person served, on a monthly or annual basis. ***An estimate can be provided with the provision of project scope parameters.***
- *How long it will take to fully implement the project within a region where you expect it will have to be phased in.* ***A full scope program can be operational in approximately one year.***
- *The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.* ***Dependent on many factors; others state's results are available via the links elsewhere in this response.***

Project Metrics

The state will monitor implementation of transformation projects at regional and statewide levels through process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Wherever possible describe:

- *Key process and outcome measures (and specific benchmark performance data if known) against which the performance of the project would be measured. Include priority measures sets described in the Waiver application* http://www.hca.wa.gov/hw/Documents/waiverappl.pdf *pages 46-47*[iii]. ***See reply immediately below.***
- *If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation*? ***As discussed elsewhere in this response, the recommended approach is to develop WA state benchmarks for (5) potentially preventable event outcomes measures and use risk-adjusted performance results in incentive based payment arrangements with health plans and/or other risk bearing entities. Use can also be made of the state's priority measures alongside the recommended outcomes measures in the incentive design and dashboard and reporting.***

Footnotes

1. "Value based payment arrangements" includes the use of a 'population health' approach to measuring value. The population health approach used by the 6 states noted here (including WA) is one that determines the statewide benchmark for the occurrence of potentially preventable events (e.g. readmissions, admissions, ED visits etc.) and compares the severity and risk adjusted rates of these events for individual entities (e.g. hospital, health plan, coordinated care entity) against the statewide or other benchmark. Typically these results are shared with the measured entities and reported by the state and/or used in incentive payment arrangements. Use of this population health approach emphasizes measurement of 'whole person' care as compared with process and quality measures deployed for specific diseases (e.g. diabetes) or sub-populations (e.g. well baby visits). Those 6 states using value based payment incentives also continue to use these specific quality and process measures in their gradual transition to value measurement. The population health/whole person care approach enables measurement of the effectiveness of coordination and integration of care across the multiple care delivery entities (e.g. hospital, physician, community health center, home care, etc.). It is also critical part of any approach to integrating physical and behavioral health programs. Another critical ingredient in the population/whole person care approach is a patient centered model for risk adjustment (e.g. 3M Clinical Risk Grouping Software) that considers all the conditions for each enrollee *and the interacting effect* of multiple conditions. The traditional risk adjustment methods widely used by Medicaid programs (e.g. CDPS and others) make use of whole person risk adjustment more difficult. For a further discussion of the value in the use of outcomes based measures in value based care these national thought leaders make some compelling observations ->http://bivarus.com/new/wp-content/uploads/2014/10/www.rwjf .pdf (see page 2)

2. Through our extensive work in other states as well as with 20+ commercial health plans, an important aspect of every Value-Based Payment (VBP) program is the ability to capture total cost as a means to avoid improving parts of a complex system without noticeable improvements to overall system performance. We have repeatedly seen efforts to monitor process indicators (e.g. the rate of testing for blood sugar control in people with diabetes) that ultimately have little impact on the total cost of care. We suggest WA HCA uses total cost of care (TCC) as the ultimate model for the DSRIP initiative. We also recommend adjusting the goals of the program based on the illness burden of the population served (e.g. 3M's Clinical Risk Groups or similar methodology). Total Cost of Care is a measure of all healthcare-related expenses for a specific population and it is the only measure that informs whether or not financial program objectives are being met in the aggregate and how the total cost of healthcare is being impacted. It is important that the DSRIP program provide clear signals to the health care delivery system highlighting outcomes that require systematic improvement of complex behaviors. For example, reducing hospitalization rates for potentially preventable asthma exacerbations requires not only consistent and effective treatment of asthma by a primary care provider but also improved access to primary care services, comprehensive services with nurses and specialists trained in management of complex asthma care, and coordination with home and community based agencies to reduce non-medical factors that can drive children into the hospital with exacerbations. Measuring all potentially preventable hospitalizations (all ambulatory sensitive conditions, not just asthma) signals to the health care delivery system that WA HCA wants improvement not only in pediatric asthma care but fundamental and systematic changes that improve the care of all Washingtonians. Establishing TCC goals and thresholds is a

necessary step to support the design, implementation and evaluation of any delivery or payment reform initiative, including episode payments, bundled payments, year-long episodes for the chronically ill, shared savings, capitation payments, and care management fees for medical home initiatives. It is only with a grounding in total cost of care that any program and therefore any supporting metric can be truly evaluated. Being able to evaluate relative performance of a program to total cost of care makes it possible to understand the underlying value of that initiative (for example: Is it sustainable? How is it impacting other programs and initiatives? Are there unintended consequences?). The impact any given program and thus supporting metrics have on total cost of care should be understood by all program stakeholders (e.g. front line provider, provider groups, or health plan and HCA) allowing program's performance-to-goal to be adequately measured. It is understood that WA HCA does not, at present, have access to all plans costs. Adoption of the TCC approach can be undertaken in steps with use of available and in some cases inferred costs. As the approach matures, policies can be put in place to require the submission of these data.

3M Description for (5) requests:

- **Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).**

  The Washington Health Care Authority has the flexibility to deploy the proposed use of value based care tools in those regions and/or with those sub-populations that hold the most promise for attaining the largest potential for lowering per-capita Medicaid spending. One useful investment is to develop a statewide profile of *which* avoidable intensive services are ordered and *which* sub-populations are involved. 3M performed such an assessment for the Minnesota Department of Health (MN DOH) in 2015 that identified $1.9B in potentially avoidable utilization statewide and those specific avoidable events (e.g ED visits) and sub-populations that contributed most significantly. See this link for the MN DOH report: http://www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf One sub-population, in particular, those enrollees in home or community based care can benefit from an advance in risk adjustment of this population (including frail elderly, post-acute rehabilitation care, and others). The advance is the mapping of assessment results from MDS and/or OASIS into the appropriate severity of illness subgroups in the 3M Clinical Risk Grouping software. The benefit is more rationally alignment of payment (severity appropriate rates) for this subpopulation that cannot be achieved through the use traditional diagnosis coding (ICD) alone with money spent. See page 85 in this research presented at a recent poster session at Academy Health -> http://www.academyhealth.org/files/ARM/photos/2014%20ARM%20Posters2.pdf

- **Relationship to Washington's Medicaid Transformation goals.**

  1. **Reduce avoidable use of intensive services**: Use of the 3M Potentially Preventable Events (more detail here-> http://multimedia.3m.com/mws/media/855236O/3m-ppe-solutions-fact-sheet.pdf?&fn=3m_ppe_solutions_fact_sheet.pdf) and appropriate incentives for contracted managed care organizations to improve performance is a method currently in use by Medicaid programs in WA, NY, TX, IL, CO, MD and IA. See these links for further details about each:

  WA: http://www.hca.wa.gov/rulemaking/Documents/102-15-19-159.pdf
  NY: see pages 6, 25, 32, and 36
  https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/dsrip_specif_report_manual.pdf
  TX: http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml
  IL: http://www.illinois.gov/hfs/MedicalProviders/hospitals/PPRReports/Pages/default.aspx
  CO: see pdf pages 4 and 5
  https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%20Annual%20Report%202013.pdf and
  http://multimedia.3m.com/mws/media/1021352O/colorado-aco-case-study.pdf
  MD: http://www.nejm.org/doi/full/10.1056/NEJMp1508037 see page 2; if access is denied as non-subscriber, see attachment 1 appended here. See also this Health Affairs article:
  http://content.healthaffairs.org/content/31/12/2649.abstract

IA: http://dhs.iowa.gov/ime/about/iowa-health-and-wellness-plan/ACO-VIS

2. Improve population health, focused on prevention

Of the above states, NY and TX within their DSRIP waiver programs, and CO in its regional coordinated care entities have explicitly deployed 3M Potentially Preventable Admissions (PPA) and Potentially Preventable Visits (PPV) to reward Medicaid health plans (NY and TX) and the regional CCOs (in all 3 states) that treat patients with chronic illness preventatively outside the acute care setting.

3. Accelerate transition to value-based payment

A good way to accelerate the transition to value is to learn from peer Medicaid departments in other states who have lessons to share. Each of the states below, as noted, have multiple years of experience and published results of successful use to achieve the triple aim. As of 1/1/16, WA Health Care Authority has begun use of the 3M Potentially Preventable Readmission (PPR) methodology, a value-based payment arrangement where excess preventable hospital readmissions are tied to payment reduction in the state FFS program. A logical next step is to consider incorporating use of the PPR methodology in Apple Care.

State summary of transition to value based payment using 3M value based care tools:

State	Years of Use	FFS/MCO	Published Results
TX	2009 - present	both	Y
NY	2010 - present	both	Y
CO	2011 - present	FFS/regional coordinated care	Y
MD	2012 – present	FFS	Y
IL	2013 - present	FFS	Y
IA	2015 - present	FFS/ACO + MCO in process	N

It is important to note that each of these states continues to employ traditional quality measures that are pertinent to each of the clinical areas of focus (e.g. well baby, diabetes management, cardiac health etc.) alongside the population health/value based measures.

4. Ensure Medicaid per-capita growth is below national trends

As noted, to optimize the reduction in per capital spending, effective incentives that align MCOs and delivery organizations are needed and the states, as noted above, have all shown significant reduction in preventable care and the associated cost of that care. An additional success factor for these states in reducing preventable care and its associated cost is the ability to identify variances in PPE performance at a high level (hospital, plan, region, and by APR DRG) *and* to drill down to the patient level to pinpoint the reason for the variance and thus inform the quality improvement process.

- **Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health equity /reducing health disparities.**

  Conduct a strategic assessment using statewide FFS and plan data, using value based care tools including a total cost of care model. 3M can offer such an assessment which will pinpoint priority challenges that involve types of preventable events, types of patients (e.g. physical or behavioral health or both), regions etc.

  Appropriate further research and policy discussions with stakeholders would ensue about needed incentives in payment design and impacted populations, programs etc.

  To pinpoint health equity and disparities involving access to care, quality, and/or poor health outcomes a critical ingredient in a value based care toolkit is a whole person centric risk adjustment methodology (e.g. Clinical Risk Groups) which is compatible to work alongside identifying social determinants to create a combined clinical and social model. 3M HIS Medical Director, Norbert Goldfield, a key architect of all 3M methodologies including CRG served on the NQF work group charged with advising NQF on the use of social determinants of health. See this discussion for more on our views on this topic-> https://3mhealthinformation.wordpress.com/2014/10/22/integrating-sociodemographic-factors-into-risk-adjustment-important-considerations-for-nqfs-robust-trial-period/

- **Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.**

  NY state uses 3M CRG's to identify the prescribed population in their CMS Health Home program - https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm#patient_enr see question 4.

- **Potential partners, systems, and organizations (e.g., health and social service providers, ACH participants) needed to be engaged to achieve the results of the proposed project**

  3M serves roughly 60 hospitals in WA State and has held preliminary discussions with one of the largest health systems regarding value based payment. We have also had exploratory discussions with an organization comprising multiple community-based health centers throughout the state on ways to measure and improve the value of health delivered based on our tools and approach. All 3M value based care solutions can be scaled from a pilot with one organization to a statewide deployment as in the states noted above.