State Approaches to Providing Health-Related Supportive Services through Medicaid

June 2, 2016
1:00-2:30 pm ET

For Audio Dial: 1-888-819-8046
Passcode: 916263

Made possible through The Commonwealth Fund
Welcome and Introduction
Landscape of Health-Related Supportive Services
State Spotlight 1: Oregon’s Flexible Services
State Spotlight 2: Massachusetts’ Pediatric High-Risk Bundled Payment
Questions and Discussion
Closing Remarks
About the Center for Health Care Strategies

CHCS is a non-profit policy center dedicated to improving the health of low-income Americans

Our Priorities and Strategies

- Enhancing access to coverage and services
- Advancing delivery system and payment reform
- Integrating services for people with complex needs

- Best practice dissemination
- Collaborative learning
- Technical assistance
- Leadership and capacity building
Introductions

Center for Health Care Strategies

Anna Spencer, Senior Program Officer

Oregon Health Authority

Chris DeMars, Director of Systems Innovation, Transformation Center

University of Massachusetts Medical School

Katharine London, Principal, Center for Health Law and Economics
• Welcome and Introduction
• **Landscape of Health-Related Supportive Services**
• State Spotlight 1: Oregon’s Flexible Services
• State Spotlight 2: Massachusetts’ Pediatric High-Risk Bundled Payment
• Questions and Discussion
• Closing Remarks
Social Determinants of Health (SDOH)

- SDOH play a key role in health outcomes
  - 95% of health spending is devoted to direct medical services, but nearly half of all deaths are attributable to non-medical indicators

- Evidence that addressing SDOH can improve health outcomes and reduce health care spending
  - Medicaid beneficiaries with stable housing found to spend significantly less on health care

- Medicaid exploring programmatic and policy changes to address SDOH
  - SDOH disproportionately have an impact on the health of low-income individuals
Health-Related Supportive Services

- **Broad range of supportive services**
  - Housing support
  - Employment support
  - Education and training
  - Environmental modifications
  - Self help/support groups

- **Federal recognition of supportive services**
  - In 2015, CMS released guidance to help states design benefit programs that include flexible services to expand HBCS for homeless
  - New managed care regulations clarify ‘in lieu of’ standard, which give plans flexibility under risk contracts to provide alternate services or services in alternate settings
# State Medicaid Reimbursement Strategies

<table>
<thead>
<tr>
<th>Program</th>
<th>Payment Model</th>
<th>Examples of Services Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Massachusetts</strong>&lt;br&gt;&lt;i&gt;Children’s High-Risk Asthma Bundled Payment&lt;/i&gt;</td>
<td>- Bundled payment</td>
<td>- Home visits from community health workers&lt;br&gt;- Environmental mitigation supplies</td>
</tr>
<tr>
<td><strong>New York</strong>&lt;br&gt;&lt;i&gt;Supportive Housing Services&lt;/i&gt;</td>
<td>- State-only Medicaid funds</td>
<td>- Rental subsidy assistance&lt;br&gt;- Job training&lt;br&gt;- Tenancy support/mediation</td>
</tr>
<tr>
<td><strong>Oregon</strong>&lt;br&gt;&lt;i&gt;Coordinated Care Organizations&lt;/i&gt;</td>
<td>- Global budget</td>
<td>- Education/training&lt;br&gt;- Self-help/support group&lt;br&gt;- Home remediation</td>
</tr>
<tr>
<td><strong>Utah</strong>&lt;br&gt;&lt;i&gt;Accountable Care Organizations (ACOs)&lt;/i&gt;</td>
<td>- Risk-adjusted, capitated model with annual increase of no more than two percent</td>
<td>- Home remediation&lt;br&gt;- Housing assistance</td>
</tr>
<tr>
<td><strong>Vermont</strong>&lt;br&gt;&lt;i&gt;Blueprint for Health/SASH&lt;/i&gt;</td>
<td>- Per beneficiary, per month payment&lt;br&gt;- Capacity payment to Community Health Teams</td>
<td>- Nutritional education&lt;br&gt;- Self-help/support group</td>
</tr>
</tbody>
</table>
New York

- Use of state-only Medicaid funds to provide housing support to Medicaid beneficiaries
- Support includes tenancy support, job training, rental subsidy assistance

Utah

- Under 1115 Waiver authority, state ACOs are able to provide supportive services
- Not prescriptive, but ACOs have flexibility to pay for environmental remediation/improvements, self-help support, and housing assistance

Vermont

- Under the Blueprint for Health, Vermont uses blended funding to support SASH, a program that connects individuals with disabilities with community-based services and supportive housing
Steps for Developing Health-Related Supportive Services

1. Engage stakeholders in the planning process
   ► Agree upon the specific needs of a well-defined population participating in a specific program

2. Define the scope of services
   ► Create sufficient and consistent guidance for providers

3. Develop process for implementation
   ► Provide broad direction or defined/phased in approach

4. Establish tracking and reporting mechanisms
   ► Ensure consistency and measurement of utilization rates
Agenda

- Welcome and Introduction
- Landscape of Health-Related Supportive Services
- **State Spotlight 1: Oregon’s Flexible Services**
- State Spotlight 2: Massachusetts’ Pediatric High-Risk Bundled Payment
- Questions and Discussion
- Closing Remarks
Flexible Services in Oregon’s Medicaid Program

Chris DeMars, Director of Systems Innovation, Transformation Center
Oregon’s Health System Transformation & Flexible Services

- Triple aim: better health, better care, lower costs
- Began with coordinated care organizations (CCOs)
  - CCOs are networks of all types of health care providers (physical health, addictions and mental health, and oral health care) who work together to serve Oregon Health Plan (Medicaid) members
- Now spreading the coordinated care model to other payers (i.e. public employees, teachers)
- Medicaid dollars to support flexible services => Triple Aim
## Oregon’s Coordinated Care Organizations

<table>
<thead>
<tr>
<th>Before CCOs</th>
<th>With CCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fragmented care</td>
<td>• Coordinated, patient-centered care</td>
</tr>
<tr>
<td>• Disconnected funding streams for services with unsustainable rates of growth (i.e. mental health, dental)</td>
<td>• Integrated funding for multiple services with a targeted rate of growth</td>
</tr>
<tr>
<td>• Limited financial incentives for improving health</td>
<td>• Metrics with financial incentives to improve quality and access</td>
</tr>
<tr>
<td>• Limited investment in services outside traditional medical care</td>
<td>• Flexible services beyond state-plan services may be provided to improve health</td>
</tr>
<tr>
<td>• Health care delivery disconnected from population health</td>
<td>• Community health assessments and improvement plans</td>
</tr>
<tr>
<td>• Limited community voice and local area partnerships</td>
<td>• Local accountability and governance, including a community advisory council</td>
</tr>
</tbody>
</table>
Fragmented Managed Care to CCOs

Physical Care
Mental Care
Oral Care

Coordinated Care Organizations
Physical Care
Mental Care
Oral Care
Other Services
Admin/Flexible Services
Defining Flexible Services

• Oregon’s 1115 waiver gives CCOs flexibility to provide non-medical services that result in better health/lower costs

• **Current flexible services definition:**
  - Health-related services
  - Not covered benefits under Oregon’s State Plan
  - Lack billing or encounter codes
  - Consistent with member’s treatment plan developed by provider and documented in medical record
  - Likely to be cost-effective alternatives to covered benefits
  - Likely to improve health outcomes
Wide Variety of Flexible Services

- CCOs use flexible services to provide a range of supports that generally fall in these categories:
  - Housing supports & services
  - Wellness
  - Mental health & counseling
Flexible Services: Housing Supports & Services

• **Housing supports and services include:**
  – Transitional housing supports
  – Home improvements: critical repairs, air conditioners, child safety locks, ramps
  – Rental assistance, utilities, moving expenses, deposits

• **Example:**
  – CCO periodically uses flexible services to cover transitional, stable housing for members in need of stable shelter post hospital discharge
Flexible Services: Wellness Supports

• **Wellness supports include:**
  – Exercise shoes
  – Gym memberships
  – Healthy cooking and exercise classes

• **Example:**
  – CCO offers a community-wide “Complete Health Improvement Program”
    • Includes health screens and group lifestyle education sessions
Flexible Services: Mental Health & Counseling Supports

• Mental health & counseling supports include:
  – Mental health professionals embedded in school systems
  – Employment counseling to support job searches
  – Community Health Workers
  – Mental health courts

• Example:
  – CCO provides school-based mental health counseling program in every school in a rural Eastern Oregon county

  • $580,000 in savings as a result of averted outpatient services
Flexible Service Expenses in 2015

CCO report minimal, but climbing, expenses in flexible services

- **$2.3M** was spent by CCOs in 2015 on flexible services (~0.07% of total CCO service expenses)
- **278,000** Medicaid members of over 1,000,000 received support from flexible services
  - 40% of these members supported through community-wide programs
- Five of the 16 CCOs reported they did **not** use any flexible service dollars
Barriers to Use of Flexible Services

• Flexible services are not counted as medical expenditures in the CCOs’ rates
  – Current waiver renewal proposal would change this
• Uncertainty re: member communication on flexible services
• Concern about potential demand if flexible services are widely advertised
  – Lack of capacity to manage flexible services for large numbers of members
• Lack of understanding among providers when to recommend flexible services
Barriers to Use of Flexible Services (cont.)

- Some CCOs have requested clarification about what counts as a flexible service
  - Other CCOs are comfortable not having this direction
- Administrative challenges:
  - Time intensive (e.g., processing gym memberships)
  - Balancing need for timely decisions with need for provider authorization
- Reporting to the state: how to count the members and report impact/outcomes
- Challenge identifying effectiveness/return on investment
Individual & Group Investment

Proposed Future Definition: Health-Related Services

- **Flexible services** are cost-effective services offered instead of or as an adjunct to covered benefits (e.g., home modifications and healthy cooking classes).

- **Community benefit initiatives** are community-level—as opposed to member-specific—interventions such as investments in care management capabilities and provider capacity.

- **Proposal**: Consider health-related services in medical component of rate development instead of administrative component.
Optimism

• Despite challenges, CCOs generally seem to be optimistic about flexible services
  – “It doesn’t cost a lot to improve someone’s living situation or pay for exercise classes, so we’re not spending a lot of money. That doesn’t mean flexible services aren’t important.”
  – “We’ve only been doing this for three years. We need more time to make flexible services work”

• With more experience and Oregon’s renewed 1115 waiver, CCOs’ use of flexible services may increase
Welcome and Introduction
Landscape of Health-Related Supportive Services
State Spotlight 1: Oregon’s Flexible Services
State Spotlight 2: Massachusetts’ Pediatric High-Risk Bundled Payment
Questions and Discussion
Closing Remarks
Massachusetts Children’s High-risk Asthma Bundled Payment (CHABP) Demonstration

Katharine London, Principal, Center for Health Law and Economics
University of Massachusetts Medical School

June 2, 2016
New Payment Methods

**Bundled Payment:** A single payment to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care (e.g., a knee replacement surgery, Health Homes services)

- **Program design** targets services and funds to people who need them

**Global Payment:** A fixed-dollar payment (“capitation”) for the care that patients may receive in a given time period, such as a month or year. Global payments place providers at financial risk for both the occurrence of medical conditions as well as the management of those conditions

- **Providers** target services and funds to people who need them

Statutory Mandate – Key Provisions

• EOHHS “shall develop a **global or bundled payment system** for high-risk pediatric asthma patients enrolled in the MassHealth program, designed to prevent unnecessary hospital admissions and emergency room utilization.”

• “The global or bundled payments shall reimburse expenses necessary to manage pediatric asthma, including, but not limited to, **patient education, environmental assessments, mitigation of asthma triggers and purchase of necessary durable medical equipment.**”

• “The global or bundled payments shall be designed to **ensure a financial return on investment** through the reduction of costs related to hospital and emergency room visits and admissions not later than 2 years after the effective date of this act.”

Goal and Objectives

Goal: To evaluate the degree to which a bundled payment and flexible use of funds enhances the effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower cost.

Objectives:

• to develop a bundled payment system for members with high-risk pediatric asthma enrolled in selected MassHealth Primary Care Clinician Plan Practices, designed to support a comprehensive chronic disease management approach to asthma in order to prevent the need for hospital admissions and emergency department visits and to improve health outcomes;

• to demonstrate whether a financial return on investment can be achieved through the reduction of costs related to hospital admissions and emergency department visits in order to justify and support the sustainability and expansion of the model;

• to help pediatric providers begin developing skills and infrastructure they will need to manage global payments as accountable care organizations; and

• to help children and their families learn practical and actionable methods for managing asthma in the context of their lives and for optimally controlling asthma symptoms to minimize asthma’s impact on their health, wellbeing and quality of life.
# Chronology

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2010</td>
<td>Statutory mandate included in outside section of Massachusetts fiscal year 2011 budget</td>
</tr>
<tr>
<td>Spring 2011</td>
<td>Pediatric Asthma Advisory Committee convened</td>
</tr>
<tr>
<td>December 2011</td>
<td>CMS approved 1115 Waiver, including expenditure authority for a Pediatric Asthma Pilot Program, subject to CMS approval of required protocols</td>
</tr>
<tr>
<td>January – December 2012</td>
<td>Massachusetts developed detailed program design and protocols</td>
</tr>
<tr>
<td>January 2013</td>
<td>Massachusetts submitted to CMS a full set of protocol documents, including a draft RFR and model contract amendment</td>
</tr>
<tr>
<td>April 2013</td>
<td>Request for Responses (RFR) issued</td>
</tr>
<tr>
<td>June 2013</td>
<td>Responses to RFR due</td>
</tr>
<tr>
<td>August 2014</td>
<td>CMS approved 1115 Waiver protocols</td>
</tr>
</tbody>
</table>
Design Process

Established an internal program design team, including clinicians, program and policy experts, and data analysts

- Developed program design through an iterative process
- Reviewed relevant literature and model programs
- Analyzed Medicaid claims and eligibility data to determine:
  - number of children and practices that might be eligible to participate in the pilot under various proposed criteria
  - cost to Medicaid for asthma care in hospitals for eligible children in prior years (baseline cost)
- Collaborated closely with DPH asthma prevention staff
- Obtained expert advice from Advisory Committee
Advisory Committee

20 members, including
• Physicians – primary care and asthma specialists
• Nurses
• Pharmacists
• Researchers
• representatives of professional organizations
• health care administrators

Advisory Committee provided input on
• Providers’ qualifications for participation
• Eligible patients, including definition of high-risk asthma
• Scope of services: clinical as well as financial/operational
• Bundled payment methodology and services to include in bundle
• Data submission and evaluation plan
Patient Enrollment Criteria

Patients must meet all 5 criteria to be enrolled in the CHABP:

1. Age 2-18 at CHABP Enrollment
2. Current MassHealth Member enrolled in participating practice site panel
3. Clinical diagnosis of Asthma
4. **High-risk asthma**: In prior 12 months had at least one:
   a. Inpatient admission for asthma,
   b. Hospital observation stay for asthma,
   c. Hospital emergency department visit for asthma, or
   d. Oral systemic corticosteroid prescription for asthma
5. **Poorly controlled asthma**: Asthma Control Test (ACT)* score of 19 or lower twice within a 2 month period in 12 months prior to enrollment

*ACT is available at www.asthmacontroltest.com
Clinical Services

1. **Traditional MassHealth Covered Services**
   Practice must continue to provide all medically necessary MassHealth-covered services to assess, monitor & manage asthma

2. **Required Services**
   At least once per month, practice reviews all CHABP Enrollees to identify need for follow-up or review by Interdisciplinary Care Team
   - Make best effort to contact families at specified times to offer services
   - Offer CHW home visit
   - Contact child’s school & childcare program, with parent permission

3. **Optional Services**
   Practice prioritizes use of CHABP funds to best meet CHABP Enrollees’ needs. Services may include, but are not limited to:
   - CHW home visits, environmental assessment, care coordination, additional family contacts and assistance
   - Environmental supplies to mitigate asthma: mattress & pillow covers, vacuum, HEPA filter, pest management supplies, etc.
Potential cost avoidance

Pediatric asthma, SFY2011 costs in millions

Inpatient hospitalizations  544
Potentially preventable admissions*  232
MassHealth cost for inpatient care  $2.0 M
Potentially avoidable cost  $0.9 M

Emergency department visits  2992
Potentially preventable ED visits*  255
MassHealth cost for emergency care  $1.3 M
Potentially avoidable cost  $0.1 M

Total inpatient and ED cost  $3.3 M
Total potentially avoidable cost  $1.0 M

Payment

**Phase 1:** $50 PMPM bundled payment:

- Includes services to manage high-risk pediatric asthma: community health worker (CHW) home visits, environmental mitigation supplies, educational materials
- Does not include clinical services currently covered by MassHealth

**Phase 2:** Bundled payment will include, subject to CMS approval:

- All Phase 1 services
- Other Medicaid ambulatory services required for both the effective treatment and management of pediatric asthma for high-risk patients: MD, NP, RN visits, care management, DME, etc.
- May include a infrastructure stipend:
  - systems to coordinate services provided by other entities
  - financial, legal and information technology systems needed to accept and redistribute the bundled payment
Reporting & Communications

Participating Practices:
• Participate in monthly Learning Collaboratives
• Submit Required Reports
  1. Enrollment Report, monthly
  2. Utilization Report, quarterly
• Maintain record of home visits, telephone contacts, in-office education, and supplies provided
• Participate in Evaluation activities, including pre- and post-intervention interviews
Outcome Measures for CMS

- Difference, relative to other children with high-risk asthma enrolled in the MA Medicaid PCC Plan, in:
  - Hospital admissions and observation stays for asthma
  - Emergency department visits for asthma
  - Cost of asthma care
- Change in asthma control (shortness of breath, waking at night, need for rescue medication, and interference with normal activities)
- Return on investment
- Qualitative evaluation of provider experience managing bundled payments; lessons learned
Visit CHCS.org to...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services

- **Subscribe** to CHCS e-mail, blog and social media updates to learn about new programs and resources

- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries