State Medicaid Innovations

United States of Care
Legislator Learning Collaborative
October 1, 2019

Today's Agenda

- About United States of Care
- About the Legislator Learning Collaborative
- Today's Experts
  - Jason Helgerson
  - John McCarthy
- State Medicaid Innovations
- Q&A/Discussion

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United States of Care

The mission of United States of Care is to ensure that every single American has access to quality, affordable health care regardless of health status, social need, or income.

A non-partisan non-profit, we are building and mobilizing a movement to achieve long-lasting solutions that make health care better for everyone. USofCare will help make it happen by working with Americans from across the country: patients and caregivers, advocates, physicians and other clinicians, policymakers, and business, civic, and religious leaders.

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Our Core Principles

Affordable Source of Care:
Everyone should have an affordable regular source of care for themselves and their families

Protection from Financial Devastation:
All people and families should be protected from financial devastation because of illness or injury

Political and Economic Viability:
Policies to achieve these aims must be fiscally responsible and win the political support needed to ensure long-term stability

Founder's Council

Our Founder's Council members bring a diversity of perspectives and serve as informal advisors on specific matters, offering their diverse expertise to provide targeted advice as the organization builds out the work.

These individuals joined the effort because they are aligned with the mission and principles of United States of Care and want to break the logjam in Washington to move the conversation forward on expanding health care.

USofCare Legislator Learning Collaborative

- Opportunity for legislators to network with, learn from, and discuss important health care topics with lawmakers from across the country
- Access to USofCare's extensive expert network
- Quarterly conference calls and webinars on topical health care issues, with additional opportunities for information-sharing and collaboration

Future LLC topics:

- Navigating health and human services budget constraints
- Rising prescription drug prices
- Mental health parity and access to mental health care/addiction services
- Addressing provider shortages through telehealth and scope of practice policy
- Promoting economic mobility and self-sufficiency
- Challenges and solutions unique to rural America

About Jason Helgerson:

- Jason is an entrepreneur, investor, consultant and social change agent
- Founded Helgerson Solutions Group
- Jason also advises Private Equity firms and Venture Capital funds, as well as works as Senior Advisor to McKinsey and Company
- Former New York Medicaid Director for 7+ years and served as Executive Director for New York's Medicaid Redesign Team
- Former Wisconsin Medicaid Director and principal project sponsor for BadgerCare Plus

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About John McCarthy:

- John has more than 20 years of health care consulting and government leadership experience
- A foundering partner at Speire Healthcare Strategies
- John works with clients across the industry to help them respond to policy and legislative changes and make sound business decisions
- Former Medicaid Director in Ohio for 6 years
- Former Medicaid and Policy Director in the District of Columbia for 5 years

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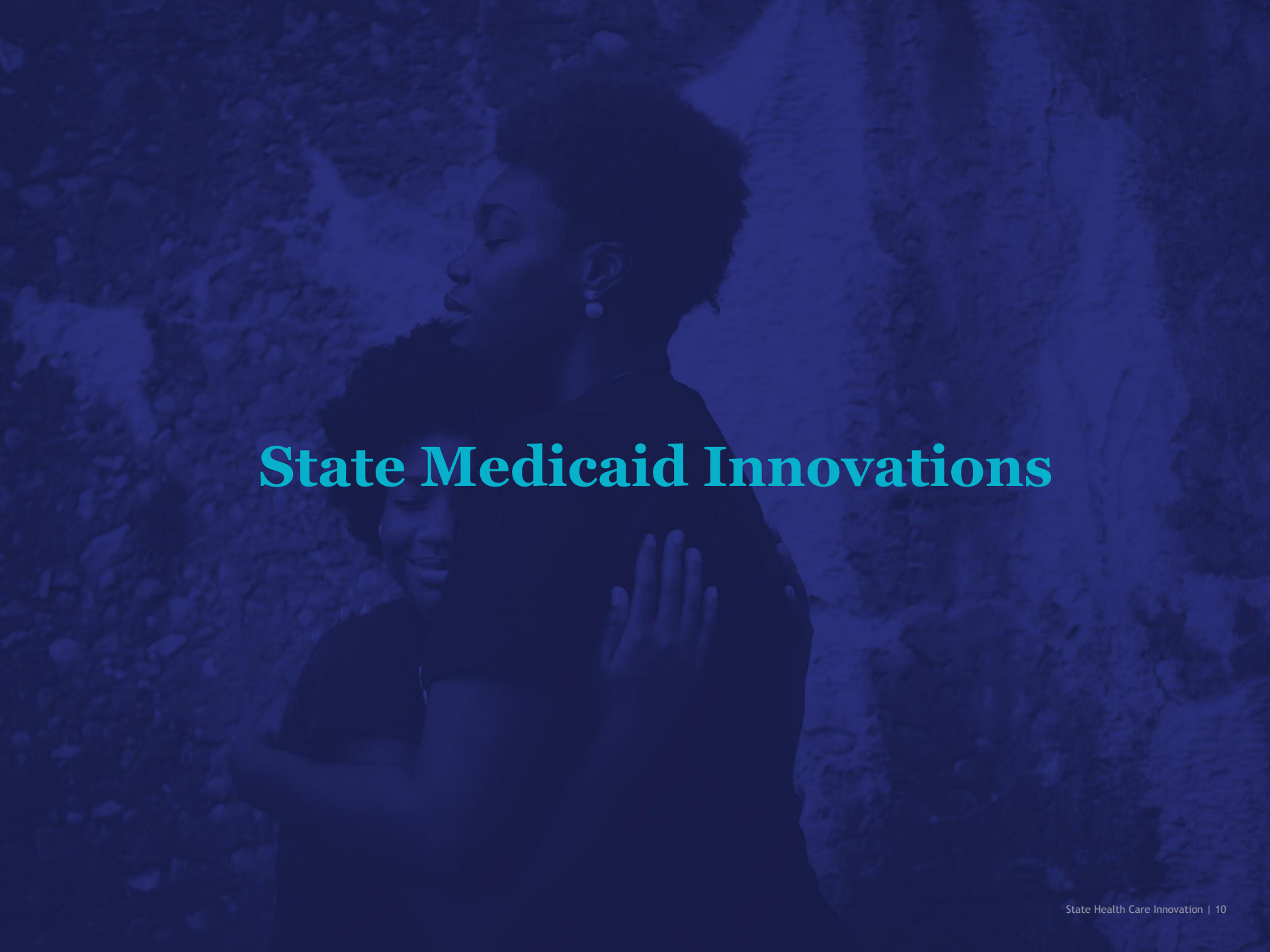
Some Opening Thoughts

- Not all state Medicaid programs are alike. Period. Not all “good ideas” work in all states.
- Not all big ideas require new funds. Too much focus on adding more and not fixing what already exists.
- Specific ideas are more likely to get implemented than vague problems are to get fixed. Be specific!
- Complex problems are very hard to solve with legislation. At some point you need to trust - and verify - the Medicaid agency.



State Medicaid Innovations

A few innovations happening in Medicaid at the state level:

- ★ Social Determinants of Health
- ★ Value Based Payments
- ★ First 1K Days Initiative
- ★ Justice-Involved Individuals

Social Determinants of Health

Social Determinants of Health

- Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- Examples:
  - Housing
  - Food
  - Clothing
  - Education
  - Community

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Source: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Minimum Effort Threshold in Managed Care for SDOH Efforts

- Everyone is talking about what states can and should be doing to address the social determinants of health
- Movement nationally is slow and community-based organizations and others are frustrated
- States should start to mandate that health plans take more direct action - One option is a minimum threshold for spending on SDOH efforts
- States can require that all plans submit SDOH plans to the state and then commit to a % of premium to those plans
- Managed care RFPs can give additional points to plans that commit more funds to these efforts

SDOH in North Carolina

- NC's 1115 waiver lets them spend up to $650 million in Medicaid on SDOH pilot programs.
  - Up to $100 million can be used on infrastructure
- NCCARE360 is a statewide resource and referral platform.
  - Its role is to make it easier for providers, insurers and human service organizations to connect people with the community resources they need to stay healthy.
  - The platform is a public-private partnership of a broad group of stakeholders and will be administered by the Foundation for Health Leadership and Innovation (FHLI).
- NCCARE360 has two core functionalities:
  - Resource Database: A directory of community-based resources throughout the State
  - Referral platform: Health care providers, insurers and human service providers are able to connect people who have identified unmet needs with resources in their communities.

SDOH in North Carolina *(continued)*

Eligibility requirements for SDOH pilot services

Must be enrolled in managed care	+	Meet at least one needs-based criteria: • Adults – 2 or more chronic conditions • Pregnant women – multifetal gestation • Children ages 0 to 3 – Neonatal intensive care unit graduate • Children 0 to 21 – Experiencing three or more categories of adverse childhood	+	Have at least one Social Risk Factor: • Homeless and/or housing insecure • Food insecure • Transportation insecure • At risk of, witnessing, or experiencing interpersonal violence

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Source: https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf

SDOH in North Carolina *(continued)*

Examples of Services Offered

- Housing
  - Targeted tenancy support and sustaining services
  - Housing quality and safety improvements
  - One-time payments to secure housing (e.g. first month's rent and security deposit)
  - Short-term post hospitalization housing
- Food
  - Linkages to community-based food services (e.g. Supplemental Nutrition Assistance Program (SNAP)/Women, Infants and Children (WIC) application support, food bank referrals
  - Nutrition and cooking coaching/counseling
  - Healthy food boxes
  - Medically tailored meal delivery
- Transportation
  - Linkages to transportation resources
  - Payment for transit to support access to Pilot services include: public transit & taxis, in areas with limited public transit infrastructure
- Interpersonal Violence/Toxic Stress
  - Linkages to legal services for interpersonal violence (IPV) related issues
  - Services to help individuals leave a violent environment and connect with behavioral health resources
  - Evidence-based parenting support programs
  - Evidence-based home visiting services

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Source: https://files.nc.gov/ncdhhs/documents/Healthy-Opportunities-Pilot_Policy-Paper_2_15_19.pdf

SDOH in New York State

- ★ Created bureau within the Medicaid agency dedicated entirely to SDOH efforts
- ★ Requirement that all advanced Value Based Payment (VDP) contracts include community-based organization partner to address SDOH

Specific Examples

- ★ Housing is Health - CDPHP - a regional health plan - providing housing interventions for those with multiple chronic conditions - intensive support to obtain safe, affordable housing, plus rental subsidies when needed
- ★ Breathe Better Bronx - CHW delivers in-home assessment & interventions including advocacy efforts with landlord, mattress protectors, green cleaning supplies

Value Based Payments

VBP Roadmap for Medicaid

- ★ Medicaid is either the largest or second largest payer in any state
  - As a result, the program can help drive system change
- ★ VBP is coming but slower than many have hoped
- ★ Every state should have an approved Medicaid path to VBP
  - That path should be implemented in concert with Medicare alternative payment models (APMs) to the max degree possible to magnify its impact
  - See NYS for an example
- ★ The legislature could require that a plan be developed and then hold hearings to discuss it

VBP in States

States have taken two approaches

1. Design alternative payment models and require all providers to be paid in that manner in both fee-for-service and managed care (a few states)

   OR

2. Place VBP requirements in managed care contracts and require plans to implement (most states with managed care)

Example of VBP Success - New York

- Under terms of 1115 Medicaid Waiver - DSRIP - the state is obligated to ensure that 80% of all provider payments are value-based by 2020
- 65% value-based in the latest health plan survey
  - Cuts across all populations and services in managed care
  - Representing ~90% of the total program population
- Plans and providers are offered a menu of choices that are considered by the state and CMS as "value-based"
  - Three levels of risk - upside only, upside/downside and prepayment/capitation
  - Plans that fail to hit targets are penalized

Example of VBP Success - Ohio

- Implemented two types of payment models: Patient Centered Medical Homes (named Ohio CPC) and episodic payments (similar to bundled payments)
- Ohio CPC launched on January 1, 2017
  - Includes nearly 1.25 million members statewide
  - Representing ~40% of the state Medicaid population
- The Episodes program was launched in 2015
  - Includes over 43 episodes in reporting
    - With 18 linked to payment as of January 1, 2019
  - Covering care for more than 1.5 million members
  - Representing ~51% of the state Medicaid population

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Example of VBP Success - Ohio

Ohio Early Results

- ★ Across CPC and Episodes, there is evidence of improvement on the goals for transformation in Ohio's health delivery system
  - In 2017, total overall quality performance improved by 2.1%; and
  - Total cost avoidance across the two programs was $121.1-$181.5 million

Ohio CPC program

- ★ Overall quality performance of CPC practices improved by ~2.2% annually from 2015-2017
- ★ There was a negative 1.9% cost trend compared with the non-CPC control group for risk-adjusted total cost of care per member per month (PMPM), resulting in $78.1 million in net annual savings and $89.3 million in gross annual savings
- ★ For 2017, 95% of CPC practices met all program requirements including exceeding quality and efficiency thresholds on relevant measures and performing activity requirements

Episodes program

- ★ Efficient performance in the average episode spend trend did not have an adverse impact on quality, as average performance rates across all episode quality metrics held largely steady for the first two years of the program
- ★ Average costs per episode decreased for the nine episodes linked to payment in 2017
- ★ The average non-risk-adjusted spend trend decreased by .9% annually from 2015 to 2017, resulting in an estimated $31.8-$92.2 million in annual savings
- ★ In 2017, episode providers (referred to as Principal Accountable Providers, or PAPs) received $4 million in positive incentive payments across nine episodes

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Source:https://medicaid.ohio.gov/Portals/0/PROVIDERS/PaymentInnovation/SIM-Grant-Final-Report.pdf

First 1K Days Initiative

First 1K Days Initiative

- Launched in New York and a number of other states
- Over 50% of children under 3 years old spend at least a portion of their lives on Medicaid
- Young kids rarely get a major focus because they don't cost much
- Create a cross-sector task force to develop an agenda to improve outcomes for this important population
- The agenda should explore kids VBP, better birth outcome models, efforts to improve school readiness as well as how best to serve complex families
- Give the agency a fixed amount of time to develop an agenda and then look to fund it over a period of years

New York State's First 1K Days Initiative

- ★ Stakeholder group representing child care, child welfare, community-based organizations, philanthropy, public health and mental health
- ★ 10 point plans created to enhance access to services and improve outcomes
- ★ Program uses Medicaid levers, including VBP to improve the health and development of New York's infants and toddlers
- ★ Includes home visiting, peer family navigators, Reach Out & Read early literacy program, group-based model of prenatal care, 'hub-and-spoke' data system for cross-sector referrals
- ★ Recommendations were approved by the legislature and are currently being implemented

Justice Involved Individuals

Medicaid and the Criminal Justice System

- Individuals who are incarcerated and meet eligibility criteria and can enroll or remain enrolled in Medicaid
- However, under federal law, state Medicaid agencies cannot claim federal matching dollars for health services to people who are incarcerated
  - The exception is if the incarcerated person receives inpatient hospital services outside of the prison or jail
- States realized that a large number of people being released qualified for Medicaid (especially in expansion states) and had multiple chronic conditions and/or behavior health needs (for example mental illness or substance use disorder)

Connecting People to Services

- States began to suspend Medicaid eligibility while the person was incarcerated instead of terminating eligibility
  - This is extremely helpful for people with short periods of incarceration (less than 1 year) because they do not have to go through the enrollment process again
- A few states began to offer both enrollment and case management to individuals being released 60 to 90 days before release
- The case managers
  - Set-up necessary appointments with providers after release
  - Ensure all prescriptions would be available after the supply from the institution was taken

Success of Programs

Ohio

- ★ Over 94% of people going through the prerelease program who had a primary opioid use disorder diagnosis received one or more types of treatment (including psychosocial and/or MATs) in 2016-2017
- ★ 86% of people going through the prerelease program with a primary congestive heart failure diagnosis received congestive heart failure medication in 2016-2017

Connecticut

- ★ Individuals who were enrolled in Medicaid prior to release connected to outpatient care more quickly than those that were not pre-enrolled
- ★ They also used more outpatient care and had reduced use of inpatient care

Massachusetts

- ★ Of those that had Medicaid coverage in the year after their release, 84% used a covered service, including nearly half (47%) who had a behavioral health visit
- ★ More than half of those who had a medical or behavioral health visit were seen within the first 60 days post release

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Source: https://medicaid.ohio.gov/Portals/0/Resources/Research/OMRES-Final-Report.pdf
http://files.kff.org/attachment/Issue-Brief-Connecting-the-Justice-Involved-Population-to-Medicaid-Coverage-and-Care

Questions and Answers

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