UNITED STATES of CARE

Creating a Better Health Care System in the Wake of COVID-19:

Models & Recommendations for People

United States of Care is working towards building a better, stronger and more equitable health system in the wake of COVID-19. The pandemic has illuminated long standing flaws in our health system and it is not enough simply to go back to the way it was before. This national trauma has also shone a light on persistent and growing inequities coursing through the American health care system. While the presence and magnitude of gaps in the American health care experience may be new to some, they have long been known by those whom they affect. Building a better, more equitable health system means listening to those affected by these gaps, and finding new and innovative ways to deliver affordable, high quality health care to everyone regardless of health status, social need or income.

At United States of Care, we envision a future where all people have dependable access to high-quality health care in a way that meets their unique needs at a price they can afford. **This means building a better health care system based on the following outcomes:**

- ★ People have certainty that they can **afford** their health care.
- ★ People have the security and freedom that **dependable** health care coverage provides as life changes.
- ★ People can get the **personalized** care they need, when and how they need it.
- ★ People experience a health care system that's **understandable** and easy to navigate.

Likewise, the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) is charged with:

- ✓ Improving patient care;
- ✓ Lowering costs and;
- ✓ Better aligning payment systems to promote patient-centered practices[1].

In the wake of the pandemic, the Innovation Center has an important opportunity to test models of care delivery to move the system closer to one that meets the needs of people. As we developed this document, we solicited the views of a diverse cadre of our Leadership Council experts, including our Board of Directors, Founders, and Entrepreneurs Councils, which are composed of experts from the public, private, and nonprofit sectors who support both our mission and our vision for the future of health care in the United States.

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[1] About the CMS Innovation Center

Designing Models Based On The Needs of People

Addressing the root causes behind disparate health care experiences and outcomes requires structural solutions, but it also mandates a rigorous dedication to considering and assessing exactly which attempts at moving toward equity actually work and which ones do not. We believe a commitment to equity in everything CMMI tests–in a deliberate, structured way–is essential. Data collected in these models will prove an effective tool as we seek to develop more responsive and fair health policies in the years to come.

We also believe that the voices and lived experiences of people are critical to achieve equity and must be infused throughout the health policy decision making process. When it comes to making future policy, CMMI can have an influential role in conducting proactive outreach to people. The Center can do this either by administering focus groups and feedback sessions outside of those run by providers and plans or by attempting to solicit greater feedback to Requests for Information (RFI) from people who otherwise would not normally respond. Here are some ways that can happen:

- In order to amplify the voices of people enrolled in CMMI models, participating health plans and provider groups of certain minimum sizes should be required to incorporate regular focus group activities that are demographically representative of the larger population experiencing the model. An alternative could be for health plans and provider groups to partner with community based organizations to facilitate the focus groups. The design of these models should provide funding and technical assistance to carry this out.
- CMMI should issue an RFI to broadly solicit ideas from health care providers, community groups, local not-for-profit organizations and other entities deeply embedded in neighborhoods including directly from people. These entities can provide specific approaches and ideas accounting for the unique needs of their local service population. The RFI should seek feedback on methods, models, and strategies to ensure the equitable distribution of care to populations that have been traditionally underserved by the U.S. health care system, including communities of color, tribes, and rural individuals.
  - » In conjunction with this recommendation, CMMI could issue an RFI to solicit ideas from the field for how the Center can create models or allocate resources to ensure equitable distribution or care and resources.
- CMMI is well positioned to be a convener of collaboration across the federal government with a goal of sharing data to improve health outcomes for people. The Innovation Center should look to build on successful cross-governmental collaborations that occurred during the pandemic, including demographic data sharing with the U.S. Census or the Health Resources and Services Administration (HRSA) and prescription drug data sharing with the Food and Drug Administration (FDA). This could be based on the existing and ongoing pandemic blueprint but should be standardized to include populations that have multiple needs and have otherwise not been adequately served. As data for certain populations are not disaggregated, CMMI should design models that collect robust data sets for these populations and/or existing data collection practices should be augmented to allow for such parsing within aggregate data.

Learning What Works By Testing New Incentives in Medicaid

CMMI can assist policymakers, providers and entrepreneurs in creating a more equitable health care system by designing models reflected in the recommendations below.

- Maternal mortality in the United States is in crisis. In 2018, the United States ranked last in this measure among industrialized countries. The maternal mortality rate of African-American women is particularly shameful and 2.5 times higher than that of white women and three times more than Hispanic women.[2] CMMI should run a model to test many aspects of maternal care with an aim of learning what will improve quality and outcomes. The model could include testing the results of utilizing a doula or midwife, for instance, or embedding local community health workers into the lives of pregnant and postpartum people, as well as with new parents in the

[2] Maternal Mortality in the United States: A Primer

first year of a baby's life. The model could also address and test the factors most impacting infant and maternal mortality and inform policy change in education, engagement, and systems.[3]

- CMMI should test whether allowing Medicaid to pay at Medicare rates results in a meaningful percentage increase in providers joining a network and whether patient outcomes improve. This could be accomplished by establishing criteria for the regions of the country with the widest gaps in health outcomes based on certain factors including race/ethnicity, income and education.[4]

Improving Care for People with Disabilities and Multiple Health Conditions

Many times, health care decisions are made without considering how different groups of people will likely be affected. A population for which this is all too common includes both children and adults with disabilities, as well as those requiring complex care due to multiple health conditions. The pandemic has forced changes in the way health care is provided to people with disabilities, wiping away some long-held policies limiting certain ways of providing care and making access more convenient and less physically and mentally demanding. The expansion of these technologies creates an opportunity to learn if these changes improve or widen access gaps.

Here are ideas that can further assist people with disabilities get the care they need:

- CMMI should create a model in Medicaid and/or for people with disabilities enrolled in Medicare to test outcomes for conducting routine services in a beneficiary's home. These services could include in-home lab testing options such as blood draws, blood pressure screenings, followup appointments for medications with psychiatrists and prescription drug refills in general, as well as in-home appointments for wheelchair adjustments. For many people with disabilities, travelling to and from appointments can be mentally taxing, physically exhausting and logistically challenging; this model would help clarify if any adverse or unintended consequences occur–or if beneficiaries experience improved outcomes–when these services are conducted at home or virtually as appropriate.
- For individuals enrolled in Medicaid who also have complex care needs, CMMI should run a model allowing access to out-of-state specialists. Many people with disabilities who rely on Medicaid are not permitted to travel out of state to see specialists, effectively making some specialists out-of-network and inaccessible for these beneficiaries. In some regions, this could be a substantial barrier to providers with the right and highly specialized expertise.
- Care management has proven an effective value-add to those enrolled in Medicare Advantage; CMMI should run a model to experiment with adding this support for those in traditional Medicare. CMMI could tailor the model to a narrow subset of a medically complex population such as, for example, a tightly targeted subset of the most expensive beneficiaries from the previous year. This model would seek to determine the quantifiable impact of care management, and if this provider/patient relationship dynamic–widely utilized in Medicare Advantage–should be expanded to those in the traditional program.
- Avoiding hospitalizations for mental health and substance misuse crises among dual-eligible beneficiaries is important. CMMI should develop a model aimed at identifying the most salient social determinants of health associated with hospitalizations for mental health and substance misuse-related crisis as experienced by dual-eligible beneficiaries. This would allow Medicaid managed care organizations greater visibility into existing patterns, and potentially offer a road map to improve outcomes and prevent costly hospilizations.
- CMMI should develop and then test a set of standards for care and coverage of specific chronic conditions in order to incentivize the most effective, efficient and equitable care programs–rather than relying on each individual payor's metrics. The goal would be to align incentives across payers and ensure all payers are working from the same set of guidance for the same sets of conditions regardless of how the care is being paid for.

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[3] A possible resource for designing a model like this is the Ohio based Birthing Beautiful Communities program.

[4] MACPAC - January 2019: Physician Acceptance of Medicaid Patients

Putting Mental Health Care on Equal Footing with Physical Health Care

The ability of our nation's health system to deliver quality mental health services was under stress before the pandemic, but has only been exacerbated since its onset. During COVID-19, about four in ten adults have reported symptoms of anxiety or depressive disorders. This is an increase from one in ten prior to the pandemic.[5] As need rises, all aspects of mental health and care for substance misuse disorder must be more integrated into our health care system. Here are some models CMMI can consider to test what works:

- CMMI should design a model to test funding the mental health crisis care continuum and testing expanded Medicaid coverage for crisis contact centers, mobile crisis, and crisis stabilization centers to encourage crosssector partnerships including among health care providers, community organizations and law enforcement. Along with this, CMMI could design a model that includes Medicare, private payers and Medicaid, to design a demonstration to fund a continuum of mental health crisis services.
- In order to further test the impact of value-based care, CMMI should design a model aiming to promote primary care integration with a global budget that includes robust mental health and substance misuse process and quality measures.
- Data integration and sharing, when done well, can highlight successful interventions and care modalities, illuminate long-term patient outcomes, and improve the quality of care. CMMI should test a model in which financial incentives are offered to mental health and substance misuse providers to more widely utilize electronic health records in order to facilitate information exchange between providers and across payers.
- CMMI should collaborate with other agencies to evaluate innovative approaches to financing for mental health and substance misuse services including "whole of budget" savings models.

Partnering with America's Employers and Health Plans for the Public Good

The private sector is one of the engines continuing to push the American health care system to new heights and new discoveries. Both employers and health plans innovate on a daily basis. In fact, employers, both large and small, are one of the most important players in our health care system. Employers need talented, dedicated employees but, in many instances, an entire segment of our population, people with disabilities, are driven to make a decision not to work or to earn less money in order to keep the public health benefits on which they rely. By partnering with employers, states can provide their job markets with an infusion of new talent and potentially even reduce costs in their Medicaid programs. In addition, Medicare Advantage has demonstrated significant utility in paying for greater value and can do even more. Here are two ways to test how employers and health plans can keep moving our system forward:

- Recognizing both the critical role of employers in our health care paradigm and the ever present need for a large and diverse talent pool of employees, CMMI should create a model allowing employers to partner with public payers and pay a portion of Medicaid premium costs to see if quality and cost of care improves while also potentially expanding the employment market. This type of model would have the additional benefit of identifying how to best administer this approach and whether it helps people with disabilities who are able to remain in the workforce to indeed do so. Medicaid coverage in some states is often more comprehensive and affordable than job-connected health insurance, forcing some people with disabilities to choose between labor force participation and their health benefits, in addition to vital relationships with providers.

[5] The Implications of COVID-19 for Mental Health and Substance Use

This potential model could also include these variations:

1. Incentivize businesses to provide employees the option of jointly paying into Medicaid rather than into a private insurance company if that person is dually-eligible and/or eligible for Medicaid based on their disability status.
2. Incentivize plans servicing dually-eligible beneficiaries to invest in Money Follows the Person (MFP)-style programs to reduce institutionalization and/or homelessness.

- CMMI should develop a model which creates direct financial incentives for Medicare Advantage Organizations to engage a meaningful percentage of their provider networks in advanced alternative payment model (APM) contracts. One way to do this is to connect a weighted star measure to APM adoption in order to adequately measure if this model is working and improving quality. CMMI could also include as part of this star measure feedback from people who have participated in this model.

→ Testing Virtual Care Models to Optimize Quality and Access for People

The COVID-19 pandemic has increased the integration and adoption of virtual care into more health care interactions than ever before. However, this quick adaptation has brought about unforeseen patient barriers and quality concerns while also revealing needed process improvements aimed at maximizing the effectiveness of virtual care for as many people as possible. CMMI can play a critical role in testing models that incorporate virtual care modalities to determine which approaches improve quality for people. Here are some ways to do that:

- Models should be created to study outcomes for specific conditions and unique health care needs within the newly expanded telehealth and virtual care services paradigm. For instance, the COVID-19 pandemic now offers a trove of information regarding patient outcomes from virtual care services administered by providers who have been reimbursed at the same level as in-person visits. What effect, if any, has this had in quality and outcomes? Some areas where this can be directly studied and then developed into a CMMI model and tested include:
  - » Hip and knee replacement after-care
  - » Physical, occupational and speech therapy
  - » Primary care, particularly for those services which billing data demonstrates are most frequently able to be performed using telehealth or virtual care modalities
- Gaining a more clear understanding of the optimal virtual care reimbursement levels for both payor-provider negotiated reimbursements in fee-for-service (FFS) and value-based reimbursement in risk-based care models would go a long way to best harnessing virtual care in the most beneficial way for people. The goal of this type of model would be to determine the appropriate reimbursement levels for synchronous, asynchronous and audio-only virtual care modalities.
  - » In addition, some populations are in need of increased support to help them access the benefits of telehealth and virtual care. Testing a model which continues to pay for the assistance of social workers, community health workers, a personal digital assistant/telepresenter and potentially language interpreters to support these interactions and the outcomes related to the expansion of the virtual care modality could yield valuable information.
- CMMI should create a model removing most boundaries for telehealth and virtual care to determine if doing so achieves better quality and outcomes for people. At a minimum, this should include increasing the utilization of dual-use non-medical equipment such as tablets, smartphones and the internet. Populations to focus on here include those in rural areas, communities of color, and tribal nations.

Conclusion

The changes over the past year in how people in the United States live, work, exercise, entertain themselves and seek health care services have been significant. These changes, however, are also a historic opportunity to create a more intentionally equitable health care system; CMMI can assist in this effort by testing the models above while simultaneously collecting data which will be critical to developing more equitable health policies in the future. While we know these ideas may be different than others which CMMI receives, we think they will not only provide insight into what works and what does not, but out of them we are also likely to learn what makes a difference in moving our health care system towards one that works for as many people as possible.

Have questions?

For additional information or to explore these recommendations in greater detail, please contact **Andrew Schwab**, USofCare Director of Policy, Federal Affairs & Partnerships at aschwab@usofcare.org

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