Medicaid Innovation Accelerator Program

Utilizing Value-Based Payment to Incentivize Maternal and Infant Health Care Delivery Models

Thursday, May 17, 2018
2:00PM to 3:30PM Eastern Time
Webinar Logistics

• Audio is being streamed to device speakers (recommended)
• A phone line has also been set up. All lines will be muted:
  – Call-in number: 866-575-6535
  – Passcode: 796515
• To participate in a polling question, exit out of "full screen" mode
• Use the chat box on your screen to ask a question or leave a comment
Learning Objectives

• Identify payment models and contractual approaches that incentivize the use of innovative maternal and infant health (MIH) care delivery models within Medicaid and Children’s Health Insurance Program (CHIP) populations.

• Outline considerations for incorporating care delivery models into state value-based payment (VBP) initiatives.

• Describe state Medicaid experiences, opportunities, and challenges when aligning MIH delivery models with VBP initiatives.
Agenda

• Overview of Medicaid Innovation Accelerator Program (IAP) and the Maternal and Infant Health Initiative (MIHI) VBP Technical Support
• Innovative MIH care delivery models
• Medicaid VBP Approaches in MIH
  – Questions
• State perspective: New York
• State perspective: Ohio
  – Questions
Today’s Presenters

Crystal Tyler, PhD, MPH
Senior Research Leader
IBM Watson Health

Whitney Witt, PhD, MPH
Director, Center for Maternal and Child Health Research
IBM Watson Health

Thomas Flottemesch, PhD, MS
Senior Research Leader
IBM Watson Health
Today’s Presenters

Douglas Fish, MD
Division of Program Development & Management
New York State Department of Health

Amy Jesaitis, MPH, RD
Division of Family Health
New York State Department of Health
Today’s Presenters

Kara Miller
Section Chief, Care Management and Quality Improvement
Ohio Department of Medicaid

Mark Redding, MD
Quality Director and Co-Founder, Pathways Community HUB Institute
Director Community Care Coordination and Risk Reduction Research, Rebecca D. Considine Research Institute, Akron Children's Hospital
Overview of Medicaid IAP and MIHI VBP Technical Support

Whitney Witt
IBM Watson Health
Overview of Medicaid IAP

• Four year commitment by the Centers for Medicare & Medicaid Services (CMS) to build state capacity and support ongoing innovation in Medicaid through targeted technical support\(^1\)

• A program funded by the Center for Medicare and Medicaid Innovation (CMMI) that is led by and lives in the Center for Medicaid and Children’s Health Insurance Program (CHIP) Services (CMCS)

• Supports states’ Medicaid delivery system reform efforts:
  – The IAP goal is to increase the number of states moving toward delivery system reform across program priorities

• Not a grant program; provides targeted technical support

\(^1\) IAP refers to *technical support* as general support, program support, or technical assistance.
Medicaid VBP Approaches for MIH (November 2017)

Utilizing VBP to Incentivize MIH Care Delivery Models (Today)

MIHI VBP State Experiences Designing and Testing a VBP Approach
Overview of MIHI VBP states

Nevada
Reduce the proportion of infants admitted to neonatal intensive care among the Medicaid population

Colorado
Increase screening and successful referral rates for postpartum depression among women covered by Medicaid

Maine
Increase the proportion of mothers covered by Medicaid who are screened and receive medication assisted treatment (MAT) for opioid use disorders

Mississippi
Improve birth outcomes by reducing tobacco use among pregnant women on Medicaid
MIH Care Delivery Models

Whitney Witt

IBM Watson Health
Health Care Costs Associated With Adverse Birth Outcomes

• Adverse birth outcomes disproportionately affect Medicaid beneficiaries¹
• Preterm birth is a leading cause of infant morbidity and mortality²,³
• Average health care utilization costs are higher for preterm births compared with uncomplicated deliveries⁴
• Preterm birth accounts for half of all pregnancy-related costs⁵
  – Costs are projected to top $32.3 billion in 2017⁶

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On Average, Medicaid Pays for Nearly Half of U.S. Births

Percentage of Births Financed by Medicaid

Example MIH Care Delivery Models

- Birth Center Model of Care
- Home Visiting Model Pathways Community HUB Model
- Doula Model Prenatal Care Coordination Interconception Care Project

Community Caring Collaborative Model
Pregnancy/Maternity Medical Home
Maternity Care Coordination
Prenatal Care Coordination
Improved MIH Outcomes Along the Perinatal Time Period

- Preconception
- Pregnancy
- Birth
- Postnatal
- Interconception care

↑ Contraception Use
↑ Prenatal Care

↑ Breastfeeding initiation
↓ Severe maternal morbidity
↓ Cesarean sections
↓ Preterm birth
↓ Low birthweight
↓ Infant mortality

↑ Contraception Use
↑ Well-child visits
↑ Pregnancy spacing
Poll Question #1

How familiar are you with MIH care delivery models?  
(Please select one)

1. I have implemented an MIH care delivery model.
2. I am aware of care models to address MIH outcomes but have never implemented a model.
3. I am new to the term *MIH care delivery models.*
Payment Reform in Maternal and Infant Health

Thomas Flottemesch
IBM Watson Health
Health Care Payment Learning and Action Network Alternative Payment Model Framework

Categorization of Alternative Payment Models:

**Category 1: Fee for Service - No Link to Quality & Value**
- A: Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)
- B: Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)
- C: Pay-for-Performance (e.g., bonuses for quality performance)

**Category 2: Fee for Service - Link to Quality & Value**
- A: APMs with Shared Savings (e.g., shared savings with upside risk only)
- B: APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

**Category 3: APMs Built on Fee-For-Service Architecture**

**Category 4: Population-Based Payment**
- A: Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
- B: Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
- C: Integrated Finance & Delivery Systems (e.g., global budgets or full/percent of premium payments in integrated systems)
- 3N: Risk-Based Payments NOT Linked to Quality
- 4N: Capitated Payments NOT Linked to Quality

# Examples of VBP Models in MIH

<table>
<thead>
<tr>
<th>Payment approach</th>
<th>Example</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay-for-performance</td>
<td>Louisiana's 17P initiative</td>
<td>Prevent preterm birth</td>
</tr>
<tr>
<td>Nonpayment policy</td>
<td>South Carolina’s nonpayment policy</td>
<td>Reduce early elective cesarean sections</td>
</tr>
<tr>
<td>Shared savings</td>
<td>Tennessee Health Care Innovation Initiative</td>
<td>Provide high-quality care during the perinatal period</td>
</tr>
<tr>
<td>Bundled payment</td>
<td>Ohio perinatal bundle</td>
<td>Improve pregnancy outcomes</td>
</tr>
<tr>
<td>Population-based models</td>
<td>Oregon global payments</td>
<td>Provide integrated prenatal and postpartum care</td>
</tr>
</tbody>
</table>
Considerations for Implementing VBP

- Patient population of focus
- Services included in the VBP approach
- Measurement, measures and Health Information Technology (HIT) capacity
- Attribution of patients
- Benchmarking
- Risk adjustment
- Current Medicaid contracts and care arrangements
- Broader healthcare environment
Measures, Measurement, and HIT Capacity

• VBP is based upon linking performance and payment

• Key factors to consider:
  – Relevant and reproducible measures
    • Are attributable to the level targeted by the VBP initiative
    • Track process (immediate) and outcome (long-term) change
    • Are seen as changeable by those incentivized by the VBP initiative
  – Timeliness of reporting
    • Accessing data: claims, electronic health records, and a health information exchange system
    • Providing performance feedback in an actionable manner
  – HIT capacity and parallel initiatives
    • Current level of data capture and reporting
    • Ability to develop and create new reports
Current Medicaid Contracts and Care Arrangements

• Any VBP initiation must work in conjunction with other Medicaid contracts and care arrangements

• Key factors to consider:
  – Current Medicaid structure
    • Payment schedule (e.g., fee for service, managed care)
    • Existing withholds, gain sharing
    • Attribution and enrollment rules
  – Other state initiatives
    • Will this initiative introduce a new structure?
    • Will this initiative parallel an existing arrangement?
  – Alignment with overall state goals
Broader Healthcare Environment

• A VBP arrangement must align with other initiatives facing providers

• Key factors to consider:
  – Private payer initiatives
    • Potential for coordinating or aligning efforts with the variety of private-led VBP and value-based care initiatives that currently are underway
  – Community-based organizations and initiatives
    • Opportunities for provider partnerships
  – Shortcomings of the current system
    • What and where are the targeted aspects of care?
Poll Question #2

How would you describe your familiarity with VBP approaches? (Please select one)

1. I am well-versed in VBP approaches.
2. I am aware of VBP approaches, but don’t consider myself an expert.
3. I am new to the term VBP.
Questions or Comments?
State Perspectives:

• New York
• Ohio
New York State’s Home Visiting Models in the Delivery System Reform Incentive Payment and VBP Programs

Douglas Fish, MD
Amy Jesaitis, MPH, RD

New York State Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program Objectives

- DSRIP Program was built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

- 25 Performing Provider Systems (PPS) were recognized by New York to lead Medicaid’s health care transformation efforts

DSRIP Program Perinatal Care Project (3.f.i) Core Component Interventions

1. Implement an evidence-based home visiting model for pregnant, high-risk mothers, including high-risk, first-time mothers. (2 PPS selected)

2. Establish a care/referral community network based on a regional center of excellence for high-risk pregnancies and infants. (No PPS selected)

3. Implement a community health worker program on the model of the Maternal and Infant Community Health Collaboratives Program (3 PPS selected)

DSRIP Program’s Project Toolkit
DSRIP Program Perinatal Care Project’s Home Visiting Models

New York State Department of Health
Maternal and Infant Health Community Health Collaboratives
Project Associated Measures

<table>
<thead>
<tr>
<th>Perinatal Measures (Pay-for-Performance in Years 4 and 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Birth Weight</td>
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<tr>
<td>Well Care Visits in the First 15 months</td>
</tr>
<tr>
<td>Timeliness of Prenatal Care</td>
</tr>
<tr>
<td>Timeliness of Postpartum Visits</td>
</tr>
<tr>
<td>Frequency of Ongoing Prenatal Care (retired in 2018 by measure steward)</td>
</tr>
<tr>
<td>Lead Screening in Children</td>
</tr>
<tr>
<td>Early Elective Deliveries</td>
</tr>
<tr>
<td>Childhood Immunization Status by Age 2</td>
</tr>
</tbody>
</table>

DSRIP Program’s Measure Specification and Reporting Manual
Integrating Initiatives

Prevention Agenda
2013 – 2018: New York State’s (NYS) Health Improvement Plan

Related Indicators:
- Premature births
- Maternal mortality
- Well child visits
NYS - Percentage of Preterm Births

Abbreviation: PA, prevention agenda.
Source: Vital records data as of May 2017.
NYS - Maternal mortality rate per 100,000 births

Abbreviation: PA, prevention agenda.
Source: Vital records data as of May 2017.
NYS - Percentage of children who had the recommended number of well child visits in government-sponsored insurance programs

Abbreviation: PA, prevention agenda.
Source: NYSDOH Office of Quality & Patient Safety data as of December 2016
Considerations for Adding Home Visiting

- Existing home visiting programs
- Acceptability of home visiting
- Cost of models
Challenges/Lessons Learned

- Competition
- Coordination
- Reach
- Attribution
New York State’s Value Based Payment Maternity Care Arrangement
The VBP Maternity Care Arrangement has three components:
1) Prenatal care
2) Delivery and postpartum care
3) Newborn care
Managed Care Organization and Provider can Choose Different Levels of VBP

In addition to choosing which integrated services to focus on, the Managed Care Organizations and contractors/providers can choose different levels of Value Based Payments.

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP Retrospective Reconciliation</th>
<th>Level 2 VBP Retrospective Reconciliation</th>
<th>Level 3 VBP Prospective(^a)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS payments</td>
<td>FFS payments</td>
<td>FFS payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No risk sharing</td>
<td>↑ Upside Only</td>
<td>↑ Upside &amp; ↓Downside Risk</td>
<td>↑ Upside &amp; ↓Downside Risk</td>
</tr>
</tbody>
</table>

Abbreviations: FFS, fee for service; PMPM, per member per month.

\(^a\) Feasible after experience with Level 2; requires mature contractors.

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. June 2016 updated version approved by CMS March 2017
# 2018 VBP Maternity Care Arrangements
## Quality Measure Set

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Steward</th>
<th>NQF Measure Identifier</th>
<th>Classification</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive Care – Postpartum Women</td>
<td>United States Office of Population Affairs</td>
<td>2902</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>C-Section for Nulliparous Singleton Term Vertex (NSTV)</td>
<td>The Joint Commission</td>
<td>0471</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>Frequency of Ongoing Prenatal Care</td>
<td>NCQA</td>
<td>1391</td>
<td>Removed from Measure Set</td>
<td>Measure retired by NCQA</td>
</tr>
<tr>
<td>Incidence of Episiotomy [% of Vaginal Deliveries With Episiotomy]</td>
<td>Christiana Care Health System</td>
<td>0470</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>Low Birth Weight [Live births weighing less than 2,500 grams (preterm v. full term)]</td>
<td>AHRQ</td>
<td>0278</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>Percentage of Babies Who Were Exclusively Fed with Breast Milk During Stay</td>
<td>TJC</td>
<td>0480</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>Percentage of Preterm Births</td>
<td>NYS</td>
<td>Not endorsed</td>
<td>P4R</td>
<td></td>
</tr>
<tr>
<td>Prenatal &amp; Postpartum Care —Timeliness of Prenatal Care &amp; Postpartum Visits</td>
<td>NCQA</td>
<td>1517</td>
<td>P4P</td>
<td></td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>CMS</td>
<td>0418</td>
<td>P4R</td>
<td></td>
</tr>
</tbody>
</table>

*Measure is also part of TCGP/ IPC Measure Set*

*Red:* Indicates measure change from 2017

*Purple:* Pay-for-Performance (P4P) measure

Take-Home Messages

**DSRIP**
- Small sample
- Results not yet available
- Integration important

**VBP**
- Path to sustain gains from DSRIP is VBP program
- Working to address provider concerns with VBP Maternity Care arrangement
- Align quality measures with other payers, e.g. Medicare and Commercial
Take-Home Messages

• **DSRIP Measure Specification and Reporting Manual** is published for Measurement Year 4

• **VBP Quality Measure Sets** are published for Measurement Year 2018 (Please expand “VBP Quality Measures”)

• **VBP Measure Specification and Reporting Manual** is published for Measurement Year 2017 (Please expand “VBP Quality Measures”)

Please send questions and feedback to—

[dsrip@health.ny.gov](mailto:dsrip@health.ny.gov)

[vbp@health.ny.gov](mailto:vbp@health.ny.gov)
Ohio Medicaid’s Transformational Quality Strategy and the Pathways Community HUB Model

Kara Miller
Ohio Department of Medicaid
Mark Redding, MD
Pathways Community HUB Institute
Ohio Medicaid’s Transformational Quality Strategy

Better Health Outcomes Through Innovation

Focus Populations
- Healthy Children & Adults
- Women’s Health
- Behavioral Health
- Chronic Conditions

Design & Implement “Pay for Value”
- Social Determinants of Health
- Patient-Centered Medical Homes
- Episodes of Care
- Community Engagement
- Actionable Data

Desired Health Improvements: Health Equity
- Preventative Screenings
- Improved pre-term birth & infant mortality rates
- Integrated Behavioral & Physical Health Care
- Appropriate Prescribing
- Well Managed Asthma, Diabetes & Hypertension

Special Initiatives
- Infant Mortality Reduction
- Opioid Abuse Prevention and Treatment
- Behavioral Health Redesign
Ohio’s 2017-2019 State Health Improvement Plan (SHIP)

<table>
<thead>
<tr>
<th>3 priority topics</th>
<th>10 priority outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health and addiction</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Suicide</td>
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<tr>
<td></td>
<td>Drug dependency/abuse</td>
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<td></td>
<td>Drug overdose deaths</td>
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<tr>
<td>Chronic disease</td>
<td>Heart disease</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
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<td></td>
<td>Child asthma</td>
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<tr>
<td>Maternal and infant health</td>
<td>Preterm births</td>
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<tr>
<td></td>
<td>Low birth weight</td>
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<tr>
<td></td>
<td>Infant mortality</td>
</tr>
</tbody>
</table>

**Equity:** Priority populations for each outcome above
Ohio Medicaid’s Transformational Quality Strategy

Better Health Outcomes Through Innovation

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- Healthy Children & Adults
- Women’s Health
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**Desired Health Improvements: Health Equity**
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- Appropriate Prescribing
- Well Managed Asthma, Diabetes & Hypertension

**SPECIAL INITIATIVES**
- Infant Mortality Reduction
- Opioid Abuse Prevention and Treatment
- Behavioral Health Redesign
Ohio Medicaid Managed Care:

- Nearly 90% of Ohio Medicaid recipients are enrolled in a Managed Care Plan (MCP).
- Full risk managed care model is the primary delivery system
- Per-member-per-month payment to the MCPs.
- Accountability strategy that rewards MCPs by measuring their impact on population health outcomes.
# Medicaid MCP Incentives - Indices & Measures

<table>
<thead>
<tr>
<th>Ohio SHIP</th>
<th>Medicaid Pop Stream/Index</th>
<th>Incentive</th>
<th>Measure</th>
<th>MMC Contract</th>
<th>CPC Quality Metric</th>
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<tbody>
<tr>
<td><strong>Chronic Disease</strong></td>
<td>Healthy Children</td>
<td>Quality Withhold</td>
<td>Well Child Visits, 1st 15 months of life</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Well Child Visits in 3-6 years of life</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Adolescent Well-Care Visits</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>BMI Percentile Documentation Children/Adolescents:</td>
<td>Y</td>
<td>Y</td>
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<td><strong>Mental Health and Addiction</strong></td>
<td>Behavioral Health</td>
<td>Quality Withhold</td>
<td>Follow-up After Hospitalization for Mental Illness</td>
<td>Y</td>
<td>Y</td>
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<td></td>
<td></td>
<td></td>
<td>Initiation of AOD Dependence Treatment</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Psychosocial Care for Children on Antipsychotics</td>
<td>Y</td>
<td>-</td>
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<td></td>
<td></td>
<td></td>
<td>Multiple Concurrent Antipsychotics in Children</td>
<td>Y</td>
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<tr>
<td><strong>Chronic Disease</strong></td>
<td>Chronic Condition: Cardio-vascular</td>
<td>Quality Withhold</td>
<td>Controlling High Blood Pressure</td>
<td>Y</td>
<td>Y</td>
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<td></td>
<td></td>
<td></td>
<td>Statin Therapy for Patients with Cardiovascular Disease</td>
<td>Y</td>
<td>Y</td>
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<td>Adult BMI Assessment</td>
<td>Y</td>
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<td>Annual Monitoring for Patients on Persistent Meds</td>
<td>Y</td>
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<tr>
<td><strong>Chronic Disease</strong></td>
<td>Chronic Condition: Diabetes</td>
<td>Quality Withhold</td>
<td>Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>Y</td>
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<td></td>
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<td>Eye Exam</td>
<td>Y</td>
<td>Y</td>
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<td>HbA1c poor control (&gt;9.0%)</td>
<td>Y</td>
<td>Y</td>
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<td></td>
<td></td>
<td></td>
<td>HbA1c testing</td>
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<td>Y</td>
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<tr>
<td><strong>Maternal and Infant Health</strong></td>
<td>Women's Health</td>
<td>Quality-Based Assignments</td>
<td>Breast Cancer Screening</td>
<td>Y</td>
<td>Y</td>
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<td></td>
<td></td>
<td></td>
<td>Cervical Cancer Screening</td>
<td>Y</td>
<td>Y</td>
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<td></td>
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<td></td>
<td>Timeliness of Prenatal Care</td>
<td>Y</td>
<td>Y</td>
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<td>Postpartum Care Visit</td>
<td>Y</td>
<td>Y</td>
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<td></td>
<td></td>
<td></td>
<td>Percent of Live Births &lt; 2,500 grams</td>
<td>Y</td>
<td>Y</td>
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Aligns with:
1. Medicaid Managed Care (MMC) Contract Measures
2. Comprehensive Primary Care (CPC) Quality Metrics
3. 2018 Pay-for-Performance (P4P) (MY 2017)
Risk Factors

Wellness

Health Care
- Health insurance
- Primary care
- Specialty care
- Screenings
- Child development

Behavioral Health
- Drug use
- Alcohol use
- Depression
- Anxiety
- Domestic violence

Education & Employment
- Job readiness
- Self-esteem
- Clothing
- Application assistance

Social
- Food
- Clothing
- Housing
- Heat
- Electricity

Safety
- Infant
- Child
- Adult
Immediate – smoking, chronic disease, homelessness

Preventive – early child obesity prevention, evidence-based parenting

Interlocking and interdependent – an at-risk expectant mother with homelessness, depression, and no access to medical care must have all three factors addressed. Addressing one factor may not change the outcome.
Health, Social and Behavioral Risk Factors Addressed to Achieve Wellness
Health and Social Service System
Fragmented Siloed Approach

- Medical Care
- Medication Access
- Day care
- Behavioral Health Services
Premise for Improving Outcomes

• Pay-for-value strategies can drive financing towards improved outcomes that result from multiple components
  – Improved birth outcomes
  – Chronic disease control
  – Improved school performance
  – Employment success
• How can health and social service funding purchase work products that produce better outcomes?
• Modifiable risk factors and their mitigation represent critical underlying product with greatest evidence for improving outcomes
• Outcomes and cost of care improve when a comprehensive approach is utilized to identify and mitigate risk across medical, social and behavioral health domains
Outcome-Focused System

Two Basic Categories of Health and Social Service

**Care Coordination** – To identify risk factors and coordinate connection to an intervention

**Direct Service** – Provide an intervention that has been proven to address the risk factor
Today’s System
“Typical” At-Risk Family

Marisol, 21
• Is pregnant
• Lost her job
• No housing
• No transportation
• May be depressed

Angelina, 16 months
• Needs medical home
• Is behind on immunizations
• Is behind on well visits
• May have developmental concerns
Care Coordination Service Approach

- Multiple agencies involved – limited direct interaction with family
- Limited communication across agencies
- Minimal tracking of identified and addressed risk factors
- Little or no financial accountability for the achievement of work products with evidence for improving outcomes (reduced risk)
Pathways Community HUB Model

Find  ➔  Treat  ➔  Measure

1. Engage Client and Assess Risk

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you need a prenatal care provider?</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Do you need health insurance?</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Do you smoke cigarettes?</td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Do you need food or clothing?</td>
<td>✔</td>
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</table>

2. Assign Pathways

Initiation Step

Action Step

Action Step

Completion—Risk Addressed

3. Track Completed Pathways—Risk Addressed

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW A</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>CHW B</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>CHW C</td>
<td>9</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site</th>
<th>Medical Home</th>
<th>Pregnancy</th>
<th>Social Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency A</td>
<td>50</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td>Agency B</td>
<td>64</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Agency C</td>
<td>40</td>
<td>32</td>
<td>19</td>
</tr>
</tbody>
</table>

IAP
Medicaid Innovation Accelerator Program
Medical Home Pathway

**Initiation**
Client needs an ongoing source of prenatal care
Date______________

**Determine and record client’s payer source:**
- Medicaid
- Medicare
- Private Insurance
- Self Pay
- Other______________

**Outcome**
Confirm risk factor addressed

**Completion**
Confirm that appointment was kept
Date__________

1. Identify provider ________________
2. Assist client in scheduling appointment
   Date______________
3. Document education pathways as appropriate

Identify risk factor

Identify and overcome barriers
Payment is tied to each factor of risk as it is addressed
Comprehensive – Pay for Performance

Health Care
- Health Insurance
- Primary Care
- Specialty Care
- Screenings
- Child development

Behavioral Health
- Drug Use
- Alcohol Use
- Depression
- Anxiety
- Domestic Violence

Education Employment
- Job Readiness
- Self Esteem
- Clothing
- Application Assist

Social
- Food
- Clothing
- Housing
- Heat
- Electricity etc.

Safety
- Infant
- Childhood
- Adult

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Community HUB

One care coordinator for the entire family

Community Care Coordinator

Community-based care coordination agencies
Community HUB and Funders

Large health and social initiatives can contract and collaborate with community-based organizations via their local Community HUB.
20 Core Pathways

- Adult Education
- Employment
- Health Insurance
- Housing
- Medical Home
- Medical Referral
- Medication Assessment
- Medication Management
- Smoking Cessation
- Social Service Referral

- Behavioral Referral
- Developmental Screening
- Developmental Referral
- Education
- Family Planning
- Immunization Screening
- Immunization Referral
- Lead Screening
- Pregnancy Services
- Postpartum Services
<table>
<thead>
<tr>
<th>Pathways</th>
<th>No. Found</th>
<th>No. Addressed</th>
<th>No. Not Addressed</th>
<th>Average Time Days</th>
<th>Cost per Addressed $25-$250</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home</td>
<td>55</td>
<td>44</td>
<td>11</td>
<td>10</td>
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</tr>
<tr>
<td>Medical Referral</td>
<td>272</td>
<td>227</td>
<td>45</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>Medication Assessment</td>
<td>49</td>
<td>41</td>
<td>8</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>85</td>
<td>71</td>
<td>14</td>
<td>101</td>
<td></td>
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<tr>
<td>Family Planning</td>
<td>54</td>
<td>42</td>
<td>12</td>
<td>75</td>
<td></td>
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<tr>
<td>Post Partum</td>
<td>58</td>
<td>48</td>
<td>10</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Social Service Referral</td>
<td>276</td>
<td>201</td>
<td>75</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td>45</td>
<td>43</td>
<td>2</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td>28</td>
<td>22</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>52</td>
<td>25</td>
<td>27</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td>17</td>
<td>4</td>
<td>13</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>35</td>
<td>14</td>
<td>21</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>29</td>
<td>3</td>
<td>26</td>
<td>112</td>
<td></td>
</tr>
</tbody>
</table>
# Example Pathway System Billing

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Checklists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Completed at each face-to-face encounter</td>
<td>G9005</td>
<td>G9010</td>
<td>R</td>
</tr>
<tr>
<td>Pediatric</td>
<td>Completed at each face-to-face encounter (home visits minimum one time per month)</td>
<td>G9005</td>
<td>G9003</td>
<td>P</td>
</tr>
<tr>
<td>Pathways</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Kept three scheduled behavioral health appointments</td>
<td>G9002</td>
<td>G9009</td>
<td>RB</td>
</tr>
<tr>
<td>Education</td>
<td>Delivered educational module</td>
<td>G9002</td>
<td>G9009</td>
<td>RE</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Discussed long-acting, reversible contraceptive or permanent method</td>
<td>G9002</td>
<td>G9009</td>
<td>G1</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Discussed all other family planning methods</td>
<td>G9002</td>
<td>G9009</td>
<td>G2</td>
</tr>
<tr>
<td>Housing</td>
<td>Residing in affordable and suitable housing for 2 months</td>
<td>G9002</td>
<td>G9009</td>
<td>RI</td>
</tr>
</tbody>
</table>
Funding for Pathways Community HUBs

- Funding sources for HUBs include MMCs, Department of Health, social services, addiction services, grants, community benefit (hospitals), local donations
- Reimburse HUB sites on a Pay-for-Success arrangement tied to *completion* of core pathways including comprehensive risk assessments and mitigation of specific risk factors spanning:
  - General health and wellbeing
  - Behavioral health
  - Social determinants of health (e.g., housing)
- HUBs distribute payment to the Community Based Organizations
Risk Identification and Reduction
Outcome Focused System

• Results for adults and children
  – Improved birth outcomes
  – Decreased cost of care
  – Reduced emergency room utilization
  – Greater access to preventive services
  – Increased enrollment in education
  – Increased employment
Published Study Results

Cost Savings: $3.36 for every $1 spent in the 1st year of life; $5.59 long-term for every $1 spent

Pathways Community Care Coordination in Low Birth Weight Prevention

Sarah Redding · Elizabeth Conrey · Kyle Porter · John Paulson · Karen Hughes · Mark Redding

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Abstract: The evidence is limited on the effectiveness of home visiting care coordination in addressing poor birth outcome, including low birth weight (LBW). The Community Health Access Project (CHAP) utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to health and social services, and provide additional care support. This study aimed to evaluate the impact of the CHAP intervention on reducing low birth weight rates. The intervention group was matched through propensity score to a control group from the same census tract and year. Logistic regression was used to examine the association of CHAP participation with reduced low birth weight rates.
HUB Outcome Payment Distinction from Other Financial Models

• **HEDIS Measures**
  – Focus on medical factors which represent a smaller part of the risk burden
  – Use a percentage (2-3%) based accountability method which places a very small amount of financial accountability per person/risk factor on assuring risk is addressed

• **Fee-for-service**
  – Medical focus without uniform requirement of addressing outcome

• **Pay-for-Value Based on Achieved Cost Savings**
  – Drives financial efficiencies with and without quality focus
  – Does not always drive improved outcomes
  – Actuarial adjustments in response to cost savings reduce income

• **HUB model of Payment**
  – Ties payment to each confirmed risk mitigation across medial, social, and behavioral health domain
  – At least 50% of dollars must be tied to confirmed risk mitigation
Foundational Components

• Community Relationships
  – Strong supportive relationships and related education are proven to be critical in changing behavior
  – Engaging communities and community health workers brings key strengths to support behavioral change, reduced risk, and improved outcomes

• Accountability
  – Assuring payment drives the critical micro and macro levels of the system to produce outcomes that can be transformative
Thank You

For more information on the Community Pathways HUBs please refer to the Resource List accompanying this webinar

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Kara Miller – Kara.Miller@Medicaid.Ohio.Gov
The Ohio Department of Medicaid
614-752-4826
Questions or Comments?
Key Presentation Takeaways

• MIH care delivery models can be implemented in various care settings and integrated into state VBP initiatives

• There is a lot to consider when implementing a VBP that supports a MIH care model, including:
  – Measurement, measures and HIT capacity
  – Current Medicaid contracts and care arrangements
  – Broader healthcare environment
  – Stakeholder engagement
  – Strong supportive relationships and related education are critical in changing behavior

• Assuring payment drives the micro and macro level systems to produce outcomes that can be transformative
Thank You for Joining Today’s Webinar!

Please take a moment to complete a short feedback survey.

Webinar slides and other related resources are available on Medicaid.gov at this link: