



Creating Partnerships to Address Non-Medical Needs of Medicaid Beneficiaries with Complex Care Needs and High Costs

IAP BCN National Webinar Series
February 27, 2017

2:00pm – 3:30pm EST

Logistics

- Please mute your line & do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
 - Note: chat box will not be seen if you are in “full screen” mode
 - Please exit out of “full screen” mode to participate in polling questions
- Moderated Q&A will be held during the webinar
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Welcome & Overview

- **Karen LLanos**
- Director, IAP, Center for Medicaid and CHIP Services, CMS



Polling Question

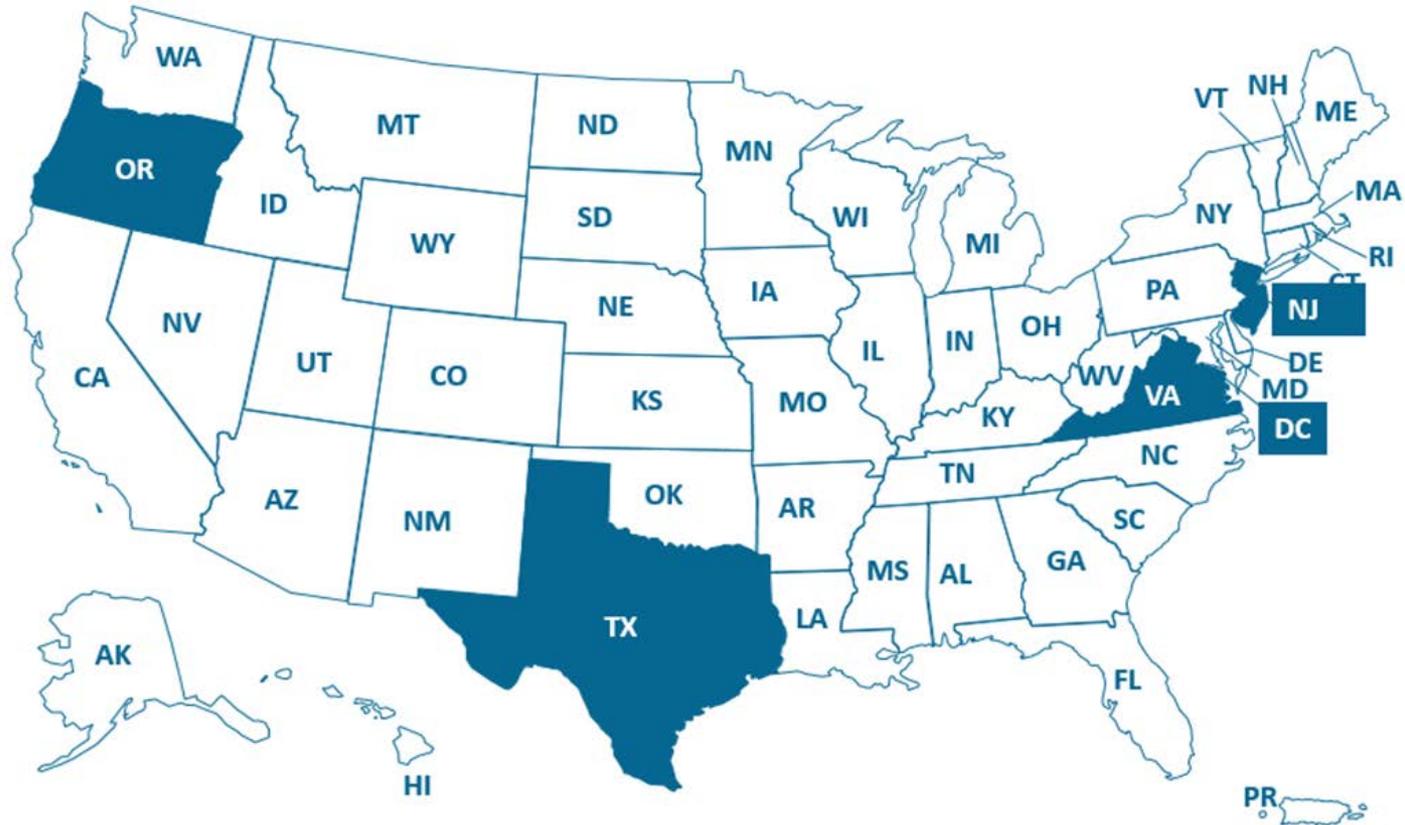
- Please select the type of organization you are representing.
 - State Medicaid Agency
 - State Agency other than Medicaid Agency
 - Managed Care Organization
 - Healthcare Provider
 - Consultant
 - Other

Welcome

- As part of the Medicaid IAP, we have worked with five states since October 2015 on issues such as:
 - Identifying and stratifying BCN target populations
 - Designing effective care management strategies
 - **Creating partnerships to address non-medical needs of Medicaid beneficiaries with complex care needs and high costs**
 - Designing alternative payment methodologies

Background: IAP BCN Participating State Teams

- District of Columbia
- New Jersey
- Oregon
- Texas
- Virginia



Agenda

- Background: Non-medical factors that influence health and BCN efforts
 - Lynn Dierker, Principal, Health Management Associates
- Perspectives from the Field
 - Kate McEvoy, Esq., Director, Division of Health Services, Department of Social Services, State of Connecticut
 - Tom Curtis, Director, MI SIM Project, Michigan Department of Community Health
- Q&A
- Topic Wrap Up
- Closing Remarks

Background

Non-Medical Factors that Influence Health and BCN Efforts

Speaker

- **Lynn Dierker, BSN, RN**
- Principal, Health Management Associates

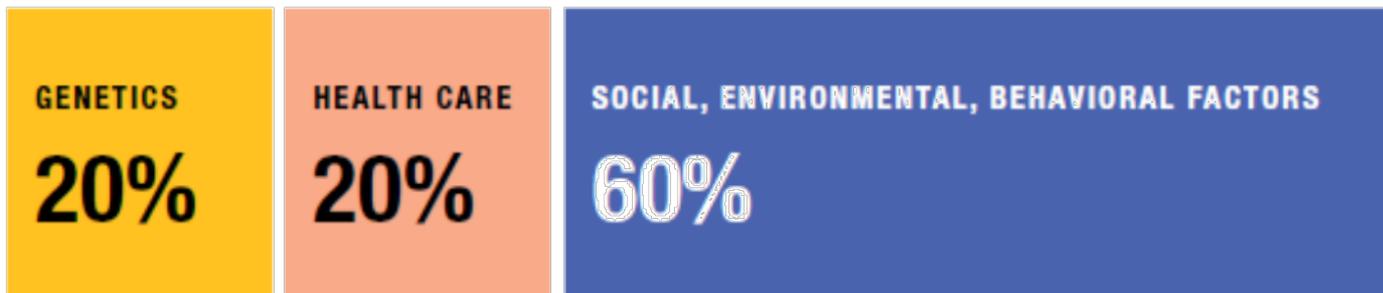


Fostering Health...A Broader View

- “Extensive scientific literature has investigated the relative contributions of genetics, health care, and social, environmental, and behavioral factors in promoting health and reducing premature mortality (Chiu et al., 2009; Lee & Paxman, 1997). These studies uniformly suggest that nonmedical factors play a substantially larger role than do medical factors in health.”

WHAT DETERMINES HEALTH?

(ADAPTED FROM MCGINNIS ET AL., 2002)



“Leveraging the Social Determinants of Health: What Works?” Yale Global Health Leadership Institute, BCBS Foundation MA, June 2015

Health-Related Social Factors*

Core Issues to Address	Other Needs
Housing Instability Food Insecurity Interpersonal Violence Transportation	Family & Social Supports Education Employment & Income Health Behaviors

* This list is not all-inclusive

Impacting Health Outcomes for Complex Medicaid Populations with High Costs & High Needs

- Multiple variables impact the nature of health care utilization that can lead to avoidable ED admissions and hospitalizations
 - Geographic, cultural, economic and health care resources
 - High prevalence of co-occurring mental health, substance use, combined with physical conditions and social factors
- Interventions are multifaceted
 - Target “root causes” of barriers to health care access, engagement, and adherence
 - Align and leverage resources across sectors, agencies, systems, etc.

Addressing Non-Medical Factors: Issues for States to Consider

- **Considerations to address non-medical factors and improve outcomes**
 - Data: understand health demographics and factors in a local context
 - The landscape: community-based organizations, formal/informal networks of services
 - Leadership: MCOs, health systems, providers; safety net size and influence
 - Innovations: building from what exists
- **Practical solutions to interconnect “systems” (physical, behavioral, community)**
 - Provider readiness and capacity
 - Technological supports
 - Data governance
- **Available programmatic supports**
 - Policy levers
 - Data analytics capacity
 - Incentives and financing
 - Performance monitoring and measurement

Connecticut

Deploying Comprehensive Medicaid Strategies that Address
Non-Medical Factors Influencing Health

Speaker

- **Kate McEvoy, Esq.**
- Director, Division of Health Services,
Connecticut Department
of Social Services



Background

- Connecticut Medicaid serves over 750,000 individuals, almost 21% of the state population
- Connecticut is an expansion state, and integrated eligibility, health homes, Community First Choice, Balancing Incentive Program, State Innovation Model Test Grant
- In contrast to many other Medicaid programs, Connecticut Medicaid no longer utilizes capitated managed care arrangements - instead, Connecticut has adopted a self-insured, managed fee-for-service approach

Key Elements:

The CT Medicaid Reform Agenda

- **A simplified administrative structure**
 - State acting in partnership with Administrative Services Organizations effectively supports and empowers both members and providers
- **A fully integrated claims dataset**
 - Enables the program to illuminate needs, influence policy direction, ensure accountability and support cost savings
- **A strong emphasis on preventive care**
- **Focus on Integration**
 - Health (medical, behavioral, dental) and social services
- **Building long-term services and supports**
 - An long-term services and supports system that enables true choice and integration

Background: Broadening Efforts

- Since migration away from capitated arrangements, fully effective in 2012, Connecticut Medicaid has embedded various strategies to connect across programs to also address social factors influencing health and health care
 - Administrative Services Organization (ASO) structure and Intensive Care Management (ICM)
 - Health homes
 - Money Follows the Person “housing plus services” model
 - Development of an upside-only shared savings initiative (PCMH+)

Supporting the Vision

- **Connecticut's vision is an effective health care delivery system for eligible people in Connecticut:**
 - Promotes well-being with minimal illness and effectively managed health conditions
 - Maximizes independence
 - Fosters full integration and participation in their communities
- **This work has been enabled by the following factors:**
 - A fully integrated, statewide Medicaid claims data set
 - Development of data analytic and data match capabilities
 - Emerging Medicaid authorities
 - State Innovation Model emphasis on development of value-based purchasing

Aligned Strategies: A Comprehensive Approach

Strategy	Relationship to Care Delivery Reform	Relationship to Payment Reform
1. Program-wide adoption of an applied definition of person-centeredness	Re-establishes the member and his/her values and preferences as center point of development of health goals	Improves probability of effective and efficient provision of services
2. Integration of questions around housing stability, food security, and personal safety as threshold elements of ASO ICM assessments	Acknowledges and attends to the fact that members cannot meaningfully engage around health goals if basic human needs are not effectively met	Improves probability of effective and efficient provision of services

Aligned Strategies (Continued)

Strategy	Relationship to Care Delivery Reform	Relationship to Payment Reform
<p>3. Implementation of a range of ICM modes (medical through nurse care management, BH through community care teams/peer supports, dental through community educators)</p>	<p>Avoids past one-size-fits-all disease education/management strategies by tailoring the care team and care delivery approach to fit needs of involved population</p>	<p>Improves probability of effective and efficient provision of services</p>
<p>4. Implementation of health homes for individuals with serious and persistent mental illness (SPMI) and high Medicaid claims via Local Mental Health Authorities and social service partners</p>	<p>Situates primary medical services (via Advanced Practice RNs) and social services connections within existing, trusted network of behavioral health providers</p>	<p>Utilizes per member per month payment to enable flexible care coordination support to attributed members</p>

Aligned Strategies (Continued)

Strategy	Relationship to Care Delivery Reform	Relationship to Payment Reform
5. Requirement that FQHCs and ACOs that will participate in an upside-only shared savings initiative enter into formal agreements with social services partners	Acknowledges and attends to the fact that even an entity that has made extensive progress in practice transformation will benefit from close nexus with social services	Will utilize supplemental payments for enhanced care coordination, and upside-only shared savings arrangements, to support providers in achieving improved outcomes

Leveraging Medicaid: Targeting Populations

- Targeted populations include:
 - Entire Medicaid membership (ICM strategies)
 - Individuals with SPMI and high costs (health homes)
 - MFP eligible individuals (MFP “housing plus services”)
 - Non dual-eligible members served by FQHCs and ACOs (PCMH+)
- Connecticut uses a Johns Hopkins tool (CareAnalyzer) for risk stratification and predictive modeling and also has just begun to use “edge server” technology for data matching efforts

Key Features:

Stakeholders and Partnerships

- Medicaid's role ranges from seat of strategy to convener among sister departments to partner with state entities and community partners
- Stakeholder engagement is intense and has attached from inception of plans for implementation
 - Statutory Medicaid oversight bodies and associated committees
 - Longstanding, consumer-focused Money Follows the Person Steering Committee
 - Medicaid Innovation Accelerator on Medicaid-Housing Partnerships project team

Progress and Challenges

- Accomplishments have included:
 - Success with ASO ICM strategies in reducing emergency department, inpatient care, and readmissions
 - New conceptions of care team (e.g. health homes, peer supports) and emphasis points for care coordination
 - Over 4,000 successful transitions under MFP, and greatly improved self-report of independence, integration and happiness
- Challenges have included:
 - Long developmental curve for projects
 - Past hurdles to cross-set data matching

Insights from Michigan

Addressing Other Determinants of Health for BCN
Populations

Speaker

- **Tom Curtis, MPA**
- Director, Michigan State Innovation Model Project
- Michigan Department of Community Health



Michigan Background

- Michigan Medicaid Strategy
 - Leverage managed care contracting
 - Priorities
 - Primary care model: Integrated, Patient Centered Medical Home
 - Population Health Management
- Michigan State Innovation Model (SIM) Project
 - Aligned with managed care contracting strategy
 - Structured community collaboration between health care partners across sectors to address priorities

Michigan Agenda: Addressing Non-Medical Factors

- Michigan Medicaid Managed Care Contract Community Integration Policy Levers
 - Community Health Workers
 - Population Health Management
 - Community Collaboration Project
- Michigan SIM-Project
 - Model for structured community collaboration between health care partners across sectors
 - Priorities to address social determinants, population health management
 - Model for care coordination

Community Integration Policy Levers: Michigan's Medicaid Managed Care Contract

- Contractors must provide or arrange for the provision of Community Health Worker (CHW) services for beneficiaries
 - **Care coordination**
 - Social and Health Assessment
 - Referral to health care and social services
 - Track referrals and problem solve
 - **Sustainability**
 - Training topics aligned with State CHW Association
 - Establish reimbursement methodology
 - 1:20,000 beneficiary ratio

Community Integration Policy Levers: Michigan's Medicaid Managed Care Contract

- Population Health Management
 - Incorporate non-medical determinants of health into interventions
 - Begin developing partnerships with community-based organizations
 - Participate in SIM pilot efforts
 - Local, collaborative infrastructure
 - Clinical-community linkage partnerships
 - Data collection and decision-making

Community Integration: Medicaid Managed Care Performance Bonus

- Population Health Management
 - Submit and annually update multi-year plan to meet all Population Health Management contractual requirements
 - Incorporate non-medical determinants of health data into analysis and intervention design
 - Analyze member data to identify subpopulations experiencing disparate outcomes
 - Address health disparities through services beyond telephonic and mail-based care management
 - Pursue community-based approaches to care coordination, health promotion, and disease management where applicable
 - Measure and report on all interventions designed to impact subpopulations experiencing disparities

Community Integration: Medicaid Managed Care Performance Bonus

- Community Collaboration Project
 - Report participation in MDHHS-approved community-led project to improve population health in each service area
 - Including Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) processes conducted by hospitals, local public health agencies, or regional health coalitions
 - May develop their own if such an initiative does not exist in the service area
 - Describe activities, timelines, and updates relative to new initiatives
 - All projects subject to prior approval

Community Integration: State Innovation Model Efforts

- Pilot local, multi-sector collaborative infrastructure to support Medicaid managed care plans in coordination to address social and behavioral health determinants
 - Governance to include providers, physician/hospital organizations, Medicaid managed care plans, and behavioral health entities
 - Requirement to implement clinical-community linkage partnerships to impact social/behavioral determinants of community-defined ED utilization issue

Community Integration: State Innovation Model Efforts (con't)

- Leveraging **Michigan Pathways to Better Health Demonstration**
 - CMMI Health Care Innovation Award project led by the Michigan Public Health Institute and Michigan Department of Health and Human Services
- Piloted Pathways **Community Hub model**
 - Coordinated community care and leveraged data to inform collaborative decision making
 - Community Health Workers employed by designated Pathways organization
 - Used quality assurance/data collection tools called Pathways to address determinants of health outcomes
- **Local variation/choices** determined targeted issues, business processes, and partnership roles/responsibilities

Community Integration: State Innovation Model efforts (con't)

- Support Medicaid managed care plan adoption of new contract requirements
 - Consider partnerships with community-based community health workers as augmentation of plan-based CHWs and care management services
 - Collect social determinant of health data for incorporation into health plan intervention design and implementation
 - Identification of community-based partners for coordination, health promotion, and disease prevention/management
 - Participation in broad community collaboration project

Community Integration Vision

Function

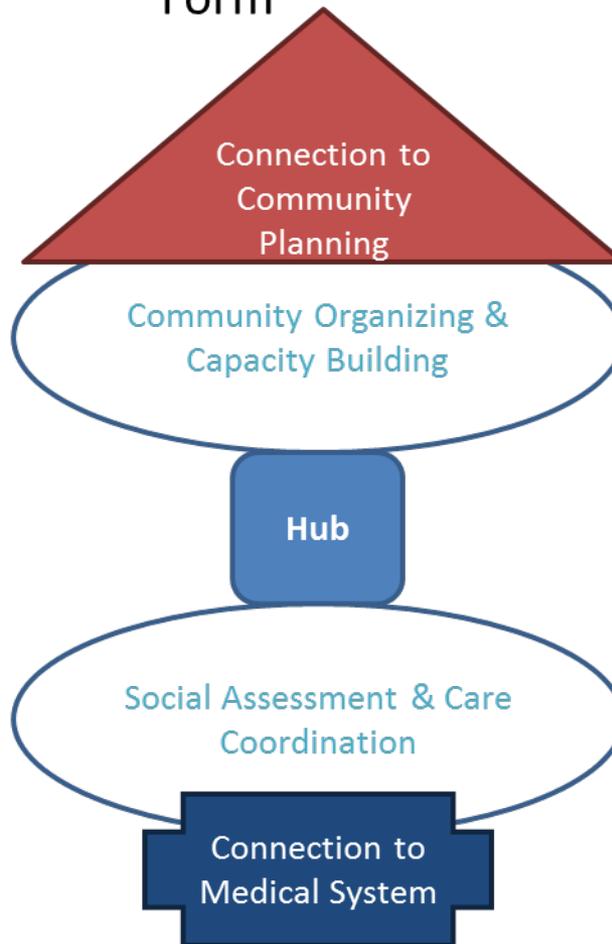
Community-wide
Social/Health Resource
Planning

Community Data
Sharing & Governance

Service Integration &
Quality Assurance

Clinical-Community
Linkage Functionality

Form



Policy/Payment

Integrate with single
CHNA/CHIP

Align with Statewide
HIT/HIE & CMS
Accountable Health
Communities Initiative

Payment Reform &
CHW Institution

Discussion & Questions



Summary Observations and Key Takeaways

Key Takeaways

- A variety of approaches to address non-medical factors can be incorporated as part of broad state Medicaid and reform strategies.
- The realities of each state's policy and health care landscape create opportunities and challenges.
- The state can play an important role to call for and structure new care and service models and collaborations.
- Blending medical and non-medical approaches to BCN efforts requires building knowledge and partnerships across typically siloed "systems of care" (i.e., clinical care vs community services).
- Multi-level data sharing capacity is a critical component for care partnerships, measuring outcomes, and value-based payment.
- Lessons learned for addressing non-medical factors are available from population specific care systems e.g., LTSS.

Closing Remarks

Karen LLanos

Closing Remarks

- National Dissemination Series continues:
 - March 27, 2017: Applying Alternative Payment Strategies for BCNs
 - 2:00 p.m.-3:30 p.m. ET

Thank You!

**Thank you for joining us for this
National Dissemination Webinar!**

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