Building on the Movement from Value to Health: Integrating DOH into Medicare and Medicaid Payment

Investing in Health Topic #1

Pre-Read Materials for May 26, 2021 Meeting

With generous support from Blue Shield of California Foundation and The Commonwealth Fund

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Meeting Agenda, Objectives, and Expectations

Agenda for the May 26 Meeting

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- ***How will we make change?***
  - Discussion and Next Steps

Investing in Health Convening Objectives and Expectations

Secretary Becerra has pledged to: *"Take a department-wide approach to the advancement of equity, consistent with President Biden's charge to federal departments and agencies, and this would include examination of ways to address the social determinants of health"*

Objectives for Our Convening Series

- Identify **high value policy changes** to invest in health that could be launched or implemented in the next year
- **Chart a pathway** to action within existing federal authority
- Define next steps to leapfrog barriers and **achieve meaningful change**

Vegas Rules: To foster candid conversation, no quotes or attribution without explicit consent.

Looking Ahead to the Meeting Series

Topic Area #1: Integrating DOH into Medicaid and Medicare Payment

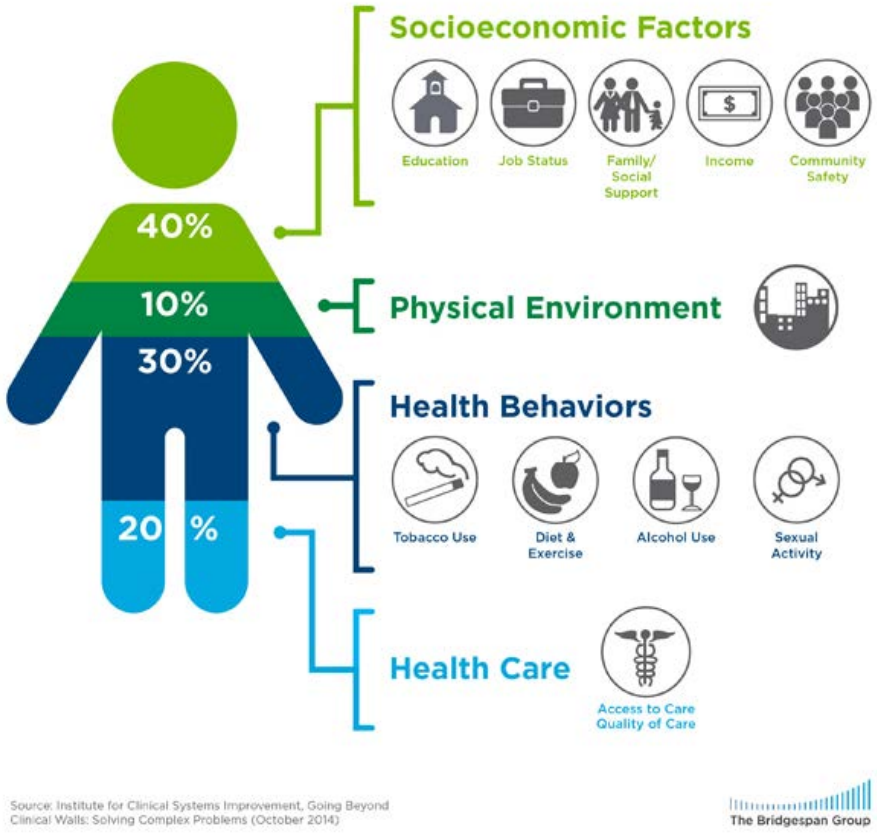
Topic Area #2: Standardizing DOH Quality Measures

Topic Area #3: TBD

Why are we here?
Investing in Health

Improvement in *Healthcare* Is Not Enough to Improve *Health*

Drivers of health (DOH) – sometimes called 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



Socioeconomic factors, physical environments, and health behaviors drive health outcomes more than medical care

Having at least one unmet social need is associated with increased rates of depression, diabetes, hypertension, ED overuse, clinic "no-shows" and higher overall healthcare costs

States and countries with higher ratios of social-to-health spending have statistically better health outcomes

Sources: Booske, B.C., Athens, J.K., Kindig, D. A., et al. Different Perspectives for Assigning Weights to Determinants of Health. University of Wisconsin Population Health Institute. February 2010; Bachrach, D., Pfister, H., Wallis, K. and Lipson, M. Addressing Patients' Social Needs: An Emerging Case for Provider Investment. Commonwealth Fund. May 2014; Blendon, R.J., Donelan K., Hill C., Scheck A., Carter W., Beatrice D., Altman, D. "Medicaid beneficiaries and health reform." Health Affairs, 12, no.1 (1993): 132-143; Berkowitz, Seth A., et al. "Food insecurity and healthcare expenditures in the United States, 2011–2013." *Health services research* 53.3 (2018): 1600-1620.

Health Equity and Drivers of Health

Health disparities exist independently from, but are substantially compounded by, drivers of health

People of color experience health disparities even after controlling for economic and environmental factors.

Example: Maternal Mortality

The maternal mortality rate for "black women with at least a college degree was five times as high as white women with a similar education."

People of color are disproportionately impacted by the social and economic factors that affect health outcomes.

Example: COVID-19

People of color have been disproportionately impacted by both the economic and health effects of COVID-19.

Example: Accountable Communities of Health

Early Results from the Accountable Health Communities Model demonstrate wide-spread social needs, with 33% of Medicare and Medicaid beneficiaries screened having at least one health-related social need.

Addressing DOH is central to efforts to advance health equity

What it Means to Invest in Health

Investing in Health requires that we leverage our country's significant public and private resources to achieve health, not just deliver healthcare.

It requires direct investment in the drivers of health—decent wages, healthy food, safe housing—and it requires unlocking the approximately $11 billion we spend every day on healthcare to maximize health.

When brought to scale, Investing in Health is good for people, good for business and good for government.

Investing in Health: A Federal Action Plan

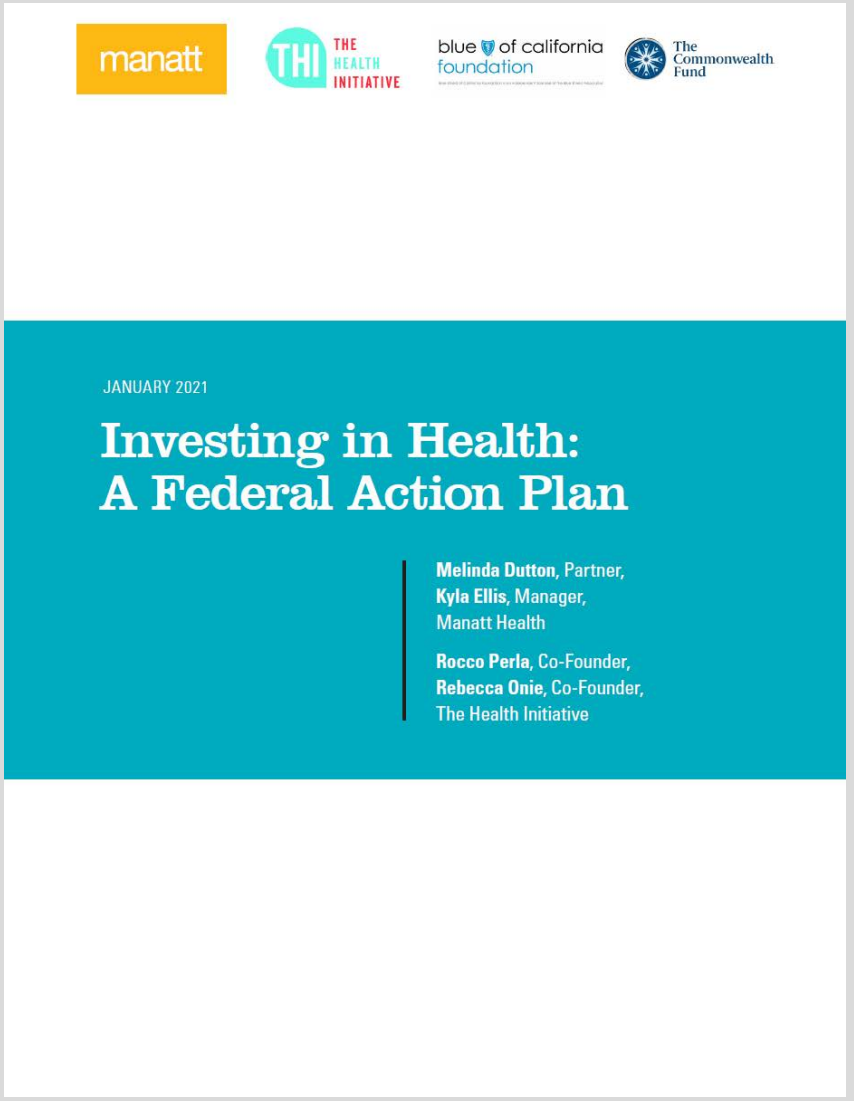
- ***Rethink the role of federal leadership in creating a healthier America.***

- ***Make Investing in Health CMS's central organizing principle -*** *administers programs serving more than 145 million people and operates with a budget of approximately $1 trillion –* ***changing the paradigm of what the health system can and should achieve.***

7 *Federal strategies to maximize health and address inequities;*

45 *Associated policy/program changes for Medicaid, Medicare, the ACA Marketplace, and CMMI; and*

129 *Specific actions to implement these changes under CMS's existing legislative authority.*



Federal Strategies to Address Drivers of Health: Focus of May 26 Meeting

- Address Drivers of Health in Combating COVID-19
- **Integrate Drivers of Health into Payment Policy for Providers and Payors**
- Develop Shared Assets to Enable Interventions Addressing Drivers of Health
- Maximize Participation in Public Programs that Address Drivers of Health
- Create New Standards for DOH Quality, Utilization, and Outcome Measurement
- **Make Drivers of Health Central to CMMI's Innovation Agenda**
- Incentivize Community Accountability and Stewardship

Criteria Used for Selecting Strategies and Policy Change

- Actionable through the executive branch
- Feasible within existing program and agency infrastructure
- Advances a commitment to Investing in Health
- Advances health equity

Payment Policy as a Tool to Incentivize Change

Why Payment Policy Matters

Sustainable change requires realignment of financial incentives

- ***The need:*** Align financial incentives for providers and plans to invest in tracking, reporting, and acting to address DOH and advancing health equity
- ***The goal:*** Define a three-year glide path to scalable changes in provider and plan reimbursement that integrate DOH and incentivize improvements in health
- ***Meeting #1 Strategies of Focus:***
  - Strategy 2: Integrate Drivers of Health into Payment Policy for Providers and Payors
  - Strategy 6: Make Drivers of Health Central to CMMI's Innovation Agenda
- ***Policy/Program Changes of Focus:***
  - Expand the range of services that can be reimbursed under Medicare and Medicaid
  - Integrate DOH into risk arrangements, including CMMI risk-based payment models

Payment Policy to Incentivize Change: Key Concepts

To hardwire incentives to improve health into our healthcare reimbursement system we must address several questions

What is reimbursed?

- Covered services are defined in statute, but CMS/states have flexibility to define those broad categories of services.
- Managed care arrangements provide additional flexibility (e.g., in lieu of services under Medicaid managed care, supplemental benefits under Medicare Advantage).
- Medicaid waivers provide still more flexibility

What is rewarded?

Quality incentive programs, quality initiatives, and value-based payment arrangements may incentivize investment in activities not directly reimbursed, but have entry barriers, depend heavily on the scale of cost/reward to sustain, and can inadvertently exacerbate health disparities.

What "counts"?

Across all payors, medical loss ratio (MLR) requirements under the ACA seek to ensure health plan dollars are spent on health. Limitations on what are counted as health-related costs can limit DOH investments.

How are rates calculated?

Adjustment for social risk factors acknowledges the high costs and increased barriers to health associated with patients experiencing DOH.

Key Executive Levers for Action and Timeline

What are the most impactful policy levers to integrate DOH into Medicaid and Medicare?

Policy Change	Related Guidance/Rulemaking Activities	Timing
Allowable Services	Medicare Hospital Inpatient Prospective Payment System	Spring: Proposed rule* Fall: Final rule
	Medicare Physician Fee Schedule	July: Proposed rule November: Final rule
	Ongoing guidance and waiver approvals: ▪ State Plan Amendment (SPA) templates ▪ Learning collaboratives ▪ Toolkits and waiver templates ▪ Program guidance	Ongoing
Provider Payments	Medicare Physician Fee Schedule	July: Proposed rule* November: Final rule
	Medicare Hospital Inpatient Prospective Payment System	Spring: Proposed rule* Fall: Final rule
Risk Adjustment	Medicaid Managed Care Rule	Irregular**
	▪ Medicare Advantage Capitation Rates and Part D Annual Notice ▪ Annual Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Rule	Winter/January: Advance notice/call letter/proposed rule* Spring: Final rule
	Ongoing Medicaid guidance and waiver approvals (see above)	Ongoing

CMMI authority to develop and test new healthcare payment and service delivery models also serves as an important tool across these policy changes

*60 day comment period

**Fall 2020 regulatory agenda lists September 2021 for proposed rule

Policy Recommendation #1: Expand Allowable Services Under Medicare and Medicaid

Given unprecedented increases in food insecurity, housing instability, and interpersonal violence, what new health-related services, provider types, and settings should be included as ***allowable services under Medicaid and/or Medicare****?*

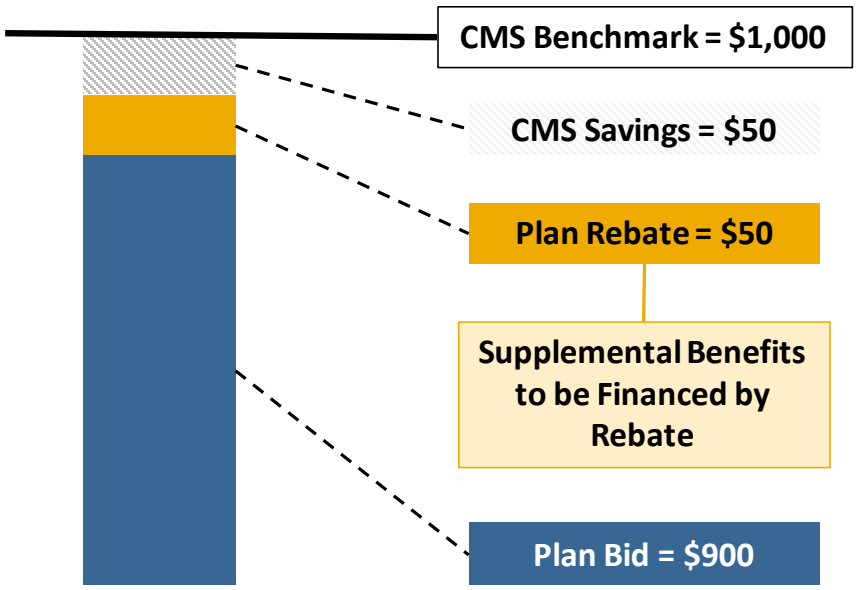
State of Play: Medicare Advantage DOH Supplemental Benefits

Recent policy changes afford MA plans greater flexibility to cover DOH services

MA Rate-Setting Overview

CMS sets a regional benchmark for MA benefit and non-benefit spending. If plans submit "bids" below the benchmark, they can use a portion of the savings to finance supplemental benefits.

Illustrative Example



Recent Policy Changes

2018: Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act: Expanded definition of health-related supplemental benefits that MA plans could offer (to support "daily maintenance of health") starting in 2020 for people with serious chronic conditions

2019: CMS Rule: Allowed MA plans to offer even broader range of supplemental benefits; benefits must compensate for physical impairments, diminish the impact of injuries or health conditions, and/or reduce avoidable ED visits

2020: CMS Rule: Changed Medical Loss Ratio calculation to include all covered services—regardless of whether they are performed by a healthcare provider—in the numerator, meaning that DOH supplemental benefits can be treated as service costs for purposes of the MLR calculation.

Implications

- Plan has finite rebate dollars to spend on supplemental benefits, and only when plan bid is below CMS benchmark
- **MA plans are accelerating their focus on DOH benefits, with a particular focus on addressing food insecurity:**
  - 57% of MA plans will offer meals as a supplemental benefit in 2021, compared with 23% in 2018*
  - Anthem and Humana, in particular, are using supplemental benefits to address DOH; for example, Anthem is increasing the number of plans offering DOH benefits by 50% nationally in 2021

* Milliman analysis: Overview of Medicare Advantage supplemental healthcare benefits and review of Contract Year 2021 offerings

Building on the Movement from Value to Health: Integrating DOH into Medicare and Medicaid Payment

Notes: If a plan's bid goes above the CMS benchmark, plans receive the benchmark payment from CMS and charge a higher premium for enrollees to cover the overage.

State of Play: Medicare Fee-for-Service and DOH

Today, there are limited tools to reimburse DOH services in Medicare fee-for-service

Chronic Care Management Codes. Since 2015, providers have been able to bill Medicare for care management furnished to beneficiaries with multiple chronic conditions, which can include some DOH coordination activity.

Evaluation and Management Codes. Providers may document that diagnosis or treatment is significantly limited by DOH to support increase in E&M complexity level.

ICD-10-CM Z Codes. A subset of ICD-10-CM codes, Z-codes can accompany any performed procedure code to document "factors that influence health status and contact with health services." Awareness and use of Z-codes has accelerated since their inception in 2015. *While not currently linked to reimbursement, the codes represent a future opportunity.*

These codes may serve as a chassis for additional payments for beneficiaries with additional social needs, including standalone psychosocial evaluation and referral.

Levers for Action, Based on Provider Type:

Inpatient Hospital Services: DRGs within Medicare Inpatient Prospective Payment System

Outpatient Hospital or Ambulatory Services: APC in the Medicare Outpatient Prospective Payment System

Physician Office Services: CPT codes in Medicare Physician Fee Schedule

State of Play: Medicaid DOH Allowable Services

States may classify a range of social supports as Medicaid plan benefits

- Recent SMDL outlined opportunities in Medicaid and CHIP to address DOH
- Federal Medicaid law permits Medicaid coverage for DOH for:
  - Linkages to social service programs
  - Stable housing support
  - Assistance in finding and retaining employment
  - Peer support
- Opportunities under "case management" or "targeted case management" (both optional Medicaid benefits)
- Some key social supports, such as direct costs of housing, cannot be classified as Medicaid benefits

- Additional flexibility through:
  - Medicaid managed care (e.g., "in lieu of" services (ILOS))
  - Targeted waiver authorities
  - 1115 demonstration

Spotlight: In Lieu Of Services (ILOS)

- Medically appropriate, cost-effective alternatives to services covered under the State Plan.
- Provided in the context of Medicaid managed care.
- Service costs are included when setting capitation rates and in the numerator of the MLR.
- Must be voluntary and included in the contract.

Example: Allowing medically tailored meals as a substitute for a home visit by an aide in certain circumstances.

Recommendation: Expand Allowable to Services Under Medicare

Include DOH as allowable services to give providers and carriers financial incentives to meet the full range of beneficiary needs

Policy Tactic	Authority/Vehicle	Estimated Timing
Expand Medicare Advantage plans' ability to offer DOH-related supplemental benefits	Annual Medicare Advantage rulemaking	Within 12 months
Broaden definitions of allowable services in Medicare fee-for-service by expanding chronic care management codes and code definitions that include DOH; create standalone codes for psychosocial evaluation and referral	Medicare Physician Fee Schedule	Within 12 months, aligned with summer proposed rule
Leverage CMMI waiver authority to test expanded benefits (e.g., development of a fee schedule based on AHC pilot and screening tool)	Model authority	Between 6 to 12 months, depending on complexity

Recommendation: Expand Allowable to Services Under Medicaid

Provide additional clarity about what flexibilities states can use and how to use them to cover DOH services within the Medicaid program

Managed Care	▪ Create learning collaboratives ▪ Provide model contract language ▪ Update the Medicaid Managed Care rule to account for DOH-related services
Fee-for-Service	▪ Create a State Plan Amendment template for coverable services
Waivers	▪ Create 1115 templates for coverable services ▪ Focus explicitly on DOH interventions/health equity in Section 1115 demonstration monitoring and evaluations ▪ Develop tools (e.g., templates and guidance) for monitoring protocols and reports, and evaluations designs ▪ Issue guidance clarifying that short-term post-hospitalization, transitional housing, etc. can be covered under Medicaid ▪ Support states in moving beyond pilots and taking learnings to scale

Spotlight: In Lieu Of Services (ILOS)

CMS should clarify state discretion to provide ILOS to address DOH where states:

- Review and **consider evidence** to determine whether ILOS are cost-effective and medically appropriate
- **Track ILOS and State Plan services health outcomes and cost/utilization trends** over time, and adjust based on findings
- Ensure **application of these standards is non-discriminatory and provides equal access**

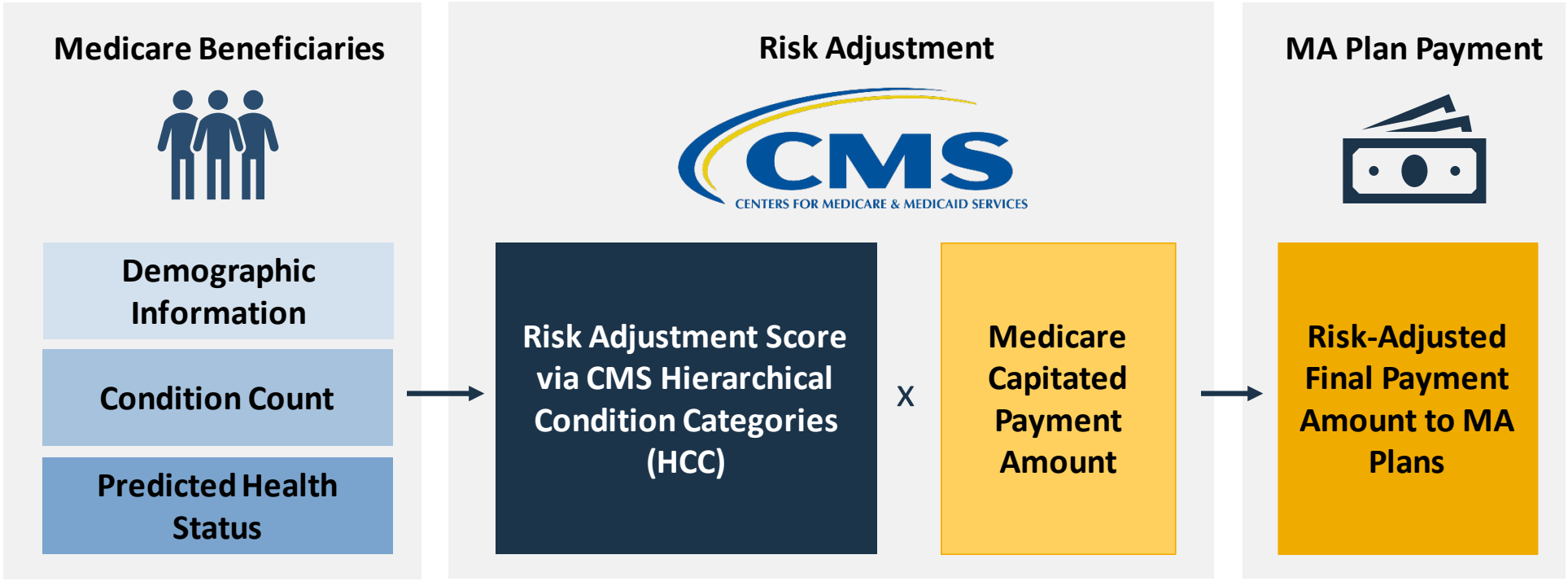
Policy Recommendation #2: Integrate DOH into Risk Scoring and Risk Adjustment Methods

*What will it take to build drivers of health into **standardized risk scoring and risk adjustment methods** for payors/providers to avoid disincentives to investing in health?*

How can CMMI help accelerate integration of DOH into risk-based payment models?

State of Play: Medicare Risk Adjustment Structure

Adding DOH factors to risk adjustment methodology can deter insurers from avoiding populations with social needs and provide additional resources to invest in DOH



- Insurers that serve high-risk and high-need populations are compensated through risk adjustment
- Defining risk factors is complex and requires engagement of plans, providers, and other stakeholders
- Adding social factors requires analytic capabilities to collect reliable data and assess value of incorporating SES factors

State of Play: Looking to Medicaid Risk Adjustment

Massachusetts MassHealth

- The MassHealth risk adjustment model uses a claims-based medical-risk model (DxCG) to determine rates, including MCO rate setting and ACO rate and target setting
- Adds proxy measures to assess SDOH factors, including:
  - Unstable housing (multiple addresses)
  - Disability diagnosis
  - SMI/SUD
  - Summary measure of "neighborhood stress" based on census data
  - Relationships with other government agencies (e.g., Department of Mental Health)

Minnesota Integrated Health Partnership

- Integrated Health Partnership, the ACO model within the Minnesota Medicaid program, uses social risk factor measures for children and for adults to adjust their population-based payments quarterly.
- Metrics include:
  - Homelessness
  - Mental illness
  - SUD
  - Past incarceration
  - Child protection involvement

Recommendation: Standardize Risk Adjustment Across Medicare and Medicaid

Across programs, standardized CMS risk scoring and risk adjustment models that incorporate DOH will more accurately predict cost and utilization, deliver better care to beneficiaries, and establish more precise cost benchmarks for advanced payment models

Policy Tactic	Authority/Vehicle	Estimated Timing
Develop and test a Medicare Advantage risk adjustment model that incorporates patient-level DOH risk factors into the HCC score	CMMI model authority, in collaboration with CMS and Office of Actuary	Two to three years for stakeholder engagement and implementation
Implement for full Medicare Advantage program; leverage for ACA risk adjustment methodology	Annual Medicare Advantage rulemaking	Four to five years; pending results from CMMI model
Encourage states to implement the DOH risk adjustment model in Medicaid managed care	CMS guidance and toolkits; encouragement in Medicaid managed care rule	One to two years

How will we make change?

Discussion and Next Steps

Discussion Questions for Meeting #1

- Stepping back : What are our baseline assumptions as we review potential policy changes? Is it enough that DOH investments improve health and health equity? Or must DOH investments demonstrate a financial ROI? Could we evolve from ROI to cost-effectiveness as the measure of success?
- Drilling down: Are these the right recommendations? Which should be prioritized? Are any crucial policy changes missing? Which could be fast-tracked?
- Looking ahead: What actions are necessary to move these changes forward? What can be done in the next 2 weeks; 6 months; 2 years to move these changes forward? How can we leapfrog potential barriers?