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

Investing in Health Topic #1

Pre-Read Materials: Relevant Policy Changes and Tactics

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

Table 1: Federal Strategies to *Invest in Health*

Federal Strategies to Invest in Health Shaded rows to be implemented in first 100 days	
1. Address Drivers of Health in Combating COVID-19	
Cross-Sector	Provide funding to address DOH-related barriers to isolation and quarantine.
	Ensure DOH are considered during the distribution of COVID-19 vaccines.
	In response to COVID-19, test a new model with a focus on identifying gaps and coordinating public and private investments in DOH.
	Develop new Provider Relief Fund distribution methodologies for any future appropriations and disbursements that recognize providers' investments in DOH.
	Repurpose Provider Relief Funds allocated to the Health Resources and Services Administration (HRSA)- administered "uninsured fund" to more effectively support health care providers serving uninsured and vulnerable patients who are more likely to struggle to meet basic needs.
2. Integrate Drivers of Health into Payment Policy for Providers and Payors	
Cross-Sector	Build DOH into standardized CMS risk scoring and risk adjustment methods.
	Update medical loss ratio (MLR) calculation requirements across programs to account for DOH investments.
	Issue an Request for Information (RFI) to Medicaid, Medicare and Marketplace stakeholders seeking best practices and recommendations for eliminating barriers to addressing DOH in current coverage and payment models.
	Integrate DOH into alternative payment models by updating the (HCP-LAN) annual measurement effort to include more DOH indicators.
	Create financial incentives for reporting race and ethnicity data in all CMS payment models.
	Encourage use of and tie provider reimbursement to ICD-10Z codes.
	Establish/quantify baseline spending on DOH-related expenditures and develop goals for future spending growth.
Medicaid	Encourage states to hold managed care organizations (MCOs) harmless for "premium slide" attributed to DOH investments during rate setting.
	Encourage states to include DOH interventions as a covered service.
Medicare	Broaden definitions of allowable supplemental benefits in Medicare Advantage.
	Pay for DOH screening and navigation to community resources by Medicare providers beyond the current Medicare reimbursement codes for psychosocial elements of chronic care management.
	Recalibrate county benchmarks to account for differences in socioeconomic status (SES) in ways that increase benchmarks in low-SES counties and encourage Medicare Advantage participation.
Marketplace	Include specific references to DOH-related services in the definition of essential health benefits (EHBs), such as enhanced care management, social service referral/navigation and community coordinators (peer support, community health workers, doulas).
	Include DOH interventions in standardized qualified health plans (QHPs) and promote these plans on the Marketplaces.
	Encourage insurers to voluntarily cover DOH interventions, or permit states to require coverage.
	Design a model for wellness programs that addresses DOH without discriminating by health risk.

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5. Create New Standards for DOH Quality, Utilization and Outcome Measurement	
Cross-Sector	Establish comprehensive nationwide standards for drivers of health (DOH) data, collection and measurement focused on both process and outcomes measures.
Medicaid	Update the Medicaid core measures set to include DOH measures.
	Add DOH to state quality strategy under Medicaid Managed Care.
Medicare	Build DOH into the Quality Payment Program (QPP) via the Center for Clinical Standards and Quality (CCSQ).
Marketplace	Build DOH into the health insurance exchange Quality Ratings System (QRS).
6. Make Drivers of Health Central to CMMI's Innovation Agenda	
CMMI	Develop and test a social services fee schedule to be used by health care payers and providers to pay for DOH interventions.
	Integrate the Accountable Health Communities Model DOH-related components, such as screening and navigation, into other existing models and new CMMI payment models.
	Direct CMMI to incorporate DOH into all payment and care delivery models.
	Restructure CMMI models to promote participation among providers serving middle/low-income and marginalized groups.
	Increase use of Quality Improvement Organizations (QIOs) in Medicare to support efforts to address DOH.
7. Incentivize Community Accountability and Stewardship	
Medicaid	Encourage or require states to direct managed care organizations to contribute to locally governed community wellness and equity organizations.
	Tie certain supplemental payments to DOH expectations for community stewardship.
	Incentivize healthy living wages, particularly for the long-term care (LTC) workforce.
Medicare	Update the Medicare wage index to incentivize healthy living wage compensation for hospital workers.
	Provide rate increases for critical access hospitals (CAHs) that invest in healthy living wage compensation.

Strategy 2: Integrate Drivers of Health into Payment Policy for Providers and Payors

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
Cross-Sector	Build DOH into standardized CMS risk scoring and risk adjustment methods.	There is growing pressure on CMS and the health care sector to incorporate social risk factors into risk adjustment models to more accurately predict cost and utilization, deliver better care to beneficiaries, and establish more precise cost benchmarks for advanced payment models (APMs) that go beyond HCC score (based on hierarchical condition categories, disability, demographics and Medicaid status). Select states have pursued risk adjustment models that include social risk factors: Massachusetts' Medicaid model, for example, includes variables such as unstable housing or homelessness, categories of disability and a neighborhood-level score (calculated for census block groups) that summarizes several measures of socioeconomic stress. The Minnesota Integrated Health Partnerships social risk adjustment methodology includes a set of social risk factor measures for children and for adults (e.g., homelessness, deep poverty (<50% of the federal poverty level), substance use disorder and/or serious mental illness diagnosis) that are used to enhance the medically based risk adjustment methodology obtained from administrative and claims data.	• Develop and test a Medicare Advantage risk adjustment model that incorporates patient-level DOH risk factors into the Hierarchical Condition Category score (e.g., adding specified ICD-10 Z codes). • Validate and implement for Medicare Advantage. • Encourage states to implement the model in Medicaid Managed Care. • Explore use for Marketplace risk adjustment methodology.

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Cross-Sector	Update the medical loss ratio (MLR) calculation across programs to account for investments in DOH	The Affordable Care Act (ACA) requires insurers to provide a rebate to enrollees if a plan's MLR is less than 80% for individual market products (i.e., if the insurer does not spend at least 80% of the premium on "medical" expenses and keep "administrative" expenses and profits under 20%). While quality improvement activities are included in the numerator of this calculation, it is unclear whether, under current guidance, DOH interventions would qualify. This uncertainty disincentivizes investments in health, leaving carriers at risk if DOH costs are considered administrative expenses rather than medical expenses. For example, an insurer can buy a diabetic medicine, but if it buys her healthy food to manage her disease, that may be treated as an administrative cost. MLR rebates have consistently increased in the individual market since 2017, signaling an opportunity to repurpose unspent premium dollars on DOH interventions. One state, North Carolina, currently encourages its Medicaid Managed Care plans to voluntarily contribute to high-impact DOH-related initiatives within the communities it serves and allows those contributions to count toward the numerator of its MLR.	• Provide guidance clarifying that DOH interventions that improve health may be counted as quality improvement activities and provide examples of the types of DOH interventions that meet 45 CFR §158.150 definition of "quality improvement activities." • Disseminate guidance through the Marketplace, Medicaid, and Medicare programs.
Cross-Sector	Issue a Request for Information (RFI) to Medicare, Medicaid and Marketplace plans, state officials, providers, and community stakeholders seeking best practices and recommendations for eliminating common barriers to addressing DOH in current coverage and payment models.	An RFI will signal CMS' commitment to future investments in DOH intervention and interest in partnering across the health care sector. Dissemination of best practices will accelerate market adoption.	• Issue a cross-program RFI on the Federal Register asking cross-cutting and program-specific questions (Medicaid, Medicare, and Marketplace). • Develop a comprehensive compendium of best practices based on the findings from the RFI, including guidance on legal authorities and key implementation strategies • Update this resource regularly

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
Cross-Sector	Integrate DOH in alternative payment models (APMs)/ value-based payment (VBP) initiatives by updating Health Care Payment Learning & Action Network (LAN)'s annual measurement effort to include DOH indicators.	Designing and implementing VBP initiatives and rewards improved health outcomes and cost-efficiency by moving away from reimbursing providers based on the volume of care they provide and moving toward reimbursing them for improving outcomes and reducing costs. Payment incentives (or withholds) can be also be designed to promote DOH interventions that have been proven to improve health outcomes. The LAN is a public-private effort to create a common framework for classifying APMs. DOH are a strategic focus for the LAN yet the LAN measurement framework does not include DOH cost or quality measures.	• Charge the LAN stakeholders to build DOH measures into the alternative payment model (APM) measurement framework that account for DOH-related expenditures, which could include, for example, consideration of ICD-10 Z codes, supplemental benefits or in-lieu-of services as part of Category 4 (population-based payments) to establish a baseline investment in health. • Build upon payment guidance encouraging Value-Based Care Opportunities in Medicaid to promote additional innovation across programs.
Cross-Sector	Create financial incentives for reporting race and ethnicity data in all CMS payment models, including fee-for-service and alternative payment models.	The link between racial disparities and DOH is clear and is only becoming more acute given COVID-19. As of 2012, section 4302 of the ACA requires population health surveys in federal health programs, including Medicare and Medicaid, to collect and report race, ethnicity, language, and other data to understand and help reduce health and health care disparities. Nonetheless, recent studies confirm that Medicare, Medicaid and commercial plans have largely incomplete data on race and ethnicity, though some positive outliers exist. Recent delivery reform recommendations call for public and private payers to require the collection, use, and application of race and ethnicity data, as essential to identifying and improving disparities.	• Leverage CMS's authority under Section 4302 of the ACA to require Medicare, Medicare Advantage and Medicaid payments be tied to specific performance levels for reporting race and ethnicity data (e.g., >95% complete reporting equals 100% financial reward, adjusted downward for lower rates of complete reporting). • Encourage states to include analogous requirements and financial incentives in their Medicaid managed care organization contracting and performance metrics tied to reimbursement.

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
Cross-Sector	Encourage use of and tie provider reimbursement adjustments to ICD-10 Z codes for potential socioeconomic and psychosocial circumstances (Z55-Z65).	Encouraging and standardizing the widespread use/adoption of Z-codes across payors will enable changes in provider reimbursement, support DOH data collection, inform future research on DOH impacts, and strengthen the case for increased payment for DOH services as a value driver.	• Weight Medicare provider payment for services when Z-codes are reported via annual fee-schedule rulemaking: – Link Z-codes to reimbursement in the Physician Fee Schedule – Reweight Diagnosis-related groups (DGRs) to treat DOH factors as co-morbidities via annual Hospital Inpatient Prospective Payment Systems rulemaking. • Encourage states to require use of Z-codes in Medicaid billing and encounter reporting, and to update Medicaid reimbursements to align with Medicare changes incorporating Z-codes.
Cross-Sector	Establish/quantify baseline spending on DOH-related expenditures (e.g., spending on supplemental benefits, in-lieu-of services (ILOS), non-medical allowable services) to understand the federal investment in health overall and by market segment (Medicare, Medicaid/CHIP and individual) and develop goals for future spending growth..	The link between racial disparities and DOH is clear and is only becoming more acute given COVID-19. As of 2012, section 4302 of the ACA requires population health surveys in federal health programs, including Medicare and Medicaid, to collect and report race, ethnicity, language, and other data to understand and help reduce health and health care disparities. Nonetheless, recent studies confirm that Medicare, Medicaid and commercial plans have largely incomplete data on race and ethnicity, though some positive outliers exist. Recent delivery reform recommendations call for public and private payers to require the collection, use, and application of race and ethnicity data, as essential to identifying and improving disparities.	• Establish a DOH-related expenditure category through OACT that is reported annually as outlined in HHS leadership priorities, or a part of a larger quality-focused Executive Order. • (Legislative) Include this spending analysis as part of Medicare Payment Advisory Commission (MedPAC)'s and Medicaid and CHIP Payment and Access Commission (MACPAC)'s Report to Congress.

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Medicaid	Encourage states to hold managed care organizations (MCOs) harmless for "premium slide" attributed to DOH investments during rate setting.	Currently, when health care utilization falls, it is reflected within a few years as lower capitation payments for plans. If there were a DOH-related value-added service that led to a reduction in utilization, that plan would see lower payments in the future and would no longer have the dollars to fund the successful DOH intervention. The purpose of this recommended intervention is to preserve funding for successful DOH investments that reduce health care utilization.	• Educate states on strategies to address premium slide and offer technical support in implementing strategies including: – Incorporating social risk scores in risk adjustment. For example, Massachusetts includes housing instability, neighborhood stress scores, and an additional measure of disability as part of its risk adjustment methodology—in effect, redistributing capitation dollars among plans based on the socioeconomic status of each plan's beneficiaries. – Integrating ILOS costs into capitation rates to fund interventions. – Offering enhanced care management payments for members with social needs/high social risk scores to cover, for example, screening and navigation assistance and assistance with enrollment in other public programs. – Leveraging existing authority under federal Medicaid managed care regulations to provide incentive payments up to 5% of capitation payments when plans meet goals consistent with the state's quality strategy. – Providing kick payments for targeted populations, which are permissible under current regulations, outside of rate, and can be held constant over time. • Refining managed care rate setting to permit delinking of capitation payments from utilization. Under such a model, a base capitation rate would be trended forward, taking into account changes in population health and medical inflation, but would not rebase rates relying on utilization. This is similar to applying the hospital global budgets seen in Maryland and Pennsylvania to a managed care environment.

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
Medicaid	Encourage states to include DOH interventions as a covered service..	CMS recently issued guidance describing opportunities for state Medicaid and CHIP programs to better address DOH, including outlining legal authorities that permit the provision of DOH-related services for specific populations under Medicaid, along with examples of existing state initiatives. CMS also has approved through North Carolina's 1115 waiver a set of evidence-based, high-value interventions addressing DOH. These services are illustrative of the types of services states should be encouraged to include as a covered service under Medicaid. Some services, such as housing navigation services, can be covered under existing federal law as a standalone fee-for-service benefit or under the rubric of targeted case management. Others, such as healthy food boxes can be provided by Medicaid managed care plans under quality initiatives, or as a value-added or in-lieu-of service. Still others, including services not offered statewide, could be offered through waiver. The recent CMS guidance reiterates previous guidance prohibiting the use of Medicaid funds to pay for room and board except in certain medical institutions. CMS defines "board" as three meals a day or any other full nutritional regimen.	• Build upon this guidance to create new template and tools to assist states in leveraging this authority and to create greater clarity on the full range of services that can be made available under Medicaid. • For services offered under managed care, create learning collaboratives and tools including model contract language to support states as • they implement DOH screening and navigation services, ILOS or other payment mechanisms (value-added services, quality incentive payments, withholds, etc.), and rate-setting options in the Medicaid Managed Care rule to account for DOH-related services. • For services offered via fee-for-service, create a State Plan Amendment (SPA) template for coverable services. • For services requiring a waiver: – Create an 1115 template for coverable services. – Include explicit focus on DOH interventions in Section 1115 demonstration monitoring and evaluations and develop tools to support states in monitoring and evaluating DOH 1115 – demonstrations, such as templates and guidance for implementation plans, monitoring protocols and reports, and evaluations designs. – Issue guidance clarifying that short-term posthospitalization, transitional housing, such as the service approved in the NC waiver, can be covered under Medicaid.

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
Medicare	Broaden Medicare Advantage coverage of DOH services and ability to target benefits to individuals based on social need.	Recent legislation and CMS guidance have begun to broaden the ability of Medicare Advantage plans to offer some supplemental benefits that might address DOH, within limited parameters. Plans have begun to offer DOH benefits to the extent allowed. The remaining constraints on these benefits have in some cases prevented plans from offering some DOH benefits because the benefits are not primarily health-related (even under a broader CMS reinterpretation) or from allocating some of these benefits strictly on the basis of the beneficiary's social, rather than medical needs. Financial constraints also prevent plans from offering these benefits, as plans must pay for them from rebate dollars or premiums, potentially crowding out other benefits.	Expand Medicare Advantage plans' ability to offer DOH-related supplemental benefits in annual Medicare Advantage rulemaking. • Allow allocation of all supplemental DOH benefits based solely on beneficiary's social need. • Further broaden the types of DOH benefits allowed beyond those that are "primarily health related" by interpreting the term "supplemental health care benefits" to include all benefits with a plausible nexus to improving health or wellness, even if their primary purpose is to address DOH. • Remove requirement that DOH benefits be recommended by a licensed medical professional as part of a health care plan. • Improve financial incentives for Medicare Advantage plans to offer DOH-related supplemental benefits treating them as basic benefits for bid purposes through a CMMI model test.
Medicare	Pay for DOH screening and navigation to community resources by Medicare providers beyond the current Medicare reimbursement codes for psychosocial elements of chronic care management.	The link between racial disparities and DOH is clear and is only becoming more acute given COVID-19. As of 2012, section 4302 of the ACA requires population health surveys in federal health programs, including Medicare and Medicaid, to collect and report race, ethnicity, language, and other data to understand and help reduce health and health care disparities. Nonetheless, recent studies confirm that Medicare, Medicaid and commercial plans have largely incomplete data on race and ethnicity, though some positive outliers exist. Recent delivery reform recommendations call for public and private payers to require the collection, use, and application of race and ethnicity data, as essential to identifying and improving disparities.	• Broaden definitions of covered services in Medicare fee-for-service by expanding chronic care management codes and code definitions that include DOH. • Establish care management codes for standalone psychosocial evaluation and referral. • Leverage the Accountable Health Communities (AHC) pilot and its screening tool to require health plans and delivery systems to screen patients for health-related social needs like any other vital sign and to navigate them to relevant community resources. • Leverage CMMI waiver authority to expand covered benefits. • Interpret "treatment of illness or injury" in Social Security Act 1862(a)(1)(A) to include purely DOH-related activities when related to diagnosis or treatment of illness or injury. • (Legislative) Amend Social Security Act 1862(a)(1)(A) to permit coverage of DOH-related activities for prevention of illness or injury.

Strategy 6: Integrate DOH Into CMMI's Innovation Agenda

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
CMMI	Develop and test a social services fee schedule to be used by health care payers and providers to pay for DOH interventions.	A primary barrier to scaling sustainable interventions is a lack of common understanding of how to quantify the costs of interventions that address DOH. A social services fee schedule provides a common starting point for forging new partnerships between health care payors and providers and the community-based organizations best equipped to provide social services impacting health. A fee schedule also provides baseline information necessary for measuring the impact of DOH in the context of cost and risk modelling. CMS has approved one such fee schedule as part of North Carolina's 1115 waiver. Multipayor models, such as SIM or CPC+, are ideally suited to test the development of such a fee schedule.	• Select five SIM states to develop and test an initial social services fee schedule. • Test the social services fee schedule through Medicare Advantage chronically ill populations that already have flexibility in non-medically related spending. • Build a Community Based Organizations (CBO) fee schedule into State Innovation Model (SIM) states in partnerships with CBOs and Medicaid offices.
CMMI	Integrate the Accountable Health Communities Model DOH-related components, such as screening and navigation, into other existing models and new CMMI payment models.	Integrating AHC learning, tools and data across all models will provide data on how these mechanisms interact with other care delivery interventions, and make them available to more participants. Some of the major CMMI models (e.g., Accountable Care Organization (ACOs) do not address DOH). To the extent CMS lacks administrative authority to implement changes to the Medicare fee schedules directly for coverage of DOH- related services, CMMI could use its authority to test the implementation of these services.	• Require new models to integrate AHC screening and navigation of social needs processes through the Innovation Center Investment Plans. • Require existing models to consider adding AHC program elements in annual contract renewals or contract extensions with grantees/ contractors.

Strategy 6: Integrate DOH Into CMMI's Innovation Agenda

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Sector/Program	**Policy and Program Changes**	**Description/Impact**	**Federal Action**
CMMI	Direct CMMI to incorporate standard DOH considerations into all payment and care delivery models.	AHC and Comprehensive Primary Care Plus (CPC+), are models designed specifically to account for DOH. It is possible that many other CMMI models languish or fail to produce predicted savings and quality outcomes because they fail to fully account for DOH factors that impact health outcomes and cost.	• Include DOH-related measures as part of the standard CMMI measure framework maintained by the Rapid Cycle Evaluation Group at CMMI. • Require DOH standards/criteria be applied to every Innovation Center Investment Plan required for every model. • Require DOH commitments/attestation as part of award applications. • Build DOH into terms and conditions of participation. • Build standard DOH measures into the core CMMI measure framework and contracted model evaluations. • Add social need performance metrics to reporting requirements (e.g., screen/closed loop referrals).
CMMI	Restructure CMMI models to promote participation among providers serving middle/low-income and marginalized groups.	Currently the application processes alone for model participation can require substantial financial and administrative resources, which may be a participation deterrent for less-resourced practices that serve marginalized groups. CMMI can take steps to promote participation among these providers, providing opportunities to benefit from DOH-related demonstrations.	• Implement tiered/sliding payment scales for providers in these categories. • Set targets for awards given to providers in these groups (e.g., 15% of all awards). • Offer application support services for under-resourced practices.
Medicare	Increase use of Quality Improvement Organizations (QIOs) in Medicare to support efforts to address DOH.	The QIO Program is one of the largest federal programs and networks dedicated to improving health quality for Medicare beneficiaries. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries. The QIOs could be highly leveraged to provide DOH-related support to health systems across the country, especially given the impact of COVID-19 on beneficiaries' basic health needs.	Build DOH task orders into the future QIO Scope of Work, including for the Quality Innovation Network (QIN)-QIOs, and add DOH perspective as a contract modification to the existing scopes of work.