



State Approaches to Financing Social Interventions through Medicaid

—
Medicaid and CHIP Payment and Access Commission

Rick Van Buren

Enabling Sustainable Investment in Effective Social Interventions:

A Review of Medicaid Managed Care Rate Setting Tools

MACPAC Panel

April 19, 2018

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To identify practical strategies that states can deploy to support – directly and indirectly – Medicaid managed care (MMC) plans and their network providers in addressing social issues



Literature review of ~30 documents, spanning academic articles, grey literature and state and federal documents



25 expert interviews, including state Medicaid directors, plan officials, actuarial experts and academic/other experts



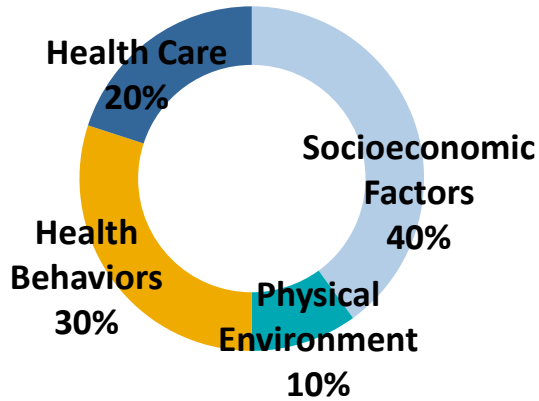
Two virtual meetings with an **advisory committee** to review project findings and emerging themes



Partnership with **Milliman**, a leading actuarial firm, to add depth and rigor to project team

Imperatives

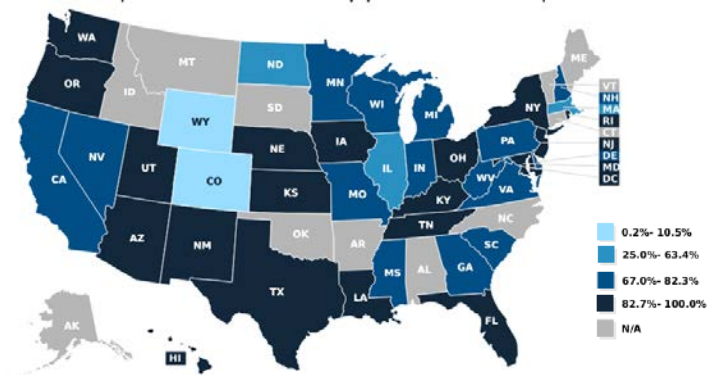
Increasing recognition that social factors, such as unstable housing and lack of healthy food, have a substantial impact on health care outcomes and spending¹



1. B. C. Booske, J. K. Athens, D. A. Kindig et al., Different Perspectives for Assigning Weights to Determinants of Health (University of Wisconsin Population Health Institute, Feb. 2010).

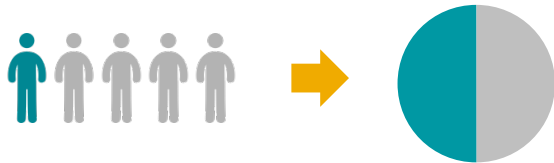
Medicaid is increasingly focusing on how the program can cover and reimburse for nonclinical interventions when cost-effective, particularly in managed care – now the dominant service delivery model in Medicaid

% of Medicaid Population in Managed Care Organization (MCO)²



2. Kaiser Family Foundation's State Health Facts.

High prevalence of mental illness and substance use, particularly among new enrollees in states that expanded Medicaid

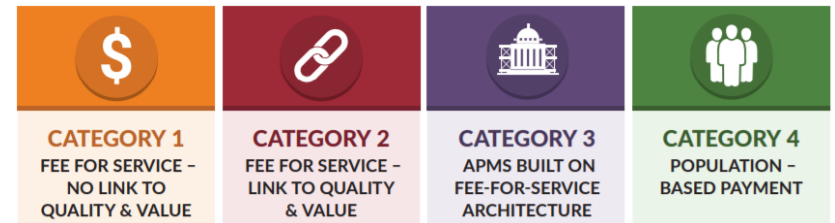


1 in 5 beneficiaries had behavioral health diagnoses, representing ~50% of total Medicaid expenditures³

3. Medicaid and CHIP Payment and Access Commission, "Chapter 4: Behavioral Health in the Medicaid Program—People, Use, and Expenditures."

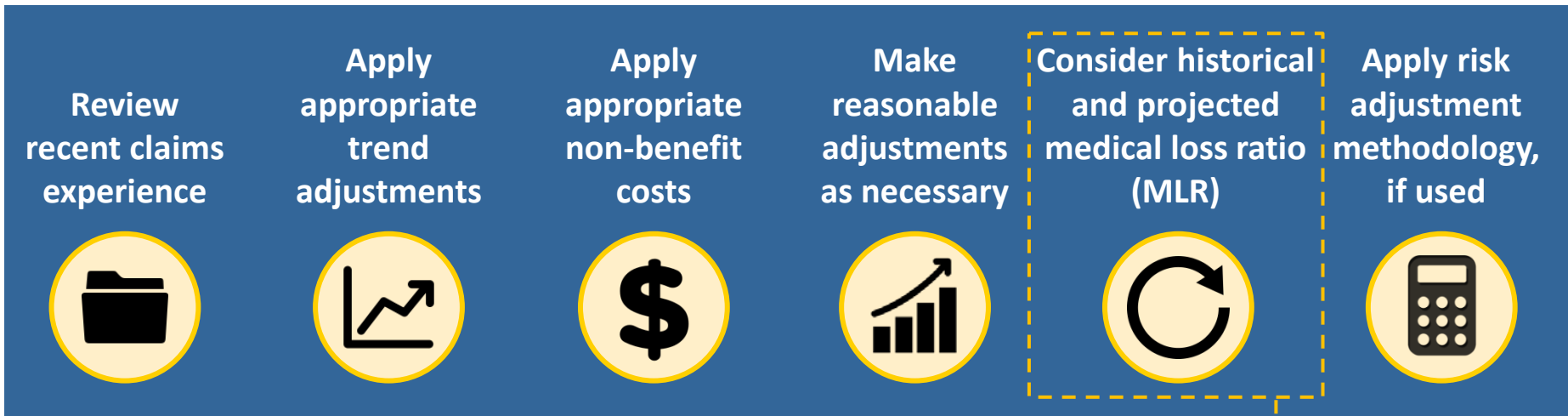
Increasing authority for states to require plans to engage in value-based payments (VBP) and other delivery system reforms

Alternative Payment Model Framework⁴



4. Health Care Payment Learning & Action Network.

MMC Rate-Setting: Rules, Policies, and Procedures



Formula to Calculate the Medical Loss Ratio

$$\text{MLR} = \frac{\text{Claims} + \text{Quality Improvement Expenses} + \text{Fraud Prevention Expenses}}{\text{Premiums} - \text{Taxes} + \text{Fees}}$$

- States must set their capitation rates at a level that results in plans, on average, being projected to incur a MLR of at least 85%
- The MLR calculation is designed to ensure plans are spending a sufficient amount of their capitation funds on services for beneficiaries
- As a result, it is key to assess where the cost of social interventions fits into the MLR calculation

Where do plan investments in social interventions fit?

- 1 How can the cost of social interventions be built into a plan's capitation rate?
- 2 How can the cost of social interventions be considered part of the numerator of a plan's MLR?

What options are available to states who want to respond to plans' concerns about premium slide – the reduction in future managed care rates due to plans successfully utilizing non-clinical interventions to lower medical spending?
- 3

Option 1. Classify Certain Social Services as Covered Benefits Under the State's Medicaid Plan



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

- Federal Medicaid law permits Medicaid coverage of:
 - Linkages to social service programs
 - Stable housing support
 - Assistance in finding and retaining employment
 - Peer support
- Costs of covered social supports can be built into rates



Considerations

- Medicaid “statewideness” and “comparability” requirements apply
- Benefits may carry unique requirements and obligations
 - States who offer services as part of “case management” or “targeted case management” (both optional Medicaid benefits) must ensure that managed care plans also meet federal requirements
- Some key social supports, such as direct costs of food and housing, cannot be classified as Medicaid benefits

Option 2. Explore the Additional Flexibility Afforded States Through Section 1115 Waivers



1115 waivers offer broad authority to waive provisions of the Medicaid statute and finance services not otherwise included in Medicaid.

- States have frequently used 1115 waivers in recent years for Medicaid delivery system reform and sought to encourage investments in social interventions
 - “Health-related services” offered by Oregon’s Coordinated Care Organizations (CCOs) include short-term housing assistance (see Appendix)



Considerations

- Negotiating a waiver with CMS can be time-consuming and complex
- 1115 demonstrations are not permanent; innovation occurring under the waiver is expected to gradually be built into MMC contracting strategy
- CMS has not expressed substantial interest in approving 1115 waivers to cover the cost of social interventions; recent guidance on work requirements indicates that supportive services will not be matched by the federal government via waiver

Option 3. Use Value-Based Payments to Support Investment in Social Interventions



States may incentivize or mandate plans to make VBP to providers that, in turn, can use these payments to invest in social services.

- Because VBP are not linked to providing specific medical services, providers may use VBP for social investments beyond services covered by Medicaid
 - Arizona requires that a specified share of payments from managed care plans to providers are made under VBP arrangements (see Appendix)



Considerations

- Plans may remain concerned that future rates will be based on lower medical costs (i.e., premium slide)
- States and plans need an effective way to measure and reward performance outcomes and an accounting system to track, monitor and build shared savings and other VBP into MMC rates
- VBP may incentivize cutting costs without delivering value

Option 4. Use Incentives and Withholds to Encourage Plan Investment in Social Interventions



States can make incentive payments or use withholds to reward plans for improving outcomes for beneficiaries.

- States can indirectly encourage investments in social supports by linking incentive and withhold payments to outcomes that can be improved by offering social supports
 - **Incentive payments** are a payment mechanism under which plans receive additional funds for meeting targets in the contract
 - **Withhold arrangements** are any payment mechanism under which a portion of a plan's capitation payment is withheld unless a plan meets performance targets
- Option 4 can be combined with Option 3 to reinforce plan incentives to participate in VBP arrangements



Considerations

- Incentive payments are an “add-on” to capitation payments and require additional funding
- Initiatives may be unreliable, short-term revenue sources
- Metrics need to incentivize plans' investment in social supports

Option 5. Integrate Efforts to Address Social Issues into Quality Improvement Activities



States have the authority to include the cost of quality improvement activities in the nonbenefit portion of their MMC rates.

- Quality improvement activities are defined as activities that improve health quality, increase likelihood of desired health outcomes and are grounded in evidence-based medicine, best practice or issued criteria¹
- States can incorporate the cost of social investments that are considered quality improvement activities into their managed care rates
- Certain social interventions may qualify as quality improvement activities



Considerations

- Unclear which initiatives CMS will recognize as quality improvement activities
- Classifying too many activities as “quality” could undermine effectiveness of the MLR in limiting spending on profits and administrative costs

1. See 45 CFR § 158.150 for more details.

Option 6. Reward Plans with Effective Investments in Social Interventions with Higher Rates



States may provide a higher profit and risk margin to plans that demonstrate that they have lowered medical costs through investments in social interventions.

- Option 6 may address plans' concerns about premium slide
- A related strategy is for the state to establish an MLR above 85%, then offer relief from this higher standard to those plans that invest in social interventions and succeed in driving down medical utilization



Considerations

- States will need to design criteria to establish which plans should receive a higher profit margin — or relief from the MLR standard — and determine how best to monitor and evaluate plan compliance with the criteria
- It may be challenging to publicly justify a higher profit margin for selected plans
- Plans are likely to push back on MLRs greater than 85%

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Appendix

Oregon's Section 1115 Waiver: Using Medicaid to Provide "Health-Related" Services



Using an 1115 waiver, Oregon established CCOs that are responsible for covering physical health, behavioral health and health-related services.

- Health-related services – which include “flexible services” and “community benefit initiatives” – are those not otherwise covered by Medicaid that affect health
- Costs of health-related services if related to quality initiatives can be included in the numerator of the MLR
- Oregon incentivizes plans to offer health-related services by rewarding high-quality and relatively efficient plans with a higher profit margin

Arizona's Multipronged Approach to Addressing Social Issues



Arizona employs a multi-pronged approach to encourage integrated delivery systems – known as Regional Behavioral Health Authorities (RBHAs) – to address social issues.

- **Maximize use of Medicaid coverage for nonclinical services:** Arizona includes several nonclinical services in its Medicaid benefit package, including respite services and care management
- **State and local funding for nonmedical services:** Arizona provides approximately \$35 million in state-only grants for housing to RBHAs
- **Reinvestment requirements:** Arizona requires RBHAs to reinvest 6% of their profits back into the community
- **Leverage equity requirements:** Arizona allows plans to use a share of their equity as a line of credit to invest in low-income housing
- **Value-based payments:** Arizona's VBP strategy allows for plans and providers to provide a continuum of health and social services

Using VBP to Provide a Continuum of Health & Social Services: An Example in Circle the City



Circle the City, an Arizona-based non-profit community health organization, uses shared savings payments from plans to finance a comprehensive array of medical and social services.

- In response, plans have established shared savings arrangements with organizations like Circle the City, a non-profit community health organization that provides a continuum of health care and related social services, including medical respite care
- Arizona reinforces the VBP requirement by withholding 1% of premiums and allowing plans that meet the VBP threshold to earn a share of the withheld funds
- Shared savings payments are part of a plan's medical claims and are included in the numerator of the MLR

MASSHEALTH AND SOCIAL DETERMINANTS OF HEALTH: USING THE DATA WE HAVE

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Overview

- What did MassHealth do relating to using social determinants of health data in their managed care program
- Why did they do it?
- What did they find?
- Where do we go from here?



MassHealth MCO Payment Models

- MassHealth had been using a claims-based medical-risk model (the DxCG-HCC RRS)
- Our charge: Improve the RRS model
 - Find and add new variables (especially SDH)
 - Test new “SDH model” performance
 - Interact regularly with stakeholders to identify and address concerns

New MassHealth SDH Payment Model

- In use since October 2016
- Uses SDH as well as age, sex, and diagnoses
 - Purpose was to recognize the extent to which SDH contribute to the need for extra resources in order to sustain health
 - MassHealth is separately working to ensure that resources are used for those purposes
- A constraint was to use readily available data
- Our goal was to make sure there was enough money for vulnerable subgroups
- We did not look at other outcomes

What we added to the medical RRS

- Use claims and enrollment files (MMIS)
 - Address data: Neighborhood Stress Score (NSS) and unstable housing
 - ICD code for “homeless” (with caveats)
- Stratify the disabled population using data from DMH and DDS
- “Tune” for age/sex (right amount “for kids”)
- Separately recognize SMI and SUD

Some things we couldn't address

- Identify “very low income”
- Limited English proficiency
- Child protection, incarceration
- Need for LTSS
- Food insecurity
- Transportation/access problems
- Social isolation/poor acculturation
- Race/ethnicity



Building the SDH model

- Data were from 2013 MassHealth records (now 2015)
 - Claims from the (FFS) Primary Care Clinician (PCC) program and “dummy claims” from MCOs
 - Administrative records
- We only modeled members enrolled for 183+ days
 - Because it takes time to “manage” care
- “Cost” \neq *total* cost of care
 - No long-term support services (LTSS)
 - We could not reliably measure the *need* for such services (we are now adding LTSS \$ to what we predict)
 - No costs over \$125,000 for a single person-year (now \$200K)

SDH Model Predictors

- A medically-based relative risk score (RRS) +
- Age-sex indicators +
- Markers for: unstable housing, disability, serious mental illness, substance use disorder +
- A summary measure of neighborhood stress, based upon census data that describe where you live (NSS)

Model Details (1 of 2)

- **DxCG v4.2 concurrent Medicaid relative risk score (RRS)**
- **Age/Sex Indicators**
 - 10 age categories each for male and female
 - Ages: 0-1, 2-5, 6-12, 13-17, 18-24, 25-34, 35-44, 45-54, 55-59, 60+
- **Disability**
 - Client of Department of Mental Health (DMH)
 - Non-DMH, Client of Department of Developmental Services client (DDS)
 - All others entitled to Medicaid due to disability

Model Details (2 of 2)

- **Behavioral Health**
 - Serious mental illness, substance use disorder
- **Housing Issues**
 - People with 3 or more addresses in a single calendar year **OR** with an ICD code for homeless indicated on a claim or encounter record
- **Neighborhood Stress Score**
 - A composite measure of “financial stress” from census data (based on addresses geocoded to the census block group or tract)

Neighborhood Stress Score (NSS)

- A measure of “economic stress” summarizing 7 census variables:
 - % of families with incomes < 100% of FPL
 - % < 200% of FPL
 - % of adults who are unemployed
 - % of households receiving public assistance
 - % of households with no car
 - % of households with children and a single parent
 - % of people age 25 or older who have no HS degree
- Set NSS = 0 when address cannot be geocoded (<5%)
- NSS is standardized (Mean = 0; SD = 1)

■ New dollars *could* support innovations

- Paying ~\$50 per unit increase in “neighborhood stress” gives providers with 2,000 patients in a distressed neighborhood \geq \$100,000/year to address social complexity
- Paying ~\$600 annually for coded homelessness may be less than needed, but it will
 - Support useful services now
 - Encourage the more comprehensive coding needed to accurately price homelessness in the future
- Could lead to *health care system/community* partnerships
- Could facilitate cooperation across state agencies

MassHealth started using the new formula October 1, 2016

- MassHealth took pains to listen to stakeholders and explain the model and its logic in multiple venues
 - Public meetings and posted details at the Mass Innovations website
- So far the model has been well received
- Too early to know its effect on health plan behaviors and beneficiary health

Moving forward

- Housing problems (HP)
 - Most of the difference in costs between those with unstable housing and homeless codes are explained by differences in illness burden.
 - New model adds an interaction: $HP * RRS$
- We are still waiting to see changes in the data based on paying for ICD-coded homelessness
- We hope to be able to exploit richer descriptors of SDoH in ICD-10

ICD-10 Codes that Address SDoH

- Z Codes (Chapter 21): Factors influencing health status and contact with health services (Z00-Z99).
- Z55-Z65 – Persons with potential health hazards related to **socioeconomic and psychosocial circumstances**
 - E.g., literacy, employment, occupational risk, housing, social environment, and upbringing

Source: <http://www.icd10data.com/ICD10CM/Codes/Z00-Z99>, accessed 2/6/18



Several ICD-10 Codes Address SDoH

Each code has sub-codes, e.g., **Z59** - Problems related to housing and economic circumstances (h&e)

- Z59.0 - **Homelessness**
- Z59.1 - **Inadequate housing**
- Z59.2 - Discord with neighbors, lodgers and landlord
- Z59.3 - Problems related to living in residential institution
- Z59.4 - **Lack of adequate food and safe drinking water**
- Z59.5 - **Extreme poverty**
- Z59.6 - Low income
- Z59.7 - Insufficient social insurance and welfare support
- Z59.8 - Other problems related to h&e
- Z59.9 - Problem related to h&e, unspecified

Summary and Future Ideas

The bad news = the good news: We had to rely on readily available data, so should be easy to replicate

What's next?

- Promote use of other SDoH codes, such as
 - Z59.1 - Inadequate housing**
 - Z59.4 - Lack of adequate food & safe drinking water**
 - Z59.5 - Extreme poverty**
- Collect (or find) other indicators of social risk
- Explore other interactions of social & medical risk
- Study linked (social service & health care) data to facilitate interventions and identify effective ones

Read more at:

<https://www.mass.gov/masshealth-innovations-0>

MassHealth Risk Adjustment Methodology “box” near the top of the MassHealth Innovations website)

Ash AS, Mick EO, Ellis RP, Kiefe CI, Allison JJ, Clark MA. “Social Determinants of Health in Managed Care Payment Formulas.” JAMA Intern Med. 2017 Oct 1;177(10):1424-1430.

Thank you!

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State Efforts to Address Social Determinants of Health Through Medicaid

Medicaid and CHIP Payment and Access Commission (MACPAC)

April 19, 2018

Kevin Moore

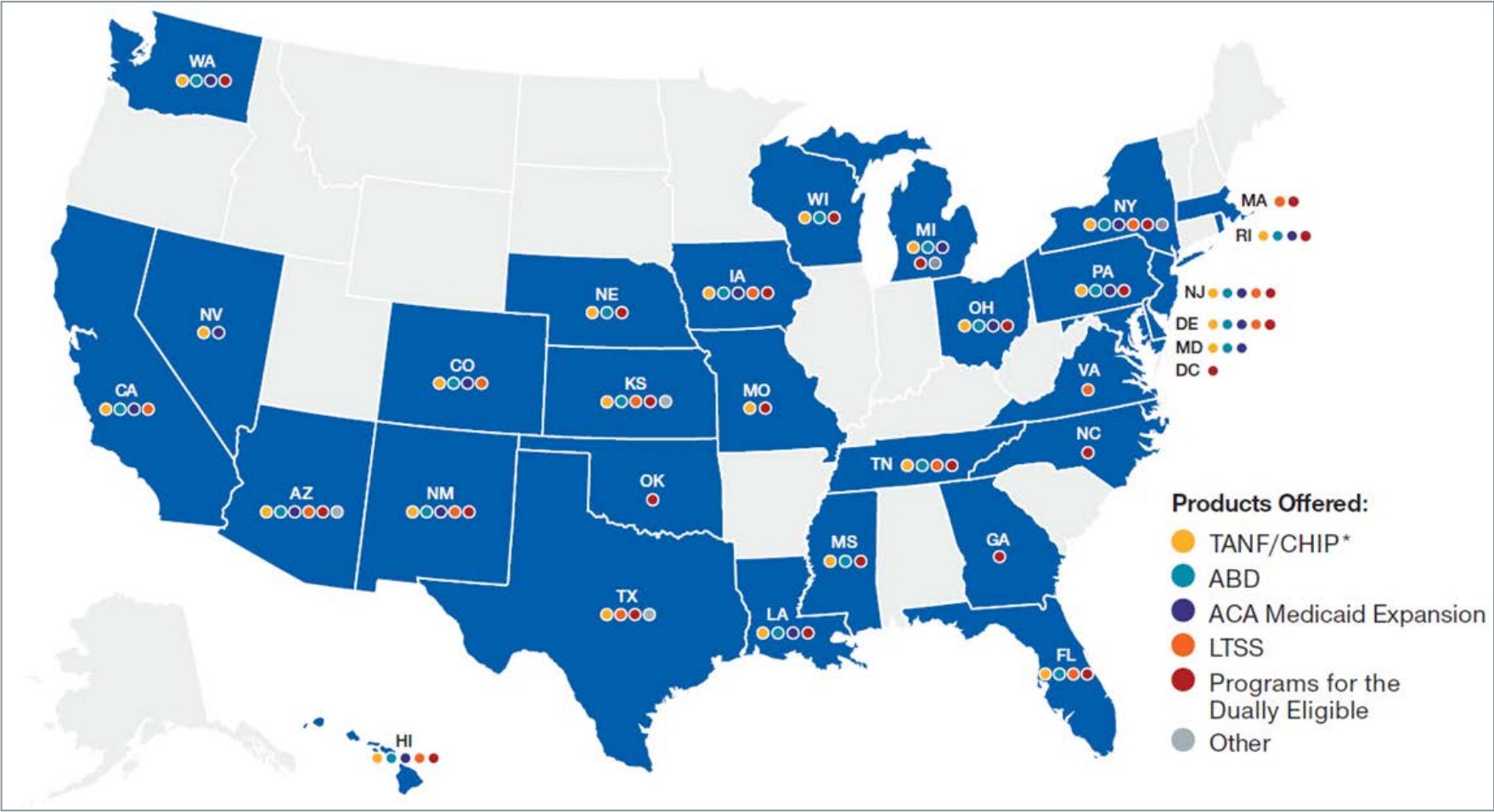
VP of Policy

Health and Human Services

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Serving nearly 6.4 million people**

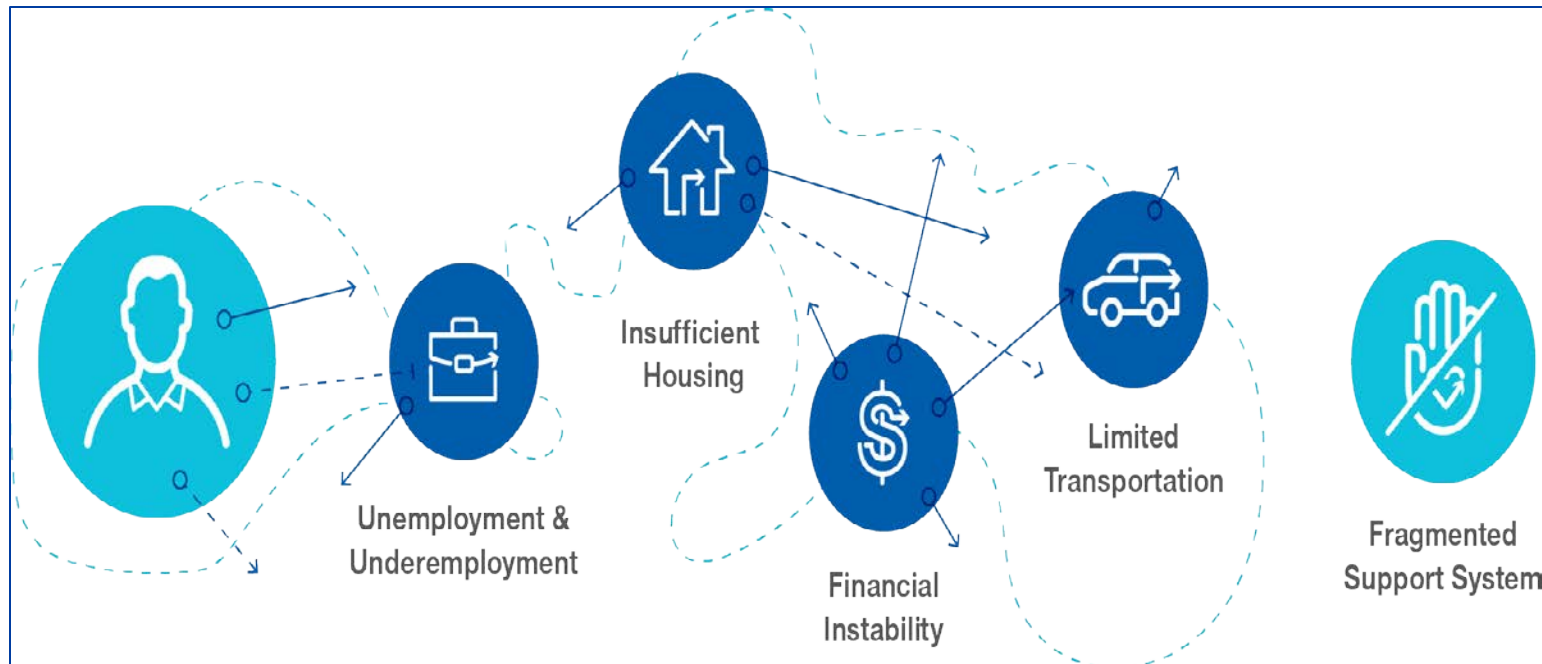


*Includes programs serving TANF and/or CHIP populations
 ** Approximation

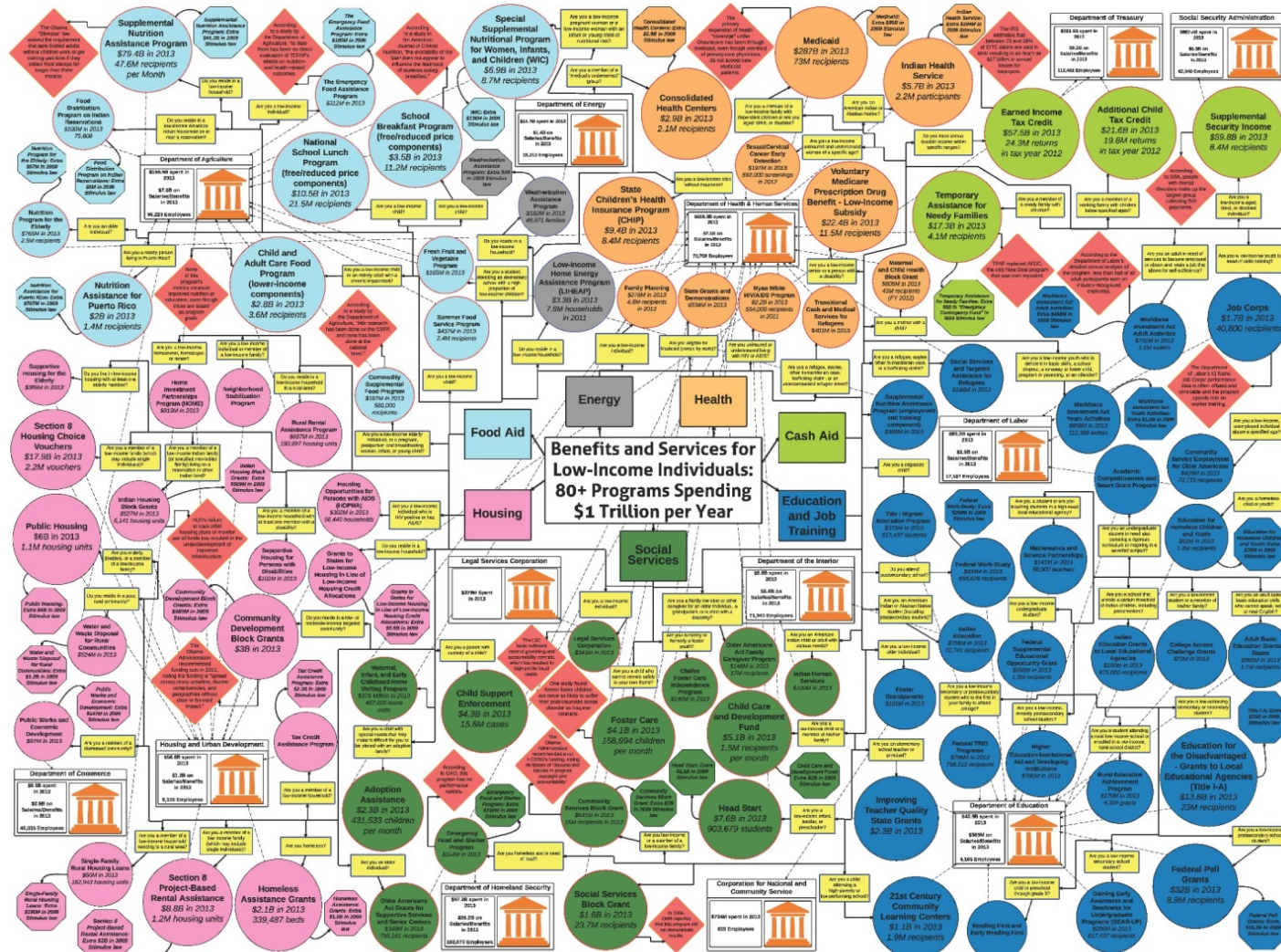
The Problem

Individuals with complex health needs and histories of housing instability face an array of problems which drive up health care costs...

...and the financial resources and delivery systems to address them are fragmented and misaligned.



The "Solution(s)"?



Source: House Ways and Means Committee staff, using Congressional Research Service reports and other data.

CMMI Accountable Health Communities Grant

- Identify and address health-related social needs of Medicare and Medicaid beneficiaries
- Analyze the impact to health care quality, utilization, costs, and experience
- Waianae Coast and Honolulu
- April 1, 2017-March 31, 2022
- Goals:
 - 75,000 screenings per year
 - Provide tailored, streamlined referral and navigation services
 - Align the efforts of community-based organization partners
 - Perform continuous quality improvement and gap analysis

myConnections Arizona

- Invested in local community development agency to rehabilitate 500 affordable housing units in Phoenix, AZ
- 100 units are set aside for UHC with high medical utilization and/or complex health care needs.
- UHC investment reduced the rent for members with set-aside units.
- myConnections works with local homeless providers and FQHCs to identify members who can succeed through a housing first initiative.

Key Issues Looking Forward

- Supply and Demand
 - Number of members in need vs. the supply of services and resources available.
- Sustainability
 - Long-term investments vs. short-term financing
 - Medicaid capitation rate setting
- Budget Reality
 - Reductions and changes in state and federal financing

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