HEALTH MANAGEMENT ASSOCIATES

Medicaid 101: Program Basics, Key Variations and Behavioral Health

HMA Conference Pre-Session | September 8th, 2019

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AGENDA

- Overview
- Background on Medicaid
- Behavioral Health
- MLTSS/Duals Integration
- Delivery System Reform
- Waivers and Introduction to Prescription Drugs
- Pharmacy Deeper Dive and State Expectations of MCO Solutions
- The Crystal Ball: What I Am Seeing for the Short & Long Term
- Digging Deeper: Questions & Answers

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1:00 PM – 1:05 PM

OVERVIEW

JEAN GLOSSA, MD, MBA, FACP

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Demonstrate the foundational concepts of Medicaid and how the topics during today's sessions affect providers and payers.

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1:05 PM – 1:35 PM

BACKGROUND ON MEDICAID

IZANNE LEONARD-HAAK, MPA

HEALTH MANAGEMENT ASSOCIATES

In The Beginning: The Original Concept of Medicaid

July 30th, 1965

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LEARNING OBJECTIVES

Explain the origin of Medicaid.

Outline the differences between Medicare and Medicaid.

Provide insight on the Federal-State partnership in Medicaid.

Demonstrate the tremendous growth of the Medicaid program since its inception.

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MEDICARE & MEDICAID ENACTED IN 1965

Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act.

- Providing hospital, post-hospital extended care, and home health coverage to almost all Americans aged 65 or older (e.g. those receiving retirement benefits from Social Security or the Railroad Retirement Board)
- Giving states the option of receiving federal funding for providing health care services to low-income children, their caretaker relatives, the blind, and individuals with disabilities
- At the time, seniors were the population group most likely to be living in poverty, about half had health insurance coverage.

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MEDICARE VS MEDICAID

	Medicare	Medicaid
Administration	Federally Administered	State Administered
Funding	Federally Funded	Jointly State and Federally Funded
Beneficiaries	• People 65 and older • Certain people under 65 with disabilities • People of any age with End-Stage Renal Disease	• Low-income adults • Pregnant women • Children
Coverage	Consistent Nationally • Inpatient (Part A) • Outpatient (Part B) • Pharmacy (Part D) • Limited Post Hospitalization Primary Payor	Varies By State • Federal Government specifies mandatory & optional services • Significant LTC (Nursing Home and Home & Community Based Services) and Behavioral Health services Payor of Last Resort

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MEDICAID IS A FEDERAL/STATE PARTNERSHIP

- The federal government provides matching funds to states to enable them to provide medical assistance to residents who meet certain eligibility requirements.
- The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services.
- The federal Centers for Medicare and Medicaid Services (CMS) monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards.
- States are not required to participate in Medicaid.

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STATES ARE NOT REQUIRED TO PARTICIPATE IN MEDICAID

- Participating states must comply with Federal Medicaid laws under which each participating state:

Administers its own Medicaid program

Establishes eligibility standards

Determines the scope and types of services it will cover

Sets the rates for payment

- Benefits vary from state to state; because someone qualifies for Medicaid in one state, it does not mean they will qualify in another.

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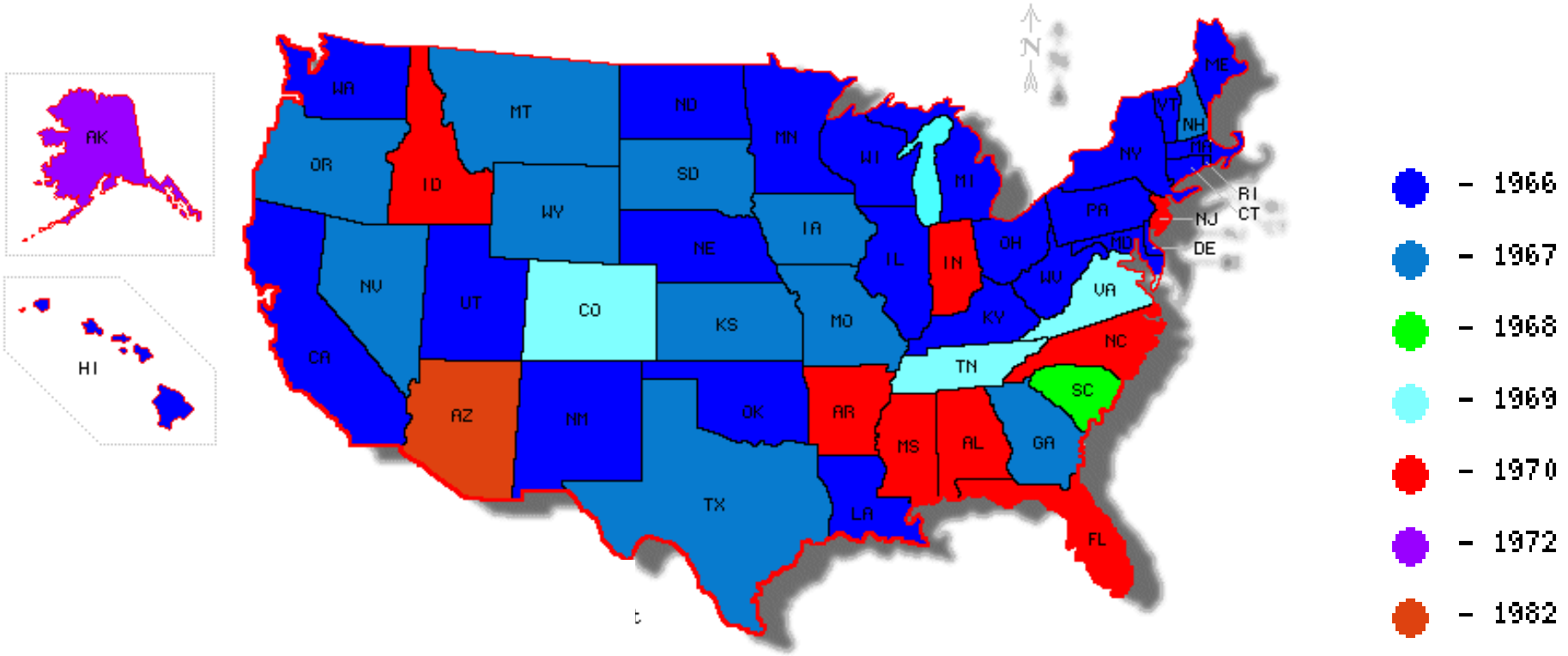
THE LAST STATE CREATED ITS MEDICAID PROGRAM IN 1982



Source: *Presentation on May 7, 2015 by Len Nichols, Ph.D., George Mason University*

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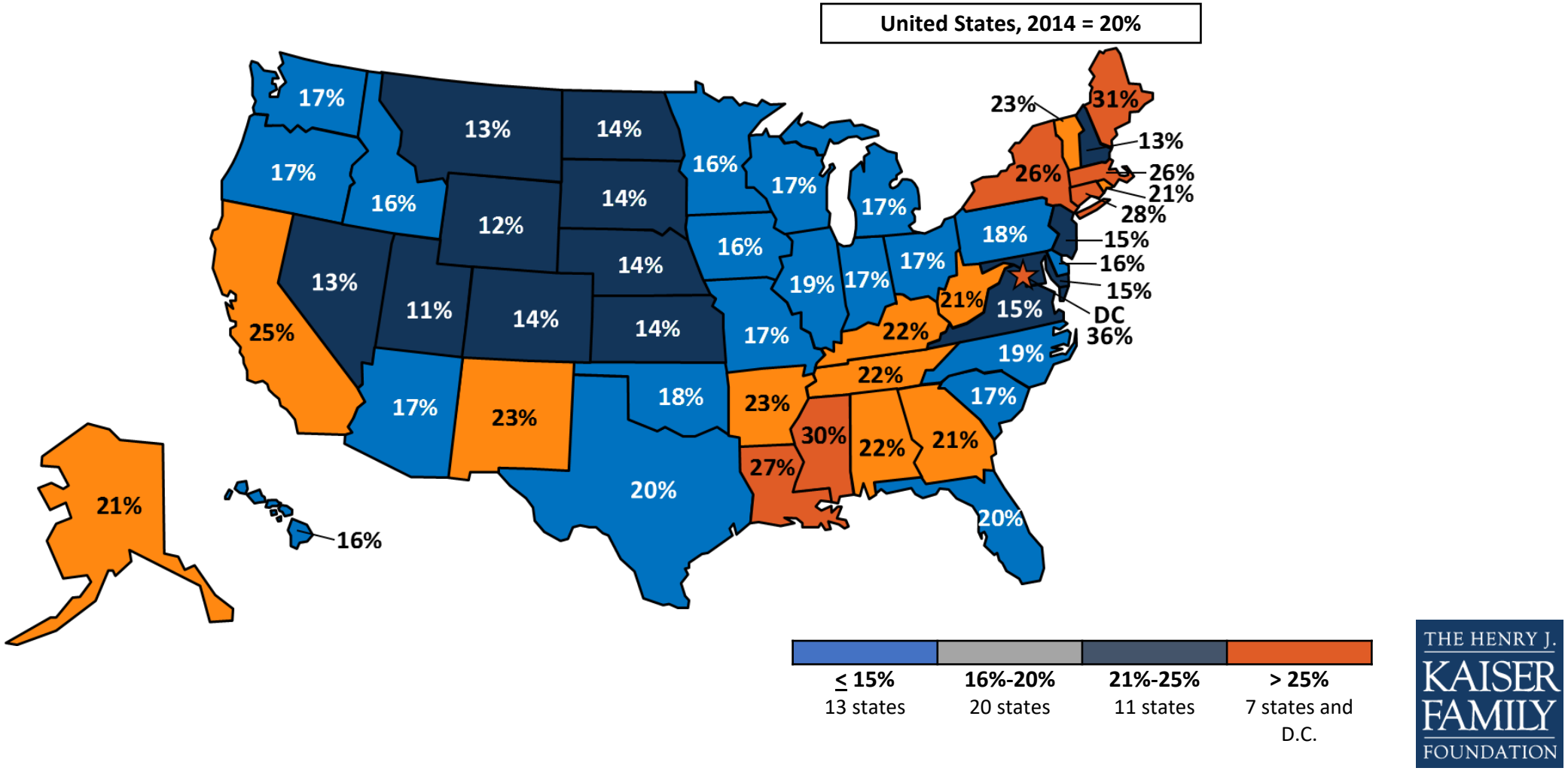
ONE IN FIVE PEOPLE ON MEDICARE RECEIVE ASSISTANCE FROM MEDICAID

Dual Eligible Beneficiaries as a Share of Medicare Enrollees, by State



SOURCE: Kaiser Family Foundation, "What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?" March 2017.

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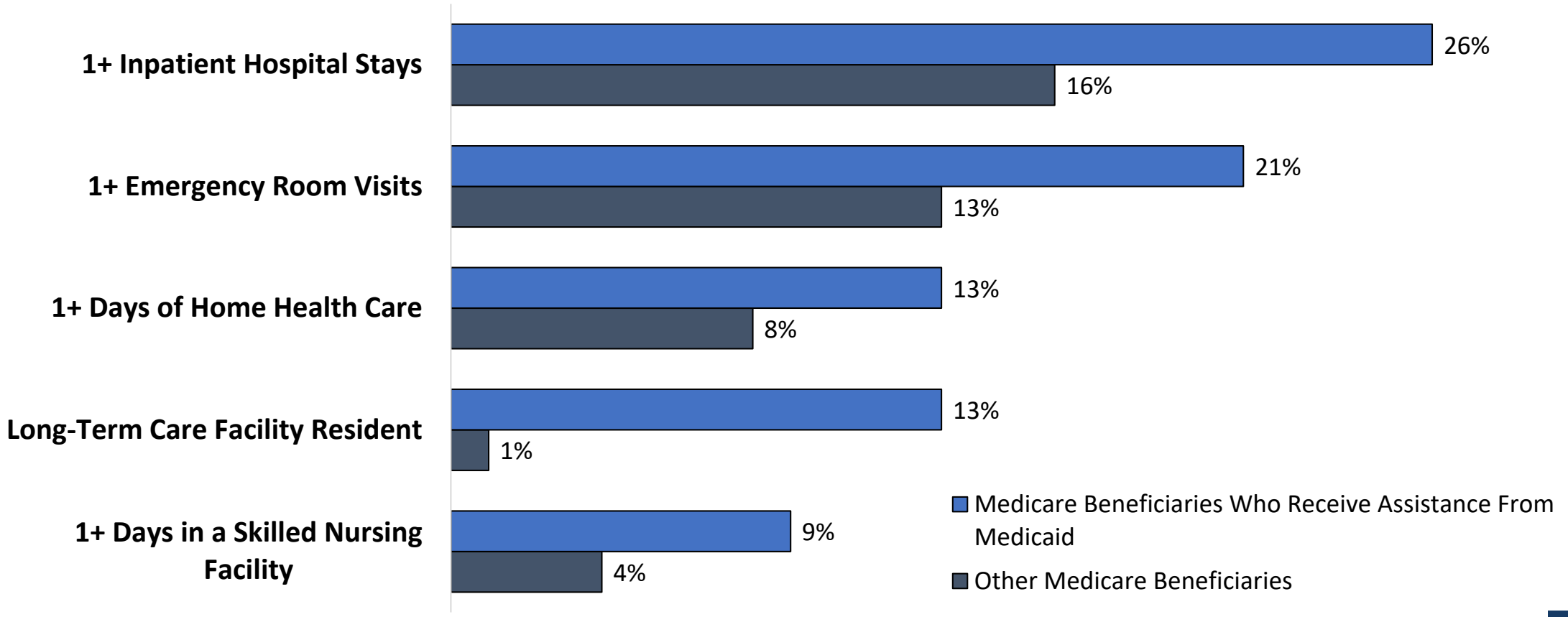
PEOPLE ON MEDICARE WHO RECEIVE ASSISTANCE FROM MEDICAID USE MORE MEDICAL SERVICES THAN OTHER PEOPLE ON MEDICARE



- **NOTE:** Excludes Medicare beneficiaries in Medicare Advantage plans
- **SOURCE:** Kaiser Family Foundation, "What Could a Medicaid Per Capita Cap Mean for Low-Income People on Medicare?" March 2017.

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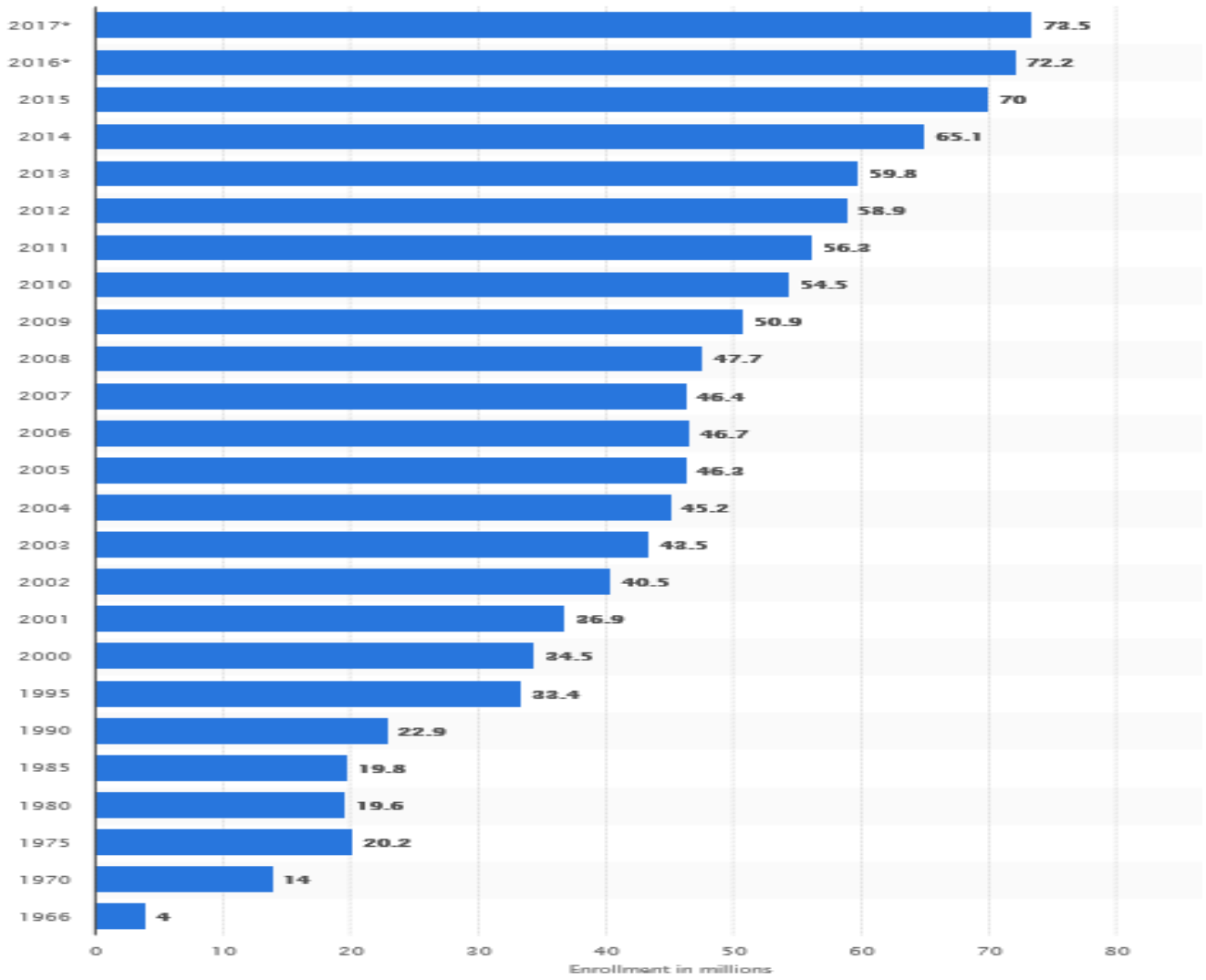
MEDICAID ENROLLMENT FROM 1966 T0 2017



As of March 2019, CMS reports almost 73 million Medicaid beneficiaries.

CMS Medicaid & CHIP Data

Source: The Statistical Portal

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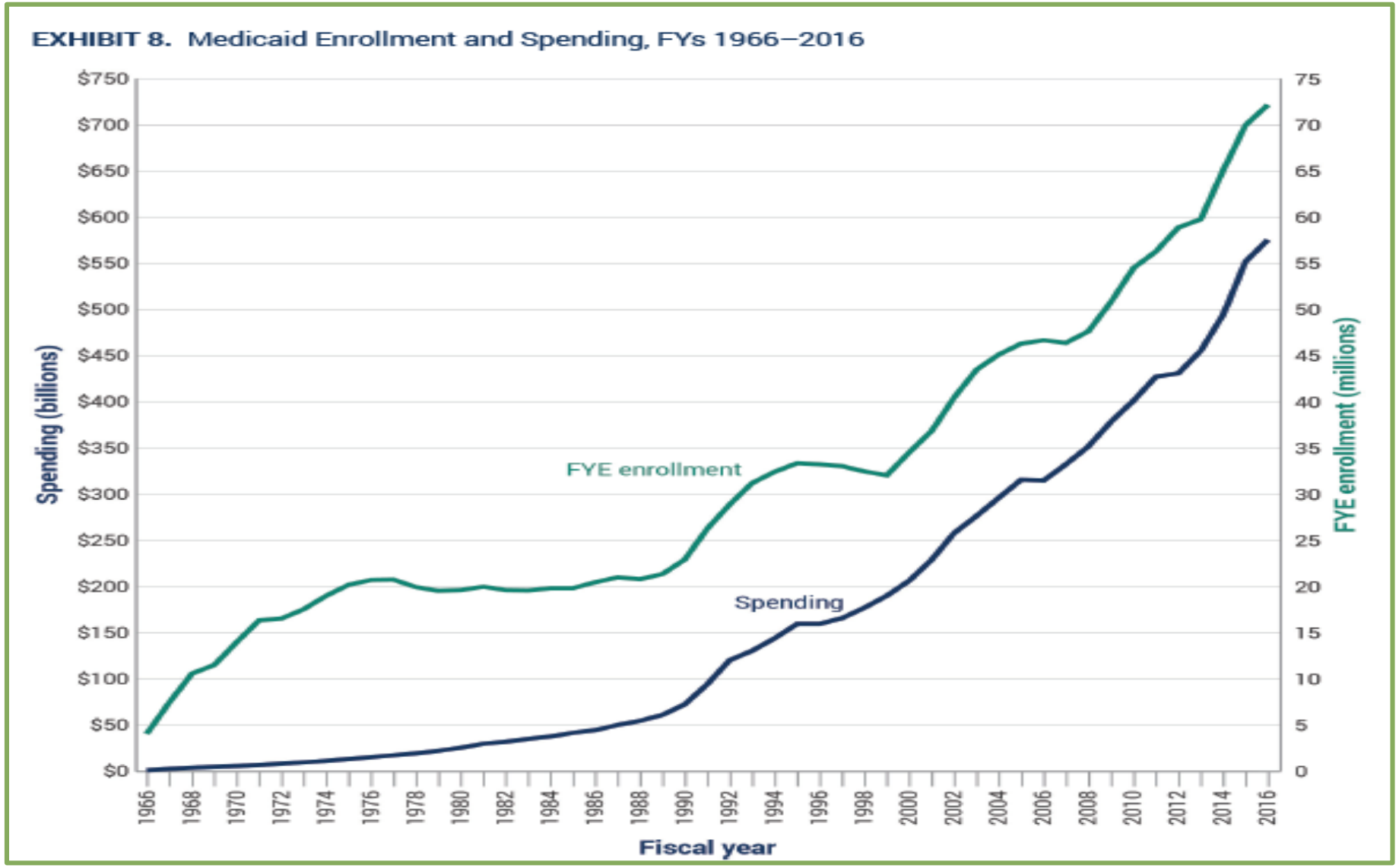
MEDICAID SPENDING HAS ALSO GROWN SIGNIFICANTLY



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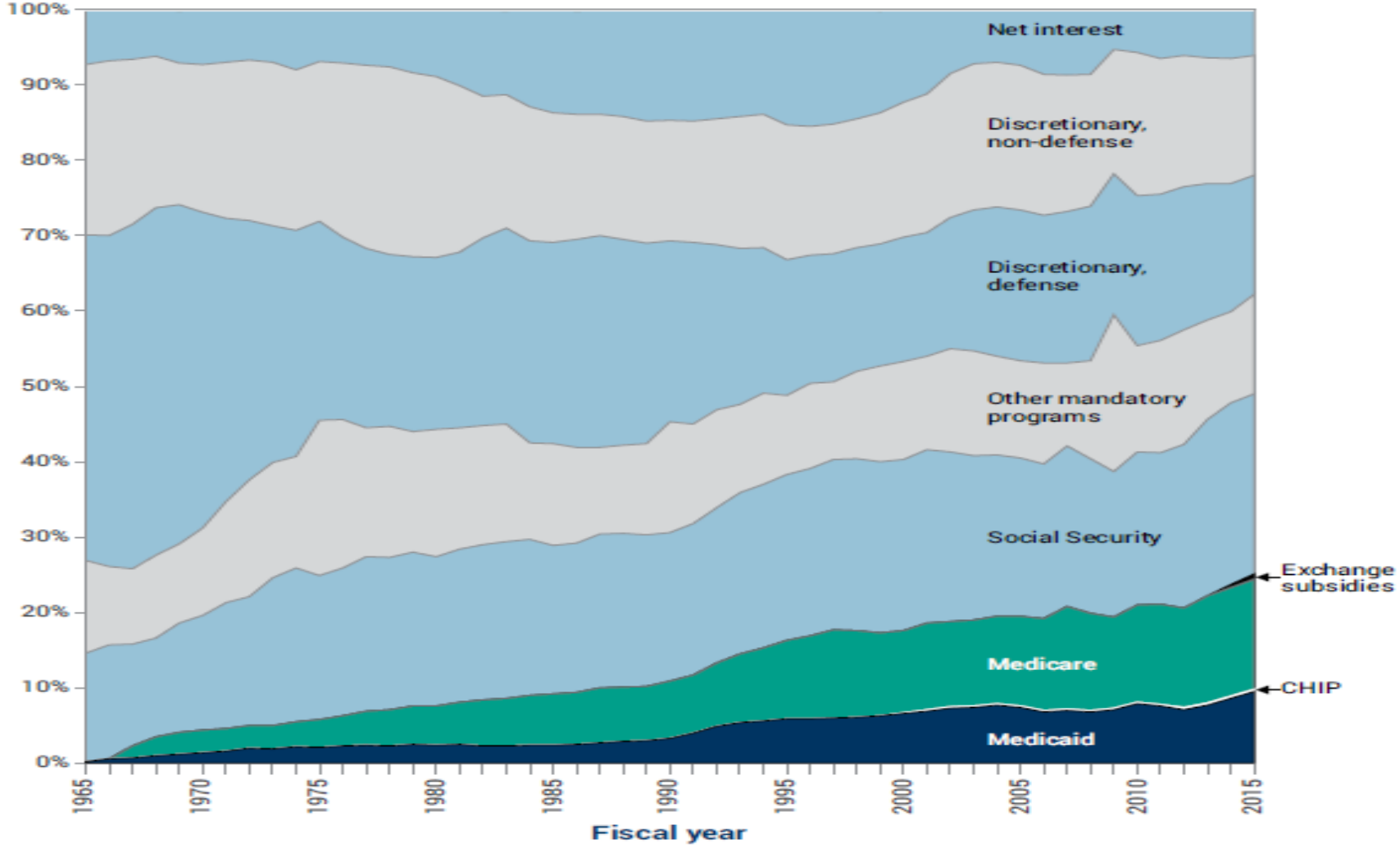
MEDICAID IS A SIGNIFICANT PART OF FEDERAL BUDGET

EXHIBIT 4. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015



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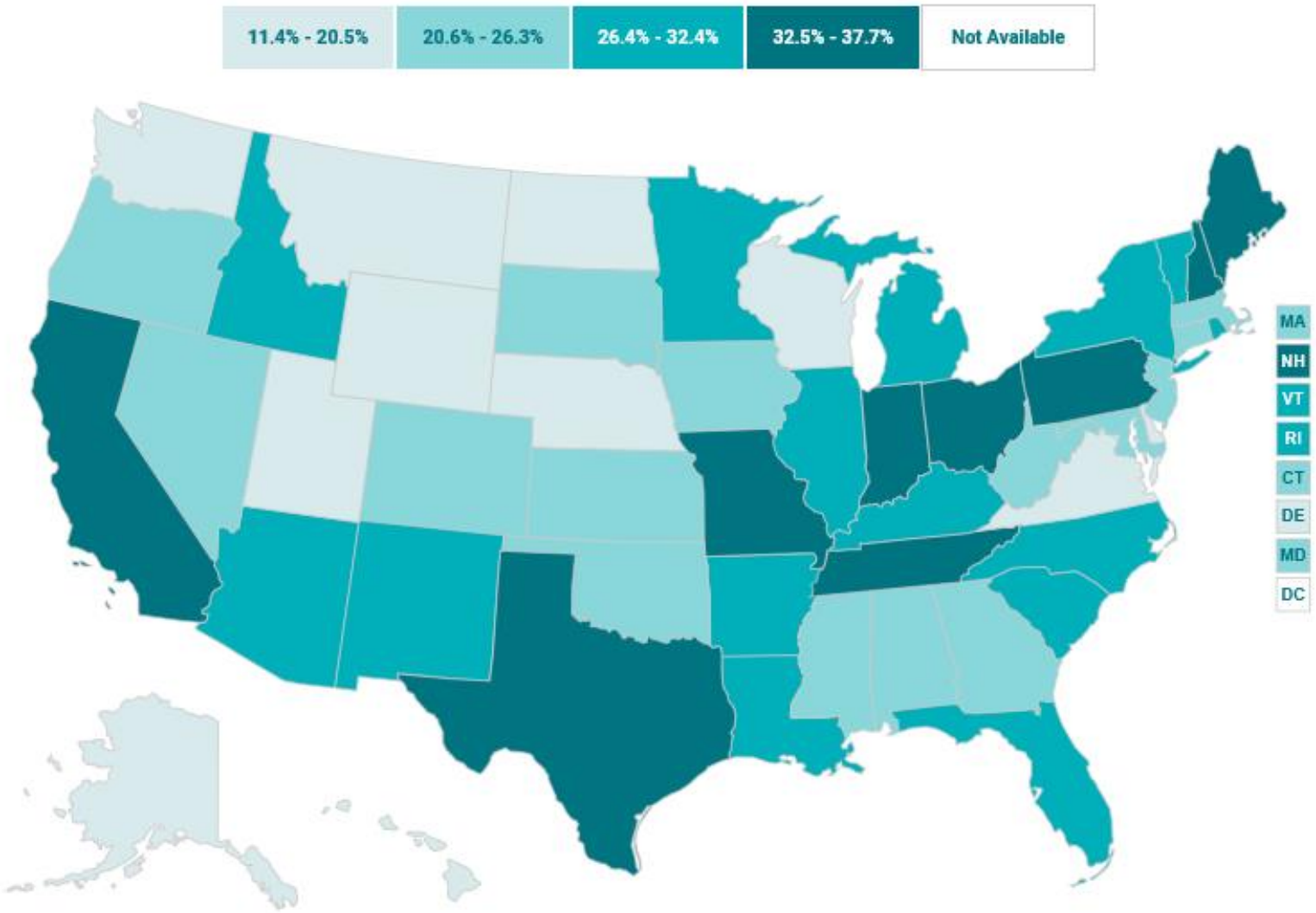
MEDICAID IS ALSO A LARGE PART OF STATE BUDGETS – RANGES FROM 11% TO 37%



Source: *State Expenditure Reports, National Association of State Budget Directors, 2016*

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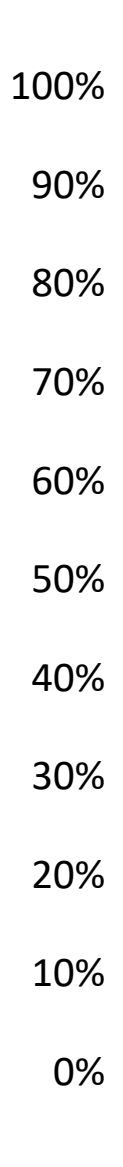
TODAY, MOST MEDICAID ELIGIBLES ARE CHILDREN; MOST EXPENDITURES ARE FOR THE ELDERLY & DISABLED.

Source: Peter G Peterson Foundation, 2016



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The Basic Building Blocks of Medicaid

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LEARNING OBJECTIVES

Describe top-level Medicaid eligibility criteria and key changes in eligibility since the ACA.

Describe core Medicaid benefits.

Describe the two primary service delivery models for the Medicaid program.

Understand the overall scale of the program within the context of the larger health care sector.

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MEDICAID ELIGIBILITY

Medicaid eligibility is complicated.

Pre ACA:

- Until the ACA, adults without children were generally not eligible (no matter how poor), unless elderly or disabled.
- Until the ACA, low-income adults with children were generally not eligible, unless they had very low income.
- Undocumented immigrants are ineligible for Medicaid, except for emergency services.

Post ACA:

- Expansion to adults with incomes up to 138% FPL
- Aligned states' minimum Medicaid eligibility threshold for children at 138% FPL
- Standardized how income is determined for Medicaid eligibility ("MAGI")
- Undocumented immigrants are ineligible for Medicaid, except for emergency services.

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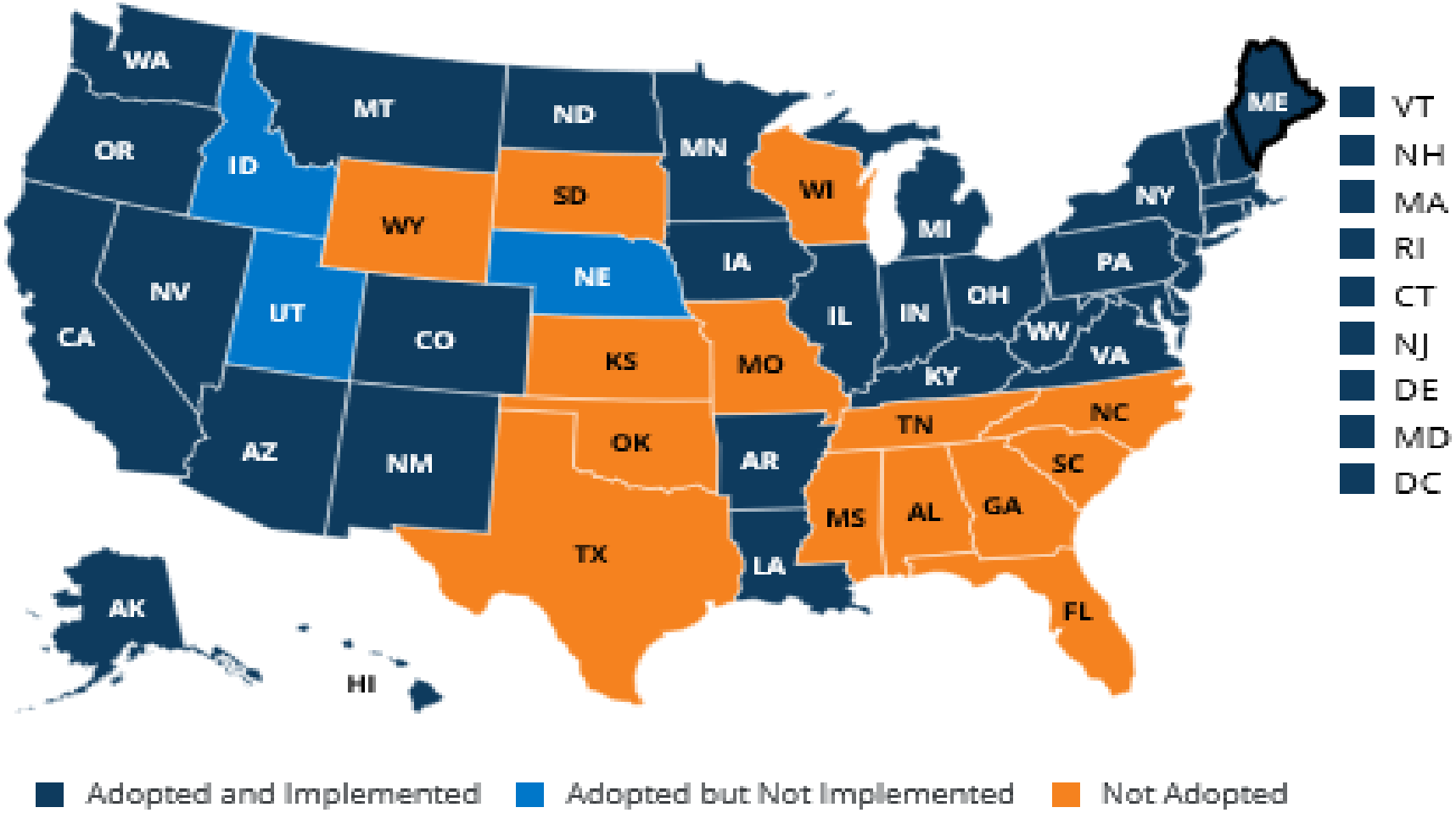
MEDICAID ELIGIBILITY – EXPANSION

37 States (including DC) have adopted the Medicaid Expansion; 14 States have not adopted expansion

May 13, 2019



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MEDICAID ELIGIBILITY – CRITERIA

General Qualifying Criteria

Citizenship (or certain non-qualified citizens)

Eligibility Category		Financial Eligibility
Mandatory	Optional	

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MEDICAID ELIGIBILITY | MANDATORY VS. OPTIONAL

Mandatory Eligibility Groups	Optional Eligibility Groups
Pregnant women	Childless adults*
Children	Mandatory groups above income thresholds
Parents	Medically needy
Elderly individuals	
Individuals with disabilities	

** Under the ACA, all adults under 138% FPL were added as a categorical group; the subsequent Supreme Court decision made this optional for states.*

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MEDICAID BENEFITS | MANDATORY

Mandatory Benefits	
Inpatient Hospital	Nurse Midwife Services
Outpatient Hospital	Freestanding Birth Center Services
Early & Periodic Screening, Diagnostic and Treatment Services	Certified Pediatric and Family Nurse Practitioner services
Nursing Facility	Transportation to medical care
Home Health	Tobacco cessation counseling for pregnant women
Physician	Lab and X-ray
Rural Health Clinics/FQHCS	Family Planning

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MEDICAID BENEFITS | OPTIONAL

Optional Benefits (selected)	
Prescription drugs	Optometry
Physical therapy	Dental services
Occupational therapy	Dentures
Speech, hearing and language services	Prosthetics
Respiratory care services	Eyeglasses
Podiatry	Chiropractic services
Private duty nursing services	Hospice

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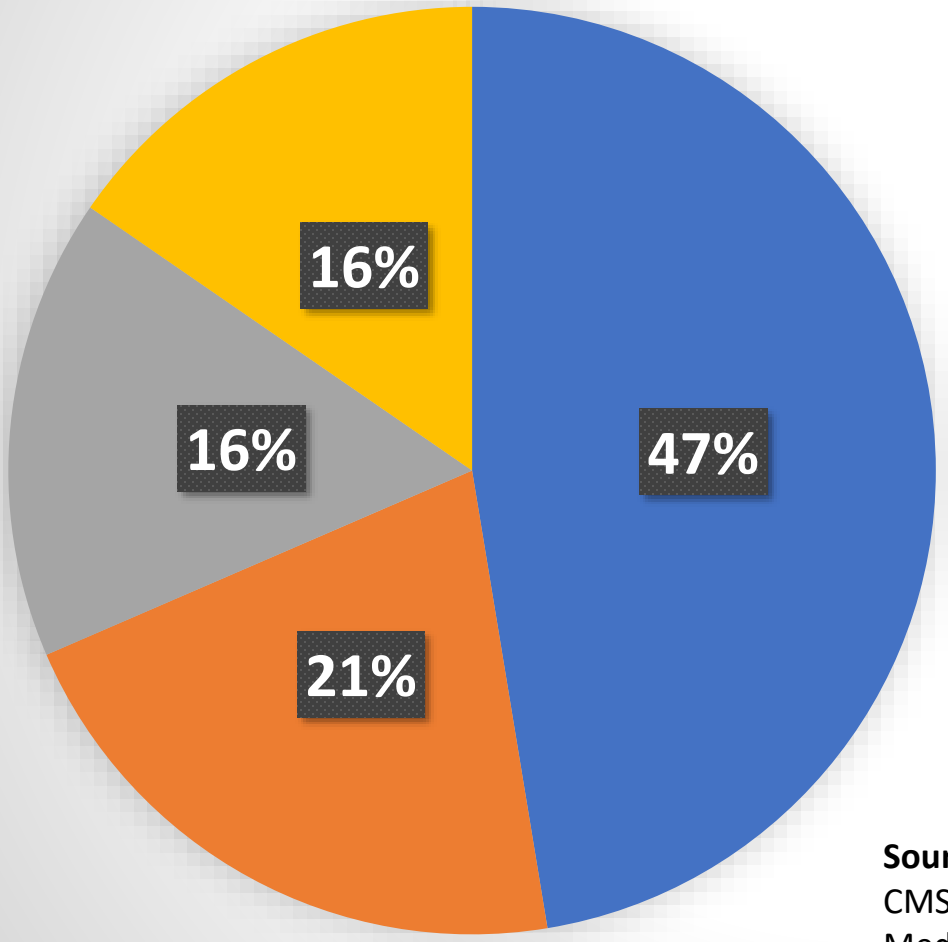
Medicaid Spending on Mandatory vs. Optional Populations and Services (2013)



- Mandatory enrollment and mandatory services
- Mandatory enrollment and optional services
- Optional enrollment and mandatory services
- Optional enrollment and optional services

Source: MACPAC, 2017, analysis of MSIS data as of December 2015 and analysis of CMS-64 Financial Management Report net expenditure data from the Centers for Medicare & Medicaid Services as of June 2016.

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MEDICAID SERVICE DELIVERY

- Medicaid is publicly financed, but it is not "government-run" health care.
- State Medicaid programs have historically paid for services through two models (or a combination of the two):
  - Fee-for-service
    - Direct contracts with Medicaid providers
    - Payment based on utilization of a service
  - Risk-based managed care
    - Managed care entities paid a fixed amount to provide covered services
- The majority of Medicaid beneficiaries now receive services through a managed care plan (even though not all states have Medicaid managed care plans).
- A variety of newer delivery system reforms and payment models are now emerging across the country, some of which we will touch on later today.

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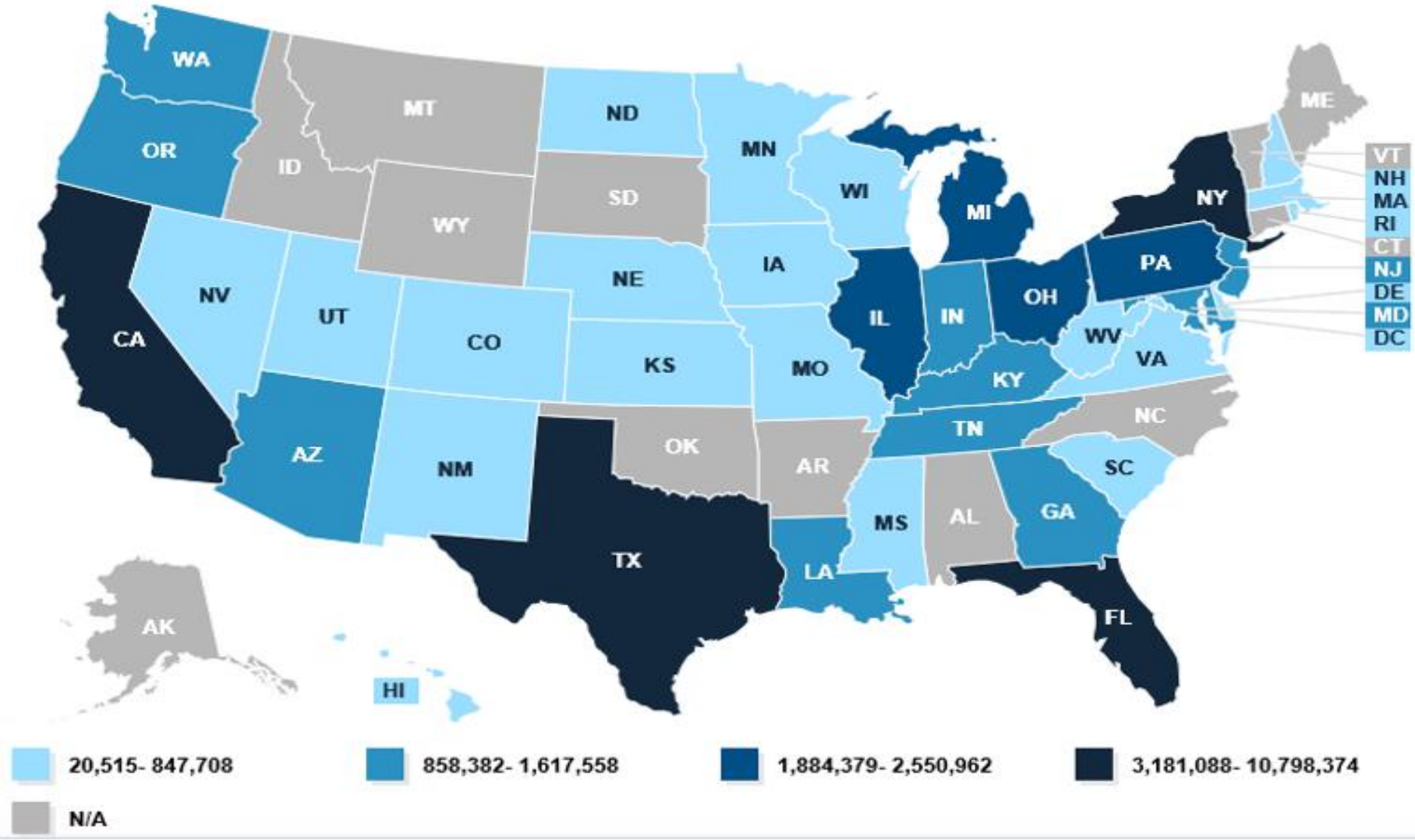
ALL BUT 12 STATES NOW HAVE MANAGED CARE.

Medicaid Enrollment in Managed Care



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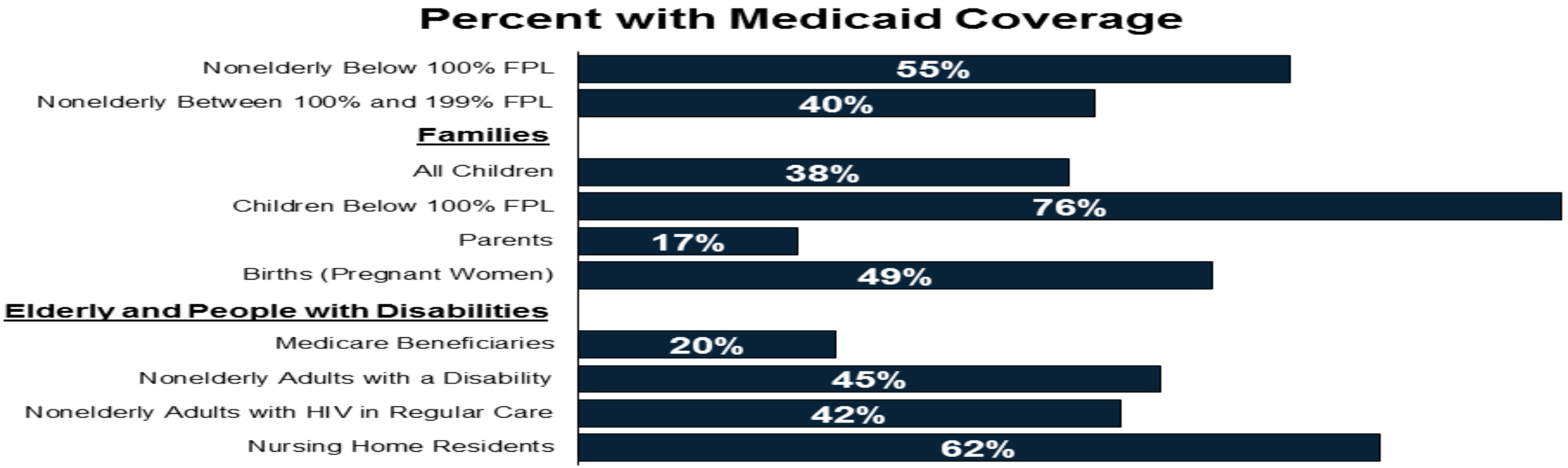
2017

MEDICAID PROGRAM SCALE

Medicaid's role for selected populations.



NOTE: FPL-- Federal Poverty Level. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016.
SOURCES: KFF analysis of 2017 Current Population Survey, Annual Social and Economic Supplement; Birth data -Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, KFF, October 2016.; Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2018), 2013 data; Disability - KFF Analysis of 2016 ACS; Nonelderly with HIV - 2014 CDC MMP; Nursing Home Residents - 2015 OSCAR/CASPER data.

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MEDICAID PROGRAM CHANGES

- States have substantial flexibility in designing their Medicaid programs.
- States may continually make changes to their programs – within the limitations of federal law and regulation – via “State Plan Amendments”.
- States may request “waivers” of certain Medicaid requirements; conditions apply.

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1:35 PM – 2:05 PM

BEHAVIORAL HEALTH

JOSH RUBIN

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Recognize different ways in which behavioral health care is managed for different populations in different state Medicaid systems, understand carve-ins, carve-outs, special needs plans, and the evolution of service models as a result of changes in the knowledge base about how to produce better outcomes, and changes in financing methodologies.

Recognize the potential impact on the community behavioral health sector of value-based payments and the trend toward carving behavioral health care and people with Serious Mental Illness into managed care.

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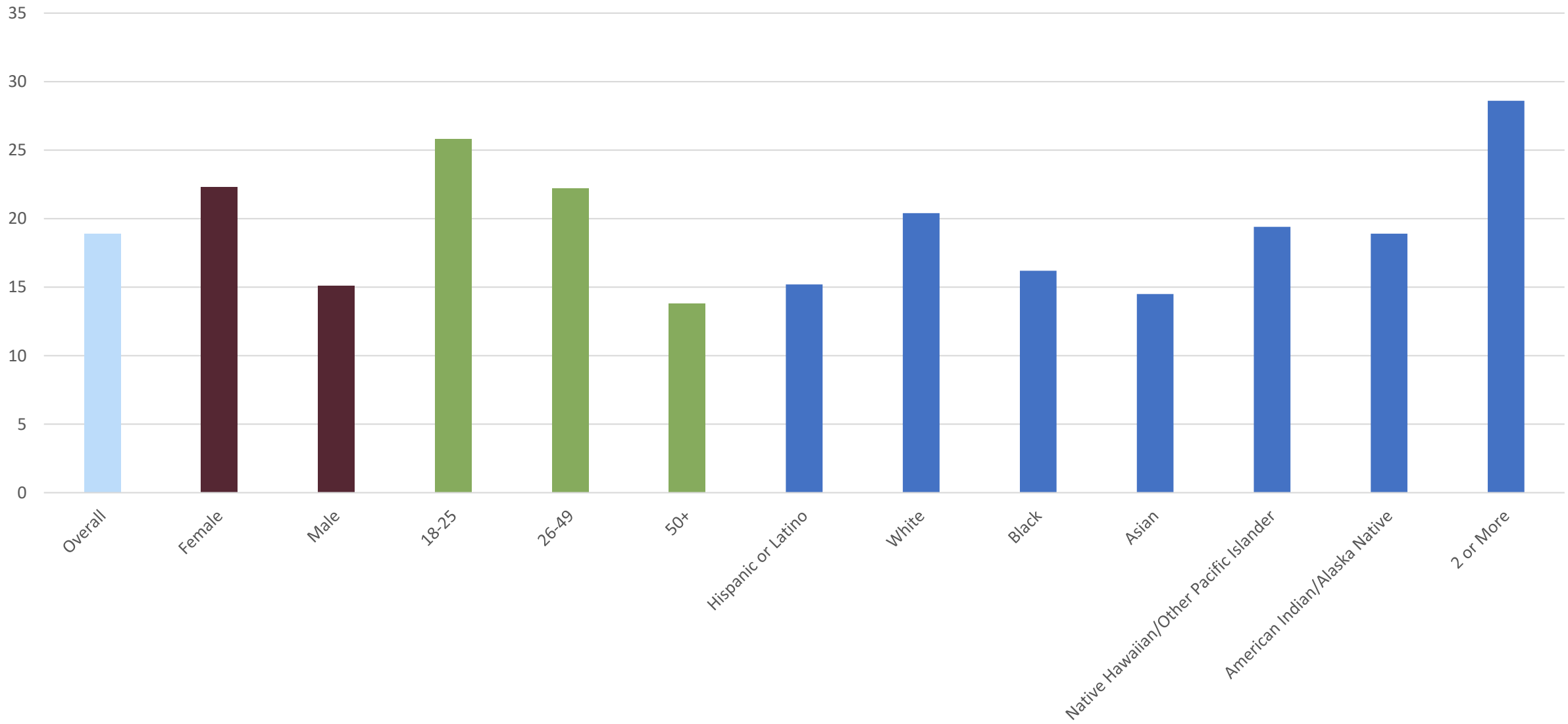
PAST YEAR PREVALENCE OF ANY MENTAL ILLNESS AMONG U.S. ADULTS



Source: Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSUDH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

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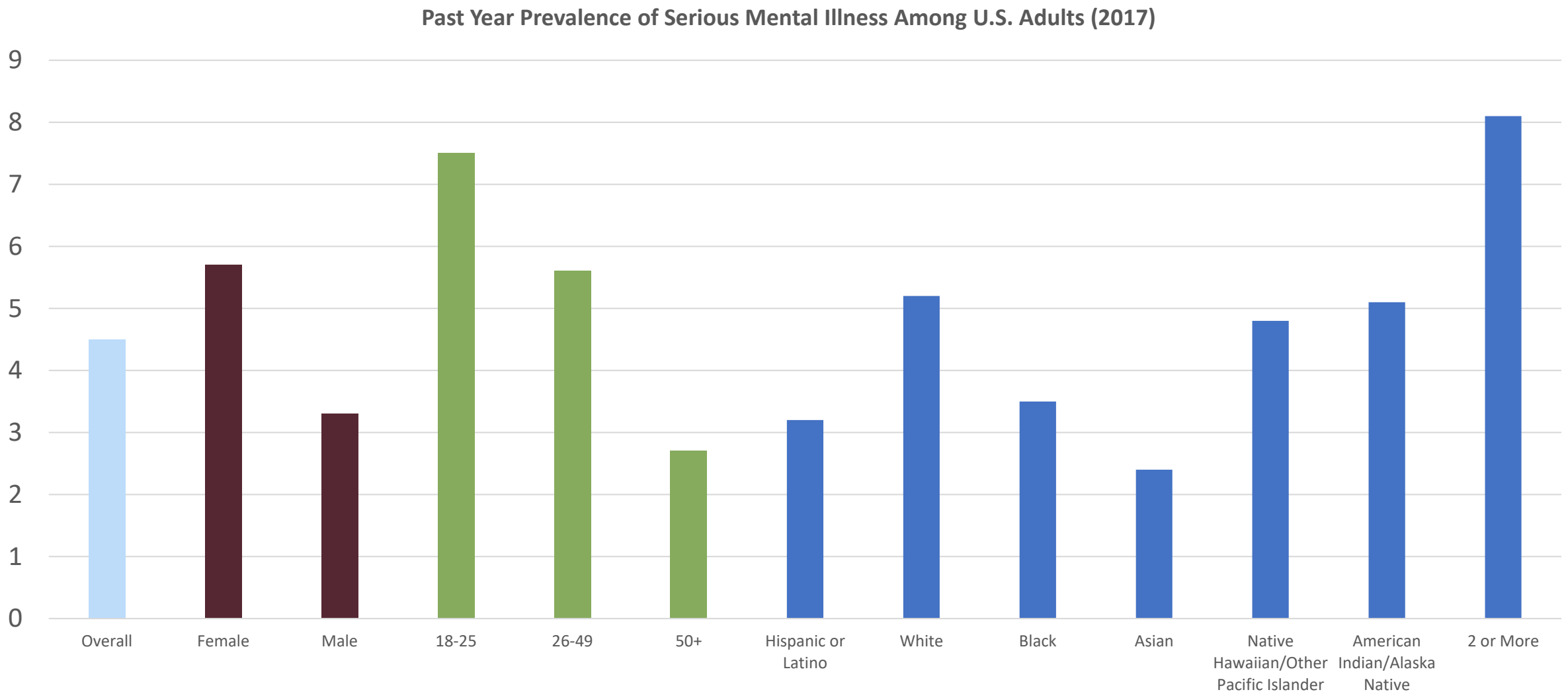
APPROXIMATELY 1 OUT OF 4 ADULTS WITH MENTAL ILLNESS HAVE A SERIOUS MENTAL ILLNESS



Source: Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSUDH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

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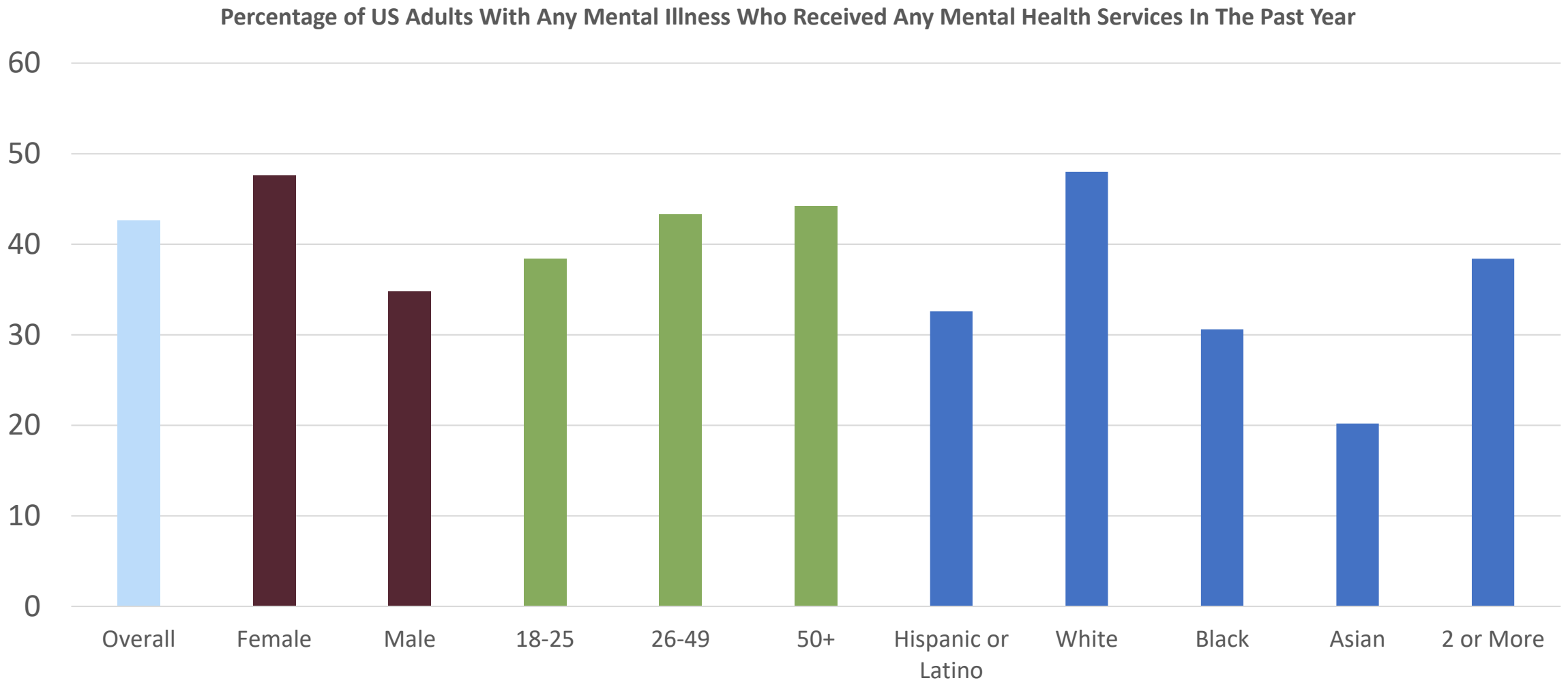
ACCESS TO CARE IS A PERSISTENT PROBLEM FOR ADULTS WITH MENTAL ILLNESS



Source: Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSUDH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

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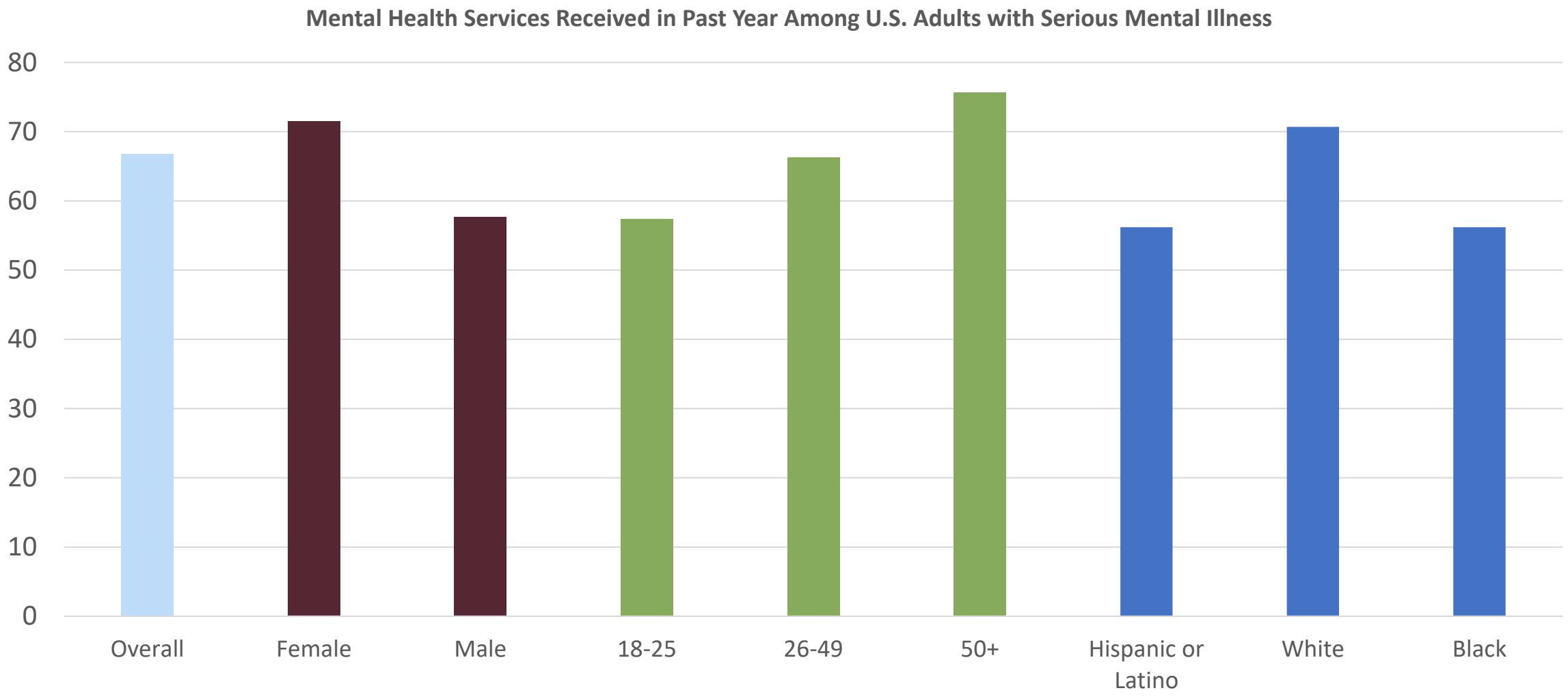
ACCESS TO CARE IS BETTER FOR ADULTS WITH SERIOUS MENTAL ILLNESS, BUT THE CONSEQUENCES OF INSUFFICIENT ACCESS ARE WORSE.



Source: Substance Abuse and Mental Health Services Administration. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSUDH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

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People with Serious Mental Illness die 25 years younger than the general population.

Source: National Association of State Mental Health Program Directors Council. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: Parks, J., et al.

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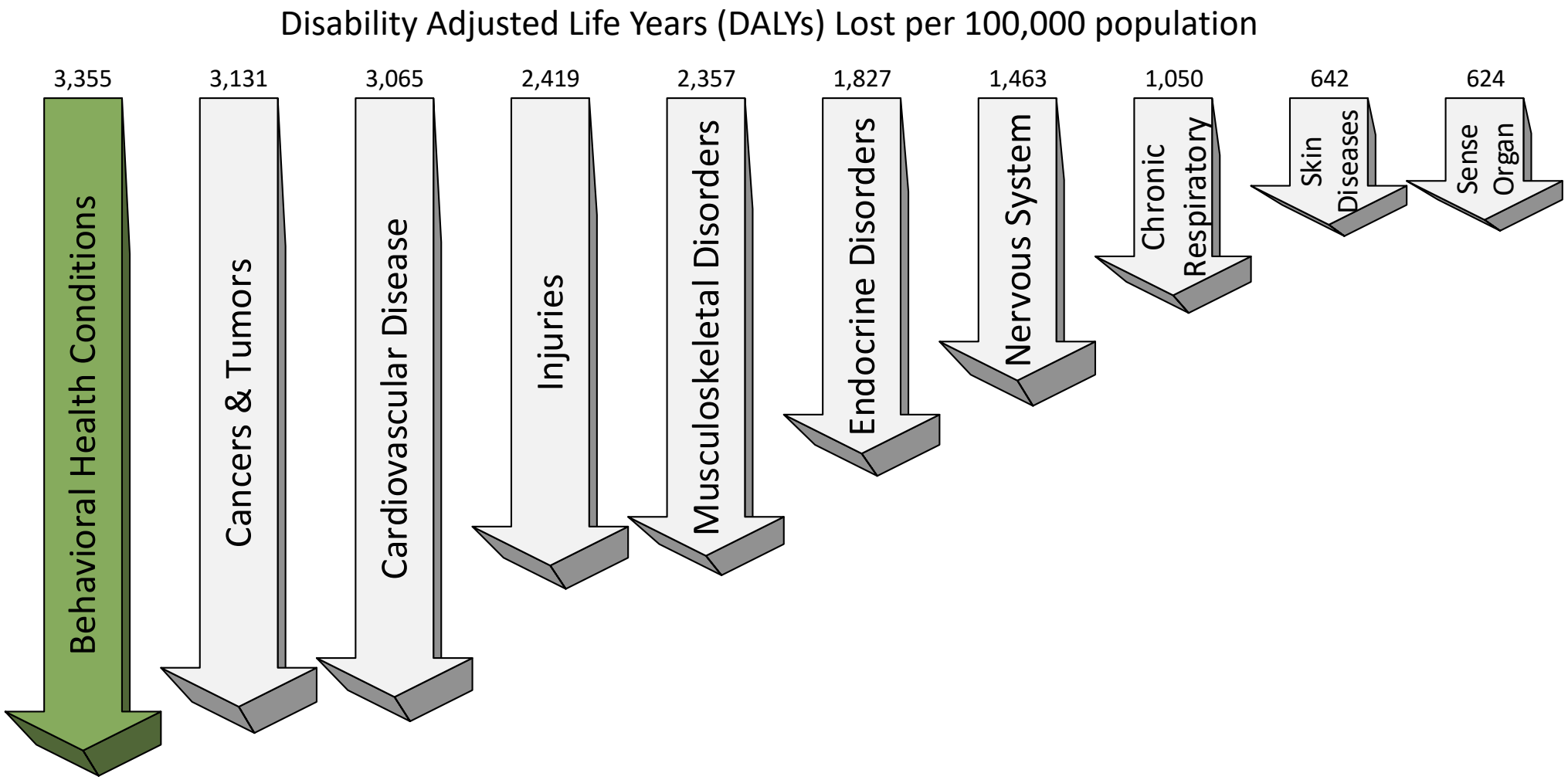
BEHAVIORAL HEALTH DISORDERS WERE THE LARGEST CAUSE OF DISEASE BURDEN IN THE UNITED STATES IN 2015.



Source: Kamal R, Cox C, Rousseau D, et al. Costs and Outcomes of Mental Health and Substance Use Disorders in the US. JAMA 2017;318(5): 415.

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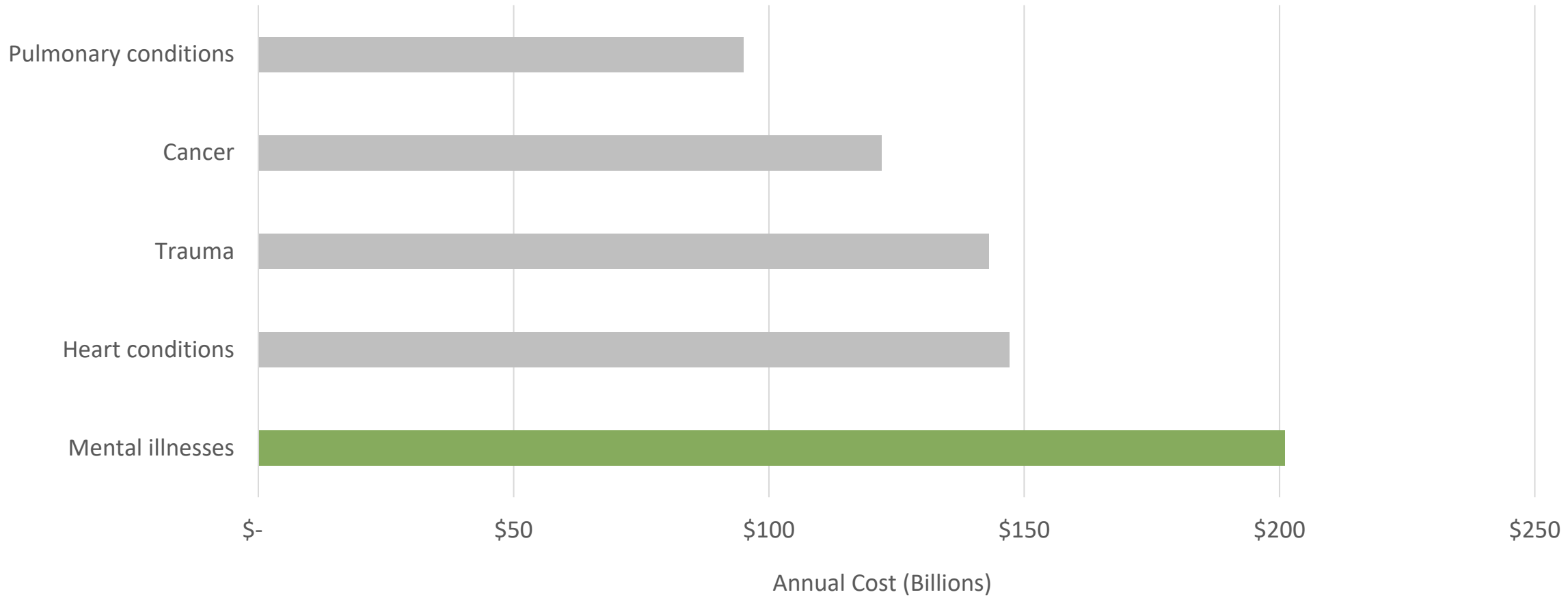
MENTAL DISORDERS ARE THE COSTLIEST CONDITIONS IN THE UNITED STATES



Source: Roehrig C, Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. Health Affairs 35, no. 6 (2016) 1130 – 1135.

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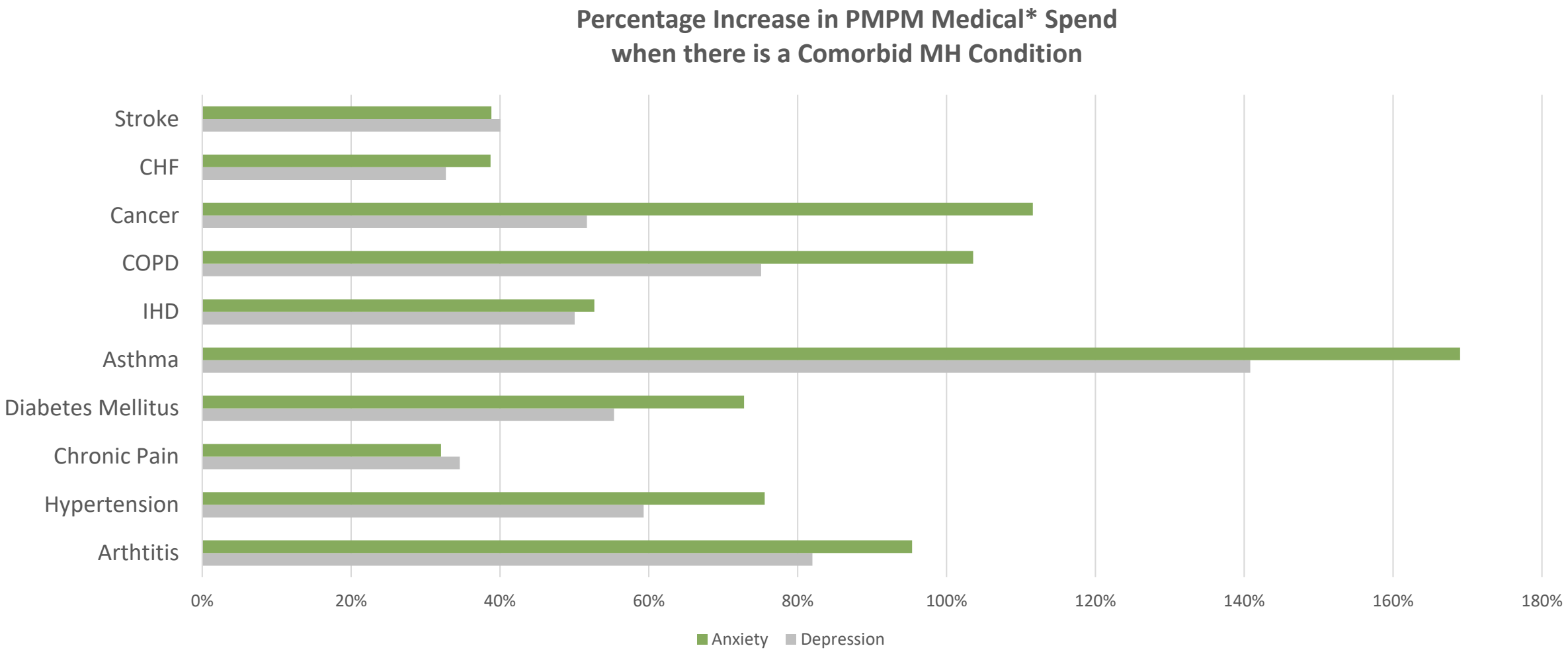
MENTAL HEALTH CONDITIONS INCREASE MEDICAL COSTS



*Note: Does not include any BH spend

Source: Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Milliman Research Report. July, 2008.

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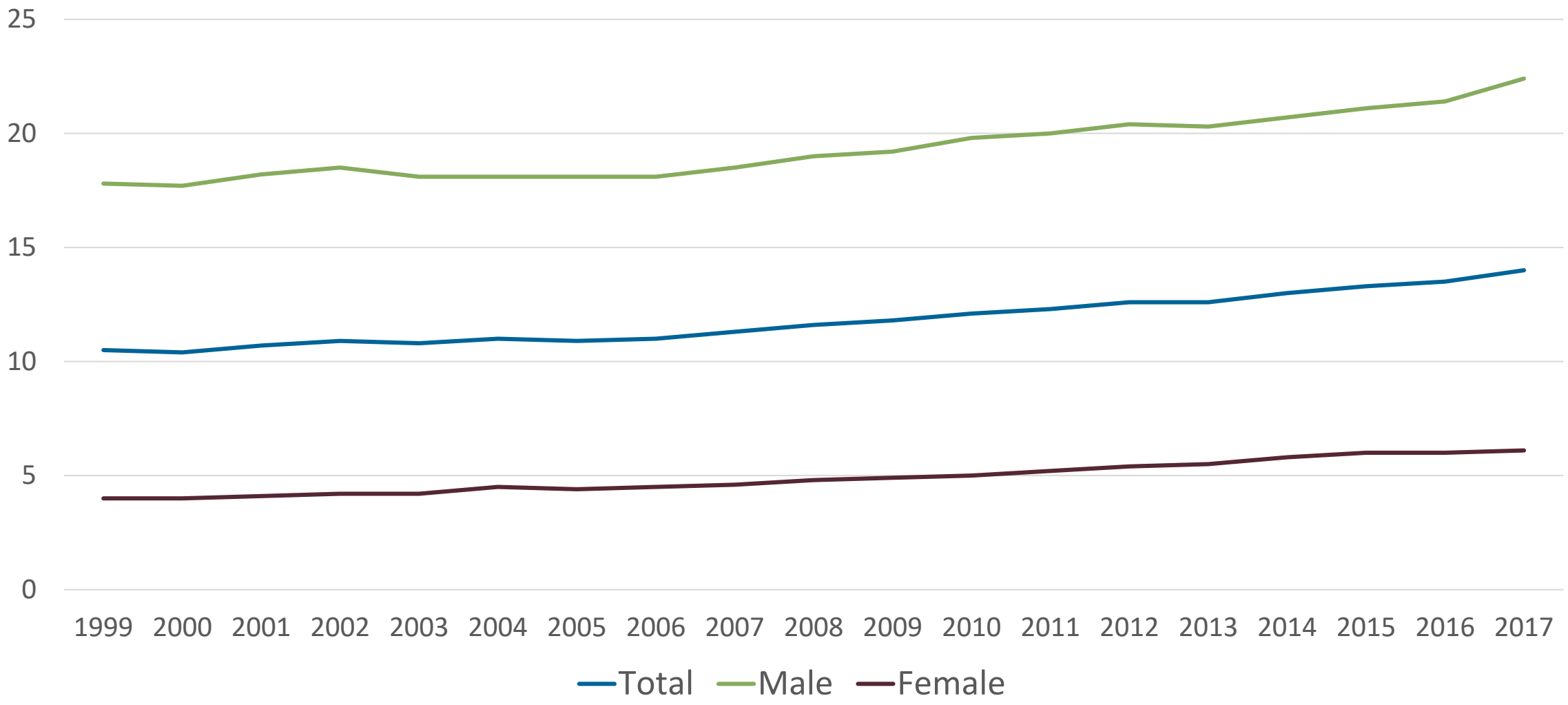
AGE-ADJUSTED SUICIDE RATES IN THE UNITED STATES



Source: NCHS, National Vital Statistics System, Mortality.

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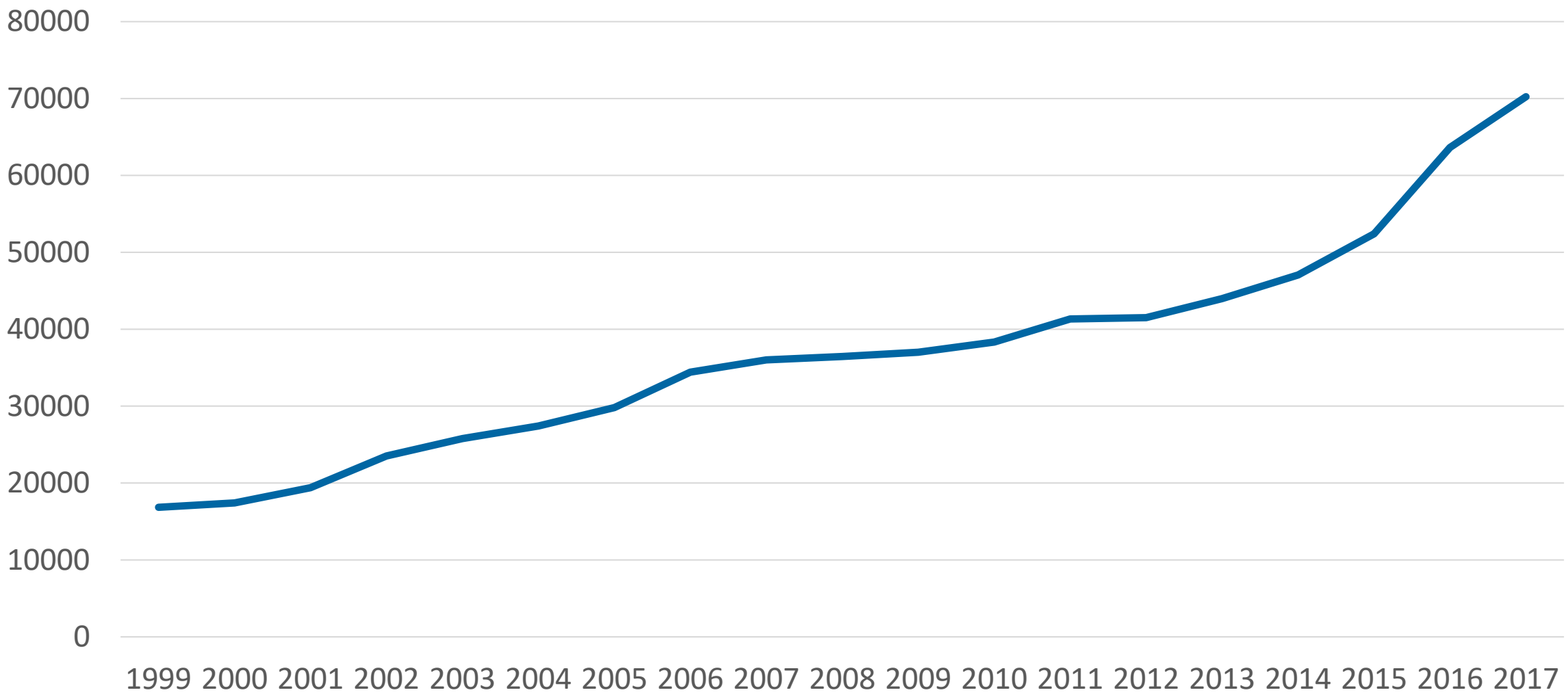
DRUG OVERDOSE DEATHS IN THE UNITED STATES



Source: NCHS: National Vital Statistics System, Mortality.

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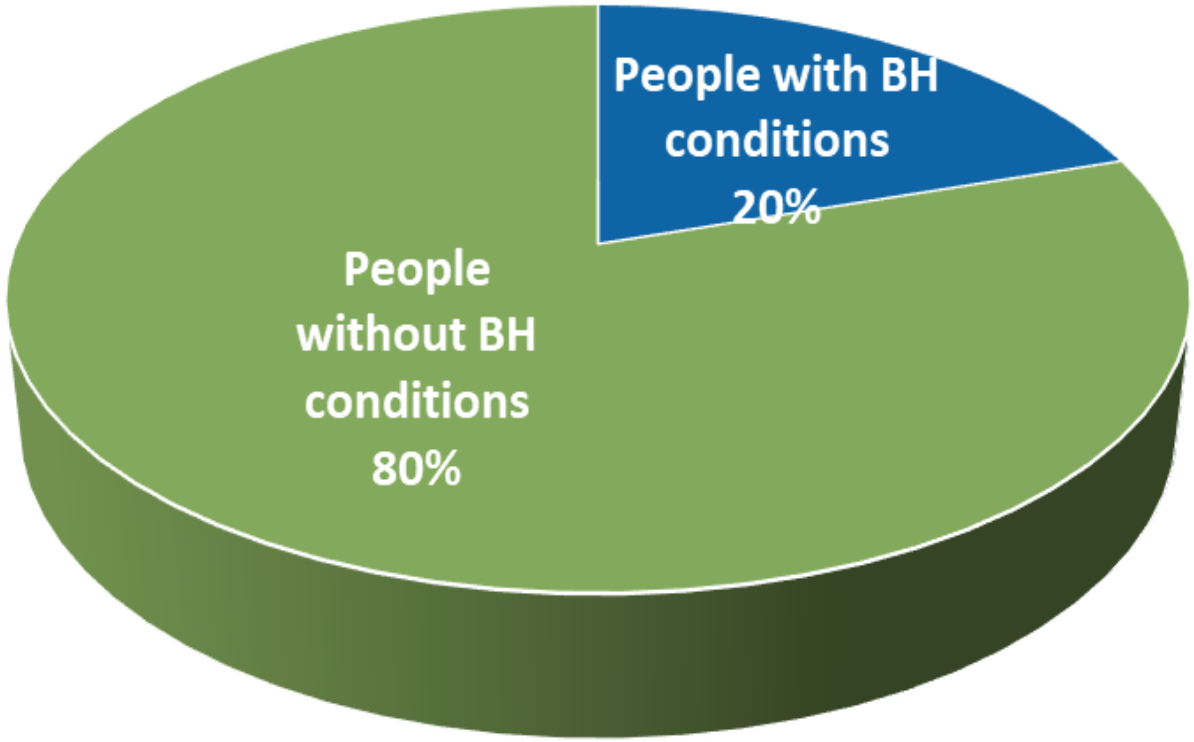
FOLLOW THE MONEY

Medicaid Spending on people with mental health conditions is nearly **four times** as much as for other enrollees

Nearly **half** of Medicaid spending is for enrollees with BH conditions…

…but only 20% of Medicaid enrollees have BH conditions



Source: Medicaid's Role in Behavioral Health, Henry J. Kaiser Family Foundation, May 2017.

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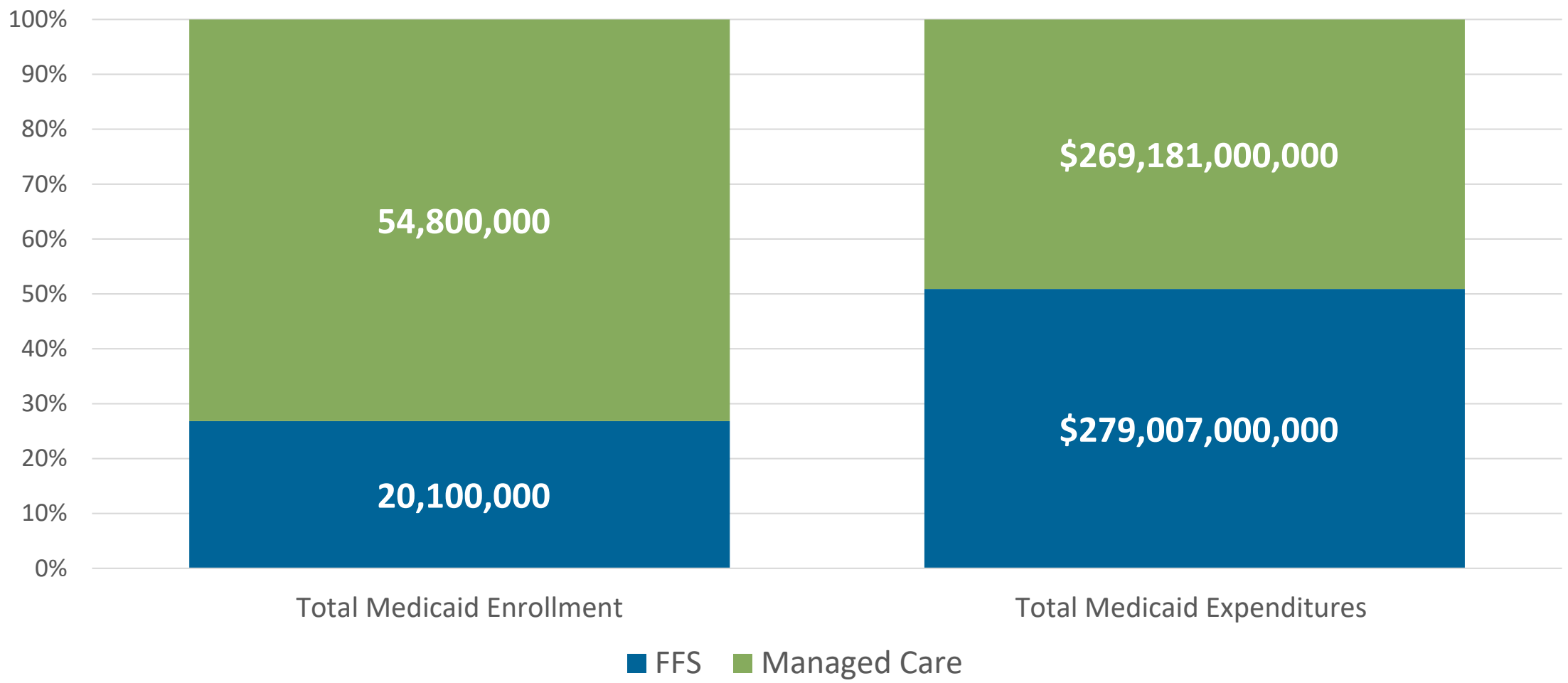
COMPARISON BETWEEN MANAGED POPULATION AND MANAGED DOLLARS IN MEDICAID



Source: Expenditure data is from CMS-64. Enrollment data is from The Complicated State of Medicaid in the United States: Stability amidst considerable future uncertainty, October, 2017.

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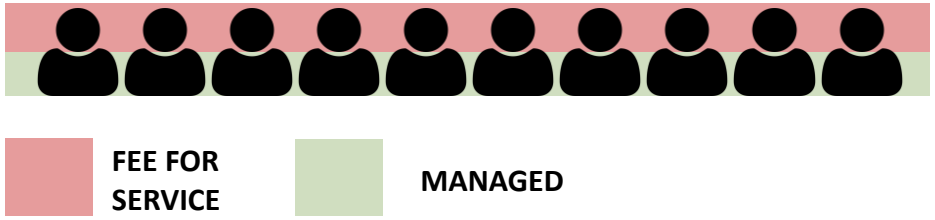
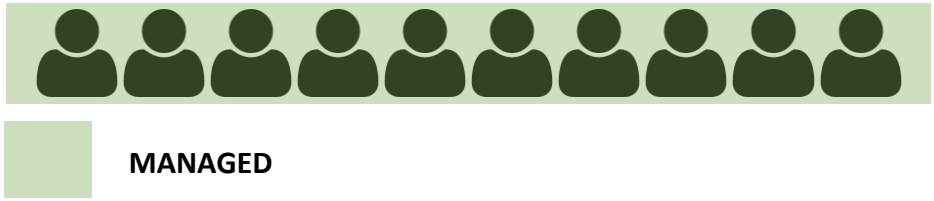
FROM CARVE OUT TO CARVE IN

CARVE OUT



CARVE IN



SPECIALTY PLAN

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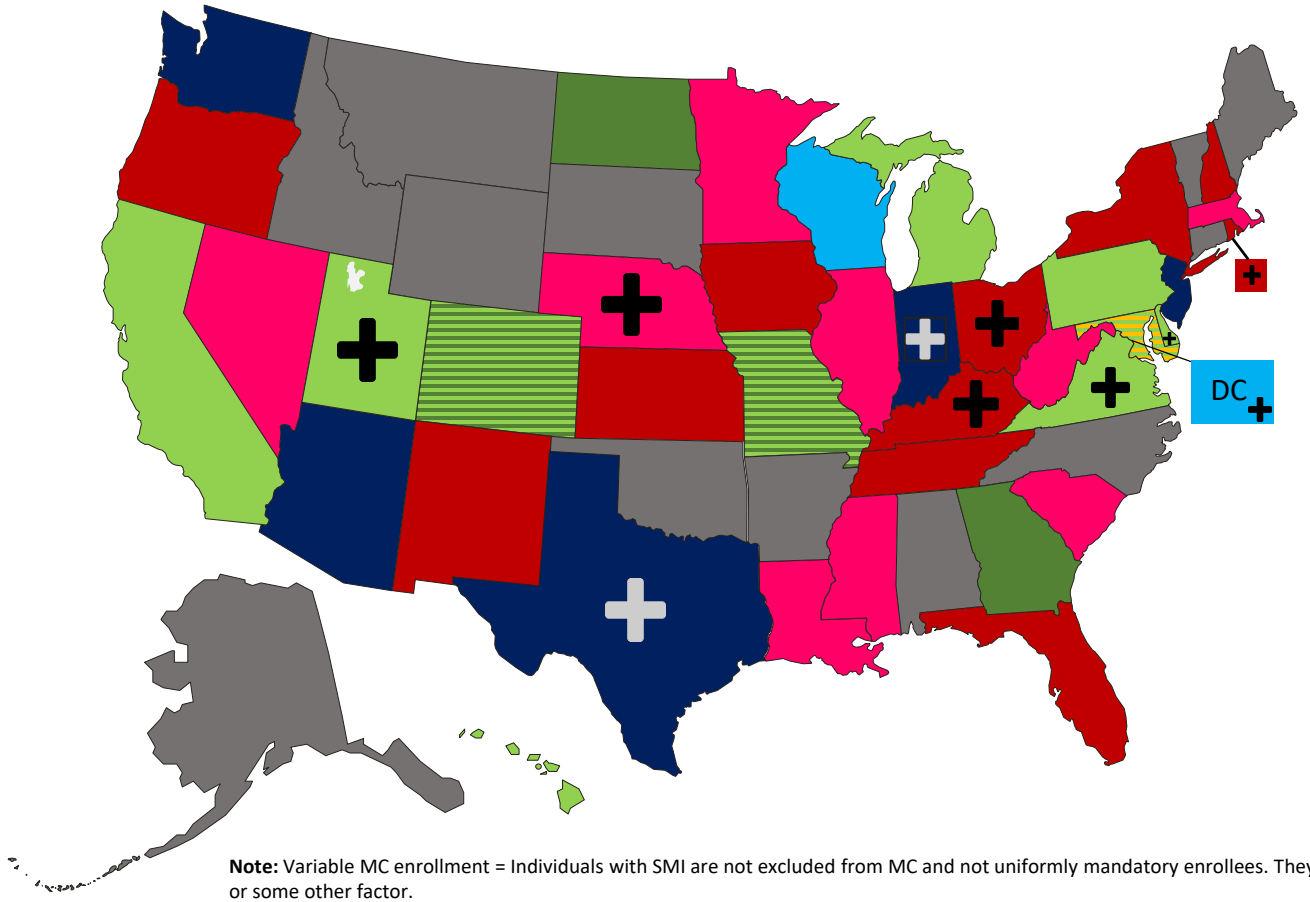
MEDICAID ACUTE MANAGED CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS (PWSMI)



- No MCOs
- Specialty Outpatient MH Always Carved In – MC Enrollment Always Mandatory for PWSMI
- Specialty Outpatient MH Always Carved In – Variable MC Enrollment for PWSMI
- Specialty Outpatient MH Sometimes Carved Out – MC Enrollment Mandatory for PWSMI
- Specialty Outpatient MH Sometimes Carved Out -- MC Enrollment Variable for PWSMI
- Specialty Outpatient MH Always Carved Out – MC Enrollment Always Mandatory for PWSMI
- Specialty Outpatient MH Always Carved Out – MC Enrollment Variable for PWSMI
- Specialty Outpatient MH Always Carved Out – PWSMI Excluded from MC
- Indicates a change from 2017 to 2018

Note: Variable MC enrollment = Individuals with SMI are not excluded from MC and not uniformly mandatory enrollees. They are either exempted from MC (voluntary enrollees) or state enrollment policies vary by geography or some other factor.

"Specialty outpatient mental health" refers to services utilized by adults with Serious Mental Illness (SMI) and/or youth with serious emotional disturbance (SED) commonly provided by specialty providers such as community mental health centers.

Source: The Kaiser Family Foundation, Health Management Associates, and the National Association of Medicaid Directors, "States Focus on Quality and Outcomes Amid Waiver Changes," Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019." October 2018, and The Kaiser Family Foundation, Health Management Associates, and the National Association of Medicaid Directors, "Medicaid Moving Ahead in Uncertain Times," Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018." October 2017.

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SOME DESIGN QUESTIONS

- Population definition
- Benefit package
  - HCBS
    - Eligibility process
- Permit BHOs?
- 2703 Health Homes?
- IMD
- Differential MLR
- Voluntary enrollment?
- Performance indicators
- How to integrate care
  - Integrated funding ≠ integrated care
- Off ramps

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A CRITICAL PIECE TO REMEMBER

Integrated funding

≠

Integrated care

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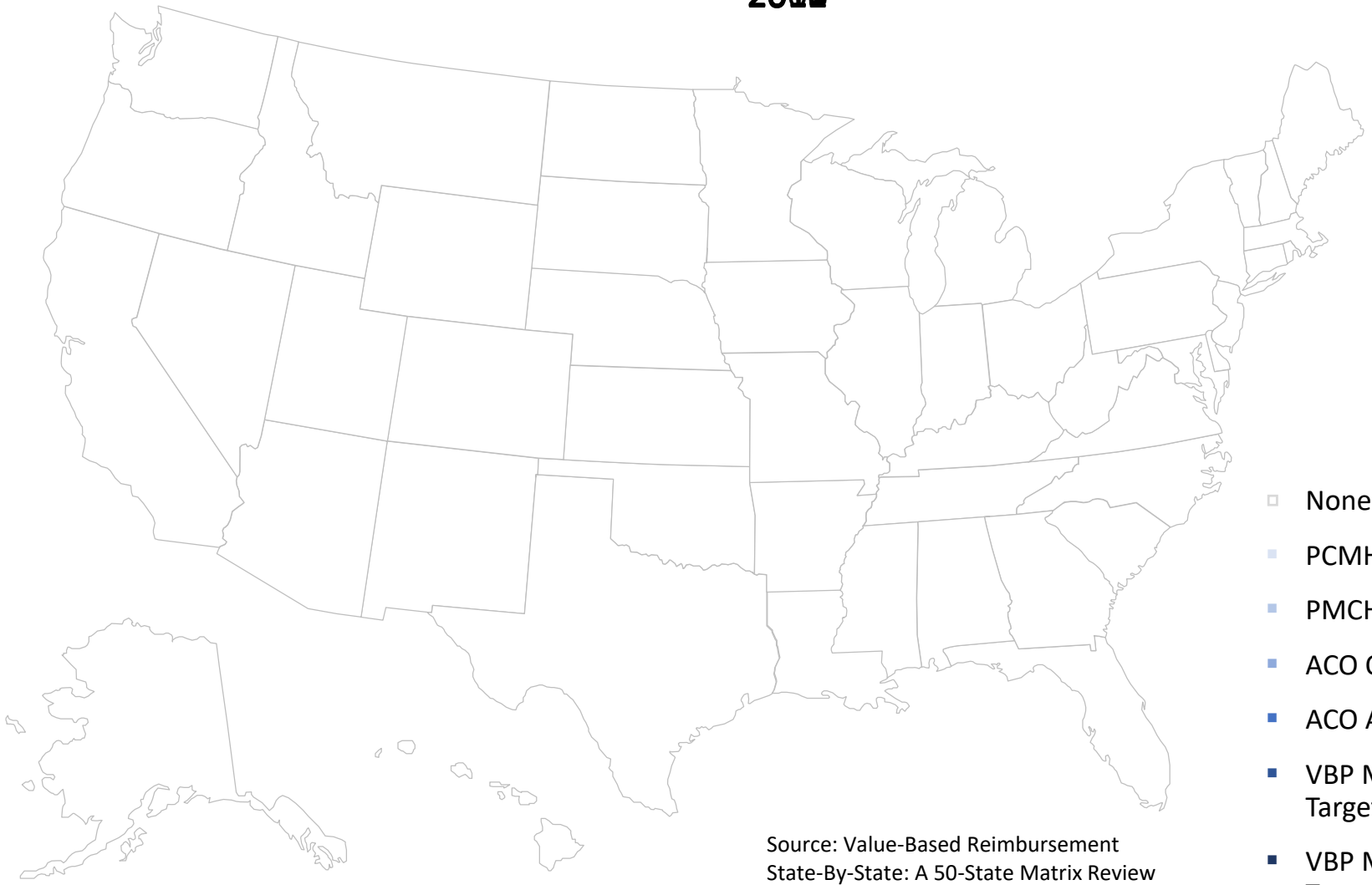
ACCOUNTABLE CARE & VALUE-BASED PAYMENTS

VBP AND ACCOUNTABLE CARE: TWO SIDES OF THE SAME COIN

VBP SPREAD

2018



- None
- PCMH/HH
- PMCH/HH + P4P
- ACO OR EOC
- ACO AND EOC
- VBP Mandates or Targets
- VBP Mandates or Targets AND ACO or EOC

Source: Value-Based Reimbursement State-By-State: A 50-State Matrix Review of Value-Based Payment Innovation. Change Healthcare, 2017.

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SIMPLY PUT

- Value-Based Payment (VBP) is an emerging type of payment approach that:
  - Pays for value:
    - Better care
    - Better outcomes
    - Reduced costs
  - Instead of paying for volume:
    - Visits
    - Procedures
- We expect that VBP will increasingly become the dominant payment method for health care providers.
  - Including from Medicare, Medicaid, and commercial payers

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WHAT IS VALUE?

$$V = \frac{\uparrow Q}{\downarrow \$} \times S$$

(Value) (Quality) (Cost) (Service Volume)

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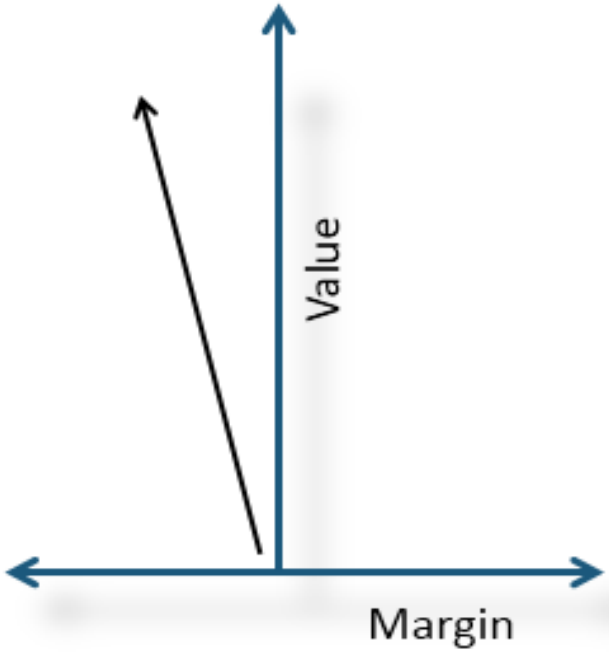
THE THEORY BEHIND VBP

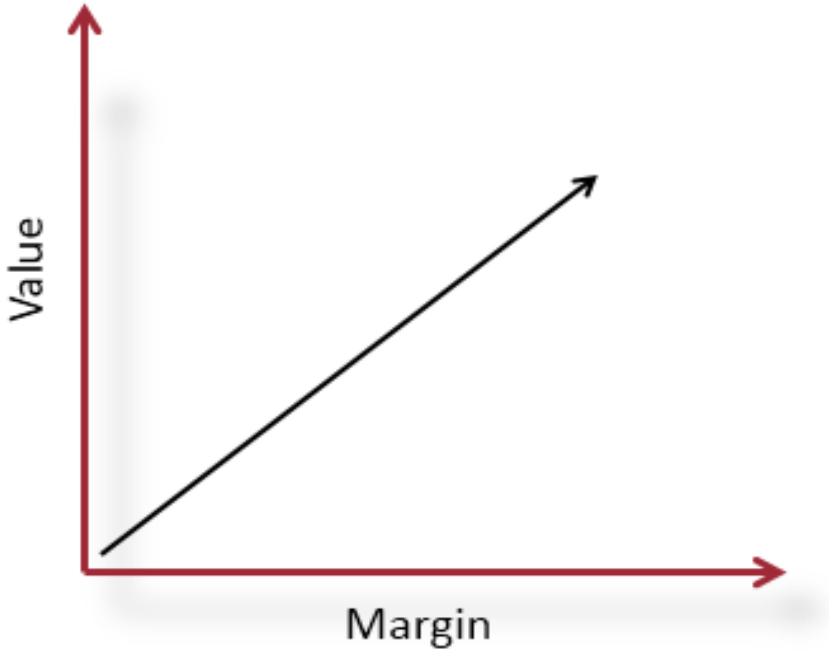
Current State

Increasing the value of care delivered more often than not threatens providers' margins



Future State

When VBP is done well, providers' margins go up when the value of care delivered increases



Source: NYS DOH Medicaid Redesign Team, A Path toward Value Based Payment

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Paying for volume (FFS) provides the wrong set of incentives

Expensive intervention instead of an inexpensive one

Focus on illness, not health
Lack of accountability for the wellbeing of the consumer

Doesn't promote innovation

Inconsistent with virtual and technological interventions

No payment for important parts of the service

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KEY ELEMENTS OF VALUE-BASED PAYMENT MODELS

Payments are not based on service volume

Based on the population's size and characteristics

Payment is not limited to "billable encounters"

Rewards for reaching performance measures

- Care cost
- Care process
- Care outcome
- Structural changes
- Consumer satisfaction/ perception of care

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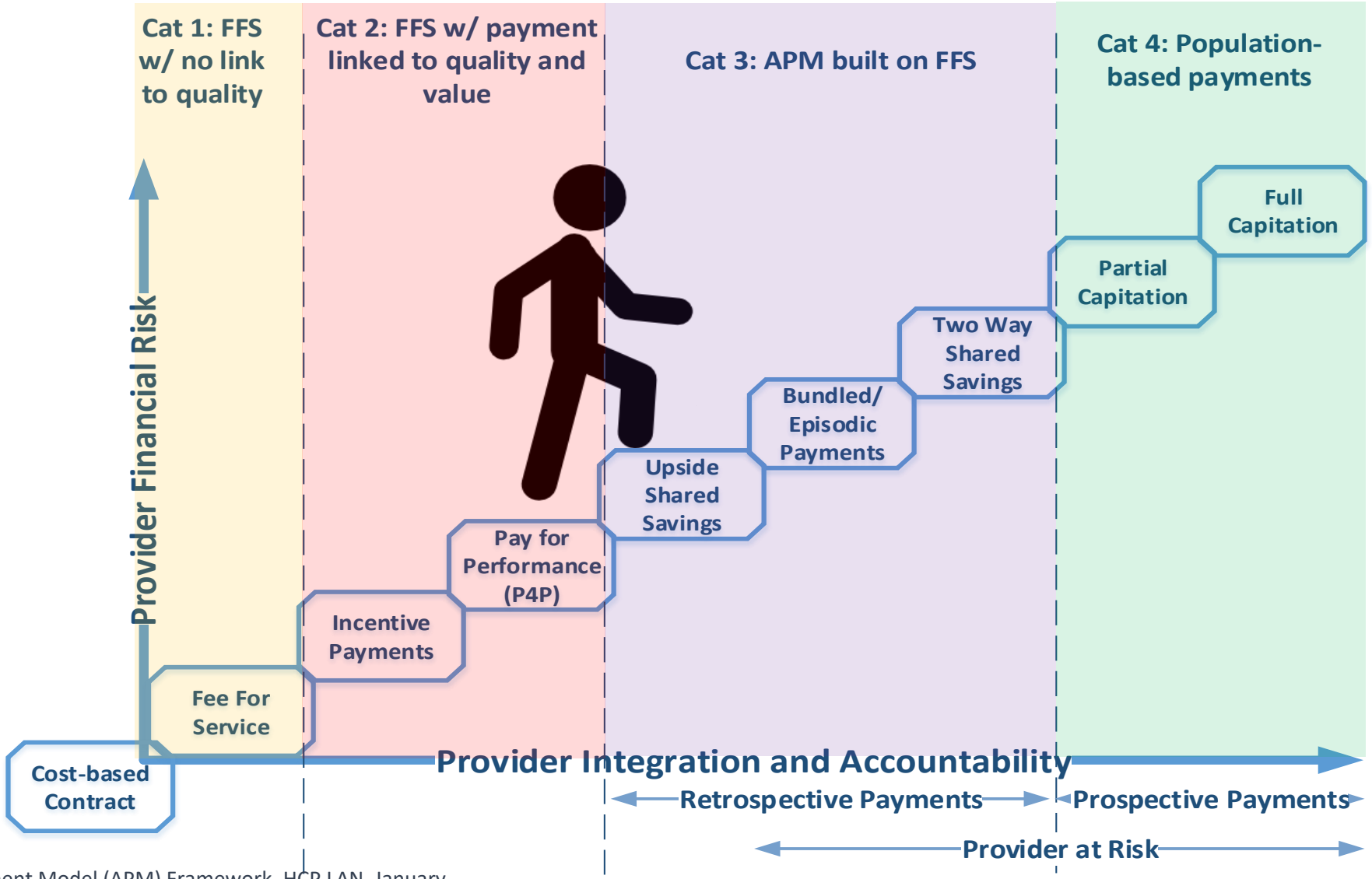
ACCOUNTABILITY, INTEGRATION, AND RISK GO TOGETHER



Source: Alternative Payment Model (APM) Framework. HCP LAN. January 2016. Retrieved from https://hcp-lan.org/workproducts/apm-whitepaper.pdf

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KEY VBP CONCEPTS

- **Benchmarking:** What is the baseline spend against which the future spend will be measured?
- **Risk Adjustment:** A change to the benchmark to reflect consumer characteristics (e.g. age, sex, health status)
- **Attribution:** How and to whom is the care and wellbeing of the consumer assigned?
- **Predictive Modeling:** Analyzing data to create a statistical model of expected future performance or results
- **Stop loss:** An upper limit on the amount a provider can lose in a shared risk arrangement

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THE VBP STEW

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THE PROMISE OF VBP FOR BH PROVIDERS

WOULD THIS BE BETTER FOR BH PROVIDERS?

- Remember

$$V = \frac{Q \times S}{\$}$$

(Value) (Quality) (Service Volume) (Cost)

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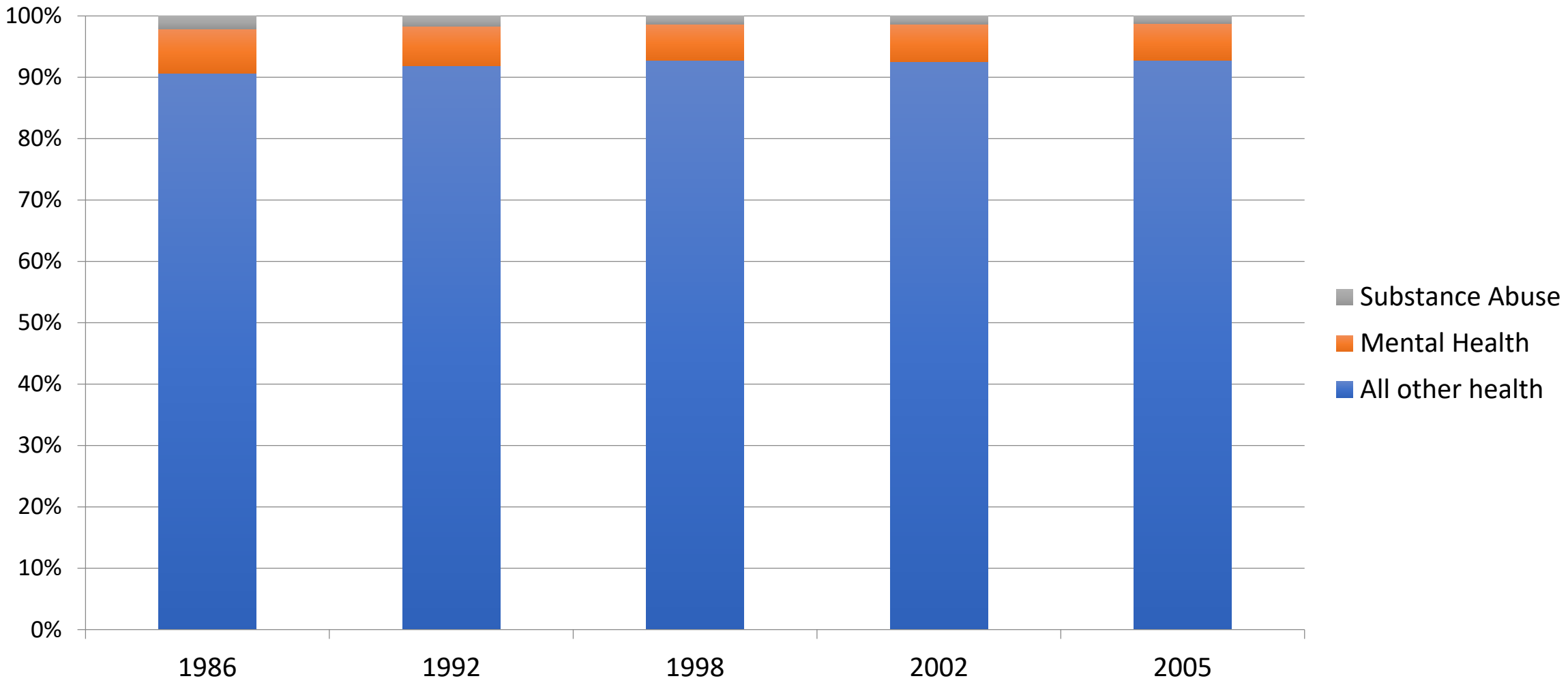
FOLLOW THE MONEY | NATIONAL SPENDING ON BEHAVIORAL HEALTH



Source: Mark, Tami, et al, Changes in US Spending on Mental Health and Substance Abuse Treatment, 1986-2005, And Implications for Policy, Health Affairs, 30:2,284-292.

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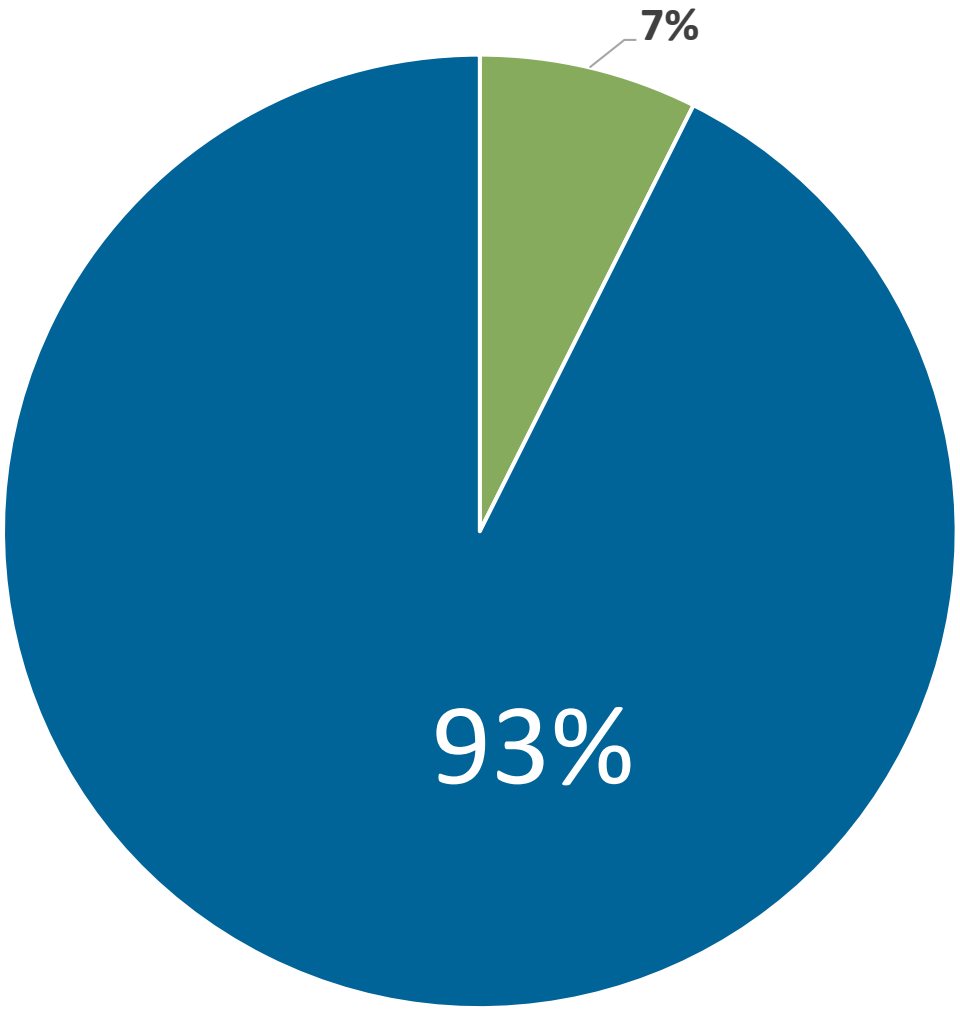
WHICH PIECE OF THE PIE LOOKS MORE FILLING?



Behavioral Health Medical

Source: Mark T, Levit K, Yee T, Chow C. Spending on Mental and Substance Use Disorders Projected to Grow More Slowly Than All Health Spending Through 2020. Health Affairs, August 2014, 33:8,1407-1415.

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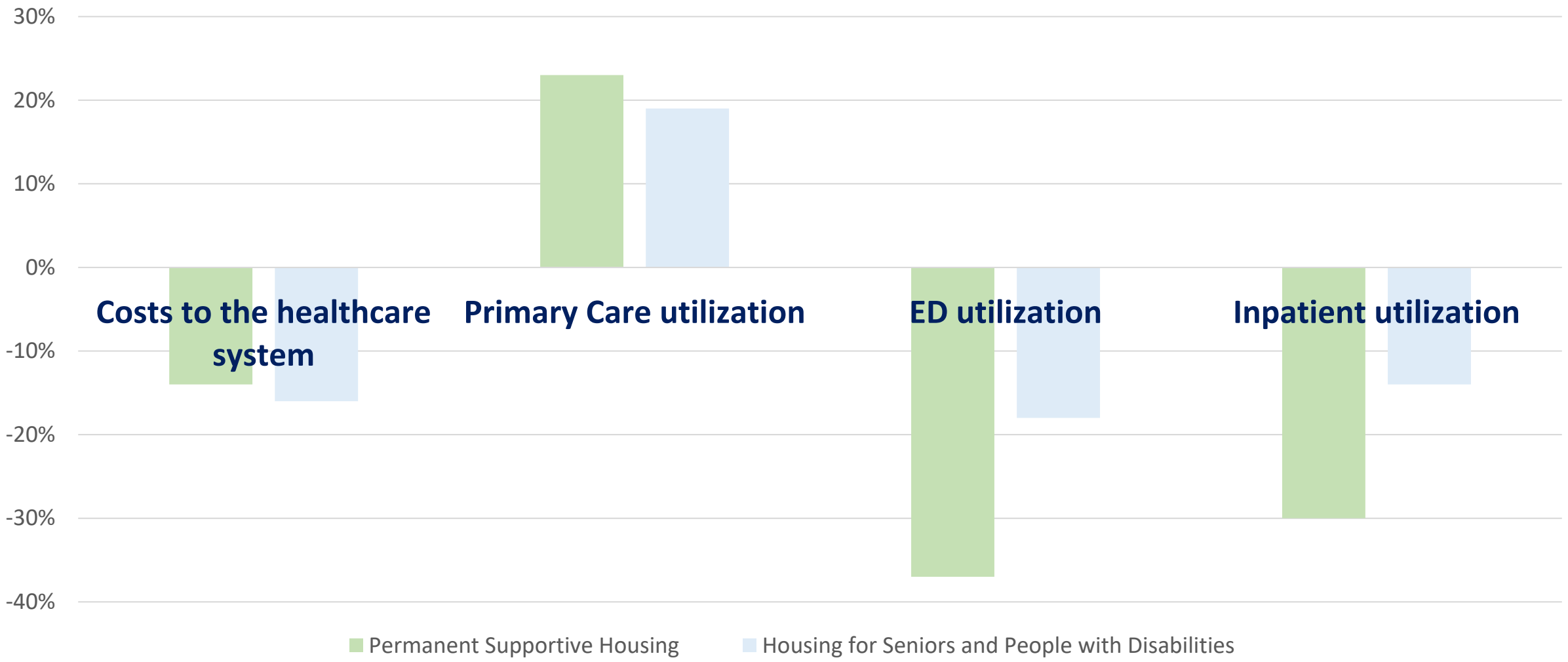
THE IMPACT OF HOUSING ON HEALTH CARE



Source: Health in Housing: Exploring the Intersection Between Housing and Health Care. Center for Outcomes Research and Education. February 2016.

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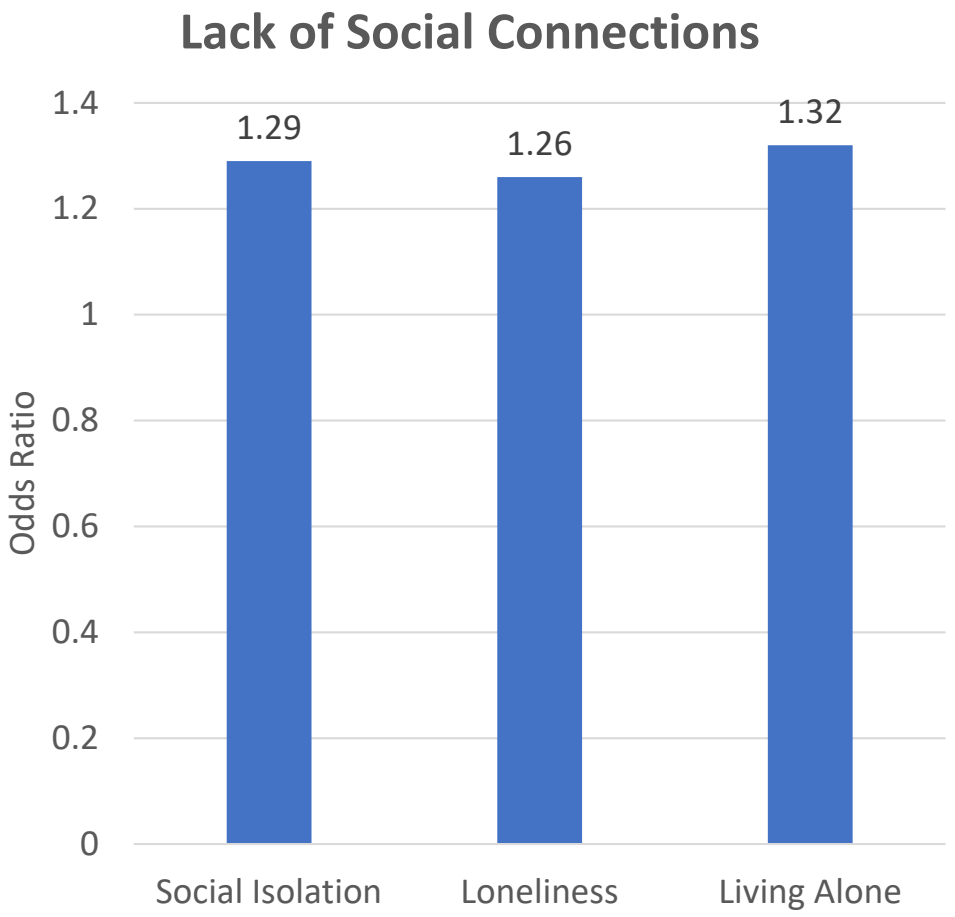
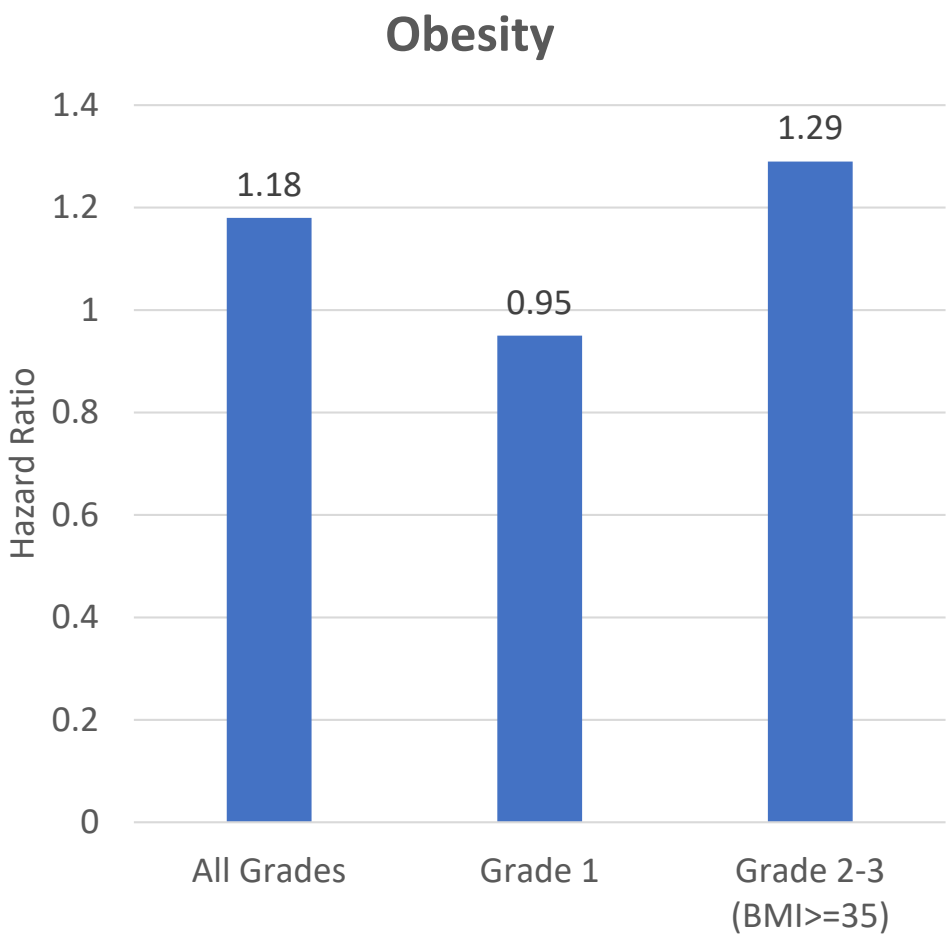
LACK OF SOCIAL CONNECTIONS LEADS TO MORTALITY LIKE OBESITY





Source: Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspect Psychol Sci. 2015 Mar;10(2):227-37.

Source: Flegal KM, Kit BK, Orpana H, et al. Association of All-Cause Mortality With Overweight and Obesity Using Standard Body Mass Index CategoriesA Systematic Review and Meta-analysis. JAMA. 2013;309(1):71-82.

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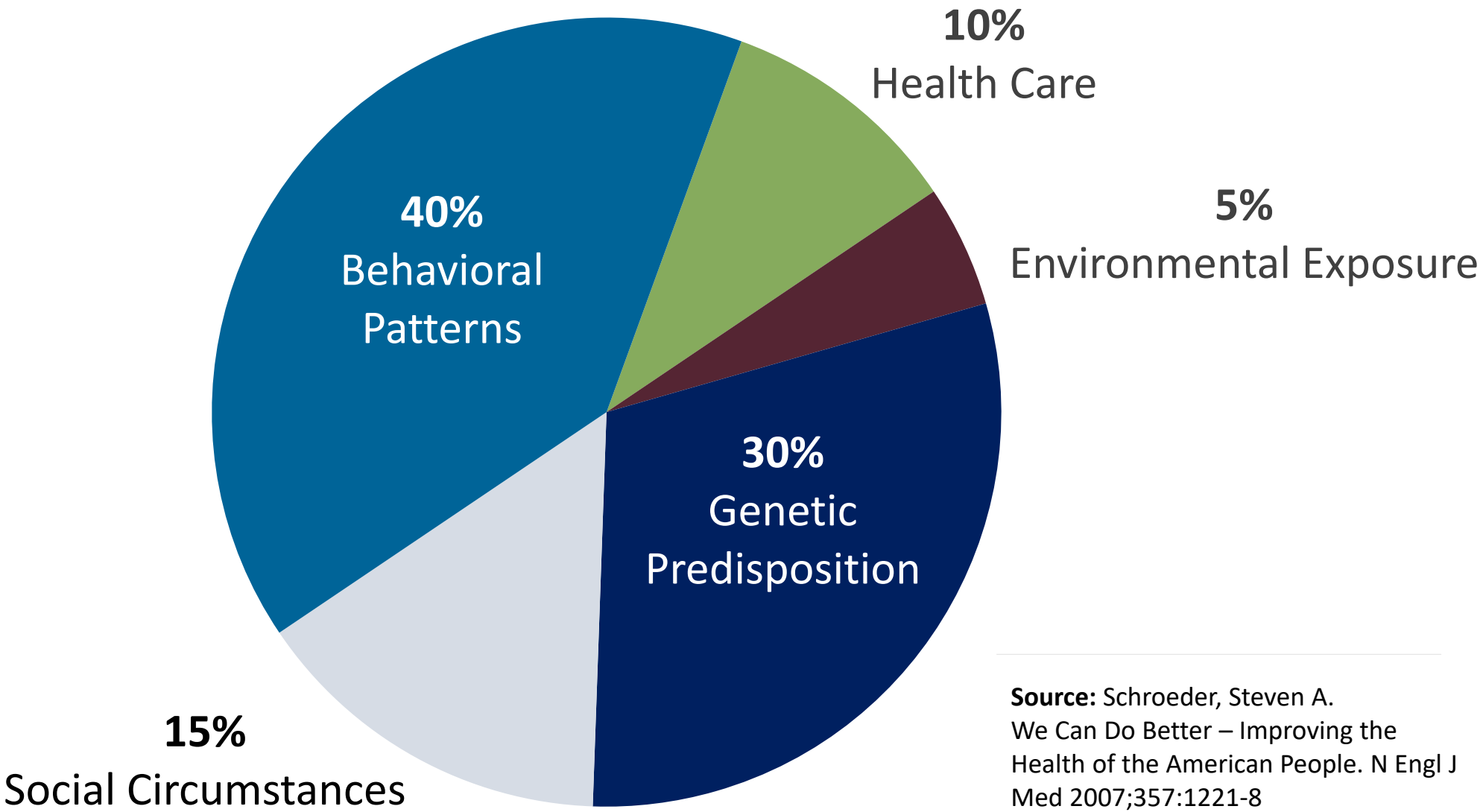
WHAT IMPACTS HEALTH OUTCOMES?



Source: Schroeder, Steven A. We Can Do Better – Improving the Health of the American People. N Engl J Med 2007;357:1221-8

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VBP IS A CHANCE TO GET PAID BY THE MEDICAL SYSTEM FOR WORK BH PROVIDERS HAVE BEEN DOING

- Helping people get jobs
- Helping people get into and stay in school
- Helping people get and stay housed
- Helping people stay out of jails
- Helping people stay out of the hospital

CME Disclosure: *This slide contains editorial comment from presenter.*

THE PERIL OF VBP FOR BH PROVIDERS

VBP IS A MARKET BASED SOLUTION

- Competition
- The ‘invisible hand’
- Joseph Schumpeter
- What gets measured gets paid for
  - What gets measured is contested, complex and critical
  - How can we reduce the work of our community to a de Minimis set of performance indicators?

VBP ARE COMPLICATED

The challenges are varied

SERVICE DELIVERY TRANSFORMATION

Population health management

DEFINING QUALITY

What are the metrics unique to us?

INFRASTRUCTURE

Significantly more complex than historically necessary

SIZE MATTERS

Leverage and cash reserves are critical to success

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VBP ADVANTAGES PROVIDERS WITH CERTAIN CHARACTERISTICS

Size	Sophistication	Data Capture and Analysis Capacity
Risk-Readiness	Strong, Strategic Leadership	Administrative Depth

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2:05 PM – 2:35 PM

MLTSS/DUAL INTEGRATION

SARAH BARTH, JD

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Identify Medicare and Medicaid basics and distinctions:

- Eligibility requirements
- Program benefits

Identify the diverse demographics and needs of dually eligible individuals.

Discuss the current Medicare and Medicaid systems of care for individuals not enrolled in integrated programs, including state migration to Medicaid managed long-term services and supports (MLTSS).

Describe the efforts to date to integrate care through demonstrations and other program models.

Describe new Medicare-Medicaid integrated program opportunities.

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MEDICARE-MEDICAID DUAL ELIGIBLE POPULATION

- Over 12 million people nationwide are dually eligible for Medicare and Medicaid.
  - Some qualify for full Medicaid benefits, referred to as full benefit dually eligible individuals.
  - Some solely qualify for assistance with payment of Medicare premiums, and in some cases, Medicare cost sharing, referred to as partial benefit dually eligible individuals.
- Historically, dually eligible beneficiaries account for a disproportionate share of spending for both programs. They represent:
  - 20% of the Medicare population and 34% of Medicare spending
  - 15% of Medicaid beneficiaries and 33% of Medicaid spending

Source: CMS State Medicaid Director Letter #18-012, Ten Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare, December 2018.

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MEDICARE AND MEDICAID PROGRAM ELIGIBILITY

- Medicare
  - People age 65 and older
  - People under age 65 with certain disabilities
  - People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)
- Medicaid (must qualify categorically and financially)
  - Must cover certain groups of individuals including low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) referred to as mandatory eligibility groups
  - May optionally cover certain groups including individuals receiving home and community-based services, children in foster care not otherwise eligible, and single adults (ACA expansion population) with applicable financial eligibility requirements

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MEDICARE-MEDICAID DUAL ELIGIBLE POPULATION BENEFITS

+ Medicare is the primary payer for their care, mainly covering medical services (primary, acute, post-acute and pharmacy).
+ Medicaid wraps around Medicare benefits (LTSS, behavioral health, other).

Medicare

- ✓ Hospital care
- ✓ Physician & ancillary services
- ✓ Hospice
- ✓ Prescription drugs
- ✓ Durable medical equipment
- ✓ Skilled nursing facility (SNF) post-acute care (up to 100 days)
- ✓ Home health care (homebound only)

Medicaid

- ✓ Nursing home (once Medicare post-acute benefits exhausted)
- ✓ Home- and community-based services (HCBS)
- ✓ Wrap-around to Medicare (premiums and cost-sharing; services beyond Medicare limits, including pharmacy, home health, hospital)
- ✓ Optional services not covered by Medicare (vary by state): behavioral health, dental, vision, personal care, other)

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DIVERSITY OF MEDICARE-MEDICAID DUAL ELIGIBLE POPULATION

The dual eligible population is diverse in age, gender, race, ethnicity, language, chronic conditions, and disabilities, which include cognitive, behavioral and physical disabilities.

- Close to 60% are 65 years of age and older
- Disproportionately female at 61%
- 20% African American/non-Hispanic; 17% Hispanic
- 41% have at least one mental health diagnosis
- 68% have three or more chronic conditions
- Approximately 50% use LTSS
- 45% do not have a high school diploma
- Face many adverse social determinants of health (SDOH) – housing, transportation, food security, employment, health literacy, etc.

Much of this diverse group of consumers access health care and LTSS through fragmented and uncoordinated systems, which can contribute to poor health and quality of life outcomes and higher costs of care

Source: Beneficiaries Dually Eligible for Medicare and Medicaid, Data Book, jointly produced by Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC), January 2018.

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CURRENT DELIVERY SYSTEMS FOR DUALLY ELIGIBLE INDIVIDUALS

- The majority of dually eligible individuals must navigate multiple sets of rules and benefits to access health care and LTSS through fragmented, uncoordinated systems.
- Most receive primary and acute care medical services through Medicare fee-for-service (FFS) or a Medicare Advantage (MA) plan, while obtaining personal care services, adult day services and other HCBS from different Medicaid health plans and providers.
- There is often little or no communication between providers and coordinators across Medicare and Medicaid.
- Social services generally must be sought separately.

✓ **Medicare Advantage enrollment is voluntary – individuals may choose to enroll and disenroll.**
✓ **Medicaid managed care enrollment can be mandatory with lock-in for a specified period of time with disenrollment only "for cause".**

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MOVE TO MANAGED CARE FOR DUALLY ELIGIBLE INDIVIDUALS

- States are increasingly turning to managed care to deliver and coordinate care and support for Medicaid consumers with higher needs – many are dually eligible for Medicare and Medicaid.
  - 20+ states have Medicaid managed long-term services and supports programs.
  - There is an emphasis on care coordination, person-centered care planning, transitions between care settings, flexibility in services, cost efficiencies, and improved quality outcomes.
- Dually eligible beneficiaries are increasingly enrolling in Medicare managed care options. Enrollment:

Dually Eligible Beneficiaries	2006	2017
All	11%	35%
Partial benefit	18%	44%
Full benefit	10%	32%

Source: Data Analysis Brief: *Managed Care Enrollment Trends among Dually Eligible and Medicare-only Beneficiaries, 2006 through 2017*, CMS Medicare-Medicaid Coordination Office, December 2018.

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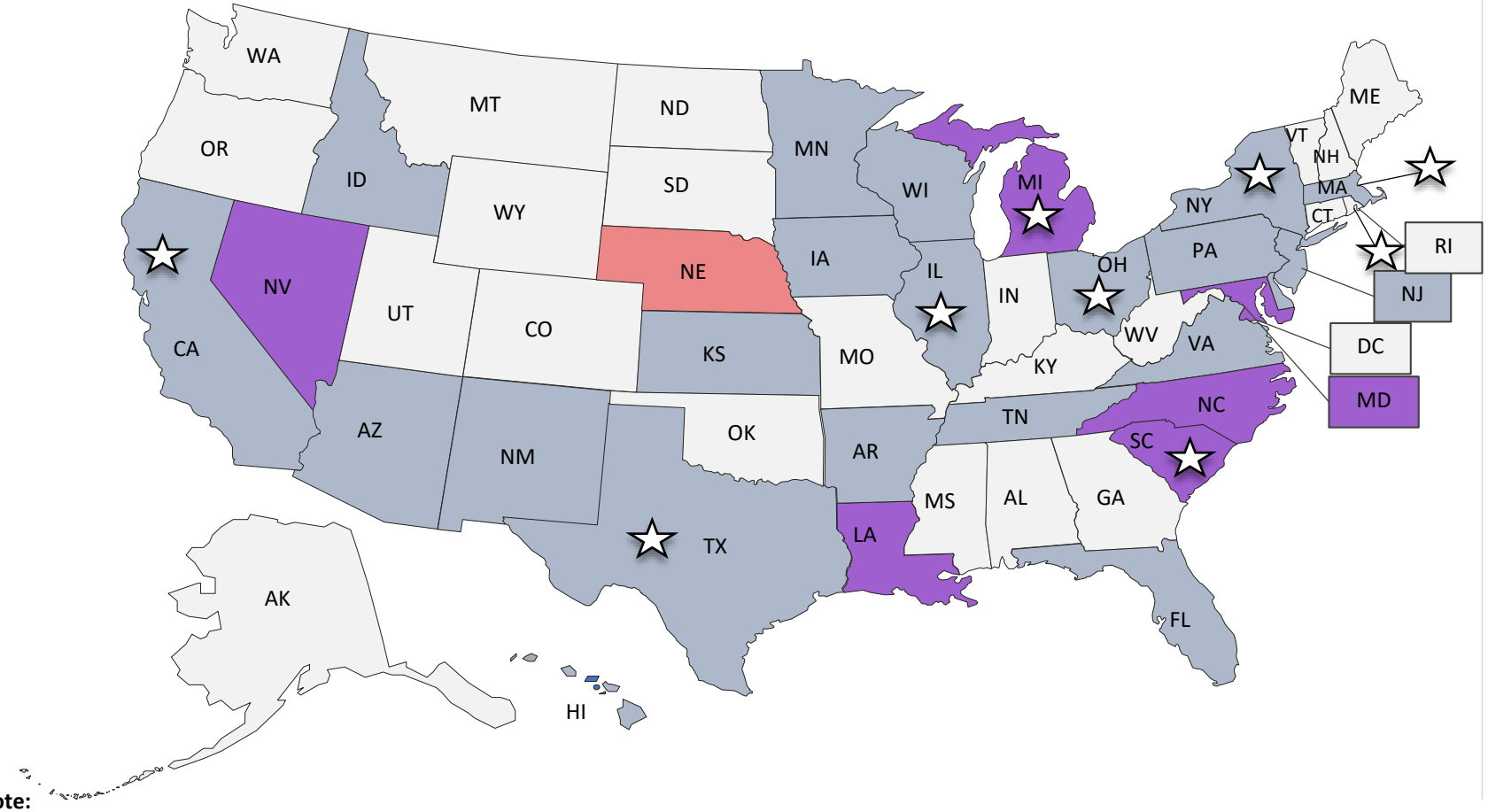
Medicaid Managed Long-term Supports and Services (MLTSS) Status

As of July 2019



Active MLTSS Program

Intends to Implement

Active capitated Duals Demo (MLTSS for duals in demo)

States to Watch for Potential MLTSS Activity

Note:

Provider-owned Arkansas Shared Savings Entities (PASSEs) began taking full risk March 1, 2019, covering individuals with significant behavioral health needs and those with intellectual or developmental disabilities.

ID began regional implementation of MLTSS for dually eligible individuals not enrolled in its FIDE SNP program - November 2018 in Twin Fall county, with a planned April 2019 expansion to Bonneville, Bingham, and Bannock counites.

In May 2019, the NE Senate advanced a bill that delays LTSS transition to managed care until July 1, 2021. Originally, Phase 1 populations (older individuals and individuals with physical disabilities) would have been carved in on January 1, 2020, with phase 2 populations (I/DD) to follow on January 1, 2021.

NY FIDA demonstration (dual demo) ends December 31, 2019; FIDA/IDD ends December 31, 2020.

HEALTH MANAGEMENT ASSOCIATES

STATE GOALS FOR MLTSS

Improve quality and lower costs

Accelerate movement to HCBS over institutional care

Integrate services through care coordination and management

Achieve person-centered care

Increase access to primary and preventive care

Reduce unnecessary hospital admissions and readmission, ED use

Slow loss of function

Administrative simplicity and budget predictability

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KEY COMPONENTS OF MEDICAID MLTSS

- Comprehensive care management and support including an assessment process that addresses functional status and support needs. Functional limitations:
  - ADLs (e.g., eating, bathing, dressing, and IADLs, (e.g., buying groceries, laundry, light cleaning)
- Proactive identification of change in condition/status to avoid preventable episodes of care
- Broad benefit package including an array of non-medical HCBS
- Integrated provider networks across a broad range of services (primary, acute, behavioral health and substance use, LTSS)
- Proactive engagement with stakeholders from design to implementation to program oversight

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STATE MLTSS PROGRAM DESIGNS VARY

- Eligibility: In addition to meeting financial eligibility status, states may set age criteria as well as apply one or more of the following:
  - Functional limitations
  - Developmentally disabled
  - Dual eligible status
  - Institutional status
- Voluntary versus mandatory enrollment
- Degree of integration With Medicare: partially to fully integrated models
- Benefits/services and carve-outs (HCBS waiver, nursing facility)
- Geographic service area (statewide, regions)
- Capitation/rate setting methodology

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CURRENT MEDICARE-MEDICAID INTEGRATED CARE MODELS

- Medicare-Medicaid Financial Alignment Initiative (FAI) Demonstrations
  - *Capitated model* – Medicare and Medicaid services are provided by Medicare-Medicaid plans (MMPs) under a three-way contract with CMS and the state (9 states).
  - *Managed fee-for-service model* – CMS and a state enter into an agreement through which the state would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid (1 state – Washington).
- Aligned Medicaid (MLTSS) and Dual Eligible Special Needs Plans (D-SNPs) with dual integration requirements in state Medicaid contracts (SMACs) that D-SNPs must follow in order to operate in a state.
- Medicare Advantage Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) that provide Medicare and required Medicaid benefits by a single health plan entity.
- Program of All-Inclusive Care for the Elderly (PACE) Under capitated payment, PACE provides all Medicare and Medicaid services primarily in an adult day health center (supplemented by in-home and referral services in accordance needs) to certain frail, elderly people age 55 and older still living in the community.

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CURRENT INTEGRATED MEDICARE-MEDICAID MANAGED CARE MODELS

Capitated Financial Alignment Initiatives (aka "dual demos")

9 States
(CA, IL, MA, MI, NY (2 FAIs), OH, RI, SC, TX)

Medicaid Managed Long-Term Services and Supports and MA D-SNP

10 states require Medicaid MLTSS plans operate a D-SNP (AZ, HI, ID, MA, NM, MN, PA, TN, TX, VA)

A few states require D-SNPs operate Medicaid MLTSS health plans (AZ, NJ, *TN)

Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP)

10 states
(AZ, CA, FL, ID, MA, MN, NJ, NY, TN, WI)

Program of All-Inclusive Care for the Elderly (PACE)

120 PACE programs in 31 states

*TN does not allow "new" D-SNP entrants that do not also operate a TennCare plan.

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THE GOALS OF DUAL ELIGIBLE INTEGRATION MODELS

Integrate primary and acute care, behavioral health services, and long-term services and supports

Improve individual and family experience of care

Increase overall quality of care

Appropriate utilization of services

Align finances and reduce costs

Align administrative policies and procedures (beneficiary materials, enrollment processes, grievances and appeals)

INTEGRATED PRODUCTS THROUGH HEALTH PLANS

- Alignment between Medicare and Medicaid varies from full alignment to no alignment.
- Full alignment is widely recognized as needed for FBDE population.

#	Illustrative Continuum: The role that MMPs and D-SNPs play in driving integration and alignment.	ALIGNMENT		Degree of Integration Based on Medicaid Coverage		
	HIGH		Requirements: care coordination data sharing	Medicare Cost Sharing	Some Medicaid services	All Medicaid services
1	Medicare-Medicaid Plans (MMPs)	Full	x	x		x
	D-SNP-Based Integration					
2	FIDE SNPs	Full	x	x		x
3	D-SNP Contract	Less than Full	x	x	x	
4	D-SNP Contract	Modest	x	x		

Note: PACE is not included on this chart, since the chart focuses on plans.

Source: U.S. Department of Health and Human Services. Integrating Care through Dual Eligible Special Needs Plans : Opportunities and Challenges. April 2019. Retrieved from https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges

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RECENT REGULATORY SUPPORT FOR INTEGRATION (1 OF 4)

- SNP Provisions in Bi-Partisan Budget Act of 2018
  - Permanent SNP authorization supporting MLTSS+D-SNP as a more "permanent" model/pathway for integration
  - Strengthened authority of CMS Medicare-Medicaid Coordination Office (MMCO) to develop rules and guidance regarding D-SNPs and provide resources to states to support using D-SNPs as integration model
    - Improve integration and coordination for D-SNPs
    - Unify grievances and appeals for services and items provided by D-SNPs
- Default Enrollment - August 2018 CMS guidance
  - Individuals enrolled in a Medicaid managed care plan when they become eligible for Medicare are automatically enrolled in the D-SNP offered by the same organization
  - Plans must have state approval to use default enrollment and state commitment to provide monthly data to identify Medicaid plan members approaching Medicare eligibility

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RECENT REGULATORY SUPPORT FOR INTEGRATION (2 OF 4)

- **CMS April 24, 2019, State Medicaid Director Letter (SMDL) extends new dual integration demonstration opportunities.**
  - Revise or continue current FAI capitated models via multi-year extensions and expand to new geographic areas within the state
  - Initiate new capitated FAI programs
  - Initiate new managed FFS FAI programs similar to Washington
  - Pursue state-specific models based on the FAIs or other delivery system reforms (e.g., alternative payment methodologies, value-based purchasing, or episode-based bundled payments)

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RECENT REGULATORY SUPPORT FOR INTEGRATION (3 OF 4)

- **Medicare Advantage (MA) Calendar Year 2020 and 2021 Final Rule**
  - Identifies three types or levels of D-SNPs health plans may offer, subject to obtaining SMACs and CMS application approval.
  - All participating health plans must coordinate the delivery of Medicare and Medicaid services for eligible individuals.
  - Each type or level of D-SNP has varying service provision, integration, and unified grievance and appeals requirements.

Source: Centers for Medicare & Medicaid Services. Contract Year 2020 Medicare Advantage and Part D Flexibility Final Rule. April 2019. https://www.cms.gov/newsroom/fact-sheets/contract-year-2020-medicare-advantage-and-part-d-flexibility-final-rule-cms-4185-f

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CY 2020 AND 2021 MA RULE D-SNP CATEGORY OVERVIEW (4 OF 4)

Dual Eligible Special Needs Plan (D-SNP) that is not a HIDE or FIDE SNP

Must meet additional state Medicaid agency contract requirements for integration, which include sharing data on hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals enrolled in the D-SNP, as determined by the state. They may also provide coverage of Medicaid services, including LTSS and BH for eligible individuals.

Highly Integrated Dual Eligible Special Needs Plan (HIDE SNP)

Offered by a MA org whose parent org or another entity owned or controlled by the parent org covers Medicaid LTSS and/or BH under contract with the state. Those with exclusively aligned enrollment are clinically and financially responsible for provision of Medicare and required Medicaid benefits and must conduct unified grievances and appeals.

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

Under capitated contract with state to cover specified primary care, acute care, BH, and LTSS, and cover nursing facility services for at least 180 through the same entity with a CMS contract to be a MA plan.
Requirements: Coordinate delivery of Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; Coordinate or integrate enrollee materials, enrollment, communications, grievance and appeals, and quality improvement

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BREAK

2:35 PM – 2:50 PM

2:50 PM – 3:30 PM

DELIVERY SYSTEM REFORM

BETSY JONES, MBA, MSW
JEAN GLOSSA, MD, MBA, FACP

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Recognize delivery system reform and practice transformation initiatives, including the basics on Delivery System Reform Payment (DSRIP) Program, Accountable Care Organizations, behavioral health integration, telemedicine, medical homes, social determinants of health, and person-centered care.

Identify the core features of a select set of programs and how they bring value in improved access and quality care for the Medicaid member.

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PRESENTATION CONTENTS

- DSRIP basics – scaffolding for delivery system reform
- Key words – value-based purchasing, integrated care, population health, quality outcomes, accountability
- Related delivery system innovations
  - Health Homes
  - Collaborative Care (behavioral health integration)
  - Tele-psychiatry

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DSRIP WAIVER BASICS

OVERVIEW

- State and federal policymakers have expressed interest in reforming the health care delivery system to use resources more efficiently and direct resources in ways that improve health outcomes and population health.
- States have implemented various strategies for changing health care delivery in their Medicaid programs, including delivery system reform incentive payment (DSRIP) programs.
- Thirteen states have implemented DSRIP or DSRIP-like programs that invest in provider-led projects designed to advance statewide delivery system reform goals.
- California implemented the first DSRIP program in 2010. Since then, 12 additional states—Alabama, Arizona, Kansas, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Texas, and Washington—have implemented DSRIP or DSRIP-like programs. All of these efforts have been approved as part of broader demonstrations under Section 1115 of the Social Security Act.

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PROGRAM DESIGN

DSRIP is a mechanism for providing Medicaid payments to qualifying organizations implementing infrastructure and care transformation initiatives that support state and federal delivery system reform goals.

Each state adapts this framework to its specific Medicaid program goals, as negotiated between the state and CMS.

These programs allow states to make supplemental payments to providers that otherwise would not be permitted under federal managed care rules and to invest in provider-led projects to advance statewide delivery system reform goals.

As of June 2017, $48.6 billion in state and federal funds had been approved for such efforts.

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FOCUS ON REFORM

- Key differences between early DSRIP programs (approved prior to 2014) and more recent programs:
  - increased focus on delivery system reform goals
  - increased use of provider partnerships
  - the addition of statewide performance milestones
  - more standardized monitoring and evaluation requirements
  - requirements to develop plans for sustaining DSRIP activities through value-based purchasing strategies in managed care

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WASHINGTON STATE: KEY COMPONENTS OF STATEWIDE ACCOUNTABILITY

- 100% of total DSRIP incentives are at risk if the state fails to demonstrate statewide integration of physical and behavioral health managed care by January 2020.
- For years 3 to 5, a portion of DSRIP incentives will be at risk depending on the state's advancement of quality and VBP goals.
- DSRIP incentives are available to reward MCO adoption of value-based payment models. These incentives are referred to as MCO VBP Incentives and are earned on the basis of Pay for reporting (P4R) and Pay for performance (P4P).
- Quality Goals (next slide)

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WASHINGTON STATE: STATEWIDE ACCOUNTABILITY QUALITY METRICS

- All-Cause Emergency Department Visits per 1,000 Member Months Antidepressant Medication Management
- Comprehensive Diabetes Care: Blood Pressure Control Comprehensive Diabetes Care: Hemoglobin A1c
- Poor Control (>9%) Controlling High Blood Pressure (<140/90)
- Medication Management for People with Asthma: Medication Compliance 75% Mental Health Treatment
- Penetration (Broad)
- Plan All-Cause Readmission Rate (30 days) Substance Use Disorder Treatment Penetration
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

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WASHINGTON ACCOUNTABLE COMMUNITY OF HEALTH: KING COUNTY PROJECT PORTFOLIO

- **Bi-directional Integration of Physical and Behavioral Health:** Integrated Whole Person Care
- **Transitional Care:** Increased safe and successful transitions for those leaving jail and hospitals
- **Addressing the Opioid Crisis:** Expanded access to appropriate services and treatment for Opioid Use Disorder and improved prescribing practices
- **Chronic Disease Prevention and Control:** Expanded community and self-management supports for those with chronic conditions

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HEALTH HOME PROGRAMS

HEALTH HOME POLICY BACKGROUND

- “Health Homes” (HHs) were authorized as a Medicaid State Plan Option under the Affordable Care Act, Section 2703.
- Optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions
- The Centers for Medicare & Medicaid Services (CMS) expects states health home providers to operate under a "whole-person" philosophy.
- Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.
- As of March 2019, 23 states and DC have implemented 35 HH models.

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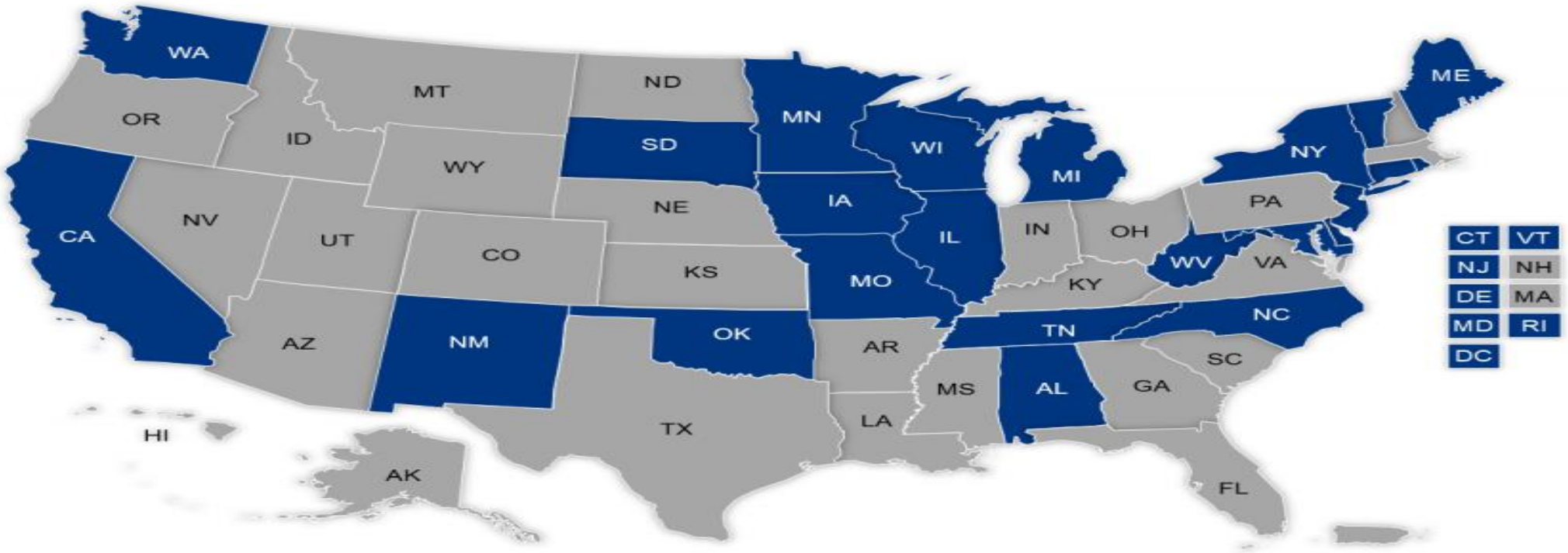
HEALTH HOMES MODELS NATIONWIDE

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Approved Medicaid Health Home State Plan Amendments *(March 2019)*



As of March 2019, 23 states and the District of Columbia have a total of 38 approved Medicaid health home models.

States with Approved Health Home SPAs (number of approved health home models)	Alabama, California (2), Connecticut, Delaware, District of Columbia (2), Illinois, Iowa (2), Maine (3), Maryland, Michigan (3), Minnesota, Missouri (2), New Jersey (2), New Mexico, New York (2), North Carolina, Oklahoma (2), Rhode Island (3), South Dakota, Tennessee, Vermont, Washington, West Virginia (2), Wisconsin

Note that Idaho, Kansas, Ohio, and Oregon have terminated their Medicaid health home state plan amendments and are no longer providing health home services.

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HEALTH HOME BENEFICIARIES

- Health Homes are for people with Medicaid who:
  - Have two or more chronic conditions
  - Have one chronic condition and are at risk for a second
  - Have one serious and persistent mental health condition
- Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease, and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval.
  - States can target health home services geographically.
  - States cannot exclude people with both Medicaid and Medicare from health home services.

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HEALTH HOME SERVICES: WHOLE PERSON CARE

Services include the following:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

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States have flexibility to determine eligible health home providers.

Health home providers can be:

A designated provider:

- May be a physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other provider

A team of health professionals:

- May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, and can be free-standing, virtual, hospital-based, or a community mental health center

A health team:

- Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractors, licensed complementary and alternative practitioners

- **HH have created pathways and systems for integration by:**
  - Shared electronic medical records between behavioral and physical health providers;
  - Embedded mental health professionals in primary care and primary care consultants in mental health clinics;
  - Depression and substance use screenings in primary care; and
  - Co-location of behavioral and physical care within a building or clinic.

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HEALTH HOME OUTCOMES

- May 2018: Report to Congress on Health Home State Plan Option

- The evaluation covers the first 13 programs in the first 11 states to launch health homes: Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, and Wisconsin.

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HEALTH HOME OUTCOMES | 6 KEY LESSONS LEARNED

1. Using the health home state plan option allows states to target high-cost, high-need patients; initial results suggest potential for improvements in care utilization patterns, costs (five states), and quality (four states).

2. The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from health homes.

3. Initial and continuing assistance with practice transformation and team-based care is important, particularly to address the behavioral health needs and social determinants of health that impact patients.

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HEALTH HOME OUTCOMES: 6 KEY LESSONS LEARNED (CONT.)

4 Well-developed HIT and other infrastructure is needed for care coordination and quality improvement.

5 Health home programs show promise in effectively addressing needs of individuals with complex chronic physical and mental health conditions and substance use disorder, particularly those who also have high social needs.

6 Most of the early health home states continue to offer the health home benefit beyond their initial enhanced match period, which suggests that states have found value and promise in the health home model for improved care for their chronically ill populations.

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COCM (BHI)

- Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of "whole-person care," is a rapidly emerging shift in the practice of high-quality health care. It is a core function of the "advanced patient-centered medical home."

- Integrated behavioral health care is sometimes called "behavioral health integration," "integrated care," "collaborative care," or "primary care behavioral health." No matter what one calls it, the goal is the same: better care and health for the whole person.

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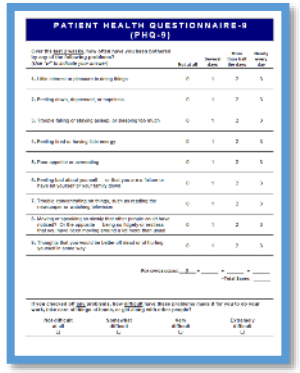
EFFECTIVE INTEGRATED CARE

Informed,
Activated Patient

Effective Collaboration

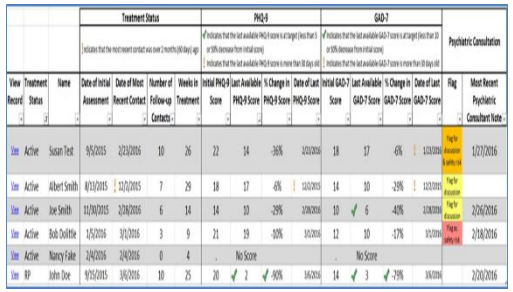
PRACTICE SUPPORT

PCP supported by Behavioral Health Care Manager



Measurement-based
Treat to Target

Psychiatric
Consultation



Caseload-focused
Registry review

Training

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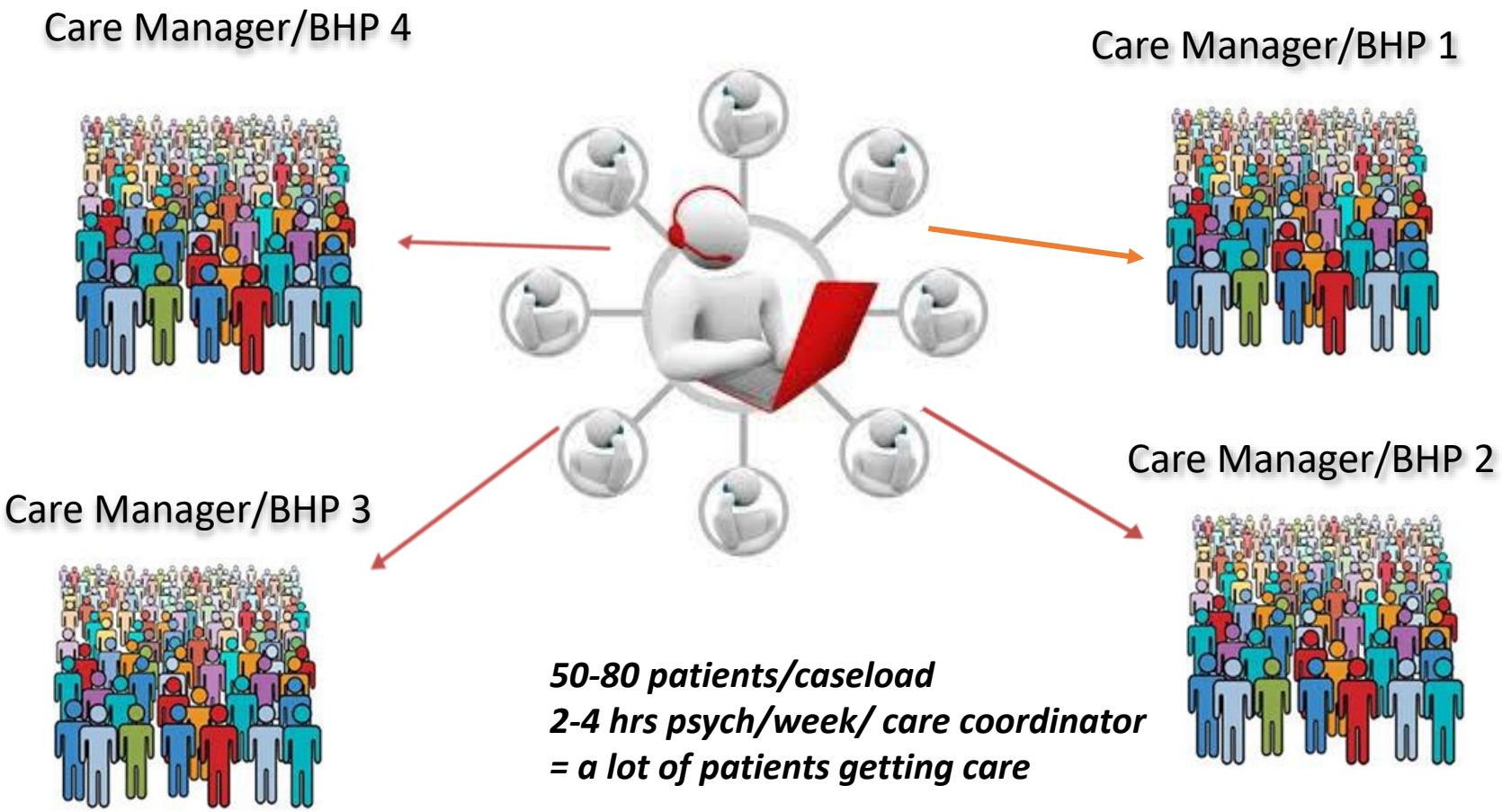
PSYCHIATRIC PROVIDERS SUPPORTING TEAMS: LEVERAGES EXPERTISE ACROSS LARGER POPULATIONS IN NEED



50-80 patients/caseload
2-4 hrs psych/week/ care coordinator
= a lot of patients getting care

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MEDICAID & TELEHEALTH

JEAN GLOSSA, MD

HEALTH MANAGEMENT ASSOCIATES

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DEFINITIONS

Telemedicine/Telehealth **mHealth; digital health** **Virtual visits**	▪ Telehealth conveys a more broad scope of technology based exchange of information for medical care and health and wellness; TM is more specific to a provision of provider based medical care; used interchangeably with some specific exceptions; mhealth/digital health more consumer focused.
Originating site **Remote/distant site**	▪ OS: location of the patient at the time of the service ▪ RS: location of the provider at the time of the service ▪ Providers must be licensed in OS state; credentialed at OS facility; follows all regulations of OS medical boards; malpractice ▪ Payment depends on OS/RS restrictions; varies per state
Store and Forward	▪ Asynchronous exchange of health information
Remote Patient Monitoring	▪ Usually asynchronous transmission of health metrics such as vital signs, glucose readings, motion sensors
Direct to Consumer	▪ Patient initiated from non-clinical location
Telepresenter	▪ Individual assisting patient during medical encounter
Peripherals	▪ Equipment used during TM visit to collect and transmit clinical images or recording

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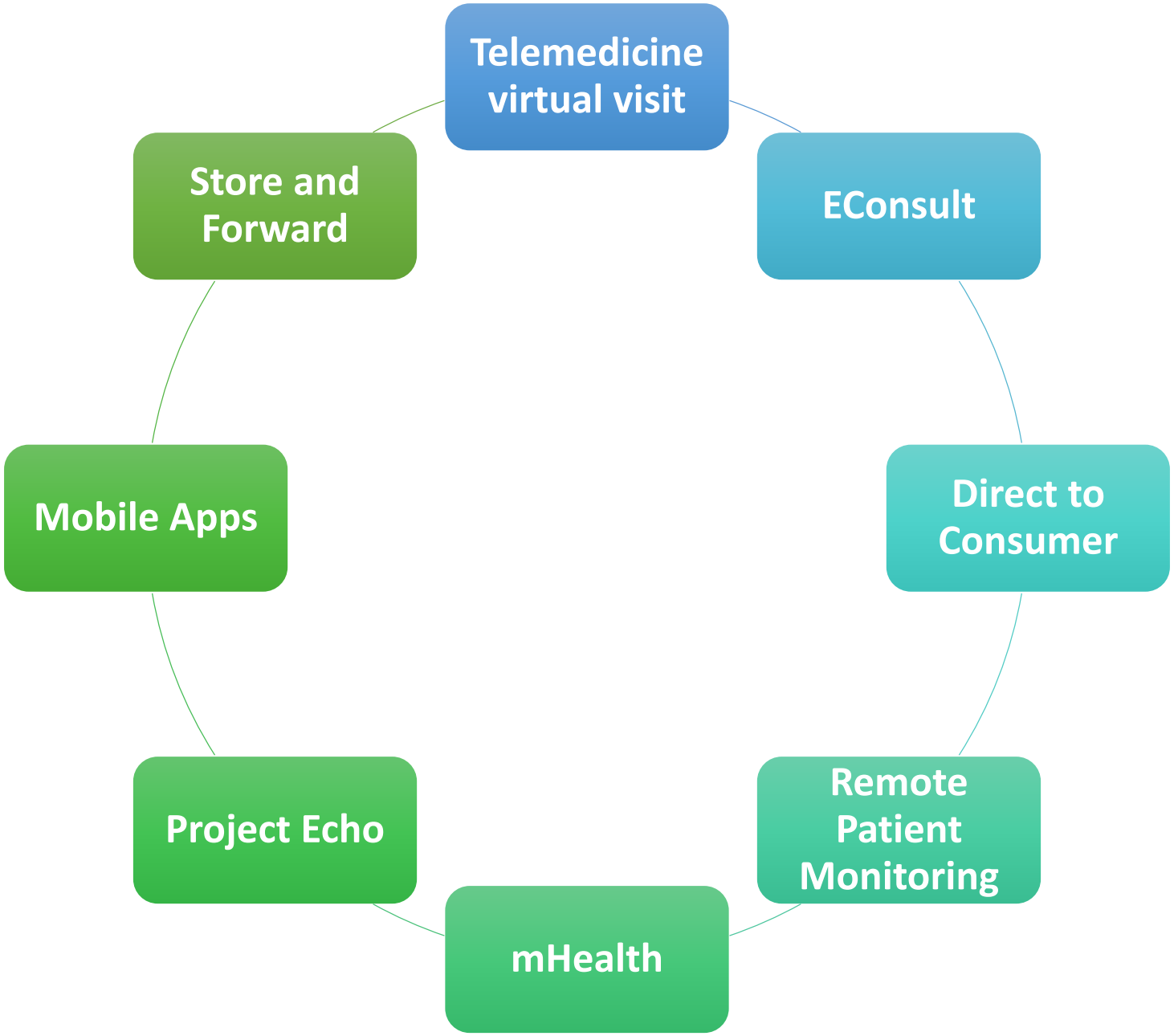
Telemedicine virtual visit
EConsult
Direct to Consumer
Remote Patient Monitoring
mHealth
Project Echo
Mobile Apps
Store and Forward

STANDARDS AND GUIDELINES

- American Telemedicine Association (**ATA**) Accreditation
- ClearHealth Quality Institute (**CHQI**)
- Utilization Review Accreditation Commission (**URAC**)
- Joint Commission on the Accreditation of Healthcare Organizations (**JCAHO**)
- National Committee for Quality Assurance (**NCQA**) certification for credentialing
- Telemedicine training programs

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Telehealth policy trends continue to vary from state-to-state, with no two states alike in how telehealth is defined, reimbursed or regulated. A general definition of telehealth used by CCHP is the use of electronic technology to provide health care and services to a patient when the provider is in a different location.

49 states and the District of Columbia (D.C.) have a definition for telehealth, telemedicine, or both

Medicaid Policy Trends

Live video Medicaid reimbursement continues to far exceed reimbursement for store-and-forward (S&F) and remote patient monitoring (RPM). Massachusetts' Medicaid program recently began reimbursing for mental and behavioral health delivered via telehealth. **Eleven** state Medicaid programs reimburse for store-and-forward and **twenty-one** states reimburse for remote patient monitoring (RPM), with additional states having laws requiring Medicaid reimbursement for store-and-forward or RPM, yet no official written policies indicating that such policy has been implemented.

11 Medicaid programs reimburse for S&F

50 states and D.C. reimburse for live video

21 Medicaid programs reimburse for RPM

14 states reimburse service to the home

Many of the reimbursement policies that do exist continue to have restrictions and limitations, creating a barrier to utilizing telehealth to deliver services. One of the most common restrictions is a limitation on where the patient is located, referred to as the originating site. While most states have dropped Medicare's rural geographic requirement, many Medicaid programs have limited the type of facility that can serve as an originating site, often excluding a patient's home from eligibility. However, **fourteen** states (DE, CO, MD, MI, MN, MT, NH, NV, NY, SC, TX, VT, WA and WY) have policies to explicitly allow the home to be an eligible originating site under certain circumstances.

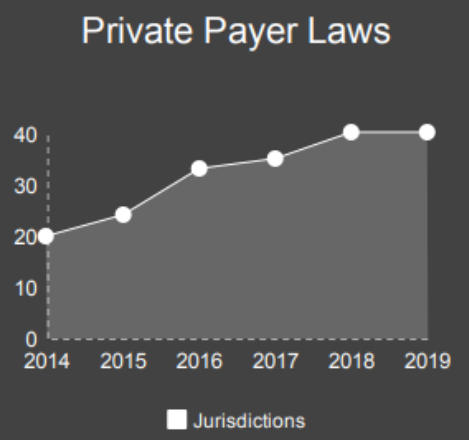
Other Common Telehealth Restrictions

- The specialty that telehealth services can be be provided for
- The types of services or CPT codes that can be reimbursed (inpatient office, consult, etc.)
- The types of providers that can be reimbursed (e.g. physician, nurse, etc.)

Private Payer Reimbursement

39 states and the District of Columbia have laws that govern private payer reimbursement of telehealth. There was no increase since Fall 2018. Some laws require reimbursement be equal to in-person coverage, however most only require parity in covered services, not reimbursement amount. Not all laws mandate reimbursement.

39 states and the District of Columbia have active laws

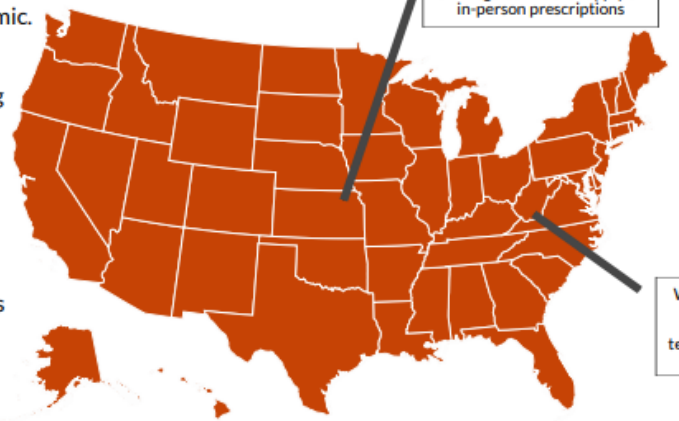


Online Prescribing

Most states consider an online questionnaire only as insufficient to establish the patient-provider relationship and prescribe medication. Some states allow telehealth to be used to conduct a physical exam, while others do not. Some states have relaxed requirements for prescribing controlled substances used in medication assisted therapy (MAT) as a result of the opioid epidemic.

More and more states are passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards.

Internet/online questionnaires are not adequate; states may require a physical exam prior to a prescription



29 states and D.C. participating in Interstate Medical Licensure Compact

Licensure

Nine state boards issue licenses related to telehealth allowing an out-of-state licensed provider to render services via telehealth. Licensure Compacts have become increasingly common. For example:

- **29 States and D.C.:** Interstate Medical Licensure Compact
- **33 States:** Nurse Licensure Compact
- **25 States:** Physical Therapy Compact
- **9 States:** Psychology Interjurisdictional Comp act (PSYPACT)

Source: Center for Connected Health Policy
https://www.cchpca.org/sites/default/files/2019-05/50-State%20Infograph%20Spring%202019%20FINAL.pdf

PROCUREMENT QUESTIONS RELATED TO THE USE OF TELEMEDICINE / TECHNOLOGY

Florida

- The respondent shall **describe its overall approach to utilizing telemedicine services** to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network …

Washington

- How will the Bidder implement **alternative care options**, including but not limited to: **Use of telemedicine, telepsychiatry, telepsychology, and remote psychiatric case review** and consultation to the primary care team for rural, urban or geographically isolated communities…

Pennsylvania/HealthChoices

- Describe your **experience using technology such as telehealth, social media or other methods** to engage members in managing their health care benefits and provide access to resources.

  How do **you assess the effectiveness of the use of technology to achieve improved health outcomes?**

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PROCUREMENT QUESTIONS RELATED TO THE USE OF TELEMEDICINE / TECHNOLOGY

Colorado

- The Contractor shall promote and ensure the use of the Department-adopted electronic consultation software, through which specialists consult with PCMPs via a telecommunication platform.

  (sic) Econsult has been shown to improve access, satisfaction and quality of care

Oklahoma/SoonerHealth*

- Provide an example of one of your benchmark programs of an innovative approach you took to **improve member health outcomes through social media**, the results achieved and how you will apply this experience to SoonerHealth.

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PROCUREMENT QUESTIONS RELATED TO THE USE OF TELEMEDICINE / TECHNOLOGY

North Carolina:

- The PHP shall pilot new approaches to telemedicine and value-based payment and shall support providers in optimizing the use of telemedicine in their practices.
- Experience with innovative telemedicine modalities and pilot programs in other states/markets, and the proposed telemedicine approach to encourage use of telemedicine, including types of programs, and targeted providers, geographies (including rural), services, and members

Washington DC:

- The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

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3:30 PM – 4:00 PM

WAIVERS AND INTRODUCTION TO PRESCRIPTION DRUGS

MATT POWERS

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Identify the primary focus of waivers (1115) and how states are typically using them (e.g. work requirements; health savings accounts; Medicaid expansions), as well as other waiver options such as 1332 waivers which are directed more at the Marketplace.

Describe the unique nature of the Medicaid drug benefit including preferred drug lists (PDLs), common PDLs, the extent to which MCO and state FFS drug benefits interact, new reimbursement tweaks from states and drug spending and policies in context of overall health care spending and health policy on the public and private side.

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WAIVERS ARE A MECHANISM FOR STATES TO ASK CMS FOR PERMISSION TO TEST IDEAS THAT DEVIATE FROM THE SOCIAL SECURITY ACT

- Social Security Act: Roots of Waivers – Section 1115, 1915, 1332
- Passing Federal tests including budget neutrality, state wideness
- Big picture observations about waiver approval process including Federal/State priorities, State Plan Amendments and/vs. waivers
- What used to be waivers are now fundamental part of programs
  - Risk-based managed care; coverage expansions; family planning
- While fundamental program elements have waiver roots, much of the current energy around waivers is with:
  - Work or community engagement requirements
  - Improving behavioral health
  - Home and community supports (still hanging steady)
  - Always stay tuned! Discussion around the finer points of waivers (e.g. DSRIP, CNOM) vs. Medicaid provisions like quality, P4P, MCO contract

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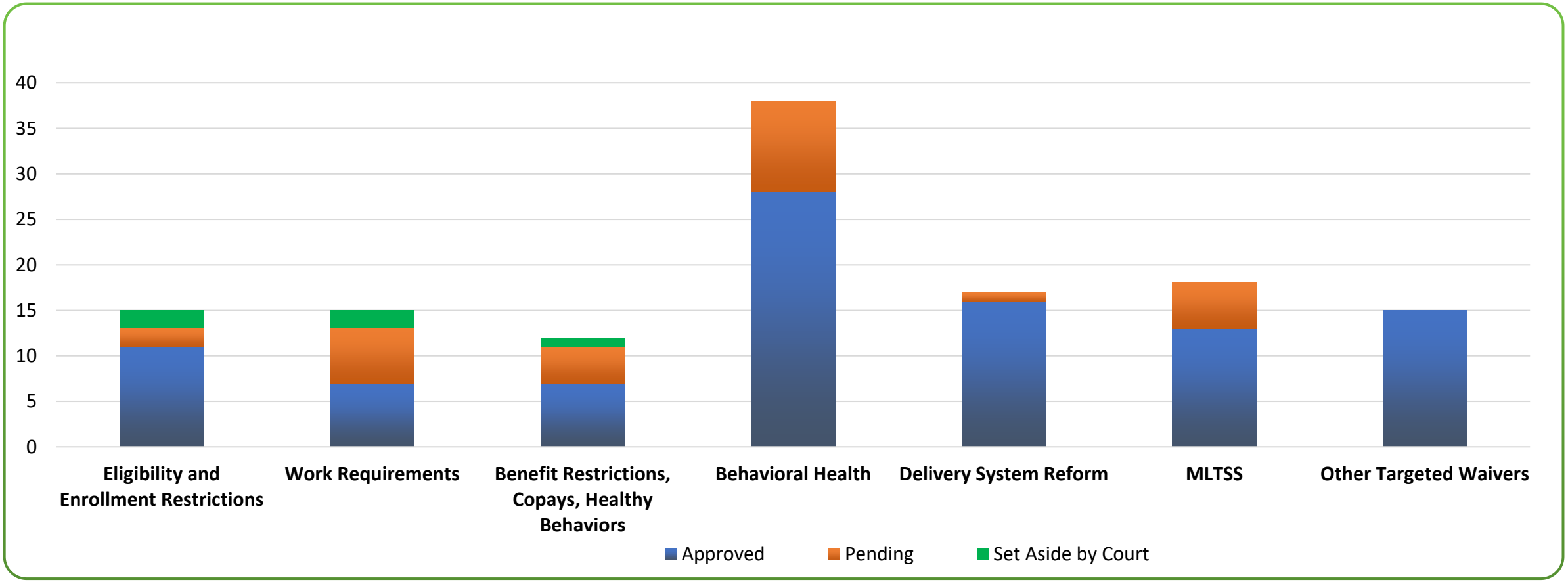
LANDSCAPE OF APPROVED AND PENDING SECTION 1115 WAIVERS

+ Medicaid Demonstration Waivers, April 1, 2019



NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page.
"MLTSS" = Managed long-term services and supports.

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MEDICAID DRUG BENEFIT – HOW IT FITS AND HOW IT WORKS

SPENDING IN CONTEXT FROM CMS AND ACTUARIAL POINT OF VIEW

OPTIONAL SERVICE

NUANCE OF MANDATORY COVERAGE AND PRIOR AUTHORIZATION

PREFERRED DRUG LISTS – DISCUSSION INCLUDING COMMON PDLS

CARVING AND CARVING OUT

MEETING STATES WHERE THEY ARE – TRENDS IN PHARMACY INCLUDING TEEING UP OPIOID CONVERSATION

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2019 MEDICAID PHARMACY COST-CONTAINMENT STRATEGIES

STATES REPORTED:

MCO Pharmacy Policies

(35 of 39 MCO states carve-in Rx)

- Uniform clinical protocols
- Uniform PDLs (to maximize rebates)
- Risk sharing or mitigation (e.g., carve-outs, kick payments, risk pools)
- Value-based Purchasing for Rx (CO, MI, OK)

Pharmacy Cost-Containment Actions

- Initiatives to increase rebates
- Utilization controls
- Ingredient cost reductions
- Medication therapy management, case management, or adherence programs
- Pharmacy vendor contracting

SOURCE: HMA, based on: Kathleen Gifford, et al., *"States Focus on Quality and Outcomes Amid Waiver Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2018 and 2019,"* KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2018. www.kff.org

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4:00 PM – 4:30 PM

PHARMACY DEEPER DIVE & STATE EXPECTATIONS OF MCO SOLUTIONS

COREY WALLER, MD, MS, FACEP, DFASAM

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Compare how Medicaid payers (states and/or plans) decide how to reimburse medications for SUD.

Recognize the ROI on long term medications for OUD.

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LEARNING OBJECTIVES

Discuss the strategies the Medicaid state agencies and plans use to address impact of the epidemic in their members.

Describe how payers cross walk the challenges of the opioid epidemic to their daily operations such as quality metrics, contract provisions, providers, network adequacy, prior authorizations, and P4P metrics.

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THE CRYSTAL BALL: WHAT WE ARE SEEING FOR THE SHORT & LONG TERM

DONNA CHECKETT, MPA, MSW

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Identify the key learnings from today's session and consider what to look for in the near term.

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MEDICAID EXPANSION WILL CONTINUE TO BE HOT TOPIC FOR HOLD-OUT STATES

Work requirements and other "price of entry" requirements will remain moral high-grounds for some states and federal government until resolved by the courts.

Look for debate to end in some states by the voters via ballot, by governors/ legislatures desperate for solutions for rural health care access, and ultimately by the courts.

STATE AND FEDERAL GOVERNMENT WILL CONTINUE TO STRUGGLE WITH OWNERSHIP OF THE PROGRAM

What is the true meaning of the Federal-State partnership?

How much can be waived, by whom, when and why?

When do "state flexibility and health care transformation" too fundamentally change the principles of the program?

Look for this struggle to continue for many years, changing somewhat depending on which party controls the White House and the individual preferences of HHS/CMS administrators/state governors and Medicaid leadership.

MEDICAID MANAGED CARE JUGGERNAUT APPEARS UNSTOPPABLE

Market Consolidation: Who is left to be acquired by whom? Do the states ultimately care as long as there is enough choice to satisfy federal requirements?

Watch for new and nontraditional players to enter the market—CVS, Amazon, Walgreens.

Look for MCO growth to continue despite continually dissatisfied critics.

Look for states to raise the bar for market entry via rigorous RFPs, carefully managed scoring processes and efforts to "protest-proof" the final contracts.

HEALTH CARE COST CONTAINMENT DEBATES WILL CONTINUE IN THE FORM OF RIGHTEOUS INDIGNATION

Pharmacy/PBM/the "true" cost of drugs will continue to be debated. Government health care payers will continue to demand more transparency in pricing and access.

Look for Pharma to continue its lobbying and for the American consumer to continue to demand access to all drugs at any price.

RECOGNITION OF THE ROLE OF SOCIAL DETERMINANTS OF HEALTH WILL CONTINUE TO GROW

Watch for the big conversation to shift from “who is responsible for paying for SDOH” to “how do systems leverage federal and state resources in order to meaningfully address health equity”.

Look for states to continue to seek solutions for the problems that have beset us since the dawn of mankind through creative financing, 1115 waivers, and mandatory provision of services through MCO contracts.

STATES CONTINUE TO USE RFPS TO TRANSFORM HEALTH CARE, MEET LEGISLATIVE MANDATES (NO MATTER HOW IRRATIONAL), AND SOLVE FUNDING, ACCESS AND RESOURCE SHORTFALLS

What will take for a vendor to say No to an opportunity?

Look for the enormous Medicaid spend to continue to draw businesses to the Medicaid space, despite traditionally low margins and high price of entry.

BEHAVIORAL HEALTH AND ITS MANY ASPECTS AND NUANCES WILL CONTINUE TO DOMINATE THE CARE MANAGEMENT WORLD

Will the carve in-carve out debate ever end? Will there ever be enough money in the system to meet the needs of the members?

As the major purchaser of care for individuals living with serious mental illness, look to Medicaid agencies and partner mental health/SUD authorities to continue to seek solutions via integrated care, trauma-informed approaches, IMD/SUD waivers.

VALUE-BASED PURCHASING EXPECTATIONS WILL BECOME MORE SOPHISTICATED AS STATES RECOGNIZE THE COMPLEXITY OF CREATING TRUE "VALUE" FOR PROVIDERS, MEMBERS, PAYERS AND BUYERS

Look for managed care RFPs to contain increasingly stringent VBP targets along with hefty carrots and sticks linked to plan performance.

Health Plans will no longer be able to just check the boxes and providers no longer able to protect FFS.

States will transition from crude VBP measures to:

- What portion is in shared savings model
- What portion is at financial risk
- How much of overall payment is APM versus FFS

A MORE COMPASSIONATE UNDERSTANDING OF THE CYCLE OF INCARCERATION AND THE IMPACT OF SOCIAL INEQUITY, RACE, INCOME AND THE IMPACT OF MENTAL ILLNESS WILL FINALLY GAIN TRACTION

Is this the year we finally recognize that homelessness and mental illness are not solved by incarceration? What will it take to make sure people fighting addiction have access to life-saving medications while in jails and prison?

Look for these connections to finally be made on a more national scale than ever before. Look for the Justice- involved population to begin to get long-overdue attention.

TECHNOLOGY SOLUTIONS – IN THE FORM OF TELE-HEALTH, POWERFUL AI SYSTEMS, AND EVEN APPS FOR MEDICAID MEMBERS – WILL CONTINUE TO GROW

Look for increasing focus on using technology to manage chronic diseases at lower cost, outside the clinic setting and helping older/people with disabilities live at home.

How can we measure effectiveness and outcomes?

How can we be sure Medicaid members can access smart phone technology?

Look for more sophisticated data analytics to continue to try to predict high cost members (the holy grail of data analytics).

THE PAIN AND CHALLENGE OF ADDICTION WILL CONTINUE TO DOMINATE THE MEDIA WHILE CHALLENGING PUBLIC HEALTH OFFICIALS, HEALTH CARE PROVIDERS, PAYERS, FAMILIES AND USERS

Will it ever end? Look for funding to potentially slow pending litigation outcomes

Building treatment systems for all drugs of abuse, not just opioids

Understanding addiction as a chronic disease and treating it in PCP offices, clinics

Finding community wide solutions such as InCK and MOM models

DEMANDS ON STATE MEDICAID AGENCIES – LEADERSHIP CAPABILITIES, RESOURCE AVAILABILITY, AND UNBELIEVABLE PRESSURE TO SOLVE FUNDING, ACCESS AND SOCIAL PROBLEMS THROUGH WAIVERS AND STATE PLAN AMENDMENTS – WILL CONTINUE UNABATED

Look for states to continue to raise the bar of expectations from providers and vendors.

Look for tremendous market growth to continue unabated while Medicaid directors ask tough questions about what works.

4:40 PM – 5:00 PM

DIGGING DEEPER: QUESTIONS & ANSWERS

HEALTH MANAGEMENT ASSOCIATES

LEARNING OBJECTIVES

Restate key learnings from today's session.

Question more complex issues and nuances of specific topics presented today.

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THANK YOU!

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Donna Checkett, MPA, MSW

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Jean Glossa, MD, MBA, FACP

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5:00 PM – 6:00 PM

Please Join Us for a Reception!

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HEALTH MANAGEMENT ASSOCIATES