CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Exploring Strategies for Managing Costs Associated with SDOH Interventions

Texas MCO SDOH Learning Collaborative

January 19, 2021

12:30-2:00 PM CT

With support from the Episcopal Health Foundation

Rules of Engagement

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- To ask a question, click the raise hand feature located at the bottom of the Participants window. We will call on you, and then you should unmute your line to ask your question.
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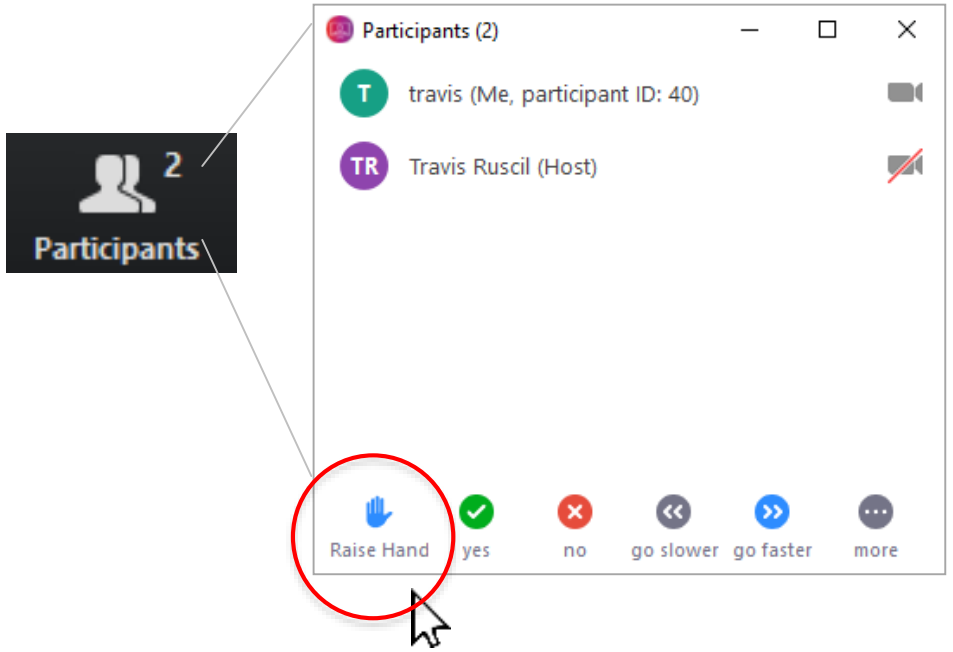

Meet Today's Presenters

Diana Crumley,
Senior Program Officer,
Center for Health Care Strategies

Justin Birrell,
Principal and Consulting Actuary,
Milliman

Shao-Chee Sim,
Vice President for Applied Research,
Episcopal Health Foundation

Jeff Milton-Hall,
Consulting Actuary,
Milliman

Jennifer Quereau,
Senior Policy Advisor,
Health and Human Services Commission

For Today's Session

Review how SDOH-related activities are being classified and reported, with a specific emphasis on "activities that improve health care quality" (i.e., QI)

Identify what additional guidance would be helpful for plans to support additional SDOH-related interventions.

Agenda

- Opening remarks and MCO survey results (EHF)
- National landscape (CHCS)
- MCO survey results and potential QI guidance (HHSC)
- Perspective of an Actuary (Milliman)
- Discussion
- Wrap up

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SDOH Strategies During the COVID-19 Pandemic: Select Findings from the 2020 Texas MCO Survey

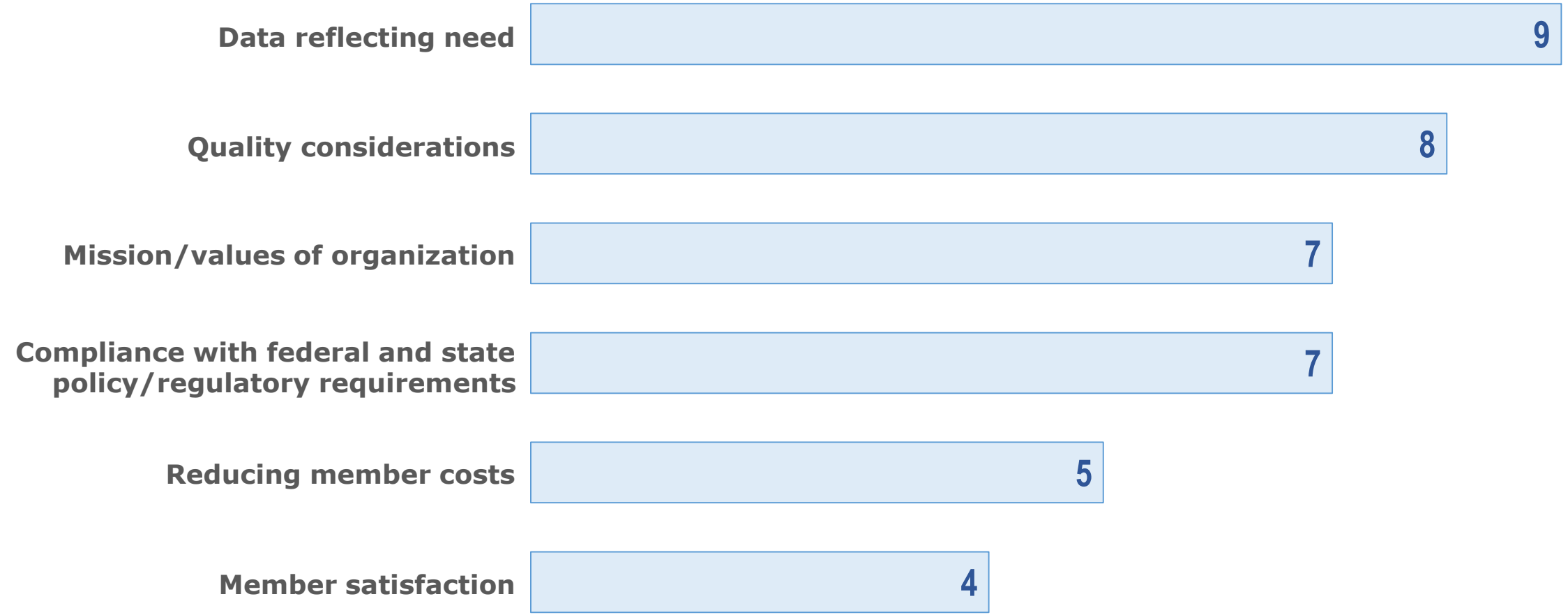
Episcopal Health Foundation

SDOH Strategies During the COVID-19 Pandemic: Select Findings from the 2020 Texas MCO Survey

Shao-Chee Sim, Kay Ghahremani, & Laurie Vanhoose

January 19, 2021

Factors Influencing SDOH Investment



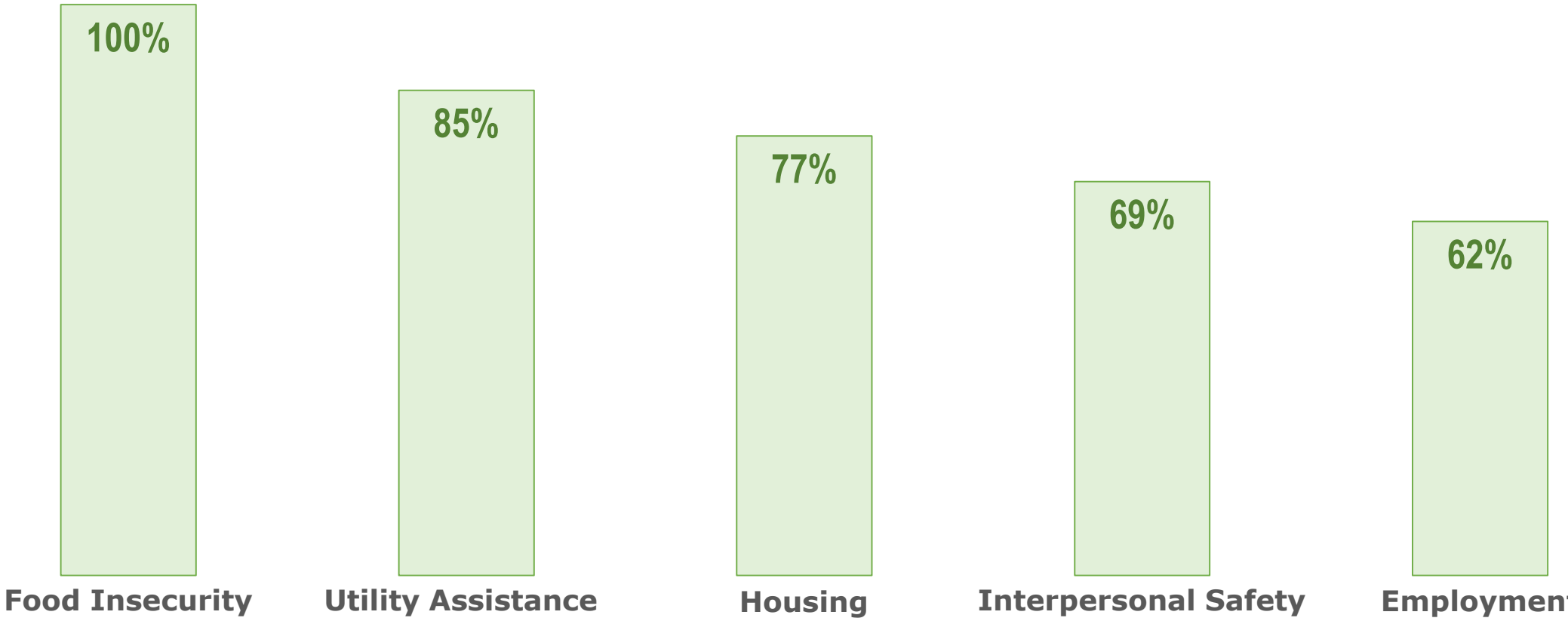
EPISCOPAL HEALTH FOUNDATION

TAHP The Texas Association of Health Plans

TACHP Texas Association of Community Health Plans

Source: *Social Determinants of Health Strategies During the COVID-19 Pandemic: Findings from a 2020 Survey of Managed Care Organizations in Texas*

Top Priorities for MCO SDOH Investment



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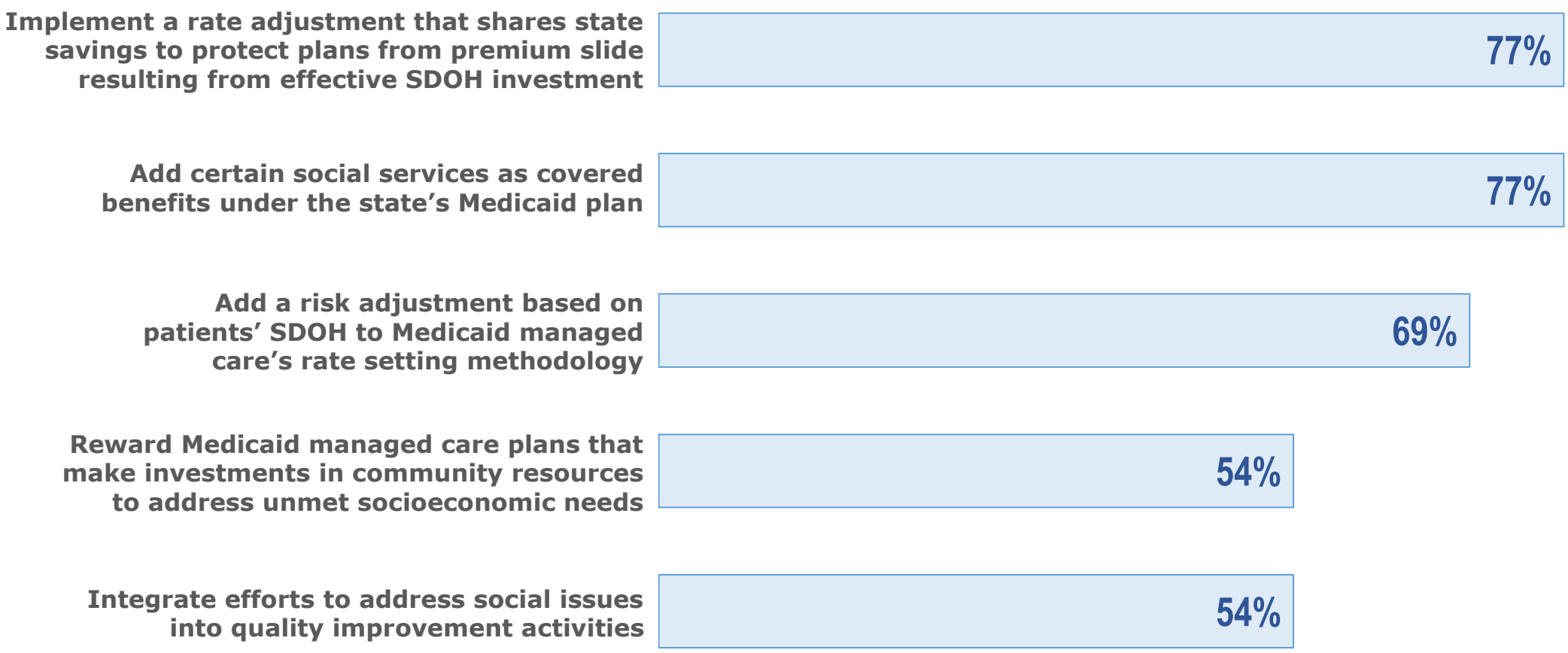
MCO Favorability for Government Action on SDOH



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National Landscape

Center for Health Care Strategies

Managed Care Flexibilities

Under federal law, rates must be based on state Medicaid benefits, but:

- MCOs can provide ***any service***, including services that address health-related social needs.
- MCOs have significant flexibility to target and tailor approaches for different patient populations ***to improve health care quality***.

42 C.F.R. 438.3(c)(1)(ii); 42 C.F.R. 438.3(e)(1)(i); 45 C.F.R. 158.150.

Key Questions: The Numbers

- Can the cost be reported in the numerator of the medical loss ratio (MLR)?
- Can the cost be used to develop rates?
- Will the initiative help the MCO earn:
  - Incentive payments based on quality performance?
  - An auto-assignment preference?
  - Changes to the profit margin/efficiency adjustments?

See CMS State Health Official Letter #21-001.

Key Questions: Program & Policy

- What does the state require as it relates to:
  - Care Coordination?
  - Quality Assessment and Performance Improvement?
  - Value-based Payment?
  - Community reinvestment?
- Will the SDOH-related initiative:
  - Improve health outcomes?
  - Address disparities?
  - Support network providers, and enable innovation?

See CMS State Health Official Letter #21-001.

State Example: Oregon

- "Health-related services"
  - Must meet the federal definition of QI
  - SDOH examples: Veggie Rx, legal assistance
- Costs are:
  - Reported in the MLR numerator
  - Not used to develop rates (but there is a non-benefit load adjustment)
- MCOs can earn:
  - Quality incentive payments (indirectly)
  - "Performance-based reward" (variable profit margin)

State Example: New York

- Advanced value-based payment arrangements must include:
  - One SDOH intervention
  - One partnership with a community-based organization
- MCO expenses within VBP contract are:
  - Reported in the MLR numerator
  - Used to develop rates
- MCOs can earn (indirectly):
  - Quality incentive payments
  - Auto-assignment preference

Emerging State Practice: Community Reinvestment

- Arizona MCOs must:
  - Contribute 6% of annual profits
- Ohio MCOs must:
  - Contribute 3% of its annual profits
  - Increase the percentage of the MCO's contributions by 1% each subsequent year, for a maximum of 5% of the MCO's annual profits.
- North Carolina plans can contribute to health-related resources in lieu of MLR-related rebates.

See also CMS State Health Official Letter #21-001.

DSRIP Transition: Survey of MCOs on Quality Improvement Cost Reporting

Health and Human Services Commission

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Health and Human Services

DSRIP Transition: Survey of MCOs on Quality Improvement Cost Reporting

Quality Improvement Costs

- In Texas, "Quality Improvement Costs" (QI costs) are the label we have for activities that improve health care quality as described by 45 C.F.R. §§ 158.150 and 158.151.
- They are reported on the Financial Statistical Reports (FSRs) separately from Administrative costs. They count in the numerator of the medical loss ratio (MLR), which can help MCOs to meet minimum MLR requirements, they are included in the rate development process, and they do not count toward the administrative cap when calculating the experience rebate.
- QI cost claiming can support flexibility for MCOs to implement certain interventions to address social determinants of health (SDOH) for Medicaid clients.

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HHSC survey

- As part of the DSRIP Transition Plan, HHSC surveyed MCOs to better understand their questions about reporting QI costs.
- The survey was open from April 9 to April 30, 2020, and 17 of 20 MCOs/DCOs responded for an 85% response rate.
- Using categories of QI costs found in federal code, the survey asked MCOs whether they were reporting all potential costs in those categories. HHSC also asked MCOs general qualitative questions about QI costs and reporting.
- This presentation will highlight responses from that survey and give opportunities for additional feedback from MCOs.

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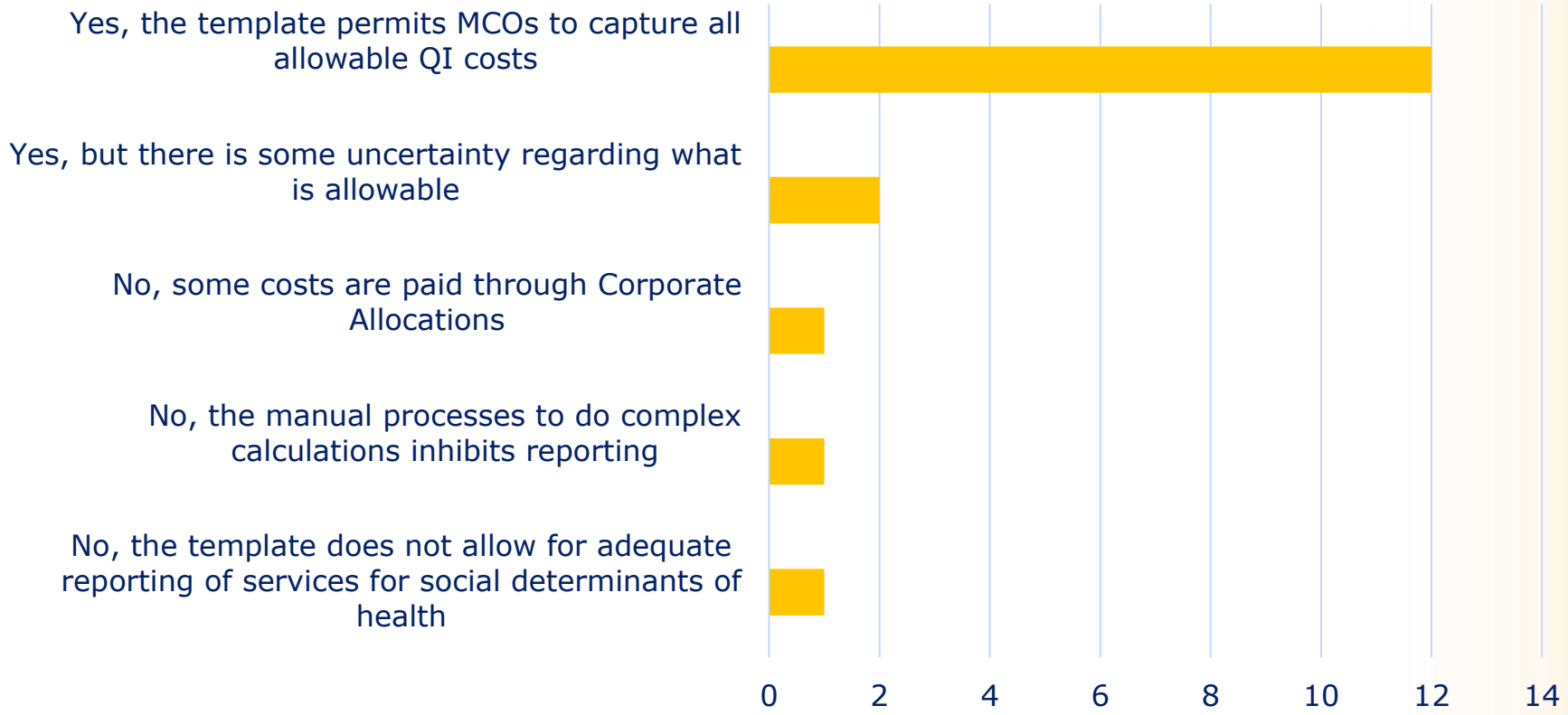
MCO Opinions on the Combined Admin and FSR Template

Does your MCO feel that the Combined Admin and QI FSR template permits MCOs to capture all allowable QI costs? If not, what are the limitations or clarifications needed to enable comprehensive reporting?



Additional Guidance

Just over half of the MCOs stated that some additional guidance for reporting activities as QI costs would be helpful.

Examples from MCOS mostly focus on the following:

- Guidelines in greater detail for allowable QI costs, including examples;
- Points of contact at HHSC, including opportunities for quick clarifications and meetings for conversation in more depth.

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Categories of QI Costs
(Federal Code 45 CFR §158.150-151)

1. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
2. Prevent hospital readmissions through a comprehensive program for hospital discharge.
3. Improve patient safety, reduce medical errors, and lower infection and mortality rates.
4. Implement, promote, and increase wellness and health activities
5. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with §158.151.

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1. Improve Health Outcomes and Reduce Health Disparities

Per federal code, examples include direct interaction of the MCO, providers and the enrollee (or their representative) around the following activities:

- **Effective case management, care coordination, chronic disease management, and medication and care compliance** initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act;
- Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;
- Quality reporting and documentation of care in non-electronic format;
- Health information technology to support these activities;
- Accreditation fees directly related to quality of care activities.

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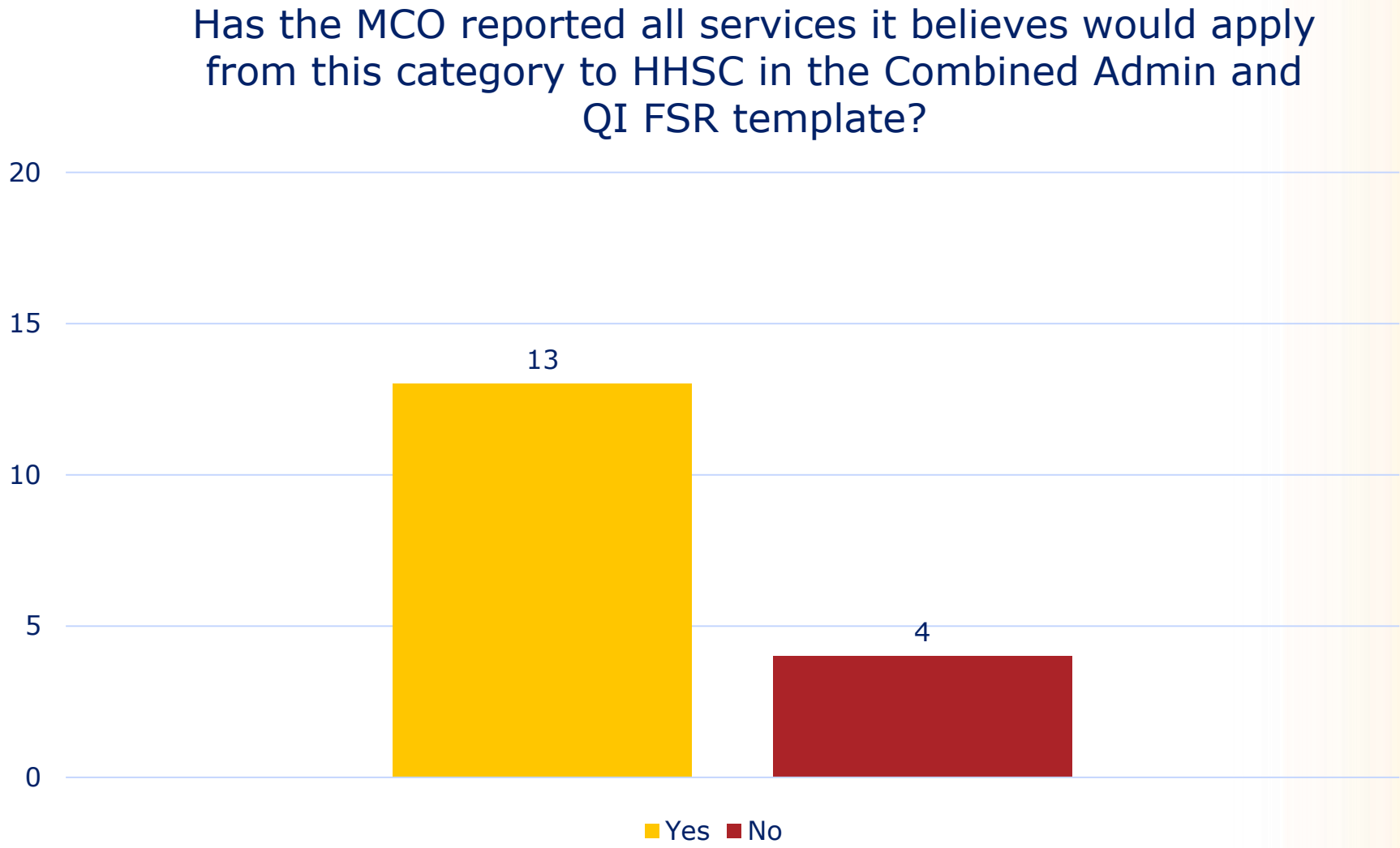
1. Improve Health Outcomes and Reduce Health Disparities



1. Improve Health Outcomes and Reduce Health Disparities

Additional services MCOs did not report as QI costs:

- Costs related to HEDIS administration metrics, reported under "Admin";
- Vendor related activities that were already reported in "Medical Spend";
- Health IT supporting QI:
  - GeoMapping, Care Coordination Information System, HEDIS analytics.
  - Not reported due to complexity of estimating time allocated to these projects.

2. Prevent Hospital Readmissions

Prevention through a comprehensive program for hospital discharge.

Examples in federal rules:

- **Discharge planning** (e.g. manage transitions between setting) to assure appropriate care;
- **Patient-centered education/counseling;**
- **Personalized post-discharge reinforcement and counseling** by an appropriate health care professional;
- Quality reporting and Health IT to promote these initiatives.

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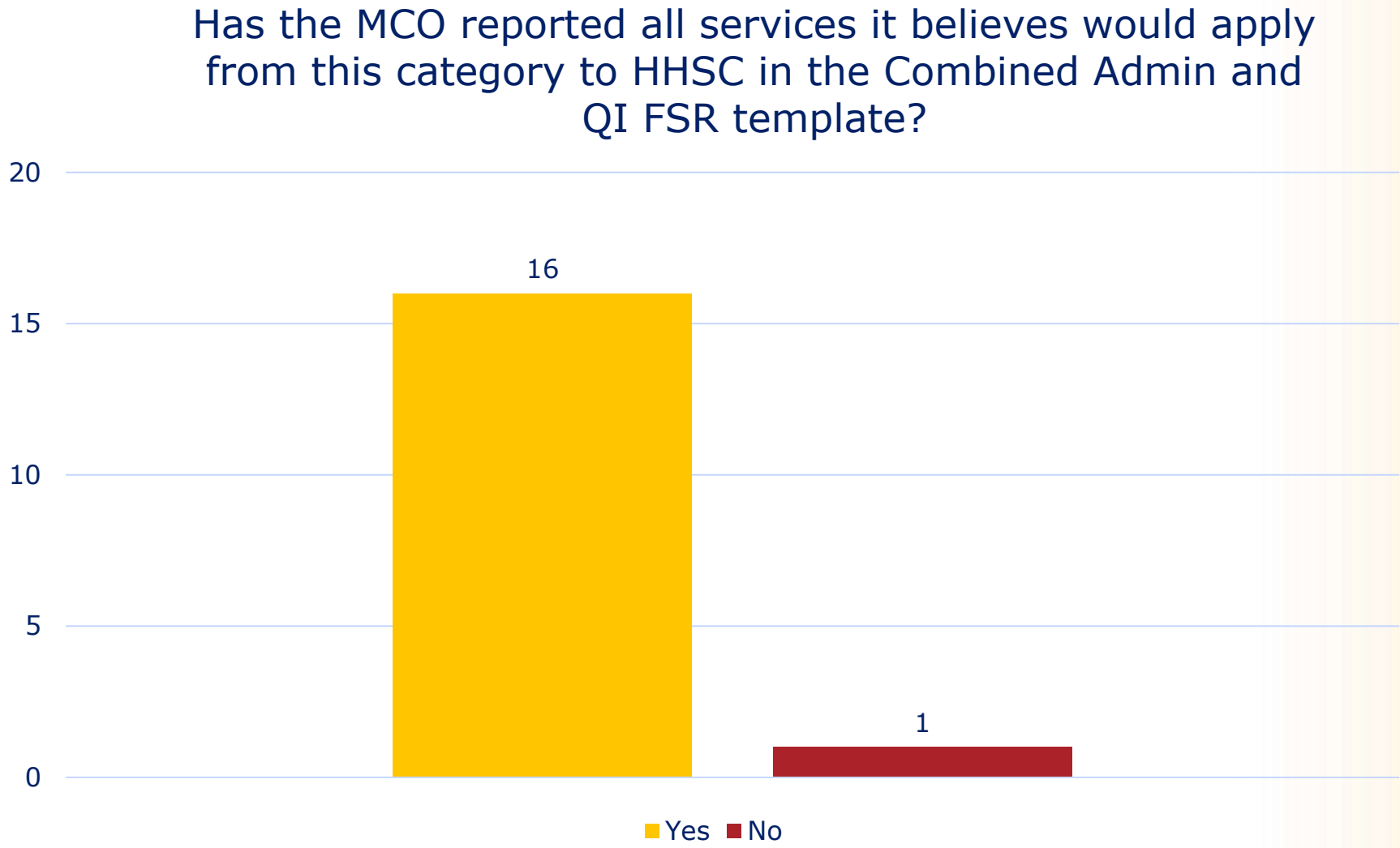
2. Prevent Hospital Readmissions



3. Improve Patient Safety

Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

- The appropriate identification and use of best clinical practices to avoid harm.
- Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns
- Activities to lower the risk of facility-acquired infections.
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions
- Any quality reporting and Health IT to promote these initiatives.

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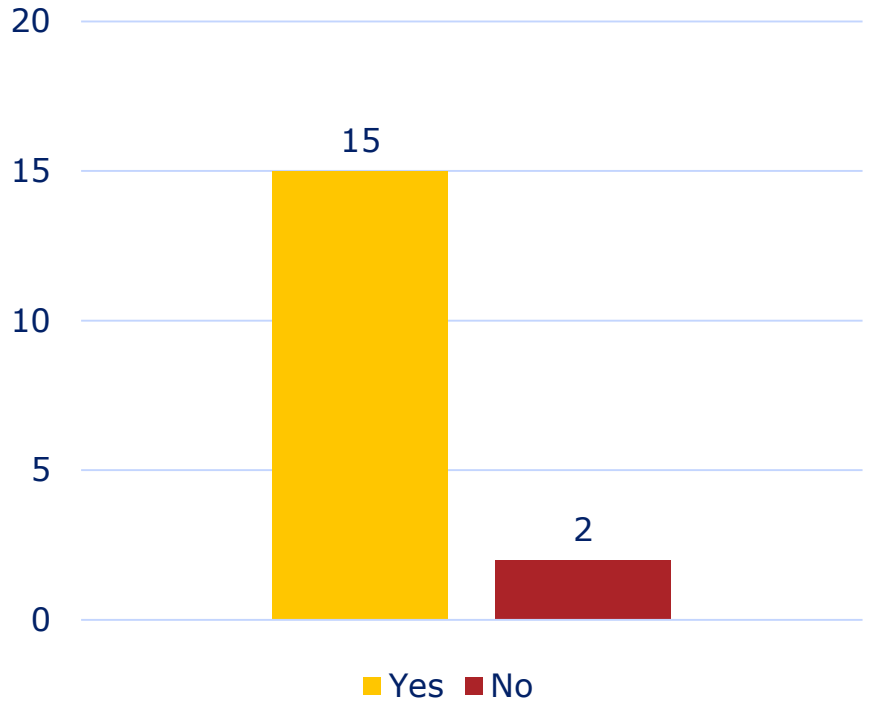
3. Improve Patient Safety

Has the MCO reported all services it believes would apply from this category to HHSC in the Combined Admin and QI FSR template?



- One MCO stated that prospective prescription drug utilization review, aimed at identifying potential adverse drug interaction costs was reported elsewhere.

4. Implement, Promote and Increase Wellness and Health Activities

Examples in federal rules include:

- **Wellness assessments and coaching programs** designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with State or local health departments;
- Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;
- **Coaching or education programs and health promotion activities designed to change member behavior and conditions** (for example, smoking or obesity); and
- Quality reporting and Health IT to promote these initiatives.

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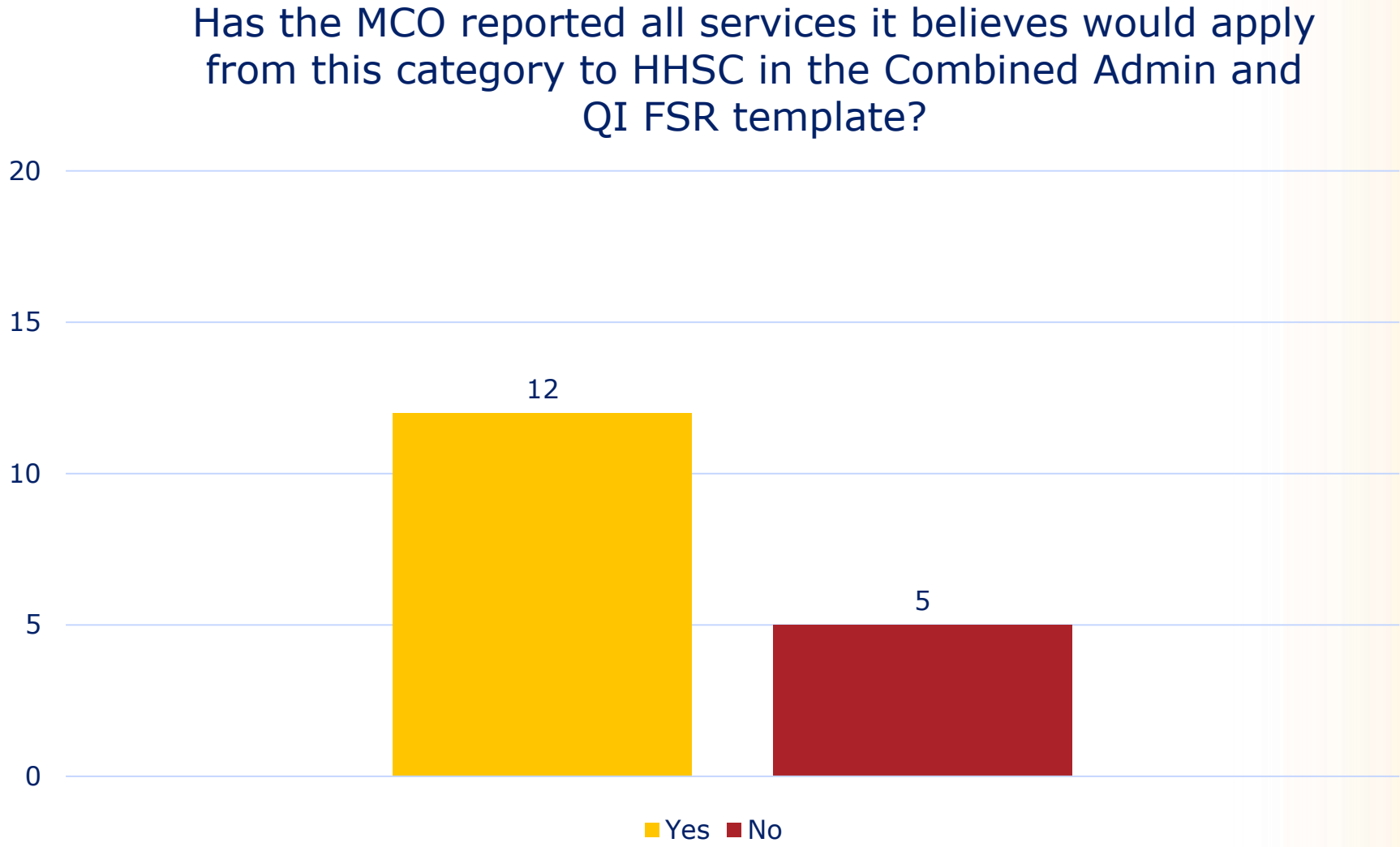
4. Implement, Promote and Increase Wellness and Health Activities



4. Implement, Promote and Increase Wellness and Health Activities

- The majority of MCOs that responded "No" did so due to uncertainty in what value-added service (VAS) could be reported as QI costs. Examples included:
  - Rewards and incentives;
  - Staff associated with value-based contracting/provider work or with wellness events;
  - Other costs associated with VAS designed to promote wellness and health activities.

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5. Enhance the Use of Health Care Data

- An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses that support quality, transparency and outcomes.

- Examples:
  - Incentive payments to health care providers for the adoption of certified EHR technologies and supporting their use.
  - Monitoring, measuring and tracking clinical effectiveness and patient outcomes based on interventions.
  - **Advancing communication with patients and providers and supporting the management and transfer of data.**

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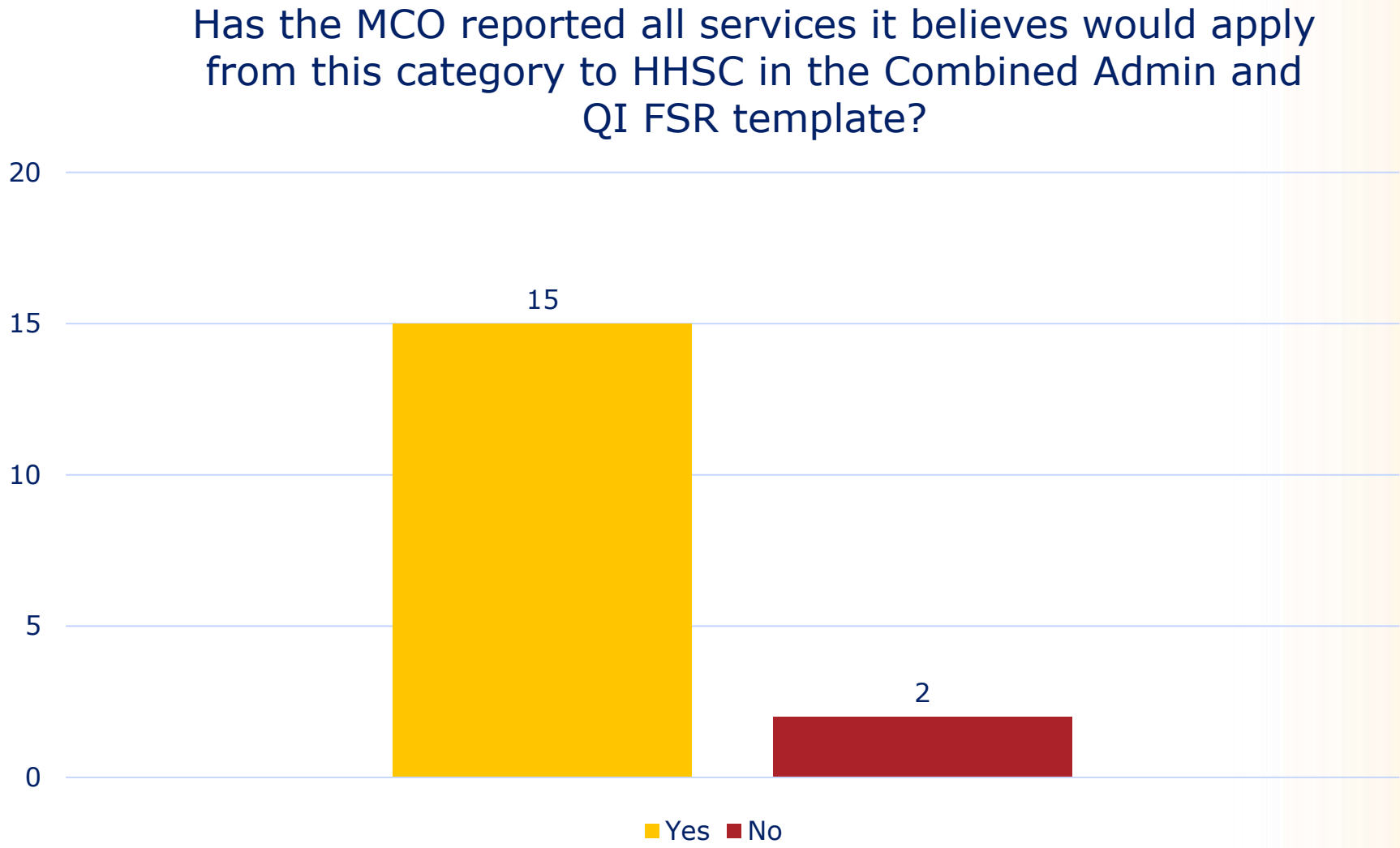
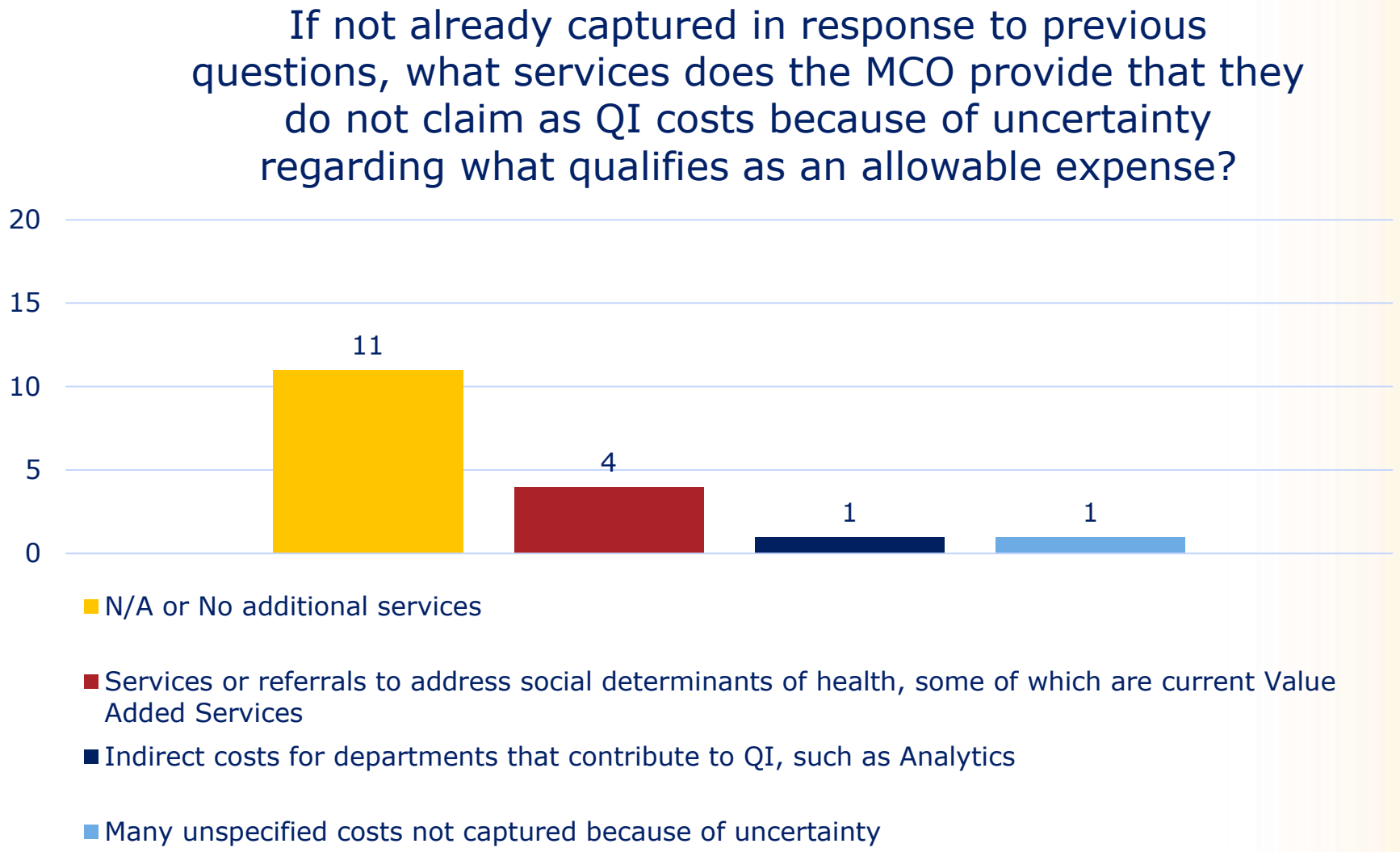
5. Enhance the Use of Health Care Data



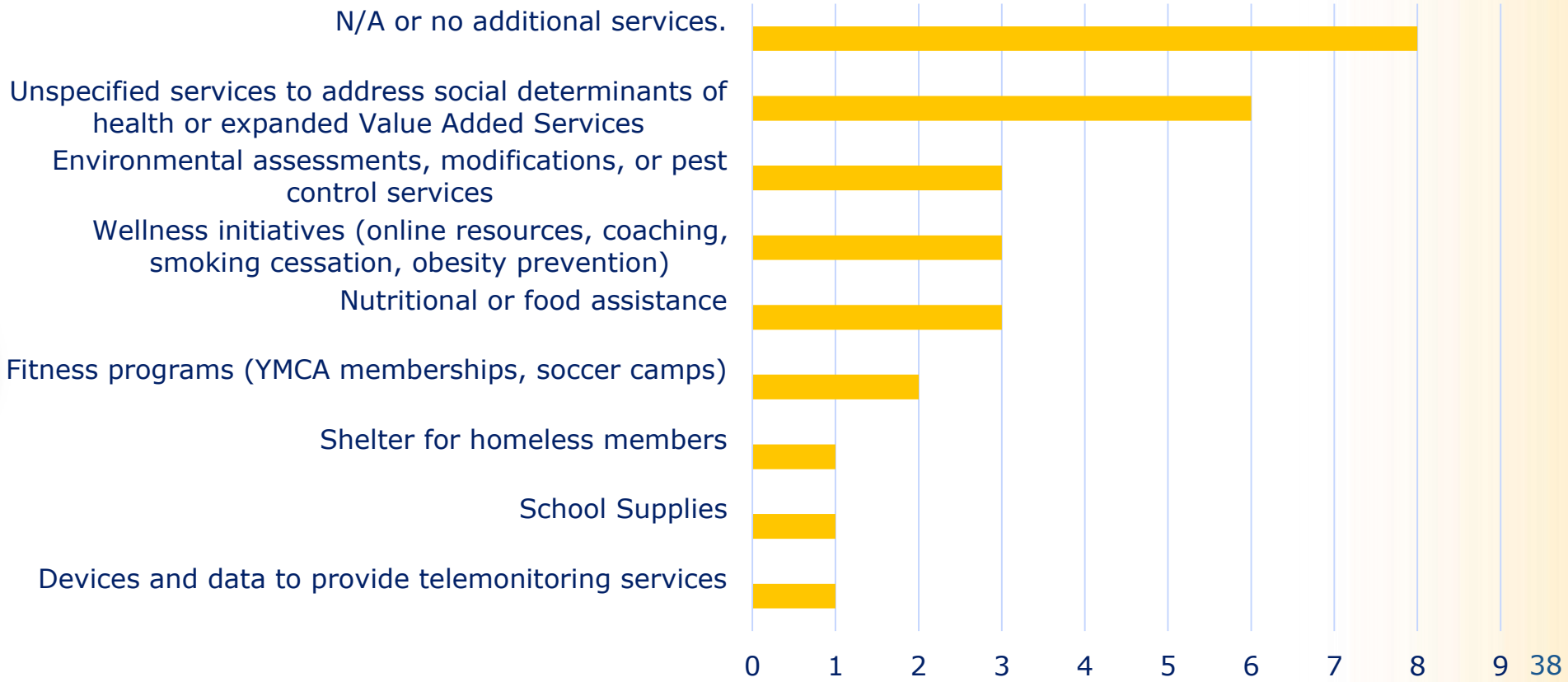
Uncertainty in Reporting



Services Suggested as QI Expenses

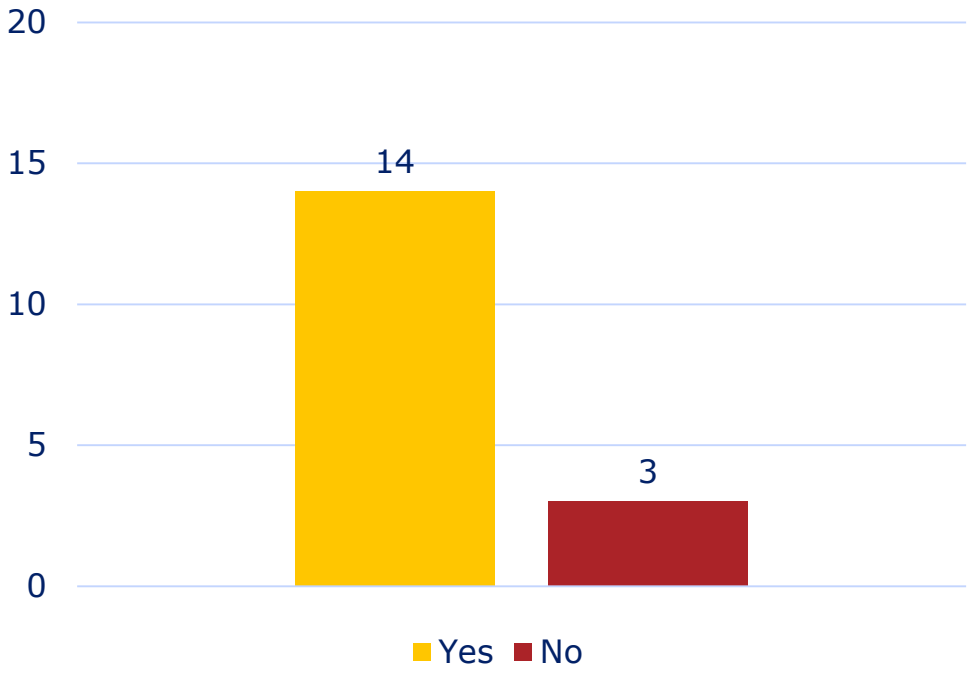
What services would the MCO provide, that it does not currently, if they were allowable QI expenses?

An MCO may have more than one coded response.



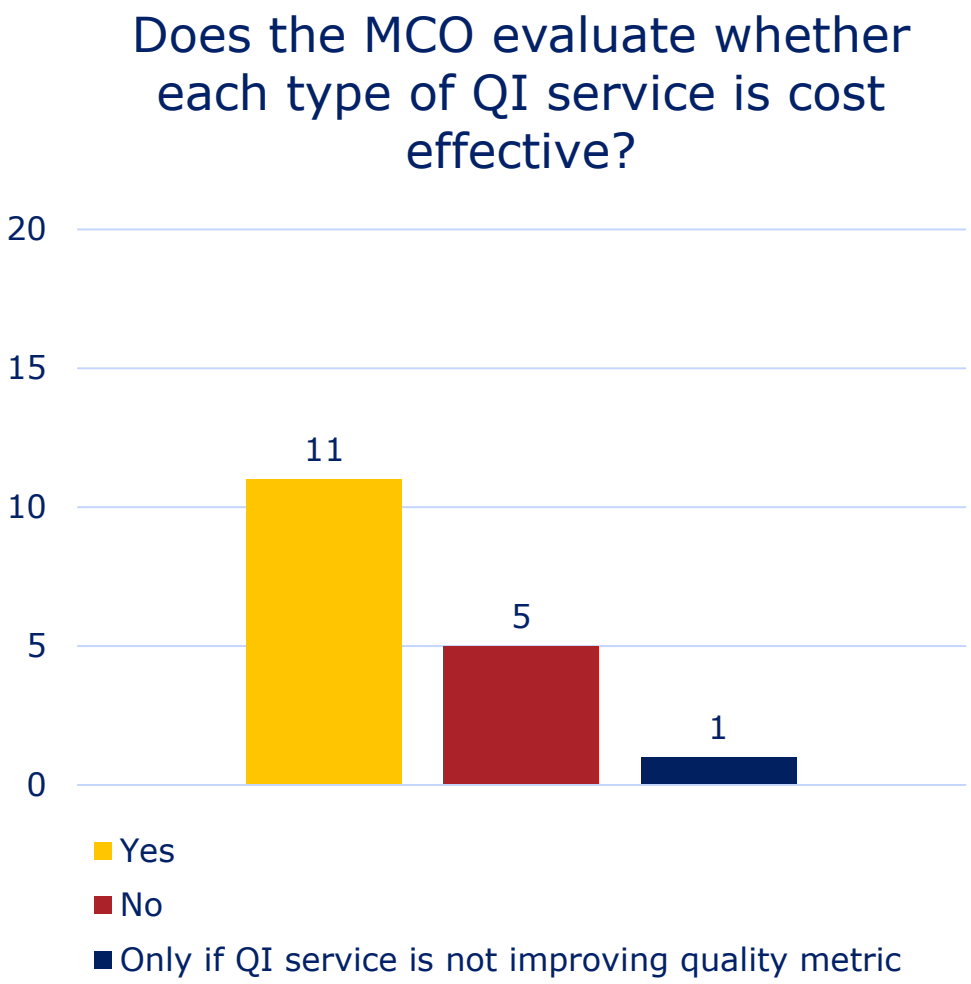
Contracting QI Costs

Does your MCO contract any of your reported QI costs to Medicaid providers (e.g., community health worker costs for patient navigation or education)?



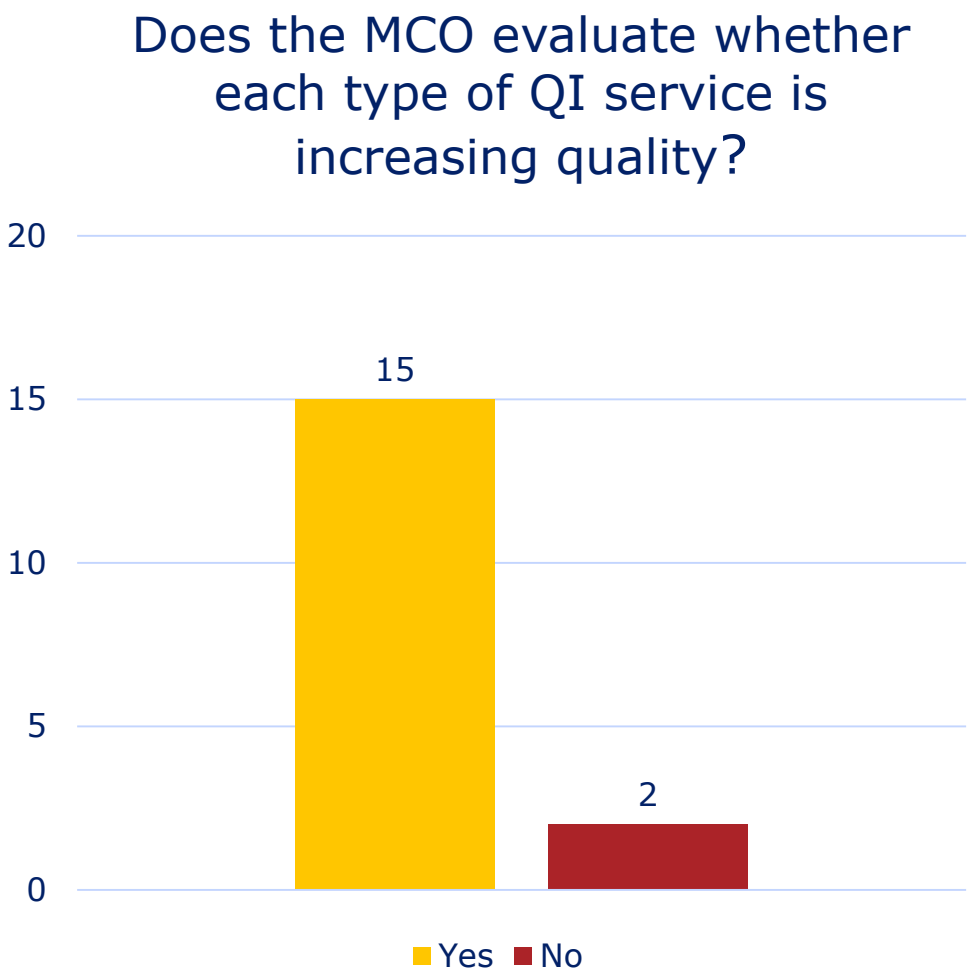
- Examples from MCOs (unclear if the contract is with Medicaid providers):
  - Translation/interpretation services;
  - Disease management;
  - Health IT;
  - Patient Education;
  - Other member incentives.

Quality/Efficiency Evaluation



- MCOs that evaluate the cost effectiveness of a QI service generally tied it to the corresponding quality evaluation.
- Return on investment (ROI) and VAS/VBP effectiveness are often used when analyzing a QI activity.
- In some cases, MCOs believe that benefits from QI services will be long term or not easily evaluated (such as ROI from technology improvements).

Quality/Efficiency Evaluation



- Examples from MCOs mostly fell into the following categories:
  - Root cause analyses;
  - Analyzing health outcomes, often HEDIS monitoring or other National/State benchmarks;
  - Goal setting based on health outcomes.

Question & Answer

Social Determinants of Health and Quality Improvement Activity Reporting in Texas Medicaid Managed Care

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Social Determinants of Health and Quality Improvement Activity Reporting in Texas Medicaid Managed Care

Texas Medicaid Managed Care SDOH Learning Collaborative Session:
Exploring Strategies for Managing Costs Associated with SDOH Interventions

Jeff Milton-Hall, FSA, MAAA

Justin Birrell, FSA, MAAA

19 JANUARY 2021

Milliman

- **Medicaid managed care** experience, including supporting MCOs with **financial reporting and forecasting**, **value based contracting**, analysis of state **risk adjustment** programs and drivers of risk adjusted **financial performance**, and responding to **competitive procurements** across physical, behavioral, and dental health
- Extensive experience modeling **healthcare policy changes** and market **disruptions**, including **1115/1332 waivers** and market impacts from **COVID-19**
- Priced and prepared **ACA filings** in over 20 states (including **Texas**)

Jeff Milton-Hall

FSA, MAAA
Consulting Actuary

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- **Medicaid** actuary experienced supporting states (including Hawai'i, Idaho, Nevada, Utah, Washington, and Vermont) and with non-state work (including Kentucky, Arizona, Georgia, and Massachusetts)
- Extensive experience developing state **capitation rate structures** for integrated healthcare models, including **CMS documentation**
- Experience encompasses **medical**, **long-term care**, **behavioral health**, **transportation**, **disease management**, **procurement**, **healthcare reform**, **risk adjustment**, and other state analyses

Justin Birrell

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Social Determinants of Health (SDOH)

"**Conditions in the environments** in which people are born, live, learn, work, play, worship, and age **that affect** a wide range of **health, functioning, and quality-of-life** outcomes and risks"

Examples:

- Access to **affordable housing**
- **Food security**
- Access to **education**
- Access to **transportation**
- **Employment**
- **Safety** and environment
- **Childcare**

Key Challenges for Tackling SDOH through Medicaid

- **Financing**
- **Sustainability / premium slide**
- Categorization for **financial reporting** and **rebate / gain sharing calculations**
- **Timeline** for return on investment
- Tailoring SDOH-adjacent **quality measures**
- **Data** collection and quality
- Fitting interventions into **Medicaid regulatory framework**, e.g.
  - Restrictions on **covered benefits**
  - **1115 waivers**
  - Restrictions on **non-benefit expenses, profit, and incentive payments**

Quality Improvement Activities (QIA)

- Non-benefit activities and expenditures that meet certain criteria related to improving health outcomes and quality. Defined in federal regulation[1], as referenced in Texas FSR instructions.

Must satisfy all of the following:	**Must be primarily designed for one of the following:**	**Certain activities are excluded, such as:**
• Improve health quality • Can be measured objectively with verifiable results • For the benefit of plan enrollees (or no additional cost if benefits non-enrollees) • Generally accepted by recognized professional bodies or quality organizations	• Improve health outcomes and/or reduce health disparities • Prevent hospital readmissions • Improve patient safety • Promote health and wellness • Facilitate external quality review • Health information technology (HIT) / data and meaningful use in support of QIA	• Provider network development • Retrospective/concurrent utilization review • Fraud prevention activities • Activities designed primarily to control or contain costs

- **Treated as a benefit expense** rather than administrative for experience rebates / gain sharing
- Some (not necessarily all) **SDOH interventions may qualify as QIA** (e.g. community health workers, housing supports for beneficiaries at risk of readmission)

1. 45 CFR § 158.150, 45 CFR § 158.151

Challenges for addressing SDOH through QIA

- **Not all SDOH activities comply** with QIA definition (e.g. solely for enrollee population, improves health outcomes, evidence based with verifiable results)
- **Compliant activities must be appropriately documented** and accounted
- **Ambiguity and uncertainty** regarding whether state and/or CMS will accept activity/expense
  - *We understand this may be a particularly substantial challenge with FSR in Texas*
- **Sustainability due to "Premium Slide"** if QIA is not considered in rate setting

Key QIA/SDOH considerations – state and plan perspectives

- **State considerations**
  - Population health outcomes
  - Impact on short and long term program costs
  - Regulatory authority
  - Communicating guidance, preferences, and permissible processes for addressing SDOH
  - Actuarial soundness and SDOH costs

- **Plan considerations**
  - Supporting member and community health outcomes
  - Determining and operationalizing effective and permissible SDOH QIA interventions
  - QIA categorization, accounting, and documentation
  - Financial sustainability of SDOH QIA investment

Data reliance and limitations

- This presentation is intended to provide a limited educational overview of the current landscape, considerations, challenges related to financial reporting of social determinants of health (SDOH) interventions by Medicaid Managed Care Organizations (MCOs) participating in the Texas Medicaid managed care program. The opinions expressed in this presentation are attributable to the authors and not Milliman as a whole. The information herein is intended for educational purposes, and represents the authors' best estimates at the time of publication based on available information; actual results will vary. We make no guarantees or warranties regarding the accuracy of the information within. Emerging experience should be monitored and adjustments made as necessary.
- In preparing this presentation, we relied on information regarding Texas financial reporting requirements from the Texas Health and Human Services Commission and the Center for Healthcare Strategies, summaries on SDOH interventions and financing from the Commonwealth Fund and Manatt, Phelps, and Phillips LLP, as well as our expertise from our colleagues at Milliman. To the extent the information in these summaries is incomplete or out of date, our conclusions may likewise be incomplete or out of date.
- Jeff Milton-Hall and Justin Birrell are members of the American Academy of Actuaries, and meet its qualification standards to provide this analysis.

Group Discussion

For discussion

What SDOH-related services and initiatives do you categorize as "quality improvement" on the Financial Statistical Report (FSR)?

For discussion

Are there SDOH activities that your plan has not yet pursued due to lack of clarity around cost categorization in the FSR?

For discussion

What detail/additional guidance would be helpful to your plan?

Wrap Up