Systems for Action
National Coordinating Center
Systems and Services Research to Build a Culture of Health

Strategies to Achieve Alignment, Collaboration, and Synergy across Delivery and Financing Systems

Testing a New Terminology System for Health and Social Services Integration

Research-in-Progress Webinar
Wednesday, October 3, 2018
12:00-1:00 pm ET/ 9:00 am-10:00 am PT

College of Public Health
Center for Public Health Systems and Services Research

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Agenda

Welcome: **CB Mamaril, PhD**
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Presenters: **Miriam Laugesen, PhD**
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Commentary: **Harold Pollack, PhD**
Professor
School of Social Service Administration
University of Chicago

Q & A: Moderated by **CB Mamaril, PhD**

Presenter

Miriam Laugesen, PhD

Associate Professor

Department of Health Policy and Management

Columbia University Mailman School of Public Health

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Commentary Speaker

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Columbia University Mailman School of Public Health

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The System Problem: A Lack of Alignment

- Medical services are well codified, and there is an established process for defining “medical” services
- Medical services have a standardized billing language—social services do not
- There is no best practice or “package” of defined nonmedical services to address social determinants
- States are innovating, but a macro perspective is needed

Study Aims and Questions: Aim 1

- **AIM 1:** Legal and regulatory alignment of reimbursement of nonmedical service providers*
  - How are nonmedical service providers reimbursed by Medicare and Medicaid?
  - How are nonmedical service providers reimbursed by private insurers?

FEDERAL REGISTER
The Daily Journal of the United States Government

*For example, nonclinical social workers, housing agency staffers, health education specialists, nonemergency transportation providers

Methods Aim 1

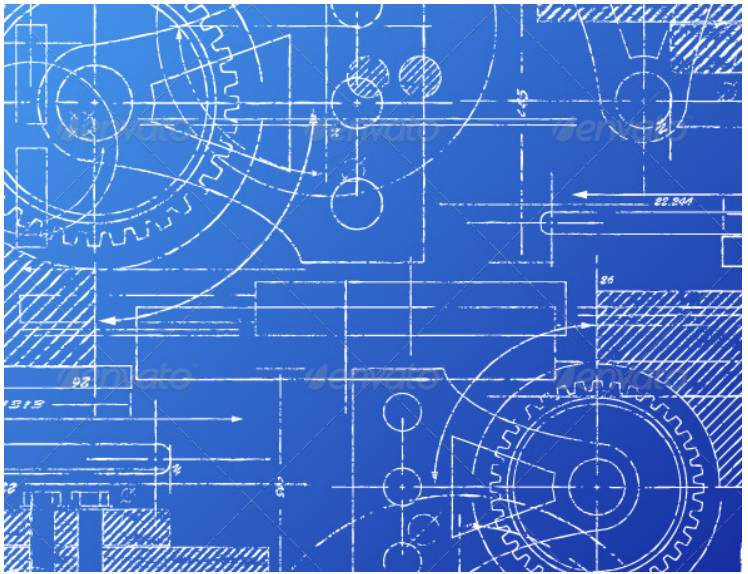
- **AIM 1: Review relevant laws and regulations that define the scope of payment rules under CMS and outline payment coding methodologies for private insurers**
  - Review specific legislative databases, court opinions, court dockets, legal analyses of medical reimbursement codes, legal portfolios on regulation and management of clinical services and accounting, codified statutes and regulations, regulatory and administrative rules, and guidance and interpretation
  - Review and catalog private payer plans that are governed by various state insurance and managed care laws and self-funded employer plans under the Employee Retirement Income Security Act (ERISA)

Study Aims and Questions: Aim 2

Investigate delivery and financing alignment and test the feasibility of current or new parallel mechanisms.

I. What organizing principles would guide greater alignment?

II. Which current systems could be developed, or would new systems be needed?



Methods Aim 2

AIM 2: Review integration models and current policies and practices, including:

- Organizations and processes determining the definition and coverage of services
- Reimbursement and coverage policies

Study Aims and Questions: Aim 3

Acceptability and alternative options via engagement with stakeholders

I. What do stakeholders perceive as the biggest challenges to integration?

II. How can reimbursement systems encourage integration and address the full range of social services provided?

III. Are Medicaid “T” codes an option?

Methods Aim 3

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- Stakeholder interviews to gain perspectives from a diverse pool of respondents and organizations
- Analysis of stakeholder policy documents and position papers.

Findings

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1. Regulatory and legal mechanisms

- **Patient Protection & Affordable Care Act (ACA): Title V**
  - Section 5102: state and local grants for “comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies”
  - Section 5313: authorizes CDC grants to promote positive health behaviors and outcomes in underserved areas
  - Section 5507(a): authorized a demonstration project to train low-income individuals for health care professions
- **Social Security Act Section 1115: Medicaid Demonstration Waivers**
  - Section 1115: demonstration projects allow expansion beyond routine medical care to evidence-based interventions improving health outcomes and quality of life
  - 1915(c) Home and Community-Based Services Waivers: 1915(c) for long-term services

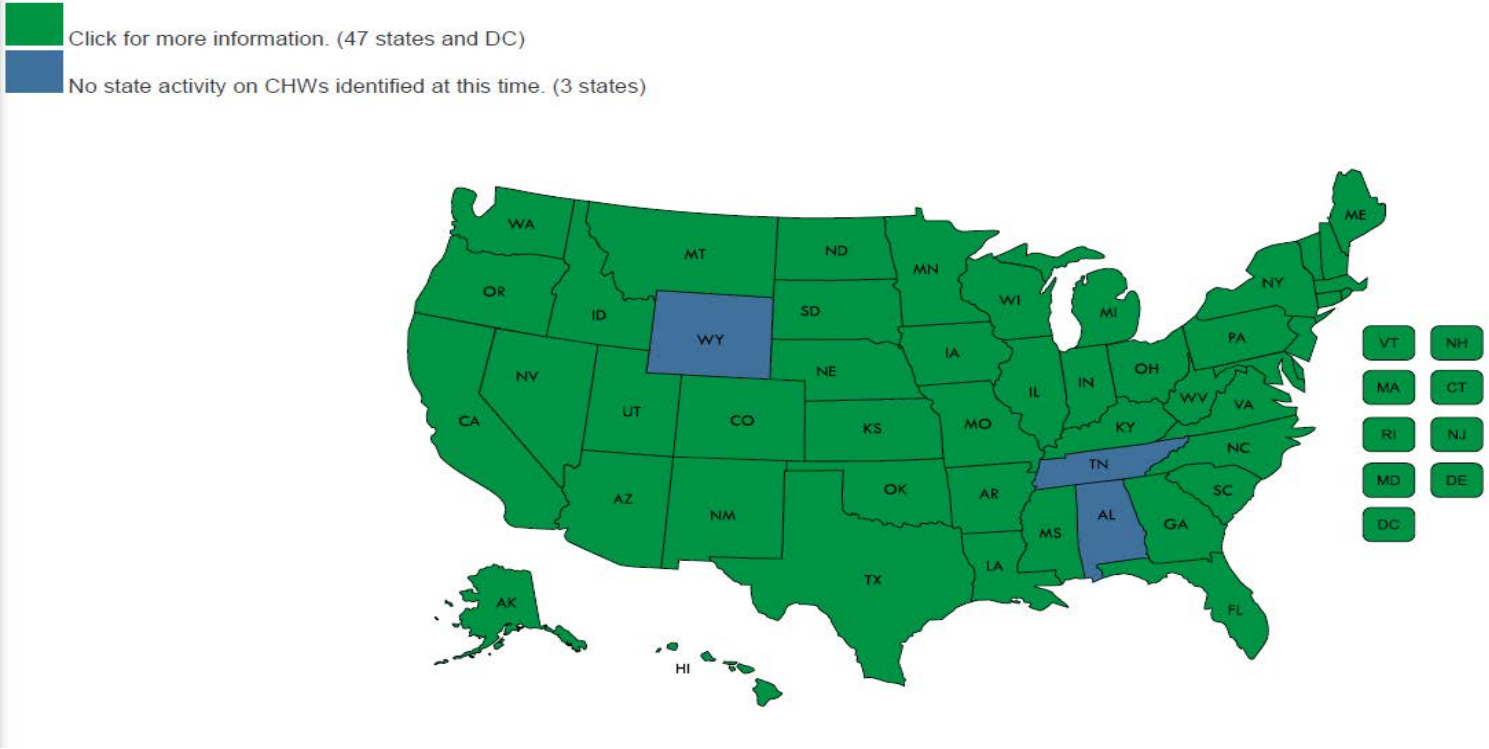
Study Findings: Current Regulatory & Legislative Approaches to Service Integration

- **Managed Care Organizations (MCOs)**
  - MCOs have flexibility to cover additional services- including social support services- that are not covered in state Medicaid plan
  - MCOs must notify the state of intent to cover "value added" service
  - Costs of "value added" services are included in administrative portion of rate

- **Government funding for innovative payment and service delivery models**
  - CMS Innovation Center
    - Accountable Health Communities: identifying and addressing social needs of Medicaid beneficiaries
    - Health Care Innovation Awards: focus on engaging beneficiaries in prevention, wellness, and comprehensive care that extend beyond clinical care
    - State Innovation Models (SIM): state-based multi-payer health care delivery & payment systems; may extend beyond Medicaid beneficiaries

Study Findings: Current Regulatory & Legislative Approaches to Service Integration

State Community Health Worker Models



Source: National Academy for State Health Policy. Available at https://nashp.org/state-community-health-worker-models/

Study Findings: Current Regulatory & Legislative Approaches to Service Integration

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Table 1: State Community Health Worker Financing Models, Northeastern Region

State	Financing Mechanism	Medicaid Reimbursment for CHW Services?
Connecticut	Grant funding through federally qualified healthcare centers (FQHCs), community-based organizations (CBOs), and the CDC	No
Delaware	Federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program	No
Maine	Maine's Health Homes Program	Yes
Massachusetts	Delivery System Reform Incentive Payment (DSRIP) through Section 1115 Demonstration; ACOs; Prevention and Wellness Trust Fund; Healthcare Workforce Transformation Fund	Yes
Maryland	Grant funding	No
New Hampshire	Grant funding; DSRIP through Section 1115 Demonstration	No
New Jersey	Medicaid managed care organizations (MCOs)	Yes
New York	New York Health Homes Program	No
Pennsylvania	Medicaid managed care organizations (MCOs)	Yes
Rhode Island	Grant funding	No
Vermont	Vermont's Multi-Payer Advacned Primary Care Practice Demonstration	Yes

Source: National Academy for State Health Policy. Available at https://nashp.org/state-community-health-worker-models/

Law and regulations on Medicare coverage

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I. Principal model is 1965 base: healthcare services are physician-provided services, hospitals and medically based services

II. Where services are provided, there are strict limitations: e.g. § 410.73, e.g. social workers can only address mental illness and 75% of the payment of a physician

III. The current legal and regulatory framework sharply limits Medicare coverage of social services

Sources: Medicare Benefit Policy Manual

Law and regulations: Medicaid coverage

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I. Waivers are the main mechanism Medicaid uses to integrate health and social services.
II. Strengths include:
    I. Comprehensive wrap-around approach
III. Weaknesses:
    I. Federal approval
    II. Often targets long-term supports, not so much chronic illnesses
    III. Unclear how it fits with managed care plans

2. Principles and current approaches

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- Paradigm a continuum of “low touch” integration, such as case management programs. and more ambitious “high touch” integration models” including team - based care (health and social service providers working on the same care team to address patients’ wide - ranging needs)
- No payer-neutral set of principles on addressing social determinants: each sector approaching this unilaterally

“low touch” “high touch”

Current alignment paradigm

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- Many integration models focus largely on co-location or integrated delivery system the ideal.
  - This requires major shifts in the organization of healthcare
- Payment reform incentives, esp. within Medicaid, are driving value-based payments
  - Depends on continued federal efforts
- Payer-specific alignment policies create a patchwork of arrangements, rather than a seamless system

Billing code systems could facilitate integration

Health Care Procedure Code Service (HCPCS) "*Hicspics*" codes used to standardize descriptions of services

Level 1: physician services
Level 2: codes are those codes for goods and services outside a physician's office

- The CMS-HCPCS workgroup is in charge of maintaining and distributing Level II codes.
- This is a collaboration between CMS staff, contractors, federal agencies, representatives of state Medicaid, private insurance sector

“T” (HCPCS) Codes as a model

Some HCPCS codes apply to social services

- There are approximately 100 “T” codes
- Medicaid state agencies use T codes for services not covered by Medicaid

Advantages and disadvantages

- T codes can’t be paid by Medicare and only through a waiver in Medicaid
- Stakeholders report varying familiarity with the T code system

“T” HCPCS - examples

Table 1. A Potential Foundation for Integrating Health and Social Services (Priority #1,2,3,4)

Healthcare Common Procedural Coding System, (HCPCS) “T” Sample Codes
T1018: School-based individualized education program services
T1009: Childcare for children of a person receiving alcohol and/or substance abuse services
T1010: Meals for individuals receiving alcohol and/or substance abuse services, where meals are not provided
T1028: Assessment of home, physical and family environment, in relation to the patient's medical needs
T1026: Intensive, extended multidisciplinary clinic services for children with complex medical, physical, medical and psychosocial impairments
T1029: Comprehensive environmental lead investigation (in-home)
T2003: Non-emergency transportation service

“H” codes also used for social services

- Mainly used for alcohol and drug abuse Treatment Services / rehabilitative services e.g.
  - H0043 Supported housing, per diem
  - H0045 Respite care services, not in the home, per diem

Advantages and disadvantages:

- Standardization – mixed, some standards but not a broad package of social services: specific to one area of illness

Stakeholder findings

- Stakeholders increasingly believe addressing the social determinants of health is important; the scope of what we mean by social services is an area of greater uncertainty
- Opioid abuse is motivating new ways of thinking about health and social services
- Stakeholders lack a common language to talk about financing social services
- Medicare's limited coverage of social services means limited national models; Medicaid is more comprehensive, but in the state experimentation also makes a system-wide perspective more challenging

Potential audience discussion points

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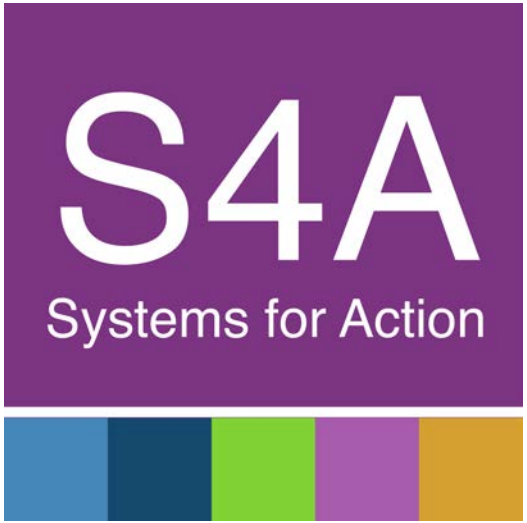
1. How broad should medical services be?
2. Is delivery integration necessary, or can payment mechanisms drive integration?
3. Should we aim for service integration, or do we need new systems?

Questions?



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Acknowledgements

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