Attachment M

Potential Initiatives under HOPE

Value-Based Payment (VBP) and Alternative Payment Methodologies (APM)

Below are specific initiatives that MQD is interested in understanding and potentially incorporating into its managed care program.

- *Re-evaluate VBP and APM standards in the QUEST contract.* MQD's current managed care program employs a number of VBP and APM initiatives such as the promotion of primary care homes, hospital-based VBP, a mandate that 80 percent of MCO contracts with hospitals and primary care providers have VBP targets, and the promotion of shared savings arrangements with ACO-like entities. MQD also has the pay-for-performance capitation payment withhold program for MCO performance described in the previous section. MQD will review these requirements and see if they should be updated and modified in line with the HOPE vision. This will include reviewing primary care spending and primary care payment models.

- *Increase the use of health-related services and in-lieu services by MCOs*. MQD is interested in increasing MCO investment into health-related services and in-lieu of services. In-lieu of services are defined in 42 CFR 438.3. Health-related services or flexible services would be services that improve the health of beneficiaries but are not covered under Medicaid. This could include MCO participation in community-driven initiatives. In order to accomplish this, MQD understands that new capitation methodologies that reward MCOs for creative initiatives may be needed, such as changing MCO profit margins and including health-related services and in-lieu of services in MLR numerators.

- *Targeting payments to particular providers*. MQD is interested in promoting greater utilization of primary care and greater integration of behavioral health with primary care. MQD is interested in payment models through MCOs that would enhance payments to primary care practices and/or other provider groups. These payment models may fall under 42 CFR 438.6(c) or may fall under different authorities. These payment models could include incentive payments or alternative payment methodologies.

- *Incorporating the Social Determinants of Health (SDOH) into payment*. MQD is interested in incorporating SDOH into risk adjustment for capitation payments ***and*** into MCO payments to providers.

- *Developing a process where ACO-like entities can exist under MCOs.* In Hawai‘i, a number of organizations have sprung up that resemble ACOs – groups of providers that are willing to engage in care coordination and care management or organizations that wish to support providers in those activities. These entities may be better suited in some circumstances to provide care management and care coordination for beneficiaries at the point of care. MQD will work to see how ACOs could be financially supported through the managed care program.

High Needs High Cost (HNHC) Individuals

One of the HOPE priority projects is focused on individuals with the highest cost, most complex health and social needs. This is a priority because they are a vulnerable population that experiences significant

disparities, they use a majority of health care resources, and there is potential for a strong return on investment. The goals of this project include improving outcomes, and to use the accrued savings to support the sustainability of HOPE initiatives including investments in primary care, behavioral health integration, and health-related services.

MQD wants to explore opportunities to further develop MCO requirements and programs that can be leveraged to improve outcomes for HNHC individuals. Below are some of the areas MQD is interested in exploring.

- Service Coordination System (SCS). MCOs are required to have a SCS that is designed to address the needs of HNHC adults, adult and children with Special Health Care Needs (SHCN), beneficiaries with chronic conditions, those receiving LTSS, and other vulnerable populations. The MCOs are required to provide service coordination, conduct health and functional assessments, develop service plans, and other services. In addition, MCOs are required to identify beneficiaries whose utilization causes the beneficiary to be in the top five (5) percent of all MCO members by utilization frequency and/or expenditures, and provide service coordination.
- Other Quality Projects/Programs. MCOs are also required to have a disease management plan, quality plans, and other projects and programs that can be leveraged to improve outcomes for HNHC individuals.

One of the reasons MQD wants to reassess the MCO requirements for SCS and the other programs is because a significant amount of resources are used to staff and operate these programs. MQD wants to identify and implement best practices, maintain what is working, and eliminate ineffective, unnecessary and duplicative requirements. The goal is to implement evidence-based programs that are proven to be effective in addressing the Triple Aim as it related to HNHC individuals.

Behavioral Health Integration (BHI)

Another HOPE priority project is focused on promoting BHI across the continuum to improve outcomes for individuals with behavioral health conditions. The overarching goals are to integrate behavioral health (mental health and substance use) with physical health at the primary care level, through the continuum to the most intensive level for individuals with complex conditions and health-related social needs. Other goals include integrating care with value-based payment structures, and screening, diagnosing, and treating conditions as early as possible.

Some of the specific areas MQD is exploring include:

- Research on evidence-based practices and best practices from other states.
- Developing payment models to reimburse PCPs and members of the interdisciplinary team for providing integrated services using the Collaborative Care Model (CoCM) and other evidence-based integration models.
- Developing payment models that reward health plans and providers for integrating care at the most intensive level for individuals with complex conditions and health-related social needs.
- Explore the development of a psychiatric consultation service that supports smaller and rural PCPs that are not affiliated with ACOs or with larger health care systems endowed with accessible behavioral health resources.

- Identifying specific populations (i.e. racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes and develop a plan to improve outcomes and achieve health equity.
- Identifying MCO requirements that will result in improved outcomes. This could include, but is not limited to, changes to MCO staffing requirements, and strategies on how to address the needs of individuals with co-morbid conditions.
- Developing program oversight and management for MCOs related to BHI.
- Identifying if MQD or MCO staffing changes are needed and position descriptions of new positions if appropriate.

Community Care Teams

Currently MQD requires the Managed Care Organizations (MCO) to provide care coordination and other services through the SCS. The MCOs tend to provide many of the services at the health plan level, and MQD received feedback from stakeholders that some of the services need to be based "on the ground" where the providers and members are located. MQD is exploring the development of Community Care Teams (CCTs) in collaboration with the MCOs to ensure that a narrow set of supports for primary care providers (PCPs) that treat patients with complex behavioral health needs are provided where patients are located. The goal of the locally-based CCTs is to support PCPs in delivering quality-driven, cost-effective and culturally appropriate patient-centered care.

One of the reasons MQD is exploring this option is because PCPs, especially PCPs in small and rural practices, have expressed hesitation to routinely screening patients for behavioral health conditions because of the added time required to treat and coordinate care for patients with moderate to serious behavioral health conditions. With limited referral options, the practice staff often spend hours attempting to locate resources for these patients, which places undue strain on practices with limited staffing resources. Currently the MCOs do not assist PCPs in providing this service. In appreciation for the scarcity of time and resources at most PCPs, MQD is currently exploring potential core services the CCT would provide to aid in the adoption of BHI.

Potential core services include triage and referral for patients with complex behavioral health conditions, and linkage to health-related social services. The goal of this service would be to assist PCPs with connecting patients with complex needs to appropriate medical and health-related resources in the community, thus allowing PCPs to focus more time on treating mild or moderate behavioral health conditions in the primary care setting.

Other potential non-core services. Depending on the needs of the community and the MCOs needs, the CCTs could also potentially provide:

- Outreach to individuals who need behavioral health services, but who have not yet presented in a primary care setting.
- Urgent intervention services to individuals who are in emotional or mental distress.
- Health promotion activities, such as health coaching and education.

Community Paramedicine

Community Paramedicine (CP) is an emerging field where Emergency Medical Technicians (EMT) and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations. Services CP programs typically provide include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the Ambulance Medical Director. There is currently one CP program operating on a Neighbor Island that is targeting HNHN individuals, and individuals with behavioral health conditions. MQD would like to explore covering these services and supporting CP programs that target HNHC Medicaid beneficiaries.

Health Promotion and Prevention

Initiatives included in HOPE emphasize the importance of health promotion, prevention, and early detection of disease by encouraging and incentivizing providers to screen and educate individuals and families on the impact of lifestyle choices on health. MQD will promote best practice models of care that emphasize care coordination across providers and have robust primary care capabilities at their center. Additionally, QI plans will focus on more convenient access to routine primary and preventive services. Specific initiatives will include:

- *Community Health Workers*. MQD will create a community health workers benefit and will review whether CHW should provide or be part of a model that would provide care coordination and educational counseling, home visiting, group health education, lactation consultation, child development screening, diabetes prevention programs in a community setting, and science informed parenting education.
- *Diabetes Prevention*. MQD will offer a lifestyle change diabetes prevention benefit or initiative that incorporates education and is provided in a primary care setting.
- *Asthma Education (AS-ME).* MQD will develop and implement an AS-ME benefit that will be focused on assisting beneficiaries to self-monitor and control their symptoms in part through a written asthma action plan, goal setting, training, management skills, proper medication technique, and avoidance of environmental irritants.
- *Ornish Lifestyle Medicine*. MQD will develop and implement a benefit based on the Ornish Lifestyle Medicine model.
- *Project Extension for Community Healthcare Outcomes (ECHO).* MQD will seek to support and promote medical educational opportunities that increases workforce capacity to provide best-practice care to HNHC individuals.
- *Health Promotion in general*. MQD will identify and possibly implement other evidenced-based health promotion, health education, and prevention programs as time goes on. MQD will develop a process where MQD and the MCOs review the latest EBPs on a regular basis and make coverage decisions.

Dual Eligibles

In order to achieve the goals of the HOPE project, Hawai‘i intends to pilot polices that drive the integration and alignment between Medicare and Medicaid for individuals dually eligible for both programs. Hawai‘i currently includes dual eligibles in its managed care program for both physical health and long term services and supports, as well as mandates that plans in Hawai‘i offering MLTSS also offer a companion D-SNP product.

Existing authorities in this waiver proposal and federal Medicaid regulations should provide MQD with the flexibility needed for integration and alignment initiatives for managed care, value based purchasing, and care management for the Medicaid benefit. MQD will also work with colleagues in CMCS's State Demonstrations Group, the Medicare-Medicaid Coordination Office (MMCO), and the Center for Medicare & Medicaid Innovation (CMMI) to explore further authorities that could bring greater integration between the two programs.

In particular, MQD is interested in authorities that would bring more sustainability, coherence, and predictability toward enrollment in D-SNPs, including implementation of enrollment lock-in policies with opt-outs only for cause and allowing seamless conversion. CMS's recent proposed rule [CMS—4182—P] solicited comments on codifying seamless conversion for D-SNPs which may negate the need for a waiver to accomplish a seamless conversion policy. MQD may also seek seamless conversion for Medicaid full benefit dual eligibles both receiving and not receiving MLTSS. This policy would ensure that the state's dual eligibles utilizing behavioral health services not covered by Medicare are able to receive coverage in a D-SNP that would help coordinate physical and behavioral health services.

Finally, MQD intends to bring better coordination between the programs in the administration of the benefits. Strategies may include quality and performance measure alignment, integrating care management payments to providers where applicable, designing strategies that could reduce potentially avoidable inpatient hospitalizations from long term care settings, and broadening the scope of flexible supplemental benefits.

Future Initiative – Substance Use Disorder Residential Treatment

MQD is not requesting a waiver for SUD treatment in this demonstration proposal, but may submit an amendment if this 1115 renewal request is approved. Like other states and the federal government, Hawai‘i recognizes that access to care for substance use disorder (SUD) treatment is essential to raise health outcomes for beneficiaries, and to stem the tide of chronic addiction. Historically, Hawai‘i has supported a SUD delivery system through Medicaid-covered services, state-only funds, and grant funding. However, MQD has found it essential to expand the services eligible for reimbursement in order to meet a rising need for treatment, to more fully bring standardization and evidence based practices (EBPs) to service delivery, and to offer long term sustainability for providers.

Hawai‘i has yet to experience the opioid use disorder (OUD) epidemic to the degree experienced in other states, but history has shown that the state often experiences public health trends after they occur on the mainland. Hawai‘i views a future SUD amendment proposal as an opportunity to proactively address the opioid epidemic and to provide needed additional resources for the state's other SUD conditions, notably methamphetamine use.

A SUD waiver amendment would conform to the guidance in State Medicaid Director letter #17-003 (SMD #17-003).