Health Care Reform: Opportunities for Peer Support

Harvard Law School Center for Health Law and Policy Innovation
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• **Insurance Reforms** protect people with chronic illness.

• Peer Supporters can help with enrollment and advocate for reimbursement in new insurance plans.
  - **Healthcare Marketplaces** make insurance easier to get. Federal subsidies help people afford coverage.
  - **Medicaid Expansion** increases coverage options for low-income adults.

• Peer supporters can work with new healthcare organizations - **Chronic Health Homes** and **Accountable Care Organizations**.

• Grant opportunities in **Preventive Services and Programs**.
What does the ACA do?

1) Insurance Reforms
   – Making the healthcare marketplace fairer
   – Making insurance more affordable/accessible

2) Moving towards new delivery models
   – Provider incentives
   – Encouragement of Health Home Models
   – Accountable Care Organizations
   – Shift towards Prevention
I. Insurance Reforms
Insurance Reform #1
Ends Discriminatory Insurance Practices

- Cannot be denied insurance or charged higher premium because of preexisting condition (2014)
- Health plans cannot drop people from coverage when they get sick (already in effect)
- No lifetime limits on coverage (already in effect)
- No annual limits on coverage (2014)
Insurance Reform #2
Health Insurance Marketplaces

**Affordability:**
- Federal subsidies for people with income up to 400% FPL

**Consumer-Friendly:**
- Transparency
- Streamlined Enrollment

**Coverage Guarantees:**
- Essential Health Benefits
- No Discrimination based on Gender or Health Status
### Essential Health Benefits Package

**ACA Essential Health Benefits**

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity/newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

- **All** insurance plans sold in marketplaces **MUST** include these 10 benefit categories.

- Federal regulations set a “floor” for what each category must include. State-based marketplaces can add to the requirements in their states.

- Plans will still be different within each category. Prescription drug formularies, for example, might be different.
Role of Peer Support in Marketplaces


- Navigators
- Consumer Assistance Programs
- In-Person Assistance Programs

Negotiate for peer support to be reimbursed by plans in the Marketplaces.
Navigator Programs

• Experts on Marketplace coverage options, do outreach and public education on them.
• Give fair, accurate, impartial information.
• Help people sign up for plans.
• Make referrals for grievances, complaints, appeals, questions about using coverage.
• Culturally competent, accessible.
• ALL Marketplaces will have these.
Role of Navigators

• In federally-facilitated and partnership marketplaces, federal government will select navigators and award grants.

• In partnership marketplaces, states monitor navigators, provide support, can train.

• In state-based marketplaces, states select navigators, award grants, provide training, monitoring, and support.
In-Person Assistance Programs

• An addition to – not substitute for – Navigators. Supplements, fills gaps.
• NOT available in federally-facilitated marketplaces.
• MUST be available in partnership marketplaces.
• ALLOWED, not required, in state-based marketplaces.
Consumer Assistance Programs

• CAPs help consumers solve insurance problems and conduct outreach.
• ACA provided $30 million to states to launch or expand CAPs in 2011. CAPs do appeals, collect data on common problems, educate consumers, and help with enrollment.
• No additional 2012 funding, future funding uncertain. Some states are continuing on their own.
Role of Peer Supporters

• Training is available, community connection is most important.

• Peer supporters may work for community organizations or health care providers that get grants to be navigators or in-person assisters.
2. Medicaid Expansion

- Lets states expand Medicaid eligibility to adults with income under 138% FPL (2014)
  - $15,856 for an individual/$32,499 for family of four (2013)
  - Individuals earning federal minimum wage at 40 hours/week would qualify.

- Improves Services
  - Medicaid expansion includes Essential Health Benefits (EHB)

- Streamlines Application and Enrollment

- Higher Primary Care Reimbursement
  - Reimbursement to Medicare levels for PCPs in 2013-14
Expansion Groups Gets EHB Plus Medicaid Benchmark

Medicaid Benchmark Requirements

- Prescription drugs
- Mental health services
- Family planning services
- Non-emergency transportation
- Inpatient & outpatient hospital services
- Physicians’ surgical and medical services
- Laboratory and x-ray services
- Well-baby and well-child care
- Emergency services
- Access to rural health centers and federally qualified health centers (FQHCs)

ACA EHB Requirements

- Prescription drugs
- Mental health and substance use disorder services
- Hospitalization
- Maternity and newborn care
- Emergency services
- Ambulatory patients services
- Rehabilitative and habilitative services
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care
What happens in a state that does not expand Medicaid?

**Traditional Medicaid**
- Limited to people with very low income AND who fall into qualifying category:
  - Disabled
  - Low-income parents w/ dependent children
  - Pregnant women
  - Low-income children

**The Gap**
- People with incomes below 100% FPL, but who cannot qualify for Medicaid under current rules may be left out of reform if the state does not expand

**Subsidized Private Insurance through Exchanges**
- Private insurance available through exchanges:
  - Premium tax credits for people with income between 100 and 400% FPL
  - Cost-sharing subsidies for people with income between 100 and 250% FPL
State Decisions on Medicaid

Where the States Stand: March 13, 2013
25 Governors Support Medicaid Expansion

Source: The Advisory Board
Role of Peer Support in Medicaid Expansion

Eligibility/Enrollment
• Help clients enroll or refer to enrollment assistance.

Opportunities to Integrate Peer Support
• In states that reimburse for peer support in behavioral health, push to include in expansion plan.
• In states without peer reimbursement, push to add.
• Push for states to reimburse for other chronic disease support too.

Advocacy
• Advocate for expansion
Possible Medicaid Options for CHWs/Peer Supporters

- Medicaid administrative funds
- Medicaid Managed Care Organizations (MCOs)
- Section 1115 waivers.
– ACA requires states to establish outreach procedures to vulnerable populations
– Federal funds are available to states to administer Medicaid programs
  • Outreach, eligibility determination, coordination and translation services have all been funded
  • Could apply to expansion as well as regular Medicaid
– Possible CHW/peer supporter collaboration with public health departments and community groups providing administrative services
Medicaid MCOs

- 70% of all Medicaid beneficiaries nationally are enrolled in MCOs
- Capitation main source of MCO payment
- Provides opportunity for innovative models that incorporate CHWs
  - Some MCO programs have funded CHW programs, (direct employment by the MCO or inclusion of CHW services as a reimbursable benefit)
  - Good way to target medically underserved groups

Source: National Health care for the Homeless Council
Section 1115 Waivers

- Waivers let states change federal rules.
- Have been used by states to cover CHW programs.
  - CHW as reimbursable provider (AK, CA and MN).
  - Remember this is an opportunity even where state does not expand Medicaid.
  - Problem: burdensome process.
II. Changing the Model for Health Care Delivery

- Chronic Health Homes
- Accountable Care Organizations
- Long-Term Supports and Services
- Emphasis on Prevention
Need for Coordinated Whole Person Care

• Current fee-for-service system leads to fragmentation across many providers
• Tendency not to pay for care coordination and case management services
• Incentive to see many patients = not enough time with each patient individually
• Often insufficient cultural competence and health navigation

Existing system not ideal for chronic disease management
Medicaid Chronic Health Homes: A Model for Chronic Disease Management
Characteristics of a Medical Home Model

Coordination and integration of whole person care
- Each patient has a personal physician who arranges care with subspecialists and consultants, and oversees and coordinates the team
- Exchange of health-related information through electronic health records; patient registries; care coordinator services
- Comprehensive care including preventive and end-of-life care

Enhanced access
- Flexible scheduling system; easy access to members of the team

Quality and safety
- Decision support based on updated practice guidelines

Payment
- Quality-based payment and sharing of savings achieved from reduced care costs; reimbursement for care coordination; recognition of complexity and severity of illness

Taken from “Joint Principles of Patient-Centered Medical Homes, American Academy of Family Physicians; the American Academy of Pediatrics; the American College of Physicians; and the American Osteopathic Association.”
The Medicaid Health Home Option

- The ACA authorizes a new state option in the Medicaid program to implement health homes for individuals with chronic conditions.

- This model builds on the PCMH models already implemented in many states to focus specifically on people living with chronic conditions.

- Development of health homes can help states:
  - Improve care for people with chronic conditions
  - Restrain growth in Medicaid costs
Who is eligible for a Health Home?

Medicaid Beneficiaries who:

• Have 2 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 ACA: mental health, substance abuse, asthma, diabetes, heart disease, and being overweight.
What services are included in the ACA Health Home Option?

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services
As of 2/15/13, **8 States** have had their Health Homes SPAs approved by CMS:

- Missouri (2 SPAs approved 10/20/11 and 12/22/11)
- Rhode Island (2 SPAs; approved 11/23/2011)
- New York (approved 2/3/12)
- Oregon (approved 3/13/12)
- North Carolina (approved 5/24/12)
- Iowa (approved 6/8/12)
- Ohio (approved 9/17/12)
- Idaho (approved 11/21/12)
States Have Considerable Flexibility to Design Their Own Health Homes

States can determine their own

• Population
• Providers
• Payment
Selection of Health Home Population

• States determine which chronic conditions to cover
  – Most have adopted the chronic conditions listed in the ACA - including mental health, substance abuse, asthma, diabetes, heart disease and being overweight
    • Rhode Island and Ohio limit adult programs to those with mental illness or substance abuse problems
    • NC considers certain diagnoses such as diabetes to place a person at risk for other qualifying conditions.
  – States can also target individuals with chronic conditions outside the ACA list with CMS’ approval
    • Oregon includes people with HIV, cancer and Hepatitis C
• Can be limited to certain acuity levels/ those with more severe conditions
• Can be limited to specific geographic areas, but all states have chosen to implement statewide
Selection of Health Home Providers

• **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 operating w/ desig. provider**
  – May include physicians, nurse care coordinators, nutritionists, social workers, behavioral health professionals, or others
  – Can be free-standing, virtual, hospital-based, or a community mental health center or another appropriate setting

• **Health team**
  – Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, chiropractic, licensed complementary and alternative practitioners
What are the Financial Benefits to States?

- 90% federal matching funding for health home services for the first two years
  - After 2 years match rate reverts to the state’s normal Medicaid rate
  - Enhanced match does not apply to the underlying Medicaid services provided to individuals enrolled in a health home, only to the specific health home services (e.g. care coordination) listed in the statute
  - A state may receive more than one period of enhanced match, but will only be allowed to claim the enhanced match for a total of 8 quarters for one beneficiary

- States are also eligible for up to $500,000 in planning funds to explore the feasibility of creating health homes
Payment methodologies:

- Monthly management care fee (most states)
  - Can vary based on the severity of a person’s condition or the capabilities of health home provider

- Fee-for-service

- State may propose alternative approach
Medical Homes vs. Health Homes

Similar goals but a few important differences:

• Unlike PCMHs, Health Homes must coordinate with behavioral health providers

• Health Homes are required to help enrollees obtain non-medical supports and services (e.g. public benefits, housing, transportation)

• Health Homes can move coordination beyond primary care

*Health Homes offer flexibility to address the specific needs of the chronically ill*
Role of Peer Support in Health Homes

• Peer supporters can become members of care teams. Excellent for retention in care, care coordination and case management.

• A way to expand peer support in Medicaid:
  - Beyond behavioral health;
  - To states currently without any peer support system in Medicaid.
Community Health Teams (CHTs) for PCMHs

- Grants provided to states or state designated entities to fund interdisciplinary teams to support patients and providers using the PCMH model.
- The CHT would supplement primary medical care with community-based prevention, patient education and care management.
- CHWs are not listed as eligible members of CHT, but the list is not exclusive.
- Currently unfunded (though look at VT Blueprint for Medical Homes)
Changing the Model for Health Care Delivery

Long-Term Supports and Services
Long-Term Supports and Services (LTSS)

- State Medicaid programs must pay for nursing home care. However, states are not required to provide long-term services outside of an institutional setting.
- The ACA encourages state experimentation to shift away from institutional care toward community and home support services.
- Opportunities for community health workers to play important role.
ACA Provisions: Long-Term Support and Services

Enhanced Medicaid funding:
1. The Balancing Incentive Payments Program
2. The Community First Choice Option
3. Home and Community Based Services Option
4. Money Follows the Person Demonstration Extension

ACA funding:
4. Community-Based Care Transition Program
5. Workplace Grants
The Balancing Incentive Payments Program

- Started in 2011, a 4-year, $3 billion program for states to make home and community-based services more accessible and reduce costs
- For states that spent under 50% of their Medicaid long-term care money on non-institutional care in 2009.
- States submit a plan to increase the use of home care in Medicaid.
- States can get either 2% or 5% FMAP increase.
- 8 states signed up so far.
The Community First Choice Option

• Gives states 6% FMAP increase for providing community-based attendant services and supports as an alternative to institutional services.

• For services to assist with activities of daily living and health-related tasks.

• Can cover transition costs from institution to community.

• Services must be offered statewide-- no waiting list.

• Medicaid-eligible individuals with incomes up to 150% of the federal poverty level.
Medicaid HCBS State Plan Option

- Allows states to create new eligibility category for individuals to receive home and community based services, even if they do not meet the requirements for institutional level care.
- Individuals with incomes up to 150 percent of poverty with functional limitations can qualify.
- Went into effect in October 2010.
- More flexibility in services; eligibility maximums; and protections.
- Must be statewide.
Money Follows the Person

- Medicaid demonstration project connects individuals in institutions to transition coordinators long-term community supports
- Served than 19,000 people since 2008.
- ACA extends through 2015; broadens eligibility; adds $2.25 billion, allowing 12 additional States to join
Workforce Capacity

• $10 million for new training opportunities for direct care workers who provide long-term services and supports.

• $5 million for demonstration projects to develop training and certification for personal and home care aides.
Community-Based Care Transition Program

- $500 million in ACA funding
- Focused on Medicare beneficiaries with complex health needs as they transition from hospital care
- Currently 47 community-based organizations partnering with acute-care hospitals around the country to provide these supports
Use of Peer Support in LTSS

• Opportunities for CHWs in long-term support services in Medicaid
  – Arkansas’ Community Connector Program
• Opportunities for CHWs/Peer supporters in Community-Based Care Transitions Program
• Workforce/Cultural competency training grants
Changing the Model for Health Care Delivery

Accountable Care Organizations
Accountable Care Organizations

An entity made up of health care providers across the continuum of care that agrees to be held accountable for improving the health of its patients. If patients’ health care costs end up being less than would otherwise be expected while quality is maintained or improved, providers keep a share of that savings.

Source: Families USA
ACOs in the ACA

- Medicare Shared Savings Program and Pioneer ACOs: Began in 2012.
- Medicaid Pediatric ACO 5-year demonstration project. Some states launching broader Medicaid ACO programs too.
- ACA is silent on ACOs in private market, but insurers are very interested; Aetna and UnitedHealthcare are both exploring options.
State ACO Activity

• Colorado has an active Medicaid ACO
• New Jersey is promulgating regulations
• Oklahoma, Oregon, Utah, Massachusetts, and Vermont are all planning Medicaid ACO projects.
Peer Support Opportunities in ACOs

• Provider organizations have incentives to reduce costs. Peer supporters would make excellent members of care teams and can be employed by provider groups.

• Use training and certification from behavioral health programs, either in your state or another state as needed. Make new training and certification programs for chronic disease programs.
Some Thoughts on Inclusion in Insurance Plans Going Forward

• Quantitative + Qualitative Data Collection: identify criteria around health outcomes and track them for all patients.

• Use the data to argue for cost-effectiveness and inclusion in Marketplace, Medicaid, Medicare plans.

• Ongoing professionalization.
Changing the Model for Health Care Delivery

Emphasis on Prevention
Preventive Services

• Medicare and new private plans must cover routine preventive services graded A and B by the USPSTF at no cost to the consumer, along with additional preventive care and screenings for women

• States that opt to provide preventive services to all Medicaid beneficiaries receive a 1% FMAP increase for their Medicaid programs
Examples of Free Screenings

Aspirin to prevent cardiovascular disease
Blood Pressure Screenings
Cholesterol abnormalities screening
Type 2 Diabetes Screening
Cholesterol Abnormalities Screening
Healthy Diet Counseling
Obesity Screening and Counseling
Tobacco Use Counseling and Interventions
Depression Screening (for adults only)
Investments in Prevention

Investments in Prevention and Public Health Fund

Investments in Community Health Centers

Investments in Health Workforce
Prevention and Public Health Fund

Programs Across the Country:

• Community Transformation Grants:
http://www.cdc.gov/communitytransformation/.

• Positive Health Behaviors and Outcomes: CDC grants to support CHWs.

• Preventing Chronic Diseases in the Medicaid Population:
http://innovation.cms.gov/initiatives/MIPCD/.

• Maternal, Infant, Early Childhood Home Visiting Program:

• National Diabetes Prevention Program:
Community Transformation Grants

• Focus on: Clinical and community services to prevent and control high blood pressure and cholesterol; Tobacco-free living; Active living and healthy eating.

• Available to state and local governments, tribes and territories, non-profit organizations, and community-based organizations

• In 2012, added Small Communities Program and National Dissemination and Support Initiative
Possible Future Opportunities

• Watch for possible CDC grants to promote the Community Health Workforce
• Watch for possible Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training
• Watch for possible grants for small businesses to provide workplace wellness programs
• Watch for renewal of Patient Navigator grants.
Re- Cap

• More people will have health insurance. You can help them sign up.
• This is the perfect time to advocate for peer support reimbursement in Medicaid and private insurance/marketplaces.
• New healthcare models will benefit from peer supporters – work on partnering with health homes and ACOs.
• There is federal money for preventive care.
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