# Capacity

Prevention and self-management services for Medicaid could be provided and financed in a variety of ways. A mix of models to save money and achieve improved health outcomes may be utilized to fully reach the Medicaid patient population. These include a state health plan amendment, value-based payments, the state-based health information system, and private health information technology options. Details of these models are discussed below.

**State health plan amendment**

The Centers for Medicare and Medicaid (CMS) changed the rule for prevention services, which opens the door to implementing a coordinated team-based care framework. The CMS ruling "Medicaid and Children's Health Insurance Programs: Essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, and premiums and cost sharing; exchanges: eligibility and enrollment" (CMS-2334-F) revised the regulatory definition of prevention services at 42 CFR 440.130(c), which became effective January 1, 2014. The rule allows state Medicaid programs to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. Each state must implement a health plan amendment to accept this rule in their Medicaid program.

Preventive services are defined as services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency

While Medicaid is the target for this business case, there are examples from Medicare and private payers that could be utilized as models. It will require a variety of strategies to significantly impact the health outcomes of our most disparate populations.

**Value based payment models**

Value based payments are "payment arrangements that pay physicians, hospitals, medical groups, and other health care providers based on measures including quality, efficiency, cost, and positive patient experience." Examples of these models include:

- **Medicare quality incentive programs.** "Medicare quality incentive program is a pay-for-reporting program that gives eligible professionals incentives and payment adjustments if they report quality measures satisfactorily. Although the physician quality reporting system (PQRS) is a standalone program, it touches on other CMS programs that require quality reporting, such as the eRx Incentive Program, the electronic health records incentive program, the Medicare shared savings program, and the value-based payment modifier."
- **Pay-for-performance.** "In a pay-for-performance system, providers are compensated by payers for meeting certain pre-established measures for quality and efficiency. Pay-for performance-programs have been implemented by both Medicare and private insurers."
- **Accountable care organizations (ACO).** "Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to

ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."

- **Bundled payments.** "Episode or bundled payments are single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings."
- **Patient centered medical home (PCMH).** The PCMH is a team-based model based on the premise that the best healthcare begins with a strong primary care foundation, accompanied by quality and resource efficiency incentives. Patients in a PCMH have a personal provider, who along with his/her team, provides continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes. The PCMH section collaborates closely with the services in implementation efforts, policy development and the formal recognition process. The PCMH is a model of healthcare based on an ongoing, personal relationship between a patient, doctor and the patient's care team. Whatever the medical needs – primary or secondary, preventive care, acute care, chronic care, or end-of-life care – the patient has a medical "home"; a single, trusted doctor and care team, through which continuous, comprehensive and integrated care is provided."
- **Payment for coordination.** "This model involves payment for specified care coordination services, usually to certain types of providers. The most typical example of this is the medical or health care home model whereby the medical home receives a monthly payment in exchange for the delivery of care coordination services that are not otherwise provided and reimbursed."[i]

**Health information systems**

A critical piece to the coordinated team-based care framework is the exchange of health information. Currently, there is no one system that has the capacity to manage all of the health information and serve as a communication network among all providers. However, there are a number of promising opportunities to consider. Wisconsin's health information exchange has the potential for expansion and could eventually serve as the communication platform for all parties involved in the coordinated team-based care framework.

- **Wisconsin Statewide Health Information Network (WISHIN).** WISHIN provides a health information network that currently connects participating physicians, clinics, hospitals, pharmacies and clinical laboratories. The purpose of this exchange is to provide timely, relevant information leading to better clinical decisions, less duplication, more effective transitions of care and reduced administrative costs.[ii] The WISHIN community health record (WISHIN Pulse) has the potential for expansion to include prevention and self-management providers to view and exchange information. The types of information could be expanded to include prevention and self-management services as well as the practitioners providing these services. This expansion would improve communication between clinical and prevention and self-management providers to work as an effective team.

**Health information technology options**

Other technology options are being discussed by key leaders representing health systems, payers and public health. These options could potentially implement pieces of the coordinated team-based care framework. Several of these tools are described below.

- **Camden Health Information Exchange.** "Launched in 2010, the Camden Health Information Exchange (HIE) is a collaborative data-sharing effort to improve care delivery in Camden. The Camden HIE is a web-based technology offering participating local and regional health care providers secure, real-time access to shared medical information. For providers, having access to shared clinical information fosters improved care coordination and reduces unnecessary,

costly duplication. For Camden Coalition staff, data from the HIE can identify individuals eligible for enrollment in the Coalition's intervention programs.

Camden HIE participants include hospitals, primary care practices, laboratory and radiology groups, social service organizations, correctional facilities, and other licensed health care facilities and providers. In order to protect patient privacy, the Camden HIE is built and governed to ensure that only health care providers can access the personal health information of their patients." [iii]

- **Epic Healthy Planet.** Epic Healthy Planet aims to consolidate information across systems to take the best care of your community. Epic software can be extended to independent practices and hospitals through Community Connect. Community providers can be kept in the loop with an integrated portal that lets them stay up-to-date with their patients, submit referrals, order labs and imaging, schedule visits, and more. Users can bring in data from any vendor source, including claims, revenue and other electronic health records (EHRs). Epic Healthy Planet creates a single longitudinal plan of care accessible to patients, providers, care managers, and affiliates. Providers can communicate with other EHRs and allow external providers to review and resolve care gaps through a web-based care management portal. The program engages the patient by providing access to key health data, self-service capabilities, and health and wellness reminders through an EHR-agnostic patient portal.

- **Health Leads Reach.** Health Leads Reach is a purpose-built, cloud-based solution enabling health systems to manage and track the success of their social needs programs. The case management feature guides patients and providers from screening to intake to action plan. Providers can search thousands of nearby community resources, using intelligent filters to quickly identify the best resources for your patient. With over 50 standard on-demand reports, providers can make more effective and dynamic treatment decisions for their patients. Case managers and patients can track progress through a plan of care. Integrated communications allow text or email right in the program. Health Leads Reach is available through an internet connection, through any web browser on any device. This software has passed numerous independent IT security audits and is trusted by some of the country's leading healthcare providers.

- **Healthify.** This software tool is for care managers, community health workers, and social workers to **coordinate referrals** with community-based organizations. Healthify is a software provider to health plans, hospitals, and provider networks working in low-income communities. Their platform can be used by care teams to make quick and accurate referrals for patients who need additional help from social services. Healthify identifies five services to help organizations manage the social determinates of health. Users on the Healthify Community Resource Platform can search, filter and refer to community organizations, social services and government benefits. Integration services are offered to make the user's experience seamless.

  The Referral Platform is an advanced tool for care teams to refer patients in need of social services to community organizations. Users can verify completed referrals by communicating directly with participating community services. Referral information is stored on the patient dashboard. Trends in community needs can be used to see the most common needs and service gaps in any community through an analytics dashboard. Feedback can be provided to community organizations about the resources from the users. Currently, the database has over

125,000 resources in 25 states. Patient-centered tools also are available including profiles, referral tracking and texting.

An assessment platform can be used by care teams to determine psychosocial risk levels. An algorithm automatically recommends services to address those needs. Multiple assessments can be hosted in Healthify to fit all patient population's health needs.

- **MyHealthDirect.** MyHealthDirect is a data driven platform for referral management and online scheduling. MyHealthDirect coordinates care by consolidating referral activities into a single platform with real-time scheduling. The system automates scheduling workflows with business rules and enables providers to define appointment criteria. MyHealthDirect simplifies access for people across the healthcare system with the right provider match for online engagement. This tool also visualizes trends and drives behavioral change to optimize capacity, outcomes and practice performance with actionable analytics.

- **NowPow.** NowPow connects health care to self-care by connecting people to high quality community resources. From stress management to smoking cessation, fitness classes to family planning, NowPow collects and shares detailed information on the services everyone needs to stay well and live long. NowPow creates customized community resource e-prescriptions that extend, complement and complete care plans. Their technology includes seamless EHR integration, including Epic, so providers can automatically generate and deliver customized e-prescriptions at the point of care. While NowPow has an enormous inventory of resources, e-prescriptions are personalized to the patient based on their address, conditions, age, gender and language spoken to create customized service referrals.

  Patient engagement tools are embedded throughout the technology to nudge patients and keep self-care top of mind, increasing the likelihood of taking action. Any individual that extends care past the provider's office can use this tool to easily access self-care plans and customize them to meet the needs of their patients. Mobile-enabled applications empower patients and community health workers to create self-care plans and search for services in non-clinical settings. In the referral tracker tool, service providers update referral information which allows care professionals to monitor patient activity and report on referral success rate.[iv]

- **Pathways Community HUB Model.** The "Pathways Community HUB Model helps identify, care for, and track treatment outcomes of those at-risk in a coordinated, cost-effective manner. This model helps meet the goals of healthcare reform … and achieve an emphasis on preventative, rather than reactionary, care. The Pathways Community HUB Model cost-effectively meets the health, physical, behavioral and social needs of at-risk individuals." [v]

  "The Pathways HUB Connect database collects and retains the social determinants of health information gathered by the care coordinators using the Pathways processes. HUB administrative staff access the system through secure channels and manage the HUB operations, reporting and invoicing. Care coordinators access the system through the Pathways Mobile tablet applications, mobile tablets accessing the HUB portal through secure web browsers, and directly via the user-enabled HUB portal that the HUB administration staff use. In this way, the HUB and the care coordinators are able to enter client information timely and available for use in real-time by other HUB users. "

The Pathways Mobile application delivers the client caseload to the care coordinator. The application includes the entire pathway system and checklist for each client allowing the care coordinator to record information gained during client meetings.[vi]

**Mapping tools to the coordinated team-based care framework**

Table 5 on page 44 maps each of the health information tools, described on pages 40-43, to the coordinated team-based care framework in Figure 6, copied below for your reference. Each column in the table represents a shape in the framework (e.g., Medicaid payer, clinical care team, value-based financing) and the corresponding "X" in the columns indicate the current capacity of each tool to interact with the identified portion of the framework.

**Figure 6. Coordinated team-based care framework**

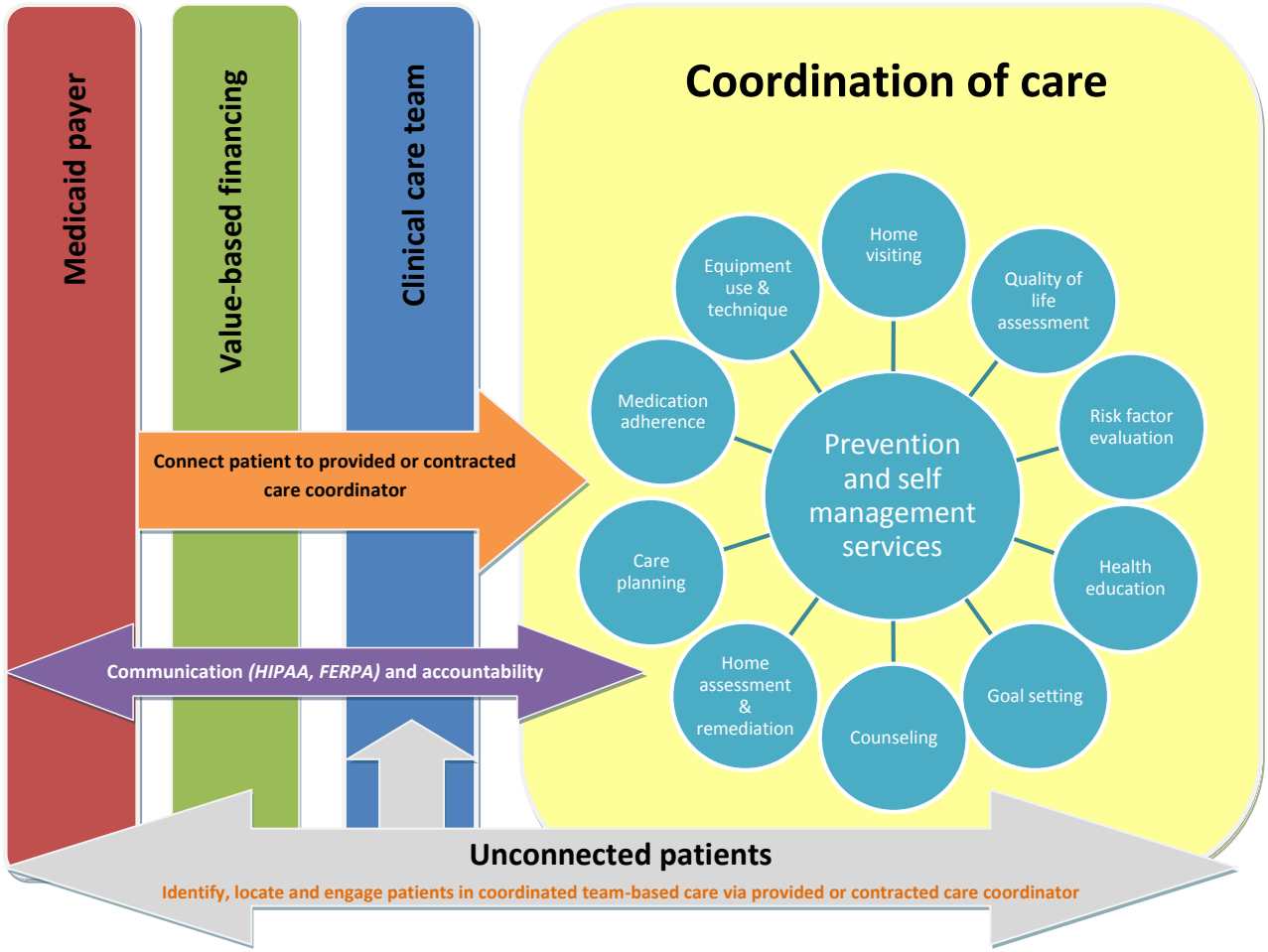

**Table 5. Health information tools mapped to the coordinated team-based care framework**

| | Medicaid payer | Value-based financing | Clinical care team | Connect patient to provided or contracted care coordinator | Prevention and self-management services | Unconnected patients | Communication (HIPAA, FERPA) and accountability |
|---|---|---|---|---|---|---|---|
| **Camden Health Information Exchange (HIE)** | | | X | X | X | | X |
| **Epic Healthy Planet** | | | X | X | X | | X |
| **Health Leads Reach** | | | X | X | X | | X |
| **Healthify** | X | | X | X | X | | X |
| **MyHealthDirect** | | | X | X | X | | X |
| **NowPow** | | | X | X | | | X |
| **Pathways Community HUB** | X | X | X | X | X | X | X |
| **WISHIN** | X | | X | X | | | X |

[i] HIT Consultant. Six most common value-based payment models. http://hitconsultant.net/2014/05/29/6-most-common-value-based-payment-models/

[ii] WISHIN. (2013). Who is WISHIN? http://www.wishin.org/AboutWISHIN.aspx

[iii] Camden Coalition of Healthcare Providers. (2016).Camden Health Information Exchange. Linking patient data across systems for improved care delivery. https://www.camdenhealth.org/programs/health-information-exchange/#

[iv] Metastar. (2016). Linking Clinical Delivery Community Resources: A Landscape Assessment August 2016. http://www.metastar.com/wp-content/uploads/2016/08/Linking-Clinical-Delivery-to-Social-Resources-August-2016.pdf

[v] Care Coordination Systems. (2016). http://carecoordinationsystems.com/

[vi] Redding, S. and Harnach, R. Care Coordination Systems. Pathways HUB Connect Technologies.