Bridging to Preventive Care: The Roadmap to Medicaid Coverage of Community Based Chronic Disease Prevention & Management Programs

September 20, 2017
Introductions & Agenda

• Introduce Panelists
• Overview of Bridging to Preventive Care Project
• Overview of National Diabetes Prevention Program (DPP) at YMCAs
• DPP at the Greater Joliet YMCA
• Overview and Pilot of Diabetes Self-Management Program (DSMP) by AgeOptions
• Overview of Harmony Wellcare’s Interest in the Pilots
• Group Discussion
Bridging to Preventive Care: Medicaid Coverage of Community-Based Chronic Disease Prevention & Management

**Goal:**
Leverage new CMS rules on Medicaid payment of community-based providers to expand diabetes prevention and management services to Medicaid clients

**Task**
Develop a Roadmap; launch a pilot; expand capacity; scale
How we got to the Roadmap:

• CMS willing to pay community providers in Medicaid
• Coordination amongst IL public health/community partners
• April, 2016 kick-off meeting- explored challenges to chronic disease prevention
Roadmap Development Process:

• Summer working groups:
  • Quality/qualifications
  • Data and reporting
  • Payment and billing
  • Care coordination/referrals
  • Community-based infrastructure

• 2 meetings of advisory committee
• Draft MOU developed for discussion
• Roadmap drafted
Roadmap finalized: Called for demonstration project to provide Medicaid coverage for:

- Diabetes Prevention Program and
- Diabetes Self-Management Program
Bridging to Preventive Care State Forum

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<th>Demonstration Project Goals</th>
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<td>• Learn how Medicaid clients can be successfully recruited and motivated to participate</td>
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<td>• Demonstrate contracting mechanisms—including CBO infrastructure and data communication practices</td>
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<td>• Share best practices</td>
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<td>• Facilitate expansion from demonstration programs to state-wide involvement by mid-2018</td>
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Next Steps

• Pilot Program Implementation
• Bi-monthly learning collaborative
  • What’s working, what’s not for Medicaid clients?
  • How’s referral systems, payment mechanisms, etc. working?
  • Quality improvement goals
• Take lessons learned to try to scale across state
• Engage more Medicaid MCOs
MEASURABLE PROGRESS UNLIMITED SUPPORT

THE Y AND POPULATION HEALTH: EMERGING TRENDS AND CONTEXT FOR THE YMCA’S DIABETES PREVENTION PROGRAM
TRENDS IN POPULATION HEALTH: THE Y’S CHANGING ROLE
THE CHANGING HEALTH CARE LANDSCAPE

**Past**

**Acute Health Care System**
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

**Present**

**Coordinated Seamless Health Care System**
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

**Future**

**Community Integrated Health Care System**
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and Preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

HHS’S VIEW OF COMMUNITY BASED ORGANIZATIONS’ VALUE IN HEALTH CARE

Y-USA’S STRATEGIC PLAN
IMPROVING THE NATION’S HEALTH AND WELL-BEING

Critical Social Issues Affecting Our Communities:
• High rates of chronic disease and obesity (child and adult)
• Needs associated with an aging population
• Health inequities among people of different backgrounds

Our Shared Intent:
To improve lifestyle health and health outcomes in the U.S., the Y will help lead the transformation of health and health care from a system largely focused on treatment of illnesses to a collaborative community approach that elevates well-being, prevention and health maintenance.

Our Desired Outcomes:

- People achieve their personal health and well-being goals
- People reduce the common risk factors associated with chronic disease
- The healthy choice is the easy, accessible and affordable choice, especially in communities with the greatest health disparities
- Ys emphasize prevention for all people, whether they are healthy, at-risk or reclaiming their health
- Ys partner with the key stakeholders who influence health and well-being
COMMUNITY INTEGRATED HEALTH

The Y’s Model of Community Integrated Health

- Healthier Communities Initiatives
- Evidence-based Programs
- Compliance
- Shared Spaces
- Capacity Building
- Health Equity
- Community Health Navigation
EVIDENCE BASED PROGRAMS AND THE Y
• ACOs have the capacity to risk stratify the target population using clinical indicators and claims data

• Targeted high-risk beneficiaries should be referred to the appropriate primary or secondary prevention program

• YMCA evidence-based programs provide the capacity to implement preventive health strategies that are proven to drive improvement of clinical outcomes and reduction in overall healthcare expenditures
THE Y’S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS

- YMCA’s Diabetes Prevention Program
- Enhance Fitness (Arthritis Self-Management)
- LIVESTRONG at the YMCA (Cancer Survivorship)
- Moving For Better Balance (Falls Prevention)
- Blood Pressure Self-Monitoring
- Childhood Obesity Intervention
- Brain Health
- Parkinson’s
- Tobacco Cessation

Building the pool of the 21st century
THE YMCA’S DPP
### THE STORY OF THE YMCA’S DPP

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<td>Y not involved. NIH funded study.</td>
<td>Indiana University School of Medicine works with the YMCA of Greater Indianapolis to successfully translate group based DPP at lower cost.</td>
<td>YMCA of Greater Louisville validates in non-research environment. The Y could recruit participants.</td>
<td>Became inaugural partner in the National Diabetes Prevention Program with CDC, and worked with TPA to create system to allow for any third party payors to reimburse the Y for outcomes.</td>
<td>Y-USA launched scaling and dissemination plan with the long-term goal of ensuring the program is available to every Y who wants to sustainably offer it in their community.</td>
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YMCA’S DIABETES PREVENTION PROGRAM

THE PROGRAM IS:
• Led by a trained Lifestyle Coach
• A one-year program: 19 sessions in the first 6 months, then 6 sessions in the second six months
• Open to all community members; YMCA membership is not required
• A Centers for Disease Control and Prevention (CDC)-approved curriculum

PROGRAM QUALIFICATIONS:
• At least 18 years old,
• Overweight (BMI ≥25), and
• Prediabetes confirmed via one of 3 blood tests or previous diagnosis of gestational diabetes
• If no blood test, a qualifying score on a risk assessment

PROGRAM GOALS:
• Reduce body weight by 5-7%
• Increase physical activity to 150 minutes per week
PARTICIPANTS

• DO NOT need to be members of the YMCA to enroll in the program
• MUST NOT already have diabetes or blood values in the diabetes range
• Typically receive a participation incentive tied to attendance
In September of 2013, Ys voted to establish a national program fee for the YMCA’s DPP.

- All participating Ys offer program at uniform price: $429 for the year-long program.
- Reduces price discrepancies for Ys in close proximity of each other and keeps program value consistent across all providers.
- Ys can sell directly to payors (flat fee/participant) through a direct payor partnership option.
- Ys can still provide scholarships or financial assistance to self-pay program participants.
- Payors interested in providing the program via a pay-for-performance claims-based model can be connected to TPA.
All numbers represent data collected to date.
1 Includes Indiana’s 392 participants from 2005 – June 2010
2 Does not include # of classes in Indiana prior to June 2010
MEDICARE
The YMCA’s award

- YMCA of the USA and its partners worked to engage nearly 8,000 Medicare beneficiaries with prediabetes in the YMCA’s Diabetes Prevention Program.

  - The intervention was delivered by 17 Ys in 8 states
  - Claims were “reimbursed” using 2011 fee schedule from commercial market
  - About 1/3 of these participants were covered by Medicare Advantage plans

- Participants had to be overweight and have a qualifying blood value within the prediabetes range

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MEDITICARE PROJECT RESULTS

• 7,731 Medicare participants were served
  • Average of 13.3 (of 16) core sessions attended
  • Avg Weight Loss of 5.3% through core sessions

• Historic certification of cost savings by CMS Actuary
  • $2,650 in savings over 15 months (5 to 1 ROI)
MOVING FORWARD

- We’re on the path to Medicare coverage of the YMCA’s Diabetes Prevention Program
  - Rule-making took place in summer 2016
  - Coverage anticipated 1/1/2018

- Working with Bridging Preventative Care Project to expand opportunity to Medicaid recipients

- Convening Illinois YMCAs DPP Task Force to create a network of program sites throughout Illinois.
QUESTIONS
Bridging to Preventive Care: Diabetes Self-Management Program

Rob Mapes, Director of Program and Community Support
AgeOptions

• Area Agency on Aging for suburban Cook County
• Managing statewide IL Pathways to Health grant from ACL
  – Statewide website https://www.ilpathwaystohealth.org/
  – Over 1,500 people completed workshops over 2 last years
• License holder of CDSMP/DSMP for over 10 years
• Diabetes Self-Management Program
• Workshops are 6 weeks long
• Each weekly session is 2.5 hours long
• Workshops are conducted by two trained facilitators
• Facilitators must successfully complete a 4 day training conducted by certified Master Trainers
Meeting the Triple Aim Outcomes

1. Better Health
   – Improvement in self-reported health
   – Improved symptom management

2. Better Care
   – Improvement in communication with doctors and medication compliance

3. Lowered Health Care Cost
Dollars and Sense

• $714 per person savings in emergency room visits and hospital utilization.
• Member satisfaction from workshop could lead to member retention
Suggested Eligibility and Referral System

• Eligibility: People with diabetes who have
  – A1C levels of 9 or higher; and
  – Have seen their physician within 90 days

• Referral system:
  – Panel referral of people with above qualifications
  – AgeOptions engages and enrolls members
  – Attendance and goals reported back to MCO
Lessons Learned

• HIPAA compliance
• Must be flexible and nimble (RFP timeline change)
• Contracting takes time
• Build for scale
Next Steps

• Bi-monthly learning collaborative
• Get more MCOs involved
• Plan to scale
Group Discussion

• Questions for presenters?
• What other communities are working to promote DPP or DSMP or other similar programs?
• How might we address some of our challenges on scaling this?
  • Getting more MCOs involved?
  • Ensuring community-based capacity to provide to all those in need?
  • Ensuring appropriate contracting/billing systems?
  • Ensuring appropriate referral systems?
  • Ensuring adequate support for Medicaid clients?
Questions?
Thank you!

For additional assistance or questions, contact Janna Simon at janna.simon@iphionline.org or 312-850-4744