

# MO HealthNet Clinical Initiatives

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# Outline

- Clinical Initiatives In Progress
  - Weight Management and Diabetes Prevention
    - Biopsychosocial Treatment for Obesity in Youths and Adults
    - Diabetes Prevention Program
  - Complementary and Alternative Therapies for Chronic Pain Management
- Clinical Initiatives on the Horizon
  - Community Health Workers
  - Patient-Centered Medical Homes

# Weight Management and Diabetes Prevention

# Weight Management and Diabetes Prevention

- Burden of Disease: Obesity
  - Obesity is a public health crisis of epidemic proportions
    - The younger generation predicted to be the first to have shorter lifespan than its parents
  - Prevalence
    - CDC: 36% of adults have obesity; Roughly 20% of low income 2-19 year olds have obesity
    - MHD Primary Care Health Home
      - 74% BMI>25 in 2013; 83% 2017 (eligibility change)
      - 50% with Obesity in 2013; 60% in 2017 (eligibility change)

# Weight Management and Diabetes Prevention

- Financial Impacts: Obesity

- Each Medicaid beneficiary with obesity on average costs \$1,021 more than normal weight beneficiaries (Finkelstein EA, Trogdon JG, Cohen JW, DietzW. Annual medical spending attributable to obesity: Payer-and service-specific estimates. *Health Affairs*. September/October 2009;28(5):w822-w831. doi: 10.1377/hlthaff.28.5.w822.)
- Pediatric: Missouri will expend \$12 billion annually on obesity-related health care costs by 2030 (CSC Childhood Obesity Task Force Report, 2014)
- Medicaid
  - Enrolls a population with higher rates of obesity
    - Self-reported obesity prevalence among adult Medicaid recipients is roughly 50% higher than that for the general population.
  - Incurs greater obesity-attributable costs
    - Percentage of U.S. adult Medicaid expenditures that are devoted to treating obesity-related medical conditions (11%) is nearly double the percentage for non-Medicaid medical expenditures. (FINKELSTEIN, ERIC A., IAN C. FIEBELKORN, AND GUIJING WANG. State-level estimates of annual medical expenditures attributable to obesity. *Obes Res*. 2004;12:18–24. <http://districts.teachade.com/resources/support/5035b250c0cd6.pdf> Web. 1 Sept. 2015)
- Fiscal Impact Projections:
  - The annual cost of the program for children and adults is \$550,242 (children \$41,081 and adults \$509,161). The annual cost savings was estimated at \$610,839 (children \$33,988 and adults \$576,851). Total first year savings of \$60,597 (\$610,839 savings less \$550,242 cost).

# Weight Management and Diabetes Prevention

- Burden of Disease: Pre-Diabetes
  - Based on fasting glucose or A1C levels, 37% of U.S. adults aged 20 years or older had prediabetes (51% of those aged 65 years or older).
  - 15–30% of people with prediabetes will develop type 2 diabetes within 5 years.
  - 9 out of 10 people (or 89%) with prediabetes do not know they have it (11% know they have it).

- <http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf>
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf>

# Weight Management and Diabetes Prevention

- Financial Impacts: Diabetes/Prediabetes
  - People with diagnosed diabetes incur average medical expenditures of about \$13,700 per year, of which about \$7,900 is attributed to diabetes. People with diagnosed diabetes, on average, have medical expenditures approximately 2.3 times higher than what expenditures would be in the absence of diabetes.
  - The CMS Office of the Actuary certifies that an expansion of a DPP in Medicare would not result in an increase in spending.
  - Fiscal Impact Projections:
    - There is a potential for savings for implementing the Diabetes Prevention Program. The total annual cost for fiscal year 2019 is \$939,500 and for fiscal year 2020 is \$1,110,489. The assumption of the department is that the annual savings will be \$8,611,000 and will offset the costs.

- <http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf>
- <https://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf>
- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf>

# Weight Management and Diabetes Prevention

- What do we have in place?
  - Surgical Interventions
    - ex Bariatric Surgery
      - MHD has already made evidence-based modifications to eligibility criteria to include
        - BMI of 35 with Diabetes or Hypertension OR
        - BMI or 40
        - Additional criteria as part of prior-authorization review
    - Obesity-related office visits
- What are we developing?
  - Structured Medical Interventions
    - Biopsychosocial Treatment of Obesity in Youths and Adults
    - Diabetes Prevention Program

# Weight Management and Diabetes Prevention

## Structured Medical Interventions: Biopsychosocial Treatment of Obesity for Youths and Adults

- United States Preventive Services Task Force
  - The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status (B recommendation)
  - The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m<sup>2</sup> or higher to intensive, multicomponent behavioral interventions. (B Recommendation)
- Outcomes
  - Leads to clinically important weight loss
  - Improves glucose tolerance and other CVD physiologic risk factors
  - Decreases incidence of Diabetes diagnosis by about 50% over 2-3 years (NNT 7)

# Weight Management and Diabetes Prevention

- Biopsychosocial Treatment of Obesity for Youths and Adults
  - Medical Nutritional Therapy
    - Nutritional diagnostic therapy and counseling services furnished by a Missouri or bordering state-licensed dietitian. Medical Nutrition Therapy includes a review by the licensed dietitian of the participant's nutritional health, eating habits, and the development of a personalized nutrition treatment plan.
  - Intensive Behavioral Therapy
    - Biopsychosocial treatment of obesity in youth and adult participants consists of the following:
      - A. Screening for obesity in adults using the measurement of Body Mass Index (BMI) and screening for obesity in youth participants is by a BMI percentile;
      - B. Dietary (nutritional) assessment/medical nutrition therapy;
      - C. Intensive, multicomponent, behavioral interventions to promote sustained weight loss for adult participants; and
      - D. Comprehensive, intensive, family-based, behavioral interventions tailored to participant needs and designed to promote improvement in weight status for youth.
  - Regulation filed
  - SPA going through internal approval process

# Weight Management and Diabetes Prevention

- Structured Medical Interventions: CDC National Diabetes Prevention Program (DPP)
  - The DPP:
    - Provides a framework for diabetes prevention efforts
    - Brings together partners from the public and private sectors to prevent or delay type 2 diabetes in the United States
    - Lifestyle change program to prevent or delay type 2 diabetes, like eating healthier, adding physical activity into their daily routine, and improving coping skills.
    - To ensure high quality, CDC recognizes lifestyle change programs that
      - Meet certain [standards \(https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html\)](https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html)
        - These standards include following an approved curriculum, facilitation by a trained lifestyle coach, and submitting data every 6 months to show that the program is having an impact
      - Show they can achieve results
    - Anthem, Cigna, and UHC provide coverage in MO.; KC BCBS plans to begin coverage; Medicare has added coverage; when add Medicaid, will cover 56% of the population per DHSS program staff

(<https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html>)

# Weight Management and Diabetes Prevention

- Structured Medical Interventions: CDC National Diabetes Prevention Program (DPP)
  - The DPP outcomes:
    - People with prediabetes who take part in a structured lifestyle change program can
      - Cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old).
        - result of the program helping people lose 5% to 7% of their body weight
        - the impact of this program can last for years to come
          - even after 10 years, people who completed a diabetes prevention lifestyle change program were one third less likely to develop type 2 diabetes.

(<https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html>)

- Proposed State Plan Amendment and regulation under development

# Weight Management and Diabetes Prevention

- Structured Medical Interventions Summary
  - The Biopsychosocial Treatment for Obesity and DPP programs are complementary
    - Together, address those with obesity and those who do not yet have obesity but may be pre-diabetic
    - Cannot be in both at the same time

# Complementary and Alternative Therapies for Chronic Pain Management

# Complementary and Alternative Therapies for Chronic Pain Management

- Goals:
  - Follow the evidence and best practice
  - Learn from other states and insurers
  - Provide alternatives to opioids for the management of chronic pain
    - Reduce dependence on opioids as the only perceived treatment option
    - Enhance self-efficacy, and physical and emotional function
    - Reduce the incidence of Opioid Use Disorder and its complications
    - Reduce financial and human costs associated with inappropriate opioid use and its complications
- SPA in internal review process
- Regulation filing pending

# Complementary and Alternative Therapies for Chronic Pain Management

- Framework
  - Eligible conditions
    - Chronic non-cancer neck and back pain
    - Documented post-trauma/injury (example MVC)
    - Others as medically necessary
  - Therapies
    - Acupuncture
    - Physical Therapy
    - Chiropractic
    - Cognitive Behavioral Therapy (existing service)
    - No change to interventional and surgical therapies currently available

# Complementary and Alternative Therapies for Chronic Pain Management

- Framework
  - Medications
    - Non-opioid and opioid therapy for chronic pain shall include initiating the first-line of non-opioid treatment, use of alternative pain therapy, establishing treatment goals, the use of opioids as supported by clinical guidelines, and the implementation of a tapering plan and schedule as clinically appropriate based upon the adult participant's clinical presentation.
      - “First-line non-opioid medication therapy” includes, but is not limited to, analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, cyclooxygenase 2 (COX-2) inhibitors, SAM-E herbal therapy, topical analgesics, selected antidepressants, and selected anticonvulsants

# Complementary and Alternative Therapies for Chronic Pain Management

- Framework
  - Stratify population into risk categories to determine level of service (similar to Oregon):
    - Low risk: Up to a maximum of four (4) total visits or sixteen (16) units (1 unit=15 minutes) per year of any combination of the allowed services with the amount of units to be determined on a case by case basis by a clinical provider
    - Medium to High Risk: Up to a maximum of thirty (30) total visits or one hundred twenty (120) units per year of any combination of the allowed services with the amount of units to be determined on a case by case basis by a clinical provider

# Complementary and Alternative Therapies for Chronic Pain Management

- Framework
  - Prior-Authorization/Limits
    - Alternatives Therapies for Chronic Pain program requires a prescribing provider's referral
    - Must prescribe the service in the participant's plan of care during a regular office visit.
    - Requires coordination of care
    - The licensed chiropractor, acupuncturist, behavioral health provider, and physical therapist make recommendations regarding recommendations for a treatment plan, continuation of services, and the final determination of care to the prescribing provider, who makes final determination and requests prior authorization for additional therapy treatments.

# On the Horizon

# On the Horizon

- Community Health Workers (CHW)
  - Ample national programs and research with outcomes
  - Considerations:
    - Coordinating efforts and aligning with DHSS and the Statewide CHW Task Force recommendations
    - DMH Peer Support and Community Support Worker programs
    - Evidence-base
    - Other state examples
    - Primary Care Health Home CHW Pilot
    - Medicaid Budget
  - Modelling complete
    - Projected net savings range start at \$12 million depending on the population considered
      - High Utilizer (all DX) as well as High Utilizers with a Qualifying Medical or Behavioral Health Diagnosis
      - High Utilizer with a Qualifying Medical or Behavioral Health Diagnosis
      - High Utilizer with a Qualifying Medical Diagnosis Only

# On the Horizon

- Community Health Workers (CHW)
  - Primary Care Health Home Pilot Program in the Kansas City, Springfield, Joplin, and Branson area Primary Care Health Homes
    - Focus on high utilizers of emergency department and hospital services, including those with obesity and/or diabetes, as well as other high risk, medically complex patients
    - Outcomes:
      - Net savings \$33 PMPM pre-post
      - Assessed the change and rate of change in ED and hospital usage for 764 individuals between July 2016 and December 2016. The total number of ED and hospital visits six months prior to first CHW service, and the total number of ED visits six months post CHW visits, were compared.
        - A 38% decrease was seen in ED use for these 764 individuals. Over the same time period, individuals enrolled in the PCHH who did not have access to a CHW had only an 8% decrease in ER visits.
        - A 16.6% decrease was seen in the number of hospitalizations for these 764 individuals. During the same time frame, individuals enrolled in the PCHH who did not have access to a CHW had only a 6% decrease in hospitalizations.
        - Thus rate of change and change are enhanced by the addition of a CHW.
    - Practice setting: medical homes and health homes
      - Team-based care
      - Drives practice transformation
      - KC PCHH CHW pilot results demonstrate that CHW need to be integrated into the practice and team
  - Have developed draft proposed regulation and SPA for internal review

# On the Horizon

- Patient Centered Medical Home
  - Continuation of MHD practice and care delivery transformation efforts
  - Planned to be a Fee-For-Service program (managed care counterparts are LCCCP and potential pregnancy medical home)
  - National Models for Medical Home
    - Other State examples include: CO, NC, MN
    - Research and outcomes available
    - Accreditation established
      - National Committee of Quality Assurance (NCQA)
      - The Joint Commission
      - Accreditation Association for Ambulatory Health Care, Inc (AAAHHC)
  - Evidence Base Review/Other state program review
  - Already existing base of nationally certified medical homes in Missouri
  - Intended to be a step down from Primary Care Health Homes (PCHH)
    - Same foundational principles
    - All PCHHs already required to achieve PCMH certification
    - Direct patient care impacts like PCHH; Both programs require MHD medical direction
    - Similar PCHH infrastructure requirements related to practice transformation and services
    - Different patient population than PCHH- No eligibility criteria
    - Tiered payments by patient complexity

# On the Horizon

- Patient Centered Medical Home
  - Modelling
    - NC example:
      - **Lower costs:** 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; **total annual savings** to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.
  - Have developed draft proposed regulation for internal review
  - Discussion with CMS regarding waiver versus SPA (content drafted)