December 6, 2023
Study packet contents

Team-Based Care Approaches to Improve Health Outcomes

- Report in brief
- Policy options
- Staff follow-up memo excerpt

Team-based Care Approaches to Improve Health Outcomes

POLICY OPTIONS IN BRIEF

There are 6 policy options in the report for consideration.

Option: Direct DMAS to establish a reimbursement rate and develop a Collaborative Care Model program. (Option 1, page 7)

Option: Direct DMAS to establish a reimbursement rate for medication therapy management provided via telehealth. (Option 2, page 9)

Option: Direct JLARC to evaluate state-funded health care workforce incentive programs. (Option 3, page 13)

Option: Fund Virginia Task Force on Primary Care to expand pilot programs on core team-based care criteria for payers. (Option 4, page 14)

Option: Fund staff AHECs to support primary care practices transitioning to team-based care. (Option 5, page 16)

Option: Direct DMAS to develop a plan for participation in the Medicaid health home program. (Option 6, page 18)

FINDINGS IN BRIEF

Team-based care is evidence-based but reimbursements for behavioral health and pharmacy services are limited

Practice teams have a positive impact on chronic conditions and have evolved to integrate behavioral health and pharmacy services. Health care professionals cited lack of insurance coverage for integrated behavioral health services and medication therapy management delivered via telehealth as significant barriers to providing these much-needed services to patients.

The impact of state-funded incentive programs to address primary care workforce shortages is unclear

Successful team-based care depends on a robust health workforce. Practices rated difficulty recruiting or retaining clinical staff as the top factor limiting optimal implementation. Virginia has invested state funds in multiple primary care work force incentive programs; however, the value and impact of these programs is unknown.

Practices need implementation support to transition from traditional to team-based primary care

Team-based care is cost-effective but requires up front investments in infrastructure, staffing, and training that may not be attainable for all practices. With additional resources, the existing structure of Virginia's regional Area Health Education Centers could be leveraged to provide implementation support to smaller or independently owned practices.

Current fee-for-service payment models are a barrier to team-based care sustainability

Stakeholders and survey respondents reported that the current fee-for-service payment models are a significant deterrent to sustaining team-based primary care. Virginia could support expansion of team-based care using value-based payment models with Medicaid beneficiaries.

Policy Options

Joint Commission on Health Care
Team-Based Care Approaches to Improve Health Outcomes

OPTION 1 - The Joint Commission on Health Care could introduce a budget amendment directing DMAS to develop a establish a reimbursement rate and Collaborative Care Model program guidelines for behavioral health services delivered in primary care practices. (Page 7)

OPTION 2 - The Joint Commission on Health Care could introduce a budget amendment providing funds to DMAS to develop a reimbursement rate for pharmacist-provided medication therapy management via telehealth in team-based primary care practices. (Page 9)

OPTION 3 - The Joint Commission on Health Care could direct the Joint Legislative Audit and Review Commission (JLARC) to evaluate the value and impact of state-funded health care workforce scholarship and loan repayment programs. The evaluation should include perspectives from health care professionals eligible for such incentives and longitudinal analysis of retention outcomes among program recipients. (Page 13)

OPTION 4 - The Joint Commission on Health Care could introduce a budget amendment to fund the VCHI Virginia Task Force on Primary Care to expand their pilot programs developing multi-payer directional alignment of high-quality team-based care criteria and performance metrics. (Page 14)

OPTION 5 - The Joint Commission on Health Care could introduce a budget amendment for the Virginia Health Workforce Development Authority to hire and train additional staff within each of their eight regional AHECs to support primary care practices meeting certain needs-based criteria that wish to transition to team-based care. (Page 16)

OPTION 6 - The Joint Commission on Health Care could direct DMAS to develop a plan to participate in the Medicaid health home program, in consultation with the VCHI Virginia Task Force on Primary Care. (Page 18)

JOINT COMMISSION ON HEALTH CARE

Senator George L. Barker, Chair *Delegate Robert D. Orrock, Sr., Vice Chair*

Team-based Care Approaches to Improve Health Outcomes

Funding Levels for State Health Care Incentive Programs

Table 3 of the *Team-based Care Approaches to Improve Health Outcomes* report highlights state-funded scholarship and loan repayment programs administered by the Virginia Department of Health (VDH). Members requested a comparison of Virginia funding for health care incentive programs compared to other states.

Incentive programs vary considerably by state, and may differ by eligible disciplines, practices sites, length of required service commitment, and amount of assistance offered. Table 1 provides comparisons between Virginia's programs and select health care incentive programs from other states.

TABLE 1. Funding Levels for Select State-funded Health Care Incentive Programs

Program Type: **U.S. Health Resources and Services Administration State Loan Repayment Program**	
Virginia Requirements	*Other State Requirements*
Awarded $2.466 million in federal funds for the 2022-2025 grant period Award requires a state match Maximum individual award is $50,000 per year for the first two years, with renewal for additional years of service	46 states, Washington D.C., and 3 territories received funding for the 2022-2025 grant period Total awards to states range from $555,624 to $3 million Maximum allowable individual award is $50,000 for a two-year service commitment
Program Type: **Additional State-Funded Nursing Scholarship and Loan Repayment Programs**	
Virginia Requirements	*Other State Requirements*
Virginia has multiple programs and incentive amounts vary by nursing professional level CNA – $1,000 per year for 1 year LPNs and RN – $4,000 per year for 4 years NP – up to $20,000 per year for 4 years	Florida - $4,000 per year for 4 years Illinois - $5,000 per year for 4 years Iowa - $6,000 per year for 5 years Minnesota - $6,000 per year for 2 years Montana - $3,750 per year for 4 years Ohio - 100% loan forgiveness after 5 years of service Texas - $10,000 for one year of service Vermont - $15,000 per year for 4 years

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Program Type: **Additional State Funded Physician Scholarship and Loan Repayment Programs**	
Virginia Requirements	*Other State Requirements*
Unfunded	Arkansas - $20,000 per year for 4 years Delaware – $50,000 per year for 4 years Georgia - $25,000 per year for 4 years Kansas - $10,000 per year plus community match Maine - $25,000 per year for 4 years Minnesota - $33,000 per year for 4 years Montana - $150,000 for 5 years of service Nebraska - $60,000 per year for 3 years New Mexico - $25,000 per year for 4 years Ohio - $25,000 for 2 years, then $35,000 for 2 years Oklahoma - $50,000 per year for 4 years Oregon - $35,000 for 1 year Texas - $30,000 for 1 year, increasing by $10,000 each year for the next 3 years Utah - $15,000 per year with match from hospitals Wisconsin - $50,000 per year, up to $100,000 total

SOURCE: Virginia Department of Health and JCHC analysis of state health care workforce incentive programs, 2023

Evaluation of Medicaid Health Home Programs

Pages 16 through 18 of the *Team-based Care Approaches to Improve Health Outcomes* report presents the federal Medicaid health home program as an opportunity to expand team-based care supported by value-based payment models. Members requested results from evaluations of Medicaid health home programs implemented in other states.

The U.S. Department of Health and Human Services (HHS), Office of Assistant Secretary for Planning and Evaluation contracted with the Urban Institute to conduct a national, independent evaluation of the Medicaid health home option. HHS submitted a final report to the U.S. Congress in 2018 summarizing evaluation findings. The full report is available from Medicaid (here).

Key findings from the evaluation include:

1. Using the health home state plan option allows states to target high-cost, high-need patients, and initial results from states and health home providers in the first 11 states suggest potential for improvements in care utilization patterns, costs, and quality.
2. The use of multidisciplinary care teams was broadly recognized as the most important change to emerge from health homes.
3. Initial and continuing assistance with practice transformation and team-based care is important, particularly to address the behavioral health needs and social determinants of health that impact patients.

4. Well-developed health information technology and other infrastructure is needed for care coordination and quality improvement.
5. Health home programs show promise in effectively addressing the needs of individuals with complex chronic physical and mental health conditions and substance use disorders, particularly those who also have high social needs.
6. Most of the early health home states continue to offer the health home benefit beyond their initial enhanced match period, which suggests that states have found value and promise in the health home model for improved care for their chronically ill populations.