

# Medicaid's Role in Prevention, Population Health, and Building a Culture of Health at the State Level

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WEBINAR

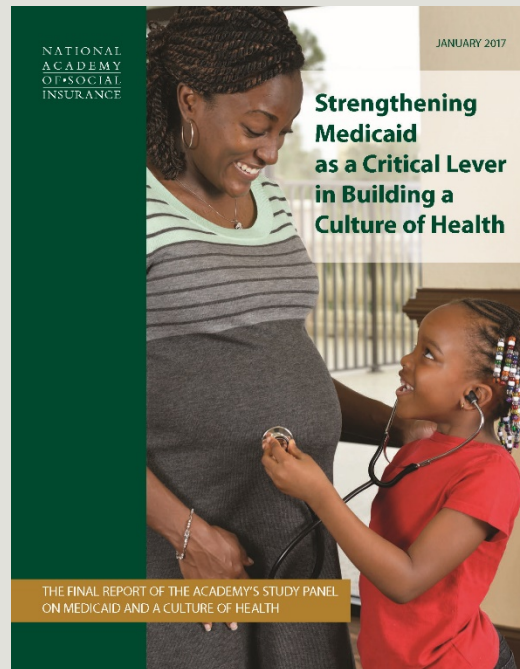
MARCH 20, 2017

3:30PM – 4:45PM ET

# Project Materials

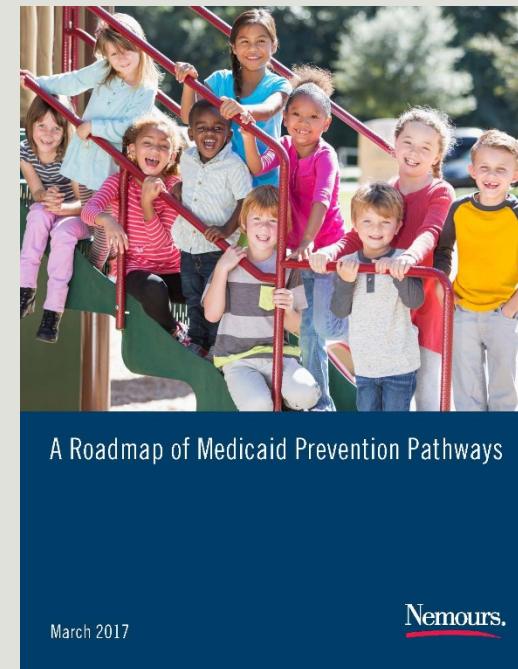
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# Speakers

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**Trish Riley**  
*Executive Director*  
National Academy for  
State Health Policy



**Debbie I. Chang**  
*Senior Vice President of  
Policy and Prevention  
and Corporate Officer*  
Nemours



**Shannon M. McMahon**  
*Deputy Secretary,  
Health Care Financing*  
Maryland Department of  
Health and Mental  
Hygiene



**Alexandra L. Bradley**  
*Health Policy Analyst*  
National Academy of  
Social Insurance

# Trish Riley

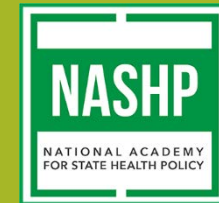
Executive Director, National Academy for State Health Policy (NASHP)

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# Medicaid's Role in Prevention, Population Health, and Building a Culture of Health

March 20, 2017 3:30-4:45 pm ET



**Trish Riley**  
Executive Director, Co-Chair NASHP Study Panel  
National Academy for State Health Policy

## Medicaid's Role – Culture of Health

- Supported by the Robert Wood Johnson Foundation
- Charge to Study Panel & Membership

# Study Panel

**Sara Rosenbaum**, *Co-Chair*, Harold and Jane Hirsh Professor of Health Law and Policy, Milken Institute School of Public Health, The George Washington University

**Trish Riley**, *Co-Chair*, Executive Director, National Academy for State Health Policy

**John Auerbach**, Associate Director for Policy, Centers for Disease Control and Prevention

**Deborah Chang**, Senior Vice President for Policy and Prevention and Corporate Officer, Nemours Children's Health System

**Ajay Chaudry**, Senior Fellow, New York University and Visiting Scholar, Russell Sage Foundation

**Julie Cox-Kain**, Deputy Secretary of Health and Human Services and Senior Deputy Commissioner, Oklahoma State Department of Health

**Leonardo Cuello**, Director, Health Policy, National Health Law Program

**Deborah De Santis**, President and Chief Executive Officer, Corporation for Supportive Housing

**Patricia A. Gabow**, Professor Emerita of Medicine, University of Colorado School of Medicine

**Daniel Hawkins**, Senior Vice President, Public Policy and Research Division, National Association of Community Health Centers

**Paloma Hernandez**, Chief Executive Officer and President, Urban Health Plan

**Kathy Ko Chin**, President and Chief Executive Officer, Asian & Pacific Islander American Health Forum

**Paula Lantz**, Associate Dean for Academic Affairs and Professor of Public Policy, Gerald R. Ford School of Public Policy, University of Michigan

**MaryAnne Lindeblad**, Medicaid Director, Washington Health Care Authority

**Jewel Mullen**, *Federal Liaison*, Principal Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services

**Margaret A. Murray**, Chief Executive Officer, Association for Community Affiliated Plans

**Matt Salo**, Executive Director, National Association of Medicaid Directors

**Christian Soura**, Director, South Carolina Department of Health & Human Services

**Marilyn Tavenner**, President and Chief Executive Officer, America's Health Insurance Plans

**Cathy Ficker Terrill**, Senior Advisor, The Council on Quality and Leadership

**Julie Trocchio**, Senior Director of Community Benefit and Continuing Care, Catholic Health Association of the United States

**James D. Weill**, President, Food Research & Action Center

**Leana S. Wen**, Commissioner of Health, Baltimore City

**Gail Wilensky**, Senior Fellow, Project HOPE

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## Advisers to the Panel

**Lynn Etheredge**, Consultant, The Rapid Learning Project

**Judith Solomon**, Vice President for Health Policy, Center on Budget and Policy Priorities

**Karin VanZant**, Executive Director, Life Services, CareSource

# Medicaid's Role – Culture of Health

- Largest Public Insurer
  - Low income and medically vulnerable families
  - Facile – accommodates changing needs
- Health care as entry point for more comprehensive responses to address social determinants of health
- Medicaid as partner, not piggybank



## Administrative Options: System transformation, quality improvement, and payment reform

A1. Develop health improvement demonstrations that employ a longer-term savings time frame, focus on the social determinants of health, recognize health related expenditures as qualified for federal funding, and count a broader range of estimated cost offsets when calculating budget neutrality.

A2. Develop a fast-track approval process, a clear implementation roadmap, and a series of definable outcome measures for promising service delivery transformation models.

A3. Better align federal health, nutrition, housing, and social support eligibility, benefit, and expenditure policies to enable coordination with Medicaid coverage and system transformation efforts in order to extend the reach of programs and ensure that people are connected to the full range of assistance needed to improve health.

## Administrative Options cont.

A4. Restructure Medicaid payment policies to improve access to behavioral health services.

A5. Improve data sharing between physical health, mental health, and substance use disorder services and providers to enhance care coordination.

A6. Modernize and update Medicaid's role in improving the health of children.

## Administrative Options cont.

A7. Strengthen access standards for individuals whose primary language is not English who require language services and people with disabilities who experience challenges in communication.

A8. Develop and disseminate information on best practices in coverage of comprehensive preventive and primary care for adults.

A9. Disseminate social determinants screening tools for utilization in managed care and integrated delivery systems and adopt payment methods that foster comprehensive care and the integration of health and social services.

## Administrative Options cont.

A10. Develop safety net health care payment reform models that promote access, quality, efficiency, and a Culture of Health.

A11. Include consultation with state Medicaid and public health agencies as an express requirement for tax-exempt hospitals in developing community health needs assessments under the Internal Revenue Code.

A12. Make Medicaid an equal priority to Medicare for the Center for Medicare and Medicaid Innovation (CMMI), with special emphasis on pilots aimed at health improvement and prevention



# Thank You

Trish Riley

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# Debbie I. Chang

Senior Vice President of Policy and Prevention and Corporate Officer, Nemours Children's Health System

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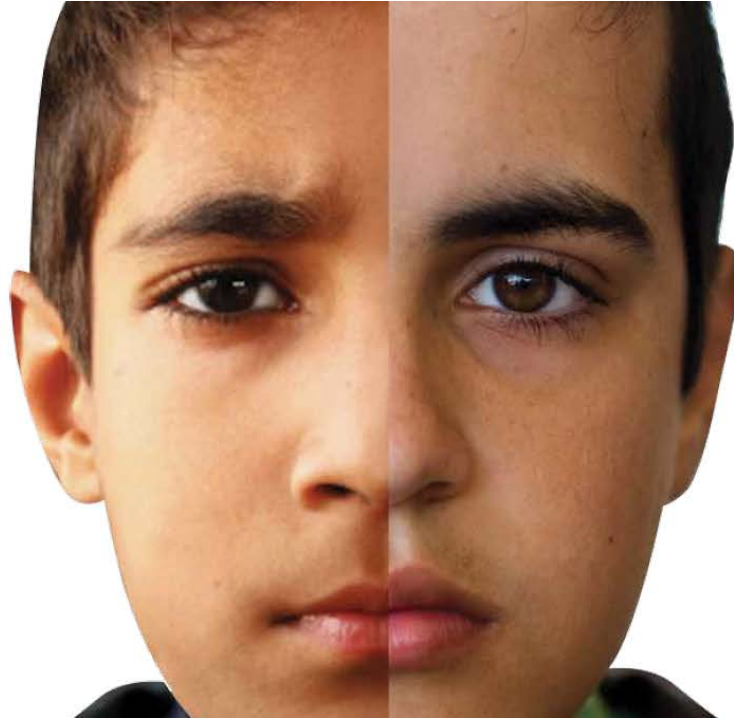
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MARCH 20, 2017

**Debbie I. Chang, MPH**

Senior Vice President Policy and Prevention

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Your **ZIP Code** shouldn't predict **how long you'll live**, but it does.



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# Expanding the Clinical Model: Promoting Health and Prevention

## Traditional Medical Model

Rigid adherence to biomedical view of health

Focused primarily on acute episodic illness

Focus on Individuals

Cure as uncompromised goal

Focus on disease



## Expanded Approach

Incorporate a multifaceted view of health

Chronic disease prevention and management

Focus on communities/populations

Prevention as a primary goal

Focus on health



# Pathways through Medicaid to Prevention Project

- Nemours received a 1 year grant from RWJF to examine programs that meet 3 criteria:
  - Medicaid funded
  - Prevention component
  - Link clinic to community—that is, strategies that link traditional clinical preventive care with community-based initiatives to address chronic disease
- Rationale:
  - There are almost no examples of Medicaid-funded clinic to community prevention in the literature
  - Conversations with collaborators revealed many programs only focused on a single component of integrated care delivery
  - Help states understand ***the range of options under*** Medicaid that state can use to implement, support, sustain, and integrate clinic to community prevention into their delivery reform efforts as a part of comprehensive approaches to address chronic diseases such as childhood obesity and ***how best to successfully*** put them into place on the ground

# Pathways through Medicaid to Prevention Project

- Focuses on Medicaid *financing* of prevention through Medicaid
- Creates a roadmap to demonstrate how states/Managed Care can cover prevention, including obesity prevention
- Looks at what can be covered upstream, beyond care in a traditional setting
  - Identifying the specific authorities used to support existing programs
  - Providing options for both FFS/PCCM and Managed Care
- Identifies strategies to implement, support, sustain, and scale up these programs
- Uses the lens of:
  - A pediatric population
  - Population health prevention, including obesity prevention

# Pathways through Medicaid to Prevention Toolkit

- The toolkit:
  - A Roadmap of Medicaid Prevention Pathways and planning tools for states (*Roadmap*)
  - A White Paper synthesizing the accelerators, barriers, and lessons learned from this project
  - 3 case studies (to also be posted on National Academy of Medicine's *Perspectives* website) that profile:
    - MCO considerations for covering population-level prevention (Nationwide Children's Hospital)
    - State considerations for covering upstream and population-level prevention (Washington State)
    - An exemplary partnership between Medicaid and Public Health aimed at health system transformation (Oregon)

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By the end of March the toolkit will be available at:

<http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>

# Roadmap

- Goal: provide options for states that are considering using Medicaid to support prevention for chronic disease, including obesity prevention
  - Uses 40 on-the-ground examples from 23 states plus hypothetical examples of what we believe is permissible under current Medicaid and CHIP authority
  - Progression of intervention strategies along a continuum moving from individual level (IL) to population level (PL)
  - When possible the examples reference or link to the Medicaid authority used (e.g., CMS-approved SPAs and waivers, and other background materials)



# Roadmap: Medicaid Authorities

INDIVIDUAL LEVEL	POPULATION LEVEL
<i>A physician or other licensed practitioner (OLP) provides an individual Medicaid enrollee a prevention service in a medical setting (IL-1) and may take an added step of referring the enrollee to a community-based organization for additional non-medical supportive services. (IL-2)</i>	<i>A population health prevention intervention is provided to an entire community or geographic area. The service is aimed at improving the health of the population rather than improving the health of a specific individual. The intervention is not limited to patients in a particular medical practice or enrollees in an MCO. (PL-1)</i>
Medicaid Covered Services (Section 1905(a))	Health Services Initiatives under the Children’s Health Insurance Program (CHIP) (Section 2105(a)(1)(D)(ii))
Early Periodic Screening Diagnosis and Treatment (EPSDT) (Section 1905(r))	Section 1115 Waiver Authority (Research and Demonstration Waivers)
Case Management (Section 1905(a)(19) and Targeted Case Management Section 1915(g)(1))	Delivery System Reform Incentive Payment (DSRIP)
Medicaid Health Homes (Section 1945)	Center for Medicare and Medicaid Innovations (CMMI), including:
<i>A physician or OLP provides an individual Medicaid enrollee a covered preventive service in non-traditional settings such as schools. (IL-3A)</i>	<ul style="list-style-type: none"> <li>•Accountable Health Communities</li> <li>•Health Care Innovation Awards Round 2</li> <li>•Health Care Innovation Awards Round 1</li> <li>•State Innovation Models (SIM)</li> </ul>
EPSDT (Section 1905(r))	
Preventive services (Section 1905(a)(13))	
Free Care Guidance (December 2014 State Medicaid Director Letter)	
Medicaid Health Homes (Section 1945)	
<i>A non-traditional provider (e.g., community health worker (CHW)) provides an individual Medicaid enrollee a preventive service. (IL-3B)</i>	
Preventive Services Rule Change (42 CFR 440.130 (c))	
Managed Care: <ul style="list-style-type: none"> <li>•Section 1932(a) State Plan Authority</li> <li>•Section 1915(a) Waiver Authority</li> <li>•Section 1915(b) Waiver Authority</li> <li>•Section 1115 Waiver Authority</li> </ul>	
<i>An individual Medicaid enrollee receives an upstream service in the community. Upstream services include those non-medical services that address the systemic conditions (e.g., environmental, economic) that contribute to poor health. (IL-3C)</i>	
Managed Care	
Coverage of Housing Related Activities and Services for Individuals with Disabilities	

# Roadmap

*A physician or other licensed practitioner (OLP) provides an individual Medicaid enrollee a preventive service (e.g., nutritional counseling) in a medical setting.*

**Example:** The OK Medicaid program reimburses for health and behavior CPT codes delivered by mental health providers for a primarily medical weight-related diagnosis. The codes they use have a particularly useful application in the prevention of mental health conditions associated with adolescent overweight/obesity.

*For additional examples in CO, MN, PA, & WY, please refer to **Roadmap Appendix C: Summary Matrix of State Activities***



# Roadmap

*A physician or OLP provides an individual Medicaid enrollee a preventive service in a medical setting. **The provider takes an added step of referring the enrollee to a community-based organization for additional non-medical supportive (and upstream) services.** At a minimum, the provider makes the referral to the CBO. Case management and care coordination of community services also may be provided.*

**Example:** MO PHIT Kids (Promoting Health in Teens and Kids) has a multi-disciplinary weight management program and **refers to CBOs such as Big Brothers, Big Sisters (for children) or to a parenting program (for parents).** The family receives follow-up at subsequent clinic visits to find out if they obtained the support services. **The program first focuses on families' basic needs (housing, transportation, safety) before weight loss becomes a goal.** PHIT Kids staff anticipates the MO Medicaid program will partially cover clinic- and hospital-based RD services and their group education sessions in 2017.

*For additional examples in CO and OR, please refer to **Roadmap Appendix C: Summary Matrix of State Activities***





# Roadmap

*An individual Medicaid enrollee receives a preventive service in a non-traditional way:*

- A) *A physician or OLP provides an individual enrollee a Medicaid covered preventive service **outside of a medical setting in the community (e.g., home, school, child care, community program).***
- B) *A **non-traditional provider (e.g., community health worker)** provides an individual Medicaid enrollee a preventive service.*
- C) *An individual enrollee receives an **“upstream” or non-medical service in the community.***

**MCO Example:** In Ohio, the accountable care organization (ACO) Partners For Kids, which is affiliated with Nationwide Children’s Hospital, provides mobile care centers that **travel to schools and communities (non-traditional setting)** to ensure health care access for children across central Ohio. Nationwide also partners with Columbus City Schools to provide on-site **nurse practitioners and behavioral health providers (non-traditional providers)** in select locations. Behavioral health specialists also provide assistance to teachers and school administration.

*For additional examples in AL, CA, GA, MA, ME, MI, MN, NM, OR, PA, RI, TX, WA, & VT, please refer to **Roadmap Appendix C: Summary Matrix of State Activities***



# Roadmap

*A population health intervention is provided **to an entire community or geographic area**, rather than a specific individual. The intervention is not limited to patients in a particular medical practice or enrollees in an MCO. Medicaid pays for the service even though it is provided to non-enrollees.*

**MCO Example:** In MA, the state uses CHIP funds to cover 9 public health programs related to **improving the health of all children** (e.g., youth violence prevention, young parent support).

*For additional examples in DC, ME, OK, & OR, please refer to **Roadmap Appendix C: Summary Matrix of State Activities***



# Roadmap

*A population health intervention in which **Medicaid and another state agency or department (e.g., public health) share goals for a population in a geographic region and collaborate as partners.***

**MCO Example: OR is aligning its health care and early learning systems.** For example, Oregon aims to improve kindergarten readiness by coordinating services across CCOs and Early Learning Hubs. **One of the CCOs, Health Share, meets monthly with the three Early Learning Hubs in their region to discuss joint initiatives and align work.** The initiative uses Race to the Top funding to implement approved screening tools and assist with developmental screening training.

*For additional examples in IA, MO, NY, WA, & WY, please refer to **Roadmap Appendix C: Summary Matrix of State Activities***



# Facilitators to Success

- Example facilitators to success:
  - A high-level champion
  - State Medicaid/MCO plays a role as an integrator and/or convening entity
  - Long-term prevention and population health goals
  - Infrastructure that encourages interagency and cross-sector collaborations
  - Robust data collection and sharing systems
  - Incentives for shifting to value-based payment
  - Prior experience with practice transformation and/or value-based payment

# Barriers & Strategies for Success

- Taking on population health requires a change in how Medicaid provides care  
**Educate providers about community resources at their disposal; establish cross-sector & interagency relationships; invest in credentialing non-traditional providers.**
- Inability to demonstrate ROI for prevention, especially childhood obesity prevention  
**Take a portfolio approach to address a range of shorter- and longer-term issues; Implement an intergenerational prevention program.**
- No established interagency collaboration  
**Create a work group to identify overlapping goals/areas to collaborate and meet regularly; Assign a point person to track cross-agency work**
- Concerns about Medical Loss Ratios (MLRs) creating disincentives for investment in population health  
**Classify population health activities as “medical services” rather than administrative services, when possible; Research the range of Medicaid and other authorities available, and how other states have successfully financed population health.**

# Barriers & Strategies for Success Cont'd

- No leadership buy-in

**Provide the evidence-base needed (ROI studies, MLR figures, our toolkit) to demonstrate that the investment is worthwhile.**

- Antiquated or non-existent data collection or sharing infrastructure

**Build these systems into any future project from the start to ensure ease of data collection/sharing in the future; Research incentive programs that provide funding for development of data infrastructure.**

- Difficulty knowing where and how to begin

**Use our Medicaid toolkit to find out what states similar to yours are able to achieve and how using existing Medicaid and CHIP authority; Set small, achievable goals.**

# Lessons Learned

- Leadership buy-in is critical
  - Without a mandate from the top, it will be difficult to make upstream and population health a priority among needed partners
- Develop long-term strategies from the start
  - Sustainability is easier to achieve if it's built into all aspects of health system transformation
- Collaboration is key
  - State Medicaid/MCOs can't, and shouldn't, do it all themselves
- Take a bottoms-up approach
  - Target services to community needs to ensure maximum utilization and health improvement outcomes
- Develop standardized measures and metrics and build the infrastructure for data collection and sharing
  - It's hard to get stakeholder or community buy-in, or plan for sustainability, unless there's an evidence base to build from
  - It is also time-consuming to build this into existing projects

# Phase II: Medicaid Payment Strategies

- **Goal:** test and share Medicaid approaches to financing upstream prevention and addressing social determinants of health for all states
  - 9-month grant from AcademyHealth
- **Process:** provide technical assistance to help three states (MD, OR, WA) explore possible pathways to Medicaid payment for prevention strategies
- **Deliverables:**
  - A summary of the payment strategies
  - A “How-To” Guide walking states through the process of planning and/or implementing Medicaid funded population health
  - Additional How-To appendices (yet to be determined)
  - A revised Roadmap of Medicaid Prevention Pathways, based on user feedback
  - An in-person meeting of the 3 states to share lessons learned



Check back at the end of March to view our full toolkit:  
[http://movinghealthcareupstream.org/innovations/  
pathways-through-medicaid-to-prevention](http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention)

**Questions?**

# Shannon M. McMahon

Deputy Secretary, Health Care Financing, Maryland  
Department of Health and Mental Hygiene

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# Maryland Medicaid Prevention Strategies

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- Maryland Healthy Kids Program (EPSDT program)
  - Standards for the Healthy Kids Program are developed through collaboration with key stakeholders such as the DHMH Prevention and Health Promotion Administration, the Maryland Chapter of the American Academy of Pediatrics, the University of Maryland Dental School, and the Maryland Department of the Environment.
  - The Maryland Healthy Kids Preventive Health Schedule closely correlates to the American Academy of Pediatrics' periodicity schedule.
- New State Plan Amendment: Group dietary counseling



# Maryland's Phase 2 Project Overview

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- Multifaceted approach to promote healthy eating and obesity prevention, as well as to address families' upstream needs
- Explore Medicaid payment for activities within Head Start centers, an innovation that has potential lessons for other states



# Maryland's 5 Project Elements

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1. Research, develop, test payment models for a social determinants of health screener at Head Start centers

a. IL-2: Provider makes referral to non-medical and upstream services

2. Identify pathways for Medicaid funding of dietician services embedded in Head Start

a. IL-3A: Medicaid enrollee receives a preventive service in the community



# Maryland's 5 Project Elements

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3. Explore how dietician group counseling could support individuals not eligible for Medicaid
  - PL-1: Population health intervention is provided to non-Medicaid enrollees
4. Research intersections between Eat Play Grow curriculum in Head Start Centers and Bright Futures guidelines on EPSDT anticipatory guidance (PL-1)



# Maryland's 5 Project Elements

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5. Contribute to the business case for states—and in particular MCOs, given their added flexibility—to pay for upstream prevention strategies.



# Potential Project Opportunities

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- Build on families' daily, sustained connections to child care settings to address upstream needs
- Foster new relationships among MCOs and Head Start centers
- Leverage Head Start infrastructure to scale up and replicate efforts
- Push the envelope on MD's new dietician group counseling SPA
- Consider ROI within MD's robust managed care delivery system





# Moderator: Alexandra L. Bradley

Health Policy Analyst, National Academy of Social Insurance

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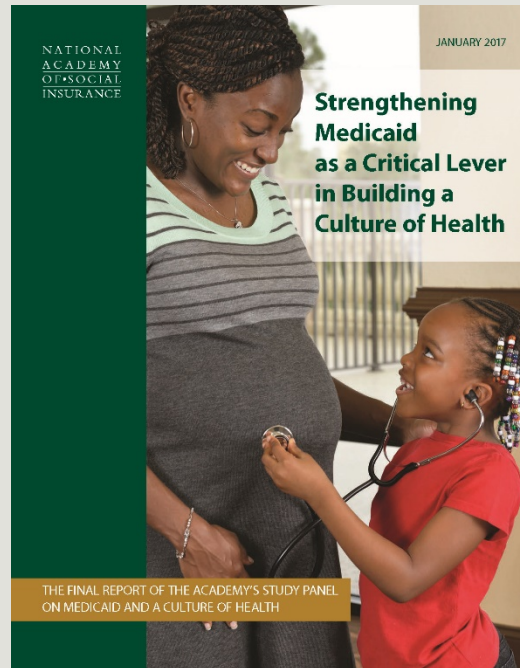
# Q & A

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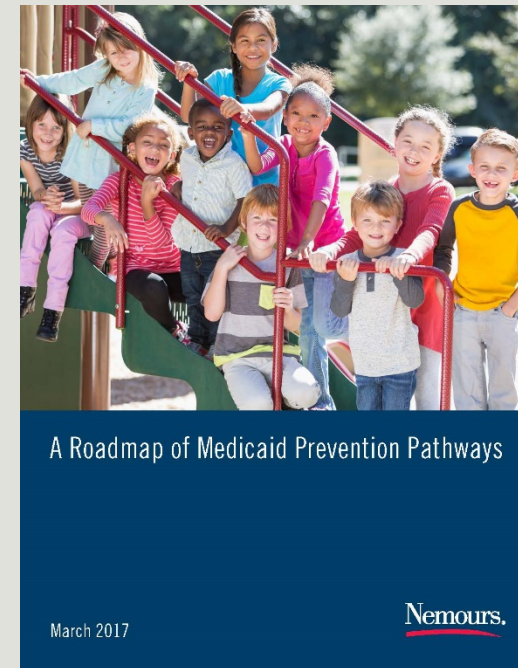
# Thank you!

## National Academy of Social Insurance Study Panel Report



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## Nemours Coming late March 2017



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