Nemours Children's Health System

Medicaid Pathways to Prevention: Realizing the Promise of Population Health

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

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Nemours Integrated Child Health System

- Nemours is a non-profit organization dedicated to children's health & health care
- Nemours offers pediatric clinical care, research, education, advocacy, and prevention programs. Nationally, the goal is to improve child health and wellbeing, leveraging clinical and population health expertise
- Nemours operates Alfred I. duPont Hospital for Children and outpatient facilities in the Delaware Valley and a new state-of-the-art Children's Hospital in Orlando and specialty care services in Northern/Central Florida.
- Nemours focuses on child health promotion and disease prevention to address root causes of health
  - Preventing childhood obesity and emotional/behavior health were the first initiatives
  - Complements and expands reach of clinicians using broader, community-based approach

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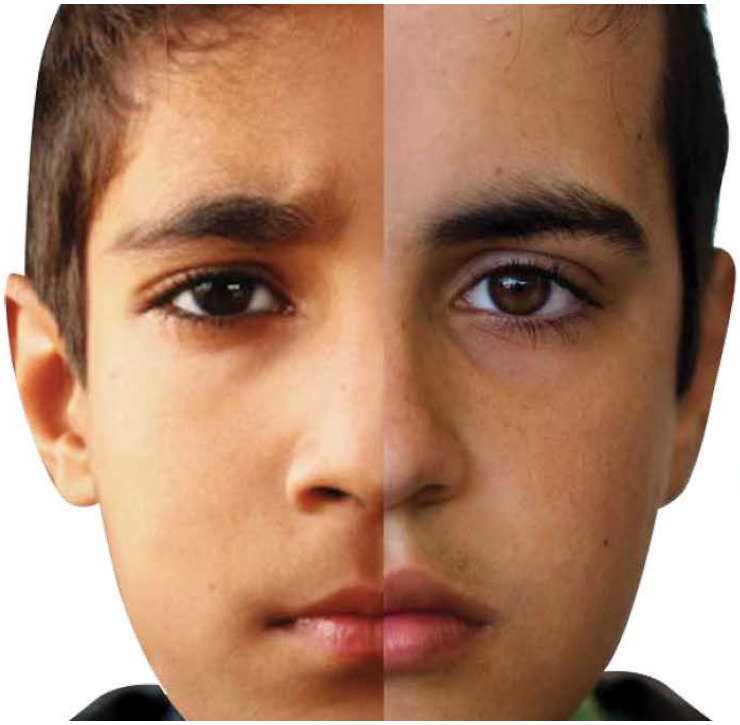
STOCKTON
95202
Life Expectancy
73



IRVINE
92606
Life Expectancy
88

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

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health happens here

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Expanding the Clinical Model: Promoting Health and Prevention

Traditional Medical Model		Expanded Approach
Rigid adherence to biomedical view of health	→	Incorporate a multifaceted view of health
Focused primarily on acute episodic illness	→	Chronic disease prevention and management
Focus on Individuals	→	Focus on communities/populations
Cure as uncompromised goal	→	Prevention as a primary goal
Focus on disease	→	Focus on health

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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

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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

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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)

Our toolkit, which has been optimized for Google Chrome, is available at: **http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention**

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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

INIVIDUAL LEVEL
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)
Medicaid Covered Services (Section 1905(a))
Early Periodic Screening Diagnosis and Treatment (EPSDT) (Section 1905(r))
Case Management (Section 1905(a)(19) and Targeted Case Management Section 1915(g)(1))
Medicaid Health Homes (Section 1945)
A physician or OLP provides an individual Medicaid enrollee a covered preventive service in non-traditional settings such as schools. (IL-3A)
EPSDT (Section 1905(r))
Preventive services (Section 1905(a)(13))
Free Care Guidance (December 2014 State Medicaid Director Letter)
Medicaid Health Homes (Section 1945)
A non-traditional provider (e.g., community health worker (CHW)) provides an individual Medicaid enrollee a preventive service. (IL-3B)
Preventive Services Rule Change (42 CFR 440.130 (c))
Managed Care: •Section 1932(a) State Plan Authority •Section 1915(a) Waiver Authority •Section 1915(b) Waiver Authority •Section 1115 Waiver Authority
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)
Managed Care
Coverage of Housing Related Activities and Services for Individuals with Disabilities

POPULATION LEVEL
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)
Health Services Initiatives under the Children's Health Insurance Program (CHIP) (Section 2105(a)(1)(D)(ii))
Section 1115 Waiver Authority (Research and Demonstration Waivers)
Delivery System Reform Incentive Payment (DSRIP)
Center for Medicare and Medicaid Innovations (CMMI), including: •Accountable Health Communities •Health Care Innovation Awards Round 2 •Health Care Innovation Awards Round 1 •State Innovation Models (SIM)

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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***

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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

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