Medicaid Financing for Upstream Prevention Activities

NOPREN Monthly Call

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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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to Sustain
Population
Health Work

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Life Expectancy
73

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Life Expectancy
88

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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 (2016)

- **Goal**: Explore and promote the use of existing Medicaid authority to support prevention.

- **Process**: Nemours conducted an environmental scan and developed a toolkit for states.

- **Toolkit** includes:
  - A Roadmap of Medicaid Prevention Pathways and planning tools for states
  - A White Paper synthesizing the accelerators, barriers, and lessons learned
  - 3 case studies that profile:
    - MCO considerations for covering population-level prevention (Nationwide Children's Hospital)
    - State considerations for covering upstream and population-level prevention (Washington State)
    - Medicaid and Public Health Partnership aimed at health system transformation (Oregon)

- Toolkit is available at: **http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention**

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Phase I: 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, about half focus on childhood obesity prevention
  - 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)

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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***

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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***

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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****.*

In **Alabama**, the Children's Center for Weight Management receives Medicaid reimbursement for sending nurses and social workers to **assess home environment of children with obesity and for providing education, counseling and medication adherence assistance** as part of a Health Homes SPA.

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***

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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.*

Maine uses CHIP **funding—approved as a health services initiative** (HSI) under Maine's 10 percent administrative cap—to promote a variety of activities, including health education in schools regarding tobacco use, **physical activity and healthy eating**, outreach campaigns for community-based pregnancy prevention and family planning, and media campaigns to discourage the use of tobacco products.

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

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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****.*

Iowa's SIM grant is intended to integrate Medicaid and Public Health to address referral systems, care coordination and social determinants of health. **Community intervention topics include obesity,** patient engagement, tobacco use, and **diabetes**.

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

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Case Study 1: Nationwide Children's Hospital: ACO going Upstream to Address Population Health

- NCH created an ACO (Partners for Kids) in the '90s to take on risk, address cost challenges, and improve care quality
- NCH had to make the business case for going upstream/providing population health initiatives
- NCH has a long-term strategy for population health, including:
  - Long-term funding strategies (e.g., reinvestment of savings, blended funding), in addition to short-term reforms
  - Portfolio approach which encourages innovation
  - With community partners, co-develops 10-year population health improvement goals for target communities
- NCH created a community-centered plan to align community needs and joint investments
  - View this as a continuous process, periodically conducting surveys, assessments, and focus groups to keep a pulse on the needs of their communities

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Case Study 2: Oregon: The Case for Medicaid and Public Health Collaboration

- Oregon’s former governor championed health system transformation over a number of years
  - 2012: Convinced CMS to invest $1.9B in CCOs in exchange for a commitment to reduce Medicaid costs
  - Set clear prevention, integration and care coordination goals to improve outcomes and bend the cost curve
- Developed infrastructure to encourage collaboration between Medicaid and Public Health
- Oregon’s experience shows it’s possible to break down silos and work together to achieve health improvements

Case Study 3: Washington State: Improving Population & Individual Health through Health System Transformation

- Healthier Washington takes a bottom-up approach
  - Established 9 ACHs to plan and coordinate upstream and population health activities (PL-2)
- The recently approved 1115 waiver enables MCOs to work upstream to address social determinants of health
  - They will receive Medicaid reimbursement for foundational community supports (supportive housing and employment assistance) for eligible enrollees (IL-3)
- ACHs and MCOs work collaboratively to address local, regional, and state-wide health and prevention needs as established by state outcomes and objectives

Overcoming Barriers

-Understand what Medicaid can and can't pay for
-Demonstrate business case for prevention, especially for children
-Establish interagency collaboration
-Medical Loss Ratio changes allow for investment in population health
-Establish leadership buy-in
-Address antiquated or non-existent data collection or sharing infrastructure
-Understand where and how to begin

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Facilitators to Success

– A high-level state champion
– Involve "c-suite" executives and community champions
– Long-term prevention and population health goals
– Alignment of Medicaid and child serving organizations
– Robust data collection and sharing systems
– Incentives for shifting to value-based payment

Medicaid Payment Strategies Project (2017)

- **Goal:** Test and share Medicaid approaches to financing upstream prevention and addressing social determinants of health
  - 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:**
  - An in-person meeting of the 3 states to share lessons learned
  - Policy/Issue Briefs
    - **Issue Brief #1: Making The Case for Prevention: Why Accountable Communities of Health Should Pursue Domain 3D Disease Prevention Projects**
    - **Issue Brief #2: Implementing Community Care Coordination in Medicaid: How to Leverage Existing Authorities and Shift to Value Based Purchasing**
    - **Issue Brief #3: Medicaid and Head Start: Opportunities to Collaborate and Pay for Upstream Prevention**
    - **Issue Brief #4: Profile of an Initiative to Embed Medicaid Dietitian Services in Head Start Settings**
    - **Issue Brief #5: Community Care Coordination Systems: Connecting Patients to Community Services**
    - **Issue Brief #6: Supporting ACH Chronic Disease Prevention Transformation Projects: Integrating Community Health Workers into Domain 3D Projects — Program and Financing Implications**

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Medicaid Managed Care Regulation provides authorities to cover SDOH interventions

Type of SDOH Services	Applicable Federal Regulations and Guidelines	Financial Implications
Community Care Coordination Services An MCO's contractual responsibility to identify and coordinate community based, nonmedical services that are related to meeting a patient's health needs, with medical services. Examples: • Coordinate the transition between settings of care • Coordinate services enrollee receives from community and social support providers	"Coordination and Continuity of Care" provision: 42 C.F.R. § 438.208(b)(2)(iv) Medical loss implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (referring to direct claims paid to providers for services covered under the contract) 42 C.F.R. § 438.8(e)(1), (e)(3)(i), (referring to activities that improve health care quality) 45 C.F.R. § 158.150(b)(2)(i)(A)(1) (listing care coordination as an activity that improves health care quality) Calculation of capitation rate: 42 C.F.R. § 438.4(b)(3)	May be considered in the numerator of the medical loss ratio for the MCO as a standard contract requirement for all MCOs and an activity that improves health care quality Must be considered for MCO capitation rate setting purposes
Value-added Services Additional services that are outside of the Medicaid benefit package but that seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. Examples: • Assessing the home for asthma triggers • Medication compliance initiatives • Identifying and addressing ethnic, cultural, or racial disparities • Mosquito repellant to prevent Zika transmission	"Value-added Services" provision: 42 C.F.R. § 438.3(e)(1)(i) Medical loss implications: 42 C.F.R. § 438.8(e)(1), (e)(2)(i)(A) (referring to incurred claims and services under 42 C.F.R. § 438.3(e)) 42 C.F.R. § 438.8(e)(1), (e)(3)(i) 45 C.F.R. § 158.150(b) (referring to activities that improve health care quality) Calculation of capitation rate: 42 C.F.R. § 438.3(e)(1)(i) Referred to as Value-added Services *Federal Register (May 6, 2016), Vol. 81, No. 88, page 27526.*	May be considered in the numerator of the medical loss ratio for the MCO as "incurred claims" or "activities that improve health care quality." May not be considered for MCO capitation rate setting purposes.

Brief will be available in April at http://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention

Summary of State Projects (2017)

- **Maryland:** research, develop and test models that would lead to better coordination between Medicaid and Head Start by:
  - Embedding a dietician in a Head Start center to bill for services provided to Medicaid enrollees including through group and individual counseling. Maryland's initiative moves prevention upstream because it shifts the provision of a basic preventive health measure—healthy eating—into the community in Head Start centers.
- **Oregon:** develop a sustainable financing model for one of the state's CCOs that had recently established a Pathways Community HUB model that connects patients to community services. The HUB is now seeing a contract to begin billing for many of the services provided to Medicaid beneficiaries through its Pathways.
- **Washington:** promote and develop ACH transformation projects specifically related to chronic disease prevention in two phases:
  - Phase 1: Worked with the Health Care Authority (Medicaid) to develop a resource for ACHs that makes the case for investing in chronic disease prevention
  - Phase 2: Worked with two of the state's ACHs to focus on leveraging the expertise and skills of community health workers to meet chronic disease and prevention goals

Maryland State Project

- **Goal:** Create a partnership between Medicaid and Head Start to deliver an obesity prevention initiative.
- **Process:**
  - Maryland was approved for a SPA allowing Medicaid reimbursement for dieticians providing group nutritional counseling as part of EPSDT
  - State is piloting effort with an MCO (Priority Partners) to embed a dietician in a Head Start center to provide nutritional counseling in non-traditional settings
- **Overcoming Barriers:**
  - Create guide explaining Medicaid credentialing and reimbursement process for dietitians
  - Help dietitians understand contracts needed with MCOs, as well as how to enroll and seek credentialing with MCOs
  - Assessing reimbursement rates and how dietitians can break even on costs

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Medicaid Financial Simulator (2017-2018)

- **Goal:** Design an economic simulation tool that would assist State Medicaid Directors and MCOs in making the economic argument for investing in obesity prevention and other associated conditions
  - A 12-month grant from the Robert Wood Johnson Foundation
- **Process:** Partnership with Maryland Dept. of Health and SVT Group to design an economic simulation tool; test and refine that tool with a state; and disseminate the tool for further testing in additional states
- **Deliverables:**
  - Financial simulation model to estimate the cost savings and health outcomes for various childhood obesity prevention interventions;
  - User guide and compendium of research on childhood obesity prevention interventions;
  - Case study on Maryland’s experience using the financial simulation model.
- **Intended Results:**
  - Capture quantitative savings to provide the most realistic representation of the benefits of a given intervention or suite of interventions over time;
  - Link cost savings (if any) to health behaviors and outcomes to the extent possible to ensure that the economic decisions do not have unintended consequences on the health of the population;
  - Specify the time horizon for achieving the outcomes and savings; and
  - Understand the benefit that accrues to the whole family from a heath perspective and the health-related savings that accrue to the payer and the State.

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Questions and Discussion

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