



Executive Summary:
Innovative Medicaid Payment Strategies for
Upstream Prevention and Population Health



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Innovative Medicaid Payment Strategies for Upstream Prevention and Population Health

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INTRODUCTION

Medicaid and other payers are increasingly aware that health outcomes and costs are driven by factors beyond clinical care that are rooted in the community, such as housing, food security, transportation and the environment in which people live. Consequently, payers are exploring ways to move upstream and collaborate with community partners to connect patients to health-related, non-clinical services. Coordinating such community-based services with medical care can help address non-medical drivers of poor health and control or prevent chronic conditions. Furthermore, Medicaid agencies are examining how to integrate such interventions into broader delivery system and payment reform strategies they are deploying to transform how medical care is delivered.

Numerous efforts are underway at national, state and local levels to implement cost-effective strategies that address these “social determinants of health.” Efforts include, but are not limited to: using staff like community health workers (CHWs) to reach at-risk individuals in the community; accountable communities of health (ACHs) and the Center for Medicare & Medicaid Innovation’s (CMMI) Accountable Health Communities model¹; the Pathways Community HUB model²; and health care organization and community based organization (CBO) partnerships³. A number of state Medicaid agencies such as: California, Colorado, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Washington are pursuing these various strategies. A wide range of funding mechanisms are used, including: (1) CMMI funding opportunities; (2) federal §1115 waivers including Delivery System Reform Incentive Payment programs (DSRIP); (3) managed care capitation payments; (4) foundation funding; (5) social impact investing; and (6) grants and operational funding from health care providers, including community benefit investments.

In 2017, AcademyHealth contracted with Nemours Children's Health System as part of their RWJF-funded Payment Reform for Population Health initiative to conduct a project in partnership with Maryland, Oregon and Washington to test how Medicaid payment authorities and new payment models can be used to support interventions to address the social determinants of health. This project builds on an earlier Nemours project (funded by RWJF) that developed a Roadmap and other resources with a range of examples showing how states and managed care organizations (MCOs) can implement prevention interventions under Medicaid. In partnership with AcademyHealth, the Center for Health Care Strategies and Burton Policy Consulting, the Nemours team worked with state Medicaid agencies and key stakeholders such as Head Start centers, coordinated care organizations (CCO) and ACHs in those three states to investigate and implement payment solutions and position key stakeholders to better leverage existing Medicaid payment authorities. These state projects applied lessons from the Medicaid Roadmap and, in so doing, illustrated the possibilities for using current Medicaid authority to provide services in community settings, cover upstream prevention and deliver services using nontraditional community-based providers.

In Maryland, the team worked with Medicaid to explore connecting one Medicaid managed care organization (MCO) with Head Start programs in the interest of linking families to needed services and addressing the social determinants of health. In Oregon, the team worked with the Oregon Health Authority and the PacificSource Columbia Gorge CCO to assess the extent to which the CCO could use its global capitation payment to cover community care coordination and non-medical services delivered under the Bridges to Health Pathways HUB model, and how to structure such payments so that they align with the principles of value-based payment (VBP). The Nemours team worked with two ACHs in Washington and with the Washington Health Care Authority to help define the business case for investing in upstream prevention, to encourage all state ACHs to consider developing community initiatives to prevent chronic diseases and to integrate CHWs to help achieve their goals.

In the course of this work, the team identified several practical lessons and approaches that other state Medicaid agencies, health plans, providers and other stakeholders can use in pursuing similar efforts. We identify both barriers that can be overcome and accelerators that enable this type of work. This executive summary briefly highlights those lessons and synthesizes important takeaways.

Nemours Children's Health System was awarded a one-year grant to help three state Medicaid programs test approaches to financing upstream prevention and population health through AcademyHealth's Payment Reform for Population Health initiative, with funding from the Robert Wood Johnson Foundation (RWJF). While almost all states have begun Medicaid delivery system reform, initiatives and programs geared toward upstream prevention and population health are in varying stages of development. Nemours provided technical assistance to three states – Maryland, Oregon and Washington – as they developed or implemented upstream prevention strategies using Medicaid funds. This executive summary shares practical lessons learned and key takeaways for how states can use existing Medicaid authority to finance innovative upstream prevention and population health initiatives. The entire series of briefs can be found at: <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention>. To learn more about AcademyHealth's Payment Reform for Population Health initiative, visit www.academyhealth.org/p4ph.

OVERCOMING BARRIERS

What is the business case for investing upstream?

Many stakeholders struggle with making the business case to payers for investing in upstream prevention and therefore confront an immediate barrier. The Nemours team worked with the Washington Health Care Authority to examine the evidence base supporting such investments from a business perspective. As highlighted in a companion issue brief, *Making the Case for Prevention: Why Washington's Accountable Communities of Health (ACHs) Should Pursue Domain 3D Chronic Disease Prevention Projects*, upstream prevention projects provide an opportunity to: (1) reduce Medicaid spending on treatments and services for acute and chronic conditions; (2) improve the health of Medicaid members by preventing chronic disease; (3) reduce costs in other sectors (because of the downstream effects of a healthier population, like greater workforce participation); and (4) promote the goals of moving toward value- and outcomes-based payments that reward positive health outcomes.

How can Medicaid pay for upstream prevention services?

Understanding what Medicaid can and cannot pay for is another critical barrier to investing in upstream prevention. Our work in Oregon revealed that the 2016 Medicaid Managed Care rules enable Medicaid to fund and pay for a wide range of upstream interventions via managed care. One example is assessing the home for asthma triggers; another is paying for care coordination of non-medical services related to overall health needs. These revised regulations clarified the significant opportunities that Medicaid managed care organizations (MCOs) have to pay for community care coordination and value-added or health-related services that can improve outcomes and lower costs. The regulations also clarified the considerable authorities under Medicaid that states have to drive adoption of VBP models within MCO and provider contracts. Together, these provisions create a clearer financing pathway for MCOs to invest their capitation payments in upstream interventions and to structure payments to community-based organizations delivering such services in ways that align with VBP. Building off of recent work that Nemours undertook with PacificSource Columbia Gorge CCO in Oregon, the brief titled “*Implementing Social Determinants of Health Interventions in Medicaid Managed Care*” identifies the Medicaid managed care authorities that can be used to cover upstream prevention. The brief provides examples of how other states and managed care plans are using those authorities and also examines how payers can apply the principles of VBP to structuring payments for these interventions, using pay for performance, pay for success, shared savings and bundled payment approaches.

What are common upstream interventions that states are implementing to link clinical delivery systems to community systems and how are they paying for them?

Given the nascency of this work, states, health plans and providers often feel like they are starting from scratch when determining which upstream interventions to deploy. It is helpful to understand what emerging best practices look like. Two commonly used approaches to address the social determinants of health include Community Health Workers (CHWs) and community care coordination systems. Both models have an evidence base demonstrating improved health outcomes. Building on work with two ACHs in Washington, this brief, *Integrating Community Health Workers into Washington's Medicaid Transformation Projects: Program and Financing Considerations*, explores the benefits of employing CHWs for upstream interventions. The brief: (1) outlines a common definition of and roles for CHWs; (2) examines the evidence behind incorporating CHWs into upstream prevention efforts; and (3) discusses financing options available to support CHWs.

Managed care plans also are funding community care coordination systems, which are systems that connect patients with both the health and social service sectors, so all needs identified can be addressed. We examine such models, which use closed-loop referral mechanisms, in *Community Care Coordination Systems: Connecting Patients to Community Services*. Within these models, the comprehensive system performs the following functions: (1) identifies and engages patients who are likely to have multiple health and social needs; (2) screens patients for social determinants of health (SDOH) needs and determines the appropriate organizations with the resources and knowledge to address their specific needs; (3) connects patients with these community organizations to address their social needs within the community care coordination system; (4) follows up to ensure patients are connected and facilitates completion of the SDOH intervention; and (5) tracks outcomes of patients receiving community-based services. These efforts involve forming partnerships with organizations in the community, setting policy (e.g., payment, training requirements), collecting data, and tracking outcomes. The Pathways Community HUB model is one example of a comprehensive community-based system that has been deployed in Michigan, Ohio and Oregon, where some Medicaid MCOs are paying for various aspects such as community care coordination, medical services and value-added services. We developed a checklist of functions and features of comprehensive community care coordination systems so that states, communities and providers can easily determine what they need to have in place to ensure patients are connected to and receive needed services in the community.



How is Medicaid partnering with other agencies and organizations in community settings?

Medicaid cannot address and invest in social determinants on its own — it must partner with other state agencies, as well as encourage partnership with community-based organizations at the local level. Head Start is one natural partner to address social determinants of health and connect families to needed health services. Serving many of the same families, Head Start and Medicaid also have shared health goals, given that health care is a core component of Head Start. Head Start also has expertise in engaging families, assessing risks and addressing social determinants of health. Significant potential exists for alignment of care coordination and service delivery between Head Start and Medicaid. Building on work in Maryland, the brief *Medicaid and Head Start: Opportunities to Collaborate and Pay for Upstream Prevention* explores opportunities for connecting Medicaid MCOs with local Head Start programs in the interest of linking children and their families to needed services. The issue brief explores opportunities to leverage existing infrastructure between Head Start and Medicaid, and opportunities to braid financing/optimize funding for upstream prevention. A second issue brief, *Moving Medicaid Prevention Upstream: An Exploration of How to Embed Medicaid Dietitian Services in Head Start Settings*, looks at planning in Maryland to deliver nutritional counseling in Head Start settings by licensed dietitians, as part of an obesity prevention strategy. The Medicaid MCO-participating dietitian would provide the service on site at the Head Start center and be reimbursed by the child's MCO. The issue brief explores early lessons, considerations for a managed care environment, and key implementation questions.



LESSONS LEARNED

As we reflect on the innovative work undertaken by the three states in this project, a number of accelerators emerge that drive state actions.

- First, it is critically important to have a **state champion** involved in the work from the beginning. The engagement of a state's Medicaid director facilitates decision-making, collaboration with counterparts at other state agencies, and can build momentum for new initiatives or policy changes. Conversely, we found that a departure of a state Medicaid director can greatly slow down the pace of innovation.
- In addition to government leaders, we learned that **including both the “C-suite” executives and community champions at the table**, including payers and hospitals, can facilitate change. Involving the private sector accelerates change by having both the public and private sectors work toward achieving common goals related to upstream prevention and population health.
- Our state partners indicated that while government should set transformation goals, it should **provide stakeholders with flexibility on how to accomplish these goals**. These goals serve as enablers that bring local stakeholders together around a shared agenda. In Washington State, for example, the ACHs select and collaborate on regional transformation projects with common goals to address local health priorities.
- **Alignment of Medicaid and child-serving organizations** can improve access and foster better coordinated care for children. Our work in Maryland, for example, showed how Medicaid Early and Periodic Screening, Diagnostic, and Treatment, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening requirements overlap with Head Start health requirements. States can look for opportunities to reduce

duplication of care management activities and services by increasing collaboration across child-serving programs.

- Approaching this work – strategies that link traditional clinical care with community-based prevention initiatives to address chronic disease – as a **portfolio of investments** and across a range of populations with both near- and long-term impacts mitigates the perceived risks of focusing on prevention in the short run. At the same time, this allows consideration of strategies with longer-term impacts.
- **Focusing on the family as the unit of partnership** represents another lesson learned. States should consider how delivery systems can best meet consumers' and entire households' needs. For example, efforts in Maryland suggest that in some cases health care services could be delivered in a child care setting rather than at a child's medical home. Considering the family, rather than the individual, broadens our understanding of which patients may be positively impacted by an intervention.
- We heard that including the **Centers for Medicare & Medicaid Services (CMS) as a partner**, rather than viewing them as only a payer, improves states' ability to make upstream investments. States could approach CMS early, starting with the goal of the initiative and then inquire about the best authority or pathway to achieve the goal. Keeping the regional office apprised of initiatives and demonstrating collaboration across sectors by bringing other state partners to the table can be helpful in negotiations between CMS and the state.
- **Thinking broadly about ways to use payment reform** – rather than addressing a specific issue – can facilitate change. Patient needs and community resources will vary greatly, so a broader approach that has built-in flexibility and adaptation will enable local stakeholders to develop tailored solutions. Oregon, for example, provides its CCOs with a global budget for which they have flexibility to address specific community health needs and are incentivized to address SDOH. As discussed above, the PacificSource Columbia Gorge CCO is funding its comprehensive community coordinated care system, in part, with these funds.
- Finally, there is **flexibility under current federal Medicaid regulations** to: provide services in different community settings, like a child care center; use non-traditional providers such as CHWs and dietician to provide upstream non-medical but health-related services; and pay for community care coordination systems. States need technical assistance and support to do this work, as it is forging new and complicated territory.



CONCLUSION

We set out to help states test approaches to finance upstream prevention and address the social determinants of health under Medicaid. We are grateful to the state governments and community partners in Maryland, Oregon and Washington for the opportunity to collaborate with them on testing different payment strategies. Our collective work resulted in many new pathways forward for action in this area under Medicaid that those working in the field can benefit from, including delivering services in community settings like Head Start centers, using non-traditional providers like CHWs and dietitians, providing upstream non-medical but health-related services, and paying for comprehensive community care coordination systems. Along the way, we learned essential lessons that will enable quicker adoption by other states and accelerate adoption of innovative partnerships between Medicaid agencies, health plans, other state agencies and community-based organizations.

Medicaid Payment Strategies for Financing Upstream Prevention “How To” Briefs

Making the Case for Prevention: Why Washington’s Accountable Communities of Health Should Pursue Domain 3D Chronic Disease Prevention Projects. <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/making-the-case-for-prevention>

Implementing Social Determinants of Health Interventions in Medicaid Managed Care: How to Leverage Existing Authorities and Shift to Value Based Purchasing. <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/implementing-social-determinants-of-health-interventions-in-medicaid-managed-care>

Medicaid and Head Start: Opportunities to Collaborate and Pay for Upstream Prevention <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/medicaid-and-head-start>

Moving Medicaid Prevention Services Upstream: An Exploration of How to Embed Medicaid Dietitian Services in Head Start Settings. <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/embedding-medicaid-dieticians-in-head-start>

Community Care Coordination Systems: Connecting Patients to Community Services. <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/community-care-coordination-systems>

Integrating Community Health Workers into Washington’s Medicaid Transformation Projects: Program and Financing Considerations. <https://movinghealthcareupstream.org/innovations/medicaid-payment-strategies-for-financing-upstream-prevention/integrating-community-health-workers-into-domain-3d-projects>

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