

Promoting Prevention in Medicaid and CHIP



Building
partnerships and
financing
prevention in
Medicaid and
CHIP

June 13, 2013

Agenda

Welcome

- Anand Parekh, MD, MPH, Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services

Projects to Promote Cross-Sector Collaboration and Health in All Policies

- Julia Pekarsky Schneider, MPH, Director, Chronic Disease Prevention, ASTHO

Partnerships between Medicaid and Public Health in Oregon

- Rhonda Busek, MBA, Deputy Director, Oregon Health Plan (Medicaid)
- Mel Kohn, MD, MPH, Director, Oregon Public Health Division

Medicaid-Public Health Collaborations in New York

- Nirav Shah, MD, MPH, Chief Health Official, New York Dept. of Health
- Jason Helgerson, Medicaid Director, New York Dept. of Health

Financing preventive services in Medicaid and CHIP

- Elizabeth Garbarczyk, Division of Benefits and Coverage, CMCS

Questions and Discussion

Future opportunities

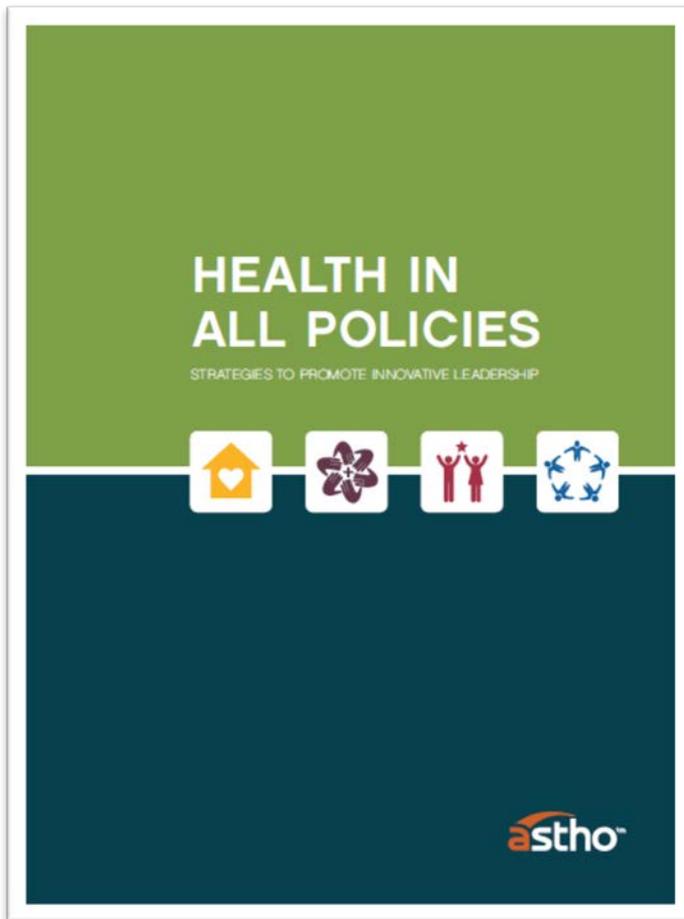


Building Partnerships and Financing Prevention in Medicaid and CHIP

ASTHO's Projects to Promote Cross-Sector Collaboration
and Health in All Policies

Julia Pekarsky Schneider, MPH
Director, Chronic Disease Prevention
Association of State and Territorial
Health Officials (ASTHO)

Health in All Policies Toolkit



In support of the National Prevention Strategy, ASTHO produced this innovative resource to educate and empower public health leaders to promote a Health in All Policies (HiAP) approach to policymaking and program development. By collaborating across multiple sectors to address health disparities and empower individuals, promoting healthy communities, and ensuring quality clinical and community preventive services, we can increase the number of Americans who are healthy at every stage of life.

New Online Toolkit to Support the National Prevention Strategy

NATIONAL PREVENTION STRATEGY

Access »
Accreditation and Performance »
Branding Public Health »
e-Health »
Environmental Health »
Evidence-Based Public Health »
Health Equity »
Health in All Policies »
Health Reform »
Immunization »
Infectious Disease »
Preparedness »
Prevention »
Workforce and Leadership Development »

NPS Implementation Toolkit

Explore each Strategic Direction and Priority Area in this graphic to find topic-specific resources for each action step

[Learn how!](#)

Submit your story and resources on how you are implementing the National Prevention Strategy in your state!

This summer, ASTHO will release an online toolkit with over 200 resources for and by states to help you implement the strategies in the NPS.

ASTHO's President's Challenge and Primary Care Integration Project

- ASTHO's Current President's Challenge is to Advance the Reintegration of Public Health and Healthcare.
- Dr. Montero has challenged each State Health Official to identify at least one example from their state/territory that demonstrates successful integration of public health and healthcare delivery.
- The President's Challenge builds off of the IOM report, Primary Care and Public Health: Exploring Integration to Improve Population Health
- The strategic map developed by a collaboration of ASTHO, the IOM, and key public health and primary care leaders provides a framework for strengthening and supporting public health and primary care integration, and will help guide the work of the challenge throughout the year.

<http://www.astho.org/Programs/Access/Primary-Care-and-Public-Health-Integration/>



Enhancing the Role of Public Health to Support Million Hearts



millionhearts.hhs.gov

ASTHO is supporting the goal of Million Hearts to enhance collaboration around the ABCS- aspirin, blood pressure, cholesterol, and smoking cessation. A key focus of this project is the role of public health in linking with clinical care to advance the ABCS.



Thank you!

Julia Schneider

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www.astho.org/programs/prevention

Building Partnerships and Financing Prevention in Medicaid and CHIP



Partnerships Between
Medicaid and Public
Health in Oregon

Rhonda Busek

Deputy Director, Division of
Medical Assistance Programs

Mel Kohn, MD MPH

Public Health Director

Oregon Health Authority

The Oregon Context

- The old way wasn't working
 - Health care costs too high, health outcomes too low, care fragmented
- So Oregon chose a new way
 - Governor's vision
 - Robust public process
 - Bi-partisan support
 - 15 new Coordinated Care Organizations (CCOs) certified and launched in 2012
 - Serve Oregon Health Plan (Medicaid) members
 - 600,000 transitioned to CCOs in three months last fall
 - 200,000 more eligible in 2014 under ACA Medicaid expansion

CMS Waiver

- Signed July 5, 2012
- \$1.9b federal assistance over 5 years for implementation
- State must reduce growth of per capita costs to 2% less than national average
- Must meet quality and access targets
- Some public health funds used for state match

Key Characteristics of CCOs

- Not tied to county boundaries
 - Organic variation in size of catchment areas
- Benefits and services are integrated and coordinated
 - Includes physical, behavioral health and dental care
- One global budget that grows at a fixed rate
- Metrics related to standards for safe and effective care
- Local accountability for budget and health outcomes
- Encourage wellness, not just treat illness
 - Prevention, chronic disease management, community health workers
- Local flexibility

CCO Governance

- Governed locally by governing body that includes:
 - Major components of health care delivery system
 - Entities that share in financial risk
 - At least two practicing health care providers
 - Primary care physician or nurse practitioner
 - Mental health or chemical dependency treatment provider
 - At least two community members
 - At least one member of Community Advisory Council (CAC)
 - CAC duties include developing a Community Health Improvement Plan and reporting on progress of CCO

CCO Metrics

- Legislature established ongoing committee to identify metrics using a public process
- If met CCOs will get additional funds from quality pool
- 17 metrics in seven categories selected for first year
 - Addressing chronic conditions
 - Reducing preventable and costly utilization
 - Integrating physical and behavioral health care
 - Improving access to effective and timely care
 - Improving perinatal and maternity care
 - Reducing preventable rehospitalizations
 - Improving primary care for all populations
- Metrics to be reported quarterly on website

Supports for Testing, Accelerating and Spreading Innovations

- CCO legislation established an Innovation Center
 - “Innovator Agents” embedded in CCOs
 - Learning collaboratives for peer-to-peer learning
 - Some areas of focus so far
 - Community health assessments
 - Community health improvement plans
 - Health equity
 - Patient-centered primary care homes
 - Community health workers

Collaboration with Public Health

- In Oregon public health authority resides at the county level
 - 34 county health departments
 - State role is oversight, coordination, assurance
- Data expertise of public health staff
 - Selection of metrics
 - Development of Community Health Assessments and Community Health Improvement Plans
- County public health and local advocates participating in CACs and Governance
 - Local relationships key

Some Examples of Collaboration Between CCOs and Public Health

- Trillium Community Health Plan is setting aside \$10 per member per year to enable the local health department to hire an epidemiologist and two health analysts to develop evidence-based tobacco prevention measures.
- Columbia Pacific and Jackson Care Connect are using local health data to determine priorities for their transformation plans

Integration in CCOs Builds on Previous Collaboration

- Medicaid Assessment Initiative
 - Funded by CDC for 10 years
 - Created tools and trained staff to enable use of Medicaid claims data for public health assessment and surveillance
 - Lessons used in creating new Medicaid data system
- Public health helped frame issues and opportunities for quality improvement projects
 - Undertaken by medical directors group for capitated plans
 - Expertise on best practices for prevention
 - Asthma, diabetes

Tobacco Control Integration Project

- Huge disparity in tobacco use by income
 - Low income Oregonians smoke at 3x rate of more affluent
- Project aimed to leverage existing human services structures to reach this population
- Bottom up approach
 - Identify and support champions in human services agencies to find opportunities that fit their business processes
- Medicaid identified tobacco cessation services
 - Plans required to provide evidence-based services
 - Surveys done to describe what is actually offered

Variation in tobacco cessation benefits

- 2012 survey of Medicaid managed care plans showed improvement from 2011, but:
 - 13/15 require prior authorization for accessing at least one of their covered cessation benefits
 - 12/15 do not assess tobacco use status of all patients
 - 9/15 do not cover all seven FDA-approved cessation meds
 - 5/15 require enrollment in a counseling program to get meds
 - 2/15 do not cover telephonic counseling
- Given potential for cost savings from tobacco cessation CCOs have incentive to address

Some Challenges for the Future

- Expanding the mindset and skills of health systems to include the full suite of prevention tools, not just clinical preventive services
- Funding prevention activities outside of the healthcare provider's office
 - Funding streams often tied to individual patient encounters but group care or policy change can be most effective at improving health

References and Resources

- CCOs: <https://cco.health.oregon.gov/pages/aboutus.aspx>
- CDC Assessment Initiative in Oregon: Howard RN, Marshall LM, Peterson JM, Kohn MA. Tracking Oregon Medicaid patients' enrollment and health utilization patterns. J Public Health Management Practice. 2002;8(4):70–76.
- Collaboration between Medicaid and Public Health in Oregon on Quality Improvement: Rebanal RD, Leman R. Collaboration between Oregon's chronic disease programs and Medicaid to decrease smoking among Medicaid-insured Oregonians with asthma. Prev Chronic Dis [serial online] 2005 Nov [date cited]. Available from:
URL: <http://www.cdc.gov/pcd/issues/2005/>
- Oregon's Tobacco Control Integration Project:
<http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/tcip.aspx#dmap>



Building partnerships and financing prevention in Medicaid and CHIP

Medicaid – Public Health Collaborations in New York

Nirav Shah, MD, MPH
Chief Health Official

Jason Helgeson
Medicaid Director
New York State Dept. of Health

The Medicaid Problem in New York

- Cost the state \$53.8 billion.
- Annual increases of 13% a year.
- Ranked 22nd in the country for quality.
- Ranked lowest in U.S. for readmissions.

The Key Questions

- What are we paying for that we shouldn't?
- What aren't we paying for that we should?
- What kinds of prevention could we deliver in public health?
- How do we advance the Triple Aim?



The Medicaid Redesign Team

- Assembled stakeholders in 2011 to find ways to increase quality and reduce costs.
- Collected 4,000 ideas from across the state.
- Adopted 200 ideas and began implementing in two phases.

Expand Prevention and Improve Population Health

- Cover all USPSTF Grade A/B recommendations.
- Lactation counseling for pregnant women to encourage breastfeeding.
- Podiatry services for patients with diabetes.
- Expanded smoking cessation to ALL Medicaid beneficiaries.
- Enrolled 30,000 in Health Homes.

Reduced Unnecessary and Costly Ones

- Inappropriate percutaneous coronary Interventions.
- Certain treatments for low-back pain.
- Arthroscopy of the knee for osteoarthritis w/o mechanical destruction.
- Human growth hormone for short stature.

Public Health Initiatives Worth Money

- GOLD Stamp Program (bedsores)
- Supportive housing
- Fluoridated water



The Financial Impact of Our Efforts

- Set a Global Spending Cap of \$15.9 billion.
- In 2011-2012, state came in \$14 million below that.
- First year: \$4 billion in combined state and federal savings for Medicaid.
- Second year: state was \$200 million under the GSC.

The Impact on Patients

- By 2016, increase patients in managed care from 77% to 95% of the Medicaid population.
- Higher rates of childhood immunization, blood pressure control for people diabetes, more colorectal cancer screening and assistance to help people quit smoking.
- +10% reduction in preterm births results in Virginia Apgar Award from March of Dimes.

NYC Medicaid Improvements

- NCQA ranked NYS #2 in the nation for quality, second only to Massachusetts.
- Especially successful for diabetes, childhood obesity, smoking cessation and follow-up care for the mentally ill.
- Managed long-term care is receiving favorable reviews.
- Among patients in Health Homes, admissions and ER use is down.

Where do we go from here?

- Estimated \$34 billion in savings over next five years.
- \$10 billion waiver from federal government.
- Advance toward Triple Aim.
- Continuous improvement via transparency, stakeholder collaboration and clinical integration.



Building partnerships and financing prevention in Medicaid and CHIP

Financing preventive services in Medicaid

Elizabeth Garbarczyk

Division of Benefits and Coverage

Center for Medicaid and CHIP Services, CMS

Pre-ACA Coverage of Preventive Services

- Adults: Preventive services are an optional benefit under traditional Medicaid
- Children under 21 under traditional Medicaid and a CHIP Medicaid expansion: Preventive services are a mandatory benefit under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit
- Separate CHIP programs provide, at a minimum, well baby/well child care and immunizations

ACA Changes Impacting Preventive Services in Medicaid

- Section 4106 of the Affordable Care Act
- Inclusion of the Essential Health Benefits in the Alternative Benefit Plans
- Statutory and Regulatory alignment of Preventive services language

ACA Section 4106

- Section 4106 is an optional ACA provision
- Requirements: Coverage of all USPSTF grade A and B preventive services, ACIP recommended vaccines and their administration without cost-sharing
- States who receive approval of a state plan amendment implementing this provision receive 1% additional federal medical assistance percentages on such services

Alternative Benefit Plans (ABPs)

- ABPs (previously called Benchmark plans) are currently in use by some states
- In 2014, the new eligibles receiving 100% FMAP will be enrolled in ABPs
- All ABPs (previous and new) will include Essential Health Benefits (EHBs)
- Preventive services are an EHB

Align Preventive Services Regulation and Statute

- Notice of proposed rule to align 42 CFR 440.130 Preventive services regulation with statutory provision 1905(a)(13)
- Hope to have an early summer publication date
- If finalized, providers other than physician or other licensed practitioners who may not have a license may be permitted to provide services (subject to state law and approval of a state plan amendment)

References and Resources

- State Medicaid Director Letter 13-002 on Affordable Care Act section 4106
- Affordable Care Act section 4106 Frequently Asked Questions (to be posted on Medicaid.gov shortly)
- Notice of Proposed Rule: Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, etc. (CMS 2334-P; RIN 0938-AR04)
- <http://www.Medicaid.gov>
- Email: MedicaidCHIPPrevention@cms.hhs.gov