



Realizing the Promise of Medicaid Prevention and Population Health

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ACKNOWLEDGEMENT

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EXECUTIVE SUMMARY

The Robert Wood Johnson Foundation awarded Nemours a one-year grant to explore options and promote the use of existing Medicaid authority to support childhood obesity prevention. Nemours developed a number of products to help states understand the range of Medicaid and Children’s Health Insurance Program (CHIP) options that they can use to sustain approaches that link clinic to community prevention to address chronic disease including childhood obesity. These are strategies that link traditional clinical preventive care with community-based initiatives to address chronic disease. Each of the products developed for the project provide lessons learned for states considering adopting new prevention strategies.

One of the products—The Roadmap of Medicaid Prevention Pathways—illustrates how state Medicaid agencies and their partners can maximize the authority that exists under Federal Medicaid and CHIP law to deliver a range of preventive health services at both the individual and population levels. The Roadmap includes 40 examples from 23 states. The examples of states’ prevention strategies are presented along a continuum spanning from the individual level (services targeted at an individual Medicaid enrollee) to the population level (services targeted at an entire geographic area including Medicaid and non-Medicaid enrollees).

In addition to the Roadmap, the companion documents to this paper include: planning tools for states interested in prevention and population health and three in-depth case studies. The case studies’ titles are: (1) “Oregon: The Case for Medicaid and Public Health Collaboration;” (2) “Nationwide Children’s Hospital: An ACO Going Upstream to Address Population Health;” and (3) “Washington State: Improving Population and Individual Health through Health System Transformation.”

A number of factors were identified that affect the successful implementation of prevention strategies financed through Medicaid. Some of the accelerators

that facilitate innovative strategies include: a champion within state government; an integrator—a person or entity—that works intentionally and systematically across sectors to achieve improvements in health and wellbeing; an entity that provides integrator functions, including conveners that bring key players together to develop shared priorities and goals; alignment of Medicaid and public health goals; an infrastructure that encourages collaboration across agencies; robust data systems; incentives in Medicaid managed care contracts to promote non-traditional providers and non-traditional preventive services; learning collaboratives for exchanging information; and educating providers to achieve practice transformation.

The barriers identified include: difficulty in establishing a return on investment for obesity and other types of prevention; Medicaid’s historical focus on clinical care, not population-level services; concern about medical loss ratio; challenges for a state wanting to shift from a clinical focus to a population-level focus; conflicting sets of priorities across agencies and community partners; lack of established working relationships across agencies; credentialing of non-traditional providers; enrollee churning in Medicaid; and lack of provider training about community linkages. Potential solutions to each of these barriers are presented.

Over the course of the project, several broad features emerged that are critical for a state to have in place as it begins transforming its health care delivery system to include a population health focus. These “conditions of success” include: leadership from a high-ranking state official who can make prevention a priority across the state or department; a state planning process that begins by focusing on the state’s unique goals; collaboration across state and community partners to address population health; and recognition that state Medicaid agencies are one piece of the population health puzzle.

The project primarily emphasized actions that can be taken at the state level to address prevention. In

addition, the federal government should consider the following recommendations to facilitate innovative state prevention strategies. First, the federal government should consider allowing a longer time period to demonstrate a return on investment for childhood obesity prevention. Second, we encourage continued strong support of the Center for Medicare and Medicaid Services' (CMS) Innovation Center, which we believe has accelerated health system transformation across the states. Finally, we urge CMS to design templates for states to use for State Plan Amendments (SPAs) relating to preventive health measures.

This project demonstrates that Medicaid currently plays, and should continue to play, a critical role in sustaining innovative clinic to community prevention linkages and population health interventions. States start at various places along a continuum in terms of

the types of prevention services that they currently offer to their Medicaid enrollees and the strategies for broader population. Regardless of where they are on the continuum, states should consider the options that exist in Medicaid and CHIP to sustain or build on their current efforts.

The health policy landscape changed dramatically in recent years with the passage and implementation of the Affordable Care Act. Federal and state level health policy will continue to evolve in the coming years. This White Paper will continue to be important to promoting the health and wellbeing of children by showing states how they can accelerate the innovative efforts already underway to strengthen prevention.

INTRODUCTION

The Robert Wood Johnson Foundation awarded Nemours a one-year grant to explore options and promote the use of existing Medicaid authority to support childhood obesity prevention. Medicaid plays an essential role in promoting the health and wellbeing of American's children. Today, 40 percent of children—over 35.5 million—are enrolled in Medicaid or the Children's Health Insurance Program (CHIP).¹ Many of these enrollees are children of color.²

Medicaid is essentially a public insurance program that provides medical assistance to eligible individuals and, while there is flexibility under current law, there are clear boundaries limiting Medicaid's reach to social determinants of health and population health. Given this, community prevention initiatives that directly connect to the delivery of medical care will more easily align with Medicaid models. For this White Paper, we define the linkage of "clinic to community prevention" as strategies that link traditional clinical preventive care with community-based initiatives to address chronic disease.

Nemours set out to identify innovative strategies that illustrate ways in which state Medicaid agencies and their partners can maximize the authority that exists in federal law for Medicaid and CHIP to deliver a range of childhood obesity prevention strategies at both the individual and population levels. The project intended to highlight prevention programs that included three

criteria: (1) Medicaid funding; (2) a childhood obesity prevention component; and (3) a clinic to community prevention linkage.

Our environmental scan of the research and grey literature, as well as conversations with our Ad Hoc Work Group—experts in various sectors who helped us think through substantive issues and provided input on our work (see Appendix A for a list of members)—and other collaborators failed to uncover the type of prevention initiatives that met our original criteria. There were almost no obesity-related examples in the literature of Medicaid-funded approaches with a clinic to community prevention linkage. The limited examples we did find were of Medicaid-funded hospital-based weight management programs. Our conversations with collaborators revealed many programs focused only on a single component of integrated care delivery. For example, physicians or other licensed practitioners (OLPs) that provide a non-traditional service (exercise class) in a traditional setting (clinic). We, therefore, broadened our scope to include examples of prevention and population health strategies to address chronic diseases rather than focusing solely on childhood obesity.

We also shifted the focus of the project to helping states understand the range of Medicaid and CHIP options they can use to implement, support, sustain and integrate clinic to community prevention

approaches addressing chronic diseases, and how best to successfully put them into place on the ground. The result is a toolkit of resources that illustrate and enable states and managed care organizations (MCOs) to implement the many options for prevention under Medicaid. All of these strategies can be applied by states and MCOs to childhood obesity prevention. Our intent is to bring to light the options that are available so states can take advantage of existing opportunities under current law.

Each of the products developed for this project examine lessons learned to provide “how to” guidance for states considering adopting new prevention strategies. When bundled together, the toolkit will provide states and MCOs with a practical resource to guide their prevention efforts. The toolkit includes: (1) a Roadmap for states with 40 examples from states doing innovative prevention work (including the Medicaid authorities and links to approval documents) that can be adapted and applied to obesity prevention; (2) a planning document as an appendix to the Roadmap that will lay out a series of questions for states to help states develop and implement effective prevention strategies; (3) three case studies profiling state (Oregon and Washington) and managed care (Nationwide in Ohio) efforts to provide innovative preventive strategies including drawing out key accelerators and barriers; and (4) this White Paper with recommendations.

A focal point of the project was a meeting we convened in August 2016 with 35 leaders representing a range of perspectives including states, federal government officials, managed care organizations, national experts and foundations. (See Appendix B for the list of meeting participants.) At the meeting, we: highlighted opportunities for states to use existing Medicaid and CHIP authorities to cover innovative prevention strategies; identified accelerators and barriers to using current Medicaid and CHIP authorities to support prevention; compiled the conditions for success that can be adopted in other states; and examined how these conditions can be applied to childhood obesity prevention through a series of hypothetical case scenarios.

We believe this project is distinct from other, similar efforts in several ways. First, our project focuses on prevention strategies that are financed by Medicaid. Medicaid financing offers states an assurance of sustainable funding as opposed to grant funding that typically lasts only for defined time periods. Second, this project creates a Roadmap to demonstrate how

states and MCOs can cover prevention and population health. This includes identifying Medicaid authorities used by states and MCOs to support initiatives. Third, the project pays special attention to what upstream approaches can be covered by Medicaid. That is, the non-medical services that address the systemic conditions (e.g., environmental, economic) that contribute to poor health. Finally, it uses the lens of a pediatric population rather than an adult population.

This White Paper attempts to synthesize and expand upon the learnings from our environmental scan, the August 2016 convening, the four project deliverables described above and ongoing consultations with our Ad Hoc Work Group. We hope states will use these resources as a guide for leveraging Medicaid funding to go upstream to tackle the social determinants of health that address preventable conditions among vulnerable groups, including high rates of childhood obesity.

The health policy landscape changed dramatically in recent years with the passage and implementation of the Affordable Care Act. Federal and state level health policy will continue to evolve in the coming years. This White Paper will continue to be important to promoting the health and well-being of children by showing states how they can accelerate the innovative efforts already underway to strengthen prevention.

BACKGROUND ON CHILDHOOD OBESITY PREVENTION AND THE CHALLENGES OF ADDRESSING PREVENTION UNDER MEDICAID

Childhood obesity is a serious public health problem in the United States. It affects 17 percent of children (or 12.7 million)³ nationwide, disproportionately affects children of color and children living in poverty⁴ and is associated with health conditions that lead to early development of type 2 diabetes, cardiovascular disease, hypertension and nonalcoholic fatty liver disease.⁵

Although pharmaceutical, medical and surgical interventions to treat obesity exist, they are relatively rare. The costs attributable to obesity, therefore, mainly result from treating the diseases associated with obesity. These associated conditions (e.g., diabetes, cardiovascular disease, high blood pressure) have substantial financial costs.⁶ Health care spending related to obesity is estimated to be as high as \$210 billion annually, or 21 percent of total health care spending.⁷

A recent study on obesity spending found that individuals with obesity had per capita medical spending that was 42 percent greater than spending for individuals with normal weight.⁸ Children who are overweight or obese are associated with an additional \$2.9 billion per year in health care.⁹ Due to the disproportionate share of children with obesity who live in poverty, the costs result in a significant burden on the public insurance programs. In 2008, obesity contributed to 11.8 percent of Medicaid costs.¹⁰

Reducing the costs of care for patients with childhood obesity and other chronic conditions will not be achieved by clinical interventions alone.¹¹ Recent research has shown that medical care is not the only factor that affects health outcomes even though 95 percent of health care spending is devoted to direct medical care.¹² Rather, a person's health status is significantly influenced by a variety of social and physical conditions including economic circumstances, education level, family life, and neighborhood and physical environment.¹³ Integration of clinical and community systems is necessary to address chronic conditions.¹⁴

Healthy eating and regular physical activity are two strategies that can lower the risk of becoming obese and developing serious health conditions.¹⁵ The dietary and physical activity behavior patterns of children are influenced by many sectors of society including families, communities, schools, early care and education settings, medical care providers, government agencies, the media and the food and beverage industries and entertainment

industries.¹⁶ Prevention of obesity will require all these sectors working together to make healthy eating and physical activity a priority.

Prevention strategies—for childhood obesity and other conditions—should be broad, multi-sector and target change at both the individual and population health levels.¹⁷ A “population health” approach strives to improve the health of populations by focusing on prevention and wellness. In this paper and the companion documents, “population” is defined as the entire population living in a geographic area, such as a neighborhood, city or county. “Population health-oriented” strategies include services beyond the traditional preventive services provided in a doctor's office (e.g., immunizations); they also include those services that are provided outside the clinic in the community and address other social determinants of health such as socioeconomic status, education, the physical environment and social support networks. In addition, they are often targeted at groups of individuals rather than at individual patients.

The focus on populations rather than individuals and need for integration of clinical and community prevention approaches that are needed to address chronic diseases is at the root of the challenge for Medicaid. Medicaid funding is generally limited to coverage of health care services provided to Medicaid-enrolled individuals by providers enrolled in Medicaid.¹⁸ Many community-based prevention strategies do not meet these criteria as they target a broad population or address environmental or other non-medical factors.

We believe, however, that community-based prevention efforts can decrease the incidence of preventable diseases at the population level. Previous work by Nemours presents evidence and science that supports this conclusion.¹⁹ Services can be provided in a non-traditional setting such as a home, school or community program. Non-traditional providers, such as community health workers or lactation consultants, can provide certain preventive services. Preventive interventions that look upstream to address the root causes of disease can be especially effective. Research over the last decades has shown that effective economic, environmental, transportation, agricultural, social, political and other sector interventions play a significant role in creating the conditions that prevent risk factors from emerging.²⁰

The Affordable Care Act (ACA) has a number of provisions aimed at supporting population health interventions that improve the health of whole communities. Many of these ACA provisions can complement and support the work of Medicaid agencies engaged in population health. The Prevention and Public Health Fund and the National Prevention Strategy support disease-reducing efforts outside the traditional health care system. They encourage

engaging with other sectors outside the health system (e.g., business, urban planning, transportation and agriculture) to partner in policy changes that affect social and environmental factors and, thereby, affect chronic disease prevalence.²¹ The Community Transformation Grants and the CMS Innovation Center offer additional grant programs funded through the ACA that promote population health.

MANAGED CARE DELIVERY SYSTEM: INCENTIVES AND IMPLICATIONS FOR POPULATION HEALTH

For the purposes of this project, we are distinguishing between two major types of delivery systems—fee-for-service (FFS) and managed care—even though many additional types have evolved in recent years. The type of delivery system used by a state for its Medicaid population has important implications for population health.

In a FFS delivery system, the state is the key decision-maker about the settings where services are provided, the type of providers who can deliver services and the range of services offered. Providers in FFS are rewarded for quantity of services regardless of health outcome or whether or not root causes are addressed. Primary Care Case Management (PCCM) is another type of delivery system in which providers are paid a small case management fee in addition to regular FFS payments for each service provided. This paper groups FFS and PCCM into one category—FFS—since the underlying payment model and many of the issues are the same for both delivery systems.

In a managed care delivery system using capitation, however, the leadership of the managed care organization (MCO) makes these decisions though the state still has a role. The MCO can choose to deliver preventive services through non-licensed but otherwise qualified providers in many different settings and can opt to cover extra preventive services beyond what is required by FFS Medicaid. If these “value added” services (e.g., non-medical, social support services) are activities that improve health care quality under 45 CFR Section 158.150, their costs may be counted as medical rather than administrative, and therefore be incorporated in the MCO’s medical loss ratio.²²

This rule specifically calls out provision of “health improvements to the population beyond those enrolled in coverage.” MCOs also can substitute services or settings “in lieu of” services or settings that are covered in the State Plan. Under 45 CFR Section 438.3, the alternative services must be deemed by the state to be medically appropriate and cost-effective substitutes, included in the MCO contracts and must be voluntary for members. “In lieu of” services are counted as medical costs in MCO capitation rates. These critical decisions—the setting in which a service is delivered, the type of provider who delivers the service and the type of “value added” service that can be offered—are made by the MCO rather than the state Medicaid agency.

In this project, we were looking for examples where Medicaid was actually paying for the strategies as opposed to typical MCO marketing and communications efforts, for example, marketing campaigns or health fairs and screenings. Though we found examples where large health plans financed pilots, Medicaid did not actually finance the initiatives.

As states adopt payment models that reward outcomes over volume, these types of systems will facilitate the ability of payers to invest in non-medical interventions that improve health. The presumption is that focusing on outcomes over volume will create financial incentives to promote prevention and reduce more costly types of care such as readmissions and emergency room visits.

Additional background on Medicaid delivery systems and the number of states that use them are provided in Appendix C.

PROMISING STATE PREVENTION STRATEGIES

Nemours developed a “Roadmap for Medicaid Prevention Pathways” (Roadmap) that provides options for states that are considering using Medicaid to fund childhood obesity and other prevention activities. The Roadmap includes 40 examples from 23 states. Slightly fewer than half of the examples are specific to childhood obesity prevention. The other examples describe initiatives that are broader in scope including: health system navigation and linkage to social services; housing stability and accessibility; asthma management; tobacco cessation and lead abatement. Furthermore, there were far fewer examples of Medicaid-funded activities at the population level than individual level. This White Paper provides a single example of a state activity for each of the five categories in the Roadmap. (For more detail and examples, the full Roadmap can be found at <http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>.)

The Roadmap categorizes states’ prevention activities along a continuum of five main categories. This categorization is based on the basic tenet that Medicaid provides medical assistance to eligible individuals, not to populations defined geographically or otherwise. The continuum moves from individual level (IL) engagement, with services targeting individual Medicaid enrollees, to population level (PL) engagement, with services targeting an entire geographic area including non-Medicaid enrollees. The five categories are not mutually exclusive; a single state could implement multiple interventions along the continuum.

The first category, Individual Level 1 (IL-1), includes standard clinical prevention interventions where a physician or other licensed practitioner (OLP) provides an individual Medicaid enrollee a preventive service (e.g., nutritional counseling) in a medical setting. An example is Oklahoma’s Medicaid program that reimburses for health and behavior services delivered by mental health providers for a primarily weight-related diagnosis.

The second category, Individual Level 2 (IL-2), takes an added step beyond IL-1. In this case, a physician or OLP provides an individual Medicaid enrollee a preventive service in a medical setting and refers the enrollee to a community-based organization (CBO) for additional non-medical, social support (and upstream) services. At a minimum, the provider makes the referral to the CBO. Ideally, case management and care coordination also

are provided across clinical and community services and supports. Missouri’s PHIT (Promoting Health in Teens and Kids) Kids is an example. This multi-disciplinary weight management program is based in a hospital and refers patients to CBOs such as Big Brothers, Big Sisters (for children) or a parenting program (for parents). They follow up with the family at subsequent clinic visits to find out if they obtained the support services. The program focuses on families’ survival needs (housing, transportation, safety) first before weight loss can become a goal.

In the third category, Individual Level 3 (IL-3), an individual Medicaid enrollee receives a preventive service in a non-traditional way. The three subcategories include: (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, early care and education setting, community program); (b) a non-traditional provider (e.g., a community health worker (CHW)) provides an individual Medicaid enrollee a preventive service; or (c) an individual Medicaid enrollee receives an upstream, non-medical or supportive service in the community.

An MCO example of IL-3 is Hennepin Health in Minnesota. CHWs (non-traditional providers) provide health education and coaching at sites such as the county’s mental health center and correctional facility (non-traditional setting). Hennepin Health funds this intervention out of Accountable Care Organization reinvestment funds and start-up grants. As a FFS example, Rhode Island Medicaid pays for window replacement (non-medical service) for lead-poisoned children. Rhode Island uses Section 1115 waiver authority to cover this service through Medicaid.

The fourth category, Population Level 1 (PL-1), is a population health intervention provided to an entire community or geographic area rather than to 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. As an MCO example, Massachusetts uses CHIP funds to cover nine public health programs related to improving the health of all children (e.g., youth violence prevention, young parent support). Under CHIP law, states can obtain a state plan amendment to implement “health services initiatives” if they are within the state’s 10 percent administrative cap.

The final category is Population Level 2 (PL-2). This category includes interventions in which Medicaid and another state agency or department (e.g., public health) share specific goals for a population in a geographic region and collaborate as partners. For example, Oregon is aligning its health care and early learning systems as a way to improve health outcomes for children. The state aims to improve kindergarten

readiness by coordinating services across Coordinated Care Organizations (CCOs) and Early Learning Hubs. Additionally, one CCO, Health Share, meets monthly with three Early Learning Hubs in their region to discuss joint initiatives and align work. With Race-To-The-Top funding, the Oregon Health Authority is blending funding to implement approved screening tools to assist with developmental screening training.

MEDICAID AUTHORITY FOR PREVENTION

Medicaid may be a source of optional sustainable funding for prevention strategies that address chronic diseases including childhood obesity. This section provides a chart illustrating a variety of pathways to Medicaid reimbursement for preventive services.

INDIVIDUAL 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>
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)(11))
Medicaid Health Homes (Section 1945)
<i>A physician or OLP provides an individual Medicaid enrollee a covered preventive service in non-traditional settings such as schools. (IL-3A)</i>
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"> • Section 1932(a) State Plan Authority • Section 1915(a) Waiver Authority • Section 1915(b) Waiver Authority • Section 1115 Waiver Authority
<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
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)
Medicaid and another state agency or department (e.g., public health) share goals and collaborate as partners on a population health/prevention intervention. The funding of the initiative is often a blend of financing mechanisms including Medicaid. (PL-2)
Health Services Initiatives under CHIP (Section 2105(a)(1)(D)(ii))
Section 1115 Waiver Authority (Research and Demonstration Waivers)
Delivery System Reform Incentive Payment (DSRIP)
CMS Innovation Center
<ul style="list-style-type: none"> • Accountable Health Communities • Health Care Innovation Awards Round 2 • Health Care Innovation Awards Round 1 • State Innovation Models (SIM)

Appendix D includes a description of each of the Medicaid reimbursement pathways included in the chart above. While the list is not comprehensive, it gives a broad sense of the options available to states.

SPECIAL CONSIDERATIONS RELATING TO CHILDHOOD OBESITY PREVENTION

At the expert convening in August 2016, a number of considerations were raised about the challenges involved with preventing childhood obesity. First, it is important to recognize that obesity prevention takes time because it requires changing behaviors.

Second, the health complications of childhood obesity often do not present for many years. As a result, much of the return on investment will likely occur over the course of many years, especially for children. Investments in obesity prevention made in the short-term are likely to accrue to someone else—other stakeholders or another sector—at a later day. This becomes a barrier to states and MCOs focusing on obesity prevention.

Third, experts in the field do not know the specific suite of interventions that work best in preventing childhood

obesity, although there is a wealth of literature on promising science-informed strategies that are important components of any work in obesity prevention.²³ Some meeting participants argued that there is no standard of care or clinical protocol for preventing childhood obesity, and that this barrier makes it difficult for states and MCOs to act. Given the state of evidence, the evaluations may have simply not been completed.

Finally, sustainability from year to year is a problem for prevention strategies. If money is saved in the first year, it will not be available to the MCO in the second year due to the rate-setting process where rates are based on overall costs. The fear is if the medical costs are reduced due to prevention strategies, then the rates will eventually decrease.

HYPOTHETICAL EXAMPLES OF POSSIBLE INNOVATIVE PATHWAYS TO PREVENTION

At the convening in August 2016, Nemours gathered state and national experts to consider the options and help to imagine different pathways for states interested in pursuing prevention and population health strategies. (See Appendix B for a list of meeting participants.) The outcome was a set of hypothetical Medicaid/CHIP examples of possible prevention pathways for states to consider, which we believe are permissible under current law. All of the hypothetical case scenarios were related to childhood obesity since many of the state examples that had been identified earlier were prevention-related but not specific to childhood obesity. The participants considered each scenario from the perspective of a state in a managed care environment and then in a FFS environment. The experts identified pathways needed to undertake childhood obesity prevention initiatives using Medicaid and CHIP authority.

A key learning from these discussions is that it is much easier to conceive of pathways to prevention in a managed care environment compared to a FFS system. A financial incentive system that rewards quality and improved outcomes and puts providers at risk for health outcomes (e.g., an MCO) is more likely to address population health-based improvements because the MCO benefits by reducing expensive care, such as emergency department visits. Addressing social determinants of health, like asthma triggers in the community, saves money for the MCO. In contrast, providers in FFS are rewarded for quantity of services regardless of health outcome or whether or not root causes were addressed.

1st Possible Pathway to Prevention (IL-3)

In the first scenario (IL-3 on the Nemours' continuum), Peter is a 13-year-old Medicaid enrollee who requires preventive services for childhood obesity. He is at risk for obesity and has some indications of asthma. Peter's parents are obese and both smoke and drink alcohol; his mother is pregnant.

Approaching the scenario from a managed care perspective, the group focused on both Peter and his family. The MCO could offer a "value added" service (through Medicaid administrative dollars) of providing a community health worker (CHW) to assess Peter's home environment and work with his parents. His family could benefit from nutritional counseling and the CHW would refer them to various resources such as Weight Watchers and local gyms, all covered by Medicaid. Peter's physician would educate the family about weight-related chronic conditions such as asthma and diabetes. The CHW would continue to work with the family to ensure any recommended changes were implemented related to his needs, including providing allergen covers for Peter's bed or purchasing an air purifier for the home.

The participants reported that the FFS environment made finding solutions more challenging because MCOs have flexibility to add additional services and use non-traditional providers. If the state were to obtain an approved Health Homes state plan amendment (SPA), however, Medicaid would cover

preventive services for Peter’s multiple chronic conditions (obesity and asthma) in the home setting. Peter’s provider team could then coordinate care for his chronic conditions with a focus on the behavioral health care and social supports needed.

2nd Possible Pathway to Prevention (PL-1)

This scenario featured a distressed neighborhood in a food desert with safety issues and aging housing stock. Families in the neighborhood experience high rates of crime and have low literacy and employment rates. The people in the community use urgent care and emergency care for conditions such as diabetes, hypertension and asthma.

The meeting participants chose to focus on a cohort of children aged 6 to 11 years old. One option discussed by the group to address these complex issues at the population level in a FFS environment was for the state to obtain a Health Services Initiative SPA under CHIP. Using this funding, the state could support public health programs that support children including programs aimed at employment, youth violence, nutrition, physical health, substance abuse and mental health, literacy and prenatal support. Ideally, these programs would be provided in a neighborhood community center that is easily accessible. An MCO could support these types of programs at a community center using its administrative dollars.

The group advocated for a convening entity that brings the key community stakeholders together to jointly address an issue. When the community sets the priorities, the participants at the August convening argued, the foundation is established for a trusting working relationship. Medicaid could foster integration across programs. For example, state agencies would have to collaborate to bring housing and education together. Medicaid would need to contract with the Women, Infants and Children Program to provide nutrition education programs that benefit the whole population.

3rd Possible Pathway to Prevention (PL-2)

In this scenario, the state ranks in the top ten states where childhood obesity and poverty rates are highest. The new governor announced his top priorities include: improving childhood obesity, access to health care and school readiness. The state legislature mandated a “health in all policies” approach across state and county governments. Since the hypothetical

scenario involved a population-level approach, the state Medicaid agency and another statewide agency (such as public health) would need to collaborate to achieve these goals. Toward this end, Medicaid and public health would establish a workgroup at the State Secretary level to develop a systematic approach. The workgroup would determine gaps and how the respective departments could address the gaps.

Since the mandate for the project came from the governor, the breakout group operated under the assumption that all agencies were cooperative. Many conversations would have to take place at the higher levels of bureaucracy as well as across all the agencies to reach agreement on policies. In addition to collaborating with state agencies, the Medicaid office would need to work with local officials and community members to jointly set goals, identify benchmarks and establish measurements.

Depending on the delivery system, a convening entity would need to pull the infrastructure together and unite the multiple stakeholders in order to adopt population level changes. The convening entity is likely to vary across states; it also depends on how the target population is defined within a state. In a managed care environment, this entity could possibly be an Accountable Care Organization (ACO) or a regional care organization.

Implementing a population-level prevention intervention would require practice transformation—changing the way providers manage patients, record data and share resources and results. Significant work would have to be done to explain to the provider community about why a practice transformation is needed. Solutions would have to be applied across all payers. Some features could be achieved through incentives; others would need to be mandated. It would be important to connect Medicaid-billable hours to the broad public health agenda. Data synchronization across all systems would be essential so information could be available to the provider community as a whole, not just to Medicaid.

The participants in the breakout group argued that the FFS environment does not facilitate going upstream to address housing, safety or the outdoor environment. The challenges they cited relate to a state’s processes for making changes, including time required for federal approvals and the time and energy needed to integrate different sectors and establish a collaborative relationship. It also does not recognize the value of obesity screening, education and prevention because the return on investment is not immediate.

FACTORS THAT AFFECT THE SUCCESS OF PREVENTION STRATEGIES

Through its work on the various facets of this project, Nemours identified multiple factors that affect the successful implementation of prevention strategies financed through Medicaid. “Accelerators” are specific state actions that drive innovative prevention strategies. “Barriers” impede the development of prevention and population health initiatives. “Conditions of success” facilitate, but are not a requirement, for a state transforming its health care delivery system to include a population health component. The following section includes a discussion of these factors that contribute to the success of an initiative.

Accelerators

Champion. A champion within state government who cares deeply about implementing a prevention strategy can accelerate the process. Having a vision for what needs to be done and inspiring others to act are two ways a champion can ensure continued progress on prevention and help overcome barriers. It takes creative leadership and sustained effort to navigate the different programmatic aspects of Medicaid to fully support prevention initiatives. Likewise, a community champion can be an effective accelerator in engaging the private and public sectors to work toward a common goal of preventing disease or improving health.

Integrator. An integrator is a person/entity that works intentionally and systematically across sectors (e.g., health, public health, community-based organizations (CBOs)) to achieve improvements in health and wellbeing. Leveraging Medicaid to fund population health will require leaders who can forge partnerships with public health and other sectors such as education and housing. It is essential to have an understanding of the various programmatic requirements, data challenges and big picture goals. Designating and funding a state employee, for example, who has the responsibility and accountability for ensuring collaboration between Medicaid and public health can help ensure concrete action on population health and integrator functions occur at the state level.

Convening entity. A state agency—or another entity such as a foundation—can play a convening role (one of the integrator functions) to achieve broad support for goals. As a convener, the state can build trust and leverage that trust to develop shared priorities and goals. Building community buy-in and support will allow for all partners to contribute resources or

knowledge. If the community is part of the process and working to achieve the same goals, it will facilitate and accelerate progress. Having the infrastructure for multi-sector collaboration will go a long way. It’s better if everyone has “skin in the game” including the state, MCOs, providers and CBOs.

Alignment of Medicaid and public health goals.

In many communities, the population of Medicaid and CHIP-covered children has significant overlap with the population targeted for public health initiatives. Working together to tackle the social and environmental determinants of health makes sense for both Medicaid and public health. In addition, it is important to align Medicaid with the provider community, especially the child health-serving community, in terms of strategy and focus.

Infrastructure that encourages collaboration across agencies.

A state infrastructure that facilitates collaboration can contribute to successful prevention work. In the Oregon Health Authority, the leadership team, which is comprised of division heads, develops a set of policy priorities across the agency and these priorities trickle down to all levels. This type of established infrastructure can provide a bridge across state agencies by bringing leaders together through collaborative policy development and encourage partnership.

Robust data systems. Access to relevant and timely health data is critical to population health. Providers need to understand the health status of the population in their geographic region. State agencies need to understand clinical data trends to guide decisions about whether upstream prevention strategies should be implemented. Connectivity of data across state agencies and sharing of appropriate data with social service organizations can facilitate working together on shared goals. Data use agreements also can aid in the sharing of information across sectors.

Incentivize MCOs. States can use their contracts with MCOs to promote non-traditional providers or other preventive services. States, through their contracts with MCOs, can require that they make community health workers (CHWs) available to enrollees or establish a minimum list of services that CHWs must provide. Similarly, states also can offer additional services not covered as traditional state plan benefits, such as community-based asthma interventions.²⁴

Learning collaboratives. A forum for learning serves as a means for exchanging information about successes

and failures and, in turn, can help spread and scale programs. In Oregon, for example, the learning collaboratives helped establish formal commitments such as data sharing agreements between Coordinated Care Organizations (CCOs) and local public health agencies. These agreements and other resources can be shared within the state and across other states.

Practice transformation. Educating providers about obesity prevention or other types of disease prevention can serve as an effective means of reaching broad populations. In Oklahoma, the Medicaid agency used tobacco settlement funds as state share of Medicaid expenditures to educate Medicaid providers about effective tobacco cessation strategies. While these providers serve Medicaid enrollees, they also serve non-Medicaid enrollees so the reach extends beyond the Medicaid population.

Barriers

A number of barriers to implementing prevention initiatives were identified through Nemours work with states and MCOs on this project. The following are the key barriers and some solutions to address them.

Difficult to establish a return on investment (ROI) for obesity and other types of prevention. One of the most significant roadblocks to prevention is demonstrating an ROI for childhood obesity prevention. In order for states to invest in community-based population health initiatives, it helps to show savings. A short time frame for ROI may result in missed opportunities to benefit from prevention and likely will not indicate effectiveness of various measures. The evaluation of savings that result from population health initiatives may require a longer time frame for study and a broader study population than does the evaluation of direct medical services on a Medicaid enrollee. Longer time frames for ROI studies would help policymakers better understand whether and how much savings can be realized from prevention initiatives. Obesity prevention strategies take time as they are attempting to change behavior. Moreover, the data needed to project long-term impacts and to construct a business case for population health measures are not well developed.

Medicaid's historical focus on clinical care, not population-level services. Traditionally, Medicaid treats individuals in the clinical care setting. A fee-for-service (FFS) environment does not facilitate addressing upstream conditions like housing or the outdoor environment. Moreover, the boundaries are often blurred about whose responsibility it is to finance population-

based interventions. Medicaid agencies may not want to tackle population-level initiatives for fear of the budgetary consequences. States should learn more about the range of Medicaid authorities available and see how others have successfully financed population health initiatives through Medicaid or CHIP. (See the Roadmap at <http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>).

Concern about medical loss ratio (MLR). MCOs must submit data showing the proportion of premium dollars spent on medical care such as clinical services and quality improvement versus administrative costs. They must spend at least 80 to 85 percent on medical care. Preventive services offered by an MCO that are not required by Medicaid are often considered an administrative cost. Thus, it negatively affects the MLR if they spend too much on preventive services. As noted earlier, the Medicaid managed care regulation stipulates that activities that improve health care quality, as defined under 45 CFR Section 158.150, can be included as a medical cost. To the extent allowable, population health activities should be classified as medical services rather than administrative services.

Difficult to know where to begin. Shifting the Medicaid paradigm from a clinical focus to a population-level focus can be challenging. States can start by setting goals and then determining the best pathway to achieve the goals. Nemours developed a planning document to help states answer the key questions needed to get started on population health. This document helps states identify and prioritize goals for prevention and then determine the best Medicaid pathway for implementation. (See State Planning Document in Appendix E.)

Different sets of priorities. Collaborating across agencies or with community partners may require putting aside one's own priorities. If clear goals are not set, each agency/partner may feel like they are being asked to forego their own goals. It can be difficult to let go of and work on a different set of priorities. Population health and medical models are still two distinct approaches. Medicaid and public health often have different programmatic experiences and perspectives on policy, metrics, budgeting and goals. Bridging these two worlds may take time and a commitment to working together. Developing shared goals and priorities may encourage these partnerships.

No established working relationship. Some agencies have not worked together in the past as they have very different missions (e.g., Medicaid and housing). Moreover, some individuals get set in their routines and

it can be difficult to change long-standing practices. One way to overcome these barriers is to create a work group to identify overlapping goals and areas for collaboration. Meeting regularly to discuss issues while clearly defining goals and responsibilities is critical.

Credentialing of non-traditional providers. As noted earlier, the 2014 Medicaid preventive services rule change allows Medicaid to reimburse for preventive services provided by a health professional when recommended by a physician or OLP. If states choose to pursue a state plan amendment, they will need to determine the education, training and credentialing qualifications for these providers who are not physicians or OLPs. States will need to find a balance between establishing a reliable credentialing process and developing a supply of non-traditional providers who are closely rooted to the communities they serve.

Enrollee churning. The average Medicaid beneficiary maintains enrollment in the program for approximately 10 months. With this amount of “churning,” states and Medicaid MCOs may not want to invest in making their enrollees healthier since they will not reap the benefits of this investment if the enrollee has moved to a different plan. To address the churning, states can conduct research into when and why enrollees are leaving Medicaid and whether the enrollee leaves temporarily only to re-enroll at a later date.

Clinical staff uninformed about community linkages. Some of the experts at our August 2016 meeting noted that most physicians are not taught about the importance of working with the community in medical school. Furthermore, they may be unaware about prevention services, activities and programs available in the community for their patients. Providers should be educated about the tools at their disposal.

Conditions of Success

Nemours identified several broad features that are critical to have in place as a state begins transforming its health care delivery system to include a population health focus. These “conditions of success” enable a state to successfully undertake significant reforms.

High-level leadership. A high-ranking state official (e.g., Governor, Secretary of Health) can make prevention a priority across the state or department. Former Oregon Governor, John Kitzhaber, championed the state’s health care delivery system transformation. His clear articulation of goals helped state agencies align their efforts and collaborate to accomplish these goals. One of his goals,

for example, was to transform Oregon’s Medicaid delivery system to focus on prevention, integration and coordination of health care across the continuum of care with the goal of improving outcomes and bending the cost curve. Oregon’s current governor has continued to champion the state’s health system transformation.

Similarly, a supportive Board of Directors or Chief Executive Officer can prioritize prevention in an MCO. The Inland Empire Health Plan is a Medicaid MCO whose top leadership recognized the importance of social determinants of health and decided to address the needs of the entire family, not just the plan member. They also invested in a community resource center that serves plan members and non-members alike. The center hosts health and fitness classes and courses on nutrition, asthma, gardening, CPR and more.

State planning process. States should begin the transformation process by focusing on their unique goals first. States should undertake a strategic process and answer key questions. Once the goals of the initiative are determined, it will be easier to determine the best pathway through Medicaid. Toward that end, Nemours developed a state planning document that includes a questionnaire to help states identify goals and determine the best pathway to prevention. Some of the key categories of questions that need to be answered include goals and objectives, delivery system flexibility, baseline authorities, nature of the intervention, sphere of influence, funding availability and other enablers. This document can be found in Appendix E.

Collaboration across state and community partners. The sphere of influence is very broad when a state is attempting to address population health. Medicaid staff will have control over some aspects of population health initiatives, but not all. Medicaid officials should become comfortable with this approach of working with others in areas where they do not maintain control.

The Medicaid agency will need to collaborate across state agencies by aligning goals. Public health, early care and education and housing are a few of the partnerships that need to be made at the state level. At the programmatic level, this entails Medicaid, public health and social service agencies working together to establish mutually agreed upon population health goals and to jointly accomplish health promotion/prevention activities.

In addition, engaging the CBOs to develop a set of shared goals can make the effort more productive. There are many issues that need to be addressed outside of what Medicaid can control, so joining forces with community partners can be critical.

Recognition that State Medicaid agencies are one piece of the population health puzzle. As noted earlier, population health efforts will require multiple sectors working together. Federal Medicaid reimbursement policy has drawn a line around the types of services for which it will pay. Medicaid has an important role but it does not need to assume financial responsibility for all aspects of a population health initiative.

In addition to paying for a defined set of services, Medicaid can play a convening role of bringing the

partners together to build trust and leverage that trust to develop priorities and goals for all involved in population health. Medicaid also can play a role in connecting enrollees to social services outside of health care. Medicaid, for example, has recently begun to play a role in connecting its beneficiaries to resources and helping to supplement the social safety net in the areas of housing, employment and peer and community supports.²⁵ Thus, Medicaid can sit side-by-side with other governmental entities, providers, payers and community partners in population health efforts.

FEDERAL RECOMMENDATIONS

The previous sections have discussed specific factors at the state level that affect the success of prevention strategies. In addition, there are several steps that the federal government should take to facilitate innovative state prevention strategies.

First, we believe that the federal government should allow a longer time period to demonstrate a return on investment for childhood obesity prevention. As noted in a recent report, one of the major impediments to pursuing obesity prevention policies at the federal level lies in how their budgetary impacts are assessed.²⁶ The Congressional Budget Office generally uses a 10-year budget window. This report found, however, that preventive health measures have significant long-term impacts that will not be reflected in the 10-year time period, especially if an intervention is geared toward children or young adults. The majority of federal savings from obesity prevention is achieved through children becoming normal-weight adults and eventually normal-weight retirees.

We understand, however, that states may not have longer time periods to demonstrate savings. One option for demonstrating return on investment (ROI) over a shorter time period is to focus obesity prevention on the entire family (i.e., a “two generation” approach). Parents significantly affect their children’s nutritional habits and may be overweight or obese themselves. Parents may experience more immediate benefits affecting ROI calculations. The federal government should allow states to test strategies that treat the family as the unit of care to determine if this “two generation” approach affects the ROI.

Another option we recommend exploring, if longer time frames for ROI studies are not feasible, is for the federal government to allow states to undertake

a “portfolio” approach. By combining efforts to prevent childhood obesity with other chronic diseases (a “portfolio” approach), states may be able to show an ROI over a shorter time period. Many of the interventions (e.g., physical activity and healthy eating) for preventing and managing these chronic diseases overlap, so it makes sense to combine efforts.

Second, we believe the CMS Innovation Center has accelerated health system transformation, and the federal government should continue to build on this success by providing additional grants and technical assistance to states. We believe the federal government should continue to award funding to test innovative payment and service delivery models and that they should provide technical assistance to states based on the learnings from these grant awards. The grants provided to date have served as a catalyst for many states to explore and implement transformation of their health care delivery and payment systems. Several of the CMS Innovation Center grants have been or can be used to support a population health prevention model including the State Innovation Model, Health Care Innovation Awards (Round 1 and Round 2) and the new Accountable Health Communities.

Finally, we urge CMS to design templates for states to use for SPAs relating to preventive health measures. Streamlining the process of applying for SPAs for states will encourage more states to adopt measures aimed at preventing obesity and other chronic health conditions. Templates would greatly improve the likelihood of spreading and scaling Medicaid population health interventions across the states. In addition, CMS should commit to providing technical assistance and training for using these templates.

CONCLUSION

The “Pathways through Medicaid to Prevention: Realizing the Promise of Population Health” project demonstrates that Medicaid currently plays and should continue to play a critical role in sustaining innovative clinic to community prevention linkages and population health interventions. States start at various places along a continuum in terms of the types of prevention services that they currently offer to their Medicaid enrollees and the strategies for the broader population. Regardless of where they are on this continuum, states should consider the options that exist in Medicaid and CHIP to sustain or build on their current efforts.

This paper highlights examples of preventive strategies offered at various stages of progression along the continuum. Our Roadmap (which can be found at <http://movinghealthcareupstream.org/innovations/pathways-through-medicaid-to-prevention>) shows a fuller range of state examples. The Roadmap notes the Medicaid authority used and provides a link to the CMS approval documents for those states that want additional information.

Accelerators, barriers and conditions of success are noted. These factors contribute to the successful implementation of prevention and population health

strategies financed by Medicaid. For states wishing to adopt a population health focus in the context of broad health care delivery system transformation, it is helpful to already have in place some of the accelerators and conditions for success outlined in this paper.

It is worth reiterating that Nemours expected to find many more examples of Medicaid-funded clinic to community prevention linkages to address childhood obesity. This lack of childhood obesity prevention examples funded by Medicaid led Nemours to broaden the scope of the project to include prevention strategies generally. The hypothetical obesity prevention case scenarios and the resulting pathways are included to guide states that may be considering action in this programmatic area.

Our work suggests that states should consider Medicaid as a piece of a broader coalition engaged in implementing population health initiatives. Medicaid should sit beside other payers and stakeholders who also have a role in funding these initiatives. In addition to its financing role of a critical safety net program, Medicaid can act as a convener of a broad group of governmental agencies and community partners and serve as a connector between health and social service agencies and organizations.

WHITE PAPER APPENDICES

- A. Ad Hoc Work Group
- B. August 2016 Meeting Participants
- C. Managed Care Delivery System: Incentives and Implications for Population Health
- D. Medicaid Authorities for Prevention—Reference Document
- E. State Planning Document

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