MANAGED MEDICAID
Moving Upstream and Outside for Long Term Savings and Better Health
INTRODUCTION
FIRST THINGS FIRST

- Background
- Our Population
- Our Journey
  - High Utilizers
  - Incentive Metrics
- Current Strategies
Background
Health Share of Oregon

Non-profit, tax exempt Member organization
Oregon’s Medicaid plan operates under an 1115 waiver with CMS called the Oregon Health Plan
Full risk contract ($1.2 billion) with State of Oregon for Medicaid benefits
Benefits include physical, mental and dental health, addictions and transportation
Cost increases are capped at 3.4% annually
Premised on flexible benefits/global funding
Business Model

Founded in 2012 by local delivery systems, county governments and managed care plan
Subcapitated agreements with partners for various benefits and service areas
Centralize/Standardize/Align
Collective Impact Model
Our Population
Both Traditional and Nontraditional

- Half of the babies born in Oregon are covered by Medicaid
- Every 32 hours a future kindergarten class of 20 is born
- Social determinants of health are stacked against our members – nutrition, housing, day care, schools, socioeconomic environment, employment, public safety, violence, etc.
- Lifetime of traumatic events takes a tremendous toll on health status and likelihood of successful life
- Generational poverty versus situational poverty
ACA Enrollment – 40% Increase

% Increase by Age

- 0-5: 6%
- 6-12: 11%
- 13-18: 18%
- 19-21: 118%
- 22-30: 152%
- 31-50: 127%
- 51-64: 115%
- 65+: 7%
Demographics

20% of our members select language other than English

50% Caucasian

8% African American and African

17% Hispanic/Latino

7% Asian & Pacific Islander

18% Unknown

Less than 1% AI/AN
Our Journey
Start with the High Utilizers!

Concentration of High Cost Members

- The top 5% of HSO Members make up 56.4% of total costs.
- The bottom 50% of HSO Members make up 3.2% of total costs.
Some Successes

Intensive Case Management
High Touch/Low “n”
Select Co-location
Workforce is Different
What High Needs/High Cost Patients Have Taught Us

The question is not
What’s wrong with them?

The question is
What has happened to them?

Almost all of the problems these individuals face start upstream on a socially constructed pathway to super utilization
Life Stories with Chain Reactions of Adversity

**Miranda**

- **Birth**: Tumultuous, violent relationship between parents, unstable housing
- **5 yo**: Parents split, dad got “left behind”
- **11 yo**: Lived with multiple caretakers in various locations
- **15 yo**: First pregnancy/birth, stepbrother is father
- **18 yo**: 3 children, still living in abusive household
- **21 yo**: Moves back in with mom, daily sexual abuse from stepfather
- **27 yo**: Drops out of school
- **47 yo**: Begins heavy drug use and selling
- **3 more children born**: Goes to prison on drug charges
- **47 yo**: Suicide attempt
- **47 yo**: Heavy alcohol use, drug relapses, cancer, car accidents

**Age 47**
- 6 children age 15-32
- No GED/diploma, no employment
- In recovery from severe substance use
- Chronic pain, cancer, multiple surgeries, no teeth or dentures
- Multiple psychiatric medications
Meanwhile…Pursuing P4P Funds

Federally mandated quality metrics (33) of which 17 have financial incentives attached
Must either meet a benchmark or improve performance year over year
Teach to the Test/Check the Box
Eventually developed more comprehensive programs to succeed in the Pay for Performance
Developmental Screening

Approximately 34,000 children 0-5

Approximately 20,000 children 0-3

Target 45%/Benchmark 50%

Then What?
Children 0 - 3

Not screened

Screened (PCP, Child Care, Home Visiting...)

Screened, at risk

Screened, normal

Exposed patients

Screened, at risk

Exposed patients

Contacted by EI/ECSE and evaluated

Qualify

Referral to early intervention/early childhood special education

Community Based Organizations; Mental Health; Parenting Support; Relief Nurseries, Library programs; Other Community Resources

Specialty therapy: speech, OT and/or PT

OHSU

Private practice

Legacy

Albertina Kerr

Kaiser

Providence

Developmental & Behavioral Pediatrics

No symptoms or concerns

Long term services and transition to IEP

Short term services to catch up

Do not qualify

Family contacted but don't want services or are unable to participate

Family cannot be contacted

50%

63%

14%

16%

20%
“Foster Kids”

Screening for Children in DHS Custody (PH/MH/DH) within 60 Days

Each month 300 children are eligible for metric
Each month 3,500 children are in DHS Custody
Target 36%/Benchmark 90%
Effect of DHS Custody – 0-5 yrs

Chronic Condition Prevalence: 0-5 year olds

- Asthma: Non-foster child 5.2%, Current foster child 6.2%, Former foster child 11.2%
- Obesity: Non-foster child 3.1%, Current foster child 2.2%
- Autism: Non-foster child 0.6%, Current foster child 0.5%, Former foster child 2.4%
- PTSD: Non-foster child 0.2%, Current foster child 7.1%, Former foster child 8.3%
Effect of DHS Custody – 6-12 yrs

Chronic Condition Prevalence: 6-12 year olds

- **Obesity**: Non-foster child - 10.8%, Current foster child - 6.0%, Former foster child - 12.1%
- **Asthma**: Non-foster child - 8.9%, Current foster child - 6.9%, Former foster child - 11.1%
- **ADD**: Non-foster child - 5.6%, Current foster child - 20.2%, Former foster child - 19.2%
- **Autism**: Non-foster child - 1.7%, Current foster child - 2.1%, Former foster child - 4.9%
- **PTSD**: Non-foster child - 1.2%, Current foster child - 13.2%
- **Affective disorder**: Non-foster child - 0.7%, Current foster child - 3.00%, Former foster child - 3.60%
- **Depression**: Non-foster child - 0.3%, Current foster child - 1.2%, Former foster child - 1.6%
Effect of DHS Custody – 12-18 yrs

Chronic Condition Prevalence: 12-18 year olds

Obesity: 14.8% (Non-foster), 10.8% (Current), 13.5% (Former)
Asthma: 9.0% (Non-foster), 8.4% (Current), 15.5% (Former)
ADD: 6.7% (Non-foster), 15.2% (Current), 15.2% (Former)
Affective disorder: 26.0% (Non-foster), 25.9% (Current), 25.9% (Former)
Depression: 4.3% (Non-foster), 10.8% (Current), 10.8% (Former)
PTSD: 14.6% (Non-foster), 19.2% (Current), 19.2% (Former)
Autism: 1.6% (Non-foster), 2.4% (Current), 2.4% (Former)
Tobacco use: 0.9% (Non-foster), 0.9% (Current), 3.5% (Former)
PTSD: 0.1% (Non-foster), 0.1% (Current), 1.6% (Former)
Bipolar: 0.1% (Non-foster), 0.1% (Current), 2.0% (Former)
Chemical dependency: 0.1% (Non-foster), 0.1% (Current), 0.3% (Former)
Current Strategies
What are we trying to prevent?

Future generations of “high utilizers”
Cascading adverse life events that derail a healthy life
Chronic illness, substance use, mental illness, criminality, isolation, disability
What are we trying to prevent?

- Unintended Pregnancy
- Birth
- 3 yo
  - Poor Attachment
  - Parents not able / ready to “parent”
  - Kindergarten / School Failure
  - Risky Behaviors
  - Social Deprivation
- 5 yo
- 6-12 yo
- 12-21 yo
- 21 yo +
- Adult violence, SUD
- Abuse Neglect
- Behavioral & Skill Deficits
- Substance Use
  - Unhealthy Relationships
- Housing Insecurity
- Job Insecurity
- Unhealthy Relationships
- Housing Insecurity
- Job Insecurity
- Unintended pregnancy
Creating a healthy productive adult

Wanted Pregnancy

Birth

Healthy Mom / Child

3 yo

Strong Attachments

5 yo

Ready for kindergarten

6-12 yo

Positive Relationships

12-21 yo

Academic Success

21 yo +

Healthy Lifestyle

Healthy Lifestyle
Before entering school, the health care system is the social institution with the most contact with young children and their families.

Toxic stress is the early childhood roots of lifelong impairments in physical and mental health.

Students from low income families are six times less likely to graduate high school when they are not reading at grade level by the end of third grade.

High school dropouts are 63 times (!) more likely to be incarcerated than college graduates.

Not graduating high school correlates with poor health outcomes and shorter life.

The earlier the investment, the greater the return.
Build Capacity – Create Partnerships

Alternate workforce
Extend knowledge
Leverage technology
Make new friends
Translating to a prevention strategy

Identify key touch points in the care delivery system where we can provide meaningful support:

• Promote stable families with healthy early attachments, relationships are critical and form the foundation of brain development (Before 9 to 5)

• Ensure that at risk families get the mental health, substance use disorder treatment and social services they need to prevent adverse outcomes

• Focus on highest risk children

• Use the health care system’s frequent contacts with children to help them be ready for kindergarten by age 5
Early Life Health Strategy
Preventing Unintended Pregnancies

Poor women (<100% FPL) are more than 5 times as likely as higher income women (>200% FPL) to have an unintended pregnancies.

Unintended pregnancies are associated with worse birth outcomes and can set the stage for child abuse and neglect.

Loss of employment and educational opportunities are a leading reason why families on the edge fall into poverty.
Preventing Unintended Pregnancies

Tactics:

• Improve rate of effective contraception use among women at risk of unintended pregnancies with particular attention to underserved populations and communities with poor access
• Screen women for pregnancy intentions in primary care

Metrics:

• Effective contraception use among women at risk of unintended pregnancy (P4P)
Preventing Adverse Childhood Events

There is a strong link between Adverse Childhood Events, such as child abuse and neglect and household dysfunction, to lifelong health and mortality.

The most important factor in child abuse and neglect is parental substance abuse.

ACEs are directly related to the health and well-being of the child’s caregivers as well as community level problems.

Having at least one emotionally stable caregiver who can build a strong attachment to the child is critical for the child’s wellbeing, success in school and lifelong health.
Preventing Adverse Childhood Events

Tactics:

• Screen and refer pregnant women for behavioral health and family resource needs
• Pilot and evaluate new models that integrate behavioral health and substance use treatment into maternity care

Metrics:

• Early entry into prenatal care (P4P)
• Pregnancy risk assessment completed
• Risk stratification of maternity population
• Reduction of foster care placement for children under 1 year of age
Kindergarten Readiness

Kindergarten is usually a child’s first foray into society and it is the first stepping stone for lifelong success and health.

The strongest predictor of lifelong career achievement and economic stability is high school graduation.

The strongest predictor of high school graduation is third grade reading level.

The strongest predictor of third grade reading level is being ready for kindergarten.

Social and emotional skills are as important as knowing numbers and letters.

Social and emotional skills are derived from parental attachment, boundary-setting and emotional stability.
Kindergarten Readiness

Tactics:

• Identify populations, with a focus on communities of color, with low rates of developmental screening and implement initiatives to improve screening rates
• Improve primary care capacity to address developmental delays and disabilities
• Ensure children receive all preventive health care services needed for kindergarten readiness
• Support robust Reach Out and Read programs in clinics serving high proportions of our pediatric members
Kindergarten Readiness

Metrics:

• Developmental screening rates for child by race, ethnicity and primary language
• Proportion of children 0 – 6 who are up-to-date on well child visits, immunizations (P4P) and preventive dental care
• Reduction in waiting times for developmental pediatrics
• Parental report of better access to child development and parenting resources
Children in foster care have already experienced significant life trauma (removal from their biological family often due to extensive abuse and neglect).

The system may help with immediate safety concerns but it can also re-traumatize children because of inconsistencies and multiple transitions.

Physical health and mental health needs may not be met if there is no consistent communication across providers.
Creating Foster Care Centers of Excellence

Tactics:

• Ensure real time dashboards are effective in monitoring system performance including disparities related to race, culture and language for children in foster care
• Create and implement a coordinated and integrated system to identify, assess and provide services to children in foster care
• Pilot and evaluate new models to improve care for children in foster care through Foster Care Advanced Practice Medical Homes

Metrics:

• Children in DHS custody receiving a physical, mental and dental health assessment within 60 days of placement
The objectives are intended to intervene with families at key touchpoints in the health care system with the goal of optimizing the likelihood of good health outcomes.

Our objectives intersect and overlap with one another, addressing the root issues from multiple angles.

Preventing the next generation of high utilizers requires a deep investment in prevention that matters.

Working upstream is the most promising way to change the course not only of health care spending, but of the lives and health of families in our community.
The last word

“It’s easier to build strong children than to repair broken men.”

--Frederick Douglas