Aligning population health management with Medicaid enterprise transformation
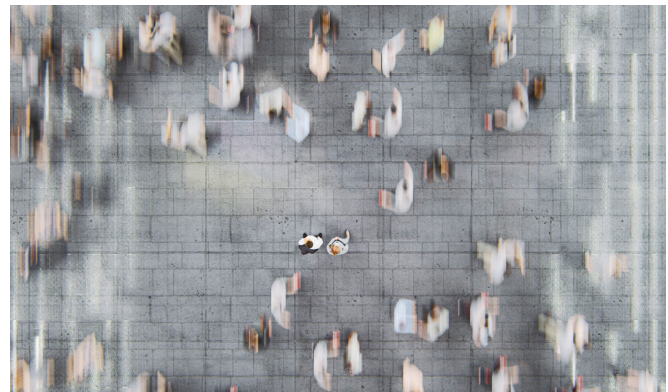
Key considerations for state Medicaid agencies and partners

Introduction

Health and Human Services (HHS) programs are increasingly looking to implement coordinated strategies to improve the health and wellbeing of their beneficiaries, promote equity, and support sustainable cost growth across the health, behavioral, and social care continuums. Over the past years, several State Medicaid Agencies (SMAs) have focused on improving population health and quality of outcomes through approaches that address whole-person care needs. This includes making investments to improve coordination, engagement, and the infrastructure needed to shift from reactive episodic care to proactive holistic care coordination and tailored service delivery.

Parallel to the development of population health strategies, many states have also been working on Medicaid Enterprise Systems (MES) modernization efforts. As states seek programmatic flexibility and funding maximization support from the Centers for Medicaid and Medicare Services (CMS) for enterprise transformation initiatives, there is an opportunity to include population health management strategies into the comprehensive enterprise transformation approaches. By integrating population health management transformation with MES efforts, enterprise investments may be maximized while providing a blueprint for population health strategies that can be further expanded to additional payers, programs, and populations.

This issue brief will examine considerations and practical approaches to improving cross-continuum coordination by harnessing advancements in technology, data and analytic capabilities, improved processes, and person-centric adaptations for population health management and health equity.

Strategic goals for implementing population health management

The starting point for any population health management strategic journey is to develop a robust approach and roadmap that outlines the tactical goals and objectives in conjunction with the overarching MES transformation strategy. An initial gap assessment can be helpful to consider when working through what current technology assets can be reused versus where new technologies are needed to serve new functions across the organization. For example, a state may seek to reuse capabilities within an existing business intelligence solution for internal data storage and analytics but require a platform that enables multimodal transfer and access to data for a variety of stakeholders for population-based needs. Assessing additional business capabilities that such new technologies may offer for consuming, distributing, and rationalizing data across the social service domain can help achieve strategic benefit.

A common challenge for states in their population health management efforts is how to deal with the reality that the same data is collected in many different forms and stored in multiple locations across the care continuum. To avoid the common process of collecting at each service delivery point, SMAs may consider deploying a standardized screening tool and technology that supports streamlined collection, rationalization, and connectivity through artificial intelligence using a single platform. This not only streamlines the process, improving experiences across the stakeholder continuum, but also allows for critical data element collection that can be beneficial within additional enterprise strategies, such as tailored risk-based services and supports, developing alternative payment arrangements, and aiding in programmatic flexibilities through demonstration waivers for short- and long-term advancements.

When outlining considerations for the population health strategy, states should be mindful of three key elements:

1 The intended and alternative impacts to the global care continuum workforce and program beneficiaries

2 How to account for varied organizational norms and business processes between health, behavioral, social, and additional stakeholder organizations

3 How both existing and new technologies can be leveraged to streamline, measure, and mature strategic business goals.

Personnel considerations

The adoption of tools and technologies to support population health management are only beneficial when utilized by stakeholders across the care continuum and program beneficiaries themselves. To that end, a key consideration is the human-centered approach to both program and technology design and adoption.

For each stakeholder domain, there should be considerations on "what's in it for them" to gain the buy-in and support to work together to achieving common goals. For example, a community-based organization (CBO) may be inclined to share and receive data regarding health outcomes or health equity. This data may help the CBOs track their programmatic information and support grant writing and reporting.

Spotlight: State of California Population Health Management (PMH) Service

In 2022, the State of California Department of Health Care Services (DHCS) launched California Advancing and Innovating Medi-Cal (CalAIM) to transform Medi-Cal (California's Medicaid program) through a framework grounded in population health management. DHCS's approach has been developed from the ground up and is outlined in a multiyear strategy and roadmap based around a new PHM Service intended to provide several functions: integrate data from disparate sources, support streamlined assessment and care coordination, allow for multiparty data access and exchange, and support risk stratification, segmentation, and tiering (RSST). The PHM Service will evolve over time and be dynamic to meet the goal of Medi-Cal members achieving longer, healthier, and happier lives in addition to reducing disparities. The result of the completed PHM Service will provide California with a critical solution to help address social determinants of health (SDOH), reduce silos, and advance coordinated whole-person care throughout the state.[1]

Achieving this balance requires the early involvement and continuous engagement of stakeholders throughout strategy, design, implementation, and adoption. Key considerations gained through stakeholder interactive sessions relative to the intended programmatic approach can provide beneficial insights for ultimate adoption and long-term success. Involving stakeholders across the Medicaid program, including managed care organizations (MCOs), inpatient and outpatient healthcare entities, CBOs, and other government partners will help to foster a collaborative approach that should benefit all stakeholders involved, encourage buy-in, and avoid unintended barriers.

[1] CalAIM, California Department of Health Care Services website, July 2022

Process standardization

Through a comprehensive business-driven approach to MES transformation focused on population health capabilities, SMAs can create alignment internally and across stakeholders in the care continuum by reducing duplication of business processes and through the alignment of enabling technologies. A few examples may include:

- Implementing a standardized social needs assessment tool as part of the population health strategy through either a self-established or industry assessment promotes the collection of standard data when assessing social needs and understanding an individual beyond their medical health.

- Leveraging population health management solutions capable of integrating with health information exchanges (HIEs), electronic medical record systems (EMRS), case management systems, and other information systems to increase interoperability through application programming interfaces (APIs) or other file transfer modalities.

- Incentivizing end-user adoption through a single point of entry, via single sign-on (SSO), will allow users to more seamlessly adopt coordinated population health strategies and support more synced care delivery.

- Establishing preconfigured analytic tools for assessing data outcomes to include a variety of data domains allowing for uniform reporting among stakeholder entities to make strategic decisions for the populations they serve.

SMAs have the ability to influence population health capabilities among Medicaid populations, with the long-term capability to scale to additional payers. Additionally, SMAs have the ability to leverage fiscal investments from the CMS to assist with funding the planning, implementation, and ongoing operations and maintenance of technology platforms associated with population health management strategies.

Example social needs assessments

Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool:
The CMS Center for Medicare and Medicaid Innovation (CMMI) originally developed AHC for screening of social needs among individuals eligible for Medicare and Medicaid. Core domains include housing, food, transportation, utilities, and interpersonal violence, along with eight supplemental domains.[2]

Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE):
PRAPARE was developed by the National Association of Community Health Centers (NACHC) and is used by a number of Federally Qualified Health Centers (FQHCs) and other provider groups. Core domains include housing, education, employment, transportation, food, financial strain, and social support. PRAPARE also includes questions on incarceration and safety as supplemental domains. NACHC has translated the questionnaire into 26 languages and has developed a companion implementation toolkit.[3]

Health Leads' Social Needs Screening Tool:
Health Leads developed a 10-question screening tool available in English and Spanish. Core domains include food, housing, financial strain, transportation, and safety, with supplemental domains such as education, employment, and social support. Health Leads also provides a companion implementation toolkit that it updates annually.[4]

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[2] "The Accountable Health Communities Health-Related Social Needs Screening Tool", Center for Medicare and Medicaid Innovation website, July 2022

[3] "What is PRAPARE?", PREPARE website, July 2022

[4] "The Health Leads Screening Toolkit", Health Leads website, July 2022

Technology enablement

An emerging market of population health technology suppliers are providing capabilities aligned with such business-critical needs, including consent management, end-point solution integration, common data sharing formats, and intuitive end-user experience modalities. Such platforms also include advanced capabilities to automate identification of at-risk populations through risk stratification and segmentation algorithms, enabling various entities to apply microlevel approaches to address specific populations. The ultimate reward comes through engaging with and supporting stakeholders across the care continuum and achieving long-term gains for identified population needs.

Leveraging such tools, offered typically through a Software-as-a-Service (SaaS) model, provides SMAs with a lower cost of ownership versus a "home grown" solution while also accounting for many limitations with access and information sharing traditionally encountered among beneficiaries and stakeholders. Population health management platforms currently offered in the market, such as Azara Healthcare, Health Catalyst, Innovaccer, InterSystems, UniteUs, and ZeOmega, among numerous others, provide robust functionality supporting adoption across a wide array of business processes and in many instances account for direct integration with legacy technology solutions for a near seamless integration.

Inherently, these solution offerings are continuing to evolve with new market entrants and capabilities introduced frequently. Over the past several years, an array of new technology platforms has also emerged with the shared aim of enabling healthcare organizations to more easily identify and refer patients to social service organizations and CBOs. If these investments in resource and referral systems are not coordinated or centralized in some way, this may impede the smooth exchange of information between community-based and healthcare organizations, rather than improve them given the potential for different data formats, requirements, etc., for each system.

Spotlight: NCCARE360

North Carolina's NCCARE360 is the first statewide coordinated care network to better connect individuals to local services and resources. NCCARE360 helps providers connect individuals with identified needs through integrated risk assessment tools to community resources while offering feedback and follow-up via a uniform technology platform. This solution ensures accountability for services delivered, provides a "no wrong door" approach, closes the loop on every referral made, and reports outcomes of that connection.

Implemented through a partnership with the North Carolina Department of Health and Human Services (NCDHHS) and the Foundation for Health Leadership & Innovation, the NCCARE360 platform is sustained entirely through grant funding. Since being launched in 2020, NCCARE360 has been adopted by health, behavioral, and social organizations throughout the state's 100 counties, providing a single platform for exchanging social needs data and assessing quality outcomes for program beneficiaries.[5]

Additional considerations

Beyond the people, processes, and technology considerations for approaching population health management strategies, additional considerations such as human-centered design and health equity, data-driven insights, and long-term investment realization are important for SMAs to take note of.

Incorporating approaches to advance health equity
Health equity is a meaningful consideration and area of focus when implementing strategies to address population health. In theory, health equity is the state in which everyone has the same opportunity and level-playing field to achieve their highest level of health. In order to achieve this, ongoing efforts to address SDOH and health disparities are at the forefront. This may include

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[5] About NCCARE360, NCCARE360 website, July 2022

addressing historical and current injustices (e.g., racism and social policies); overcoming economic (e.g., socioeconomic status), social (e.g., health access, education access, and built environment) and other challenges to healthcare; and eliminating preventable health disparities. Additionally, this involves the provision of services in a manner that is best received by the program beneficiary to "meet them where they are" in an effort to develop buy-in to holistic care strategies.

In recent years, many states have made significant gains across the care continuum to address health equity. These have included developing mechanisms for exchanging data and information related to a program beneficiary among stakeholder organizations. It is important to highlight that there continues to be additional opportunities to build programs and policies that range the spectrum of the individuals they serve. Through a population health lens, states should take into consideration how best to leverage a human-centered design in meeting an individual's cultural beliefs, language, and other social characteristics when engaging in whole-person needs and care planning to effectively advance health equity.

Harnessing data and analytics

Real-time data provides necessary capabilities for more timely decision-making. While limitations may currently exist in achieving this reality, technology platforms, including HIEs, are improving realization of this concept. However, HIEs provide limited benefits outside of healthcare entities with integrated EMRS, limiting data exchange and reliability among nonhealth organizations.

While many SMAs maintain robust enterprise data warehouse and data analytic capabilities, these resources are often contained to internal stakeholders with limited use by the public domain. A population health management strategy that includes technical components enabling multistakeholder data exchange and analytic capabilities provides extensive benefits to program beneficiary and stakeholders. This also allows for the introduction of standardized approaches to risk stratification and segmentation, allowing for targeted interventions to specified populations as prescribed within an SMA's population health strategy. With robust data insights, entities across the care continuum are better able to identify health disparities using prediction and risk models to address gaps in care.

Conclusion

As SMAs continue transforming their programs, operations, and technology footprints, the increasing strategic focus on whole-person, population-based approaches to care delivery warrants a continued focus within the broader context of MES transformation strategies. From aligning strategic program goals with business-driven technology transformation to harnessing data insights for equitable health delivery and cost maximization, incorporating a population health lens within an SMA's MES transformation provides opportunities for multifaceted value across the health and social care domains.

Technology, coupled with strategic population health roadmaps laid out by SMAs, has the potential to streamline processes and improve outcomes. With meaningful collaborations across the care continuum and the desire to address health equity, whole-person care delivery can be transformed to improve the overall quality of life of program beneficiaries and stakeholders. By harnessing a strategic approach, SMAs have the opportunity to transform, measure, and continuously improve care in a meaningful manner that provides existential value to those providing and benefiting from a coordinated system, simplified and coordinated process, and technical capabilities that automate and streamline capabilities to improve lives and advance equity within our communities.

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