

Population Health in Medicaid Delivery System Reforms

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The phrase “population health” is increasingly used by policymakers, practitioners, and researchers in health care, public health, and other fields. Many see a policy focused on the health of a population as a vehicle for bringing health care delivery systems, public health agencies, behavioral health, social services, and other entities together to improve health outcomes in their communities. New opportunities provided by the Affordable Care Act enable states and regional jurisdictions to test innovative payment and delivery system reform initiatives, often through accountable care collaboratives, including Medicaid Accountable Care Organizations (ACOs) and regional care organizations.

This paper looks at ways in which states have incorporated population health goals and priorities into ACOs or ACO-like models. It highlights both the challenges states have faced and the strategies that have been used. It also provides case studies of promising work in three states. The paper was commissioned by the Milbank Memorial Fund-supported Reforming States Group, a bipartisan, voluntary group of state health policy leaders from both the executive and legislative branches who, with a small group of international colleagues, work on practical solutions to pressing problems in health care.

It is our hope that this issue brief will encourage further effort among policymakers and practitioners as they develop policies and programs that both enhance health care delivery and improve population health and ultimately social well-being.

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There is growing recognition among state policymakers that improving health outcomes is as much about addressing the social determinants of poor health as it is about providing high-quality medical care. Unfortunately, the traditional fee-for-service (FFS) payment

system does not support the kinds of reforms that would enable states to focus on the nonmedical factors influencing health. A number of states are, however, finding ways to use payment models that reward good outcomes over greater volume and allow providers to invest in nonmedical interventions that improve health.

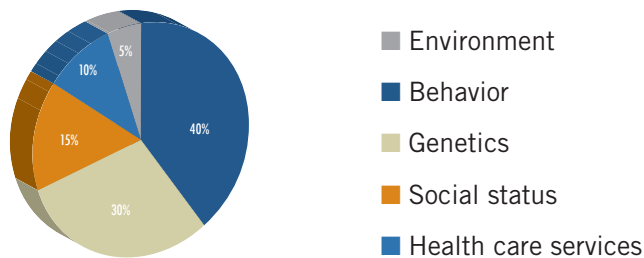
Medicaid Accountable Care Organizations (ACOs), or other ACO-like models, constitute a prime opportunity to meld population health and payment and delivery system reforms in complementary and coordinated ways. Population health–focused Medicaid ACOs seek to transform how care is delivered (in a team-based, person-centered, primary care–centered manner) and how it is paid for (via non-FFS payment mechanisms like shared savings and global budgets), while addressing the Medicaid population’s social services needs and promoting population health goals.

This paper offers state strategies for promoting Medicaid ACOs that improve the health of populations. It provides background information on population health approaches and Medicaid delivery systems reforms. Then it describes various state strategies to inform ACOs’ design and governance structures, program components, metrics, and information-sharing mechanisms. Finally, it includes some promising early examples of states working to embed population health strategies in Medicaid ACO program requirements.

Background on Population Health

Population health initiatives aim to improve the health of populations by focusing the health care system on prevention and wellness rather than illness.^{1,2} While the study of population health is a relatively nascent field, recent research has demonstrated that health outcomes are not primarily determined by the health services a population receives, but rather by a variety of nonmedical factors.³ The United States spends up to 95 percent of health care dollars on direct medical services, yet access to quality medical care prevents just 10 percent of avoidable deaths. The remaining 90 percent of preventable deaths are attributable to nonmedical indicators, including genetic predispositions, social circumstances, environmental exposures, and behavioral patterns (see Figure 1).

Figure 1. Factors Influencing Health Status



Source: J.M. McGinnis, P. Williams-Russo, and J.R. Knickman. “The case for more active policy attention to health promotion.” *Health Affairs* 21.2 (2002): 78-93.

The passage of the Affordable Care Act (ACA) in 2010 heightened interest in wellness and prevention. In addition to providing new funding for prevention and public health initiatives, the ACA works to alter incentives that encourage health care professionals to test, prescribe, and treat—even when there is little apparent health value in doing so—through the promotion of value-based, non-FFS payment methodologies that improve clinical outcomes and cost efficiency (such as bundled payments, shared savings arrangements, and pay-for-performance initiatives).^{4,5} States, counties, employers, and health care organizations are also adopting and supporting wellness and prevention programs that use a range of health and social services interventions to keep people healthy, prevent chronic diseases, and avoid hospitalizations. Examples include the U.S. Department of Health and Human Services’ Healthy People 2020 goals, the Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services’ Million Hearts campaign, the Robert Wood Johnson Foundation’s Culture of Health initiative, and Massachusetts’ Prevention and Wellness Trust Fund.

A major obstacle to developing a population health approach is that the term “population health” means different things to different people. A widely accepted definition asserts that population health is “the health outcomes of a *group of individuals*, including the distribution of such outcomes within the group.”^{6,7} Within this definition, however, there is great latitude for interpretation regarding which population group is being referred to. Payers and providers tend to define the population in question differently than government and public health agencies.⁸ Medicare, Medicaid, and commercial health plans are inclined to think of the population as their current enrollees or covered lives. Health care providers most often view the term “population health” as referring to a defined group of their organization’s panel of patients. These approaches are akin to “panel management,” which focuses on a defined set of patients or members. Alternatively, public health professionals are more likely to view the defined group as the entire population living in a geographical area, such as a city or county. This last interpretation—in which population health includes a broad group of people unified by geography, not health care provider—is the most expansive and aspirational of the definitions.

A second question involves the definition of the *type of health services* considered to be population health-oriented. Medicaid programs, other insurers, and health care providers are likely to think of population health services as clinical services provided in a doctor’s office or health care facility. These could include preventive measures (e.g., immunizations), screening for diseases (e.g., colonoscopies or mammography tests), and gathering information on and counseling for behavioral risk factors (e.g., tobacco use or obesity). However, there are a growing number of examples of population health services that extend literally and/or figuratively beyond the traditional walls of a clinical setting. Examples include: (1) delivering prevention messages by telephone or computer to targeted patients, such as those recently released from the hospital; (2) offering home visits by a community health worker or clinician to assess or reduce risk in the home, reinforce medication com-

pliance, and/or provide direct assistance; and (3) promoting community or public health services like lead testing, disease surveillance, improving access to fresh produce, and swimming classes to prevent accidental drownings. While usually not reimbursable under FFS mechanisms, such services are more likely to be offered in value-based or capitated per-member-per-month reimbursement systems.

In addition to the challenge of *defining* population health, another key challenge is how to *operationalize* initiatives to improve population health. Providers, payers, and government agencies often have different ideas about which populations to target, which prevention/health promotion strategies and incentives to employ, and which measures to use to track progress. As a result, parallel efforts emerge that could have benefited from collaboration, but instead lack consistency or fail to take advantage of the economies of scale associated with a unified effort. This lack of coordination is also evident in how public health departments and Medicaid programs approach population health improvement. Public health tends to emphasize the prevention of disease and the health needs of the population as a whole, while Medicaid—which is limited in the types of services it can offer based on federal reimbursement requirements—views health through the lens of a system composed of individual patients, providers, health facilities, and government regulatory structures. Bridging the gap between these differing approaches will streamline efforts and lead to more robust and effective interventions.

Background on Medicaid ACOs

An ACO is a care delivery model that private and public payers, including Medicaid, are using to improve health care quality and control costs. Generally speaking, ACOs assume responsibility for, and reap the financial rewards of, coordinating and managing care for a population of patients across a spectrum of providers. What differentiates ACO programs from managed care is greater accountability for health care costs and quality at the delivery system level, rather than the insurer level. Within Medicaid, which covers more than 20 percent of Americans, the ACO model offers a promising vehicle to promote accountability for integrating care for beneficiaries with multiple chronic conditions and for those who face social barriers to health, while retaining the system-level benefits of an existing managed care program.^{9,10} Medicaid ACOs are also well-suited to promoting population health because participating providers assume some financial accountability for patient health outcomes, giving them the incentive to keep people healthy.

Core components of a Medicaid ACO include: (1) on-the-ground care coordination and management by providers; (2) payment incentives that promote value over volume; (3) provider and community collaboration; (4) robust quality measurement and accountability; and (5) data sharing and integration. States have significant flexibility regarding how

to structure Medicaid ACOs, including determining the risk-bearing entity, defining care coordination guidelines, and establishing quality reporting and measurement. States can also tailor ACO programs to support population health goals. Additionally, Medicaid ACOs can be aligned with commercial and Medicare ACO models, which could lead to larger and more comprehensive ACOs that cover a more expansive and diverse population and therefore make a larger impact on population health.

As of January 2015, more than 15 state Medicaid programs are actively engaged in either developing or running ACO or ACO-like delivery system reforms (both will be referred to throughout the remainder of this paper as ACOs). States with more established ACOs are beginning to think about how these programs can best address population health goals and work toward assuming accountability for medical and nonmedical services affecting health (see the Case Study boxes below for examples of current Medicaid ACOs that incorporate population health improvement strategies).

Opportunities for Pursuing Population Health Goals in Medicaid ACOs

The opportunity for Medicaid ACOs to produce positive individual- and community-level results is promising, as Medicaid beneficiaries tend to have poorer health outcomes and greater social needs than higher-income populations.¹¹ In other words, individuals with Medicaid may have the most to gain from a health delivery system that focuses on keeping people healthy. States that have expanded Medicaid to cover all individuals up to 138 percent of the Federal Poverty Level have an especially strong incentive to incorporate population health improvement goals into payment and delivery system reforms. While many pre-expansion Medicaid programs primarily covered pregnant women and children, who often leave Medicaid after giving birth or “aging out” of the program, post-expansion programs include more beneficiaries who will remain in Medicaid across their entire life spans—and whose behaviors and exposures early in life may impact their future health status.¹²

However, many Medicaid ACOs currently use an FFS plus shared savings payment structure modeled after the Medicare Shared Savings Program, which gives ACOs the incentive to focus resources on high-cost, high-need patients—those most likely to experience short-term health improvements that result in cost savings. Subject to different financial incentives (i.e., non-FFS payment arrangements that reward quality instead of quantity and put providers at risk for patient health outcomes), these ACOs would be more inclined to address population-based health improvements. States have an important role to play in helping Medicaid ACOs embrace a population-wide focus through value-based payment approaches and a variety of other strategies, discussed in detail on page 6.

States that prioritize population health in Medicaid ACOs should seek to align their efforts with non-Medicaid population health initiatives in their states and nationally. As a starting place, Medicaid leaders can form alliances with their public health and social services

counterparts to achieve a unified population health strategy. In a practical sense, this means Medicaid and public health and social services representatives work closely to establish mutually agreed upon population health goals and cross-agency health promotion activities. This may also entail promoting joint use of state or local resources—like health information exchanges—and establishing open information-sharing channels. Given the purchasing dominance of Medicaid programs, state purchaser decisions can also have a positive ripple effect on private payers and non-Medicaid providers. The following chart describes potential challenges of incorporating population health strategies into Medicaid ACOs:

Potential Challenges of Incorporating Population Health Strategies in Medicaid ACOs

- The social determinants of health affect population health outcomes through multiple pathways and mechanisms, making it difficult to establish clear cause-and-effect relationships;
- Few models exist that successfully integrate clinical health care with social, public health, and/or community-based interventions like housing assistance, food access, early childhood education, and environmental protection;
- The data and strategies needed to project long-term impacts, construct a business case, measure population health outcomes and improvements, and establish accountability mechanisms are in the early stages of development;
- There is an inherent tension between targeting a subset of high-need, high-cost patients to achieve a short-term return on investment and targeting a broader population without the likelihood of any immediate cost savings; and
- ACOs tend to lack the incentives, infrastructure, expertise, partnerships, and authority necessary to assume responsibility for a population broader than their narrowly defined members (also known as “attributed” members)—or for a broader set of services than the medical services agreed to in existing contracts.^{13,14}

Incorporating Population Health in Medicaid ACOs: Lessons from State-Based Initiatives

States possess various statutory and regulatory tools that can facilitate how population health measures and activities are integrated into delivery and payment system reform initiatives. This section outlines four broad strategies state policymakers can use to promote population health in Medicaid ACOs (see Table 1).

Table 1. State Strategies to Establish Population Health–Focused Medicaid ACOs

ACO Governance and Design	Delivery System Enhancements	Population Health Metrics	Data Sharing across Sectors
<ul style="list-style-type: none"> • Develop ACO governance standards that promote population health • Establish geographically defined ACOs • Leverage existing data sources to identify population health needs • Partner with public health, social services, and community agencies • Employ more sophisticated value-based payment mechanisms 	<ul style="list-style-type: none"> • Offer comprehensive preventive and social services • Use community health workers and other nontraditional providers 	<ul style="list-style-type: none"> • Develop population health metrics that incorporate both short-term actions/processes and longer-term outcomes • Begin the measure development process with widely used categories like tobacco use, obesity, and asthma 	<ul style="list-style-type: none"> • Leverage existing collaborations and data-sharing arrangements between Medicaid and other state agencies • Promote electronic records as a reservoir for population health measures • Support new processes to enable secure information sharing

1. Use State Authority to Inform ACO Governance and Design

States have the authority to use the legislative or regulatory process to shape ACO governance structures and program design.

Develop ACO Governance Standards that Promote Population Health

At the outset, states can establish governance standards for ACOs to help promote a population health focus. For instance, states could require ACOs to have public health and social services organization representatives on their boards; they could also provide guidance about how ACOs should define clinical policies, revenue-sharing structures, and patient attribution to enhance population health.

Establish Geographically Defined ACOs

A geographically focused Medicaid ACO program—in which ACO attribution is based on where patients live instead of which providers they use—can offer a more ground-level view of Medicaid patients’ health needs, as health determinants (e.g., the availability of healthy food, parks and playgrounds, and safe housing) often have a geographic focus. A geographic orientation will also help the ACO in coordinating more effectively with public health agencies, which tend to track health based on geography.¹⁵ A handful of current Medicaid ACO programs are organized by region. For example, Colorado’s Medicaid program contracts with Regional Care Collaborative Organizations (RCCOs) in seven different geographic locations. The RCCOs serve as care coordination sites, connecting patients with health care providers and other services. While RCCOs do not put providers at risk for cost and quality

targets, they are accountable for some population-based results and could serve as a foundation for a more robust geographically based Medicaid ACO model in the future. Oregon's Coordinated Care Organizations (CCOs) and New Jersey's Medicaid ACO demonstration project also have a geographic focus.

[Leverage Existing Data Sources to Identify Population Health Needs](#)

States can encourage Medicaid ACOs to gather and share information about local populations' health determinants and needs through many existing data sets. States can also play a more active role by providing data directly to ACOs or helping to facilitate the data-sharing process.

ACOs can collect information from nonprofit hospitals' community health needs assessments and implementation plans (conducted every three years as a requirement to maintain nonprofit status) and local health departments' community health assessments (required every five years for health departments seeking Public Health Department Accreditation). The quality of these data sources, however, could vary significantly from location to location. ACOs can also use publicly available data sources to map medical and social needs/assets, including the Robert Wood Johnson Foundation's County Health Rankings, the Health Resources and Services Administration's Area Health Resources File and Medically Underserved Areas data, U.S. Department of Housing and Urban Development data on housing assistance, and resources from the Administration for Community Living. ACOs can also reference state- and community-level health improvement plans to identify existing shortcomings and health goals. To acquire patient-level data about specific health needs, however, new data collection may be necessary. States may require or encourage ACOs to use risk assessment tools to screen patients for social determinants of health.

[Require ACOs to Partner with Public Health, Social Services, and Community Agencies](#)

States can require Medicaid ACOs to establish formal partnerships or referral networks with county-based or local public health agencies and/or social services organizations. A public health agency, for example, could become a member of the ACO network through a shared governance arrangement or could enter into a contractual relationship to work collaboratively with the ACO.¹⁶ These types of partnerships may enable ACOs to provide nonclinical, health-promoting services they otherwise could not provide, such as disease surveillance, immunization tracking, job placement, and housing support. Maine's Accountable Communities program requires participating ACO providers to partner with local public health entities on issues like nutrition and women's health. Oregon's CCOs, meanwhile, are required to coordinate with Area Agencies on Aging and regional offices for people with disabilities to address the complex health and social needs of patients who are elderly or have disabilities. CCOs also must have a community advisory board and take responsibility for initiating community improvement activities based on input from board members.

Employ Value-Based Payment Mechanisms

In forming population health–focused Medicaid ACOs, states should focus particular attention on how the ACOs, and their providers, are paid. Without appropriate financial incentives, ACOs may find that it is not in their best interest to address social determinants of health and support initiatives that impact future health status. At a basic level, the payment process needs to incentivize inclusion of population health activities—something an FFS model, or shared savings on top of FFS, is unlikely to do. More sophisticated value-based payment schemes may be necessary, such as bundled payments or global budgets.

A global budget or total spending limit, for example, would likely motivate an ACO to invest its limited resources in services (including nonclinical services) that maximize health outcomes. Under this payment model, the ACO would be paid a single fee for all the services provided to its members that impact health. At the end of the year, any savings could be recouped or any losses withheld. Payment and outcomes targets could evolve over time, in response to changes in the population’s health.¹⁷ Currently, Oregon’s CCOs have a global budget with upside and downside risk and are accountable for a wide range of health-related services.

Medicaid ACO Case Study: Minnesota

Minnesota’s Integrated Health Partnerships (IHP) program is a Medicaid ACO demonstration that uses a shared savings/risk payment arrangement based on a total cost of care calculation and quality metrics. The individual IHPs are expected to develop coordinated service delivery models and are encouraged to address the social determinants of health at the community level.

The state also supports Hennepin Health, a county-level safety net ACO (and one of the state’s IHPs) that serves the unique needs of a subset of Hennepin County’s childless adult Medicaid population by integrating medical, behavioral health, and human services in a patient-centered model of care. Hennepin Health’s affiliated Medicaid managed care organization receives a global capitation payment, providing flexibility to invest in nonmedical services like care coordination and housing units. At year’s end, a portion of accrued savings is distributed back to providers, with another portion reinvested in projects to improve patient health and well-being. Recently, Hennepin Health used reinvested savings to create a clinic-based vocational services program to help patients with behavioral health conditions reenter the workforce.

In September 2014, Minnesota released a request for proposal for a new demonstration called Accountable Communities for Health (ACHs)—local entities that will engage in population health improvement activities and work toward population- and prevention-based health goals.¹⁸ ACHs must identify a target population (based on geography, resource utilization, marginalized status, or condition/disability) and a population-based prevention project to implement. While ACHs can take a variety of forms, they must include partnerships with people living in the community, provider organizations, local public health departments, and at least one ACO. To evaluate the effectiveness of ACHs, the state will compare ACOs that adopted ACH models with those that did not.

2. Incorporate Delivery System Enhancements

An important consideration for states promoting population health–focused Medicaid ACOs will be deciding which types of programs and services to encourage ACOs to adopt. While all services provided under Medicaid must be “medically necessary,” the definition of medical necessity is quite broad, allowing states to include some nontraditional services in their Medicaid plans. Below are two examples of delivery system additions or enhancements that states could encourage their Medicaid ACOs to offer beneficiaries.

Encourage Comprehensive Preventive and Social Services

States can encourage or require Medicaid ACOs to offer patients a wide range of preventive services, including primary care, mental health, oral health, substance use services, care coordination, long-term services and supports, and social and public health services. A state may set general guidelines for Medicaid ACOs, then allow each individual ACO to choose its covered benefits based on which services will be most cost-effective for its patient population. ACOs could include both clinical and preventive health services like smoking cessation programs and quit lines, as well as community-wide preventive services like lead testing (assuming federal approval).¹⁹ The Hennepin Health safety net ACO, which has the flexibility to include nonmedical services and providers in its total cost of care calculations, is leasing public housing units to 112 homeless patients with complex medical conditions in an effort to reduce unnecessary hospitalizations and emergency department visits.

Medicaid ACO Case Study: Oregon

Oregon’s CCOs are regional entities—composed of multiple payers, providers, and county public health departments—that accept a single global budget and are directly accountable for the cost and quality of local Medicaid beneficiaries’ physical, behavioral, and dental health care. Two percent of a CCO’s global budget is withheld each year and can only be recouped by meeting quality targets, including preventive health metrics. The global budget and quality withholds encourage greater integration and coordination across sectors, and many CCOs are in regular contact with local social services agencies. For example, Health Share of Oregon, Oregon’s largest CCO, is investigating the possibility of providing housing services to a subset of its members. CCOs are also required to establish agreements with local public health authorities to develop a community health assessment and community health improvement plan—and then work collaboratively with a variety of community partners to meet shared goals. In the future, CCOs could evolve into population-wide risk-bearing entities. Oregon is clearly one of the leading-edge states in its initial plans to promote population health in Medicaid, though many opportunities still exist for the state to better incorporate population health strategies and metrics in its Medicaid delivery system reforms.

Promote the Use of Community Health Workers and Other Nontraditional Providers

Community health workers (CHWs) and other nontraditional health care providers, including care coordinators and case managers, can be an integral part of a Medicaid ACO care team. These individuals can promote population health improvement by facilitating access to primary and preventive services, assisting with the management of chronic conditions, promoting health engagement and empowerment in a culturally competent manner, and connecting patients with community-based social and public health services. CHWs can also provide contextual information about patients' home environments to inform care planning and identify population-level needs to be addressed through larger-scale programs and interventions.²⁰ Finally, nontraditional health care providers can play an invaluable role in educating community members about the purpose of a population health–focused Medicaid ACO, the services the ACO provides, and the ways they can take advantage of its offerings. Community education will help ACOs maximize their benefits by reaching as many eligible beneficiaries as possible.

CHWs and other nontraditional health workers could be reimbursed as part of Medicaid ACO care teams under a global budget. For example, Oregon's CCOs, subject to a global budget, are required to make nontraditional health care workers available to beneficiaries, including community health workers, peer wellness specialists, patient navigators, and doulas. States with existing CHW programs may also wish to play a proactive role in connecting ACOs to these programs.

3. Establish Standard Population Health Metrics

Another important role for states establishing Medicaid ACOs is to set clear expectations about how ACOs should track and quantify population health outcomes and changes over time. States can require ACOs to incorporate specific population health metrics into their measure set, provide ACOs with a list of metrics to choose from, or set guidelines around the need to move away from only using clinical, encounter-based metrics.

A number of organizations have considered or developed population health indicators that Medicaid ACOs could adopt as quality outcome measures. For example, the National Quality Forum (NQF) has endorsed 24 population health measures, 19 of which address immunizations across health care settings or screenings for specific cancers, sexually transmitted infections, and osteoporosis. The remaining five measures address smoking, overweight and obesity prevention and control, and other indicators of risk behaviors. NQF has formed a Population Health Framework Committee and a Health and Well-Being Standing Committee to further consider such measures.²¹ The Robert Wood Johnson Foundation has also developed 20 measures that comprise its County Health Rankings formula using community-level data that are available throughout the country.

Despite these ongoing efforts, there is still no consensus regarding the optimal population health metrics for payers. In sorting through the options, it is necessary to differentiate between measures that assess outcomes (the desired form of measure, as health outcomes

are ultimately what population health programs are trying to improve) and those that assess action steps or processes. Outcome measures, which are useful as indicators of the impact of health and health care activities, can include risk factors (such as reduced tobacco use), disease prevalence (such as fewer cases of diabetes), costs (such as those associated with preventable hospitalizations and emergency room visits), length of life (mortality), and health-related quality of life.²²

An alternative category of measures involves action steps or processes. These are the short-term steps that are likely to contribute to the desired outcome measures. A few examples of population health action steps or process measures are (1) clinical linkages to behavior change counseling, such as smoking cessation groups; (2) referrals to community or social services agencies that offer job training; and (3) assistance with finding safe, affordable housing. Progress in meeting established goals in these areas is more easily measured on an annual basis. However, because population health research is not as precise or as well developed as clinical research, it may be necessary to track the long-term impact of such action steps on outcome measures to guarantee that the action steps result in improved health or cost controls.

While there is not universal agreement about which population health metrics to employ, there are certain widely used categories. The following chart offers a few examples:

Topic	Action/Process Measure	Outcome Measure
Tobacco use	<ul style="list-style-type: none"> • Referral to smoking cessation services • Resources devoted to tobacco bans and taxes • Routine screening for tobacco use and prescribing of nicotine replacement therapy 	<ul style="list-style-type: none"> • Reduced rates of smoking
Obesity	<ul style="list-style-type: none"> • Referral for supported exercise and nutrition counseling • Resources for accessible healthy foods (e.g., farmers markets in low-income neighborhoods with financial support) 	<ul style="list-style-type: none"> • Reduced rates of overweight and obesity
Asthma	<ul style="list-style-type: none"> • Home visits (with counseling and risk assessment) for patients with asthma • Material assistance with provision of mattress covers and vacuum cleaners 	<ul style="list-style-type: none"> • Fewer emergency department visits and hospitalizations

A Medicaid ACO program currently using population health-oriented metrics is Minnesota's IHP demonstration, which produces monthly reports on patient-level chronic condition indicators. These metrics combine encounter and pharmacy data to paint a nuanced picture of patients' chronic health status and needs. One specific metric included in Minnesota's IHP report is the Optimal Diabetes Care Composite, which includes information on patients' HbA1c control, LDL control, blood pressure, tobacco cessation, and aspirin use. Providers can track this measure on a patient or population level and are held accountable for patients' scores.

4. Facilitate Data Sharing across Sectors

Acquisition and use of pertinent and timely health data are critical precursors to addressing population health. In order to measure the health of an ACO's enrollees, or within a total geographic area, providers and administrators need quick access to large amounts of health data. The HITECH Act of 2009 (short for Health Information Technology for Economic and Clinical Health) was implemented to address this issue.²³ Since its inception, the HITECH Act has administered more than \$25.1 billion in incentive payments to Medicare and Medicaid providers for the adoption of electronic medical records (EMRs).²⁴

The law has been shaped by the setting of “meaningful use” standards, which can include the requirement that medical providers share information outside their organization—including with immunization registries, syndromic surveillance systems, and other public health registries. These narrow areas, however, do not comprehensively address the broader issue of population health. A population health approach would allow a bidirectional flow of information to help providers understand the context of the health status of the broader population. On a parallel track, public health authorities could implement upstream prevention strategies in response to trends seen in the clinical setting. This is the next generation of interoperability: where the focus is on using data in health records to inform surveillance and population health improvement efforts in robust ways.

States can promote population health information sharing by helping Medicaid ACOs leverage existing collaborations and data-sharing arrangements between Medicaid and other state agencies—or by helping ACOs establish new information-sharing channels. Washington State Medicaid, for example, shares data across multiple state agencies through the state's Predictive Risk Intelligence System (PRISM), which integrates information from medical, public health, behavioral health, social services, and long-term care data systems to identify beneficiaries most in need of comprehensive care coordination.²⁵

Many ACOs face difficulties sharing patients' personal health information across programs or sectors, so states can work to create new legislative or regulatory processes to enable secure information sharing. An Oregon law, for example, grants CCOs the authority to share confidential information within their provider network, the Oregon Health Authority, and the Oregon Department of Human Services, facilitating CCOs' ability to provide coordinated, whole-person care.²⁶

Medicaid ACO Case Study: Vermont

Vermont Medicaid's ACO shared savings pilot has two payment tracks that parallel those in the Medicare Shared Savings Program ACO demonstration: (1) an upside-only risk track and (2) an upside/downside risk track. ACOs have the option of expanding total cost of care calculations in the second year to include "noncore services," such as personal care, pharmacy, dental, nonemergency transportation, and other services. In the third year of the demonstration, ACOs will be required to include additional state-defined noncore services. The ACO pilot leverages data from the Vermont Health Information Exchange, which transmits clinical data to ACOs from participating providers' electronic health record systems to provide population health analytics.

To enhance the Vermont Medicaid ACO program and other health delivery system models, the state's Population Health Work Group created the Accountable Health Communities (AHC) demonstration request for proposal released in August 2014 to serve an integrator function at the community level, connecting clinical care, public health initiatives, and community-based services to address communities' needs.²⁷ An AHC will assume accountability for the overall health of a geographic population by defining shared goals; assessing the community's needs and gaps; initiating population health interventions; and assessing performance.

In addition to using EMRs to exchange information between clinical systems and external agencies, states can help to promote EMRs as a reservoir for population health measures. The Institute of Medicine published recommendations in April 2014 on the information that should be included in EMRs to support a focus on social and behavioral determinants of health. One key recommendation is that clinical providers should collect information on behaviors, socioeconomic, demographics, and geo-codable neighborhood characteristics.²⁸ Incorporating these types of data into electronic health records will change the future of population health analysis dramatically; instead of Medicaid agencies, ACOs, and other entities collecting information through surveys and independent, piecemeal systems, they can draw data from large comprehensive systems.

While these recent advances are promising, there are barriers to fully realizing an electronic system that supports population health within Medicaid ACOs and more broadly across health care, public health, community-based organizations, and research entities. These barriers include security and privacy of patient data; IT development costs; lack of common classifications, labels, and data-sharing structures across sectors; and a complex array of overlapping state and federal laws. States must also consider whether the Medicaid ACO itself, or another entity, is going to serve as the "integrating entity" that assumes responsibility for sharing information across sectors. Depending on the extent of a Medicaid ACO's collaboration with other entities, this integrator could also serve as the coordinator of pooled funding and other resources.

Conclusion

Medicaid ACOs have the potential not only to align payment and care delivery incentives to promote high-quality, well-coordinated care, but also to improve population health within their enrolled population and beyond. States, in conjunction with county governments and commercial payers, can help ensure that Medicaid ACOs play an important role in improving health outcomes across the life course by (1) requiring ACOs to incorporate population health–focused design and governance structures, patient services, metrics, and information-sharing systems; and (2) focusing on building strategic partnerships between ACOs and other population health–oriented entities. States that incorporate population health components in Medicaid delivery system reforms will experience health improvements and cost reductions—but these improvements will only reach the height of their potential if states coordinate these initiatives with other agencies, insurers, and providers.

Notes

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