Integrating Public Health into State Health Reform Implementation

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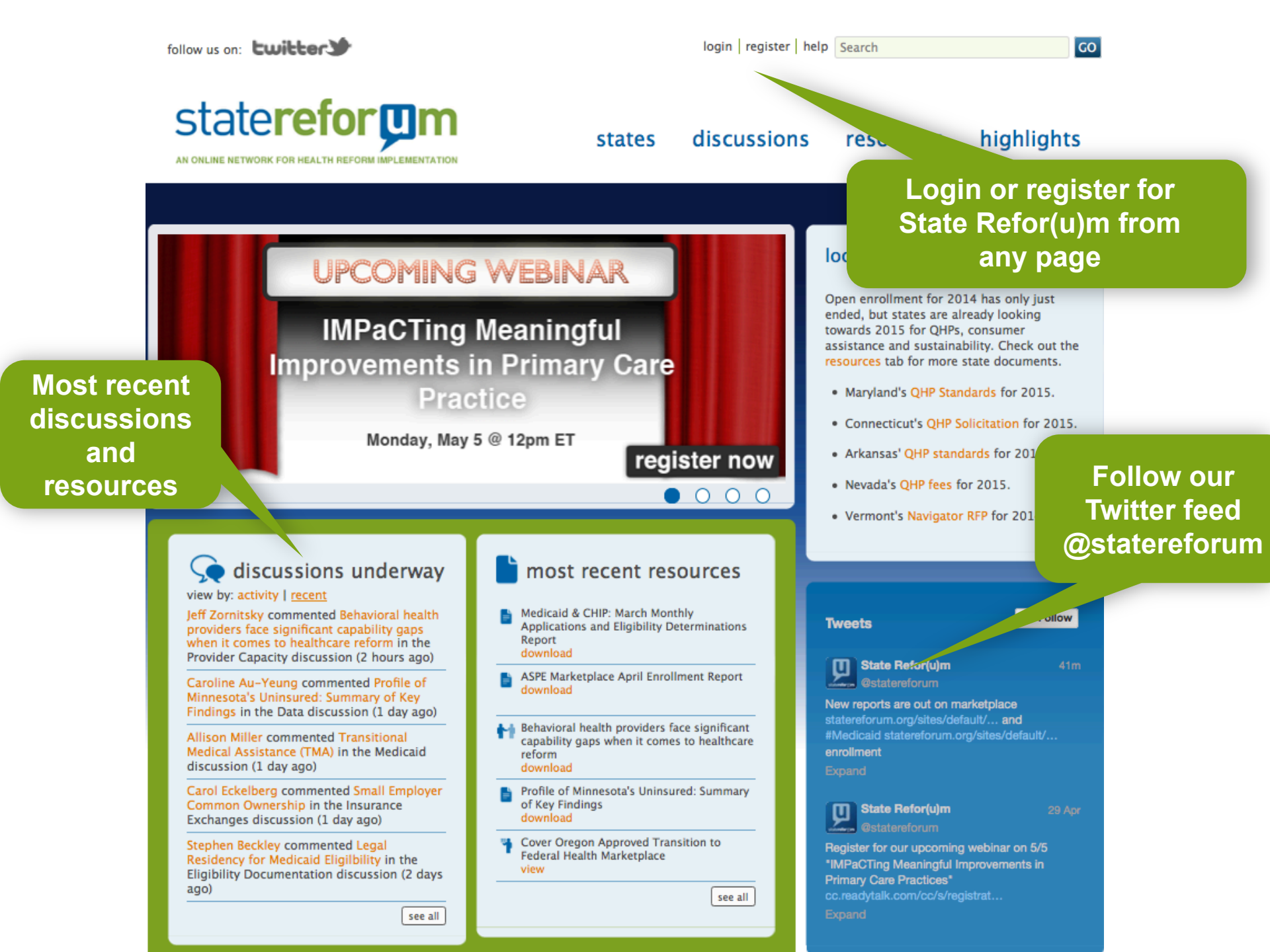
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Monday, May 5 @ 12pm ET
register now
Open enrollment for 2014 has only just ended, but states are already looking towards 2015 for QHPs, consumer assistance and sustainability. Check out the resources tab for more state documents.
Maryland's QHP Standards for 2015.
Connecticut's QHP Solicitation for 2015.
Arkansas' QHP standards for 201
Nevada's QHP fees for 2015.
Vermont's Navigator RFP for 201
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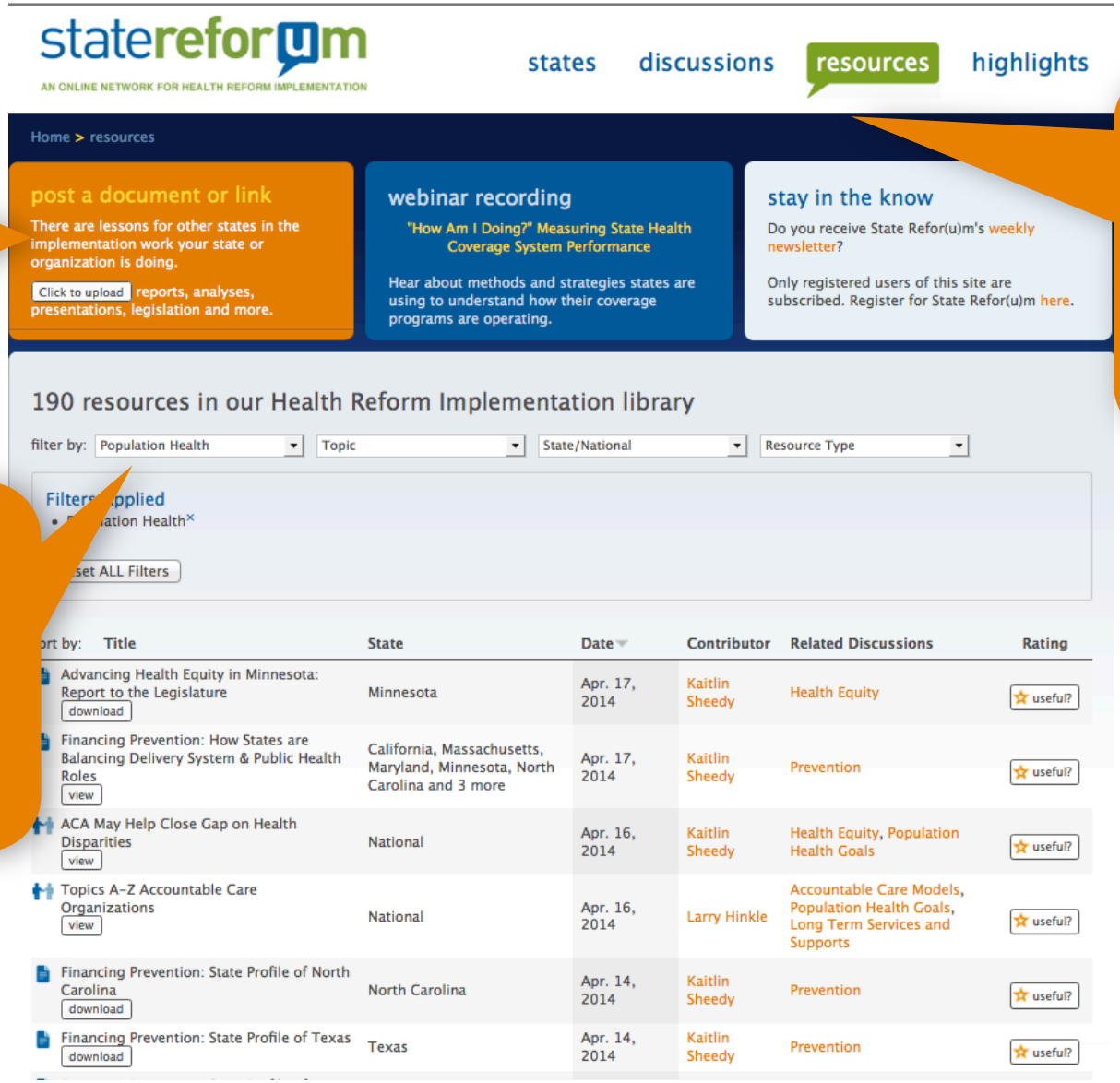

Charts and maps:

- **SIM**
- **Primary Care Extension Models**

Blog entries:

- **HIT and meaningful use**
- **Collaboration across state agencies**
- **CHWs (coming soon)**

Webinars:

- **ACOs and population health**
- **Primary care practices**
- **Meaningfully using data (coming soon)**

Population Health Components of State Innovation Model (SIM) Plans: Round 1 Model Testing States

*Chart updated January 3, 2014

As we noted in a previous analysis, the State Innovation Model (SIM) Testing Awards that HHS awarded to six states (Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont) were to support states' work on multi-payer payment and delivery system reform. Strategies to improve the population's health were a critical aspect of the SIM awards. The SIM Funding Opportunity Announcement (FOA) required that states explain how the model would improve the population's health in a number of areas including health disparities, determinants of health, mental health, and substance abuse. The FOA also noted that states should describe how [illegible] Health Care Innovation Plan integrates community health and prevention into their delivery system and payment models.

This chart lays out the population health strategies the selected states plan to implement through their SIM initiatives. These [illegible] based on the states' proposals and other SIM documents that you will find linked in the text below and in our document library. For information on the payment and delivery system reforms that these states are testing, their health information technology and data capabilities, as well as the scope of their models, please see our previous chart. Please note that because the information in both of these charts was abstracted from early documents, we anticipate that this information may change as the states implement their models.

We encourage our community to share and discuss more details, ideas, issues and emerging products and results on State Refor(u)m. Especially as SIM Design and Pre-Testing states complete their State Health Care Innovation Plans there is interest in how population health strategies will be integrated. Do you know of state activity or analyses that we should add to this chart? Eager to update a fact we've included? Your contributions are central to our community's ongoing, real-time learning, so tell us in a comment below, or email the author with your suggestion. Larry can be reached at lhinkle@nashp.org.

State	Arkansas	Maine	Massachusetts	Minnesota	Oregon	Vermont
Project Narrative	X	X	X	X	X	X
Population Health Objectives in the Model	Arkansas' primary strategy for population health is through its medical home and health home initiatives. Arkansas plans to expand access to medical homes within 3-5 years. These medical homes will proactively examine the patient's health with a focus on preventive services and chronic disease management. Arkansas will also change the payment mechanism to underwrite the costs of primary care practice transformation and reward providers for effective population health management.	Maine's model will deliver care through patient-centered, primary-care based, multi-payer Accountable Care Organizations that are responsible for improving population health, patient experience of care, and controlling healthcare costs. These ACOs will also integrate primary care and behavioral health, align healthcare and public health systems to support improving chronic disease outcomes and address health disparities, and improve health measures and equity. These ACOs will also build on the model of MaineCare (state Medicaid program) Accountable Communities (SIM plan 7-8).	Massachusetts will integrate public and population health into its multi-payer model. The state defines primary care providers broadly to include not just primary care practices and hospital-based providers, but also community health/mental health centers that provide primary care services. These provider organizations may be embedded in larger organizations, ranging from integrated delivery systems to independent practice associations to ACOs. Additionally, the Department of Public Health serves with the four other departments as an Implementing and Strategic Partner (see pg. 7).	Minnesota's Health Care Delivery System (HCDS) demonstration aligns with ACO models from other public and private payers creating financial incentives for delivery system innovation to bring better integration and coordination of care across the spectrum of services. Participating organizations are given incentives to partner with community organizations to create 15 Accountable Communities for Health that integrate medical care with behavioral health, mental health, public health, long-term care, social services, and other providers and share accountability for population health.	Oregon's primary focus is the reduction of chronic diseases and the risk factors that contribute to them. Oregon is using SIM to accelerate population health goals in 3 areas: 1. Advancing the spread of the Coordinated Care Model – with emphasis on prevention and proactive population health management; 2. Providing targeted support for a handful of local "flood the zone" collaborations aimed at creating changes in practice around leading causes of death and disease. 3. Enabling increased population health performance measurement.	Vermont's SIM model seeks to reach the three overarching priority areas for health improvement as identified in Vermont's 2012-2015 State Health Improvement Plan including: 1. Reduction in the prevalence of chronic disease through improving physical activity, nutrition and decreasing the rates of tobacco use 2. Reduction in the prevalence of Vermonters with or at risk of substance abuse and/or mental illness 3. Improvement of childhood immunization Vermont also believes that the primary models it will pursue through SIM-- Shared Savings ACOs,

Population Health Components of SIM Plans: Round 1 Model Testing States

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Example Map: Medicaid Expansion Decisions

Map: Where States Stand on Medicaid Expansion Decisions

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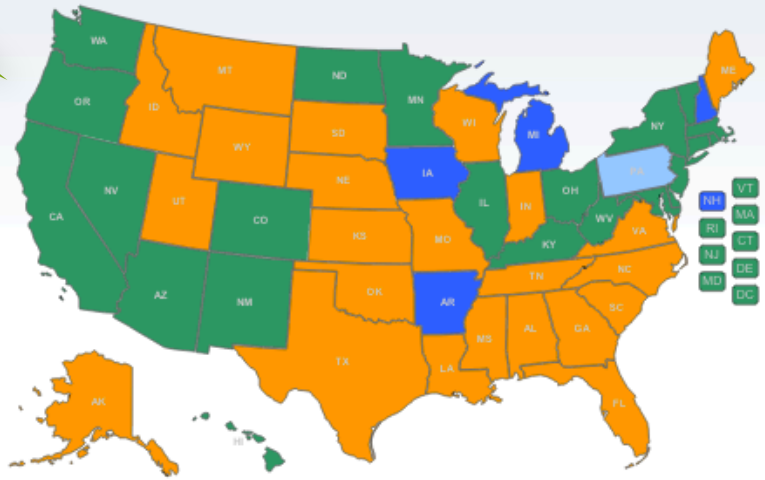
*Map updated April 25, 2014

This map tracks state Medicaid expansion decisions and approaches states are taking for expanding eligibility to 138 percent of the Federal Poverty Level (FPL). This map also includes information on 2014 state legislative activity around Medicaid expansion {1}, the Governor's stance on the issue, and fiscal and demographic analyses from the state or other institutions. For states that are expanding Medicaid, but using an alternative to traditional expansion, the map also contains brief descriptions of these demonstration waivers.

Like all State Refor(u)m research, this map is a collaborative effort with you, the user. State Refor(u)m captures the health reform comments, documents, and links submitted by health policy thinkers and doers all over the country. And our team periodically supplements, analyzes, and compiles this key content.

Know of something we should add to this compilation? Your feedback is central to our ongoing, real-time analytical process, so tell us in a comment, or email the authors with your suggestion. They can be reached at acardwell@nashp.org or ksheedy@nashp.org.



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Key:
- 23 states are not expanding Medicaid in 2014
- 23 states (count includes the District of Columbia) are expanding Medicaid in 2014
- 4 states are expanding Medicaid in 2014, but using an alternative to traditional expansion
- 1 state with Medicaid expansion waivers pending approval from CMS

{1} This map provides a record of legislation introduced in 2014, but does not track the exact status of bills moving in state legislatures. Map is updated when bills pass chambers and/or are signed by the Governor. For information about 2013 legislative activity, see this State Refor(u)m chart.

{2} CMS approved IN's waiver for a one year continuation of the Healthy Indiana Plan; under the waiver extension, HIP eligibility levels were decreased from 200% FPL to 100% FPL for parents and childless adults beginning 4/30/14.

Click on a state to view the status of Medicaid expansion in 2014, including:

Type of Expansion

Traditional: State is implementing Medicaid expansion as outlined in the ACA

Alternative to traditional expansion: State is using a demonstration waiver to expand Medicaid

N/A: State is not expanding Medicaid at this time

Governor's Stance on Expansion

Indicates whether the current Governor is against or supportive of Medicaid expansion

2014 Legislative Activity

For states that have chosen not to expand Medicaid in 2014, view bills introduced in 2014 related to expansion. For information about 2013 legislative activity, see this State Refor(u)m chart.

Fiscal and Demographic Analyses

Includes state-specific analyses related to Medicaid expansion, conducted directly by a government agency, contracted out by the state to another institution, or conducted by organizations or institutions independent of the state.

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Blog post: Collaboration across state agencies in Maryland

weekly insight (blog)

Breaking Down Siloes to Improve Population Health in Maryland

April 24, 2014 by Kaitlin Sheedy

Along with increasing access to health coverage, the Affordable Care Act (ACA) presents many opportunities to reform the health care delivery system and invest in public health and prevention. Traditionally, there have been two predominantly siloed systems for supporting and improving health—the health care delivery and the public health systems—making it challenging to forge partnerships across the state agencies that direct them. In addition, leaders in the field are often separated by differences in the language and terminology they use and their ways of thinking about population health. Despite these complexities, states are working hard to create new partnerships spanning state and local government agencies, communities and private sector stakeholders in order to achieve population health goals. Maryland is leading the charge and has several initiatives underway to foster new or revitalize existing partnerships while encouraging investment in population health activities.

Maryland received a State Innovation Model (SIM) "model design" award from the Centers for Medicare and Medicaid Innovation (CMMI). As part of this initiative, the state is engaging in a planning process to develop the Community-Integrated Medical Home (CIMH) model. This model of care aims to integrate patient-centered medical care with community-based resources while enhancing the capacity of local health entities to monitor and improve both individual and community health. Public Health Services within Maryland's Department of Health and Mental Hygiene (DHMH) took the lead on SIM efforts, supported by the governor's office. In Maryland, the Medicaid agency sits with public health in the DHMH. This arrangement has facilitated collaboration between public health and Medicaid on the SIM initiative and successfully kept population health goals as the centerpiece of their planning.

Around Maryland, hospitals, local health departments and other community partners convene as Local Health Improvement Coalitions (LHICs) to prioritize the needs of the community in advancing state and local health improvement goals. The state promotes these partnerships and provides technical assistance support around communication, collaboration and sharing promising practices through its State Health Improvement Process toolkit. As this work progresses, providers and agencies from the various stakeholder groups involved in LHICs are expected to further understand each other's language, the unique perspective each brings to the table, and how they can best work together towards the shared goal of improving the health of their community.

Additionally, the Centers for Medicare & Medicaid Services (CMS) approved a waiver to modernize Maryland's unique all-payer rate-setting system for hospital services. Maryland and CMS expect that this model will be successful in improving the quality of care while reducing costs for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries. Both the delivery and public health systems are integral to the success of this model. Hospitals are transforming the way they operate to provide more comprehensive care for people and communities, instead of just focusing on treating illness. For example, hospitals are linking with LHICs because of their unique

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Medicaid expansion resources
Twenty-seven states have decided to expand Medicaid in 2014 and state legislatures are gearing up to potentially take up the issue in a number of states. Stay up to date with our resources focused on the expansion:
• Where States Stand on Medicaid Expansion: see which states are expanding on our interactive map
• Tracking Medicaid Expansion Decisions chart: track state legislative activity and decisions
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In an accountable care model, providers assume responsibility for a defined population across a continuum of care, including across different institutional settings. Participating providers agree to achieve specified financial and quality outcomes. This structure, if correctly designed, creates incentives to ensure that care is coordinated across sectors.
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Eduardo Sanchez
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Re: Risk adjustments based on social determinants of health
These are sciences that are evolving. There's an interesting initiative in New York City where they are looking at health payer data and comparing this claims data to population-based data from health interview surveys and trying to see correlations... read more
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Jeanene Smith
Oregon
Re: Risk adjustments based on social determinants of health
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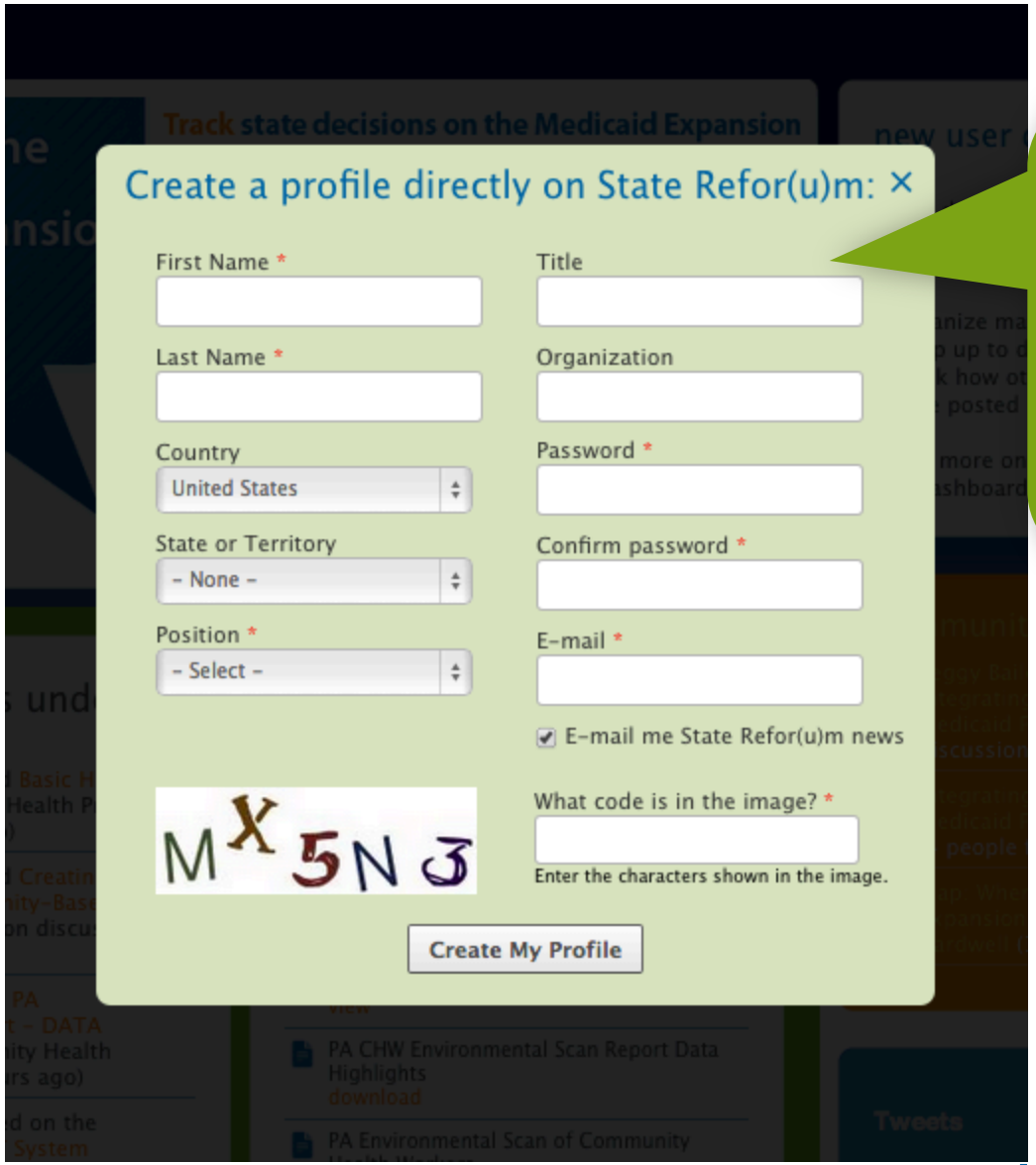

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