The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Population Health — A Bipartisan Agenda for the Incoming Administration from State Leaders

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The common goal of health policy leaders at the level of state government in the United States is promoting the health and well-being of all populations to the greatest extent possible within fixed resource constraints. Our health is affected by our physical and social environments, our genes, our economic and educational opportunities, and to a much lesser degree, the medical care we receive.[1] State leaders understand that as a society we are spending our health care dollars in the wrong ways for the wrong things — emphasizing treatment over prevention and medical care over social services.[2]

States have responsibility for many of the factors that affect population health, including Medicaid programs, public health activities, commercial insurance regulation, and economic development and education. And the health challenges faced by states continue to grow. High-cost, high-need patients swamp Medicaid programs; prisons have become de facto treatment systems for substance use disorders; today's neglected children are tomorrow's state responsibilities; low- and middle-income families struggle with rising health care payments; and the demands of an aging population increasingly tax families, health care systems, and communities.

Even as Congress debates the future of the Affordable Care Act (ACA), state officials working in partnership with new federal executive branch leaders, primarily within the Department of Health and Human Services (HHS), can do much to respond to these challenges. Understanding the need to provide specific guidance for federal–state health policy to improve population health, the governing body of the Reforming States Group, a bipartisan group of health policy leaders from the executive and legislative branches of state governments convened by the Milbank Memorial Fund, has developed an agenda for the new administration proposing several health policy initiatives that have documented bipartisan appeal, are supported by evidence, and are achievable without new legislation.

We suggest a number of ways (see table) that state and federal officials could respond systematically to the health challenges faced by the United States, acknowledging the political and technical complexities of the task and the incremental nature of policy progress, and bypassing the ideological rhetoric that mars much of the current policy debate.

We think that Medicare's leadership in provider-payment reform policy through the work of the

Policy Concepts and Proposals.*

Policy Concept	Specific Proposals
Support state efforts for broad reforms of health care payment and delivery	Allow Medicaid funds to be used for building state capacity Increase Medicare participation in state innovation Increase flexibility for managing drug purchasing
Support state efforts to address causes and improve management of chronic illness	Integrate Medicaid finances into multipayer public health strategies Provide flexibility in funding for social supports (e.g., housing, employment) Strengthen community-benefit requirements
Support state use of data to inform policy	Improve federal data collection and state access Adopt consistent federal standards for data sharing and interoperability
Strengthen state–federal partnership on health to ensure greatest impact from federal investments	Ensure federal interagency coordination of investments Establish focal point of accountability in HHS to facilitate state–federal interactions

* Adapted from the Milbank Memorial Fund (www.milbank.org/publications/letter-to-the-new-administration).

Center for Medicare and Medicaid Innovation (CMMI) and the goals of the secretary of HHS for adoption of value-based payment methods[3] should continue. The Centers for Medicare and Medicaid Services (CMS) can also provide specific guidance to states explaining how to engage Medicare in local all-payer delivery-reform efforts, including shared-savings approaches. Similarly, states could use clear guidance on using Medicaid administrative funds to support planning, implementation, and oversight of all-payer delivery-system reform, as well as on investment in evidence-based practices to improve quality and reduce costs.

Payer alignment is crucial in a multipayer system, since no payer accounts for a sufficient share of a provider's revenue to change the economic incentives. We are learning through the CMMI State Innovation Models Initiative and the CMS Comprehensive Primary Care Initiative that it is best for this alignment to happen at the local level, where payers can learn how to collaborate, not compete, on common challenges such as identification of population health priorities, provider-performance measurement, and primary care transformation. This work takes time, trust, and government-facilitated leadership. With clearer CMS guidance on the terms of Medicare participation, states will be encouraged to continue leading in payment-reform efforts. These efforts might take the form of variations on existing Medicare models, such as accountable care organizations or patient-centered medical homes. Alternatively, all-payer reform efforts could involve innovative solutions tailored to a state's health care system, such as statewide or regional global budgets.

Although they stand to benefit from these delivery-system reform efforts, state Medicaid agencies are stymied by management capacities that have not kept pace with program complexity: leadership turnover is high, skills development is often low, and critical management functions are outsourced. When state-led payment-reform innovations will benefit the Medicaid program, it seems proper and efficient for the program to support their development and implementation.

Second, HHS can adopt consistent national policies that would improve interoperable data exchange across health care, including behavioral health care, beginning with clarification of the rules governing permitted uses of data and the exchange of data related to services for mental health and substance use disorders. In addition, the federal government could develop a coherent approach that facilitates state access to health care data about state residents across federal programs, with appropriate assurances for privacy and security.

If the delivery system is to be reformed, clinicians, payers, and patients need to be able to share reliable clinical and administrative information. The federal government can assign responsibility to an individual or office to work with states and information technology vendors to remove policy barriers and promote compatibility of key state public health data and communications across disparate public health programs and funding sources. Although improvements are being made, states and local payer–provider collaboratives also need faster, easier access to federal Medicare and Medicaid data to plan and measure the efficacy of local policies.

Third, CMS can encourage states to develop and participate in population health models that cut across insurance and payment sources. It could allow state Medicaid funds to be used for health promotion activities, even if they are not Medicaid-covered

services or billed on a beneficiary-specific basis, if they are part of an organized, multistakeholder, statewide or regional plan to improve population health.

It's estimated that people with one or more chronic conditions account for more than 85% of health care spending in the United States.[4] Our health care system is better at treating than preventing these diseases. Interpretations of federal policy, however, have occasionally allowed state officials to pay for services for Medicaid-eligible populations, rather than individuals — for instance, with respect to immunizations and tobacco-control efforts. States have then advanced community-wide prevention approaches by coordinating with other payers. A similar path could be followed for other evidence-based chronic-disease prevention efforts, in areas such as obesity reduction and addiction treatment. Federal Medicaid funds could be allocated on the basis of the percentage of the population served or according to another proportional formula negotiated with states.

The challenges of chronic-disease treatment and prevention are heightened for Medicaid by the social and economic disadvantages experienced by its enrollees. These conditions — such as homelessness, poor diet, and lack of stable employment — are often major barriers to stable health.

To acknowledge this reality, CMS could facilitate state efforts to build new services and supports outside the health care system[5] — from providers such as community health workers, community paramedics, and peer-support specialists, and including efforts to increase supportive or temporary housing, supportive employment, and general transportation. New policies regarding state-plan amendment and waiver models could facilitate state use of Medicare and Medicaid funds to enhance the availability of services through comprehensive, flexible community-based models for vulnerable people with complex care needs.

Our proposed policy agenda is foundational but limited. Given the very nature of bipartisan action, there are important policy choices on which even members of the Reforming States Group do not agree — many of them regarding the future of the ACA.

Our proposal is also a long-term agenda for governing and avoids focusing on any single health care issue currently grabbing headlines. It can be achieved only when state and federal governments agree on their roles and responsibilities. We believe that states will have to accept financial and performance accountability for the funds and flexibility they seek, and that federal agencies will have to view state officials as true partners in efforts to serve citizens and acknowledge the diversity of political and cultural values in the United States.

Implementation of this agenda could improve the capacity of state officials to work with their federal partners and private-sector stakeholders — payers, patients, and providers — toward a common goal that none can accomplish by themselves: healthy people living long and fulfilling lives in healthy communities.

Disclosure forms provided by the authors are available at NEJM.org.

From the Milbank Memorial Fund, New York (C.F.K.); the South Carolina State Senate, Columbia (T.A.); the Department of Health Care Policy and Financing, State of Colorado, Denver (S.B.); and the Reforming States Group Executive Committee (T.A., S.B.).

This article was published on December 14, 2016, at NEJM.org.

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DOI: 10.1056/NEJMp1613250