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Understanding Medicaid's Role in CDC's 6|18 Initiative: A Primer for Public Health Partners

Medicaid officials bring an important knowledge base to CDC's 6|18 Initiative, particularly related to: (1) tracking the utilization of health services; (2) calculating programs' budgetary impacts; (3) implementing payment and policy changes; (4) promoting provider and patient awareness; and (5) assessing impact and outcomes. Public health team members offer a different set of competencies, complementing Medicaid's contributions. It is this marriage of different perspectives, proficiencies, and resources that makes CDC's 6|18 Initiative a successful cross-agency program that has resulted in significant policy changes and increased use of preventive services in dozens of states and jurisdictions across the country.

This resource is divided into five sections, each focused on a key Medicaid role to support CDC's 6|18 Initiative:

1. Collecting and analyzing utilization and cost data;
2. Conducting a cost analysis;
3. Implementing coverage changes;
4. Promoting provider and patient awareness; and
5. Measuring quality improvement and impact.

IN BRIEF

This document describes the core roles of Medicaid program staff when partnering with their public health counterparts to implement evidence-based prevention interventions under CDC's 6|18 Initiative. It is intended to help both public health as well as Medicaid agency staff interested in partnering to improve preventive care services in understanding the 6|18 Initiative activities that Medicaid officials are best suited to lead. Public health and Medicaid partners can refer to this foundational resource when establishing roles and responsibilities for new collaborative activities to address preventive care priorities.

*See a companion resource, **Understanding Public Health's Role in CDC's 6|18 Initiative: A Primer for Medicaid Partners**.*

Each section includes background context addressing why staff from Medicaid agencies are well positioned to lead these 6|18 Initiative responsibilities, as well as descriptions of potential Medicaid activities. This list of roles and activities is not exhaustive, but rather meant to highlight some of the more common and relevant skills that Medicaid officials are deploying when participating in the 6|18 Initiative.

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1. Collecting and Analyzing Utilization and Cost Data

Background

Medicaid programs maintain records of all health care services paid for with Medicaid dollars and provided to Medicaid-enrolled individuals, resulting in a huge repository of cost and utilization data. Medicaid officials analyze these data for a variety of program purposes, including:

- Assessing the quality of services provided;
- Developing budgets and capitation rates;
- Monitoring provider and health plan performance and compliance; and
- Analyzing program costs, utilization rates, and other trends over time.

Data collection and reporting vary according to the format of the Medicaid delivery system. In a fee-for-service (FFS) arrangement, in which the state directly pays health care providers for delivered services, providers submit claims for payment using billing codes that describe the patient's condition and the activities performed ("claims data"). Claims data are generally submitted in a standard electronic format directly to the state and provide a complete record of the financial transactions for each service provided.

Under a managed care arrangement, in which Medicaid agencies pay managed care organizations (MCOs) a per member per month payment to deliver medical services to enrollees, MCOs submit data to the state detailing all of the health care services that MCOs paid contracted providers to perform ("encounter data"). States specify in their MCO contracts how encounter data are collected, labeled, and submitted, as well as how frequently reports are due. States with both FFS and managed care programs can combine claims and encounter data to produce a complete picture of all Medicaid services at the state level.

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Medicaid agencies participating in CDC's 6|18 Initiative can use Medicaid cost and utilization data in a number of ways to support the Initiative's objectives. Opportunities include:

- ***Identifying interventions and populations to focus on***. Medicaid can use claims/encounter data to better understand population-wide trends in health care utilization, including the most common and costly diagnoses and procedures. These data can help the state choose the 6|18 health condition and intervention(s) most likely to have the greatest impact, as well as decide whether to focus on any specific Medicaid sub-populations.
- ***Establishing baseline utilization rates and tracking utilization over time***. In order to quantify the impact of a 6|18 Initiative policy change, states can use Medicaid data to establish a baseline for the use of a particular benefit, and then compare the baseline to post-implementation utilization rates. This will enable the state to know how a policy change may have influenced enrollees' utilization of the Medicaid benefit. For example, a state can compare the utilization of tobacco cessation counseling services before and after the launch of a 6|18-reated tobacco cessation campaign to gauge the potential influence of the campaign.
- ***Calculating anticipated and actual intervention costs***. When states work to make the case for Medicaid to cover a new program or policy, they generally present decision makers with data on the financial implications of that change. If a particular program is covered on a limited or pilot basis, Medicaid can use existing claims data for enrollees participating in the pilot program to estimate the costs of expanding the program statewide. If adopting a new policy is likely to change capitation rates for Medicaid MCOs, the state can use encounter data to estimate the size of the rate change.

2. Conducting a Cost Analysis

Background

Medicaid programs represent a large portion of state budgets. In state fiscal year 2016, Medicaid accounted for more than 28 percent of state spending from all sources (including federal funding) and more than 15 percent of expenditures using state-only dollars. Given Medicaid's large footprint within state budgets, Medicaid programs are often subject to pressure from the legislature, governor, or agency leaders to reduce spending on non-essential or less impactful programs. Medicaid program staffers looking to cover a new program (or enhance an existing one) therefore need to make a persuasive case for including the new program in the budget. In many states, leadership will be reluctant to add any new Medicaid budget line items unless anticipated short-term savings offset upfront costs.

Cost analyses can help staff make a case for coverage by demonstrating to policymakers and budgetary staff the anticipated financial impact of a proposed Medicaid policy change in the next 12- to 24-month budget cycle. This information will help those in charge of setting the next year's budget determine whether to cover the program. A cost analysis should include information about the number of expected users, fixed and variable operational costs, and estimated costs avoided because of the program (e.g., fewer emergency department visits and hospitalizations). In a managed care context, state Medicaid staff and health plan leaders could use the cost analysis to determine whether to include the new program in the MCO's benefit package, which could affect its capitation rate.

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If a 6|18 Initiative team is working to secure Medicaid funding for a particular prevention intervention, Medicaid representatives can help prepare a financial case for why covering the benefit is in the best interest of the state (or Medicaid MCO(s), if targeting health plans). The most crucial information a Medicaid 6|18 team member can produce is the anticipated financial impact of covering the new benefit over the next Medicaid budget cycle. While some Medicaid decision makers may also be interested in how the policy changes improve Medicaid enrollees' health, this information is generally not enough on its own to make the case for changes to Medicaid coverage.

Medicaid staff are best positioned to conduct a cost analysis after the state first tests the program on a small scale; they can then use data from the pilot to estimate the program's financial impact on a larger scale. The budget estimate will ideally take into account a wide range of factors that could influence program costs, thereby producing the most accurate cost estimate possible. Overestimating the cost of a new program will make decision-makers less likely to support covering it, while underestimating costs could lead to budget shortfalls and put the program's future in jeopardy. Once the calculations have been made, Medicaid representatives can engage their public health counterparts in putting together a set of resources for presenting the case to Medicaid leadership (e.g., talking points for in-person meetings, one pagers, policy reports, and infographics).

3. Implementing Coverage Changes

Background

Medicaid programs have a certain amount of flexibility in designing their Medicaid programs. They are required by the federal government to cover a set of mandatory benefits such as hospital stays, primary care, and vaccinations for children, and then may choose to cover additional, optional benefits (e.g., prescription drugs, dental care, behavioral health services, and some non-medical services). States can also place limits on the amount, duration, and scope of the service offered, as well as require some enrollees to contribute toward the cost of their coverage through nominal

copayments or limited premiums. In managed care arrangements, Medicaid health plans have significant flexibility to design benefits that best meet the needs of their enrolled populations. Medicaid MCOs may offer services not specified by the Centers for Medicare & Medicaid Services (CMS) as mandatory or optional Medicaid services, as long as they are included in the plan's contract with the state and the plan agrees to pay for them under their negotiated capitation rate.

States have the ability to make coverage changes through a number of mechanisms. For states seeking to change coverage within existing federal regulations, state Medicaid agencies can apply to the CMS for a state plan amendment (SPA). They can also seek to formally waive some federal requirements by applying for a program or demonstration waiver. States can use SPAs and waivers to test a wide range of service delivery approaches, adopt value-based payment strategies, and implement small- or large-scale program changes. For states looking to alter how Medicaid health plans offer benefits to enrollees, they can engage with health plan leaders about opportunities to amend benefits or work to update health plan contracts during the next contracting cycle.

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A number of 6|18 Initiative interventions involve expanding access to Medicaid prevention benefits, either by reimbursing for a preventive service that was not previously covered by Medicaid or by removing barriers such as co-pays, prior authorization requirements or quantity/duration limits for an existing benefit. Medicaid can work to implement these coverage changes at the state-level through SPAs, waivers, or changes to Medicaid MCO contract language or guidance. In some cases, desired 6|18 Initiative policy changes can be coupled with other related policy changes in a large federal waiver, MCO contract update, or other package of Medicaid reforms. In other cases, the policy change may be treated as a standalone action.

Medicaid staff participating in CDC's 6|18 Initiative will likely have a good sense of the current political and budgetary climate and any windows of opportunities to move forward with the proposed policy change. Making the case for a new or enhanced benefit may include: presenting state Medicaid or health plan leadership with a cost analysis of the policy in question; developing fact sheets and one-pagers to describe a prevention program's benefits; scheduling in-person meetings with decision-makers; and inviting Medicaid leaders to 6|18 Initiative meetings and events. While Medicaid representatives participating in 6|18 will likely drive the process of how and when to move forward with the policy change, public health officials can play a critical role in supplying evidence and data, reviewing and contributing to materials supporting the policy change, and attending meetings with decision-makers.

4. Promoting Provider and Patient Awareness

Background

State Medicaid agencies regularly communicate with providers and enrollees for a variety of reasons, including: sharing information about program changes, clarifying misunderstandings, soliciting feedback, and promoting utilization of available programs and services. Medicaid agencies often communicate with providers about program updates — such as changes in covered services and billing procedures — through provider bulletins, which are often available via email listservs and posted on state websites. To get in touch with enrollees, Medicaid agencies send information through the mail and post information on the state's official Medicaid website and social media pages. Some agencies also invest in provider- or consumer-focused mass media campaigns to reach wider audiences about how or why to take advantage of a particular Medicaid benefit (e.g., radio, TV, billboard or social media ads to

encourage utilization of smoking cessation or family planning benefits). Medicaid MCOs have their own provider and member communication channels and are able to share updates and information via print and online media.

6|18 Role for Medicaid

Medicaid agencies and health plans are a trusted source of information for both providers and enrollees and can play a key role in promoting CDC's 6|18 interventions, especially those focused on increasing provider or consumer utilization of a prevention strategy or highlighting a recent policy change. In addition to utilizing provider bulletins to update clinicians about new programs/policies, Medicaid agencies can work independently or with public health agencies to develop provider-focused reference sheets and billing guides, giving Medicaid providers an at-a-glance resource outlining what Medicaid covers and how to bill for it. They can also host virtual or in-person trainings to enhance providers' knowledge and understanding of Medicaid prevention programs or practices. Additionally, Medicaid can promote new incentive structures to encourage provider utilization of a particular prevention program or benefit — such as enhancing reimbursement for the intervention or linking provider payments or quality scores to their use of the benefit. For enrollee-focused media campaigns, states have found success in using simple taglines that let people know that Medicaid will pay for a particular benefit (e.g., "Medicaid covers it!").

5. Measuring Quality Improvement and Impact

Background

Medicaid agencies develop and track a wide range of quality metrics to assess how health care is being delivered to enrollees and influencing their health. While CMS developed the Adult and Child Core Sets to standardize Medicaid data collection and reporting, each state can choose which Medicaid quality metrics to track to best reflect its current circumstances and priorities. Many Medicaid programs develop quality indicators to assess the impact of new delivery system and value-based payment arrangements (e.g., patient-centered medical homes, accountable care organizations, and health homes) on health care quality and costs. In some cases, Medicaid agencies tie provider and/or health plan performance in these arrangements to payment.

In managed care delivery systems, Medicaid uses quality data from a variety of sources to assess the performance of its contracted health plans. Although most states generally rely on Healthcare Effectiveness Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance, some states also rely on Consumer Assessment of Healthcare Providers and Systems surveys, which assess the experience of Medicaid beneficiaries with their health plans and providers. Federal regulations also require Medicaid programs to develop a quality strategy to track patient outcomes and develop improvement targets for Medicaid MCOs. Medicaid MCOs are also required to develop and execute performance improvement projects (PIPs) in accordance with state specifications. States contract with External Quality Review Organizations to evaluate the PIPs and perform other evaluative duties related to Medicaid managed care performance and compliance.

6|18 Role for Medicaid

Medicaid staff participating in CDC's 6|18 Initiative can help their team choose appropriate quality metrics to track intervention impact over time. States may consider different types of metrics to best assess progress and outcomes, including measures related to process and implementation, utilization, and health outcomes (or a combination thereof). In most cases, teams can use existing metrics, such as those included in the Adult Core Set or HEDIS set,

rather than creating new metrics from scratch. These should be decided upon at the outset of the team's participation in CDC's 6|18 Initiative and included in the team's action plan.

Following the selection of metrics, Medicaid staff can assist in setting appropriate benchmarks for the state to meet because of implementing its chosen interventions. These benchmarks — which can be based on either achievement or improvement — should reflect realistic progress from the status quo. Medicaid team members can also provide details on how chosen metrics are already being tracked (e.g., when and how they are reported, how frequently they are updated, etc.) and make recommendations for how the 6|18 Initiative team can access data and track its own progress, such as by creating its own 6|18 Initiative measurement dashboard.

Conclusion

Medicaid representatives partnering with public health peers to advance 6|18 Initiative evidence-based prevention interventions play a crucial role in many activities, including but not limited to: intervention planning and promotion, policy implementation, messaging, and metrics development. Given the many hats that Medicaid officials can wear — payer, policy developer, contractor, evaluator — they offer a wealth of knowledge and experience that complements their public health counterparts' skills and resources.

ADVANCING IMPLEMENTATION OF THE CDC'S 6|18 INITIATIVE

Through support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, in collaboration with a number of partners, is coordinating technical assistance to facilitate state Medicaid and public health implementation of the Centers for Disease Control and Prevention's (CDC) 6|18 Initiative. The CDC's 6|18 Initiative promotes the adoption of evidence-based interventions that can improve health and control costs related to six high-burden, high-cost health conditions — tobacco use, high blood pressure, inappropriate antibiotic use, asthma, unintended pregnancies, and type 2 diabetes. For more information and additional resources, visit www.618resources.chcs.org.