White Paper

Public Health Agency-Payer Collaboration to Address Hypertension

Partnerships between state health agencies and public and private payers are critical to effective statewide efforts to improve hypertension identification and control. This white paper describes opportunities, strategies, and example partnerships identified through the ASTHO Million Hearts Learning Collaborative.

Executive Summary

Achieving the goals of the Million Hearts initiative requires collaboration between a broad range of stakeholders, particularly state health agencies and public and private payers. States in the ASTHO Million Hearts Learning Collaborative have identified a range of opportunities for public health agencies and public and private payers to partner to support hypertension identification, management, and control. These opportunities fall under six broad strategies. States in the learning collaborative are already testing many of these strategies, and plan to explore others in the near future.

Summary of Opportunities

Build strong, leadership-led partnerships

- Identify mutual goals, priorities, and vision.
- Understand each other's motivators.
- Identify each partner's resources and skill sets.
- Leverage leader champions.
- Identify and engage other key stakeholders.

Share data to inform efforts

- Use payer clinical and claims data sets to identify individuals with undiagnosed or uncontrolled hypertension for targeted intervention.
- Use payer medication claims data to calculate medication adherence and identify members to support in improving adherence to antihypertension medications.
- Use geospatial analysis, mapping software, and other health information technology (IT) tools to identify priority populations and community resources to support self-management.
- Address barriers to data sharing.
- Explore additional opportunities including: continuing to leverage the ongoing shift toward regional and statewide health information exchanges; using public health agency data sources such as community health assessments to inform allocation of community benefit funds and payer investment in community-based prevention and management resources; and leveraging payer data sets to monitor population-wide metrics and performance measures.

Promote team-based care models

- Learn about, and promote, team-based care and care coordination initiatives.
- Support the workforce of community-based healthcare professionals.
- Explore additional opportunities including collaborating to develop and test models that leverage both payer and public health resources, as well as testing multi-payer care delivery models.

Engage patients and support self-management

- Engage patients, providers, and the public to provide education and raise awareness.
- Identify and address patient barriers to blood pressure self-management.
- Identify and promote evidence-based programs and services to support blood pressure self-management.
- Explore additional opportunities including: supporting blood pressure self-monitoring and engaging individuals through worksite wellness programs.

Implement payment models and policies

- Test payment models for community team-based care and care coordination.
- Measure and monitor performance.
- Update payer policy to improve coverage for care delivery models and services.
- Explore options to pay for the workforce of community-based healthcare professionals.
- Analyze and communicate the value proposition of prevention and coordinated care.
- Address challenges related to coordinating and aligning payment models, performance measures, and efforts across payers.
- Explore additional opportunities including: financing and incentivizing provider performance; leveraging existing Medicaid rules that support community prevention; and leveraging managed care contracts.

White Paper

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Background

The Million Hearts initiative focuses, coordinates, and enhances cardiovascular disease prevention activities across the public and private sectors with the goal of preventing one million heart attacks and strokes by 2017. Million Hearts aims to prevent heart disease and stroke by improving access to effective care, improving the quality of care for the "ABCS" of heart health,[i] focusing clinical attention on preventing heart attack and stroke, activating individuals to lead a heart-healthy lifestyle, and improving prescription and adherence to appropriate medications for the ABCS.[1]

In support of these goals, the ASTHO Million Hearts Learning Collaborative supports state health agencies and payers in 22 states to test strategies to identify, manage, and control hypertension. This white paper summarizes key findings from the learning collaborative about opportunities and strategies for state health agencies and payers to collaborate to achieve these goals. Findings are drawn from stakeholder panel discussions, state project reports, and key informant interviews with state health agency and payer leadership, staff, and other key stakeholders. These opportunities fall under five broad strategies: build strong, leadership-led partnerships; share data to inform efforts; promote team-based care models; engage patients and support hypertension self-management; and implement payment models and policies to support successful strategies.

Strategy: Build strong, leadership-led partnerships

Summary of opportunities:

- **Identify mutual goals, priorities, and vision**
- **Understand each other's motivators**
- **Identify each partner's resources and skill sets**
- **Leverage leader champions**
- **Identify and engage other key stakeholders**

Regardless of whether partnerships between state health agencies and payers are new or long-standing, cultivating a strong, sustainable partnership requires: identifying mutual goals and priorities; understanding each other's motivators; identifying each partner's resources and assets; leveraging leader champions; and identifying other key stakeholders to bring to the table.

Identify mutual goals, priorities, and vision. Identifying a common vision and goals will allow partners to coordinate existing initiatives or develop new joint initiatives that align with organizational missions. Initiatives that are particularly well-suited to this type of alignment include those that target individuals with multiple chronic conditions and advance population health management.

Understand each other's motivators. An important part of deepening partnerships is understanding the underlying motivations and priorities of each entity. For example, many state health agencies prioritize cardiovascular disease prevention when allocating resources. Payers are motivated by a variety of factors, including insurance regulator priorities, ratings systems that impact consumer perceptions (such as those used in Medicare advantage plans or managed care drug plans), accreditation, and performance reporting

[i] The ABCS are: Aspirin therapy when appropriate, Blood pressure management, Cholesterol control, and Smoking cessation. (Million Hearts. "The Initiative." Available at http://millionhearts.hhs.gov/aboutmh/achieving-goals.html. Accessed 5-28-2014.)

(e.g. the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set scores). Insurance regulators hold health plans accountable for coverage quality and cost priorities, and their priorities are particularly powerful motivators since they influence how payers invest resources. Regulator priority issues commonly include reducing preventable events such as hospitalizations or emergency department visits, managing specific chronic conditions such as diabetes, or addressing broad priority areas such as coronary heart failure. Understanding these priorities is important to identifying opportunities to collaborate around mutual priorities.

Spotlight: Identifying and aligning mutual goals

The Virginia Department of Health and Anthem (the largest health plan in the state) both support using electronic health record (EHR) data to identify individuals with hypertension, schedule a blood pressure check, and visit a pharmacist to assess medication adherence. They identified several future opportunities to collaborate around these similar goals, including: spreading lessons learned and sharing best practices with primary care providers across the state through the Virginia Health Quality Center (the quality improvement network for Virginia and Maryland); identifying provider champions; developing multimedia communications materials to support spreading best practices; and exploring opportunities to use successful strategies to target state employees with hypertension.

Identify each partner's resources and assets. Public health agencies and payers each bring unique strengths and resources to the table, and can identify how these resources can be used to complement, enhance, and sustain joint efforts. State health agencies can use the strategic planning process for state health improvement plans and other state-level chronic disease plans to engage payers and spread successful strategies related to healthcare transformation, payment, and healthcare coverage policies. For example, through the learning collaborative, BlueCross BlueShield Oklahoma joined the leadership team for Oklahoma's state health improvement plan. The lessons learned from the New York Million Hearts Learning Collaborative have been incorporated into the New York State Prevention Agenda 2013-2017 (the state health improvement plan), as well as New York's grant through the Centers for Medicare & Medicaid Services (CMS) State Innovation Models (SIM) initiative. In addition, identifying areas of overlap between partner activities is important to coordinate activities and ensure consistent messaging. For example, public health agencies and payer entities such as managed care organizations may both conduct direct outreach to the same population groups.

Leverage leader champions. Partnerships cultivated by agency and organization leadership, rather than staff, can effectively develop shared vision and goals that become part of one another's cultures over time. Leadership-led partnerships can also establish hypertension as an organizational priority, which may free up staff time to focus on implementing strategies rather than convincing leaders that hypertension should be a focus. The overall result is that hypertension becomes, and remains, an organizational priority over time.

Identify and engage other key stakeholders. Public health agencies and payers can collaboratively convene other key partners and stakeholders to identify common vision, map assets, and test promising strategies. Important stakeholders to engage include:

- State insurance regulators
- State Medicaid directors and their advisors (particularly Medicaid medical directors)

- Health plan medical directors
- Managed care organizations
- Pharmacists
- Pharmacy benefit managers
- Healthcare provider organizations, such as state medical associations, state primary care associations and offices, boards of pharmacy, hospital associations, and federally qualified health center networks
- Other regional or state networks, such as area health education centers
- Quality improvement organizations and other quality and health IT partners
- Other state-level health and healthcare experts and decision makers (for example, health and healthcare advisors to the governor)

State health agencies play an important role in convening these stakeholders to identify a shared vision and build a culture of public-private partnerships that include many different public and private payers.

State Spotlight: Convening cross-sector stakeholders to coordinate efforts

The North Dakota Department of Health supported the North Dakota Health Care Reform Review Committee, which was directed by the state legislature in House Bill 1035 to study federal rules relating to essential health benefits under ACA. As part of its role, the department convened public and private payers including Medicare, BlueCross BlueShield, Sanford Health Plan, and the North Dakota Public Employee Retirement System, to engage in strategic planning and determine methods for public health and private medical system collaboration. As a result, Sanford identified hypertension as a priority issue for collaboration with local public health agencies. The Sanford Occupational Health plan and local public health agencies now plan to implement coordinated prevention activities within worksites.

Strategy: Share data to inform efforts

Summary of opportunities:

- **Use payer clinical and claims data sets to identify individuals with undiagnosed or uncontrolled hypertension for targeted intervention**
- **Use payer medication claims data to calculate medication adherence and identify members to support in improving adherence to antihypertension medications**
- **Use geospatial analysis, mapping software, and other health IT tools to identify priority populations and community resources to support self-management**
- **Address barriers to data sharing**
- **Explore additional opportunities:**
  - **Continue leveraging the ongoing shift toward regional and statewide health information exchanges (HIEs)**
  - **Use public health agency data sources such as community health assessments to inform allocation of community benefit funds and payer investment**
  - **Leverage payer data sets to monitor population-level metrics and performance measures**

Public health agencies and payers each have proprietary data sets that can help identify individuals to target for hypertension control initiatives. State and local public health agencies collect and manage data

from a wide range of sources including: community health needs assessments; local, state, and national surveillance and prevalence data; clinical data from public health clinic EHR systems; and community resources. Payers collect and manage a variety of data on their members, including medical and prescription drug claims, member demographic information, and clinical data. In addition, some payers have community resource mapping platforms (such as the BlueCross BlueShield Association's Community Health Management Hub) that include data on social determinants of health and map a wide variety of community resources such as facilities for physical activity, healthy food access, social services, healthcare coverage enrollment, and primary care providers. By sharing data with each other, public health agencies and payers can effectively identify priority populations and target resources. States in the learning collaborative have tested a variety of strategies to share and use data to inform hypertension identification and control initiatives. Some of the methods for sharing data that have been tested include: reports from EHR, claims, pharmacy, and health information exchange data sets; presentations to healthcare and local public health networks; through quality reporting systems; and others.

Use payer clinical and claims data sets to identify individuals with undiagnosed or uncontrolled hypertension for targeted intervention. Through the learning collaborative, state health agencies and payers in several states have partnered to test using payer data to identify members to target for intervention. For example, United HealthCare Community Plan of Texas (UHC), which offers Medicare and Medicaid plans, analyzed claims and clinical data for UHC members in three counties and found 840 members with a hypertension diagnosis. UHC also identified members who are high utilizers of local emergency departments or other hospital services. Local health departments in the three pilot counties hope to use the data to engage these members' providers and develop outreach and follow-up interventions.

State Spotlight: Using medical claims data to identify undiagnosed or uncontrolled hypertension

The Oklahoma State Department of Health and the Oklahoma Health Care Authority (the state Medicaid agency) designed a reverse referral system to identify and generate lists of SoonerCare (Oklahoma Medicaid) beneficiaries with uncontrolled hypertension in the state Medicaid payment database, which includes 30,000 individuals. This process identified approximately 450 individuals in a five-county pilot region who met eligibility criteria. Oklahoma Health Care Authority then contacted their providers with a request to refer them to local public health care coordination services.

Use payer medication claims data to calculate medication adherence and identify members to support in improving adherence to antihypertension medications. Several states in the learning collaborative tested the usefulness of medication claims data to inform clinical hypertension management, monitor population-wide metrics, and inform care coordination and clinical management efforts. For example, in Vermont, the Department of Health partnered with BlueCross BlueShield Vermont and the Department of Vermont Health Access (the state Medicaid agency) to test a different measure of nonadherence—the medication possession ratio[ii]—and determined that this measure also had limited usefulness to inform clinical patient panel management. More information about Vermont's work in this area is available in an ASTHO case

[ii] MPR is one claims data-based metric to assess the degree of medication adherence. It is defined as the "sum of days' supply for all prescription fills in the period divided by number of days in the period." (Source: Durthaler J and Ritchey M. 2015. "Assessing and Addressing Medication Non-adherence at the Population and Clinic Level." Presented during ASTHO Million Hearts technical assistance call, March 12, 2015. Available at: http://www.astho.org/Prevention/Million-Hearts/Assessing-and-Addressing-Med-Adherence/. Accessed 7-21-15.)

study. In Wisconsin, WEA Trust, a not-for-profit organization offering health plans for Wisconsin public employees, analyzed its own claims data to identify members who were potentially non-adherent to their anti-hypertensive medications and conducted targeted outreach to raise awareness of their adherence and identify barriers to adherence. WEA Trust pharmacy staff analyzed the organization's database of 54,000 members and identified 2,300 members with a hypertension diagnosis. Of these members, 800 members were determined to be potentially non-adherent. WEA Trust mailed a letter to each of these members and their healthcare providers recommending follow-up. Staff received responses from 116 members and one provider, and 87 of these individuals were identified as adherent. Nearly one quarter (24%) of individuals contacted were determined to be, in fact, non-adherent. WEA Trust plans to refine the PDC algorithm to reduce false positives, develop a more robust documentation tool, and conduct a second round of analysis and outreach with pharmacy students. Staff also plan to establish partnerships with local public health departments to conduct further outreach and connect members to community resources to help them address barriers to medication adherence. WEA Trust hopes to expand use of this process to other chronic conditions and share the practice with the Wisconsin Department of Employee Trust Funds.

State spotlight: Using medication claims data to identify medication non-adherence

The New York State Department of Health Division of Chronic Disease worked with IPRO (New York State's quality improvement organization), the Health Center Network of New York, and the Office of Patient Quality and Safety (the state Medicaid claims data steward) to determine if two medication adherence measures (primary non-adherence, defined as never filling an initial prescription, and proportion of days covered (PDC)) could help providers support patient adherence to anti-hypertension medications. Due to the time lag in availability of claims data and the lack of data-sharing agreements between Medicaid and federally qualified health center partners, the department determined it was not feasible to use PDC rates to address individual medication adherence at a clinic level, and the data would be better used as a state-level surveillance tool. In addition, the department determined the primary adherence measure could not be reliably calculated at a statewide level due to lack of a single system capturing both prescribing and dispensing prescription information.

Use geospatial analysis, mapping software, and other health IT tools to identify priority populations and community resources to support self-management. Geospatial analysis can be particularly powerful tool to visualize data, such as preventable hypertension-related events such as hospital admissions or emergency department visits, in a way that can identify priority geographic areas. Geospatial analysis and mapping can also be used to identify community resources to support individuals in addressing barriers to managing their blood pressure.

In some cases, state health agencies have the data and capacity to conduct this type of analysis. For example, the Illinois Department of Public Health analyzed statewide hospital discharge data to calculate rates of hypertension-related hospital admissions by zip code. The department then created geographic information system maps of discharge rates by zip code, graphs of discharge rate trends over time, and stratified case counts by race/ethnicity and payer. The maps were used to engage local partners in multiple counties and inform local hypertension initiatives. A more detailed description of this work is available in an ASTHO state story.

In other cases, payers have both data and the capacity to analyze it. For example, the Alabama Department of Public Health partnered with BlueCross BlueShield of Alabama, Alabama Medicaid, and Cahaba Government Benefit Administrators (the state Medicare administrator) to access and analyze hypertension diagnosis data from payer databases. This data was used to generate data visualization maps (known as heat maps) that color-coded counties and zip codes based on hypertension prevalence. These maps were then used to identify geographical areas with higher percentages of individuals with hypertension to prioritize for intervention. In Texas, UnitedHealthcare care coordinators, member advocates, and other staff connect members to community services using a mobile app that includes directories of a broad range of resources including local financial institutions, food pantries, and homeless shelters.

State spotlight: Using health IT to map community resources and target interventions

The Arkansas Department of Health (ADH) uses the BlueCross BlueShield Association's (BCBSA) Community Health Management Hub to target chronic disease prevention interventions to at-risk populations. ADH uses the hub to: identify farmers markets to target for technical assistance to accept federal Supplemental Nutrition Assistance Program benefits and ADH's Double Dollars incentive program; identify healthy food retail sources; obtain chronic disease prevalence data to use to engage communities in targeting geographic areas and populations in need of services; and support public health nurses in identifying community-based health and social resources for patients such as housing, transportation, unemployment services, healthcare coverage enrollment, places to engage in physical activity, and community pharmacies.

Address barriers to data sharing. Payers and public health agencies may encounter challenges and barriers to sharing data. Some of these challenges relate to data security and data governance. Data governance relates to the processes, policies, and procedures that determine how data is managed, shared, and used. Many data sharing challenges relate to liability and security concerns about sharing protected health information[iii] in ways that could compromise data security or potentially violate laws such as the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule or Security Rule. Promoting data sharing requires addressing organizational culture that may hinder data sharing, as well as establishing strong data governance structures. Many organizations have their own internal data governance processes in place, but may not have any for sharing data externally.[2] Addressing data governance issues for shared data often requires establishing data sharing agreements between a variety of partners including state and local public health agencies, state Medicaid agencies, and private payers. For example, the Alabama Department of Public Health's (ADPH) Bureau of Health Promotion and Chronic Disease developed a memorandum of understanding with the Alabama Medicaid Agency to allow ADPH access to state Medicaid data. A variety of other examples of data sharing agreements from states and partner organizations are available on the ASTHO Million Hearts Tools for Change website.

Explore additional opportunities. Payers and public health agencies identified several additional future opportunities for payers and public health agencies to partner to share data and use it to drive action. These opportunities include:

[iii] The HIPAA Privacy Rule defines "protected health information" as individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral, or paper) by a covered entity or its business associates, excluding certain educational and employment records. (Source: National Institutes of Health. "What Information is Protected by the Privacy Rule?" Available at https://privacyruleandresearch.nih.gov/pr_07.asp. Accessed 6-2-2016.)

- Supporting the ongoing shift toward regional and statewide health information exchanges (HIEs) by contributing data and learning how to access and extract data for analysis. Several states in the learning collaborative have tested sharing and extracting data from HIEs, but many additional opportunities remain.
- Supporting development and implementation of all payer claims databases, to facilitate access to medical and medication claims data across payers within a state.
- Using public health agency data sources such as community health assessments to inform allocation of community benefit funds and payer investment in community-based prevention and management resources.
- Leveraging payer data sets to monitor population-level metrics and performance measures. This is discussed more in the following sections.

Strategy: Promote team-based care models

Summary of opportunities:

- **Learn about, and promote, team-based care and care coordination initiatives**
- **Support the workforce of community-based healthcare professionals**
- **Explore additional opportunities:**
  - **Collaborate to develop and test models that leverage payer and public health resources**
  - **Test multi-payer care delivery models**

Public health agencies and payers can collaborate to identify promising healthcare delivery models that connect clinical, public health, and community resources. These models may involve community team-based care delivery, care coordination, and referral and follow-up. Several specific opportunities to promote these models are described below.

Learn about, and promote, team-based care and care coordination initiatives. Public health agencies and payers can jointly promote healthcare delivery models that support population health management, chronic disease prevention, and healthcare cost reduction. Some of these models include:

- Team-based care that involves community-based healthcare professionals (sometimes called healthcare extenders) such as public health nurses, community health workers, promotoras, emergency services personnel, community pharmacists, parish nurses, and others.
- Care coordination or case management services that connect patients with resources in the community or clinic to help them manage their hypertension.

These models may originate from payers, primary care clinics, or public health agencies. In Oklahoma, the Oklahoma State Department of Health supported local health departments and primary care providers to implement a community-based care coordination model (Heartland OK) that used public health nurses to coordinate and refer patients to local community resources and connect with their providers. This initiative is described in more detail in an ASTHO case study.

Public health agencies and payers can also promote each other's care coordination services and incorporate them into their own referral systems. For example, public health agencies can raise awareness among providers that payer care coordination services are available to covered patients. They can also refer eligible individuals who access public health clinics to care coordination services.

Support the workforce of community-based healthcare professionals. Community-based healthcare professionals engage with community members who may not otherwise access the healthcare or public health systems. They deeply understand the barriers and challenges individuals face to managing their hypertension and other chronic conditions and provide important opportunities to identify and refer to care individuals with undiagnosed or uncontrolled hypertension. Public health agencies and payers can jointly identify opportunities and barriers within their states to growing this workforce, communicate the benefits of and build support for these professionals, and explore financing models. Two specific opportunities include: communicating information about existing payer coverage for these healthcare providers (such as Medicaid preventive services benefits); and addressing issues related to accreditation, training, and professional scope of practice.

Explore additional opportunities.

These include:

- Designing and testing models that leverage both payer and public health resources, such as care coordination systems, outreach activities, and population health management through medical neighborhoods.
- Testing multi-payer care delivery models. State health agencies can play an important role in convening public and private payers to discuss opportunities to collaborate and coordinate to test such models. CMS's SIM Initiative and other demonstration models may offer lessons learned about how multiple payers can overcome historic barriers to sharing resources, data, and agreeing on a protocol or model.

Strategy: Engage patients and support hypertension self-management

Summary of opportunities:

- **Engage patients, providers, and the public to provide education and raise awareness**
- **Identify and address patient barriers to blood pressure self-management**
- **Identify and promote evidence-based programs and services to support blood pressure self-management**
- **Explore additional opportunities:**
  - **Support blood pressure self-monitoring**
  - **Engage individuals through worksite wellness programs**

Engaging patients and providing direct support to help them manage their blood pressure is a critical strategy for public health-payer partnerships. Several key opportunities for public health agencies and payers to expand support for blood pressure self-management are described below.

Engage patients, providers, and the public to provide education and raise awareness. Payers and public health agencies can work together to engage patients, providers, and the general public to raise awareness about hypertension and educate individuals on how they can monitor and manage their blood pressure. Increasing members' knowledge of chronic diseases such as hypertension and ways to prevent or manage them could result in long-term cost savings. In this area, public health agencies may be a particularly valuable partner for payers. Payers may lack the capacity to conduct this type of outreach and could benefit from public health agencies' access to communities with higher risk of hypertension and other chronic conditions. Public health agencies can also coordinate with managed care organizations, which may conduct similar types of outreach, to ensure consistent messaging about coverage for services to support blood pressure management and strategies to self-manage blood pressure. Payers can develop their own policies to support this type of outreach and engagement.

Identify and address patient barriers to blood pressure self-management. Many individuals face barriers that reduce their ability to manage their blood pressure, such as lack of transportation or stable housing, or financial issues. Public health agencies often have deep understanding of these factors and, armed with insights from payer data (such as medication adherence data), can help identify and address each individuals' unique challenges to managing their blood pressure. Some payers also focus on addressing these underlying social determinants of care. For example, United Healthcare Community Plan of Texas partners with affordable housing units and homeless advocacy coalitions in two cities to identify homeless members and connect them to healthcare services.

Identify and promote evidence-based programs and services to support blood pressure self-management. Providing individuals with knowledge and resources to track and manage their blood pressure themselves is an important opportunity. Specifically, public health agencies and payers can:

- Identify and promote evidence-based programs to support healthy lifestyles and chronic disease self-management. States in the learning collaborative have promoted programs including the Stanford Chronic Disease Self-Management Program, the American Heart Association's Check. Change. *Control.*, and CDC's WISEWOMAN. Both payers and public health agencies may offer additional programs.
- Expand access to services that improve medication adherence. In addition to lifestyle change programs, public health agencies and payers can promote evidence-based interventions and services that support medication adherence, such as medication therapy management (MTM). MTM[iv] is an effective, evidence-based set of pharmacist-delivered services that is highly effective at supporting better patient medication self-management, improving clinical outcomes, and reducing healthcare costs for diabetes and other chronic conditions. In 2015, an ASTHO expert roundtable identified expanding access to, and use of, MTM services, as a key opportunity to improving medication adherence for a broad range of conditions, including hypertension. State health

[iv] MTM refers to a group of services pharmacists offer to help patients better manage their drug therapy regimens and address medication-related issues. MTM has five elements: medication therapy review, personal medication records, medication action plans, intervention/referral and documentation, and follow-up. (Source: Rodriguez de Bittner M. "P3 Program Progress Report: January 1, 2011 through June 30, 2012." University of Maryland School of Pharmacy. 2012.)

agencies and payers can encourage broader MTM adoption by exploring opportunities to establish and improve MTM reimbursement policies.[3] Specific policy opportunities are discussed in the following section.

Explore additional opportunities. Other potential opportunities key stakeholders identified include:

- Supporting blood pressure self-monitoring.
- Engaging individuals through worksite wellness programs. Several states in the learning collaborative have worked with employers, including public school systems, large manufacturing companies, and the energy sector, to offer blood pressure screenings and referral to MTM services. In addition, state health officials can leverage the purchasing power of states to explore opportunities in state employee health plans.

Strategy: Implement payment models and policies to support successful strategies

Summary of opportunities:

- **Test payment models for community team-based care and care coordination**
- **Measure and monitor performance**
- **Update payer policy to improve coverage for care delivery models and services**
- **Explore options to pay for the workforce of community-based healthcare professionals**
- **Analyze and communicate the value proposition of prevention and coordinated care**
- **Address challenges related to coordinating and aligning payment models, performance measures, and efforts across payers**
- **Explore additional opportunities:**
    - **Finance and incentivize provider performance**
    - **Leverage existing Medicaid rules that support community prevention**
    - **Leverage managed care contracts**

Increasingly, national initiatives such as CMS's SIM, the Medicaid Innovation Accelerator Program, the Comprehensive Primary Care Initiative (CPC), and Comprehensive Primary Care Plus (CPC+, beginning in 2017), support state efforts to advance payment and service delivery reforms that emphasize prevention, care coordination, and population health. These strategies require collaboration across payers and a shift toward accountability based on outcomes rather than services delivered. States in the learning collaborative have explored a variety of approaches to pay for and communicate the economic impact of strategies identified in previous sections. These opportunities are described below.

Test payment models for community team-based care and care coordination. Healthcare reform efforts continue to shift focus toward improving patient outcomes through better healthcare quality rather than volume of services delivered. These value-based purchasing (sometimes called pay for performance) models encourage a more holistic approach to managing patient health by focusing on overall health status improvement, reducing use of high-cost healthcare services (such as preventable hospitalizations or emergency department visits) and increasing overall cost savings. ASTHO national partners have identified several emerging payment models that focus on patient outcomes and involve a team-based care

approach, including: health homes, bundled payments and episode-based payments, accountable care organizations, and other shared savings and pay for performance models.[4] Funding these models will require payers to introduce flexibility in the types of services covered, the providers who deliver services (such as pharmacists, community health workers, and public health nurses), and the settings in which services are delivered. These payment models will also require high-functioning data systems and capacity to monitor performance and track outcomes.[5] Many of these models are currently being tested and many additional opportunities exist to pilot novel models.

States in the learning collaborative are testing various payment mechanisms to finance team-based care delivery models that include clinical, public health, and community resources. Across these models, public health agencies can act as a facilitator, convener, and connector to bring together clinical and community partners at the local or state level. They can also help initiate or strengthen collaboration between regional payers and community health plans. Finally, state health agencies can help communicate existing payment options for clinical hypertension management services. For example, in 2014, the District of Columbia Department of Health conducted an awareness-raising campaign promoting use of Medicare billing codes to provide intensive behavioral therapy to patients with or at risk for cardiovascular disease or obesity. After the campaign, use of these codes among providers in D.C. increased by 1,000 percent.

State Spotlight: Partnering to test community team-based care payment models

The Oklahoma State Department of Health and BlueCross BlueShield of Oklahoma tested a value-based allocation model that paid providers and the care coordination team for patients who successfully completed the Heartland OK program (a community-based care coordination model, described in previous sections) once their blood pressure was brought under control. Partners encountered challenges in finalizing necessary contracts with providers that prevented full implementation of the test and gained valuable insight into limitations and barriers around contractual agreements that will inform future strategies around payment for chronic disease prevention and management.

Measure and monitor performance. Measuring performance is a critical component of pay for performance payment models. Payers, providers, and other stakeholders must be able to measure and monitor the quality of care delivered and whether or not it improves patient health outcomes and overall healthcare costs.

Payers already use performance measures to inform adoption of care delivery models and provider incentive payments. For example, state Medicaid agencies increasingly work with managed care organizations to design and implement team-based care models within their provider networks that require providers meet certain performance benchmarks.[6] State health agencies also use performance measures to monitor progress in achieving the goals of state health improvement plans, other chronic disease plans, SIM grant activities, and CDC cardiovascular disease prevention-funded initiatives. Aligning hypertension quality and performance measures across stakeholders can streamline and strengthen focus on blood pressure control, as well as build reporting capacity. With input from CDC and four learning collaborative states, ASTHO developed a white paper discussing challenges and opportunities to align and leverage hypertension clinical quality measures.

Public health agencies and payers can collaborate to identify shared performance measures that are meaningful benchmarks of provider performance and also useful to inform population health initiatives. They can also partner to identify assets and infrastructure available to support achieving these benchmarks, including robust data systems, as discussed in previous sections.

Update payer policy to improve coverage for care delivery models and services. Both public and private payers establish policies that govern coverage of services, providers, and settings. State health agencies can help strengthen policy support for evidence-based services that improve blood pressure control, such as mediation therapy management (MTM). Policies that improve MTM reimbursement may expand reimbursement for pharmacists to deliver MTM services and relax criteria for eligibility. Other important opportunities include updating and refining the criteria prescription drug plans can use for defining MTM services (particularly through Medicare Part D), and addressing quality improvement and implementation considerations. A number of states are testing strategies to address these opportunities. Existing programs such as BlueCross BlueShield CareFirst's MTM program and Maryland's Patients, Pharmacists Partnerships (P^3) program could serve as valuable models.[7] In addition, public health agencies and payers can collaborate to address policy barriers for patients refilling their anti-hypertension medications. Finally, state health agencies and payers can institutionalize the process for soliciting and incorporating state health agency input and perspectives to inform the process for reviewing and updating payer policies. The Indiana Office of Medicaid Policy and Planning (OMPP) is institutionalizing direct involvement of the Indiana State Department of Health in its policy review and research process. OMPP has a standardized process for researching potential impacts of proposed policy and coverage

State Spotlight: Adopting hypertension as a payment category

In Vermont, as a result of exploratory work to calculate population-level medication adherence rates using Medicaid and BlueCross BlueShield Vermont claims data, the Vermont Department of Health catalyzed state-level discussion through the Green Mountain Care Board[i] that led to adoption of the National Committee for Quality Assurance's Controlling High Blood Pressure measure as a payment category for shared savings programs among commercial and Medicaid accountable care organizations across the state.

State Spotlight: Using claims data to advocate for Medicaid policy change

In collaboration with the New York State Office of Health Insurance Programs, the New York State Department of Health is promoting adoption of a 90-day pharmacy benefit for anti-hypertension medications by Medicaid managed care plans within the state. The department conducted a literature review and analyzed Medicaid claims data to determine the potential health and cost impact of providing a 90-day supply of anti-hypertension medication. The Medicaid claims data analysis found that Medicaid members who consistently received a 90-day or higher supply of anti-hypertensive medications had a higher adherence rate based on the proportion of days covered measure compared to those Medicaid members who consistently received a 30-day or less supply of medication. The analysis also investigated other outcomes, such as preventable hospital admissions due to hypertension and a controlling high blood pressure measure. However, the data was inconclusive due to the small number of Medicaid members who received a 90-day supply of medication. The department presented findings to medical directors and pharmacy directors of Medicaid managed care plans across the state. Partners continue to discuss health plans' concerns about adopting the benefit, which include cost, waste, and patient safety issues.

changes that involves soliciting input from stakeholders including managed care organizations, clinical and research partners, state boards, and organizations. OMPP is beginning to involve the department's clinical experts in this process, to help address a gap in clinical expertise within OMPP itself. OMPP plans to incorporate the department into its written procedures for soliciting input and feedback. It is currently updating its procedures.

Explore options to pay for the workforce of community-based healthcare professionals. States are exploring a variety of mechanisms to reimburse these community-based healthcare professionals and their services. Some states have addressed this through legislation. For example, Minnesota has state regulations that cover care coordination and patient education services offered by community health workers who meet specific criteria (including training and supervision requirements). Other states in the learning collaborative plan to explore these type of opportunities. North Dakota plans to explore opportunities to cover services offered by emergency medical services to support blood pressure self-monitoring. These services are available thanks to recently passed legislation recognizing emergency medical services personnel as eligible providers for health-related services provided to recipients of medical assistance. States may also choose to test payment models for community health workers based on successful pilots. For instance, a pilot in New Mexico used a capitated payment structure that significantly reduced claims and payments, emergency department visits, and inpatient admissions among super-utilizer Medicaid patients, along with overall cost savings of more than two million dollars.[8]

Analyze and communicate the value of prevention and coordinated care. Community team-based care and care coordination models aim to help patients manage their conditions effectively and reduce overall healthcare costs. Building stakeholder support for these models requires making their business case, particularly by analyzing return on investment (ROI) or cost-effectiveness. Public health agencies and payers can work together to analyze and communicate the economic impact of these models to inform discussions about cost and cost savings.

Several states in the learning collaborative are testing these strategies. For example, the Michigan Department of Community Health is partnering with HealthPlus of Michigan (a local health plan located in Flint) to analyze the ROI of using community health workers, medical technicians, and the Diabetes Prevention Program. Partners hope to use the findings to gain support from financial partners.

State Spotlight: Calculating the ROI of community team-based care models

The Oklahoma State Department of Health calculated the ROI of Heartland OK (the community team-based care coordination model described above) using ASTHO's ROI analysis tool. A detailed description of the process, as well as the specifications used to calculate the Heartland OK ROI, are available here. The department estimated that, assuming a 45 percent reduction in cardiovascular disease-related preventable hospitalizations, community-based care coordination models such as Heartland OK could result in an ROI of $160.00:$1.00. The department uses this estimate to engage payer partners and other key stakeholders about the value of investing in community-based care coordination models, particularly those in which local public health nurses serve care coordination roles. The department anticipates additional opportunities to build on this initial analysis, including analyzing the ROI of Oklahoma's SIM grant activities to test provider incentive payments. Staff incorporate economic impact as a standing agenda topic when addressing reimbursement for lifestyle change programs during state-level diabetes committee meetings.

While promising, conducting these type of analyses for chronic disease prevention is still an emerging practice. Both public health agencies and payers in the learning collaborative identified several challenges to this work, including lack of understanding among colleagues and other key stakeholders about what the analyses actually mean, as well as challenges in selling the value of initiatives that will result in long-term cost savings but may not necessarily result in immediate fiscal impact.

Address challenges related to coordinating and aligning payment models, performance measures, and efforts across payers. Key informants identified coordinating multi-payer efforts as an important challenge to address. Private payers have different inherent motivators than do public payers, and they also work with different types of healthcare providers. For example, while federally qualified health centers serve patient populations that are often at higher risk for certain conditions, they receive federal funding through different payment structures than other primary care clinics. These differing payment structures present challenges for state Medicaid agencies to support adoption of team-based care models statewide.[9]

Explore additional opportunities to address payment and policy. Key informants and national experts have identified several other potential opportunities for public health-payer partnerships to address payment and financing:

- Coordinate with other national initiatives. In addition to those already mentioned (SIM, CPC and CPC+, and the Medicaid Innovation Accelerator Program), CDC's 6|18 Initiative presents an important opportunity. This initiative involves partnerships with health care purchasers, payers, and providers to use evidence-based strategies to improve health outcomes and reduce cost for six high-burden health issues (tobacco use, hypertension, diabetes, asthma, unintended pregnancy, and healthcare-associated infections).
- Finance and incentivize provider performance. Payers in the learning collaborative are considering testing incentive payments for providers who meet benchmarks for blood pressure control across their entire patient panel.
- Leverage existing Medicaid rules that support community prevention. Some existing rules include: the Medicaid preventive services rule change to allow reimbursement for non-licensed providers; the Free Care rule change that allows schools to bill Medicaid; chronic health homes; waivers and other CMS programs such as SIM, Health Care Innovation Awards, and the Delivery System Reform Incentive Payment program that cover additional services, providers, and settings; and Medicaid coverage of tobacco quit lines.[10]
- Leverage managed care contracts. This strategy may offer opportunities to incentivize delivery of high-quality care, care coordination, and other strategies.[11,12]

Conclusion

States in the ASTHO Million Hearts Learning Collaborative are testing a wide variety of strategies that leverage public health-payer partnerships to improve hypertension identification, management, and control. They have also identified a number of additional potential opportunities to test in the future. State health agencies can play a range of important roles in identifying, implementing, spreading, and sustaining these strategies.

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