ROADMAP APPENDIX B: STATE PLANNING DOCUMENT

State goals must drive strategies for childhood obesity prevention. This State Planning Document is included as part of the overall Pathways through Medicaid to Prevention toolkit as a tool for states to identify and prioritize goals for prevention. It is an appendix to the *Roadmap of Medicaid Prevention Pathways* (Roadmap). The potential range of prevention pathways is broad and exists along a continuum: from individual-level engagement, with services targeting individual Medicaid enrollees, to population-level engagement, with services targeting an entire geographic area including non-Medicaid enrollees. A state could implement multiple interventions along the continuum to achieve its goals.

Output from the Planning Document will help states use the Roadmap to identify potential Medicaid authorities available for addressing childhood obesity and other chronic diseases. Before states use the Roadmap to identify pathways for implementation, this Planning Document can help them clearly identify goals by answering the questions posed. The Planning Document presents a menu of questions; not all questions will be relevant to all states. States can also use the Planning Document as a resource for engaging local community and other partners in identifying opportunities to collaborate on common goals.

I. Goals and Objectives

This section of the Planning Document identifies key considerations and corresponding questions to help set goals and objectives for prevention initiatives.

A. Define the Problem

It is important to start by identifying the problem the state wants to address, so that the policy solution is tailored to the need. This also provides the basis for the state to communicate how the strategy will meet needs.

Questions

1. What are the prevention and health care needs and gaps the state wants to address?
2. What health disparities exist in the state, particularly among children?
3. What data or other evidence are available to determine this?
4. Who is the target population? To what extent would the intervention target individuals who are not covered by Medicaid in addition to those who are?
5. What services will meet the identified needs?
6. Who are the potential providers of those services?
7. Is there agreement—among the Medicaid agency, other state agencies, and potential state and local partners—regarding the prevention and health care gaps to be addressed? How does this vary between local communities?
8. Is there gubernatorial or other high-level support for addressing the problem?
9. How do the identified priorities align with initiatives that have already been established as state priorities?

B. Set Goals and Objectives

A clear set of goals and objectives will help to ensure that the intervention is responsive to the problem, and will help partners identify common ground.

Questions

1. What are the prevention or population health goals you want to achieve?
2. What are the specific outcomes?
3. What stakeholders—internal and external to state government—would it be helpful to work with to achieve your objectives?
4. Does the state need to designate a lead agency or person for planning?

C. Nature of the Intervention

The response to the questions above regarding the problem, goals, and objectives will help define the intervention. The following questions address how the intervention may build on existing initiatives and considerations for evaluation.

Questions

1. What are the best options for achieving goals (see Roadmap)?
2. How can the intervention promote health equity among the state's children?
3. What state and local stakeholders need to weigh in on the nature of the interventions?
4. Is there a system in place to measure progress? If so, what are the metrics for measuring progress? If not, what needs to happen to create this?
5. Can an evaluation of the initiative be conducted? If so, what are the indicators/data available for evaluation?
6. How can findings from other relevant evaluations inform this initiative?
7. Is the starting point a new intervention, or an effort to leverage new Medicaid funds for expansion of existing interventions?

II. Strategy for Implementation/Designing Your Approach

Having defined your state goals and objectives, this section moves on to identify specific strategies and/or initiatives or programs to achieve them. Please refer to the Roadmap.

A. Baseline Authorities

Assessing baseline Medicaid authorities will help states understand current options for implementation without needing to apply for new authorities.

Questions

1. What relevant authorities does your state already have in place (e.g., Section 1115 waiver)?
2. What relevant administrative structures does the state already have in place (e.g., community health worker credentialing systems)?
3. Are there examples from other states that would provide helpful models?
4. Will the state need to rely on grant funding opportunities that are constrained by grant cycles or future availability?

B. Delivery System Flexibility

A state's key consideration in determining the pathway for coverage of preventive services is the extent to which its Medicaid delivery system is characterized by fee-for-service (FFS) versus managed care payment models. In a FFS system, or with primary care case management (PCCM) that builds on a FFS structure, the state Medicaid agency determines the preventive services and population health strategies that will be covered. Twenty-two states use at least some FFS to pay for services. However, the majority of Medicaid enrollees are covered by comprehensive risk-based managed care organizations (MCOs).

MCOs can cover preventive services delivered by non-licensed but otherwise qualified providers in many different settings and can opt to cover extra preventive services beyond what is required by FFS Medicaid. Designing prevention initiatives in a managed care environment is easier due to the degree of flexibility MCOs have to cover additional services and credential non-traditional providers. In addition, MCOs may be better positioned to leverage relationships with providers. There is a key distinction between a single MCO opting to offer additional services, and a state requiring MCOs to cover additional services through contractual or regulatory requirements; the latter provides states more authority to enforce requirements.

Questions

1. Where does the state's existing delivery system fall on the spectrum of FFS payment models to comprehensive risk-based managed care?
2. For managed care environments, what is the process and timing for adding new requirements to managed care contracts?
3. What are incentives for MCOs to add services voluntarily (e.g., market share, public relations)?
4. How stable is the managed care market? How competitive is the market?

C. Sphere of Influence

The process of prioritizing goals helps foster early buy-in among stakeholders as well as cross-agency collaboration, which is particularly important for upstream prevention activities. One consideration is the different sphere of influence of the state Medicaid agency in moving from individual-level to population-level activities. As the target population expands beyond Medicaid enrollees in a geographic area, many other partners to the state Medicaid agency will have a role in improving health (e.g., the housing authority). The state Medicaid agency will potentially share control of the initiative with others, including private sector partners. Medicaid could play a crucial role as a convening entity, bringing key stakeholders together to jointly address the population-based strategy.

It will be important to be specific about what Medicaid would and would not pay for. Medicaid would pay for certain preventive services (e.g., housing support services), but there are other needed services for which Medicaid might—through case management on an individual basis or as a convening entity on a broad basis—connect to, but not finance (e.g., housing costs).

Questions

1. Who are the partners that can be leveraged?
2. What are the strong relationships that currently exist?
3. What is the degree of gubernatorial or legislative leadership driving collaboration?
4. What existing state or local public health initiatives align with Medicaid prevention priorities? What is the level of engagement by state or local public health agencies with the Medicaid agency?
5. What are the partners' needs to make the case for investment in initiatives (e.g., mission alignment, clear ROI)?

D. Funding Availability and Other Enablers

A major barrier to Medicaid funding for any intervention is the ongoing strain on Medicaid budgets, and state budgets more generally. The availability of other state funds, for example from public health or education agencies, can also accelerate or impede efforts. Other factors include the ability of the state to share data across agencies, and the availability of electronic health records and health information exchanges.

Questions

1. What is the magnitude of cost of the proposed intervention?
2. What are potential sources of funding (e.g., funding external to the state Medicaid agency, potential future federal grant funds)? To what extent can these funds leverage Federal Medical Assistance Percentages (FMAP)?
3. What is the availability of providers, and how does it vary throughout the state?
4. What resources are available for primary care practice transformation, if needed?
5. What data are needed for this strategy?
6. Are electronic health records and health exchanges available?
7. Is there a need to share data across agencies from FFS Medicaid or MCOs? If so, what other leadership needs to be involved to set priorities related to data needs? What other factors in the state and local environment will accelerate or impede prevention efforts?

E. Approaches to Return on Investment

Treating obesity on an individual level presents unique challenges. One of the hurdles for states is demonstrating return on investment (ROI), both from a federal perspective as well as in negotiations between a state and MCO. From a federal perspective, savings from prevention initiatives may not be realized in the short term, potentially impacting the state's ability to calculate and meet budget neutrality requirements for a Section 1115 waiver, among other challenges. From an MCO perspective, costs for services outside of required benefits may not be reflected in their capitation payments, and the MCO may not realize savings from obesity prevention efforts during the course of a member's enrollment.

States may consider different options for approaching ROI. First, a portfolio approach to prevention efforts—addressing asthma, diabetes, heart disease, or other chronic conditions at the same time as childhood obesity—may balance savings across different interventions. Second, states may want to consider the entire family in their calculation of ROI. Parents significantly affect a child's nutritional habits, and may be overweight or obese themselves. Parents may experience more immediate benefits affecting ROI calculations. Another consideration may be assessing the internal rate of return, to incorporate both the time value of money and variable returns in calculating the rate at which an investment breaks even.[1] Inclusion of quality of life measures may also help make the case for obesity prevention investments.

Questions

1. What timeframes are necessary for showing ROI?
2. How prevalent is coverage of parents by the same MCO as children (facilitating family calculation of ROI from an MCO perspective)?
3. How does Medicaid churning in eligibility and enrollment affect ROI?

1. Borner KB et al. "Making the Business Case for Coverage of Family-Based Behavioral Group Interventions for Pediatric Obesity." *J Pediatr Psychol*. 2016 Sep;41(8):867-78. Available at: https://www.ncbi.nlm.nih.gov/pubmed/26743573