

## **State Medicaid and State Public Health Interview Guide** **Mapped to CDC's 6 | 18 Initiative Case Studies Specific Aims**

Public reporting burden of this collection of information is estimated to average 1 hour and 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329-4027; ATTN: PRA (0920-XXXX).

### **Specific Aims:**

1. Describe the **facilitators and barriers to implementation** of the 6 | 18 Initiative interventions selected by the participating state.
2. Describe how **collaborative activities** between the health care and public health sectors **informed changes** to Medicaid payment policy change and increased utilization of evidence-based preventive services.
3. Describe how **participation in CDC's 6 | 18 Initiative informed changes** to (or accelerated progress towards) Medicaid payment policy change and increased utilization of evidence-based preventive services.
4. Describe how **state-level factors** (e.g., organizational state-level infrastructure, federal investments in improving the delivery of state-level health care) **facilitated, or posed barriers to, implementing changes** to Medicaid payment policy change and increasing utilization of evidence-based preventive services.

### **Intended Use:**

Findings from this information collection will be used:

1. To describe, disseminate, and scale best practices to participating and non-participating states
2. For program improvement of the CDC's 6 | 18 Initiative

**NOTE TO REVIEWER:**

This discussion guide is not a script and therefore will not be read verbatim. The moderator will use these questions as a roadmap and probe as needed to maintain the natural flow of conversation. Question probes are *italicized*.

**Introduction**

□ Thank you for taking the time to speak with us! My name is [name] and I am from [CDC/George Washington University]. My colleague, [name], from [CDC/George Washington University], will take notes. Some time ago, you should have received an email describing the purpose of this interview. As a brief reminder, we are interested in learning about: 1. Facilitators and barriers to implementation of the 6 | 18 Initiative interventions; 2. How collaboration between public health and Medicaid contributed to success (i.e., implementing changes to Medicaid payment policy and increasing utilization of evidence-based preventive services); 3. How CDC’s 6 | 18 Initiative supported progress; and 4. How state-level factors facilitated, or posed barriers to, success. You will be given an opportunity to review products before they are shared publicly. Also, may we record our discussion to ensure our notes are accurate? Do you have any questions or comments before we begin?

[If **no**] We respect your decision and will make every effort to capture your responses in our notes. Therefore, I do ask that you speak clearly. Also, I may ask you to repeat something if we did not get it.

[If **yes**] Thank you. Let’s begin.

Interview guide items	Probes	Aims			
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<b><u>Background and Objectives</u></b>					
□ We’d like to learn a little more about you and your role in the 6   18 Initiative.					
1. Please briefly describe your role in [agency], as well as your role in the Medicaid-public health collaboration around [condition(s)] in [state], in the context of the 6   18 Initiative?	N/A		•	•	
2. How did [agency] come to collaborate with [counterpart agency] around [condition(s)], to make changes in state Medicaid payment policy, and/or increase utilization of evidence-based interventions as part of the 6   18 Initiative?	<i>Reasons for collaboration: Leadership-buy in, prior history of collaboration on other projects, external factors (e.g. 6   18, health reform), cuts to public health spending</i>		•	•	
3. Are Medicaid and Public Health housed in the same agency? If so/if not, has this structure either facilitated or challenged your ability to work together on the 6   18 Initiative? How?	<i>Or, do the Medicaid Agency and Public Health Department report to the same supervisor in the Governor’s office?</i>	•			

Interview guide items	Probes	Aims			
		1	2	3	4
4a. What goals, related to making changes in state Medicaid payment policy, did your agency identify when you initiated work on the 6 18 Initiative? 4b. What goals, related to increasing utilization of evidence-based interventions, did your agency identify when you initiated work on the 6 18 Initiative?	<ol style="list-style-type: none"> <li><u>Payment policy change</u>: E.g., pass a State Plan Amendment (SPA), make billing changes, perform a baseline coverage and utilization assessment</li> <li><u>Increased utilization</u>: Expand awareness of payment change among providers and/or enrollees; focus on high utilizers</li> </ol>		•	•	
5. How did your two agencies determine shared goals when you decided to apply for participation in the 6 18 Initiative?	Who were the decision makers in the state, both in defining shared goals and in deciding to apply for this opportunity?		•		
<b>Progress and Determinants of Success</b>					
□ My next set of questions will help us learn about [state's] successes and challenges related to your 6 18 work around [condition].					
6a. What are the biggest "successes" or accomplishments you've seen so far in your 6 18 work, around Medicaid payment policy change? 6b. Around increased utilization of evidence-based interventions?	<ol style="list-style-type: none"> <li><u>Payment policy change</u>: SPA passed or in progress, Medicaid MCO contracts re-negotiated, changes in billing, payment pilots; undertaking similar efforts in conditions outside of 6 18</li> <li><u>Increased utilization</u>: Provider and member engagement, increased claims of preventive services, decreased claims related to preventable conditions</li> <li><u>Other</u>: Baseline coverage and utilization assessments</li> </ol>		•	•	
7a. What major resources or facilitators do you think were critical to making Medicaid payment policy change? 7b. To increasing utilization of evidence-based interventions?	<ol style="list-style-type: none"> <li>Or, what steps did you have to take, and/or what factors were present, to help your team make Medicaid payment policy change? Increase utilization of evidence-based interventions?</li> <li>Or, do you have thoughts on whether the structure and environment in your state is particularly suited in a way that may be different from elsewhere, and how those factors may have facilitated Medicaid payment policy change? Increased utilization of evidence-based interventions?</li> <li><u>Payment policy change</u>: <ol style="list-style-type: none"> <li>Resources, competency drivers, supporting staff in gaining technical knowledge and skills: technical assistance, tools from other states</li> <li>Fit: aligned with existing state priorities; timing, windows of opportunity</li> </ol> </li> <li><u>Increased utilization</u>: <ol style="list-style-type: none"> <li>Resources, systems intervention drivers: CDC division funding and TA</li> </ol> </li> </ol>	•	•	•	•

Interview guide items	Probes	Aims			
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	<ul style="list-style-type: none"> <li>b. Resources, competency drivers: implementing staff have technical support and expertise needed</li> <li>c. Facilitative administration drivers: staff time allocated for work, organizational infrastructure to support collaboration and implementation</li> <li>d. Leadership drivers: leadership buy-in, implementation climate)</li> </ul>				
<p>8a. What challenges have you experienced in your efforts to make Medicaid payment policy change?</p> <p>8b. To increase utilization of evidence-based interventions?</p> <p>8c. How have you addressed these challenges?</p>	<p>Or, looking back, what would you have done differently when making changes to Medicaid payment policy? When increasing utilization of evidence-based interventions?</p> <ol style="list-style-type: none"> <li>1. <u>Payment policy change:</u> <ul style="list-style-type: none"> <li>a. Fit: competing priorities, lack of alignment with existing priorities and programming</li> <li>b. Facilitative administration drivers: lack of organizational infrastructure for work (e.g., mechanism to communicate and resolve challenges across agencies or teams)</li> <li>c. Gaining technical knowledge and skills: requires time, resources</li> </ul> </li> <li>2. <u>Increase utilization:</u> <ul style="list-style-type: none"> <li>a. Leadership drivers, technical: lack of funding, capacity, resources for implementation and/or data collection and monitoring</li> <li>b. Organizational drivers: lack of organizational infrastructure for work;</li> <li>c. Decision support data system drivers: lack of access to timely data in order to support decision-making</li> </ul> </li> </ol>	•			
<p>9a. Has participation in the CDC's 6 18 Initiative helped your team make Medicaid payment policy change? If so, how?</p> <p>9b. Increase utilization of evidence-based interventions? If so, how?</p>	<ol style="list-style-type: none"> <li>1. <u>Payment policy change:</u> <ul style="list-style-type: none"> <li>a. Fit: demonstrated that 6 18 interventions align with current state efforts;</li> <li>b. Evidence: 6 18 team provided evidence of intervention effectiveness and cost-effectiveness data to improve quality and control costs;</li> <li>c. Resources and competency drivers: 6 18 team and partners shared information, like business</li> </ul> </li> </ol>	•		•	

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	<p><i>practices/toolkits/contract language</i></p> <p>2. <u>Increase utilization:</u></p> <p>a. <i>Readiness and capacity: 6  18 team helped assess state readiness and capacity to collaborate to increase utilization of evidence-based interventions</i></p> <p>b. <i>Systems intervention drivers: strengthened collaboration between public health and Medicaid; increased profile/attention to the topic; increased accountability/greater impetus to move forward</i></p>				
<p>10a. Are you involved with other state-wide initiatives to improve the delivery of state-level health care? If so, to what extent have those other initiatives influenced and/or accelerated your work to make Medicaid payment policy change?</p> <p>10b. To increase utilization of evidence-based interventions?</p>	<p>1. <u>State-wide initiatives:</u> <i>E.g., 1115 waivers, 1332 waivers, SIM, DSRIP, CDC funding from divisions, state priorities, and foundation funding</i></p> <p>2. <u>Extent of influence on payment policy change:</u></p> <p>a. <i>Facilitative administration drivers: created organizational infrastructure for quality improvement work</i></p> <p>b. <i>Leadership drivers: strengthen staff and leadership motivation to work on 6  18 payment policy change; raise visibility of condition; cultivated “champions” outside state public health and Medicaid who can help support the work</i></p> <p>c. <i>Resources and competency drivers: subject matter expertise and familiarity with condition, payment reform, and quality improvement</i></p> <p>3. <u>Extent of influence on increasing utilization:</u></p> <p>a. <i>Fit: Leadership and staff leverage existing efforts by aligning 6  18 work with existing work</i></p> <p>b. <i>Leadership drivers, technical: state-wide initiatives fund coverage change so that state can take the next step to focus on implementation</i></p>	•			•
<p>11a. Are there other contextual factors within your state that either facilitated or challenged your ability to make Medicaid payment policy change?</p> <p>11b. Increase utilization of evidence-based interventions?</p>	<p>1. <u>Payment policy change:</u></p> <p>a. <i>Fit: alignment with current initiatives, priorities</i></p> <p>b. <i>Leadership: leadership works to align 6  18 activities with the overall mission of the organization</i></p> <p>2. <u>Increase utilization:</u></p> <p>a. <i>Leadership drivers, technical: team and leaders designated to manage day-to-day implementation processes</i></p>	•			

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	b. <i>Facilitative administration drivers: mechanisms exist to communicate challenges to leadership, and receive feedback on addressing challenges</i>				
<b><u>Evolution of Partnerships</u></b>					
□ As you know, building and expanding partnerships is an important part of the 6   18 Initiative. We would like to understand how the partnership between your agency and [counterpart agency] has evolved, if at all, since you began working together around [condition(s)]. We are interested in both your work around the specific partnership around [conditions], and also your overall collaborative relationship.					
12a. What specific roles and tasks did your agency take on in the collaboration with (other agency) when making Medicaid payment policy change? 12b. What roles and tasks did (the other agency) take on in the collaboration when making Medicaid payment policy change?  12c. What specific roles and tasks did your agency take on in the collaboration with (other agency) when increasing utilization of evidence-based interventions? 12b. What roles and tasks did (the other agency) take on in the collaboration when increasing utilization of evidence-based interventions?	<p><b><u>Public health roles and tasks, e.g.:</u></b>  <u>Payment policy change:</u>  Provide evidence, resources:</p> <ol style="list-style-type: none"> <li>1. <i>Highlighted the most compelling evidence of health and cost improvement from the interventions to address high burden and high cost conditions</i></li> <li>2. <i>Contributed condition-specific subject matter expertise and developed tools to enable effective implementation of evidence-based clinical and community interventions for use by the health care system</i></li> <li>3. <i>Translated epidemiologic evidence into data to develop actuarial and cost calculations as well as business cases to create a compelling message for key decision makers</i></li> </ol> <p><u>Increase utilization:</u></p> <ol style="list-style-type: none"> <li>4. <i>Competency drivers: Created and evaluated awareness campaigns targeting providers and patients</i></li> <li>5. <i>Systems intervention drivers: Built the infrastructure for and maintained linkages with community services, to increase uptake of the intervention</i></li> <li>6. <i>Evidence, decision support data system drivers: Used surveillance data to identify hotspots (high burden and high cost conditions) and to track progress towards improvement in health and costs</i></li> <li>7. <i>Systems intervention drivers: Acted as a neutral convener and broker to coordinate activities across partners</i></li> </ol> <p><b><u>Medicaid roles and tasks, e.g.:</u></b>  <u>Payment policy change:</u></p>		•	•	

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	<p>8. <i>Competency, systems intervention drivers: Highlighted the available and sector-specific levers and processes needed to improve benefits coverage</i></p> <p>9. <i>Evidence, decision support data system drivers: Developed a business case for prioritized evidence-based interventions to share with key decision makers to ensure their inclusion as covered benefits</i></p> <p><u>Increase utilization:</u>  <i>Competency, systems intervention drivers:</i></p> <p>10. <i>Highlighted the available and sector-specific levers and processes needed to promote increased uptake of services, and/or deploy programs that deliver these interventions</i></p> <p>11. <i>Partnered and coordinated with Medicaid managed care plans to strengthen coverage and utilization of benefits</i></p> <p>12. <i>Meaningfully engaged providers and used incentives to ensure patients' referral to and utilization of the covered benefits or new programs</i></p> <p>13. <i>Decision support data systems drivers: Set targets for patient uptake of the interventions or benefits and tracked progress towards those goals in health and cost terms</i></p>				
<p>13a. What has changed, if anything, in the way Public Health and Medicaid work together, when making Medicaid payment policy change?</p> <p>13b. When increasing utilization of evidence-based interventions?</p>	<p>1. <u>Payment policy change:</u></p> <p>a. <i>Fit: increased visibility for how priorities are aligned across agencies</i></p> <p>b. <i>Systems intervention drivers: more regular communication across agencies</i></p> <p>2. <u>Increase utilization:</u></p> <p>a. <i>Decision support data system and systems intervention drivers: More data sharing, e.g., to understand effects of payment policy changes and/or track increased utilization of evidence-based interventions; increased consultation with other agency when planning outreach campaigns, executing quality improvement initiatives</i></p> <p>b. <i>Resources: increased leveraging of resources across agencies</i></p>		•		

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<p>14a. What challenges have you encountered when collaborating to make Medicaid payment policy change?</p> <p>14b. When collaborating to increase utilization of evidence-based interventions?</p> <p>14c. How have you addressed these challenges?</p>	<p>1. <u>Payment policy change</u>:</p> <p>a. Leadership drivers: lack of support or commitment from state leadership (e.g., governor) or partners; view that existing initiatives are sufficient, and no new collaboration or initiatives are needed</p> <p>b. Evidence, fit: lack of a sufficiently compelling return on investment (ROI) for certain stakeholders</p> <p>c. Resources, competency (training, coaching) drivers: lack of model collaborations to emulate</p> <p>2. <u>Increase utilization</u>:</p> <p>a. Leadership, facilitative administration drivers: competing priorities, time or resources are not allocated specifically for this work</p> <p>b. Changes were needed in roles and routines: e.g., increased coordination, information sharing</p>	•	•		•
<p>15. If applicable: Did other sectors support you in the 6   18 Initiative goals of making changes in Medicaid payment policy, and/or increasing utilization of evidence based interventions? If so, which sectors, and how were they involved?</p>	<p>1. <u>Sectors</u>: Medicaid managed care organizations, Quitline administrators, community partners, health systems</p> <p>2. <u>Involvement</u>: Implementation, data collection and reporting, provider and member engagement</p>	•	•	•	
<p><b><u>Partnerships with Medicaid Managed Care Organizations (MCOs)</u></b></p> <p>□ We recognize that Medicaid Managed Care Organizations (MCOs) are vital partners in implementing the 6   18 interventions. We would like to learn more about the relationship between your team and MCOs, and how that may have been affected by 6   18.</p>					
<p>16. How many MCOS are in your state? Who are they? (If not publicly available)</p>	<p>1. MCO names</p> <p>2. National, regional, or local</p>				
<p>17. How often do you interact with them, and in what capacity?</p>	<p>1. Monthly or quarterly meeting on quality metrics, performance improvement projects</p> <p>2. Annual contract negotiation</p>				
<p>18. Is there an MCO quality improvement initiative going on in your state on this topic? Can you tell us more about that? How has that supported other 6   18-related activities?</p>	<p>1. Quality metrics</p> <p>2. Performance improvement projects focused on 6   18 conditions</p> <p>3. MCOs are required to report data to state Medicaid</p> <p>4. Track patients when they move from one MCO to another</p>				

Interview guide items	Probes	Aims			
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	5. <i>Common formulary across MCOs</i>				
19. Have you noticed changes in how Medicaid and MCOs work together, since partnering with 6 18 and starting efforts to increase utilization of preventive services?	1. <i>State team provides training and resources to MCOs to support implementation</i> 2. <i>MCOs now meet a more uniform standard</i>				
<b><u>Future Efforts and Suggestions for Improvement</u></b>					
□ For our final set of questions, we will shift gears to your thoughts about the future, and suggestions for improvement.					
20. How will you collaboratively monitor the health and cost outcomes that will result from changes in Medicaid payment policy and/or increased utilization of evidence-based interventions?	1. <i>Data sharing</i> 2. <i>Harmonizing existing data across different sources</i>			•	
21a. Do you anticipate sustained collaboration across sectors to make changes in Medicaid payment policy? What specific steps would you take to sustain the working relationship? What factors may affect these plans? 21b. Do you anticipate sustained collaboration across sectors to increase utilization of evidence-based interventions? What specific steps would you take to sustain the working relationship? What factors may affect these plans?	1. <u>Payment policy change:</u> a. <u>Sustained collaboration, steps to sustain relationship:</u> Work towards Medicaid payment policy change for non-6 18 conditions b. <u>Factors affecting plans:</u> Changing policy environment 2. <u>Increasing utilization:</u> a. <u>Sustained collaboration, steps to sustain relationship:</u> Work towards increased utilization of evidence-based interventions for non-6 18 conditions b. <u>Factors affecting plans:</u> Changes in funding levels, competing priorities	•		•	•
22a. Is there anything additional that CDC can do to support your work (i.e., accelerate your ability to make changes in Medicaid payment policy, and/or increase utilization of evidence-based interventions)?	1. <i>Work to align approaches across federal agencies</i> 2. <i>Streamline technical assistance</i> 3. <i>Provide more peer state examples</i>	•		•	
23. Is there anything else you would like to share that we haven't already asked you about in the interview?	1. <i>What are you proudest of, when you think about this collaboration and your work with 6 18?</i> 2. <i>What lessons learned would you share with other states? What do you wish you had known when you started? What advice would you give to a state that is starting out where you started?</i>	•	•	•	•
□ That was my final question. Thank you for taking the time to speak with me today.					

**References:**

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