Americans with OUD by promoting integration of SUD treatment and mainstream health care. Innovations such as Medicaid Health Homes, Coordinated Care Entities, Accountable Care Organizations and Patient Centered Medical Homes, allow a broad range of services to be reimbursed under a unified budget, thus creating incentives to increase integration and coordination of care across SUD, mental health, and medical care needs. Given the complex needs of most SUD patients, especially those with OUD, integrating services with primary care and other specialty services, as well as community-based social supports, is considered crucially important.

A TREMENDOUS OPPORTUNITY FOR STATES

States that have expanded Medicaid are better positioned to address the opioid epidemic. However, many of the states that have been hardest hit by the opioid epidemic have not expanded Medicaid (i.e., Maine, Missouri, Oklahoma, Tennessee, and Utah). While extending coverage is extremely important, 10 states that accepted Medicaid expansion limit access to OUD medications. Most concerning, however, are the nine states that have not expanded Medicaid and do not cover methadone, the best studied and most effective treatment of OUD.[7]

The ACA represents a tremendous opportunity for states to address the opioid epidemic. Of course, the ACA raises many implementation challenges. States are still learning how to use these numerous and varied tools, and how to determine which tools are most effective. That said, most of the ACA reforms are optional and allow significant state discretion. As a result, despite crucially important reforms that have enabled some states to mount comprehensive responses to the opioid epidemic, other states continue to lag behind. Nonetheless, the Obama administration will have made a difference. AJPH

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This editorial was written prior to the November 2016 election, the results of which are likely to produce changes to the ACA. Whatever those are, they would not minimize the positive impact the law has already had on the lives of people with substance use disorder as described in this editorial.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

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Population Health During the Obama Administration: An Ambitious Strategy With an Uncertain Future

No innovations in health policy of the Obama Administration have attracted as little attention from Democratic and Republican office holders, journalists, and researchers as its efforts to improve population health. Considerable research over many years has found that the most effective and efficient policies and professional practices for improving the health of populations and the individuals who constitute them address making access to health care and social services more equitable; raising the quality of education, diet, and housing, and encouraging individual physical activity; increasing the availability of jobs that offer a living wage and security; reducing and remediating drug and domestic abuse; and eliminating toxins from the environment.[1] The effectiveness of the Obama Administration's prioritization of population health has, however, not yet been evaluated rigorously; and as we write this commentary, its political future is uncertain.

TRIPLE AIM STRATEGY

Explicit attention to population health in the Obama Administration began with the appointment of Donald Berwick as Administrator of the Centers for Medicare and Medicaid Services

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(CMS) in July 2010. Although Title IV of the Affordable Care Act (ACA; Pub L No. 111–148), enacted in March of that year, established new programs and authorized funding for the "Prevention of Chronic Disease and Improving Public Health," it mentioned neither population health nor its multiple determinants.[2]

Berwick and his colleagues at the Institute for Healthcare Improvement (IHI) had, in 2008, published an article in *Health Affairs* advocating a strategy they called the Triple Aim to transform the American health care system. They derived this strategy from IHI's several decades of leadership in measuring and improving the quality of care. The Triple Aim is "better care for individuals . . . better health for populations . . . [and] reducing *per capita* costs." In his first major address as CMS Administrator, Berwick proposed to achieve the Triple Aim with policy that included "attacking the upstream causes of so much of our ill-health, such as poor nutrition, physical inactivity, and substance abuse."[3]

Triple Aim remained a priority for CMS after Berwick left the agency in December 2011, as a result of Senate Republicans refusing to confirm his nomination. Guidelines for provider organizations seeking designation as accountable care organizations required adherence to the three aims. So did several generations of guidelines for the State Innovation Models Initiative, the Delivery System Reform Incentive Payment waivers, and the Comprehensive Primary Care Initiative. The goal of the latter, for instance, is to establish a "medical home model" that would "deliver better care to result in a healthier patient population." It attempts to achieve this by linking, through capitated payments, primary, secondary, tertiary and long-term care, and such related services as renovating homes to reduce the risk of falls and adult day care that has social as well as clinical purposes.[4]

COMMUNITY HEALTH NEEDS

Another population health initiative of the Obama Administration was the implementation of the new section 501(r) of the Internal Revenue Code, introduced in the ACA. This section requires tax-exempt hospitals to assess "community health needs" at least once every three years. The Internal Revenue Service, assisted by guidance issued by the Centers for Disease Control and Prevention, requires hospitals to use these assessments as the basis of "implementation strategies" that respond to "identified needs." Although hospitals may define their "community" geographically or by identifying "target populations," they may not exclude "medically underserved, low income or minority populations." They must, moreover, "seek input" into the design of assessments and strategies "from public health departments and members of underserved and/or minority populations." Failure to comply with these regulations—especially the prompt adoption of strategies—could result in a hospital paying an excise tax of $50 000 as well as revocation of its tax-exempt status.[5]

IMPLEMENTATION

CMS programs based on the Triple Aim have grown rapidly. In mid-2016, 838 accountable care organizations had been designated in all 50 states and the District of Columbia; 28 states, comprising 61% of the US population, had State Innovations Model Initiative programs; six states received Delivery System Reform Incentive Payment waivers, which require the goals of the Triple Aim to be the core objective of health delivery reform; and the Comprehensive Primary Care Initiatives included 2188 providers linked to 450 primary care practices and 38 public and private payer organizations.

Most of the governmental organizations, provider groups and health systems participating in these programs define their populations as the people to whom they provide care and their caregivers.[6] Similarly, leaders in some of the numerous communities in IHI's original Triple-Aim Program sponsor initiatives aggregating populations served by different provider organizations to collaborate in improving their health status.[7] Unlike the IHI, however, which is uncomfortable about involvement in making public policy, CMS has facilitated leaders of its new projects sharing their experience of improving population health with each other and with policymakers.

Impediments to the new priority accorded to population health remain, despite evidence of successful implementation of the Triple Aim. The most important impediment is opposition to it in many states. At this writing, 19 states have not expanded eligibility for Medicaid, as mandated in the ACA but made voluntary by the Supreme Court in 2012. Some states have gone further in their opposition to Medicaid expansion and the Triple Aim. Georgia, for instance, prohibits any public agency, its employees, and contractors from advocating or attempting to influence citizens to support Medicaid expansion or a state-based exchange. Most of these states are also reluctant to embrace the CMS programs that include improving population health among their goals.

A final generalization is that, although Medicaid and Medicare now reimburse for integrated action to address some socioeconomic determinants of population health, others are excluded. On the one hand, the new CMS programs pay for some nutrition, food security, and housing-related services; on the other, these programs do not address chronic homelessness, joblessness, and poor-quality education.

A POLARIZED ENVIRONMENT

There is evidence that a growing, if still limited, number of Americans support policy that addresses the broad determinants of population health. But these supporters and their organizations are widely dispersed among states and local jurisdictions. As a result, they have usually been overpowered in the politics of policymaking by interest groups representing manufacturers of prescription drugs and medical devices, advocacy groups that promote research and treatment of persons with particular diseases, as well as lobbyists for particular health professions and the agricultural and food industries.

The current polarization of US politics has, moreover, itself

become a determinant of population health. If this polarization persists, population health will, in many jurisdictions, continue to be constrained by inequality in access to services and unwarranted variation in their quality. As a result of litigation and potential changes in legislation, political polarization could also reverse or inhibit policy to link exposure to toxins in air and water that create health risks for populations.

AN OPEN FUTURE

Nobody can predict the future of the prioritization of population health by the Obama Administration. This Administration could, eventually, be praised for initiating national policy to address the multiple determinants of health. The Triple Aim could be described as the strategic concept that legitimized policy to improve population health through the convergence of health care, public health practice, and professions and public bodies that address its other determinants. As a result of the recent presidential election, the ACA could be repealed or substantially revised. Any speculation that the recent history of according priority to population health will be a first step toward improving it is now only fantasy. AJPH

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