HMA

HEALTH MANAGEMENT ASSOCIATES

Wyoming Coordinated Care Study

PRESENTED TO

WYOMING DEPARTMENT OF HEALTH

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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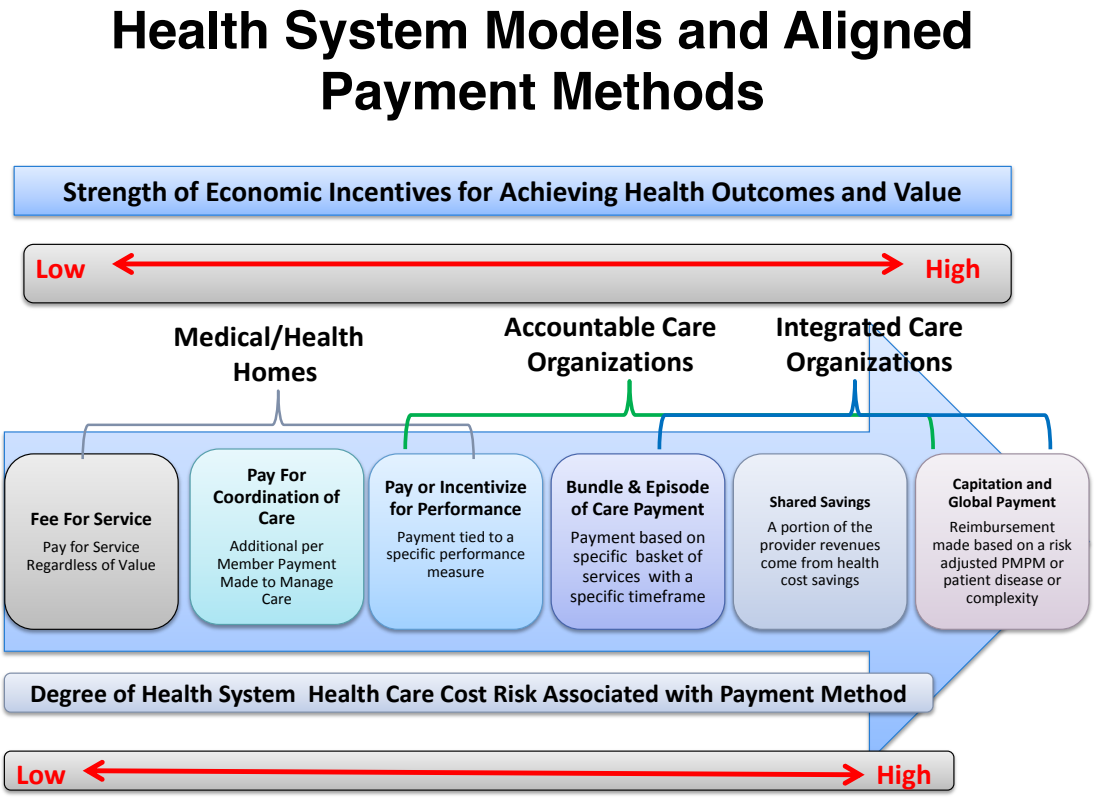
Executive Summary

In 2012, the Wyoming Legislature enacted Senate Enrolled Act No. 58, which required the Wyoming Department of Health (WDH) to analyze the cost drivers within Medicaid and identify areas within the program that would benefit from redesign. In response to this mandate, WDH recommended three packages of reforms that could be implemented.

One of its recommendations was to study whether it would be beneficial to move some or all of the Medicaid population into managed care. To ensure comprehensive analysis of the feasibility of this change, during the 2013 General Session, Senate Enrolled Act No. 82 (SEA0082) was passed. SEA0082 directs the WDH to study the use of managed models of care for some or all of the people enrolled in the Medicaid program with the goal of delivering care of the same or better quality as currently delivered, while also reducing costs.

In studying managed care models, Wyoming is pursuing a path that many other states already have or are currently pursuing. To address increasing Medicaid spending, states are looking to existing and new forms of managed or coordinated care and payment reforms. As shown in Figure 1 below, the Medicaid managed care continuum includes programs with no or very low provider risk such as Primary Care Case Management (PCCMs), with gradually increasing levels of provider risk through models such as Patient Centered Medical Homes (PCMHs), Health Homes and Accountable Care Organizations (ACOs), all the way to full-risk managed care with very high provider risk. Most states have some level and type of managed care; only two currently do not have any, Alaska and Wyoming.

Figure 1



Source: HMA

A. Why States Pursue Managed Care Models

Many states are expanding their managed care programs to include new services, such as behavioral health and long-term care (LTC), as well as new populations, such as those with disabilities, and people who have both Medicare and Medicaid. In addition to managed care, many states are also pursuing new care coordination models, including Patient Centered Medical Homes (PCMHs), Health Homes, and Accountable Care Organizations (ACO). In 2013, 25 states implemented care coordination models, and in 2014, there will be 33 states doing so. While states are pursuing a variety of models, the most common is the Health Home, created under the Patient Protection and Affordable Care Act of 2010 (ACA) to focus on people with mental health and substance use disorders, as well as those with multiple chronic conditions. More than one-third of states are pursuing Health Homes. Many states also are coupling these enhanced care coordination models with new reimbursement mechanisms geared toward paying more for quality rather than quantity. These various shared savings/share costs, pay–for-performance, and incentive programs all increase provider risk to some degree.

States often focus on specific sub-populations within the Medicaid program when creating these initiatives. Individuals with both chronic conditions and mental health issues, for example, are often the highest utilizers and highest-cost enrollees. By focusing on and coordinating care for these individuals, states hope to improve care and reduce spending.

States are pursuing delivery and payment reforms for a variety of reasons, but the four most common include:

- State Medicaid agencies want to address the growth rate in Medicaid spending by creating payment models that encourage quality improvement, reward value over volume, as well as by providing greater budget certainty.
- States are developing delivery system approaches that establish medical homes for enrollees – attempting to coordinate care across providers and facilitate beneficiaries' access to care.
- States desire to further integrate physical and behavioral health care and reduce service fragmentation to improve care and health outcomes, and improve efficiency and cost-effectiveness of care.
- States want to take advantage of the financing opportunities made available through the ACA such as planning grants for PCMHs, and enhanced federal matching funds for home and community based services, Health Homes, and other models of care coordination and quality improvement.

B. WDH's Approach to the Study

In conducting the study, WDH used the term "coordinated care" in lieu of "managed care" because the term is broader and includes newer models such as Health Homes, PCMHs, and ACOs. The WDH defined managed or coordinated care as "any system of healthcare delivery that focuses on management of healthcare services with the intent to provide integrated and coordinated care at a lower cost." Under this definition, managed or coordinated care could take many forms and be accomplished using various models and payment methods. The WDH did not focus on one model of managed or coordinated care or one type of payment method, and was most interested in models and payment methods that will work well within Wyoming's unique geography, provider community, and for the enrollees. In the summer of 2013, WDH used a competitive procurement process and selected Health Management Associates (HMA) to complete the study.

HMA conducted extensive research on managed and coordinated care models in place across the country and selected states for additional research and interviews with key Medicaid officials. The states chosen for analysis are similar to Wyoming in population, geography, infrastructure, and/or Medicaid enrollment. Other states that are dissimilar, such as Oregon, were chosen because of the innovative models currently being implemented. Wyoming's current initiatives were also identified and researched to determine how they would impact managed or coordinated models of care. Finally, HMA elicited extensive stakeholder feedback that included use of an e-mail inbox, conducting key informant interviews, holding five public forums, and coordinating two electronic surveys.

C. Models of Care

i. Recommended

HMA's care model recommendations are supported by the research, assessment of Wyoming's current initiatives, and stakeholder feedback. In making these recommendations, HMA considered the:

- Feasibility of the various managed or coordinated care models and value-based payment methods in Wyoming, given its large geography and sizable rural/frontier areas within the state.
- Administrative burden of implementing, managing, and monitoring each model.
- Degree to which vendors and providers are interested and would participate.
- Impact on Wyoming Medicaid enrollees and providers.
- Unique features of Wyoming's health care system, both its strengths and weaknesses.

HMA recommends that WDH pursue the two coordinated care models shown in Table 1. These models, implemented in concert with one another, build on one key initiative already underway in Wyoming – PCMHs.

Table 1

Model	Rationale for Recommending the Model
Targeted PCMH	• As Medicaid prepares to begin participation in the multi-payer effort already underway establishing and enhancing PCMHs provide a targeted group of high-utilizing and high-cost enrollees with enhanced care management through the PCMH structure.
Super Utilizer Program	• A small number of enrollees are considered "super utilizers" because of the level of services they use and the high cost of those services. Wyoming can create a care management model that provides very high-touch care management to these individuals, on top of the enhanced care coordination they would receive through a PCMH.

ii. Not Recommended

Also based on stakeholder engagement, care model research, extensive literature reviews, as well as Wyoming's unique characteristics, HMA recommends that WDH not pursue the care models shown in Table 2 at this time. As current initiatives begin to yield results and WDH has expanded both experience and expertise with those models, the state may want to reassess the feasibility of implementing some of these other models.

Table 2

Model	Rationale for Not Recommending the Model
PCCM	• Wyoming already is further along the managed care continuum than PCCM, with existing PCMHs and Medical Neighborhoods initiatives, and planning for Health Homes.
ACO	• Once the other initiatives currently underway or planned are stable and demonstrating success, Wyoming could identify appropriate candidates for further evolution to the ACO model. • ACO is still a relatively new model; Wyoming could benefit from lessons learned in other states as they roll out their ACOs.
ASO	• Wyoming already has a program that effectively is an ASO through its case management contract with Xerox Care and Quality Solutions (CQS). There may be opportunities for the state to modify its contract with Xerox CQS to better align it with other initiatives underway or expand the current scope of work to support and supplement current initiatives.
Full Risk Managed Care	• Research is mixed on the extent to which managed care can improve quality and save money for Medicaid enrollees, particularly in rural areas. • Provider participation is critical for Wyoming Medicaid and lack of providers willing to participate in risk-based managed care would be a significant obstacle for any managed care organization to establish a viable network • There is very little commercial managed care in Wyoming now, which would mean Medicaid would bear the brunt of laying the managed care groundwork in the state. • Other states that have moved to managed care recommend an iterative approach that builds on current structures – risk-based managed care would be a major transition and would require a substantial investment in infrastructure needed to successfully support it, meaning a longer time to achieve any real cost savings.

D. Next Steps

Given the above recommended models and considerable work that WDH already is doing, HMA suggests the following next steps, as detailed in Table 3.

Table 3

Next Step	Action Items
Continue the focus on successfully implementing the multiple efforts already underway or planned to integrate Wyoming's health care system, improve care coordination, and slow Medicaid cost growth	• The only new initiative Wyoming could consider is a super-utilizer program (SUP) built on the existing PCMHs to provide enhanced care coordination to the most expensive and high-needs enrollees (see above recommended models).
Create a strategic road map for all Medicaid reforms and care coordination initiatives	• WDH should create a strategic plan for how all of the current initiatives fit together. The roadmap should include: o All old, new, and planned care coordination activities and initiatives for the next three to five years. o Enrollees and providers that would be included in each initiative. o How WDH is connecting and leveraging each, including funding - whether state funds, federal funds, or other external funds. o The current status of each, as well as expectations for where they will be each year for the next five years. • WDH should share this roadmap with stakeholders as it is being developed to get their feedback before it is finalized and help to build their buy-in for the plan.
Conduct ongoing, comprehensive stakeholder outreach, education, and engagement	• WDH should continue to inform and educate stakeholders about the need for, and the value of integrated care coordination and management, what it means for them, and their roles and responsibilities. • WDH should create a comprehensive stakeholder education and engagement plan based on its roadmap (see above recommendations). The plan should identify specific groups of stakeholders and their needs, preferred modes of communication, level of understanding, ability to impact (positively and negatively) initiatives, their role in each initiative, and the messages and information they need from WDH.
Enhance and expand the necessary infrastructure	• Particularly because it is a largely rural and frontier state with shortages of most types of providers, Wyoming must continue to build and enhance the infrastructure needed to support all of its care coordination and management initiatives to fully realize their potential for quality improvement and cost savings. This infrastructure includes both information technology and data, as well as workforce development. • WDH should take a lead role in revitalizing and fully building out the state's Health Information Exchange (HIE).

	• WDH should work with providers to enhance and expand the use of the Total Health Record. • WDH should continue to support and expand the use of tele-health services. • Wyoming should consider building internal capacity or procuring services from a vendor to increase and enhance its capacity to use data to support program decisions. • Wyoming should continue and enhance its healthcare workforce development strategies.
Implement value-based payments	• For each of the initiatives underway or planned, WDH should consider moving more quickly to incorporate value-based payments for quality improvements, cost savings, or both. • As part of the roadmap, WDH should include specific reimbursement structures and timelines for each initiatives. • WDH also needs to build and expand its technical expertise in-house to manage and support new reimbursement options.

Section I: Overview of Legislation and Reports

During the 2012 Budget Session, the Wyoming Legislature passed Enrolled Act No. 58 (hereinafter SEA0058 or the Medicaid Options Study legislation). It requires the WDH to:

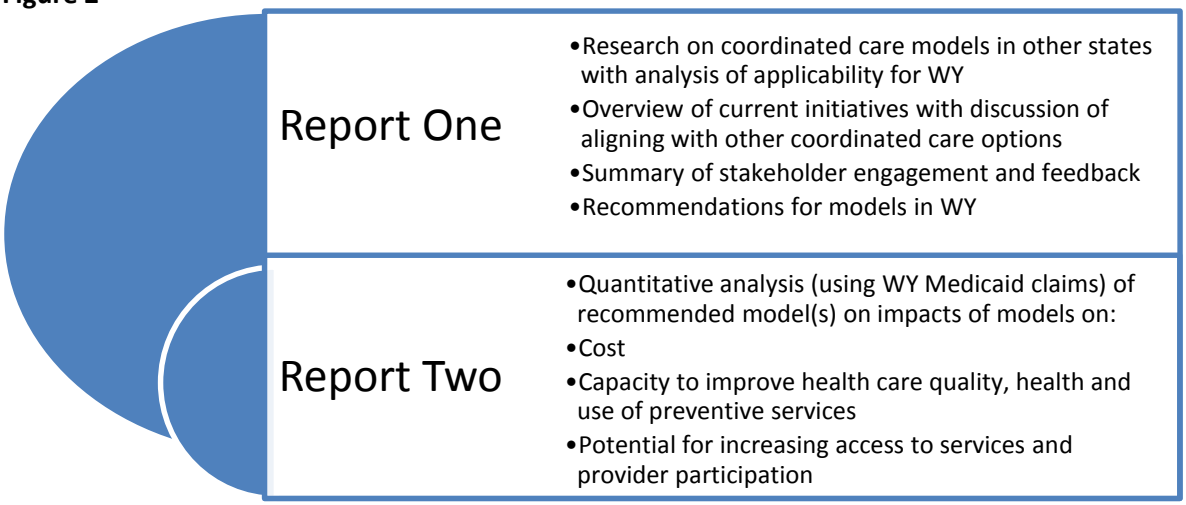
1. Analyze the cost drivers and identify other areas within the Medicaid program that may benefit from redesign.
2. Evaluate potential redesign of current Medicaid programs.
3. Evaluate the design of Medicaid programs mandated by the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, hereinafter referred to collectively as 'the health care reform acts.'

The WDH issued three separate reports. In the final report, the WDH identified areas where the Medicaid program would benefit from reform or redesign and recommended three packages of reforms that could be implemented. One of those recommendations was to study moving some or all of the Medicaid population into managed care. In response to the Department's recommendations, the Wyoming Legislature in the 2013 General Session required a study of managed care through Senate Enrolled Act No. 82, which specifically:

- Requires WDH to conduct "an evaluation of enhanced use of managed care using tiers of services and more intense management for high cost clients."[1]
- Requires WDH to "explore the use of managed care for all or a designated part of the Medicaid population, with the goal of delivering care of the same or better quality as currently delivered but at reduced cost."

The Care Coordination Study has two primary reports as described in Figure 2 below:

Figure 2



[1] The WDH is using the term "coordinated care" in lieu of "managed care" because the term is broader and includes newer models such as Health Homes (as authorized by Section 2703 of the Affordable Care Act), Patient Centered Medical Homes (though not new, use of it as a model has increased over the past five years), and Accountable Care Organizations.

This is the first report in the series. Report Two will be completed after discussion with WDH about the recommended models presented here.

Section II: National Trends and Coordinated Care Models

A. The Range of Managed Care Projects

Shortly after Medicaid was enacted in 1965, states began experimenting with different models of care, including capitated managed care.[2] Appendix A: Managed Care History and National Activities, provides an overview of key time-periods and activities in the growth of full-risk Medicaid managed care, as well as a number of other national trends for various types of care coordination models.

Today, states are:

- Expanding capitated managed care to all populations, including behavioral health and aged, blind, and disabled enrollees.
- Expanding to new geographic regions.
- Including additional services such as long-term care or behavioral health services, either through carve-out programs (FL and TX for long-term care, and CO and ID for behavioral health) or by integrating them into a capitated model already in place (TN and HI).
- Exploring ways to integrate services by including the services in the capitation payment and making managed care plans responsible, or by requiring establishment of MOUs or even contracts between providers.

B. Managed and Coordinated Care Models and Payment Structures

The remainder of Section II provides an overview of the different models of managed and coordinated care and the reimbursement methodologies states commonly use. When possible, data and findings from any research and evaluations are included. These models and payment methodologies, excluding fee-for-service (FFS), are described along the continuum, moving from least risk to greatest risk. Detailed information about each of these models can be found in Appendix B: Models of Care.

For each of the models described below, states may elect to "carve out" certain populations or benefits, instead covering them under another payment structure or specialized model. Populations that are often carved out of various models include those who receive special waiver program services, such as Home and Community Based Services (HCBS) or Developmental Disability services, those receiving long-term care services, individuals living in institutions, and individuals in PACE programs and those receiving hospice care. However, since some of these individuals are the most expensive and drive the highest utilization, many states are looking at ways to re-integrate them into their coordinated care programs, and enhance their case management across various providers through the better data sharing, communication and collaboration that these models support.

The most common benefit carve-outs have been for behavioral health, pharmacy, dental services, and non-emergency transportation. For example, behavioral health has been one of the more common carve-outs, developed from concerns that behavioral health services would get lost in the larger medical

[2] Michael Sparer, "Medicaid managed care: Costs, access, and quality of care," Robert Wood Johnson Foundation, *Research Synthesis Report*, No. 23. September 2012. http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html

component of care. However, states recently have begun to bring behavioral health back into their medical care programs with particular emphasis on integrating services and supports. Many states also are integrating long-term care and HCBS service requirements into their coordinated care models for the same reasons.

i. Primary Care Case Management

PCCMs are generally primary care providers or practices who are responsible for approving and monitoring the care of enrollees based on the specific criteria established by the state for the program. This model works well in rural areas because it does not require significant infrastructure or staff investments from providers who may have limited resources. A PCCM model can be managed by the state or by a contractor for relatively low administrative costs.

CMS does not require much oversight of a PCCM and the model can be implemented without requiring a waiver or extensive changes to a State Plan Amendment (SPA). Twenty-two states have PCCMs:

- 10 with PCCM only
- 22 with PCCM and risk-based capitated managed care

Providers usually are paid FFS plus a monthly care management fee (typically between $2 and $5 per member per month (PMPM)). Some states include pay-for-performance financial incentives (e.g., Pennsylvania's ACCESS Plus program). There is not a lot of evidence that PCCMs provide significant cost savings or quality improvements.

ii. Patient Centered Medical Homes (PCMHs)[3]

The PCMH is not a new concept, having been around since 1967. Yet it was not until 2007 that the American Academy of Family Physicians and three other medical associations issued guiding principles for PCMHs. That same year, the National Committee for Quality Assurance (NCQA) also issued specific standards that providers must meet to be recognized as a PCMH, setting a high bar for care delivery and coordination. Interest in the model has increased significantly in the last several years, including for both commercial health coverage and in Medicaid/Medicare.

PCMHs attempt to integrate care delivery for each patient, ensuring access to all needed services in a "whole person" approach. The PCMH model is distinct from a primary care practice or PCCM model in that the assigned provider team has responsibilities beyond coordination of medical services, such as ensuring after-hours access, maintaining electronic health records and tracking quality metrics, conducting comprehensive health assessments for all new patients, and proactively managing and reducing barriers for high-risk patients[4]. PCMHs are largely an expanded primary care medical model,

[3] For the purposes of this study a PCMH is a practice that has attained NCQA certification.

[4] Standards and Guidelines for Physician Practice Connections® – Patient Centered Medical Home (PPC-PCMH ™), NCQA, CMS version, October 6, 2008.
http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/detailed_standards.pdf

Federally Qualified Health Centers (FQHCs) or Community Health Centers (CHCs), and other primary care settings.

PCMH also is a model that can be viable in both urban and rural areas. Many states have used their existing PCCM infrastructures to build PCMHs, since they are fundamentally based on primary care practices, similar to PCCMs. The majority of states pay providers a PMPM care management fee, but the fees vary considerably from state to state and are often adjusted for patient age, acuity, and PCMH NCQA accreditation level (there are three levels). PCMHs do require an additional level of data access and sharing, as well as changes to how providers practice in a team-based environment.

The literature shows that cost-savings and quality improvements vary for PCMHs, but generally it appears that using the PCMH model to help target high-utilizer and high-cost enrollees is where states see the most potential for savings.[5]

iii. Health Homes

Health Homes are a new delivery system and payment model authorized by Section 2703 of the ACA. The program was designed to focus on enrollees with mental health and substance abuse issues, as well as multiple chronic conditions. There are specific statutory requirements for the target populations that can be enrolled and the services that must be provided, although CMS has allowed states some room to identify other conditions to include and definitions of the services their Health Homes will provide; these then must be detailed in the State Plan Amendment.

States may target geographic areas for focus, and unlike other Medicaid programs which must be implemented statewide, no waiver is needed for geographic implementation. To encourage states to pursue this model and to ensure sufficient funding is available, states can receive a 90 percent federal match for certain services for the first eight quarters of their program. Each time a state expands geographically or includes new conditions, eight more quarters of enhanced match are available to those individuals meeting the new criteria.

Health Homes differ from PCMHs in several fundamental ways:

- They are required to integrate physical and behavioral health services.
- They must target enrollees with specific high-risk behavioral health and chronic physical health conditions.
- They are required to extend coordination beyond medical services to social and community supports.
- They can be established in a variety of different kinds of providers, including behavioral health and non-traditional providers such as supportive housing programs; the focus is always on integrating multiple services.

Most states pay a PMPM for Health Home services, but some also are experimenting with other reimbursement methodologies, including shared savings, risk-adjusted payments, bundled payments, and capitation. Because of the level of service integration required, the number and types of providers participating, and the comprehensive reporting requirements from CMS, successful Health Homes need

[5] Susannah Higgins, MS; Ravi Chawla, MBA; Christine Colombo, MBA; Richard Snyder, MD; and Somesh Nigam, PhD, "Medical Homes and Cost and Utilization Among High-Risk Patients," American Journal of Managed Care, March 24, 2014. http://www.ajmc.com/publications/issue/2014/2014-vol20-n3/medical-homes-and-cost-and-utilization-among-high-risk-patients.

significant data collection, reporting and sharing capabilities. Additionally, all of these factors generally push participating providers to make substantial changes in their approaches to care delivery and support of the "whole person" needs across multiple providers, agencies, services and systems.

However, there is a growing body of evidence that Health Homes can result in significant impacts in quality and cost for their target populations.[6] Health Homes have seen care and cost improvements in reduced inpatient admissions, reduced emergency visits and reductions in pharmacy costs.

iv. Accountable Care Organizations (ACOs)

An ACO is an entity consisting of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of the care delivered. In many cases, the ACO is a provider-based organization, but in some cases, it is a managed care organization. The ACO model is most often associated with Medicare or, to a certain extent, the commercial market. However, 17 states have or plan to have Medicaid ACOs.[7] While the states have different names for their models – Coordinated Care Organization (Oregon), Regional Care Organization (Alabama), Regional Collaborative Care Organizations (Colorado) – they all have the same goal: improve population health and reduce spending, while providing care in a more coordinated and efficient manner.

The organizational structure of Medicaid ACOs differs from state to state and even within a state, depending on benefits, as well as participating providers and partners. Many ACOs are provider- or community-based. Despite these differences, in all cases, states have built their ACOs on the existing delivery system, including well-established PCCM programs, PCMHs, or MCOs. Having these existing programs with experience coordinating care and with some of the necessary infrastructure is a pre-requisite to building a successful ACO.

Medicaid ACOs use a variety of payment mechanisms to incentivize coordinated, high quality care, including fully capitated and global budgets. The most common payment mechanism is shared-savings or shared-savings and losses. Generally, providers are assuming more risk with ACO models than the previously described models of coordinated care. As with Health Homes, access to timely patient data is critical for all the partners in an ACO. Also similar to Health Homes, providers who participate in ACOs must learn how to practice as part of a collaborative team, particularly when shared savings and/or costs are calculated across the entire team's performance as a whole.

The cost savings potential of ACOs is still not certain. However, within Medicare, the ACO model is showing potential for savings. Cost savings and quality improvement have also been demonstrated in some Medicaid ACO models, such as in Colorado and Oregon, where there were significant reductions in inpatient admissions, emergency visits, and the use of high-cost imaging, as well as increases in primary care and wellness visits.[8]

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[6] "Medicaid Health Homes: Implementation Update," Center for Health Care Strategies, March 2014.
[7] See http://nashp.org/state-accountable-care-activity-map and http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf
[8] Colorado Department of Health Care Policy and Financing, "Legislative Request for Information #1: Accountable Care Collaborative," November 1, 2013.

v. Administrative Services Organization

In an ASO model, a state contracts with a third party organization to administer certain Medicaid services, such as predictive modeling based on Medicaid data, disease management, care management, quality management, or member services. The third party organization can be any organization capable of carrying out the contracted services, but is often a managed care organization. Some states use the ASO model for specific programs or services, such as dental and behavioral health.

An ASO is typically paid an administrative fee to provide the contract services and is not at financial risk. The state maintains the financial risk for the care provided to enrollees, and maintains responsibility for important functions such as eligibility determination and paying provider claims. States also have attached performance goals to ASO payments to help ensure they deliver the level of services and quality expected.

Data required for an ASO depends largely on the level and types of services the state has contracted with an ASO to conduct. ASOs can offer states one way of getting better data about providers and enrollees through the tools they bring to their contracts, such as predictive modeling, utilization management, health risk assessments, and provider profiling. Also, states do not need to have specific infrastructures in place to oversee ASOs in the same way they need for full-risk managed care (e.g., sophisticated rate setting, more intensive reporting requirements, etc.). Similarly, providers do not need to significantly change their practices, as ASOs typically do not require providers to do much in terms of care coordination with other providers.

Not a lot of information exists about the savings for ASO models in general, although Connecticut and Maine have seen improvements in both quality and costs from their respective ASO models for physical health (CT) and behavioral health (ME) services.[9]

vi. Full-Risk, Capitated Managed Care

Full-risk, capitated managed care programs are the most common type of Medicaid managed care. Currently, 37 states use this model for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services. Although managed care is broadly defined (some of the federal managed care regulations apply to PCCM programs), full-risk capitated managed care is what is most thought of as “managed care.” States contract with health plans - Managed Care Organizations (MCOs) or Prepaid Health Plans (PHPs) – for the delivery of services to Medicaid enrollees. These health plans are responsible for providing the services articulated in a contract to the specific populations identified in that contract. Contracts may include all Medicaid services, or specifically exclude some services, such as behavioral health, or transportation. Some also include all Medicaid populations or exclude particular groups, such as those with long-term care needs or those who receive other waiver program services.

Health plans are paid pre-established, actuarially-certified, capitated PMPM rates that usually are adjusted for age, sex, existence of Medicare or other private insurance, or Medicaid eligibility category.

Oregon Health Authority, "Oregon Health System Transformation: Quarterly Progress Report,” February 2014. http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf.

[9] Connecticut Department of Social Services, “Medical Assistance Program Oversight Council Presentation.” APS Healthcare, “Maine Behavioral Health ASO Annual Report FY 2011,” January 2012.

While traditionally MCOs have just paid providers FFS rates, states are becoming more involved in how the plans pay providers to deliver better quality and outcomes, including through different reimbursement structures for MCO contracts with Federally Qualified Health Centers, Community Health Centers, PCMHs, Health Homes, and ACOs in their networks.

Although MCOs are responsible for paying provider claims, states must provide encounter data as part of their quarterly CMS Medicaid Statistical Information System (MSIS) reports. Timely, accurate and clean encounter data are critical for states to ensure that their MCOs are complying with contract requirements such as quality assurance and utilization measures, and to be able to set accurate capitation rates for MCOs.

Moving providers to a full-risk, capitated model requires a significant investment in provider relations, particularly for providers who do not have experience with payment mechanisms other than FFS, or who have not had to meet more rigorous quality and performance metrics that are typically part of Medicaid MCO provider agreements today. Additionally, MCOs face particular challenges in rural and frontier areas such as Wyoming because it is hard to develop adequate provider networks, especially for specialists.

On the national level there is little evidence of any savings. Only one researcher found overall cost savings while all others conclude managed care is either cost-neutral or even more costly than FFS programs. Studies conducted by consulting firms on behalf of managed care companies or industry trade groups do find savings, primarily as a result of reduced inpatient utilization. One of these reports concluded that savings in rural areas are about half what they are in more urban regions.[10]

[10] Lewin Group, "Report for America's Health Insurance Plans: Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies : Final Report," March 2009. http://www.lewin.com/publications/publication/395/.

Section III: Selected States' Approaches to Coordinated Care

Most states have some level and type of Medicaid managed care; only two currently do not have any: Alaska and Wyoming. Historically, New Hampshire has not had Medicaid managed care, although the state began enrollment into full-risk managed care in 2014. Connecticut also recently moved away from full-risk managed care to an Administrative Service Organization (ASO) model. Connecticut uses a pay-for-performance withhold on the quarterly administrative fee to ensure accountability of the ASO to deliver high quality services to enrollees.

To gather more information about states' experiences with coordinated care models and payments that are designed to reward quality and not quantity, HMA conducted additional research and interviewed Medicaid directors and other senior Medicaid program staff from nine other states. From this research, HMA compiled lessons learned that Wyoming can use as it moves forward implementing its own versions of these models. HMA also created individual state profiles with additional details, which can be found in Appendix C: State Profiles. Table 4 below identifies how states were selected and the process for obtaining information. To learn more about each model, see Appendix A: National Trends and Activities.

Table 4

Selection Criteria	Research Steps
States similar to Wyoming based on: • **Population** • **Geography** • **Infrastructure or** • **Medicaid enrollment**	Reviewed information publicly available on the 11 state Medicaid and CMS websites
Dissimilar states developing innovative approaches to care coordination, integration and quality-driven reimbursement	Reviewed reports produced by national Medicaid policy organizations such as Kaiser Family Foundation and National Academy for State Health Policy

A. Care Delivery and Payment Reform Models from Study States

This overview of the different coordinated care models and reimbursement approaches used by a number of other states starts with the PCMH and moves along the continuum to full-risk managed care. The following, Table 5, shows the models in place in the selected states.

Table 5

State	PCCM	PCMH	Health Home	ACO	Full-risk Managed Care
***Alabama**	X		X	X	X
****Colorado**	X			X	X
Missouri			X		X
*****Montana**	X	X			
+New Mexico		X			X
North Dakota	X				X
Oklahoma	X	X			
^Oregon			X	X	X
South Dakota	X		X		
Utah	X			X	X
#Washington			X		X

Table 5 Key:

* Alabama is in the process of implementing Medicaid Regional Care Organizations (RCO), which will be provider and community-led ACOs; they will most likely be paid on a fully-capitated basis.

** Colorado has mandatory managed care for Behavioral Health only. By law, LTC/LTSS cannot be included in a managed care model, with the exception of PACE.

*** Montana will launch 4 – 6 PCMHs in the fall of 2014.

+ Includes all populations and all services in its Centennial Care full-risk managed care program: physical health, behavioral health, long-term services and supports.

^ Oregon has implemented Coordinated Care Organizations (CCO). The CCO's are paid a global budget that grows at a fixed rate to provide the full continuum of Medicaid Services. Over time, dental and long-term services and supports will be added.

Washington is implementing Health Homes in a managed FFS environment and requiring MCOs to provide Health Home services. MCOs can also receive a fee to serve as a lead entity in the Health Home model through a competitive procurement process.

i. Patient Centered Medical Homes

Of the 11 study states, six have some form of Medicaid/CHIP PCMH model implemented and four have development of PCMH models underway.[11] Many of these states implementing or designing PCMHs are leveraging PCCM programs that currently, or had previously, existed in the state. Table 6 below includes information about the PCMH programs in the three study states.

[11] Oregon, Washington, Colorado, Alabama, New Mexico and Missouri have PCMH models implemented. Colorado's PCMHs are part of a larger initiative – the Accountable Care Collaborative program – which is described in the ACO section. Montana, Utah, Arizona and South Dakota have PCMH models underway. National Academy for State Health Policy. http://nashp.org/medical-home-patient-centered-care-maps/index.html

Table 6

State	PCMH Model Highlights
Montana	Medicaid officials reported they are working toward implementing a PCMH model. DPHHS and the Insurance Commissioner staff are working with the National Academy for State Health Policy (NASHP) to pilot PCMHs in four to six provider locations starting in fall 2014.
New Mexico	New Mexico built into the MCO contracts for its new Medicaid reform program, Centennial Care, that the MCOs must participate in a PCMH Initiative based on the NCQA PCMH Recognition Program. MCOs are required to work with providers who are interested in and capable of becoming PCMHs and encourage them to become certified as NCQA PCMHs as quickly as possible. MCOs are allowed to delegate most care coordination functions to a PCMH. MCOs must compensate PCMHs in a way as that "appropriately recognizes the added value of PCMH."
Oklahoma	Modified SoonerCare Choice to a PCMH model with three tiers based on level of PCMH services; providers may apply to be assigned to a tier once a year.[12] Pays providers a monthly capitated "bundled" payment, which includes a case management/care coordination fee, primary care office visits and limited lab services. Other codes are paid on FFS basis. Additionally, providers who meet quality standards for child immunization rates can earn a lump-sum incentive payment.[13] Despite these findings and general satisfaction with the program, on March 13, 2014, Oklahoma's Senate narrowly approved a bill that would test "privatizing the management of health care services to the poor in Oklahoma."

Of the three study states with PCMH models, Oklahoma's program is clearly the most mature, with some level of risk-sharing for providers. New Mexico has experience with PCMH's, but given that it just launched Centennial Care, there has not been much new information about how the model is working so far with the change in MCOs and new care coordination requirements in the MCO contracts.

ii. Health Homes

Several study states are developing care coordination approaches for specific populations and health conditions through the new Health Home initiative created in the Affordable Care Act. Health Homes specify populations that can qualify for enrollment and services that must be provided to meet CMS requirements; however, they also come with additional federal funding to support their establishment. Table 7 is an overview of Health Home activities in the study states.

[12] OHCA Patient Centered Medical Homes
http://www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165
[13] Early Periodic Screening Diagnostic and Treatment 4th DTaP.

Table 7

State	Health Home Model Highlights
Alabama	Alabama currently administers a Section 2703 Health Homes initiative, called Patient Care Networks (PCNs). The primary care providers serve as the health home and are paid an enhanced PMPM care coordination fee ($9.50 per qualifying recipient), supported by the PCNs. The PCNs provide data analytic support, care management services and provider training in evidence-based guidelines. To support its growing ACO program, Alabama may allow regions to first develop a PCN program that they can use as the foundation for transitioning to a Regional Care Organization (see the RCO description below in Table 8).
Missouri	One of the first in the nation to take advantage of the Section 2703 opportunity. State operates two types of Health Homes: • Primary Care Health Home (PCHH) for individuals with chronic disease, implemented in January 2012 for more than 15,000 enrollees. • Community Mental Health Center Health Home (CMHCHH) for individuals with serious and persistent mental illness, implemented in December 2011, for more than 18,000 enrollees. [14] CMHCs certified by the Department of Mental Health (DMH) are the designated providers for enrollees with behavioral health conditions. Providers that meet requirements receive a PMPM payment of $60.05; they are required to pay $3.47 PMPM to cover administrative costs associated with data management, training, technical and administrative support. Missouri expects to modify its current state plan in the future to add a request for a second payment method so providers may receive incentive payments based on shared savings for meeting specific performance metrics.
Oregon	Program involves contracts with 198 providers to serve 38,000 enrollees. Using a state plan-approved Section 2703 Health Home model to make payment to participating practices. The Patient Centered Primary Care Home (PCPCH) was implemented in 2012 and operates within Oregon Medicaid's Coordinated Care Organizations, described in more detail in the ACO section.
South Dakota	Implemented its Health Home Initiative in July 2013 with close to 600 providers that have completed the application and attestation processes. Nearly 6,000 enrollees are currently receiving Health Home services. State Medicaid partnered with several IHS providers to create some of its Health Homes, and negotiated with CMS to cover 100 percent of the cost of care Native American enrollees receive at IHS.
Washington	Uses an ASO to identify lead entities that will contract with care organizations to coordinate care and help enrollees connect with community providers, and facilitate the coordination of care between those providers. It is a "person-centered Health Home" model.

Washington is an example of a number of states now contemplating a "Managed FFS" model. This can be as simple as contracting with an ASO to perform utilization management and prior authorization

[14] Centers for Medicare and Medicaid Services http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v30.pdf

activities, or as in Washington, using an ASO to contract with and manage the providers and care coordination functions. Recent analyses of Health Home models show that Health Homes have real promise to both bend the cost curve and improve quality of care for enrollees.

iii. Accountable Care Organization Model

Though ACOs are often viewed primarily as a Medicare model, a growing number of states have begun to experiment with the model for their Medicaid programs. State Medicaid ACO models employ a variety of payment mechanisms to encourage quality improvement and care coordination, as shown in the highlights from study states in Table 8. Any savings that are realized as a result of these efforts are shared between providers and the Medicaid program.

Table 8

State	ACO Model Highlights
Alabama	Uses Regional Care Organizations (RCOs) to manage and coordinate care for the majority of Alabama's Medicaid enrollees. The RCOs are provider-based, community-led organizations that manage a broad scope of Medicaid benefits for included populations for a capitated PMPM payment. The state can contract with a for-profit MCO only in very specific situations when an RCO organization cannot be formed, and efforts to work with other qualifying RCO organizations are unsuccessful. As part of the 1115 waiver, Alabama is seeking to create a Delivery System Reform Incentive Payment (DSRIP) pool to encourage provider reform to match the RCO delivery system. Incentive payments will be made to providers to incentivize infrastructure development, innovation, and quality improvement focused on care coordination and health outcomes. Incentive pools will also be used to reward Health Information Exchange (HIE) utilization for care coordination and improved health outcomes.
Colorado	Colorado's ACC Program operates statewide, serving more than 350,000 enrollees. There are three components to the program: • 7 Regional Care Collaborative Organizations (RCCOs) that ensure cost and quality outcomes for Medicaid members. RCCOs receive a PMPM, of between $8 and $10, with one dollar placed in an incentive pool to be distributed based on meeting utilization targets for key performance indicators. • Primary Care Medical Providers (PCMPs) that serve as the focal point of care and, through relationships with specialist and community-based organizations, ensure cost and quality outcomes for Medicaid members. There are more than 400 PCMP locations with 2,350 Rendering Practitioners. PCMPs receive a $3 PMPM payment, plus billing FFS. One dollar is placed in a PCMP incentive pool and distributed based on performance on the same key performance indicators as for the RCCOs. • A Statewide Data Analytics Coordinator (SDAC) that provides actionable data to the state, the RCCOs, and the PCMPs at both the population and enrollee level. Data includes: diagnoses, prescriptions, and other health information on both aggregate and individual member levels. The state is moving toward greater integration of the ACC Program and its

	mandatory behavioral health managed care program, and building on the model for its dual eligible financial alignment demonstration.
Oregon	Awarded a $45 Million State Innovation Model Test Grant from the CMS Innovation Center to test what it calls Coordinated Care Organizations (CCOs). The state expects the CCOs to better coordinate care and concentrate more on management of high-cost enrollees to: • Provide more reliable budgeting for the state. • Reduce emergency room visits. • Reduce inpatient hospitalizations. • Improve the quality of life for clients. • Allow for providers to be rewarded for quality outcomes through shared savings. The CCOs operate under a global budget that grows at a fixed rate, with one to two percent of payments held back pending attainment of quality metrics. The payment system includes quality outcome-based incentives and, eventually, shared savings between the state and contracted entities. Medicaid also pays for the services of non-traditional health care workers, such as community health workers, doulas, client navigators and peer wellness workers; Oregon plans to train 300 community health workers by 2015 and to provide a loan repayment program for primary care physicians who agree to work in rural or underserved communities.
Utah	Beginning in January 2013, Utah replaced its managed care contracts with ACO-like contracts in four counties — Salt Lake, Davis, Utah and Weber — impacting 70 percent of its Medicaid population. Enrollees in rural counties can choose an ACO, but are not required to do so. The following components were implemented as part of the model: • Restructured provider payments using risk-adjusted capitated payments for all of contracts and pays providers for episodes of care rather than for billable events. • Integrated non-behavioral pharmacy benefits into the ACO scope of service to better align the incentive of prescribers with the goals of the State. • Rewards enrollees for personal efforts to maintain or improve their health.

ACOs offer states a viable option for creating accountable care coordination programs with flexibility to meet provider and patient needs. However, as was the case with the three states studied here, ACOs require considerable infrastructure and the ability to get providers to align with the state. Each of these states built their ACO models on existing infrastructure, then created additional infrastructure to support them more fully. There is good evidence that ACOs can save money and improve quality. In Colorado, the ACC program is realizing positive outcomes for its enrollees, [15] including:

- A 15-20 percent reduction for hospital readmissions and 25 percent reduction in high-cost imaging services relative to a comparison population prior to program implementation.

[15] Colorado Department of Health Care Policy and Financing, "Accountable Care Collaborative Annual Report. Response to Legislative Request for Information #6." November 1, 2013. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251910367781&ssbinary=true

- A 22 percent reduction in hospital admissions among ACC Program members with COPD who have been enrolled six months or more, compared to those not enrolled.
- Lower rates of exacerbated chronic health conditions such as hypertension (%) and diabetes (9%) relative to clients not enrolled in the ACC Program.
- Emergency room utilization by ACC Program enrollees increased 0.9 percentage points less than utilization by those not enrolled in the ACC program (an increase of 1.9% for ACC enrollees compared to an increase of 2.8% for those not enrolled.
- $44 million gross, $6 million net reduction in total cost of care (cost avoidance) for clients enrolled in the ACC Program.

ACOs can serve as the foundation for other pilots and initiatives. For example, again in Colorado, the state is implementing a payment reform pilot and two super-utilizer pilots under the ACC umbrella. One important lesson Colorado has learned through the ACC Program is that even with better coordinated care among regional providers, a small group of Medicaid enrollees require a more intensive level of case and care management than what is provided. To address this, Colorado hopes to launch its super-utilizer program in coordination with the RCCOs and a number of PCMPs in the summer of 2014.

iv. Full-Risk Managed Care

Full-risk managed care has historically been an attractive option for many states because:

- It provides expenditure predictability for budgeting purposes.
- The assumption that health plans have the incentive to ensure enrollees access primary care to prevent the occurrence of more serious (and costly) conditions and that primary care and specialty care is better coordinated, furthering the potential to reduce costs.

Some states are now including nearly all services and populations in one comprehensive program, while others have risk-based managed care only for certain populations, specific regions, or particular services. Table 9 shows the various managed care structures of the study states.

Table 9

State	Full-Risk Managed Care Model Highlights
Alabama	Alabama is currently implementing a health care delivery system reform plan. As noted and described above, the cornerstone of the reform plan is the development and implementation of regional care organizations (RCOs) across the State that would manage and coordinate care for the majority of Alabama Medicaid's beneficiaries. These RCOs are provider-based, community-led organizations that will, through a capitated payment, manage a broad scope of Medicaid benefits for included populations. The state can contract with a for-profit MCO only in very specific situations when an RCO organization cannot be formed, and efforts to work with other qualifying RCO organizations are unsuccessful. There is a provision in the new law that states that Medicaid can contract with an alternate care provider if the RCO fails to provide adequate service pursuant to its contract, has its certification terminated, or if Medicaid cannot award a contract to an RCO.
Colorado	Only has full-risk, managed care for some services, as well as for some individuals in some geographic regions. • A full-risk program for physical health care in Denver for any Medicaid enrollee in the county. • A full-risk program for all services except dental for enrollees in the CHIP program (children and pregnant women). • A full-risk mandatory program for the provision of behavioral health services, which operates statewide. • A new dental managed care program for Medicaid, plus a managed care program for CHIP enrollees.
Missouri	Missouri Medicaid operates HMO-style managed care program called MO HealthNet Managed Care. The State contracts with managed care health plans to provide health care services for a monthly capitation payment for each enrollee. Participation in MO HealthNet Managed Care is mandatory for certain eligibility groups within the three regions with managed care: Eastern, Western and Central. There are still some rural counties in Missouri where HealthNet is not available; in these areas, Medicaid remains all FFS.
New Mexico	Has one of the longest histories of the study states with full-risk managed care and over the past 15 years the program has undergone many changes. Prior to January, 2014, New Mexico operated three full-risk managed care programs: • Salud! for acute/physical care. • A separate, full-risk capitated program for behavioral health care (which has been carved in, carved out, and then spun off to be a separate state agency). • A full-risk capitated program for long-term care services called Coordination of Long-Term Services (CoLTS). In 2014, the state launched Centennial Care, an integrated, comprehensive managed care program. It contracts with four MCOs, each providing services

	statewide. Nearly all Medicaid enrollees are mandatorily enrolled and receive all services through the program. There are two exceptions: 1. Because of an existing lawsuit, the Intellectually/Developmentally Disabled (I/DD) population receives their waiver services outside of Centennial Care; although, they receive other Medicaid benefits and services through the Centennial Care health plans. 2. Native Americans who meet long-term care level of care or are not dually eligible for Medicare and Medicaid are mandatorily enrolled. All other Native Americans may opt-in to Centennial Care if they choose. This compromise is a result of extensive negotiations between the New Mexico Medicaid agency, CMS and the many Tribes located in the state.
North Dakota	The Northland Healthcare Alliance runs two PACE service areas in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 35 enrollees.
Oregon	As noted and described above in the ACO section, in July 2012, CMS approved Oregon's request to extend and amend its Section 1115 waiver to launch new Coordinated Care Organizations (CCOs) to replace the current managed care delivery system. The waiver plan includes a commitment for Oregon to reduce the annual per capita Medicaid expenditure growth trend by 2%.
Utah	Beginning in January 2013, Utah replaced its managed care contracts with ACO contracts in four counties — Salt Lake, Davis, Utah and Weber — with 70% of the state's Medicaid population. Medicaid clients in rural counties have the option of enrolling in an ACO, but are not required to do so, and in total, the ACOs cover about 180,000 of the state's total Medicaid population of about 245,000. CHIP is separately administered by Utah Department of Health. CHIP currently contracts with SelectHealth (PCCM) and Molina Healthcare of Utah (full-risk capitated) to provide health care services. Additionally, CHIP contracts with Premier Access and DentaQuest to provide dental care services.
Washington	Washington State Health Care Authority (WSHCA) operates full-risk contracts with five health plans. Additionally, the Washington Medicaid Integration Partnership (WMIP) is managed care for Supplemental Security Insurance (SSI) or SSI-related Medicaid enrollees in Snohomish County. One health plan covers medical, mental health, chemical dependency treatment services, and long term care services for this pilot project. The pilot, started in 2005, has demonstrated some success, specifically in lowering growth in prescriptions filled for mental illness[16], and the state has an eye toward expanding the project to other geographic areas.

[16] Davis Mancuso, Melissa Ford Shah, Barbara Felver, Daniel Nordlund. "Washington Medicaid Integration Partnership: Medical Care, Behavioral Health, Criminal Justice, and Mortality Outcomes for Disabled Clients Enrolled in Managed Care," December 2010. http://www.dshs.wa.gov/pdf/ms/rda/research/9/100.pdf

Full-risk managed care does provide states with an opportunity to use outside expertise to build and manage provider networks, conduct enrollee education and outreach, ensure care coordination and collaboration among providers and handle claims payments. However, as Washington State discovered through a recent audit of two of its largest MCOs,[17] use of MCOs to handle these program elements is not always successful. The audit found that the plans may have significantly over-paid providers, which in turn may have resulted in higher than appropriate payments to the MCOs. To avoid such issues, states should provide strong oversight of and insight into the activities of their managed care partners.

B. Lessons Learned from Study States

State officials interviewed for this project shared a number of lessons from their experiences that are relevant to Wyoming's efforts. Each of these states continues to address challenges as they develop new delivery systems and payment models. However, some common themes emerged in our discussions with state officials and independent research of their initiatives.

i. Build on Existing Structure

In most cases, study states have been working to enhance and expand the delivery system they have in place, both in terms of payment arrangements and provider infrastructure.

- Montana added HIP and Team Care to its 1915(b) waiver for the Passport to Health Program. In doing so, Montana DPHHS leveraged provider relationships already in place and reduced the need to create totally new contracts and administrative processes.
- Utah modified its contracts with health plans to transition to an ACO-like model, using this to do more enhanced risk-adjustment methodologies in their rate setting and pay providers for episodes of care rather than for billable events.
- Missouri's experience with the Chronic Care Improvement Program in 2006, informed the state's efforts to develop the current Missouri Primary Care and Community Mental Health Center Health Home initiatives. Their ability to learn from both the successes and challenges of previous projects, and to often do so on a pilot basis, offered a definite advantage in designing the current initiatives.
- Even though Alabama, Colorado and Oregon have or are in the process of making major delivery system changes, they are largely doing it with locally operated provider organizations that have an historical relationship with their respective Medicaid agencies. This is helpful given that the move from FFS to risk-based managed care will impact both staffing needs and business processes. Adapting to this new model is an ongoing adjustment for agency staff and providers.

ii. Involve Stakeholders

All study states emphasized the importance of engaging stakeholders early and often in any change process.

- When Missouri implemented the Health Home models, the Department of Social Services partnered with other state agencies, foundations, the Primary Care Association, the Coalition of Community Mental Health Centers, the Hospital Association and the School Board Association to create a process that worked for everyone and benefited from the best ideas from each. In

[17] Carol M. Ostrom, "State Medicaid audit suggests $17.5 million overpaid: An audit of the state Health Care Authority says the overpayments may have gone to contracted managed-care organizations to care providers," *Seattle Times*, April 15, 2014.

other states that also have implemented Health Homes, the Governor or legislature convened multi-stakeholder advisory groups or commissions to ensure all views were represented.

- Montana's PCMH Advisory Group was convened by the Insurance Commission at the direction of the legislature.[18]
- Alabama's Governor convened a commission comprised of entities or organizations including executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance company representatives, consumer advocates, medical providers, and professional organizations representing the hospitals, physicians, pharmacy, nurses, primary and rural health, hospice, and nursing homes.
- New Mexico met regularly with stakeholders, in particular the Native American tribes and with long-term care advocates. Despite their efforts, they were forced to withdraw and re-submit their 1115 Demonstration Waiver because CMS concluded they had insufficient notice and involvement.
- Colorado held multiple stakeholder meetings during the ACC Program development process and continues to involve stakeholders in a formal way through its advisory committees. The primary Advisory Committee includes subcommittees that address the following topics:

    - Payment Reform
    - Provider and Community Relations
    - Quality Health Improvement
    - Full Benefit Medicare-Medicaid Enrollees

iii. Leverage Financing Available for Development

Through CMS' Center for Medicare and Medicaid Innovation (CMMI), 33 states are participating in 55 competitive grant-funded initiatives to implement delivery system and payment reform.[19] There are enhanced federal matching funds and planning grants available for Health Homes, community-based services, health care integration, and information technology infrastructure. Of the study states, Colorado, Oregon, Utah and Washington were awarded State Innovation Model grants to design or test innovative approaches to improve care coordination, quality and lower costs. There are also technical assistance resources available to states through organizations such as the Center for Health Care Strategies, National Academy for State Health Policy and the National Governors' Association.

iv. Integrate Care and Focus on Quality

In an effort to better coordinate care and increase savings, many states are revisiting decisions to "carve out" certain services (e.g., mental health, substance abuse/chemical dependency) or medications. In a behavioral health "carve-out" model, states often operate completely separate administrative structures along with separate financing/reimbursement arrangements for PCPs and behavioral health providers. Oregon is using its State Innovation Model Test grant to design more integrated care delivery systems. Colorado is using its State Innovation Model Pre-Test grant to integrate behavioral health care and physical health care across all payers. Additionally, each state pursuing a Health Home model is focusing on integrating physical and behavioral health care.

Efforts to integrate behavioral and physical health care can be fraught with challenges. Providers who have traditionally been responsible for services are often reluctant to hand over control of those

[18] Montana Commissioner of Securities and Insurance, "Montana Patient Centered Medical Homes," http://www.csi.mt.gov/medicalhomes/index.asp

[19] Eileen Griffin, Vikki Wachino, Robin Rudowitz, "Managing a High-Performance Medicaid Program" The Kaiser Commission on Medicaid and the Uninsured," October 2013. http://nashp.org/medical-home-patient-centered-care-maps/index.html.

services (and dollars) to another entity in the name of care coordination. Washington's original 1915(b) waiver for the state's managed mental health carve-out was designed to let counties or groups of counties form Regional Support Networks, while the substance abuse treatment dollars are contracted separately, but also with counties. As the state moves toward greater integration and requiring that MCOs take on responsibility for coordinating care, the counties want to ensure they are included in discussions and negotiations with the MCOs.

Despite the fact that the long-term care population is typically the most expensive and complex, states are somewhat slower in integrating long-term care services with physical health care services. However, that is starting to change: New Mexico has launched Centennial Care, which combines all services for all populations, and states such as Tennessee and Hawaii have combined programs and re-procured for MCOs to provide comprehensive benefits and services to most, if not all, of their Medicaid populations.

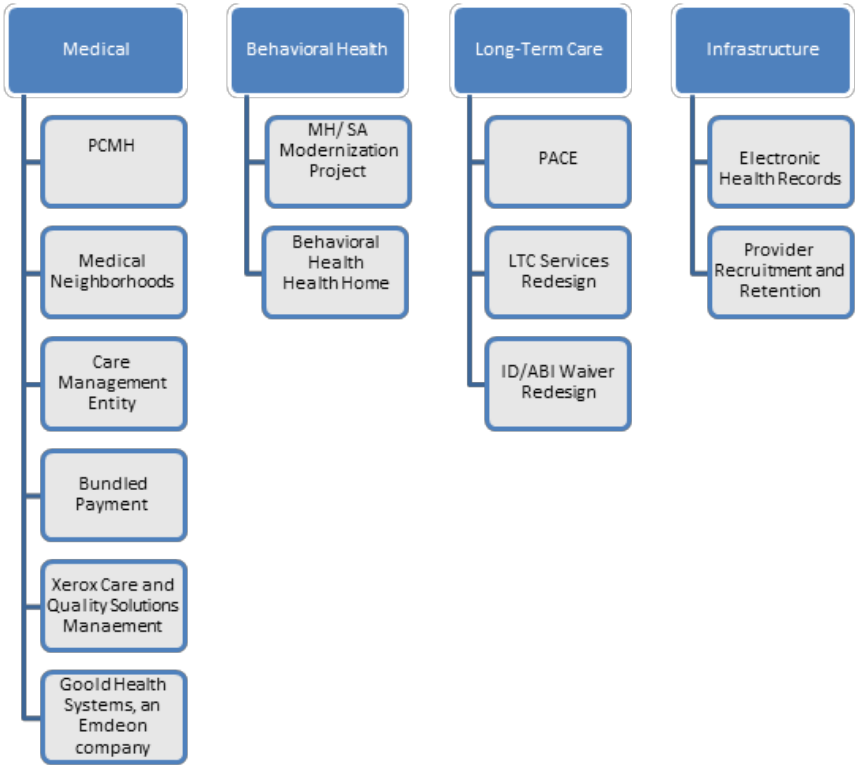
v. Information Technology Infrastructure is Essential

To fully evaluate payment reform options, state Medicaid agencies need the capacity to conduct comprehensive analysis of utilization trends and cost drivers. Quality measurement and reporting serve an integral role in delivery system and payment reform efforts. As states transition to active purchasing and work to maintain transparency and public accountability, effective data analysis becomes even more important. Data analysis capacity ranges from basic predictive modeling to identify chronically ill patients, to more sophisticated operations such as Colorado's Statewide Data Analytics Coordinator. Additionally, providers and payers must have the ability to electronically share enrollee health information to coordinate services and ensure enrollees are accessing needed care in the right place at the right time.

Section IV: Current Initiatives in Wyoming

Wyoming is already taking significant steps to improve the quality of the care delivered in its health care system – including Medicaid. This section looks at the key initiatives in Wyoming, with a description of status and activities, and how they might align with any new care coordination or managed care activities. This is not an exhaustive list of all activities required by Senate Enrolled Act No. 82. Rather, the focus is on WDH's major initiatives and those that stakeholders requested be considered in making recommendations. Figure 3 below shows how these initiatives are organized into groups:

Figure 3



A. Medical Care

i. Patient Centered Medical Homes (PCMH)

Structure

Wyoming has already launched a Patient Centered Medical Home (PCMH) effort through the Wyoming Institute of Population Health, a division of the Cheyenne Regional Medical Center, with the Wyoming Department of Health, the Wyoming Integrated Care Network (WYiCN), the University of Wyoming, and Cheyenne Regional Medical Center as strategic partners. A $14.2 million CMMI Health Care Innovation Award from CMS, plus an additional $700,000 in state funds is supporting the project as it builds PCMHs across the state. The goal of the grant is to transform Wyoming's health care system into a more integrated, coordinated *medical neighborhood* based on a solid primary care foundation and evidenced-based care. PCMHs are at the center of this effort.

Today Wyoming has 27 PCMHs:

- 8 practices began transforming into PCMHs prior to the Health Care Innovation Award through a grant from WINHealth and the Cheyenne Regional Medical Center.
- 19-20 practices were part of the Health Care Innovation Award through a grant from WINHealth and the Cheyenne Regional Medical Center.[20] One practice began the transformation on its own but recently joined the initiative. Two exited the initiative since the grant began.

Payment Methodology

This PCMH effort at the provider and system level is being supported by the major payers in the state including Wyoming Medicaid and several commercial partners – Cigna, United, and Blue Cross Blue Shield of Wyoming. These payers have generally agreed to work together to ensure that there is an incentive structure in place to support further development of PCMHs in Wyoming.
Currently, the PCMHs are paid differently by different payers:

- United and Blue Cross Blue Shield are participating in the pay-for-performance component, and have integrated PCMH participation and certifications as a consideration in determining negotiated rates.
- Today, quality metrics are focused on nine measures included in the CMMI grant; however, new quality metrics that align with NCQA PCMH Recognition requirements and with the electronic health record Meaningful Use clinical quality reporting requirements will be added in the near future.

Planned for Fall 2014:

- Medicaid will pay an estimated $3 PMPM (CMS approval of State Plan Amendment pending, exact amount to be determined) for providers who report the quality metrics and contractually agree to meet all desired characteristics of a Primary Care Medical Home. The program is beginning with a single level in the first year to encourage participation, and plans on moving to a three level structure in future years (1- participation, 2- improvement, 3- meeting or exceeding quality benchmarks). Providers will continue to be paid FFS for medical care claims, in addition to the PMPM payments related to the PCMH program.
- Wyoming Medicaid is using the same quality metrics included in the CMMI grant; however, providers must agree to meet other requirements such as pulling Continuity of Care documents on a regular basis for Medicaid clients.
- The 27 PCMHs expected to participate in the first wave of Wyoming Medicaid's Primary Care Case Management PMPM program will serve an estimated 25 percent of Medicaid members in the first year. As practice participation grows, Wyoming Medicaid expects more than 50 percent of all Medicaid enrollees to have a primary care medical home and receive care coordination and care management services through a PCMH.
    - Medicaid members may already be receiving PCMH level of care from their primary care practice but Wyoming Medicaid has not yet begun the PMPM payment for PCMH because it is waiting for CMS approval of its State Plan Amendment.

Planned for 2015 and beyond:

- Employee Group Insurance (administered by Cigna) has indicated that it will mimic Medicaid's data reporting, performance targets, and other requirements, as well as Medicaid's payment structure and levels sometime in 2015 for PCMHs.

[20] One of the practices is in Nebraska but serves a large number of Wyoming Medicaid clients.

- As the PCMH program matures, the strategic partners hope to partially move some of the FFS payment structure to a value-based payment structure. For now, the focus is on educating and engaging providers on the value of PCMHs, helping them transform the way they practice, and improving the health care infrastructure through the implementation of electronic health records and tele-health.

ii. Medical Neighborhoods to Transform Rural Care21

Structure and Payment Methodologies

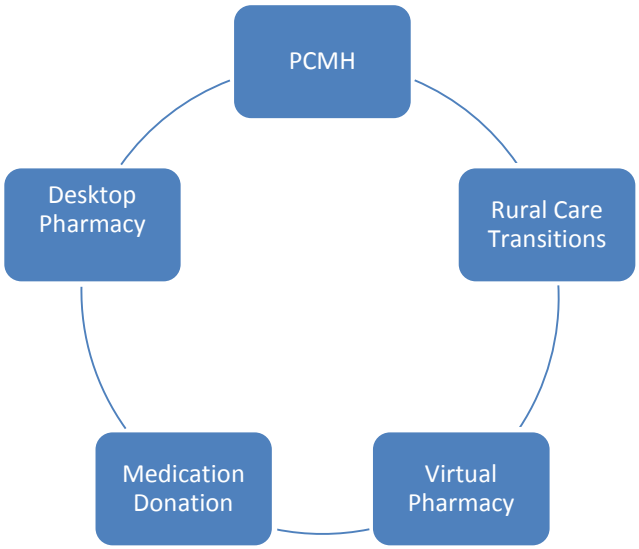
A "medical neighborhood" generally is defined as one or more PCMH and the many other clinicians and types of providers (hospitals, labs, etc.) caring for a group of patients, as well as the community and social service organizations, State and local public health agencies that also support that group of patients. In Wyoming, the Medical Neighborhoods to Transform Rural Care project is creating a state-wide network of medical neighborhoods with support from a $14 million CMS CMMI Award. The initiative, directed by the Wyoming Institute of Population Health at the Cheyenne Regional Medical Center (CRMC), was established on the idea that medical neighborhoods will:

- Encourage the flow of information across and between clinicians and patients.
- Focus on patients and a balance of evidence-based care with patient preferences.
- Support reductions in waste in the health care system that result from failures of: care delivery, care coordination and care communication, pricing, and transparency.

The initiative builds on the Institute's work in Cheyenne by supporting rural areas in creating medical neighborhoods by focusing work in five areas, depicted in Figure 4 below. Part of the project is to assess what new methods of reimbursing providers can better support their participation in the project and help all to achieve the overall goals.

Figure 4

[21] Wyoming Institute of Population Health, Health Care Innovation Award. http://cheyenneregional.org/sites/wyoming-institute-of-population-health/heathcareinnovationaward/



Patient Centered Medical Homes (PCMH)

The PCMH, described above, is a fundamental component of the initiative.

Wyoming Rural Care Transitions (WYRCT)

The second component, the WYRCT, supports medical neighborhoods by providing education and continuity of medical care as complex patients transition between hospitals and post-acute sites of care. There are 14 hospitals participating, and a total of 21.8 full time equivalent (FTE) nurses, along with back-up and supervisors, have successfully completed training in the model and processes. The target population is individuals 65 or older who have one of the 10 most frequently occurring hospitalization diagnoses in Wyoming. Individuals receive support for 30, 60, or 90 days to help them achieve their goals for care and to empower them to learn to manage their health and care. This program is unique in that most care transition programs last only 30 days; the duration was adjusted to accommodate the rural areas where on-going support might be required (individuals are often more isolated). According to stakeholders interviewed, the WYRCT is working closely with the PCMHs to ensure collaboration across all providers in the medical neighborhood.

The Institute is also piloting a program in one hospital with a younger target population – those 18 and older with a diagnosis relevant to a younger population. Their plan is identify other communities for expansion.

Virtual Pharmacy

The University of Wyoming, School of Pharmacy, is coordinating this effort in which pharmacists perform Medication Therapy Management (MTM), while virtually connecting with PCMHs via tele-health. This video-conferencing technology connects participating pharmacists and patients with PCMH clinical teams for consultations. The participation goals and number of actual participants are:

- Participation Goal - Eight pharmacies and 12 pharmacists.

- Actual participation to date – four pharmacies and six pharmacists (4 of which have completed training).[22]

Growth in the program was initially slowed by staff continuity issues, but recently hired staff have been actively working to grow the program. There is renewed interest in recruiting additional PCMHs; currently, only patients presenting to a participating pharmacy on behalf of the University of Wyoming Family Medicine program are offered this service.

Medication Donation Program

Designated donation sites collect any unused, sealed medications including medication samples from hospitals, health care professionals, and community members. Enrolled prescribers monitor the medication inventory for medications that match eligible patients' needs and refer eligible patients (low-income and un/underinsured individuals) to the program. Patients receive donated medications from approved dispensing sites or by mail.

As with the other strategies, the Medication Donation Program is expanding upon an existing program. The Health Care Innovation Award has allowed it to scale state-wide and there are now 18 public donation sites and five hospital donation sites that act as donation collection sites for facilities in their communities. The number of prescriptions filled and mailed also has increased: 1,255 prescriptions were filled and mailed in 2013, an increase from 727 in 2012. Currently, the Institute is focusing on establishing relationships with each medical neighborhood.

Physician Desktop Solution

The Physician Desktop Solution installs, upgrades, and supports video-conferencing technology to provide tele-health/telemedicine at clinics and hospitals across Wyoming.

- The Physician Desktop Solution strategy provides equipment, setup, camera and software use, and technical support.
- Through the Health Care Innovation Award, primary care clinics and hospitals receive assistance to install or upgrade video-conferencing technologies at their location.
- From tele-health locations, patients and health care providers can have live video consultations with physicians, specialists, and pharmacists regardless of location.
- All but five hospitals have executed contracts, and while there has been the most focus on deploying and enabling technology to create the infrastructure for connections between healthcare workers, there were more than 2,000 tele-health visits across Wyoming in February 2014 alone.
- Moving forward the emphasis will shift to more clinical outcome-related work that will develop and promote clinical programs.

iii. Care Management Entity for High Fidelity Wraparound and Intensive Care Coordination for Children and Youth

Structure and Payment Methodology

Wyoming was awarded a CHIPRA Demonstration Grant (with Maryland and Georgia) to implement a Care Management Entity (CME) provider model to provide High Fidelity Wraparound and Intensive Care Coordination to Medicaid financially eligible children and youth for a PMPM payment. Table 10 depicts the target population and the services provided.

[22] Source: "HCIA Sixth Quarter Narrative Progress Report. October – December 2012." January 31, 2014.

Table 10

Target Population	Services and Approach
• **Youth with serious emotional disorders, including a medical or educational diagnosis of serious emotional disturbance/emotional disturbance** • **Youth at risk of out-of-home placement and/or children who currently meet Psychiatric Residential Treatment Facility (PRTF) level of care** • **Youth identified by WDH because their use of prescription drugs does not meet prescribing guidelines established by WDH** • **Youth living in the service area (the seven southeastern counties)**	• **High Fidelity Wraparound care coordination** • **Focus on developing self-sufficiency, building natural supports and increasing family capacity to respond to crises** • **Because these youth are typically involved with multiple providers and systems, Wyoming Access (the contractor) coordinates across agencies and providers to develop and provide intensive care management home and community based alternatives to costly residential care** • **Strength-based, family-drive approach**

Enrollment in the program has been somewhat slow; in December 2013 there were only about 40 enrollees and Wyoming Access, the contractor, said that it has been quite difficult to find eligible youth and children due to churn and other challenges typical of working with highly transitional populations.

iv. Bundled Payments

Structure and Payment Methodology

Although not mentioned as a key initiative by anyone other than state employees, the WDH is exploring a transition to bundled payments for some services. For example, maternity, some joint surgeries, pneumonia, and congestive heart failure are services under consideration for bundled payments. The state considers a maternity bundled payment as the most likely to produce large savings but has delayed implementation of any change pending decisions on other initiatives such as developing a maternity medical home or other service delivery changes.

v. WYHealth - Xerox Care and Quality Solutions Case Management

WYHealth is a total population health and utilization review program for Wyoming Medicaid enrollees. WDH has been contracting for these telephonic case management services for a number of years, most recently with Xerox Care and Quality Solutions (CQS). CQS identifies candidates for case management outreach from provider referrals, from patient or patient family member self-referrals, from predictive modeling, from ED and inpatient hospital discharge reports, from lists of individuals with specific diagnoses, or from WDH referrals. Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs) or other licensed behavioral health professionals conduct telephone assessments of individuals to better understand their health care needs and how to support them.

Assessments help to stratify individuals into one of three tiers:

- Tier I – general population outreach that includes promotions for age/gender appropriate health and wellness screenings, as well as for services related to Healthcare Effectiveness Data and Information Set (HEDIS) measures commonly used as quality metrics for health care providers and plans.

- Tier II – outreach and support to individuals with chronic conditions, multiple morbidities, or specific diagnoses or needs, such as those with diabetes and pregnant women. Individuals in Tier II receive two to four telephone calls per month from a case manager who follows up on any recent hospitalizations, ED visits, or other doctor visits and makes sure the individual is getting needed services in a timely manner.
- Tier III – outreach and support to individuals with more complex care needs, offering high-fidelity wrap-around services and coordination among providers. These individuals are contacted at least three to six times per month and case managers work with other social services providers to secure non-medical supports as needed and available. CQS case managers will occasionally do face-to-face visits for hospital discharge planning or other critical transitions.

CQS case managers deliver provider training and support, helping to educate providers on programs such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) and a pay-for-performance program for referrals to case management. CQS manages enrollees in the pharmacy lock-in program, and pregnant women taking narcotics. They have a number of tools to support these programs, such as their MedCompass system to track time and enrollee contact information, and a "Due Date Plus" smartphone application that allows pregnant women to reach a nurse quickly and directly for help. Additionally, CQS oversees utilization management for behavioral health services, as well as a number of high-cost physical health services such as gastric by-pass surgery, transplants, and acute rehabilitation. They receive referrals for people requesting long-term care services and conduct all Preadmission Screening and Resident Review (PASRR) and disability reviews for the state.

As of March 2014, on a monthly basis, CQS was actively managing approximately:

- 219 individuals in Tier I
- 247 individuals in Tier II
- 263 individuals in Tier III

Some enrollees are active in case management for only a few months, many are active for nine to 12 months. There is a 10 to 20 percent decline rate for case management services; however, CQS staff note that while it can be difficult to reach many individuals, once they do contact them and explain the benefits of the program, people are generally happy to participate. If they are not able to reach someone by phone after multiple attempts, CQS will send a letter with information about the program and services available.

vi. Pharmacy Benefit Manager

Wyoming Medicaid spends about $40 million every year on medications for enrollees. Approximately 50 percent of the funding for pharmaceuticals comes from the federal match, but the state also gets nearly 50 percent in rebates so actual costs to the state total only about $10 million. Currently, WDH contracts with Goold Health Systems (GHS) for pharmacy benefit management services. GHS handles processing for all pharmacy claims, managed a preferred drug list, oversees the state maximum allowable cost program for certain drugs, and manages the federal and supplemental drug rebates.

GHS also runs a utilization management program and prior authorizations for drugs specified by the state, and they manage a lock-in program that limits high-utilizers to specific pharmacies for accessing medications. Additionally, GHS manages the Medication Donation program that is part of the Medical Neighborhood project (described above).

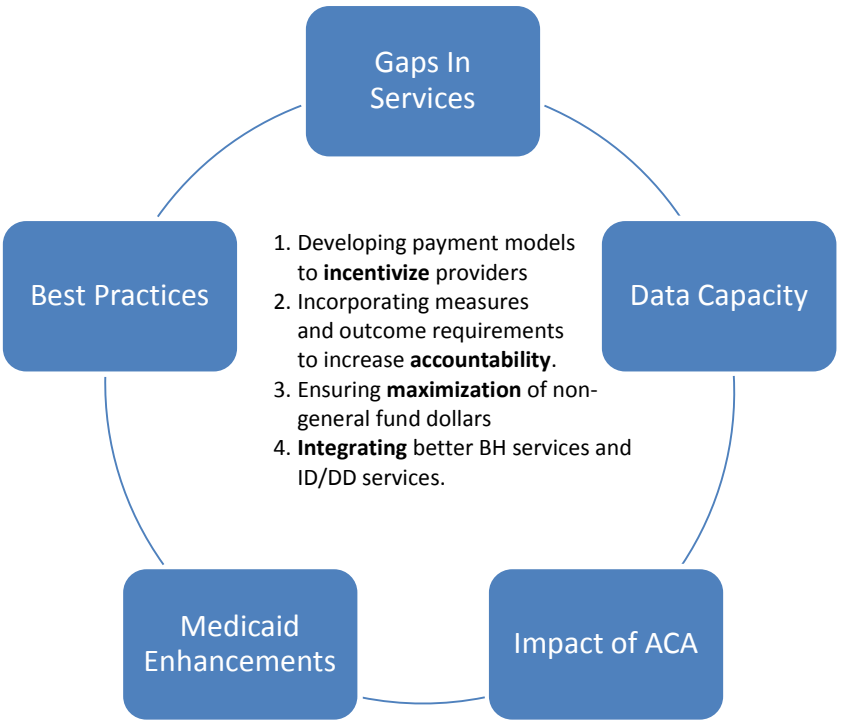
B. Behavioral Health Care

i. Mental Health and Substance Abuse Modernization Project

Structure and Payment Methodology

The Mental Health and Substance Abuse Modernization Project was developed to align the multiple reform initiatives which had been operating independent of one another. The goals are to develop a system that will support individuals with behavioral health needs in getting appropriate and needed care and in ensuring they are on the path to recovery, and to design appropriate reimbursement mechanisms to help providers achieve those goals. As shown in Figure 5, there are five sub-committees (in the blue boxes) collaborating to develop an approach that will support the four activities in the middle of the circle.

Figure 5



At the time of this report, the WDH expected that:

- The sub-committees would each develop a report with recommendations by June.
- An overall recommendations report will be completed in July.

ii. Behavioral Health Homes

Structure and Payment Methodology

For the past 18 months, the Behavioral Health Division (BHD) has been researching the BH Health Home model with the purpose of developing and implementing such an approach in Wyoming. Specifically state staff has:

- Visited BH Health Homes in Missouri.
- Worked with providers to educate them and solicit input to ensure buy-in.

According to WDH staff, the large behavioral health centers are very interested in Health Homes and some already have staff to provide case management and care coordination services. Other behavioral health centers are more anxious about the likely changes. WDH had originally hoped to implement a pilot by July 2014, but this has been delayed to work through a number of outstanding issues:

- The best model to ensure functionality in rural and frontier, the small behavioral health centers, are unlikely to have sufficient Medicaid patients in their panels (it was noted that Medicaid expansion would mitigate this challenge). Potential solutions include collaboration with other centers or community-based organizations and expanding the model to all payers.
- Whether to start statewide or develop pilots in one or two areas to evaluate the model in both areas (e.g., one rural region and one urban region).
- What might be the best approach to accommodate Medicaid expansion.
- The types of operational and business practices that will be needed.

- The best reimbursement approach (PMPM is most likely with some requirements about minimum contacts per month) and how to align payment with quality and performance targets.

C. Long-Term Care Supports and Services

i. PACE

Structure and Payment Methodology

In addition to the CME for high-needs youth described above, PACE is the other managed care program currently operating in Wyoming that pays for services on a capitated PMPM basis. It was implemented in 2013 and is available in Laramie County only. Growth has been faster than anticipated and there are nearly twice as many enrolled after one year than had been expected (49 enrolled, 27 expected). There are discussions underway as to whether a second location might be needed in Cheyenne or whether there is opportunity for expansion into additional communities.

ii. Long-Term Care Services Redesign

Structure and Payment Methodology

As a result of the 2013 Wyoming Medicaid Reform legislation, WDH is already implementing several changes to how LTC and LTSS are provided, including:

- Redesign of skilled nursing facility (SNF) reimbursement rates to reflect patient acuity, percentage of Medicaid occupancy and regional economic factors. The goal is to create incentives that will encourage SNFs to provide care to the sickest and most expensive enrollees (according to stakeholders, there is currently a financial disincentive for NFs to serve these enrollees) instead of caring for lower-needs patients who might be better and more cost-effectively served in an Assisted Living Facility (ALF) or at home.
- Elimination of the caps on the number of enrollees admitted to the LTC and ALF waiver programs. Provider capacity still limits access for some enrollees, though the wait is generally not longer than a month. Over time, the state will rebalance the percent of dollars going to NFs from the current 50/50 split between NFs and home and community-based services, to one with a higher percentage of dollars going toward home and community-based services.
- Development of a new assessment tool to replace the LT101, used to determine medical necessity for various LTC programs. The LT101 has an all-or-nothing cut-off score whereby people either receive services or do not, and the tool does not capture behavioral health conditions or needs well.

There is a workgroup for each of these three activities. A fourth group is developing the visions and goals for the entire LTC system, tackling issues such as lack of communication between systems, use of supplemental programs to support individuals who are isolated in rural areas and ensuring that the components of change are aligned and coordinated.

iii. Intellectually Disabled/Developmentally Disabled (ID/DD) and Acquired Brain Injury (ABI) Waiver Reform

Structure and Payment Methodology

As a result of the 2013 Wyoming Medicaid Reform legislation, WHD redesigned the Medicaid Home and Community Based-Services (HCBS) waiver programs that serve individuals with ID/DD and ABI. Two new waivers – a Comprehensive Waiver and a Supports Waiver - were created to replace the Adult Developmental Disabilities Waiver and the Child Developmental Disabilities Waiver. Because costs per enrollee for these populations in Wyoming are among the highest in the region, WDH wants and needs to establish effective cost controls while also:

- Providing an updated menu of services across the continuum of residential and employment support environments.
- Offering the opportunity for self-direction to all waiver participants.
- Establishing targeted outcomes for each participant served.

The new waivers, recently approved by CMS, launched in April 2014. Participants on the current Adult DD Waiver will transition to the new waiver between April 1 and September 30, 2014. Child DD Waiver participants will transition between July 1, 2014 and June 30, 2015.

D. Infrastructure

i. Electronic Health Records (EHR) and Health Information Exchange (HIE)

The Wyoming health information technology (HIT) environment is currently experiencing significant growth in the use of EHRs and HIE, expanding and enhancing ways of using these new tools to positively impact patient care.

Wyoming is participating in the EHR Incentive Program in accordance with the American Recovery and Reinvestment Act (ARRA) and the HITECH Act from 2009. This program was designed to offer incentive payments to eligible professionals and hospitals for the Adoption, Implementation and Upgrade (AIU) of EHRs and using them in a meaningful way (Meaningful Use, or MU). To date, Wyoming has paid more than $15 million of federal dollars to 117 professionals and 21 hospitals that have met the requirements for this program. Of this group of participants, 19 professionals and nine hospitals have received second and third payments as they advance through the program meeting the requirements of MU. Additionally, through the Medicaid State Level Registry, WDH MU clinical quality information can be reported at the individual patient level and at the aggregate level. With this information, providers are able to compare the quality of care they are delivering against the quality of other providers in the state. Using this information, WDH can help providers identify areas that need improvement. Importantly, the Meaningful Use quality measures include metrics on patient engagement and care coordination. WDH can monitor these metrics to monitor care coordination and identify where there may be a need for intervention to improve care coordination.

Wyoming Medicaid also has the Total Health Record project. This is a web-based program with three components: an EHR, a Personal Health Record (PHR) and the Gateway (Health Information Exchange, or HIE). Currently, the EHR component is offered to Wyoming Medicaid providers at no cost. This EHR is a certified system and meets the requirements for the EHR Incentive Program. There are currently 30 providers using the THR system as their EHR. The PHR component is available to all Wyoming Medicaid enrollees at no cost, to access their health records if their provider is using the THR. In addition, all Wyoming patients can sign up to use the PHR to keep an electronic copy of their health records and can access at any time.

Direct Messaging has just recently been added to the THR. This will enable patients to correspond with any provider regarding their care and also give them the ability to upload documentation from providers to their record. Direct Messaging can be used by WDH Program Managers to correspond securely with Medicaid enrollees regarding care options. An additional component to Direct Messaging will be introduced soon that will give PHR users the capability to use the secure messaging functionality with providers that use other EHRs.

The Gateway offers an electronic connection to certain programs within the WDH. As the EHR Incentive program requires more interoperability, electronic reporting to Public Health is an important function. The Gateway hosts this connection and is currently in the process of onboarding several hospital and providers.

Wyoming has faced many challenges getting a statewide HIE implemented. An independent consultant will be reviewing all of the technology currently available to assist Wyoming providers with each of their specific needs while meeting the requirements of Meaningful Use.

ii. Tele-Health Development

There are currently several major tele-health projects underway in Wyoming.

- The CMMI Health Care Innovation Award from CMS (noted above in the PCMH section), has supported the Cheyenne Regional Medical Center (CRMC) network and helped to transform it into a major statewide system. CRMC currently is supporting 256 sites and hosting approximately a thousand calls per month.
- The State-owned system supported by Ptolemy, whose main function is to support the State owned sites, as well as some other sites that could not fit into the CRMC system. Ptolemy has 33 sites that host just under 100 calls per month.
- The Health Link Now tele-psychiatry project reports it is connected to 19 Wyoming Hospitals and is doing about 50 consults and 50 Case Navigator Interventions per month.
- Avera has tele-health systems in three hospitals and also is using these systems to do tele-ER, tele-ICU and tele-pharmacy for about 7,000 contacts per month.
- Seattle Children's Hospital continues to provide services for child psychiatry, with approximately 15 tele-health consults per month, as well as the PAL line, and the Second Opinion project.
- The Barbara Davis Diabetes tele-health center conducts tele-health visits in four sites around the State.

Medicaid currently pays for about 800 tele-health contacts per month; Medicare also does a significant number of tele-health consults per month. WDH is working with CRMC, Ptolemy and Health Link Now tele-psychiatry project to have Rural Health do a needs assessment for Wyoming's Critical Access Hospitals that have not embraced tele-health to determine what barriers they are facing to increasing their use of tele-health. Additionally, WDH has been actively recruiting specialist providers such as Infectious Disease and Oncology to provide services via tele-health. One of the biggest barriers to participation today is not licensing, but getting the hospitals to adopt the tele-health credentialing wording approved by CMS, which requires hospital has to amend their bylaws. Until they do, every provider must to go through full credentialing at every facility, an expensive and time consuming process.

iii. Health Care Professional Workforce Development

Wyoming has a several workforce development programs designed to recruit and retain various kinds of health care providers. Some of these programs are operated by the WDH Office of Rural Health; some by other state agencies, such as the University of Wyoming. However, the programs identified in Appendix B are all state-funded.[23] Most are highly competitive programs. For example, the Wyoming Healthcare Professional Loan Repayment Program received 165 applications in 2013, but offered only 10 awards from its $500,000 program funding. Nonetheless, these programs have been successful in

[23] There are many federal programs that help recruit and retain health care professionals to underserved areas, such as Wyoming, including programs administered by the Health Resources and Services Administration. These programs also help recruit and retain providers within Wyoming, but are not included in this report.

recruiting and retaining health care providers across Wyoming. In 2010, 64 percent of WWAMI (Wyoming, Washington, Alaska, Montana, Idaho) Medical Education Program graduates returned to practice in Wyoming. Further, the University of Wyoming Family Medicaid Residency Program estimates 35 to 40 percent of its residents have stayed in Wyoming over the last 30 years of the program.

E. Aligning Current Initiatives with Future Care Models

It is important to note that the reforms and initiatives described above are not the only ones underway in Wyoming – there are several others. Many state staff and other stakeholders believe that with these initiatives, the state and its collaborative partners are on the right path toward:

- Better integrating care across benefits and services.
- Encouraging and supporting providers to communicate and collaborate more with one another.
- Collaborating with other payers to establish consistent standards for providers.
- Focusing on increased accountability and payment reforms that will improve the care of Medicaid enrollees.

Moreover, through changes to how the state provides and pays for LTC for individuals with ID/DD and ABI, and the CME pilot program for high-needs children in the southeastern counties, WDH already is working to tackle many of the highest-cost programs and services in Medicaid. However, the number of initiatives happening simultaneously has created stakeholder frustration and concern that not all the initiatives will be successful.

Section V: Stakeholder Engagement and Analysis

WDH and HMA dedicated significant time and resources to engage a full range of stakeholders in this Coordinated Care Study. The goal was to assure that model recommendations reflect the realities, needs, and values of the people and organizations involved in implementing them, making them work, and using them.

Through an iterative process, WDH and HMA assembled a comprehensive stakeholder matrix that included state agency staff, political offices, providers (hospitals and other institutions, physicians and other clinicians), community-based and advocacy organizations, and vendors (managed care organizations and case management entities). Additional stakeholders were added based on referrals and requests for the opportunity to contribute to the discussion. *It is important to note that the feedback summarized here reflects the opinions, concerns and thoughts of only those stakeholders who participated in the stakeholder engagement activities conducted for this project.*

A. Summary of Stakeholder Feedback

Stakeholders are generally supportive of enhanced care coordination or management. They support key strategies for expansion of care coordination within the existing health care system, including locating care coordinators or care managers in provider practices and training health care providers and their staff so care coordination becomes a central part of their workflow and patient management.

However, they do not believe that Wyoming has the key infrastructure to successfully implement coordinated models of care and lacks an adequate number and distribution of health care providers along the care continuum. This impacts patients' ability to obtain the care that they need. When residents have to go out-of-state to obtain needed care, it impacts the ability of providers in Wyoming to coordinate and manage their patients' care. Additionally, the current culture within the healthcare system will need to change significantly to get providers to work together better and communicate effectively. For example, many dentists did not understand how or why such a change in health care delivery would affect them, since dentists and physicians do not currently work together with any degree of regularity. In a coordinated care model, physicians and dentists would communicate and work together to ensure that patients receive the full range of appropriate care and services. Patient stakeholders also said that providers do not really understand what "patient-centered care" is or how to deliver such care. Providers will need training and technical assistance to change their practice patterns.

Technology can be used to address some of the issues with limited provider access and communication among providers. Many stakeholders support increased funding and expansion of tele-health and EHRs. Stakeholders noted the need to not only put this technology in place, but to educate and train providers on how to use it. Importantly, mental health and substance use treatment providers noted the need for ensuring that such technological solutions are designed in a way that delivers appropriate privacy protections for these patients. Many people believe that existing federal regulations prohibit or greatly limit the ability of mental health or substance use treatment providers from using and exchange information with other providers. Mental health providers in Wyoming who participated in the study wanted the state to understand that while protections must be put in place, federal regulations do not prohibit them from using and exchanging information through EHRs. Ensuring full use by all healthcare provides along the healthcare continuum will be vital fully integrated care coordination and management.

In addition to a change in provider culture, there also is a need to inform and engage Medicaid enrollees so they understand their role as patients in new care coordination and management models and how they will be impacted. Enrollees often have very low health literacy and do not understand how to effectively navigate their system of care. Building self-management skills will be highly valuable to enrollees. The vast majority of stakeholders understood the importance of and need for putting in place the supports and services that enrollees require to change their behavior, and some stakeholders supported the use of incentives to encourage enrollee behavior. However, HMA cautions the state on the use of incentives, and particularly the use of financial disincentives, until the system of care available to enrollees is adequate to fully meet their needs and help them build self-management skills.

B. Discussions with Vendors

The vendor interviews included organizations interested in providing managed or coordinated care services to Wyoming's Medicaid population. Because these interviews were conducted using a different approach and the feedback differs, this is included as a separate section of the report. These vendors included Medicaid MCOs and Medicaid CMEs. A structured interview protocol was developed for interviews with all vendors.

i. Vendor Feedback

In conversations with representatives from various national health plans it is clear that there is a medium-to-high level of interest to do business with the state and to serve the Medicaid population. However, most of the plans also stated their interest would be greater if the state expanded Medicaid to include all populations statewide in a full-risk managed care contract, especially if the state wants a two-plan model with choice. A few of the vendors mentioned the need to modernize the MMIS before launching any kind of new managed care contracting arrangement or implementing new payment models. All of the plans recognize the sensitivities in rural and frontier communities and the need to stay engaged with providers.

All of the vendors recognize the first decision the state must make is to determine what aid categories would be included in a managed care arrangement. That decision drives whether the state uses a state plan amendment to contract with health plans, or whether the state needs a rural exception or waiver if managed care is mandatory for all populations. Who is included also determines the models of care needed to serve the clients and staffing needs for case management and care coordination. The state and the plans need different infrastructure (e.g., data collection and reporting, metrics and key performance indicators, contract management and accountability, etc.) when different populations are served. The plans also believe that as long as providers can pass credentialing requirements that all should be welcomed into whatever program is developed.

Vendors generally like full-risk arrangements and there is greater potential to see a savings on expenditures, at least in the early years, with a full-risk, capitated model (if the entire population is included). It also provides greater budget predictability for the state. Plans, especially Medicaid-only plans, have extensive experience managing the care of low-income, diverse populations and are also experienced in states like Wyoming where there are one or two population centers with much of the rest of the state being rural or frontier. Plans can bring sophisticated predictive modeling and data analytics, health risk assessment tools, tracking and referral systems, tested care coordination models, experience working with community organizations and supportive services, and knowledge of state and federal requirements for benefits, payments, and transparency of reporting outcomes and enrollee satisfaction.

There is opportunity, but no guarantee, for plans to save the state money primarily by using the following approaches or tools:

- By working closely with the state eligibility determination processes, plans that receive enrollment files quickly, and reach out to new enrollees immediately, have a better opportunity to ensure continuity of care (e.g., medication management, prior authorizations) and to reduce the risk of gaps in services that might lead to visits to the ED or even hospitalization.
- Plans use health risk assessments and other tools to determine the highest-need enrollees so they can deploy case managers early, allowing the plan and the enrollee to develop a patient-centered, comprehensive care plan that will meet all of their health and social needs. Plans can assess quickly the social needs of an enrollee, such as housing and food, and get enrollees plugged into community based services quickly. Plans can assign or help enrollees choose a PCP, ensuring that their network of providers is willing and able to take new enrollees.
- Health plans have the tools and analytic capabilities to monitor utilization and expenditures so they can intervene quickly if they see patterns of use (e.g., excessive use of ED, high number of inpatient stays) that are not only expensive, but not consistent with the desire to have everyone in a health care home.
- Plans have the infrastructure and staff to work with provider groups to set quality metrics, report back to providers, and to develop incentive payments that motivate providers to concentrate on interventions and approaches that will save money and improve outcomes for enrollees. Plans are held responsible for assuring an adequate network of providers and helping enrollees get to the right provider, which in turn will save money by avoiding unnecessary trips to the ED or to over- or misuse of benefits. Plans can also monitor enrollee compliance through registries and notify and work with enrollees if there is underuse of benefits or services (e.g., Rx renewal reminders, screening or lab test follow-up, etc.) also then avoiding a more expensive intervention.
- Providing community workers and navigators to help enrollees in their home and community can save the system unnecessary expenditures by teaching enrollees about their treatment recommendations, getting to and from appointments, connecting them with social needs such as housing and nutrition, and educating them about using the healthcare system in appropriate ways. Plans often engage with trusted community groups to provide these services or supplement those resources with their own staff.
- Most health plans have web-based education tools, classes, or other mechanisms to teach enrollees how to better manage their own care and chronic conditions, giving them a better sense of control over their own lives and saving money when an enrollee can learn or report information electronically versus making an office visit, or worse a visit to the ED. Plans also have 24-hour nurse lines available to enrollees to help determine if a symptom or condition requires a visit to the provider or ED, or whether it can be managed in the home or with over-the-counter remedies.

Table 11 below summarizes vendor responses related specifically to their interest in working in Wyoming.

Table 11

Areas of Discussion	Summary of Feedback
The MCO/CME's level of interest in entering the Wyoming Medicaid market (high, medium, or low)	• Medium to high interest. • There was universal agreement that Wyoming would benefit from some type of reform resulting in greater care coordination and managed care. • One vendor said that if the state expands Medicaid, their level of interest would increase since the enrollee population would be larger.
Whether the MCO/CME would be interested in a program that: • Is statewide or only in limited regions • Includes the entire Medicaid population or limited sub-populations	• Most vendors supported statewide implementation of the model, as well as inclusion of the entire Medicaid population. This would result in sufficient enrollment to allow them to manage risk and create economies of scale. • However, one vendor that specializes in care management for the high-risk/high-needs populations supported a small pilot targeted to their niche. Conversely, a vendor with experience working with WDH said that the state has a pattern of small pilots and should think more globally this time. • One vendor suggested that it might make sense to pursue a regional implementation, for example in Casper, Cheyenne and Laramie.
Thoughts on the best approach for Wyoming	• Several vendors said that the state first needs to decide which aid categories would be included, since it drives other decisions about models of care and infrastructure. • In general, vendors preferred full-risk programs saying, "It would serve reform better." • A phased-in approach could help address challenges of implementing in rural/frontier areas. The state could start with some populations and expand. This would give vendors the opportunity to engage with and educate providers. A phased approach would be fine if there were clear intent and a timeline for expansion. Vendors want to know the full scope of enrollment prior to making significant infrastructure investments.
Number of plans/enrollees	• Some vendors supported having two vendors to allow for choice and prevent enrollees from feeling "locked in." • Others vendors recommended Wyoming seek a rural exception and only contract with one plan that would cover the entire state, as this would ensure a larger membership. In a state with fewer than 100,000 Medicaid enrollees, splitting the enrollment would make it harder for them to achieve economies of scale.
Perceived Challenges with Medicaid managed care in Wyoming	• Vendors have experience with rural states and acknowledged existing limitations in the current system that could present barriers to implementation of managed or coordinated care.

Areas of Discussion	Summary of Feedback
	• The significant distance between where people live and where services can be accessed presents challenges for the development of a model of care and assuring that enrollees can access needed services in a timely manner (i.e., availability of non-emergent transportation). • The rural nature of the state could impact the model of care developed. • To solve provider shortage issues, several vendors said they would contract with providers in border-states to ensure access standards were met. • Despite benefits of managed care, the vendors also acknowledged that it could not solve all of the issues around infrastructure needs and provider shortages (they couldn't bring more providers to the state). • One vendor with experience working with state noted the lack of experience of WDH staff with managed care. This could have significant ramifications for the design and implementation of the program, including setting an appropriate reimbursement rate and conducting ongoing monitoring and enforcement. • The lack of provider experience with managed care would require significant outreach and engagement of providers by vendors, which could be a barrier to network development. • The lack of providers in general would further impact network development.

ii. ASO Vendors

There are ASO vendors that the state can contract with to perform some of the functions of a health plan, but without having a full-risk capitated payment arrangement. ASOs can deliver the utilization management, care coordination, provider credentialing, and data collection and analytics but still pay providers FFS. The data and management of care and utilization still allows for payment reform and provider accountability in this managed FFS model and is used in a few states - especially with rural populations. These firms use claims and historical data to stratify the Medicaid populations to determine the intensity of the care management needs of individual enrollees, and they are often paid a PMPM fee for case management.

iii. HMA Assessment of Vendor Feedback

HMA believes that whether WDH decided to implement full-risk managed care statewide and include the entire Medicaid population or to take a more limited approach, the vendors who are most interested in expanding into Wyoming will likely be interested either way. Based on the feedback received through extensive stakeholder engagement process, HMA believes that some, if not most, of the health plans do not understand how difficult it will be to establish adequate networks in many parts of Wyoming, even with inclusion of out-of-state providers, or the level of resistance among providers to moving to full-risk capitation.

Section VI: Recommendations and Next Steps

A. Recommended Models

HMA conducted extensive research on managed or coordinated care models implemented in several states, obtained feedback from a broad spectrum of stakeholders through comprehensive engagement activities, interviewed health plans that have Medicaid managed care programs in many states, and identified the current initiatives underway in Wyoming. HMA recognizes that no two states are alike and has not recommended an approach simply because it has worked in other states. Our recommendations are supported by the quantitative and qualitative data gathering and analyzed for this study.
HMA recommends that WDH continue to pursue the PCMH model of care coordination, but target two subsets of the population for enhanced care management services:

- Identify Medicaid enrollees who meet specific utilization, diagnoses and cost criteria to receive an enhanced level of care coordination through a PCMH. Pay PCMHs a risk-adjusted rate for the enhanced services.
- Identify Medicaid enrollees who are "super utilizers" – the small number of individuals who have extraordinarily high needs, utilization and costs. Buy or build a structure for very high-touch care coordination and care management services for these individuals in addition to the enhanced care management they receive through a PCMH.

B. Models Not Recommended at This Time

HMA does not recommend that Wyoming pursue PCCM, ASO, ACO, or Risk-Based Managed Care at this time. We have not recommended these models for several reasons:

- Wyoming is already moving beyond the more basic forms of managed care and should not "go backwards."
- Wyoming already has a number of initiatives underway and adding yet another to the mix would dilute the ability for those initiatives to achieve success.
- Stakeholders, both within the WDH and externally, were opposed to changes that would bring in organizations unfamiliar with Wyoming's unique communities, issues and needs. This opposition included strong sentiments against anything that might jeopardize participation of providers in the Medicaid network.

C. Next Steps

In addition to implementing the above initiatives as part of the work already underway, HMA recommends a number of next steps and action items that would support all of WDH's efforts, as well as help to ensure ongoing stakeholder buy-in and engagement.

i. Focus on successfully implementing initiatives currently underway or planned

Discussions with stakeholders, as well as research into efforts underway in the state revealed a great deal of transformation already underway – many of which will lead to improved care and slow the growth of Medicaid expenditures. The one new initiative that HMA believes Wyoming should consider is a Super-Utilizer program (SUP) in concert with a targeted PCMH effort. Through the SUP, Wyoming can provide intensive outpatient care management to these enrollee subpopulations who have very complex physical, behavioral, and social needs and target effective interventions.

WDH should continue to build on these efforts to secure buy-in for the model and identify potential sites/providers willing to participate. Again, as the state learns from its PCMH initiative, it can identify

important “lessons learned” and continue to build the infrastructure supports that will be necessary to fully implement successful Health Homes.

Given its comprehensive redesign of Medicaid LTC and ID/DD waivers, HMA does not recommend that WDH pursue any additional reforms to these service areas. WDH already has multiple workgroups and committees supporting the LTC Service Redesign and the ID/DD/ABI Waiver Reform and should continue these to help inform the progress and process as these new programs are operationalized. However, HMA does recommend that these initiatives be connected to the others through the roadmap (see Recommendation #2). Doing so can help WDH identify opportunities for leveraging components of other initiatives that may benefit waiver recipients, and vice-versa. HMA also does not believe that waiver recipients should be excluded from the other care coordination initiatives WDH is pursuing. For example, many of these enrollees likely would be candidates for the SUP because they typically are high-cost and high-utilizers of services.

Additionally, the state's PACE program appears to be high-functioning and participation is greater than had been expected. HMA recommends that WDH continue and expand the PACE model as demand dictates and so long as the program is meeting the state's goals. As noted in the earlier discussion of PACE programs, while PACE can effectively meet the needs of a specific patient population, it is generally not cost efficient to scale the model significantly. Maintaining a separate PACE program will not impact care coordination efforts for other Medicaid enrollees.

ii. Create a Roadmap for Medicaid Reforms

To help WDH track and manage the myriad reforms currently underway and to help stakeholders understand everything that is being done, HMA recommends that WDH create a roadmap of Medicaid reform activities. The map should be created with stakeholder involvement and feedback to ensure buy-in. The roadmap should include:

- All old, new, and planned care coordination activities and initiatives for the next three to five years – <u>all</u> care coordination activities WDH is engaged in or planning should be part of this overview, including work being done by CQS, the Pharmacy Benefit Management (PBM) program, PCMHs, new LTC and ID/DD waivers, and planning for Health Homes and a super-utilizer program if expected to add one.
- Clear definitions of the enrollees and providers encompassed by each initiative or activity – this would help to show where there are overlaps and allow for better coordination for enrollees in those situations. It also could help to identify opportunities for leveraging technical assistance and technology support, as well as gaps in both WDH experience/expertise and stakeholders’ capabilities.
- How WDH is connecting and leveraging each initiative, including funding - whether state funds, federal funds, or other external funds. A comprehensive review of programs and initiatives and their funding sources can help WDH better hold all stakeholders accountable for the dollars and services they receive (i.e., enrollees, providers, community service organizations, advocates, and WDH staff).
- The current status of each activity and initiative, as well as expectations for where they will be each year for the next five years – a timeline of ongoing monitoring for existing programs, as well as for implementation activities for new programs will help all stakeholders understand when things will be happening so they can appropriately prepare for the changes. This also serves as a mechanism for WDH to plan for what it needs to support each of these activities in terms of additional staff, systems and tools, training, and policy or legislative changes.

Once final, this road map and timeline would help guide WDH's policy, program, budget and staffing decisions through the life of the roadmap.

iii. Conduct Comprehensive Stakeholder Outreach, Education, and Engagement

Comprehensive, on-going stakeholder engagement is vital to the success of new initiatives. Such engagement helps inform the development of the initiative so that it will work within the existing system and engenders support and buy-in from the people affected by the change. We encourage the continuation and expansion of current stakeholder outreach activities through the creation of a comprehensive stakeholder engagement plan. Many stakeholders do not fully understand how the various models of care and health information technology systems work and what their role is in them.

The Wyoming Integrated Care Network, the Wyoming Institute for Population Health and others have led efforts to educate providers about the need for and viability of the PCMH model. There are multiple workgroups and committees for the LTC Service Redesign and the ID/DD/ABI Waiver Reform. Yet even with these efforts, there is still significant need for education and engagement among the provider community, enrollees, advocates and policy-makers.

Additionally, some non-primary care providers failed to see how a more coordinated approach to providing care might change their practices and didn't always understand that there would be an increased expectation that they collaborate and communicate with other practitioners. During the public forums and stakeholder interviews, many participants, including providers, were unfamiliar with the concepts and models for care coordination and management. Many providers believe they are coordinating and managing care, but when asked to describe how they do it, it becomes apparent that many are not yet meeting the more stringent and comprehensive care coordination/care management requirements that these models comprise or that are required to successfully meet some of the new shared savings/losses models or quality performance metrics. Providers will need technical assistance, training and support to be able to successfully implement many of these changes.

WDH should create a comprehensive stakeholder education and engagement plan based on its roadmap (see Recommendation #2 above). The plan should:

- Identify all the relevant stakeholders for each activity/initiative. For example, specific stakeholder groups may include providers (all types), associations, enrollees, advocates, community-based service organizations, commercial insurers, legislators, leaders of other state agencies, other leaders within WDH, among others.
- Identify each stakeholder group's key issues (e.g., reimbursement, access to care, quality improvement, cultural competency, etc.).
- Identify each stakeholder group's preferred modes of communication (e.g., in person meetings, e-mail alerts, public forums, surveys, etc.).
- Assess each stakeholder group's level of awareness and understanding of the activities/initiatives and their capabilities with each (e.g., access to and ability to use technology such as EHR and HIE, current care coordination practices and staffing, experience and expertise working with target populations, reporting and evaluation resources, etc.).
- Assess each stakeholder group's ability to impact (positively and negatively) activities/initiatives and their role in each.
- Develop specific messages and information each stakeholder group needs from WDH to ensure their support and to help them be as successful as possible in each activity/initiative.

- Establish timelines for communicating with each stakeholder group based on the timing of specific activities and initiatives, as identified in the roadmap.

iv. Build the Necessary Infrastructure

Universally, stakeholders noted the need for increased and improved infrastructure – from technology to workforce development – across the state. While Wyoming has a number of initiatives underway to enhance technology, including a Health Information Exchange and Total Health Record, more work remains, including educating providers and attaining widespread use.

Technology

For example, given the importance of sharing data among providers and building future value-based payment methodologies, WDH should take a lead role in revitalizing and fully building out the state's Health Information Exchange (HIE). It may be necessary to identify other partners who can help to support the project, including foundations or other private funders. Additionally, despite the extensive work Wyoming Medicaid has done to design, implement, and deploy the THR and Gateway system, many providers in Wyoming remain unaware of it. Stakeholders were asked during interviews to identify the top three things that need improvement before care coordination could be successful in Wyoming - a statewide electronic health record was always among the top three (increased number and types of providers and tele-health were the others).

Stakeholders also noted the value that an all payer claims database has, but believe the legislature would not mandate participation by all payers in the state. WDH could have a role in moving this initiative forward, even on a voluntary basis. Recent "All Payer" meetings with the major commercial payers in Wyoming (Cigna, WinHealth, BCBS) have indicated there is a willingness to create a "Quality Foundation" with the payers represented on the Board, where all payer data is managed in a way that does not threaten the competitive business model, while allowing Wyoming to recognize and reward quality practices.

With the multitude of data and new technologies that are being implemented to share that data, it becomes more important for the state to be able to effectively manage and maximize the use of data. WDH should consider building out its capacity to do more sophisticated data analysis or securing a vendor that can provide such services. This might include predictive modeling software or tools to help identify enrollees for enhanced care management interventions, tools to conduct population-based or geographic based interventions, and tools to profile providers to understand variations across geographic areas or identify outliers who may need additional education and training.

Workforce Development

A number of workforce development programs are in place across Wyoming, and Medicaid could serve as special champion for many of them through various efforts such as:

- Supporting the University of Wyoming's development of an Educational Health Center (EHC of Wyoming) umbrella for the two residency programs. If successful, the state will be able to add residency slots either for the traditional programs or under a federally qualified rural training track.
- Supporting innovative medical education programs that can be funded through philanthropic donations, similar to the University of Colorado - Denver Family Medicine Patient Centered Medical Home Residency Program, which is funded through a $2.8 million grant from the Colorado Health

Foundation.[24] Similarly, the state could pursue funding sources to support programs to train and certify Community Health Workers as part of integrated care coordination practices and for enrollee education and engagement.

- Supporting an assessment of existing scope of practice and licensure requirements to determine if existing requirements allow all provider types to practice at the fullest extent of their education and training.

v. Implement value-based payments

For each of the initiatives underway or planned, WDH should begin to incorporate value-based payments for quality improvements, cost savings, or both. Value-based payments seek to align incentives across providers and require them to take on greater accountability in an attempt to get them to consider the costs of their decisions, reduce waste and overuse, provide appropriate care, and increase coordination. They also create incentives for providers to deliver the right care, at the right time, in the right setting. Such payments are most effective when they are tied to performance requirements, determined through quality measurement reporting and other quality monitoring.

WDH will need to build up and expand its technical in-house expertise to manage and support new reimbursement options and the different reporting and reconciliation processes for each, as well as offer technical support for providers. A new, more flexible MMIS system would help WDH better track and manage new payment models and ensure that providers still receive timely and accurate compensation for the new initiatives they undertake. It also would allow the state better management reporting capabilities so staff could identify and resolve issues more quickly and effectively.

Because providers in Wyoming generally have experience only with fee-for-service, movement to value-based payments should be done slowly and with meaningful participation by all stakeholders. For example, starting with a shared savings pool would allow providers to earn bonuses or incentives if they meet state-specified metrics, e.g., quality targets, practice changes that enhance care coordination, or better communications with other providers. This could help to build the necessary experience, systems and reporting foundations for moving to greater financial accountability over time, including shared losses and capitated payments.

D. Conclusion and Tie to Task II of the Project

This report comprises the final deliverable for Task I. Based on the research from this paper, and in ongoing consultation with WDH, HMA has begun work on Task II of the project – data analysis of models of care to identify cost savings and quality improvements WDH could potentially achieve through them. That data analysis will focus on implementation of the PCMH model, with a super-utilizer program built on it for the most complex enrollees.

[24] To learn more about the program, visit http://www.ucdenver.edu/about/newsroom/newsreleases/Pages/FamilyMedicineResidencyProgramLeadsPatientCenteredMedicalHomeInitiative.aspx

Appendices

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Appendix A: Managed Care History and National Activities

History of Managed Care

Shortly after Medicaid was enacted in 1965, states began experimenting with different models of care, including capitated managed care.[25] Table 1 provides an overview of key time-periods and activities in the growth of full-risk Medicaid managed care.[26]

Table 1: History of Managed Care

Period	Activities	Key Outcomes
1965	Medicaid enacted	
Late 1960s – mid 1970s	States begin experimenting with different models of care CA pursues Medicaid managed care – state believes its established commercial managed care marketplace will make a solid foundation	In CA Capitation rates set too low Lawsuits over marketing activities Under-capitalization of plans
1976	In response to CA "scandals" U. S. Congress passes legislation requiring HMOs be federally qualified to receive full-risk Medicaid contracts No more than 50% of covered lives in any HMO could be Medicare or Medicaid enrollees	In CA Enrollment in managed care plummets Number of plans reduced by more than two thirds
Early 1980s	New federal regulations and policies Encourage federal government to delegate to states Encourage states to expand use of Medicaid managed care and other service delivery methods Increase maximum percentage of Medicaid/Medicare enrollees in a qualified HMO to 75 percent AZ implements program in 1982 - the last state to do so - and receives permission to use capitated managed care plans to provide all Medicaid services (start was fraught with challenges but state continues to use this model)	Many states pursue managed care CA reorganized managed care programs NY encouraged safety-net providers to form prepaid health service plans One researcher (1994 study) compared AZ to NM's FFS program and concludes that AZ beneficiaries received more primary care services and better overall care GAO, though not critical, reports in 1995 that the AZ's focus on limiting costs "appears not to have adversely affected the care provided to AZ Medicaid beneficiaries."

[25] Michael Sparer, "Medicaid managed care: Costs, access, and quality of care," Robert Wood Johnson Foundation, Research Synthesis Report No. 23, September 2012. http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html.

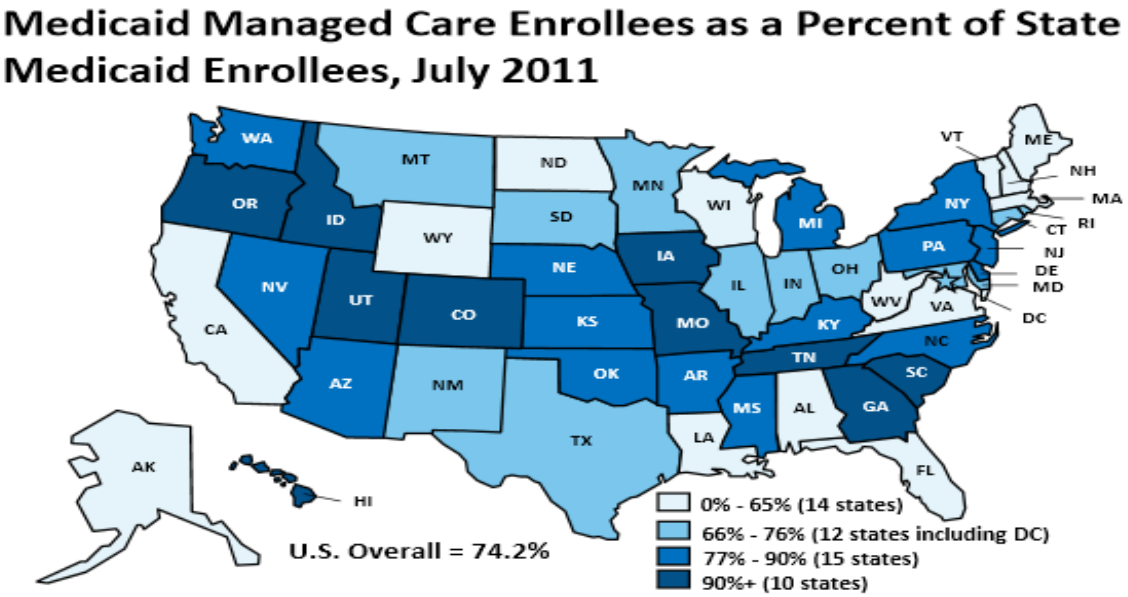
[26] Embry M Howell, Ashley Palmer, Fiona Adams, "Medicaid and CHIP Risk-Based Managed Care in 20 States. Experiences Over the Past Decade and Lessons for the Future," Final Report to the Office of the Assistance Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, July 2012. *http://www.urban.org/UploadedPDF/412617-Medicaid-and-CHIP-Risk-Based-Managed-Care-in-20-States.pdf* and Sparer, *Medicaid Managed Care,* at 1.

Period	Activities	Key Outcomes
Early – mid 1980s	• Little growth in Medicaid managed care, most states continue to rely on FFS	•
Late 1980s – late 1990s	• Medicaid growth and expenditures soar due to • Enrollment growth from new eligibility mandates and economic recession • New federal law requires higher reimbursements for safety net providers • States pursue managed care, hoping it will • Lower costs • Improve access and quality	• Urban states focused on shifting young adults and children to commercial HMOs • Rural states used PCCM models • Some states used PCCM in rural areas and full-risk managed care in cities and suburbs •
Late 1990s – early 2000s	• Balanced Budget Act (BBA) passes (1997) • States can use State Plan Amendment (SPA) to implement mandatory managed care for some populations (parents and children) - 1115 or 1915(b) waiver not required • Repeal 75/25 rule governing proportion of Medicare/Medicaid enrollees in an HMO - states can create Medicaid-only managed care plans • BBA regulations state that full-risk capitation programs must have contracts that articulate requirements for: • Access, provider credentialing, appointment availability • Annual external independent quality reviews • choice of plans with mandatory enrollment (except for rural areas) • Actuarially sound rates (in statute since 1981 – enforced after BBA)	• Medicaid capitated managed care expands greatly • Dominant delivery system for children and young adults – (commonly referred to as TANF populations since many are also enrolled in the Temporary Assistance for Needy Families program). • Generally fewer have special needs – easier to develop network • Costs tend to be more predictable and it is easier to establish actuarially sound rates (especially early on when data collection and analysis were not as sophisticated as they are now) • Can be mandatorily enrolled with SPA – much simpler approval process and more predictable membership for HMOs through mandatory enrollment requirements • Most aged, blind, disabled beneficiaries continued to receive care through FFS system

National Managed Care Activities

Figure 1 below depicts the percentage of Medicaid enrollees in each state that are in some form of managed care. It is important to note that the data are from 2011; CMS has been slow to release the 2012 information, but there have been changes since then. Additionally, the map below counts anyone who is in any form of managed care. For example, both Colorado and Iowa have mandatory managed care for their behavioral health services, meaning all Medicaid enrollees are categorized as being in managed care. However, in 2011, both states only had small PCCM programs and capitated managed care in several urban counties for their physical health care services and neither state was using managed care for their long-term care services, with the exception of the Program for All-Inclusive Care for the Elderly (PACE).

Figure 1: Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees, July 2011

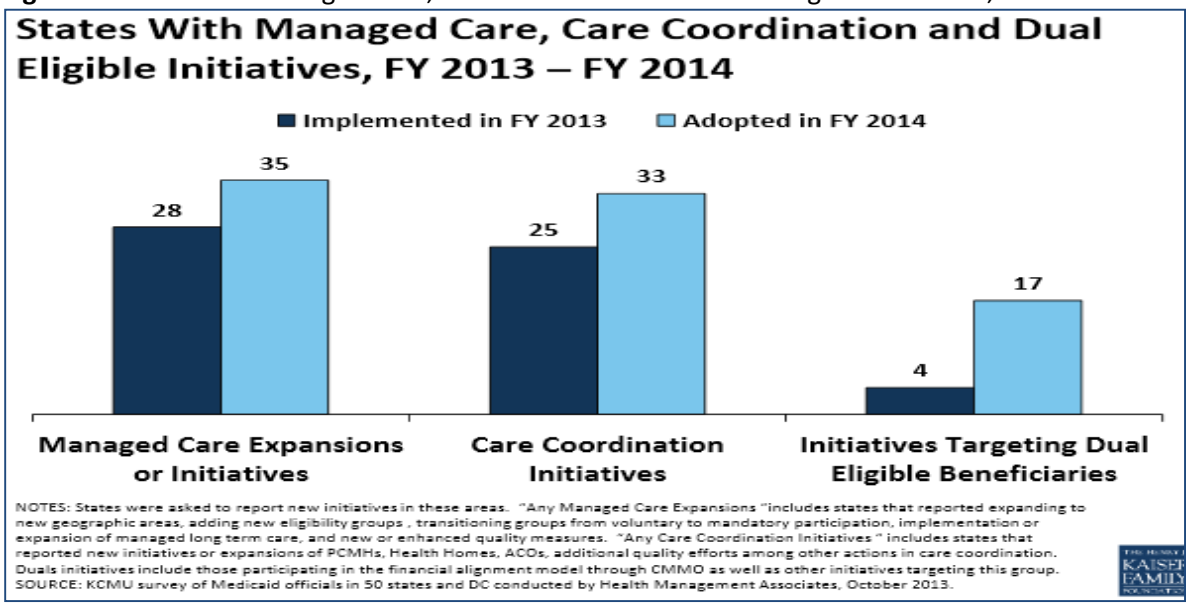


NOTE: Includes enrollment in MCOs and PCCMs. Data are as of July 2011. The data shown here are unduplicated managed care enrollment figures that include individuals in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards and enrollees receiving comprehensive and limited benefits.
SOURCE: Medicaid Managed Care Enrollment Report, CMS, November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf.

Increasingly, states are also exploring new models of care such as PCMHs, Health Homes (as authorized by Section 2703 of the ACA), and ACOs.[27] States are also developing programs to target super-utilizers, and are changing reimbursement models by moving to bundled payments, incentives, and shared savings and losses. As demonstrated in Figure 2 below, in 2013 alone, the majority of states initiated some kind of managed care or coordinated care change.

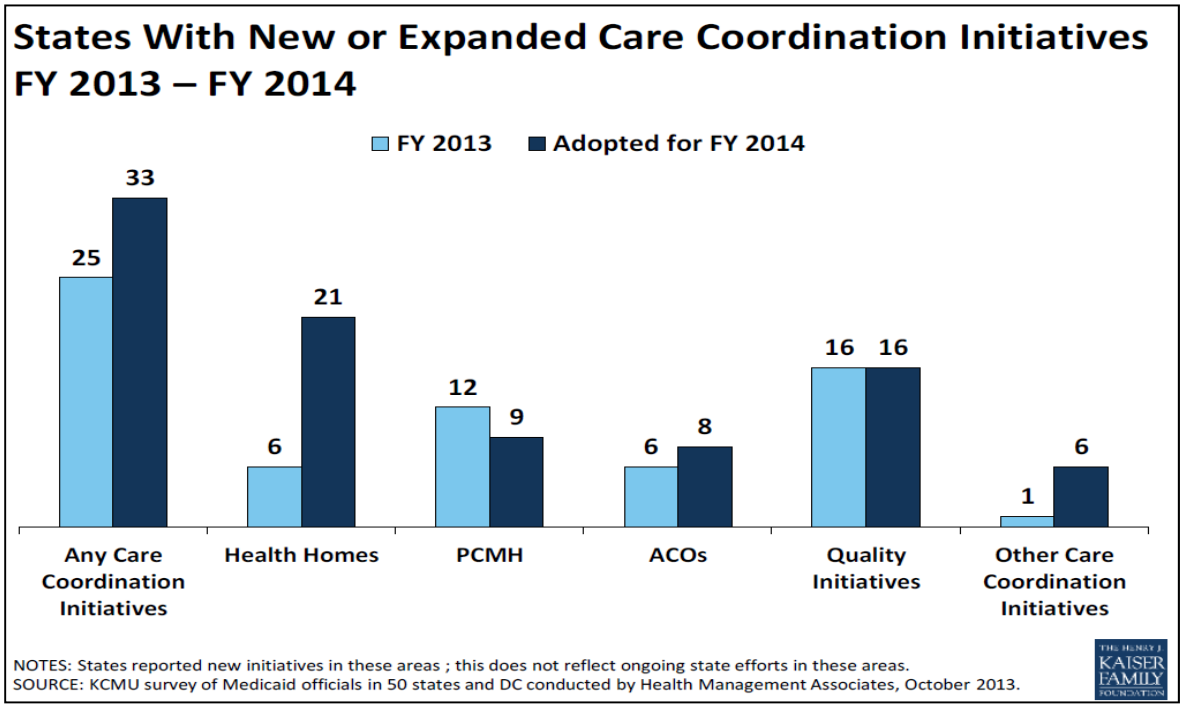
[27] These models are described later in this Appendix.

Figure 2: States with Managed Care, Care Coordination and Dual-Eligible Initiatives, FY2013-FY014



The most common care coordination initiative is the Health Home, which focuses on people with mental health and substance use disorders, as well as those with multiple chronic conditions. As shown here in Figure 3, more than one in three of the states implementing care coordination models are pursuing Health Homes.

Figure 3: States with New or Expanded Care Coordination Initiatives, FY2013-FY2014



Appendix B: Models of Care

i. Primary Care Case Management Model

Structure

PCCMs are generally primary care providers or practices who are responsible for approving and monitoring the care of enrollees based on the specific criteria established by the state for the program. This model works well in rural areas because it does not require significant infrastructure or staff investments from providers who may have limited resources. A PCCM model can be managed by the state or by a contractor for relatively low administrative costs.

CMS does not require much oversight of a PCCM and the model can be implemented without requiring a waiver or extensive changes to a State Plan Amendment (SPA). Twenty-two states have PCCMs:

- 10 with PCCM only
- 22 with PCCM and risk-based capitated managed care

Payment Methodologies

Providers usually are paid FFS plus a monthly care management fee (typically between $2 and $5 per member per month (PMPM)). Some states include pay-for-performance financial incentives (e.g., Pennsylvania's ACCESS Plus program).

Data Needs

PCCM programs do not require states to collect a lot of sophisticated data, although better data gives states information about how providers in the network are performing, outcomes for enrollees, and can be used to develop quality improvement initiatives and possible incentives or performance rewards.

Culture Change

PCCMs do not require providers to change much in their practices or invest a lot in staff and systems. Enrollees are assigned to a PCP who delivers their primary care, preventive care, and some care management. PCPs make referrals and provide authorizations when enrollees' need hospital and specialty care. There are some enhanced PCCMs that include more intensive care coordination and care management services, but not at the level of a PCMH or Health Home.

Savings and Quality Improvement

There is limited research on savings and improved quality of care in PCCM programs.

An evaluation of Iowa's program concluded that it generated savings of 3.8 percent ($66 million) between 1989 and 1997.[28] For the study, researchers compared PMPM actual costs with expected costs in the absence of the PCCM program. Use of the PCCM program was associated with increases in outpatient care and pharmaceutical expenses, but a decrease in hospital and physician expenses. A synthesis report by the Robert Wood Johnson Foundation on managed care's impact on cost and access concluded that this study's findings are limited by use of older data and focus on only one state.[29]

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[28] *Michael Sparer. "Medicaid managed care: Costs, access, and quality of care. Robert Wood Johnson Foundation, Research Synthesis Report No. 23. September 2012. http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html*

[29] Ibid.

Other studies on both MCOs and PCCM models found little evidence of improved access in PCCM models. A study across multiple states found that "children in PCCM had higher rates of unmet needs and more were without usual sources of care as compared to FFS."[30]

Recently, some states have begun transitioning away from the PCCM model to more comprehensive models such as risk-based capitation (Delaware, Florida, Georgia, Kentucky, Illinois, Nebraska, New York, Pennsylvania, Texas and Virginia), while others are retaining the PCCM model but requiring more from their existing programs.[31]

ii. Patient Centered Medical Homes

Structure

The PCMH is not a new concept, having been around since 1967. Yet it was not until 2007 that the American Academy of Family Physicians and three other medical associations issued guiding principles for PCMHs. That same year, the National Committee for Quality Assurance (NCQA) also issued specific standards that providers must meet to be recognized as a PCMH, setting a high bar for care delivery and coordination. Interest in the model has increased significantly in the last several years, including for both commercial health coverage and in Medicaid/Medicare.

The goal of a PCMH is to treat the whole person through all stages of their life using a coordinated, integrated approach to care delivery, ensuring access to all needed services. The PCMH model is distinct from a primary care practice (PCP) or PCCM program in that the assigned provider team has responsibilities beyond coordination of medical services, such as ensuring after-hours access, maintaining electronic health records and tracking quality metrics, conducting comprehensive health assessments for all new patients and proactively managing and reducing barriers for high-risk patients[32]. PCMHs are generally primary care practices, Federally Qualified Health Centers (FQHCs) or Community Health Centers (CHCs), and other primary care settings.

The PCMH is a model that can be viable in rural areas. For example, in 2011, Nebraska conducted a two-year pilot PCMH project with two rural practices that had a total of 7,000 Medicaid members. The goals of the project included transforming the two practices into recognized (NCQA-certified) PCMHs to 1) improve health care access and health outcomes for patients and 2) contain costs. A November 2013 final report of the Nebraska PCMH pilot prepared for the Governor and legislature concluded that: “This pilot demonstrated improved patient satisfaction, marked efficiencies with the modification of office practices, improvements in patient health through care coordination and patient education, and indicators showing potential for containment of costs.”[33]

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[30] *Michael Sparer. "Medicaid managed care: Costs, access, and quality of care. Robert Wood Johnson Foundation, Research Synthesis Report No. 23. September 2012. http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html*

[31] Smith et. al., November 2013.

[32] Standards and Guidelines for Physician Practice Connections ® - Patient Centered Medical Home (PPC-PCMN™), NCQA, CMS Version, October 6, 2008.

[33] *FINAL REPORT: Patient-Centered Medical Home Pilot* (LB 396 – 2009); Provided to the Governor of the State of Nebraska and the Health and Human Services Committee of the Legislature, prepared by Vivianne M. Chaumont, Director, Division of Medicaid and Long-Term Care, Nebraska Department of Health and Human Services, November 1, 2013.

Payment Methodologies

Many states are building on their existing PCCM infrastructures to establish their PCMHs. In 2012, at least half of the states reported having a Medicaid/CHIP PCMH.[34] The majority of states pay providers a PMPM care management fee. These fees vary considerably from state to state and are often adjusted for patient age, acuity and PCMH NCQA accreditation level (there are three levels). Fourteen states use performance-based payments, but very few make upfront payments. One of the key recommendations in the final report of the Nebraska PCMH pilot was that the state should consider "linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency and improved health outcomes."[35]

Data Needs

According to Health IT in the Patient Centered Medical Home,[36] a compendium of information about HIT needs and best practices for PCMHs. HIT can assist a PCMH in its ability to:

- Collect, store, manage and exchange relevant patient health information, including patient-generated data.
- Enhance or facilitate communication among providers and options for delivering care to patients.
- Measure, analyze and report on quality and other outcomes.
- Communicate with patients via mechanisms such as web portals.

Culture Change

Despite the promise of PCMHs, there are still limitations as well as challenges with implementation. PCMHs are largely an expanded primary care medical model and don't always effectively coordinate with non-medical services. Becoming a PCMH requires a primary care practice to undergo a fundamental shift in how care is delivered – which can be especially difficult for small, rural practices with limited staff resources to meet some requirements such as more coordinated referral and management of enrollees' care with other providers (specialists, hospitals, behavioral health, etc.) and for any social services they may also need. Practices are at varying levels of readiness, so a state's approach must account for these different needs.

When the two practices that participated in the Nebraska PCMH pilot project were asked if they would do it again, staff from one PCMH responded they absolutely would, while staff from the other PCMH said that given the reluctance of some of the providers in the practice, they probably would not. A

[34] Mary Takach, "About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations," *Health Affairs*, Nov. 2012 31(11):2432–40.

[35] Nebraska Department of Health and Human Services, "FINAL REPORT: Patient-Centered Medical Home Pilot (LB 396 – 2009)," Provided to the Governor of the State of Nebraska and the Health and Human Services Committee of the Legislature, prepared by Vivianne M. Chaumont, Director, Division of Medicaid and Long-Term Care, November 1, 2013.

[36] Patient Centered Primary Care Collaborative, "Transforming Patient Engagement: Health IT in the Patient Centered Medical Home: A compendium of resources from the Patient Engagement task force of the Patient-Centered Primary Care Collaborative," October 2010, www.pcpp.net

lesson learned from the pilot was that adequate time is needed at the beginning of a PCMH project for change management.[37]

Savings and Quality Improvement

Since the PCMH model in the Medicaid program is relatively new, there is limited information on cost savings and improvements in care and health status. The February 25, 2014, *Journal of the American Medical Association* (*JAMA*), includes an evaluation of a three-year medical home pilot in Pennsylvania – the Southeastern Pennsylvania Chronic Care Initiative - one of the first multi-payer medical home programs in the country.[38] The authors examined changes in care quality, utilization, and costs in 32 primary care practices that had achieved NCQA recognition as medical homes, compared with 29 practices that did not receive recognition. The evaluation suggested that the program was not associated with significant improvements in quality of care or cost reductions.

However, a study in the American Journal of Managed Care looked at this same cohort of Pennsylvania PCMH patients in a slightly different way – to see if there were differences between the total PCMH patient population vs. a pool of the highest-risk patients in those PCMHs. "PCMH model adoption was shown to lead to a significant relative reduction in total costs in years 1 and 2, and significantly lower numbers of inpatient admissions in all 3 years [2008-2010]. This suggests that the average patient may not be the relevant unit of observation for evaluating the impact of PCMH adoption. Rather, high risk patients with multiple comorbidities are the most logical targets for interventions aimed at supporting self-management, conveying test results in a timely and clear fashion, and coordinating follow-up and specialist care. Researchers may miss cost and utilization improvements if they confine their analyses to the typical patient, since healthcare costs are primarily driven by relatively rare events concentrated in few individuals. For example, during the baseline year, all cases and controls had 73 and 78 admissions per 1000 patients, respectively; but among the high-risk pool, these numbers increased to 566 and 540."[39]

The authors go on to point out that based on this method of evaluation of PCMH effectiveness, it appears the model can and does have the intended effect of reducing cost through better patient care coordination. They note that even though their study found a decrease in the total costs of patient care of $107 and $75 (2009 and 2010, respectively), there were increased costs and utilization for specialist care. However, that increase was offset by the decrease in inpatient hospitalization. This, they suggest, is likely the result of better information sharing and coordination among providers and a focus on earlier and more appropriate interventions.

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[37] *FINAL REPORT: Patient-Centered Medical Home Pilot* (LB 396 – 2009); Provided to the Governor of the State of Nebraska and the Health and Human Services Committee of the Legislature, prepared by Vivianne M. Chaumont, Director, Division of Medicaid and Long-Term Care, Nebraska Department of Health and Human Services, November 1, 2013.

[38] "Association Between Participation in a Multipayer Medical Home Intervention and Changes in Quality, Utilization, and Costs of Care," Mark W. Friedberg, MD, MPP; Eric C. Schneider, MD, MSc; Meredith B. Rosenthal, PhD; Kevin G. Volpp, MD, PhD; Rachel M. Werner, MD, PhD *JAMA.* February 2014 311(8):815-825.

[39] Susannah Higgins, MS; Ravi Chawla, MBA; Christine Colombo, MBA; Richard Snyder, MD; and Somesh Nigam, PhD, "Medical Homes and Cost and Utilization Among High-Risk Patients," American Journal of Managed Care, March 24, 2014. http://www.ajmc.com/publications/issue/2014/2014-vol20-n3/medical-homes-and-cost-and-utilization-among-high-risk-patients.

At least one other health policy expert also noted that as the PCMH model has evolved significantly over the last several years, it has become clear that reimbursement structures need to reward cost savings, as well as quality improvement. For example, the Capital District Physicians Health Plan innovation in Albany, NY, which started in 2008, is testing payment models that reward reductions in unnecessary care utilization, increased cost savings, and improvements in quality. Early result show significant improvements in these areas.[40] Similarly, the Nebraska PCMH pilot project found mixed results, with improvements in reductions in high-cost imaging, reductions in the number of prescriptions per 1,000 members, reduced ED utilization, and improved patient satisfaction. However, there was a slight increase in overall inpatient admissions, no measurable difference in ED re-visits for the same complaint, and fluctuations in the levels of provider satisfaction over the course of implementation.[41]

iii. Health Homes[42]

Structure

Health Homes are a new delivery system and payment model authorized by Section 2703 of the Affordable Care Act (ACA). The program was designed to focus on enrollees with mental health and substance abuse issues, as well as multiple chronic conditions. There are specific statutory requirements for the target populations that can be enrolled and the services that must be provided, although CMS has allowed states some room to identify other conditions to include and definitions of the services their Health Homes will provide; these then must be detailed in the State Plan Amendment.

Target populations for Health Homes are Medicaid enrollees with:

- Multiple chronic conditions
- One chronic condition and at risk for another
- One serious and persistent mental health condition
- A mental health condition
- A substance use disorder
- Asthma, diabetes, heart disease, and a body mass index (BMI) over 25

States must provide the following services in their Health Homes:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support services
- Referrals to community and social supports
- Use of health information technology to link services, as feasible and appropriate

States may target geographic areas for focus, and unlike other Medicaid programs which must be implemented statewide, no waiver is needed for geographic implementation. To encourage states to

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[40] *A Health Plan Spurs Transformation Of Primary Care Practices Into Better-Paid Medical Homes,* J. Lester Feder, Health Affairs, April 2014, Volume 33, Number 4.

[41] *FINAL REPORT: Patient-Centered Medical Home Pilot* (LB 396 – 2009); Provided to the Governor of the State of Nebraska and the Health and Human Services Committee of the Legislature, prepared by Vivianne M. Chaumont, Director, Division of Medicaid and Long-Term Care, Nebraska Department of Health and Human Services, November 1, 2013.

[42] Barbara Ormond, Elizabeth Richardson, Brenda Spillman, Judy Feder, "*Health Homes in Medicaid: The Promise and the Challenge*," Urban Institute, February 2014.

pursue this model and to ensure sufficient funding is available, states can receive a 90 percent federal match for the first eight quarters of their program. Each time a state expands geographically or includes new conditions, eight more quarters of enhanced match are available to those individuals meeting the new criteria.

Health Homes differ from PCMHs in several fundamental ways as shown in Table 2 below.

Table 2

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• PCMHs	• **Health Homes**
• May not be required to integrate physical and behavioral health care services	• Must integrate physical and behavioral health care services
• Provides care to anyone a state chooses to assign	• Targeted to specific high-risk enrollees with chronic conditions
• Not necessarily required to extend coordination beyond medical services to social and community supports	• Required to extend coordination beyond medical services to social and community supports
• Based in a medical setting, generally primary care providers	• Variety of providers, including behavioral health and non-traditional providers such as supportive housing programs; a priority focus on integrating multiple services

Many of the early Health Home states have built this initiative upon existing structures and programs and aligned them with other reform initiatives. As of December 2013:

- 14 states have approved programs (three have two approved SPAs for different programs)
- 12 additional states have submitted SPAs or have made official Health Home planning requests[43]
- 21 states plan to adopt or expand use of Health Homes in 2014.[44]

Payment Methodologies

Most states pay a PMPM for Health Home services, but some also are experimenting with other reimbursement methodologies:

- Missouri, the first state to receive federal approval, established its PMPM by estimating the costs required for Health Home providers to develop necessary clinical and administrative capability. Missouri also has expressed interest in shared savings strategies and performance incentive payments.
- Iowa has built risk adjustment and pay for performance into its model.
- New York has committed to sharing with its Health Home providers any savings gained through reductions in Medicaid expenditures.

[43] Ormond et al.

[44] Vernon K Smith, Ph. D., Kathleen Gifford, and Eileen Ellis of Health Management Associates, Robin Rudowitz and Laura Snyder, "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014," October 2013. http://kff.org/medicaid/report/medicaid-in-a-historic-time-of-transformation-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2013-and-2014/.

Data Needs

According to a CMS Technical Brief in 2012 on Health Homes,[45] at minimum, states should consider the following data needs for establishing and monitoring Health Homes under Section 2703:

- Cast the Net Widely - As a starting point, identify all enrollees who meet the eligibility requirements under Section 2703.
- Stratify Beneficiaries into Sub-Populations - The eligible population will be heterogeneous. Stratification of the population can develop more homogenous subgroups and, therefore, help define the array of services that need to be included in Health Home design.
- Understand High-Cost Enrollees - Analyze service use and cost patterns for enrollees who comprise the top 5, 10 or 20 percent of Medicaid costs. Identify what services they are receiving, who is providing their care, and how much opportunity there is to avoid high-cost services with strong care management supports.
- Identify Enrollees Who Have a High Medical Risk - If a state does not use predictive modeling, it can identify individuals with several diagnoses and sort the population by the number of conditions or utilization or cost metrics. Data from health risk assessments are also valuable in identifying people at high risk.
- Understand Where Enrollees Live - Identify "clusters" where a sufficient critical mass of eligible enrollees resides.
- Consider Including Sub-Populations - When stratifying and targeting eligible subpopulations, identify the: (1) total number of enrollees in each subpopulation; (2) total Medicaid expenditures; (3) average PMPM costs; and (4) rate of potentially avoidable and costly services.
- Differentiate Emergency Department Visits - Outpatient ED visits may lead the Health Home to focus on building a connection between the enrollee and his/her primary care provider (PCP), while ED visits that result in inpatient admissions may demand a strong focus on care transitions, discharge planning, and follow up with the PCP.
- Define Care Providers Used by the Target Population - Identify whether the target population has a usual source of care and whether that source of care is appropriate.
- Identify Missing Links to Primary Care Providers - It is important to identify and address missing linkages to primary care, particularly for Health Homes programs that "reside" in the behavioral health care delivery system.
- Understand Who Manages the Care of the Target Population - If an enrollee has an existing relationship with a care management program, the state should build on those services, replace them, or target Health Home services to a population not already receiving care management.
- Complete, timely, and accurate data is important both for Health Home services – case management, care coordination, and care transitions – and for program evaluation.

Culture Change

Due to the newness of the Health Home model, evaluation of it has focused primarily on the design, motivations and goals, monitoring measures to be collected, and other basic parameters for each program.[46] Evaluators report five key challenges for early implementer states:[47]

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[45] CMS Technical Brief, "Data Analysis Considerations to Inform Medicaid Health Home Program Design," June 2012.

[46] The Urban Institute is conducting a long-term evaluation for the U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation and, at the time of this study, only the first year's evaluation was publicly available (submitted December 2012).

[47] Ormond, et. al.

- Treating the whole patient through teamwork and collaboration with providers not accustomed to working together requires a major cultural change.
- Real-time and thorough communication is essential but also technically, legally, and operationally complex. Facilitating communication through technology requires:
    - Investments in systems and staff training
    - Addressing design limitations and high cost of EHRs
    - Motivation of providers who lack financial or other incentives to reduce hospitalizations and use of unnecessary services.
- It is risky to develop these systems, and substantial human and financial resources are required.
- Because care coordination changes the distribution of resources (personnel and financial), developing payment mechanisms that align with the new distribution of effort is important and also hard to achieve.
- Establishing the benefit of Health Homes is administratively challenging. Generally, Health Homes are implemented as only one of multiple initiatives, and it is difficult for both states and providers to identify definitively the specific outcomes and benefits related to Health Homes alone.

Savings and Quality Improvement

In 2012, Missouri launched a Health Home initiative in 28 community mental health centers (CMCHs) for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Between February 2012 and June 2013, these CMCH Health Homes reported a 12.8 percent reduction in inpatient hospital admissions and an 8.2 percent reduction in ED visits among the 12,105 individuals continuously enrolled during that time. This resulted in a savings of $217.55 PMPM; after subtracting the $78.74 PMPM payment the state made to the CMCHs, the state realized a total cost savings of $48.81 PMPM just on the reductions in hospital admissions and ED visits. Nearly 6,000 of the enrollees were Medicaid-only (non-dual eligible), and the state calculated that it saved a total of $2.4 million in the cost of their care over the year before they were enrolled in the CMHC Health Home. In addition to the cost savings, however, the state noted that: "CMCH Health Homes have made remarkable progress in improving clinical outcomes and impacting the service delivery system."[48]

Early indications from New York's Health Home projects are that at least for a subset of the Health Home population, there was an increase of 14 percent in primary care visits, but a decrease of 23 percent in inpatient admissions and emergency department visits.[49]

[48] Missouri Department of Mental Health and Missouri Health Net, "Progress Report: Missouri CMCH Healthcare Homes," November 1, 2013. http://dmh.mo.gov/docs/mentalillness/18MonthReport.pdf.
[49] "Medicaid Health Homes: Implementation Update," Center for Health Care Strategies, March 2014.

iv. Accountable Care Organizations (ACOs)

Structure

An ACO is an entity consisting of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of the care delivered. In most cases, the ACO is a provider-based organization, but in some cases, it is a managed care organization. The ACO model is most often associated with Medicare or, to a certain extent, the commercial market. However, 17 states have or plan to have Medicaid ACOs.[50] While the states have different names for their models – Coordinated Care Organization (Oregon), Regional Care Organization (Alabama), Regional Collaborative Care Organizations (Colorado) – they all have the same goal: improve population health and reduce spending, while providing care in a more coordinated and efficient manner.

The organizational structure of Medicaid ACOs differs from state to state and even within a state, depending on benefits, as well as participating providers and partners. Many ACOs are provider- or community-based, such as Alabama's RCOs, while others are built entirely on traditional Medicaid managed care organizations like in Utah. Colorado's RCCOs each have different organizational structures:

- A managed care organization
- A prepaid inpatient health plan that has commercial, Medicare and Medicaid lives
- A collaborative of a hospital system and a physician managed services organization
- A community-based coalition of providers.

Despite these differences, in all cases, states have built their ACOs on the existing delivery system, including well-established PCCM programs, PCMHs, or MCOs. Having these existing programs with experience coordinating care and with some of the necessary infrastructure is a pre-requisite to building a successful ACO.

Payment

One of the ways that providers are encouraged to work together in ACOs is through alignment of financial incentives. Medicaid ACOs use a variety of payment mechanisms to incentivize coordinated, high quality care, including fully capitated and global budgets, but the most common is shared-savings or shared-savings and losses.

Shared savings typically pay providers FFS and a bonus payment if they deliver care under an established threshold budget and meet established quality requirements; the bonus payment is usually a percentage of the amount below the threshold (i.e., the savings).

With shared losses, providers are usually paid FFS and are required to pay back a portion of any expenditures above an established threshold budget; the payment is generally a percentage of the amount above the threshold (i.e., losses). The pay back amount often is tied to quality performance - the better the quality, the lower the percentage to be paid back.

[50] See http://nashp.org/state-accountable-care-activity-map and http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf

Data Needs

The importance of timely, complete, actionable patient data to the success of an ACO cannot be over-stated. States that have pursued this model have developed innovative solutions to make needed data available to both agency staff and providers. For example, Colorado's Statewide Data Analytics Contractor (SDAC) delivers secure electronic access to clinically actionable data to the RCCOs and Primary Care Medical Providers (PCMPs). The data includes Medicaid paid claims data, clinical risk group (CRG) identifiers and predictive risk scores, and Behavioral Health Organization managed care encounter data. The state, RCCOs and PCMPs can access a variety of reports, including profiles of individual clients based on predictive modeling, identification of areas for clinical process improvement at the client, provider and RCCO levels, and aggregate reporting of cost and utilization performance indicators.[51]

Culture Change

ACOs require a change in culture among providers and patients which involves significant outreach and education:

- Establishing value- and outcome-based payment mechanisms requires a thoughtful and deliberative process so providers who have little or no experience with these mechanisms can learn to operate within a new paradigm.
- Providers frequently need to learn how to practice in teams and to work across the care continuum, including with non-medical providers, such as social service providers.
- Providers usually do not have a lot of experience being held accountable for the cost of care they deliver.
- Patients also have to be educated on their role and responsibilities in an accountable care model. For example, educating patients on the need for and value of working with a primary care provider to get needed care, rather than seeking care in the emergency room, is essential.

Savings and Quality Improvement

The cost savings potential of ACOs is still not certain. However, within Medicare, the ACO model is showing savings potential.

In January 2014, the Centers for Medicare and Medicaid Services (CMS) announced the interim results of the first wave of Medicare Shared Savings Program (MSSP) ACOs. Of the 114 Medicare MSSP ACOs that started operating in 2012, 54 had lower expenditures compared to the benchmark. Of those, 29 generated shared savings in the amount of $126 million, with a total of $128 million in net savings for the Medicare Trust Fund. Two of the ACOs that are in a shared savings/losses track generated losses, meaning their expenditures exceeded the established benchmark and they must pay back a percentage of the savings.

The Pioneer ACOs, more advanced and with additional risk, generated gross savings of $147 million in the first year. Additionally, the Physician Group Practice Demonstration, the precursor to the Medicare

ACO program, saved Medicare $108 million over the course of the demonstration, with seven out of 10 group practices sharing in savings. In addition to savings, the quality of care was also improved.[52]

Cost savings and quality improvement have also been demonstrated in Medicaid ACO models. Colorado's program has generated $44 million gross savings, with a $6 million net reduction in total cost of care (cost avoidance) for clients enrolled in the ACC Program. It has also resulted in significant quality improvement, including reductions in inpatient admissions, ER utilization, and the use of high-cost imaging.[53]

Oregon's CCO model is showing similarly positive quality trends, with reduced ER utilization and increased use of primary care. Through the use of a global budget, Oregon has built in savings estimated at $3 billion. Results from the first year demonstrate reductions in spending.[54]

v. Administrative Services Organization

Structure

An ASO is a model that only a few states are currently using. In such a model, the state contracts with a third party organization to administer certain Medicaid services, such as predictive modeling based on Medicaid data, disease management, care management, quality management, or member services. The third party organization can be any organization capable of carrying out the contracted services, but is often a managed care organization. Some states use the ASO model for their dental programs, as Colorado does for its new adult dental benefits, or for behavioral health, such as Maine has used to provide utilization review, prior authorization, quality management and customer and provider relations for its Medicaid behavioral health enrollees, as well as some state-funded patients.

In 2011, Connecticut decided to move away from full risk-based Medicaid managed care because the state did not feel that it was getting the value it desired from managed care. The State sought to centralize and streamline the administration of multiple programs with the goal of improving quality and reducing spending. To achieve this, the state procured a single contract with Community Health Network of Connecticut, a Connecticut non-profit, provider-sponsored managed care organization, previously a Medicaid managed care organization, to serve as an ASO for Medicaid, CHIP, and a state-sponsored program for uninsured adults.[55] All populations are served under the contract, resulting in approximately 600,000 covered lives. The ASO only administers the medical portions of these programs.

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[52] U.S. Department of Health and Human Services, HHS Press Office, "Medicare's delivery system reform initiatives achieve significant savings and quality improvements – off to a strong start," January 30, 2014. http://www.hhs.gov/news/press/2014pres/01/20140130a.html. Accessed March 12, 2014.

[53] Colorado Department of Health Care Policy and Financing, "Legislative Request for Information #1: Accountable Care Collaborative," November 1, 2013. http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251781891208&ssbinary=true.

[54] Oregon Health Authority, "Oregon Health System Transformation: Quarterly Progress Report," February 2014. http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf.

[55] Office of State of Connecticut Lieutenant Governor Nancy Wyman, "Department of Social Services Awards Contract to Community Health Network of Connecticut Inc.," September 2011. http://www.ct.gov/dss/lib/dss/pdfs/2011pressrelease/chnrel9.29.11.pdf

Behavioral health and dental services are administered by other, previously existing ASOs. The ASO provides a centralized customer call center service, utilization management, care coordination, intensive care management, quality management, reporting, predictive modeling, health risk assessment, provider profiling and other administrative services.[56] The state maintains responsibility for provider reimbursement rates, provider payments, and enrollee eligibility determinations.

Payment Methodologies

An ASO is typically paid an administrative fee to provide the contract services and is not at financial risk. The state maintains the financial risk for the care provided to enrollees and maintains responsibility for important functions such as eligibility determination and paying provider claims. This is the case in Connecticut, where the ASO is paid an administrative fee to provide the contracted services. But, to drive accountability and ensure the provision of quality services, the Department of Social Services withholds 7.5 percent of each quarterly administrative payment contingent upon the ASO's success in meeting performance targets related to enrollee health outcomes and experience of care, as well as provider satisfaction.

Data Needs

Data required for an ASO depends largely on the level and types of services the state has contracted with an ASO to conduct. As with any model of care coordination or managed care, the more data states have about how providers in the network are performing, outcomes for their enrollees, high-cost utilizers and providers, the easier it is for them to develop cost and quality improvement initiatives and possible incentives or performance rewards. ASOs can offer states one way of getting better data about providers and enrollees through the tools they bring to their contracts, such as predictive modeling, utilization management, health risk assessments, and provider profiling.

Culture Change

States do not need to have specific infrastructures in place to oversee ASOs in the same way they need them for full-risk managed care (e.g., sophisticated rate setting, more intensive reporting requirements, etc.). Providers do not need to significantly change their practices, as ASOs typically do not require providers to do much in terms of care coordination with other providers. They may need to build new processes and systems to meet quality metrics or performance standards, and they may be able to earn incentives for doing so, depending on how states structure their ASO programs and contracts. Enrollees may also benefit from an additional level of outreach or engagement for specific disease management, chronic care management or health and wellness programs conducted by an ASO.

Savings and Quality Improvement

Not a lot of information exists about the savings for ASO models in general; however, in the first two years of its operation with the ASO model, Connecticut has seen quality improvements and cost reductions. Based on claims data comparison six months pre- and six months post–engagement in the Intensive Care Management program, the ICM program resulted in reductions in inpatient admission

[56] Connecticut Department of Social Services, "REQUEST FOR PROPOSALS: Medical Care Management Administrative Services Organization," April 2011. http://www.ct.gov/dss/lib/dss/pdfs/aso_rfp_final_040511d1.pdf.

(43.17%) and emergency department visits (6.14%).[57] Between January 1, 2012 and March 31, 2013, the PMPM cost of inpatient admissions decreased by 1.8 percent or $95.65 to $93.95 and the cost per admission decreased by $200.[58] While the rate of ED visits decreased, the cost per visit increased by 8.5 percent; however, the PMPM for non-emergent ED visits decreased by 11.7 percent.[59]

Access to care has also improved in Connecticut. The ASO is tasked with working in conjunction with the state to increase provider participation. Provider participation increased from 14,027 in-state providers in June 2012 to 18,019 in-state providers in June 2013. Additionally, the number of PCMHs in the state increased. The ASO delivers a range of services to providers, including supporting them in their efforts to become PCMHs. More than one-third of Medicaid enrollees are now served in a PCMH.[60]

Enrollee satisfaction with the ICM program is high. A survey in 2013, found that 95 percent of members are likely to recommend the program to friends or family, and 94 percent believe the program led to at least some improvement in their health and ability to self-manage.

In Maine, from July 2006 – June 2010, the state saw a reduction of $30 million in claims for managed behavioral health and a 13 percent increase in members receiving managed behavioral health services annually. They also saw a 42 percent reduction in youth in residential care from the first quarter of SFY 2009 through the fourth quarter of SFY2011. Additionally, they were able to achieve better compliance with many state and federal behavioral health requirements such as moving people off of waiting lists, moving youth more quickly into appropriate and less restrictive care settings, and meeting extensive reporting requirements.[61]

vi. Full-Risk, Capitated Managed Care

Structure

Full-risk, capitated managed care programs are the most common type of Medicaid managed care. Currently, 37 states use this model for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services. Although managed care is broadly defined (some of the federal managed care regulations apply to PCCM programs), full-risk capitated managed care is what is most thought of as "managed care."

States contract with health plans - Managed Care Organizations (MCOs) or Prepaid Health Plans (PHPs) – for the delivery of services to Medicaid enrollees. These health plans are responsible for providing the services articulated in a contract to the specific populations identified in that contract. Features of full-risk, managed care programs are described in Table 3 below. This is not an exhaustive list, but rather a high-level overview.

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[57] Connecticut Department of Social Services, "Medical Assistance Program Oversight Council Presentation," November 8, 2013. http://www.cga.ct.gov/med/council/2013/1108/2013110ATTACH_MAPOC%20Presentation.ppt.
[58] Connecticut Department of Social Services, "Medical Assistance Program Oversight Council Presentation."
[59] Connecticut Department of Social Services, "Medical Assistance Program Oversight Council Presentation."
[60] Connecticut State Senate, "Hearing for the Human Services Committee," DSS Commissioner, March 11, 2014. Transcript from: http://www.cga.ct.gov/2014/HSdata/chr/2014HS-00311-R001200-CHR.htm
[61] APS Healthcare, "Maine Behavioral Health ASO Annual Report FY 2011," January 2012.

Table 3

Feature	
Populations Included	Traditionally included primarily women and children, commonly referred to as "TANF," since many are also enrolled in the Temporary Assistance for Needy Families program. For these populations, managed care is a dominant form of service delivery in many states today. States have been slower to move their aged, blind, disabled (ABD) and long-term care (LTC) populations into full-risk managed care. It is challenging to develop comprehensive networks, difficult to set capitation payments and, historically few managed care plans had the experience serving them. Further, these populations tend to have very vocal and organized advocacy at the state and federal levels, which has made it more difficult for states to enroll them in managed care. Nevertheless, in FY 2014, a total of 14 states were implementing or expanding managed long term care programs.[62] The intellectually disabled/developmentally disabled (ID/DD) populations still are the most likely to be excluded from managed care programs.
Services Provided	There is great variation in the services for which health plans are responsible. Some states have comprehensive programs that cover medical, behavioral and LTC services (e.g., Tennessee and New Mexico). Others operate multiple programs. For example, Florida has different programs with different health plans to provide services to its LTC population. Programs for the ABD and those receiving LTC usually have a broader array of services and providers included. In the past, states have carved out some benefits from their full-risk managed care, such as behavioral health, dental benefits, transportation services and prescription medications.
MCO Responsibilities	Federal regulations require that MCOs create "adequate" provider networks and state contracts often establish specific guidelines for maximum time and distance enrollees must travel for care. Health plans can have limited provider networks, but if services are not available within network they must make them available out-of-network. MCOs are usually responsible for provider credentialing. They also often hold providers to professional standards of care and quality measures that are more rigorous than the standards in FFS Medicaid. Health plans must have member services, provider services, grievance and appeals processes, data and reporting infrastructure, fraud and abuse protocols, and quality improvement plans.
Oversight	States oversee the activities of health plans and ensure compliance with contractual terms such as maintenance of "adequate" networks, compliant grievance and appeals processes, and member services, and quality improvement programs. States have become sophisticated managers of managed care contracts and several offer examples of excellent contracts that include ways to hold MCOs accountable

[62] Smith et al, October 2013.

	for quality care and for performance that meets or exceeds established standards of care specified in the contract. Increasingly, financial rewards for high performance and financial penalties for failing to meet established standards are core components of states' health plan contracts. The federal government also has significant oversight responsibility for full-risk managed care in Medicaid. CMS must approve contracts before a state can collect federal dollars for payments. There are detailed federal regulations that dictate marketing practices, processes for appeals, network adequacy requirements and what populations can be mandatorily enrolled.

Payment Methodologies

Health plans are paid a pre-established, actuarially-certified, capitated PMPM rate. The rates are often adjusted for age, sex, existence of Medicare or other private insurance, Medicaid eligibility category. Some states may use more complex predictive risk methodologies. Increasingly, states are building performance targets and incentive payments into the capitated rates they pay health plans and are becoming more involved in how the plans pay providers in their networks to ensure that the plans are incenting providers to deliver better quality and outcomes. States also have different ways of reimbursing MCOs that contract with FQHCS, CHCs, PCMHs, Health Homes, and ACOs in their networks.

Data Needs

Since MCOs pay providers directly in full-risk, capitated managed care, states do not get claims data for services those providers deliver to Medicaid enrollees. However, states are required by CMS to provide encounter data as part of their quarterly Medicaid Statistical Information System (MSIS) reports. CMS made available an Encounter Data Tool Kit for states as a "practical guide to understanding, validating and reporting" encounter data from MCOs.[63] This report notes that timely, accurate and clean encounter data are critical for states to ensure that their MCOs are complying with contract requirements such as quality assurance and utilization measures, and to be able to set accurate capitation rates for MCOs.

Culture Change

Moving providers to a full-risk, capitated model requires a significant investment in provider relations, particularly for providers who do not have experience with payment mechanisms other than FFS, or who have not had to meet more rigorous quality and performance metrics that are typically part of Medicaid MCO provider agreements today. These differences usually require providers to make changes to their practices and to make investments in IT systems. Additionally, providers must learn how to work with an external partner who can control their patients' access to various care and services. Navigating different provider networks can be as challenging for providers as it is for patients. Most MCOs devote a lot of effort to provider relations, and have built sophisticated tools and trainings to support providers in their networks to make the necessary transitions not only to effectively work within managed care, but to do more care coordination and care integration to improve the care they deliver to their patients.

The relationships between MCOs and providers can be tenuous, and states with Medicaid managed care often have strict provider network management requirements in their MCO contracts to help ensure

[63] Vivian Byrd, Jessica Nysenbaum, and Debra Lipson, "Encounter Data Toolkit," prepared for CMS by Mathematica Policy Research, November 2013.

that providers get the support they need to succeed and deliver the highest quality care to their Medicaid patients. This is particularly true for some of the more specialized populations that states are moving into full-risk managed care, such as those with serious mental illness, the aged/blind/disabled groups and those receiving long-term supports and services. There are other factors that can complicate MCO-provider interactions; for example, a 2012 report entitled *Medicaid and CHIP Risk-Based Managed Care in 20 States,* identified several populations that warrant special deliberation when considering managed care programs.[64] Two of them have special relevance for Wyoming:

- The rural population which has been challenging because health plans have had difficulty developing adequate provider networks, especially for specialists.
- American Indians, who are typically excluded because they are entitled to receive services from the Indian Health Service.

It also is important to note that in virtually every state with full-risk managed care for Medicaid, there first was a managed care market in the commercial health sector. This experience was important when building Medicaid managed care, as providers and patients were likely to have at least some experience with managed care.

Savings and Quality Improvement

There is no consensus on whether full-risk, capitated managed care saves money. Frequently savings occur in the early years but not always in the longer-term. Because of the tremendous interest in managed care programs, in 2012, the Robert Wood Johnson Foundation published a synthesis paper on the costs, access and quality of care of Medicaid managed care programs.[65] The paper reviewed existing literature and found that on the national level, there is little evidence of any savings. Only one researcher found overall cost savings; all others conclude managed care is either cost-neutral or even more costly than FFS programs. Studies conducted by consulting firms on behalf of managed care companies or industry trade groups do find savings, primarily as a result of reduced inpatient utilization. One of these reports concluded that savings in rural areas are about half what they are in more urban regions.[66]

The research on whether managed care improves beneficiaries' access to care suggests that the model can sometimes improve access, but the effects are usually state-specific and not consistent in the ways in which access is improved. There is little evidence that Medicaid managed care improves the quality of care or health outcomes. The authors note that assessing quality is particularly challenging regardless of model or payer (Medicare also struggles with evaluating quality of care).

[64] Embry M. Howell, Ashley Palmer, Fiona Adams, "Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future," Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S, Department of Health and Human Services, July 2012.
[65] Sparer, September 2012.
[66] Lewin Group, "Report for America's Health Insurance Plans: Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies : Final Report," March 2009. http://www.lewin.com/publications/publication/395/.

Appendix C: State Profiles

Alabama Managed Care Profile

i. Name of the Program

Alabama Regional Care Organizations

ii. Background

Alabama Medicaid Agency (Agency) officials report that Medicaid costs are on an unsustainable trajectory. Approximately one-third of the State's General Fund spending is devoted to the Medicaid program. Costs are disproportionately concentrated in a small portion of the population consisting of the aged, blind, and disabled, who together comprise only 31 percent of the Medicaid population but account for 66 percent of program spending. The anticipated growth of this population threatens the State's ability to maintain even a modest benefit package and eligibility criteria for Medicaid beneficiaries.

The problems resulting from growing Medicaid costs in Alabama are compounded by the State's fragmented delivery system, which has minimal infrastructure or incentives to coordinate care across providers to drive improved health outcomes. The statewide primary care case management program (PCCM), Patient 1st, functions primarily as a gatekeeper to specialty services and is not sufficiently robust to comprehensively manage the State's most vulnerable populations. Moreover, State reimbursement methodologies are based on per diem or fee schedule payments, which mean that both providers and the State are focused on utilization and volume, rather than value and quality.

Service fragmentation is particularly acute for some of the state's most vulnerable populations, including individuals with mental illnesses and substance use disorders. Alabama's Medicaid expenditures for behavioral health services exceed $400 million annually, and are surpassed only by spending for hospital care, nursing homes, and pharmacy services, demonstrating considerable opportunity to more effectively coordinate care for these beneficiaries.

The State has concluded that short-term solutions, such as tweaks to benefit packages or eligibility criteria, will not solve these service fragmentation or cost issues or improve health outcomes or quality of services. Rather, a transformation of the State's Medicaid delivery system is necessary to effectively manage and coordinate care for the majority of Medicaid beneficiaries and reduce costs.

iii. Current Delivery System Structure

At present, the Agency operates on a fee-for-service basis. All Primary Medical Providers (PMP) in the Agency's Patient 1st program are paid a medical case management fee per month for each recipient the PMP has enrolled, as of the first day of each month. Federally Qualified Health Centers, Independent Rural Health Clinics and Provider Based Rural Health Clinics do not qualify for the case management fee. There is no limit on the accumulation of case management fees; however, the fees paid are contingent upon the fee components referenced in Section 39.4.1 in the Alabama Medicaid Agency Billing Manual. The PMP agrees to the number of enrollees on a PMP's panel with a cap set at 2,000 (with extenders) enrollees. The case management fee will generally be paid on the first checkwrite of the month. The medical case management fee will be automatically generated based on Medicaid enrollment reports. Therefore, the PMP is not required to file a claim for the medical case management fee. All other services are reimbursed by the current fee-for-service method.

Figure 1

Components of Monthly Case Management Fee for Pilot Counties

Applicable to PMPs located in Bibb, Chambers, Fayette, Greene, Hale, Tuscaloosa, Lee, Pickens, Limestone, Macon, Madison, and Tallapoosa counties. The components of the fee are delineated below.

24/7 Coverage (REQUIRED)	The PMP must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week. For this service, **$1.00 PMPM** is added to the case management fee. The PMP's 24/7 contact information will be obtained from Attachment A.
Participation in the Patient Care Networks of Alabama (PCNA) Program (OPTIONAL) *The PMP must sign an agreement with the PCNA Administrative Entity.* *You will be notified of the PCNA Administrative Entity when it is formed. The case management fee for the patient acuity level (B in the right column) will be applied to all Patient First providers effective 4/1/2011; however, after the Entity is functional, you will only receive A and B if you sign a contract to participate with the Entity.*	**$0.50 PMPM** will be added to the case management fee. **AND** **Patient Acuity Level (Case Mix):** The illness burden of each physician/practice's panel of patients as reflected on the Patient 1st Profiler Report produced in January 2011. The Profiler Report uses Adjusted Clinical Groupings (ACG) weights designed by John Hopkins University to determine the illness burden of recipients assigned to the provider peer group. For PMPs with a value of 0.9 or greater, **$1.60 PMPM** is added to the case management fee. For PMPs with a value, less than 0.9, **$1.00 PMPM** is added to the case management fee.

Figure 2

Components of Monthly Case Management Fee for Non-Pilot Counties

24/7 Coverage (REQUIRED)	The PMP must provide voice-to-voice access to medical advice and care for enrolled recipients 24 hours a day 7 days a week. For this service, **$1.00 PMPM** is added to the case management fee. The PMP's 24/7 contact information will be obtained from Attachment A. **Patient case mix based on risk stratification of patients in PMP's panel -**Based on the illness burden of each physician/practice's panel of patients as reflected on the Patient 1st Profiler Report produced in January 2011. The Profiler Report uses Adjusted Clinical Groupings (ACG) weights designed by John Hopkins University to determine the illness burden of recipients assigned to the provider peer group. For PMPs with a value of 0.9 or greater, **$1.60 PMPM** is added to the case management fee. For PMPs with a value, less than 0.9, **$1.00 PMPM** is added to the case management fee.

Section 39.4.1 in the Alabama Medicaid Agency Billing Manual further outlines the reimbursement structure for the Case Management Fee paid, based whether or not the provider participates in the Patient Care Networks (PCN) program. Alabama currently administers a Section 2703 Health Homes initiative, called Patient Care Networks (PCNs). The primary care providers serve as the health home and are paid an enhanced per member per month care coordination fee ($9.50 per qualifying recipient), supported by the PCNs. The PCNs provide data analytic support, care management services and provider training in evidence-based guidelines. Alabama may allow regions to first opt to develop a PCN program to serve as the foundation for a future transition to RCO.[67]

iv. How RCO was Designed and Status of Implementation

In October 2012, Governor Robert J. Bentley convened a multi-stakeholder Medicaid Advisory Commission to develop recommendations to improve the State Medicaid program. The commission brought together a large and diverse group of representatives to review and develop its recommendations. Entities or organizations included: executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance companies, consumer advocates, medical providers, and professional organizations representing the hospitals, physicians, pharmacy, nurses, primary and rural health, hospice, and nursing homes.

The Commission submitted its recommendations to the Governor on January 30, 2013, and these recommendations became the building blocks for a comprehensive Medicaid reform plan.

The cornerstone of this reform plan was the development and implementation of regional care organizations (RCOs) across the State that would manage and coordinate care for the majority of Alabama Medicaid's beneficiaries. These RCOs are provider-based, community-led organizations that

[67] Alabama 1115 Concept Paper. Provided to Centers for Medicare and Medicaid Services on May 17, 2013.

will, through a capitated payment, manage a broad scope of Medicaid benefits for included populations. The state can contract with a for-profit MCO only in very specific situations when an RCO organization cannot be formed, and efforts to work with other qualifying RCO organizations are unsuccessful. There is a provision in the new law that states that Medicaid can contract with an alternate care provider if the RCO fails to provide adequate service pursuant to its contract, has its certification terminated, if Medicaid cannot award a contract to an RCO, or if no organization has received a RCO contract by October 1, 2016.

The plan to transform Medicaid delivery in Alabama by creating RCOs was incorporated into Senate Bill 340, which was approved on May 7, 2013 by the Alabama Legislature and signed into law by Governor Bentley later that month. During June 2013, the Agency met with hospitals, physicians and other provider groups and worked with an actuarial consultant to propose districts for the planned Regional Care Organizations. The map and the required state Administrative Code changes were submitted on June 28, 2013. Public input on the new map was received at a public hearing held on July 15, 2013, and additional comments were received by the Agency through August 2, 2013. The new rules were finalized September 17 in advance of the October 1, 2013, deadline established in the law.

The reimbursement structure has not been finalized and is still under discussion. Agency officials expect to reimburse providers in a capitated fashion and anticipate that RCOs will reimburse providers in a variety of forms. The State expects to mandate a “floor” or minimum level of reimbursement for network and non-network providers. Another consideration to be factored into this will be which payer functions will be maintained at the state level.

As part of the 1115 waiver, Alabama Medicaid is seeking a Delivery System Reform Incentive Payment (DSRIP) pool in order to encourage reform on the provider side to match the RCO delivery system. Incentive payments will be made to providers in order to incentivize infrastructure development, innovation, and quality improvement focused on care coordination and improved health outcomes. Incentive pools will also be used to reward Health Information Exchange utilization focused on care coordination and improved health outcomes.

At the time of this interview, Agency officials reported that the collaboration portal is open and issuing certificates of collaboration. The major focus up to this point has been on developing rules related to collaboration and reporting, and preparing the 1115 waiver for submission. Other activities include communicating and working with stakeholders, and the initial meeting and activities of the legislatively-mandated Quality Assurance Committee.

v. State Resources Required to Implement/Operate

At the time of the interview, it was unknown how many staff positions and administrative resources would be required to implement and operate the RCO program. The Agency has issued an intent to award letter to an implementation vendor. The proposed scope of work for this consultant includes an assessment of staffing and resource needs and submission of recommendations for what is needed to implement RCOs to the Agency.

vi. Implementation Challenges

The most significant challenge is the overarching shift from a fee-for-service system to using at-risk managed care. This shift will impact both staffing needs and business processes. Adapting and adjusting to this new and different strategy and business model will be an ongoing adjustment for staff and for providers.

vii. Options considered, but ultimately rejected

Part of the process followed by the Governor's Alabama Medicaid Commission was to look at other states to see what Alabama could learn from their experiences. The Executive Committee heard presentations from officials in Louisiana, Kentucky, Tennessee, Oklahoma, Arkansas, Oregon, and Connecticut.

During those presentations, information was provided by Kentucky identifying the problems associated with the very rapid implementation of a new delivery system. Both Tennessee and Louisiana shared their success with commercial managed care. Louisiana has a unique system where both managed care organizations and patient care networks were operating and competing with each other. Conversely, Oklahoma and Connecticut explained why they had chosen to abandon commercial managed care. Arkansas provided information on their new delivery system which does not use a managed care organization but relies on a very robust data analytics system to drive payment incentives and disincentives to improve outcomes. Oregon described their new delivery model based on community care organizations. The current Alabama plan is informed in part, by the experience of Oregon, but also certain elements from the state of Colorado.

viii. Anticipated Outcomes

Alabama Medicaid officials reported their intent to achieve the following outcomes through the implementation of RCOs:

- The State will improve quality in covered Medicaid services by integrating services and eliminating the current silos between physical health services and behavioral health services.
- Providing health homes to individuals with complex needs will improve quality and reduce costs.
- By holding RCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.
- The shift from a volume-based reimbursement system to a comprehensive, quality-based, capitated system will reduce the growth rate of the Medicaid budget, while improving outcomes.
- By contracting with locally-led Regional Care Organizations, the state will better engage providers in solving cross-cutting health system issues such as how to coordinate and work with primary care providers to establish standards of care; how to assist providers in effectively managing more costly and complex patients; and how to use claims and other data to identify recipients most likely to benefit from intervention and to provide feedback to providers regarding care patterns and interventions.
- The state will test how to balance RCOs' need to be innovative versus the state's need for specific contract requirements to ensure appropriate access to care and quality care.

ix. How the RCO model is perceived by stakeholders

As far as provider stakeholders, Alabama officials reported having strong engagement throughout the process. The Medicaid Commission included a wide variety of providers along with consumer representation. Alabama ARISE, an advocacy group representing low-income individuals and families, has been actively involved in this process, starting with its participation on the Medicaid Commission appointed by the Governor. Other groups, notably advocates for individuals with disabilities and advocates for individuals with mental illness have also been very involved and interested in the State's activities.

x. Medicaid Expansion Status

The Governor opposes expansion "in its current form" but there is the possibility that the door has been left open to expansion in 2015.

Colorado Managed Care Profile

i. Name of the Programs

Physical/Medical Care

Colorado has multiple managed care programs that provide physical/medical care to Medicaid enrollees. The Accountable Care Collaborative (ACC) Program operates state-wide as does the Primary Care Physicians Program (PCPP). Two other programs operate in some counties of the State.

- Accountable Care Collaborative Program: more than 520,000 enrolled[68]
- Denver Health Medicaid Choice (DHMC): Serves Denver, Arapahoe, Adams, and Jefferson Counties. 50,469 enrolled
- Program of the All Inclusive Care of the Elderly (PACE) 2,260 enrolled
- Primary Care Provider Program (PCPP): 22,439 enrolled
- Rocky Mountain Health Plan (RMHP) 22,737 enrolled

Behavioral Health Care

Community Mental Health Services Program for nearly all Medicaid enrollees

Long Term Care Supports and Services

- PACE program: 2,260 enrollees with three providers operating multiple sites
- Colorado Revised Statute Section 25.5-5-402(2)(b), C.R.S. prohibits LTSS from being included in a managed care delivery structure

Child Health Plan Plus (CHP+)

CHP+ As of July 2013, CHP+ enrollment was 68,481 children and 1,204 pregnant women.

ii. Delivery System Structure

Physical/Medical Care

ACC Program:
There are three components:

- 7 Regional Care Collaborative Organizations (RCCOs) that ensure cost and quality outcomes for Medicaid members (contracts are held primarily with primary care providers but they are expected to have informal relationships with specialists and community-based organizations)
- 1 Statewide Data Analytics Coordinator (SDAC) that provides actionable data at both the population and client level
- Primary Care Medical Providers (PCMPs) to serve as the focal point of care. As of October there are more than 400 PCMP locations with 2,350 Rendering Practitioners.

Payment:

The RCCO receives a per member per month (PMPM) payment which varies between $8 and $10. One dollar is placed in an incentive pool to be distributed based on performance on meeting utilization reduction targets for key performance indicators (inpatient hospital readmissions, ER visits and high-cost imaging services and well-child visits).

[68] Enrollment numbers are as of April 1, 2014

- Each PCMP receives a $3 PMPM payment. In addition, one dollar is placed in a PCMP incentive pool and distributed based on performance on the same key performance indicators.
- The SDAC is a fixed price contract with a third party data and analytics vendor.

Enrollment:

- Passive for nearly all enrollees - the State enrolls individuals into the RCCO in their region and gives them a period of time to disenroll.
- At the time of enrollment, the member is assigned (attributed) to a PCMP or is asked to select one.
- The State is not enrolling those who are dually eligible for Medicaid and Medicare though these individuals can select the ACC Program.
- The State is mandatorily enrolling all of the Adults without Dependent Children into the ACC Program. This program is time-limited (the waiver expires on 12/31/13) and has a limited enrollment. The full expansion population to 133% FPL will also be enrolled into the ACC Program as one of the options provided to other Medicaid members (i.e. DHMC or RMHP).

Denver Health Medicaid Choice (DHMC):

- DHMC serves Medicaid enrollees (including medically needy, aged blind and disabled and families and children) in the counties of Denver, Arapahoe, Adams, and Jefferson.
- Their system includes 9 community health centers, 12 school-based health clinics, a hospital, a public health department, nurse advice line and regional poison control center.
- DHMC is a full-risk program and the MCOs are paid a PMPM that is equivalent to 100% of fee-for-service (FFS) rates. These rates are based on eligibility category, age, gender, etc. and there is no opportunity for incentives in the program.
- Individuals in Denver are passively enrolled into DHMC and then can select out of the program. If they opt-out of DHMC they are eligible for passive enrollment into the ACC Program.

Rocky Mountain Health Plan (RMHP)

- Prepaid Inpatient Health Plan (PIHP) serving enrollees in Delta, Mesa, Moffat, Montrose, Ouray, Rio Blanco and San Miguel counties (the "Western Slope")
- RMHP clients select a PCP and are assigned a case manager
- RMHP pays a network of contracted physicians a set amount for services regardless of clients' insurance coverage.
- They have a robust network of providers
- RMHP receives claims from its providers, re-prices them based on Medicaid Fee Schedule and submits to the Department for payment
- RMHP receives a PMPM for claims adjudication, care coordination and quality activities and RMHP receives and reimburses providers and then submits claims for FFS reimbursement of services.
- Participate in an incentive program
- Recently selected for State pilot focusing on payment reform for services delivered to clients in seven counties in Colorado. The pilot program is a global budget, global payment, reporting and gain-sharing model that integrates behavioral and health services for a target population of approximately 11,000 Coloradans.

Primary Care Physicians Program (PCPP)

- A gatekeeper model in which Medicaid clients select an enrolled primary care physician (PCP)
- The PCP acts as case manager/care coordinator
- Clients must obtain a PCP referral for most services not available from the PCP
- Enrolled PCPs are reimbursed based on the FFS provider schedule.
- No additional payment for care coordination activities and providers have no additional opportunities to earn incentive payments. There had been a PMPM but it was eliminated due to budget cuts approximately 10 years ago.
- The State plans to phase out the PCPP and nearly all PCPs are enrolling in the ACC Program as PCMPs.

BEHAVIORAL HEALTH

Community Mental Health Services Program

- Operates under a 1915(b) waiver to allow mandatory enrollment for Medicaid enrollees (CHP+ enrollees are not included)
- With a few exceptions, all Medicaid clients are enrolled in the BHO serving their region.[69]
- 5 Behavioral Health Organizations (BHOs), each serving a geographical region
- Full risk with monthly capitation payments to provide all behavioral health services and to cover any administrative costs.
- PMPM rates are established for distinct eligibility categories and differ for each BHO
- There are extensive performance measures in the contract; program has evolved to become more outcomes-focused
- Provides additional mental health services for individuals with specific diagnoses
- Substance use treatment services had been "carved-out" but BHOs became responsible for services in 2013
- New RFP expected in fall of 2013 for implementation July 1, 2014. State's goal is to achieve greater integration of care and to align systems of care (also in alignment with their State Innovation Model grant).

Long Term Services and Supports

- Colorado Statute prohibits the inclusion of LTCSS into managed care programs but PACE is permitted.
- Individuals receiving LTCSS may be enrolled in managed care programs but those services are not included in the capitation payments nor are providers held accountable in any way for those services.

PACE

- 3 PACE providers operating multiple sites.
- Providers receive a PMPM from Medicaid plus an additional capitated payment from Medicare.
- Each provider has a different rate, ranges from $1,999.49-$4,426.36
- There are no opportunities to earn incentive payments

[69] Clients exempted include but are not limited to those enrolled in PACE, Medicare Buy-In clients and individuals who are inpatient at an inpatient mental health institute. A complete list of exempted individuals is available on page 8 and 9 of the current BHO contract that is located on the Department's web site http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251804884306&ssbinary=true.

State Staffing and Monitoring
There are multiple staff members responsible for contract management and monitoring. The ACC Program has a team of two contract managers, a division manager, as well as staff developing rates, budgets, and working on communication materials. There are several stakeholder groups that meet regularly, and State staff are responsible for these meetings.

In addition to the ACC Program team there is one dedicated contract manager that is responsible for DHMC and RMHP and 1.5 FTE that manage the behavioral health organization contracts.
With the transition from FFS Medicaid to managed care, the qualifications and expertise needs of State staff have changed. Staff no longer manage the benefits, services, or other initiatives, rather they provide oversight of and support to the contracted entities (the RCCOs and the managed care plans).

iii. How the Programs were Designed and Implemented
Note: because the State is seeking to align all programs within the ACC Programs structure (including improved integration with behavioral health and improved coordination of care for those who are dually eligible for Medicare and Medicaid) and the ACC Program is the newest program, the discussion below focuses primarily on its design and implementation.

- Initially FFS system
- Subsequently developed a primary care case management (PCCM) program
- Later (mid-1990s through 2002) the majority of clients (70 percent) received services from full-risk, capitated MCOs
- In 2002, as a result of legal suit over capitation rates the majority of MCOs ended their involvement
- In 2007, the State began engaging stakeholders to help identify a different model of care to improve outcomes and quality of care while reducing costs
- In 2008 the Department submitted a formal budget action to implement the newly designed ACC Program on a pilot basis.
- The ACC Program began enrolling clients in the spring of 2011 following a competitive procurement in 2010.
    - Prior to issuing the RFP the State developed a Request for Information in which questions were asked of everyone; potential regional entities; clients/advocates; data entities; primary care providers; hospitals and other providers
    - The State received more than 1200 pages of responses to the RFI
    - There was a protest for one of the regions which delayed implementation in that area
    - The State issued the RFP for the RCCOs prior to the RFP for the SDAC (State suggested the SDAC should have been on board first to get the data "out the door" more quickly and for more education to providers about the data)
- The ACC Program Improvement Advisory Committee is made up of stakeholders representing client advocates, Primary Care Medical Providers, other provider groups, and clients and families. Meetings are open to the public.
- Four subcommittees on: payment reform; provider and community relations; quality; and health improvement.
- Each RCCO has a local Performance Improvement Advisory Committee.
- The CMHS program has been operating statewide since 1998.

iv. How they are perceived by stakeholders

- RMHP is well received by providers (due to enhanced payment) and members since there is good access to providers (many providers in the region do not take FFS Medicaid, they only work with RMHP).
- DHMC is also a good option for many since there is a wide variety of clinics.
- The ACC Program is evolving and though there have been challenges (specifically with the attribution of members to the PCMPs as well as some system challenges which have limited ability for more creative financing strategies and data collection) it is viewed by most stakeholders as a good program for CO and a good model for moving from FFS to a program whereby the RCCOs accept more risk.
- As the State is bringing in those dually eligible for Medicaid and Medicare, as well as individuals receiving LTCSS, stakeholders will continue to be involved (both populations tend to be very involved).
- The State has been clear with stakeholders that the ACC Program is the primary program moving forward and that other activities will align with it. There has been consistent messaging on this which has likely helped reduce providers and others from advocating for other programs and initiatives.

v. Recommendations

- If the State were to do it again, they would make sure there was solid, proactive communication plan right from the beginning and, ideally, one person solely responsible for communicating with all stakeholders.
    - There was a fair amount of misunderstanding about how members would be attributed to providers, with some providers thinking that all of their Medicaid patients would be enrolled in the ACC Program and attributed to them.
    - In reality, many of their patients were either not targeted for enrollment initially (the State limited the number of children enrolled since savings targets necessitated enrollment of more expensive, adult populations) or were attributed to another provider based on analysis of claims history.
    - Providers did understand the approach once it was explained to them but it created more work for State staff and generated some concerns about the program that were based more on perception than reality.
- If the program requires strong data analytics the analytics vendor should be on-board very early in the process.
- There is a delicate balance between the political reality of meeting a timeline for implementation (particularly if there are savings goals built into the budget or chance of leadership change) and being "ready." Colorado started with a smaller, pilot program but did implement state-wide.
- State staff need to understand data and analytics if it is to be a data-drive, performance-based program.
- To the extent possible, the systems should have the capacity to make changes to support new payment and delivery models. Colorado is re-procuring their MMIS and has requirements of the vendor that will support enhanced analytics and capacity for alternative payments. In the interim, they are working with the SDAC vendor and their in-house systems to work-around system limitations.

vi. Medicaid Expansion Status

Colorado is a Medicaid expansion state. As of December 31st, over 86,000 individuals had been enrolled in Medicaid as a result of the expansion.

Missouri Managed Care Profile

i. Name of the Program
Missouri Health Home Initiatives

ii. Delivery System Structure
Section 2703 of the Affordable Care Act allows states to access 90% Enhanced Federal Match when implementing Health Homes.

Missouri operates two types of health homes:

- Primary Care Health Home for individuals with chronic disease: CMS Approval 12-23-11 Effective Date 1/1/12
- Community Mental Health Center Health Home for individuals with serious and persistent mental illness: CMS approval 10-20-11 Effective date 12-1-11

Medicaid enrollees qualify for enrollment in a Health Home is they have a combination of the following conditions:

- Diabetes (CMS approved to stand alone as one chronic disease and risk for second)
- Heart Disease, including hypertension, dyslipidemia, and CHF
- Asthma
- BMI above 25 (overweight and obesity)
- Tobacco Use
- Developmental Disabilities
- Serious and Persistent Mental Illness (Community Mental Health State Plan Amendment)

Provider Requirements

- Medicaid/Uninsured Threshold
- Using EMR for six months
- Plans to apply for National Committee for Quality Assurance (NCQA) Patient Centered Medical Home Recognition within 18 months

Organizations Selected to Participate

- 18 FQHCs operating 67 clinic sites
- 6 Hospitals operating 22 clinic sites

Providers that meet the Health Home requirements will receive a Per-Member-Per-Month (PMPM) payment of $60.05 for performing Health Home services and activities. Providers will be required to pay a small PMPM (approximately $3.47) to cover administrative costs associated with data management, training, technical and administrative support. The current state plan will be amended in future to add a request for a second payment method so that providers may receive incentive payments based on shared savings and relating to performance.

iii. How Program was Designed and Implemented
Integrating and coordinating primary care and behavioral health is not a new concept in Missouri. During the 2007 Missouri legislative session, the Missouri Department of Mental Health (DMH) received approval and funding for mental health and primary care integration through partnerships between Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs). The

Integration Initiative was supported at the state level by DMH, the Missouri Primary Care Association (MPCA), and the Missouri Coalition of Community Mental Health Centers (MOCMHC). The funding provided allowed seven partnerships to provide integrated physical health services and behavioral health services.

The Mental Health and Primary Care integration was implemented by co-located staff at each organization's site. The FQHCs applied and received a change to their federal scope of work to establish a satellite site at the CMHC to provide primary care services to the patients being seen at the CMHC with serious and persistent mental illness and/or provide primary care services to the CMHC clients at existing FQHC sites. The CMHC located a mental health professional at the FQHC to provide mental health services in the primary care setting to screen for underlying mental health issues and provide behavioral health interventions to patients with uncontrolled chronic diseases. Provider training was an important component of the program to increase the comfort level of the mental health professionals in dealing with primary care needs and the primary care staff in dealing with mental health needs for stable patients. The goals of this project were to improve access to care and coordination of care, and the project achieved both goals. Although reducing Medicaid costs was not a specific goal of this project, the results indicated this was also a reality. This initiative informed the need for the behavioral health consultant on the primary care side and the need for the primary care physician consultant on the CMHC side.

In 2006, the Missouri's Department of Social Services developed an initiative called the Chronic Care Improvement Program (CCIP), an enhanced primary care case management program that incorporated the principles of disease management, care coordination and case management to serve patients identified through a risk assessment and disease stratification model. APS Healthcare was selected by the State of Missouri, Department of Social Services, MO HealthNet Division (MHD), to administer the statewide CCIP serving fee-for-service patients (including those also served by the Department of Mental Health).

The goals of the CCIP were to improve health status and decrease complications for patients with chronic illness including asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, cardiovascular disease, Gastroesophageal Reflux Disease (GERD) and sickle cell disease, as well as to reduce Medicaid costs. FQHCs, CMHCs and private physician offices participated in this project.
The overall number of participants in the Chronic Care Improvement Program (CCIP) for the period July 1, 2007-June 30, 2008 was 103,308, and the total number of continuously enrolled participants (at least 12 consecutive months) was 24,700. The project showed significant Medicaid savings in just one year.

Missouri used experience gained from these previous integration projects in developing the current Missouri Primary Care and Community Mental Health Center Health Home initiatives. The ability to learn from both the successes and challenges of previous projects offered a definite advantage in designing the current initiatives.

iv. Resources Required to Implement and Oversee Programs

In July 2011, MO HealthNet solicited applications from primary care providers interested in participating in the health home initiative. Applicant requirements included:

- Participation in health home transformation training
- Having a substantial percentage (not less than 25%) of the patient panel enrolled in MO HealthNet or uninsured

- providing a health home capable of overall cost effectiveness
- having strong, engaged leadership personally committed to and capable of leading the practice through the transformation process and sustaining transformed practice processes as demonstrated through the application process and agreeing to participate in the learning collaborative
- Having patient panels assigned to specific primary care clinicians
- Actively utilizing MO HealthNet's comprehensive electronic health record for care coordination and prescription monitoring for MO HealthNet participants
- Utilizing an interoperable patient registry to input annual metabolic screening results, track and measure care of individuals, automate care reminders, and produce exception reports for care planning
- Securing a memorandum of understanding with area hospitals within three months of implementing health home services
- Meeting the minimum access requirements of third-next-available appointment within 30 days and same-day urgent care
- Having completed EMR implementation and having a minimum of six months of experience in using the EMR as the primary medical record, and for e-prescribing and generating data (either directly or through a third party such as a data repository) on clinical quality measures relevant to improving chronic illness care and prevention.

All applications were thoroughly reviewed by MO HealthNet and Department of Mental Health staff members. Several organizations under consideration received a site visit by staff teams. Out of a total of 27applications received, 26 primary care organizations were selected to participate in the primary care health home initiative. Prior to implementation, two organizations decided not to go forward with the initiative, leaving a total of 24 primary care health home organizations operating health homes in 86 sites throughout Missouri. These are further broken down as follows:

- 18 federally qualified health centers
- 6 public and private hospitals (including 15 rural health clinic sites)

Missouri's primary care health home SPA was not formally approved until December 23, 2011. Because of this proximity to the initiative's January 1, 2012 start date, many of the health home providers elected to start their programs later to allow them to secure staff and "gear up" for implementation. This resulted in a staggered implementation schedule from January through April 2012, broken down as follows:

Month	Number of Health Homes Starting
January 2012	4
February 2012	11
March 2012	5
April 2012	4

Health home provider organizations were required to sign to letters of acknowledgement that require them to adhere to various aspects of MO HealthNet's Primary Care Health Home State Plan Amendment.

Primary care health homes are required to have the following staff and ratios for participation in MO HealthNet's initiative:

- 1 FTE health home director:2500 participants
- 1 FTE nurse car emanager:250 participants
- 1 FTE behavioral health consultant:750 participants
- 1 FTE care coordinator:750 participants

At the state level, a core group of 4 staff run the program with staff from other programs contributing significantly.

v. Program Successes

Successes include both transformational growth and development and improved outcomes. Briefly, the health homes are making the transition to thinking and operating in terms of population health management in addition to caring for the individual patients they see on a daily basis. This includes making cultural transitions in traditional roles in development of the health home team. Relationships across primary care and mental health continue to develop and integration of primary care and mental health continues to develop on an operational level. Finally, clinical outcomes are improving as demonstrated by primary care health home data below.

Figure 3

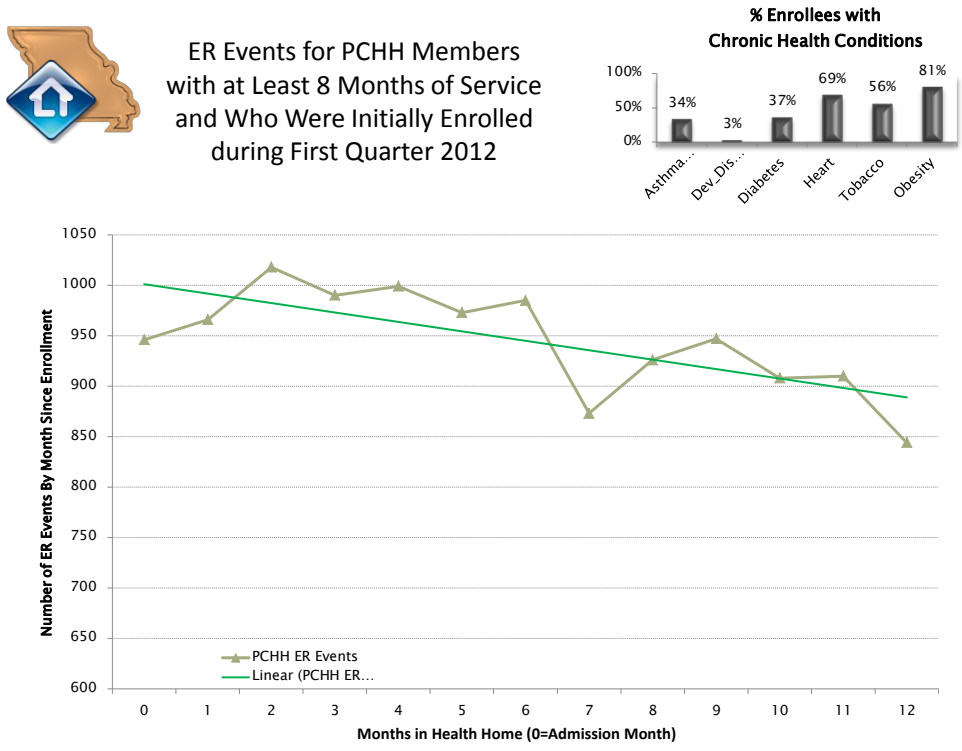
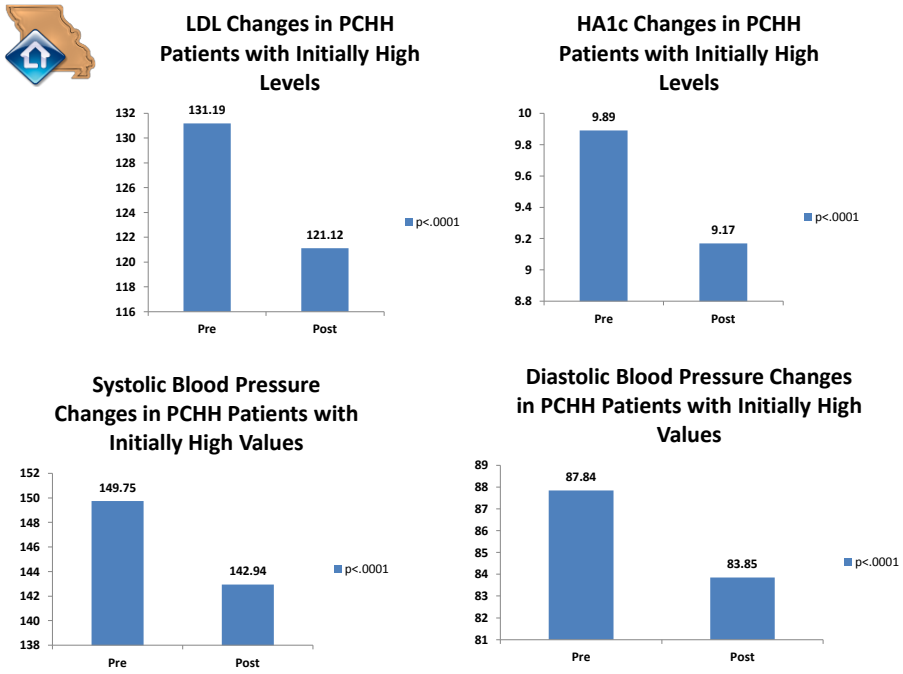


Figure 4



vi. Challenges

Challenging aspects of program design include:

- Minimal data/evidence base available nationally on developing similar models
- A very short development timeframe that was not conducive to extensive testing of various operational functions before implementation
- Systems design
- Anticipating all reports and data needs prior to implementation- needs have evolved over time and have required developing a comprehensive flexible database and reporting structure to which we make ongoing changes.

Challenging aspects of program management include:

- The volatility/churn of Medicaid eligibility which negatively impacts continuity of participation in the health home
- Getting participants to be actively involved in developing care plans and setting goals
- Retaining staff at the health homes/need to make the cultural transition to practicing as part of a health home team
- Standardizing and validating data across the health homes in a central data warehouse

vii. How they are perceived by stakeholders

The program is perceived positively.

Many groups and organizations were involved in the development of Missouri's primary care health home initiative.

- Department of Social Services (DSS)
- Department of Mental Health (DMH)

- MO Foundation for Health (MFH)
- MO Primary Care Association (PCA)
- MO Coalition of Community Mental Health Centers (CMHCs)
- Consultants: Michael Bailit & Alicia Smith
- Missouri Hospital Association (MHA)
- Missouri School Board Association (MSBA)

viii. Medicaid Expansion Status

A committee to further study Medicaid expansion has been established. The Governor supports expansion, but there is currently not enough support in the legislature.

Montana Managed Care Profile

i. Name of the Programs

- Passport to Health
- Team Care
- Health Improvement Program

ii. Delivery System Structure

Passport to Health

In 1993, the Department of Public Health and Human Services (DPHHS) received approval, through a 1915(b) waiver, to implement a primary care case management program, Passport to Health (Passport). Prior to this, the Medicaid program operated on a fee for service basis. The Passport program remains today, as the primary delivery system for most Medicaid and Healthy Montana Kids Plus (Montana's Medicaid Expansion Children's Health Insurance Program) enrollees. The waiver is operated in all 56 counties and involves 71 percent of all Montana Medicaid members. The waiver is up for renewal in April 2014. The state implemented the program to minimize ineffective or inappropriate care, ensure access to care and improve quality.

Periodic surveys show that more than 80% of both providers and clients are satisfied with Passport to Health. Passport cost savings were realized as well, although staff have not published a specific amount. The Centers for Medicare and Medicaid Services (CMS) recently awarded DPHHS an Adult Medicaid Quality Grant and is developing measures based on the Initial Core Set of quality measures to further evaluate the impact of Passport program.

DPPHS also contracts with a Centene-owned company, Nurse Response, to administer a 24/7 Nurse First Advice Line. The Nurse First Advice Line is available statewide for all Medicaid members. DPHHS contracts with Xerox as the Enrollment Broker. DPHHS staff report the vendor is meeting performance expectations. The call center handles 4,000 to 5,000 calls per month, on issues related to enrollment, PCP assignment, and a variety of other issues.

Team Care

Team Care was implemented in August 2004 to replace the original "restricted card" program. Team Care is a component of the Passport 1915(b) waiver. DPHHS sought to provide some additional reimbursement for managing care for individuals that have been identified as super utilizers, "frequent flyers" of emergency rooms (defined as individuals seeking care at the ER at least 12 times per year), or exceptionally high prescription drug utilizers. Team Care-eligible individuals are identified by the Drug Utilization Review Board and Provider referrals. Team Care participants are restricted to one Emergency Room, one pharmacy, and one primary care provider (PCP). Passport PCPs are paid six dollars per member per month (PMPM) for Team Care participants – double the case management fee providers receive for Passport to Health enrollees. PCPs provide education to Team Care enrollees about how to access appropriate care.

Health Improvement Program

Implemented through the same 1915(b) waiver as Passport, the Health Improvement Program (HIP) took the place of a private vendor (McKesson) in 2010. Citing concerns that the "out-of-state" Disease Management (DM) vendor was just costing a lot of money with no measurable outcomes, DPHHS decided to end the contract. DPHHS approached the Community Health Centers (CHC) and Tribal Health

Centers (THC) about a plan to contract with them for the care management functions, since they were seen as already playing a major role in care management for the Medicaid population. To start, DPHHS staff worked with CMS to develop a model to contract. Over a five month period, all but one CHC decided to participate. The plan was originally to implement cost-based reimbursements. However, CMS officials were having a hard time figuring out which regulatory provision would be the best fit for this model. They determined it would be an enhanced primary care case management (EPCCM) waiver benefit and the care management should be reimbursed on a PMPM basis. Staff report that a key strength of the HIP program is that the Department now has 30 nurses serving the population compared to the 4.5 nurses they had with the DM vendor. These CHC and THC- employed nurses are certified in chronic care management and serve as health coaches for HIP enrollees. This model is relatively unique in the country, although DPHHS staff believe Connecticut is implementing a similar model with their FQHCs.

DPHHS pays a $3.75 PMPM for all passport eligible individuals participating in the HIP program. Individuals are identified through predictive modeling software, Impact Pro. These enrollees are estimated to be the top five percent of health care utilizers and include 3,000 to 4,000 participants per month. Providers at the CHCs and THCs have access to Impact Pro in their offices and download their list of assigned enrollees from the software each month. Individuals may also be referred by their PCP. DPHHS is working on developing greater provider awareness of HIP.

Each HIP enrollee has a health assessment and written care plan. The providers have process measures built into their contract, but no quality measures, currently. DPHHS staff are currently working with the Primary Care Association (representing the CHCs and THCs) to develop outcome measures related to Emergency Room use and hospital readmissions.

iii. Challenges

While the Passport program has earned good enrollee satisfaction ratings, there can be challenges sometimes with provider office staff fully understanding their role in care management. Some enrollees have reported difficulties in obtaining PCP referrals for specialty care. DPHHS staff address these concerns when they arise. The Enrollment Broker (Xerox) conducts outreach to individuals on health care services such as well child appointments and prenatal care to promote the use of preventive services. However, DPHHS staff are working on identifying ways to improve provider outreach and education efforts on promotion of preventive care and roles in care coordination.

Because not much funding is available for evaluation, it is difficult to measure the overall impact of these programs. HIP staff have stated that they know the details of what services clients are getting for their dollars, but they are not able to calculate savings at this point. Quality measures are minimal, but there are plans to improve data collection on that front. Also, DPHHS staff are currently considering ways to coordinate more closely between Team Care and HIP care managers. A fair number of HIP-eligible Medicaid enrollees are also Team Care participants. They have the option of opting out of HIP, but do so at a lower rate than other HIP eligible individuals.

iv. Anticipated Outcomes

Team Care has seen a reduction in claims costs. A program cost savings analysis completed in August 2007 showed a cost savings of $381 PMPM. Estimated annual savings based on 600 enrollees was $2.6 million. The analysis found a 36.7% reduction in Emergency room claims costs, a 47.36% reduction in non-controlled prescription claims costs, and a 50.34% reduction in inpatient covered days (290 days to 144 days).

The Team Care program has maintained an enrollment of approximately 600 participants for the past seven years. Citing the program's successes, the Department intends to increase enrollment, but details on this expansion are not currently available.

v. History with Risk-Based Managed Care Models

Montana's history with risk-based managed care in Medicaid has been mostly unsuccessful. In 1997, the state contracted with Magellan to manage the mental health care programs in Medicaid. After many problems, including Magellan's failure to pay provider bills, Governor Marc Racicot was forced to terminate the contract. In 2012, under Governor Schweitzer, the state considered implementing a five-county pilot of risk-based capitated care with Centene Health Plan. However, an analysis conducted by Mercer could not identify significant potential savings. The proposal was widely opposed by both political parties in the legislature and the provider community, due to the history with Magellan and a generally negative sentiment toward "out-of-state" companies.

In 2008, DPHHS implemented a Program for All Inclusive Care for the Elderly (PACE) in Yellowstone and Livingston Counties. However, the PACE program was discontinued by the Legislature, as part of budget reduction measures in 2011.

vi. New Initiatives: Montana Patient Centered Medical Homes

The 2013 Montana Legislature passed the Patient Centered Medical Home Act (Senate Bill 84). The law requires the Montana Insurance Commissioner, in collaboration with a council of stakeholders, to create standards for the multi-payer program, determine how to qualify health care providers and insurers to participate and promote the program. The council consists of representatives of primary care providers, health plans, Medicaid, public health and consumer advocates.

Montana and Wyoming jointly share a $7.7 Million Health Care Innovation Grant from CMS to implement a Patient Centered Medical Home model for Behavioral Health. This telemedicine model of care is being developed in partnership with HealthLinkNow, Inc. The model will offer videoconferencing between local patients and HealthLinkNow, Inc. psychiatrists as well as email and instant messaging. The initiative is currently in the design phase.

vii. Governance and Organization

The Medicaid program is administered through a variety of divisions within DPHHS, with primary responsibility residing with the Medicaid Director, in the Medicaid and Health Services Branch. DPHHS is the single state agency responsible for administering the Medicaid program. The mega-agency is also responsible for administering Montana's other major social service programs including Public Health, Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP) and Child and Family Services. The Director of DPHHS, **Richard Opper,** was appointed by Governor Steve Bullock in December 2012.

viii. How they are perceived by stakeholders

Enrollee satisfaction surveys show that patients are generally satisfied with their care and access to providers. There are sometimes difficulties with PCPs making timely referrals for specialty care; DPHHS staff deal with these concerns directly on a case by case basis. Provider and consumer advocate stakeholders are generally supportive of these programs, but feel Montana is missing out on some opportunities to implement payment reforms and more enhanced models of care coordination for high

needs patients. The PCMH initiative and potentially a 2703 Health Home state plan amendment are being promoted by many stakeholders as a necessary next step.

ix. Medicaid Expansion Status

During the 2013 legislative session, Democratic Governor Steve Bullock developed a proposal for expanding Medicaid, which became legislation sponsored by Rep. Chuck Hunter, the House Minority Leader. The legislative session ended without successful passage of that legislation or any of the alternative bills that were developed. The Legislature does not reconvene until 2015.

In the meantime, a coalition of stakeholders, under the name of Healthy Montana Initiative, has taken the initial steps of creating a ballot initiative to expand Medicaid. On November 21, 2013, the group submitted proposed ballot language to the Secretary of State intending to put the vote on the 2014 ballot.

New Mexico Managed Care Profile

i. Name of the Program

Was**:**

- Salud! 1915(b) waiver: Acute managed care for children and parents;
- CoLTS 1915(b)(c) waiver: Managed long term services and supports for dual eligible and individuals with a nursing facility level of care (This was Amerigroup. Molina was the Third Party Administrator);
- Behavioral health 1915(b) waiver: Managed behavioral health services through a statewide behavioral health organization (Optum (United));
- Mi Via-Nursing Facility 1915(c) waiver[70]: Self-directed home and community based services;
- AIDS 1915(c) waiver: Home and community based services for people living with HIV/AIDS; and
- Medically Fragile 1915(c) waiver: Home and community based services for individuals who are determined to be medically fragile.[71]

Starting January 1, 2014: *the above waivers are all included in one 1115 waiver program called Centennial Care*

Centennial Care included populations:

- Childless Adults
- Parents
- Pregnant Women
- Individuals for Family Planning
- Women for Breast and Cervical Cancer
- Low Income Children Below 138% of FPL
- Qualified Children up to age 19 138-185% FPL
- CHIP Uninsured children above age 19 185-235% FPL
- Foster Children
- ABD SSI Recipients
- Medically Needy
- Working Disabled
- Nursing Facility residents
- Community Benefit
- Medically Fragile Waiver population will be enrolled in June or July 2015.

Groups Excluded from Waiver:

- DD populations receiving HCBS and those in the Mi Via program that meet ICF/MR level of care.
- Program for All-Inclusive Care for the Elderly (PACE)

[70]Note: The state's Mi-via/ICF/IID 1915(c) waiver is not being consolidated into this 1115 demonstration.

[71]Note: Initial Centennial Care implementation will provide acute care services only to participants in the Medically Fragile 1915(c) waiver. The Medically Fragile 1915(c) waiver services will be phased in effective July 1, 2015, with a six month transition period beginning January 2015.

- Qualified Medicare Beneficiaries (QMB)/Specified Low-Income Medicare Beneficiary (SLMB)/Qualified Individuals (QIs).
- Refugees
- Undocumented aliens
- Subsidy adoptions with out-of-state placements

ii. Delivery System Structure

Under Centennial Care, four Managed Care Organizations (MCOs) will deliver the full range of Medicaid services, including HCBS and institutional services. Service offered in the Medically Fragile HCBS waiver to be phased in effective July 1, 2015. The four MCOs are:

- Blue Cross Blue Shield of New Mexico
- Molina Health Care of New Mexico, Inc.
- Presbyterian Health Plan, Inc.
- United Health Care Community Plan of New Mexico

Behavioral Health

MCOs are responsible for all aspects of care and are not allowed to subcontract with a risk-based capitated Behavioral Health Organization (BHO) for behavioral health care. Instead, the MCOs will contract with individual behavioral health providers and CSAs and create behavioral health home pilots.

Long Term Services and Supports

All MCOs must contract with the same Fiscal Management Agency, Xerox, for self-directed care services, and must either provide or contract with agencies that can provide support broker services to members in the self-directed community benefit. They also must contract with individual providers for HCBS services, both agency-based and self-directed.

iii. How Program was Designed and Implemented

Centennial Care is now an 1115 waiver that encompasses all of the programs that were previously provided through separate waivers and SPA services.

In June of 2011, New Mexico embarked on an ambitious plan to modernize its Medicaid program to accomplish the following goals:

- To assure that Medicaid enrollees in the program receive the right amount of care at the right time and in the most cost effective or “right” settings
- To assure that the care being purchased by the program is measured in terms of its quality and not its quantity
- To bend the cost curve over time
- To streamline and modernize the program in preparation for the potential increase in membership of up to 175,000 individuals beginning January 2014 with the expansion of Medicaid under the federal Patient Protection and Affordable Care Act

As a beginning place for the development of a modernized Medicaid program, the State articulated four guiding principles:

- Developing a comprehensive Service Delivery system that provides the full array of benefits and services offered through the State’s Medicaid program;

- Encouraging more personal responsibility so that beneficiaries become more active participants in their own health and more efficient users of the health care system;
- Increasing the emphasis on payment reforms that pay for performance rather for the quantity of services delivered; and
- Simplifying administration of the program for the state, for providers and for beneficiaries where possible.

The ideas behind these concepts were fleshed out over a series of public stakeholder meetings, suggestions and comments delivered to the state via the internet, email and "snail mail," cross-stakeholder workgroups and Tribal Consultation.

To avoid cuts in eligibility, services, and payments to providers, New Mexico developed a comprehensive system of care that focuses on:

- Care Coordination;
- Health Literacy by increasing the work of community health workers and "promotoras;"
- Prevention and patient-centered medical homes;
- Payment reforms to reward cost-effective, "best-practices" care;
- The use of technology to bring healthcare to the rural and frontier areas of the state; and
- Encouraging more engagement in personal health decisions while rewarding those who engage in healthy behaviors. This includes both a small, sliding co-pay for non-emergency use of an emergency room, as well as rewards for engaging in healthy behaviors, or actively participating in a member's care plan.

Administratively, New Mexico:

- Combined most of its existing waivers into a single, comprehensive waiver to reduce internal bureaucracy and the number of programs over which the federal government has control; and
- Built effective management capacity and capability to hold private sector partners accountable through all levels of the program, while reducing the number of managed care plans.

iv. How they are perceived by stakeholders

New Mexico has been a "managed care" state for many years, so stakeholders from the various member, provider and advocacy communities understand the managed care structure and systems. This includes physical/acute care, behavioral health, and long term care. One of the biggest challenges to the original Centennial Care proposal was from the Native American tribes in New Mexico; they were opposed to the state's plan to require mandatory enrollment in Centennial Care with an opt-out provision for Native Americans. Ultimately, the Tribes were successful in getting the state to agree to a voluntary opt-in provision to Centennial Care for Native Americans, with the exception of those who are full dual eligibles (Medicare/Medicaid) and those with a nursing facility level of care. These two Native American groups must enroll in Centennial Care.

v. Medicaid Expansion Status

The state has expanded Medicaid to include childless adults up to 133 percent FPL. Many of these individuals were in a state-only plan called "SCI" prior to being moved into Medicaid on January 1, 2014. New Mexico has created a federally-approved benchmark plan for those in the newly eligible population who are not exempt from benchmark coverage.

North Dakota Managed Care Profile

i. Name of the Program

North Dakota PCCM. The program is authorized through a 1915(b)(4) waiver.

ii. Delivery System Structure

Medicaid and CHIP Expansion Medicaid

Physical Health

Beginning in December 2009, the following eligibility groups are mandatorily enrolled in ND PCCM program:

- Categorically needy: Family Coverage Group 1931 and Transitional Extended Medicaid
- Optionally Categorically Needy
- Medically Needy nonexempt
- Poverty Level: Pregnant Women, Children ages 6 to 19

Excluded populations include:

- Aged, blind, or disabled individuals
    - Individuals with Medicare health insurance coverage
- Residents of the following facilities:
    - Nursing facilities/Long term care,
    - ICF/MR facilities,
    - State Hospital,
    - Institution for Mental Disease (IMD)
- Individuals in receipt of home and community based services
- (HCBS), Foster Care, Subsidized Adoption, and refugees.
- Individuals eligible for Medicaid through the Women's Way Program.
- A PCP is not required during any of the three months prior to the Medicaid application month.

Behavioral Health

Behavioral Health services are provided fee for service through eight regional human service centers. The N.D. Department of Human Services' regional human service centers provide an array of community-based services, either directly or through contracts with providers. Services include: aging services, vocational rehabilitation, mental health services, developmental disability services, addiction treatment, vulnerable adult protective services, crisis and outreach services, and other human services. Source: ND Department of Human Services: http://www.nd.gov/dhs/info/pubs/docs/hsc-contact-info.pdf

iii. Separate CHIP Program: Healthy Steps

In 2011, 7,115 children were covered by Healthy Steps. The ND DHS contracts with BCBS North Dakota, via a managed care arrangement, for physical and behavioral health services.

iv. Long Term Services and Supports

Experience Health*ND* is a North Dakota Medicaid benefit for recipients with chronic health conditions. Conditions covered by the program include asthma, chronic obstructive pulmonary disease, diabetes

and congestive heart failure (CHF). The Department contracts with Health Management Team, which participates in the North Dakota Medicaid Program to provide health management (HM) services to certain Medicaid recipients. This program is authorized with CMS approval of its 1915(b)(4) waiver. The North Dakota Department of Human Services, Medical Services Division contracts with a vendor named USCM, a wholly owned subsidiary of U.S. Preventive Medicine.

Populations included for participation on a voluntary basis:

- Section 1931 Adults and Children
- Aged, Blind and Disabled
- Foster care Children
- Title XXI CHIP enrolled Children

Populations excluded from participation:

- Medicare Dual Eligibles
- Medicaid enrollees with other insurance
- Medicaid enrollees living in Nursing Facilities or ICF/MR
- PACE enrollees

PACE

The Northland Healthcare Alliance runs two PACE service areas in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 35 enrollees.

v. How Program was Designed and Implemented

North Dakota's PCCM program has been in place since the late '90s, predating the current management team.

Healthy Steps is the stand-alone CHIP program contracted to Blue Cross. The policy decision was made at its inception to employ a managed care (MCO) model. The program has been very well accepted and very popular.

Experience HealthND is the state's disease management program for Medicaid clients suffering from diabetes, asthma, COPD and congestive heart failure. The state obtained a waiver when the program started in 2008 and competitively procured a contract with US Care Management. CMS subsequently refused to renew the waiver due to negative comments from clients. Disease management is now a state plan service, and any primary care provider willing to comply with the reporting requirements can participate in the program, although few have elected to do so. State officials report that an evaluation of the program will be conducted in 2014.

vi. Challenges

The legislature has directed the Medicaid program to enroll the Medicaid expansion population into MCOs effective January 1, 2014. Two plans have been awarded contracts (Blue Cross and Sanford Health Plan), but CMS is balking on approving the rates set by the Medicaid actuary. ND is proposing rates that are closer to commercial rates than to the Medicaid fee schedule. For many individual providers, ND Medicaid pays 140% of Medicare. In addition, Medicaid staff note the considerable workload involved with securing waiver renewals, state plan approvals and reporting requirements.

Another significant challenge has been their legacy MMIS (circa 1978) that does not allow the state access to good data in a timely manner in order to better manage the programs and determine whether they are cost effective or yielding improvements in care quality.

vii. How they are perceived by stakeholders

The PCCM program continues to enjoy support from providers even though the PMPM rates ($2) have not been increased. A study was conducted of a population that had been served by an MCO in the Grand Forks region until the plan folded in 2006. No appreciable increase in costs were seen when the population moved to the PCCM model.

The Healthy Steps (CHIP) program has yielded good results for children, providing access to dental and vision benefits, and good encounter information on the covered population.

viii. Medicaid Expansion Status

Regarding the procurement process for the Medicaid expansion MCO's, the two MCOs who submitted proposals, BCBS of ND and Sanford Health Plan, were awarded contracts. However, in December, BCBS of ND withdrew as a health plan. The state will move forward with implementation with Sanford Health Plan.

As of January 15, 2014, 2,138 individuals had enrolled in the Medicaid expansion plan.

Oklahoma Managed Care Profile

i. Name of the Program

SoonerCare Choice is a Primary Care Case Management Program (PCCM) with a patient centered medical home model, implemented in 2009. SoonerCare Choice primary care providers are paid fee-for-service along with a monthly case management/care coordination fee.

ii. Delivery System Structure

The statewide program includes contracts with primary care providers and covers approximately 425,267 people in the following categories:

- SSI Children
- Medicaid Expansion CHIP
- All Other Children
- Pregnant Women
- Parents/Caretakers
- Non-Dual Blind/Disabled

The below boxes are the number of medical homes by Tier type as of 2009. The Tiers are defined by OHCA on pg. 7 of the link: http://okhca.org/pdf/Physician_Addendum.pdf

January 2009	
Tier 1	= 445
Tier 2	= 223
Tier 3	= 31
Total	= 699

January 2011	
Tier 1	= 555
Tier 2	= 214
Tier 3	= 44
Total	= 813

According to OHCA presentation, SoonerCare Choice providers are paid a Monthly Capitated "Bundled" payment which includes:

- Case Management / Care Coordination Fee
- Primary care office visits
- Limited lab services

Other codes are paid on FFS basis. OKHA has lump sum incentive payments for providers who meet quality standards for EPSDT / 4th DTaP rates.

Health Access Networks

Oklahoma piloted three non-profit, administrative Health Access Networks (HANs) to support care coordination and quality improvement. All sites have EHR and Telemedicine capabilities.
According to Oklahoma Health Care Authority's 2012 Annual Report, the state's three HANs served 382 practices and over 78,000 SoonerCare Choice members as of June 2012. Currently, the University of Oklahoma- Tulsa is operating the Sooner Health Access Network, which provides administrative services to a network of providers including advanced analytics, care management for at-risk patients, electronic referral tracking software, assistance with PCMH Tier Advancement and quality improvement programs for patients.

iii. How Program was Designed and Implemented

SoonerCare Choice

For many years, Oklahoma operated a traditional managed care program. After several cycles of difficult rate negotiations, with the MCO demanding higher reimbursement than the state thought reasonable, the contract was cancelled. 2003 was a tipping point in Oklahoma. That year only two of the original five plans remained operating in Oklahoma City, Tulsa and Lawton (the minimum federally required for mandatory enrollment in managed care) and those plans were demanding an 18% increase in rates for the next year or they were threatening to withdraw. The state had published a report indicating that the SoonerCare Choice model was performing as well or better than the SoonerCare Plus plans on most or all of the consumer satisfaction and quality metrics.

In 2004, the state engaged providers in the adoption of a Primary Care Case Management model (PCCM) and have operated the program with state agency staff to date. Oklahoma Health Care Authority (OHCA) hired 32 nurse care managers and 2 social services coordinators to enhance care management in SoonerCare Choice. Oklahoma started paying physicians 100% of Medicare rates in 2005. OHCA modified the SoonerCare Choice program in 2009 to implement Patient Centered Medical Home model with three Tiers of Medical Homes. In 2010, on-line provider enrollment was introduced to further increase participation rates.

Originally, the OHCA estimated they could save 25% of the administrative expense incurred by the MCOs and reduce the state staff dedicated to managing the plans by 75%. However, the legislature also transferred $10M to the OHCA administrative budget.

iv. Program Successes

- Greater participation in the program (44% increase in contracted providers, SoonerCare Choice PCPs provided 84 to 90% more visits in 2007 than 1997)
- Reduced ER utilization (76 visits per 1000 enrollees in 2007, down from 80 visits in 2004 – bucking an increase in the national trend.)
- Overall improvement in all 19 HEDIS measures between 2001 and 2007

A 2011 OHCA presentation[72] reports the reduced per capita cost from $24.95 in 2008 to $22.53 in 2010.

v. How they are perceived by stakeholders

Stakeholders, in general, are satisfied with the SoonerCare program. Providers benefit from relatively generous reimbursement rates, strong leadership at OHCA, and a streamlined eligibility and enrollment system that removes hassles for enrollees and improves continuity of coverage.

vi. Medicaid Expansion Status

Oklahoma is not moving forward with Medicaid expansion option at this time. The Governor opposes the policy.

[72] Oklahoma Health Care Authority, "SoonerCare Choice PCMH," Presentation to 3rd State Consortium to Advance Medical Homes in Medicaid and CHIP, March 31, 2011.

Oregon Managed Care Profile

i. Name of the Program
Oregon Care Coordination Organizations.

ii. Background
Oregon started the managed care journey in 1994 when they contracted with large commercial plans to provide care to Medicaid clients. To do so, they were obliged to pay commercial rates to the plans to gain access to the commercial provider network. Medicaid Fee-for-service (FFS) rates were kept low to incentivize providers to join commercial plan networks.

This model worked well for a few years, but when the economy worsened and the state had to reduce rates, plans accordingly had to pay lower rates to providers seeing Medicaid clients. This caused some plans to withdraw from the market and reduce choice – particularly in rural areas. Several Independent Practice Associations (IPAs) offered to contract directly with the state on an at-risk basis. At one point there were more than 15 such small Managed Care Organizations (MCOs) across the state. As state revenues continued to decline, medical cost inflation prompted the state to propose amending their 1115 waiver to put plans on a budget and require them to meet several quality metrics to improve care, thus promoting the "triple aim" framework identified by CMS's Don Berwick.

State officials reported that moving to the CCO model was the only option for the state, there was no "Plan B." If coordinated care does not result in lower costs and improved quality, the terms of the waiver call for the state to pay tens of millions of dollars to the federal government. If this doesn't work, the state could well revert to FFS.

iii. Delivery System Structure
Medicaid and CHIP
Physical Health and Behavioral Health
In July 2012, CMS approved Oregon's request to extend and amend its Section 1115 waiver to launch new Coordinated Care Organizations (CCOs) to replace the current managed care delivery system. The waiver plan includes a commitment for Oregon to reduce the annual per capita Medicaid expenditure growth trend by 2%.

Fifteen CCOs will operate on a regional basis with enhanced local governance. The COOs are a network of all kinds of providers that will integrate physical, mental and ultimately dental health services. The CCOs will also provide care coordination and a menu of flexible non-medical services. Long-term services and supports will not be included initially.

The CCOs will operate under a global budget that grows as a fixed rate. The payment system includes quality outcome-based incentives and, eventually, shared savings between the state and contracted entities.

To meet the goals of improving quality of care and improving population health measures, the waiver also allows the state to pay for the services of non-traditional health care workers, such as community health workers, doulas, client navigators and peer wellness workers, in Medicaid. It also allows Oregon to train 300 community health workers by 2015 and to provide a loan repayment program for primary care physicians who agree to work in rural or underserved communities.

State Innovation Model:

Oregon was awarded a $45 Million (over 3 and a half years) State Innovation Model Grant from the CMS Innovation Center to test the CCO Model design, including:

- Focus on key payment and delivery system elements as part of test:
  - Global budget and incentives from State → CCOs
  - Alternative payment methods from CCOs → providers
  - Spread of the PCPCH model
  - Integration of physical and behavioral health
  - New workforce development (NTHWs, etc.)
  - Long-term care alignment strategies
  - Evidence-based guidance for providers and consumers

iv. State Resources Required to Implement/Operate

The Oregon Health Care Authority expects the CCO model to require fewer FTEs than what is currently required to manage the existing plan contracts. There are no firm staffing numbers or organizational chart available at the time of the interview. The state expects to retain some audit oversight of expenditures, but will rely strongly on local oversight, the global budgets and the quality metrics to demonstrate that the model is successful.

The procurement process was fairly inclusive. The state had expected a number of MCOs to self-select out of the process of becoming CCOs, but to-date that has not occurred.

v. Challenges

When asked about some of the more challenging aspects of implementation experienced so far, state officials reported that they have struggled with the best approach for getting information to providers as to how they perform relative to their peers. Also, it has been difficult to get providers to understand how high the stakes are and to accept that the status quo is no longer sustainable. Getting the plans used to a local governance structure to identify community goals and priorities has been an additional challenge.

vi. Anticipated Outcomes

Oregon Medicaid officials stated that better coordination of care and more concentrated management of high cost clients is anticipated to provide more reliable budgeting for the state, a reduction of emergency room visits, fewer inpatient hospitalizations, a better quality of life for clients. Additionally, the CCO Model will allow for providers to be rewarded for quality outcomes through shared savings (one to two percent of per cap is held back pending attainment of quality metrics).

There is a strong emphasis on innovation and the sharing of best practices across CCOs that is hoped to serve to change the delivery system to be better coordinated and client-focused.

vii. How the CCOs are perceived by stakeholders

The planning process has utilized a very robust stakeholder outreach and considerable transparency. There has also been an extraordinary level of support from the Governor's office. So far, public perceptions are positive.

viii. Medicaid Expansion Status

Oregon is moving forward with expansion of Medicaid in January 2014. As of March 1, 2014, approximately 104,000 individuals have been determined eligible for Medicaid through the health insurance Marketplace.

South Dakota Managed Care Profile

i. Name of the Program

Provider and Recipient in Medicaid Efficiency (PRIME) is a PCCM program implemented statewide in 2002. As of July 2013, 90,814 individuals are enrolled in PRIME.

ii. Delivery System Structure

The PRIME PCCM program covers most Medicaid populations (approximately 80%):

- Section 1931 Children and Related Poverty Level Populations (TANF/AFDC)
- Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF/AFDC)
- Blind/Disabled Adults and Related Populations (SSI)
- Title XXI CHIP

Exempt populations include:

- Medicare recipients
- Nursing home residents
- Recipients residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR)
- Participants in a home and community-based waiver program
- Have an eligibility period that is only retroactive
- Enrollees under age 19 with special needs that are
    - Eligible for SSI
    - Determined to be Children with Special Health Care Needs (CSHCN) through Title V
    - Eligible under a Maternal Child Health Services Block Grant
- Foster care children
- Subsidized adoption

Most physical and behavioral health services are provided through PRIME. Medical Assistance eligible recipients diagnosed as SED (Severely Emotionally Disturbed) or SPMI (Severely and Persistently Mentally Ill) by their mental health professional are excluded from PRIME for Mental Health Services Only.

iii. How PRIME was Implemented/Operational

The implementation of PRIME pre-dates current managed care staff and leadership. South Dakota manages and operates the PRIME program internally. They do not contract with external MCOs or other organizations. The PRIME program has two FTEs, as well oversight by the Deputy Director of Medical Services. Other staff within the Division also support the functions of PRIME on a more limited basis. However, when asked about challenges related to managing the program, staff indicated they were primarily related to working within the constraints of a legacy MMIS system.

iv. PRIME Program Successes

Staff interviewed reported that more than 800 primary care providers are enrolled as PCP providers under the PRIME program. They are paid a $3 PMPM case management fee. These PCPs have been instrumental in preventing unnecessary medical services due to the referral requirement.

v. Stakeholders' Perceptions of PRIME

At this point, PRIME is an accepted component of SD Medicaid, with general support across stakeholders.

vi. Other New Initiatives

Health Home Initiative

South Dakota implemented the Health Home Initiative on July 1, 2013. Close to 600 providers have completed the application and attestation processes. Close to 6,000 recipients are currently receiving Health Home services.

South Dakota continues to work with CMS to finalize the Health Home State Plan Amendment.

Care Management for Individuals with Chronic Conditions

DSS issued a Request for Information in February 2012 to solicit care management program proposals. Approaches such as hospital care transition services and intensive case management were submitted by some of the twenty seven respondents. Because there is overlap between the populations eligible for Health Homes and individuals who would benefit for enhanced care management, DSS says they will resume work on this after implementation of the Health Home initiative to ensure future services are not duplicative and best meet the needs of high cost Medicaid enrollees.[73]

Emergency Room Diversion Program

The implementation of the Health Home model is expected to have an impact on unnecessary ER utilization for Health Home recipients – some of the most frequent users of ER services. Additionally, South Dakota Medicaid is exploring other diversion programming and policy options. DSS was exploring an Emergency Room diversion program modeled after the Utah "Safe-to-Wait" program, but have not yet finalized a model for implementation.

vii. Medicaid Expansion Status

A committee to further study the Medicaid expansion has been established. However, the Governor opposes expansion and DSS is not moving forward with expansion plans at this time.

[73] "Medicaid Solutions Workgroup: Annual Progress Report," December 2012. http://dss.sd.gov/1.03.13_MEDSOLWORKGROUP.pdf

Utah Managed Care Profile

i. Name of the Program
Utah Medicaid Accountable Care Organizations and Utah CHIP Managed Care Plans.

ii. Delivery System Structure
Medicaid

Physical Health
Except for the four most populous counties in the state (see ACO discussion below), the Utah Department of Health (DOH) contracts with Select Access as a Primary Care Case Management contractor to deliver all medical services. Mental health and dental services are carved out.

Behavioral Health
In most areas of the state, mental health services are provided only through a Prepaid Mental Health Plan (PMHP). Medicaid clients who live in certain counties of the state must receive mental health services from community mental health centers which have contracted with the Medicaid agency as a PMHP. The program is authorized through a 1915(b) waiver.

ACO Initiative for Medicaid
Beginning in January 2013, Utah replaced its managed care contracts with ACO contracts in four counties — Salt Lake, Davis, Utah and Weber — with 70% of the state's Medicaid population. Medicaid clients in rural counties have the option of enrolling in an ACO, but are not required to do so, and in total, the ACOs cover about 180,000 of the state's total Medicaid population of about 245,000.

The program is authorized through a 1915(b) waiver.

The state has ACO contracts with the following health plans:

- Select Access (part of SelectHealth, the managed care subsidiary of Intermountain Healthcare),
- Molina Healthcare of Utah,
- Health Choice of Utah
- Healthy U (part of University of Utah Health Care)

The Division submitted an 1115 Waiver request in 2012. Although the Waiver Request was not approved in full, the following components were implemented as part of Utah's Accountable Care Organization (ACO) model:

- Restructure provider payments using risk adjusted capitated payments for all of its ACO contracts and pay providers for episodes of care rather than for billable events in an effort to maintain or improve the quality of care and recipient health status.
- Integrate non-behavioral pharmacy benefits into the ACO scope of service to better align the incentive of prescribers with the goals of the State.
- Reward recipients for personal efforts to maintain or improve their health.

CHIP

CHIP is separately administered by Utah Department of Health. CHIP currently contracts with SelectHealth and Molina Healthcare of Utah to provide health care services. Additionally, CHIP contracts with Premier Access and DentaQuest to provide dental care services.

Utah is reportedly looking at how it could integrate the ACO program into its Children's Health Insurance Program (CHIP). The state's CHIP contract ends in December, but it's likely the state will take advantage of a one-year renewal clause while it waits to get results on the Medicaid ACO program, and begin considering changes in CHIP in 2014.

Emergency Room Diversion Program

Utah has developed an Emergency Room diversion program called "Safe-to-Wait." The DOH identified fee for service and Select Access members, through claims analysis, that had used the ED inappropriately. The DOH provided information and education about other options available for obtaining medical care. For instance, they helped clients find a PCP and provided a list of urgent care clinics throughout the state. They also maintain a website with education and resource information.

State Innovation Model:

Utah proposes to design an innovative statewide initiative to facilitate improved physician/patient communication and care coordination, with the goal of improving health care quality and lowering costs. The state will convene a multi-stakeholder group that will address strategies for healthcare transformation in five key areas: expanded health information technology; adequate healthcare workforce; wellness and healthy lifestyle promotion; payment reform; and medical malpractice and dispute resolution.

iii. Medicaid Expansion Status

The Medicaid Expansion Options Community Workgroup continues to explore the state's options regarding a potential expansion of the Medicaid program under the Patient Protection and Affordable Care Act.

Appendix D: Definitions

Accountable Care Organization: An entity made up of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of the care delivered; also known as Coordinated Care Organizations, Regional Care Coordination Organizations, or Regional Care Organizations.

Administrative Services Organization: An entity, usually an insurance company, which is contracted with the state to perform certain administrative tasks, such as member services, as well as care coordination and care management tasks. Data analysis and identification of high-needs enrollees is a common requirement.

Bundled Payment: A single payment made for a defined set of services (episode of care) delivered by two or more providers, usually delivered within a certain period of time. Examples: joint replacement surgery and organ transplants; one payment is made for services provided by the hospital, surgeon, and anesthesiologist, rather than three separate payments. Case rate and episode of care payment are types of bundled payments.

Capitation: A payment method in which the provider is paid a fixed amount for each person served, usually per member per month (PMPM). The fixed payment covers the full range of contracted services, such as hospital, doctor, and lab services.

Care Coordination: A set of activities through which teams of health care professionals work together to ensure that the patient receives needed care and services at the right time and in the right setting.

Carve-outs: An approach in which a portion of benefits are separated from the benefits package the insurance company or other entity is required to cover; usually mental health and/or long-term care benefits.

Care Management: A set of activities designed to engage providers, patients, and their caregivers in a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive needs and to help them manage their health and well-being; also known as case management.

Coordination of Benefits: A set of activities performed to ensure that an enrollee receives the full extent of coverage for services under two or more forms of insurance (i.e. Medicaid and Medicare).

Disease Management: A system of coordinated health care services, education, and self-management training for populations with chronic conditions, such as diabetes or COPD.

Enrollee: Any person eligible for and receiving coverage from Medicaid.

Fee-for-Service (FFS): A method of reimbursement based on payment for services rendered.

Global Payment: A single payment made to a group of providers for all services delivered to a defined patient population over a defined period of time. This is similar to, but different from, capitation because it is paid to a group of providers rather than a single provider or practice, and the providers together agree to be accountable for the total cost of care for a patient population.

Managed Care: A general term for organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care.

Medicaid: The federal-state program that provides medical assistance for low-income and medically vulnerable citizens.

Patient-Centered Medical Home: The organization of primary care so that it delivers the core functions of primary health care, prevention and wellness, and comprehensive care coordination and care management.

Pay-for-Performance (P4P): A payment mechanism that pays providers a bonus payments (or sometimes payment reductions) for meeting (or missing) specified performance requirements (i.e. quality measures).

Primary Care Case Management (PCCM): A system in which enrollees are assigned to a primary care provider who provides primary and preventive care, as well as care coordination and care management services. Providers are paid fee-for-service for the health care services provided and a fee (usually PMPM) for care coordination/management services.

Risk: The chance or possibility of financial loss.

Risk-Based Managed Care: The most common type of Medicaid managed care in which an entity, usually an insurance company, is contracted with the state to provide coverage for a defined set of Medicaid benefits; paid on a capitated basis.

Shared Savings: A payment mechanism that pays providers fee-for-service and a bonus payment if the provider delivers care under an established threshold budget. The bonus payment is usually a percentage of the amount below the threshold (i.e. the savings).

Shared Losses: A payment mechanism that pays providers fee-for-service and are required to pay back a portion of any expenditures above an established threshold budget. The payment is usually a percentage of the amount above the threshold (i.e. losses).