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*State Levers for Improving
Managed Care for Vulnerable Populations
Strategies with Medicaid MCOs and ACOs*

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Abstract

This report describes ten leading states' strategies for using managed care to promote quality, cost-effectiveness, and better health outcomes for vulnerable Medicaid populations. Authors examined Medicaid "levers" used with both licensed managed care organizations (MCOs) and new integrated delivery systems such as accountable care organizations (ACOs). States are strengthening and expanding contractual requirements and financial incentives to MCOs to: report and improve quality measures; identify and target services to special needs and high-risk populations; integrate medical care with behavioral and social services; and engage in community-based or population health. Some state Medicaid programs are returning carved-out benefits to MCOs for better care integration; convening MCOs to share best practices; and aligning quality improvement efforts with other public or private payers; and others. States pioneering ACO-like reforms are contracting directly with providers or regional networks and shifting risk for quality and cost-effectiveness of care to those entities. Mechanisms include performance-based per member per month payments, quality-based shared savings, and bundled/global/ and population-based payment pilots. States are also partnering with commercial insurers and Medicare to support multi-payer primary care medical homes and community health teams with enhanced care coordination for high-risk patients.

This review reveals that there is much room for MCOs and ACOs to co-exist and interface, that they are in fact moving in similar directions. State Medicaid programs can play an essential leadership role in convening MCOs, ACOs, and other stakeholders; engaging them in developing and implementing new managed care strategies; facilitating the sharing of best practices and alignment of QI efforts; and providing support for data sharing and analysis, technology, technical assistance, and evaluation. These activities have much potential for improving quality, access, and cost-effectiveness of care for vulnerable populations.

About HMA

Health Management Associates (HMA) is an independent, national research and consulting firm with 15 offices nationwide, specializing in the fields of health system restructuring, health care program development, health economics and finance, health policy analysis, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, providers, and foundations, with a special concentration on those who address the needs of the medically indigent and underserved. www.healthmanagement.com

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Introduction

State Medicaid programs are at a crossroads. They face serious budget constraints, higher enrollment resulting from the recent recession, an upcoming eligibility expansion in many states that will include individuals with complex needs, and staff shortages. The need for value – better cost-effectiveness and higher quality of care for the vulnerable populations they cover – has never been greater. At the same time, state Medicaid agencies' experience and ingenuity coupled with new federal funding for health system changes create numerous prospects for extensive health system redesign. In almost every state, teams of interested people both inside and outside state government are exploring and in some cases grasping opportunities to design and implement changes intended to enhance value. By the time these new initiatives come to fruition, health care purchasing and delivery in state Medicaid programs may bear little resemblance to the current system.

One of the significant Medicaid transformations underway is the greatly expanded and innovative use of managed care, in both licensed managed care organizations (MCOs) and other integrated delivery systems such as accountable care organizations (ACOs). States are contracting with health plans and provider networks in ways that they hope will achieve higher quality and cost-effectiveness than has been possible under more traditional Medicaid purchasing arrangements. Some of the new arrangements cover not just low-income Medicaid populations, but also those with the most complex health care needs such as people with disabilities and people dually eligible for Medicaid and Medicare.

This report describes ten leading states' use of managed care, through MCOs and ACOs, to promote quality, cost-effectiveness, and better health outcomes for vulnerable Medicaid populations. It is based on interviews with Medicaid leaders in ten states identified as forward-thinking in their use of managed care and delivery system reforms. Officials in these states reported that they are working with their existing managed care organizations to improve care by establishing broader and higher standards, and shifting more risk to motivate plans and providers to achieve desired outcomes. In addition, they are working with other state agencies, and challenging MCOs and providers to collaborate with each other and in new ways that work around limitations in the older models of care delivery. Notably, these approaches emphasize care coordination and integration of a wide range of health and social services to meet enrollees' needs.

A few states are contracting with newly formed health care organizations in 2012 and 2013, hoping to accelerate improvements in care delivery. They are using ACO-type models as tools for delivery system reform in Medicaid, and some are preparing to care for more complex patients who in the past have been excluded from managed care. The degree and type of interface between these ACOs and traditional MCOs varies, depending on the role and history of managed care in the Medicaid marketplace. Some MCOs are participating in or developing into ACOs.

Background

With severe budget constraints and rising Medicaid enrollment during the recession of the late 2000's, state Medicaid officials have been increasingly using risk-based managed care to rein in costs. Medicaid MCO enrollment increased from 12.4 million (34% of Medicaid enrollees) in 2000 to 26 million (50% of

Medicaid enrollees) in 2010, with thirty-six state Medicaid programs engaged in risk-based contracts with managed care organizations (MCOs).¹ Another sharp increase occurred in 2011, to more than 28 million Medicaid beneficiaries in commercial or Medicaid-only MCOs.² Seventeen states in 2011 and 24 states in 2012 reported they had or would soon expand their managed care programs into previously unmanaged geographic areas or to populations not previously eligible for managed care.³

Cost containment and predictability are long-standing goals in choosing to contract with MCOs, but Medicaid officials are increasingly looking to promote quality, coordination, and integration of care through managed care. Concerns that traditional risk-based arrangements could lead to substandard care have led to greater monitoring of quality over past decades. The Balanced Budget Act requires states to develop quality standards for Medicaid health plans and monitor compliance, but it gives states much flexibility -- resulting in a wide range of approaches. States are using a variety of strategies to not only guard against abuses, but to encourage or require MCOs to improve access, care delivery and management, and health outcomes for the Medicaid population. Thirty-five state Medicaid programs engaged in new or enhanced quality improvement work related to MCOs in 2011-2012. For example, six states and Washington, D.C., tied the amount of capitation payments to meeting performance criteria; nine states required their MCOs to work on emergency department diversion; and ten states added new quality measures to their MCO contracts.⁴

When establishing quality measures, Medicaid programs are guided by existing standards. Optional but widely-used standards were established by the National Committee for Quality Assurance (NCQA) accreditation and recognition programs⁵ (used by 29 state Medicaid programs). The NCQA-developed Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) developed by the Agency for Healthcare Research and Quality (AHRQ) are commonly used tools to monitor quality and member experience, respectively. In addition, the Centers for Medicare and Medicaid Services (CMS) established quality-related requirements for Medicaid MCOs,⁶ and federal legislation calls for development of standard quality measures for children (CHIPRA) and more recently for adults (the Affordable Care Act). Other sets of standards, such as the National Standards on Culturally and Linguistically Appropriate Services (CLAS), are focusing on critical aspects of quality, but are not yet widely incorporated into state requirements or policies.⁷

¹ V.K. Smith, K. Gifford, E. Ellis, R. Rudinowitz, and L. Snyder. *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012.* (Washington, D.C., The Henry J. Kaiser Family Foundation, Oct. 2011), pp. 59-60, and www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/2010Trends.pdf

² These figures exclude Primary Care Case Management and other programs sometimes considered "managed care." Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>.

³ Smith et al., 201

⁴ Ibid.

⁵ See: <http://www.ncqa.org/tabid/135/Default.aspx>

⁶ See: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=0dadbd84b2429d95158b6b075e177af7&rgn=div6&view=text&node=42:4.0.1.1.8.4&idno=42>

⁷ CLAS standards are meant to help organizations and providers better meet the needs of their patients assuring access to care is culturally and linguistically appropriate.

While risk-based managed care is growing in Medicaid programs, states are also exploring new strategies to transform and improve care delivery for their vulnerable populations outside of traditional MCOs. A few states are pioneering accountable care organizations (ACOs) or ACO features such as bundled payments, global budgets, and integrated community networks. The Affordable Care Act promotes ACOs primarily in Medicare but also includes funding opportunities available to Medicaid programs, such as a bundled payment demonstration (Section 2704), global payment demonstration (Section 2705), Medicaid health homes (Sec 2703), and integration of care for the Medicare-Medicaid dual eligible population (Section 2602).^{8,9} The experiences of states pioneering these kinds of strategies will clearly shape future federal support and guidance.

Purpose & Methodology

The purpose of this study, supported by The Commonwealth Fund, is to identify innovative state strategies for promoting quality and cost-effectiveness in Medicaid managed care, considering both traditional MCOs and new ACO-like care management arrangements that more directly incentivize health care providers to improve quality and value.¹⁰

To identify states for inclusion in the study, the authors conducted an extensive literature review and considered states' degree of involvement in managed care transformation as well as the length of time relevant activities had been underway. After identifying states that had implemented one or more innovative strategies, we presented the list to an expert advisory group consisting of researchers and policy leaders who had experience in Medicaid managed care, seeking their advice about which states to choose for further analysis. Based on this process, ten Medicaid Directors were invited to participate in individual, semi-structured telephone interviews. Additional interviews were conducted with Medicaid staff such as the managed care director or health reform director and others as needed. One state declined to be interviewed and was replaced in the sample.

States included in the study are: California, Colorado, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Vermont. These states generally have significant managed care use – about half or more Medicaid enrollees in seven of the states (Table 1). Colorado, with just a small share of its Medicaid enrollees in MCOs, is shifting some of its fee-for-service population into “managed” medical home arrangements through its ACO model. Vermont does not use a traditional MCO. The Agency of Human Services (AHS), as Vermont's Single State Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access is responsible for operating the managed care model under a Global Commitment Demonstration (42 CFR 438) regulatory structure, and more than 95 percent of Vermont's program participants are enrolled.

⁸ The ACA called for a Medicaid pediatric ACO demonstration project (Section 2706) but this has not been funded.

⁹ See Riley, P, Berenson, J, and Dermody, C. How the Affordable Care Act Supports a High-Performance Safety Net, The Commonwealth Fund, January 16, 2012. <http://www.commonwealthfund.org/Blog/2012/Jan/Affordable-Care-Act-Safety-Net.aspx>

¹⁰ Initiatives in state primary care case management programs were outside the scope of this study.

The interview protocol included questions about strategies for contracting with MCOs and providers, involvement of stakeholders, and the impact of these changes. Notes were produced from each interview, and key facts were subsequently checked with interviewees to ensure accuracy and completeness.

Table 1: Medicaid Population Enrolled in Managed Care Organizations in Study States as of July 2011

State	Percent of Medicaid population enrolled in commercial or Medicaid-only managed care organizations	Upcoming changes in Medicaid managed care enrollment
California	47%	Adding mandatory MCO enrollment for dual eligibles in 2012-2013
Colorado	8%	Shifting increasing portion of FFS population into 7 regional ACO-like entities
Massachusetts	33%	Planning to implement ACOs and a risk-based primary care system in 2013
Minnesota	66%	Began Medicaid ACO enrollment January 1, 2013, with one safety net ACO already active as of January 1, 2012
Oregon	76%	Implemented Coordinated Care Organizations (CCOs) in 2012 with emphasis on the medical home delivery model
Pennsylvania	54%	Adding mandatory managed care in remaining third of counties.
South Carolina	50%*	Remaining FFS population moving into managed care. Managed care reforms are being planned for 2013 and 2014, including performance based auto-assignment, withholds, and incentives.
Tennessee	96%	Planning/preparing for a dual demonstration project to be implemented in January of 2014 that would integrate the Medicare benefit for dual eligibles into the managed care program
Texas	47%	Regional health care partnerships under development
Vermont	58%**	Nearly all Medicaid enrollees (as well as other state residents) are moving into the Vermont Blueprint for Health medical home practices in 2013. Also, Medicaid is expected to join multi-payer payment pilots including ACO-type models

*Managed care organization enrollment in this table excludes PCCM enrollment through South Carolina's Medical Home Network, which involves significant risk sharing. Approximately 70% of South Carolina's Medicaid beneficiaries are enrolled in MCOs or the Medical Home Network. (Personal Communication from South Carolina Medicaid Director Anthony Keck, July 2012).

**In Vermont there are no traditional MCOs serving Medicaid beneficiaries; the 58% figure includes beneficiaries in the "Global Commitment to Health" demonstration initiative, whereby the state Medicaid organization became a Managed Care Entity and adheres to Medicaid MCO rules.

Source: Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, November 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf>.

Findings

The ten study states are actively managing the purchase of health care services in attempts to reduce Medicaid costs and achieve improvements in quality and cost-effectiveness. Many have worked with managed care organizations over time and note valuable but incremental progress towards the state's goals. They are strengthening and using new contract requirements, incentives, and other "levers" to encourage Medicaid MCOs to achieve better health care delivery and/or health outcomes. Several states, however, reported the pace of change is too slow, given the severe budget pressures they are facing. A few state planners said that they reached the limits in promoting quality and value through MCOs under traditional payment structures and provider relationships. In these states, Medicaid and other stakeholders are working to define enhanced care management and delivery systems and the entities that can provide them, with the hope that changing the relationship between providers and payers can result in greater integration, quality of care, and cost containment. Known nationally as accountable care organizations, these entities have been given different names in some states.

The first Findings section describes the efforts states have undertaken to work with MCOs, including expanding MCO partnerships to address systemic problems. The second section discusses activities being undertaken directly with provider organizations and related reforms to achieve care management goals in new ways.

Strategies Involving Managed Care Organizations

CMS requires that state Medicaid agencies assure quality of care delivered through managed care plans by establishing several mandatory quality measurement and improvement activities. It is at states' discretion, however, to undertake additional activities or direct their plans to do so if they feel the basic strategies are insufficient. During interviews with the ten states, officials discussed numerous activities (which we call "levers") they are undertaking with their MCOs to improve quality and save money.¹¹ Table 2 delineates fifteen levers, with some condensed into broader strategies in the discussion below.

¹¹ In this time of transition, some states are highly engaged in developing their ACO programs (described further below) and are working less with their MCOs on some of the quality improvement strategies described here, though they may have done so in the past.

Table 2: State Requirements and Activities to Improve Quality by MCOs

Levers (in order of most to least used among the 10)	States Using Lever (out of 10 states interviewed)
Requiring quality measurement and data reporting in MCO contracts, using data to identify priority improvement topics	California, Colorado, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont*
Requiring targeting of high-risk enrollees, coordinating and integrating care (physical, behavioral, social), meeting special needs	California, Colorado, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont
Convening MCOs to collaborate on quality improvement and share best practices	California, Colorado, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Texas (forthcoming)
Publicly reporting MCO quality data compared to benchmarks	California, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Texas
Medicaid working with other agencies and community providers to foster integration	California, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, Tennessee, Vermont
Financial rewards, penalties, or other payment adjustments to MCOs based on achievement of performance or contract goals	California (under development), Colorado (BH), Minnesota, Pennsylvania, South Carolina, Tennessee, Texas
Engaging MCOs to promote community and population health (educational campaigns, region-based efficiency adjustments, readmission reduction efforts)	California, Massachusetts, Minnesota, Pennsylvania, South Carolina, Tennessee
Competitive bidding for MCO contracts using quality measures in the selection criteria	California, Massachusetts, Minnesota, Pennsylvania, South Carolina, Tennessee
Expanding the population eligible for managed care (such as rural, disabled, or expansion populations)	California, Pennsylvania, Texas, Vermont **
Requiring plans to meet NCQA accreditation standards	Massachusetts, South Carolina, Tennessee, Texas
Requiring collection and reporting of managed care quality measures by race and ethnicity	Massachusetts, Pennsylvania, South Carolina, Tennessee
Encouraging of MCOs to implement gain-sharing or other pay for performance with its contracted providers	Pennsylvania, South Carolina, Tennessee
Developing or identifying quality measures to be reported for people with special needs (dual eligible, seniors, people with disabilities)	California, Colorado, Massachusetts
Providing supplemental care coordination through community-based coordinators or health teams	Minnesota, Pennsylvania (paid directly or indirectly by MCOs), Vermont
Returning carved-out benefits to the single Medicaid MCO for care integration (such as pharmacy, dental, or behavioral health services)	South Carolina, Tennessee, Texas
Auto-assigning members based on MCO performance on quality metrics	California, Pennsylvania, South Carolina

*In some states, such as Massachusetts, Oregon, and Tennessee, these populations are already in managed care.

In Vermont, the State operates a comprehensive health reform managed care model under Section 1115 Demonstration authority. The Blueprint model is discussed further in the ACO section further below.

** Excludes some states that already had broad MCO enrollment.

Requiring Data Collection and Using MCO Data for Quality Improvement

All ten states require their health plans to report on the quality of care provided to Medicaid enrollees using a defined set of quality and utilization measures. HEDIS measures are the most common set of quality measures, used by at least 34 states in the U.S.¹² and eight of the ten study states, but states vary in the number of HEDIS measures they require and for which populations, and many states select additional measures related to a particular priority. Fewer require that MCOs report consumers' experiences of care, such as through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Some states have developed or require that health plans report quality measures for people with special needs. For example, a few of the ten states are developing new measurement requirements applicable to dual eligibles (for example, Massachusetts, California, and Colorado) or seniors and people with disabilities (California) who are newly enrolled or may soon be enrolled in Medicaid managed care. Tennessee and Texas have similar requirements that plans report all HEDIS measures and CAHPS results stratified for children, adults, and children with special health care needs. Several states track other population data by MCO, including ambulatory care sensitive hospitalizations and readmissions.

Quality information is regularly used as part of the process of accrediting managed care plans. Four states in our sample (and 29 nationally¹³) use NCQA as their Medicaid plan accreditation standard or as part of their broader accreditation process.

All ten states use health plan-reported data to identify priority improvement topics. Often, but not always, the states' External Quality Review Organization (EQRO)¹⁴ or other contractor compiles Medicaid MCO data into a report that facilitates identification of problem areas as well as comparison between plans. Texas, for example, tracks HEDIS, CAHPS, and other measures across all plans to identify trends and set overall program goals.

Once Medicaid and MCO staff review health plan performance data compared to state goals, MCOs are directed to investigate any measures not meeting targets and, for selected measures, develop a plan for improvement. Written reports must address their results, barriers, and next steps. This work sometimes leads to specific contractual requirements intended to improve health outcomes. For example, Massachusetts MCO contracts include requirements related to NCQA accreditation; submitting performance improvement projects to the EQRO; HEDIS and CAHPS reporting; participation in a quality improvement (QI) committee; and quality improvement goals to improve care around a core set of prevalent health conditions. Currently, the conditions that are prioritized are asthma, diabetes, maternal and child health measures, and behavioral health. Massachusetts has recently added an emphasis of looking at racial and ethnic differences in diabetes measures.

¹² www.NCQA.org

¹³ Ibid.

¹⁴ CMS requires an External Quality Review Organization (EQRO) participate in auditing health plan quality, verifying data, and reviewing QI reports. The EQRO relieves the state of some of the quality burden, but all states we interviewed use state staff to go beyond the CMS requirements.

Identifying High-Risk Enrollees and Integrating Services Across Agencies

For complex health problems, states and MCOs sometimes work collaboratively to identify activities that could provide lasting solutions. Activities focus on identifying high-risk enrollees, providing enhanced care coordination, and integrating physical health with social, behavioral and other services to meet the individuals' special needs. This often requires creating new partnerships across state agencies or with community-based organizations and working in new ways outside the typical MCO boundaries.

- Pennsylvania requires MCOs to have a Special Needs Unit to provide complex care management for members with special needs, which may include social supports as well as complex health care needs. Plans must report twice a year on the capacity and use of this unit.
- Pennsylvania MCOs and behavioral health plans recently began sharing pharmacy claims to foster understanding of patient medication use. Pennsylvania has also undertaken a physical/behavioral health project in two large urban areas for patients with severe mental illness and/or substance abuse. Requiring greater coordination and integration is contributing to more appropriate use of health care services and reducing use of the hospital and emergency department.
- South Carolina and Tennessee have returned behavioral health services to Medicaid managed care plans to facilitate greater integration of services for people with behavioral and physical health needs. Tennessee also integrated long-term care into MCO contracts in 2010 to better coordinate long term and other services, and California is moving its long term care enrollees into managed care.
- Tennessee requires plans to provide disease management services for ten conditions. Over time, the focus has narrowed from all patients with the conditions to focus on the highest-risk patients in each category. Additional quality improvement strategies are also incorporated into MCO contracts when there is a strong scientific basis for them. In other cases, MCO innovation is encouraged.
- South Carolina has two activities involving collaboration with other state agencies to address health needs of specific vulnerable Medicaid-eligible populations.
 - A partnership was formed among Medicaid, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), the Department of Mental Health, managed care plans, and the Medical Home Network to screen, refer, and treat pregnant women with risk factors for poor birth outcomes (such as smoking, alcohol or other drug use, depression, and domestic violence.) Providers are receiving an enhanced rate for the screening.¹⁵
 - A collaborative of health plans, providers and researchers is working to improve pediatric asthma outcomes. The group has met to identify ways of improving pediatric asthma care, using linked state datasets to identify Medicaid enrollee's missed school days and use of various services. As a result, Medicaid policy was modified to fund a second spacer – an asthma inhaler add-on device which makes it easier for children to

¹⁵ The screening tool was specifically designed for pregnant women and was developed by the Institute for Health and Recovery. www.daodas.state.sc.us/documents/SBIRT%20Integrated%20Screening%20Tool.pdf. For more information about the screening, referral, and treatment program, see www.daodas.state.sc.us/SBIRT.asp.

use their inhaler correctly – that can be available when needed at school (alleviating the need to bring one from home).

- Pennsylvania requires MCOs to oversample their HEDIS results in order to report on race, ethnicity, and geographic variation.
- Massachusetts' new needs assessment tool, developed by the MCOs and state, will be used for new patients within 30 days of joining the plan. This will assist plans in identifying earlier those members who should be managed more aggressively (as well as allow stratification by race/ethnicity).
- California has added new MCO requirements for their newly added Seniors and Persons with Disabilities population. New requirements include risk-stratification and risk-assessment processes, requirements for personalized care plans, enhanced coordination of carved-out and community-based services, and identification of provider sites accessible to people with disabilities.

A few states are working to provide community-based care coordination for physician practices to complement the work of physicians in supporting patients with complex needs. Depending on the practice size, these states have either embedded care coordinators or provided for shared resources (discussed further in the ACO section below).

- Vermont provides care coordinators to supplement and work with primary care providers in support of Medicaid enrollees with especially complex needs.
- Minnesota has funded Community Health Teams in three delivery systems to help with the additional coordination they need to integrate community-based social supports for complex patients. One site is working with the elderly, one with underserved populations with large health disparities, and the third with patients with mental health diagnoses.

Engaging MCOs in Community Health and Population Health Management

Acknowledging the benefits of going beyond individual care to a more holistic approach, states are engaging their MCOs in broad educational campaigns, partnerships with community-based organizations, and other approaches intended to improve the health of the population:

- Joint Medicaid/MCO educational campaigns are targeting widespread needs such as improving adolescent well-care visit rates (Tennessee) or increasing diabetes foot exams (Massachusetts).
- Pennsylvania Medicaid links incentives to broader population health, using “efficiency adjustments” that increase or decrease a health plan’s payments if the region does much better or worse than expected on selected measures including preventable admissions, readmissions, C-sections, low acuity Emergency Department (ED) visits, and overuse of high-tech radiology. This could encourage the MCOs to work collaboratively to improve health in the community.
- In 2011 Pennsylvania’s Medicaid agency began including in its MCO contracts four broad “pillars” to promote community involvement, though there are no numerical requirements tied to them as of yet:
 - embed care managers in medical practices;
 - develop transitions of care;

- help PCPs achieve medical home status;
- work with collaborative learning networks.
- Minnesota requires health plans to file “collaboration plans” on their local health improvement activities every four years. It is moving toward more formal links between these collaboration plans and statewide health goals.
- Minnesota Medicaid joined a multipayer program called “RARE” to reduce readmissions. Though data on the impact are not yet available, the drop in the rates that plans bid likely reflects anticipated declines in readmissions.
- California Medicaid is working with Medi-Cal MCOs to reduce hospital readmissions. To date, guiding principles and measure specifications have been developed, and plans have submitted their Quality Improvement Plan proposals.
- Massachusetts has a Community Benefits program with voluntary guidelines for health maintenance organizations to collaborate with community organizations to identify and address needs, and report on their activities annually, without requiring or recommending specific activities.¹⁶

Medicaid will likely benefit from additional innovations in provider and health plan arrangements funded by the CMMI Innovations grants announced in July 2012.¹⁷ For example, the Healthy Columbia campaign in Columbia, South Carolina, seeks to achieve the triple aim of better healthcare, improved health outcomes, and lower health related costs at the community level. The initial targets are: 1) to reduce utilization of higher-cost healthcare services like preventable emergency department (ED) visits and hospital admissions by maximizing access to and utilization of preventive and primary care services within the community; 2) to mobilize teams of community health workers into the areas of this community with the poorest health status and greatest need for primary healthcare services; and 3) to provide education and related technical resources through a network of faith-based and neighborhood organizations that promote healthier nutrition and physical activity for Eau Claire residents. A key partner in this effort is one of the Medicaid managed care plans.

Convening MCOs for Collaboration and Sharing Best Practices

Most of the ten states meet with their Medicaid health plans collectively to prioritize performance improvement projects and encourage them to share best practices – specific strategies for achieving positive results on given measures. These collaborations have been occurring for a dozen or more years in a few states, while others are newer to the collaborative model. States report it takes time for health plans to accept the idea of sharing information and to adjust to the level of transparency needed to undertake improvement work, but many have reached that point.

- In California, Massachusetts, and Pennsylvania, health plan and Medicaid clinical leadership meet quarterly to discuss measures and improvement strategies. Performance data are also part of operational discussions between Medicaid officials and MCO top executives.

¹⁶ See “The Attorney General’s Community Benefits Guidelines for Health Maintenance Organizations,” Office of the Massachusetts Attorney General, 2009. <http://www.mass.gov/ago/docs/healthcare/hmo-guidelines.pdf>.

¹⁷ The Center for Medicare & Medicaid Innovation (CMMI) Health Care Innovation Challenge grant recipients were announced in May and June 2012. <http://innovations.cms.gov/initiatives/Innovation-Awards.html>

- In South Carolina, MCOs, Medicaid, and other stakeholders are part of a Care Coordination Improvement Group to identify delivery system and payment changes that can improve health outcomes.
- In Tennessee, TennCare staff and MCOs meet quarterly to review comparative performance data and share information about improvement strategies and outcomes. Several collaborative projects have resulted – for example, the development of a newsletter for teens to improve health service use, to which the plans contribute articles.
- In Texas, recent legislation calls for the creation of a quality advisory committee to work with MCOs and the relevant health agencies to shape quality improvement strategies including patient-centered medical homes and provider incentives. The quality advisory committee will be building on existing plan requirements related to disease management and quality measurement.

In Massachusetts, Medicaid and the MCOs are working together tackling the challenging problem of disparities, as seen across quality measures when they are reported by race and ethnic group, and seeking to eliminate disparities that continue despite very high overall quality scores. Race and ethnicity are not accurately nor fully collected by most states, and in Massachusetts, an early step in the collaboration has been improved data collection. The plans and Medicaid have worked together on a new health needs assessment to be completed by Medicaid enrollees, which will ask improved race and ethnicity questions. Subsequently, quality indicators will be stratified and improvement work developed to target the areas of greatest disparity.

Applying Financial Incentives to MCO Performance

Six of the ten states are using financial incentives for MCOs as a lever to motivate quality improvement, and a seventh is in the process of designing their approach.¹⁸ The most commonly used “pay for performance” (P4P) incentives are additional payment in excess of the capitation rate for achievement of goals; an amount withheld from capitation rate to be “earned” back; and financial penalties (reduced payment) for failure to meet a contract requirement. The standards underlying the payment incentives are almost always tied to meeting national benchmarks for the most commonly used quality targets, usually HEDIS measures, and/or to improving over the plan’s own prior year data. Some states are also setting targets for reductions in overuse of certain services such as emergency department visits, readmissions, high tech imaging, and cesarean-sections.

- Pennsylvania’s pay-for-performance program is based on 12 HEDIS measures and rewards plans that make improvement over their prior year’s score and who reach the 50th, 75th or 90th percentile NCQA benchmarks. The reward varies based on the state budget but is generally equivalent to about half of one percent (0.5%) of the premium. Further, plans that do not achieve the 50th percentile compared to the NCQA benchmark are financially penalized. (Pennsylvania’s efficiency adjustments are discussed above).
- Texas increased its performance incentive pool from 1% to 5% of plan rates in March 2012. Plans can earn back the withheld amount based on their performance on quality metrics. In the

¹⁸ Numerous state Medicaid programs use P4P directly with health care providers; these are not discussed here.

first year, criteria are primarily administrative and in the second year, they will shift toward clinical quality measures. As the program was previously structured, plans met administrative targets easily, and there was not enough of an incentive pool left to cover quality improvements, too.

- Effective July 1, 2012, South Carolina has begun withholding 1% of MCO's capitated payment to incentivize plans to meet HEDIS goals. In 2013, 1.5% of the rate will be withheld for meeting HEDIS targets. In addition, South Carolina has created a separate 1% incentive pool, of which three-quarters is earmarked as incentives to encourage providers to pursue and achieve medical home recognition. The amount of the reward is tiered based on pursuit of NCQA recognition and achievement of levels 1, 2, or 3. The other quarter of a percent is available to plans that improve birth outcomes (e.g., reduce the percent of low-birth-weight and premature babies born to Medicaid plan members) through programs such as the high-risk screening (described above) and other patient and provider engagement strategies.
- Tennessee pays a modest reward of three cents per member per month per measure for 8–10 HEDIS measures if they show improvement. Tennessee has a sizable financial penalty for underuse of EPSDT services: \$5,000 for each percentage point the EPSDT screening is below 80%.
- From 2003 on, Minnesota has used a combination of rewards and penalties to incentivize MCO performance on HEDIS and other state measures. While plans met targets at first, few measures showed consistent improvement over time, possibly because of competing priorities for health plan attention. In 2011, measures related to admissions and readmissions were added as performance measures.
- Colorado is working with its behavioral health MCOs to develop performance measures and conduct a gain sharing pilot related to the overuse of psychotropic drugs.
- California is planning a P4P program to encourage MCOs to meet state and national benchmarks and demonstrate improvement. Details are not yet available.

States are aware that adjusting Medicaid payments for quality is somewhat risky because Medicaid often pays less than other payers, and adding risk could deter plans from wanting to participate in Medicaid. In some states with this concern, the Medicaid agency has invited the input of its plans and engages them in the process of selecting measures and goals.

Another strategy states use to incentivize quality improvement is to assign high-performing plans a larger share of the new enrollees. California, Pennsylvania, and South Carolina, for example, use HEDIS scores and other quality data as a basis for auto-assignment of patients who did not pick a provider on their own.

Promoting Financial Incentives/Gain-sharing between MCOs and Providers

While states incentivize MCOs to improve HEDIS scores and other performance indicators, only one state of the ten reviewed (Pennsylvania) actually sets aside a \$1 per member per month (PMPM) to the MCOs that must be passed through to providers based on performance. In the other states, it is up to each MCO to encourage and work with physician practices and other providers within their network to

make changes in how they practice. State officials were aware that some of their MCOs have been working with providers on QI initiatives, for example, increasing screening and well-care visits, reducing waiting time, and reducing avoidable ED visits may involve reminders, outreach, changes in scheduling and patient flow, and greater coordination of care at the physician/practice level. In addition to MCOs providing information, technology, and other supports to practices, some have begun to include financial incentives such as “gain-sharing” or “shared savings” models with their providers. For example, state officials in South Carolina were aware that some MCOs have capitated arrangements with primary care providers, and all the medical home networks have shared savings arrangements with primary care practices.

In South Carolina, one of the large health plans that participate in Medicaid has begun working with an integrated delivery system to jointly manage patients. The health plan has committed to limiting the provider network and ceding certain medical management functions to the health care system. The health care system has agreed to preferred rates. Together they will jointly manage the Medicaid population, analyzing both clinical and financial outcomes. There is a target medical loss ratio, and any savings beyond that will be shared equally. In addition, the partners have created an oversight structure in which additional functions can be delegated from health plan to health care system at any time (or vice versa). This is important, because they envision a shifting of responsibilities as they learn more about the members and add clinical initiatives.

Publicly Reporting MCO Quality and Recognizing Top MCOs

Some states are posting quality data for consumers to view plans’ performance and to judge for themselves which plan may fit them best. Texas, for example, publishes the EQRO report that includes health plan HEDIS measures and CAHPS survey responses. Quality reports across states vary in their accessibility to the public, however, and there is no clear evidence that Medicaid (or even private-sector) consumers make much use of such information in their decision-making. Medicaid officials report, however, that the health plans themselves pay close attention to performance comparisons, and that public reports motivate health plans to improve. At least one state, California, also recognizes their leading MCOs in a public forum, which officials believe does carry weight with the plans. And, as noted above, California and Pennsylvania also assign new enrollees who do not choose a plan to the highest-performing plans.

Selective Contracting Based on Quality

In most states, the selection of managed care plans is based on a range of factors including the interest of plans in participating in the Medicaid program, price, network, and past performance. A few states discussed an increased emphasis on quality of care in their selection process, noting that it can work only when there are sufficient numbers of plans bidding. In 2011, for example, Minnesota adopted a competitive bidding process in its largest urban area, and the scoring methodology was weighted 50% based on quality and 50% on cost. California reported that health plan leadership related to quality improvement was a factor in health plan selection. Pennsylvania’s expansion RFPs used quality reporting as a key criterion for selection. South Carolina’s managed care procurement in the Fall 2012 placed a heavy emphasis on demonstrated performance.

Impact of State MCO Levers

National studies assessing the effectiveness of some of the performance improvement mechanisms described above are largely lacking. HEDIS and CAHPS measures compiled by NCQA from Medicaid managed care plans show very small improvements in most measures since tracking began (less than five percentage points up or down), similar to trends in the commercial market.¹⁹ NCQA also found no significant differences in HEDIS scores *in the aggregate* in states that require health plan accreditation or publicly report scores. However, data problems raise questions about the analyses and suggest it would be more meaningful for states to examine trends with their own plans over time.²⁰ One study of California's pay-for-performance program that automatically assigned new Medicaid enrollees to plans that achieved higher quality scores led to no improvement in quality over the existing regulations.²¹

There is not a large body of evidence yet on the impact of some of the newer and stronger levers states are now implementing to improve care through MCOs. However the study states have reported some promising results. Though the states rarely have the funds or staff to conduct controlled experiments and rigorous evaluations of their work, most have looked at trends in utilization, costs, and other performance metrics and seen improvements they attribute to the levers described in this report. For example:

- A six-year evaluation of Pennsylvania's P4P program found statistically significant improvements for 11 of 12 measures between the baseline year 2004 and CY 2010, and 9 of 11 HEDIS® measures met or exceeded the NCQA 50th percentile benchmark in CY 2010.²³ The impact varies by MCO, however, suggesting the plans differ in how they have created ongoing quality improvement processes that track performance measures, identify problem areas, make quality improvements, and reassess to ensure the problems were addressed.
- Pennsylvania's P4P penalty (offset) for scoring below the 50th percentile benchmark does not seem to be reducing poor performance; the number of measures with rates below the 50th percentile increased for three MCOs, and decreased for only one MCO.²⁴ It is possible that this is due to the small size of the penalty – less than 1 percent of plan's annual revenues.
- During the first year that Pennsylvania Medicaid implemented efficiency adjustments, the state realized more than \$40 million in savings.²⁵

¹⁹ NCQA, "Continuous Improvement and the Expansion of Quality Measurement: The State of Health Care Quality 2011." Washington, D.C. www.ncqa.org.

²⁰ National analyses of annual plan-reported data is not fully comparable, making analysis extremely difficult. It often takes several years for health plan data, which is most often based on claims, to be complete and accurate as plans work with their providers to improve data reporting. Further, states may switch plans from one year to the next. In addition, many Medicaid beneficiaries who lose coverage or switch plans within a year are excluded from the data.

²¹ B. Guthrie, G. Auerback, and A. Bindman, "Health Plan Competition for Medicaid Enrollees Based on Performance Does Not Improve Quality of Care," *Health Affairs*, Aug. 2010 29(8):1507-16.

²² The baseline year varied between 2004-2007 depending on implementation of measure.

²³ http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002207.pdf

²⁴ *Ibid.*

²⁵ The program spent \$107 million on Prevention Quality Indicator (PQI)-related encounters. PQIs are measures that identify quality of care for "ambulatory care sensitive conditions" for which good outpatient care or early intervention could potentially prevent complications, more severe disease, or the need for hospitalization. See http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

- Preliminary findings from Pennsylvania’s pilot involving collaboration between behavioral and physical health providers is showing significant reductions in inpatient and ED utilization²⁶
- In Massachusetts, after MassHealth and MCOs partnered on an educational campaign and outreach strategy specifically targeted to adolescents, there was an increase in adolescent visits and immunizations. Similarly, an education and outreach program targeting patients with diabetes succeeded in improving use of eye and foot exams.
- Tennessee’s use of disease management programs along with performance incentives may be responsible for the upward trend in HEDIS results over the past several years. From 2006 to 2010, there has been improvement in 6 of 8 diabetes measures, 5 of 6 women’s health measures, and all 12 of the 12 child health measures. Well-child screening, for example, reached about 95% in 2009.²⁷
- After South Carolina’s Medicaid program selected birth outcome improvement as a Quality Improvement Project for MCOs, it partnered with other agencies and stakeholders, and both the state and health plans began training providers on screening tools. Data for the first quarter show a declines (though not-statistically –significant) of 2 percent in preterm births and 3 percent in NICU utilization.
- Minnesota estimates that moving to competitive bidding based 50% on quality has saved \$175 million for state fiscal years 2012 and 2013.

Current and ongoing evaluations of the state levers will be critical to determining the long-term impact on care delivery, outcomes, and costs.

Accountable Care as Medicaid Strategy

Though the Accountable Care Organization (ACO) concept grew out of Medicare and commercial markets, some state Medicaid programs are examining and moving toward an ACO model for vulnerable populations. An ACO is a provider-run entity that is responsible for the overall quality and costs of care for a defined patient population and may share in savings achieved. Payment mechanisms may vary but should incentivize care delivery improvements; payment models include global budgets, bundled payments, capitation, FFS plus PMPM, or combinations.

The states pioneering Medicaid ACOs are driven by a desire to more directly motivate providers to improve care delivery and enhance efficiencies and to encourage an integrated, community-based approach that may better serve low-income, vulnerable populations. The emphasis and incentives in the ACO model to coordinate and integrate enrollees’ care across multiple specialties, care settings, and over time make this model promising for Medicaid beneficiaries, who tend to be sicker, more disabled, and in greater need of social and behavioral health supports than the privately-insured. However the churning of Medicaid enrollees in and out of the program presents challenges for attributing care to one provider and for capturing long-term savings.

²⁶ Full evaluation is in process. See preliminary findings at: http://www.chcs.org/usr_doc/PA-RCP_Early_Lessons_Brief051412.pdf

²⁷ How to Implement Quality in Exchanges, Webinar sponsored by AcademyHealth and the National Committee for Quality Assistance (NCQA), April 9, 2012. <http://www.academyhealth.org/files/AHNCQAHIXQuality4912pdf%281%291.pdf>

ACOs build on models already used in some state Medicaid programs such as medical homes and primary care case management (PCCM). ACOs also build on many elements of traditional, risk-based (capitated) managed care including: flexibility in benefits and services provided; incentives to promote prevention, care coordination, and reduction in avoidable use of high-cost services; and the measurement and reporting of performance indicators. For example, Oregon already convenes Medicaid managed care plans and publicly reports plan data and is expanding these activities in its CCO program. Oregon is also introducing new levers for its CCOs such as returning carved-out benefits to the CCO for care integration and emphasizing community and population health. Though still largely untested, the ACO model is expected to go farther than traditional MCOs in its emphasis on provider accountability for health outcomes as well as cost, a more global approach to the long-term health of a population, and integration of community-based and/or behavioral health services with medical care.

Among the states examined for this report, five have an ACO-type model involving Medicaid implemented or under development. Table 3 summarizes key elements of these programs in Minnesota, Oregon, Colorado, and Vermont.^{28, 29} Massachusetts is developing an ACO approach but is not included in the table because its plans are too preliminary.

²⁸ While Vermont does not consider its Blueprint model an ACO per se, we are including it here because the model contains some ACO delivery system characteristics. In addition, Vermont is planning pilots for bundled payments and global budgeting that fits the ACO payment models (see below and profile in Appendix).

²⁹ For more information on these activities, see synthesis report (“How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs”) and associated case studies by Silow-Carroll, Edwards, and Rodin on www.commonwealthfund.org, February 2013.

Table 3. States Driving ACO-Type Payment/Delivery Initiatives

States Driving ACO-Type Payment/Delivery Initiatives						
	Colorado	Minnesota		Oregon	Vermont	
	Accountable Care Collaborative (ACC)	Hennepin Health	Health Care Delivery System Demonstration	Community Care Organizations (CCO)	Blueprint for Health	Payment Pilots (may include ACOs and FQHCs)
Key Care Delivery Entities	Primary Care Medical Practices (PCMPs) – medical practices, FQHCs, rural health clinics	Metropolitan Health Plan, Hennepin County Medical Center, Northpoint Health and Wellness (FQHC), and various social service providers.	8 integrated delivery systems and 1 group of FQHC providers	Community Care Organizations, which integrate physical, behavioral, and dental health services	Advanced Primary Care Medical Practices (APCPs)	Hospital-physician partnerships, ACO, FQHCs
Key Network/Payment Management Entities	7 Regional Care Collaborative Organizations (RCCOs)	Metropolitan Health Plan (MCO/ACO)	Same.	CCO	Blueprint division based in state agency that operates Medicaid	Hospital-physician partnerships, FQHCs
Care Coordination/Integration Mechanism	RCCO provides and/or supports care coordination, medical management; PCMPs also coordinate care across specialties	A care manager who organizes health and social support services	Minnesota health care homes	To be developed by each CCO, with accountability standards set by Medicaid. State-run learning collaboratives will foster transformation and improvement in cc/integration	Community Health Teams and community-based Medicaid Care Coordinators and discharge planners for most complex cases	To be determined
Medicaid Fund Flow	PMPM to RCCOs, FFS plus PMPM to PCMPs, fixed price contract with state data contractor	DHS pays PMPM for all Medicaid services and Hennepin County purchases some non-Medicaid social services.	Varies based on existing payment type (FFS, capitated) plus risk/gain-sharing payments	Global budget to each CCO based on their enrolled population	FFS plus PMPM to APCPs, PMPM to CHTs, employed care coordinators	Models: bundled payments; global budget; ACO/population-based payment to risk-bearing entity
Performance-Related Incentives	Portion of PMPM to be held back & tied to ED use,	Not at this time. Hope to pay for outcomes, requires CMS SPA	Shared savings (between payer and delivery system), delivery system	Global budget, with accountability measures to be	PMPM to practices based on medical home status	Risk-based payments; quality incentives to be

States Driving ACO-Type Payment/Delivery Initiatives						
	Colorado	Minnesota		Oregon	Vermont	
	Accountable Care Collaborative (ACC)	Hennepin Health	Health Care Delivery System Demonstration	Community Care Organizations (CCO)	Blueprint for Health	Payment Pilots (may include ACOs and FQHCs)
	readmissions, high cost imaging; incentives to expand in future		returns portion of spending above minimum threshold; quality measures established by the State Quality Reporting and Measurement System ³⁰	defined		determined
Multi-payer status	Medicaid only	Medicaid. Medicare MCO payment can be linked for duals	Medicaid only initially, expect to align with state employees and large self-insured purchasers	Medicaid only CCOs at this time, but dual Medicaid/Medicare to follow in 2013	All major insurers required to participate	All payers will be expected to participate in future

³⁰ Includes 6 physician measures and 4 hospital measures.

www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

ACO Designs

Just as our review of state strategies to improve care through MCOs found some common approaches but also much variation across states, states share a common basic ACO concept but then have many variations in their models. In Minnesota, Oregon, Colorado, and Vermont, the Medicaid agency now contracts directly (or will soon do so) with networks of providers or care systems to provide medical homes, care coordination, and/or comprehensive care, with emphasis on the use of local community-based entities that address local needs. However, the states have developed different program designs, including the following:

- In Colorado, Regional Care Collaborative Organizations (RCCOs) develop the provider network and provide and/or support care coordination, medical management, administrative support, and technical assistance. The RCCOs and the Medicaid program contract with Primary Care Medical Providers (PCMPs), including physician practices, Federally Qualified Health Centers, and rural health clinics, to provide comprehensive primary care.
- In Oregon, Coordinated Care Organizations (CCOs), local, provider-sponsored risk-bearing networks, integrate care, with a focus on community-level accountability and reducing health disparities. The networks are paid global budgets that cover physical health, behavioral health and eventually dental services. Noting that CCOs do not have all these skills at the outset, and that there will be a period of growth and new learning, Medicaid intends to convene the CCOs to collaborate on key functionalities such as population management, coordination with community entities, and care integration.
- Minnesota Medicaid is contracting with eight integrated delivery systems and one consortium of FQHC providers that have developed their own ACO designs. A tenth organization, Hennepin Health (a safety-net ACO in the Minneapolis-St. Paul area), began serving low-income childless adults in January 2012. Payment mechanisms for ACOs include risk/gain-sharing payments on top of capitation or FFS.
- In Vermont's Blueprint for Health model, the state operates under a managed care model, enrolling beneficiaries in Advanced Primary Care Medical Practices (APCPs) that are associated with community health teams (CHTs) comprised of a variety of providers (including social workers, nurse coordinators, community health workers and others). Medicaid provides additional care coordinators and discharge planning support for the most complex cases. Also, OneCare Vermont ACO began January 2013 for Medicare members, and plans to include Medicaid and commercial payers in 2014–2015. Other multipayer payment pilots that may involve Medicaid are in development, as the state explores ways to use a "unified health care budget" to constrain total health care costs.

A number of states studied have developed Health Homes or Patient-Centered Medical Homes, in which a primary care provider (or another provider, such as a behavioral health provider or a specialist) is

responsible for coordinating patients' care and receives a supplemental payment for the administrative and clinical capabilities this requires.³¹

Performance Assessment and Risk-sharing to Promote Population Health

The four states implementing ACO-like reforms emphasized the importance of using performance data and creating risk-sharing arrangements that incentivize population health. They are (or will be) conducting data collection, analysis, and to varying degrees reporting the results of their delivery system reforms publicly; they view their ongoing performance monitoring as critical to their efforts. They have contracts or other relationships with academic institutions or commercial data analysis entities to help them evaluate spending, service use, and health outcomes associated with their programs.

The four states have begun financing their ACO-like activities using a fee-for-service structure, with an additional per-member-per-month payment to participating providers to provide care coordination and other supplemental services. A portion of the PMPM is tied to performance (Minnesota, Colorado, and Oregon) or medical home status (Vermont). However, the states are also testing other payment approaches that would help reduce their use of fee-for-service payment within their ACO models. Vermont, for example, is working with providers and other stakeholders to develop pilots to test global budgeting for hospitals that include physician services; payment bundling for groupings of services; and regionally-defined population-based payment to a provider organization that bears risk (Vermont has one ACO that has applied for CMS recognition using this model). Colorado plans to increase the number of performance measures for which providers and the RCCOs are at risk. In Oregon, CCOs are intended to use global budgets.

Information Technology and other Supports

In their development of ACOs and other payment arrangements, states are also relying on their Medicaid programs and other state agencies to provide information technology support, technical assistance, quality assessment, and in some cases direct care coordination. All of the states with the most ACO activity – Minnesota, Vermont, Colorado, and Oregon—have or are developing multi-payer databases. In Minnesota's safety-net ACO, the state has provided an electronic health record to the large providers to share patient information.

Impact of State ACO-related Strategies

Most state efforts to foster and pilot ACO-like delivery and payment reforms – among the four study states and elsewhere in the nation – are just beginning, so there is little evidence yet of their impact. As noted above, these states have significant measurement, data analysis, and evaluation activities. The planners are expecting reduced readmissions and avoidable ED use, improved HEDIS and other performance measures, and budget savings. Colorado is focusing initially – in measurement and forthcoming financial incentives – on ED utilization, hospital readmissions, high cost imaging, and budget

³¹ For the definition of a Medicaid health home for people with chronic conditions, see State Medicaid Director Letter #10-024, released November 16, 2010, "Health Homes for Enrollees with Chronic Conditions," at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>. For the Agency for Healthcare Research and Quality's definition of a Patient-Centered Medical Home, see http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/what_is_pcmh.

savings. Colorado Medicaid officials reported positive trends in their first annual report, released in November 2012, which found reduced utilization of emergency room services, hospital readmissions, and high-cost imaging; lower rates of aggravated chronic health conditions; and lower total costs of care for enrollees in the ACC program.³² Hennepin Health in Minneapolis-St. Paul is focusing on reducing inappropriate ED use, managing prescriptions, and reducing duplicative services. Hennepin Health reports success on all three, though the data are incomplete: 111 patients with dental pain were diverted from the ED to a nearby dental clinic; pharmaceutical spending was reduced by more than 50 percent; and there are anecdotal reports of less duplication of services. Hennepin Health reports that within six months of implementation, health spending on the 5 percent of patients utilizing the most services decreased by 40 percent to 95 percent per person, while use of preventive services improved.³³ A wide range of other delivery system changes have been implemented though not yet evaluated, including using mobile primary care, coordinating behavioral health services, coordinating with adult corrections, and linking health records across community-based providers.

Vermont Chronic Care Initiative's use of care coordinators to work with community health teams and provide enhanced care coordination for Medicaid beneficiaries with complex medical and social needs is associated with: 11 percent lower inpatient utilization and 6.5 percent lower Emergency Room use in SFY 2010 compared with baseline; higher prescription fulfillment (5.6 percent to 23.5 percent); and higher evidence-based testing (10.8 percent to 16.5 percent). The addition of one care manager position for discharge planning resulted in reduction in inpatient days (initial and readmissions), with estimated cost savings of over \$1 million in its first year.³⁴

An evaluation of *commercially* insured patients in Vermont's first two multipayer Blueprint pilot communities compared with controls found lower growth in expenditures and inpatient admissions and greater declines in ED visits; however, authors caution that these should be seen as directional trends and not as significant differences. Stakeholders are hoping that a follow-up evaluation in 2013 based on a larger sample will show more concrete impact on utilization and costs for Medicaid enrollees as well as other patients.

MCO-ACO Relationship

It appears that the interface between Medicaid MCOs and ACOs will vary across states, depending on the role and history of managed care in the Medicaid marketplace. Among the four states profiled that are implementing ACO-like arrangements for their Medicaid populations, Colorado's ACC and Vermont's Blueprint programs are doing so without MCO involvement since they are building on mainly non-MCO Medicaid markets. Yet in Vermont's planning for (multi-payer) payment reform pilots, health plans are invited to the discussion. Minnesota and Oregon are starting with a highly managed care environment. While these states want to shift to more direct contracting with provider networks, they understand the

³² See the Accountable Care Collaborative Annual Report at http://www.colorado.gov/cs/Satellite?c=Document_C&childpagename=HCPF%2FDocument_C%2FHCPFAddLink&cid=1251633513486&pagename=HCPFWrapper

³³ Hennepin Health Project Update, December 31, 2012. <http://hennepin.us/files/HennepinUS/HSPHD/Department/Hennepin%20Health%20Care/Files/HennepinHealthUpdateDecember2012.pdf>.

³⁴ Memo to Vermont House Health Care Committee from Mark Larson, Commissioner, February 28, 2012,

benefits of leveraging existing MCO expertise and network infrastructure and are allowing MCOs to conduct administrative services or to “morph” into ACOs.

While proponents of ACOs are careful to highlight how ACOs differ from traditional MCOs – such as greater financial risk for quality and outcomes (with direct incentives for providers), stronger coordination and integration of care across a broader array of services, focus on highest risk patients, and provider-led governance – it is clear that MCOs are moving in similar directions. The state levers described in this report that pressure MCOs to improve quality and value, integrate physical health care with behavioral and long term care, and reduce avoidable readmissions and ED visits are leading them to put similar pressures on their provider networks – effectively creating ACO-type arrangements. As MCOs are bidding for contracts to care for populations dually eligible for Medicare and Medicaid, and for contracts that integrate behavioral or long term care with physical health, MCOs are expanding their networks and adopting greater integration and coordination across the continuum of care. Many are instituting gain-sharing with their network practitioners – i.e., shifting some financial risk to hospitals and individual practitioners based on achieving efficiency and quality goals.

Further, new federal opportunities to innovate (such as CMMI grants) are leading MCOs to partner with integrated networks in new ways that promote accountability for quality and cost. Newly forming ACOs can consist of an MCO and a provider-owned network of hospitals, primary care clinics, multi-specialty clinics, and surgery centers. In other cases, an MCO may perform the administrative and marketing functions for a provider-owned ACO. Thus, there appears much room for MCOs and ACOs to co-exist and interface.

Multipayer Activities

Although this report focuses primarily on state levers with MCOs and ACOs, we briefly mention state efforts to align Medicaid activities with other payers in an effort to promote care management, integration, and improvement. Many of the ten study states are collaborating with private-sector payers and health plans and with Medicare. These efforts are mostly new or in development and have little experience to date in transforming practices. However, to the extent that they are focusing on complex patients such as people with chronic conditions, states are optimistic that they will achieve improvements.

The most common multipayer initiatives are multipayer medical homes, dual eligible integration design, and multipayer databases.

- Seven of the ten states – Colorado, Massachusetts, Minnesota, Oregon, Pennsylvania, South Carolina, and Vermont – participate in multipayer medical home initiatives where Medicaid and other payers agree to pay an additional fee to practices that have achieved medical home recognition. Massachusetts, Oregon, and Vermont are promoting achievement of the NCQA medical home standards, whereas Minnesota has developed its own standards. Payment methods include a per member per month fee for case management, fee adjustment for level of medical home level (Vermont) or complexity of patients (Minnesota), and additional payments for meeting quality targets.

- Three study states – Minnesota, Pennsylvania, and Vermont – are participating (along with Maine, New York, Rhode Island, North Carolina, and Michigan) in the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP). Over the next three years Medicaid, private payers, and Medicare will align payments to promote medical homes, testing for impact on improving health, reducing unnecessary variation, and engaging beneficiaries in care.
- Seven states including Colorado and Oregon were selected in April 2012 to participate in the Comprehensive Primary Care initiative, a Medicare-led demonstration whereby selected medical practices will be given resources to better coordinate care.³⁵ Along with Medicare, private health plans, state Medicaid agencies, and employers may participate.
- A federally led medical home initiative seeks to provide Medicaid enrollees who also receive Medicare benefits (dual eligible) with a more integrated health home. Fifteen states including nearly all of the study states – California, Colorado, Massachusetts, Minnesota, Oregon, South Carolina, Tennessee, and Vermont – each received \$1 million to develop a model of coordinating care for this population that tends to have multiple co-morbidities and several providers.
- Seven of the ten study states – Colorado, Massachusetts, Minnesota, Oregon, Tennessee, South Carolina, and Vermont – have developed or are developing an all-payer database that allow analysis and comparisons across Medicaid and commercial plans related to service utilization, costs, outcomes, and other indicators.³⁶ In addition, California and Texas have reported strong interest in creating comparable data across payers. Nationally, ten states have implemented all-payer databases, six states are in the process of implementing them, and 17 have reported a strong interest.³⁷

Stakeholder Involvement

The experiences of all ten studied states underscore the importance of stakeholder involvement in the selection, development, and ongoing refinement of delivery system and financing reforms. MCOs, providers, consumers and advocates have been key participants in workgroups and planning committees. Medicaid officials noted the importance of input from stakeholders on issues such as: which quality measures to use and when; the details of how incentive payments are structured and administered; reasonable performance expectations; and potential unintended consequences.

MCOs' reactions to states' quality improvement efforts varied, but MCOs that had longer relationships with the state, had closer community ties, and were more involved in the planning process appeared to have more positive reactions. Where MCOs were initially critical, involvement was important to addressing and reducing concerns, and one state noted that the health plans have become much more comfortable sharing information and best practices with one another over time through participation in multi-plan meetings convened by the state.

Accurate and ongoing communication between the state and stakeholders from program development through implementation and beyond are critical. This includes bringing MCOs (or ACOs) together to

³⁵ <http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html>

³⁶ The All Payer Claims Database Council tracks state activity and interest at: www.apcdouncil.org/state/map

³⁷ Ibid.

share best practices and address challenges together. A few state officials reported that MCOs (or RCCOs in Colorado) also meet with each other separately from the state-convened meetings to report on progress and share best practices.

Collaboration among payers fosters alignment of quality improvement strategies. State officials reported that providers are more likely to respond if quality standards and incentives are similar across Medicaid and commercial plans. Collaboration is also occurring in several states through multipayer medical home initiatives and databases, as noted above.

Collaboration with other state and county entities to avoid duplication, leverage resources, and share data is also valuable. For example, Medicaid programs working to better integrate behavioral health services must work closely with mental health agencies to clarify responsibilities for oversight of quality and administration and to coordinate funding.

Particularly for states that are moving toward payment models or program designs intended to incorporate a broader range of social services and focus on improving population health, stakeholder involvement and coordination with other state agencies, various types of service providers, and community organizations will continue to be important.

Challenges

States and Medicaid MCOs face a number of challenges, some of which are common to quality improvement efforts across the health care system and others that are more specific to Medicaid.

Measurable Results

Though quality improvement and payment reform strategies are often viewed and sometimes enacted based on their potential to control costs, results can be challenging to measure, and some strategies may not reduce costs in the short or even long term even if they succeed in improving quality. However, legislatures' expectations for such programs are often high. For example, Colorado increased its enrollment target for its ACO-like RCCOs even before implementation when it found additional budget cuts had to be made, on the assumption that projected savings will materialize.

Engagement of High-Risk Enrollees

Some problems are wide-spread and intractable and have more to do with the health care system design and incentives than any single health plan or insurance program. For example, states have identified and struggled with how to improve the engagement of high-risk patients (and patients in general) in their own care, appropriate ED use, breast cancer screening, and adherence to treatment plans and medication in general. They have tried working collaboratively across plans and institutions to share best practices – as well as strategies that did not succeed.

Attribution and Churning

Attribution of patients to providers under ACO models, an important precursor to paying incentives, is an ongoing challenge. Patients get their care from multiple providers, and the ones providing the most care are not necessarily equipped or best suited for care coordination and ongoing case management. In Colorado, Medicaid officials hope to work with providers and clients so that members begin to develop a

relationship with one provider. The state has responded to the concern that certain providers are not always the best to provide care coordination by allowing the RCCO to provide that care coordination in whatever way they think is best. In addition, churning of Medicaid enrollees in and out of coverage poses challenges not only for coordinating and providing care, but also to administering incentives in an ACO-like program or for MCOs.

Insufficient or Misaligned Incentives

Provider incentives must be substantial enough to influence behavior. State officials noted that alignment of incentives across payer and programs is more likely to produce results. However, if doctors have only a small portion of their patients on Medicaid, incentives may have no effect.

Additional challenges reported include:

- lack of robust evidence for definitive best practices to improve quality in Medicaid managed care;
- the need to tailor strategies to the specific populations and program requirements;
- pressure on state Medicaid programs to keep pace with rapidly changing legislative priorities and budget cuts;
- historical silos between state agencies serving a single population; and
- payment and privacy rules and laws that impede coordination.

Conclusion and Policy Implications

Our examination of Medicaid efforts to improve care for vulnerable populations found that many state efforts support one of two basic strategies.

The first approach builds on traditional state contracting with managed care organizations, particularly relevant as many states are shifting more Medicaid enrollees into mandatory managed care. This report illustrates the wide range of strategies available to states to promote high-quality care through MCOs, from greater use of performance and quality improvement criteria in plan procurement, to pay-for-performance programs and increasing the range of measures, the goals and benchmarks, and the level of financial risk to the MCO. This expanded role of performance measurement and improvement aligns well with the growing national health priorities.

Medicaid programs that contract with MCOs are using a number of levers to improve care for enrollees, including requiring that plans target patients with special needs, requiring greater transparency between plans to uncover best practices, and incentivizing achievement of tougher quality standards. Many Medicaid programs are partnering with other payers and are looking more holistically at population health, as they have fully transitioned from the old days of just paying bills.

The second approach, used by a small but increasing number of states, involves forming relationships more directly with providers or regional provider networks and shifting risk for quality and cost-effectiveness of care from the state or health plans to those entities. Payment mechanisms include quality-based shared savings programs, bundled and global payment pilots, and other variations of

accountable care organizations. States are also partnering with commercial insurers and Medicare to support multi-payer primary care medical homes and community health teams with enhanced care coordination for highest risk patients.

Though ACOs differ from traditional MCOs in a variety of ways, these states' experience suggests that MCOs – particularly with pressures and opportunities from state and federal governments – are moving in similar directions, taking greater accountability for quality, identifying high-risk members for intensive care management, integrating a broader range of services, and sharing gains with practitioners. We are seeing these entities co-exist and interface through new kinds of contractual and organizational arrangements.

Regardless of whether a Medicaid agency takes the MCO or ACO approach or a combination, states have a leadership roles to play in convening MCOs, ACOs, and other stakeholders – engaging them in developing and implementing new managed care strategies; facilitating the sharing of best practices and alignment of QI efforts; and providing support for data sharing and analysis, technology, technical assistance, and evaluation. A history of Medicaid/MCO collaboration has made these conversations easier. However it also appears to be possible to introduce and build a collaborative culture by stressing the shared benefits from raising the level of care and health of the population. States note that leadership at the local health plan, provider system, or legislature has been critical to their progress to date.

Medicaid performance improvement agendas should be linked to the agenda of other agencies, such as mental health, public health, substance abuse, corrections, other state and county departments. There is a greater appreciation for the role these agencies play in insuring timely and effective use of health care services by Medicaid beneficiaries. These partnerships are facilitated by identifying shared goals, leveraging the expertise and resources of the various departments, and communicating the benefits that accrue to all participants. Separate funding streams make such collaboration a challenge, but not insurmountable.

States are increasingly relying on good data infrastructure and expertise to facilitate quality measurement, comparison, and effective use of incentives for delivery system change. Linking data across payers, providers, and/or patients to better identify care delivery strategies that work, for example, has potential to improve health as well as bring efficiencies and savings. Universities and foundations can play important role in providing or funding expertise for building or guiding such infrastructure and using the data to evaluate impact. Further, Medicaid officials can benefit from experiences of their peers in other states.

The promising efforts by Medicaid agencies described in this report, and in other states, to improve care underscores the importance of Medicaid's inclusion and key role in a state's broad health system reform efforts. This calls for aligning incentives and goals across Medicaid, other public payers, and private payers. Strategies that target specific vulnerable populations are critical, but to be most effective in improving care delivery system for some is to promote accountability and improve the delivery and integration of care for all.

Appendix: Managed Care Strategy Profiles of Ten Study States

CALIFORNIA	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 47% of Medicaid population enrolled in MCOs • 2012 interviews: About 57% in MCOs (4.1 million); CA Medicaid contracts with 26 MCOs • Approximately 43% of the Medi-Cal (California's Medicaid program) population is in fee for service (FFS) (3.1 million) • Very small PCCM program with fewer than 1,000 enrollees • Bridge to Reform waiver will: <ul style="list-style-type: none"> ○ add childless adults under 133% of poverty into the county-based low-income health program (LIHP); about 500,000 people are expected to be gain coverage and transition to Medi-Cal managed care in 2014 ○ mandate enrollment in managed care for dual eligibles, seniors and persons with disabilities, and almost all other remaining populations not in managed care, except for foster children and Native American populations, between January 2013 and 2015 ○ Counties can also choose to further expand coverage up to 200% of poverty through the county-based Health Care Coverage Initiatives.
Additional Quality Measures and Reporting Requirements for Seniors and Persons with Disabilities	<ul style="list-style-type: none"> • Medi-Cal currently requires annual reporting of selected HEDIS measures related to quality, access, and timeliness of care. • For 2012, California added measures relevant to seniors and persons with disabilities (SPD). • SPD beneficiaries must be enrolled in managed care plans long enough for plans to be able to collect enough data to generate statistically significant performance scores, so it will take several years before performance measurement scores will be fully reflective of these members' health outcomes. However, CA is collecting baseline measurements for these members' health status upon enrollment into the managed care plans, and will track utilization of key services (such as emergency room use, inpatient admissions, and outpatient care) over time. • Also beginning to develop quality measures appropriate to enrollees who are dually eligible for Medicare and Medi-Cal. <ul style="list-style-type: none"> ○ About 40% of these beneficiaries receive long term care services, and therefore the quality measures will need to address care provided in nursing homes and community based organizations. • Also reviewing measures most appropriate to the CHIP population, in anticipation of the Healthy Families Program moving into managed care. • Additional reporting related to SPDs will be required in the areas of case management and coordination of care, such as provider access, risk stratification, risk assessment, and personalized care plans. Though CA already monitors all grievances/complaints, it will be increasing its call center capacity and monitoring activities. • These changes are part of the Bridge to Reform waiver's shift to mandatory enrollment in managed care for almost all populations. The waiver was motivated by California's overall enthusiasm for implementing the ACA, and desire to take advantage of opportunities to phase in the coverage expansion that will take place in 2014. • The waiver was developed following the enactment of the ACA. Implementation began in 2011, and specifically the new HEDIS measures and additional reporting requirements were scheduled to go into effect during 2012. • The Bridge to Reform was authorized by a section 1115 Medicaid waiver in 2010. The following legislation was enacted to support the waiver: <ul style="list-style-type: none"> ○ Senate Bill (SB) 208 / Steinberg/Alquist <ul style="list-style-type: none"> ▪ Mandates alternative health care delivery systems in the form of mandatory managed care for seniors and persons with disabilities and managed care pilots for other populations including persons dually eligible

	<p>for both Medicare and Medi-Cal. Establishes pilot programs to unify care management for children with special health care needs.</p> <ul style="list-style-type: none"> ▪ Supports the budget neutrality justification for the state to request \$10 billion in federal funding for programs proposed in the waiver. ○ Assembly Bill (AB) 342 / John Pérez <ul style="list-style-type: none"> ▪ Authorizes coverage expansion up to 133% of poverty, or up to 200% of poverty, at the option of counties.
Quality Withhold of 5% from Capitation Rate	<ul style="list-style-type: none"> • This strategy is still under development and will be implemented in the future • From the beginning, the motivation has been to promote access to quality care • There are no withholds yet, so won't be able to measure the impact for a while; improvement would be tracked from year to year • The withholds would be based on improvement and also state and national benchmarks
Developing Statewide QIPs	<ul style="list-style-type: none"> • All contracted health plans are required by federal regulations and contract language to participate in a state-wide collaborative quality improvement project and at least one other quality improvement project. The most recently completed state-wide collaborative was focused on decreasing avoidable use of emergency departments. Interim reports are on the DHCS website. The current state-wide collaborative is focused on reducing the number of beneficiaries who are re-admitted to a hospital within 30 days of being discharged. • For the current statewide Quality Improvement Project (QIP), CA has just started working collaboratively with Medi-Cal managed care health plans to reduce hospital readmissions. Two subcommittees comprised of MMCD staff, health plans and EQRO have finalized guiding principles and a modified HEDIS measure specific to the Medicaid population. • The final specifications were approved by the state in December 2011. Health plans submitted their statewide collaborative QIP Proposals at the end of March 2012, and submitted the hospital readmissions collaborative QIP study design phase data on September 1, 2012. More detail will be publicly available in the baseline report published in 2014.
Annual Public Recognition for High-Performing Plans	<ul style="list-style-type: none"> • Medi-Cal holds quarterly meeting with executive leaders of plans • HEDIS scores are annually reported, and high performers are publicly recognized at an annual quality meeting with plans' leadership • There is no monetary prize, and the recognition does not typically generate media coverage – it is purely an award that all the plans are aware of • Driven by desire by Medicaid program to motivate plans and recognize strong performance • Well-established policy (since 2002) • All plans participate • No legislative or other action necessary • The state believes that the public recognition of high-performing plans is a strong motivator, and highly valued among plan leadership and staff
Auto-assignment Based on HEDIS Scores	<ul style="list-style-type: none"> • The state has a longtime policy of using performance (combination of HEDIS and state-developed measures) to auto-assign enrollees who do not select a plan • Driven by desire to improve quality/value in managed care • Difficult to evaluate

We thank the following individuals for sharing their time and information: Jane Ogle, Deputy Director, Health Care Delivery Systems, and Margaret Tatar, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services.

COLORADO	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 8% of Medicaid population enrolled in MCOs • 2012 interviews: Medicaid Managed Care- 15% Medical, 100% Behavioral • Shifting FFS population into 7 regional ACO-like entities
Accountable Care Collaborative (ACC)	<p><i>Description</i></p> <ul style="list-style-type: none"> • Medicaid is shifting its FFS population into an ACO model that provides comprehensive coordinated care with outcomes-based incentives • State contracts with one Regional Care Collaborative Organization (RCCO) in each of seven regions that creates a network of primary care providers and provides them care coordination, medical management and administrative support, technical assistance and training, and creates 'virtual' network with hospitals, specialists and social services • RCCOs and Medicaid contract with Primary Care Medical Providers (PCMPs) – medical practices, FQHCs, rural health clinics - to provide comprehensive primary care for ACC Program clients and coordinate a client's health needs across specialties • State contracts with a Statewide Data and Analytics Contractor (SDAC) to create a data repository and web portal, provide data and analytic reports to RCCOs, PCMPs, and Medicaid intended to foster accountability among RCCOs and PCMPs and identify opportunities to improve care and outcomes Medicaid pays \$20PMPM: \$3 to SDAC (the state has a fixed-price contract with the SDAC, but the total amount is equivalent to roughly \$3 PMPM); \$13 to RCCO; \$4 to PCMP <ul style="list-style-type: none"> ○ At least 1 RCCO also pursues private grant funding in its region to support its activities • Beginning in early 2013, \$1 for RCCO and \$1 for PCMP will be paid out from an incentive pool, if performance measures are met <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • A combination of economic and political factors contributed to the enactment in 2008 of the Medicaid Value-Based Care Coordination Initiative, aka the Accountable Care Collaborative Program (the ACC Program) as part of the Medicaid agency's budget request for FY 2009 • Leadership from the Governor and the Medicaid agency made delivery system reform a priority in conjunction with an expansion of public coverage • Passage of the Colorado Health Care Affordability Act (Colorado House Bill 09-1293) in April 2009, which enacted a Medicaid coverage expansion financed with provider taxes, along with unprecedented growth in the Medicaid caseload because of the economic recession, reinforced the need for the Department to implement the ACC Program • Expansion is being driven by the need to meet lower budget targets • While CO is starting from a fee-for-service system, it intends to move toward paying for value – but potentially without using traditional MCOs in Medicaid <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • The Colorado Department of Health Care Policy and Financing (Department) submitted a formal budget action for the ACC Program on November 3, 2008 • Through competitive bidding, the Department selected RCCOs and SDAC; the RCCOs began with clusters of PCPs, expanding network. Now all seven regions are up and running. • In spring 2011, the Legislature doubled the initial enrollment limit from 60,000 to 123,000 due to \$20m Medicaid cut; faster enrollment expected to accelerate savings. • Client enrollment began May 2011 • Reached 210,000 enrollees in December 2012 • As of August 2012, RCCOs contracted with 535 provider organizations that included 3,776 practitioners <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Workgroups including 1-clients and advocates; and 2-providers and health plans made recommendations on design in 2008; stakeholders helped create RFIs & RFPs

	<ul style="list-style-type: none"> • State presented plan to stakeholders & feedback through ongoing communications • Program has robust advisory committee structure, including three subcommittees; a Quality subcommittee includes representatives from the 7 RCCOs, provider organizations, advocates, and others interested through public advertising • RCCOs also meet regularly, separate from state, to share issues and best practices <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • Program implemented through budget action (no state legislation needed) • CO filed state plan amendment to CMS <p><i>Challenges</i></p> <ul style="list-style-type: none"> • Communication: Need to continually inform stakeholders (especially providers) about program development; required much support and collaboration with medical society and RCCOs • Attribution: Assigning enrollees to PCPs took more effort and time than expected • Contracts: Completing contracts with providers was more complex and required more time and resources than expected • Risk adjustment to be implemented <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • 3 metrics: ER utilization, hospital readmissions, high-cost imaging (SDAC currently establishing baseline and risk adjustment mechanism); overall costs will also be measured • First annual report shows positive trends: reduced utilization of emergency room services, hospital readmissions, and high-cost imaging; lower rates of aggravated chronic health conditions; and lower total costs of care for enrollees. • Metrics are outcome-based, allowing each RCCO to develop strategies best suited for that region; eg: <ul style="list-style-type: none"> ○ Identify an ACC member in ER and assess whether he/she can go to a different level of care ○ After hospital discharge ensure follow-up appointment with PCP • EQRO will assess strategies that are effective • As of July 2012, \$2 PMPM at risk tied to the metric at regional level; payments will be made beginning early 2013 • Plan for payment reform over time: increasing portion of payment to be at risk, expansion of metrics, and gain sharing component • 3% budget savings projected
Behavioral Health Gain Sharing	<ul style="list-style-type: none"> • State is working w/ the behavioral health MCOs to develop performance measures and conduct a gain sharing pilot re: use of psychotropic drugs
Agency Quality Improvement Teams	<ul style="list-style-type: none"> • Agency staff from each program (MCO, FFS, and LTC) collaborating on issues relevant to all clients. • Focusing on Emergency Department (ED) use, readmissions, and unintended pregnancies. • ED use strategies have included: putting the nurse call line phone number on the membership card, working with behavioral health organizations on educational initiatives, ER diversion pilot programs, using ED use as a metric in the ACC. • Working on a toolkit for reducing unintended pregnancies.

We thank the following individuals for sharing their time and information: Laurel Karabatsos, Deputy Medicaid Director; Marci Eads, Medicaid Reform Unit Manager; Katherine Jantz, Program Performance Specialist; Jed Ziegenhagen, Director, Rates and Analysis Division, Colorado Department of Health Care Policy and Financing; Julie Holtz, Deputy Director of Medicaid at Colorado Access and Region 5 Contract Manager; Patrick Gordon, Director of Government Programs, Rocky Mountain Health Plans.

MASSACHUSETTS	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 33% of Medicaid population enrolled in MCOs • 2012 interviews: 39% Medicaid MCO enrollment
State Goals and Quality Management Workgroup	<p><i>Description</i></p> <ul style="list-style-type: none"> • Medicaid convenes the medical directors of its contracted health plans every other month. They review health plan and state performance data to identify areas for improvement and talk about strategies for improving outcomes. This activity complements the scope of quality improvement strategies embedded in MCO contracts. • The MCO contract includes requirements for NCQA accreditation (includes reporting HEDIS and customer satisfaction), auditing of the plans' Performance Improvement Projects (PIPS) and PIMS by the EQRO, having a QI committee, developing an annual quality management workplan, participating in the Quality management workgroup, and achieving quality improvement goals. • State has 5 QI goals, set on two year cycles, related to HEDIS measures. <ul style="list-style-type: none"> ○ MCOs tell Masshealth how they will intervene to reach improvement targets, and report results, barriers, and next steps ○ Currently, there are goals related to asthma, diabetes, maternal and child health, care management, and behavioral health • Newly identified priority is improving health outcomes by race. Plans have to collect racial and ethnic data upon enrollment as part of a newly developed Health Needs Assessment, and then stratify data to demonstrate interventions are effective for populations whose care is most problematic. This activity started in September 2011 and planned to start stratifying data by end of 2012. • MCOs developed a common Health Needs Assessment, which took 1.5 years to develop and test. <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Assuring quality of care for MassHealth beneficiaries. However, quality is starting at a very good level. MA has four of the top national health plans in state. • MA supports implementation of CLAS standards which assure access to care is culturally and linguistically appropriate. <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • Has been ongoing since managed care contracting began in the 1980s. • Workgroups have been meeting for the duration of the MassHealth managed care program (about 20 years) <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Health plan medical directors are active participants with the state. <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • The requirement to participate is embedded in health plan contracts. <p><i>Challenges</i></p> <ul style="list-style-type: none"> • Difficulty in making improvements in some areas. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • Recent improvement in eye and foot exams for people with diabetes. Medical homes and the MCOs worked together on an initiative to educate patients and do outreach to get them to obtain needed care. • Improved adolescent immunization rates. Again, MassHealth and MCOs partnered on an educational campaign and outreach strategy specifically targeted to adolescents, including an "invitation to see your doctor," Reminder cards, billboards, etc. There was an increase in adolescent visits and immunizations.

ACO Development/Planning	<p>Massachusetts passed a new health care reform law in August 2012 that sets targets for cost containment and recommends expanded use of ACOs for all public purchasers. The bill provides explicit benchmarks to for MassHealth to meet in this transition: 25% of enrollees by July 1, 2013; 50% of enrollees by July 1, 2014; and 80% of enrollees by July 1, 2015. The bill authorizes MassHealth to “take actions necessary to amend its managed care organization and primary care clinician contracts as necessary to include such contracts in the innovation project.”</p> <p>The bill also uses MassHealth to encourage a transition to alternative payment methodologies by other providers. It provides a 2% Medicaid rate increase “bonus” (above any other ordinary base rate calculations) to hospitals and primary care providers that demonstrate a “significant transition” to the use of alternative payment methodologies.</p> <ul style="list-style-type: none"> •
Multi-payer medical home³⁸	<ul style="list-style-type: none"> • MA is seeking to help medical practices transform into patient centered medical homes. Through a multi-agency, multi-payer initiative, 47 enrolled practices are receiving a small capitated fee on top of their regular payment to change care delivery and improve outcomes • 16 of the 47 receive technical assistance • All health plans agree to pay the same fee • An evaluation of the first year of the program is underway. In three years, they will decide whether or not to expand this model.
Community Health Benefit guidelines	<ul style="list-style-type: none"> • Voluntary principles encourage MassHealth MCOs to provide community benefits. • 2009 guidelines issued by the Massachusetts Attorney General’s Office identify statewide priorities that MCOs were asked to consider: to improve and maintain health status, to promote health equity for diverse populations, and to expand access to health care

We would like to thank the following individuals for sharing their time and information: Sharon Hanson, Director of managed care); Robert Seifert, McCormick Institute, University of Massachusetts Medical Center.

³⁸ The Medicaid program, MassHealth, is planning to implement in July 2013 a Comprehensive Primary Care Payment (CPCP) initiative that combines a shared savings/risk arrangement with quality incentives for practices that contract with MassHealth and commit to delivering primary care consistent with the Commonwealth’s definition of a patient-centered medical home with a focus on behavioral health integration.

MINNESOTA	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 66% of Medicaid population enrolled in MCOs • The majority of plans serve both Medicaid and commercial populations. • 1 plan serves Medicaid and Medicare, but not commercial population. • There are 3 county-based purchasing plans and 1 county-run HMO. • 3 plans serve only Medicaid clients
Competitive Bidding of Managed Care Contracts	<p><i>Description</i></p> <ul style="list-style-type: none"> • In 2011, MN shifted their managed care contracting strategy in the 7-county, Twin Cities region from rate setting to a competitive bidding process. Half of MMC enrollees are in this area. • Contracts were awarded based 50% on price and 50% on quality (including quality scores, networks, and additional special services) • In each county, just 2-3 of the original five plans won a contract and about 85,000 members had to change plans • Builds value into MCO contracting. <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Cost savings • Accelerating the pace of quality improvement <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • 2011 implementation • Intend to expand to other parts of the state where there are enough plans to promote competition <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • MCOs were helpful with implementation, contributing to a smooth transition of enrollees across MCOs; even the MCOs losing the Medicaid contract worked closely with the state <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • Legislative action needed to be able to “book” the savings. <p><i>Challenges</i></p> <ul style="list-style-type: none"> • Concern about backlash from members or advocates, so worked closely with plans on communication and transitions. Little backlash actually took place. <p><i>Impact on Quality & Cost-Effectiveness</i></p> <ul style="list-style-type: none"> • \$175million saved in 2012 • Too soon to assess other changes
Community Health Collaboration Plans	<ul style="list-style-type: none"> • Minnesota requires health plans to file “collaboration plans” on their local health improvement activities every four years. • 2011 legislation calls for the state to move toward more formal links between these collaboration plans and statewide health goals.
Health Care Delivery System Demonstration (ACOs)	<p><i>Description</i></p> <ul style="list-style-type: none"> • 2010 Health Care Reform Law called for the implementation of ACOs by Medicaid to encourage providers to innovate to deliver higher value care. • The demonstration enhances primary care and improved care coordination through health homes meeting MN-specific standards (see below) • Tests payment models that increase provider accountability for cost and quality • Creates alignment of similar initiatives across public and private payers to help providers attain a critical mass of value based incentives³⁹ • Shared Savings between providers/system and state based on more cost-effective utilization • There will be a behavioral health component 3-5 years out to ensure improvement in outcomes <p><i>Impetus/Drivers</i></p>

³⁹ RFP website

	<ul style="list-style-type: none"> The state is seeking new opportunities to promote health care delivery change faster and more consistently by working directly with large care systems to support provider innovation The state believed integration would happen faster and more consistently with state/health system negotiation than through health plans; MCOs are viewed by state less as 'driver' of reform and more as financing & enrollment partner Made possible statewide by the large number of integrated care systems throughout the state Reflects overall direction of state providing leadership versus reliance on MCOs to create innovations <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> 2010 law 2011 RFP released 2012 bids submitted and negotiated. Enrollment of 150,000 beneficiaries occurred on 1/1/13. <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> Stakeholder input helped shape the delivery system requirements, payment model options, role of quality measures, role of MCOs, and other data collection and feedback plans. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> MN already had excellent quality on many indicators MN will try to leverage some of the statewide QI initiatives to the ACOs, such as readmissions.
Hennepin County ACO	<p><i>Description</i></p> <ul style="list-style-type: none"> Also authorized by the 2008 health care reform law, Hennepin Health is a safety net ACO. Created to deliver integrated services to Medicaid eligible, low-income childless adults with incomes up to 70% FPL in the Twin Cities area. Uses an integrated care team that includes medical, social services, behavioral health, and coordinates with the correctional system. The MCO is paid a capitated amount by DHS, and the Department of Health provides additional funding for social services. <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> Delivery system with experience serving adults with multiple chronic illnesses, the homeless, heavy users of mental health and substance abuse services, which will be particularly important for the ACA expansion population (childless adults up to 70% FPL) Savings from more appropriate and timely use of care and social services. <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> Began January 2012 Approximately 10,000 as of 12/31/12. <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> Active collaboration among care providers who care for poor adults in the region is helping in care management, data sharing, and enrollment. Medicaid and providers of services to the poor/uninsured Workgroup has developed a balanced scorecard to assess the impact on patients, utilization, costs, efficiency, providers, and the market <p><i>Challenges</i></p> <ul style="list-style-type: none"> Large initial technology investment has helped connect patient information across providers. Care coordination has been consolidated, connecting information across agencies Waiting on state plan amendment for the FFS population. Not needed for MCO population. In discussions with CMS about paying for outcomes <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> As of May 2012, medication costs for high utilizers have been reduced by over 50%;

	<p>transportation vouchers decreased by delivering medications to shelters;</p> <ul style="list-style-type: none"> • Top 5% most expensive patients experienced reduction in spending by 40 to 95%. • 111 patients seeking relief of dental pain in the ED were redirected to same day dental care nearby • Improved community placement for behavioral health care reduced behavioral health hospital costs by 70% • Electronic health record reducing duplication of services
Health Care Homes⁴⁰	<p><i>Description</i></p> <ul style="list-style-type: none"> • The 2008 Health Care Reform law required health care homes be made available for all Medicaid, CHIP, state employees, and privately insured individuals in MN. • The Department of Health developed MN health home standards and conducts annual, onsite accreditation of health homes annually, including private practices, clinics, and health centers • MCOs and FFS payers all pay the same per patient care coordination fee based on number of chronic conditions of the patients. • Outcome measurement focuses on patient- and family-centered care <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Strengthening primary care delivery is a necessary element of system transformation. • The ACO initiative supports health care home spread by requiring ACOs include HCH's or another strong base of primary care. <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • As of January 2013, there were 220 certified health homes with over 1600 certified providers, serving over 2 million patients <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • The Health Department certifies health homes based on MN-specific standards which exceed the NCQA standards in scope and in the requirement of an onsite assessment. • Recertification is required annually and HCH's must demonstrate improvement. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • There will be a legislatively mandated external evaluation
Pay for Performance⁴¹	<ul style="list-style-type: none"> • The 2008 Health Care Reform Law directed the development of incentive payments to reward high quality and promote improvement over time. • The law mandates inclusion of all state public health insurance programs and state employees benefit plan, with hope that other payers will follow. • In 2011 and 2012, the measures are: optimal diabetes and vascular care (physician/clinic quality measures) and appropriate inpatient care for acute myocardial infarction (AMI), heart failure, and pneumonia. The state is aligning quality measures used across all programs.⁴² • Earlier pay-for-performance incentives in place from 2003-2009 showed improvements in many categories, by many health plans.⁴³
Reducing ED use and readmissions	<ul style="list-style-type: none"> • Medicaid is participating in two QI projects with MCOs. • For ED use, the state experienced a reduction between the base year, 2009, and the first year of experience. However, in the second year, there has not been an improvement. • For readmissions, the plans and hospitals have been working collaboratively with ICSI to reduce readmissions. Program is called "RARE." Other payers have already been working on this topic. The baseline for readmissions was 2010, and they expect the 2011 data, when available, will show improvements.

⁴⁰ <http://www.health.state.mn.us/healthreform/homes/index.html>

⁴¹ <http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf>

⁴² http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestRelease&dDocName=dhs16_142133

⁴³ http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs16_160130.pdf

	<ul style="list-style-type: none"> • The anticipated readmissions improvements are thought to have contributed to lower MCO rates in the 2011 contract bidding process. • State is looking into increases in observation days and determining the implications.
Provider Profiling	<ul style="list-style-type: none"> • The 2008 law also authorizes the development of an all-payer database and risk adjustment methodology to measure quality and price for hospital and physician services. The purpose of the database is to support prudent purchasing by all payers, including Medicaid and MCOs, as well as to create information and incentives that can lead to consumers choosing high quality, low cost providers. • The effort is being led by the MN Health Department.
Enrolling Dual Eligibles in Managed Care	<ul style="list-style-type: none"> • MN was awarded a CMS contract to develop integrated service and payment models for dual eligibles. • The plan is for full integration of Medicaid and Medicare services, including medical and behavioral health care, long term care, and social services. • Shared savings between Medicaid and Medicare intended

We would like to thank the following individuals for sharing their time and information: Scott Leitz, Assistant Commissioner, Health Care, Marie Zimmerman, Health Policy Director, Mark Hudson, Director, Managed Care and Purchasing, and Susan Castellano, Director, Performance Measurement.

OREGON	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 76% of Medicaid population enrolled in MCOs • 2012 interviews: 83% of Medicaid enrollees are in fully-capitated plans • 90% are in fully-capitated mental health plans and 95% in fully-capitated dental plans. • Newly eligible adults in 2014 will be in CCOs
Coordinated care organizations (CCOs)	<p><i>Description</i></p> <ul style="list-style-type: none"> • OR has begun widespread reform to move the Medicaid delivery system from one that is predominantly MCOs to one entirely based on Coordinated Care Organizations, as proposed by Gov. Kitzhaber and approved by the legislature in March 2012. • Medicaid has invited providers to form integrated delivery systems called CCOs and bid to deliver care to Medicaid beneficiaries starting August 1, 2012 and dual eligibles starting January 1, 2013. • Key features of CCOs include: a global budget for Medicaid costs including mental, physical, and later dental health care; CCO responsibility for care management, integration, quality, and reduction of disparities; governance by a partnership of providers, community, and those with financial responsibility and risk (Medicaid and later Medicare as well). • Plans are to look for alternative methods (to FFS) of paying providers that help them achieve goals for quality and cost. • Quality and financial solvency requirements are being established with stakeholder input. <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Health care costs are unaffordable, even while disparities continue. Lack of coordination is a pervasive problem. Better outcomes are possible for less money. The state's vision is the triple aim to improve outcomes, reduce costs, and improve health. • Governor is a strong advocate of health reform. • OR has a long tradition of community-involvement in setting direction in health care policy <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • Planning and development meetings have been taking place for 18 months. • Legislation passed March 2, 2012 • OR sought changes to its 1115 waiver to permit a global budget which will allow the state to pay for some services and supports that are not "medically necessary," to modify some provider payment rates set at the federal level (FQHC's) and to cap spending growth. In May, CMS approved the proposal. • OR expects to sign contracts with the new CCOs by the end of June • Next steps: continue public process to work on implementing SB1580; and to work on the Medicare-Medicaid integration proposal (now through Jan 2013). <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Extensive community, provider, and plan involvement in discussions to get to this design. • Governor's plan includes spread of CCOs to other payers once successful for Medicaid <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • Federal approval needed to make several changes seen as key to the program's success including global budget, shared savings based on quality, CMS providing FFP for some non-traditional health workers, supporting PCMH's, and changing FQHC payment method. Some additional changes related to member communication and marketing provisions were also sought. <p><i>Challenges</i></p> <ul style="list-style-type: none"> • Transformation is a process. Some CCOs will be ready to meet quality and care management goals quickly, while others will take 3-5 years. OHP will provide technical assistance, learning collaboratives, and other supports to help achieve the goals. • Breaking down silos to truly integrate care (particularly speaking about physical and mental health) • The frontier areas lack the infrastructure at this time, though it is being developed

	<p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> Medicaid expects savings of \$11 billion over the next decade.⁴⁴
Medicare-Medicaid Alignment Demonstration Project	<ul style="list-style-type: none"> OR has begun to plan how the integration of services and funds could work, but need to wait on CMS guidance. OR hopes to solicit bids in the summer, write contracts in the Fall, and begin operations 1/1/13.
PCMH/Health Homes (Section 2703)	<ul style="list-style-type: none"> OR's PCMH program targets enhancements in medical homes for all populations covered by the Oregon Health Authority, including Medicaid and public employees. CMS has granted OR approval to pay for care coordination and panel management services for people eligible under Section 2703 of the ACA. OR has additionally sought CMS approval to pay for these additional services for all Medicaid enrollees. Using the NCQA MH standards, and a PMPM fee associated with each tier Any practice can get certified and be eligible for enhanced payments CCOs are supposed to use PCMH's to the extent they are available in the service area
Pay for Performance	<ul style="list-style-type: none"> Not at this time for state payment to CCOs Will be incorporated into CCOs payment to providers

We would like to thank the following individuals for sharing their time and information: Judy Mohr Peterson, Director, Medical Assistance Programs, Oregon Health Authority

⁴⁴Press release from Governor Kitzhaber's office:

http://governor.oregon.gov/Gov/media_room/press_releases/p2012/press_050312.shtml

PENNSYLVANIA	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 54% of Medicaid population enrolled in MCOs • 2012 interviews: Risk-based managed care is mandatory in 25 urban and suburban counties; voluntary in 26 counties, covering about 2/3 of non-dual Medicaid population • New: expanding mandatory managed care to virtually all Medicaid enrollees; eg, into rural counties in 2012; newly eligible population under ACA will be enrolled in MCOs <ul style="list-style-type: none"> ○ 8 MCOs serve Medicaid members in state divided into 3 geographic zones ○ Behavioral health is carved out • PCCM: ACCESS Plus in 42 rural counties serves 1/3 of non-duals as well as all dual-eligibles under 21 years old • Fee-for-service: only for dual eligibles age 21+
Pay for Performance	<p><i>Description</i></p> <ul style="list-style-type: none"> • Based on 12 HEDIS® measures; Plan to add avoidable readmissions in 2013; payments for: <ul style="list-style-type: none"> ○ Incremental improvement over prior year score ○ Reach NCQA benchmark • Rewards are above actuarial-based capitation, equivalent to .5% of premium (reduced from about 2% due to state budget pressures) • Financial penalty if a plan does not meet 50th percentile on HEDIS measure • Plans report performance measures quarterly <p>Poor performance plans required to submit corrective action plan <i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • MCOs, members, Medical Assistance Advisory Committee, industry experts and DPW staff • Collaborative approach to major design questions, including: number and type of performance measures, fair and effective methodology, reasonable performance expectations (goals), amount of incentive dollars at stake, consideration of unintended consequences • MCOs appreciated rewards above capitation rates <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • A 6-year evaluation (2005-2010) found performance improved though the impact varies by plan⁴⁵ <ul style="list-style-type: none"> ○ Quality improved for 11 of 12 P4P measures between the baseline year and CY 2010 ○ 9 of 11 HEDIS® measures met or exceeded the NCQA 50th percentile benchmark in CY 2010
Efficiency Adjustments	<p><i>Description</i></p> <ul style="list-style-type: none"> • State makes “efficiency adjustments” -- reductions in MCO rates -- when assess preventable/unnecessary care in Inpatient, Emergency Department, Pharmacy, Outpatient • Metrics assessed: Ambulatory care sensitive admissions for adults and children; readmissions; C-section rates; low acuity non-emergent ED visits; high-tech radiology; dental; pharmacy-pricing, duplicative therapy, drug/diagnosis; TPL • With high C-section rates, DPW added C-section efficiency adjustments in 2008: It now pays a percentage of cesarean deliveries at the (lower) vaginal delivery rate in an effort to discourage unnecessary cesarean deliveries. <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • MCOs were not supportive when initiated <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • During the first year, Medicaid realized more than \$40 million in savings; the program spent \$107 million on PQI-related encounters • From 2007 to 2008, asthma and CHF admissions fell, but diabetes and COPD admissions increased • Benefits of program include:

⁴⁵ See http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/communication/s_002207.pdf

	<ul style="list-style-type: none"> ○ Transparency- puts PQIs/PDIs in the public domain ○ Can be used to evaluate the health system's coordination of outpatient care to prevent hospitalizations ○ PQI/PDI efficiency adjustments can focus MCOs on targeted care management strategies ○ Purchaser value in not paying for preventable inpatient stays
Auto assignment	<ul style="list-style-type: none"> ● Use P4P HEDIS scores for auto-assignment of enrollees who do not select plan
Special Needs Units/ Care Management Report	<ul style="list-style-type: none"> ● MCOs required contractually to have units that provide complex care management for members with special needs; this service may not be subcontracted to disease management companies ● "Special needs" may be defined by consumers, to include social needs, special health care needs, etc. ● MCOs must submit care management reports semi-annually containing #FTEs in unit, # and types of populations served, how they were served, how much care is being managed
Behavioral-Physical Health Integration	<ul style="list-style-type: none"> ● MCO contracts specify must work with behavioral health plans ● Data Sharing Pilot: pharmacy claims data are shared between MCOs and behavioral health plans via Medicaid (to avoid HIPAA concerns), fostering understanding of patient medication use. State is planning to expand claims sharing beyond pharmacy by early summer 2012. ● Innovations pilot: begun in June 2009 in the Philadelphia and Pittsburgh areas, includes collaboration between behavioral and physical health providers to use navigator model (Phila) and co-location/med home model (Pittsburgh) for more than 6,000 high risk patients with severe mental illness and/or substance abuse. MCOS, providers, and patient navigators share patient care plans, reported hospitalizations and medication adherence to each other. Preliminary data is showing significant reductions in inpatient and ED utilization.⁴⁶
Community Involvement Pillars	<ul style="list-style-type: none"> ● Last year DPW included in contracts 4 broad pillars to promote community involvement (no numerical requirements as of yet): <ul style="list-style-type: none"> ○ Embed care managers in medical practices ○ Develop transitions of care ○ Help PCPs achieve medical home status ○ Work with collaborative learning networks through the multi-payer Chronic Care Initiative
Core Teams and Access Data Base	<ul style="list-style-type: none"> ● RFP and contract based on performance measures makes monitoring critical ● Contract monitoring tools
Convene MCO Leaders and Share Best Practices	<ul style="list-style-type: none"> ● DPW shares each plan's P4P HEDIS scores with other plans; promotes competition and identification of improvement needs ● Medicaid Chief Medical Officer (CMO) and all MCOs' CMOs and heads of quality and utilization management meet quarterly to discuss HEDIS measures and improvement strategies that work and don't work; behavioral health plans attend twice/year ● Measures are also discussed with MCOs' top executives during semi-annual operations meetings ● DPW prepares and shares with MCOs a powerpoint grid with MCO QI activities
Consumer report	<ul style="list-style-type: none"> ● Annual report for consumers comparing health plans along dimensions:⁴⁷ <ul style="list-style-type: none"> ○ 9 quality measures ○ 9 access measures ○ 9 measures of how plans provide care for special need

⁴⁶ Full evaluation is in process. See preliminary findings at: http://www.chcs.org/usr_doc/PA-RCP_Early_Lessons_Brief051412.pdf

⁴⁷ See http://www.dpw.state.pa.us/ucmprd/groups/public/documents/communication/s_002194.pdf

SOUTH CAROLINA	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 50% of Medicaid population enrolled in MCOs • Approx. 70% in MCOs or Medical Home Network (PCCM with significant risk sharing) • There are 4 MMC plans and 3 medical home networks (enhanced primary care case management program with shared savings.) • New eligibles in 2014 will be in managed care.
Expanding Managed Care Enrollment	<p><i>Description</i></p> <ul style="list-style-type: none"> • Medicaid has funded the University of South Carolina to conduct claims analyses of quality and access in the three types of delivery systems – MCOs, MHNs, and FFS; and Milliman has conducted the financial analyses. Reports were issued in 2010 and 2011, and will be issued twice a year beginning in 2013 in order to support ongoing assignment and payment based on quality • This information has helped the state set programmatic direction, such as determining what populations should be served in more managed settings. Recently, data analysis has helped the state with decisions to move Foster Care beneficiaries and Duals into more coordinated programs. <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Legislature’s desire for comparative information about how well managed care works compared to FFS. <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • Began in 2009 (or 2007 – according to Ana) and is still active in 2012. • Quality reports were produced in 2010 and 2011, and will be published every six months beginning in 2013 <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Data analysis is an activity of Medicaid and its contracted analysts, but it has led to several collaborative activities among stakeholders, described below. <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • The legislature called for analysis of quality and costs to be able to compare the impact of Medicaid capitated managed care and Medical Home Networks relative to fee for service. <p><i>Challenges</i></p> <ul style="list-style-type: none"> • Some challenges to the data analysis methodology at the outset. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • Quality is better in both managed care environments relative to FFS, which helps the Medicaid agency gain support for expanding managed care enrollment. • New managed care contracts are under development for 2013 which put plans and providers at risk of performance and state officials are considering changes to the bidding process for 2014, including increased emphasis on achievement of quality standards. Another under consideration is to promote greater enrollee choice by holding open enrollment and sharing plan information with beneficiaries.
Care Coordination Improvement Group	<p><i>Description</i></p> <ul style="list-style-type: none"> • Medicaid convened a stakeholder group to review quality and cost-effectiveness data. • The Group has been discussing the best use of Medicaid funds and the necessary evolution of the delivery system in SC, primarily through payment reform. • Some small changes to Medicaid purchasing will take place this year (see pay for performance section) and there will be more in the future. • The director supports greater movement towards managed care because capitated payments to plans and providers will allow more flexibility in plan-provider arrangements, for example: <ul style="list-style-type: none"> ○ A large, capitated health plan and a large health care system have formed a 50/50 risk sharing partnership for the medical management of all the health plan members in a large, pilot county.

	<ul style="list-style-type: none"> ○ Palmetto Health Care System is paying physicians to achieve greater efficiency, and building support for physician practice transformation into contract with plans ○ Some plans choose to provide benefits because they contribute to health (e.g., adult preventive dental care) <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> ● Evidence of a high degree of variation in quality and cost-effectiveness in care being purchased, and a desire to make the best use of funds. <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> ● After reviewing 2011 analysis, the Medicaid Director formed this group in January 2012. <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> ● Medicaid, MCOs including BCBS (which is not only a Medicaid managed care plan but represents 60% of the private market), providers, and other stakeholders <p><i>Challenges</i></p> <ul style="list-style-type: none"> ● Plans want more time to prepare for performance-based contracting. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> ● Not yet, expect some modifications to payment methods and to care delivery systems, possibly including ACOs or other more integrated care models
Pay for Performance	<ul style="list-style-type: none"> ● Health plans have had a contractual requirement to carry out two quality improvement projects each year, one identified by the state and one that each plan selects. ● As of 7/1/12, Medicaid began withholding a portion of the total managed care contract amount (1% in 2012; 1.5% in 2013, est. at \$24 million), which plans can earn based on performance on quality activities. An additional 1% in incentives can be earned for PCMH achievement (by the practices) and for improved birth outcomes (by the plans) ● Stakeholders involved in planning include MCOs, hospital association, provider associations, and the March of Dimes (for birth outcomes portion). ● Medicaid has been meeting with BCBS to pursue alignment between Medicaid and BCBS's P4P and MH initiatives. ● Defining the focus and selecting the specific opportunities to pursue have been challenging. The group identified the need for payment reform, reducing the hassle factors for physicians (e.g., multiple standards as forms), and patient engagement.
Auto Assignment	<ul style="list-style-type: none"> ● Unassigned managed care-eligible beneficiaries are auto-assigned to health plans based on quality-weighted Health Plan Score Card results.
Improving Birth Outcomes	<ul style="list-style-type: none"> ● This program has four goals: <ul style="list-style-type: none"> ○ End elective pre-term births from 37-39 weeks ○ Promote the appropriate use of progesterone (17P) to prevent subsequent pre-term births ○ Screen and treat women at high risk for a bad birth outcome ○ Identify and target disparities in outcomes ● Improving birth outcomes is one of the 2011 health plan Quality Improvement Projects (QIPs) selected by the state. ● SC has poor indicators on prenatal care and birth outcomes ● Medicaid pays for 50% of all births in the state, so improving outcomes for Medicaid women can have a major effect on state health ● Planning began in June 2011 and first changes were implemented in October 2011. ● The first quarter of referral data will be analyzed in spring 2012. ● Providers will screen pregnant women for risk factors related to poor birth outcomes such as smoking, alcohol use, depression, and domestic violence. Results of the screener are sent to Medicaid, who has formed partnerships with other agencies to facilitate referrals for needed services. ● Plans are training their providers, and the state is training other non-plan providers on using the screener. ● The referral is tracked, with follow-up between the treating agency and Medicaid to assure

	<p>women get recommended care.</p> <ul style="list-style-type: none"> • Medicaid is working with other state agencies including mental health and substance abuse providers, health plans, providers. • SC is paying an enhanced rate for screening • Medicaid and other state agencies formed partnership to collaborate on screening, referral, treatment, and follow-up • The first quarter of data show a very small and not significant drop in preterm births and NICU utilization. • Over the first six months of the program, 981 women have been screened, with 344 at risk of a poor birth outcome, and 113 have been referred for treatment. The gap between a positive screen and a referral is being investigated, and improvements are being made to improve reporting and referrals.
Pediatric Asthma QI Initiative	<ul style="list-style-type: none"> • Improvements have been seen in HEDIS asthma data over time as plans and providers have worked on asthma care. • However, a geographic analysis of asthma hospitalizations, ED visits, and missed school days, showed that outcomes were poor. • Medicaid convened a group of plans, medical providers, and USC researchers to discuss improvement opportunities. • Data sharing between state agencies is a key part of this initiative – linking data sets, e.g. across Medicaid, school system, juvenile justice system, mental health agency, and hospital data allows them to identify Medicaid enrollees’ missed school days and use of various services • Each plan had to develop an improvement plan, which the state reviewed in December 2011. • In April 2012, they will review plans first quarter of experience on asthma care. • CHIPRA practices (those who are voluntarily working to improve child health with federal CHIPRA funding) are working on it as part of their commitment to quality PDSA cycles • As a result of sharing best practices, the state has agreed to reimburse for a second spacer to be used at school, which may encourage more students on asthma medication to adhere to the regimen.
Healthy Columbia	<ul style="list-style-type: none"> • The Eau Claire Cooperative Health Centers has been awarded a CMMI grant worth \$2.33 million over 3 years to support community health teams in low income areas of Columbia, SC. • Eau Claire will use health care teams of nurse practitioners, registered nurses, and community health workers affiliated with a Federally Qualified Health Center to provide patient education, home visits, and care coordination, leading to reduced use of high cost health care services, including emergency room visits and hospitalizations, improved self-management for patients with chronic conditions, a decrease in low birth weight infant care, and improved health outcomes in general.

We would like to thank the following individuals for sharing their time and information: Anthony Keck, Medicaid Director; Jennifer Campbell, Director of Managed Care; Deirdre Singleton, Chief of Staff; and Ana Lopez-De Fede, Research Professor, Institute for Family Health, USC.

TENNESSEE	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 96% of Medicaid population enrolled in MCOs • Most TennCare enrollees are in full-risk managed care; however, out of a total enrollment of about 1.2 million, about 50,000 children in the custody of the state, SSI children, and developmentally disabled adults are enrolled in a partially capitated plan, TennCare Select. • TennCare contracts with three managed care plans: UnitedHealthcare, Amerigroup, and Volunteer State Health Plan, which is the Blue Cross Blue Shield plan of Tennessee. • The program anticipates 250,000 new enrollees in full risk MCOs when the Medicaid expansion takes effect in 2014.
Integration of Behavioral and Long-term Health Care	<ul style="list-style-type: none"> • TN integrated behavioral health and physical health services starting in 2007, region by region, with the transition completed in 2009 • The transition was motivated by a desire to improve quality and increase coordination for high risk group • Because of the substantial overlap between behavioral and physical health care, TN believed integration at the plan level would lay the foundation for greater integration at the provider level • The state has achieved better integration between primary care and care for serious mental illness, which has been reflected in their HEDIS scores • TennCare's readiness reviews in preparation for the change made clear that the managed care staff responsible for administering the behavioral and physical health benefits must be co-located, with protocols for how they will be coordinated. • The Medicaid agency took on a lot of responsibility from the Department of Mental Health when the integration took place • There was concern from the mental health community prior to the change that care for serious mental illness would be "lost" once integration took place, because the financing for mental health services would no longer be carved out • TN took steps to address these concerns using targeted funding, for example by initially making an extra "kicker" payment to providers serving patients with serious mental illness, which was later rolled into the capitation rate; they also used funding from the mental health agency to strengthen crisis stabilization units • Long-term care was integrated into the existing MCO contracts in 2010, to eliminate the incentive toward institutional care created by carving out long-term care, and to better coordinate long-term and other services • There has been a shift toward educating people better about alternatives to nursing home care and services that can help them stay in their homes <ul style="list-style-type: none"> ○ TN has seen a substantial reduction in nursing home use since 2010: from 82.5% of long-term care enrollees in nursing homes in 2010, to 68% in nursing home (with the remainder receiving home and community-based services) in January 2012
Disease Management Requirements	<p><i>Description</i></p> <ul style="list-style-type: none"> • TennCare has disease management requirements for ten conditions: maternity care management, in particular high-risk obstetrics; diabetes; congestive heart failure; asthma; coronary artery disease; chronic-obstructive pulmonary disease; obesity; bipolar disorder; major depression; and schizophrenia. • Plans may develop their own strategies to manage each condition, within the constraints of NCQA standards and some general requirements in the contract • When the requirements were first implemented in 2005, disease management was population-based, without much stratification according to disease severity or patient needs, but as the field has progressed both nationally and in TN since then, it has become more reliant on predictive modeling that can identify high-risk individuals <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Quality improvement and pressure to control program costs led to a variety of program

	<p>changes at the time these requirements were implemented (though TN emphasized that the purpose of the disease management program is quality improvement and substantial cost savings are not expected)</p> <ul style="list-style-type: none"> • The disease management changes were made solely through changes to the TennCare contract, and did not require a waiver or legislation <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • Implemented new disease management requirements in about 2005, at a time when significant budget challenges had motivated a variety of policy changes, including a shift to full-risk managed care (in the mid-late 1990s, the state had tried full-risk managed care and then moved away from it in the early 2000’s – the 2005 transition was its second effort to implement full-risk managed care) • The disease management program started with a few physical health measures (behavioral health was carved out at the time) and gradually added additional measures – eventually including behavioral health <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • MCOs have had a lot of input into the development of the requirements, and share strategies and data related to carrying them out • TennCare has face-to-face meetings with all plans on a quarterly basis at which they see each other’s performance data and share information about their strategies and the outcomes • In the first few years, plans were reluctant to share information, but now are more transparent with each other <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • The purpose of this strategy has been to improve quality, rather than to save money – they don’t expect to see substantial savings • Their evaluations have focused on the quality impact – measures have included: <ul style="list-style-type: none"> ○ Utilization ○ Inpatient admissions ○ Readmissions • They have found improvement in some areas, not in others – maternity has been a successful area because they are able to engage the members • They measure both disease non-disease outcomes such as satisfaction and quality of life, which have shown improvement • Challenges include engaging and retaining members in care, adherence to treatment plans and medication • The disease management programs are typically separate for separate diseases and differ among plans, and members often have more than one condition, making reporting and attributing improvements to specific programs difficult
<p>HEDIS reporting and public reports</p>	<ul style="list-style-type: none"> • All plans are required to report all HEDIS measures, not just those required for NCQA accreditation, and also 3 sets of CAHPS measures (children, adults, and children with special health care needs) • The state’s EQRO compiles all the plans’ HEDIS and CAHPS data into an annual public report that allows easy comparisons between plans • TennCare holds quarterly “Voice of the Customer” meetings with each plan individually, to review past performance relative to other health plans and to discuss future initiatives • MCOs are also required to report race and ethnicity data
<p>NCQA Accreditation of Plans with State subsidies</p>	<ul style="list-style-type: none"> • Requires NCQA accreditation of plans (starting in 2005 – TN was the first state to require this) • From the beginning, the state established in its contract language that it would reimburse MCOs for a portion of the direct costs of becoming accredited, on a scale commensurate with their level of accreditation – i.e., plans that achieved the highest level had all of their costs paid, those at the next level had 75% of their costs paid, etc. • The state laid out an aggressive timeline with benchmarks for plan accreditation and was successful

Pay for Performance	<ul style="list-style-type: none"> • TN has a pay-for-performance program that provides a reward of three cents per member per month above the capitation rate, per measure, for 8-10 HEDIS measures according to an NCQA methodology that sets improvement targets based on plans' starting level of performance • Penalty: \$5,000 for each full percentage point EPSDT screening ratio is below 80 percent • Plans also can and some do have their own pay-for-performance programs with network providers
Performance Improvement Plans	<ul style="list-style-type: none"> • TN has always required plans to conduct 5 Performance Improvement Plans (PIPs) annually; one must focus on behavioral health, two on long-term care, and two are at the plans' discretion, with the approval of TennCare • In a given year, if the state has identified a particular priority, it may be more proscriptive about PIP topics
MCO Collaboration	<ul style="list-style-type: none"> • Statewide MCO Collaborative: In addition, MCOs and staff from TennCare and the Department of Health participate in a Managed Care Contractor (MCC) Collaborative. Meetings are held on a quarterly basis to identify innovative methods of providing TENNderCARE outreach to Youth under the age of 21 with a focus on teens
Results Observed	<ul style="list-style-type: none"> • Well-child screening rates in TennCare have shown steady growth from 1999-2009 • Member satisfaction in TennCare improved dramatically over 1994-2011, with satisfaction above 90% in 2011 • 6 out of 8 adult diabetes HEDIS measures improved from 2006 to 2010 • 5 out of 6 women's health HEDIS measures improved from 2006 to 2010 • All 12 child health measures improved from 2006 to 2010

We would like to thank the following individuals for sharing their time and information: Wendy Long, MD, MPH, Chief Medical Officer, Bureau of TennCare.

TEXAS	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 47% of Medicaid population enrolled in MCOs • As of June 1, 2012 Medicaid managed care programs include: <ul style="list-style-type: none"> ○ STAR program (managed care for pregnant women, children, and TANF) enrollment totaled 2,482,461 ○ STAR+PLUS (managed long-term care) enrollment totaled 400,790 • Texas continues to expand mandatory Medicaid managed care including moving PCCM enrollees into fully capitated managed care. Some parts of the state are adding MCOs for the first time. In March 2012, the legislature mandated pharmacy services be “carved-in” to MCOs and children be enrolled in managed dental care plan(s). • Interviewees anticipate the legislature will continue to move Medicaid beneficiaries into MCOs
Regional Health Care Partnerships	<ul style="list-style-type: none"> • The 1115 Medicaid waiver being implemented in 2012 includes plans to develop regional health care partnerships (RHPs) that would develop and implement delivery system reforms on a regional basis. • RHPs are being developed and led by public hospitals or local governmental entities in partnership with regional health stakeholders, in a process taking place starting in May 2012 • RHPs will be responsible for developing five-year plans that outline projects and interventions that support delivery system reforms tailored to the needs of their communities and populations • The plans will include regional assessments, identify the regional goals, rationale for projects, annual milestones associated metrics, and expected results • Plans will also include coordination of current state-funded indigent care programs to transition those programs to anticipated coverage expansions in 2014
Performance-Based Incentives & Disincentives	<p><i>Description</i></p> <ul style="list-style-type: none"> • Starting March 1, 2012, TX is increasing the performance incentive pool from 1% of plans’ capitation rates to 5% as a greater incentive to improve quality. Plans can earn back the withheld amount based on their performance on quality metrics. <ul style="list-style-type: none"> ○ For the first year, metrics will be primarily administrative – for example, provider network adequacy, percentage of claims paid on time, and call center accessibility. ○ During the second year, the metrics will shift toward clinical quality measures, but these have not yet been selected • Any funds that are withheld and not distributed will go toward a “Quality Challenge Award” that would be distributed to plans that perform well on clinical quality measures (these measures are different from the metrics that will be used to distribute the amount withheld from the capitation rate).⁴⁸ <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> • Looked at other states and recognized that some others were using larger performance incentives - 3-5% of rates rather than the 1% withholding that Texas had been using <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • For about 4 years, Texas had a 1% withhold for performance improvement but found that plans were meeting the administrative criteria, leaving no money available to incentivize quality improvements. • The new health plan RFP gave them an opportunity to test a new approach. They sought an even higher withhold level, but CMS has only approved 5% due to concerns about actuarial soundness of plans. • The 5% rate withhold began March 2012. Statewide data will take about a year to collect due to claims lag and new system development in some parts of the state.

⁴⁸ If one or more MCOs does not earn the full amount of the performance-based at-risk portion of the Capitation Rate, the money goes to the MCO Program’s Quality Challenge Award, where it is used to reward MCOs with superior clinical quality, service delivery, access to care, and/or member satisfaction.

	<p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Consumers have not been involved in STAR program changes, though STAR PLUS consumers are much more activated and are expected to be involved in future quality incentives related to duals. <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • CMS approval required as part of waiver. • State implemented the incentives through their contracting process. <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • Data on clinical quality will not be available until after measures are implemented next year
<p>Quality Advisory Committee</p>	<ul style="list-style-type: none"> • S.B. 7 (2011), and the 2012-13 General Appropriations Act, H.B. 1 included a variety of state-level health reforms but also provisions intended to motivate the development of a broad quality improvement strategy for publicly-financed care in Texas. • Among the initiatives included was a quality advisory committee that will be working with all relevant agencies, and with MCO stakeholders, to shape quality strategies including patient-centered medical homes and provider incentives • The quality advisory committee will be building on existing requirements for plans to define how they will conduct disease management activities to support medical homes – the goal is to standardize these requirements further, not with legislation but in contracting requirements • A range of stakeholders are involved in the quality advisory committee including advocates, consumers, plans, and state officials • Strategy and metrics not yet identified
<p>Quality dashboard</p>	<ul style="list-style-type: none"> • Texas tracks HEDIS, CAHPS and other measures across all plans using a dashboard that includes many measures • There are no financial incentives directly tied to the dashboard, but it is used to identify trends, set overall program goals and select areas of focus for plan Performance Improvement Projects (PIPs) • The Medicaid program sets two goals, and each plan also submits a goal of its own • Based on these goals, each plan does three PIPs for each part of the Medicaid program in which it operates (e.g., STAR, STAR+PLUS)

We would like to thank the following individuals for sharing their time and information: Scott Schalchlin, Director of Health Plan Operations, Medicaid/CHIP Division, Eugenia Andrew, MCO Quality Assurance Manager and Julia Marsh-Klepac, Team Lead, MCO Quality Assurance, Medicaid/CHIP Division, Texas Health and Human Services Commission.

VERMONT	
Medicaid Managed Care	<ul style="list-style-type: none"> • CMS July 2011: 58% of Medicaid population enrolled through “Global Commitment to Health” demonstration initiative (described below), whereby the state Medicaid organization became a Managed Care Entity and adheres to Medicaid MCO rules • The Department of Vermont Health Access (DVHA), within the Agency for Human Services (the designated state Medicaid agency), operates the managed care model for publicly funded populations; No other MCOs serve Medicaid enrollees • More than half of Medicaid members are in ‘Blueprint’ practices (described below); for the remaining members, physicians are reimbursed under FFS, hospitals reimbursed through DRG reimbursement; Medicaid rates and changes are approved by the legislature
Blueprint Model (medical home, community care teams, CHT extenders)	<p><i>Description</i></p> <ul style="list-style-type: none"> • Multi-payer care delivery reform including Medicaid, Medicare, large commercial insurers • Administered by the Vermont Agency for Human Services; • Model includes: <ul style="list-style-type: none"> ○ Advanced Primary Care Medical Practices (APCPs) – FFS + PMPM based on NCQA medical home recognition level ○ Community Health Teams (CHTs) – supported by all payers ○ CHT Extenders – for complex patients: Medicaid Care Coordinators under VT Chronic Care Initiative (VCCI) for Medicaid (protocols determine whether a Medicaid patient is more appropriate for CHT or Medicaid Care Coordinator); ‘SASH’ teams for Medicare ○ IT Support & Quality Assessment – state supported <p><i>Impetus/Drivers</i> Launched in 2003, Vermont’s Blueprint for Health seeks to improve the health of all Vermonters, but includes a particular focus on those with chronic conditions.</p> <p><i>Development & Timeline</i></p> <ul style="list-style-type: none"> • 64% of state population and 29% of Medicaid beneficiaries in BP practices as of October 2012, plan to shift nearly entire population including all Medicaid beneficiaries in 2013 • Legislative statute: all ‘willing’ providers will participate in Blueprint by Oct 2013 <p><i>Stakeholder Involvement</i></p> <ul style="list-style-type: none"> • Collaborative environment, facilitated by: small number of providers, very few payers (3 commercial insurers, supportive legislature and governor) • Legislation mandates that all insurers must participate and contribute PMPM and toward CHTs • Medicaid is heavily involved: sits on all Blueprint executive committees, contributes toward PMPM and CHT, pays all costs of Medicaid CHT extenders (Medicaid Care Coordinators) who are fully integrated into care teams, provides IT (EMR assistance) and quality assessment support • Stakeholder involvement is considered the key to success <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • In 2006 the Blueprint was endorsed in state legislation (Act 191) as Vermont’s plan for a statewide system of care • In 2010 further legislation (Act 128) established a schedule for the statewide implementation of the Blueprint by 2013 <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • Early evaluation of pilot communities shows positive trends re: cost and quality; currently in Level/Phase 1; evaluation due in 2013 • Expect to move more Medicaid enrollees into BP
Payment Reform Pilots	<ul style="list-style-type: none"> • State is collaborating with providers and payers to develop payment reform pilots based on hospital-physician/FQHC partnerships including: <ul style="list-style-type: none"> ○ bundled payments; ○ global budget;

	<ul style="list-style-type: none"> ○ ACO/population-based payment to risk-bearing entity ● OneCare Vermont ACO (led by Dartmouth Hitchcock health system and Fletcher Allan Health Care (FAHC) and including multiple providers across state) is expected to begin early 2013 for Medicare members, and to include Medicaid and commercial payers in 2014/2015 ● Other multi-payer payment pilots in development ● State is exploring ways to use a “Unified Health Care Budget” to constrain total costs with accountable care organizations (ACOs)/ payment pilots, and other strategies
State Managed Care Entity with Care Coordinators (VCCI)	<p><i>Description</i></p> <ul style="list-style-type: none"> ● The Department of Vermont Health Access is responsible for operating the managed care model. More than 95 percent of Vermont’s program participants are enrolled in the Global Commitment Demonstration ● VT’s publicly funded health insurance programs under the Green Mountain Care set of products include: Medicaid, Vermont Health Access Plan (for low income adults), Dr. Dynasaur (subsidized coverage for children and pregnant women); miscellaneous pharmacy and premium assistance programs ● DVHA monitors quality and access, reporting HEDIS measures based on claims data to an EQRO ● DVHA implements targeted PIPs to address areas with low HEDIS scores <ul style="list-style-type: none"> ○ Recent PIPs include Heart failure initiative, screening for developmental delays ○ One formal PIP at a time through EQRO, with about 4-5 improvement initiatives ongoing ● Under the Vermont Chronic Care Initiative (VCCI), Medicaid employs 30 care coordinators (registered nurses and medical social workers) to provide face-to-face case management to Medicaid, Dr. Dynasaur and DVHAP members with chronic conditions and/or complex health problems (targeting 5% highest risk Medicaid population). Care coordinators: <ul style="list-style-type: none"> ○ Are based in physician offices, field district offices, hospital ERs and other community sites with high density of Medicaid beneficiaries ○ Provide coordination across specialists/providers, health coaching, connections with other resources available in communities and from the state (e.g., housing, food supports) ○ Work with medical offices to provide population management (e.g., ensure members receive preventative care, medications) ○ Also contact members identified through claims-based risk stratification and ER referrals with high number of non-emergent ER visits ● DVHA’s Quality Improvement and Clinical Integrity unit employs clinical care coordinators to conduct concurrent utilization review and discharge planning for certain members, including children hospitalized for a mental health condition and adults hospitalized for medical detoxification services. The care managers collaborate with inpatient facilities and other agencies to reduce barriers to discharge and ensure patients receive necessary services ● DVHA delegates responsibility through intergovernmental agreements with other state departments (eg, Mental Health, Children and Family Services) to provide specific services <p><i>Impetus/Drivers</i></p> <ul style="list-style-type: none"> ● Pursued global waiver to enhance financial and programmatic flexibility to expand coverage and services, and better manage care for covered populations ● Other activities driven by belief that coordination of care under holistic approach for highest-risk members can ensure needed services and reduce costs <p><i>Evolution/Timeline</i></p> <ul style="list-style-type: none"> ● In 2005 Vermont entered into a five-year comprehensive 1115 Federal Medicaid

	<p>Demonstration Waiver named Global Commitment to Health (GC).</p> <ul style="list-style-type: none"> • In 2007, CMS approved request to include Catamount Health and the Employer-Sponsored Insurance (ESI) premium assistance programs under the financial umbrella of this waiver⁴⁹ • In 2009, CMS approved request to include Catamount Health and the Employer-Sponsored Insurance (ESI) premium assistance programs over 200 % (but under 300%) under the financial umbrella of this waiver. • VCCI began in 2007 with telephonic and on-site care management; in 2011, shifted to fully community-based placement with face-to-face contact <p><i>State & Federal Actions</i></p> <ul style="list-style-type: none"> • State legislation approved global commitment waiver and annual changes in Medicaid reimbursement rates and overall budget CMS approved demonstration waiver and request to include additional programs <p><i>Impact on Quality & Cost-Effectiveness (expected or achieved)</i></p> <ul style="list-style-type: none"> • Members receiving VCCI services during SFY 2010 had: <ul style="list-style-type: none"> ○ 11% lower inpatient utilization and 6.5% lower ER use compared with baseline ○ Higher prescription fulfillment (5.6-23.5%) and evidence-based testing (10.8-16.5%) than comparable members not receiving VCCI services • Addition of one care manager position for discharge planning resulted in reduction in inpatient days (initial and readmissions), with estimated cost savings of over \$1 million in its first year.⁵⁰
<p>Opiate Dependency Programs</p>	<p><i>Hub & Spoke</i></p> <ul style="list-style-type: none"> • Proposed new system of care for medication assisted therapy (MAT) patients to create a coordinated systematic response to the complex issue of addiction. It is intended to improve health outcomes, improve access for new patients, address high direct and indirect costs associated with high rates of co-occurring mental health and other health issues resulting in high use of emergency rooms, pharmacy benefits, and other health care services; • Program would establish: <ul style="list-style-type: none"> ○ Hubs: specialty treatment centers responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care ○ Spokes: the ongoing care system comprised of a prescribing physician and collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services; for Blueprint patients, spokes may be PCPs that team up with mental health counselors and nurses from CHTs • Assuming State Plan Amendment under ACA Section 2703 for Health Homes and SFY 2013 ADAP appropriation request are approved, new system is cost neutral for first two years (SFY 2013-2014) • There will be five specialty hubs statewide for individuals with co-occurring substance abuse and mental health conditions. Two additional clinicians (nurses and licensed counselors) will be added to physician practices for every 100 patients to support care coordination. • 3,400 eligibles <p><i>Global Budget Pilot</i></p> <ul style="list-style-type: none"> • In addition to participating in payment reform pilots (above), Medicaid is working with psychiatric providers to pilot a global budget for detoxification for opiate dependent patients. • One global payment will cover all services from one day before admission to 90 days after

⁴⁹ with the exception that federal match for premium assistance was approved only for people with household incomes at or below 200% FPL

⁵⁰ Draft memo to Vermont House Health Care Committee from Mark Larson, Commissioner, February 28, 2012, https://leg2.vermont.gov/sites/legislature/Committees/HCommittees/HealthCare/Committee%20Documents/2012_02_28_ReplyMemo_HHC_FY13_Budget-1.pdf

	<p>discharge</p> <ul style="list-style-type: none">• Providers expected to develop best practice protocols• Implementation planned for 2012; Medicaid will then consider global budgets for other high risk populations
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