

HUSKY A & B Restructuring Workgroup

Best Practices as a
Roadmap to the Future

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HUSKY Report Content

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Background and Context

- Senator Toni Harp asked the Connecticut Health Foundation (CT Health) to objectively assess models of care to re-structure the HUSKY A&B Program for the Managed Care Council
- CT Health responded by funding this effort
- Project done in collaboration with the HUSKY A&B Restructuring Workgroup with broad participation
 - Oversight and leadership from CT Health
 - Open, collaborative process with stakeholder input
 - Objective and data-driven process

Background: Goals and Objectives

- To support stakeholders in obtaining unbiased information to successfully re-structure the HUSKY A&B program
 - Identify factors in CT that support or hinder development and implementation of health care purchasing options
 - Obtain information on best practices
 - Identify research-based strategies to improve cost-effectiveness while maintaining or improving quality
 - Generally assess cost implications of different models
 - Identify pros and cons of relevant models
- This is NOT intended to be an evaluation of the CT program

Background: Scope of Work

- Step 1: Establish goals, objectives and criteria
- Step 2: Identify PPACA and state reform impact
- Step 3: Conduct best practice research
 - Targeted interviews with a selection of states (IL, MA, NC, OK, RI, TX)
 - Literature review overview
 - Expert interviews
- Step 4: Synthesize information
 - Document findings with pros and cons by model type (with consideration to landscape)
 - Develop financial scenarios
 - Suggest next steps

Context: Some Connecticut-Specific Factors to Consider

- Medicaid federal match rate at 50%
 - Per capita income prevents higher FFP
 - No use of county matching mechanisms (e.g., CA, NY, WI)
- Urban/rural mix of providers with dominant presence of “small” practices that are geographically dispersed
- Provider rates of payment (closer to 100% of Medicare is ideal) warrant consideration
- Many providers in CT are working on medical home efforts already in the commercial market
 - Remember that Medicaid is only a portion of each MD’s practice and the % of total business varies; volume gets attention as do multi-payor efforts
- Significant insurance industry presence
- Strong advocate presence
- Opportunity to improve transparency
- Significant workload for few Department staff

Context: Criteria for Model Development

- Value defined as both quality and cost-effectiveness
 - With an eye toward MLR and continuous improvement
- Feasibility from stakeholders' perspective
- Timely, transparent, accessible, credible data with a focus on health outcomes
- Accountability and adaptability
- Open relationships that facilitate trust
- Integration/coordination for consumers & families

Models Reviewed

- Pure Fee For Service (FFS)
- PCCM
- MCO
- ASO

Included in the original project scope

- ACO
- Medical Home
- Health Home

Added to scope given prevalence of models in the literature, legislation and/or pilots (ACO, Medical Home and Health Home)

(Pure) FFS Key Model Features

- Focus on paying for services vs. purchasing value
- Providers receive a fee for each service provided (e.g. office visit)
 - Generally state-specific rules surrounding prior authorization and monitoring for a very limited number of services
- Consumers can go where they want (e.g. no consistency encouraged) for primary and specialty care and typically like this model
- States can control payment rates but not volume; no incentives to coordinate or manage
- Generally serves special populations that are excluded from managed care (e.g. persons with dual eligibility) in FFS
- Without quality incentives and very limited cost controls, it is hard to deliver value, including quality or cost-effectiveness
 - States conduct varying levels of prior authorization (PA) in FFS
 - PA is typically viewed by medical professionals as being useful for a limited number of high-cost, low-volume services
- Improved outcomes is not a focus
- Most states do not consider Pure FFS a viable model

ASO Programs Key Model Features

- Medicaid Fiscal Agents (FAs) typically provide ASO services on a non-risk basis
 - Claims administration, customer service, network “management”, care coordination, utilization management, reporting, provider relations, etc.
- FAs typically deliver specific services (e.g. BH, dental, pharmacy) with value added for a specific service (if at all)
 - If ASO services are wrapped around a PCCM properly, it could be viable; however, incorporating the full continuum of services is not typical and ultimately, claims would still be paid on a Pure FFS basis
 - Typically includes outsourcing of claims, network and contracting
- Some states have implemented BH programs that are well regarded in an ASO arrangement with vendor incentives
- Employers (and to some degree, Medicare) can contract out policy-like functions (e.g. payment rates and medical policy)
 - States can’t delegate “governmental functions” (e.g. rate setting)
- Very difficult to control costs given similarities to FFS but modifications are possible, especially for quality incentives

MCO Program Key Model Features

- Consumers (ideally) select a plan or Managed Care Organization (MCO) and a PCP within the health plan
- Health plans are capitated; spending is “fixed” and varies with volume
- Management of high-risk, high-cost clients is a typical focus
- The program is only as good as the level of attention paid: purchasing standards, data monitoring and levers are critical to managing
- States are similar with regard to:
 - Types of requirements (access, preventive care, service, reporting, etc.)
 - Delegation to MCOs to drive implementation of policy
 - Use of federal guidelines on MCO marketing efforts
- States vary with regard to:
 - The nature of the relationship (e.g. nature of oversight *and* collaboration)
 - How prescriptive they are re: meeting requirements
 - How much data they collect and publish
- States may be moving more toward the MCO option; however, this varies by numerous factors in states



PCCM Program Key Model Features

- Federal designation for authority to organize care for Medicaid consumers
- Primary Care Provider (PCP) to provide *and* coordinate care
- Per Member Per Month (PMPM) PCP fee; and/or some states pay higher fees for “Evaluation & Management”
- Care management of high-risk, high-cost clients is a focus in many (but not all) states (especially for ABD clients) sometimes called “Enhanced” PCCM
- The program is only as good as the level of attention paid and resources
- Completely unmanaged PCCM programs are like Pure FFS
- States utilize PCCM to:
 - Gain leverage with health plans by offering another option to consumers
 - Ensure access, especially in rural areas that lack managed care options
- States vary widely with regard to:
 - The rationale for offering a PCCM
 - Resources and oversight including data collected and published
 - Support offered to providers and /or consumers
- This model can be integrated with Medical Home, Health Home, ACO



Medical Homes Key Model Features

- Introduced by the AAP in 1967 with more popularity recently
- Approach to providing comprehensive, coordinated primary care w/ partnerships between patients and their personal physicians
- Additional key principles include: Physician directed medical practice; Whole-person orientation (and patient experience); Care is coordinated and/or integrated; Quality and safety are hallmarks (evidence-based, data-driven); Enhanced access; Payment recognizes value-added (by paying PCPs more)
- Pediatric Family Centered Medical Home includes medical and non-medical needs
- IT/Electronic records are part of this model (hard for many)
- Do not typically include true performance incentives
- Could be a strong complement to MCO, PCCM, ACO and are evolving
- NASPH is on a second round of pilots with states
- This model can be integrated with PCCM, MCO, ACO models



Health Homes Key Model Features

- Leverage Medical Homes with similar history and focus
 - Multi-disciplinary care: coordination of physical and BH + Long Term Care (LTC) and community-based care
- Consistent with data on multi-morbid condition management and priorities in Medicaid (co-management of physical and BH)
- 37 states planning or implementing health homes or medical homes for Medicaid populations
- Many multi-payor efforts (MA, CO, LA, ME, MN, NE, PA, RI and VT) as part of SCHIP or Medicaid emerging
- 90% federal match for states that create health homes for two years
 - Unclear what happens after two years
 - FFP is likely (if successful) at the usual match rate
 - States (and vendors) are trying to determine how to leverage this model
- Can be integrated into PCCM, MCO, ACO



Accountable Care Organizations: (ACO)

Key Model Features

- Theory without outcomes data (cost or quality) to prove its value in the Medicaid market YET
- Requires a big picture, long-term view; benefits will take time
- Typically an organization or consortium of provider types and locations (MD, hospital, home care, etc.) across a region or geographic areas (not a PCCM) who act as a provider team
- More information is provided than for other models here: the model promises good quality and cost outcomes and, because is not well known or understood
 - *Not because it is a proven best practice based on data*
- The promise results from the notion that this model:
 - Focuses on the patient and places responsibility at the provider level for delivering care with incentives for effective care delivery
 - Offers all of the resources and tools needed to manage effectively
 - Aligns incentives at the payor and provider level
- Can be combined with models such as PCCM (and elements can be combined with MCO too)



ACO Model: Combining Redesign and Payment Reform

Delivery System Redesign +

- Patient-centered care delivery
- Emphasis on primary care and prevention
- Evidenced-based practice
- Care management and coordination
- Technology-enabled care: electronic health records, e-prescribing, decision support
- Specific performance expectations: quality of care, patient safety, readmission reduction, disparity reduction
- Measurement and reporting of performance

Payment Reform =

- Replace fee-for-service with fee-for-value
- Performance risk: financial incentives for higher quality and reducing excess utilization
- Shared savings
- Flexible range of financial models, from FFS with shared savings to partial capitation

ACOs

- Quality care
- Cost savings

ACOs: Financial Incentive Models

	ACO Bonus Only	ACO Bonus and Penalty	Global Fee, Partial Cap
Responsibility	<ul style="list-style-type: none"> • Bonus for low spending • Bonus contingent on quality scores • No insurance or performance risk (no down-side) 	<ul style="list-style-type: none"> • Bonus for low spending • Penalty for higher spending • Partial performance risk but no insurance risk 	<ul style="list-style-type: none"> • Retain savings from low spending • Absorb cost of higher spending • Bonuses for quality • Partial insurance and performance risk
Operations	<ul style="list-style-type: none"> • FFS claiming as usual • Distribute bonus payments to ACO providers • Coordinate care 	<ul style="list-style-type: none"> • FFS claiming as usual • Distribute bonuses and pay penalties • Coordinate care 	<ul style="list-style-type: none"> • Receive global payment or partial capitation • Share net savings and losses with ACO providers • Coordinate care
Incentives	<ul style="list-style-type: none"> • Incentive to reduce volume, redesign care • Enough to compensate for lower FFS volume? 	<ul style="list-style-type: none"> • Strong incentive to constrain utilization and redesign care • But will provider volunteer for down-side risk? Especially poor performers? 	<ul style="list-style-type: none"> • Finances aligned with lower utilization growth and comprehensive care redesign

Source: Sellers Dorsey



Colorado Medicaid Approach to Accountable Care

- CO is working toward an ACO to replace Pure FFS delivery for 60,000 beneficiaries (initially)
- Approach is based on the Medical Home model;
- State will contract with “RCCOs” to support primary care practices (7 regions):
 - Support (but not manage) groups of practices
 - Case management of high-risk beneficiaries
- Hybrid payment mechanisms:
 - Regular FFS payments for services rendered +
 - Primary care coordination fee +
 - Incentives for improved care +
 - Shared savings planned for the future
- Operational challenges to implement and no outcomes data yet

ACO, Medical Home and Health Home Models: Common Characteristics

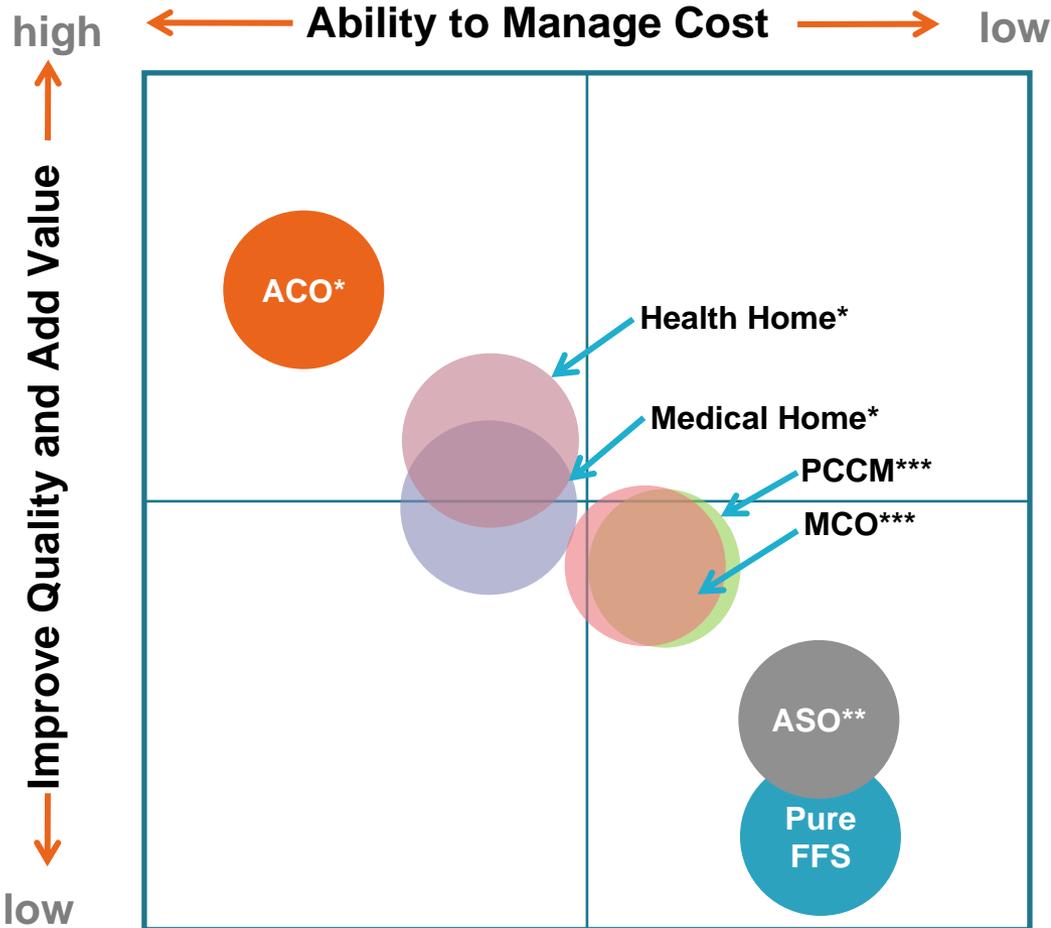
Characteristic	PCMH	ACO	Health Home
Lead provider*	Personal MD	PCP focus	Team-based interdisciplinary approach
Accountability	Physician-directed	Team-directed	Team-directed
Whole-person orientation	Comprehensive needs including acute, chronic, preventive and end-of-life	Care is patient-centered	Whole-person oriented including medical and behavioral health needs
Care integration	Coordination across elements of the system; sometimes more of a primary care focus	Care is integrated and coordinated. Comprehensive care redesign including the full continuum of services	Care is integrated with a focus on including BH and social supports
Quality-focus	Quality and safety are hallmarks. Measures focus on prevention.	Range of quality measures. Provider accountability via data collection, decision support, continuous improvement	Culture of continuous improvement with standards that require improvement at the individual and population-based levels
Enhancements to access	Key attribute achieved through a variety of strategies	Implicit in focus on accountability and patient-centeredness	Improved access includes preventive, BH, care management, coordination, chronic disease and LTC supports
Payment reform and reimbursement incentives	Payment recognizes value-adds for patients (typically no “incentives” or penalties for providers)	Payment reform is a key component and includes shared savings. Global fee (partial capitation) an option.	Increased FMAP at a rate of 90% is provided two years following implementation

* NCQA’s requirements include PAs. ACA allows PAs and APRNs to also act as PCPs.



Analysis: Adding Value

NOT representative of the HUSKY program



- The graph represents the intrinsic value of each model as defined irrespective of program management
- BUT...the true ability to add value depends on how each model is implemented. Keys to success are:
 - Effective management and oversight
 - Availability and effective use of key tools and best practices
 - Resources (Staff, vendors, knowledge, systems and DATA)
 - Opportunity to align the delivery system with incentives
 - Collaboration and trust
- Models can generate more value (beyond their basic characteristics) as these elements are increased
- Models can be “mixed and matched” (e.g. PCCM or ACO and PCMH or Health Home could theoretically result in an effective program)
- **Actual results depend on a multitude of factors**

*Theoretical only, limited data available

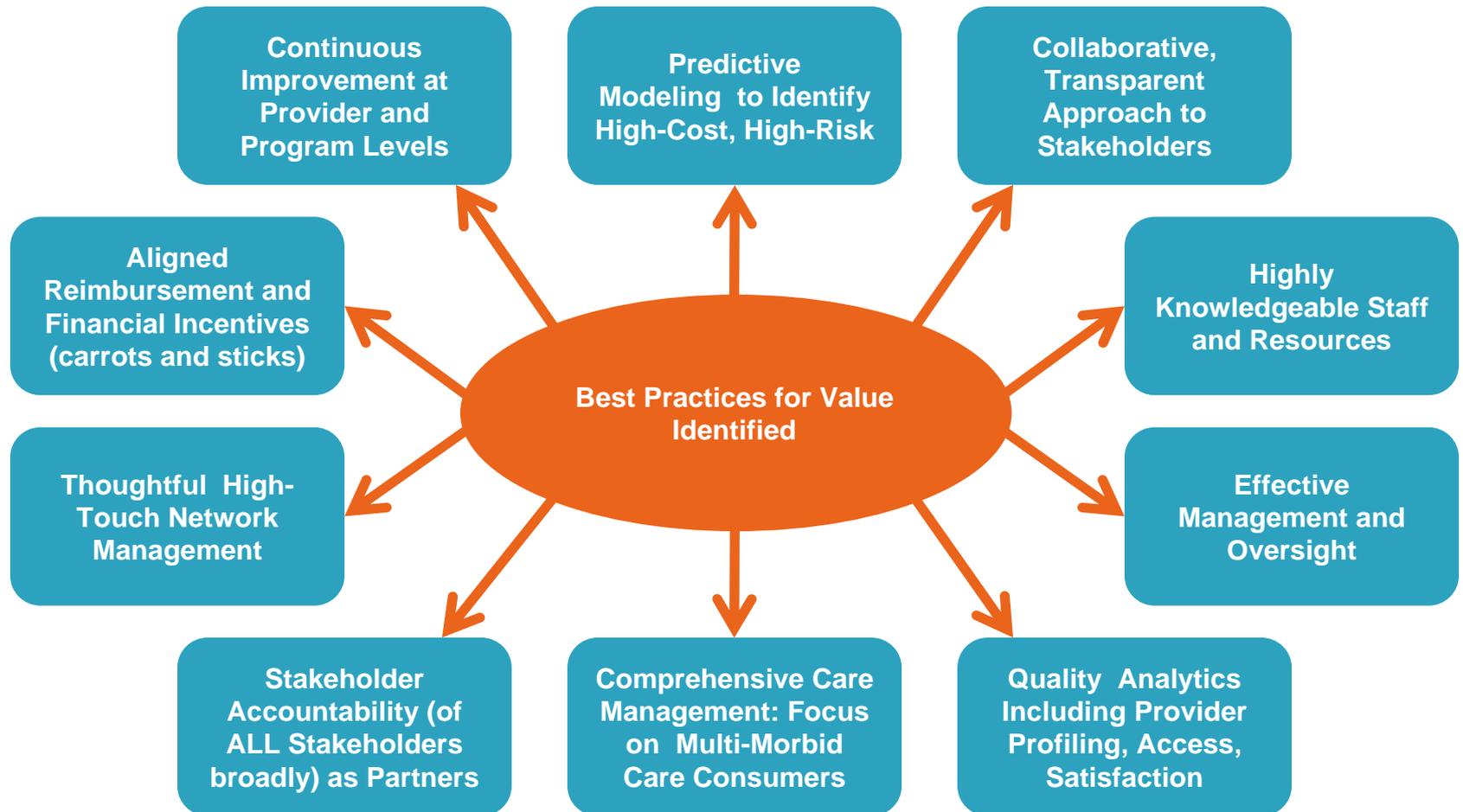
** Can add value on single carved-out services but reimbursement is typically FFS ; success depends on the model and how it is implemented; based on practices in states reviewed (excluding Connecticut)

*** PCCM and MCO are equal/fully overlapping in this theoretical chart; individual states Have varied (published and unpublished) results with each model



Analysis: Adding Value Via Delivery

System Design Determines Effectiveness



Quality Scenarios for Key Models [^], ^{^^}

	Quality Potential	Documented Improved Outcomes	Notes
Pure FFS	* or very limited	No	No mechanisms to manage or improve quality are present.
PCCM	*, ** or *** depending	Yes, typically for HEDIS measures and Case or Disease Management programs	PCCM programs vary widely. The care model can be effective based on staff, vendor and technical resources (e.g. data), state commitment to the program (driven by needs, budget, resources, etc.), use of vendors and their specific role as a resource.
MCO	*, ** or *** depending	Yes, typically for HEDIS measures and Case or Disease Management programs	MCO programs vary widely; however, resources tend to be present (because this is what MCOs do as a business). Ability to improve quality depends on state management and MCO ability and knowledge, resources (tied to rates of payment), relationship with the state, volume, and data resources among other factors.
ASO	*, depending	Improved performance for specific goals, initiatives or outcomes related to specific services	Incentives may exist to improve aspects of quality for a contracted service; however, does not typically address the full continuum of integrated services.
ACO	*** depending (anticipated)	Early unpublished positive results	Potential to improve quality depends on resources, staff, vendors, data, etc. And the specific way in which the model is implemented.
Medical Home/ Health Home	*** depending (anticipated)	Early unpublished positive results	Potential to improve quality depends on resources, staff, vendors, data, etc. And the specific way in which the model is implemented. HH is stronger than MH because of BH integration.

[^] Conceptual scenarios for illustrative purposes only. Actual results vary considerably based on policies, design, resources, incentives, population, etc.

^{^^} Models can be combined/mixed and matched which changes potential results

*Low potential outcomes improvement; ** = moderate potential and ***= high potential



Financial Scenarios for Key Models *,^

	Baseline Savings Potential Initial or Early Reduction in Costs**	Trend Line Savings Potential Reduction in Rate of Cost Growth **	Notes
Pure FFS	~0%	~0%	No significant savings absent changes to payment methods or program integrity efforts.
PCCM	~0% to ~3%***	~0% to 2%	PCCM programs vary widely. Care model can be effective but incentives are weak, tied to FFS.
MCO	~5%	~0% to 2%	Initial 5% is typical. Trend savings depend on rate setting and policy.
ASO	~0%	~0%	No significant savings absent changes to payment methods or program integrity efforts. Savings in specific areas possible (e.g., Rx, BH).
ACO	~5% to ~15%+	~2% to 3%	Strong savings potential, both in baseline and trend, from combo of care reform and incentives of shared savings.
MH / HH	~3% to ~10%+	~1% to 2%	Care model likely to generate savings. However, real potential depends on link to payment reform.

* Conceptual scenarios for illustrative purposes. Actual results vary considerably based on policies, design, incentives, population, resources, etc.

** In percentage points

*** Savings can increase over time as the program develops and becomes more robust

^ Models can be combined/mixed and matched which changes potential results



Health Reform Implications for CT

- Children covered by HUSKY between 100% and 133% of FPL will be transitioned to Medicaid; Medicaid roles will increase
- Many options for formation and operation of CT's State Exchange:
 - SustiNet as a Qualified Health Plan in Exchange?
 - SustiNet performing some Exchange functions?
 - Create a State-run Basic Health Plan via SustiNet?
 - Coordinate State's health plan purchasing across markets?
 - Open the Exchange to all employers in 2017?
- Long-term future of CHIP (as separate program) is uncertain at federal level after FY 2015. May continue or be wrapped within Medicaid and State Exchanges
- New options/tools to improve care for dual eligible population
- Federal waivers of ACA health reform requirements possible in 2017. An option if CT wants major reforms not possible under ACA

Health Reform Implications for CT

- Medicaid is driven by very specific rules that affect FFP
- Memorandum of Understanding (MOU) is anticipated between Sustinet; not a merger
- Best practices can (and should) run across populations
- The devil is in the detail
 - ▶ Medicaid benefits vary (e.g. definition of medical necessity)
 - ▶ Focus on LTC, community-based services and coordination with social supports
- *If the Council develops and implements best practices that are programatically consistent with Sustinet, improvements will work long-term*
- Value-based purchasing initiatives
- Provider-driven improvement
- Data and technology-driven

Analysis: Pure FFS

Criteria Defined for all Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> • Cost-effective (MLR) • Quality driven with continuous improvement 	<ul style="list-style-type: none"> - Enrollees may have access without many “rules” 	<ul style="list-style-type: none"> - Does not deliver value - Exposure for volume without value, coordination or possibly consistency - The model does not promote accountability - Costs cannot be predicted for services - Incentives are not aligned - Provider rates, hassle factor, etc. are important to get participation and increase access
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice • Offers convenience 	<ul style="list-style-type: none"> - Offers consumers access, choice and control (with limited rules) - Consumers typically view Pure FFS favorably (except authorization processes) - Has the ability to incorporate case management of high-cost, high-risk cases and/or Disease Management of high-risk patients 	<ul style="list-style-type: none"> - Lack of care coordination and management to assist the consumer
Provider Feasibility <ul style="list-style-type: none"> • Rates are seen as adequate (closer to Medicare is better) • Claim payment is timely • Low hassle factor 	<ul style="list-style-type: none"> - Can be viewed favorably by providers, especially if rates are acceptable and the provider serves a high volume of Medicaid consumers - Varies based on climate in state - Key elements of success are rates, administrative ease and ability to obtain support to treat (hard to serve) clients that typically does not exist in FFS systems - Providers who want to serve Medicaid will accept rates 	<ul style="list-style-type: none"> - Rates of payment may not be adequate; providers may not accept Medicaid limiting access
Payor Feasibility <ul style="list-style-type: none"> • Levers to manage • Need resources • Offers access to care • Affordable • Delivers quality • Stakeholder acceptability 	<ul style="list-style-type: none"> - Ability to leave non-managed care clients, duals, etc in FFS - Offers accessibility in rural areas that lack managed care presence - Fewer resources and effort required to manage than a robust PCCM - Supports rural and urban areas 	<ul style="list-style-type: none"> - Orientation to simply paying for services rather than buying value - Cost exposure - Difficulty managing - Limits on ability to improve quality and/or cost effectiveness
Data <ul style="list-style-type: none"> • Timely • Transparent • Accessible • Credible • Supports improvement 	<ul style="list-style-type: none"> - States have direct access to claims data to monitor expenditures 	<ul style="list-style-type: none"> - Maintaining claims or collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> - With significant volume, a state can get the providers' attention - When a provider commits, they are typically supportive of serving consumers 	<ul style="list-style-type: none"> - Orientation to simply paying for services rather than buying value - Incentives are not be aligned across stakeholders and therefore, do not necessarily promote harmony - Hard to get a providers' attention without significant volume - Resources to truly manage providers are not there
Care Management <ul style="list-style-type: none"> • Focus on high-cost/high-risk • Integration and coordination of care dominates 	<ul style="list-style-type: none"> - Limited to Disease or Case Management if provided; limited (additional) expectations on providers 	<ul style="list-style-type: none"> - Cost exposure can dominate in an unmanaged environment - Lack of attention to outcomes - Exposure on high-risk clients for both quality and cost - Not a priority



Analysis: ASO

Criteria Defined for all Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> • Cost-effective (MLR) • Quality driven with continuous improvement 	<ul style="list-style-type: none"> - Delivers value for specific services depending on how the agreement is structured ; generally does not deliver value across the continuum of service - This approach is well-liked in CT and MA specifically for BH services - if an ASO is wrapped around a PCCM and the ASO is responsible for linkages the model could work well 	<ul style="list-style-type: none"> - Exposure for cost without value - Focus on a single service rather than a continuum - The model does not promote accountability across all services - Costs cannot be predicted for services (possibly for the specific ASO-run service but not others) - Provider rates, hassle factor, etc. are important to get participation and increase access - Incentives are generally not aligned across the continuum
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice • Offers convenience 	<ul style="list-style-type: none"> - Offers consumers access, choice and control ; ASO-run service can be more managed but typically other services are unmanaged - Consumers may view FFS-like system favorably; depends on the specific program - Has the ability to incorporate case management of high-cost, high-risk cases and/or Disease Management of high-risk patients for the ASO-run services; however, unlikely to include coordination across all services 	<ul style="list-style-type: none"> - Lack of care coordination and management for the complete continuum of care
Provider Feasibility <ul style="list-style-type: none"> • Rates are seen as adequate (closer to Medicare is better) • Claim payment is timely • Low hassle factor 	<ul style="list-style-type: none"> - Can be viewed favorably by providers , especially if rates are acceptable and the provider serves a high volume of Medicaid consumers - Provider acceptance depend on the program, climate, etc. - Provider incentives (e.g. P4P) can be incorporated on top of a FFS system for the specific contracted services that the ASO is managing 	<ul style="list-style-type: none"> - ASO-run service can be well managed but other areas are not attended to - FFS rates must be adequate
Payor Feasibility <ul style="list-style-type: none"> • Levers to manage • Need resources • Offers access to care • Affordable • Delivers quality • Stakeholder acceptability 	<ul style="list-style-type: none"> - Ability to leave non-managed care clients, duals, etc in FFS - Offers accessibility in rural areas that lack managed care presence - Fewer resources and effort required to manage than a robust PCCM - Supports rural and urban areas 	<ul style="list-style-type: none"> - Orientation to managing the ASO run service but not other services - Cost exposure - Difficult for providers to manage across the continuum
Data <ul style="list-style-type: none"> • Timely • Transparent • Accessible • Credible • Supports improvement 	<ul style="list-style-type: none"> - States can develop strong improvement efforts for the ASO-run service - States have direct access to claims data to monitor expenditures 	<ul style="list-style-type: none"> - The state can manage the ASO-run service with data but integrating or managing care across the continuum is challenging if the ASO is managing a specific services rather than the continuum of care - Maintaining claims or collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> - With significant volume, a state can get the providers' attention 	<ul style="list-style-type: none"> - Hard to get a providers' attention without significant volume - Resources to manage providers would tend to be limited to the ASO-run service but not the full continuum of care
Care Management <ul style="list-style-type: none"> • Focus on high-cost/high-risk • Integration and coordination of care dominates 	<ul style="list-style-type: none"> - Limited to Disease or Case Management if provided; limited (additional) expectations on providers 	<ul style="list-style-type: none"> - Poor outcomes and cost exposure can dominate in an unmanaged environment - Exposure on high-risk clients depends on what service the ASO is managing and how services are paid; it depends - Priority on the ASO-run service within a broader benefit package



Analysis: MCO

Criteria Defined for All Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> • Cost-effective (MLR) • Quality driven with continuous improvement 	<ul style="list-style-type: none"> - Can deliver cost/quality value but strong, effective management is key - Costs can be predicted (to the extent that enrollment is known) - Continuous improvement approach is possible with monitoring and strong relationship management - Contract “levers” support value-based purchasing - Enhanced by medical homes (in combination with alignment of financial incentives at the plan or provider level) 	<ul style="list-style-type: none"> - Value isn’t “free”;resources (staff, vendors, data systems) cost - Challenging to manage well (requires staff, expertise, etc.) - Fair rates are key to participation - Ability to offer strong management is key; levers are not meaningful without ongoing management and willingness to act - Potential for financial incentives to negatively impact quality - Challenges to monitor and oversee
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice 	<ul style="list-style-type: none"> - Offers consumers a product that is “like what everyone else has” with access, choice and control - Consumers view MCO membership favorably - Requirements to incorporate case management of high-need cases typically exist 	<ul style="list-style-type: none"> - Lack of care coordination and management (depending on the model) - Lack of access and choice depending on network adequacy - Profit motive could (but does not necessarily) affect care delivery
Provider Feasibility <ul style="list-style-type: none"> • Rates are seen as adequate (closer to Medicare is better) • Claim payment is typically timely 	<ul style="list-style-type: none"> - Varies based on climate in state (e.g. managed care acceptance) - Key elements of success are capitation rates, relationship management (e.g. collaborative vs. adversarial) requirements and the cost of doing business relative to rates of payment - MCO resources and skills may be richer state resources - Allows states to “buy” rather than “make” the service; hard to make something that is equal to a private company 	<ul style="list-style-type: none"> - Capitation rates may or may not be seen as adequate - Opponents of managed care may (rightly or wrongly) assume that profit motive can negatively impact care - MCO requirements can be significant relative to reimbursement
Payor Feasibility <ul style="list-style-type: none"> • Levers to manage • Need resources • Offers access to care • Affordable • Delivers quality 	<ul style="list-style-type: none"> - Allows the state to “buy” a service from “experts” rather than trying to “make” it themselves - Capitation supports states’ ability to predict their costs (as long as they know their volume) - MCOs typically have the ability to attract and retain staff expertise that may not otherwise be available to the state (higher private sector salaries, benefits, etc.) - The State can benefit from enhanced MCO systems; however, this depends on whether data systems are actually better than what the state has and this varies 	<ul style="list-style-type: none"> - Significant resources (staff and/or vendors) are required to manage an MCO program effectively - Effective monitoring is challenging: it requires knowledge, skill, good relationships and sufficient staff resources - Claims data is held by the MCOs; burden is on the state to obtain good data from the MCO vendors to evaluate and manage the program; comparability may be challenging relative to other models - Profit motive may (but does not necessarily) affect care delivery - The state is depending on the MCOs to implement policy, obtain data, findings, etc.; requires management effort to monitor and ensure compliance
Data <ul style="list-style-type: none"> • Timely, transparent, accessible, credible data • Supports cost and outcomes management 	<ul style="list-style-type: none"> - Data is a key component of an MCOs business: data is essential to managing care - MCOs have claims data to mine and distribute - MCOs may be more nimble than a state (PCCM) program - Ability to hire in the private sector may be better than at the state 	<ul style="list-style-type: none"> - Having knowledgeable MCOs with expertise is essential; willingness to provide resources in this area is necessary but not guaranteed (especially for ABD) - There are costs (to the Plan) associated with data collection, mining and reporting; data is only as good as its ability to improve care - Collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> - Ability to create true partnerships with MCOs - single points of contact with a reasonable number of MCOs offers a manageable opportunity to aggressively address needs (but still requires significant skills and resources) 	<ul style="list-style-type: none"> - Historic events, budgets, nature of a regulatory relationship with levers can make it difficult to foster trust - There is a delicate balance in a collaborative relationship that also has a regulatory aspect with levers (e.g. contractual requirements and levers) to it
Care Management <ul style="list-style-type: none"> • Focus on high-cost/high-risk • Integration and coordination of care dominates 	<ul style="list-style-type: none"> - Care management has the ability to improve quality and cost- effectiveness - Technology in MCOs can support the ability to identify and address the needs of high-cost, high-risk, multi-morbid consumers - CM resources is typically available even if it is not expressly reimbursed in capitated payments - MCOs “own their data” as they pay claims and have encounters to promote care management, analysis, improvement, etc. 	<ul style="list-style-type: none"> - CM may not be reimbursed in the states’ methodology and therefore, a plan may not be willing to provide the level of effort required to provide effective case management or other required services - Client needs are complex and plans may or may not have the resources to address such needs (e.g. multi-morbid conditions with physical and BH needs)



Analysis: PCCM

Criteria Defined for all Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> • Cost-effective (MLR) • Quality driven with continuous improvement 	<ul style="list-style-type: none"> - Can deliver value depending on how/what is provided - Alternative to an MCO offering for consumers and providers - Potentially provides leverage to states by having an option in addition to MCO - Continuous improvement approach is possible - Enhanced in an ACO, medical or health home model 	<ul style="list-style-type: none"> - Resources (staff, vendors, data systems) cost money - Significant effort required to “make” an effective product - Favorable rates and provider support are key to access ; no \$., no performance - The model does not typically promote accountability but it depends on.... - Costs associated with utilization cannot be predicted - Incentives are not aligned in a “basic” PCCM
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice • Offers convenience 	<ul style="list-style-type: none"> - Offers consumers access, choice and control (often with few rules) - Consumers view PCCM favorably - Has the ability to incorporate case management of high-cost, high-risk cases with DM or ASO overlay (e.g. BH for high-risk co-morbid cases) - Advocates often provide strong support for this model which can influence resources, etc. 	<ul style="list-style-type: none"> - Lack of care coordination and management (depending on the model) - Lack of access and choice depending on network adequacy
Provider Feasibility <ul style="list-style-type: none"> • Rates are seen as adequate (closer to Medicare is better) • Claim payment is timely • Low hassle factor 	<ul style="list-style-type: none"> - Can be viewed favorably by providers if rates are acceptable and interest in Medicaid - Varies based on climate in state (e.g. managed care acceptance) - Key elements of success are rates, administrative ease and ability to obtain support to treat (hard to serve) clients - With ASO supports (e.g. BH) can potentially function better for providers 	<ul style="list-style-type: none"> - Rates of payment may not be adequate - Care management can be absent , especially for high-risk, high-need consumers - PCCM requirements can be significant relative to reimbursement
Payor Feasibility <ul style="list-style-type: none"> • Levers to manage • Need resources • Offers access to care • Affordable • Delivers quality • Stakeholder acceptability 	<ul style="list-style-type: none"> - Acts as an alternative to MCOs - Benefit to contracting directly with MDs - States can use an “NCQA Plus” model (medical home) within PCCM - Offers states leverage w/ MCO providers (another option) - Offers accessibility in rural areas that lack managed care presence - Provides the state with more direct control of care delivery - Some states have created significant effort and value with limited resources (but this varies across the country) 	<ul style="list-style-type: none"> - Significant resources (staff and/or vendors) are required to manage a PCCM program effectively - Focus on primary care services – not specialty care; need to look at community-based supports to truly serve this population - Classic “make or buy” argument: Better to purchase or create? - Requires the state - Challenging to manage in states with many “small” providers to take more responsibility for care delivery
Data <ul style="list-style-type: none"> • Timely • Transparent • Accessible • Credible • Supports improvement 	<ul style="list-style-type: none"> - The state is “in the drivers’ seat” with regard to defining data priorities and products - States have direct access to claims data to mine and distribute 	<ul style="list-style-type: none"> - Developing, mining, distributing and re-measuring data requires considerable expertise and resources - Often state data isn’t timely, suffers from credibility issues; requires resources and very diligent efforts - Structure and process proceeds outcomes: outcomes take time - There are costs (to the State) associated with data collection, mining and reporting; data is only as good as its ability to improve care - Collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> - Ability to create trust, transparency and accountability based on an intensive delivery system effort with good infrastructure, attitude, etc. - With significant volume (and rates), a state can get providers’ attention - When a provider commits, they are typically supportive of this approach 	<ul style="list-style-type: none"> - Historic events and factors can make it difficult to foster trust - Incentives may not be aligned across stakeholders and therefore, do not necessarily promote harmony - Hard to get a providers’ attention without significant volume (and rates)
Care Management <ul style="list-style-type: none"> • Focus on high-cost/high-risk • Integration and coordination of care dominates 	<ul style="list-style-type: none"> - States (largely those with vendors to manage high-cost/high-risk cases) have robust strategies to integrate and coordinate care to make or buy within a PCCM - Technology can support identification of high-cost, high-risk consumers - Opportunity to focus on decreased ED utilization with enhanced primary care access 	<ul style="list-style-type: none"> - Integration and coordination require expertise and resources - Enhancements such as predictive modeling , case management resources, care plan technology and community-based resources are all central to integration and coordination of care; these are resource and time intensive



Analysis: Medical/Health Home

Criteria Defined for all Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> •Cost-effective (MLR) •Quality driven with continuous improvement 	<ul style="list-style-type: none"> -Can deliver value but incentives are lacking -Alternative to an MCO offering -Potentially provides leverage to states as a strong enhancement to PCCM -Continuous improvement approach is possible 	<ul style="list-style-type: none"> - Resources (staff, vendors, data systems) cost money - Significant effort required to “make” an effective product - Favorable rates and provider support are key to access - The model does not typically promote accountability - Costs cannot be predicted for services - Incentives are not aligned in a “basic” PCCM w/ medical home
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice • Offers convenience 	<ul style="list-style-type: none"> - Offers consumers access to primary care but possibly less choice - Consumers view medical home favorably - Has the ability to incorporate case management of high-cost, high-risk cases - Strong primary care relationship: education, access, coordination 	<ul style="list-style-type: none"> -Lack of choice depending on network adequacy and the extent of the model in the state (e.g. now many states have pilots with limited access)
Provider Feasibility <ul style="list-style-type: none"> • Rates are seen as adequate (closer to Medicare is better) • Claim payment is timely • Low hassle factor 	<ul style="list-style-type: none"> - Can be viewed favorably by providers - Varies based on climate in state (e.g. managed care acceptance) - Key elements of success are rates, administrative ease and ability to obtain support to treat (hard to serve) clients 	<ul style="list-style-type: none"> - Rates of payment may be inadequate to incent participation - Care management can be challenging especially for high-risk, high-need consumers - Practices vary in ability to meet medical home requirements - Requirements can be significant relative to reimbursement
Payor Feasibility <ul style="list-style-type: none"> •Levers to manage • Need resources • Offers access to care •Affordable • Delivers quality • Stakeholder acceptability 	<ul style="list-style-type: none"> - Acts as an alternative to MCOs - Offers states leverage w/ MCO providers (another option) - Offers accessibility in rural areas that lack managed care presence - Provides the state with more direct control of care delivery - Challenging to manage in states with many “small” providers - Some states have created significant effort and infrastructure with somewhat limited resources (but this varies across the country) 	<ul style="list-style-type: none"> -Significant resources (staff and/or vendors) are required to manage a medical home program effectively - An effective medical home requires many resources - Classic “make or buy” argument: Better to purchase or create? – - Requires the state to take more control for care delivery - very “high touch” especially as medical homes are new
Data <ul style="list-style-type: none"> • Timely • Transparent • Accessible • Credible • Supports cost and outcomes management 	<ul style="list-style-type: none"> -Data services can be “made” or “bought” (e.g. CO is purchasing data services) ; the state is “in the drivers’ seat” with regard to defining data priorities and products -States have direct access to claims data to mine and distribute 	<ul style="list-style-type: none"> -Developing, mining, distributing and re-measuring data requires considerable expertise and resources - Often state data isn’t timely, suffers from credibility issues; requires resources and very diligent efforts - Structure and process proceeds outcomes and take time -There are costs associated with data collection, mining and reporting; data is only as good as ability to improve care -Collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> -Ability to create trust, transparency and accountability at the core of the medical home (but no real incentives) - With significant volume, a state can get the providers’ attention 	<ul style="list-style-type: none"> -Historic events and factors can make it difficult to foster trust -Incentives may not be aligned across stakeholder and therefore, do not promote harmony - Hard to get a providers’ attention without significant volume
Care Management <ul style="list-style-type: none"> •Focus on high-cost/high-risk •Integration and coordination of care dominates 	<ul style="list-style-type: none"> - Medical home seeks to manage care; however, the original PCCM model is less focused on BH or co-morbid conditions (this is not implicit in the medical home model but IS incorporated in health homes) - Technology supports the ability to identify and address the needs of high-cost, high-risk, multi-morbid consumers (in the health home) 	<ul style="list-style-type: none"> -Integration and coordination require expertise and resources - Resources such as predictive modeling, case management resources, care plan technology and community-based resources are all central to integration and coordination of care are resource and time intensive



Analysis: ACO

Criteria Defined For All Models	Potential Advantages	Potential Disadvantages
Value <ul style="list-style-type: none"> • Cost-effective (MLR) • Quality driven with continuous improvement 	<ul style="list-style-type: none"> - Can deliver cost/quality value but strong, effective management is required - Continuous improvement approach is possible with monitoring and strong relationship management - Contract “levers” support value-based purchasing - Enhanced by medical homes (in combination with alignment of financial incentives at the plan or provider level) - Depending on financial model, costs can be predicted 	<ul style="list-style-type: none"> - ACOs may have differing internal capacity to align quality and cost - Significant resources are required on state level to coordinate and monitor local ACOs - Fair rates are key to participation
Consumer Feasibility <ul style="list-style-type: none"> • Offers access • Offers choice • Offers convenience 	<ul style="list-style-type: none"> - Offers consumers access, choice and control - Although the ACO concept is new, emphasis on local, coordinated care should be viewed favorably - Has the ability to incorporate case management of high-cost, high-risk cases 	<ul style="list-style-type: none"> - Great variation in capabilities of ACO's; potential for consumer dissatisfaction. - Lack of access and choice depending on network adequacy
Provider Feasibility <ul style="list-style-type: none"> • Provider driven organizations • Ability to determine rates 	<ul style="list-style-type: none"> - Varies based on climate in state (e.g. provider community readiness to look at new models of care) - Key elements of success are ACO rates, state/provider relationship management and the cost of doing business relative to rates of payment - ACO resources and skills may be richer state resources - Allows states to bypass MCOs and provide richer payment directly to providers 	<ul style="list-style-type: none"> - ACO rates may or may not be seen as adequate versus investment required on provider level to make the ACO functional - Risk sharing model between provider and state needs to be defined - New ACOs may have significant internal investment requirements to provide case management and other ACO services
Payor Feasibility <ul style="list-style-type: none"> • Levers to manage • Need resources • Offers access to care • Affordable • Delivers quality • Stakeholder acceptability 	<ul style="list-style-type: none"> - Acts as an alternative to MCOs (and can offer leverage w/ MCO providers) - Offers accessibility in rural areas that lack managed care presence - Provides the state with more direct control 	<ul style="list-style-type: none"> - Significant resources (staff and/or vendors) are required to manage a ACO program effectively - Classic “make or buy” argument in that the providers will be required to create care management and quality infrastructure - Effective monitoring is challenging: it requires knowledge, skill, good relationships and sufficient staff resources
Data <ul style="list-style-type: none"> • Timely, transparent, accessible, credible data • Supports cost and outcomes management 	<ul style="list-style-type: none"> - Data is a key element for success of ACOs; quality improvement activities integral to ACO programs - Claims payment may be on the state level to critical to develop a way to quickly share data with ACOs - Ability to hire in the private sector may be better than at the state 	<ul style="list-style-type: none"> - ACO expertise may be limited - There are costs associated with data collection, mining and reporting; data is only as good as its ability to improve care delivery. - Collecting data alone does not support improvement
Strong Relationships <ul style="list-style-type: none"> • Open and trusting • Accountability 	<ul style="list-style-type: none"> - Opportunity to recast provider/state relationships 	<ul style="list-style-type: none"> - Historic events and factors can make it difficult to foster trust - There is a delicate balance in a collaborative relationship that also has a regulatory aspect to it
Care Management <ul style="list-style-type: none"> • Focus on high-cost/high-risk • Integration and coordination of care dominates 	<ul style="list-style-type: none"> - Care management has the ability to improve cost effectiveness and quality - Patient registries in ACOs can support the ability to identify and address the needs of high-cost, high-risk, multi-morbid consumers 	<ul style="list-style-type: none"> - If CM is not reimbursed under the ACO payment system providers may not be able/willing to provide the level of effort required - Client needs are complex and multi-faceted, ACOs will have varying internal capabilities to manage them



Analysis: Select PCCM Findings

	IL	MA	NC	OK	RI	TX
Models offered	PCCM, MCO, Medical Home	PCCM, MCO, Medical Home (new)	PCCM/Medical Home	PCCM	PCCM/medical home, MCO	PCCM, MCO
Coordination of care	DM for ABD (high-risk) consumers with a move toward “whole person” management. More coordination for ABD	Limited: BH focus in a carve-out ASO model; BH/SA is coordinated w/ a past pilot to coordinate medical and BH	Community Care Networks coordinate care; CMs are part of the clinical team plus Rx integration	Two vendor programs coordinate high-risk; medical homes and staff coordinate care. More coordination for ABD	Coordination is provided through medical home for high-risk consumers. Coordination for ABD only	Medical homes coordinate but no formal responsibility for coordination
PCC Compensation	\$2 pmpm child \$3 pmpm adult \$4 pmpm disabled adult	Enhanced fees for key primary care codes	\$2.50 pmpm for TANF \$5.00 pmpm for ABD PLUS fees of \$3.73 pmpm and \$13.72 pmpm to CCNs respectively	9 different levels of payment to PCPs (RANGE) plus incentive payments	\$4 pmpm \$8 pmpm with EMR	\$4.95 pmpm
Access as an issue	No	No	No	No	No	No
Staff and vendor resources	5 FTEs AHS staff DM staff	•13 FTEs with 2 FTEs at the state •Enrollment Broker •BH vendor	12 staff 450 staff in the CCNs	465 staff including the Fiscal Agent DM vendor; staff work on multiple programs	< 1 FTE plus 9 contracted nurses	6 FTEs plus TMHP (Requested the number of TMHP Staff)
Vendor functions	Administrative services vendor DM Program	BH carve out for PCCM Network management contract for MD data and improvement projects	CCNs provide contracted services to support the physician networks	DM services (being brought in-house) Member help line Patient advice line	Care management and coordination within select practices (nurses staff 2-3 practices each)	DM services
Value based on interviewer opinion	Yes	Yes	Yes	Yes	Yes	Yes
Effectiveness Data	Yes	HEDIS only	Yes	Yes	No	Yes



Analysis: Select MCO Findings

	IL	MA	RI	TX
Coordination of care	Yes, MCOs are responsible for coordination of care; new contract has very detailed and specific requirements for consumers under the ABD designation	Yes, MCOs are responsible for coordination of care Requirements apply for the full contract; however, specific requirements are provided for individuals with various chronic conditions as well as high-risk pregnancy	<ul style="list-style-type: none"> •Yes, MCOs are responsible for coordination of care •For the ABD population, HCS is carved out but the plans must use a single plan of care for all members •Recent focus on ABD coordination in a new contract •Key differences for ABD features care management protocol and reporting •ED management program w/ CMS grant 	<ul style="list-style-type: none"> •Yes, MCOs are responsible for coordination of care •MCOs get pharmacy data (pharma is carved out but it will be carved in going forward) •Requirements mandate coordination for consumers under the ABD designation • ABD service coordinators exist for the ABD population; mandatory staff to assist members per the contract
Changes contemplated	Moving the ABD population into managed care They are consciously making the MCO program much more rigorous going forward Looking at metrics that do not incent inappropriate denial of services as key metrics	MA is about to re-procure their BH program contract Likely focus on coordination of medical and BH conditions for high-risk consumers	None	The state is looking at eliminating PCCM (even though it works well for them) to collect a premium tax Looking at EPO, ASO with significant increases in coordination and integration; in process/no further information provided
Incentives for MCOs to manage care and strategies to enforce	Withholds, sanctions, P4P, restrictions on enrollment	<ul style="list-style-type: none"> • Improvement plans, withholds, sanctions and routine monitoring, restrictions on enrollment 	Improvement plans, Sanctions and P4P, financial penalties, restrictions on enrollment	Withholds, sanctions, restrictions on enrollment, financial penalties and improvement plans "Hard but Fair"
MCOs offer incentives to manage care	P4P payments	<ul style="list-style-type: none"> •P4P and rates that are greater than Medicaid FFS 	One plan has P4P; another uses enhance3d fees. Some sites are capitated for primary care	One vendor does P4P. Increased fees after hours Greater than FFS payment is typical
Staff resources	6 FTEs	•13 FTEs	35 FTEs	68 FTEs
Value based on interviewer opinion	No but hopefully going forward with new requirements and data	Yes	Yes	Yes
Effectiveness Data	Yes	Yes	Yes	Yes



State Overview: IL



■ PCCM

- AHS provides administrative services
 - ▶ Enrollment and provider contracting now; CMS will not allow going forward
- A DM vendor provides case management for high-risk consumers; savings demonstrated (\$ not given) but no attribution to the program specifically. No other savings noted on interview with an official from the state
- Beyond vended services, access is a major focus
- IL is using data to support the PCCM model w/ drill downs; partnership with AAAP to train providers to leverage data

■ MCO

- The state is not satisfied with their current MCO program
- As they prepare to enroll the ABD population, they are trying to make the program much more robust
- The did not have anything to recommend from their current MCO program (but described what they believe to be a strong program plans going forward)

State Review: MA



- MCOs “compete” with the PCC Plan: Enrollment of approximately 600,000 individuals are roughly split between PCCM and MCO program enrollment
- PCCM Option for enrollees is seen as a good thing by the State, advocates, etc.
- Cost and savings data not provided for either program
- PCCM
 - Robust vended network management effort including reporting, monitoring and improvement efforts
 - Many consumers with BH needs select the PCCM to access a BH carve-out with many high-risk consumers enrolled
 - 15 year-old BH contract that is well regarded among many
 - Significant management of individuals with BH needs
 - Interest in better managing multi-morbid conditions
 - Awaiting BH procurement now
- MCO
 - Program dates back 20 years with a robust management approach
 - Dominant Medicaid-only plans with only one (true) commercial player (with small Medicaid population)
 - Strong improvement focus

State Review: NC



■ PCCM only

- Community Care Networks (CCNs) are 20 years old
- CCNs are organized and operated by physicians, hospitals, health departments, and departments of social services that collectively contract with the state
- Regional networks act as local systems to achieve quality, cost, access and utilization objectives
- Robust staffing with a strong focus on data and quality
- Collaborative approach; broad stakeholder support including advocates
- Savings (*over FFS*) in 2005/2006 was \$77-85M in State Fiscal Year (SFY) 2005 and \$154-170M in SFY 2006 (Mercer 2007) without any efforts to control costs
- Savings (*over FFS*) in 2005/2006 savings of \$218-240M and \$284-315M respectively; however, attribution is not clear
 - ▶ Current data on savings over FFS was not provided by NC (nor was it provided by most states interviewed)

State Review: OK



- PCMH approach program dates back to 2009 with PCCM going back to 2003; results eliminating MCOs due to controversy
 - A report from Mathematica states that OK could manage at lower costs with a PCCM relative to MCOs following controversy over rates (with equal outcomes) *with sufficient resources and leadership commitment*
 - The Oklahoma Healthcare Authority (OHA) made a conscious decision *not* to identify itself as Medicaid
 - Tiered medical home approach with standards, fees and a strategy to help provider practices act as medical homes: more ability = more money
 - Health management and disease management for high-risk individuals
 - Quality orientation with provider profiles and incentive payments
 - Robust state staff and infrastructure: Legislature granted 99 FTEs when the MCO program was eliminated
 - Member and provider help lines are provided (\$3.2M/year) by FA
- Currently reported savings from the Health Management Program (PCCM component) for high-cost/high-need enrollees are as follows:
 - “Tier 1” members: decline in expenditures compared to 12 months prior to Health Management Program participation from reductions in hospitalization and ED use rates
 - “Tier 2” members have not shown a decline to date, but firm conclusions should not be drawn until at least another year of data has been collected/analyzed. There is early evidence that the HMP is beginning to yield results. Some measures are moving in a positive direction
 - The HMP is still maturing & over the next several years, its impact will become more certain.
 - Progress will continue to be tracked and in a final report to be issued in 2013
- Overall \$3.93M in savings reported by the state in 2004
 - Savings drivers are not clear and a new model is in place today (PCMH)



State Review: RI



■ PCCM

- Relatively small program with a single FTE and nine nurses who work in practices
- MD practices were hand-picked based on their ability to act as medical homes
- Significant activity but monitoring and measurement efforts are informal
- No savings information available at this time; currently under evaluation

■ MCO

- A vendor manages the MCO program for RI; hard to tell who is state staff and who is vended staff in this long-standing arrangement
- Requirements are focused on high-risk individuals (ED users, individuals with multi-morbid conditions)
- Collaborative relationships with a shared reporting environment
- Monthly meetings between MCOs and vendor staff
- Improvement goals are a key program focus; 3-4 program-wide Quality Improvement Projects annually plus review the QI plans

State Review: TX



- The state is contemplating moving to all MCOs *to collect a premium tax on insured.*
- PCCM
- The Texas Medicaid Health Partnership (TMHP) manages contracting, providers & monitoring which must meet MCO requirements
- Only offered in rural areas of the state (where there are no MCOs contracted)
- Shifting DM to manage multi-morbid conditions
- “Theoretically”, medical homes coordinate care; but not a formal requirement
- Program is well regarded and produces roughly = outcomes to MCO
- Savings data not provided
- MCO Program
- Coordination for high-risk enrollees with “Service Coordinators” for ABD enrollees
- Standards and quality guide program operations
- The state graduates liquidated damages if plans don’t respond to sanctions
- High-touch, aggressive but collaborative plan management; “Hard but fair”
- Mandatory marketing training for MCOs
- Savings data not provided
- Outcomes reported as close to equal in PCCM and MCO programs



Literature: Key Findings

- *There is a lack of data directly comparing cost effectiveness and outcomes in PCCM versus MCO programs*
- Both PCCM and MCO programs have shown positive outcomes in different states
- Best financial results have occurred as state programs have managed emergency room and inpatient utilization
- High-risk Medicaid consumers typically have multiple chronic conditions including BH issues
- Value-based health care purchasing is about:
 - ▶ Being clear about what you want to buy
 - ▶ Measuring whether you are getting what you want
 - ▶ Identifying ways to improve, setting goals, collaborating and re-measuring with incentives or disincentives

Literature Review: Key Findings

- Impact/Characteristics of State Programs
 - Studies PCCM program in GA and AL showed that PCCM caused access to PCPs and primary care visits to decline; other articles report improved outcomes in PCCM
 - Studies on MCO programs also report improved outcomes
 - States with successful PCCM programs have worked hard to gain PCP participation with outreach, training and support
 - Successful MCO programs focus on value purchasing and improvement
 - PCCM programs with ACO like provider networks (NC) have documented decreases in asthma utilization and management of chronic diseases; however, ACO model in Medicaid is still too new to fully evaluate

Expert Interviews: Key Findings

- Models and needs vary tremendously by state (e.g. NC is unique; they have been at it for many years in an anti-managed care state with engaged providers)
- The interventions matter more than the specific model and must “fit” within the state
- States need to focus on purchasing standards and measurement
 - Transition management is critical but not often done within care management
- It is all about where you set the bar
- Physical and BH integration is a critically important focus given what we know about high-risk multi-morbid clients
 - Exchange of information between physical and BH providers w/ policies and procedures to share clinically relevant information
 - Real-time notification on hospitalization, re-admissions and ED use
 - Use of integrated care plans (that consumers buy-into with self-care focus)
 - P4P incentives (e.g. PA) that measure specific and simple outcomes (e.g. is there an integrated care plan or “profile”, did you identify and engage high-cost/high-risk members)

Expert Interviews: Key Findings

- States need levers to incent improvement (e.g. financial models and alignment)
- Rates of payment are critical to access and developing a strong program
 - OK was at 100% of Medicare but decreased rate 3% because of financial crisis
 - NC protects some codes at 92% of Medicare
 - Look for ways to cover alternative services (e.g. telephonic visits for rural areas)
- States should take advantage of ACA funding (e.g. health home, duals)
- Key health care reform impact will be increased enrollment and consumers who alternate between Medicaid and Exchange coverage
- Open relationships really help
 - Openness supports relationships with the advocacy community (transparency, communication)
 - Collaboration and transparency among stakeholders

Also Worth Noting: Center for Medicare and Medicaid Innovation

- Within CMS, PPACA creates a new Center for Medicare and Medicaid innovation (CMMI):
 - New authority and flexibility to test major new models for payment and delivery system reforms in Medicare and/or Medicaid
 - Test ways to improve quality and manage costs
 - \$10 billion in new funding for demos and another \$500 million to administer them
 - In short-term, budget neutrality not required. Demos allowed to spend more federal money if quality is improved
 - Successful models may go nationwide without further Congressional action
- Extraordinary opportunity for forward-looking States
- Law also created new federal coordination office for dual eligibles to improve quality and manage costs

Conclusions

- There is no magic bullet
- Interventions, incentives, an eye toward value and collaboration matter more than the specific model
- Consider what is possible and when
 - Short-term
 - Long-term
- An effective program should incorporate:
 - Quality choices for consumers with well-managed options
 - Resources at the state level that support interventions & monitoring
 - ▶ Nothing will improve without sufficient resources regardless of the model
 - ▶ Data to focus, identify priorities, manage and improve

Conclusions

- Clear standards and expectations for all vendors and providers, regardless of the model you select, that are measured, monitored and improved
- Effective approach to high-risk individuals, especially where needs are significant and resources are limited
- Collaboration among stakeholders (with a “hard but fair” mentality) with a constant eye toward the “greater good”
- Incentives that are aligned
- Reimbursement that is acceptable to all parties given that it affects both quality and cost
- The ability to leverage federal dollars (e.g. health homes and Center for Innovation) wisely while recognizing the uniqueness of Medicaid rules

Potential Next Steps for Consideration By The Council

- Define an “ideal” program based on best practices and research, combined with CT-specific factors and needs
- Digest information on models and discuss
- Conduct a review of Connecticut’s priorities
- Solidify and rank key factors that drive program design in CT
 - ▶ Determine if funds are available to make program enhancements
 - ▶ Determine if there an appetite to “spend to save”
 - ▶ Identify optimal interventions
 - ▶ Determine potential for future provider rates (based on Sustinet)
- Explore strategies to increase collaboration and transparency
- Identify short-term and long-term goals

Potential Next Steps for Consideration By The Council

- Evaluate the HUSKY A&B as a basis to move forward
 - How are the current programs managed? Can use of current resources be improved to get closer to best practices? Can steps be taken now to improve?
- Develop a short-term and long-term plan for success
 - It would be impossible to do everything at once; change must be incremental, planned and data driven

Abbreviated Terms

Acronym		Acronym	
AAFP	American Academy of Family Physicians	FA	Fiscal Agent
AAP	American Academy of Pediatrics	FFP	Federal Financial Participation
ACP	American College of Physicians	FFS	Fee for Service
AOA	American Osteopathic Association	LTC	Long Term Care
AMA	American Medical Association	MLR	Medical Loss Ratio
ACO	Accountable Care Organization	MCO	Managed Care Organization
ASO	Administrative Services Organization	PCCM Program	Primary Care Case Management Program
BH	Behavioral Health and Substance Abuse	PCMH	Patient Centered Medical Home
CHIP	Children's Health Insurance Program	PMPM	Per Member Per Month
CMS	Center for Medicaid and Medicare Services	PPACA	Patient Protection and Affordable Care Act
EMTALA	Emergency Medical Treatment and Active Labor Act	PCP	Primary Care Physician



Consultant Team Under the Direction of the CT Health

- Meryl Friedman Price
 - 20+ years in Medicaid managed care with significant public and private sector experience in Medicaid and the uninsured
 - Broad experience in MCO, PCCM, ACO program design with a focus on data-driven development, evaluation and improvement on the public and private sides
 - Focus on care management program design to drive outcomes
- Kip Piper
 - National expert in Medicare, Medicaid and the uninsured
 - Public and private sector experience advising state leadership, legislators, state agencies and businesses
- Marcia Stein
 - 15+ years in Medicaid managed care with a focus on dual eligibles
 - Broad experience in MCO management and quality

About The Connecticut Health Foundation (CT Health)

- Patricia Baker, CEO of CT Health, provided leadership and funding for this initiative.
- CT Health is the state's largest independent, philanthropic organization dedicated to improving lives by changing health systems. Since it was established in July 1999, the foundation has supported innovative grant-making, public health policy research, technical assistance and convening to achieve its mission - to improve the health of the people of Connecticut particularly the unserved and underserved. Since it was established, CT Health has awarded 530 grants totaling over \$41 million.
- The foundation achieves its mission by focusing on the following:
 - Improving Access to Children's Mental Health Services
 - Reducing Racial and Ethnic Health Disparities
 - Supporting the incorporation of oral health in health care, human service and education systems
- Aside from directly supporting community-based and institutional grant proposals, CT Health fosters discussions surrounding public health issues by convening meetings, conferences, educational briefings, grantee technical assistance workshops, etc.
- The foundation invests resources into conducting objective, nonpartisan policy research on issues important to the public health care debate such as the state budget spending cap, the state's Medicaid system, and expanding oral health care for publicly insured children throughout the state.

