Innovations in Medicaid: Considerations for MassHealth

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by Suzanne Gore, Center for Health Care Strategies

CHCS Center for Health Care Strategies, Inc.

MMPI Massachusetts Medicaid Policy Institute

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About the Massachusetts Medicaid Policy Institute

The Massachusetts Medicaid Policy Institute (MMPI) — a program of the Blue Cross Blue Shield of Massachusetts Foundation — is an independent and nonpartisan source of information and analysis about the Massachusetts Medicaid program, "MassHealth." MMPI's mission is to promote the development of effective Medicaid policy solutions through research and policy analysis.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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Executive Summary

Massachusetts is renowned as a national leader in health reform and has a strong history of innovation in Medicaid. The increasing complexity of care, tightening of budgets, and growing enrollment numbers have forced MassHealth as well as other state Medicaid programs to look for innovative and more efficient ways to deliver care. The resourcefulness of states combined with new opportunities afforded by the Affordable Care Act of 2010 has resulted in a number of innovative strategies for state Medicaid programs.

This paper summarizes a range of cutting-edge Medicaid strategies such as purchasing strategies to optimize delivery systems; payment strategies to leverage existing funds; integrated models of care to improve services for complex populations; and opportunities for improved organizational capacity. This landscape scan is intended to encourage MassHealth to continue its leadership and identify new opportunities for the state to explore.

Following is a "non-exhaustive" list of opportunities to spark a new burst of program innovation:

- **Conduct a targeted purchasing strategy study** to evaluate the effectiveness of purchasing in states that, like Massachusetts, operate a number of purchasing approaches, compared to states that operate or are moving to a single purchasing strategy, such as Oklahoma and Tennessee.
- **Conduct a targeted Accountable Care Organization study** with states identified as leaders, such as New Jersey and Colorado, in incorporating this new model.
- **Develop stakeholder engagement strategies for integrated care** around member materials and outreach and communication venues. While state staff are already engaged in stakeholder work, providing additional support in this area would likely benefit program development.
- **Work with providers** to help them to be maximally effective when providing input into program design and innovation.
- **Outline a clear long-term (five-year) vision with measurable short-term program goals.** Program leadership can monitor progress on these measures on a scheduled basis through publication of a dashboard.
- **Analyze the political and fiscal pros and cons** of options for reforming MassHealth's organizational structure, including the creation of an "innovation" or "planning" unit; and the reconsolidation of accountability for all Medicaid-funded services.

Massachusetts can go in many different directions to improve the quality and efficiency of care. Through a strategic long-term vision and doable and measurable short-term goals, MassHealth can secure its spot as a leader in Medicaid innovation. By combining the new opportunities

afforded by the ACA with the investment of Massachusetts' stakeholders and history of innovation, the nation will undoubtedly look toward Massachusetts to chart the course for innovation and system reform for the next decade.

I. Introduction

The Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation, engaged the Center for Health Care Strategies (CHCS) to conduct a national environmental scan to identify cutting-edge ideas in Medicaid that may be beneficial to the Massachusetts Medicaid program ("MassHealth"). This scan draws from a series of more than 20 interviews with key Medicaid stakeholders from across the country as well as CHCS' extensive experience working with states to provide higher quality, more cost-effective care. The resulting environmental scan identifies promising innovations and areas that may warrant further in-depth exploration. Findings are summarized in three focus areas:

- Purchasing, Payment, Plans, and Providers;
- Complex Populations: Dual Eligibles and Behavioral Health; and
- Medicaid's Organizational Capacity in an Affordable Care Act and Technology-Driven World.

Massachusetts is renowned as a national leader in health reform and has a strong early history of value-based purchasing in Medicaid. The Massachusetts Connector is a national model for states implementing the Affordable Care Act (ACA) and developing health insurance Exchanges. Further, MassHealth is still on the cutting edge of a wide range of innovations including integrated care for Medicare-Medicaid beneficiaries under age 65, a multi-payer patient centered medical home initiative, Money Follows the Person initiative, and bundled payments for pediatric asthma. Yet, despite the state's position as a national health care leader, respondents to this scan unanimously agreed that like most states, MassHealth faces enormous challenges, including budget cuts, limited staffing, and a slowed pace of program improvement.

Given the current budgetary environment, observers noted that Massachusetts has two options: (a) go forward with blunt cuts to programs, services, eligibility, and rates; or (b) find and implement innovative solutions to address these budget challenges. MassHealth provides essential services to a growing number of people, with 1.3 million beneficiaries in 2011 and an additional 60,000 beneficiaries expected in 2012. Fresh leadership from the recently appointed MassHealth Director, Dr. Julian Harris, and new opportunities afforded by the ACA make this an opportune time for the state to ensure that it builds on its role as a leader in publicly-financed health care innovation.

II. Purchasing, Payment, Plans, and Providers

A. Purchasing Strategy

Overview: Since the 1990s states have been deploying managed care options to improve the quality and efficiency of Medicaid services. Today, over 70% of Medicaid beneficiaries receive at least a portion of their services through managed care. Managed care can range from a fully capitated arrangement, wherein the state pays a fixed monthly fee to managed care organizations (MCOs) to provide health services, to a primary care case management (PCCM) arrangement in which states provide enhanced reimbursement to primary care providers to coordinate care. In 2008, 34 states enrolled 21.7 million beneficiaries in MCOs and 29 states enrolled 6.1 million beneficiaries in PCCM programs.[1] Yet even with these managed purchasing strategies, per capita health care expenditures continue to rise faster than inflation, and states and health plans are looking for new ways to improve efficiency and decrease costs.

The ACA establishes authority for several new purchasing models. Two of considerable interest to Medicaid agencies are accountable care organizations (ACOs) and health homes. An ACO would reward providers for keeping patients healthy and out of the hospital and create savings incentives by paying bonuses when providers keep costs down and meet quality benchmarks. While ACOs were initially targeted to Medicare patients, a number of states are now developing ACO-like models for Medicaid. States are also looking at health homes as a way of improving service delivery and controlling cost growth due to fragmented and duplicative care. Health homes are designed to offer person-centered care that improves access to and coordination of the full array of medical care, behavioral health care, and long-term supports and services (LTSS). Health homes expand on the traditional medical home model by enhancing coordination and building additional linkages (e.g., behavioral health and LTSS) to better meet the needs of people with multiple chronic conditions. Both ACOs and health homes appear promising, though it will undoubtedly take time to design and implement them and evaluate their effectiveness.

National Landscape

1. PCCM vs. MCOs

MassHealth, like many other state Medicaid programs, uses a combination of purchasing strategies to provide services for Medicaid beneficiaries. MassHealth provides coverage for close to 490,000 beneficiaries through contracted MCOs, 350,000 beneficiaries through a Primary Care Clinician (PCC) Plan, and nearly 370,000 beneficiaries through fee-for-service (FFS) and other program

1 *Medicaid and Managed Care: Key Data, Trends, and Issues.* Kaiser Commission on Medicaid and the Uninsured, February 2010.

options.[2] These delivery systems overlap across the state and provide choice to beneficiaries. Nationally, states are pursuing a variety of different purchasing strategies, including combined approaches. However, some states are finding that investment in a single approach is the best option.

Some state leaders are convinced about the power of capitated managed care to improve quality and reduce costs and continue to expand capitated programs geographically, including new populations and services within full-risk models. States such as Arizona and Tennessee have integrated behavioral health and LTSS into their health plan contracts. The next step for these states is to blend Medicare financing and services into the same plans for beneficiaries dually eligible for both Medicaid and Medicare. Many states pursue capitated programs in order to have more predictable costs while simultaneously improving quality. While many capitated plans have strong quality standards, some concern lingers that capitation creates financial incentives to withhold necessary care.[3] As a number of observers have noted, "Good buyers make good sellers," and states need to be attentive purchasers to ensure that health plans meet quality targets and adhere to contractual requirements.

California is expanding its capitated MCO program and is currently transitioning its seniors and people with disabilities (SPD) into capitated managed care. In doing so, the state is seeking to both improve the quality of services through care coordination and take advantage of the expected savings that result from setting a reduced capitated rate. Of particular interest, California achieved a reduced capitation rate through a negotiation process where the actuaries working with the state presented health plans with initial rates assuming a certain rate of decreased acute care utilization. The health plans felt that the initial proposed decrease could not be achieved in the first year and thus the state agency and health plans agreed to compromise on the assumed utilization savings.

TennCare transformed Tennessee's Medicaid program a few years ago with a rapid expansion of capitated MCOs to new geographic regions and new populations, resulting in improved outcomes and cost savings. TennCare has also integrated behavioral health and LTSS into its managed care delivery system. TennCare obtained federal authority for its program through an §1115 demonstration waiver.

On the other hand, in 2003, Oklahoma Medicaid eliminated capitated managed care in the state and developed an enhanced PCCM (EPCCM) program. This change was due in part to contracting and rate-setting challenges with its Medicaid MCOs. Oklahoma's EPCCM program is built upon the Patient Centered Medical Home principles and offers providers tiered care coordination payments (in addition to FFS rates that are currently 96.75% of Medicare) based upon the level of service and technological advancement employed by the practice. Oklahoma's

2 Massachusetts Medicaid Policy Institute, MassHealth: The Basics Facts, Trends and National Context; October 2011.

3 R. Mechanic and S. H. Altman. "Payment Reform Options: Episode Payment is a Good Place to Start." *Health Affairs,* March/April 2009, vol. 28, no. 2, w262-w271.

EPCCM also uses a tiered approach that identifies high-need beneficiaries for a more intensive level of care management as well as an emergency department (ED) utilization program that targets high ED utilizers. State staff are convinced that this change has both saved money and improved quality; an evaluation of the program in 2009 indicated that the PCCM program resulted in a shift from emergency department utilization to primary care and a decline in preventable hospitalizations.[4] Vermont has taken Oklahoma's model a step further, forming a state-run health plan called 'Global Commitment' in 2005. The state itself manages Global Commitment as a managed care entity. Global Commitment covers all Medicaid-eligible individuals with the exception of people receiving traditional long-term care, who are covered under a separate §1115 waiver known as 'Choices for Care.' While Global Commitment currently includes all other Medicaid funding and services, planning is underway to also include Medicare funding and services for those people who are dually eligible. These states are being good buyers and getting good results from their contracted providers for their beneficiaries.

2. Accountable Care Organizations

Health systems across the country are exploring ACOs, but there are significant questions about what this model will ultimately look like, who will carry the insurance risk, and what role ACOs will have within states that operate a predominantly capitated managed care system. Conceptually, this emerging model offers a unique opportunity for partnership between medical centers and state Medicaid programs and is attractive to providers since it aims to shift decision-making authority back to the provider community. ACOs are also of great interest to safety net providers. The Camden Coalition of Health Care Providers in Camden, New Jersey, has pioneered efforts to develop safety-net ACOs with the goals of improving health and health care and reducing costs for an entire population of high-need patients within a region. The Camden-based demonstration creates the infrastructure to establish critical linkages across health and social services for a high-need subset of beneficiaries. The Camden Coalition and other partners are currently working with other sites across the country. These additional sites, however, are at very early stages of development.

Several state Medicaid programs are seeking to support ACO initiatives. Stemming from the successes of the Camden Coalition pilot, the New Jersey Legislature recently passed a bill authorizing Medicaid to create and administer a multi-site ACO demonstration. Under the bill, Medicaid ACOs may be certified by New Jersey Medicaid to provide an enhanced set of services to FFS and MCO beneficiaries. Through an application process, Medicaid ACOs must describe how the organization will provide for: care coordination; medication management; open access scheduling; use of health information technology (HIT); patient and family education and health

4 J. Verdier, M. Colby, D. Lipson, S. Simon, C. Stone, T. Bell, et al. *SoonerCare Managed Care: History and Performance — 1115 Waiver Evaluation*. Mathematica Policy Research, January 2009. www.mathematica-mpr.com/publications/pdfs/soonercare%20summary.pdf

promotion; interdisciplinary collaboration between behavioral health and PCPs; improved access to dental services; and improved quality of care. ACOs may form among local general hospitals, clinics, pharmacies, health centers, qualified primary care and behavioral health care providers, and public health and social services agencies. New Jersey's program does not mandate the formation of ACOs and does not provide additional state funding for ACOs, but rather relies on a shared savings model in which the ACO receives a portion of the Medicaid savings generated as a result of the organization's efforts.

Utah Medicaid announced plans to replace its managed care contracts in the state's four most populous counties with ACO contracts by July 2012. The ACOs will be financially responsible for providing inpatient and outpatient hospital, physician and ancillary services, and pharmacy benefits and must meet soon-to-be finalized National Committee for Quality Assurance (NCQA) ACO Standards.[5] To create the appropriate financial incentives, Utah is enlisting actuaries to create actuarially sound, baseline per-member-per-month (PMPM) global capitation rates and retain those rates over time, rather than make annual adjustments for actuarial soundness, which would reduce payments over time. The state will work with the Centers for Medicare & Medicaid Services (CMS) to get the necessary approvals for this approach. As part of the program, Utah also seeks to introduce beneficiary co-payments and limit out-of network payments.

One notable challenge facing the development of Medicaid ACOs nationally arises with the concept of shared savings between the ACO and the state. With a prolonged shared savings calculation, if savings actually result, eventually the "savings rate" will zero out. In other words, prolonged savings could drive reimbursements unsustainably low. The Utah approach of retaining the baseline rate could address this issue.

ACOs will require significant infrastructure, which some states are beginning to feel may be too resource-intensive. A number of states have been returning their focus to health homes, which are expected to be much easier to create.

5 For more information and updates regarding the National Committee for Quality Assurance ACO Standards (draft standards were released during the summer of 2011), see http://www.ncqa.org/tabid/1266/Default.aspx

State ACO Profile: Colorado's Accountable Care Collaborative

Colorado's Accountable Care Collaborative (ACC), launched in April 2010, is designed to improve the health of Medicaid beneficiaries and control costs by transforming the health care delivery system. The ACC will shift the health care system from a traditional fee-for-service model to a regional, outcomes-focused, client/family centered, coordinated system of care for Medicaid beneficiaries. It was developed prior to the federal ACO concept, but combines primary care case management with the ACO model. The program consists of three key components: (1) seven regional care collaborative organizations (RCCOs); (2) a statewide data and analytics organization; and (3) primary care medical providers (PCMP).

Colorado officials envision that all FFS Medicaid beneficiaries will be enrolled in the ACC when statewide expansion, which begins July 2012, is complete. The RCCOs have several key responsibilities:

- Network Development: Each RCCO must develop a formal network of contracted primary care Medicaid providers and an informal network of specialists, hospitals, and community resources.
- Provider Support: The RCCOs will be responsible for supporting providers in delivering a medical home level of care. This support may include administrative support (i.e., Medicaid billing), clinical tools, client materials, practice support or redesign.
- Medical Management and Care Coordination: The RCCOs will be responsible for ensuring that each Medicaid beneficiary member receives care coordination. They may provide this directly or delegate it.
- Accountability and Reporting

The statewide data and analytic contractor, Treo Solutions, will develop a data repository of Medicaid claims data. This data will be cleaned and aggregated and then made available to providers, RCCOs, and the State in a format that is useful as a medical management tool and easily interpretable. This will allow the state to identify best practices and opportunities for quality improvement. They will also conduct the cost evaluation and calculate incentive payments. The PCMPs are medical homes for beneficiaries managing patient health needs across specialties and along the continuum of care.

Under the ACC model, Medicaid benefits remain the same, but services are expanded to include enhanced care coordination. Beneficiaries are enrolled in the ACC through a passive enrollment process, which means they are notified 30 days prior to enrollment and have the opportunity to opt out or tell the Department they do not want to be enrolled. Beneficiaries then have an additional 90-day opt-out period once they officially start in the program.

To be eligible for the ACC, providers must be enrolled in Medicaid and be one of the following:

1. Certified by the Department of Health Care Policy and Financing as a provider in the Medicaid and CHP+ Medical Homes for Children program;
2. A Federally Qualified Health Center, Rural Health Center, or a clinic or group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology; or
3. An individual physician, advanced practice nurse or physician assistant with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

PCMPs that contract with an RCCO and Medicaid receive a PMPM payment for the medical home services they provide, in addition to FFS payments for services provided. In the first year, PCMPs will receive a $4 PMPM payment. After the first year, that decreases to $3, with the opportunity to earn an additional $1 PMPM incentive for helping the RCCO meet utilization and outcome goals. In the first year, performance measures consist of monthly utilization and quarterly cost measures, with a more robust set of measures in subsequent years. Monthly PMPM payments are made electronically, and are calculated based on the number of members enrolled in each practice at the start of the month. Incentive payments are calculated quarterly.

3. Health Homes

The ACA offers a major opportunity to develop Medicaid health homes for patients with multiple chronic conditions and/or severe mental illness. Through health homes, Medicaid may reimburse for six new health home services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care; (5) individual and family support; and (6) referrals to community and social support services. Care management-related services are increasingly thought of as the "glue" to ensure that clinical services are provided at the right time in the right place by the right provider. Health homes would coordinate and potentially integrate primary, acute, behavioral health, and LTSS for beneficiaries with complex and chronic conditions. States will be eligible to receive 90/10 federal matching funds for two years, thus creating a significant opportunity to demonstrate how coordinated care management can improve quality and potentially bend cost trends. The growing evidence base pointing to the effectiveness of care management models coupled with the availability of enhanced federal matching dollars makes the health home option particularly attractive to state Medicaid programs.

As a result, most Medicaid programs are exploring and planning for the health homes opportunity. States are seeking ways to "layer" these new care management services on top of existing building blocks. For example, some states, like Missouri and New Mexico, are planning to provide health home services to eligible beneficiaries through community mental health centers that would become the health home for individuals with serious mental health conditions. Other states, are considering strategies to enhance existing EPCCM programs (North Carolina), patient-centered medical home programs (Maine), or complex care management programs (Washington) with health home services. States with risk-based managed care delivery systems, like Ohio, are considering the role that health plans could play either in administering health home programs and/or participating as part of the health home team.

States can initiate the health home planning process and access Medicaid funds to design and plan a health home program by submitting a letter of request to CMS. States must submit a state plan amendment to CMS to make the health home services part of the Medicaid benefit package.

4. Leveraging State Purchasing Power

Several respondents suggested that the best opportunity to see real delivery system reform is to work within an "all-payer framework." States can look at the totality of health care purchasing made at the state level and leverage the combined market influence of the Medicaid, CHIP, and state employee health plans. In Massachusetts this market power is even more pronounced through its current funding of the Connector program. The state can use this purchasing influence to help drive aligned payment reform initiatives. Colorado for example, intends to leverage purchasing across the states' Medicaid and employee insurance program through uniform

payment models and quality measures. Vermont is developing a single-payer system aimed at reducing the inefficiencies resulting from cost-shifting and duplicated administrative functions inherent in a system with multiple payment arrangements and payers.

B. Payment Reform Strategies

Overview: A myriad of payment reform strategies are grabbing the attention of state Medicaid programs today. Models that incentivize quality over quantity, such as episode of care or global payments, however, will face resistance from providers who have learned to maximize reimbursement under the current FFS payment structure. Others, such as the health home model, may offer attractive incentives to providers, but require additional capacity and capital investment in HIT that may be prohibitive for many medical practices, especially smaller ones. Fundamental payment reform is difficult, so many states get trapped in a "cut and privatize" cycle where they see their only options as cutting reimbursement rates or outsourcing operational functions to a low-cost vendor to reduce costs. This often short-sighted strategy, however, can lead to cost-shifting, poor outcomes, and increased costs in the long run.

National Landscape: Nationally, there are high expectations that the new payment reform opportunities in the ACA will have significant effects. However, most such strategies in Medicaid are still in early stages of development and few, if any, replicable examples exist. The following payment reform strategies arose during stakeholder interviews.

1. Bundled Payments

Effective January 1, 2013, the ACA offers new opportunities for hospitals, doctors, and providers to be reimbursed a "bundled" or flat rate from Medicare for an episode of care rather than the current fragmented system in which each service or test is billed separately. The "bundled" payment could provide incentives to deliver health care services more efficiently while improving quality. It also allows for savings to be shared between providers and the Medicare program.

Though this provision was created for the Medicare program, states are looking at bundled payments as a way to more efficiently reimburse Medicaid providers. When considering bundled payment strategies, one respondent warned states to remember that Medicare's interests are very different from those of Medicaid. Hospital care accounts for close to half of all Medicare expenditures,[6] but only about 20% of Medicaid expenditures nationally.[7] Thus, hospitals are not the big cost center for Medicaid. While bundled payments may make sense when targeting a certain procedure or limited group of services, when all services are "bundled" and a rate is established, this is arguably no different than a capitation or partial-capitation payment.

6 2010 — 48% of Medicare payments were made for inpatient and outpatient hospital care: http://facts.kff.org/chartbooks/Medicare%20Chartbook,%20Fourth%20edition,%202010.pdf (figure 8.5, page 80).

7 2009 — 13.9% of Medicaid expenditures were on inpatient, 7.1% on outpatient/clinic: http://facts.kff.org/chart.aspx?ch=472 (slide 10).

Bundled payment methodologies have generally been designed for acute care episodes, often involving a hospital stay. A prime example is Geisinger Health System's ProvenCare coronary artery bypass surgery (CABG) program, which pays a flat fee for surgery and all related care for 90 days after discharge. The program has been associated with reduced readmission rates, length of hospital stays, and hospital charges.[8] Within Medicaid, Arkansas announced in March 2011 that it had received federal approval through an §1115 waiver to transition away from FFS payment and use an episode-of-care payment approach to make a single payment to a group of providers. This payment approach will be applied across multiple payers in the state, including Medicare, Arkansas Blue Cross and Blue Shield, and QualChoice. The state expects to begin making payments in mid-2012 starting with elective deliveries of babies before 39 weeks, neonatal intensive care, and hospital readmission.

Medicaid programs should probably focus first on bundled payment opportunities in maternity, pediatrics, preventive care, primary care, and LTSS. For example, Washington State has made strides in reimbursing a C-section delivery at the cost of a complex vaginal delivery. States are also beginning to analyze payment levels for LTSS to see if opportunities exist to bundle those reimbursements. The most prevalent "bundling" examples of LTSS services are individualized budgeting, where the total dollar value of services and supports are under the control of the LTSS program participant. Participants use the budgeted amount to develop a service plan that best meets their needs and can be provided within their allocated budget. Fifteen states participated in a national Cash and Counseling initiative and continue to operate programs. Capitation for LTSS services also continues to gain traction. Bundling payments through a capitation payment to a health plan or other management entity gives the entity more flexibility to provide a wider range of services that can both improve quality of life and cost effectiveness (e.g., through assistive technology).

2. Outcome-Based Contracting

With state Medicaid programs holding such a significant purchasing position in the health care system, respondents believe that Medicaid programs should be an incubator for payment reform and shift payment strategies away from pure FFS reimbursement for the mere provision of services toward outcome-based payments. Restructuring the contracts of managed care organizations, behavioral health vendors, and providers to tie at least some portion of reimbursement or enrollment to outcome- and value-based measures would begin to shift the system toward performance-based contracting. Any such effort, however, will not be easy to design or implement. Establishing outcome-based performance measures (as opposed to process measures such as immunization rates) and reconciling these measures for reimbursement are both

8 A. S. Casale and R. A. Paulus. "ProvenCare℠: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care." *Annals of Surgery*, Volume 246, Number 4, October 2007, p 613.

extremely challenging and resource-intensive. It would take staff with both the time and expertise to reconcile agreed-upon measures as well as robust information technology systems that can handle encounter data analysis.

The ACA takes steps toward promoting outcome-based payments by requiring Medicaid programs to adjust or deny reimbursements for provider-preventable conditions. ACA §2702 and its final rule[9] requires states to adopt a baseline policy for nonpayment of provider-preventable conditions, a new umbrella term that includes two distinct categories: health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). While the ACA only mandates nonpayment of HCACs, the law enables states to deny payment for care and services related to OPPCs as well. The final rule does not provide guidance on any specific payment models nor does it discuss the issue of overall rate reductions for hospitals with high rates of PPCs. States are required to amend their Medicaid State Plans as well as their managed care contracts to comply with the statute, which is set to take effect on July 1, 2012.

While CMS anticipates that the budgetary impact of this provision will be positive, savings are not anticipated to be significant — just $35 million over five years, from FY 2011 through FY 2015. However, the provision was not intended as a cost reduction measure. Rather, it was meant primarily to promote outcome-based contracting and improve quality by incentivizing best medical practice, the prevention of adverse outcomes (including serious injury, death, and addition health care), and the adoption of quality reporting mechanisms.

III. Complex Populations: Long-Term Services and Supports, Dual Eligibles, and Behavioral Health

A. Long-Term Supports and Services

Overview: Nationally, an estimated 94 percent of Medicaid beneficiaries needing LTSS receive their care through the fragmented FFS system.[10] LTSS costs represent almost one-third of all Medicaid spending and these costs will continue to account for greater proportions of Medicaid spending as the nation's aging population generates an increasing need for services. By rebalancing their LTSS delivery systems states can offer consumers broader access to home- and

9 For more information, see Final Rule: Medicaid Program; Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions. Federal Register, Vol. 76, No. 108, June 6, 2011. http://www.gpo.gov/fdsys/pkg/FR-2011-06-06/pdf/2011-13819.pdf

10 P. Saucier. "Overview of Medicaid Managed Long-Term Care." Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.

community-based service (HCBS) alternatives and begin to build the infrastructure and financial policies to better manage overall LTSS spending.

Ultimately, states will be faced with the challenge of deciding whether to fully integrate the care of dual eligibles. A majority of individuals receiving Medicaid-funded LTSS are dual eligibles and they currently receive their primary and acute care separately through Medicare. Some states will start with changes that can be made to improve LTSS delivery without facing all of the complexities encountered in fully integrating the separate financing streams for the dual eligibles.

Efforts are already underway in most states to improve the delivery of LTSS, particularly to move individuals from institutional settings to home and community settings. A significant subset of these states have embarked on fully capitated managed long-term care approaches, thereby creating strong financial incentives for managed LTSS organizations to reduce avoidable institutionalizations in favor of more cost-effective and consumer-friendly HCBS. A number of states, actively encouraged by the federal Medicare-Medicaid Coordination Office, are now realizing that they can simultaneously improve care, control costs and enhance the quality of life for beneficiaries by overhauling their fragmented care systems for those dually eligible for Medicare and Medicaid.

National Landscape: Most states are rebalancing LTSS systems toward community-based care through care management or other non-capitated approaches and a significant number of others are developing and implementing managed long-term supports and services programs. Georgia, Oregon, Vermont, and Washington are examples of states at the forefront with programs that help individuals with long-term care needs live in community settings.[11] Arizona, Hawaii, New Mexico, Tennessee, Texas, and Wisconsin have implemented broad, even statewide, managed care approaches for individuals with long-term care needs.[12] A few leading edge states like Massachusetts, Minnesota, and Wisconsin have been involved in innovative smaller scale efforts to fully integrate care for the duals.

11 A. Lind, S. Gore, S.A. Somers. *Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services,* Center for Health Care Strategies, November 2010.

12 Lind, et al. op.cit.

State Managed Long-Term Care Profile: Arizona Long Term Care System Program

The Arizona Long Term Care System (ALTCS) program was established in 1989 under a §1115 waiver and operates statewide. Enrollees must need a nursing home level of care and be Medicaid beneficiaries or dually eligible for Medicaid and Medicare. Enrollment is mandatory with 49,501 served as of November 2010. Covered benefits include Medicaid acute, behavioral health, and LTSS (including HCBS and nursing facility services). Contractors are not required to be special needs plans (SNPs), but many are. This allows for "virtual" integration of care for beneficiaries who choose to receive both sets of services from a single plan. Program contractors are at risk for all covered benefits, including acute and LTSS services, to create incentives for placement in the community through program rate structures. Contractors include large, national managed care organizations (MCOs) as well as local, public (county-based) plans.[13]

While developing and implementing the ALTCS program, Arizona placed great emphasis on streamlining eligibility systems, growing the state's capacity to support people in the community and creating strong contract oversight with good LTSS-specific performance measures. Specifically, Arizona:

- Recognized the importance of getting individuals assessed and eligible prior to deterioration in their health status. It implemented policies and procedures designed to expedite the financial and eligibility determinations for Medicaid-funded LTSS and used its pre-admission screening tool rather than SSI disability determination.[14]
- Focused on growing its in-home programs by including family members as paid caregivers in its attendant care program, with inclusion of protocols to ensure quality of care. States are reluctant to do this because of concerns about potential fraud but Arizona includes spouses as potential paid caregivers and has not reported problems with this policy. The state further recognized the need to build greater service provision flexibility by allowing contractors to establish Interdisciplinary Care Teams that focus on behavioral health needs of the ALTCS beneficiaries.
- Put mechanisms in place to ensure close oversight of program contractors. The state monitored contractors to ensure that they were providing a state-specific model rather than a more generic, "off-of-the shelf" product. The State additionally put a prescriptive contract in place and worked closely with health plan staff. Performance measures included strict LTSS-focused measures to determine increases in access to HCBS services.[15]

Arizona places great emphasis on providing beneficiaries with alternatives to institutional care and diverting individuals from entering those settings where appropriate. Arizona serves 70 percent of its seniors and population with disabilities in HCBS settings. Yearly, Arizona has a one to two point increase in the proportion of individuals served in the community. Even so, the state continues to review policies to ensure it serves as many beneficiaries as possible in the community, if that is their choice.

13 Ibid.

14 G. Engquist, C. Johnson, and W.C. Johnson, *Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation,* Center for Health Care Strategies, May 2010.

15 Lind et al. op.cit.

B. Integrated Care for Dual Eligibles

Overview: There are over 9.2 million individuals eligible for Medicaid and Medicaid benefits ("dual eligibles") in the U.S.; fewer than 100,000 of them are in fully coordinated delivery systems. Dual eligibles account for close to $120 billion annually in federal and state health care dollars,[16] and many are among the health care system's most complex and costly beneficiaries. The ACA established the Medicare-Medicaid Coordination Office within CMS to work with states to support the development and implementation of new integrated programs for dual eligibles. By the end of 2012, CMS hopes to have over one million dual eligibles enrolled in integrated delivery systems that offer coordinated medical care, behavioral health services, and long-term supports and services. The Coordination Office partnered with the CMS Innovation Center to award 15 states — including Massachusetts — $1 million contracts for the development of these programs. Massachusetts is focusing on the development of an integrated program for dual eligibles under age 65. Further, in September 2011, CMS asked states interested in working with the Coordination Office to develop integrated care programs to submit a Letter of Intent to the office. Twenty-two states, in addition to the 15 states that received Innovation Center funding, submitted letters. The tide of national interest in integrated care is rapidly rising.

National Landscape: Only Massachusetts and a handful of other states, such as Minnesota, New York, Texas, and Wisconsin have had success integrating care for subsets of the dual eligible population; however, to date, no state has been able to integrate care for all dual eligibles statewide. A number of states are now moving quickly in response to new federal support for integrated care. Improving the care of dual eligibles is an issue that has traction on both sides of the political aisle, and for states focused on this population with ideas and the will to move forward, there could not be a more propitious time for seizing the opportunity. A significant challenge exists, however, in that a clear "winner" in program design has not yet emerged, and CMS continues to look for programs that can be replicated and expanded statewide.

States are proposing a wide range of integrated care program models and CMS recently provided guidance on financial models for states. On July 8, 2011, CMS released a State Medicaid Director letter outlining two basic financial models for states to consider: (1) a capitated financial arrangement where states, CMS, and participating plans would enter into a three-way contract to provide care; and (2) a managed fee-for-service arrangement where states can share in Medicare savings that result from Medicaid investments in care coordination.[17] Approved models will be authorized to operate for a three-year demonstration period and CMS will contract for

16 *People Enrolled in Medicare and Medicaid*. Fact sheet from the Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services, August 2011. http://www.cms.gov/medicare-medicaid-coordination/downloads/MedicareMedicaidCoordinationOfficeFactSheet.pdf

17 State Medicaid Director's Letter re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8, 2011. See http://www.cms.gov/smdl/downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

an independent evaluation of these models. They must all address the integration of primary, acute, LTSS, and behavioral health care. CMS and state respondents have also emphasized the importance of stakeholder work for integrated care, not only including providers and plan administrators, but also the beneficiaries themselves. Since integrated care combines services and funding across the full range of agencies, programs, and providers — it is imperative to include the perspective of beneficiaries, who are after all at the center of these efforts.

C. Physical and Behavioral Health Care Integration

Overview: States are more fully recognizing that Medicaid-funded behavioral health services present an important opportunity for program improvement. Behavioral health conditions, including substance abuse and mental illness, are pervasive among Medicaid's high-need, high-cost beneficiaries. Many beneficiaries who have behavioral health conditions have co-occurring chronic conditions and more than 50 percent of Medicaid beneficiaries with disabilities also have a mental illness.[18] The presence of mental illness is linked with health-related costs up to 75 percent higher than for those without a mental illness in individuals with chronic conditions.[19]

Over the past two decades, a significant number of private behavioral health providers have entered a marketplace once dominated by local and publically administered provider networks, and management vehicles such as behavioral health organizations (BHOs) have emerged as a way for states to contract for enhanced management of these services. These changes have increased access to behavioral health services, but have also driven up expenditures and exacerbated fragmentation among medical, LTSS, and behavioral health providers. While some states are satisfied with their current behavioral health delivery system, integrating data and coordinating behavioral health services with medical and LTSS care remains a challenge. Medical providers are often unaware of the behavioral health services, including medications, that their patients receive — services that can play a significant role in a patient's adherence to a medical plan of care. Beneficiary demand for behavioral health services will continue to increase with Medicaid expansion in 2014, and unless states integrate delivery, it will remain inefficient and expenditures will continue to escalate.

National Landscape: States such as Arizona, New York, Minnesota, and Pennsylvania are exploring various models for integrating behavioral health with other services, but replicable best practices are still emerging. Historically, advocates have fought hard against any "management" of behavioral health, but they are now reengaging on these issues, and the ACA, the Mental

18 R.G. Kronick, M. Bella, and T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions.* Center for Health Care Strategies, Inc., October 2009. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1058416.

19 C.Boyd, B.Leff, C.Weiss, J.Wolff, A.Hamblin, and L.Martin. *ClarifyingMultimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies, December 2010. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201.

Health Parity Act, and CMS have re-emphasized the need for improved behavioral health service delivery. Yet the number of stakeholder groups, combined with the complexities of a behavioral health delivery system that includes public and private providers, means that change will not be easy.

1. Data Sharing

One step toward improving behavioral health integration is to promote data sharing between medical and behavioral health providers. Pennsylvania developed a pilot to integrate care for individuals with serious mental illness, facilitated by systematic and timely data exchange between MCOs and BHOs. This included joint identification and risk-stratification of the target population, real-time hospital notifications across systems, and the creation of integrated health profiles updated monthly and shared with PCPs and behavioral health providers. This data exchange is a powerful tool for care coordination, offering each system a more complete view of its members' needs and laying the foundation for productive communication among all care team members. Independent evaluation results from the two-year pilot are expected in early 2012.

2. Integrated Behavioral Health Contracting

Medicaid-funded behavioral health services have historically operated in isolation from medical services, but many states are looking to rectify this fragmentation. Some states contract with Behavioral Health Organizations (BHOs) to provide behavioral health services. BHOs provide specialty knowledge and capacity for managing behavioral health needs, however, until recently, most BHO services were not integrated with medical care. While there are no examples of states that have fully integrated medical care with a BHO's services, states such as Arizona and Iowa are developing programs to enhance medical service integration within their contracted BHOs. Arizona is pursuing a new procurement of its Regional Behavioral Health Authority (RBHA) in Maricopa County. Under the new model, one or more "specialty RBHAs" will manage all physical and behavioral health services for Medicaid beneficiaries with severe mental illness in the county. Iowa is also seeking to better integrate medical services within its BHO. In 1999, Iowa launched the Iowa Plan which is a mandatory, statewide Medicaid BHO that provides behavioral health services to almost all Medicaid beneficiaries under age 65. The plan is currently administered by Magellan and Magellan is at full risk for behavioral health services, whereas physical health services are funded by Medicaid FFS payments. Iowa is currently working to broaden this program to include "Integrated Health Homes" aimed at improving the coordination and integration of behavioral and physical health services.[20]

States are also looking to better integrate contracting for behavioral health services through MCOs. Combining the services and financing for physical and behavioral health services in a

20 A. Hamblin, J. Verdier, M. Au. *Options for Integrating Physical and Behavioral Health.,* Center for Health Care Strategies, October 2011.

comprehensive managed care arrangement helps states ensure accountability for management of a more complete range of beneficiary needs. TennCare integrated behavioral health benefits with mainstream MCOs in 2009. Further, states seeking to develop an integrated care program for dual eligibles through CMS demonstration authority are required to incorporate behavioral health services into their program designs. Michigan is currently incorporating its robust community behavioral health network into its integrated care program design and Arizona plans to do so in October 2013.

IV. Medicaid's Organizational Capacity in an Affordable Care Act and Technology-Driven World

A. Organizational Capacity

Overview: Nationally, the organizational structure and the financial and contracting authority of state Medicaid programs varies widely. Investing in staff and consolidating operational authority for Medicaid-funded services were two themes that resonated with respondents.

National Landscape: Respondents offered a wide range of thoughts for how states can improve the organizational capacity of their Medicaid programs. One respondent suggested that states should focus solely on implementing initiatives that do not require much administrative support or that can be carried out by external contractors. While this may be a very realistic view of the status quo, it is not a sustainable approach. Even if contractors could complete the work, their efforts still need to be monitored and contract provisions have to be enforced. Therefore, states must continue to invest in internal staffing and infrastructure to support contract management and ensure that contractors are achieving contracted goals and meeting performance standards.

Other respondents suggested encouraging leadership to crystallize a vision for the program in both the near and long term that builds on a few key measurable (and "winnable") goals. They also emphasized the need to create an environment conducive to nourishing new ideas — including ideas generated from state staff, policymakers, and external stakeholders. For example, Oklahoma Medicaid has a designated staff unit with the skills and expertise to develop and launch new programs. Without having day-to-day operational responsibilities, these staff members can dedicate the time needed to push scalable innovation throughout the agency. Such a unit would be primed to capitalize on the Affordable Care Act's many opportunities for innovation.

Further, while some states house the administration of all Medicaid-funded services within a single agency, most others administer services through a number of agencies. For example,

states, such as Pennsylvania and Virginia, have agencies that are organizationally separate from the medical assistance program to oversee certain populations and provide certain services (e.g., behavioral health, developmental and intellectual disabilities, and LTSS). Some of the most innovative new programs can be found in Medicaid agencies that have the broadest fiscal and administrative authority over Medicaid-funded services, such as Tennessee's TennCare and the Oklahoma Health Care Authority. Restoring a Medicaid agency into a unified organization would require significant analysis, resources, and political capital. Nonetheless, to meet the demands of being the state's largest health care insurer, such an endeavor may be a worth pursuing.

B. Reengaging Providers in Innovation

Overview: Many Medicaid programs' increased reliance on MCOs has resulted in state staff losing touch with the provider community. Contractual relationships are often between the MCOs and providers. Most Medicaid programs no longer expend resources to build or maintain provider networks, so engaging providers and maintaining open lines of communication with them is no longer a priority. As a result, programs often only hear from providers when rumors of rate cuts circulate. This disconnect makes decisions on reforms and innovations even more difficult because decision-makers are so removed from "on the ground" delivery of care.

National Landscape: A number of respondents felt that the arm's-length relationship between state government and the actual providers of care contributes to provider underperformance. Respondents felt states should consider allocating resources to provider practices, then hold them accountable for a higher standard of services. Providers who are unwilling to accept such accountability standards would be ineligible for enhanced resources or bonuses.

To help create an environment for innovation, states could identify and partner with clinical champions to break down the barriers between state officials and providers. These partnerships would not need to be limited to medical providers. For example, partnerships between behavioral health and LTSS providers would strengthen and provide avenues for innovation in these areas of care. Respondents also recommended that providers receive training on how to be most effective when working within a state bureaucracy and its decision-making structure. Helping providers better understand the policy and program development process may help them make more targeted and achievable recommendations.

The Camden Coalition, the safety-net based ACO in Camden, NJ, provides a model of how facilitated discussion among health care providers can lead to innovation within a delivery system. Most initiatives in Medicaid are top-down; meaning they start with the federal government, state legislature, or Governor's office and are passed down to the Medicaid program to implement. The Camden Coalition started with providers and is now working with the New Jersey Medicaid

program to see how it can partner with Medicaid and ultimately, serve as a new model of care delivery. States should partner with innovative local initiatives, such as the Camden Coalition, to reconnect with providers and bring on-the-ground innovations to a broader, statewide, scale.

C. IT Infrastructure: Health Information Technology and Streamlining Enrollment

Overview: The functionality of state HIT infrastructures varies widely; some state systems are literally decades apart. Certain states such as Washington have invested heavily in HIT and use systems such as Provider One for managing eligibility and another, PRISM, for monitoring individual beneficiary services. Other states have yet to migrate from a DOS-based to a Windows-based system. Electronic medical records (EMR) and enrollment and eligibility systems depend on a robust HIT infrastructure, yet few states even have systems in place to handle basic eligibility determinations, much less optimize technological opportunities. Information technology will play a pivotal role in Medicaid reform operations; however, HIT systems are optimal in only a handful of states.

National Landscape: Real-time online enrollment is one of the single most important contributors to meeting the future needs of Medicaid programs across the country, especially if Medicaid enrollment systems can be linked with state health benefit exchanges. States see clear advantages to automating eligibility and enrollment processes, especially for new populations.

A number of states have embraced the Medicaid Information Technology Architecture (MITA) to build a new HIT infrastructure that will be able to support the business and information needs of Medicaid programs and their Exchange partners. Even with a 90% federal match, however, state Medicaid programs cannot afford to finance these changes in a silo. States are working to determine how these IT innovations can embrace all human services to share the financing responsibility and ensure streamlined coverage.

Despite all the advantages that a well-developed EMR system would bring, neither health plans nor Medicaid programs have fully embraced them. One respondent indicated that under 15% of the non-profit Medicaid health plans that she works with utilize personal health records for plan members, and the states and plans that are investing in EMR systems seem to be investing in systems for select medical providers, but not necessarily for providers who deliver care to complex populations — the population most in need for HIT-based improvements in Medicaid.

V. Opportunities for Further Exploration

State Medicaid programs should be laboratories for innovation and the ACA should be a catalyst for more of it. MassHealth has, in the past, been among the nation's leaders in purchasing value in Medicaid. This landscape scan is intended to encourage MassHealth to continue its leadership in areas like integration of care for dual eligibles but also to identify new opportunities. Following is a "non-exhaustive" list of opportunities to spark a new burst of program innovation.

- **Conduct a targeted purchasing strategy study** to evaluate the effectiveness of purchasing in states that, like Massachusetts, operate a number of purchasing approaches, compared to states that operate or are moving to a single strategy, such as Oklahoma and Tennessee. This would include a thorough data analysis of all costs and supplemental payments such as: Disproportionate Share Hospital (DSH) Payments and Upper Payment Limit (UPL) Payments;[21] per diem rates (Illinois and California are examining these); provider taxes; and other supplemental payments. It may be difficult to build bundled payments or reform approaches while maintaining multiple payment systems and purchasing approaches including ACO, global payment, managed care, etc.
- **Conduct a targeted ACO study** with states identified as leaders, such as New Jersey and Colorado, in incorporating this new model.
- **Develop stakeholder engagement strategies for integrated care** around member materials and outreach and communication venues. While state staff are already engaged in stakeholder work, providing additional support in this area would likely benefit program development.
- **Work with providers** to help them to be maximally effective when providing input into program design and innovation.
- **Outline a clear long-term (five-year) vision and measurable short-term program goals.** Program leadership can monitor progress on these measures on a scheduled basis through publication of a dashboard.
- **Analyze the political and fiscal pros and cons** of options for reforming MassHealth's organizational structure, including the creation of an "innovation" or "planning" unit; and the reconsolidation of accountability for all Medicaid-funded services.

21 The 2011 DSH allotment for Massachusetts is over $305 million and in 2005, the DSH and UPL payments represented 18.9% of Medicaid spending (retrieved August 11, 2011 from http://www.statehealthfacts.org/profileind.jsp?rgn=23&cat=4&ind=185 and http://content.healthaffairs.org/content/26/5/1469/T1.expansion.html.

VI. Conclusion

States are facing enormous challenges in reforming their health care delivery systems, but at the same time, it is a propitious time for progress. Opportunities abound through payment reform strategies, improvements in care of complex populations, provider engagement, and the strengthening of organizational capacity. Massachusetts can go in many different directions to improve the quality and efficiency of care. Through a strategic long-term vision and doable and measurable short-term goals, MassHealth can secure its spot as a leader in Medicaid innovation. Massachusetts and MassHealth have innumerable strengths to further innovation. By combining the new opportunities afforded by the ACA with the investment of Massachusetts' stakeholders and history of innovation, the nation will undoubtedly look toward Massachusetts to chart the course for innovation and system reform for the next decade.