Alaska Healthcare Transformation Project

National Scan

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I. Project Overview and Summary

During the fall of 2018 and the spring of 2019, NORC at the University of Chicago (NORC) and its partners at the University of Alaska Anchorage (UAA), referred to as the NORC team, worked with the Alaska Healthcare Transformation Project and its Project Management Committee (the PMC) to support the state's vision of improving "the health of Alaskans while also enhancing patients' and health professionals' experience of care and lowering the per-capita healthcare growth rate."[1] NORC's charge consisted of four separate scopes of work (SOW), as follows:

- **Alaska Historical Project Scan.** Identify and assess selected delivery system reform experiments in Alaska over the past decade (2008 to the present), with priority to characterizing regional innovation within the state.
- **Alaska Studies—Meta-Analysis.** Identify and assess a group of Alaska-focused reports and studies issued over the past decade (2008 to the present) that concern health reform.
- **National Scan.** Develop case studies for selected states where delivery system reform relevant to Alaska's five key topics of interest offers lessons for prospective innovation.
- **Drivers of Health Care Costs and Spend in Alaska.** Review health care spending in the state and the prospects and limitations of available data sources that would support a fine-grained analysis of cost drivers relevant to these reforms. Based on this review, prepare a set of estimates of potential reform-related savings and a draft roadmap with proposed short-term (within one year) and long-term steps that comprise one or more pathways to reform.

This report focuses on the third SOW, a National Scan of states engaged in innovative reform or transformation initiatives "focused on improving citizens' health, enhancing patients' and/or professionals' experience of care, and lowering the per-capita health care growth rate from 2008 through 2018."[1] A main objective of the National Scan is to assist Alaska's future decision-making with regard to developing and implementing health care transformation that achieves the three goals specified by the PMC:

- **Healthy Alaskans:** Increase the percentage of Alaskan residents with a usual source of primary care by 15 percent within five years.
- **Healthy Economy:** Reduce the overall per-capita health care growth rate to the greater of 2.25 percent or CPI within five years.
- **Everybody's Business:** Align all payers—public and private—toward value-based alternative payment models with streamlined administrative requirements within five years.

In addition, the PMC defined five priority topics as building blocks of health care transformation in the state: (1) **increase primary care utilization; (2) coordinate patient care; (3) implement payment reform; (4) increase data analytics capacity;** and **(5) address social determinants of health (SDOH).** These priority topics are described in more detail in Exhibit 1.

Exhibit 1. Alaska Healthcare Transformation Project Strategies and Building Blocks by Priority Area

Increase Primary Care Utilization	Coordinate Patient Care	Increase Data Analytics Capacity
▪ A primary care system comprising a team of professionals ▪ Offers comprehensive whole patient care ▪ Patients have a usual source of care ▪ Includes communities of engaged practitioners actively involved in their patient's wellbeing ▪ Involves patients in the management of their care ▪ Behavioral health integrated into primary care ▪ Increased supply of primary care providers ▪ Workforce practices at top of licenses	▪ A system wide approach to patient-centered, whole-person care ▪ Primary care providers serve as care navigators care across specialists, facilities, and provider groups ▪ Aligns payment incentives to support care coordination ▪ Focuses on emergency care coordination and behavioral health in emergency departments	▪ A system that supports and is accessible to providers, hospitals, insurers, government payers, policymakers, and consumers ▪ Data warehouse that can compile claims data across state payers and other payers as appropriate ▪ Professional staff with appropriate quantitative and qualitative data analysis background to analyze data ▪ Increases access to and use of data in coverage decisions ▪ Improves public perception of health care accomplishments/ outcomes/ cost, with quality and cost data transparent to the public

Implement Payment Reform	Address Social Determinants of Health (SDOH)
▪ Payment reforms with a specific focus across payer groups (e.g., physical, behavioral and supportive services, etc.) ▪ Integrates value-based payments and benefit design into existing structure ▪ Promotes and expands the use of pilot projects to identify successful strategies ▪ Reinvests a portion of savings back into the system ▪ Integrates evidence-based medicine into health benefits ▪ Develops standards for specific categories of service (e.g., technology, pharmaceuticals, etc.) ▪ Includes leverage points in the payment structure to create incentives for provider participation and behavior change (e.g., shared cost savings) ▪ Reduces the differences in payments across providers	▪ Identifies and quantifies the impacts of SDOH ▪ Develops strategies for addressing SDOH 9e.g., integration into care plan) ▪ Focuses on adverse childhood experiences ▪ Identifies and coordinates resources

Source: Alaska Healthcare Transformation Project, Scope of Work for National Scan

This report presents the findings, key takeaways, and relevant resources from seven in-depth case studies, as well as considerations on the various approaches for Alaska's own transformation efforts. We open this report with a description of the state initiatives and characteristics. Then we present top-level findings across the seven state case studies and discuss lessons learned. We follow with the seven individual, detailed case studies. The technical appendices include the initial environmental scan of states used to select the final seven states prepared under this SOW and a table comparing the demographic, socioeconomic, and geographic characteristics across the seven states and Alaska.

The successes, experiences, challenges, and outcomes of other states' initiatives provide lessons and approaches that Alaska can tailor to meet the needs of its population. Though no two states are exactly alike and wholesale adoption of an initiative is unlikely, an understanding of how other states implemented their initiatives and the similarities among other state populations and that of Alaska residents can inform the state on ways to adapt models or elements of models to meet the unique characteristics of the state.

II. Selection of Case Study States

The NORC team conducted a targeted environmental scan of innovative models or approaches being used in other states. The scan was guided by the five priority areas noted above and defined in Exhibit 1. NORC identified a range of different models implemented in states that are similar to Alaska in one or more key characteristics: relatively low population density, large rural areas, a significant percentage of Medicaid enrollees who are American Indian/Alaska Native (AI/AN), and using a predominantly fee-for-service (FFS) payment model for Medicaid. The scan provides basic state characteristics and a high-level description of the model(s) featured and offers references for more in-depth information and future research. In addition, the initial list of states also emphasized multiple-payer (multipayer) health reform initiatives—that is, reform efforts that incorporate and/or align payments across different types of payers (e.g., Medicaid/CHIP, Medicare, commercial). Further, the scan noted whether the state participates in the Centers for Medicare & Medicaid (CMS) State Innovation Models (SIM) Initiative; maintains an All-Payer Claims Database (APCD); or uses the Health Care Payment Learning and Action Network's (HCP-LAN) definitions of Alternative Payment Models (APMs)[2] as a framework for structuring or describing their payment models.

The scan included 3 to 7 examples of state initiatives for each priority area and highlighted 17 states in total, as a number of states were highlighted in more than one priority area. The NORC team submitted findings from the scan—an initial list of states with selected delivery system reform efforts—to the PMC for discussion at its November 9, 2018 meeting. The PMC then selected the seven states described in greater detail in this report. The environmental scan submitted to the PMC can be found in Appendix 1.

III. Overview and Summary of the State Case Studies

In November 2018, the NORC team met with the PMC to discuss the environmental scan and identify states for in-depth case studies. Based on the discussion, the PMC selected on seven states with a wide range of health reform models and strategies: Arkansas, Colorado, Maryland, New Mexico, North Carolina, Oregon, and Washington.

The NORC team relied on publicly available information, such as state websites, state reports and policy documents, evaluation reports, issue briefs, and research articles, for the case studies. This section summarizes the health reform efforts undertaken by the seven states and state characteristics, and discusses key themes and considerations for Alaska and lessons learned. The detailed case studies provide information on each state's context, goals, and health reform implementation process; the mechanics of each approach; and results, lessons learned, and next steps. It is worth noting that most, if not all, of the states reviewed have been engaged in health reform activities over an extended period of time. This

highlights the interactive nature of health reform, but also provides Alaska an opportunity to learn and take lessons from the experiences of other states. Further, the efforts highlighted are a mix of multipayer and Medicaid initiatives, although in most cases the Medicaid initiatives could be adapted to a multipayer environment.

Description of State Health Reform Initiatives

Following are summaries of the health reform efforts the PMC was interested in highlighting for each of the seven case study states:

Arkansas's *Health Care Payment Improvement Initiative* (AHCPII) is a multipayer strategy (Medicaid, state and public school employees, commercial plans, and Walmart) focused on establishing patient-centered medical homes (PCMHs) and episodes of care (EOC) to:

- Contain the cost of care and improve quality of care through the use of PCMHs; and
- Improve quality of care and reduce variation in both the treatment of acute conditions and delivery of specialized procedures by incentivizing providers to manage patient care within designated timeframes through EOC.

Colorado has two initiatives of interest:

- The ***Colorado Framework*** is a multipayer SIM initiative to integrate behavioral and physical health in primary care settings. Practices participating in the Colorado Framework integrate behavioral health and primary care along a continuum, from coordination between services to co-location to fully integrated care with an embedded behavioral health provider.
- The ***Accountable Care Collaborative (ACC) Program*** uses value-based payment (VBP) approaches to move Medicaid enrollees into Primary Care Medical Provider (PCMP) offices, which serve as medical homes for the enrollee. The model is person-centered, promotes self-management, and provides culturally sensitive care. Based on the PCMP attribution, the member is assigned to one of seven Regional Accountable Entities (RAEs), which oversees both medical and behavioral health services. In addition, RAEs oversee networks, onboard enrollees, and use VBP approaches through their arrangements with providers.

The **Maryland *Total Cost of Care* (TCOC)** demonstration is a multipayer strategy that leverages global budgets to set a limit on hospital expenditures by setting a per-capita limit on Medicare total cost of care in the state. Various elements of the program support the state in limiting expenditures:

- TCOC builds upon Maryland's 40 year all-payer (commercial, Medicaid/CHIP, Medicare) rate setting history whereby each hospital receives a population-based payment to cover all hospital services provided during the year. In addition, the Care Redesign Program (CRP) allows hospitals to make incentive payments to nonhospital health care provider partners who perform care redesign activities to improve quality of care and achieve certain savings under a fixed global budget.
- The Maryland Primary Care Program offers incentives to providers who deliver advanced primary care services to patients to transform the primary care system. Providers receive an

additional per beneficiary per month (PBPM) payment from CMS to cover care management services.

- With data from commercial payers, third-party administrators (TPA)/self-funded payers, Medicaid, and Medicare to support health system transformation, TCOC leverages Maryland's state health information exchange (HIE) system—the Chesapeake Regional Information System for Our Patients (CRISP)—and the state's all-payer claims database (APCD).

New Mexico's *Centennial Care* program, the state's Medicaid managed care program, requires Medicaid managed care organizations (MCOs) to have VBP arrangements with their contracted providers in order to reduce costs and coordinate care.

- The program operates by contracting enrollee care to MCOs, each of which finances and delivers health care to their enrolled members.
- It also incorporates VBP features into its managed care contracting to improve quality and decrease cost of care by offering incentives for targeted outcomes.
- In addition, the state legislature funded an ongoing evaluation of options to allow non-Medicaid eligible populations to buy into the Medicaid program. The study recommended targeted Medicaid buy-in as a preferred option for the state, in which the state would offer Medicaid-like coverage outside of the marketplace, targeting residents ineligible for public programs.

North Carolina's *Medicaid Transformation* demonstration pilots programs that addresses SDOH for high-risk enrollees, shifts its Medicaid population into managed care, and utilizes VBP approaches within the MCOs and advanced medical home (AMH) structure. The demonstration includes the following components:

- The demonstration shifts Medicaid and NC Health Choice (CHIP) beneficiaries to managed care through a regional, phased-in approach. Prepaid health plans (PHPs), which are managed care plans, that provide integrated physical, behavioral, and pharmacy services and will eventually offer tailored plans that provide integrated physical, behavioral, intellectual/development disability (I/DD), and pharmacy services.
- PHPs are required to screen beneficiaries for unmet health-related social needs, and if needs are identified, connect them to social services. In addition, the *Healthy Opportunities Pilots* will test evidence-based interventions targeting housing stability, food security, transportation access, and interpersonal safety.
- AMHs will be the primary vehicle for delivering care management as the state transitions its Medicaid program to managed care, and will serve as the state's primary care case management (PCCM) program. The AMH program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity.

Oregon's *Care Coordination Organization* (CCO) model uses a VBP approach – global budgets – with regional collaboratives to provide integrated physical, mental, and dental health care for its Medicaid population. The CCO model includes the following elements:

- CCOs integrate and coordinate health care services, integrating financial streams previously carved out for separate organizations to achieve administrative efficiencies and better meet the needs of beneficiaries with co-occurring physical and behavioral health conditions. CCOs also enroll patients in patient-centered primary care homes (PCPCHs) to offer case management, support patients with special health care needs, and emphasize preventive health care services.
- They provide flexible services that address non-clinical needs, including housing assistance and traditional health worker initiatives through CCOs.
- Alternative payment methodologies are utilized by CCOs to incentivize value. CCOs track their progress on a set of quality metrics that are reported to CMS, and they can receive annual bonus payments tied to their performance on a set of incentive measures.

The ***Healthier Washington*** multipayer initiative undertakes comprehensive health system transformation for its Public Employees Benefit Board (PEBB) and Apple Health (Medicaid) enrollees by implementing VBPs, building healthier communities, and promoting whole-person care. The initiative aims to:

- Integrate physical and behavioral health, with the state contracting with MCOs to provide integrated physical and behavioral health services for Apple Health enrollees;
- Leverage regional organizations, called Accountable Communities of Health (ACHs), to work in parallel with MCOs to coordinate and integrate health and social services, develop regional health improvement plans, and promote health equity; and
- Test four VBP models, with the goal of ultimately transitioning 90 percent of provider payments under PEBB and Apple Health to VBP mechanisms by 2021.

The diverse representation of states provides the Alaska Healthcare Transformation Project and the PCM with important information to learn about the different ways states designed, implemented, and incorporated features such as quality measurement, data analytics, and stakeholder engagement into their approaches. Understanding the rationale behind these decisions can support Alaska with future similar decision-making.

State Characteristics

Alaska's state demographics and health care delivery system differ from most other states in various ways:

- The economy is mainly driven by the oil and gas industries, which make up nearly 85 percent of the state budget. Other important industries in Alaska are tourism, fishing, timber, mining, and agriculture. It is worth noting that, while the oil and gas industries have historically been a major source of funding for the state budget, this is evolving due to a decline in throughput and price per barrel. For instance, portions of the earnings from the permanent fund are being used for state services, with this being an issue of discussion at the state legislature.[3]

  Alaska has a large rural population (34 percent in 2018). While there is not one definition of frontier communities, in general, frontier America consists of sparsely populated areas that are geographically isolated from population centers and services and a large majority of Alaska is frontier in that it has a low population density (a population per square mile of 1.2 in 2010),

which creates challenges for delivery of health care services to many areas within the state. In addition, a large share of the Alaska population is AI/AN (15.3 percent), which requires coordination with the state's tribal health system.

- Alaska has a complex health care system grappling with per capita health care costs vastly higher than national average (as compared with $11,064 in Alaska in 2014). Potential causes of the high health care costs include: a relatively small population; large areas that are remote; problems with attracting workers (including physicians) to the state, resulting in high payments to doctors and hospitals, especially specialty physicians; and high cost of transporting drugs, equipment and/or patients, often by air or sea.
- The state has limited experience with cost-containment strategies, including gate-keeper approaches and managed care. There is minimal managed care presence in both public and private insurance markets. While the state has recently implemented a Medicaid managed care pilot program, virtually all of the Medicaid and commercial population is in FFS.
- The state is grappling with socioeconomic factors that impact population health, including unemployment (6.3 percent) that is higher than national average.

Despite a few key differences, Alaska shares some of the same health care challenges and considerations as other states, including increasing health care costs, minimal use of a managed delivery system, and an increasing need for behavioral health and SDOH integration and services. The seven selected case study states are similar to Alaska in the following ways (a more detailed table of how Alaska compares to the seven case study states is available in in Appendix 2):

- **Arkansas** has a large rural population (37 percent) and a population density (56 residents per square mile) lower than the national average of 87.4 residents per square mile. Like Alaska (139.1), the share of primary care providers per 100,000 residents in Arkansas (120.9) is lower than the national average of 156.7. Both Arkansas and Alaska are Medicaid expansion states with similar eligibility levels for enrollees.
- Though not as high as Alaska, **Colorado** also has a share of residents living in rural areas (22 percent) higher than the national average of 14 percent. Nearly two-fifths (39 percent) of counties in Colorado are considered frontier. Both Alaska ($72,231) and Colorado ($65,458) have median household incomes above the national average of $57,652. Like Alaska, Colorado is a Medicaid expansion state and its FMAP is 50 percent. In addition, as in Alaska, the share of primary care providers per 100,000 residents in Colorado (141.3) is lower than the national average of 156.7.
- **Maryland** and Alaska are the most dissimilar of the seven selected states, given it has a low share of residents living in rural areas and has a high population density. Maryland ($59,983) and Alaska ($70,683) both have state per capita spending, median household incomes ($78,916), and per capita health care spending ($8,602) above the national average of $55,418 state per capita spending, $57,652 median household income, and $8,045 per capita health care spending. Like Alaska, Maryland is a Medicaid expansion state and receives 50 percent FMAP for Medicaid spending. Neither state has a PCCM program.
- **North Carolina** has 21 percent of its population living in rural areas. Both North Carolina (11 percent) and Alaska (14 percent) have uninsured rates higher than the national average of 9 percent. Though North Carolina is transitioning its Medicaid population to managed care in 2019,

both states previous had no Medicaid population in managed care. Furthermore, like in Alaska, North Carolina has 2.1 hospital beds per 1,000 and the number of primary care providers per 100,000 (132.5) is lower than the national average of 156.7.

- Of the seven case study states, **New Mexico** is the most similar to Alaska in demographics. The state has a large share of rural residents (34 percent), is a low density state (population density per square mile of 17), and 47 percent of its counties are frontier. New Mexico also has a large AI/AN population (11 percent). Both states (New Mexico: 5.1 percent and Alaska: 6.3 percent) face unemployment rates higher than national average of 3.9 percent. Government is a large non-farm industry in both states. Both states adopted Medicaid expansion. Both states (New Mexico: 141.6 and Alaska: 139.0) have the number of primary care providers per 100,000 residents below national average (156.7).
- In **Oregon,** the share of residents living in rural areas (16 percent) is above the national average of 14 percent, the population density per square mile (39.9) is lower than national average (87.4), and the share of frontier counties is 27 percent. Both Alaska and Oregon are Medicaid expansion states. Similar to Alaska (139.0), the number of primary care providers per 100,000 residents in Oregon (145.4) is below national average (156.7).
- An eighth (12.5 percent) of counties in **Washington** are frontier. Like Alaska, the state spending per capita ($64,937) and median household income ($66,174) are above the national averages of $55,418 state per capita spending and $57,652 median household income. In addition, both states have unemployment rates (4.3 percent in Washington) higher than the national average of 3.9 percent. Both states adopted Medicaid expansion and have a 50 percent FMAP matching rate. Furthermore, like Alaska, the number of primary care providers per 100,000 residents in Washington (146.5) is below national average (156.7).

Overarching Themes and Considerations for Alaska

In this section, we summarize high-level findings from our seven in-depth state case studies to address each of the PMC's five priority topics as well as other relevant considerations for Alaska. Each state reform model has design features that may facilitate or challenge Alaska in implementing a similar structure. Details on the impact, lessons learned, challenges, successes, and considerations specific to each state studied are included in the detailed case studies in subsequent sections of this report. The state initiatives highlighted are in varying stages of maturity with some in early stages of implementation. Therefore, there is limited information on the impact of many of the state's approaches on cost of care or health outcomes. The case studies highlight findings when available. In addition, it is important to understand Alaska's unique factors when considering these high-level findings and their application to Alaska, including its state-specific regulations and legislation (e.g., Alaska's "80th percentile rule,"[4] and Statute 21.07.030 [Choice of Health Care Provider, COHP] under SB282[5]) and the state's unique integration with Indian Health Services (IHS).

PMC Priority: Implement payment reform

Multipayer reform may help reduce or slow the growth of health care costs.

Alaska Background Context. Alaska's health care system is fragmented into multiple systems and a decentralized structure, with a complex landscape of payers. It ranks as the state with the lowest share of private-sector employers that offer health insurance (32 percent) and Alaska Native Tribal Health Consortium's (ANTHC) facilities serve as a de facto safety net for AI/AN and their neighbors. One of the key goals of the Alaska Healthcare Transformation Project is alignment of all payers—both public and private—toward VBP innovation.

Examples from Case Study States. Various case study states align health care payments across multiple payers.

- **Arkansas's** AHCPII is a statewide multipayer initiative across Medicaid, commercial plans, and state and public school employee plans. It is built around patient-centered delivery models and is now supporting care delivery for a large and increasing number of the state's citizens. Arkansas was able to take advantage of the relatively small number of commercial payers in the state to develop close and actively engaged relationships with payers. State officials describe the multipayer approach as one of AHCPII's major strengths.
- **Colorado's** Framework uses a multipayer collaboration between Medicaid and five health plans to help primary care practices throughout the state integrate physical and behavioral health services. In addition, the Framework includes partnership with the Colorado Multipayer Collaborative, which is expected to facilitate an ongoing relationship for reform efforts in the state.
- **Maryland**'s All-Payer and Total Cost of Care models build on over 40 years of history with rate-setting and establishes hospital payment rates across payers (commercial, Medicaid, Medicare) using global budgets. This approach has reduced fragmentation within Maryland's health care delivery system, resulted in an estimated $429 million in total Medicare hospital savings since implementation of the All-Payer model in 2014, sustained rural health services, and improved quality of care. Maryland administrators note that value-based incentives are aligned across hospitals' entire business. For this reason, hospitals can fully invest in transformation and care delivery, rather than grapple with a mix of payers and incentives, a challenge that can result in less-than-full investment in transformation. Hospitals in Maryland were willing to restructure their business models in exchange for financial stability and predictability.
- **Washington** is testing an integrated, multipayer data platform capacity that will allow providers to coordinate care, share risk, and engage a sizeable population across payers. In addition, Washington's Rural Multipayer Model will implement global budgets for rural hospitals with incentives for quality and primary care measures. Payers include Medicare FFS, in-network Medicare Advantage, Medicaid FFS, Medicaid MCOs, and large commercial payers.

Key Considerations for Alaska. A shift towards multipayer reform in Alaska may provide the state with fixing a fragmented system as well as new opportunities to align payments and promote consistency across payers. This in turn may lead to slowed down growth in health care costs as well as support a value-based framework focused on improving quality and access and greater efficiency across the

delivery system. Multipayer reform, however, will require cooperation and buy-in from the state's key commercial payers, tribal organizations, as well as state and local governments, public school districts, and retiree benefit programs. Alaska could begin initial conversations with its larger commercial payers and tribal organizations regarding what types of VBP models are of interest.

One VBP option—global budgets—may be paired with care transformation to address the critical financial condition of hospitals in tandem with the health needs of their communities, particularly in rural areas.

Alaska Background Context. The cost of care for payers and consumers is higher in Alaska than in most other states. In 2014, Alaska had the highest per-capita health care spending, almost 38 percent above the U.S. average. Between 1991 and 2014, Alaska's health care spending grew at a rate of almost 8 percent, almost two percentage points above the average U.S. growth rate.

Examples from Case Study States. Two case study states have used global budgets to achieve savings and/or reductions in cost of care and stabilize costs in rural hospitals, providing extra support for rural hospitals to ease transitions into an all-payer program, as follows:

- **Maryland's** Health Services Cost Review Commission has been setting hospital payment rates across payers for over 40 years. This approach, which has evolved over time, has allowed the state to address fragmentation, reduce costs, improve quality of care, and provide hospitals a more predictable stream of revenue through its global budget. In 2011, Maryland initiated a total patient revenue system (TPR) for 10 of its hospitals serving rural communities, forming a transformation collaborative to develop care strategies to support patients beyond hospitals, and improve quality of care and population heath using care management strategies and multidisciplinary clinics. With TPR, these hospitals were able to maintain financial viability and reinvest resources in needed community supports and care.
- **Washington's** State Health Care Authority (HCA) has partnered with providers, health plans, CMS, and others to explore a new payment approach to drive delivery system transformation in rural communities. This includes a fixed annual revenue (global budget) paid monthly to provide a stable stream of revenue, and stabilize cash flow and care transformation support. The HCA, in partnership with the Washington State Hospital Association, awarded $10,000 mini-grants to each of 10 rural hospitals designated as a Critical Access Hospital, to support them as they move their health and wellness systems to integrated care.

Key Considerations for Alaska. Alaska's residents are scattered across its vast geography, meaning that rural hospitals are a critical part of the state's safety net. Global budgets tied to care transformation metrics may provide hospitals overall, and rural hospitals specifically, with more predictable streams of revenue. However, the state would need to consider how its low population density would affect its ability to implement global budgets, and determine the need for multipayer collaboration within a global budget structure in order to have sufficient population.

Integrating payment reform into a non-managed care environment is an option for states where managed care may be challenging or not feasible.

Alaska Background Context. Alaska's Medicaid population is entirely FFS, although the state is in the process of implementing a three-year Medicaid managed care pilot with UnitedHealth Care in more urban parts of the state (the Mat-Su Borough, Anchorage Municipality, Juneau City and Borough, and Fairbanks Borough).

Examples from Case Study States. Though many case study states have moved their Medicaid population into managed care, some have established payment reform efforts within non-managed care environments in order to reduce costs. These "middle road" options enable VBP incentives and related payment reform while operating within an FFS environment.

- **Arkansas's** PCCM program manages care for adult Medicaid enrollees, with exceptions for adults with disabilities, enrollees eligible for both Medicare and Medicaid, and AI/ANs. Providers are paid PMPM for case management.
- **Colorado's** RAEs allow Colorado to leverage specific parts of managed care within its ACC program, such as bidding for contracts, medical homes, and capitated payment. RAEs receive incentive payments and have the flexibility to design VBP arrangements to work with their network providers. Enrolled PCMPs receive FFS payments for medical services they provide to ACC members and a PMPM to assist in supporting medical home services. Providers are also eligible for quarterly performance incentive payments, based on key performance indicators. Colorado describes this mixed payment structure as "managed FFS." This design is sensitive to local experiences with payment reform and allows health plans and providers to acclimate to the reform more slowly.
- **North Carolina's** PCCM has been part of its Medicaid program since 1991, under the auspices of Community Care of North Carolina (CCNC). CCNC has operated statewide, covering 90 percent of the Medicaid population in 2018, providing enrollees with a designated medical home and primary care provider to coordinate care. The PCCM contained a strong care management infrastructure for all enrollees, as well as transitional care populations, high-risk/high-cost patients, and supports for pregnancy care and other programs. PCCM has been folded into the AMH program for managed care enrollees under the Medicaid Transformation demonstration.

Key Considerations for Alaska. Alaska may consider arrangements for payment reform that exist outside of a managed care environment, using regional organizations or PCCM programs. An incremental design approach could allow Alaska to try new care delivery and payment mechanism options while maintaining the basic structure and integrity of the current market and system and expand and build as programs mature.

Incorporating flexibility into VBP approaches and models allows states to meet health plan and enrollee needs.

Alaska Background Context. AKHCC made payment reform one of its key recommendations, calling for payment reform that makes local approaches (acknowledging the Nuka System's home-grown character) and primary care a priority. In recent years, Alaska has launched several VBP efforts, following expansion of the Medicaid program in 2015. For example, SB74 includes multiple provisions around

VBP and alternate payment models (APMs), including expansion of an earlier program to assess penalties on hospitals for avoidable readmissions and testing of bundled payments for specific episodes of care and global payments; the bundled payment initiatives include participation in the national Bundled Payments for Care Improvement (BPCI) initiative and testing a bundled payment approach under the Alaska Innovative Medicine (AIM) model. In addition, Alaska is developing a group of coordinated care demonstrations projects, including a Medicaid managed care model and a PCMH model.

Examples from Case Study States. All case study states incorporate VBP into their health reform efforts. Four are notable for offering flexibility in VBP arrangements that allow participating plans and providers to engage in risk-sharing arrangements at various levels.

- **Maryland**'s Care Redesign Program (CRP) allows hospitals to make incentive payments to nonhospital health care provider partners who perform care redesign activities. These activities must be aimed at improving quality of care if a certain level savings have been met under a fixed global budget.
- **New Mexico** mandates that its participating MCOs incorporate VBP initiatives into their arrangements with their contracted providers but provides them some flexibility in the VBP models they chose to implement. Plans may participate at various levels: Level 1: includes a fee schedule with financial rewards/incentives and penalties/withholdings based on achieved metrics; Level 2: involves full or partial-risk capitation through a shared savings model or two or more bundled payments for episodes of care; and Level 3: can be implemented through a fee scheduled-based system, full or partial-risk capitation, or global payment.
- **North Carolina**'s Healthy Opportunities pilots will develop a pathway to VBP for providers and plans, to include incentive payments during the first two years, withholding of payment for failure to meet defined metrics in the next two years, and a shared savings model in the final year.
- **Washington** has committed to transitioning 90 percent of HCA provider payments under its PEBB and Medicaid to VBP mechanisms by 2021. It will test four payment models, including an APM for Medicaid managed care patients who receive care at FQHCs and rural health centers.

Key Considerations for Alaska. As Alaska continues to move toward VBP approaches, incorporating flexibility and tiers may allow providers and plans time to establish needed infrastructure for payment reform. It is important to understand that different providers have different capacities and resources available to implement reforms. In addition to flexibility is consideration for providing sufficient time and technical assistance for moving forward to all stakeholders involved. This will be key to gaining support and buy-in.

Establishing alternative individual coverage options for the Medicaid expansion or other population may be another potential strategy for health reform.

Alaska Background Context. While Alaska has adopted the Medicaid expansion option under the Affordable Care Act (ACA), uninsured rates in Alaska remain above the national average (14 percent) and Alaska has only one issuer in its individual insurance Marketplace.[7] Buy-in programs vary greatly and can be tailored to meet health reform goals of specific market dynamics. These include public options that involve offering consumers a more affordable health care coverage option by leveraging, in some way, the administrative savings and bargaining power of public programs. One report finds that buy-in

programs can "reduc[e] the uninsured rate by expanding access to subsidized or lower-cost coverage… Reduc[e] costs and increasing the affordability of coverage and care for consumers… Introduc[e] a new, stable option into the individual market; Injec[t] greater competition into insurance markets; [and] Simplif[y] coverage."[8] Across the country, federal and state policymakers, including those in Medicaid expansion states, are considering the benefits and drawbacks to buy-in programs.

Examples from Case Study States. Some case study states have assessed the feasibility of establishing alternative options for individual coverage for those ineligible for Medicaid.

- **New Mexico**'s legislature passed a bill to study options for improving affordability and access for non-Medicaid eligible New Mexicans. The study revealed four potential options: a targeted Medicaid buy-in that offers Medicaid-like coverage outside of the marketplace to residents ineligible for public programs; a qualified health plan public option for low-cost coverage on the marketplace; a basic health plan option for coverage of individual residents who have an income up to 200 percent of the federal poverty line but are ineligible for Medicaid; and a Medicaid buy-in for all option that offers Medicaid coverage to everyone in the state, except Medicare beneficiaries, with a broad range of options. Most, except the targeted Medicaid buy-in, require a federal waiver to implement. A subsequent study modeled the impact of the targeted Medicaid buy-in, focusing on consumers who were currently ineligible for subsidized coverage. After the release of the study, two companion bills have been introduced to implement the targeted Medicaid buy-in for 2021 coverage and to study the remaining three designs in more detail for potential expansion.
- In 2018, consumer advocates in **Colorado** sponsored a feasibility study on Medicaid buy-in as a possible response to the high increase in ACA premiums that state residents have experienced since 2014. The study found that with Medicare provider reimbursement rates, a buy-in plan could have a 28 percent lower premium than the average individual market plan in Colorado before the buy-in. Two coverage bills have since been introduced in the state legislature. The first calls for a detailed analysis and proposal for a state coverage option before the next legislative session, and the second proposes a pilot program that would allow residents of high-cost regions to access the state employee health plan via a buy-in.
- In addition, **Arkansas**' Private Option requires the Medicaid expansion population to enroll in private health plans offered through the Arkansas Marketplace and Medicaid pays the premiums. Early findings on the Private Option include improved access to primary care and prescription medications; reduced reliance on the emergency department; increased use of preventive care; and improved perceptions of health and quality among low-income adults. The Private Option has also been credited with increasing competition in the Arkansas Marketplace

Key Considerations for Alaska. Following the footsteps of these other case study states, Alaska could consider assessing potential alternative individual coverage options as a way of enhancing coverage options in its Medicaid and individual insurance marketplace, increasing access to insurance for its uninsured population, and promoting affordability of health care coverage. State-administered buy-in programs can offer a more localized solution to the problems of a particular region, tailored to unique market dynamics. Alaska can learn from the studies being conducted in other states that are exploring such options.

PMC Priority: Increase primary care utilization

Reform of primary care delivery can reduce costs and improve health, particularly for complex or high needs populations.

Alaska Background Context. Alaska has begun setting a foundation for primary care transformation. In 2011, the Alaska legislature approved a capital grant to support transition to a PCMH model for three community health centers in Alaska. Furthermore, in January 2014, the Alaska Primary Care Association released a request for health care providers to participate in the Alaska Patient Centered Medical Home Initiative (AK-PCMH-I), a five-year, statewide, multi-stakeholder program to assist practices in transforming to a PCMH model of care.

Examples from Case Study States. All seven case study states have developed programs that prioritize overall care management, including primary care, through their arrangements with MCOs, PCCMs, or regional entities such as RAEs and CCOs Three states offer considerations especially relevant for Alaska:

- **Arkansas's** AHCPII includes using the PCMH model to offer preventive care and care management to enrollees. Early evaluation results have identified success in controlling health care costs for Arkansas Medicaid.
- **Maryland's** Primary Care Program offers incentives to providers who deliver advanced primary care services to patients, including access to care; care management; comprehensiveness and coordination; patient and caregiver experience; and planned care and population health. Providers receive an additional PBPM payment from CMS to cover care management services.
- **North Carolina's** Medicaid Transformation demonstration leverages the use of AMHs, which will become the state's PCCM program. Advanced AMH practices provide comprehensive primary and preventive care services to PHP enrollees, e.g., patient-centered access, team-based care, population health management, and care coordination across medical and social settings.

Key Considerations for Alaska. Alaska could leverage its existing PCMH initiative and other efforts to expand primary care transformation to all primary care practices. The COHP statute in Alaska means that the state must assess how primary care models may be integrated in ways that align with COHP or whether COHP may be modified to enable primary care transformation.

PMC Priority: Coordinate patient care

Integration of physical and behavioral health services is a promising approach used by states to improve care coordination.

Alaska Background Context. In November 2018, the Alaska Department of Health and Social Services (DHSS) received CMS approval for part of its Medicaid Section 1115 Behavioral Health Demonstration waiver. The approval authorizes Alaska to receive federal financial participation (FFP) for providing a continuum of services to treat opioid use disorder (OUD) and/or other substance use disorders (SUD) for Medicaid enrollees receiving short term Institution of Mental Disease (IMD) treatment.

Examples from Case Study States. Most case study states include VBP approaches that support care coordination and care management. Four case study states have focused on behavioral health, particularly related to integrating physical and behavioral health services, as follows:

- **Arkansas's** Behavioral Health Transformation Program for its Medicaid enrollees makes primary care physicians in its PCMH program responsible for behavioral health cost of care based on tiers (Tier 1: counseling services and medication management; Tier 2: targeted home and community-based services; and Tier 3: additional residential setting services).
- **Colorado**'s Behavioral Health Organizations (BHOs) managed mental and behavioral health services for enrollees during the first phase of delivery system reform in the state. In 2018, Colorado moved from using Regional Care Collaborative Organizations (RCCOs) that managed medical care and BHO models into RAEs, a single organization that oversees both medical and behavioral health services, manages provider networks, on-boards enrollees, and utilizes VBP approaches for their contracted providers.
- **North Carolina's** shift to Medicaid managed care will require health plans to integrate physical, behavioral, and pharmacy services. Future phases call for plans tailored to provide integrated physical, behavioral, pharmacy, and I/DD services for enrollees with serious mental illness, substance abuse disorders (SUD), and intellectual and developmental needs.
- **Washington**'s Health Care Authority (HCA) contracted with MCOs to provide integrated physical and behavioral health services to Medicaid enrollees to increase access to behavioral health services; reduce avoidable use of EDs, hospitalizations, and crisis services; and improve quality and coordination of care. The state took an incremental, regional approach to implementing integrated care. For example, MCOs that serve the Southwest region implemented integrated care in 2016, while plans that serve the Great Rivers region will not roll out until 2020.

In addition, beyond integration of physical and behavioral health, care coordination models reviewed in this report often use care coordinators to manage the care of high-risk or complex patients.

- For example, **New Mexico's** Centennial Care program has over 900 care coordinators across four MCOs to ensure members have access to appropriate care depending on beneficiaries' health care needs (healthy versus low-to-moderate needs versus moderate to high-care needs). An interim evaluation notes that Centennial Care has improved care coordination and integration activities, including percentage of members whom MCOs were able to reach, percentage for whom health risk assessments were completed, rates of telephonic and in-person outreach, and care coordination for individuals receiving behavioral health services.

Key Considerations for Alaska. Alaska has experience with developing and implementing care coordination programs for its Medicaid population and should consider ways to expand or broaden them. Starting in 2014, the state's Medicaid Coordinated Care Initiative (AMCCI) has provided one-on-one case management to enrollees with high health care utilization and complex needs. Case managers provide participants with care navigation, support them in making healthy choices, assist with addressing barriers to care and obtain referrals to specialists, manage chronic conditions through early identification, and improve compliance with medication/care plans. In addition, Medicaid reform under SB74 includes coordinated care demonstrations to test payment options that support primary care delivery system reform, including a PCMH model to be fielded by the Providence Family Medicine Center for Medicaid enrollees in the Mat-Su Valley, Kenai Peninsula, and Anchorage areas, and a Medicaid managed care program that UnitedHealth Care will test in Mat-Su and Anchorage. As with primary care reform models, Alaska must consider the effects of its COHP statute on possible care coordination approaches, for all case study states mandate beneficiary enrollment into these models.

PMC Priority: Increase data analytics capacity

Investing in data capacity and analytics infrastructure is critical to supporting health reform efforts.

Alaska Background Context. Reforms related to health IT and data analytics feature prominently in AKHCC's set of recommendations, including a phased implementation of an APCD for coordinating data collection, analytics, and data-sharing across multiple providers and delivery systems. In addition, Alaska is considering strategies to expand support for electronic health records, state health information exchange (HIE), and reimbursement for telemedicine to reform delivery systems and improve quality. Hospitals need exceptional data analytics expertise in-house. Some of the strategies and models used by case study states and described in these key findings rely on hospital/provider data expertise to make real time decisions (e.g., global budgets). Without investing in strong analytical components (a robust HIE and APCD) and an organization to analyze the data, these solutions may not be feasible or may hinder moving forward with successful implementation and monitoring.

Examples from Case Study States. The case study states have invested in data infrastructure through HIE systems and APCDs, among other strategies. Five (**Arkansas, Colorado, Maryland, Oregon, and Washington**) of the seven states operate an APCD that includes claims information from public and private payers. Examples of strong data infrastructure and analysis capabilities include:

- **Arkansas's** AHCPII program relies heavily on data analytic features to calculate VBP payments, identify areas of improvement, and support clinical outcomes. The Arkansas Health Data Initiative has improved access to public health databases. In addition, the state launched the Medical Neighborhood Reports program to support broad-spectrum data transparency performance reports, providing episode-based performance reports; episode-based PCMH cost and quality reports; behavioral health reports; and transparency reports, which include ED services, opioids, attempted suicide, and a quality measures catalog. Further, Arkansas has an APCD that includes claims data from Medicaid, Medicare, and commercial insurance plans within Arkansas. In the future, the database plans to add hospital discharge and emergency data for the uninsured, cancer registry data, birth and death records, and a flag for medical marijuana-qualifying patients. Arkansas's data feedback to their providers on their performance around bundled offers is an important element of quality improvements efforts.
- **Colorado's** ACC program uses a statewide contractor, IBM Watson Health (formerly Truven), for data repository, data analytics, reporting, and web-portal for accountability and continuous improvement activities. Phase two of the ACC program, which is operating simultaneously, works to increase use of state agency systems and the region's available HIE to improve care coordination and track the changing demographics of the state Medicaid population. In addition, ACC is working on a public reporting dashboard that would allow stakeholders to interact with RAE performance and trends over time. In addition, Colorado set out to promote widespread adoption of HIT tools, leverage the statewide HIE, align with state agency efforts, evaluate existing privacy laws and forms, connect public health to statewide HIE, and in particular to target rural and frontier communities for access and interoperability. Colorado seeks to expand telehealth using the existing statewide health care broadband infrastructure to improve electronic health record adoption in rural areas. The Colorado Telehealth Initiative included a statewide

video telehealth network platform, a resource center, promotion of telehealth, telehealth advisory committee, and a monitoring and evaluation program.

Colorado's APCD, which is administered by the Center for Improving Value in Health Care (CIVHC) contains over 500 million claims from Medicaid, Medicare, Medicare Advantage, and commercial plans. CIVHC began collecting claims and providing data analysis to advance the Triple Aim in 2012. The CO APCD is the state's most comprehensive claims data set, representing the majority of insured lives in Colorado. CIVHC provides public access to interactive reports and publications using CO APCD data, as well as offering custom access to the data. CIVHC holds quarterly meetings and regular data, education, and work groups to improve access to health data.

- **Maryland's** HIE, the Chesapeake Regional Information System for Our Patients (CRISP), focuses on supporting data infrastructure needs to be accomplished cooperatively and leveraging resources of payers, health systems, and providers. CRISP's encounter notification service and related analytic capability supports clinical decision-making. In addition, Maryland's APCD contains medical claims, eligibility, and pharmacy data from commercial payers, third-party administrator (TPA) or self-funded payers, Medicaid, and Medicare. Both HIE and APCD systems in Maryland are important infrastructures underlying the state's health care transformation efforts.
- The **Washington** State All-Payer Claims Database (WA-APCD) focuses on promoting transparency of health care costs by helping consumers and stakeholders make informed choices, allowing providers and practices to compare their performance on key quality measures, and promoting competition. The database contains all medical, pharmacy, and dental claims from both private and public payers. WA-APCD also offers a public-facing dashboard, Washington HealthCareCompare, which allows consumers to compare local prices for procedures and treatments. Users can also view quality results by ACH area and compare target, ACH, and statewide scores on quality measures. In addition, the tool displays quality scores by type of coverage: commercial, health exchange, and Medicaid. Washington's Office of Financial Management directs WA-APCD, which is operated by the Center for Health Systems Effectiveness at Oregon Health & Science University.
- **Oregon**'s All Claims All Payers (APAC) database aims to provide a comprehensive data source of health care costs, quality, and utilization in Oregon. Since 2011, APAC has collected information about claims and other relevant data for all individuals covered by private insurance, Medicaid fee-for-service plans and CCOs, and Medicare Parts A, B, C, and D. APAC was designed to help determine the demand and distribution of health care resources; provide better information to policymakers and consumers; evaluate the effects and costs of interventions on health outcomes; improve the quality and affordability of health care and insurance; and identify health disparities. From 2011 to 2016, APAC received between 42 and 51 million medical claims and 36 and 46 million pharmacy claims per year.

Key Considerations for Alaska. Alaska's HIE system, healtheConnect, offers services to facilitate the exchange of health information across providers. However, the state and system lack the data or analytic capacity to help guide policy around data analytics and data infrastructure. The state, payers, providers need to access and analyze different types of data to target resources, share data, when needed, and be able to track cost and quality. As the state continues to consider reform strategies, it will need to evaluate

its capacity to implement the reform and identify the level of and type of analytic infrastructure needed and readiness. It is essential to invest adequately in a health IT system, data sharing technology and other data analytics capacities that provides the capabilities to not only adopt the reforms at hand but also evaluate and make adjustments to state reform efforts overtime. The development of an APCD would be extremely helpful. The state may be able to leverage and build upon its existing HIE system, to offer data analytics and other more advanced services that can facilitate care management and quality improvement efforts.

PMC Priority: Address social determinants of health

Many states are considering strategies that pilot programs addressing one or more social determinants of health (SDOH) to reduce health care costs and improve population health.

Alaska Background Context. While in many ways Alaska's experience is similar to the rest of the United States, the state's substantial rural and AI/AN populations influence the impact of SDOH in unique ways. As the largest and least densely populated state, Alaska is predominantly rural and frontier and faces unique challenges in ensuring access to affordable health care services for its residents. For example, rural areas in Alaska have higher poverty rates than urban areas, and AI/ANs have lower rates of high school graduation or equivalence than the state's other racial/ethnic groups. In addition, almost 12 percent of households in Alaska are food-insecure and the state faces significant housing challenges, including overcrowding that is twice the national average, high costs of housing and household energy, and rates of chronic homelessness above the national average. Furthermore, transportation and communication remain significant challenges to health care delivery, and communities often require regular use of air transport (i.e., fixed wing).

Examples from Case Study States. Several case study states have implemented programs or pilots that seek to address SDOH.

- **New Mexico**'s MCOs may offer unique packages of value-added services, including enhanced transportation, infant care needs, and post-discharge meals.
- **North Carolina** is the first state to establish a statewide initiative under its section 1115 Demonstration waiver to test innovative models of covering evidence-based health-related social services. The Healthy Opportunities Pilot will test evidence-based interventions targeting housing stability, food security, transportation access, and interpersonal safety. In addition, MCOs will be required to screen beneficiaries for health-related social needs and connect them to social services, as appropriate. The state supports integration of SDOH within the pilots and more broadly, including an interactive statewide map of SDOH indicators, a standard screening tool to identify and assist patients with unmet health-related resource needs, and a statewide resource platform that connects patients to appropriate community resources.
- **Oregon's** CCOs use global budgets to pay not only for physical, dental, and behavioral health care, but also nonmedical services that address SDOH. Services include helping individual members with housing assistance (e.g., rent payments, temporary housing, and housing repairs); fruit and vegetable prescriptions; and transportation assistance. At the community level, services could include educational programs, community health worker initiatives, and support for homeless shelters and farmers markets.

- **Washington's** ACH organizations work with managed care plans to address SDOH by coordinating and integrating health and social services, developing regional health improvement plans, and promoting health equity.

In addition to state-led strategies for addressing SDOH, various case study states have adopted organization-led or regional approaches to SDOH, including using federal monies. For example, **Colorado**, **Maryland**, **New Mexico**, and **Oregon** have university-, provider-, or local-government led models for SDOH via the Accountable Health Communities Model. The Centers for Medicare & Medicaid Innovation (CMMI) provides bridge organization funding over five-years to test promising service delivery approaches aimed at linking beneficiaries with community services that may address their health-related social needs (i.e., housing instability, food insecurity, utility needs, interpersonal violence, and transportation needs).

- The Western **Colorado** Accountable Health Community Model led by the Rocky Mountain HMO uses social needs screening at participating practices, community navigators to help clients identify and access community services, and conducts community gap assessments. In addition, the Denver Regional Council of Governments received $4.51 million to also implement an Accountable Health Community model that seeks data to show connecting people with community-based services improves health outcomes and decreases health care costs. It will work with Medicare and Medicaid beneficiaries and five clinical partners across various counties.
- The Baltimore City Health Department in **Maryland** was awarded a $4.3M grant to screen for health-related social needs of Medicaid and Medicare beneficiaries at participating providers; refer qualified beneficiaries to receive navigation support in accessing social needs-related services; use technology, data, and quality improvement to support this program; and convene health care, community stakeholders, and city/state agency partners to drive alignment around both enabling and evaluating clinic-community linkages.
- Led by Presbyterian Healthcare Services, Santa Fe County's Accountable Health Community project in **New Mexico** addresses the unmet, non-medical social needs of county residents by strengthening the network of community service organizations. The model seeks to improve communication, sharing of information and resources, and working collaboratively to undress unmet social needs. The aim is to improve community health, increase quality of care for individuals, and reduce health care costs to the system overall.
- The **Oregon** Accountable Health Community, led by the Oregon Health & Science University, helps clinical sites better understand and address their patients' social needs by screening Medicare and Medicaid beneficiaries to identify five health-related social needs; providing a tailored referral summary to community services; providing personalized navigation to services; and facilitating sharing of data across clinical and social service sites.

Key Considerations for Alaska. In the absence of broad, statewide reform, Alaska can consider more measured approaches to SDOH. Through its Medicaid program, Alaska can help drive the use of SDOH approaches for supporting their low-income residents with issues such as housing, food insecurity, and employment support. Nationally, SDOH conversations are happening not just at the state level but also among health providers, community based organizations, insurers through AHCs and other means. AK can leverage these discussions and form partnerships and collaborations.

Other considerations

A phased or incremental approach to health care transformation, with attention to the implications of voluntary versus mandatory enrollment, is likely to improve prospects for success.

Alaska Background Context. As Alaska has learned from undertaking health reforms in the past, effective and thoughtful change takes time and significant planning. Incrementalism in reform, setting a path, and keeping to it with ongoing course corrections, as needed, has proven to be an effective approach. The benefit of introducing and rolling out reform efforts over a period of time is that the state can revise or introduce new program requirements and guidelines as lessons are learned and experience is gained.

When developing a plan for implementing any type of health reform approach, Alaska can learn important lessons from states that have used an incremental approach as well as a mandated versus voluntary strategy toward reform.

Examples from Case Study States. Several case study states have used incremental approaches to health care transformation.

- **New Mexico's** Medicaid program began a transition to managed care in 1997 and gradually expanded and refined the program before consolidating under section 1115 Demonstration waiver and incorporating VBP in 2014. This approach allowed the state to try new care delivery and payment mechanism options while maintaining the basic structure and integrity of the current market and system.
- **North Carolina** has established a phased-in approach to managed care. Enrollees are to be moved into managed care by region, and tailored plans for special populations will not be available until the third year of the demonstration. This approach provides flexibility and time to transition high-needs and complex populations and establish the necessary infrastructure for a smooth transition from FFS to managed care.
- Since 1994, health care reform has been on **Arkansas'** radar, when the state implemented ConnectCare, its PCCM program in a predominantly FFS environment. AHCPII was developed in 2011 and has since been implementing additional phases to the program, starting with launching its financial EOC model in 2012 with three episodes. Subsequently, the state increased the number of available episodes. The PCMH model was implemented beginning in 2014, after two years of experience with the EOC model component.

In implementing these approaches, most case study states have programs that mandate beneficiary enrollment, whether it is in managed care (**New Mexico, North Carolina, Maryland, Washington**), a PCCM program (**Colorado),** or another type of delivery model (**Oregon**). In most cases, there are select populations, such as individuals with special health care needs and tribal populations, who are either exempt or excluded from mandatory enrollment. In Washington, for example, AI/AN populations may opt out of the program and stay in Medicaid FFS. In **Arkansas**, providers are required to participate in the EOC model as are hospitals in **Maryland's** TCOC demonstration.

Key Considerations for Alaska. As Alaska considers new approaches to health care delivery, it will have to determine how mandatory versus voluntary enrollment will affect the success of these approaches. The transition to mandatory participation can be phased in over time, slowly rolling out implementation either by population, region, provider, depending on the type of approach. In addition, all the states have made difficult decisions regarding mandating participation, whether for beneficiaries or providers. Most of the states examined allow new enrollees to choose among health plans participating in their region or county and enrolled members have an opportunity to switch to a different plan either at any time or during a specified enrollment period. However, enrollees are still required to use only providers participating in their plan's network. A decision on whether or not to have an opt-out provision for the AI/AN populations would be a consideration for Alaska as well as the impact of the COHP statute and whether modifications to the statute are necessary to allow the state greater flexibility in designing health reform approaches.

Coordination and integration with Indian Health Service (IHS) and tribal health organizations is key to gaining buy-in and helps ensure adequate care and coverage for AI/AN populations.

Alaska Background Context. About 15 percent of Alaska's population is AI/AN. The state is home to 229 federally recognized tribes with about 80,000 members and approximately 150,000 Alaska Natives are served by the tribal health system. Given the high share of AI/AN population in the state, Alaska is familiar with engaging IHS and tribal health organizations for its 12 tribal health regions, including coordinating with the Alaska Native Tribal Health Consortium that serves about 20 percent of the population. In addition, the Alaska Tribal Health System (ATHS), a voluntary affiliation of nearly 40 tribes, is a critical element in organizing the state's delivery system. Coordination with its member tribal health authorities is crucial to the success of any health reform initiative.

Examples from Case Study States. Similarly, other states have taken steps to ensure coordination and integration with IHS and the tribal health system to determine which models are most appropriate for AI/AN populations.

- Healthier **Washington** collaborates with Indian health care providers, federally recognized tribes, the American Indian Health Commission for Washington State, and other tribal representatives to implement Medicaid transformation projects that seek to enhance the Indian health delivery system. Since 1989, the state has had a Centennial Accord agreement to reaffirm tribal sovereignty and establish an action plan for specific programs and policies. ACHs are also required to formally adopt a collaboration policy with local IHS programs, tribal health systems, and Urban Indian Health Programs. Washington also requires that ACH governing boards include tribal representatives.
- In **New Mexico**, Centennial Care has increased the percentage of eligible AI/AN patients who opted into managed care. The program is optional for AI/AN populations, although it is highly recommended for those with chronic or complex health needs because care coordinators can help coordinate physical health, behavioral health, and long-term care or community benefits, as needed.
- In **Oregon**, tribal leaders who participated in the Health Care Transformation Committee, which developed the CCO framework, expressed initial concerns about participation of tribal members in Medicaid managed care. Their participation on the Committee was instrumental in the

development of a care coordination model for AI/AN members enrolled in Medicaid FFS. Tribal representatives were particularly concerned about 1) shifting from a fee-for-service model to managed care because Medicaid is a key source of revenue for poorly funded IHS clinics and tribal providers and 2) decreased access to services for tribal members if tribal providers were unable to attain in-network status in CCOs.

- In **North Carolina**, discussions with the only federally recognized tribe in the state, EBCI, resulted in exempting members of federally recognized tribes from the shift to managed care; instead, the population has a choice between Medicaid FFS or enrollment in a managed care plan.

Key Considerations for Alaska. As Alaska moves forward with health care transformation, continuing to include IHS and tribal health organizations in conversations on and, encouraging their active participation in, the development of future health reform efforts is essential for transparency, supporting bi-directional communication, facilitating buy-in, and ensuring the development and implementation of strategies that benefit this high-need population.

Where statewide reform may prove challenging due to political, geographic, and/or contextual factors, states have established regionalized structures that leverage regional health improvement plans and systems for managing and integrating health and social services.

Alaska Background Context. Alaska is not unique among the states in having multiple health care systems that serve overlapping groups of residents. However, the distances that separate populations and the concentration of beneficiary populations within the state contribute to a uniquely complex set of institutional and provider relationships. Often, the state requires a regional approach to health reform, as the needs of each region may differ.

Examples from Case Study States. Similarly, other case study states have relied on regional approaches for health reform efforts to account for varying geographical and contextual factors.

- **Colorado** uses a regional approach in its ACC program. Beneficiaries are assigned to one of seven RAEs, based on their assigned medical home and these RAEs oversee the management of both medical and behavioral health services, oversee networks, onboard enrollees, and make VBP to the health team providers. RAEs receive PMPM payments and distribute incentive payments to medical homes based on key performance indicators.
- In **Washington**, nine ACHs, comprising a regional coalition of representatives from a variety of sectors working together to improve population health, are self-governed and develop their own decision-making processes and organizational structures. These regional organizations, which are aligned with the managed care plan regions, work in parallel with managed care plans to address population health and SDOH, coordinate and integrate health and social services, develop regional health improvement plans, and promote health equity.
- The **Oregon** CCO model also uses regional organizations to manage and coordinate care for Medicaid beneficiaries. CCOs receive risk-adjusted, prospective global budgets to meet the integrated health needs of members paid via PMPM.

Key Considerations for Alaska. Regional efforts may be a more feasible approach for Alaska, given the state's large size and its defined seven geographic regions. Strategies should take into consideration the

difference in local and regional health care infrastructures, needs, and concerns with regard to provider networks and access to primary care and specialty care. The state will need to consider how participation in the regional organization structure would incorporate IHS (e.g., whether or not IHS would become a regional organization); whether the COHP statute and mandatory versus voluntary enrollment will affect participation; how a regionalized structure would work with some health care services and sub-specialties; and how the state's low population density within regions would affect its ability to sustain regional efforts and structures. The state will need to consider these factors and how they would affect the ability of the state to implement regionalized networks.

Maximizing federal dollars helps states with limited budgets establish needed health care infrastructure for health system transformation and reform.

Examples from Case Study States. All of the case study states received substantial funding for their reform initiatives through various federal programs, including SIM and CPC/CPC+. In addition, a number of provider groups, community-based organizations, and universities are taking advantage of opportunities through CMMI's Accountable Health Communities opportunity.

- **Maryland's** participation in CPC+ served as the foundation for its Maryland Primary Care Program, while its SIM activities, though they fell outside of the All-Payer Model agreement, supported those efforts by designing a Medicaid Integrated Delivery Network for individuals dual eligible for Medicaid and Medicare, designing new population health measurement activities, and funding studies of connectivity between Maryland's HIE and skilled nursing facilities.
- **New Mexico's** Health System Innovation Final Design, produced under a SIM grant, aligns with the goals of the Centennial Care program.
- **Washington**'s State Health Care Innovation Plan, developed under SIM, provided the framework for its Healthier Washington demonstration to reduce the use of intensive services and improve population health.
- In **Colorado**, collaboration with the Colorado Multipayer Collaborative started as part of its CPC initiative, while the Colorado Framework is funded through SIM.
- **Oregon** also received federal funding through CPC/CPC+ and SIM. Although Alaska did not participate in the SIM dollars made available during the early stages of implementation of the ACA, the state can leverage other programs and opportunities that will allow it to leverage federal monies for health care transformation infrastructure. For example, starting October 2019,
- **Colorado** will implement a delivery system reform incentive payment (DSRIP) initiative under a Section 1115 Demonstration waiver to build partnerships, create a plan for community and health neighborhood engagement, discuss needs in the community, report on activities and findings, and develop an informed application based on input.

In addition, states also relied on their own state investments to advance health care infrastructures.

- **Arkansas's** participation in SIM, CPC, and CPC+ allowed the state to test its PCMH and episodes of care models that are central to AHCPII. However, the state had already developed AHCPII prior to receiving the SIM grant; the program was a state-directed priority from the outset that used state funding in the early design stage. In 2013, the state received $42 million in

SIM funding but the state also committed spending $32.8 million from the state budget for implementation.

Key Considerations for Alaska. Alaska should considers ways to leverage federal monies for health care transformation efforts through new funding opportunities or technical assistance programs that could support Alaska's specific interests. The state must also assess how state investments can be leveraged while also grappling with competing state needs and limited resources.

Lessons Learned

The NORC team analyzed the seven case studies for trends, facilitators of success, and lessons learned to inform Alaska's approach as it considers health care transformation. In addition to the identified lessons contained in the case studies, the literature revealed other trends among successful programs.[9,10] These takeaways are summarized in Exhibit 2.

Exhibit 2. Lessons Learned from Case Studies on Developing and Implementing Health Reform Initiatives

Develop a strategy based on incremental progress

- Build a strong foundation; leverage that foundation to progress to more advanced payment models
- Phase in new payment and delivery models by cohort or region; consider beginning with a pilot
- Balance an incremental approach with the administrative and reporting challenges of managing a fragmented system
- Technical assistance for stakeholders will likely be needed to support any initiative

Engage stakeholders early and ensure ongoing engagement to garner input and create buy-in

- Buy-in from providers, other payers, and beneficiaries is vital to the success of any reform
- Transparency and trust among all stakeholders, especially the tribal population is crucial
- Communication plan, which is ongoing and frequent must be in place that provides information for providers, administrators, boards, and consumers. Misinformation can derail the best initiatives.
- States used a mix of voluntary, incentivized, and mandatory participation in reform strategies; stakeholder engagement was essential either way
- Multipayer strategies can increase effectiveness, particularly with small Medicaid populations
- Consider conducting a scan of models being implemented or considered by providers or other payers in the state before moving forward

Incorporate flexible design features in VBP models

- Flexibility in approach gives plans, providers, and other stakeholders time and flexibility to establish needed infrastructure
- In terms of designing and introducing financial incentives for providers, the larger financial incentives—commensurate with level of effort expected from providers—are often associated with larger performance impact

Consider the availability of federal/outside funding or technical support when developing a feasible VBP strategy

- Many of the states studied (Colorado, Maryland, New Mexico, Washington) received funding and technical support from the SIM Initiative, which helped implement their reform efforts; Arkansas, Colorado, Maryland, and Oregon also participate in the federal CPC/ CPC+ Initiative
- A few current/future federal opportunities may include the Medicaid Innovation Accelerator Program, the Pediatric Alternative Payment Model, the Financial Alignment Initiative for Medicare-Medicaid Enrollees, DSRIP, Section 1115 Demonstrations, or Section 1332 Demonstrations

Establish strong HIT and data analysis infrastructure to support health reform efforts

- Assess HIT readiness and establish sufficient HIT infrastructure for quality and cost reporting; begin with pay-for-reporting
- Data analytical support at the local level in the form of technical assistance is needed for success
- Balance the need for timely reporting and public release of required performance measures with the challenges and burden of auditing and ensuring accuracy of data reported by payers and providers
- The design of performance measures should be consistent across each VBP strategy or model to align incentives and reduce provider burden.; performance targets for those measures should reward both achievement and improvement among participating providers

Monitor and evaluate state efforts to assess impact and outcomes

- Rapid Cycle reporting can provide the most up-to-date information in a timely manner
- Monitoring reports should evaluate not only implementation effectiveness but also outcomes
- Early identification of barriers and challenges in order to enable mid-course correction

IV. Conclusion

While the case studies presented in this report highlight a wide variety of reforms, they are just a sample of what is being undertaken by states nationwide today. The case study states illustrate how state governments have a strong track record for driving positive and sustaining health reform. A commonality among the states reviewed is the realization that there was a problem, most often in the form of out-of-control health care costs and concerns about quality and value, and that hard and important decisions were required. While the impetus for reform often times derived from state leadership, the process for developing reform efforts generally included a broad array of stakeholders and expansive stakeholder outreach to obtain commitment and buy-in and ensure perspectives from an array of stakeholders (e.g., providers, health insurance plans, rural, tribal health organizations, and consumers). In addition, most health transformation efforts included substantial investments in infrastructure, data analytics, training, and outreach to make their programs work. Effective approaches to health care reform are often multi-faceted, flexible, and incremental while also staying the course to achieve the intended goal: reducing costs while improving quality and health.

From our experiences working with states, the NORC team has found that states that have been working on health reform initiatives for several years are eager and willing to share their experiences and lessons learned with other states, particularly those considering or interested in learning more about their models. As Alaska considers a path forward for a health care transformation strategy that is best for Alaska, it may be useful to understand how these case study states underwent their own efforts and assess how the various elements of reform may be applicable to or adapted in Alaska, while considering the state's unique geography and structure. The Alaska Healthcare Transformation Project may also find links to resources within the case studies useful as it moves forward with developing and implementing its health reform strategy.

Case Study: Arkansas Health Care Payment Improvement Initiative

Executive Summary

The **Arkansas Health Care Payment Improvement Initiative (AHCPII)** program is a statewide multipayer initiative across several payers, including Medicaid, state and public school employees, a number of commercial health plans, and Walmart. This market factor has allowed Arkansas to build reform and engage stakeholders more effectively. The AHCPII aims to move toward a patient-centered health care system by means of three components:

- **Patient Centered Medical Homes (PCMH),** a care delivery model where patient treatment is coordinated through the primary care physician.[11] The PCMH aims to improve quality of care and contain the cost of care.
- **Episodes of care (EOC),** a payment model that bundles all the care a patient receives in the course of treatment for a specific illness, condition or medical event.[12] The EOC aims to improve quality of care and reduce the variation in both the treatment of acute conditions and delivery of specialized procedures by incentivizing providers to manage patient care within designated timeframes.
- **Health homes** for individuals with complex needs, where a provider operates under the "whole person" philosophy to integrate and coordinate primary, acute, behavioral health and long-term supports and services [13]

This case study will focus on the first two components. It also provides information on Arkansas' Private Option, which requires the Medicaid expansion population to enroll in private health plans offered through the Arkansas Marketplace. Key considerations for Alaska from this case study include:

- ***Complementary Design Features.*** Arkansas used a multifaceted approach to implementing value-based payment (VBP) within their initiative. PCMHs focus on primary care transformation while EOCs focus on improving care and cost-effectiveness of acute health care episodes. Results from both model components have demonstrated success in controlling health care costs for Arkansas Medicaid. In addition, publicly available findings indicate improved practice patterns and a shift to more efficient treatment and utilization options. The EOC design allows for significant state tailoring to target the high-cost health care events within each market as well as offers incentives for desired outcomes (e.g., quality, utilization, and cost) through payment structure.
- ***Rural Design.*** For Arkansas and other states, PCMH is a common component of a multi-pronged approach, as well as a common VBP approach in rural areas. PCMH models work to address challenges common to rural areas, such as growing PCP shortages, increasing rates of chronic conditions, and a need for improved management of patient care. In addition, RHCs may be eligible for better Medicare and Medicaid reimbursement support by obtaining PCMH recognition compared to operating as an FQHC.[14] While EOC designs have benefits in all

contexts, rural implementation may raise some considerations and challenges, which are explained in the conclusion of this case study.[15]

- ***Incremental Approach.*** While Arkansas' major VBP initiatives are now mature, they were implemented incrementally from modest beginnings in 2012. In terms of implementing an EOC, Alaska could consider starting with the implementation of two to three episodes based on high-priority health care events then adding more episodes as the state gains experience. For Arkansas, the higher-volume episodes that achieved reductions to average costs were the attention-deficit/hyperactivity disorder (ADHD), perinatal, colonoscopy, oppositional defiance disorder, and tonsillectomy episodes.
- ***Stakeholder Engagement.*** The AHCPII gained widespread support and participation through prioritization from state leadership, extensive stakeholder engagement, and by leveraging partnerships with commercial payers. Continued success of the Arkansas AHCPII program relies on ongoing, engaged participation across the state from multiple payers, including continuous innovation and adaptation. The formation and implementation of the AHCPII program benefitted from experienced government leaders who knew their market well and had the ability to develop a program that could both overcome challenges and gain the interest of stakeholders.[16]
- ***Multipayer Participation.*** The state was able to take advantage of the relatively small number of commercial payers, who were responsible for the majority of lives in the state by developing close and actively engaged relationships with the payers, both of which participate in the EOC model component voluntarily. The state leveraged these initial relationships to build a larger coalition of participating payers, including Medicaid, state employees, and employer-sponsored plans. Similarly, Alaska could begin conversations with its larger commercial payers regarding what types of VBP models are of interest. Arkansas public officials describe the multipayer approach as one of AHCPII's major strengths as a reform effort. While commercial payer participation began at implementation, the program engaged Medicare participation in 2017 when the Comprehensive Primary Care (CPC) initiative began. At that point, the PCMH model component had already gained traction and achieved successes within Medicaid, prior to the implementation of the Comprehensive Primary Care Plus (CPC+) model, indicating that Medicare participation is not essential to model success in the Medicaid program.
- ***Funding and Cost Containment.*** The AHCPII benefitted from financial and operational support received through the federal State Innovation Models (SIM), CPC, and CPC+ initiatives. However, the state had already developed AHCPII prior to receiving the SIM grant, indicating that the program was a state-directed priority from the outset and used state funding in the early design stage. In 2013, the state received $42 million in SIM funding but also committed $32.8 million from the state budget for implementation. While Alaska potentially may not have the benefit of similar federal funding, it would benefit from the understanding the experiences of states that have successfully done so already (including Ohio[17] and Tennessee,[18] in addition to Arkansas). Many of these states have made robust and detailed information on the specifications of their episodes publicly available. Both the EOC and PCMH models have shown success so far in controlling Medicaid costs. Average episode costs have decreased for several episodes and held steady for most others. The PCMH model generated $34 million in cost avoidance in 2014, and $54.4 million in cost avoidance in 2015.

In this chapter, we will examine health care reform in the state of Arkansas. This case study will focus on the **Arkansas Health Care Payment Improvement Initiative (AHCPII)**. We will also provide information on the Private Option or Arkansas Works, the state's initiative to conduct Medicaid expansion through the use of private plans.
The chapter starts with background on state demographic and economic characteristics and moves to details on the approach. We discuss the impetus for reform and then provide an overview of the approach and its implementation followed by details of its mechanics and structure. This is followed by an examination of the results, lessons learned, and considerations for Alaska.

Background

State Characteristics – Demographics and Economic Indicators. Arkansas is a southern state bordering the Mississippi River with a population of three million people and population density of about 56 persons per square mile (see Exhibit AR1).[19] Out of the state's 75 counties, 55 are rural.[20] None of the states' counties are classified as frontier (having seven people per square mile). The state is predominantly White (79.3 percent) or White, non-Hispanic (72.5 percent), with 15.7 percent Black or African American residents, and 2 percent American Indian or Alaska Native (AI/AN) residents.[19] There are no federal Native American lands in the state. Between 2013 and2017, the median household income (in 2017 dollars) was $43,813. The percent of the population living in poverty in Arkansas is 16.4.[19] The unemployment rate of Arkansas in January 2019 was 3.7 percent.[21] In 2017, the gross domestic product (GDP) of Arkansas in 2017 was $122,703.5 million and the per capita real GDP was $37,930. The 2017 budget was $2.5 billion for Arkansas.[21] The three largest industries in the state are trade, transportation, and utilities, government, and education and health services.

Exhibit AR1. Demographics and Economic Indicators

	Arkansas	Alaska	U.S.
Population, as of July 1, 2018[19]	3,013,825	737,438	327,167,434
Rurality			
Population per square mile, 2010[19]	56.0	1.2	87.4
Share of population in rural areas, 2017[22]	37%	32%	14%
Race/Ethnicity, 2017[19]			
White Alone	79.3%	65.8%	76.6%
Black or African American Alone	15.7%	3.7%	13.4%
Asian Alone	1.6%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	2.0%	15.3%	1.3%
Hispanic/Latino	7.6%	7.1%	18.1%
Two or More Races	2.1%	7.4%	2.7%
White (non-Hispanic)	72.5%	60.8%	60.7%
Poverty			
Median Household Income (2017 Dollars) [19]	$43,813	$76,114	$57,652
Minimum Wage, 2019[23]	$9.25	$9.89	$7.25
Share of Population in Poverty (2017) [19]	16.4%	11.1%	12.3%
Economy			
Unemployment Rate, as of December 2018[24]	3.7%	6.3%	3.9%
Gross State Product (GSP), 2017[25]	$122 billion	$52.8 billion	$19.5 trillion
Per Capita Real GDP, 2017[26]	$37,930	$70,683	$55,418
Expenditures, SFY 2017[27]	$2.5 billion	$9.7 billion	$1.9 trillion
Expenditures per Capita, SFY 2017[28]	$7,408	$13,171	$5,976

State Health Insurance Market – Health Coverage and Uninsured. As of 2014, Arkansas spent $7,408 per capita on health, including all privately and publicly funded personal health care services and products, which is below the national average of $8,045 per capita.[29]

Private Health Insurance Market. Of the total state population, 42 percent have health insurance coverage through their employer.[30] Arkansas Blue Cross Blue Shield holds 78 percent of the large group market share followed by UnitedHealth with 14 percent and Catholic Health Initiatives with 6 percent of the market.[31] In 2014, the per capita private health insurance spending was $3,906 in Arkansas.[31] Between 2001 and 2014, the average annual percent growth in private spending was 4.9 percent in the state.[32]

State Employee Health Care System. Arkansas offers health plans to Arkansas State Employees (ASE) and Public School Employees (PSE) through ARBenefits. Each group has a choice of a Premium, Classic, or Basic Plan. The State and Public School Life and Health Insurance Board is the Plan Sponsor, a 15-member group designated by law to establish the benefit design, set rates, and set policies for the plan. The Employee Benefits Division of the Arkansas Department of Finance and Administration administers the plan. This is a self-insured plan such that expenses are paid through contributions from the state as an employer and through beneficiary premiums.[33] The current carrier for both plans is Health Advantage at Arkansas Blue Cross Blue Shield.[34] ASE operates as a part of AHCPII.

A retired employee is eligible for continued coverage as long as they are eligible to draw an annuity from their retirement agency and be actively enrolled in ARBenefits on the last day of their employment. The monthly premiums for ASE are deducted from a retiree's annuity. Retirees have the option to join at a later time should they involuntarily lose an alternative coverage choice. A non-Medicare eligible retiree has a choice between the Premium, Classic or Basic plan, but a Medicare eligible retiree is placed on the Medicare Primary plan.[35]

Health Insurance Marketplace. Arkansas currently has a state-based exchange called My Arkansas Insurance, which uses the federal enrollment platform at HealthCare.gov. This is a change from the first three years where Arkansas' exchange was a state-partnership, where plan management and administration of customer assistance was done by the state and other functions by HHS.[36]. The state continues to operate its own exchange for small businesses, which began in 2015. In 2019, 67,438 individuals selected a Marketplace plan.[37] The average benchmark (second-lowest cost silver) premium in Arkansas is $378.[38] There are four insurers offering plans: AR BCBS, Centene/Ambetter, QualChoice, and QCA Health Plan.[39]

Medicaid and CHIP Program and Population. As of January 2018, Arkansas's Medicaid program had 931,000 enrollees, or about 30 percent of the state's population. This is a decrease from just over one million in enrollment in 2017. Prior to the 2014 expansion, eligibility criteria was limited to mostly children and women from low-income families, individuals living with disabilities, and older residents with limited income.[39] After expansion, there was an increase of more than 300,000 enrollees with the addition of mostly non-elderly adult beneficiaries without disabilities.[40] The Medicaid expansion population is covered by the Private Option, described in the text box.[16]

The Private Option

As part of their 2014 Medicaid expansion, the state implemented the **Arkansas Health Care Independence Program**, also called the Private Option, in which Arkansas Medicaid pays the premiums for expansion enrollees to purchase private health care coverage on the health insurance marketplace.

Arkansas aimed to create delivery system efficiencies, encourage commercial participation and competition, and improve continuity of care. In addition, without an established Medicaid managed care system, there were some concerns whether providers would be able to take on the quantity of new expansion patients.

Early findings on the Private Option include:

- Improved access to primary care and prescription medications;
- Reduced reliance on the emergency department;
- Increased use of preventive care; and
- Improved perceptions of health and quality among low-income adults.

The Private Option has also been credited with increasing competition in the Arkansas Marketplace.

In 2016, total Medicaid spending in Arkansas was $6 billion, about $1.4 billion of which was federal spending specifically for the expansion population. Medicaid spending accounts for 18 percent of the state budget, and 64 percent of all federal funds received by the state are dedicated to Medicaid spending.[41] The federal government pays for a relatively large share of Medicaid costs in Arkansas – 78.3 percent of all Medicaid spending, with a Federal Medical Assistance Percentage of 70.87 percent for 2018. As of 2014, average annual Medicaid spending per enrollee ranged from $3,372 for children to $21,342 for older adults.[42],[41]

In June 2018, a community engagement requirement went into effect as part of the eligibility criteria for people between the ages of 19 and 49. This requirement mandates that these enrollees work 80 hours per month or engage in other activities including job training or searching, education, or volunteering.[43] The enrollee must document work hours online. In addition to the community engagement requirement,

enrollees with income above the federal poverty level must pay modest monthly premiums. Finally, the program has shortened the retroactive eligibility period from 90 days to 30 days. These changes were approved by the state legislature in April 2016 and May 2017, and the necessary section 1115 demonstration was approved by Centers for Medicare & Medicaid (CMS) in March 2018.[44,45,44] In October 2018, the expansion population had declined to 252,642 people, a decrease of about 20,000 people from July 2018.[44] On March 27, 2019 a federal judge ruled that the Arkansas work requirement "cannot stand", such that the program has been remanded to HHS for future decision-making.[46]

Exhibit AR2. Medicaid Eligibility Levels, as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
Arkansas	138% FPL	138% FPL	216% FPL	214% FPL	73% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

Uninsured Population. The uninsurance rate among Arkansas residents was 10.2 percent in 2016, which was a drop by 12.3 percentage points from the rate in 2013 prior to the Medicaid expansion.[47]

Providers and Service Use. Arkansas has 80 hospitals in the state, of which 62.5 percent are non-profit, 25 percent are for-profit, and 12.5 percent state-owned.[48] [49]Arkansas has 3,473 primary care physicians and 3,609 specialist physicians.[50] There are 88 Medicare certified rural health clinics and 12 community health centers.[51] [52]

Tribal Health. There are not any federally or state recognized tribes within the state, and although Arkansas is a part of the Nashville Area of the Indian Health Service, none of the Nashville area facilities are within Arkansas. Eligible tribal members are able to receive services at facilities outside of the state. The area covers tribes within 14 different states, and assists patients across 24 states across the eastern, southeastern and mid-United states. This area serves 29 tribes or nations with 16 Title I Tribally Administered programs, nine Title V Tribally Administered programs, four IHS Federal Direct Care Service Unity programs, and three Urban Indian Health programs.

History of the Initiative

Impetus for Health Care Reform. Prior to the reform, Arkansas was experiencing what the state viewed as unsustainable growth in costs. Insurance premiums had doubled for employers and families within the past decade, and the state was expecting large budget shortfalls for the Medicaid program, as well as a looming potential Medicaid Trust Fund shortfall with predicted deficits as high as $400 million.[53] [16]

The health status of Arkansans remains relatively poor, with the state sitting near or at the bottom compared to other states on a number of national health indicators (e.g., heart disease, diabetes). More than 50 percent of Arkansan adults had at least one chronic condition. Prior to expansion of the Medicaid

program, Arkansas's income eligibility level was the lowest in the nation, and the state experienced an uninsurance rate higher than the national average. In addition, state officials have noted that the system prior to ConnectCare did not provide incentives for providers to improve care coordination.[54],[16]

Preexisting Health Reform Models and Infrastructure. Health care reform efforts are ongoing in the state. Since 1994, Arkansas has operated the **ConnectCare Primary Care Case Management (PCCM)** program.[55] Enrollment in the program is mandatory for almost all Medicaid beneficiaries, with the exception of people who are dually eligible for Medicare and Medicaid and those with short-term "spend-down" eligibility criteria. The program offers beneficiary education, manages provider attribution, and is a point of contact for beneficiaries for follow-up and reminders. There is a focus on supporting providers by offering education tools and creating incentives to conduct care management activities.[56] Providers are paid $3 per member per month (PMPM) for case management in the program. Beginning in 2008, the program paid a Physician Quality Incentive to providers who met or exceeded screening thresholds for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Providers received quarterly profiles of their quality and performance measures, including costs, utilization rates for pharmacy, PCP visits, referrals, ED utilization and hospitalization.[56]

Overview and Implementation of the Initiative

Overview of the Initiative. The **Arkansas Health Care Payment Improvement Initiative (AHCPII)** program is a multipayer initiative that leveraged the high degree of market concentration shared by two local payers, Arkansas Blue Cross Blue Shield (AR BCBS) and QualChoice, to engage them in reform. AR BCBS and QualChoice collectively held 80 percent of the commercial market when the initiative began, allowing the state to align both payers with Medicare and Medicaid more effectively, as well as engaging with other payer groups such as state employees and schools. This allowed the program to provide a strong incentive for provider participation, since commercial payers, state and public school employees, and Medicaid were participating under the same umbrella and providing reimbursement under the same mechanisms.

Overall, the AHCPII aims to moves towards a patient-centered health care system through three different components:

- **Patient Centered Medical Homes (PCMH**), a care delivery model where patient treatment is coordination through the primary care physician [56]
- **Episodes of care (EOC),** a payment model that bundles all the care a patient receives in the course of treatment for a specific illness, condition or medical event [57]
- **Health homes** for individuals with complex needs, where a provider operates under the "whole person" philosophy to integrate and coordinate primary, acute, behavioral health and long-term supports and services [58]

This case study will focus on the first two components, since the health home component is currently on hold. The PCMH component aims to improve quality of care and contain the cost of care. The EOC component aims to improve quality of care and reduce the variation in both the treatment of acute conditions and delivery of specialized procedures by offering incentives to providers to manage patient care within designated timeframes.

Goals for Health Care Reform. Arkansas has framed its goals in terms of the triple aim of improving population health and enhancing patient experience with health services (e.g., quality, access, and reliability of care), while reducing or improving management of health care costs.[54] In addition, the state has articulated an interest in avoiding rate cuts or reduction of benefits as policy responses to Medicaid funding shortfalls.

Population, Scope, and Participation. The population, scope and level of participation in the AHCPII differs based on the model. The models are broken out below.

Episodes of Care. The EOC program is statewide in scope and participation is mandatory for providers. However, payers are able to decide which episodes best suit their population's needs and their corporate interests, meaning that not every available episode has been implemented by both payers. Each episode has specific inclusion criteria that trigger the EOC to begin. There are exclusion criteria per episode, as well as global exclusion criteria for certain enrollees. See Exhibit AR3 below.

Exhibit AR3. Global Exclusion Criteria for EOC for Provider Enrollees

Global Exclusion Criteria

- Residents who are dually eligible for Medicaid and Medicare
- Those with non-continuous Medicaid enrollment during the episode timeframe
- Enrollees with Third Party Liability
- Enrollees with one or more of the following:
  - End State Renal Disease
  - Clinically pertinant metabolic, nutritional, or immunity disorders
  - Clinically pertinant disorders of blood and blood forming organs
  - Clinically pertinant cancers
  - Active chemotherapy
  - Clinically pertinant organ transplants
  - Acute Leukemia
  - Cystic Fibrosis
- Enrollees leaving against medical advice
- Enrollees who die during episode timeframe
- Enrollees in hospice care
- Enrollees whose episodes result from trauma

PCMH. Practice enrollment is voluntary, and practices must re-enroll annually. Beneficiaries are automatically enrolled when their practice enrolls. To complete enrollment, practices submit a completed Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement through the Advanced Health Information Network (AHIN) provider portal. Provider participation has increased over time, starting with 123 practices in 2014 at the model component launch and increasing to 190 practices (about 900 providers) in 2017. Exhibit AR4 displays the number of PCMH enrollees in PCMS by payer.

Exhibit AR4. Number of Enrollees by Payer (2016)[53]

Payer and Type	Beneficiaries	Practices	Primary Care Providers
Arkansas Medicaid	330,000	193	919

Arkansas BCBS	250,000	158	678
QualChoice	11,000	85	618
Centene/Ambetter	16,000	237	606

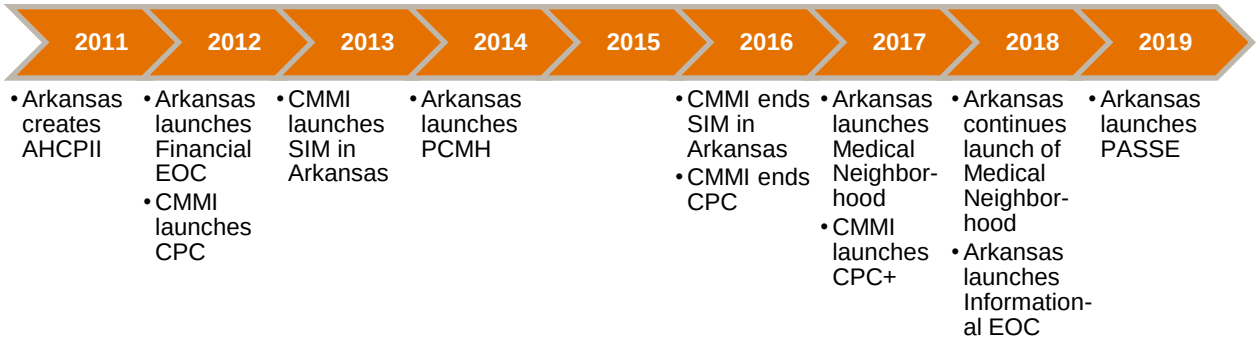
To enroll, entities (i.e., providers or groups of providers) must meet five main criteria, as follows:

- Meet the definition of a participating practice, which may include an individual primary care physician, an affiliated physician group of primary care providers, a rural health clinic, or an area health education center.
- Include primary care physicians that have enrolled in the ConnectCare PCCM Program.
- Not be participating in a PCCM shared savings pilot (established under Act 1453 of 2013).
- Work towards adopting an Electronic Health Record (EHR) that is certified by the Office of the National Coordinator for Health Information Technology.
- Have at least 150 attributed beneficiaries at the time of enrollment.

A provider is only eligible to participate in one PCMH at a time. Practices are eligible to withdraw from the PCMH model component at any time.[53] FQHCs are not currently included in the model, as they do not enroll in the ConnectCare PCCM Program.

Timing and implementation process. The AHCPII's implementation began in 2011 with the development of staged work plans for its three main components. Implementation included a two-stage roll out, first for the EOC component followed by the population-based care delivery through PCMHs. Within each component, implementation occurred in waves.

Exhibit AR5. Timeline of Health Care Reform



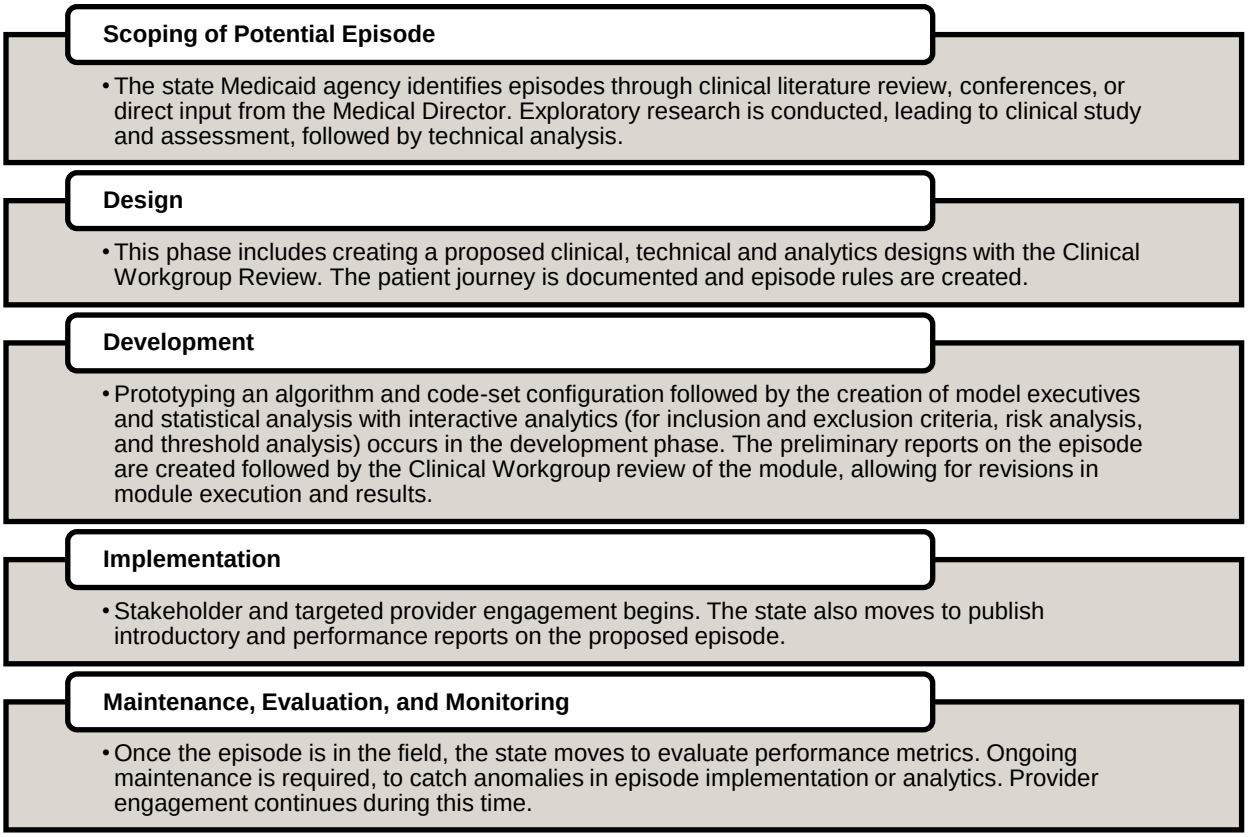
Targeting. The state determined that each component would have a different target population. The population-based initiatives, including PCMH and the health home, would work with healthy but at-risk Arkansans and those with chronic diseases (e.g., congestive heart failure, diabetes). The EOC component would target acute medical needs (e.g., congestive heart failure, pneumonia) and acute procedural needs (e.g., hip replacement). For beneficiaries with developmental disabilities or long-term care or behavioral

health needs such as mental illness or substance use, a combination of the two approaches would be used to best serve their needs.[54]

Implementation of the Episodes of Care model. The EOC model was the first to be implemented within AHCPII, beginning in 2012 with three episodes: upper respiratory infection, perinatal care, and attention deficit hyperactivity disorder. Subsequently, the state increased the number of available episodes. The 14 newer episodes include congestive heart failure, colonoscopy, tonsillectomy, cholecystectomy, coronary artery bypass graft, asthma, chronic obstructive pulmonary disorder, oppositional defiant disorder, and total joint replacement. The state continues to develop new episodes. EOCs related to surgical intervention and hospitalization management are currently under consideration.[53]

The design and development of EOCs is a multistep process. Steps may not occur sequentially and may overlap or repeat, if necessary to improve upon the episode (see Exhibit AR6 below). The process for developing an episode takes the state between six and nine months.

Exhibit AR6. Episode Development Process



Implementation of the Patient Centered Medical Home model. The PCMH model was implemented beginning in 2014, after two years of experience with the EOC model component. Arkansas was participating in the federal CPC Initiative, and officials expressed interest in the PCMH component as a

means to expand the framework to new populations over time, enhancing reimbursement for primary care and improving care delivery in community settings. At the time of implementation, the PCMH component aimed to have the majority of Arkansans enrolled in a PCMH by 2018, and by 2016, 80 percent of Medicaid beneficiaries were enrolled in the PCMH program.[53] The PCMH program also collaborates with the state's long-standing PCCM program.

Stakeholder engagement. In developing AHCPII, the state worked closely with technical development workgroups, stakeholders, and private payers. The Arkansas Department of Human Services held a number of workshops to engage the public, payers, and stakeholders. An important partner in this work has been the Arkansas Center for Health Improvement (ACHI), a policy-setting organization that focuses on improving access to and quality of care, increasing coverage, and improving population health in the state.

The Arkansas Medicaid agency conducts stakeholder engagement activities as a part of developing and designing new EOCs, prior to implementation. The process involves working with the Governor's Office, the Health Care Payment and Policy Advisory Committee, CMS, and the public. There is a public comment period for each new episode and a public hearing for discussing the changes that implementation of the new episode will bring. After this point, the proposed episode moves to the Public Health and Welfare Committee, the Administrative Rules and Regulations Committee, and finally the Legislative Council. The state continues to engage providers throughout the implementation and maintenance periods.[54]

Other Parallel Health Reform Models and Infrastructure. Arkansas did not have VBP prior to the implementation of the AHCPII in 2011. Rather, Medicaid's PCCM program was predominantly fee-for-service (FFS), with low payment rates and dependence on provider rates and supplemental payments. Since that time, three VBP reforms in addition to the AHCPII have been implemented, as follows:

Comprehensive Primary Care (CPC) Initiative. Beginning in 2012, Arkansas was selected to implement the CPC model in 2012 and the Comprehensive Primary Care Plus (CPC+) model in 2017. CPC+ is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multipayer payment reform and care delivery transformation. There were 69 clinics across the state participating in CPC, and under CPC+, an estimated 182 practices are expected to implement the model.[59] Arkansas PCMH component includes the CPC/CPC+ initiative.

Behavioral Health Transformation Program. Launched on January 1, 2018, the Behavioral Health Transformation Program operates within Arkansas Medicaid to share risk with primary care physicians enrolled in the PCMH component. There are three behavioral health tiers. Tier 1 behavioral health includes counseling services and medication management, tier 2 includes additional targeted home and community-based services, and tier 3 includes additional residential setting services.[60] Primary care physicians in the PCMH program are responsible for Tier 1 behavioral health costs of care. To assist primary care providers, Arkansas plans to release new financial and quality data on behavioral health services in the state. Recently, Arkansas Medicaid announced that they would be removing Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder from the EOC program because of this new initiative.[61]

Provider-Led Arkansas Shared Savings Entity (PASSE). This new organization, formed by providers and their managed care partners, performs the administrative functions of managed care organizations (MCOs) for a small segment of Medicaid enrollees who, based on an evaluation, have complex medical, behavioral health, and social service needs. The model targets about 30,000 individuals for whom Arkansas Medicaid has historically spent about $1 billion annually for care. The program launched September 1, 2017 for risk assessment of the target population. Beginning in October 1, 2017, PASSE assumed responsibilities for care coordination for their members. The Arkansas Insurance Department (AID) licenses and regulates the PASSEs to be risk-sharing. Services for the beneficiaries in PASSE are paid for on a FFS basis, but an additional care coordination fee is paid on a PMPM basis.

Details and Mechanics of Approach

Governance and Organizational Characteristics. The ACHI, Arkansas Department of Human Services, and Arkansas Medicaid agency collaborate with commercial payer participants to operate both EOC and PCMH model components. ACHI has an Administrative Committee composed of the chief administrators from each of their sponsoring organizations. ACHI's Administrative Committee acts as the governing body for the organization. The sponsoring organizations for ACHI are Arkansas BCBS, Arkansas Children's Hospital, Arkansas Department of Health and the University of Arkansas for Medical Sciences. ACHI also has a Health Policy Board, which is an independent board that identifies and establishes strategic priorities, and provides guidance. The Board has 21 voting members from stakeholder organizations across the state.[62]

Payment Mechanisms. The payment mechanisms for the AHCPII differ based on the model component, as detailed below.

EOC. The state measures quality of care across all providers who submit claims for the particular type of episode and averages the costs for treating the particular condition in the specified length of time. For most EOCs, the period of performance is 12 months. Providers are reimbursed, as usual, for submitted claims for services provided. The state identifies the provider who has the greatest potential to influence treatment decision-making and outcomes for each episode, and this provider is designated as the Principal Accountable Provider (PAP). The PAP is eligible to share in savings or excess costs of an EOC in comparison to the average cost; if the average cost is acceptable but not exceptional, the provider has no payment change. Providers are eligible to share in separate performance incentives based on the quality and outcome measures when compared to the performance of their peers.[63] Providers receive quarterly performance reports.

EOC costs are calculated based on multiple data sources, including the data from paid claims that have been processed through Medicaid FFS reimbursements and the data submitted through the AHIN, which is a provider portal for data other than FFS claims. In addition, providers are able to access reports showing their own quality of care and cost of care results. From the payer side, the portal is available to Medicaid and private insurers to determine which provider holds the majority of responsibility for an episode. This provider portal is the main change in care process that accompanies the EOC model component.

Currently, the active EOCs are categorized as financial, which includes medical and procedural/surgical episodes, and informational. Financial EOCs are paid on a retrospective FFS basis including upside and

downside shared risk. Informational EOCs are also paid on a retrospective FFS basis, but without risk included. Active episodes are listed below in Exhibit AR7.[63]

Exhibit AR7. Active Episodes of Care

Financial	Informational

• *Medical:*
  • Asthma
  • Chronic Obstructive Pulmonary Disease (COPD)
  • Heart Failure (HF)
  • Upper Respiratory Infection (URI)
 	
• *Procedural/Surgical:*
  • Cholecytectomy
  • Colonoscopy
  • Coronary Artery Bypass Graft (CABG)
  • Perinatal
  • Tonsillectomy
  • Total Joint Replacement (TJR)
	• Appendectomy (APPY)
	• Hysterectomy (HYST)
	• Urinary Tract Infection (UTI)
	• Uncomplicated Pediatric Pneumonia

The state is currently developing informational episodes for diabetic ketoacidosis, lower back pain, Crohn's Disease, and Percutaneous Coronary Intervention, as well as beginning the initial design phase for EOCs on kidney stones, migraine, and hospice oncology. Detailed information on each episode, including episode triggers, duration, included services, episode-specific exclusions, PAPs, quality measures, and procedure codes are available on the state's website at https://www.paymentinitiative.org/episodes-of-care.

PCMH. This model component places financial responsibility for the total experience of attributed patients and associated costs on the PCMH. Providers in the PCMH can receive upside gain-sharing should they meet the quality metrics and keep the total cost of care below the established thresholds. There are two types of shared savings: one is an incentive payment for performance improvement and the other is an incentive for absolute performance. To qualify for the shared savings, the PCMH or group of PCMHs must have a minimum of 5,000 attributed beneficiaries. Shared savings are calculated using an historical baseline per beneficiary cost of care for each shared savings entity. The per-beneficiary cost of care for the performance period is subtracted from the benchmark cost for each performance period. To calculate the benchmark costs, a 2.6 percent benchmark trend is applied to the baseline costs.[64]

To support the required activities of the program, the practices receive care coordination payments and practice transformation support from a Division of Medical Services (DMS) vendor. The prospective care coordination payments are risk adjusted, ranging from $1 to $30 PMPM based on the demographics, diagnoses, and utilization of each PCMH's patient population, in a calculation called the Risk Utilization Band (RUB). RUB scores are between 0 and 5, with a score of 0 or 1 associated with a $1 PMPM care coordination payment and a score of 5 associated with a $30 payment.[65,66]

Alignment across payers. The AHCPII is a multipayer initiative, involving Medicaid, the State and Public School Employee benefits programs, and commercial partners such as AR BCBS, QualChoice,

Centene/Ambetter, HealthSCOPE and UnitedHealthcare, as well as Walmart and other self-funded employers. The PCMH model component includes not only the Medicaid PCMH but also the state's Medicare CPC/CPC+ initiative and qualified health plans (QHPs), which are required to participate. For the EOC model component, AR BCBS and QualChoice participate alongside Arkansas Medicaid.[53] To create this engagement, the SIM funding was used to support providers and payers via regular and transparent communication. Arkansas believes that the communication efforts have contributed positively to sustainability efforts of the two models. Arkansas was also able to use a combination of legislative mandates, voluntary participation, and operational flexibility during implementation to increase provider and payer buy-in.[67]

Federal assistance and cost of initiative. There are a number of federal programs in Arkansas that are instrumental to the state's AHCPII. In February 2013, Arkansas was selected as to receive a Round One Model Test award through the federal SIM Initiative. Arkansas was awarded up to $42 million to test the PCMH, EOC, and health home models during Round One.[67] SIM funds were used to contribute to this hybrid model, including technical analysis, infrastructure and contractors to build capacity and accelerate development. In addition to federal dollars, the state spent $32.8 million from its own budget for implementation.[65]

Quality measurement. The quality metrics in the AHCPII differ based on the model component, as detailed below.

EOC. There are two main types of quality measurement: "to pass" and "to track." "To pass" measures are required for a PAP to be eligible to share in the shared savings created by the EOC. "To track" measures are not linked to financial incentives but are provided to the Medicaid Office to track general quality in the program. Each EOC is measured under different thresholds due to their distinct clinical requirements. Those thresholds are listed in Exhibit AR8 below.[63]

Exhibit AR8. Quality Measures for EOCs

	Quality Measures "To Pass"	Quality Measures "To Track"
Ambulatory Upper Respiratory Infection (URI)	▪ 47 percent minimum threshold got frequency of strep testing for beneficiaries who receive antibiotics	▪ Frequency of antibiotic usage ▪ Frequency of multiple courses of antibiotics during a single episode ▪ Average number of visits per episode
Perinatal Care	▪ 80 percent minimum threshold for HIV screenings ▪ 80 percent minimum threshold for Group B streptococcus screening ▪ 80 percent threshold for Chlamydia screenings	▪ Ultrasound screening ▪ Gestational Diabetes screening ▪ Asymptomatic Bacteriuria screening ▪ Hepatitis B specific antigen screening ▪ C-Section Rate
Congestive Heart Failure	▪ 85 percent minimum threshold for percent of patients with LVSD prescribed an ACEI or ARB on discharge	▪ Frequency of outpatient follow-up within 7 and 14 days ▪ Proportion of patients matching hyperdynamic, normal, mild dysfunction, moderate dysfunction or severe dysfunction descriptions ▪ Average ejection fraction value ▪ 30-day all-cause readmission rate ▪ 30-day heart failure readmission rate ▪ 30-day outpatient observation care rate

	Quality Measures "To Pass"	Quality Measures "To Track"
Total Joint Replacement	▪ N/A	▪ 30-day all cause readmission ▪ Frequency of use for prophylaxis compared to post-op DVT/PE ▪ Frequency of post-op DVT/PE ▪ 30-day wound infection rate
Colonoscopy	▪ 75 percent minimum threshold for cecal intubation rate (aggregated quarterly) ▪ 80 percent threshold of valid episodes that have withdrawal time must be greater than six minutes	▪ Perforation rate ▪ Post polypectomy/biopsy bleed rate
Tonsillectomy	▪ 85 percent minimum threshold for percent of episode with administration of intra-operative steroids	▪ Post-operative primary bleed rate ▪ Post-operative secondary bleed rate ▪ Rate of antibiotic prescription post-surgery
Cholecyst-ectomy	▪ 44 percent maximum threshold for percent of episodes with CT scan	▪ Rate of major complications during procedure or post-procedure window ▪ Number of laparoscopic cholecystectomies converted to open surgeries ▪ Number of cholecystectomies initiated via open surgery
Acute Exacerbation of Asthma	▪ 59 percent minimum threshold for rate of corticosteroid usage (determined through prescription rate within 30 days) ▪ 38 percent minimum threshold for patients visiting outpatient physician within 30 days	▪ Rate of repeat acute exacerbation within 30 days post-triggering episode
Acute Exacerbation of Chronic Obstructive Pulmonary Disease	▪ 36 percent minimum threshold for visiting outpatient physician within 30 days	▪ Rate of repeat acute exacerbation within 30 days post-triggering episode
Coronary Arterial Bypass Graft	▪ 0 percent maximum threshold for patients with stroke 30 days post-procedure ▪ 0 percent maximum threshold for patients with deep sternal wound infection 30 days post-procedure ▪ 0 percent maximum threshold for patients with renal failure 30 days post-procedure *Note: PAP must satisfy 2 out of 3 to qualify for gain sharing*	▪ Percent of episodes with at least 1 adverse outcome ▪ Percent of patients on a ventilator longer than 24 hours post-procedure ▪ Average length of pre-procedure inpatient stay ▪ Percent of patients admitted same day as procedure ▪ Percent of patients with internal mammary artery

Note: LVSD =Left Ventricular end-systolic Dimension, ACEI =Angeiotension Converting Enzyme Inhibitors, ARB = Angiotension II Receptor Blockers, DVT/PE = Deep Vein Thrombosis/Pulmonary Embolism

PCMH. Practices must complete practice transformation activities, use quality and utilization milestone measurements, and provide live voice access to care around the clock. PCMHs that do not meet deadlines and targets for activities within the practice support component are required to remediate their performance or face possible suspension or termination from the practice support component of the PCMH.

Incorporation of Social Determinants of Health (SDOH)

No information available at this time.

Implementation of HIT and Data Analysis Infrastructure

Moving to a data-based focused program has been a priority for Arkansas since before ACHPII implementation. In 2003, the Arkansas General Assembly established the Arkansas Health Data Initiative, which improved access to public health databases.[53] The ACHPII program relies heavily on data analytic features to calculate the VBP payments, identify areas of improvement, and support clinical outcomes. For example, within the first wave of episodes, there were 15,600 quarterly performance reports distributed to almost 2,000 PAPs to assist clinical improvement.[54] More information about data analytic methods is noted throughout this case study.

Medical Neighborhood Reports. Arkansas launched the Medical Neighborhood Reports program to support broad-spectrum data transparency performance reports across the state. There are four components to the program:

- Episode-based performance reports will be released for appendectomy, uncomplicated pneumonia and urinary tract infection, with the report for upper respiratory infection currently available.
- Episode-based PCMH cost and quality reports have not yet been released, but the proposed topics include upper respiratory infection, appendectomy, pediatric pneumonia and urinary tract infection.
- Behavioral health reports include the provider financial profile, a PCMH cost contribution report (in initial design phases), and two proposed topics for provider quality and PCMH quality reports.
- Transparency reports include ED services, opioids, attempted suicide, and a quality measures catalog.

All Payers Claim Database (APCD)

Arkansas has an APCD, which started in 2013, operated by the Health Insurance Rate Review Division (HIRRD) of the AID. The APCD was initially funded through a Cycle III grant of over three million dollars from CMS and the Center for Consumer Information and Insurance Oversight. The Arkansas Center for Health Improvement (ACHI) received the contract to establish the APCD with this funding.[68] The Arkansas APCD includes claims data from Medicaid, Medicare and commercial insurance plans within Arkansas. In the future, the database plans to add hospital discharge and emergency data for the uninsured, cancer registry data, birth and death records, and a flag for medical marijuana qualifying patients. [69]Currently, the primary use for the data is by state agencies for health policy support, but the APCD anticipates opening access to academic researchers in the future.

Results, Lessons Learned, and Next Steps

Results. The AHCPII results differ based on the model component, as detailed below.

EOC. The state has measured progress in EOC since initial implementation. To date, results have been positive overall, with quality improvements such as a reduction in the C-section rate, increased physician follow-up for asthma and chronic obstructive pulmonary disease, and improved care for children with oppositional defiant disorder. There have been quality concerns with the coronary artery bypass graft (CABG) and colonoscopy episodes. Average episode costs have largely decreased or held steady, with

larger cost decreases in the attention deficit hyperactivity disorder (ADHD), colonoscopy, chronic obstructive pulmonary disease (COPD), and total joint replacement episodes. Results for each episode are summarized in Exhibit AR9 below.[53]

Exhibit AR9. Quality and Cost Results for Episodes of Care

Episode	Quality Results	Cost Results
ADHD *Volume: 4,426*	■ All quality metrics have improved slightly or held steady	■ Average episode costs fell by 19 percent from 2013 to 2015
Asthma *Volume: 3,183*	■ Rate of physician follow-up increased by 15% from 2014 to 2016 ■ Rate of episodes with appropriate medication decreased slightly	■ Average episode costs increased from $482.57 in 2014 to $489.81 in 2015 (1.5 percent increase) ■ Number of PAPs in the non-acceptable cost category dropped from 17 to 6 from 2014 to 2016
CABG *Volume: 30*	■ Adverse outcomes increased from 6 percent in 2014 to 10 percent in 2015 ■ Average length of stay increased from 1.6 days in 2013 to 2.8 days in 2015	■ Average episode costs increased from $9,840 in 2014 to $9,916 in 2015 (0.8% increase)
Cholecystectomy *Volume: 600*	■ Quality metrics have largely held steady; CT scan rate increased from 17 percent in 2013 to 24 percent in 2015	■ Average episode costs increased from $1,739 in 2014 to $1,804 in 2015 (4 percent increase)
Congestive Heart Failure *Volume: 207*	■ Quality metrics have largely held steady, although the rate of follow-up outpatient visits decreased from 48 percent in 2014 to 41 percent in 2015	■ Number of PAPs in the non-acceptable cost category dropped from 4 in 2014 to 1 in 2015
Colonoscopy *Volume: 1,624*	■ Cecal intubation rate and rate of withdrawal time of at least 6 minutes declined slightly from 2014 to 2015	■ Average episode cost fell 9 percent from 2013 to 2015
COPD *Volume: 924*	■ Rate of physician follow-up visits increased by 87 percent from 2014 to 2015 ■ Rate of acute exacerbation within 30 days worsened from 17 percent in 2014 to 21 percent in 2015	■ Average episode costs fell from $1,355 to $1,242 from 2014 to 2015 (8 percent decrease)
Oppositional Defiant Disorder *Volume: 3,183*	■ Rate of episodes with remission increased from 28 percent in 2014 to 51 percent in 2015 ■ Rate of repeat episodes with medication improved from 29 percent in 2014 to 20 percent in 2015	■ Average episode cost decreased from $2,363.73 in 2014 to $2,265.93 in 2015 (4 percent decrease)
Perinatal *Volume: 7,230*	■ C-section rate has reduced from 39 percent in 2012 to 32 percent in 2015 ■ Screening rates increased for asymptomatic bacteriuria and chlamydia, but decreased slightly for HIV	■ Average episode costs fell from $3,508 in 2012 to $3,413 in 2015 (3 percent decrease)
Tonsillectomy *Volume: 3,409*	■ Use of surgical pathology lab tests fell (improved) 47 percent from 2013 to 2015 ■ All other metrics improved slightly, except a decrease in intra-operative steroids, from 2014 to 2015	■ Average episode cost fell 0.5 percent from 2014 to 2015
Total Joint Replacement *Volume: 132*	■ Episode volume has been low in Medicaid and quality results are mixed	■ Average episode costs fell by 4 percent from 2014 to 2015

Episode	Quality Results	Cost Results
Upper Respiratory Infection *Volume: 111,101*	■ 28 percent reduction in unnecessary antibiotic prescriptions from 2012 to 2015	■ Average episode costs remained flat despite an increase in drug prices

Note: The volume noted in the first column is the 2015 Medicaid-only volume for each episode.

PCMH. Based on 2015 results (the most recently available), the PCMH model component saw improvements in three quality metrics – statin therapy for diabetes, breast cancer screening, and thyroid screening. The program has also achieved improvements in experience of care, as demonstrated by Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures such as getting needed care, coordination of care, and customer service. Further, PCMHs experienced a 16.5 percent decrease in hospitalizations and a 5.6 percent decrease in emergency room visits in 2015. However, there were declines in other quality metrics – ADHD assessment, congestive heart failure control, and the rates of infant, child, and adolescent wellness visits. According to the state's third annual report, there may be primary care access limitations due to the Medicaid expansion, and the state is monitoring these factors moving forward.[53]

The state reports two consecutive years of cost avoidance resulting from the PCMHs. For 2015, the program generated $54.4 million in cost avoidance, $14.8 million of which went to care coordination payments to providers, and the remaining $39.6 million was shared between the state and providers that had met both quality and cost targets. In 2014, the state avoided $34 million in Medicaid costs due to PCMHs.[70] [71]

Challenges and Lessons Learned. Key drivers of the success of the AHCPII have been the early support and prioritization from the Governor's office, and the state's stakeholder engagement efforts, which began early and continue even after implementation. In addition, the state has deliberately included clinical leaders (e.g., physicians, nurse practitioners, and pharmacists) in each stage of the decision-making process.[72] Payer engagement and participation in the AHCPII, including both major commercial payers, Medicare, and large self-funded employers, has been one of the program's greatest strengths from the beginning. However, bringing Medicare to the table was a slow process, which did not come into fruition until the launch of CPC+ in 2017. The state's participation in federal initiatives including SIM, CPC, and CPC+ has also contributed to the success of reform efforts.[73]

In addition to the PCMH and EOC model components, Arkansas had originally planned to implement a Medicaid health home model for individuals with more complex health care needs, including the frail elderly, individuals with severe and persistent mental illness, and individuals with developmental disabilities. However, the health homes component has received less stakeholder support than have the PCMH and EOC components; to date, the health homes model component has not yet been implemented.[53]

As noted above, Arkansas' implementation of the AHCPII has overlapped with its implementation of a modified Medicaid expansion, which has been both a benefit (due to expanding coverage and the pool of individuals covered under payment reform) and a challenge (due to the influx of new enrollees into the Medicaid program). The Medicaid expansion has also been politically controversial at times and must be reauthorized annually with a 75 percent majority in both the House and the Senate. While the state reports that Medicaid expansion has saved money overall, critics of the private option approach argue that it is less cost-effective than a traditional direct benefit program. Future cost increases may present a concern,

since Arkansas is currently paying 6 percent of the cost of covering the expansion enrollees, but this is expected to increase to 10 percent by 2020. However, there is speculation that a decrease in Medicaid enrollees due to changes in eligibility criteria, such as the new community engagement requirement, may change these projections.[73,40,74]

Implementation of the HIT components of the EOC and PCMH models has been successful overall; however, Arkansas Medicaid's transition to the Medicaid Management Information System (MMIS) in November 2017 has presented some challenges. The state has had to re-program the retrospective calculations for the PCMH and EOC reports. As a result, the 2018 first quarter PAP report for the EOC program will be delayed.[61]

Next Steps. Arkansas is not planning any major changes to the structure or payment mechanisms of their VBP initiatives. The state does continuously reevaluate its approach and make modifications as needed.

Key Considerations for Alaska

Multipayer Participation. The state was able to take advantage of the relatively small number of commercial payers, who were responsible for the majority of lives, in the state by developing close and actively engaged relationships with the payers, both of which participate in the EOC model component voluntarily. Similarly, Alaska could begin conversations with its larger commercial payers regarding what types of VBP models are of interest. Arkansas public officials describe the multipayer approach as one of HCPII's major strengths as a reform effort. While commercial payer participation began at implementation, the program engaged Medicare participation in 2017 when the CPC+ initiative began. At that point, the PCMH model component had already gained traction and achieved successes within Medicaid, prior to the implementation of CPC+, indicating that Medicare participation is not essential to model success.

Complementary Design Features. Arkansas used a multifaceted approach to implementing VBP within their reform initiative—PCMHs focus on primary care transformation, while EOCs focus on improving care and cost-effectiveness of acute health care episodes. Results from both model components have demonstrated success in controlling health care costs for Arkansas Medicaid. In addition, publicly available findings indicate improved practice patterns and a shift to more efficient treatment and utilization options. EOC design allows for significant state tailoring to target the high-cost health care events within each market, as well as offering incentives for desired outcomes (e.g., quality, utilization, and cost) through appropriate payment structure.

Rural Design. For Arkansas and in other VBP initiatives within Medicaid, PCMH is a common component of a multi-pronged approach, as well as being the most common VBP approach in rural areas.[14] A combined VBP approach allows for a different focus in the rural areas compared to urban areas, although a singular program does allow for additional administrative simplicity. While EOC designs have benefits in all contexts, rural implementation merits additional considerations, including the following:

- The potential for varied impact depending on geographic regions (i.e., urban/rural);
- The possibility of increasing provider consolidation, which could reduce provider choice, particularly in rural markets;

- Incorporating critical access hospitals into EOC can be a funding challenge due to contradictory reimbursement structures; and,
- Additional consumer protections may be important for the design of an EOC in order to protect choice and existing provider-patient relationships where provider consolidation may be increasing.[14]

Incremental Approach. While Arkansas' major VBP initiatives are now robust and widespread, they were implemented incrementally beginning in 2012 from modest beginnings. In terms of implementing an EOC, Alaska could consider implementing two to three episodes based on high-priority health care events, then adding more episodes as the state gains more experience. For Arkansas, the higher-volume episodes that achieved reductions to average costs were the ADHD, perinatal, colonoscopy, oppositional defiance disorder and tonsillectomy episodes. With regard to PCMH, Alaska could build off of their existing PCMH program.

Stakeholder Engagement. The AHCPII gained widespread support and participation through prioritization from state leadership, extensive stakeholder engagement, and by leveraging partnerships with commercial payers. Continued success of the Arkansas AHCPII program relies on full, engaged participation across the state and by multiple payers, including continuous innovation and adaptation. The formation and implementation of the AHCPII program benefitted from experienced government leaders who knew their market well and had the ability to develop a program that could both overcome challenges and gain the interest of stakeholders.[14]

Funding and Cost Containment. The AHCPII benefitted from financial and operational support received through the federal SIM, CPC, and CPC+ initiatives. However, the state had already developed AHCPII prior to receiving the SIM grant, indicating that the program was state-directed from the outset and relied on state funding for the early design stage. In 2013, the state received $42 million in funding from SIM while also committing to spending $32.8 million from the state budget for implementation. While Alaska potentially may not have the benefit of similar federal funding to develop an EOC model, it would benefit from the experience of states who have successfully done so already (including Ohio[14] and Tennessee,[18] in addition to Arkansas) and made robust information on the specifications of their episodes publicly available. Both the EOC and PCMH models have shown success so far in controlling Medicaid costs. Average episode costs have decreased for several episodes and held steady for most others. The PCMH model generated $34 million in cost avoidance in 2014, and $54.4 million in cost avoidance in 2015.

Case Study: The Colorado Framework and Accountable Care Collaborative Program

Executive Summary

The Colorado Framework, Colorado's State Innovation Model (SIM), is helping primary care practices throughout the state to integrate behavioral and physical health in primary care settings, as well as alternative payment models. Under the framework, participating practices will integrate behavioral health and primary care along a continuum, from coordination between services, to co-location, to fully integrated care with an embedded behavioral health provider. The participating practices are offered coaching, tools and other resources to help determine which approach to integration is best suited to improve the health of their patients. The framework takes into account practice resources, interest, funding, and their patient payer mix.[75]

The **Accountable Care Collaborative (ACC) Program** moves Medicaid enrollees into Primary Care Medical Provider (PCMP) offices, which serve as medical homes for the enrollee. The model is person-centered, promotes self-management, and provides culturally sensitive care.[76] Based on the PCMP attribution, the member is assigned to one of seven Regional Accountable Entities (RAEs), which oversee both medical and behavioral health services. In addition, they oversee networks, onboard enrollees, and make value-based payment (VBP) to the health team providers.[77]

Key takeaways from Colorado's approach include:

- ***Multipayer Participation.*** The Colorado Framework reform focused on Medicaid, as the budgetary concerns at the time of the innovation surrounded the program, but they have been careful to build and engage in multipayer support. Stakeholder engagement and buy-in is a critical piece of health care reform efforts. Colorado has five commercial health plans and the state Medicaid plan working directly with the Colorado Framework. The Colorado Framework includes partnership with the Colorado Multipayer Collaborative, a group started in connection with the CMS CPC initiative, which it continues to support, and now also works on data aggregation and the Colorado Framework. The goal of the Collaborative is for public and private payers to work to strengthen primary care. This will facilitate an ongoing relationship for reform efforts in the state.
- ***Unique Managed Fee-for-Service Approach.*** Colorado has a modest history of managed care, with some difficulties. The ACC has found a middle road method for payment reform by operating in a managed fee-for-service (FFS) environment. This design is sensitive to local experiences with payment reform and allows health plans and providers to acclimate to the reform more slowly**.** An incremental design approach, potentially incorporating the results of Alaska's current pilot project with Medicaid managed care, could allow Alaska to try new care delivery and payment mechanism options, while maintaining the basic structure and integrity of the current market and system.

- ***Community-based Approach.*** By using seven separate regions under the ACC, the program design allowed for regional flexibility and modification, which promotes the development of community-based healthcare solutions. In addition, the integration focus of the ACC program allows for more collaboration with local organization that can assist in meeting social needs for members with complex healthcare needs. The ACC attribution process focuses on maintaining or creating sustainable member-provider relationships, deferring to existing claims-based relationships, family relationships or geography, while also giving members the ability to change their attributed provider at any time.
- ***Funding and Costs.*** The Colorado SIM project relied on funding from the federal government to design, implement, and evaluate its model. Although additional SIM funding is not available at this time, there may be components designed and implemented under funding that are replicable under Alaska's state budget. Alaska may also want to consider looking carefully at Colorado's sustainability planning as the Colorado Framework comes to a close in 2019.

In this paper, we will examine health care reform efforts in the state of Colorado. This case study focuses on the **Colorado Framework**, the state's health reform initiative to integrate behavioral and primary care services and settings. We will also provide information on the **Accountable Care Collaborative (ACC)** program, which uses regional entities to provide a "managed fee for service" style payment mechanism under the Colorado Medicaid plans.

The paper starts with background on state demographic and economic characteristics and moves to details on the approach. We discuss the history of and impetus for reform and then provide an overview of the approach and its implementation followed by details of its mechanics. We then provide information related to the state's health reform efforts on social determinants of health, implementation of health IT, and of all-payers claim database, to the extent that those exist. This is followed by an examination of the results, lessons learned, and considerations for Alaska.

Background

State Characteristics – Demographics and Economic Indicators. Colorado is a western U.S. state with a population 5.7 million as of July 1, 2018.[78] The population per square mile (in 2010) was 196.1, and 39 percent of the counties had less than 7 people per square mile. About 14.7 percent of Coloradans live in poverty. The median household income (in 2017 dollars) was $65,458, and minimum wage was $11.10 an hour.[78] Unemployment in the state was 3.6 percent in December 2018, somewhat lower than the national average of 3.7 percent at the same time.[24] The geography of the state is diverse, with 25 out of 64 counties considered rural. In 2018, the majority of Coloradans identified as White (87.3 percent), followed by Hispanic or Latino (21.5 percent), Black or African American (4.5 percent), and American Indian or Alaska Native (AI/AN; 1.6 percent).[78]

The state operating budget for fiscal year 2018-2019 was $30.63 billion.[25] In 2017, the Gross Domestic Product (GDP) across all industries was $345,233.1 million, and per-capita real GDP was $47,142.[26]

Exhibit CO1 provides Colorado's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit CO1. Demographics and Economic Indicators

	Colorado	Alaska	U.S.
Population, as of July 1, 2018[78]	5,695,564	737,438	327,167,434
Rurality			
Population per square mile, 2010[78]	196.1	1.2	87.4
Share of population in rural areas, 2017[22]	22%	32%	14%
Race/Ethnicity, 2017[78]			
White Alone	87.3%	65.8%	76.6%
Two or more races	3.0%	7.4%	2.7%
Black or African American Alone	4.5%	3.7%	13.4%
Asian Alone	3.4%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	1.6%	15.3%	1.3%
Hispanic/Latino	21.5%	7.1%	18.1%
** White non-Hispanic	68.7%	60.8%	60.7%
Poverty			
Median Household Income (2017 Dollars) [78]	$65,458	$76,114	$57,652
Minimum Wage, 2019[79]	$11.10	$9.89	$7.25
Share of Population in Poverty (2017) [78]	14.7%	11.1%	12.3%
Economy			
Unemployment Rate, as of December 2018[24]	3.6%	6.3%	3.9%
Gross State Product (GSP), 2017[25]	$540.5 billion	$52.8 billion	$19.5 trillion
Per Capita Real GSP, 2017[26]	$47,142	$70,683	$55,418
Expenditures, SFY 2017[27]	$48.2 billion	$9.7 billion	$1.9 trillion
Expenditures per Capita, SFY 2017[27]	$4,688	$13,171	$5,976

State Health Insurance Market – Health Coverage and Uninsured. As of 2014, Colorado spent $6,804 per capita on health, including all privately and publicly funded personal health care services and products, which is below the national average of $8,045 per capita. Total health spending for Colorado, including all privately and publicly funded health services, was $36.4 million in 2014.[27] Between 1991 and 2014, Colorado experienced an average annual growth in health care spending of 6.5 percent.[28]

Private Health Insurance Market. As of 2016, there were 425 health insurers in Colorado. The top 10 largest insurance companies accounted for most health market coverage (81 percent). Over half of Coloradans had employer-based health insurance, which is in line with the national average. Among private-sector employers, 45 percent offer health insurance, and among that number, 48 percent self-insure their plans.[80] For private health insurance, Colorado spent $15.7 million in 2014, with an average annual growth in private health spending of 6.6 percent between 2001 and 2014.[81,82]The commercial HMO penetration rate is 17.1 percent.[31]

State Employee Health Care System. The Colorado Department of Personnel and Administration's Division of Human Resources (DHR) is the central provider of human resources for the state. DHR is responsible for the self-funded benefits system for the 38,000 eligible employees, and covers 44,000 lives.[83] The state is self-insured for liability, workers' compensation, and state property.[84] Medical benefits are provided through UnitedHealthcare or Kaiser Permanente.

Colorado public employees are eligible to enroll in either the Defined Benefit or Defined Contribution Retirement plans for pension or 401(k) plans. The Public Employees Retirement Association (PERA) offers PERACARE, a health benefits program for retirees and benefit recipients. The plan includes health, dental, and vision care. For pre-Medicare, retirees can chose between two PPO plans, an HMO plans, and a high deductible health plan. For Medicare-eligible retirees, the choices are two Medicare Preferred (PPO) Medicare Advantage plans, and a Medicare HMO plan.[85]

Health Insurance Marketplace. Connect for Health Colorado is the state-run exchange and includes the operation of the state's exchange and enrollment platform.[86] Colorado has an extended open enrollment period that runs for 2.5 months, with seven health plans offered in 2019. In addition, there were 124 individual market plans available in 2018. About 95 percent of the marketplace enrollees live in areas where at least two different insurers offer plans. Unlike other parts of the country that favor silver plans on the exchange, since 2016 Coloradans have preferred bronze level plans.[86]

Single Payer Care in Colorado

In 2016, Colorado voters rejected a state-based single-payer system, which would have been the first of its kind in the country. In both 2017 and 2019, the Colorado Senate postponed a measure to provide premium relief for Coloradans who did not qualify for ACA premium subsidies. Colorado Democrats are expected to reintroduce the measure in 2019.

Medicaid and CHIP Program and Population. Colorado is a Medicaid expansion state.[78] Since expansion began in 2013, enrollment has grown by 73 percent. As of July 2018, almost 1.4 million enrollees are covered by Health First Colorado, the state's Medicaid program.[78] Colorado's income limits for Medicaid are 142 percent of the federal poverty line (FPL) for children up to 18 years of age, 195 percent of FPL for pregnant women, and 260 percent FPL for pregnant women with children. For nonelderly adults, the income limit is 138 percent of FPL.[86] Children with family incomes of up to 260 percent of FPL qualify for Child Health Plan Plus. In addition, Colorado Medicaid covers lawfully present children and pregnant women who have not been in the United States for five years, which is the requirement under most Medicaid programs.[87]

Colorado Buy-In Discussions

- In 2018, consumer advocates in Colorado sponsored a feasibility study on Medicaid buy-in, as a possible response to the high increase in ACA premiums since 2014. The study found that with Medicare provider reimbursement rates, a buy-in plan could have a 28 percent lower premium than the average individual market plan in Colorado before the buy-in. These estimates are lower than current premiums due to lower administrative and provider reimbursements costs, and would leave the state with savings to use to strengthen coverage for residents. The study concludes that results are preliminary and outcomes could differ should the design be altered.
- Since this study, two bills have been introduced to the state legislature.
- The first calls for the development and submission of a proposal concerning the design, costs, benefits and implementation of a state option for health care coverage. (HB19-1004)
- The second authorizes the implementation of a pilot program for residents living in high-cost areas to participate in state employee medical plans. (SB-19-004)

Similar to Alaska, Colorado has little comprehensive managed care for its Medicaid population. Colorado has two types of delivery arrangements in their Medicaid program: comprehensive risk-based managed care organizations (MCOs) and primary care case management (PCCM). Among those receiving managed care in Medicaid, about 10 percent are in MCOs and 90 percent are in PCCM.[55] MCO enrollees are part of Rocky Mountain Health Plans "Medicaid Prime" program, a pilot program for new payment methods within Medicaid, established by law in 2012. These enrollees are based in six Western Slope counties of

Colorado.[88] PCCM enrollees are part of the ACCs, described in more detail below.[89] They are enrolled in RCCOs based on their geographic location.

Colorado Medicaid spends a total of $7.9 billion on services.[90] The Federal Medical Assistance Percentage (FMAP) in Colorado is 50 percent.[91] Adults and children account for 41 percent of the expenditures and elderly and disabled account for 59 percent. In 2017, Medicaid spending accounted for 26 percent of the state budget.[90]

Exhibit CO 2. Medicaid Eligibility Levels, as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
Colorado	138% FPL	138% FPL	142% FPL	195% FPL	59% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

The Colorado legislature has introduced two bills about potential health care buy-in discussions for the state health coverage, including a general buy-in option and an option targeting residents in high-cost areas. See the box on the left for more information.[92,93]

Uninsured Population. Between 2013 and 2017, the uninsured rate fell by 47 percent after the implementation of Medicaid expansion—from 14.1 percent in 2013 to 7.5 percent in 2017.[94]

Providers and Service Use. As of 2016, there were 79 community hospitals in Colorado.[95] Among those, 30.4 percent are state- or local-government operated, 50.6 percent are operated by nonprofit organizations, and almost 19.0 percent by for-profit organizations.[49] In October 2018, there were 14,347 physicians in Colorado, with 7,109 primary care physicians and 7,238 specialist physicians.[50] There are 53 Medicare-certified rural health clinics and 20 community health centers in Colorado.[96] In addition, the state has 123 primary care health professional shortage area (HPSA) designations.[97]

Tribal Health. Colorado is within the Indian Health Service (IHS) Albuquerque Area, which services 27 tribal groups, including 20 Pueblos, 2 Apache bands, 3 Navajo chapters, and 2 Ute tribes. The service area spans New Mexico and Colorado. The administrative headquarters for this service area are in Albuquerque. The service area facilities include 5 hospitals, 11 health centers, and 12 field clinics; the New Sunrise Regional Treatment Center, which provides residential substance abuse treatment services; and the Albuquerque Indian Dental Clinic, which provides dental care for people under the age of 26. With the exception of the Ute Mountain Ute Service Unit, all the facilities are located outside of the state of Colorado. There are five special IHS programs in which the Albuquerque area participates:

- Special Diabetes Program for Indians (SDPI)
- Improving Patient Care (IPC)
- Meth and Suicide Prevention Initiative (MSPI)
- Domestic Violence Prevention Initiative (DVPI)

- Baby-Friendly Initiative[97]

The Southern Ute Reservation has uncoupled from IHS, placing its health system under tribal control.[75] The Southern Ute Tribal Health Department aims to be the primary choice for health and preventive care for enrolled tribal members.[98] The program covers medical, pharmacy, dental, and vision services through a contract with the First Health Network of providers.[99]

History of Reform

Impetus for Health Care Reform. Declining health status for Coloradans and increasing costs spurred Colorado's movement toward reform. First, the generally healthy Colorado population began showing a decline in health at the population level. Colorado was experiencing a rising obesity rate and tobacco use, and lagged behind other states in access to mental health and substance use treatment. Second, despite having a competitive health insurance market, insurance premiums were continuing to climb. Considering the wealth disparity within the state—including stagnant and decreasing income rates—increasing premiums created financial pressure for Coloradans in low-income and moderate-income households.[75]

Preexisting Health Reform Models and Infrastructure. In response to these issues, the state and its Governor undertook a multipronged approach for delivery system reform. The first was **the Accountable Care Collaborative (ACC) program**, which began in 2011, and is now entering a second phase that is advancing team-based care and Health Neighborhoods. The second is **the Colorado Framework**, which is transforming primary care practices throughout the state to integrate behavioral and physical health. The Framework also is introducing alternative payment models (APMs) into the Colorado's health care system. Additional details on these ongoing efforts are provided in the sections below.

Overview and Implementation of Initiative

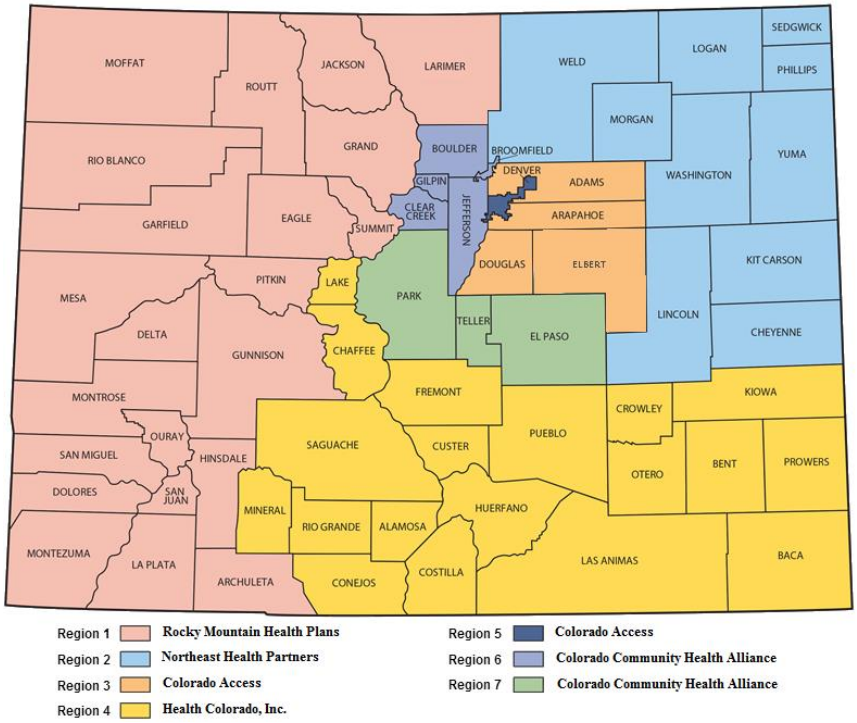
Overview of the Initiative

Accountable Care Collaborative (ACC). In Colorado, the ACC program was created in response to a number of factors: the state's unsuccessful experience with capitated managed care; a Medicaid program where 85 percent of Medicaid enrollees were in fee for service (FFS); high Medicaid caseload and expenditures, and a desire not to pay for higher volume and utilization.[93] ACC moved enrollees into Primary Care Medical Provider (PCMP) offices, which serve as medical homes for the enrollee. The model is person-centered, promotes self-management, and provides culturally sensitive care.[76] Enrollees were assigned to one of approximately 550 PCMP's by the Regional Care Collaborative Organizations (RCCOs), which also did network development, network management, provider support, and care coordination tasks. RCCOs allowed Colorado to leverage specific parts of managed care within ACC, such as bidding for contracts, medical homes, and capitated payment. In addition to the RCCOs, the ACC had Behavioral Health Organizations, which managed mental and behavioral health services for the enrollees. There were five BHOs that were assigned geographically, and each arranged and paid for the behavioral health services at the Community Mental Health Centers.[77] The BHOs and RCCOs have capitated contracts. The state paid the BHOs, RCCOs, and providers on a per-member per-month

(PMPM) fee; however, the state could adjust the per-enrollee payment based on quality measurement results. The PMPM fee for RCCOs covered care coordination and medical homes, meaning that medical services are paid on a FFS basis. Colorado describes this mixed payment structure as "managed fee for service."[88]

ACC entered a second phase on July 1, 2018, with CMS approval of Colorado's Section 1915(b) Waiver proposal for a Health Neighborhood model to incorporate behavioral health, primary care, long term services and supports (LTSS), and certain specialists into a single care team.[77] During the second phase, the RCCO and BHO model transformed into Regional Accountable Entities (RAEs), which oversee both medical and behavioral health services. In addition, they oversee networks, onboard enrollees, and make value-based payment (VBP) to the health team providers. There are seven regions, which are organized as seen below in Exhibit CO3.

Exhibit CO3. Map of Regional Accountable Entities



The payment model has evolved, moving PMPM payment to the RAE and enacting a new VBP formula to support integration while continuing pay-for-performance incentives. There are functionalities for hospital payments, and the model is exploring alternative payment methodologies for Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Community Mental Health Centers (CMHCs), which are not currently included in the model.[100] There is an enhanced provider portal, additional analytics with new data sources, and a growing focus on Health Information Exchange (HIE) during phase two.

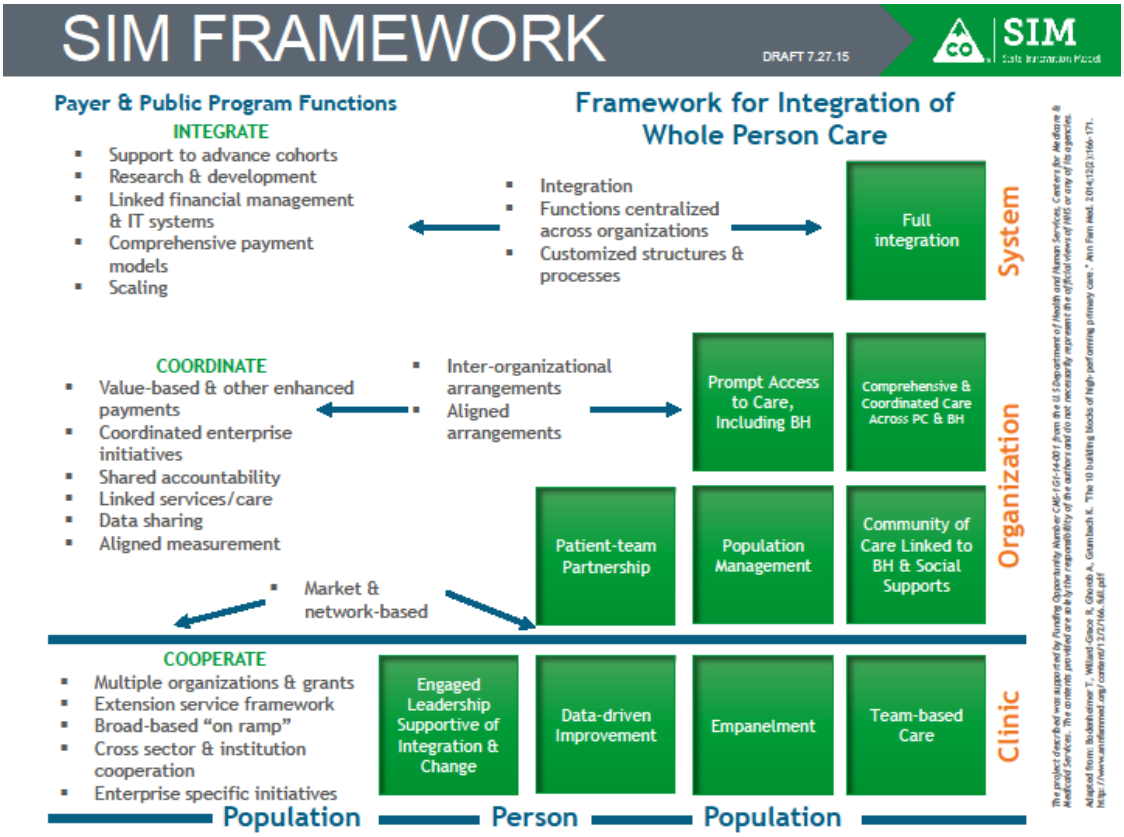
The Department is continuing to work on how best to facilitate and coordinate care for tribal members. The Department is collaborating with IHS and non-IHS providers to facilitate Care Coordination Agreements, which will detail how referrals to non-IHS providers will be coordinate, and how

information will be shared with the referring physician. Complying with CMS regulations would mean that the state would be eligible for 100 FMAP for these beneficiaries. [101]

Colorado Framework. In March 2013, Colorado received a six month pre-testing award from CMS under SIM, which aimed to help the state develop its Colorado Framework proposal. At the end of the pre-testing award, Colorado submitted the Colorado State Health Innovation Plan (SHIP), its proposal to implement the Colorado Framework.[65] The proposal was accepted by CMS in December 2014. In 2015, Governor John Hickenlooper created the SIM Colorado Office to oversee its implementation and the SIM Advisory Board to "provide[s] advice, oversight, and guidance over the management of SIM grant funds."[102]

The Colorado Framework is helping primary care practices throughout the state integrate behavioral and physical health in primary care settings, as well as alternative payment models (APMs). Colorado offered significant support to practices as they began their integration transformation efforts. There are 17 approved practice transformation organizations, which assist practices in creating an improvement plan based on the practice's needs and resources.[75] The University of Colorado is providing assistance and oversight for practice transformation activities. Participating practices are offered coaching, tools, and other resources to guide selection of approaches best suited to improve the health of their patients. The framework takes into account the practice resources, interest, funding, and their patient payer mix.[103] The framework can be seen in more detail in Exhibit CO4.

Exhibit CO4. Colorado SIM Framework[104]



Goals for Health Care Reform

Accountable Care Collaborative. Phase II of the ACC aims to improve member health and reduce costs. The objectives include integrating physical and behavioral health within an RAE, strengthen coordination of services, promoting member choice, paying providers based on increased value, and ensuring greater accountability and transparency.[76]

Colorado Framework. Through the Colorado Framework, the state aims to improve the health of Coloradans by 1) providing access to integrated primary care and behavioral health services in coordinated community systems; 2) applying VBP structures; 3) expanding information technology efforts, including telehealth; and 4) finalizing a statewide plan to improve population health.[105]

Population, Scope, and Participation.

Accountable Care Collaborative. In June 2016, there were 1,025,176 Medicaid members enrolled in the program, which is 80 percent of the Colorado Medicaid population.[106] Beginning in July 2018 all Health First Colorado members were assigned to a PCMP, the primary point of care, and one of the seven RAE. Members are attributed to a PCMP by either having a claims history with the provider, having a family member with history for that provider, or by geographic proximity.[106] While these attribution methods occur automatically, the member can contact Health First Colorado and choose a different PCMP at any time.[75] After initial attribution, there is reattribution done every six months. This is intended to allow a member to be attributed to a new PCMP should they develop a stronger or more consistent relationship with them.

Colorado Framework. By the end of the SIM implementation period, the Colorado Framework aims to provide 80percent of Coloradans with coordinated systems of care that integrate physical and behavioral health and connect public health agencies, clinical care delivery systems, and community organizations. In the same time period, the project will work with one quarter of primary care practice sites in the state. In 2018, the Colorado Framework had 328 participating primary care practice sites, including 132 providing care for children, 63 FQHCs, and 116 rural practices, for a total of 2,395 participating providers.[107] In addition, the primary care practices had access to services and coordination with four community mental health centers, eight local public health agencies, and two behavioral health transformation collaboratives that partnered with the program.[107]

However, the model allows for flexibility for participating providers, recognizing that not all clinics will be able to fully integrate the two. Therefore, the framework also considers a closely coordinated model with effective referral and follow up between primary care and behavioral health providers a success.[75]

Timeline and Implementation Process.

Accountable Care Collaborative. Colorado began moving forward with a second phase of the ACC in 2014, when stakeholder meetings were held across the state. This continued through the following year, when the department held stakeholder engagement sessions and discussions with CMS.[106] In 2016, the department drafted and released a request for proposal. The new RAE contracts began in 2017 but full implementation began in July 2018.

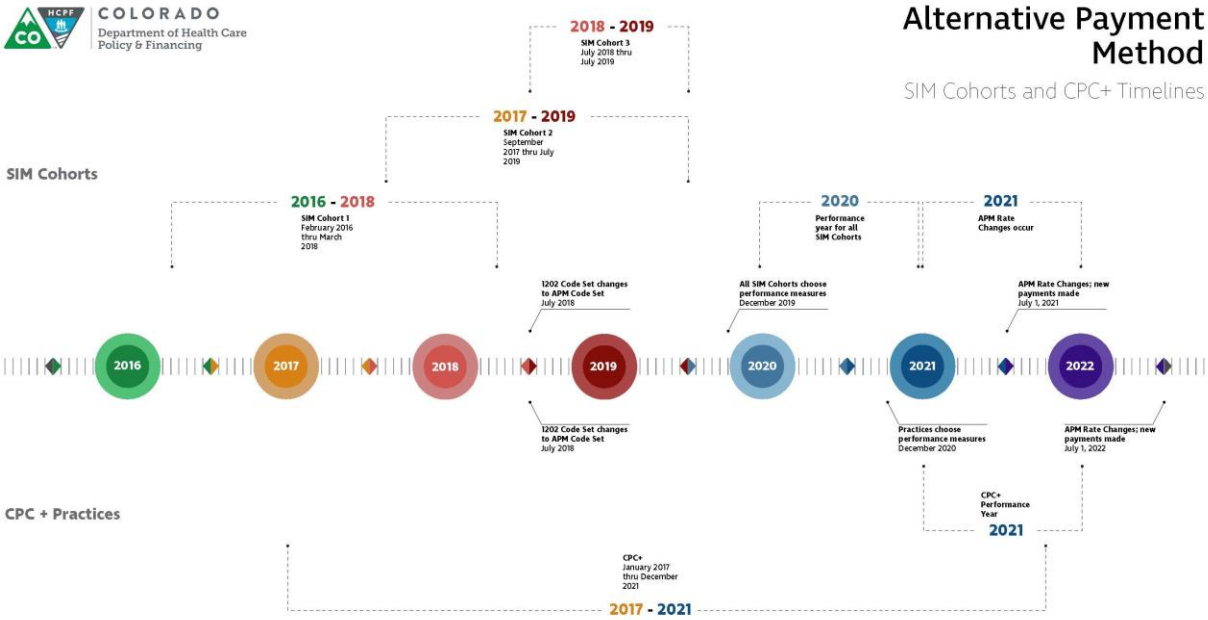
Colorado Framework. In early 2016, the Colorado's SIM Operational Plan was submitted to CMMI. In this plan, the SIM office laid out a number of milestones to accomplish quarterly between 2016 and 2018. The timeline of milestones included activities within the following categories:

- Governance, Management and Decision Making
- Stakeholder Engagement
- Population Health Plan
- Practice Transformation Plan
- Payment Reform
- Leveraging Regulatory Authority
- Workforce Development Monitoring
- Health Information Technology
- Program Monitoring and Reporting

Within the first quarter of 2016, the Practice Transformation Organizations (PTOs), the practices that are integrating behavioral health and primary care, were on-boarded, trained and matched to primary care practices. At the same time, the practice transformation primary care cohorts were selected and on-boarded, and the health homes participating in the Bi-Directional Health Homes pilot began operating and participating in the peer-supporting learning group.[105,108]

The SIM Office implemented using a staged cohort approach that ran parallel to other initiatives occurring in the state. Exhibit CO5 (below) shows how the cohorts each operated for two years, with one starting each year from 2016-2018. During these implementation periods, the CPC+ practices also began implementing their program. Colorado is planning, based on the SIM framework developed through this program, to build alternative payment methods out in future years as well.[108]

Exhibit CO5. SIM Cohort Implementation



Stakeholder Engagement.

Accountable Care Collaborative. The Department of Health Care Policy and Financing maintains a Provider and Stakeholder Resource Center. Information on key concepts, provider resources, attribution materials, behavioral health services, performance measurement, county resources, implementation updates and other resources are available. In addition, the Department uses an email list to provide regular implementation updates to providers and stakeholders.[106]

Colorado Framework. To build engagement for the Colorado Framework, the Colorado SIM office held a variety of meetings, including three advisory committee meetings, attended by roughly 150 stakeholders. In these meetings, the SIM office provided progress updates and requested stakeholder feedback on the direction of the project. The advisory committee meetings also included breakout sessions for three small workgroup discussions on the topics of public health, children and youth, and provider/workforce perspectives. In addition, the SIM office held steering committee meetings to solicit input on the draft State Healthcare Innovation plan; 25 participating stakeholders represented consumers, providers, insurers, agencies, academics, technology, businesses, and behavioral health.[108]

Other Parallel Health Reform Models and Infrastructure.

Colorado participated in the **Comprehensive Primary Care (CPC) initiative**, a multipayer, four-year effort to encourage collaboration between public and private health care payers to improve primary care. Launched in 2012, the Colorado Multipayer Collaborative included Medicare, Medicaid, and the commercial payers Aetna, Anthem Blue Cross Blue Shield of Colorado, Cigna, ColoradoAccess, Colorado Choice Health Plans, Humana, and UnitedHealthcare. Three hundred sixty participating providers in 71 primary care practices served approximately 450,000 patients, including 86,500 Medicare and Medicaid beneficiaries. Participating practices conducted practice transformation and improvement

activities in exchange for a monthly non-visit-based care management fee and an opportunity to share in any net savings to Medicare; participating primary care physicians were eligible for bonus payments.[18]

CPC served as the foundation for the Comprehensive Primary Care Plus (CPC+) initiative, which is a five-year advanced primary care medical home (PCMH) model that launched in 2017 and continues to emphasize bringing value-based care into primary care settings.[59] In Colorado, five payers are participating in CPC+ to support 207 practice sites.[109]

The Colorado Framework includes collaboration with the **Colorado Multipayer Collaborative (Collaborative).** The Collaborative started in 2012 as a part of the CMS CPC initiative, which it continues to support, and has added work on data aggregation and the Colorado Framework. The goal of the Collaborative is for public and private payers to work to strengthen primary care. Currently, the Collaborative includes Anthem Blue Cross/Blue Shield of Colorado, CMS/CMMI, Cigna, Colorado Choice Health Plans, Colorado Department of Health Care Policy and Financing, Kaiser Permanente, Rocky Mountain Health Plans and United Healthcare. [110]

Beginning October 1, 2019, Colorado will implement a **delivery system reform incentive payment (DSRIP)** under a section 1115 demonstration waiver. Colorado's DSRIP, the Hospital Transformation Program (HTP), aims to transform care coordination, complex care management, behavioral health, and perinatal care; to address social determinants of health (SDOH); and to reduce the total cost of care.[111]

The Western **Colorado Accountable Health Community Model** led by the Rocky Mountain HMO uses social needs screening at participating practices, community navigators to help clients identify and access community services, and conducts community gap assessments. In addition, the Denver Regional Council of Governments received $4.51 million to also implement an Accountable Health Community model that seeks data to show connecting people with community-based services improves health outcomes and decreases health care costs. It will work with Medicare and Medicaid beneficiaries and five clinical partners across various counties.

Details and Mechanics of Approach

Governance and Organizational Characteristics.

Accountable Care Collaborative. The ACC is structured such that governance occurs within the RAE level, which means that each regional organization has a degree of autonomy and flexibility in managing themselves, their providers and their beneficiaries, as long as they meet ACC requirements. This allows leadership and operations to remain at a local level. For example, there are some RAEs that include health care provider governance boards to inform their strategy and decision-making. Within this, RAEs may decide there are different criteria, such as provider size for providers to participate in an advisory capacity.[112]

Colorado Framework. The SIM Advisory Board, created in 2015, has responsibilities that include overseeing the strategic direction of Colorado health care, sustaining the Colorado Framework, and reviewing results for payment reform and integration of care. Tasked with providing recommendations to the Colorado SIM office, the Advisory Board consists of the director of the SIM; subject matter experts (behavioral health, primary health care, health care delivery, and health information technology); the

executive directors of the Department of Health Care Policy and Financing, the Department of Human Services, and the Department of Public Health and Environment; and the commissioner of Insurance.[102]

Payment Mechanisms.

Accountable Care Collaborative. In the second phase of the ACC program, there are four main program performance mechanisms, which are key performance indicators, behavioral health incentives, public reporting and a performance pool. Incentive payments are paid to the RAEs, with the intention of allowing them each flexibility in designing value-based payment arrangements to work with their network providers. Enrolled PCMPs receive the usual FFS payments for medical services that they provide to ACC members, as well as a PMPM to assist in supporting medical home services. PCMPs are eligible for quarterly performance incentive payments, which are calculated on regional success on the key quality measures and distributed by the RAEs. These measures are described in greater detail below.

Key Performance Indicators (KPIs). KPIs are measurements that assess the overall health of the ACC program, and then reward the RAEs for improvement within their regional delivery of care. The measurements are selected by the Department to evaluate progress towards coordinated and community-based care that improves patient health and reduces overall costs. For 2018-2019, there are seven KPIs, which are

- Potentially avoidable costs
- Emergency room visits
- Behavioral health engagement
- Well visits
- Prenatal engagement
- Dental visit
- Health neighborhood

For the KPI measures, RAEs can earn back the $4.00 PMPM payment that is originally withheld by the Department. Each KPI has the same financial value, but there are two tiers of performance within each indicator. Under the first tier, the RAE is eligible for 75 percent of the incentive payment for the 1-5 percent improvement based off of the baseline year. Under the second tier, the RAE is eligible for 100 percent of the incentive payment for 5percent or more improvement from the baseline year. KPI performance is based off of 12 months of data and paid to the RAEs quarterly.

Performance Pool. KPI funds that are not earned back by the RAEs become a pool of funds that are available for additional performance measures or in parallel state or federal initiatives that align with the ACC program.

Behavioral Health Incentive. RAEs are eligible to earn 5 percent of their annual behavioral health capitation rate for reaching performance target goals. The behavioral health incentive measures are:

- Engagement in outpatient substance use disorder (SUD) treatment
- Follow-up within 7 days after an inpatient hospital discharge for a mental health condition

- Follow-up within 7 days after an emergency department visit for a SUD
- Follow-up after a positive depression screening
- Behavioral health screening or assessment for foster care children.

Public Reporting. The Department publicly reports on RAE performance on a series of clinical and utilization measures. RAEs are not eligible to earn payments for performance on the Public Reporting measures. [113]

Colorado Framework. As a part of this integrated model, the Colorado Framework aims to move away from an FFS model to an outcomes-based payment model, with a provider performance-based payment mechanism. Implementation is expected to inform ongoing refinement of the framework. This is part of Colorado's approach to Alternative Payment Models (APMs), which are payment approaches that provides incentives for high-quality and cost-efficient care.[113] The payment models that payers will apply include three main features. First, they include fee-for-service payments. Second, they include payments to integrate behavioral health, which is operationalized through options of upfront payments, population-based payments (e.g., PMPM), care coordination payments or payments for additional codes. Finally, the payers will use shared savings or incentive payments based on performance and/or quality measures.[114] In 2019, claims data will be available to practices, which the Colorado SIM office hopes will help each practice understand and improve their performance. The Colorado SIM office plans to evaluate the 2019 performance year and issue incentive payments based on each practice's reporting of quality measures.

Alignment among Payers.

Accountable Care Collaborative. The ACC is an exclusively Medicaid initiative.

Colorado Framework. There are five health plans working directly with the Colorado Framework: Anthem Blue Cross Blue Shield, Kaiser Permanente, Cigna, Rocky Mountain Health Plans, and UnitedHealthcare. In addition, Health First Colorado, the state Medicaid plan, is collaborating. These organizations have all signed a Memorandum of Understanding with the SIM office to participate in improving the delivery and financial support of physical and behavioral health.[107]

The Collaborative meets monthly and often seeks and incorporates perspectives from other stakeholders from across the state. The primary objective of Collaborative meetings is to work on organizational alignment and consistency across payers in order to best support practice transformation and improved patient outcomes.[107]

Federal Assistance and Cost of Initiative.

Accountable Care Collaborative. The ACC operates through Colorado's Section 1915(b) Waiver Proposal for a Health Neighborhood model to incorporate behavioral health, primary care, long term services and supports (LTSS), and certain specialists into a single care team.

The total administrative costs for the ACC were $143,232,862 during fiscal year 2015-2016. This includes payments made to the RCCOs, the PCMPS, and the SDAC. The majority of the administrative cost covers PMPM payments, payments for Key Performance Indicators and pay-for-performance incentive payments.[115]

Colorado Framework. To implement the Colorado Framework, CMS awarded Colorado up to $65 million as a part of the SIM program, in a cooperative agreement to cover costs of implementation and testing.

Quality Measurement.

Accountable Care Collaborative. The quality measurements used by the ACC program mirror the provider incentive measures discussed within the payment mechanism section, with the Department collecting information on the KPIs. The Department has retired certain KPIs, such as postpartum follow-up care, well-child checks (ages 3-9), and 30-day follow-up care following an inpatient discharge.

In addition to evaluating quality using the KPI measures, the Department uses 12 other measurements. These are childhood obesity and overweight, chronic use of opioids, depression screens, developmental screens, diabetes HbA1c, high school graduation rates, LARC conception, low birth weight, medication management for asthma, short-term behavioral health therapy in primary care, suicide rates, and teenage pregnancy.[116]

Colorado Framework. The Colorado Framework separates clinical quality measures into primary and secondary reporting requirements. Primary measures are focus areas, where the program aims to affect the most change throughout program implementation. Secondary measures, which are optional for practice reporting, are still important for practice transformation and data quality efforts, but are not considered equally important to primary measures. However, all practices are expected to make a good faith effort to report on the measures.[117]

The clinical quality measures and reporting schedules differ based on the type of practice and the practices' participation in other initiatives. When possible, the Colorado Framework accepts measures submitted for CPC+ practices, and does not require those practices to submit additional clinical quality measures for SIM. Exhibit CO6 presents measures for adult practices, pediatric practices, and dual SIM/CPC+ practices.

Exhibit CO6. The Colorado Framework Adult Measure Set

Measure Condition	SIM Metric Title	Citation	CPC+	QPP
Primary CQMs				
Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	NQF 0418 CMS 2v6	Depression Remission at 12 Months	✓
Diabetes: Hemoglobin A1c	Diabetes: Hemoglobin A1c Poor Control	NQF 0059 CMS 122v5	✓	✓
Hypertension	Controlling High Blood Pressure	NQF 0018 CMS 165v5	✓	✓
Obesity: Adult	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	NQF 0421 CMS 69v5	No obesity measure (not required for SIM if in CPC+)	✓
Substance Use Disorder: Alcohol and Other Drug Dependence	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	NQF 0004 CMS 137v5	✓	✓
Substance Use Disorder: Tobacco	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF 0028 CMS 138v5	✓	✓
Secondary CQM				
Asthma	Medication Management for People with Asthma	NQF 1799 CMS n/a	No asthma measure	✓
Fall Safety	Falls: Screening for Future Fall Risk	NQF 0101 CMS 139v5	✓	✓
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4	No maternal depression measure	✓
Substance Use Disorder: Alcohol	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	NQF 2152 CMS n/a	Alcohol & Other Drug Dependence measure *(above)*	✓
Measures reported via APCD claims data automatically				
Breast Cancer	Breast Cancer Screening	NQF 2372 CMS 125v5	✓ *(clinical)*	✓ *(clinical)*
Colorectal Cancer	Colorectal Cancer Screening	NQF 0034 CMS 130v5	✓ *(clinical)*	✓ *(clinical)*

Note: Exhibit from the Colorado SIM Framework and Milestones. [CQM = Clinical Quality Measure, NQF =National Quality Forum, CMS = Center for Medicare & Medicaid Services, CPC+ = Comprehensive Primary Care Plus, QPP = Quality Payment Program]

Exhibit CO7. The Colorado Framework Pediatric Measure Set

Measure Condition	Metric Title	Citation	QPP
Primary CQMs			
Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	NQF 0418 CMS 2v6	✓
Development Screening	Developmental Screening in the First Three Years of Life *(developed by Mathematica)*	NQF 1448 CMS 664	No developmental screening measure
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4	✓
Obesity: Adolescent	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NQF 0024 CMS 155v5	✓
Secondary CQM			
Asthma	Medication Management for People with Asthma	NQF 1799 CMS n/a	✓

Note: Exhibit from the Colorado SIM Framework and Milestones.

Exhibit CO8. The Colorado Framework Clinical Quality Measures that Count for CPC+ and SIM

Measure Condition	Metric Title	Citation
Group 1		
Depression	Depression Remission at Twelve Months *(OR SIM depression measure above)*	NQF 0710 CMS 159v5
Diabetes: Hemoglobin A1c	Diabetes: Hemoglobin A1c Poor Control	NQF 0059 CMS 122v5
Hypertension	Controlling High Blood Pressure	NQF 0018 CMS 165v5
Group 2		
Fall Safety	Falls: Screening for Future Fall Risk	NQF 0101 CMS 139v5
Substance Use Disorder: Alcohol and Other Drug Dependence	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NQF 0004 CMS 137v5
Group 3		
Substance Use Disorder: Tobacco	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF 0028 CMS 138v5
Breast Cancer	Breast Cancer Screening *(SIM reported via claims)*	NQF 2372 CMS 125v5
Colorectal Cancer	Colorectal Cancer Screening *(SIM reported via claims)*	NQF 0034 CMS 130v5

Note: Exhibit from the Colorado SIM Framework and Milestones. [NQF =National Quality Forum, CMS = Center for Medicare & Medicaid Services]

Incorporation of Social Determinants of Health (SDOH)

Accountable Care Collaborative. The second phase of the ACC is working towards further integration and coordination with community providers and resources. RAEs are required to form Health Neighborhoods, which are responsible for providing Medicaid beneficiaries with "holistic, integration, and person- and family centered medical care". The Health Neighborhoods will work across services and providers, including outside of medical supports. Through the incentives programs, the RAEs have the flexibility to incentivize their providers to connect beneficiaries to SDOH services to improve health outcomes.[116]

Colorado Framework. Regional health connectors (RHC)—local residents who work to improve the coordination of services—comprise a key component of the Colorado Framework. Many of these services include social or community services. RHCs work to connect practices across the state with resources, including tobacco cessation groups, chronic disease management programs, school-based health services, and mental health trainings.[107]

Implementation of the HIT and Data Analysis Infrastructure

Accountable Care Collaborative. Currently, the program uses a statewide data analytics contractor for the data repository, data analytics, reporting, and web-portal. This allows the program to have accountability and to conduct continuous improvement activities. Phase Two of the ACC program, which is operating simultaneously, is working to increase use of state agency systems and the HIE available in the region. These data will be used to improve care coordination and track the changing demographics of the state Medicaid population.[113] In addition, the ACC program is working on a Public Reporting Dashboard that would allow stakeholders to interact with RAE performance and trends over time. The dashboard will include KPIs, as well as clinical and social determinant of health measures. The Department anticipates adding measures over time.[116]

Colorado Framework. The Colorado Framework faces three key informatics challenges, namely, the incompatible electronic health record (EHR) systems among hospitals and practices across the state, patient access to medical records, and common misunderstandings of state and federal privacy laws. As part of the framework, the state set out to promote widespread adoption of HIT tools, leverage statewide HIE, align with state agency efforts, evaluate existing privacy laws and forms, connect public health to statewide HIE, and target rural and frontier communities for access and interoperability.[116]

Colorado planned to leverage HIT to improve rural and frontier access to care, in particular. For example, Colorado plans to expand telehealth, using the existing statewide health care broadband infrastructure, in order to improve EHR adoption in rural areas. The Colorado Telehealth Initiative included a statewide video telehealth network platform, a resource center, promotion of telehealth, telehealth advisory committee, and a monitoring and evaluation program.[113]

All-Payer Claims Database (APCD)

The Colorado APCD was created by state legislature in 2010. The nonprofit Center for Improving Value in Health Care (CIVHC) is the administrator of the CO APCD.[118] The project planning and implementation was funded with a private grant from the Colorado Trust and the Colorado Health Foundation. CO APCD partnered with 3M (previously Treo Solutions) as the data management vendor. Beginning in 2012, 3M collected and processed data, including three years of historic claims information from Medicaid and commercial payers. CIVHC maintains a public website that allows for interactive reports, as well as the creation of custom data requests. The interactive health care data tool includes statewide measures for cost of care, utilization of services, condition prevalence, and quality measures.[119] In July 2017, CIVHC transitioned to new vendors, HSRI and NORC, for the data warehouse and analytics. As of May 2018, the CO APCD contains over 500 million claims from Medicaid, Medicare, Medicare Advantage, and commercial plans.[69]

Results, Lessons Learned, and Next Steps

Results.

Accountable Care Collaborative. Since ACC began in 2011, the program has produced a variety of positive outcomes, including avoiding a net total of $139 million in costs[118]. For the first two fiscal years 2012-2013, there were net reductions in the total cost of care of $6 million and $30 million in fiscal years 2013-2014. [113]In addition, since the implementation of ACC, enrollees have had lower rates of hypertension and diabetes relative to non-enrollees.[116] During fiscal year 2015-2016, the ACC increased utilization of many recommended services, decreased utilization of higher-cost services, and maintained member satisfaction. [113]

In fiscal year 2016-2017, Health Services Advisory Group (HSAG) conducted a site visit evaluation of the RCCOs for the Department. HSAG found that there were significant differences between the ACC model and traditional medical managed care. First, there was more integration with social needs for members with complex needs, and successful collaborations with community organizations, agencies and providers. Second, the regional structure of the RCCOs allowed for a non-competitive organizational

model with flexibility of local needs while staying within overarching goals of the program. HSAG also found that the regional model promoted the development of community-based healthcare solutions.[119]

Colorado Framework. Full evaluation results of the Colorado Framework are not yet available. When fully implemented, the plan is projected to generate $126.6 million in total cost of care savings by 2019, with annual savings of $85 million thereafter. While the evaluation is underway, the Colorado SIM office has reported quarterly results. In the first quarter of the second implementation year, improvements included that approximately 30 percent of practices reported achieving Practice Improvement Plan (PIP) goals, which were included in the Building Blocks, practice transformation, behavioral health, and HIT. In addition, the number of sites reporting on all required clinical quality measures increased from 61 to 71 practices within the quarter.[119] In the second quarter of that year, sites continued to improve their clinical quality measure reporting. However, the Colorado SIM office noted variability in reporting that may indicate more technical assistance on reporting could be beneficial. Initial satisfaction survey results also indicated that sites with fewer patient visits had higher job satisfaction and lower burnout among clinicians. In addition, sites that specialized in adult populations had higher satisfaction and lower burnout than family or pediatric practices.[119]

Challenges and Lessons Learned.

Accountable Care Collaborative. Like Medicaid programs around the country, ACC continues to see a high rate of emergency room use among enrollees. The Department has proposed a number of solutions to meet this need, including incentivizing RCCOs to connect members to a PCMP, incentivizing practices for meeting higher medical home standards (i.e., extended or after-hours care). These incentives aims to encourage members to use their routine medical providers rather than the emergency room. ***Colorado Framework***. During the first year of implementation, the Colorado SIM office identified the following challenges facing their program:

- Stakeholders did not feel that they were systematically aware of what was happening outside of their SIM workgroup.
- Participating practices required additional support for data sharing and reporting activities, including being able to consistently report on clinical quality measures.
- Participating practices required technical assistance to work with EHR vendors. In order to capture SIM clinical quality measures, the practices needed to adjust their EHRs. [114]

In the following quarter, the quarterly report indicated that the Colorado SIM office was implementing steps to improve information sharing, HIT and data reporting support, and other practice transformation support.[114]

Next Steps.

Accountable Care Collaborative. The second phase of the ACC began in July 2018 and operationalization is still relatively new. The Department's website has a Provider and Stakeholder Resource Center that provides information on implementation updates to keep providers and other interested parties up to date on issues related to the launch of ACC Phase II.[114]

Colorado Framework. The Colorado Framework ends in July 2019. The SIM office has requested that every program manager create plans for sustainability for vendors and workgroups, as the vision for the program is long-term sustainability. The SIM office is in the process of drafting their fourth year sustainability plan.[120]

Key Considerations for Alaska

Multipayer Participation. The Colorado Framework reform focused on Medicaid, as the budgetary concerns at the time of the innovation surrounded the program, but they have been careful to build and engage in multipayer support. Stakeholder engagement and buy-in is a critical piece of health care reform efforts. Colorado has five commercial health plans and the state Medicaid program working directly with the Colorado Framework. The Colorado Framework includes partnership with the Colorado Multipayer Collaborative, a group started in connection with the CMS CPC initiative, which it continues to support, and now also works on data aggregation and the Colorado Framework. The goal of the Collaborative is for public and private payers to work to strengthen primary care. This will facilitate an ongoing relationship for reform efforts in the state.

Unique Managed Fee-for-Service Approach. Colorado has a modest history of managed care, with some difficulties. Through ACC it has found a middle road method for payment reform while still operating in a managed FFS environment through a PCCM type managed care model and the use of regional RAEs. This design is sensitive to local experiences with payment reform and allows health plans and providers to acclimate to the reform more slowly**.** An incremental design approach, potentially incorporating the results of Alaska's pilot project with Medicaid managed care, could allow Alaska to try new care delivery and payment mechanism options, while maintaining the basic structure and integrity of the current market and system.

Community-based Approach. By using seven separate regions under the ACC, the program design allowed for regional flexibility and modification, which promotes the development of community-based healthcare solutions. In addition, the integration focus of the ACC program allows for more collaboration with local organization that can assist in meeting social needs for members with complex healthcare needs. The ACC attribution process focuses on maintaining or creating sustainable member-provider relationships, deferring to existing claims-based relationships, family relationships or geography, while also giving members the ability to change their attributed provider at any time.

Funding and Costs. The Colorado SIM project relied on funding from the federal government to design, implement, and evaluate its model. Although additional SIM funding is not available at this time, there may be components designed and implemented under funding that are replicable under Alaska's state budget. Alaska may also want to consider looking carefully at Colorado's sustainability planning as the Colorado Framework comes to a close in 2019.

Case Study: Maryland's Total Cost of Care All-Payer Model

Executive Summary

For over 40 years, Maryland has had a federal waiver allowing its Health Services Cost Review Commission (HSCRC) to set hospital payment rates at the state level for all payers, including Medicare, Medicaid, and commercial insurance companies. In 2014, the Centers for Medicare & Medicaid Services (CMS) approved Maryland's **All-Payer Model**, requiring the state to generate $330 million in Medicare savings over a five year period, limit its annual all-payer per capita total hospital cost growth, shift its hospital revenue into global payment models, and achieve a number of quality targets. To date, the model has resulted in: payment and delivery system transformation that has reduced fragmentation within its health care delivery system and sustained rural health services, as well as an estimated $429 million in total Medicare hospital savings.

In 2018, CMS approved Maryland's **Total Cost of Care (TCOC) Model**, which sets a per capita limit on Medicare total cost of care in the state. The goals of the model, which became effective January 2019, are to achieve person-centered care, promote innovation, improve population health, and moderate the growth in costs through the transformation of the health care delivery system. These goals are to be achieved through the following strategies:

- ***Establishing All-Payer Rate Setting.*** Through a Hospital Payment Program in the TCOC and leveraging its history with the All-Payer Model, each hospital in Maryland receives a population-based payment to cover all hospital services provided during the course of the year.
- ***Transforming Primary Care Design.*** The Maryland Primary Care Program offers incentives to providers that deliver advanced primary care services to patients. Providers receive an additional per beneficiary per month (PBPM) payment from CMS to cover care management services.
- ***Leveraging Health IT and Maryland's All-Payer Claims Database***. Maryland uses its state health information exchange system—the Chesapeake Regional Information System for Our Patients (CRISP)—to support health system transformation. CRISP receives and exchanges information with hospitals and several other facilities and provides reporting and analytics resources to inform decision-making. In addition, the state's all-payers claims database (APCD) contains data from commercial payers, third-party administrators (TPA)/self-funded payers, Medicaid, and Medicare.

The TCOC Model covers commercial, Medicaid/CHIP, and Medicare beneficiaries and extends beyond hospitals to include some doctors' visits and other outpatient services. Initial implementation focuses on a subset of approximately 800,000 Medicare FFS beneficiaries, prioritizing the dual eligible population and patients with chronic and complex conditions. Overall, reform efforts are expected to involve six million Marylanders.

Key takeaways from Maryland's efforts include the following:

- ***Standardize payments across payers.*** Through its HCSRC and subsequent demonstration efforts (i.e., the All-Payer Model and the TCOC Model), Maryland has been setting hospital payment rates across all payers. This approach has achieved Medicare savings, improved quality of care, and provided hospitals with more predictable funding streams. Global budget models are one potential strategy to address the critical financial condition of rural hospitals in tandem with the health needs of their communities in Alaska, particularly to provide a predictable and steady source of revenue for rural hospitals.
- ***Including physicians in multipayer reform.*** Within Maryland's TCOC model, the CRP allows hospitals to make incentive payments to nonhospital health care provider partners who perform care redesign activities aimed at improving quality of care if they have achieved certain savings under a fixed global budget. Within the CRP program, the Episode Care Improvement Program (ECIP) allows a hospital to link incentive payments across providers during an episode of care, hospitals, physicians, and post-acute care facilities. Given the high cost of care in Alaska, particularly among specialty services, designing arrangements that incorporate non-hospital providers and physicians may be a potential approach for reducing costs.
- ***Focus on primary care transformation.*** Through Maryland's Primary Care Program, the state seeks to provide participating practices with additional payment incentives for primary care management and care coordination for high-cost populations. Alaska considers how to further its primary care transformation efforts, Maryland's Primary Care Program may provide a potential model.
- ***Maximize federal funding.*** Maryland leveraged federal funding for health reform initiatives that has established the foundation for and supported transformation of its health care delivery system.

In this paper we will examine health care reform efforts in the state of Maryland. This case study will focus on the **Total Cost of Care Model**, the state's initiative to maintain and update its all-payer rate setting model. We will also provide information on Maryland's efforts building its health IT infrastructure and its all-payer claims database. The paper starts with background on state demographic and economic characteristics and moves to details on the approach. We discuss the background on reform and then provide an overview of the approach followed by details of its mechanics, structure, and implementation. This is followed by an examination of the results, lessons learned, and considerations for Alaska.

Background

State Characteristics – Demographics and Economic Indicators. Maryland is a mid-Atlantic U.S. state with a population of nearly 6.1 million residents as of July 1, 2018.[121] Five out of 24 counties in the state were considered rural in 2014[121] and the population per square mile was 594.8 in 2010 and none of the counties were frontier counties with a population of less than 7 people per square mile.[122]Only 4 percent of the non-elderly population lived in rural areas in 2015. The majority of the population in Maryland in 2017 was White alone (59.0 percent) followed by White non-Hispanic (50.9 percent), non-Hispanic Black or African American (30.8 percent), Hispanic or Latino (10.1 percent), and non-Hispanic Asian (6.7 percent) and more than two races (2.8 percent). Only 0.6 percent of the state population are non-Hispanic American Indian or Alaska Native (AI/AN). The median household income (in 2017 dollars) in the state was $78,916,[121] minimum wage is $10.10 an hour,[23] and 9.3 percent of the population lives in poverty. The state's unemployment rate is 3.9 percent as of December 2018, in line with the national average.[24] The total gross domestic product (GDP) of Maryland in 2017 was nearly $400 billion and the GDP per capita was $59,983.[123] State expenditures (state fiscal year) were $43.3 billion in total[124]and $7,158 per capita.[125] The three largest nonfarm industries in Maryland as of December 2018 are government (18.2 percent), education and health services (17.4 percent), and trade, transportation, and utilities (17.0 percent). Exhibit MD1 provides a summary of Maryland's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit MD1. Demographics and Economic Indicators

	Maryland	Alaska	U.S.
Population, as of July 1, 2018[122]	6,042,718	737,438	327,167,434
Rurality			
Population per square mile, 2010[122]	594.8	1.2	87.4
Share of population in rural areas, 2017[22]	2%	32%	14%
Race/Ethnicity, 2017[122]			
White Alone	59%	65.8%	76.6%
Two or More Races	2.8%	7.4%	2.7%
Black or African American Alone	30.8%	3.7%	13.4%
Asian Alone	6.7%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	0.6%	15.3%	1.3%
Hispanic/Latino	10.1%	7.1%	18.1%
**White Non-Hispanic	50.9%	60.8%	2.7%
Poverty			
Median Household Income (2017 Dollars) [122]	$78,916	$76,114	$57,652
Minimum Wage, 2019[79]	$10.10	$9.89	$7.25
Share of Population in Poverty (2017) [122]	9.3%	11.1%	12.3%
Economy			
Unemployment Rate, as of December 2018[24]	3.9%	6.3%	3.9%
Gross Domestic Product (GDP), 2017[123]	$400 billion	$52.8 billion	$19.5 trillion
Per Capita Real GDP, 2017[26]	$59,983	$70,683	$55,418
Expenditures, SFY 2017[27]	$51 billion	$9.7 billion	$1.9 trillion
Expenditures per Capita, SFY 2017[125]	$8,602	$13,171	$5,976

**White Alone non-Hispanic individuals are people who responded “no, not Spanish/Hispanic/Latino” and who reported “white” as their only entry in the race question.

State Health Insurance Market – Health Coverage and Uninsured. In 2014, Maryland spent more than $51 billion on health care,[27] which includes spending for all privately and publicly funded personal health care services and products. The state’s per capita spending on health was $8,602, nearly in line with the national average of $8,045 per capita.[125]

Private Health Insurance Market. Over half (54.2 percent) of private sector organizations in the state offer insurance coverage to employees in 2017.[126] This same year, over half (56 percent) of Marylanders had employer-based health insurance, a little over the national average.[127] Maryland spent $17.3 million on private health insurance in 2014, with an average annual growth in private health spending of 5.3 percent between 2001 and 2014, similar to the national average.[82] In 2016, Maryland had 14 commercial HMOs[128] enrolling 829,688 Marylanders.[129] The commercial HMO penetration rate is 23.7 percent, higher than the national average of 12.8 percent.[130]

State Employee Health Coverage. Maryland offers five medical plans using three carriers (CareFirst BlueCross Blue Shield, UnitedHealthcare, and Kaiser) from which state employees, retirees, and their dependents can choose.[131] The state provides health insurance for its 81,000 employees; the 23 counties and Baltimore City provide insurance for their 42,000 employees; and the 24 school systems provide health insurance for another 120,000 employees.[132]

Approved by the Governor and effective as of October 2018, HB1400 creates a Task Force to study pooling of government health insurance purchases (cooperative purchasing) among state, county, and school system employees. The Task Force is to report its findings and recommendations by January 2020. The goal of this approach is to save taxpayers as much as $300 million annually while providing employees with better health insurance. Eventually, nonprofits could participate as well.[133] [134]

Health Insurance Marketplace. In 2017, 6 percent of the Maryland population had non-group coverage.[29] Maryland, which utilizes a state-based Marketplace, Maryland Health Connection, has two participating issuers in 2019.[38] In 2018, 153,584 individuals in Maryland selected a Marketplace plan.[135]

Medicaid and CHIP Program and Population. Nearly one-fifth (18 percent) of Maryland's population was covered by Medicaid in 2017. As of November 2018, total enrollment in Medicaid and CHIP was nearly 1.3 million in Maryland.[136] Of Medicaid enrollees, one in eight were adults ages 19-64, three in ten were children, five in eight were nursing home residents, four in nine were individuals with disabilities, and one in seven were Medicare beneficiaries.[137] Medicaid income eligibility limits in Maryland are 138 percent of the Federal Poverty Level (FPL) for parents and childless adults, 322 percent for children, 264 percent for pregnant women, and 74 percent for seniors and people with disabilities in January 2018.[138] Maryland adopted the Medicaid expansion, covering 277,000 adults in the Medicaid expansion group.[138]

In FY2017, total Medicaid spending was over $11.2 billion in Maryland,[140] of which a fifth of spending was for older adults, two-fifths for people with disabilities, a quarter for adults, and nearly two-fifths for children.[139] The Federal Medical Assistance Percentage (FMAP), which determines the federal share of the cost of Medicaid services in each state, is 50 percent through FY2020.[141] HealthChoice is Maryland's Medicaid managed care program. In 2018, Maryland had nine Medicaid managed care organizations (MCOs) covering 86 percent (1.2 million) of the Medicaid population[142]while 14 percent are in fee for service (FFS) or other arrangement.[143] Non-HealthChoice populations under a FFS arrangement include individuals who are dually-eligible for Medicaid and Medicare, enrollees who are institutionalized or have spent down assets, those who are part of Model Waiver for Medically-Fragile Children or participating in a family planning program waiver participations, newly eligible Medicaid enrollees until enrolled in MCO, and those enrolled in rare and expensive case management (REM) within the HealthChoice program. Total Medicaid MCO spending in 2017 was $4.8 billion. [144]

Medicaid Buy-In Task Force Bills

Delegate Kelly and Senator Feldman introduced bills in 2018 calling for a Task Force to study the potential of creating a Medicaid Buy-in, or public option, which would provide more affordable coverage than is currently available in the private market. While both bills ultimately did not pass, HB 1782, which did pass, charges the Maryland Health Insurance Coverage Protection Commission to study and make recommendations for individual and group health insurance market stability, including whether to pursue a Basic Health Program or a Medicaid buy-in program for the individual market.[139]

Exhibit MD2. Medicaid Eligibility Levels, as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
Maryland	138% FPL	138% FPL	322% FPL	264% FPL	74% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL

National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

Uninsured Population. In 2017, 7.1 percent of the Maryland population was uninsured, below the national average of 10.2 percent.[145] Between 2013 and 2017, the uninsured rate decreased by 4.4 percentage points in Maryland as compared to 6.6 percentage points nationally.

Providers and Service Use. As of October 2018, Maryland has 10,808 primary care physicians and 13,493 specialists (2018 data)[146] and 188.2 physicians per 100,000 residents.[147] In 2016, Maryland had 1.9 hospital beds per 1,000 population, all of which were owned by non-profits.[148] As of December 31, 2018, Maryland has 62 total primary care HPSA designations, which meets only 43.8 percent of needs, and 59 mental health HPSA designations, which meets only 27.3 percent of need, both in line with the national average.[149] There are 17 community health centers with 126 delivery sites in Maryland, accounting for nearly 1.5 million patient encounters (2016 data).[150] There are no rural health clinics or critical access hospitals in Maryland (2017 data) but nine short term hospitals located outside of urbanized areas. [51]

Tribal Health. Most of the AI/AN population in Maryland lives in the Baltimore Metro and National Capital Areas.[151] The AI/AN population had a median household income of $54,961, 6.8 percent unemployment rates, and 13.3 percent poverty rates. This population in Maryland is less likely to have private health insurance, more likely to have public health insurance, and more likely to be uninsured, compared with all Marylanders. AI/AN residents as a group face significant health challenges, as indicated by higher HIV incidence, infant mortality, and low birth weight infants rates compared with White residents; and older AI/ANs have a higher incidence of end state renal disease (ESRD) across all racial groups.

History of the Initiative

Background on Health Care Reform. For over 40 years, Maryland has had a federal waiver allowing the state to set hospital payments at the state level for all payers, including Medicare, Medicaid, and commercial insurance companies. As part of this arrangement, the federal government required Maryland to meet annual tests evaluating growth of inpatient hospitals costs for each hospital stay. As national patterns of care and standards have changed over the years, the waiver test became outdated and required updated arrangements. The section below gives an overview of the evolution of the Maryland system into an all-payer rate setting model designed to address increasing health care costs.

Pre-existing Health Reform Models and Infrastructure. Maryland has a number of reforms that laid the foundation for Maryland's Total Cost of Care (TCOC) Model:

A 1971 Maryland law created the **Health Services Cost Review Commission (HSCRC)**. Beginning in 1974, the HSCRC was given the authority to set hospital rates which would apply to all Maryland payers. In 1977, Maryland received a federal waiver that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates. The Section 1814(b) waiver exempted Maryland from the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS), allowing Maryland instead to set rates for these services. Under the waiver, all third parties, including commercial, Medicare, Medicaid, and CHIP, pay the same rate.[152]

In 2010, Maryland launched a pilot program, **Total Patient Revenue (TPR)**, which provided a global budget across all payers for rural hospitals that offered incentives to provide high quality and reduce utilization while providing financial stability for rural hospitals. By July 1, 2010, 10 rural hospitals transitioned to this global budget system.[153]

In 2014, Maryland received approval from the Centers for Medicare & Medicaid Services (CMS) to enact a demonstration, the **Maryland All-Payer Model**, to modernize the all-payer rate-setting model for all acute care hospital services. The model, authorized by Section 3021 of the Affordable Care Act (ACA), requires Maryland to generate $330 million in Medicare savings over a five-year performance period (January 2014-January 2019), to limit its annual all-payer per capita total hospital cost growth to 3.58 percent, to shift virtually all of its hospital revenue over the five year period into global payment models, and to achieve a number of quality targets, including reductions in 30-day hospital readmissions and rates of hospital-acquired conditions.[152] This Model ended on December 31, 2018. One of the requirements of the agreement was that Maryland develop a model to address the total cost of care for Medicare beneficiaries by 2019.[154]

In July of 2017, CMS and Maryland announced an amendment to the All-Payer Model called the **Care Redesign Program (CRP)**, an initiative that advances efforts to redesign and better coordinate care in Maryland. The CRP provides hospitals participating in the All-Payer Model the opportunity to partner with certain providers, who are offered incentives and resources, to improve quality of care and reduce spending growth. The CRP includes redesign initiatives along two tracks:[152]

- The ***Hospital Care Improvement Program (HCIP)***, which allows hospitals to partner with hospital-based specialists to improve care coordination during and after a hospital admission; and
- The ***Chronic Care Improvement Program (CCIP)***, which allows hospitals to partner with primary care physicians and other community-based providers to improve care coordination and care management outside of the hospital.

Sixteen hospitals participated in the first performance period of CRP.[155] The CRP was transitioned into Maryland's Total Cost of Care (TCOC) All-Payer Model, discussed in more detail below.

Other pre-existing health reform efforts in Maryland include:

The **Comprehensive Primary Care Plus (CPC+)** model, a national advanced primary care medical home model that aims to strengthen primary care through multipayer payment reform and care delivery transformation. It builds on a predecessor program, the Comprehensive Primary Care (CPC) initiative, and offers selected practices additional financial resources and the flexibility to make investments in primary care to reduce unnecessary services. Maryland's CPC+ program was transitioned into its Maryland Primary Care Program (MDCPC).

A Round Two **State Innovation Model (SIM)** design grant that MDH received in 2014. The scope of activities has focused on designing a Medicaid Integrated Delivery Network (IDN) for individuals dually-eligible for Medicaid and Medicare, designing new population health measurement activities, and funding to study connectivity between Maryland's health information exchange—the Chesapeake Regional Information System for our Patients (CRISP)—and skilled nursing facilities (SNFs). The activities that have taken place under SIM have supported all-payer health system transformation and were determined

to be key initiatives by the State and its stakeholders during its SIM Round One Design project. While SIM activities formally fell outside of the All-Payer Model Agreement, SIM activities surrounded and supported the All-Payer Model and the All-Payer Model provided a foundation for SIM activities.[156] [156]

Overview and Implementation of the Initiative

Overview of the Initiative. In 2018, Governor Larry Hogan announced CMS' approval of Maryland's **Total Cost of Care Model**, also known also as the Maryland Model or TCOC Model. Authorized under Section 1115A of the Social Security Act, the TCOC Model sets a per capita limit on Medicare total cost of care in Maryland. It expands Maryland's All-Payer Model, which set a limit on per capita hospital expenditures in the state. While the Maryland All-Payer Model historically focused solely on the hospital setting, the Maryland TCOC Model builds on the success of the Maryland All-Payer Model by creating greater incentives for health care providers to coordinate with each other and provide patient-centered care, and by committing the State to a sustainable growth rate in per capita total cost of care spending for Medicare beneficiaries. The 10-year initiative, which includes eight demonstration years (January 2019 – December 2026) and two transition years (January 2027- December 2029), is expected to save Medicare over $1 billion within the first five years (by the end of 2023) and creates new opportunities for a range of non-hospital health care providers to participate in the initiative to limit Medicare spending across the state.[157]

The TCOC Model includes three programs[157]

The Hospital Payment Program. The **Hospital Payment Program,** in which each hospital receives a population-based payment amount to cover all hospital services provided during the course of a year. This program creates a financial incentive for hospitals to provide value-based care and reduce the number of unnecessary hospitalizations, including readmissions.

Care Redesign Program. Building off of Maryland's previous program, the **Care Redesign Program (CRP)** allows hospitals to make incentive payments to non-hospital health care providers who partner with the hospital and perform care redesign activities aimed at improving quality of care. A participating hospital may only make incentive payments if it has attained certain savings under its fixed global budget and the total amount of incentive payment made cannot exceed such savings. In order to participate in the CRP, a hospital must enter into a participation agreement with CMS and the State. As of January 1, 2019, 42 hospitals are participating in at least one of three active CRPs[158] These CRPs are as follows:

- The **Hospital Care Improvement Program (HCIP),** implemented by participant hospitals and hospital-based physician care partners. Objectives are to:
    a. Improve inpatient medical and surgical care delivery
    b. Provide effective transitions of care
    c. Ensure effective care delivery during acute event, beyond hospital walls
    d. Encourage the effective management of inpatient resources
    e. Reduced potentially avoidable utilization, to reduce the cost per acute care event

- The **Complex and Chronic Care Improvement Program (CCIP),** implemented by participating hospitals and community physicians and other practitioners. Objectives are to:
    a. Strengthen primary care supports for complex and chronic patients in order to reduce otherwise avoidable hospital utilization

b. Enhance care management through tools such as effective risk stratification, health risk assessments, and patient-driven care profiles and plans
c. Facilitate overall practice transformation towards person-centered care that produces improved outcomes and meets or exceed quality standards

- The **Episode Care Improvement Program (ECIP)** is designed to align incentives across hospitals, physicians, and post-acute care facilities. Alignment is expected to generate savings and improve quality through better care management during episodes, elimination of unnecessary care, and reduction of post-discharge emergency department visits and hospital readmissions. Providers will receive a bundled payment for certain items and services furnished during an episode of care. ECIP's bundled payment approach provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals. Maryland modeled ECIP on CMS' Advanced Bundled Payments for Care Improvement Program.

- ***Maryland Primary Care Program (MDPCP).*** The **MDPCP** is structured to offer incentives to providers that deliver advanced primary care services to their patients. Participating practices will receive an additional per beneficiary per month (PBPM) payment directly from CMS, intended to cover care management services. The MDPCP also offers a performance-based incentive payment to health care providers, intended as an incentive to reduce the hospitalization rate and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements. The five primary care functions services under MDPCP are: access to care; care management; comprehensiveness and coordination; patient and caregiver experience; and planned care and population health. There are two tracks that advance care delivery requirements and payment options incrementally, as follows:[159]
  - **Track 1:** expands on the Five Primary Care Function services to visit based, FFS care
  - **Track 2:** includes Track 1 services and redesign visits to offer non-visit based care (e.g., phone, email, telehealth, text message, and secure portal) for more comprehensive health management)

Twenty-five organizations have been chosen to participate **as Care Transformation Organizations (CTOs)** for the MDPCP.[160]

As part of the TCOC Model, Maryland selected six high-priority areas in which to focus for population health improvement: substance-use disorder (SUD); diabetes; hypertension; obesity; smoking; and asthma. Practices participating in MDPC can contract with a CTO, a coordinating entity that provides care management infrastructure (nurses, pharmacists, nutritionists, health educators, community health workers, licensed clinical social workers), and resources such as technical assistance for after-hours, social support connections, "hot-spotting" areas with high and/or specific needs, pharmacist support for medication management and consultations, holding practices accountable to PCM requirements, physician training resources, and CRISP connectivity.

During the final three years of the initiative, CMS and Maryland will negotiate either an expanded model test, a new model test, or a return to the national prospective payment systems.[160]

Goals for Health Care Reform. Maryland lays out a vision for delivery system reform that supports the triple aim of improved population health, improved outcomes for individuals, and addressing growth related to the total cost of care, with specific attention to the goals of person-centered care, clinical innovation and high quality of care.[155]

Five specific objectives support this vision, as follows:[155]

- Continuing and expanding efforts focused on improving care management for complex and high-need patients.
- Accelerating prevention and chronic care management and payment reform through the MDPCP.
- Aligning payment reform beyond hospitals to include Medicare Access and CHIP Reauthorization Act (MACRA) bonus-eligible programs and developing payment and delivery changes applicable to long-term and post-acute care settings.
- Aligning public health efforts with the population health improvement goals of the TCOC Model.
- Increasing responsibility for system-wide goals through provider incentives, Accountable Care Organizations (ACOs), and improved management of dual-eligible beneficiaries.

Population, Scope, and Participation. Maryland's waiver is statewide, including commercial, Medicaid/CHIP, and Medicare beneficiaries. The TCOC model extends beyond the All-Payer Model, which covered hospitals, to include some doctors' visits and other outpatient services, e.g., long-term care. Community health care providers will be able to choose whether they want to participate in the model.

The immediate focus for implementation is expected to be a targeted subset of approximately 800,000 Medicare FFS beneficiaries, prioritizing the dual eligible population and patients with chronic and complex conditions. This subset will receive care management interventions while other efforts target the broader Maryland population, including more robust prevention and support that will help those with moderate risk to prevent future high utilization. Overall, reform efforts will affect six million Marylanders.[155]

MDPCP. The MDPCP will extend comprehensive primary care services to Medicare beneficiaries and is designed to encompass up to one-fourth of Maryland's physicians and other providers out of the more than 15,000 practicing in Maryland.[155] The model presents an unprecedented opportunity to participate in care transformation for physicians, clinical nurse specialists, nurse practitioners, and physician assistants with a variety of specialty designations, including: General Practice, Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatric Medicine, Geriatric Medicine, and co-located Psychiatry. Among other requirements, Maryland practices that meet program integrity standards, use a certified electronic health record (EHR), and provide services to a minimum of 125 attributed Medicare fee-for-service beneficiaries are eligible to apply. Use of a CTO is voluntary for all practices.

Timing and Implementation Process.

TCOC Model. The demonstration timeline is detailed in Exhibit MD3 below:[155]

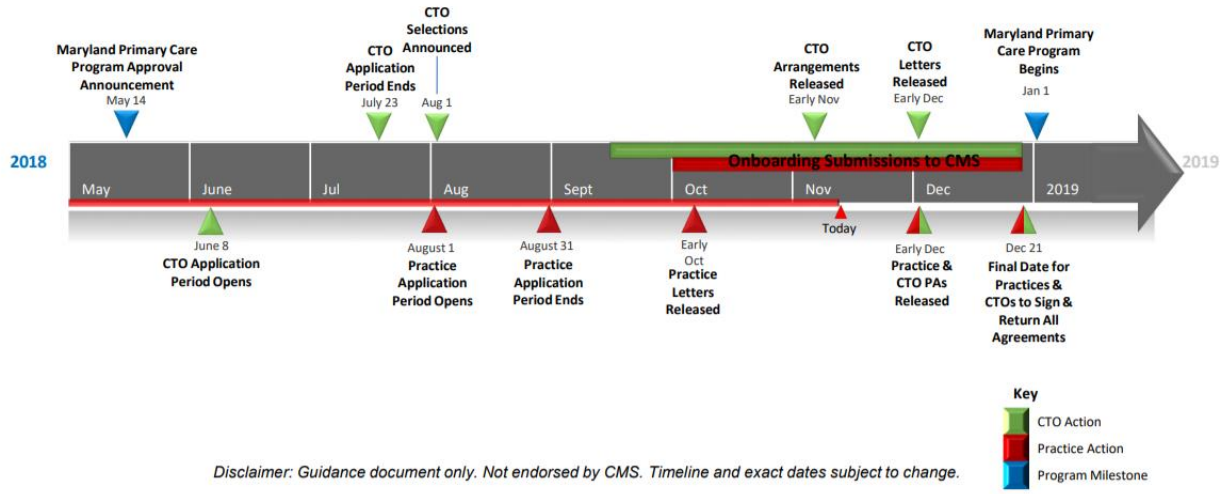
Exhibit MD3. Maryland TCOC Model Timeline

Year	Major Milestone
Year 1: 2019	January 1, 2019: The demonstration begins.
Year 2: 2020	N/A
Year 3: 2021	N/A
Year 4: 2022	■ By the end of Year 4 (2022), CMS and Maryland will assess Model progress and determine if savings are on track to meet the savings target. Adjustments will be made to assure that the Model will reach its target by the end of Year 5 (2023), unless otherwise agreed to by CMS.
Year 5: 2023	■ The State commits to reach an annual savings target in total spending for Part A and Part B services of $300 million by Year 5 (2023). Savings will be calculated using Maryland's Medicare growth trend relative to the national total cost of care trend over a 2013 base year. ■ If the State has not met the Year 5 (2023) savings target, or if additional savings are required to incorporate investments, then the additional savings requirement, net of any portion already adjusted for through the application of the Medicare Performance Adjustment, will be considered in the development of the allowed growth rate. If CMS and Maryland cannot agree to a growth calculation, CMS will require an additional $36 million in annual savings per year, equal to the relative incremental savings in the first five years for the remainder of the contract.
Year 6: 2024	■ Prior to Year 6 (January 2024), the State and CMS will agree on a formula to determine the maximum allowable Medicare total cost of care growth rate for the second five years of the TCOC Model Agreement and potential permanent model. This growth rate will be set to ensure that the compounded annual payment growth in Maryland is no greater than the national average growth. CMS and the State will develop a formula to smooth the requirement (e.g. two-year cycle with corrections from estimates to actual, three-year rolling average period). A rolling average would assure CMS of ongoing limits in the growth per beneficiary, while addressing normal variation that can occur on a year-to-year basis. ■ Beginning with Year 6 (2024), the State may offset primary care or other approved investment costs with CMS-approved population health savings or credits, which will be determined annually for Year 6 through Year 10 (2028) of the Model. ■ During the initial five years of the TCOC Model, the State will progressively plan and implement aligned payment and delivery transformations for dually-eligible beneficiaries. By Year 6, the State will incorporate an alignment model for Medicaid that limits the growth in both Medicare and Medicaid expenditures for dually-eligible beneficiaries, while also improving the coordination and delivery of care. ■ By Year 6 (2024), CMS will consider whether to make the Model an ongoing Model and test whether Maryland can maintain the $300 million savings level on an ongoing basis through Year 10 of the TCOC Model.
Year 7: 2025	N/A
Year 8: 2026	■ If the Model is not expanded, CMS will consider Maryland's proposal for a new Model, which will be submitted to CMS no later than the beginning of Year 8 (January 1, 2026). If CMS does not approve Maryland's proposal by the end of Year 8 (December 31, 2026), hospital payment for Medicare will begin the transition to a CMS system over a two-year timeframe, subject to the provisions described in Section VII.
Year 9: 2027	■ By Year 9 (January 2027), if the Model will be expanded, the State and CMS will work to draft regulations to make other changes and agreements needed to accomplish this outcome for implementation no later than January 2029.
Year 10: 2028	N/A

Source: https://hscrc.maryland.gov/Documents/Modernization/05-30-18%20Maryland%20All-Payer%20Model%20Progression%20Plan%27.pdf

MDPCP. The timeline for the MDPCP is noted in Exhibit MD4 below.

Exhibit MD4. Maryland Primary Care Program Timeline



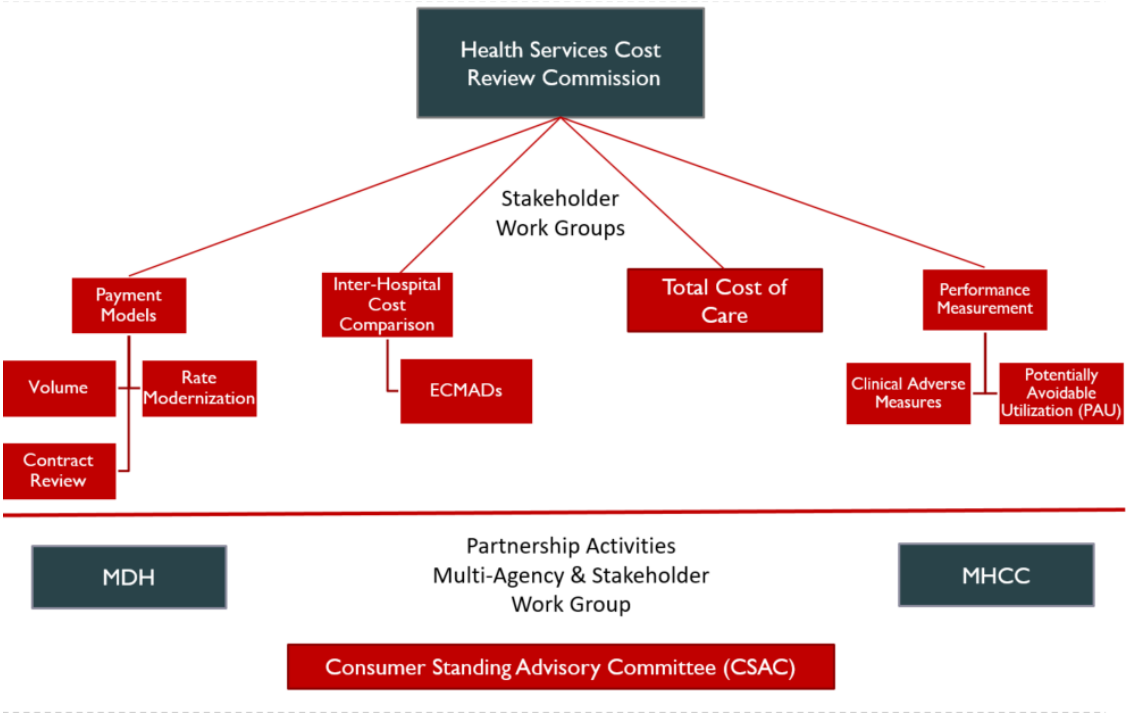
Source: https://health.maryland.gov/mdpcp/Documents/MDPCP%20Timeline_for%20web.pdf

Stakeholder engagement. The state, HSCRC, and MDH have conducted stakeholder engagement activities over time. For example, for the 2014 All-Payer Model waiver application process, the state and HSCRC leadership held over 50 meetings with stakeholders. More than 200 people were actively involved in the development and review of the progression plan. The HSCRC implements a broad stakeholder engagement approach to healthcare transformation through stakeholder Workgroups. All Workgroup meetings are conducted in public sessions, and comments are solicited from the public at each meeting. There are also a number of sub-workgroup meetings and task forces to discuss technical, data-driven matters related to specific policies, which report back to the larger Workgroups. Input is also solicited in informal meetings with stakeholders. Exhibit MD5 depicts the current structure of the stakeholder engagement Workgroups.[162,163,156]

The Rural Health Voice

In Maryland, rural communities wanted to have a voice in determining what health services are available and how to leverage resources to address SDOHs. In response to the need for flexibility for general acute care hospitals to convert to ambulatory medical services campuses (Freestanding Medical Facilities), while preserving access to needed emergency services, the Maryland legislature passed SB707. In 2016, SB707 established a workgroup on rural health care delivery to oversee a study of health care delivery in the Middle Shore region a develop a plan for meeting the health care needs of its five counties. The workgroup released a report, Transforming Maryland's rural healthcare system: A regional approach to rural healthcare delivery.[161] Based on recommendations from this workgroup, in 2018 Maryland Passed SB1056, which establishes a Rural Health Collaborative Pilot for the Midshore Region within MDH. The pilot seeks to establish "rural Health complexes," community-based ambulatory care settings that integrate primary and other health care services determined to be essential and sustainable by the collaborative.

Exhibit MD5. Maryland Stakeholder Engagement



Source: https://hscrc.state.md.us/Pages/Workgroups-Home.aspx

Other Parallel Health Reform Models and Infrastructure. One key reform was enacted in 2018, when HHS and the Department of Treasury approved Maryland's 1332 waiver application. This waiver will run from 2019 to 2023, to establish a **state-based reinsurance program**, building on Maryland's prior experience administering a supplemental state-based reinsurance program in 2015 and 2016. The Maryland Health Benefit Exchange will administer the reinsurance program. For 2019, insurers will be reimbursed for 80 percent of an enrollee's claims with a cap of $250,000. The attachment point has not yet been determined but was modeled by actuaries at $20,000. The total expected cost of the reinsurance program is $462 million for 2019. It will be funded through a 2.75 percent assessment on certain health insurance plans and Medicaid managed care organizations. This assessment would have been owed to the federal government under the ACA's health insurance tax, which was suspended by Congress for 2019, but will now be collected by the state.[164] [165]

Through a $4.3 million grant, the Baltimore City Health Department is participating in the CMS-funded **Accountable Health Community program**. Funding is being used to screen for health-related social needs of Medicaid and Medicare beneficiaries at participating providers; refer qualified beneficiaries to receive navigation support in accessing social needs-related services; use technology, data, and quality improvement to support this program; and convene health care, community stakeholders, and city/state agency partners to drive alignment around both enabling and evaluating clinic-community linkages.

Details and Mechanics of Approach

Governance and Organizational Characteristics. The All-Payer Model Agreement of 2014 began a significant shift in Maryland's historical hospital regulatory structure to a platform for broad system change. While the HSCRC is the regulatory body for the Maryland hospitals and is positioned to support the state in negotiating changes to the Model, the leadership and oversight for the model must have a broader perspective than hospitals. Likewise, consumers and purchasers also have a pivotal role in achieving a responsive person-centered system. The state expects to emphasize using public-private partnerships and broad stakeholder advisory approaches to governance. Some of the infrastructure will be implemented through CRISP. Other aspects will require a reorientation of state resources to provide oversight. The MDH, with input from stakeholders and guidance from the executive branch and legislative leaders, will lead efforts to establish the appropriate governance and infrastructure approach for the strategies proposed in the plan and potential new legislation to support the plan.[155]

Payment Mechanisms. CMS and Maryland intend for the TCOC Model to be classified as an Advanced Alternative Payment Model (AAPM), and regulated hospitals under Global Revenue agreements with Medicare Performance Adjustment Requirements, to be qualified as Advanced APM Entities. CMS and Maryland may amend the Model to assure MACRA qualification and will work together to ensure that Care Redesign or other programs such as the MDPCP enable physicians and other clinicians to participate in the All-Payer Model. Amendments may be made to the Model as needed to ensure that it meets the requirements of an Advanced APM.[155]

MDPCP. For the MDPCP, CMS will provide funding directly to practices (and CTOs by practice designation) to strengthen and transform the delivery of primary care. The funding may be provided in several forms, as follows; see Exhibit MD6 for summary.[159]

- **Care Management Fees (CMF)** are funds designated to provide care management to patients. Funds would be provided quarterly in advance on a PBPM basis to practices in both tracks based on the risk levels of the Medicare beneficiaries attributed to that practice. Payments range from $6 to $100 PBPM and average $17 PBPM for Track 1 and $28 PBPM for Track 2, which includes a $100 CMF for "complex" patients.[166] CTOs will be compensated for their partnership by receiving a portion of the practices' CMF. The Model is designed around Medicare FFS and Dual Eligible beneficiaries with the intent of expansion to all-payers. Other payers do not have to follow this CMF PBPM fee structure and payments may be lower since the acuity level for patients may be lower.
- **Performance Based Incentive Payments (PBIP)** would be provided to practices and CTOs on a rate of between $2.50 to $4.00 PBPM. Funds would be provided in advance annually and retrospectively reconciled based on how well the practice performs on patient experience measures, clinical quality measures, and utilization measures that drive total cost of care. [166]
- The **payment structure** is based on Medicare FFS under the **Medicare Physician Fee Schedule**. Track 1 receives payment from Medicare FFS as usual. In the advanced track (Track 2), the typical Medicare FFS payment system gradually transforms to a partial prepayment system with practices receiving quarterly payments in advance.

Exhibit MD6. MDPCP Financial Summary Table

Track	Care Management Fees (PBPM)	Performance-Based Incentive Payments (PIBP)	Payment Under Medicare Physician Fee Schedule
1	$17 average	Utilization and Quality/ Experience Components	FFS
2	$28 average	Utilization and Quality/ Experience Components	↓FFS + ↑Comprehensive Primary Care Payments (CPCP)

Source: https://health.maryland.gov/mdpcp/Documents/MDPCP%20FAQs%20-%20State%20Guidance.pdf

In addition, **Medicare's Quality Payment Program** may also provide an additional opportunity for practices to receive a 5 percent lump sum bonus on historical evaluation and management (E&M, outpatient) claims and exemption from additional reporting as an Advanced APM.

For practices partnering with a CTO, there are two payment options under the CMF payment structure:[166,167]

- Option 1: The CTO will receive 50 percent of the CMF payment; the remainder will be paid to the partner Participant Practice. CTO will provide each partner Participant Practice with at least one Lead Care Manager for every 1,000 attributed Medicare FFS beneficiaries.
- Option 2: The CTO will receive 30 percent of the CMF; the remainder will be paid to the partnering Participant Practice. The partner Participant Practice has its own Lead Care Manager for every 1,000 attributed Medicare FFS beneficiaries, so the CTO does not need to deploy a Lead Care Manager to the practice.

The CTOs will also receive a PBIP that is a PBPM payment. The PBIP will be based on utilization and quality measures of all practices with which a CTO partners.

Alignment Among Payers. All payers (commercial, Medicare, Medicaid) reimburse hospitals at the same rates. These rates are set by HRSCS based on annual global budgets for hospitals to cover both inpatient and outpatient care. Maryland previously functioned under a Total Patient Revenue (TPR) system. A global budget cap was introduced under Maryland's 2014 waiver using a Global Budget Revenue (GBR) methodology. While an extension of the TPR, the GBR prospectively establishes a fixed annual revenue cap for each hospital. TPR is available to sole community provider hospitals and hospitals operating in regions of the state that do not have densely overlapping service areas. Under GBR and TPR contracts, each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from an historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of UCC. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings. The TCOC builds on the existing hospital all-payer rate-setting mechanisms through the addition of a fixed global hospital budget for services connected through an attributed population of patients, along with several pay-for-performance programs.[168]

Medicare Performance Adjustment. HSCRC will utilize a Medicare Performance Adjustment (MPA), which incorporates attribution, episodes and/or geographic measures of total cost of care for Medicare

into hospital value-based payments. This will provide a level of direct hospital accountability within the All-Payer Model for total cost of care and support the process of aligning physicians within the TCOC Model. For 2019, the revenue-at-risk will be 1 percent of Medicare hospital revenues. The HSCRC will determine the need to increase the revenue-at-risk in the succeeding years based on performance and other factors. The HSCRC will administer the MPA through a discount mechanism, subject to CMS' review of the associated calculations and specifications under a timeline to be specified in the Care Redesign Program calendar. The state will also submit proposals for efficiency adjustments through the MPA. This will allow statewide or program-specific adjustments to be made based on established methodologies approved by CMS.[168]

In order to conform with MACRA requirements for quality performance payment, MPAs will be increased or reduced by multiplying the adjustment by each hospital's revenue adjustment percentages for the all-cause readmissions and hospital acquired conditions quality programs. Positive MPAs will be increased and negative MPAs will be reduced for positive quality adjustments. Conversely, negative MPAs will be increased or positive MPAs will be reduced for negative quality adjustments.[168]

Because the TCOC Model is classified as an Advanced Alternative Payment Model (AAPM) under CMS' Quality Payment Program, hospitals with Global Revenue Agreements and the Medicare Performance Adjustment are classified as Advanced APM entities under the TCOC Model. After 2019, Maryland will submit a request to CMS to introduce an MPA for non-hospital providers, which will also incorporate population health targets. The modifier could be applied to voluntary participants in the Care Redesign Program that have a direct relationship with CMS and Maryland through a Participation Agreement.[168]

Care Redesign Program. For care redesign programs beyond hospitals, Maryland will seek to design programs that would be available to multiple payers, if they choose to participate. Although, in some instances, initial implementation will be focused on Medicare, aligned efforts can serve to support transformation goals and to increase effectiveness and reduce administrative burden for providers and payers. CMS and Maryland will work to develop care redesign components of the TCOC Model that further Model goals and foster alignment across the delivery system. These components can be initiated as new Tracks under Maryland's existing CRP or as New Model Programs. Total Cost of Care guardrails applicable to incentive payments under Care Redesign Program will be replaced with the Medicare Performance Adjustment; this tool is expected to ensure that care redesign participants will be attentive to the total cost of care performance when designing and implementing care redesign interventions.

Federal assistance and cost of initiative. The TCOC model will affect more than $20 billion in annual health spending, including Medicare spending outside of hospitals and Medicaid costs for dually eligible beneficiaries; see Exhibit MD7 below.[155]

Exhibit MD7. Costs Addressed by Maryland's All-Payer Model Progression Plan

For 6 million Marylanders, including approximately ~800,000 Medicare FFS Beneficiaries	Estimated Costs to be Addressed
All Payer Hospital Revenues (including Medicare) for Maryland Residents	$14.8 billion
Medicare FFS Non-Hospital Spend and Other	$4.4 billion
Medicaid Costs for Dual Eligible Patients	$1.7 billion
Total Costs	**$20.9 billion**

Source: https://hscrc.maryland.gov/Documents/Modernization/05-30-18%20Maryland%20All-Payer%20Model%20Progression%20Plan%27.pdf
NOTE: estimates are given in calendar year 2015 dollars.

Quality Measurement. HSCRC has increasingly focused on potentially avoidable utilization, in turn influenced by outpatient and community care. HSCRC's FY 2017 changes to value-based programs emphasize potentially avoidable utilization, increasing the alignment of hospitals' incentives with those of ACOs, PCMHs, and other accountability structures. As HSCRC, in concert with stakeholders, updates value-based incentive programs for hospitals for 2020 and beyond, it will focus on measures of prevention, care management and care coordination, care outcomes, and care transitions. This focus will assure better care supports for complex and chronic conditions, improving health, and reducing potentially avoidable utilization. Measures incorporating potentially avoidable utilization encourage hospitals to strengthen investments in improving care transitions and collaborating with community providers. Optimally managed and coordinated outpatient care can potentially prevent the need for hospitalization, or early intervention can prevent complications or more severe disease.[155]

HSCRC is also beginning the process of reorienting hospital measures to focus on episodes of care. This builds on the hospital inpatient measures currently in place, and extends to incorporate outpatient activity. Focusing at the episode level has several important advantages. From a patient perspective, it improves the care experience by smoothing the transitions across sites and types of care. In addition, measures of care episodes can engage a range of providers, including specialty physicians and post-acute care providers. HSCRC, working in partnership with stakeholders, will update its value-based payment approaches to be more meaningful to consumers and more useful in engaging physicians and other providers across the system, and across payers and settings.[155]

The TCOC Model includes an Outcomes-Based Credits framework, which enables CMS to grant the state credits for its performance on the CMS-approved population health measures and targets, structured as a discount to the state's actual TCOC used in calculating the State's performance against the Model's savings targets. The amount of these Outcomes-Based Credits will be based on the return on investment (ROI) that Medicare would expect from the State's improved performance on the CMS-approved population health measures and targets.

Quality measures are reported by practices using a state designated process in conjunction with CRISP, the state-designated Health Information Exchange (HIE), which enables the ability to report eCQMs.

Incorporation of Social Determinants of Health (SDOH)

The TCOC Model does not explicitly incorporate SDOH. However, Maryland hospitals, physicians and other providers are coming together to transform delivery systems. These partnerships are designed to meet the needs of their shared patients, particularly those who are vulnerable, and reduce potentially avoidable utilization. Partnerships have focused on initiatives that support complex and high-needs patients who use extensive healthcare resources. Throughout the Maryland All-Payer Model, hospitals have taken responsibility for managing patient care beyond the hospital stay through the development of post-discharge programs. Many of these programs include social services that are needed for patients' well-being, e.g., transportation assistance, access to food, and other home supports. Most of these efforts are in early stages of implementation and must continue to mature. The pool of high-needs patients will increase with the aging population unless the State focuses on preventing the escalation of chronic

conditions and provide better community-based access and supports for individuals with chronic conditions. System-wide care redesign that incentivizes the right care to be given at the right time and place is necessary to achieve better health outcomes and cost performance for Maryland. Clearly this effort must move beyond hospitals and into the community to create sustainable success.[155]

Implementation of HIT and Data Analysis Infrastructure

Maryland's HIE, the Chesapeake Regional Information System for Our Patients (CRISP), is uniquely positioned as a tool to support health system transformation in Maryland. CRISP is a private, not-for-profit enterprise governed by a volunteer board. CRISP focuses on supporting data infrastructure needs that can best be accomplished cooperatively, augmenting resources of payers, health systems, and providers.[155] Hospitals in Maryland and Washington, DC submit near real-time admission, discharge, and encounter information to CRISP. CRISP receives and exchanges information with several other facilities in states that border Maryland. CRISP's functions extend beyond those of a traditional HIE.

CRISP's Encounter Notification Service, which notifies physicians, other providers and care managers when patients are hospitalized, has become a critical coordination service in the state. A web-based capability to proactively manage patient transitions allows a care manager to quickly and efficiently detect recent inpatient and emergency department admissions and discharges. High-needs individuals and their care team members can also be identified through the new capabilities. More than a million Encounter Notifications are sent and received annually.

A key CRISP initiative is increased connectivity with ambulatory practices. Ambulatory integration capabilities allow physicians to view clinical data and receive hospitalization alerts. This helps to coordinate follow-up with patients who have had an acute episode and to reach out to attending physicians; monitor the prescribing and dispensing of drugs that contain controlled dangerous substances; and view more comprehensive patient information, including treatments with other physicians and providers, to make more informed treatment plans. In addition, automated reports allow physicians and other providers to monitor and improve quality performance, reduce redundant testing and treatment, and easily communicate treatments delivered. New capabilities automate physician and other providers' workflow, reducing unnecessary manual work. As of the end of October 2016, more than 1,100 physicians are sharing clinical and encounter data with CRISP and 4,200 more physicians are sharing encounter data only.

CRISP also provides reporting and analytics resources to inform decision-making. These efforts fulfill several different functions, including guiding care coordination, identifying populations, and providing metrics for care monitoring. Analytics data draw from multiple sources including Medicare data, HSCRC case-mix data, U.S. Census and population data, and CRISP-reported data and provider panels. These data are enriched with analytics and methodologies such as geocoding.

CRISP is currently piloting two key strategies: (1) offering basic care management software as a shared platform; and (2) supporting hospital-selected care management software with data feeds. Both programs will help to create an environment where risk assessments, care plans, care plan updates and other important information and tools can be shared among hospitals, care managers, physicians and other providers involved in the coordinated care of an enrolled patient.

Under the TCOC Model, CRISP will support new participants, such as post-acute and long-term care providers, which will require intense focus, additional resources and skills training to actively participate in CRISP.[155] [169]

All Payers Claim Database (APCD)

The Maryland Health Care Commission (MHCC) is responsible for collecting, maintaining, releasing, and reporting on a variety of health care data to inform decision-making by policy makers, payers, providers, and consumers through its APCD. MHCC collects data directly from health care facilities and insurance companies, and requests and maintains data from quality reporting organizations, the Centers for Medicare & Medicaid Services, and Maryland and Washington DC Hospitals.[161] The APCD contains data from commercial payers, third-party administrators (TPA)/self-funded payers, Medicaid, and Medicare. Pharmaceutical hospital claims data were added in 2010 and medical data was expanded to full, including race/ethnicity/language, in 2011. The APCD collects medical claims, eligibility, and pharmacy data. It does not contain data from the VA, self-pay, uninsured, or stand-alone TPA payers. DME data is excluded. The Maryland APCD is pushing to enhance its geographic/racial difference capabilities. The APCD allows users to analyze cost, efficiency, and system utilization and is a decision support tool for state partners such as the Maryland Insurance Administration and HSCRC.[170]

The Maryland Medical Care Data Base (MCDB), the main component of the APCD, collects the privately insured data on a quarterly basis. Although the APCD includes enrollment, provider, and claims data for Maryland residents enrolled in private insurance, including through Medicare Advantage, Medicare FFS, and Medicaid MCOs, only private claims are available for approved data release. Private claims exclude self-insured ERISA health plans as of 2015 due to a Supreme Court ruling.[171] The MCDB comprises about 90-95percent of the privately fully insured market and 25-30 percent of the self-insured market. Data files are available for 2010-2016.

The MCDB can generate reports on utilization, cost, and quality of health care services in Maryland. Measures available within the APCD include data on health care expenditures (e.g., payments to physicians and other health care practitioners; total, per-capita, and out-of-pocket expenditures; shares of income devoted to healthcare; breakdown by type of service and payer source) [360]. The MHCC also reports on trends in the service volume and level of payments for health care services provided by physicians and other professionals to privately insured, nonelderly residents of Maryland. In addition, the APCD contains data on the utilization patterns of health care services, including quality measures related to Assisted Living Facility Performance; hospital-acquired infections; Health Benefit Plans; Home Health; Hospice Quality; health care workers' Influenza Vaccination; and Nursing Home Performance. MHCC publishes a Maryland Health Care Quality Guide with both general and specific quality and outcome measures on the quality of hospital efforts in surgical infection prevention; the Maryland Guide to Long Term Care Services, which provides comparative information on performance quality and nursing home resident and family experience of care measures; and the Maryland Healthcare Quality Reports on the quality and performance of the most prominent commercial health benefit plans[361].

Results, Lessons Learned, and Next Steps

Results. The HSCRC notes that the Maryland All-Payer Model resulted in the transformation of Maryland's payment and delivery systems, the creation of demonstrable value, and sustaining rural health care.[155]

Payment and Delivery System Transformation. The All-Payer Model addressed fragmentation within its health care delivery system by beginning to fund hospital initiatives to strengthen care coordination and care transitions with the goal of providing better support for patients before and after hospitalizations.

Creation of Value. In 1974, before the HSCRC began setting rates, hospital costs per admission in Maryland were 23.6 percent above the national average. By 2005, hospital costs per case in Maryland had fallen to 5.1 percent below the national average. During this period, Maryland has experienced the absolute lowest rate of cost increase per admission of any state. Since the implementation of the new model in 2014, Maryland has achieved an estimated $429 million in total Medicare hospital savings, exceeding the five-year requirement of $330 million. Maryland hospitals have reduced potentially preventable complications by 48 percent since 2013. From 2013 to 2015, Maryland's readmission rate decreased by 57 percent. A more detailed description of the All-Payer Model results is available in Exhibit MD8.

Exhibit MD8. All-Payer Model Results, CY 2014-2017

Performance Measures	Targets	Results			
		2014	2015	2016	2017
All-Payer Hospital Revenue Growth	≤3.58% per capita annually	1.47% growth per capita	2.31% growth per capita	0.80% growth per capita1	3.54% growth per capita
Medicare Savings in Hospital Expenditures	≥ $330m cumulative over 5 years *(Lower than national average growth rate from 2013 base year)*	$120m *(2.21% below national average growth)*	$155m $275m cumulative *(2.63% below national average growth since 2013)*	$311m $586m cumulative *(5.50% below national average growth since 2013)*	$330m $916m cumulative *(5.63% below national average growth since 2013)*
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$142m *(1.62% below national average growth)*	$121m $263m cumulative *(1.31% below national average growth since 2013)*	$198m $461m cumulative *(2.08% below national average growth since 2013)*	$138m $599m cumulative *(1.36% below national average growth since 2013)*
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	25% reduction	34% reduction since 2013	44% reduction since 2013	53% reduction since 2013
Readmission Reductions for Medicare	≤ National average over 5 years	19% *reduction in gap above nations since 2013*	58% *reduction in gap above nation since 2013*	79% *reduction in gap above nation since 2013*	116% *reduction in gap above nation since 2013*

Performance Measures	Targets	Results			
		2014	2015	2016	2017
					(Currently 0.19% lower than National RR)
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	95%	96%	100%	100%

Source: https://hscrc.state.md.us/Documents/Modernization/Updated%20APM%20results%20through%20PY4.pdf

Sustaining Rural Health Care. Rural hospitals in Maryland experienced the challenges faced by rural hospitals nationally. In 2011, Maryland initiated a global revenue system for 10 of its hospitals serving rural communities. Under the 2011 global revenue system, Maryland's 10 rural hospitals formed a transformation collaborative to develop care strategies to support patients beyond hospitals, reduce readmissions, increase resources for population health, and share successful approaches. Rural hospitals accelerated investments in care management strategies (e.g., placing social workers in emergency departments to address medication needs, connecting patients to primary care providers, and addressing social determinants such as transportation). They also created multi-disciplinary clinics to provide intensive supports to complex and high-needs patients in the initial two-to-seven days post-discharge by educating and stabilizing complex patients before they returned to their primary care providers for ongoing care. These and other initiatives accelerated the reduction of admissions and readmissions in these hospitals, and with global revenue supports, these hospitals were able to maintain financial viability and reinvest the resources in needed community supports and care. After achieving some success, Maryland extended the global revenue model for rural hospitals to all acute hospitals statewide in 2014. Maryland continues to focus on local initiatives and sustainability of rural health care, including through the MDPCP which is well suited to support primary care practices in rural settings through care management resources and transformation support.[172]

However, a recent study found that Maryland's global budgets have had limited impacts on rural hospitals[362]. The study, which estimated the effects of Maryland's global budget program for rural hospitals from its 2010 implementation through 2013 found no statistically significant effects of TPR on inpatient utilization, though it did find that that TPR had substantial reductions in outpatient utilization.

Challenges and Lessons Learned. While Maryland's all-payer model is unique, it offers lessons for officials and providers in other states even if specific reforms differ from those implemented in Maryland. Lessons learned from Maryland's All-Payer Model include:[173,172]

- ***Multipayer payment reforms catalyze delivery system change****:* One of the defining elements of Maryland's payment model is its all-payer nature. While hospitals in other states have started to transform their models of care delivery, the mix of fee-for-service and value-based incentives they face across payers results in less-than-full investment in transformation. Because value-based incentives are synchronized across Maryland hospitals' entire business, the hospitals can fully invest in dramatically transforming their strategy and care delivery.
- ***Hospitals are willing to restructure their business model in exchange for financial stability and predictability:*** Maryland hospitals benefited enough from the stability they enjoyed under the rate-setting system that they were very invested in efforts to maintain the state's waiver status.

Maintaining—and even improving—budget predictability was sufficient motivation for the hospitals to agree to cap their revenue.

- ***Consistent evolution of the model has helped it endure over time:*** Although Maryland has used basically the same framework for its model over the last 40 years, the HSCRC has made adjustments on a regular, ongoing basis. This measured evolution of the model has allowed it to withstand changes in the state's health care environment and outlast other states' attempts at rate-setting. Other payment reform efforts might similarly benefit from concerted efforts to improve models as stakeholders gain experience with the model.
- ***Hardwiring specific state and provider goals into model increases confidence in expectations and improves engagement:*** Because the state's commitment to CMS outlines specific, challenging goals that it must meet over five years to maintain the waiver, providers have improved visibility into the trade-offs that lie ahead. With agreed upon targets in hand, the state and providers can focus discussions on how to achieve those targets as opposed to negotiating the targets themselves.
- ***All-payer models that include only hospitals and excludes payments to physicians may lead to conflicts between the incentives of the hospital and those of their associated physicians***. Maryland's TCOC model moves towards an approach that goes beyond hospitals to incorporate physicians. Maryland's CRP allows hospitals to make incentive payments to nonhospital health care provider partners who perform care redesign activities aimed at improving quality of care if they have achieved certain savings under a fixed global budget[362].

Next Steps. During the Performance Period of the Model, Maryland will submit to CMS a proposal for a new Model Program or for modifications to an existing Model Program (i.e., the Hospital Payment Program, CRP, and the MDPCP). All New Model Programs or requested modifications to existing Model Programs will need to enhance Maryland's ability to meet the population health outcomes and measures and targets and overall TCOC Model goals.

In developing the Model Program Proposal, the Maryland will collaborate with Care Partners and other stakeholders, including but not limited to physicians, hospitals, long-term care providers, post-acute care providers, behavioral health providers, and Maryland Payers, as appropriate, to ensure input into the new or modified Model Program. New Model Program proposals will need to include operational plans, including any waivers needed, impacts on total cost of care per beneficiary growth rate, key stakeholder perspectives, plans for encouraging participation, and a monitoring/evaluation strategy. New Model Program proposals could include one or more of the following: Payment for Alcohol and Substance Use Disorder; Non-Hospital Performance Adjustment; Alignment with Medicaid, and Post-Acute and LTSS. Maryland will submit to CMS a proposal for a payment and delivery system transformation that includes post-acute care and LTSS by no later than January 1, 2021. The Post-Acute and LTSS Proposal must include a plan for progressively increasing Maryland's accountability for Maryland Medicaid beneficiaries' TCOC.[174]

Key Considerations for Alaska

All-payer rate setting approach. Through its HCSRC, Maryland has been setting hospital payment rates across payers, including commercial, Medicare, and Medicaid/CHIP. This approach, which the state has built upon and modernized through various iterations, has allowed the state to address fragmentation within its health care delivery system, reduce costs, including achieving $429 million in total Medicare

hospital savings since 2014, improve quality of care, including reducing potentially preventable complications and readmissions rates, and provide hospitals, including rural hospitals, a more predictable stream of revenue through its global budget. Global budget models are one potential strategy to address the critical financial condition of rural hospitals in tandem with the health needs of their communities in Alaska, particularly to provide a predictable and steady source of revenue for rural hospitals.[174]

In 1993, Maryland enacted the Maryland Patient Referral Law (MPRL). Patterned after the federal Stark Law, the MPRL prohibits a health care practitioner from referring a patient to a health care entity in which the practitioner (or an immediate family member) owns a "beneficial interest" or has a "compensation arrangement."[363] [6]The Maryland Health Care Commission has expressed concern that the MPRL limits innovation as the state transitions to value-based compensation and many arrangements considered integral to value-based care are not clearly protected under MPRL[364].

Including physicians in multipayer reform. Multipayer reform efforts can incorporate providers outside of hospitals. Within Maryland's TCOC model, the Maryland's Care Redesign Program (CRP) allows hospitals to make incentive payments to nonhospital health care provider partners who perform care redesign activities aimed at improving quality of care if they have achieved certain savings under a fixed global budget. Within the CRP program, the Episode Care Improvement Program (ECIP) allows a hospital to link payments across providers during an episode of care, hospitals, physicians, and post-acute care facilities. The aim is to generate savings and improve quality through better care management during episodes, eliminating unnecessary care, and reducing post-discharge emergency department visits and hospital readmissions. ECIP provides hospitals with the opportunity to provide incentive payments to care partners that help achieve these goals. Given the high cost of care in Alaska, particularly among specialty services, designing arrangements that incorporate non-hospital providers and physicians may be a potential approach for reducing costs.

Focus on primary care transformation. Through Maryland's Primary Care Program, the state seeks to provide participating practices with additional payment incentives for primary care management and care coordination for populations with SUD, diabetes, hypertension, obesity, smoking, and asthma. These efforts seek to further improve population health management, health care quality, and reduce costs. As Alaska considers how to further its primary care transformation efforts, Maryland's Primary Care Program may provide a potential model.

Maximizing federal funding. Maryland leveraged federal funding for health reform initiatives, including for the CPC+ model and SIM funding. While both of these programs existing outside of its all-payer rate setting model, the CPC+ program provided the foundation for and was transitioned into the Maryland Primary Care Program under the TCOC model while SIM efforts supported the all-payer model through integration of population health measurement activities, establishing health IT connectivity, and designing a Medicaid IDN for dual eligible beneficiaries. In addition, federal funding for the State HIE program allowed Maryland to build out its HIE infrastructure through CRISP, which supports state efforts via promotion exchange of health information, reporting, and data analytics.

Case Study: Centennial Care in New Mexico

Executive Summary

Centennial Care, New Mexico's Medicaid Section 1115 Demonstration that began in 2014, operates by contracting beneficiary care to four managed care organizations (MCOs). Each of the participating MCOs delivers health care to its enrolled population and is reimbursed by the state using a set per-member per-month (PMPM) payment for services provided to Medicaid enrollees. New Mexico's approach incorporates value-based payment (VBP) features into its managed care contracting; requiring MCOs to have a certain percentage of their overall payments in VBP arrangements. The aim is to improve quality and decrease cost of care by offering MCOs incentives to achieve targeted outcomes. MCOs have the flexibility to use an array of VBP strategies to achieve these outcomes. The Centennial Care 2.0 demonstration launched on January 1, 2019.

In addition, ongoing Medicaid reform in the state has focused on developing accessible and affordable health care coverage to all New Mexicans. Toward this end, the New Mexico legislature requested a study on options to allow non-Medicaid eligible populations to buy into the Medicaid program. In phase 1 of the study, released in December 2018, the authors recommended targeted Medicaid buy-in as a preferred option over three others considered, including:

- **Qualified Health Plan (QHP) Public Option:** Low-cost coverage on the marketplace
- **Basic Health Plan (BHP):** Coverage for individual residents who have an income up to 200 percent of the federal poverty level (FPL) but are ineligible for Medicaid
- **Medicaid Buy-In for All:** Medicaid coverage to everyone in the state, with the exclusion of Medicare beneficiaries

Although New Mexico's approach and history of managed care programs may not be the history or future path of Alaska, many important lessons can be distilled from its experience. Key takeaways include the following:

- ***Incremental Approach toward Managed Care.*** New Mexico Medicaid program began using managed care in 1997, and gradually expanded and refined the program over time before consolidating it under a Section 1115 Demonstration and incorporating VBP in 2014. An incremental design approach could allow Alaska to try new care delivery and payment mechanism options while maintaining the basic structure and integrity of the current market and system. One potential benefit of introducing reform efforts, such as VBP, through Medicaid MCOs is that the state can introduce requirements and guidelines through the contracting process. This also allows the state to share responsibility for implementing reform efforts with payer partners.

- ***Funding and Costs.*** New Mexico did not rely on additional sources of federal funding outside of regular federal financial participation (including the enhanced match rate for the expansion population) to develop and implement Centennial Care. As part of its Section 1115 Demonstration, Centennial Care is required to achieve budget neutrality for the federal government. So far the program has exceeded that requirement, and in the first three years costs were about $2.5 billion (16 percent) lower than expected.
- ***Stakeholder Engagement.*** Stakeholder engagement and buy-in is a critical piece of health care reform efforts. New Mexico conducted extensive stakeholder engagement around Centennial Care beginning in 2011, beyond the public input activities required for a Section 1115 Demonstration. An extensive engagement strategy was effective in achieving buy-in from providers for VBP. The flexibility of provided to MCO with regard to meeting their VBP requirements for has contributed positively to garnering buy-in from participating MCOs.
- ***Effects of Medicaid Expansion and Access to Care.*** New Mexico's expansion of Medicaid to the newly eligible population after the passage of the ACA occurred during the same timeframe as implementation of Centennial Care. Enrollment in Medicaid increased by about 18 percent. While there were some concerning declines in certain performance measure scores related to access to preventive care, it is difficult to disentangle the effects of the increase in Medicaid enrollment with the effects of transitioning to Medicaid managed care and having adequate provider networks. It will be important to continue to assess the program's effect on quality of and access to care, and as final evaluation results for Centennial Care become available. It is unclear whether issues with access to care have been more prominent in rural areas since implementation of Centennial Care. But if Alaska were to implement a program influenced by this program design, the state should carefully plan ahead for ensuring sufficient provider networks and closely monitoring access in rural regions during the transition.
- ***Program Enrollment, Rural, and Tribal Considerations.*** New Mexico's Centennial Care managed care program has 696,811 enrollees, which is significantly more than Alaska Medicaid would have if it transitioned to managed care. According to the Kaiser Family Foundation, in 2016 Centennial Care was the seventh smallest program among the 29 active Medicaid managed care programs, although there is considerable variability in the size of programs using managed care across the country. While the AI/AN population can chose to opt out of managed care, 33 percent of the AI/AN Medicaid population is enrolled in a MCO. In states with both rural and urban centers, the design could be further adjusted to create separate access to care requirements that would allow for MCOs to provide adequate care with a realistic understanding of provider network availability in rural settings and accommodating Alaska's member-run tribal health system tribal.[175] In New Mexico, MCOs use categories of urban, rural, and frontier for distance requirements between the provider and the majority of enrollees.[176]

In this paper, we will examine health care reform in New Mexico (NM). This case study will focus on Centennial Care, the state's initiative to reform the Medicaid Managed Care system. We will also provide information on the possibility of pursuing Medicaid buy-in in New Mexico. The paper starts with background on state demographic and economic characteristics and moves on to detail reform efforts. We discuss the impetus for reform and then provide an overview of the approach followed by details of its mechanics, structure, and implementation. This is followed by an examination of the results, lessons learned, and considerations for Alaska.

Background

State Characteristics – Demographics and Economic Indicators. New Mexico is a southwestern state with about two million residents. Of those, 686,089 people live in a rural setting.[177] Twenty-six of the state's 33 counties are considered rural.[178] In 2017, the population of New Mexico was 48.8 percent Hispanic, 37.5 percent White, and 0.3 percent Black or African American. There are 23 federally recognized tribes in the state, with about 11 percent of the population identifying as American Indian or Alaska Native (AI/AN) alone.[179–181] The median household income between 2013 and2017, in 2017 dollars, was $47,855. Nearly 20 percent of the state population lives in poverty.[182] The unemployment rate in November 2018 was 5.1 percent.[183] The size of the state economy in gross domestic product (GDP) is $94.2 billion (2017) and the per-capita real GDP is $43,566.[184] The overall state budget for fiscal year 2019 is $19.5 billion.[185] Exhibit NM1 provides New Mexico's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit NM1. Demographics and Economic Indicators

	New Mexico	Alaska	U.S.
Population, as of July 1, 2018[181]	2,095,428	737,438	327,167,434
Rurality			
Population per square mile, 2010[181]	17.0	1.2	87.4
Share of population in rural areas, 2017[22]	34%	32%	14%
Race/Ethnicity, 2017[181]			
White Alone	82.2%	65.8%	76.6%
Two or More Races	2.5%	7.4%	2.7%
Black or African American Alone	0.3%	3.7%	13.4%
Asian Alone	1.7%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	11%	15.3%	1.3%
Hispanic/Latino	48.8%	7.1%	18.1%
**White Non-Hispanic	37.5%	60.8%	60.7%
Poverty			
Median household income (2017 dollars) [181]	$47,855	$76,114	$57,652
Minimum wage, 2019[186]	$7.50	$9.89	$7.25
Share of population in poverty (2017) [181]	19.7%	11.1%	12.3%
Economy			
Unemployment rate, as of December 2018[24]	5.1%	6.3%	3.9%
Gross domestic product (GDP), 2017[184]	$51.5 billion	$52.8 billion	$19.5 trillion
Per-capita real GDP, 2017[184]	$43,566	$70,683	$55,418
Expenditures, SFY 2017[140]	$19.5 billion	$9.7 billion	$1.9 trillion
Expenditures per capita, SFY 2017[29]	$15,027	$13,171	$5,976
**White Alone non-Hispanic individuals are people who responded “no, not Spanish/Hispanic/Latino” and who reported “white” as their only entry in the race question.			

State Health Insurance Market – Health Coverage and Uninsured. In 2014, state health spending per capita was $7,214. At the same time, total health spending, including private and publicly funded personal health care services, was just over $15 billion.[187]

Private Health Insurance Market. Fifty percent of private sector organizations in New Mexico offer insurance coverage to employees, covering 36 percent of the state population.[126,188] In 2014, total spending on private health insurance in New Mexico was approximately $4.1 billion and per-capita spending was $4,155.[29,140] Between 2001 and 2014, the average annual percent growth in private health insurance spending was 4.9 percent.[82]

State Employee Health Care System. New Mexico offers a group benefits plan and allows state employee health plans to combine with those offered for local or regional government employee participants for cities, towns, and counties.[133] The two plans offered to state employees are those administered by Blue Cross and Blue Shield of New Mexico, which is a preferred provider organization (PPO), and a health management organization (HMO) plan administered by Presbyterian Healthcare Services.[189,190] The state’s Risk Management Division is responsible for employee benefits. The agency serves active employees of state agencies, local public bodies, and participating higher education institutions.[191]

The New Mexico Coalition for Healthcare Value (NMCHCV), an employer-led and statewide collaborative group, works with state employee plan organizations to incorporate VBP into health plans.[192] The coalition board includes three of the four members of the Interagency Benefits Advisory Council (IBAC) that represents state public purchasers: the New Mexico Public School Insurance Authority, New Mexico Retiree Health Care Authority, and Albuquerque Public Schools. Most of the coalition's employer members are public/governmental entities, reflecting the relatively high proportion of public employers in the state. Current initiatives include working with major state employee plans to integrate VBP into health plan contracts, with specific objectives related to managing high-cost chronic illness and acute care episodes (a key annual action item for state plans).

Health Insurance Marketplace. New Mexico has a state-run exchange, **beWellnm** (also referred to as the New Mexico Health Insurance Exchange or NMHIX), which was created in 2013, although the state currently uses the federal enrollment platform at HealthCare.gov for individual enrollments. The exchange works closely with the Office of the Superintendent of Insurance and is governed by a 13 person governance board, which also includes committees on finance, operations, outreach and education, Native American standing, an executive group, legislative affairs, research, innovation, and a vision, mission, goals, and objectives group.[194] The Native American standing committee promotes communication and collaboration between the exchange and Native American communities in the state, as well as ensuring adherence to Native American-specific regulations within the Affordable Care Act (ACA), Indian Health Care Improvement Act or other exchange policies.[195] The state is planning to **operate its own enrollment platform** as of fall 2020.[196,197] Four insurers offer individual market plans in the state for 2019: Blue Cross Blue Shield of New Mexico, New Mexico Health Connections, Molina Healthcare of New Mexico, and Christus Health System. New Mexico's open enrollment for 2019 ended in December 2018; however, AI/AN enrollees are eligible for year-round enrollment into the marketplace exchange.

Medicaid and CHIP Program and Population. New Mexico expanded Medicaid under the Affordable Care Act. New Mexico Medicaid covers a little over 900,000 people, which is approximately 40 percent of the state's population.

Medicaid Buy-In

In 2018, New Mexico's legislature requested a study on Medicaid buy-in options, in which individuals earning less than 200 percent of and otherwise ineligible for Medicaid would be able to pay a premium to enroll in NM Medicaid. The goal would be to offer an affordable health coverage option for individuals who do not receive employer-sponsored health insurance and cannot afford private coverage. Phase one of the study presented four options:

1. **Targeted Medicaid Buy-In**: The state would offer Medicaid-like coverage outside of the marketplace, targeting residents ineligible for public programs.
2. **Qualified Health Plan (QHP) Public Option**: The state would offer low-cost coverage on the marketplace, targeting residents seeking individual or small employer coverage.
3. **Basic Health Plan (BHP)**: The state would offer coverage for individual residents who have an income up to 200 percent of FPL, but are ineligible for Medicaid.
4. **Medicaid Buy-In for All**: The state would offer Medicaid coverage to everyone in the state, with the exclusion of Medicare beneficiaries, as a low-cost insurance coverage option. It would be offered outside of the marketplace.

All but the targeted Medicaid Buy-In option would require a federal waiver to implement. The study's authors recommended the Targeted Medicaid buy-in option for meeting the goals of accessible and affordable health care coverage. Phase two of the study is a quantitative assessment.[193]

Exhibit NM2. Medicaid Eligibility Levels as of January 2018

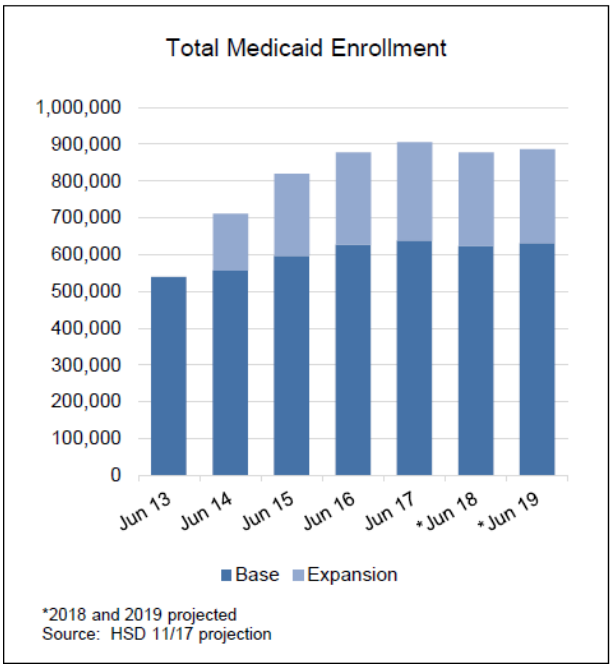
	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
New Mexico	138% FPL	138% FPL	216% FPL	201% FPL	100% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

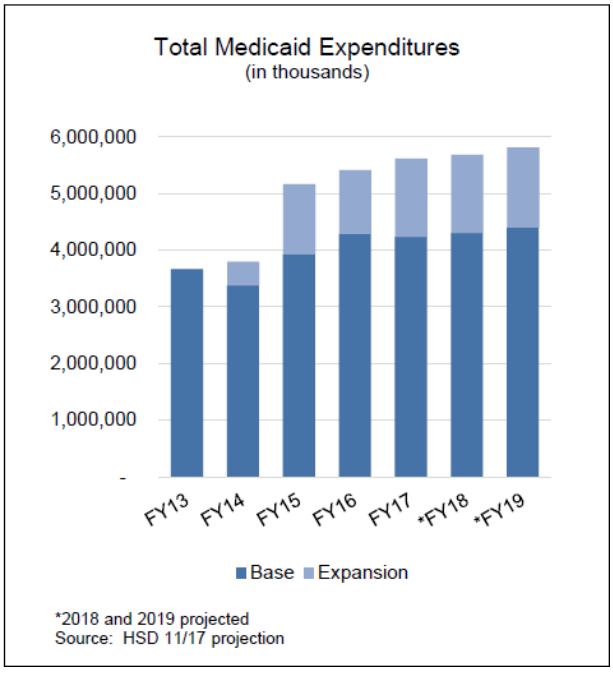
Source: https://www.kff.org/98Medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/.

In 2014, the state implemented Centennial Care, a new managed care program that consolidated 12 prior waivers into a Section 1115 Demonstration and added a VBP requirement.[198] Nine in ten of the state's Medicaid enrollees are in managed care, served by four MCOs.[55] American Indians/Alaska Natives are not required to participate in Centennial Care but may choose to.[198] As of June 1, 2017, 135,244 AI/AN residents were enrolled in New Mexico Medicaid, with 33 percent of those individuals enrolled in managed care and the remaining in fee for service (FFS). Each Medicaid MCO is required to have people who are trained about Native American culture.[198–200]

Since expansion, New Mexico's Medicaid enrollment has grown for both base and expansion groups, with a leveling of enrollment numbers since 2017, while expenditures have continued to increase for both groups (see Exhibit 3). Total Medicaid spending in New Mexico for 2016 was about $5.4 billion, 21 percent of which was state spending. Average annual spending per enrollee ranged from $3,186 for adults under age 65 without disabilities (which includes the expansion population) to $15,379 for individuals with disabilities.[201] The Federal Medicaid Assistance Percentage means that the federal government pays approximately 70 percent of the state's traditional Medicaid costs.[202,203]

Exhibit NM3. New Mexico Medicaid Enrollment and Expenditures





Source: New Mexico Legislative Finance Committee, 2017 Accountability Report: Medicaid.

Uninsured Population. New Mexico expanded Medicaid under the Affordable Care Act, and the uninsured rate dropped from 18.6 percent in 2013 to 9.2 percent in 2016, which was a larger decrease than the national average decrease.[204]

Providers and Service Use. The state has 36 hospitals, 10 of which are Critical Access Hospitals.[205] Among the 36 hospitals, 44.4 percent are for-profit, 38.9 percent are nonprofit organizations, and 16.7 percent are state- or local-government owned.[48] There are 11 Rural Health Clinics and 17 Federally Qualified Health Centers (FQHCs).[205] New Mexico has 2,869 primary care physicians and 2,795 specialists.[50] There are 104 primary care health care shortage area designations (HPSAs) in an area that covers about one million residents. The Kaiser Family Foundation estimates that about 23 percent of the primary care need is met, and an additional 261 practitioners would be needed to remove the HPSA designations.[206]

Tribal Health. New Mexico is within the Indian Health Service Albuquerque Area, which covers both New Mexico and Colorado and supports 27 tribal groups, comprising 20 Pueblos, 2 Apache bands, 3 Navajo chapters, and 3 Ute tribes. The administrative headquarters for this service area are in Albuquerque. In 2009, Governor Bill Richardson signed the State-Tribal Collaboration Act into law, which aims to promote and strengthen the relationship between the New Mexico state government and the region's sovereign tribes and pueblos. Under the Act, cabinet-level agencies created policies to communicate and coordinate with tribal governments, including that each Executive agency has a designated tribal liaison.[207,208] The Office of the Tribal Liaison within New Mexico's Department of Health Services works to support better health and wellness outcome among the sovereign nations under the tenets of sovereignty and self-determination. Activities and objectives include:

- Providing technical assistance on the development and implementation of policies, agreements or programs
- Provide coordination and leadership to direct resources to improve equity and reduce health disparities among AN/IN populations
- Act as the central resource and communication hub between tribal and state staff for discussions on the integration of western science and best practices in public health to complement indigenous knowledge and practices
- Facilitate training on the State Tribal Collaborate Act[209]

Within the Albuquerque service area, IHS and tribally run clinics and hospitals are available to the AI/AN population, including 5 hospitals; 11 health centers; 12 field clinics; the New Sunrise Regional Treatment Center, which provides residential substance abuse treatment services; and the Albuquerque Indian Dental Clinic, which provides dental care for people under the age of 26.[162,200] In addition, the Albuquerque Area participates in five special IHS programs:

- Special Diabetes Program for Indians (SDPI)
- Improving Patient Care (IPC)
- Meth and Suicide Prevention Initiative (MSPI)
- Domestic Violence Prevention Initiative (DVPI)

- Baby-Friendly Initiative[210]

History of the Initiative

Impetus for Health Care Reform. Prior to implementing Centennial Care in 2014, New Mexico Medicaid faced multiple challenges, including rising costs, an administratively complex and fragmented program, and a lack of mechanisms to control or measure quality of care. The Medicaid program accounted for 16 percent of the state budget, and operated through FFS and managed care under 12 separate federal waivers. Seven different MCOs provided plans as a part of the program, each offering unique benefits to enrollees, resulting in little continuity across plans.[211] Through Centennial Care, New Mexico officials planned to improve cost and quality outcomes for the state's Medicaid program as well as reduce administrative burdens, in order to allow more time and financial resources for oversight of contractors and compliance with program goals.

Preexisting Health Reform Models and Infrastructure. In 1997, New Mexico first implemented a Medicaid managed care program called "Salud!" The program mandated enrollment and covered acute, primary, and specialty care, as well as pharmacy, dental care, and transportation. The covered populations included children, low-income adults, and non-dual eligible adults over 65 years old. Salud! was expanded over time to include the Personal Care Option in 1999, a Health Insurance Flexibility and Accountability waiver in 2002, the InterAgency Behavioral Health Purchasing Collaborative in 2004, the Salud! Behavioral Health program in 2005, the Coordinated Long Term Supports and Services program in 2008, and a state coverage initiative in 2010. A number of MCOs were involved in Medicaid during this period, including BlueCross BlueShield of New Mexico, Lovelace Health System, Molina Healthcare of New Mexico, Presbyterian Healthcare Services, AmeriGroup, UnitedHealthcare, and Optum Health, each of which had one or more contracts with the state. By July 2011, two-thirds of New Mexico Medicaid beneficiaries were enrolled in one of the six managed care plans under Salud!.

Overview and Implementation of the Initiative

Overview of the Initiative. Centennial Care is a Medicaid Section 1115 Demonstration that was approved by CMS in July 2013 for a four-year period (2014 through 2018). This demonstration consolidated New Mexico's previous 1915(b) and 1915(c) waivers to create a comprehensive managed care delivery system.[212] The program operates by contracting enrollee care to one of the MCOs. During 2014-2018, there were four MCOs, which were BlueCross BlueShield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Healthcare Services, and UnitedHealthcare. Starting in 2019 under Centennial Care 2.0, there are three MCOs, which are BlueCross BlueShield of New Mexico, Presbyterian and Western Sky Community Care.

Each MCO participating in Centennial Care finances and delivers health care for its enrolled Medicaid population and is reimbursed by the state using a set PMPM payment for services provided. New Mexico's approach incorporates VBP features with the aim of improving quality and decreasing cost of care through incentives offered to MCOs for targeted outcomes. MCO strategies include creating a limited provider network, requiring the enrollee to use a primary care physician, and not covering out-of-network services.

Each MCO is required to offer a full list of services in an integrated model of care. Care coordination is a central part of the model; more than 900 care coordinators across the MCOs ensure members are able to access appropriate care at the appropriate time. Care coordinators are assigned at the discretion of each MCO to members depending on their health needs. The state has established three levels of care coordination:

- **Level 1:** Healthy individuals
- **Level 2:** Individuals with low to moderate care needs
- **Level 3:** Individuals with moderate to high care needs

In addition, each MCO provides a unique package of value added services (VAS). The types of services offered through VAS include additional environmental modifications, adult chemical dependency residential treatment center services, enhanced transportation, infant car seats, new mothers benefits, post-discharge meals, prenatal classes, school sports physicals, and vision care.[213]

The MCOs offer Centennial Rewards to Medicaid enrollees as incentives earned for making healthy choices. For example, taking the Annual Health Risk Assessments or the Comprehensive Needs Assessment earns an enrollee $10 in Centennial Rewards points. Points are awarded for certain medical tests or prescriptions that help maintain health and self-management. Rewards points can be spent on health, wellness, and fitness items.[214]

Goals for Health Care Reform. New Mexico had four main objectives in implementing its health reform program:

1. Slow the rate of cost growth in the Medicaid program while avoiding reductions to program eligibility or enrollment
2. Focus on improving beneficiary disease self-management
3. Focus on program services such as integrated care and case management
4. Create a program that aligns the incentives of all participating groups (the state, plans, providers, and beneficiaries) to work together towards improved health at decreased cost[211]

Population, Scope, and Participation. The Centennial Care model is statewide with 90 percent of enrollees participating in managed care.[55] Of the 903,681 people enrolled in New Mexico Medicaid in January 2017, 461,889 were in the MCO physical health and long-term services and supports (LTSS) group; 234,922 were in the MCO "other adults" group (including the expansion population); and 204,000 remained in FFS. Enrollment in managed care is mandatory for most populations and optional for AI/AN enrollees. However, New Mexico recommends that AI/AN enrollees with chronic or complex health needs opt-in to Centennial Care due to the care coordinator assistance for managing complex needs. A Native American care coordinator can be requested and language interpreters are available if needed.[365] Home and community-based services are provided through Centennial Care, and those requiring specific waiver or long-term care needs cannot opt out of the program. [200] MCOs are required to make their best efforts to contract with the Indian Health Service and tribal clinics and hospitals for health care services.[365]

Timeline and Implementation Process. New Mexico Medicaid implemented the Centennial Care program on January 1, 2014.[198] During the first contract period of Centennial Care (2014-2018), the MCOs —BlueCross BlueShield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Healthcare Services, and UnitedHealthcare—were required to submit two VBP projects in their submissions to participate. The state evaluated these projects for scalability.[204] [215] The second phase of the program, called Centennial Care 2.0, began on January 1, 2019. MCOs participating in Centennial Care 2.0 have changed from the first iteration of Centennial Care, and are Blue Cross Blue Shield, Presbyterian, and Western Sky Community Care. This next phase of the program will continue to build on the accomplishments of the original program.

Stakeholder engagement. In developing Centennial Care, the New Mexico Human Services Department (HSD) reached out extensively to stakeholders through a number of channels. HSD requested informal and formal feedback through formats such as advisory groups, recipient satisfaction surveys, and tribal consultation. It also collected additional information from sources such as grievances and appeals. Feedback topics ranged from provider performance, plan performance, access to care, satisfaction with care coordination, and quality of care. The Medicaid Advisory Committee (MAC) was established as an advisory body that represents and encourages the participation of health care professionals, consumers, advocates, public health entities, and other stakeholders in Medicaid policy development and program administration.[216]

Formal stakeholder engagement began with a series of public meetings around the state in 2011, each of which included a presentation from the Secretary of HSD and discussion in smaller groups. After the public meetings, the state organized a series of workgroups for focused discussion on a particular topic: Comprehensive, Coordinated Service Delivery System; Payment Reform; and Personal Responsibility.[217] In addition, HSD created a website to help circulate information and collect public comments. Comments were also gathered by phone and mail. A detailed concept paper on Centennial Care as well as the draft Section 1115 Demonstration proposal was posted on the website to provide further information to the public.[218] MAC held a day-long hearing on the concept paper and next steps for implementation.

The state continues to engage stakeholders for Centennial Care 2.0 using a number of engagement activities described below:

- ***Subcommittee Meetings:*** Beginning in October 2016, the MAC 1115 Waiver Renewal Subcommittee met five times to discuss the goals and objectives, program components, care integration, VBP, personal responsibility, and eligibility components.
- ***Concept Paper:*** The state developed a concept paper outlining the current program, including successes and areas of improvements, and explaining the changes to implement under the waiver renewal.
- ***Tribal Consultation:*** HSD held five public meetings for presentation and public comment with tribal leaders, members, and health care providers. The presentations aimed to review the history of New Mexico Medicaid while opening up the planned changes in Centennial Care for comments and suggestions based on the unique needs and experiences of AI/AN populations.
- ***Public Comment.*** HSD posted on its public website its initial proposal for Centennial Care 2.0, as well as a summary of revisions in response to comments. Request for comment was printed in local publications and news outlets.[162]

Other Parallel Health Reform Models and Infrastructure. In addition to the SIM initiative mentioned above, providers in New Mexico participated in multiple other state and federal reform initiatives:

- **Round One and Round Two Health Care Innovati**on Awards funded organizations to implement innovative ideas to deliver improved health, improved care and lower costs to people enrolled in Medicare, Medicaid, and CHIP. There were five Round One programs and one Round Two program in New Mexico.
- **The Accountable Health Communities Model** addressed the gap between clinical care and community services. There is one health system participating in New Mexico.
- **The Bundled Payment for Care Improvement Initia**tive linked payments for multiple services across an episode of care. There are four participating groups in New Mexico.
- **The FQHC Advanced Primary Care Practice Demonstration** aimed to improve quality of care, promote better health, and lower cost through patient-centered medical home models. There are 11 clinics participating in New Mexico.[219]
- Led by Presbyterian Healthcare Services, Santa Fe County's **Accountable Health Community project** addresses the unmet, non-medical social needs of county residents by strengthening the network of community service organizations. The model seeks to improve communication, sharing of information and resources, and working collaboratively to undress unmet social needs. The aim is to improve community health, increase quality of care for individuals, and reduce health care costs to the system overall.

Details and Mechanics of Approach

Governance and Organizational Characteristics. No information is available at this time.

Payment Mechanisms. By 2017, MCOs were required to have at least 16 percent of provider payments within VBP arrangements, sometimes referred to as "payment reform projects," based on what best fit each MCO population. Each MCO is required to submit its proposed VBP arrangement for HSD approval. Exhibit NM4 shows the different types of payment arrangements that New Mexico requires MCOs to enter into with providers, which are based on the amount of risk that the plan or provider is willing to share. The lowest risk option is on the left and increases towards the right. MCOs are required to report on process, efficiency, and quality metrics from these initiatives to HSD.[220]

Exhibit NM4. Value-Based Payment Levels

A variety of arrangements are available within the three levels depicted in Exhibit NM4. The first level is fee schedule-based with financial incentives and/or withholding at least 5 percent of the provider payment; these incentives are available to the providers when quality measures meet the previously agreed upon threshold. At least 5 percent of an MCO's payments to providers must be in level one or above. The second level can be met either through upside-risk shared savings for meeting an agreed-upon threshold for performance measures, or through two or more bundled payments for episodes of care. A minimum of 8 percent of an MCO's provider payments must meet at least the level two criteria. The third VBP level involves both upside and downside risk sharing of at least 5 percent. This can be implemented through a fee schedule-based system, full or partial-risk capitation, or global payments. A minimum of 3 percent of all MCO provider payments must fall within level three.[221]

MCOs must include payments to behavioral health providers in the community when calculating their percentage of overall spend in the VBP arrangements. Starting in fiscal year 2017, MCOs were also required to ensure that at least 3 percent of their provider payments involved VBP contracting with high-volume hospitals (this is a subset of the requirement to have 16 percent of provider payments in VBP arrangements, not in addition). Additionally, through these VBP arrangements, MCOs had to implement readmission reduction targets of at least 5 percent from the hospital's baseline.[200]

Under this framework, New Mexico HSD approved 10 payment reform projects that launched in fall 2015. For example, one MCO was working with a large provider group to establish an Accountable Care Organization model, in which members are assigned to a primary care provider to manage their care, and providers are eligible for shared savings when cost, utilization, and quality thresholds are met. Eventually, this initiative aims to transition participating providers to a PMPM risk-sharing arrangement. Other examples of MCO payment initiatives include:

- Bundled payments for maternity, diabetes, pneumonia, and colonoscopy episodes of care
- Patient-centered medical home (PCMH) models with VBP components, including shared savings for PCMHs that achieve specific quality targets, tiered PMPM reimbursement structures, and quality incentive payments
- Subcapitation with an FQHC held to agreed-upon performance measures to manage total care of assigned members

- Health Homes providing comprehensive care coordination for members with serious mental illness and severe emotional disturbance[211] [221]

Alignment among Payers. Centennial Care covers Medicaid beneficiaries, and as such, there is no participation by other payers.

Federal Assistance and Cost of Initiative. New Mexico has a number of active projects and programs aimed at health care innovation. In 2014, the state was selected to participate in the State Innovation Models (SIM) Initiative: Round Two Model Design Awards. New Mexico received nearly $2 million under this initiative and used those funds to develop its statewide Health System Innovation Design and engage stakeholders. New Mexico's Health System Innovation Final Design, completed in April 2016, aligns with the goals of Centennial Care but also includes plans for workforce development, health information technology, and statewide population health improvement.[220]

Quality Measurement. During the early stage of the Centennial Care contracts, New Mexico HSD collaborated with MCOs to develop common performance measures to be used in their payment reform projects in order to improve alignment for providers. These measures combined Healthcare Effectiveness Data and Information Set (HEDIS) and efficiency metrics, such as decreasing inpatient readmission rates; however, a full list of measures is not publicly available. In 2017, Centennial Care worked to refine and streamline its quality measurement system, focusing on measuring value in the areas of care coordination, physical and behavioral health integration, LTSS, care transitions, and population health.[221]

As part of the 1115 waiver, HSD is required to submit and follow a quality management (QM) plan. The Quality Bureau within HSD is responsible for oversight of MCO quality performance and improvement initiatives. HSD uses uniform quality and cost metrics across the MCOs, and measures their progress towards program goals through a reporting template for qualitative and quantitative results. MCOs are required to comply with state and federal standards for quality management (QM) and quality improvement (QI), including establishing a QM/QI program for continuous quality improvement, developing a work plan for each year, and submitting an annual QM/QI evaluation to HSD. MCOs are required to establish and implement utilization management (UM) systems that comply with the National Committee for Quality Assurance (NCQA) UM standards. MCOs must promote quality of care, adherence to proper standards of care, efficient and effective use of resources, member choice, and identification of gaps in care. In addition, each MCO must be accredited by the NCQA in New Mexico or in another state in which it provides Medicaid services. New Mexico Medicaid must meet all federal standards for network adequacy in order to ensure delivery of covered benefits to beneficiaries.[222]

Incorporation of Social Determinants of Health (SDOH)

Centennial Care plans to incorporate social determinants of health in the future.[211]

Implementation of the HIT and Data Analysis Infrastructure

Centennial Care relies on the data analysis infrastructure of participating MCOs. Within the state, there is a New Mexico Health Information Exchange. The 2016 SIM Health System Innovation Final Design plan addressed various HIT-related challenges, such as complex patient data integration, statewide adoption,

and the need for improved analytics. Improved HIT was identified as a funding priority; however, the state would fund this work and acknowledged it would be rolled out as the state budget allowed.[220]

All-Payer Claims Database (APCD)

There is not an active APCD in New Mexico. In the 2016 SIM Health System Innovation Final Design, HSD had plans to collaborate with stakeholders to develop an APCD in the state.[220]

Results, Lessons Learned, and Next Steps

Results. Available quality of care, access to care, and cost of care results are presented below, based on the interim 1115 waiver evaluation and the state's routine performance monitoring. Additional results will be available when the final third-party evaluation of Centennial Care is completed; the evaluation report is expected to be submitted to CMS mid-2019. The evaluation plan includes a wide range of proposed measures focused on access, utilization, process, quality of care, and costs. The evaluation is using data from the Medicaid Management Information System, encounter data, HEDIS/NCQA, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data, and MCO reports.[223]

In addition to the quality, access, and cost results discussed below, the state reports the following successes achieved by Centennial Care as of 2017:

- MCOs have hired more than 100 community health workers to serve Medicaid beneficiaries.
- The number of members served by a PCMH increased from 200,000 at the end of 2014 to 250,000 at the end of 2015. One MCO had 53 percent of members in a PCMH.
- 70 percent of members were participating in the Centennial Care Member Rewards program, a level 1 payment mechanism feature.
- Member satisfaction, as measured through a 2015 CAHPS survey, is above national benchmarks; across MCOs, about 85 percent of members report satisfaction with their health care overall and about 85 percent also report satisfaction with their care coordination.[224]

Quality and Access Results. According to the results of an interim evaluation covering 2014 to 2016, Centennial Care has had mixed results for measures related to timely access to care when compared to the baseline time period. There have been improvements in the percentage of the eligible population in the state that was enrolled in Centennial Care (including the percentage of AI/AN individuals who opted in to managed care); the ratio of providers to members; utilization of behavioral health services; and the rate of flu vaccinations. Yet, there were declines in the percentage of members who had an annual dental visit, the percentage who had an annual primary care visit, screening rates for breast cancer and cervical cancer, child and adolescent immunization rates, and prenatal and postpartum care utilization. However, the evaluator noted that the large influx in Medicaid enrollees due to Medicaid expansion in New Mexico, which resulted in a nearly 18 percent increase in Centennial Care member months during the interim evaluation period, likely significantly impacted these results.[224]

In addition, the interim evaluation measured improvements for care coordination and integration activities, including the percentage of members who MCOs were able to reach, the percentage for whom Health Risk Assessments (HRAs) were completed, rates of telephonic and in-person outreach, and care

coordination for individuals receiving behavioral health service. New Mexico has also been successful in transitioning members receiving LTSS to home and community-based services when appropriate; of LTSS participants, 84.6 percent receive long-term care in their homes while only 13.6 percent reside in nursing facilities. However, Centennial Care saw an increase in the number of LTSS members with emergency department (ED) visits, and a decrease in rates of diabetes screening and monitoring for individuals with schizophrenia or bipolar disorder.[200]

Centennial Care has achieved a decrease in hospital admissions for ambulatory care sensitive conditions, as well as a decrease in potentially avoidable ED visits. Other improvements during the first two years of the program include rates of early and periodic screening, diagnostic, and treatment; monitoring of body mass index for all age groups; and asthma medication management. Further, overall member satisfaction and member engagement in the Centennial Rewards program increased.[224]

Separate from the waiver evaluation, the state collects and reports on a number of performance measures for Centennial Care, including effectiveness of care, disease management, and access to care. Results in 2017 from these performance monitoring activities are summarized in the exhibit below:[202]

Exhibit NM5. Performance Measurements and Outcomes for Physical Health (2017)

Effectiveness of Care	**Adult patients receiving body mass index assessment**	**Child/adolescent patients receiving body mass index assessment**	**Patients with lower back pain who did not have an imaging study for diagnosis**	**Children receiving appropriate treatment for upper respiratory infections**
2016 New Mexico	79% ↑	61% ↑	70% ↓	88% ↓
2015 New Mexico	76%	53%	83%	89%
2016 National Average	80%	70%	71%	89%
MCO with best rating	PHP 83%	Molina 62%	PHP 72%	UHC 89%
Disease Management	**Patients with poor diabetes control (lower is better)**	**Cardiovascular patients with controlled high blood pressure**	**Patients with COPD managed with corticosteroid medication**	**Patients 75% compliant with asthma medication**
2016 New Mexico	48% ↑	54%	43%	29% ↑
2015 New Mexico	50%	54%	44%	27%
2016 National Average	43%	56%	66%	35%
MCO with best rating	Molina 41%	Molina 58%	Molina 65%	UHC 41%
Access to Care	**Children ages 1 – 6 years with access to primary care**	**Adults with access to preventive & ambulatory care**	**Women receiving at least 81% of recommended prenatal visits**	**Women receiving timely postpartum care**
2016 New Mexico	84%	76% ↓	56% ↑	58% ↑
2015 New Mexico	85%	78%	46%	51%
2016 National Average	91%	80%	58%	64%
MCO with best rating	Molina 91%	PHP 79%	Molina 57%	PHP 59.5%

Source: New Mexico Legislative Finance Committee, 2017 Accountability Report: Medicaid.

Exhibit NM6. Performance Measurements and Outcomes for Behavioral Health (2017)

Effectiveness of Care	Children with ADHD who had one follow-up visit within 30 days after first prescription	Children with ADHD who remained on medication for at least 210 days and had at least two follow-up visits	Members with alcohol and other drug dependence (AOD) who initiate treatment within 14 days of diagnosis[1]	Members with AOD who had two or more follow-up services within 30 days of initiation[1]
2016 New Mexico	50%	62%	39% ↑	14%
2015 New Mexico	50%	62%	38%	14%
2016 National Average	44%	55%	41%	13%
[1]UHC did not report 2015 data for these measures.				
Access to Care	**Behavioral health practitioners**	**Behavioral health facilities**	**Total behavioral health providers**	**MCO with highest ratio of behavioral health providers to members**
2017 *(1st quarter)*	9,365	1,225	10,590	BCBS 1:52
2016 *(1st quarter)*	10,131	1,310	11,441	PHP 1:46
Source: MCO network adequacy reports; CY17 Q1 is most recent available from HSD. MCO enrollment from March 2017 (end of Q1) enrollment reports.				
Consumer Satisfaction	**Adults generally happy with the services they received**	**Families generally happy with the services provided to their child**	**Adults feel they can manage their daily activities better**	**Families feel their child is better able to do the things they want to do**
2016	86%	84%	72%	77%
2015	88%	87%	74%	79%
2016 US Average	88%	88%	74%	73%

Source: New Mexico Legislative Finance Committee, 2017 Accountability Report: Medicaid.

Cost Results. The interim evaluation from January 2014 through December 2016 found that the Centennial Care program demonstrated significant savings in comparison to the waiver budget neutrality threshold that is required as a part of the 1115 waiver. The total cost of Centennial Care for the first three demonstration years was 15.8 percent, or about $2.5 billion, lower than the budget neutrality threshold as defined by the Special Terms and Conditions. The program has reduced expenditures in part by shifting utilization to less costly services.[198]

According to the state, the per-capita cost of medical services under Centennial Care has grown 1.3 percent year, driven primarily by pharmacy costs. HSD believes that this is a mark of success for the program, as the nation saw an inflation of 2.6 percent on average in 2015 and 3 percent on average in 2016.[162] The program has seen a lower per-person cost than in other parts of the New Mexico Medicaid program. In addition, the per-capita cost for the Centennial Care program decreased from $261.57 per month in 2016 to $257.04 per month in 2017, representing a 2 percent decrease.[162]

Challenges and Lessons Learned. While Centennial Care has seen positive outcomes and progress, remaining challenges need to be addressed. Use of FFS within New Mexico Medicaid continues, which can cause confusion among patients and providers, as well as dilute the power of aligned incentives for managed care. In addition, some of the pay-for-performance bonuses are being layered on top of these FFS structures. Communication with providers could be improved, particularly by increasing transparency around costs and cost data. Even with aligned incentives and engaged providers, a number of circumstances remain outside the realm of control for providers. This is in part because patient engagement remains a challenge for Centennial Care, as members churn within practices and resist engagement activities that may reduce costs through self-management.[221] While MCOs have achieved

improvements in reaching and engaging members in the HRA process, the rate of HRA completion remains relatively low, with the highest-performing MCO in this area reporting 36 percent timely completion in 2017. MCOs report that many members either declined care coordination or could not be reached by card coordinators. HSD has recognized these challenges and aims to further address them during Centennial Care 2.0.[185]

Timely reporting and public release of required performance measures have also been somewhat challenging. This is in part due to the time-consuming nature of auditing and ensuring the accuracy of data reported to HSD by MCOs, but also due to MCOs' preference for more flexible and streamlined reporting requirements. HSD has decided to drop certain measures from the originally proposed program evaluation and change some required reporting measures from quarterly to annual. While this reduces administrative burden for MCOs and HSD, the state's legislative finance committee argues that it also reduces the ability to oversee the program's quality and cost-effectiveness.[225] [221] Frequent changes to required performance measures could also reduce the ability to analyze changes in performance over time.

Centennial Care aims to strike a difficult balance between flexibility and alignment. Through recent onsite visits to providers participating in VBP arrangements with MCOs, HSD found that the providers wanted flexibility within the VBP options. Yet, providers also needed comprehensive data and agreed-upon calculations of total cost of care in order to take on more risk. MCOs are working with providers on this issue and are sharing data through score cards, claims data, and, in some cases, delivering health information technology solutions that allow providers to view utilization and expenditure data for attributed beneficiaries.[221]

Next Steps. January 1, 2019, marked the beginning of Centennial Care 2.0. The participating MCOs are Blue Cross Blue Shield of New Mexico, Presbyterian Healthcare Services, and Western Sky Community Care. The next phase of the program will continue to build on accomplishments of the original program. The new goals include:

- Refining care coordination efforts, especially for high-cost, high-need populations, and during transitions of care
- Expanding access to LTSS
- Improving the integration between behavioral and physical health services, including an increased emphasis on SDOH
- Expanding payment reform through VBP
- Increasing policies to support beneficiary disease self-management
- Continuing to simplify program administration[226]

The expansion of VBP will focus on increasing the required percentage of MCO's provider payments that are in VBP arrangements while also leveraging VBP to drive further movement toward program goals of care coordination, physical and behavioral health integration, quality in LTSS, and improved population health.[211]

Key Considerations for Alaska

Incremental Approach toward Managed Care. New Mexico Medicaid program began using managed care in 1997, and gradually expanded and refined the program over time before consolidating it under a Section 1115 Demonstration and incorporating VBP in 2014. An incremental design approach could allow Alaska to try new care delivery and payment mechanism options while maintaining the basic structure and integrity of the current market and system. One potential benefit of introducing reform efforts, such as VBP, through Medicaid MCOs is that the state can introduce requirements and guidelines through the contracting process. This also allows the state to share responsibility for implementing reform efforts with payer partners.

Funding and Costs. New Mexico did not rely on additional sources of federal funding outside of regular federal financial participation (including the enhanced match rate for the expansion population) to develop and implement Centennial Care, As part of its Section 1115 Demonstration, Centennial Care is required to achieve budget neutrality for the federal government. So far the program has exceeded that requirement, and in the first three years costs were about $2.5 billion (16 percent) lower than expected.

Stakeholder Engagement. Stakeholder engagement and buy-in is a critical piece of health care reform efforts. New Mexico conducted extensive stakeholder engagement around Centennial Care beginning in 2011, beyond the public input activities required for a Section 1115 Demonstration. An extensive engagement strategy was effective in achieving buy-in from providers for VBP. The flexibility of provided to MCO with regard to meeting their VBP requirements for has contributed positively to garnering buy-in from participating MCOs.

Effects of Medicaid Expansion and Access to Care. New Mexico's expansion of Medicaid to the newly eligible population after the passage of the ACA occurred during the same timeframe as implementation of Centennial Care. Enrollment in Medicaid increased by about 18 percent. While there were some concerning declines in certain performance measure scores related to access to preventive care, it is difficult to disentangle the effects of the increase in Medicaid enrollment with the effects of transitioning to Medicaid managed care and having adequate provider networks. It will be important to continue to assess the program's effect on quality of and access to care, and as final evaluation results for Centennial Care become available. It is unclear whether issues with access to care have been more prominent in rural areas since implementation of Centennial Care. But if Alaska were to implement a program influenced by this program design, the state should carefully plan ahead for ensuring sufficient provider networks and closely monitoring access in rural regions during the transition.

Program Enrollment, Rural, and Tribal Considerations. New Mexico's Centennial Care managed care program has 696,811 enrollees, which is significantly more than Alaska Medicaid would have if it transitioned to managed care. According to the Kaiser Family Foundation, in 2016 Centennial Care was the seventh smallest program among the 29 active Medicaid managed care programs, although there is considerable variability in the size of programs using managed care across the country. While the AI/AN population can chose to opt out of managed care, 33 percent of the AI/AN Medicaid population is enrolled in a MCO. In states with both rural and urban centers, the design could be further adjusted to create separate access to care requirements that would allow for MCOs to provide adequate care with a realistic understanding of provider network availability in rural settings and accommodating Alaska's

member-run tribal health system tribal. In New Mexico, MCOs use categories of urban, rural, and frontier for distance requirements between the provider and the majority of enrollees.

Case Study: North Carolina Medicaid Transformation

Executive Summary

Until recently, North Carolina shared Alaska's status as a state where Medicaid remained fee-for-service rather than delivered through managed care plans. The states differ in demographic and economic characteristics. For example: the percentage of American Indian or Alaska Native populations (relatively low for North Carolina), share of rural residents (lower for North Carolina), and adoption of Medicaid expansion (North Carolina has not expanded Medicaid). However, there are lessons to be learned from North Carolina's recent turn toward Medicaid managed care through its Section 1115 waiver. Under the waiver, the **North Carolina Medicaid Transformation** Demonstration is a five-year initiative to shift the state's Medicaid population to managed care to measurably improve health, maximize value to ensure sustainability of the program, and increase access to care by:

- **Shifting Medicaid beneficiaries to managed care.** Through a regional, phased-in approach, North Carolina will shift 80 percent of its Medicaid and NC Health Choice (CHIP) beneficiaries to managed care by contracting with managed care organizations—prepaid health plans (PHPs)—that will be responsible for care management, including for high-need enrollees, through screening, risk scoring and stratification, and comprehensive assessment. PHPs will offer: (1) standard plans that provide integrated physical health, behavioral health, and pharmacy services and will serve most Medicaid and NC Health Choice enrollees; and (2) tailored plans that provide integrated physical health, behavioral health, intellectual/development disability (I/DD), and pharmacy services to enrollees with serious mental illness (SMI), substance use disorder (SUD), and/or I/DD.
- **Meeting beneficiaries' unmet health-related social needs.** The demonstration incorporates a focus on social determinants of health (SDOH). PHPs are required to screen beneficiaries for unmet health-related social needs and, if needs are identified, connect them to social services. In addition, the *Healthy Opportunities Pilots* will test evidence-based interventions targeting housing stability, food security, transportation access, and interpersonal safety. Pilot providers will deliver health and federally-approved social services, paid for with Medicaid funds, and coordinate non-medical care to address SDOH. North Carolina will develop a pathway to value-based payments (VBP) for pilot providers by linking payments for services to demonstration outcomes and the gathering of data and experience necessary for complex risk based models. Beneficiary participation will be voluntary with the option to opt-out at any time while PHPs will be under contract to be a participating entity in all pilots operating in any geographic region in which the PHP operates. To support these efforts, North Carolina has developed or partnered with organizations that developed the following resources:
    - An **interactive statewide map of SDOH indicators**, including the economic, social and neighborhood, and housing and transportation status of residents across the state, that can guide community investment and prioritizing of resources
    - A **standard screening tool** to identify and assist patients with unmet health-related resource needs. North Carolina will require its PHPs to screen every Medicaid beneficiary for access to food, stable housing, and transportation using this standardized tool. This tool is also available more broadly for provider use.

- NCCARES360, a **statewide resource platform** so that once SDOH are identified for a particular beneficiary, providers can connect that patient to appropriate community resources.

- **Leveraging the use of advanced medical homes (AMHs) for care management.** To support care management of enrollees, PHPs may contract with or become AMHs, which will be the state's primary vehicle for delivering care management and North Carolina's primary care case management program. More advanced AMH practices provide comprehensive primary and preventive care services to PHP enrollees, e.g., patient-centered access, team-based care, population health management, and care coordination across medical and social settings.

Key takeaways from North Carolina's Medicaid Transformation demonstration include the following:

- ***Leverage opportunities to pilot programs that incorporate SDOH***. North Carolina's Healthy Opportunities Pilots allows its Medicaid managed care plans to cover and coordinate evidence-based, non-medical interventions. Findings and lessons learned from the Healthy Opportunities Pilots will allow the state to incorporate successful pilots and strategies into its Medicaid managed care program.

- ***Develop state resources to support the integration of SDOH.*** The development of a statewide map of SDOH indicators, a standard screening tool, and NCCARES360, a statewide resource platform of community resources, helps North Carolina support the integration of SDOH within its Healthy Pilot Programs and more broadly within its Medicaid managed care program.

- ***Engage stakeholders to identify community needs.*** Stakeholder engagement was instrumental in the development of the North Carolina Medicaid Transformation demonstration. This engagement continues to be a key resource for the state to identify the needs of the community and develop resources for its providers that support the integration of SDOH.

- ***Use a regional, phased-in approach to shifting Medicaid beneficiaries to managed care.*** This allows the state to provide stability for Medicaid enrollees and providers during the transition to managed care, and flexibility for managed care organizations as they enter North Carolina's Medicaid system for the first time.

- ***Develop integrated systems of physical and behavioral health care***. This helps reduce fragmentation in the health care delivery system and improve care management and care coordination for patients, particularly high-needs patients with mental or behavioral health care needs.

In this paper, we will examine health care reform efforts in the state of North Carolina. This case study will focus on the **North Carolina's Section 1115 Medicaid Transformation demonstration**, the state's initiative to shift its Medicaid population to managed care. We will also provide information on the Healthy Opportunities Pilots, which will pilot a program that allows Medicaid managed care plans (PHPs) to cover and coordinate evidence-based, non-medical interventions for populations with unmet health-related social needs under the 1115 demonstration.

Background

State Characteristics – Demographics and Economic Indicators. North Carolina is a southeastern U.S. state with a population of nearly 10.4 million residents, over 10 times larger than the population of Alaska.[122] Less than a quarter of the population lived in rural areas in 2015, lower than the rural population in Alaska. None of the counties in North Carolina qualified as frontier counties, with less than 7 people per square mile, in comparison to 87 percent of Alaska's boroughs. [20] The population per square mile in North Carolina was 196.1 in 2010 compared to 1.2 in Alaska. Similar to Alaska, the majority (70.8 percent) of the population in North Carolina is White alone. However, only 1.6 percent of the North Carolina population are American Indian or Alaska Native (AI/AN) alone, lower than the AI/AN share in Alaska.[122] Median household income was $50,320, lower than in Alaska, but both states have a similar share of the population in poverty. [122]The 3.6 percent unemployment rate in North Carolina is lower than that of Alaska. North Carolina's total gross domestic product (GDP) in 2017 ($540.5 billion) was nearly 10 times that of Alaska while the GDP per capita ($47,142) was 1.5 times lower.[123] [26] North Carolina state expenditures in SFY 2017 ($48.2 billion) were nearly five times higher than that of Alaska while the per capita expenditures were nearly three times lower.[140] The three largest nonfarm industries in North Carolina are trade, transportation, and utilities (18.9 percent), government (16.3 percent), and professional and business services (14.2 percent).[227]Exhibit NC1 provides North Carolina's demographic and economic characteristics as compared to Alaska and the United States.[227] Exhibit NC1 provides North Carolina's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit NC1. Demographics and Economic Indicators

	North Carolina	Alaska	U.S.
Population, as of July 1, 2018[122]	10,383,620	737,438	327,167,434
Rurality			
Population per square mile, 2010[122]	196.1	1.2	87.4
Share of population in rural areas, 2017[228]	21%	32%	14%
Race/Ethnicity, 2017[122]			
White Alone	70.8%	65.8%	76.6%
Two or More Races	2.2%	7.4%	2.7%
Black or African American Alone	22.2%	3.7%	13.4%
Asian Alone	3.1%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	1.6%	15.3%	1.3%
Hispanic/Latino	9.5%	7.1%	18.1%
**White Non Hispanic	63.1%	60.8%	60.7%
Poverty			
Median Household Income (2017 Dollars) [122]	$50,320	$76,114	$57,652
Minimum Wage, 2019[186]	$7.25	$9.89	$7.25
Share of Population in Poverty (2017) [122]	14.7%	11.1%	12.3%
Economy			
Unemployment Rate, as of December 2018[24]	3.6%	6.3%	3.9%
Gross Domestic Product (GDP), 2017[123]	$540.5 billion	$52.8 billion	$19.5 trillion
Per Capita Real GDP, 2017[26]	$47,142	$70,683	$55,418
Expenditures, SFY 2017[140]	$48.2 billion	$9.7 billion	$1.9 trillion
Expenditures per Capita, SFY 2017[125]	$4,688	$13,171	$5,976

**White Alone non-Hispanic individuals are people who responded “no, not Spanish/Hispanic/Latino” and who reported “White” as their only entry in the race question.

State Health Insurance Market – Health Coverage and Uninsured. In 2014, North Carolina health care expenditures,[229] including spending for all privately and publicly funded personal health care services and products, was more than $72 billion. Per capita spending on health was $7,264, below the national average of $8,045 per capita and much lower than the Alaska per capita spending of $11,064.[125]

Private Health Insurance Market. North Carolina has a higher share of private sector organizations in the state offering insurance coverage (41.2 percent) to employees in 2017 than Alaska.[126] However, similar to Alaska and in line with the national average, nearly half (46 percent) of North Carolinians had employer-based health insurance.[30] North Carolina spent $22.6 billion on private health insurance in 2014, with an average annual growth in private health spending of 5.4 percent between 2001 and 2014, similar to that of Alaska and to the national average.[140],[82] In 2016, North Carolina had 21 commercial HMOs [128]enrolling 132,972 North Carolinians.[129] The commercial HMO penetration rate is 2.4 percent, lower than the national average of 12.8 percent but higher than that of Alaska.[130]

State Employee Health Care System. The North Carolina State Health Plan is a self-funded plan that covers more than 720,000 teachers, state employees, retirees, and their dependents.[230] [231] This includes approximately 496,000 active employees and dependents, 167,000 Medicare eligible retirees and their dependents, 58,000 non-Medicare eligible retirees and their dependents, and 1,300 COBRA participants

and their dependents. [230,231] This includes approximately 496,000 active employees and dependents, 167,000 Medicare eligible retirees and their dependents, 58,000 non-Medicare eligible retirees and their dependents, and 1,300 COBRA participants and their dependents. The State Health Plan offers two Preferred Provider Organization (PPO) plans, the 70/30 and 80/20 Plans, for active and non-Medicare members. The Plan also offers a High Deductible Health Plan for those deemed eligible by their employing agency. For Medicare eligible retirees, the Plan offers three health plan options. Although the health plan does not combine state employee health plans with other local or regional government employee participants, this action is allowed for universities and colleges and public schools.

In October 2018, the State Treasurer Dale R. Folwell announced that the State Health Plan will launch a new reimbursement strategy. Effective January 1, 2020, the State Health Plan will move away from a commercial-based payment model to a reference-based government pricing model based on a percentage of Medicare rates (see Exhibit NC2). The shift is intended to provide transparency in provider rates by indexing fees to a published schedule and aligns the plan as either government or commercial payer. The overall goal is to offer quality health care and generate savings of $300 million, allowing the plan to reduce premiums and be more affordable for state employees and their dependents.[135] The plan will enlist providers through Blue Cross and Blue Shield of North Carolina (Blue Cross NC), which the state currently uses for its State Health Plan, through July 2019.[232] Providers who do not join will be out of network for state employees[366].

Exhibit NC2. State Health Plan Reimbursement Rates, as a Percentage of Medicare Rates

Hospital Inpatient	Hospital Outpatient	Critical Access Inpatient	Critical Access Outpatient	Professional
155%	200%	200%	235%	160%

Source: https://files.nc.gov/ncshp/documents/shp-documents/provider_reimbursement_at_a_percentatge_of_medicare_letter.pdf

Health Insurance Marketplace. In 2017, seven percent of the North Carolina population had non-group coverage, higher than the share in Alaska.[127] North Carolina, which like Alaska utilizes a federally-facilitated Marketplace exchange, has three issuers participating in the Affordable Care Act (ACA) marketplaces in 2019.[38] Most of the counties in the state have only one carrier, Blue Cross NC, but five counties in the Raleigh/Durham area (Chatham, Johnston, Nash, Orange, and Wake) have access to Cigna as of 2017. Ambetter (Centene) entered the ACA-compliant individual market in Durham and Wake counties for 2019 coverage.[233] In the 2018 open enrollment period, 501,271 individuals in North Carolina selected a Marketplace plan for 2019.[135]

Medicaid and CHIP Program and Population. As of January 2019, total enrollment was nearly 2.1 million in Medicaid and over 100,000 children were enrolled in North Carolina Health Choice, the state's CHIP program.[234] One in eight Medicaid enrollees were adults ages 19-64, two-fifths were children, five in eight were nursing home residents, three in eight were individuals with disabilities, and one in six were Medicare beneficiaries.[138] Unlike Alaska, as of January 2019 North Carolina has not expanded its Medicaid program under the ACA, resulting in 208,000 adults in the coverage gap (i.e., individuals with incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits).[138] In January 2018, Medicaid income eligibility limits in North Carolina was 43 percent of the Federal Poverty Level (FPL) for parents and other adults are ineligible—much lower than the national median and eligibility levels in Alaska—and 100 percent for seniors and people with disabilities, higher

than both Alaska and the national median (Exhibit NC3). Eligibility levels for children and pregnant women in North Carolina are comparable to Alaska.[235]

Exhibit NC3. Medicaid Eligibility Levels, as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
North Carolina	43% FPL	0% FPL	216% FPL	201% FPL	100% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

In FY 2017, total Medicaid spending was over $13.5 billion,[236] comprised of 18 percent spending on older adults, 46 percent on people with disabilities, 24 percent on children, and 12 percent on adults.[139] The Federal Medical Assistance Percentage (FMAP) for FY2019, which determines the federal share of the cost of Medicaid services in each state, is 67.15 percent in North Carolina, higher than Alaska.[237]

Like Alaska, in 2018 North Carolina had no Medicaid managed care organizations (MCOs). However, unlike Alaska, North Carolina has had a primary care case management (PCCM) program as part of its Medicaid program since 1991. Originally called Carolina ACCESS (CA), the program was enhanced to support Carolina ACCESS primary care practices in 1998 and has since been renamed as Community Care of North Carolina (CCNC). The program operates statewide and provides beneficiaries with a designated medical home and primary care provider to coordinate care.[238, 240] The PCCM system contains a strong care management infrastructure for mainstream beneficiaries, transitional care populations, high-risk/high-cost patients, and supports for pregnancy care and other programs. North Carolina's PCCM program covers 90 percent of the Medicaid population as of July 1, 2018.[239,240] CCNC/CA is the PCCM health care plan for a majority of Medicaid and North Carolina Health Choice beneficiaries in the state, with over 1.7 million enrollees.[240] Unlike Alaska, only a tenth of the Medicaid population is in fee for service (FFS) or other arrangement as of July 1, 2018.[239] As detailed further below, beginning in 2019, in total, approximately 90 percent of current beneficiaries will be required to enroll in Medicaid managed care.[241]

Uninsured Population. In 2017, 11 percent of the North Carolina population was uninsured, higher than the national average of 9 percent but lower than Alaska's uninsured rate.[127] Between 2013 and 2017, the uninsured rate of the nonelderly population decreased by 5.5 percentage points in North Carolina as compared to by 6.6 percentage points nationally.[145]

Providers and Service Use. As of October 2018, North Carolina had 13,187 primary care physicians and 14,755 specialists.[50] Similar to the rate in Alaska, North Carolina has 132.5 physicians per 100,000 residents.[242] In 2016, North Carolina had 2.1 hospital beds per 1,000 population, similar to the rate in Alaska, including 0.6 per 1,000 owned by state/local government, 1.3 per 1,000 owned by non-profits, and 0.2 owned by for-profits.[243] As of December 31, 2018, North Carolina has 186 total primary care HPSA designations, which meets less than half (47 percent) of needs, slightly above the national average of 44 percent, and 167 mental health HPSA designations, which meets only 14 percent of need, lower than the national average of 26 percent.[244]

In 2016, there were 38 community health centers with 229 delivery sites in North Carolina, accounting for over 1.7 million patient encounters.[52] As of May 2017, there are 73 Medicare certified rural health clinics in North Carolina.[245]

Tribal Health. The Eastern Band of Cherokee Indians (EBCI) is the only federally recognized tribe in North Carolina. Five counties in North Carolina have EBCI Tribal lands: Swain, Jackson, Haywood, Graham, and Cherokee Counties. An assessment of the EBCI community in North Carolina revealed that as of March 2013, the EBCI has over 14,500 members, over half who live on Tribal Lands. From 2007 to 2011, the rate of smoking among pregnant AI/AN living in the five-county Contract Health Service Delivery Area (CHSDA) ranged from a low of 28 percent in 2010 to almost 40 percent in 2011. The leading cause of death among the AI/AN population in the CHSDA is heart disease. The CHSDA population in North Carolina also suffers from higher rates of diabetes, obesity, and other chronic conditions, compared with general state and national populations.[246] Approximately 4,000 EBCI members are enrolled in Medicaid.[247] The Cherokee Indian Hospital is the primary medical home for over 13,000 members of the EBCI.[248]

History of the Initiative

Impetus for Health Care Reform. In their Section 1115 Waiver Application, North Carolina noted that the state grapples with unmet health-related social needs daily, including food insecurity, housing instability, unmet transportation needs, and interpersonal violence. The state specifies that:[249]

- "More than 1.2 million North Carolinians cannot find affordable housing and one in 28 children under age 6 is homeless.
- North Carolina has the 8th highest rate of food insecurity in the U.S., with more than one in five children living in food insecure households. In some North Carolina counties, one in three children live in food insecure households.
- Forty-seven percent of North Carolina women have experienced intimate partner (domestic) violence.
- Nearly a quarter of North Carolina children have experienced adverse childhood experiences (ACEs), including physical, sexual or emotional abuse or household dysfunction, like living with someone struggling with a substance use disorder."

Given these conditions and rising health care costs, in 2015 the North Carolina General Assembly enacted Session Law 2015-245 directing the transition of Medicaid from a predominantly FFS structure to managed care.

Preexisting Health Reform Models and Infrastructure. Other health reform initiatives in place in North Carolina include:

Transitional Care Program (TCP). In 2008, the state legislature expanded Community Care of North Carolina (CCNC), a public–private partnership between the state and 14 non-profit community care networks, to include older Medicaid beneficiaries and those living with disability. This population has multiple chronic conditions and an array of socio-economic disadvantages that make them high-risk for gaps in care coordination and multiple hospitalizations. This population made up only a quarter of North

Carolina Medicaid beneficiaries but accounted for over 40 percent of all Medicaid inpatient admissions, two-thirds of all potentially preventable hospitalizations, and 80 percent of total Medicaid costs.

Recognizing the value of coordination and continuity of care, CCNC strengthened its care management model for people with multiple chronic conditions. North Carolina established the TCP, a medical home program in which individuals are enrolled in a practice that participates as a medical home in their community. Regional networks provide practice support to improve care management, with training, data, and tools provided by the central CCNC office. Care management staff are assigned to the medical home practices. The TCP, which is an enhancement of CCNC, identifies high-risk CCNC enrollees when they are admitted to a hospital, and plans, coordinates, and arranges their transition back to the community. The idea is that robust discharge and transition planning for patients with complex needs can reduce their risk of emergency department use and readmission. The TCP has three main elements:

5. An *Informatics Center* provides the regional networks and medical home practices with real-time data on Medicaid inpatient admissions and the characteristics and utilization history of the patients;
6. Networks receive additional funding to hire hospital-based, *embedded care managers* to coordinate transition planning with the care managers who staff the medical home practices; and
7. *Training and tools* provide guidance on care management support the embedded care managers.[250]

A 2013 evaluation of the TCP program found that it had considerable success in reducing readmissions among beneficiaries who receive transitional care.[250] Medicaid beneficiaries with complex chronic conditions who received transitional care were 20 percent less likely to experience a readmission during the subsequent year, compared to clinically similar patients who received usual care, and they were also less likely to have multiple readmissions.[251]

Managed Behavioral Health Care through Local Care Management-Managed Care Organizations (LME-MCOs). In 2005, DHHS implemented a concurrent 1915(b)/(c) Medicaid waiver to establish managed behavioral health and I/DD care through LME-MCOs. The LME-MCO concept was initially designed as a pilot project to serve Medicaid beneficiaries with mental health, I/DD and substance use needs in a limited catchment area. In 2009, DHHS expanded the waiver statewide. Currently, DHHS contracts with LME-MCOs to operate Medicaid-funded services through a capitated prepaid inpatient health plan (PIHP) in different regions of the state.

Overview and Implementation of the Initiative

Overview of the Initiative. In October 2018, the Centers for Medicare & Medicaid Services (CMS) approved North Carolina's five-year Section 1115 waiver to shift its Medicaid population into managed care beginning in 2019.

Transition to Managed Care. As part of the transition to managed care, the state will contract with prepaid health plans (PHPs) that target high-need Medicaid populations, including plans for beneficiaries with behavioral health (BH) and intellectual/developmental disability (l/DD) diagnoses and specialized plans for foster care youth and former foster care youth. PHPs will be responsible for the care management of enrollees, including high-need enrollees, via care needs screening, risk scoring and stratification; and comprehensive assessment.[252] The North Carolina Department of Health and Human

Services (DHHS) will contract with two types of PHPs: commercial plans (CPs) and Provider-Led Entities (PLEs) that will offer two types of plans:[253]

- **Standard Plans** will serve most Medicaid and NC Health Choice enrollees, including adults and children. They will provide integrated physical health, behavioral health, and pharmacy services.
- **Tailored Plans** will provide integrated physical, behavioral, I/DD, and pharmacy services to enrollees with serious mental illness (SMI), substance use disorder (SUD), and/or I/DD needs. In future years, DHHS may create additional tailored plans for other high-needs populations, e.g., individuals dually eligible for Medicare and Medicaid. Approximately 1.8 million Medicaid beneficiaries will ultimately receive coordinated physical, behavioral, I/DD and other services (now provided through the Traumatic Brain Injury (TBI) waiver, Innovations waiver[1]) through one plan.

SDOH and the Healthy Opportunities Pilot. North Carolina is the first state to receive CMS approval for using Medicaid dollars to pay for SDOH through the Healthy Opportunities Pilots. These pilots will use Medicaid funding to cover evidence-based interventions targeting four areas: housing stability, food security, transportation access, and interpersonal safety. Pilot providers will deliver health and social services and coordinate non-medical care to address these areas. North Carolina will require its PHPs to screen every Medicaid beneficiary for access to food, stable housing, and transportation. Physicians or case managers will use a standardized tool to screen patients for SDOH. The state's long-term goal is to incorporate successful pilots into the Medicaid managed care program. Pilot applicants will be required set at least one specific objective within each of the following categories:

Focus on Social Determinants of Health

North Carolina's Medicaid Transformation program incorporates social determinants of health through its **Healthy Opportunities Pilot.** Lead pilot entities will identify cost-effective, evidence-based strategies focused on addressing Medicaid enrollees' needs. Providers or care managers will screen patients for health-related social needs, deliver health and social services, and coordinate non-medical care for Medicaid beneficiaries.

- ***Reach:*** North Carolina will launch Healthy Opportunity Pilots in two to four Medicaid geographic regions
- ***Target populations****:* The pilots must target individuals with complex health and social needs and/or children and families with children experiencing or at risk of significant and multiple adverse childhood experiences.
- ***Target areas:*** housing stability, food security, transportation access, and interpersonal safety

In addition, MCOs will be required to screen enrollees for unmet health-related social needs and connect them to resources and services if needs are identified. The state also developed or partnered with other organizations who developed various resources:

- An ***interactive statewide map of SDOH indicators*** to guide community investment and prioritizing of resources
- A ***standard screening tool*** to identify and assist patients with unmet health-related resource needs
- NCCARES360, a ***statewide resource platform*** to connect patients to appropriate community resources and track the outcome of the referral

- Increase integration among health and social services entities
- Improve health care service utilization and/or health care costs for target population
- Improve health outcomes for target population
- Improve general well-being and reduce non-health care costs for target population (optional)

[1] The Innovations Waiver: The 1915 (c) portion of the 1915(b)/(c) waiver that serves people who would otherwise live in an intermediate care facility for people with intellectual disabilities. This program gives people the opportunity to live in a community setting instead of an institution or group home.

In addition, as part of standard plan requirements, PHPs will be required to address non-medical factors by implementing a standardized screening tool to assess enrollee's non-medical needs. If an unmet need is identified, PHPs will connect beneficiaries to community resources. In select regions where Healthy Opportunities Pilots are available, PHPs will be required to work with these pilots. The state has also developed a resource platform, the NCCARE360, so that once a patient's social determinants are identified, providers can connect that patient to appropriate community resources, similar to the process to refer a patient to a medical specialist (see Section on SDOH).

The AMH program and its evolution are at the heart of North Carolina's strategy for care management. The North Carolina AMH program will be the primary vehicle for delivering care management as the state transitions its Medicaid program to managed care, and will serve as the state's PCCM program. The AMH program will be the framework under which providers can choose to take primary responsibility for care management, either at the individual practice level or in a contractual relationship with a care management/population management entity (e.g., a Clinically Integrated Network)—and receive higher reimbursement for such responsibility—or choose to coordinate with PHPs' care management approaches. Providers and PHPs can have varying levels of care management responsibilities:[254,255] Providers and PHPs can have varying levels of care management responsibilities:[254,255]

- **Tier 1 and Tier 2**: PHPs will have primary responsibility for care management functions. PHPs will assume responsibility for monitoring high and rising risk within their populations and may deploy staff and resources toward both long-term and episodic forms of care management and care coordination, working with AMHs as appropriate. AMHs will closely coordinate with contracted PHPs to provide medical home services similar to the existing Carolina ACCESS program, and will receive per member per month (PMPM) compensation from PHPs for those services.
- **Tier 3 and Tier 4**: AMH practices will take the lead in organizing and delivering care management services for managed care beneficiaries across all Medicaid PHPs with whom they contract, with care management oversight and support provided by PHPs. AMHs will provide comprehensive primary and preventive care services to PHP enrollees, including patient-centered access, team-based care, population health management, care coordination across medical and social settings, and care management for high risk populations. AMHs will provide medical home services and will also be responsible for care management for their beneficiaries, and they will receive compensation for this work. DHHS will require PHPs to contract with a large majority of AMH practices in each of their regions that have demonstrated advanced care management capabilities (Tier 3 and 4 practices). Starting in 2021, BH I/DD Tailored Plans will be required to contract with Tier 3 AMHs or other local entities to provide care management for enrollees.

AMH requirements and recognition will initially be based on the current Carolina ACCESS program. The AMH program will replace Carolina ACCESS in the managed care environment. Carolina ACCESS will continue to operate for certain beneficiaries that remain in FFS. Existing care management programs for pregnant women and at-risk children, including Pregnancy Medical Home (PMH), Obstetrics Care Management (OBCM), and Care Coordination for Children (CC4C), will continue to operate under managed care, although under new names (Pregnancy Management Program (PMP), Care Management for High-Risk Pregnancy (CMHRP), and Care Management for At-Risk Children (CMARC), respectively).[256] For the first two years of managed care, DHHS will require PHPs to contract with Local Health Departments at the same payment levels as today for the delivery of OBCM and CC4C.

Goals for Health Care Reform. DHHS seeks to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health. The state's goals for the Medicaid 1115 demonstration are to:[241]

1. "Measurably improve health, through tailored plans for certain individuals with complex needs, integration of physical and behavioral health for all beneficiaries covered through PHPs, improving access to inpatient behavioral health treatment, and strategies to address enrollees' social determinants of health;
2. Maximize value to ensure sustainability of the program through, among other things, actuarially sound capitation rates; and
3. Increase access to care."

Population, Scope, and Participation. The population, scope, and participation of beneficiaries in the various elements of the demonstration vary.

Transition to Managed Care. North Carolina's Medicaid Transformation demonstration will operate statewide, to transition 80 percent of its Medicaid beneficiaries to managed care.[257] All Medicaid and NC Health Choice populations will be required to enroll in PHPs, except for the exempt populations, who will continue to receive benefits through Medicaid FFS or their existing delivery system:

- Beneficiaries dually eligible for Medicaid and Medicare, except those eligible to enroll in behavioral health or I/DD tailored plans
- Beneficiaries participating in a Program of All-inclusive Care for the Elderly (PACE)
- Medically needy beneficiaries except those covered by Innovations or TBI waivers
- Beneficiaries only eligible for emergency services
- Those who are presumptively eligible, during their period of such eligibility
- Health Insurance Premium Payment (HIPP) beneficiaries
- Family Planning enrollees
- Prison inmates
- Waiver enrollees in the Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA), pending legislative change
- Medicaid-only beneficiaries receiving long stay nursing home services, pending legislative change

Exempt populations also include members of federally recognized tribes. North Carolina consulted with EBCI and concluded that tribal members will benefit from having the choice between Medicaid FFS or enrollment in a PHP. DHHS is in discussions with EBCI on pathways for it to become the first Native American managed care entity in the country. DHHS will work with the General Assembly, if necessary, on any changes needed to allow EBCI to offer a Tribal Option.[253]

Exhibit NC4 describes the state's phased-in approach for enrolling beneficiaries in managed care. Beneficiaries will be provided with information on the health plans available in their area, and beneficiaries will then choose their preferred health plan.

Exhibit NC4. Delivery System for Medicaid and NC Health Choice Demonstration Populations

Populations	Years 1-2	Years 3-4	Years 5+
Medicaid and NC Health Choice populations included in the demonstration except populations listed below	Standard plan	Standard plan	Standard plan
Medicaid enrollees with a serious mental illness, serious emotional disturbance or substance use disorder who have used an enhanced behavioral health service, enrollees with I/DD and TBI waiver enrollees	Medicaid FFS/ LME/MCO	BH I/DD tailored plan	BH I/DD tailored plan
NC Health Choice enrollees with a serious mental illness, serious emotional disturbance or substance use disorder who have used an enhanced behavioral health service or who have an I/DD	Medicaid FFS	BH I/DD tailored plan	BH I/DD tailored plan
Legal non-citizen residents with an SMI, serious emotional disturbance or SUD who have used an enhanced behavioral health service or who have an I/DD	Medicaid FFS	BH I/DD tailored plan	BH I/DD tailored plan
Children in foster care	Specialized foster care plan	Specialized foster care plan	Specialized foster care plan

Source: https://files.nc.gov/ncdhhs/documents/files/NC-Amended1115DemonstrationWaiverApplication_GovCooperLtr_20171120.pdf?PpFJgK3wwi.BFkdX4t6e5L8oSXK6_c8B

Healthy Opportunities Pilots. North Carolina will launch Healthy Opportunity Pilots in two to four geographic areas of the state. Pilot regions for the Healthy Opportunity Pilots will be determined through a competitive procurement process in which Lead Pilot Entities (LPEs) will submit proposals based on target populations, objectives, and evidence-based interventions for health and cost outcomes in mid-2019. Working with PHPs, LPEs will identify cost-effective, evidence-based strategies focused on addressing Medicaid enrollees' needs in its priority areas. PHPs will be responsible for determining program eligibility and scope of services. The pilots must target individuals with complex health and social needs and/or children and families with children experiencing or at risk of significant and multiple adverse childhood experiences. Medicaid managed care enrollees must have at least one needs-based criteria and at least one social risk factor to quality for pilot services. Populations that may meet the definition include, but are not limited to:

- Children and adults with poorly controlled chronic conditions (e.g., diabetes, asthma)
- Children and adults who are homeless, at risk of being homeless, living in unsafe/unhealthy housing conditions or lack appropriate heat/lights
- Children and adults who are food insecure
- Children who have experienced or are experiencing multiple adverse childhood experiences and/or toxic stress
- Pregnant women with complex social needs such as housing, food and interpersonal violence
- Adults with repeated incidents of avoidable emergency department use, hospital admissions or nursing facility placement
- Elderly and disabled experiencing or at risk for social isolation

- Children, pregnant women, and adults with behavioral health or substance use disorders

Beneficiary participation will be voluntary with the option to opt-out at any time. PHPs will be required to be a participating entity in all pilots operating in any geographic region in which the PHP operates. PHPs will be expected to collaborate with the lead and other participating entities, including participation in meetings, data exchange, and coordination with respect to any PHP member enrolled in the pilot.

Federally-approved Pilot services are listed in Exhibit NC5. These services were selected based on evidence indicating that addressing them will have a positive impact on health outcomes and health care cost.

Exhibit NC5. Overview of Federally-Approved Pilot Services

Domain	Overview of Approved Services
Housing	Targeted tenancy support and sustaining services Housing quality and safety improvements One-time payments to secure housing (e.g., first month's rent and security deposit) Short-term post hospitalization housing
Food	Linkages to community-based food services (e.g., SNAP/WIC application support, food bank referrals) Nutrition and cooking coaching/counseling Healthy food boxes Medically-tailored meal delivery
Transportation	Linkages to transportation services Payment for transit to support access to pilot services (e.g., public transit, taxis in areas with limited public transit infrastructure)
Interpersonal Violence (IPV)/Toxic Stress	Linkages to legal services for IPV-related issues Services to help individuals leave a violent environment and connect with behavioral health resources Evidence-based parenting support programs Evidence-based home visiting services

The AMH Model. Not all tiers will be available in the first year of Medicaid managed care operation. Participation in AMH is voluntary. Practices may join one or more PHP provider networks as a non-AMH practice if they wish to participate in managed care but not AMH. Participation in AMH also has no bearing a practice's ability to participate in FFS.

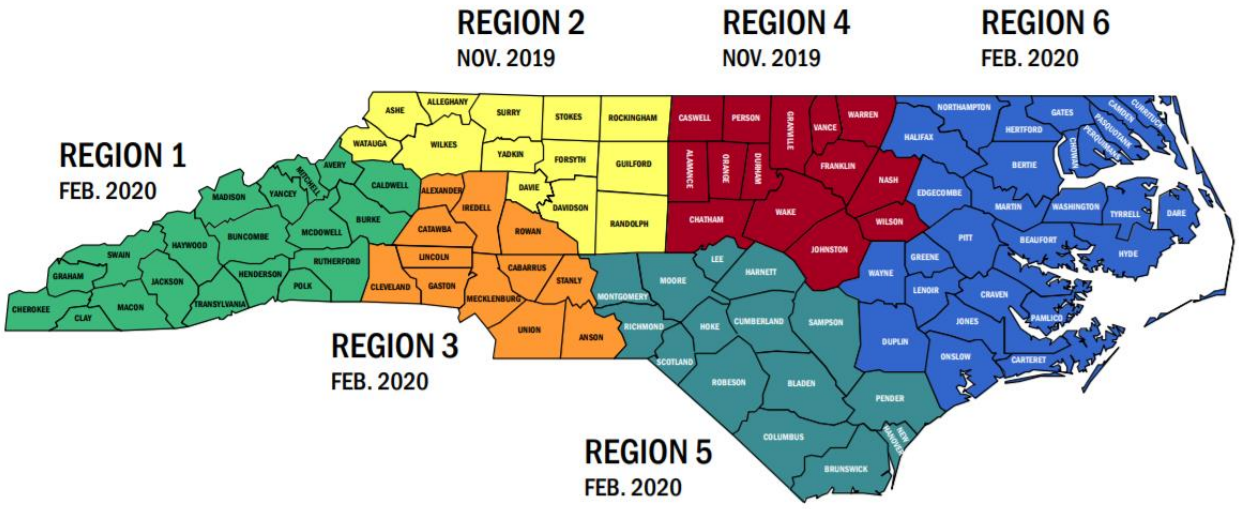
Timing and Implementation Process. On October 24, 2018, North Carolina received CMS approval of its 1115 demonstration for a five-year demonstration period. The state will transition to a managed care approach from November l, 2019 until the end of the demonstration in October 2024.

Managed Care Transition to Standard Plans. The demonstration will follow a regional phase-in approach to transition Medicaid beneficiaries to managed care, with the first phase scheduled to begin on November 1, 2019. North Carolina Medicaid and NC Health Choice beneficiaries who are not members of designated special populations will be transitioned from Medicaid FFS into Medicaid Managed Care on a regional basis (see section on details and mechanism of approach).[258] Medicaid managed care Standards plans will launch in two phases:[259]

- **Phase 1 (Regions 2 and 4)**: Managed care will being in November 2019 for beneficiaries in 27 counties (Alamance, Alleghany, Ashe, Caswell, Chatham, Davidson, Davie, Durham, Forsyth, Franklin, Granville, Guilford, Johnston, Nash, Orange, Person, Randolph, Rockingham, Stokes, Surry, Vance, Wake, Warren, Watauga, Wilkes, Wilson and Yadkin). Beneficiaries transitioned in the first phase will select their plans in July 2019.
- **Phase 2 (Regions 1, 3, 5, 6):** Beneficiaries in the second phase (i.e., in the remaining counties) will begin managed care in February 2020. Phase 2 beneficiaries will select a plan in October 2019.

Six Medicaid regions will cover the state (see Exhibit NC6). Beneficiaries in each region must have the choice of at least two PHPs.[249]

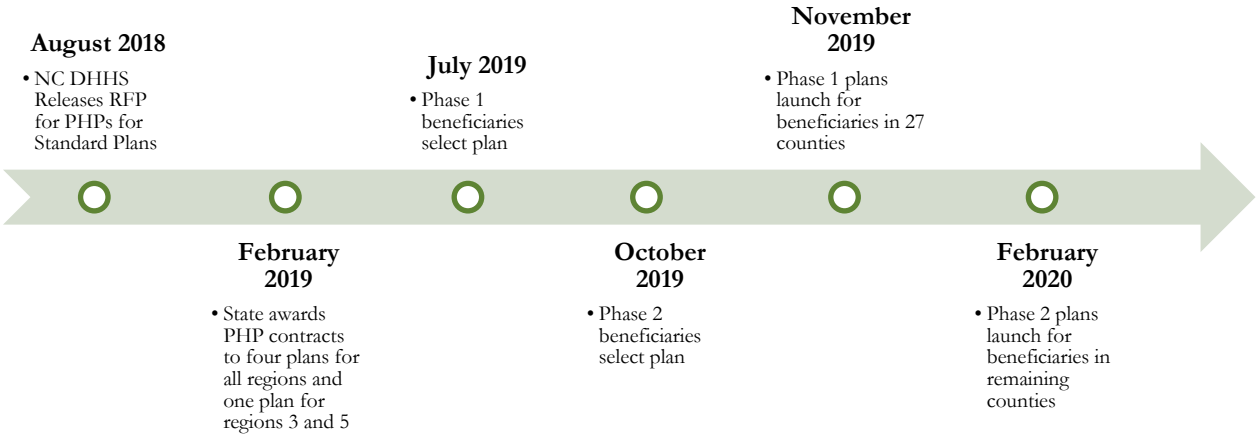
Exhibit NC6. North Carolina Medicaid Managed Care Regions and Rollout Dates



Source: https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf

North Carolina released a request for proposals (RFP) in August 2018 and accepted responses from health plans until October 2018 (see Exhibit NC7). In February 2019, the state awarded PHP contracts to four plans to offer coverage in all regions: AmeriHealth Caritas North Carolina, Inc.; Blue Cross and Blue Shield of North Carolina; UnitedHealthcare of North Carolina, Inc.; and WellCare of North Carolina, Inc. Carolina Complete Health, Inc. received a regional contract for Regions 3 and 5.[259] This procurement covers selection for Standard Plans, in which 1.6 million Medicaid managed care beneficiaries will be enrolled.

Exhibit NC7. Timeline for Medicaid Managed Care Implementation of Standards Plans



Managed Care Transition to Tailored Plans. The tailored plans will be implemented by the end of third year of the demonstration. Prior to the implementation of BH and I/DD tailored plans, qualified beneficiaries will remain in Medicaid FFS for physical health services and in the state's 1915(b) program for BH/I/DD services rather than being required to enroll in the standard plan. Once the BH and I/DD tailored plans are implemented, eligible beneficiaries will be transitioned to (or if they had opted into standard plans, given the option to transition to) the tailored plan in their region with the option to opt out within 90 days to a standard plan. Tailored Plans will be procured at a later, currently undisclosed date.[259]

Healthy Opportunities Pilot Timeline. The anticipated timeline for the Healthy Opportunities Pilot Program is as follows:

- Early 2019: DHHS released a Request for Information to inform Healthy Opportunities Pilot design
- Mid-2019: DHHS to release a Request for Proposals, to procure LPEs. LPEs would contract directly with other organizations to build a network of human services organizations (HSOs) to deliver pilot services in their geographic area
- Late 2019: DHHS anticipates selection of LPEs. Organizations awarded LPE contracts will have access to limited capacity-building funding for up to two years to develop the necessary infrastructure to effectively execute on their responsibilities.
- Late 2020: pilots to begin delivering services

AMH Timeline. The AMH program will launch concurrently with the implementation of managed care. AMH Tier 1 will be phased out after two years while Tier 4 will launch after Year 2.

Stakeholder engagement. From 2015 to 2018, extensive collaboration with and feedback from stakeholders informed development of a detailed program for Medicaid managed care that is innovative, consistent with North Carolina and federal laws, and responsive to the needs of the beneficiaries, as well as clinicians, hospitals, and health plans.[260]

- Early stakeholder engagement focused on design decisions, with later efforts supporting education, readiness and implementation.
- In April and May 2017, DHHS hosted listening sessions across the state and solicited written and verbal public input on key policy issues. Over the next six months, DHHS continued to facilitate stakeholder input into the process by encouraging public comment on the proposed design. Through the end of 2017, DHHS supplemented the open invitation for written comment with targeted outreach to stakeholders representing consumers and their advocates, rural and urban providers, hospitals, potential PHPs, and members of the EBCI) on policy and strategic topics and implementation issues.
- Starting in August 2017, DHHS worked closely with a standing Medical Care Advisory Committee (MCAC), open to the public, as the formal stakeholder engagement body charged with providing feedback and comment on all transformation efforts. The diverse membership of the MCAC, including beneficiaries, advocates, urban and rural physicians, and hospitals with representation from each region, is intended to ensure that DHHS engages with a wide range of perspectives.[241]

North Carolina has noted it will to continue seeking stakeholder input throughout Medicaid managed care launch and ongoing operations.

Stakeholder engagement was also critical for developing the SDOH elements of the Demonstration (see section on SDOH):[261]

- ***Standard screening instrument.*** In the summer of 2017, DHHS met with key stakeholders across North Carolina who were interested or working on initiatives related to SDOH. DHHS then reviewed best practices related to screening and identifying SDOH and existing screening tools, focusing on four priority domains: (1) food insecurity; (2) housing instability; (3) lack of transportation; and (4) interpersonal violence. In winter 2017-18, DHHS convened a Technical Advisory Group (TAG) comprised of subject matter experts and stakeholders from across the state. Together, the Department and the TAG came up with a set of design principles for the screening questions, reviewed other SDOH tools and questions, and drafted a set of screening questions.
- ***NC resource platform.*** In the summer of 2017, the state conducted a series of stakeholder interviews with over 80 departments of social services, health care providers and community-based organizations across North Carolina. The organizations voiced the desire to better support families by working in partnership and referenced numerous barriers to doing so. Many cited the idea of an IT platform that would unite these different organizations in a person-centered way to best support the state's most vulnerable residents.

Other Parallel Health Reform Models and Infrastructure. In addition to Medicaid reform, other value-based payment (VBP) efforts are occurring in the state. See Exhibit NC8 for a list of other Medicare, commercial, and employer efforts in North Carolina; this list is illustrative rather than comprehensive.

Exhibit NC8. Other VBP Reforms in North Carolina

Payer/Purchaser	Example of Value-Based Reforms
Medicare	▪ There are currently 30 Medicare Accountable Care Organizations [ACOs] (three in advanced Medicare ACO programs) ▪ Major NC health systems are participating in advanced Medicare ACOs, and are on track to move into advanced Pathways to Success payment arrangements (with substantial downside risk) by 2021. These systems are expected to move into payment models with substantial downside risk and shift away from FFS. ▪ About half of major NC health systems have hospitals or affiliates participating in bundled payment programs such as Comprehensive Care for Joint Replacement (CJR) and Bundled Payments for Care Improvement Advanced [BPCI-A]
Commercial	▪ There are six commercial-only ACOs operating ▪ BCBS NC stated a goal of covering 50 percent of its customers in the state under VBP arrangements by early 2020 and having all customers in APMs within five years. ▪ BCBS NC announced in January that it is launching Blue Premier as a new ACO five-year contract with at least 5 major NC health systems, starting in 2020. The contracts feature minimal price increases for the duration of the contract and an increasing shift into population-based payments linked to outcomes and total cost of care, with "downside risk" implemented by 2022. BCBS NC is also implemented ACOs with significant upside and downside risk in independent primary care practices and health centers, with analytics and population health management supports provided through a partnership with Aledade ▪ Other payers are participating in or expanding accountable care programs (e.g., United, Aetna, and Cigna). For example, Aetna expanded its Whole Health program, which features population-based reforms and enhanced care coordination and data support. Aetna and Human are both implementing bundled payment programs.
Employers	▪ As part of its "Vision for 2030," the NC Chamber is developing a "Roadmap to Value-Driven Health" to make NC a top-10 state for health and health care value. It reflects goals such as enhanced data sharing, increased physician and patient accountability, and the implementation of more meaningful and aligned performance measures ▪ The State Treasurer has proposed reference-based pricing model for the State Health Plan to link reimbursement for state employees and retirees to Medicare FFS reimbursement rates (see State Employee Health Care System section above)

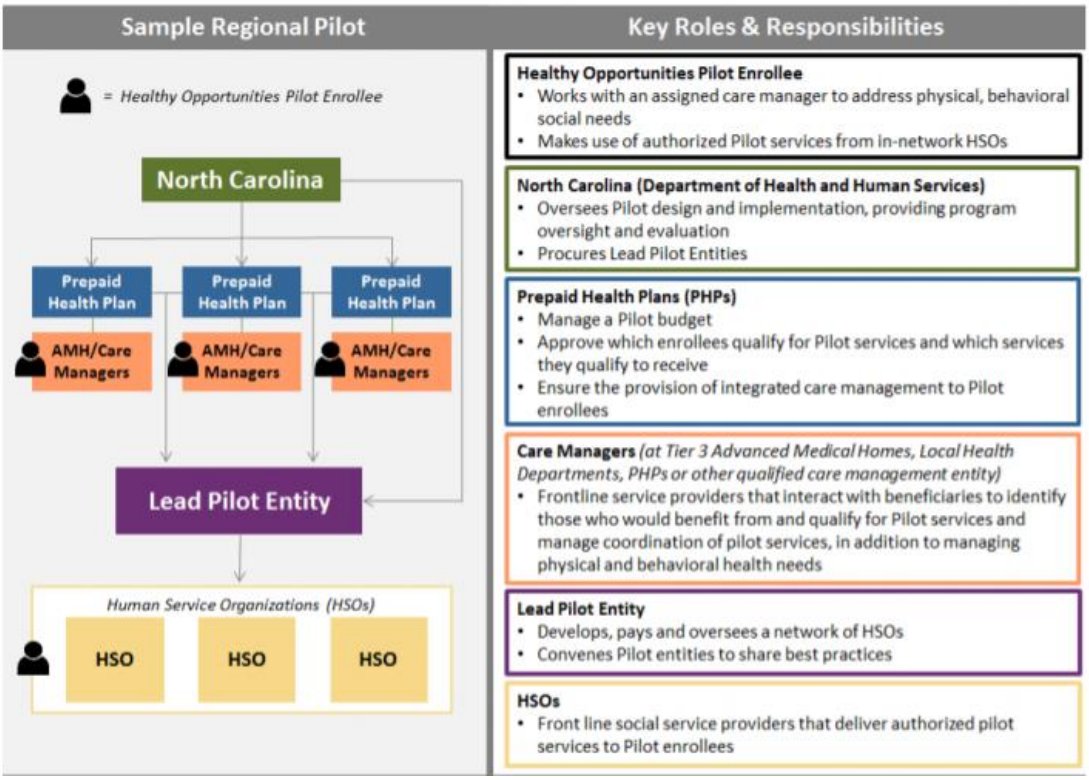
Source:
https://www.healthaffairs.org/do/10.1377/hblog20190206.576299/full/?utm_source=Newsletter&utm_medium=email&utm_content=Health+Care+Transformation+In+North+Carolina%3B+Cultivating+Ideas+To+Improve+Community+Health%3B+E-prescribing+Patterns+After+Major+Hurricanes&utm_campaign=HAT

Details and Mechanics of Approach

Governance and Organizational Characteristics. NC DHHS will be accountable for all aspects of Medicaid and NC Health Choice but will delegate the direct management of certain health services and financial risks to PHPs.[212] PHPs will receive a monthly capitated payment and will be expected to contract with providers to deliver health services to the PHP's members. DHHS will monitor and oversee the PHPs, using multiple metrics intended to ensure adequate provider networks, high program quality, and other key aspects of a successful Medicaid managed care program.[253]

For the Healthy Opportunities Pilots, PHPs will be responsible for determining eligibility to receive these services and which services they will receive. A network of community-based organizations and social service agencies will deliver the pilot services, to be established, managed and overseen by LPEs that connect the PHPs and community-based providers. Exhibit NC9 below shows the key pilot players and their roles and responsibilities in the Healthy Opportunities Pilots program.

Exhibit NC9. Healthy Opportunities Program Governance Structure



Payment mechanisms. This section describes North Carolina's payment mechanism for the various elements of the Medicaid Transformation program:

Managed Care. The managed care demonstration will use capitated payments. PHPs will be required to make additional payments, above those built into the PMPM capitated rate, to certain providers. DHHS will make payments to PHPs outside the PMPM capitation rates to cover the cost of these additional payments. DHHS is working with the North Carolina Community Health Center Association (NCCHCA) on reimbursement requirements for federally qualified health centers and rural health clinics, and additional information on these requirements is anticipated to be forthcoming.[253] Over time North Carolina will develop a pathway to VBP for the pilot providers, Medicaid PHPs, and LPEs by creating incentives to support the delivery of high quality enhanced case management and related services. Plans include provisions to link payments to outcomes, and gather data and experience necessary to develop complex risk based models.[249] The payment structure will offer incentive payments during the first two years of the waiver, withhold payments for failure to meet defined metrics in the next two years, and a shared savings model in the final year, based on performance on outcome- and process-related quality measures.

Healthy Opportunities Pilot. DHHS continues to work through the details of financing for the Healthy Opportunities Pilots. Broad framework for payment is as follows:

- Each PHP serving a Pilot region will qualify for a capped allotment outside of their Medicaid managed care capitation payments from which to finance Pilot services for their beneficiaries. In

addition, a minimum share of funds will be dedicated to each of the four key domains to ensure funding is invested in a range of interventions. Payments will also include an administrative fee.

- If a PHP has delegated care management responsibilities to a Tier 3 AMH, local health department, or other local care management entity, these entities will receive payment for Pilot-related activities.
- For the first two years of the Pilot, LPEs will have access to a limited amount of capacity building funding for startup activities (e.g., hiring and training staff, establishing contacts, supporting HSOs) that will be defined during the procurement process. DHSS will also work with LPEs to provide some direct capacity building funds to HSOs supporting the pilot. Once they start providing services, HSOs will be reimbursed by LPEs who in turn will secure payment from the PHP whose enrollee received the Pilot service.

North Carolina has released a Request for Information (RFI) due in March 2019 from HSOs, stakeholders, and other interested parties to inform the state's fee schedule for federally-approved services. The state will submit a proposed fee schedule to CMS by July 1, 2019.[258]

AMH. Payment mechanisms by AMH tier are described in Exhibit NC10. All AMH practices will continue to receive payments for clinical services provided to PHP members. In addition, they may receive additional reimbursement for medical home fees, care management fees, and performance-based payment. All payments will flow through the PHPs. Each PHP will be required to adopt alternative payment models (APMs), with a contract expectation of increasing usage by 20 percentage points a year, or at least 50 percent of expenditures, by the end of 2021.[257]

Exhibit NC10. AMH Payment Mechanism, by Tier

AMH Tier	Design in Years 1 and 2 of Managed Care: Medical Home Fee (paid by PHP)	Design in Years 1 and 2 of Managed Care: Care Management Fee (paid by PHP)	Design in Years 1 and 2 of Managed Care: PHP Performance Incentives to Practices	Payment Design After Year 2
Tier 1	$1 PMPM	None	None required – but encouraged	NA – Tier phased out after two years
Tier 2	$2.50 PMPM (most enrollees) $5 PMPM (members of the aged, blind, and disabled eligibility group)	None	None required – but encouraged	DHHS will continue to set minimum medical home fees based on Carolina ACCESS II; practices can negotiate higher rates PHPs will offer AMHs performance incentive payments
Tier 3	$2.50 PMPM (most enrollees) $5 PMPM (members of the aged, blind, and disabled eligibility group)	Negotiated between practices (or CINs on behalf of practices) and PHPs	PHP must pay performance incentive payments to practices if practices meet performance thresholds on standard AMH measures, which may include total cost of care	State will continue to require both medical home fees and care management fees PHPs will offer AMHs performance incentive payments
Tier 4	NA – Tier will launch after Year 2			PHP payment models will need to meet state thresholds for amounts that the practice potentially owes or foregoes annually based on performance

Alignment across payers. As North Carolina's initiative involves only Medicaid, there is no alignment among payers.

Federal assistance and cost of initiative. The demonstration will be financed through a state-federal partnership using Medicaid funding. The federal government has authorized up to $650 million in federal and state Medicaid funding for the Healthy Opportunities Pilots over five years (November 1, 2019 – October 31, 2024). These funds will pay for delivery of federally-approved pilot services as well as capacity building for LPEs to strengthen the ability of HSOs to participate effectively in the pilot and IT and systems development (up to $100 million of the $650 million may be used for infrastructure investments). Each PHP operating in a pilot region will have a capped funding allocation to spend on services and will need to manage its budget within this allocation.

Quality measurement. North Carolina has developed standard performance measures that PHPs are required to measure and report to DHHS. Exhibit NC11 describes the state's quality strategy aims, goals, and objectives. A full description of the state's quality improvement measures are available in the Managed Care Quality Strategy and Provider Health Plan Quality Performance and Accountability reports. Measures include quality outcome measures specific to user satisfaction, including overall provider satisfaction with the PCP, rating of all health care, and rating of personal doctors[367].

Exhibit NC11. North Carolina's Quality Strategy Aims, Goals and Objectives

Aims	Goals	Objectives
Aim 1: Better Care Delivery. *Make health care more person-centered, coordinated and accessible.*	**Goal 1: Ensure appropriate access to care**	Objective 1.1: Ensure timely access to care
		Objective 1.2: Maintain Medicaid provider engagement
	Goal 2: Drive patient-centered, whole person care	Objective 2.1: Promote patient engagement in care
		Objective 2.2: Link patients to appropriate care management and care coordination services
		Objective 2.3: Address behavioral and physical health comorbidities
Aim 2: Healthier People, Healthier Communities. *Improve the health of North Carolinians through prevention, better treatment of chronic conditions, and better behavioral health care, working collaboratively with community partners.*	**Goal 3: Promote wellness and prevention**	Objective 3.1: Promote child health, development, and wellness
		Objective 3.2: Promote women's health
		Objective 3.3: Maximize long term services and supports (LTSS) populations' quality of life
	Goal 4: Improve chronic condition management	Objective 4.1: Improve behavioral health care
		Objective 4.2: Improve diabetes management
		Objective 4.3: Improve asthma management
		Objective 4.4: Improve hypertension management
	Goal 5: Work with communities to improve population health	Objective 5.1: Address unmet resource needs
		Objective 5.2: Address the opioid crisis
		Objective 5.3: Address tobacco use
		Objective 5.4: Reduce health disparities
		Objective 5.5: Address obesity
Aim 3: Smarter Spending *Pay for value rather than volume, incentivize innovation and ensure appropriate care.*	**Goal 6: Pay for value**	Objective 6.1: Ensure high-value, appropriate care

Incorporation of Social Determinants of Health (SDOH)

To support its integration of SDOH and the Healthy Opportunities Pilots, North Carolina has developed or partnered with organizations that developed the following supports:[262]

An interactive statewide map of SDOH indicators to guide community investment and prioritize resources. The NC DHHS State Center for Health Statistics created an interactive map showing SDOH indicators in North Carolina, including the economic, social and neighborhood, and housing and transportation status of residents across the state. The map is organized by local health department region and is tabulated at the census-tract level. Data comes from the U.S. Census Bureau's 2016 American Community Survey and the U.S. Department of Agriculture's Food and Nutrition Service.[263]

- Economic conditions are described using several metrics, including median household income, percent of people living below poverty and percent of people who are uninsured.

- Housing and transportation conditions are described by metrics such as percent of households spending more than 30 percent of income on housing, percent of people living in an overcrowded household and percent of households without a vehicle.
- For social and neighborhood conditions, metrics include education level, percent of households with low access to healthy foods and areas identified as food deserts.
- A cumulative index is calculated from the metrics to provide an overall measure of SDOH indicators.[263]

A set of standardized screening questions to identify and assist patients with unmet health-related resource needs, developed by DHHS in partnership with a diverse set of stakeholders from across the state.[264] The screening questions are grounded in the following principles:

- Include domains where high-quality evidence exists to link to health outcomes, and identify needs for which there are community resources and services available.
- Keep questions simple, brief and applicable to most populations, so they can be easily integrated into workflows in diverse and varied settings across the state.
- Validate questions, drawing from best practices and writing at accessible reading levels to ensure that the questions may be effectively used.
- Align questions with those in existing screening tools (e.g., Bright Futures Questionnaire, 9 Meaningful Use, Uniform Data Set [Community Health Centers], PRAPARE [Community Health Centers], Accountable Health Community, Pregnancy Medical Home Screen).

In fall 2019, PHPs will be required to include screening questions in their care needs assessment. Though SDOH screening is not required for other practices, DHHS strongly encourages practices, providers, social services agencies and community organizations to carry out this function.[261]

A **statewide resource platform** to connect those with an identified need to community resources. NCCARE360 is North Carolina's statewide resource and referral platform, developed through a public-private partnership of philanthropy, healthcare, and community partners administered by the Foundation for Health Leadership and Innovation (FHLI). While DHHS will not administer the NC Resource Platform, the tool is an integral component of the state's Healthy Opportunities strategy. The platform will be the foundation for connecting people with community resources they need to improve their health and well-being and to decrease health care costs and utilization. The NCCARE360 platform serves two main functionalities:

- *Resource Database*: Includes a robust directory of community-based resources throughout the State and accessible online and through a call center; and
- *Referral Platform*: Supports health care and human service providers and insurers in connecting people with identified unmet needs to resources in the community. The referral platform allows for "closed-loop referrals" which give providers and insurers the ability to track whether an individual access the community-based service to which they were referred.

This approach will foster resource connections, link health and social services in communities, develop high-quality data regarding the non-clinical factors impacting health outcomes and costs, and track

outcomes. The platform will be open to all providers, payers, community-based organizations, agencies and residents across North Carolina. Rollout of the platform began in 2018.[264] PHPs will be expected to use NCCARES as their platform to connect patients to needed services and track and monitor those referrals.

Implementation of HIT and Data Analysis Infrastructure

Data are expected to play a crucial role in the state's Medicaid transformation efforts. DHHS will need to develop new infrastructure and processes to support timely data collection and produce and disseminate data and information, such as protocols for claims data collection, exchange, and analysis. DHHS describes its data infrastructure considerations as follows:[241]

- ***Capture of claims and encounter data for analysis.*** Under its current system, DHHS' Medicaid data infrastructure captures both FFS claims and encounter data from local management entities (LME)-MCOs. Much of the data analysis and reporting to providers is managed through a DHHS contract with CCNC. To manage utilization, outcomes, and quality in Medicaid managed care, DHHS will need to collect and process encounter data from PHPs and integrate these data from plans with FFS claims for carved-out populations and services. As the claims processor, PHPs will be required to report encounter data to DHHS on a regular basis and will be held accountable for submitting timely and accurate encounter data. PHP contracts will provide guidance specifying the format, frequency, quality review, and other standards for encounter data submission. DHHS will support the infrastructure development required to receive and validate the data. As the infrastructure for encounter data is being established, DHHS plans to assess how best to incorporate other data sources (e.g., other clinical data, data from AMHs, data from state agencies).
- ***Use of analytic data for care management and coordination.*** Providers in North Carolina currently have access to a range of information systems that support management and coordination of patient care. These include tools such as the NC HealthConnex Clinical Portal and CCNC's Care Management Information System (CMIS), Provider Portal, and quality performance reports. With these, clinicians and care managers can use aggregate and patient-level information as well as alerts on hospital admissions/discharges and patient assessments, risk stratification, and care plans. A key decision will be which of these functions DHHS conducts directly through a contracted vendor or through PHPs with DHHS guidance. In either case, DHHS will be responsible for establishing appropriate data governance and processes to assure data quality, consistency and appropriate protections for patient health information.

DHHS has begun developing the basic data system components needed to support data processing and payment functions for Medicaid managed care. DHHS is also developing a longer-term roadmap for the additional functionality that will support broader quality and value goals. The state intends to maintain processes now in place to combine data sets to produce important maternal and child health process and outcome measures and measures related to infectious diseases. In addition, DHHS priorities include: (1) developing a standardized social needs screening instrument, with a focus on food insecurity, housing instability, and transportation; (2) assessing how best to ensure data are integrated with physical and BH services; and (3) providing training and support so that the tools are used efficiently and effectively.

All Payers Claim Database (APCD)

North Carolina does not have an APCD in place.

Results, Lessons Learned, and Next Steps

Results. Given the demonstration started in January 2019, no results are available at this point in time. The Healthy Opportunities Pilot includes rapid cycle assessments to determine what implementation strategies and which services are proving most and least effective and allow DHHS to re-deploy resources to those that are most promising. In the later years of the Pilots, part of the design will be a Sequential Multiple Assignment Randomization Trial (SMART) methodology to understand when and who would most benefit from services of escalating intensity. The Department will also conduct a summative evaluation to assess the impact of the services on health outcomes and health care costs of participating populations.

Challenges and Lessons Learned. Observations on implementation to date are limited. A recent Health Affairs article notes a range of potential challenges.[257] Many are shared broadly by states involved in the transition to Medicaid managed care and VBP, related to data infrastructure, coordination and alignment across different initiatives running concurrently, and engagement and support for providers as well as purchasers (and specifically for employers). Of particular concern for North Carolina are the importance of tailoring payment and data infrastructure approaches to achieve the demonstration's specific objectives related to SDOH and tailoring the model to North Carolina's demographic, socioeconomic, and geographic circumstances (e.g., rural and low-income communities).

Next Steps. North Carolina remains in negotiations with CMS related to several waiver requests that were not approved in this 1115 demonstration, including:

- Behavioral health and I/DD health home capacity building funds. Funding to support upfront investments to ensure that health homes are prepared to meet the needs of people with I/DD or significant behavioral health needs.
- Uncompensated care pool for tribal providers. Expenditure authority for an uncompensated care pool to address the high burden of uncompensated care borne by the Cherokee Indian Hospital Authority (CIHA), an Indian Health Service (IHS) hospital that serves as a primary health system for the EBCI population.
- Innovation workforce fund. Expenditure authority to establish an "Innovation Workforce Fund," which would support loan repayment and recruitment bonuses for targeted, critical Medicaid provider types. This would include financing for community health workers (CHWs).

Key Considerations for Alaska

Pilot programs that incorporate SDOH. North Carolina's Medicaid Transformation demonstration includes Healthy Opportunities Pilots, which allows Medicaid managed care plans (PHPs) to cover and coordinate evidence-based, non-medical interventions targeting housing stability, food security, transportation access, and interpersonal safety, the first pilot program of its kind. These pilots will allow the state to develop pathways to VBP and link payments for services to demonstration outcomes. In

addition, they will facilitate the gathering of data and experience necessary to develop complex, risk-based models. Findings and lessons learned from the Healthy Opportunities Pilots will allow North Carolina to incorporate successful pilots and strategies into its Medicaid managed care program as well as provide a framework for other states and managed care plans seeking to reduce health care costs and improve quality of care by addressing health-related social needs.

Develop state resources to support the integration of SDOH. In order to support the integration of SDOH within its Healthy Pilot Programs and more broadly within its Medicaid managed care program, North Carolina developed an interactive statewide map of SDOH indicators, including the economic, social and neighborhood, and housing and transportation status of residents across the state. This map can guide community investment and prioritize resources. In addition, the state has developed a set of standardized screening questions that providers can use (and PHPs will be required to use) to identify and assist patients with unmet health-related resource needs. Further, the Foundation for Health Leadership and Innovation (FHLI) administers NCCARES360, a statewide Resource Platform to connect residents with an identified need to community resources. The platform is a statewide public-private partnership of philanthropy, healthcare, and community partners that will include a call center and serve as a referral platform for providers, social workers, care coordinators and others to connect patients directly to community resources. One study notes that a shared data platform can help managed care plans close the loop on referrals and evaluate the impact of interventions on health outcomes, utilization, and spending.[265]

Engage stakeholders to identify community needs. Stakeholder engagement was instrumental in the development of the Demonstration program. In addition, engagement continues to be a key resource for the state to identify the needs of the community and develop resources for its providers, for example, the development of the standardized screening questions and NC Resource Platform.

Use a regional, phased-in approach to transition to managed care. North Carolina's transition to managed care for its Medicaid beneficiaries uses a regional, phased-in approach that provides beneficiaries, providers, and plans with time and flexibility to adjust infrastructure to meet the needs of this high-needs, complex population. North Carolina's phased in approach when shifting enrollees to managed care and establishing their care management strategy seeks to provide stability for Medicaid enrollees and providers during the transition to managed care, and flexibility for PHPs as they enter North Carolina's Medicaid system for the first time.

Develop integrated systems of physical and behavioral health care. Similar to Alaska, North Carolina had separate payment and delivery systems for physical health, behavioral health, and I/DD services, each delivered through different payment mechanisms (i.e., physical health services are delivered through FSS and managed through the PCCM program while behavioral health and I/DD services are delivered by local management entity-managed care organizations [LME-MCOs]). Through the Medicaid Transformation program, North Carolina is transitioning most beneficiaries into fully capitated PHPs that will allow the state to more closely coordinate physical, behavioral, and I/DD services for its Medicaid enrollees. PHPs will be required to provide integrated physical, behavioral, and pharmacy services at the launch of the managed care program through its standard plans and develop tailored plans that also include I/DD services for individuals with serious mental illness, SUD, and/or I/DD.

Case Study: Oregon Coordinated Care Organizations

Executive Summary

For over two decades, Oregon has committed to increasing health insurance coverage for low-income populations and better controlling the costs of Medicaid services. In 2009, the Oregon legislature established the Oregon Health Authority (OHA) to streamline health care purchased by the state and in 2012, the Centers for Medicare & Medicaid Services (CMS) approved **Oregon's Coordinated Care Organizations (CCOs)**, the foundation of the state's health system transformation. These comprehensive managed care organizations receive global budgets to offer integrated health services to Medicaid enrollees within defined regions of the state. The original five-year Medicaid demonstration achieved its goals of reducing statewide Medicaid spending growth and improving access to and quality of care for beneficiaries.

Oregon used the following strategies to achieve its health system transformation goals:

- ***Integration and coordination of health care services***. CCOs receive a global budget to provide whole-person care, which includes integrated physical, oral, and mental/behavioral health care. Integrating financial streams that were previously carved out for separate organizations allowed CCOs to achieve administrative efficiencies and better meet the needs of beneficiaries with co-occurring physical and behavioral health conditions. CCOs also focus on enrolling patients in patient-centered primary care homes (PCPCHs) to offer case management, support patients with special health care needs, and emphasize preventive health care services.
- ***Provision of flexible services that addressed non-clinical needs***. CCOs can also provide flexible services to members, which are nonmedical services that contribute to the triple aim of better quality of care, improved health outcomes, and lower costs. CCOs are responsible for addressing social determinants of health (SDOH), among other functions. CCOs offer a wide range of flexible services depending on the needs of their region and enrollees, including housing assistance and traditional health worker initiatives.
- ***Implementing alternative payment methodologies that incentivize value***. CCOs track their progress on a set of quality metrics that are reported to CMS as part of the waiver demonstration. In addition, CCOs can receive annual bonus payments tied to their performance on a set of incentive measures.

The next iteration of health system transformation, **CCO 2.0**, builds on lessons learned from the 2012-2017 demonstration and is focusing on improving the behavioral health system, promoting value-based payment models, increasing health equity, and maintaining sustainable cost growth. Key takeaways from Oregon's efforts include the following:

- ***Focus on regionalization, local governance and control.*** The CCO model is based on the principles of local governance and community-oriented solutions. There are 15 CCOs operating across Oregon and each is responsible for providing integrated health care to populations within their region, which allows CCOs to tailor programs to meet the needs of their local communities.

- ***Prioritize involvement of tribes in health care reform.*** In 2018, more than half of tribal members were still enrolled in FFS plans, in part due to concerns from tribes about reimbursement for Medicaid services. Ensuring network adequacy for Indian Health Care Providers and full inclusion of tribal representatives in all community engagement processes is a key priority for the next iteration of the CCOs.
- ***Maximize federal funding.*** Implementing the CCO model required significant federal investments and benefited from existing state-level health care delivery infrastructure.

In this paper we will examine health care reforms in the state of Oregon. This case study will focus on **Coordinated Care Organizations** in Oregon, the state's initiative to provide coordinated and integrated health care to the Medicaid population. We will also provide information on Oregon's regionalized approach to delivering health care and lessons learned from engaging tribal populations. The paper starts with background on state demographic and economic characteristics and moves to details on the approach. We discuss the background on reform and then provide an overview of the approach followed by details of its mechanics, structure, and implementation. This is followed by an examination of the results, lessons learned, and considerations for Alaska.

Background

State Characteristics – Demographics and Economic Indicators. Oregon has a population of 4,190,713 and a population density of 39.9 per square mile.[266] Out of 36 counties in Oregon, 23 are rural.[267] The percent of Oregon's population living in rural areas is much smaller than in Alaska, 16 percent in Oregon versus almost one third in Alaska. In 2017, the state's poverty rate was 13.2 percent, which was higher than the national rate of 12.3 percent, and the median household income was $56,119, lower than the national median household income of $57,652.[266] In 2018, the majority of Oregonians identified as White (87.1 percent), followed by White non-Hispanic (75.8 percent), Asian (4.7 percent), two or more races (3.8 percent), Black or African American (2.2 percent), American Indian or Alaska Native (AI/AN; 1.8 percent), and Native Hawaiian or other Pacific Islander (0.4 percent).[266] In addition, 13.1 percent of Oregonians identified as Hispanic or Latino. In October 2018, the unemployment rate was 3.8 percent and the five largest industries were 1) trade, transportation, and utilities; 2) government; 3) education and health services; 4) professional and business services; and 5) leisure and hospitality.[268] The Gross Domestic Product (GDP) of Oregon was approximately $559 billion in the second quarter of 2018, while the per-capita real GDP was $50,138 in 2017.[123] The total operating budget from 2017-2019 is $75.7 billion.[269] Exhibit OR1 provides a summary of Oregon's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit OR1. Demographics and Economic Indicators

	Oregon	Alaska	U.S.
Population, as of July 1, 2018[266]	4,190,713	737,438	327,167,434
Rurality			
Population per square mile, 2010[266]	39.9	1.2	87.4
Share of population in rural areas, 2017[270]	16%	32%	14%
Race/Ethnicity, 2017[266]			
White Alone	87.1%	65.8%	76.6%
Two or more Races	3.8%	7.4%	2.7%
Black or African American Alone	2.2%	3.7%	13.4%
Asian Alone	4.7%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	1.8%	15.3%	1.3%
Hispanic/Latino	13.1%	7.1%	18.1%
**White non-Hispanic	75.8%	60.8%	60.7%
Poverty			
Median Household Income (2017 Dollars[266]	$56,119	$76,114	$57,652
Minimum Wage, 2019[271]	$10.75	$9.89	$7.25
Share of Population in Poverty (2017)[266]	13.2%	11.1%	12.3%
Economy			
Unemployment Rate, as of December 2018[268]	3.8%	6.3%	3.9%
Gross Domestic Product (GDP), 2017[123]	$559 billion	$52.8 billion	$19.5 trillion
Per Capita Real GDP, 2017[123]	$50,138	$70,683	$55,418
Expenditures, SFY 2017[140]	$40.0 billion	$9.7 billion	$1.9 trillion
Expenditures per Capita, SFY 2017[29]	$9,665	$13,171	$5,976

[1313]**State Health Insurance Market – Health Coverage and Uninsured.** In 2014, health care expenditures in Oregon totaled $31.9 billion.[229] In the same year, per-capita health care expenditures were $8,044.[124]

Private Health Insurance Market. In 2017, 47.5 percent of Oregon residents had private group health insurance, including employer-sponsored health plans, student health insurance, and military-affiliated health insurance programs.[272] In addition, 5.2 percent had individual private insurance, including plans purchased through the Oregon health insurance marketplace. In 2014, private health insurance spending was $4,232 per capita.[273] From 2001 to 2014, the average annual percent growth in private health insurance spending was 5.4 percent, which was similar to the national average of 5.3 percent.

Private Health Insurance Market. In 2017, 47.5 percent of Oregon residents had private group health insurance, including employer-sponsored health plans, student health insurance, and military-affiliated health insurance programs.[272] In addition, 5.2 percent had individual private insurance, including plans purchased through the Oregon health insurance marketplace. In 2014, private health insurance spending was $4,232 per capita.[273] From 2001 to 2014, the average annual percent growth in private health insurance spending was 5.4 percent, which was similar to the national average of 5.3 percent.[82] In 2016, the largest insurer in the large group insurance market, Kaiser Foundation Health Plan of the Northwest,

held 42 percent of the market share, and the largest insurer in the small group insurance market, Providence Health Plans, held 27 percent.[274,275]

State Employee Health Care System. OHA purchases health care for the Oregon's Public Employees' Benefit Board (PEBB), which offers coverage for employees of Oregon state government agencies, Oregon's seven public universities, local Governments, and semi-independent state agencies.[276,277] There are approximately 136,000 individuals in the member pool, 53,000 of which are employees and 83,000 of which are covered dependents.[276] In addition, OHA purchases health care for the Oregon Educators' Benefit Board (OEBB). Employees of many of the state's K-12 school districts, education service districts, community colleges, charter schools, and local governments are eligible. Both PEBB and OEBB offer plans for retirees.

Health Insurance Marketplace. Oregon participates in the federal health insurance marketplace. In the 2018 open enrollment period from November 1 to December 23, cumulative individual plan selections totaled 156,105.[278]

Medicaid and CHIP Program and Population. In 2017, 26 percent of Oregon residents were enrolled in Medicaid, referred to as the Oregon Health Plan (OHP).[272] Approximately 43 percent of the state's Medicaid population is under age 18.[279] In 2017, total Medicaid spending was $8,383,182,732.[280] Oregon is set to have the greatest Federal Medical Assistance Percentage (FMAP) decrease among states between fiscal years 2018 (63.62 percent) and 2019 (62.56).[42] In FY2019, FMAP rates range from 50 percent (14 states, including Alaska) to 76 percent (Mississippi).[42] In 2014, Medicaid spending was $6,207 per enrollee, $13,334 per aged individual, $16,252 per individual with disabilities, $5,663 per adult, and $2,737 per child.[281] Oregon is a Medicaid expansion state.

Eligible Medicaid enrollees include pregnant women with income up to 190 percent of the federal poverty limit (FPL); children aged 1 through 18 with income up to 138 percent of the FPL; infants born to women receiving Medicaid benefits at the time of birth with incomes up to 190 percent of the FPL; foster care and substitute care children; low-income adults with income up to 138 percent of the FPL; and the aged, blind, and disabled population. Some women with breast and cervical cancer are also eligible for Medicaid in Oregon. Specifically, women with breast or cervical cancer can qualify for Medicaid if they are under 65, were screened and diagnosed through the National Breast and Cervical Cancer Early Detection Program, and lack adequate coverage for cancer treatment. In 2018, Oregon also began offering Medicaid/CHIP coverage to income-eligible children who would otherwise not be eligible for coverage because of immigration status. Medicaid coverage for this population is funded by the state.[282] Exhibit OR2 describes Medicaid eligibility levels as of January 2018.

Exhibit OR2. Medicaid Eligibility Levels, as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
Oregon	138% FPL	138% FPL	305% FPL	190% FPL	73% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

As detailed below, Oregon implemented a system of Coordinated Care Organizations (CCOs) to manage the health of its Medicaid enrollees. As of 2018, 93 percent of the Medicaid population is enrolled in a CCO, while 7 percent is in a FFS program or other type of delivery system.[89] As of 2019, there are 15 CCOs in Oregon.

Uninsured Population. In 2017, Oregon's uninsured rate was 6.2 percent.[283] The Oregon Health Authority (OHA) also estimates that between one-third and one-half of Oregonians could be underinsured, as defined by spending large out-of-pocket costs for medical care, experiencing difficulties paying for medical care, or declining to receive medical care because of high costs.[284]

Providers and Service Use. In 2016, there were 59 hospitals, 83 Medicare-certified rural health clinics, 31 community health centers, and 212 community health center service delivery sites in Oregon.[150,142,51] Of these hospitals, 18.6 percent were owned by state or local government (0.2 beds per 1,000 population); 78 percent were owned by non-profit entities (1.4 beds per 1,000 population); and 3.4 percent were owned by for-profit entities (fewer than 0.05 beds per 1,000 population).[285] In 2018, a total of 5,839 primary care and 5,947 specialists were actively practicing in Oregon.[286,146] The state has 127 total primary care Health Professional Shortage Area (HPSA) designations, which includes just over one-fourth of the total population of Oregon.[97]

Tribal Health. There are nine federally recognized tribes in Oregon. In 2018, the state reported that there were 34,346 tribal members who were enrolled in Medicaid in Oregon, of which 52.6 percent were covered under FFS and 47.4 percent were part of a CCO.[287]

History of Reform

Impetus for Health Care Reform. Oregon's 2012 health care transformation was championed by then-Governor John Kitzhaber, a physician who was the chief author of the original 1994 Oregon Health Plan.[288] In 1994, Oregon received a Section 1115 Demonstration waiver from CMS to implement a full-risk, capitation-based managed care program for Medicaid enrollees called the Oregon Health Plan (OHP).[288] Mental health and oral care funds were managed separately by mental health organizations and dental care organizations, respectively. While this managed care structure led to some improvements in cost containment and care quality, Medicaid costs mounted.[289] Oregon's state budget was also severely affected by the Great Recession from 2008 to 2010, during which the state unemployment rate doubled. When Governor Kitzhaber won a third term as governor in 2010, the state was experiencing a $1 billion deficit in its Medicaid budget.[290]

In 2009, the Oregon legislature began working toward comprehensive health reform. The legislature established the *Oregon Health Authority* (OHA) to streamline health care purchased by the state. The legislature also established the Oregon Health Policy Board (OHPB) to direct policymaking and provide general oversight to OHA.[289] In 2010, OHPB released Oregon's *Action Plan for Health*, a blueprint for strategies to achieve the triple aim of decreasing health care costs, increasing quality of care, and improving the lifelong health of Oregon residents.[291] The key strategies outlined in the plan included reforming payment mechanisms, focusing on prevention, decreasing inequities, increasing access to care, promoting safe and effective models of care delivery, increasing collaboration and engagement, and measuring progress.

The *Action Plan for Health* included recommendations for two key facets of health care transformation in Oregon: primary care homes and CCOs. First, the plan called for the state to "move decisively to patient-centered primary care" in order to offer coordinated and comprehensive primary care services to all Oregonians.[291] In 2009, the state legislature approved the Patient-Centered Primary Care Home (PCPCH) Program, with a goal of allocating at least 75 percent of Oregon residents to a PCPCH by 2015.[70] Practices with a PCPCH designation must meet core standards of care that is comprehensive, continuous, accessible, accountable, coordinated, and patient- and family-centered.

Second, the plan described a vision for a "coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian."[291] In 2011, Governor Kitzhaber and OHA convened a group of health stakeholders to develop a framework for CCOs, a new delivery system model for their Medicaid program.[290] CCOs are regional collaboratives that receive a global budget to provide integrated physical, mental, and dental health care. In addition, CCOs are responsible for promoting prevention, helping patients manage chronic conditions, and addressing social determinants of health (SDOH), among other functions.[292] CCOs require health plans to collaborate not only with providers, but also with local public health systems, social service providers, community-based organizations, early childhood organizations, and other entities with a stake in health.[292]

The Oregon House of Representatives approved the framework for CCOs in 2011 and directed OHPB to develop an implementation plan which was approved by the Oregon in 2012.[290] The state submitted a section 1115 waiver application and received federal approval to implement the new delivery system model in July 2012.

Oregon also received funding from some federal initiatives to support the formation of CCOs. In particular, the Center for Medicare and Medicaid Innovation (CMMI) awarded Oregon a $45 million State Innovation Model (SIM) grant to support payment realignment, develop the CCO delivery model, and establish a Transformation Center that helps CCOs share best practices and provide technical assistance.[293] In addition to testing the global budget structure for the CCOs, the SIM grant also allowed Oregon to test models for alternative payment mechanisms for providers.

In 2017, OHA released the 2017-2019 Refresh of the Action Plan for Health.[294] The updated plan acknowledges the progress that Oregon achieved since 2010 and identifies new strategic opportunities to achieve the triple aim. Key actions include continuing to shift to paying for outcomes and value, addressing upstream factors that affect health, improving health equity, increasing access to care, and enhancing care coordination. The plan calls for a "public health approach" that emphasizes evidence-based methods and focuses on SDOH and other root causes of inequities.

Preexisting Models and Infrastructure that Facilitated Health Reform. Oregon's health system infrastructure and preexisting models helped the state to establish CCOs, enroll Medicaid patients, and determine what kinds of services OHP should cover. First, Oregon had already invested heavily in managed care prior to implementing the CCO model. Many current CCOs were previous Medicaid Managed Care Organizations (MCOs) that made changes and built new partnerships to meet the financial and operational requirements for CCOs. Second, a unique aspect of OHP is the Prioritized List of Health Services, which lists treatments covered by OHP by clinical and cost effectiveness

Overview and Implementation of the Initiative

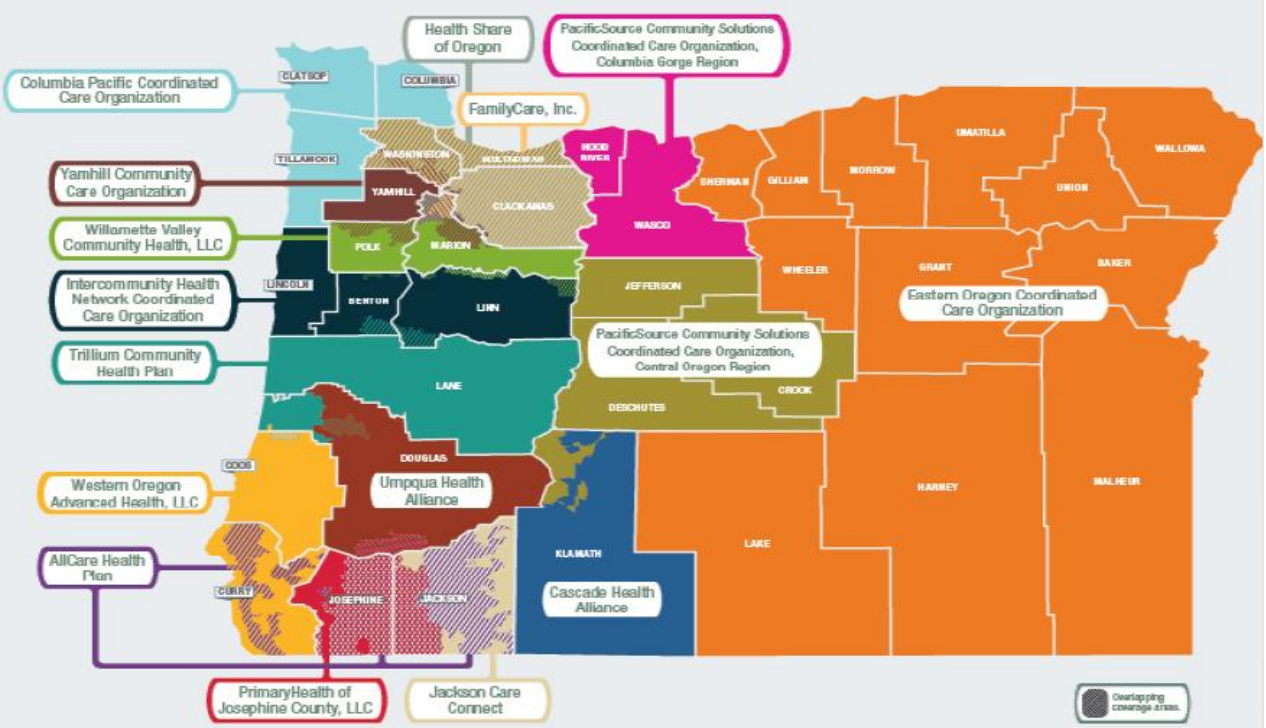
The CCO model involves six key elements:

1. Implementing best practices to manage and coordinate care, which involves promoting the use of health care integration, primary care homes, health information technology, and value-based payment designs;
2. Promoting shared responsibility for health, including shared decision-making between providers and patients, providing benefits for healthy behavior, and engaging community members and stakeholders in advisory councils;
3. Measuring performance through metrics that are aligned and regularly assessed across CCOs;
4. Paying for outcomes and health, which includes paying for performance on a set of common quality measures;
5. Providing clear information, such as the price of services and comparative progress on outcome measures among different CCOs; and
6. Maintaining costs at a sustainable rate of growth.

Goals for Health Care Reform. Oregon's waiver stated two key goals for health care transformation: 1) focus on reducing growth of per-capita Medicaid spending by two percentage points, and 2) focus on improving access to and quality of care in the state over the five-year period compared to a baseline level of performance. OHA sought to achieve these goals by reducing waste, improving health, creating local accountability, aligning financial incentives, paying for performance and outcomes, and creating fiscal sustainability.

Population, Scope, and Participation. Each of the 15 CCOs serve a defined region of Oregon (see Exhibit OR3). All patients enrolled in Oregon Health Plan (Medicaid) are assigned to their regional CCO. As of 2019, Oregon will begin auto-enrolling dual eligible individuals in CCOs.[368] In 2018, OHA reported that 56.8% of dual eligible members had voluntarily enrolled in a CCO.[368]

Exhibit OR3. CCO Coverage Areas, Regions, and Names



Reproduced from OHA. Source: https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/le8116.pdf

Enrollment in a CCO is mandatory for almost all of the Medicaid population into a CCO. Notable exemptions include AI/ANs and related groups; mandatory enrollment of tribal members is prohibited by Oregon state statute.

Implementation of Initiative

Timeline and Implementation Process. As soon as CMS approved the 1115 Medicaid demonstration waiver in mid-2012, Oregon began a full-forward implementation of the CCO model, which has a flexible organization. The central organization of some CCOs is a previous MCO that continues to contract out with providers to fully integrate behavioral, dental, and physical health for their members.[295] Some CCOs do not have a central organization, but are composed of an alliance of former MCOs, health systems, practices, and public health departments. Other CCOs were formed through new partnerships and serve areas not previously covered by MCOs. For example, in rural Yamhill County, representatives from the government, providers, and a local hospital joined to establish the Yamhill Community Care CCO, a nonprofit organization.[296]

OHA required each CCO to develop a transformation plan in late 2012 to describe how they would make progress in eight key areas of transformation (see Exhibit OR4) and establish benchmarks for performance metrics.[369]

Exhibit OR4. Areas of Transformation

1. Develop and implement a health care delivery model that integrates mental health (including addiction and severe and persistent mental illness); physical health care; and dental health.
2. Continue implementation and development of Patient-Centered Primary Care Homes.
3. Implement consistent alternative payment methodologies that align payment with health outcomes.
4. Prepare a strategy for developing the Community Health Assessment (CHA) and adopt an annual Community Health Improvement Plan (CHP).
5. Develop a plan for encouraging electronic health records, health information exchange, and meaningful use.
6. Assure that communications, outreach, member engagement, and services are tailored to cultural, health literacy, and linguistic needs.
7. Assure that the culturally diverse needs of members are met (e.g., cultural competence training, provider composition reflects member diversity, nontraditional health care workers composition reflects member diversity).
8. Develop a Quality Improvement Plan focused on eliminating racial, ethnic, and linguistic disparities in access, quality of care, experience of care, and outcomes.

Reproduced from OHA: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Oregon-CCO-Transformation-Plans.aspx

Stakeholder Engagement. Since the beginning, the state has pursued an inclusive, transparent, and communicative public process for implementation and monitoring. OHPB consistently convenes workgroups of state agency representatives, holds community meetings, and solicits public comments in order to inform the development of their policies and recommendations for change.[290] To develop the original Health Action Plan, OHPB met with more than 300 stakeholders and 800 members of the public through roundtable discussions and community engagement meetings.[291] Several advisory groups also helped develop and implement the CCO model. For example, OHPB convened workgroups of state agency representatives and other stakeholders to develop the original CCO framework for the state legislature.[290]

In the past, some policymakers and advocates have criticized CCOs for lacking transparency about their governance, decision-making, and spending.[297] In April 2018, Governor Kate Brown signed a new CCO transparency bill into law.[298] CCOs are now required to open all governance meetings to the public, make meeting recordings available to the public, and provide opportunities for members of the public to offer testimonies. In addition, OHA releases quarterly transformation progress reports that give CCO-specific updates on performance measurements, utilization, and costs.

Ongoing engagement activities include the following:

- **Committees.** Five committees help lead policy development and stakeholder engagement at OHPB: the Health Care Workforce Committee, the Public Health Advisory Board, the Health Information Technology Oversight Council, the Health Plan Quality Metrics Committee, and the Health Equity Committee. CCOs also have their own committees at OHA, including the CCO Metrics and Scoring Committee and the CCO Member Engagement and Outreach Committee.

- **Technical Advisory Groups.** Technical advisory groups regularly provide subject matter guidance to CCOs. For instance, the Metrics Technical Advisory Group meets periodically to advise the Metrics and Scoring Committee on CCO incentive metrics. Many of the technical advisory groups are open to the public.
- **Public Engagement.** OHPB solicits input from members of the public and OHP consumers to guide strategic planning processes. For example, OHPB conducted public forums and surveys with OHP members and other stakeholders to plan for the next phase of health care transformation.[287] In addition, all outcome and quality measures have been determined through a public process.
- **Governance Boards and Advisory Councils.** Stakeholders are engaged through Governance Boards and Community Advisory Councils (CACs), of which 51 percent are Medicaid consumers and that include at least one representative from each county government in the CCO region.[292] CACs are responsible for directing the CCOs' community health needs assessment, which identifies regional and local health priorities, and community health improvement plan, which establishes goals and actions to increase the health status of community members.[299] In addition, one member of each CAC must serve on the CCO Governance Board. CCOs may choose to organize several CACs, depending on their geographic region and member population. For example, the Eastern Oregon CCO has 12 local CACs and 1 regional CAC.

Transformation Center. OHA used SIM grant funds to establish the Transformation Center, an innovation hub that supports CCOs in achieving health system transformation. The Center facilitates CCO learning collaboratives, organizes trainings, and consults with CCOs to offer personalized technical assistance[16]The Center also helps CCOs develop their Community Health Assessments, Community Health Improvement Plans, and Transformation Plans.

Role of tribes. Tribal leaders played an active role in the development of the CCO framework through participation in the Health Care Transformation Committee. Tribal leaders expressed concerns with shifting their health care delivery arrangement from fee-for-service to managed care because Medicaid is a key source of revenue for poorly funded IHS clinics and tribal providers.[300] Tribal leaders also described concerns about decreased access to services for tribal members if tribal providers were unable to attain in-network status.[300] OHA did not originally release guidance for involving tribes or tribal providers in CCOs in 2012.

In 2017, OHA announced a partnership with a nonprofit health insurance company, CareOregon, to build a care coordination model for AI/AN members enrolled in Medicaid fee-for-service.[301] Oregon's nine federally recognized tribes asked OHA to develop the model in order to provide culturally appropriate care coordination services that directly engaged tribal health care systems.[301] In 2018, OHA also established a Tribal Consultation and Urban Indian Health Program Confer Policy that describes the process for communicating and working with tribes on health policies and programs that affect tribal health.[302]

Other Parallel Health Reforms and Infrastructure. Oregon is implementing three other key initiatives as part of its health care transformation: the federal Comprehensive Primary Care (CPC) Initiative, the Hospital Transformation Performance Program (HTPP), and the Oregon Accountable Health Community.

- **Comprehensive Primary Care (CPC) Initiative**. The implementation of the CPC Initiative in Oregon was built on the existing infrastructure of state PCPCHs. In addition, CMS selected Oregon to participate in the CPC Initiative in 2012. Through this model, CMS works with Oregon health insurance plans to support key comprehensive primary care functions, including care management, coordination, and continuity. Health plans offer population-based care management fees and shared savings opportunities to participating primary care practices that meet these functions. In 2017, CMS selected Oregon as a CPC Plus (CPC+) state, which provides additional support to practices seeking to reform primary care and those already delivering advanced primary care. As of 2017, 155 primary care practices and 13 CCOs are participating in the CPC+ advanced medical home model.
- **Hospital Transformation Performance Program (HTTP)**. In 2014, Oregon also established HTPP, which was approved through OHA's section 1115 waiver agreement with CMS.[303] Funding for HTPP comes from the Hospital Provider Assessment Program authorized by the Oregon Legislature with Oregon's DRG hospitals paying the provider assessment. HTPP is structured so that providers receive funding by meeting targets tied to certain metrics and outcomes. All hospitals participate in HTPP and receive incentive payments for meeting a set of 11 hospital incentive measures. An overarching focus of these measures is building coordination between hospitals and CCOs. Metrics in a hospital-CCO collaboration focus on following up with CCOs after hospitalization for illness; providing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the emergency department (ED); and reducing revisits for frequent ED users. OHA considers HTPP to be integral to the state's health care transformation.[303]
- The **Oregon Accountable Health Community**, led by the Oregon Health & Science University, helps clinical sites better understand and address their patients' social needs by screening Medicare and Medicaid beneficiaries to identify five health-related social needs; providing a tailored referral summary to community services; providing personalized navigation to services; and facilitating sharing of data across clinical and social service sites.

Details and Mechanics of Approach

Governance and Organizational Characteristics. Local governance is a defining feature of the CCO model. Both nonprofit and for-profit entities own CCOs. The corporate status of CCOs includes private corporations, LLCs with single and multiple owners, 501(c)(3) and 501(c)(4) organizations, and publicly traded corporations. Each CCO has a Governance Board that includes at least two community members, at least two actively practicing health care providers, and local health system stakeholders who bear financial risk for patient outcomes. One of the health care providers must be a primary care physician or nurse practitioner, and another must be a mental health or chemical dependency treatment provider. As described below, each CCO also has at least one CAC.

Payment Mechanisms. CCOs receive risk-adjusted, prospective global budgets to meet the integrated health needs of members. CCOs use global budgets not only to pay for physical, dental, and behavioral health care, but also fund non-medical services that address SDOH. Oregon pays capitation rates to CCOs on a per-member per-month basis. Rates are geographically determined and split into the Central/Eastern region, Northwest region, Southwest region, and Tri-County (Portland Metro) region. In addition, rates differ by category of aid, such as adults between 19 and 64 who receive Temporary Assistance to Needy Families (TANF); children in adoptive, substitute, or foster care; and ACA Medicaid expansion

populations, among others. The CCO model also features a two-phase payment scheme for meeting targets for quality measures. Total funds for incentive payments are combined into a "quality pool." Phase 1 of the quality pool distribution depends on both the number of enrolled members and performance on the 18 incentive metrics (see Exhibit OR5). In Phase 2, remaining funds are re-pooled into a "challenge pool." The challenge pool funds are distributed to CCOs based on their performance on four additional measures, which may change from year to year per the recommendation of the Metrics and Scoring Committee and their technical advisors.

Exhibit OR5: Percent of Quality Pool Payment by Number of Targets Met for Incentive Measures

Number of targets met	Percent of quality pool payment (%)
At least 12, including EHR adoption and at least 60% PCPCH enrollment	100
At least 12, not including EHR adoption or less than 60% PCPCH enrollment	90
At least 11.6	80
At least 10.6	70
At least 8.6	60
At least 6.6	50
At least 4.6	40
At least 3.6	30

Past challenge pool metrics have included:

- Diabetes HbA1c poor control
- Depression screening and follow up
- Developmental screening
- Alcohol and drug misuse screening (SBIRT)
- Cigarette smoking prevalence
- Childhood immunization status
- Assessments within 60 days for children in Oregon Department of Human Services custody
- Timeliness of prenatal care

Alignment among Payers. From 2014 to 2016, OHPB convened the Coordinated Care Model Alignment Work Group to align the principles of the CCOs' coordinated care model among PEBB, OEBB, the individual health insurance marketplace, and the broader market.[304] The work group developed several resources to help implement coordinated care across the markets, including a framework for procurement and contracting that describes best practices and suggestions for paying for value-based care.[305]

Federal Assistance and Cost. In July 2012, the U.S. Department of Health and Human Services agreed to give Oregon $1.9 billion in funding as part of the demonstration waiver to implement the CCO

model over the course of five years. The state received $620 million in 2012, $620 million in 2013, and smaller annual amounts thereafter. As described above, the SIM grant provided an additional $45 million to support the development of CCOs.

Quality Measurement. The Metrics and Scoring Committee is responsible for developing incentive quality measures for CCOs through a public process. The committee revises benchmarks and improvement targets for quality measures every year. Benchmarks are typically determined by national Medicaid percentiles, CCO percentiles, or through committee consensus. For example, the 2018 benchmark for ED utilization was 44.2 visits per 1,000 member months, which represents the 2017 national Medicaid 90th percentile. Improvement targets are typically calculated with the Minnesota method, derived from the Minnesota Department of Health's Quality Incentive Payment System. This method requires a minimum 10 percent reduction between the baseline rate and the benchmark in order to meet the target. Quality measures include patient satisfaction with care. In 2017, statewide patient satisfaction with care increased by 2.6% over the previous year, with 13 CCOs showing improvement and 8 CCOs achieving the target benchmark[370].

Incorporation of Social Determinants of Health

CCOs are tasked with addressing SDOH that affect the ability of their members to live healthy lives. OHA emphasizes the role of "traditional" health workers in helping to connect members to social services and providing outreach, system navigation, and health coaching. OHA specifies five different types of traditional health workers: community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators.

CCOs are designed to achieve a high level of integration across clinical and social services. The organizations receive a global budget to provide whole-person care, which includes integrated physical, oral, and mental/behavioral health care. CCOs can also provide flexible services to members, which are nonmedical services that contribute to the triple aim of better quality of care, improved health outcomes, and lower costs. Individual-level services include housing assistance (e.g., rent payments, temporary housing, and housing repairs); fruit and vegetable prescriptions; and transportation assistance. Group-level services include educational programs, community health worker initiatives, and support for homeless shelters and farmers markets. In addition, CCOs are required to build partnerships with Early Learning Hubs, which are regional collaborations that promote coordination among early learning and early childhood services in Oregon. OHA is exploring the possibility of creating an additional shared incentive metric with the Early Learning Hubs in order to assess kindergarten readiness.

In April 2018, Oregon's Medicaid Advisory committee made policy recommendations to OHA on incorporating additional SDOH into CCOs.[306] These recommendations are summarized in Exhibit OR6.

Exhibit OR6. Summary of Recommendations of the Medicaid Advisory Council to OHA

1. Increase tracking of CCO SDOH initiatives and policies, spending, and outcomes data, and share information publicly to identify best practices and areas for improvement. Use increased tracking and data to establish clear goals and metrics to assess CCO spending and work on SDOH and equity.
2. Increase expectations for CCOs to assess health inequities, and establish infrastructure and systems to improve health equity.
3. Ensure CCOs are using the unique tools provided by the CCO model to spend on SDOH, including health-related services, and to invest additional savings and profits back into the community to impact SDOH.
4. Strengthen requirements for CHAs and CHPs, to ensure CCOs work with appropriate community partners and include SDOH and equity strategies in their CHAs and CHPs.
5. Establish clear expectations that CCOs have the necessary connections and relationships in the community to advance community-driven work in SDOH (e.g., community based organizations, social service organizations, public health, etc.).
6. Provide SDOH learning and information-sharing opportunities for CCOs to promote replication and scaling up of SDOH efforts.

Implementation of the HIT and Data Analysis Infrastructure

Oregon has a legislatively established Health Information Technology Oversight Council (HITOC) that provides strategic direction for statewide implementation of health information technology and health information exchange.[301] HITOC developed Oregon's Strategic Plan for Health Information Technology and Health Information Exchange for 2017–2020, which describes HIT efforts to support value-based care, promote health information exchange, implement HIT infrastructure, and develop long-term HIT sustainability.[307] In 2015, the state also established the Oregon Health Information Technology Program within OHA, which is tasked with managing HIT initiatives across the health system.

Several HIT initiatives have helped or will help CCOs collect, track, and report on data related to access to care, care quality, and health outcomes. For example, the Emergency Department Information Exchange (EDIE) provides critical information about ED hospitalizations to participating CCOs. All hospitals in Oregon have implemented EDIE, largely with investments from OHA that were funded through the SIM grant.[308] CCOs, health plans, and providers receive information from EDIE through a complementary program called PreManage, which shares data about admissions and discharges.[308] Oregon is one of several states, including Alaska, using the EDIE and PreManage systems. The state is also developing a Clinical Quality Metrics Registry to help CCOs report on quality metrics that are captured from electronic health records.[307]

All-Payer Claims Database (APCD)

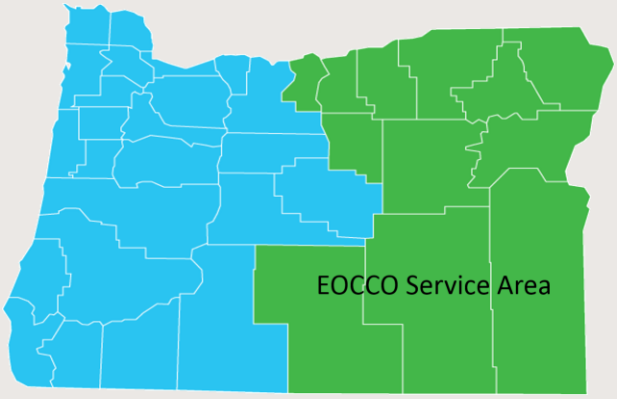
The Oregon state legislature authorized the Oregon All Payer All Claims Database (APAC) in 2009. APAC aims to provide a comprehensive data source of health care costs, quality, and utilization in Oregon.[309] According to the Oregon Revised Statutes for Health Care Data Reporting, APAC was

designed to meet the following purposes: determine the demand and distribution of health care resources; provide better information to policymakers and consumers; evaluate the effects and costs of interventions on health outcomes; improve the quality and affordability of health care and insurance; and identify health disparities.[310]

Since 2011, APAC has collected information about claims and other relevant data for all individuals covered by private insurance, Medicaid fee-for-service plans and CCOs, and Medicare Parts A, B, C, and D.[310] From 2011 to 2016, APAC received between 42 to 51 million medical claims and 36 to 46 million pharmacy claims per year. APAC collects information on:

- Medical and pharmacy claims that are both charged and paid;
- Member enrollment information, including basic demographic information;
- Provider information, including provider identifiers, locations, and specialties; and
- Premium information, including the total premium amounts billed to members.
- As of 2017, APAC is also collecting information on alternative payment models, including capitation.[310]

Case Study: The Eastern Oregon Coordinated Care Organization (EOCCO)



Background. EOCCO serves Medicaid beneficiaries in 12 rural counties in Eastern Oregon, a service region that contains almost half of the land area of the state, but only 5% of Oregon's total population.[371] Prior to implementing the CCO model, six counties had individual Medicaid MCOs, and the delivery of behavioral, mental, and physical health care was largely fragmented.

Governance. EOCCO is owned by eight entities: Greater Oregon Behavioral Health, Inc.; Moda Health Plan; Good Shepherd Health Care System; Grand Ronde Hospital; Saint Alphonsus Health System; St. Anthony Hospital; Eastern Oregon Independent Physicians Association; and Yakima Valley Farm Workers Clinic.[371] These organizations, in addition to other stakeholders and providers, are represented on the 17-member governing board of the CCO. Each of the 12 counties in the service region has its own CAC that meets monthly to discuss key issues and help make decisions. These local CACs inform the regional CAC, which reports to the governing board.

Programs. EOCCO offers members additional services and programs that are intended to address nonmedical needs, improve patient engagement, and increase access to care. For example, the Free Ride Program allows members without access to transportation to request free rides to any covered medical, dental, or behavioral health appointments.[371] EOCCO also offers classes to help members manage chronic and behavioral health conditions, such as an online pain school that provides strategies for managing chronic pain and reviews treatment options.

EOCCO established a Transformation Grant program to reinvest funds from its share of the incentive quality pool in order.[311] EOCCO's 2018 grant program focused on projects that sought to increase rates of adolescent well care visits and colorectal cancer screenings, reduce ED utilization, implement population health management strategies for chronic health conditions, and improve reporting for incentive measures. Grantees include local CACs, local health departments, community coalitions, medical practices, farm workers clinics, hospitals, and other community-based organizations. Some projects are focusing on rural health care access and delivery. For example, EOCCO granted $50,000 to Advantage Dental in 2018 to help fund the Oregon Telehealth Network for Oral Health, a program that helps improve the oral health of rural children.

SDOH. EOCCO has made investments to address upstream factors that affect the health and well-being of members. For example, EOCCO has built relationships with public health agencies that offer population-based community services[372]. Efforts funded through these partnerships include maternal case management programs that provide home visits and connect pregnant women with community resources. EOCCO also uses Transformation Grants to fund programs that focus on SDOH. For example, one grantee used grant funds to integrate social and health services and develop a universal referral process for at-risk children and families. EOCCO also funds Community Health Workers to provide resource navigation and enroll eligible CCO members into benefits programs.

Results, Lessons Learned, and Next Steps

Results. An independent evaluation of the CCO model compared outcomes from 2011 to 2015 to a similar Medicaid population in Washington State.[312] While Washington also expanded Medicaid in 2014, the state did not undertake major Medicaid reforms in the study timeframe.[312]

- ***Reductions in spending growth.*** Total spending per-member per-month decreased by a greater percentage among Oregon CCO members when compared to Washington Medicaid members.[312] The larger decrease among Oregon CCO members was driven by reduced spending on inpatient facilities. While Oregon met the conditions of reduced growth in per-capita spending established by the waiver, the state experienced significant increases in spending on prescription drugs when compared to a baseline. However, prescription drug spending was lower among Oregon CCO members than Washington Medicaid members.
- ***Improvements in quality of care.*** The evaluation reported mixed results for improvement of quality measures. For example, from 2011 to 2015, the rate of avoidable ED visits decreased significantly among Oregon CCO members in comparison to Washington Medicaid members.[312] A separate analysis conducted by the state also reported that from 2012 to 2017, avoidable ED visits decreased by nearly half among CCO members compared to a baseline rate and hospital readmissions decreased by one-third compared to a baseline rate. However, CCOs did not achieve improvements in many measures related to prevention, care coordination, services integration, and chronic disease management. For example, the rate of glucose testing for people with diabetes decreased marginally among Oregon CCO members and increased slightly among Washington Medicaid members.[312]
- ***Improvements in patient experience of care.*** Four key measures for experience of care improved consistently from year to year from 2011 to 2015.[312] CCO members reported improved ratings for overall health care, specialist care, communication from providers, and customer service.
- ***Improvements in health status.*** Similarly, self-reported health status improved from year to year from 2011 to 2015. The number of people who rated their overall health as "good" or better increased consistently.

- ***Decreased access to care.*** Most measures of access to care decreased slightly from 2011 to 2015.[312] Researchers attribute these decreases to Medicaid expansion in 2014: the influx of recently enrolled CCO members could have limited the ability of existing CCO members to receive services.

Challenges and Lessons Learned. Evaluations of the CCO model have documented several challenges and lessons learned related to the implementation process. Key considerations include:

- ***Report spending on and measuring impact of flexible services***. CCOs record total spending on flexible services and the number of members who receive these services on quarterly financial reports.[312] However, many CCOs may be underreporting their flexible services because of difficulty attributing services to specific members. For example, CCOs may provide money to a food pantry that serves their target population, but may be unable to identify the specific members that are affected.[312]
- ***Establish greater transparency for governance boards***. The Oregon state legislature passed a bill in 2018 in order to promote transparency among CCO governance boards. The legislature now requires that governance boards be open to the public, which will provide policymakers, stakeholders, and consumers with greater insight about decision-making.
- ***Improve monitoring of access to and timeliness of care***. External evaluation reports state that most CCOs do not monitor enrollees' access to care for all required primary care, behavioral health, and dental care services.[313] In addition, most CCOs do not measure timeliness of access of care to these key health services.[313] Improving tracking and monitoring of these measures could identify important gaps in services and opportunities to better meet patient needs.

Next Steps. Independent evaluators recommended several strategies for continued transformation of health care through CCOs.[312]

- Value-based payment: Increase payments for quality and access, increase the threshold of targets for receiving payment from the quality pool, and report more detailed information about VBP agreements.
- Improve care coordination and integration: Provide additional funding and incentives to encourage clinics to improve the functionality of EHRs and address billing issues that create challenges to integrating health services.
- Improve health services: Create a centralized hub of reporting and regulations information for CCOs and stakeholders, and require additional data reporting on person-level use of services.
- SDOH: Suggest committing additional resources from the global budget, which will help address challenges outside of the health system that affect health.
- Promote sustainable spending: Identify strategies to reduce the growth of spending on prescription drugs.

In 2018, OHA released policy recommendations and proposed work plans for "CCO 2.0," the next phase of Oregon's health care transformation[373]. These policies aim to address persistent challenges in four key areas over the next five years:

- ***Improve the behavioral health system.*** Suggested policies include incentivizing behavioral and oral health integration into primary care, developing a diverse and culturally responsive workforce, and requiring CCOs to be fully accountable for the behavioral health benefit.
- ***Increase value and pay for performance.*** OHA will focus on shifting from fee-for-service to value-based payments in several areas of care. By 2024, OHA aims to achieve a 70 percent rate of value-based payment in each CCO. CCOs will be asked to create specific growth targets and to increase their support for PCPCHs.
- ***Maintain sustainable cost growth***. OHA will focus on maximizing efficiencies, strengthening financial incentives, and developing better tools for reporting and evaluation.
- ***Focus on SDOH and health equity***. Suggested policies focus on increasing investments in nonclinical providers and traditional health workers. CCOs will also prioritize building partnerships with community-based organizations and strengthening relationships with CACs.

Key Considerations for Alaska

Generalizability. Oregon successfully reduced its Medicaid spending through its comprehensive health reform efforts. Implementing the CCO model required significant federal investments and benefited from existing state-level health care delivery infrastructure. For example, Oregon implemented its PCPCH program in 2009 and encouraged populations covered by OHA to join PCPCHs. The CCO model and the CPC+ program capitalized on this infrastructure and facilitated further development of PCPCHs. In addition, Oregon received almost $2 billion in federal investments to implement the CCO model. The state was also able to quickly transition existing MCOs to CCOs due to widespread use of managed care for Medicaid enrollees.

Regionalization, local governance and control. The CCO model is based on the principles of local governance and community-oriented solutions. CCOs are responsible for providing integrated health care to populations within their region, which allows CCOs to tailor programs to meet the needs of their local communities. The largest CCO covers the majority of Eastern Oregon and is focused on implementing innovative solutions to address health care access and quality in rural and frontier communities. For example, to address health care worker shortages in the region, EOCCO partnered with Oregon State University Professional and Continuing Education and the Oregon State University College of Public Health and Human Sciences to develop an online CHW training. Students who complete the course will become certified CHWs in the state of Oregon, with roles that could include providing health education, offering peer counseling, and connecting community members to needed resources.

Tribal considerations. Tribal leaders in Oregon were reluctant to buy into the CCO model because of a reliance on Medicaid fee-for-service payments to fund under-resourced IHS clinics and tribal health care systems. Researchers have suggested that similar models should require Medicaid CCOs to contract with tribal health care systems in order to ensure that tribal providers can establish in-network status.[300] This requirement could facilitate timely reimbursement for tribal health care providers and improve participation from tribes in health care reform.

Limited flexibility in choice of provider. Medicaid members must enroll in a regional CCO, and most Oregon counties only have one available CCO option. One notable exception are American Indian/Alaska Native populations, who are not automatically enrolled, but may voluntarily enroll. Alaska will need to

consider how Alaska Statute 21.07.030 (Choice of Health Care Provider) will affect the ability of the state to implement regionalized managed care networks. For example, the statute requires managed care entities to offer non-network options for health care providers, which could require managed care entities to create agreements with providers over large geographic regions.

Case Study: Healthier Washington

Executive Summary

Washington is undertaking a comprehensive health system transformation that seeks to implement value-based payments, build healthier communities, and promote whole-person care. The Washington Health Care Authority (HCA) is leading the implementation of the **Healthier Washington** initiative, which affects more than one-third of all Washington residents who are insured through the Public Employees Benefit Board (PEBB) and Apple Health (Medicaid). The framework of Healthier Washington is rooted in the 2014 Washington State Health Care Innovation Plan, which was developed with the support of a State Innovation Model grant. Healthier Washington also involves a five-year Medicaid demonstration project that launched in 2017, reducing the use of intensive services and improving population health.

Washington is using the following strategies to achieve its health system transformation goals:

- **Integrated physical and behavioral health**. HCA contracted with managed care organizations (MCOs) that are providing integrated physical and behavioral health services for Apple Health enrollees. These organizations aim to increase access to behavioral health services; reduce avoidable use of emergency departments, hospitalizations, and crisis services; and improve the quality and coordination of care.
- **Accountable Communities of Health (ACHs)**. ACHs are regional organizations that work in parallel with managed care plans to address population health and social determinants of health. ACHs are helping to coordinate and integrate health and social services, develop regional health improvement plans, and promote health equity.
- **Value-based payment (VBP) models**. HCA is committing to transitioning 90 percent of HCA provider payments under PEBB and Apple Health to VBP mechanisms by 2021. Healthier Washington is testing four payment models to achieve this goal, including a value-based alternative payment methodology for Medicaid managed care patients who receive care at Federally Qualified Health Centers and Rural Health Centers.

Key takeaways from Washington's efforts include the following:

- ***Focus on rural health.*** Healthier Washington is emphasizing the importance of increasing access to care in rural communities and improving the sustainability of rural health care delivery. Payment models focused on rural communities include the Rural Multipayer Model, which will implement global budgets for rural hospitals with incentives for quality and primary care measures.
- ***Collaboration with tribes.*** Healthier Washington collaborates with Indian Health Care Providers, federally recognized tribes, the American Indian Health Commission for Washington State, and other tribal representatives to implement Medicaid transformation projects that seek to enhance the Indian health delivery system.

- ***Regionalized approach to building healthier communities.*** Washington established high-level goals and an overarching framework for ACHs, but allowed communities to select projects based on their priorities and local needs.

In this paper we will examine health care reforms in the state of Washington. This case study will focus on **Healthier Washington**, the state's comprehensive health system transformation that seeks to implement value-based payments, build healthier communities, and promote whole-person care. We will also provide information on Healthier Washington's rural health initiatives, collaboration with tribes, and regionalized approach to improving population health. The paper starts with background on state demographic and economic characteristics and moves on to detail reform efforts. We discuss the impetus for reform and then provide an overview of the approach followed by details of its mechanics, structure, and implementation. We present results, lessons learned, and considerations for Alaska in the final section.

Background

State Characteristics – Demographics and Economic Indicators. Washington has a population of 7,535,591 and a population density of 101.2 per square mile.[314] While 30 of 39 counties in Washington meet the state's definition of rural (counties with a population density less than 100 persons per square mile or counties smaller than 225 square miles), only 10 percent of the state's population lives in rural areas.[315] In Washington, 12.5 percent of the counties meet the states definitions of frontier (with less than 7 people/square mile). In 2017, the state's poverty rate was 11.0 percent and the median household income was $66,174.[314] In December 2018, the unemployment rate was 4.3 percent and the five largest industries were 1) trade, transportation, and utilities; 2) government; 3) education and health services; 4) professional and business services; and 5) leisure and hospitality.[316] The gross domestic product (GDP) of Washington was approximately $524 billion in 2017, while the per-capita real GDP was $64,937 in 2017.[123] In December 2018, Governor Jay Inslee proposed a $54.4 billion state operating budget for 2019-2021.[317] In 2018, the majority of Washingtonians identified as White (79.5 percent), followed by White non-Hispanic (68.7 percent), Hispanic or Latino (12.7 percent), Asian (8.9 percent), two or more races (4.7 percent), Black or African American (4.2 percent), American Indian or Alaska Native (AI/AN; 1.9 percent).[314] Exhibit WA1 provides Washington's demographic and economic characteristics as compared to Alaska and the United States.

Exhibit WA1. Demographics and Economic Indicators

	Washington	Alaska	U.S.
Population, as of July 1, 2018[314]	7,535,591	737,438	327,167,434
Rurality			
Population per square mile, 2010[314]	101.2	1.2	87.4
Share of population in rural areas, 2017[318]	10%	32%	14%
Race/Ethnicity, 2017[314]			
White Alone	79.5%	65.8%	76.6%
Two or More Races	4.7%	7.4%	2.7%
Black or African American Alone	4.2%	3.7%	13.4%
Asian Alone	8.9%	6.5%	5.8%
American Indian or Alaska Native (AI/AN) Alone	1.9%	15.3%	1.3%
Hispanic/Latino	12.7%	7.1%	18.1%
**White non-Hispanic	68.7%	60.8%	60.7%

Poverty			
Median Household Income (2017 dollars)[314]	$66,174	$76,114	$57,652
Minimum wage, 2019[319]	$12.00	$9.89	$7.25
Share of population in poverty (2017)[314]	11.0%	11.1%	12.3%
Economy			
Unemployment rate, as of December 2018[316]	4.3%	6.3%	3.9%
Gross domestic product (GDP), 2017[123]	$524 billion	$52.8 billion	$19.5 trillion
Per-capita real GDP, 2017[123]	$64,937	$70,683	$55,418
Expenditures, SFY 2017[140]	$44.7 billion	$9.7 billion	$1.9 trillion
Expenditures per-capita, SFY 2017[125]	$6,034	$13,171	$5,976

**White Alone non-Hispanic individuals are people who responded "no, not Spanish/Hispanic/Latino" and who reported "White" as their only entry in the race question.

State Health Insurance Market – Health Coverage and Uninsured. In 2014, health care expenditures in Washington totaled $55.8 billion.[229] In the same year, per-capita health care expenditures were $7,913.

Private Health Insurance Market. In 2017, 52 percent of Washington residents had employer-sponsored health insurance and 6 percent had non-group insurance, which includes individual private insurance purchased directly from an insurance company.[127] In 2014, private health insurance spending was $4,328 per capita.[273] From 2001 to 2014, the average annual percent growth in private health insurance spending was 5.9 percent, which was higher than the national average of 5.3 percent.[82] In 2017, the largest insurer in the large group insurance market, the Kaiser Foundation Group, held 34 percent of the market share and the largest insurer in the small group insurance market, Premera Blue Cross Group, held 36 percent.[274,275]

State Employee Health Care System. The Washington State Health Care Authority (HCA) is responsible for purchasing health care for the state Medicaid program (Apple Health) and the Public Employees Benefits Board (PEBB) program. More than 300,000 public employees and retirees receive health care through PEBB.[320] Participating health plans include Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, and Uniform Medical Plan. As of March 2019, eligible members include 1) employees of state agencies, 2) employees of counties, municipalities, political subdivisions, and tribal governments, and 3) employees of school districts, educational service districts, and charter schools.[321] However, in 2020, Washington will introduce a separate School Employees Benefits Board (SEBB) program that will offer health insurance and other benefits to school employees in Washington.[322]

Retirees are eligible to receive health insurance coverage through PEBB. However, the PEBB member must enroll in Medicare Part A and Part B as soon as they become eligible in order to maintain their PEBB retiree insurance coverage.[323]

Health Insurance Marketplace. Washington has a state-run health insurance marketplace, Washington Healthplanfinder. As of September 2018, almost 1.7 million people were enrolled through the exchange.[324] In 2018, the exchange offered seven qualified health plans for enrollees: BridgeSpan, Coordinated Care, Kaiser Northwest, Kaiser Permanente WA, LifeWise, Molina, and Premera.[325] Each of the seven plans was limited to certain counties; no single health plan was available statewide.

Medicaid and CHIP Program and Population. In 2018, 22 percent of Washington residents were enrolled in Medicaid, referred to as Apple Health.[326] Approximately 65.2 percent of the state's Medicaid population is under the age of 18.[137] In 2017, total Medicaid spending was $12 billion.[280] The Federal Medical Assistance Percentages (FMAP) for 2020 is 50 percent.[237] In 2014, Medicaid spending was $5,296 per enrollee, $11,313 per aged individual, $13,073 per individual with disabilities, $6,018 per adult, and $1,969 per child.[281] As of 2018, 92 percent of the Medicaid population was enrolled in an MCO, 2 percent were enrolled in Primary Care Case Management, and 6 percent were in a fee-for-service program or other type of delivery system.[89] Washington is a Medicaid expansion state.

Exhibit WA2. Medicaid Eligibility Levels by Federal Poverty Level (FPL) as of January 2018

	Parents (in a family of three)	Other Adults (individual)	Children (upper limit)	Pregnant Women	Seniors and People with Disabilities
Washington State	138% FPL	138% FPL	300% FPL	193% FPL	75% FPL
Alaska	139% FPL	138% FPL	208% FPL	205% FPL	59% FPL
National Median	138% FPL	138% FPL	255% FPL	200% FPL	74% FPL

Source: https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/.

Specifically, eligible Medicaid enrollees include:

- Adults from 19 to 65 with income up to 138 percent of the federal poverty limit (FPL)
- Parents with children under 18 with income up to 138 percent of the FPL
- Pregnant women with income up to 193 percent of the FPL, regardless of immigration status
- Children under 19 from families with income up to 317 percent of the FPL
- Medically needy children under 18 with income above 312 percent of the FPL after medical costs equal the amount of the household income over the 312 percent FPL
- Foster care and substitute care children and former foster youth between the ages of 18 and 26
- The aged, blind, and disabled population
- Refugees and persons granted asylum
- Noncitizens who are eligible for a Medicaid program except for immigration status and have a qualifying emergency medical condition
- Women with breast or cervical cancer under the age of 65 who were screened and diagnosed through the National Breast and Cervical Cancer Early Detection Program and lack adequate coverage for cancer treatment

Uninsured Population. In 2017, the uninsurance rate was 6 percent.

Providers and Service Use. In 2016, there were 90 hospitals, 118 Medicare-certified rural health clinics, 27 community health centers, and 306 community health center service delivery sites in Washington.[150,142,51] Of these hospitals, 45.6 percent were owned by state or local government (0.4 beds per 1,000 population); 46.7 percent were owned by nonprofit entities (1.1 beds per 1,000 population); and 7.8 percent were owned by for-profit entities (fewer than 0.1 beds per 1,000 population).[285] In 2018, a

total of 10,539 primary care and 10,676 specialists were actively practicing in Washington.[286,146] The state has 207 total primary care Health Professional Shortage Area (HPSA) designations, which includes 42.9 percent of the total population of Washington.[97]

Tribal Health. Indian Health Care Providers (IHCPs) in Washington include 29 tribes, two Urban Indian Health Programs (UIHPs), and six federal Indian Health Service (IHS) clinics. In 1989, Washington State and federally recognized tribes in the state signed the Centennial Accord, which emphasized the importance of strengthening the government-to-government relationship. For more information on the Centennial Accord, see preexisting and parallel models section of the case study. HCA also collaborates closely with Washington's American Indian Health Commission (AIHC) to help IHCPs implement health care reform.

History and Implementation of Initiative

Impetus for Health Care Reform. Washington has a long history of implementing comprehensive health care reform in an effort to provide affordable coverage to all residents.

In 1987, Washington implemented the **Basic Health Plan (BHP)** as a pilot program to help improve access to health insurance.[327] The BHP was state-funded and offered subsidies to help insure low-income adults who did not meet eligibility criteria for Medicaid. In 1988, Washington established HCA in order to develop health care benefit programs for state employees and their dependents, and to identify procurement strategies that minimized costs to the state while maximizing the provision of comprehensive health care.[328]

In 1993, Washington State attempted to guarantee universal access to health care by passing the **Health Services Act (HSA).**[329] HSA mandated that most employers provide health insurance to employees, required that individuals enroll in health insurance, and prohibited insurance companies from denying coverage issuance based on preexisting conditions. Plans had to offer certain basic benefits, and employers and individuals who failed to meet the insurance mandate were required to pay a penalty.

HSA was never fully implemented due to subsequent elections that changed the composition of the state legislature.[330] The 1995 state legislature repealed the individual mandate, but kept the requirement that insurance companies accept all eligible members, regardless of preexisting conditions. Consequently, due to adverse selection, individual insurance premiums rose substantially. By 1999, no insurance companies were selling individual policies, where previously there had been 19 options in the state.[331]

By 2006, over half a million Washington residents were uninsured and the state was experiencing rapidly increasing health care costs. In an effort to improve access to high-quality affordable health care, the legislature established a **Blue Ribbon Commission on Health Care Costs and Access**.[332] The commission developed a five-year plan that established a vision for increased access to health coverage, improved health outcomes, improved health equity, increased use of evidence-based interventions, and decreased health care spending.[332] The report included a range of strategies and recommendations that would become the basis of health care transformation efforts, including greater transparency about cost and quality for consumers and an increased focus on prevention.

With these initial investments and commitments to health care reform, Washington was able to quickly capitalize on provisions of the Affordable Care Act (ACA). To prepare for ACA implementation, in 2010 former Governor Christine Gregoire signed an executive order, "Implementing Health Reform the Washington Way."[333] The order established a Health Care Cabinet comprising directors of key health care agencies to guide health care reform in Washington. The state received a waiver from the Centers for Medicare & Medicaid (CMS), called the Transitional Bridge, to begin enrolling adults with income up to 133 percent of FPL in Medicaid in 2011.[334] In 2014, full Medicaid expansion went into effect and the state fully transitioned members of BHP to Medicaid.

Washington also received a **State Innovation Models (SIM)** grant to develop and implement the Washington State Health Care Innovation Plan, which laid out the framework for Healthier Washington. In 2014, the Washington legislature passed HB 2572, which concerned "the effectiveness of health care purchasing and transforming the health care delivery system."[335] The bill set into motion key pieces of health care transformation described in the Innovation Plan, including:

- Requiring HCA to establish geographic areas and a grant program for nonprofit or public-private partnerships known as Accountable Communities of Health (ACHs);
- Requiring the Department of Health to establish a health extension program to disseminate tools, training, and resources to providers;
- Establishing a statewide all-payer claims database and require health carriers and employers to submit claims data to the database;
- Directing a stakeholder committee to develop and recommend statewide measures of health performance, and require state agencies to use the measures to inform purchasing and set benchmarks; and
- Requiring HCA and the Department of Social and Health Services to restructure Medicaid procurement of health care services and agreements with managed care systems to better support integration of physical and mental health, including substance use treatment.

Preexisting and Parallel Models and Infrastructure that Facilitate Health Reform. As described above, Washington has a long history of investing in statewide initiatives to expand access to affordable health care to low-income individuals and their families. Implementation of BHP infrastructure in 1987 facilitated the state's ability to quickly expand Medicaid in 2014 and then again to support and move toward achieving the objectives of Healthier Washington.

Managed Care. Washington had previously established infrastructure for both MCOs and behavioral health organizations (BHOs). Since 1987, the state has contracted with MCOs to provide physical health care coverage for its Medicaid beneficiaries. Since 1993, the state has also operated a mandatory managed care behavioral health program under Section 1915(b) waiver authority. Eleven county-based Regional Support Networks (RSNs) delivered behavioral health services, operating as prepaid health plans. HCA leveraged the existing infrastructure to established managed care regions in an effort to fully integrate physical and behavioral health care for Medicaid members by 2020.

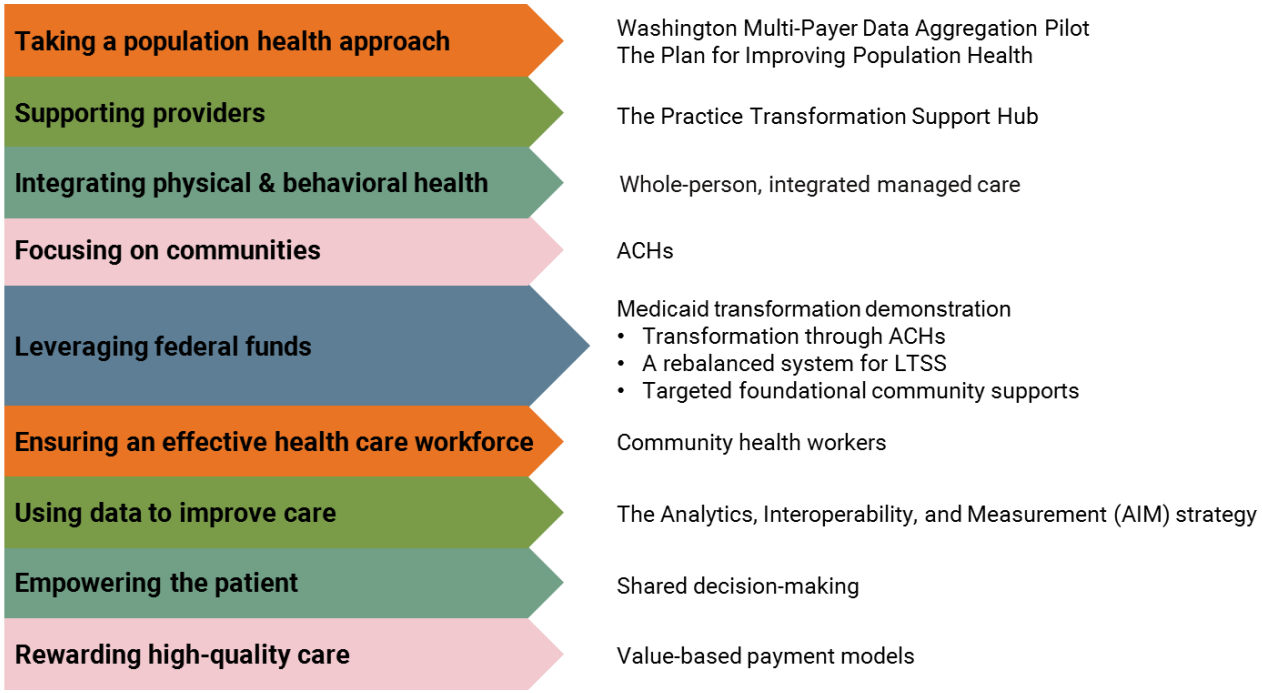
Centennial Accord. In 1989, federally recognized tribes in Washington and the state government signed the Centennial Accord, an agreement that reaffirmed tribal sovereignty and outlined a process for establishing government-to-government relations. In 2008, HCA developed a Centennial Accord Plan that

described an action strategy for specific programs and policies. Each year, Washington State agencies also report Centennial Accord highlights that provide additional detail about the relationship and enrollment numbers of AI/AN in HCA programs.[336]

Overview and Implementation of the Initiative

Overview of the Initiative. Healthier Washington focuses on increasing value-based, accountable care for both PEBB and Apple Health. Exhibit WA3 describes the key initiatives of Healthier Washington. Some of them, such as the Medicaid transformation demonstration and some VBP models, focus only on Apple Health enrollees.

Exhibit WA3. Key Initiatives of Healthier Washington



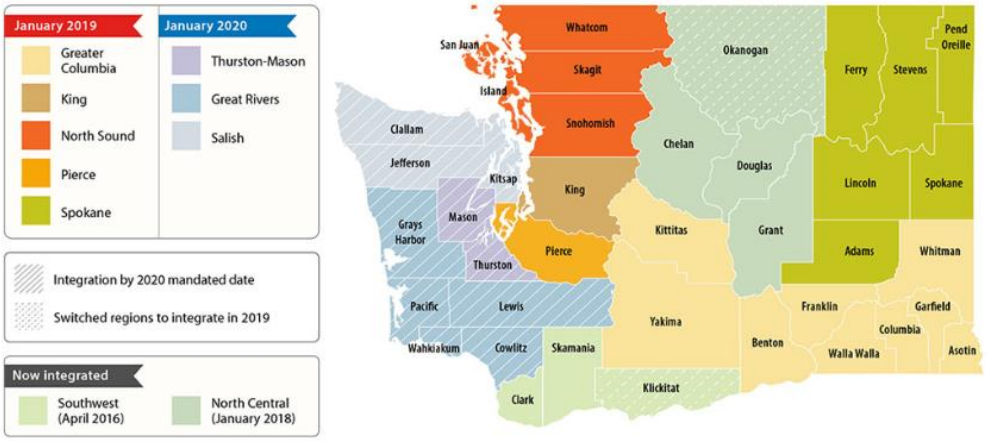
Taking a population health approach. Healthier Washington is testing four payment models that shift reimbursement of health care from volume of services to value and quality. One of these payment strategies, the Washington Multipayer Data Aggregation Pilot, aims to improve the ability of providers to manage the health of patient populations across multiple payers.[337] We include additional information about the pilot in the Details and Mechanics of Approach section. We also discuss another approach to promoting population-level health, the Plan for Improving Population Health, in the Incorporation of Social Determinants of Health section.

Supporting providers. Funded by the SIM grant, the Practice Transformation Hub offers support to small and medium practices to facilitate their transition to VBP models. For example, practices can request assistance from a practice transformation coach to implement quality improvement strategies and report clinical quality data.

Integrating physical and behavioral health. Managed care plans that serve Apple Health enrollees will integrate physical and behavioral health by January 2020[374]. HCA took an incremental, regional approach to implementing integrated care. For example, managed care plans that serve the Southwest region implemented integrated care in 2016, while plans that serve the Great Rivers region will not roll out integrated care until 2020. Exhibit WA4 displays the 10 integrated managed care regions. Apple Health members generally stayed enrolled in their original managed care plan, unless their plan declined to offer integrated care in their region. In those cases, HCA auto-enrolled the Apple Health member into an available plan[375].

HCA intentionally aligned managed care regions with ACHs in order to facilitate the implementation of regional transformation projects.

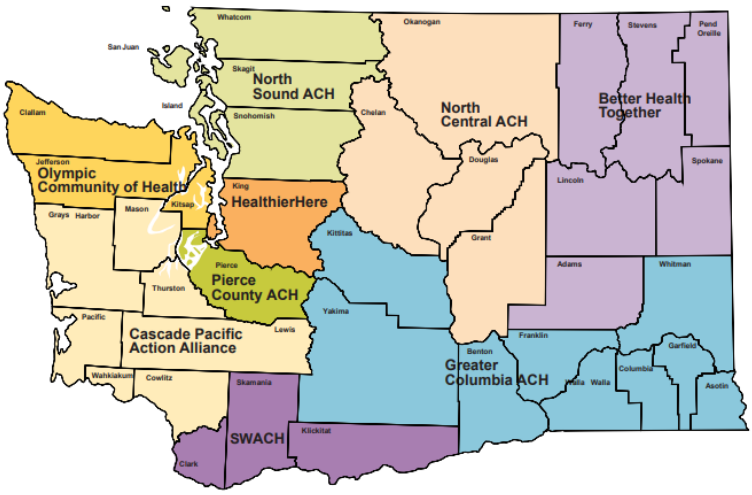
Exhibit WA4. Integrated Managed Care Regions



Reproduced from the Washington State Health Care Authority: https://www.hca.wa.gov/assets/free-or-low-cost/19-0025.pdf

Focusing on communities. Washington used SIM funds to support the implementation of ACHs, regional organizations that work in parallel with managed care plans to address population health and social determinants of health. ACHs are helping to coordinate and integrate health and social services, develop regional health improvement plans, and promote health equity. Each of the nine ACHs serves defined regions of Washington that align with integrated managed care regions (see Exhibit WA5). In the following paragraph, we describe how ACHs are playing a key role in Washington's Medicaid transformation.

Exhibit WA5. ACH Coverage Areas, Regions, and Names[2]



Reproduced from the Washington State Health Care Authority: https://www.hca.wa.gov/assets/program/ach-map.pdf

Leveraging federal funds. In 2017, CMS approved a Section 1115 Waiver for the five-year Washington State Medicaid Transformation Project (MTP) demonstration that authorizes up to $1.5 billion in federal initiatives to invest in three initiatives. CMS will provide $1.125 of the $1.5 billion for Delivery System Reform Incentive Payment (DSRIP) incentive payments to providers based on targets achieved for projects coordinated by ACHs.

MTP Initiative 1: Transformation through ACHs. As part of MTP, ACHs are planning and implementing local transformation projects based on regional needs. ACHs pick regional transformation projects from the MTP Toolkit, which is part of the state's DSRIP program planning protocol.[376] Exhibit WA6 highlights the three domains linked to ACH transformation and their corresponding projects.[377]All ACHs must complete the system-wide planning and capacity-building projects in Domain 1, as well implement four additional projects in Domains 2 and 3. These include Project 2A (integration of physical and behavioral health); Project 3A (addressing opioid misuse); one additional project from Domain 2; and another from Domain 3. For each proposed project, the toolkit describes an overarching goal, VBP targets, governance requirements, and statewide and regional activities for the planning and implementation phases[25].

[2] The Southwest and North Central integrated managed care regions are represented by a single ACH, the North Central ACH.

Exhibit WA6. ACH Transformation Projects and Goals

Domain	Project Title	Overarching Goal (Domain 1) or Project Objective (Domains 2 and 3)
Domain 1: Health Systems and Community Capacity Building	Financial sustainability from VBP	Achieve the Healthier Washington target of having 90% of state payments tied to value by 2021
	Workforce	Promote a health workforce that supports comprehensive, coordinated, and timely access to care
	Systems for population health management	Leverage and expand health information technology (HIT) and health information exchange (HIE) infrastructure and tools to capture, analyze, and share relevant data
Domain 2: Care Delivery Redesign	Project 2A: Bidirectional integration of physical and behavioral health through care transformation	Taking a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need
	Project 2B: Community-based care coordination	Promote care coordination across the continuum of health for Medicaid beneficiaries, ensuring those with complex health needs are connected to the interventions and services needed to improve and manage their health
	Project 2C: Transitional care	Improve transitional care services to reduce avoidable hospital utilization and ensure beneficiaries are getting the right care in the right place
	Project 2D: Diversion interventions	Implement diversion strategies to promote more appropriate use of emergency care services and person-centered care through increased access to primary care and social services, especially for medically underserved populations
Domain 3: Prevention and Health Promotion	Project 3A: Addressing the opioid use public health crisis (required)	Support the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports
	Project 3B: Reproductive and maternal/child health	Ensure that women have access to high-quality reproductive health care throughout their lives and promote the health safety of Washington's children
	Project 3C: Access to oral health services	Increase access to oral health services to prevent or control the progression of oral disease and ensure that oral health is recognized as a fundamental component of whole-person care
	Project 3D: Chronic disease prevention and control	Integrate health system and community approaches to improve chronic disease management and control

MTP Initiative 2: A rebalanced system for long-term services and supports (LTSS). Washington is testing a next generation system of care to offer additional support for unpaid family caregivers who provide 80 percent of care to people receiving LTSS.[378] The program aims to protect individuals in need of LTSS, their caregivers, and their families from severe financial consequences of providing long-term care. Medicaid members in need of LTSS will receive access to two programs that promote the wellbeing of caregivers and delay or avoid the need for Medicaid-funded LTSS.

- **Medicaid Alternative Care (MAC)** provides a benefit package for unpaid family caregivers of a Medicaid patient over 55 years of age who needs help with activities of daily living. Benefits include training, support groups, and respite services, as well as general assistance with housekeeping and errands.

- **The Tailored Supports for Older Adults (TSOA)** program provides benefits to individuals and/or their caregivers who need help with daily activities and are at risk for future LTSS use, but do not currently meet financial eligibility for Medicaid. In addition to some of the same caregiver supports offered in MAC, individuals who are enrolled in TSOA can access adult day care, transportation, counseling, and other services.

MTP Initiative 3: Provision of targeted foundational community supports. The demonstration funds programs for vulnerable Medicaid patients who need additional support to reside in stable community settings. Community Transition Services (CTS) and Community Support Services (CSS) are targeted to high-risk populations and seek to decrease dependence on institutional care and prevent events that can negatively affect continuity of care, including eviction.[379] Although the demonstration does not directly fund housing payments or wages, CTS and CSS provide support housing and employment services. This includes helping beneficiaries develop the skills they need to fund and remain in stable housing. Employment services include job training and assistance with job placement.

Ensuring an effective health care workforce. As part of Healthier Washington, the state convened a community health worker (CHW) task force that in 2016 released policy recommendations for integrating CHWs into the health care system.[380] In 2019, the Washington Department of Health will release guidelines for implementing CHW training and education recommendations.

Using data to improve care. Healthier Washington is implementing an Analytics, Research, and Measurement (ARM) strategy that seeks to dismantle data siloes across agencies, improve health data management, and promote population health improvement strategies. Implementation of the HIT and Data Analysis Infrastructure section describes key initiatives of ARM, including data dashboards that allow consumers to compare health utilization information across managed care regions.

Empowering the patient. HCA began certifying high-quality patient decision aids in 2016 to help patients engage in shared decision-making with their providers.[380] As of 2019, HCA has certified several patient decision aids in the areas of maternity care, labor/delivery, total joint replacement, spine care, and end of life care. Implementing shared decision-making is a focus of two Healthier Washington initiatives, the Practice Transformation Support Hub and Accountable Care Programs.

Rewarding high-quality care. As described in the Details and Mechanics of Approach section, Healthier Washington is implementing four payment models that are shifting the health care system from rewarding volume to quality of care.

Goals for Health Care Reform. The state describes three goals for Healthier Washington.[380]

- Build healthier communities through a collaborative regional approach
- Integrate physical and behavioral health needs to offer whole-person care
- Improve payment for services by rewarding quality over quantity

The five-year Medicaid transformation project also has four specific goals.[381]

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional long-term services and supports (LTSS), and jails

- Improve population health, with a focus on coordinated and whole-person centered prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders, and oral health
- Accelerate the transition to VBP, while ensuring that access to specialty and community services outside the Indian health system are maintained for Washington's tribal members
- Ensure that Medicaid per-capita cost growth is two percentage points below national trends

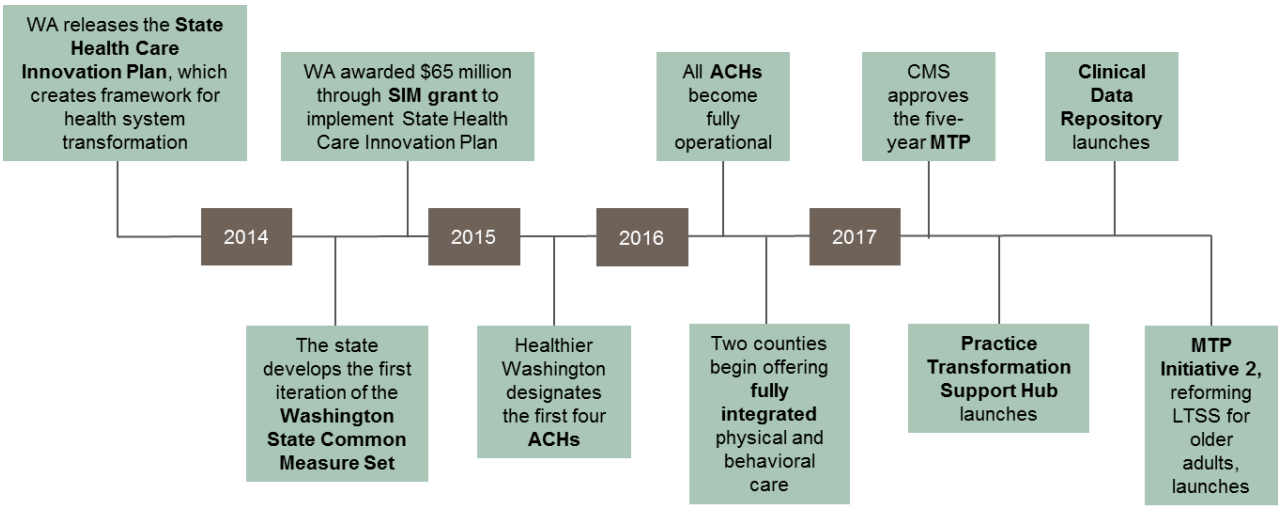
Coordination with the Indian Health System. The Indian health system is also a key building block of a Healthier Washington. State agencies are required to make reasonable efforts to collaborate with tribes when developing policies that will affect tribal communities. HCA set aside transformation funds for infrastructure investments in projects directed by IHCPs. IHCP projects use a framework of culturally appropriate practices, which include addressing historical and intergenerational trauma, using a socio-cultural-ecological approach, promoting prevention and recovery support, and integrating health care.[338]

In addition, ACHs are required to adopt either Washington's "Model ACH Tribal Collaboration and Communication" policy or a tailored policy developed by the ACH and every IHS program, tribally operated program, or UIHP in the ACH's region.[339] ACH governing boards must also include one or more representatives from the region's tribes, IHS facilities, and UIHPs in the region. Finally, the governing boards must also "make reasonable efforts to receive ongoing training on the Indian health care delivery system with a focus on their local [Indian health system programs] and on the needs of both tribal and urban Indian populations."[339] AICH has played an active role in facilitating relationships between ACHs and Indian health programs, including providing trainings to ACH administrators and holding formal workshops with governing boards to discuss Tribal partnerships.[339]

Population, Scope, and Participation. HCA is responsible for purchasing health care for both PEBB and Apple Health (Medicaid) members, which account for almost one-third of all Washington residents.

Timing and Implementation Process. The state began planning for comprehensive health system reform in 2006 and completed the official Washington State Health Care Innovation Plan in 2013. The legislature enacted pieces of the Innovation Plan in 2014, including creating a grant program for ACHs, which were formally approved by CMS in 2017 as part of MTP. Exhibit WA7 provides an abbreviated timeline from 2013 to 2014 with some key pieces of Healthier Washington.[340]

Exhibit WA7. Abbreviated Healthier Washington Timeline from 2013 to 2017



Stakeholder engagement. HCA's stakeholder engagement activities focus on building open communication and convening meetings to keep partner agencies informed of progress. HCA holds public forums, conferences, and webinars, and provides direct technical assistance to ACHs. ACH stakeholder engagement efforts focus on building true community participation and incorporating multiple voices into decision-making and priority-setting processes. For example, some ACHs have established "community voice councils" to advise ACH workgroups on community priorities.

HCA has also led more intensive stakeholder engagement processes to develop plans for health system transformation. For example, to develop the Innovation Plan, HCA engaged more than 1,000 stakeholders including agency representatives, tribes, state legislators, consumers, and other stakeholders. In addition, HCA released a draft Innovation Plan for public comment and contracted with consultants to assess the capacity of community-based health organizations to implement the plan's proposed innovations.

Other Parallel Health Reform Models and Infrastructure

Healthier Washington is a complex and far-reaching initiative that built upon extensive existing infrastructure, including the state's Basic Health Plan and SIM funding. While most health reform activities are part of Healthier Washington, HCA also separately administers the **Washington Prescription Drug Program** (WPDP), which provides information about and assistance with prescriptions.[341] WPDP seeks to increase the affordability of prescriptions through two strategies. First, HCA convenes the Pharmacy and Therapeutic Committee/Drug Utilization Review Board, which regularly updates the evidence-based Washington Preferred Drug List (PDL). Apple Health and PEBB health plans use the PDL to determine coverage for prescriptions, which are divided into a Value Tier (most cost-effective drugs), Tier 1 (generic drugs), Tier 2 (preferred brand-name drugs), and Tier 3 (non-preferred brand-name drugs).[342] Second, HCA participates in the Northwest Prescription Drug Consortium, through which Washington and Oregon pool their prescription drug purchasing to lower costs for all residents who participate in their prescription drug discount program. Together, WPDP and the Oregon Prescription Drug Program are able to leverage the purchasing power of over a million residents to achieve lower drug prices.[343]

In 2012, Washington State partnered with CMS to implement a demonstration for dual eligible individuals that implements a managed-fee-for-service model for integrated care delivery across services.[382] The initiative is part of the Financial Demonstration Initiative. Washington is integrating care through Health Homes, which are responsible for coordinating long-term support services and primary, acute, and behavioral health care.

Details and Mechanics of Approach

Governance and Organizational Characteristics. Although HCA manages health care transformation efforts, the state has specified, "No one entity or agency 'owns' Healthier Washington."[383] The implementation of large-scale health reform required close collaboration between HCA, the Department of Health, and the Department of Social and Health Services.

ACHs are self-governed regionally and have developed their own decision-making process and organizational structures. Many ACH-contracted entities were original applicants to a 2014 Community of Health planning grant funded by SIM. Currently, all contracted agencies are either local public health agencies or health-focused nonprofits that bring together multidisciplinary workgroups and committees. In 2017, HCA defined foundational requirements for the primary decision-making body of an ACH. Each decision-making board or steering committee must include the following voting members:[384]

- One or more primary care providers, including practices and facilities serving Medicaid beneficiaries
- One or more behavioral health providers, including practices and facilities serving Medicaid beneficiaries
- One or more health plans, including but not limited to Medicaid MCOs; if only one opening is available for a health plan, it must be filled by a Medicaid MCO
- One or more hospitals or health systems
- One or more local public health jurisdictions
- One or more representatives from the region's tribes, IHS facilities, and UIHPs in the region, unless alternative mechanisms are agreed upon by the ACH, including the region's tribes, IHS facilities, and UIHPs
- Multiple community partners and community-based organizations that provide social and support services reflecting the social determinants of health for a variety of populations in the region, including, but not limited to, transportation, housing, employment services, education, criminal justice, financial assistance, consumers, consumer advocacy organizations, childcare, veteran services, community supports, and legal assistance, among others

Payment Mechanisms. HCA is aiming to make VBPs for 90 percent of payments made to providers for service delivery by 2021[36]. As of 2017, 43 percent of payments are value-based. In addition to VBPs, Healthier Washington emphasizes the importance of multipayer alignment. Payers involved in multipayer models include commercial payers, Medicaid, PEBB, and Medicare.[163] Washington is testing four strategies for payment redesign:

Integrated physical and behavioral health care. A key component of Healthier Washington is moving toward integrating physical and behavioral health care through MCOs. HCA provides capitated payments to MCOs, which contract with providers to pay for services.

Encounter-based to value-based. Washington seeks to align payment for primary care providers who see Medicaid managed care enrollees. In particular, the state is testing a value-based alternative payment methodology for Medicaid managed care patients who are seen at Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs). This alternative payment methodology transitions FQHCs and RHCs from encounter-based payments to value-based, per-member-per-month payments that are adjusted based on performance on quality measures.

Accountable Care Program (ACP) and multipurchaser. HCA is testing ACP, a new accountable delivery and payment model that focuses on integrating physical and behavioral health care for PEBB members. ACPs will participate in shared savings and shared risks depending on their performance on 19 quality measures.

Washington Multipayer Data Aggregation Pilot. A rural medical center and an urban physician's network are piloting the multipayer data aggregation pilot, which is increasing providers' access to patient utilization data across multiple payers.[337] The pilot will test whether access to a shareable data aggregation solution increases the willingness of providers to participate in VBP arrangements.

The state and ACHs also collaborated to define Use Categories for payment of DSRIP funds (Exhibit WA8)[37]. Each ACH's board develops a funding distribution approach to define the timing of incentives to participating providers. Table 7 describes the definitions of each Use Category as specified in the demonstration waiver. Each ACH project specifies the reporting-based progress measures and performance-based outcome metrics that ACHs must reach to receive incentive payments.

Exhibit WA8. ACH Use Categories for DSRIP Funds

Category	Definition
Administration	Payments for the administrative operating expenses of the ACH (e.g., financial, legal, administrative salaries, facilities and equipment, taxes).
Community Health Fund	Payments held to address long-term health improvement strategies in alignment with Medicaid Transformation goals. These payments focus on primary prevention and social determinants of health. This category is not intended for payments made to nontraditional providers as part of the two provider-specific use categories.
Health Systems and Community Capacity Building	Payments for population health management systems (EHRs, HIE/HIT, data); strategic improvement/quality improvement activities; workforce development; VBP support; revenue cycle management and supply chain management support; Pathways HUB operations; training and education on community and provider engagement; and consumer empowerment.
Integration Incentives	Incentives earned by "mid-adopter" regions and used to support the integration of behavioral health.
Project Management	Payments for transformation project-related design and project management support.
Provider Engagement, Participation, and Implementation	Payments to partners for engagement and participation (signed partner agreements, and meaningful leadership and participation on workgroups and operational committees), and implementation costs for early infrastructure and process changes that actively move the partner and team toward integration and community-based care.
Provider Performance and Quality Incentives	Payments to partners for reporting on project milestones; performance-based, metric-driven payments; and transitioning to new payment models.
Reserve/Contingency Fund	Payments reserved for unanticipated costs and support for administration if unforeseen expenses arise, or if overall earned incentives are adjusted.
Shared Domain 1 Incentives	Payments for specific (to be defined) Shared Domain 1 support for designated providers across all nine regions.

As part of MTP, Washington developed a comprehensive DSRIP funding and mechanics protocol that further specifies payment mechanisms. Transformation projects are weighted according to total DSRIP project funding available. In addition, each metric is awarded an Achievement Value, which is also weighted, and used to calculate the distribution of dollars earned. ACHs are paid according to their progress on measures, as weighted by the Achievement Value and the value of the chosen project.

Alignment among Payers. In HCA's Value-Based Roadmap for 2018-2021 and Beyond, the agency identifies four initiatives as vehicles of transformation for multipayer alignment.[344] The first two—the alternative payment methodology for FQHCs and RHCs and the multipayer data aggregation pilot—are described in the Payment Mechanisms section. The third involves aligning certain performance measures in state purchasing contracts. For example, five performance measures tied to VBPs are common among all state purchasing contracts. As part of initiative, the state aims to align measures in agency purchasing contracts with national reporting requirements as well. The final vehicle of transformation is the Rural Multipayer Model. The rural model will involve a global budget for hospitals and common incentives for primary care providers, including RHCs.[344] Payers will include Medicare FFS, in-network Medicare Advantage, Medicaid FFS, Medicaid MCOs, and large commercial payers.

Federal Assistance and Cost of Initiative. Washington is receiving substantial federal assistance to implement its current health care transformation efforts. In 2012, Washington applied for and received nearly $1 million for a SIM Pre-Testing Award, which funded an extensive planning process for the

Innovation Plan. In 2014, the state received another $65 million in SIM funding to support Healthier Washington initiatives and implement the Innovation Plan. SIM funding was dedicated to supporting the ACHs, testing four payment reform models, creating a Practice Transformation Support Hub for integration of primary and behavioral health care, developing the Plan for Improving Population Health, strengthening workforce capacity, and establishing a collaborative governance structure. In 2017, the state received a waiver for the five-year Medicaid Transformation Demonstration that will provide up to $1.5 billion. In particular, the demonstration provides $1.1 billion in DSRIP incentives for delivery system reform and $375 million for foundational community supports for Apple Health members.

Quality Measurement. Several providers and entities involved in Healthier Washington track quality measures and are compensated for meeting quality improvement targets. Healthier Washington initiatives pull quality measures from the Washington State Common Measure Set for Health Care Quality and Cost, which were selected by a legislatively mandated committee composed of three multidisciplinary workgroups. Quality measure results are publicly reported on Community Checkup, a website that allows consumers to compare outcomes by measure at the state, county, and ACH level.[345]

Incorporation of Social Determinants of Health (SDOH)

Healthier Washington involves initiatives that focus on population-level health and SDOH. For example, the state proposed a Prevention Framework that established objectives related to promoting prevention, improving social and physical environments, engaging community members, and integrating health and social services that affect SDOH.[346] These efforts formed the basis of the Plan for Improving Population Health, a set of strategies and resources in Washington State.[347] The plan aims to ensure that Healthier Washington is addressing SDOH.

Supportive housing and supported employment for Medicaid members are also key initiatives of Healthier Washington. The state recognizes that homelessness and employment status are SDOH that significantly affect the ability of enrollees to address physical and mental health concerns.

Implementation of the HIT and Data Analysis Infrastructure

HIT initiatives to support Healthier Washington focus on increasing interoperability of data across the care continuum. In 2009, the legislature approved the development of a secure electronic HIE, called the Clinical Data Repository (CDR), which currently provides a platform linking clinical data across providers, regardless of their EHR system.[385]

HCA's ARM team also works on HIT-related initiatives with the goal of breaking down data siloes among state agencies, providers, and other partners. ARM developed the ARM Data Dashboard Suite, which describes health utilization information for varied Washington populations, and the Healthier Washington Data Dashboard, which contains Medicaid enrollment and administrative claim data tied to quality measures.[348,349] Stakeholders, including ACHs, can use these dashboards to inform local planning efforts.

All-Payer Claims Database (APCD)

In 2014, the Washington legislature authorized the Washington State All-Payer Claims Database (WA-APCD) in order to promote transparency of health care costs. WA-APCD works to help consumers and stakeholders make informed choices, allow providers and practices to compare their performance on key quality measures, and promote competition. The database collects all medical, pharmacy, and dental claims from both private and public payers.[350]

Washington HealthCareCompare serves as the public-facing component of WA-APCD.[351] The tool promotes transparency by allowing consumers to compare local prices for procedures and treatments. Users can also view quality results by ACH area, which compares target, ACH, and statewide scores on quality measures. The tool also displays quality scores by type of coverage: commercial, health exchange, and Medicaid. Washington's Office of Financial Management directs WA-APCD, which is operated by the Center for Health Systems Effectiveness at Oregon Health & Science University.[352]

Spotlight on Rural Health

Healthier Washington includes strategies and programs that focus on transformation of health care delivery in rural communities. The stated goal of rural transformation is to "improve the health of rural Washingtonians and preserve access to care in rural areas in a manner that is sustainable and better serves the health needs of local populations."[353] Key initiatives include:

Mini-Grants to Rural Hospitals. In 2019, HCA and the Washington State Hospital Association awarded $10,000 grants to 10 rural hospitals to help support integrated care transformation. Rural hospitals can use funds to work with ACHs, improve care coordination, support behavioral health integration, improve health information technology infrastructure, and prepare for VBP models.

Rural Multipayer Model. This model will implement global budgets for rural hospitals with incentives for quality and primary care measures. Payers include Medicare FFS, in-network Medicare Advantage, Medicaid FFS, Medicaid MCOs, and large commercial payers.

Alternative Payment Methodology for FQHCs and RHCs. This alternative payment methodology advances adoption of VBP models in rural communities by introducing PMPM rates that are adjusted based on performance on quality metrics.

Results, Lessons Learned, and Next Steps

Results. While the state has not evaluated the overall Healthier Washington initiative, researchers have studied different components of health care transformation.

SIM. An evaluation of the four-year SIM test award found mixed results.[354] Washington was successful in reaching some of its SIM goals, including transitioning at least 50 percent of commercial payments to value-based arrangements by 2019. However, as annual Medicaid expenditure growth rates varied widely from 2013 to 2017, evaluators were unable to conclude that the state met its SIM goal of achieving an annual health care cost growth that was 2 percent less than the national trend by 2019.

Integrated Managed Care. An evaluation of integrated managed care for Medicaid beneficiaries in Southwest Washington assessed changes in health care performance metrics from April 1, 2016 to March 31, 2017, one year after implementation of the model.[355] The two counties included in the study, Clark and Skamania, were the first in the state to implement the integrated managed care model. Compared to other Medicaid beneficiaries across the state, Medicaid beneficiaries in Clark and Skamania counties showed statistically significant improvements in access to care measures, including access to ambulatory

and preventative care and mental health treatment. Beneficiaries in the region also experiences statistically significant improvements in some social outcomes compared to the rest of the state, including fewer arrests and a decreased rate of homelessness.

ACHs. An evaluation of ACH activity between 2015 and 2018 found that ACHs had successfully built collaborative organizations that fostered trust between multiple sectors, established the necessary infrastructure and capacity to implement health system transformation, and meaningfully incorporated a wide range of voices into their work.[356]

Medicaid Transformation. The Center for Health Systems Effectiveness at Oregon Health & Science University is serving as the independent evaluator for Washington's Medicaid transformation effort. As Medicaid transformation only began in 2018, results are forthcoming.

Lessons Learned. Healthier Washington is a complex, multifaceted health system transformation that benefitted from decades of investment in extending affordable health insurance to all residents. Nevertheless, other states could benefit from understanding lessons learned from Healthier Washington's attempt to improve population health, promote high quality care, and reduce the cost of health care.[357]

Multiple levels of buy-in were critical for success. Healthier Washington requires collaboration between agencies at the local, regional, and state level. While the initiative is helmed by HCA, the agency worked closely with the Department of Social and Health Services, the Department of Health, and interagency teams. Healthier Washington was also championed by the Governor and received bipartisan support from state legislators.

Regional infrastructure was lacking. HCA requires ACHs to conduct regional health assessments. However, the state had never implemented regional approaches to health and lacked the infrastructure to monitor and assess health on a regional scale. Agencies within a region, such as local health departments, did not use standardized data collection methods or timeframes. While ACHs have now established the necessary infrastructure to conduct future regional assessments, additional guidance and support could have facilitated the process.

ACHs facilitated the success of regional health care transformation. ACHs served as "integrator entities" that fostered collaboration among local health systems, providers, public health departments, and other community stakeholders. While ACHs did not directly provide care, their regions were intentionally aligned with MCOs that provide integrated care. ACHs work closely with MCOs to communicate the identified needs of the regional population and implement transformation projects. HCA also dedicated funds to implement Medicaid transformation projects with tribal health care providers and worked with AIHC to meet with each of the state's 29 tribes and 3 UIHPs to help develop reporting requirements for the projects.

Formal policies and dedicated funds helped ensure tribal representation in health system transformation. The state created formal policies to engage tribal governments, IHS programs, and UIHPs in Healthier Washington. For example, HCA required ACHs to describe plans for tribal engagement and collaboration as part of their certification process. ACHs could either adopt Washington's Model ACH Tribal Collaboration and Communication policy or develop a written policy in collaboration with every tribal health program in the region.

Next Steps. The state will continue to implement Medicaid transformation through 2023.

Considerations for Alaska

Focus on rural health. Healthier Washington emphasizes the importance of increasing access to care in rural communities and improving the sustainability of rural health care delivery. Payment models that focus on rural communities include the Rural Multipayer Model, which will implement global budgets for rural hospitals with incentives for quality and primary care measures.

Collaboration with tribes. Healthier Washington collaborates with IHCPs, federally recognized tribes, the AIHC for Washington State, and other tribal representatives to implement Medicaid transformation projects that seek to enhance the Indian Health delivery system.

Regionalized approach to building healthier communities. Washington established high-level goals and an overarching framework for ACHs, but allowed communities to select projects based on their priorities and local needs.

Limited flexibility in choice of provider. When new members enroll in Apple Health, they can choose among the health plans offered in their region. Washington also allows enrolled Apple Health members to switch to a different plan within their region at any time. In addition, American Indian/Alaska Native populations may opt out of managed care and elect Medicaid FFS. However, while Apple Health allows members to select their plan, enrollees may only see providers in their plan's network. Alaska will need to consider how Alaska Statute 21.07.030 (Choice of Health Care Provider) will affect the ability of the state to implement regionalized managed care networks. For example, the statute requires managed care entities to offer non-network options for health care providers, which could require managed care entities to create agreements with providers over large geographic regions.

Appendix 1: National Scan, Initial List

To: Sandra Heffern, Effective Healthcare Design, for the Project Management Committee, Alaska Healthcare Transformation Project

From: Scott Leitz

Re: Initial List, National Scan, Alaska Healthcare Transformation Project

Date: November 7, 2018

The NORC team is pleased to submit an initial list of states with delivery system reform efforts that we have identified that are relevant to Alaska and for consideration in the selection of states for further in-depth review. This list is based on the specific topic areas identified in the National Scan statement of work (SOW) and was informed by our knowledge of and previous experience with other state's health care payment and delivery reform initiatives. The states and their programs are broken down by the topic areas identified in the SOW and are defined as:

- **Primary care utilization.** A primary care system is made up of a team of health care professionals that together offer comprehensive whole patient care. Best practices show that ideally primary care should look like a community of engaged practitioners actively involved in the well-being of their patients. The patient also plays a role in the management of their care.
- **Coordinated care.** System wide approach to patient centered whole person care.
- **Data analytics.** Data analytic system will support and be accessible to providers, hospitals, insurers, government payers, policymakers and consumers to decrease health care cost, improve quality, ensure access and improve the patient experience.
- **Payment reform.** Diverse provider network that includes physical, behavioral and supportive services, contracting with multiple payers for a shared savings/risk model to serve a large group of members with a goal of improved value for payers, providers and members.
- **Social determinants of health (SDOH).** Infrastructure support for social determinants of health: identification and coordination of resources.

The initial list of states focuses on multipayer programs and highlights whether the state participates in CMS's State Innovation Models (SIM) Initiative, maintains an All Payer Claims Database (APCD), and uses the Health Care Payment Learning and Action Network's (HCP-LAN) definitions of Alternative Payment Models (APMs). We provide some basic state characteristics, a high-level description of the model, and references for more in-depth information and future research.

The NORC team looks forward to hearing your feedback on the initial list, and stands ready to add and modify states of interest based on that feedback.

Exhibit A below presents the list of models.

Exhibit A. National Scan: Initial List

State & Program	State Characteristics	Description of Model	References
Primary Care Utilization			
Oklahoma **Comprehensive Primary Care Plus (CPC+)** Model type: Primary Care Transformation Payer: Medicare, Medicaid, Commercial **2012-Present** LAN Category: 3A (Track 1), 4A (Track 2) SIM state: yes APCD: yes	▪ 59 out of 77 counties are rural[358] ▪ 8.6% of state population are American Indian/Alaska Native[122] ▪ 186 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Greater Tulsa area, Oklahoma ▪ **Population:** Medicare, Medicaid, and some commercial patients at participating primary care practices; a few tribal providers are participating ▪ **Goal of model:** The model aims to improve collaboration between public and private health care payers to ultimately strengthen primary care. ▪ **Current status:** Began participating in the CMS CPC demonstration in 2012, with the collaboration of Blue Cross and Blue Shield of Oklahoma. The CPC+ demonstration began in April 2017, again with the collaboration of BCBSOK. Participation is voluntary and 61 primary care practices are participating. Under Track 1, practices receive a prospective, quarterly care management fee based on number of enrollees and enrollees' risk tier, in addition to regular FFS claims payments. Practices also receive a prospective, at-risk performance-based incentive payment at the beginning of each year, to be reconciled retrospectively based on performance on quality and utilization measures at the end of the year. Under Track 2, practices also receive the prospective, quarterly case management fee and the prospective, at-risk performance-based incentive payment. The underlying fee structure for Track 2 is a hybrid of a reduced FFS payment along with a prospective, quarterly Comprehensive Primary Care Payment based on historical FFS payment amounts. ▪ **High Level Results:** The aggregate CPC results report a slight improvement in patient experience. The evaluation report noted a reduction in ED visits in the Medicare population. Due to Medicaid data lags, the comparison between CPC practices and non-CPC practices was not available in the initial report.	CMS CPC Description for Oklahoma CPC+ Fact Sheet CPC+ Payment Methodologies CPC Evaluation Third Annual Report List of participating providers

State & Program	State Characteristics	Description of Model	References
Arkansas **Multipayer Total Cost of Care PCMH Program** Model type: PCMH Payer: Medicaid, Commercial, Employee **2014-Present** LAN Category: 3A SIM State: yes APCD: yes	▪ 55 out of 75 counties are rural[20] ▪ 0.8% of state population are American Indian or Alaska Native[20] ▪ 103 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Patients attributed to participating providers and covered by Medicaid, AR BCBS, the Arkansas State and Public School Employee Plans, Walmart, and Qualified Health Plans participating in the health insurance marketplace. The only services excluded are inpatient neonatal services, LTSS, and inpatient psychiatric care for those with severe & persistent mental illness. ▪ **Goal of model:** The model is a single component of the larger initiative to transform the structure of the Arkansas health care system in order to control growth in health care costs and to reward providers for high-quality, and cost-effective care delivery. ▪ **Current status:** The PCMH program was launched in 2014. Provider participation is voluntary and has increased from 123 practices in 2014 to 190 practices in 2017; in 2015, the model covered 83% of Medicaid enrollees. Implementation of this model was supported by Arkansas' participation in the Comprehensive Primary Care Initiative (CPC), CPC+, and State Innovation Models (SIM) planning and testing grants. The model places financial responsibility for the total experience of attributed patients and their associated costs on PCMHs. Providers receive upside gain-sharing if they meet quality metrics and bring total costs under established thresholds. All practices also receive up-front care coordination payments and are required to complete practice transformation activities and achieve specified quality and utilization milestones as a condition of participation. ▪ **High Level Results:** For Medicaid enrollees, the state reports two consecutive years of cost avoidance. For 2015 the program generated $54.4 million in cost avoidance, or $39.6 million after gain-sharing payments to providers. The state also reports reduced rates of hospitalizations and ED visits. Results for quality and access measures have been mixed.	Arkansas Health Care Payment Improvement Initiative 3rd Annual Statewide Tracking Report

State & Program	State Characteristics	Description of Model	References
Idaho **Statewide Healthcare Innovation Plan (SHIP)** Model type: PCMH Payer: Medicaid, Medicare, Commercial **2014-Present** LAN Category: 2B SIM State: yes APCD: no	▪ 35 out of 44 counties are rural[206] ▪ 1.4% of state population is American Indian or Alaska Native[122] ▪ 103 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Voluntary participation statewide ▪ **Population:** Medicaid enrollees receiving primary care at participating sites; alignment with Medicare and commercial payers ▪ **Goal of model:** The PCMH program is a component within the larger effort to transform the health care system in Idaho**.** The goals of transformation are to improve health outcomes, improve quality and patient experience of care and to lower costs of care for Idahoans. ▪ **Current status:** The Idaho SHIP began in 2014 with a focus on transforming primary care practices to PCMHs. As of the end of 2017, 110 clinics were participating, 50 of which have achieved national PCMH recognition. The Idaho Medical Home Collaborative and the Idaho Healthcare Coalition provide guidance and support for multipayer alignment. PCMHs receive a tiered per-member per-month (PMPM) payment based on level of PCMH capabilities as well as incentive payments for certain milestones. In 2018, the state is launching three new VBP models within Medicaid: Regional Care Organizations (RCOs) (similar to ACOs), shared savings, and bundled payments for specialty providers. RCOs and PCMHs will both be eligible for shared savings. Additionally, the state aims to shift payment strategies across payers to VBP, and aggregates data each year from Medicaid, Medicare and commercial payers on the percentage of payments to providers that fall under each stage of the LAN framework. The state reports on progress to the Idaho Healthcare Coalition and the state's Multipayer Workgroup, both of which work with payers to accelerate transitioning away from fee-for-service (FFS). ▪ **High Level Results:** Results are not yet available.	Statewide Healthcare Innovation Plan Operational Plan – Award Year 4 Idaho PCMH webpage SHIP At-a-Glance

State & Program	State Characteristics	Description of Model	References
Vermont **Vermont Blueprint for Health** Model type: Pay-for-Performance, PCMH Payer: Medicare, Medicaid, commercial, self-insured employers **2010-Present** LAN Category: 2B SIM State: yes APCD: yes	▪ 11 out of 14 counties are rural[20] ▪ 0.4% of state population are American Indian or Alaska Native[122] ▪ 33 primary care HPSA (health professional shortage area) designations[206]	▪ Geographic scope: Statewide ▪ **Population:** Medicaid and Medicare beneficiaries, commercial insurers (BlueCross, MVP, Cigna) and two self-insured employers (IBM and the State). ▪ **Goal of model:** The program aims to turn primary care practices into PCMHs that provide physical and mental health services and support. ▪ **Current status:** The pilot began in 2006 and was expanded statewide in 2010. The model has moved to include the social determinants of health, such as nutrition, housing, social connections, and more. The model has aligned with the quality and cost objectives of Vermont's All-Payer Model, working to partner with OneCare Vermont, the Vermont Department of Health, The Green Mountain Care Board, Bi-State, and many other partners. This program utilizes two payment funding streams: transformation and capacity payments. Vermont makes per patient per month (PPPM) payments directly to primary care practices with NCQA-PCMH recognition. An additional quality-based payment of up to $0.50 PPPM is provided for achieving excellence in preventative and chronic care. ▪ **High Level Results:** The BluePrint for Health has demonstrated lower average risk-adjusted expenditures for patients in the PCMH and Community Health Teams relative to comparison groups. Additionally, patients in more mature PCMHs and with access to the Community Health Teams have a slower growth in health care expenditures by an average of $332 per participant. In addition, PCMH participants showed lower pharmacy spending but increased spending in the Special Medicaid Services, which are targeted SDOH services.	Vermont BluePrint for Health Website Vermont BluePrint for Health Annual Report (2017)

State & Program	State Characteristics	Description of Model	References
Michigan **The Michigan Primary Care Transformation Project (MiPCT)** Model Type: Multipayer Advanced Primary Care Practice (MAPCP), PCMH Payer: Medicaid, Medicare, Commercial **2012-2016** LAN Category: 2A-2C SIM State: yes APCD: yes	▪ 57 out of 83 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 361 primary care HPSA (health professional shortage area) designations[97]	▪ **Geographic scope:** Statewide. ▪ **Population:** Michigan patients attributed to participating providers and covered by Medicare, Medicaid, Priority Health, Blue Cross Blue Shield of Michigan, or the Blue Care Network. ▪ **Goal of model:** The Michigan Primary Care Transformation Project (MiPCT) was a five-year multipayer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship. ▪ **Current status:** MiPCT launched in 2012 with Medicare's participation as a payer as part of the MAPCP Demonstration. The project demonstration period was extended through December 31, 2016, and has now ended. Michigan's initiative was by far the largest among the MAPCP Demonstration states, with over 1.17 million participating individuals. With the Demonstration now over, MI has transitioned over to ongoing programs such as CPC+ and the SIM PCMH initiative. ▪ **High Level Results:** MiPCT general and high-risk patients reported a significantly better experience than non-PCMH patients in most domains, including: access, communication, and coordination. MiPCT resulted in Medicare savings between $140 and $295 million during 14 quarters of the MAPCP Demonstration. Most savings were due to reduced expenditures among Medicare beneficiaries with multiple chronic conditions. Most results on other outcomes were inconsistent or not statistically significant. Of the 8 states in the MAPCP demonstration, Michigan is one of 2 states that reduced the rate of growth in Medicare FFS expenditures in the first year of implementation. The Demonstration resulted in estimated reductions of about $148 per full-year eligible Medicare beneficiary.	Patient-Centered Primary Care Collaborative- MiPCT MiPCT Demonstration Project Website RTI- Evaluation of the Multipayer Advanced Primary Care Practice Demonstration Patient Experience with the Patient-Centered Medical Home in Michigan's Statewide Multipayer Demonstration: A Cross-Sectional Study

State & Program	State Characteristics	Description of Model	References
Colorado **Colorado State Innovation Model (SIM)** Payer: Medicaid, Medicare, Commercial **2015-Present** LAN category: 2A-2B SIM State: yes APCD: yes	▪ 47 out of 64 counties are rural[20] ▪ 1.1% of state population are American Indian or Alaska Native[122] ▪ 123 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Coloradans ▪ **Goal of model:** The state will improve the health of Coloradans by: 1) providing access to integrated primary care and behavioral health services in coordinated community systems, 2) applying value-based payment structures, 3) expanding information technology efforts, including telehealth, and 4) finalizing a statewide plan to improve population health. ▪ **Current status:** Between February 2015 and January 2019, the State of Colorado will receive up to $65 million from CMMI to implement and test its State Health Care Innovation Plan. Colorado SIM will recruit 400 primary care practices and community mental health centers (CMHCs) to participate in practice transformation efforts over the course of the grant. The first cohort, consisting of 100 practices, officially launched in February 2016. Two additional cohorts of 150 practices each were on-boarded in 2017 and 2018. Colorado also aims to bring the majority of payers into shared risk and savings programs by 2019. ▪ **High Level Results:** Results are not yet available. When fully implemented, the plan is projected to generate $126.6 million dollars in total cost of care savings by 2019, with annual savings of $85 million thereafter.	Colorado.gov- what is SIM? Colorado's State Health Innovation Plan Colorado SIM Operational Plan SIM Practice Transformation
Coordinated Care			
Ohio **Ohio Patient-Centered Primary Care Collaborative (OPCPCC)** Model type: PCMH, EOC Payers; Medicaid, Commercial **2013-Present** LAN Category: 2A-2C SIM State: yes APCD: no	▪ 50 out of 88 counties are rural[20] ▪ 0.2% of state population are American Indian or Alaska Native[122] ▪ 150 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Medicaid, employee and commercial payer populations ▪ **Goal of model:** The PCMH program aims to control costs and ensure that healthcare in Ohio is affordable, to improve health outcomes and to enhance the patient experience. ▪ **Current status:** In 2013, Ohio was awarded a federal SIM design grant, and in December 2014, the CMS awarded Ohio an implementation grant. Led by the Ohio Department of Health, the OPCPCC is a coalition of primary care providers, insurers, employers, consumer advocates and other stakeholders. The coalition is built around the PCMH model and was initiated as the PCMH Education Pilot Project, authorized by the Ohio General Assembly in 2010. The other component of the Ohio effort is to improve coordinated care through an Episodes of Care (EOC) model. In April 30, 2017, Ohio had implemented 13 EOCs and expects to roll out another 34 EOCs during the remainder of 2017. ▪ **High Level Results:** Results are not yet available.	OPCPCC Website SIM Round 2 Second Annual Report

State & Program	State Characteristics	Description of Model	References
New York **New York Health Homes** Model type: Health Homes Payer: Medicaid **2012-Present** LAN Category: 2A, 4A SIM State: yes APCD: yes	▪ 24 out of 62 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 197 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** NY Medicaid enrollees with chronic conditions. ▪ **Goal of model:** Health Home providers will integrate and coordinate all primary, acute, behavioral health, and long term services and supports to treat the whole person. Health Homes will improve the health care provided to both Fee-for-Service (FFS) and Managed Care Plan (MCP) members of the Medicaid program (who are medically needy) and will save money by reducing preventable hospitalizations, emergency room visits, and unnecessary care. ▪ **Current status:** Health Homes for Medicaid enrollees with chronic conditions was adopted into law effective April 1, 2011 and implemented on January 1, 2012. At that time, the state converted existing case management programs into Health Homes. ▪ **High Level Results:** Results are not yet available.	New York Health Homes Billing Guidance for Providers SIM Round 2 Second Annual Report New York Health Homes Program Update

State & Program	State Characteristics	Description of Model	References
Rhode Island **Care Transformation Collaborative of Rhode Island (CTC-RI)** Model type: MAPCP, PCMH Payer: Medicaid, Medicare, Blue Cross Blue Shield RI, Neighborhood Health Plan, Tufts Health Plan, United Health Plan **2008-Present** LAN category: 2A SIM State: yes APCD: yes	▪ 0 out of 5 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 14 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Rhode Island patients attributed to participating providers and covered by a participating payer. ▪ **Goal of model:** To improve the quality of care, the patient experience of care, the affordability of care, and the health of the populations we serve. To engage providers, payers, patients, purchasers and policy makers to develop high quality, family and patient centered medical homes providing health care in an affordable, integrated healthcare system that promotes active participation, wellness, and delivers high quality comprehensive health care dedicated to data-driven system reform. ▪ **Current status:** Launched in 2008 by the Office of the Health Insurance Commissioner, CTC-RI brings together key health care stakeholders to promote care for patients with chronic illnesses through the PCMH model. CTC-RI began with 5 pilot sites in 2008, added 8 sites in 2010, and another 3 sites in October 2012. Medicare joined the initiative in 2011, after which participating practices received PCMH payment support for nearly all insured patients. Currently, CTC-RI includes 43 primary care practices with 73 total practice sites, providing more than 320,000 Rhode Islanders with access to a PCMH. Over the next five years, 20 practices will be added each year, with the goal of providing over 500,000 Rhode Islanders with access to a PCMH. ▪ **High Level Results:** 7.2% reduction in hospital admissions in most experienced CTC-RI practices. More experienced CTC-RI practices saw reduced inpatient hospitalization, while the comparison group (primary care practices that are not CTC-RI patient-centered medical homes) experienced an increase. 11.6% reduction in ambulatory care-sensitive emergency department (ED) visits. Fewer overall ED visits, inpatient admissions and ambulatory care sensitive inpatient admissions. Improvements across diabetes care measures in PCMHs versus control groups. Practices collectively met every targeted patient health outcome, including areas of weight management, diabetes, high blood pressure and tobacco cessation, and practices are showing improvement over time in all of the targeted areas. CTC-RI practices reported higher patient experience scores compared with other MAPCP states. CTC-RI practices received increased, positive patient experience ratings including access to care, communication with their care team, office staff responsiveness, shared decision making, and self-management support. Primary care spending increased by 37% between 2008 and 2012. Total medical spending fell 14%.	Care Transformation Collaborative of Rhode Island (CTC) Care Transformation Collaborative of Rhode Island- official site Evaluation of the Multipayer Advanced Primary Care Practice (MAPCP) Demonstration

State & Program	State Characteristics	Description of Model	References
Oregon **Coordinated Care Organizations** Model type: ACO Payer: Medicaid **2012-Present** LAN category: 2C SIM state: yes APCD state: yes	▪ 23 out of 36 counties are rural[20] ▪ 1.4% of state population are American Indian or Alaska Native[122] ▪ 127 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Medicaid enrollees ▪ **Goal of model:** The model aims to improve management of chronic conditions, focus on primary care and prevention, and to ultimately lower to cost of health care while increasing quality of care. ▪ **Current status:** In 2012 Oregon established 16 CCOs, which are networks of health care providers (physical health care, additions and mental health) who collaborate to focus on prevention and disease management. The CCOs partake in a variety of innovative efforts, including providing incentives for primary care home enrollment, data utilization to target high-risk beneficiaries, care transition programs, and flexible funds that will support social services access. Oregon identifies key model elements to be care coordination, shared responsibility for health, transparency in price and quality, measuring performance, paying for outcomes and health, and a sustainable rate of growth. ▪ **High Level Results:** In a study comparing Oregon Medicaid to Washington Medicaid, the Oregon CCO transformation was associated with a 7% relative reduction in expenditures. The results were driven by a reduction in inpatient utilization, avoidable emergency department visits and an improvement in measures of appropriateness of care. However, there was also a reduction in primary care visits for Medicaid patients in the CCOs. On October 15, 2018, the Oregon Health Policy Board finalized recommendations for the CCO 2.0 plan.	Coordinated Care in Oregon OHSU Study on Oregon Medicaid Reform CCO 2.0 Recommendations of the Oregon Health Policy Board

State & Program	State Characteristics	Description of Model	References
Data Analytics			
Maine **Accountable Communities Initiative** Model type: Health Home, Behavioral Health Home and ACO Payer: Medicaid (MaineCare), Commercial and Medicare **2013-2018** LAN Category: 3A SIM State: yes APCD: yes	▪ 8 out of 16 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 68 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide (4 regional Accountable Communities) ▪ **Population:** 55,314 MaineCare members ▪ **Goal of model:** The main goals of the Maine SIM award were to reduce the total cost of care per member per year, improve the health of Maine's population in at least four categories of disease prevalence, improve patient experience scores for targeted practice compared to the baseline survey, and to increase the number of practices reporting patient experience information. ▪ **Current status:** In 2013, Maine was awarded a three-year $33 million SIM grant. The program was launched in 2014 with 28 practices and 32,070 members, building upon the state's health home program. By the third year, the Accountable Communities had 80 participating practices and 55,314 members with plans to continue expanding the provider list in 2017. Services include physical and behavioral health, long-term supports and services, and dental. Maine has also received a one year No-Cost Extension to continue with a narrower focus. The main data analytic and HIT activities within the SIM project were expanding the Behavioral Health and HIT, expanding the use of innovative HIT across their SIM models, collecting public health data for MaineCare and the Maine Centers for Disease Control, and training on the data focused learning collaborative. ▪ **Results:** The state reports savings of 3.16%, which totaled $5.41 million in savings in the first year. The shared savings payments to the Accountable Communities were $856,675, so net savings to MaineCare were $4.56 million. According to a 2016 evaluation, quality results were similar to a control group.	Maine State Innovation Model Website Maine SIM Efforts to Centralize Data Accountable Communities Initiative List of Maine Accountable Communities and Practices Maine State Innovation Model Self Evaluation: Year Three Final Report
Minnesota **Minnesota Health Economics Program (HEP)** Model type: Health economics program LAN category: N/A SIM State: yes APCD: yes	▪ 60 of 87 counties are rural[20] ▪ 1.1% of state population are American Indian or Alaska Native[122] ▪ 128 primary care HPSA (health professional shortage area) designations[206]	▪ **Goal of model:** The Health Economics Program (HEP) conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. The HEP collects, maintains and analyzes health care data to support the activities listed above. Tools include the health Care Cost Information System (HCCIS), a tool started in 1984 to provide accurate and reliable information on the financial, utilization and service data from hospitals and outpatient surgical centers in the state. HEP also conducts health plan, provider and capital expenditure reporting tasks. ▪ **High Level Results:** Results are not available.	Minnesota Department of Health-Health Economics Program

State & Program	State Characteristics	Description of Model	References
Colorado **Colorado Data Analytics Portal** Model type: Data analytics Payer: Medicaid LAN category: N/A SIM State: yes APCD: yes	■ 47 out of 64 counties are rural[20] ■ 1.1% of state population are American Indian or Alaska Native[122] ■ 123 primary care HPSA (health professional shortage area) designations[206]	■ **Goal of model:** Colorado has a sophisticated infrastructure for data analysis. The Health First Colorado Data Analytics Portal (DAP) supports the Accountable Care Collaborative's (ACC's) goal of improving member health and reducing costs. Operated by the Department of Health Care Policy & Financing, the DAP includes a data analytic tool for Primary Care Providers and Regional Accountable Entities with population health data and performance information. In addition to the state's data analytics work, there are well-established public-private analytics partnerships in the stat. The Center for Improving Value in Health Care (CIVHC) identifies and advances initiatives across Colorado to enhance consumers' health care experiences, contain costs and improve the population health. Additionally, the Colorado Health Institute (CHI) provides the state with evidence-based data and information to inform policy, advance health, promote collaboration and support better access to care. ■ **High Level Results:** Results are not available.	Colorado Data Analytics Portal (DAP) Spotlight on Data Analytics in Medicaid: Colorado The Center for Improving Value in Health Care Colorado Health Institute

State & Program	State Characteristics	Description of Model	References
Payment reform			
Arkansas **Multipayer Total Cost of Care** Model type: EOC Payer: Medicaid, Commercial, Employer Plans **2012-Present** LAN Category: 3A SIM state: yes APCD: yes	▪ 55 out of 75 counties are rural[20] ▪ 0.8% of state population are American Indian or Alaska Native[122] ▪ 186 primary care HPSA (health professional shortage area) designations[206]	The Arkansas Health Care Improvement Initiative (HPII) is built around patient-centered care delivery payment reform models, which includes PCMH (see above), health homes, and episodes of care. ▪ **Geographic scope:** Statewide ▪ **Population:** Patients attributed to participating providers and covered by Medicaid, AR BCBS, the Arkansas State and Public School Employee Plans, Walmart, and Qualified Health Plans participating in the health insurance marketplace. The only services excluded are inpatient neonatal services, LTSS, and inpatient psychiatric care for those with severe & persistent mental illness. ▪ **Goal of model:** The goal of the Arkansas reform effort is to improve the health of the Arkansas population, enhance patient experience (including quality, access and reliability of care), and reduce or improve control over costs of health care. ▪ **Current status:** The EOC model was the first VBP model to be implemented within AHCPII, beginning in 2012. When the EOC program began, the state implemented three episodes: Upper Respiratory Infection, perinatal care, and Attention Deficit Hyperactivity Disorder. Since then, the state has vastly expanded the available episodes. The fourteen newer episodes are congestive heart failure, colonoscopy, tonsillectomy, cholecystectomy, coronary artery bypass graft, asthma, Chronic Obstructive Pulmonary Disorder, Oppositional Defiant Disorder and total joint replacement. The state is continuing to develop new episodes for future implementation. Currently under development are areas of surgical intervention and hospitalization management. ▪ **High Level Results:** The state's year 3 report shows positive results such as a reduction in the C-section rate; increased physician follow-up for asthma and COPD; and decreased average episode costs for perinatal, ADHD, total joint replacement, COPD, and colonoscopy.	Arkansas Health Care Payment Improvement Initiative 3rd Annual Statewide Tracking Report Episodes of Care Initial Findings on Payment Improvement Episodes Arkansas Center for Health Improvement: Arkansas Health Care Payment Improvement Initiative

State & Program	State Characteristics	Description of Model	References
Maryland **Health Services Cost Review Commission/ Care Redesign Program** Model type: All payer rate setting **1971- present with newest iteration beginning in 2014** LAN category: N/A SIM State: yes APCD: yes	▪ 5 out of 24 counties are rural[20] ▪ 0.4% of state population are American Indian or Alaska Native[122] ▪ 60 primary care HPSA (health professional shortage area) designations[206]	▪ Geographic scope: Statewide ▪ **Population:** All patients receiving hospital care in Maryland. ▪ **Goal of model:** To provide an opportunity for Maryland to reform its delivery system to align with the goals of delivering better health, better care, and lower cost. ▪ **Current status:** A 1971 Maryland law created the Health Services Cost Review Commission (HSCRC). Beginning in 1974, the HSCRC was given the authority to set hospital rates which would apply to all Maryland payers. In 1977, Maryland received a federal waiver that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates. In 2014, CMS and Maryland announced a new initiative to modernize the all-payer rate-setting model for hospital services. The new model requires Maryland to generate $330 million in Medicare savings over a five year performance period, to limit its annual all-payer per capita total hospital cost growth to 3.58%, to shift virtually all of its hospital revenue over the five year period into global payment models, and to achieve a number of quality targets. In July of 2017, CMS and Maryland announced the Care Redesign Program (CRP) that advances efforts to redesign and better coordinate care in Maryland. The CRP provides hospitals participating in the All-Payer Model the opportunity to partner with and provide incentives and resources to certain providers and suppliers in exchange for improving quality of care and reducing spending growth. The All-Payer Model, including the CRP, ends on December 31, 2018. ▪ **High Level Results:** In 1974, before the HSCRC began setting rates, hospital costs per admission in Maryland were 23.6% above the national average. By 2005, hospital costs per case in Maryland had fallen to 5.1% below the national average. During this period, Maryland has experienced the absolute lowest rate of cost increase per admission of any state. Since the implementation of the new model in 2014, Maryland has achieved an estimated $429 million in total Medicare hospital savings, exceeding the five-year requirement of $330 million. Maryland hospitals have reduced potentially preventable complications by 48% since 2013. From 2013 to 2015, Maryland's readmission rate decreased by 57%.	CMS.gov- Maryland All-Payer Model CMS Newsroom- Maryland All-Payer Model to Deliver Better Care and Lower Costs Health Services Cost Review Commission- Maryland's All-Payer Hospital Payment System Health Affairs- Maryland's All-Payer Model- Achievements, Challenges, and Next Steps

State & Program	State Characteristics	Description of Model	References
Vermont **Vermont All-payer Accountable Care** Model type: ACO Payer: All **2017-present** LAN category: 3A SIM State: yes APCD: yes	▪ 11 out of 14 counties are rural[20] ▪ 0.4% of state population are American Indian or Alaska Native[122] ▪ 33 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Entire insured population of Vermont. ▪ **Goal of model:** The Vermont all-payer accountable care organization model incentivizes health care value and quality for the most significant payers throughout the state- Medicare, Medicaid, and commercial health payers- with a focus on improving health outcomes. The all-payer ACO model provides opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients more routinely for episodic illness to providing longitudinal and preventive care. ▪ **Current status:** The model agreement between CMS and Vermont was signed in October 2016 with a performance period from January 1, 2017 to December 31, 2022. ▪ **High Level Results:** This model is still in its performance period. Statewide targets for health outcomes for Vermont's entire population include: 1) By 2022, 70% of all Vermont insured residents, including 90% of Vermont Medicare beneficiaries, are attributed to an ACO. 2) Vermont will limit the annualized per capita health care expenditure growth for all major payers to 3.5%. 3) Vermont will focus on achieving health outcomes and quality of care targets in four priority areas: substance use disorder, suicides, chronic conditions, and access to care.	CMS.gov- Vermont All-Payer ACO Model Report on the Green Mountain Care Board's Progress in Meeting All-Payer ACO Model Implementation Benchmarks Overview of Vermont's All-Payer Accountable Care Organization Model

State & Program	State Characteristics	Description of Model	References
Rhode Island **Rhode Island Medicaid Accountable Entity (AE) Program** Model type: ACO Payer: Medicaid **2015-Present** LAN category: 2A SIM State: yes APCD: yes	■ 0 out of 5 counties are rural[20] ■ 0.6% of state population are American Indian or Alaska Native[122] ■ 14 primary care HPSA (health professional shortage area) designations[206]	■ **Geographic scope:** Statewide ■ **Population:** High-cost/high-need Medicaid beneficiaries. ■ **Goal of model:** This program is intended to break through the financing and delivery system disconnects and build partnerships across payment systems, delivery systems and medical/social support systems that effectively align financial incentives and more effectively meet the real life needs of individuals and their families. The core objectives of the accountable entity (AE) program include: substantial transition from fee-for-service models to managed care, define Medicaid-wide population health targets and tie them to payments where possible, maintain and expand on the delivery of high quality care, deliver coordinated accountable care for high-cost/high-need populations, ensure access to high-quality primary care, and shift Medicaid expenditures from high-cost institutional settings to community-based settings. ■ **Current status:** The AE program is a core component of the Governor's Reinventing Medicaid initiative (2015.) In October, 2015 EOHHS issued certification standards for the AE pilot program and invited applications for participation. Six entities were certified as Pilot Comprehensive AEs during 2016. The certification period for non-pilot applicants began in 2018 and will continue through December 31, 2021. ■ **High Level Results:** As of Q3 2017 over half of managed care enrollment is now attributed to AEs. For the first year of the program (SFY 2017), four of seven AE contracts accomplished shared savings.	Rhode Island Medicaid Accountable Entity Program-Accountable Entity Certification Standards Rhode Island Medicaid Accountable Entity Program-Program Description Medicaid Accountable Entities Program Update

State & Program	State Characteristics	Description of Model	References
Pennsylvania **Rural Health Model** Model type: Global budgets for hospitals Payer: Medicare, Medicaid, Commercial **2017-2023** LAN Category: 4B SIM State: yes APCD: no	▪ 30 of 67 counties are rural[20] ▪ 0.2% of the state's population are American Indian/Alaska Native[122] ▪ 166 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Voluntary participation by hospitals in rural areas. ▪ **Population:** All patients receiving care at participating hospitals and covered by participating payers (Medicare, Medicaid, commercial). ▪ **Goal of model:** The model aims to increase rural Pennsylvanians' access to high-quality care and improve their health. The model hopes to reduce the growth of hospital expenditures across payers. ▪ **Current status:** CMS will provide $25 million in funding over the first four years to support implementation. Rural hospitals will receive global budgets from Medicare, Medicaid, and commercial payers for all inpatient and outpatient services, to cover 90% of each hospital's revenue by year 2. Global budgets are set in advance and paid monthly. Each hospital must submit a Rural Hospital Transformation Plan for the state's and CMS' approval. The model will scale from eight hospitals in the first year to about 30 hospitals by year 3. ▪ **High Level Results:** Pennsylvania's model is in the early stages of implementation, but Maryland has had success with a similar model, achieving reductions in preventable admissions, readmissions, and expenditures, as well as improved balance sheets for hospitals.	Global Budgeting for Rural Hospitals webinar presentation Pennsylvania Rural Health Model Evaluation of the Maryland All-Payer Model: Second Annual Report

State & Program	State Characteristics	Description of Model	References
Washington **Accountable Communities of Health (ACH)** Model type: ACO Payer: Medicaid, Commercial **2015-Present** LAN category: 2A, 2C SIM State: yes APCD: yes	▪ 19 out of 39 counties are rural[20] ▪ 1.5% of state population are American Indian or Alaska Native[122] ▪ 207 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic Scope:** Statewide ▪ **Population:** Washingtonians covered by participating payers ▪ **Goal of Model:** Accountable Communities of Health (ACHs) bring together leaders from multiple health sectors around the state with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. ACHs promote health equity throughout the state; create, support, and collaborate on local health improvement plans; support local and statewide initiatives as the Medicaid Transformation, practice transformation, and value-based purchasing; and align resources and activities that improve whole-person health and wellness. ▪ **Current Status:** Washington received a Round Two State Innovation Model (SIM) Model Test Award in December 2014, and used this federal funding to launch "Healthier Washington." Beginning with two pilot ACHs, a total of nine ACHs received designation between July 2015 and January 2016. These nine ACHs cover the entire state and align with the state's Medicaid regional service areas. As of 2017, all nine regional ACHs were implementing at least one SIM Initiative-funded project. ▪ **High Level Results:** There are not yet quantitative evaluation results for the ACH program, but a participant survey from 2017 gives some insight to program functionality. Respondents reported high levels of satisfaction. More than 2/3 were satisfied or very satisfied with how their ACH is operating. Ratings indicate that ACHs are generally performing well. Areas of strength across ACHs included: organizational function, such as how ACH staff and leaders further the agenda of the collective; and governance, such as having an effective board. Opportunities for growth included: engaging diverse communities, providing opportunities for public comment/participation, and effective communication with the broader community. The majority of survey respondents agreed that ACHs are making a positive impact on health system transformation, cross-sector collaboration, and regional health.	Accountable Communities of Health Fact Sheet Washington State Health Care Authority ACH Participant Survey 2017 State Innovation Models (SIM): Model Test Annual Report Two State Levers to Advance Accountable Communities of Health ACH FAQ

State & Program	State Characteristics	Description of Model	References
Oregon **Prioritized List of Health Services** Model type: Payer: 1989-Present LAN category: N/A SIM state: yes APCD state: yes	▪ 23 out of 36 counties are rural[20] ▪ 1.4% of state population are American Indian or Alaska Native[122] ▪ 127 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Medicaid and SCHIP ▪ **Goal of model:** In 1989, the Oregon Legislature created the Health Services Commission to develop a prioritized list of health services ranked in order of importance to the entire population to be covered. The approach rank- orders general categories of health services (e.g., maternity and newborn care; comfort care) based on relative importance as gauged by public and Commissioner input. Within these general categories, individual condition/treatment pairs are prioritized according to impact on health, effectiveness and (as a tie-breaker) cost. The original policy goals that spurred the creation of the Prioritized List were that the goal is health rather than health services and a commitment to the public process, meeting budget constraints, and the use of available resources to fund clinically effective treatments. ▪ **Current status:** The Oregon Health Evidence Review Commission (HERC) ranks health care conditions and treatments in order of clinical effectiveness and cost effectiveness. The Prioritized list emphasizes prevention and patient education, such that treatments to help prevent illnesses are ranked higher than those to treat illnesses. There are 17 categories of services, and within the categories, certain services were prioritized based on effectiveness and cost. The list works to avoid "rationing" of health care by excluding certain people from coverage or access to care. If there are restrictions due to budget limitations, health services are eliminated according to the priorities made by the HERC in the list. The Commission is mandated to include five physicians, one public health nurse, one social worker and four purchasers or consumers of health care. ▪ **High Level Results:** The prioritized list has aided the state in making decisions about the allocation of public resources and funding with regards to health coverage. Additionally, health policy in Oregon is evidence-based in clinical effectiveness research. However, the list has not succeeded in eliminating reductions in benefits, which occur when necessary for the budget.	Brief History of Health Services Prioritization in Oregon 2018 Prioritized List of Health Services Health Evidence Review Commission

State & Program	State Characteristics	Description of Model	References
Social Determinants of Health			
Minnesota **Integrated Health Partnership 2.0 (IHP)** Model type: ACO Payer: Medicaid **IHP 2010-2017, IHP 2.0 2018-Present** LAN category: 3A SIM State: yes APCD: yes	▪ 60 of 87 counties are rural[20] ▪ 1.1% of state population are American Indian or Alaska Native[122] ▪ 128 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** 24 providers deliver care to more than 465,000 Minnesotans enrolled in Minnesota Health Care Programs. ▪ **Population:** Vulnerable populations who are socially complex, meaning that the population experiences contextual factors that influence a person's health, health behaviors, and health maintenance (i.e., poverty, low levels of education or literacy, limited English proficiency, minimal or no social support, poor living conditions, etc.). ▪ **Goal of model:** By including social factors in these models, Minnesota's Department of Human Services (DHS) may improve the accuracy of payments to IHPs and provide them the resources needed to invest in coordinated comprehensive interventions that improve health outcomes. Improved payments can help providers make infrastructure or human resources changes necessary to support people with social risk factors. In addition, the collection and use of SDOH data supports recommendations from the Minnesota State Innovation Model Data Analytics Subgroup that such measures be collected by organizations involved in ACO models to support shared accountability for cost and health outcomes. ▪ **Current status:** Minnesota is a leader for incorporating SODH data in payments to providers for socially complex patients. In 2015, the state legislature added language to the IHP authorizing legislation to examine health disparities payment enhancements, which would require DHS to provide a higher payment to providers who serve a disproportionate number of individuals with high social risk factors. Provider organizations have the opportunity to use population based payment (PBP), shared savings and/or shared risk for a portion of their total payment. The quarterly population-based payment amount is determined using predictive models based on historical trends in beneficiary health and resource utilization. ▪ **High Level Results:** Results of the IHP include a decrease in hospital stays and in emergency room visits.	MN Department of Human Services IHP MN Department of Human Services SDOH Presentation MN Department of Health Impacts of SDOH Integrated Health Partnerships Demonstration Integrated Health Partnerships Home Page Payment Model Overview Evaluation of the Minnesota Accountable Health Model: Final Report

State & Program	State Characteristics	Description of Model	References
Massachusetts **MassHealth Social Determinants of Health Project** Model type: Risk adjustment Payer: Medicaid **2016- Present** LAN category: 2A SIM State: yes APCD: yes	▪ 3 out of 14 counties are rural[20] ▪ 0.3% of state population are American Indian or Alaska Native[122] ▪ 68 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Medicaid enrollees experience SDOH complexities ▪ **Goal of model:** The model aims to improve the health of Massachusetts residents and to account for the impact of SDOH on the State's Medicaid spending. ▪ **Current status:** Massachusetts uses social risk factors for payment adjustment and setting reimbursement rates. The modeling measures were selected based on availability in claims data and reliability. These measures include: very low income, Limited English Proficiency, child protection, incarceration, food insecurity, access to transportation, social isolation/poor acculturation, and race/ethnicity. The model uses most recent 12 months of data for beneficiaries in managed care plans and is refreshed every three months. In 2017, MassHealth moved from a predictive to concurrent modeling design. ▪ **High Level Results:** Results are not yet available.	MassHealth Social Determinants of Health Project Model Design (2017) MassHealth Risk Adjustment Presentation (2016) MassHealth Risk Adjustment Methodology
New York **New York Health Homes** Model type: Health Homes Payer: Medicaid **2016-Present** LAN category: 2A, 4A SIM State: yes APCD: yes	▪ 24 out of 62 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 197 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** Medicaid enrollees with multiple chronic conditions and other risks for high resource utilization ▪ **Goal of model:** The health home model aims to improve communication between health care professionals involved in a members care. ▪ **Current status:** In December 2016, providers implemented the MAPP Assessment that measures clinical acuity as well as social risk factors of homelessness, incarceration, mental illness and substance use treatment. Patients are categorized as high, medium, or low risks, and billing rates monthly are adjusted according to these risks. Data are to be collected at enrollment, and then via a monthly assessment in order to have a current indication of each member's attributes. Initially, PMPM care management fee paid at two levels depending on enrollee status, and adjusted for case-mix and geography. ▪ **High Level Results:** Results are not yet available.	New York Health Homes New York Health Home Chronic Condition Eligibility Evaluation of Select Home Health Models (including NY)

State & Program	State Characteristics	Description of Model	References
North Carolina **Medicaid Transformation** Model type: Managed Care Payer: Medicaid **January 2019-October 2024** LAN category: VBP mechanisms still under development SIM State: no APCD state: no	▪ 54 out of 100 counties are rural[20] ▪ 1.3% of state population are American Indian or Alaska Native[122] ▪ 159 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic Scope:** Statewide ▪ **Population:** Medicaid enrollees ▪ **Goal of Model:** This proposed program design seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. DHHS' goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health. ▪ **Current Status:** Beginning in 2019, North Carolina is transitioning its fee-for-service Medicaid program to a managed care program. As part of this transition, North Carolina will require managed care organizations (MCOs) to screen every Medicaid beneficiary for access to food, stable housing, and transportation. Physicians or case managers use a standardized tool to screen patients for their social determinants of health. MCOs will be required to use the tool to screen all Medicaid beneficiaries starting next year. North Carolina is also building a resource platform so that once a patient's social determinants are pinpointed, providers can connect that patient to appropriate community resources, similar to the process to refer a patient to a medical specialist. ▪ **High Level Results:** Results are not yet available for this program.	Medicaid Managed Care Proposed Program Design Social Determinants of Health are Core of North Carolina's Medicaid Overhaul Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina
All Payer Claims Database			
Oregon **Oregon All Payer All Claims (APAC) Database** Model: All payer claims database **2009-Present** SIM State: yes APCD: yes	▪ 23 out of 36 counties are rural[20] ▪ 1.4% of state population are American Indian or Alaska Native[122] ▪ 127 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** APAC houses administrative health care data for Oregon's insured populations, including medical and pharmacy claims, enrollment data, premium information, and provider information for Oregonians who are insured through commercial insurance, Medicaid, and Medicare. ▪ **Goal of model:** APAC aims to provide access to timely and reliable data essential to improving quality, reducing costs, and promoting transparency. ▪ **Current status:** The Oregon State Legislature established APAC in 2009 to assist in measuring health care costs, quality, and utilization. APAC is operated by the Oregon Health Authority (OHA) and collects data on all paid claims from commercial health insurance carriers, licensed third party administrators, pharmacy benefit managers, Medicaid managed care organizations, Medicaid fee-for-service and Medicare parts C and D.	Oregon Office of Health Authority APAC Overview

State & Program	State Characteristics	Description of Model	References
Maine **Maine Health Care Claims Database** Model: All payer claims database **2003-Present** SIM State: yes APCD: yes	▪ 8 out of 16 counties are rural[20] ▪ 0.6% of state population are American Indian or Alaska Native[122] ▪ 68 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** APCD has claims from commercial insurance carriers, third party administrators, pharmacy benefit managers, dental benefit administrators, MaineCare (Maine Medicaid), and CMS (Medicare). ▪ **Goal of model:** The goal was to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens. ▪ **Current status:** Operated by the Maine Health Data Organization (MHDO) since 2003, the database holds claims for all health care records for Maine residents. Claims are submitted monthly to the MHDO. MHDO also collects data from Maine hospitals, including general inpatient and outpatient information, quality and financial data.	MHDO APCD
Washington (Mandated) **Washington State All-Payer Claims Database (WA-APCD)** Model: All payer claims database **2015-Present** SIM State: yes APCD: yes	▪ 19 out of 39 counties are rural[20] ▪ 1.5% of state population are American Indian or Alaska Native[122] ▪ 207 primary care HPSA (health professional shortage area) designations[206]	▪ **Geographic scope:** Statewide ▪ **Population:** WA-APCD includes medical services claims, cost data including billed, allowed, and paid, pharmacy claims, dental claims, member eligibility and enrollment data, and historical claims from January 1, 2013. ▪ **Goal of model:** Aims to support transparent public reporting to: assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices; enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost. WA-APCD intends to provide information to consumers on a public website, including costs and quality of health care services. ▪ **Current status:** In 2015, the WA legislature designated the start of a statewide all-payers health care claims database as a public resource. Oregon Health Sciences University (OHSU) is the lead organization that maintains the WA-APCD. They have subcontracted with Onpoint Health Data to be the data vendor. The data set is available, with an associated fee, to researchers, public agencies and others. There are specific protections within the data set to guard patient privacy and proprietary financial information.	Oregon Health Sciences University Website WA Health Compare Analytic Data Overview

State & Program	State Characteristics	Description of Model	References
Washington (Voluntary) **Washington All Payer Claims Database** Model: All payer claims database **2004-Present** SIM State: yes APCD: yes	■ 19 out of 39 counties are rural[20] ■ 1.5% of state population are American Indian or Alaska Native[122] ■ 207 primary care HPSA (health professional shortage area) designations[206]	■ **Geographic scope:** ■ Focus on the 5-county area in the greater Seattle metropolitan area (the Puget Sound region). ■ **Population:** Voluntary population. ■ **Goal of model:** The APCD was started to address concerns about rising health care costs and quality in the delivery of health care services. ■ **Current status:** Beginning in 2004, King County started the Puget Sound Health Alliance (now called the Washington Health Alliance). The Alliance is a purchaser-led, multi-stakeholder collaborative. The initial financial investment into the database was 1.5 million dollars, with an estimated 20 million dollar investment over time. Currently, the Alliance's database comprises approximately 65% of the non-Medicare claims in the region. The database currently captures information from 1/1/2004 through 12/31/2016, representing over 4 million lives and approximately 1.6 billion claim lines from commercial insurance, managed Medicaid and Medicaid Fee for Service. Access to the Alliance's database by researchers and other interested parties is possible but is quite limited.	Washington Health Alliance

Notes:

- The LAN framework category for each state's model refers to activities that have already been implemented. Sources:
  - https://www.shvs.org/wp-content/uploads/2018/02/SHVS_APM-Categorization_Brief-Final.pdf
  - http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

Appendix 2. State Characteristics Table

Exhibit 2. Summary of State Characteristics: Demographics, Economics, and Health Systems

	Alaska	Arkansas	Colorado	Maryland	New Mexico	North Carolina	Oregon	Washington
State Characteristics: Demographics and Economics								
Demographics								
Population, July 2018[122]	739,000	3.0 million	5.7 million	6.1 million	2 million	10.4 million	4.1 million	7.5 million
Population density per square mile, 2010[122]	1.2	56.0	196.1	594.8	17.0	196.1	39.9	101.2
% of frontier counties	87	0	39	0	47	0	27	12.5
% of population living in rural areas, 2017[122]	34	37	22	2	34	21	16	10
% population by race/ ethnicity, 2017[122]	▪ White Alone: 65.8 ▪ *White (non-Hispanic): 60.8 ▪ AI/AN: 15.3 ▪ Black: 3.7 ▪ Hispanic: 7.1 ▪ Asian: 6.5 ▪ Two or More Races: 7.4	▪ White Alone: 79.3 ▪ *White (non-Hispanic): 72.5 ▪ AI/AN: 2.0 ▪ Black: 15.7 ▪ Hispanic: 7.6 ▪ Asian: 1.6 ▪ Two or more races: 2.1	▪ White Alone: 87.3 ▪ *White (non-Hispanic): 68.7 ▪ AI/AN: 1.6 ▪ Black: 21.5 ▪ Hispanic: 21.5 ▪ Asian: 3.4 ▪ Two or more races: 3.0	▪ White Alone: 59.0 ▪ *White (non-Hispanic): 50.9 ▪ AI/AN: 0.6 ▪ Black: 30.8 ▪ Hispanic:10.1 ▪ Asian: 6.7 ▪ Two or more races: 2.8	▪ White Alone: 82.2 ▪ *White (non-Hispanic): 37.5 ▪ AI/AN: 11 ▪ Black: 0.3 ▪ Hispanic: 48.8 ▪ Asian:1.7 ▪ Two or more races: 2.5	▪ White Alone: 70.8 ▪ *White (non-Hispanic): 63.1 ▪ AI/AN: 1.6 ▪ Black: 22.2 ▪ Hispanic: 9.5 ▪ Asian:3.1 ▪ Two or more races: 2.2	▪ White Alone: 87.1 ▪ *White (non-Hispanic): 75.8 ▪ AI/AN:1.8 ▪ Black: 2.2 ▪ Hispanic: 13.1 ▪ Asian: 4.7 ▪ Two or more races: 3.8	▪ White Alone: 79.5 ▪ *White (non-Hispanic): 68.7 ▪ AI/AN: 1.9 ▪ Black: 4.2 ▪ Hispanic: 12.7 ▪ Asian: 8.9 ▪ Two or more races: 4.7%
Economic Indicators								
Gross state product (GSP), 2017[123]	$52.8 billion	$122 billion	$540.5 billion	$400 billion	$51.5 billion	$541 billion	$559 billion	$524 billion
GDP Per Capita, 2017[26]	$70,683	$ 37,930	$47,142	$59,983	$43,566	$47,142	$50,138	$64,937

	Alaska	Arkansas	Colorado	Maryland	New Mexico	North Carolina	Oregon	Washington
% Unemployment Rate, December 2018[122]	6.3%	3.7%	3.6%	3.9%	5.1%	3.6%	3.8%	4.3%
State Budget, SFY 2017	$9.7 billion	$2.5 billion	$48.2 billion	$43.3 billion	$19.5 billion	$48.2 billion	$40.0 billion	$44.7 billion
Median Household Income, 2017 dollars	$72,231	$43,813	$65,458	$78,916	$47,855	$50,320	$56,119	$66,174
% population living in poverty[122]	11.1	16.4	14.7	9.3	19.7	14.7	13.2	11.0
Top 3 Largest non-farm industries (employers), %, December 2018[3]	▪ Government: 24.4 ▪ Education & health services: 15.4 ▪ Leisure and hospitality: 10.9	▪ Trade, transportation, and utilities: 19 ▪ Government: 16.7 ▪ Education & health services: 15	▪ Trade, transportation, and utilities: 17 ▪ Government: 16 ▪ Professional and business services: 15	▪ Government: 18.2 ▪ Education & health services: 17.4 ▪ Trade, transportation, and utilities: 17.0	▪ Government: 21.9 ▪ Trade, transportation, and utilities: 16.1 ▪ Professional and business services:: 12.6	▪ Trade, transportation, and utilities: 18.9 ▪ Government: 16.3 ▪ Professional and business services: 14.2	▪ Trade, transportation, and utilities: 18 ▪ Government: 15.5 ▪ Education & health services: 15.5	▪ Trade, transportation, and utilities: 18.6 ▪ Government: 16.8 ▪ Education & health services:: 1.4
State Health Insurance Market – Health Coverage and Uninsured								
$ spent on health care, 2014[124]	Total: $8.1 million Per capita: $11,064	Total: $21.9 million Per capita: $7,408	Total: $36.4 million Per capita: $6,804	Total: $51 billion Per capita: $8,602	Total: $15 million Per capita: $7,214	Total: $72 billion Per capita: $7,264	Total: $31.9 billion Per capita: $8,044	Total: $55.8 billion Per capita: $7,913
Health Insurance Market[135]								
% Employer-sponsored, 2017	45	42	45	56	36	46	47.5	52
% Medicaid, 2017	22	30	27	18	40	18	26	22
% Medicare, 2017	9	16	12	12	14	15	15	13

	Alaska	Arkansas	Colorado	Maryland	New Mexico	North Carolina	Oregon	Washington
% no group, 2017	3	6	8	6	5	7	7	6
% uninsured, 2017	14	10.2	7.5	6	9.2	11	6.2	6
State Employee System: Pooled purchasing (Y/N)	N	N	N	N – But in 2018 state passed a bill establishing a task force to study pooling	N	N – Effective 2020 will have reference-based government pricing model based on a percentage of Medicare rates	N – But under discussion in legislature in 2018	Y
Medicaid								
Total Medicaid spending, 2017[140]	$0	$6.4 billion	$7.9 billion	$11.2 billion	$5.4 billion	$13.5 billion	$8.3 billion	$12 billion
% FMAP, 2019[203]	50	71.4	50	50	72.71	67.0	61.2	50.0
Medicaid expansion (Y/N)	Y	Y	Y	Y	Y	N	Y	Y
Income eligibility by eligibility group, % of FPL, January 2018	▪ Parents: 139 ▪ Other adults: 138 ▪ Children: 208 ▪ Pregnant women: 205 ▪ Seniors and people with disabilities: 59	▪ Parents: 138 ▪ Other adults:138 ▪ Children: 216 ▪ Pregnant Women: 214 ▪ Seniors and people with disabilities: 73	▪ Parents: 260 ▪ Other adults: 138 ▪ Children: 142 ▪ Pregnant Women: 195 ▪ Seniors and people with disabilities: 59	▪ Parents: 138 ▪ Other adults: 138 ▪ Children: 322 ▪ Pregnant women: 264 ▪ Seniors and people with disabilities: 74	▪ Parents:138 ▪ Other adults: 138 ▪ Children: 305 ▪ Pregnant Women: 255 ▪ Seniors and people with disabilities: 73	▪ Parents: 43 ▪ Other adults: 0% ▪ Children: 216 ▪ Pregnant women: 201 ▪ Seniors and people with disabilities: 100	▪ Parents: 138 ▪ Other adults: 138 ▪ Children: 305 ▪ Pregnant Women: 190 ▪ Seniors and people with disabilities: 73	▪ Parents: 138 ▪ Other adults: 138 ▪ Children: 300 ▪ Pregnant Women: 193 ▪ Seniors and people with disabilities: 75
% of Medicaid Population in MCO[239]	--	--	10.1	86.0	90.1	--	93.0	92.0
% of Medicaid Population in PCCM[239]	--	--	89.9	--	--	90.0	--	2.0

	Alaska	Arkansas	Colorado	Maryland	New Mexico	North Carolina	Oregon	Washington
% of Medicaid Population in FFS/Other [239]	100	--	0	14.0	9.9	10.0	7.0	6.0
Managed Care % of Medicaid population, 2018[239]	0	69.8	10	81.5	77.4	77.9	80.6	100
Providers and Service Use								
Hospital beds per 1,000, 2017[147]	2.5	3.2	1.9	1.9	1.8	2.1	1.7	1.7
Primary Care Providers per 100,000 residents, 2019[147]	139.0	120.9	141.3	188.2	141.6	132.5	145.4	146.5

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