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Unfinished Business: Medicaid and Delivery Innovation

Summary

Some states are implementing exciting health delivery innovations in their Medicaid programs. Examples discussed in this issue brief include the New York State Medicaid program's "care management for all" initiative; the development of a safety net accountable care organization (ACO) for a Medicaid expansion population in Hennepin County, Minnesota; and a system of 14 nonprofit, community care networks developed to serve Medicaid and uninsured people throughout North Carolina.

Federally qualified health centers (FQHC) and state Medicaid programs, which both serve low-income children and adults, can be partners in implementing innovations related to primary care, including patient-centered medical homes (PCMH). Moreover, state and regional Primary Care Associations and the National Association of Community Health Centers (NACHC) can help implement innovations in primary care and take them to scale. Accountability for entities such as ACOs and PCMHs can be improved through the National Committee for Quality Assurance's (NCQA) accreditation, certification, and recognition programs.

Introduction: Medicaid And Health Care Delivery Innovation

The Affordable Care Act (ACA) of 2010[i] and other recently enacted federal laws have set the stage for innovations in the organization, delivery, and financing of U.S. health care. The law established the Center for Medicare and Medicaid Innovation within the Centers for Medicare & Medicaid Services (CMS) for the express purpose of testing "innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits".[1]

Recently, delivery innovations at the federal level have largely focused on innovations such as accountable care organizations (ACOs) in Medicare, which provide health insurance coverage for Americans age 65 and over. At the same time, some state Medicaid programs are implementing delivery innovations that hold great promise.

Medicaid, the nation's principal safety net health insurance program, is a joint federal-state program that covers more people than any other public or private health care program in the country. In 2007, it covered nearly 60 million individuals, including 29 million children, 15 million adults (primarily working-poor parents), 6 million seniors, and 8.8 million persons with disabilities (including

4 million children).[2] The number of Medicaid enrollees is expected to increase under the ACA.

Medicaid serves highly diverse populations, including low-income mothers and children, people with developmental disabilities or serious mental illness, young adults with spinal cord injuries, and seniors with Alzheimer's disease or other dementias. The populations served by Medicaid are also racially and ethnically diverse.

The ACA affirmed and altered four of Medicaid's four long-standing roles in U.S. health care:[3]

1. Medicaid provides health insurance for low-income children and adults. To reduce the number of low-income people without health insurance, the ACA expanded eligibility for Medicaid to all U.S. citizens and legal immigrants under age 65 with incomes up to 138 percent of the federal poverty level.[ii] Assuming full participation in the Medicaid expansion by all states, the CMS Office of the Actuary estimated that the expansion would bring 20 million people into Medicaid.[4] The U.S. Supreme Court ruled in June 2012 that the ACA's Medicaid expansion was optional for states.[5] As of late February 2013, 24 states and the District of Columbia indicated that they would definitely participate in the Medicaid expansion, and 13 had indicated that they would not participate.[6]

2. Medicaid provides comprehensive coverage to disabled, chronically, and complexly ill beneficiaries without access to other insurance, including Medicare. Section 2703 of the ACA gives states the option of creating "health homes" to coordinate physical health, behavioral health, and long-term care services for Medicaid beneficiaries with serious, persistent mental illness and/or specified combinations of serious, high-cost, chronic conditions.[7]

3. Medicaid supplements Medicare coverage for elderly and disabled individuals who need long-term care services and supports. With the creation of CMS's Federal Coordinated Health Care Office (Medicare-Medicaid coordination office), the ACA places a new emphasis on coordinating care more efficiently for low-income, elderly, and disabled individuals who are dually eligible for Medicare and Medicaid.[8]

4. Medicaid, beyond reimbursing for services, provides various types of financial support for safety net providers, including hospitals, community health centers, and faith-based and mission-driven organizations. The ACA expands health insurance coverage for previously uninsured people served by safety net providers and gives FQHCs[iii] incentives and opportunities to promote the coordination and integration of care for the patients they serve.

5. At the same time, however, the ACA mandates cuts in Medicaid disproportionate share funding to safety net and other hospitals that serve large numbers of uninsured people beginning in 2014.[9]

Below, we present some examples of delivery innovations in Medicaid: care management for all in New York State;[3] a safety net ACO for a Medicaid expansion population in Hennepin County, Minnesota;[10] and a system of 14 nonprofit, community care networks that serve more than a million Medicaid and uninsured people throughout North Carolina.[11]

We also discuss the role of FQHCs, state/regional Primary Care Associations, and the NACHC in the efforts of the CMS Center for Medicare and Medicaid Innovation to transform primary care through the provision of medical homes for Medicaid enrollees and uninsured people.[12] Finally, we outline NCQA's accreditation, certification, and recognition programs, which set standards for entities such as ACOs and PCMHs that can help improve such entities' accountability.[13]

Medicaid Redesign In New York State

The New York State Medicaid program, with a budget of over $50 billion annually, is currently the largest Medicaid program in the United States, covering 5.1 million low-income state residents, including 1.9 million children, 2.0 million adults under age 65 and without disabilities, and 1.2 million elderly or disabled beneficiaries.[3]

Upon taking office in 2011, New York Governor Andrew Cuomo created a Medicaid Redesign Team, with 27 stakeholders from virtually every sector of the health care system, to propose changes that would constrain costs and improve health outcomes.[3] New York's Medicaid program spends twice the national average on a per recipient basis and faces some significant quality issues.[14]

"It is of compelling public importance that the state conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."

– Governor Andrew M. Cuomo
January 5, 2011

In Phase 1, New York's Medicaid Redesign Team developed a blueprint for lowering by $2.2 billion the state's Medicaid spending in state fiscal year 2011–2112 without cuts to eligibility.[15] The legislature approved nearly all of the recommendations in the plan, which reflected extensive feedback from citizens and stakeholders. The recommendations are now undergoing implementation.[14] To bring greater fiscal discipline and transparency into state Medicaid program spending, New York adopted the key recommendation, which called for imposing a global spending cap on the state's share of Medicaid spending.

In Phase 2, the Medicaid Redesign Team broke into 10 workgroups, which included additional citizens and stakeholders, to address more complex issues and oversee the process of implementing the team's recommendations. The result was a five-year plan for a thorough overhaul of New York's Medicaid program. Under the plan, the state began work in 2012 to ensure that virtually all Medicaid enrollees are in care management by April 2016.[16] Over time, the goal is to integrate fully the management of individuals' acute, long-term, and behavioral health care.[17] New York is also redirecting almost all Medicaid spending from a fee-for-service basis to care management, under which an intermediary is paid a capitated rate and is responsible for managing patient care and reimbursing service providers.

Embracing the "Triple Aim" of improving the patient's care experience (including quality and satisfaction), improving the health of populations, and reducing, or at least controlling, the per capita cost of care,[14] New York State is staking its Medicaid redesign on a major program innovation. The key elements of innovation include the following:[3]

- **Mainstream Medicaid managed care plans.** Most Medicaid recipients in New York who are not enrolled in Medicare are now either enrolled in "mainstream" Medicaid managed care plans or will be required to enroll soon.

- **PCMH.** To ensure that all Medicaid enrollees have access to high-quality primary care, New York plans to expand access to PCMHs to all Medicaid recipients over the next several years.[3]

- **Health homes.** New York's Medicaid program views the health home option for people with severe, persistent mental illness and/or specified chronic conditions in Section 2703 of the ACA as an essential part of its strategy of care management for all.[17] One challenge is to coordinate with health homes the care delivered by different types of providers to Medicaid enrollees.

- **Behavioral health organizations.** New York's Medicaid program is committed to improving the care management of people with mental health and/or substance use disorders through behavioral health organizations. It hopes eventually to integrate and coordinate behavioral health care delivery with physical health care delivery.[17]

- **Managed long-term care.** New York has made a major commitment to providing managed long-term care to help people in need health and long-term care services remain in their homes and communities as long as possible.[18]

- **Fully Integrated Duals Advantage Program.** To improve the coordination and integration of care provided to people who are dually eligible for Medicare and Medicaid and tend to be older than the average Medicaid recipient, New York plans to move such people in 2014 into its Fully Integrated Duals Advantage Program, established under a Medicaid waiver.[19]

- **Developmental Disabilities Individual Support and Care Coordination Organizations (DISCO).** The New York State Office for People with Developmental Disabilities is developing a new Section 1115 Medicaid waiver (People First Waiver) to serve people with developmental disabilities through specialized care coordination entities.[20]

Hennepin Health: A Safety Net Aco For A Medicaid Expansion Population In Minnesota
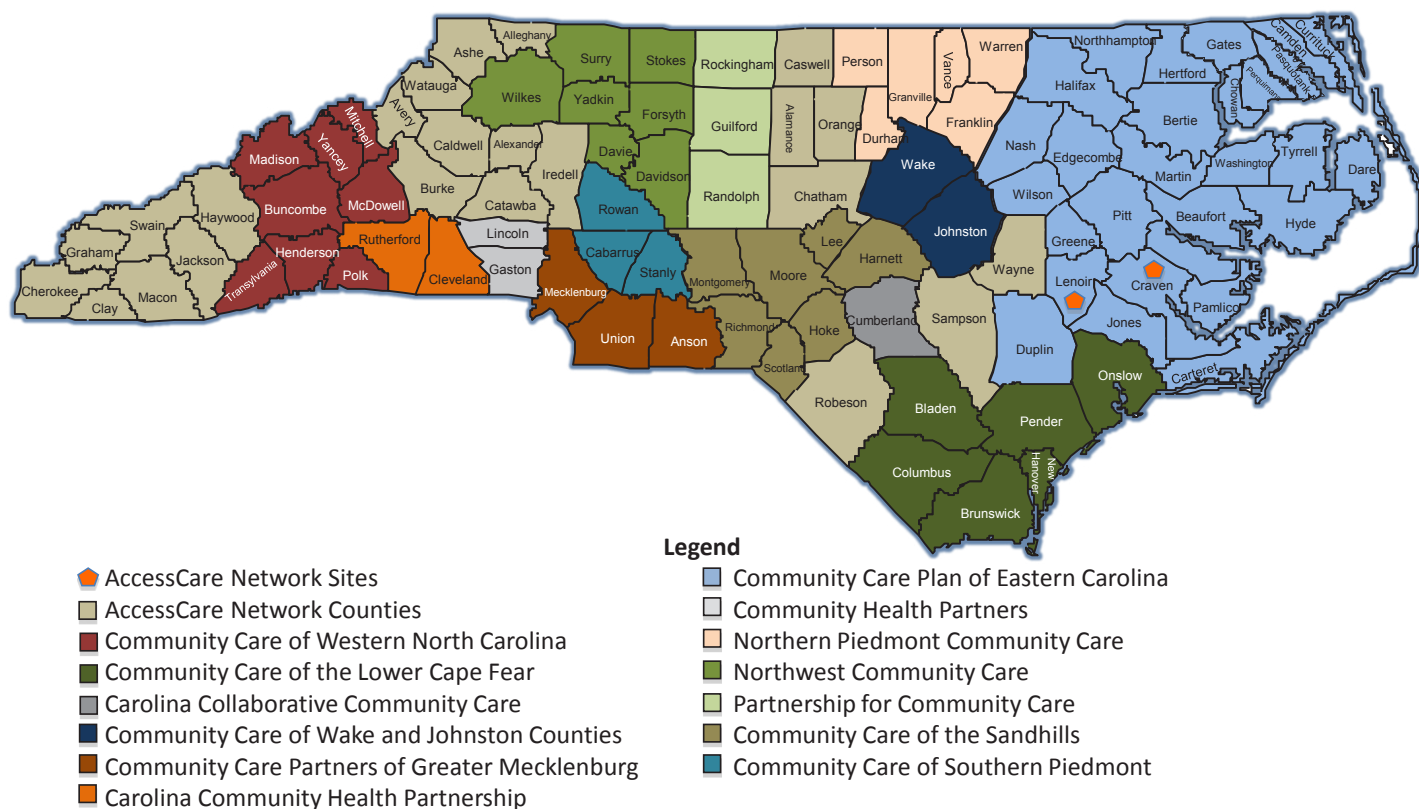
Minnesota is one of the states that is pioneering efforts to develop safety net ACOs to serve Medicaid patients.[21] Hennepin Health in Hennepin County, Minnesota—a provider-sponsored entity that is accountable for improving the health and care experience of a defined Medicaid population and is 100 percent at risk for financial outcomes—is the country's first safety net ACO.

Hennepin Health launched in 2012 as a two-year Medicaid demonstration to provide care for up to 10,000 of the poorest Medicaid patients—namely, childless adults age 21 to 64 with incomes at or below 75 percent of the poverty level ($677 per month for one person). The idea behind Hennepin Health is that significant health outcomes for the target population cannot be achieved without addressing the social determinants of health, including food, housing, transportation, and finding and retaining a job.[10]

By coordinating systems and services, Hennepin Health must provide the basic Medicaid benefit, but it may also provide other physical, mental, dental, and social support services to bring down overall costs. Minnesota pays a per member per month fee to Hennepin Health, which is the same amount that insurance companies receive for treating childless adults with incomes under 75 percent of the poverty level. The four partners participating in Hennepin Health (Hennepin County Medical Center, NorthPoint Health & Wellness, Hennepin County's Human Services and Public Health Department, and Metropolitan Health Plan) share and reinvest profits from the venture and are 100 percent at risk in the case of losses.[22]

Hennepin Health's goals for years 1 and 2 were to improve its enrollees' health outcomes and reduce overall costs; decrease hospital admissions/readmissions by more than 10 percent; reduce emergency department visits by more than 10 percent; increase primary care "touches" by more than 5 percent; and reduce churn (maintain coverage by more than 95 percent).[10] Recognizing that 5 percent of its enrollees were using 64 percent of funds, Hennepin Health has worked to integrate care coordination for its high-cost and high-need beneficiaries. Hennepin Health has also focused on responding to individuals with high behavioral health needs who were "stuck" in hospital beds; helping individuals failing transitions between programs; ensuring that individuals were not misusing crisis care venues; and reducing system fragmentation and duplication.

Figure 1: Map of Areas Served by Community Care of North Carolina's (CCNC) Community Networks

Legend

- ⬠ AccessCare Network Sites
- ☐ AccessCare Network Counties
- ☐ Community Care of Western North Carolina
- ☐ Community Care of the Lower Cape Fear
- ☐ Carolina Collaborative Community Care
- ☐ Community Care of Wake and Johnston Counties
- ☐ Community Care Partners of Greater Mecklenburg
- ☐ Carolina Community Health Partnership
- ☐ Community Care Plan of Eastern Carolina
- ☐ Community Health Partners
- ☐ Northern Piedmont Community Care
- ☐ Northwest Community Care
- ☐ Partnership for Community Care
- ☐ Community Care of the Sandhills
- ☐ Community Care of Southern Piedmont

Source: CCNC March 2013

The results from the Hennepin Health Medicaid ACO demonstration project are extremely encouraging, and both patients and providers are enthusiastic about the outcomes.[10] Hospital admissions and emergency room use have dropped significantly while primary care has increased. Moreover, 87 percent of served patients report that they are "likely to recommend" Hennepin Health.[10] The outcomes point to a huge opportunity in "managing" care for the Medicaid expansion population in order to alter the cost curve while improving patient satisfaction.

Moreover, with health plans and providers operating on a level playing field in Hennepin Health, all entities are motivated to work together to achieve shared outcomes, including improved health and cost savings. What makes the Hennepin Health ACO model sustainable are the flexibility of funding from Minnesota's leaders to bridge funding gaps and the reinvestment of savings into enhancements for Hennepin Health, leading to cost reductions of at least 30 percent.[10]

Medicaid officials in Minnesota believe that, unlike other entities, ACOs are better able to integrate services across settings.[23] Six other Medicaid ACOs became operational in Minnesota in January 2013, and three more are negotiating with Minnesota Medicaid to

start later in the year. In February 2013, CMS awarded Minnesota a State Innovations Model Initiative grant to test and implement a statewide accountable care model. The initiative will create linkages among Medicaid ACOs, Medicare, and commercial insurers to promote care coordination and access to a wide range of acute care, behavioral care, long-term care, public health, and social services.

Roles Of FQHCs, Primary Care Associations, And NACHC In Medicaid In Delivery Innovation

FQHCs are the largest network of safety net primary care providers in the nation.[12] FQHCs and Medicaid are likely partners in delivery innovation. Their missions are aligned, and they both serve low-income populations, face the need for strong and effective primary care supported by payment reforms and a quality improvement infrastructure, and must account for and affect the social and behavioral health aspects of health.[11]

Under the ACA, FQHCs are the nucleus for many of the nation's efforts to eliminate disparities in health and health care by expanding access to high-value primary care in underserved populations. Moreover, they are poised to play an essential role in implementing the provisions of the law that are intended to reinvent the delivery of primary care.[12] Below, we highlight a few examples of how FQHCs, state and regional Primary Care Associations (private,

4

nonprofit membership organizations of FQHCs and safety net providers), and the NACHC can help implement innovations in primary care and take them to scale.

North Carolina: FQHCs as Partners in Innovation in Primary Care Infrastructure

North Carolina provides a medical home and care management to more than a million Medicaid enrollees and uninsured people through a nonprofit organization known as Community Care of North Carolina (CCNC). CCNC has established an innovative model of care built around 14 nonprofit, community networks made up of physicians, hospitals, social service agencies, and county health departments that provide and manage care for residents throughout the state (Figure 1). All of North Carolina's FQHCs are members of the CCNC community networks, and some FQHCs lead CCNC networks.[11]

CCNC's community networks are responsible for managing their enrollees' care, including linking enrollees to a medical home, providing disease and case management services, and implementing quality improvement initiatives.[24] North Carolina identifies priorities for statewide disease and care management initiatives and provides supplemental funding to the networks for care management and quality improvement initiatives.[25] Primary care providers in the network receive a payment on a per member per month basis, and each network receives an additional per member per month payment ($2.50 and $5 for elderly and disabled enrollees, respectively) for care management.

CCNC is in the top 10 percent of HEDIS (Healthcare Effectiveness Data and Information Set) measures for health plans for diabetes, asthma, and heart disease. Moreover, the 2007 to 2010 health care utilization patterns and trends of the populations enrolled in CCNC are consistent with high-performing medical homes. A recent analysis by the actuarial firm Milliman, Inc., estimated savings achieved by CCNC from 2007 through 2010 at nearly $1 billion.[25]

Other payers and major employers are interested in the benefits of CCNC's approach, which has been adopted successfully in both urban and rural areas and has reduced costs while improving quality of care. With the support of the Commonwealth Fund, CCNC has launched a new Web site dedicated to helping others learn from its experience.[26]

Oregon: State Primary Care Association's Role in Health Innovation

Oregon, along with Minnesota, Utah, and Colorado, is in the forefront of efforts to develop safety net ACOs for Medicaid populations.[21] In September 2012, with nearly $2 billion in federal funds, Oregon launched a five-year Medicaid ACO demonstration involving 15 coordinated care organizations (CCO). Each CCC, operat-

ing under a fixed budget that grows at a fixed rate, is accountable for coordinating and integrating the physical, mental/substance abuse, and dental health care of the Oregon Health Plan patients it serves.[27] The objective is to cut health cost by 2 percentage points and improve health outcomes.

The arrangements for payments to Oregon's CCOs have not included any risk adjustment for social determinants of health such as homelessness, joblessness, and lack of social support. In response, the Oregon legislature passed Senate Bill 1522 in 2012 that requires the Oregon Health Authority to account for the psychological and social factors facing members of coordinated care organization when establishing quality measures and global budgets.[28]

Working with a group of pilot FQHCs, the Oregon Primary Care Association is identifying, through its electronic health record, the social and individual barriers to health and health care as well as the enabling services, such as language services, outreach, home visits, and coordination, needed to address these barriers. The aim is to document resource requirements for future payment models.

Missouri: State Primary Care Association's Role in Capacity Building and Alignment

Missouri operates two separate health home programs for Medicaid beneficiaries with chronic conditions, each of which received CMS approval under a separate state plan amendment:

- The first is a Primary Care Health Home initiative for Medicaid beneficiaries with at least $2,600 in annual health costs who qualify for enrollment by virtue of at least two chronic conditions—including asthma, diabetes, cardiovascular disease, obesity, tobacco use, and developmental disability—or one chronic condition and risk for another.

- The second is a Community Mental Health Center (CMHC) Health Home Initiative for Medicaid beneficiaries with serious mental health conditions.

The operation of two health home programs proved to be a challenge because of overlapping providers—FQHCs, CMHCs, and public entity primary care clinics—serving Medicaid beneficiaries who might qualify for both programs.[11]

To address that challenge, several partners—including MO HealthNet (Missouri Medicaid), the Missouri Department of Mental Health, Missouri Foundation for Health, Missouri Primary Care Association, and Missouri Coalition of Community Mental Health Centers—worked together to coordinate the two state initiatives through learning collaboratives and individualized practice coaching for health home providers in the state. The Missouri Foundation for Health funded the learning collaboratives and coaching. The partnership has helped health home

providers gain PCMH recognition from NCQA as well as CMHC accreditation from the Commission on Accreditation of Rehabilitation Facilities. It also illustrates the role of a state Primary Care Association in capacity building and as a system integrator in collaboration with state partners.

National Partnership: Role of NACHC in Harnessing State Innovation PCMH Initiatives

About 1,200 FQHCs across the country serve 20 million patients, including low-income individuals and families, migrant and seasonal farm workers, individuals without health insurance, and people who are homeless or living in public housing. Nearly 500 FQHCs are now participating in the CMS FQHC Advanced Primary Care Practice Demonstration to evaluate the effect of the PCMH on the care provided to Medicare beneficiaries served by FQHCs, including Medicare beneficiaries also covered by Medicaid.[29]

State Primary Care Associations, the American Institutes for Research, MacColl Center for Healthcare Innovation, National Association of Community Health Centers' (NACHC) Patient-Centered Medical Home Institute (which includes Primary Care Associations), and Qualis Health have all joined forces to help the FHQCs participating in the CMS demonstration achieve the highest level of PCMH recognition (Level 3) from NCQA. A system of state-based practice facilitators, Webinars addressing NCQA recognition and practice transformation, monthly "office hours" for participating sites, and monthly forums for practice coaches all offer support for practice transformation to PCMH.

NCQA's Standards Related To Medicaid Delivery Innovation

NCQA offers a range of health care accreditation, certification, and recognition programs to improve accountability at all levels in the U.S. health care system: health plans, insurers, ACOs and other organized delivery systems, and medical practices.[13]

In 2008, NCQA launched a recognition program with standards for PCMHs.[30] The program requires participants to satisfy elements in nine standard categories, and NCQA offers various levels of PCMH recognition (Level 1, 2, or 3) depending on whether the various elements are in place. Thirty-three states have launched public and private PCMH initiatives that use NCQA recognition. Moreover, as noted, FQHCs participating in the CMS Center for Medicare & Medicaid Innovation's FQHC Advanced Primary Care Practice Demonstration must have Level 3 PCMH designation from NCQA.[29]

More recently, NCQA has developed a recognition program for specialty practices interested in becoming part of a PCMH "neighborhood".[13] NCQA hopes that the program, which began in March 2013, will help improve communication and coordination among specialty practices that work with PCMHs to coordinate care, provide timely access to services, use information technology to reduce test duplication, and work toward continuous quality improvement.

Challenges Ahead

Any consideration about innovation should focus on the following three questions:[3]

- Innovation. What is different?

- Scale. Once an innovation has been piloted and validated at the local level, can it be scaled up and replicated elsewhere?

- System change. How can several innovations (information technology, patient engagement, patient reform, and so forth) be channeled to lead to system change?

Innovations in Medicaid can potentially affect health care throughout the country. Unlike the case of Medicare, however, the states administer Medicaid. Thus, one of the challenges for the CMS Center for Medicare and Medicaid Innovation and others is to ensure that islands of successful Medicaid innovations at the local or state level are taken to scale in the states and adopted broadly across the country.[31]

Another challenge is to channel several innovations to achieve the "Triple Aim" of improving the patient experience of care, improving the health of populations, and reducing the cost of health care for individuals, families, employers, and government by reducing or at least controlling the per capita cost of care.

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Endnotes

i.   The Affordable Care Act (ACA) of 2010 refers to two separate pieces of legislation—the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)—that, together, expand Medicaid coverage and make numerous changes to Medicaid and the Children's Health Insurance Program (CHIP).

ii. The ACA expands Medicaid eligibility to U.S. citizens and legal immigrants below 133 percent of the federal poverty level, but, with no mandatory income disregard in the ACA equal to 5 percent of the federal poverty level, the effective income limit is 138 percent of the federal poverty level.

iii. FQHCs are federally funded, nonprofit, community-based health centers or clinics that serve medically underserved areas and populations. They provide comprehensive primary care and preventive care to residents of all ages regardless of their ability to pay and charge for services on a sliding-fee scale based on the patient's ability to pay.

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