



Assessment of Medicaid Reform Options

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I. Introduction

The Menges Group was hired by the Legislative Budget and Audit Committee to provide information and analyses with regard to other states' experiences with Medicaid reform and expansion initiatives. This report conveys the following information.

- Following up on our January 2016 report, "Assessment of Medicaid Expansion and Reform, Initial Analysis," Section II of this report describes opportunities for Medicaid savings to occur through case management of individuals with frequent hospitalizations.¹ Section III addresses opportunities to reduce pharmacy costs through more rapid Preferred Drug List (PDL) adjustments and by re-visiting Medicaid pricing policies to ensure that large pharmacy corporations are not paid more for any given mix of prescriptions by Alaska's Medicaid program (overall, across ingredient and dispensing fees) than these organizations are willingly accepting as payment from commercial and Medicare Part D payers.
- Section IV focuses on Medicaid managed care program design options. We recommend that Alaska contract with a single managed care organization (MCO) on an administrative services only (ASO) basis to provide care coordination and utilization management services to all of Alaska's Medicaid beneficiaries. We also recommend that Alaska match each Medicaid beneficiary to a primary care provider, a dental provider, and – for persons with behavioral health needs – a "behavioral health home" provider as well. We recommend that Alaska *not* contract with multiple managed care organizations (MCOs) or with accountable care organizations (ACOs) and provide our rationale.
- Section V focuses on whether and how Alaska's Medicaid reform effort might incorporate employment supports to assist adult beneficiaries who are able to work in securing employment.
- Section VI focuses on improving and monitoring access to care for beneficiaries residing in Alaska's many rural areas.
- Section VII reviews other states' experiences with efforts to reduce unnecessary emergency department (ED) utilization.

¹ Evans et al. "Assessment of Medicaid Expansion and Reform: Initial Analysis," The Menges Group, January 16, 2016. Available at: <http://lba.akleg.gov/download/publications/Initial%20Analysis%20Assessment%20of%20Medicaid%20Expansion%20and%20Reform,%20January%202015,%202016%20Prepared%20by%20The%20Menges%20Group.pdf>.

II. Care Teams for Frequently Hospitalized Persons

This section provides additional detail on how we derived our recommendation on high-utilizers contained in the December 2015 report. The recommendation is shown below.²

Create a care coordination program for persons who have been hospitalized more than three times during the past two years (excluding obstetrical admissions and persons dually eligible for Medicare). Alaska has 347 Medicaid beneficiaries who have been hospitalized at least five times during the time frame 2012-2015 (including at least one 2015 admission). These persons can be readily identified, as can all emerging beneficiaries reaching any selected threshold of multiple hospitalizations. These individuals' admissions *after* their 5th hospitalization cost approximately \$13 million during 2015. A care coordination team explicitly focused on outreach and care coordination for this subgroup is projected to have an annual cost of \$1.2 million and create a Medicaid inpatient cost savings of approximately \$5 million, yielding a net annual savings of approximately \$4 million. This approach creates significant clinical improvements, whereby all savings would occur through reducing the degree to which these high-need beneficiaries continue to “down-spiral” into health crises.

We assessed the degree to which Alaska Medicaid beneficiaries were being hospitalized repeatedly during the January 2012 to November 18, 2015 timeframe, and quantified the savings opportunity of a case management team focused on selected subgroups of these members. Exhibits 1 and 2 present two examples of Alaska Medicaid recipients with large numbers of medical, surgical, and/or psychiatric admissions across the timeframe. Note that maternity-related and newborn admits were removed from our analyses, and that “admissions” on the file that occurred simultaneously or on consecutive days to another admission for the same person were not counted as multiple admissions.

Exhibit 1. Person #1: 17 hospitalizations, all respiratory, \$137,949 paid

Admission	Length of Stay	Days from Previous Discharge to This Admission	Type of Admission	Prim Dx
#1	2		Respiratory System	493.22
#2	6	29	Respiratory System	491.22
#3	1	61	Respiratory System	493.22
#4	3	170	Respiratory System	493.92
#5	3	47	Respiratory System	493.22
#6	4	54	Respiratory System	493.22
#7	2	123	Respiratory System	493.92
#8	6	60	Respiratory System	491.21
#9	1	182	Respiratory System	491.21
#10	4	69	Respiratory System	491.21
#11	3	324	Respiratory System	493.22
#12	4	15	Respiratory System	518.81
#13	3	65	Respiratory System	518.84
#14	3	5	Respiratory System	493.21
#15	4	35	Respiratory System	518.81
#16	2	11	Respiratory System	493.22
#17	3	42	Respiratory System	J96.02

² Ibid.

Exhibit 2. Person #2: 12 admissions, mix of behavioral and physical health challenges, \$116,529 paid

Admission	Length of Stay	Days from Previous Discharge to This Admission	Type of Admission	Primary Diagnosis Code
#1	2		Behavioral	300.11
#2	3	250	Ill-Defined Conditions	784.0
#3	2	168	Behavioral	300.11
#4	1	19	Endocrine	250.02
#5	1	27	Digestive System	562.11
#6	2	19	Nervous System	345.80
#7	6	64	Nervous System	345.90
#8	18	6	Digestive System	562.11
#9	3	143	Digestive System	560.9
#10	3	59	Musculoskeletal	729.89
#11	2	208	Digestive System	552.21
#12	11	39	External Causes	V55.3

Hundreds of individuals had large numbers of hospitalizations, and these individuals are readily discernable in Alaska's claims data for purposes of triggering care management efforts. As shown in Exhibit 3, **652** Medicaid beneficiaries had 5+ hospitalizations across the roughly 45-month timeframe assessed, over half of whom had at least one CY2015 admission. This population's claims patterns strongly suggest that something different is needed to support these individuals while they are *not* hospitalized, and not rely primarily on the hospitals' work to address their clinical crises as they occur.

Exhibit 3. Distribution of Alaska Medicaid Beneficiaries by Number of Non-Maternity Hospitalizations

Number of Hospitalizations 2012-2015	Total Persons with this Number of Admits	Total Number of Persons with at Least One Admit to Date in 2015	Total Paid Across All Admits	Total Paid Across 2015 Admits	Total Admits	Total 2015 Admits	Cost per Admit
1	11,826	2,500	\$114,836,414	\$26,398,174	11,826	2,500	\$9,711
2	2,722	803	\$67,123,355	\$13,483,219	5,444	1,070	\$12,330
3	987	371	\$41,026,750	\$8,112,143	2,961	592	\$13,856
4	497	206	\$28,371,465	\$6,869,676	1,988	399	\$14,271
5	272	133	\$19,499,154	\$3,649,699	1,360	247	\$14,338
6	114	62	\$11,358,535	\$2,257,352	684	140	\$16,606
7	80	44	\$8,918,864	\$1,698,391	560	101	\$15,927
8	56	23	\$6,962,288	\$1,175,229	448	57	\$15,541
9	37	24	\$5,029,687	\$1,013,265	333	67	\$15,104
10	23	12	\$2,874,863	\$722,989	230	45	\$12,499
11	13	9	\$2,026,094	\$308,538	143	35	\$14,168
12	10	6	\$1,639,864	\$158,203	120	17	\$13,666
13	12	9	\$2,473,175	\$290,224	156	19	\$15,854
14	10	7	\$2,880,633	\$579,727	140	28	\$20,576
15	6	3	\$1,340,776	\$173,902	90	14	\$14,898
16	5	4	\$1,972,122	\$231,626	80	9	\$24,652
17	2	2	\$307,973	\$108,011	34	14	\$9,058
18	4	2	\$1,210,783	\$190,597	72	10	\$16,816
20	1	1	\$327,337	\$167,489	20	7	\$16,367
22	2	2	\$288,943	\$52,939	44	7	\$6,567
23	1	1	\$305,638	\$14,630	23	1	\$13,289
26	1	1	\$221,617	\$159,647	26	16	\$8,524
30	1	-	\$486,230	\$0	30	-	\$16,208
33	1	1	\$145,321	\$22,639	33	5	\$4,404
53	1	1	\$1,122,138	\$284,141	53	18	\$21,172
Total	16,684	4,227	\$322,750,020	\$68,122,451	26,898	5,418	\$11,999
Persons with 3+ Admits	2,136	924	\$140,790,252	\$28,241,058	9,628	1,848	\$14,623
Persons with 5+ Admits	652	347	\$71,392,037	\$13,259,239	4,679	857	\$15,258
Persons with 10+ Admits	93	61	\$19,623,508	\$3,465,303	1,294	245	\$15,165

The 652 persons' additional admissions during 2015 *after* their fifth hospitalization represented 5.3% of all Alaska Medicaid medical, surgical, and/or psychiatric admits during the assessed timeframe, and collectively cost \$13 million during 2015 as shown in Exhibit 4. We estimate that a pointed case management program would eliminate 25% to 50% of the additional admissions these types of enrollees have, which would reduce medical costs by approximately \$3.3 million to \$6.5 million for persons with five or more admits, and \$6.8 million to \$13.5 million for persons with three more admits.

Exhibit 4. Initial Savings Estimate, Focused Care Coordination Program

Threshold	# of Persons Reaching This Level	# of Persons with at Least One Hospitalization in 2015	% With at Least One Hospitalization in 2015	Subsequent Admits Above Threshold	Subsequent Admits as % of All Non-Maternity, Non-Newborn Admits	Estimated 2015 Cost of Subsequent Admits	Savings at 50% Reduction	Savings at 25% Reduction
Persons with 3+ Admits	2,136	924	43%	3,220	12.0%	\$27,023,305	\$13,511,653	\$6,755,826
Persons with 5+ Admits	652	347	53%	1,419	5.3%	\$13,076,079	\$6,538,040	\$3,269,020
Persons with 10+ Admits	93	61	66%	364	1.4%	\$3,715,425	\$1,857,712	\$928,856

Care management efforts should focus on the highest-cost and most frequently hospitalized persons, then expand to other members, as value is achieved and being demonstrated with the initial target population.

The cost of providing the tailored care coordination team would be low relative to the expected savings. Exhibit 5 conveys a draft care team, who would focus initially on the 347 identified beneficiaries with more than five hospitalizations, including at least one hospitalization during CY2015. This team includes a set of physician advisors (supporting the team on an hourly consulting basis), five full-time RNs, and four full-time community outreach staff. Note that the salary and other costs in Exhibit 5 are reasonable approximate values and do not reflect detailed analyses of Alaska market costs.

Exhibit 5. Projected Care Team Configuration and Costs

Position	Salary	FTEs	Annual Cost
Physician Consultant Advisors	\$400,000	0.5	\$200,000
Supervisory RN	\$100,000	1	\$100,000
Behavioral Health RN	\$72,500	1	\$72,500
Staff RN	\$72,500	3	\$217,500
Community Outreach Specialist	\$50,000	4	\$200,000
Total Salary		9.5	\$790,000
Loading Factor for Benefits, IT Support, Office Space, Local Travel, etc.			0.5
Non-Salary Costs			\$395,000
Total Annual Cost for Care Team			\$1,185,000
Team Caseload (persons with 5+ admits with 1+ during 2015)		347	
Caseload per Overall Care Team FTE		37	
Caseload per RN		69	
Caseload per Outreach Specialist		87	

The team would assess each individual's Medicaid claims history (diagnoses, providers seen, medication regimens, etc.), and conduct an assessment of the person's needs, caregiver situation, etc. (interviewing the enrollee, caregiver, and key physicians). For persons in the Anchorage Metropolitan Statistical Area (MSA), one of the community outreach workers would seek to conduct a home assessment and establish a direct personal connection with the enrollee and/or caregivers. The assessment and care coordination work would occur primarily telephonically (and through email if desired), outside of the Anchorage MSA. An individualized plan of care would then be developed to support the enrollee and seek to improve her/his clinical trajectory.

This individually-tailored approach is necessary because the frequently hospitalized population is afflicted with a widely diverse set of clinical conditions. Exhibit 6 conveys the distribution of admissions for the 652 persons with more than five hospitalizations during the assessed four-year timeframe. Behavioral health was the most common disease category, but accounted for only 18% of all these individuals' admissions. Exhibit 7 shows that even within the behavioral health category, a wide array of specific hospitalization-causing conditions exists.

Exhibit 6. Distribution of Admission Type for Individuals with 5+ Hospitalizations during 2012-2015 Timeframe (excluding pregnancy/newborn admissions)

Admission Type	Number of Admissions	% Total
Behavioral	814	17.8%
Respiratory System	608	13.3%
Digestive System	503	11.0%
Endocrine	405	8.9%
Injury and Poisoning	354	7.7%
Circulatory System	309	6.8%
Infectious Disease	285	6.2%
External Causes	224	4.9%
Ill-Defined Conditions	196	4.3%
Musculoskeletal	156	3.4%
Neoplasms	153	3.3%
Genitourinary System	151	3.3%
Nervous System	141	3.1%
Blood Diseases	122	2.7%
Skin Diseases	103	2.3%
Congenital Anomalies	36	0.8%
Sense Organs	7	0.2%
Perinatal	6	0.1%
Total	4,573	100.0%

Exhibit 7. Admission Distribution of Frequently Hospitalized Persons Within Behavioral Health Admissions

Primary Diagnosis for Admission	Number of Admissions	% of Total
Depressive Disorder	128	15.7%
Schizophrenia	106	13.0%
Attention-Deficit/Hyperactivity Disorder	93	11.4%
Post-Traumatic Stress Disorder	89	10.9%
Bipolar Disorder	60	7.4%
Alcohol-Induced Disorder/Withdrawal	57	7.0%
Intermittent Explosive Disorder	52	6.4%
Psychotic Disorder NOS	50	6.1%
Mood Disorder NOS	21	2.6%
Borderline Personality Disorder	15	1.8%
Adjustment Disorder	13	1.6%
Autistic Disorder	12	1.5%
Reactive Attachment Disorder of Infancy or Early Childhood	10	1.2%
Cognitive Disorder NOS	8	1.0%
Unspecified Mental Disorder (nonpsychotic)	8	1.0%
Anxiety Disorder	6	0.7%
Dysthymic Disorder	5	0.6%
Cyclothymic Disorder	5	0.6%
Impulse-Control Disorder NOS	4	0.5%
Substance Withdrawal/Delirium	3	0.4%
Affective Psychoses	3	0.4%
Drug Dependence/Abuse	3	0.4%
Acute Stress Disorder	2	0.2%
Conversion Disorder	2	0.2%
Disruptive Behavior Disorder NOS	2	0.2%
Oppositional Defiant Disorder	2	0.2%
Substance-Induced Sleep Disorder	1	0.1%
Delusional Disorder	1	0.1%
Pervasive Developmental Disorder	1	0.1%
Child Psychos NOS-Active	1	0.1%
Obsessive-Compulsive Disorder	1	0.1%
Psychogenic Respir Dis	1	0.1%
Feeding Disorder of Infancy or Early Childhood	1	0.1%
Communication Disorder NOS	1	0.1%
Conduct Disorder, Childhood-Onset Type	1	0.1%
Mild mental retardation	1	0.1%
Unknown	11	1.4%
Total	814	100.0%

Note that if the enrollee and/or their caregiver refuses to participate in the care coordination efforts, we encourage that the case nonetheless remain active. In these situations, we recommend that the care team remain responsible for supporting this person working with providers and family members, sending educational information, etc.

The care team's annual costs of operation are estimated at approximately \$1.2 million (Exhibit 5). The annual medical cost savings for this subgroup, created by the care team's efforts, are estimated at \$3.3 million to \$6.5 million. Only a nine percent reduction in subsequent admissions would be needed for the care team to cover its costs, and for Alaska Medicaid to reach breakeven. At a 37.5% reduction in subsequent hospitalizations (our midpoint estimate), inpatient costs would be lowered by \$4.9 million creating a net savings of \$3.7 million (with the return on investment being 4.1 to 1).

Evidence of Impacts

Our recommendation in this area was not arrived at through published research evidence from other states' experience. Rather, we offer this recommendation based on our data analytics and a conviction that pointedly connecting with these high-need, high-cost individuals is going to yield substantial savings to Alaska's Medicaid program by favorably impacting the frequently hospitalized persons' future trajectory.

Across many payers and regions of the country there has been a focus on preventing and reducing the amount of quick (e.g., 30 day or 60 day) readmissions for the same condition. While that focus is important, in our view the more compelling opportunities lie in supporting the "full iceberg" – the group of individuals with large numbers of hospitalizations across a two- to three-year timeframe, regardless of diagnosis and the degree to which the admissions fall within 60 days of one another. This is not a hospital performance issue but rather challenge and opportunity related to a current lack of care coordination. We envision that the Department of Health and Social Services (DHSS) would contract on a statewide basis with a single care coordination firm to conduct this work, independent of the hospitals (although hospital-sponsored care coordination entities would also be welcome to bid for this contract).

We found similar dynamics in Connecticut's program two years ago, and encouraged the Community Health Plan of Connecticut (CHNCT) to implement a similar care management approach. CHNCT's Intensive Care Management (ICM) approach, described in further detail in Appendix A, has not focused only on frequently hospitalized persons, but has included those individuals in its target population. CHNCT's efforts have achieved an overall inpatient usage reduction of 12%, and a reduction of between 30% and 50% in specific populations targeted for ICM support.

III. Prescription Drug Savings Opportunities

Alaska's costs per Medicaid prescription during FFY2013 - FFY2015 (encompassing the timeframe October 2012-September 2015) are summarized in Exhibit 8.

Exhibit 8. Cost Per Medicaid Prescription, FFY2013 -FFY2015

Statistical Measure and Federal Fiscal Year	Alaska	USA	Alaska Rank Among States
Initial Cost Per Prescription			
2013	\$80	\$66	11 th highest
2014	\$80	\$72	18 th highest
2015	\$91	\$78	15 th highest
Rebates Per Prescription			
2013	\$42	\$33	6 th highest
2014	\$35	\$35	28 th highest
2015	\$39	\$37	23 rd highest
Net Cost Per Prescription (initial cost less rebates)			
2013	\$38	\$33	16 th highest
2014	\$45	\$37	9 th highest
2015	\$52	\$41	7 th highest

Alaska's net (post-rebate) pharmacy costs per Medicaid prescription were 26% above the U.S. average during FFY2015, which is not as concerning as it appears given that Alaska's underlying cost structure is generally much higher than the nation's. For example, the 2015 Federal poverty line in Alaska, which is a benchmark of cost of living differentials, was 23% above the 48 contiguous states.³ Alaska has recently implemented a new Medicaid pharmacy payment approach, based on Actual Acquisition Cost (AAC) of medications plus a state-determined dispensing fee. The AAC approach is required by the Centers for Medicare and Medicaid Services (CMS), and the transition to this model was a considerable undertaking. As Alaska gains experience with this new payment model it is likely that specific savings opportunities will emerge.

As shown in Exhibit 9, Alaska has also demonstrated strong progress in increasing the use of generic drugs, steadily gravitating towards the national average. During FFY2013, Alaska lagged 4.0 percentage points behind the national average in use of generics, and as of the most recent available quarter (Q3 of 2015), this gap had narrowed to 1.7 percentage points. This improvement, which results from pointed efforts on the part of DHSS staff, have generated large-scale dollar savings to Alaska's Medicaid program during recent years.

³ Families USA publication working with US Department of Health and Human Services data: <http://familiesusa.org/product/federal-poverty-guidelines#2015>.

Exhibit 9. Generics as Percentage of Medicaid Prescriptions, FFY2013 -FFY2015

All Prescriptions			
Time Period	Generic % of Medicaid Prescriptions		
	Alaska	US Total	Difference
Q1 2013	75.2%	78.8%	3.6%
Q2 2013	75.7%	79.8%	4.1%
Q3 2013	75.6%	79.9%	4.2%
Q4 2013	77.2%	80.0%	2.8%
Q1 2014	77.7%	80.5%	2.8%
Q2 2014	77.5%	81.0%	3.5%
Q3 2014	79.1%	81.3%	2.1%
Q4 2014	78.3%	80.8%	2.4%
Q1 2015	78.9%	80.7%	1.8%
Q2 2015	79.1%	81.9%	2.8%
Q3 2015	80.1%	81.9%	1.7%
FFY 2013	75.5%	79.5%	4.0%
FFY 2014	77.9%	80.7%	2.8%
FFY 2015	79.1%	81.3%	2.2%

Notwithstanding these important accomplishments, Alaska's pharmacy costs are relatively high and have recently increased more rapidly than the national average on a cost per prescription basis (both pre-rebate and post-rebate).⁴ It is important in the current state fiscal climate to access available savings promptly.

We anticipate that Alaska can achieve savings against its current baseline in two key ways:

- Quickly adjust the Preferred Drug List (PDL) to achieve savings opportunities when prices of products change, when new products are introduced (including the emergence of low-cost alternatives to existing products), and when new levels of supplemental rebates take effect. Currently, DHSS is constrained from promptly modifying the PDL by the Alaska Administrative Procedures Act. Modifications to the PDL typically require a six to twelve month waiting period from the point DHSS desires to implement a give change. We encourage that these restrictions be removed, such that the PDL steers volume to the lowest cost, clinically effective product more quickly and more often. Patient protections around PDL changes can be ensured through other and more effective means, such as verifying that similar changes have already been made by other Medicaid programs (and/or Medicaid MCOs) using a clinical assessment process of equal or greater rigor to what Alaska's assessment process would involve.

⁴ The introduction of new specialty pharmacy products, particularly in the Hepatitis C arena, have driven prescription drug costs up sharply in Alaska and the country as a whole in 2015. Due to implementing Medicaid expansion, Alaska's average cost per prescription will likely again increase at a relatively high rate in 2016 due to the prevalence of Hepatitis C in the adult male population (which comprises much of the expansion population).

- Avoid above-market payments to large pharmacies. The move to an Actual Acquisition Cost (AAC) payment model has understandably led to much higher dispensing fees as Alaska’s pharmacies have very limited opportunity to earn a margin on their ingredient cost under this methodology, although this needs to be monitored over time. (We are concerned that the ingredient costs under the AAC could also evolve in “game-able” directions, similar to what occurs when car dealers indicate that their product is being sold “at or under invoice.”) However, the appropriateness of the pharmacy payments made in Alaska on behalf of Medicaid beneficiaries is driven by the *amounts* paid, not by whether the AAC or any other methodological approach is used.

Alaska’s overall unit costs per prescription remain high, even after taking into account ingredient cost, rebates, dispensing fees, and the state’s overall cost of living dynamics. A large proportion of Alaska’s Medicaid prescription volume occurs at chain commercial pharmacies. These organizations have consistently and willingly accepted lower dispensing fees from private insurance (commercial, Medicare Part D, etc.) than Medicaid paid, even before the AAC approach was adopted. Specifically, we encourage Alaska to compare overall costs per prescription for Medicaid with amounts paid on behalf of private sector payers (commercial and Medicare Part D plans). Wherever Medicaid is paying a large chain store pharmacy above private payers – as measured across both ingredient and dispensing fees, given that the Medicaid AAC payment approach does not allow for an appropriate comparison with private payers other than at the aggregate unit price level – the dispensing fee component should be reduced in the AAC methodology to ensure that Medicaid is no longer an “above market” payer to these entities for the overall prescription.

To avoid diminishing payments to critical access pharmacies, separate accommodations can be considered to provide extra Medicaid dispensing fee compensation when a store is the only pharmacy available within a given geographic radius (e.g., 10 miles). However, given that all pharmacies *want* higher Medicaid reimbursement, DHSS should provide added compensation only to pharmacies where a legitimate *need* exists (and not pay unnecessarily high amounts to all pharmacies to achieve the objective of supporting a few critical access entities).

IV. Coordinated Care Model Recommendations

Alaska's current Medicaid program essentially uses the traditional fee-for-service model (FFS). There is widespread acceptance that this approach – in merely “paying for whatever happens” – needs to be modernized in the direction of more pointedly and systematically seeking to measure and promote access to needed care, measure and improve quality, and achieve available cost savings. Alaska's current fiscal climate requires a particular and acute emphasis on this latter need: achieving cost savings. This section explores the following models:

- Capitation Contracting with Managed Care Organizations (MCOs)
- Contracting with a Single MCO on an Administrative Services Only (ASO) basis
- Contracting with Accountable Care Organizations (ACOs)
- Contracting with Primary Care Providers (Primary Care Case Management or “PCCM”)

Capitation Contracting with Managed Care Organizations (MCOs)

Full-risk capitation contracting with MCOs is the most commonly-used approach by state Medicaid agencies. During FFY 2015, 45.3% of all Medicaid spending occurred through capitation contracting with MCOs.⁵ Forty states currently utilize the capitated MCO model, and additional states have announced intentions to move in this direction (e.g., North Carolina and Oklahoma).

While there are many reasons states have implemented this model, the key attractions involve the dollar-for-dollar risk that MCOs accept, the administrative services MCOs deliver with economies of scale (member services, provider relations, etc.), and the opportunity to leverage competition among health plans – both at the point of selecting the best-qualified MCOs through a competitive procurement, and an ongoing basis as plans compete for enrollment and strive to operate in a financially successful manner. The capitated MCO model does more to facilitate access, measure and improve quality, and contain costs than any other alternative.

Nonetheless, we do not recommend this model as the best fit for Alaska. Our rationale was described in detail in our January 2015 report and is summarized below.

- Alaska has one of the nation's smallest Medicaid programs in terms of spending (ranked 45th) and in terms of covered beneficiaries (ranked 47th). Alaska currently has approximately 130,000 Medicaid enrollees.
- Being the largest state in land area, Alaska's Medicaid population is uniquely and widely dispersed. Alaska has only 0.2 Medicaid enrollees per square mile, far below every other state. The remainder of the United States has 18.6 Medicaid beneficiaries per square mile.

⁵ CMS 64 Reports, FFY 2015.

- Even Alaska's most urban areas have highly dispersed populations. The Anchorage MSA has 15.2 persons per square mile overall, which is much more dispersed than the USA average (90.5) and the non-Alaska average (107.7). Fairbanks, the next-largest Alaska MSA with approximately 100,000 residents, is the 26th largest MSA in the nation with regard to land area. Fairbanks' population is also unusually dispersed for an MSA – its population per square mile (13.6) is smaller than the Anchorage MSA.

These dynamics do not line up well for use of capitation contracting with MCOs as a central vehicle for Medicaid reform. The challenges are apparent in Medicare's MCO capitation contracting program (known as Medicare Advantage), where Alaska has the second-lowest enrollment percentage (5.3% in June 2013) in the nation, only Wyoming is lower.⁶ There is very little existing MCO involvement in Alaska, and no meaningful platform that can be drawn upon to extend this model to the Medicaid population.

Capitation contracting with MCOs in Medicaid requires at least two competing health plans for purposes of beneficiary choice in a mandatory enrollment setting. While a single plan model has been used for rural areas in a few states, many states prefer to ensure that at least three MCOs operate in each area. This assures that no MCO has leverage (e.g., with regard to the capitation rates being paid) to unravel the entire coordinated care program by terminating its contract with the state. The Medicaid population across the two large MSAs, Anchorage and Fairbanks, totals fewer than 100,000 persons, which would need to be divided among at least two health plans.

Introducing the MCO capitation model in Alaska would also be a massive and complex undertaking, and would require years to put in place. DHSS is not well-positioned to take on the implementation tasks needed. While this implementation work could largely be contracted out (as well as ongoing oversight), we are still wary that the multi-MCO capitation model is poorly suited to serve Alaska's relatively small and extremely dispersed Medicaid population.

Contracting with Accountable Care Organizations

Another option for Alaska involves creating a provider-driven care coordination program that involves promoting the formation of accountable care organizations (ACOs). Under the ACO model, providers typically continue to be paid on a FFS basis, with the ACO contractors being given financial incentives to achieve the state's care coordination objectives. ACO models vary widely with regard to the level of risk/reward that ACOs accept, and the degree of administrative services the ACOs perform. At the most sophisticated end of the ACO spectrum, this model can closely resemble the capitated MCO model (albeit with only provider-sponsored owner entities).

⁶ Menges Group tabulations using CMS county-level reports on Medicare eligibility and Medicare Advantage enrollment.

The ACO model has been put in place in various forms in several Medicaid programs, and is under strong consideration for implementation in additional states. The Agnew Beck report describes Medicaid ACO initiatives in Arkansas, Colorado, Minnesota, Oregon, and Vermont.

We do not recommend that Alaska pursue the ACO model as part of its Medicaid reform agenda. Our rationale is summarized below.

- The ACO model has been tested extensively across a large scale of participating organizations in the Medicare arena, a coverage setting where care coordination is likely to yield more favorable results than in Medicaid. Medicare has stable eligibility dynamics (persons obtaining Medicare coverage remain on Medicare for the rest of their lives), and the program's costs are driven by chronic conditions where persons' health cost trajectory can be most favorably impacted by coordinated care interventions. Medicare also has very high average per capita costs (relative to Medicaid overall) for services that a well-designed coordinated care program can impact: inpatient hospital, outpatient hospital, and pharmacy.

Notwithstanding these advantages, the findings from the ACO model in Medicare have been far from compelling. Across their first year of program operations, for example, 114 ACOs operated and only 54 achieved savings against the pure FFS model's cost target. If *none* of the 114 ACOs even *attempted* to achieve medical cost reductions, one would expect roughly 57 ACOs to have "achieved savings" just through a normal statistical outcome (e.g., 114 coin flips). This suggests that the entire program with 114 participants accomplished absolutely nothing in terms of impacting medical costs in its first year (relative to a pure FFS cost target). Many ACOs have also dropped out of the program including 9 of the 32 "pioneer ACOs" that have had the longest-standing experience operating the ACO model.

A more recent evaluation of the 32 pioneer ACOs found that 10 achieved statistically significant savings in both of their first two performance years, 10 had statistically significant savings in just one of the two years, and 12 had no statistically distinguishable savings or losses.⁷ This report identified collective savings of \$11.18 per member per month (PMPM) during the second year (oddly, a smaller savings than in the first year for the same entities deploying the same interventions but with more experience/maturity), which we estimate to be a modest cost reduction of approximately 1.5% in Part A and Part B Medicare expenditures. A further concern is that three of the 32 ACOs, all operating in Massachusetts, accounted for 70% of these program-wide savings relative to the pure FFS setting. Collective cost results across the other 29 ACOs were essentially equal to the FFS setting.

⁷ "Evaluation of CMMI Accountable Care Initiatives, Pioneer ACO Evaluation Findings from Performance Years One and Two," L&M Policy Research, March 2015.

- ACOs are not explicitly paid for the administrative care coordination services that are needed to achieve medical cost reductions, access enhancements, and quality improvements. ACOs need to cover the costs for whatever administrative investments they make through the incentive payments they are hoping to earn (and which they often fail to earn – hence the frequent drop-outs Medicare has experienced). This leaves the ACOs unable to deliver the type of coordinated care services that have proven to be effective in the Medicaid arena.
- As a contrasting example, Medicaid MCOs provide comprehensive member services to their enrollees, supported by sophisticated technology. In many health plans, if a member calls in about a lost ID card (or any other reason), the representative receiving the call will immediately know via her/his computer screen if that member – and the other family member enrollees – have accessed all their indicated preventive screenings. If not, the representative will assist in getting appointments scheduled for those services (while taking care of the lost ID card). In the ACO arena, there typically isn't any member services function whatsoever.
- Saving money in Medicaid unavoidably means lowering the revenues providers, in the aggregate, receive. Enlisting providers – *and only providers* – to achieve this objective is conceptually counter-intuitive. The ACO model puts the provider community in a conflicted position. Hospitals have played a central role in most of the nation's ACOs, for example, but hospitals are not fundamentally interested in reducing inpatient volume and shifting outpatient care away from themselves to lower-cost settings.

There are some notable exceptions, including a pilot program initiated by PeaceHealth Ketchikan Medical Center that focused on reducing avoidable readmissions using a coordinated care model. The PeaceHealth pilot was not an ACO, but their success in reducing readmissions highlights the conflict inherent in these types of models as the pilot resulted in loss of revenue for the institution.⁸

Under an ACO model, providers *might* manage Medicaid beneficiaries' costs effectively – and many examples of effective provider-sponsored care coordination programs exist around the country. However, “betting” the entire Medicaid reform effort on Alaska providers' willingness and ability to coordinate care and manage costs effectively is not an approach we can recommend.

- As with the capitated MCO approach, the ACO model is a large and complex undertaking which would need to be built from essentially a zero base in Alaska. A CMS report lists Alaska as having one ACO entity through Providence Health, although it does not appear that this entity has extensive Alaska operations (e.g., just one of its 15 Board Members is Alaska-based).

⁸ Eisenhower M. Presentation to House Finance Committee, PeaceHealth Ketchikan Medical Center, April 9, 2015. Available at: http://www.akleg.gov/basis/get_documents.asp?session=29&docid=7312.

In summary, we view the ACO model to be over-achieving in the political arena to date and under-achieving operationally. This model is based on a premise that does not appear to be particularly sound – relying entirely on providers to achieve medical cost reductions and not fostering the administrative infrastructure needed to deliver comprehensive care coordination.

Contracting with One MCO on an Administrative Services Only Basis

Given the limitations of the above-described models (multi-MCO and ACO) to achieve successful Medicaid reform in Alaska, we recommend that Alaska strongly consider contracting with a single experienced Medicaid coordinated care entity to deliver, at a minimum, the following services:

- Access facilitation – systematically identifying care gaps for each beneficiary and conducting outreach to beneficiaries, caregivers, and providers to help address these gaps.
- Care coordination for high-need, high-cost beneficiaries whose cost trajectory is determined to be favorably impactable. The highest level of intervention would involve an intensive care management (ICM) approach – including clinicians and community outreach workers – similar to that used by Community Health Network of CT, Inc. (CHNCT) in Connecticut’s ACO program (see slides 4-9 in Appendix 1). If the MCO ASO program can be put in place expeditiously, this contractor could also be enlisted to provide the care teams for frequently hospitalized persons as described in Section II.
- Prior authorization of high-cost services (e.g., medical, surgical, and psychiatric admissions, certain diagnostic and surgical procedures, etc.)

The MCO would be selected through a competitive procurement and would have statewide responsibility for all beneficiary subgroups. The MCO would be paid a Per Member Per Month (PMPM) fee for conducting its administrative services and would have bonus incentives to achieve Alaska’s objectives, as well as possibly a withhold on the base administrative payments which could serve as downside risk for failing to meet basic program outcome targets.

The key strengths of this approach are summarized below:

- The ASO MCO approach enlists the involvement of a contracting partner with vast relevant experience in Medicaid care coordination and cost containment on a large scale.
- It does not require any new provider contracting or that providers re-organize themselves in any manner. This model works with providers “as they are,” but supports them with information to identify and address gaps in care. The model focuses on allowing providers to do what they do best (treatment) while utilizing an objective, non-conflicted entity to serve as the broader care coordination function. Nothing would inhibit providers who want to directly enter the “whole person care coordination business” from forming Medicare health plans (ACOs or MCOs), commercial health plans, patient-centered medical homes, etc.

- The single MCO can operate with economies of scale by serving Alaska’s entire beneficiary population, and by adding the Alaska “account” to the existing information technologies and proven processes that the organization has already purchased and/or created to conduct its work elsewhere.
- The MCO would not need to take on the roles of payer or negotiator of payment terms.
- Under the ASO arrangement, beneficiaries would not “enroll” in the MCO. However, the MCO would have incentives to coordinate care effectively and achieve cost savings for the entire Alaska Medicaid population.
- The ASO model dovetails well with any DHSS primary care case management (PCCM) initiative, dental home initiative, behavioral health home initiative, etc. that is put into place.
- The scope of work of the ASO contractor can be broadened to include fraud detection, member services functions, claims administration, etc. as desired by the State. At the outset, however, it may make sense to enlist the ASO to perform a more limited scope of work, focused on achieving the greatest net short-term savings (medical cost reductions less payments made to the ACO MCO entity).

Linking Beneficiaries with a Medical Home

We also recommend that Alaska implement a model whereby every Medicaid beneficiary is linked with a primary care provider (PCP), a dental provider, and where appropriate a behavioral health provider. These “provider homes” would serve as the beneficiary’s front-line point of access for routine care, with specialized care occurring through referrals from the beneficiary’s PCP.

Given the limited administrative resources available and the minimal savings expected to occur through the “medical home” model, we place higher timing priority on putting the other recommendations into place (securing an ASO partner, providing care management to frequently hospitalized persons, etc.). However, the medical home approach, coupled with dental and behavioral health homes, creates a valuable point of accountability for payment reforms and Medicaid savings to occur. Primary Care Providers receive a very small percentage of Medicaid’s payments, but these front-line providers can favorably impact health status and spending across the entirety of the Medicaid benefits package. Roughly two decades ago, a managed care chief executive officer was quoted as saying: “A motivated and informed primary care physician is our organization’s greatest asset.” The same concept seems applicable to Alaska’s Medicaid program and the reform efforts that are now underway.

One important payment reform to test would be capitation of these front-line services. Currently, a face-to-face visit is needed for FFS payment to occur. Under a capitated model for primary care services, face-to-face visits create a cost but no additional payment, fostering the development of

greater use of telehealth and other means of communication that limit face-to-face interactions to those situations where there is marginal clinical value over telephonic and other approaches. The primary care capitation pilot will, however, need to include an array of data reporting requirements and quality incentives to ensure that the model enhances access to front-line care as intended.

While many Medicaid MCOs utilize a capitation payment model for primary care providers, several have also switched to, or maintained, a FFS payment structure for PCPs, on the premise that a FFS approach most strongly encourages utilization to occur. However, Alaska's rural geography and challenges with regard to time/distance to access care accentuate the value of a monthly capitation payment approach that, in effect, creates a means of compensating PCPs for rendering telehealth services.

V. Employment Supports

As states increasingly explore new provisions through the use of Section 1115 waivers, the Center for Medicaid and Medicare Services (CMS), has consistently and firmly rejected approving any provisions that tie employment support or work-related requirements to Medicaid eligibility. Historically, states have had significant flexibility in designing coverage and the administration of Medicaid plans, however the federal government has determined eligibility criteria. This has been tested and upheld through several court cases.⁹

As a result, despite ongoing efforts by several states, CMS has not permitted states to require persons to seek employment as a condition of being eligible for, or maintaining, Medicaid coverage. Many states have sought to incorporate provisions of this nature, to move the program away from a pure “entitlement” model to one that provides motivation and resources for workforce participation, but they have been unsuccessful.

This hasn’t stopped states from pursuing this idea, and several have been successful in using employment supports as either incentives, or through passive opt-in programs. As long as these employment programs are fully funded and managed through the state, and participation in such programs will not impact the coverage or cost for Medicaid eligible individuals, CMS had not raised any issues.¹⁰

Three states are notable in their efforts to connect employment support programs with Medicaid beneficiaries: Indiana, Arizona, and New Hampshire.

Healthy Indiana Program (HIP). Indiana, in designing its Medicaid reform initiative (named the Healthy Indiana Program and referred to within the state as the “HIP”) has included a requirement that enrolled non-disabled adults receive a referral to job training support through the state’s Department of Workforce Development (DWD). Initially Indiana attempted to tie participation in their DWD programs to eligibility, but CMS denied that request.¹¹ Clear language is included in the program materials indicating that beneficiary participation in the employment training program is completely voluntary and not tied to coverage.

The following information is excerpted from Indiana’s request for proposal document to solicit an HIP evaluation contractor.

“All eligible HIP members are provided with general information on the state’s job search and training programs. Unemployed HIP participants and those working less than 20 hours a week

⁹ Davis C. “Medicaid Expansion Work Requirements,” National Health Law Program. October 4, 2013, Available at: <http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/Medicaid-expansion-work#.VuC1SsdFeFI>.

¹⁰ “The ACA and Medicaid Expansion Waivers,” Kaiser Commission on Medicaid and the Uninsured, November 2015. Available at: <http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers>.

¹¹ “CMS and Indiana Agree on Medicaid Expansion,” CMS Press Announcement, January 27, 2015. Available at: <https://www.cms.gov/newsroom/mediareleasedatabase/press-releases/2015-press-releases-items/2015-01-27.html>.

are referred to available employment, work search and job training programs. (Full-time students are exempted from the referral for each year they are enrolled in a postsecondary education institution or technical school.) The HIP application screens for education and employment status and contains an acknowledgement of the referral.”

All identified eligible individuals receive information on available employment resources, including IndianaCareerConnect.com available through the Indiana DWD. IndianaCareerConnect.com is the most comprehensive source of Indiana job openings in the state. It provides individuals access to current job openings, the ability to create and upload a resume, explore a career, and research the job market.

This program was implemented during 2015 and its evaluation has just begun. Issues the evaluation will be addressing related to the employment training/supports component include:

1. What percent of members referred to DWD become employed (part time vs. full time)?
2. How will referrals to the DWD impact member income and eligibility for HIP? How many stay in HIP and how many referred individuals leave HIP?
3. How will referrals to the DWD impact the number of Indiana residents enrolled in HIP Link?

Despite the absence of evidence of the impacts of its approach, we view Indiana’s employment-related requirements and processes to be important for Alaska to seriously consider. There does not seem to be any meaningful “downside” to the state’s referral to employment training and support provision.

Arizona Health Care Cost Containment System (AHCCS) Works. Arizona has submitted a Section 1115 waiver to CMS and is currently pending evaluation. The waiver is broad in nature and seeks approval for a variety of programs, including one called Arizona Health Care Cost Containment System (AHCCCS) Works. AHCCCS Works is a program based on state legislation that required (without regard to CMS approvability) unemployed Medicaid beneficiaries to actively seek employment or participate in job training programs. Unlike the state legislation, the Arizona waiver does not tie participation in AHCCCS Works to Medicaid eligibility, but does promote a “connection to services.”¹²

What makes Arizona’s waiver different is that it ties participation in AHCCCS Works to a beneficiary’s ability to access an HSA-like savings account. Under the proposed waiver, certain adult Medicaid beneficiaries would be required to pay two percent of their household income into an AHCCCS Care Account, which is similar to a Health Savings Account (HSA). Members could use funds from the Care Account to pay for health-related services that are not already covered by Arizona’s Medicaid program including vision and dental services. To be eligible to access the Care Account, beneficiaries must complete the following requirements:

- Pay their two percent contribution on time.
- Participate in the AHCCCS Works program.

¹² “Arizona Health Care Cost Containment System: Arizona’s Application for a New Section 1115 Demonstration,” September 30, 2015. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/az-hccc-pa2.pdf>.

- Meet a requirement outlined in a Healthy Arizona program

Beneficiaries not meeting these three requirements would be ineligible to access their AHCCCS Care Account. This waiver is still pending review, and it is not clear what the reaction from CMS will be to this requirement.¹³

New Hampshire. New Hampshire expanded Medicaid in the middle of 2014, but did so under the premise that the state would seek to implement a section 1115 waiver moving certain portions of the adult expansion population to a premium assistance model, titled the New Hampshire Health Protection Program (NHHPP).¹⁴ The waiver was implemented on January 1, 2016, however, Medicaid expansion was only funded through the end of 2016.

In March, a bill was introduced into the house that would fund the expansion through 2018, but it included a provision requiring the state to tie work requirements to eligibility for that population. Specifically, the provision required that adult expansion recipients engage in at least 30 hours of the following to remain eligible for benefits: employment, work experience, on-the-job training, job search and readiness assistance, community service programs, vocational educational training, job skills directly related to employment for individuals who have not received a high school diploma or equivalency, or the provision of child care services to an individual participating in a community service program.¹⁵ After intense debate, an amendment was added that would allow the expansion program to continue, even if CMS rejected the work requirement clause.

The bill passed out of the house on March 10, and is headed to the senate.¹⁶ There is no reason to believe that CMS will approve the proposed work requirement.¹⁷

¹³ Ollove M. "Should Medicaid Recipients Have to Work?," Pew Charitable Trusts. Available at: <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/09/30/should-medicaid-recipients-have-to-work>.

¹⁴ "New Hampshire Health Protection Program," New Hampshire Department of Health and Human Services. Available at: <http://www.dhhs.nh.gov/ombp/nhhpp/>.

¹⁵ New Hampshire General Court. HB 1696- FIN- As Amended by the House. Available at: http://gencourt.state.nh.us/bill_status/billText.aspx?id=795&txtFormat=html.

¹⁶ Sutherland P. "N.H. Medicaid Expansion Overwhelmingly Passes Republican-Backed House," New Hampshire Public Radio, March 10, 2016. Available at: <http://nhpr.org/post/nh-medicaid-expansion-overwhelmingly-passes-republican-backed-house>.

¹⁷ Sutherland P. "N.H.'s Medicaid Expansion Could Face Hurdle Around Work Requirements," New Hampshire Public Radio, March 7, 2016. Available at: <http://nhpr.org/post/nhs-medicaid-expansion-could-face-hurdle-around-work-requirements>.

VI. Promoting Access to Care in a Rural Setting

As described earlier in our report, Alaska has 0.2 Medicaid enrollees per square mile compared to 18.6 Medicaid enrollees per square mile in the remainder of the country. Alaska has implemented several initiatives to address this challenge, including limited provider capacity, access to and successful implementation of telehealth and/or telemedicine, providing access to preventive care by funding transportation for non-emergent care, and sharing information to deliver high quality and timely care. However, Alaska's current FFS model and infrastructure have not supported the successful implementation of various strategies.

The following section explores best practices states, including Alaska, have used to address access to care in rural settings.

Telehealth

States are implementing telehealth technology in their public health efforts to increase access to underserved populations, especially for recipients in rural areas, as well as to reduce emergency room admission and utilization. It is important to note the distinction between telehealth and telemedicine; telemedicine is more specific to delivering care via technologies, while telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services. For the purposes of this report, we are using the broader term, telehealth, to address a wider range of programs within this field.

It is important to note that while most states (49 states and the District of Columbia) are reimbursing for a live telehealth video call, access to these video calls are particularly difficult. Each state maintains its own regulations as to the type of equipment that must be used and the location the equipment must be accessed from to reimburse for these calls.¹⁸ Only nine states, including Alaska, allow for care to be delivered via "store and forward" – where Medicaid reimburses for beneficiaries to share pictures, x-rays, scans, reports, and medical records to physicians in different locations to receive medical advice.

Telehealth strategies are steadily proving to provide access to high quality care to individuals in a timely and cost-efficient manner. State Medicaid programs have noted that reduction in travel costs, including time for physicians to travel long distances to meet with patients as well as for patients to use expensive modes of travel to access care, has achieved savings due to the advancements achieved through telemedicine.

¹⁸ "State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia," Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2015. Available at: <http://cchpca.org/sites/default/files/resources/STATE%20TELEHEALTH%20POLICIES%20AND%20REIMBURSEMENT%20REPORT%20FINAL%20%28c%29%20JULY%202015.pdf>.

As of 2015, 25 states allow for telehealth services to be delivered from the home and 16 states allow for telehealth services to be delivered from a school or school-based health center site.¹⁹ Other states are deploying telehealth services at local community centers, federally qualified health centers (FQHCs), rural health centers (RHCs), community mental health centers (CMHCs), health departments, provider offices, and hospitals. Since 2005, New Mexico has been offering coverage for telehealth services to Medicaid recipients and funds telehealth services at school-based health centers.

Alaska's Medicaid telehealth program is quite robust and reimburses for initial visits, follow-up visits, consultations to confirm diagnoses, diagnostic, therapeutic, or interpretive services, psychiatric or substance abuse assessment, psychotherapy, or pharmacological management services.²⁰ The State does not cover the expense of the telemedicine equipment use or for simple modes of telecommunications, including telephone calls – still limiting access to the country's most rural State.

Telemedicine Licensure. While one of the ultimate goals of increasing use of telemedicine is to address physician shortage capacities, rural areas continue to be challenged with regulations that do not permit cross-state licensure – where telemedicine providers located in a different state as the patients they serve are not allowed to provide care for these individuals, creating the need for interstate licensure or specific telemedicine practice licensure.

Currently, most states have stringent licensure policies, making interstate telemedicine access difficult. According to the Center for Connected Health Policy (CCHPCA), Alabama, Louisiana, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, and Texas have cross-state licensure regulations.²¹ Additional states permit cross-state licensure for its contiguous states only and other states allow for temporary licenses.

While Alaska's telemedicine allows for limited telemedicine practice, the licensing rules require that the provider have an Alaska Medical license and have generated concern over ambiguity regarding the State Medical Board's ability to sanction providers practicing telemedicine. This limits the State's ability to secure a stronger and adequate provider network. The CSSB 74(FIN) currently being heard in the House Finance Committee authorizes DHSS to identify areas where telemedicine policies can be improved – specifically addressing licensure barriers and board sanctions – and put these programmatic changes in place to give the state greater opportunity to leverage telemedicine.

Home Health Monitoring. Home health monitoring devices allow patients to transmit data remotely to their providers to help manage their disease and reduce preventable emergency room visits by receiving medical intervention in a timely manner. As of 2013, Alabama, Alaska, Colorado, Kansas, Minnesota²²,

¹⁹ Thomas L and Capistrant G. "State Telemedicine Gaps Analysis: Coverage and Reimbursement," American Telemedicine Association, May 2015. Available at: <http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf>.

²⁰ 7AAC110.625. Telemedicine applications; limitations

²¹ "State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia."

²² Minnesota only permits the equipment rental.

New York, Pennsylvania, South Carolina, South Dakota, Texas, and Washington permitted remote monitoring in their Medicaid program.²³

Community Health Aides/Practitioners

Alaska has been at the forefront of the effort to deliver care to rural communities, and has gained recognition for the early development, adoption, and strong use of a community health aide program. Informally adopted during the 1940's and 50's as the former territory struggled to respond to various tuberculosis crises, the program was formalized by Congress in 1968 under the Indian Health Service.²⁴ This federal program has since developed and evolved into a foundational aspect of Alaska's tribal rural health care delivery system.

There are currently 550 community health aides/practitioners (CHA/Ps) serving over 170 villages in Alaska.²⁵ They are operated and managed by tribal health entities with training and practitioner standards set by the Community Health Aide Program Certification Board.²⁶ This same board is also responsible for maintaining the Community Health Aide/Practitioner Manual (CHAM) that provides step-by-step guidance for practicing CHA/Ps.

Unlike other models, individuals interested in becoming a CHA/P are first hired, and then trained over a period of no less than 15 weeks, with 3-4 week sessions occurring over set intervals. The CHA/P must pass a written exam and preceptorship with a mid-level clinician, and they are further subject to additional training and recertification at certain prescribed intervals. CHA/Ps certification is offered at five different levels based on the completion of different training curriculum selection.

Once trained, the CHA/P is under medical supervision by a licensed physician. Their ability to treat patients varies, but is based on a physician's (or their designee's) approval except in urgent circumstances where they are authorized to administer emergency care before asking for authorization. The care CHA/Ps provides is diverse as they are often the first line of treatment in their community. They can provide care for acute, chronic, emergency, and preventive conditions. As residents of the villages they serve, they are often uniquely aware of the health challenges and logistical challenges facing their clients.

An estimated 50,000 residents receive care from a CHA/P annually, representing around 25,000 clinical encounters.²⁷ A 2012 study identified the most frequent cause for visits with ears, nose, and throat

²³ "State Medicaid Best Practice: Remote Patient Monitoring and Home Video Visits," Center for Connected Health Policy, The National Telehealth Policy Resource Center, July 2013. Available at: <http://www.americantelemed.org/docs/default-source/policy/state-medicare-best-practice---remote-patient-monitoring-and-home-video-visits.pdf?sfvrsn=6>.

²⁴ Golnick et al. "Innovative Primary Care in Rural Alaska: a review of patient encounters seen by community health aides," Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3417638/pdf/IJCH-71-18543.pdf>.

²⁵ "Alaska Community Health Aide Program." Available at: <http://www.akchap.org/html/about-chap.html>.

²⁶ "Overview of the Alaska Community Health Aide Program." Available at: http://www.akchap.org/resources/chap_library/Referral_Physician/CHAM_CHAP_Overview.pdf.

²⁷ Golnick et al.

issues accounting for around 40% of diagnosis, followed by circulatory problems (8.9%), skin problems (6.1%), preventive care (5.4%), injuries (5.3%), and digestive/abdominal issues (5.2%).²⁸ Of the urgent and/or emergency visits, the two most frequent problems were respiratory distress (16.7%) and acute ischemic problems (9.8%).

While the CHA/P program is operated, funded, and managed by tribal health entities, the state has provided varying levels of financial assistance through the DHSS Community Health Training and Supervision Grants program. Additionally, CHA/Ps are generally the only health care provider in an area, and thus service Medicaid beneficiaries as a result. This program has been widely recognized for the tremendous value it brings in providing health care access to areas that would otherwise go without. The success of CHA/Ps has led to the development of other community health worker programs focusing on dental care and behavioral health care.

Other States have been repurposing emergency medical services (EMS) and Community Paramedics (CPs) to act as primary care providers with the main goal of reducing ER visits. The following paragraphs describe programs from different states. Among all the programs, one similarity and distinction from how Alaska operates its program is in the fact that emergency responders are reacting to situations where Medicaid and underserved recipients are addressing emergent phone calls with adequate care that often eliminates the need to go to an emergency room.

- Idaho is testing a “Virtual PCMH” model in rural and underserved communities. This model will test a different approach to delivering the PCMH care coordination model by offering telehealth technology, community health workers, and community health emergency medical services (CHEMS). CHEMS utilizes emergency medical services (EMS) staff to provide primary care and preventive services to address scenarios where enrollees seek healthcare via 911 and hospital care due to lack of access to transportation and/or an adequate or high quality provider network. The goal of the virtual PCMH model is to provide in-home monitoring and follow-up thereby reducing inappropriate ED use. Idaho has been using CHEMS since February 2015, with positive results. Community health workers (CHWs) will be assigned to a virtual PCMH site or to a Community Behavioral Organization (CBO), which will determine the details of their role. The telehealth components of the virtual PCMH model includes the delivery of specialty care, behavioral healthcare, and or mobile EMS units.
- The Minnesota legislature passed a bill (SF 1543) in early 2013, backed by CMS approval, to reimburse community paramedics (CPs) for a range of health care activities, including health assessments, immunizations and vaccinations, chronic disease monitoring and education, collection of lab specimens, medication compliance checks, hospital discharge follow-up care, and minor medical procedures approved by a medical director.²⁹ The CPs are employed by

²⁸ Golnick et al.

²⁹ Erich J. “How Minnesota Got its Community Medics Paid,” EMSWorld, Integrated Healthcare, May 1, 2013. Available at: <http://www.emsworld.com/article/10913443/medicaid-reimbursement-for-community-paramedics-in-minnesota>.

primary care clinics and focus their efforts towards patients who have prescribed 10 or more medications, mediations with tight therapeutic windows, multiple chronic diseases, mental health issues, or disability issues. Many states have enacted legislation allowing CPs to receive additional training and allowing them to serve in an expanded capacity.

Build infrastructure via clinic sites, and electronical health records (EHRs)

Idaho. As per the December 2015 State Innovation Model (SIM) Operational Plan, the Idaho Department of Health and Welfare (IDHW) reported approximately 18% of Idaho's 1.6 million residents are uninsured, 30% of the population resides in a rural area, 96.7% of Idaho is a federally-designated shortage area for primary care, and 100% of the State is a federally-designated shortage area for behavioral health care.³⁰

In 2012, the Idaho Department of Health and Welfare (IDHW) began its quest to move away from the predominantly FFS system the state had been operating under to a delivery model that incorporated principles of managed care in pursuit of making the Medicaid program sustainable. Given the highly rural nature of the state, Idaho has leaned towards building seven regional health collaboratives and strong electronic health record and health data backing to support patient-centered medical homes (PCMH) as well as virtual PCMHs within a medical neighborhood.

In 2014, IDHW solicited and procured a behavioral health managed care organization and hired Optum to care for outpatient mental health and substance abuse treatment services.

The model has been designed to address the challenges the State faces as a largely rural state – provider capacity, quality of care, and lack of local leadership. The state is proposing to establish a PCMH model, specifically 165 PCMH primary care practices or clinic sites which are integrated into the larger medical/health neighborhood of specialists, hospitals, behavioral health providers, as well as non-medical community-based organizations and that does not need to undergo the NCQA accreditation process, to address the state's workforce shortage. The regional health collaboratives, which includes representation from the regional PCMH, Medical/Health Neighborhoods, and public health districts, is designed to foster additional care coordination opportunities between these three entities.

Additionally, as described earlier, Idaho is also testing a "Virtual PCMH" as a part of this model to address its rural and underserved communities. The State is also testing the use of electronic health records (EHRs) and clinical decision tools to advance telehealth and identify remote patient monitoring solutions by fostering provider collaboration and patient engagement.

North Dakota. Almost two-thirds of North Dakota has been designated as Health Professional Shortage Areas (HPSAs). There are over 50 RHCs in the state.

³⁰ "2010 Census Urban and Rural Classification and Urban Area Criteria" United States Bureau of the Census. Available at: <http://www.census.gov/geo/www/ua/2010urbanruralclass.html>.

North Dakota authorized the Rural Health Clinic Services Act, to fund and establish rural health centers (RHCs) in medically underserved areas and in areas with primary care physician shortages. The Act also allows for mid-level providers, such as nurse practitioners, physician assistants, visiting nurses, and nurse mid-wives, to provide care to recipients in these areas.^{31, 32}

As per Federal law, each RHC is led by a physician, who visits the site at least once every two weeks. Under the RHC designation, a clinic can receive more than twice as much as a Medicaid office visit at a non-RHC site.

Non-Emergency Medical Transportation

State Medicaid programs are required to provide non-emergency medical transportation (NEMT) to low-income Medicaid beneficiaries to ensure they can access necessary medical care. In urban areas, this can include bus fare, community share rides, public transportation, taxi fares, or others related costs. In rural areas, this can include transportation to the nearest available facilities for preventive treatment, testing, diagnostic, and other necessary medical services that are not accessible in the recipient's community. Transportation costs can include airfare, meals, lodging, and associated costs for an attendant. These services are utilized most by beneficiaries with chronic health conditions, those who are disabled, and those who reside in rural areas.³³

A 2014 study by the Transit Cooperative Research Program estimates that state Medicaid programs spend a combined \$3 billion annually on NEMT services, however the exact amount can be difficult to tease out as NEMT services can be reimbursed in several different ways.³⁴ Every state has the option to cover NEMT services as either a medical cost, or an administrative cost. The benefits to covering travel as an administrative cost include increased flexibility in designing the program, but results in reduced FMAP. Covering NEMT as a medical cost increases the requirements states must comply with, but it allows them to receive a higher FMAP for services.

Parts of Alaska lack automobile transportation to the nearest hospital or specialty care. Medical evacuation via air transport is expensive and is used in a last resort situation. In Alaska, covering NEMT travel as a medical cost which the state currently does is a no-brainer given the combination of high rural NEMT needs, particularly among Alaska Native Medicaid beneficiaries, and the recent expansion of 100% FMAP for transportation services for Native beneficiaries by the Center for Medicaid and Medicare Services (CMS).

³¹ "North Dakota's Rural Health Clinics," January 23, 1997. Available at: <http://www.ndhealth.gov/publications/admin/rhc/rhc.htm>

³² "Rural Health Clinics and Federally Qualified Health Centers," North Dakota Department of Human Services. April 2015. Available at: <https://www.nd.gov/dhs/info/mmis/docs/rhc-fqhc.pdf>

³³ "Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers," The Kaiser Commission on Medicaid and the Uninsured, February 2016. Available at: <http://files.kff.org/attachment/issue-brief-medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers>.

³⁴ "Transit Cooperative Research Program." Available at: http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rrd_109.pdf.

Aside from the choice to cover NEMT as an administrative or medical cost, states rely on a variety of management tools for NEMT services including:

- Prior Authorization
- Co-Payments
- Service Limits
- Administrative Service Organizations
- Brokerage Firms

Prior Authorization (PA)- This requires the beneficiary to gain authorization for travel services prior to traveling. Twenty-six states, including Alaska, use PA services to control NEMT costs.³⁵

Copayments- Seven states require minimum co-payments by beneficiaries using NEMT services. These copayments range from \$0.50 to \$2.00 and are usually administered on a per-ride basis. It is unclear what impact, if any, these copayments have in reducing NEMT services. Additionally, the cost-benefit to administering such copayments is unproven.³⁶

Service Limits- Five states have limits on the number of rides beneficiaries are eligible for within a certain time frame. Limits vary from 24 wheelchair van trips per year in New Hampshire to 20 one-way trips of 50 miles or less per year in Indiana. Other states have broader limits including only covering NEMT services for beneficiaries who are otherwise unable to use private or public transportation in California or who are unable to access necessary care through other transportation means in Florida.³⁷

Administrative Service Organizations (ASO)- At least eight states contract with an ASO to provide services that would normally be administered by the state Medicaid agency under a FFS model including oversight and logistical planning, while the state determines reimbursement rates for providers. A benefit to using an ASO is that it removes the administrative responsibility for certain NEMT service provisions while still allowing the state to maintain control of payment determination.

Brokerage Firms- Widely used by states to help manage their NEMT services, brokerage firms offer a way for states to meet complex federal requirements for coordinating services and care without inadvertently running afoul of federal regulations.³⁸ As a result of certain provisions in the Deficit Reduction Act of 2005 (DRA), states can utilize brokers without having to apply for a waiver, however they must ensure the brokerage agreement meets the following qualifications: must provide for freedom of choice of providers, must be cost-effective, must be the result of a

³⁵ Cohen RK, "OLR Research Report: Medicaid Non-Emergency Transportation," Office of Legislative Research, Connecticut General Assembly, January 28, 2013. Available at: <https://www.cga.ct.gov/2013/rpt/2013-R-0035.htm>.

³⁶ Ibid.

³⁷ Ibid.

³⁸ Myers A, "Non-Emergency Medical Transportation: A Vital Lifeline for a Healthy Community," National Conference of State Legislatures, January 7, 2015. Available at: <http://www.ncsl.org/research/transportation/non-emergency-medical-transportation-a-vital-lifeline-for-a-healthy-community.aspx>.

competitive procurement process, and must not run afoul of self-referral limitations.³⁹ Over 40 states use some type of brokerage model, either public or private. Public brokerage models, where a state agency is coordinating travel, must be set up with certain firewalls between the public entity brokering travel and the Medicaid agency as a whole in order to comply with federal regulations.

Brokerage fees can vary, from capitated payments to full-risk agreements. At least seventeen states report using a full-risk and/or capitated payment model for brokerage firms.⁴⁰ States with larger rural areas generally rely on a combination, using a brokerage services to coordinate travel in urban areas, while using a FFS model to cover care in rural areas. Four states, including Colorado, Michigan, New York, and Texas used a mixed model.⁴¹

A number of states seeking section 1115 waivers for covering the adult Medicaid expansion population have specifically asked to carve out and exclude coverage for NEMT services for the expansion population.⁴² CMS has approved such exclusions on a temporary and limited basis for Iowa and Indiana. Arizona has asked for such an exclusion in their pending waiver, which has not been approved, while Tennessee and Utah have also talked about applying for an exclusion but have not yet done so. It is important to note that the approved waivers in both Indiana and Iowa require NEMT services to be covered for adults who are deemed medically fragile, and Arizona's proposed exclusion would only apply to expansion beneficiaries with incomes between 101% and 138% of the Federal Poverty Level.

Arkansas considered applying for such a waiver, but decided against excluding NEMT services after they were provided evidence that covering NEMT delivered a cost benefit ratio of 11:1 and 10:1 based on previous studies looking at inpatient cost avoidance as a result of improved outpatient care access.⁴³

³⁹ Ibid.

⁴⁰ "Non-Emergency Medical Transportation (NEMT) 2014," Hause Actuarial Solutions, June 1, 2014. Available at: http://www.hauseactuarial.com/newsletter/2014_NEMT_Report.pdf.

⁴¹ Myers A.

⁴² Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers," The Kaiser Commission on Medicaid and the Uninsured, February 2016. Available at: <http://files.kff.org/attachment/issue-brief-medicare-non-emergency-medical-transportation-overview-and-key-issues-in-medicare-expansion-waivers>.

⁴³ "Arkansas Health Reform Task Force, Volume II Recommendations," The Stephen Group, October 2015. Available at: <http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20II%20Recommendations.pdf>.

VII. Emergency Department Utilization Reduction

Several factors have contributed to the rise in emergency department (ED) use, especially in the Medicaid program. These factors include a lack of a sufficient provider network, lack of access to a primary care provider – including transportation, non-business hour access, and appointment availability.

Overall, success in ED usage reduction is evident from programs that address lack of access by connecting members to providers as well as programs that built infrastructure to foster collaboration between hospitals, primary care providers, managed care entities, and specialty care providers.

Medicaid programs have been tackling this issue throughout the past decade through CMS funding of the Emergency Room Diversion Grant Program. States continue to tackle the issue with additional guidance from CMS. A January 2014 State Medicaid Director letter from CMS encouraged states to consider expanding access to primary care, focus on super-utilizers, and target beneficiaries with behavioral health needs.⁴⁴ Similarly, a 2007 study conducted by the National Association of Community Health Centers (NACHC) and the Association of Community Affiliated Plans (ACAP) reports that patients served by health centers have fewer preventable ED visits than those in underserved areas without a health center. The report also touts health care homes – in which care is delivered in a patient-centered manner – for reducing unnecessary ED utilization.

Utah and Washington State are examples of states focusing on improving access to health home providers through 24 hours a day, 7 days a week availability.

Utah: Safe To Wait. Utah's ED diversion program, Safe To Wait, was centered around educating Medicaid beneficiaries that were utilizing EDs for non-emergent use on whether their health need should be addressed by a primary care provider or whether urgent treatment is necessary. The program also created stronger relationships between members and Federally Qualified Health Centers (FQHCs). The Medicaid agency worked with the State's FQHCs to identify after hours and urgent care providers, providers who are taking new patients, providers who accept walk-in appointments, and the health plans the providers have contracting arrangements with. This information was packaged in an educational pamphlet and mailed to participants. The State's staff and local health departments extended support and reached out to members to conduct telephonic outreach and education and assisted members in finding a primary care provider.

The program resulted in a 55 percent reduction in repeat non-emergent ED visits. Only three percent of program participants used the emergency room for non-emergent care, as compared to a control group that reported 11 percent. Between October 2008 and December 2009, the Medicaid agency saved \$2,018,952.

⁴⁴ Mann C, "CMCS Informational Bulletin: Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings," January 16, 2014. Available at: <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf>.

Washington State: ED Diversion Strategy. Washington’s Medicaid program worked collaboratively with various stakeholders including the State’s emergency room physicians, hospital association, and medical association and developed seven strategies to address over-utilization.⁴⁵ These strategies include:⁴⁶

- Creation of an information-sharing network among EDs to continually identify emergency room high-utilizers – with care plans that provide a unified case management approach
- Washington’s Health Information Exchange (HIE), Emergency Department Information Exchange (EDIE), also supports provider integration regarding adherence to narcotic guidelines and participation in a prescription drug monitoring program
- Patient outreach and education by hospital staff – who also assist beneficiaries in making primary care appointments within 96 hours of their emergency room visit
- A 24-hour nurse hotline, where beneficiaries can receive advice about whether they are having a true medical emergency

The Washington State Health Care Authority, the State’s Medicaid program, reported in the first year of the program the following statistical accomplishments:

- Rate of emergency department visits declined by 9.9%;
- Rate of visits by frequent clients (who visited five or more times annually) decreased by 10.7%;
- Rate of visits resulting in a scheduled drug prescription decreased by 24.0%; and
- Rate of visits with a low acuity diagnosis decreased by 14.2%.⁴⁷

Washington’s FFS enrollees were transitioned to a managed care program during this effort; as such, the results are compounded by a managed care platform where members were receiving coordinated care that they did not have access to previously.

Additional Approaches

In addition to these strategies, states and Medicaid health plans are also testing and finding positive results with value-based payment strategies where providers take on downside risk and share upside reward based on emergency room utilization metrics. Incentives related to ED usage can be incorporated into Alaska primary care providers’ payments within the primary care case management structure, for example.

One initiative that many states have implemented and has *not* proven successful is charging co-payments to Medicaid members. The reason for this is three-fold.⁴⁸

⁴⁵ Kellermann AL, Weinick RM. “Emergency Departments, Medicaid Costs, and Access to Primary Care — Understanding the Link,” *New England Journal of Medicine*. 2012;366(23):2141-2143

⁴⁶ “ER is for Emergencies Seven Best Practices,” Washington State Hospital Association, January 2015. Available at: http://www.wsha.org/wp-content/uploads/er-emergencies_ERisforEmergenciesSevenPractices.pdf.

⁴⁷ “Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation,” Washington State Health Care Authority, March 20, 2014. Available at: http://www.hca.wa.gov/documents_legislative/EmergencyDeptUtilization.pdf.

1. Most ED use among Medicaid beneficiaries is appropriate; various studies report that non-urgent visits are usually between six and ten percent of all emergency room visits.⁴⁹
2. Many non-emergent issues have similar symptoms to diseases that are urgent.
3. Emergency rooms cannot prohibit care based on ability to pay.

Co-payments are also administratively burdensome on providers and often result in a payment discount when providers are unwilling or unable to collect the copay from an impoverished patient.

Recommended Action Steps for Alaska

With regard to ED usage reductions, we do not recommend that any specific initiatives be undertaken beyond the prescription drug abuse/overuse programs proposed in SB74. We recommend that one component of the selection of Alaska's MCO ASO contractor involve assessing each applicant's proposed initiatives to identify and eliminate unnecessary ED usage, as well as to support the primary care providers (and behavioral health home and dental home providers, as appropriate) with information to help them reinforce their intended role as the front-line provider for persons who have frequent ED visits.

⁴⁸ "MACfacts. Key Findings on Medicaid and CHIP. Revisiting Emergency Department Use in Medicaid," Medicaid and CHIP Payment and Access Commission, July 2014. Available at: https://www.macpac.gov/wp-content/uploads/2015/01/MACFacts-EDuse_2014-07.pdf.

⁴⁹ Raven, et al. "Comparison of Presenting Complaint vs Discharge Diagnosis for Identifying 'Nonemergency' Emergency Department Visits," The Journal of American Medical Association, 2013;309(11):1145-1153.

Appendix A

Overview of Connecticut's Administrative Services Only (ASO) Contractor Model and Outcomes



HUSKY HEALTH PROGRAM MEDICAL ASO CARE MANAGEMENT

Community Health Network of CT, Inc.
March 1, 2016



HUSKY HEALTH PROGRAM

- The Connecticut Department of Social Services (DSS) is the single state agency for the administration of Connecticut Medicaid and the Children's Health Insurance Program (CHIP). Medicaid and CHIP are collectively described as the HUSKY Health Program.
- By contrast to almost all other Medicaid programs throughout the nation, Connecticut Medicaid is not using any managed care arrangements and is structured as a managed, fee-for-service program. Each of the four Administrative Services Organizations (ASOs) are contracted to administer services and to achieve improved health and satisfaction outcomes for beneficiaries, as well as improved experience for providers enrolled in the Medicaid program.
- DSS has entered into contracts with ASOs for each of the four major service types:
 - Medical,
 - Behavioral health,
 - Dental, and
 - Non-emergency medical transportation

1



HUSKY HEALTH MEDICAL ASO MODEL

Since January 1, 2012, Community Health Network of Connecticut, Inc. (CHNCT) has been contracted with the Connecticut Department of Social Services (DSS) as the Medical Administrative Services Organization (ASO) for the entire HUSKY Health program. Program attributes include:

- Care coordination focusing on the whole person and improved health outcomes
- Nationally recognized Person-Centered Medical Homes that provide an enhanced care experience for members and caregiver
- Single provider network (CMAP), enrollment process and provider reimbursement methodology
- Streamlined administrative processes for the providers, including one claims payment system and policies
- Single data warehouse that includes all Medicaid claims data
- New technology introduced, which allows the program to assess and predict member risk, profile provider performance, measure outcomes and analyze the costs and utilization of the entire Medicaid population
- Primary Care Provider direct system access to their attributed members risk profiles, gaps in care and utilization of services

As of December 2014, there were 770,383 members enrolled in the HUSKY Health program. Membership increased by 17.28% from December 31, 2013.

2



HUSKY Health Medical ASO Services to Support Care Management

- Care Management is a system of collaborative processes which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs and promote quality, cost-effective improved health outcomes for members who have complex or specific health-care needs.
- The Medical ASO utilizes multiple care teams to support care management for HUSKY Health members:
 - Intensive Care Management
 - Community Support Services
 - Inpatient Discharge Care Management
 - Transitional Care Management
 - Emergency Department Care Management
- HUSKY Health care management teams provide care and resource coordination to support member quality of life and to empower them to take control of managing their health care needs
- Care management focus includes high risk, high need members which includes those with frequent hospitalizations or emergency department visits

3



Intensive Care Management

- Intensive Care Management (ICM) is a voluntary person-centered program developed to support HUSKY members in reaching their health goals through education and access to quality healthcare.
- The ICM team recognizes that members present with complex needs and barriers that place them at higher risk for poor health outcomes. The ICM program strives to minimize barriers by utilizing a culturally aware and person-centered approach that recognizes the many factors can impact a person's ability to successfully manage their health, such as:
 - Social
 - Environmental
 - Behavioral
 - Physical
 - Cultural
 - Financial
- In CY 2014 there were 9,473 HUSKY Health members engaged in ICM

4



ICM Model Design

- ICM Regionalized Care Teams consist of:

Registered Nurses	Administrative Care Coordinators
Community Health Workers	Pharmacist Consultants
Social Workers	Physician Consultants
Registered Dietitians	
- Members engagement is through multiple forms:
 - Face-to-Face visit with member:
 - Home or in community setting
 - Hospital, ED and/or Provider office
 - Videoconference between ICM and member
 - Telephonic Outreach
- ICM assesses needs based on a *person- and family-centered* approach
- A member centered care plan is developed based on evidence-based guidelines and provider and care team collaboration

5



ICM Member Identification

- CHNCT utilizes a variety of sources to identify and stratify emerging or high risk members for care management engagement not limited to:
 - Member or caregiver requests
 - New member Health Risk Questionnaires
 - Provider referrals
 - Hospital Discharge Planners
 - State and Community Agencies
 - CHNCT internal departments (e.g. UM, Appeals, Member Services, etc.)
 - Nurse Helpline calls
 - Various data analytics reports including, but not limited to:
 - Predictive modeling and other data analytic reports
 - Readmission utilization data
 - ED utilization including real time Admission, Discharge, Transfer (ADT) transactions received from CT hospitals
 - Pharmacy drug utilization and medication risk score reports
 - Clinical lab values
 - Condition specific gap(s) in care
 - Pain management medication usage

6



ICM Assessment

- Included in the ICM assessment is identification of the member's immediate needs (e.g., unstable housing, food, utilities, safety). Elements of the assessment include:
 - Medical and behavioral health history
 - Nutritional intake
 - Social supports
 - Risk taking behaviors
 - Tobacco, alcohol and substance use
 - Perceived stress assessment
 - Depression screening
 - Health perception/self care
 - Domestic violence
 - Identification of learning needs
 - Medication reconciliation
 - Functional needs assessment
 - Cultural Influences related to self care and health care utilization

7

ICM Assignment

- Members are assigned to an ICM team based on the health condition that is "driving" their risk and utilization pattern. Overutilization and underutilization of healthcare services are considered when determining risk. Utilization patterns are used to determine risk and the member's health driving condition determines team assignment

Driving Condition	Risk	Team Assignment
Complex Co-Morbidity including Behavioral Health conditions and members with hospital readmissions	High	Complex-Comorbid Care Management
Asthma	High	Healthy Airways Condition Care Management
Heart Failure (CHF)	High	Heart Failure Condition Care Management
COPD	High	COPD Condition Care Management
Diabetes	High	Healthy Living with Diabetes Care Management
Perinatal	High	Healthy Beginnings Condition Care Management
Perinatal	Low	Low Risk Perinatal Coaching
Sickle Cell Disease	High	Sickle Cell Condition Care Management
Asthma, Diabetes or COPD co-occurring with specific SPMI conditions: <ul style="list-style-type: none"> Schizophrenia including schizoaffective disorder Bipolar disorder Borderline personality disorder Major depressive disorder (recurrent) 	High	Behavioral Health Care Management

8

Community Support Services/Community Health Worker (CHW)

As part of the Intensive Care Management team, the CHW assist members with addressing social determinants of health and provide health coaching to promote health and wellness:

- Assist members in meeting their community resource needs including basic needs such as food, shelter, clothing
- Outreach to HUSKY Health members with gaps in care as identified by ICM
- Educate and coach member on condition specific issues as part of the member's care plan and goals
- Assist members in overcoming barriers to meeting their health goals
- Support is given to members to schedule and attend doctor appointments

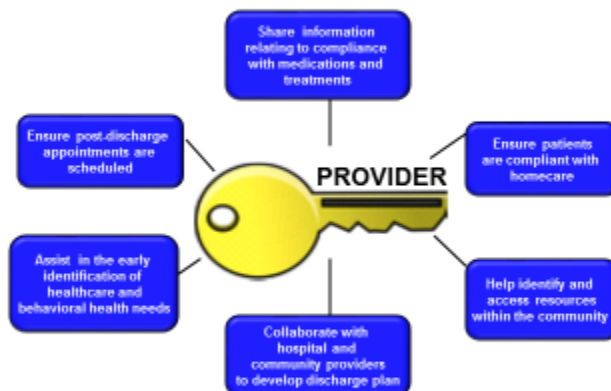
9

Inpatient Discharge Care Management

- Inpatient Discharge Care Management (IDCM) consists of a dedicated team of nurses who provide hospital onsite intensive discharge planning support for members with complex discharge planning needs at risk for readmission
- The IDCM collaborates with hospital care coordinators, primary care physicians, specialists, members, caregivers, community based providers and CHNCT Intensive Care Managers (ICM) to identify and address medical and psychosocial gaps that contribute to readmission
- IDCMs collaborate with the hospital to develop a comprehensive discharge plan that promotes safe and effective transition of care to an alternate setting
- The IDCM also connects members to their primary care provider within 7 days of hospital discharge post discharge appointments.

10

Key Support Post-Discharge Coordination of Care



A single point of contact in the clinics and provider practices is key for Transitional Care nurses to discuss the member's needs and Gaps in Care

11



Transitional Care Management

- Transitional Care (TC) outreaches to members post-hospital discharge to:
 - Review the hospital discharge plan to ensure understanding of the post-discharge instructions and the importance of follow-up appointments
 - Review medications ordered upon discharge and provide the list to the primary care providers
 - Confirm a follow-up appointment is scheduled
 - Ensure patient has transportation to all follow-up appointments
 - Assess for referral to Intensive Care Management for coaching and ongoing support or for behavioral health follow-up
 - Assess for need of community resources
 - Ensure patient is in a safe environment
 - Ensure that all necessary support and healthcare services are in place
- TC outreaches to the member's primary care and/or post hospital discharge care provider to:
 - Inform providers of recent admission and discharge
 - Inform providers of the medications ordered post-discharge for reconciliation
 - Confirm or schedule a post-discharge follow-up appointment
 - Assist providers in securing post discharge services and transportation for members

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Emergency Department Care Management

- CHNCT collaborated with the CT Hospital Association for receipt of daily "real time" Admission, Discharge and Transfer (ADT) transactions from CT hospitals in order to identify HUSKY Health members for ED Care Management (EDCM) while the members is still in the ED
- Utilizing the ADT data, CHNCT programed logic to systematically stratify for alerts to EDCM or ICM Care teams for various levels of member outreach based on frequency of member ED utilization, targeted health conditions (e.g., sickle cell disease, asthma, COPD, diabetes, prenatal etc.), member age and whether member has a primary care provider.
- EDCM collaborates with hospital ED staff to assess and determine underlying causes of the member's frequent visits. Assessment is done to identify:
 - Medical, functional, social and emotional needs that increase the member's risk for continued use of the ED
 - Immediate assistance needs with psychosocial issues, access to care or services, or education on self-management of their chronic condition

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ED Care Management (cont.)

- EDCM collaborates with hospital ED staff for members with frequent ED visits to:
 - Refer to ICM programs to coordinate medical and behavioral health services and address longer term needs
 - Deploy ICM to ED to engage with member while in hospital or if member not amenable to onsite engagement, ICM contact is initiated within 24-48 hours of discharge to the community
 - Schedule an ED post discharge follow up appointment or connect the patient to a PCP
- EDCM refers for telephonic outreach within 24 hours of ED discharge those members who are identified with a first time ED visit or not having a PCP to provide education on:
 - Importance of having a PCP
 - Assistance with selecting a PCP
 - Availability of alternatives for using the ED, such as the Nurse Helpline and urgent care providers

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Hospital Admission Outcomes

- Overall admissions per 1,000 member months (MM) decreased by 12.2% in CY 2014)
- Members managed by IDCM showed a 28.08% reduction in their readmissions 6 months post the initial IDCM assessment as compared to their readmissions six months prior to IDCM
- Members engaged in ICM showed a 43.87% reduction in their readmissions 6 months post ICM engagement
- Members with specific conditions engaged in ICM in CY 2014 showed the following results six months post ICM engagement:
 - Members with asthma showed a 39.79% reduction in their inpatient hospital utilization
 - Members with diabetes showed a 38.40% reduction in their inpatient hospital utilization
 - Members with sickle cell disease showed a 34.52% reduction in inpatient hospital utilization

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ED Visit Reduction Outcomes

- A comparison of CY 2013 vs. CY 2014 HEDIS® ED Measure Results showed a reduction in the Emergency Department visit rate by:
 - 4.70% for HUSKY A and B
 - 2.16% for HUSKY C
 - 23.51% for HUSKY D
- Members who were engaged with the EDCM program was showed a 31.55% decrease in ED utilization 6 months after entering the EDCM program

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ED Visit Reduction Outcomes (cont.)

- ED utilization decreased by 22.72% for those members engaged in the ICM program in 2014
- Targeted chronic conditions for members engaged in ICM in CY 2014 showed the following results six months post ICM engagement:
 - Members with asthma engaged in ICM resulted in a 22.42% reduction in their ED utilization
 - Members with diabetes engaged in ICM resulted in an 11.28% reduction in ED utilization
 - Members with sickle cell disease engaged in ICM resulted in an 18.39% reduction in ED utilization

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Key Health Outcomes

CY 2014 Child and Adolescent Well Care Outcomes for HUSKY A and B:

- Increased the CY 2013 Well Child Visit rate in the third, fourth, fifth and sixth year of life 3.70%
- Increased the Adolescent Well Care Visit rate by 11.60%
- Increased the Lead Screening rate by 3.95%
- Increased the Immunization Rates by:
 - 11.82% for DTaP/DT
 - 5.71% for Hepatitis A
 - 11.59% for Hepatitis B
 - 6.93% for HiB
 - 7.35% for IPV
 - 3.25% for MMR
 - 11.90% for Pneumococcus
 - 29.43% for Rotavirus
 - 16.49% for HPV for females
- Increased the Immunizations for Adolescents rate by:
 - 6.87% for Meningococcus
 - 7.92% for Tdap/Td

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Key Health Outcomes (cont.)

CY 2014 Diabetes Outcomes:

- Increased the HbA1c testing rate by:
 - 5.27% for HUSKY A and B
 - 6.96% for HUSKY C
 - 11.32% for HUSKY D
- Increased the number of members with a HbA1c result <7 by:
 - 7.22% for HUSKY A and B
 - 22.85% for HUSKY D
- Increased the number of members with a HbA1c result <8 by:
 - 11.46% for HUSKY A and B
 - 45.63% for HUSKY C
 - 32.21% for HUSKY D

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Key Health Outcomes (cont.)

CY 2014 Diabetes Outcomes (cont.):

- Reduced the number of members with a HbA1c in poor control by:
 - 12.94% for HUSKY A and B
 - 23.43% for HUSKY C
 - 21.28% for HUSKY D
- Increased the rate of retinal eye exams by:
 - 12.35% for HUSKY A and B
 - 17.50% for HUSKY C
 - 4.30% for HUSKY D
- Increased the rate of controlling high blood pressure for diabetic members (<140/90 mm Hg) by:
 - 59.32% for HUSKY A and B
 - 33.88% for HUSKY C
 - 47.71% for HUSKY D

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Key Health Outcomes (cont.)

CY 2014 Maternity Outcomes:

- Increased the Timeliness of Prenatal Care measure visit rate by 6.66% for HUSKY A and B
- Increased the Frequency of Prenatal Care measure visit rate by 26.85% for HUSKY A and B
- Increased the Postpartum Care measure visit rate by 17.00% for HUSKY A and B

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