APPENDICES

APPENDIX A: Financing Authority Detail

Table 1: Federal Medicaid Financing Authorities[1]	
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	
General Description[2] [3] [4]	*1915(a) authorizes voluntary enrollment into capitated managed care programs on a statewide basis or in limited geographic areas. Section 1915(a) is not technically a state waiver; rather, 1915(a) is categorized as a Voluntary Program under which a state may operate its managed care program *The state submits a managed care contract to the CMS regional office, which then approves or denies it *The state is allowed to use passive enrollment with an opt-out Current states implementing the Voluntary Program: CA, CO, DC, IL, MN, NE, NY, PN, PR, TX, UT, WA, WI
Uses[5]	*The default delivery system in Medicaid is fee for service (FFS). To run a delivery system other than FFS, the State must get approval from CMS. The 1915(a) exception is used by the State to enter a contract with an entity which provides plan services in a capitated managed care delivery system. MCOs are selected through a competitive procurement process. *When there is a stand-alone 1915(a), the State submits the 1915(a) contract to the CMS Regional Office for approval. If the section 1915(a) contract is being drafted to operate concurrently with another waiver, the same process applies, along with the concurrent review process required for the review and approval of the secondary wavier application.
Advantages	*No "cost" criteria for approval *Approval is infinite so long as CMS approves managed care contracts and payment rate *May include HCBS services in a stand-alone 1915(a) contract when there is an approved 1915(c) waiver or 1915(i) State Plan Amendment in the same geographic region of the State that contains the same services and would be available to the same population as those proposed in the 1915(a) contract

	*State is exempt from the following federal Medicaid requirements of Freedom of Choice of Providers, Statewideness, & Comparability:[6] - (Freedom of Choice of Providers): § 1902(a)(23) provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. Exemption allows Medicaid managed care plans to apply certain specified and allowable restrictions which limit enrollees' choice of providers. - - - - (Statewideness): § 1902(a)(1): Exemption allows for Managed care services to be limited to Medicaid enrollees in certain geographic areas, rather than available throughout a state. - (Comparability): § 1902(a)(10)(B): Exemption allows for the state to offer to those enrolled in managed care plans, a different benefits package than that under traditional Medicaid
Restrictions	*Mandatory enrollment not allowed. Beneficiaries must have the option to receive FFS services *Selective contracting is not allowed; the state must contract with any qualified, willing provider
Section 1915(b) - Freedom of Choice Waiver[7] [8]	
General Description[9]	*Waiver Section 1915b allows the State to waive Medicaid's requirements of beneficiary freedom of choice with respect to providers, statewideness, and comparability of services. In return, states must ensure that their waiver programs are budget neutral, meaning they must not exceed the cost of traditional fee for service programs *The waiver authorizes mandatory enrollment in a capitated managed care program on a statewide basis, or in limited geographic areas. When using 1915(b), states have four options: 1915(b)(1) - (4), described below: *1915(b)(1): Used to implement a managed care delivery system that restricts types of providers whom enrollees visit for Medicaid services *1915(b)(2): Used to allow a county or local government to act as a choice counselor or enrollment broker to help individuals pick a managed care plan *1915(b)(3): Used to allow the state to use savings obtained from a managed care delivery system for additional services

	*1915(b)(4): Used to restrict the number or type of providers who provides specific Medicaid services Current states using the waiver: AL, AR, CA, CO, FL, IA, KY, MA, MI, MN, MO, NE, NJ, NM, NY, PA, TX, UT, VA, WA, WV
Uses	*Used to permit the state to contract with private managed care organizations to provide Medicaid services
Advantages	*Allows for mandatory managed care or primary care case management (PCCM) for dual eligibles for Medicaid services through 1915(b)(1) *Allows for locality to act as central enrollment broker through 1915(b)(2) *Allows for provision of additional, health-related services through 1915(b)(3) *Allows for selective contracting through 1915(b)(4) *Waiver approval is for two-years (or, five-year if serving dual-eligible), with option to renewal *Can identify excluded populations *State is exempt from the federal Medicaid requirements of Freedom of choice, Statewideness, & Comparability statutes: - (Freedom of Choice of Providers): § 1902(a)(23) provides that beneficiaries may obtain services from any qualified Medicaid provider that undertakes to provide the services to them. Exemption allows Medicaid managed care plans to apply certain specified and allowable restrictions which limit enrollees' choice of providers. - (Statewideness): § 1902(a)(1): Exemption allows for Managed care services to be limited to Medicaid enrollees in certain geographic areas - (Comparability): § 1902(a)(10)(B): Exemption allows for the state to offer people enrolled in managed care plans a different benefits package than traditional Medicaid
Restrictions	*Must demonstrate cost-effectiveness, meaning the program is cost neutral or costs less than traditional fee for service Medicaid *Section 1915(b) authorizes waiver of the section 1902(a)(23) freedom of choice of providers requirement in certain specified circumstances, but not with respect to providers of family planning services

	*1915(b) waivers must not substantially impair beneficiary access to medically necessary services of adequate value *CMS monitors implementation of waiver; federal reports are required every quarter during the life of the waiver *State is required to conduct separate evaluations of managed care entities
Section 1915(c) Home & Community-Based Services (HCBS) Waiver [10] [11] [12] [13] [14]	
General Description[15] [16]	*Waiver 1915c authorizes HHS to waiver certain Medicaid statutory requirements so that a state may offer home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care; specifically waivers for: Comparability, Statewideness, and Income and Resources for the Medically Needy. *(Income and Resources for the Medically Needy): § 1902(a)(10)(c)(i)(III):Exemption allows the state to apply institutional income and resource "eligibility" rules for medically needy in the community who otherwise quality for waiver services *Must demonstrate cost neutrality in the waiver application and each year during the period that the waiver is in operation. In particular, the average per participant expenditures for the waiver and non-waiver Medicaid services must not cost more than the average per person costs of furnishing institutional (and other Medicaid state plan) services to persons who require the same level of care *Allows for implementation in limited geographic areas. *Initial three or five-year approval. Option for subsequent five-year approval *May include individuals with income up to 300% of the Federal SSI benefit rate *State may have a single 1915(c) waiver or may operate as many of these waivers as necessary Current states using the waiver: In 2014, all states except for AZ, RI, VT operate 1915c waivers. These three minority states use 1115 demonstrations to deliver HCBS instead.
Uses	*Used to allow the state to provide long term care services in home and community based settings under Medicaid
Advantages	*State can offer a variety of services, both medical and non-medical (i.e. case management, home health aide, etc.)

	*State can propose other types of services that may assist in diverting or transitioning individuals from institutional setting into the home and community *State can limit number of individuals and scope of services *State can claim federal reimbursement for all HCBS authorized under 1915(c)4(B) as well as "other services" approved by the Secretary of HHS (i.e., day treatment, partial hospitalization, clinic services for people with chronic mental illnesses, etc.) *Sections 1915(c), 1915(i), and 1915(j) allow for the state to rebalance both the distribution of HCBS participants in Medicaid LTC as well as the expenditures between the programs
Restrictions	*Programs are limited to individuals who meet all the following criteria: those who would need institutional care if the waiver services were not available; who are members of a target group that is included in the wavier; who meet Medicaid financial eligibility criteria; who require one or more waiver services in order to function in the community; and who exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care. *Must specify number of participants for each waiver year *Must specify criteria for selection of entrants *CMS monitors implementation of waiver; federal reports are required every quarter during the life of the waiver
Concurrent 1915(a)/(c) Authority	
General Description[17]	*Authorizes enrollment in voluntary managed care programs that include HCBS in the plan contract *State has the ability to use passive enrollment with an opt-out *Must demonstrate cost neutrality Current States using the waiver are: FL, MA, MN
Uses	*Used to provide HCBS under a managed care contract using the section 1915(a) authority *HCBS may be included in a stand-alone 1915(a) contract when there is an approved 1915(c) waiver or 1915(i) State Plan Amendment in the same geographic region of the

	State that contains the same services and would be available to the same population as those proposed in the 1915(a) contract
Advantages	*Same as those for 1915(a) and 1915(c)
Restrictions	*No mandatory enrollment allowed *Selective contracting is not allowed *Without a concurrent 1915(c) waiver, the State cannot cover HCBS for individuals eligible for Medicaid by virtue of section 1902(a)(10)(A)(ii)(VI) and regulation 42 CFR §435.217. Concurrence with the 1915(c) waiver means that individuals receiving services under the 1915(a) contract must simultaneously be enrolled in the section 1915(c) waiver. Concurrent waivers are available for States to use at their election. When the 1915(a) contract operates concurrently with the section 1915(c) waiver, the section 1915(c) waiver must be approved simultaneously with, or prior to, the implementation of the contract *CMS monitors implementation of waiver. Federal reports are required every quarter during the life of the waiver
Concurrent 1915(b)/(c) Waiver	
General Description[18]	*Authorizes enrollment in a mandatory or voluntary managed care delivery system that includes waiver HCBS in the contract. In other words, State mandates enrollment in managed care plans that provides these HCBS services through 1915(b); State targets eligibility and provides HCBS services through 1915(c) waiver *Must demonstrate cost neutrality. *Current states using the waiver are: KS, MD, MI, MN, NM, NC, WI
Uses	*Used to mandate enrollment into a managed care arrangement that provides HCBS services *Or, used to limit the number or types of providers which deliver HCBS services
Advantages	*Options specific to Waiver 1915(b) are allowed; i.e. selective contracting with managed care providers
Restrictions	*States apply separately & concurrently for each waiver authority *Administrative (i.e. renewal) & reporting requirements are separate

	*CMS monitors implementation of waiver *State is required to conduct separate evaluations of managed care entities *CMS monitors implementation of waiver. Federal reports are required every quarter during the life of the waiver.
Section 1915(i) - Home and Community-Based Services State Plan Option [19] [20]	
General Description[21]	*Authorizes the state to amend their state plan and offer HCBS as a state plan optional benefit statewide *State Medicaid agency submits a State Plan Amendment to CMS *Individuals must meet State-defined criteria based on need. Individuals typically receive a combination of acute-care medical services and long-term services *ACA expanded financial eligibility for 1915(i) by allowing the state to make people up to 150% above the Federal Poverty Line (and people with an income up to 300% of the SSI payment standard) eligible without regard to whether the individual met the need for an institutional level of care *As of May 2015, there were a total of 20 Section 1915(i) benefits in 17 states; Idaho has two benefits and Indiana has three benefits. Those 17 states are: CA, CO, CT, DE, DC, FL, ID, IN, IA, LA, MD, MS, MT, NV, OR, WI)
Uses	*Used to allow the state to expand access to Home and Community-Based services for individuals who are not eligible for Medicaid waiver programs.
Advantages	*The ACA gave the state enhanced flexibility to determine the group(s) eligible to receive HCBS state plan services by establishing a new Medicaid eligibility group. In other words, the State now has the ability to target services and create benefits packages based on population and may also establish separate additional needs-based criteria for individual HCBS. *For example, since the state can establish need-based eligibility criteria, it may qualify people with psychiatric disabilities under 1915(i) coverage who would otherwise be ineligible for Medicaid-reimbursable HCBS due to the institution for mental disease exclusion. *The State has the option to allow any or all HCBS to be self-directed in a manner similar to those receiving 1915(j) services

	*Exemption of the comparability statue (§ 1902(a)(10)(B)) allows for the state to offer people enrolled in managed care plans a different benefits package than traditional Medicaid. *No cost neutrality requirement *States have the option to provide HCBS to individuals with incomes up to 300% of the Federal SSI benefit rate if eligible for HCBS under a 1915(c) or 1115 demonstration *States can provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States can also use spousal impoverishment rules to determine financial eligibility for waiver services under Section 1902(a)(10)(C)(i)(III) *Sections 1915(c), 1915(i), and 1915(j) allow for the state to rebalance both the distribution of HCBS participants in Medicaid LTC as well as the expenditures between the programs
Restrictions	*State plan HCBS benefits do not have a time limit on approval except when the state chooses to target the benefit to specific populations. When this is the case, there is a five-year approval, with the option to extend the benefit for five additional years if the all federal and state requirements are met *Statewideness statute cannot be waived *The ACA eliminated the ability of states to impose an enrollment cap on 1915(i) services. The state can also no longer establish waiting lists for these services
Section 1915(j) - Self Directed Personal Assistance Services (PAS)	
General Description	*Waiver 1915(j) authorizes individuals or their representatives to be self-directed in their pursuit of PAS under the Medicaid State plan and/or section 1915(c) waivers the state already has in place. Participation is all-voluntary. Participants set their own provider qualification ("employer authority") and even determine how much they will pay for a service, support, or item ("budget authority") *Must demonstrate cost neutrality
Uses	*Used to permit the state to provide self-directed PAS as part of their Medicaid plan. Used to offer participants an alternative to the traditionally delivered and managed services. This section targets people already receiving 1915(c) waiver services and allows them to purchase goods, supports, services, or supplies (including those items

	not otherwise listed in the budget) that increase their independence or substitute for human help to the extent they would otherwise have to pay for human help
Advantages	*State can limit the number of people who will self-direct their PAS *State can limit the option to certain geographic locations, or offer it statewide *Along with 1915(i), this section enables the state to achieve compliance with their obligation to the 1999 U.S. Supreme Court ruling in Olmstead v. L.C. that people with disabilities have the right live at home or in the community if they are able and do not oppose doing so, rather than to be institutionalized (Kaiser Commission Report, Oct 2011) *Sections 1915(c), 1915(i), and 1915(j) allow for the state to rebalance both the distribution of HCBS participants in Medicaid LTC as well as the expenditures between the programs
Restrictions	*A support broker/consultant/counselor must be available to each individual who elects the self-direction option *Financial management services (FMS) must be available to assist individual in exercising budge authority *Each state Medicaid agency (SMA) must have a system of continuous quality assurance and improvement in place. The SMA has overall responsibility for monitoring the system and individual outcome measures. *Common characteristics of self-direction authorities include: (1) A Person-Centered Planning Process, meaning the individual is directing the planning process himself. A contingency plan must also become part of the planning process (2) A service plan, a written document specifying services and supports (essentially an assessment),must be created to meet the preferences, choices, abilities and needs of the individual (3) The State must describe the method for calculating the dollar values of individual budgets, which is the amount of funds under the control and direction of the participant. The dollar values calculation is based on reliable costs and service utilization, and is adjusted when changes in the participant's service plan occurs (4) The State is required to provide or arrange for the provision of a system of supports that is responsive to an individual's needs and desires for assistance in developing the person-centered service plan

	*CMS monitors implementation of the waiver; federal reports are required every quarter during the life of the waiver
Section 1915(k) - Community First Choice	
General Description	*Established under the Affordable Care Act of 2010, this option authorizes the state to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their State Plan. Note this does not create a new eligibility group; eligible individuals are still those who: are eligible for Medicaid under the state plan, have incomes up to 150% FPL or over 150% FPL and meet institutional level of care standards. *States currently using this state plan option are: CA, MD, MT, OR
Uses	*Used to further support the state to serve Medicaid-eligible people with chronic disabilities in home and community-based settings
Advantages	*State receives a six percentage point increase in its federal Medicaid matching ratio for community-based attendant and other services aimed at assisting people with ADLs and IADLs deficits and aimed at helping them acquire and maintain the necessary skills to live independently. *Services can be offered through an agency or a self-directed model
Restrictions	*State must offer 1915(k) enrollees the option of self-directing their services and support. If provided through a self-directed model, financial management services must be available *State must cover assistance and maintenance with ADLs/IADLs and health-related tasks *State must ensure continuity of services and supports *State must provide voluntary training on how to select, manage and dismiss staff *Statewideness statute cannot be waived *CMS monitors implementation of waiver; federal reports are required every quarter during the life of the waiver
Section 1115 Demonstrations [22] [23] [24] [25]	
General Description[26]	*Section 1115 waivers authorize state projects that test policy innovations likely to further the objectives of the Medicaid & CHIP programs. Under the ACA, the federal

	government will pay 100% of the costs of those newly eligible for 2014-2016 and then the federal share phases down to 90% in 2020 and beyond. *Demonstrations are at the discretion of the HHS Secretary who approves the projects *Granted for up to five years, with possibility for three-year renewal *Must demonstrate cost neutrality States using Section 1115 demonstrations are: TN, CA, CO, DE, IL, ME, NM, OR, UT
Uses	*Used to permit the state to provide a defined demonstration population with different health benefits or different service limitations than are specified in the state plan *Or, used to pilot innovative service delivery systems that improve care, increase efficiency and reduce costs *CMS has denied a number of provisions included in Section 1115 Waiver proposals. Provisions that CMS had denied waiver authority for include: - Premiums for individuals with incomes < 100% FPL as a condition of eligibility; - Requirements to provide wrap-around EPSDT benefits and free choice of family planning providers - Work requirements as a condition of Medicaid eligibility
Advantages	* Provides the most flexibility to waive Medicaid requirements *Freedom of choice of providers, statewideness, and comparability of services statues are waived *Managed care enrollment may be voluntary or mandatory
Restrictions	*Must further the objectives of the Medicaid program *Requires eligibility or benefit expansion, quality improvement, or delivery system restructuring to improve program *Must have a demonstration hypothesis that will be evaluated with data resulting from the demonstration *Must be budget neutral

	*Under the ACA, development and approval for new demonstrations are now subject to public input. CMS will not act on any demonstration request from the state until 15 days minimum have passed since the closing of a 30-day Federal comment period, during which the general public and stakeholders will have submitted comments *CMS monitors implementation of waiver; federal reports are required every quarter during the life of the waiver *Periodic external evaluations also required
Section 1932(a) - State Plan Amendment Authority[27]	
General Description[28]	*A permanent state plan amendment which authorizes mandatory and voluntary managed care program enrollment on a statewide basis or in limited geographic areas. There is no cost-effectiveness or budget-neutrality requirement
Uses	*Used to permit a state to amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with the statewideness, freedom of choice, and comparability of services statutes.
Advantages	*Amendment can address any aspect of Medicaid program administration, unlike waivers which must relate to an area specified in the Medicaid statute *No cost-effectiveness or budget-neutrality requirement *Allows for selective contracting *Comparability of services, freedom of choice of providers, and statewideness statues are not required (may be waived) *Approval from CMS is within 90 days unless disapproved or unless CMS requests additional information. Approval or disapproval by CMS is within 90 days of receipt of additional information *No renewal period since this is a permanent state plan authority
Restrictions	*State cannot mandate enrollment for disabled children, American Indians, and dual-eligibles *CMS monitors implementation of State Plan Amendment *State is required to conduct separate evaluations of managed care entities
Section 1945 Health Home State Plan Option[29]	

General Description	*Created under the ACA, this is an optional Medicaid State plan benefit for states to establish Health Homes for people with Medicaid who have chronic conditions. State must submit a Medicaid State Plan Amendment to create a health home program *Not to be confused with patient-centered medical homes, health homes under section 1945 are specifically for Medicaid beneficiaries living with chronic illnesses *CMS expects the state to adopt a 'whole-person' philosophy: integrating all types of services to treat the whole person, with particular focus on behavioral health care and social supports and services Current states with Health Homes in place are: WA, OR, ID, SD, IA, MO, WI, MI, OH, AL, NC, DC, MD, NY, RI, VT, ME. The following states plan to implement Health Homes in 2015: CA, WY, NM, KS, OK, MN, OK, AR, IL, TN, SC, WV, VA, DE, CT, MA). Nationwide since May 2015, there are approximately 1,045,875 enrollees.
Uses	*Used to permit states the opportunity to improve care coordination and care management for the following Medicaid beneficiaries: those with two or more chronic conditions; with one chronic condition and are at risk for a second; and/or with one serious and persistent mental health condition
Advantages	*State can target health home services geographically *State has flexibility to determine eligible health home providers *State has flexibility to define core health home services *State has flexibility in designing payment methodologies and may propose alternatives *State can prioritize enrollment or tier payments based on severity/risk of the patient *States may request federal planning funds at their medical assistance service match rate to support health home program design. *States receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for specific health home services, however this does not apply to the underlying Medicaid services also provided to people enrolled in a health home *Comparability and Statewideness statute is waived
Restrictions	*The 90% enhanced FMAP is good for the first eight quarters that the program is effective. The state can get more than one period of enhanced FMAP, but can only

	claim the enhanced FMAP for a total of eight quarters for one enrollee. After this period, services are matched at the state's usual rate Health Home service providers must report quality measures to the state. States are also required to report utilization, expenditure, and quality data for an interim survey and an independent evaluation *Mandatory enrollment is not authorized *Dual eligibles cannot be excluded *Comparability requirements only apply to categorically eligible individuals with selected conditions *As with State Plan Amendment requirement, a public notice is required *State must take part in an initial impact assessment survey and independent evaluation *The following six core services must be offered, linked as appropriate and feasible using health information technology: comprehensive care management; care coordination; health promotion; comprehensive transitional care/follow-up; patient and family support; referral to community & social support services.
Alternative Benefit Plans (ABPs) [30] [31] [32]	
General Description	*Authorizes a state's option to provide alternative benefits specifically tailored to meet the needs of certain Medicaid populations, target residents in certain areas of the state, or provide services through specific delivery systems instead of following the traditional Medicaid benefit plan *In July 2013, the term 1937 Medicaid Benchmark or Benchmark Equivalent Plan was renamed Alternative Benefit Plan *The state must submit a Medicaid State Plan Amendment to CMS describing the ABPs Current states using ABPs are: AR, CA, CO, DE, IA, MA, MD, MI, ND, NJ, NH, NM, PA, OH, WA, WV
Uses	*Used by the state to expand eligibility to low-income adults through the benefit options available under Section 1937. The state provides certain groups of Medicaid enrollees with 'benchmark' or 'benchmark-equivalent' coverage by selecting one of three commercial insurance products as the basis for providing Essential Health Benefits (EHB): (1) Federal employees' health benefit plan; (2) State employee coverage; or (3) Health Maintenance Organization plan with the largest commercial

	enrollment in the state. Alternatively, the Base Benchmark Plan can be based on a fourth product, a 'Secretary-approved' coverage option. Note: 'Benchmark' means that the benefits are at least equal to one of the statutorily specified benchmark plans; 'benchmark-equivalent- means that the benefits included certain specified services, and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages.
Advantages	*The state can target populations *Comparability of services and statewideness are not required *State can choose different ABPs for different groups, or use the same plan for multiple groups *State can also use its traditional Medicaid benefits package as their ABP as long as it provides coverage of required services. The added costs to the state for adopting a more comprehensive benefit package would be minimal because the federal government is covering nearly all the costs of the Medicaid expansion. In addition, because the state will have only one benefit package to administer, administrative costs might be lower than with other approaches *Allows flexibility for the state to align benefits packages with their Medicaid State Plan or with the most robust plan in the state market place. This will offer consumers a consistency with regard to value and services among private plans and Medicaid. *The state can include HCBS service and create several ABPs to meet the specific health care needs of certain populations. *Creating plans that are tailored to meet the health care needs of people gaining Medicaid coverage can mean better health for enrollees --- and both higher cost savings and better health in the long run for individuals who gain coverage.
Restrictions	*ABPs must cover the ten Essential Health Benefits (EHB) as described in section 1302(b) of the ACA, whether the state uses an ABP for Medicaid expansion or coverage of any other groups of individuals *Individuals in the new adult VII eligibility group only will receive benefits through an ABP (all non-elderly, non-pregnant adults with incomes at or below 138% FPL. *State is not permitted to offer HCBS or 1915(i) services as part of the benchmark plan benefits, since they are not part of a traditional Medicaid benefit package *Enrollment caps are not permitted

	*Certain populations are exempt, such the blind and disabled; also dual eligibles. However members of exempt populations have the option to voluntarily enroll *For children under age 21, state must provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services as part of the benefit package itself or through a combination of the benefit package and additional services *The ten benefit categories which EHBs must cover are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services, (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care *ABP must also comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) * As with State Plan Amendment requirement, a public notice is required, with reasonable opportunity for public comment prior to submitting a SPA to CMS
Delivery System Reform Incentive Pool (DSRIP) [33] [34]	
General Description	*DSRIP is a Section 1115 Waiver that authorizes the state to reward providers for implementing successful delivery system and payment reform projects by establishing a framework for projects and objectives that CMS approves. This hospital-based effort is financed by redirecting supplemental payments that have traditionally only been available to hospitals for the provision of uncompensated care *Funding for DSRIP initiatives varies across states, but can be significant. DSRIP funding is part of broader Section 1115 waiver programs that are required to be budget neutral for federal spending. *States currently using DSRIP waivers are: NJ, KS, MA, CA, TX, NY. Other states in various stages of developing DSRIP waivers or are operating initiatives that share key elements of DSRIP waivers include: FL, NM, OR, AL, IL, NH.
Uses	*Used to incentivize the innovation of sustainable Medicaid programs that will lead to more efficient and effective health care delivery and better health outcomes
Advantages	*Entities eligible for DSRIP funds select targets and approaches from the state's framework and has the flexibility to shape an implementation plan *When hospitals partner with other providers to be eligible for DSRIP funds, a common financial interested and alignment is created to affect change

Restrictions	*The entity's implementation plan is subject to state and federal approval *DSRIPs must be created through Section 1115 waivers only *The long-term viability is unclear--CMS hasn't provided guidance on DSRIPS
1916(f) Waiver	
General Description	*Section 1916(f) allows for a state to impose higher cost sharing than otherwise allowed under federal law (for instance, Section 1115 waiver authority does not extend to Medicaid cost-sharing requirements; to impose cost sharing charges beyond what Medicaid rules already allow, the state must meet the criteria for a Section 1916(f) waiver).The final regulations released in July 2013 simplify rules around premiums and cost-sharing in Medicaid, increased allowable cost-sharing amounts for non-preferred drugs, and non-emergency use of the emergency room. *Indiana gained approval for a two-year Section 1916(f) waiver. Under this waiver, beneficiaries are subject to an $8 co-pay for their first non-emergency visit to an emergency room and $25 for each subsequent non-emergency visit. *Section 1916(f) waivers are approved in IN, and are proposed in TN and UT.
Uses	*Used to permit a state to seek a demonstration waiver to charge cost sharing above otherwise allowable amounts if the state meets specific requirements, including testing a unique and previously untested use of copayments and limiting the demonstration to no longer than two years.
Advantages	*Cost sharing waivers may be imposed under demonstration projects.
Restrictions	*For CMS approval, the waiver must test a unique use of copayments *The waiver must provide benefits to Medicaid recipients which can be reasonably expected to be equivalent to the risks to the recipients. *The waiver must demonstrate that it is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner. *The waiver is limited to a two-year period or less *The waiver is either voluntary or makes provision for assumption of liability for injury to the health of beneficiaries that results from involuntary participation.

APPENDIX B: Care Model Detail[35]

This appendix includes more detailed descriptions of the different models of care and the reimbursement methodologies states commonly use with each of them. For each of the care frameworks we have included:

- How the models generally are structured.
- The types of data that are required to ensure the model can work effectively.
- Unique issues related to changing provider cultures when states or other payers have implemented these models.
- What payment methodologies states typically use with the model, and how Alaska might use other innovative payment structures for each model.
- Some available outcome data from states that have implemented a form of the model.

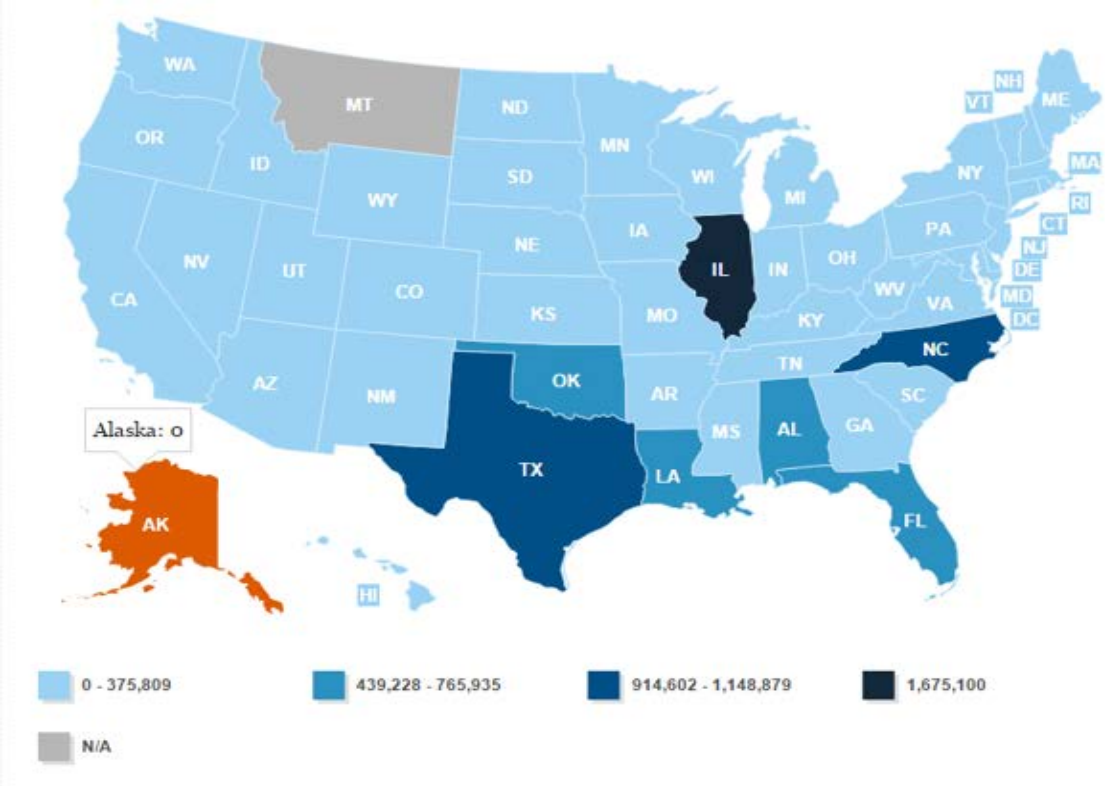
Primary Care Case Management Model (PCCM)

Structure

CMS defines a PCCM as "a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts directly with the state to locate, coordinate, and monitor covered primary care (and sometimes additional services)." PCPs participating in PCCM programs are expected to "manage" beneficiaries' care by monitoring and approving utilization of services against criteria set by the state. For example, PCPs conduct minimal care coordination and ensure that beneficiaries get referrals for certain specialty care, as well as prior authorizations for high-cost services or medications.

PCCMs are the easiest coordinated care model to implement in rural areas because they do not require significant provider or state infrastructure or staff investments. PCCMs also are relatively easy for states to administer, although some states contract with vendors to oversee provider management and reporting functions. PCCMs do not require that states get a waiver from CMS or make major changes to their State Plan Amendments (SPAs). However, new proposed managed care rules from CMS include additional managed care requirements states with "enhanced PCCMs" will need to meet. In the NPRM, CMS distinguishes between PCCMs that use individual providers to manage a basic level of care vs. PCCM programs that use care management entities ("PCCM entities") to oversee a more robust set of administrative functions similar to those of managed care organizations. CMS proposes to require PCCM entities to meet the same standards and rules as PAHPs and PIHPs for some things such as contract reviews, and the same standards and rules as full-risk MCOs for other things such as enrollee information and customer service.[36]

Figure 1: Kaiser Family Foundation Medicaid Enrollment in Managed Care by Plan Type[37]



Data Needs

Generally, states do not require PCCM providers to collect and report many quality or outcome data; they rely primarily on existing claims data for program performance analysis. Therefore, providers do not need to have sophisticated electronic health records (EHRs) or systems to participate as PCPs in these programs. More recently, states with enhanced PCCM programs or that use PCCM entities, are asking more from providers in order to track how providers are performing vis-à-vis other providers, see outcomes for beneficiaries, create quality improvement initiatives and structure additional pay-for-performance incentives or performance rewards.

Provider Culture Change

Implementing a standard PCCM program does not have a significant impact on participating providers' existing practice operations, staff or systems. Often the most complicated aspect of the program is the assignment of beneficiaries to PCPs, which can be either mandatory (with options to change) or voluntary. PCPs oversee beneficiaries' primary care, preventive care, and offer some minimal care management (as noted above). They make referrals and obtain authorizations when beneficiaries need hospital and specialty care. With enhanced PCCMs and PCCM entities that include more care coordination and care management services, providers must make additional adaptations or have more advanced data collection and reporting capabilities.

Payment Methodologies

PCCMs use the FFS payment model for most benefits and services, but pay a small monthly per member per month (PMPM) for care coordination. Typically, such PMPM fees range $2 and $5 depending on the state's expectations of participating PCPs. As noted above, some states are implementing enhanced PCCMs that include pay-for-performance, quality incentives, and even shared savings reimbursement models. CMS has identified these as PCCM entities and is proposing that they meet most of the same managed care requirements as full-risk MCOs. For example, Colorado's Medicaid Accountable Care Collaborative (ACC) pays a PMPM fee to Regional Care Collaborative Organizations (RCCOs) to "manage" care coordination supports and services in a specific geographic region; but providers contract with the state and are paid a FFS rate by the state. Some RCCOs have entered into agreements with providers to share part of their PMPM payment in exchange for helping the RCCO to meet care coordination and cost saving goals.

Savings and Quality Improvement

There is limited research on savings and improved quality of care in PCCM programs. An evaluation of Iowa's program concluded that it generated savings of 3.8 percent ($66 million) between 1989 and 1997.[38] For the study, researchers compared PMPM actual costs with expected costs in the absence of the PCCM program. Use of the PCCM program was associated with increases in outpatient care and pharmaceutical expenses, but a decrease in hospital and physician expenses. A synthesis report by the Robert Wood Johnson Foundation on managed care's impact on cost and access concluded that this study's findings are limited by use of older data and focus on only one state.[39]

Other studies on both MCOs and PCCM models found little evidence of improved access in PCCM models. A study across multiple states found that "children in PCCM had higher rates of unmet needs and more were without usual sources of care as compared to FFS."[40]
Recently, some states have been transitioning away from the PCCM model to more comprehensive models such as risk-based capitation (Delaware, Florida, Georgia, Kentucky, Illinois, Nebraska, New York, Pennsylvania, Texas and Virginia), while others are retaining the PCCM model but requiring more from their existing programs.

Patient Centered Medical Homes (PCMH)

Structure

The primary focus of a PCMH is on "whole person care" and serving individuals with a coordinated, integrated approach to care delivery that promotes access to and coordination with all needed services – medical/health and social. The PCMH model generally builds on a PCP practice or clinic. PCMH providers are expected to establish team-based care and offer services and supports beyond the basic coordination of medical services, such as after-hours access for patients, maintaining electronic health records and tracking quality metrics, conducting comprehensive health assessments for all new patients and proactively managing and reducing barriers for high-risk patients[41]. Many Federally Qualified Health Centers (FQHCs),

Community Health Centers (CHCs), and other large primary care practices have made the transition to become PCMHs.

Although the concept of PCHMs has been around since the 1960s, it was not until 2007 that the American Academy of Family Physicians, the National Committee for Quality Assurance (NCQA), and three other medical associations issued guiding principles for PCMHs that standardized criteria for recognition and certification of practices as PCMHs. For example, NCQA has three levels (three being the highest) of PCMH certification, each of which has increasing requirements for team-based practice and care coordination services. Some state require NCQA or other evidence-based certification before they will recognize a practice as a PCMH, but often will provide assistance (financial and technical) for practices to achieve certification. More states have become interested in PCMHs for both Medicaid and Medicare beneficiaries, even those covered in full-risk managed care plans. Many private payers also have invested in developing PCMHs in their provider networks for commercial members.

The PCMH has been a good care model for practices in rural areas, particularly those with more robust primary care structures already in place, such as FQHCs and Rural Health Clinics (RHCs). Indeed, Alaska has had three PCMH pilot projects in place since 2011:

- Tri-State Children's Health Improvement Consortium (TCHIC): a three-state (AK, OR, WV) demonstration to improve children's health and health care quality measurement, integrate HIT systems, and develop the best models of health care delivery for children and adolescents enrolled in Medicaid and Denali Kid Care.
- The Alaska PCMH-I project seeks to increase implementation of the PCMH practice/delivery model among Alaska's primary care providers. Phase I in 2014 funded one round of sub-recipient awards to Alaska primary care providers, while Phase II is being developed with the Alaska Primary Care Association (APCA), the Alaska Mental Health Trust Authority, and DHSS.
- The DHSS DPH Section of Women's, Children's & Family Health (WCFH), Perinatal and Early Childhood Health Unit, has specifically focused on PCMH model access for children and youth with special health care needs and condition (CYSHCN) since 2011. DHSS staff piloted care coordination for CYSHCN on-site for two clinical practices in Southcentral Alaska and WCFH staff worked with the All Alaska Pediatric Partnership, the University of Alaska-Anchorage (UAA), the American Academy of Pediatrics, and Boston Children's Hospital to adapt a nationally developed pediatric care coordination training curriculum.

PCMH has worked in other states with large rural areas, as well. For example, in 2011, Nebraska conducted a two-year pilot PCMH project comprised of two rural practices with 7,000 Medicaid members. The goals of the project included transforming the two practices into recognized (NCQA-certified) PCMHs to 1) improve health care access and health outcomes for patients and 2) contain costs. A November 2013 final report of the Nebraska PCMH pilot prepared for the Governor and legislature concluded that: "This pilot demonstrated improved patient satisfaction, marked efficiencies with the modification of office practices, improvements

in patient health through care coordination and patient education, and indicators showing potential for containment of costs."[42]

Data Needs

According to Health IT in the Patient Centered Medical Home,[43] a compendium of information of HIT best practices for PCMHs, HIT is a critical component for PCMHs to successfully engage patients and measure patient outcomes. A solid HIT infrastructure allows PCMHs to:

- Collect, store, manage and exchange relevant patient health information, including patient-generated data.
- Enhance or facilitate communication among providers and options for delivering care to patients.
- Measure, analyze and report on quality and other outcomes.
- Communicate with patients via mechanisms such as web portals and telemedicine.

Culture Change

Despite the promise of PCMHs, there are still limitations, as well as challenges with implementation. PCMHs are largely an expanded primary care medical model and don't always effectively coordinate with non-medical services. Becoming a PCMH requires most practices to shift fundamentally how they deliver care. It can be particularly hard for small, rural practices with limited staff resources to meet some of the certification requirements such as more coordinated referrals and care management across providers (specialists, hospitals, behavioral health, etc.), and for any social services they also may need. Practices are at varying levels of readiness, so a state's approach must account for these different circumstances. Achieving the different levels of certification under NCQA also can be difficult. For example, the investment in staff changes and infrastructure necessary to meet the more stringent requirements for Level 3 NCQA certification (the highest level), which generally comes with increased reimbursement, may be too much for some smaller practices without significant support.

As an example, when the two practices that participated in the Nebraska PCMH pilot project were asked if they would do it again, staff from one PCMH responded they absolutely would, while staff from the other PCMH said that given the reluctance of some of the providers in the practice, they probably would not. A key lesson learned from that pilot was that practices need time and support for change management.[44] Similarly, the Alaska PCMH pilot for CYSHCN at two clinical practices in Southcentral Alaska found that it was not able to sustain the two care coordination positions after the initial grant funding ended because the current payment structure does not cover care coordination services and clinic organizational changes.

Payment Methodologies

Many states are building on their existing PCCM infrastructures to establish PCMHs. In 2013, at least half of the states reported having a Medicaid/CHIP PCMH.[45] The majority of states pay providers FFS plus a PMPM care management fee. These fees vary considerably from state to state and are often adjusted for patient age, acuity and PCMH NCQA accreditation level. Some states offer start-up assistance, and 14 states use performance-based payments. One of the key

recommendations in the final report of the Nebraska PCMH pilot was that the state should consider "linking payment rates to the quality of care and realigning provider incentives away from promoting utilization and toward efficiency and improved health outcomes."[46]

In the same vein, the Alaska PCMH-I pilot found that sustainability given the current payment structure was difficult and warranted continued exploration of more viable payment models. "Primary care practices incur significant ongoing costs to sustaining the PCMH model of care. Phase II of PCMH-I will focus on sustainability and alternatives to fee for service and per-visit payments, as current payment models do not address care coordination for patients with chronic conditions or integration of behavioral health into primary care – both of which affect some of our highest consumers of health care in Alaska. While the recognition of PCMH is foundational, supporting delivery models for coordination of services, provision of behavioral services and self-management is a critical component in improving health outcomes and system savings, especially for patients with special health care needs."[47]

As PCMHs become more established, there will be opportunities for additional or expanded value-based payment models such as risk-adjusted PMPMs, shared savings/risk and bundled payments for certain kinds of care services. Building on these various value-based payment structures also can help to create the foundation to expand PCMHs into more advanced care systems with more shared risk, such as ACOs.

Savings and Quality Improvement

It is hard to find information on cost savings and improvements in care and health status from PCMH models that have been implemented so far. The February 25, 2014, *Journal of the American Medical Association* (*JAMA*), includes an evaluation of a three-year medical home pilot in Pennsylvania – the Southeastern Pennsylvania Chronic Care Initiative - one of the first multi-payer medical home programs in the country.[48] This study evaluated changes in care quality, utilization, and costs for 32 primary care practices with NCQA certification as medical homes, compared with 29 practices that did not receive NCQA certification. The outcome of the study suggested that the program was not associated with significant improvements in quality of care or cost reductions.

However, a separate American Journal of Managed Care study evaluated these same Pennsylvania PCMHs from a different perspective, looking for differences between the total PCMH patient population vs. a pool of the highest-risk patients in those PCMHs. "PCMH model adoption was shown to lead to a significant relative reduction in total costs in years 1 and 2, and significantly lower numbers of inpatient admissions in all 3 years [2008-2010]."[49] Along the same vein, a Health Affairs article published in January 2015 highlighted the limited effects of whether obtaining NCQA PCMH certification made a difference in higher quality care and lower costs for Medicaid beneficiaries enrolled in them.[50] This study found that having NCQA certification had a minimal effect on whether a PCMH improved care quality and cost; however, where researchers did see improvements were in those certified PMCHs with large percentage of chronically ill patients. These studies indicate that the types of beneficiaries that states enroll in PCMHs, or how they evaluate the effectiveness of PCMHs based on their beneficiary mix, can

be very important. For example, the authors of the American Journal of Managed Care study point out that based on this method of evaluation of PCMH effectiveness, it appears the model can and does have the intended effect of reducing cost through better patient care coordination. They note that even though their study found a decrease in the total costs of patient care of $107 and $75 (2009 and 2010, respectively) there were increased costs and utilization for specialist care. However, that increase was offset by the decrease in inpatient hospitalization. This, they suggested, is likely the result of better information sharing and coordination among providers and a focus on earlier and more appropriate interventions. The PCMH model may not necessarily improve care and cost for all individuals enrolled, but it does show promise for significantly improving care and cost for high-risk individuals who are enrolled.

Both the 2015 Health Affairs study and at least one other health policy expert also noted that as the PCMH model has evolved significantly over the last several years, it has become clear that reimbursement structures need to evolve also to reward cost savings, as well as quality improvement. For example, the Capital District Physicians Health Plan innovation in Albany, NY, which started in 2008, is testing payment models that reward reductions in unnecessary care utilization, increased cost savings, and improvements in quality. Early result show significant improvements in these areas.[51] Similarly, the Nebraska PCMH pilot project found mixed results, with improvements in reductions in high-cost imaging, reductions in the number of prescriptions per 1,000 members, reduced ED utilization, and improved patient satisfaction. However, there was a slight increase in overall inpatient admissions, no measurable difference in ED re-visits for the same complaint, and fluctuations in the levels of provider satisfaction over the course of implementation.[52]

These results can be useful to Alaska as it evaluates its current PCMH initiatives, in particular for CYSHCN and as the State begins to integrate behavioral health more into primary care settings.

Health Homes[53]

Structure

Health Homes are a newer delivery system and payment model authorized by Section 2703 of the Affordable Care Act (ACA). The program was designed to focus on enrollees with mental health and substance abuse issues, as well as multiple chronic conditions. There are specific statutory requirements for the target populations that can be enrolled and the services that must be provided, although CMS has allowed states some room to identify other conditions to include and definitions of the services their Health Homes will provide; these then must be detailed in the State Plan Amendment.

Target populations for Health Homes are Medicaid enrollees with:

- Multiple chronic conditions
- One chronic condition and at risk for another
- One serious and persistent mental health condition

- A mental health condition
- A substance use disorder
- Asthma, diabetes, heart disease, and a body mass index (BMI) over 25

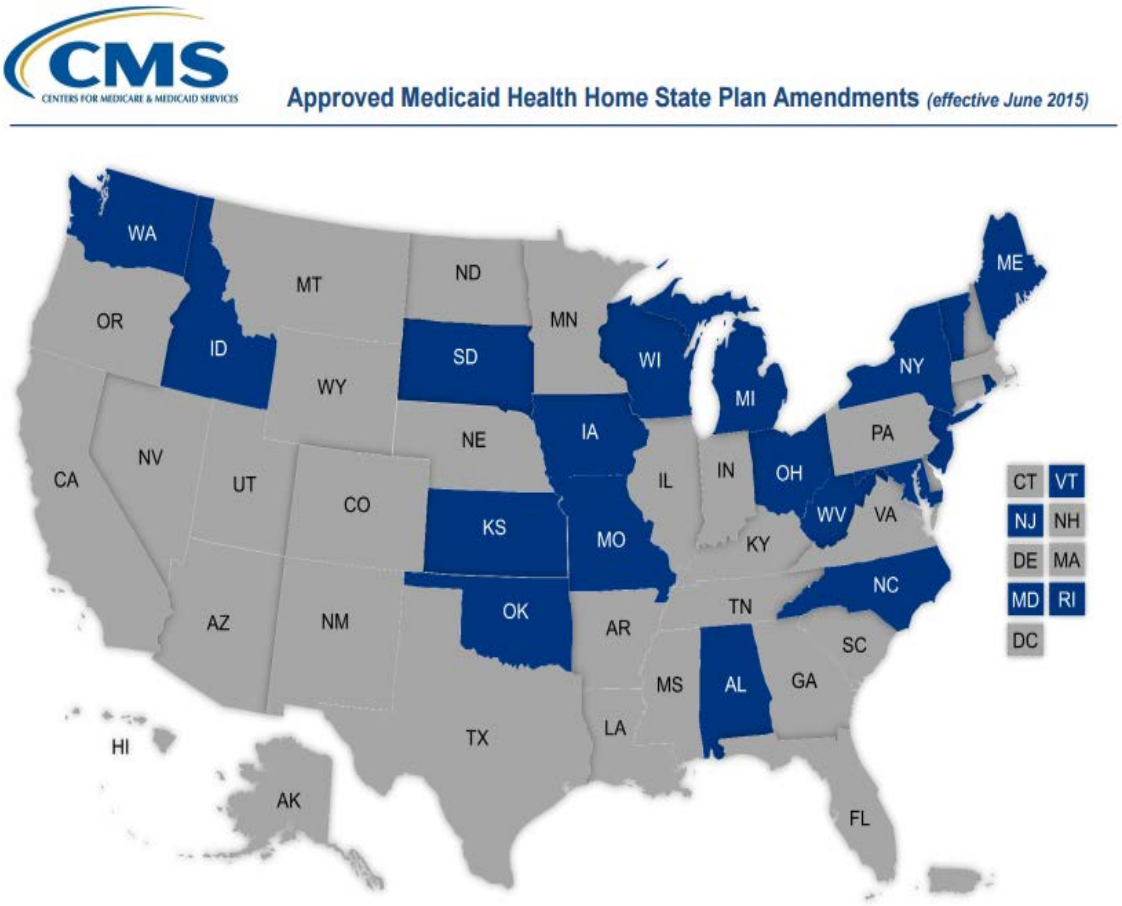
States must provide the following services in their Health Homes:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support services
- Referrals to community and social supports
- Use of health information technology to link services, as feasible and appropriate

With 2703 Health Homes, States may target geographic areas for focus, and unlike other Medicaid programs which must be implemented statewide, no waiver is needed for geographic implementation. To encourage states to pursue this model and to ensure sufficient funding is available, states can receive a 90 percent federal match for the first eight quarters of their program. Each time a state expands geographically or includes new conditions, eight more quarters of enhanced match are available to those individuals meeting the new criteria. Many of the early Health Home states built on existing structures and programs and aligned them with other reform initiatives. Several states integrated their Health Homes with their MCOs, such as New Mexico and Missouri.

According to a report released in 2014 by the Urban Institute on behalf of the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE), Office of Disability, Aging and Long-Term Care Policy, which is charged with evaluating the 2703 Health Homes program, states have created essentially three types of Health Homes: specialty provider-based models, medical home-based models, and care management networks.[54] Specialty providers consist of entities that have traditionally served special populations and now also are integrating specialized care with primary care. The model based on the patient-centered medical home extends to include specialty and other providers beyond the traditional primary care practice, while care management networks have a lead organization or administrative entity that oversees a coalition of physical and mental/behavioral health care providers, care coordination entities, social services agencies, and other community organizations.

Figure 2: CMS Approved 2703 Health Home SPAs, as of 6/2015[55]



Fundamentally, Health Homes differ from PCMHs in several ways as detailed below in Table 2.

Table 2: PCMH vs. Health Homes Comparison

PCMHs	Health Homes
• May not be required to integrate physical and behavioral health care services	• Must integrate physical and behavioral health care services
• Provides care to anyone a state chooses to assign	• Targeted to specific high-risk enrollees with chronic conditions
• Not necessarily required to extend coordination beyond medical services to social and community supports	• Required to extend coordination beyond medical services to social and community supports
• Based in a medical setting, generally primary care providers	• Variety of providers, including behavioral health and non-traditional providers such as supportive

	housing programs; a priority focus on integrating multiple services

Data Needs

According to a CMS Technical Brief in 2012 on Health Homes,[56] at minimum, states should consider the following data needs for establishing and monitoring Health Homes under Section 2703:

- Cast the Net Widely - As a starting point, identify all enrollees who meet the eligibility requirements under Section 2703.
- Stratify Beneficiaries into Sub-Populations - The eligible population will be heterogeneous. Stratification of the population can develop more homogenous subgroups and, therefore, help define the array of services that need to be included in Health Home design.
- Understand High-Cost Enrollees - Analyze service use and cost patterns for enrollees who comprise the top 5, 10 or 20 percent of Medicaid costs. Identify what services they are receiving, who is providing their care, and how much opportunity there is to avoid high-cost services with strong care management supports.
- Identify Enrollees Who Have a High Medical Risk - If a state does not use predictive modeling, it can identify individuals with several diagnoses and sort the population by the number of conditions or utilization or cost metrics. Data from health risk assessments are also valuable in identifying people at high risk.
- Understand Where Enrollees Live - Identify "clusters" where a sufficient critical mass of eligible enrollees resides.
- Consider Including Sub-Populations - When stratifying and targeting eligible subpopulations, identify the: (1) total number of enrollees in each subpopulation; (2) total Medicaid expenditures; (3) average PMPM costs; and (4) rate of potentially avoidable and costly services.
- Differentiate Emergency Department Visits - Outpatient ED visits may lead the Health Home to focus on building a connection between the enrollee and his/her primary care provider (PCP), while ED visits that result in inpatient admissions may demand a strong focus on care transitions, discharge planning, and follow up with the PCP.
- Define Care Providers Used by the Target Population - Identify whether the target population has a usual source of care and whether that source of care is appropriate.
- Identify Missing Links to Primary Care Providers - It is important to identify and address missing linkages to primary care, particularly for Health Homes programs that "reside" in the behavioral health care delivery system.
- Understand Who Manages the Care of the Target Population - If an enrollee has an existing relationship with a care management program, the state should build on those services, replace them, or target Health Home services to a population not already receiving care management.
- Complete, timely, and accurate data is important both for Health Home services – case management, care coordination, and care transitions – and for program evaluation.

Following these guidelines is important, as CMS mandates that states meet a variety of reporting requirements for their Health Homes. The Urban Institute is currently conducting a five-year evaluation of Health Homes for a report due to Congress in 2017 and will include these kinds of quantitative and qualitative data.

Provider Culture Change

A number of Health Homes have now been in place long enough to start seeing common themes and trends emerge, although it still is difficult to obtain much outcome data. The Urban Institute Year Two Health Home evaluation notes a number of key issues states have identified so far in their Health Home experiences:[57]

- The states' health care context for implementing Health Homes matters. For example, decisions about the appropriate health home model to fit within each state's broader policy goals, what kind of existing health system infrastructure a state already had, and where Health Homes fit into each state's overall reform efforts all impacted what kind of Health Homes.
- Treating the whole patient through teamwork and collaboration with providers not accustomed to working together requires a major cultural change. Particularly for primary care practices incorporating behavioral health, it is challenging to achieve real care integration.
- Real-time and thorough communication is essential but also technically, legally, and operationally complex. Facilitating communication through technology requires:
    - Upfront investments in systems and staff training
    - Addressing design limitations and high cost of EHRs and other technology requirements to share information across systems and providers
    - Motivation of providers who lack financial or other incentives to reduce hospitalizations and use of unnecessary services.
- The way a state pays its Health Homes is a significant factor in how successful their health homes are. Except for a specialized children's Health Home in Rhode Island, states reimburse Health Homes with a PMPM rate; Wisconsin's also pays a flat fee to cover initial assessment and care plan development, which providers can bill annually. These different payment structures and amounts affect providers differently, through a variety of different data reporting requirements and levels of administrative complexity and costs.
- Identifying beneficiaries to enroll in Health Homes is not easy. Whether eligibility is managed centrally by the state, or through providers, many individuals who would benefit from being in a Health Home fall through the cracks because they are not being systematically identified and enrolled. States have started using a combination of both centralized and provider-based processes, to increase the number of beneficiaries who get enrolled in Health Homes.
- Changes in beneficiary Medicaid eligibility complicate the work of Health Homes. When individuals go on and off of coverage, which is common in Medicaid, they don't receive consistent coordinated care, even if they are enrolled in a Health Home.

- Establishing the benefit of Health Homes is administratively challenging. Generally, Health Homes are implemented as only one of multiple initiatives, and it is difficult for both states and providers to identify definitively the specific outcomes and benefits related to Health Homes alone.

Savings and Quality Improvement

In 2012, Missouri launched a Health Home initiative in 28 community mental health centers (CMCHs) for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Between February 2012 and June 2013, these CMCH Health Homes reported a 12.8 percent reduction in inpatient hospital admissions and an 8.2 percent reduction in ED visits among the 12,105 individuals continuously enrolled during that time. This resulted in a savings of $217.55 PMPM; after subtracting the $78.74 PMPM payment the state made to the CMCHs, the state realized a total cost savings of $48.81 PMPM just on the reductions in hospital admissions and ED visits. Nearly 6,000 of the enrollees were Medicaid-only (non-dual eligible), and the state calculated that it saved a total of $2.4 million in the cost of their care over the year before they were enrolled in the CMHC Health Home. In addition to the cost savings, however, the state noted that: "CMCH Health Homes have made remarkable progress in improving clinical outcomes and impacting the service delivery system."[58]

Early indications from New York's Health Home projects are that at least for a subset of the Health Home population, there was an increase of 14 percent in primary care visits, but a decrease of 23 percent in inpatient admissions and emergency department visits.[59]

Payment Methodologies

As noted above, most states pay a PMPM for Health Home services. However, a few states are beginning to experiment with other kinds of reimbursement models. For example, Missouri, the first state to receive federal approval for Health Homes, established its PMPM by estimating the costs required for Health Home providers to develop necessary clinical and administrative capability. Missouri currently is exploring shared savings strategies and performance incentive payments. Iowa has built risk adjustment and pay for performance into its model, and New York has committed to sharing with its Health Home providers any savings gained through reductions in Medicaid expenditures. There is much interest in continuing to explore ways to align payment structures to better support the efforts of Health Home providers in meeting the increased demands for integrated care, more sophisticated data reporting, and improved data sharing with other providers. There is opportunity for shared savings and potentially shared loss models, as well as bundled payments for certain kinds of services. For example, the alternative payment methodology Rhode Island uses in its CEDARR Health Home for children with SMI/SED and other special health care needs, which uses a rate based on level of effort required plus a market-based hourly rate for services.

Accountable Care Organizations (ACOs)

Structure

An ACO is an entity consisting of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of

the care delivered. In most cases, the ACO is a provider-based organization, but in some cases, it is a managed care organization. The ACO model is most often associated with Medicare or, to a certain extent, the commercial market. As of August 2015, nine states have implemented Medicaid ACOs and another 10 have plans to do so.[60] The states may have different names for their ACO models – Coordinated Care Organization (CCOs, Oregon), Regional Care Organization (RCOs, Alabama), Accountable Care Collaborative (ACC) and Regional Collaborative Care Organizations (RCCOs, Colorado), and Integrated Health Partnerships (IHPs, Minnesota) – but they all have the same goal: improve population health and reduce spending, while providing care in a more coordinated and efficient manner.

Figure 3: Center for Health Care Strategies map of state Medicaid ACOs, as of August 2015

The organizational structure of Medicaid ACOs differs from state to state and even within a state, depending on benefits, as well as participating providers and partners. Many ACOs are provider- or community-based, while others are built entirely on traditional Medicaid managed care organizations. Illinois, Iowa, Maine, Minnesota, New Jersey and Vermont all use provider-led Medicaid ACOs, while Oregon's and Utah's models are payer-based. In Colorado, it is a mix, with both providers and payers who are regionally-based, including:

- A managed care organization with CHIP and Medicare lies of business, as well as Qualified Health Plans in the State's exchange

- A prepaid inpatient health plan that has commercial, Medicare and Medicaid lives
- A joint venture between a hospital system and a physician managed services organization
- A community-based coalition of providers
- A partnership between a national administrative service organization and five Colorado-based service delivery organizations

States also are including more community involvement in their ACO structures. For example, New Jersey requires that at least two members of an ACO's governing board be from community organizations that represent populations served by the ACO. In Vermont there must be at least one Medicaid beneficiary on the governing board, and Minnesota's IHPs have to demonstrate how they partner with community organizations and social service agencies to integrate their supports into beneficiaries' care.[61]

Despite these differences, in all cases, states have built their ACOs on the existing delivery system, including well-established PCCM programs, PCMH/Health Homes, or MCOs. Having these existing programs with experience coordinating care and with some of the necessary infrastructure is a pre-requisite to building a successful ACO.

Data Needs

Nearly all the reports and analyses, whether from the commercial, Medicare or Medicaid environments, emphasize the critical need for timely, complete, and actionable beneficiary data to the success of any ACO. States that have pursued this model have developed innovative solutions to make needed data available to both agency staff and providers. For example, Colorado's Statewide Data Analytics Contractor (SDAC) delivers secure electronic access to clinically actionable data to the RCCOs and Primary Care Medical Providers (PCMPs). The data includes Medicaid paid claims information, clinical risk group (CRG) identifiers and predictive risk scores, and Behavioral Health Organization managed care encounter data. The state, RCCOs and PCMPs can access a variety of reports, including profiles of individual clients based on predictive modeling, identification of areas for clinical process improvement at the client, provider and RCCO levels, and aggregate reporting of cost and utilization performance indicators.[62]

Most states require ACOs to meet quality metrics, key performance indicators and/or performance goals to participate in shared savings plans. This requires that both states and providers have the capability to capture, manage and report a lot of clinical as well as administrative information. ACOs that integrate across provider types such as primary care, specialty care and hospitals need business processes and technical systems that support data sharing and yet still meet stringent privacy, confidentiality and security regulations. This can be costly for ACOs and may present a barrier for some providers to participate. States could consider offering up-front financial support to help ACOs establish the needed health information technology to ensure adequate data management needs.

However, too much data can become overwhelming for providers in an ACO structure. Here are ways in which an ACO can prevent provider data overload:

- Determine which data really are the most useful and actionable for providers.
- Share targeted or filtered information with provider they can use at their practice level.
- Make available to providers analytic and care coordination tools through easy to access and use data management systems.
- Encourage providers to dedicate personnel to data management, such as a data coordinator.[63]

Provider Culture Change

ACOs require a major change in culture among providers, which involves significant outreach, education, and support. Most states with ACOs have built on existing care delivery initiatives such as PCMHs and Health Homes, expanding those efforts into ACOs that shift more of the risk to providers. Generally, providers already operating as a PCMH or Health Home have achieved some success in taking a more team-based approach to care delivery and already are beginning to integrate primary care with behavioral health and social services providers. It is essential that providers understand the level of risk they are being asked to take on within an ACO, particularly if they are expected to participate not only in shared savings but in shared losses. They also must have clear guidance on the performance metrics related to their level of risk and how they can meet those goals. Establishing value- and outcome-based payment mechanisms requires a thoughtful and deliberative process so providers who have little or no experience with these mechanisms can learn to operate within a new paradigm. Most providers still do not have a lot of experience being held accountable for the cost of care they deliver. For example, in August 2015, The Commonwealth Fund and Kaiser Family Foundation (KFF) published results of a primary care provider survey reported that 29 percent of all primary care physicians said they participate in an ACO arrangement with Medicare or private insurers. Fewer than 18 percent of nurse practitioners and physician assistants reported currently participating in an ACO, and a substantial percentage of providers (28% of physicians and 56% of nurse practitioners and physician assistants) reported they were unsure whether their practices participate in ACO arrangements. Physicians were also more likely to see the growth in the number of ACOs as having a negative vs. positive impact on quality of care (26% vs. 14%); nurse practitioners and physician assistants were more evenly split in their views of ACOs (16% negative vs. 17% positive)[64]

Although the Commonwealth Fund/KFF primary care provider survey summarized that primary care providers don't like the financial penalties and increase in quality and performance metrics they are seeing, the trend toward such accountability for providers is not likely to slow. As the report notes, "*In early 2015, the Centers for Medicare and Medicaid Services announced that 85 percent of Medicare FFS payments should be tied to quality or value by 2016. And, by the end of 2018, 50 percent of all Medicare payments should be tied to quality or value through specific alternative payment models, like ACOs and bundled payments. Dissatisfaction with new models*

may not be solely attributable to a difficult transformation process; larger culture change within the practice of medicine may be a necessary first step before delivery system reforms such as ACOs and medical homes are fully accepted on the ground."[65]

Savings and Quality Improvement

The cost savings potential of ACOs is still not certain, yet some of the states that were early adopters of the ACO model are beginning to show positive trends:

- During the 2013-2014 SFY, Colorado's ACC reported a $30 million net savings for Colorado Medicaid, with more than 700,000 of the State's Medicaid beneficiaries enrolled. Colorado began enrolling dual eligibles (Medicaid/Medicare) in RCCOs in the fall of 2014 and expects to start seeing savings from better management of these complex individuals. Most savings to date have resulted from reductions in emergency department (ED) visits, high-cost imaging, and hospital readmissions for adult patients who have been enrolled in the program for more than six months. Also in 2014, the ACC launched a pilot with the RCCO administered by Rocky Mountain Health Plans on the Western Slope of the state, which is designed to test a full-risk capitation payment model that includes integration of Primary Care Medical Providers and Community Mental Health Clinics in shared savings opportunities.[66]
- Minnesota Governor Mark Dayton in a 2014 press release noted that through the State's IHPs, six health care providers serving 100,000 Minnesotans spent $10.5 million less than projected within the program's first year.[67] By year two, the state had revised the first year savings to more than $14 million and achieved a total of $61.5 million in savings across nine provider groups serving 165,000 Minnesotans. Based on initial 2014 data, all nine provider groups were eligible for shared savings. Minnesota's IHPs generated these savings through innovations such as providing more intensive primary care services and integrating mental health and community resources; employing community health workers to support beneficiaries' social services needs such as housing and transportation.[68]
- Oregon reported that so far, it has achieved its goal of a 2 percent annual growth target for CCOs, in part through reduced ED visits (down 21%) and fewer inpatient admissions for asthma and COPD (down 48%).[69] A qualitative evaluation of Oregon's CCOs, conducted by Lauren Broffman and Kristin Brown in early 2015, also found several interesting takeaways two years into the ACO program. "First, when it comes to accountable care, legislative and market forces are still the most powerful drivers of collaboration among traditional competitors. Second, tensions between those traditional adversaries can be smoothed out over time if all partners, including the state, are invested in the success of the model. And third, the shift

> from extrinsic (they're requiring us to do it) to intrinsic (we believe we should do it) motivation is facilitated by an organization's ability to maintain strong financial health."[70]

Among Medicare ACOs, some of the first to launch, there also has been encouraging news. CMS reports that in 2013, many ACOs had higher quality and better patient experience than published benchmarks and that most had significant improvements in quality and patient experience measures. Combined, Medicare Pioneer ACOs and Medicare Shared Shavings Program (Shared Savings Program) ACOs generated more than $417 million in savings, while qualifying for $460 million in shared savings payments.[71] CMS is expected to release 2014 Medicare ACO outcome data and analysis soon.

Payment Methodologies

One of the ways that providers are encouraged to work together in ACOs is through alignment of financial incentives. Medicaid ACOs use a variety of payment mechanisms to incentivize coordinated, high quality care, including fully capitated and global budgets, but the most common is shared-savings or shared-savings and losses.

Shared savings typically pay providers FFS and a bonus payment if they deliver care under an established threshold budget and meet established quality requirements; the bonus payment is usually a percentage of the amount below the threshold (i.e., the savings).

With shared losses, providers are usually paid FFS and are required to pay back a portion of any expenditures above an established threshold budget; the payment is generally a percentage of the amount above the threshold (i.e., losses). The pay back amount often is tied to quality performance - the better the quality, the lower the percentage to be paid back.

However, models such are Oregon's CCOs, which use a global budget, and Colorado's RCCO pilot with Rocky Mountain Health Plan that employs a full-risk capitated payment offer opportunities to test how well the ACO model can support states and providers in assuming additional risk and still achieving desired Medicaid beneficiary outcomes.

ACOs demonstrate the value of connecting providers' reimbursement to beneficiary health outcomes and cost savings rather than the volume of services, as in the traditional FFS model. Although the model continues to evolve, ACOs offer significant potential for positive change at the provider level to support a healthier population at lower cost.

Prepaid Inpatient or Ambulatory Health Plans[72]

Structure

Prepaid Health Plan

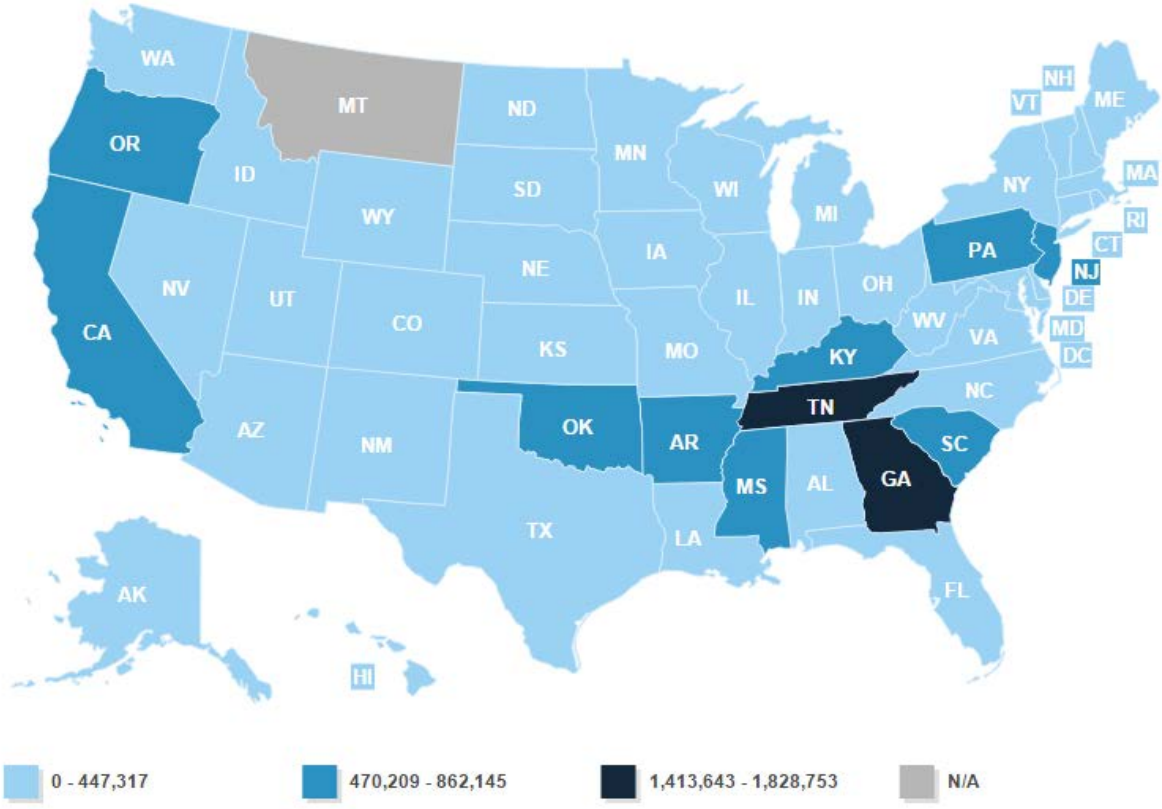
Prepaid health plans (PHPs) provide either comprehensive or non-comprehensive benefits to Medicaid enrollees through risk-based contracts with the state Medicaid agency. Medicaid managed care organizations are comprehensive PHPs, while prepaid inpatient health plans

(PIHPs) and prepaid ambulatory health plans (PAHPs) are non-comprehensive PHPs. PAHP and PIHP contractors frequently offer services that are carved out of the responsibilities of MCO contractors.

Prepaid Ambulatory Health Plan

A prepaid ambulatory health plan (PAHP) is a non-comprehensive prepaid health plan that provides only certain outpatient services, such as dental services or outpatient behavioral health care. PAHPs provide no inpatient services and are paid on an at-risk or capitated basis.

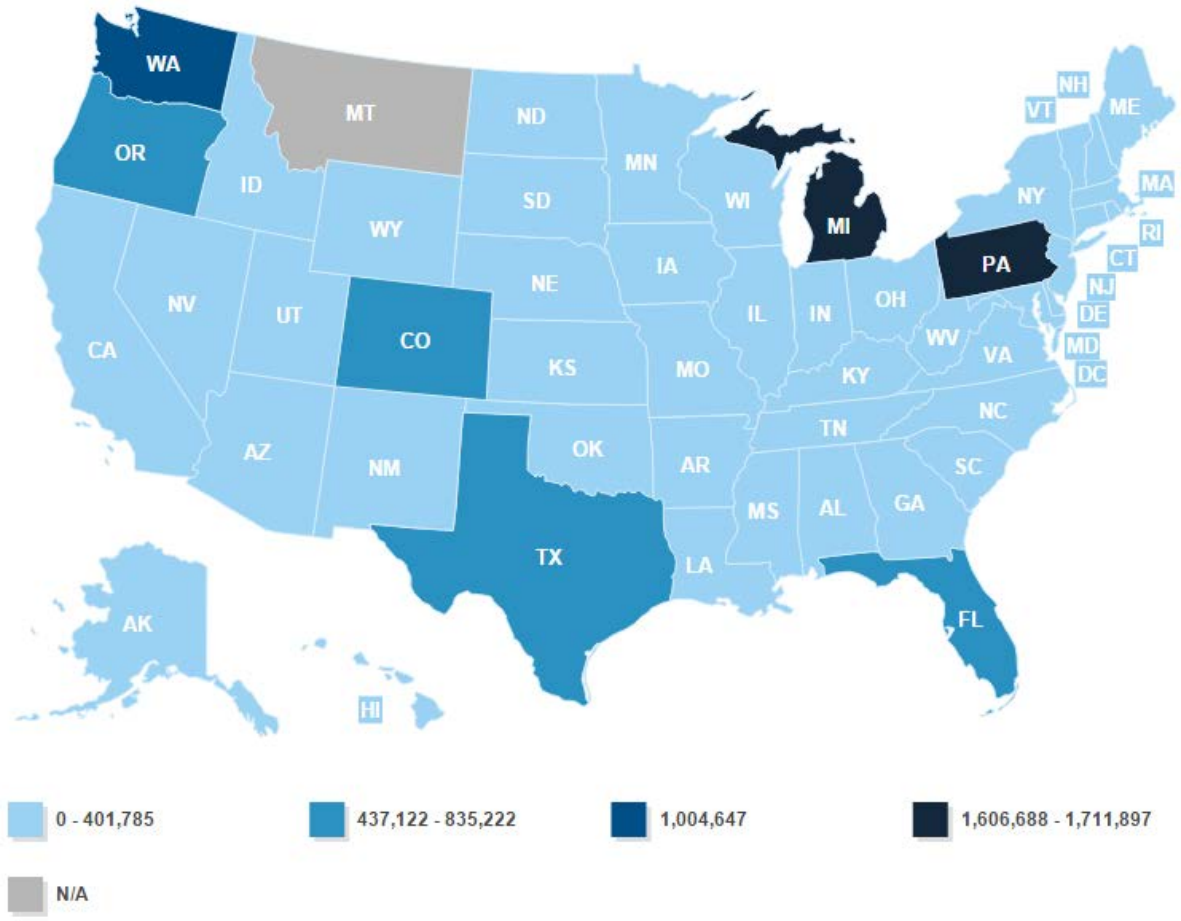
Figure 4: Prepaid Ambulatory Health Plan enrollment, 2011, Kaiser Family Foundation[73]



Prepaid Inpatient Health Plan

A prepaid ambulatory health plan (PIHP) is a non-comprehensive prepaid health plan that offers only inpatient or institutional services, such as inpatient behavioral health care. PIHPs received fixed PMPM payments and are at risk of financial overruns.[74]

Figure 5: Prepaid Inpatient Health Plan enrollment, 2011, Kaiser Family Foundation[75]



Data Needs

States generally pay PHPs a PMPM capitated rate for a specific set of services accessed by a specific set of beneficiaries. CMS considers PHPs as "managed care" entities and in the recent Notice of Proposed Rule Making (NPRM) document it released in May 2015 added clarifications that for many regulations, it regards PCCMs, PAHPs and PIHPs similarly to managed care organizations (MCOs). PHPs are expected to meet similar provider network adequacy criteria, encounter data reporting requirements, beneficiary enrollment and provider choice rules, and quality standards. [76, 77] This requires that PHPs have the capability to capture and report specific data and information related to the benefits and services they provide. They also are increasingly being held to higher standards for care coordination and care management, particularly for transitions of beneficiaries between care settings such as a hospital and home, or home and a nursing facility or inpatient treatment facility.

Provider Culture Change

As with managed care in general, providers must acclimate to the additional oversight of a PHP, such as quality and performance metrics (particularly if tied to payment), and increase emphasis on care coordination across providers (for example, with transitions of care). Yet the nature of PIHPs and PAHPs is such that if they have very limited benefits or populations, they may not experience the same level of cultural change as providers working in PCMH/Health Homes, ACOs or broader MCO networks. For example, transportation providers or dental

providers may not feel as much pressure to change their practices, since they are responsible for very specific services. As is true with many of the care coordination models, the level of provider cultural change is a function of the breadth and depth of the risk assumed by providers and the requirements on those providers to comply with new value-based purchasing structures.

Savings and Quality Improvement

During the advent of the managed care era, PHPs were initially exempt from most Medicaid managed care regulations. However, this changed in 2001 and PHPs were recognized as managed care entities and required to comply with the same standards of care, consumer safeguards and external review requirements as managed care entities.[78] These same federal rules made the distinction between PHIPs and PHAPs, noting the PHIPs include inpatient care in the limited risk-based contracts and thus was more similar to managed care entities than PHAPs, which insure a scope of services that doesn't include inpatient care. Through this designation, CMS placed tighter restrictions that mirrored those placed on MCOs, compared to PHAPs. Under the federal guidelines, PHAPs are eligible for exemptions from requirements for quality improvement, grievance systems and program integrity.[79]

Payment Methodologies

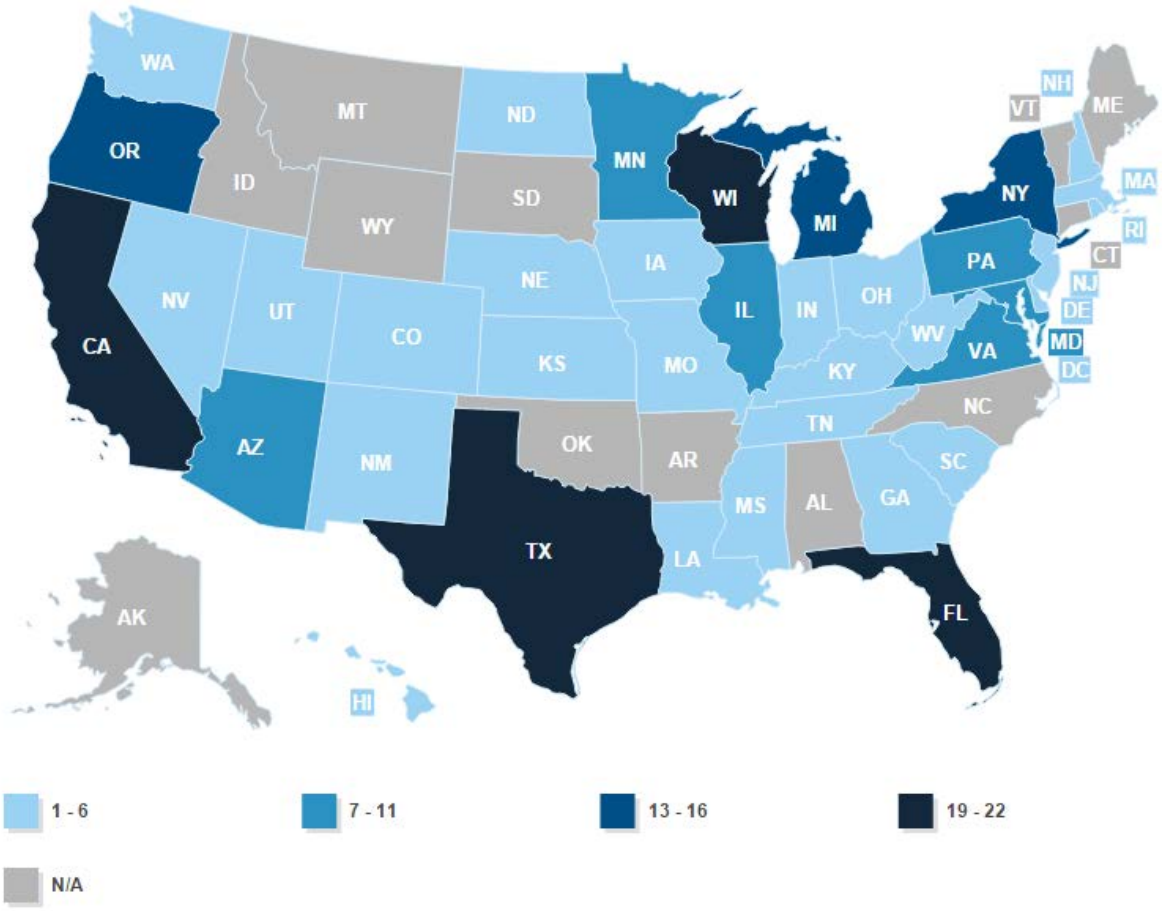
PHPs are very similar to MCOs in that they must develop adequate networks of providers to support the benefits and services for which they are contracted to deliver. They have flexibility in how they pay providers and may either pay FFS, pass through a part of the PMPM they receive, or develop other payment structures such as pay-for-performance, shared savings/losses, and bundled payments. PHP rates must be actuarially sound and states must submit actuarial certification documents for PHP rates.[80] These rates will of course vary by the scope of services included in the partial-capitation structure.

Full-Risk Managed Care

Structure

Full-risk, capitated managed care programs are the most common type of Medicaid managed care. Currently, 37 states use this model for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services. While CMS broadly defines managed care to include PCCMs and prepaid health plans, full-risk capitated managed care is typically what people think of when talking about "managed care."

Figure 6: Total number of Medicaid MCOs in the United States, Kaiser Family Foundation, 2014[81]



States contract with health plans, today commonly called Managed Care Organizations (MCOs), for the delivery of services to Medicaid beneficiaries. These health plans are responsible for providing the services articulated in a contract to the specific populations identified in that contract. Features of full-risk, managed care programs are described in Table 3 below. This is not an exhaustive list, but rather a high-level overview.

Table 3: Features of full-risk managed care programs

Feature	
Populations Included	Traditionally included primarily women and children, commonly referred to as "TANF," since many are also enrolled in the Temporary Assistance for Needy Families program. For these populations, managed care is a dominant form of service delivery in many states today. States have been slower to move their aged, blind, disabled (ABD) and long-term care (LTC) populations into full-risk managed care, although this trend is beginning to change rapidly. It can be a challenge to develop comprehensive networks, difficult to set capitation payments and engage beneficiaries and stakeholders in making the change to a different model of receiving services. These populations often are very vocal and have well-organized advocacy at the state and federal levels, which has made it harder for states to move them into managed care. In 2008, eight states had

	managed care contracts for long-term services and supports (LTSS); by May of 2015, 22 states had managed LTSS programs.[82] While states had begun to move more behavioral health into managed care even before their LTC populations, new managed care rules proposed by CMS in May 2015 regarding mental health parity are expected to improve and increase integration of behavioral health services into existing and any new Medicaid managed care programs.[83]
Services Provided	There is great variation in the services for which health plans are responsible. Some states have comprehensive programs that cover medical, behavioral and LTC services (e.g., Tennessee, New Mexico, and Iowa's new managed care program). Others operate multiple programs. For example, Florida has separate programs with different health plans to provide services to its LTC population vs. its traditional Medicaid "moms and kids" beneficiaries. As noted above, states using managed care often have "carved out" either certain benefits or certain populations, such as behavioral health, dental benefits, transportation services and prescription medications. However, changes in regulations and market environments have made it easier and more feasible for states to include these services and populations in their managed care programs.
MCO Responsibilities	Federal regulations require that MCOs create "adequate" provider networks and state contracts often establish specific guidelines for maximum time and distance enrollees must travel for care. Health plans can have limited provider networks, but if services are not available within network they must make them available out-of-network. MCOs also must have robust, provider services, member services, grievance and appeals processes, data and reporting infrastructures, fraud and abuse protocols, and quality improvement plans. In May 2015, CMS released a Notice of Proposed Rule Making (NPRM) document of updated managed care rules, which put forward significant new requirements for both states and MCOs. These sweeping new rules cover multiple areas: • Better Market Alignment with Medicare and commercial plans o *Cross-Market Advertising options* o *Grievances and appeals requirements* o *Medical loss ratios guidance* • Updates to Standard Contract Provisions o *Prescription drug coverage* o *Mitigating the IMD exclusion* o *Updates to the "In lieu of" provisions* • Actuarially Sound Capitation Rates o *Actuarial soundness definitions* o *Updates on special contract terms* o *Sub-contractual arrangements clarifications* • Increased Beneficiary Protections

	○ *Enrollment, voluntary and mandatory provisions* ○ *Coverage and authorization of services* ○ *Special focus on beneficiaries receiving Long term services and supports* • Modernizing Regulatory Standards ○ *Availability of services, assurances of adequate capacity and services, provider network standards* • Quality of Care ○ *Care coordination*[84]
Oversight	As evidenced in the proposed managed care rules, CMS expects that States will oversee the activities of health plans and ensure compliance with all federal/state requirements and contractual terms, including adequate provider networks, compliant grievance and appeals processes, and robust member services, quality improvement, and program integrity programs. As more states have moved more of their Medicaid beneficiaries into managed care, they have become more sophisticated managers of managed care contracts. This has required states to develop staff with different skills and expertise than what they previously needed to administer large, FFS programs. For example, they have had to build capacity in actuarial analysis and rate setting, data collection and analysis, contract development and management, and compliance and regulatory requirements. Increasingly, financial rewards for high performance and financial penalties for failing to meet established standards are core components of states' MCO contracts. Some states are even requiring MCOs to incorporate wellness and prevention programs for beneficiaries and innovative payment structures for their providers, as an effort to promote better outcomes and more value-based payments. The federal government also has significant oversight responsibility for full-risk managed care in Medicaid. CMS must approve contracts before a state can collect federal dollars for payments. The new NPRM from CMS further strengthens and expands CMS's oversight role for both states and MCOs.[85]

Data Needs

Since MCOs pay providers directly in full-risk, capitated managed care, states do not get claims data for services those providers deliver to Medicaid enrollees. However, states are required by CMS to provide encounter data as part of their quarterly Medicaid Statistical Information System (MSIS) reports. CMS made available an Encounter Data Tool Kit for states as a "practical guide to understanding, validating and reporting" encounter data from MCOs.[86] This report notes that timely, accurate and clean encounter data are critical for states to ensure that their MCOs are complying with contract requirements such as quality assurance and utilization measures, and to be able to set accurate capitation rates for MCOs. In addition, the new CMS NPRM includes considerable updates to encounter data reporting requirements for both states and MCOs, as well as significant requirements related to data and reporting for quality improvement, program integrity, rate setting and MLR determinations.[87] Most Medicaid MCOs have built robust data management infrastructures to support these kinds of new

requirements, as well as make it possible to try new payment models with providers. As states continue their experiments with various care models such as PCMH/Health Homes and ACOs, they are increasingly expecting MCOs to integrate these models into their networks, which requires MCOs to have even more sophisticated data collection, tracking and management capabilities.

Provider Culture Change

Moving providers to a full-risk, capitated model requires a significant investment in provider relations, particularly for providers who do not have experience with payment mechanisms other than FFS, or who have not had to meet more rigorous quality and performance metrics that are typically part of Medicaid MCO provider agreements today. These differences usually require providers to make considerable changes to their practices and to make investments in new business process and IT systems. Additionally, providers must learn how to work with an external partner who can control their patients' access to various care and services. Navigating different provider networks can be as challenging for providers as it is for beneficiaries. Most MCOs devote a lot of effort to provider relations, and have built sophisticated tools and trainings to support providers in their networks to make the necessary transitions not only to effectively work within managed care, but to do more care coordination and care integration to improve the care they deliver to their patients.

The new CMS NPRM includes a number of new or expanded requirements for how MCOs interact with and manage providers. For example, there are greater expectations related to network adequacy, particularly for LTSS providers, and regarding MCO efforts to prevent provider fraud/waste/abuse.[88] CMS also is pushing to allow states greater authority to require MCOs to pay providers using a variety of value-based payment structures.[89]

The relationships between MCOs and providers can be tenuous, and states with Medicaid managed care often have strict provider network management requirements in their MCO contracts to help ensure that providers get the support they need to succeed and deliver the highest quality care to their Medicaid beneficiaries. This is particularly true for some of the more specialized populations that states are moving into full-risk managed care, such as those with serious mental illness, the aged/blind/disabled groups and those receiving long-term supports and services. Other factors, some of which are of particular relevance to Alaska, can further complicate MCO-provider interactions. For example, a 2012 report, *Medicaid and CHIP Risk-Based Managed Care in 20 States,* identified several populations that warrant special deliberation when considering managed care programs, including:

- Rural population which has been challenging because health plans have had difficulty developing adequate provider networks, especially for specialists.
- AI/ANs, who are typically excluded because they are entitled to receive services from an I/T/U. [90]

It also is important to note that in virtually every state with full-risk managed care for Medicaid, there first was a managed care market in the commercial health sector. This experience was

critical when building Medicaid managed care, as providers and patients were likely to have at least some experience with managed care. This can be a significant issue for Alaska, which has virtually no managed care in either the commercial or Medicaid markets. Some states that have implemented full-risk managed care in their Medicaid programs noted that they would not recommend moving directly from a traditional FFS environment to full-risk managed care, but rather would suggest building toward full-risk managed care from other types of reforms such as ACOs and shared savings payment models.

Savings and Quality Improvement

There are number of studies that have been conducted over the years to identify whether full-risk managed care offers cost savings for Medicaid programs, and if so, what those savings are and how they are achieved. In most states MCOs were first successfully established in their commercial health care markets, where they showed early success in helping to reduce costs from those typically seen by FFS insurance plans. For example, one early study cited finding that "group and staff HMOs saved about 10 percent of the cost of traditional indemnity insurance, mostly through fewer hospital admissions."[91] Those savings levels appear to be typical of many early managed care results in the commercial market.

However, despite Medicaid managed care programs having been implemented in several states, no consensus exists about the actual amount of savings that a state can expect from the implementation of managed care for Medicaid. A recent review of research results on cost, quality and access related to Medicaid managed care plans from the Robert Wood Johnson (RWJ) Foundation found that, "peer-reviewed literature finds little savings from Medicaid managed care on the national level, but some states have been more successful than others."[92] According to a report developed by The Lewin Group for America's Health Insurance Plans (AHIP), MCOs typically achieve savings for Medicaid managed care through two primary mechanisms:

- Reductions in inpatient hospitalizations; and
- Reductions in pharmacy costs.[93]

These types of clinical and care coordination mechanisms do not differ much from other kinds of care management initiatives, such as PCMH/Health Homes, ACOs and programs that target enhanced care management to beneficiaries with the highest utilization and costs ("super utilizers"). There is limited evidence to suggest that the savings resulting from these mechanisms applied to Medicaid beneficiaries through full-risk capitated managed care are much greater than those implemented directly by states. Regarding reductions in provider reimbursement rates, the RWJ study found that "[t]hose states with relatively high historic fee-for-service reimbursement rates save money when they switch to managed care (because of a general reduction in prices), while those states with low historic fee-for-service reimbursement lose money (as health plans need to raise prices to attract providers).[94] This same RWJ study provided the following reasons why savings may be limited in Medicaid managed care:

- Medicaid already is a low-cost program with typically lower FFS rates and per capita cost growth than commercial insurance or Medicare.

- Many states already had implemented some kind of cost-reduction and utilization management tools such as prior authorization and utilization review, even before moving to managed care.
- MCOs cannot impose any additional cost-sharing on Medicaid beneficiaries, which limits their ability to discourage inappropriate utilization behaviors such as using emergency rooms for non-emergent care.
- In the short term, it can cost states more to build the necessary infrastructure to manage MCOs and meet all the CMS reporting and oversight requirements than to pay providers directly.
- Because CMS requires managed care capitation rates to be "actuarially sound" MCOs may have leverage to push for higher rates.
- Generally speaking, there is little that MCOs can do themselves to change the health delivery systems for low-income individuals enrolled in Medicaid, particularly when there are multiple MCOs in a market.
- MCOs are charged with ensuring that Medicaid beneficiaries have access to a usual source of care, which could in fact lead to higher costs if their previously unmet needs now are being treated.

This finding is consistent with the research of Cutler et al., 2000[95], which suggests that managed care companies reduce the costs of health care more through a reduction of the reimbursement rates paid to health care providers than through care management. Finally, rural and frontier regions present particular problems for Medicaid managed care. Another report developed for the Association of Community Affiliated Plans and Medicaid Health Plans of America by The Lewin Group indicated that, "rural regions create very limited opportunity for competitive provider networks, for example, and pose economies of scale challenges for many MCO activities (e.g., outreach initiatives that involve face-to-face interaction with enrollees become prohibitively expensive)." This same report estimates that savings from capitated managed care in rural areas generally will be only half (on a percentage basis) of what it is in urban areas.[96]

However, as more states move toward MCOs for some of all of their Medicaid beneficiaries, there are a growing number of reports advocating the potential for cost savings and improved care. For example, an infographic released by the trade group America's Health Insurance Plans (AHIP) in July 2015 notes overall program savings of 20 percent, with improvements in case management, wellness and prevention, and supporting the needs of special populations.[97] As North Carolina has debated about the future of its Medicaid program, a State Senate hearing on the matter prompted North Carolina Health New reporter, Rose Hoben, to research the pros and cons of managed care in Medicaid. She found, as many others have, that it depends on who you ask. "*It's hard to generalize results, not only because each state has its own programs, but there's often variation within states; there's a lot of concern over comparing apples to oranges. There's … variation in every aspect of Medicaid managed care: limited risk, safety-net plans, reimbursement plans, competitive biddings, negotiated rates*."[98]

Payment Methodologies

States pay MCOs pre-established, actuarially-certified, capitated PMPM rates. The rates are often adjusted for age, sex, existence of Medicare or other private insurance, and Medicaid eligibility category. Some states may use more complex predictive risk methodologies. States also have different ways of reimbursing MCOs that contract with FQHCS, CHCs, PCMHs, Health Homes, and ACOs in their networks. Increasingly, states are building performance targets and incentive payments into the capitated rates they pay health plans and are becoming more involved in how the plans pay providers in their networks to ensure that the plans are incenting providers to deliver better quality and outcomes. In fact, as noted above, the new CMS NPRM gives states more authority to direct MCOs to pay providers in ways other than FFS, in efforts to help move the system away from volume-based to value-based payment methods that invest in improvements in quality and health outcomes for beneficiaries.

APPENDIX C: State Alternative Medicaid Experiences[99]

State	AR	IA	IN	MI	PA	MT
Financing Authority	1115 Waiver	1115 Waiver	1115 Waiver	1115 Waiver	1115 Waiver	1115 Waiver
Status	Approved by CMS September 27, 2013	Approved by CMS December 10, 2013	Approved by CMS January 27, 2015	Approved by CMS 2014	Approved by CMS August 2015	Published proposed 1115 Waiver on July 7, 2015
Program Dates	10/1/2013 – 12/31/2016	1/1/2014 – 12/31/2016	February 1, 2015 – 1/31/18	4/1/2014-12/31/2018	*Approved 1/1/15 to 12/31/19 * PA is now pursuing traditional Medicaid expansion	Proposed: 5 years (pending reauthorization of HELP program by state legislature in 2019)
Geographic coverage	Statewide	Statewide	Statewide	Statewide	Statewide	Statewide
Estimated or Actual Medicaid Expansion (Comparison of April 2015 to July-September 2013 average)[100]	285,000 (51% increase)	99,422 (20.2% increase)	153,130 (13.7% increase)	392,000 (20.5% increase)	224,000 (9.4% increase)	Estimated: 40,000 – 70,000
Voluntary or Mandatory Enrollment in Managed Care?	Mandatory	Mandatory	Mandatory	Mandatory (unless MCOs or PHIPs are deemed by State to not meet readiness or and network requirements)	Mandatory	NA
Enrollment caps	No	No	No	No	No	No
Eligibility Requirements	Individuals eligible for Medicaid expansion are 1) childless adults with incomes below 133% FPL or 2) parents/ caretaker relatives with incomes between 17-133% FPL	Childless adults between 19-64 with incomes from 100-133% FPL	Adults with incomes below 133% FPL plus a 5% income disregard	Non-pregnant, childless adults 19-64 with incomes up to 133% FPL	Covers newly eligible parents between 33-138% FPL and newly eligible adults without dependent children between 0-138% FPL with Medicaid managed care.	Childless adults: 0 – 138% FPL Parents: 50-138% FPL (parents covered under current MT Medicaid program)
Exempt Populations	* AI/AN and medically frail members. The	*AI/AN are not required to enroll in QHPs	*AI/AN individuals	AI/AN; beneficiaries	Individuals who are medically frail, pregnant	*AI/AN and individuals with exceptional

	term "medically frail" includes both enrollees who meet the medically frail definition and those who have special medical needs as determined through the Arkansas health care needs questionnaire.	*Medically frail * Members who have access to cost-effective ESI	are exempt from cost sharing and POWER account contributions * Excludes children, seniors, and dual eligible beneficiaries. American Indian/Alaska Natives may opt out of the demonstration 30 days after enrollment.	with other HMO or PPO coverage	women, children up to age 21, seniors, beneficiaries living in institutions, and dual eligible beneficiaries	health care needs, including medically frail, members with mental health needs and individuals with developmental disabilities; State may exclude individuals in regions where the TPA is unable to provide an adequate network
Payment Model	*AR uses the waiver to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs instead of the fee-for-service delivery system *Members with incomes between 50-133% FPL receive Independence Account (IA) HSAs from which they can pay copayments *AR pays premiums for QHPs in the Marketplace for Private Option beneficiaries.	* IA uses this demonstration to provide coverage for state-plan eligible adults with benefits through QHPs offered in the individual market instead of the fee-for-service delivery system that serves the traditional Medicaid population *IA pays premiums for QHPs in the Marketplace for Marketplace Choice Plan members		Individuals enrolled in Healthy Michigan Program will receive from the managed care program the benefits in the approved Alternative Benefit Plan (ABP) SPA		Montana will contract a single commercial insurance provider as a fee-for-service TPA to operate the HELP Program across the state. State wants to contract with an insurer with an established statewide network, and the state is looking for alignment with the Federally Facilitated Marketplace to minimize the impact of churn between Medicaid and QHPs.
Benefit Plan	*Beneficiaries enrolled in the QHP will be offered benefits through the QHP with wrap around provisions by the state Medicaid agency including non-emergency medical	*Members enrolled in the QHP will be offered benefits through the QHP * Beneficiaries who return for a periodic exam within 6-12 months of their first visit qualify for	*IN offers both a HIP Plus and HIP Basic ABP plans. Individuals in the HIP Plus ABP have access to additional benefits not available to HIP Basic members. *1115 waiver exempts IN	*Enrollees may be required to receive prior authorization from their assigned county health plans or the State before accessing certain ambulatory service	*The benefits package for current and newly eligible beneficiaries will be pursuant to state plan amendments still to be submitted. * The state will provide non-emergency	*Benefits covered for expansion population are same as for existing Medicaid population *LTSS services not provided in MT * The State will not apply

	transportation (NEMT), family planning at non-network providers, and for individuals aged 19 and 20, early and periodic screening and diagnostic treatment (EPSDT).	Enhanced benefits, and Enhanced plus benefits for beneficiaries who return for a second periodic exam within 6-12 months *Wraparound benefits such as family planning at non-network providers, and for individuals aged 19 and 20 (EPSDT). *Marketplace Choice Plan does not include non-emergency medical transportation (NEMT).	from providing non-emergency medical transportation.	* HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law.	medical transportation to these beneficiaries beginning in year 2. During year 1, the state shall undertake efforts to ensure that newly eligible adults will have the ability to use non-emergency medical transportation by year 2 and shall provide a readiness plan to CMS by March 31, 2015.	copayments for: preventive health care services; immunizations provided according to a schedule established by the DPHHS that reflects guidelines issued by the Centers for Disease Control and Prevention; medically necessary health screenings ordered by a health care provider, or, any other services that are legally exempt.
MLTSS Program in Place[101]	No	No		Yes	Yes	No
Premium/Cost Sharing Responsibility	* Cost sharing is consistent with both the State Plan and with cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. *All individuals who are statutorily required will be exempt from cost sharing, including pregnant women and American Indians/Alaska Natives	* Premiums are based on 2% of income * Monthly premiums for enrollees with incomes above 100 percent of the FPL, up to and including 133 percent of the FPL, can occur in Year 2 *Enrollees who complete all required healthy behaviors during year 1 have their premiums waived in year 2. For each subsequent year, enrollees will have the opportunity to complete healthy behaviors and will not need to	*The 1115 waiver allows the state to collect monthly contributions to a savings (POWER) account (from individuals up to 133 % FPL. *Contribution can't exceed 2% of income, except for individuals with less than 5% FPL who do not have contributions greater than $1 per month. *POWER account contributions are required for enrollees with incomes above 100% FPL. For individuals with incomes lower	* Newly eligible adults from 0 to 133 percent of the FPL will pay required Medicaid copayments through a credit facility operated by the Medicaid Health plan *Newly eligible adults with incomes above 100 percent of the FPL will be required to make contributions equal to two percent of their family income toward the cost of their health care * A MI Health Account is created for each enrolled individual, to track	* All demonstration beneficiaries will pay state plan co-payments in demonstration year 1. *In year 2, beneficiaries subject to monthly premiums as described above will only have co-payments for non-emergency use of the emergency room ($8 per state plan amount). * In 2016, state will collect data about average monthly co-payments for beneficiaries below 100% FPL and submit a waiver amendment	*New adults covered in Medicaid Expansion will pay monthly premiums equal to 2% of household income and maximum copayment amounts allowed under federal law *Participants with incomes above 100 percent of the FPL who fail to pay premiums will be dis-enrolled from coverage until they pay overdue premiums (participants may be exempt from disenrollment if they do a wellness program)

		make financial contributions * State can impose copayment for non-emergency use ED use	than 100% FPL, they are enrolled in HIP Basic if they don't pay their contributions. * Individuals With incomes above 100% FPL who begin but then cease making POWER account contributions, are, after a grace period of 60 days, disenrolled for a 6 month period. * Non-emergency ED use has an 8$ copayment for the first instance, and a 25$ copayment for subsequent visits within the year.	beneficiaries' contributions A beneficiary's contribution requirement is based on previous copays. The beneficiary is required to remit this amount each month into his or her MI Health Account going forward.	seeking a premium model * Cost-sharing (including premiums and co-payments) is limited to 5% of household income. *State will submit a premium and co-payment protocol by August 2015. *Requires monthly premiums for newly eligible adults above 100% FPL	
Premium Assistance	AR pays premiums for QHPs in the Marketplace for Private Option beneficiaries.		*HIP Link plan is a premium assistance plan that allows eligible individuals over 21 years old that choose to participate in an ESI plan to also enroll in HIP Link. In this case, HIP Link creates a POWER account, which the enrollee can use to defray copayment and coinsurance costs from the ESI.			The DPHHS operates a federally approved voluntary employer sponsored insurance (ESI) premium assistance program under its State Plan. Montana intends to amend the State Plan Amendment to add the newly eligible adults to the voluntary ESI premium assistance program.

Personal Health incentives		Premiums are waived in Year 2 if enrollees complete healthy behaviors in their annual period as outlined in the Healthy Behavior Incentive Protocol, including a wellness exam and Health Risk Assessment (HRA)	*HIP Plus beneficiaries who make timely premium payments will be eligible to rollover their share of the unused POWER account balance at the end of 12 months. . *HIP Basic beneficiaries can rollover unused POWER account funds, up to 50% of the amount of premiums required for HIP Plus	Beneficiaries will have opportunities to reduce their regular or average utilization based contribution by demonstrating achievement of Healthy Behaviors Healthy behavior requirements include an annual health-risk assessment to identify unhealthy characteristics	Beginning in demonstration year 2, beneficiaries can reduce their premiums or co-payments by completing healthy behaviors in the prior year. To qualify for decreased premiums or co-payments in year 2, beneficiaries must complete an annual wellness exam and make timely co-pays in year 1.	*Wellness program can allow members who fail to pay premiums to remain eligible for Medicaid
Health Benefit Exchange Status	State-Partnership Marketplace[102]	State-Partnership Marketplace	Federally-Facilitated Marketplace	State-Partnership Marketplace	Federally-Facilitated Marketplace	Federally-Facilitated Marketplace[103]

APPENDIX D: Ongoing Alaska Initiatives

Medical Home Pilot for Children and Adolescents

- Medical home pilot initiative to identify and evaluate methods for expanding access to services for children and adolescents enrolled in Medicaid and Denali Kid Care.
- Funded by the U.S. DHHS Centers for Medicare and Medicaid Services (CMS CHIPRA demo) and Alaska TCHIC managed by Division of Public Health, Section of Health Planning and Systems Development
- Aimed to drive continuous quality improvement in child health care:
    - Improve children's health and health care quality measurement
    - Integrate Health Information Technology (HIT) systems
    - Develop the best models of health care delivery for children and their families
- Alaska clinical demonstration sites: Iliuliuk Family and Health Services in Unalaska; Peninsula Community Health Services in Soldotna; South Central Foundation Primary Care in Anchorage
- All Alaska TCHIC practices received PCMH recognition by final year of project (SCF recognition expanded to 4 rural sites)
- TCHIC clinics' progress measured with semi-annual Medical Home Office Report Tool (MHORT)
    - Improvements in PCMH competencies for all patients (MHORT NCQA module):
        - Plan and Manage Care (+18% overall improvement)
        - Enhance Access and Continuity (+13% overall improvement)
        - Measure and Improve Performance (+13% overall improvement)
- Of those practices showing improvement, most improved on items related to collecting data into and reporting data from an EMR, care planning, and coordination of care
- Alaska TCHIC clinic improvements in CHIPRA core quality measures for children and adolescents:
    - Developmental screening
    - BMI assessment
    - Immunization rates
    - Well child visits
- TCHIC patient experience of care survey project - Consumer Assessment of Healthcare Providers and Systems - Clinicians and Group (CAHPS-CG) PCMH
    - Standardized tool being expanded to other clinics
    - New learning collaborative for working with survey results
    - Contributes to quality improvement for Alaskan populations

The following were identified as ways the Department "… *could control growth in the current Medicaid program*" in a February 17, 2015 memo from Commissioner Davidson and Sana Efird, Assistant Commissioner for Finance & Management Services, to the OMB Director.

1115 waiver: Tribal Health System Partnership

- There is work underway with the Tribal Health System

- Expecting a two-part waiver process:
  - Transportation (target implementation date: July 2016)
  - Drafting a waiver that will develop medically necessary transportation case management capacity to facilitate timely and efficient delivery of health care services to Alaska Natives and American Indians (AI/AN), and receive transportation needs at 100% federal match if they are coordinated by a Tribal provider.
- Referrals by Tribal Health to another provider, target implementation date July 2018
  - Expand scope of Medicaid-reimbursable services available to AI/ANs, and enhance referral coordination. Alaska will seek approval for 100% federal match when a Medicaid beneficiary who is also an IHS beneficiary is referred by a Tribal Health Provider to a non-tribal health provider.

1915(i) & 1915(k) option

- RFP for contract for assistance with development of these options and the federal application process was awarded in August 2015.
- Target implementation date: July 2017

Provider Tax Proposal Development RFP

- Deadline for proposal submission was May 21, 2015; contract will awarded soon. Feasibility study and recommendation due December 1, 2015.

Pharmacy Reform Initiatives

- On-going reforms are underway that build on earlier reforms to increase use of generics and implement State Maximum Allowable Cost and pain Rx controls (implemented in FY 13).
- Current efforts include utilization management of specialty drugs.

Change eligibility for Personal Care Assistance (PCA) services

- More stringent eligibility requirements
- Change threshold to qualify for PCA services from one to two activities of daily living (ADL) or more and possible other eligibility changes
- Note: The PCA program has gone under significant changes with the re-write of PCA regulations that were adopted by reference in January of 2012. The primary focus was the result of numerous complaints that the program became over-inflated with unnecessary hours for care as well as waste, fraud, and abuse.
  - The Division of Senior & Disabilities Services enhanced their efforts to identify Medicaid waste, fraud, and abuse, that has resulted in significant cost savings. SDS is working closely with the PCA Provider association as a partner in getting the right amount of care to individuals in need.

DME, Vision, and Audiology

- Initiative to add limitations and restrictions to covered benefits to drive more appropriate utilization
- Audiology fee schedule adjustments to see reduction in equipment costs (hearings aides at billed charges to be reduced to national average)

Care Management "Super Utilizer" Pilot

- Currently have a contract with MedExpert to provide telephonic outreach to a group of high utilizers of Emergency Room services to manage their care and get them assigned to a primary care provider
  - Utilize services that cost less, i.e. a physician vs ER visit
  - MedExpert contract with Medicaid implemented December 2014

Dental

- Another initiative to add limitations and restrictions to covered benefits to drive more appropriate utilization.
- Implement guidelines on no decay in the past year and/or an oral hygiene requirement before beginning orthodontia
- Changing dentures to every 7-10 years vs 2 years as it currently stands
- Implement the recommendations on use of panoramic films and full mouth films allowing for justified exceptions

Implement Utilization Control for Behavioral Health Services

- Development of clearer program standards and stronger admission criteria and thorough review for Residential Psychiatric Treatment Centers, Behavioral Rehabilitation Services and Acute Psychiatric service settings
- Revise requirements for Recipient Support Services

Transportation

- Examining current travel and reinforcing current policies, e.g., travel to closest provider not necessarily the desired provider
- Longer term plan includes adoption of a fee schedule instead of paying billed prices for ground transportation.
- Analyze utilization data, number of escorts required, which must be medically necessary
- Consolidation of family travel needs to reduce overall travel
- Implementing and operationalizing the policies and procedures in place, including new training

10% shift in expenses to 100% FMAP for tribal for NICU, Orthopedic and OB

- Recent IHS-funded expansion of service capacity at the Alaska Native Medical Center, Norton Sound Health Corporation, Arctic Slope Native Association, Copper River Native Association, Kenaitze Indian Tribe, Tanana Chiefs Conference, and the

Southeast Alaska Regional Health Corporation is expected to result in a shift in Medicaid patients from non-tribal to tribal providers.

- Based on FFY12 figures, Alaska Native/American Indian Medicaid recipients received services at non-tribal providers that totaled $316 million, which is approximately $158 million in general funds. A conservative 10% of this would equate to a $10 million savings from 100% FMAP for services provided by tribal rather than non-tribal providers.

APPENDIX E: Alaska Cost-Sharing Requirements

Except for services that are exempt from cost sharing [7 AAC 105.610(b)], Alaska Medicaid reduces payment to a provider by the recipient's cost-share amount [7 AAC 105.610(a)]. A provider is required to collect the cost-share amount from the recipient but cannot charge a Medicaid recipient an amount that exceeds the cost-share.

Cost Share Amounts

- $50 per day, up to a maximum of $200 per discharge for inpatient hospital services
- 5% of the allowable charges for outpatient hospital services
- $3 per day for physician services
- $.50 for each prescription filled/refilled with a reimbursement amount of $50 or less
- $3.50 for each prescription filled/refilled with a reimbursement of more than $50

Services Exempt from Cost Sharing

- Services provided to a recipient under age 18
- Services provided to a recipient in a long-term care facility
- Services provided to a pregnant woman, including postpartum services
- Family planning services and supplies
- Emergency services (includes inpatient care for a recipient who was admitted through ED)
- Hospice services
- Services provided to an American Indian or an Alaska Native by a tribal health program
- Services provided to an individual who is eligible for both Medicare and Medicaid

Impending Cost Sharing Changes

The Affordable Care Act (ACA) modified cost-sharing rules for Medicaid Effective January 1, 2014. The Department is currently soliciting federal guidance/technical assistance on implementation of the following new federal rules that place income-based formulaic and aggregate caps on cost sharing structures for recipients and families:

Maximum Allowable Cost Sharing

(1) At State option, cost sharing imposed for any service (other than for drugs and non-emergency services furnished in an emergency department, as described in §§447.53 and 447.54 respectively) may be established at or below the amounts shown in the following table except that the maximum allowable cost sharing for individuals with family income at or below 100 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

Outpatient Services

Physician visit, physical therapy, etc. (Maximum Allowable Cost Sharing):

- Individuals with Family Income =<100% of the FPL = $4
- Individuals with Family Income 101-150% of the FPL = 10% of cost the agency pays
- Individuals with Family Income >150% of the FPL = 20% of the cost the agency pays

Inpatient Stay

(Maximum Allowable Cost Sharing):

- Individuals with Family Income =<100% of the FPL = $75 per stay
- Individuals with Family Income 101-150% of the FPL = 10% of total cost the agency pays for the entire stay
- Individuals with Family Income >150% of the FPL = 20% of total cost the agency pays for the entire stay

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