

2015 Medicaid Health Care Purchasing Compendium



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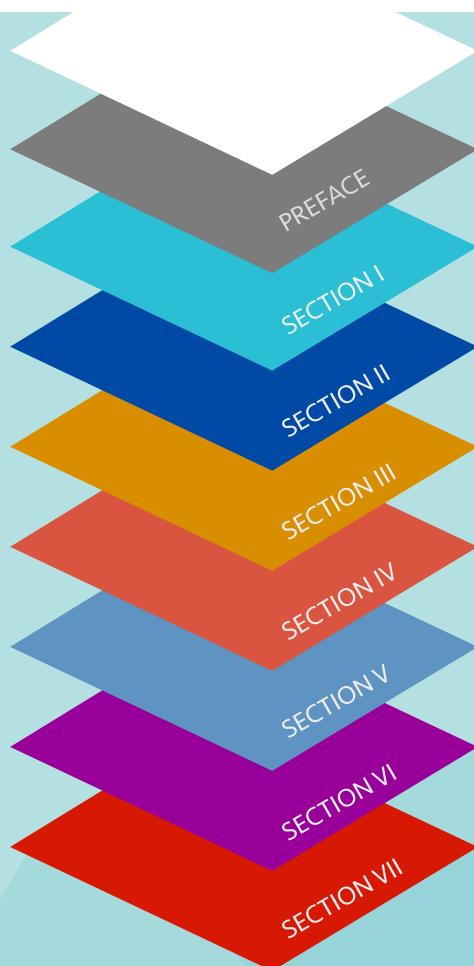
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Medicaid Health Care Purchasing Compendium

READER'S GUIDE



GETTING STARTED — HOW TO USE THE COMPENDIUM

HOW TO USE THE COMPENDIUM

The *Medicaid Health Care Purchasing Compendium* (Compendium) is a reference guide or toolkit for states to use when purchasing health services. It is not a comprehensive, exhaustive manual for implementing every aspect of a state's Medicaid program. Rather, it is intended to be both a primer for policymakers looking for an overview of a topic, and a source of detailed information for Medicaid agency staff on key purchasing issues.

The Compendium is made up of sections written by different authors, each of which was crafted as a standalone piece. At the beginning of each section, there is a **ROADMAP** feature to guide the reader to topics of interest:

OVERVIEW highlights the most relevant information and key takeaways of the section. It provides a high-level introduction to the section's topics and is aimed at governors' health policy advisors and secretary-level staff.

FUNDAMENTALS includes a detailed description of the essential issues that health policy advisors, as well as state Medicaid directors or other state health leaders, need to know about the section's topics.

ADVANCED provides more in-depth coverage of topics that Medicaid agency subject-matter experts and those involved in hands-on program development and implementation would find helpful and relevant.

Readers are encouraged to dip into topics of interest rather than read cover to cover.

INTRODUCTION

States face the ongoing challenge of managing the costs of their Medicaid programs while ensuring beneficiaries have access to quality health care. A more rigorous purchasing approach can help states better control costs without sacrificing quality or access to care.

The *Medicaid Health Care Purchasing Compendium* (Compendium) is intended to serve as a reference guide for states when purchasing health care services for their Medicaid programs, whether through managed care organizations or directly from health care providers. This practical resource focuses on managed care contracting as it continues to become the predominant mode in Medicaid for purchasing health and long-term care services. The Compendium also includes information on emerging models of direct provider contracting such as accountable care organizations and other integrated care models.

The Compendium is geared toward Medicaid leadership as well as governors' health policy advisors and other health officials in states and territories. It is a working document that will be updated regularly to help policymakers make informed health care purchasing decisions and position Medicaid agencies to capitalize on new opportunities for transforming the health care system.

OVERVIEW OF COMPENDIUM TOPICS

PREFACE: AN OVERVIEW OF EMERGING STATE HEALTH CARE PURCHASING TRENDS

This introductory section serves as a breaking news supplement to the core compendium topics. It highlights emerging opportunities in health care purchasing poised to influence the Medicaid landscape in the near future. Trends fall into five categories: delivery system and payment reforms, proposed Medicaid managed care regulations, population-specific reforms, data improvements, and opportunities for federal investment and support.

SECTION I: OVERVIEW AND KEY PRINCIPLES OF HEALTH CARE PURCHASING

State health care purchasing must be strategic and driven by a clear understanding of the goals for operating Medicaid. This section introduces overarching considerations state health purchasers must address and highlights the issues and processes that significantly influence the effectiveness of Medicaid purchasing decisions.

SECTION II: FEDERAL AUTHORITIES AND COMPLIANCE

State health care purchasing decisions must be made within the context of federal statutes, regulations, and official guidance. This section describes federal authorities applicable to Medicaid health care purchasing and identifies the key requirements and considerations involved.

SECTION III: PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT AND DELIVERY SYSTEM TRANSFORMATION IN STATE MEDICAID PROGRAMS

The foundation of any Medicaid health care purchasing strategy is the provider network that serves enrollees and the delivery system within which the providers work. This section focuses on provider payment strategies and performance monitoring and oversight of the provider network.

SECTION IV: QUALITY IMPROVEMENT STRATEGIES

Medicaid programs have the opportunity to leverage purchasing power to drive quality improvement throughout the delivery system. This section explores strategies for measuring quality across a large beneficiary population, convening partners and stakeholders to advance shared quality goals, and funding quality initiatives.

SECTION V: FINANCIAL MODELS: RATE-SETTING, RISK ADJUSTMENT, AND PERFORMANCE INDICATORS

Through strategic rate-setting, states can build incentives to improve health outcomes and quality and promote cost containment. This section describes the fundamental principles and considerations of rate-setting and risk adjustment and how states can use financing strategies to promote improvement in health outcomes, quality, and performance efficiency.

SECTION VI: MEDICAID PROGRAM INTEGRITY

Program integrity consists of the systems and processes that work to prevent; identify; and adjudicate fraud, waste, and abuse within Medicaid. This section describes current best practices to ensure program integrity.

SECTION VII: DATA ANALYSIS AND REPORTING

State Medicaid agencies use data to assess program benefit design, support health care purchasing, and assess the quality of care provided to beneficiaries. This section provides an overview of various data analytics and modeling techniques that can help states improve Medicaid program design.

An Overview of Emerging State Health Care Purchasing Trends

PREFACE

An Overview of Emerging State Health Care Purchasing Trends

By Tricia McGinnis and Rob Houston, Center for Health Care Strategies

INTRODUCTION

This *Overview of Emerging State Health Care Purchasing Trends* serves as a supplement to the *Medicaid Health Care Purchasing Compendium* (Compendium), highlighting emerging opportunities in health care purchasing. Trends of note fall into the following categories: delivery system and payment reforms, proposed Medicaid managed care regulations, population-specific reforms, data improvements, and opportunities for federal investment and support.

DELIVERY SYSTEM AND PAYMENT REFORMS

With continued fiscal pressures in both the private and public health care sectors and new delivery system and payment approaches authorized in the Affordable Care Act (ACA), there has been a growing focus among policymakers to improve the quality and efficiency of the health care system. Emerging trends in this area include: alternative payment models, re-designed managed care payments, multi-payer alignment efforts, and strategies to curb high-cost drug spending.

ALTERNATIVE PAYMENT MODELS

Alternative payment models (APMs) are value-based payment methods that move beyond the fee-for-service (FFS) payment model, which many experts believe is a major driver of high-volume care, to incentivize care that is high-quality and cost-effective. The U.S. Department of Health and Human Services (HHS) has set a goal of shifting 30 percent of Medicare fee-for-service payments to APMs by 2016 and 50 percent by 2018, signaling an increased federal effort toward achieving these types of payment reforms.¹ Several states already have begun to expand beyond traditional pay-for-performance programs by shifting from paying their providers on a FFS basis toward arrangements such as shared savings/risk models and bundled payments. In some instances states do this directly with providers and in other instances states require their contracted health plans to pass risk for cost and quality on to their provider networks. These models will likely become more sophisticated in the future.

A growing number of states are implementing total cost of care (TCOC) models, which hold a risk-bearing entity (such as a provider-led accountable care organization [ACO]) responsible for the totality of a patient's care, in terms of both outcomes and costs. As of mid-2015, states are generally pursuing two types of TCOC models:

- **Shared savings/risk model** – In this model, FFS payments remain in place but the accountable provider entity is eligible for a portion of savings achieved, or is at risk for any increase in costs, relative to the projected total cost of care; and
- **Capitated per member per month (PMPM) or global payment model** -- In this model, the accountable provider entity receives upfront lump sum payments intended to cover the risk-adjusted projected TCOC.

TCOC models range in complexity. Most TCOC approaches currently in place include only physical health services, while some also cover behavioral health services, long-term supports and services (LTSS), or dental services. Some states also are exploring the inclusion of select social services in TCOC calculations, recognizing that social determinants are a driver of health care costs. Examples of TCOC models include: Oregon's Coordinated Care Organization (CCO) model,² which pays for physical health, behavioral health, and dental services through a global payment;

¹ Centers for Medicare and Medicaid Services, "Better Care, Smarter Spending, Healthier People: Paying Providers for Value, Not Volume," January 26, 2015, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html> (accessed July 22, 2015).

² Oregon Health Policy Board, "Coordinated care: the Oregon difference," Oregon Health Authority, <http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx> (accessed July 22, 2015).

Medicaid ACO programs in Maine³ and Minnesota,⁴ which transition from shared savings to symmetrical risk programs; and projects within New York's Delivery System Reform Incentive Payment (DSRIP) model,⁵ which measures population-based costs and outcomes.

RE-DESIGNING MANAGED CARE PAYMENTS

States with Medicaid managed care are leveraging their contracts with managed care organizations (MCOs) to implement APMs by including requirements around: developing pilot projects (for example, New Mexico is implementing payment pilots proposed by its four MCOs); linking a percentage of medical expenditures to value-based payment approaches (for example, Arizona required that 5 percent of provider payments transition to value-based payments in 2014, which will increase to 50 percent by October 2017); and adopting specific payment models (for example, Tennessee is requiring MCOs to participate in its episodes-of-care program). Central to all of these initiatives are states' efforts to ensure that some portion of the risk for providing value (measured through cost and quality) is being passed on to providers (such as hospitals, physician groups, and primary care practices).

MULTI-PAYER ALIGNMENT

To create a stronger economic signal that supports migration from FFS payment systems toward value-based payment systems and to make it easier for providers to participate in APM arrangements, states are seeking to align key parameters of their delivery system and payment reform programs with Medicare and commercial counterparts. For example, states pursuing ACOs and episodes-of-care models for Medicaid are incorporating payment methodologies, including attribution models and quality metrics that are similar to those used in the Medicare Shared Savings Program and commercial programs. First, such alignment allows value-based payment systems to be more viable for provider organizations by allowing the organizations to capture a larger portion of the revenue lost when decreasing volume and orienting toward value. In addition, standardizing requirements, where possible, helps reduce the burden on providers, thereby facilitating provider buy-in. One challenge to creating alignment across these parameters is addressing the unique services provided and populations served in Medicaid, which vary significantly from Medicare and commercial plans. There are several federally funded multi-payer alignment initiatives underway, such as the State Innovation Models (SIM) initiative,⁶ Financial Alignment Initiative for Medicare-Medicaid Enrollees,⁷ Comprehensive Primary Care Initiative,⁸ and the Health Care Payment Learning and Action Network,⁹ providing even greater impetus for this industry-wide shift.

CURBING HIGH-COST DRUG SPENDING

Especially challenging for state purchasers are the effective but very expensive new breakthrough therapy drugs, such as Sovaldi which treats Hepatitis C, that have limited or no market competition.¹⁰ Sovaldi, in particular, creates a dilemma for Medicaid budgets because of the disproportionate prevalence of Hepatitis

- 3 MaineCare Services, "Accountable Communities Initiative," Maine Department of Health and Human Services, <http://www.maine.gov/dhhs/oms/vbp/accountable.html> (accessed July 22, 2015).
- 4 Minnesota Department of Human Services, "Integrated Health Partnerships (IHP) Overview," http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441 (accessed July 22, 2015).
- 5 New York State Department of Health, "Delivery System Reform Incentive Payment (DSRIP) Program," https://www.health.ny.gov/health_care/medicaid/redesign/dsrp/ (accessed July 22, 2015).
- 6 Center for Medicare and Medicaid Innovation, "State Innovation Models Initiative: General Information," Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/state-innovations/> (accessed July 22, 2015).
- 7 Center for Medicare and Medicaid Innovation, "Financial Alignment Initiative for Medicare-Medicaid Enrollees," Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/Financial-Alignment/> (accessed July 22, 2015).
- 8 Center for Medicare and Medicaid Innovation, "Comprehensive Primary Care Initiative," Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/> (accessed July 22, 2015).
- 9 Center for Medicare and Medicaid Innovation, "Health Care Payment Learning and Action Network," Centers for Medicare and Medicaid Services, <http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/> (accessed July 22, 2015).
- 10 "Health Policy Brief: Breakthrough Therapy Designation," Health Affairs, May 15, 2014, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=115 (accessed July 22, 2015).

C among Medicaid beneficiaries, including those in the Medicaid expansion population (in those states that have chosen to expand as authorized under the ACA).¹¹ Similarly, the expense of this drug places considerable pressure on state corrections' budgets because of the high incidence of Hepatitis C among incarcerated populations.¹² Adding to the concern in this area is the growth of genetically based therapies, also expected to have much higher costs than the typical pharmacological therapies of today.¹³ Additionally, the underlying cost of generic drugs has gone up in recent years, putting more pressure on state purchasers.¹⁴ Moving forward, state purchasers are negotiating with MCOs to determine how to bear the risk of these high-cost drugs. It is critical that states and Medicaid MCOs carefully monitor the drug pipeline to anticipate and prepare for new, breakthrough entrants. Options for states include developing new utilization management strategies around specialty drugs to target approved usage more effectively (such as adopting prior authorization requirements or readiness for treatment criteria).¹⁵

PROPOSED MEDICAID MANAGED CARE REGULATIONS

The Centers for Medicare and Medicaid Services' (CMS) proposed Medicaid managed care regulations, published in May 2015, represent the first significant update to Medicaid managed care regulations in over a decade. Key regulatory changes that will affect Medicaid purchasing strategies include: proposed mandatory 14-day plan selection period for new enrollees; increased standardization in rate setting/actuarial certification; establishment of a federal medical loss ratio standard for Medicaid; new minimum provider credentialing standards; expanded plan responsibilities for program integrity/monitoring fraud and abuse; enhanced requirements for standardized, timely, and complete encounter data submission; more rigorous network adequacy standards; new uniform quality rating system, using a common set of metrics similar to those already used in Medicare Advantage and the health insurance marketplaces; and adoption of a clear definition and principles for LTSS.¹⁶

The proposed Medicaid managed care regulations also support the states' use of MCOs to implement APMs. For example, if finalized, the proposed regulations would enable states to: continue to use MCO contracts to require the adoption of APMs and have MCOs participate in broad-ranging delivery system and performance improvement initiatives.¹⁷

POPULATION-SPECIFIC REFORMS

In tandem with system-wide reforms around paying for care, Medicaid agencies also are pursuing strategies for targeted opportunities to improve how care is delivered and reduce the associated costs. This section explores some emerging trends in population-focused reforms, including: integration of physical and behavioral health, complex care patient programs, and population health integration models that aim to integrate health care with social services and community supports.

11 Michael Ollove, "Could New Hepatitis C Drugs Bust State Budgets?" The Pew Charitable Trusts, Stateline, February 28, 2014, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2014/02/28/could-new-hepatitis-c-drugs-bust-state-budgets> (accessed July 22, 2015); and National Alliance of State & Territorial AIDS Directors, "The Affordable Care Act and the Silent Epidemic: Increasing the Viral Hepatitis Response Through Health Reform," March 2013, <http://nastad.org/sites/default/files/Primer-ACA-Hepatitis-March-2013.pdf> (accessed July 22, 2015).

12 Centers for Disease Control and Prevention, Hepatitis C & Incarceration (Atlanta, GA, October 2013), <http://www.cdc.gov/hepatitis/HCV/PDFs/HepCIncarcerationFactSheet.pdf> (accessed July 22, 2015).

13 Ron Leuty, "Gene therapy: How much for a magic bullet?" San Francisco Business Times, April 25, 2014, <http://www.bizjournals.com/sanfrancisco/print-edition/2014/04/25/gene-therapy-magic-bullet-randy-curtis-gilead.html> (accessed July 22, 2015).

14 Ed Silverman, "Generic Drug Prices Keep Rising, but is a Slowdown Coming?" Wall Street Journal, April 22, 2015, <http://blogs.wsj.com/pharmalot/2015/04/22/generic-drug-prices-keep-rising-but-is-a-slowdown-coming/> (accessed July 22, 2015).

15 Sandra Wilkniss, Sophia Tripoli, and Frederick Isasi, New Hepatitis C Treatments: Considerations and Potential Strategies for States (Washington, D.C.: National Governors Association Center for Best Practices, February 25, 2015), <http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1502NewHepCTreatments.pdf> (accessed July 22, 2015).

16 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, Proposed Rule, 80 Fed. Reg. 31097 (June 1, 2015), <https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered> (accessed July 22, 2015).

17 Ibid.

INTEGRATION OF PHYSICAL AND BEHAVIORAL HEALTH

The siloed nature of the traditional financing and delivery of behavioral and physical health services (such as behavioral health carve-outs) creates disincentives for coordinated and efficient care. While states use various arrangements to pay for and provide Medicaid behavioral health services, there is a general trend of moving toward managed systems of care to integrate physical and behavioral health services. For example, during the last two years, Arizona, Florida, Kansas, and Texas have carved Medicaid specialty behavioral health services (for some or all Medicaid enrollees) into comprehensive managed care contracts that also cover physical health services. Other states, such as New York, plan to implement a similar model in 2015. Meanwhile, a number of states have opted to preserve a carve-out of behavioral health services, in favor of maintaining a specialty system of care for individuals with serious behavioral health needs. Among these states, which include Idaho and Louisiana among others, the general trend has similarly been toward managed care and risk-based contracting.

Likewise, there are several efforts underway in states to promote integration at both the systems level and the point of care. States are requiring payers or providers to report process and outcome measures that are jointly impacted by physical and behavioral health services for individuals with behavioral health conditions. Examples of these measures include emergency department utilization rates, rates of avoidable hospitalizations, and medication adherence for both physical and behavioral health treatments. For example, the Serious Mental Illness Innovations Project in Pennsylvania expanded requirements for coordination across health plans and local county agencies to provide seamless access to physical and behavioral health services. Results included decreases in mental health hospitalizations, all-cause readmissions, and emergency room use for individuals who used those specialty services.¹⁸

Nineteen states plus the District of Columbia have implemented Medicaid health homes to improve integration across physical health, behavioral health, and LTSS for individuals with serious mental illness or chronic medical conditions (as defined by the state). Health homes offer states an opportunity to pay for difficult-to-reimburse services that are important for this population (such as care management and care coordination) and provide an enhanced federal match for the first two years of implementation.

COMPLEX CARE PATIENT PROGRAMS

Medicaid patients using a large volume of hospital services, often referred to as high-cost and complex-care patients, tend to have inadequate ambulatory care, poor continuity of care between care settings, co-occurring behavioral health conditions, and a variety of social barriers that contribute to overall poor health. Recognizing that 5 percent of the highest-cost Medicaid patients generate more than 50 percent of program costs, several states are pursuing focused programs to address avoidable costs and improve the health of this high-need population.¹⁹

Many of these programs were inspired by the work of innovators such as the Camden Coalition of Healthcare Providers in Camden, New Jersey²⁰ and CareOregon.²¹ These models combine an array of interventions to address the complex medical, behavioral health, and social services needs of high-cost patients.²² Generally speaking, complex care patient programs are structured to identify patients and deploy multi-disciplinary

18 Jung Y. Kim et al., SMI Innovations Project in Pennsylvania: Final Evaluation Report (Hamilton, NJ: Center for Health Care Strategies, October 1, 2012), <http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/> (accessed July 22, 2015).

19 Steven B. Cohen and William Yu, Statistical Brief, no. 354: The Concentration and Persistence in the Level of Health Expenditures over Time: Estimates for the U.S. Population, 2008–2009 (Rockville, MD: Agency for Healthcare Research and Quality, January 2012), http://meps.ahrq.gov/mepsweb/data_files/publications/st354/stat354.shtml (accessed July 22, 2015).

20 For more information, visit <http://www.camdenhealth.org/> (accessed July 22, 2015).

21 For more information, visit <http://www.careoregon.org/LearningAndInnovation.aspx> (accessed July 22, 2015).

22 Center for Health Care Strategies, “Fact Sheet: Programs Focusing on High-Need, High-Cost Populations,” March 2015, http://www.chcs.org/media/SU-Fact-Sheet_41715_Final.pdf (accessed July 22, 2015).

care teams that have the expertise to connect patients with the appropriate clinical staff, including both primary care and specialty care, provide access to necessary social supports, and empower patients to achieve their own health goals. The care teams draw on a range of health professionals including nurses, care managers, social workers, community health workers, and care navigators. They also tap into a range of care delivery models including integrated mental health and substance use disorder services, housing support, and trauma-informed care. Some states, including Minnesota through its county-based Hennepin Health²³ model, are using ACOs to provide new incentives for providers to share in savings they generate by providing higher quality and more integrated care for high-need populations. These shared savings opportunities create new incentives for providers to invest in care coordinators for high-need populations to help deliver those savings.

POPULATION HEALTH INTEGRATION MODELS

Some states are exploring opportunities to strengthen linkages to complementary state and local investments in public health and social services. The idea is to create a multi-sector infrastructure to better integrate clinical interventions with community-based health efforts, thereby maximizing the return on investment in related state and local programs. Given the impact that communities have on population health, states are seeking to create the necessary linkages and partnerships between clinical care and the community, while also establishing a shared sense of accountability.

There are a few nascent models underway. For example, as part of their SIM initiatives, Minnesota, Michigan, Vermont, and Washington are all pursuing accountable communities for health models. Minnesota and Washington were awarded grants to select communities to pursue specific local health improvement projects while building the necessary community governance structures, decision-making processes, engagement strategies, and administrative support functions.

DATA IMPROVEMENTS

For states to successfully advance health care purchasing initiatives, it is critical to improve both the flow of data within the system (interoperability) and the analytics available to surface insights from the data. In many instances, such efforts require high-level support such as the leadership of governors' offices. States are engaged in an array of efforts to improve access to and analysis of data, including: investments in health information technology, such as health information exchanges (HIEs), adoption of electronic health records (EHRs), and analytic tools to ensure timely and accurate data access across providers and state agencies. Current trends in data management include: developing HIEs, developing all-payer claims databases, linking and analyzing data across agencies and organizations and the anticipated 2015 release of the Transformed Medicaid Statistical Information System (T-MSIS).

HEALTH INFORMATION EXCHANGES

Using SIM grant funds and other federal sources, many states are developing cohesive HIEs to transmit patient data between providers. In implementing HIEs, states face challenges with reliable and timely access to data, ensuring interoperability between EHRs and record-keeping systems, addressing privacy concerns, and providing a sustainable funding source for these efforts. States are increasingly looking to partner to form multi-state or regional HIEs, such as the Chesapeake Regional Information System for our Patients,²⁴ a nonprofit membership-based HIE that exchanges data between entities in Maryland and Washington, D.C., and provides additional services such as an encounter notification, direct messaging, and a prescription drug monitoring program.

23 For more information, visit <http://www.mhp4life.org/about-us/about-hennepin-health> (accessed July 22, 2015).

24 For more information, visit <https://crisphealth.org/> (accessed July 22, 2015).

ALL-PAYER CLAIMS DATABASES

All-payer claims databases (APCDs), a rising trend among states, offer the capability to aggregate multi-payer data to better understand cost, quality, and utilization patterns. As of June 2015, 15 states have operational APCDs, including 12 states with APCDs where data submission by carriers is mandated by state law and three states with APCDs where data is provided on a voluntary basis.²⁵ Six additional states are in active design and implementation of APCDs, and many other states have expressed interest or are pursuing legislation.

APCDs typically integrate enrollee demographics, claims information, and provider information from public and private insurers for all publicly and privately insured residents in a state. Because APCDs collect multi-payer data, the information provides a valuable repository of information about a provider's total insured panel of patients. As performance-based contracting moves from performance incentives at an MCO level to performance incentives at a provider level, APCDs can provide a risk-adjusted profile of a provider's entire insured patient panel, their health care use over time, and health care costs. This information is critical for multi-payer performance-based purchasing efforts involving provider-level incentives. While there are many important considerations when developing an APCD,²⁶ there are benefits from having these data handy for in-depth analysis across payers and populations to help focus and drive public policy initiatives.

LINKING AND ANALYZING DATA ACROSS AGENCIES AND ORGANIZATIONS

Data also play a critical role in addressing the social factors that influence health outcomes. Linking and analyzing data across state agencies and organizations creates opportunities to improve program analysis, development, and care coordination. States have begun to work along this vein, including Washington State's Predictive Risk Intelligence System (PRISM),²⁷ which is made up of an integrated client database linking 16 state agency databases including Medicaid, social services, corrections, and public health. PRISM also features a predictive modeling tool that can generate valuable reports across departments.²⁸ Similar connections have been made through contracting across providers and organizations, such as Minnesota's Hennepin Health,²⁹ which involves collaboration across public health and social service agencies, the corrections department, hospitals, Federally Qualified Health Centers, a health plan, and community organizations.

T-MSIS

CMS is developing T-MSIS,³⁰ which will allow the federal government and states to report, analyze, and monitor aggregate clinical and cost data at the state and national levels. The system aims to streamline and standardize reporting procedures and data feeds. States should monitor the roll-out of T-MSIS as they may be expected to provide specific data once the system is operational. While it will likely take some time for the system's analytic capabilities to become fully functional, it could present a new opportunity to analyze data both within and across states and programs. T-MSIS roll-out by CMS is slated to begin sometime in 2015.

OPPORTUNITIES FOR FEDERAL INVESTMENT AND SUPPORT

States must often seek federal approval in order to implement payment and care delivery initiatives. States also face the challenge of financing these initiatives, which often require upfront investment to implement changes to systems that may ultimately lead to improved care and reduced costs. As discussed below, states have been able to receive additional federal Medicaid funds through the use of certain models.

25 For more information, visit <http://www.apcdouncil.org/state/map> (accessed July 22, 2015).

26 Jo Porter et al., The Basics of All-Payer Claims Databases: A Primer for States (Durham, NH: APCD Council, 2014) http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988 (accessed July 22, 2015).

27 Milbank, "PRISM: The Predictive Risk Intelligence System," http://www.milbank.org/our-work-with-states/reforming-states-group/resource-library?view=download&file=f72ef75067656985207cccd274a5cac0.pdf&name=prism:_the_predictive_risk_intelligence_system_ (accessed July 22, 2015).

28 Services and Enterprise Support Administration, "Research and Data Analysis," Washington State Department of Social and Health Services, <https://www.dshs.wa.gov/sesa/research-and-data-analysis> (accessed July 22, 2015).

29 For more information, visit <http://www.mhp4life.org/about-us/about-hennepin-health> (accessed July 22, 2015).

30 Center for Medicaid and CHIP Services, "RE: Transformed Medicaid Statistical Information System (T-MSIS) Data," Centers for Medicare and Medicaid Services, <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-004.pdf> (accessed July 22, 2015).

1115 WAIVERS/DELIVERY SYSTEM REFORM INCENTIVE PROGRAM/DESIGNATED STATE HEALTH PROGRAMS

Some states have received approval from HHS for Medicaid Section 1115 demonstrations that have provided states with the authority to make sweeping changes to their Medicaid programs while receiving additional funding from the federal government. For example, states have Section 1115 demonstrations that allow them to implement large-scale delivery system and payment reform efforts and to receive additional federal funds through the DSRIP, which states have used to make additional payments to providers and other entities, and Designated State Health Programs (DSHP), which are state-funded programs that would not otherwise be eligible for federal Medicaid matching funds. Since the first DSRIP program was approved in California in 2010, seven additional states (Kansas, Massachusetts, New Jersey, New Mexico, New York, Oregon, and Texas) have received approval from HHS for DSRIP programs and several of these states have extended their programs. Early DSRIP programs provided federal funding for payments to hospitals, and particularly safety net hospitals, with metrics tied to the success of individual projects. More recent DSRIP programs provide federal funding for payments to integrated delivery networks linking hospitals to other providers and social service agencies, with metrics tied to system transformation. Significantly, in more recent waivers, both the integrated delivery networks receiving DSRIP funds and the state are at risk based on quality and cost measures – meaning that a failure to achieve these metrics results in reductions of DSRIP funds.

New York is using its DSRIP to invest in 25 Performing Provider Systems, each of which must include a network of acute, long-term care, and behavioral health providers with linkages to community-based social services organizations. Providers must form partnerships to implement innovative projects focusing on system transformation, clinical improvement, and population health improvement. DSRIP funds are used to reward performance linked to achievement of specific project milestones associated with specific projects. One keystone of New York's demonstration is the link between DSRIP funds and demonstrable metrics with an overarching goal of reducing avoidable hospitalizations by 25 percent over five years.³¹

Oregon is using its Section 1115 demonstration waiver to implement its CCO program. Under this demonstration, Oregon obtained a significant level of federal matching funds to support CCO implementation. The state used DSHP funds to invest in a Transformation Center, innovator agents, learning collaboratives, and other technical supports, which are part of the quality strategy that Oregon developed to meet its program goals. DSHP is tied closely to specific terms and conditions pertaining to the annual expenditure reduction in spending targets and quality and access standards. For example, CMS is authorized to reduce DSHP funding if Oregon does not meet those terms.

1332 STATE INNOVATION WAIVERS

Under Section 1332 of the ACA, which takes effect in 2017, states may seek waivers to the law's coverage design requirements (otherwise known as state innovation waivers).³² States can waive the following requirements for innovation programs: imposition of penalties for the health insurance mandate for individuals, imposition of penalties for the health insurance mandate for employers, essential health benefit requirements and tax subsidies and certain marketplace and qualified health plan requirements. A 1332 waiver must satisfy certain criteria to be approved, including providing coverage to at least as many people as would be covered without the waiver, maintaining minimum coverage requirements, maintaining affordability of coverage and care, and ensuring federal budget neutrality.

To date, HHS has published only preliminary regulations on the process states must use to secure the

31 New York State Department of Health, "Redesigning New York's Medicaid Program," https://www.health.ny.gov/health_care/medicaid/redesign/ (accessed July 22, 2015).

32 Deborah Bachrach, Joel Ario, and Hailey Davis, *Innovation Waivers: An Opportunity for States to Pursue Their Own Brand of Health Reform* (Washington, D.C. and Princeton, NJ: The Commonwealth Fund and The Robert Wood Johnson Foundation, April 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/apr/innovation-waivers-and-health-reform> (accessed July 22, 2015).

waiver, but has not addressed how the approval criteria described above will be defined or met by states.³³ Regardless, a number of states have expressed interest in Section 1332 waivers. For example, Vermont initially sought to implement a universal, statewide single-payer system using a 1332 waiver, but has decided not to pursue that plan at this time. Hawaii's legislature formed a State Innovation Task Force in 2014, which has been considering a 1332 waiver to maintain Hawaii's longstanding statewide employer mandate.³⁴

Section 1332 waivers can be coordinated with Medicaid Section 1115 demonstrations to provide states the opportunity to coordinate and eliminate some of the differences between Medicaid and Marketplace coverage. Minnesota is reportedly considering seeking a Section 1332 waiver to streamline the continuum of eligibility, coverage, and enrollment between Medicaid and the state marketplace, building on its existing Basic Health Plan.³⁵ Arkansas is considering building on its existing Section 1115 demonstration through a Section 1332 waiver, which could provide a combined Medicaid and Marketplace budget neutrality agreement while allowing the state to enroll Medicaid-eligible individuals into private coverage.³⁶ Oregon may consider a Section 1332 waiver to expand on its CCOs with incentives to improve health outcomes, or to harmonize value-based purchasing standards in contracts with Medicaid MCOs, state employee plans, and state-based marketplace plans.³⁷

The number of states interested in exploring 1332 waiver opportunities continues to grow. Recently, for example, a legislative task force was proposed in New Mexico to consider a 1332 waiver to investigate how the state may be able to use its federal tax subsidy funds differently in order to improve access and quality of health care.³⁸

INNOVATIONS THROUGH STATE PLAN AMENDMENTS

States pursuing payment reforms to drive quality improvement are increasingly using State Plan Amendments (SPAs) to do so as an alternative to a waiver. In 2012, CMS released guidance on how states can use SPAs to implement integrated care models such as ACOs and Medicaid health homes, which seek to incentivize quality improvement in FFS models without a waiver.³⁹ Since that guidance was issued, Arkansas has received CMS approval of a SPA to implement its episodes-of-care payments, while Minnesota and Maine received CMS approval of SPAs to implement shared savings/risk models that are part of their Integrated Health Partnership programs.⁴⁰ CMS also has published regulations in which the agency explains how states may reimburse new models of non-licensed health care workers through Medicaid to provide community-based services.⁴¹

33 Application, Review, and Reporting Process for Waivers for State Innovation, Final Rule, 77 Fed. Reg. 11700 (Feb. 27, 2012), <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4395.pdf> (accessed July 22, 2015).

34 Jessica Schubel and Sarah Lueck, "Understanding The Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, February 5, 2015, <http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers> (accessed July 22, 2015).

35 Heather Howard and Galen Benshoof, "Section 1332 Waivers and The Future of State Health Reform," Health Affairs, December 5, 2014, <http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/> (accessed July 22, 2015).

36 Ibid.

37 Laura Dunn et al., 2017 and Beyond: Using the ACA Innovation Waiver to Reach Minnesota's Triple Aim (Princeton, NJ: Woodrow Wilson School of Public & International Affairs, Princeton University, January 2015), <http://www.princeton.edu/sites/default/files/content/2017%20and%20Beyond%20-%20Minnesota%20and%20the%201332%20Waiver%20-%202.3.15%20Final.pdf> (accessed July 22, 2015).

38 Jessica Schubel and Sarah Lueck, "Understanding The Affordable Care Act's State Innovation ("1332") Waivers," Center on Budget and Policy Priorities, February 5, 2015, <http://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers> (accessed July 22, 2015).

39 CMS, State Medicaid Directors Letters, Policy Considerations for Integrated Care Models, #1 and #2 (July 10, 2012), <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-001.pdf>, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf> and <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf> (accessed July 22, 2015).

40 Health Care Payment Improvement Initiative, "Episodes of Care," Arkansas Center for Health Improvement, <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx> (accessed August 12, 2015); Centers for Medicare and Medicaid Services, "Minnesota – Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy: Integrated Care Models (FFS Primary Care Case Management)," <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-11-031-Att.pdf> (accessed August 12, 2015); and Maine Department of Health and Human Services, "State Plan Title XIX of the Social Security Act: Integrated Care Model," http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Reimbursement_Section4_9%20AC_SPA%205%2012%20.pdf (accessed August 12, 2015).

41 Medicaid and CHIP, Final Rule, 78 Fed. Reg. 42160 (July 15, 2013), <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf> (accessed July 23, 2015).

CONCLUSION

The health care purchasing trends outlined in this overview are at various stages of development but all are poised to influence the Medicaid landscape in the near future. While some of the topics discussed in this supplement will be touched on in greater detail in the Compendium, others will be incorporated into the Compendium over time.

Overview and Key Principles of Health Care Purchasing

SECTION I

Section I

ROADMAP

Read this section to learn about the issues that significantly influence the effectiveness of the health care purchasing decisions made by state Medicaid programs. Learn about core principles for health care purchasing, including a detailed description of the procurement process. Following are key section takeaways:

OVERVIEW

As health care spending increases, health care purchasing decisions become more critical and are closely scrutinized. Obtaining the best value for every dollar will result in not only a more cost-effective program but also a higher-quality product and a healthier Medicaid population. Carefully designed state health care purchasing strategies offer the opportunity to align with, and provide meaningful support to, governors' overall health policy objectives.

FUNDAMENTALS

This section provides a basic overview of the following health care purchasing topics:

- Statutory and regulatory authority;
- Covered populations, services, and provider networks;
- Purchasing models, including risk-based managed care contracting and non-risk provider contracting; and
- Selecting, obtaining, and maintaining state and federal authority.

ADVANCED

This section details considerations for the state procurement process, including:

- Procurement process considerations;
- Staff capacity and competency;
- Timing of procurement;
- Role of quality measures;
- Data to provide to managed care organizations and other contractors prior to procurement; and
- Designing and conducting readiness reviews.

Section I. Overview and Key Principles of Health Care Purchasing

By Pat Finnerty and Jennifer Wiens, The Lewin Group

OVERVIEW

Spending for health care is projected to consume ever-greater shares of both state and federal government budgets. As a result, health care purchasing decisions made by state Medicaid programs have become more important and more closely scrutinized. As Medicaid is now the single largest component of total state expenditures, surpassing education spending, it is imperative that states make informed, strategic, and value-based decisions when purchasing health care services.¹ Obtaining the best value for every dollar results in not only a more cost-effective program but also higher-quality services and a healthier Medicaid population.

Medicaid health care purchasing, first and foremost, must be strategic. A clear understanding of the specific goals to be attained through the purchasing decision—before the process is initiated—is critical. Although the day-to-day reality of administering a Medicaid program often involves external pressures for quick programmatic changes and cost savings, the best purchasing decisions are the product of strategic planning and careful consideration regarding the many factors that determine success. Program goals and desired outcomes—rather than a predetermined course of action, which could have unintended consequences—should drive purchasing decisions. Broad considerations for states to address include the following:

- Is the goal of implementing, expanding, or changing the current health care purchasing arrangement primarily cost savings? Improved care management? Greater provider access? Or is it addressing external contingencies presented by provider or advocacy group pressures and political influences?
- Is the health care purchasing decision consistent with the governor's overall health policy objectives?
- How will the purchasing decision affect beneficiaries, health plans, providers, other state agencies, and advocacy groups?
- What are the major internal and external factors that affect the decision?

Rigorously analyzing the design and structure of the program or set of services to be purchased will pay substantial dividends in the long term. This section highlights the issues, considerations, and processes that will significantly influence the effectiveness and efficiency of the health care purchasing decisions made by state Medicaid programs.

FUNDAMENTALS

STATUTORY AND REGULATORY AUTHORITY

Federal Authority

As with any component or operation of the Medicaid program, states should be familiar with and comply with federal statutory and regulatory provisions when making health care purchasing decisions. In addition to the state plan or federal waiver authorities (for example, sections 1915(a), 1915(b), 1115, and 1932(a) of the Social Security Act) that may be used to operate risk-based managed care programs, several other statutory provisions and implementing federal regulations (for example, sections 1902, 1903, and 1932, of the Social Security Act and Part 438 of Title 42 of the Code of Federal Regulations) must be followed when operating these programs as a condition for obtaining federal matching dollars for qualifying expenditures. Specifically, these requirements direct how state Medicaid managed care programs must be developed and administered.

¹ National Association of State Budget Officers, *The Fiscal Survey of States*, (Washington, DC: Fall 2014), <http://www.nasbo.org/sites/default/files/NASBO%20Fall%202014%20Fiscal%20Survey%20of%20States.pdf> (accessed August 17, 2015).

States also must follow the Medicaid state plan amendment (SPA) process when implementing new programs or program modifications. Likewise, managed fee-for-service programs, as well as other service delivery models discussed in [Section III](#), “Provider Network Development and Delivery System Transformation,” also must meet certain federal requirements. Medicaid programs must comply with not only Medicaid-specific laws and regulations but other federal statutory and regulatory requirements, including fraud and abuse provisions, civil rights laws, and laws and regulations pertaining to persons with disabilities. Medicaid agencies need a sound understanding of this legal framework when operating programs that include the development and implementation of health care purchasing strategies.

Refer to [Section II](#), “Federal Authorities and Compliance,” for more detailed information regarding federal laws and regulations that states must adhere to when designing and administering Medicaid health care delivery systems.

State Authority

Medicaid programs also must adhere to state laws, regulations, and policies. Although state laws and regulations that relate to the Medicaid program are known and referenced on a routine basis, there likely are other more broadly applied provisions that also affect Medicaid programs, including health care purchasing decisions made by the Medicaid agency. Such requirements include:

- State procurement laws;
- State budget or appropriations acts adopted by the legislature;
- Goods and services purchasing requirements promulgated by the state’s central purchasing agency;
- Budget, finance, and spending directives issued by the state’s central budgeting or finance agency; and
- Administrative process mandates such as freedom of information and open meeting laws.

Understanding the full spectrum of state requirements that apply to the Medicaid program will help guide health care purchasing decisions and limit the potential for protests of any contract award. (A more comprehensive discussion of procurement issues is presented later in this section.)

COVERED POPULATIONS, SERVICES, AND PROVIDER NETWORKS

Populations

Determining which populations will be served within a state’s Medicaid program is critical and needs to be addressed early in the decision-making process. Developing a broad-based program that affects large segments of the Medicaid population (for example, children and Temporary Assistance for Needy Families beneficiaries) requires a much different approach than developing more targeted programs focused on select populations (for example, pregnant women, foster care children, persons with disabilities, or dually eligible individuals).

Decisions about covered populations and services also must recognize special circumstances within the broader population. People who are medically fragile or chronically ill or who have other special health care needs are often relatively few in number, but their care can be extraordinarily expensive. More than half of Medicaid spending is attributable to the 5 percent of beneficiaries with the highest costs.² Broad program designs that apply to large segments of the population likely will have to include provisions to address the special needs of such high-cost subpopulations.

² The Kaiser Commission on Medicaid and the Uninsured, “Medicaid Moving Forward,” March 2015, <http://files.kff.org/attachment/issue-brief-medicaid-moving-forward> (accessed August 17, 2015).

Identifying and understanding the target population early in the decision-making process establishes a framework in which the state can begin addressing other central aspects of the health care program, such as covered services, providers, program costs, and quality improvement goals. Each population group to be served will likely require focused attention to ensure that its members' particular needs and challenges are met.

State Medicaid agencies also need to consider the effects of their purchasing decisions on other state agencies or programs serving the same populations. For instance, purchasing decisions that affect Medicaid beneficiaries receiving behavioral health services may also affect the state's behavioral health agency that serves the same population. State and local health departments and other safety net agencies that provide primary or specialty care services to Medicaid beneficiaries also can be affected by Medicaid purchasing decisions. If a purchasing decision requires a particular segment of the Medicaid population to receive care from a more limited number of "contracted providers," beneficiaries might look to other sources of care, creating greater service demands on those providers. Imposing tighter controls or administrative requirements also can affect state and local safety net providers.

Finally, Medicaid decisions that move certain populations into risk-based managed care organizations (MCOs) with tighter provider networks could result in some state and local agencies and other safety net providers becoming unable to serve as care providers. For example, community providers such as school health programs, community mental health providers, and community public health agencies may be excluded from some health plan networks. This exclusion can raise concerns for those organizations, as well as the affected Medicaid enrollees. Consulting with other health and human services agencies and safety net providers about populations affected by Medicaid purchasing decisions can reduce unintended negative impacts and identify ways that decisions can benefit sister agencies, local health departments, nonprofit providers, and similar bodies.

Advocacy groups also should be considered during the decision-making process. Depending on the affected populations, advocacy groups often have powerful voices that resonate with the general public, as well as within the governor's office and the state legislature. Their voices can provide strong support or equally strong opposition for health care purchasing decisions. Although the relative strength and importance of the groups varies from state to state, strong advocacy for people with disabilities (for example, cognitive, intellectual, and physical) generally exists in every state. In addition to their true advocacy role, those groups also provide information and insights about the populations they serve and can be valuable partners in designing and implementing programmatic changes. Safety net providers also are strong advocates for their patients and often are intertwined with advocacy groups, making it even more important that Medicaid agencies work with the groups, seek their assistance in developing and administering health care programs, and join with them to improve patient outcomes.

A state Medicaid agency should know its advocacy community, involve its members as appropriate in the decision-making process and, to the degree possible, work with them to shape the design and implementation of the program.

Services

What services a state's Medicaid program covers is also an important consideration. States must cover certain mandatory services – such as inpatient, outpatient, laboratory services, and nursing facility services. States have the option of covering additional services such as pharmacy, dental and home- and community-based waiver services. When state Medicaid agencies opt to provide services through MCOs, Medicaid enrollees generally must have access to at least the same benefit package as would otherwise be available under the

traditional fee-for-service program. States, however, may decide which services – mandatory or optional – will be covered through purchasing mechanisms such as an MCO or other contract. A critical first step in decision making regarding covered services is developing a thorough understanding of federal requirements that apply. Sections 1902, 1905, and 1932 of the Social Security Act establish the legal framework for defining covered services. Part 438 of Title 42 of the Code of Federal Regulations (42 CFR Part 438) outlines specific requirements for Medicaid managed care plans, including requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services, and other key points. See [Section II](#), “Federal Authorities and Compliance,” for a complete review of these and other provisions of federal law and regulation.

In addition to determining what specific services will be included under a purchasing mechanism – such as a contract with an MCO – Medicaid agencies must make several other key decisions, including whether to apply any “amount, duration, and scope” limitations; how the concept of “medical necessity” will be defined and enforced; and which administrative and operational aspects of managing the authorization and payment of services will be handled internally and which will be delegated to a contracted entity. Again, 42 CFR Part 438 provides states with regulatory guidance on these issues as they relate to health care purchasing decisions that involve managed care programs. See [Section II](#), “Federal Authorities and Compliance,” for more information about these and other provisions of federal Medicaid laws and regulations.

Consideration of the following questions can help states reach sound decisions about which purchasing strategies are employed for various covered services:

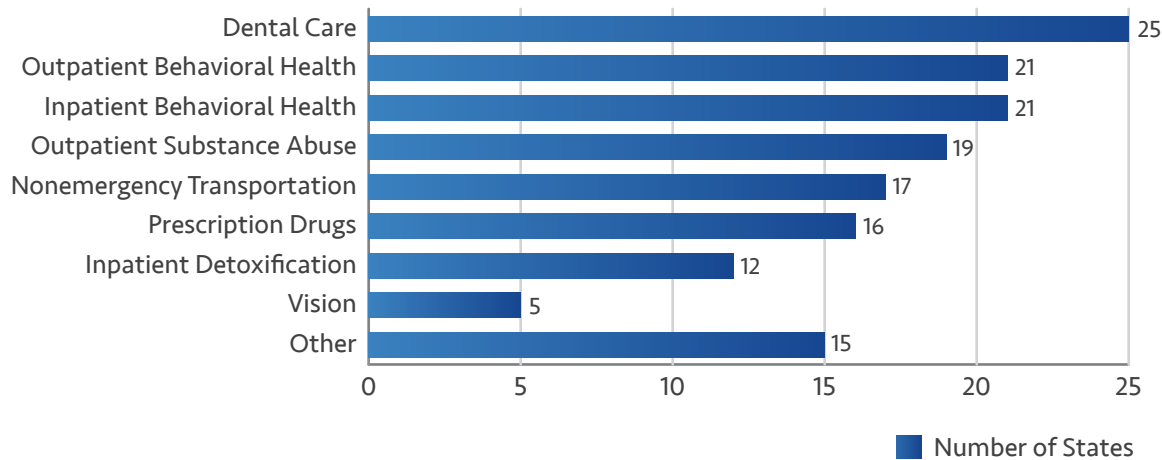
- Will including this particular service or group of services in the purchasing decision help achieve the stated program goals?
- Will the purchasing decision improve the quality or cost-effectiveness of the services being considered for inclusion?
- How will access to the covered services be affected by the purchasing decision?
- What effect will the purchasing decision have on the providers of the covered services? Have affected provider groups been consulted?
- Should any “grandfathering” provisions be included to ensure continuity of certain critical services for current beneficiaries? Similarly, what provisions are needed to ensure the continuity of a patient’s care and treatment plan during the transition from one delivery system to another?
- Should certain services be excluded or “carved out” of the purchasing decision? (See below for more detail about carve-out services.)
- Does the inclusion or exclusion of certain services affect other state or local health agencies that are purchasing or providing the same services to the Medicaid beneficiaries affected by the purchasing decision?

“Carve-Out” Services—Implications and Considerations

States that use risk-based managed care programs in which the MCOs administer a broad range of services often carve out, or exclude, some services and administer them either directly or under separate arrangements. Some common examples of carved-out services are dental, certain home- and community-based waiver services, behavioral health, substance abuse, pharmacy, and non-emergency transportation services.

Figure 1 shows the numbers of Medicaid programs across the nation administering various carve-out services.³

Figure 1. Acute Care Benefit Carve-Outs in Medicaid MCOs



Source: Kaiser Commission on Medicaid and the Uninsured Survey of Managed Care, September 2011.

States elect to carve out certain services from Medicaid MCOs for various reasons:

- *Clinical or management expertise of the vendor of the carved-out service.* Typically, vendors of carved-out services have specific expertise. Because those vendors have a more focused business model related to a service or set of related services, they often develop more administrative or clinical expertise in managing that particular service. For instance, dental benefits administrators (sometimes referred to as dental maintenance organizations) have expertise in managing dental benefits, establishing provider networks, and driving program improvements. Other carve-out administrators have similar strengths.
- *Additional cost savings.* Depending on the service being purchased, states may be able to negotiate lower costs through carve-out arrangements. Savings may be realized through lower per member per month (PMPM) capitation rates or, if the vendor is paid on a non-risk, administrative services only basis, savings may be achieved through more effective utilization controls, enhanced methods to detect fraud and abuse, or more cost-effective provider networks.
- *Provider demands.* States may be pressed by provider groups to carve out the services they render to beneficiaries. Often, providers argue that having a single carve-out vendor (for example, a behavioral health services contractor), as opposed to an MCO, provide a service reduces the burden of compliance with credentialing, billing, and payment system requirements and utilization management protocols. Providers also may refuse to contract with a managed care entity. That is commonly the reason behavioral health remains carved out.

A study for the Department of Health and Human Services (HHS), completed in 2012 by the Urban Institute, noted that state Medicaid officials cited similar reasons for carving out various services.⁴

³ The Kaiser Commission on Medicaid and the Uninsured, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," September 2011, <http://kff.org/medicaid/report/a-profile-of-medicare-managed-care-programs-in-2010-findings-from-a-50-state-survey/> (accessed August 17, 2015). See appendix 7 for carved-out services by state.

⁴ Embry Howell, Ashley Palmer, and Fiona Adams, Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future – Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, DC: Urban Institute, July 1, 2012), <http://aspe.hhs.gov/sites/default/files/pdf/76526/rpt.pdf> (accessed August 17, 2015).

Depending on the strategic goals of the health care purchasing decision, carve-outs can be an effective component of the overall program strategy. However, in assessing the value of a carve-out, a number of considerations should be addressed.

- *Carve-outs vs. integrated models:* As the overall health care system moves to a more integrated delivery and payment structure, carve-outs can be viewed as movement in the opposite direction. Several initiatives and trends are moving toward more integrated service delivery models, including the current Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative, in which CMS is working with a number of states to integrate and improve the financing and delivery of Medicare and Medicaid services for dually eligible beneficiaries (This work is further discussed later in this section).

A number of states also are considering greater integration of behavioral and physical health services, given the clear and growing evidence of the interrelatedness of these health conditions and their treatments. The Center for Health Care Strategies (CHCS) reported in 2012 on its work with the state of Pennsylvania that tested new strategies for integrating physical and behavioral health services for adult Medicaid beneficiaries with serious mental illness and physical health conditions. An independent evaluation of the two-year pilot identified significant impacts on cost and quality outcomes.⁵

Another example of states moving toward more integrated financing and delivery of health care services is in the area of prescription drug benefits. A number of states (for example, Illinois, New York, Ohio, Texas, and Utah) that had previously carved out the pharmacy benefit so as to invoice for prescription drugs dispensed to MCO enrollees, have moved back to including this benefit in the overall package of MCO-managed services. Those transitions were made following passage of the Affordable Care Act (ACA), in which pharmacy rebates were extended to prescription drugs dispensed or paid for by MCOs. In addition to the application of rebates expanded by the ACA, states also cite the close connection between prescription drugs and physical health as an advantage of reconnecting these two services.

States that choose to pursue carve-out arrangements can promote integration through contracting provisions that require the MCO and carve-out vendors to share critical clinical and administrative data. When a Medicaid MCO subcontracts certain services (such as pharmacy or behavioral health services) to another vendor operating directly under its control, sharing claims information and other data among the state, the MCO, and carve-out vendors that is compliant with the Health Insurance Portability and Accountability Act can help provide a seamless administration of the entire package of covered services. In that way, each party is able to know about patients' use patterns, health conditions and other factors. Beneficiaries receive a coordinated set of health care benefits. In a similar manner, as states, payers and providers continue to move toward integrated personal health records, it is also important to consider the sharing of claims and other health information with any vendor contracted to build or maintain enrollees' personal health records. Whatever data are shown must be transmitted in a timely fashion for both clinical and compliance purposes.

- *Care management implications:* Another concern is that a carve-out removes the service in question from any type of care management in place with the MCO to ensure appropriate use. However, depending on how the carve-out is structured, the arrangement does not necessarily mean that the services are unmanaged. Rather, utilization management, fraud, and abuse control functions are being performed by a separate entity with expertise in this area.

5 Jung Y. Kim, et al, SMI Innovations Project in Pennsylvania: Final Evaluation Report (Washington, DC: Mathematica Policy Research, October 1, 2012), <http://www.chcs.org/resource/smi-innovations-project-in-pennsylvania-final-evaluation-report/> (accessed August 17, 2015).

- *Rate-setting considerations:* Carve-outs clearly have an effect on the PMPM rates paid to the MCO, which must be calculated carefully not only to arrive at an actuarially sound rate for the MCO but also to ensure that funds formerly paid to the MCO for managing the carved-out service are available to be redirected to the carve-out vendor.
- *Clear stakeholder communication:* Communication of any covered service carve-outs to beneficiaries and providers is critical to ensure a successful program. Beneficiaries need to know how to access services, which vendor to contact for information and assistance, and other information about how the carve-out affects their overall benefits. Similarly, providers need to know how the program affects them in terms of network participation, utilization management protocols, billing and payment appeals, and so on. Some providers may express concerns about a carve-out arrangement if it separates the delivery of, and payment for, services that previously were managed and coordinated through one system and now must involve another.
- *Comprehensive carve-out strategy:* In some situations, carving out one service can result in other provider or advocacy groups pushing for additional carve-outs. Understanding the potential for that response and having clear programmatic and strategic reasons for pursuing a carve-out can help states respond to such overtures.

Service Areas

The delivery of health care services often varies substantially by locality. For that reason, determining which geographic areas of the state to include in a health care purchasing initiative is a critical decision. Several issues must be considered when defining the service area of a new or revised health care program.

- *Adequate provider base:* Ensuring an adequate base of providers that is accessible and able to serve the Medicaid population is of paramount importance. The provider network must have an appropriate mix of specialties to provide the full range of covered services. Moreover, depending on the type of delivery system, the health plan, MCO, or other contractor must be able to demonstrate that its provider network is capable of meeting the service demands of the population. Rural areas often present greater challenges to provider network development because of smaller patient populations. Medically underserved areas and health provider shortage areas exist in urban as well as rural areas and can present significant challenges. High concentrations of Medicaid enrollees in urban areas can often strain the ability of providers to ensure adequate access. Further discussion of the issue is provided later in this section.
- *Critical health care providers and systems:* Most states contain localities or geographic areas in which major health care systems or provider groups play a dominant role in the delivery of services. They may be multispecialty physician practices with several locations, a critical specialty or subspecialty care provider, or a major hospital system or other integrated health care delivery system. Because of their position in the market, they often hold an advantage in negotiating payment rates and other contract provisions with the state or MCO, and that can complicate the process of ensuring access, quality, and cost savings. In some instances, the absence of one or more of those critical providers could preclude the state from including the locality within its service area. In selecting service areas, it is crucial to have a clear understanding of how critical health care providers and systems fit into the overall delivery of care to the Medicaid population.
- *Political issues:* “All politics is local” is a common phrase in U.S. politics. The delivery of health care services in localities or geographic regions is no different. Although the political issue here is not a matter of party affiliation, political values, or philosophy, locally elected government officials, including state legislators, often have strong ties to advocacy groups and local health care providers and may have specific interests in any Medicaid changes that will affect their

constituents. Understanding the broader landscape that exists in the service areas being considered for inclusion in a health care purchasing decision helps states to anticipate and respond to reactions from important public officials whose areas are affected by the decision

- *Phased introduction of managed care arrangements:* When implementing a major change in Medicaid, pilot programs with limited service areas can be an effective means of evaluating the concept and structure of the planned change. Pilots allow states to: test new delivery systems or program changes with limited financial exposure; learn from contracted partners (for example, MCOs and third-party administrators), providers, and beneficiaries about the pros and cons of the program; and make necessary adjustments prior to a broader expansion. They are useful when implementing new types of managed care or reaching new populations (such as persons with traumatic brain injury or rural managed care) before a broader expansion.
- *Staggered implementation:* Similar to pilot programs, staggered or phased implementation allows the state to begin a new program in a limited way, learn from the initial stages, and make improvements as the program is expanded. Tennessee found that approach effective in the development and implementation of its TennCare managed care program. Bringing up regions in a sequenced manner allowed Tennessee to refine its request for proposals (RFP), making it a more effective contracting tool, and assisted in the implementation process, resulting in a measured, focused approach.⁶

Provider Networks

Although determining which populations and services to include in a health care purchasing decision is a fundamental step, an adequate network of quality providers must also be available to enrollees to ensure the timely and appropriate delivery of care. For some services, such as dental, non-emergency transportation, and long-term services and supports, provider access may be increased under managed care if MCOs are able to cultivate new providers to better ensure that members have access to covered services and have a choice of providers. A number of federal regulatory requirements regarding Medicaid managed care provider networks are contained in 42 CFR Part 438. State Medicaid agencies clearly need to be well versed in these regulations. These and other provisions of federal law and regulation are presented in [Section II](#), “Federal Authorities and Compliance.”

Developing a responsive institutional and ambulatory care provider network requires not only contracting with an adequate number of providers but also ensuring that the proper mix of primary, specialty, and subspecialty services is available within certain time and distance standards. The chronic and special care needs of many Medicaid enrollees create an even greater need to make certain that a suitable network of providers is accessible. Another aspect of Medicaid provider networks that is somewhat different from commercial networks is the reliance on essential community providers (ECPs) or “traditional” Medicaid providers. Federally Qualified Health Centers (FQHCs) and rural health centers are examples of these ECPs which, over the years, have become a vitally important access point for Medicaid enrollees. Requirements for inclusion of a certain percentage of such ECPs in health plan networks (as in the ACA) help to retain the provider-patient relationships that many Medicaid enrollees have formed, but they also limit the plans’ ability and leverage to manage and improve provider performance. [Section III](#), “Provider Network Development and Delivery System Transformation,” includes a full discussion and analysis of these and other provider networking issues.

State Experience with Managed Care

Perhaps the best guide to making sound decisions about health care purchasing is to capitalize on the state’s

6 TennCare, “Managed Care Model Design,” Briefing by Darin Gordon, TennCare Deputy Commissioner; Dr. Wendy Long, Deputy Director; and Casey Dungan, Chief Financial Officer.

own experience in implementing managed care programs and other types of health care delivery systems. Learning best practices and successful decision-making strategies from other states' experience is also a valuable tool and can help states avoid mistakes encountered elsewhere. However, learning what worked and did not work from its own previous health care purchasing decisions is irreplaceable. Each state has its own health care history, culture, and norms. Although a state need not be bound to the past, learning from it is invaluable.

In the course of making a health care purchasing decision, it can be very instructive to complete a thorough internal and external assessment of prior program changes. From an internal perspective, learning from the various units and staff within the Medicaid agency that were involved in previous decisions can help in identifying successful aspects to replicate or emphasize, as well as aspects that were problematic and should be modified or avoided.

Learning what works well and does not work well from external partners can be useful. All successful Medicaid health care purchasing decisions require effective partnerships with external parties, such as health plans and providers. Reaching out to those partners to understand the Medicaid purchasing decision from their perspective can provide insights into how the program affects their businesses and how it can be improved to attain mutually sought goals. Although that approach might require the state to manage partner demands for program features that may complicate its administration or increase costs, learning from such an exercise will contribute to a more informed purchasing decision.

The Health Care Market in the State

Although Medicaid is a significant health care purchaser and payer in every state, and in some states the largest, it is still part of a larger health care marketplace. To assess whether a new or modified Medicaid program is likely to succeed or to struggle, it is useful to understand how the broader health care marketplace operates in terms of:

- The current level of risk-based and other forms of managed care in the state;
- Provider payment mechanisms;
- Utilization management techniques;
- Provider networking and contracting practices;
- Providers' use of electronic health records, as well as the level of electronic claims filing and payment;
- Specialty care referral patterns;
- Dominant health providers; and
- Leading health insurance plans and other pertinent characteristics.

Moreover, learning from the successes and problems encountered by commercial payers in the state marketplace in implementing their purchasing decisions also can be of significant value.

In addition to understanding how the health care marketplace operates, it is equally important to understand how the state's health care marketplace is regulated and monitored. Knowing which state statutory and regulatory requirements apply to MCOs and other risk-based insurance plans that participate in the Medicaid program can be helpful in determining which provisions to include in a health plan contract. Commercial insurers must meet licensing, marketing, and financial solvency requirements, which are generally enforced by the state's insurance department. Some states, such as Virginia, also have charged the state's health

department with the regulation of managed care plans.⁷ The Managed Care Health Insurance Plan unit within the Virginia Department of Health works with the Bureau of Insurance to ensure compliance with various quality assurance components of managed care insurer licensing.

Although not all states do so, requiring Medicaid MCOs and other health plans to meet the state's health plan licensing and quality assurance requirements ensures that the plans serving Medicaid beneficiaries receive the same level of oversight and monitoring that plans serving private purchasers receive. That practice also keeps Medicaid in the mainstream of the state's larger health care regulatory structure. With the major health insurance coverage expansions authorized by the ACA (the establishment of health care marketplaces and optional Medicaid expansion) implemented beginning January 1, 2014, the practice of requiring Medicaid MCOs to meet state licensing and quality assurance requirements also provides for greater continuity among plans, as people transition between Medicaid and coverage available through the insurance marketplaces.

A number of states have enacted statutory provisions requiring insurers to comply with "any willing provider" laws, mandated benefit requirements, direct access to certain providers, and other consumer rights provisions. The National Conference of State Legislatures maintains a comprehensive database of state managed care laws and regulations that states can use to understand their particular regulatory landscape.⁸ Those laws shape the larger health care market and establish the framework within which Medicaid operates. Although state law might exempt Medicaid MCOs from certain provisions, it is still helpful to understand their relevance and effect on Medicaid.

PURCHASING MODELS

As states continue to move toward greater reliance on Medicaid managed care delivery systems, a fundamental consideration is whether to use a risk-based model, wherein some or all of the financial risk is assumed by a health plan, or to use a "non-risk," managed fee-for-service model. Other sections of this compendium will discuss financial issues, such as rate setting and risk adjustment, and federal laws and regulations regarding managed care purchasing in detail. This section provides an overview of the basic models of managed care and some key decision points for states to address.

Risk-Based Managed Care Contracting

Managed Care Populations

Historically, state Medicaid programs have enrolled children, pregnant women, and caretaker adults in risk-based managed care plans, as these populations are more easily transitioned to managed care and are more similar to the types of enrollees that commercial MCOs have served. However, because elderly beneficiaries and persons with disabilities are a far more costly cohort of Medicaid enrollees, states are now moving to enroll these patients in MCOs and other forms of risk-based managed care. Given the limited experience that risk-based plans have had with these higher-cost populations and the significant financial risk of insuring them, health plans may hesitate to contract with states on a full-risk basis. One potential means of addressing this concern is some level of reinsurance provided by the state to mitigate the financial risk. Reinsurance can also be used to address other forms of possible adverse selection in a risk-based managed care program. [Section V](#), "Financial Models," provides a fuller discussion of financial models, rate setting, risk adjustment, and related matters.

Delivery Mechanisms

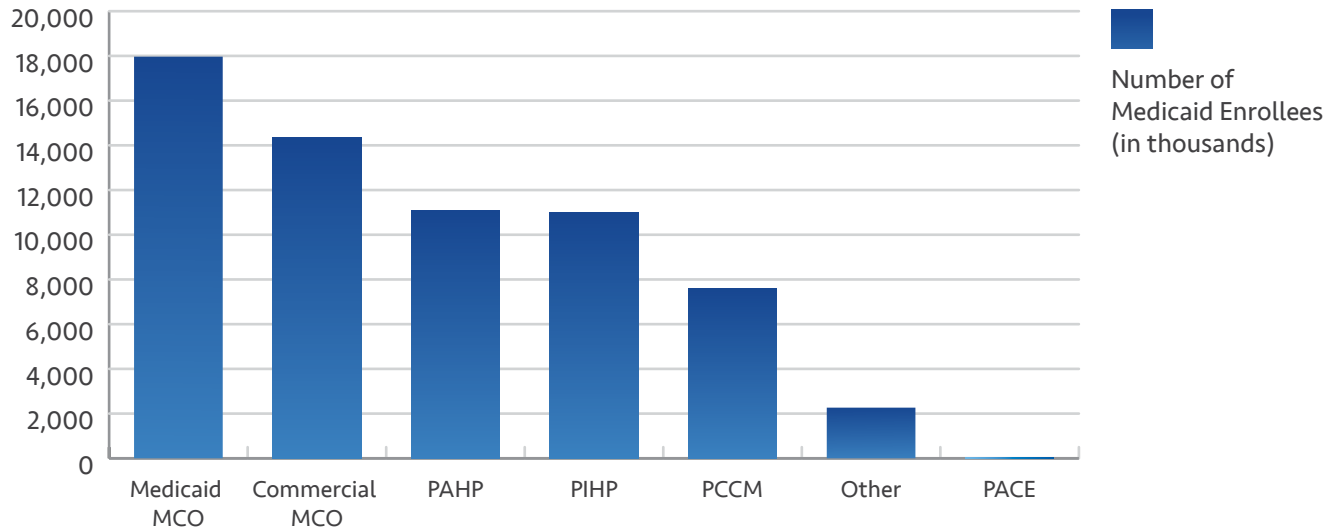
According to CMS, roughly 74 percent of Medicaid beneficiaries are enrolled in some form of managed

7 Virginia Department of Health, "The Managed Care Health Insurance Plan (MCHIP) and Private Review Agents (PRA)," <http://www.vdh.state.va.us/OLC/AcuteCare/mchip.htm> (accessed August 17, 2015).

8 National Conference of State Legislatures, "Managed Care State Laws and Regulations, Including Consumer and Provider Protections," <http://www.ncsl.org/issues-research/health/managed-care-state-laws.aspx> (accessed August 17, 2015).

care delivery system. Risk-based models are the most prevalent form of Medicaid managed care.⁹ Figure 2 illustrates CMS data on national enrollment in various forms of managed care as of July 2012.

Figure 2. National Enrollment in Medicaid Managed Care Plans (in thousands)



Source: Lewin analysis of CMS Managed Care Enrollment Report; enrollment as of July 1, 2012.

Notes: This table provides duplicated figures that include enrollees receiving comprehensive and limited benefits. Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in state health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

PCCM = Primary Care Case Management Programs; PIHP = Prepaid Inpatient Health Plans; PAHP = Prepaid Ambulatory Health Plans; PACE = Program of All-Inclusive Care for the Elderly.

In risk-based managed care, states contract with MCOs to provide a comprehensive, full-service package of benefits to enrolled Medicaid beneficiaries.¹⁰ States also contract with other types of prepaid health plans on a risk basis to provide less-than-comprehensive benefits. Federal regulations identify two types of non-comprehensive prepaid health plans: inpatient health plans and ambulatory health plans. Each risk-based model is described below.

- **Managed Care Organizations:** This type of plan is the more traditional managed care model, in which the MCO is responsible for the entire range of covered services and is paid by the state primarily on a capitation basis (a PMPM amount). Medicaid MCOs may be part of a larger commercial managed care plan, or they may be Medicaid-only plans that do not participate in the commercial market.
- **Prepaid Inpatient Health Plans (PIHP):** This type of risk-based managed care model “provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees and does not have a comprehensive risk contract.”¹¹ Services covered by a PIHP may be provided in a hospital or other institutional setting, such

⁹ Centers for Medicare & Medicaid Services, “Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2012,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf> (accessed August 17, 2015).

¹⁰ Under 42 C.F.R. § 438.2, a “comprehensive risk contract” is defined as a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: outpatient hospital services; rural health clinic services; FQHC services; other laboratory and x-ray services; nursing facility services; early and periodic screening, diagnostic, and treatment (EPSDT) services; family planning services; physician services; and home health services.

¹¹ 42 C.F.R. § 438.2.

as inpatient behavioral health care. Most of the PIHPs serve persons with mental health or substance use disorders.

- » Arizona, Iowa, Massachusetts, North Carolina, Pennsylvania, Puerto Rico, Texas, Utah, Washington, and Wisconsin report using PIHPs to serve persons with mental health and substance use disorders. As of July 1, 2012, total enrollment in these states' PIHPs serving that population was 4.97 million.
- » California, Colorado, the District of Columbia, Florida, Pennsylvania, and Tennessee report having PIHPs to provide "medical only" benefits; however, the total number of enrollees is much smaller (747,626).¹²
- *Prepaid Ambulatory Health Plans (PAHP)*: In a PAHP, medical services other than those provided in an inpatient hospital or other institutional setting are covered based on prepaid capitation payments.¹³ Common types of PAHPs provide behavioral health or dental-only services, which are often carved out of the comprehensive benefits administered by an MCO (see the discussion of carve-out benefits above).
 - » California, Florida, Idaho, Michigan, Oregon, Rhode Island, and Tennessee report using PAHPs for dental enrollees (total of 2.3 million enrollees).
 - » Eighteen states report using PAHPs to provide transportation services to enrollees. As of July 1, 2012, the total enrollment in these transportation PAHPs was 8.3 million.¹⁴
- *Program of All-Inclusive Care of the Elderly (PACE)*: The PACE program is a unique, capitated managed care benefit for the frail elderly, provided by a not-for-profit or public entity.¹⁵ The PACE program features a comprehensive medical and social service delivery system, using an interdisciplinary team approach, in an adult day health center that is supplemented by in-home and referral services according to participants' needs.¹⁶ Due to the intensive level of services and the structure of the program, PACE sites typically serve a smaller population than other, broader managed care programs. As of July 1, 2012, there were 26,536 PACE enrollees.

Purchasing Mechanisms

Developing, operating, and financing a managed care system to ensure that Medicaid beneficiaries receive appropriate services in a high-quality and cost-effective manner is a complex endeavor that requires significant infrastructure, staffing, and expertise. Although it is possible for a state Medicaid agency to build these capacities internally rather than buy them from a vendor, doing so presents challenges. First, building and administering the necessary components of a health plan, such as network development, provider and enrollee services, utilization management, actuarial and financing components, product development, and so forth, can be costly, and the process requires staff with specific skill sets and expertise. State agencies typically struggle to offer compensation packages sufficient to attract and retain the highly specialized staff that would be necessary. Moreover, in an era of budget tightening, state governments are often reluctant to hire additional state employees to perform functions that are available in the private sector through contracting.

In view of the challenges and cost of developing their own health plans, states purchase the services of risk-based managed care plans through contracts that are structured and negotiated in either a competitive

¹² Centers for Medicare & Medicaid Services, "Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2012," <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf> (accessed August 17, 2015).

¹³ 42 C.F.R. § 438.2.

¹⁴ Ibid.

¹⁵ 42 C.F.R. § 460.

¹⁶ Centers for Medicare & Medicaid Services, "PACE Fact Sheet," <http://www.cms.gov/Medicare/Health-Plans/pace/downloads/pacefactsheet.pdf> (accessed August 17, 2015).

procurement or an “open cooperative” process (see detailed discussion of the procurement process in this section).

Contracts with MCOs and other types of managed care entities must be detailed, with each requirement carefully defined. The contract not only reflects the agreement between the state and the risk-based plan regarding eligible populations, covered services, and other administrative and operational details, it also serves as the state’s legal basis for enforcing health plan performance. It must clearly define the responsibilities of both parties, set contractor performance expectations, and ensure accountability. The contract, therefore, is a critically important document that must be comprehensive in scope and precise in language. Above all, it must define and support the state’s program goals and objectives.

Comprehensive contracts for risk-based managed care must include an extensive array of details. Accordingly, they can be quite lengthy. For example, the Virginia Medicaid Medallion II Managed Care MCO contract is 283 pages long.¹⁷ Key provisions in the Virginia contract, as well as other states’ risk-based managed care contracts, address:

- Eligibility and enrollment;
- Member services;
- Provider networks and relations;
- Quality improvements;
- Payments and financial management;
- Management information systems, electronic data submissions, and information security;
- Program integrity;
- Member and provider appeals;
- Readiness reviews; and
- Remedies for contract violation, breach, or non-performance.

Reviewing MCO contracts in other states (which generally are available online) can identify best practices that can be used to construct a contract that meets a state’s particular needs.

Although risk-based managed care contracting must be precise, a healthy balance of specificity and flexibility can allow the state and its partner health plans to respond to unforeseen circumstances or new requirements that are placed on the state or the health plan. Contract modifications, negotiated with the health plans, are used to address necessary changes in the administration of the risk-based program.

Performance Monitoring and Outcome Measurement Features

The outcomes and performance goals that are incorporated into a risk-based contract are developed in concert with the Medicaid program’s overall quality plan. [Section IV](#), “Quality Improvement Strategies,” provides specific information to help states develop and operate a comprehensive quality improvement and measurement strategy.

Performance and quality outcomes goals established by the state should be included in the health plan contracts. Contract provisions to monitor performance also are essential features of the contracting

¹⁷ Commonwealth of Virginia Department of Medical Assistance Services, “Medallion II Managed Care Contract,” July 1, 2013, http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_cntrct710.pdf (accessed August 17, 2015).

process. Performance and outcomes requirements are of only marginal value to the Medicaid program without monitoring provisions because state officials have only limited ability to ensure that plans are living up to their contractual obligations. In addition to the items listed above, provisions are also included in the Virginia Medicaid Managed Care contract relating to: health plan reporting requirements; annual audit by an independent contractor; contract monitoring; and subcontractor management and monitoring.

Health plan reporting requirements are included to provide information on key performance metrics. Depending on the area of performance, reporting cycles can be monthly, quarterly, or annually. Some states, such as Tennessee, have emphasized the importance of including contractual provisions that allow the Medicaid agency to require ad hoc reports that supplement standard, ongoing reports. Ad hoc reporting is often needed to respond to unanticipated events or special circumstances that require data not included in routine or recurring reports. Officials in Tennessee also highlighted the advantages of requiring MCO reporting of standardized, evidence-based performance measures (for example, Healthcare Effectiveness Data and Information Set measures) that allow for tracking trends over time and for comparison to national norms.¹⁸

States uniformly designate internal Medicaid agency staff as “contract monitors” to ensure accountability and contract compliance. Contract monitors use health plan reports and other metrics to ensure that plans are meeting performance standards, for example, paying claims according to timeliness standards, achieving quality measures, and responding quickly to member or provider inquiries or complaints. Including in the contract a description of the role of the contract monitor, along with the records and other information that are to be made available by the plan, also helps to ensure an effective monitoring system.

[Section IV](#), “Quality Improvement Strategies,” provides fuller information and discussion on designing and measuring quality improvement indicators to help states ensure that their health care purchasing decisions are achieving their program goals. [Section VII](#), “Data Collection, Reporting, and Analysis,” complements [Section IV](#) by reviewing the various reporting systems and the analytical tools that capture and analyze the data needed for monitoring and driving quality improvements.

Non-Risk Provider Contracting

Delivery Mechanisms

Non-risk contracting is often referred to as “managed fee-for-service” (FFS). These programs also are considered a form of comprehensive Medicaid managed care. However, rather than contracting with MCOs or other health plans on a risk basis to manage beneficiaries’ access to services, state Medicaid programs typically pay a “management fee” to primary care physicians (PCPs) in addition to the fee-for-service reimbursement they receive for each rendered service. The management fee generally is a nominal amount that is paid monthly as an incentive to provide case management services to the Medicaid beneficiaries assigned to them. The most common form of managed FFS Medicaid is a primary care case management program, or PCCM. The Code of Federal Regulations (42 CFR 440.168) defines PCCM programs as case-management-related services that include location, coordination, and monitoring of primary health care services. These services are provided under a contract between the state and physicians, physician group practices, or clinics (such as federally qualified health centers). States also may recognize nurse practitioners, nurse midwives, and physician assistants as PCPs. PCCM services may be offered by the state as a voluntary option under the state Medicaid plan or on a mandatory basis under certain federal authority.¹⁹ [Section II](#), “Federal Authorities and Compliance,” provides detail on the federal authorities associated with PCCM purchasing.

Although enrollment in PCCM programs is significantly less than that in risk-based managed care programs,

¹⁸ “The TennCare Experience, Past, Present and Future,” presentation to the Medicaid Leadership Institute, December 11, 2012.

¹⁹ 42 C.F.R. § 440.168

information provided by CMS indicates that, as of July 1, 2012, approximately 7.6 million Medicaid beneficiaries were enrolled in PCCM programs in 27 states.²⁰

North Carolina has operated Community Care of North Carolina (CCNC) and Carolina ACCESS (CA) as PCCM programs since the 1990s. CCNC/CA is the health care plan for the majority of Medicaid beneficiaries in the state. The objective of CCNC/CA is to create community health networks to achieve long-term quality as well as cost, access, and utilization objectives. A beneficiary's category determines whether enrollment in CCNC/CA is mandatory or optional or if the person is exempted from the program.²¹ CCNC/CA is similar to other PCCM programs in design and has evolved over the years to become the mainstay delivery system for Medicaid beneficiaries in the state. Although estimating program savings is difficult and can lead to different conclusions, CCNC cites analyses conducted by an independent actuarial firm that estimate that CCNC saved nearly \$1 billion over the four years from 2007 to 2010. Savings reflect what program costs would have been without any concerted efforts to control them.²² Some have challenged the validity of the CCNC program savings; a recent North Carolina state audit included a recommendation to "engage medical researchers to perform a scientifically valid study based on actual data to determine whether the CCNC model saves money and improves health outcomes." Despite the various challenges to the savings estimates, CCNC maintains that the program is producing substantial savings.

The Center for Health Care Strategies (CHCS) published a report in 2009 titled "Enhanced Primary Case Management Programs in Medicaid: Issues and Options for States."²³ The study provides an overview of PCCM programs and provides several options for enhancing them to improve care management for beneficiaries with chronic illnesses and disabilities. It examines programs in five states—Arkansas, Indiana, North Carolina, Oklahoma, and Pennsylvania. The CHCS report and several others are available to help states develop and administer PCCM programs.

Purchasing Mechanisms

Unlike risk-based managed care models, in which the state contracts with MCOs or other health plans to administer Medicaid-covered services, managed fee-for-service programs involve direct contracting with providers of care. The PCCM contracts used by states require the physicians or other primary care case managers to locate, coordinate, and monitor covered primary care and other services specified under the contract. The contracts must meet certain federal requirements, including: reasonable and adequate hours of operation; 24-hour availability of information, referral, and treatment with respect to emergencies; limits on distances beneficiaries must travel to the service delivery site; and referrals to specialists. States also include other contract provisions related to care management, case management fees, and so forth.

Performance Monitoring and Outcome Measurement Features

North Carolina has developed an array of performance data and analyses on the operation of its CCNC program.²⁴ In addition, CCNC has developed a dashboard of key performance measures such as: basic program statistics; behavioral health; case management; pharmacy; outpatient services; and emergency room use.²⁵

20 Centers for Medicare & Medicaid Services, "Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2012," <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf> (accessed August 17, 2015).

21 North Carolina Department of Health and Human Services, "Community Care of North Carolina/Carolina ACCESS," <http://www.ncdhhs.gov/dma/ca/ccncproviderinfo.htm> (accessed August 17, 2015); and Community Care Network of North Carolina, "Working Together," <http://www.communitycarenc.com/our-networks/> (accessed August 17, 2015).

22 Community Care Network of North Carolina, "The Community Care Story," <http://www.communitycarenc.com/about-us/> (accessed August 17, 2015).

23 James M. Verdier, Vivian Byrd, and Christal Stone, *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States* (Hamilton, NJ: Center for Health Care Strategies, September 2009) http://www.chcs.org/publications3960/publications_show.htm?doc_id=1013920 (accessed August 17, 2015).

24 Community Care of North Carolina, "Publications and Reports," <https://www.communitycarenc.org/about-us/publications/> (accessed August 17, 2015).

25 North Carolina Department of Health and Human Services Division of Medical Assistance, "Dashboard Measures—though FEB 2011," March 9, 2011, <http://www.ncdhhs.gov/dma/pub/MeasuresDashboard.pdf> (accessed August 17, 2015).

Emerging Models: In recent years, additional managed fee-for-service models have been developed. Variations include medical homes, patient-centered medical homes, health homes, ACOs, and ACO-like models, all of which coordinate patient treatment through a primary care physician to ensure that patients receive necessary care when and where they need it, in a manner that they can understand. [Section II](#), “Federal Authorities and Compliance,” provides detail on the federal authorities associated with these approaches. These new types of models support a centralized setting that facilitates partnerships among individual patients, their personal physicians, and, when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchanges, and other means to ensure that patients receive care in a culturally and linguistically appropriate manner.²⁶ In these new models, there can also be opportunities for shared risk, and savings arrangements can be built in such that the health plan, the state, and providers agree to share in the responsibility and results of the financial terms.

An increasing number of states are looking to the new models of managed FFS programs as innovative ways to improve the coordination and quality of care and derive cost savings. One particular area of interest relates to the CMS Financial Alignment Initiative. A long-standing barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address that, CMS is testing two models—a capitated model and a managed fee-for-service model—that allow states to better align the financing of the two programs and integrate primary, acute, and behavioral health and long-term services and supports for their Medicare-Medicaid enrollees.²⁷ In the managed fee-for-service model, a state and CMS enter into an agreement by which the state would benefit from savings resulting from initiatives to improve quality and reduce costs for both Medicare and Medicaid. The state of Washington was the first to partner with CMS to implement that model.²⁸ In HealthPath Washington, eligible Medicare-Medicaid enrollees can elect to receive health home services from health home care coordinators, supplemented by multidisciplinary teams that include primary and acute care providers, prescription drugs, behavioral health, and long-term services and supports. Health home services will include comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family supports; referral to community and social support services; and the use of a web-based clinical decision support tool and other health information technology to improve communication and coordination of services.²⁹

Monitoring and Outcome Design Features

As with risk-based contracts, PCCM and other managed FFS contracts must be monitored to ensure that performance is adequate and that the state’s overall purchasing goals and objectives are being met. However, states’ ability to demand certain performance levels of physicians and other case managers may be less than their ability to monitor and hold MCOs and other health plans accountable for quality improvement and performance measures. Unlike the situation with risk-based plans, which compete vigorously for state managed care contracts, states often struggle to find an adequate number and geographic distribution of physicians and other health care providers to serve Medicaid beneficiaries. Although levels of participation by providers vary by state, low reimbursement rates, administrative requirements, and lost revenues as a consequence of patient no-shows are among the concerns providers cite for limiting their participation in Medicaid.

26 American College of Physicians, “What Is the Patient-Centered Medical Home?” http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/understanding/what.htm (accessed August 17, 2015).

27 Centers for Medicare & Medicaid Services, “Financial Alignment Initiative,” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html> (accessed August 17, 2015).

28 AQ-IQ, “Managed Fee-For-Service Model Demonstration,” October 12, 2012, <http://aq-iq.com/managed-fee-for-service-model-demonstration/> (accessed August 17, 2015).

29 The Centers for Medicare & Medicaid Services (CMS), “Memorandum of Understanding Between CMS and the State of Washington Regarding A Federal-State Partnership to Test a Managed Fee-for-Service Financial Alignment Model for Medicare-Medicaid Enrollees,” <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/WAMFFSMOU.pdf> (accessed August 17, 2015).

Nevertheless, reasonable performance and quality requirements are essential components of PCCM and other managed FFS contracts. Similar to risk-based performance monitoring, monthly, quarterly, and annual performance reports allow the state to monitor beneficiaries' access to care, providers' adherence to contractual provisions, and progress toward overall program goals. Inasmuch as a good deal of the information to be monitored will be included in the FFS claims data, states are able to develop specific reports and data analysis protocols to monitor various aspects of program and specific provider performance. [Section IV](#), "Quality Improvement Strategies," and [Section VII](#), "Data Collection, Reporting, and Analysis," provide more information and discussion on designing and measuring desired program outcomes. In addition, [Section III](#), "Provider Network Development and Management," reviews the emerging models of care delivery systems and how these new models can be incorporated into Medicaid.

SELECTING, OBTAINING, AND MAINTAINING STATE AND FEDERAL AUTHORITY

Federal Law and Regulations

State officials who make health care purchasing decisions must be familiar with pertinent federal law and regulations. In addition to the state plan or federal waiver authorities (for example, sections 1915(b), 1115, or 1932(a) of the Social Security Act) that are required to operate risk-based managed care programs, several other laws and implementing regulations (for example, sections 1902, 1903, and 1932 of the Social Security Act and 42 CFR Part 438) must be followed when operating those programs to obtain the state's federal matching dollars for qualifying expenditures. Although state laws and regulations promulgated with specific reference to the Medicaid program are known and referenced on a routine basis, broadly applied provisions also affect the health care purchasing decisions made by a state's Medicaid agency. Such requirements exist in: state procurement laws; the state budget or appropriations acts adopted by the legislature; goods and services purchasing requirements promulgated by the state's central purchasing agency; vendor registration requirements; minority, small business, or historically underutilized business requirements; budget, finance, and spending directives issued by the state's central budgeting or finance agency; and administrative process mandates such as freedom of information and open meeting laws.

Enrollment Broker

Most states use an enrollment broker in their managed care programs to help enrollees make informed decisions about the various plans that are available to them. Enrollment brokers are engaged by states to provide independent counseling services to enrollees to help them understand managed care concepts, select plans, and enroll in a managed care program. That type of assistance also helps to head off inappropriate marketing activities on the part of an MCO to entice enrollees to select its plan.

States typically contract for the services of an enrollment broker through a competitive procurement process. The request for proposals issued in 2011 by the state of New York exemplifies the range of services typically provided.³⁰ The following are some of the key services required of New York's enrollment broker:

- Educate Medicaid applicants and consumers, providers, and other interested parties regarding Medicaid managed care and other plans;
- Educate potential enrollees about managed care concepts and their enrollment options and provide assistance with health plan selections;
- Process exemption and exclusion requests for Medicaid recipients;
- Process enrollments and disenrollments for all managed care programs;
- Help enrollees select a primary care provider if they wish such assistance;

³⁰ New York State Department of Health, Office of Health Insurance Programs, Division of Managed Care, "A Request for Proposal for Enrollment Broker Services," March 23, 2011, <http://www.health.ny.gov/funding/rfp/inactive/1102040410/1102040410.pdf> (accessed August 17, 2015).

- Provide an efficient and cost-effective enrollment process; and
- Provide an effective data reporting system regarding enrollments, disenrollments, exemptions, transfers, outreach and education activities, and complaints and grievances.

As with the process for purchasing services from an MCO or other managed care vendor, clear and measurable performance requirements are critical when contracting for enrollment broker services. Performance and quality standards regarding enrollment application processing, timely mailings of program information, member outreach and education activities, and establishing a beneficiary help line are common requirements in RFPs soliciting an enrollment broker. As already stated, the New York enrollment broker RFP provides good insight into the structure of such contract performance standards and requirements.

Mandatory Versus Optional Enrollment

Deciding whether to require certain Medicaid beneficiaries to enroll in a managed care program or make it optional is a critical aspect of the overall health care purchasing decision. Mandatory enrollment, particularly in risk-based MCOs, continues to increase across the nation. Historically, the mandated populations primarily have included children, pregnant women, parents, and other caretaker adults, populations that tend to have fewer and more predictable health risks and for which capitation rates are easier to set. In recent years, states have begun to include other Medicaid beneficiaries, such as children with special health care needs, seniors, and people with disabilities.³¹ As previously noted, a number of states also are participating in the CMS Financial Alignment Initiative, in which the state, CMS, and the MCO contract to enroll dually eligible beneficiaries in risk-based managed care.³²

To implement a mandatory managed care program, states must receive approval from CMS exempting them from the freedom of choice requirement contained in Section 1902 of the Social Security Act. There are three basic types of federal authority that states can use to implement a mandatory managed care enrollment strategy: state plan authority in Section 1932(a); waiver authority in Section 1915(a) and (b); and waiver authority in Section 1115.³³ [Section II](#), “Federal Authorities and Compliance,” provides further details on these provisions.

States have been able to reduce their Medicaid costs by mandating enrollment in managed care programs. However, states are obligated to connect beneficiaries with appropriate plans that are capable of meeting their health care needs in accordance with federal and state requirements. Increasing the number of people who are covered under a predictable capitation rate is a plus for states for budgeting. States also are able to limit any potential for “adverse selection” against the MCOs by requiring individuals to choose among MCOs, rather than between an MCO and a fee-for-service delivery model. Another advantage of mandatory enrollment is that states are able to increase the capacity of the MCOs in terms of their care management, quality improvement initiatives, network development, provider relations, utilization controls, and member outreach and education. Very often, state Medicaid agencies simply do not have the staff resources to perform those functions; mandating enrollment in contracted MCOs ensures that all managed-care-eligible beneficiaries benefit from these care and cost management functions.

Section 1932(a)(4) of the Social Security Act contains several provisions regarding individuals’ enrollment in a managed care program, including permissible methods of default enrollment, or “auto-assignment,” in a

31 The Kaiser Commission on Medicaid and the Uninsured, “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey,” September 2011, <http://kff.org/medicaid/report/a-profile-of-medicaid-managed-care-programs-in-2010-findings-from-a-50-state-survey/> (accessed August 17, 2015).

32 Centers for Medicare & Medicaid Services, “Financial Alignment Initiative,” <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html> (accessed August 17, 2015).

33 The Centers for Medicare & Medicaid Services, “Managed Care,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (accessed August 17, 2015).

health plan if the individual does not select one during the open enrollment period. Within this guidance, states have implemented various methods of ensuring that every managed-care-eligible enrollee is enrolled in a plan. Recently, some states have begun to reward high-performing health plans by including a provision in the auto-assignment algorithm that assigns a greater number of enrollees to the plans that meet certain quality and access metrics.

In addition to complying with pertinent federal laws and regulations, states must consider a number of other issues in deciding whether to pursue a mandatory or optional managed care enrollment strategy. The Medicaid and CHIP risk-based managed care study conducted in 2012 by the U.S. Department of Health and Human Services includes information on the issue of mandatory versus optional managed care enrollment in 20 states with well-established Medicaid risk-based managed care programs. Among the issues assessed were: the advantages of gradually rolling out a mandatory enrollment program; specific populations and geographic areas of the state that present particular challenges for Medicaid programs; and examples of states that curtailed their mandatory risk-based managed care programs.³⁴

Advocacy groups, especially those representing Medicaid beneficiaries who are medically fragile or have physical or intellectual disabilities, sometimes resist mandatory enrollment out of concern that those patients would not be served appropriately by an MCO. Similarly, some providers may oppose mandatory managed care enrollment for the patients they treat because they have concerns about how a managed care program would affect their practice, both administratively and financially. There may also be concerns in some states about specific MCOs based on their business model or care management practices.

A careful consideration of all aspects of mandatory versus optional managed care enrollment will help the state determine which approach best meets the goals of its health care purchasing decisions and overall program direction.

Stakeholder Engagement

The importance of engaging stakeholders in Medicaid health care purchasing decisions has been cited throughout this section. Whether the decision relates to program services, populations, benefit carve-outs, managed care delivery model, or mandatory or optional managed care enrollment, stakeholders can facilitate or impede the implementation of a state's health care purchasing decision. Although stakeholder engagement does require an investment of staff time and resources, it is crucial to the long-term viability of major program initiatives.

Stakeholders are typically patients, beneficiary or other health advocacy groups, provider organizations, health plans, administrative services contractors, other state or local government health care or social service agencies, and other entities that may be affected by a particular purchasing decision. In addition, members of the state legislature and legislative staff often have interests in either specific program areas or Medicaid more broadly. Engaging stakeholders early in the process helps to build a sense of partnership and stakeholder investment or ownership in a new initiative. It is recognized that there are situations in which confidential or other sensitive issues need to be addressed outside of the public eye. Also, concerns that stakeholders may develop a sense of entitlement to the decision-making process are understandable. Establishing expectations and the "rules of engagement" early on can help abate these concerns and ensure a healthy dialogue.

³⁴ Embry Howell, Ashley Palmer, and Fiona Adams, Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future – Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, DC: Urban Institute, July 1, 2012), <http://aspe.hhs.gov/sites/default/files/pdf/76526/rpt.pdf> (accessed August 17, 2015).

Stakeholder engagement can take various forms, from informal telephone calls or brief meetings to more formal approaches such as regularly scheduled briefings monthly or quarterly or forming an advisory committee to help with the design or implementation of an initiative. The form of engagement for a particular project or initiative can differ by stakeholder group and change during the planning, start-up, and ongoing operation of a program decision, depending on the need and benefit derived from the engagement. Many states, including Rhode Island, have successfully worked closely with the advocacy community to initiate and effect major program changes.

Stakeholders who feel a sense of ownership in the program decision can be of value through the initial implementation process, as well as afterward in determining necessary modifications or improvements.

ADVANCED

PROCUREMENT PROCESS CONSIDERATIONS

Timeframe and Expectations

States purchase managed health care services through one of two general approaches—either through an “open cooperative process” or a procurement or competitive contracting process.³⁵ The open cooperative process is often referred to as an application process. The procurement process involves competitive contracting, whereby states solicit plans, request proposals, and select plans to participate based on their proposals. A plan’s response to the state’s solicitation may be both a technical response and a price bid or only a technical response (in which case the state would set or negotiate the plan’s capitation rate). For example, the technical response would specify which parts of the state and which populations the plan proposes to serve and how it would meet the state’s quality, coverage, performance, and network adequacy standards. In some states, a “reference price,” or PMPM capitation rate, is set by the state, and offerors are expected to bid accordingly. States do not necessarily take all bidders through the procurement approach.

A second approach, the open cooperative process, is any-willing-provider contracting. With this approach, the state provides the contract terms and requirements and sets an actuarially sound rate or range of rates within rate cells, such as age groups or geographic regions. Any health plan meeting those requirements and willing to provide the contracted services within the rate range may do so.³⁶

The Urban Institute study that was conducted for HHS asked state Medicaid officials in 20 states about their views on the advantages and disadvantages of competitive contracting (for example, RFP processes) versus the open cooperative process.³⁷ Table 1 summarizes the findings.

35 The Centers for Medicare & Medicaid Services, “Application for Section 1915(b) (4) Waiver Fee-for-Service Selective Contracting Program,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/1915b4-FFS-Application.pdf> (accessed August 17, 2015).

36 Embry Howell, Ashley Palmer, and Fiona Adams, Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future – Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, DC: Urban Institute, July 1, 2012), <http://aspe.hhs.gov/sites/default/files/pdf/76526/rpt.pdf> (accessed August 17, 2015).

37 Ibid.

Table 1. Advantages and Disadvantages of Competitive Purchasing versus the Open Cooperative Process

Purchasing Approach	Advantages	Disadvantages
Competitive	<ul style="list-style-type: none"> • Ability to obtain better (lower) capitation rates. • Ability to control the number, quality, and geographic distribution of plans. 	<ul style="list-style-type: none"> • Initially administratively burdensome. • May lead to more turnover in plans and instability for program enrollees.
Open Cooperative Process	<ul style="list-style-type: none"> • Not as burdensome to administer initially. • May result in more plans, leading to more beneficiary choice and back-up if plans drop out. 	<ul style="list-style-type: none"> • Little ability to control the number and geographic distribution of plans. • No guaranteed market share for health plans.

Source: "Medicaid and CHIP Risk-Based Managed Care in 20 States," <http://ASPE.hhs.gov>, July 2012.

Although the terminology of the procurement or competitive contracting methodology varies from state to state, most states use an RFP as the procurement mechanism. However, different states use different procurement processes, with important differences in how the procurement is administered. In addition to an RFP process, some states may also use an invitation to bid (ITB), a request for application, or an invitation to negotiate (ITN). In Florida, state agencies use one of three different procurement mechanisms, depending on the particular goods or services being purchased:

- An ITB is issued when an agency is capable of establishing precise specifications for a commodity or defining with specificity a scope of work for the commodities or contractual services sought. Through this process, vendors are able to compete on a cost basis for like items or services.
- An RFP is used when it is not practicable for the agency to specifically define the scope of work for which the commodities or contractual services are needed. The agency can describe what it wants to accomplish, but the methods or means to accomplish the desired outcome cannot be easily defined. Several methods may be available to accomplish a task, and the agency is considering all of the options.
- An ITN is used when the agency determines that negotiations may be necessary for the state to receive the best value. This method of procurement is frequently used in areas experiencing constant change in the marketplace. Agencies want the opportunity to obtain up-to-date goods or services at the time of contracting.³⁸

In a competitive procurement process to purchase health care services, a complete understanding of the state's procurement methods and controlling regulatory guidance is essential. Although states use different procurement mechanisms, the considerations identified herein apply to all. For ease of presentation, these considerations are discussed in terms of an RFP process.

Depending on the complexity of the managed care program or services being purchased, an RFP can exceed 200 pages, including attachments and appendices. The document forms the basis for the contract between the state and the managed care entity, which ultimately will set out the services to be provided, program costs, cost savings and other financial terms, quality provisions, and administrative requirements. The contents of an RFP will vary by state and differ depending on the type of procurement being conducted. The

38 Florida Department of Environmental Protection, Bureau of General Services, "Responding to ITBs/RFPs/ITNs - What Vendors Need to Know," November 9, 2011, <http://www.floridadisaster.org/mitigation/rcmp/documents/Responding%20to%20State%20Procurement%20FDEM.pdf> (accessed August 17, 2015).

following are typical provisions found in RFPs:

- Introduction and background of Medicaid program;
- General terms and conditions governing the procurement;
- Special terms and conditions governing the procurement;
- Response format and organization;
- Mandatory requirements;
- Evaluation process, weights, and scoring;
- Technical proposal;
- Cost proposal; and
- Program data and appendices.

Allocating sufficient time to research, prepare, and request input on a draft and to finalize the RFP is key to effective purchasing. The following paragraphs describe a procurement process that includes several key steps and considerations to help ensure a successful outcome.

The overall time required to conduct an RFP process is usually between 10 and 15 months, depending on the steps in the process and other variables, such as the complexity of the services or program being purchased, the sensitivity of the project, the number of vendors submitting proposals, and the length of the planning phase.

Table 2. Sample RFP Procurement Timeline

RFP process	Estimated length of time
Planning/RFI/overall RFP development	6-9 months
Preparation of RFP response by offerors	2-3 months
Staff scoring of RFP proposals	3-4 weeks
Executive team review/approval	1-2 weeks
Final contract negotiations/contract award	2-4 weeks

Source: Excerpts from Arizona Health Care Cost Containment System (ACHCCS) "Managed Care Workshop," sponsored by Milbank Memorial Fund for the National Association of Medicaid Directors, January 2013; TennCare, "The TennCare Experience: Past, Present and Future," December 2012.

Notes: The estimates presented in this table represent a typical timeline; variations, some of which can be significant, can occur at any point in the process that can shorten or lengthen it. The potential for a protest of an award is always present and is not reflected in the estimated timeline. RFI = Request for Information.

For large system procurements, the planning process deserves at least as much attention as the actual procurement. The following paragraphs identify some specific steps that can be taken to ensure an effective planning process and ultimately a successful procurement.³⁹

³⁹ Information provided by Patricia Casanova, director of Indiana Medicaid, Family and Social Services Administration.

Request for information process: The Request for Information (RFI) process can be very helpful for states, in that it allows for an “environmental scan” of procurements nationally and informs the health care purchasing decision through input from various sources regarding new approaches being considered.⁴⁰ RFIs do not commit the state, vendors, or other respondents to any contractual terms; rather they help to frame new or revised health care programs to reflect latest trends, business processes, and research on outcomes. The RFI also allows the state to learn from other states’ successes and challenges. Although RFIs can lengthen the procurement timeline, they often generate information that helps to avoid difficulties encountered by other states, saving time in the long run and resulting in a more successful purchasing decision. As an example of how an RFI can assist in the procurement process, Texas released an RFI in October 2012 in advance of an RFP regarding the Texas Medicaid Management Information System (MMIS) Modernization and Fiscal Agent Services. The RFI looked for input on different approaches to the services being sought through the RFP.⁴¹

Issuance of a draft RFP: Another means of obtaining useful information to ensure that an RFP will result in a successful purchasing decision is to issue a draft of the RFP and request public comment on the draft. Again, issuing a draft RFP increases the time the process takes, but it can help a state avoid other problems that could cause schedule delays, such as having to issue RFP addenda or, worse, not receiving responsive bids and having to cancel the procurement. During its restructuring of its Medicaid/CHIP dental program, Virginia released a draft RFP to learn if the proposed program design would be workable and to gauge vendor interest in bidding. Through that process, the state learned from the vendor community that some of the program features proposed were not in line with current market practices and would have discouraged offerors from bidding. Consequently, Virginia made some key modifications to the RFP, which resulted in a competitive procurement and successful program.⁴²

In addition to a formal RFI process and issuance of draft RFPs, the RFPs used by other states for similar services or programs are readily available online or can be obtained from state Medicaid agencies for use in crafting a workable solution.

Offeror-submitted questions/preproposal conference: During the period when offerors are preparing their RFP responses, two common, but not required, elements that many states build into their procurement process are allowing offerors to submit written questions to the sponsoring agency and convening a preproposal conference. A question-and-answer period is an opportunity for offerors to gain a better understanding of the state’s intentions, expectations, and requirements. During a state-sponsored preproposal conference, the state can provide additional or updated information that might not have been available when the RFP was released. Also, potential offerors have an opportunity to ask questions about the RFP. States may mandate attendance at the preproposal conference by all vendors who plan to submit a proposal, or attendance may be optional. Generally, the preproposal conference is held a short time after release of the RFP, perhaps within one or two weeks. In all instances, answers provided during the preproposal conference are documented and provided to attendees to ensure a common understanding of the information.

Avoiding bidder protests: To avoid a protest of a contract award is a paramount concern of a Medicaid agency. In addition to the drain on staff time and agency resources, a protest can create delays in moving forward with the contracted services and program initiative. Review by the Medicaid agency’s legal counsel, whether the attorney general’s office or other department, of the RFP before it is released is essential to limiting the

40 TennCare, “Managed Care Model Design,” Briefing by Darin Gordon, TennCare deputy commissioner, Dr. Wendy Long, deputy director, and Casey Dungan, chief financial officer.

41 Texas Health and Human Services Commission, “Request for Information for Texas Medicaid Management Information System Modernization and Fiscal Agent Services,” October 25, 2012, <http://www.hhsc.state.tx.us/contract/529132000102125/docs/529-13-2000102125.pdf> (accessed August 17, 2015); and Florida Department of Environmental Protection, Bureau of General Services, “Responding to ITBs/RFPs/ITNs - What Vendors Need to Know,” November 9, 2011, <http://www.floridadisaster.org/mitigation/rcmp/documents/Responding%20to%20State%20Procurement%20FDEM.pdf> (accessed August 17, 2015).

42 Interviews with officials within the Virginia Department of Medical Assistance Services (Virginia’s Medicaid agency).

potential for protests. In addition, a Medicaid agency can take several operational steps to avoid a protest as the RFP is developed, proposals are scored, and decisions are reached.

In a managed care workshop that the Milbank Foundation and the National Association of Medicaid Directors sponsored in January 2013, the Arizona Health Care Cost Containment System presented some important recommendations for minimizing protests, including the following:

- Clearly outline expectations of offerors:
 - » Develop clear, concise submission requirements; and
 - » Have an outside party review submission requirements in advance of releasing the RFP.
- Allow offerors the opportunity to submit questions for written response following RFP release.
- Consider including language in the RFP allowing the current contractor to continue past the implementation date if a protest delays transition.
- Post public records request information to maximize transparency.
- Avoid scoring based on key words in responses.
- Establish internal controls, including the following:
 - » Minimize e-mail and written communication pertaining to scoring issues;
 - » Maintain only final scoring tools;
 - » Assign staff with appropriate levels of expertise to evaluate responses;
 - » Administer mandatory training for all staff involved in scoring and evaluation;
 - » Include a second review by an alternate scoring team member; and
 - » Have an outside party validate the scoring and evaluation method.⁴³

The Arizona managed care workshop includes a number of other best practices that states can follow in conducting procurements. Additionally, in a 2012 presentation to the Medicaid Leadership Institute, Tennessee offered some lessons learned that provide keen insights into managed care purchasing and effective procurement practices.⁴⁴

Whom to Bring into the Process and When

In major health care purchasing decisions, the first order of business is early involvement of the governor's office, to ensure that the decision and the resulting new or revised program are consistent with the governor's vision and direction. Legislative committees with jurisdiction over the Medicaid program also will have an interest in major procurements. In some states, legislative authority may be necessary to proceed. If legislative authority or approval is not necessary to move forward, it is often helpful nonetheless to brief committee staff members on the project to gauge if there are concerns and to keep them apprised concerning the procurement. It is important to note that a Medicaid agency's engagement with the legislature and legislative staff is often managed or directed by higher authorities within the executive branch.

However, keeping legislators and their staff informed about major procurements reduces the likelihood that concerns will be raised later in the process that derail or delay the initiative. Medicaid agencies that operate

⁴³ Arizona Health Care Cost Containment System (ACHCCS), "Managed Care Workshop," sponsored by Milbank Memorial Fund for the National Association of Medicaid Directors, January 2013.

⁴⁴ "The TennCare Experience, Past, Present and Future," presentation to the Medicaid Leadership Institute, December 11, 2012.

with policy-setting or advisory boards also should involve the board early in the purchasing decision process.

Engaging CMS early in the process, to understand what approvals are necessary and receive guidance on how best to proceed with the procurement, is a key next step. As the procurement process proceeds, periodically checking in with CMS is helpful to safeguard against surprises later in the process. See [Section II](#), “Federal Authorities and Compliance,” for further details on CMS requirements.

As discussed earlier, issuing an RFI or a draft RFP is an effective way to engage stakeholders in the health care purchasing process. In addition, for procurements that require integration of other systems or vendors, having the various parties engage in regular face-to-face meetings is helpful in keeping everyone at the table.⁴⁵

STAFF CAPACITY AND COMPETENCY

Managed care and other large system procurements can be staff-intensive, complex undertakings and in large states can involve billions of dollars. The complexity and financial impact of health care purchasing decisions require competent and experienced staff.

Large managed care procurements typically involve multidisciplinary RFP teams comprising team leads and subject matter experts (SMEs) from various units within the Medicaid agency, such as plan management, provider enrollment, claims, MMIS or IT, eligibility, Medicaid policy, pharmacy, and medical policy.⁴⁶ Depending on the particulars of the procurement, the expertise of the agency staff, the state’s experience in large managed care purchasing decisions, and available funding, the Medicaid agency may find it useful to engage a consulting firm to perform certain functions (for example, RFI or RFP development, proposal evaluation and scoring, or cost proposal analyses) in high-profile procurements. Medicaid agencies also may determine that involving procurement experts from the state’s central purchasing agency to augment agency staff provides an independent voice in the evaluative and decision-making process. It can also be helpful to include SMEs from other state agencies with specific clinical or program expertise to assist and inform the procurement team. Training the staff members who will evaluate RFP responses will bolster their competency level and ensure consistency across the RFP team.⁴⁷

TIMING OF PROCUREMENT

In determining the frequency of procurement, states must weigh the advantages of a longer contract period, which lengthens the time before procurement has to be conducted, against the possible disadvantage of having an unsatisfactory contractual arrangement in place for a longer period. All contracts include penalties or sanctions that vendors can incur if they do not meet contractual provisions on performance requirements. Moreover, termination clauses are part of every RFP. However, invoking those contract provisions often can be difficult and time-consuming, drain staff resources, and require extensive legal support.

Procurements often include an initial contract period of two or three years, with options to extend the contract for one-year periods up to a maximum of three to five additional years. State procurement laws and regulations may also require rebidding the contract at certain intervals or limiting the number of optional years. A 2012 managed care study conducted for HHS by the Urban Institute discussed how often states have solicited proposals over the past decade using a competitive procurement approach.⁴⁸ The study found

45 Information provided by Patricia Casanova, Director of Indiana Medicaid, Family and Social Services Administration.

46 Arizona Health Care Cost Containment System (ACHCCS), “Managed Care Workshop,” sponsored by Milbank Memorial Fund for the National Association of Medicaid Directors, January 2013.

47 Ibid.

48 Embry Howell, Ashley Palmer, and Fiona Adams, Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future – Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, DC: Urban Institute, July 1, 2012), <http://aspe.hhs.gov/sites/default/files/pdf/76526/rpt.pdf> (accessed August 17, 2015).

that solicitations are relatively rare; only three of the 15 study states using the competitive procurement approach had solicited three times during the past decade: Florida (CHIP only), Michigan (Medicaid only), and New Mexico. All other states had solicited only once or twice in the decade. The study also reported that some state officials indicated a preference for less frequent procurements because of the staff resources needed to solicit and review proposals and because it takes time to develop collaborative relationships with plans.⁴⁹

ROLE OF QUALITY MEASURES

Quality and performance measures are critical components of RFPs and the resulting health care purchasing contracts. They need to be considered carefully during the RFP development process and, whenever possible, be formulated in such a way that outcomes rather than process are being measured. [Section IV](#), “Quality Improvement Strategies,” provides a detailed discussion of quality measures and their important role in successful health care purchasing decisions.

DATA TO PROVIDE TO MCOS AND OTHER CONTRACTORS PRIOR TO PROCUREMENT

The program data that the Medicaid agency provides to MCOs and other offerors before procurement are critically important. Those data will affect how closely the contractor’s service levels will match the agency’s performance requirements, how accurate the offeror can be in estimating the financial components (for example, cost, payment, profit, or losses) of the program, and ultimately how successful the program will be in terms of service delivery and meeting cost and budget requirements. Including detailed actuarial data in the information provided to the bidding MCOs ensures that prospective plans have a clear understanding of the past financial performance of the program, as well as the ability to assess the performance requirements that they would be assuming and their costs. The more current the data, the more accurate the offerors can be in developing their proposals to match program needs.

States develop “data books” that include pertinent information for MCO offerors. They typically include enrollment history, claims and utilization data, program expenditures, and provider enrollment information. In addition to listing such program operational data, states include descriptive information such as: an explanation and history of the program; how the services being procured relate to other aspects of the Medicaid program; recent and planned changes in the program; overall program philosophy and values, the grievance and appeals process; readiness review requirements; and expectations for program management and performance under the contract. Data or procurement libraries are often created that give offerors access to program and procurement information, to be used in the development of their proposals.

DESIGNING AND CONDUCTING READINESS REVIEWS

A thorough readiness review is the Medicaid agency’s best tool for ensuring that vendors are capable of performing under the contract. A readiness review should include a visit to the site where the contractor will be performing the administrative functions of the contract and where the key staff members assigned to the contract are located.

Tennessee has identified several key areas of focus for its readiness reviews of MCO vendors participating in the TennCare managed care program, including the following:

- Care coordination and management;
- Provider network adequacy;
- Service authorization and delivery;

⁴⁹ Ibid.

- Claims processing and payment;
- Data transfer and management; and
- Quality monitoring.

Those focus areas are reviewed a variety of ways including: review of key desk deliverables; on-site review of critical processes and operating functions; systems testing; and other verification and validation activities. The readiness reviews are conducted primarily by units within the TennCare Bureau, including managed care operations, provider networks, quality oversight, information technology, and program areas such as pharmacy, dental, and long-term care. Other Tennessee state agencies also are involved. The department of human services reviews the eligibility component, and the department of commerce and insurance completes a contract review.⁵⁰

Similarly, Virginia's readiness review for its MCO contractors covers network provider composition and access; staffing; content of provider agreements; financial solvency; and information systems performance and interfacing capabilities. The Virginia Medicaid program has placed added emphasis on services for children and pregnant women and therefore includes review of the MCOs' high-risk perinatal and Early and Periodic Screening, Diagnostic, and Treatment plans.⁵¹ Both Tennessee's and Virginia's review protocols make it clear that the readiness review may assess the contractor's ability to meet any requirements set forth in the contract and the documents referenced in it.

Arizona's readiness review process mirrors those of Tennessee and Virginia and includes the following major areas:

- Administration and management;
- Delivery system;
- Quality management;
- Medical management;
- Financial reporting;
- Claims processing and provider support;
- Encounter reporting;
- Management information systems;
- Member services; and
- Acute care, behavioral health and long-term care.⁵²

Each state begins the process shortly after award of the contract and conducts the reviews on a schedule that allows sufficient time to correct deficiencies, if problems are uncovered, and still remain on schedule. States reserve the right to delay enrollment in the MCO until major shortcomings are resolved.

50 TennCare, "Managed Care Model Design," Briefing by Darin Gordon, TennCare Deputy Commissioner; Dr. Wendy Long, Deputy Director; and Casey Dungan, Chief Financial Officer.

51 Commonwealth of Virginia Department of Medical Assistance Services, "Medallion II Managed Care Contract," July 1, 2013, http://dmasva.dmas.virginia.gov/Content_attachments/mc/mc-mdl2_cntrct710.pdf (accessed August 17, 2015).

52 Embry Howell, Ashley Palmer, and Fiona Adams, Medicaid and CHIP Risk-Based Managed Care in 20 States: Experiences Over the Past Decade and Lessons for the Future – Final Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (Washington, DC: Urban Institute, July 1, 2012), <http://aspe.hhs.gov/sites/default/files/pdf/76526/rpt.pdf> (accessed August 17, 2015).

Federal Authorities and Compliance

SECTION II

Section II

CHAPTER 1. FEDERAL AUTHORITIES

ROADMAP

Read this chapter to learn about various federal authorities and how they can be used to implement Medicaid managed care or integrated-care models. Following are key takeaways:

OVERVIEW

State health care purchasing decisions must be made in the context of federal statutes, regulations, and official guidance. To implement a Medicaid purchasing strategy that uses managed care or integrated care, a state must request federal authority using a state plan amendment or submit a waiver/demonstration request if the desired managed care or integrated care program does not comply with current state plan requirements.

FUNDAMENTALS

This section includes tools such as an authorities matrix and tips for working with the Centers for Medicare & Medicaid Services, and provides an introduction to the federal authorities related to the following topics:

- State plan amendments;
- Waiver and related demonstration authorities;
- “In lieu of” services and managed care entity incentive arrangements in capitated managed care contracts;
- Premium assistance;
- Use of concurrent authorities to provide managed long-term services and supports;
- Integrated programs for Medicare-Medicaid enrollees; and
- Preparation and tips for working with CMS.

Section II. Federal Authorities and Compliance

This section describes various federal authorities that are applicable to the Medicaid program, including some of the requirements and considerations involved in Medicaid health care purchasing models. It is divided into two chapters: Federal Authorities and Compliance with Federal Law and Regulations.

Chapter 1. Federal Authorities

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OVERVIEW

To implement a health care purchasing strategy for Medicaid that uses managed care or integrated care models, a state must request and receive authority from the secretary of the U.S. Department of Health and Human Services (HHS). There are two basic ways for a state to request federal authority to implement a change to its Medicaid program: a state plan amendment (SPA) and a waiver/demonstration request. A SPA is a proposal to make a change to the state's Medicaid state plan.¹ Any such change must conform to applicable federal statutes and regulations and, once approved, does not need to be renewed. A waiver/demonstration requests the secretary, consistent with the applicable waiver/demonstration authority, to waive specified statutory provisions so that the state can implement the proposed model or program. Unlike a SPA, all waiver requests require a budget test to demonstrate that the proposed model or program will not require more federal funds than would be required without the change. In addition, unlike a SPA, a waiver is a temporary authority. Depending on the type of waiver and whether it includes beneficiaries dually eligible for Medicare and Medicaid, a waiver can be effective for a maximum of five years and must then be renewed, requiring another application and budget test.

Although states have always had flexibility, within statutory limits, to design their Medicaid programs—which populations to cover, what services to provide, how much to pay providers—prior to the Balanced Budget Act of 1997 (BBA), the state generally had to comply with key statutory provisions of Title XIX of the Social Security Act, such as freedom of choice,² statewideness,³ and comparability.⁴ A state seeking to implement a program that did not comply with those provisions (such as mandatory managed care) had to request a waiver of the applicable provisions as permitted by law (for example, Section 1915(b) or Section 1115 of the Social Security Act, for mandatory managed care). However, the BBA and subsequent legislation allowed states to implement mandatory managed care, despite not meeting certain provisions of Title XIX. For example, Section 1932(a) of the act provides that a state may require beneficiaries to enroll in managed care, despite not meeting freedom of choice, statewideness, or comparability requirements.⁵

There are various types of state plan authority that can be used to implement health care purchasing models, including Section 1932(a) of the act (to implement specified managed care models); Section 1937 (to implement alternative benefit plans); Section 1945 (to implement health homes for enrollees with chronic conditions); and Sections 1905(a)(25) and 1905(t)(1) (to implement integrated care models in fee-for-service [FFS]). Three basic types of authority allow for waivers of certain provisions of the act or allow states to claim federal Medicaid matching funds for services that would not be covered under the state plan — Section

¹ States must have submitted and received approval from the secretary of Health and Human Services for state plans in order to receive federal Medicaid matching funds. State plans must meet a number of requirements, as defined by federal law. See Sections 1901 and 1902 of the Social Security Act; for additional information about state plans, see below under SPAs-General.

² Section 1902(a)(23) of the act requires a Medicaid state plan to permit all Medicaid beneficiaries to obtain medical assistance from any qualified provider willing to provide the service. Without a waiver of this provision, a state cannot require a beneficiary to use a particular provider or entity.

³ Section 1902(a)(1) of the act requires a Medicaid state plan to be in effect in all political subdivisions of the state. Without a waiver of this provision, a state cannot limit a program to a particular geographic area of the state.

⁴ Section 1902(a)(10)(B) of the act requires a Medicaid state plan to provide that all services for categorically needy individuals be equal in amount, duration, and scope. Without a waiver of this provision, a state cannot provide services to a subgroup of beneficiaries that differ in amount, duration, or scope from services to other categorically needy beneficiaries.

⁵ Section 1932(a) of the act.

1915(b), Section 1915(c), and Section 1115.

The scope, limitations, and requirements for each state plan and waiver authority are specified in the applicable statutes (Title XIX) and regulations (42 CFR), as well as subregulatory guidance provided by HHS.⁶

As described further under “Preparation and Tips for Working with CMS” later in this chapter, in deciding which state plan or waiver approach to use, a state should familiarize itself with the requirements, processes, and procedures applicable to each potential approach. States should also pursue an informal discussion with the appropriate Centers for Medicare & Medicaid Services (CMS) regional office or central office staff about the state’s proposal and the best approach for requesting authority to implement it.

The federal authorities covered in this section are not an exhaustive list of those that might be applicable to Medicaid health care purchasing,⁷ nor does the section identify all of the requirements and considerations for each authority. In addition, the available federal authorities and applicable requirements are not static. Congress may implement new authorities, and requirements for existing authorities may evolve through statutory changes, new or revised regulations, or subregulatory guidance. In addition, although the section summarizes federal authorities for health care purchasing and the applicable requirements, readers should not construe this document as constituting legal advice. Any state that is considering a new health care purchasing strategy should consult with legal counsel about the possible authorities and applicable requirements and considerations.

Note: On June 1, 2015, CMS published its long-awaited proposed rule that significantly revises Medicaid managed care rules, codified at 42 CFR Part 438. See 80 F.R. 31097 (June 1, 2015). Until this rule is finalized, it is advised that, in addition to reviewing current requirements contained in 42 CFR Part 438, the reader review the proposed rule for any potential revisions to sections of 42 CFR Part 438 cited here. Key provisions of the proposed rule address enhanced beneficiary experience, state delivery system reform, quality improvement, increased program and fiscal integrity, best practices for managed long-term services and supports programs, aligning Children’s Health Insurance Program (CHIP) managed care regulations with Medicaid, and alignment with Medicare Advantage and private coverage plans. Several key impacts of the proposed rule include a mandatory 14-day plan selection period for new enrollees; increased standardization in rate setting/actuarial certification; medical loss ratio standards for Medicaid; minimum provider credentialing standards; expanded plan responsibilities for program integrity/monitoring fraud and abuse; and new requirements for encounter data submission.⁸ The final regulations will be addressed in a future compendium update.

FUNDAMENTALS

STATE PLAN AMENDMENTS

General

As a condition of receiving federal funds for its Medicaid program, a state must have in effect a state Medicaid plan (state plan) approved by the secretary of the U.S. Department of Health and Human Services (HHS).⁹ The state plan is a comprehensive written statement that outlines the state’s Medicaid program and provides assurance that the state will administer the program in accordance with applicable federal statutes,

⁶ Subregulatory guidance includes the State Medicaid Manual (SMM), State Medicaid Director (SMD) letters, State Health Officer (SHO) letters, and information bulletins. The SMM is available on the Centers for Medicare & Medicaid Services (CMS) website at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html?DLPage=1&DLSort=0&DLSortDir=ascending> (accessed August 17, 2015). Note that the SMM is not regularly updated and might be superseded by statute, regulation, or other subregulatory guidance. The SMD and SHO letters and informational bulletins are available on the CMS website at <http://www.medicaid.gov/Federal-Policy-Guidance/federal-Policy-Guidance.html> (accessed August 17, 2015).

⁷ For example, the state plan option to implement pay for performance in fee-for-service is not discussed. See SHO letter April 6, 2006.

⁸ For more information, see 80 F.R. 31098 (June 1, 2015).

⁹ Section 1901 of the Act.

regulations, and official guidance.¹⁰ The state plan must include a description of the state Medicaid agency; Medicaid eligibility standards; the amount, duration, and scope of covered services; provider qualifications; reimbursement methodologies; and how the program will be administered.¹¹

If a state wants to make a change to the design or administration of its Medicaid program, as described in its approved state plan, the state must receive approval from the secretary of HHS. If the change is consistent with state plan requirements and does not require a request for a waiver of these requirements, the state submits the applicable state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) for review and approval.¹² To streamline the SPA process, CMS has developed a web-based application system, the Medicaid and CHIP Program (MACPro) system.¹³ If the state is proposing a change in its methods and standards for setting payment rates, the state may need to provide public notice as specified in 42 CFR 447.205.

Once CMS receives a SPA, it has 90 calendar days to approve or deny it or send a formal Request for Additional Information (RAI) letter.¹⁴ Sending an RAI stops the 90-day clock.¹⁵ The clock will not start again until CMS receives the state's written response to the RAI.¹⁶ Another 90-day clock starts at that point.¹⁷ CMS has the option of asking informal questions by e-mail or phone, which does not stop the clock.¹⁸ If significant problems are identified in a SPA, the state can take the SPA off the clock by notifying CMS that its submission is incomplete. Once the state has addressed the problems, it may resubmit the SPA, and a new 90-day clock will start. Throughout the process, the state also maintains the option to formally withdraw its SPA.

Based on its review of the SPA and any additional information provided during the review process, CMS will determine whether the SPA conforms to applicable federal statutes and regulations.¹⁹ If CMS approves a SPA, the changes can take effect retroactive to the first day of the quarter of the federal fiscal year in which the SPA was submitted.²⁰ However, because CMS will not provide federal financial participation (FFP) for a SPA until it has been approved, the state has to wait until approval to receive FFP (including retroactive funding).²¹ Once approved, a SPA does not expire, but a state can change it through a subsequent SPA. If CMS denies a SPA, a state may appeal the denial through the administrative review process.²²

The following provides information on those sections of the Social Security Act that relate to health care purchasing models: Section 1932(a) (managed care), Section 1937 (alternative benefit plan), Section 1945 (health homes), and Sections 1905(a)(25) and 1905(t)(1) (integrated care models).

Managed Care Pursuant to Section 1932(a) of the Act

Section 1932(a) of the Act enables a state to implement mandatory managed care using specified managed

¹⁰ 42 CFR § 430.10.

¹¹ Section 1902 of the Act.

¹² 42 CFR § 430.12.

¹³ The Centers for Medicare & Medicaid Services, "Medicaid and CHIP Program Portal," <http://www.medicaid.gov/State-Resource-Center/Medicaid-and-CHIP-Program-Portal/Medicaid-and-CHIP-Program-Portal.html> (accessed August 17, 2015).

¹⁴ 42 CFR § 430.16 and SMD letter January 2, 2001.

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid. For the Children's Health Insurance Program, the clock picks up from the day CMS issued the RAI (it does not restart). See 42 CFR § 457.160.

¹⁸ This is not specified in the regulations or subregulatory guidance but has been CMS practice for several years.

¹⁹ 42 CFR § 430.14 and 430.15.

²⁰ 42 CFR § 430.20.

²¹ SMD letter January 2, 2001.

²² 42 CFR § 430.18.

care models (primary care case management²³ or managed care organization²⁴ model) for most Medicaid populations without having to request a waiver. Under Section 1932(a) state plan authority, a state can implement managed care without regard to current Medicaid requirements, including freedom of choice,²⁵ statewideness, or comparability. Thus, a state can mandate enrollment of individuals who are not in an exempt population specified in Section 1932(a), provide managed care in specific geographic areas of the state, and provide services through managed care that are different than the benefit package provided in FFS.²⁶ In addition, the state may selectively contract for managed care as long as, in non-rural areas, individuals have a choice of at least two managed care entities.²⁷

However, a state can only use this authority to implement primary care case management (PCCM)²⁸ or managed care organization (MCO) models.²⁹ A state cannot use the authority to require enrollment in a prepaid inpatient health plan (PIHP),³⁰ such as a managed behavioral health organization, or a prepaid ambulatory health plan (PAHP),³¹ such as a prepaid dental benefits manager. In addition, under this authority enrollment must be voluntary for children with special needs,³² Medicare-Medicaid enrollees,³³ and American Indians.³⁴ To require enrollment in a PIHP or PAHP or require enrollment of any exempt population, the state would need to request a waiver pursuant to Section 1915(b) or Section 1115 of the act.

A state seeking to use Section 1932(a) managed care authority would complete a 1932(a) SPA using the state plan procedures and timeframes described above. The current 1932(a) SPA preprint is approximately 18 pages long and includes the following sections:

- General description of the program and public process;
- State assurances and compliance with the statute and regulations;
- Eligible groups;
- Identification of mandatory-exempt groups;
- Other eligible groups;
- Eligible groups who will be permitted to enroll on a voluntary basis;
- Enrollment process;

23 Primary care case management is a system under which a primary care case manager contracts with the state to furnish case management services (which include the location, coordination, and monitoring of primary health care services). "Primary care case manager" means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services, or, at state option, a physician assistant, a nurse practitioner, or a certified nurse-midwife. See 42 CFR § 438.2.

24 A managed care organization is an entity that has a comprehensive risk contract. See 42 CFR § 438.2.

25 Section 1902(a)(23) requires a Medicaid state plan to permit all Medicaid beneficiaries to obtain medical assistance from any qualified provider willing to provide the service.

26 However, unlike the authority in section 1937 of the Act, the state must provide services at least equal in amount, duration, and scope to services in the state plan. See CFR § 438.210.

27 Section 1932(a)(3) of the Act.

28 "Primary care case management" refers to a system under which a primary care case manager contracts with the state to furnish case management services (which include the location, coordination, and monitoring of primary health care services). "Primary care case manager" means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services, or, at state option, a physician assistant, a nurse practitioner, or a certified nurse-midwife. See 42 CFR § 438.2.

29 Section 1932(a)(1)(B) of the Act.

30 A prepaid inpatient health plan is an entity that provides health care services; is responsible for the provision of inpatient hospital or institutional services to enrollees; is paid on the basis of prepaid capitation payments or other payment arrangements that do not use state plan payment rates; and does not have a comprehensive risk contract. See 42 CFR § 438.2.

31 A prepaid ambulatory health plan is an entity that provides health care services; is not responsible for the provision of any inpatient hospital or institutional services for its enrollees; is paid on the basis of prepaid capitation or other payment arrangement that does not use state plan payment rates; and does not have a comprehensive risk contract. See 42 CFR § 438.2.

32 Section 1932(a)(2)(A) of the Act for the definition of children with special needs.

33 Section 1932(a)(2)(B) of the Act.

34 A state may require American Indians to enroll in managed care if Indian Health Service, Tribal, or Urban Indian providers are available to them as managed care entities. See section 1932(a)(2)(C) of the Act.

- State assurances on the enrollment process;
- Disenrollment;
- Information requirements for beneficiaries;
- Services excluded from managed care; and
- Selective contracting (whether the state will selectively contract and if so the criteria the state will use).³⁵

Most of the application sections require the state to check the appropriate box. However, there are requests for some narrative descriptions. For example, the state must: describe its public process; list mandatory, voluntary, and exempt populations; explain how it identifies exempt populations (for example, children with special needs); and describe the default enrollment process, including its automatic assignment algorithm.

In addition to the completed SPA, the state must submit the contract to CMS for prior approval.³⁶ CMS recommends that a state submit the contract at least 60 days before its desired effective date to ensure no delay in implementation or loss of FFP.³⁷ All Medicaid managed care programs must comply with applicable federal requirements, including the Medicaid managed care requirements in Section 1932 of the act and 42 CFR Part 438 (see [chapter 2](#) of this section for additional information).

Alternative Benefit Plans Pursuant to Section 1937 of the Act

Section 1937 of the act permits a state to amend its Medicaid state plan to provide for the use of benefit packages other than its standard Medicaid benefit package for certain populations. Under this state plan authority, a state can implement one or more alternative benefit plans³⁸ (ABPs) without complying with requirements for statewideness and comparability.³⁹ Thus, unlike with regular state plan services, the state may offer an ABP in certain geographic areas and may have different benefit packages for different populations. In addition to providing a different benefit package, a state can use Section 1937 authority to provide the ABP through managed care as long as it complies with all managed care requirements in Section 1932 of the act and 42 CFR Part 438.⁴⁰ However, if a state intends to use a payment methodology ABP that is not currently in its state plan, it needs to submit a separate payment SPA.⁴¹

Although Section 1937 provides flexibility to implement ABPs, there is a limit to that flexibility. Any ABP must be based on benchmark⁴² or benchmark-equivalent⁴³ packages and, as required by the Affordable Care

35 The section 1932(a) SPA preprint is currently not available on the CMS website. The state can request a copy from its CMS regional office.

36 42 CFR § 438.6 and 42 CFR § 438.806.

37 The Centers for Medicare & Medicaid Services, “Providing Long-Term Services and Supports in a Managed Care Delivery System,” December 2009.

38 78 F.R. 42160 (July 15, 2013) (final rule) and 42 CFR § 440.300 et seq.

39 Section 1937 of the Social Security Act. In addition, the statute says that a state does not need to comply with “any other provision” of Title XIX that “would be directly contrary to the authority under” section 1937. In the preamble to the proposed rule, CMS stated that all Title XIX provisions apply, unless “a state can satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement Alternative Benefit Plans under section 1937 of the act.” See 78 F.R. 42224 (July 15, 2013).

40 42 CFR § 440.385. See also chapter 2 of section 2 for additional detail on Medicaid managed care requirements.

41 Section 1937 SPA template available on the CMS website through the Medicaid and CHIP program portal at <http://157.199.113.99/MMDLDOC/abp.html> (accessed August 17, 2015).

42 Four benchmark packages are described in section 1937 of the act: the benefit package provided by the Federal Employees Health Insurance Benefit plan Standard Blue Cross/Blue Shield Preferred Provider Option; state employee health coverage that is offered and generally available to state employees; the health insurance plan offered through the HMO with the largest insured, commercial non-Medicaid enrollment in the state; and secretary-approved coverage. See also 42 CFR § 440.330.

43 To be benchmark-equivalent, the aggregate actuarial value of the proposed benefit package must be at least actuarially equivalent to the coverage provided by one of the benchmark plans. Section 1937 of the act further provides that certain categories of benefits must be provided in any benchmark-equivalent plan, and other categories of benefits must include “substantial actuarial value” compared with the benchmark package. See also 42 CFR § 440.335.

Act (ACA), must also include essential health benefits (EHBs).⁴⁴ To demonstrate that its ABP includes EHBs, the state must identify a base benchmark plan for EHBs and, in general, compare each benefit in each EHB category to ensure that the benefit in the ABP is as rich as the benefit in the base benchmark. If the ABP does not include a benefit that is in the base benchmark or an ABP benefit is not as rich as the benefit in the base benchmark plan, the state can substitute an actuarially equivalent ABP benefit or group of benefits within that EHB for the benefit in the base benchmark plan. In addition, to meet EHB requirements the ABP must include a broad range of preventive services as well as habilitation services and must meet the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). A state must also either include or provide access to specified Medicaid services, such as non-emergency transportation and early and periodic screening, diagnostic and treatment (EPSDT) for children under the age of 21.⁴⁵

Except for the new group of adults authorized by the ACA,⁴⁶ most Medicaid populations cannot be required to enroll in an ABP. Besides the new adult group, a state may require individuals who are not identified as exempt from enrollment in an ABP (for example, “optional parents” or those above a certain income level and certain children) to enroll in an ABP. A state may not require exempt individuals (for example, “mandatory parents” or those below a certain income level, individuals who are eligible for Medicaid based on age or disability, Medicare-Medicaid enrollees, and individuals who are medically frail)⁴⁷ to enroll in an ABP. However, a state may provide the option for exempt individuals to voluntarily enroll in an ABP if the state complies with specified protections, including allowing enrollees to disenroll from the ABP at any time.⁴⁸

To implement an ABP, a state would complete and submit a Section 1937 SPA using the state plan procedures and timeframes described above under “General.” However, under 42 CFR 440.386, the state must provide for public notice and comment before submitting a Section 1937 SPA.

The ABP SPA⁴⁹ includes the following sections, and CMS issued implementation guides for each section.⁵⁰

- **ABP1:** ABP Populations (identifies the eligibility groups that will be included in the ABP population and the geographic area).
- **ABP2a:** Voluntary Benefit Package Selection Assurance (for the new adult group if the ABP for the new adult group is not aligned with the state’s Medicaid plan).
- **ABP2b:** Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group (if the state will voluntarily enroll exempt populations).
- **ABP2c:** Enrollment Assurances – Mandatory Participants (if the ABP for the new adult group is not aligned with the state’s Medicaid plan or the state will mandatorily enroll one or more other eligibility groups).
- **ABP3:** Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package (identifies the state’s benchmark benefit package or benchmark-equivalent benefit package and the base benchmark plan for EHBs).

44 Section 1937 of the act and 42 CFR § 440.347. The ACA requires health plans offered in the individual and small group markets, both inside and outside of Health Insurance Exchanges/Marketplaces to offer a core package of items and services, known as EHBs. Under the ACA, EHBs must include items and services within the following 10 benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

45 Section 1937 of the act and 42 CFR § 440.345, 440.365, and 440.390.

46 Sections 1902(a)(10)(A)(i)(VIII) and 1902(k) of the act.

47 Section 1937(a)(2)(B) of the act and 42 CFR § 440.315.

48 42 CFR § 440.320.

49 The section 1937 SPA template is available on the CMS website at <http://157.199.113.99/MMDLDOC/abp.html> (accessed August 17, 2015).

50 Implementation guides are available at <https://wms-mmdl.cdsvdc.com/MMDLDOC/abpIG.html> (accessed August 17, 2015).

- **ABP4:** ABP Cost-Sharing.
- **ABP5:** Benefits Description.
 - » Description of each ABP benefit, by EHB category, that duplicates a benefit in the base benchmark plan, including the name of the benefit, the type of authorization (if any) and any amount, duration or scope limits;
 - » Description of any benefits in the ABP from the base benchmark plan that are not EHBs;
 - » Description of benefits in the base benchmark plan that are covered in the ABP through duplication (the ABP includes the same benefit but maybe has a different name) or substitution (the ABP does not include the same benefit but includes another benefit in the same EHB category that is actuarially equivalent to the benefit in the base benchmark plan);
 - » Description of benefits in the base benchmark that are not covered in the ABP, including why the benefit is not covered in the ABP;
 - » Description of benefits in the ABP that are not EHBs and are not used for substitution; and
 - » Description of additional ABP benefits (not applicable to the adult group).
- **ABP6:** Benchmark-Equivalent Benefit Package (if the state selects the benchmark-equivalent benefit package option instead of the benchmark benefit package option).
- **ABP7:** Benefits Assurances (includes, for example, assurances regarding EPSDT and prescription drug coverage).
- **ABP8:** Service Delivery Systems (describes the delivery system, such as managed care or FFS, the state will use to provide the ABP benefits)
- **ABP9:** Employer Sponsored Insurance and Payment of Premiums (if the state will provide the ABP through employer sponsored insurance or otherwise provides for payment of premiums).
- **ABP10:** General Assurances.
- **ABP11:** Payment Methodology (state assures that services provided FFS will be reimbursed using the payment methodology in the state's Medicaid plan or submits a SPA for a new payment methodology).

While most sections of the ABP SPA can be completed relatively quickly, ABP5: Benefits Description is fairly complicated and requires a significant amount of time to complete, including multiple calls with CMS. Some of the key issues include determining where/how to list the benefits, the approach to habilitation services, compliance with MHPAEA, and substitution/actuarial equivalence.

In addition to the completed SPA, if the state is contracting with an MCO, PIHP, or PAHP, it must submit the contract to the appropriate CMS regional office for prior approval.⁵¹

Health Homes Pursuant to Section 1945 of the Act

Section 1945 of the act, added by Section 2703 of the ACA, allows a state to amend its state plan to establish health homes to coordinate care for Medicaid beneficiaries who have chronic conditions and to pay health homes using innovative payment methodologies.⁵² Because the statute authorizes a state not to comply

⁵¹ 42 CFR § 438.6 and 438.806.

⁵² Section 1945(c)(2)(A) of the act specifically permits states to structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the "capabilities" of the provider. In addition, section 1945(c)(2)(B) of the act permits states to propose alternative models of payment that are not limited to per-member per-month payments for CMS approval. See section 1945 of the act and SMD letter November 16, 2010.

with statewideness and comparability requirements,⁵³ a state can offer health home services in a specific geographic location and offer them in a different amount, duration, and scope than services provided to individuals not in the health home population. However, it is difficult to narrowly target a specific population. For example, states may not specifically target by age or delivery system.⁵⁴

Although CMS does not allow states to require enrollment in a health home, a state can assign beneficiaries to a health home as long as they can opt out.⁵⁵ Unlike a Section 1932(a) managed care SPA or a Section 1937 ABP SPA, a health home SPA must include detailed information on how the state will monitor the program⁵⁶ and how it will provide information for evaluation.⁵⁷ Also, after approval of a health home SPA, the state needs to submit an administrative reporting document with several specified quality measures.⁵⁸ A state may include health homes as part of a non-FFS service delivery system (for example, a PCCM or MCO authorized through a Section 1932 SPA or a Section 1915(b) waiver).⁵⁹

A state may provide health homes to individuals who have at least two chronic conditions; who have one chronic condition and are at risk of another; or who have a serious and persistent mental health condition.⁶⁰ A state can specify the population criteria, including whether the person must have two chronic conditions, one chronic condition with risk for another, and so on, and the eligible conditions. For example, a state could develop a health home SPA for individuals with diabetes who are at risk for heart disease or one for individuals who meet the state's definition of serious mental illness. As provided in the statute, health home services must include comprehensive care management; care coordination and health promotion; comprehensive transitional care; individual and family support; referral to community and social support services; and use of health information technology.⁶¹ The statute provides a financial incentive for states to implement this option by authorizing an enhanced (90 percent) federal medical assistance percentage (FMAP) during the first two years that a health home SPA is in effect (a state may have more than one health home SPA but can only claim eight quarters of enhanced FMAP for each health home enrollee).⁶²

To implement a health home for individuals with chronic conditions, a state would complete and submit a health home SPA using the state plan procedures and timeframes described above under "General." However, CMS requires that health home SPAs be submitted via a web-based system.⁶³ In addition, because a health home SPA changes payment methodologies, the state must provide public notice in accordance with 42 CFR 447.205. The SPA timeframes apply, but because this is a fairly complicated option, many health home SPAs have required considerable negotiation with CMS. Also, after approval of a health home SPA, the state must submit an administrative reporting document with information on monitoring, quality measures, and the

53 Section 1945(a) of the act provides "notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the secretary determines it is necessary to waive in order to implement this section." However, the secretary has not provided guidance regarding what other provisions may be waived.

54 The Centers for Medicare & Medicaid Services, "Guide to Medicaid Health Home Design and Implementation," <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/guide-to-health-homes-design-and-implementation.html> (accessed August 17, 2015).

55 The Centers for Medicare & Medicaid Services, "Health Home Information Resource Center," <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html> (accessed August 17, 2015).

56 This includes the state's methodology for tracking avoidable hospital readmissions, the state's methodology for calculating cost savings, and the state's proposal for using HIT. See section 1945(f) of the act and the health home SPA preprint.

57 This includes how the state will collect information from health home providers to determine the effects of the program on reducing hospital admissions, ER visits, and skilled nursing facility (SNF) admissions and how the state will collect information to inform the CMS evaluation, including information on program implementation, lessons learned, and clinical outcomes. See section 1945(g) of the act and the health home SPA preprint.

58 Health home SPA preprint and SMD letter January 15, 2013, regarding health home core quality measures.

59 See the health home SPA preprint.

60 Section 1945(h) of the act and SMD letter November 16, 2010.

61 Section 1945(h) of the act and SMD letter November 16, 2010.

62 Section 1945(c)(1) of the act and SMD letter November 16, 2010.

63 The Centers for Medicare & Medicaid Services, "MMDL Medicaid Model Data Lab," <https://wms-mmdl.cdsvdc.com/MMDL/faces/portal.jsp> (accessed August 17, 2015).

state's goals and quality measures and provide information for evaluation of the program.

The health home SPA consists of two parts: the health home SPA template and the health home administrative component SPA template, an administrative addendum. The health home SPA template is approximately 11 pages long but requires a significant amount of narrative.⁶⁴ The template includes the following sections:

- Public notice (how public comment was solicited);
- Tribal input (which organizations were consulted and method of tribal input);
- Consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) (the date of the SAMHSA consultation);
- Population criteria and enrollment (population criteria, geographic area, enrollment of participants, including whether individuals opt in or are auto-assigned with an opt-out option, and assurances);
- Provider requirements (types of providers, supports for providers, provider infrastructure, and provider standards);
- Service delivery system (type of delivery system such as FFS, PCCM, risk-based managed care, or other; PCCM information [whether duplicate payments are provided to PCCM and health homes]; risk-based managed care information [summary of contract language regarding health home services, and payment methodology for health home services]; health plans as a designated provider or part of a team [summary of contract language regarding health home services and payment methodology for health home services]; other service delivery system [if providers will be designated providers or part of a team and how payment will be made]);
- Payment methodology (type of payment methodology, for example, FFS, PCCM, risk-based managed care, or other, and whether payment will be tiered);
- Health home services (for each service, the service definition, ways that health information technology [HIT] will link services, provider types furnishing the service, health home patient flow, and benefits to medically needy groups);
- Monitoring (the state's methodology for tracking avoidable hospital readmissions, the state's methodology for calculating cost savings, the state's proposal for using HIT, and assurances regarding quality measurement); and
- Evaluations (how the state will collect information from health home providers to determine the effects of the program on reducing hospital admissions, ER visits, and skilled nursing facility [SNF] admissions and how the state will collect information to inform the evaluations as it pertains to hospital admission rates, chronic disease management, coordination of care, assessment of program implementation, processes and lessons learned, assessment of quality improvements and clinical outcomes, and estimates of cost savings).

The health home administrative component SPA template⁶⁵ is approximately three pages long but requires a significant amount of narrative. The template includes the following sections:

- Monitoring (estimate of the number of individuals to be served during the first year of operations and the estimate of cost savings);

⁶⁴ The Centers for Medicare & Medicaid Services, "Health Home SPA Template," <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-spa-template-2/14.pdf> (accessed August 17, 2015).

⁶⁵ The Centers for Medicare & Medicaid Services, "Health Home Administrative Component SPA Template," <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/administrative-component-spa-template.pdf> (accessed August 17, 2015).

- Quality measurement (the health home core quality measures); and
- State goals and quality measures (state-specific goals and measures).

CMS has established a health home information resource center that includes legal resources (for example, the statute, state Medicaid director letters (SMDLs), and the preprint), approved SPAs, and resources to help states design and implement health homes for individuals with chronic conditions, including one-on-one technical assistance.⁶⁶

Integrated Care Models (ICMs) Pursuant to Sections 1905(a)(25) and 1905(t)(1) of the Act

CMS has issued a series of letters providing states with guidance on designing and implementing integrated care models (ICMs).⁶⁷ CMS uses the term “ICM” to describe models that include (but are not limited to) medical homes, health homes, accountable care organizations (ACOs), ACO-like models, and other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care.⁶⁸ The first letter in the series (SMDL #12-001) describes the context for the development of the ICM guidance. The second letter in the series (SMDL #12-002) describes a new state plan option under PCCM authority (Sections 1902(a)(25) and 1905(t) of the Social Security Act) for states to implement ICMs through the state plan as an alternative to 1915(b) waivers and managed care. In that letter, CMS indicates that it will “issue future guidance specifically addressing ICM implementation within risk-bearing managed care contracts,” but as of May 2015, that guidance had not been provided.⁶⁹ The third letter in the series (SMDL #13-005) focuses on shared savings methodologies. The fourth letter (state health official letter [SHOL] #13-007) provides a framework for quality improvement and measurement.

According to SMDL #12-002, states may use the authority “to offer coordinating, locating and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures. Under this authority, states may opt to reimburse providers through a ‘per member per month’ (PMPM) arrangement or create quality incentive payments that could be calculated as a percentage of demonstrable program savings and shared with participating providers either directly or through umbrella provider network arrangements, also known as ‘shared savings’ (for example, ACO or ACO-like programs).”⁷⁰

SMDL #12-002 also identifies requirements⁷¹ that the state should consider when designing and implementing ICMs as an optional state plan service using the authority of Section 1905(t)(1), including provider qualifications and service definitions; comparability and freedom of choice; beneficiary protections; reimbursement (FFS, PMPM care coordination payments, or payment for quality improvement and shared program savings); and accountability of PMPM activities (states “must have a transparent process to review evidence of these activities and the resulting benefit”).⁷² Other considerations, which apply regardless of the authority (state plan or waiver), include provider designation, provider attribution methodology, connecting incentives to outcomes improvement, and patient engagement. Attachment 2 of SMDL #12-002 lists questions for states to consider in developing ICMs. These questions have also been incorporated into a Concept Development Toolkit for ICMs that CMS encourages states to review to assist in the ICM design and submission to CMS.⁷³

66 The Centers for Medicare & Medicaid Services, “Health Home Information Resource Center,” <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html> (accessed August 17, 2015).

67 The Centers for Medicare & Medicaid Services, “State Toolbox: Value-Based Purchasing,” <http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Learning-Collaborative-State-Toolbox/State-Toolbox-Value-Based-Purchasing.html> (accessed August 17, 2015).

68 SMD letter July 10, 2012, regarding integrated care models, and SMDL July 10, 2012, regarding policy considerations for integrated care models.

69 SMD letter July 10, 2012, regarding policy consideration for integrated care models.

70 Ibid.

71 Chapter 2 of this section provides additional detail on these requirements.

72 SMD letter July 10, 2012, regarding policy considerations for integrated care models.

73 Medicaid and CHIP Learning Collaboratives, “Integrated Care Models in Medicaid: Concept Development Toolkit,” The Centers for Medicare & Medicaid Services, <http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Downloads/ICM-toolkit-for-states.pdf> (accessed August 17, 2015).

To implement an ICM as a state plan option under Section 1905(t), a state would need to submit a SPA and comply with the state plan requirements for comparability, freedom of choice, and statewideness. However, at this time there is no ICM SPA preprint/template available. Instead, a state interested in this option is encouraged by CMS to review the ICM SMDLs/SHOLs, review the questions in the ICM Concept Development Toolkit, and work with CMS in advance on the ICM concept development. CMS requests that states submit a concept paper before submitting an ICM SPA that includes an overview, programmatic considerations, gaps and barriers, program design, quality strategy, and payment methodology. The sections are outlined in the ICM Concept Development Toolkit and covered by CMS as part of a webinar sponsored by the Medicaid and CHIP (MAC) Learning Collaborative on Value-Based Purchasing on ICMs.⁷⁴ Also, because an ICM SPA changes payment methodologies, the state must provide public notice in accordance with 42 CFR 447.205.

To implement an ICM that operates on a sub-state basis, restricts freedom of choice, targets populations in a manner not consistent with state plan requirements for comparability, selectively contracts with providers, or operates under a capitated payment methodology, a state would need to consider an alternative authority (for example, Section 1932(a) state plan authority or 1915(b) waiver authority).

WAIVER AND RELATED DEMONSTRATION AUTHORITIES

If a state's desired program does not comply with current state plan requirements and cannot be implemented through a SPA (for example, the state wants to enroll exempt populations into managed care), the state must request waiver authority to implement the program. There are three basic types of authority that allow for waivers of certain federal requirements – Section 1915(b), Section 1915(c), and Section 1115 of the Social Security Act. In addition, although not technically a waiver authority, Section 1915(a) of the act can be used to implement a voluntary managed care program.

Contract for Voluntary Managed Care Pursuant to Section 1915(a) of the Act

Section 1915(a) of the act provides a vehicle for a state to implement voluntary enrollment into capitated managed care, based on CMS approval of a contract, without submitting a SPA or a waiver.⁷⁵ Section 1915(a) provides that a state is not out of compliance with freedom of choice, statewideness, or comparability of services if it has entered into a contract with an organization to provide services in addition to state plan services to Medicaid beneficiaries who reside in the geographic area served by the organization.⁷⁶ The state can design a contract that serves a particular geographic region of the state or that provides a uniquely designed service package for particular populations.⁷⁷ The state can specify the type of entity (PAHP, PIHP, or MCO), under current CMS policy, but cannot limit the number of qualified providers who can serve as the contracting entity.⁷⁸ Also, the state cannot require Medicaid beneficiaries to receive services through the contract; however, a state may assign enrollees to a contractor if enrollees can opt out.⁷⁹ States generally use this authority for specialized, voluntary programs, such as paying capitation to providers to provide primary care and other services to individuals with HIV/AIDS or capitating a local agency to provide support to children with severe emotional disturbance.⁸⁰ As with Medicaid managed care programs authorized under other authorities, Section 1915(a) managed care programs must comply with applicable federal requirements,

74 The Centers for Medicare & Medicaid Services, "State Toolbox: Value-Based Purchasing," <http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Learning-Collaborative-State-Toolbox/State-Toolbox-Value-Based-Purchasing.html> (accessed August 17, 2015).

75 The Centers for Medicare & Medicaid Services, "At-a-Glance Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment," April 2012, <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf> (accessed August 17, 2015).

76 Section 1915(a) of the Act.

77 The Centers for Medicare & Medicaid Services, "Providing Long-Term Services and Supports in a Managed Care Delivery System," December 2009.

78 Ibid; and The Centers for Medicare & Medicaid Services, "At-a-Glance Guide to Federal Medicaid Authorities Useful in Restructuring Medicaid Health Care Delivery or Payment," April 2012, <http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf> (accessed August 17, 2015).

79 Ibid.

80 The Centers for Medicare & Medicaid Services, "National Summary of State Medicaid Managed Care Programs as of July 1, 2011," <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-national-summary-mc-report.pdf> (accessed August 17, 2015).

including the Medicaid managed care requirements in Section 1932 of the act and 42 CFR Part 438. See [Chapter 2](#) of this section for additional information.

Waiver Pursuant to Section 1915(b) of the Act

Historically (before the enactment of Section 1932(a) of the act), Section 1915(b) waiver authority was used to mandate enrollment into managed care. Today, states use Section 1915(b) authority instead of Section 1932(a) managed care authority for three primary reasons. First, under a Section 1915(b) waiver, a state can request mandatory enrollment of populations exempt from enrollment under Section 1932(a), including children with special needs and Medicare-Medicaid enrollees. Second, under a Section 1915(b) waiver a state can mandate enrollment in PIHPs and PAHPs or a single PIHP or PAHP. Third, under a Section 1915(b) waiver a state can offer enrollees additional services paid for through savings achieved under the waiver. A couple of states also use a Section 1915(b) waiver to implement selective contracting in FFS.

To receive approval for a Section 1915(b) waiver, the state must complete a Section 1915(b) application, including demonstrating that the proposed program is cost-effective. Also, unlike a SPA, a Section 1915(b) waiver must be renewed periodically. In general, Section 1915(b) waivers are approved initially for two years and renewed for two-year periods; however, pursuant to the ACA, the secretary of HHS has authority to approve waivers that include Medicare-Medicaid enrollees for up to five years (initial and renewed).

Section 1915(b) of the act authorizes the secretary of HHS to waive certain requirements of Section 1902 for the following purposes to the extent it is cost-effective and efficient:

- Require beneficiaries to obtain medical care through a PCCM, MCO, PIHP, or PAHP (Section 1915(b)(1)), including populations exempt from Section 1932(a) managed care authority and models excluded from Section 1932(a);
- Allow a county or local government to act as a choice counselor or enrollment broker to help individuals pick a managed care entity (Section 1915(b)(2));
- Share cost savings resulting from the use of more cost-effective medical care with enrollees, by providing them additional services (Section 1915(b)(3)); and
- Require enrollees to obtain services only from specified, qualified providers (Section 1915(b)(4)).

Section 1915(b) authorizes the secretary to waive requirements of Section 1902 of the act (State Plans for Medical Assistance) related to the purposes listed above. However, in practice CMS generally uses this authority to waive three key Medicaid state plan requirements--freedom of choice, statewideness, and comparability--and also uses Section 1902(a)(4) to allow a state to mandate enrollment into a single PIHP or PAHP or to waive managed care requirements related to PIHPs or PAHPs.

CMS has developed preprints and instructions for Section 1915(b) waivers, and states can complete the application through a web-based system.⁸¹ The most recent standard Section 1915(b) preprint⁸² is approximately 80 pages long and includes the following key sections:

- Program overview;
- Access;
- Quality;

⁸¹ CMS Waiver Applications, <https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp> (accessed August 17, 2015). Note that a username and password are required to access this portal.

⁸² This preprint is currently not available on the CMS website. States should request a copy of the preprint from their CMS regional office.

- Program operations;
- Monitoring; and
- Cost-effectiveness.

Except for the section on cost-effectiveness, the Section 1915(b) application mostly requires the state to check the appropriate box or provide a couple of sentences of narrative. Also, certain items apply only to a specific model (for example, PCCM, PAHP, or MCO/PIHP) and therefore may not need to be completed.

The cost-effectiveness section generally requires significant time and resources. The section includes several tables/spreadsheets that need to be completed with information on base year and projected member months, service costs, and administrative costs. To complete the tables/spreadsheets, the state must determine the grouping of beneficiaries into Medicaid Eligibility Groups (MEGs) based on eligibility, geography, or cost (to group populations with similar costs and similar caseload growth together); project the number of member months by Medicaid eligibility group for each year of the waiver; identify the state plan services to be included in the waiver and project PMPM state plan costs by MEG for each year of the waiver; and identify and project the PMPM cost of administrative costs by MEG for each year of the waiver. In addition, if the state will provide incentive payments to the managed care entity outside of capitation,⁸³ it must project the PMPM costs by MEG for the incentive payments for each year of the waiver. Also, if the state will provide Section 1915(b)(3) services, it must project the PMPM cost of those services by MEG for each year of the waiver. Note that by including incentive payments and the cost of Section 1915(b)(3) services in the cost-effectiveness test, the costs for these items are limited to the savings of state plan service costs under the waiver.⁸⁴

For cost-effectiveness, the state must demonstrate that waiver cost projections (including costs for services, administration, incentive payments, and Section 1915(b)(3) services) for the waiver period are reasonable and consistent with statute, regulations, and guidance.⁸⁵ For CMS to renew a Section 1915(b) waiver, the state must demonstrate that the actual waiver cost (as reflected in the state's CMS-64s) was less than the projection during the retrospective period.⁸⁶

CMS has modularized its current Section 1915(b) waiver application to separate the various statutory authorities.⁸⁷ First in this process is a streamlined application for states to selectively contract with providers under their FFS delivery system.⁸⁸ The Section 1915(b)(4) template for FFS selective contracting is only 14 pages and includes a simplified methodology for demonstrating cost-effectiveness.⁸⁹

The state submits the completed preprint to both the CMS central office (electronic and hard copy) and the applicable regional office (at least one hard copy) for review and approval.⁹⁰ States can use the CMS waiver management system to complete and submit an electronic copy of the Section 1915(b).⁹¹

83 For example, the state might make an incentive payment if the managed care entity meets specified performance standards as part of a pay-for-performance program.

84 In other words, the cost for incentive payments and 1915(b)(3) services cannot exceed the projected savings for the program.

85 The Centers for Medicare & Medicaid Services, "Draft Regional Office Resource for 1915(b) Cost Effectiveness," November 2006. A state should request this document from its CMS regional office.

86 Ibid. Form CMS 64 is a quarterly statement of actual program costs and administrative expenditures for which states are entitled to federal reimbursement under the authority of Title XIX of the act.

87 The Centers for Medicare & Medicaid Services, "MMDL Medicaid Model Data Lab," <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Managed-Care-1915-b-Waivers.html> (accessed August 17, 2015).

88 Ibid.

89 Ibid.

90 Instructions to the section 1915(b) preprint are available from the state's CMS Regional Office.

91 CMS Waiver Applications, <https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp> (accessed August 17, 2015).

The timeframe for CMS review of a Section 1915(b) waiver is the same as for a SPA.⁹² However, unlike with a Section 1932(a) SPA (or a Section 1915(a) contract), a federal review team is often assigned to review the waiver. That team includes staff from the Office of Management and Budget (OMB) and may include staff from SAMHSA and Health Resources and Services Administration (HRSA). Unlike with a SPA, a Section 1915(b) waiver is effective prospectively; it cannot be effective prior to the date of actual approval.⁹³

As with a Section 1932(a) SPA or Section 1915(a) authority, if the state uses a Section 1915(b) waiver to deliver services using a managed care system, the contract must be approved first by CMS. In addition, unless a provision is waived, the program must comply with applicable federal requirements, including the Medicaid managed care requirements in Section 1932 of the Act and 42 CFR Part 438.⁹⁴ Unlike what happens with a Section 1932(a) SPA or Section 1915(c) authority, for CMS to track cost-effectiveness, the state must amend its CMS-64⁹⁵ to reflect costs by MEG and provide reports on member months by MEG.⁹⁶ Also, as part of the first two renewal requests, the state must submit a completed independent assessment of the program's impact on access, quality, and cost-effectiveness.⁹⁷

HCBS Waiver Pursuant to Section 1915(c) of the Act

Section 1915(c) of the Social Security Act authorizes the secretary to waive certain requirements of Section 1902 of the act for states that want to offer an array of home- and community-based services (HCBS), such as homemaker, habilitation, and respite, as an alternative to services in institutional settings for individuals who meet the state's criteria (level of care) for institutional services.⁹⁸ Section 1915(c) authorizes the secretary to waive requirements of Section 1902 related to statewideness, comparability, and income and resource rules.⁹⁹ Thus, under a Section 1915(c) waiver (often referred to as an HCBS waiver) a state can target services to certain populations, provide the services in specified geographic areas, and expand Medicaid eligibility to include individuals who would be eligible if institutionalized (by applying the state's institutional income and resource rules in the community). In addition, the statute permits a state to limit the number of individuals served by the waiver program.¹⁰⁰ To receive approval for an HCBS waiver, the state must complete a comprehensive application that, among other items, requires the state to describe its quality management strategy, including specific performance measures, and demonstrate that the cost of providing services (HCBS and state plan services) to an individual enrolled in the waiver is no more than the cost of providing services (institutional and other state plan services) to an individual in an institution.

CMS has developed a preprint and instructions for Section 1915(c) waivers and requires states to submit a Section 1915(c) application through a web-based system.¹⁰¹ The current preprint is 125 pages long and includes the following sections:

- Administration and operation (state lines of authority and distribution of waiver operational and administrative functions);

92 42 CFR § 430.25(f).

93 42 CFR § 430.25(h).

94 Chapter 2 of this section has additional detail on these requirements.

95 The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS 64) is a quarterly statement of actual program costs and administrative expenditures for which states are entitled to federal reimbursement under the authority of Title XIX of the act. See, for example, chapter 11 of the Medicaid Program Integrity Manual, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mpii15c11.pdf> (accessed August 17, 2015); and also 42 CFR § 430.30.

96 The Centers for Medicare & Medicaid Services, "Draft Regional Office Resource for 1915(b) Cost Effectiveness," November 2006. A state should request this document from its CMS regional office.

97 Section 1915(b) waiver preprint and instructions are available from the state's CMS regional office.

98 Section 1915(c) of the act, 42 CFR § 441 subpart G and 42 CFR § 440.180(b).

99 Section 1915(c) of the act and 42 CFR § 430.25(d)(2).

100 Sections 1915(c)(9) and (10) of the act.

101 CMS Waiver Applications, <https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp> (accessed August 17, 2015). A username and password may be obtained through the state's CMS regional office.

- Participant access and eligibility (the target group(s), the projected number of participants per year, Medicaid eligibility and post-eligibility requirements, and procedures for the evaluation and re-evaluation of level of care);
- Participant services (the HCBS, including applicable limitations on such services, and applicable provider qualifications);
- Participant-centered service planning and delivery (the state's procedures and methods to develop, implement, and monitor the participant-centered plans of care);¹⁰²
- Participant direction of services (if applicable, the participant direction opportunities that are offered and the supports that are available to participants who direct their services);
- Participant rights (how the state informs participants of their fair hearing rights and other procedures to address participant grievances and complaints);
- Participant safeguards (the safeguards that the state has established to ensure the health and welfare of waiver participants, including critical events and medication management and administration);
- Quality improvement strategy (specific performance measures must be included in the other sections of the waiver);¹⁰³
- Financial accountability (the state's payment method, how it ensures the integrity of the payments, and how it complies with applicable federal requirements concerning payments and federal financial participation); and
- Cost neutrality demonstration.¹⁰⁴

Most of the Section 1915(c) application requires checking the appropriate boxes and providing a couple of sentences of narrative; however, several sections require a few paragraphs of explanation. For cost neutrality, the state needs to complete tables to demonstrate that the average per-participant expenditures for the waiver and non-waiver Medicaid services are no more costly than the average per-person costs of furnishing institutional and other Medicaid state plan services to persons who require the same level of care. Areas that states have found challenging when completing and seeking approval of an HCBS waiver include the requirements for a quality improvement strategy (developing performance measures, methods for remediation, and systems improvement strategies), developing an effective critical event or incident reporting process, and ensuring effective oversight if the state delegates functions to another state agency.

In addition, states have to comply with the HCBS final rule, which was effective March 17, 2014.¹⁰⁵ This rule makes several important changes to the 1915(c) HCBS waiver program.¹⁰⁶ One of the biggest changes is the requirement that home- and community-based settings have certain qualities. For example, the setting must be integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same

¹⁰² As discussed below, in January 2014 CMS issued a final rule that includes specific requirements for the person-centered planning process and the person-centered service plan. See 79 F.R. 2948 (January 16, 2014) and information on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html> (accessed August 17, 2015).

¹⁰³ CMS recently modified the quality assurance systems needed to meet the assurances for section 1915(c) waivers. All new waiver applications and renewals submitted after June 1, 2014 must incorporate these modifications, which can be found at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf> (accessed August 17, 2015).

¹⁰⁴ The current preprint (version 3.5) is available at <https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp> (accessed August 17, 2015).

¹⁰⁵ 79 F.R. 2948 (January 16, 2014). See also information on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html> (accessed August 17, 2015).

¹⁰⁶ Ibid; Note, this rule also makes changes to requirements for section 1915(i) and section 1915(k) programs.

degree of access as individuals not receiving Medicaid HCBS.¹⁰⁷ The rule also includes specific requirements for the person-centered planning process and minimum requirements for the person-centered service plan. The rule provides states with the opportunity to combine existing waiver target groups (for example, aged or disabled individuals and individuals with intellectual or developmental disabilities), which removes a barrier for states that wish to design a waiver that meets the needs of more than one target population. The rule also clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates. Finally, it describes the additional strategies available to CMS to ensure state compliance with the statutory provisions of Section 1915(c).¹⁰⁸

Section 1915(c) waivers that do not include Medicare-Medicaid enrollees are approved initially for three years and renewed for five-year periods. Pursuant to the ACA, the secretary has authority to approve waivers that include Medicare-Medicaid enrollees for up to five years (initial and renewed). The state submits the completed application through the CMS waiver management system.¹⁰⁹

The timeframe for CMS review of a Section 1915(c) waiver is the same as for a SPA.¹¹⁰ However, all 1915(c) waiver applications are reviewed jointly by the central office and the appropriate regional office. After approval, states must submit annual reports (CMS-372s) with cost, utilization, and quality data related to the waiver. This report is submitted online.

Until the Deficit Reduction Act (DRA) of 2005, states could only use state plan authority to provide a limited set of long-term services and supports in the community (primarily personal care and home health services). With the enactment of the DRA and subsequent legislation, states now have additional state plan options for providing HCBS, including Sections 1915(i), 1915(j), and 1915(k) of the act. In addition, almost all states have been awarded funds under the Money Follows the Person demonstration grant program, which provides states with an enhanced FMAP for 12 months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting.¹¹¹

Demonstration (Waiver or Expenditure) Authority Pursuant to Section 1115 of the Act

Section 1115 of the act provides the secretary broad authority to approve demonstration projects that, in his/her judgment, are likely to assist in promoting the objectives of the Medicaid program. This authority is used by states when their proposed changes require a waiver of Medicaid requirements that cannot be approved through a SPA, a Section 1915(b) waiver, or a Section 1915(c) waiver. CMS has stated that it will not approve a Section 1115 demonstration¹¹² unless the changes cannot be approved under state plan or another waiver authority. Therefore states should carefully consider whether the proposed program could be authorized by a SPA or a different waiver authority and identify the reasons the Section 1115 demonstration authority is needed. Also, CMS has recently indicated that it will place a greater emphasis on whether the Section 1115 demonstration program will demonstrate and evaluate policy approaches in a rigorous and timely manner. So, in its Section 1115 application the state should be clear about what is being tested and explain how that will be measured, including timely reporting of quality measurement and outcomes of the hypothesis and the demonstration program.

107 42 CFR § 441.301(c)(4)(i).

108 Center for Medicaid and CHIP Services, "Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (CMS 2249-F/2296-F)," Centers for Medicare & Medicaid Services, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915c-Fact-Sheet.pdf> (accessed August 17, 2015).

109 CMS Waiver Applications, <https://wms-mmdl.cdsfdc.com/WMS/faces/portal.jsp> (accessed August 17, 2015).

110 42 CFR § 430.25(f)(3).

111 Kaiser Commission on Medicaid and the Uninsured, "Money Follows the Person: A 2012 Survey of Transitions, Services and Costs," February 2012, <http://kff.org/medicaid/issue-brief/money-follows-the-person-a-2012-survey-of-transitions-services-and-costs/> (accessed August 17, 2015). For additional information go to the CMS website, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html> (accessed August 17, 2015).

112 While technically a demonstration authority, a section 1115 demonstration is often referred to as a "section 1115 waiver."

Historically states have used this authority to expand eligibility to groups not otherwise eligible for Medicaid (for example, childless adults), expand eligibility but impose an enrollment cap, provide benefits or require cost sharing not permitted under a state plan, or implement special financing arrangements (such as payments for state funded programs and funding pools).¹¹³ States also have submitted Section 1115 applications in order to have a single authority to expand managed care to include most Medicaid beneficiaries and services, including long-term services and supports.¹¹⁴ In the last couple of years, states have submitted Section 1115 applications to implement Medicaid expansion in ways that do not meet all of the requirements set forth in the ACA but allow the state to access enhanced federal match for newly eligible adults. As of May 2015, six states had received approval of a Section 1115 demonstration to implement alternative Medicaid expansions (Arkansas, Indiana, Iowa, Michigan, New Hampshire, and Pennsylvania).

Under Section 1115, the secretary may waive compliance with any requirements of Section 1902 (State Plans for Medical Assistance) and may provide expenditure authority to match costs that would not otherwise be considered Medicaid expenditures and matched pursuant to Section 1903 (Payments to States) for demonstrations that are likely to promote the objectives of the Medicaid program.¹¹⁵ Although the secretary has broad authority, he/she has the discretion to decide what he/she will or will not waive and what costs will or will not be matched. In addition, in a few cases courts have found that the secretary has exceeded his/her authority.¹¹⁶

States that choose to pursue a Section 1115 demonstration are encouraged to submit a concept paper and work collaboratively with CMS from the concept phase through program development (see “Preparation and Tips for Working with CMS” below). CMS released a Section 1115 demonstration program interim template.¹¹⁷ The template (without attachments) is 17 pages long but requires a significant amount of narrative (many Section 1115 demonstration applications are at least 100 pages long). The key sections of the template are as follows:

- Program description (including the rationale for the demonstration, the hypotheses that will be tested/evaluated, and the plan to test the hypotheses);
- Eligibility;
- Benefits and cost sharing;
- Delivery system and payment rates;
- Implementation (implementation schedule);
- Demonstration financing and budget neutrality (see below for additional information);
- List of proposed waivers and expenditure authorities; and

¹¹³ For information on existing and proposed section 1115 demonstrations go to <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html> (accessed August 17, 2015). For information on approved special financing arrangements, see GAO-15-239 Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives (April 2015) <http://www.gao.gov/assets/670/669582.pdf> (accessed August 17, 2015).

¹¹⁴ For information on existing and proposed Section 1115 demonstrations, go to http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html (accessed August 17, 2015). See also the materials related to MLTSS on the CMS website at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html> (accessed August 17, 2015).

¹¹⁵ Section 1115 of the act.

¹¹⁶ For example, see *Newton-Nations, et al. v. Betlach, et al.* 660 F.3d 370 (9th Cir. 2011).

¹¹⁷ The Centers for Medicare & Medicaid Services, “Section 1115 Demonstrations,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html> (accessed August 17, 2015).

- Public notice in accordance with the transparency regulations and tribal consultation requirements.

Before submitting an application for a Section 1115 demonstration, a state must comply with federal notice requirements,¹¹⁸ including the transparency regulations, which require the state to publish a public notice, post a summary and draft of the application on its website, and hold at least two public hearings at least 20 days before submitting the application.¹¹⁹ Public notice, including tribal consultation, takes time and resources and lengthens the process, and if a state does not comply with these requirements, CMS will reject the application.¹²⁰

One of the most challenging aspects of securing a Section 1115 demonstration is preparing and negotiating budget neutrality. Per HHS policy, Section 1115 demonstrations must be budget neutral to the federal government. Budget neutrality is an equation that is built on historical cost trend data compared with projected cost trend data for federal spending. Federal spending under the demonstration must not be more than projected federal spending would have been for the state without the demonstration. As part of a Section 1115 demonstration application, the state must submit tables that demonstrate budget neutrality by showing member months, PMPM costs, and total expenditures for the base year and each year of the waiver period, both with and without the demonstration.¹²¹ The state also needs to provide five years of historical data on member months and PMPM costs to help justify trend assumptions.¹²² The Office of Management and Budget plays a key role in the negotiations related to financing and budget neutrality.

CMS works closely with its federal partners, including OMB, as well as other divisions within HHS such as the Office of the Assistant Secretary for Financial Resources, Office of the Assistant Secretary for Planning and Evaluation, HRSA, and SAMHSA, to review Section 1115 demonstration applications. Unlike what occurs with SPAs and other waiver authorities, there is no specified review period for Section 1115 demonstrations. The length of time necessary to obtain approval for a Section 1115 demonstration varies widely and is affected by a number of factors, including the scope and complexity of the waiver. Most waivers take a year or more to negotiate. The typical steps of negotiation include an initial meeting with CMS; conference calls to discuss issues and ask informational questions; formal questions; and negotiation of the sections of the Social Security Act to be waived, the expenditure authorities that would not otherwise receive FFP ("costs not otherwise matchable"), and the special terms and conditions (STCs) of the approval, which are the federal requirements for the demonstration. The STCs are often more than 100 pages. Although some of the language in the STCs is boilerplate, the state and CMS spend a considerable amount of time crafting and negotiating the STCs, particularly those related to budget neutrality. Under 1115 demonstration authority, no FFP may be paid until the demonstration is approved by CMS.

If a Section 1115 demonstration is approved, CMS issues an award letter to the state, along with a listing of the expenditure authorities that are not otherwise matchable that will be matched under the demonstration, a listing of the specific sections of the Social Security Act that are being waived, and the special terms and conditions of approval. New Section 1115 demonstrations are typically approved for a five-year period, although some recent waivers have been approved for shorter periods because they included individuals covered by the new adult group under the ACA. After approval, the state is required to implement ongoing

¹¹⁸ Section 1115(d) of the Act; and 42 CFR § 431, subpart G.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

¹²¹ The Centers for Medicare & Medicaid Services, "How States Apply," <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/application.html> (accessed August 17, 2015). Note: this includes a link to the budget neutrality form but does not include the tables. The state should request the tables from CMS.

¹²² *Ibid.*

reporting (for example, monthly calls with CMS and quarterly and annual progress reports). In addition, CMS may ask to participate in the state's readiness review of contractors. States also are required to design and conduct a formal evaluation of the demonstration.

If the state uses Section 1115 authority to deliver health services in a managed care delivery system, a managed care contract is still required. The state must submit the contract to CMS for prior approval, in accordance with the state's special terms and conditions. Unless a provision is waived as part of the demonstration, any managed care program must comply with applicable federal requirements, including the Medicaid managed care requirements in Section 1932 of the act and 42 CFR Part 438.¹²³

"IN LIEU OF" SERVICES AND MANAGED CARE ENTITY INCENTIVE ARRANGEMENTS IN CAPITATED MANAGED CARE CONTRACTS

In addition to the state plan and waiver authorities described above, 42 CFR 438.6 (contract requirements for managed care contracts) provides flexibility for capitated MCOs, PIHPs, or PAHPs to provide substitute ("in lieu of") services and to be paid incentive payments in addition to the capitated payments.

"In Lieu of" Services Provided by a Capitated Managed Care Entity

An MCO, PIHP, or PAHP that is at risk may provide lower-cost services that substitute for—are "in lieu of"—state plan services.¹²⁴ For example, an MCO or PIHP might provide HCBS as an alternative to nursing facility services.¹²⁵ Although a state may encourage an MCO, PIHP, or PAHP to use "in lieu of" services, it cannot require the entity to provide them, and it cannot require an enrollee to accept the "in lieu of" service instead of the state plan service.¹²⁶ However, the state may modify its capitation rates to account for the expected cost and use of "in lieu of" services as a proxy for the cost of the covered state plan service.¹²⁷ The actuary must describe that approach in its rate certification.¹²⁸ Also, "in lieu of" services can be included in future rates, as long as the state can identify the state plan services they replace and the efficacy of the "in lieu of" services.¹²⁹

Incentive Arrangements to a Capitated Managed Care Entity

Provisions of 42 CFR 438.6(c)(5)(iii) and (v) allow a state to provide funds to a capitated managed care contractor over and above the capitation rates paid for meeting targets specified in the contract.¹³⁰ For example, a state could make an incentive payment to a contractor for meeting specified performance standards as part of a pay-for-performance program. Specifically, these regulations provide that contracts with capitated MCOs, PIHPs, or PAHPs may include incentive arrangements for the entity if the incentive payment does not exceed 105 percent of the approved capitation payments and the arrangement is for a fixed period, will not be renewed automatically, is available to both public and private contractors, is not conditioned on intergovernmental transfer agreements, and is necessary for the specified activities and targets.¹³¹

PREMIUM ASSISTANCE

In addition to providing direct coverage (by paying providers directly or contracting with managed care entities), states have the option to provide premium assistance to subsidize the purchase of private health

¹²³ Chapter 2 of this section has additional information on Medicaid managed care requirements.

¹²⁴ The Centers for Medicare & Medicaid Services, "Providing Long-Term Services and Supports in a Managed Care Delivery System," December 2009.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ 42 CFR § 438.6(c)(5)(iii) and (iv).

insurance. According to a 2010 report from the U.S. Government Accountability Office (GAO),¹³² 39 states have one or more premium assistance programs. Most of those programs are fairly small (only three states had more than 10,000 participants).¹³³ As specified in the GAO report,¹³⁴ barriers to expanding the programs include a limited number of individuals with access to private insurance, identifying individuals with access to private insurance, obtaining the necessary information from the employer or insurer, and determining whether the cost of paying the premium plus any wraparound benefits is less than providing direct coverage, to meet the cost-effectiveness standard.

Several provisions of the Social Security Act¹³⁵ authorize states to provide premium assistance under Medicaid or CHIP. Each of those provisions specifies the applicable population (for example, Medicaid or CHIP and family members); whether the state can require participation; the type of coverage (group or individual insurance); the extent of wraparound benefits (additional services that must be paid for by the state in addition to the premium); and the cost-effectiveness standard. Many premium assistance programs are authorized through the state plan, but several programs are authorized through a Section 1115 demonstration and are not required to comply with all of the statutory requirements.

Historically, little regulatory guidance has been offered on premium assistance.¹³⁶ However, as part of rulemaking to implement the ACA, CMS issued regulations that allow states to provide premium assistance for the purchase of individual insurance, including the purchase of qualified health plans (QHPs) through the health insurance exchange.¹³⁷

The premium assistance regulation authorizes states to purchase health plans offered in the individual market under specified conditions, including (1) the insurer is primary payer; (2) the state provides wraparound services to state plan benefits; (3) the individual does not incur any cost sharing in excess of Medicaid limits; (4) the cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits and cost-sharing assistance, is comparable to the cost of providing direct coverage under the state plan; and (5) the individual is not required to enroll in premium assistance, is informed of his/her choice between direct coverage and coverage through premium assistance, and is provided information on how to access wrap-around services and cost-sharing assistance.¹³⁸

In March 2013, CMS provided additional guidance regarding premium assistance in the form of frequently asked questions (FAQs).¹³⁹ In this guidance, CMS stated that HHS will consider approving a limited number of premium assistance Section 1115 demonstrations for the purchase of QHPs in the exchange but will only consider proposals that include certain specifications, including that the demonstration end no later than December 31, 2016 (when state innovation waiver authority begins).¹⁴⁰ As of May 2015, CMS had approved demonstrations in three states (Arkansas, Iowa, and New Hampshire) allowing the states to use Medicaid funds to purchase QHPs for some or all individuals in the new adult group.¹⁴¹

132 United States Government Accountability Office, "Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs," January 19, 2010, <http://www.gao.gov/new.items/d10258r.pdf> (accessed August 17, 2015).

133 Ibid.

134 Ibid.

135 Sections 1905(a), 1906, 1906A, 2105(c)(3), and 2105(c)(10) of the Act.

136 42 CFR § 440.350 and 355, which allow states to provide benchmark or benchmark-equivalent coverage through premium assistance for employer-sponsored plans.

137 42 CFR § 435.1015.

138 Ibid.

139 The Centers for Medicare & Medicaid Services, "Medicaid and the Affordable Care Act: Premium Assistance," March 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf> (accessed August 17, 2015).

140 Ibid; and 42 USC section 18052; 31 CFR § 33; and 45 CFR § 155 subpart N.

141 Information on the Arkansas, Iowa, and New Hampshire 1115 demonstrations can be found by searching on this page of the CMS website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html (accessed August 17, 2015).

USE OF CONCURRENT AUTHORITIES TO PROVIDE MANAGED LONG-TERM SERVICES AND SUPPORTS

As an alternative to requesting a Section 1115 demonstration, a state may implement managed long-term services and supports (MLTSS) by combining a managed care authority (for example, 1915(a), 1932(a), or 1915(b)) with an HCBS authority (for example, 1915(c) or 1915(i)).^{142,143} The most common combination thus far is a Section 1915(b) and a Section 1915(c), but other combinations, including 1915(a) and 1915(c), have been approved.¹⁴⁴

When a state uses a Section 1915(b) waiver with a Section 1915(c) waiver, it uses the Section 1915(b) waiver authority to mandate enrollment in a managed care plan (limit freedom of choice or selectively contract with MCOs, PIHPs, or PAHPs) and uses the Section 1915(c) waiver authority to provide HCBS and target eligibility for the program.¹⁴⁵ By using both authorities, a state can provide long-term services and supports in a managed care environment.¹⁴⁶

States can implement concurrent Section 1915(b) and Section 1915(c) waivers, as long as all federal requirements for each waiver are met.¹⁴⁷ A state must complete and submit a separate application for each waiver authority and satisfy all of the applicable requirements; for example, the state must demonstrate cost neutrality in the Section 1915(c) waiver and cost effectiveness in the Section 1915(b) waiver.¹⁴⁸ States must also comply with the reporting requirements for each waiver.¹⁴⁹

If the state uses Sections 1915(b) and 1915(c) as concurrent waiver authorities to deliver services through a managed care delivery system, the state must submit the contract to CMS for prior approval.¹⁵⁰ If the managed care contract includes HCBS, the regional office will consult with the CMS central office.¹⁵¹ CMS may require the state to include safeguards in the contract similar to the assurances required for Section 1915(c) waivers¹⁵² if those requirements cannot be satisfactorily addressed under the managed care requirements in 42 CFR Part 438.¹⁵³

INTEGRATED PROGRAMS FOR MEDICARE-MEDICAID ENROLLEES

Medicare-Medicaid enrollees may voluntarily enroll in programs authorized through various SPAs and a Section 1915(c) waiver and may be required to enroll in a program authorized by a Section 1915(b) or Section 1115 demonstration, but none of those authorities provides a state with the ability to align Medicare and Medicaid administration, payment, and service delivery. Three potential options for a state to create an integrated program for dual eligibles are the Financial Alignment Initiative for Medicare-Medicaid Enrollees; Dual Eligible Special Needs Plans (D-SNPs); and Programs of All-Inclusive Care for the Elderly (PACE).

142 Section 1915(i) of the Act, State Plan Amendment Option to Provide Home and Community-Based Services for Elderly and Disabled Individuals; and 42 CFR § 441, subpart H.

143 States considering developing a MLTSS program should review the information, including CMS guidance, available on the following CMS website: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html> (accessed August 17, 2015).

144 The Centers for Medicare & Medicaid Services, "National Summary of State Medicaid Managed Care Programs as of July 1, 2011," <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/2011-national-summary-mc-report.pdf> (accessed August 17, 2015).

145 The Centers for Medicare & Medicaid Services, "Providing Long-Term Services and Supports in a Managed Care Delivery System," December 2009.

146 Ibid.

147 Ibid.

148 Ibid.

149 Ibid.

150 Ibid.

151 Ibid.

152 Section 1915(c)(2) of the Act; 42 CFR § 441.302; the 1915(c) waiver preprint; and <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf> (accessed August 17, 2015) for the required assurances for a section 1915(c) waiver.

153 Ibid. Chapter 2 of this section has information on Medicaid managed care requirements.

Financial Alignment Initiative¹⁵⁴

In 2011, CMS (the Medicare-Medicaid Coordination Office, in partnership with the Center for Medicare and Medicaid Innovation [CMMI]) established a demonstration opportunity for states to align incentives between Medicare and Medicaid through Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees (the Financial Alignment Initiative).¹⁵⁵ The Financial Alignment Initiative was designed to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees.¹⁵⁶ Through the initiative, CMS is partnering with states to test two models: (1) a capitated model, in which a state, CMS, and a health plan enter into a three-way contract and the health plan receives a prospective, blended payment to provide comprehensive, coordinated care and (2) a managed FFS model, in which a state and CMS enter into an agreement by which the state would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.¹⁵⁷

States interested in the financial alignment opportunities were required to submit a letter of intent by October 1, 2011.¹⁵⁸ A total of 26 states submitted proposals, and as of May 2015, 12 states had a memorandum of understanding (MOU) with CMS. The waiver authority provided to the secretary by Section 1115A is fairly limited as it relates to Medicaid (see section on 1115A below), so, depending on the program design, states participating in the Financial Alignment Initiative are likely to need additional state plan or waiver authority. For example, Ohio's approval was contingent on CMS' approval of a concurrent 1915(b) and (c) waiver, and Washington's authorities included a health home SPA. Although this grant opportunity is not currently available, states wishing to pursue integrated care for Medicare-Medicaid enrollees may want to review the MOUs and other information posted on the CMS websites¹⁵⁹ and contact other states that are implementing this initiative for ideas and lessons learned. In addition, CMS is conducting an evaluation of each initiative, which should provide valuable information to other states interested in integrating care for Medicare-Medicaid enrollees.

Dual Eligible SNPs

For states that are not participating in the Financial Alignment Initiative, the most promising approach to integrating care for dual eligibles on a larger scale than PACE is by contracting with D-SNPs. A D-SNP is a type of Medicare Advantage plan that enrolls beneficiaries who are entitled to both Medicare and Medicaid and provides or coordinates benefits available through both programs.¹⁶⁰

The state does not need a separate authority to contract with D-SNPs. However, if the state requires Medicare-Medicaid enrollees to enroll in a D-SNP for their Medicaid benefits, the state will need a Section 1915(b) waiver or a Section 1115 demonstration. Similarly, if the state wants to include HCBS in the contract, it will need to use "in lieu of" authority, an HCBS authority (1915(c), 1915(i)), or a Section 1115 demonstration. CMS developed a state plan preprint for states to use on a voluntary basis to demonstrate and highlight the arrangements between states and D-SNPs that also contract with the state to provide Medicaid services to

¹⁵⁴ The following CMS websites provide additional information: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>; and <http://innovation.cms.gov/initiatives/Financial-Alignment/> (accessed August 17, 2015).

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Ibid.

¹⁶⁰ For additional information, including information on fully integrated dual eligible SNPs created by section 3205 of the ACA "to promote the full integration and coordination of Medicare and Medicare benefits for dual eligible beneficiaries by a single managed care organization," see <http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html> (accessed August 17, 2015).

dual-eligible individuals enrolled in the SNP.¹⁶¹ A handful of states have contracted with D-SNPs to provide the full array of Medicare and Medicaid services, and others, including a couple of states that withdrew from the Financial Alignment Initiative, are pursuing this approach.

*Programs of All-Inclusive Care for the Elderly*¹⁶²

Programs of All-Inclusive Care for the Elderly (PACE) is a capitated benefit for frail elderly people that features a comprehensive service delivery system and integrated Medicare and Medicaid financing.¹⁶³ One of the limitations of PACE as a statewide model is the requirement that the PACE organization operate at least one PACE center with sufficient capacity for routine attendance by its participants.¹⁶⁴ The use of the center-based model and other organizational requirements limit the number of participants that a PACE organization can serve. As of January 2014, the largest PACE organization served approximately 3,800 participants, and the average number of participants per PACE organization was approximately 300.¹⁶⁵ Participants must be able to disenroll at any time without cause.¹⁶⁶

Sections 1905(a)(26) and 1934 of the act provide the authority for states to elect PACE as a state plan option. A state using that authority would complete the PACE SPA using the state plan procedures and timeframes described above under “SPAs - General.” The current PACE SPA preprint¹⁶⁷ is approximately 10 pages long and, except for a description of the rate-setting methodology, requires checks and minimal narrative. In addition to the SPA, a state needs to sign a three-way agreement among the PACE organization, CMS, and the state.¹⁶⁸ The template for the agreement is approximately 43 pages.¹⁶⁹

Section 1115A and the Center for Medicare and Medicaid Innovation

Section 1115A of the Social Security Act (as added by the ACA) established CMMI for the purpose of testing “innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care” for individuals who receive Medicare, Medicaid, or CHIP benefits.¹⁷⁰ Section 1115A requires the innovation center to test payment and service delivery models in accordance with specified selection criteria and authorizes the secretary to waive requirements of Title XI (General Provisions, Peer Review, and Administrative Simplification), Title XVIII (Medicare), and Sections 1902(a)(1) (statewide), 1902(a)(13) (related to payment for certain services), and 1903(m)(2)(A)(iii) (requirement that payments to MCOs be actuarially sound and that the MCO contract receive prior approval by the secretary) of the act.¹⁷¹ If certain criteria are met, the secretary may, through rulemaking, expand the duration and scope of a model (including implementation on a nationwide basis).¹⁷²

161 This preprint is available by clicking on “Integrated Care Roadmap” on the following CMS website: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Integrating-Care.html> (accessed August 17, 2015).

162 The Centers for Medicare & Medicaid Services, “Program of All-Inclusive Care for the Elderly (PACE),” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html> (accessed August 17, 2015).

163 Ibid.

164 The Centers for Medicare & Medicaid Services, “Program of All-Inclusive Care for the Elderly (PACE) Manual,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html> (accessed August 17, 2015).

165 National PACE Association, “PACE in the States,” http://www.npaonline.org/website/download.asp?id=1741&title=PACE_in_the_States (accessed August 17, 2015).

166 Section 1934(c)(5) of the act; and 42 CFR § 460.154.

167 The SPA preprint is available on the CMS website at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/PACE-4-States.html>. (accessed August 17, 2015).

168 Section 1934 of the act; and 42 CFR § 460.30.

169 The Centers for Medicare & Medicaid Services, “PACE Program Agreement,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/integrating-care/downloads/pace-agreement-template.pdf> (accessed August 17, 2015).

170 The Center for Medicare & Medicaid Innovation, “About the Innovation Center,” Centers for Medicare & Medicaid Services <http://innovation.cms.gov/About/index.html> (accessed August 17, 2015).

171 Sections 1115A(b) and (d) of the act.

172 Section 1115A(c) of the act.

Unlike with Section 1115 demonstration authority, although a state can propose an idea to be tested, it can only submit a proposal in response to solicitations initiated by the innovation center. The center develops new payment and service delivery models and then solicits and selects organizations to participate in model tests through open, competitive processes.¹⁷³

Current models that states have applied for include the Financial Alignment Initiative for Medicare-Medicaid Enrollees (described above) and the State Innovation Models (SIM) initiative. SIM is a competitive funding opportunity to provide “support to states for the development and testing of state-based models for multi-payer payment and health care delivery system transformation.”¹⁷⁴ In August 2012, CMMI issued the first funding opportunity announcement for SIM and in February of 2013 awarded nearly \$300 million to 25 states to design or test improvements to their health payment and delivery systems. The second round of the SIM initiative was launched by CMMI in May 2014 and over \$600 million were awarded to 11 model test states and 21 model design states and territories. Combining the two rounds, there are 38 states and territories that have received SIM funding for either testing or designing plans to reform their payment or delivery systems.¹⁷⁵

¹⁷³ For information on current initiatives, see <http://innovation.cms.gov/initiatives/index.html#views=models> (accessed August 17, 2015).

¹⁷⁴ The Center for Medicare & Medicaid Innovation, “State Innovation Model Initiatives: General Information,” Centers for Medicare & Medicaid Services <http://innovation.cms.gov/initiatives/State-Innovations/> (accessed August 17, 2015).

¹⁷⁵ Ibid.

Table 3. Authorities Matrix -- Overview of the Major Federal Authorities Available for Different Health Care Purchasing Strategies and Applicable Considerations

Considerations	Section 1932(a) Managed Care SPA	Section 1937 Alternative Benefit Plan SPA	Section 1945 Health Home SPA	
Statutory and Regulatory Authority*	Section 1932(a) 42 CFR Part 438	Section 1937 42 CFR Part 440 subpart C	Section 1945	
General purpose	Mandatory enrollment in managed care (MCO or PCCM)	Providing alternative benefit plans	Implementing health homes for individuals with chronic conditions	
Public notice required?	No (but see 42 438.50(b)(4))	Yes	Yes	
Form of submission to CMS	SPA preprint	SPA preprint	SPA preprint through online system	
Can the state require enrollment (waive freedom of choice)?	Yes (for non-excluded populations)	Yes (for non-exempt populations)	No (but can auto-assign with option to opt out)	
Can the state offer the model in specific geographic areas (not statewide)?	Yes	Yes	Yes	
Can the state offer different benefits through the model than through the state's approved state plan (not meet comparability)?	Yes	Yes	Yes	
What additional requirements do not apply or can be waived?	None	Per statute, any other Medicaid provision that would be directly contrary to the authority in Section 1937	Any other Medicaid provision the secretary determines necessary to waive in order to implement the section	

	ICM SPA Pursuant to Section 1905(t)	Section 1915(a) Contract	Section 1915(b) Waiver	Section 1915(c) HCBS Waiver	Section 1115 Demonstration
	Sections 1905(a) (25) and 1905(t)(1) 42 CFR 440.168	Section 1915(a) 42 CFR 431.54	Section 1915(b) 42 CFR 430.25 and 431.55	Section 1915(c) 42 CFR 430.25, 440.180 and Part 441 subpart G	Section 1115 42 CFR Part 431 subpart G
	Payment reform in an FFS delivery system	Voluntary enrollment in capitated managed care (MCO, PIHP, or PAHP)	Mandatory enrollment in managed care (MCO, PIHP, PAHP, or PCCM)	Provide HCBS as an alternative to institutional care	Demonstration program to test innovative Medicaid policy
	Yes	No	No, but encouraged	Yes	Yes (see 42 CFR Part 431 subpart G)
	Concept paper and SPA (no preprint)	Managed care contract	1915(b) template or web-based application	1915(c) web-based application	Section 1115 demonstration template
	No (but can auto-assign with option to opt out)	No (but can auto-assign with option to opt out)	Yes	No	Yes
	Yes	Yes	Yes	Yes	Yes
	No (but can target based on medical necessity and stratify payment levels)	Yes	Yes	Yes	Yes
	None	None	Per statute, most provisions of Section 1902 (State Plans for Medical Assistance) but generally only managed care requirements related to PIHPs and PAHPs	Income and resource rules applicable in the community	Most provisions of Section 1902 and costs for which the state would not otherwise get FFP as specified in Section 1903 (Payments to States)

Considerations	Section 1932(a) Managed Care SPA	Section 1937 Alternative Benefit Plan SPA	Section 1945 Health Home SPA	
Delivery system options	Managed care (MCO or PCCM)	Managed care (MCO, PCCM, PIHP, or PAHP) or FFS	Managed care (MCO, PCCM, PIHP, or PAHP) or FFS	
Payment methodology options	FFS, capitation, and other	FFS, capitation, and other	FFS, administrative PMPM, and capitation	
Budget test	None	None	None	
Approval Time	Two 90-day clocks	Two 90-day clocks	Two 90-day clocks	
Form of approval	Approval of SPA and managed care contract	Approval of SPA and managed care contract (if applicable)	Approval of SPA	
Can approval be applied retroactively?	Yes	Yes	Yes	
Duration of approval	Permanent	Permanent	Permanent (but enhanced FMAP only for 2 years)	
Special reporting requirements	No	No	Yes (quality measures and information for evaluation)	
Special monitoring/evaluation requirements	No	No	Yes	
Other considerations		Amended by the ACA	Created by the ACA	

*All statutory authorities referenced in this matrix are to the Social Security Act.

	ICM SPA Pursuant to Section 1905(t)	Section 1915(a) Contract	Section 1915(b) Waiver	Section 1915(c) HCBS Waiver	Section 1115 Demonstration
	FFS	Managed care (MCO, PIHP, or PAHP)	Managed care (MCO, PCCM, PIHP, or PAHP) or FFS	FFS	Managed care (MCO, PCCM, PIHP, or PAHP) or FFS
	FFS, care coordination PMPM, and payment for quality improvement or shared savings	Capitation	Capitation, FFS, shared savings, and other	FFS	Capitation, FFS, supplemental/pool payments, DSRIP, shared savings, and other
	None	None	Cost-effectiveness	Cost neutrality	Budget neutrality
	Two 90-day clocks	No set timeframe	Two 90-day clocks	Two 90-day clocks	No set time frame; historically often 12 months or longer
	Approval of SPA	Approval of managed care contract	Approval of waiver and managed care contract	Approval of waiver	Approval letter and special terms and conditions and approval of managed care contract (if applicable)
	Yes	No	No	No	No
	Permanent	Duration of contract	2 years (or 5 years if duals included)	3 years (or 5 years if duals included)	5 years initially, then 3 years. (or 5 year rule applies for duals)
	No	No	Yes (separate reporting on CMS 64 and enrollment by MEG)	Yes (CMS-372s)	Yes (calls, status reports, and annual reports)
	No	No	Yes	Yes	Yes
	New approach developed by CMS				CMS discourages the use of a Section 1115 demonstration when other authorities are available

PREPARATION AND TIPS FOR WORKING WITH CMS

States can approach changing their Medicaid programs via a state plan amendment or a waiver/demonstration application. Within each category, the complexity of the change being pursued can range from a relatively simple SPA, which may pertain only to adding or dropping an optional Medicaid service, to a complex Medicaid Section 1115 demonstration that is attempting to reform the entire eligibility, reimbursement, and delivery systems of a state's program. Regardless of the complexity of the change, the state must secure CMS approval.

Accordingly, a state must familiarize itself with the requirements, processes, and procedures applicable to each approach it is considering, as the approach selected will dictate some of the interactions it will have with CMS. In addition to required interactions (for example, regular negotiating calls and meetings), the state must decide what other interactions (for example, calls, meetings, and formal correspondence with political appointees) with CMS it believes will facilitate an effective approval process, resulting in a positive decision on the state's request.

Finally, states should come to CMS with their SPA or waiver or demonstration proposal fully supported by all the necessary legal, financial, and program information and rationale that will enable CMS to approve the request. The state's rationale for approval must be developed with appropriate legal and regulatory support and financial and program information and should indicate how the proposal fits into the current administration's policy and program priorities. The state should essentially outline the path to approval for CMS. Such an outline will serve as the basis for the discussion and negotiation process and allow the state to have more focused and controlled interaction with CMS during the approval process.

Preliminary Research

Before submitting a SPA or waiver, it is very important for a state to determine whether CMS has recently approved or denied a SPA, waiver, or Section 1115 demonstration that is similar to what the state is considering. The recent approvals (posted on CMS' website or identified in discussions with state counterparts) normally indicate the preferences of the current administration, and the precedents that are set by previous approvals can provide the state with the path it should follow for its SPA, waiver, or demonstration to secure CMS approval. The approvals typically reflect the policy priorities of the current administration, as well as the latest health care delivery or financing approaches that the administration is willing to consider. That is especially critical for Section 1115 demonstrations, waivers and complex, integrated care model or reimbursement SPAs. A state needs to understand that if it is proposing a financing or coverage SPA, waiver, or demonstration that is inconsistent with the policy priorities of the current administration, the path to approval will be difficult.

Preliminary Feedback from CMS

State officials should present and discuss their intention and approach with CMS before submitting a formal SPA or waiver or Section 1115 demonstration request. Such discussions will provide state officials with an initial reading from CMS and save the state unnecessary effort if the approach is not one that CMS is willing to consider. Discussing the proposal ahead of time allows CMS to provide the state with suggestions or recommendations for modifications to be included in a formal submission and can increase the chances that the state's request will be approved.

State Plan Amendment

When seeking a SPA, state officials should initiate informal contact with the appropriate CMS regional office or central office staff to outline the SPA being sought. An informal phone call could suffice, or more detailed, face-to-face meetings could be best, particularly if the desired SPA includes complex reimbursement, coverage, or eligibility changes. After such preliminaries, state officials should assess the complexity and

nature of its submission to determine the next steps. For example, CMS currently requests a concept paper for an ICM SPA, whereas a simple template SPA change may require no formal discussion at all.

Waiver or Demonstration

When seeking a waiver or especially a Section 1115 demonstration, state officials should typically prepare a detailed draft concept paper to share with CMS and then follow up with one or more meetings on the key design and financing issues described in the paper. The content of the concept paper and the types and number of meetings that are necessary depend on the nature and complexity of the waiver/demonstration. Preparation of that type is especially important in light of the new Section 1115 demonstration review and approval process that was implemented on April 27, 2012; that is discussed in more detail below.

The Formal Submission

Once the preliminary work has been completed, and the initial feedback from CMS is received, the state will need to prepare a formal submission to CMS.

State Plan Amendment

When preparing a SPA, desired changes should be made to current state plan pages that reflect the changes being proposed. If an entirely new state plan provision is being proposed, the state must include the new state plan pages in its submission. In many instances, CMS has developed state plan preprints that enable the state to simply check boxes or fill in specific information to complete the formal submission documents. The state should know the approach to use for its formal SPA submission, based on its preliminary research and preliminary discussions with CMS. The formal SPA must be transmitted with a completed Form CMS-179, Transmittal and Notice of Approval of State Plan Material. In addition, even if public notice is not required, states should consider providing public notice prior to SPA submission.

An important policy issue that states need to be aware of in any SPA submission is that once the SPA submission is made, CMS may review any of the information contained on the state plan pages submitted and any other information in the state plan integral to understanding the state plan pages that the state is amending. That is referred to as the “same-page review” issue. CMS’ review may lead to the discovery of other problems in a state plan that are not integral to the proposed SPA but that CMS must address with the state. The state may choose to resolve a newly identified issue as part of the current SPA review or may choose to resolve it separately so as not to delay consideration and approval of the current SPA. CMS outlined that process in a State Medicaid Director Letter (#10-020) dated October 1, 2010.

A state plan amendment is typically approved with an effective date of the first day of the calendar quarter in which the amendment was submitted, but a state may request a later approval date; thus, the state needs to consider the timing of the submission if the approval date is critical to the change the state is making. Typically, the SPA approval process runs on a 90-day clock that can be stopped when CMS submits requests for additional information (RAIs) to the state and restarted when CMS receives the state’s response. Therefore, it is important that the state respond to the questions as quickly and completely as possible, to keep the approval process moving. In some instances, CMS will issue informal RAIs to states that will not officially take the SPA “off the clock.” Again, the state needs to respond quickly to those requests, so that CMS does not have to issue a formal RAI and actually stop the clock.

Waiver or Demonstration

Certain waivers require a state to submit materials in prescribed formats or templates. There are templates for 1915(c) waivers and 1915(b) waivers, and a Section 1115 demonstration interim template, all of which can be found on the <http://Medicaid.gov> website.

Section 1915(b) and 1915(c) waivers do not have any formal federal transparency requirements, except for posting information on the <http://Medicaid.gov> website. Effective April 27, 2012, the ACA requires new Section 1115 demonstrations to be subjected to a comprehensive review and approval process. The implementing regulations were issued by CMS on February 27, 2012, and the related guidance is contained in the state Health Official Letter (#12-001) issued on April 27, 2012. The final regulations detail the specific steps that states will need to complete during the course of submitting a new Section 1115 demonstration application to CMS and the steps that must be taken once the application has been submitted. Those include (1) standard application elements, (2) public input at the state and tribal level prior to submission to CMS, (3) public input at the federal level, and (4) the post-approval requirements. CMS strictly enforces the requirements in the regulations, and violations of the requirements can jeopardize or significantly delay approval of the Section 1115 demonstration. States must be mindful of those processes and ensure that they are completed correctly and thoroughly before the waiver is submitted. It is important to work closely with CMS in ensuring compliance with the requirements. These processes should be addressed in the state's concept paper and discussed with CMS during the preliminary meetings and discussions described above.

Submission Follow Up and Negotiations

Once the state has submitted its SPA or waiver or demonstration application, state officials should identify the key CMS staff members responsible for reviewing the state's submission. The state agency should also identify contact staff on its side during preliminary discussions with CMS.

State Plan Amendment

CMS will typically assign a regional office or a central office staff person to process a SPA. That is typically done based on subject matter expertise in the areas of eligibility, reimbursement, or coverage. For example, reimbursement SPAs are typically handled by the National Institutional Reimbursement Team or the Non-Institutional Provider Team, depending on the nature of the amendment. However, if the SPA also affects coverage, those teams will involve a coverage staff member in the review. To ensure a coordinated and timely CMS approval, the state must identify each of the CMS staff involved in the approval process and ensure that they are included in all the calls, meetings, decisions, and correspondence in the approval process. State officials can increase the prospects of success for their plan amendment by confirming with CMS that the staff members necessary to review and approve all aspects of the submission are part of the review team throughout the review process.

Waiver or Demonstration

CMS' review team for a waiver or demonstration includes a large number of federal staff officials representing various parts of the executive branch, including the CMS central office, the appropriate CMS regional office, other HHS offices, OMB, and the White House. For complex Section 1115 demonstration proposals, that is certainly the case. However, CMS will typically assign a lead project officer to the project who is the state's point of contact. Getting a good CMS project officer can be critical to how the waiver approval process works. That is why preliminary research with other states and preliminary discussions with CMS are crucial; they can help determine who the state's project officer will or should be, and the state may be able to influence the selection. A state should work with CMS if it has a particular project officer in mind.

As with a SPA, a state enhances its prospects for timely success by confirming with CMS that the staff members necessary to review and approve all aspects of the waiver or demonstration are part of the review team throughout the review process and that staff participate actively in the review of the waiver/demonstration. In the waiver/demonstration context, that can be difficult to manage, as federal staff have a variety of competing work requirements and are spread very thin over several projects. However, it is critical to the approval process that the state ensure that the waiver/ demonstration review team remains intact

and that each member actively participates in the review process, as all the components of the review team must agree on the terms of the approval.

General

The state can facilitate the ongoing review process by working with the CMS review team to establish a timeline for consideration of the state's SPA or waiver/demonstration application. The state should establish regular calls and meetings according to a timeline leading up to the date when the state seeks to receive final approval from CMS. Setting a schedule with the CMS review team makes it easier to keep the team intact over the life of the approval process, as its members can schedule the time in advance to participate in review team meetings and calls.

Most SPAs, waivers, and demonstrations require negotiation between the state and the federal reviewers, which typically results in changes (minor or major) to the SPA, waiver, or demonstration design. Normally, if the state has done preliminary research on what CMS has previously approved and has had good preliminary discussions with CMS, it can anticipate the significant areas of inquiry that the federal reviewers will have and be prepared to respond quickly and thoroughly to questions and concerns raised during the review process.

For both SPAs and waivers, financing issues take a significant amount of time to negotiate and resolve. State agencies should be prepared to have the necessary key staff, financial data, and supporting information available for this process and devote the time necessary to resolve the issues as quickly as possible. When pursuing a Section 1115 demonstration, the budget neutrality negotiations can have a wide-ranging impact on the overall waiver design. Changes in budget neutrality can affect the size of the expansion population, the services covered, and the funding for the project. Thus, the state should resolve the financing issues, including any outstanding state plan finance issues, as quickly as possible, so that any other impacts can be addressed and the waiver design revised as quickly as possible to keep the approval timeline established with CMS on track.

During the negotiation process for SPAs, waivers, and demonstrations, it is important for the state to document in writing each decision that is made by the review team and to ensure that the decision that has been made has been confirmed with the appropriate decision makers within CMS and the other federal agencies involved. The state cannot assume that a decision made by a staff person on the federal review team is sufficient for the state to make changes in the SPA, waiver, or demonstration under consideration, without having it confirmed by a decision maker in the review process. That can be confirmed by an e-mail or through a formal letter or memo from CMS. More significant decisions should be more formally confirmed.

Section II

CHAPTER 2. COMPLIANCE WITH FEDERAL LAW AND REGULATIONS

ROADMAP

Read this chapter to learn about federal statutes and regulations pertaining to purchasing, provider networks, quality, financial models, program integrity, and data analysis and reporting for state plan amendments and waiver/demonstration programs. Following are key takeaways:

OVERVIEW

All relevant federal requirements apply to managed care and integrated care models unless waived. Regulations and guidance around integrated care models are still evolving, and states should refer to the latest information provided by CMS.

FUNDAMENTALS

This section provides an introduction to federal Medicaid requirements in the following areas:

- Health care purchasing and procurement;
- Provider networks and delivery system transformation;
- Quality improvement strategy;
- Financial models (including related provisions in the Affordable Care Act);
- Program integrity; and
- Data analysis and reporting.

Chapter 2. Compliance with Federal Law and Regulations

By Stefanie Kurlanzik, JD, and Bill Lasowski, Mercer Government Human Services Consulting

OVERVIEW

Note: On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) published its long-awaited proposed rule that significantly revises Medicaid managed care rules, codified at 42 CFR Part 438. See 80 F.R. 31097 (June 1, 2015). Until this rule is finalized, it is advised that, in addition to reviewing current requirements contained in 42 CFR Part 438, the reader review the proposed rule for any potential revisions to sections of 42 CFR Part 438 cited herein. Key provisions of the proposed rule address enhanced beneficiary experience, state delivery system reform, quality improvement, increased program and fiscal integrity, best practices for managed long-term services and supports programs, aligning the Children's Health Insurance Program managed care regulations with Medicaid, and alignment with Medicare Advantage and private coverage plans. Several key impacts of the proposed rule include mandatory 14-day plan selection period for new enrollees; increased standardization in rate setting/actuarial certification; medical loss ratio standards for Medicaid; minimum provider credentialing standards; expanded plan responsibilities for program integrity/monitoring fraud and abuse; and new requirements for encounter data submission. The final regulations will be addressed in a future compendium update.

This chapter discusses key federal statutes and regulations that apply to the purchasing of the types of health care service delivery arrangements described in [Chapter 1](#). It focuses on the key federal statutes and regulations that apply to purchasing, provider networks, quality, financial models, program integrity, and data analysis and reporting (as such topics are addressed in this compendium). The chapter does not discuss federal law as it relates to other aspects of health care purchasing models, such as enrollment and disenrollment, enrollee rights and protections, and grievance and appeals.

For each topic covered, the chapter reviews the requirements of federal laws related to managed care and integrated care models (ICMs), in particular, Section 1932 of the Social Security Act and related federal regulations. Note that all relevant federal requirements apply unless otherwise waived, and that some federal requirements apply to both managed care and ICM. Many requirements apply just to managed care, and some requirements apply to different models of managed care. For purposes of this chapter, managed care is defined as contracting with a managed care organization (which by definition is risk-based) or contracting on a risk or non-risk basis with a primary care case manager (PCCM), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP). ICM is defined as contracting on a non-risk basis with entities other than PCCMs, PIHPs, or PAHPs, such as health homes, accountable care organizations, and "other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care."¹⁷⁶ While CMS is encouraging the use of ICMs, the requirements surrounding such arrangements are evolving and in many instances are not clearly defined in federal regulations or written policy. In addition, it is important to note that ICMs can be used in both fee-for-service and managed care models. Indeed, CMS has stated that it "plan[s] to issue future guidance specifically addressing ICM implementation within risk-bearing managed care contracts."¹⁷⁷ Because of that, when reviewing this chapter as it relates to ICMs, it is necessary to refer to the latest CMS guidance on ICMs, available at <http://Medicaid.gov>.

This chapter highlights and summarizes federal provisions but is not meant to serve as a substitute for the actual statutes and regulations or to provide legal advice. The chapter does not fully address applicable federal case law, federal policy, or state law.¹⁷⁸ As appropriate, the chapter makes references to federal policy

¹⁷⁶ SMD letter #12-001, ICM #1, "Integrated Care Models," July 10, 2012 (hereinafter "SMD letter #12-001, ICM #1").

¹⁷⁷ SMD letter #12-002, ICM #2, "Policy Considerations for Integrated Care Models," July 10, 2012 (hereinafter "SMD letter #12-002, ICM #2"). It is important to note that the information contained in this SMD letter focuses on fee-for-service ICMs.

¹⁷⁸ Unless otherwise noted, references to "state" include the U.S. territories.

documents, such as state Medicaid director letters, as well as approved Medicaid state plan amendments. It is crucial that states consult their attorneys to ensure that they are complying with all applicable law.

In general, managed care models must comply with Section 1932 of the Social Security Act and 42 CFR Part 438. However, requirements may vary depending on the type of model and the authority under which the state contracts with the entity. With respect to ICMs, as stated above, there is limited guidance at present related to federal requirements. The requirements highlighted below are based on CMS guidance in state Medicaid director letters released in 2012 and 2013. The chapter focuses on Medicaid requirements; however, when states purchase health care for Medicare-Medicaid enrollees, they must ensure that they are complying with applicable Medicare requirements.¹⁷⁹

FUNDAMENTALS

HEALTH CARE PURCHASING AND PROCUREMENT

Requirements and procedures that are applicable to Medicaid procurements because of the use of federal funds are contained in 45 CFR Part 74. In general, these federal regulations require a competitive bidding process, to the maximum extent possible. For more general information on health care purchasing and procurement, please see [Section I](#), “Overview and Key Principles of Health Care Purchasing.”

Generally, the Centers for Medicare & Medicaid Services (CMS) does not require review and approval of procurement documents prior to the state’s initiating a procurement process (for example, releasing a request for proposals). However, in certain instances federal prior review and approval of state procurement documents are necessary.¹⁸⁰

For example, sole source procurements are subject to CMS approval because they violate 45 CFR 74.43, which includes a general requirement that procurement transactions permit, to the greatest extent possible, open competition. CMS permits sole source procurements only in limited circumstances.¹⁸¹

Table 4. Requirements and Procedures Applicable to Medicaid Procurement

Federal Citation	Summary	Applies to Managed Care	Applies to ICM	Where to Find More Information
45 CFR Part 74	Federal requirements for procurements, including Medicaid procurements	Yes	Yes	
CMS Guidelines for Pre-Approval and Sole Source	Guidelines on when CMS prior approval of procurement documents is necessary and when sole source contracting is permitted	Yes	Yes	State Medicaid director letter (SMDL) Dec. 5, 1995

In addition to complying with federal procurement requirements, states must also comply with their own procurement codes and procedures, as applicable. State procurement codes often contain requirements for procurement processes, including public notice and procedural submission requirements. It is crucial that

¹⁷⁹ As noted in chapter 1, “Federal Authorities,” in an effort to better coordinate compliance with requirements and care, CMS created a dual demonstration that permits it to waive certain Medicare requirements.

¹⁸⁰ SMD letter, December 5, 1995.

¹⁸¹ Ibid.

Medicaid staff reach out to procurement officers or general counsel to discuss procurement requirements in advance of developing a new procurement.

At the completion of the procurement process, CMS requires approval of all managed care contracts before the state receives federal funding for the contract.¹⁸² Readers should refer to the State Guide to CMS Criteria for Managed Care Contract Review and Approval (the State Managed Care Guide) for additional information on CMS requirements for managed care contracts.¹⁸³ In addition, if the state contracts with Dual Eligible Special Needs Plans (D-SNPs), each D-SNP has to be approved by CMS through the annual Medicare application and contracting process, which includes review of the D-SNP's Medicaid contract.¹⁸⁴

PROVIDER NETWORKS AND DELIVERY SYSTEM TRANSFORMATION

Federal requirements pertaining to developing and maintaining a provider network depend on both the delivery system type (for example, managed care model or integrated care model [ICM]) and the federal authority invoked to implement the system (for example, state plan amendment [SPA] or waiver). For example, a health home model developed in a managed care setting through a waiver will likely have different provider requirements than a health home developed through a SPA. For more information on provider networking and delivery system transformation, please see the discussion below in this chapter of payment rates and the proposed access rule, as well as [Section III](#), "Provider Network Development and Management and Delivery System Transformation."

According to SMDLs issued in July 2012, states implementing ICMs must comply with Sections 1902(a)(30) and 1905(t)(3) of the Social Security Act, 42 CFR 431.51, and 42 CFR 440.168 when developing and maintaining their provider networks.¹⁸⁵ A summary list of these requirements is included in the chart below.

For managed care, 42 CFR Part 438 includes a variety of requirements related to establishing a provider network, access requirements, and provider contracting requirements. A summary list of these requirements is also included in the chart.

Although the federal regulations do not contain access requirements for both managed care and ICM, states often (through statute, regulation, policy, or contract) develop access standards related to caseload requirements, distance requirements between an individual and his or her provider, and appointment wait times.

Federal requirements that relate to provider qualifications are applicable to all providers in Medicaid regardless of the delivery system. Certain federal requirements are highlighted below. Federal regulation 42 CFR 455.104, related to disclosures by Medicaid providers regarding ownership and control, was revised to comply with the Affordable Care Act (ACA). Subpart E of 42 CFR 455 was added to create state plan requirements related to provider screening and enrollment. In addition, subpart E requires all providers of medical or other items or services and suppliers that qualify for a national provider identifier (NPI) to include their NPI on applications to enroll in Medicare and Medicaid programs, as well as all claims for payment submitted under the Medicare and Medicaid programs.¹⁸⁶

¹⁸² 42 CFR § 438.6(a).

¹⁸³ The 2015 guide is available on the CMS website at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (accessed August 17, 2015).

¹⁸⁴ For more information on D-SNPs see chapter 1, "Federal Authorities." Beginning in 2013, all Medicare Advantage organizations offering a D-SNP must execute a contract with the state Medicaid agency in each state where it is intending to offer D-SNP plans. States can be selective in choosing which D-SNPs to contract with; however, each contract is subject to CMS review. See http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/D_SNP_Contracting_Issues_Discussion_092611.pdf (accessed August 17, 2015).

¹⁸⁵ SMD letter #12-001, ICM #1; SMD letter #12-002, ICM #2.

¹⁸⁶ 76 F.R. 5682-5969 (February 2, 2011); and 77 F.R. 25283 (June 26, 2012).

The following chart highlights applicable provisions and indicates whether the provision is applicable to a particular delivery system.

Table 5. Federal Requirements Pertaining to Developing and Maintaining a Provider Network

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICM	Where to Find More Information
Social Security Act §§ 1128, 1128A	State must exclude providers prohibited from participating in the Medicaid program.	Managed care organization (MCO) Prepaid inpatient health plan (PIHP) Prepaid ambulatory health plan (PAHP) Primary care case manager (PCCM)	Yes	
Social Security Act § 1902(a)(30)(A) 42 CFR Part 447 Subpart B	State's provider rates must be sufficient for the state to have enough providers to have Medicaid state plan services available to the same extent as services to the general population.	No	Yes	
Social Security Act § 1905(t)(1) 42 CFR 440.168	State may "identify reasonable qualifications for the case managers and related providers." ¹⁸⁷	PCCM	Yes	
Social Security Act § 1932(b)(3)(B)(i) 42 CFR 438.102	Entity is not required to provide, reimburse for, or provide coverage of a counseling or referral service if the entity objects to the service on moral or religious grounds.	MCO PIHP PAHP		SMDL 2/20/98
Social Security Act § 1932(b)(5)	Entity must provide adequate assurances to the state that it has the capacity to provide services.	MCO		
Social Security Act § 1932(b)(7) 42 CFR 438.12	Entity shall not discriminate against providers.	MCO PIHP PAHP		SMDL 2/20/98

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICM	Where to Find More Information
42 CFR 438.206	State must ensure that all services covered under the state plan are available and accessible by enrollees, including requirements related to provider network, direct access to a women's health specialist, second opinions, and access to out-of-network providers.	MCO PIHP PAHP		
42 CFR 438.207	State must ensure that the entity has adequate capacity to serve the expected needs of the Medicaid members in the service area.	MCO PIHP PAHP		
42 CFR 438.214	State must ensure the entity implements written policies and procedures for selection and retention of providers that meet specified requirements.	MCO PIHP PAHP		
42 CFR Part 455 Subpart E	State must ensure that participating providers are enrolled and screened prior to participating in the program.	No	Yes	
42 CFR 431.51 ¹⁸⁸	State must ensure that individuals have freedom of choice in selecting providers.	MCO PIHP PAHP PCCM ¹⁸⁹	Yes	

QUALITY IMPROVEMENT STRATEGY

There are different federal requirements for quality improvement strategies depending on the delivery system and the services. For more information on developing quality strategies for different delivery systems, please see [Section IV](#), "Quality Improvement Strategies." As in many other areas, federal requirements for managed care are more prescriptive than federal requirements for ICM models.

¹⁸⁷ SMD letter #12-002, ICM #2, p.3.

¹⁸⁸ This regulation is not applicable to Puerto Rico, the Virgin Islands, or Guam.

¹⁸⁹ In managed care, individuals have access to any willing provider only for family planning services.

Quality improvement and assessment requirements for managed care contracts are found in 42 CFR Part 438 Subpart D.¹⁹⁰ Included in those regulations is a requirement that states ensure that a qualified external quality review organization (EQRO) conduct an annual external quality review (EQR) of each contracted MCO and PIHP. States are permitted to conduct those reviews directly but may contract with EQROs to fulfill the requirement.¹⁹¹ Federal regulations specify mandatory and optional EQR activities, the qualifications of EQROs, and the information that must be produced. Please note that some of the requirements in 42 CFR Part 438 Subpart D were addressed in the provider network paragraphs above. The chart below includes a summary of applicable provisions.

In its first ICM letter, CMS indicated that it would be providing additional guidance related to a quality framework for ICMs.¹⁹² To that end, in January 2013, CMS issued an SMDL¹⁹³ on a recommended core set of quality measures for health homes, and in November 2013, CMS issued a letter¹⁹⁴ that provides a framework for quality improvement and measurement and encourages states to develop statewide quality strategies using the components highlighted in the letter. In general for ICMs, CMS has stated that quality requirements contained in Sections 1902(a)(30) and 1905(t)(3) of the Social Security Act do apply. Given that the goal of ICMs is to lower costs through improved quality care, quality measures and standards will likely play an important role in the ICM.¹⁹⁵

The following chart highlights applicable quality requirements and indicates whether the provision is applicable to a particular delivery system.

Table 6. Applicable Quality Requirements

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICM	Where to Find More Information
Social Security Act § 1932(c)	Requirements for the state related to quality and improvement monitoring strategies and external quality reviews.	Yes (all models)	Unclear	
42 CFR 438.204 and 438.350	Entity is subject to annual external reviews on quality outcomes and access to services.	MCO PIHP		
42 CFR 438.208	Entity is required to provide primary care and coordination of services.	MCO PIHP PAHP		

¹⁹⁰ 42 CFR §§ 438.200-.242.

¹⁹¹ The state will receive 75 percent FMAP if the external quality review (EQR) activities are performed by a qualified EQRO (see 42 CFR § 433.15(b)(10)).

¹⁹² SMD letter #12-001, ICM #1.

¹⁹³ SMD letter #13-001, ACA #23.

¹⁹⁴ SHO letter #13-007, ICM #4.

¹⁹⁵ SMD letter #12-002, ICM #2, p. 5.

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICM	Where to Find More Information
42 CFR 438.210	Each contract with an entity must define the amount, duration, and scope of each covered service, which shall be no less than what is offered under FFS; provide that the entity may place appropriate limitations on services pursuant to medical necessity or utilization control to achieve the purpose of the service; include a definition of “medically necessary” that is no more restrictive than FFS; and include authorization requirements.	MCO PIHP PAHP		
42 CFR 438.236	Entity must adopt practice guidelines.	MCO PIHP PAHP		
42 CFR 438.240	Entity must have a quality assessment and improvement program.	MCO PIHP		Children’s Set of Core Health Care Quality Measures ¹⁹⁶ 2013 Adult Set of Core Health Care Quality Measures ¹⁹⁷
42 CFR Part 438 Subpart E	State must contract with an organization to conduct an EQR.	MCO PIHP		NCQA Medicaid Managed Care Toolkit 2014 Health Plan Accreditation Standards ¹⁹⁸ CMS Quality of Care External Quality Review Website ¹⁹⁹

¹⁹⁶ The Centers for Medicare & Medicaid Services, “CHIPRA Initial Core Set of Children’s Health Care Quality Measures,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html> (accessed August 17, 2015).

¹⁹⁷ The Centers for Medicare & Medicaid Services, “Adult Health Care Quality Measures,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html> (accessed August 17, 2015).

¹⁹⁸ National Committee for Quality Assurance, “NCQA Medicaid Managed Care Toolkit 2014 Health Plan Accreditation Standards – Assistance for State Agencies in Using NCQA Accreditation for Medicaid Managed Care Oversight,” October 2014, <http://www.ncqa.org/Portals/0/Public%20Policy/2014%20NCQA%20Medicaid%20Managed%20Care%20Toolkit%20Summary%20-%20Final.pdf> (accessed August 17, 2015).

¹⁹⁹ The Centers for Medicare & Medicaid Services, “Quality of Care External Quality Review (EQR),” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html> (accessed August 17, 2015).

FINANCIAL MODELS

This section addresses federal requirements for managed care and ICMs and highlights requirements added by the ACA, as well as requirements that address payments to certain specialty providers. For more information on financial models, please see [Section V](#), “Financial Models.”

Managed Care Models

Various Social Security Act and federal regulation provisions apply to managed care models. The following is a summary of applicable provisions that must be complied with in a managed care model. Unless specified as applying only to at-risk models, the requirements listed below apply to all managed models, as the term has been defined and used in this chapter.

Table 7. Applicable Provisions in a Medicaid Managed Care Model

Federal Law or Regulation	Summary	Only Applies to Risk-Based Models	Where to Find More Information
Social Security Act § 1903(m)	Requirements for MCOs related to payments made to entities.	Yes	
42 CFR 422.208 42 CFR 422.210 42 CFR 438.6(h)	Requirements for entities related to physician incentive plans.		
42 CFR 433 Sub D 42 CFR 434.6(a)(9) 42 CFR 447.20	Requirement that state contracts specify any activities the entity must perform related to third-party liability.		
42 CFR 438.6(c)	Requirement that the state ensure all payments under risk contracts and all risk-sharing arrangements be actuarially sound.	Yes	Section V of the Compendium
42 CFR 438.6(c)	Requirement that the state ensure contracts with incentive arrangements do not provide for payment in excess of 105% of approved capitation payments and include specific requirements on incentive arrangements.	Yes	CMS Rate Setting Checklist ²⁰⁰
42 CFR 438.106	Requirement that the entity hold harmless Medicaid members.		Social Security Act §1903(m) (1)(a)(2); 1932(b)(6) CMS Checklist J.1.03 SMDL 12/30/97
42 CFR 438.116	Requirements for entities related to solvency standards.		CMS Checklist J.2.01; J.2.02

²⁰⁰ The Centers for Medicare & Medicaid Services, “Managed Care,” <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (accessed August 17, 2015).

Integrated Care Models

The following chart outlines applicable federal statutes and regulations that apply to financial aspects of ICM models. The chart is based on initial guidance received from CMS.

Table 8. Federal Statutes and Regulations Applicable to Financial Aspects of ICM Models

Federal Law or Regulation	Summary	Where to Find More Information
Social Security Act §1902(a)(30)(A) 42 CFR 447 Subpart B	The state plan must describe the methods and procedures that relate to the payment of services.	SMDL #12-002, ICM #2
Social Security Act §1905(t)(1)	The state may develop provider payment methods for ICMs (for example, on a per-member per-month basis, shared saving and incentive payments).	SMDL #12-002, ICM #2

In an effort to clarify and standardize the access requirements in Section 1932(a)(30)(A) of the Social Security Act, CMS proposed a new rule on May 6, 2011, regarding access to covered Medicaid services. According to CMS, the proposed rule was meant to clearly define the member access issues that must be considered when setting and adjusting payment rates.²⁰¹ Arguably, clarification was necessary because some states that adjusted their fee-for-service (FFS) payment rates have been sued for noncompliance with Section 1902(a)(30)(A) of the act. The lawsuits alleged that states had failed to comply because they did not produce a cost study on the effects of a rate change prior to implementing the change.²⁰²

The proposed rule amends existing 42 CFR 447.204 relating to Section 1902(a)(30)(A) of the act, requiring that “payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available to the general population in the geographic area.” The proposed rule also amends the regulations at 42 CFR 447.205 to clarify when states are required to issue public notice to providers when changing Medicaid payment methods and standards.²⁰³

The proposed rule requires that before submitting a SPA to reduce rates or alter the structure of provider payment rates, a state must submit information from an access review conducted within the year prior to submission of the SPA. Through this process, states that identify access issues are then required to submit a corrective action plan to CMS. The process outlined in the proposed rule could create significant administrative tasks for states wishing to set or adjust ICM rates. CMS has not yet issued a final rule.

Medicare-Medicaid Enrollees

States have a variety of options for financial models for Medicare-Medicaid enrollees. As mentioned in [chapter 1](#) of this section and above, states are pursuing different avenues to coordinate care for Medicare-Medicaid enrollees (for example, the Financial Alignment Initiative for Medicare-Medicaid enrollees, D-SNPs,

201 76 F.R. 26344 (May 6, 2011).

202 The courts’ holdings have been inconsistent on whether a cost study is a prerequisite to implementing a rate change. See *Orthopedic Hospital v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997) (requiring cost studies), cert. denied, 522 U.S. 1044 (1998); *Independent Living v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (same); compare with *The Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding the statute does not require states to conduct advance cost studies for every modification).

203 For more information, visit: <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf>; <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/Info-Bulletin-5-27-11.pdf>. (accessed August 17, 2015).

and Programs of All-Inclusive Care for the Elderly. Depending on how the state develops the coordinated care model (SPA, waiver, or Section 1115 demonstration), the state will have to comply with applicable Medicaid and Medicare rules.

ACA Changes to Federal DSH Allotments

Sections 2251(a)(4) and 10201(e)(1) of the ACA amended Section 1923(f) of the Social Security Act by reducing the aggregate available federal disproportionate share hospital (DSH) allotments to states over time. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and low-income individuals. The ACA amended the federal DSH allotments because the number of uninsured was expected to drop following the Medicaid eligibility expansion in the ACA.²⁰⁴ Pursuant to subsequent legislation, the reduction to Medicaid DSH allotments has been delayed until federal fiscal year 2018.²⁰⁵

Although the aggregate DSH reduction amounts are specified in statute, the secretary is responsible for determining how to distribute the aggregate reductions among the states by developing a DSH Health Reform Methodology (DHRM). The statute directs that the DHRM take into consideration the following five factors:

- Impose larger percentage reductions against states that have the lowest percentage of uninsured individuals during the most recent fiscal year with available data (as specified in the law);
- Impose larger percentage reductions against those states that do not target their DSH payments to hospitals with high volumes of Medicaid patients;
- Impose larger percentage reductions against states that do not target their DSH payments to hospitals with high levels of uncompensated care (excluding bad debt);
- Impose smaller percentage reductions on low-DSH states (total DSH payments for FY 2000 between 0 percent and 3 percent of total Medicaid medical assistance expenditures); and
- Take into account the extent to which the DSH allotment for a state was included in the budget neutrality calculation for a coverage expansion approved under a Section 1115 demonstration as of July 31, 2009.

Special Payment Requirements

There are also federal requirements that relate to payments to certain provider types. Some of those special payment requirements are highlighted below.

IHS and 638 Facilities

The ACA also made the Indian Health Care Improvement Act permanent.²⁰⁶ The Indian Health Care Improvement Act is important to the provision of health care services to American Indians and Alaska Natives. The act authorizes 100 percent federal medical assistance percentage (FMAP) for Medicaid-enrolled American Indians and Alaska Natives who receive care through an Indian Health Service (IHS) facility. CMS has narrowly interpreted this requirement; therefore, a service must be provided at the IHS facility to be eligible for 100 percent FMAP. Transportation services to the IHS facility and services performed at an Urban Indian Health organization or other contracted provider are not eligible for the 100 percent match.²⁰⁷ IHS

²⁰⁴ Federal regulations for DSH are included in 42 CFR § 447 subpart E.

²⁰⁵ See the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, section 412.

²⁰⁶ Indian Health Service, "Indian Health Care Improvement Act," <http://www.ihs.gov/ihsia/> (accessed August 17, 2015).

²⁰⁷ Megan J. Renfrew, "The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives," *Columbia Journal of Law and Social Problems* 173 (2006), <http://www.columbia.edu/cu/jlsp/pdf/Winter2006/Renfrew.pdf> (accessed August 17, 2015).

and 638 facilities are paid rates that are agreed upon between IHS and the Office of Management and Budget (OMB). The rates are published in the *Federal Register* annually.²⁰⁸

Hospice

Medicaid hospice payment rates are calculated pursuant to annual hospice rates that are established and authorized under Medicare.²⁰⁹ Section 1814(i)(2)(B) establishes a hospice cap amount for Medicare, but the cap is optional for the Medicaid hospice program and must be specified in the state's Medicaid state plan.²¹⁰

Federally Qualified Health Centers and Rural Health Clinics

States are required to pay Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) using a prospective payment system (PPS) but may use an alternative payment methodology (APM) as long as it results in payment that is at least the amount that would be required under a PPS and the FQHC/RHC agrees.²¹¹ In a managed care model, states are required to make wraparound payments to FQHCs and RHCs to cover any difference between the amount the entity has been paid by an MCO (or other managed care entity) and the PPS/APM per visit rate at least every fourth month.²¹²

PROGRAM INTEGRITY

A variety of provisions in federal law pertain to program integrity, including but not limited to ones on: (i) provider licensing, screening, and background check requirements; (ii) excluded providers; (iii) conflict of interest safeguards; and (iv) reporting fraud and abuse. For more information on program integrity, please see [Section VI](#), "Medicaid Program Integrity."²¹³

The ACA amended and added program integrity requirements to the Social Security Act that apply regardless of delivery system. The following ACA sections relate to program integrity:

- Section 6401 amended Social Security Act Section 1886(j) to include additional screening and enrollment requirements for providers in Medicaid. It also requires providers to have an NPI and that providers terminated under Medicare be disclosed.²¹⁴
- Section 6402 added Social Security Act Section 1128(j) to include certain program integrity provisions, including data matching, reporting and returning overpayments, and including the NPI on applications and claims.
- Section 6411 expanded the recovery audit contractor program to Medicaid. States were required to submit state plan amendments to implement this provision.
- Section 6501 requires that providers terminated under Medicare also be terminated under Medicaid.²¹⁵
- Section 6502 added Social Security Act Section 1902(a)(78) to exclude entities from participating in Medicaid depending on certain ownership, control, and management affiliations;

208 Reimbursement Rates for 2015 are available at <https://www.federalregister.gov/agencies/indian-health-service> (accessed August 17, 2015).

209 Section 1814(i)(1)(C)(ii) of the act.

210 The current hospice rates can be found on the CMS website at <http://www.cms.gov/Center/Provider-Type/Hospice-Center.html> (accessed August 17, 2015).

211 Section 1902(bb)(6)(B) of the act.

212 Section 1902(bb)(5)(B) of the act.

213 For more information also see, Kaiser Commission on Medicaid and the Uninsured, "Program Integrity in Medicaid: A Primer," July 2012, available at <http://www.kff.org/medicaid/upload/8337.pdf> (accessed August 17, 2015).

214 For more information also see, CMCS Informational Bulletin, December 23, 2011, available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf> (accessed August 17, 2015).

215 For more information also see, CMCS Informational Bulletin, May 31, 2011, available at <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf> (accessed August 17, 2015).

- Section 6503 added Social Security Act Section 1902(a)(79) to require billing agents, clearinghouses, or other alternate payees to register under Medicaid.
- Section 6505 added Social Security Act Section 1902(a)(80) to prohibit payments to institutions or entities located outside of the United States;
- Section 6506 amended Social Security Act Section 1903(d)(2) to extend the period for collecting overpayments from 60 days to one year; and
- Section 6507 amended Social Security Act Section 1903(r) to require states to use national correct coding.

The following chart summarizes the federal requirements related to program integrity that apply to the delivery systems indicated.

Table 9. Federal Requirements Related to Program Integrity

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICMs	Where to Find More Information
42 CFR 438.608(a) 42 CFR 438.608(b)	Entity general requirements for administrative and management procedures.	MCO PIHP		
Social Security Act § 1903(i)(2) 42 CFR 431.55(h) 42 CFR 438.808	State may not receive FFP for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.	MCO PIHP PAHP PCCM	Yes ²¹⁶	
Social Security Act § 1932(d)(1) 42 CFR 438.610	Entity prohibited from having relationships with individuals who have been debarred by federal agencies.	MCO PIHP PAHP PCCM	Yes ²¹⁷	SMDL 2/20/98
Social Security Act § 1932(d)(3)	State must have conflict of interest safeguards with respect to officers and employees of the state with responsibilities relating to contracts prior to entering into contracts with entities.	MCO PIHP PAHP	Yes ²¹⁸	SMDL 12/30/97
Social Security Act § 1932(d)(4)	Entity shall require each physician providing services to have a unique identifier.	MCO PIHP PAHP PCCM	Yes	

Federal Law or Regulation	Summary	Applies to Managed Care	Applies to ICMs	Where to Find More Information
42 CFR 455.1(a)(1)	State requirements regarding fraud and abuse detection, disclosure, and reporting.	MCO PIHP PAHP	Yes	

In addition to federal Medicaid regulations, there are other laws that apply to program integrity that must be followed by states and all delivery systems during the procurement, purchasing, and implementation phases. The following chart highlights some key federal laws that pertain to program integrity.

Table 10. Key Federal Laws Pertaining to Program Integrity

Federal Law or Regulation	Summary	Where to Find More Information
The Stark Law	The Stark Law governs physician self-referral for Medicare and Medicaid patients.	<ul style="list-style-type: none"> Social Security Act § 1877 http://Starklaw.org
The Anti-Kickback Statute	The Anti-Kickback Statute is a criminal statute that prohibits both the exchange and offer to exchange anything of value in an effort to persuade or reward the referral of federal health care program business. ²¹⁹	<ul style="list-style-type: none"> Social Security Act § 1128B Comparison of the Stark Law and the Anti-Kickback Statute developed by the Health Care Fraud Prevention and Enforcement Action Team and the Office of Inspector General, available at https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf.
Civil Monetary Penalties Statute	The Civil Monetary Penalties Statute imposes civil monetary penalties on a person (including an organization, agency, or other entity) for false or fraudulent claims and other acts as specifically identified in the statute.	<ul style="list-style-type: none"> Social Security Act § 1128A "Use of Federally Imposed Civil Money Penalty Funds by States," CMCS Informational Bulletin, January 13, 2012
Health Insurance Portability and Accountability Act (HIPAA)	HIPAA provides federal protections and gives patients various rights with respect to their personal health information.	<ul style="list-style-type: none"> 42 U.S.C. §§ 300gg et seq. Summary of the HIPAA privacy rule: http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html. Understanding health information privacy: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

²¹⁶ While not addressed in CMS guidance, it is likely that this provision will apply to ICMs.

²¹⁷ Ibid.

²¹⁸ Ibid.

DATA ANALYSIS AND REPORTING

The *Code of Federal Regulations* (CFR) contains specific requirements related to data analysis and reporting for managed care entities.²¹⁹ For more information, please see [Section VII](#), “Data Analysis and Reporting.”

With respect to ICM data requirements, there is no definitive guidance. However, it is clear from the SMDLs that CMS wants states to collect quality data to measure the outcomes associated with ICMs.²²⁰ Indeed, using Minnesota’s approved ICM SPA as an example, it requires, among other things, that providers have the capabilities to receive data from the state electronically and use data to identify opportunities for beneficiary engagement.

As shown in the chart below, data certification requirements in 42 CFR 438.604 and 606 are only required for MCO and PIHP models. However, states do have reporting obligations pursuant to 42 CFR 430.30 that are prerequisite to their receiving federal matching funds. Specifically, states must submit a quarterly budget report to CMS on form CMS 37.²²¹ As this CMS reporting is necessary regardless of delivery system, in order for states to submit accurate and timely reports to CMS, they should consider similar (or more stringent) data reporting and certification requirements for ICMs.

The ACA made some changes to data reporting requirements. Of note, the ACA amends Section 1903(r)(1)(f) of the Social Security Act to require that CMS withhold federal matching for any individuals for whom the state does not report data to the Medicaid Statistical Information System (MSIS) in a timely manner.²²² The ACA also amends Section 1903(m)(2)(A)(xi) of the act to require that managed care risk contracts provide “for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the state at a frequency and level of detail to be specified by the secretary,” or the federal match will be withheld.²²³

Table 11. Requirements for Data Analysis and Reporting for Managed Care Entities

Federal Citation	Summary	Applies to Managed Care	Applies to ICMs	Where to Find More Information
Social Security Act § 1903(r)(1)(F)	State is required to submit data through the Medicaid Statistical Information System (MSIS) to CMS quarterly.	Yes	Yes	MSIS on http://Medicaid.gov

²¹⁹ 42 CFR § 438.242, 438.604 and 438.606.

²²⁰ SMD letter #12-001, ICM #1 and SMD letter #12-002, ICM #2.

²²¹ The CMS-37 is a quarterly financial report submitted by the state that provides a statement of the state’s Medicaid funding requirements for the upcoming quarter, as well as estimates for the current and next fiscal year. CMS issues an advance grant award to the state for the upcoming quarter based on this estimate as approved or adjusted by CMS. Additional information on the CMS-37 is available on the CMS website at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/mbes/cms-37-medicaid-program-budget-report.html> (accessed August 17, 2015). See also 42 CFR § 430.30.

²²² ACA § 6504.

²²³ Ibid. For more information on submitting encounter data see Vivian L. H. Byrd and James Verdier, “Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States,” Mathematica Policy Research Final Report, October 19, 2011.

²²⁴ Even if this provision does not apply to ICMs, CMS may impose a similar requirement for data certification.

Federal Citation	Summary	Applies to Managed Care	Applies to ICMs	Where to Find More Information
42 CFR 430.30	State reporting obligations that are a prerequisite to receiving federal matching funds.	Yes	Yes	CMS-37 Medicaid Program Budget Report - http://Medicaid.gov CMS-64 Quarterly Expense Report - http://Medicaid.gov
42 CFR 438.242	State is required to ensure that entities maintain health information systems that collect, report, and verify data related to, among others, utilization, grievances, and disenrollments.	MCO PIHP		
42 CFR 438.604	State must require data certification when state payments are made pursuant to such data, including enrollment and encounter data.	MCO PIHP	Maybe ²²⁵	
42 CFR 438.606	MCO/PIHP data certifications must be provided by the chief executive officer, chief financial officer, or an individual who has delegated authority to sign for, and who reports directly to, the chief executive officer or chief financial officer.	MCO PIHP		

²²⁵ Even if this provision does not apply to ICMs, CMS may impose a similar requirement for data certification.

Provider Network Development and Management and Delivery System Transformation in State Medicaid Programs

SECTION III

Section III

ROADMAP

Read this section to learn about provider payment strategies and performance monitoring as they relate to provider agreements and oversight of the provider network. The following are key section takeaways:

OVERVIEW

The foundation of any Medicaid health care purchasing strategy is the provider network that serves the enrollees and the delivery system within which the providers work. Principles of provider network development and management apply across a range of delivery models serving all Medicaid beneficiary groups.

FUNDAMENTALS

This section provides an introduction to the following topics related to provider network development and system transformation:

- Development and management of provider networks;
- Overview of delivery system transformation, including accountable care organizations, patient-centered medical homes, health homes, care management programs, and pay for performance programs;
- Key characteristics of delivery system transformations; and
- Provider payment strategies in provider agreements.

ADVANCED

This section includes detailed explanations of the following provider network development and system transformation concepts:

- Types of providers required to be in a network;
- Network adequacy requirements;
- Provider credentialing and accreditation requirements;
- Provider payment strategies in provider agreements;
- Provider performance requirements;
- Plan and provider enrollment policies; and
- Intersection of care management programs and patient-centered medical homes.

Section III. Provider Network Development and Management and Delivery System Transformation in State Medicaid Programs

By Beth Waldman, JD, MPH, and Michael Bailit, MBA, Bailit Health Purchasing, LLC

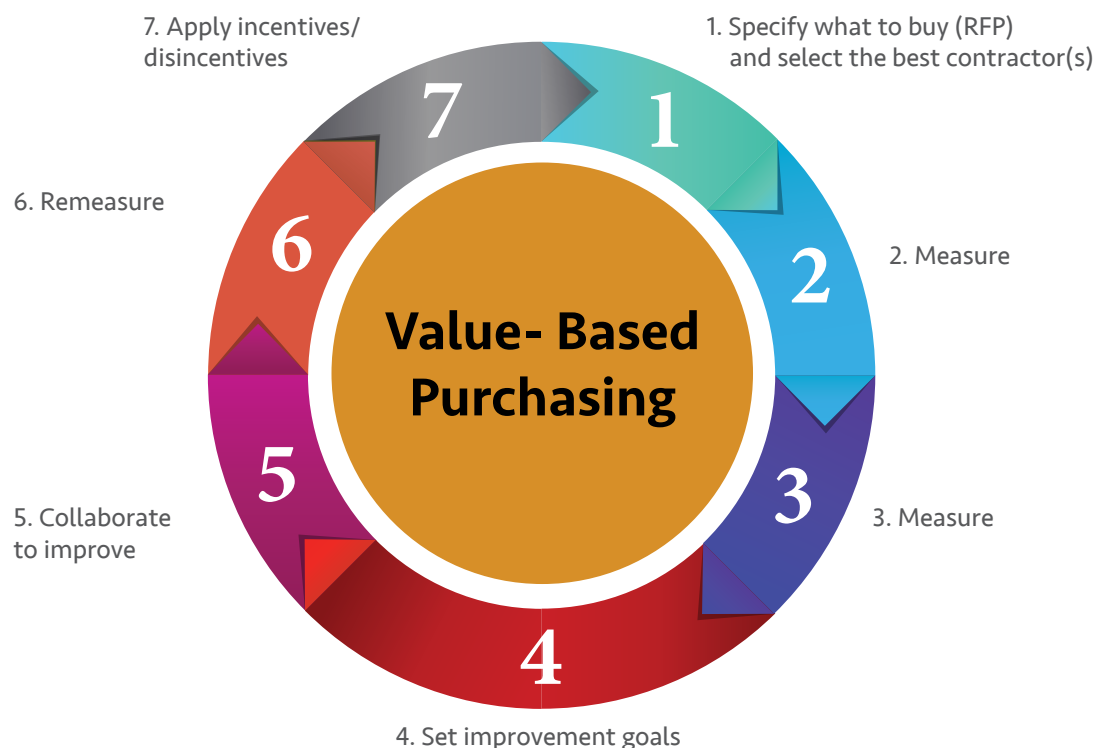
OVERVIEW

The foundation of any Medicaid health care purchasing strategy is the provider network that serves the enrollees (who provides the services) and the delivery system within which the providers work (how the services are provided). That is true regardless of the Medicaid population being served by a program and regardless of whether a state Medicaid agency: purchases health care services directly; has a traditional fee-for-service program, a primary care case management model, or an accountable care organization model; or contracts with an administrative services vendor or a Medicaid managed care organization.

VALUE-BASED PURCHASING

Value-based purchasing is an overall strategy used by both private and public sector purchasers of health care and health insurance services.¹ It begins with a strategic, focused approach to specifying performance requirements and identifying clear consequences for performance. Contractors and providers are then held accountable not only for standard performance requirements but also for performance improvements identified and achieved through a collaborative business relationship with the state purchaser. Figure 3 below depicts the ongoing, seven-step cycle that begins with procurement and continues iteratively throughout the term of a contract. Medicaid programs should focus on the cycle itself and the need to perform and connect the steps.²

Figure 3. Value-Based Purchasing



¹ James Maxwell, et al., "Managed Competition in Practice: 'Value Purchasing' by Fourteen Employers," Health Affairs (May/June 1998): 216–26, <http://content.healthaffairs.org/content/17/3/216.full.pdf> (accessed August 17, 2015).

² Joshua Slen, Michael Bailit, and Margaret Houy, Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans: A Purchaser Guide (Washington, DC: Bailit Purchasing, LLC, April 2010) http://www.bailit-health.com/articles/042810_bhp_scivaluebased_report.pdf (accessed August 17, 2015).

This section of the compendium focuses mainly on step 1 of the cycle and provides a brief overview of provider payment strategies and performance monitoring as they relate to provider agreements and oversight of the provider network. Steps 2 through 6 focus on quality and are described in detail in [Section IV](#), “Quality Improvement Strategies.” Step 7 focuses on payment and other incentives, which are described in detail in [Section V](#), “Financial Models.”

FUNDAMENTALS

THE DEVELOPMENT AND MANAGEMENT OF PROVIDER NETWORKS

In traditional fee-for-service Medicaid programs, state agencies function as indemnification systems and allow any willing provider to participate, as long as the provider meets the state’s application and credentialing requirements (when applicable) and is not otherwise barred from the program. Under this system, any provider that meets participation standards and requirements receives payment for providing covered services.

Under Section 1902(a)(23) of the Social Security Act, states must provide beneficiaries with freedom of choice of provider. This requirement was put in place to reduce the likelihood that states, in the interest of saving money, would limit beneficiaries to a substandard delivery system. In implementing managed care programs, states typically have this requirement waived in order to limit choice of provider and enable selective contracting.³ Under Section 1932 of the act, states also may implement managed care programs. Under this model, states need not seek a waiver of freedom of choice and instead have the authority to limit enrollees to provider networks and to use selective contracting as long as the state and the managed care plans meet certain requirements.

When contracting with vendors either to manage provider networks on the state’s behalf or to manage care overall, including the provider network, states are required to monitor vendors to ensure that their networks meet state and federal adequacy requirements. See 42 CFR 438.206(b). Network adequacy is determined based on membership, geographic access, specialty access, and cultural competency. States and their contractors must ensure that all practitioners are appropriately licensed and competent through a comprehensive credentialing process. As required by 42 CFR 438.214, each state must create a uniform credentialing process that all contractors must follow. States or their vendors must also develop clinical practice guidelines in accordance with 42 CFR 438.236, offer training to their provider network, and monitor the quality of providers’ performance. Among the areas where managed care raises tensions with stakeholders, this one may be the biggest area of concern; therefore, stakeholder involvement in shaping network standards is important to overall support by stakeholders of the managed care model.

OVERVIEW OF DELIVERY SYSTEM TRANSFORMATION

Nationwide, encouraged by additional funding and incentives provided in the Affordable Care Act (ACA), state Medicaid programs are looking at ways to transform their health care delivery systems, in conjunction with payment reform, to create a marketplace that contains incentives to provide high-quality, value-based care. It is important to note that there is no “right” answer to delivery system transformation and that, although some evidence is emerging that the currently popular models are effective in improving health outcomes while reducing costs, those models have been in effect for too short a time to show sustained improvement over the longer term. These delivery system transformations may be implemented directly by the state or through contractors, with or without standard requirements. In many states, delivery system transformation is occurring through statewide initiatives, such as the Center for Medicare and Medicaid Innovation (CMMI)-sponsored State Innovation Models (SIM), which includes both public and private purchasers.

³ Under Section 1932 of the Social Security Act, states may also implement managed care programs that limit categories of enrollees to certain provider networks.

States, plans, providers, and consumers are all in varying states of readiness for delivery system reform. Given that the success of reforms will depend greatly on readiness, states should carefully consider the appropriate strategy based on their own circumstances. Here is a brief overview of the delivery system transformations that are under way or being considered, including accountable care organizations, patient-centered medical homes, health homes, care management/disease management, and pay for performance.

Accountable Care Organizations

An accountable care organization (ACO) is a provider entity that takes responsibility for most or all of the health care services and related expenditures for a defined population of patients. The payment model involves defining a budget for the services for which the ACO will be responsible for its patients and then sharing either savings only or savings and losses based on how the ACO performs relative to the target. This topic is further discussed in [Section V](#), “Financial Models.” The ACO concept was conceived relatively recently,⁴ but it builds upon past experience with health plans that contract with medical groups on a capitated basis. Since the enactment of the ACA, which created opportunities for ACOs to contract with Medicare, providers across the nation have organized themselves to become ACOs. In theory, an ACO can take a number of organizational forms, including a hospital and its naturally occurring referral network, a primary care or multispecialty medical group (including a Federally Qualified Health Center), an independent physician association or other provider network, or an integrated delivery system composed of doctors, one or more hospitals, and potentially other providers. The narrower an ACO is, the greater its need to develop contractual relationships with outside providers and to create incentives to coordinate care across settings.

Patient-Centered Medical Home (PCMH)

A patient-centered medical home (PCMH) is a primary care practice designed to give patients the individualized care and support they need to stay healthy and to manage any chronic conditions. In a medical home, the patient, the primary care clinician, and a practice team work together to develop and implement a plan of care that details the patient’s optimal medication use, diet, exercise, behavioral health treatments, and other needs to make and keep the patient as healthy as possible. Although other payment models are in use, state Medicaid programs or their managed care organizations (MCOs) typically pay the primary care practice a certain amount of money per patient per month to provide enhanced outreach, communication, and coordination. In exchange, the practices are required to operate as a PCMH—sometimes as indicated through PCMH certification—and sometimes to report certain performance measures. In most current applications of the PCMH model, providers continue to be paid on a fee-for-service basis for patient visits.⁵

Patients who have significant behavioral health needs are better served by obtaining primary care within a behavioral health setting, in what is known as reverse co-location. Such care often is provided by a community mental health center and offers the same level and types of supports as the alternatives.

As of March 2015, 46 states and the District of Columbia had adopted policies and programs to advance medical homes.⁶ In addition, 31 states are actively involved in PCMH initiatives and making payments to medical homes.⁷

Health Homes

Section 2703 of the ACA provides states with the option of creating a “health home” program within Medicaid, designed to improve the health of high-risk beneficiaries with complex care needs through a new model of

4 Elliott S. Fisher, et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs* (December 5, 2007): w44–w57, <http://content.healthaffairs.org/content/26/1/w44.full> (accessed August 17, 2015).

5 Massachusetts Medicaid pays a “comprehensive primary care payment” instead of fee-for-service. This is essentially an enhanced primary care capitation payment intended to support medical home operations, including the delivery of traditionally non-reimbursed primary care services.

6 For more information, see <http://www.nashp.org/med-home-map> (accessed August 17, 2015).

7 Ibid.

service delivery. Health homes build on the PCMH model described above, but rather than targeting the entire population of a practice, they limit the provision of enhanced care management, coordination, and support services to individuals with chronic conditions. To be considered eligible, an individual must have at least two chronic conditions or one chronic condition and be at risk of developing a second chronic condition or serious and persistent mental health condition. Although primary care providers (PCPs) and other eligible providers or entities (physicians, clinical practices or clinical group practices, rural clinics, community health centers, community mental health centers, home health agencies, or any other approved entity or provider) may provide a range of services to health home enrollees, Section 2703 specifies that participants provide the following services to enrolled patients:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- Patient and family support (including authorized representatives);
- Referral to community and social support services, if relevant; and
- Use of health information technology to link services, as feasible and appropriate.⁸

States are eligible to receive an enhanced federal medical assistance percentage (FMAP) of 90 percent for all health home payments made within the first eight fiscal year quarters after the effective date of the health home state plan amendment. Other activities conducted by the health home are reimbursed at the state's standard FMAP rate.

As of May 2015, 19 states have implemented a total of 26 Medicaid health homes under Section 2703.⁹ Others are in the process of developing a health home program and related state plan amendment.

Care Management Programs

Many states and their Medicaid MCOs have developed care management and disease management programs that support beneficiaries in managing and coordinating their health care. A disease management program is a population-based health program that provides care coordination and education on particular conditions. Typically, disease management programs for Medicaid populations target asthma, diabetes, depression, congestive heart failure, and chronic obstructive pulmonary disease. States and their health plans also often have wellness-focused programs, including prenatal programs. A beneficiary who is enrolled in a disease management program receives written educational materials that provide instruction on self-care and limited support in managing that disease. An individual with multiple complex diseases is typically referred to a care management program for higher-intensity support.

A care management program provides support through an individualized plan of care that focuses on a beneficiary's health care and sometimes social service needs. In some cases, care managers' roles are limited to managing a beneficiary's care in a particular area (for example, behavioral health), but in others a care manager may have a bigger role, working with an interdisciplinary care team and the beneficiary to determine a person-centered, strength-based plan supporting and coordinating services that address the individual's physical, behavioral, and psychosocial needs.

⁸ Ibid.

⁹ For more information, see CMS Health Home Information Resource Center: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html> (accessed August 17, 2015).

States typically implement care management models with the goal of improving health outcomes and reducing health care costs by reducing nonemergency use of emergency rooms, avoidable hospitalizations, and readmissions. Many care management programs are closely linked with plan transitional care programs that support beneficiaries as they are discharged from one care setting to another, particularly returning home after a hospital stay. It is typically easier for a state to implement care management programs through Medicaid MCOs or an administrative service vendor than on its own because of the need for a number of skilled staff.

Pay for Performance (P4P) Programs

Pay for Performance (P4P) programs are one way for states to move incrementally from fee-for-service. Although providers typically continue to receive payments for services provided, P4P programs give providers incentive to improve quality and reduce health care costs to receive bonus payments that are tied to specific quality measures. P4P is in broad use, by state Medicaid programs with their MCOs and by states and MCOs directly with providers, particularly with primary care providers and hospitals. Strong design is critical to the success of P4P programs. Financial incentives must be large enough to motivate providers, measurement should focus on performance in areas where improvement will also reduce costs, and there should be rewards for improvement over time. P4P is most effective when it is aligned across multiple payers to maximize provider impact.

KEY CHARACTERISTICS OF DELIVERY SYSTEM TRANSFORMATION

Transforming delivery systems requires a series of operational capabilities to succeed:¹⁰

- Practice transformation must be at the core of the delivery system transformation if the transformation is to be meaningful and sustainable. Delivery system transformation requires real change in the way providers practice today, including more flexibility and teamwork across all levels of the organization.
- Strong leadership and governance that will support a clear mission of transformation and, where applicable, alignment across a group of providers are crucial. Any initiative to change the culture of an organization requires strong leadership and commitment at all levels of the organization. Delivery system transformations must be viewed as key initiatives that are central to the direction of the organization. That means that leadership at the top of the organization, among managers and informal opinion leaders, is essential. Since change takes time and will confront many obstacles, sustained, multiyear leadership commitment to delivery system transformation is essential.
- Provider partnerships are essential to a delivery system model that is focused on a holistic view of patient care. Primary care providers must work diligently with their colleagues in medical specialties, behavioral health, and long-term services and support to communicate and collaborate in the care of individual patients.
- Health information technology supports the integrated and actionable data required to inform care management in ongoing retrospective population analysis and monitoring of fiscal and clinical performance.
- Use of data to manage care gives providers and their care management staff key tools to understand beneficiary interaction with the health care system, including when individuals are not following recommended care protocols, and is necessary to allow provider follow-up with patients prior to a potential health crisis.

¹⁰ Deloitte Center for Health Solutions, "Accountable Care Organizations: A New Model for Sustainable Innovation," 2010; and Bailit Health Purchasing, LLC and Mathematic Policy Research, "Briefing Paper for the Special Commission on the Health Care Payment System: Success Factors for Providers Accepting Global Payments," May 2009.

- Use of evidence-based guidelines and clinical process mapping is needed to provide appropriate care to each patient, such as appropriate screenings and treatments.
- Risk assessment of the population within the provider's care is needed to allow patients to be categorized as low-, moderate-, or high-risk for purposes of care management. Depending on level of risk, care management staff will provide care coordination and support services at varying levels of intensity, as described above.
- Operational capacity is required to align incentives for quality and cost (discussed further in [Section IV](#), "Quality Improvement Strategies," and [Section V](#), "Financial Models"); to receive and distribute funds across ACO participants; and, if delegated by health plans, to administer quality assurance, provider credentialing, and handling of patient complaints.

To drive delivery system transformation, the state must bring significant, skilled resources to bear. Given the restraints on state agency budgets and flexibility, it is often easier to effect provider change through an MCO or administrative services vendor. In doing so, the relationship between the state and the vendor and between the vendor and the network providers is key. States and their vendors should work in partnership to develop the most appropriate approaches to identified challenges. To do so, the state must assign a senior manager to be responsible for and actively engaged in the management of the vendor contract. Providers will need ongoing technical assistance and support to change, as well as consistent monitoring, oversight, and feedback. Provider profiling, learning collaboratives, and ongoing technical assistance will help providers improve their performance.

States must appropriately staff the management of vendor contracts and provide that staff with the training and tools to manage the contract. Depending on the skills of the senior manager, job coaching may be important. In addition, all staff should be trained in value-based purchasing and contract management. States also must have appropriate tools to manage contracts, including a deliverables calendar and a consolidated dashboard report with key metrics.

PROVIDER PAYMENT STRATEGIES IN PROVIDER AGREEMENTS

New payment models have important implications for provider agreements. The new models are aimed at providing incentives to providers to improve the quality of care, leading to improved health outcomes and at the same time reducing cost. Global payment terms tie payment in some fashion to performance on measures of access, consumer experience, and clinical quality. Links to quality measures include bonus arrangements and making the percentage of earned savings contingent on the level of quality. The provider agreement must carefully describe the elements of the alternative payment arrangement.

ADVANCED

TYPES OF PROVIDERS REQUIRED TO BE IN A NETWORK

The types of providers that are included within a provider network vary from narrow to broad, based on the type of program that is being developed or contracted for and the target population. Managed care contracts providing a full array of services, including medical, behavioral, and long-term services and supports, will have a broad provider network. However, if the contract is only for adults, pediatricians will not be required to be included. Figure 4 includes an example of providers for an integrated managed care product serving individuals eligible for both Medicare and Medicaid (dually eligible) that offers a continuum of services within the plan and limited out-of-plan services. Because of increasing demand for access, quality, and efficiency, many states allow mid-level practitioners to play a role in the provider network. Examples include nurse practitioners and physician assistants, as well as individuals providing social supports, such as peer navigators and community outreach workers.

Figure 4. Providers in an Integrated Managed Care Product for Dually Eligible Individuals

- | | |
|--|---|
| <ul style="list-style-type: none"> • Primary care providers (including Federally Qualified Health Centers, primary care practices recognized as patient-centered medical homes, and home-based primary care) • Specialty providers • Behavioral health providers • Hospitals • Therapy providers (occupational therapy, physical therapy, and speech therapy) | <ul style="list-style-type: none"> • Durable medical equipment • Labs and radiology • Institutional long-term care providers (including licensed nursing homes and assisted living residences) • Home and community-based service providers (including home care agencies, home health, adult day care, and care management and fiscal agents for self-directed care) |
|--|---|

Source: Rhode Island Executive Office of Health and Human Services Integrated Care Initiative, Letter of Interest, February 18, 2013.

Most states now require that a Medicaid beneficiary select a PCP. The type of provider who can serve as a PCP may vary based on the type of population being served. For all populations, family practitioners and internists are available to serve as PCPs. For a population focused on elders, a gerontologist may serve as a PCP. For a population that includes children, a pediatrician will likely serve as the PCP. For women of child-bearing age, a gynecologist may serve in that role. Depending upon a state's practice regulations, a nurse practitioner may serve as a PCP. Finally, some state managed care programs permit a specialist physician other than a gynecologist to serve as a beneficiary's PCP under prescribed conditions.

When agreeing to serve as a PCP for Medicaid beneficiaries, the practitioner typically agrees to provide some night and weekend hours, provide routine screenings, and take on some level of management of a beneficiary's overall care. Some states and MCOs have other requirements. For example, in **Rhode Island**, one Medicaid MCO requires PCPs to maintain an appointment system that promotes and provides same-day access, an electronic health record that includes evidence-based protocols and guidelines, and a disease registry that tracks patients with preventive and chronic care needs.¹¹

Finally, states may seek to encourage or require that primary care be physically and operationally integrated with behavioral health care. For example, the **Massachusetts** Medicaid program, MassHealth, is encouraging primary care practices to integrate services at the primary care site and provides financial support for doing so.¹² The **Missouri** Medicaid health home program makes community mental health centers (CMHCs) the locus of primary care for adults with serious and persistent mental illness and established relationships with the CMHCs.¹³

NETWORK ADEQUACY REQUIREMENTS

Network adequacy is a prime concern for state Medicaid programs. A 2012 study found that more than 50 percent of all active physicians in the United States did not participate in the Medicaid program in 2009 or saw

¹¹ Neighborhood Health Plan of Rhode Island.

¹² For more information, see Request for Applications for the Primary Care Payment Reform Initiative, Massachusetts Executive Office of Health and Human Services, March 7, 2013.

¹³ For more information about Missouri Department of Mental Health Community Mental Health Center Healthcare Homes, visit <http://dmh.mo.gov/mentalillness/mohealthhomes.html> (accessed August 17, 2015).

five or fewer Medicaid beneficiaries during the year.¹⁴ As a result, when states contract with an administrative service vendor or MCO, it is essential for the state Medicaid program to define clear network adequacy requirements within the MCO's contract to ensure that the MCO's provider network has sufficient numbers and types of practitioners to provide the services required under a particular program. States must establish quantifiable and measurable standards for both types of practitioners and geographical distribution.

Typically, states include specific network adequacy requirements for primary care, specialty care, and behavioral health care providers in MCO contracts. To determine the appropriate size of the provider network, states and their contractors must base decisions on anticipated enrollment and expected utilization. States may determine adequacy based on a ratio of practitioners to beneficiaries (for example, pediatricians to beneficiaries, 1:2,000) or on geographical distribution related to beneficiary residence by miles or driving time (for example, two PCPs within 10 miles or 20 minutes' driving time). For example, in **Wisconsin's** 2010 health maintenance organization procurement for the BadgerCare Plus program, the state included both drive time requirements and provider ratios.¹⁵ For driving time requirements, Wisconsin required a PCP within 10 miles of beneficiaries who reside in or near cities within the service area or 20 miles of beneficiaries who reside in the more rural region of the service area and an urgent care clinic within 10 miles of beneficiaries.

Table 12 provides network adequacy requirements in the form of provider-to-beneficiary ratios as included in the recent Wisconsin managed care procurement. These provider ratios focus only on the number of providers a managed care plan must have per number of members. They do not include the provider's capacity to see patients (that is included as a separate contract provision for timely access requirements). As shown below, Wisconsin required each managed care plan to have one PCP for every 100 BadgerCare Plus members.

Table 12. Wisconsin's Network Adequacy Requirements—Select Provider-to-Beneficiary Ratios

Provider	Provider-to-beneficiary ratio
PCP	1:100
Allergy	1:5,000
Dentist	1:1,600
Dermatology	1:4,200
Gastroenterology	1:1,400
General surgery	1:1,000
Nephrology	1:3,000
Neurology	1:1,500
Nuclear medicine	1:35,000
Oncology and hematology	1:1,600
Orthopedic surgery	1:1,400
Pathology	1:1,800
Psychiatry	1:900

To confirm that contractors are meeting adequacy requirements, states should monitor provider networks using adequacy monitoring tools (such as those provided by Optum Insight—formerly GeoAccess—or Quest Analytics). States also should require ongoing reporting by a contractor on significant changes in its

¹⁴ David Baugh and Shinu Verghese, "Physician Service Use and Participation in Medicaid, 2009," Centers for Medicare & Medicaid Services Medicaid Policy Brief #11, Mathematica Policy Research, October 2012, https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_IB11_PhysicianParticipation.pdf (accessed August 17, 2015).

¹⁵ Contract Amendment for BadgerCare Plus Services, 2010.

provider network and a formal plan for how the contractor will address capacity issues. Some states include contractual requirements that limit the amount of provider churn that should occur within a network. For example, to help promote continuity of care and stability within the provider network, the Massachusetts Medicaid MCO contract includes language requiring the contractor to “make best efforts to ensure that PCP turnover does not exceed seven percent annually.”¹⁶

States should be aware that access limitations may persist because of provider shortages in geographic regions. For example, it was reported in 2008 that 24 **Texas** counties lacked even one primary care physician.¹⁷ In contracting for provider services, state Medicaid agencies must be aware of capacity existing within the state and what innovations are available to improve access, such as expanded roles for nurse practitioners or telemedicine options. States can use vendors to help expand and build capacity, particularly in behavioral health services and long-term services and supports.

Assessments of network adequacy, while important, have significant limitations. Although an assessment can ascertain how many providers are in the network and their geographic distribution, it cannot determine how much capacity the provider has to treat existing or new patients. As a result, states need to ensure not only that an adequate number of appropriately distributed providers are in the network but also that those providers are truly available to see beneficiaries.

To address that concern, states should require contractors, through contractual provisions, to ensure that beneficiaries have timely access to services, for example, 24/7 access to emergency care, urgent care appointments within 48 hours, routine care within 10 days, and preventive care within 30 days. States often also require that beneficiaries receive a home visit within 24 to 48 hours of discharge from a hospital or nursing facility. Some require that providers make same-day appointments available for sick or urgent visits for children, medically frail enrollees, and pregnant women. Contractors should provide a mechanism for 24/7 access to services for clinical needs, either through a nurse help line or through provider offices. To improve access to care, states should consider requiring that PCPs offer enhanced hours, including on weeknights and during the day on weekends.

To determine network availability, it is important to know whether providers are accepting new patients and how long the wait times are for appointments relative to state-defined standards. States and their managed care contractors often monitor wait times and the ability of provider networks to accept new patients by regularly calling providers to inquire about time for appointments, either identifying themselves or as “secret shoppers.” Other ways of measuring accessibility include patient satisfaction surveys such as the Consumer Assessment of Health Care Providers and Systems, which questions beneficiaries regarding their satisfaction with timeliness, and tracking rates of beneficiary complaints about appointment availability.

In considering network adequacy, states must also consider the cultural, ethnic, racial, and linguistic needs of beneficiaries. To address cultural competency of the provider network, the contractor should be required to use the services of qualified providers who speak beneficiaries’ languages and have similar cultural and ethnic backgrounds, where possible. If a provider does not speak the language of the patients, the provider should be required to provide interpreter services. All providers, regardless of contracting method, should be required to complete cultural competency training courses based on the racial or ethnic composition of a state’s Medicaid program.

¹⁶ Massachusetts MCO Contract, 2008.

¹⁷ Nancy Shute, “Can’t Find a Doctor? You’re Not Alone,” US News and World Report, March 19, 2008, <http://health.usnews.com/health-news/family-health/articles/2008/03/19/cant-find-a-doctor-youre-not-alone> (accessed August 17, 2015).

States that are focusing programs on the elderly or persons with disabilities may want to consider disability competency, that is, the structural capacity of providers to see people with disabilities in their offices and to support their needs, based on experience with that population. A recent study revealed that many doctors are not able to serve people with disabilities, despite the requirement of the Americans with Disabilities Act that they provide reasonable accommodations.¹⁸ The study looked at four cities—Houston; Dallas; Portland, Oregon; and Boston. Portland’s physicians were best able to serve individuals with disabilities, but 14 percent still could not accommodate those patients. The percentage of physicians unable to accommodate the disabled was higher in each of the other three cities.

Where providers are in short supply, states often require their contractors to assist with capacity-building initiatives as part of their network development activities. For example, through its request for proposals for the **Iowa** Plan for Behavioral Health, the Iowa Medicaid Enterprise put a strong focus on vendors’ ability to build behavioral health capacity in the state; it required the vendor to expand capacity for recovery and rehabilitation services specifically and to develop statewide service capacity for other behavioral services.¹⁹

PROVIDER CREDENTIALING AND ACCREDITATION REQUIREMENTS

Typically credentialing involves collection of a provider application, review of key materials (such as licenses and accreditations), and checking state and federal sources that may exclude certain providers from practicing in a state or within Medicare and Medicaid. Providers should be credentialed on a regular basis, typically every three years.

The credentialing process reviews individual providers to determine whether they have the following:

- A current unrestricted professional license in the state(s) in which he or she practices;
- Current medical malpractice insurance coverage (with set minimum requirements);
- Training appropriate to current practice;
- Current drug enforcement agency registration in the state(s) of practice (if applicable) allowing providers to issue prescriptions;
- Current controlled dangerous substances certificate in the state(s) of practice (if applicable); and
- For physicians, board certification or recertification and admitting privileges at an inpatient facility or coverage arrangements should a patient need hospitalization.

Credentialing of practitioners includes primary source verification of credentials and information collected from other secondary sources such as the National Practitioner Data Bank. Where states are providing coverage to dually eligible beneficiaries, credentialing staff also must monitor the Medicare Opt Out list, as a physician or other practitioner opting out of Medicare may not accept federal reimbursement for a period of two years and therefore cannot be a contracted network provider.

Organizational or facility-based providers also require credentialing. For organizations, credentialing includes evaluating that the provider has met all state and federal licensing and regulatory requirements, including Medicare and Medicaid certification, and has been accredited by an accreditation and certifying organization approved by the Centers for Medicare & Medicaid Services for the particular provider organization. States may decide to include providers that are not accredited by another organization. In those cases, trained credentialing staff or medical management from a state or its contractor can conduct a quality site visit and

¹⁸ Deborah Kotz, “Doctors Say Offices Not Equipped for Disabled,” The Boston Globe, March 19, 2013, <http://bostonglobe.com/lifestyle/health-wellness/2013/03/18/boston-specialist-physicians-can-accommodate-disabled-patients/jl0X744wsMoZVSUiGU4JIK/story.html> (accessed August 17, 2015).

¹⁹ Iowa Plan for Behavioral Health.

on-site evaluation of the provider organization to determine whether to include the provider within the state's network. Site assessments should include a review of the provider's policies and procedures specifically to ensure that the provider verifies that its practitioners are credentialed, licensed, and/or certified as applicable. For provision of long-term services and supports, states may consider requiring criminal background checks of individuals who will be interacting directly with beneficiaries, such as personal care attendants, peer navigators, and home health workers.

In developing a credentialing process, states or their contractors should look at ways to reduce the burden for all. To that end, states or their contractors must continue to devote resources to monitoring provider networks and credentialing providers in cycles. When a state contracts with multiple vendors, it might consider requiring standard credentialing processes and allowing MCOs to leverage the credentialing activities of one another in order to reduce the overall cost of the process to the health care system. For example, through the Massachusetts Physician Credentialing Initiative, health plans, including Medicaid MCOs, participate in a standardized process for physician credentialing. Under the initiative, providers submit credentialing information to one shared location to reduce their administrative burden; however, each health plan still conducts its own credentialing activities.

PROVIDER PAYMENT STRATEGIES IN PROVIDER AGREEMENTS

As noted above, new payment models have important implications for provider agreements as providers qualify for incentives based on quality and/or cost reductions. The provider agreement must carefully describe the elements of the alternative payment arrangement. That entails clear description of how the payment mechanism works; the level of financial risk, including any risk involved in the payment method; how performance standards are measured and the implications of performance for payment; treatment of risk adjustment and high-cost outliers; services included in the payment arrangements; reinsurance or stop-loss coverage requirements; and prohibiting providers from refusing to serve high-risk patients. In addition, episodes of care need to have clear start and end dates, and condition-defined bundled payments need tight definitions so that it is clear which patients are eligible and which are not.

Because alternative payment methodologies are performance based, the provider may be required to report performance data that will influence payment levels. In some circumstances, providers may also be contractually required to participate in education and training programs, including learning collaboratives.

PROVIDER PERFORMANCE REQUIREMENTS

Regardless of whether payment is tied to performance, once a state or its vendor has procured a provider network, ongoing monitoring is necessary to ensure that providers meet state and federal quality requirements and are providing services of value. As part of a provider agreement, states should require providers to cooperate with and participate in quality improvement and utilization management activities, including provider learning sessions and trainings and provider-specific improvement activities based on results of provider profiling activities.

Contracts should also require that providers communicate and collaborate with one another. Today, integration of physical health care and behavioral health care is receiving significant attention. However, need for integration, communication, and collaboration exists across the entire provider system—for example, between primary care providers and specialists, between primary care providers and behavioral health care providers, between primary care providers and long-term services and supports (LTSS) providers, and between behavioral health providers and LTSS providers. Providers must also collaborate with staff from county and other state agencies, such as care management staff focused on individuals with developmental disabilities or serious mental illness.

Valid and reliable performance measures that capture the relevant dimensions of patient outcomes and provider behavior are important to monitoring provider performance and are a prerequisite for value-based purchasing. This topic is further discussed in [Section IV](#) “Quality Improvement Strategies.” When possible, the measures should be standardized and nationally recognized.²⁰ Using such validated measures will shorten the time required to put measures in place, reduce the cost of designing and developing measures, present fewer challenges in terms of processing decisions with providers, and potentially reduce the need for testing and auditing of data. A number of evidence-based standardized measures exist for evaluating quality of care among pediatric and maternal populations. But fewer measures are available to assess the quality of care provided to the elderly and people with disabilities, notably for those requiring long-term care or who are dually eligible. The difficulty of measuring the quality of care provided to these populations is compounded because the existing measures specific to them often do not use administrative (claims) data, making data collection expensive, and there are no national benchmarks available against which to gauge those existing measures. Finally, the populations comprising beneficiaries with disabilities and the elderly are heterogeneous, making it hard to use common measures for subpopulations. For example, the population of people with disabilities consists of at least three major groups—people with serious mental illness, those with developmental disabilities, and those with significant physical disabilities. Within each group are many subgroups, and some beneficiaries fall into more than one of the three groups. Although it can be beneficial to use measures that are specific to the situation of a subpopulation, statistically significant results become difficult to generate as population size shrinks.

The lack of measures that reveal the quality of services provided to the elderly and people with disabilities is a significant problem for states and Medicaid MCOs that are attempting to establish incentive programs to improve quality. It also presents a difficulty to states working with the Centers for Medicare & Medicaid Services (CMS) on capitated financial alignment demonstrations for dually eligible individuals.

Table 13 provides a summary of quality-of-care measures for individuals age 65 and older used by state Medicaid programs and their contracted MCOs.

Table 13. Medicaid MCO Provider Quality Measures in Use with Senior Populations in Massachusetts and Minnesota

Measure	Description	Used by
Completion of advanced directives/advanced care plans	Designed to ensure that MCO members complete advanced directives/care plans	Senior Whole Health and Commonwealth Care Alliance (Massachusetts-based special needs plans)
Care management coordination	Assesses whether providers hold a minimum number of meetings between the practice nurse care coordinator and the plan’s nurse care manager	Senior Whole Health (a Massachusetts-based special needs plan)
Annual pain assessment	Measures whether providers conduct an annual pain assessment	Commonwealth Care Alliance (a Massachusetts-based special needs plan)

20 R. Adams Dudley and Meredith B. Rosenthal, Pay for Performance (P4P): A Decision Guide for Purchasers (Rockville, MD: Agency for Healthcare Research and Quality, 2006), <http://www.allhealth.org/briefingmaterials/PayforPerformance-ADecisionGuideforPurchasers-AgencyforhealthcareResearchandQuality-498.pdf> (accessed August 17, 2015).

Measure	Description	Used by
Functional status assessment	Measures whether providers conduct an annual functional status assessment	Commonwealth Care Alliance (a Massachusetts-based special needs plan)
Medication reconciliation	Measures whether providers conduct medication reconciliations during transitions of care	Commonwealth Care Alliance (a Massachusetts-based special needs plan)
Completion of and submission to the state of care plan audit results	Designed to ensure that the MCOs are auditing their providers' care plans to ensure quality in accordance with a Medicaid-defined protocol	Minnesota Medicaid with Minnesota Senior Health Options and Minnesota Senior Care Plus Services plans
Completion of initial health risk screening or assessments within 75 calendar days for community non-Elderly Waiver enrollees new to the MCO	Designed to ensure that MCO members are receiving timely health risk assessments from their providers upon enrolling in the plan	Minnesota Medicaid with Minnesota Senior Health Options and Minnesota Senior Care Plus Services plans

PLAN AND PROVIDER ENROLLMENT POLICIES

State policies vary in how often beneficiaries may change health plans or providers. In Massachusetts, for example, beneficiaries may change enrollment among the five available MCOs and the state-administered Primary Care Clinician Plan as often as they choose. Other states require beneficiaries to remain within a plan for a specified period, with exceptions for cause. For example, in both **Louisiana** and **Nevada**, beneficiaries are given 90 days to select a provider, and after the initial 90-day period they are locked into their plan until the annual open enrollment period. States are required to allow beneficiaries a choice of plans, but if beneficiaries do not select one within a specified time (for example, two weeks) the state will assign them to a plan. The plan assignment is based on a state-developed algorithm that may be random or may assign beneficiaries based on a plan's price, performance, or a combination. Assignment policies based on quality performance provide MCOs with significant incentives to maintain quality performance. In **California**, Medicaid MCOs are awarded a greater percentage of assigned beneficiaries based on plan performance on six Healthcare Effectiveness Data and Information Set measures related to access, timeliness, and quality, and two additional measures of safety net commitment.²¹

Most states require beneficiaries to select a PCP, regardless of whether the state's program is a primary care case management model or uses MCOs or is a combination. As with plan selection, some states allow beneficiaries to select a new PCP as often as they choose, and others require beneficiaries remain with the provider for a specified period, with exceptions for cause. States have also adopted, or required their contractor to adopt, lock-in policies aimed specifically at polypharmacy users, which limit the number of prescribers and pharmacies from which a beneficiary may obtain services.

INTERSECTION OF CARE MANAGEMENT PROGRAMS AND PCMHs

As noted above, many states are actively involved in delivery system transformation. As part of that, many states have implemented or are actively working to implement PCMH models. When states and health plans

²¹ For more information, see <http://www.dhcs.ca.gov/provgovpart/Pages/MMCDAAIncentive.aspx> (accessed August 17, 2015).

have care management programs and patient-centered medical homes, it is important to delineate how a state or plan-based care management program will work with PCMH providers in the network. Specifically, it is important to understand the responsibilities of both the health plan and the PCMH practice in care management and how the two together can best work to support the ultimate goal of improving the quality of care provided to beneficiaries through both of these initiatives. Table 14 delineates the responsibility of a state or plan-based care management program both with and without a PCMH.

Best Practices in Purchasing in the Face of Delivery System Transformation

As described above, it is essential that contractual agreements be clear and concise in their terms and the responsibilities placed on each party, particularly as they relate to provider payment links to provider performance. Agreements, both between the state and its vendors and between vendors and providers, should be reviewed and updated regularly. Equally important are the relationships between the state, vendor, and network providers. State staff must have a senior manager overseeing their activity who is actively engaged in the management of the vendor contract. The senior manager should develop, consistent with the overall goals of the state Medicaid program, contract-specific goals and management strategies. The manager should actively manage to those goals and must have regular internal meetings with key contract management staff to disseminate information and identify key issues. Ongoing, substantive meetings and meaningful reporting are essential pieces of contract management to allow for effective oversight and timely feedback. Contracts should also anticipate and include the need for ongoing technical assistance to providers both individually and through learning communities and should require plans to conduct regular provider profiling.

Table 14. The Role of Care Management with and without PCMHs

Program Component	CM if no PCMH	PCMH	CM if PCMH
Medical Home Competencies			
Patient-centered care	Care management (CM) program and services will be patient focused and include patient as key part of care team.	Medical home competency – responsibility of PCMH.	Health plan to monitor PCMH to ensure providing patient-centered care.
Multidisciplinary team	CM integrated care teams will be multidisciplinary.	Medical home competency – responsibility of PCMH.	Health plan to monitor to ensure use of multidisciplinary team and to assist in finding resources for team where necessary.
Population-based tracking/analysis	CM program will use data to identify potential gaps in beneficiary care.	Medical home competency – responsibility of PCMH.	Health plan will use data to identify potential gaps in beneficiary care and share data with PCMH.
Care coordination across settings	CM program will lead this effort.	Medical home competency – responsibility of PCMH.	Health plan to provide support to PCMH.

Program Component	CM if no PCMH	PCMH	CM if PCMH
Integrated clinical care management	Health plan lead an RN; work with integrated care team and engage primary care and other providers.	Medical home competency – responsibility of PCMH.	Health plan to provide support to PCMH.
Patient and family education	Health plan CM will provide.	Medical home competency – responsibility of PCMH.	Health plan to provide support to PCMH.
Self-management support	Health plan CM will provide.	Medical home competency – responsibility of PCMH.	Health plan to provide support to PCMH.
Involving patient in goal setting, action planning, problem solving, and follow-up	Health plan CM will involve patient as part of the interdisciplinary care team.	Medical home competency – responsibility of PCMH.	Health plan to monitor PCMH.
Evidence-based care delivery, including stepped care protocols	Health plan CM will focus on gaps in care.	Medical home competency – responsibility of PCMH.	Health plan to monitor PCMH.
Integration of quality improvement strategies and techniques	Health plan will provide to network of providers through profiling and other management services.	Medical home competency – responsibility of PCMH.	Health plan to provide support to PCMH.
Enhanced access to care	Health plan will provide 24-hour access to care managers, as necessary.	Medical home competency – responsibility of PCMH.	Health plan to monitor PCMH.
Clinical Care Management			
Covered population	Available across continuum to low-, moderate-, and high-risk dually eligible individuals; the greater the clinical need, the more intensive the clinical care management.	Available across continuum to low-, moderate-, and high-risk dually eligible individuals; the greater the clinical need, the more intensive the clinical care management.	Health plan to monitor PCMH.

Program Component	CM if no PCMH	PCMH	CM if PCMH
Care coordination activities	CM will monitor care plan, ongoing contact with beneficiary, assist with accessing appointments and referrals, reminders for well visits and follow-up care, linkages with state agencies and community resources; provide educational materials.	Practice to provide identifying community resources, ensuring timely referrals external to practice; obtaining reliable information about services not initiated by practice; interfacing with case management or disease management staff of insurers, publicly funded programs, state agencies, schools, etc.	Health plan to provide support to PCMH.
Clinical care management	Health plan to provide discharge planning, medication review and reconciliation, disease management education; communicate with providers; monitor medical and pharmaceutical utilization; self-management and education; ongoing reassessment and monitoring.	Practice to provide frequent patient contact, clinical assessment, medication review and reconciliation, communication with treating clinicians, and medication adjustment by protocol.	Health plan to provide support to PCMH.
Support to primary care practices	Health plan to provide support in coordinating care as indicated in individual care plan, provide updates on care plan progress, potential co-location of care managers at high-volume sites.	n/a	Health plan to alert PCMH to known info on beneficiaries; care management consultation as requested by PCMH; linkages to community resources, as needed.
Patient Registries			
Patient registries	Health plan will provide PCPs with data to assist in managing beneficiaries.	Practices required to have own patient registries.	Health plan will provide PCPs with data to assist in managing beneficiaries.

Quality Improvement Strategies

SECTION IV

Section IV

ROADMAP

Read this section to learn about opportunities to leverage state purchasing power to achieve quality improvement goals. Following are key section takeaways:

OVERVIEW

Although poor health care quality is an issue for all Americans, the quality gap is substantially greater for Medicaid beneficiaries, particularly those with chronic needs. Medicaid has a tremendous opportunity to leverage its purchasing power to drive quality improvement throughout the delivery system, thereby improving health care quality and reducing costs. A variety of state innovations and federal opportunities exist that states can build upon to expand strategies for improving quality and curbing costs in Medicaid.

FUNDAMENTALS

This section provides basic information that state decisionmakers need to be aware of in developing a quality improvement strategy, including:

- Defining quality;
- Federal foundations for Medicaid quality;
- Quality-focused Affordable Care Act initiatives; and
- State foundations for Medicaid quality.

ADVANCED

This section addresses core building blocks of quality, including:

- Performance measurement;
- Reporting and use of quality information;
- Designing and implementing quality improvement initiatives;
- Alignment with other purchasers, payers, and partners;
- Future trends in quality improvement; and
- Quality improvement resources.

Section IV. Quality Improvement Strategies

By Dianne Hasselman, Alice Lind, Jessica Newman, and Lorie Martin, Center for Health Care Strategies

OVERVIEW

Poor health care quality is an issue for all Americans, regardless of their insurance coverage. The quality gap, however, is substantially greater for Medicaid beneficiaries, particularly those with chronic health care needs. Medicaid beneficiaries have greater difficulty accessing services and quality care. They have more complex health care needs and chronic diseases and conditions, including a high prevalence of behavioral health and substance abuse. Medicaid beneficiaries contend with life stressors such as joblessness, lack of stable housing, food insecurity, lack of child care, and neighborhoods that are unsafe. They may have a lower reading proficiency or health literacy. All of these factors impact health.

Medicaid currently serves roughly 68 million Americans – more than one in five Americans.¹ This increases opportunities for state programs to improve health care quality across the country. As the nation's largest health coverage program – costing federal and state taxpayers \$449 billion in 2013 – Medicaid has a tremendous opportunity to leverage its purchasing power to drive quality improvement throughout the delivery system.² For example, Medicaid programs have the opportunity to measure quality across a large beneficiary population, convene partners and stakeholders to collaborate and align around quality, and fund quality initiatives.

FUNDAMENTALS

DEFINING QUALITY

While there is no single definition for quality, a few descriptions are often used.

- The Agency for Healthcare Research and Quality (AHRQ) – the agency within the U.S. Department of Health and Human Services (HHS) charged with improving the quality, safety and efficiency, and effectiveness of health care for all Americans – has described health care quality as “doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”
- The Institute of Medicine (IOM) has defined quality as “The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” And in its seminal 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, IOM defined quality health care as “safe, effective, patient-centered, timely, efficient, and equitable.”
- Perhaps another perspective would be to define an absence of quality as underuse, misuse, or overuse of health care.

FEDERAL FOUNDATIONS FOR MEDICAID QUALITY

Key pieces of legislation have had notable impact on Medicaid quality. These include:

- Balanced Budget Act (BBA) of 1997;
- Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009;
- Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009; and
- Affordable Care Act (ACA) of 2010.

1 The Kaiser Commission on Medicaid and the Uninsured, “Medicaid Moving Forward,” March 9, 2015, <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/> (accessed August 18, 2015).

2 The Centers for Medicare & Medicaid Services, “NHE Fact Sheet,” July 28, 2015, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (accessed August 18, 2015).

The BBA of 1997 - Managed Care and the State Quality Strategy

The BBA of 1997 changed managed care policy options available to states under the federal Medicaid statute and required that managed care programs have standards on accessibility and quality of care. For the first time, states were required to have a quality strategy, including quality performance improvement projects (PIPs) for their managed care programs, and to perform an annual, external quality review for their Medicaid managed care programs.

Implementing federal regulations at 42 CFR 438.200 require each state that contracts with health plans to have a State Quality Strategy, which is a written strategy for assessing and improving the quality of their managed care services. The state must have a process for obtaining beneficiary and stakeholder input before finalizing the State Quality Strategy. States must submit to the Centers for Medicare & Medicaid Services (CMS) the initial quality strategy and an updated document when significant changes have been made. A state can submit its quality strategy as part of its annual External Quality Review (EQR) technical report (submitted to CMS by April 30 annually) or through a separate annual report on State Quality Strategy implementation.³

Examples of the elements in the State Quality Strategy include:

- Procedures that assess the quality and appropriateness of care and services for beneficiaries, including those with special health care needs;
- An annual external independent review of the quality outcomes and timeliness of, and access to, covered services; and
- An information system that supports initial and ongoing operation and review of the State Quality Strategy.

CMS has developed a Quality Strategy Toolkit to help states develop and assess their strategy.⁴

The HITECH Act: Meaningful Use and Health Information Exchange

Through the HITECH Act, part of the American Recovery and Reinvestment Act of 2009, CMS provided \$27 billion in incentive payments to eligible professionals and hospitals that adopt, implement, upgrade, or demonstrate “meaningful use” of certified electronic health records (EHR). Through the meaningful use program, eligible Medicaid providers can receive \$63,750 in incentives per eligible health care professional. Eligible hospitals can qualify for incentive payments totaling \$2 million or more. As of January 1, 2015, more than 433,000 health care providers have received payment for participating in the Medicare and Medicaid EHR incentive program.⁵

EHRs are computerized versions of patients’ paper charts and are intended to centralize information about an individual’s health in one location. Compared with paper charts, EHRs have patient information readily available and can be used by multiple providers and across multiple health care organizations. Timely access to patient information at the point of care can allow providers to avoid costly readmissions and medication errors, improve diagnoses, and reduce unnecessary duplication of services. In other words, EHRs can help providers deliver the right care at the right time in the right setting.

3 The Centers for Medicare & Medicaid Services, “Quality of Care External Quality Review (EQR),” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html> (accessed August 18, 2015).

4 The Centers for Medicare & Medicaid Services, “Quality Strategy Toolkit for States,” <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf> (accessed August 18, 2015).

5 The Centers for Medicare & Medicaid Services, “Data and Program Reports,” <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html> (accessed August 18, 2015).

EHRs provide an easier way for states to obtain data than the current strategy of relying on claims and encounter data, again improving the capacity of state Medicaid programs to measure quality. They allow the collection and transmission of clinical data that are more complete, aggregated, and faster than claims data. Health information exchange is the electronic transmission and sharing of health care data among health care professionals through health information organizations in accordance with national standards for interoperability, security, and confidentiality. The Office of the National Coordinator for Health Information Technology provided approximately \$550 million to states to help health information organizations build the capacity to exchange health information across the health care system.⁶

For more information about the health IT efforts at the federal level, visit <http://www.healthit.gov/policy-researchers-implementers/health-it-adoption-programs>.

CHIPRA and Core Performance Measure Sets

To gain a national perspective on Medicaid performance, CMS developed a core set of performance measures that would facilitate uniform collection and reporting across all states, starting with the quality of services provided to children in state Medicaid and CHIP programs as required by the CHIPRA. Medicaid and CHIP programs can voluntarily adopt these measures, although states may be required to report on them in the future. CHIPRA requires HHS to issue updates to the Child Core Set annually.

In 2015, there are three initial core sets of performance measures:

- Children in Medicaid and CHIP: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf>;
- Medicaid adults (required by ACA): <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-health-care-quality-measures.html>; and
- Health home programs (required by ACA, recommended by CMS, to be promulgated in the rulemaking process): <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-core-set-manual.pdf>.

QUALITY-FOCUSED AFFORDABLE CARE ACT INITIATIVES

The ACA made many advances in quality improvement. A few key initiatives are listed below.

The National Quality Strategy

The National Strategy for Quality Improvement in Health Care, also known as the National Quality Strategy, was established under the ACA and is led by the AHRQ. This federal directive was developed to provide a national roadmap for improving the delivery of health care services, patient health outcomes, and population health. The roadmap is intended to create alignment across quality improvement and cost reduction priorities and efforts in the public and private sectors.

Since 2010, HHS has launched several quality initiatives that align with the National Quality Strategy including:

- *Partnership for Patients*, a national campaign to reduce preventable hospital-acquired conditions and 30-day hospital readmissions;⁷

⁶ The Office of the National Coordinator for Health Information Technology, "State Health Information Exchange," <http://www.healthit.gov/policy-researchers-implementers/state-health-information-exchange> (accessed August 18, 2015).

⁷ The Centers for Medicare & Medicaid Services, "About the Partnership for Patients," <http://partnershipforpatients.cms.gov/about-the-partnership/aboutthepartnershipforpatients.html> (accessed August 18, 2015).

- *Million Hearts Campaign*, a national effort to prevent 1 million heart attacks and strokes over the next five years;⁸ and
- *Multi-Payer Advanced Primary Care Practice Demonstration*, a multi-payer collaboration to transform primary care practices around quality outcomes.⁹

State Medicaid agencies can look to the National Quality Strategy and related HHS initiatives to advance state-specific quality goals and keep abreast of federal opportunities to drive quality across the health care system.

The National CAHPS Survey

In fall of 2014, CMS began collecting baseline data from a Nationwide Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to gather uniform information on access to care and experiences of care of adult Medicaid enrollees.¹⁰ These data will be collected in both managed care and fee-for-service (FFS) delivery systems, using procedures that will avoid duplication of existing CAHPS surveys by states or their health plans.

Federal Quality Improvement Initiatives

Through the ACA, CMS reinforced the focus on quality through a variety of initiatives:

- ACA required HHS to implement Medicaid payment adjustments for health care–acquired conditions. On June 30, 2011, CMS published a final rule requiring that states implement nonpayment policies for provider-preventable conditions, including health care–acquired conditions and other provider-preventable conditions; New York and Pennsylvania were early adopters of this type of payment reform prior to ACA;
- ACA supported several national pilot programs and demonstration programs (primarily focused on Medicare) to test value-based purchasing (VBP) strategies such as using bundled payments, global payments, health homes, and accountable care organizations (ACOs); and
- ACA established the Center for Medicare and Medicaid Innovation (CMMI), which is providing federal funding for states to design and test innovative care and payment models and adopt practices that will deliver better health care at lower cost. CMMI’s State Innovation Models (SIM) Initiative provided \$300 million to 25 states to support state-based models for multi-payer payment and health care delivery system transformation during the first round of funding.¹¹ In 2014, CMMI presented a second round of SIM cooperative agreements. There are now 38 total SIM awardees, comprising 34 states, three territories, and the District of Columbia.

More recently, in an announcement in January 2015, CMS set a goal to link 50 percent of Medicare payments through VBP arrangements by 2018, with an interim goal of 30 percent of all payments by the end of 2016.¹² This is the first time in Medicare’s history that such explicit and far-reaching goals for alternative payment models and value-based payments have been set. Medicaid purchasers are likely to be fueled by this momentum to accelerate linkage of payment to quality through a variety of alternative payment models,

8 Million Hearts, “The Initiative,” <http://millionhearts.hhs.gov/> (accessed August 18, 2015).

9 The Centers for Medicare & Medicaid Services, “Multi-Payer Advanced Primary Care Practice,” <http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/> (accessed August 18, 2015).

10 The Centers for Medicare & Medicaid Services, “Nationwide Adult Medicaid CAHPS,” <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/nationwide-adult-medicare-cahps.html> (accessed August 18, 2015).

11 The Centers for Medicare & Medicaid Services, “State Innovation Models Initiative: General Information,” <http://innovation.cms.gov/initiatives/state-innovations/> (accessed August 18, 2015).

12 U.S. Department of Health & Human Services, “Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value,” January 26, 2015, <http://www.hhs.gov/news/press/2015pres/01/20150126a.html> (accessed August 18, 2015).

including ACOs, health homes, and bundled payment arrangements. The new Health Care Payment Learning and Action Network will support public and private payers in making the shift to “value over volume.”¹³

Federal Guidance on Quality Strategies for New Integrated Care Models

In 2013, CMS released a series of four letters to state health officials and state Medicaid directors related to new Integrated Care Models (ICMs). Purchasers and payers have been adopting alternative payment methodologies that reward providers for value (that is, managing costs while maintaining or improving quality) as opposed to FFS, which rewards providers for rendering more services. CMS defines ICMs as care models that hold the providers and delivery system more accountable for delivering person-centered, continuous, coordinated, and comprehensive care. Examples of ICMs are medical homes, health homes, ACOs, ACO-like models, and other health care delivery and financing models.

The letters provided guidance on developing ICMs to advance care delivery and payment reform. Because ICMs directly link cost and quality to payment, CMS provided states with information on developing an integrated statewide quality strategy to drive payment.

CMS listed five steps as integral to a state’s quality improvement vision and strategy:¹⁴

1. Identify shared goals and aims, which begins with a baseline analysis of data, which could include costs, utilization patterns, health needs of target populations, quality of life issues facing beneficiaries, barriers to care, and past performance;
2. Select interventions – such as payment reforms, delivery reforms, and collaborative quality improvement initiatives – that achieve the shared goals;
3. Measure and monitor progress toward these goals, considering a blend of process, structure, and outcome-focused quality metrics – particularly those endorsed by nationally recognized entities or measures already in use by federal or state programs, including Medicare programs;
4. Define the starting point and targets for performance; and
5. Create transparency and feedback loops to understand what quality measures are improving (or not), creating the opportunity for the spread of best practices and lessons.

CMS also suggests that state Medicaid agencies should create a cohesive plan in the context of what is happening in the state across purchasers related to quality. CMS encourages Medicaid programs to leverage existing and emerging initiatives in the state or nationally.

STATE FOUNDATIONS FOR MEDICAID QUALITY

States must follow federal quality standards and guidelines; however, each state has its own unique quality strategy. State legislation, regulations, and guidance establish the foundation for each state’s quality strategy. Each Medicaid agency can consider several factors as part of the strategy development process, including:

- State and national quality priorities;
- The unique needs of the state’s Medicaid population and subpopulations;
- Resources and infrastructure within the state that can facilitate quality improvement;
- The local market, its facilitators, and barriers to quality improvement;

¹³ The Centers for Medicare & Medicaid Services, “Health Care Payment Learning and Action Network,” <http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/> (accessed August 18, 2015).

¹⁴ Center for Medicaid & CHIP Services, “Quality Considerations for Medicaid and CHIP Programs,” Centers for Medicare & Medicaid Services, November 22, 2013, <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-007.pdf> (accessed August 18, 2015).

- The Medicaid delivery system, including the degree of prior experience with quality improvement initiatives; and
- An awareness of the larger industry trends around quality.

States should adjust their quality strategy over time to accommodate federal and state policy changes, advances in performance measurement, evolving quality goals, new quality concerns, and the like. Therefore, states should revisit their overall quality strategy regularly, along with partners and stakeholders, and modify when needed.

The state of Tennessee provides an insightful case study in terms of how the Medicaid director created tools to help him evaluate the Medicaid program's performance and identify areas needing improvement.

CASE STUDY: TennCare's Data Revolution

In 2006, when Darin Gordon became Tennessee's Medicaid director, the agency was awash in data, but scant information was available to actually help agency leadership with decision making. One of his first goals was to reduce "recreational data collection"—collecting data with no plan for how to use it—and create a data-rich environment to help the state evaluate program performance and identify opportunities for improvement.

Initially the state took two key steps to develop a more robust data infrastructure. First, agency leadership sought to improve quality control of encounter data to avoid scenarios where entire data sets were invalidated because of poor data. A new system allowed the state to move from full file rejections and significant time lags and data gaps to individual record rejections and better inventory management. The agency also purchased a new server to expand capacity and avoid dependency on the information technology (IT) department for all data runs.

Second, to improve data collection and analytical capacity, TennCare leadership employed a divide-and-conquer strategy that maximized staff time and capabilities. The state's IT department continued to handle routine data collection, but a new data analytics group (that Gordon had recently established as TennCare's chief financial officer) provided the capacity to support strategic analysis and timely ad hoc reporting. The analytics shop, which started with three staffers and grew to 10 full-time employees, is staffed with a team that understands data, including economists, statisticians, epidemiologists, and actuaries.

Through these two key steps, within six months TennCare shortened the time required for a basic demographic data report from up to six months to 24 hours, and ad hoc analyses could be easily developed. As a next step, the state focused on targeting the right data and building a set of dashboards to help drive decision making across the TennCare program.

CASE STUDY: TennCare's Data Revolution

(Con't)

To target value-add data, TennCare began employing particular criteria to identify data that can provide the best “bang for the buck” in supporting state quality goals:

1. Value – Are the data aligned with key program information needs?
2. Access – Are the data readily available?
3. Timely – Are there any delays in receipt or processing of the data?
4. Complete – Are there gaps or missing values?
5. Accurate – Are there errors or inconsistencies?
6. Usable – Is extensive expertise or manipulation required to use the data?

Using these criteria, the analytics team worked with the agency's project management team and established a regularly produced set of data dashboards to ensure that the program is driving in the right direction. The at-a-glance tool serves as an early indicator system to alert program leadership to problems, as well as point out key successes. Key dashboard focus areas include: program operations and performance; membership; utilization; financial trends; plan performance; contract performance; and provider network. To make them as usable as possible, the dashboards are also available in a mobile technology interface for 24/7 access. Additional enhancements are underway to improve usability further.

TennCare's experience offers several lessons for other states. Most important, walk before you run. Ensure that your data are good. Identify what you need to be looking at. Determine how to make the data more useful and accessible to leadership. And finally, hire the right people who understand the data and program needs.

External Quality Review Organizations

For states with managed care arrangements, health plans play a critical role in measuring and improving quality for Medicaid beneficiaries. This work is validated and evaluated through an external quality review organization (EQRO), as required by CMS. States can perform EQR tasks directly, but the vast majority choose to contract with independent EQROs. CMS provides states with federal Medicaid matching funds for review-related expenditures, including the writing of required reports and results. More detail on the federal regulations regarding EQRO qualifications and eligibility for matching funds can be found at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>.

For the EQR, each state must undertake, annually, three mandatory activities and may also implement five optional activities, as listed below. The state should align these EQR tasks with the overall Medicaid quality strategy. For example, after considering the existing quality goals, areas for improvement, or alignment with other statewide initiatives, the state can require the contracted health plans to conduct specific performance improvement projects to further the goals. The EQRO would then validate the performance improvement projects as part of the mandatory activities listed in the sidebar below. The optional activities offer states the opportunity to conduct, with the support of a federal match, additional quality initiatives to assist the state quality team.

State External Quality Review (EQR) Activities	
Mandatory EQR Activities	Optional EQR Activities
<ol style="list-style-type: none"> 1. Validate performance improvement projects (PIPs). 2. Validate performance measures. 3. Review the previous three-year period to determine MCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement. 	<ol style="list-style-type: none"> 1. Validate encounter data reported by a managed care organization (MCO) or PIHP (prepaid inpatient health plan). 2. Administer or validate consumer or provider surveys of quality of care. 3. Calculate performance measures in addition to those reported by an MCO or a PIHP and validated by an EQRO. 4. Conduct PIPs in addition to those conducted by an MCO or a PIHP and validated by an EQRO. 5. Conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

States can leverage their EQRO contracts to accelerate quality improvement. Innovative states work closely with their EQRO as a quality partner, sharing the state quality strategy and goals and looking for opportunities to advance quality continually.

Pennsylvania, for example, partners with its EQRO on several initiatives to enhance the state quality strategy. Through this partnership, the state:

- Developed a comprehensive data warehouse containing 10 years of claims and eligibility data to support key projects, such as a behavioral and physical health focus study and performance measure validation;
- Implemented a joint behavioral and physical health readmission focus study to identify beneficiaries at the highest risk for readmission, using both behavioral and physical health diagnostic data. Access to physical health and behavioral health encounter data enables complete analysis of the data; and
- Developed state-specific performance measures using literature reviews and developing initial measurement specification for state review and approval.¹⁵

At a minimum, states are able to leverage additional quality and clinical expertise and staff time to develop, carry out, and enhance their state quality strategy. In selecting an EQRO and designing the contract or scope of work, states can look for organizations with experience in quality improvement and with staff who are prepared to implement new initiatives that will improve quality in the state, beyond the mandatory activities described above. For example, states can explore contracting with EQROs that have the skill set to support transformation of primary care practices, run learning collaboratives for health plans or provider practices, or facilitate work with payers outside of Medicaid to align quality improvement efforts.

¹⁵ Division of Quality, Evaluation, & Health Outcomes, "External Quality Review of Medicaid Managed Care: Building Partnerships for Meaningful Improvement," Center for Medicaid & CHIP Services, February 20, 2013, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/eqrwebinar.pdf> (accessed August 18, 2015).

ADVANCED

QUALITY BUILDING BLOCKS

State strategies to support quality improvement for Medicaid beneficiaries typically include the following building blocks:

1. Collecting performance measure data to assess quality of care;
2. Using results of performance measures to drive better care and to inform consumers; and
3. Supporting quality improvement initiatives to help address any deficiencies or gaps in quality identified by the performance measurement.

PERFORMANCE MEASUREMENT

With the advent of managed delivery systems of care within Medicaid, states are using increasingly advanced mechanisms to measure access, accountability, and quality for beneficiaries. As Medicaid agencies have evolved from bill payers to sophisticated purchasers of health care, the importance of performance measurement has increased exponentially. State Medicaid agencies have grown to rely on well-defined quality measures to provide a barometer for program performance.

In the past, states often added performance measures one program at a time, without synthesizing or aligning approaches across providers, programs, or settings. However, more Medicaid leaders are taking a broad, program-wide approach to performance measurement. Measures typically cover a broad array of needs, including specific initiatives, such as a focus on childhood obesity; urgent health problems, such as an outbreak of a vaccine-preventable disease; or federal mandates, such as access to services. As a result, states often require a wide array of performance measures, often with too little focus on identifying inconsistencies, eliminating duplication, or reducing measure burden. Innovative states are approaching performance measurement strategically, creating cross-agency internal or stakeholder work groups for a more unified, streamlined, and aligned measurement strategy.

Types of Measures

Because measures need to be meaningful, states should select measures that reflect the ultimate outcome of care, for example, an improvement in the condition or well-being of the beneficiaries being measured. However, especially in the first months or years of a new program, outcomes may not be measurable or may be difficult to measure precisely. For example, if the outcome is avoidance of an undesired event, such as inappropriate emergency department use, it is not always possible to determine whether that event would have occurred in the absence of an intervention or program. As a result, Medicaid officials often track structure and process measures to find indicators of program success.

The three types of measures can be described as follows:

- **Structure measures.** Structure measures are usually determined during the procurement or contracting process and include administrative aspects of care, that is, the infrastructure elements that must be in place for delivering a high quality of care. For example, a structure measure could be at the health plan level, such as a minimum ratio of case managers to beneficiaries in a complex care management program, or at the provider level, such as an access standard of beneficiaries' having a provider within 30 minutes or 30 miles.
- **Process measures.** Process measures reflect intermediate aspects of the delivery of care. The best process measures are closely linked to outcomes; for example, measuring whether vaccines have been given is closely linked to preventing infectious disease, and timely prenatal care is closely tied to healthy birth outcomes. In non-medical settings, the link tends to be less clear, usually because the research has not been conducted to prove cause and effect.

In behavioral health, for example, screening for clinical depression is a common measure; however, research has not shown that screening is tied to improved outcomes of depression. In long-term supports and services (LTSS) programs, an individual's quality of life is the main outcome of concern, but that is a difficult value to measure, let alone link to a particular way of delivering LTSS.

- **Outcome measures.** Although structure and process measures are important, direct measurement of outcomes provides the ultimate measurement tool. Outcomes may be measured in terms of hospital admissions and readmissions avoided, reductions in the number of primary care–preventable emergency department visits, or decreases in other events that could have been avoided with sufficient primary care or preventive interventions. Outcome measures are the “gold standard” because measurement has a direct relationship to cost and beneficiary health. There is a significant opportunity in Medicaid to pursue outcomes measures. As a start, states can explore ways to incorporate the AHRQ prevention quality indicators, such as the Uncontrolled Diabetes Admission Rate or Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate, into Medicaid measurement strategies.¹⁶

Selecting and Streamlining the Measurement Set

State staff can identify and select a measurement set in consultation with clinical and evaluation experts. There are a number of considerations in selecting a measurement set, including a measure's importance to the state's overall quality strategy and the feasibility of and data available for collection. See the sidebar, “What Makes a Good Measure?” for additional considerations.

When selecting measures, states should pay attention to areas historically not well addressed in quality strategies. Common gaps in measurement to which many states are beginning to devote resources include measures for complex, new, or expanded Medicaid populations and measures aligned with other agencies or broad, coalition-based efforts. Many regional and statewide efforts to improve quality have had positive effects on population health outcomes, as plans and providers participate in setting goals and choosing interventions across all of their populations.

Table 15. What Makes a Good Measure¹⁷

Attribute	Description
Importance	Impact on health, costs of care; potential for improvement, existing gaps in care, disparities.
Evidence	Scientific evidence for what is being measured.
Validity	Does the measure capture the intended content?
Reliability	Precision, repeatability.
Meaningful difference	Is there variation in performance? Is there room for improvement?
Feasibility	Susceptibility to errors or unintended consequences.
Costs of data collection	Burden of retrieving and analyzing data.
Usability	Testing to see if users understand the measure.

¹⁶ More information on these measures is available at: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx (accessed August 18, 2015).

¹⁷ Adapted from Sarah Scholle, NCQA, presentation “Introduction to Quality Measurement” for Friday Morning Collaborative, November 20, 2012.

Standard Measurement Foundations: HEDIS and CAHPS

The Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys form the backbone of most state Medicaid quality measurement sets.

- HEDIS, developed and maintained by the National Committee for Quality Assurance, is a tool used to measure performance on important dimensions of health care and services. More than 90 percent of health plans in the U.S. collect HEDIS measures.
- The CAHPS surveys, developed by the Agency for Healthcare Research and Quality, are designed to capture accurate and reliable information from consumers about their experiences with health care. The surveys include a core set of questions—with some questions grouped to provide summary results—on key areas of care and service. Health plans report CAHPS survey results as part of HEDIS data collection.

States should consider the use of standard measures, such as the CMS Core Measure Sets described earlier or the Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS (see sidebar). These tools offer clear measurement specifications and the opportunity to benchmark and compare performance across states. Providers and health plans are often asked to collect different measures for Medicaid, Medicare, and commercial populations. States should also consider opportunities to coordinate or align measures with other payers to alleviate the administrative burden on providers and health plans.

Medicaid officials are increasingly turning to a dashboard approach for performance measurement—selecting a critical set of measures that reflect the priorities of the program and that can be tracked on a regular basis. Tennessee Medicaid has worked to refine a Medicaid dashboard in recent years; more information is provided earlier in this section.

State staff should periodically revisit the measure set to confirm that selected measures are still used and valuable. For example, measures that have consistently reached performance targets for several

years might be discarded, especially if the program is stable in terms of provider or health plan continuity. Or if measures have not been used for quality improvement purposes, maybe they should be removed. These measures can be replaced with additional ones representing new quality improvement goals.

Measures can be evaluated on a regular basis against criteria such as the following:

- The potential to improve performance relative to the current performance level or rate;
- The priority or value of the measure compared with the full complement of measures used;
- The trend of the rate of performance (improving or worsening over time);
- Whether providers or plans use the measure to track the effect of quality improvement activities; and
- Whether stakeholders rely on the measure to monitor quality.

Minimizing Measurement Burden

One consideration in selecting performance measures is the burden the measure will place on plans or providers for data collection, analysis, and reporting. That includes the cost of data collection and analysis, measurement audits, and reporting measures—but some costs are hard to estimate. For example, health plans and state agencies are often in the role of persuading providers to serve the Medicaid population,

considering the proportionately low Medicaid reimbursement in most states. Therefore, requirements for record keeping, data reporting, or office visits for medical record review may negatively affect a provider's willingness to participate in Medicaid.

In assessing potential burden, states can consider the following questions:

- **Is the measure unique to Medicaid (in other words, not used by commercial insurers)?** For example, pediatricians have long complained about Early and Periodic Screening, Diagnostic, and Treatment standards that differ from typical well-child checks in periodicity or that require different elements to report. As such, states need to weigh whether the need for unique measures or measurement approaches is justified by differences in the population or program. For example, if the HEDIS measure definition requires a member to be eligible for Medicaid for at least 12 months in order to be "counted" in the measure's denominator, this may exclude a large percentage of Medicaid members because their eligibility tends to fluctuate more than members of commercial plans. In that case, the state might consider tweaking the measure so that it can capture Medicaid members who may not meet the eligibility requirements for a continuous 12-month period. If a state can adequately assess quality of care or access using the same measures and specifications used by commercial insurers, it is wise to do so.
- **Is the measure based on data that the state already requires for reporting?** States generally require that plans report encounter or claims data. Using required data sets to calculate measures lessens the burden to plans because the plan or provider does not need to collect new or additional data. If the measure requires clinical data (data from medical records), the effort to access and collect the data for required measures could be more burdensome even though the value of clinical data is significant. Even providers with comprehensive electronic health records may find that certain measures rely on data that can be ascertained only by examining individual medical records. Still, it is incumbent on states to weigh the value of the data against the burden of collection.
- **If data are being collected from EHRs, does the EHR capture the data elements in a structured format?** As more providers implement EHRs, states have a significant opportunity to collect clinical data for measurement purposes more easily, eliminating the need for medical record review and other time-consuming methods of data collection. As states establish measurement requirements, it is important to understand how data will be extracted from the EHR. For example, if the measure relies on "free text"—non-structured narrative that cannot be readily analyzed—the EHR may be just as difficult to use as a paper chart.

Even measures that rely solely on electronic data and are standardized across Medicaid and commercial populations can pose a burden for state staff and health plans. For example, as measures evolve to match new evidence (for instance, as the target level for glycated hemoglobin changes to match new recommendations), the programming required for analysis must be updated. Large changes in the underlying data, such as the transition of the International Statistical Classification of Diseases and Related Health Problems (ICD) from ICD-9 to ICD-10, mean that analytic programs must be updated. States are frequently hampered by competing demands for analytic staff, and in health plans, the administrative overhead is limited by contract or law.

Performance Benchmarks

Benchmarks provide a valuable point of reference in quality reporting and are often included in health plan or provider performance reports to illustrate how one entity performed in contrast to its peer group. States can compare quality performance across plans, medical groups, or regions, or they can compare statewide

performance to national benchmarks.

Benchmarks are calculated in different ways. For example, the mean or the median outcome can be a benchmark. For HEDIS measures, the benchmarks for each quartile are provided. For example, the 75th percentile means that 75 percent of plans are performing at a lower level than the benchmark; 25 percent are performing better.

When comparing performance measurements, particularly at the provider level, states should recognize and, if possible, risk adjust for patient mix, which may vary by health plan and provider. In other words, a provider who treats a sicker patient population may have lower performance outcomes than one treating a healthier population. That said, the ultimate goal is high-quality care for all patient populations.

Measuring Quality of Care for Complex Populations

Medicaid leaders face an ongoing challenge in understanding how to improve quality for individuals with complex needs. Complex populations include beneficiaries who use a disproportionate amount of health care resources, including those whose eligibility is tied to a disability or need for long-term supports and services. The quality of care and services delivered to these beneficiaries is a critical issue for Medicaid. Standardized mechanisms for measuring quality of care, such as HEDIS, that work well with commercial or healthier Medicaid populations fall short in measuring the complexity of care needs of these individuals.

Alternatives include:

- Stratifying measures across the population to capture results for high-need beneficiaries;
- Selecting measures for low-frequency but high-risk conditions, such as adherence to medication regimen for HIV/AIDS;
- Measuring the delivery of care management or coordination services;
- Including measures related to behavioral health needs, given the frequency of mental illness and substance use disorder among complex populations; and
- Oversampling for complex populations in surveys.

Following are some examples to show how three states are using innovative measurement approaches to improve the ways quality of care is being evaluated for select populations with complex needs:

- **Tennessee**¹⁸ augments traditional HEDIS measures to ensure that quality of care is measured in some way for the entire Medicaid population. In 2013, the state Medicaid agency transitioned from a disease management-only model to a population health model that addresses needs of all members. Tennessee requires that MCOs develop both “opt out” health risk management programs and “opt in” chronic condition programs that provide beneficiaries with integrated care management. These programs use evidence-based clinical practice guidelines that address both physical and behavioral health needs. Effectiveness of Tennessee’s Population Health Program is measured according to impact on select measures such as emergency department utilization, inpatient hospitalizations and readmissions, and member satisfaction.
- **California** requires its Medicaid managed care plans to stratify the all-cause readmission rate for their populations of seniors and persons with disabilities (SPD), who transitioned into managed care starting in 2011. MCOs are required to report the HEDIS-like measure as an overall rate, as well as broken out for subpopulations. The state also incorporated new

18 State of Tennessee, “2014 Annual Update Report of the 2013 Quality Assessment and Performance Improvement Strategy,” <https://www.tn.gov/assets/entities/tennicare/attachments/qualitystrategy.pdf> (accessed August 18, 2015).

measures for cultural competency and facility access for its SPD population (see Medi-Cal sidebar for details).¹⁹

- **Pennsylvania**, through a CMS grant under the Adult Quality Measures initiative, has begun tracking the HEDIS measure called Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. In partnership with local health systems and managed care organizations, the state has used performance data on this measure to spur major collaboration across stakeholders in the Pittsburgh region, where Medicaid clients with identified substance use disorders are now being connected to appropriate treatment after hospital discharge.
- **Kansas**, following integration of behavioral health and LTSS into its KanCare managed care program for all beneficiaries statewide, worked closely with stakeholders to redefine MCO performance measures and related financial incentives. Included among the new measures is a broad array of holistic outcomes, representing the complexity and important role of social determinants of health for individuals with behavioral health or LTSS needs. New measures include competitive employment, housing status, and criminal justice involvement.²⁰

California Medicaid's Measurement Requirements for Complex Need Populations

In transitioning seniors and persons with disabilities into Medicaid managed care, California's Medi-Cal agency created mechanisms to ensure that care was meeting beneficiary needs, including the following:

- *Competency and Sensitivity Training* -- The California Department of Health Care Services (DHCS) requires plans to provide its seniors and persons with disabilities (SPD) Medi-Cal beneficiaries with access to quality health care that is delivered in a culturally competent manner. All appropriate health plan and provider staff must be trained using a DHCS-developed sensitivity training curriculum. DHCS provided plans with web-based training and tools to conduct the training. DHCS Policy Letter 11-010 is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-010.PDF>.
- *Facility Site Review Tool* -- Medi-Cal plans are required to implement a facility site review tool to assess the physical accessibility of provider sites, including specialist and ancillary service providers that serve a high volume of SPDs. Plans must make the site review results publicly available through their websites and provider directories to assist new SPD members in selecting provider sites that are accessible. DHCS Policy Letter 11-013 is available at: <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2011/PL11-013.pdf>.

¹⁹ California Department of Health Care Services, "Medi-Cal Managed Care - Quality Improvement & Performance Measurement Reports," <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsrRpts.aspx> (accessed August 18, 2015).

²⁰ State of Kansas, "KanCare Program - Medicaid State Quality Strategy," September 2014, http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf (accessed August 18, 2015).

REPORTING AND USE OF QUALITY INFORMATION

Reporting quality information — such as HEDIS rates, CAHPS scores, or other information — advances accountability, informs decision making, and promotes greater transparency. Pay for performance (P4P) programs — where plans or clinicians can receive financial incentives for improving process or outcomes measures — are ubiquitous throughout both public and private markets. Even though there is limited evidence of the impact on costs, P4P is a common first step in getting plans and providers to think about how they are more accountable to state purchasers, health plan payers, and patients. Whether purchasers or payers report quality information publicly or not, sharing quality outcomes information can increase motivation to improve performance.

Public Reporting

In recent years, purchasers have been more and more interested in public reporting of quality information. Through regional health improvement collaboratives (RHICs), states are aggregating data to report quality metrics across purchasers and health plans. The ACA also supports new opportunities for public reporting. The National Quality Strategy, for example, includes public reporting of performance information through health care quality websites. The ACA called for public reporting of performance measures on quality, cost, and other metrics. The initial core set of quality measures for Medicaid adults was made publicly available on an annual basis starting in 2014. In addition, consumers use publicly available quality information to make decisions on the insurance marketplaces.

Medicaid programs have publicly reported quality information, specifically HEDIS and CAHPS data at the health plan level, for many years. States typically update these public reports annually to illustrate trends in quality improvement and changes in rates. The National Committee for Quality Assurance (NCQA) — described in the text box — also produces annual reports of HEDIS information that provide a national snapshot of quality for commercial as well as Medicaid and Medicare plans.

National Committee for Quality Assurance *Accreditation of Medicaid Managed Care Organizations*

The National Committee for Quality Assurance (NCQA) accredits health plans and other health care organizations. Currently, 42 states formally recognize NCQA managed care organization (MCO) accreditation in whole or in part for their commercial health insurance market or their Medicaid managed care program. NCQA awards an accreditation status to organizations with programs for service and clinical quality that meet certain requirements for consumer protection and quality improvement.

In 2006, NCQA created its Medicaid Managed Care Toolkit in response to numerous inquiries from state Medicaid agencies. The toolkit is updated each year to reflect the newest Health Plan Accreditation Standards and any federal changes related to deeming MCO compliance with quality assurance requirements.

The toolkit explains how states can take advantage of the federal allowance to streamline oversight of Medicaid MCOs through the use of private accreditation of health plans, reducing unnecessary duplication in the oversight process. It highlights the areas where NCQA's evaluation standards and performance measures can be used to supplement or serve in lieu of relevant Medicaid requirements.

State Medicaid agencies also commonly recognize NCQA's Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems measures as part of their effort to hold MCOs accountable for quality and patient satisfaction. A summary of state laws relating to the use of these measures can be found at NCQA's website, <http://www.ncqa.org>. The toolkit can be downloaded at: <http://www.ncqa.org/Portals/0/Public%20Policy/2014%20NCQA%20Medicaid%20Managed%20Care%20Toolkit%20Summary%20-%20Final.pdf>.

Quality information at the medical group or provider level is arguably much more valuable to patients and consumers but can also be more challenging to collect and report publicly. That said, public reporting at the medical group or practice level is a growing strategy as providers become more accountable for delivering quality health care through efforts such as patient-centered medical homes. An example of public reporting at the community level can be found in Minnesota, where MN Community Measurement, an independent, nonprofit organization, collects and analyzes quality data from medical groups and clinics; it publishes quality ratings for 1,400 clinics, 535 medical groups, and 140 hospitals in the state.²¹

With these new opportunities for publicly sharing quality measures comes the need for careful consideration regarding public reporting tactics. Public reporting must be done with care, as providers to a great extent remain wary of moving toward more transparency.

Some of the concerns include:

1. What measures are selected to be reported, how they are selected, and whether they are well validated;
2. Whether providers have a chance to review their rates and correct or submit information that might be missing before the rates are published;
3. Whether adjustments are made to rates to reflect providers' serving more complex populations; and
4. Whether the information is actually valuable and relevant to consumers and whether and how consumers use the information.

Private Reporting

Purchasers and payers share provider- or practice-level quality information more commonly through private reporting. Through quality coaches, practice facilitators, or provider network staff, providers receive information about their individual performance, sometimes compared against their peers, which can be an effective tool to spur them to improve how they deliver care. Medicaid programs in Maine, North Carolina, and Oklahoma all support and deploy quality experts to work one-on-one with providers to understand and improve quality. This strategy is most effective and compelling when a provider receives the information aggregated across all his/her panel, as opposed to fragmented by insurance program or health plan.

The impact of private reporting is also more effective when it is accompanied by support to assist the practitioner in making the needed changes to improve quality. For example, it could be quite demoralizing for a physician to receive poor performance scores – and even be financially penalized – without receiving some resources or technical assistance to raise those scores. Likewise, providers will be much more successful at providing better care when they have access to effective strategies and supports for improvement.

21 Minnesota Health Scores, "Measuring Quality," <http://www.mnhealthscores.org/> (accessed August 18, 2015).

CASE STUDY: Public Reporting of Health Plan Data in Minnesota

One of the more intriguing examples of public reporting is found on the *Consumer Reports* website, which published ratings of both private and public health plans in Minnesota, as well as patient satisfaction with providers. Access to the Minnesota Medicaid health plan information is free and allows the public to compare plans' overall scores and their performance in consumer satisfaction, treatment coverage for common conditions, and providing preventive services (access to commercial plan information is by subscription only).

The rankings of Minnesota's private, Medicare, and Medicaid health insurance plans posted by *Consumer Reports* are based primarily on Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers and Systems data from the National Committee for Quality Assurance (NCQA). For prevention and treatment measures in 2012, NCQA used measures in different areas of care, such as asthma medication use and controlling high blood pressure. Commercial, Medicare, and Medicaid plans are scored on many of the same measures, but unique measures for each were added to provide the best picture of care for beneficiaries.

States using similar strategies to offer public reporting to beneficiaries should consider offering education or providing guidance on how beneficiaries might use the information. For example, *Consumer Reports* provides the following information to educate consumers on how to understand and use the health plan reports:

You can use them to look closely at a single plan or compare up to five plans. In either case, focus on three things. First look at a plan's 1 to 100 overall score; then see how it ranks in your state and nationally; and then look at its scores for prevention, treatment, and customer satisfaction. For even more detail, click on the plan's name and see how it did in dozens of measures, such as how well it cared for people with diabetes.

Don't focus too much on minor differences in overall scores or rank, such as between plans with scores from, say, 82 to 86 or ones ranked 70th and 80th nationally. Instead, pay attention to larger differences in overall score and rank and on the 1-to-5 scale for prevention, treatment, and customer satisfaction.

And remember that non-accredited plans generally have lower scores than accredited plans because accreditation can add as much as 15 points to a plan's overall score.

Thus far, Minnesota is the only state that is sharing health plan performance data via *Consumer Reports*, but other states may be compelled to consider this public option to facilitate sharing with their beneficiary population. The site is available at:

<http://www.consumerreports.org/health/insurance/minnesota-health-insurance.htm>.

DESIGNING AND IMPLEMENTING QUALITY IMPROVEMENT INITIATIVES

Medicaid quality improvement initiatives strive to identify, implement, and institutionalize best practices to improve the health care and health outcomes of patients. There is no single or right model for a Medicaid

quality improvement initiative. They come in many different shapes and sizes and can be designed to incorporate numerous areas, including:

- The health care goals of the state;
- Opportunities to improve the quality of care received by patients or delivered by providers;
- The existing delivery system infrastructure (as building blocks) or its gaps (as opportunities for improvement);
- Best practices;
- Regional or statewide innovations; or
- Quality initiatives that go beyond the Medicaid program.

Increasingly, quality improvement is only one part of the equation; with ongoing pressure to bend the cost trend, states are seeking opportunities to invest in programs that not only improve patient outcomes but also reduce costs. One way Medicaid agencies are looking to improve quality and reduce costs is through ACOs. These entities incorporate provider-level risk for health costs and outcomes by tying quality metrics to shared savings, or capitated arrangements. As of March 2015, eight states have already launched Medicaid ACO programs, with many more actively pursuing ACO programs. While many programs are too new to have measurable results, quality improvement and cost savings or containment have been seen in the states of Colorado, Minnesota, and Oregon.²²

Designing a Quality Improvement Initiative

With an infinite number of options for quality improvement initiatives, selecting an area of focus can be an overwhelming task. States might use strategies such as the following to identify opportunities for improvement:

- **Target a measurable goal that will likely provide a tangible return on investment.** Performance measures indicate areas for quality improvement, and initiatives can be designed to improve a specific clinical area, such as improving poor control of diabetes, reducing inappropriate emergency department use or avoidable readmissions, or eliminating early elective deliveries. States identify opportunities by comparing Medicaid's performance against national or other benchmarks. States give priority to opportunities that will not only improve quality but also reduce costs.
- **Invest in gaps in much-needed infrastructure.** Like other payers, Medicaid programs have invested heavily in recent years in strengthening the primary care network. Through medical home initiatives, states have provided support to practices via changes in reimbursement, practice facilitation coaches, health information technology, technical assistance and learning collaboratives, and other interventions. Through health homes (Section 2703 of ACA), states are funding care management teams that were previously not funded through Medicaid. As of September 2015, 19 states plus the District of Columbia have launched health homes and nearly a dozen additional states are planning to implement this approach.²³
- **Leverage existing infrastructure and align with other payers.** If data aggregators, medical home initiatives, or learning collaboratives already exist independent of Medicaid, states should join, adopt, and leverage those efforts. Collaborating with other purchasers creates

22 Tricia McGinnis, "A Unicorn Realized? Promising Medicaid ACO Programs Really Exist," The Commonwealth Fund Blog, March 11, 2015, <http://www.commonwealthfund.org/publications/blog/2015/mar/unicorn-realized-medicaid-acos> (accessed August 18, 2015).

23 Center for Health Care Strategies, "Medicaid Health Homes: Implementation Update," September 2015, <http://www.chcs.org/resource/medicaid-health-homes-implementation-update/> (accessed October 8, 2015).

greater momentum and provides a strong signal to plans and providers across a state or region, as well as economies of scale.

- **Invest in “high-value target” opportunities.** States target quality improvement efforts to providers who serve a large number of Medicaid beneficiaries, as opposed to practices without many Medicaid patients. Providers must have a critical mass of patients before they will make a change in how they deliver care. The intent is for states to receive more impact from their investment.
- **Focus on reducing disparities in care.** Performance data can be stratified by race, ethnicity, language, geographic location, disability, or other factors to identify inequities in health care quality. This in turn can create opportunities to “raise all boats” through specific quality interventions.
- **Eliminate silos and integrate care.** In general, when more integration is present within a delivery system, quality improvement activities will be more effective. It is very difficult to have a meaningful impact on chronic health conditions when different delivery systems provide pieces of the total care package. Care coordination and collaboration among providers become difficult. An integrated care approach that brings together physical, behavioral, and long-term services and supports allows for improved coordination, better outcomes, and reduced costs.

CASE STUDY: Examples of Quality Improvement Initiatives

Numerous quality improvement initiatives are being implemented by state Medicaid agencies and other payers across the country. Here are types of initiatives underway in several states.

Reducing inappropriate emergency department use: Patients use the emergency department (ED) inappropriately for a variety of reasons. Some patients use it because they have poor access to health care services. Some high-cost, complex patients show extraordinarily high use of the ED and may visit numerous times a week or month, at a tremendous cost to the Medicaid program. Many Medicaid agencies are considering strategies to reduce inappropriate ED use, whatever the reason, and create a delivery system that is more effective and efficient in delivering care. States can use care managers to work with patients to navigate the system and access care more appropriately. A close partnership with hospitals can provide the state and care managers with real-time data, allowing them to be alerted when beneficiaries are in the ED for a non-emergency concern and allowing the care manager to visit or call the beneficiary immediately.

Promoting appropriate use of medication: Adherence to medication is critical for a number of chronic conditions (for example, heart disease) to avoid complications. However, patients may forget to take their medication with the recommended frequency or may have difficulties filling or refilling a prescription. Care managers can reinforce provider messaging and educate patients on the importance of medication to improve adherence. Care managers can follow up with regular reminders by phone or text message to help beneficiaries remember to take their medication. If pharmacy data are available, care managers can review patient data to ensure that medications are filled with appropriate frequency. Finally, the care managers can compile prescription fill and medication adherence data and share that with the patient’s physician, to be sure that the patient is receiving a consistent message.

CASE STUDY: Examples of Quality Improvement Initiatives

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Developing performance improvement projects for managed long-term supports and services (MLTSS) programs. This is especially important for emerging MLTSS programs in which the procurement approach allows managed care organizations (MCOs) with no previous LTSS experience to take on this high-risk population. Examples of performance improvement projects might include:

- Measuring and improving the MCO's approach to person-centered care planning, use of motivational interviewing in setting goals, and incorporating the social model philosophy into its model of care;
- Measuring and improving on outcomes of interest for community-based services, such as assessment, intervention, and prevention of adverse events related to falls; and
- Measurement and improving quality of life and beneficiary experience of care.

Roles in Quality Improvement

It is important to keep in mind that states, health plans, and providers all have different roles in a quality improvement initiative. The state's role is to provide leadership in driving a culture of performance measurement and quality improvement. The state can set the vision and goals, provide the overall framework for the effort, convene the stakeholders, help design the initiative, select performance measures and interventions, and spread and sustain best practices. The state may provide claims data for the performance measures, supply financial incentives for improved quality, and coordinate a learning network or collaborative for the overall initiative.

Besides providing input on the project design, the health plan's role in a multi-payer collaborative may include: identifying eligible members; calculating baseline and ongoing performance (using claims, encounter data, pharmacy data, lab results, etc.); working directly with the provider network to implement the quality intervention; leveraging its care management programs and infrastructure; and reporting outcomes to the state. Plans can measure performance at different levels—by individual provider, by region, by plan, and so on.

In addition to lending a practical, on-the-ground perspective to the initiative, the provider's role is typically to: implement the intervention within the practice; provide feedback on obstacles or challenges; learn about quality improvement by participating in learning collaboratives; and use data to find opportunities to improve care delivery.

Reducing Disparities in Care

Health disparities are differences in health outcomes among groups of people. For example, more than half of non-elderly Medicaid beneficiaries are from racially and ethnically diverse populations. These populations experience more barriers to care, a greater incidence of chronic disease, lower quality of care, and a higher mortality rate than others. In addition to minorities, people in rural areas and people with disabilities also face disparities, as they often have lower quality of care.

Identifying where the disparities exist is an important first step in raising the quality of care for all Medicaid beneficiaries. States collect data that facilitate the identification of disparities by stratifying or grouping beneficiaries into subpopulations. States collect race, ethnicity, and language data as one vehicle for identifying disparities. States can also look at subpopulations or regional pockets to identify potential disparities, such as disability status. Differences in quality scores for different subpopulations indicate the existence of disparities. Once disparities have been identified, the next step is to understand why disparities might exist and identify interventions or strategies that might reduce them. Identifying the right strategies for reducing disparities can be challenging (what intervention, what “dosage,” how frequently, etc.), and seeking input from the provider and patient population is invaluable in identifying ways to understand what drives patients and how to improve the experience of care. An alternative approach to reducing disparities is helping providers who have large disparities to address quality.

Small primary care practices play a critical role in caring for low-income individuals with chronic conditions, particularly patients who are racially and ethnically diverse. Such practices typically have limited resources for quality improvement, particularly those practices that are unaffiliated with a larger health care system. The text box below describes an initiative that focused on reducing disparities with small primary care practices in four states.

Reducing Disparities at the Practice Site²⁴

Reducing Disparities at the Practice Site (RDPS), an initiative funded by the Robert Wood Johnson Foundation, was designed to support quality improvement in small practices serving high volumes of low-income and diverse patients with diabetes. It sought to test the ability of state Medicaid agencies, health plans, primary care case management, and other Medicaid partners to assist small practices in improving diabetes care. State-led teams in Michigan, North Carolina, Oklahoma, and Pennsylvania participated from October 2008 to December 2011, including six to 12 small primary care practices in each state. Each state developed its own practice-based intervention, supporting practices with data, health information technology resources, care management resources, quality improvement training, and capital.



The initiative confirmed that Medicaid agencies must provide the vision and leadership for quality improvement investment in these critical but often forgotten practices. Furthermore, health plans, primary care case management programs, external quality review organizations, and other community-based organizations are key partners for Medicaid in working directly with these practices to improve chronic care management and reduce disparities in care. Medicaid investment in supporting these practices requires a long-term commitment to address the medical, behavioral, and social needs of their patient population.

Absent locally available reports of quality data by race and ethnicity, states can look to national reports, such as the National Healthcare Disparities Report, released annually by AHRQ. It reports on individual and rolled-up results and how they change over time. The findings can point state leaders to areas of focus (see sidebar for select findings).²⁵

24 Center for Health Care Strategies, “Reducing Disparities at the Practice Site,” December 2011, <http://www.chcs.org/project/reducing-disparities-at-the-practice-site/> (accessed August 18, 2015).

25 Agency for Healthcare Research and Quality, “2011 National Healthcare Quality and Disparities Reports,” U.S. Department of Health & Human Services, March 2012, <http://www.ahrq.gov/qual/qdr11.htm> (accessed August 18, 2015).

Table 16. Key Findings from National Healthcare Disparities Report, 2013²⁶

	Status	Change Over Time	Areas Improving	Areas Lagging
Quality	<u>FAIR</u> <ul style="list-style-type: none"> • 70% of recommended care actually received • Large variation across states 	 GETTING BETTER	<u>Improving more quickly</u> <ul style="list-style-type: none"> • Hospital care • Publicly reported measures from the Centers for Medicare & Medicaid Services • Adolescent vaccines <u>Performing Well</u> <ul style="list-style-type: none"> • New England and West North Central States 	<u>Improving More Slowly</u> <ul style="list-style-type: none"> • Ambulatory care • Diabetes care • Maternal and child health <u>Performing at a Lower Level</u> <ul style="list-style-type: none"> • West South Central and East South Central states
Access	<u>FAIR</u> <ul style="list-style-type: none"> • 26% have difficulty getting care* 	GETTING WORSE* 	<u>Improving</u> <ul style="list-style-type: none"> • Availability of providers by telephone 	<u>Not Improving</u> <ul style="list-style-type: none"> • Private health insurance coverage*
Disparities	<u>POOR</u> <ul style="list-style-type: none"> • Minorities and people in poverty experience worse quality and access for a large proportion of measures 	NO CHANGE	<u>Disparities Getting Smaller</u> <ul style="list-style-type: none"> • HIV disease • Patient perceptions of care Few gaps in disparities data on African Americans, Latin Americans, and Asian Americans	<u>Disparities Getting Bigger</u> <ul style="list-style-type: none"> • Cancer screening • Maternal and child health Many gaps in disparities data on Native Hawaiians and Other Pacific Islanders

* Findings reflect access prior to implementation of most of the health insurance expansions included in the Affordable Care Act.

ALIGNMENT WITH OTHER PURCHASERS, PAYERS, AND PARTNERS

In recent years, quality improvement initiatives have increasingly advanced into multi-payer, multi-stakeholder efforts to achieve systemwide reforms. Although Medicaid is the largest purchaser of health care in terms of covered lives, it is still only one piece of that system. It is difficult for one purchaser—even one as large as Medicaid—to move the health care marketplace. Therefore, multiple purchasers and payers must collaborate to drive larger delivery system changes. The SIM initiative, which is funded by CMMI, is supporting state efforts to test multi-payer strategies to implement statewide payment and delivery reform.

From the provider's perspective, multi-payer collaboration on quality reduces fragmentation of quality goals, performance measures, reporting requirements, and quality improvement interventions. Providers typically contract with multiple payers and health plans serving Medicare, Medicaid, and commercial beneficiaries. If

26 Agency for Healthcare Research and Quality, "2011 National Healthcare Quality and Disparities Reports," U.S. Department of Health & Human Services, March 2012, <http://www.ahrq.gov/qual/qdr11.htm> (accessed August 18, 2015).

each health plan has its own unique quality initiative, practices could potentially be participating in several quality improvement efforts. This creates inefficiencies and confusion for the practice if each initiative requires different measures, incentives, reporting, and interventions. Furthermore, the number of patients in each initiative will become very small, reducing the potential for generating meaningful performance outcomes. When payers and plans align their quality improvement goals, they send a stronger message to the practice about what needs to be done.

From the patient's perspective, multi-payer collaboration is also beneficial. Beneficiaries change health plans and churn between insurance products as eligibility and personal income fluctuate. A beneficiary in one Medicaid health plan today could be enrolled in a different one next month or next year. With implementation of the insurance marketplaces through the ACA in 2014, the level of churn is anticipated to increase. Payers can obtain a more complete picture of quality over time if they aggregate performance data, so that quality follows the patient or provider, not the payer or plan.

CASE STUDY: A Study in Collaboration in Maine

MaineCare, the state's Medicaid program, has an ongoing and successful collaboration with its regional health improvement collaborative that comprises two entities: Maine Quality Counts and Maine Health Management Coalition. The three entities work together to convene consumers, providers, purchasers, payers, and public health organizations to improve the quality and cost of health care in the state. The collaboration includes collecting, measuring, and public reporting of quality data; providing quality improvement initiatives and support for providers; helping consumers become more actively involved in their health care; and driving delivery system and payment reform throughout the state. Maine Quality Counts has worked closely with the state to design, implement, and support a statewide multi-payer, patient-centered medical home initiative, as well as to implement health homes made possible through Section 2703 of the Affordable Care Act. The partners have also worked closely on value-based purchasing strategies in the state, such as the design and implementation of the state's accountable care communities and State Innovation Models test grant.

For more information about this partnership, visit <http://www.mainequalitycounts.org/>.

As a state begins to think about a quality improvement initiative, it should consider the key partners and stakeholders with whom it can collaborate. In addition to Medicaid health plans, these include:

- **Other state agencies:** State agencies outside Medicaid, such as the department of health, department of insurance, employee insurance office, and state school board, can offer alignment with other quality improvement initiatives in the state and invaluable expertise in key topic areas, such as mental health or substance abuse. The governor's office is also a critical partner for quality improvement, particularly for states with SIM grants.
- **Large employers:** Large employers, particularly those who self-insure, will have some similar goals as Medicaid in terms of purchasing greater value from the delivery system. Local or state business coalitions and the National Business Coalition on Health (NBCH) can be important partners for states. Health plans often have multiple product lines – one for Medicare, one for commercial, and one for Medicaid – so alignment of quality improvement requirements can be an effective and administratively efficient strategy. For more information about NBCH, visit <http://www.nbch.org>.

- **Regional health improvement collaboratives:** RHICs are nonprofit, nongovernmental organizations that work regionally or sometimes statewide to advance health care transformation in a collective and collaborative manner. When present in a state, RHICs can be a trusted third party to convene all purchasers and payers around collaboration and alignment of measurement, reporting, payment reform, and improvement strategies. The state of Maine provides an example of a successful partnership between a Medicaid agency and an RHIC.
- **Consumers:** States should involve consumers in work groups and task forces to provide insight on how quality improvement initiatives should be designed so that they will be patient centered and more likely to engage patients and will address areas of care that matter to consumers.
- **Hospitals:** Hospitals can partner with primary care and other providers in quality improvement efforts to increase coordination and communication and improve care transitions. Many costly and serious errors that should be avoided occur in the hospital setting, such as widespread incidence of medical errors per IOM reports, poor or misunderstood discharge instructions, and poor medication management.
- **Universities:** Local universities can offer clinical, research, and data analysis expertise to assist Medicaid programs in planning, implementing, and evaluating a quality improvement initiative.
- **Provider associations:** Provider participation is key to the success of any quality improvement initiative. Provider associations can help to plan a quality improvement initiative, identify provider champions to promote the program, and spread information to their members about the effort, including lessons and timelines.

FUTURE TRENDS IN QUALITY IMPROVEMENT

Several emerging themes are gaining momentum in the health care industry. These trends are examples of initiatives that are being advanced by Medicare and the commercial sector and are also taking hold within Medicaid agencies:

Creating a macro-level quality strategy for the Medicaid program. Medicaid leaders at the federal and state level are thinking about the larger, collective quality strategy that will measure, assess, improve, and ultimately demonstrate the value of the largest health insurance program in the country. Medicaid must identify the top opportunities to address common and costly gaps in quality care across states and then develop a common set of guidelines or parameters to close those gaps. For example, addressing the universal and unrelenting problem of poor access to primary care should be part of a macro-strategy. Medicaid could create a strategy for using nontraditional health care workers as a release valve for overburdened primary care physicians to help manage patients with chronic care conditions, engage people in their health care, and focus the community on staying well.

Expanding performance measurement and reporting of population health. Social determinants of health—that is, social and economic factors such as schools, transportation, literacy levels, public safety, playgrounds and parks, and availability of fresh food markets—that contribute to the overall health of a community have been central to public health and quality for years. However, these concepts have not been incorporated into or linked with quality improvement efforts in Medicaid. In the future, policy makers, program administrators, communities, advocates, and others will focus on linking public health and traditional health care so that payers, states, regions, and communities have a more complete and meaningful understanding of the health and wellness of Americans. Development and use of measures that go beyond the traditional paradigms will be increasingly critical in the quality discussion. State SIM efforts have begun to explore opportunities for a

population health focus.

CASE STUDY: Delivery System Reform Incentive Payment Program: Focus on New York

The Delivery System Reform Incentive Payment (DSRIP) program provides a new opportunity for states to advance delivery system and payment reform projects in Medicaid. This hospital-based reform effort, authorized through Medicaid Section 1115 waivers, enables states to reward providers for meeting performance milestones. Since 2010, seven states have established DSRIP programs, and many more are exploring the opportunity.

New York's comprehensive DSRIP initiative, approved in 2014 and launched in 2015, is unique in its inclusion of a broad set of health and social service providers and in the way it is being leveraged to drive transformational delivery system integration. Through DSRIP, the state is looking to reduce avoidable hospital use by 25 percent for both Medicaid beneficiaries and uninsured New Yorkers. Under New York's definition, avoidable hospital use encompasses preventable hospital readmissions as well as inpatient admissions that can be avoided with proper preventive care services.

The state's DSRIP program will hold networks of providers accountable as Performing Provider Systems for delivering population-based health care. Hospital and non-hospital based providers can participate by meeting specific eligibility criteria to share in performance payments. Funding for these performance payments is authorized under New York's Section 1115 Medicaid waiver that allows the state to reinvest \$8 billion of \$17.1 billion in federal savings generated by Medicaid reforms.

For more information, visit: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/.

Advancing value-based purchasing. Like other purchasers, states will continue to become more and more sophisticated in linking payment to better quality at lower cost through risk-sharing arrangements. States are moving toward shared savings arrangements with up- and downside risk, global and partially capitated payments, episode-based care payments, and other strategies that directly link payment to specific quality and cost outcomes. The prominence that quality plays in these new arrangements cannot be overstated – providers must be able to maintain or achieve a certain threshold of quality performance to benefit financially from any cost savings. Entering into these risk-sharing arrangements will require careful consideration of the scope of services for which the provider is accountable, the expectations for quality and utilization impacts, risk adjustment of patient populations, and other factors.

Aligning performance measurement and reporting across state agencies. With the ACA's insurance marketplaces, millions more Americans now have insurance coverage. Medicaid and the state agency responsible for the marketplace (if applicable) should look for opportunities to align performance measures and public reporting to inform consumers about their choices in a way that allows apples-to-apples comparison of quality and value. The state agency that purchases health care benefits for public employees is another potential partner for Medicaid.

Looking to the private sector and Medicare for effective strategies. Commercial payers and Medicare are implementing strategies that drive consumers toward greater value. Increasingly these payers use the term "value," not "quality," when communicating to consumers who do not understand what quality is but understand value. Through value-based insurance design, for example, copayments are waived for patients

who choose high-value providers. Although there may be challenges to adopting private-sector strategies in Medicaid, there are many ways that states can incorporate similar principles and pull similar levers. Medicare developed Hospital Compare and other web-based resources that allow consumers to choose providers based on readmission rates; timely and effective care; patient satisfaction survey information; and other information. Medicaid and its stakeholders should consider how the program could develop tools and resources to drive Medicaid beneficiaries toward greater value.

Arizona's Acute Care Program Payment Reform Initiative

In 2013, Arizona implemented the Acute Care Program Payment Reform Initiative. The state began making incentive payments to health plans that meet quality measures and make 5 percent of provider payments through shared savings arrangements. In 2015, the percentage of alternative payment arrangements increased to 10 percent, and the initiative expanded to include the state's long-term care managed care organizations.

Creating transparency around health care costs.

The release of Medicare hospital pricing, or "chargemaster," information by CMS caused quite a stir, not only in the health care industry but, perhaps more important, among the general public. Although debate about the usefulness of chargemaster information continues, there is less debate about the need for consumers to have access to cost information in a responsible and informative manner. Medicaid programs should consider how they might join and contribute to this effort.

Using health information technology with patients to improve quality. Beyond the health information technology (HIT) movement to increase adoption of electronic health records by providers, payers are exploring HIT approaches to better engage patients in their health care management. For example, EHRs may have a patient portal where patients can access portions of their own health records. Alternatively, through case management programs, case managers can use text messaging to remind patients to attend scheduled medical appointments, perform personal health checks (monitor daily weight, check glycated hemoglobin levels), or take daily medications.

QUALITY IMPROVEMENT RESOURCES

There are many organizations that provide tools, resources, and reports useful for states in thinking through and developing a quality strategy. Here are several to consider.

- The **Agency for Healthcare Research and Quality** is a federal agency that produces evidence to improve patient care and provide policymakers and other health care leaders with information to make critical health care decisions. AHRQ's work focuses particularly on low-income and Medicaid populations. It conducts and supports research on topics that aim to improve the quality of health care and reduce costs of the Medicaid program. AHRQ is partnering with CMS to develop and maintain the adult core measures set, described earlier. More information can be found at <http://www.ahrq.gov>.
- The **Centers for Medicare and Medicaid Services** is the federal agency responsible for the administration of Medicaid and the Children's Health Insurance Program (CHIP). The Medicaid and CHIP programs seek to provide safe, effective, efficient, patient-centered, high-quality, and equitable care to all enrollees. To achieve these goals, CMS partners with states to share best practices and to provide technical assistance to improve the quality of care. CMS has developed, with its partners, the core measure sets for adults and children and offers technical

assistance opportunities to help states refine their quality strategy. More information is available at <http://www.Medicaid.gov>.

- The **Center for Health Care Strategies (CHCS)** is a nonprofit organization dedicated to improving the health of low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative, cost-effective programs with a focus on people with complex needs. Through a variety of technical assistance activities, CHCS supports states in designing and implementing comprehensive, statewide multi-payer delivery system and payment reforms that reward quality and seek to improve population health. Its work focuses on alternative models that link payment with improved quality. More information is available at <http://www.chcs.org>.
- The **Robert Wood Johnson Foundation (RWJF)** is committed to improving the quality of health care for all Americans. Specifically, the foundation aims to help communities across the country set and achieve ambitious goals to improve the quality of health care in ways that matter to patients and their families. The approach is shaped through extensive investments in improving chronic care and the knowledge that everyone who receives care, gives care, and pays for care must work together to achieve meaningful improvement. More information on RWJF's quality-focused initiatives can be found at <http://www.rwjf.org/en/our-topics/topics/health-care-quality.html>.
- The **Commonwealth Fund** is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. To achieve this goal, the Commonwealth Fund provides grant support and research funding to improve health care practice and policy. Recent focus areas related to Medicaid and quality include state scorecards on quality and developing community partnerships in Medicaid. More information is available at <http://www.cmwf.org>.
- The **National Business Coalition on Health (NBCH)** is a national, nonprofit membership organization of purchaser-led health care coalitions. NBCH and its members are dedicated to value-based purchasing of health care services through the collective action of public and private purchasers. NBCH seeks to accelerate the nation's progress toward safe, efficient, high-quality health care and improved health status of the American population. NBCH's efforts focus on four pillars of value-based purchasing: standardizing performance measurement; reporting performance measurement results publicly; reforming the health care delivery payment system; and engaging consumers in informed decision making. More information on NBCH can be found at <http://www.nbch.org/>.
- The **National Committee for Quality Assurance** is a not-for-profit organization dedicated to improving health care quality. NCQA is responsible for the development, maintenance, and collection of national data for the HEDIS and CAHPS measures described throughout this section. Furthermore, NCQA provides accreditation to health plans to help purchasers identify high-value plans and has developed tools to help state Medicaid agencies use accreditation in managed care oversight. More information on NCQA is available at: <http://www.ncqa.org>.
- The **National Quality Forum (NQF)** is a public service organization committed to transforming the health care system to be safe, equitable, and of the highest value. NQF reviews, endorses, and recommends use of standardized health care performance measures; it played a key role in developing and stewarding the CMS adult core measure set described earlier. Working with members and the public, NQF also helps define the national health

care improvement to-do list and encourages action and collaboration to accomplish quality improvement goals. More information on NQF can be found at <http://www.qualityforum.org>.

- **Network for Regional Healthcare Improvement (NRHI)** brings together RHICs to share best practices in health care redesign, including efforts to improve the delivery of health care with a focus on reducing costs and maintaining quality. NRHI collaboratives address ways to overcome the barriers to improved health care cost and quality that many communities and their stakeholders face, such as difficulties obtaining access to timely, actionable data; problems implementing appropriate and coordinated changes in payment systems; legal impediments to collaboration among payers and providers; and inadequate resources to support planning and implementation of dramatic changes. More information is available at <http://www.nrhi.org/>.

Financial Models: Rate Setting, Risk Adjustment, and Performance Indicators

SECTION V

Section V

CHAPTER 1. RATE SETTING

ROADMAP

Read this chapter to learn about key concepts related to rate setting for risk-based managed care and alternative financial models. Following are key takeaways:

OVERVIEW

Rate setting involves a complex set of decisions with the objective of promoting cost containment and providing incentives to improve health outcomes and quality.

FUNDAMENTALS

This section provides a basic overview of the following rate-setting topics:

- Risk-based, capitated managed care rate setting;
- Goals of managed care capitation rate setting;
- Actuarially sound Medicaid managed care capitation rates;
- Key determinants of risk, including populations, services, geographic service area, time period, type of managed care enrollment;
- Key components of risk-based managed care rate setting;
- Incorporating program or policy changes into capitation rates; and
- Rate setting for uninsured or expansion populations; and
- Rate setting for special populations.

ADVANCED

This section details considerations for rate setting, including:

- Overview of other managed care payment models;
- Alternative financial models;
- Shared savings arrangements;
- Transforming provider payments; and
- Contracting and negotiating with business partners.

Section V. Financial Models: Rate Setting, Risk Adjustment, and Performance Indicators

This section describes the fundamental principles and considerations of rate setting and risk adjustment and how states can promote improvement in health outcomes, quality, and performance efficiency. It is divided into three chapters: Rate Setting; Risk Adjustment; and Performance Indicators in Financial Payment Models. Note, at press time for the Medicaid Health Care Purchasing Compendium (“Compendium”), the Centers for Medicare & Medicaid Services (CMS) released its long-awaited proposed regulations to update Medicaid managed care regulations that had last been published in 2002 and 2003.¹ CMS has requested comments on the proposed rule. Therefore how the rule will change based on comments received and which provisions will be included in the final rule are unknown at the time of this writing. References to items in the new proposed rule have been made in this section where practicable and for informational purposes only. The final Medicaid managed care rule, however, will be addressed in a future Compendium update.

Chapter 1: Rate Setting

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OVERVIEW

Risk-based Medicaid managed care is a payment strategy in which the program sponsor (for example, the state Medicaid agency) periodically pays a contractor (for example, a health plan) a fixed payment rate for the provision of all covered services per the requirements of the managed care program. As a result, the contractor has an opportunity to earn a profit or incur a loss based on many factors and hence is “at risk” under the terms of the managed care contract. In practice, risk-based managed care involves a complex set of decisions with ramifications for both the state’s contractors and the state’s administrative management staff. Much of this chapter is devoted to describing how capitation rates are developed and key concepts for states to consider.

KEY CONCEPT Risk Contract

A risk contract is a contract under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

FUNDAMENTALS

RISK-BASED, CAPITATED MANAGED CARE RATE SETTING

The payment from the state to the risk contractor is often referred to as a prospective capitation payment rate, or “capitation rate” for short, and is commonly given in dollar terms on a per-member per-month (PMPM) basis. The standard PMPM rate is calculated by dividing the total dollars available to provide services by the total population member months; the resulting value is called a PMPM rate. The numerator in the PMPM equation is dollars, reflecting the Medicaid medical service expenditures, plus any related expenditure such as administrative costs that the managed care contractors will be responsible for under the contract. The denominator is the member months from the total Medicaid population that the managed care contractors will be at-risk for -- the same population from the same time period that generated the medical service expenditures. Although the description of a PMPM capitation rate is simple, the steps, decisions, and options involved can turn a relatively straightforward PMPM into a complicated payment mechanism with many facets and consequences, some intended and some unintended.

¹ 80 Fed. Reg. 31098 (June 1, 2015).

To ensure that this computation is done correctly, it is important that the dollars and member months are derived from or applicable to the same population and same time period (that is, avoid mixing). It would be incorrect to use dollars associated with a population group A and member months from a population group B to derive a PMPM for either population group. Moreover, capitation rates are computed based on the total number of Medicaid enrollees who would be eligible for the managed care program or may already be enrolled in the program, not just individuals who used medical services. It would also be incorrect to compute a capitation rate based solely on individuals who had generated a medical claim expense (a user rate), since not all enrollees will have medical expenses in a given period. As a result, a PMPM capitation rate is effectively an average value that includes all high-, medium-, low-, and even no-cost individuals in the calculation.

KEY CONCEPT Capitated Payment Rate

A capitation payment is a prospective, average payment that the state makes periodically to a contractor on behalf of each recipient enrolled under the contract for the provision of services. The state makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

A common practice is to develop separate PMPM rates for population groups, often referred to as “rate cohorts” or “rating groups,” that have distinctly different risk attributes (for example, newborns, children, adults, pregnant women, institutionalized, and disabled). Additional factors that could result in developing separate rate cohorts are regional differences in the cost of care, access to care, or utilization practices. Paying an average capitation rate for all individuals results in the payment rate being too high, too low, or just right on a person-specific basis; that is one of the well-known challenges or advantages associated with capitation, depending on perspective. [Chapter 2](#) of this section discusses methods of refining the capitation payment process to better align payment to higher- and lower-risk populations. PMPM rates are not the only form of capitation payment that states use in risk-based

Medicaid managed care programs. Later in this chapter, other forms of capitation payment will be described, such as a separate maternity delivery payment rate.

GOALS OF MANAGED CARE CAPITATION RATE SETTING

One of the key objectives of establishing a capitation rate for Medicaid managed care is to match payments to risk. The risk borne by a managed care program is expressed as the expected value of the services the program commits to provide. Those costs are a function of many factors, including populations, services, marketplace dynamics, time period, and policies applicable to the program, which can involve state, local, and federal factors (for example, provider access and network composition, historical and prospective provider payment rates, provider consolidation, efficiency and effectiveness of program contractors, mandated benefit changes, new federal or state legislation or regulations). Because of that, rate setting is contingent on future events that can and likely will differ from the assumptions and projections used. Thus, in general terms, the goal of actuarial rate setting is to develop a rate range (or payment rate) that is reasonable and appropriate for the specific attributes of the managed care program, not for every contractor, which the state can then use to negotiate with or pay a contractor for the required services and contractual obligations associated with the program.

Promote Cost Containment and Quality Health Outcomes

From an operational point of view, the key objectives of capitation rate development are to promote cost containment and provide incentives to improve health outcomes and quality. Since the risk-based contractors receive a prospective fixed dollar amount regardless of the actual increases or decreases in utilization or

cost of services, they have a financial incentive to control costs. To capture those rewards, contractors have offered the populations they serve various innovative incentives to engage in healthy behaviors and have taken actions to educate members and providers, avoid unnecessary or wasteful services, reduce or eliminate fraud and abuse, and direct care to the most cost-effective setting. Accordingly, applying capitation rates to providing Medicaid services is a lever that states can use to potentially become more efficient and effective as purchasers of health care.

Provide a Reasonable Level of Payment

Developing capitation rate ranges or rates using a methodology intended to estimate an actuarially sound rate does not necessarily equate to payments matching an individual health plan's costs, nor does it guarantee a profit. Instead, an objective of capitation rate development is to create a reasonable, appropriate reimbursement process between the state and its contractors for the transfer of risk, the provision of services as required, and the opportunity to earn a profit (a formal definition of "actuarially sound rates" is provided later in this chapter). Reasonable capitation rates enable a state to attract and retain quality contractors that will benefit the Medicaid program over the long run. Reasonable rates also provide for the health plans' reasonable costs of doing business, including staffing, office space, information technology, provider management, and marketing and outreach.

Capitation rates that are too low for too long can result in adverse financial outcomes for the state's risk-based contractors, who are also essentially the state's business partners. Contractor losses have a negative effect on a health plan's financial solvency and, if large enough, may lead to one or more plans exiting the program. That in turn can lead to significant member confusion, disruption of care management programs, lack of trust, and instability in the program. Capitation rates that are too high can contribute to health plan indifference and complacency in regard to innovation, appropriate care management, and provider-member engagement. Reasonable capitation rates strike a balance between too little and too much, taking all things into consideration, but there is no guarantee that a state and its risk-based contractors will always agree on what constitutes a reasonable capitation rate. A state can empower itself by being knowledgeable about how the health plans are operating through analyses of information sources, such as financial statements, encounter data, quality metrics, outcome measures or provider/consumer satisfaction surveys, and reports. The resulting knowledge provides the state with a picture of plan performance that can aid the state in finding a proper balance in payment terms. For example, a below-average performing contractor may need to focus more on improving internal operations to hold down costs and improve outcomes as opposed to getting a higher rate from the state. See [Chapter 2](#) of this section for information regarding risk adjustment that can be used to better match payment to risk without necessarily increasing the total cost of the program.

Support Budgetary Predictability

Because capitation rates are by definition fixed payments that do not change during the contract's rating period, a state seeks to use capitated rates to provide a measure of budgetary predictability for both the state and the risk-based contractors.

From the state's perspective, capitation can provide stability and a more predictable Medicaid budget, compared with a traditional fee-for-service (FFS) environment in which provider claim payments can fluctuate from week to week and month to month. After the capitation rates are contractually agreed to, the state knows the specific financial terms that will govern the program for the applicable rating period, and those terms typically do not change over the course of the contract. Total payment amounts can still fluctuate, based on changes in the number and mix of program enrollees, but the underlying base capitation rates are

typically fixed once the contracts are agreed to.² However, since state Medicaid budget forecasting often requires planning that precedes the completion of the capitation rate development process, the negotiations with the health plans, and obtaining approval from the Centers for Medicare & Medicaid Services (CMS), there is still uncertainty between the time when state budgets are forecast and the time when managed care payment terms are finalized.

From the health plans' perspective, knowing the basis for payment enables plans to produce the forecasts of revenues and expenses necessary to prepare required financial forms, report to their board of directors, and make informed business decisions on matters such as staffing, management, resource allocation, and budgetary needs. The health plans also can evaluate capitation payment rates relative to their contractual obligations in the areas of plan operations, care management, membership engagement, and provider contracting. In business, uncertainty and unpredictability are the foes of successful planning and growth; capitation rates provide a measure of certainty and predictability to the business equation.

"ACTUARIALLY SOUND" MEDICAID MANAGED CARE CAPITATION RATES

Medicaid managed care capitation rates are subject to federal review and approval, as defined under current federal regulations at 42 CFR 438.6(c). A key federal requirement is that risk-based capitation rates must be actuarially sound. Complying with the relevant federal requirements is a prerequisite for states to obtain federal matching funds for the capitation payments made to risk-based contractors, and thus states should expect CMS to review their process and question the state as needed. Current federal regulations define actuarially sound capitation rates as rates that:

- Have been developed in accordance with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered and the services to be furnished under the contract; and
- Have been certified by actuaries credentialed by the American Academy of Actuaries and follow practice standards established by the Actuarial Standards Board.³

The current federal regulations further describe requirements for Medicaid managed care rate development in additional subsections of 42 CFR 438.6(c). In implementing these requirements, CMS created a checklist in July 2003 for rate setting. The checklist was a step-by-step tool that was expected to be used by the CMS regional offices to assess whether a state's capitation rates were actuarially sound as specified in federal regulations. More recently, CMS has created a *Managed Care Rate Setting Consultation Guide* (consultation guide) for states and their actuaries to use in developing their Medicaid managed care capitation rates.⁴

The consultation guide includes guidance to states and their actuaries on topics (for example, base data sources, description of adjustments made, and other assumptions) that should be addressed in the applicable rate-setting documentation in order for CMS to approve the state's capitation rates. The consultation guide is revised every year to incorporate updated guidance as the Medicaid program evolves.

For rating periods beginning in calendar year 2016, CMS released a draft consultation guide on June 5, 2015.⁵ In the draft guide, CMS added topics related to developing capitation rates for Medicaid-managed long-term services and support programs such as capitation rate structure and effect on community-based

2 For example, different capitation rates are set for Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) populations. A change in the proportional mix of these two populations during a rating period will affect overall capitation expenditures, even though the respective TANF and SSI rates remain constant.

3 42 CFR § 438.6(c)(1)(i).

4 To download CMS' managed care rate-setting guides, see <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (accessed August 20, 2015).

5 Center for Medicaid & CHIP Services, "Draft 2016 Medicaid Managed Care Rate Development Guide," Centers for Medicare & Medicaid Services, June 5, 2015, <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/draft-2016-managed-care-rate-guidance.pdf> (accessed August 20, 2015).

care settings. Generally, states and their actuaries address the topics raised in the consultation guide by providing CMS a reference to where responses can be located (for example, page 18 of the actuarial rate certification letter) or separately adding responses to the consultation guide document itself and submitting the documentation to CMS.

As part of the proposed Medicaid managed care rule, CMS is also planning to update the definition of actuarially sound rates to include the use of a medical loss ratio (MLR) to help gauge actuarial soundness.⁶ The use of a minimum MLR in the definition of actuarially sound rates is new, and the effect of this requirement may influence rate setting in the future. The proposed changes by CMS regarding the definition of actuarially sound rates should not pose much difficulty for experienced actuaries to adapt to, but questions could arise regarding interpretation and the meaning of the changes, which states, their actuaries, and CMS would need to address. The additional documentation required by CMS might add time to completing the rate development process, and states should consult with their actuaries on how the new CMS requirements could affect timelines, work budgets, or workloads.

States should also be aware that in 2015, CMS, as part of its oversight, review, and approval responsibilities, has significantly increased the number of questions and inquiries on the rate development process and managed care contracts. In some states, this has resulted in a multitude of questions about the methodology, data, and assumptions. CMS appears to be giving states around two weeks to answer these questions, which has proven easier for some questions than for others. Since this is a new and evolving process, some states have been successful in requesting additional time to complete responses if required. It is foreseeable that the actuarial documentation related to capitation rate development could evolve to more proactively address these new types of questions from CMS and reduce the burden of responding. But at present, this is requiring additional time and cost for states and their actuaries to complete the rate development process.

Federal regulations describe the general process of how Medicaid risk-based capitation rates should be developed, but CMS has generally expected credentialed actuaries to apply their professional opinion, experience, and discretion to specific details and assumptions embodied in Medicaid managed care capitation rates. The American Academy of Actuaries is the voice of the profession on public policy and professionalism issues; it establishes, maintains, and enforces professional standards of actuarial qualification, practice, and conduct.⁷ As it pertains to generally accepted actuarial principles and practices, the Code of Professional Conduct and, by reference, the Actuarial Standards of Practice (ASOP) have the highest standing. Relevant ASOPs include ASOP 1, *Introductory Actuarial Standards of Practice*; ASOP 5, *Incurred Health and Disability Claims*; ASOP 12, *Risk Classification*; ASOP 17, *Expert Testimony by Actuaries*; ASOP 23, *Data Quality*; ASOP 41, *Actuarial Communications*; and ASOP 42, *Determining Health and Disability Liabilities other than Liabilities for Incurred Claims*.

KEY CONCEPT Actuarially Sound Rates

Actuarially sound rates are more about the process or methodology used to develop the rates than the final value of the rates. States should anticipate some disagreement with their risk-based contractors over the level of payment, but if the process used to develop the rates was reasonable and appropriate, states and contractors may agree to disagree on individual pieces of the total rate.

Most notably, in March 2015 the Actuarial Standards Board (ASB) issued a new ASOP specifically applicable to Medicaid managed care rate development. ASOP 49, titled “Medicaid Managed Care Capitation Rate Development and Certification,” is the first ASOP to

⁶ 80 Fed. Reg. at 31257-8 (proposed at 42 CFR § 438.4).

⁷ American Academy of Actuaries, “About Us,” <http://www.actuary.org/content/about-us> (accessed August 20, 2015).

establish guidance for actuaries in preparing, reviewing, or giving advice on capitation rates for Medicaid programs.⁸ Within this ASOP, the ASB defined actuarially sound rates as:

Section 2.1 Actuarially Sound/Actuarial Soundness—Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

ASOP 49 should not pose a challenge for experienced actuaries, as the guidance in the ASOP generally reflects common rate-setting practices being employed already. For the ASB to issue a dedicated ASOP on Medicaid managed care rate setting indicates the relative importance Medicaid managed care has in the total health care marketplace.

KEY DETERMINANTS OF RISK

Developing appropriate risk-based capitation payments requires an understanding and analysis of the determinants of risk, which typically begin with an actuary asking the state questions that begin with who, what, where, when, and how. The key attributes of the program that help define and quantify risk include the following:

- Populations covered by the managed care program (for example, Temporary Assistance for Needy Family (TANF) recipients, Supplemental Security Income (SSI) recipients, pregnant women, and children);
- Services provided by the capitated contractors (for example, pharmacy, inpatient, home health care, transportation, and physician services), as well as services excluded from capitation;
- Geographic service area -- such as dense metropolitan area, suburban/rural, or rural/frontier -- which includes provider market and practice pattern influences;
- Time period of the contract rating period;
- Type of managed care enrollment: voluntary, mandatory, or passive enrollment with opt-out;⁹ and
- Specific policies regarding benefit limits, cost sharing, reporting requirements, provider taxes, management duties, and operational aspects required of the health plans by the state and CMS.

⁸ Medicaid Rate Setting and Certification Task Force, “Medicaid Managed Care Capitation Rate Development and Certification,” Health Committee of the Actuarial Standards Board, March 2015, http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf (accessed August 20, 2015).

⁹ Passive enrollment programs typically involve the consumer being automatically enrolled in the program and then having to take action to disenroll, or opt out.

On a more qualitative basis, the cultural, societal, and even educational attributes of a state can influence risk, health cost, and utilization. For example, smoking may be more prevalent in a particular state or population group, and pollution from industry may be more significant in one part of the country than another. Even weather patterns that influence exercise can play a part in creating costs in the health care system. As a result, it is impractical to quantify and isolate every determinant of risk, and thus actuaries must take a practical approach in rate setting.

Populations Covered by Managed Care

This is the “who” part of the rate-setting equation. Depending on the design of the managed care program, capitation rates must reflect the projected risk of the specific populations eligible for the program for the period prescribed by the contract. Different populations can have significantly different cost and utilization characteristics, which contribute to different risk profiles and average PMPM rates. For example, children ages 1 to 10 on average have a lower expected PMPM than adults ages 65 to 75 because of the underlying risk characteristics, health status, and service utilization patterns of each population. Accordingly, a managed care program that is primarily covering TANF adults and children has different risk profiles and PMPM rates than a program focusing on the elderly and disabled. That is one of the reasons why a capitation rate structure typically involves multiple rating cohorts or groups.

Moreover, any population that is excluded from managed care must be also excluded from the process of developing a capitation rate. For example, some states exclude from managed care individuals who are dually eligible for both Medicare and Medicaid (known as dual eligibles) but include similarly elderly or disabled individuals who are without Medicare benefits. That distinction is critical to Medicaid managed care rate setting, since Medicare covers most acute care services for dual eligibles (for example, hospital, physician, and pharmacy). Thus the Medicaid acute care PMPM rates for a person with Medicare and one without can be vastly different. States need to take those situations into consideration and convey the specific eligibility requirements to their actuary to ensure that the capitation rates reflect only the populations eligible for the program. That also likely requires that the state collaborate with the actuary to correctly establish how to identify the included or excluded populations based on the state’s eligibility coding and classification system.

The populations covered by managed care can also indicate the range of potential cost variation or risk stratification. The level of homogeneity or heterogeneity in the managed care population can affect uncertainty regarding risk. For example, some population groups, such as those receiving TANF or general assistance, may have more frequent gaps in enrollment compared with a chronically ill or disabled group. Data used for rate setting reflect only the months and related costs for periods when the person is covered by Medicaid; yet it may be more challenging for managed care to positively affect the health of a transient population than a stable population that remains in the program for a longer time. States and actuaries should be aware of those situations and anticipate that risk-based contractors will raise concerns about the appropriateness of average PMPM payment rates, as the variation in risk, attraction patterns, and differences in cost increases in the covered population. The following hypothetical exhibit illustrates how population risk can affect the process of developing a capitation rate.

Variation in Population Risk PMPM and Rate Structure

In the following table, two different population groups, children ages 1 to 10 and adults ages 65 to 75, some of whom are disabled, are compared in terms of average PMPM rates to illustrate the effect that population can have on capitation rates. In this example, paying a single, weighted average capitation rate of \$281.82 for every managed care enrollee may be operationally easy for the state; however, as the table illustrates, compared with the \$281.82 average PMPM, children ages 1 to 5 have a 66.3 percent lower PMPM and the disabled ages 65 to 75 have a PMPM that is more than five times the average. This level of mismatch between payment and

risk is an indicator that a single-rate cohort structure may not be the most appropriate payment structure. Indeed, even paying an average PMPM rate of \$1,100 for all adults ages 65 to 75 still creates a relatively wide range of variation as the subgroup of non-disabled adults ages 65 to 75 would be underpaid by an average of 22.7 percent while the disabled adults ages 65 to 75 would be overpaid by an average of 34.1 percent. In this hypothetical example, the state and its actuary would need to consider the merit of having separate rating groups for older adults and older disabled adults, respectively, which would increase the requirements to develop the rates and require sufficient information systems capability on the part of the state to pay the correct rate for the applicable managed care enrollee. Accordingly, this example also illustrates the importance of considering a state's information technology requirements and limitations when developing a capitated payment structure in order to ensure that the state can accurately implement it.

Table 17. Per-Member, Per-Month Differences among Population Groups

Population Group	Member Months	Total Dollars	Average PMPM	Variation to population-specific PMPM	Variation to total weighted avg. PMPM of \$281.82
Children Ages 1-10	45,000	\$4,500,000	\$100.00		-64.5%
Ages 1-5	12,000	\$1,140,000	\$95.00	-5.0%	-66.3%
Ages 5-10	33,000	\$3,360,000	\$101.82	+1.8%	-63.9%
Adults Ages 65-75	10,000	\$11,000,000	\$1,100.00		+290.3%
Ages 65-75	6,000	\$5,100,000	\$850.00	-22.7%	+201.6%
Ages 65-75 and disabled	4,000	\$5,900,000	\$1,475.00	+34.1%	+423.4%
Weighted average total	55,000	\$15,500,000	\$281.82		

Services Covered by Managed Care

This is the “what” part of the rate-setting equation. Depending on the design of the managed care program, capitation rates must reflect the risk of the specific services that will be the responsibility of the risk-based contractors, as defined under the Medicaid state plan and the managed care contract. The state decides what services will be capitated versus services that will continue to be paid on a FFS basis or through other programs. Services that are a part of the state's Medicaid benefits package but remain outside of the managed care capitation rates are often referred to as carve-out services. The capitation rates must exclude any cost and utilization data for carved-out services to ensure that payment matches risk and that the state does not inadvertently pay twice for the same services -- once through capitation and again through FFS or another program. That requires the state to identify the carved-out service using provider type, provider specialty, claim type, procedure code, taxonomy, or other identifiers to ensure that the capitation rates can be developed correctly. Examples of managed care carve-outs include the following:

- Blood factor products;
- Home- and community-based services;

- Certain behavioral health services; and
- Service settings such as school-based services or services that exceed a predefined limit under managed care (for example, 30 outpatient behavioral health visits).

Non-State Plan Services and “In Lieu of” Services

Unlike traditional FFS where states are limited to offering services as defined in the state plan, risk-based managed care offers some flexibility to be more creative in offering nontraditional services. The primary methods for non-state plan services to be offered under managed care are:

- As part of a waiver, states seek federal permission to offer additional services through managed care by means of Section 1915(b)(3) authority, concurrent Section 1915(c) authority, or a Section 1115 demonstration waiver, and these services are included in capitation rate setting;
- Managed care plans, solely at their option, have flexibility to provide additional services not covered in the contract or state plan, but the actuary does not include the costs of these services in capitation rate setting.
- States can opt to use rate setting to incentivize managed care plans to use capitation premium revenue to offer optional cost-effective services in lieu of contract services. The state cannot require these substitute services, but the actuary can account for the managed care plan’s use of more cost-effective alternative services in the rate development.

KEY CONCEPT **Carve-outs**

In the context of managed care, carve-outs are any service or population that is excluded from the managed care program and covered by other programs, most notably fee-for-service but also separate contractors or other delivery systems. Carve-outs can negatively affect the value of integration but can also allow a state to address special conditions that may not be suitable for a particular type of risk-based managed care.

Receiving formal waiver authority to cover nontraditional state plan services allows a state to define and mandate services that can be added to the managed care program and built into prospective capitation rates. In the absence of waiver or state plan authority, managed care plans have long had flexibility to offer other benefits and services to members “out of their profits” to improve health outcomes and care for a member’s overall well-being or reduce expenditures (for instance, air conditioners or car seats). However, in the absence of state support for the managed care plan to provide cost-effective alternative services, a managed care plan may perceive a disincentive to offer non-state plan services because the costs are not included in rate setting.

If a state wants to encourage managed care plans to provide cost-effective alternative services (including more cost-effective alternative settings), the state and its actuary can develop an “in lieu of” approach when developing and updating capitation rates. States may support in lieu of services for a number of reasons, including lower costs, greater access, and increased member satisfaction. Programs for behavioral health and long-term services and supports (LTSS) often use this approach where more innovative service delivery options can be developed to substitute for traditional state plan services. More recently, with value-based purchasing goals in mind, states are thinking through how this approach can encourage managed care plans to think outside the box in caring for members in cost-effective ways.

To use this flexibility, the in lieu of service needs to substitute for a state plan service in the contract, be cost-

effective relative to that service, and be documented in the rate setting process. Encounter data (or other data) and documentation of the cost-effective nature of the alternative service are critical to this approach and can be one of the biggest challenges with alternative services. As part of enhanced CMS oversight of state Medicaid-managed care programs, CMS is asking more questions about how in lieu of services are defined and accounted for in rate setting. While CMS has been generally supportive of in lieu of services, as a matter of routine federal policy, CMS may not offer as much flexibility as states would like in this regard even though, for example, an air conditioner improved the member's health and perhaps avoided a visit to the emergency room. As more states expand managed care into LTSS and also explore value-based purchasing, this issue is likely to arise more frequently and is a topic that states and their actuaries may need to discuss more frequently with managed care plans and CMS.

Service Integration

The number and diversity of services covered by the managed care program affect the level of risk associated with the program and also increase the opportunity for efficient contractors to improve quality health outcomes, constrain cost growth, and be accountable for their members' care. Those factors can translate into lower capitation rates or opportunities to use incentive programs to reward positive outcomes. Additionally, by integrating complementary services into a single managed care program, an actuary may reasonably assume that the risk-based entity can achieve lower overall costs and develop PMPM rate ranges reflecting those assumptions. In one state, the risk-based contractors asked the state to include nonemergency medical transportation in the capitation rates, to allow the contractors to coordinate care and ensure that their members were getting to their scheduled appointments instead of missing them, which can lead to more costs and less desirable health outcomes. Combining behavioral health and physical health under one integrated program can mitigate cost shifting, reduce levels of uncoordinated care, and reduce data sharing concerns if one qualified entity has responsibility for the provision and integration of a wide range of services.

However, some states have existing, separate delivery systems for different types of services, so integrating services under one delivery system may disrupt established provider-member relationships, customary business arrangements, or flow of funds to and from providers. Integrating services such as behavioral health or substance abuse treatment, LTSS, and acute care can increase the complexity of the program, and there may be fewer qualified plans with enough experience to effectively coordinate and manage the array of services. This can increase the importance of states selecting plans carefully through the procurement process and then closely monitoring performance to ensure goals and outcomes are being achieved. Some plans may choose to outsource responsibility for a subset of services (for instance, substance abuse) to a third-party vendor that may have already been under direct contract with the state. While the state can still hold the primary health plan responsible for all required contract provisions, including the performance of subcontracted vendors, the system of care delivery may not be as fully integrated as the state envisioned.

States need to weigh the various pros and cons when designing their managed care programs, and likewise, actuaries must take these program attributes into consideration when developing capitation rates.

Geographic Service Area

This is the "where" part of the rate-setting equation. Every state has some unique element attributable to its geography -- including its mix of urban, rural, and frontier environments; location of certain centers of excellence such as teaching hospitals; and the infrastructure of roads, bridges, and communication channels -- which can affect access to care. Those state-specific characteristics can influence the cost, utilization, and mix of services that Medicaid consumers obtain and thus can directly affect the assumptions underlying the capitation rate.

Cost and utilization of health care services can be high in some areas of a state, and the ability of managed care to improve health outcomes may vary. For example, in more urban areas, costs might be high because consumers are not linked to good primary care and as a result seek more expensive care in emergency rooms or inpatient hospital settings. Individuals residing in designated Health Professional Shortage Areas or Medically Underserved Areas may have lower costs (or different cost patterns) simply because there is a shortage of providers and health needs have gone unmet. That could be justification for an upward adjustment in capitation rates if access is expected to improve under managed care. Indeed, even the marketing and advertising efforts of certain high-profile providers can influence costs. In rural or frontier areas, costs might be relatively high because there is a general lack of primary or ambulatory care settings, so that facility-based care is the main source of care available. In urban areas, well-organized, efficient, and innovative managed

KEY CONCEPT Provider Consolidation

Provider consolidation can make it more difficult for risk-based contractors to establish reasonable provider unit costs and other contract terms. This dynamic can increase the cost of managed care relative to traditional fee-for-service or other delivery models. States may have to decide whether to become involved in managed care provider contracting, such as legislating provider payment fees, using state influence to resolve conflicts, or simply letting the market play itself out, with results being reflected in future rating cycles.

care can connect members with primary care and take advantage of alternatives to costlier forms. But that same tactic may be impractical in other areas of the state. Therefore, the capitation rates may be developed with different sets of assumptions that are reasonable and appropriate for particular geographic service areas.

Recent years have witnessed provider consolidation in several markets, such as hospitals acquiring other hospitals and controlling more outpatient and primary care settings and independent or small-practice physicians joining larger organizations.¹⁰ Consolidation can affect competition, leverage, and the ability of risk-based managed care entities to negotiate favorable provider contracts. As some reports have recently noted, hospital consolidation can result in higher prices.^{11,12} Indeed, many providers have become educated about managed care and know that the state's contractors are required to meet specific provider access standards or risk being out of compliance with contract provisions.

Some savvy providers can take advantage of that to demand large cost increases compared with traditional Medicaid FFS or to restrict the ability of the managed care plans to make decisions on a member's plan of care. As a result, states need to discuss those issues with their actuary and have realistic expectations about the ability of risk-based managed care to be successful in certain areas of the state. Capitation rates should be based on realistic assumptions about the level of competition in different areas of a state, so that in the aggregate, rates are appropriate for the risk.

Time

This is the "when" part of the rate-setting equation. As will be discussed below actuaries commonly use historical data for the population, services, and geographic area applicable to a state's managed care program. Since Medicaid managed care rate setting is predicated on developing prospective rates, time becomes a determinant of risk. Actuaries develop capitation rates for the future contract period as defined

10 Catalyst for Payment Reform, "Provider Market Power in the U.S. Health Care Industry: Assessing its Impact and Looking Ahead," http://www.catalyzepaymentreform.org/Market_Power.html (accessed August 20, 2015).

11 Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs* 33, no. 5 (May 2014): 756-763, doi: 10.1377/hlthaff.2013.1279.

12 Robert Wood Johnson Foundation, "The Impact of Hospital Consolidation-Update," June 2012, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 (accessed August 20, 2015).

by the state, commonly either a calendar year or a state fiscal year. Typically, capitation rates are developed for a 12-month future rating period, but it is also possible to develop rates for shorter or longer periods, such as six months or 18 months. Since capitation rates are intended to stay the same during the contract period, the longer the rating period is, the more uncertainty there is from the actuary's point of view in trying to estimate the future cost of the program. Likewise, more risk is transferred to contractors that accept a fixed capitation rate for an extended period because the underlying determinants of risk and marketplace dynamics can change in ways unforeseen when the rates were developed, negotiated, and agreed to.

In addition to the difference between the historical data and the future rating period, the specific time period that is being rated has risk characteristics of its own. For example, for a state that has expanded Medicaid as authorized under the Affordable Care Act (ACA), calendar year 2014 was significantly different than calendar year 2013 in the risk profile of the Medicaid program. For a state that set rates on a state fiscal year basis that spans July to June, the changes that occurred in January 2014 affected the latter part of the rating period more substantially than the early part of the year.

Since the future remains an unknown variable, prospective capitation rate setting should not be considered an exact science. Actual results will inevitably differ from the individual assumptions used in the rate development process. The goal of rate setting is to match payment to risk, and that goal is generally measured in the aggregate. Over time, individual assumptions can be refined, more data can be collected and analyzed, and expectations can be calibrated to outcomes in order to ensure that the state has a stable yet innovative managed care program.

Type of Managed Care Enrollment

This is the “how” part of the rate-setting equation. Managed care enrollment can be mandatory, voluntary, or a hybrid form of opt-out or opt-in. How the state defines managed care enrollment affects risk and thus the capitation rates. To an actuary, mandatory enrollment means that everyone who is eligible will be enrolled; that allows the actuary to look at the population as a whole when developing capitation rates. Non-mandatory enrollment, whether voluntary or any other optional form of enrollment, requires the actuary to make assumptions regarding what segment of the eligible population will actually enroll or remain in the program, and that increases the uncertainty in the rates. If managed care attracts and retains a higher average-cost population (that is, adverse selection), the capitation rates must reflect that risk through appropriate actuarial assumptions. If higher-cost individuals are more likely to opt out or forgo enrollment, the capitation rates should be lower on average. Depending on the state's managed care enrollment policy, it may also prove difficult to compare the costs of the managed care program with those of the non-managed care population without taking into consideration the difference in risk between the two groups.

The composition of managed care enrollment can also create uncertainty for the state's contractors about the number and type of members they will enroll and manage. That uncertainty affects assumptions about staffing levels, resource allocation, care management programs, provider networking, and even marketing. Most risk-based contractors prefer mandatory enrollment because of the certainty it provides in terms of likely number of enrollees and less potential for adverse selection. States may also find it difficult to decide the financial terms to offer their contractors when enrollment is not mandatory, if the population is tending to change frequently or if there is wide variation in risk between contractors.

Program or Policy Changes

The policies associated with a state's Medicaid managed care program contribute to the risk of the program and are reflected in the capitation rates. Elements such as cost sharing, benefit limits, and medical necessity requirements influence medical services cost and utilization levels, and the state's contract requirements

affect the contractor's administrative overhead expenses. Material changes in policies must be reflected in capitation rates through program change adjustments to ensure that the rates reflect the risk of the program. The incorporation of program or policy changes into capitation rates is discussed in more detail later in this chapter.

What to Expect from the Actuary

Developing actuarially sound rates requires matching payments to risk. Opinions differ as to how best to quantify risk in terms of PMPM rates. Although a thorough analysis is necessary, analyzing every piece of data is costly and time consuming. Also, not all of the available data is reasonable or valid to use. It also is not a requirement from either a regulatory or professional standpoint to analyze every piece of available information. Rather, actuaries must use a measure of professional judgment in analyzing data and developing the managed care rates. Those judgments can lead to differences of opinion among the state's actuary, the contractor's actuary, and state officials. An actuary's responsibility is to make reasonable and appropriate assumptions in the course of rate development and thus remain independent from some of the influences emanating from either the state or the state's contractors.

The State's Actuary

Most states procure the services of an experienced actuary to support their Medicaid managed care program. Using an outside actuary supports the state in selecting a qualified vendor and brings a level of professional independence that some states prefer, so as to avoid the appearance of a conflict of interest with an in-house state actuary. The major Medicaid actuarial firms often work in multiple states, which can benefit each state because of the experience and perspectives that the actuary can offer, within the limits of confidentiality. Arizona is one of a handful of states that directly employs credentialed actuaries on the staff of its Medicaid agency. One reason Arizona has this internal capacity is that the state has been operating risk-based managed care since the early 1980s and thus has a long and successful track record with managed care. However, at times even Arizona seeks an outside actuary to review work products or assist with a special project.

The state's actuary is a partner of the state and should ensure that the actuarial capitation rates comply with all applicable federal and state requirements. Ultimately, the actuary must provide the state and CMS an actuarial certification statement attesting to the soundness of the rate development process, a responsibility that actuaries do not take lightly. The state should expect its actuary to ask many questions about the state's program; request various forms of eligibility, cost, and utilization data; offer new ideas on how rates can be developed; participate in rate negotiations with the state's contractors; defend its work product; identify areas of risk for the state; offer alternative solutions to these challenges; and be a sounding board for the state on various financial and programmatic changes. Accordingly, those services can be costly. States can expect the costs of actuarial services to support their managed care program to range from the low six digits to over \$1 million, depending on the complexity of the program and the goals of the state. Actuarial services for managed care rate setting are considered state administrative costs and are subject to 50 percent federal matching funds.

The Health Plan's Actuary

Nearly all health plans that contract with a state have an actuary on staff or use an external actuary. Since the health plan's actuary represents the plan's interests, the state can expect the health plan's actuary to question the rate development process and the reasonableness of specific assumptions and make suggestions for alternative payment terms which need to be evaluated in the context of the program as a whole, not just the individual plan making the suggestion. The health plan may have good ideas to offer and can provide information that is useful in the rate development process, since the plan has direct experience working with the provider community and member engagement.

It is important to note that a health plan actuary typically has a detailed understanding of the specific operating requirements of the health plan, including any planned medical innovations, enhanced marketing and outreach efforts, or direct changes to provider contracts. However, the actuary typically does not have access to the experience of all of the state's Medicaid-enrolled members, including information from other health plans. That is a different perspective than that of the state's actuary, who develops actuarially sound rate ranges on behalf of the entire program.

KEY COMPONENTS OF RISK-BASED MANAGED CARE RATE SETTING

The process of developing actuarially sound capitation rates can be summarized in a handful of key components, as follows:

- Experience or base data;
- Trend assumptions;
- Program or policy changes;
- Managed care assumptions;
- Administrative/risk contingency/underwriting gain (in other words, non-medical expenses); and
- Point estimates or rate ranges.

Base Data

The most important component of rate setting is the experience data used to develop the prospective rates. CMS requires that Medicaid managed care rates be based on eligibility, utilization, and cost data that are derived from the Medicaid population for the services covered under the state plan, or costs directly related to providing the state plan services.¹³ The data should be recent and free from material omission.

States and their actuaries have to decide which source or sources of data have the highest degree of reliability, completeness, and accuracy for the purpose of rate development.

KEY CONCEPT

Obtaining Complete and Accurate Managed Care Experience Data

As states implement Medicaid managed care programs, historical fee-for-service (FFS) data can be a good source of data to develop capitation rates. However, FFS data are no longer useful once managed care is fully implemented. Therefore, states should be aware that future rate-setting projects will need to rely on actual managed care experience data to remain current. That will require them to invest time and resources into developing good financial statements and, ideally, complete and accurate encounter data.

The most common data used for rate setting are Medicaid FFS data and actual experience data from the managed care program, which can take the form of either encounter data or audited financial statements. CMS permits states to use non-Medicaid data (for example, state employee data) to develop Medicaid capitation rates, so long as the data are adjusted to make them comparable to the applicable Medicaid population. Typically states and their actuaries use Medicaid FFS data for new managed care programs, since the FFS data are recent, typically complete, and applicable to the actual population and services covered by managed care. However, over time, the usefulness of FFS data dwindles as managed care replaces FFS. Eventually, states need to integrate managed care data into the rate development process, and

¹³ 42 CFR § 438.6(c).

that requires states to proactively collect, validate, and store managed care experience data. See also [Section VII](#), “Data Analysis and Reporting.”

Actuaries prefer to work with both cost and utilization data in developing capitation rates, a preference shared by CMS. However, in some states only cost information is available. Using only cost information is an acceptable practice if that data is reliable and audited and if fully complete and reliable encounter data is not available. However, states should also try to include utilization information for major service categories in the development of rates. Moreover, it is not uncommon for actuaries to consider data over several years to smooth single-year anomalies. It is better to use two or possibly three years of experience data, if available. Otherwise, a single year of base data is often used when large populations are involved.

States should expect their actuaries to request data and should assist the actuary in performing reasonability checks of the data, for example, confirming record counts, total paid expenditures, number of unique individuals, and cost by category. Sometimes data requested by an actuary are not available or may not be fully credible, so that states must collaborate with the actuary to determine what data are available and appropriate to use and what resources are needed to obtain additional information. Actuaries also perform various reasonability checks by comparing the state’s data with previous extracts, analyzing the changes in the data over time, or comparing the data with external sources of information, such as CMS 64 reports, Medicaid Statistical Information System data, and health plan financial statements, taking into consideration the differences in the data sources (for example, date of service versus date of payment). To ensure that the actuary understands how to interpret the various codes and data fields that are unique to each state, state staff must provide data layouts.

The selected data can then be analyzed by the actuary and summarized into a manageable data set. That typically involves segregating the data by population group, major category of service, date of service (for example, a state fiscal year or calendar year), and geographic area, so that the information aligns with the design of the managed care program. Adjustments might need to be applied to the selected base data to account for missing or incomplete information, exclusion of populations or services that are carved out of the managed care program, eligibility time periods (for example, retroactive coverage or managed care enrollment lag), specific funding streams (for example, disproportionate share hospital payments), or smoothing of data anomalies. If managed care experience data are used, some of these situations are already accounted for, and more focus is put on collecting and validating the data.

Trend

Trend is the estimated change in cost and utilization over a particular period. It is the actuary’s forecast of what costs and utilization will be in the contract rating period, compared with the levels in the base data. Typically, trend is displayed as an annualized percentage that can be either specific to unit cost and utilization separately or applied to the total PMPM, depending on the availability of data and the steps undertaken by the actuary. If separate unit cost and utilization factors are developed, the equivalent PMPM trend can be derived by multiplying the two factors together as shown in the following example:

- **Trend Example 1:** If the annualized unit cost is 3.0 percent, and utilization is 1.5 percent, the equivalent annualized PMPM trend is computed as $[(1+.030)*(1+0.015)] = 1.04545$, or simply 4.545 percent.

The trend factors are applied for the length of the projection period, which is commonly the number of months between the midpoint of the base data and the midpoint of the contracting rating period. For example, if the base data are from 2012, and the contract rating period is 2014, the midpoint of the base data

is July 1, 2012, and the midpoint of the rating period is July 1, 2014, which results in 24 months of trend. The following example shows the cumulative effect that trend has on the rate development process:

- **Trend Example 2:** Using a 4.545 percent annual PMPM trend assumption, the total effect of trend over the projection period would be computed as 1.0454 compounded for two years (24 months), or in a formula version as $[1.04545^{(24/12)}] = 1.093$, meaning that the base data PMPM is increased by 9.3 percent to arrive at the assumed contract period PMPM.¹⁴

Accordingly, the longer the difference in time between the base data and the contract period, the more trend assumptions influence the final capitation rates. It is generally preferred to avoid long trend forecast periods, if possible, as they create more uncertainty about changes in cost over time. CMS likewise prefers that risk-based capitation not exceed 60 months of trend, but that is not a formal CMS requirement.

To develop trend assumptions, actuaries analyze historical data on the population and services associated with the managed care program using various statistical and regression analyses. In addition, the trend analysis can incorporate prospective information that is not captured in historical data such as anticipated or expected utilization shifts to alternative services like personal care assistants or anticipated pricing affects for new drugs or therapies anticipated to hit the market during the contract period (see following discussion on program or policy changes).

Several different sources of health care cost and utilization data can be considered by the actuary in arriving at the specific trend factors used for a given rate-setting project. In addition to the state's program experience data (for example, FFS or managed care data), which is a primary source of trend information, national cost indices such as the Consumer Price Index can provide another perspective on the change in health care cost or utilization. Other sources of information on emerging trends or new developments on a local, regional, or national basis can also be formally or informally factored into the development of the final trend factors. For example, there is generally more information publicly available on pharmaceutical products coming to market. Considerations of what products are in the pharmacy "pipeline" can be useful, especially if the actuary can confer with registered pharmacists to better understand how new drugs may replace or supplement existing drug therapies and possibly reduce other costs in the health care system.

It is also important to note that historical changes in cost or utilization need not be indicative of the future, as the estimated cost of the program will change if changes are occurring in the marketplace or if the historical data contain one-time anomalies that distort the data patterns. Moreover, very recent developments in the marketplace may have a pronounced effect on recent cost or utilization patterns, but over a longer trend period the effect can be muted. For example, the availability of drugs such as Sovaldi, Harvoni and Viekira Pak for treatment and potential cure of hepatitis C drastically increased expenditures for this narrow segment of pharmaceuticals. If the actuary is trending base data from 2013 for rates effective in 2016, the recent developments will certainly influence trends, but it would be inappropriate to base a 36-month, annualized trend factor based on costs that peaked dramatically in the second and third quarter of 2014.¹⁵ Therefore, actuaries must use both subjective and objective means to arrive at final annual trend factors that are reasonable and appropriate for the program being rated and for the time gap between the historical data and prospective rating periods.

INCORPORATING PROGRAM OR POLICY CHANGES INTO CAPITATION RATES

Program or policy changes can result from changes made at the state, local, or federal level that materially

¹⁴ ^ = raised to the power of

¹⁵ "Analysis of Medicaid Costs and Usage of Selected Specialty Medications – Sovaldi, Harvoni, and Kalydeco." The Menges Group, April 2015. Available at: https://www.themengesgroup.com/presentation/april_2015_medicaid_data_on_sovaldi_harvoni_and_kalydeco.pdf (accessed August 20, 2015).

change the risk of the state's managed care program. Changes may have occurred in the historical base data that are not yet fully reflected in the data. Changes may have occurred, or may be expected to occur, after the base data time period through the contract rating period. Regardless, if there is a material effect on the rates, the actuary must ascertain the effect of the program change and make an adjustment accordingly. However, it is equally important that the actuary not "double count" the effect of program changes in developing trend or other assumptions. For example, if a state has routinely increased its dental fee schedule 2 percent every year, the historical dental data will reflect those annual increases, and thus the expectation that those annual increases will continue can be included in the trend assumptions; no separate dental fee adjustment needs to be factored into the rates. Some examples of program or policy changes include the following:

- Eligibility criteria changes that add or remove certain populations or otherwise change the way people become eligible for the program;
- Addition, deletion, or major changes of health care services;
- Changes in cost sharing, such as new or different co-pays or premiums for some populations;
- Limits, along with possible exceptions, on the number of services a person can receive, such as six prescription drugs in a month;
- Federal mandates on the coverage of certain services, such as mental health, or coverage of certain populations; and
- State legislative actions, such as changes to fee schedules, new taxes, or minimum coverage rules.

KEY CONCEPT

Assessing the Effect of Program or Policy Changes

Incorporating program changes into capitation rates can be straightforward or extremely complex. Much time may be spent understanding the details of a particular program change before computing the estimated effect. The final rate adjustment may be the result of an iterative process, as data are collected and analyzed while the details of the program change are being worked through.

Depending on the type of program change, the effect on managed care capitation rates can be immaterial or substantial, and the state must work with its actuary to evaluate the effect. Rates might need to increase if the state's contractors are expected to provide a new service or eliminate existing restrictions on service use. Rates might need to decrease if limits are imposed or provider fees are mandated that are less than those the contractors are currently paying. States should also be aware that their Medicaid FFS fees and policies often serve as a starting point in health plan provider contracting, and changes to FFS can have a spillover effect on managed care, whether intended or not. Some states contractually require their managed care contractors to pay at FFS levels (for example, Delaware and Tennessee both required their managed care plans to pay nursing homes at FFS fee levels for the first years of the program), or legislative changes may explicitly include payments to risk-based contractors. Absent any contract or legislative requirements, capitation rates need not automatically be adjusted for changes in FFS. Instead, the change should be evaluated for its effect on managed care. One state official noted in regard to managed care rate negotiations that what happens in FFS stays in FFS.

Each program change has unique elements that must be considered so that the actuary can perform the

analyses to quantify the effect on the risk of the managed care program. States should therefore be prepared to provide as much information as possible on the change to the actuary, which can involve reviewing the legislative record, talking with other agencies in the state, or providing ad hoc data at the request of the actuary. Sometimes the actuary must obtain ad hoc data from the state's contractors, a burdensome but necessary part of the process.

Managed Care Assumptions

In building managed care capitation rates, actuaries make assumptions about how the managed care program is likely to affect cost and utilization, relative to the base data that have been trended and any program changes applied. Managed care adjustments should be mutually exclusive to any prior adjustment to avoid double counting. Examples of managed care assumptions include the following:

- Increase in primary care use and corresponding decrease in the use of some higher-cost inpatient services;
- Reduction in the cost or utilization of emergency room services;
- Increases in certain provider unit costs if the base data are known to reflect low provider fees or if provider participation has been a challenge because of low fees;
- Reduction in the average unit cost of a major category of services if the mix of services is expected to become more weighted to lower-cost services;
- Increase in the use of home-based care and a corresponding reduction in facility-based care; and
- Increase in the proportion of the population that is served in community-based care settings, even if the average PMPM of both community-based and facility-based care is expected to increase.

In developing capitation rates, an actuary might target specific managed care assumptions for individual service categories or decide to make an overall adjustment to the aggregate PMPM. Managed care assumptions can vary across different populations and geographic areas, and even the same service category could have different managed care assumptions if the actuary believes that managed care affects the service differently. For example, managed care assumptions applied to a child ages 6-12 rating group may be significantly different than the assumptions applied to an SSI or aged, blind, and disabled (ABD) group, if the actuary believes that appropriate managed care can have a more positive effect on the diverse and chronic needs of an SSI/ABD group. Often the actuary incorporates a range of managed care assumptions into the final PMPM rate ranges. The level of managed care assumptions can be moderate (for example, minimal or no savings) or more aggressive (for example, higher savings levels), depending on the actuary's opinion, the design of the program and expectations of the state, and even the experience level of the risk-based contractors.

Furthermore, if the base data reflect unnecessary utilization of inappropriate services, and the state's contractors have promoted their years of experience managing similar populations, it may be reasonable to employ more aggressive managed care assumptions than would be employed in a situation where the data reflects very low provider payment rates or lack of access to services, or where the managed care program is covering a nontraditional population for which the contractors lack experience and techniques to adeptly coordinate and manage care. Additionally, the first year of a new managed care program might present less opportunity to reduce costs and improve health outcomes for both individuals and the covered population than subsequent years. A state whose population is already relatively healthy in a comparative sense may have more limited opportunity for savings (but more focus on preventive maintenance and sustaining health) than a state whose population has a higher percentage of service users and higher disease prevalence, where

costs may historically have been excessive or unmanaged. States should also be aware that managed care savings might not materialize immediately upon the implementation of a program; it may require time for improvements to accrue in the system of care.

In general, managed care assumptions are applied more broadly when rates are developed utilizing FFS base data. As the managed care program matures, the effect of managed care is captured and reflected more and more in the experience data. As this happens, certain managed care assumptions such as adjusting provider fees may no longer be necessary, but other managed care assumptions may still be relevant, such as adjustments for potentially preventable emergency room visits.

Deciding on the final managed care assumptions incorporates the policy expectations of the state for its managed care program and involves both objective analyses and subjective professional actuarial opinion. Experience from other Medicaid managed care programs, results from previous managed care initiatives in the state, intensive data analyses, and reasonable expectations of attainability can all be considered by an actuary in developing managed care assumptions. However, not all events or outcomes will be accounted for in rate development. Natural disasters and epidemics are examples of unpredictable events that will not likely be accounted for in average capitation rates. Other tools -- such as risk sharing, reinsurance, and risk corridors -- can provide added layers of protection against catastrophic events. Indeed, if the historical experience data used to develop prospective rates includes costs from a 100-year flood event, it may be appropriate to adjust the rates downward (that is, data smoothing), so as to not perpetuate the anomalously high cost into a future rating period.

Since rate setting involves valuing the future cost of a specific program, actual results will differ from the assumptions used, particularly on an individual service category basis. The risk-based contractors might find ways to increase use of ambulatory care services to avoid more costly inpatient care, or they might develop new care plans to serve more people in the community than was assumed in the rates. On the other hand, a health plan that fails to secure reasonable and competitive provider contracts or lacks experience in managing a Medicaid population may incur excessive, unnecessary costs. As a result, on an individual service category basis, the contractor's experience may be more or less than assumed even if in the aggregate the rates were reasonable and appropriate. Therefore, the focus should be more on the reasonability of the rates in the aggregate and less on individual assumptions. With each successive rating cycle, individual assumptions can be refined based on further data and analysis.

Administrative/Risk Contingency/Underwriting Gain (Non-Medical Expenses)

Capitation rate development typically concludes with an adjustment to the rates for the contractor's administrative costs of doing business, risk, and underwriting gain, all of which are reasonable and appropriate elements to compute and include in risk-based capitation rates. Collectively known as the non-medical expenses" this component of the rates is commonly expressed as a percentage of the total capitation rate or "percent of premium." For example, if non-medical expenses are expressed as 10 percent of premium, and the total capitation rate is \$250 PMPM, then the non-medical expenses are, in PMPM terms, \$25 (10 percent of \$250), and the remaining 90 percent, or \$225, is attributable to the underlying medical services risk.

Since this rate component is typically expressed as a percent of premium, the non-medical expenses are somewhat inversely related to the medical expenses. For example, a managed care program that enrolls primarily TANF adults, children, and pregnant women may have non-medical expenses of 15 percent of premium, since the underlying medical expenses are relatively low. Yet the contractors still need to perform all the business functions and staffing necessary to support the program. If the average PMPM rate is \$200, a 15 percent of premium equates to \$30 PMPM. Conversely, a managed care program covering the elderly and

disabled, including institutionalized patients, may have non-medical expenses in the mid-single digits because the underlying medical costs are very high, but administrative costs, risk contingency, and underwriting gain are not in the same proportion. For example, 7 percent non-medical expenses on an average \$4,250 PMPM equates to a \$297.50 PMPM.

As with the other components of the rates, the non-medical expenses should be reasonable and appropriate for the program being rated. The state's contractors are business entities that have overhead, rent, salaries and benefits, and other liabilities to pay that should be considered part of the capitation rates. Moreover, by definition, the state's contractors are taking on risk, meaning that they will likely have certain risk-based capital requirements to provide a cushion of resources against the prospect of insolvency. Like other businesses, the state's contractors may be given the opportunity to earn a reasonable underwriting gain if they are efficient and well managed. Absent an opportunity to earn a reasonable gain over time, some entities may choose to do business elsewhere, and that could leave the state without a viable program or unable to attract sufficient competition of qualified contractors. Explicit underwriting gain assumptions included in the non-medical expense load of the capitation rates can be in low single digits but vary based on the program-specific elements. Ultimately in considering these factors, the state and the contractor must come to mutually agreeable terms and sign a contract for rates that are actuarially sound and approvable by CMS. Actual results will likely differ from the assumptions made in the prospective capitation rates; in each cycle of rate-setting, new, and ideally better, information is gained to continually improve the rate development process.

States and their actuaries also should be aware of the administrative cost structures of managed care contractors and ensure that the non-medical expense load is reasonable. Examples of administrative costs that may be inappropriate or unreasonable to use in prospective capitation rate development include:

- Penalties or sanctions reported by the risk-based contractor for failing to comply with contract requirements, such as prompt payment rules, or other sanctions;
- Parent company management fees that are unrelated to the actual performance of the entity;
- Related-party administrative agreements that contain payment terms that are not within the realm of reasonableness; and
- Excessive salary or compensation arrangements.

A challenge experienced by actuaries developing rate ranges for states is that managed care plans do not routinely report their administrative expenses specific to each population group or rate cell-specific basis in their audited financial statements and administrative expenses are not captured in managed care encounter data. The more common practice is for plans to allocate all or most of their administrative costs (such as rent, salaries, and marketing) across all lines of business based on a metric such as member months or revenue. This means that each population group -- such as TANF, SSI, and institutionalized -- receive the same relative proportion of administrative expenses even though it is unlikely that each population requires the same level of effort or associated administrative expenses. As a result, actual reported administrative expenses on a line of business basis are often uninformative or misleading for purposes of prospective rate setting, although aggregate administrative expenses can be useful. The situation is further exacerbated if a risk-bearing entity takes the negotiation posture that it wants each capitation rate to provide the same medical loss and conversely same non-medical expense ratio. For example, a managed care plan that expects a TANF Child rate and an Institutionalized Non-Dual rate to provide the same 89 percent MLR and corresponding 11 percent non-medical expense load fails to recognize the differences in risk and aspects of capitation rate setting. A state that is informed on these reporting differences and has analyzed the managed care plans'

financial statements can be in a better position to note these items in negotiations with plans and raise awareness that excessive administrative costs that are not contributing to improved health outcomes or member and provider experience may not be factored into the payment rates offered by the state.

As noted previously, in the proposed Medicaid managed care rule there is a new requirement that MLR be considered in developing capitation rates. MLR is basically computed as allowable expenses divided by allowable premium revenue. For example, if a plan has \$88 in allowable expenses and \$100 in premium revenue, the MLR is computed to be $\$88/\100 or 88.0 percent. CMS proposes that capitation rates be developed in such a way that a plan would reasonably achieve at least an 85 percent MLR. As noted in the preamble of the proposed rule, the use of MLR is to “ensure that program dollars are being spent on health care services, covered benefits and quality improvement efforts rather than on potentially unnecessary administrative activities.”

Premium assessments or other taxes imposed by the state or the federal government can be incorporated into the non-medical expense load or separately accounted for through an explicit adjustment to the final capitation rates. A separate adjustment is often used to ensure that the risk-based contractors receive the value of the tax in addition to the capitation rate being paid in full. Using the \$250 total PMPM rate from the earlier example, suppose that a state mandates a 5 percent premium tax on the managed care plans. In that case, the capitation rates could be adjusted by dividing the rate by 1, minus the premium tax percentage, or $\$250 / (1 - .05) = \263.16 . The state would pay the contractors \$263.16 PMPM, from which the contractor would pay a 5 percent tax, or \$13.16 PMPM, leaving the contractors with a net, full amount of \$250 PMPM.

The Health Insurer Providers Fee (HIPF), as established under the ACA, is another example of a cost of doing business that will be accounted for in Medicaid managed care rate setting. The challenge with the HIPF tax is that the exact value of the tax is unknown until each applicable entity receives its tax bill from the federal government. Unlike most other taxes or assessments that are a flat percentage, the HIPF is a dollar-allocated amount that is computed each year by the federal government and will change from year to year. Methods to address the HIPF in prospective Medicaid rate setting include estimating the HIPF liability and building a value into the prospective rates with or without a final settlement or retroactively adjusting the final fee year capitation rates after the HIPF tax bills are received. Alternatively, due to the challenges with prospectively predicting the HIPF, another option may be to retrospectively apply the current fee to the data year in which the basis of the fee is derived. This would be a retrospective adjustment made to prior year’s capitation rates.

To complicate matters, the revenue a contractor receives from the state to cover the cost of the HIPF tax will be considered taxable revenue, and the tax bill itself will not delineate the amount attributable to each state Medicaid program. So some states are evaluating whether the capitation rate payments should also take into consideration federal or state corporate income taxes that the risk bearing entity will have to pay and adding contractual requirements that the health plans provide the state copies of their tax bills and tax forms related to HIPF. Due to the complexity of the new HIPF, states will need to evaluate options and decide on what course of action to take in collaboration with their actuary and other contractors.

Rate Ranges or Single Point Estimates

In developing capitation rates, the state or the actuary can choose to provide a single rate or a rate range for each population being rated separately. If a single rate is constructed, that rate is typically the actuary’s best estimate, taking all things into consideration, and provides the state with only a single value to use in finalizing payment terms with all of the risk-based contractors. By contrast, a rate range can reflect a range of assumptions, with the low point being the actuary’s most aggressive rate and the high point being the actuary’s most conservative rate. A best estimate can also be provided, which may or may not equal

the mathematical midpoint of the actuarial rate range. States that use competitive bidding often evaluate bids against a range of acceptable and actuarially sound rates. A rate range can reflect the uncertainty of projecting the future cost of a program, the variation of all of the assumptions used or considered in developing the rates, as well as actuarial opinion. Ranges also provide the state with flexibility to negotiate rates with different contractors while still being actuarially sound, as long as the final rates fall within the range applicable to each population group being rated.

RATE SETTING FOR UNINSURED OR EXPANSION POPULATIONS

For states that opt to expand Medicaid to previously ineligible or uninsured populations, the challenges of rate setting become more complex, even though the fundamental goal of matching payment to risk remains the same. The process is also similar, except that the main obstacle is the typical absence of actual cost and utilization data specific to the expansion population. As a result, it may become necessary to use a relatively similar known population as the basis to develop a rate range. For example, TANF adults might be a reasonable reference pricing point for creating a rate applicable to adults that exceed current Medicaid eligibility thresholds. Some states may have reliable and complete data on state employees or other non-Medicaid populations that might also serve as a basis for an expansion rate-setting project. The state and its actuary need to discuss the availability and appropriateness of data sources and move forward with an approach that produces reasonable results. The key concept in using a known population to develop a rate for an unknown population is making appropriate adjustments to the reference rate to account for material differences between the expansion population and the reference population. Such differences include the following:

- Different mix of ages or genders, as the expansion group may have a higher prevalence of males or non-elderly adults as a result of existing Medicaid coverage policies;
- Variation in covered benefits or in limits on benefits (for example, essential health benefits under ACA may not be as comprehensive as a full Medicaid package of services);
- Geographic differences; the mix of rural and urban dwellers, depending on existing enrollment patterns and the nature of the expansion;
- Cost-sharing differences, which may decrease the nominal cost of care but change the acuity risk of the individuals who choose to enroll or change when they choose to enroll (participation is not 100 percent even in mandatory programs); and
- Disease prevalence and relative health acuity can be very difficult to estimate and have offsetting factors. Because of lack of health care, uninsured populations may have greater health care needs; yet existing Medicaid eligibility rules already provide opportunities for the disabled and medically needy to be covered. Moreover, some Medicaid expansions might include individuals who already have employer-sponsored insurance and who thus have had regular access to health care services.
- Income levels are different between traditional Medicaid populations (such as TANF and SSI) and the ACA Medicaid adult expansion populations. Income can be an indicator of overall health status, so the higher incomes of the newly eligible adults could suggest better overall health on average compared with the existing Medicaid population.¹⁶

Of the situations noted above, assessing relative health risk of the uninsured or expansion population is one of the most important, yet most difficult, because of the general lack of historical information; thus, the need to make several assumptions arises. In these situations of uncertain risk, the use of supplemental risk mitigation tools such as risk sharing, risk pools, and risk corridors can mitigate some of the uncertainty and

¹⁶ Steven C. Hill et al., "Adults in the Income Range For The Affordable Care Act's Medicaid Expansion Are Healthier Than Pre-ACA Enrollees," Health Affairs, March 2014, <http://content.healthaffairs.org/content/early/2014/03/17/hlthaff.2013.0743.abstract> (accessed August 20, 2015).

provide a level of protection to the state, the federal government, and the contractor. These supplemental risk mitigation tools are discussed further in [Chapter 2](#) of this section.

To help inform the actuary on the situations noted above, some states have local survey data on the uninsured that can provide insight. National survey sources, such as the Current Population Survey, American Community Survey, or the Medical Expenditure Panel Survey, also can be analyzed. Information from other states that have expanded Medicaid to higher-income populations prior to the ACA, such as Arizona, Delaware, and New York, can also be reviewed.¹⁷ Additionally, some states (including California and Pennsylvania) offered programs for adults through a state-funded health insurance program not under Medicaid prior to the ACA. These state-only programs may have offered a more limited benefits package or had tighter eligibility rules, but if the population is similar to the Medicaid ACA adult expansion and if reliable data are available, these populations and programs can serve as a reference point. However, other state information should not be taken at face value, as the policies, program, politics, practices, and populations typically make each state unique. The adage, “if you’ve seen one state Medicaid program, you’ve seen one state Medicaid program,” should not be forgotten in this regard.

For reference purposes, a state and its actuary may choose to use a single population group such as TANF adults. However, there are many approaches that can be used to develop rates for a new expansion group. Weighting experience from TANF adults and SSI adults is another approach. Depending on the reference population used, the subsequent adjustments will likely be materially different. For example, if SSI adults are used exclusively, it may be appropriate to apply adjustments that reduce the PMPM, whereas using more TANF-based experience could result in positive adjustments. Therefore, comparisons of assumptions used in developing rates for new expansion populations across states may not be appropriate unless the whole process is understood and acknowledged.

Depending on the nature of the expansion (for example, providing state plan benefits to the adult expansion population, purchasing coverage for newly eligible adults on marketplace exchanges/premium assistance, or enrolling the expansion population in consumer-driven health plans), the number of individuals added to Medicaid may be sufficient to establish a stand-alone rating group; separate capitation rates may not even be applicable if a state chooses to pursue a premium assistance model. In other cases, the new enrollees may need to be combined with an existing rating group, as long as the state complies with federal claiming (that is enhanced versus regular federal match rates) or other requirements applicable to the different populations.¹⁸ When combining a new group with an existing rating group, the number and composition of the expansion population take on more importance. That is because the weighting of the two groups will directly affect the resulting capitation, which will be applicable to everyone included in the rate cell. This can pose a particular challenge because accurate counts of the uninsured, assessment of their health care risk, and the ramp-up in enrollment are difficult variables to get right. Moreover, after enrollment, previously uninsured populations and individuals who lacked access to comprehensive health care may seek out health care services at higher-than-average levels as a result of unmet needs. This is commonly referred to as pent-up demand and can increase the initial PMPM cost of an expansion population. Actuaries often account for pent-up demand with an explicit, temporary rate adjustment. Over time, actual experience data will become available on the expansion population, which will be incorporated into future rate-setting cycles as applicable.

With the uncertainty of risk, it may be reasonable to consider segmenting the new population into multiple rate cells based on age, gender, or other variables instead of combining all new individuals into one aggregate

¹⁷ State-specific decisions on eligibility, covered benefits, and other policy and program design issues should be carefully considered before using one state’s experience to establish rates in another state.

¹⁸ Under the ACA, states receive an enhanced federal matching rate for the non-elderly non-pregnant adults, which is 100 percent in 2014, with graded reductions to 90 percent by 2020.

rate cell. The difference in average cost of individuals ages 19- to 29 and individuals ages 55- to 64 can be substantial, so having multiple rate cells can better match payment to risk and alleviate some concern by the risk-bearing entities that they will attract the older populations and be disadvantaged. Risk corridors and other risk-sharing programs can further mitigate some of the unknown risk. With additional program experience, the new expansion populations can be evaluated for inclusion in more sophisticated risk adjustment techniques discussed in [Chapter 2](#) of this section.

As noted previously, CMS developed a consultation guide, updated on an annual basis, to help states and their actuaries prepare documentation and proactively address topics that CMS will be evaluating.¹⁹

The types of questions in the consultation guide are intended to provide CMS a better understanding of how these rates were developed, since the federal government initially pays 100 percent in 2014 (declining to 90 percent by 2020) of the costs associated with the newly eligible adults. The CMS Office of the Actuary (OACT) has also been more involved in discussions on capitation rates applicable to newly eligible adults. A sample of topics and questions from Section III New Adult Group Capitation Rates of the 2016 Draft CMS Consultation Guide is as follows:

1. Data A. *In addition to the expectations for all Medicaid managed care rate certifications, as supported by assurances from the State, described in Section I, the rate certification must describe any data used to develop new adult group rates.*

B. *For states that have covered the new adult group in Medicaid managed care plans in 2014 or 2015, CMS expects the rate certification, as supported by assurances from the State, to describe:*

- i. *Any new data that is available for use in 2016 rate setting;*
- ii. *how the state and the actuary followed through on any plans to monitor costs and experience for newly eligible adults;*
- iii. *how actual experience and costs in 2014 or 2015 have differed from assumptions and expectations in previous rate certifications; and*
- iv. *how differences between projected and actual experience in 2014 or 2015 have been used to adjust the 2016 rates.*

2. Projected Benefit Costs A. *In addition to the guidance for all Medicaid managed care rate certifications described in Section I, states should include in the rate certification submission and supporting documentation a description of the following issues related to the projected benefit costs for the new adult group:*

- i. *For states that covered the new adult group in 2014 or 2015:*
 - (a) *Any data and experience specific to newly eligible adults covered in 2014 or 2015 that was used to develop projected benefits costs for capitation rates.*
 - (b) *Any changes in data sources, assumptions, or methodologies used to develop projected benefits costs for capitation rates since the last certification.*
 - (c) *How assumptions changed from the 2014 or 2015 rate certification on the following issues:*
 - (i) *Acuity or health status adjustments (in most cases comparing the new adult group enrollees to other Medicaid adult enrollees);*
 - (ii) *adjustments for pent-up demand;*

¹⁹ To download CMS' managed care rate-setting guides, see: <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html> (accessed August 20, 2015).

- (iii) adjustments for adverse selection;
- (iv) adjustments for the demographics of newly eligible adults;
- (v) differences in provider reimbursement rates or provider networks, including any differences between provider reimbursement rates or provider networks for newly eligible adult rates and other Medicaid population rates; and
- (vi) other material adjustments to newly eligible adults projected benefit costs.

CMS is particularly interested in assumptions or rate adjustments that differ from those of existing populations that receive standard federal match and the basis for why the adjustments are different. This

KEY CONCEPT

The Centers for Medicare & Medicaid Services Consultation Guide for Newly Eligible Adults

The Centers for Medicare & Medicaid Services (CMS) consultation guide contains several questions on the capitation rates for new Medicaid adults per the Affordable Care Act (ACA) that are subject to higher federal match rates. States should expect a longer and more detailed CMS Office of the Actuary review of these rates.

may lead to some differences of opinion between CMS/OACT and the actuary certifying the capitation rates. These differences can generally be resolved through discussion, and it is not CMS that has to attest to the actuarial soundness of the rates. For example, some states and their actuaries have decided that due to the increased uncertainty of the expansion population, a higher-risk contingency load is appropriate. CMS has noted concerns with this adjustment in reviewing submitted rate documentation even though the 2014 CMS consultation guide explicitly noted “any expansion population included in this eligibility group may present increased uncertainty regarding utilization and cost of health care services.” CMS has indicated a preference to see the non-medical expense load for the expansion adults align with that of other populations in future rating cycles.

This would likely occur anyway as actual experience data for the newly eligible adults become available to assist in refining the rate-setting process.

Initial Year of Rate Setting and Subsequent Years Sustainability

For the initial year of a managed care contract, states typically undertake a complete rate development process using all the steps described previously. States have more flexibility and options in subsequent program years. Instead of undertaking a complete rate development process, involving another round of data extracts, analyses, and adjustments, states have the option to have their actuaries perform what is called a rate update. Compared with a complete re-basing of the capitation rates, a rate update leverages the work that was done the year before by, for example, retaining the same base data and most of the adjustments incorporated in the rates. For a rate update, the actuary may only have to evaluate trends for the additional year of forecast and any program changes that are not already included in the rates from the prior year. Depending on time and budget, the actuary may have the opportunity to update other elements of the rate development process using more recent data and information but may do so in a manner that involves much less time and cost than using a new set of base data and going through all the steps.

A rate update can be used only for a limited number of rating cycles because eventually the base data will be out of date. As noted above, when the time between the base data and the contract rating period becomes too great, the actuary will need to rebase rates on newer information and go through the complete process once again. This cycle can then continue as needed. Some states prefer to have their capitation rates rebased

each year to ensure that the latest concepts, purchasing strategies, and results can be incorporated in the next cycle of rates. States and their actuaries should discuss the merits of both approaches, decide what is practical and appropriate for each rating cycle, and plan accordingly.

As noted previously, as managed care matures in a state, less Medicaid FFS data will be available. Within a few years, states will likely need to transition to incorporating managed care data into the rate development process. Encounter data are the best source of detailed cost and utilization data, but using that source requires states to commit significant resources to collecting, processing, and storing encounter data from risk-based contractors, who may have different data systems and methods of paying providers. For example, the state may use diagnosis-related groups (DRGs) to pay for all inpatient acute hospitalizations under traditional FFS; however, the contracted health plans may use any combination of DRG, case rates, per diems, or other reimbursement mechanisms to pay for the same hospitalizations. It can be a significant challenge for a state to transition from adjudicating FFS claims to collecting and validating encounter data, but reliable experience data will enable the state and its actuary to develop better and more innovative payment terms and, most important, enable the state to be a more informed buyer.

As managed care matures, states may face pressure from external or internal stakeholders over program funding levels. Unlike traditional FFS, where expenditures can be spread over different state budget appropriations, capitated managed care usually appears as a single line item on a state's budget, which can draw more attention, especially during recessionary times. The risk-based contractors may want the state to "adequately fund" the program, at the same time that budget directors may be looking for any opportunity to reduce spending. Unlike FFS, in which a state may be able to reduce provider fees, risk-based capitation rates are harder to reduce to fit within a state's budget forecast inasmuch as they are subject to both federal regulations and professional actuarial standards. In FFS, a provider who chooses to stop seeing Medicaid patients because payments have been reduced can affect a few dozen, a few hundred, or even a few thousand consumers. However, if a state destabilizes a managed care program through providing too little funding or overaggressive capitation rates, the result could disrupt care for hundreds of thousands of consumers. Hundreds of providers in the contractor's network may have to renegotiate contracts, and a large administrative effort may be required for the state to reassign individuals to other contractors, create alternative programs, or reestablish a working FFS program that may have been put out of mind years earlier. Therefore, as active and engaged program sponsors, states need to balance financial sustainability with program stability to ensure that managed care is a viable and valuable component of the state's overall Medicaid purchasing strategy.

RATE SETTING FOR SPECIAL POPULATIONS

States initially experimented with Medicaid managed care for traditional populations, such as TANF families, pregnant women, and children, since those populations were assumed to be more similar to non-Medicaid managed care populations in the commercial sector. However, as states have gained experience and become more familiar with the advantages and disadvantages of managed care, they have begun to expand risk-based managed care to more difficult and challenging populations, such as the elderly and physically disabled, the developmentally disabled, and dual eligibles.

From an actuarial rate-setting perspective, special or unique populations can pose challenges in matching payment to risk, since the risk is often difficult to quantify or subject to large variation, or because data to support full analysis and decision making are limited. However, unlike a traditional TANF family or child, for whom costs are relatively low and chronic disease is less prevalent, the opportunity for efficient risk-based managed care to improve health outcomes for an elderly, disabled, or chronic disease population increases dramatically even as the risk of the population rises. To address those special populations, capitation rate

development can be augmented from the average PMPM rate approach described previously in several different ways. [Chapter 2](#) of this section provides additional techniques and approaches to risk mitigation.

Maternity Care Payment

Pregnancy and childbirth are among the services most often paid for by Medicaid. According to a January 19, 2011, issue brief from the National Governors Association Center for Best Practices, 64 percent of total births were Medicaid births in Arkansas; 48 percent in Missouri and Nevada; and 43 percent in Oregon.²⁰ A common approach in capitation rate setting, which is used by states such as Arizona and Pennsylvania, is to develop a separate, supplemental maternity delivery payment that the state pays to the contractor that incurs the cost of the delivery. To develop the supplemental maternity care payment, the actuary identifies and quantifies the maternity-related dollars, separate from other expenditures. Then, using the number of birth events, the calculation is similar to a PMPM rate, except that maternity dollars are divided by the applicable maternity birth events to create a one-time, supplemental maternity delivery payment, which can amount to several thousand dollars. The non-maternity dollars are used in the computation of standard monthly capitation rates, along with all the member months associated with the population, including the month of delivery. That means that the state will continue to make a monthly capitation payment for non-maternity services for all pregnant females, as well as a second, supplemental payment for the birth event. That is an effective mechanism to better match payment to risk, since a birth is high-cost, one-time event that can be relatively easy to identify.

Multiple Rate Cohorts/Rating Groups

Populations that are physically disabled, institutionalized, or intellectually disabled represent a different type of risk and have higher average costs than a traditional TANF population. Adults have different cost and utilization patterns than children. Developing one capitation rate that combines all of those populations is arithmetically possible, but the practical limitations of paying the same average PMPM rate for the diversity in risk outweigh the simplicity of using a single rating group structure. Most states in collaboration with their actuaries use multiple rating groups or rate cells to define and distinguish key population groups that represent materially different risk and cost profiles. TANF recipients are typically separately rated from those receiving SSI; children of various ages can be rated separately from adults; newborns can be their own rating group; and urban areas are rated separately from rural counties. Specific disease conditions can be used to create distinct rating groups, such as breast and cervical cancer program participants, hemophiliacs, and individuals with HIV/AIDS.

The use of more distinct rating groups improves the ability of the state to match payment to risk. It also takes more administrative effort to support, requires more actuarial rate development time and cost, and requires more systems capabilities to ensure that the correct rate is paid each month for the correct person. Separate rating groups may also enable assumptions to be tailored to a particular population group, instead of an assumption being watered down within a large population rating group. For example, separating TANF or SOBRA children from adults may enable the state and its actuary to target specific services such as Early and Periodic Screening, Diagnostic and Treatment in rate development more easily than if the populations were all combined.²¹ And as data are collected over time from the managed care plans, subsequent rate-setting cycles can take into consideration differences in trend and utilization patterns unique to each population. However, if a rating group is defined by a specific disease condition, the state needs to have robust policies and program integrity rules to ensure that gaming of the capitation payment structure by the risk-based plans does not occur.

20 National Governors Association Center for Best Practices, "2010 Maternal and Child Health Update: States Make Progress Towards Improving Systems of Care," January 19, 2011, <http://www.nga.org/files/live/sites/NGA/files/pdf/MCHUPDATE2010.PDF> (accessed August 20, 2015).

21 SOBRA, derived from the Sixth Omnibus Budget Reconciliation Act of 1986 and other subsequent legislation, provides coverage for pregnant women and children up to age 19 who meet certain income requirements.

Long-Term Care Populations

Multiple rating groups can also defeat the objective of risk-based managed care to provide incentives for cost-effective care management. As more states expand risk-based managed care to Medicaid LTSS, two new populations are included: individuals residing in institutional facilities such as nursing homes and individuals receiving care through one or more 1915(c) home- and community-based waiver services (HCBS). Even though the population groups might require similar levels of care (as defined by the state's eligibility parameters), the PMPM costs of the groups can be significantly different. It is not uncommon for the average PMPM for the institutionalized to be well over \$6,000, compared with an HCBS population's average PMPM of \$2,000. Initially it may seem prudent to develop separate capitation rates for each population, but in doing so, the state might miss an opportunity to use financial incentives for the risk-based contractors to become more cost-effective by delivering care in a community-based setting and actively engaging in maintaining the health and functional status of members to avoid costly institutional care. An alternative rating structure would involve blending the two PMPM rates together, using a target population mix assumption and paying the same final rate for all enrollees, regardless of setting of care.

For example, nursing home PMPM of \$6,000 and HCBS PMPM of \$2,000 are blended together using an assumed, target mix of 60/40, resulting in a final PMPM capitation rate that is computed as $(\$6,000 \times .60 + \$2,000 \times .40) = \$4,400$.

In the example, the risk-based contractor will lose, on average, \$1,600 each month on every nursing home member and gain \$2,400 on every community-based member. That provides a significant financial incentive to serve members in lower-cost community-based settings.²² Steering members in that direction in many cases aligns with the primary goal of the state, and each year, the state can adjust the population mix to promote continued improvement (Arizona reviews and adjusts the nursing home and HCBS target mix each rating cycle). However, that type of rating structure also transfers a higher level of risk to the state's contractors, and so supplemental forms of risk adjustment and mitigation might be considered. The state should monitor the financial status of its contractors closely until the program stabilizes. Using the rating group structure can thus be a tool to promote desired outcomes, as long as the risk structure is considered in the decision-making process and contractors are willing to participate in the program with payment terms in that form. Various iterations of blended capitation payment structures can be deployed to refine the model or limit risk, such as creating a separate rate for long-term institutionalized individuals (for example, a cohort of individuals continuously institutionalized for more than 6 or 12 months).

ADVANCED

OVERVIEW OF OTHER MANAGED CARE PAYMENT MODELS

Non-capitated managed care programs differ from risk-based, capitated managed care in that the state remains the direct payer of medical claims, though the actual state payment mechanism or process may change. States can choose among a variety of program and payment forms that do not require them to enter into full-risk contracts. These include accountable care organizations, health homes, bundled provider payments or episodes of care payments, and shared savings programs. Actuarially sound capitation rates are not relevant to these alternative managed care programs, and thus many of the federal requirements applicable to risk-based contracting do not apply. However, states can still take advantage of the technical assistance and insight that actuaries and other professionals can offer in developing and monitoring alternatives to risk-based managed care. Fiscal discipline, objective points of view, independence, and a well-defined payment structure are common elements in Medicaid financing, regardless of the financial model employed. Since other sections of this Compendium cover policy and regulatory topics associated with

22 Suzanne Gore and Julie Klebonis, "Medicaid Rate-Setting Strategies to Promote Home- and Community-Based Services," Center for Health Care Strategies, May 2012, <http://www.chcs.org/resource/medicaid-rate-setting-strategies-to-promote-home-and-community-based-services/> (accessed August 20, 2015).

different delivery systems, the focus here is on describing the key attributes of alternative financial models.

States are not limited in their choices of how to deliver and manage the care of their Medicaid populations. In fact, the menu of options available to states is increasing rather than decreasing, as innovation continues in the health care field. As one recent report noted, the two fundamental goals of care coordination are to transfer information, such as medical history, medication lists, test results, and patient preferences appropriately from one participant in a patient's care to another, including transferring information to and from the patient, and to establish accountability by clarifying who is responsible for each aspect of a patient's overall care, including specifying who is primarily responsible for key care delivery activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants.²³ Those are broad goals that can be achieved with a variety of models. Indeed, payment reform is not an end in itself but rather a means to give providers incentives to improve the way they deliver health care.²⁴ Massachusetts,²⁵ Oregon,²⁶ and Vermont²⁷ have been experimenting with new Medicaid financial models that focus on community-based care and community-level involvement and accountability for outcomes.

Risk-based managed care has an established record and a process for developing and evaluating policies, procedures, and payment terms that is more formal than alternative financial models, but formality might not be the best solution for a particular state's goals and objectives. Indeed, risk-based managed care might not be a viable option for a state for a variety of reasons: a small population base over which to spread risk, large geographic areas with limited provider supply, health care services highly concentrated in a dominant service provider, or a lack of infrastructure or resources to support risk-based contracting. That is not to say that states will not be successful with risk-based managed care if those conditions exist, but to create a vibrant and sustainable program might be more of a financial or operational challenge. Therefore, regardless of whether a state is rolling out a new program in its most urban or most rural area, the state should evaluate the merits of different delivery systems and financial models and choose the ones that are expected to yield the best return on investment over the long run.

ALTERNATIVE FINANCIAL MODELS

A detailed discussion of all the financial models available to states is beyond the scope of this Compendium. However, this chapter presents key attributes of alternative models. States are encouraged to seek out additional information, which is readily available in the public domain. Several sources are listed at the end of the chapter. The following table describes the key characteristics of alternative financial models:²⁸

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- 23 Agency for Healthcare Research and Quality, "The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care," December 2010, <https://pcmh.ahrq.gov/sites/default/files/attachments/Roles%20of%20PCMHs%20And%20ACOs%20in%20Coordinating%20Patient%20Care.pdf> (accessed August 20, 2015).
 - 24 AcademyHealth, "Payment Matters: The ROI for Payment Reform," February 2013, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404563 (accessed August 20, 2015).
 - 25 Zirui Song, et al., "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical Spending and Improved Quality," Health Affairs, July 12, 2012, <http://content.healthaffairs.org/content/early/2012/07/09/hlthaff.2012.0327.short> (accessed August 20, 2015).
 - 26 Oregon Health Authority, "Coordinated Care Organizations," <https://cco.health.oregon.gov/Pages/Home.aspx> (accessed August 20, 2015).
 - 27 Christina Bielaszka-DuVernay, "Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health At Lower Cost," Health Affairs, March 2011, <http://content.healthaffairs.org/content/30/3/383.extract> (accessed August 20, 2015).
 - 28 Michael Bailit, et al., "Paying for the Medical Home: Payment Models to Support Patient-Centered Medical Home Transformation in the Safety Net" Safety Net Medical Home Initiative, (Seattle, WA: Bailit Health Purchasing and Qualis Health, October 2010) <http://www.statecoverage.org/files/SNMHI-PayingForMedicalHome.pdf> (accessed August 20, 2015).

Table 18. Key Characteristics of Alternative Financial Models

Financial Model	Description
Accountable Care Organizations (ACOs)	ACOs comprise providers who voluntarily meet specified criteria, including reporting quality measures. ACOs can share in or fully retain the cost savings they achieve or may shoulder some of the losses, depending on the adopted payment model. ACOs can be made up of a variety of networks, from large, integrated delivery systems to physician-led hospital groups, multispecialty practice groups, group physician practices, or health center networks. ACOs can receive bundled or global payments for services or contract on a shared savings basis. Colorado, Maine, Massachusetts, Minnesota, New Jersey, Oregon, and Vermont are among the states pursuing ACO or ACO-like payment reforms. ²⁹
Bundled or Episode Payments	Bundling is the process of grouping services, either for a particular person over a predefined period or for a particular clinical diagnosis or procedure (for example, nonemergency coronary artery bypass graft). ³⁰ Providers assume financial risk for the cost of services associated with a particular condition or treatment, as well as costs associated with preventable complications but not for the occurrence of the medical condition (insurance risk). Bundled payment supports coordination of care by sharing payment for treatment of a condition across multiple providers in multiple settings. Financial risk is mitigated by reinsurance or other means to limit or cap risk. Bundled payments can serve as a middle ground between fee-for-service (FFS) and global payment for all services. Arkansas and Tennessee have been evaluating or deploying episode-based payment strategies. ^{31,32}
Global Payment	Global payment is prospective reimbursement to a health care provider, such as a physician or hospital, that reflects the total expected spending of its patient population over the continuum of care for a defined period (very similar to capitation). Full global payments apply to primary, specialty, hospital, and other covered services. Partial global payments cover primary care or specialty services. Global payments place providers at some risk for utilization of services as well as management of conditions. Providers can be protected from the total insurance risk by risk adjustment of payments, reinsurance, and other mechanisms that limit or cap risk. Global payments are designed to contain costs, encourage integration and coordination, and reduce unnecessary services. Global payments can include incentives for improving the quality of care. Global payment systems can be administratively complex for providers and require additional infrastructure to help manage financial risk. The risk and administrative burden in global payment potentially excludes small provider groups and solo practitioners.

Financial Model	Description
Medical Home ³³	A medical home is an enhanced model of primary care that is designed to provide comprehensive, patient-centered preventive and primary care. The model aims to reduce costs and improve quality and efficiency through greater access to and coordination of care. The medical home relies on a team of providers—such as physicians, nurses, nutritionists, pharmacists, and social workers—to meet a patient’s health care needs. Although medical home payment systems assume various forms, payment structures often build on FFS payments. One common method of financing pays providers a per-member per-month fee for medical home activities, such as case management and care coordination, in addition to the regular FFS payments. Payment policies often compensate providers for services that are not currently reimbursable—such as care coordination, use of health information technology, and patient education to improve self-management of disease. Additionally, some medical homes offer bonuses or shared savings if specific cost and quality measures are met.

An interesting and evolving issue is determining the role existing managed care plans have in the adaption and implementation of alternative financial models. In the past, states have often turned to managed care as a method to drive the development of innovative payment and care management models. However, as states continue to look for ways to control growth in expenses, improve health outcomes, and create a sustainable health care ecosystem, states are becoming more innovative and taking a more hands-on approach to the delivery of health care services to push more innovation (for example, Arizona, Arkansas, Pennsylvania, and Tennessee). Managed care plans that are already innovative can be a valuable source of information on what works well or has not worked well in the local marketplace and can share this experience with the state or other health plans. For example, in 2015 Pennsylvania convened a meeting with all of its Medicaid-managed care plans to share ideas and best practices in the management of members with hepatitis C (for example, use of 340b pharmacies, consistent prior authorization criteria, and use of centers of excellence).

In regard to the alternative financial models noted above, managed care plans can be involved or affected when states pursue these alternative models in a variety of ways such as:

- Existing managed care plans may be required by the state to contract with Accountable Care Organizations (ACOs) and even have a certain percentage of their members covered by ACO arrangements (for example, 10 percent in year 1 and 25 percent in year 2). One challenge that has not been fully vetted yet is how payments from the managed care plan to the ACO can be factored into the capitation rate development process. Often ACOs have a shared savings arrangement (see “Shared Savings Arrangements” below) with the “sponsor” organization such as the managed care plan. If the managed care plan makes a shared savings payment to the ACO, is that expense allowable for inclusion in prospective capitation rates? Likely the answer is yes, but this is an evolving issue as of this writing. Furthermore, the state’s actuary may need to have more detailed information on the nature of the plan-to-ACO arrangement

29 Center for Health Care Strategies, “Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States,” February 2014, <http://www.chcs.org/resource/medicaid-accountable-care-organization-program-design-characteristics-review-of-six-states/> (accessed August 20, 2015).

30 Gwyn Volk and James Pettersson, “Global and Episodic Bundling: An Overview and Considerations for Medicaid,” AcademyHealth, April 2011, http://www.statecoverage.org/files/SCI_report_navigantFINAL2.pdf (accessed August 20, 2015).

31 For more information on Tennessee’s innovation initiative, see the state’s website: <http://www.tn.gov/HCFa/strategic.shtml> (accessed August 20, 2015).

32 For more information on Arkansas’s Medicaid health care payment improvement initiative, see the state’s website: <http://www.paymentinitiative.org/Pages/default.aspx> (accessed August 20, 2015).

33 National Conference of State Legislatures, “The Medical Home/Health Home,” <http://www.ncsl.org/issues-research/health/medicaid-payment-reform.aspx#5> (accessed August 20, 2015).

to assess the appropriateness of any payment expense for inclusion in the prospective capitation rates (for example, contract terms, is the health plan a related party to the ACO, calculation of baseline expense, projected expense, computation of shared savings), which the health plan may or may not be willing to share.

- Alternatively, a state may bring up an alternative financial model to be in direct competition or perhaps even replace the existing managed care delivery system. In an ACO example, since ACOs are typically provider-based organizations, the competing ACO entity might also be a provider within the existing managed care plan network. This could result in the existing plans competing against and doing business with the same provider-based organization. States may implement competing delivery systems to assess which delivery system provides the best outcomes, quality metrics, or cost efficiency.
- Existing managed care plans may be contractually required or highly encouraged by the state to adopt the state's bundled payment methodology, implement a very similar financial model with certain providers (for example, hospitals), or create medical homes for their members. This would likely result in the existing plans having to renegotiate some provider contracts and modify their internal business strategies. It might even affect staffing levels. Some plans may appreciate the state setting the provider payment level and methodology, particularly those plans with minimal market leverage or purchasing power. But other plans may view this more of an intrusion by the state into the plan's business and management strategy.
- Even if a state does not contractually mandate the plans to adopt alternative financial model, the marketplace will be affected by whatever the state does or promotes, especially in states with moderate to low managed care penetration. As a result, the plans might get pressure from certain providers to adopt similar payment strategies for consistency and administrative simplicity, which could lead to provider network changes or negotiations. Whether this occurs or not may be directly related to how providers perceive or are affected financially by the actions taken by the state.
- To the extent that alternative financial models have a positive effect on health outcomes, change the existing status quo, or reduce inefficiency and waste in the health care system, the managed care plans, as well as the public at large, can benefit through such results as slower growth in health care expenditures, healthier members and populations, and better overall performance.

SHARED SAVINGS ARRANGEMENTS

Shared savings arrangements are similar to global payment arrangements, except that the provider entity bears no risk for financial losses, should expenditures exceed what was budgeted or targeted. Moreover, these arrangements can involve direct contracting by the state with practice groups and integrated delivery systems, or a state may choose to use an intermediary to function much like a third-party administrator (TPA). The TPA may not be at risk for any service, but a state can use performance metrics or targets to set performance incentives and create a level of accountability with the TPA. Also, rather than have the provider entity retain all of the savings that it might generate through its efforts, those savings are shared with the payer. The extent to which savings are shared is often dependent upon performance metrics that assess patient experience, clinical quality, or efficiency. Shared savings programs are relatively new, and prior endeavors have not always produced favorable results, so that states should be aware that although shared savings is an attractive concept, program design, monitoring, and stakeholder engagement are critical in whether success is achievable.³⁴

From a financial modeling perspective, shared savings programs involve process steps that are similar to

34 David M. Eddy and Roshan Shah, "A Simulation Shows Limited Savings from Meeting Quality Targets under the Medicare Shared Savings Program," *Health Affairs*, October 2012, doi: 10.1377/hlthaff.2012.0385.

the development of capitation rates as described previously (for example, target population, base data, trend, and program changes). The key difference is that the savings or excess costs are determined through retrospective analyses rather than prospective managed care assumptions. Even though the term “shared savings” is commonly used, states can also require their partners to share in losses to the extent that the state wants to add more financial risk and accountability to the program. Key financial model components essential to shared savings programs, which the state will need to deliberate carefully, include the following:

- **The target or benchmark spending or budget level:** The target or benchmark level of spending is the amount that the state expected to pay in the absence of the program, taking into consideration the unique attributes of the population and marketplace. Since actual program expenditures will be compared with that expected cost, making the benchmark projection accurate is vital. However, determining what a state would have spent in the absence of a new program is essentially a hypothetical analysis of what might have happened and involves numerous factors. Methods to estimate the expected cost of the “shared savings” target population include the following:
 - » *Forecast population cost.* Using historical data from the population that is eligible for the shared savings program, the state (or its actuary) can forecast what the expenditure levels would have been if the new program were not implemented. That can be useful in the initial years of the new program, but over time the projection period becomes extended, creating more uncertainty about the accuracy of the expected cost; this is similar to the issue of dwindling usefulness of FFS data for developing managed care capitation rates.
 - *Example:* Shared savings target population has a historical average cost of \$3,000 per capita that is trending at 4 percent per year. Costs are projected for two years to align with the first year of the shared savings program, resulting in an expected per capita cost of \$3,244.80.
 - » *Relative population cost.* Historical data from the population covered by the shared savings program can be analyzed and compared with data from a population that will not be eligible for the program. Statistical and financial analyses can be performed to determine the relationship between the two populations over time. By projecting those relationships forward, the expected cost of the target population can be estimated relative to the known cost of the comparison population.
 - *Example:* The shared savings target population has a historical average cost that is 85 percent of a comparison population. The actual cost of the comparison population in the first year of the program is \$4,000 per capita, resulting in an expected cost for the shared savings population of \$3,400.

Changes in population demographics make the calculation challenging, including changes in enrollment duration, cost outliers, services mix, and health status. These changes can materially affect the validity of historical trends and relative cost comparisons. If the shared savings population’s (or the comparison population’s) health status changes, the actual program expenditures will reflect the risk of the population, but the expected expenditure levels may not. That can lead to inaccurate conclusions about the program’s success and may result in a shared savings payment being made when not deserved or vice versa.

- **Patient attribution:** Because patients often receives care from a variety of providers, including different primary or specialty care providers, the state must have a process to attribute each patient to a specific program entity for purposes of assigning savings or losses. That can

involve setting a minimum patient population size for program entities as a condition for their inclusion in the shared savings program. Patient attribution can be done prospectively, based on historical provider service utilization, or retrospectively, based on actual provider service utilization. If patients are attributed prospectively, the participating program entities will know which of their patients they will be held accountable for when savings are evaluated. That might lead to more engaged providers but could also erroneously assign some patients if historical patterns do not hold true through the performance period. Retrospective assignment attributes patients based on actual provider service use in the performance period; it is more accurate but prevents the program entities from knowing who are and are not “their” patients. CMS revised the original Medicare ACO program design and now informs ACOs in advance which Medicare beneficiaries are likely to be part of their system.

- **Determining how savings (or losses) will actually be shared:** Three key questions are involved in determining how savings will be shared: What percentage of savings will the program participants be eligible to receive? How will each program participant’s share be determined? and Will the state incorporate performance metrics in the shared savings algorithm? Each of those answers can be contingent on the others, so that participating program entities can qualify for shared savings at progressive levels as each requirement is met. As described in a report from the Commonwealth Fund, in some basic models, performance measures can define a minimum qualification for a fixed percentage of savings; however, more complex models can specify that the provider can increase its share of savings by performing better relative to a performance measurement set.³⁵ Accordingly, savings can be shared in numerous ways. States must decide on the right combination that creates incentives for high performance, while being practical to administer.
- **Measuring savings (or losses) occurred:** To measure savings or losses, the state must collect and analyze actual program expenditures for the shared savings populations. Key issues include how much run-out time is given to collect claims data, versus adjusting the data for expected claims run-out, ensuring that the data collected are for the same services that were used in the benchmark expenditure forecasts and that the time period of expenditures aligns with the benchmark forecasts. The objective is to ensure that the benchmark forecasts and actual program expenditures are an “apples-to-apples” comparison, so that the state can accurately assess whether the program has generated savings, versus just measuring changes that are unrelated to the performance and outcome such as changes in data collection or population shifts.

It is key to determine what percentage, or absolute dollar amount, of savings is required (for example, a minimum savings rate) to avoid the influence of random fluctuation. For example, CMS has opted to use a minimum savings rate of 2 percent as part of the Medicare ACO program. To calculate savings (or losses), actual expenditures are compared with the benchmark forecast expenditure levels. Depending on the level of savings observed, the distribution of savings proceeds according to the program design parameters noted above. The following table illustrates how this process might unfold, but there are a multitude of potential outcomes to consider. The scenarios shown in the table below include ones with and without a quality performance element.

35 Michael Bailit and Christine Hughes, “Key Design Elements of Shared-Savings Payment Arrangements,” The Commonwealth Fund, August 2011, http://www.commonwealthfund.org/~media/files/publications/issue-brief/2011/aug/1539_bailit_key_design_elements_sharesavings_ib_v2.pdf (accessed August 20, 2015).

Table 19. Measuring Savings or Losses

Scenario 1:

Savings computed to be 3 percent in total, or \$1 million; 75 percent of savings shared if quality targets met.

Program Participant	Contribution to Savings	Quality Targets Met	Shared Savings Payment
Provider #1	\$400,000 (40%)	Yes	\$300,000 ($\$1m \cdot .75 \cdot .40$)
Provider #2	\$600,000 (60%)	Yes	\$450,000 ($\$1m \cdot .75 \cdot .60$)

Scenario 2:

Savings computed to be 3 percent in total, or \$1 million; 75 percent of savings shared if quality targets met.

Program Participant	Contribution to Savings	Quality Targets Met	Shared Savings Payment
Provider #1	(\$100,000)	Yes	\$0 ($\$1m \cdot .75 \cdot 0$)
Provider #2	\$1,100,000	Yes	\$750,000 ($\$1m \cdot .75 \cdot 1.0$)

Scenario 3:

Savings computed to be 3 percent in total, or \$1 million; 75 percent of savings shared if quality targets met, but if quality target not met savings payment reduced by 50 percent.

Program Participant	Contribution to Savings	Quality Targets Met	Shared Savings Payment
Provider #1	\$400,000 (40%)	No	\$150,000 ($\$1m \cdot .75 \cdot .40 \cdot .50$)
Provider #2	\$600,000 (60%)	Yes	\$450,000 ($\$1m \cdot .75 \cdot .60$)

TRANSFORMING PROVIDER PAYMENTS

In managed care, the state does not pay providers directly for services covered under the contract, the managed care plan does. In some cases, a managed care plan can be a provider-sponsored organization, but in this context, the state is making a capitation payment to the plan to fulfill the obligations of the contract as opposed to paying claims directly. Therefore, the state generally needs to work with and through the managed care plans to transform how providers are ultimately paid for services rendered. One reason states move to managed care is to get away from an “a la carte” FFS payment system. However, if the managed care plans pay their providers mostly on a FFS-like basis, real transformation in the health system may not be achieved as the state intends. Likewise, mandating changes to how plans pay providers could be disruptive to existing processes, be too much change too quickly for the overall systems, or have unintended consequences (for example, providers become financially incentivized to avoid complex or difficult patients). Therefore, states should be strategic in promoting transformation in how providers are paid and work collaboratively with stakeholders. This could include:

- Frequent meetings with key stakeholders representing providers, health plans, and consumers, including health plans that do not participate in Medicaid to gain insight into developments occurring in the commercial or Medicare systems;³⁶
- Political leadership within the state to support health care transformation and innovation;
- Development of a strategic purchasing plan with public input and comments to engender buy-in and support;
- A systematic approach to change with sufficient time for affected stakeholders to adapt to and assess how well changes are being operationalized and whether the change is really having the intended effect; and
- Being open to reassessing options and modifying the plan based on lessons learned.

When it comes to provider payment, there has been historical tension between federal requirements for risk contracts that are intended to prevent states from bypassing the risk for price and utilization that a capitated managed care plan accepts and states' policy goals to design provider performance improvement and pay-for-performance programs that include managed care providers. These rules often limit the degree to which a state may "direct" provider payments through a managed care plan, but the following are some examples of practices that can be used to incentivize managed care plans to transform provider payments:

- Convening meetings with the managed care plans to share best practices and new ideas;
- Performing analyses of encounter data to show the health plans how different provider payment models could affect their expenses;
- Contractually mandating that the health plans implement alternative and innovative provider payment methodologies (either subject to prior state approval or not); and
- Adding funds to the capitation rates and requiring the health plans to use this additional money for the sole purpose of developing new and innovative provider payment methodologies. For example, Pennsylvania has added \$1 PMPM to the capitation rates and required the plans to use this additional money for provider pay-for-performance programs.

Support for provider payment transformation within managed care programs has been increasing in recent years as there has been more interest in value-based purchasing on the part of states and providers and increased support from CMS. The proposed Medicaid managed care rule notes this interest in the preamble comment of proposed rule to "strengthen the ability of states to use managed care to promote innovative and cost-effective methods of delivering care ...and to identify strategies for [value-based purchasing] models for provider reimbursement."³⁷ Within the proposed rule, CMS has included new provisions in proposed 42 CFR 438.6(c) that acknowledge the wider adoption of value-based purchasing models, multi-payer models, and mandated provider fee levels. In these specific situations, the proposed rule appears to offer states the ability to require certain payments. It is unknown whether this flexibility will be retained in the language of the final rule or how it will be subsequently operationalized in the capitation rate or contract approval process.

CONTRACTING AND NEGOTIATING WITH BUSINESS PARTNERS

States must follow their internal procurement policies when contracting with external business partners. For the financial component of the contracting process, options include requiring competitive bids, negotiating payment levels, and offering a "take it or leave it" rate. Competitive bids are primarily a tool to select initial

³⁶ One aspect of the State Innovation Model demonstration is to create multi-payer initiatives and align purchasing strategies across different insurers/programs.

³⁷ 80 Fed. Reg. 31098.

contractors, whereas in subsequent rating periods, states will typically negotiate rates in some manner. However, initial procurements do not necessarily require competitive bidding. For example, depending on state-specific procurement rules, potential contractors can first be evaluated and scored based on their technical proposal (for example, experience, capabilities, and references). Subsequently, only those entities that meet the state's technical requirements are given the opportunity to negotiate financial terms. That strategy places more emphasis on technical ability because price is not discussed until the entity passes the first hurdle. States must thus decide what procurement strategy aligns with their program goals and is also consistent with applicable state rules.

Sharing Information

There is no standard for how much information states should share with their managed care contractors. Unless state regulations or laws require a certain level of disclosure, sharing of information is a state-by-state decision based on the goals, and objectives of the state. As little or as much information as the state wishes regarding the data, adjustments, assumptions, and variation in payment terms can be made available. The state's contractors will appreciate having information on the rating process. The state should also expect the plan's actuary to request as much information as possible on the rate development process; however, it is ultimately the state's decision what level of detail to share. Some states provide only summary-level information on the rate development process, but others provide more detail. In states that use actual managed care experience to build rates, some managed care plans may resist or object to a state releasing information sufficiently detailed to enable competitors to infer provider payment rates or other reference pricing points that are viewed as confidential. Accordingly, there is no current standard for sharing information on how capitation rates are constructed.

In some cases, such as competitive bidding, the state can undermine its ability to obtain the best offer by sharing too much information about the rate development process and rate range. But even that can be mitigated by state policies that reward health plans that have larger memberships for submitting competitive bids, make the lower bound rate publicly available so that plans do not bid too low, or discard or discount bids above a certain threshold. States usually provide interested contractors historical program experience data (such as cost and utilization data, average capitation rates, and average fee schedules), summarized financial experience, information on policies and program changes, and descriptions of how the state develops rates and any supplemental risk adjustment techniques.

The state should also be aware that sharing more information may help the contractors understand the rate development process, but it also can add time and cost to the overall process as opinions will differ on actuarial assumptions. Most states have multiple contractors, and each contractor may take exception to a component of the rates, even though in the aggregate, the rates are reasonable. The state and its actuary should also question the health plans on their assumptions and internal modeling so that there is a fair exchange of information. As one state official commented, "The state is under no obligation to defend our rate offer to the HMO [Health Maintenance Organization]." Therefore, states need to balance being good business partners with managing their program and moving forward.

What to Expect in Payment Negotiations

States should expect their contractors to disagree on the level of payment the state is offering. That is part of the negotiation process between a willing buyer and willing seller. Since some of the larger health plans operate in many states, they have experience with different state policies and practices and will occasionally contrast one state's approach to that of another in the hope of securing a favorable outcome by telling a state, "In {state name} they do it this way." States should take those comments for what they are and, if possible, confirm their accuracy before acting on them, since every state is unique. For example, in one

rate negotiation meeting, a health plan complained that the non-medical expense load was too low at approximately 12 percent. The health plan tried to justify its comments by noting that in a neighboring state's program the non-medical expense load was closer to 15 percent, which was more reasonable in its opinion. The state's actuary was knowledgeable about the neighboring program and was able to clarify that because the neighboring program enrolled only families and children in managed care, the non-medical expense load as a percentage of premium was higher compared with the state's program that enrolled SSI recipients along with other populations. The reality was that even though the percentage of premium was lower in the state, the PMPM value of the non-medical expense load was higher than in the neighboring program. Negotiations then proceeded to the next agenda topic.

The state should also expect that its contractors will send senior staff to negotiate payment terms with state. It is not uncommon for the health plan's president, chief financial officer, controller, medical director, and actuary to attend a financial negotiation meeting and share different perspectives of the plan's operations and financial status, perhaps including recent innovative activities as well as concerns with specific contract requirements or payment or funding levels. Appropriate state resources for financial negotiations can include senior program managers representing finance, quality, and contracting areas, as well as the state's actuary to help answer questions and listen to the plan's concerns. Those meetings can be informative as well as tense at times since large sums of money are being discussed. The more aggressive the state's offer, the more challenging the negotiations will likely be, but all parties are professionals and have an interest in the success of the program. A state may seek to avoid negotiations by giving the contractors a firm "take or leave it" rate, but that is a more aggressive purchasing tactic that may not engender goodwill between buyer and seller over the long run.

See [Section I](#), "Overview and Key Principles of Health Care Purchasing," for information on the procurement process.

ADDITIONAL SOURCES OF INFORMATION

In addition to the reference citations included in this chapter, many other sources of good information are available to states on the topics covered herein. We encourage states to take advantage of these sources and to be advised that information is continually being made available in the public domain.

- AcademyHealth – A leading national organization serving the fields of health services and policy research. Information available at <http://www.academyhealth.org>.
- America's Health Insurance Plans – A national trade association representing the interests of the health insurance industry. Information available at <http://www.ahip.org/>.
- American Academy of Actuaries – 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. Studies, reports, and issue briefs available at <http://www.actuary.org>.
- Arkansas Medical Payment Reform Initiative – A new payment reform model based on episodes of care. Information available at <http://www.paymentinitiative.org/Pages/default.aspx>.
- Accountable Care Organization Learning Network – Toolkit and other information, available at <http://www.acolearningnetwork.org/>.
- Agency for Health care Research and Quality – Information on quality, performance measures, and health care research, available at <http://www.ahrq.gov/index.html>.

- Association for Community Affiliated Plans - A national trade association representing 58 nonprofit safety net health plans in 24 states. Information available at <http://www.communityplans.net/>.
- Catalyst for Payment Reform – Action brief on implementing global payments, available at http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Global_Payment.pdf.
- Center for Health Care Strategies, Inc. – Information on state activities regarding pay for performance, primary care improvement, and payment reform, available at <http://www.chcs.org>.
- Center for Healthcare Quality and Payment Reform – Information on payment and delivery systems, available at <http://www.chqpr.org/>.
- CMS Integrated Care Resource Center – General information on a variety of topics, including health homes, dual eligibles, and state-specific integration activities, available at <http://www.integratedcareresourcecenter.com/default.aspx>.
- CMS Center for Medicare and Medicaid Innovation – Large amount of information on all aspects of innovative financial payment models, including policy briefs, archived webinars, and technical assistance, available at <http://innovation.cms.gov/index.html>.
- The Commonwealth Fund – A private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency. Information available at <http://www.commonwealthfund.org/>.
- The Council of State Governments – In 2009, the Council of State Governments convened a conference to consider new initiatives to link health care purchasing to quality. Information on the lessons learned, topical reports, and presentation slides are available at <http://valueovertime.org/>.
- National Academy for State Health Policy– Independent academy of state health policymakers providing information on a variety of topics. Information available at <http://www.nashp.org>.
- National Conference of State Legislatures – Provides research, technical assistance, and opportunities for policymakers to exchange ideas. Information available at <http://www.ncsl.org/research/health.aspx>.
- Oregon’s Coordinated Care Organizations – A new payment model using coordinated care organizations being formed by existing health plans and groups in local communities. Information available at <http://www.oregon.gov/OHA/OHPB/Pages/index.aspx>.
- Patient-Centered Primary Care Collaborative – “Report of the Payment Reform Task Force,” July 2010, available at <https://www.pcpcc.org/sites/default/files/media/paymentreformpub.pdf>.
- Society of Actuaries – Professional organization for actuaries. Reports and studies available at <http://www.soa.org>.
- Tennessee Health Care Innovation Initiative – Over the next 5 years, the Tennessee Health Care Innovation Initiative will shift a majority of health care spending, both public and private away from fee for service to three outcomes based payment strategies. Information available at <http://www.tn.gov/hcfa/section/strategic-planning-and-innovation-group>.
- Vermont Blueprint for Health – Since 2006, Vermont has implemented a series of reforms designed to increase access to health care for Vermonters, improve the quality, and contain the cost. Information available at <http://hcr.vermont.gov/home>.

Section V

CHAPTER 2. RISK ADJUSTMENT

ROADMAP

Read this chapter to learn about key concepts related to risk adjustment.

OVERVIEW

A well-designed risk-adjustment system is one that properly aligns incentives, limits gaming, and protects risk-bearing entities.

FUNDAMENTALS

This section provides a basic overview of the following risk adjustment topics:

- Risk adjustment techniques;
- Key concepts to consider when selecting a risk adjustment model;
- Key decision points for implementing risk adjustment;
- Importance of data for risk adjustment; and
- Other tools to adjust for risk differences, including risk sharing, reinsurance, targeted stop-loss, risk pools, and risk corridors.

Chapter 2: Risk Adjustment

By Frederick Gibson Jr, MBA, Doug Shannon, and Amanda Rhodes, Mercer Government Human Services Consulting

OVERVIEW

States attempt to better match payment to risk by allocating payments to their contractors based on relative differences in risk among them. A well-designed risk-adjustment system is one that properly aligns incentives, limits gaming, and protects risk-bearing entities.³⁸ Rarely, if ever, does a state with multiple contractors have a program in which each health plan attracts and enrolls exactly the same mix of members. Instead marketing, outreach, provider network composition, reputation, or word-of-mouth inevitably results in an uneven distribution of high- and low-cost individuals among the state's contractors. Because capitation is an average payment rate, paying the same average rate to a contractor with higher-cost members and one with lower-cost members contributes to inequity in payment, as well as inequity in the resulting financial performance of the contractors. Accordingly, risk adjustment has become a common practice in contracting with risk-based managed care providers, and in fact the Society of Actuaries created a separate Actuarial Standard of Practice specific to health-based risk adjustment.³⁹

Risk adjustment makes the distribution of payments among contractors more efficient because each contractor's payment is better aligned with the risk it bears. Specifically "stretching" the average capitation rate to align payments more closely to the costs of providing care to different populations spreads risk more efficiently. Adjustments need not increase the state's spending overall because the increases enjoyed by some contractors can equal the losses suffered by others, maintaining budget neutrality. In practice, because risk adjustment methodologies are not completely objective, states can end up paying more to some contractors than others as a result of subjective impressions of the plan's risk, the negotiation skill of the contractor's staff, or a lack of understanding of the plan's financial performance.

Paying higher rates to some contractors without the objective means to reduce rates to others increases the total cost of the program unnecessarily and results in some misalignment of payment among contractors. Therefore, risk adjustment complements the state's underlying capitation payment structure by providing additional tools and techniques that the state can develop to reimburse contractors more fairly; that can also contribute to the financial sustainability of the program over the long run. Some form of risk adjustment is a good idea. However, risk adjustment still works on the law of averages and will overpay on the low end of risk and underpay on the high end of risk.

KEY CONCEPT

Risk Adjustment Improves States' Abilities to Match Payment to Risk

Using various forms of risk adjustment, states can better match payment to risk by paying more to contractors who enroll sicker or costlier members (adverse risk) and paying less to those who enroll healthier or less costly members (favorable risk).

38 American Academy of Actuaries, "Risk Assessment and Risk Adjustment," May 2010, http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf (accessed August 20, 2015).

39 Health Risk Adjustment Task Force of the Health Committee, "Actuarial Standard of Practice No. 45," Actuarial Standards Board, January 2012, http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop045_164.pdf (accessed August 20, 2015).

FUNDAMENTALS

RISK ADJUSTMENT TECHNIQUES

Many states adjust their capitation rates to account for demographic differences in the populations that different providers serve. Demographic factors include age, gender, county or region, and eligibility categories. For example, instead of having one capitation rate for all Temporary Assistance for Needy Families (TANF) recipients, a state might have separate TANF rates for various age and gender combinations, such as children under age 1, males ages 14 to 18, or females age 21 to 44, to account for the different degrees of risk inherent in serving those population groups. Risk adjustments to capitation rates can also be made to account for the cost differences in serving TANF or Supplemental Security Income (SSI) recipients, SOBRA women, or dual eligible populations.⁴⁰ Contractors that attract more SSI members than TANF recipients are paid adjusted capitation rates because the average SSI rate is generally higher than an average TANF rate. Adding county or geographic region to age, gender, and eligibility category provides further stratification of risk. As noted in [chapter 1](#), a supplemental maternity care payment is a form of risk adjustment recognizing the higher cost of a delivery event and paying contractors more equitably for that defined event. But demographics have limited power to align payment to risk. Even within a TANF Male Adult Region 1 population group, the prevalence of disease conditions and health status can vary significantly and can indicate more accurately who is likely to be low or high cost than simply age, gender, or county of residence. An adult male with diabetes, coronary heart disease, and depression is higher risk and likely more costly than a male with only one of those health conditions and is most assuredly more costly than a male with no present health conditions.

More advanced forms of risk adjustment incorporate disease information and prescription drug use to vary payments to risk-based contractors in a budget-neutral manner. The most commonly used and vetted forms of advanced risk adjustment are often referred to as diagnostic-based risk adjustment, as they use diagnostic or prescription drug information to assess health risk. Those models are constructed based on mapping diagnosis or drug codes onto different disease categories, levels, or conditions, such as cardiovascular, skeletal, central nervous system, and psychiatric. The respective disease conditions are then assigned a numerical “cost weight,” reflecting the conditions’ relative cost of treatment, compared with the average. Higher cost weights signify conditions that are more costly to treat, and lower cost weights represent those less costly to treat. For example, a score of 2.8 for John Doe means that he is 2.8 times sicker and hence has higher costs than an average member of the relevant population (whose risk score is 1.0).⁴¹ The specific algorithms and methodologies constituting a particular risk-adjustment model that defines disease conditions and assigns cost weights may be considered proprietary and confidential. The following table illustrates the concept of disease category and cost weight.

KEY CONCEPT

Risk Adjustment Is Not One-Size-Fits-All

There are many different tools and techniques for assessing risk and varying payments to risk-based contractors. Some techniques are simpler than others, and risk adjustment models vary. States should evaluate available options and choose a solution that is administratively supportable and produces valid results.

40 SOBRA, derived from the Sixth Omnibus Budget Reconciliation Act of 1986 and other subsequent legislation, provides coverage for pregnant women and children up to age 19 who meet certain income requirements.

41 Edwin Park, “Ensuring Effective Risk Adjustment—An Essential Step for the Success of the Health Insurance Exchanges and Market Reforms under the Affordable Care Act,” Center for Budget and Policy Priorities, May 18, 2011, <http://www.cbpp.org/sites/default/files/atoms/files/5-18-11health.pdf> (accessed August 20, 2015).

Table 20. Disease Category and Cost Weight

Disease Category	Condition Description	Cost Weight
Pulmonary		
Very high	Cystic fibrosis, lung transplant, or tracheotomy complications	2.752
High	Respiratory arrest or selected pneumonias	1.341
Medium	Pulmonary collapse, acute respiratory failure, or congenital cystic lung	1.318
Cardiovascular		
Very high	Heart transplant status or artificial heart replacement	3.210
Medium and Rx Anticoagulants	Congestive heart failure, primary pulmonary hypertension, or cardiomyopathy	1.116
Low	Heart valve transplant, atrial fibrillation, or angina	0.470
Psychiatric		
High	Schizophrenia	0.406
Medium	Bipolar affective disorder or hallucinations	0.286
Medium low	Major depression or impulse control disorder	0.229

Using the risk adjustment model's disease categories and cost weights, an individual risk score can be computed for a person based on the demographic, diagnostic, or prescription drug information in that person's medical claims data (for example, inpatient, outpatient, professional, and pharmacy). Individual risk scores are expressed as numerical values, and the higher the number the higher the person's risk. For example, a person diagnosed with diabetes will have a higher risk score than a person without diabetes, assuming all other characteristics are the same. A person with diabetes and cardiovascular and psychiatric conditions will receive a higher score than a person with diabetes alone. Some risk adjustment models are additive, so that each disease condition adds to the person's risk score, but other models assign the person to a final disease category that reflects an effect of comorbidity greater than the simple additive score.

Scoring each individual or most individuals can provide the state additional benefits, such as evaluating population changes over time, contractor performance efficiency, predictive modeling, and risk assessment for policymaking, which increase the return on the investment in developing a robust risk adjustment methodology. The following example illustrates the additive approach to computing an individual risk score:

Table 21. Additive Approach to Computing Individual Risk Score

Component	Category	Cost Weight
Demographic	Male age 15 to 24	0.004
Diagnostic	Metabolic, medium	0.819
	Cardiovascular, medium	1.116
Pharmacy	Diabetes	0.229
Individual risk score (sum of cost weights)		2.168

After the risk adjustment process, all of the individual risk scores are compiled, and an average score is computed for each risk-based contractor (the “raw risk score”). There are different methods of arriving at an overall average score for each contractor, such as weighting scores based on enrollment or using a point-in-time assignment process. That will be one of the many decision points that states and their actuary will need to consider and then share with the state’s contractors. Because risk adjustment is intended to be budget neutral, the initial, average plan-level scores are adjusted to ensure that the total amount of capitation revenue is not increased or decreased. The final, budget-neutral, plan-specific risk scores are then used to pay the respective contractors until the next cycle of risk adjustment. The following table illustrates how this step works, using a hypothetical example of three different contractors.

Table 22. Examples of using Risk Scores to Pay Contractors

Budget-Neutral Risk Adjustment	Contractor #1	Contractor #2	Contractor #3	Program Total
Member months	100,000	150,000	200,000	450,000
Base capitation rate	\$250.00	\$250.00	\$250.00	\$112,500,000
Initial average plan risk score	1.0757	0.9865	1.0285	1.0250
Budget-neutral plan risk score	1.0495	0.9624	1.0034	1.0000
Risk-adjusted capitation rate	\$262.38	\$240.60	\$250.85	\$112,500,000

Most models used today focus on adjusting capitation rates for physical health and acute care services (for example, inpatient, outpatient, pharmacy, clinics, and emergency room), as the probability of risk and cost being correlated is more pronounced for certain diseases, and diagnostic and drug codes are standardized. Unfortunately, Medicaid programs using managed providers for long-term care have a limited choice of risk adjustment tools because experience is limited and only a few models have been developed. Delaware, New York, and Wisconsin have developed their own risk adjusters for long-term services and supports, which vary in level of sophistication. One challenge to applying traditional risk adjustment techniques to long-term care capitation rates is that risk and cost are often functions of the individual’s family or social support network and not solely the health or disability status of the individual. Two individuals with similar health challenges, such as dementia, Alzheimer’s disease, or autism, can have significantly different Medicaid costs if one has a family to provide care and support and the other relies on the Medicaid program for all needed support and services. Traditional risk adjusters that rely on diagnostic or pharmacy data will not be able to distinguish that type of variation in risk and therefore will not be as predictive. More advanced risk adjusters must incorporate functional needs assessment data, family support information, and other indicators of risk if such information can be consistently, completely, and accurately obtained. A challenge in that step is that state staff often performs functional needs assessments inconsistently, so that using the information to adjust capitation rates might produce invalid results. More research is needed in the area.⁴²

The diagnostic-based risk adjustment models used today by states were built from actual medical claims or prescription drug data, from different population samples, using sophisticated statistical algorithms to identify and categorize indicators of risk. The technical details of the various risk adjustment models vary and are beyond the scope of this Compendium.⁴³ However, the following table provides a summary description of the commonly used risk adjustment models available to states for refining their risk-based capitation payments.

42 Eric Schone and Randall S. Brown, “Risk Adjustment: What is the current state of the art, and how can it be improved?” Robert Wood Johnson Foundation, July 2013, <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf407046> (accessed August 20, 2015).

43 For more information on the specifications and technical attributes of various risk adjustment models, see <https://www.soa.org/research/research-projects/health/hlth-risk-assessment.aspx> (accessed August 20, 2015).

Table 23. Summary Description of Risk Adjustment Models

Risk Adjustment Model	Model Description and Model Website for More Information
Adjusted Clinical Groups (ACGs)	Developed by Johns Hopkins University. Highly marketed and well supported. Designed initially for commercial and Medicare populations but has been adopted for Medicaid use. Maryland uses the ACG model. See also http://acg.jhsph.org/ .
Chronic Illness and Disability Payment System (CDPS)	Developed by University of California at San Diego. Transparent application process, not direct fees for use. Designed specifically for Medicaid populations. Uses demographic and diagnostic information. States can also choose to use both diagnostic and pharmacy data in a combined CDPS + Rx model. Used by several states such as Delaware, New Jersey, Ohio, and Pennsylvania. See also http://cdps.ucsd.edu/ .
DxCG	Developed by Verisk Health. Can be refined to analyze specific types of populations, including Medicaid. Assigns recipients to hierarchical condition categories and age and gender categories to predict medical cost. Massachusetts uses the DxCG model for risk adjustment. See also http://www.veriskhealth.com/answers/population-answers/dx-cg-risk-analytics .
3M Clinical Risk Grouping Software	Developed by 3M Health Information Systems. Uses standard claims data and, when available, additional data—such as pharmaceutical data and functional health status—collected longitudinally to assign each individual to a single, mutually exclusive risk group. Used by New York. See also http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Products-List-A-Z/Clinical-Risk-Grouping-Software/ .
Episode Risk Groups	Developed by Optum (formerly Ingenix), a subsidiary of UnitedHealth Group. Symmetry Episode Risk Groups predict current and future health care usage for individuals and groups by creating individual risk measures that incorporate episodes-of-care methodology, medical and pharmacy claims information, and demographic variables. See also https://www.optum.com/providers/analytics/health-plan-analytics/symmetry/symmetry-episode-risk-groups.html .

KEY CONCEPTS TO CONSIDER WHEN SELECTING A RISK ADJUSTMENT MODEL

Actual data from the Medicaid population being rated is used to assess relative risk. In that way all models are similar. However, the construction of each model and its inner workings will produce different results, even if the same data are fed through the risk adjustment process. Therefore, a risk adjustment model should not be selected lightly, as it will take time to understand how the model works, interpret the results, and ensure that the process is valid and understood by all parties. The following list sets out some of the key elements and attributes of various risk adjustment models. States should consider them and discuss them with stakeholders and advisers before adopting a specific model.⁴⁴

44 Ross Winkelman and Rob Damler, "Risk Adjustment in State Medicaid Programs," Health Watch, January 2008.

- What information does the model use to assess risk? Does it use both diagnostic information and prescription drug information, or only one or the other? Can the model be adapted to use other information? The predictive power of the model can be positively or negatively affected, based on how much and what type of information is used to assess risk.
- Was the model based on data from a Medicaid population or a non-Medicaid population? A model calibrated to a Medicaid population may have better risk assessment capabilities when applied to a Medicaid population, but that is not guaranteed, as each state is unique and each population being rated has unique characteristics.
- How many discrete disease categories does the model use? Does it stratify or score disease conditions into low, medium, and high levels? How are disease stratifications defined, and what are the ramifications for the model's output? That can affect how easily understood the model is and can also indicate the potential for gaming by maximizing disease scores to maximize capitation payment adjustments.
- How transparent is the model? Are its mechanics easily understood? An overly complex model may measure more differences in risk, but if the inner workings of the model are not easily understood, the output may be difficult to describe or interpret. That can be especially problematic if the model outputs change from one run to the next, which will likely happen at some point as the data inputs are updated through each risk-adjustment cycle.
- Is there a cost associated with the model, and if so, how much? Do all parties using the model have to pay the same fee? Because research and design time is necessary to build a model, there is often a cost or licensing fee that the state and its contractors have to pay. The fee can be high, and since the state's contractors will likely want to perform their own risk adjustment analyses to review the state's results, the state may inadvertently choose a risk adjuster that has a large fee that each contractor will have to pay.
- How easily can the model be customized to fit a particular state's program? Are changes allowed by the model creators? What is the process for completing revisions, updates, or modifications? State programs are unique in the populations and services covered by managed care. For example, if a state carves out pharmacy from the capitation rates, it would be reasonable to consider modifying the risk adjustment model to remove or diminish the effect of pharmacy drug cost on assessing risk.

KEY CONCEPT

Don't Expect to Please Everyone

Risk adjustment measures relative risk among the state's contractors, and payments are adjusted up or down accordingly on a budget-neutral basis. If one health plan receives more, another will receive less. Some plans will gain at the expense of others. States that try to mitigate one side or the other find that it is difficult or impossible to please everyone all the time.

KEY DECISION POINTS FOR IMPLEMENTING RISK ADJUSTMENT

Similar to actuarial rate development, described in [chapter 1](#), states must make many decisions about how to implement risk adjustment. With capitation rates, those decisions will have ramifications over many years for the state, the risk-based contractors, and the actuaries and consultants who work with each party. Accordingly, states should not underestimate the time and resources required to implement risk adjustment correctly. Moreover, risk adjustment requires close collaboration between a state's financial or rate-setting

unit and its data or IT units, so that data managers are aware of the importance of valid and complete data. Likewise, financial staff often needs to learn more about how claims data are generated and collected. That is often an iterative process, in which each party learns from the others. Because of those challenges and the complexity of risk adjustment, a minimum of 12 to 18 months of planning and testing is recommended. If the infrastructure related to data and reporting is lacking, an even longer time may be necessary. Some of the key issues requiring policy decisions by states during the design and planning process are presented in the following table.

Table 24. Key Issues for Implementing Risk Adjustment

Key Risk Adjustment Issues	Options and Considerations
Populations to Risk Adjust	Risk adjustment models do better with populations who have a higher prevalence of chronic diseases, such as Supplemental Security Income recipients. However, risk adjustment can still be better than traditional, demographics-only rate adjustments for Temporary Assistance for Needy Families recipients and child groups. Newborns and pregnant women are challenging for risk adjustment models and could be excluded. Unless detailed Medicare claims are available, individuals eligible for both Medicare and Medicaid are also difficult to evaluate from Medicaid data alone.
Type of Model – Concurrent or Prospective	Concurrent models use data from a specific time period to assess risk in the same period. For some acute events, concurrent models can work well, but they can require retrospective payment adjustments that disrupt case flow and budgeting. Prospective models use data from a prior time period to predict relative risk in a future time period. Prospective risk adjustment enables a state to share risk scores and rate adjustments in advance of actual payment changes and thus is the more commonly used application model.
Use Data for Only Individuals with a Minimum Length of Enrollment	Individuals accumulate diagnostic and drug data over time by engaging the health care system and generating claims. New enrollees with only a couple months of enrollment might not be representative of a health plan's average risk. Using only individuals with a minimum number of enrollment months (for example, six months) makes it more likely that risk scores will accurately reflect a plan's actual risk. Months can be accumulated in both managed care and fee-for-service if claims data from all sources are used to score people.
Conduct One or More Practice Runs	Performing a practice run or two is useful to ensure that the model inputs, processes, and results are working as expected. Practice runs can reveal bugs in the system that can be rectified before actual capitation payments are adjusted. That also provides the risk-based contractors a preliminary look into what the results might be, so that they can plan accordingly.

Key Risk Adjustment Issues	Options and Considerations
Data Study Period and Run-out Time	Most risk adjustment processes use 12 months of claims data to assess risk in order to ensure completeness and accuracy. That can require an additional three to six months of data after the end of the study period. It can take several additional weeks to validate the data, run the model, review the results, and upload adjustments into a state's payment system. Anticipate a minimum of six to nine months between the end of the data study period and the application of risk adjustment factors.
Data Feedback to Contractors	Risk adjustment is a complex process that depends on good data. To help their risk-based contractors, some states provide data feedback files so the health plans can check the validity of the data used; interim data volume charts so dips in data can be addressed before risk scores are developed; or individual risk score files, with the final score shown for each member, for validation. Some states use only accepted encounter data, which provides another incentive to health plans to submit complete and accurate data.
Assigning Risk Scores	Since individual risk scores are determined based on a prior period's data, the assignment of risk scores to a specific health plan can be based on the proportion of time that a member was in each plan during the data study period, a point in time during the study period, or where the individual is at a point closer to the rating application period for which capitation will be adjusted. Each option has merit, with the study period approach relying on the assumption that risk patterns remain static among the state's contractors. If enrollment shifts occur that can change risk attraction patterns, picking a date closer to the application period will better reflect the changes. States will also need to consider the difference in potential risk between individuals who actively select a Managed Care Organization (MCO) (a "chooser") and individuals who do not and who ultimately are auto-assigned to an MCO.
Phase-in Risk Adjustment or Not	Depending on the variation in risk among contractors and the state's prior capitation payment strategy, risk adjustment can move a lot of money among contractors. Phasing-in allows losing health plans time to adjust to changes in revenue but also penalizes the gaining health plans that deserve more. Adjusting rates by the full effect of risk adjustment can disrupt revenue expectations and cash flow for the risk-based contractors. States should be proactive in deciding that policy in advance in order to let contractors know.
Limiting Change in Payment Levels	Each time a risk adjustment is run, results will change -- especially in the first few cycles -- depending on the completeness of data. Over time, risk scores should stabilize, unless events occur that change risk patterns (for example, a provider leaves the network and members switch plans). States can set a maximum or minimum change in scores and payment in either dollar or percentage terms. Any limit on change will be welcomed by the losing plan but not by the gaining plan.

Key Risk Adjustment Issues	Options and Considerations
Unscored Members	Not all managed care enrollees may be scored in the risk adjustment process; for example, some people do not have sufficient months of enrollment (a new enrollee or possibly an auto-assignee). For those unscored members, the state must decide what to do as a formal policy. Options include assigning a 1.000 neutral risk score, applying the contractor's average risk score (assuming that new enrollees appear similar to existing enrollees), or not including them in risk adjustment at all (paying the base capitation rate unadjusted).
Frequency of Risk Adjustment Cycles	Theoretically, states can rerun the risk adjustment process every month using rolling 12 months of data; however, that is impractical because of the time and resources required. Most states create new individual risk scores every six to 12 months, using newer data in each run and incorporating any refinements to the process. Interim monthly updates have been done by some states based only on changes in membership among the contractors.
Cost Weight Updates	Each risk adjustment model has its internal cost weights based on the model creator's analyses and data inputs. States can evaluate when and if the cost weights should be recomputed based on newer data and possibly more customized to the state's own population and service offerings.

IMPORTANCE OF DATA FOR RISK ADJUSTMENT

The risk adjustment models discussed in this chapter have one thing in common: data. Data are the single most important ingredient to successful risk adjustment. However, as some states have learned, obtaining complete, accurate, and consistent data can be a continuous challenge. For most risk adjustment models, the primary data are demographic, diagnostic, and prescription drug data. Of those, diagnostic data can be the most critical and the most prone to difficulties because the necessary information is contained in detailed medical service claims, such as inpatient hospital, professional, outpatient, and emergency room records. Within managed care, encounter data become the main source of risk adjustment data, but difficulties in obtaining good encounter data from the state's contractors can hamper the development of risk adjustment strategies, even while the contractors are voicing concerns that the state's capitation rates are unfair. Some states have also been able to get better encounter data after implementing risk adjustment because the contractors have a direct financial incentive to submit complete and accurate data. The following are some examples of challenges that states have encountered with data, resulting in workarounds and delays and requiring additional effort to resolve:

- Missing Data:** Incomplete data hamper the ability of risk adjustment models to accurately assess relative risk differences. If a batch of inpatient hospital records fails to be accepted or transmitted, all of the diagnostic information will be missing for those records, and that could lead to the undercounting of disease conditions. Moreover, if data are missing for just one of the state's contractors, that contractor is at a disadvantage, compared with its peers, in receiving credit through the risk adjustment process for the health risk of its enrolled members. Even if the missing data are the direct fault of the contractor, the process may be compromised to a point where special data requests must be made or ad hoc files must be

obtained to ensure that the integrity of the risk adjustment process is maintained. That adds time and cost to the process.

- **Altered Diagnosis Codes:** Information systems occasionally have faults that can affect the integrity of the data used for risk adjustment. Sophisticated risk adjusters rely on accurate and complete diagnostic data to compute risk scores. If diagnosis codes are truncated or altered (intentionally or unintentionally), the evaluation of relative risk can be compromised and the risk scores could be materially wrong.
- **Shadow Codes:** Claims processing systems are complicated information platforms. In one state, it was discovered that inpatient claims from one of the health plans were being populated with diagnosis codes being carried over from the previous record. Those shadow codes replaced the actual diagnostic codes on the subsequent claims, compromising the integrity of the risk adjustment process.

OTHER TOOLS TO ADJUST FOR RISK DIFFERENCES

In addition to the diagnostic-based risk adjustment approaches described in this chapter, additional tools are available to help states address differences in risk, better allocate capitation revenue, and provide protection to contractors from the adverse financial effect of high-cost members. Those supplemental risk mitigation tools are often used to address targeted high-dollar or catastrophic cases that average capitation rates and risk adjustment models cannot fully account for because of low volume and high cost or unique risk attributes. To comply with the Centers for Medicare & Medicaid Services (CMS) requirements for rate setting, the risk mitigation tools described below should be designed or constructed to be budget neutral.⁴⁵ Even so, supplemental risk mitigation tools can become administratively burdensome.

Risk Sharing, Reinsurance, and Targeted Stop-Loss

Through different forms of risk sharing, the state shares in the risk (cost) of a certain group of individuals who are known to be costly and could be disproportionately enrolling in one health plan. Such risk sharing is sometimes referred to as “reinsurance,” or “targeted stop-loss,” because the health plan is protected from financial losses on the target population beyond an agreed-to level of expenses. The structural details of the risk-sharing program can take different forms. For example, a state could decide to reimburse any plan for 50 percent of the medical expenses for hemophiliacs that exceed \$100,000 in a given year.⁴⁶ All health plans are charged a premium for the risk sharing protection, which is usually a per-member per-month (PMPM) value that the state deducts from the capitation payments. The risk-sharing premium PMPM is the expected value of the state’s liability for the applicable rating period, based on the design parameters of the risk sharing program (50 percent of the expected expenses over \$100,000, in this example). The state assumes the risk that actual risk-sharing payments will exceed the amount of money withheld from the rates, so that the state then has to reach into its pocket to cover the risk-sharing arrangement. That can and likely will occur, as risk-sharing programs are difficult to price accurately for any given year because they usually target a low-volume, high-dollar population whose costs can fluctuate. In some years the state may withhold too much, but the design of the program is intended to be budget neutral, since the premiums withheld were computed to match the state’s expected liability.

Risk Pools

Risk pools are similar to risk-sharing arrangements in many ways, except for the state’s financial liability. As with risk sharing, the state identifies (usually at the request of one of the contractors) a target population or service and selects an expense level after which the risk protection becomes available. For example, a

⁴⁵ 42 CFR § 438.6(c)(4)(iv).

⁴⁶ Instead of targeting a population group or specific service, a state can instead provide risk protection for the entire program, often referred to as “global reinsurance.”

state could choose to create a risk pool for ventilator-dependent children or individuals with hepatitis C for expenses that exceed \$10,000 in a year. A PMPM risk pool premium withhold amount is computed, which again represents the state's expected liability for covered costs attributable to the target population under the risk pool arrangement. The amount withheld from the rates funds the pool, which is then distributed among the contractors based on the proportion of expenses above the threshold of \$10,000 that each contractor incurred. For example, if contractor A had 40 percent of the total expenses exceeding \$10,000 for ventilator-dependent children, that contractor would get 40 percent of the risk pool funds even, if the contractor only contributed 10 percent of the funds in the pool. With that approach, the state's financial liability is capped at the amount of money that was withheld from the rates, regardless of whether actual expenses greatly exceeded the size of the risk pool. Since the full amount of money in the risk pool is distributed among the contractors, a risk pool is designed to be budget neutral.

Risk Corridors

Risk corridors are typically used on a temporary basis when an unknown risk, such as an expansion population, is being rated and the state wants to include (or the plans ask for) a layer of protection against too-high profits or losses. Over time, experience data from the new population will become available, and the capitation rate development process and other risk adjustment tools can reduce the need for a risk corridor. But for the first two or three years, a risk corridor can be useful. Risk corridors have elements similar to risk sharing and risk pools. But the key differences are that risk corridors are usually set for a larger population or on a program basis and involve the state's sharing in the gains or losses of a health plan within established profit-and-loss bands or corridors, instead of charging an explicit premium for requisite risk protection.

The specific details of the risk corridor need to be defined and contractually agreed to (for example, what expenditures are counted, how administrative costs are handled, what the corridors are, and how financial results will be validated) and can involve many different combinations. In simple terms, however, the following table illustrates a hypothetical risk corridor. Even though the results of the risk corridor might not be budget neutral, CMS considers the design of what will be budget neutral since gains or losses are shared equally (the sharing is two-sided). In the proposed Medicaid managed care rule, CMS explicitly acknowledges the use of a risk corridor as a means to share in profits or losses under the contract and has proposed to add this flexibility in the language of 42 CFR 438.6(a). This indicates that CMS is becoming more receptive to a one-sided profit or loss sharing arrangement as opposed to only a two-sided risk corridor, which has been the standard.

Table 25. Hypothetical Risk Corridor

Risk Corridor Bands	Risk Corridor Coverage
Gains or losses of less than 2 percent	Contractor retains all gains or losses
Gains or losses 2 percent to 4 percent	Contractor and state share 25 percent
Gains or losses 4 percent to 6 percent	Contractor and state share 50 percent
Gains or losses 6 percent to 8 percent	Contractor and state share 75 percent
Gains or losses more than 8 percent	Contractor and state share 90 percent

Section V

CHAPTER 3. PERFORMANCE INDICATORS IN FINANCIAL PAYMENT MODELS

ROADMAP

Read this chapter to learn about strategies for determining performance in financial payment models. Following are key takeaways:

OVERVIEW

States can promote improvement in health outcomes, quality, and performance efficiency by incorporating various elements of paying for value over volume in a state's financial payment model.

FUNDAMENTALS

This section provides a basic overview of the following topics:

- Methodological considerations;
- Payment withholds;
- Bonus payments; and
- Financial adjustments based on performance efficiency.

Chapter 3: Performance Indicators in Financial Payment Models

By Frederick Gibson Jr, MBA, and Amanda Rhodes, Mercer Government Human Services Consulting

OVERVIEW

States are actively seeking new methods and strategies to pay for value in health care instead of volume.⁴⁷ They are focusing on improved health outcomes, better health overall, and reducing costs by eliminating unnecessary procedures, duplicative tests, and substandard care.⁴⁸ In fact, 38 states (including the District of Columbia and several territories) are currently exploring innovative ways to promote quality, improve health outcomes, and create new payment strategies through the federal State Innovation Model initiative.⁴⁹ In addition, the Centers for Medicare & Medicaid Services (CMS) is testing other ideas with states, as well as a variety of payment reforms in the Medicare program that may in time translate into new ideas that other states can adopt.⁵⁰ Value-based purchasing is a work in progress, and not all tactics will prove successful. States should view this facet of the health care financing model as continually evolving. This chapter focuses on the mechanics of incorporating various elements of paying for value over volume in a state's financial payment model.

FUNDAMENTALS

METHODOLOGICAL CONSIDERATIONS

Promoting value over volume through financial payment models can take various forms. Capitation promotes value because a fixed payment is made regardless of the volume of services used. However, states are looking to other tools and techniques to promote improvement in health outcomes, quality, and performance efficiency. One key decision point for states to consider is what level of financial consideration or incentive payment is needed to promote change and achieve desired outcomes. There is no easy answer to this question, and states need to work with a variety of stakeholders to make a determination. If financial incentives are not strong enough, stakeholders might be unwilling to make necessary changes or invest in new ways of doing business. Too much change too quickly to traditional payment methods could alienate stakeholders and generate more resistance to change. If the state makes too large an incentive reward available, the return on investment might not be positive; it could increase instead of decrease total expenditures (although important non-financial improvements may be made in the system of care that provide tangential benefits).

In addition to the size of the incentive reward, the method a state uses to determine who earned a reward can be at least as important to the success of the value proposition. Even if a substantial pool of funds is made available, if the "to-do" list is exceedingly difficult, some entities may opt to not make the desired changes because the return on their internal investment is insufficient. States will also need to determine how change is measured and what baseline will be used to evaluate change over time. Depending on the measure, improvement might be associated with an increase or a decrease. For example, if evidence-based guidelines are adhered to more uniformly, the provision of unnecessary or duplicative services could decrease what would be considered a good outcome. Options for measuring change include percentage change over time (for example, 10 percent improvement in cancer screening rate), absolute change in value (for example, a 10 point reduction in the average body mass index of a patient group), or relative performance against an external benchmark (for example, the 90th percentile for all Medicaid programs). A particularly challenging issue for states in moving to a value-based financial model is not penalizing already high-performing entities

47 Health Affairs, "Pay-for-Performance," October 11, 2012, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78 (accessed August 20, 2015); and America's Health Insurance Plans, "Innovations in Recognizing and Rewarding Quality," March 2009, <https://www.ahip.org/Innovations-in-Quality/> (accessed August 20, 2015).

48 Denis A. Cortese, Natalie Landman, and Robert K. Smoldt, "The First Step toward Value-Based Health Care," Institute of Medicine, September 2012, <http://nam.edu/wp-content/uploads/2015/06/VSRT-First-Step.pdf> (accessed August 20, 2015).

49 For more information, visit: <http://innovation.cms.gov/initiatives/State-Innovations/> (accessed August 20, 2015).

50 Centers for Medicare & Medicaid Innovation, "The CMS Innovation Center," <http://innovation.cms.gov/index.html> (accessed August 20, 2015).

or over rewarding poor performers who simply come up to average standards. Avoiding that error requires thoughtful and deliberate planning by states and can involve complex algorithms that consider both current performance and relative change in performance, so that all participants have an opportunity to gain (or lose) under the value-based financial model.

Moreover, assigning credit for positive change can be a challenging undertaking for the state, since health care costs are dynamic and influenced by a large number of factors, some of which are unrelated to the state's purchasing strategy. For example, health care costs, utilization, and outcomes can be affected by population growth or decline, workforce changes, socioeconomic conditions, or even the weather. States should not financially reward improvement if the improvement is caused by random chance, gaming, or statistical fluctuation. Determining whether savings are real or random is a challenging technical and financial issue.⁵¹ States must carefully consider how change will be measured, how input variables will be controlled for, and what source of information will be used and verified for accuracy (for example, claims data, consumer surveys, or self-reported information) in their efforts to move from volume- to value-based purchasing. From a modeling perspective, the level of financial incentive and an accurate method of evaluating performance are complementary components that must be balanced. Both absolute and relative payment levels have implications for access, quality, and cost of care.⁵²

The remainder of this chapter describes various mechanisms that states can use to link payment to performance and motivate a shift from volume to value. Because so much research and testing are now under way in the health care arena, new ideas and tactics will likely surface that were beyond the scope of this Compendium.

PAYMENT WITHHOLDS

Payment withholds are fairly commonly used to promote better performance and outcomes. The process is self-explanatory—a portion of the provider or contractor payment is withheld, and the entity is given an opportunity to earn some or all of the amount withheld, based on specified performance metrics. If the performance goals are not reached, the entity forgoes the funds that were withheld. Payment withholds are an aggressive approach to value purchasing because the entity immediately receives a reduction in payment and must wait to see if it earns any payment reward. It may require waiting many months and the loss of interest payments on the balances withheld.

From a process perspective, the payment withhold can take the form of either a fixed dollar value or a percentage of the base payment. As noted previously, the amount withheld and the conditions for earning a performance payment contribute to both the success and complexity of this type of value-based purchasing strategy. Often states leverage existing performance metrics, such as the Health Care Effectiveness Data and Information Set or Consumer Assessment of Healthcare Providers and Systems for purposes of a performance payment. Using existing performance measures avoids the need to develop and validate new measures, but often measures are more process than outcome driven. If the state wants to focus on improving outcomes, metrics should be selected that specifically motivate applicable behavior changes. For example, instead of rewarding how many diabetic A1c blood tests are performed, the state could focus attention on lowering glucose levels in diabetics as an outcome measure. However, that requires obtaining the results of the A1c tests, instead of just measuring the volume of occurrences. The following table illustrates the mechanics of a withhold-based financial payment model.

51 American Academy of Actuaries, "An Actuarial Perspective on Accountable Care Organizations," June 2011, http://www.actuary.org/pdf/ACO_issue_brief.pdf (accessed August 20, 2015).

52 Deborah Bachrach, "Payment Reform: Creating a Sustainable Future for Medicaid," Center for Health Care Strategies, May 2010, http://www.chcs.org/media/Medicaid_Payment_Reform_Brief.pdf (accessed August 20, 2015).

Table 26. Mechanics of Withhold-Based Financial Payment Model

Payment Amount Withheld	2 % of Base Payment
No performance criteria are met.	Entity earns 0% of the amount withheld.
Criterion 1 is met (minimal improvement).	Entity earns 25% of the amount withheld.
Criterion 2 is met (moderate improvement).	Entity earns 50% of the amount withheld.
Criterion 3 is met (exceptional improvement).	Entity earns 100% of the amount withheld.

Prior to the release of the proposed Medicaid managed care rule, there was little in terms of federal requirements for capitation rate withholds except a generic requirement that any risk-sharing methodologies be computed on an actuarially sound basis. However, within the proposed rule, the Centers for Medicare & Medicaid Services (CMS) is proposing to elaborate on the requirements applicable to capitation rate withholds to ensure that the capitation rate net of the amount withheld is still considered reasonable through proposed wording in 42 CFR 438.6(b)(3) as noted below:

Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's [Managed Care Organization], PIHP's [Prepaid Inpatient Health Plan] or PAHP's [Prepaid Ambulatory Health Plan] financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under § 438.7(b)(6)...

BONUS PAYMENTS

Unlike payment withholds, bonus payments provide an additional payment or source of revenue above and beyond the base payment. Bonus payments do not reduce the contractor's anticipated cash flow but provide an incentive by presenting an opportunity to increase revenues if specific performance measures or outcomes are materially improved. Because bonus payments represent additional funds that can be earned without any direct loss of existing revenue streams, the value of bonus payments in motivating change may be less as opposed to a withhold amount that has to be earned (depending on the size of the bonus payment). States should also be aware that for risk-based, capitated managed care, CMS, by regulation, restricts the use of incentive-based payment arrangements. Specifically, states must include, among other conditions, an explanation of the incentive program, and incentives cannot exceed 5 percent of the capitation payments.⁵³ This requirement was retained in the proposed Medicaid managed care proposed rule although reordered to proposed 42 CFR 438.6(b)(2).

Bonus payments can be used by states to target a specific activity or outcome that is particularly important or has related health or social benefits such as immunizations, cancer screenings, and successful transitions in care settings (for example, nursing home to community). The following table illustrates the mechanics of a bonus-based financial payment model.

⁵³ 42 CFR § 438.6(c).

Table 27. Mechanics of Bonus-Based Financial Payment Model

For each person successfully transitioned from a nursing home to a community-based care setting, the state will pay:	
Bonus Payment Strategy Option #1	a \$1,500 one-time bonus payment
Bonus Payment Strategy Option #2	50 percent of the difference in average cost of a month of nursing home care versus community-based care
Bonus Payment Strategy Option #3	\$500 for each month the person remains in a community-based care setting, up to a maximum of \$2,500

FINANCIAL ADJUSTMENTS BASED ON PERFORMANCE EFFICIENCY

States increasingly expect that their Medicaid managed care programs will improve over time and produce better health outcomes, reduce waste, provide more coordinated and efficient care, and better control costs. Accordingly, some states are incorporating innovative payment adjustments to achieve those objectives and hold contractors to a higher standard of performance and efficiency. Examples of specific performance-related measures that can be analyzed and converted to quantifiable payment adjustments include the following:

- The number of emergency room visits that were not emergencies or low acuity and could have been avoided or provided in lower-cost settings of care through better ambulatory care, primary care, active and hands-on patient engagement, or provider education;⁵⁴
- High rates of potentially preventable hospital admissions indicate areas where possible improvements in the health care delivery system could be made to enhance patient outcomes and decrease costs;⁵⁵
- Reduction in preventable hospital readmissions through better care transitions, coordination, and outpatient service follow-ups;⁵⁶
- Large disparities in provider unit costs that could indicate poor provider contracting on the part of the managed care plans leading to excessive and unnecessary costs relative to their peers;
- Related-party transactions in which the risk-based contractor does not negotiate with related parties (for example, subsidiaries or a parent company) at arm's length, creating inappropriate expenses or cost shifting;
- Pharmacy generic prices that are not competitive with industry norms, other health plans' prices, or the state's fee-for-service generic pricing levels;

54 California HealthCare Foundation, "Overuse of Emergency Departments among Insured Californians," October 2006, <http://www.chcf.org/publications/2006/10/overuse-of-emergency-departments-among-insured-californians> (accessed August 20, 2015); and Amerigroup Public Policy Institute, "Reduce Unnecessary Emergency Room Use with Enhanced Primary Care Access," April 2011, https://hcr.amerigroupcorp.com/wp-content/uploads/2013/05/Reduce_Unnecessary_Emergency_Room_Use_with_Enhanced_Primary_Care_Access1.pdf (accessed August 20, 2015).

55 Healthcare Cost and Utilization Project, "Trends in Potentially Preventable Hospital Admissions among Adults and Children, 2005–2010," Agency for Healthcare Research and Quality, March 2015, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb151.pdf> (accessed August 20, 2015).

56 Center for Policy and Research, "Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use," America's Health Insurance Plans, June 2010, <https://www.ahip.org/Innovations-in-Hospital-Readmissions/> (accessed August 20, 2015); and Jenny Minott, "Reducing Hospital Readmissions," AcademyHealth, November 2008, <http://www.academyhealth.org/files/publications/ReducingHospitalReadmissions.pdf> (accessed August 20, 2015).

- Pharmacy mix of generic and brand drugs that is less than ideal or below the average of other contractors in the same program, indicating substandard pharmacy management or delays in dispensing generics after a brand drug loses patent protection and generics become generally available in the marketplace;⁵⁷
- Lackluster efforts on the part of the risk-based contractors to proactively maximize third-party payers (for example, Medicare or employer-based insurance) to pay for some or all of a covered service, resulting in higher, avoidable costs for the Medicaid program;⁵⁸
- Level of uncoordinated care as measured by the cost and outcomes of episodes of care and benchmarking the performance of the program to industry standards;⁵⁹ and
- Missed opportunities to improve outcomes and eliminate unnecessary or duplicative services as a result of breakdowns in coordination across the spectrum of physical, behavioral, and long-term services and supports (poor integration of care).⁶⁰

The analyses underlying successful financial adjustments related to performance efficiency requires the state and its actuaries to draw on actuarial, clinical, and informatics resources. These analyses are largely dependent on reliable and complete managed care encounter data, due to the detailed and complex nature of analyzing distinct events such as a hospital readmission. Collecting and processing data can require a significant investment of time and resources to develop appropriate methodologies. For example, unless the encounter data capture details on the emergency room claim, such as diagnosis or procedure code, it is difficult to determine the nature and severity of the condition prompting the enrollee's visit. Longitudinal data analyses can determine if a managed care enrollee saw a primary care provider following a hospitalization and to what extent the enrollee was connected to appropriate outpatient care, which could be indicators of breakdowns in care management or care transition contributing to avoidable costs. The diagnosis-related group and other encounter data elements can help determine if a hospital readmission was likely a consequence of a lack of planning or connection to outpatient services or other follow-up care. Combining analysis based on claims with targeted reviews of medical records further improves the state's ability to know what it is buying and identify areas that might be improved by using payment adjustments or other financial incentives.

Even if payments are not explicitly adjusted based on the aforementioned performance-based analyses, analysis of cost and utilization can identify opportunities for improvement. Sharing the results with the state's business partners or producing publicly available "report cards" on plan performance can provide an incentive to improve performance if enrollees move from health plans with lower grades to those with higher grades. When a state has reliable data that can be turned into usable and actionable information, many activities can be undertaken to improve health care and health outcomes.

Another return on investment in financial performance analysis is that the state becomes a more informed program sponsor, more capable of reducing program expenditures by holding its contractors to higher levels of efficiency, performance, and outcomes. In one mature state Medicaid managed care program, the state and its actuary identified over \$175 million in cost savings related to preventable hospitalizations, reduced emergency room utilization, and better pharmacy management, creating a large return on investment and direct capitation rate adjustments.

57 National Community Pharmacists Association, "Community Pharmacists Can Help Maximize the Use of Low-Cost Generic Drugs," <http://www.ncpanet.org/advocacy/pbm-resources/cost-saving-generic-drugs> (accessed August 20, 2015).

58 Kansas Health Policy Authority, "2009 Medicaid Transformation Program Review – Third Party Liability (TPL)," http://www.kdheks.gov/hcf/program_improvements/downloads/Third_Party_Liability_2%2023%2010.pdf (accessed August 20, 2015).

59 APS Healthcare, "Clinical and Financial Impact of Care Coordination: Medicaid Populations," October 25, 2012, <http://www.apshealthcare.com/site/files/cm/file/posters%26presentations/FinancialImpactCareCoordinationMHPA2012.pdf> (accessed August 20, 2015).

60 George Rust, et al., "Economic Impact of a Medicaid Population Health Management Program," *Population Health Management* 14, No. 5 (November 5, 2011) doi: 10.1089/pop.2010.0036, <http://online.liebertpub.com/doi/pdf/10.1089/pop.2010.0036> (accessed August 20, 2015).

Since a state that pursues these types of performance-based financial analyses will be holding its contractors to higher performance standards, the state should expect resistance from the contractors to reductions in their capitation payments. A willingness to explain the state's purchasing strategy and send consistent messages to the health plans, as well as giving the contractors an opportunity to provide input, is conducive to the long-term success of a value-based purchasing strategy. Gradually incorporating more aggressive rate adjustments over time will enable the state's contractors to adjust to the new purchasing strategy. States should also be aware that circumstances beyond the direct control of the health plans (for example, state policies on dispensing certain medications, socioeconomic aspects of the covered population, and difficulty communicating with members) may be a contributing factor to health care costs, and thus elimination of all unnecessary costs may not be practical. States can work with their actuaries to develop reasonable targeted efficiency levels, such as a 1-percentage point increase in the generic drug dispensing rate, and reflect these targets in the payment rates.

Performance and value are goals that the state needs to foster within the system, and ideally contractors, providers, and stakeholders can assist the state in developing innovative solutions to reach those goals. Flexibility with accountability for these partners is a good recipe for achieving more value.

ADDITIONAL SOURCES OF INFORMATION

In addition to the reference citations included in this chapter, there are many other sources of good information available to states on the topics covered. We encourage states to take advantage of these other sources of information and to be aware that information is continually being made available in the public domain.

- Agency for Healthcare Research and Quality – A plethora of information on quality, performance measures, and health care research, available at <http://www.ahrq.gov/index.html>.
- Catalyst for Payment Reform – Action brief on implementing global payments, available at http://www.catalyzepaymentreform.org/images/documents/CPR_Action_Brief_Global_Payment.pdf.
- Center for Health Care Strategies, Inc. – Information on state activities regarding pay for performance, primary care improvement, and payment reform, available at <http://www.chcs.org>.
- Center for Healthcare Quality and Payment Reform – Variety of information on payment and delivery systems, available at <http://www.chqpr.org>.
- CMS Integrated Care Resource Center – General information on a variety of topics, including health homes, dual eligibles, and state-specific integration activities, available at <http://www.integratedcareresourcecenter.com/default.aspx>.
- CMS Center for Medicare and Medicaid Innovation – Large amount of information on all aspects of innovative financial payment models, including policy briefs, archived webinars, and technical assistance, available at <http://innovation.cms.gov/index.html>.
- The Commonwealth Fund – A private foundation that aims to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency. Information available at <http://www.commonwealthfund.org/>.
- The Council of State Governments – In 2009, the Council of State Governments held a conference to consider initiatives to link health care purchasing to quality. Information on the

lessons learned, topical reports, and presentation slides, available at <http://valueovervolume.org/>.

- Health Care Incentives Improvement Institute – A nonprofit organization developing new payment models, including the PROMETHEUS bundled payment methodology. Information available at <http://www.hci3.org/>.
- The Leapfrog Group – A voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big advances in health care safety, quality, and customer value will be recognized and rewarded. Information available at <http://www.leapfroggroup.org>.
- National Academy for State Health Policy – Independent academy of state health policymakers providing information on a variety of topics. Information available at <http://www.nashp.org>.
- National Conference of State Legislatures – Provides research, technical assistance, and opportunities for policymakers to exchange ideas. Information available at <http://www.ncsl.org/research/health.aspx>.
- State Refor(u)m website – An online network for health reform implementation sponsored by NASHP and the Robert Wood Johnson Foundation. Information available at <http://www.statereforum.org/>.
- The Urban Institute – An organization that gathers data, conducts research, and evaluates programs. Information available at <http://www.urban.org/research-area/health-and-health-policy>.

Medicaid Program Integrity



SECTION VI

Section VI

ROADMAP

Read this section to learn about Medicaid program integrity activities and best practices to limit fraud, waste, and abuse. Following are key takeaways:

OVERVIEW

Program integrity consists of the systems and processes that work to prevent, identify, and adjudicate fraud, waste, and abuse in various aspects of the Medicaid program, including the purchasing of health care services.

FUNDAMENTALS

This section addresses the core goals and concepts behind the practice of program integrity, encompassing definitions of fraud and abuse in Medicaid, including variations on state definitions, and a discussion of how waste is defined in the broader health care system.

ADVANCED

This section delves into program integrity issues and examines select best practices for Medicaid purchasers across a variety of areas, including:

- Program integrity processes;
- Provider enrollment;
- Oversight of managed care organizations;
- Working with Medicaid Fraud Control Units;
- High-risk segments in Medicaid, particularly home- and community-based services and prescription drug programs; and
- Regulatory agency insights for best practices.

Section VI. Medicaid Program Integrity

By Jeremy Brown and Charlene Frizzera, CF Health Advisors

OVERVIEW

Program integrity is an often overlooked but critical component of the Medicaid program. In recent years, the rapid growth in the size and complexity of Medicaid has led to a corresponding growth in the frequency of fraud, waste, and abuse in the program. To help combat these activities, the Centers for Medicare & Medicaid Services (CMS) and the states have given program integrity more attention. Today, the resources available to mitigate fraud, waste, and abuse in the Medicaid program are greater than ever.

The primary purpose of this section is to describe some of the best practices being used to ensure program integrity. The concepts and practices described here were identified in an extensive literature review and in conversations with stakeholders, including state Medicaid directors, state offices of inspectors general, CMS officials, providers, contractors, and congressional staff. The description of best practices is not exhaustive. Every state is different in the size and scope of its Medicaid program and the resources available for its program integrity efforts. Best practices in one state do not necessarily translate well to other states, and the financial and staffing requirements to implement some practices might not be available to all states. The section describes the core goals and concepts behind the practice of Medicaid program integrity oversight. Next, the section reviews the key parts of the program integrity process and describes effective practices and insights from various state programs. Two high-risk areas of the Medicaid program, where targeted interventions can help improve program integrity significantly, are analyzed. Finally, several resources available to states to help generate program integrity initiatives are reviewed.

FUNDAMENTALS

WHAT IS PROGRAM INTEGRITY?

In this compendium, program integrity is defined as follows:

Program integrity consists of the systems and processes that work to prevent, identify, and adjudicate fraud, waste, and abuse in the Medicaid program.

This definition is minimalist. It is broadly consistent with the single federal definition and the 50 different state definitions. To illustrate, the following is from the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity (CPI):

The central purpose of and role of the Center for Program Integrity is to ensure that correct payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries in the Medicare and Medicaid programs.¹

In various states, program integrity is defined as follows:

- **Arizona:** “The chief goal of the Arizona Health Care Cost Containment System (AHCCCS) Office of the Inspector General is to ensure that AHCCCS (Medicaid) funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies.”²

¹ The Center for Program Integrity, “New Strategic Direction and Key Antifraud Activities,” Centers for Medicare & Medicaid Services, November 3, 2011, <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/Downloads/cpiinitiatives.pdf> (accessed August 18, 2015).

² Arizona Health Care Cost Containment System, “AHCCCS Fraud, Abuse, Or Abuse of a Member,” <http://www.azahcccs.gov/fraud/Default.aspx> (accessed August 18, 2015).

- **California:** *“The overall goal of A&I [Audits and Investigations] is to improve the efficiency, economy, and the effectiveness of DHCS [the Department of Health Care Services] and the programs it administers.”*³
- **Florida:** *“The Bureau of Medicaid Program Integrity audits and investigates providers suspected of overbilling or defrauding Florida’s Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal investigation.”*⁴
- **Indiana:** *“The mission of the Office of Medicaid Policy and Planning Program Integrity Unit is to guard against fraud, abuse, and waste of Medicaid program benefits and resources.”*⁵
- **Nebraska:** *“The purpose of the Program Integrity Unit is to guard against fraud, abuse, and waste of Medicaid program benefits.”*⁶
- **North Carolina:** *“It is the mission of Program Integrity to ensure compliance, efficiency, and accountability within the N.C. [North Carolina] Medicaid Program by detecting fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance.”*⁷
- **Utah:** *“Program Integrity actively monitors the quality and reliability of Utah Medicaid providers, ensures the fiscal integrity and compliance with State and Federal Regulations and develops, implements, and enforces measures to identify, prevent and reduce fraud, waste and abuse in the Medicaid System.”*⁸

All of the state versions have many of the same elements, but no matter how program integrity is defined either in scope or in practice, the one true statement is that no state views program integrity in exactly the same way as another.

Medicaid program integrity is provided by a system that consists of both federal and state agencies. CMS, law enforcement agencies, and congressional bodies work at the federal level, and the Medicaid agencies and Medicaid Fraud Control Units (MFCUs) and local law enforcement agencies operate on the state level. Ideally, all of those agencies work both separately and in tandem to ensure that the Medicaid program works efficiently and in compliance with all applicable federal and state laws and regulations.

The process of program integrity is the oversight of how Medicaid dollars are spent. The process may differ slightly depending on, for instance, a state’s penetration of managed care organizations (MCOs) versus traditional fee-for-service (FFS) programs. The first step in the process is to ensure that the people receiving Medicaid coverage are eligible and that the claims they submit (or that are submitted on their behalf) are not subject to any third-party liability payments. The second step is to screen providers to ensure that the providers of services to beneficiaries are not subject to any exclusionary standards. Then, particularly in an FFS system, some form of prepayment review should be completed to ensure that claims are medically necessary in the broadest sense; for example, that claims are not issued after death or that claims for a single provider did not exceed 24 hours in a day. Lastly, states need to conduct post-payment reviews to

3 California Department of Health Care Services, “Audits and Investigations,” <http://www.dhcs.ca.gov/individuals/Pages/AuditsInvestigations.aspx> (accessed August 18, 2015).

4 Agency for Health Care Administration, “Office of Medicaid Program Integrity,” http://www.fdhc.state.fl.us/Executive/Inspector_General/mcicaid.shtml (accessed August 18, 2015).

5 Indiana Family and Social Services Administration, “Program Integrity,” <http://provider.indianamedicaid.com/about-indiana-medicaid/program-integrity.aspx> (accessed August 18, 2015).

6 Nebraska Department of Health and Human Services, “Nebraska Medicaid Program – Program Integrity Home,” http://dhhs.ne.gov/medicaid/Pages/med_pi_index.aspx (accessed August 18, 2015).

7 North Carolina Division of Medical Assistance, “Program Integrity,” North Carolina Department of Health and Human Services, <http://www.ncdhhs.gov/dma/pi.htm> (accessed August 18, 2015).

8 Utah Office of the Inspector General, <http://www.oig.utah.gov/> (accessed August 18, 2015).

search for aberrant trends in billing patterns that can indicate potential fraud and abuse. After the agency has completed that process, it then refers cases of potential fraud and abuse to the state MFCU or other law enforcement agency, as necessary.

Fraud and abuse are two central issues in program integrity. Both are defined in federal regulation:

Fraud is “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law” (42 CFR 433.304).

Abuse is defined as “Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of health care” (42 CFR 455.2).

Fraud is an intentional violation of the law for gain. In contrast, abuse is the failure to operate within the generally acceptable industry standards. These two criminal actions are at the core of program integrity activities but do not, and should not, encapsulate all of the activities of program integrity efforts. Errors and improper payments are another critical component of program integrity practice. Given the complexity of the billing process and the effort involved, many providers simply make honest mistakes. Whether these mistakes occur because of a lack of sufficient documentation or a typo in a procedure code, honest mistakes do happen, but they still need to be identified and rectified within the system.

The federal Payment Error Rate Measurement (PERM) program seeks to measure and evaluate these types of errors in state Medicaid programs. PERM results are derived from a random sample of state payment and eligibility determinations. The PERM is reported both on a total program basis and in the categories of FFS payments, managed care payments, and eligibility. Although the PERM has limitations—for example, the most commonly occurring error in PERM is missing documentation—the measurement remains a useful tool to determine the effectiveness of payment systems and processes for a state Medicaid program. States should use these measures as a benchmark to evaluate their processes for internal improvement and also review PERM results from elsewhere to identify states from which best practices in payment accuracy can be learned.

Although fraud, abuse, and errors are fairly easy to comprehend, identify, and agree on, the third pillar of program integrity, waste, is a little more difficult to oversee. First, there is no definition of “waste” in the federal Medicaid regulations. Second, waste is not a criminal act but an inefficient allocation of resources within the program. Third, waste can exist in any part of the system, and at the margins it is very difficult to identify and prevent. For these reasons, waste has not traditionally been a large part of the literature on effective program integrity activities. For that reason, a brief treatment of the issue follows here, before the section returns to the more traditional concepts of program integrity best practices.

A Brief Detour on Waste

Although not specifically focused on Medicaid, an article in the *Journal of the American Medical Association* by Donald Berwick and Andrew Hackbarth identified six major categories of waste in the health care system that are also applicable to the Medicaid program: failures in care delivery; failures of care coordination; overtreatment; administrative complexity; pricing failures; and fraud and abuse.⁹ Under the categorical framework, Berwick notes that state Medicaid programs should focus on two categories, overtreatment and

9 Donald M. Berwick and Andrew D. Hackbarth, “Eliminating Waste in US Health Care,” *Journal of the American Medical Association*, 307 (April 11, 2012): 1513–16, doi:10.1001/jama.2012.362.

administrative complexity, as a starting point to address waste in their programs. Overtreatment is “the waste that comes from subjecting patients to care that, according to sound science and the patient’s own preferences, cannot possibly help them—care rooted in outmoded habits, supply-driven behaviors, and ignoring science.” One example of overtreatment is unwanted end-of-life care for patients who prefer hospice and home care, which is important for Medicaid programs, given that 41 percent of the \$342 billion spent on long-term care in the United States is paid for by Medicaid.¹⁰

Although overtreatment has not historically been the first thought in program integrity, it should be an important emphasis in contemporary program integrity efforts. It should also be noted that overtreatment should be more closely scrutinized in FFS programs because of the economic incentives to provide beneficiaries with higher volumes of treatment. Many overtreatment issues can and should be detected during prepayment review, with the development of algorithms to detect medically unnecessary events and identify outliers from clinical practice guidelines and errors that are serious and preventable, so-called never events.

In addressing overtreatment, as data systems and analytics evolve, future program integrity best practices will be focused on having data systems with edits and algorithms that are based on industry standards and guidelines for medical conditions. One example would be edits that generate a flag if a 30-day prescription in a high-risk category is being refilled more than twice a month. Many medical associations issue clinical guidelines and standards for industry practices, and a future can be envisioned in which those standards can be included in claims system reviews, so that claims that are clear outliers from clinical practice can be flagged for review to ensure that the treatments are medically necessary. As the system continues to move away from pay-and-chase strategies to a greater use of prepayment review procedures, the effective use of clinical standards will become increasingly important to prevent improper payments.

A second area of waste that program integrity efforts should focus on is administrative complexity. It is defined by Berwick as “the waste that comes when government, accreditation agencies, payers, and others create inefficient and misguided rules.” For example, payers may fail to standardize forms, thereby consuming limited physician time in needlessly complex billing procedures.¹¹ When reforming, modifying, or updating program integrity policies and procedures, state Medicaid directors should be mindful of administrative complexity. Program integrity is complex enough, and with the number of agencies and operators that must interact, the consolidation and standardization of processes and procedures should be of paramount importance. As detailed later in this section, the standardization of data, forms, and procedures can greatly increase the effectiveness of program integrity practices, but more important, it will give a state’s Medicaid staff more time to focus on more value-added operations.

Administrative complexity is highlighted because many of the best practices in this compendium are process-oriented ideas that are aimed at simplifying, streamlining, and eliminating duplication from the program integrity system. Other stakeholders, including the U.S. Government Accountability Office (GAO) and National Association of Medicaid Directors, have highlighted the extent of duplicative and redundant services from a national perspective. Even within the state agency or division that oversees program integrity efforts, processes can be improved and inefficiencies eliminated through better communication, cooperation, and attention with respect to minimizing administrative complexity. Every agency, even one with a perfect Payment Error Rate Mechanism rate or record fraud convictions and collections, could

10 The Kaiser Commission on Medicaid and the Uninsured, “Medicaid’s Role in Meeting the Long-Term Care Needs of America’s Seniors,” January 14, 2013, <http://www.kff.org/medicaid/upload/8403.pdf> (accessed August 18, 2015).

11 Donald M. Berwick and Andrew D. Hackbarth, “Eliminating Waste in US Health Care,” *Journal of the American Medical Association*, 307 (April 11, 2012): 1513–16, doi:10.1001/jama.2012.362.

benefit from reviewing its daily process through the lens of reducing administrative complexity. In some cases, duplication may be beneficial, as in some auditing or review processes, but if time and effort can be saved by standardizing, digitizing, or streamlining any part of an agency's daily practice, it will allow greater resources to be put to use in more effective ways to combat fraud and abuse.

ADVANCED

PROGRAM INTEGRITY PROCESSES

Risk Assessment

To have an effective program integrity operation, the state must first understand the existing and potential avenues for fraud and abuse in its system. A robust analysis of relevant data should allow the state to identify areas of high risk, such as disproportionately high expenditures and use or patterns of outlier services on claims. Risk assessment will enable the state to use its program integrity resources effectively to bring the best return for the resources expended.

Risk assessments will lead different states to focus on different areas. For example, one state might detect irregularities in its prescription drug program, but another might identify a risk of fraudulent home health claims. A state with a heavy penetration of managed care would likely concentrate more on risk adjustment processes, whereas a state that is predominately fee-for-service would focus more on claims-based analysis.

Once a state has completed its risk assessment and has procedures to review that assessment periodically, it can develop its strategy or approach to program integrity with a more informed and focused plan. States should analyze several key areas to make sure that they are getting the full value for the resources that they put into the program. Some of the main areas that states should focus on include the following:

- Beneficiary eligibility;
- Provider enrollment;
- Oversight of MCOs; and
- Interactions with MFCUs.

Reviews of the publicly available literature and conversations with practice area experts produced these critical areas of program integrity as processes that states should pay particular attention to when reviewing their program integrity practices.

Beneficiary Eligibility

The goal of reviewing beneficiary eligibility and enrollment practices is to make sure that the enrolled beneficiaries are eligible, that they are receiving the services for which claims have been submitted, and that there is no third-party liability, such that the claim should have been paid by another insurance company or program. Beneficiary eligibility review is even more important for Medicaid payers under the Affordable Care Act (ACA) because a set of beneficiaries now moves back and forth, or churns, between Medicaid coverage and subsidized private insurance as their incomes change.

The implementation of the ACA brings many opportunities for the program integrity system. The transition to the Modified Adjusted Gross Income standard should help states with the transition of newly eligible beneficiaries by shifting some of the eligibility determinations to the health insurance marketplaces. That will create a simpler process but possibly add another stakeholder with which the state will need to communicate and coordinate. This is especially true for states that establish their own health insurance marketplaces to screen and enroll beneficiaries.

Health exchanges also present another challenge for Medicaid program integrity efforts. A joint Robert Wood Johnson Foundation and Urban Institute study estimated that 29.4 million people -- roughly one-third of the people who will qualify for either Medicaid or exchange subsidies -- will change eligibility from one to the other, with two-thirds of the churn occurring when people move between Medicaid and nongovernmental health insurance because of changes in income and access to employer-sponsored insurance.¹² While early reports indicate that churn may not be as prevalent as anticipated, for states operating a state-run or state-federal partnership marketplace, it is imperative for Medicaid agencies to work with the entities in their state that oversee the exchange process for determining eligibility to ensure that beneficiaries are enrolled in the correct program and that claims are being paid by appropriate insurers.¹³ It is important for program integrity officials to think about what types of policies, procedures, and coordination efforts they should implement to minimize the risk of fraud and abuse in the new system.

Since eligibility is often primarily a self-attestation process, generally involving a multiagency review, focusing on third-party liability can produce a high return on the state's investment. The best practices that we have uncovered in this review process generally involved the process of checking beneficiary data against data from other governmental agencies, such as the state death files and the state wage files. States with effective beneficiary enrollment review practices work with other state and federal agencies to ensure that they are getting up-to-date -- generally quarterly -- data from other agencies to verify that the beneficiary is both still living and within the wage threshold for eligibility. South Carolina, Tennessee, and Vermont have all been identified by CMS as having effective practices using these types of external data sources to increase the accuracy of their eligibility determination process.¹⁴

PROVIDER ENROLLMENT

Effective provider enrollment practices are critical to program integrity efforts because they help to stop potential fraud and abuse before they occur and to deter potentially fraudulent providers. Would-be providers can be excluded from participating in a state Medicaid program for a number of reasons. To make determinations about provider enrollment, background checks should be performed on all potential providers, including criminal background checks and screening for ownership and corporate transactions; the managing employees of each provider should be screened as well. Best practices in provider enrollment begin with such exclusion searches but also include the key components of coordinating and communicating with other program integrity and non-program-integrity entities to ensure that databases and information systems contain the necessary information to properly screen providers.

Exclusion searches are the primary function of a successful provider enrollment process. Program integrity officials must have access to all the information necessary to run a proper exclusion search. In August 2010, the CMS Medicaid Integrity Group (MIG) issued *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment*, which outlines six recommendations and includes examples from several states, as well as federal regulations governing the provider disclosure process.¹⁵ CMS published an informational bulletin in May 2011 to provide guidance on ACA's Section 6501, which requires states to terminate all providers that have been terminated under another Medicare or Medicaid state plan and creates a mandatory database through CMS to facilitate this process.¹⁶ Terminations on or after January 1,

12 Matthew Buettgens, Austin Nichols, and Stan Dorn, Churning under the ACA and State Policy Options for Mitigation, Urban Institute, June 2012, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73183 (accessed August 18, 2015).

13 Virgil Dickson, "Income-based 'churn' in coverage less common than feared," Modern Healthcare, April 22, 2015, <http://www.modernhealthcare.com/article/20150422/NEWS/150429959> (accessed August 18, 2015).

14 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See South Carolina (2011), Tennessee (2011), and Vermont (2008).

15 For more information, visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/bppedisclosure.pdf> (accessed August 18, 2015).

16 For more information, visit: <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/6501-Term.pdf> (accessed August 20, 2015).

2011, must be reported to this database through Section 6501 guidelines.¹⁷

A best practice in many states is to require all providers, including those in managed care networks, to be enrolled in the Medicaid program. The requirement helps to ensure that any provider that receives a payment from the state Medicaid program has been screened by at least the Medicaid program integrity team. Beyond requiring all providers to enroll in Medicaid, some states place further requirements on providers that want to participate in the Medicaid program. Kentucky and North Carolina, for example, both use provider contracts that allow the state to terminate a provider's contract at will if the provider fails to comply with state rules.¹⁸ Although at-will contracts might seem extreme at first glance, the concept of creating a regulatory structure that requires providers to submit the necessary information to be reviewed for screening purposes is vital to program integrity efforts. In fact, many states have had success by denying provider status for the lack of sufficient information. Wyoming, for example, terminates providers that do not provide an accurate mailing address.¹⁹ Whatever procedures and policies a state decides to enact, every provider who receives a Medicaid payment should be required to submit at least to a preliminary screen and to submit to the state the necessary information to ensure that a thorough review can be completed efficiently and effectively.

Some states have taken the process a step farther by creating provider databases that allow them to quickly and accurately assess the quality of the enrolled providers. These databases are frequently cited by states as one of their critical tools to prevent fraud and abuse. Having a centralized provider database maintained by the state allows program integrity officials to ensure that claims are being paid only to authorized providers and that all of the information regarding a provider is accurate and up to date. Arizona, Colorado, Florida, Kentucky, and New Jersey have been identified by CMS as effective in using provider databases efficiently in their provider enrollment processes.²⁰

Several states supplement their provider databases with information from non-Medicaid information sources. Virginia, for example, uses information on providers in its Medicaid Management Information System (MMIS), with an automated monthly upload from the Medicare Exclusion Database. Utah has a database with the ability to quickly produce sanctioned provider reports and compares its provider lists with the Medicare Exclusion Database.²¹ Arizona also takes a supplemental approach by checking its providers against the Medicare Fraud Investigation Database maintained by the U.S. Department of Health and Human Services' (HHS) Office of the Inspector General (OIG).²² It should be noted that although those examples of best practices have improved the effectiveness of those states' Medicaid programs, using and sharing data between complex databases is not always a simple process. For example, the HHS-OIG database includes all investigations, some of which might not have resulted in a conviction for fraud. The database has a learning curve associated with its use. Arizona officials indicate, however, that their use of supplementary data has proved immensely helpful in weeding out fraudulent or potentially fraudulent providers from their system.

States should also be sure to use the American Medical Association's National Practitioner Data Bank (NPDB). The NPDB is an electronic repository of all payments made on behalf of physicians in connection with medical liability settlements or judgments. Under federal law, information on all medical liability payments and on

17 Ibid.

18 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Kentucky (2009) and North Carolina (2008).

19 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Wyoming SPIR (2008).

20 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Arizona (2012), Colorado (2008), Florida (2009), Kentucky (2009), and New Jersey (2009).

21 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Utah SPIR (2012).

22 Interview with Glenn Prager, Arizona inspector general, 2013.

certain adverse actions must be reported in the NPDB. By crosschecking provider enrollment with the NPDB, state agencies can create another check against enrolling providers who may increase the state's risk for fraudulent or abusive activities. Similarly, states should also routinely crosscheck their provider enrollment lists with state licensing agencies to ensure that they are not making payments to providers no longer accredited to practice in their state.

The use of supplemental databases for more effective provider searches brings up the important consideration of collaboration and coordination. States need to ensure that both they and the managed care entities operating in the state are communicating their findings and investigations to all necessary stakeholders, including the state's program integrity officials, the MFCU, the HHS-OIG, the MCOs, and other applicable law enforcement officials. All regulators in the process need to be informed of current actions or concerns regarding providers to ensure that the proper action is taken and to eliminate duplicative efforts.

After a state has an effective roadmap to ensure the coordination of efforts, it should next consider how to engage outside information sources to make its provider enrollment process more effective. New Jersey provides another best practice by publicly posting its debarment list and sharing the information with the neighboring states of Pennsylvania and New York. As part of the state's Operation X initiative, it matches the Social Security numbers of excluded individuals against the State Wage and Labor database to help identify excluded individuals who continue to work for health care entities.²³ Even though other states publicly disclose their debarment lists, it should be considered a best practice to share that information actively with other states that could exclude those providers from practicing across state lines.

Lastly, it is worth mentioning that although provider enrollment is thought to be minimized by the capitated payment system of MCOs, states should still work as a central conductor and overseer of provider enrollment procedures. Although many MCOs have sophisticated provider management tools, states should continue to have robust communication with their contracted MCOs to ensure that the system runs smoothly. States should verify that all of the providers in the networks are valid providers, but more important, state officials should also help to inform all MCOs in the state if a single MCO has decided to exclude a provider. It is necessary for the state to disseminate this type of effective communication because competing MCOs may not communicate among themselves on business practices.

OVERSIGHT OF MANAGED CARE ORGANIZATIONS

With MCOs covering almost 75 percent of Medicaid beneficiaries nationally, using best practices in working with MCOs is becoming increasingly important in many state programs.²⁴ Despite the proliferation of MCOs in Medicaid programs, many states have little experience with program integrity contract language. Others will look for ways to simplify procedures, as resources are stretched by the influx of beneficiaries in states that choose the Medicaid expansion option under the ACA. Although best practices in dealing with MCOs are relatively unfamiliar territory for many states, discussions with various stakeholders have yielded a couple of areas that should warrant attention.

Managed care in Medicaid is not a new concept, but states' experience levels with this care delivery system vary. Some states have been successfully using MCOs for decades for the vast majority of their Medicaid population, some states are just beginning statewide rollouts of managed care pilots, and some have decided after trying managed care that other service delivery models are more effective for the beneficiaries in their

23 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See New Jersey SPIR (2009).

24 The Centers for Medicare & Medicaid Services, "Medicaid Managed Care Enrollment Report – Summary Statistics as of July 2012," <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2012-medicaid-managed-care-enrollment-report.pdf> (accessed August 18, 2015).

state. MCOs are sometimes thought to be a panacea for program integrity issues because of the nature of capitated arrangements. However, because most plans are paid on a per-member per-month basis, plans might have an incentive to enroll ineligible beneficiaries or to exclude beneficiaries that may be higher cost or risk.

Eligibility determinations in a managed care environment should be a primary concern for program integrity officials because, for many accustomed to an FFS environment, eligibility was never really thought of as providing a big dollar return for program integrity efforts. In an FFS environment, an incorrectly enrolled individual beneficiary would not be able to come near the fraudulent dollar amounts that a fraudulent provider could potentially obtain. However, with the provider fraud risk partially shifted to the MCO, states should now place a greater emphasis on eligibility and third-party liability issues in Medicaid programs. Emphasis is placed on the concept of partially shifted risk because some misspent dollars can be recouped in future periods through the rate-setting process. A best practice recommended by HHS-OIG was to encourage MCOs to have providers verify eligibility for new patients and for states or MCOs to offer additional resources, such as a provider web portal and telephone line, to increase their ability to do so.²⁵

Another area of concern that states should assess is their collection and analysis of encounter data provided from the MCO. The ability to analyze encounter data allows the state to effectively audit the MCO to screen for any fraud or abuse issues with either MCOs or the providers in their network. State Medicaid programs will be aided in this process by Section 6504(a) of the ACA, which requires Medicaid MCOs to submit encounter data to the states. Because the submission of encounter data is now be mandated, states should begin to place a greater emphasis on the analysis of that information to better detect potentially fraudulent and abusive practices. Encounter data can be run against eligibility data, MCO claims data, and even the MCO's financial statements. Tennessee, for example, has a three-step process for the verification and validation of encounter data. It first reviews to make sure that data are of sufficiently high quality to be useful in its system. Bad data are then sent back to the MCO, which must correct and resend them within a specified time or incur a penalty. The clean data are then run against the FFS claims engine, using the same audits and edits as FFS claims. Through this method, as of 2007, the state had a zero percent error rate for encounter data in managed care, versus a 3.1 percent national average.²⁶ The effects of good encounter data spill over into more collaborative purposes as well, allowing the state to communicate better with MCOs and providers from an informed statistical position.

Another area of common concern for states and MCOs is that services paid for are actually received by beneficiaries. A December 2011 report from the HHS-OIG raised this issue. That office asked MCOs, states, and CMS about their concerns with MCO fraud. Despite states and MCOs having taken steps to prevent fraud and abuse, "the primary concern [was] related to services billed and not rendered."²⁷ Such fraudulent claims inflate the capitation rate paid to MCOs during the rate-setting process. States should also have a mechanism to verify beneficiary receipt of managed care services, preferably through an Explanation of Medical Benefits (EOMB). The HHS-OIG reported that MIG reviews indicated that only eight of the 46 MCOs in its sample used an EOMB to verify the receipt of beneficiary services.²⁸ Requiring that MCOs use an EOMB or other form of receipt for beneficiary services and having the MCOs report the results back to the state should be considered a best practice that can easily be implemented through contract language. This practice will enhance program integrity safeguards for states, MCOs, and beneficiaries, while providing an additional opportunity to identify fraudulent providers.

25 Office of the Inspector General, "Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards," U.S. Department of Health & Human Services, December 2011, <https://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf> (accessed August 18, 2015).

26 Interview with Darin Gordon, Tennessee state Medicaid director.

27 Office of the Inspector General, "Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards," U.S. Department of Health & Human Services, December 2011, <https://oig.hhs.gov/oei/reports/oei-01-09-00550.pdf> (accessed August 18, 2015).

28 Ibid.

Moreover, program integrity agencies should take steps to ensure that MCOs are not underserving their Medicaid beneficiaries. The EOMB is a first step because it will help to educate patients about their current benefits. So informed, they might be more likely to report any attempt by MCOs to limit or deny services that they have contracted to provide. Program integrity officials should further review MCO policies and procedures on prior authorization to make sure that MCOs are not placing overly burdensome requirements on beneficiaries, which may deny or delay care that should be provided to them. Exacerbating this problem is the fact that “the average person enrolled in Medicaid was covered for little more than three-quarters of the year” although continuity has improved slightly “from 78 to 81 percent.”²⁹ Since continuous coverage under Medicaid does not exist for a large portion of beneficiaries, there is a direct incentive for plans to delay or deny more costly care.

Although oversight of MCOs should be conducted thoroughly, MCOs should continue to be thought of as partners in program integrity efforts. Establishing frequent and effective communication between the MCOs and relevant state agencies is one of the best practices frequently mentioned. It is important to include program integrity components in contracts with MCOs. It should be clear to MCOs what the policies and procedures are for data collection and reporting of fraud and abuse issues. Three states -- Michigan, New York, and Utah -- even include program integrity components in the performance evaluation tools through either contract or request for proposal.³⁰

Setting up improved lines of communication among MCOs, providers, the MFCU, the HHS-OIG, and other stakeholders is paramount to program integrity efforts. The first step in better cooperation with MCOs is to make sure that they receive adequate training on the state’s policies and procedures covering program integrity. One of the best practices often cited is the use of regular, usually quarterly, in-person meetings with state officials, MFCU, HHS-OIG, MCOs, and even providers. These meetings can also allow for the discussion of open fraud and abuse cases, so that other stakeholders can proactively check their networks for similar problems. In-person meetings not only facilitate improved communication among the various stakeholders but also allow attendees to put names to faces and develop relationships outside of their scope, which can lead to new ideas and improved process. Again, it is important to view the MCOs as partners in the program integrity process. Many MCOs, particularly multistate plans with commercial and Medicare plans, might have greater resources and sophistication in their program integrity processes than some states do and can help states improve their reviews and audits. Instead of, or in addition to, in-person meetings, states should at a minimum require that MCOs submit program integrity reports to the state on at least a yearly— preferably a quarterly—basis. Georgia, New Jersey, and Oregon have implemented such reporting with success.³¹

Finally, state Medicaid programs and other state agencies should create or review policies and procedures to address program integrity issues with MCOs. This should include mandating that MCOs communicate fraud and abuse cases to the state Medicaid agency and the MFCU, an expected timeline for reviews and audits, expectations for data sharing, and processes for how to best communicate fraud and abuse issues. Effective and efficient communication of program integrity issues is a best practice that is critical to getting the best results when working with MCOs. These activities provide a very high return on the state’s investment because their cost is relatively low, the amount of employee time required is small, and their yield is relatively high, particularly when fraud and abuse can be identified, communicated, and adjudicated in the most efficient process possible. Although states vary in their policies, procedures, and practices in dealing with program integrity, virtually every state that can be described as having effective practices has some type of effective

29 Leighton Ku, Erika Steinmetz, “The Continuity of Medicaid Coverage: An Update,” Association for Community Affiliated Plans, April 2013, http://www.communityplans.net/portals/0/coverageyoucancounton/Continuity_of_Medicaid_Coverage_Update_4-2013.pdf (accessed August 18, 2015).

30 The Centers for Medicare & Medicaid Services, “State Program Integrity Reviews,” <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Michigan, New York, and Utah.

31 The Centers for Medicare & Medicaid Services, “State Program Integrity Reviews,” <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Georgia, New Jersey, and Oregon.

communications plan. Whether through meetings, reports, training, or better data exchanges, improvement and success in program integrity management should start with a clear and integrated communications strategy.

WORKING WITH MEDICAID FRAUD CONTROL UNITS

MFCUs are responsible for the investigation and prosecution of providers that defraud Medicaid. Their actions are critical to make sure that all of the work by the program integrity staff in identifying potential fraud leads to the proper adjudication of fraudulent providers. MFCUs are granted federal jurisdiction to investigate and prosecute Medicaid provider fraud and fraud in the administration of the program, alleged abuse and neglect in long-term care facilities, and the misappropriation of resident funds, as well as to investigate fraud involving other federally funded health care programs if the MFCU can establish a Medicaid nexus. Forty-nine states currently operate MFCUs, with North Dakota exempted by a waiver. Because of differences in state statutes, every MFCU is different.

CMS issued a best practices report for interactions with MFCUs in September 2008.³² First, CMS recommended that state Medicaid agencies meet regularly with the MFCU. The meetings should include an established agenda that outlines main discussion topics such as case updates, new complaints, possible referrals, policy changes, hot issues, and recent fraud trends. Key participants from each unit should be involved, and consideration should be given to inviting other program staff as pertinent to the agenda. For example, Maryland invited staff from its Department of Health and Mental Hygiene and the HHS-OIG to meetings after it identified high levels of fraud in its mental health program. It is particularly important that the meetings include a discussion of both current program integrity investigations and cases that are likely to be referred to the MFCU to get early input from the MFCU and augment the quality of the referrals. The formation of work groups should be clearly outlined in the memorandum of understanding with the MFCU. Kentucky, for example, has a three-way memorandum of understanding with the MFCU, the HHS-OIG, and the state agency that clearly outlines the responsibilities and obligations of each.³³

Second, CMS recommended that state agencies develop and consistently apply a standard for deciding when to refer a matter to the MFCU. The regulatory standard is outlined by CMS in the MIG's Performance Standards for Referrals of Suspected Fraud from a Single State Agency to a Medicaid Fraud Control Unit.³⁴ In each referral to the MFCU, the state agency should include the information set forth in the referrals performance standard. It is recommended that states work with the MFCU to develop a standardized template that provides at least the necessary information, as well as any other suggestions made by the MFCU to expedite the investigatory process. Oregon solicited input from the MFCU on the planned procurement of a new MMIS, and the state of Wisconsin went a step further by granting the MFCU access to its MMIS. The state arranged for training on the new system so that data runs can be requested in a more efficient manner.³⁵

CMS also recommended that states update the MFCU on ongoing investigations by holding meetings and providing periodic written reports, access to databases, and other methods of collaboration that are helpful and effective. The West Virginia MFCU regularly sends the state Medicaid agency updates on all ongoing investigations, and the two agencies have been working to establish a stronger partnership.³⁶ Indiana took the sharing of information into real time by developing a secure website for the Indiana Surveillance and

32 For more information, visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/bestpracticespiunitinteractionswithmfcu.pdf> (accessed August 18, 2015).

33 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Kentucky.

34 For more information, visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf> (accessed August 18, 2015).

35 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Wisconsin.

36 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See West Virginia (2013).

Utilization Review (SUR) unit and the MFCU that contains all SUR-developed cases that are currently being investigated, with both parties able to update the list.³⁷

Finally, CMS recommended that state agencies offer education and consultative services to the MFCU. MFCU members should be educated on program nuances with which they may not be familiar. Since members of the MFCU might not have the operating experience or the same level of policy knowledge that state agency employees have developed, educating the investigative teams of the MFCU on the policy details can give them an advantage in prosecuting fraudulent providers that leads to a higher conviction rate and greater monetary recoveries. The Georgia MFCU and HHS-OIG have developed a cross-training program that requires new MFCU employees to spend a two-week internship with the HHS-OIG to gain program experience that will assist them throughout their careers.³⁸ The state agencies should also offer to provide consultative services to the MFCUs to further aid them in their prosecutorial efforts. Most MFCUs lack the clinical expertise that the state agency has in its medical director, staff and other clinical advisers. Since a large number of MFCU cases hinge on the opinions of clinical experts, the ability of the MFCU to leverage the expertise of the state agency's staff could be the difference between successful and unsuccessful prosecutions. We would also add that knowledge exchange between state agencies and MFCUs should be a two-way street. Given their trial experiences and legal expertise, MFCU staffs are generally acutely aware of statutory loopholes and regulatory deficiencies. By actively soliciting input from the MFCU, state agencies can proactively strengthen their policies and procedures to prevent fraudulent providers from exploiting those legal limitations. The Oregon MFCU, for example, assisted the state by suggesting changing the language in the state's provider enrollment package to conform to federal disclosure regulations.³⁹

Beyond the CMS recommendations, the Ohio MFCU also offered some insights into how it became one of the most effective in the country, having recovered \$280 million over a five-year period on an operating budget of \$6 million annually. One critical success factor is the Ohio MFCU's strike force mentality. Rather than simply handing off cases among the various silos, the Ohio MFCU assigns work to interdisciplinary teams that consist of supervisors, agents, prosecutors, and analysts who collaborate, allowing each team member to bring their individual skills and experience to the case. Health care fraud cases are complex and often require specialized knowledge and skills. These diversified team efforts generate a greater success rate for the state. Further, the MFCU takes a proactive approach to program integrity activities. The MFCU does not sit back and wait for cases of suspected fraud to come to it but actively seeks to identify aberrant providers. As part of this process, the MFCU team works with the program integrity staff to assist with data mining efforts and the creation of algorithms to better detect fraud within the claims system.⁴⁰ MFCUs are critical stakeholders in an effective program integrity operation. Communication and collaboration with them should be viewed as a top priority both to strengthen the program integrity system and to ensure that identified fraudulent and abusive actions are properly, effectively adjudicated.

HIGH-RISK SEGMENTS IN MEDICAID

Another opportunity to improve program integrity activities is by targeted review and investigation of providers in high-risk segments of the Medicaid program. Detailed below are issues and opportunities to improve programs in two of the highest-risk segments of Medicaid, home- and community based services (HCBS) and prescription drug programs. There should be a focus on these two segments because they account for a disproportionate share of fraud and abuse, and numerous relevant best practices have been developed and communicated to help states strengthen their programs.

³⁷ For more information, visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/bestpracticespiunitinteractionswithmfcu.pdf> (accessed August 18, 2015).

³⁸ Ibid.

³⁹ The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Oregon.

⁴⁰ MACPAC Public Meeting, November 2011.

Targeted reviews should not be limited to those two segments, however. Other program segments that are high-risk include durable medical equipment providers, mental and behavioral health programs and providers, transportation services, the use of outpatient observational status by health care facilities, long-term care and institutional providers such as nursing homes, and dental programs. Many program integrity issues in those areas were identified in an HHS-OIG investigation that uncovered widespread, high-dollar-value instances of fraud. As an example of high-dollar-value fraud, by 2010, Texas's Medicaid program was spending more on dental braces than the combined spending of the other 49 states, accounting for hundreds of millions of dollars of fraud. Unfortunately, that fraud was not detected by site visits or internal audits, though both practices should be considered best practices for high-risk programs, but by an investigative journalist from the local area. An investigation of the fraud determined that it was a unique combination of increased reimbursement for dental services, a lapse in oversight, and limited staff resources for the review of prior authorization requests for medical necessity.⁴¹ Although that scheme was costly for both the state and federal programs, it was localized to a single state, and therefore it is difficult to pinpoint transferable best practices beyond greater oversight of program dollars and greater attention to the unintended consequences of changes in policy.

Examples of this type of widespread programmatic fraud are unfortunately numerous, and without more robust research and insights into how these types of schemes are developed, few identifiable and replicable best practices exist for prevention beyond the standard ones of better provider enrollment practices, payment and claims analysis, and on-site audits and field visits. Future research will help identify and prevent these types of schemes. Two well-documented areas of the Medicaid program where fraudulent and abusive practices can be identified nationwide, and for which there are clear procedures for prevention and detection, will be reviewed.

Home- and Community-Based Services

HCBS is one of the provider segments at highest risk for fraud, abuse, and wasteful errors. CMS includes spending for home health, personal care services, adult day care, and other specific service types in this category. According to an August 2011 CMS presentation, the PERM identified HCBS errors as 30 percent of all projected errors, which translates into a projected \$2.9 billion, or 24 percent of the total projected dollars in error during the 2008–2009 period.⁴² Beyond payment errors, the GAO noted in its September 2012 report that the number of home health care providers suspected of fraud increased 104 percent from 2005 to 2010, primarily through an increase in cases among home care aides, which tripled over the period. The GAO also found from data it received from 10 state MFCUs that home health care providers accounted for nearly 40 percent of criminal convictions and 45 percent of subjects sentenced in 2010.⁴³ In Virginia, 55 percent of the active caseload in 2011 was estimated to be attributable to home health providers, including both agency and independent providers.⁴⁴

The presented data make clear that HCBS should be a high priority for program integrity activities. As William Early, head of the Ohio MFCU noted in public testimony to the Medicaid and CHIP Payment and Access Commission (MACPAC), “we are more likely to see fraud in those categories of services where there are fewer barriers to entry...virtually anyone can qualify to be an independent home health provider in the State of Ohio, and as a consequence, because of the lack of barriers to entry within the program,

41 U.S. House of Representatives Committee on Oversight and Government Reform, *Uncovering Waste, Fraud, and Abuse in the Medicaid Program* (Washington, DC: April 25, 2012), <http://oversight.house.gov/wp-content/uploads/2012/04/4-25-12-Staff-Report-Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program.pdf> (accessed August 18, 2015).

42 For more information, visit: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/NAMPI_Supp_Metrics.pdf (accessed August 18, 2015).

43 U.S. Government Accountability Office, “Health Care Fraud: Providers Involved in Medicare, Medicaid, and the Children’s Health Insurance Program Cases,” October 2012, p. 33–34, <http://www.gao.gov/products/GAO-12-820> (accessed August 18, 2015).

44 Dr. Early, MACPAC meeting testimony, November 2011, p. 98.

we're seeing more and more fraud in those service categories."⁴⁵ As a result, many states have increased enrollment requirements for HCBS services. For example, both Alaska and Arkansas require that HCBS providers be enrolled as Medicaid providers and that personal care attendants (PCAs) enroll and reenroll as Medicaid providers; Nevada requires all PCAs to be employed through a personal care services entity. Ohio contracts with a provider management agency to ensure that PCAs and home health aides are enrolled in Ohio Medicaid in compliance with state regulations. Vermont also has taken action in this area by requiring unlicensed providers, including home health providers, to reenroll annually (licensed professionals are required to reenroll every two years).⁴⁶

States have begun to take action to reduce the risk of fraud and abuse in HCBS. Their efforts are complicated by the increasing role played by beneficiaries in various fraud schemes (accepting kickbacks for filing fraudulent claims, for example), which circumvents safeguards established by the licensing and provider enrollment processes and makes the fraud more difficult to detect. It should be noted that many independent home health providers and PCAs could simply be overwhelmed by the complexity of the billing and system processes. Program officials should therefore understand that many of these types of providers could be making honest errors, simply because they lack education about the regulatory requirements, as they try to juggle the demands of providing care to beneficiaries. That being the case, it is recommended that states increase their outreach and education programs to those providers, while simultaneously applying stricter penalties to those who have completed training but continue to submit erroneous claims. HCBS is another area where reviewing the administrative complexity of the documentation requirements and streamlining or simplifying the processes should be part of routine program reviews.

Despite the high levels of fraud and abuse, the reality is that HCBS programs are popular with beneficiaries and are a delivery setting in which costs are relatively low, compared with institutional care alternatives. Placing greater restrictions on HCBS providers could force a shift away from them and into higher-cost programs. At the federal level, CMS has observed issues with personal care services and is looking at states that have better practices to address program integrity problems. It plans to showcase that information through the Medicaid Integrity Institute.⁴⁷ Because HCBS programs are a growing segment of the delivery of health care services, attention to their integrity is recommended, and informational communication efforts from agencies such as the Medicaid Integrity Institute should be continually monitored.

Prescription Drugs

Prescription drug purchases are another high-risk area of Medicaid that merits extra attention in program integrity efforts. Some steps to improve program integrity in the area are a matter of identifying state processes and improving the data analysis, algorithms, and edits regarding prescription drug programs. States should review their preferred drug lists and formularies to ensure that prescription drug claims are consistent with state regulations as to the types and brands of drugs that should be prescribed. Further data analysis can focus on "sanity checking" prescription drug claims to ensure that they are appropriate based on age, gender, and medical condition. Algorithms can also be run to crosscheck the claims against clinical guidelines and standards of practice and against other contraindications that may result in the beneficiary receiving drugs from multiple points of care. Those prescription drug edits can and should be completed in both FFS and MCO environments where pharmacy services are carved out.

One of the largest issues in Medicaid fraud and abuse is drug diversion, which is the use of legal drugs for

45 MACPAC Public Meeting transcript, November 2011, p. 89.

46 The Centers for Medicare & Medicaid Services, "State Program Integrity Reviews," <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html> (accessed August 18, 2015). See Alaska, Arkansas, Nevada, Ohio, and Vermont.

47 Brice-Smith, MACPAC Public Meeting transcript, November 2011, p. 98, https://www.macpac.gov/wp-content/uploads/2014/12/MACPAC_2011-11_Transcript.pdf (accessed August 18, 2015).

illegal purposes. Drug diversion can take many forms and can be committed by a multitude of different actors in the health care system. At its simplest, drug diversion can simply be the falsification or forgery of prescriptions. A slightly more complicated diversion scheme involves attempts by drug seekers to scam doctors or pharmacists to obtain drugs for personal use or resale. One method of drug diversion, doctor shopping, involves drug seekers' attempting to obtain multiple prescriptions over a single period by engaging and deceiving multiple providers. A third example is the over-prescription of opioids by pain management clinics. In these clinics, which are often unregulated and at the center of diversion activities, the providers knowingly overprescribe opioids for profit. These clinics are frequented by drug seekers. They are an excellent example of how providers, not just beneficiaries, are engaged in drug diversion activities and demonstrate why program integrity officials should monitor not only the prescribing habits of individuals but providers as well in order to better identify and combat drug diversion in the Medicaid program.

Drug diversion is not just a Medicaid problem but a national one, with the number of deaths related to prescription opioids alone increasing 167 percent from 2002 to 2008.⁴⁸ Beyond the tragic loss of life, diversion dramatically increases health care costs with more doctor visits, emergency department admissions, and rehabilitation center stays and strains mental health resources. An NIH publication estimates that in 2009, prescription and over-the-counter medications contributed to more than 1 million emergency department (ED) visits.⁴⁹ Further study by the Centers for Disease Control (CDC) attributed 306,000 visits to painkillers and 272,000 to benzodiazepines.⁵⁰ With over half a million ED visits attributable to just two drug classes, there exists a clear opportunity to reduce not just fraud and abuse but also the resultant waste in the system by paying greater attention to drug diversion.

In response to this growing problem, CMS issued a letter to state Medicaid directors in January 2012 that outlined some of the key issues in drug diversion and notable actions that states are taking to safeguard their programs against these activities.⁵¹ At the federal level, CMS and the Drug Enforcement Agency (DEA) established a partnership with DEA's Office of Diversion Control to give access to the DEA Controlled Substance Registration File, which is a list of 1.3 million active registrants, including all entities and provider types, that prescribe, administer, procure, and dispense controlled substances. Further information on the use of this file can be found in a December 12, 2010, CMS Advisory Letter to state program integrity directors and at www.deadiversion.usdoj.gov. CMS has, in collaboration with its Education Medicaid Integrity Contractors, developed fact sheets to promote best practices for five therapeutic drug classes that have a high potential for improper payments.⁵² Federal laws were also established in 2007 to prohibit payments for covered outpatient drug prescriptions that are written on pads that are not tamper-resistant. The ACA contains several provisions to aid in oversight of providers and allow for suspended payments and enrollment moratoriums in the presence of suspected fraud.

Several states have taken further initiatives to combat drug diversion. Kentucky, one of the more notable examples, has access to a database of all controlled substance prescriptions filled in the state to help with identification of outliers and reduce the time and cost of investigations. Pennsylvania, with the help of its Drug Utilization Review board, identified anomalies in utilization to refine its prior authorization requirements. The state also developed a preferred drug list that limits the prescribing of physicians to appropriate drugs

48 Former National Drug Intelligence Center, "National Drug Threat Assessment, Number of Reported Unintentional Poisoning Deaths with Mention of Opioid Analgesics—5,547 in 2002"; and National Center for Injury Prevention and Control, "Policy Impact: Prescription Painkiller Overdoses," Centers for Disease Control and Prevention, November 2011, <http://www.cdc.gov/HomeandRecreationalSafety/pdf/PolicyImpact-PrescriptionPainkillerOD.pdf> (accessed August 18, 2015).

49 For more information, visit: <http://www.drugabuse.gov/publications/drugfacts/drug-related-hospital-emergency-room-visits> (accessed August 18, 2015).

50 For more information, visit: <http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf> (accessed August 18, 2015).

51 For more information, visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/drugdiversion.pdf> (accessed August 18, 2015).

52 For more information, visit: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> (accessed August 18, 2015).

in each class, allowing them to decrease per-member per-month costs from \$95.84 to \$76.90 from SFY 2005 to SFY 2007. Florida and Oklahoma have passed legislation that allows for greater monitoring of pain management clinics, previously mentioned as a high-risk provider segment for drug diversion.⁵³ Louisiana's Medicaid agency partnered with mental health rehabilitation staff to conduct a 100 percent review of all mental health rehabilitation providers, which resulted in almost \$65 million in cost avoidance savings, overpayment recoveries netting just over \$585,000, and 14 referrals to the MFCU.⁴⁹

States have also had success with recipient "lock-in" programs for beneficiaries who overuse prescription drugs. Many states have some form of lock-in program; the more successful ones require beneficiaries to obtain prescriptions from a single medical office and a single pharmacy. Iowa estimates that its robust lock-in program saves the state an estimated \$2 million per year in unnecessary costs. Given the depth and breadth of fraud and abuse via drug diversion schemes, implementing some or all of those practices could result in significant savings to state programs. One caveat regarding efforts to combat drug diversion is that states must make sure that the implementation of new policies or procedures is monitored for any unintended consequences. The Arizona inspector general, for example, said that drug diversion efforts focused on eliminating fraudulent and abusive doctors and pharmacists can lead to beneficiaries' seeking drugs from multiple hospital emergency room visits.⁵⁴ Therefore, states should make sure that their interventions are effective from a systemic cost approach, as well, and do not merely divert fraudulent beneficiaries to a higher-cost point of care.

CMS is not the only agency that has emphasized prescription drug issues in regard to Medicaid program integrity. Four of the 11 Medicaid-related unimplemented recommendations from the HHS-OIG have to do with prescription drug policies. One of the recommendations, as of December 2012, is to ensure that states are accurately identifying and collecting rebates on physician-administered drugs.⁵⁵ A June 2011 HHS-OIG report revealed that 36 of the 49 responding states self-reported that they met or exceeded federal requirements to collect rebates for certain physician-administered drugs, but 29 reported difficulties with manufacturer nonpayment of rebates.⁵⁶ The responding states attributed the difficulty to inaccuracies in drug code information that providers entered on claims, which hindered the ability of states to calculate the total rebate. Imposing policies and procedures to obtain the necessary documentation to collect funds that the state is entitled to is another recommended, high-return best practice.

REGULATORY AGENCY INSIGHTS FOR BEST PRACTICES

CMS

CMS is the central resource for policies, procedures, information, and also best practices for program integrity activities. The CPI, which was created in 2010 to bring the Medicaid and Medicare program integrity programs together under one management structure, directs all program integrity activities. This consolidation, along with a further reorganization in February 2011, signals that CMS is interested in establishing better coordination and communication between the two programs.

Now housed within the CPI, the MIG is responsible for implementing the Medicaid Integrity Program (MIP) that was established under the Deficit Reduction Act of 2005. The MIG has two broad duties under the MIP. First, the group is responsible for the oversight of the audit, review, and education of the Medicaid Integrity

53 Center for Program Integrity, "Drug Diversion in the Medicaid Program – State Strategies for Reducing Prescription Drug Diversion in Medicaid," Centers for Medicare & Medicaid Services, January 2012, <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/drugdiversion.pdf> (accessed August 18, 2015).

54 Interview with Arizona Inspector General Glenn Prager.

55 Office of Inspector General, "Compendium of Unimplemented Recommendations," Department of Health and Human Services, December 2012, p. 105, <https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2012.pdf> (accessed August 18, 2015).

56 Office of Inspector General, "States' Collection of Medicaid Rebates for Physician-Administered Drugs," Department of Health and Human Services, June 2011, <https://oig.hhs.gov/oei/reports/oei-03-09-00410.pdf> (accessed August 18, 2015).

Contractors, which review Medicaid provider activities, audit claims, identify overpayments, and educate providers on Medicaid program integrity issues. The second directive of the MIG is to provide support and assistance to states in their efforts to deter and detect fraud and abuse. The activities include the State Program Integrity Reviews (SPIRs), the Medicaid Integrity Institute (MII), and other forms of technical assistance and support for special projects to address program integrity.

In regard to best practices, a beneficial resource in the MIP for states is the MII, an interagency program of CMS and the Department of Justice, located in Columbia, South Carolina. The MII has trained over 4,200 state staff members since 2007. The program of study focuses on topics such as fraud investigation, data mining and analysis, case development, and even new initiatives, as relevant. The courses in FY 2013 by the MII included the Program Integrity Directors Symposium, Emerging Trends in Managed Care Seminar, Emerging Trends in Pharmacy Symposium, International Statistical Classification of Diseases and Related Health Problems (ICD)-10 Basics Boot Camp, Emerging Trends in Home Health and Personal Care Services, and Investigation Data Collaboration: Acquisition, Analysis, and Use.⁵⁷

The MII curriculum is developed by CMS with input from the MII Advisory Committee, consisting of state program administrators, state MFCU directors, subject matter experts, federal and state law enforcement officers, private consultants, and academics. MII courses and training are provided at no cost to the states. It is worth noting that in the March 2012 MACPAC Report to Congress, the state representatives that MACPAC spoke with “indicated that the MII was valuable,” but that several areas could be expanded, including “distance learning to allow state staff to attend courses remotely, the inclusion of more advanced topics, and providing introductory courses for more state staff.”⁵⁸ Generally, these comments indicate that states want more availability and content from the MII.⁵⁹

A second valuable source of best practices in Medicaid program integrity is the SPIRs that are conducted by CMS and are publicly available on the Internet. They are available both in summary form, highlighting noteworthy practices and vulnerabilities from all of the states reviewed in that year, and as individual SPIRs for each state in the year that it was reviewed. The SPIRs were initiated in 2007, and as of FY 2012, 96 reviews have been completed, with 43 states having been reviewed twice. The most recent Annual Summary Report covers the reviews conducted in FY 2012; individual state reviews from FY 2013 are also available online in advance of the annual summary report.⁶⁰ After reviewing all of the noteworthy practices and areas of vulnerability, it can be concluded that many of the specific best practices, including those discussed in conversations with various stakeholders, have been addressed in some format in those reviews. For those looking for a simpler, and searchable, way to review the noteworthy practices of each state, the Pew Center for States created a Medicaid Anti-Fraud and Abuse database that compiles the noteworthy picks from each state review.⁶¹ The database is an excellent time saver to quickly find the noteworthy practices of each state, listed by the Pew-generated categories that are provided. It should be noted, however, that although the Pew database is a valuable time saver, it should be used as a complement to the individual or annual reports provided by CMS because the database does not include the state areas of vulnerability, which are as

57 Center for Program Integrity, “Annual Report to Congress on the Medicaid Integrity Program,” Centers for Medicare & Medicaid Services, 2011, <https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/fy10rtc.pdf> (accessed August 18, 2015); and Center for Program Integrity, “Annual Summary Report of Medicaid Integrity Institute and Related Educational Activities,” Centers for Medicare & Medicaid Services, July 2014, <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mii-annualrpt-fy13.pdf> (accessed August 18, 2015).

58 MACPAC, March 2012, p. 212.

59 Further information regarding the MII, including course listings and descriptions, can be found at <http://www.justice.gov/mii> (accessed August 18, 2015).

60 The Centers for Medicare & Medicaid Services, “State Program Integrity Assessment (SPIA),” <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/SPIA.html> (accessed August 18, 2015); and The Centers for Medicare & Medicaid Services, “Program Integrity Review Reports List,” <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Program-Integrity-Review-Reports-List.html> (accessed August 18, 2015).

61 For more information, visit: <http://www.pewstates.org/research/data-visualizations/medicaid-anti-fraud-and-abuse-practices-85899446210> (accessed August 18, 2015).

beneficial to know as the noteworthy picks. States should be familiar with their reviews, but those that want to generate further best practices should review the practices and vulnerabilities of other states or, at the very least, use the CMS annual reports as a guide to strengths and weaknesses in program integrity activities.

Those seeking information on other initiatives from the MIG, in addition to these two key resources, can find many of them listed in the CPI Annual Report to Congress on the Medicaid Integrity Program.⁶² The report highlights all of the activities and developments that have occurred in the fiscal year and covers the program's efforts in its audit, state support, data analytics, and education initiatives. These reports highlight the most common findings and vulnerabilities identified in the SPIRs; courses and feedback from the MII; a summary of the data gathered from the State Program Integrity Assessments, Special Fraud Investigation Projects, IT and algorithm updates; and communication and collaboration initiatives, as well as health reform updates and new initiatives by the MIG. Although it is not a direct source of best practices, by understanding the path and current direction of CMS initiatives, states can better plot a future course toward improving their program integrity activities.

CMS has also published its own best practices documents on issues such as interactions with MFCUs and disclosure collections in provider enrollment, as well as Federal Policy Guidance Letters on program integrity topics of interest. Another useful resource is the Medicaid Integrity Program Internet-Only Manual, which provides a detailed overview of all aspects of the program, with updates as available.⁶³ There is also a Medicaid Integrity Provider Education Program page that has useful information provided by the Education Medicaid Integrity Contractor, which currently contains best practices to combat overprescribing and overutilization for five therapeutic drug classes.⁶⁴ As with many agencies in today's digital age, the CPI also hosts a blog that contains updates on its efforts, though it currently appears to be updated rather infrequently.⁶⁵ Familiarizing oneself and staff with all of the program integrity materials and resources located on the CMS website should be considered a best practice for all stakeholders, as updated information, analysis, and recommendations from CMS can be useful for all participants in program integrity activities.

HHS-OIG

The OIG within HHS has the stated mission of protecting the integrity of HHS programs and the health and welfare of program beneficiaries. The HHS-OIG uses a nationwide network of audits, investigations, and evaluations to communicate cost-saving or policy recommendations for decision makers and the public. This network also assists in the development of cases for criminal, civil, and administrative enforcement. The HHS-OIG develops and distributes these resources to help the health care industry comply with the nation's fraud and abuse laws and to educate the public about potential fraudulent activity.

The HHS-OIG is a valuable information resource that can help states both evaluate their deficiencies and develop best practices to prevent fraud and abuse. It releases two primary reports that should be of interest to program integrity officials—the *Compendium of Unimplemented Recommendations* and the annual *Medicaid Integrity Report*. These publications help the HHS-OIG to communicate the deficiencies and recommendations that it has discovered in the course of its investigations. Although states are probably well aware of their own deficiencies, looking at those of other states should help officials to review their own policies and procedures and begin a dialogue on how prevent deficiencies in their state.

The HHS-OIG *Compendium of Unimplemented Recommendations* “summarizes significant monetary and

⁶² For more information, visit: <https://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/repcongress.html> (accessed August 18, 2015).

⁶³ For more information, visit: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1238527.html> (accessed August 18, 2015).

⁶⁴ Learn more at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> (accessed August 18, 2015).

⁶⁵ Learn more at: <http://blog.cms.gov/category/cms-center-for-program-integrity/> (accessed August 18, 2015).

nonmonetary recommendations that, when implemented, will result in cost savings and improvements in program efficiency and effectiveness. Implementation generally requires one or more of three types of actions: legislative, regulatory, or administrative.”⁶⁶ Although many of the recommendations are focused on Medicare, public health, and CMS (in other words, the federal level), the report includes Medicaid issues, and its narrative, which often contains monetary savings estimates, makes the recommendations clear, concise, and relatively easy to present to decision makers for implementation. The current compendium, the March 2015 edition, includes Medicaid recommendations in a variety of areas, including upper payment limits, oversight of personal care services, and preventive screening services for children.⁶⁷ These recommendations provide actionable guidance directly from the HHS-OIG to help Medicaid stakeholders improve the integrity of their programs; they should be viewed as a constant source of potentially implementable best practices.

The annual Medicaid Integrity Program Reports and the semiannual Report to Congress are two further sources of best practices and ideas to improve program integrity efforts. In the Medicaid Integrity Program Report, the HHS-OIG highlights significant Medicaid-related reviews and investigations that are included in the HHS-OIG’s Semiannual Report(s) to Congress and its fiscal year work plan. Although the Medicaid Integrity Program Report is an all-inclusive document, it should be noted that both the Semiannual Reports and the work plan are also available on the HHS-OIG website and often have more up-to-date information in their respective sections. As of May 2015, both the 2015 Semiannual Report and 2015 work plan are available.⁶⁸

By law, the HHS-OIG must issue semiannual reports to Congress to keep both the Secretary of HHS and Congress informed of its findings, recommendations, and activities for the previous six months. The reports can be a source of best practices. They highlight areas where HHS-OIG has identified significant fraud and communicate new HHS-OIG initiatives, such as updates to the Health Care Prevention and Enforcement Action Team provider compliance training tools. The HHS-OIG reports to Congress also highlight findings from the Medicare Program Reviews, including legal and investigative activities.

The other primary source of information to review for best practices in program integrity is the HHS-OIG’s annual work plan, which can also be found on the HHS-OIG website. In the work plan, the OIG outlines the areas of investigation, audit, and review that it is continuing and initiating in the coming year. For example, in the 2015 work plan, the HHS-OIG focused on the following:

- Medicaid prescription drug reviews;
- Home health and other community-based services;
- Other Medicaid services, equipment, and supplies;
- State management of Medicaid;
- Medicaid information system controls and security; and
- Medicaid managed care.

The list does not include all of the important issues but provides an excellent platform to help think of new initiatives that could be implemented in a state program. The managed care section of the 2015 Work Plan provides an example of how to best use this resource. The areas of focus in Medicaid managed care, for the HHS-OIG in 2015, include description of new activities in the areas of: state payments to managed

66 For more information about HHS-OIG’s Compendium of Unimplemented Recommendations, visit <https://oig.hhs.gov/reports-and-publications/compendium/index.asp> (accessed August 18, 2015).

67 Office of Inspector General, “OIG Compendium of Unimplemented Recommendations,” U.S. Department of Health and Human Services, March 2015, <https://oig.hhs.gov/reports-and-publications/compendium/files/compendium2015.pdf> (accessed August 18, 2015).

68 To download the 2015 Integrity Program Report and Fiscal Year 2015 HHS OIG Work Plan Mid-Year Update, visit <https://oig.hhs.gov/reports-and-publications/workplan/index.asp#current> and <https://oig.hhs.gov/reports-and-publications/semiannual/index.asp> (accessed August 18, 2015).

care entities; data collection and reporting; program integrity in managed care; and beneficiary protections in managed care. The last topic, for example, details efforts around Medicaid managed care beneficiary grievances and appeals process and oversight of managed care entities' marketing practices. The information provided may be a review for some states, but others may want to review the topics addressed to inform state program direction.

The U.S. Government Accountability Office and the Medicaid and CHIP Payment and Access Commission

The GAO is an independent, nonpartisan agency that works for the Congress and is tasked with the oversight of all federal spending. GAO has identified Medicaid as a high-risk program and given it a significant amount of attention in the last several years, particularly its program integrity issues. Medicaid will continue to be a high-priority area of focus for the GAO, particularly because of the size of the expansion population and the high federal share (100 percent initially and 90 percent subsequently) of spending on this population.

Despite its broad mandate, in its publication "High-Risk Series: An Update," two of the four main topics that GAO highlighted in its "What GAO Found" section deal directly with program integrity. First, it highlighted "improper payments to Medicaid providers serving program beneficiaries," noting that whereas the national improper payment rate listed in the HHS 2012 financial report was 7.1 percent, CMS had "made positive steps toward increasing transparency and reducing improper payments" in recent years.⁶⁹ GAO highlighted the May 2011 CMS guidance to states on removing problem providers and that CMS has committed to redesign the national Medicaid audit program and use its comprehensive state reviews to better target audits toward states with weaknesses in their ability to detect overpayments. Also, with a look to the future, the GAO noted that CMS is in the process of testing the cost-effectiveness and feasibility of creating a system to edit prepayment for Medicaid.⁷⁰ For states, particularly those with high error rates, this means that additional scrutiny will be placed on the system by federal overseers, making the implementation of best practices today a high priority to avoid more oversight in the future.

The second area of high concern for GAO related to program integrity is the managed care rate-setting process and the quality of data used to set those rates. Citing a 2010 report, GAO noted that "CMS had been inconsistent in ensuring that states are complying with the actuarial soundness requirements." GAO also found that CMS efforts were not sufficient to ensure that the data used by states were of high enough quality to ensure that rates were being properly set, potentially placing billions of federal dollars at risk. GAO noted, however, that as of December 2012 "CMS was working on enhancing data systems to improve the oversight of managed care rate-setting." Again, for states this means that increased federal oversight of the managed care rate-setting process could be coming soon. Best practices, such as the data quality requirements implemented in Tennessee, should help states to get in front of this issue and proactively address rate-setting issues before the federal regulators begin to intervene.

Like GAO, MACPAC is a nonpartisan agency that works for the Congress to review state and federal Medicaid and CHIP access and payment policies. MACPAC makes recommendations to Congress, HHS, and the states on a wide range of issues affecting Medicaid and CHIP populations, including health care reform. MACPAC operates similarly to its Medicare counterpart, the Medicare Payment Advisory Commission, in that it issues semiannual reports to Congress, with a handful of public meetings in-between, to analyze and address issues in Medicaid. MACPAC also produces Medicaid statistics (MACStats), which are used in its analyses. They are available to the public and could be used for benchmarking purposes in program integrity oversight. MACPAC has thus far issued four reports to Congress and hosted over a dozen meetings since September

⁶⁹ U.S. Government Accountability Office, "High-Risk Series: An Update," February 14, 2013, <http://www.gao.gov/products/GAO-13-283> (accessed August 18, 2015).

⁷⁰ Ibid.

2010. The MACPAC reports to Congress offer a wealth of information, statistics, and analysis, but because their intended audience is members of Congress and their staffs, none of whom are involved daily in Medicaid policy, the reports tend to be too general for those working in Medicaid programs on a daily basis. For that reason, it is highly recommended that those who are interested also look through the meeting transcripts, as they often contain very insightful discussions among Medicaid experts that can produce fascinating starting points for consideration of best practices.⁷¹

One example, the November 17, 2011, public meeting, has a lengthy discussion of program integrity topics, many of which should be considered when thinking through best practices.⁷² The subject matter experts involved in the discussion, in addition to the commission members and MACPAC senior analyst Caroline Haarmann, included Angel Brice-Smith, director of MIG; William Hazel, Jr., Secretary of Health and Human Resources, Commonwealth of Virginia; and Lloyd Early III, special agent-in-charge, Health Care Fraud Section, Office of the Ohio Attorney General. With federal, state, and enforcement perspectives on program integrity issues, the discussion covered such topics as eligibility determination, MFCU processes and protocols, issues in home health and personal care services, coordination of audits, and data. In his opening statement, Hazel notes that Virginia had a PERM error rate of less than 1 percent, far below the national average. On pages 69 and 70 of the transcript, he gives an excellent overview of some of the procedures and systems that help the state to achieve the below-average error rate:

We do extensive prepayment review with prior authorizations. We have a vendor that does that...We use Claim Check, which is a national software that looks at claims...and then we also have several hundred audits in our own MMIS system...So you do prepayment review and then you do your post-payment data mining.⁷³

In this simple, high-level overview, the process and systems used by a state that has a PERM rate of less than 1 percent are described. Granted, following those three steps will not be the sole determinant of success. Virginia has an in-house staff of around 50 people and uses four national firms to assist with the process.⁷⁴ Also of note, although Virginia is pleased with its process to identify potential overpayments, Hazel has more questions than answers when it comes to managed care issues:

Another area looking forward that we – we are turning more and more towards managed care organizations in Medicaid and less Medicaid fee-for-service, and then question then is: How do you do program integrity through your vendors? The thought is that just because they are capitated doesn't mean that the opportunities for fraud go away. So I think we're challenged, and we're looking for some direction in terms of how to handle that.⁷⁵

The discussion of program integrity issues is over 40 pages long, but as is evident in the overview of Virginia's program, a clear overpayment process is identified as a strength. Even with a PERM rate below 1 percent, the state was still, at the time of the meeting, struggling to understand what best practices should be implemented in dealing with MCOs. Moreover, this is another example of a practitioner cautioning against assuming that capitation eliminates program integrity issues—a common theme.

71 Since the transcripts can be long and often cover a variety of topics, a best practice for reviewing the material is to simply search the transcripts for program integrity-related terms (fraud, abuse, program integrity, etc.).

72 MACPAC Public Meeting Transcript, November 2011, https://www.macpac.gov/wp-content/uploads/2014/12/MACPAC_2011-11_Transcript.pdf (accessed August 18, 2015).

73 MACPAC Public Meeting Transcript, November 2011, p. 69 - 70, https://www.macpac.gov/wp-content/uploads/2014/12/MACPAC_2011-11_Transcript.pdf (accessed August 18, 2015).

74 Ibid.

75 Ibid, p. 73.

MACPAC makes recommendations to Congress, and in the March 2012 report it made four program integrity-specific recommendations to enhance the states' ability to detect and deter fraud and abuse:

- Develop methods for better quantifying the effectiveness of program integrity activities;
- Assess analytic tools for detecting and deterring fraud and abuse and promote the use of the tools that are most effective;
- Improve the dissemination of best practices in program integrity; and
- Enhance program integrity training programs to provide additional courses that address program integrity in managed care.⁷⁶

Understandably, these are general recommendations aimed at Congress to help improve the program. However, some ideas on process improvement can be gleaned and reframed for state use. First, state officials should consider developing better ways to estimate the return on their investment in program integrity. A second takeaway for states is that they should assess analytic tools. Because of the high capital costs of analytic tools and systems, states often feel committed to one system, contractor, or general course of action with information technology systems once a decision has been made. States intending to install, upgrade, replace, or simply improve their analytic tools should reach out to their colleagues in other states to see what systems and processes work best. Those discussions can be as broad as determining what vendors to use for certain processes or as detailed as a new algorithm or audit that can be used in existing systems with greater success.

Lastly, both the dissemination of best practices and the enhancement of program integrity training are underway but could certainly be improved further. In terms of best practice dissemination, the goal is that this compendium will provide some helpful best practices and ideas for how to internally generate best practices, as new research and information become available from the sources we have discussed here. When it comes to learning, the MII is still the best source of information, but there are many, many sources of information that can make any program better. A recommended best practice is to make sure that program integrity teams create a program that is constantly learning and evolving, whether through stakeholder meetings or internal programs. For example, program integrity staff could use the format of a book-of-the-month club, where one individual researches a program integrity topic or reviews the literature on program integrity from a single source and presents the findings to the entire staff. The same concept could also be applied to the multitude of conferences and organizational meetings that cover program integrity issues. Again, these are just some ideas to jump-start the process, but the best practice here is clearly to institute a culture of learning among program integrity staff in order to ensure that methods and processes do not become outdated. Those committing fraud are constantly seeking new ways to manipulate the system. Constant organizational learning is necessary to keep up with those whom we seek to stop.

Congressional Activity

Congress and its various committees have taken an interest in program integrity for reasons similar to those that caused the GAO to focus on it. Although several agencies are concerned with Medicaid program integrity, committees in both the House and Senate have undertaken public hearings to help members better understand the programs and their efficacy. Committees whose jurisdictions extend to Medicaid include the Senate Committee on Finance, the House Energy and Commerce Committee, the House Committee on Ways and Means, and the House Committee on Oversight and Government Reform.

Many committees produce reports that summarize their findings on particular issues. Various third-party services can also provide valuable content when time is more valuable than marginal cost. Inasmuch as all

⁷⁶ MACPAC, Report to Congress on Medicaid and CHIP, March 2012, p.7, https://www.macpac.gov/wp-content/uploads/2015/01/2012-03-15_MACPAC_Report1.pdf (accessed August 18, 2015).

of the information is publicly available, however, a Google search or simply a check of committee websites may be all that is necessary. For example, the Senate Committee on Finance produced the insightful report *Opportunities to Curb Waste, Fraud, and Abuse in Medicare and Medicaid: An Overview of White Papers Submitted at the Request of the United States Senate Finance Committee*.⁷⁷

Released in January 2013, the overview is a summary and analysis of white papers submitted to the committee by stakeholders in the health care community after an April 2012 hearing with CMS and HHS-OIG officials. The committee received 146 white papers, totaling over 2,000 pages, from various parties offering recommendations on improving Medicare and Medicaid program integrity efforts. Of the papers, 92 dealt with both Medicaid and Medicare; only six dealt strictly with Medicaid. Also of note, 83 percent of the papers discussing audit burden were submitted by providers and suppliers, and 58 percent of the papers discussing data management were submitted by contractors—highlighting where some of the major concerns of particular stakeholders lie.

The Senate Finance Committee identified five broad themes from these papers: improper payments, beneficiary protection, audit burden, data management, and enforcement. The improper payment theme was discussed in over half of the white papers, which focused on many issues similar to those we have described in this section. Common subjects included the use of analytics for prepayment review to avoid “pay and chase”; prior authorization requirements for high-cost items where the potential for fraud is great; clarifying policies to prevent errors that can be mistaken for fraud; and legislative or policy reforms that would address outpatient status issues, allow payments to be withheld when fraud is suspected, require that the lowest-cost drug be used, and create a “noncompliance threshold” above which payment could be withheld from consistently noncompliant providers.

The second-most-cited theme was audit burden, which includes all aspects of the audit process, including contractor oversight. Audit burden concerns included the number of entities involved, the volume and complexity of payment rules and regulations, the consistency of payment rules, difficulties communicating with auditors during the process, and the financial burden on businesses of documentation requirements and payment suspensions.

The next-most-cited theme was beneficiary protection, which includes issues that affect the quality of care delivered, financial protection of the beneficiaries or patients, and their satisfaction with care. Common topics in this regard included the use of “outpatient observation status”; concerns over application of the Stark law exception, leading to overutilization of physician in-office ancillary services; and provider and patient frustration with payer documentation requirements, which could lead to ruling out certain courses of treatment or care.

The fourth-most-cited theme was data management, including data quality and systems, data sharing, and data protection. Common topics included improving data quality and systems to match medical and identification information to the correct person, verify patient identity, and validate each transaction in real time to prevent doctor shopping and drug diversion and allow for prepayment verifications. In regard to data sharing, the stakeholders suggested enhanced access to and sharing of information among agencies, removing legal barriers to such sharing, and allowing the use of state board data to identify physicians who are committing fraud. Further suggestions focused on protecting sensitive data by removing Social Security numbers from Medicare cards, safeguarding national identifier numbers for insurance companies, and creating unique identifiers for providers and beneficiaries.

77 For more information, visit: <http://www.finance.senate.gov/newsroom/chairman/release/?id=4e573856-e65f-49f5-ab73-1cb6bde47cc9> (accessed August 18, 2015).

The final theme that the Senate committee report summarized was enforcement, particularly enforcement tools not covered under the subject of audit burden. Common topics in this section included partnership between CMS and the Federal Trade Commission to better monitor advertising; increasing access by law enforcement to Medicare claims data and providing “evidence packages” to enforcement personnel containing the information needed to prosecute; distinguishing fraud from honest mistakes; and further enforcement of current laws such as the Stark law.

The committee’s overview also noted that 94 percent of the white papers submitted included recommendations, ranging from broad general commentary to very specific, narrowly focused potential improvements. Five of those recommendations could be particularly helpful in thinking about best practices in Medicaid program integrity:

- Ensuring that provider enrollment policies are consistent and are applied effectively;
- Using existing statutory authorities (for example, moratoriums and mandatory compliance programs) that are underutilized;
- Clarifying the circumstances in which particular uses of care and settings for care are appropriate, such as inpatient versus outpatient;
- Balancing incentives for contractors to identify overpayments with penalties for findings that are overturned on appeal through the CMS administrative process; and
- Creating an advisory panel to provide clinical input, as a component of contractor oversight.

Not all of these issues and ideas focus directly on Medicaid program integrity best practices. However, dozens of ideas for best practices can come from this type of aggregated information. In a span of just nine pages are more than a dozen best practices or considerations for Medicaid program integrity improvement.

CONCLUSION

This section addresses many of the common issues, opportunities, and vulnerabilities within the Medicaid program integrity system. Program integrity, by definition, includes oversight of all aspects of Medicaid to ensure that state and federal dollars are being appropriately spent. It thus is a vast and complex system comprising a variety of agencies, actors, and stakeholders. Further, given that each state has its own unique, individual program with its own policies, procedures, scale, and available resources, it is not possible simply to compile a list of best practices that could be implemented in every program. The section therefore focused on key processes in the system in an effort to identify the policies and procedures that are effective and applicable to a majority of programs. More important is the emphasis on the types of communication, collaboration, and resources that not only are best practices today but also have potential to generate best practices in the future.

One of the greatest limitations in conducting this review was the lack of published research and resources to further the goal of program improvement. Several key areas need greater attention and more research by both government agencies and outside actors. These areas for further investigation are mentioned here to encourage continued dialogue about improvements.

Areas of Interest for Improved Program Integrity

With the wave of change brought about by health care reform initiatives, better insight and more clarity concerning program integrity are needed. Some more immediate steps could also greatly benefit state program integrity programs.

Every stakeholder and agency has at one point or another brought up concerns about the availability and accuracy of data to combat fraud, waste, and abuse. Currently, a hodgepodge of datasets exists, including MMIS, the Medicaid Statistical Information System, the Medicare-Medicaid Data Match Program, and One Program Integrity, to name a few. Currently for states, the most accurate and useful are their own MMIS data. Despite repeated efforts by states and CMS to compile better data for program integrity analysis, the results to date have not been sufficient.

One specific area that could be improved relatively easily is provider exclusion lists. Some states currently publish their lists of excluded providers online and share them with neighboring states. A national database of providers excluded from the Medicaid program that could be accessed by program integrity officials in every state would clearly help to keep fraudulent providers out of the system and prevent them from simply moving from state to state to avoid exclusion. Because the states own the data, there is little to deter them from sharing the information with their colleagues nationwide.

Slightly more complex would be to fully merge the Medicaid exclusion list with the Medicare exclusion list. Technical and resource limitations aside, there is in theory little reason why a secure server, accessible only by authorized program integrity officials, cannot contain both Medicare and Medicaid data. Even today, some states are cross-checking their provider lists against Medicare exclusion lists. Merging these two resources would greatly increase transparency and administrative efficiency.

The ideal database would integrate these lists with those of other state and national databases, particularly those of law enforcement. The HHS-OIG and the state MFCUs keep active lists of their investigations, prosecutions, and convictions. The project of integrating the lists would clearly have to negotiate some technical and monetary hurdles, but again, one can envision a database in which a provider convicted of fraudulent activity is automatically flagged in every state Medicaid program for exclusion.

Creating such an exclusion database would require coordination and cooperation among the various entities involved in program integrity activities, but the resultant gains in efficiency would be astounding. In almost every aspect of program integrity reviewed, the best practices mentioned included some form of greater coordination or more streamlined processes. In an ideal world, state agencies, MFCUs, MCOs, inspectors general (both state and federal), and compliant providers would work together to eliminate fraud, waste, and abuse from the system. In reality, in different parts of the system, many of these agencies have both investigated each other in some way. For example, the HHS-OIG has prosecuted state Medicaid agencies for fraudulent rate-setting processes. Despite the sometimes adversarial roles of the various agencies, when the groups collaborate, sharing information and insights, it yields strong gains for program integrity activities. The best practice of establishing program integrity work groups or regular meetings is a step in the right direction.

If the best ideas, insights, and practices that originate in these state-by-state work groups were widely disseminated and communicated to colleagues in other states, their ability to troubleshoot problems and put best practice insights to work would elevate the knowledge of the entire system. The MII is a start down this path, and CMS should be credited with increasing knowledge about and application of best practices, as well as vulnerabilities. Allowing program integrity officials to advance their knowledge in these areas at no cost to the state is an important step forward in communicating process and technical improvements. The creation of webinars or other online information platforms would also help to disseminate this valuable information to a wider audience.

As mentioned earlier, no standard program integrity plan applies to all states. This section has provided a

variety of tools and best practices that states can consider in risk assessment and plan development. It also identifies sources where states can obtain a wealth of detail not provided in this chapter. These tools, best practices, and resources should by no means be considered a comprehensive guide. Just as state programs are in different phases of their evolution, program integrity activities will continue to evolve to become more effective and efficient at detecting and deterring fraud, waste, and abuse.

As health care is constantly changing, so should states' program activity plans. Cooperation, sharing, and communication among the states and government agencies are important to the continued improvement and evolution of program integrity. It is in everyone's best interest to have an efficient and effective program. The best practice that will not become outmoded is to create a program activity ecosystem that is constantly learning. That will require continuous evaluation of the vulnerabilities and opportunities of each program, as well as the communication of strengths and weaknesses to all of those involved in preventing fraud, waste, and abuse in the Medicaid program.

Data Analysis and Reporting

SECTION VII

Section VII

ROADMAP

Read this section to learn about key strategies for collecting, analyzing, and reporting a variety of data sources to achieve Medicaid program goals.

OVERVIEW

Data collection, analysis, and reporting are essential tools for evaluating and refining Medicaid population health and purchasing strategies to ensure the delivery of high-quality and cost-effective care. States should think creatively about data assets and how to share data strategically to identify and address areas that may benefit from increased care management or cost efficiency.

FUNDAMENTALS

This section addresses the following topics related to performing and using data analyses:

- Data collection;
- Procurement considerations;
- Reconciliation and evaluation;
- Program design;
- Rate setting;
- Incentives; and
- Informing bidders.

ADVANCED

This section addresses the following topics that can help state decision-makers develop and refine strategies for collecting, analyzing, and reporting data:

- Data sources, including eligibility data, claims data, Healthcare Effectiveness Data and Information Set, Consumer Assessment of Healthcare Providers and Systems, encounter data, and electronic health records;
- Methods of analysis, including comparative analysis, predictive modeling, and dashboards; and
- Aligning data and solutions.

Section VII. Data Analysis and Reporting

By The Lewin Group

OVERVIEW

Data collection, analysis, and reporting are instrumental components of Medicaid program evaluation and improvement. State Medicaid agencies use data to assess program benefit design; support health care purchasing; and assess the appropriateness, quality, and value of care being provided to beneficiaries. A variety of data analytics and modeling techniques can also assist the state with improving the program by identifying areas that may benefit from increased care coordination or cost efficiency. Thus, data integration and analytics have the potential to inform policy and program design on a fundamental level, allowing states to achieve the Triple Aim goals of improving population health, improving individual health experience, and reducing per capita cost of care.

FUNDAMENTALS

DATA COLLECTION

Before performing any analysis, relevant data must be collected and stored in a medium accessible by analysts. That requires the state Medicaid agency to have an infrastructure such as a data warehouse, or other data storage unit, for fee-for-service (FFS) claims data, managed care encounter data, member eligibility data, program and provider data, and clinical data from electronic health records (EHRs).

The strategic decisions surrounding the type of data required to support the desired analyses and the resources needed to conduct the analysis are critical and should be considered carefully as part of the data collection phase. The current level of state delivery system and purchasing innovations, as well as rapidly expanding access to data previously unavailable (for example, all-payer claims databases and clinical data from EHRs), requires a strategic approach that may include a phased strategy as new data become available at a volume and level of quality that create new data analysis options. States find themselves in a period of rapidly expanding opportunities for using data and analytics to achieve meaningful program transformation but can face an overload of data and information needs coupled with a lack of usable information and scant analytic resources to transform the data into meaningful information. Many states are designing and implementing significant delivery and payment system innovations; a key strategic component of these transformation efforts is early identification of the data elements and types of analytics necessary to support operations and measure outcomes of these innovations. As Medicaid agencies assess their needs, goals, and what they intend to accomplish for their Medicaid beneficiaries, it is important to coordinate and align data strategies across state agencies, including those responsible for long-term care services and behavioral health, as well as the state's department of insurance and department of health.

Innovative data and analytic approaches – turned into actionable information – are increasingly necessary to support a wide variety of state activities, such as value-based purchasing, consumer engagement, population health analytics, rapid cycle program evaluation, and program integrity. In addition, the increasing need for data transparency to help inform health care decisions necessitates that states anticipate a wider variety of internal and external audiences, including state leadership, beneficiaries, providers, health plans, and accountable care organizations (ACOs).

The following are foundational considerations for states in assessing analytic capabilities and data needs:

Infrastructure

Key considerations for states include how best to house the data. This can be a complex issue. Critical issues include: what data are currently available and what viable sources are emerging (such as EHR data, outcome

measures, and all-payer claims data); where is the data currently housed (for example, are there multiple data warehouses already housing various data components?); and how does the Medicaid agency access the data? These issues all require careful review of the state's specific data needs, particularly as they relate to new delivery and payment structures, its budget, and its existing infrastructure. An additional consideration is the required expertise and training of state staff to maintain, access, and analyze the data. Traditionally, Medicaid agencies have chosen among the following three options to provide infrastructure for Medicaid data.

- Outsource to external Medicaid Management Information Systems vendor. The Medicaid Management Information Systems (MMIS) is often the source of all Medicaid data activity for claims adjudication. The MMIS comprises state-submitted eligibility and claims data on the state's Medicaid population, which include data on use, payment, and population characteristics. MMIS functionality is memory-intensive and has high cycle capability to process FFS claims per payment cycle. Managed care claims are processed and paid by managed care entities and encounters are then sent to states by managed care entities. In addition, while the state is a receiver of FFS data and generates its own reports for the Centers for Medicare & Medicaid Services (CMS) reporting requirements or internal state use, under managed care the state becomes more of a receiver of reports from Medicaid contracted health plans rather than a generator. Thus, the state should carefully consider both reporting elements and definitional consistency across plans at the time of procurement when such reports are specified. Analytics related to MMIS tend to be based more on operations and performance, such as tracking error rates or claims appeals.
- Outsource to external data warehouse vendor. The focus of the data warehouse is not to process claims. Data warehouse vendors are used to efficiently aggregate, standardize, validate, and store data for data queries, reporting, and future analysis. Data warehouses can also be used to validate MMIS payments. The different goals of the MMIS and data warehouse dictate very different hardware and process specifications. As a result, most states use two different vendor contracts for their MMIS and data warehouse systems. Some states have contracted for a data warehouse within their MMIS, but this is less common. Data warehouse analytics generally do not focus on operational performance. Data warehouse files, enriched with risk adjustments and other factors, form the basis for population health analytics, program evaluation and financial reporting, utilization analysis, per-member per-month (PMPM) cost analyses, and a number of additional broad-based analysis and evaluation.
- Build internally. Over the years, a small number of states have chosen to internally build or take over their MMIS, data warehouse, or both. This option requires strong in-house expertise and the hardware to store the data and provide access to analysts.

The above three options all assume that an eligibility system already exists that identifies members or beneficiaries. Also assumed is a Medicaid provider file with unique provider identifiers. This is important to note as states consider and evaluate more multi-payer data collection options. State Medicaid agencies must also now consider less traditional data collection and data analysis opportunities.

- Many states have created or are in the process of implementing All-Payer Claims Databases (APCDs). As states develop APCDs, they need to evaluate options for leveraging existing systems as well as opportunities to minimize replication of data. As states use APCDs, there is increased complexity associated with data aggregation and standardization. In addition, there is no longer a single member identifier and increased variation in provider identification across payers. Member and provider identification becomes critical, resulting in the need to create a master member file and a master provider file. APCDs are discussed further in the "Advanced" analytics discussion later in this section.

- Data from Health Benefit Exchanges must also be considered in states where a portion of the Medicaid population has received health care coverage via the exchange. How this information is consolidated or accessed for analytics by both the exchanges and Medicaid is an important consideration.
- While a small number of states already operate Enterprise Data Warehouses (EDWs) that cross state agencies, an increasing number of states are considering EDWs that aggregate data across agencies, including corrections, judicial, state exchange, and educational systems.
- Given the number and variety of new payment and care delivery models, infrastructure needs to support these new systems in a cost-effective manner. Multi-payer systems may focus more on aggregating, validating, and enriching claims and clinical data from multiple payers. Conversely, states undergoing Medicaid expansions in full-risk managed care or through ACOs, bundled payment, and other shared savings vehicles need to consider the infrastructure to support these systems and any remaining FFS programs.

Analytic Capability

States need analytical resources that support both the underlying data and the state's programs and policies. Agencies will need to assess the skills of their current staff and determine whether additional expertise is needed to meet its goals for data storage, analysis, and reporting. Again, there are multiple options for the agency to consider, including:

- Develop internal analytical staff. This requires that staff (program, policy, and financial) develop the skills to access and mine the data in an efficient manner.
- Outsource to a contractor. Outsourcing data operations entails giving contractors or consultants access to the data to provide analytics for the state. A small number of states also have developed relationships with state universities to provide analytical support that takes advantage of outside expertise but keeps funding for analytics within state government.
- Hybrid approach. States are increasingly leveraging both internal and outsourced analytic capabilities. For states choosing this approach, procurements for data vendors should address the state's access to data, software, technical support, and staff training that the vendor will need to provide.

PROCUREMENT CONSIDERATIONS

Cost, expertise, capacity, support capabilities, and security are essential to consider as state Medicaid agencies debate whether to rely on internal infrastructure and staff or to outsource.

Cost

Cost-effectiveness is a dominant element of the procurement decision. Innovations in delivery and payment system design, including multi-payer initiatives, an increasing population health-focus (social determinants of health), and increasingly available clinical information and other quality outcome measures have added to the complexity of evaluating cost-effectiveness. What data are available, where the data are currently housed, legal access considerations, and the need for human and information technology resources to retrieve, aggregate, manage, and analyze the data need to be considered. For example, Medicaid programs need to compare the cost of hiring contractors with the cost of training existing staff to perform new functions. State Medicaid agencies might also examine the short- and long-term expense projections for developing a more advanced internal data system versus hiring an external vendor. Considerations include accounting for fixed costs associated with either strategy (such as acquiring hardware and software to increase the capacity and function of an existing system if developing an in-house system), as well as the variable costs to maintain sufficient analytical support and upgrade systems in a timely manner. Maintaining in-house data capabilities and analytical support requires sufficient internal technical expertise.

Analytics Expertise

Analytics expertise should be defined broadly to include knowledge of the underlying data (aggregation and data validation, as well as risk adjustments and other data enrichment), expertise in evaluating multiple types of data (administrative, clinical, and multi-payer), and ability to support a variety of analytics targeted at various audiences on a timely basis (legislative requests, CMS reporting, and shared-savings calculations for value-based purchasing).

If the state is considering a hybrid model where substantial data analytics will be conducted by both state staff and other vendors, it is critical that the procurement design clearly specify the state's access to data (frequency of updates; access to software licenses, including number and type; and level of technical support and training).

System Capacity

Adequate system resources are needed to house data that will be used to perform the analyses. Typically, the type and size of resources depend on the volume and purpose of the data. If the agency is outsourcing data storage, it should be verified that the data warehouse vendor has the capacity to house the abundance of data from the MMIS and other agencies (for example, via an EDW).

Transactional data should be housed by the fiscal agent. Medicaid agencies should determine whether the fiscal agent is able to provide an accessible data warehouse to include the transactional data. As noted earlier, Medicaid agencies have contracted separately for MMIS and data warehouse services because of the different goals of each and hardware and process needs.

Support Capabilities

Whether the data are stored internally or maintained by a third-party vendor, the state agency should ensure that technical and user support is available.

Privacy and Security

Analytic systems need to be regularly evaluated to ensure that the privacy of beneficiary data is protected. Physical security systems, network, and connections as well as procedures and staff training on information security techniques need to be part of every analytics system. Should the system also produce de-identified or encrypted data files for transport, separate procedures need to be established to maintain the confidentiality of data at all times. Many database software systems now offer the ability to encrypt data in transport.

RECONCILIATION AND EVALUATION

To ensure that appropriate data are being reported and analyzed, regular reviews of data collection and analytical procedures are recommended to reassess data needs and support capabilities. The results of data analyses should always support the specific goals of the agency to improve the program for Medicaid beneficiaries. Superfluous data reporting can be burdensome and costly and detract attention from the key information that the agency seeks to convey. Ideally, data collection would be performed with the desired outcome measures in sight, but that may be challenging for states, particularly if a state has not had abundant experience facilitating certain programs. This is especially critical during stages of rapid innovation. Contracts with managed care entities, ACOs, providers, and other vendors should include requirements for submission of data or metrics necessary for ongoing program operations, policy and financial analysis, and evaluation activities. Many states have ongoing workgroups with stakeholders during the design of new delivery and payment systems. These workgroups can be a vehicle for gathering input, establishing meaningful goals, and clearly identifying the data required to measure achievement of these goals. Early and open discussion of the outcome metrics also can help focus the goals of large-scale initiatives. States should consider how

outcome measures will be leveraged, using a mix of risk-adjusted state Medicaid data, state-specific all-payer information, and national metrics.

Additionally, the agency should determine the appropriate timing for reporting and assign priority to the data and analyses most important to operating the program. The necessity of accurate timing underscores the sensitivity of data reporting. Medicaid agencies are responsible for the continuous improvement of the program, and that can be achieved most effectively by strategically using data to evaluate the evolving needs of the Medicaid population.

Data analysis and reporting will likely require an iterative process. Over time, data collection and how the data are reported should be evaluated to assess ongoing or emerging data gaps as well as determine what data are required to meet the needs of an ever-changing program. For example, Medicaid agencies are increasingly using data visualization and geomapping to highlight regional variations in key outcome and performance measures for senior state policymakers. At the same, detailed analytics based on population, individual services, and clinical information are becoming more commonplace in supporting care coordination activities.

PROGRAM DESIGN

Data analytics can be used in a variety of ways to support value-based purchasing and integrated care delivery models. For example:

- Analytic models are used to assess the potential effects of altering benefit designs and transitioning certain benefits to managed care, accountable care organizations, and other shared-savings contracting arrangements directly with providers.
- Geomapping can help identify where to locate new pilot programs, how to structure a rollout for integrated primary care-behavioral health providers, or to identify need for increased care coordination activities.
- Predictive modeling is increasingly being used to help inform program design, from care coordination to provider workforce needs.
- Outcomes measures can be used to inform value-based purchasing procurement design.
- Analytic models have the potential to inform decisions related to Medicaid program operations. See [Section III](#), “Provider Network Development and Management and Delivery System Transformation in State Medicaid Programs,” for further discussion of data analysis and reporting.

Examples of how data analyses can drive decisions regarding components of Medicaid programs design are described below.

Specific Benefits

Because pharmacy rebates can now be collected by the state through managed care arrangements, as authorized by the Affordable Care Act (ACA), states that previously carved out the pharmacy benefit from managed care may choose to include it to facilitate more comprehensive management of the benefit by managed care organizations (MCOs) or pharmacy benefit managers (PBMs).

Data analysis of the state’s Medicaid population’s current pharmacy use and cost can be used to determine the feasibility and potential benefit of carving in pharmacy benefits. For example, agencies in states with FFS programs can use analytics to compare beneficiaries’ use of generics with the use of generics in managed care pharmacy programs to determine if there is potential for improvement. Medicaid agencies also could

compare current dispensing fees under a FFS arrangement with managed care dispensing fees in other states to determine potential savings, if any. To verify that an MCO or PBM has a suitable network, agencies can use analytics to determine geographic patterns of drug use and model the effect of adjusting the network or adopting alternative networks.

Populations

States currently carve certain populations or services out of their Medicaid programs; however, in recent years, states are increasingly contracting with MCOs or shared-savings ACOs for services or populations that historically have been FFS. Analytics will play a key role in providing states with information about the success of these new programs in achieving Triple Aim goals. Data analytics can also be used to identify any potential challenges for expansion of managed care (for example, network adequacy) that could affect expansion decisions or inform contracting performance requirements with MCOs.

Effects of Federal Requirements

Data can be analyzed to determine the effects of key federal requirements. For example, the financial effect of a required change in payments to primary care providers could be estimated. In 2013 and 2014, states were required to ensure that payments for primary care services rendered by specific providers were at least equal to the Medicare fee schedule amount. This requirement resulted in an increase in payments in all but two states. The federal government provided 100 percent match for the difference between the Medicare payment rate and the 2009 Medicaid rate. States can use claims data to monitor any potential effect on access as payment rates change or to conduct analyses to evaluate the effect of continuing increased payments without the enhanced match.

RATE SETTING

Managed Care

Accurate analysis of MCO cost and use data is critical to setting actuarially sound capitation rates. Often rates are developed so that, in aggregate, the state can capture a percentage discount from what it would have paid for the same services under a FFS arrangement.

Encounter data sent by MCOs can be used as the base dollar amount from which to develop rates. Before using those data, however, the completeness should be assessed. Encounter data also can be used to model specific adjustments to a financial base rate, such as those necessary when changes in programs or costs occur.

Financial data contained in financial reports produced by MCOs also can be used as the base dollar amount from which to develop rates. Those data, however, are not as detailed as encounter data; audited financial statements can serve as a critical verification source of information. In addition, MCOs may divide their costs among functions in different ways, thus complicating the potential development of a standardized state strategy for using these data across plans.

Capitation rates are generally calculated separately for each service area, service category, age range, and gender. For example, in Florida, managed care rate-setting methodology generally consists of the following steps:¹

1. Establish age and gender bands for each eligibility category;
2. Calculate statewide age and gender factors by age and gender band and eligibility category;
3. Compute FFS costs by eligibility category and service area for the upcoming year;

¹ The Florida Senate Committee on Health Regulation, "Medicaid Managed Care Rate-Setting," November 2010. <http://www.flsenate.gov/Committees/InterimReports/2011/2011-226hr.pdf> (accessed August 21, 2015).

4. Adjust costs for incurred but not reported claims, third-party liability recoveries, and trend factors;
5. Apply statewide age and gender factors from step 2 to projected FFS costs by service and area from steps 3 and 4 to calculate FFS equivalent (FFSE) estimates for the upcoming contract year, by age and gender band, eligibility category, and service area; and
6. Apply managed care discounts to the FFSE estimates to compute capitation rates by age and gender eligibility and service area.

See [Section V](#), “Financial Models: Rate Setting, Risk Adjustment, and Performance Indicators,” for an in-depth overview of capitation rate setting, including actuarial requirements for capitation rates.

Fee-For-Service

Medicaid FFS claims data are often used to develop Medicaid fee schedule rates for both professional and institutional providers. The advantage of using Medicaid FFS claims to set provider payment rates is that the information is based on the population that is being treated and thus has used the services being priced. However, because rates are required for many types of visits and procedures, there are often too few claims in some categories to develop accurate provider payment rates.

An alternative to using Medicaid claims to set payment rates is to piggyback on Medicare fee schedule rates and the prospective payment rates set for institutions. Medicare payment rates have been developed over many years using various data sources and methodologies. For example, the Medicare physician fee schedule was originally developed using measures of physician work and practice expense for one visit relative to an index procedure. Others, such as the relative payment weights for diagnosis related groups (DRGs) based on inpatient prospective payment systems, are constructed from claims data for inpatient hospital claims paid by Medicare. Using Medicare as a basis for the rates paid to Medicaid providers provides a complete set of reimbursement rates that include almost all procedures, visits, and services. However, Medicare payment levels may be different from what the state has budgeted for services provided under the Medicaid program. Historical Medicaid FFS volumes from claims data for each service can be used to adjust the payment rates to be budget neutral to expected Medicaid provider reimbursements.

Some specific services and illnesses—such as low birth weights, many pediatric illnesses, high-risk pregnancies, HIV, and serious psychiatric comorbidities—are common among Medicaid patients but are typically rare in the Medicare population. In these instances, Medicare payment rates for those services can be supplemented with Medicaid claims or all-payer claims data to provide a more accurate account of the provider resources used for those services.

INCENTIVES

Pay for Performance

Several states with Medicaid managed care programs have developed pay-for-performance programs to reward MCOs for delivering high-quality care. Such programs rely on quality measures calculated from encounter data to determine how to identify MCOs eligible for reward payments. States structure these outcome-based payments a variety of ways. One structure is to include a “withhold” in the capitation payment to plans; the plans then receive the withhold amount based on their achievement of pre-established outcome metrics.

States choose quality measures that determine the focus of the pay-for-performance initiative. The selected measures often target special populations and high-cost and high-prevalence conditions. States then determine whether the MCOs have met the requirements—either achieving a specified benchmark or

demonstrating adequate improvement on the selected quality measures—to receive the financial incentive. Colorado, for example, has had numerous pay-for-performance programs across the health care delivery spectrum, from patient-centered medical homes to nursing facilities to hospital quality incentive payments. These have been implemented at the program and network level.

Provider Profiling

Provider profiling is the practice of evaluating physicians based on quality measures. It is often used to compare providers to their peers and determine those that are delivering high-value care. States with a Medicaid managed care program can use provider profiling to reward primary care physicians who deliver high-quality, cost-effective care.² The state will determine which providers should receive a reward by evaluating performance on selected quality measures. For instance, an initiative could reward primary care physician practices that reduce the percentage of their asthma patients who use emergency services.

Shared Savings

Shared-savings programs are payment arrangements that provide incentives to care groups to reduce health care costs against an agreed-to baseline by sharing a portion of the savings realized with the care entity.³ Such initiatives can focus on overall spending or on specific services or sets of services. Programs also can emphasize a specific population, such as individuals with several chronic conditions. A shared-savings strategy relies on analysis of claims and utilization data to determine the amount by which the care group reduced health care expenditures. States with Medicaid managed care programs or ACOs can implement shared-savings arrangements to promote a reduction in health care costs.

FFS claims data or encounter data can be used to assign patients to particular providers within a shared-savings arrangement. Those data also can be used, along with various risk-adjustment products, to develop benchmark spending projections for the panel of patients assigned to the shared-savings providers, for which savings or overruns can be calculated.

INFORMING BIDDERS

To assist in the bidding process, states can share data with MCOs when procuring new managed care vendors or reprocurring managed care contracts. The data should include cost and utilization information to allow the vendor to determine the feasibility of its participation and its potential pricing. However, states can determine the level of data that they want to make available to the vendors. For instance, a state can provide summarized data (for example, at a geographic or program level) or detailed claims data. If states want to give access to detailed data, they must ensure that all protected health information is redacted.

ADVANCED

This section addresses the following key considerations to help states devise and refine data collection, analysis, and reporting strategies:

- Data sources;
- Methods of analysis; and
- Aligning data and solutions.

For each of these issues, detail about the underlying components and considerations for using data analytics for program support is provided.

² Optum, "Provider Profiling Services," <https://www.optum.com/government/state/analytics-hit/population-analytics/consulting/provider-profiling-services.html> (accessed August 21, 2015).

³ The Commonwealth Fund, "Key Design Elements of Shared Savings Payment Arrangements," August 2011, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/Aug/1539_Bailit_key_design_elements_sharedsavings_ib_v2.pdf (accessed August 21, 2015).

DATA SOURCES

The primary sources of statistical data on Medicaid include the Medicaid Statistical Information System (MSIS), the Medicaid Analytic eXtract (MAX) files, and the Centers for Medicare & Medicaid Services (CMS)-64 reports. MSIS includes state-submitted eligibility and claims data on the state's Medicaid population, containing data on utilization, payment, and population characteristics. The MAX files, also known as the State Medicaid Research Files, were developed to support research and policy analysis. The files contain person-level data on eligibility, utilization, and payment and are extracted from MSIS data. Several research products, including a state-level statistical compendium and a chart book of Medicaid pharmacy features, benefit use, and reimbursement, were developed from 1999 data. Most of these detailed types of files have a significant lag period (up to several years) and, although standardized, still contain some significant gaps in data.

CMS-64 reports provide aggregate Medicaid spending for various types of services, as well as administrative expenses. These reports differ from the MSIS largely in that they include non-claims-based payments, such as Disproportionate Share Hospital payments, other supplemental payments, and Medicare premiums.

Eligibility Data

Eligibility data are necessary to understand the demographic makeup of a Medicaid population, which will help determine overall risk. An accurate account of beneficiaries across multiple characteristics is necessary to develop per capita cost and utilization measures. That is more effective than measuring total spending. Federal law has required states to submit their Medicaid eligibility data electronically to CMS, through MSIS, since 1999.⁴ Data are transmitted from Medicaid programs to various file types and then synthesized to create a Medicaid data warehouse. The following eligibility fields are particularly important:

- *Age.* The risk for chronic diseases, such as congestive heart failure, and other medical conditions is correlated with age. An older population is generally associated with higher risk, with the exception of the age range for pregnancy;
- *Gender.* Gender is a driver of health status and risk. For example, older males have a higher risk of developing disease than older females. Alternatively, females exhibit substantial risk during the period in which they are pregnant; and
- *Geographic region.* Metropolitan area, county, and regional-level differences in provider infrastructure and cost can drive differences in risk. Urban and rural designations are also important in determining risk.

The nature of the adult Medicaid population presents eligibility challenges in that there is a high degree of churn, or entrance into and out of Medicaid eligibility. Reporting and analytics need to be focused on not only the continuously enrolled population but also those beneficiaries who may come in and out of Medicaid and thus present continuity of care issues.

Claims Data

Administrative claims data are essentially electronic versions of bills submitted by providers for services rendered to Medicaid beneficiaries. The primary purpose of claims data is to reimburse providers for services rendered. Thus, claims data only include information necessary for payment and do not necessarily provide clinical information. Information contained in claims data includes the following:

- Beneficiary demographic (age, gender, and residence);
- Date and location of service;

⁴ Balanced Budget Act of 1997, H.R. 2015, 105th Congress, Section 4753(a)(1); Social Security Act, Section 1903(r)(1)(F).

- Type and billed charge of services;
- Procedures and diagnosis; and
- Medicaid eligibility information.

States can use claims data to identify and analyze beneficiary populations through numerous characteristics, including age, geographic location, and diagnosis. Strategic use of the data can also identify the saturation of providers in a given region and help states understand cost drivers of the Medicaid program. It can be used to model changes to the program in order to manage complex care more effectively and efficiently.

Claims data can be used to calculate key metrics, including total program expenditures by age, gender, or service facility category; the number of beneficiaries being treated for a particular disease in a given calendar year; and total annual expenditures for medical encounters to treat specific diseases. Examples of analyses using claims data include:⁵

- Uses of imaging technology (such as CAT or PET);⁶
- Readmissions within two to 30 days by diagnosis and DRGs;
- Multiple billings within one day for single emergency room visits; and
- Reoccurring visits by a single beneficiary or category of beneficiaries.

Medicaid claims data are typically housed in MSIS, with the exception of states that do not participate in the MSIS data system. An issue that arises is that services provided through Medicaid managed care contracts are often not covered because Medicaid pays lump sum fees to MCOs, which do not report encounter records the same way that fee-for-service (FFS) providers do.

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a group of performance measures maintained by the National Committee for Quality Assurance (NCQA) and used by over 90 percent of health plans.⁷ HEDIS measures address a wide range of important health care topics, including access to care, use of preventive care, and disease management. They are calculated following clearly defined protocols on an annual basis using administrative and chart review data.

NCQA releases national data, including information specifically related to Medicaid health plans, annually. Because of their broad use, HEDIS measures allow for easy comparison among local and national health plans and can be used by Medicaid programs to understand and improve the quality of care being delivered to beneficiaries. HEDIS measures may be especially useful in states where all Medicaid health plans are required to be NCQA accredited, since they are required to submit HEDIS measures annually.

Consumer Assessment of Healthcare Providers and Systems

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys assess patient experience and satisfaction. The surveys include questions about a variety of important topics, including timely access to appointments, the physician-patient relationship, and patient involvement in care decisions.

There are several forms of the CAHPS survey, including the HEDIS version, which health plans must field as

⁵ National Association of Health Data Organizations, "NAHDO Uses of Administrative Claims Data," July 2009.

⁶ Computed Axial Tomography (CAT); and Positron Emission Tomography (PET).

⁷ National Committee for Quality Assurance, "HEDIS and Performance Measurement," <http://www.ncqa.org/HEDISQualityMeasurement.aspx> (accessed August 21, 2015).

part of their HEDIS data collection.⁸ The HEDIS version of the CAHPS survey includes additional questions that focus on health promotion and education, shared decision making, and coordination of care. CAHPS surveys also can include the Children with Chronic Conditions supplemental items and up to 20 additional supplemental questions. Medicaid programs can choose to include the optional questions to analyze certain topics of interest.

Medicaid programs can use CAHPS surveys to assess beneficiaries' satisfaction with the care they are receiving. CAHPS may be especially useful to assess vulnerable or underserved populations, such as people with special health care needs and individuals living in rural areas.

See [Section IV](#), "Quality Improvement Strategies," for further discussion of applications of quality data.

Encounter Data

Encounter data are records of the health care services used by enrollees of managed care organizations (MCOs) in a Medicaid managed care program. Conceptually, they are analogous to the claims records created by Medicaid agencies when they pay providers on a FFS basis.

States typically require MCOs to report encounter data to track the services for which the state is paying. States are required to submit both FFS and encounter data to CMS through MSIS, but states have had variable success with encounter data reporting through the years, largely because of the complexity of the managed care arrangement.⁹ For example, many states have not consistently received usable encounter data from MCOs and consequently report incomplete figures that cover only the capitated payments per enrollee instead of the full amount paid to providers. Because of these systemic inconsistencies, CMS does not perform the same validation and distributional quality checks on encounter data that apply to FFS data. Encounter data submission through MSIS has been largely overlooked over the past two decades.

However, this may soon change. Section 6402(c) of the Affordable Care Act requires Medicaid MCOs to report encounter data to states and allows CMS to withhold federal Medicaid matching payments for each individual whose encounter data is not reported through MSIS. Many states that contract with MCOs have benefited from the reporting of encounter data through MSIS. As an increasing number of states transition their Medicaid programs to a managed care model, it may be beneficial for states new to managed care to learn from those that have a long history of collecting, analyzing, and reporting encounter data through MSIS.

States use encounter data for a variety of purposes, including:¹⁰

- Monitoring MCO performance;
- Developing MCO capitation rates and performing risk adjustment of capitation rates;
- Tracking services utilization and performing trend development;
- Monitoring quality of and access to care;
- Identifying cost drivers;
- Modeling potential program changes;

8 National Committee for Quality Assurance, "CAHPS 5.0H Survey," <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification/CAHPS50HSurvey.aspx> (accessed August 21, 2015).

9 Medicaid and CHIP Payment Access Commission, "The Evolution of Managed Care in Medicaid," June 2011, https://www.macpac.gov/wp-content/uploads/2015/01/MACPAC_June2011_web.pdf (accessed August 21, 2015).

10 Florida Agency for Health Care Administration, "Medicaid Encounter Data," June 2011, http://ahca.myflorida.com/medicaid/mcac/Archive/docs/2011/06-07/Medicaid_Encounter_Data_MCAC_Meeting_06072011.pdf (accessed August 21, 2015).

- Performing provider profiling;
- Identifying fraud and abuse; and
- Informing policy decision-making.

Because of the complexity of the data collection process, encounter data are particularly prone to error. Therefore, it is critical that encounter data completeness be assessed before these data are used to make program decisions. Medicaid agencies may use state staff, actuaries, fiscal agents, or external quality review organizations to review data quality and completeness.

For a presentation of case studies with nine states that have extensive experience collecting and using encounter data (Arizona, Delaware, Michigan, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington), please refer to the publication produced by Mathematica Policy Research for CMS titled “Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States.”¹¹

Electronic Health Records

Electronic health records (EHRs), also called electronic medical records, allow health care providers to record patient medical records electronically. They are real-time digital versions of patients’ paper charts, and they bring together everything about a patient’s health. The following list is a selection of the benefits of EHRs:¹²

- Accurately organize information about patient’s medical history, diagnoses, medication, immunization dates, radiology images, allergies, and lab test results;
- Automate and streamline providers’ medical record processes across multiple types of payers;
- Have the potential to increase accuracy;
- Track data over time; and
- Monitor how patients measure up to milestones, such as vaccination.

EHRs are beneficial for coordination and continuity of care because they give providers a statewide tool to track patient health information in a relatively standardized method. While EHRs have expanded in use within and across health care delivery systems, there are still significant interoperability issues and roadblocks to changing these data into valuable additions to existing measures of performance and quality. Tools for aggregating EHR data must be flexible in their ability to address variations in information, format, and consent across multiple EHRs.

There is potential for providers to use EHRs to achieve benchmarks leading to improved patient care. CMS has developed an incentive program to encourage the expanded use of EHRs in ways that can positively affect care. Through CMS’s Medicaid EHR Incentive Program, eligible practitioners and hospitals may receive incentive payments as they “adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years.”¹³ The program is run by state Medicaid agencies and offers a maximum incentive amount of \$63,750 over a maximum period of six years. This incentive program is voluntarily offered in 43 states and territories. CMS offers a variety of decision-making tools and guidance documents to help states and

11 Vivian Byrd and James Verdier, “Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States,” Mathematica Policy Research, October 19, 2011, http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/Downloads/MAX_PDQ_Task_X_EncounterDataPrimerforStates.pdf (accessed August 21, 2015).

12 Office of the National Coordinator for Health Information Technology, “Benefits of EHRs,” <http://www.healthit.gov/providers-professionals/why-adopt-ehrs> (accessed August 21, 2015).

13 Centers for Medicare & Medicaid Services, “EHR Incentive Programs,” February 2013, <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/> (accessed August 21, 2015).

providers learn more about this initiative and how to implement EHRs with the goal of improving quality of care.¹⁴

APCDs and large Health Information Exchanges (HIEs) working with multiple payers allow broad-based, in-depth population analysis, condition-specific analysis, and provider-specific analysis. The granularity of available data analyses provides new insight, but states also need to carefully consider how best to organize and prioritize strategies for using this information.

METHODS OF ANALYSIS

The type of data analyses required to effectively operate a Medicaid program often depends on the delivery and payment systems in place.

Comparative Analysis

Risk adjustment can be used by state Medicaid programs to adjust payments to health plans that cover Medicaid managed care members. When performed properly, it allows MCOs to be compared based on how efficiently they are able to deliver care and negotiate provider payments.

Modern risk-adjustment models use demographic information and claims or managed care encounter data to develop measures of morbidity. Individuals are assigned to categories according to demographic characteristics and morbidity status. Each category is assigned a “risk weight” based on historical health care expenditures of similar individuals. Risk factors can then be used to compare disparate populations on a risk-neutral basis to provide a consistent comparison.

Primary considerations for implementing risk adjustment in a Medicaid managed care program include:

1. Choice of risk-adjustment system, based on the predictive power of available models;
2. Selection of data to be used within the system. That includes demographic information, a combination of inpatient and outpatient admissions diagnosis data, and pharmacy data;
3. Choice of applying a prospective or concurrent risk-adjustment strategy;
4. Choice of basing risk-adjustment factors on a historical period or the period in which rates are being paid;
5. Determination of criteria for inclusion of claims records; and
6. Determination of the phase-in schedule and use of risk corridors, if applicable.

When implementing risk adjustment in a Medicaid managed care setting, state agencies should be aware of a number of potential difficulties that are described in the manual, “A Guide to Implementing a Health-Based Risk-Adjusted Payment System for Medicaid Managed Care Programs.”¹⁵ For more information on risk adjustment, see [Section V](#), “Financial Models: Rate Setting, Risk Adjustment, and Performance Indicators.”

Predictive Modeling

Predictive modeling has historically been used by states to predict costs in the rate-setting process. States are also now using predictive modeling to facilitate efficient resource allocation by stratifying members into risk groups and targeting services accordingly.

¹⁴ Ibid.

¹⁵ The Hilltop Institute, “A Guide to Implementing a Health-based Risk-Adjusted Payment System for Medicaid Managed Care Programs,” March 2003, <http://www.hilltopinstitute.org/publications/Risk%20Adjustment%20Manual%20without%20appendices%20-%20March%202003.pdf> (accessed August 21, 2015).

Predictive modeling uses data algorithms to estimate individuals' future health care costs; it can be used by states to identify high-risk individuals who are likely to benefit from care management initiatives. These modeling packages are available for purchase off the shelf or can be developed or customized by states with significant analytical capability. Whether purchased or developed, these tools can vary significantly in the fullness of data applied, predictive variables used, and the range of predicted outcomes. It is suggested that users of predictive modeling begin with the end in mind and consider the outcomes first, to clearly determine the data needed to inform the modeling process.

Predictive models use a mixture of predictor variables to forecast future costs. That includes basic demographic information, historical claims information, utilization metrics, and functional status. Predictor variables are combined to forecast various outcome measures, often cost and utilization. Certain tools also include an "impactability" feature to help identify patients most likely to benefit from care management to reduce future costs. Advanced models also may predict metrics such as inpatient and outpatient utilization. Modeling tools can often be calibrated to specific populations or outcomes.

Before purchase, states should ensure that a commercially developed tool employs variables that will be useful in projecting costs for its Medicaid population. This is important because many commercially available versions were initially developed for non-Medicaid populations.

Another important consideration for Medicaid modeling programs is whether they account for behavioral health and social support needs, such as housing status, food security, and availability of caregivers.¹⁶ Although these factors are predictive of future risk and the need for care management, few predictive modeling tools include them in a comprehensive way. When possible, incorporating behavioral health and social support data into the algorithm may substantially increase the predictive sensitivity of the model.

Dashboards/Data Visualization

Dashboards and other data-visualization tools provide summary views of key cost and utilization data to inform program administrators and legislators who make policy and program decisions. These strategic data tools present and organize performance indicators in an at-a-glance format. Done strategically, these tools offer a mechanism to bring the Medicaid agency, providers, consumers, stakeholders, researchers, and policymakers into one arena to further the goal of improving the state's Medicaid health care delivery and payment systems.

Dashboards and other data-visualization tools are intended to communicate the most relevant information simply and in a form that facilitates decision making and action. Thus, they should be designed to clearly display the key information that the individual or entity needs and should not include superfluous material. Through the dashboard, the audience should be able to clearly identify specific items that require attention or action, without the need to access additional screens or click through other links.¹⁷ Effective dashboards have the following characteristics:

- They display data visually, with information presented using a combination of graphics and text; and
- Their displays are clear, concise, and easy to read, and data are presented on a single screen. It may be useful to explore various forms of graphics. For example, using a graphic resembling a thermometer or fuel gauge may capture the attention of the reader and present data in an

¹⁶ Dave Knutson, Melanie Bella, and Karen Llanos. "Predictive Modeling: A Guide for State Medicaid Purchasers," Center for Health Care Strategies, August 2009, <http://www.chcs.org/resource/predictive-modeling-a-guide-for-state-medicaid-purchasers/> (accessed August 21, 2015).

¹⁷ The Hilltop Institute, "A Guide to Implementing a Health-based Risk-Adjusted Payment System for Medicaid Managed Care Programs," March 2003, <http://www.hilltopinstitute.org/publications/Risk%20Adjustment%20Manual%20without%20appendices%20-%20March%202003.pdf> (accessed August 21, 2015).

easy-to-interpret manner. Readers can refer to the Medicaid dashboard of the Florida Agency for Health Care Administration for an example: <http://apps.ahca.myflorida.com/dashboard/>.

There are multiple ways to design dashboards, and each will need to be customized for the role of the reader. The presentation format and number of variables to be included will depend on the level of detail the viewer requires. There are numerous ways to develop and share dashboards. For example:

- Online analytical processing tools, such as Cognos, Business Objects, or MicroStrategy, can be used to deliver both standardized and customizable reports via a secure web-based portal; and
- Microsoft Excel-based dashboards can be created by an analyst and emailed to appropriate parties or placed in a shared location for download.

ALIGNING DATA AND SOLUTIONS

State and Federal Regulatory and Program Requirements

A growing number of sources of Medicaid data are available for analysis, as the health care industry implements more information technology (IT) functionality. This is particularly true considering the nationwide push for the transition to EHRs and the emphasis placed on transparency in the health care arena. When working with data, it is necessary to consider that each data source may have its own confidentiality requirements for use.

Under the Health Insurance Portability and Accountability Act of 1996, protected health information is defined as information that is “created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse” and “relates to past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.”¹⁸ The Safe Harbor method of de-identifying data lists 18 identifiers such as Social Security numbers, names, medical record numbers, telephone numbers, and others that serve to accurately identify an individual and thus must be protected. (See <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html> for additional information.)

Additionally, states should be aware of legal and audit functions of state data use across programs with stakeholder input, governance structure, and possible participation models of HIEs. The state should coordinate project timelines for health IT-related projects across all state agencies and pool resources and implementation approaches whenever applicable.

As possible, states should coordinate IT initiatives with relevant federal programs that provide incentives or enhanced match for Medicaid. For example, IT efforts may be linked to the federal EHR incentive program. Alignment with Medicaid Information Technology Architecture, a national framework supporting improved systems development and health care management for the Medicaid enterprise, is required.

See [Section II](#), “Federal Authorities and Compliance,” for further discussion of compliance with data requirements.

Demonstration, Pilots, Health Homes and Other Special Initiatives

Most demonstrations and pilot programs include an evaluation phase to determine the effectiveness of the program. It is important to identify up front the data and reporting requirements needed to perform the evaluation, so that they can be collected throughout the program. This can be done by meeting with the

¹⁸ Social Security Act, Section 1171(4)(A).

evaluation team early in the design phase of the program to define the underlying goals of the evaluation and the central questions for the study.

It is also important for Medicaid staff to participate in the evaluation plan, which outlines how the evaluation will be implemented and identify the data that need to be gathered. Data gathering includes consideration of the indicators to be evaluated, data sources and methods to use, the quality and quantity of the information required, and the context in which the data gathering occurs. Working with the evaluation team early in the design phase of the project helps in developing a data collection plan that will permit a successful evaluation of the program.

Creative use of existing eligibility data, FFS claims data, or managed care encounter data can be used to administer demonstrations, pilots, and other special initiatives. For example, FFS claims data or managed care encounter data can be used to identify prospective beneficiaries who would qualify for a health home program and determine assignment to a primary care physician. For many of these initiatives, CMS has already developed methodologies that use existing data sources and can be replicated using data available to the state. CMS also provides technical assistance that states can take advantage of for using existing data sources.

See [Section III](#), “Provider Network Development and Management and Delivery System Transformation in State Medicaid Programs,” for further discussion of data analysis and reporting.

Ad Hoc Reporting Needs

In addition to dashboards and other standardized reporting tools, ad hoc reporting capability is necessary for generating reports that are used to answer specific questions that may arise about operations of the program. Such ad hoc needs may require the creation of a single report or analysis that is never used again, or new reports that are recreated on a periodic basis.

Effectively using ad hoc reporting capabilities can lower the number of standard reports that are produced, limiting them to only the essential information needed to operate the program. A nimble ad hoc strategy also prevents cluttering dashboards with options that are rarely used. If an ad hoc report becomes important and is used on a somewhat regular basis, then it can be added to a dashboard or created as a regular standard report at a later time. In the early phases of program development, limiting the number of standard reports and dashboards reduces costs and saves time.

However, consuming valuable IT resources to develop software to produce a report that may only be used once may not be cost-effective, especially if the process requires going through the entire program development life cycle for each ad hoc report. As an alternative to using IT resources, many software packages—known as “report writing” software packages—are available to non-IT staff to support the production of ad hoc reports. The decision to provide ad hoc reports raises the following considerations:

- *Are the necessary data available to staff?* The first consideration is whether the staff has access to the data warehouse or other media where the data are stored. If not, is it possible for IT staff to extract only specific data elements or summaries of the data that could be used by non-IT staff for developing the ad hoc report?
- *Selecting an ad hoc report writing software package.* It is important to work with IT staff to select a report writing package that is compatible with the existing system and is easy to learn and use.

- *What training and skills are necessary for staff to use the software?* What training is available to support staff members, and are time and resources available to train them to use report writing software?
- *What are the confidentiality requirements for the data?* Requirements around the use of personal health information should also be considered.
- *Complexity of the report or analysis.* More complex analyses or reports that require large amounts of data (for example, multiyear reports) may need to be performed by professional IT staff. However, this decision can be made on an individual report basis.

All-Payer Databases

All-payer databases can be developed to collect claims and encounter data from multiple payer sources (such as Medicaid and Medicare FFS, managed care organizations, TRICARE, commercial self-insured, and commercial fully insured) and for multiple types of services (medical, pharmacy, and dental) for a particular state. Those databases typically include an eligibility file component with certain demographic information to develop utilization rates. The data elements are standardized, so that all of the data are in the same format.

The data can consist of service-level information, using valid claims processed by health payers. Service-level information includes charges and payments, clinical diagnosis and procedure codes, and patient demographics. The primary purpose of the databases is to inform cost containment and quality improvement efforts across all providers in the state. The data could also be used to identify health care needs and inform health care policy, determine existing health care resource capacity, review costs across various settings, providers, and payers, and provide information on providers' quality of care. As of August 2015, the following states had all-payer claims databases in place: Arkansas, Colorado, Kansas, Maine, Massachusetts, Maryland, Minnesota, New Hampshire, Oregon, Rhode Island, Tennessee, Utah, Vermont, and Washington. In addition, Virginia has an APCD with voluntary submission. Connecticut, Nebraska, New York, and West Virginia are implementing new APCDs and additional states are considering this approach.¹⁹

Including Medicaid data in an all-payer database provides Medicaid programs with information that can be used to support policy development, while also aiding in the design of Medicaid program infrastructure. Those databases can help provide benchmarking for Medicaid payments and use, compared with commercial payer plans, that allows comparison between the Medicaid population and commercial payers across settings—primary care, inpatient, and outpatient services—in the state.

For example, New Hampshire has used its all-payer database to better understand patterns, costs, and quality of care in its Medicaid program. The database has allowed the state to compare the rate of emergency department visits for Medicaid enrollees with that of similar commercially insured populations. New Hampshire uses the database to benchmark Medicaid payment levels to commercial reimbursement rates for key services. The state also uses the database to develop annual Children's Health Insurance Program (CHIP) reports that provide measures of health care access, prevention, care management, utilization, and payments for Medicaid, CHIP, and commercial populations. The reports are used by the New Hampshire Medicaid program to support policy efforts, compare health care coverage rates across providers, and evaluate and shape state health initiatives.²⁰

All-payer databases that include both Medicare and Medicaid claims data allow the state to examine cost

¹⁹ Interactive State Report Map. APCD Council, <http://www.apcdouncil.org/state/map> (accessed August 19, 2015).

²⁰ The Commonwealth Fund, "All-Payer Claims Databases in Public Health and Medicaid: A Fact Sheet," November 2010, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2010/Sep/1439_Love_allpayer_claims_databases_ib_v2.pdf (accessed August 21, 2015).

and use for Medicare, Medicaid, and dual eligibles, a particularly useful capability as states begin to enroll the dual eligible population in managed care plans. To receive help understanding Medicare data, states can contact the CMS Research Data Assistance Center (ResDAC), which provides free assistance to academic, government, and nonprofit researchers interested in using Medicare and Medicaid data. ResDAC is staffed by a consortium of epidemiologists, public health specialists, health services researchers, biostatisticians, and health informatics specialists from the University of Minnesota.

Complex databases require substantial effort to plan, implement, and maintain. Collection and standardization of data are among the most important issues. Further information on state all-payer databases can be provided by the National Association of Health Data Organizations (NAHDO), whose members include state and private health data organizations that maintain statewide health care databases and stakeholders of those databases.

Population-Based Public Health Data

A population is the full set of individuals within a group defined by a geographic, demographic, or other unifying characteristic. Population health focuses on the distribution of health outcomes within a population. Improving population health is often an objective of health policy. A broad range of factors affects population health, including physical environment, social structure, and income distribution. Understanding health needs across communities within a state, the prevalence of specific health conditions, their trends over time, and the risk behaviors of the specific populations served by the Medicaid program and its providers could be useful in targeting prevention and disease management programs. Population-based health care concepts have been used by managed care plans for several years and are becoming more necessary for individual health care providers. The emergence of patient-centered medical homes and accountable care organizations is requiring providers to be more accountable for their patients' access to health care and its cost and quality.

Data available through public health departments can play a crucial role in helping to identify community health problems and manage population health. Public health departments collect data for determining community health service needs, identifying community health risks, identifying subpopulations that are at higher risk for specific diseases, and monitoring chronic disease, injury, emerging infectious diseases, mental health, and environmental health. The collection, analysis, use, and communication of health-related information are principal public health services. Data for those purposes come from a wide variety of sources. Currently, public health predominantly relies on seven types of data to meet its needs: vital statistics; health care use data; practitioner registries; disease and injury registries; disease, injury, and behavioral risk factor surveillance systems; periodic surveys; and program data systems. Some examples of public health data include:

- *The Community Health Data Base* provides local health data to help health and human service providers across the southeastern Pennsylvania region to assess community needs, plan and develop programs, and develop policy decisions. The major goal of the Community Health Data Base is to improve the health and well-being of the community by ensuring that policies and programs address community needs. The survey provides timely information on a large sample of children and adults living in the region. The comprehensive survey supplies information on a broad range of topics, such as health status and chronic health conditions, access to care, health behaviors, health screenings, and older adult social support needs. The data are available at the neighborhood, county, and regional levels. Core health indicators such as insurance status and cigarette smoking have been collected in the survey over time, allowing for the tracking of trends.

- *The Wisconsin Department of Public Health* provides analysis of health data, including linked databases and reports, based on its data collection systems and other sources. The data include the Wisconsin Cancer Reporting System (cancer registry), the Pregnancy Risk Assessment Monitoring System, and the Wisconsin Violent Death Reporting System. The department conducts two population surveys, the Behavioral Risk Factor Survey and the Family Health Survey. Those data, coupled with Medicaid claims or encounter data, could help to identify subpopulations that are at high risk for certain conditions and help to explain what factors influence the disparities. Early interventions, care management, or preventive care initiatives could be targeted to these populations.