



# Purchasing Strategies to Improve Care Management for Complex Populations:

A National Scan of State Purchasers

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## MEDICAID BEST BUYS

This report is part of CHCS' *Medicaid Best Buys* series developed to help states, health plans, and policymakers identify programs that have the greatest potential to improve health care quality and control health care costs for high-risk beneficiaries. The series, made possible through support from the Robert Wood Johnson Foundation, provides policy recommendations and technical resources to guide program development and implementation.

### **About the Center for Health Care Strategies**

The Center for Health Care Strategies (CHCS) is a nonprofit policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies and health plans to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit [www.chcs.org](http://www.chcs.org)

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## Executive Summary

As an experienced observer of Medicaid might say, “States don’t sit still. They can’t.” Constantly being driven by Governors, legislatures, and advocates to provide the best health care value for the taxpayer dollar, Medicaid leaders are always seeking better ways to care for their beneficiaries. In particular, many Medicaid leaders are currently looking for ways to improve the management of services for those beneficiaries whose care accounts for most of Medicaid’s expenditures. Some recognize this strategy as a variant of the Willie Sutton principle: when asked why he robbed banks, Sutton would reply: “because that’s where the money is.” In a number of early innovator states, the aged, blind and disabled and/or Supplemental Security Income (ABD/SSI) populations have long been enrolled in full-risk managed care — with some documented successes, according to independent assessments (e.g., Maryland, Pennsylvania, Texas).<sup>1</sup> But not every state has the capacity, the managed care infrastructure, or the political wherewithal to jump directly from unmanaged fee-for-service (FFS) to full-risk managed care for the entire state or even in select regions. Some states may never be able to implement fully capitated models for ABD/SSI beneficiaries, but realize that leaving these beneficiaries in pure FFS represents a missed opportunity: to improve care, bend cost trends, and potentially free up resources to expand coverage.

Over the past 12 months, the Center for Health Care Strategies (CHCS) has gathered information on innovative approaches to caring for adults with chronic illnesses and disabilities that could represent significant advances from FFS without putting all of Medicaid’s eggs in the full-risk basket. We undertook this environmental scan both to guide our own work and, more importantly, to get these alternative purchasing strategies into the public domain so that as many Medicaid stakeholders as possible could benefit. We spoke with Medicaid officials and their current and potential care management partners in 12 states: California, Indiana, Minnesota, Mississippi, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Washington. Many of the ideas we have captured and chronicled herein sound very promising and — just as important — very doable in states across the country.

This environmental scan demonstrates once again that states are laboratories of innovation and that sometimes the best lab “scientists” can get better results by working closely with industry partners specializing in serving ABD/SSI populations — from administrative service organizations to disease management entities and others that are moving away from a single-disease focus

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<sup>1</sup> *HealthChoice Evaluation: Final Report and Recommendations*, Maryland Department of Health and Mental Hygiene, January 15, 2002. Available at: <http://www.chpdm.org/publications/HealthChoice%20Evaluation%20-%20January%202002.pdf>; *Comparative Evaluations of Pennsylvania’s Health Choices Program and Fee-for-Service Program*, The Lewin Group, May 2005. Available at: <http://www.lewin.com/NR/rdonlyres/8B133C09-83F9-438B-B752-086AD9B04684/0/3178.pdf>; *STAR+PLUS Medicaid Managed Care Waiver Study: An Independent Assessment of Access, Quality, and Cost-Effectiveness*, Texas A&M Public Policy Research Institute, October 1999. See also: *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies*, The Lewin Group, July 2004. Available at: <http://www.ahipresearch.org/pdfs/MedicaidCostSavings.pdf>.

to high-touch care management programs for adults with multiple needs. A number of key themes emerged from our conversations. Most important, we found these states and partners to be universally dedicated to moving beyond purely FFS or full-risk models. The new models being developed by states embody a core set of care management elements that are not unlike those of traditional managed care but give states different “levers” to achieve accountability for both quality and cost. Some of these levers, particularly in the financing and performance measurement arenas, are still evolving.

In sum, what we uncovered by opening the laboratory doors was a series of increasingly sophisticated approaches by Medicaid purchasers and their contractors alike to use alternatives to FFS and full-risk managed care. This is, by definition, a mid-course scan because these alternative purchasing strategies will continue to evolve as states pursue further improvements in care and cost effectiveness for the complex populations consuming a majority of their health care resources.

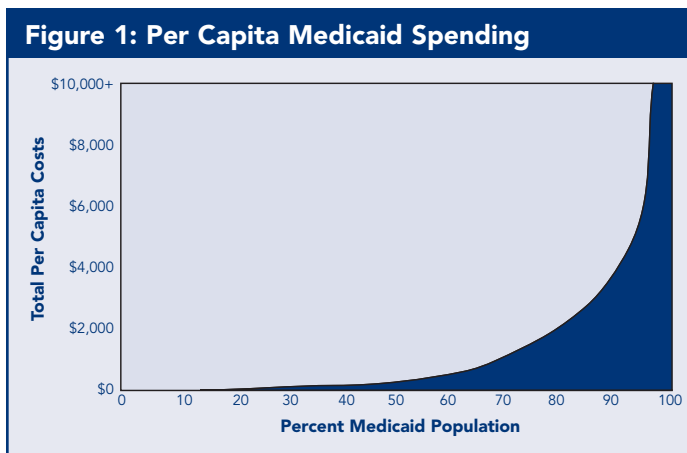
# Introduction

Driven by a desire to provide better care more cost-effectively, Medicaid stakeholders are increasingly focusing attention on beneficiaries in the aged, blind and disabled (ABD) and/or Supplemental Security Income (SSI) eligibility categories. Less than 15 percent of Medicaid beneficiaries account for over 75 percent of program expenditures, and fewer than four percent of beneficiaries account for nearly 50 percent of costs (see Figure 1). The majority of these beneficiaries are in the ABD/SSI population, often with multiple physical, behavioral, and social needs, yet they often lack access to systems of care that offer better coordination and integration.

ty for adults with a complex array of health care needs. As a result, states are exploring and implementing new systems of care that address the gamut of medical, behavioral and social needs and provide a greater level of operational, clinical, and financial accountability.

This report presents findings from interviews with 12 Medicaid programs and related contractors on emerging systems of care for ABD/SSI beneficiaries.<sup>3</sup> The models in the states interviewed vary in scope and eligible populations and fall somewhere between FFS and a fully capitated managed care environment. While there may be some financial risk involved, these new models are not fully capitated programs. As such, understanding the “levers” that states and their contractors (e.g., health plans, disease management entities, and administrative service organizations) can exercise to improve care and ensure accountability is critically important.

Combinations of different purchasing strategies to support various systems of care within states are not uncommon. Some states include ABD/SSI beneficiaries in programs that are available to all Medicaid eligibility groups, while others have developed programs solely for ABD/SSI beneficiaries. Some states may have a single option, e.g., disease management for adults with complex needs within an existing FFS or primary care case management (PCCM) structure. Other states, depending on regional characteristics and constraints, may offer a mix of fully capitated managed care, PCCM, and FFS.



Source: Sommers A. and Cohen M. *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Commission on Medicaid and the Uninsured, March 2006.

Across the country, the majority of ABD/SSI beneficiaries receive care in the fragmented, uncoordinated, and often difficult to navigate fee-for-service (FFS) health care system. States have begun to recognize that FFS provides limited opportunities to improve quali-

<sup>2</sup> Sommers A. and Cohen M. *Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?* Kaiser Family Foundation, March 2006. Available at: <http://www.kff.org/medicaid/upload/7490.pdf>.

<sup>3</sup> Although dual eligibles are part of the ABD population, because they get most of their medical care from Medicare, this scan does not focus on care models for dual-eligible beneficiaries. We should note, however, that Medicare is also experimenting with comparable models of chronic care/disease management for some of its FFS beneficiaries, e.g., the Care Management for High-Cost Beneficiaries Demonstration.



The states examined in this scan are employing a broad range of options between FFS and fully capitated managed care to improve care for ABD/SSI beneficiaries (Figure 2). The findings in this report provide states with a framework of the key components, as well as considerations, for designing and implementing care models for adults with complex needs. Intervention design, financing mechanisms, performance measurement techniques, risk distribution, and provider and vendor contract terms vary substantially within and across states, but the following key themes emerged from the interviews:

1. There is considerable momentum among the states to move beyond fee-for-service to provide more coordinated care approaches for subsets of the population that offer substantial opportunities for improving quality and controlling costs.
2. States are developing alternative financing mechanisms for providers and contractors that include shared risk, shared savings, and pay for performance.
3. Measuring clinical and non-clinical aspects of care management programs can be difficult, but states have begun to develop and test more appropriate performance measurement and monitoring strategies.

### Characteristics of States and Stakeholders Interviewed

The 12 states highlighted in this report (California, Indiana, Minnesota, Mississippi, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Washington) are all implementing an array of approaches between FFS and fully capitated managed care. All states interviewed have at least one program that targets ABD/SSI beneficiaries for some type of care management intervention. Some states have multiple systems of care for this population, offering full-risk managed care in geographic areas where it is available and variations on PCCM or FFS in other regions. A number of states interviewed have developed or are exploring new approaches tailored to the highest-need, highest-cost subsets of beneficiaries.

We also interviewed selected contractors in the scan states: CA-Inland Empire Health Plan and Partnership HealthPlan; IN-Schaller Anderson, Inc; MN-AXIS Healthcare; NY-Affinity Health Plan; PA-McKesson Health Solutions; RI-Neighborhood Health Plan of Rhode Island; SC-South Carolina Solutions; TX-Amerigroup Texas, Inc.; and WA-Molina Healthcare of Washington. These organizations were interviewed because of their experience and perspectives on serving adults with special needs, including a number with particular experience in offering partial risk and/or non-capitated products.



# Study Findings

## New Delivery System Models

**Theme 1:** There is considerable momentum among the states to move beyond fee-for-service to provide more coordinated care approaches for subsets of the population that offer substantial opportunities for improving quality and controlling costs.

States are increasingly recognizing opportunities to test alternative purchasing strategies that offer more accountability than traditional FFS. While the scan states are piloting a diverse mix of options that fall between unmanaged FFS and fully-capitated managed care, all share a common goal: to improve care management for populations with chronic and complex health care needs. This new generation of care management programs seeks to improve coordination of care while providing cost-effective, non-duplicative services. Aligning incentives and building accountability are important considerations in these models since they do not have the same clinical and financial “levers” as fully capitated models.

The alternative strategies being employed by states go by many different names — disease management, primary care case management, enhanced primary care case management, medical home, chronic care management, etc. — but all share common components. The following section describes how states are defining populations and designing tailored care management approaches. The section also discusses factors that influence state program design decisions regarding these key components. Financing and measurement are discussed in later sections.

### **Identifying and Stratifying the Population**

Scan states are using a variety of approaches to identify and stratify beneficiaries to better understand their needs, prioritize risk

levels, and design systems of care to best meet those needs. Identification approaches may include or exclude beneficiaries based on aid category, illness, disability, severity, risk, cost, or some combination of these factors. States generally rely on prior claims data to help identify target populations because claims are readily available and relatively easy to use. Claims can provide information on beneficiaries’ conditions, comorbidities, service utilization, specific patient encounters (e.g., emergency room visits), and expenditures. While claims provide a wealth of data, they may not contain the depth of diagnosis and comorbidity information optimal for identifying beneficiaries who are most likely to benefit from more intensive case management. States are also applying predictive modeling techniques to analyze prior claims to identify beneficiaries at risk for high future utilization/expenditures. The following examples highlight various approaches used by states to identify target populations.

- **Rhode Island:** In the Connect Care Choice program, the state identifies all SSI, severely and persistently mentally ill (SPMI), and developmentally disabled (DD) beneficiaries and excludes institutionalized and dual-eligible beneficiaries. The state then uses claims data to generate moderate- or high-risk scores to identify the target population.

- **Oklahoma:** The state uses commercially available predictive modeling software to identify high-cost beneficiaries for its Health Management Program. The state first excludes dual-eligible, institutionalized, and home- and community-based waiver beneficiaries and then uses the software to identify the top 5,000 beneficiaries with chronic conditions with the highest predicted future costs.
- **Texas:** The Integrated Care Management program is using predictive modeling to identify a target population of beneficiaries who are likely to incur future high costs. The state is also identifying beneficiaries who are at high risk of developing a chronic illness or its complications, and/or who are at risk of incurring high costs in the future.<sup>4</sup>

After identifying the target population, states or their contractors may further stratify the population into subgroups to tailor intensive interventions to an even smaller subset of the population. In the Oklahoma example, the 5,000 beneficiaries identified for the Health Management Program are divided into two tiers. The state uses the same predictive modeling software to identify the top 1,000 highest predicted cost beneficiaries for Tier 1, leaving the remaining 4,000 beneficiaries in Tier 2. Beneficiaries in Tier 1 receive in-person nurse care management services and self-management education, while Tier 2 beneficiaries receive less intensive services from nurse care managers based in a call center.

Stratification can also take place after the target population is enrolled in a care management program. Most of the states interviewed are using health screens to assess beneficiary needs. Some states con-

duct initial non-clinical health screens at the point of enrollment and many require physicians or contractors to conduct more in-depth clinical health assessments within 90-120 days after enrollment into a program. The information gathered through these types of tools is essential for creating care plans for ABD/SSI beneficiaries.

### Initial Health Screening/Assessment in Indiana

Indiana requires that its Care Select program contractors (care management organizations [CMOs]) use an initial health screen to ensure that newly enrolled beneficiaries who need care management are connected to the appropriate services. The screening tool, which is completed by the beneficiary, is designed to identify:

- Participation in waiver programs;
- Behavioral health history/mental health status;
- Recent emergency department use;
- Ability to perform activities of daily living;
- Durable medical equipment needs; and
- Current medications.

Care Select vendors send new enrollees the health screening tool within 30 days of enrollment into the program. Incentives are used to motivate CMOs to follow-up with enrollees who have not completed initial health screens. CMOs can receive a performance payment equal to two percent of their care management fee if they submit completed health screens for at least 70 percent of their assigned membership by the end of the first quarter; 80 percent by the second quarter; 90 percent by the end of the third quarter; 95 percent by the end of the fourth quarter; and 95 percent for every quarter thereafter.<sup>5</sup> These incentives are part of Indiana's broader two-prong incentive program in which 20 percent of the care management fee is withheld to encourage CMOs to meet specified performance targets.

<sup>4</sup> The Texas Integrated Care Management Program began enrollment in December 2007; services began in February 2008. For more information, see *Request for Information Health Management Program Texas Medicaid RFI 529-07-0178*, Texas Health and Human Services Commission, August 1, 2007. Available at: [http://www.hhsc.state.tx.us/contract/529070178/HealthMgmt\\_RFI\\_080107.pdf](http://www.hhsc.state.tx.us/contract/529070178/HealthMgmt_RFI_080107.pdf).

<sup>5</sup> RFS-7-62 Indiana Care Select Program, Attachment D: Scope of Work, State of Indiana Department of Administration on behalf of Indiana Family and Social Services Administration. Available at: <http://www.indianamedicaid.com/ihcp/CareSelect/content/documents/62attd.pdf>.

### **Care Management Approaches**

Once identified, beneficiaries are enrolled in an array of different care management programs that vary by state depending on target population, state capacity, provider availability, and other factors. Some states (e.g., Mississippi, California, and New York) are using disease management approaches that go beyond a single disease focus to provide more comprehensive care management for beneficiaries with targeted chronic conditions. Other states (e.g., North Carolina, Oklahoma, and Indiana) are using their PCCM or “enhanced” pri-

mary care case management (EPCCM) programs as the base to develop medical homes that target more comprehensive care management services for complex populations.<sup>6</sup> Still others (e.g., Pennsylvania, Texas, Rhode Island, South Carolina, and Washington) use multiple programs including some fully-capitated managed care options to provide services to high-risk beneficiaries. These systems of care may differ in structure, but they all share the common element of connecting beneficiaries with a vendor or provider that tailors care management to meet the needs of the population.

### **Multiple Strategies in the Keystone State**

Pennsylvania uses multiple purchasing strategies to tailor programs to the care needs of ABD/SSI beneficiaries in different geographic areas. Enrollment in the state’s HealthChoices managed care program is mandatory for the ABD/SSI population in 25 counties. In another 27 counties ABD/SSI beneficiaries can choose between full-risk managed care plans or the ACCESS Plus EPCCM program. In the remaining 15 counties, participation in the EPCCM program is mandatory in FFS. Dual-eligible adults and nursing home residents are exempt from mandatory enrollment throughout the state.

The state also offers both traditional disease management and more comprehensive care management interventions for qualified beneficiaries. Adults in both the EPCCM and FFS programs are eligible to enroll in a traditional disease management program, which is operated by a vendor. The vendor provides telephonic disease management services for beneficiaries with five prevalent chronic conditions: asthma, coronary artery disease, chronic heart failure, chronic obstructive pulmonary disorder, and diabetes. High-need beneficiaries in the EPCCM program with multiple chronic conditions or serious mental health comorbidities are targeted for significantly higher levels of care management and care coordination provided by a state-run Intensified Medical Case Management unit.

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<sup>6</sup> Note: The remainder of the document does not distinguish between PCCM and EPCCM programs unless describing a program that is defined by its state specifically as EPCCM.

### State “Medical Home” Programs

Many of the programs outlined in this report focus on strengthening the relationship between primary care physicians and their patients, often describing programs as medical home models. Four national physician organizations have developed a consensus definition of medical home as “a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”<sup>7</sup> While this definition garners widespread support, states, health plans, physicians, and vendors are seeking the best ways to build on the medical home concept to improve beneficiary outcomes for the ABD/SSI population and inject accountability into the system. Many of the states interviewed, including Indiana, Minnesota, North Carolina, Oklahoma, Rhode Island, and South Carolina, have embraced the concept of “medical homes” that provide beneficiaries with all primary care services and specialty and hospital referrals (see facing page sidebar for various state strategies). Their experiences will add significantly to the discussion on how states can link external care management resources with community based care management and medical home initiatives.

### Strategies to Enhance Care Management

States are using a number of alternative strategies to enhance the care management connection among beneficiaries, providers, and contractors. For example, health information technology (HIT) can facilitate stronger stakeholder connections through

the sharing of clinical information to improve care planning and management. In North Carolina, the state developed a web-based Case Management Information System that gives providers access to diagnosis and utilization data. Stakeholders including case managers, Community Care Networks, and providers can use the data to identify enrollees for targeted care management, track interventions, assess adherence to evidence-based guidelines, and review clinical outcomes and changes in utilization patterns.

Washington’s Chronic Care Management pilot program calls on one of its contractors to support the provider’s role in the chronic care process by entering enrollee-specific data directly into the provider’s information system or directly into the enrollee’s medical record. The contractor is also required to meet with providers on a weekly or biweekly basis as necessary, and obtain provider approval on patient care plans to ensure they complement the provider’s treatment plans.<sup>8</sup>

Select states are also using financial incentives to accelerate the adoption of health information technologies that can facilitate more effective care management across providers and contractors. New York, for example, is offering grants to Medicaid providers to purchase electronic health records if they agree to collect medication history, patient visit history, demographics, procedure and diagnosis data, and clinical data for all Medicaid beneficiaries.<sup>9</sup>

<sup>7</sup> *Joint Principles of the Patient-Centered Medical Home*, American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP) and American Osteopathic Association (AOA), March 2007. Available at <http://www.medicalhomeinfo.org/Joint%20Statement.pdf>.

<sup>8</sup> *Request for Proposals # HRSA/OCC-0106, Washington Chronic Care Management Project*, Washington Department of Social and Health Services, Health and Recovery Services Administration, July 2006. Available at: [http://www.chcs.org/usr\\_doc/Chronic\\_Care\\_Management\\_Project\\_RFP.pdf](http://www.chcs.org/usr_doc/Chronic_Care_Management_Project_RFP.pdf).

<sup>9</sup> *Request for Grant Applications HEAL NY Phase 5 Health Information Technology Grants, Section 7.1: Interoperable Electronic Health Records (EHRs) Use Cases*, New York State Department of Health and The Dormitory Authority of the State of New York, September 2007. Available at: <http://www.health.state.ny.us/funding/rfa/0708160258/>.

## Medical Home Models in Three States

States are implementing a variety of medical-home type models that seek to intensify the connection between Medicaid beneficiaries with complex needs and their providers. Following are three state approaches to establishing medical home models that provide an enhanced level of services for high-risk target populations:

### **North Carolina: Early Adopter of the Medical Home Model**

Community Care of North Carolina (CCNC) is an EPCCM program built on the tenets of the medical home model. It enrolls approximately 35 percent of the ABD/SSI population and includes core care management elements such as risk assessment, emergency room utilization review, disease specific case management, and pharmaceutical management. These care management strategies are delivered through 14 participating Community Care Networks, which consist of more than 3,000 physicians and numerous community support services. North Carolina is also piloting a Chronic Care Project for its highest-risk, highest-cost ABD/SSI beneficiaries with complex needs. The pilot program uses nine of the 14 Community Care Networks to provide enhanced medical home services (e.g., intense case management and interdisciplinary care plans) through the use of care coordinators.

### **Rhode Island: Connect Care Choice Medical Home Model**

The state of Rhode Island developed the Connect Care Choice PCCM program to provide care management services for a high-risk subset of ABD/SSI beneficiaries. The program targets beneficiaries with moderate- to high-risk scores for intensive nurse care management delivered through participating primary care provider's (PCPs) offices. The state requires participating PCPs to meet what it defines as "advanced medical home" criteria that include:

- Partnering with patients to ensure all of their health care is effectively managed and coordinated.
- Incorporating the "Chronic Care Model" to work with chronic disease patients to help them manage their own condition and prevent avoidable complications by providing well and preventive visits, self-management supports, and education.
- Using a chronic care coordination team that includes a dedicated nurse care manager, either in the practice or available to the practice, who is linked to community supports.
- Linking to behavioral health providers for beneficiaries with co-occurring conditions; providing screening, referral, and ongoing coordination.
- Adopting e-prescribing, e-billing, and computerized evidenced-based clinical decision guidelines at the point of care.<sup>10</sup>

### **South Carolina: Role of Contractors in the Medical Home**

The Medical Homes Network Program in South Carolina connects each beneficiary with a primary care physician who is part of a network managed by a Care Coordination Services Organization (CSO). CSOs provide disease management, care coordination, and data management services to help physicians function as medical homes. The CSOs also have a direct link with beneficiaries, providing consumer education on missed primary care appointments and appropriate emergency room utilization and engaging beneficiaries in the care management process. Through the emergency room "high flier" program, CSOs contact beneficiaries who have visited the emergency room more than twice in the previous three months, offering education about effective primary care use and linkages to additional services to help avoid future emergency room visits. CSOs also provide high flier information to primary care physicians. South Carolina reports that the program has been a leading factor in the approximate nine percent reduction in the number of emergency department claims for the state's Medicaid population from 2003 to 2006.

<sup>10</sup> Connect Care Choice Provider Participation Standards Agreement (provided by the state during the interview process).

States are also incorporating other non-financial elements to help providers care more effectively for complex needs populations. These include:

- Provider education, e.g., evidence-based guideline education in Washington’s Chronic Care Management Program;
- Performance feedback, e.g., process, outcome and cost feedback for physicians in the Community Care of North Carolina program;
- Care manager resources, e.g., state contracted nurse care managers for small practices in Rhode Island’s Connect Care Choice program; and
- On-site quality improvement training, e.g., practice site facilitators in Oklahoma (see *Innovative Practice Supports* sidebar).

California is attempting to address many of these provider supports in its proposed Chronic Care Management Program. The state will potentially require its vendor to implement various quality improvement activities, including the use of practice guidelines and assessment tools. The state may also require contractors to educate providers on issues ranging from the use of clinical practice guidelines to the availability of community resources. As part of the program, contractors will also be asked to give providers feedback regarding beneficiary adherence to treatment plans.<sup>11</sup> These and other provider education and work flow redesign tools are intended to streamline the care management process and help ensure the most efficient use of limited provider resources.

### **Innovative Practice Supports in Oklahoma**

Oklahoma’s new Health Management Program for PCCM beneficiaries includes an innovative requirement for its contractor to conduct one-on-one practice facilitation with 50-100 high-volume primary care physicians. Practice facilitators are required to spend approximately one month working full time in selected physician offices to facilitate practice improvement by performing the following activities:<sup>12</sup>

- Review claims and clinical records using an audit tool designed in collaboration with the state to determine areas for improvement;
- Assess physician care process for potential improvement;
- Develop and implement education and other interventions based on the results of the audit tool and care process assessment;
- Provide quarterly continuing practice evaluation reports to primary care physicians that include health management program participation and medical regimen adherence and physician specific quality monitoring and improvement efforts; and
- Evaluate suggested interventions for acceptance, response, and effectiveness and document successful interventions for inclusion in the state Practice Facilitation Procedure Manual.

<sup>11</sup> *Draft Request for Proposal 07-00510 Coordinated Care Management Program, Exhibit A – Scope of Work*, California Department of Health Care Services Office of Medi-Cal Procurement, October 23, 2007. Available at: [http://www.dhcs.ca.gov/provgovpart/rfa\\_rfp/Documents/CCMPdraftExh-all.pdf](http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/CCMPdraftExh-all.pdf).

<sup>12</sup> *SoonerCare Health Management Program Request for Proposal*, Oklahoma Health Care Authority, May 17, 2007. Available at: [http://www.dcs.state.ok.us/solicitations.nsf/84aa51fea272678286256c63004b3542/dd2d32373a61233e862572c9004f2086/\\$FILE/ATT4R1YB/8070000017%20-%205-17-07.pdf](http://www.dcs.state.ok.us/solicitations.nsf/84aa51fea272678286256c63004b3542/dd2d32373a61233e862572c9004f2086/$FILE/ATT4R1YB/8070000017%20-%205-17-07.pdf).

## **Factors that Influence Systems of Care Design**

A variety of factors influence a state's decision about the system of care most appropriate and achievable for its beneficiaries.

These factors can include existing state capacity, past experiences in developing alternative managed care models, consumer and provider interests in the state, and the overall political environment.

### **State Capacity**

Our scan found that states are building programs in-house as well as through outside contractors, with state efforts influenced both by past experience and existing infrastructure. Rhode Island, for example, used its experience with children with special needs in its RIte Care managed care program to help construct the requirements for its new Connect Care Choice (PCCM) and Rhody Health Partners (managed care) programs for adults with complex needs. States with sufficient internal capacity and clinical expertise (e.g., Pennsylvania and Oklahoma) are working directly with participating providers in PCCM or medical home models. Others are partnering with health plans or specialized vendors that offer disease/care management, programs for subsets of high-risk beneficiaries, and/or full-risk managed care. Many states design programs using a mix of internal and external resources. Oklahoma, for example, manages its PCCM program internally, yet contracts with a vendor to implement its Health Management Program for high-cost beneficiaries with multiple chronic conditions.

### **Consumer and Advocate Perspectives**

Medicaid agencies are seeking opportunities to engage beneficiaries and the advocacy community early in the process to collaborate on program design, incorporate consumer feedback into implementation decisions, and increase the likelihood for buy-in. Advocates may find non full-risk models more appealing because they may permit greater choice of providers, particularly those providers with whom the consumer has established relationships. Access to disability competent providers is very important to many ABD/SSI beneficiaries as is the option to "opt out" after trying the care management program. States have established various ways of monitoring the availability of providers to ensure that there is appropriate access to services.

### **Provider Perspective**

While providers may benefit from non-financial supports described earlier in this section, scan states reported that providers are concerned that increasing the level of engagement with ABD/SSI beneficiaries may add additional responsibilities without additional reimbursement. Many states in the scan brought providers to the table early in the development of programs for adults with complex needs and have adjusted reimbursement rates or created additional payments for providers who agree to perform additional services. Some states are exploring pay-for-performance or pay-for-participation strategies, such as Pennsylvania, which has a unique financial incentive program for providers engaged in disease management for chronic conditions (see page 17).

## Financing and Risk Adjustment Strategies

**Theme 2:** States are developing alternative financing mechanisms for providers and contractors that include shared risk, shared savings, and pay for performance.

Finding the “right” financing mechanisms to support providers and contractors in serving high-risk beneficiaries is a challenge. Scan states are testing variations on traditional payment strategies as well as alternative financing arrangements to balance appropriate reimbursement with accountability.

### Provider Reimbursement Strategies

Most of the provider reimbursement strategies highlighted in this report were built on the existing FFS financing structure. In PCCM programs, providers generally receive FFS payments for services rendered, with additional per-member per-month (PMPM) payments for performing care management services. The range of PMPM payments can vary by state depending on the scope of services provided. For example, primary care physicians in the Texas PCCM program receive a \$5 PMPM case management fee for specialty referrals, provider access, and EPSDT compliance. Physicians in Indiana’s Care Select program who agree to meet a number of practice standards, including working with the care management contractors on patient care plans, receive a \$15 PMPM administrative fee.<sup>13</sup> Practices participating in the Rhode Island Chronic Care Choice PCCM program receive a \$30 PMPM for employing nurse case managers.

North Carolina is using the experience from the initial years of its chronic care management pilot program to identify the optimal PMPM for practices and networks providing comprehensive care manage-

ment. Depending on the needs of an individual beneficiary, the care management offered by the state’s medical home model might include: disease management, pharmacy management, mental health referrals, social case management, interdisciplinary team review, patient empowerment and education, family/care giver involvement, and/or collaboration with community providers.<sup>14</sup> North Carolina recognizes that the state’s standard PCCM care management fees — \$2.50 PMPM for physicians and \$3 PMPM for networks — are insufficient to support the broad scope of services needed by ABD/SSI beneficiaries. The state is using non-PMPM direct funding to support networks and physicians during the program start-up phase. After obtaining two years of experience, the state hopes to develop an appropriate PMPM for both physicians and networks based on the number of ABD/SSI beneficiaries enrolled.

### Risk Adjustment in Minnesota

Minnesota is designing a risk-adjusted rate for its provider-based care coordination program. The state is developing a methodology to pay primary care physicians a monthly risk-adjusted care management/coordination fee that is likely to average \$50 PMPM, with increased payments for beneficiaries at higher-risk and a PMPM lower than \$50 for lower-risk beneficiaries. Risk adjusting the payments may alleviate concerns that providers may not agree to serve the highest risk beneficiaries.

<sup>13</sup> *Care Select Program Addendum to the Indiana Health Coverage Programs/Medicaid Provider Agreement*, State of Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning, October 2, 2007. Available at: <http://www.indianamedicaid.com/ihcp/caresselect/content/documents/cs%20pmp%20addendum.pdf>.

<sup>14</sup> *Chronic Care Program Summary*, Community Care of North Carolina, 2007. Available at: <http://www.communitycarenc.com/PDFDocs/CCNC-Chronic.pdf>.



### **Contractor Reimbursement Strategies**

Much like providers, contractors that administer all or part of the care management program may also be reimbursed a PMPM rate, with payments varying depending on the scope of services provided. For example, South Carolina medical home network vendors receive \$10 PMPM for administering the program and providing care management and care coordination services, but the state requires vendors to share approximately \$2.50 of that payment with participating providers.

In programs managed by contractors, states may use financing mechanisms that put some or all of the contractor's payment at risk for meeting cost savings or other performance targets. The scan found that some states are withholding fees or requiring contractors to pay back between 20 and 100 percent of their fees if quality, financial, and/or operational performance targets are not met. Indiana, for example, withholds 20 percent of contractor fees for performance-related payments in its Care Select program. Half of the withhold is released if contractors beat the annual cost growth trend for enrolled beneficiaries by a specific percentage. The remaining half of the payment is earned by meeting performance goals related to provider network composition and quality. Contractors are also required to pass on at least 75 percent of any performance-related payments to providers. Like programs in other scan states, New York's proposed Chronic Illness Demonstration Projects (CIDP) for adults with medically and behaviorally complex conditions puts a portion of the contractors' monthly care coordination fee at risk for meeting quality and cost performance standards. New York is unique, however, in that the program sets aside dedicated funds for CIDP contractors to receive one-time, limited reimbursement for initial startup and enrollment costs during the first year of operation.

Some states have also created shared savings programs that provide vendors with additional payments if spending reductions are more significant than expected. South Carolina, California, and Mississippi have or are considering shared savings programs for their contractors; in South Carolina, contractors are required to share at least part of such savings with providers.

Programs in states like Pennsylvania, Oklahoma, North Carolina, and Texas that provide care management for high-need, high-cost subsets of the PCCM population have all developed unique financing mechanisms. In Texas, the state is developing a program that will reimburse a contractor for providing advanced case management services above and beyond those currently available in its PCCM and disease management programs.

As California develops its new Coordinated Care Management Program it will also design a separate payment system. Currently the state pays \$17 PMPM to a disease management vendor to provide traditional disease management services in a two-county pilot program. In contrast, according to the draft RFP for the new program, the state will request PMPM bids from contractors to provide comprehensive care coordination for beneficiaries with disabilities or multiple chronic conditions. Unlike the disease management program, the Coordinated Care Management Program will require the contractor to guarantee that net medical costs for program members will not increase. The proposed guaranteed savings calculation includes the care coordination PMPM as a cost, so the contractor must reduce medical expenditures by at least the aggregate PMPM payments in order to receive full payment.

## Performance Measurement Approaches

**Theme 3:** Measuring clinical and non-clinical aspects of care management programs can be difficult, but states have begun to develop and test more appropriate performance measurement and monitoring strategies.

States that design programs for adults with chronic illnesses and disabilities can either adapt existing measures, adopt new measures, or do both to more accurately reflect the complex needs of the population. Many states use the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures for full-risk capitated Medicaid programs. Some are also using HEDIS, including newer provider-level measures, in partial- and non-risk programs; although, there is no comparable NCQA accreditation process as the one that exists for managed care organizations. While states have found that HEDIS measures cover a range of chronic conditions (e.g., asthma, diabetes, and hypertension) and provide a standardized way to hold health plans accountable, they are not designed to address co-occurring conditions, physical disabilities, or care coordination. NCQA is currently researching these areas for future measurement development. Timely creation of these types of measures is needed as many states described a large gap between the areas addressed by existing measurement sets and the clinical and non-clinical indicators needed to accurately assess the care provided to the ABD/SSI population.

A handful of scan states (e.g., Indiana and Pennsylvania) have begun to create more robust measurement strategies in their non-risk programs that address specific issues related to ABD/SSI beneficiaries. For example, Indiana's Care Select program uses indicators related to care management, disease management, and service utiliza-

tion. The state tracks care planning and coordination through the following mechanisms: percentage of beneficiaries screened; development of a care plan based on individual needs; timeliness of prior authorization responses; and care management calls answered. As a proxy measure for care management, contractors in the Care Select program must report on a subset of the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs).<sup>15</sup> The PQIs capture data on hospital admission rates for conditions common to people with chronic illnesses (e.g., dehydration, bacterial pneumonia, urinary tract infections, and respiratory failure) that are seen as avoidable or preventable if proper care management and ambulatory care had been provided. In introducing new measures and reporting requirements, scan states acknowledged the importance of clearly understanding how the measurement data will be used and setting realistic expectations for changes in outcomes.

One of the most important, yet difficult, areas to quantify and measure for programs serving beneficiaries with complex needs is care management. Some states are testing the use of PQIs as well as process measures (e.g., number of calls made by care manager or number of referrals made to specialists) to determine the effectiveness of these measures in assessing the delivery of care management. While tracking these process indicators is an important first step, states may want to consider developing mechanisms to link these process measures to clinical outcomes. Pennsylvania, for example, is

<sup>15</sup> *Prevention Quality Indicators Overview*, Agency for Healthcare Research and Quality, July 2004. Available at [http://www.qualityindicators.ahrq.gov/pqi\\_overview.htm](http://www.qualityindicators.ahrq.gov/pqi_overview.htm).

using an innovative approach to assess the effectiveness of care coordination in its ACCESS Plus program. Physicians who treat high-risk beneficiaries are eligible for a bonus if they achieve certain quality of care process improvements for beneficiaries with asthma, diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease. Pennsylvania feels that tracking the completion of specific processes critical to high-risk beneficiaries can help the state evaluate whether or not a physician is providing good care management for its high-risk beneficiaries.

As part of Pennsylvania's pay for performance (P4P) program, each participating physician can receive a bonus payment of \$17 for conducting certain care processes (e.g., LDL tests for beneficiaries with diabetes) and for each beneficiary who reports to be taking key medications (e.g., controller medications for beneficiaries with asthma, beta blockers for beneficiaries with congestive heart failure, etc.). Additional bonus payments physicians can receive include:<sup>16</sup>

- \$200 (one-time bonus) for participating in the P4P program;
- \$40 for each high-risk beneficiary the physician enrolls into the disease management program;

- \$30 (one-time bonus) when the physician provides the state with updated contact information pertaining to the high-risk beneficiary; and
- \$60 (up to twice a year) for completing a Chronic Care Feedback Form for each high-risk patient.

The state attributes certain improvements in results, including an increase in appropriate prescriptions filled for cholesterol lowering medication for beneficiaries with coronary artery disease and for beta-blockers for beneficiaries with congestive heart failure, to the P4P program.<sup>17</sup>

Performance measures that reflect the clinical and non-clinical needs of beneficiaries are fundamental components of every Medicaid program and are perhaps even more critical when it comes to monitoring the effectiveness of care for high-risk beneficiaries. Many of the scan states are testing new measurement approaches, but much can still be done in this area to ensure that there are more sophisticated appropriate measures for adults with a complex array of needs.

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<sup>16</sup> ACCESS Plus P4P program description is available at <http://www.accessplus.org/PayForPerformance.aspx>.

<sup>17</sup> ACCESS Plus P4P Program Overview, Pennsylvania Department of Public Welfare, November 7, 2007. Available at [http://www.accessplus.org/downloads/P4P/P4P\\_PhysicianPresentation.pdf](http://www.accessplus.org/downloads/P4P/P4P_PhysicianPresentation.pdf).



## Conclusion: Considerations for States

States are developing alternative systems of care for adults with complex needs. In so doing, they are breaking new ground in how to best structure the “levers” (i.e., operational, clinical, and financial) available to their contractors to ensure accountability for both quality and costs. States and their partners will continue to experiment with how to structure “levers” in these new models, not only to permit sufficient flexibility, but also to ensure appropriate accountability.

The recognition that in FFS there are virtually no levers and, therefore, no accountability, has led many states to move from FFS toward more coordinated systems of care. On the other end of the spectrum, in fully capitated models, the strongest “lever” tends to be financial in that the health plan is at risk for outcomes and costs. In exchange for accepting full risk, the contractor has a significant amount of flexibility and control over those things (e.g., services/benefits, medical management, provider networks, payment rates, claims processing, etc.) that impact outcomes and costs. States using non-risk models are testing ways to balance flexibility and control with risk and overall accountability.

By definition, these non-risk models do not have the same financial leverage. Nonetheless, there are other important levers for states and their care management contractors to consider.

**Medical Management:** These models differ regarding the scope of medical management authority given to contractors. Medical management “tools,” such as prior authorization, concurrent review, and dis-

charge planning, provide information vital to: (a) understanding and changing patterns of care; (b) ensuring appropriate referrals, discharge planning, and care transitions; and (c) linking adults with complex needs with appropriate care management interventions. As one contracting organization described it, prior authorization serves as a “flag” when someone enters the system; concurrent review tracks who is in the system; and care management attempts to help people avoid unnecessary utilization by coordinating and integrating care. Care management is likely to be enhanced by combining these other functions, which can help align incentives both clinically and financially. This increases the potential for a contractor to impact both quality and costs. Internal calculations by one of the plans interviewed found a positive return on investment (ROI) for concurrent review, prior authorization, and care management; however, the ROI for concurrent review is four to five times that of prior authorization, with both exceeding the ROI for case management.<sup>18</sup>

As states think through how to structure contractors’ scope of authority over medical management activities, it may be beneficial to consider which functions have the greatest potential impact on both quality and cost as well as how these functions reinforce one another. As the flexibility and authority a state allows its contractor increase, so should the degree to which the contractor is held accountable. Conversely, the less latitude a contractor is given over these activities, the more likely a state may need to adjust its performance expectations accordingly.

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<sup>18</sup> Conversations with officials at Schaller Anderson, Inc.

**Provider Networks:** Systems of care for adults with complex needs usually rely on primary care providers to coordinate patients' clinical and psychosocial needs. States interviewed are recognizing that there are tradeoffs if care management contractors are expected to change provider behavior but lack the authority to build or modify provider networks. Contractors in non-fully capitated models generally do not contract directly with physicians, therefore lack much leverage over the type and scope of care delivered. While financial incentives and specific provider agreement requirements may help allay some of these concerns, states recognize that the parameters they establish for contractors vis-à-vis provider network responsibility and authority influence the ability of contractors to ensure appropriate care delivery. Similarly, the requirements that states establish for working with existing providers or case managers has an impact on how much contractors can be expected to influence both the utilization of care and program costs.

**Intervention Flexibility:** Fully capitated programs for ABD/SSI populations provide managed care plans with considerable latitude to direct their resources to beneficiaries who have a high risk of future utilization/costs and the potential for positive outcomes. In other words, the plans have the flexibility to develop targeted and tailored interventions for subsets of the population. This same flexibility generally does not exist in non-fully capitated models and can leave many states with a relatively rigid one-size-fits-all care management

approach that strictly defines covered services and target populations. The complex and varied needs of the adults targeted for these new care models suggest that states would benefit by allowing contractors sufficient flexibility to: (a) focus on high-risk beneficiaries; and (b) provide the services and targeted clinical interventions that those individual beneficiaries most need. A key consideration of the former is transparency and consensus on the classification of and stratification into different levels of care/risk. With regard to the latter, many of the states interviewed seem to understand the importance of flexibility in this arena. While many require a minimum set of core care management elements, they are encouraging contractors to customize specific interventions that meet the needs of individual beneficiaries. The more flexibility a contractor has in tailoring interventions, the more the state can hold it accountable for developing holistic, patient-based plans of care.

Other issues that have an impact on the levers available to states and their contractors in these models include: integration with carved-out services, especially behavioral health care; incentives, especially at the provider level and/or linked to medical homes; primary care provider assignment vs. open models; and access to real-time, actionable data. The importance of an integrated data set cannot be understated and has a direct impact on a contractors' ability to ensure appropriate utilization, tailor services, and control costs.

An overarching theme we heard throughout our interviews is the need to set realistic expectations for both quality and costs. A concern of some plans/contractors is that states may be expecting the same level of financial and clinical accountability as is found in full-risk models. These non full-risk approaches typically do not provide the same flexibility and authority to contractors, and therefore cannot be expected to have the same accountability. However, these models are uncovering additional “levers” that have an impact on quality, cost, and satisfaction. While a natural tension exists as these programs evolve, the hope is that states and their partners are learning together about how to best balance expectations and accountability with authority and flexibility.

In sum, the state leaders highlighted in this report are testing this balance as they explore new approaches to caring for Medicaid beneficiaries with complex and costly health care needs. It is clear through their experiences that there is no one-size-fits-all approach. Rather, states are using a variety of innovative care models, financing structures, and performance measurement strategies to best address beneficiary and state needs. As more states look to

enhance care management for high-risk populations, the findings herein may guide them in developing their own programs to both improve patient outcomes and control costs.

As indicated at the outset of this report, the only hard and fast rule is that states will not and can not sit still. New models will continue to emerge in state laboratories across the nation. More states and their partners will gain experience about what works – and what does not work – for populations with complex needs. Subsequent efforts to scan the field will surely uncover new ways of enhancing integration among the state, care management contractors, and primary care providers. The growing budget pressures on publicly financed health care spending as well as the momentum for national health care reform will inevitably place states in a leadership role in balancing coverage, costs, and quality. This, of course, means that state Medicaid leaders will find themselves again and again back in the laboratory, testing new approaches, and embracing opportunities to demand more value for public dollars.





## Appendix 1: Systems of Care for ABD/SSI Beneficiaries in Scan States

State	Program Name	Target Population	Type of Programs			Enrollment for ABD/SSI	Geography
			FFS	PCCM	Full-Risk Managed Care		
<b>California</b>	Disease Management Pilot	Beneficiaries with asthma, diabetes, heart failure, coronary artery disease, chronic obstructive pulmonary disease (COPD), and atherosclerotic disease	✓			Voluntary	2 Counties
	Coordinated Care Management Program (RFP in development)	Seniors and people with disabilities who have chronic conditions or who may be seriously ill and near end of life; and people with chronic health condition(s) and serious mental illnesses (excluding duals)	✓			Voluntary	3-4 Counties
	Medi-Cal Managed Care	All beneficiaries			✓	Voluntary	22 Counties
<b>Indiana</b>	Care Select	ABD and non-disabled HCBS waiver beneficiaries (excluding duals)		✓		Mandatory	Statewide
	Minnesota Disability Health Options	Adult beneficiaries with disabilities			✓	Voluntary	Twin Cities Metro Areas
<b>Minnesota</b>	Provider Directed Care Coordination	High-cost, high-need beneficiaries	✓			Voluntary	To be determined
	Intensive Care Coordination	Top 300 chronically ill beneficiaries	✓			Voluntary	To be determined
<b>Mississippi</b>	Disease Management Program (RFP out for bid)	Beneficiaries with asthma, COPD, CHF, chronic renal failure, diabetes, hypertension, or other high-risk beneficiaries	✓			Voluntary	Statewide

continued

**Appendix 1: Systems of Care for ABD/SSI Beneficiaries in Scan States (continued)**

State	Program Name	Target Population	Type of Programs			Enrollment for ABD/SSI	Geography
			FFS	PCCM	Full-Risk Managed Care		
New York	Medicaid Managed Care & Partnership Plan	All beneficiaries			✓	Voluntary	11 Counties
	Primary Care Partial Capitation Providers	Managed care eligible beneficiaries		✓		Mandatory	44 Counties
	Medicaid Disease and Care Management Demonstration Programs	Varies by region	✓			Voluntary	5 Counties
	Chronic Illness Demonstration Projects (RFP out for bid)	Medically or behaviorally complex adult beneficiaries (excluding duals, institutionalized, HCBS waiver)	✓			Voluntary	6 Regions
North Carolina	Community Care of North Carolina	All beneficiaries		✓		Voluntary	Statewide
	Chronic Care Project (pilot)	ABD/SSI and chronically ill beneficiaries		✓		Voluntary	10 Networks
Oklahoma	SoonerCare Choice	All beneficiaries (excluding duals, institutionalized, HCBS waiver, state or tribal custody)		✓		Mandatory	Statewide
	Health Management Program	5,000 highest cost beneficiaries with chronic conditions		✓		Voluntary	Statewide
Pennsylvania	ACCESS Plus	All beneficiaries (excluding duals, nursing home residents)		✓		Mandatory	42 Counties
	HealthChoices	All beneficiaries			✓	Mandatory	25 Counties
	Voluntary Managed Care	All beneficiaries			✓	Voluntary	27 Counties
	Intensified Medical Case Management	Beneficiaries with multiple chronic conditions		✓		Voluntary	42 Counties
	Disease Management	Beneficiaries with asthma, diabetes, COPD, coronary artery disease	✓	✓		Voluntary	Statewide

continued

**Appendix 1: Systems of Care for ABD/SSI Beneficiaries in Scan States (continued)**

State	Program Name	Target Population	Type of Programs			Enrollment for ABD/SSI	Geography
			FFS	PCCM	Full-Risk Managed Care		
<b>Rhode Island</b>	Connect CARE Care Management and Wellness Program	300 disabled and chronically ill adult beneficiaries with CHF, COPD, sickle cell anemia, asthma, diabetes, depression, and others at high risk	✓			Voluntary	Limited or Statewide
	Connect Care Choice	Adult beneficiaries (excluding duals, institutionalized)		✓		Voluntary	Providence and Newport Metro Areas (expanding to statewide)
	Rhody Health Partners	Adult beneficiaries (excluding duals, institutionalized)			✓	Voluntary	Statewide
	Medical Homes Network Program	All beneficiaries (excluding nursing home, hospice, waiver programs)		✓		Voluntary	43 Counties
<b>South Carolina</b>	Managed Care Health Plans	All beneficiaries (excluding nursing home, hospice, waiver programs)			✓	Voluntary	36 Counties
	STAR Medicaid Managed Care Program	All beneficiaries (excluding duals, foster care, nursing home, medically needy)			✓	Voluntary	52 Counties
	STAR+PLUS	SSI and HCBS waiver beneficiaries (excluding institutionalized, partial benefit beneficiaries)			✓	Mandatory (voluntary for SSI children)	28 Counties
<b>Texas</b>	Primary Care Case Management	All beneficiaries		✓		Voluntary	12 Counties
	Integrated Care Management	SSI including duals, community based alternative participants		✓		Mandatory (voluntary for SSI children)	202 Counties
	Enhanced Care Program (disease management)	Beneficiaries with asthma, diabetes, CHF, COPD, coronary artery disease	✓	✓		Mandatory (voluntary for SSI children)	13 Counties
	Health Management Program (in development)	Beneficiaries with high costs and/or high risk of chronic illness	✓	✓		To be determined	To be determined
	Chronic Care Management (pilot)	High-risk adult beneficiaries (excluding HCBS waiver, hospice)		✓		Voluntary	Statewide
<b>Washington</b>	Washington Medicaid Integration Partnership	SSI and SSI-related beneficiaries			✓	Voluntary	1 County

## Appendix 2: Selected Financing Mechanisms for Systems of Care for ABD/SSI Beneficiaries

State	Program Name	Target Population	Type of Programs			Description of Financing Mechanism
			FFS	PCCM	Full-Risk Managed Care	
<b>Indiana</b>	Care Select	ABD and non-disabled HCBS waiver beneficiaries (duals excluded)		✓		<p>PCCM vendors receive approximately \$25 PMPM care management fee for each beneficiary enrolled in Care Select. The state initially withholds 20 percent of the total fee. Half of the withhold can be earned by meeting the financial performance target (beating an agreed-upon trend rate), while the other half can be earned by meeting certain process and outcome quality measures. Vendors must return 75 percent of any of the performance-related payments to providers through pay for performance and consumers through personal responsibility incentives.</p> <p>Primary care physicians who sign a Care Select addendum to the Medicaid provider agreement receive a \$15 PMPM for each enrolled Care Select Member.</p>
<b>Minnesota</b>	Provider Directed Care Coordination	High-cost, high-need beneficiaries	✓			<p>Participating providers receive a care management/coordination fee that will average \$50-\$55 PMPM. The state is working with a number of stakeholders to develop a risk adjustment strategy that adjust payments from around \$20 PMPM to over \$100 PMPM depending on individual beneficiary risk.</p>
<b>Oklahoma</b>	Health Management Program	5,000 highest cost beneficiaries with chronic conditions		✓		<p>The program vendor receives one PMPM fee to provide in-person nurse case management services to Tier 1 (1,000 in highest expected cost bracket) enrollees and a lower PMPM to provide telephonic case management to Tier 2 (remaining 4,000) enrollees. The vendor also receives a one-time payment for each beneficiary enrolled, and a monthly payment for each full-time in-office practice facilitator.</p> <p>Primary care providers in the program continue to receive a partially capitated primary care fee that puts them at risk for providing a defined set of basic office visits and labs. This fee includes a \$2-3 PMPM care management add-on. The partial capitation fee is adjusted for age, gender, and aid category (TANF or ABD/SSI).</p>

continued

## Appendix 2: Selected Financing Mechanisms for Systems of Care for ABD/SSI Beneficiaries (continued)

State	Program Name	Target Population	Type of Programs			Description of Financing Mechanism
			FFS	PCCM	Full-Risk Managed Care	
<b>Pennsylvania</b>	Intensified Medical Case Management	Beneficiaries with multiple chronic conditions		✓		Providers are reimbursed under the current PCCM payment structure and the state uses internal resources to hire nurse managers in the Intensified Medical Case Management unit to conduct care management and coordination for eligible beneficiaries.
	Disease Management	Beneficiaries with asthma, diabetes, COPD, coronary artery disease	✓	✓		Providers participating in the disease management program receive extra payments for conducting certain processes including: providing patient enrollment support and contact information; completing a chronic care feedback form; and appropriate chronic care prescribing.
<b>Rhode Island</b>	Connect Care Choice	Moderate- or high-risk ABD/SSI adult beneficiaries excluding duals, institutional		✓		Participating providers receive standard fee-for-service rates, but those rates were increased to 80 percent of Medicare for specified codes in 2007. Providers also receive \$30 PMPM to cover the costs of a nurse care manager responsible for chronic care coordination.
<b>South Carolina</b>	Medical Homes Network Program	All beneficiaries excluding nursing home, hospice, waiver programs		✓		Care Coordination Service Organizations that contract with the state to provide care management receive \$10 PMPM, and are required to share \$2.50 PMPM of that payment with participating providers.  If enrolled beneficiaries, on average, cost less than the \$184 PMPM HMO rate, contractors and the state split the shared savings 50-50. Contractors are then required to share their portion of the savings with participating providers, and have historically shared 60 percent with providers, while retaining 40 percent.



## Additional CHCS Resources

The Center for Health Care Strategies (CHCS) works with Medicaid stakeholders across the country to design, implement, and evaluate programs that more effectively address the needs of adults with chronic conditions and disabilities. Visit [www.chcs.org](http://www.chcs.org) for information and resources from the following initiatives:

**Managed Care for People with Disabilities Purchasing Institute:** Resources for developing, enhancing, or expanding managed care programs for SSI beneficiaries. Online materials include sample requests for proposals, contracts, health assessment tools, and other administrative resources.

**Medicaid Value Program: Health Supports for Consumers with Chronic Conditions:** Resources for designing/implementing programs for beneficiaries with multiple chronic conditions. Online materials include pilot project case studies and intervention logic models.

**Rethinking Care Program:** Under this new program, CHCS is working with regional or state multi-stakeholder collaborative teams to implement new care models and tools for improving the care of high-need, high-cost beneficiaries. The pilot projects will be linked to a national learning network of policy makers, researchers, and practitioners focused on disseminating replicable solutions to improve care for high-opportunity patient populations. A variety of hands-on tools, including a *Users' Guide for Predictive Modeling*, will be developed and shared nationally.

[www.chcs.org](http://www.chcs.org)

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