
HMA

HEALTH MANAGEMENT ASSOCIATES

Wyoming Coordinated Care Study

PRESENTED TO

WYOMING DEPARTMENT OF HEALTH

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*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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Executive Summary

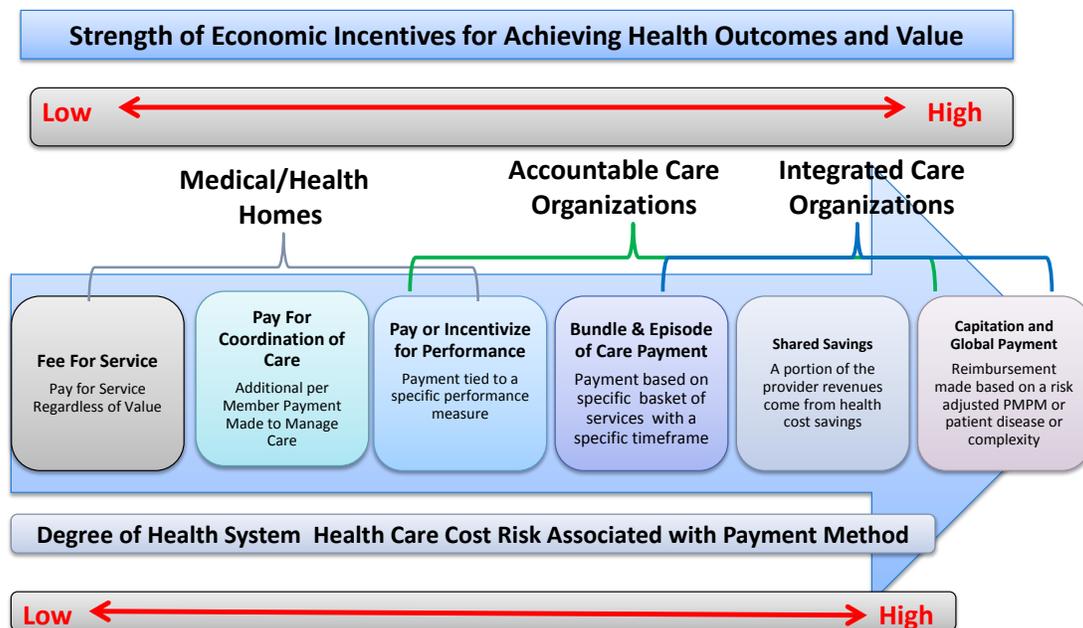
In 2012, the Wyoming Legislature enacted Senate Enrolled Act No. 58, which required the Wyoming Department of Health (WDH) to analyze the cost drivers within Medicaid and identify areas within the program that would benefit from redesign. In response to this mandate, WDH recommended three packages of reforms that could be implemented.

One of its recommendations was to study whether it would be beneficial to move some or all of the Medicaid population into managed care. To ensure comprehensive analysis of the feasibility of this change, during the 2013 General Session, Senate Enrolled Act No. 82 (SEA0082) was passed. SEA0082 directs the WDH to study the use of managed models of care for some or all of the people enrolled in the Medicaid program with the goal of delivering care of the same or better quality as currently delivered, while also reducing costs.

In studying managed care models, Wyoming is pursuing a path that many other states already have or are currently pursuing. To address increasing Medicaid spending, states are looking to existing and new forms of managed or coordinated care and payment reforms. As shown in Figure 1 below, the Medicaid managed care continuum includes programs with no or very low provider risk such as Primary Care Case Management (PCCMs), with gradually increasing levels of provider risk through models such as Patient Centered Medical Homes (PCMHs), Health Homes and Accountable Care Organizations (ACOs), all the way to full-risk managed care with very high provider risk. Most states have some level and type of managed care; only two currently do not have any, Alaska and Wyoming.

Figure 1

Health System Models and Aligned Payment Methods



Source: HMA

A. Why States Pursue Managed Care Models

Many states are expanding their managed care programs to include new services, such as behavioral health and long-term care (LTC), as well as new populations, such as those with disabilities, and people who have both Medicare and Medicaid. In addition to managed care, many states are also pursuing new care coordination models, including Patient Centered Medical Homes (PCMHs), Health Homes, and Accountable Care Organizations (ACO). In 2013, 25 states implemented care coordination models, and in 2014, there will be 33 states doing so. While states are pursuing a variety of models, the most common is the Health Home, created under the Patient Protection and Affordable Care Act of 2010 (ACA) to focus on people with mental health and substance use disorders, as well as those with multiple chronic conditions. More than one-third of states are pursuing Health Homes. Many states also are coupling these enhanced care coordination models with new reimbursement mechanisms geared toward paying more for quality rather than quantity. These various shared savings/share costs, pay-for-performance, and incentive programs all increase provider risk to some degree.

States often focus on specific sub-populations within the Medicaid program when creating these initiatives. Individuals with both chronic conditions and mental health issues, for example, are often the highest utilizers and highest-cost enrollees. By focusing on and coordinating care for these individuals, states hope to improve care and reduce spending.

States are pursuing delivery and payment reforms for a variety of reasons, but the four most common include:

- State Medicaid agencies want to address the growth rate in Medicaid spending by creating payment models that encourage quality improvement, reward value over volume, as well as by providing greater budget certainty.
- States are developing delivery system approaches that establish medical homes for enrollees – attempting to coordinate care across providers and facilitate beneficiaries’ access to care.
- States desire to further integrate physical and behavioral health care and reduce service fragmentation to improve care and health outcomes, and improve efficiency and cost-effectiveness of care.
- States want to take advantage of the financing opportunities made available through the ACA such as planning grants for PCMHs, and enhanced federal matching funds for home and community based services, Health Homes, and other models of care coordination and quality improvement.

B. WDH’s Approach to the Study

In conducting the study, WDH used the term "coordinated care" in lieu of "managed care" because the term is broader and includes newer models such as Health Homes, PCMHs, and ACOs. The WDH defined managed or coordinated care as “any system of healthcare delivery that focuses on management of healthcare services with the intent to provide integrated and coordinated care at a lower cost.” Under this definition, managed or coordinated care could take many forms and be accomplished using various models and payment methods. The WDH did not focus on one model of managed or coordinated care or one type of payment method, and was most interested in models and payment methods that will work well within Wyoming’s unique geography, provider community, and for the enrollees. In the summer of 2013, WDH used a competitive procurement process and selected Health Management Associates (HMA) to complete the study.

HMA conducted extensive research on managed and coordinated care models in place across the country and selected states for additional research and interviews with key Medicaid officials. The states

chosen for analysis are similar to Wyoming in population, geography, infrastructure, and/or Medicaid enrollment. Other states that are dissimilar, such as Oregon, were chosen because of the innovative models currently being implemented. Wyoming’s current initiatives were also identified and researched to determine how they would impact managed or coordinated models of care. Finally, HMA elicited extensive stakeholder feedback that included use of an e-mail inbox, conducting key informant interviews, holding five public forums, and coordinating two electronic surveys.

C. Models of Care

i. Recommended

HMA's care model recommendations are supported by the research, assessment of Wyoming’s current initiatives, and stakeholder feedback. In making these recommendations, HMA considered the:

- Feasibility of the various managed or coordinated care models and value-based payment methods in Wyoming, given its large geography and sizable rural/frontier areas within the state.
- Administrative burden of implementing, managing, and monitoring each model.
- Degree to which vendors and providers are interested and would participate.
- Impact on Wyoming Medicaid enrollees and providers.
- Unique features of Wyoming’s health care system, both its strengths and weaknesses.

HMA recommends that WDH pursue the two coordinated care models shown in Table 1. These models, implemented in concert with one another, build on one key initiative already underway in Wyoming – PCMHs.

Table 1

Model	Rationale for Recommending the Model
Targeted PCMH	<ul style="list-style-type: none"> • As Medicaid prepares to begin participation in the multi-payer effort already underway establishing and enhancing PCMHs provide a targeted group of high-utilizing and high-cost enrollees with enhanced care management through the PCMH structure.
Super Utilizer Program	<ul style="list-style-type: none"> • A small number of enrollees are considered “super utilizers” because of the level of services they use and the high cost of those services. Wyoming can create a care management model that provides very high-touch care management to these individuals, on top of the enhanced care coordination they would receive through a PCMH.

ii. Not Recommended

Also based on stakeholder engagement, care model research, extensive literature reviews, as well as Wyoming’s unique characteristics, HMA recommends that WDH not pursue the care models shown in Table 2 at this time. As current initiatives begin to yield results and WDH has expanded both experience and expertise with those models, the state may want to reassess the feasibility of implementing some of these other models.

Table 2

Model	Rationale for Not Recommending the Model
PCCM	<ul style="list-style-type: none"> Wyoming already is further along the managed care continuum than PCCM, with existing PCMHs and Medical Neighborhoods initiatives, and planning for Health Homes.
ACO	<ul style="list-style-type: none"> Once the other initiatives currently underway or planned are stable and demonstrating success, Wyoming could identify appropriate candidates for further evolution to the ACO model. ACO is still a relatively new model; Wyoming could benefit from lessons learned in other states as they roll out their ACOs.
ASO	<ul style="list-style-type: none"> Wyoming already has a program that effectively is an ASO through its case management contract with Xerox Care and Quality Solutions (CQS). There may be opportunities for the state to modify its contract with Xerox CQS to better align it with other initiatives underway or expand the current scope of work to support and supplement current initiatives.
Full Risk Managed Care	<ul style="list-style-type: none"> Research is mixed on the extent to which managed care can improve quality and save money for Medicaid enrollees, particularly in rural areas. Provider participation is critical for Wyoming Medicaid and lack of providers willing to participate in risk-based managed care would be a significant obstacle for any managed care organization to establish a viable network There is very little commercial managed care in Wyoming now, which would mean Medicaid would bear the brunt of laying the managed care groundwork in the state. Other states that have moved to managed care recommend an iterative approach that builds on current structures – risk-based managed care would be a major transition and would require a substantial investment in infrastructure needed to successfully support it, meaning a longer time to achieve any real cost savings.

D. Next Steps

Given the above recommended models and considerable work that WDH already is doing, HMA suggests the following next steps, as detailed in Table 3.

Table 3

Next Step	Action Items
<p>Continue the focus on successfully implementing the multiple efforts already underway or planned to integrate Wyoming’s health care system, improve care coordination, and slow Medicaid cost growth</p>	<ul style="list-style-type: none"> • The only new initiative Wyoming could consider is a super-utilizer program (SUP) built on the existing PCMHs to provide enhanced care coordination to the most expensive and high-needs enrollees (see above recommended models).
<p>Create a strategic road map for all Medicaid reforms and care coordination initiatives</p>	<ul style="list-style-type: none"> • WDH should create a strategic plan for how all of the current initiatives fit together. The roadmap should include: <ul style="list-style-type: none"> ○ All old, new, and planned care coordination activities and initiatives for the next three to five years. ○ Enrollees and providers that would be included in each initiative. ○ How WDH is connecting and leveraging each, including funding - whether state funds, federal funds, or other external funds. ○ The current status of each, as well as expectations for where they will be each year for the next five years. • WDH should share this roadmap with stakeholders as it is being developed to get their feedback before it is finalized and help to build their buy-in for the plan.
<p>Conduct ongoing, comprehensive stakeholder outreach, education, and engagement</p>	<ul style="list-style-type: none"> • WDH should continue to inform and educate stakeholders about the need for, and the value of integrated care coordination and management, what it means for them, and their roles and responsibilities. • WDH should create a comprehensive stakeholder education and engagement plan based on its roadmap (see above recommendations). The plan should identify specific groups of stakeholders and their needs, preferred modes of communication, level of understanding, ability to impact (positively and negatively) initiatives, their role in each initiative, and the messages and information they need from WDH.
<p>Enhance and expand the necessary infrastructure</p>	<ul style="list-style-type: none"> • Particularly because it is a largely rural and frontier state with shortages of most types of providers, Wyoming must continue to build and enhance the infrastructure needed to support all of its care coordination and management initiatives to fully realize their potential for quality improvement and cost savings. This infrastructure includes both <u>information technology and data</u>, as well as <u>workforce development</u>. • WDH should take a lead role in revitalizing and fully building out the state’s <u>Health Information Exchange (HIE)</u>. • WDH should work with providers to enhance and expand the use of the <u>Total Health Record</u>. • WDH should continue to support and expand the use of <u>tele-health services</u>.

	<ul style="list-style-type: none">• Wyoming should consider building internal capacity or procuring services from a vendor to <u>increase and enhance its capacity to use data</u> to support program decisions.• Wyoming should continue and enhance its <u>healthcare workforce development</u> strategies.
Implement value-based payments	<ul style="list-style-type: none">• For each of the initiatives underway or planned, WDH should consider moving more quickly to incorporate value-based payments for quality improvements, cost savings, or both.• As part of the roadmap, WDH should include specific reimbursement structures and timelines for each initiatives.• WDH also needs to build and expand its technical expertise in-house to manage and support new reimbursement options.

Section I: Overview of Legislation and Reports

During the 2012 Budget Session, the Wyoming Legislature passed Enrolled Act No. 58 (hereinafter SEA0058 or the Medicaid Options Study legislation). It requires the WDH to:

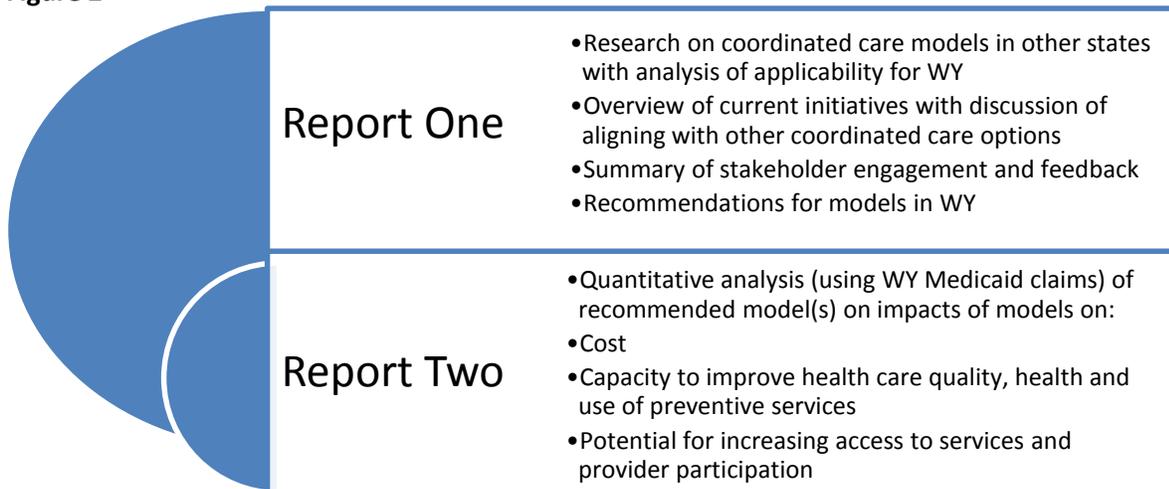
1. Analyze the cost drivers and identify other areas within the Medicaid program that may benefit from redesign.
2. Evaluate potential redesign of current Medicaid programs.
3. Evaluate the design of Medicaid programs mandated by the Patient Protection and Affordable Care Act, P.L. 111-148, and the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, hereinafter referred to collectively as 'the health care reform acts.'

The WDH issued three separate reports. In the final report, the WDH identified areas where the Medicaid program would benefit from reform or redesign and recommended three packages of reforms that could be implemented. One of those recommendations was to study moving some or all of the Medicaid population into managed care. In response to the Department's recommendations, the Wyoming Legislature in the 2013 General Session required a study of managed care through Senate Enrolled Act No. 82, which specifically:

- Requires WDH to conduct "an evaluation of enhanced use of managed care using tiers of services and more intense management for high cost clients."¹
- Requires WDH to "explore the use of managed care for all or a designated part of the Medicaid population, with the goal of delivering care of the same or better quality as currently delivered but at reduced cost."

The Care Coordination Study has two primary reports as described in Figure 2 below:

Figure 2



¹ The WDH is using the term "coordinated care" in lieu of "managed care" because the term is broader and includes newer models such as Health Homes (as authorized by Section 2703 of the Affordable Care Act), Patient Centered Medical Homes (though not new, use of it as a model has increased over the past five years), and Accountable Care Organizations.

This is the first report in the series. Report Two will be completed after discussion with WDH about the recommended models presented here.

Section II: National Trends and Coordinated Care Models

A. The Range of Managed Care Projects

Shortly after Medicaid was enacted in 1965, states began experimenting with different models of care, including capitated managed care.² Appendix A: Managed Care History and National Activities, provides an overview of key time-periods and activities in the growth of full-risk Medicaid managed care, as well as a number of other national trends for various types of care coordination models.

Today, states are:

- Expanding capitated managed care to all populations, including behavioral health and aged, blind, and disabled enrollees.
- Expanding to new geographic regions.
- Including additional services such as long-term care or behavioral health services, either through carve-out programs (FL and TX for long-term care, and CO and ID for behavioral health) or by integrating them into a capitated model already in place (TN and HI).
- Exploring ways to integrate services by including the services in the capitation payment and making managed care plans responsible, or by requiring establishment of MOUs or even contracts between providers.

B. Managed and Coordinated Care Models and Payment Structures

The remainder of Section II provides an overview of the different models of managed and coordinated care and the reimbursement methodologies states commonly use. When possible, data and findings from any research and evaluations are included. These models and payment methodologies, excluding fee-for-service (FFS), are described along the continuum, moving from least risk to greatest risk. Detailed information about each of these models can be found in Appendix B: Models of Care.

For each of the models described below, states may elect to “carve out” certain populations or benefits, instead covering them under another payment structure or specialized model. Populations that are often carved out of various models include those who receive special waiver program services, such as Home and Community Based Services (HCBS) or Developmental Disability services, those receiving long-term care services, individuals living in institutions, and individuals in PACE programs and those receiving hospice care. However, since some of these individuals are the most expensive and drive the highest utilization, many states are looking at ways to re-integrate them into their coordinated care programs, and enhance their case management across various providers through the better data sharing, communication and collaboration that these models support.

The most common benefit carve-outs have been for behavioral health, pharmacy, dental services, and non-emergency transportation. For example, behavioral health has been one of the more common carve-outs, developed from concerns that behavioral health services would get lost in the larger medical

² Michael Sparer, “Medicaid managed care: Costs, access, and quality of care,” Robert Wood Johnson Foundation, *Research Synthesis Report*, No. 23. September 2012. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/09/medicaid-managed-care.html>

component of care. However, states recently have begun to bring behavioral health back into their medical care programs with particular emphasis on integrating services and supports. Many states also are integrating long-term care and HCBS service requirements into their coordinated care models for the same reasons.

i. Primary Care Case Management

PCCMs are generally primary care providers or practices who are responsible for approving and monitoring the care of enrollees based on the specific criteria established by the state for the program. This model works well in rural areas because it does not require significant infrastructure or staff investments from providers who may have limited resources. A PCCM model can be managed by the state or by a contractor for relatively low administrative costs.

CMS does not require much oversight of a PCCM and the model can be implemented without requiring a waiver or extensive changes to a State Plan Amendment (SPA). Twenty-two states have PCCMs:

- 10 with PCCM only
- 22 with PCCM and risk-based capitated managed care

Providers usually are paid FFS plus a monthly care management fee (typically between \$2 and \$5 per member per month (PMPM)). Some states include pay-for-performance financial incentives (e.g., Pennsylvania's ACCESS Plus program). There is not a lot of evidence that PCCMs provide significant cost savings or quality improvements.

ii. Patient Centered Medical Homes (PCMHs)³

The PCMH is not a new concept, having been around since 1967. Yet it was not until 2007 that the American Academy of Family Physicians and three other medical associations issued guiding principles for PCMHs. That same year, the National Committee for Quality Assurance (NCQA) also issued specific standards that providers must meet to be recognized as a PCMH, setting a high bar for care delivery and coordination. Interest in the model has increased significantly in the last several years, including for both commercial health coverage and in Medicaid/Medicare.

PCMHs attempt to integrate care delivery for each patient, ensuring access to all needed services in a “whole person” approach. The PCMH model is distinct from a primary care practice or PCCM model in that the assigned provider team has responsibilities beyond coordination of medical services, such as ensuring after-hours access, maintaining electronic health records and tracking quality metrics, conducting comprehensive health assessments for all new patients, and proactively managing and reducing barriers for high-risk patients⁴. PCMHs are largely an expanded primary care medical model,

³ For the purposes of this study a PCMH is a practice that has attained NCQA certification.

⁴ Standards and Guidelines for Physician Practice Connections[®] – Patient Centered Medical Home (PPC-PCMH[™]), NCQA, CMS version, October 6, 2008.
http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/detailed_standards.pdf

Federally Qualified Health Centers (FQHCs) or Community Health Centers (CHCs), and other primary care settings.

PCMH also is a model that can be viable in both urban and rural areas. Many states have used their existing PCCM infrastructures to build PCMHs, since they are fundamentally based on primary care practices, similar to PCCMs. The majority of states pay providers a PMPM care management fee, but the fees vary considerably from state to state and are often adjusted for patient age, acuity, and PCMH NCQA accreditation level (there are three levels). PCMHs do require an additional level of data access and sharing, as well as changes to how providers practice in a team-based environment.

The literature shows that cost-savings and quality improvements vary for PCMHs, but generally it appears that using the PCMH model to help target high-utilizer and high-cost enrollees is where states see the most potential for savings.⁵

iii. Health Homes

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

States may target geographic areas for focus, and unlike other Medicaid programs which must be implemented statewide, no waiver is needed for geographic implementation. To encourage states to pursue this model and to ensure sufficient funding is available, states can receive a 90 percent federal match for certain services for the first eight quarters of their program. Each time a state expands geographically or includes new conditions, eight more quarters of enhanced match are available to those individuals meeting the new criteria.

Health Homes differ from PCMHs in several fundamental ways:

- They are required to integrate physical and behavioral health services.
- They must target enrollees with specific high-risk behavioral health and chronic physical health conditions.
- They are required to extend coordination beyond medical services to social and community supports.
- They can be established in a variety of different kinds of providers, including behavioral health and non-traditional providers such as supportive housing programs; the focus is always on integrating multiple services.

Most states pay a PMPM for Health Home services, but some also are experimenting with other reimbursement methodologies, including shared savings, risk-adjusted payments, bundled payments,

⁵ Susannah Higgins, MS; Ravi Chawla, MBA; Christine Colombo, MBA; Richard Snyder, MD; and Somesh Nigam, PhD, "Medical Homes and Cost and Utilization Among High-Risk Patients," *American Journal of Managed Care*, March 24, 2014. <http://www.ajmc.com/publications/issue/2014/2014-vol20-n3/medical-homes-and-cost-and-utilization-among-high-risk-patients>.

and capitation. Because of the level of service integration required, the number and types of providers participating, and the comprehensive reporting requirements from CMS, successful Health Homes need significant data collection, reporting and sharing capabilities. Additionally, all of these factors generally push participating providers to make substantial changes in their approaches to care delivery and support of the “whole person” needs across multiple providers, agencies, services and systems.

However, there is a growing body of evidence that Health Homes can result in significant impacts in quality and cost for their target populations.⁶ Health Homes have seen care and cost improvements in reduced inpatient admissions, reduced emergency visits and reductions in pharmacy costs.

iv. Accountable Care Organizations (ACOs)

An ACO is an entity consisting of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of the care delivered. In many cases, the ACO is a provider-based organization, but in some cases, it is a managed care organization. The ACO model is most often associated with Medicare or, to a certain extent, the commercial market. However, 17 states have or plan to have Medicaid ACOs.⁷ While the states have different names for their models – Coordinated Care Organization (Oregon), Regional Care Organization (Alabama), Regional Collaborative Care Organizations (Colorado) – they all have the same goal: improve population health and reduce spending, while providing care in a more coordinated and efficient manner.

The organizational structure of Medicaid ACOs differs from state to state and even within a state, depending on benefits, as well as participating providers and partners. Many ACOs are provider- or community-based. Despite these differences, in all cases, states have built their ACOs on the existing delivery system, including well-established PCCM programs, PCMHs, or MCOs. Having these existing programs with experience coordinating care and with some of the necessary infrastructure is a prerequisite to building a successful ACO.

Medicaid ACOs use a variety of payment mechanisms to incentivize coordinated, high quality care, including fully capitated and global budgets. The most common payment mechanism is shared-savings or shared-savings and losses. Generally, providers are assuming more risk with ACO models than the previously described models of coordinated care. As with Health Homes, access to timely patient data is critical for all the partners in an ACO. Also similar to Health Homes, providers who participate in ACOs must learn how to practice as part of a collaborative team, particularly when shared savings and/or costs are calculated across the entire team’s performance as a whole.

The cost savings potential of ACOs is still not certain. However, within Medicare, the ACO model is showing potential for savings. Cost savings and quality improvement have also been demonstrated in some Medicaid ACO models, such as in Colorado and Oregon, where there were significant reductions in

⁶ “Medicaid Health Homes: Implementation Update,” Center for Health Care Strategies, March 2014.

⁷ See <http://nashp.org/state-accountable-care-activity-map> and <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8498-medicaid-in-a-historic-time-of-transformation.pdf>

inpatient admissions, emergency visits, and the use of high-cost imaging, as well as increases in primary care and wellness visits.⁸

v. Administrative Services Organization

In an ASO model, a state contracts with a third party organization to administer certain Medicaid services, such as predictive modeling based on Medicaid data, disease management, care management, quality management, or member services. The third party organization can be any organization capable of carrying out the contracted services, but is often a managed care organization. Some states use the ASO model for specific programs or services, such as dental and behavioral health.

An ASO is typically paid an administrative fee to provide the contract services and is not at financial risk. The state maintains the financial risk for the care provided to enrollees, and maintains responsibility for important functions such as eligibility determination and paying provider claims. States also have attached performance goals to ASO payments to help ensure they deliver the level of services and quality expected.

Data required for an ASO depends largely on the level and types of services the state has contracted with an ASO to conduct. ASOs can offer states one way of getting better data about providers and enrollees through the tools they bring to their contracts, such as predictive modeling, utilization management, health risk assessments, and provider profiling. Also, states do not need to have specific infrastructures in place to oversee ASOs in the same way they need for full-risk managed care (e.g., sophisticated rate setting, more intensive reporting requirements, etc.). Similarly, providers do not need to significantly change their practices, as ASOs typically do not require providers to do much in terms of care coordination with other providers.

Not a lot of information exists about the savings for ASO models in general, although Connecticut and Maine have seen improvements in both quality and costs from their respective ASO models for physical health (CT) and behavioral health (ME) services.⁹

vi. Full-Risk, Capitated Managed Care

Full-risk, capitated managed care programs are the most common type of Medicaid managed care. Currently, 37 states use this model for some or nearly all of their Medicaid enrollees and for some or nearly all benefits and services. Although managed care is broadly defined (some of the federal managed care regulations apply to PCCM programs), full-risk capitated managed care is what is most thought of as “managed care.” States contract with health plans - Managed Care Organizations (MCOs)

⁸ Colorado Department of Health Care Policy and Financing, "Legislative Request for Information #1: Accountable Care Collaborative," November 1, 2013.

Oregon Health Authority, "Oregon Health System Transformation: Quarterly Progress Report," February 2014. <http://www.oregon.gov/oha/Metrics/Documents/report-february-2014.pdf>.

⁹ Connecticut Department of Social Services, "Medical Assistance Program Oversight Council Presentation." APS Healthcare, "Maine Behavioral Health ASO Annual Report FY 2011," January 2012.

or Prepaid Health Plans (PHPs) – for the delivery of services to Medicaid enrollees. These health plans are responsible for providing the services articulated in a contract to the specific populations identified in that contract. Contracts may include all Medicaid services, or specifically exclude some services, such as behavioral health, or transportation. Some also include all Medicaid populations or exclude particular groups, such as those with long-term care needs or those who receive other waiver program services.

Health plans are paid pre-established, actuarially-certified, capitated PMPM rates that usually are adjusted for age, sex, existence of Medicare or other private insurance, or Medicaid eligibility category. While traditionally MCOs have just paid providers FFS rates, states are becoming more involved in how the plans pay providers to deliver better quality and outcomes, including through different reimbursement structures for MCO contracts with Federally Qualified Health Centers, Community Health Centers, PCMHs, Health Homes, and ACOs in their networks.

Although MCOs are responsible for paying provider claims, states must provide encounter data as part of their quarterly CMS Medicaid Statistical Information System (MSIS) reports. Timely, accurate and clean encounter data are critical for states to ensure that their MCOs are complying with contract requirements such as quality assurance and utilization measures, and to be able to set accurate capitation rates for MCOs.

Moving providers to a full-risk, capitated model requires a significant investment in provider relations, particularly for providers who do not have experience with payment mechanisms other than FFS, or who have not had to meet more rigorous quality and performance metrics that are typically part of Medicaid MCO provider agreements today. Additionally, MCOs face particular challenges in rural and frontier areas such as Wyoming because it is hard to develop adequate provider networks, especially for specialists.

On the national level there is little evidence of any savings. Only one researcher found overall cost savings while all others conclude managed care is either cost-neutral or even more costly than FFS programs. Studies conducted by consulting firms on behalf of managed care companies or industry trade groups do find savings, primarily as a result of reduced inpatient utilization. One of these reports concluded that savings in rural areas are about half what they are in more urban regions.¹⁰

¹⁰ Lewin Group, “Report for America’s Health Insurance Plans: Medicaid Managed Care Cost Savings - A Synthesis of 24 Studies : Final Report,” March 2009. <http://www.lewin.com/publications/publication/395/>.

Section III: Selected States' Approaches to Coordinated Care

Most states have some level and type of Medicaid managed care; only two currently do not have any: Alaska and Wyoming. Historically, New Hampshire has not had Medicaid managed care, although the state began enrollment into full-risk managed care in 2014. Connecticut also recently moved away from full-risk managed care to an Administrative Service Organization (ASO) model. Connecticut uses a pay-for-performance withhold on the quarterly administrative fee to ensure accountability of the ASO to deliver high quality services to enrollees.

To gather more information about states' experiences with coordinated care models and payments that are designed to reward quality and not quantity, HMA conducted additional research and interviewed Medicaid directors and other senior Medicaid program staff from nine other states. From this research, HMA compiled lessons learned that Wyoming can use as it moves forward implementing its own versions of these models. HMA also created individual state profiles with additional details, which can be found in Appendix C: State Profiles. Table 4 below identifies how states were selected and the process for obtaining information. To learn more about each model, see Appendix A: National Trends and Activities.

Table 4

Selection Criteria	Research Steps
States similar to Wyoming based on: <ul style="list-style-type: none">• Population• Geography• Infrastructure or• Medicaid enrollment	Reviewed information publicly available on the 11 state Medicaid and CMS websites
Dissimilar states developing innovative approaches to care coordination, integration and quality-driven reimbursement	Reviewed reports produced by national Medicaid policy organizations such as Kaiser Family Foundation and National Academy for State Health Policy

A. Care Delivery and Payment Reform Models from Study States

This overview of the different coordinated care models and reimbursement approaches used by a number of other states starts with the PCMH and moves along the continuum to full-risk managed care. The following, Table 5, shows the models in place in the selected states.

Table 5

State	PCCM	PCMH	Health Home	ACO	Full-risk Managed Care
*Alabama	X		X	X	X
**Colorado	X			X	X
Missouri			X		X
***Montana	X	X			
+New Mexico		X			X
North Dakota	X				X
Oklahoma	X	X			
^Oregon			X	X	X
South Dakota	X		X		
Utah	X			X	X
#Washington			X		X

Table 5 Key:

* Alabama is in the process of implementing Medicaid Regional Care Organizations (RCO), which will be provider and community-led ACOs; they will most likely be paid on a fully-capitated basis.

** Colorado has mandatory managed care for Behavioral Health only. By law, LTC/LTSS cannot be included in a managed care model, with the exception of PACE.

*** Montana will launch 4 – 6 PCMHs in the fall of 2014.

+ Includes all populations and all services in its Centennial Care full-risk managed care program: physical health, behavioral health, long-term services and supports.

^ Oregon has implemented Coordinated Care Organizations (CCO). The CCO's are paid a global budget that grows at a fixed rate to provide the full continuum of Medicaid Services. Over time, dental and long-term services and supports will be added.

Washington is implementing Health Homes in a managed FFS environment and requiring MCOs to provide Health Home services. MCOs can also receive a fee to serve as a lead entity in the Health Home model through a competitive procurement process.

i. Patient Centered Medical Homes

Of the 11 study states, six have some form of Medicaid/CHIP PCMH model implemented and four have development of PCMH models underway.¹¹ Many of these states implementing or designing PCMHs are leveraging PCCM programs that currently, or had previously, existed in the state. Table 6 below includes information about the PCMH programs in the three study states.

¹¹ Oregon, Washington, Colorado, Alabama, New Mexico and Missouri have PCMH models implemented. Colorado's PCMHs are part of a larger initiative – the Accountable Care Collaborative program – which is described in the ACO section. Montana, Utah, Arizona and South Dakota have PCMH models underway. National Academy for State Health Policy. <http://nashp.org/medical-home-patient-centered-care-maps/index.html>

Table 6

State	PCMH Model Highlights
Montana	Medicaid officials reported they are working toward implementing a PCMH model. DPHHS and the Insurance Commissioner staff are working with the National Academy for State Health Policy (NASHP) to pilot PCMHs in four to six provider locations starting in fall 2014.
New Mexico	New Mexico built into the MCO contracts for its new Medicaid reform program, Centennial Care, that the MCOs must participate in a PCMH Initiative based on the NCQA PCMH Recognition Program. MCOs are required to work with providers who are interested in and capable of becoming PCMHs and encourage them to become certified as NCQA PCMHs as quickly as possible. MCOs are allowed to delegate most care coordination functions to a PCMH. MCOs must compensate PCMHs in a way as that “appropriately recognizes the added value of PCMH.”
Oklahoma	<p>Modified SoonerCare Choice to a PCMH model with three tiers based on level of PCMH services; providers may apply to be assigned to a tier once a year.¹² Pays providers a monthly capitated “bundled” payment, which includes a case management/care coordination fee, primary care office visits and limited lab services. Other codes are paid on FFS basis. Additionally, providers who meet quality standards for child immunization rates can earn a lump-sum incentive payment.¹³</p> <p>Despite these findings and general satisfaction with the program, on March 13, 2014, Oklahoma’s Senate narrowly approved a bill that would test “privatizing the management of health care services to the poor in Oklahoma.”</p>

Of the three study states with PCMH models, Oklahoma’s program is clearly the most mature, with some level of risk-sharing for providers. New Mexico has experience with PCMH’s, but given that it just launched Centennial Care, there has not been much new information about how the model is working so far with the change in MCOs and new care coordination requirements in the MCO contracts.

ii. Health Homes

Several study states are developing care coordination approaches for specific populations and health conditions through the new Health Home initiative created in the Affordable Care Act. Health Homes specify populations that can qualify for enrollment and services that must be provided to meet CMS requirements; however, they also come with additional federal funding to support their establishment. Table 7 is an overview of Health Home activities in the study states.

¹² OHCA Patient Centered Medical Homes
http://www.okhca.org/providers.aspx?id=8470&menu=74&parts=8482_10165

¹³ Early Periodic Screening Diagnostic and Treatment 4th DTaP.

Table 7

State	Health Home Model Highlights
Alabama	Alabama currently administers a Section 2703 Health Homes initiative, called Patient Care Networks (PCNs). The primary care providers serve as the health home and are paid an enhanced PMPM care coordination fee (\$9.50 per qualifying recipient), supported by the PCNs. The PCNs provide data analytic support, care management services and provider training in evidence-based guidelines. To support its growing ACO program, Alabama may allow regions to first develop a PCN program that they can use as the foundation for transitioning to a Regional Care Organization (see the RCO description below in Table 8).
Missouri	<p>One of the first in the nation to take advantage of the Section 2703 opportunity. State operates two types of Health Homes:</p> <ul style="list-style-type: none"> • Primary Care Health Home (PCHH) for individuals with chronic disease, implemented in January 2012 for more than 15,000 enrollees. • Community Mental Health Center Health Home (CMHCHH) for individuals with serious and persistent mental illness, implemented in December 2011, for more than 18,000 enrollees.¹⁴ <p>CMHCs certified by the Department of Mental Health (DMH) are the designated providers for enrollees with behavioral health conditions. Providers that meet requirements receive a PMPM payment of \$60.05; they are required to pay \$3.47 PMPM to cover administrative costs associated with data management, training, technical and administrative support. Missouri expects to modify its current state plan in the future to add a request for a second payment method so providers may receive incentive payments based on shared savings for meeting specific performance metrics.</p>
Oregon	Program involves contracts with 198 providers to serve 38,000 enrollees. Using a state plan-approved Section 2703 Health Home model to make payment to participating practices. The Patient Centered Primary Care Home (PCPCH) was implemented in 2012 and operates within Oregon Medicaid’s Coordinated Care Organizations, described in more detail in the ACO section.
South Dakota	Implemented its Health Home Initiative in July 2013 with close to 600 providers that have completed the application and attestation processes. Nearly 6,000 enrollees are currently receiving Health Home services. State Medicaid partnered with several IHS providers to create some of its Health Homes, and negotiated with CMS to cover 100 percent of the cost of care Native American enrollees receive at IHS.
Washington	Uses an ASO to identify lead entities that will contract with care organizations to coordinate care and help enrollees connect with community providers, and facilitate the coordination of care between those providers. It is a “person-centered Health Home” model.

¹⁴ Centers for Medicare and Medicaid Services http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v30.pdf

Washington is an example of a number of states now contemplating a “Managed FFS” model. This can be as simple as contracting with an ASO to perform utilization management and prior authorization activities, or as in Washington, using an ASO to contract with and manage the providers and care coordination functions. Recent analyses of Health Home models show that Health Homes have real promise to both bend the cost curve and improve quality of care for enrollees.

iii. Accountable Care Organization Model

Though ACOs are often viewed primarily as a Medicare model, a growing number of states have begun to experiment with the model for their Medicaid programs. State Medicaid ACO models employ a variety of payment mechanisms to encourage quality improvement and care coordination, as shown in the highlights from study states in Table 8. Any savings that are realized as a result of these efforts are shared between providers and the Medicaid program.

Table 8

State	ACO Model Highlights
Alabama	<p>Uses Regional Care Organizations (RCOs) to manage and coordinate care for the majority of Alabama’s Medicaid enrollees. The RCOs are provider-based, community-led organizations that manage a broad scope of Medicaid benefits for included populations for a capitated PMPM payment. The state can contract with a for-profit MCO only in very specific situations when an RCO organization cannot be formed, and efforts to work with other qualifying RCO organizations are unsuccessful.</p> <p>As part of the 1115 waiver, Alabama is seeking to create a Delivery System Reform Incentive Payment (DSRIP) pool to encourage provider reform to match the RCO delivery system. Incentive payments will be made to providers to incentivize infrastructure development, innovation, and quality improvement focused on care coordination and health outcomes. Incentive pools will also be used to reward Health Information Exchange (HIE) utilization for care coordination and improved health outcomes.</p>
Colorado	<p>Colorado’s ACC Program operates statewide, serving more than 350,000 enrollees. There are three components to the program:</p> <ul style="list-style-type: none"> • 7 Regional Care Collaborative Organizations (RCCOs) that ensure cost and quality outcomes for Medicaid members. RCCOs receive a PMPM, of between \$8 and \$10, with one dollar placed in an incentive pool to be distributed based on meeting utilization targets for key performance indicators. • Primary Care Medical Providers (PCMPs) that serve as the focal point of care and, through relationships with specialist and community-based organizations, ensure cost and quality outcomes for Medicaid members. There are more than 400 PCMP locations with 2,350 Rendering Practitioners. PCMPs receive a \$3 PMPM payment, plus billing FFS. One dollar is placed in a PCMP incentive pool and distributed based on performance on the same key performance indicators as for the RCCOs. • A Statewide Data Analytics Coordinator (SDAC) that provides actionable data to the state, the RCCOs, and the PCMPs at both the population and enrollee level. Data includes: diagnoses, prescriptions, and other health information on both aggregate and individual member levels.

	<p>The state is moving toward greater integration of the ACC Program and its mandatory behavioral health managed care program, and building on the model for its dual eligible financial alignment demonstration.</p>
Oregon	<p>Awarded a \$45 Million State Innovation Model Test Grant from the CMS Innovation Center to test what it calls Coordinated Care Organizations (CCOs). The state expects the CCOs to better coordinate care and concentrate more on management of high-cost enrollees to:</p> <ul style="list-style-type: none"> • Provide more reliable budgeting for the state. • Reduce emergency room visits. • Reduce inpatient hospitalizations. • Improve the quality of life for clients. • Allow for providers to be rewarded for quality outcomes through shared savings. <p>The CCOs operate under a global budget that grows at a fixed rate, with one to two percent of payments held back pending attainment of quality metrics. The payment system includes quality outcome-based incentives and, eventually, shared savings between the state and contracted entities. Medicaid also pays for the services of non-traditional health care workers, such as community health workers, doulas, client navigators and peer wellness workers; Oregon plans to train 300 community health workers by 2015 and to provide a loan repayment program for primary care physicians who agree to work in rural or underserved communities.</p>
Utah	<p>Beginning in January 2013, Utah replaced its managed care contracts with ACO-like contracts in four counties — Salt Lake, Davis, Utah and Weber — impacting 70 percent of its Medicaid population. Enrollees in rural counties can choose an ACO, but are not required to do so. The following components were implemented as part of the model:</p> <ul style="list-style-type: none"> • Restructured provider payments using risk-adjusted capitated payments for all of contracts and pays providers for episodes of care rather than for billable events. • Integrated non-behavioral pharmacy benefits into the ACO scope of service to better align the incentive of prescribers with the goals of the State. • Rewards enrollees for personal efforts to maintain or improve their health.

ACOs offer states a viable option for creating accountable care coordination programs with flexibility to meet provider and patient needs. However, as was the case with the three states studied here, ACOs require considerable infrastructure and the ability to get providers to align with the state. Each of these states built their ACO models on existing infrastructure, then created additional infrastructure to support them more fully. There is good evidence that ACOs can save money and improve quality. In Colorado, the ACC program is realizing positive outcomes for its enrollees,¹⁵ including:

¹⁵ Colorado Department of Health Care Policy and Financing, “Accountable Care Collaborative Annual Report. Response to Legislative Request for Information #6.” November 1, 2013. <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251910367781&ssbinary=true>

- A 15-20 percent reduction for hospital readmissions and 25 percent reduction in high-cost imaging services relative to a comparison population prior to program implementation.
- A 22 percent reduction in hospital admissions among ACC Program members with COPD who have been enrolled six months or more, compared to those not enrolled.
- Lower rates of exacerbated chronic health conditions such as hypertension (%) and diabetes (9%) relative to clients not enrolled in the ACC Program.
- Emergency room utilization by ACC Program enrollees increased 0.9 percentage points less than utilization by those not enrolled in the ACC program (an increase of 1.9% for ACC enrollees compared to an increase of 2.8% for those not enrolled).
- \$44 million gross, \$6 million net reduction in total cost of care (cost avoidance) for clients enrolled in the ACC Program.

ACOs can serve as the foundation for other pilots and initiatives. For example, again in Colorado, the state is implementing a payment reform pilot and two super-utilizer pilots under the ACC umbrella. One important lesson Colorado has learned through the ACC Program is that even with better coordinated care among regional providers, a small group of Medicaid enrollees require a more intensive level of case and care management than what is provided. To address this, Colorado hopes to launch its super-utilizer program in coordination with the RCCOs and a number of PCMPs in the summer of 2014.

iv. Full-Risk Managed Care

Full-risk managed care has historically been an attractive option for many states because:

- It provides expenditure predictability for budgeting purposes.
- The assumption that health plans have the incentive to ensure enrollees access primary care to prevent the occurrence of more serious (and costly) conditions and that primary care and specialty care is better coordinated, furthering the potential to reduce costs.

Some states are now including nearly all services and populations in one comprehensive program, while others have risk-based managed care only for certain populations, specific regions, or particular services. Table 9 shows the various managed care structures of the study states.

Table 9

State	Full-Risk Managed Care Model Highlights
Alabama	<p>Alabama is currently implementing a health care delivery system reform plan. As noted and described above, the cornerstone of the reform plan is the development and implementation of regional care organizations (RCOs) across the State that would manage and coordinate care for the majority of Alabama Medicaid’s beneficiaries. These RCOs are provider-based, community-led organizations that will, through a capitated payment, manage a broad scope of Medicaid benefits for included populations. The state can contract with a for-profit MCO only in very specific situations when an RCO organization cannot be formed, and efforts to work with other qualifying RCO organizations are unsuccessful. There is a provision in the new law that states that Medicaid can contract with an alternate care provider if the RCO fails to provide adequate service pursuant to its contract, has its certification terminated, or if Medicaid cannot award a contract to an RCO.</p>
Colorado	<p>Only has full-risk, managed care for some services, as well as for some individuals in some geographic regions.</p> <ul style="list-style-type: none"> • A full-risk program for physical health care in Denver for any Medicaid enrollee in the county. • A full-risk program for all services except dental for enrollees in the CHIP program (children and pregnant women). • A full-risk mandatory program for the provision of behavioral health services, which operates statewide. • A new dental managed care program for Medicaid, plus a managed care program for CHIP enrollees.
Missouri	<p>Missouri Medicaid operates HMO-style managed care program called MO HealthNet Managed Care. The State contracts with managed care health plans to provide health care services for a monthly capitation payment for each enrollee. Participation in MO HealthNet Managed Care is mandatory for certain eligibility groups within the three regions with managed care: Eastern, Western and Central.</p> <p>There are still some rural counties in Missouri where HealthNet is not available; in these areas, Medicaid remains all FFS.</p>
New Mexico	<p>Has one of the longest histories of the study states with full-risk managed care and over the past 15 years the program has undergone many changes. Prior to January, 2014, New Mexico operated three full-risk managed care programs:</p> <ul style="list-style-type: none"> • Salud! for acute/physical care. • A separate, full-risk capitated program for behavioral health care (which has been carved in, carved out, and then spun off to be a separate state agency). • A full-risk capitated program for long-term care services called Coordination of Long-Term Services (CoLTS). <p>In 2014, the state launched Centennial Care, an integrated, comprehensive managed care program. It contracts with four MCOs, each providing services statewide. Nearly all Medicaid enrollees are mandatorily enrolled and receive all services through the program. There are two exceptions:</p>

	<ol style="list-style-type: none"> 1. Because of an existing lawsuit, the Intellectually/Developmentally Disabled (I/DD) population receives their waiver services outside of Centennial Care; although, they receive other Medicaid benefits and services through the Centennial Care health plans. 2. Native Americans who meet long-term care level of care or are not dually eligible for Medicare and Medicaid are mandatorily enrolled. All other Native Americans may opt-in to Centennial Care if they choose. This compromise is a result of extensive negotiations between the New Mexico Medicaid agency, CMS and the many Tribes located in the state.
North Dakota	The Northland Healthcare Alliance runs two PACE service areas in Bismarck and Dickinson. The Bismarck PACE program is able to serve 150 enrollees and Dickinson is able to serve 35 enrollees.
Oregon	As noted and described above in the ACO section, in July 2012, CMS approved Oregon’s request to extend and amend its Section 1115 waiver to launch new Coordinated Care Organizations (CCOs) to replace the current managed care delivery system. The waiver plan includes a commitment for Oregon to reduce the annual per capita Medicaid expenditure growth trend by 2%.
Utah	<p>Beginning in January 2013, Utah replaced its managed care contracts with ACO contracts in four counties — Salt Lake, Davis, Utah and Weber — with 70% of the state’s Medicaid population. Medicaid clients in rural counties have the option of enrolling in an ACO, but are not required to do so, and in total, the ACOs cover about 180,000 of the state’s total Medicaid population of about 245,000.</p> <p>CHIP is separately administered by Utah Department of Health. CHIP currently contracts with SelectHealth (PCCM) and Molina Healthcare of Utah (full-risk capitated) to provide health care services. Additionally, CHIP contracts with Premier Access and DentaQuest to provide dental care services.</p>
Washington	Washington State Health Care Authority (WSHCA) operates full-risk contracts with five health plans. Additionally, the Washington Medicaid Integration Partnership (WMIP) is managed care for Supplemental Security Insurance (SSI) or SSI-related Medicaid enrollees in Snohomish County. One health plan covers medical, mental health, chemical dependency treatment services, and long term care services for this pilot project. The pilot, started in 2005, has demonstrated some success, specifically in lowering growth in prescriptions filled for mental illness ¹⁶ , and the state has an eye toward expanding the project to other geographic areas.

Full-risk managed care does provide states with an opportunity to use outside expertise to build and manage provider networks, conduct enrollee education and outreach, ensure care coordination and collaboration among providers and handle claims payments. However, as Washington State discovered

¹⁶ Davis Mancuso, Melissa Ford Shah, Barbara Felver, Daniel Nordlund. “Washington Medicaid Integration Partnership: Medical Care, Behavioral Health, Criminal Justice, and Mortality Outcomes for Disabled Clients Enrolled in Managed Care,” December 2010. <http://www.dshs.wa.gov/pdf/ms/rda/research/9/100.pdf>

through a recent audit of two of its largest MCOs,¹⁷ use of MCOs to handle these program elements is not always successful. The audit found that the plans may have significantly over-paid providers, which in turn may have resulted in higher than appropriate payments to the MCOs. To avoid such issues, states should provide strong oversight of and insight into the activities of their managed care partners.

B. Lessons Learned from Study States

State officials interviewed for this project shared a number of lessons from their experiences that are relevant to Wyoming's efforts. Each of these states continues to address challenges as they develop new delivery systems and payment models. However, some common themes emerged in our discussions with state officials and independent research of their initiatives.

i. Build on Existing Structure

In most cases, study states have been working to enhance and expand the delivery system they have in place, both in terms of payment arrangements and provider infrastructure.

- Montana added HIP and Team Care to its 1915(b) waiver for the Passport to Health Program. In doing so, Montana DPHHS leveraged provider relationships already in place and reduced the need to create totally new contracts and administrative processes.
- Utah modified its contracts with health plans to transition to an ACO-like model, using this to do more enhanced risk-adjustment methodologies in their rate setting and pay providers for episodes of care rather than for billable events.
- Missouri's experience with the Chronic Care Improvement Program in 2006, informed the state's efforts to develop the current Missouri Primary Care and Community Mental Health Center Health Home initiatives. Their ability to learn from both the successes and challenges of previous projects, and to often do so on a pilot basis, offered a definite advantage in designing the current initiatives.
- Even though Alabama, Colorado and Oregon have or are in the process of making major delivery system changes, they are largely doing it with locally operated provider organizations that have an historical relationship with their respective Medicaid agencies. This is helpful given that the move from FFS to risk-based managed care will impact both staffing needs and business processes. Adapting to this new model is an ongoing adjustment for agency staff and providers.

ii. Involve Stakeholders

All study states emphasized the importance of engaging stakeholders early and often in any change process.

- When Missouri implemented the Health Home models, the Department of Social Services partnered with other state agencies, foundations, the Primary Care Association, the Coalition of Community Mental Health Centers, the Hospital Association and the School Board Association to create a process that worked for everyone and benefited from the best ideas from each. In

¹⁷ Carol M. Ostrom, "State Medicaid audit suggests \$17.5 million overpaid: An audit of the state Health Care Authority says the overpayments may have gone to contracted managed-care organizations to care providers," *Seattle Times*, April 15, 2014.

other states that also have implemented Health Homes, the Governor or legislature convened multi-stakeholder advisory groups or commissions to ensure all views were represented.

- Montana’s PCMH Advisory Group was convened by the Insurance Commission at the direction of the legislature.¹⁸
- Alabama’s Governor convened a commission comprised of entities or organizations including executive officers of state agencies, cabinet-level leaders, State Senators and Representatives, insurance company representatives, consumer advocates, medical providers, and professional organizations representing the hospitals, physicians, pharmacy, nurses, primary and rural health, hospice, and nursing homes.
- New Mexico met regularly with stakeholders, in particular the Native American tribes and with long-term care advocates. Despite their efforts, they were forced to withdraw and re-submit their 1115 Demonstration Waiver because CMS concluded they had insufficient notice and involvement.
- Colorado held multiple stakeholder meetings during the ACC Program development process and continues to involve stakeholders in a formal way through its advisory committees. The primary Advisory Committee includes subcommittees that address the following topics:
 - Payment Reform
 - Provider and Community Relations
 - Quality Health Improvement
 - Full Benefit Medicare-Medicaid Enrollees

iii. Leverage Financing Available for Development

Through CMS' Center for Medicare and Medicaid Innovation (CMMI), 33 states are participating in 55 competitive grant-funded initiatives to implement delivery system and payment reform.¹⁹ There are enhanced federal matching funds and planning grants available for Health Homes, community-based services, health care integration, and information technology infrastructure. Of the study states, Colorado, Oregon, Utah and Washington were awarded State Innovation Model grants to design or test innovative approaches to improve care coordination, quality and lower costs. There are also technical assistance resources available to states through organizations such as the Center for Health Care Strategies, National Academy for State Health Policy and the National Governors' Association.

iv. Integrate Care and Focus on Quality

In an effort to better coordinate care and increase savings, many states are revisiting decisions to “carve out” certain services (e.g., mental health, substance abuse/chemical dependency) or medications. In a behavioral health “carve-out” model, states often operate completely separate administrative structures along with separate financing/reimbursement arrangements for PCPs and behavioral health providers. Oregon is using its State Innovation Model Test grant to design more integrated care delivery systems. Colorado is using its State Innovation Model Pre-Test grant to integrate behavioral health care and

¹⁸ Montana Commissioner of Securities and Insurance, “Montana Patient Centered Medical Homes,” <http://www.csi.mt.gov/medicalhomes/index.asp>

¹⁹ Eileen Griffin, Vikki Wachino, Robin Rudowitz, “Managing a High-Performance Medicaid Program” The Kaiser Commission on Medicaid and the Uninsured,” October 2013. <http://nashp.org/medical-home-patient-centered-care-maps/index.html>.

physical health care across all payers. Additionally, each state pursuing a Health Home model is focusing on integrating physical and behavioral health care.

Efforts to integrate behavioral and physical health care can be fraught with challenges. Providers who have traditionally been responsible for services are often reluctant to hand over control of those services (and dollars) to another entity in the name of care coordination. Washington's original 1915(b) waiver for the state's managed mental health carve-out was designed to let counties or groups of counties form Regional Support Networks, while the substance abuse treatment dollars are contracted separately, but also with counties. As the state moves toward greater integration and requiring that MCOs take on responsibility for coordinating care, the counties want to ensure they are included in discussions and negotiations with the MCOs.

Despite the fact that the long-term care population is typically the most expensive and complex, states are somewhat slower in integrating long-term care services with physical health care services. However, that is starting to change: New Mexico has launched Centennial Care, which combines all services for all populations, and states such as Tennessee and Hawaii have combined programs and re-procured for MCOs to provide comprehensive benefits and services to most, if not all, of their Medicaid populations.

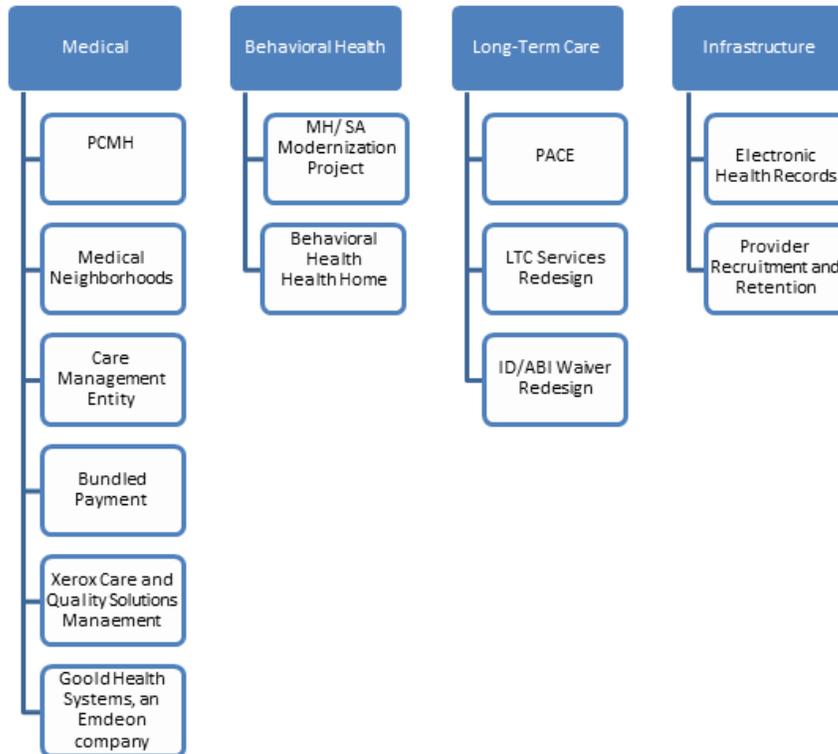
v. Information Technology Infrastructure is Essential

To fully evaluate payment reform options, state Medicaid agencies need the capacity to conduct comprehensive analysis of utilization trends and cost drivers. Quality measurement and reporting serve an integral role in delivery system and payment reform efforts. As states transition to active purchasing and work to maintain transparency and public accountability, effective data analysis becomes even more important. Data analysis capacity ranges from basic predictive modeling to identify chronically ill patients, to more sophisticated operations such as Colorado's Statewide Data Analytics Coordinator. Additionally, providers and payers must have the ability to electronically share enrollee health information to coordinate services and ensure enrollees are accessing needed care in the right place at the right time.

Section IV: Current Initiatives in Wyoming

Wyoming is already taking significant steps to improve the quality of the care delivered in its health care system – including Medicaid. This section looks at the key initiatives in Wyoming, with a description of status and activities, and how they might align with any new care coordination or managed care activities. This is not an exhaustive list of all activities required by Senate Enrolled Act No. 82. Rather, the focus is on WDH’s major initiatives and those that stakeholders requested be considered in making recommendations. Figure 3 below shows how these initiatives are organized into groups:

Figure 3



A. Medical Care

i. Patient Centered Medical Homes (PCMH)

Structure

Wyoming has already launched a Patient Centered Medical Home (PCMH) effort through the Wyoming Institute of Population Health, a division of the Cheyenne Regional Medical Center, with the Wyoming Department of Health, the Wyoming Integrated Care Network (WYICN), the University of Wyoming, and Cheyenne Regional Medical Center as strategic partners. A \$14.2 million CMMI Health Care Innovation Award from CMS, plus an additional \$700,000 in state funds is supporting the project as it builds PCMHs across the state. The goal of the grant is to transform Wyoming’s health care system into a more integrated, coordinated *medical neighborhood* based on a solid primary care foundation and evidenced-based care. PCMHs are at the center of this effort.

Today Wyoming has 27 PCMHs:

- 8 practices began transforming into PCMHs prior to the Health Care Innovation Award through a grant from WINHealth and the Cheyenne Regional Medical Center.
- 19-20 practices were part of the Health Care Innovation Award through a grant from WINHealth and the Cheyenne Regional Medical Center.²⁰ One practice began the transformation on its own but recently joined the initiative. Two exited the initiative since the grant began.

Payment Methodology

This PCMH effort at the provider and system level is being supported by the major payers in the state including Wyoming Medicaid and several commercial partners – Cigna, United, and Blue Cross Blue Shield of Wyoming. These payers have generally agreed to work together to ensure that there is an incentive structure in place to support further development of PCMHs in Wyoming.

Currently, the PCMHs are paid differently by different payers:

- United and Blue Cross Blue Shield are participating in the pay-for-performance component, and have integrated PCMH participation and certifications as a consideration in determining negotiated rates.
- Today, quality metrics are focused on nine measures included in the CMMI grant; however, new quality metrics that align with NCQA PCMH Recognition requirements and with the electronic health record Meaningful Use clinical quality reporting requirements will be added in the near future.

Planned for Fall 2014:

- Medicaid will pay an estimated \$3 PMPM (CMS approval of State Plan Amendment pending, exact amount to be determined) for providers who report the quality metrics and contractually agree to meet all desired characteristics of a Primary Care Medical Home. The program is beginning with a single level in the first year to encourage participation, and plans on moving to a three level structure in future years (1- participation, 2- improvement, 3- meeting or exceeding quality benchmarks). Providers will continue to be paid FFS for medical care claims, in addition to the PMPM payments related to the PCMH program.
- Wyoming Medicaid is using the same quality metrics included in the CMMI grant; however, providers must agree to meet other requirements such as pulling Continuity of Care documents on a regular basis for Medicaid clients.
- The 27 PCMHs expected to participate in the first wave of Wyoming Medicaid's Primary Care Case Management PMPM program will serve an estimated 25 percent of Medicaid members in the first year. As practice participation grows, Wyoming Medicaid expects more than 50 percent of all Medicaid enrollees to have a primary care medical home and receive care coordination and care management services through a PCMH.
 - Medicaid members may already be receiving PCMH level of care from their primary care practice but Wyoming Medicaid has not yet begun the PMPM payment for PCMH because it is waiting for CMS approval of its State Plan Amendment.

Planned for 2015 and beyond:

- Employee Group Insurance (administered by Cigna) has indicated that it will mimic Medicaid's data reporting, performance targets, and other requirements, as well as Medicaid's payment structure and levels sometime in 2015 for PCMHs.

²⁰ One of the practices is in Nebraska but serves a large number of Wyoming Medicaid clients.

- As the PCMH program matures, the strategic partners hope to partially move some of the FFS payment structure to a value-based payment structure. For now, the focus is on educating and engaging providers on the value of PCMHs, helping them transform the way they practice, and improving the health care infrastructure through the implementation of electronic health records and tele-health.

ii. **Medical Neighborhoods to Transform Rural Care²¹**

Structure and Payment Methodologies

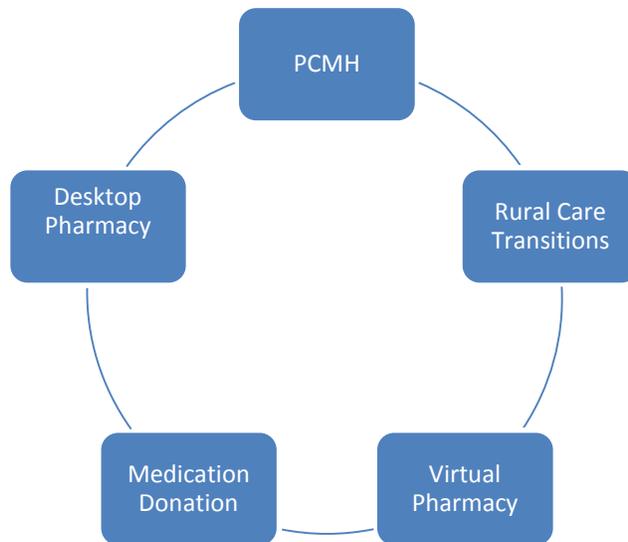
A “medical neighborhood” generally is defined as one or more PCMH and the many other clinicians and types of providers (hospitals, labs, etc.) caring for a group of patients, as well as the community and social service organizations, State and local public health agencies that also support that group of patients. In Wyoming, the Medical Neighborhoods to Transform Rural Care project is creating a state-wide network of medical neighborhoods with support from a \$14 million CMS CMMI Award. The initiative, directed by the Wyoming Institute of Population Health at the Cheyenne Regional Medical Center (CRMC), was established on the idea that medical neighborhoods will:

- Encourage the flow of information across and between clinicians and patients.
- Focus on patients and a balance of evidence-based care with patient preferences.
- Support reductions in waste in the health care system that result from failures of: care delivery, care coordination and care communication, pricing, and transparency.

The initiative builds on the Institute's work in Cheyenne by supporting rural areas in creating medical neighborhoods by focusing work in five areas, depicted in Figure 4 below. Part of the project is to assess what new methods of reimbursing providers can better support their participation in the project and help all to achieve the overall goals.

Figure 4

²¹ Wyoming Institute of Population Health, Health Care Innovation Award.
<http://cheyenneregional.org/sites/wyoming-institute-of-population-health/healthcareinnovationaward/>



Patient Centered Medical Homes (PCMH)

The PCMH, described above, is a fundamental component of the initiative.

Wyoming Rural Care Transitions (WYRCT)

The second component, the WYRCT, supports medical neighborhoods by providing education and continuity of medical care as complex patients transition between hospitals and post-acute sites of care. There are 14 hospitals participating, and a total of 21.8 full time equivalent (FTE) nurses, along with back-up and supervisors, have successfully completed training in the model and processes. The target population is individuals 65 or older who have one of the 10 most frequently occurring hospitalization diagnoses in Wyoming. Individuals receive support for 30, 60, or 90 days to help them achieve their goals for care and to empower them to learn to manage their health and care. This program is unique in that most care transition programs last only 30 days; the duration was adjusted to accommodate the rural areas where on-going support might be required (individuals are often more isolated). According to stakeholders interviewed, the WYRCT is working closely with the PCMHs to ensure collaboration across all providers in the medical neighborhood.

The Institute is also piloting a program in one hospital with a younger target population – those 18 and older with a diagnosis relevant to a younger population. Their plan is identify other communities for expansion.

Virtual Pharmacy

The University of Wyoming, School of Pharmacy, is coordinating this effort in which pharmacists perform Medication Therapy Management (MTM), while virtually connecting with PCMHs via tele-health. This video-conferencing technology connects participating pharmacists and patients with PCMH clinical teams for consultations. The participation goals and number of actual participants are:

- Participation Goal - Eight pharmacies and 12 pharmacists.

- Actual participation to date – four pharmacies and six pharmacists (4 of which have completed training).²²

Growth in the program was initially slowed by staff continuity issues, but recently hired staff have been actively working to grow the program. There is renewed interest in recruiting additional PCMHs; currently, only patients presenting to a participating pharmacy on behalf of the University of Wyoming Family Medicine program are offered this service.

Medication Donation Program

Designated donation sites collect any unused, sealed medications including medication samples from hospitals, health care professionals, and community members. Enrolled prescribers monitor the medication inventory for medications that match eligible patients' needs and refer eligible patients (low-income and un/underinsured individuals) to the program. Patients receive donated medications from approved dispensing sites or by mail.

As with the other strategies, the Medication Donation Program is expanding upon an existing program. The Health Care Innovation Award has allowed it to scale state-wide and there are now 18 public donation sites and five hospital donation sites that act as donation collection sites for facilities in their communities. The number of prescriptions filled and mailed also has increased: 1,255 prescriptions were filled and mailed in 2013, an increase from 727 in 2012. Currently, the Institute is focusing on establishing relationships with each medical neighborhood.

Physician Desktop Solution

The Physician Desktop Solution installs, upgrades, and supports video-conferencing technology to provide tele-health/telemedicine at clinics and hospitals across Wyoming.

- The Physician Desktop Solution strategy provides equipment, setup, camera and software use, and technical support.
- Through the Health Care Innovation Award, primary care clinics and hospitals receive assistance to install or upgrade video-conferencing technologies at their location.
- From tele-health locations, patients and health care providers can have live video consultations with physicians, specialists, and pharmacists regardless of location.
- All but five hospitals have executed contracts, and while there has been the most focus on deploying and enabling technology to create the infrastructure for connections between healthcare workers, there were more than 2,000 tele-health visits across Wyoming in February 2014 alone.
- Moving forward the emphasis will shift to more clinical outcome-related work that will develop and promote clinical programs.

iii. Care Management Entity for High Fidelity Wraparound and Intensive Care Coordination for Children and Youth

²² Source: "HCIA Sixth Quarter Narrative Progress Report. October – December 2012." January 31, 2014.

Structure and Payment Methodology

Wyoming was awarded a CHIPRA Demonstration Grant (with Maryland and Georgia) to implement a Care Management Entity (CME) provider model to provide High Fidelity Wraparound and Intensive Care Coordination to Medicaid financially eligible children and youth for a PMPM payment. Table 10 depicts the target population and the services provided.

Table 10

Target Population	Services and Approach
<ul style="list-style-type: none">• Youth with serious emotional disorders, including a medical or educational diagnosis of serious emotional disturbance/emotional disturbance• Youth at risk of out-of-home placement and/or children who currently meet Psychiatric Residential Treatment Facility (PRTF) level of care• Youth identified by WDH because their use of prescription drugs does not meet prescribing guidelines established by WDH• Youth living in the service area (the seven southeastern counties)	<ul style="list-style-type: none">• High Fidelity Wraparound care coordination• Focus on developing self-sufficiency, building natural supports and increasing family capacity to respond to crises• Because these youth are typically involved with multiple providers and systems, Wyoming Access (the contractor) coordinates across agencies and providers to develop and provide intensive care management home and community based alternatives to costly residential care• Strength-based, family-drive approach

Enrollment in the program has been somewhat slow; in December 2013 there were only about 40 enrollees and Wyoming Access, the contractor, said that it has been quite difficult to find eligible youth and children due to churn and other challenges typical of working with highly transitional populations.

iv. Bundled Payments

Structure and Payment Methodology

Although not mentioned as a key initiative by anyone other than state employees, the WDH is exploring a transition to bundled payments for some services. For example, maternity, some joint surgeries, pneumonia, and congestive heart failure are services under consideration for bundled payments. The state considers a maternity bundled payment as the most likely to produce large savings but has delayed implementation of any change pending decisions on other initiatives such as developing a maternity medical home or other service delivery changes.

v. WYHealth - Xerox Care and Quality Solutions Case Management

WYHealth is a total population health and utilization review program for Wyoming Medicaid enrollees. WDH has been contracting for these telephonic case management services for a number of years, most recently with Xerox Care and Quality Solutions (CQS). CQS identifies candidates for case management outreach from provider referrals, from patient or patient family member self-referrals, from predictive modeling, from ED and inpatient hospital discharge reports, from lists of individuals with specific diagnoses, or from WDH referrals. Registered Nurses (RNs), Licensed Clinical Social Workers (LCSWs) or other licensed behavioral health professionals conduct telephone assessments of individuals to better understand their health care needs and how to support them.

Assessments help to stratify individuals into one of three tiers:

- Tier I – general population outreach that includes promotions for age/gender appropriate health and wellness screenings, as well as for services related to Healthcare Effectiveness Data and Information Set (HEDIS) measures commonly used as quality metrics for health care providers and plans.
- Tier II – outreach and support to individuals with chronic conditions, multiple morbidities, or specific diagnoses or needs, such as those with diabetes and pregnant women. Individuals in Tier II receive two to four telephone calls per month from a case manager who follows up on any recent hospitalizations, ED visits, or other doctor visits and makes sure the individual is getting needed services in a timely manner.
- Tier III – outreach and support to individuals with more complex care needs, offering high-fidelity wrap-around services and coordination among providers. These individuals are contacted at least three to six times per month and case managers work with other social services providers to secure non-medical supports as needed and available. CQS case managers will occasionally do face-to-face visits for hospital discharge planning or other critical transitions.

CQS case managers deliver provider training and support, helping to educate providers on programs such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) and a pay-for-performance program for referrals to case management. CQS manages enrollees in the pharmacy lock-in program, and pregnant women taking narcotics. They have a number of tools to support these programs, such as their MedCompass system to track time and enrollee contact information, and a “Due Date Plus” smartphone application that allows pregnant women to reach a nurse quickly and directly for help. Additionally, CQS oversees utilization management for behavioral health services, as well as a number of high-cost physical health services such as gastric by-pass surgery, transplants, and acute rehabilitation. They receive referrals for people requesting long-term care services and conduct all Preadmission Screening and Resident Review (PASRR) and disability reviews for the state.

As of March 2014, on a monthly basis, CQS was actively managing approximately:

- 219 individuals in Tier I
- 247 individuals in Tier II
- 263 individuals in Tier III

Some enrollees are active in case management for only a few months, many are active for nine to 12 months. There is a 10 to 20 percent decline rate for case management services; however, CQS staff note that while it can be difficult to reach many individuals, once they do contact them and explain the benefits of the program, people are generally happy to participate. If they are not able to reach someone by phone after multiple attempts, CQS will send a letter with information about the program and services available.

vi. Pharmacy Benefit Manager

Wyoming Medicaid spends about \$40 million every year on medications for enrollees. Approximately 50 percent of the funding for pharmaceuticals comes from the federal match, but the state also gets nearly 50 percent in rebates so actual costs to the state total only about \$10 million. Currently, WDH contracts with Goold Health Systems (GHS) for pharmacy benefit management services. GHS handles processing for all pharmacy claims, managed a preferred drug list, oversees the state maximum allowable cost program for certain drugs, and manages the federal and supplemental drug rebates.

GHS also runs a utilization management program and prior authorizations for drugs specified by the state, and they manage a lock-in program that limits high-utilizers to specific pharmacies for accessing medications. Additionally, GHS manages the Medication Donation program that is part of the Medical Neighborhood project (described above).

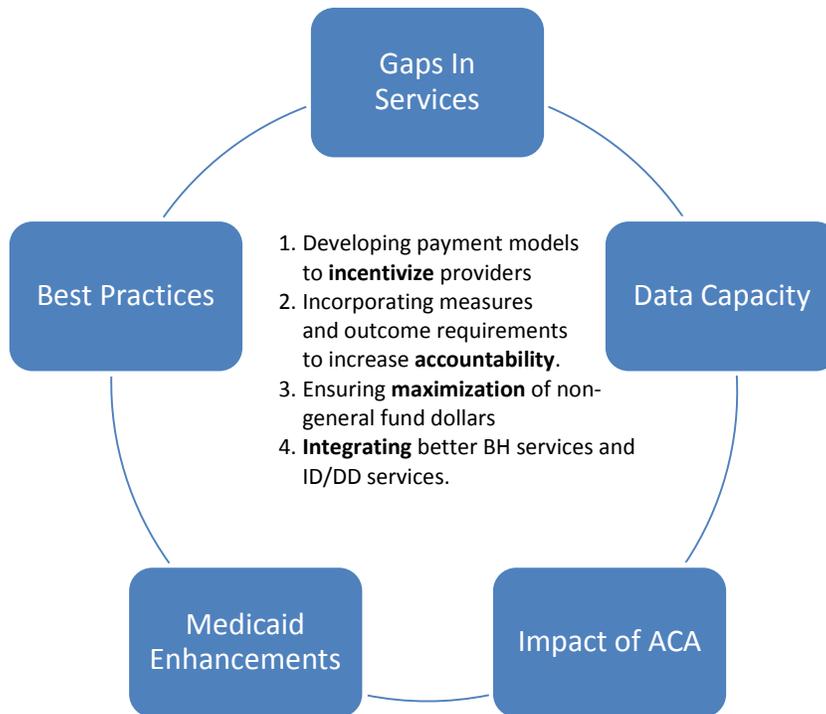
B. Behavioral Health Care

i. Mental Health and Substance Abuse Modernization Project

Structure and Payment Methodology

The Mental Health and Substance Abuse Modernization Project was developed to align the multiple reform initiatives which had been operating independent of one another. The goals are to develop a system that will support individuals with behavioral health needs in getting appropriate and needed care and in ensuring they are on the path to recovery, and to design appropriate reimbursement mechanisms to help providers achieve those goals. As shown in Figure 5, there are five sub-committees (in the blue boxes) collaborating to develop an approach that will support the four activities in the middle of the circle.

Figure 5



At the time of this report, the WDH expected that:

- The sub-committees would each develop a report with recommendations by June.
- An overall recommendations report will be completed in July.

ii. Behavioral Health Homes

Structure and Payment Methodology

For the past 18 months, the Behavioral Health Division (BHD) has been researching the BH Health Home model with the purpose of developing and implementing such an approach in Wyoming. Specifically state staff has:

- Visited BH Health Homes in Missouri.
- Worked with providers to educate them and solicit input to ensure buy-in.

According to WDH staff, the large behavioral health centers are very interested in Health Homes and some already have staff to provide case management and care coordination services. Other behavioral health centers are more anxious about the likely changes. WDH had originally hoped to implement a pilot by July 2014, but this has been delayed to work through a number of outstanding issues:

- The best model to ensure functionality in rural and frontier, the small behavioral health centers, are unlikely to have sufficient Medicaid patients in their panels (it was noted that Medicaid expansion would mitigate this challenge). Potential solutions include collaboration with other centers or community-based organizations and expanding the model to all payers.
- Whether to start statewide or develop pilots in one or two areas to evaluate the model in both areas (e.g., one rural region and one urban region).
- What might be the best approach to accommodate Medicaid expansion.
- The types of operational and business practices that will be needed.

- The best reimbursement approach (PMPM is most likely with some requirements about minimum contacts per month) and how to align payment with quality and performance targets.

C. Long-Term Care Supports and Services

i. PACE

Structure and Payment Methodology

In addition to the CME for high-needs youth described above, PACE is the other managed care program currently operating in Wyoming that pays for services on a capitated PMPM basis. It was implemented in 2013 and is available in Laramie County only. Growth has been faster than anticipated and there are nearly twice as many enrolled after one year than had been expected (49 enrolled, 27 expected). There are discussions underway as to whether a second location might be needed in Cheyenne or whether there is opportunity for expansion into additional communities.

ii. Long-Term Care Services Redesign

Structure and Payment Methodology

As a result of the 2013 Wyoming Medicaid Reform legislation, WDH is already implementing several changes to how LTC and LTSS are provided, including:

- Redesign of skilled nursing facility (SNF) reimbursement rates to reflect patient acuity, percentage of Medicaid occupancy and regional economic factors. The goal is to create incentives that will encourage SNFs to provide care to the sickest and most expensive enrollees (according to stakeholders, there is currently a financial disincentive for NFs to serve these enrollees) instead of caring for lower-needs patients who might be better and more cost-effectively served in an Assisted Living Facility (ALF) or at home.
- Elimination of the caps on the number of enrollees admitted to the LTC and ALF waiver programs. Provider capacity still limits access for some enrollees, though the wait is generally not longer than a month. Over time, the state will rebalance the percent of dollars going to NFs from the current 50/50 split between NFs and home and community-based services, to one with a higher percentage of dollars going toward home and community-based services.
- Development of a new assessment tool to replace the LT101, used to determine medical necessity for various LTC programs. The LT101 has an all-or-nothing cut-off score whereby people either receive services or do not, and the tool does not capture behavioral health conditions or needs well.

There is a workgroup for each of these three activities. A fourth group is developing the visions and goals for the entire LTC system, tackling issues such as lack of communication between systems, use of supplemental programs to support individuals who are isolated in rural areas and ensuring that the components of change are aligned and coordinated.

iii. Intellectually Disabled/Developmentally Disabled (ID/DD) and Acquired Brain Injury (ABI) Waiver Reform

Structure and Payment Methodology

As a result of the 2013 Wyoming Medicaid Reform legislation, WHD redesigned the Medicaid Home and Community Based-Services (HCBS) waiver programs that serve individuals with ID/DD and ABI. Two new waivers – a Comprehensive Waiver and a Supports Waiver - were created to replace the Adult

Developmental Disabilities Waiver and the Child Developmental Disabilities Waiver. Because costs per enrollee for these populations in Wyoming are among the highest in the region, WDH wants and needs to establish effective cost controls while also:

- Providing an updated menu of services across the continuum of residential and employment support environments.
- Offering the opportunity for self-direction to all waiver participants.
- Establishing targeted outcomes for each participant served.

The new waivers, recently approved by CMS, launched in April 2014. Participants on the current Adult DD Waiver will transition to the new waiver between April 1 and September 30, 2014. Child DD Waiver participants will transition between July 1, 2014 and June 30, 2015.

D. Infrastructure

i. Electronic Health Records (EHR) and Health Information Exchange (HIE)

The Wyoming health information technology (HIT) environment is currently experiencing significant growth in the use of EHRs and HIE, expanding and enhancing ways of using these new tools to positively impact patient care.

Wyoming is participating in the EHR Incentive Program in accordance with the American Recovery and Reinvestment Act (ARRA) and the HITECH Act from 2009. This program was designed to offer incentive payments to eligible professionals and hospitals for the Adoption, Implementation and Upgrade (AIU) of EHRs and using them in a meaningful way (Meaningful Use, or MU). To date, Wyoming has paid more than \$15 million of federal dollars to 117 professionals and 21 hospitals that have met the requirements for this program. Of this group of participants, 19 professionals and nine hospitals have received second and third payments as they advance through the program meeting the requirements of MU. Additionally, through the Medicaid State Level Registry, WDH MU clinical quality information can be reported at the individual patient level and at the aggregate level. With this information, providers are able to compare the quality of care they are delivering against the quality of other providers in the state. Using this information, WDH can help providers identify areas that need improvement. Importantly, the Meaningful Use quality measures include metrics on patient engagement and care coordination. WDH can monitor these metrics to monitor care coordination and identify where there may be a need for intervention to improve care coordination.

Wyoming Medicaid also has the Total Health Record project. This is a web-based program with three components: an EHR, a Personal Health Record (PHR) and the Gateway (Health Information Exchange, or HIE). Currently, the EHR component is offered to Wyoming Medicaid providers at no cost. This EHR is a certified system and meets the requirements for the EHR Incentive Program. There are currently 30 providers using the THR system as their EHR. The PHR component is available to all Wyoming Medicaid enrollees at no cost, to access their health records if their provider is using the THR. In addition, all Wyoming patients can sign up to use the PHR to keep an electronic copy of their health records and can access at any time.

Direct Messaging has just recently been added to the THR. This will enable patients to correspond with any provider regarding their care and also give them the ability to upload documentation from providers to their record. Direct Messaging can be used by WDH Program Managers to correspond securely with Medicaid enrollees regarding care options. An additional component to Direct Messaging will be

introduced soon that will give PHR users the capability to use the secure messaging functionality with providers that use other EHRs.

The Gateway offers an electronic connection to certain programs within the WDH. As the EHR Incentive program requires more interoperability, electronic reporting to Public Health is an important function. The Gateway hosts this connection and is currently in the process of onboarding several hospital and providers.

Wyoming has faced many challenges getting a statewide HIE implemented. An independent consultant will be reviewing all of the technology currently available to assist Wyoming providers with each of their specific needs while meeting the requirements of Meaningful Use.

ii. Tele-Health Development

There are currently several major tele-health projects underway in Wyoming.

- The CMMI Health Care Innovation Award from CMS (noted above in the PCMH section), has supported the Cheyenne Regional Medical Center (CRMC) network and helped to transform it into a major statewide system. CRMC currently is supporting 256 sites and hosting approximately a thousand calls per month.
- The State-owned system supported by Ptolemy, whose main function is to support the State owned sites, as well as some other sites that could not fit into the CRMC system. Ptolemy has 33 sites that host just under 100 calls per month.
- The Health Link Now tele-psychiatry project reports it is connected to 19 Wyoming Hospitals and is doing about 50 consults and 50 Case Navigator Interventions per month.
- Avera has tele-health systems in three hospitals and also is using these systems to do tele-ER, tele-ICU and tele-pharmacy for about 7,000 contacts per month.
- Seattle Children's Hospital continues to provide services for child psychiatry, with approximately 15 tele-health consults per month, as well as the PAL line, and the Second Opinion project.
- The Barbara Davis Diabetes tele-health center conducts tele-health visits in four sites around the State.

Medicaid currently pays for about 800 tele-health contacts per month; Medicare also does a significant number of tele-health consults per month. WDH is working with CRMC, Ptolemy and Health Link Now tele-psychiatry project to have Rural Health do a needs assessment for Wyoming's Critical Access Hospitals that have not embraced tele-health to determine what barriers they are facing to increasing their use of tele-health. Additionally, WDH has been actively recruiting specialist providers such as Infectious Disease and Oncology to provide services via tele-health. One of the biggest barriers to participation today is not licensing, but getting the hospitals to adopt the tele-health credentialing wording approved by CMS, which requires hospital has to amend their bylaws. Until they do, every provider must go through full credentialing at every facility, an expensive and time consuming process.

iii. Health Care Professional Workforce Development

Wyoming has a several workforce development programs designed to recruit and retain various kinds of health care providers. Some of these programs are operated by the WDH Office of Rural Health; some by other state agencies, such as the University of Wyoming. However, the programs identified in Appendix B are all state-funded.²³ Most are highly competitive programs. For example, the Wyoming Healthcare Professional Loan Repayment Program received 165 applications in 2013, but offered only 10 awards from its \$500,000 program funding. Nonetheless, these programs have been successful in recruiting and retaining health care providers across Wyoming. In 2010, 64 percent of WWAMI (Wyoming, Washington, Alaska, Montana, Idaho) Medical Education Program graduates returned to practice in Wyoming. Further, the University of Wyoming Family Medicaid Residency Program estimates 35 to 40 percent of its residents have stayed in Wyoming over the last 30 years of the program.

E. Aligning Current Initiatives with Future Care Models

It is important to note that the reforms and initiatives described above are not the only ones underway in Wyoming – there are several others. Many state staff and other stakeholders believe that with these initiatives, the state and its collaborative partners are on the right path toward:

- Better integrating care across benefits and services.
- Encouraging and supporting providers to communicate and collaborate more with one another.
- Collaborating with other payers to establish consistent standards for providers.
- Focusing on increased accountability and payment reforms that will improve the care of Medicaid enrollees.

Moreover, through changes to how the state provides and pays for LTC for individuals with ID/DD and ABI, and the CME pilot program for high-needs children in the southeastern counties, WDH already is working to tackle many of the highest-cost programs and services in Medicaid. However, the number of initiatives happening simultaneously has created stakeholder frustration and concern that not all the initiatives will be successful.

²³ There are many federal programs that help recruit and retain health care professionals to underserved areas, such as Wyoming, including programs administered by the Health Resources and Services Administration. These programs also help recruit and retain providers within Wyoming, but are not included in this report.

Section V: Stakeholder Engagement and Analysis

WDH and HMA dedicated significant time and resources to engage a full range of stakeholders in this Coordinated Care Study. The goal was to assure that model recommendations reflect the realities, needs, and values of the people and organizations involved in implementing them, making them work, and using them.

Through an iterative process, WDH and HMA assembled a comprehensive stakeholder matrix that included state agency staff, political offices, providers (hospitals and other institutions, physicians and other clinicians), community-based and advocacy organizations, and vendors (managed care organizations and case management entities). Additional stakeholders were added based on referrals and requests for the opportunity to contribute to the discussion. *It is important to note that the feedback summarized here reflects the opinions, concerns and thoughts of only those stakeholders who participated in the stakeholder engagement activities conducted for this project.*

A. Summary of Stakeholder Feedback

Stakeholders are generally supportive of enhanced care coordination or management. They support key strategies for expansion of care coordination within the existing health care system, including locating care coordinators or care managers in provider practices and training health care providers and their staff so care coordination becomes a central part of their workflow and patient management.

However, they do not believe that Wyoming has the key infrastructure to successfully implement coordinated models of care and lacks an adequate number and distribution of health care providers along the care continuum. This impacts patients' ability to obtain the care that they need. When residents have to go out-of-state to obtain needed care, it impacts the ability of providers in Wyoming to coordinate and manage their patients' care. Additionally, the current culture within the healthcare system will need to change significantly to get providers to work together better and communicate effectively. For example, many dentists did not understand how or why such a change in health care delivery would affect them, since dentists and physicians do not currently work together with any degree of regularity. In a coordinated care model, physicians and dentists would communicate and work together to ensure that patients receive the full range of appropriate care and services. Patient stakeholders also said that providers do not really understand what "patient-centered care" is or how to deliver such care. Providers will need training and technical assistance to change their practice patterns.

Technology can be used to address some of the issues with limited provider access and communication among providers. Many stakeholders support increased funding and expansion of tele-health and EHRs. Stakeholders noted the need to not only put this technology in place, but to educate and train providers on how to use it. Importantly, mental health and substance use treatment providers noted the need for ensuring that such technological solutions are designed in a way that delivers appropriate privacy protections for these patients. Many people believe that existing federal regulations prohibit or greatly limit the ability of mental health or substance use treatment providers from using and exchange information with other providers. Mental health providers in Wyoming who participated in the study wanted the state to understand that while protections must be put in place, federal regulations do not prohibit them from using and exchanging information through EHRs. Ensuring full use by all healthcare providers along the healthcare continuum will be vital fully integrated care coordination and management.

In addition to a change in provider culture, there also is a need to inform and engage Medicaid enrollees so they understand their role as patients in new care coordination and management models and how they will be impacted. Enrollees often have very low health literacy and do not understand how to

effectively navigate their system of care. Building self-management skills will be highly valuable to enrollees. The vast majority of stakeholders understood the importance of and need for putting in place the supports and services that enrollees require to change their behavior, and some stakeholders supported the use of incentives to encourage enrollee behavior. However, HMA cautions the state on the use of incentives, and particularly the use of financial disincentives, until the system of care available to enrollees is adequate to fully meet their needs and help them build self-management skills.

B. Discussions with Vendors

The vendor interviews included organizations interested in providing managed or coordinated care services to Wyoming's Medicaid population. Because these interviews were conducted using a different approach and the feedback differs, this is included as a separate section of the report. These vendors included Medicaid MCOs and Medicaid CMEs. A structured interview protocol was developed for interviews with all vendors.

i. Vendor Feedback

In conversations with representatives from various national health plans it is clear that there is a medium-to-high level of interest to do business with the state and to serve the Medicaid population. However, most of the plans also stated their interest would be greater if the state expanded Medicaid to include all populations statewide in a full-risk managed care contract, especially if the state wants a two-plan model with choice. A few of the vendors mentioned the need to modernize the MMIS before launching any kind of new managed care contracting arrangement or implementing new payment models. All of the plans recognize the sensitivities in rural and frontier communities and the need to stay engaged with providers.

All of the vendors recognize the first decision the state must make is to determine what aid categories would be included in a managed care arrangement. That decision drives whether the state uses a state plan amendment to contract with health plans, or whether the state needs a rural exception or waiver if managed care is mandatory for all populations. Who is included also determines the models of care needed to serve the clients and staffing needs for case management and care coordination. The state and the plans need different infrastructure (e.g., data collection and reporting, metrics and key performance indicators, contract management and accountability, etc.) when different populations are served. The plans also believe that as long as providers can pass credentialing requirements that all should be welcomed into whatever program is developed.

Vendors generally like full-risk arrangements and there is greater potential to see a savings on expenditures, at least in the early years, with a full-risk, capitated model (if the entire population is included). It also provides greater budget predictability for the state. Plans, especially Medicaid-only plans, have extensive experience managing the care of low-income, diverse populations and are also experienced in states like Wyoming where there are one or two population centers with much of the rest of the state being rural or frontier. Plans can bring sophisticated predictive modeling and data analytics, health risk assessment tools, tracking and referral systems, tested care coordination models, experience working with community organizations and supportive services, and knowledge of state and federal requirements for benefits, payments, and transparency of reporting outcomes and enrollee satisfaction.

There is opportunity, but no guarantee, for plans to save the state money primarily by using the following approaches or tools:

- By working closely with the state eligibility determination processes, plans that receive enrollment files quickly, and reach out to new enrollees immediately, have a better opportunity to ensure continuity of care (e.g., medication management, prior authorizations) and to reduce the risk of gaps in services that might lead to visits to the ED or even hospitalization.
- Plans use health risk assessments and other tools to determine the highest-need enrollees so they can deploy case managers early, allowing the plan and the enrollee to develop a patient-centered, comprehensive care plan that will meet all of their health and social needs. Plans can assess quickly the social needs of an enrollee, such as housing and food, and get enrollees plugged into community based services quickly. Plans can assign or help enrollees choose a PCP, ensuring that their network of providers is willing and able to take new enrollees.
- Health plans have the tools and analytic capabilities to monitor utilization and expenditures so they can intervene quickly if they see patterns of use (e.g., excessive use of ED, high number of inpatient stays) that are not only expensive, but not consistent with the desire to have everyone in a health care home.
- Plans have the infrastructure and staff to work with provider groups to set quality metrics, report back to providers, and to develop incentive payments that motivate providers to concentrate on interventions and approaches that will save money and improve outcomes for enrollees. Plans are held responsible for assuring an adequate network of providers and helping enrollees get to the right provider, which in turn will save money by avoiding unnecessary trips to the ED or to over- or misuse of benefits. Plans can also monitor enrollee compliance through registries and notify and work with enrollees if there is underuse of benefits or services (e.g., Rx renewal reminders, screening or lab test follow-up, etc.) also then avoiding a more expensive intervention.
- Providing community workers and navigators to help enrollees in their home and community can save the system unnecessary expenditures by teaching enrollees about their treatment recommendations, getting to and from appointments, connecting them with social needs such as housing and nutrition, and educating them about using the healthcare system in appropriate ways. Plans often engage with trusted community groups to provide these services or supplement those resources with their own staff.
- Most health plans have web-based education tools, classes, or other mechanisms to teach enrollees how to better manage their own care and chronic conditions, giving them a better sense of control over their own lives and saving money when an enrollee can learn or report information electronically versus making an office visit, or worse a visit to the ED. Plans also have 24-hour nurse lines available to enrollees to help determine if a symptom or condition requires a visit to the provider or ED, or whether it can be managed in the home or with over-the-counter remedies.

Table 11 below summarizes vendor responses related specifically to their interest in working in Wyoming.

Table 11

Areas of Discussion	Summary of Feedback
The MCO/CME’s level of interest in entering the Wyoming Medicaid market (high, medium, or low)	<ul style="list-style-type: none"> • Medium to high interest. • There was universal agreement that Wyoming would benefit from some type of reform resulting in greater care coordination and managed care. • One vendor said that if the state expands Medicaid, their level of interest would increase since the enrollee population would be larger.
Whether the MCO/CME would be interested in a program that: <ul style="list-style-type: none"> • Is statewide or only in limited regions • Includes the entire Medicaid population or limited sub-populations 	<ul style="list-style-type: none"> • Most vendors supported statewide implementation of the model, as well as inclusion of the entire Medicaid population. This would result in sufficient enrollment to allow them to manage risk and create economies of scale. • However, one vendor that specializes in care management for the high-risk/high-needs populations supported a small pilot targeted to their niche. Conversely, a vendor with experience working with WDH said that the state has a pattern of small pilots and should think more globally this time. • One vendor suggested that it might make sense to pursue a regional implementation, for example in Casper, Cheyenne and Laramie.
Thoughts on the best approach for Wyoming	<ul style="list-style-type: none"> • Several vendors said that the state first needs to decide which aid categories would be included, since it drives other decisions about models of care and infrastructure. • In general, vendors preferred full-risk programs saying, "It would serve reform better." • A phased-in approach could help address challenges of implementing in rural/frontier areas. The state could start with some populations and expand. This would give vendors the opportunity to engage with and educate providers. A phased approach would be fine if there were clear intent and a timeline for expansion. Vendors want to know the full scope of enrollment prior to making significant infrastructure investments.
Number of plans/enrollees	<ul style="list-style-type: none"> • Some vendors supported having two vendors to allow for choice and prevent enrollees from feeling “locked in.” • Others vendors recommended Wyoming seek a rural exception and only contract with one plan that would cover the entire state, as this would ensure a larger membership. In a state with fewer than 100,000 Medicaid enrollees, splitting the enrollment would make it harder for them to achieve economies of scale.
Perceived Challenges with Medicaid managed care in Wyoming	<ul style="list-style-type: none"> • Vendors have experience with rural states and acknowledged existing limitations in the current system that could present barriers to implementation of managed or coordinated care. • The significant distance between where people live and where services can be accessed presents challenges for the development

Areas of Discussion	Summary of Feedback
	<p>of a model of care and assuring that enrollees can access needed services in a timely manner (i.e., availability of non-emergent transportation).</p> <ul style="list-style-type: none"> • The rural nature of the state could impact the model of care developed. • To solve provider shortage issues, several vendors said they would contract with providers in border-states to ensure access standards were met. • Despite benefits of managed care, the vendors also acknowledged that it could not solve all of the issues around infrastructure needs and provider shortages (they couldn't bring more providers to the state). • One vendor with experience working with state noted the lack of experience of WDH staff with managed care. This could have significant ramifications for the design and implementation of the program, including setting an appropriate reimbursement rate and conducting ongoing monitoring and enforcement. • The lack of provider experience with managed care would require significant outreach and engagement of providers by vendors, which could be a barrier to network development. • The lack of providers in general would further impact network development.

ii. ASO Vendors

There are ASO vendors that the state can contract with to perform some of the functions of a health plan, but without having a full-risk capitated payment arrangement. ASOs can deliver the utilization management, care coordination, provider credentialing, and data collection and analytics but still pay providers FFS. The data and management of care and utilization still allows for payment reform and provider accountability in this managed FFS model and is used in a few states - especially with rural populations. These firms use claims and historical data to stratify the Medicaid populations to determine the intensity of the care management needs of individual enrollees, and they are often paid a PMPM fee for case management.

iii. HMA Assessment of Vendor Feedback

HMA believes that whether WDH decided to implement full-risk managed care statewide and include the entire Medicaid population or to take a more limited approach, the vendors who are most interested in expanding into Wyoming will likely be interested either way. Based on the feedback received through extensive stakeholder engagement process, HMA believes that some, if not most, of the health plans do not understand how difficult it will be to establish adequate networks in many parts of Wyoming, even with inclusion of out-of-state providers, or the level of resistance among providers to moving to full-risk capitation.

Section VI: Recommendations and Next Steps

A. Recommended Models

HMA conducted extensive research on managed or coordinated care models implemented in several states, obtained feedback from a broad spectrum of stakeholders through comprehensive engagement activities, interviewed health plans that have Medicaid managed care programs in many states, and identified the current initiatives underway in Wyoming. HMA recognizes that no two states are alike and has not recommended an approach simply because it has worked in other states. Our recommendations are supported by the quantitative and qualitative data gathering and analyzed for this study. HMA recommends that WDH continue to pursue the PCMH model of care coordination, but target two subsets of the population for enhanced care management services:

- Identify Medicaid enrollees who meet specific utilization, diagnoses and cost criteria to receive an enhanced level of care coordination through a PCMH. Pay PCMHs a risk-adjusted rate for the enhanced services.
- Identify Medicaid enrollees who are “super utilizers” – the small number of individuals who have extraordinarily high needs, utilization and costs. Buy or build a structure for very high-touch care coordination and care management services for these individuals in addition to the enhanced care management they receive through a PCMH.

B. Models Not Recommended at This Time

HMA does not recommend that Wyoming pursue PCCM, ASO, ACO, or Risk-Based Managed Care at this time. We have not recommended these models for several reasons:

- Wyoming is already moving beyond the more basic forms of managed care and should not “go backwards.”
- Wyoming already has a number of initiatives underway and adding yet another to the mix would dilute the ability for those initiatives to achieve success.
- Stakeholders, both within the WDH and externally, were opposed to changes that would bring in organizations unfamiliar with Wyoming’s unique communities, issues and needs. This opposition included strong sentiments against anything that might jeopardize participation of providers in the Medicaid network.

C. Next Steps

In addition to implementing the above initiatives as part of the work already underway, HMA recommends a number of next steps and action items that would support all of WDH’s efforts, as well as help to ensure ongoing stakeholder buy-in and engagement.

i. **Focus on successfully implementing initiatives currently underway or planned**

Discussions with stakeholders, as well as research into efforts underway in the state revealed a great deal of transformation already underway – many of which will lead to improved care and slow the growth of Medicaid expenditures. The one new initiative that HMA believes Wyoming should consider is a Super-Utilizer program (SUP) in concert with a targeted PCMH effort. Through the SUP, Wyoming can provide intensive outpatient care management to these enrollee subpopulations who have very complex physical, behavioral, and social needs and target effective interventions.

WDH should continue to build on these efforts to secure buy-in for the model and identify potential sites/providers willing to participate. Again, as the state learns from its PCMH initiative, it can identify important “lessons learned” and continue to build the infrastructure supports that will be necessary to fully implement successful Health Homes.

Given its comprehensive redesign of Medicaid LTC and ID/DD waivers, HMA does not recommend that WDH pursue any additional reforms to these service areas. WDH already has multiple workgroups and committees supporting the LTC Service Redesign and the ID/DD/ABI Waiver Reform and should continue these to help inform the progress and process as these new programs are operationalized. However, HMA does recommend that these initiatives be connected to the others through the roadmap (see Recommendation #2). Doing so can help WDH identify opportunities for leveraging components of other initiatives that may benefit waiver recipients, and vice-versa. HMA also does not believe that waiver recipients should be excluded from the other care coordination initiatives WDH is pursuing. For example, many of these enrollees likely would be candidates for the SUP because they typically are high-cost and high-utilizers of services.

Additionally, the state's PACE program appears to be high-functioning and participation is greater than had been expected. HMA recommends that WDH continue and expand the PACE model as demand dictates and so long as the program is meeting the state's goals. As noted in the earlier discussion of PACE programs, while PACE can effectively meet the needs of a specific patient population, it is generally not cost efficient to scale the model significantly. Maintaining a separate PACE program will not impact care coordination efforts for other Medicaid enrollees.

ii. Create a Roadmap for Medicaid Reforms

To help WDH track and manage the myriad reforms currently underway and to help stakeholders understand everything that is being done, HMA recommends that WDH create a roadmap of Medicaid reform activities. The map should be created with stakeholder involvement and feedback to ensure buy-in. The roadmap should include:

- All old, new, and planned care coordination activities and initiatives for the next three to five years – all care coordination activities WDH is engaged in or planning should be part of this overview, including work being done by CQS, the Pharmacy Benefit Management (PBM) program, PCMHs, new LTC and ID/DD waivers, and planning for Health Homes and a super-utilizer program if expected to add one.
- Clear definitions of the enrollees and providers encompassed by each initiative or activity – this would help to show where there are overlaps and allow for better coordination for enrollees in those situations. It also could help to identify opportunities for leveraging technical assistance and technology support, as well as gaps in both WDH experience/expertise and stakeholders’ capabilities.
- How WDH is connecting and leveraging each initiative, including funding - whether state funds, federal funds, or other external funds. A comprehensive review of programs and initiatives and their funding sources can help WDH better hold all stakeholders accountable for the dollars and services they receive (i.e., enrollees, providers, community service organizations, advocates, and WDH staff).
- The current status of each activity and initiative, as well as expectations for where they will be each year for the next five years – a timeline of ongoing monitoring for existing programs, as well as for implementation activities for new programs will help all stakeholders understand when things will be happening so they can appropriately prepare for the changes. This also

serves as a mechanism for WDH to plan for what it needs to support each of these activities in terms of additional staff, systems and tools, training, and policy or legislative changes.

Once final, this road map and timeline would help guide WDH's policy, program, budget and staffing decisions through the life of the roadmap.

iii. Conduct Comprehensive Stakeholder Outreach, Education, and Engagement

Comprehensive, on-going stakeholder engagement is vital to the success of new initiatives. Such engagement helps inform the development of the initiative so that it will work within the existing system and engenders support and buy-in from the people affected by the change. We encourage the continuation and expansion of current stakeholder outreach activities through the creation of a comprehensive stakeholder engagement plan. Many stakeholders do not fully understand how the various models of care and health information technology systems work and what their role is in them.

The Wyoming Integrated Care Network, the Wyoming Institute for Population Health and others have led efforts to educate providers about the need for and viability of the PCMH model. There are multiple workgroups and committees for the LTC Service Redesign and the ID/DD/ABI Waiver Reform. Yet even with these efforts, there is still significant need for education and engagement among the provider community, enrollees, advocates and policy-makers.

Additionally, some non-primary care providers failed to see how a more coordinated approach to providing care might change their practices and didn't always understand that there would be an increased expectation that they collaborate and communicate with other practitioners. During the public forums and stakeholder interviews, many participants, including providers, were unfamiliar with the concepts and models for care coordination and management. Many providers believe they are coordinating and managing care, but when asked to describe how they do it, it becomes apparent that many are not yet meeting the more stringent and comprehensive care coordination/care management requirements that these models comprise or that are required to successfully meet some of the new shared savings/losses models or quality performance metrics. Providers will need technical assistance, training and support to be able to successfully implement many of these changes.

WDH should create a comprehensive stakeholder education and engagement plan based on its roadmap (see Recommendation #2 above). The plan should:

- Identify all the relevant stakeholders for each activity/initiative. For example, specific stakeholder groups may include providers (all types), associations, enrollees, advocates, community-based service organizations, commercial insurers, legislators, leaders of other state agencies, other leaders within WDH, among others.
- Identify each stakeholder group's key issues (e.g., reimbursement, access to care, quality improvement, cultural competency, etc.).
- Identify each stakeholder group's preferred modes of communication (e.g., in person meetings, e-mail alerts, public forums, surveys, etc.).
- Assess each stakeholder group's level of awareness and understanding of the activities/initiatives and their capabilities with each (e.g., access to and ability to use technology such as EHR and HIE, current care coordination practices and staffing, experience and expertise working with target populations, reporting and evaluation resources, etc.).
- Assess each stakeholder group's ability to impact (positively and negatively) activities/initiatives and their role in each.

- Develop specific messages and information each stakeholder group needs from WDH to ensure their support and to help them be as successful as possible in each activity/initiative.
- Establish timelines for communicating with each stakeholder group based on the timing of specific activities and initiatives, as identified in the roadmap.

iv. **Build the Necessary Infrastructure**

Universally, stakeholders noted the need for increased and improved infrastructure – from technology to workforce development – across the state. While Wyoming has a number of initiatives underway to enhance technology, including a Health Information Exchange and Total Health Record, more work remains, including educating providers and attaining widespread use.

Technology

For example, given the importance of sharing data among providers and building future value-based payment methodologies, WDH should take a lead role in revitalizing and fully building out the state’s Health Information Exchange (HIE). It may be necessary to identify other partners who can help to support the project, including foundations or other private funders. Additionally, despite the extensive work Wyoming Medicaid has done to design, implement, and deploy the THR and Gateway system, many providers in Wyoming remain unaware of it. Stakeholders were asked during interviews to identify the top three things that need improvement before care coordination could be successful in Wyoming - a statewide electronic health record was always among the top three (increased number and types of providers and tele-health were the others).

Stakeholders also noted the value that an all payer claims database has, but believe the legislature would not mandate participation by all payers in the state. WDH could have a role in moving this initiative forward, even on a voluntary basis. Recent “All Payer” meetings with the major commercial payers in Wyoming (Cigna, WinHealth, BCBS) have indicated there is a willingness to create a “Quality Foundation” with the payers represented on the Board, where all payer data is managed in a way that does not threaten the competitive business model, while allowing Wyoming to recognize and reward quality practices.

With the multitude of data and new technologies that are being implemented to share that data, it becomes more important for the state to be able to effectively manage and maximize the use of data. WDH should consider building out its capacity to do more sophisticated data analysis or securing a vendor that can provide such services. This might include predictive modeling software or tools to help identify enrollees for enhanced care management interventions, tools to conduct population-based or geographic based interventions, and tools to profile providers to understand variations across geographic areas or identify outliers who may need additional education and training.

Workforce Development

A number of workforce development programs are in place across Wyoming, and Medicaid could serve as special champion for many of them through various efforts such as:

- Supporting the University of Wyoming’s development of an Educational Health Center (EHC of Wyoming) umbrella for the two residency programs. If successful, the state will be able to add residency slots either for the traditional programs or under a federally qualified rural training track.
- Supporting innovative medical education programs that can be funded through philanthropic donations, similar to the University of Colorado - Denver Family Medicine Patient Centered Medical Home Residency Program, which is funded through a \$2.8 million grant from the Colorado Health

Foundation.²⁴ Similarly, the state could pursue funding sources to support programs to train and certify Community Health Workers as part of integrated care coordination practices and for enrollee education and engagement.

- Supporting an assessment of existing scope of practice and licensure requirements to determine if existing requirements allow all provider types to practice at the fullest extent of their education and training.

v. Implement value-based payments

For each of the initiatives underway or planned, WDH should begin to incorporate value-based payments for quality improvements, cost savings, or both. Value-based payments seek to align incentives across providers and require them to take on greater accountability in an attempt to get them to consider the costs of their decisions, reduce waste and overuse, provide appropriate care, and increase coordination. They also create incentives for providers to deliver the right care, at the right time, in the right setting. Such payments are most effective when they are tied to performance requirements, determined through quality measurement reporting and other quality monitoring.

WDH will need to build up and expand its technical in-house expertise to manage and support new reimbursement options and the different reporting and reconciliation processes for each, as well as offer technical support for providers. A new, more flexible MMIS system would help WDH better track and manage new payment models and ensure that providers still receive timely and accurate compensation for the new initiatives they undertake. It also would allow the state better management reporting capabilities so staff could identify and resolve issues more quickly and effectively.

Because providers in Wyoming generally have experience only with fee-for-service, movement to value-based payments should be done slowly and with meaningful participation by all stakeholders. For example, starting with a shared savings pool would allow providers to earn bonuses or incentives if they meet state-specified metrics, e.g., quality targets, practice changes that enhance care coordination, or better communications with other providers. This could help to build the necessary experience, systems and reporting foundations for moving to greater financial accountability over time, including shared losses and capitated payments.

D. Conclusion and Tie to Task II of the Project

This report comprises the final deliverable for Task I. Based on the research from this paper, and in ongoing consultation with WDH, HMA has begun work on Task II of the project – data analysis of models of care to identify cost savings and quality improvements WDH could potentially achieve through them. That data analysis will focus on implementation of the PCMH model, with a super-utilizer program built on it for the most complex enrollees.

²⁴ To learn more about the program, visit

<http://www.ucdenver.edu/about/newsroom/newsreleases/Pages/FamilyMedicineResidencyProgramLeadsPatientCenteredMedicalHomeInitiative.aspx>