State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level:

Final Report

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Project Summary

This report summarizes the work conducted under a continuation of the project, "Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States." The project was funded by the Medicaid and CHIP Payment and Access Commission (MACPAC) and conducted by staff at the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, School of Public Health with the assistance of MACPAC staff. The purpose of the project was to better understand specifics of different state approaches to Medicaid payment and delivery system reform (e.g., shared savings programs, episode-based payment initiatives, global budgeting), to monitor state progress in advancing these reforms, and to identify common themes across states.

Between August 2014 and July 2015, the project involved the following key activities:

- Site visits to Connecticut, Maryland, and Oklahoma, three states new to the project (November and December, 2014);
- Periodic telephone interviews with state Medicaid officials from Arkansas, Minnesota, and Oregon, three of the states previously visited by MACPAC and SHADAC in the fall of 2013; and
- A one-day roundtable discussion on with state Medicaid officials from Arkansas, Connecticut, Maryland, Minnesota, Oklahoma, Oregon, and Pennsylvania at MACPAC's offices in Washington, DC in May of 2015.

During the site visits to Connecticut, Maryland, and Oklahoma, semi-structured interviews were conducted with state Medicaid officials and stakeholders to collect information on states' Medicaid payment reform models, the factors that influenced state decisions, what was required to launch each of the models, the challenges and barriers states have experienced, how the models operate, and how the programs will be evaluated. The periodic telephone interviews with state Medicaid officials from Arkansas, Minnesota, and Oregon focused on monitoring program developments, lessons, and results available since our site visits in the fall of 2013. Finally, the purpose of the roundtable discussion was to facilitate in-depth discussions among state Medicaid officials about results and lessons learned during the Medicaid payment reform process.

This report addresses key themes related to state Medicaid payment and delivery system reforms aimed at changing care delivery at the provider level that emerged from our many discussions throughout the last year. It is important to note that the report assumes the reader's basic familiarity with the components of each state's Medicaid payment and delivery system reform initiatives. For case studies providing additional program information on the states MACPAC and SHADAC visited during the first phase of this project, please see:

- Dybdal, K., Blewett, L., Sonier, J., and Spencer D. "Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States." Prepared for the Medicaid and CHIP Payment and Access Commission (MACPAC). February 2014. Available on MACPAC's website at: https://www.macpac.gov/publication/paying-for-value-in-medicaid-a-synthesis-of-advanced-payment-models-in-four-states/.

The table below identifies key features of the Medicaid payment and delivery reform initiatives examined in each of the states we visited.

Table 1. Key Features of Medicaid Payment and Delivery Reform Initiatives in Select States

	AR	CT	MD	MN	OK	OR	PA
Underlying Medicaid Delivery System							
Largely fee-for-service	✓	✓			✓		
Managed Care Organizations (MCOs)			✓	✓			✓
Accountable Care Organizations (ACOs)				✓		✓	
Administrative Service Organizations (ASOs)		✓	✓				✓
New Medicaid Payment Models and Initiatives							
Enhanced payments	PCMH	PCMH	PCMH		PCMH		PCMH
Pay-for-performance incentives or adjustments		PCMH			PCMH		Targeted adjustments
Shared savings (upside)	PCMH		PCMH				PCMH
Shared savings (upside) & risk (downside)	Episodes			IHP			
Global budgeting			All-Payer Model (Hospital)			CCO	
New Care Delivery Reforms							
PCMH	✓	✓	✓		✓	*	✓
Health Homes	Planned	Planned	✓	✓	✓	✓	
Integrated Care Management		✓			✓		
Payer Participation							
Medicaid	✓	✓	✓	✓	✓	✓	✓
Medicare			All-Payer Model (Hospital)				
Private insurers	Episodes & PCMH		All-Payer Model (Hospital)				PCMH
Self-insured employers	Episodes & PCMH		All-Payer Model (Hospital)				

Table 1 Notes:
*Oregon's Coordinated Care Organizations (CCOs) may offer incentive payments for recognized primary care homes, but there is no formal PCMH program sponsored by Medicaid. Oregon's Public Employees' Benefit Board (PEBB) provides incentives to recognized primary care homes in the PEBB Statewide Plan.

Table 1 Terms:

CCO	Coordinated Care Organization program, Oregon's Medicaid ACO initiative
IHP	Integrated Health Partnership program, Minnesota's Medicaid ACO demonstration
PCMH	Patient- or Person-Centered Medical Homes

State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level

A common concern shared by state officials and stakeholders interviewed is that both Medicaid fee-for-service and conventional Medicaid managed care programs do little to align incentives away from the delivery of episodic, uncoordinated care. The intent of many state Medicaid payment reform initiatives, therefore, is to change the delivery of care at the provider level with the hopes that this will lead to more efficient care delivery, improved health outcomes for enrollees, and better value for taxpayers. States have coupled Medicaid payment reforms with other provider supports, such as funding and technical assistance for patient-centered medical home (PCMH) transitions, and enhanced provider data, analytics, and infrastructure.

While, at a high level, the seven Medicaid programs we visited (Arkansas, Connecticut, Maryland, Minnesota, Oklahoma, Oregon, and Pennsylvania) are pursuing common goals and responding to similar budget realities, our site visit interviews and roundtable panel highlighted just how important each state's unique health care business environment, Medicaid program history, and culture have been in shaping state leaders' approach to reform and in the degree of reform pursued. Box 1 provides a brief snapshot of the varied approaches to reforming care delivery at the provider level in the study states.

Box 1.   Snapshot of State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level

Arkansas: Episode-based payments for 14 "episodes of care" (e.g., upper respiratory infection). Designated Principal Accountable Providers (physician practices, hospitals, and other providers) assume upside and downside risk based on cost and quality thresholds designated for each type of episode. Multiple payers (including Medicaid) participate in 10 of the episodes. Multi-payer PCMH program that includes enhanced payments, shared savings, and practice support, enrolling approximately 123 provider practices and 309,000 Medicaid beneficiaries.[1] Enhanced provider reporting and analytics to support both initiatives.

Connecticut: Transitioned from Medicaid managed care to a managed fee-for-service approach utilizing Administrative Services Organizations (ASOs) to increase access to data, enhance predictive modeling and intensive care management capabilities, and streamline utilization review and provider payment practices. PCMH program with tiered payments for primary care practices pursuing certification or certified as PCMHs as well as technical assistance. Enhanced provider reporting and analytics in support of PCMH. Includes roughly 87 provider practices serving 254,000 Medicaid beneficiaries.[2]

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[1] Figures as of December 2014.

[2] Figures as of August 2014.

Maryland: Maryland Multi-payer Patient Centered Medical Home Program (MMPP) with enhanced payments and shared savings for participating provider practices (sunsets in 2015). MMPP includes roughly 52 provider practices and 250,000 attributed patients (across all payers).[3] Though not central to our study, Maryland has also implemented an all-payer global budgeting model for hospital payments.

Minnesota: Integrated Health Partnerships (IHPs)—provider delivery systems—share upside and, in some cases, downside risk based on total cost of care (TCOC) calculations for core Medicaid services and quality metrics. Enhanced provider reporting and analytics to support IHPs. Includes 16 provider systems (both integrated and non-integrated) and 200,000 attributed patients.[4]

Oklahoma: State officials from Oklahoma described the Oklahoma Health Care Authority (OHCA) as a "public managed care organization (MCO)", with direct oversight and administration of many of the functions that had once been outsourced to private managed care companies. PCMH program with tiered payments for primary care practices as well as quality incentives for meeting performance targets. Includes roughly 880 provider practices and 493,000 enrollees.[5] Care coordination (by the state and multiple vendors) for high-cost, high-need enrollees with chronic conditions, including some care coordinators embedded in provider offices. Also includes practice facilitation.

Oregon: Coordinated Care Organizations (CCOs)—community-based organizations governed by local partnerships among health care providers, community members, and other stakeholders—share upside and downside risk for covering a comprehensive benefit set for a defined Medicaid population within specified budgets. Includes 15 CCOs covering 990,000 beneficiaries.[6] Enhanced reporting and analytics to support CCOs.

Pennsylvania: MCOs and contracted providers receive pay-for-performance incentive payments for meeting quality thresholds. MCOs and hospitals are also subject to downside risk (efficiency and payment adjustments) for unnecessary health care/costs, preventable severe adverse events, and certain readmissions.

At the core of these varied state strategies are the following elements, each of which was observed in multiple states:

- **Payment reform:** changing provider payments and financial incentives;
- **Provider reporting:** measuring cost, utilization, and quality at the provider level and disseminating this information to providers;
- **Prioritization of high-need populations:** through data analytics and new screening tools, identifying individuals with complex health issues so providers and care managers can better meet their needs;

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[3] Figures as of March 2015.
[4] Figures as of June 2015.
[5] Figures as of May 2014.
[6] Figures as of January 2015.

- **Intensive care management:** higher-touch interventions with members aimed at improving care coordination and supporting self-management behaviors, often working in partnership with providers.
- **Practice supports:** provider interventions that promote the advancement of medical homes through practice coaching, technical assistance, and other provider supports.

Each of these key elements is discussed in turn below.

Payment reform: Changing provider payments and financial incentives

The states in this study have all made some changes to direct provider payments and other financial incentives to influence provider behavior change. These payment reform strategies can be loosely categorized into three models: (1) enhanced payments; (2) shared savings/risk; and (3) global budgeting.

- **Enhanced payments:** Enhanced payments for increased care coordination and meeting medical home requirements are made directly to providers in addition to their normal, fee-for-service reimbursement. Within Arkansas, Connecticut, Maryland, and Oklahoma, enhanced per-member (or patient) per-month payments provide a foundation for PCMH implementation. One variation of this model is to create different "tiers" of enhanced payments to reward providers according to their level of PCMH certification or maturity (e.g., Connecticut, Maryland, and Oklahoma). Another is to risk-adjust care coordination payments based on factors like demographics, diagnoses, and utilization (e.g., Arkansas' PCMH program). Some states also incorporate pay-for-performance incentives linked to performance or improvement on quality of care measures or other practice goals (e.g., Connecticut's PCMH program, Oklahoma's PCMH program).

- **Shared savings/risk:** This model allows providers to retain a portion of savings generated from better managing care for a given population and set of services. Savings are calculated by assessing provider spending performance vis-à-vis established spending targets. Downside risk may also be incorporated by requiring providers to share in losses (i.e., make payments back to the state) if spending is higher than established targets. Shared savings/risk can be incorporated as part of a Medicaid Accountable Care Organization (ACO) initiative (e.g., Minnesota's IHP demonstration), episode-based payments (e.g., Arkansas' episodes), or even as part of a PCMH program (Arkansas' PCMH program, Maryland's MMPP).

- **Global budgets:** This entails one fixed payment for the total cost of care per member (global payment) or for the total cost of care for a population (global budget) over a defined time period. Global budgets can also be referred to as capitation. From a provider perspective, global budgets may be viewed as a more "extreme" form of shared savings/risk. Oregon's CCO program and Maryland's all-payer, global payment waiver for hospital services fit this payment model. Through global budgeting, an opportunity exists to integrate Medicaid funding with other funding sources (e.g., social services or public health funding) into a common pool to invest in population health outcomes. (This is commonly referred to as "blended" or "braided" funding.) Among our study states, Oregon comes closest to blended or braided funding as global budgets for CCOs integrate once separate Medicaid managed care contracts for physical, behavioral, oral health services and allow CCOs to

provide certain health-related services that have not traditionally been reimbursable under Medicaid.

Provider reporting: Measuring cost, utilization, and quality at the provider level and disseminating the data to providers

In most advanced payment models—especially those that involve performance incentives, shared savings, or global budgets—provider financial gains are dependent on achieving a certain level of performance on a set of quality measures. As such, measuring cost, utilization, and quality goes hand in hand with reforming payment structures. State Medicaid programs involved in reforming payments to providers have had to make significant investments in the data infrastructure and data analytic resources necessary to track these metrics at the provider level. In addition, states are beginning to provide information on individual patients, offering providers data to target specific patients, such as those with chronic diseases.

Arkansas' episode-based payment initiative, Minnesota's IHP demonstration, and Oregon's CCO program, in particular, have established significant "behind the scenes" data analytics and disseminate cost, utilization, and quality reporting to integrated provider delivery systems, group practices, and individual physicians on a regular basis. To do so, Arkansas continues to rely heavily on consultants (McKinsey & Company, and General Dynamics Information Technology), Minnesota relies on an actuary (Forma Actuarial Consulting Services) and internal staff, and Oregon has developed its own internal capacity through the Oregon Health Authority's Office of Health Analytics.

As part of Arkansas' episode-based payment reform, Principal Accountable Providers (PAPs) receive regular reports and data from payers outlining their performance on quality metrics and costs to support their decision-making. PAP performance reports are available online and contain summary results as well as detailed analyses showing episode costs, quality, and utilization statistics over the performance period. Arkansas also provides quarterly reports to practices participating in their PCMH program through an online portal. These reports include:

- Status updates on core practice transformation activities (e.g., integrating electronic health records and e-prescribing into workflows, identifying high priority patients, and improving patient access);

- Performance on quality and cost metrics tied to shared savings payments; and

- Performance on metrics not tied to payment but indicative of the quality and cost of care delivered to attributed patients.

In Minnesota, IHPs receive monthly patient-level data on emergency department admissions, hospital admissions, readmission counts, and other care management flags for all patients assigned to an IHP. IHPs also receive quarterly reports on Total Cost of Care performance, including population risk profiles and aggregate costs by category of service, and monthly line level detail on claims and pharmacy utilization (not including paid amounts due to legal limitations) for the most recent 12-month period for attributed patients. Finally, Oregon provides CCOs with reports on 37 measures related to cost, quality, and utilization. 17 of the measures are used to determine eligibility for quality incentive payments. CCOs receive both aggregated and individual level data for all measures.

Table 2 below provides a comparison of provider reporting efforts in leading states, including target audiences, data sources, how often the reports are shared with providers, whether and what kind of comparative information is shared, and the extent of public reporting.

Table 2. Key Features of Select Provider Reporting Efforts in Arkansas, Oregon, and Minnesota

	Arkansas: Episodes	Oregon: CCO Program	Minnesota: IHP Demonstration
How are states currently using the reports?	Analytics include some elements that are tied to shared savings/risk calculations	Analytics report on performance-based payment targets	Analytics report on performance-based shared-savings and risk targets
Who receives the reports?	PAPs (providers)	CCOs	IHPs
Comparative information shared?	Providers are given information about how their performance compares to all providers on a range of summary cost, quality, and episode specific metrics.[7]	Reports show each CCO's performance on measures, alongside a benchmark.	None
Provider or organization-specific information made public?	No	Yes	No
Main data sources	Medicaid claims; some outcomes data is submitted to state by providers via an online portal	Medicaid claims from state's All Payer Claims Database (APCD); some CCOs submit select clinical measures to the state	Medicaid claims and enrollment data; some outcomes submitted by providers through statewide quality reporting and measurement system (SQRMS)
Other payer participation in reporting	Blue Cross and Blue Shield, and QualChoice submit their reports independently	None	None
Level of reporting	Individual plus aggregated	Aggregated reports, plus access to patient-level files to validate data	Individual (e.g., medical and pharmacy utilization, care coordination reports) plus aggregated (e.g., total cost of care)
Frequency of reporting	Quarterly	Subset of data shared	Some reports are

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[7]http://www.paymentinitiative.org/referenceMaterials/Documents/Guide%20to%20Reading%20Your%20Report%20-%2009-04-2012.pdf

	Arkansas: Episodes	Oregon: CCO Program	Minnesota: IHP Demonstration
		with CCOs each month, full dashboard produced quarterly	monthly, others quarterly
Claims lag associated with key reports	3-month lag	2.5-month lag	Up to a 1.5-month lag for monthly reports; 3-month lag for quarterly reports

The states differ somewhat in the data sources for their reports. Minnesota relies on claims, enrollment, and Medicaid-specific information from a statewide quality measurement program (the State Quality Reporting Measurement Strategy or SQRMS). In addition to claims data, Arkansas incorporates some outcomes information that they receive from providers via an online portal and recently, Oregon began receiving information on select measures from electronic medical records. During our roundtable discussion, officials from other state Medicaid agencies discussed emerging planning efforts aimed at broadening the data they have traditionally used (i.e., claims and encounter data) and incorporating clinical data obtained from providers' electronic health records (EHR) into performance-based payment models and quality measurement strategies.

Among Arkansas, Minnesota, and Oregon, the frequency of data sharing with providers ranges from monthly to quarterly. Because the data source for most of the reporting elements is Medicaid claims data, there is a claims lag associated with the reports ranging from 1.5 months for monthly utilization and provider alert reports in Minnesota to 7.5 months for quarterly comparative reports in Arkansas. Minnesota's monthly reports contain all information that is available in Minnesota's claims data warehouse at the time the reports are generated – however, they may not include a full snapshot of patient activity if fee-for-service claims have not been submitted to the state in a timely fashion or for managed care encounters (the state usually receives this data 30-45 days after managed care companies pay their claims.)

The states differ in their approach to sharing comparative information about other providers or organizations. In Oregon, the reports that CCOs receive include information about all CCOs in the state. In Arkansas, providers are given information about how their performance compares to all participating providers on a range of summary cost, quality, and episode specific metrics. In Minnesota, comparative information is not shared for most metrics. One reason offered by state officials for this is that IHPs differ significantly in the populations that they target, so it is very difficult to make "apples-to-apples" comparisons.

The states also differ in the extent to which specific performance information (e.g., at the provider, CCO, or IHP level) is made public. In Oregon, results for all CCOs are made public once each organization has had the opportunity to review and contest any discrepancies. In Minnesota, IHP-level results are not made public. State officials cited a few reasons for this decision. First, Minnesota's statewide quality measurement program has an existing infrastructure and stakeholder process to make decisions about public reporting of quality measures, and state officials do not want to undermine that consensus-based process. Second, the attributed populations for IHPs are small, and so reporting out at this level would be challenging. State officials stated that public reporting for

IHPs in aggregate may be possible in the future as the program grows, so long as the efforts align with broader state quality measurement goals. Arkansas does not make its provider reports (for its episode-based payment model or its PCMH program) public.

Extensive provider reporting on cost, quality and outcomes is also becoming a feature of PCMH programs in other states we visited. For example, Connecticut, through its Administrative Service Organization (ASO) contractor, has invested heavily in the development, maintenance, and analysis of a single data set (Medicaid claims, eligibility, and provider data) to enable reporting at all levels, including the provider level. Connecticut's ASO contractor, Community Health Network of Connecticut, Inc. (CHN), utilizes the data to attribute members to PCMH providers, inform providers of their Healthcare Effectiveness Data and Information Set (HEDIS) scores and risk-adjusted total cost of care, and provide supports to provider practices in attaining higher levels of PCMH certification. In Maryland, one of the state's largest commercial payers—CareFirst—runs its own, single carrier PCMH program separate from the MMPP, and the two initiatives were often discussed in tandem during our visit to Maryland. One of the important differences between the two programs was data sharing with providers. CareFirst shares much more detailed information with participating providers than the MMPP. Similar to the Arkansas PCMH program discussed above, practices participating in the CareFirst program are given access to a portal with sophisticated metrics about their patient panels, including risk scores, medications, potentially avoidable events, imaging, chronic care maintenance, and preventive care.

Prioritization of high-need populations: through data analytics and new screening tools, identifying individuals with complex health issues so providers and care managers can better meet their needs.

A few of our study states described investments in predictive modeling tools as a means to prioritize high-need, high-cost Medicaid populations for more intensive care management strategies. Predictive models based on Medicaid claims data can be used to stratify groups of beneficiaries and estimate their future health care risks, needs, and costs. This information can be utilized by the state, care management vendors, and providers to better target staff resources to "high-opportunity" cases. In addition to predictive modeling, states have developed new screening and assessment tools to identify high-need enrollees.

As part of its new role as Connecticut's ASO, CHN is responsible for maintenance and analysis of Medicaid claims, member eligibility, and provider data, and CHN had to invest substantially in new predictive modeling tools and expertise. Its web-based "CareAnalyzer" tool, which uses the Johns Hopkins ACG (Adjusted Clinical Group) logic in conjunction with National Committee for Quality Assurance (NCQA) HEDIS measures, enables predictive modeling and health measurement at the population, care setting, provider, and member levels. CHN uses this analysis to identify individuals who are in greatest need of intensive case management. Once identified, CHN then assesses individuals' medical, behavioral, and oral health needs as well as their most basic needs (e.g., housing stability, food security, safety.)

Similarly, Oklahoma uses claims analysis/predictive modeling to identify and target high-cost, high-need Medicaid enrollees for care management services. In addition, Oklahoma's online Medicaid application now includes a 13-question health risk assessment to identify individuals in need of special care management or integrated care, and, with this information, the program initiates

referrals or opens care management cases. Starting in 2014, Oklahoma also implemented a policy that requires primary care providers to conduct behavioral health screenings for all enrollees ages five and older. Incentive payments for completed screenings started in the first year, and audits for compliance are scheduled to start in 2015.

In Minnesota, where participating IHPs develop their own clinical models and care management strategies, two of the state's monthly patient-level reports disseminated to IHPs help identify high-need beneficiaries. Minnesota's "provider alert" report contains a subset of attributed beneficiaries with either an emergency department visit or hospital admission in the prior month with their last contact clinic. This report is used by IHPs as a "high impact list" for clinics. A separate monthly care management report to IHPs also uses the ACG grouper to stratify patients by risk, likelihood of hospitalization, flags for the presence of chronic conditions, and other coordination of care indicators.

Intensive care management: higher-touch interventions with members aimed at improving care coordination and supporting self-management behaviors, often working in partnership with providers.

States oversee and carry out care management activities in a variety of ways: by outsourcing these activities to MCOs or ACOs, contracting directly with care management vendors, operating programs internally, or choosing a hybrid approach. While the majority of care management contacts with Medicaid beneficiaries still continue to be telephonic, several of our study states are investing in more intensive programs for populations with the highest needs, often in partnership with providers. Intensive care management programs can incorporate more in-person contacts with patients (and their providers), closer coordination between patients' care team members, and greater linkages to community resources and social supports.

Oklahoma is targeting high-need, high-cost enrollees with chronic conditions. Two of these programs include patient health coaches embedded in provider practices. The Health Management Program initially provided health coaching to enrollees via home visits and telephonic outreach. Since 2013, the program has had coaches located in PCMH offices with high chronic disease burden. During our visit to Oklahoma, program staff reported that it is looking into a hybrid health coaching approach—combining embedded coaches and home visits—to reach more patients in rural areas.

Similar to Oklahoma, the care management approach under Maryland's MMPP includes care managers embedded in provider practices. Care managers are responsible for identifying patients who may be at risk for poor outcomes and/or could benefit from more intensive follow-up services. They are also tasked with developing care plans for targeted patients, providing outreach services telephonically and in person, and working with patients to address financial and social issues. These care managers serve all patients seen at the participating practices, regardless of insurance source.

In Connecticut, CHN makes intensive care management (abbreviated as "ICM" in Connecticut) available to all Medicaid enrollees. CHN provides ICM through teams of nurse case managers and community health workers who are assigned to geographic areas. Care management is provided at patients' homes or at other places in the community as requested/needed by the patient. CHN

focuses on enrollees who currently need care management and those at risk of needing this assistance in the future. In 2013, CHN provided ICM to approximately 17,000 enrollees. Several states are also actively linking community resources and social services and supports as part of their intensive care management strategies. In Oklahoma, this is achieved by having community resource specialists on staff to help health coaches identify behavioral health and other resources that members need, hiring licensed social workers who serve as social service coordinators, and having an established system or database of community providers and resources to draw on for effective community referrals. In Connecticut, CHN (the state's ASO) assesses individuals' most basic needs and work to connect enrollees with homeless centers, housing agencies, employment resources, and other resources.

Practice supports: Practice coaching, technical assistance, and other provider supports

In addition to intensive care management strategies, state officials emphasized the importance of interventions aimed specifically at providers, such as practice coaching resources, technical assistance, and other offerings aimed at transforming provider practices into medical homes. This is especially critical for small, rural, or independent primary care practices that lack infrastructure, information technology, and staff needed to improve patient care.

For example, two of Oklahoma's care management programs targeting Medicaid enrollees with chronic conditions deploy "practice facilitators", registered nurses who help practices assess their capacity, establish new processes, and implement quality improvement plans. One of the programs provides participating PCMHs with practice facilitators that assist with specialist referral processes, expansion of telemedicine, interpretation of claims and other data analysis, and in achieving a higher tier PCMH status. Maryland's MMPP provides one-on-one practice transformation coaching and learning collaborative opportunities to certified practices through the University of Maryland. Arkansas also provides practice transformation support to participating PCMH practices including one on one coaching, PCMH implementation plan development, and peer-to-peer learning opportunities.

At a more programmatic level, Oregon has established a Health Care Transformation Center to accelerate health care providers' transition to a more coordinated care model, and workforce development programs. The Health Care Transformation Center provides support for CCOs to adapt to the opportunities and challenges that they face along with their increased flexibility and accountability for results. The Transformation Center provides support to individual CCOs through "Innovator Agents" embedded in CCO communities who work with CCOs to implement transformation plans and strengthen partnerships with state. In addition, the Transformation Center sponsors several learning collaboratives to promote peer-to-peer sharing of best practices among CCOs, health plans, and payers.

Lessons Learned

To secure providers' willingness to participate in reforms, states have balanced flexibility with accountability.

Securing the participation of provider groups in new accountability standards and payment methods often requires providing these same organizations with flexibility on how to implement changes and to innovate on their own terms. When working to gain stakeholder support for their initiatives, several states described the importance of determining which program requirements and payment methods needed to be standardized and where flexibility could be accommodated without losing accountability for effectiveness.

In Minnesota, participating IHPs are encouraged to develop new care models and strategies, provide comprehensive and coordinated services, engage and partner with patients and families, and institute partnerships with community organizations to encourage the integration of social services. A core shared savings/risk methodology and standard metrics of accountability are also applied across IHP providers. However, participating providers have significant discretion in how they decide to develop, refine, and invest in their own clinical models and infrastructure toward these ends.

Since MACPAC's site visit to Minnesota in 2013, the state has added 10 new provider systems to the IHP demonstration (for a total of 16), each with different geographic footprints, target populations, organizational structures, and size. One provider group (Bluestone Physician Services), for example, focuses specifically on people with disabilities, with services delivered in residential care facilities, community-based clinics and patients' homes. Another (Wilderness Health) is a community-owned, rural health care cooperative providing a full spectrum of primary care services from birth through the end of life. This diversity has meant that the state has had to "meet providers where they are" in terms of ability to take on risk—in other words, reexamine certain providers' eligibility for upside risk only when provider groups are not able or willing to take on downside risk. In these cases, Minnesota has added caps on upside savings. Another example of this flexibility is that one entrant from 2014 (Southern Prairie Community Care) has incorporated additional behavioral health services within its TCOC, providing financial incentives for behavioral health and physical health integration within its ACO model. State officials noted that there will always be a healthy tension between being open to different types of provider groups, offering flexibility in model design, and maintaining basic standards and accountability.

Stakeholders interviewed in Oregon echoed a similar theme in that the flexibility of the CCO model is a key reason why they supported the model. Individual CCOs—community-based organizations governed by local partnerships among health care providers, community members, and stakeholders—require flexibility in order to be responsive to their local communities, but are accountable for both quality and cost; even further down the chain of accountability, individual providers vary in their ability to take on the challenges associated with transforming care delivery. Several interviewees in Oregon noted that experimentation across the CCOs will be helpful in learning what strategies are most effective and highlighted the importance of learning from each other.

Other examples of state flexibility with provider requirements can be found in various states' implementations of PCMH programs. Among our five study states with PCMH programs (Arkansas, Connecticut, Maryland, Oklahoma, and Pennsylvania), provider participation in PCMH programs is voluntary in four (Arkansas, Connecticut, Maryland, and Pennsylvania). Arkansas originally required that in order to be eligible for shared savings via its PCMH program, a practice had to have 5,000 Medicaid patients attributed to its providers for at least six months. Because many practice sites lacked a sufficient number of patients and providers, the state has begun to allow multiple practices with the same tax identification numbers to virtually "pool" patients, achieve

minimum enrollment thresholds, and comply with combined quality metrics. Connecticut's implementation of its statewide PCMH program in January of 2012 included a technical assistance "glide path" to National Committee for Quality Assurance (NCQA) certification for providers which includes enhanced fee-for-service payments and performance incentive/improvement payments for providers based on their level of practice transformation. Maryland's MMPP and Oklahoma's PCMH also created different "tiers" of enhanced payments to reward providers according to their level of PCMH certification or maturity in order to "meet providers where they are".

Finally, during our roundtable discussion on changing provider behavior, several states emphasized that allowing providers "different ways to win" on quality measures—that is, rewarding providers for actual performance vis-à-vis quality benchmarks as well as improvements in performance—was important to engage a wide spectrum of providers (the "natural leaders" as well as those who "need extra support") in the practice transformation process.

Data and data analysis are becoming increasingly important to providers participating in reform efforts, but claims-based data sources are insufficient for real-time care management interventions that seek to coordinate care across settings.

Our discussions with state officials and provider groups reinforced that providers need and desire timely and accurate data to respond effectively to advanced payment models in Medicaid. Several state officials remarked that in their experience, as initial data and reports are disseminated to providers in support of payment reform, providers begin to ask for timelier, more comprehensive, data. "Providers are hungry for more and more data", "[providers] want a 'snapshot' of the total patient's journey", and "[providers] have an interest in what is happening inside and outside of their own systems" were comments heard at MACPAC's roundtable convening of state officials. Others commented on the difficulty provider practices have in understanding how to merge the clinical data internal to a provider practice reflecting actual care with reports based on lagged claims data about what was documented for billing purposes. Similarly, providers across all of the states we visited cited the need for real time clinical data sharing across practice sites to facilitate meaningful coordination. Many of our discussions pointed to provider practices' need for support and training to understand the quantity and content of data, and to leverage the information to drive change within their organizations.

States engaged in driving care delivery changes at the provider level may be called on to improve upon data provided. One of the clearest examples of this point is in Minnesota. Minnesota's Department of Human Services (DHS) provides participating IHP providers with standard data packages that help them better understand resource use and identify areas for targeted interventions. During our first round of state site visits in 2013, we heard that access to this suite of reports was a motivating factor for several provider organizations to participate in Minnesota's IHP demonstration. Yet IHP providers have varying levels of data infrastructure and analytic resources, and thus use this standard report suite differently.

Responding to formal and informal stakeholder input on provider data and analytic needs, Minnesota has made two noteworthy investments to deliver better, timelier data analytic tools to IHP providers as part of Minnesota's State Innovation Model (SIM) grant. The first was contracting with an analytic vendor who can support IHP providers with technical assistance in interpreting information and identifying care opportunities (gaps in care) as well as opportunities for

improvement at the provider and clinic levels; facilitate the integration of the providers clinical data and administrative/claims data provided by the state; and receive and incorporate prioritized transactions such as hospital inpatient census and Admission, Discharge, Transfer (ADT) data from collaborating health plans and hospitals. The second was to provide grants to IHPs who preferred to work with their data analytic contractors to enhance their own data management capabilities such as adopting or upgrading electronic health records (EHRs) and dedicating staff resources to data management and analysis.

The content of reports disseminated to providers in leading states is similar, underscoring overlap across states in the definition of high-priority issues.

Although the reforms in Arkansas, Minnesota, and Oregon differ in their scope and overall approach, there is considerable overlap in the types of metrics included in the data and reports shared with providers. Table 3 summarizes the content of provider reports in the three states with measures that fit broadly into the categories of cost, utilization and quality of care.

Arkansas and Minnesota include several similar cost metrics in their reports. Oregon does not include comparable cost measures at the CCO level, but the health system transformation report that Oregon publishes biannually includes cost information for the state's overall Medicaid program that is similar to the information included in the Arkansas and Minnesota reports. All three states are tracking inpatient, emergency department, and pharmacy utilization, potentially reflecting general consensus about the importance of monitoring services that may be overused when care is uncoordinated.

The three states also align on their reporting of prevention quality measures and behavioral health, indicating agreement about the importance of these services in achieving reform objectives. There is also considerable alignment in the other quality measures reported in Arkansas and Oregon, with both states tracking readmissions and quality related to high cost chronic conditions. Both Minnesota and Arkansas provide information about care coordination; Minnesota flags patients that are "likely" to experience care coordination issues and Arkansas' PCMH clinics receive information about what share of their "high priority patients" (those in the top 10% of spending) have a care plan on record and have been seen by a primary care physician.

Table 3. Content of Provider Reporting Efforts in Arkansas, Oregon, and Minnesota

	Arkansas: Episodes, PCMH	Oregon: CCO Program	Minnesota: IHP Demonstration
Costs			
Average total beneficiary costs	✓		✓
Inpatient costs	✓		✓
Emergency Department	✓		
Mental health/chemical dependency			✓
Pharmacy	✓		✓
Imaging	✓		
Utilization			

	Arkansas: Episodes, PCMH	**Oregon:** CCO Program	**Minnesota:** IHP Demonstration
Probability scores to predict high utilization			✓
Inpatient	✓	✓	✓
Emergency Department	✓	✓	✓
Pharmacy	✓	✓	✓
Imaging	✓		
Quality			
30-day readmissions	✓	✓	
Diabetes	✓	✓	
Cardiovascular	✓	✓	
Respiratory	✓	✓	
Behavioral Health	✓	✓	✓
Prevention	✓	✓	✓
Pediatric well-child	✓	✓	✓
Care coordination	✓		✓

It is likely that data sharing and reporting will shift and expand as reforms in these states continue to evolve. For example, Arkansas is continuously adopting new episodes, and the range of data shared with providers will shift accordingly. Also, all three states are working to better integrate behavioral health, long term services and supports, and social services into their reform efforts, which is also likely to shift and potentially expand the content (and data sources required) to generate meaningful reports.

Positive outcomes are beginning to emerge from leading states, but comparability across state models continues to be a challenge.

When we completed our first round of MACPAC site visits in the fall of 2013, results from Arkansas, Minnesota, Oregon, and Pennsylvania related to care delivery processes, service utilization, cost containment and other goals were largely unavailable or anecdotal. At that point, most of these Medicaid payment reform models were in the very early stages of implementation. Since that time, however, these states have seen several provider performance periods related to their payment models come to a close. States are also beginning to better leverage data analytic activities for a variety of purposes, such as strategic planning, continuous quality improvement, stakeholder and community engagement, and provider care decision-making.

Oregon:
By far the most comprehensive reporting comes out of the Oregon Health Authority's (OHA's) Office of Health Analytics, where quarterly and annual progress reports on individual and aggregate CCO performance. OHA uses their state all-payer all-claims (APAC) database for the state's publically-available reporting. These reports track the effect of health system reform within the state, and include detailed information on health care costs, utilization, insurance coverage, access to care, and quality metrics. The reports present information aggregated to the state level, as well as detail by

CCO (displayed by name in the reports), patient race/ethnicity, and other groups of interest (e.g., Medicaid expansion population).

In June 2015, Oregon published a report on the second full year of CCO operations.[8] Highlights of this second annual report (which covers calendar year 2014) include the following:

- 13 of Oregon's 16 CCOs qualified for full payments from the Quality Incentive Pool by meeting improvement targets on at least 12 of 17 incentive measures and having at least 60% of their enrollees in a patient-centered primary care home (PCPCH).
- Emergency department visits declined by 22% compared to the 2011 baseline, and hospital admissions for short-term complications from diabetes and chronic obstructive pulmonary disease fell substantially (27% and 60% respectively).
- Enrollment in patient-centered primary care homes has increased (56% increase since 2011).
- Areas where additional progress needs to be made include cervical cancer and chlamydia screenings for women.
- The state reports that it is on track to stay within the global budget commitment to the Centers for Medicare & Medicaid Services (CMS) to reduce the growth in spending by two percentage points per member, per year.

Arkansas:

Since we conducted our site visits in 2013. In Arkansas' most recent Statewide Tracking Report,[9] released in January of 2015, the Arkansas Center for Health Improvement (ACHI) highlights the following outcomes from the state's first five episodes of care:[10]

- A 17% drop in unnecessary antibiotic prescriptions for non-specific upper respiratory infections
- Across the board improvements in perinatal screening rates
- A reduction in hip/knee replacements costs of 1.4% for Arkansas Blue Cross Blue Shield (BCBS)
- 73% of Medicaid and 60% of AR BCBS PAPs reduced costs or remained in a commendable or acceptable cost range
- A reduction in the state's Medicaid growth rate to 2-3% per year (highlighted as a result of Arkansas' total health system transformation effort, the two main components of which are the episodes of care model and PCMH implementation)

Minnesota:

In June of 2015, a Minnesota Department of Human Services (DHS) press release announced that the IHP program—through contracts with nine providers—had delivered $61.5 million in Medicaid savings (state share only) during its second year (calendar year 2014), up from $14.8 million in savings estimated during its first year (calendar year 2013). Although details on IHP quality measures have not been made public, the press release points to double-digit decreases in hospitalizations and

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[8] Oregon Health Authority. Oregon's Health System Transformation: 2014 Final Report. June 24, 2015. Available at: http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf.

[9] Arkansas Center for Health Improvement (ACHI). Health Care Payment Improvement Initiative: Statewide Tracking Report. January 2015. Available at: http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=276.

[10] Upper respiratory infections (URIs), total hip and knee replacements, congestive heart failure (CHF), attention deficit hyperactivity disorder (ADHD), and perinatal (pregnancy)

single-digit decreases in emergency room visits in 2014. All nine provider groups participating in the IHP initiative in 2014 were eligible for shared savings payments based on preliminary 2014 results.

Maryland
Maryland used an evaluation contractor, IMPAQ, to evaluate the impacts of the MMPP on patient outcomes and costs.[11] The evaluation used a matched comparison group of practices and a difference-in-differences analysis, which accounted for outcome changes that would have occurred over time regardless of the MMPP intervention.   The vast majority of the 48 measures that were evaluated did not show significant differences between MMPP patients and the comparison group. Measures that did not show significant change included a range of quality outcomes, ED visits and costs, inpatient admissions and costs, and readmissions. IMPAQ cautioned that the lack of significant results on the other measures could be due to timing (e.g., because the results were based on the experiences in the first year of the program). Significant results included:
- Larger decrease in the share of young adults hospitalized for asthma
- Fewer specialist visits
- Relative decrease in outpatient payments
- Increase in the share of patients going to see their attributed PCP at least once in the year
- Relative increase in well-care visits among adolescents

Oklahoma
An independent evaluation conducted in 2014 by the Pacific Health Policy Group (PHPG) and commissioned by the Oklahoma Health Care Authority (OHCA) included an analysis of the PCMH, HMP, and HAN programs.[12] The final report from this evaluation indicates positive performance for Oklahoma's PCMH program. Between 2009 and 2013, improvement was documented in terms of average annual member visit rates, emergency room use rates, and average PMPM expenditures. These results, however, were for the tiers combined. The evaluation did not find any relationship between tier setting and outcomes, raising questions about the structure of the program and prompting discussions about possible program revisions for the future.

The evaluation also examined the HMP program through June 2013, comparing actual service utilization and expenditures to projected outcomes and capturing provider and member perspectives on the program. Relative to forecasted numbers, reductions in inpatient costs and expenditures for chronically ill patients were observed. High provider and member satisfaction was also reported. PHPG evaluated total expenditures under the program and reported a savings of over $181 million dollars (net of vendor payments, OHCA staffing, and overhead) through June 2013, with a return on investment of over $5 for every $1 in administrative expenditures.

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[11] IMPAQ International, Inc. Evaluation of the Maryland Multi-Payer Patient Centered Medical Home: First Annual Report. December 16, 2013. Available at:
http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/PCMH_Eval_%20MD_PCMH_Prog_First_Annual_Rpt_20131216.pdf.
[12] PHPG. SoonerCare Choice Program Independent Evaluation. September 2014. Available at:
file:///C:/Users/dybda003/Downloads/SCC_Eval_Report-Sep2014-Final%20(2).pdf.

PHPG considered the evaluation of the HANs to be preliminary due to a large growth in HAN membership over the time period. The evaluation compared SoonerCare Choice HAN and non-HAN members who visited their PCMH at similar rates during 2013 to assess utilization under the HAN program. The evaluators found that utilization was very similar between the two groups, with the exception of emergency room utilization, which was found to be lower (10%) among HAN members compared to non-HAN members. The evaluation also found that HAN and non-HAN members have nearly identical PMPM claim costs ($296 vs. $290). The evaluation concluded that the HANs are serving a higher-risk SoonerCare Choice patient population at roughly the same cost level with the exception of an additional care management PMPM fee.

Despite these outcomes, little is known yet about how these state Medicaid reforms impact care delivery decisions and behavior at the provider level.

While these emerging results from Oregon, Arkansas, Minnesota, Maryland, and Oklahoma are promising, much of this data analytics work goes on "behind the scenes" and comparing outcomes across state models is a challenge. Little is known about the specific data, methods, and measures states are using to monitor and evaluate their Medicaid payment models. With all the emerging reforms, no one analytic framework exists for:
- Choosing data sources for tracking performance
- Comparing outcomes for patients enrolled or attributed to the reform initiative to those not enrolled or attributed
- Overcoming methodological issues such as multiple Medicaid program changes and reforms occurring simultaneously
- Selecting key metrics of performance from patient satisfaction, access, utilization, or cost perspectives

Beyond anecdotal evidence, little is known about how state Medicaid payment changes are influencing provider behavior on a day-to-day basis, and if so, for whom. It is unclear whether Medicaid financial incentives are powerful enough to influence provider practices, and how they translate into the work of individual physicians. At the state level, it is difficult to know which providers are receiving better information, whether and how the information is being used, and what changes in care delivery at the patient-clinic level are taking place as a result of this information sharing, such as changes in: practice organizational models (e.g., new affiliations, mergers); practice patterns such as new approaches to care management or new roles for other health professionals; relationships between primary care, hospitals, specialists or the emergence of multispecialty teams working to prevent disease progression; and referral patterns.

Questions exist as to whether Medicaid alone can influence provider behavior, but from a Medicaid perspective, there are advantages *and* disadvantages to multi-payer reforms.

Some state officials remarked that aligning key components of payment reform models—such as performance measures, quality improvement goals, and even payment methodologies—across public and private payers may be key to helping physicians respond to changes constructively. As demonstrated in Arkansas and to a certain extent in Maryland, a multi-payer approach leads to a higher level of provider engagement. Providers favor some level of standardization to limit the burden associated with complying with multiple programs and reporting requirements.

Yet attempting to align and standardize program elements across payers also raises new issues for states, private payers, and providers. In our discussions in Maryland, for example, payers expressed concern that increased standardization and regulation would stifle innovation and their ability to be flexible to changing conditions. We also heard concerns from state Medicaid staff and representatives from Maryland's Medicaid MCOs that the program's focus on the commercial market made Medicaid's involvement more challenging because the patient populations are quite different—Medicaid enrollees tend to seek care differently than those with commercial insurance and often have different and more complex health needs. State officials emphasized that churn is also more of an issue for Medicaid, and this can make it difficult to capture savings.

Our discussions shed some light on the advantages and disadvantages of multi-payer reforms from a Medicaid perspective. On the one hand, the multi-payer approach leads to a higher level of provider engagement because a broader patient base is involved. On the other hand, programs that focus their payment reforms and quality incentives on the needs of a typical commercial population may not translate well to lowering costs and improving quality for Medicaid patients. Arkansas has attempted to thread this needle by requiring that core components of the episode-based model— e.g., how episodes are defined, how Principal Accountable Providers (PAPs) are designated, which quality metrics are associated with each episode, and the overall methodology by which provider shared savings or payments are calculated—are standard across payers. Other decisions about which episodes to pursue for episode-based payments, underlying provider fee schedules, and other items are left up to individual payers.

Discussions of the benefits of "care integration" for Medicaid enrollees are pervasive, but integration can mean a variety of things at a variety of different levels depending on the Medicaid reform context.

It is clear from our discussions with state officials, payers, providers, and other stakeholders that the "next frontier" in many state health reform efforts is to find ways to better integrate health care, mental health, long term services and supports, public health, and social services for populations with complex, interrelated needs that are generally the highest cost populations in Medicaid. Additional work to integrate the highest cost populations in Medicaid and the non-medical provider groups that serve these populations will take time and innovation on the part of states. All of the states that were part of this project are actively exploring how new funding opportunities, particularly those made available to states through the ACA (e.g., reimbursement for health home services, State Innovation Model grants), can be used to support this concept of "care integration" across health and social services, broadly defined.

Throughout available literature, there is no consistent definition for care integration. Several state officials participating in our roundtable echoed this statement and discussed their perception that there was a lack of valid metrics measuring care integration. In their opinion, this gap in data measures precludes Medicaid programs and providers from monitoring and incenting improvements in care integration. One roundtable participant acknowledged that there are few nationally endorsed measures for integration (i.e., care transitions), and others commented on the difficulties with respect to measurement for complex populations. Claims data are often relied on for quality measurement, which limits the types of integration measures that may be feasible. Likewise, patient satisfaction data also have limitations on adequately capturing integration outcomes. The lack of robust quality measures for specific high-cost populations (e.g., individuals with disabilities) and their

unique needs was mentioned by one state (Minnesota) as an obstacle to tailoring program requirements for non-standard provider groups.

With respect to care integration, there is a large and growing body of literature on the integration of behavioral health into the primary care setting. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions has described integration as the systematic coordination of general and behavioral healthcare.[13] However, more specific definitions have outlined different types and models of integration. For example, AHRQ defines integration as the care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.[14] This range in definitions for behavioral and physical health integration has resulted in the term integration to be used to describe everything from patient referrals to colocation to mission change within a provider practice or network, while also simultaneously blurring provider responsibilities, the use of technology, and contracting/financing strategies.

In a similar way, approaches to "care integration" discussed with officials from our study states ranged from system-level financing changes (such as braided funding for primary care, behavioral health, and dental health for CCOs in Oregon) to changes at the clinical level, like including embedding health care coaches in provider offices for comprehensive assessments, intensive care management, and referrals to community resources (e.g., Oklahoma, Maryland, Connecticut). The states we visited also frequently talked about informal linkages to community resources and social services and supports like maintaining a database of community resources in order to connect patients to needed services (e.g., Oklahoma, Connecticut, Minnesota, and Oregon).

Arguably the most robust discussions we had about care integration strategies occurred in Oregon. Oregon's CCO model incorporates: identification of primary care providers for patients; patient-centered primary care homes (PCPCHs) providing team-based care, integration of behavioral, physical, and dental health through, for example, shared treatment plans or co-location of services; and the use of electronic health records and information exchange across care settings. Requirements for physical health and other providers to use a unified electronic health record to share care plans, data and reports on shared patients; facilitated communication between providers and ensure beneficiaries are receiving comprehensive treatment; and co-location of services to encourage face-to-face collaboration among.

In addition to CCO attention to behavioral health in Oregon, the state has also had a focus on social determinants to health. The state gained federal approval to claim Medicaid matching funds for certain health-related services that have not traditionally been reimbursable services. The goal of these "flexible services payments" is to invest in things that improve health and reduce costs overall; for example, providing an air conditioner to a congestive heart failure patient may reduce emergency

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[13] SAMHSA-HRSA Center for Integrated Health Solutions (April 2013). A Standard Framework for Levels of Integrated Healthcare. Available at: http://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

[14] AHRQ (April 2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

room visits and inpatient admissions, potentially saving significant amounts of money for the Medicaid program. These flexible services payments can either be individual-based or population-based, but must be health-related. One issue that has slowed implementation of this component of Oregon's reform model is figuring out how to adequately account for these payments (e.g., whether they are medical costs or administrative costs, and at what level of detail to categorize and track the payments). Also in Oregon, some CCOs are focusing on adverse childhood experiences and the impact of early trauma through adulthood and how to form partnerships with other agencies and services (e.g., housing, job supports) in the community. This work goes "far beyond the concept of care manager," in that it requires a targeted approach with specific individuals.

In Minnesota, the IHPs are implementing new care models and strategies, providing comprehensive and coordinated services, engaging and partnering with patients and families, and instituting partnerships with community organizations for social service integration. Participating providers have discretion in how they decide to develop, refine, and invest in their own clinical models and infrastructure toward these ends. One example of an IHP formally incorporating additional services into their approach is Southern Prairie Community Care, which has included behavioral health services within its total cost of care calculation, thereby providing financial incentives for behavioral health and physical health integration within its ACO model. Other but less formal partnerships with social and community resources have evolved over time, particularly for some of the IHPs that have been in existence longer. For example, the Hennepin County Medical Center Hospitals and Clinics have connected with Second Harvest for attributed patients with food security concerns. North Memorial Health Care is working with Vail Place, an organization that focuses on community-based mental health recovery and healthy independent living, to help patients with social needs once discharged from the hospital.

Sustaining momentum will require documenting and communicating the value of payment reforms, particularly within the provider community.

In designing and implementing Medicaid payment reforms, many of the states we visited over the last two years have hired additional staff resources, procured consultants and actuaries, and invested in technology and data analytics. Pursuing payment reform at the state level has also come with opportunity costs as limited staff resources are pulled from other health care initiatives. It is worth noting that among the seven states we visited, three (Arkansas, Minnesota, and Oregon) received significant federal SIM test grants, three (Maryland, Oklahoma, and Pennsylvania) received federal SIM design grants in order to fund additional staff, consultants, and infrastructure needed to design and/or test enhancements and expansions to the Medicaid payment reforms studied as part of this project, and one (Connecticut) received both types of grants. Still, these grants are one time, not ongoing, which raises questions about how states can sustain their momentum.

During our roundtable event, several state Medicaid officials commented that shifting political environments, leadership changes, staff turnover, and a general sense of "reform fatigue" can impact project priorities, timelines, and sustainability. States provided examples of ways to ensure that reforms endure changes in administrations, governance, and project leadership.

Several states mentioned the importance of having a clear, concise way of documenting and communicating the value of reform and the organization history and story behind the successes achieved thus far. These "stories" were not only important in positioning Medicaid reform initiatives to new political leadership, but were equally important in continuing to communicate key facets of

the reforms to participating providers and external stakeholders. States have developed common messages around health system transformation—common presentations, talking points, and data visualizations that resonate with various audiences. And they have deliberately provided the same messages to the same audiences multiple times. As one state official remarked, "it was not an exaggeration to say we ran [our communications] like a campaign." Communications was seen as a critical component of continuing to build consensus among stakeholders, particularly within the provider community, so that partners would take "ownership" of reforms.