CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

INNOVATIONS AND INSIGHTS IN MEDICAID MANAGED CARE

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PATHS
Providing Access to Healthy Solutions

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About The Authors

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective health care and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

For the past several years, CHLPI has been deeply engaged in research and analysis on type 2 diabetes policy. This initiative is known as the PATHS Project (Providing Access to Healthy Solutions). The PATHS Project is generously supported by the Bristol-Myers Squibb Foundation's *Together on Diabetes™* (*TOD*) Initiative. As part of the *TOD* Initiative, this white paper seeks to encourage states to consider how they can use innovative models and best practices in order to improve their Medicaid systems, thereby improving care for low-income individuals coping with complex chronic diseases such as diabetes.

Innovations and Insights in Medicaid Managed Care is written by Jason Nichol, Kate Stillman, Tess Peacock, Katie Garfield, Amy Rosenberg, and Robert Greenwald.

INTRODUCTION

BACKGROUND

In its early years, Medicaid—our nation's primary health care safety-net—relied primarily on fee-for-service (FFS) systems in order to provide care to certain vulnerable populations. While the FFS model had the benefit of allowing beneficiaries significant freedom to access Medicaid services, it lacked incentives to provide efficient, coordinated care. To address these deficiencies, many states have gradually moved away from traditional FFS systems, relying instead on managed care models. Thus by 2011, more than 70% of Medicaid enrollees received at least some portion of their benefits through a managed care model,[1] and almost all states now utilize some form of managed care in their Medicaid programs.[2]

Currently, Managed Care Organizations (MCOs) are the most popular form of managed care in state Medicaid programs.[3] When contracting with MCOs, states agree to pay a fixed monthly rate for the MCO to provide certain services to Medicaid beneficiaries. Under this system, states should be better able to predict and control costs as it is the MCOs, rather than the states, which bear the risk that costs will exceed expectations. Additionally, MCOs are able to implement strategies such as emphasis of primary care and referral requirements in order to manage patient care.

In theory, MCOs thus have the potential to cut costs while providing beneficiaries with more coordinated and efficient care. However, in practice, some states have encountered difficulties when working with MCOs, including lack of transparency, excessive restrictions on access to care, and escalating fees. Ultimately, many of these issues may be symptomatic of a single systemic issue—lack of effective oversight. Oversight can be defined as watchful, responsible care and regulatory supervision.[4] While there is no one-size-fits-all formula, there are a number of key components that states can consider when trying to establish effective oversight in their Medicaid systems. These components are described below.

KEY COMPONENTS OF EFFECTIVE OVERSIGHT

- ***INCENTIVIZING QUALITY:*** Establishing mechanisms that shape managed care activities by providing incentives to improve care and the flexibility to do so in innovative ways.
- ***DATA*:** Ensuring state and public access to timely, accurate, and actionable data regarding utilization and quality.
- ***TRANSPARENCY*:** Establishing mechanisms that require managed care entities to share information regarding performance and internal processes, policies, and decisions that may affect quality and access to care.
- ***MONITORING ENTITIES*:** Establishing entities, composed of a variety of stakeholders, that are specifically tasked with monitoring managed care performance and policies.
- ***PROCUREMENT*:** Establishing a procurement process that promotes high-quality care through competition and explicit consideration of quality criteria.
- ***COMMUNICATION*:** Establishing mechanisms that encourage candid communication between the state, managed care entities, and other stakeholders, thereby encouraging trust and vested interest in the success of the system.

In acknowledgement of the need for improved oversight, the federal government recently took the historic step of proposing the first major overhaul of federal Medicaid managed care regulations since 2002.[5] These new rules touch upon a number of the key components of oversight. For example, the rules seek to increase oversight by improving data and transparency regarding topics such as network adequacy,[6] state and federal quality review,[7] and enrollment.[8]

Similar efforts are also occurring at a more local level. In recent years, a number of states have implemented significant reforms to their individual Medicaid systems by adopting new and innovative models of managed care. In implementing these changes, states have often taken steps to support the key components of effective oversight listed above. In doing so, states have seen success in overcoming some of the issues that had historically impacted communication, costs, and quality in their Medicaid systems.

PURPOSE

This white paper examines three states that have recently adopted innovative systems that either replace or refine prior MCO models of care: Connecticut, Minnesota, and Oregon. By analyzing these innovative systems, and some of the strategies that they have used to address the key components of effective oversight, we attempt to both offer alternatives to traditional managed care models, and highlight key "best practices" that can contribute to the success of any Medicaid system. It is our hope that by adopting similar "best practices" states can improve the quality of care provided to their Medicaid beneficiaries, and thereby improve the lives of low-income individuals coping with chronic conditions such as diabetes.

METHODOLOGY

The information in this report was gathered in two stages. First, initial background information regarding each Medicaid system was gathered through a review of key documents (e.g., relevant waivers, request for proposals, contracts, reports, and state websites). Then, as a second step, the authors conducted interviews with stakeholders from each state in order to gain further insight into the history and implementation of each model. In order to ensure a range of perspectives, the authors conducted interviews with at least one individual in each of the following categories of experience: (1) government; (2) managed care entity; and (3) advocacy organizations (e.g., legal services or health policy organizations) in each state. As a result, the authors conducted between 3-5 full interviews in each state, and, in some cases, conducted informal conversations with additional stakeholders.

In order to ensure the integrity of the interview process, interviewee identities and titles have been excluded from this report. Information regarding interviewee comments can be made available upon request in some instances. All inquiries regarding particular comments can be directed to Katie Garfield at kgarfield@law.harvard.edu.

CONNECTICUT: ADMINISTRATIVE SERVICE ORGANIZATIONS

ADMINISTRATIVE SERVICE ORGANIZATIONS (ASOS): Administrative service organizations are entities that provide only administrative services and do not provide or deliver physical or mental health services. In the health care context, these services include management of claims and benefits, data collection and analytics, care coordination, provider delivery reform support, and customer service.[9] Most importantly, they are not financially at risk for the health services requested or needed by enrollees; while they may conduct prior authorization reviews, they are not financially responsible for the services authorized. Thus, although ASOs perform some of the same functions as MCOs, an ASO model differs from an MCO model in that the state retains more direct control over the payment for and provision of care. By using ASOs to manage the provision of its Medicaid services, Connecticut has worked to improve quality, access, and coordination of care while controlling program costs.

Connecticut's Medicaid program is particularly effective at implementing the following three Key Components of Oversight: **(1)** ***DATA*****, (2)** ***MONITORING ENTITIES,*** and **(3)** ***TRANSPARENCY.***

HISTORY

Connecticut first introduced MCOs into its Medicaid program—now known as HUSKY—in 1995.[10] For over a decade, MCOs administered much of the HUSKY program[11] (though the state carved out behavioral health services from MCO contracts in 2006[12]). During this period, a series of issues arose regarding the MCOs. By 2000, several MCOs had dropped out of the HUSKY program, and those that remained requested higher fees.[13] Additionally, in late 2006, a "mystery shopper" survey conducted by Mercer Government Human Services Consulting showed that only about a quarter of callers could actually make an appointment with various categories of providers listed as participating in the MCO plans.[14]

Within this same period, Connecticut's Medicaid managed care entities were involved in a number of legal disputes related to utilization management decisions, due process, and overall plan transparency.[15] In the last of these legal disputes, health care advocates filed state Freedom of Information Act (FOIA)[16] requests asking that HUSKY MCOs disclose their provider reimbursement rates and data about the frequency of denials of drug access.[17] All but one of the MCOs refused,[18] and even after court rulings against them,[19] two MCOs continued to balk at accepting the obligation to be bound under FOIA disclosure requirements, leading, in large part, to the revocation of the HUSKY MCO contracts.[20]

Following the revocation, Connecticut put out a Request for Proposals (RFP) for a new set of capitated MCOs to participate in the HUSKY program, provided they accepted the FOIA obligation as a matter of contract and also participated in then-Governor Jodi Rell's limited initiative for the uninsured, known as the Charter Oak Health Plan.[21] Three plans submitted bids under the RFP, all of which were accepted.[22] But problems persisted, including

concerns regarding high capitation rates[23] and, among some of the MCOs, low medical loss ratios.[24]

In 2012, Connecticut reformed its Medicaid program by abandoning the MCO model entirely and adopting a new non-risk ASO-managed FFS Medicaid model.[25] Under the new model, the state contracted with ASOs and, working with the ASOs, contracted directly with providers.[26] Connecticut implemented the ASO model by enacting a statute (effective July 2010) that authorized the Connecticut Commissioner of Social Services to contract with ASOs.[27]

ORGANIZATIONAL STRUCTURE

The HUSKY program consists of four sub-programs (HUSKY A, HUSKY B, HUSKY C, and HUSKY D), each of which—except HUSKY B (which is Connecticut's Children's Health Insurance Program (CHIP))—covers a different subset of the Medicaid-eligible population.[28] The Connecticut Department of Social Services (DSS) is the state agency primarily responsible for administering the HUSKY program.[29] It develops the policies, procedures, and payment methodologies necessary to support the program.[30]

DSS contracts with ASOs to manage health services for HUSKY participants. In order to select each of the Medicaid ASOs, DSS issued RFPs to solicit bids, and after a competitive bidding process, awarded contracts to four non-risk entities.[31] Each of these entities is responsible for administering a specific category of Medicaid services statewide.[32] Overall medical care is administered by Community Health Network of Connecticut, Inc. (CHNCT);[33] behavioral health is administered by ValueOptions®; dental health is administered by BeneCare® Dental Plans; and non-emergency medical transportation is administered by Logisticare.[34]

ASO Responsibilities

These four ASOs are responsible for beneficiary support, referrals to providers, utilization management (e.g., providing prior authorization for services when necessary), and processing grievances and appeals.[35] The ASOs also engage in a significant amount of outreach to providers. For example, CHNCT provides hands-on technical support to providers who wish to participate in Connecticut's Person-Centered Medical Home (PCMH) initiative,[36] which now serves over one third of Connecticut Medicaid enrollees.[37] Within the ASO system, there is also an Intensive Care Management (ICM) program for high-need individuals, which works to identify and manage a broad range of patient needs including food and housing insecurity as well as medical and behavioral care.[38] The ICM program involves the three ASOs associated with medical, behavioral, and dental care, but is primarily the responsibility of CHNCT.[39]

Since 2012, CHNCT—the not-for-profit ASO responsible for overall medical care—has also been responsible for keeping claims data across all categories of Medicaid services.[40] This data is kept in a Utilization and Cost Analyzer (UCA) system and used to conduct data analysis (predictive modeling) in order to identify areas in which the state could reduce costs and increase care quality.[41] Using this data and a web-based data analysis tool

(CareAnalyzer®), CHNCT is able to monitor performance at the population, setting (e.g., PCMH), provider, and individual level.[42] CHNCT is contractually obligated to create ad hoc reports at the state's request in order to provide actionable summaries of the collected data.[43]

BEST OVERSIGHT PRACTICES: DATA. *Stakeholders in Connecticut have emphasized that having timely, accurate, and comprehensive Medicaid data in one central location has been a key benefit of the ASO system.[44] Since all payment and utilization data is reported to the ASO, as opposed to being collected and filtered by various MCOs, the ASO is able to assemble a complete picture of Medicaid care in Connecticut. This allows the state to receive faster, more accurate feedback and to find points where care can be improved.[45] For example, this data is used by the state's Health Quality Group which meets monthly with the ASO clinical staff to review the analytics reports and determine the way forward based on that data.[46]*

The ASOs are also subject to significant quality reporting requirements.[47] For example, CHNCT's contract with DSS provides that the ASO will work with DSS to develop quality measures, monitor provider performance, and conduct various satisfaction surveys in order to assess the Medicaid program.[48] The provisions regarding quality measures are open-ended so that the state and the ASO can work together to determine how quality should be assessed.[49]

ASO Oversight

A broad array of stakeholders is involved in the oversight of the Connecticut ASOs. Along with DSS, the Council on Medical Assistance Program Oversight (MAPOC)—a panel made up of government officials, Medicaid consumers, advocates, and other stakeholders—monitors ASO performance.[50] MAPOC is responsible for monitoring Medicaid care management initiatives related to eligibility standards, benefits, access, quality assurance, and outcome measures, as well as requests by DSS for use of ASOs in implementing any such initiatives.[51] DSS is required to submit reports to MAPOC regarding a range of issues, including any policy changes or proposed regulations affecting Medicaid health services (monthly report) and the financial costs associated with each of the covered Medicaid populations (quarterly report).[52] MAPOC then makes recommendations to DSS regarding the administration of the HUSKY program and submits biannual status reports to the Connecticut General Assembly.[53]

BEST OVERSIGHT PRACTICES: MONITORING ENTITIES AND TRANSPARENCY. *MAPOC plays a significant role in managing the Connecticut ASOs. The Council holds monthly meetings[54] which involve serious questioning of the ASO by well-researched stakeholders.[55] DSS sets the agenda for these meetings and can present initiatives to MAPOC and to the ASOs.[56] In addition, the proceedings are televised and take place in the legislative building, adding an element of public involvement and transparency to the proceeding.[57] Stakeholders in Connecticut have noted that in order to ensure MAPOC's effectiveness, it has been important to require that*

knowledgeable representatives of the ASO attend all primary MAPOC meetings as well as any sub-committee meetings so that problems can be discussed and worked out quickly and efficiently.[58] Additionally, stakeholders have noted that it is important to clearly define state and ASO responsibilities in order to ensure accountability for any issues that arise.[59]

Enforcement Mechanisms

To ensure compliance with program requirements, ASO contracts also contain strict sanctions, including the possibility of monetary penalties.[60] Additionally, DSS has the ability to take certain tasks away from the ASO and contract them out to another entity (e.g., during the contract renewal or RFP process or in the event that the ASO fails to meet its contractual obligations).[61] Stakeholders have indicated that this ability to carve out tasks, as well as the knowledge that the state could decide to contract with another entity entirely, serve as effective incentives for ASO compliance.[62]

SOURCES OF FUNDING

General Funding

Connecticut receives a fifty percent federal match for most Medicaid expenses.[63] In addition to traditional funding, Connecticut and its health care providers have also taken advantage of a number of federal grant opportunities to fund various aspects of its Medicaid program. These opportunities include: grants from the State Innovation Models,[64] Incentives for the Prevention of Chronic Disease in Medicaid,[65] and Health Care Innovation[66] initiatives run by the Center for Medicare and Medicaid Innovation (CMMI) and a grant from the Balancing Incentive Program.[67]

Funding for ASOs and Providers

HUSKY is structured as a managed FFS program.[68] Under this system, the state pays providers for services directly on a FFS basis, based upon a single set of coverage guidelines and a uniform payment schedule.[69] However, the state only pays the ASO a fixed administrative fee.[70] Thus, the ASO, unlike an MCO, has no financial stake in either providing or limiting access to services. However, the fixed administrative payment causes the ASO to bear some financial risk for administrative costs that exceed its fee. This risk helps to ensure that the ASO is held accountable for maintaining efficient performance.

INCENTIVES

In order to encourage ASOs to increase the quality and efficiency of Medicaid care, DSS also withholds a portion of the ASO's administrative fee.[71] The withheld portion is seven and a half percent of the quarterly administrative payment.[72] To earn the withheld portion back, the ASO must demonstrate that it has achieved certain performance targets relating to health outcomes, health care quality, and both member and provider satisfaction.[73] The ASO can lose the withheld portion by not meeting the performance targets or by failing to comply with the data reporting requirements.[74]

INTEGRATION OF SERVICES

By having only one statewide administrative entity for each large category of health

services, HUSKY has streamlined its data collection and analysis processes, creating the opportunity for DSS to better understand and provide feedback to providers on the needs of Medicaid patients.[75] Additionally, under the Intensive Care Management program, ASOs are responsible for targeting high need individuals for additional care coordination across the spectrum of their medical and social needs.[76]

Connecticut also promotes integration of services by aggressively promoting the establishment of accredited Person-Centered Medical Homes (PCMHs).[77] HUSKY defines PCMHs as a health care model in which "[c]are is organized around a person and led by a primary care provider who facilitates and coordinates a person's healthcare needs with other healthcare professionals."[78] Connecticut promotes the creation of PCMHs through its "glide path." As part of this "glide path" program, Connecticut provides technical assistance—via CHNCT, the medical ASO—and partial increased funding for practices that are working to become recognized as PCMHs by the National Committee for Quality Assurance (NCQA).[79] Practices which have gained such accreditation are eligible for extra payments based on high performance relative to peers on consensus quality measures and improvements under those measures.[80] As of October 8, 2015, there were 101 practices (366 sites and 1,332 providers) enrolled in the PCMH initiative, serving over 274,000 Medicaid beneficiaries.[81]

STATUS

As of December 2015, Connecticut had a total of 746,047 people participating in HUSKY,[82] almost all of whom were in one of the Medicaid programs (~15,000 HUSKY B children being the exception).[83] The budget for these Medicaid programs makes up 13% of the overall state budget.[84] Despite increasing enrollment, Connecticut's Medicaid expenditures have remained fairly constant under the ASO model, and per member per month costs are currently trending downward, with a reduction from $682 in June of 2014 to $654 in June of 2015.[85] As of 2014, administrative costs, including eligibility determination-related costs, made up 5.2% of program costs.[86]

Provider participation in Connecticut's Medicaid program has reportedly improved under the ASO system. In July 2014, there were a total of 3,458 primary care providers enrolled compared to 2,370 in January 2013 and 1,622 in January 2012.[87] And, over state fiscal year 2015, the number of participating primary care providers increased by 7.49%, while specialists increased by 19.34%.[88] A recent "mystery shopper" survey also found that a majority of Medicaid beneficiaries were able to receive a timely appointment (63.8%) and were not told that their insurance coverage affected the availability of an appointment (68.2%).[89]

Connecticut is also currently seeing marked improvement on a number of key indicators under the ASO model. For example, in state fiscal year 2015, emergency department (ED) visit rates dropped by the following percentages: 4.70% for HUSKY A and B; 2.16% for HUSKY C; and 23.51% for HUSKY D.[90] Improvements were particularly dramatic among beneficiaries receiving Intensive Care Management from CHNCT—Connecticut's medical ASO. In this population, ED usage and inpatient admissions dropped by 22.72% and

43.87% respectively.[91] The state has also reported recent improvements on a range of quality measures such as lead screening rates, immunization rates, well child visit rates, and timeliness and frequency of prenatal and postpartum care visits.[92]

MINNESOTA: INTEGRATED HEALTH PARTNERSHIPS

INTEGRATED HEALTH PARTNERSHIP MODEL (IHP): Minnesota's Integrated Health Partnership is an Accountable Care Organization (ACO) model designed to improve care and lower costs for its Medical Assistance (Medicaid) and MinnesotaCare[93] populations (referred to together here as Minnesota Health Care Programs or MHCP)[94] through innovative contracting and cost-sharing between the state, MCOs, and qualifying IHPs. The IHP model builds upon—but does not replace—the existing MCO and FFS models in the Minnesota Medicaid system.

Minnesota's Medicaid program is particularly effective at implementing the following three Key Components of Oversight: **(1)** ***COMMUNICATION***, **(2)** ***DATA***, and **(3)** ***PROCUREMENT.***

HISTORY

Minnesota first introduced managed care into its Medicaid system in 1985 through a demonstration program limited to the Minneapolis area.[95] Since that time, Minnesota has expanded its use of managed care to all 87 counties of the state, and has made managed care mandatory for much of the Medicaid population.[96] In recent years, Minnesota has implemented a number of reforms aimed at improving quality and cutting costs in its Medicaid program. Several of these reforms directly impact the state's MCO system.

For example, in 2012, Minnesota initiated a two-year pilot program to reform its Medicaid MCO procurement process by implementing competitive bidding.[97] The program, which was originally launched in only seven counties, became statewide in 2015.[98] Under this new system MCOs now submit a two-part bid consisting of a "technical proposal" and a "cost-bid."[99] According to reports from state government, contracting reforms have resulted in roughly $450 million in savings.[100]

BEST OVERSIGHT PRACTICES: PROCUREMENT. *In Minnesota's new competitive bidding process, MCOs must submit both a "technical proposal" and a "cost-bid."[101] The technical proposal, a relatively detailed document that discloses an MCO's past performance and ability to provide covered services through provider networks, accounts for 50 percent of an MCO's final score.[102] In the technical proposal, an MCO must provide Healthcare Effectiveness Data and Information Set (HEDIS) measures applicable to MHCP, as well as its National Committee for Quality Assurance (NCQA) national Medicaid percentile rankings for those measures.[103] The cost-bid component, accounting for the other 50 percent of an MCO's score, depicts an MCO's key financial ratios, historical administrative costs, and projected costs to provide Medicaid services.[104] DHS scores each bid on a "best-value" basis, then uses a "Best and Final Offer" (BAFO) to solicit bids from the three highest scoring MCOs in each county.[105] Minnesota's first statewide competitive bid in 2015 resulted in considerable changes for some MCOs, including a significant reduction in Medicaid business for UCare and corresponding increases for both Medica and Blue Plus.[106]*

Integrated Health Partnerships: Building upon Managed Care

In addition to its direct reforms of the Medicaid MCO program, Minnesota has taken steps to build upon both its Medicaid fee-for-service and MCO systems by introducing a unique version of the accountable care model, which it calls Integrated Health Partnerships (IHPs).

BACKGROUND: Defining ACOs. *"ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their [Medicaid] patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the [Medicaid] program."(CMS.gov)*

In 2010, the Minnesota Legislature adopted a statute requiring the Minnesota Department of Human Services to develop a demonstration project to "test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."[107] This demonstration, formerly known as the Health Care Delivery Systems (HCDS), became the IHP model, designed to improve the quality of health care and lower costs of publicly funded health care programs (both Medicaid and MinnesotaCare) in the state.[108]

In 2011, DHS developed a Request for Proposals (RFP)[109] that serves as a mechanism for health care service provider organizations to "voluntarily contract with the Minnesota Department of Human Services (DHS) to care for Minnesota Health Care Programs (MHCP) patients in both fee-for-service (FFS) and managed care under a payment model that holds these organizations accountable for the total cost of care and quality of services provided to this population."[110] The RFP's contracting requirements and risk-sharing structure serve as the foundation for the IHP demonstration.

Minnesota applies the IHP model to most of its Medicaid beneficiaries who are enrolled under both fee-for-service and managed care programs.[111] IHPs must also serve MinnesotaCare enrollees, but qualifying Medicare beneficiaries and some special MHCP groups are specifically excluded.[112]

ORGANIZATIONAL STRUCTURE

Overview of the IHP Model

As with ACOs, IHPs consist of a group of health care provider organizations (e.g., hospitals, primary and specialty care clinics, etc.) that agree to contract with the state to provide beneficiaries with the full scope of MHCP-covered primary care services, as well as to provide or coordinate the provision of additional core services (e.g., specialty and hospital services).[113] These IHPs then have the opportunity to share in any savings they are able to achieve.[114] Unlike some other ACO models, though, patients are not specifically enrolled in a particular IHP. Instead, patients remain enrolled in their Medicaid MCO or fee-for-service

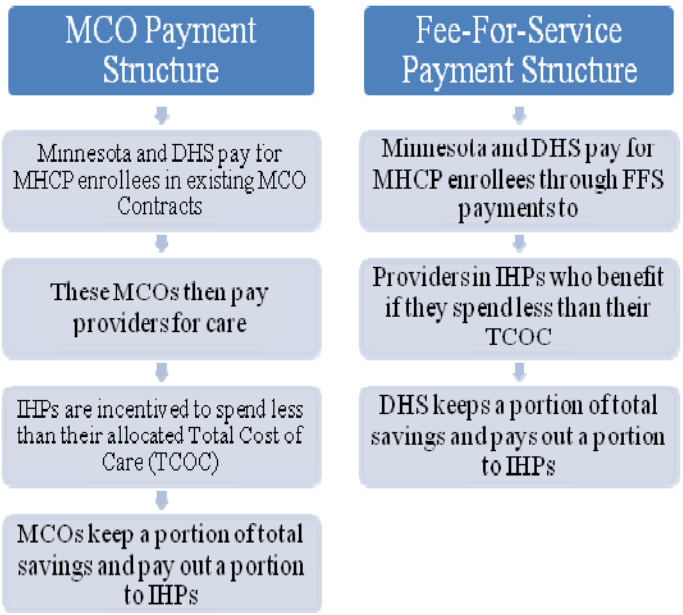
plans, but are "attributed" to the IHPs in order determine whether the IHPs are meeting their quality and cost-savings goals.[115] The IHP structure and payment model are described in more detail below.

The Role of the MCOs in the IHP Model

The IHP demonstration is applicable to qualifying providers that are paid either by the state through FFS contracts or by MCOs who use the providers' services to fulfill their contracts with the state.[116] DHS administers and executes the IHP payment model, quality measures and methodology, and patient attribution; MCOs participate only as a payor in the IHP payment process.[117]

As a state-contracted payor, each MCO is required to participate in the IHP shared-savings initiative (discussed in detail below),[118] and therefore can benefit or suffer based upon the success or failure of the IHPs to achieve savings. The MCO and IHP contracts mandate the cost-sharing relationship between MCOs and IHPs.[119] MCOs naturally benefit from any savings that the IHP achieves, because such savings mean that MCOs are paying out less than expected to providers. However, the MCOs are required to pay out a portion (50% in years one and two, and an amount that may vary in year three) of any shared savings that IHPs earn for the beneficiaries that the MCO manages.[120] Similarly, the MCO collects a portion of shared losses (50% in year two, and an amount that may vary in year three) when the IHP exceeds its target costs.[121]

Aside from these shared savings/losses, this demonstration does not change the relationship between MCOs and health services providers that happen to be in IHPs. Because IHPs contract directly with the state, MCOs simply pay IHP providers as they would ordinary providers.[122] The chart below shows the flow of payment for Medicaid services for each reimbursement model.[123]



The Role of IHPs: Driving Savings through a "Total Cost of Care" (TCOC)

As mentioned above, DHS uses the RFP to facilitate bids for providing health services to Minnesota's MHCP (Medicaid and MinnesotaCare) populations via the IHP model. Because Minnesota is interested in involving as many providers as possible in the IHP initiative, the state has generally accepted all qualified applicants, rather than promoting competition in the IHP bidding process.[124] Each of these applicants is initially expected to participate in the demonstration for a period of three years.[125]

In contracting with DHS, IHPs agree to participate in a shared savings/risk program based on a TCOC calculation and other quality metrics.[126] IHPs are financially rewarded when they are able to keep the actual cost of care (the "Performance" TCOC) for their attributed patients below their "Target" TCOC, so long as they meet quality standards (discussed below).

BACKGROUND: Total Cost of Care (TCOC)*: An IHP's "Target" TCOC is based on the expected per member per month (PMPM) cost of delivering a set of core Medicaid services to its "attributed" population. The TCOC is calculated by totaling MHCP FFS claims and encounter claims submitted by MCOs under contract with the state for the previous calendar year, trended forward to account for medical inflation rates, and then adjusting for changes in attributed populations.[127] To determine shared savings/risk, the Target TCOC is then compared to the IHP's "Performance" TCOC, a measure based on the actual realized PMPM cost of delivering core services to the IHP's attributed population in a given year.*

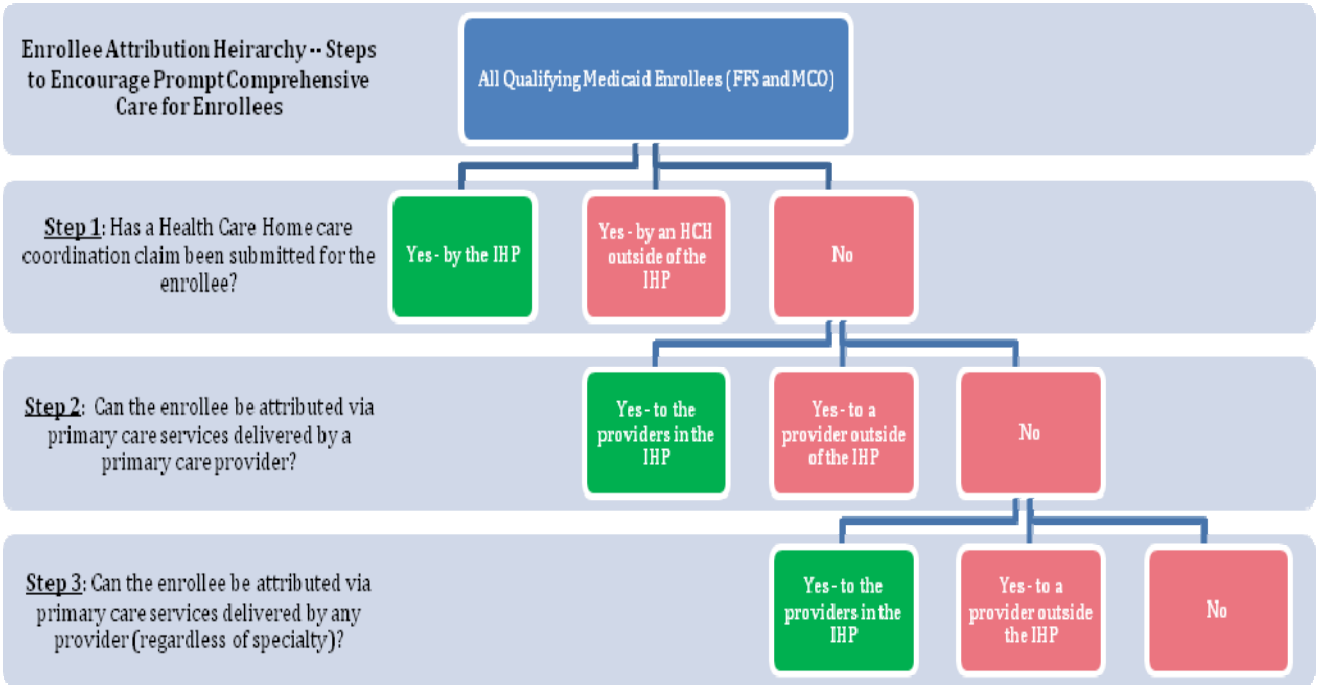
The classification structure and payment models outlined below are based on Target TCOCs for all MHPC participants that are attributed to the IHP. The higher the initial costs the attributed population has historically, the higher the Target TCOC.[128] A higher Target TCOC provides the IHP with an opportunity to share in greater cost-savings while, alternatively, exposing it to greater risk. As attribution may fluctuate throughout the year (more on this below), IHPs are strongly incentivized to provide early, comprehensive care for participants and ensure participants continue to use the IHP's services throughout the year—otherwise, IHPs may spend resources providing care to individuals that are ultimately attributed to another IHP.

The "Attribution" Process

DHS attributes qualifying MHCP enrollees to IHPs that have contracted with the state through the RFP. This attribution is used to track provider performance on cost and quality metrics and ultimately determine an IHP's TCOC. Importantly, individuals are not enrolled in an IHP as they would be enrolled in a Medicaid MCO. Instead, IHP enrollment should be viewed as an initiative that simply tracks the performance of care delivery organizations based on a "rolling group of patients" that move in and out of care organizations rather than stay assigned to a care management program.[129]

DHS uses a three-part attribution process to count patients in an IHP's TCOC calculation.[130] First, it looks to whether participants are actively enrolled in care coordination through a

certified Health Care Home (HCH)[131] submitting a monthly care coordination claim.[132] Second, if participants cannot be attributed based on HCH enrollment, they may be attributed to the IHP based on the number of primary care visits they attend with providers in the IHP.[133] Third, participants that cannot be attributed through primary care visits may be attributed to the IHP based on their non-primary care (specialty) provider visits.[134] The process is depicted in the chart below:



Source: Adapted from Mike Schoeberl, Memorandum: Payment Model Overview, FORMA Actuarial Consulting Services, LLC 2 (Jan. 17, 2013), available at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&Revision SelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177106.

Under this structure, IHPs are incentivized to provide early, comprehensive care through HCHs or primary care services. By doing so, the IHP avoids the risk that they may provide services then ultimately have another IHP "count" the enrollee in its attribution. Minnesota designed the attribution process to encourage active outreach to Medicaid and MinnesotaCare enrollees.[135]

BEST OVERSIGHT PRACTICES: COMMUNICATION. *According to stakeholders familiar with the development of the attribution process, IHPs were significantly involved in working to develop how patients would be attributed to their TCOC. IHPs meet regularly with DHS to comment on the attribution process, ensuring its fairness and refining its methodology as the reform goes forward. These meetings take place as face-to-face dialogues between DHS and IHPs, as well as annual "learning days" where all levels of health care providers discuss the system.[136] Stakeholders at various levels of Minnesota's Medicaid system characterize this open communication as a driving force in the success of the program.[137]*

IHP Classification Structure

In addition to an IHP's "attributed" TCOC, its classification as a Virtual or an Integrated IHP also determines its cost-savings/risk-sharing profile. The IHP model classifies qualifying provider organizations as either Virtual or Integrated IHPs based on their level of vertical integration and number of attributed participants. IHPs which either have a small population or which lack vertical integration are classified as Virtual IHPs.

Virtual IHP v. Integrated IHP	
Virtual IHP	***Limited Integration***. Consists of "primary care providers and/or multi-specialty provider groups that are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems."[138] In essence, a Virtual IHP may be a provider without a hospital system.[139]
	Fewer Attributed Participants. Provider organizations with an MHCP population of 1,000-1,999 attributed participants *must* register as a Virtual IHP, regardless of level of integration.[140]
	Shared Savings Only. The payment model is a shared savings model (no shared losses) "that will distribute the difference between annual expected and actual realized total cost of care if savings are achieved, a portion of which is contingent on quality and patient experience outcomes."[141]
Integrated IHP	***Significant Integration***. Provider organizations with "an integrated delivery system that provides a broad spectrum of outpatient and inpatient care as a common financial and organizational entity." [142]
	More Attributed Participants. "Provider organizations must serve an MHCP population of 2,000 attributed participants or greater in order to be eligible for the integrated model."[143]
	Shared Savings and Losses. "The payment model incorporates shared risk over time [(discussed in the Incentives section below)] and builds toward a two-way risk sharing model that distributes the difference between the annual expected and actual realized total cost of care whether savings are achieved or not."[144] Receipt of a portion of this difference is contingent on quality and patient experience measures.[145]

INCENTIVES

Each year, IHPs can share in savings or losses, provided they meet a two percent minimum performance threshold.[146] To meet this threshold, the Performance TCOC must be below 98% of the Target TCOC[147] (to share in savings) or above 102% of the Target TCOC (to share in losses).[148] In the first year of participation, both Virtual IHPs and Integrated IHPs share in savings and have no downside risk.[149] After the first year, Integrated IHPs share in both savings and risk.[150] These incentive structures are described in more detail in the following table.

Financial Incentives Over Time[151]			
		Shared Savings	**Savings/Risk Structure and Caps**
Performance Year 1	**Virtual IHP**	IHP shares any savings equally (50/50) with the State/MCOs, provided that it meets the 2% performance threshold and quality standards.	No downside risk.
	Integrated IHP	IHP shares any savings equally (50/50) with the State/MCOs, provided that it meets the 2% performance threshold and quality standards.	The maximum threshold for shared savings must be the same in Performance Years 1 and 3 and cannot exceed 85% of the Target TCOC (that is, IHPs do not incrementally benefit from spending less than 85% of their Target TCOC). No downside risk.
Performance Year 2	**Virtual IHP**	IHP shares any savings equally (50/50) with the State/MCOs, provided that it meets the 2% performance threshold and quality standards.	No downside risk.
	Integrated IHP	IHP shares any savings or shared losses equally (50/50) with the State/MCOs, provided that the IHP meets the 2% performance threshold (for savings/losses) and quality standards (for savings).	Integrated IHPs have some discretion regarding the amount of downside risk they bear, but the ratio of shared savings thresholds to shared loss thresholds must be 2:1. (*For example*, if an IHP wishes to avoid risk for claims above 106% of the Target TCOC, the maximum threshold for shared savings is 88% (6 percentage points x 2 = 12) below the Target TCOC).
Performance Year 3	**Virtual IHP**	IHP shares any savings equally (50/50) with the State/MCOs, provided that it meets the 2% performance threshold and quality standards.	No downside risk.
	Integrated IHP	IHP shares in any savings and losses with the State/MCOs, provided that the IHP meets the 2% performance threshold (for savings/losses) and quality standards (for savings). IHP may propose different sharing proportions (e.g., 70/30) for different thresholds above and below the Target TCOC. However, these proportions must be symmetrical. (*For example*, the distribution of gains if the Performance TCOC is only 90-94% of Target TCOC must be the same as the distribution of losses if the Performance TCOC is 106-110% of Target TCOC).[152]	Integrated IHPs have some discretion regarding the amount of downside risk they bear, but risk sharing thresholds must be symmetrical. (*For example*, if an IHP wishes to avoid risk at 115% of the Target TCOC, the maximum threshold for shared savings must be 85%). The maximum threshold for shared savings must be the same in Contract Years 1 and 3 and cannot exceed 85% of the Target TCOC.

BEST OVERSIGHT PRACTICES: COMMUNICATION. *By granting IHPs the ability to determine their own levels of risk and reward, the system permits health service providers to begin risk-bidding conservatively, then adapt to their capacity as they move through performance years. According to anecdotal evidence, some IHPs that participated in the first full year of contracting (2013) took a more aggressive position toward cost-savings in the third year of the demonstration (2015).[153] This approach to risk and reward is just one example of an overarching theme of flexibility and collaboration in the implementation of the IHP model.*

Quality Measures

Each year, a portion of the IHP's shared savings is withheld if the IHP fails to meet certain quality requirements. In Performance Year 1, up to 25 percent of an IHP's shared savings is contingent on the IHP meeting reporting requirements. Specifically, the IHP must adequately report on 36 measures of quality and patient experience.[154] These measures were chosen from an existing state measurement program (the Statewide Quality Reporting and Measurement System)[155] and cover a range of topics including diabetes, asthma, and vascular care, as well as patient safety and satisfaction.[156]

BEST OVERSIGHT PRACTICES: COMMUNICATION. *Although DHS bases its core quality metrics for the IHPs on the Statewide Quality Measurement and Reporting System, it also takes individual IHP requests into consideration. For instance, stakeholders note that DHS recently accommodated revised quality metrics for an IHP that focused on providing care to children, a population that may not be adequately addressed by IHP quality metrics geared toward adults.[157]*

During Performance Years 2 and 3, up to 25 and then 50 percent of an IHP's shared savings is contingent upon the IHP's actual performance on these reported measures.[158] IHP performance across these measures is used to calculate the IHP's "overall quality score," which is in turn used to determine the portion of savings withheld.[159]

BEST OVERSIGHT PRACTICES: DATA. *IHP stakeholders commented on how the IHP system has created a culture of shared data. Not only does DHS provide quality data to IHPs, but MCOs are also providing increased access to data. IHPs have hired new analysts to use this influx of data in order to identify populations of high-risk patients. They have then used a portion of shared-savings to make extra efforts to reach out to such patients. For example, analyzing new data helped one rural IHP recognize an extremely high diabetes rate in its local Hispanic population. After identifying the geographic location of those with diabetes risk, the IHP was able to partner with a centrally-located church within the Hispanic community to directly engage the population through diabetes education. The IHP noted a direct correlation between the quantity and quality of data received and the ability to succeed in targeted, community-driven activism.[160]*

FUNDING

The IHP project is largely paid for via program funding.[161] However, Minnesota also obtained a $45 million federal State Innovation Model (SIM) grant to "develop new ways of delivering and paying for health care and creating healthy communities using the Minnesota Accountable Health Model."[162] Minnesota used this SIM grant to fund enhancements to the IHP program, including data and support.[163] Additional funding is conditional upon state performance in meeting the goals of its State Innovation Model initiative (the Minnesota Accountable Health Model; IHP is one component of this model) which aims to "create linkages between the ACOs and Medicare, Medicaid, and commercial insurers, aligning payments to provide better care coordination, wider access to services, and improved coverage."[164]

INTEGRATION OF SERVICES

The structure of the IHP model encourages participants to integrate and/or coordinate services to better meet the needs of MHCP enrollees. To participate in the demonstration, IHPs must be able to "[p]rovide the full scope of primary care, and adopt methods of care delivery so that the full scope of primary care is provided and care is coordinated across the spectrum of services provided."[165] To maximize shared savings, IHPs must also maintain or improve care quality while keeping costs down across a broad range of services including: physician, laboratory, radiology, chiropractic, pharmacy, vision, podiatry, physical therapy, speech therapy, mental health, chemical dependency, outpatient hospital, inpatient hospital, hospice, home health, and private duty nursing services.[166]

Finally, DHS also encourages IHP applicants to "[d]emonstrate how formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, etc. are included in the care delivery model" and to "propose mechanisms to incorporate these organizations directly into the payment model."[167]

STATUS

In 2013, the first year of the demonstration's implementation, DHS contracted with six health care delivery systems under the IHP model.[168] Since that time, an additional thirteen health care delivery systems have joined the demonstration.[169] Thus, as of March 2016, nineteen IHPs are currently providing services to more than 342,000 of Minnesota's Medicaid enrollees[170] (roughly 33% of Minnesota's Medicaid/CHIP population).[171] Notably, these nineteen health care delivery systems include the six original IHPs, which have all completed the initial demonstration period and opted to continue in the program for another three-year cycle.[172]

The IHP program has generated savings for both the state and its participants. The IHP demonstration generated overall cost-savings of $14.8 million in 2013, and $61.5 million in 2014, for a total of $76.3 million over the first two years of the program.[173] In 2014, the second year of the program, all nine participating IHPs were eligible for shared savings.[174] In that same year, the IHPs reportedly achieved "double-digit decreases in hospitalizations and single-digit decreases in emergency room visits,"[175] suggesting that IHPs are having a positive impact on both quality and costs in Minnesota's Medicaid system.

OREGON: COORDINATED CARE ORGANIZATIONS

COORDINATED CARE ORGANIZATIONS (CCOS): CCOs are community-based organizations governed by a partnership among voluntary providers of care, community members, and the Oregon Health Authority that serve as a single point of accountability in promoting health quality and access to care for the Medicaid population they serve.[176]

Oregon's Medicaid program is particularly effective at implementing the following three Key Components of Oversight: **(1)** ***COMMUNICATION*****, (2)** ***INCENTIVIZING QUALITY,*** and **(3)** ***MONITORING ENTITIES.***

HISTORY

In 1994, Oregon first introduced a full-risk, capitation-based MCO model into its Medicaid program.[177] Over time, Oregon expanded its Medicaid managed care system, and by 2011, most Medicaid beneficiaries were required to enroll[178] with separate managed care organizations (MCOs) for mental, physical, and dental care services.[179] This siloed MCO system left patients without coordinated care and ultimately burdened the State with rising health care costs.[180]

On July 5, 2012, CMS approved Oregon's section 1115 Medicaid Waiver, a necessary step to implement Oregon's ambitious transformation to a Coordinated Care Organization (CCO) model.[181] Under this Waiver, CCOs now function as a centralized health care delivery system for their enrollees' physical, dental, and behavioral health and seek to promote "better health, better care and lower costs" for Oregon's Medicaid population.[182]

Oregon's CCOs are similar to MCOs or Accountable Care Organizations (ACOs) in their desire to limit health care costs by improving delivery systems and realigning financial incentives between the State, health care management organizations, and health service providers.[183] However, Oregon's CCOs are sometimes characterized as "ACOs on steroids"[184] because of their responsibility for coordinating physical, dental, and behavioral health through one centralized accountability and payment system. CCOs also require interdisciplinary care teams and are funded through a "Global Budget."[185] Global Budgets expand on the ACO model in a number of ways:

- They pay providers organized as CCOs to coordinate physical, dental, and behavioral health services.
- They allow for flexible spending to address the needs of high-risk, high-cost patients. For example, if social determinants, such as food or housing insecurity, are causing a patient to engage in frequent emergency department visits and hospital admissions, a care team can assign an outreach worker to work with the patient to address those needs.[186]

BEST OVERSIGHT PRACTICES: INCENTIVIZING QUALITY. *Under the Global Budget system, CCOs are able to think broadly about addressing health disparities. For example, one CCO reported helping to manage a patient's diabetes by providing transportation to and from a gym. After noticing that the patient had improper footwear that caused blisters, the CCO's health care worker was able to use the CCO's flexible spending to purchase appropriate athletic shoes for the patient.*[187]

As described in more detail below, the CCO model also includes specific requirements regarding community governance, integration, payment withholding and incentive pay systems, and comprehensive data reporting.

ORGANIZATIONAL STRUCTURE

CCOs have the flexibility to organize in a way that best meets the specific needs of the communities they serve.[188] CCOs may, for example, be consortiums of providers, including hospitals, physicians, community clinics, dentists, and mental health groups, or they may consist of insurance companies that work with a network of health care providers.[189] However, to ensure that all CCOs—regardless of structure—are fully integrated into their communities, the Oregon requires CCOs to meet following criteria for certification:[190]

CCO Certification Criteria – Community Involvement	
Governance Structure and Organizational Relationships	Each CCO Governance Board must include: • A majority interest of persons that share financial risk of the organization;[191] • Major components of the health care delivery system including two practicing health service providers; • At least two members of the community at large to ensure that the organization's decision-making is consistent with community members' values.
Community Advisory Council (CAC)	• Each CCO must establish and convene a CAC that meets at least once every three months. • The CAC must include members of the community and county government and ensure that the community's health care needs are being met. • Consumers must make up a majority of the CAC. • At least one CAC member must serve on the CCO's governing board.
Partnerships with Mental Health Authorities	• A CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.
Community Health Assessment and Community Health Improvement Plan	• The CAC is responsible for overseeing an initial community health assessment and then designing, implementing, and annually updating a community health improvement plan.[192] • The assessment should include a focus on health disparities in the community. • CCOs are encouraged to partner with local public health and mental health organizations as well as hospital systems in developing their assessment.

BEST OVERSIGHT PRACTICES: MONITORING ENTITIES. *As part of the standard CCO structure, Oregon requires that CCOs establish a Community Advisory Council (CAC). The CAC must include community members and county government officials. Unlike broader state-level entities, these entities focus on monitoring whether CCOs are meeting the needs of the communities they serve. By requiring CCOs to establish these CACs, Oregon therefore creates an additional, more specialized level of oversight that can identify and address key issues related to individual CCOs and their respective patient populations.*

The OHA has significant flexibility to determine the number of CCOs it approves. The state must contract with at least two CCOs.[193] The OHA may also choose to approve more than one CCO in a geographic region of the state if the opportunity arises.[194] According to stakeholders familiar with the CCO contracting process, the OHA wishes to encourage the development of the CCO model, and so it has generally agreed to contract with any CCO that meets the certification standards.[195] The OHA now contracts with a total of sixteen CCOs.[196] For the most part, these sixteen CCOs operate in distinct service areas, though coverage does overlap in some heavily populated regions of the state.[197]

The OHA retains significant accountability and oversight authority over the CCOs.[198] Accountability and oversight focuses primarily on "quality, access and financial monitoring"[199] of the CCOs (discussed below), as well as determining the CCOs' financial solvency.[200] The OHA may respond to poor CCO performance through numerous measures including providing technical assistance, restricting enrollment, imposing financial penalties, and choosing not to renew the contract.[201] If a CCO faces financial insolvency, the OHA may intercede to ensure patients receive adequate health services by increasing reinsurance requirements, requiring greater financial reserve requirements, imposing behavioral restraints, or mandating more comprehensive financial examinations.[202]

FUNDING THE CCO TRANSFORMATION

The federal government is providing Oregon with approximately $1.9 billion over five years in federal financial participation (FFP) through the Designated State Health Programs (DSHP)[203] to implement the CCO model.[204] Federal funding is conditioned on reducing the growth of per capita Medicaid spending from a base rate of 5.4 percent to 4.4 percent by the end of the second year of the waiver (July 2013 – June 2014) and to 3.4 percent in each of the following three years.[205] Failure to meet the per capita reduction exposes Oregon to significant penalties, beginning at $145 million for failure to meet the second year goal and increasing to $183 million in years four and five of the program.[206]

BEST OVERSIGHT PRACTICES: COMMUNICATION. *Stakeholders note that, because the state must reduce Medicaid spending or face substantial fines, the state is closely aligned with CCOs in providing the data, information, and access necessary to increase quality and reduce costs.[207] The OHA appears committed to hearing the opinions of CCOs and meets regularly with CCOs and Community Advisory Councils to refine aspects of the model.[208] This iterative process provides a basis for communication, coordination, and trust between the OHA and the CCOs.*

CCO FUNDING STRUCTURE

Oregon provides each of its sixteen CCOs with a "Global Budget" from multiple state and federal funding sources.[209] The OHA calculates each CCO's Global Budget annually—and whenever there is a change in covered services—based on a capitated per member, per month (PMPM) rate.[210] CCOs, in turn, are held accountable to use the Global Budgets to pay providers of physical, dental, and behavioral health services.[211]

To illustrate, before the implementation of the CCO model, an enrollee requiring behavioral health services would receive care from a provider, who would then seek reimbursement from a Mental Health Organization (MHO). The MHO would be at risk for a defined set of behavioral health services for those members enrolled with the MHO by the OHA. If, in contrast, the enrollee required physical or dental services, the enrollee would seek services from a provider in their MCO's or Dental Care Organization's (DCO's) network. These MHO, MCO, and DCO networks would be uncoordinated and distinct, and the MHOs, MCOs, and DCOs would be separately funded by the OHA.[212]

Today, OHA funds flow directly to the CCO's Global Budget.[213] The CCO then coordinates care and channels the flow of funds to all health service providers (mental, physical, and dental). While CCOs must offer the same core services enrollees received under Oregon's previous system,[214] Global Budgets afford significant flexibility in providing additional preventive and innovative services beyond required "core" services that may improve long-term health outcomes while minimizing overall health care spending.[215]

INCENTIVES

The OHA incentivizes CCOs to manage costs and adhere to quality standards. First, CCOs are primarily responsible for shouldering the risk in providing health care to their enrollees. CCOs benefit from staying within their Global Budgets by receiving a portion of cost-savings, but CCOs are also at risk if they exceed their Global Budget allocation.[216] Second, Oregon incentivizes CCOs to focus on health outcomes and quality care by withholding a portion of their monthly payments and placing them in a "quality pool."[217] CCOs receive a distribution from the quality pool based on their size and how well they perform on seventeen quality incentive metrics[218] determined by the OHA's Metrics and Scoring Committee.[219] In effect, the quality pool rewards CCOs for health care outcomes rather than quantity of care delivered.[220]

For 2015, the quality pool is four percent of the aggregate paid to all CCOs throughout the calendar year.[221] In 2014, the quality pool was three percent.[222] In 2013, eleven of fifteen CCOs received 100 percent or more of their quality incentive withholdings.[223] In 2014, this number increased to thirteen of sixteen.[224] Stakeholders have noted that the withholds do make a positive impact on CCOs' commitment to quality services, especially as the quality pool payments may be used as financial incentives to improve outcomes at the provider level.[225] Thus, while one CCO reported using a major portion of their reimbursed withholds to invest in infrastructure, the CCO also reported distributing the remaining funds directly to health service providers that met the CCO's expected quality standards.[226]

INTEGRATION OF SERVICES

In 2009, Oregon established its Patient-Centered Primary Care Home (PCPCH) program.[227] The PCPCH program is a team-based medical home model that focuses on preventive care, accessible and comprehensive primary care, and collaboration and communication between service providers.[228] PCPCHs have physician-led care teams that rely on mid-level health service providers including physician assistants, nurse practitioners, and health educators to work proactively with patients to manage chronic illness, promote healthier lifestyles, and encourage patient self-management.[229]

Oregon's CCO model relies heavily on coordinating care with PCPCHs. Though patient enrollment in PCPCHs is optional, the state requires CCOs to take the following to steps to promote their use:[230]

- Contract with a network of recognized PCPCHs;
- Require other contracting health and services providers to communicate and coordinate care with PCPCHs in a timely manner using electronic health information technology; and
- Ensure that beneficiaries receive integrated, culturally and linguistically appropriate person-centered care and services, and that beneficiaries are fully informed partners in transitioning to such a model.

Oregon also requires CCOs to achieve at least 60 percent enrollment in PCPCHs in order to qualify to receive their full quality pool incentives.[231]

In addition to working with PCPCHs, CCOs are required to actively integrate care with mental health services, oral health providers, and hospital and specialty services.

- *Mental Health*: CCOs must coordinate and deliver outpatient mental health[232] and substance use disorder treatment[233] as an integrated part of the person-centered care model.
- *Oral Health*: CCOs must establish formal contractual relationships with any dental care organization that serves their beneficiaries.[234]
- *Hospital and Specialty Services*. CCOs must provide "adequate, timely and appropriate access to specialty and Hospital services;" address the role of patient-centered primary care in agreements with specialty and Hospital providers; and establish performance expectations regarding communication and medical record sharing for specialty treatments.[235]

To achieve certification, the OHA requires CCOs to use Health Information Technology (HIT) to "link services and core providers across the continuum of care to the greatest extent possible."[236] Specifically, CCOs must facilitate providers' adoption and meaningful use of electronic health records (EHRs) as well as their use of electronic health information exchange to share patient health information among participating providers.[237]

STATUS

CCOs currently provide care for more than 90% of Oregon's Medicaid population, including the Affordable Care Act (ACA) Medicaid expansion population.[238] The CCO model appears to be showing improvement over 2011 baseline calculations, but additional data in the

forthcoming years will provide a more comprehensive picture. As the data stand today, the CCO model has improved Oregon's care in the following areas:[239]

- *Emergency department visits*. Emergency department visits by CCO beneficiaries have decreased 23 percent since 2011.
- *Hospital admissions for short-term complications from diabetes*. The rate of adult patients (18 and older) who had a hospital stay due to a short-term complication of diabetes dropped by 32 percent since 2011.
- *Hospital admissions for chronic obstructive pulmonary disease*. The rate of adult patients (40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 68 percent since 2011.
- *Patient-Centered Primary Care Home (PCPCH) enrollment*. PCPCH enrollment has increased 61 percent since 2012.

According to OHA reports, Oregon is also successfully meeting its cost-containment obligations by reducing spending growth by at least two percentage points per member per year.[240]

CONCLUSIONS AND RECOMMENDATIONS

Faced with limited resources, expanding Medicaid populations, and new regulatory requirements, states have a strong incentive to reshape their Medicaid programs in order to achieve the Triple Aim of improving population health while cutting costs and improving the patient experience. In order to achieve these goals, several states have developed new and innovative systems that either replace or refine more traditional managed care models. Each of these new systems remains a work in progress, and is by no means beyond improvement. For example, stakeholders have noted that problems persist in these systems related to integration of care, access to innovative treatments, and patient education regarding system changes. However, by examining and implementing the elements of these systems that stakeholders suggest are working effectively, other states can go a long way to improve their own systems.

According to stakeholders in these states, some of the most important and effective changes made under these new models are not limited to the structures of the systems themselves, but instead relate to a broader concern—the ways that state officials, managed care entities, and other stakeholders interact within those systems. To improve these interactions—and, by extension, the care provided—these new systems have each incorporated a number of the key components of effective oversight described in the introduction to this report.

We have attempted to summarize "best practices" of the states evaluated here and hope that stakeholders and states can assess whether these programs can and should be emulated. In particular, we recommend that states consider whether their systems have taken or should take the following steps with respect to each of the core key components of effective oversight:

- **INCENTIVIZING QUALITY:** All three states in this report use some level of incentives to encourage the actors within their state Medicaid program to improve quality of care. These incentives may consist of payment withholds, shared-savings, or other alternative payment models. By incentivizing quality and providing sufficient flexibility for innovative practices, these states have been able to improve care coordination and, in some cases, better address social determinants of health. We therefore encourage states to explore the possibility of adopting similar programs in order to provide oversight of the financial interests that drive managed care activity. In addition to these positive incentives, we recognize that enforcement mechanisms can be an important tool for incentivizing quality. We therefore recommend that states take steps to ensure that managed care entities see enforcement mechanisms (e.g., withholds, loss of contract, sanctions) as a real threat in the event of noncompliance or failure to meet expectations.

- **DATA:** Stakeholders have also noted that access to data is absolutely crucial to achieving the Triple Aim. We therefore recommend that states prioritize efforts to improve data reporting and collection and, perhaps more importantly, establish

methods for making that data actionable. For example, stakeholders have stated that, in order to be actionable, data must be timely and summarized in a useful way. This may require delegating responsibility to a specific entity to collect and analyze data and produce ad hoc reports regarding specific topics. Additionally, stakeholders have indicated that using financial incentives to give states, managed care entities, and providers a mutual interest in improving care can be an effective way to promote data-sharing. Finally, states should ensure that data is available not only to government officials and managed care entities, but also to the general public. By ensuring that the public has sufficient access to the data, states can impose another layer of oversight on managed care entities by allowing additional stakeholders to highlight issues that require follow-up and action.

- **TRANSPARENCY:** As seen under Connecticut's prior MCO model, lack of transparency can create significant issues for Medicaid systems. Lack of transparency regarding decision-making and appeals processes can impact patient access to care. Additionally, lack of transparency regarding managed care costs and other policies can make it difficult for states to effectively oversee their Medicaid systems. Therefore, we recommend that states establish and enforce requirements that ensure that managed care entities provide the public with information regarding key policies and decisions that impact quality and access to care. Additionally, we recommend that states require that knowledgeable representatives of managed care entities are available and able to speak on the entities' behalf at all key stakeholder meetings.

- **MONITORING ENTITIES:** All states are federally mandated to establish a Medical Care Advisory Committee (MAC), which must include stakeholders such as physicians and consumer groups, to oversee its Medicaid program.[241] However, the effectiveness of these committees may depend upon the particular practices of the state. In order to enhance the effectiveness of the MAC, we recommend that MAC meetings be not only open to the public, but also well advertised, and, if possible, televised. We also recommend that states ensure that the MAC is composed of stakeholders with a broad spectrum of viewpoints. Finally, we recommend that states consider whether they could incorporate monitoring entities specific to individual managed care communities—such as Oregon's CACs—into their Medicaid programs in order to ensure more specialized community-focused monitoring.

- **PROCUREMENT:** Procurement plays an important role in setting the tone, dynamics, and expectations of the relationship between managed care entities and states. Therefore, it is important for states to consider how they can use the procurement process to ensure that managed care entities provide high-quality care to Medicaid beneficiaries. To do so, we recommend that states consider whether they could use the procurement process to foster competition between managed care entities.[242] As seen in Connecticut's ASO system, creating an awareness of competition in the procurement process can both ensure that managed care entities agree to provide high-quality care, and encourage them to continue to meet or exceed expectations in

order to avoid losing all or part of their contract as they move forward. Additionally, states should use the procurement process to explicitly encourage managed care entities to provide quality care. For example, states can adopt a process like Minnesota's that includes quality measures in the overall scoring of MCO proposals. Additionally, all states—including those that do not use a competitive procurement process—should use the managed care contract itself to place strict, well-enforced quality requirements on all managed care entities that participate in the Medicaid program.

- **COMMUNICATION:** Based upon our interviews with stakeholders, communication appears to be a particularly key component of effective oversight. In order to establish effective communication between stakeholders, we recommend that states establish regular—and frequent—meetings between state officials and managed care entities, in which the parties are able to have candid conversations regarding current issues and concerns. In order to further enhance this sense of collaboration, states should formally solicit input from a variety of stakeholder when designing key metrics and systems (e.g., quality metrics, delivery system initiatives, etc.). By doing so, a state can both improve the design of its Medicaid program and create a sense of shared responsibility for its success.

By building upon the experiences in states such as Connecticut, Minnesota, and Oregon, states across the nation have the opportunity to improve the fundamental ways in which stakeholders interact in their Medicaid systems. It is our hope that by doing so these states will be better equipped to achieve the Triple Aim and thereby improve the lives of low-income individuals living with chronic disease.

ENDNOTES

[1] Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP* 119-120 (June 2014), *available at* https://sites.google.com/a/macpac.gov/macpac/reports.

[2] Vernon K. Smith et al., *Report: Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*, The Henry J. Kaiser Family Foundation and National Association of Medicaid Directors 20 (Oct . 2015), *available at* http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/.

[3] Vernon K. Smith et al., *Report: Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*, The Henry J. Kaiser Family Foundation and National Association of Medicaid Directors 20 (Oct . 2015), *available at* http://kff.org/medicaid/report/medicaid-reforms-to-expand-coverage-control-costs-and-improve-care-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2015-and-2016/ (stating that 39 states, including Washington D.C., currently use MCOs as part of their Medicaid system).

[4] *Oversight*, MERRIAM-WEBSTER, http://www.merriam-webster.com/dictionary/oversight (last visited Jan. 26, 2016).

[5] Andrea Callow, *New Medicaid Managed Care Proposed Rule Is Out*, FAMILIES USA, http://familiesusa.org/blog/2015/05/new-medicaid-managed-care-proposed-rule-out (last visited Jan. 26, 2016).

[6] *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31,144-48 (proposed June 1, 2015) (to be codified at 42 C.F.R. 438.68, 438.206, 438.207).

[7] *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability, 80 Fed. Reg. 31,150-53 (proposed June 1, 2015) (to be codified at 42 C.F.R. 438.330, 438.334).

[8] *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability,80 Fed. Reg.. 31,133-37 (proposed June 1, 2015) (to be codified at 42 C.F.R. 438.54, 438.56, 438.71).

[9] *See, e.g.*, The Health Law and Policy Clinic of Harvard Law School and Treatment Access Expansion Project, *An Advocate's Toolkit; Medicaid Managed Care, Mental Health Services, and Pharmacy Benefits* 8 (2011), *available at* http://www.mentalhealthamerica.net/sites/default/files/NEUS11NP038%281%29_2011_Mental_Health_Managed_Care_Toolkit_Approved_9.27.11.pdf.

[10] Susan M. Johnson, *Recent Changes in Connecticut Medicaid* 22, *available at* http://knowledgecenter.csg.org/kc/system/files/johnson.recent_changes_in_connecticut_medicaid.june_21.pdf.

[11] *See* Phil Galewitz, *Connecticut Drops Insurers from Medicaid*, KAISER HEALTH NEWS (Dec. 29, 2011), http://kaiserhealthnews.org/news/connecticut-drops-insurers-from-medicaid/.

[12] Connecticut Voices for Children, *Opportunities for Improving Care for Families in the HUSKY Program* 1 (Apr. 2008), *available at* http://www.ctvoices.org/sites/default/files/h08improvecarehusky.pdf; *see also* Connecticut Department of Social Services, *Medical Assistance Program Provider Bulletin, PB 2005-40, New Behavioral Health Partnership* (Sept. 2005), *available at* http://www.ctbhp.com/providers/bulletins/2005/PB2005-40.pdf.

[13] Christine Vestal, *Connecticut Revisits Old-School Medicaid Financing*, THE PEW CHARITABLE TRUSTS: STATELINE (Apr. 8, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing.

[14] Joachim O. Hero and Mary Alice Lee, *Medicaid Provider Reimbursement: Recent Changes to Pediatric, Obtetric, and Other Selected Fees*, Connecticut Voices for Children 5 (Apr. 2008), *available at* http://www.ctvoices.org/sites/default/files/h08medreimbursefees.pdf; Connecticut Medicaid Managed Care Council, *Medicaid Council Quarterly Report: 1st and 2nd Quarters 2007* 2-3 (Sept. 21, 2007), *available at*: https://www.cga.ct.gov/med/council/qtr/200702QTR_Quarters%201%20and%202.pdf.

[15] In 1999, then Attorney General Richard Blumenthal announced his intention to take HealthRight, Inc. and subcontractor Value Behavioral Health to court over a failure to provided medically necessary inpatient treatment to mentally ill children. The case was eventually settled out of court. In the same year, a class action suit was filed against Physicians Health Services, Inc. (PHS) and the Department of Social Services (DSS) for failing to issue required written notices of decisions that would terminate, deny, or reduce treatment (as well as notice of hearing rights), and, in the case of DSS, failing to monitor PHS's compliance with these requirements. *See* Sara Rosenbaum et al., *An Overview of Legal Development in Managed Case Caselaw and Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services* (Aug. 2001), *available at* https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_DAEA9DFC-5056-9D20-3D1BC6235F5C4A0E.pdf. In subsequent years, MCOs also faced a suit regarding their refusal to disclose records in response to state FOIA requests. *See* Sarah Somers and Sarah Gustin, *Medicaid Managed Care Litigation Docket*, National Health Law Program 11 (June 30, 2013), *available at* https://assets.documentcloud.org/documents/801542/medicaid-managed-care-litigation-docket-7-2013.pdf.

[16] CONN. GEN. STAT. ANN. § 1-200, et seq. (West 2013).

[17] Health Net of Conn. v. Freedom of Info. Comm'n, No. CV064010428S, 2006 WL 3691796, at *1-*2 (Conn. Super. Ct. Nov. 29, 2006).

[18] Christine Vestal, *Connecticut Revisits Old-School Medicaid Financing*, THE PEW CHARITABLE TRUSTS: STATELINE (Apr. 8, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing.

[19] *See e.g.*, Health Net of Conn. v. Freedom of Info. Comm'n, No. CV064010428S, 2006 WL 3691796, at *6-*11 (Conn. Super. Ct. Nov. 29, 2006).

[20] Stakeholder interview; *see also* Robin K. Cohen, *OLR Research Report 2008-R-0615: Husky and Medicaid,* OFFICE OF LEGISLATIVE RESEARCH (Nov. 2008), https://www.cga.ct.gov/2008/rpt/2008-R-0615.htm.

[21] Stakeholder interview; *see also* Robin K. Cohen, *OLR Research Report 2008-R-0615: Husky and Medicaid,* OFFICE OF LEGISLATIVE RESEARCH (Nov. 2008), https://www.cga.ct.gov/2008/rpt/2008-R-0615.htm.

[22] Stakeholder interview; *see also* Robin K. Cohen, *OLR Research Report 2008-R-0615: Husky and Medicaid,* OFFICE OF LEGISLATIVE RESEARCH (Nov. 2008), https://www.cga.ct.gov/2008/rpt/2008-R-0615.htm.

[23] Christine Vestal, *Connecticut Revisits Old-School Medicaid Financing*, THE PEW CHARITABLE TRUSTS: STATELINE (Apr. 8, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing.

[24] Arielle Levin Becker, *Oversight Group Criticizes HUSKY Managed Care Profits*, THE CONNECTICUT MIRROR (Oct. 19, 2010), http://ctmirror.org/2010/10/19/oversight-group-criticizes-husky-managed-care-profits/ (noting, in particular, the low medical loss ratios in HUSKY B (Connecticut's Children's Health Insurance Program (CHIP)).

[25] *See* Mary Fitzpatrick and Katherine M. Dwyer, *Research Report 2015-R-0010: Medicaid Managed Care in Connecticut and Other States*, OFFICE OF LEGISLATIVE RESEARCH (Jan. 12, 2015), *available at* https://www.cga.ct.gov/2015/rpt/pdf/2015-R-0010.pdf; Phil Galewitz, *Connecticut Drops Insurers from*

Medicaid, KAISER HEALTH NEWS (Dec. 29, 2011), http://kaiserhealthnews.org/news/connecticut-drops-insurers-from-medicaid/.

[26] *See* Mary Fitzpatrick and Katherine M. Dwyer, *Research Report 2015-R-0010: Medicaid Managed Care in Connecticut and Other States*, OFFICE OF LEGISLATIVE RESEARCH (Jan. 12, 2015), *available at* https://www.cga.ct.gov/2015/rpt/pdf/2015-R-0010.pdf.

[27] 2010 Conn. Legis. Serv. 10-179 (West) (codified at CONN. GEN. STAT. ANN. §17b-261m (West 2016)).

[28] HUSKY A is for families and covers low-income children, families with children, and pregnant women. HUSKY B is Connecticut's Children's Health Insurance Program (CHIP) and covers children up to age 19 whose families are not financially eligible for HUSKY A. HUSKY C covers low-income individuals that are aged, blind, or disabled. HUSKY D is the Medicaid expansion program for low-income adults and covers individuals ages 19 to 64 who do not receive Medicare, and who are no pregnant. *See How to Qualify*, HUSKY HEALTH CONNECTICUT (Feb. 29, 2016, 11:11 AM), http://www.huskyhealth.com/hh/cwp/view.asp?a=3573&q=421548.

[29] CONN. GEN. STAT. ANN. §17b-2 (West 2016). There is also a statutorily mandated Council on Medical Assistance Program Oversight (MAPOC) comprised of legislators and representatives of various stakeholders which oversees all aspects of Connecticut Medicaid (discussed in more detail below). *See* CONN. GEN. STAT. ANN. §17b-28 (West 2016).

[30] CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, CONNECTICUT INTERCHANGE MMIS: PROVIDER MANUAL: INTRODUCTION 13 (v. 4.0 Nov. 1, 2015), *available at* https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch1_iC_introduction_v4.0.pdf&URI=Manuals/ch1_iC_introduction_v4.0.pdf [hereinafter CMAP, PROVIDER MANUAL].

[31] Note that the transition to the ASO structure and relevant bids occurred at differing times for each of the four service types (medical, behavioral health, dental, and non-emergency medical transportation). *See, e.g.*, Connecticut Department of Social Services, *Connecticut Medicaid 101* 65-67 (Jan. 21, 2016), *available at* http://www.ct.gov/dss/l§Nib/dss/connect/Medicaid101January2016.pdf; *see also* Katherine Dwyer, *OLR Rep. 2013-R-0391: Community Health Network of Connecticut, Inc.*, OFFICE OF LEGISLATIVE RESEARCH (Oct. 11, 2013), http://cga.ct.gov/2013/rpt/2013-R-0391.htm (describing the 2011 competitive bid for the medical service ASO, Community Health Network of Connecticut); Connecticut BHP, *CT Behavioral Health Partnership Expands*, PARTNERSHIP IN PRINT 1-2 (Apr. 2011), *available at* http://www.ctbhp.com/providers/publications/CTBHP_Provider_Newsletter_2011-Vol1.pdf (describing the 2005 competitive bid for the behavioral health service ASO, ValueOptions).

[32] Connecticut Department of Social Services, *A Précis of the Connecticut Medicaid Program* 5 (Oct. 10, 2014), *available at* http://www.ct.gov/dss/lib/dss/powerpoint/MAPOC101014.pdf [hereinafter DSS, *Précis*].

[33] CHNCT is a 501(c)4 not-for-profit health plan that was founded in 1995 by federally qualified health centers which wanted to bring non-profit oversight to Connecticut's Medicaid managed care program. *About Us*, COMMUNITY HEALTH NETWORK OF CONNECTICUT, INC., http://www.chnct.org/ (last visited Mar. 16, 2016).

[34] *See, e.g.*, Connecticut Department of Social Services, *Connecticut Medicaid 101* 65-67 (Jan. 21, 2016), *available at* http://www.ct.gov/dss/lib/dss/connect/Medicaid101January2016.pdf; DSS, *Précis* at 3, 5.

[35] DSS, *Précis* at 6. In addition to the ASOs, Hewlett Packard provides support to the Connecticut Medicaid program by acting as a Fiscal Agent. In this role, Hewlett Packard is responsible for a variety of tasks, including processing claims, issuing payments, performing provider enrollment, providing a client assistance call center, and providing a pharmacy prior authorization service. *See* CMAP, PROVIDER MANUAL at 13.

[36] DSS *Précis* at 13; stakeholder interview.

[37] DSS, *Précis* at 13.

[38] DSS, *Précis* at 6.

[39] DSS, *Précis* at 6; stakeholder interview.

[40] DSS, *Précis* at 9.

[41] DSS, *Précis* at 9-11.

[42] DSS, *Précis* at 10.

[43] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § S.10 (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[44] Stakeholder interview.

[45] Stakeholder interview.

[46] Stakeholder interview.

[47] Stakeholder interview.

[48] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § N (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[49] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § N.2.2 (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[50] CONN. GEN. STAT. ANN. §17b-28 (West 2016); *see also About the Council*, COUNCIL ON MEDICAL ASSISTANCE PROGRAM OVERSIGHT, http://www.cga.ct.gov/med/default.asp (last visited Mar. 16, 2016).

[51] CONN. GEN. STAT. ANN. §17b-28 (West 2016).

[52] CONN. GEN. STAT. ANN. §17b-28 (West 2016).

[53] CONN. GEN. STAT. ANN. §17b-28 (West 2016).

[54] *About the Council*, COUNCIL ON MEDICAL ASSISTANCE PROGRAM OVERSIGHT, http://www.cga.ct.gov/med/default.asp (last visited Mar. 16, 2016).

[55] Stakeholder interview.

[56] Stakeholder interview.

[57] Stakeholder interview. The times and locations of MAPOC meetings can be found on the Council's website. *See Council Meetings & Presentations*, COUNCIL ON MEDICAL ASSISTANCE PROGRAM OVERSIGHT, https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2016 (last visited Mar. 17, 2016). Videos of the meetings can be found on the Connecticut Network's website. *See CT-N Online Media Files (On-Demand)*, CONNECTICUT NETWORK, http://www.ctn.state.ct.us/ondemand.asp (last visited Mar. 17, 2016).

[58] Stakeholder interview.

[59] Stakeholder interview.

[60] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § X (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[61] Stakeholder interview; Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § X (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[62] Stakeholder interview.

[63] *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/ (last visited Mar. 17, 2015). Note that federal match is higher for those patients in the Medicaid expansion population, with 100% federal

funding for the first three years of implementation (beginning in 2014), and then federal funding lowering to 90% by 2020. *See Affordable Care Act: Provisions: Financing*, MEDICAID.GOV, https://www.medicaid.gov/affordablecareact/provisions/financing.html (last visited Mar. 17, 2016).

[64] *State Innovation Models Initiative: Model Design Awards Round One*, CMS.GOV, http://innovation.cms.gov/initiatives/state-innovations-model-design/ (last visited Mar. 17, 2016) (noting that Connecticut received $2,852,335 in Round 1 funding); Centers for Medicare and Medicaid Services; *State Innovation Models Initiative: Model Design Awards Round 2*, CMS.GOV, http://innovation.cms.gov/initiatives/state-innovations-model-testing-round-two/ (last visited Mar. 17, 2016) (noting that Connecticut would receive up to $45 million dispersed over 48 months in Round 2 funding).

[65] *MIPCD: The States Awarded*, CMS.GOV, http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html (last visited Mar. 17, 2016) (noting that Connecticut received $703,578 in first year funding for its Incentives to Quit Smoking for Connecticut Medicaid Program).

[66] *Health Care Innovation Awards*, CMS.GOV, https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Connecticut.html (last visited Mar. 17, 2016) (identifying three projects impacting Connecticut).

[67] The Balancing Incentive Program increases the amount of the FMAP to states that make improvements to access to non-institutional long-term services and supports (LTSS). States must use the increased payments to provide new or enhanced home and community based LTSS or pay for related infrastructure. *Balancing Incentive Program*, MEDICAID.GOV, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Balancing-Incentive-Program.html (last visited Mar. 17, 2016).

[68] DSS, *Précis* at 3, 5.

[69] DSS, *Précis* at 6.

[70] *See* Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § BB (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf; DSS, *Précis* at 5.

[71] DSS, *Précis* at 5.

[72] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § Y (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[73] DSS, *Précis* at 5; *see also* Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § Y (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[74] Connecticut Department of Social Services, *Administrative Service Organization Contract* Part I, § Y (Oct. 14, 2011), *available at* http://www.ct.gov/dss/lib/dss/11DSS1202GQ_MED_Community_Health_Network.pdf.

[75] *See* Christine Vestal, *Connecticut Revisits Old-School Medicaid Financing*, THE PEW CHARITABLE TRUSTS: STATELINE (Apr. 8, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing; DSS, *Précis* at 10 (noting that DSS has made reports available to primary care practices detailing performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures for the practice's attributed patients).

[76] DSS, *Précis* at 6.

[77] Stakeholder interview; DSS *Précis* at 13; Christine Vestal, *Connecticut Revisits Old-School Medicaid Financing*, THE PEW CHARITABLE TRUSTS: STATELINE (Apr. 8, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/04/08/connecticut-revisits-oldschool-medicaid-financing.

[78] *Husky Health Person-Centered Medical Home*, HUSKY HEALTH CONNECT, http://www.huskyhealthct.org/providers/pcmh.html (last visited Mar. 17, 2016).

[79] Stakeholder interview; DSS, *Précis* at 13; *PCMH Enhanced Reimbursement Summary*, Husky Health Connecticut, *available at* http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Reimbursement_Summary.pdf.

[80] *PCMH Enhanced Reimbursement Summary*, Husky Health Connecticut, *available at* http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Reimbursement_Summary.pdf; *PCMH Performance-Based Payment Program*, Husky Health Connecticut, *available at* http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Performance-Based_Payment_Program.pdf.

[81] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 23 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[82] *Connecticut*, MEDICAID.GOV, https://www.medicaid.gov/medicaid-chip-program-information/by-state/connecticut.html (last visited Mar. 17, 2016).

[83] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 27 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[84] DSS, *Précis* at 1.

[85] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 30-31 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf; DSS, *Précis* at 1-2.

[86] DSS, *Précis* at 1.

[87] DSS, *Précis* at 14. Note though, that these numbers likely also reflect increased interest due to the increase in payments to primary care providers in 2013 and 2014 under the Affordable Care Act. *See Provider Payments*, MEDICAID.GOV, https://www.medicaid.gov/affordablecareact/provisions/provider-payments.html (last visited Mar. 17, 2016).

[88] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 22 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[89] DSS, *Précis* at 8.

[90] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 35 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[91] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 36 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[92] *Overview of the Medicaid Quality Improvement and Shared Savings Program*, Connecticut Department of Social Services 37 (presented Oct. 9, 2015 to the Healthcare Innovation Steering Committee), *available at* http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-10-08/hisc_mqissp_overview_10082015.pdf.

[93] MinnesotaCare is a health care program for low-income residents of Minnesota who do not qualify for Medicare or Medicaid and lack other affordable coverage. *See MinnesotaCare*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp (last visited Mar. 17, 2016).

[94] *See Integrated Health Partnerships (IHP) Overview*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441 (last visited Mar. 17, 2016).

[95] *Managed Care in Minnesota*, Centers for Medicare & Medicaid Services (Aug. 2014), *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/minnesota-mcp.pdf.

[96] *Managed Care in Minnesota*, Centers for Medicare & Medicaid Services (Aug. 2014), *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/minnesota-mcp.pdf.

[97] Donna Spencer, Kristin Dybdal, & Katherine Johnson, *Stakeholder Analysis of Medicaid Competitive Bidding in Minnesota: Final Report*, STATE HEALTH ACCESS DATA ASSISTANCE CENTER (SHADAC) 5 (Oct. 8, 2012), *available at* http://archive.leg.state.mn.us/docs/2014/mandated/140686.pdf.

[98] *State Health Care Contracting Reforms Save Taxpayers $650 million*, Office of the Governor, Mark Dayton and Tina Smith, Lt. Governor (July 28, 2015), https://mn.gov/governor/newsroom/#/detail/appId/1/id/100406.

[99] Spencer et al., *supra* note 97, at 7.

[100] *State Health Care Contracting Reforms Save Taxpayers $650 million*, Office of the Governor, Mark Dayton and Tina Smith, Lt. Governor (July 28, 2015), https://mn.gov/governor/newsroom/#/detail/appId/1/id/100406.

[101] Spencer et al., *supra* note 97, at 7.

[102] Spencer et al., *supra* note 97, at 7, 9.

[103] Spencer et al., *supra* note 97, at 9.

[104] Spencer et al., *supra* note 97, at 10-11.

[105] Spencer et al., *supra* note 97, at 11.

[106] *Compare Managed Care Enrollment Figures, December 2015*, Minnesota Department of Human Services (Dec. 2015), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_198559 *with Managed Care Enrollment Figures, March 2016*, Minnesota Department of Human Services (Mar. 2016), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs-285930.

[107] MINN. STAT. ANN. § 256B.0755 (West 2015).

[108] Kristin Dybdal, Lynn Blewett, Julie Sonier, & Donna Spencer, *Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States*, STATE HEALTH ACCESS DATA ASSISTANCE CENTER (SHADAC) 17 (Feb. 2014), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_182844.

[109] The RFP serves as a guide for helping health care delivery systems qualify as IHPs and also contains a sample contract between the Minnesota DHS and IHPs to provide services. DHS periodically revises the RFP, with the last revision in December, 2015. *See infra*, note 110.

[110] *Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration*, Minnesota Department of Human Services Health Care Administration 4 (revised Dec. 7, 2015), *available at* http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_198458.pdf [hereinafter "Request for Proposals"].

[111] Request for Proposals, *supra* note 110, at 5.

[112] Specific groups excluded from IHPs include recipients who are dually eligible for Medicare, individuals who are Qualified Medicare Beneficiaries, individuals who are Service Limited Medicare Beneficiaries, recipients who receive Medical Assistance under the Refugee Assistance Program, non-citizen recipients of emergency Medical Assistance, recipients receiving Medical Assistance on a spend-down basis, MinnesotaCare recipients who are enrolled in the Healthy Minnesota Contribution Program, recipients that may receive some state assistance but have cost-effective employer-sponsored private insurance, and individuals who receive private insurance through an HMO. *See* Request for Proposals, *supra* note 110, at 5-6.

[113] Dybdal et al., *supra* note 108, at 19.

[114] Dybdal et al., *supra* note 108, at 19-20.

[115] Dybdal et al., *supra* note 108, at 19.

[116] Request for Proposals, *supra* note 110, at 13.

[117] Request for Proposals, *supra* note 110, at 13.

[118] Request for Proposals, *supra* note 110, at 13.

[119] *See* Request for Proposals, *supra* note 110, Appendix B, at 71; Minnesota Department of Human Services, *Contract for Medical Assistance and MinnesotaCare Services*, Art. 4.9.2 (Jan. 1, 2016), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_174194.

[120] Request for Proposals, *supra* note 110, at 11.

[121] Request for Proposals, *supra* note 110, at 11.

[122] Request for Proposals, *supra* note 110, at 8.

[123] Chart drawn by author, Harvard Center for Health Law and Policy Innovation.

[124] Stakeholder interview.

[125] *Integrated Health Partnerships Demonstration: Request for Proposals (RFP) Questions*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_195674#qualitymeasures (last visited Mar. 18, 2016) (noting that DHS anticipates that some IHPs will choose to continue in the demonstration beyond this initial three year period).

[126] Request for Proposals, *supra* note 110, at 8, 11.

[127] *See* Request for Proposals, *supra* note 110, at 9-11; stakeholder interview.

[128] Stakeholder interview.

[129] Dybdal, et al., *supra* note 108, at 19.

[130] Request for Proposals, *supra* note 110, at 12.

[131] "A 'health care home,' also called a 'medical home,' is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for

individuals with chronic health conditions and disabilities." *See Health Care Homes*, MINNESOTA DEPARTMENT OF HEALTH, http://www.health.state.mn.us/healthreform/homes/ (last visited Mar. 18, 2016).

[132] Request for Proposals, *supra* note 110, at 12.

[133] Specifically, patients can be attributed based upon the number of Evaluation and Management visits they have with primary care providers in the IHP. Request for Proposals, *supra* note 110, at 12.

[134] Specifically, patients can be attributed based upon the number of Evaluation and Management visits they have with specialty providers in the IHP. Request for Proposals, *supra* note 110, at 12

[135] Request for Proposals, *supra* note 110, at 12.

[136] Stakeholder interview.

[137] Stakeholder interview.

[138] Request for Proposals, *supra* note 110, at 8.

[139] Stakeholder interview.

[140] Request for Proposals, *supra* note 110, at 8-9.

[141] Request for Proposals, *supra* note 110, at 9.

[142] Request for Proposals, *supra* note 110, at 9.

[143] Request for Proposals, *supra* note 110, at 9.

[144] Request for Proposals, *supra* note 110, at 9.

[145] Request for Proposals, *supra* note 110, at 9.

[146] Request for Proposals, *supra* note 110, at 10.

[147] Note that the Target TCOC is adjusted at the end of the performance period based to account for any changes in relative risk of the attributed population. This adjusted Target TCOC is used for determining shared savings or losses. *See* Request for Proposals, *supra* note 110, at 10.

[148] Request for Proposals, *supra* note 110, at 10.

[149] Request for Proposals, *supra* note 110, at 11.

[150] Request for Proposals, *supra* note 110, at 11.

[151] Unless otherwise specified, all information in this table can be found at: Request for Proposals, *supra* note 110, at 11.

[152] Request for Proposals, *supra* note 110, at 18, 99.

[153] Stakeholder interview.

[154] Request for Proposals, *supra* note 110, at 12, 125.

[155] Dybdal, et al., *supra* note 108, at 23; Request for Proposals, *supra* note 110, at 12.

[156] Request for Proposals, *supra* note 110, at 120-124.

[157] Stakeholder interview.

[158] Request for Proposals, *supra* note 110, at 12, 125.

[159] Request for Proposals, *supra* note 110, at 125-29.

[160] Stakeholder interview.

[161] Stakeholder interview.

[162] *Minnesota's Nation-Leading Medicaid Reform Initiative Delivers $10.5 Million in Savings During First Year*, Office of Governor Mark Dayton and Lt. Governor Tina Smith (July 14, 2014), http://mn.gov/governor/newsroom/#/detail/appId/1/id/99254.

[163] Stakeholder interview.

[164] *State Innovative Models Initiative: Model Test Awards Round One*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, http://innovation.cms.gov/initiatives/state-innovations-model-testing/ (last visited Mar. 18, 2016).

[165] Request for Proposals, *supra* note 110, at 7, 67.

[166] Note that this is not the full list of services included in the TCOC. For a full list, see Request for Proposals, *supra* note 110, at 101.

[167] Request for Proposals, *supra* note 110, at 7.

[168] *Integrated Health Partnerships (IHP) Overview*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441 (last visited Mar. 18, 2016).

[169] *Integrated Health Partnerships (IHP) Overview*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441 (last visited Mar. 18, 2016).

[170] *Integrated Health Partnerships (IHP) Overview*, MINNESOTA DEPARTMENT OF HUMAN SERVICES, http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441 (last visited Mar. 18, 2016).

[171] *See Total Monthly Medicaid and CHIP Enrollment,* THE HENRY J. KAISER FAMILY FOUNDATION (Nov. 2015), http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?state=MN (last visited Mar. 18, 2016) (listing Minnesota's full Medicaid/CHIP enrollment as 1,047,832 as of December 2015).

[172] *Innovative Reform Initiative Now Serves More than 340,000 Minnesotans in Public Health Care Programs*, Minnesota Department of Human Services (Feb. 22, 2016), http://mn.gov/dhs/media/news/news-detail.jsp?id=252-178793.

[173] *Minnesota's Medicaid Reform Initiative Saves $61.5 Million in 2nd Year*, Minnesota Department of Human Services (June 19, 2015), http://mn.gov/dhs/media/news/news-detail.jsp?id=252-166076.

[174] *Minnesota's Medicaid Reform Initiative Saves $61.5 Million in 2nd Year*, Minnesota Department of Human Services (June 19, 2015), http://mn.gov/dhs/media/news/news-detail.jsp?id=252-166076.

[175] *Minnesota's Medicaid Reform Initiative Saves $61.5 Million in 2nd Year*, Minnesota Department of Human Services (June 19, 2015), http://mn.gov/dhs/media/news/news-detail.jsp?id=252-166076.

[176] *Care Organizations, Implementation Proposal*: *HB 3650 Health System Transformation, Oregon Health Policy Board*, Oregon Health Authority, Oregon Health Policy Board, *Coordinated* 1 (Jan. 24, 2012), *available at* http://www.oregon.gov/oha/legactivity/2012/cco-implementation-proposal.pdf [hereinafter "Implementation Proposal"].

[177] *Managed Care in Oregon*, Centers for Medicare and Medicaid Services (Aug. 2014), *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/oregon-mcp.pdf.

[178] *Managed Care in Oregon*, Centers for Medicare and Medicaid Services (Aug. 2014), *available at* http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/oregon-mcp.pdf. (noting that most benefit groups, except childless adults, were required to enroll in managed care, unless they lived in a county where managed care was not available).

[179] *Coordinated Care: The Oregon Difference*, OREGON.GOV, http://www.oregon.gov/oha/OHPB/Pages/health-reform/ccos.aspx (last visited Mar. 19, 2016).

[180] *Coordinated Care: The Oregon Difference*, OREGON.GOV, http://www.oregon.gov/oha/OHPB/Pages/health-reform/ccos.aspx (last visited Mar. 19 2016).

[181] *Summary of 1115 Medicaid Demonstration,* Oregon Health Authority, Office of the Director (July 6, 2012), *available at* http://www.oregon.gov/oha/OHPB/Documents/c, ms-waiver-brief.pdf.

[182] *Coordinated Care: The Oregon Difference*, OREGON.GOV, http://www.oregon.gov/oha/OHPB/Pages/health-reform/ccos.aspx (last visited Mar. 19 2016).

[183] The Affordable Care Act (ACA) and Center for Medicare and Medicaid Innovation (CMMI) both identify ACOs as "mechanisms for achieving cost savings while ensuring high-quality care." Eric C. Stecker, *The Oregon ACO Experiment – Bold Design, Challenging Execution*, 368 NEW ENGLAND J. OF MED., 982-985 (Mar. 2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1214141?viewType=Print&viewClass=Print#ref2.

[184] Eric C. Stecker, *The Oregon ACO Experiment – Bold Design, Challenging Execution*, 368 NEW ENGLAND J. OF MED., 982-985 (Mar. 2013), *available at* http://www.nejm.org/doi/full/10.1056/NEJMp1214141?viewType=Print&viewClass=Print#ref2 (referencing Theresa A. Coughlin and Sabrina Corlette, *ACA Implementation – Monitoring and Tracking: Oregon: Site Visit Report,* ROBERT WOOD JOHNSON FOUNDATION & URBAN INSTITUTE (Mar. 2012), *available at* http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412498-ACA-Implementation-Monitoring-and-Tracking-Oregon-Site-Visit-Report.PDF).

[185] Josh Lemieux, Prashant Shah, & Stephanie Wilson, *ACOs on Steroids: Why the Oregon Experiment Matters*, INTEL CORPORATION: WHITE PAPER SERIES: CARE COORDINATION 3 (2013), *available at* http://www.intel.com/content/dam/www/public/us/en/documents/white-papers/accountable-care-organization-white-paper.pdf.

[186] Josh Lemieux, Prashant Shah, & Stephanie Wilson, *ACOs on Steroids: Why the Oregon Experiment Matters*, INTEL CORPORATION: WHITE PAPER SERIES: CARE COORDINATION 3 (2013), *available at* http://www.intel.com/content/dam/www/public/us/en/documents/white-papers/accountable-care-organization-white-paper.pdf.

[187] Stakeholder interview.

[188] *See* Implementation Proposal, *supra* note 176, at 15.

[189] *Fact Sheet: Updated ABCs of CCOs: The Basics of How Oregon Aims to Transform Health Care*, Oregon Center for Public Policy 1 (Apr. 30, 2012), *available at* http://www.ocpp.org/media/uploads/pdf/2012/04/fs20120430CCOBasicsUpdatedfnl.pdf [hereinafter "Fact Sheet"].

[190] The list includes the major criteria CCOs must meet for approval but is not exhaustive. While some additional requirements are described throughout this section (e.g., Health Information Technology), the waiver contains a comprehensive list required criteria. Unless otherwise specified, all information in the list below is taken from the waiver document and related statute. *See Amended Waiver List and Expenditure Authority Numbers 21-W-00013/10 and 11-W-00160/10,* Centers for Medicare and Medicaid Services 47-50 (amended July 5, 2012), *available at* http://www.oregon.gov/oha/healthplan/DataReportsDocs/July%205,%202012%20through%20June%2030,%202017.pdf [hereinafter "Waiver"]; *see also* 2011 Or. Laws Ch. 602 (authorizing the CCO transformation in Oregon and outlining CCO requirements).

[191] In context of the CCO demonstration, Oregon characterizes an entity as having financial risk "when it assumes risk for Medicaid health care expenses or service delivery either through contractual agreements or resulting from the administration of a global budget." *See* Implementation Proposal, *supra* note 176, at 15-16.

[192] *Community Health Assessments and Community Health Improvement Plans: Guidance for Coordinated Care Organizations*, Oregon Health Authority (May 11, 2012), *available at* https://cco.health.oregon.gov/Documents/resources/CHA-guidance.pdf.

[193] Fact Sheet, *supra* note 189.

[194] Fact Sheet, *supra* note 189.

[195] Stakeholder interview.

[196] *See, e.g.*, *Coordinated Care Organizations*, OREGON.GOV, http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx (last visited Mar. 19, 2016); *Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update*, Oregon Health Authority (Jan. 20, 2016), *available at* http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf.

[197] *See Coordinated Care Organization Service Areas*, Oregon Health Authority (May 2015), *available at* http://www.oregon.gov/oha/news/Documents/CCO%20Service%20Area%20Map%205-19-2015.pdf.

[198] *See* Waiver, *supra* note 190, at 54.

[199] Implementation Proposal, *supra* note 176, at 41.

[200] Implementation Proposal, *supra* note 176, at 41-42.

[201] Implementation Proposal, *supra* note 176, at 41.

[202] Implementation Proposal, *supra* note 176, at 42.

[203] DSHPs are state-funded health programs which are not usually eligible for Medicaid funding (e.g., care for individuals living with mental illness who are not eligible for Medicaid). As part of an 1115 waiver, a state can seek federal Medicaid matching funds for these services. If the federal government agrees to provide these matching funds, the state can use the money it saves to cover the state's share of the 1115 waiver activities (states are obligated to cover these costs under Medicaid financing rules). Alexandra Gates , Robin Rudowitz & Jocelyn Geyer, *An Overview of Delivery System Reform Incentive Payment (DSRIP Waivers)*, The Henry J. Kaiser Family Foundation (Sept. 29, 2014), *available at* http://kff.org/report-section/an-overview-of-delivery-system-reform-incentive-payment-waivers-issue-brief/.

[204] *Oregon's Medicaid Demonstration*, OREGON.GOV, http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx (last visited Mar. 20, 2016); Waiver, *supra* note 190, at 69-73.

[205] Waiver, *supra* note 190, at 66.

[206] *Summary of 1115 Medicaid Demonstration*, Oregon Health Authority, Office of the Director (July 6, 2012), *available at* http://www.oregon.gov/oha/OHPB/Documents/cms-waiver-brief.pdf.

[207] Stakeholder interview.

[208] Stakeholder interview.

[209] Fact Sheet, *supra* note 189.

[210] Stakeholder interview.

[211] *See generally* Fact Sheet, *supra* note 189.

[212] Stakeholder interview.

[213] *See* Waiver, *supra* note 190, at 55; Fact Sheet, *supra* note 189.

[214] *See* Fact Sheet, *supra* note 189.

[215] *Summary of 1115 Medicaid Demonstration*, Oregon Health Authority, Office of the Director (July 6, 2012), *available at* http://www.oregon.gov/oha/OHPB/Documents/cms-waiver-brief.pdf.

[216] *See* Fact Sheet, *supra* note 189; Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit C (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf. A stakeholder noted, however, that exceeding Global Budget allowances is unlikely due to quarterly reporting to the state. If the provision of

health services will clearly extend beyond a CCO's Global Budget, the state may increase a CCO's funding. *See* stakeholder interview.

[217] Waiver, *supra* note 190, at 245; *See also 2015 Quality Pool Reference Instructions*, Oregon Health Authority (Sept. 14, 2015), *available at* http://www.oregon.gov/oha/analytics/CCOData/2015%20Quality%20Pool%20Methodology.pdf.

[218] These metrics include: (1) adolescent well care visits; (2) alcohol and drug misuse (Screening, Brief Intervention, and Referral to Treatment (SBIRT)); (3) ambulatory care: emergency department utilization; (4) Consumer Assessment of Healthcare Providers and Systems (CAHPS) composite: access to care; (5) CAHPS composite: satisfaction with care; (6) colorectal cancer screening; (7) controlling hypertension; (8) dental sealants on permanent molars for children; (9) depression screening and follow up; (10) developmental screening; (11) diabetes: HbA1c poor control; (12) effective contraceptive use; (13) electronic health record adoption; (14) follow up after hospitalization for mental illness; (15) mental, physical, and dental health assessments for children in DHS custody; (16) Patient Centered Primary Care Home enrollment; (17) timeliness of prenatal care. *See 2015 CCO Incentive Measure Benchmarks*, Oregon Health Authority, Office of Health Analytics (Jan. 2016), *available at* http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx.

[219] *2015 Quality Pool Reference Instructions*, Oregon Health Authority (Sept. 14, 2015), *available at* http://www.oregon.gov/oha/analytics/CCOData/2015%20Quality%20Pool%20Methodology.pdf.

[220] Waiver, *supra* note 190, at 245.

[221] *2015 Quality Pool Reference Instructions*, Oregon Health Authority (Sept. 14, 2015), *available at* http://www.oregon.gov/oha/analytics/CCOData/2015%20Quality%20Pool%20Methodology.pdf.

[222] *2014 Quality Pool Reference Instructions*, Oregon Health Authority (revised Mar. 19, 2015), *available at* http://www.oregon.gov/oha/analytics/CCOData/2014%20Reference%20Instructions.pdf.

[223] Note that the Executive Summary of the report states that only ten of the fifteen CCOs met 100 percent of their improvement targets, but the graph of "Percent of 2013 Quality Pool: Phase One Distribution Earned," lists eleven of fifteen CCOs as receiving 100 percent of quality pool funds. This discrepancy may have to do with the fact that one of the CCOs, Cascade Health Alliance, was only operating as a CCO for part of the year. *Oregon's Health System Transformation: 2013 Performance Report*, Oregon Health Authority, Office of Health Analytics 3 (June 24, 2014), *available at* http://res.cloudinary.com/bdy4ger4/image/upload/v1403624810/2013PerformanceReport_tpouzo.pdf.

[224] *Oregon's Health System Transformation: 2014 Final Report*, Oregon Health Authority, Office of Health Analytics 1, 5 (June 24, 2015), *available at* http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf.

[225] Stakeholder interview.

[226] Stakeholder interview.

[227] 2009 Oregon House Bill No. 2009.

[228] *See Standards and Measures for Patient Centered Primary Care Homes*, Oregon Health Authority, Office for Oregon Health Policy and Research 1 (Nov. 2010), *available at* https://www.oregon.gov/oha/action-plan/pcpch-report.pdf.

[229] Steven W. Howard, Stephanie L. Bernell, Jangho Yoon, Jeff Luck & Claire M. Ranit, *Oregon's Experiment in Health Care Delivery and Payment Reform: Coordinated Care Organizations Replacing Managed Care*, 40 J. OF HEALTH POLITICS, POLICY AND LAW 245, 246, 250 (Feb. 2015).

[230] Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 4(a) (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[231] *2015 Quality Pool Reference Instructions*, Oregon Health Authority (Sept. 14, 2015), *available at* http://www.oregon.gov/oha/analytics/CCOData/2015%20Quality%20Pool%20Methodology.pdf.

[232] Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 2(l), Pt. 4(c)(1) (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[233] Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 2(p), Pt. 4(c)(1) (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[234] Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 4(c)(2) (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[235] Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 4(c)(3) (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[236] Waiver, *supra* note 190, at 49.

[237] Waiver, *supra* note 190, at 49; Oregon Health Authority, *Oregon Health Plan Amended and Restated Health Plan Services Contract* Exhibit B, Pt. 7 (Jan. 1, 2016), *available at* https://www.oregon.gov/oha/OHPB/docs/2016_CCO_Model_Contract.pdf.

[238] *Oregon's Health System Transformation: Annual Update*, Oregon Health Authority 1-2 (Jan. 2016), *available at* http://www.oregon.gov/oha/Metrics/Documents/HST%20Annual%20Report%20-%202016.pdf.

[239] *Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update*, Oregon Health Authority 1 (Jan. 20, 2016), *available at* http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf.

[240] *Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update*, Oregon Health Authority 2 (Jan. 20, 2016), *available at* http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf.

[241] 42 C.F.R. § 431.12 (2014).

[242] We acknowledge, however, that a competitive process is not always ideal in all states. For example, Oregon recognized that in order to foster participation in its innovative model, it initially needed to adopt a very expansive approach to procurement. In such states, it is particularly important to ensure that the actual contract with the managed care entities contains strong quality requirements to make up for the lack of competition.