Community Based Integrated Health Care Delivery in Idaho

A Managed Care Model for the Idaho Medicaid Program

Background: Over the past several years, Idaho's Medicaid program has experienced unsustainable growth in participants and costs at a time when budget pressures have been severe. In addition to this recent growth, Medicaid eligibility provisions defined in the Patient Protection and Affordable Care Act (PPACA) will add between 100,000 and 160,000 more participants to the state's Medicaid program in 2014. The current design of the state's Medicaid program, which is primarily based on fee for service arrangements, "...does not provide appropriate incentives and can be improved by incorporating managed care tools..." (Idaho State Code 56-261(1)).

Through House Bill 260, the 2011 Idaho Legislature directed the Department of Health and Welfare (DHW) to begin studying Medicaid managed care options. The direction from the Legislature is to improve the current health care delivery system by incorporating managed care tools, including contracting based on gain sharing, risk-sharing or a capitated basis, with the objective of moving towards an accountable system of care that results in improved health outcomes, increased participant accountability/responsibility for their care, and improved business practices for providers. Additionally, the Legislature directed that a plan for managed care focuses on high cost populations with specific elements that include:

- Medical home development, focusing on populations with chronic diseases using a tiered case management fee;
- Approaches that improve coordination of care for high cost, high risk populations that lead to improved outcomes and lower costs; and
- Elimination of duplicative practices that result in unnecessary utilization and costs.

In December 2011, a managed care forum was jointly hosted by DHW, the Idaho Primary Care Association, Idaho Medical Association, and the Idaho Hospital Association, to begin discussing how Idaho Medicaid could implement managed care. At the forum, providers conveyed a consistent message that reflects the values of a patient centered medical home integrated within the larger health care delivery system. The recommended system of managed care supports an accountable delivery system with improved health outcomes. The foundation should be built on an integrated patient-centered system using electronic medical records to improve care coordination and management.

This private-public collaboration resulted in identifying an opportunity to explore an acclaimed model based on community care. Provider associations and Medicaid jointly applied to the National Academy for State Health Policy (NASHP) for a state transformation grant to adopt or adapt the Community Care of North Carolina (CCNC) model in developing its Medicaid managed care program. North Carolina created a nationally-recognized Medicaid model of primary care networks that support the patient-centered medical home at both the state and local levels.

The Idaho team identified four priority areas in their NASHP application to improve patient outcomes:

- 1. Create evidence-based standards for internal practice management to address the needs of high-risk and high-cost populations statewide, and provide resources to support transformation towards these standards in community settings.
- 2. Establish a model to support medical home integration, with other aspects of the care system to improve health outcomes and access via care management and coordination. The system design must work well in both the urban and rural setting.
- 3. Create a strategy and model for developing an actionable informatics/data system that includes clinical and utilization data to improve health outcomes and reduce costs.
- 4. Create a public policy framework for a community care system to guide implementation of Medicaid Managed Care approaches in Idaho.

The Idaho team's application was accepted and they participated in an intensive two-day workshop to learn about North Carolina's CCNC model. The team studied the North Carolina model to identify how it might be applied in Idaho. The CCNC model has a proven track record of providing better care, with better health outcomes, at reduced costs.

<u>Team Proposal</u>: The team suggests a model of patient care management that would be network-based, supports the needs of primary care practices, and enhances communication and coordination of care throughout the health care continuum. Regional private not-for-profit community care networks would be developed by local Medicaid providers. The regional network would link the local health care system through partnerships with hospitals, primary care providers, county health and social service agencies, and other stakeholders that may vary from network to network.

Patient care would be managed in a primary care setting through patient-centered medical homes. Each Medicaid enrollee would select a primary care provider who provides direct medical care, makes referrals, and coordinates afterhours care. Each local network would hire care managers who assist the primary care providers in coordinating the medical needs of particularly complex patients. The networks would also have to develop a system(s) of informatics that facilitate and support the care of patients throughout the continuum.

<u>Community Care Network Model Goals and Principles:</u> The proposed model would provide community-based and coordinated care with an emphasis on wellness and preventive care for most patients, while emphasizing disease management strategies for individuals with special health needs. The goals of the model are consistent with CMS' "Triple Aim" to provide better care, with better health outcomes, at reduced costs. These goals have also been consistently expressed in various sections of Idaho Code which direct the state's Medicaid program to evolve toward managed care. The concept is built on principles of public/private partnership, long-term commitment, the patient-centered medical home, evidence-based quality improvement, and provider accountability for the care improvement process.

The proposed model incorporates key elements of House Bill 260, including patient-centered medical home, and supports key attributes of a high performance health care delivery system that includes:

- Clinically relevant patient information is available to all providers at the point of care.
- Patient care is coordinated among multiple providers, and transitions across care settings are actively managed.
- Providers (including all members of the health care team) both within and across the care settings are accountable to each other.
- Patients have easy access to appropriate care and information, even after working hours,
- Providers have clear accountability for the total care of patients.
- Members of the system are continuously innovating and learning in order to improve the patient experience and the quality and the value of health care delivery.

Next steps:

- 1. Share conceptual framework for community care network model with key provider organizations and other stakeholders to gauge interest in the approach and build consensus on direction.
- 2. Conduct a comprehensive analysis of the current system to paint a picture of approaches already in place that can support an improvement strategy likely to succeed.
- 3. Identify and gain support of key health leaders.