MEDICAL HOME MODEL REIMBURSEMENT RATES FOR IHS & TRIBAL HEALTH FACILITIES IN ARIZONA

RESOURCE REPORT

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Table of Contents

I. Executive Summary

State Medicaid programs across the United States have been operating medical home model programs since the 1980s. These programs typically have involved linking beneficiaries to primary care providers (PCPs) and paying these providers a per member per month (PMPM) fee for a range of medical home care management activities. The Arizona Health Care Cost Containment System (AHCCCS), which is Arizona's Medicaid program, has determined there is a need to propose to the Centers for Medicare and Medicaid Services (CMS) a viable PMPM reimbursement methodology that would appropriately reimburse the Indian Health Service (IHS) and tribal health facilities, operated under P.L. 93-638 (hereafter referred to as Tribal "638" facilities) in Arizona, for *medical home* programs serving American Indian AHCCCS (Medicaid) members. The reimbursement methodology would include a strong care and case management component, which appropriately addresses the significant health care needs of the American Indian population served by the IHS and 638 facilities in Arizona.

This report examines how other states have developed and implemented enhanced Medicaid medical home model programs, and how these states have created a PMPM reimbursement methodology. The States that have implemented a reimbursement process for care management activities understand that few physician and hospital systems have the resources needed to fully manage and coordinate patient care, especially for chronically ill and disabled patients with complex care needs. The time, staff, information technology resources, and knowledge of social and community support systems that are needed are not being reimbursed by current payment mechanisms. To fill these gaps, states have sought to enhance their Medicaid programs in various ways to supplement the limited ability among most primary care providers to provide care management and care coordination through a medical home based program.

The report recommends a viable PMPM reimbursement methodology that would appropriately reimburse participating IHS and tribal 638 medical home IPC programs serving American Indian AHCCCS (Medicaid) members. AIHMP was able to collaborate with the Indian Health Service Headquarters Office of Resource Access and Partnerships (ORAP) and the Eighteen Nineteen Group, Inc. to develop the proposed $11.83 PMPM flat rate. The proposed PMPM rate is justified by the administrative and staffing costs of medical home IPC programs that include, Public Health Nursing, Community Health, Public Health Nutrition and a Nurse Call Line.

An $11.83 PMPM enhanced patient care payment to IHS and tribal 638 health facilities for IPC medical home programs will assist to expand medical home capacity thereby providing better coordinated care for American Indian AHCCCS beneficiaries here in Arizona. This will directly improve patients' ability to access services, receive better care, saving the system time, money, and best of all, improving health outcomes.

II. Introduction

This project was coordinated through the Arizona Health Care Cost Containment System (AHCCCS) with the assistance of American Indian Health Management & Policy, Inc. (AIHMP), as a result of discussions with IHS and Tribal 638 facilities. IHS and Tribal 638 facilities feel there is a need for additional reimbursement to cover the cost of implementing medical home programs, which in many facilities, have already been implemented through an IHS initiative called Improvements in Patient Care Model (IPC). The aim of the Improving Patient Care Model is to change and improve the Indian Healthcare delivery system across the country. Since 2006 IPC, within Indian Healthcare, has been developing high performing and innovative healthcare programs to improve the quality and access to care for American Indians. The result is a medical home that has set new standards for healthcare delivery and further advancing the health and wellness of the American Indian and Alaska Native people.

Many American Indians in Arizona suffer from significant health disparities and generally live in impoverished conditions. Title XIX of the Social Security Act, the basis for the Medicaid system, authorizes the Centers for Medicare and Medicaid Services (CMS) to provide federal funds to states to pay for healthcare services for the poor. The result is that the American Indian (AI) population in the state of Arizona depends on Medicaid programs as a significant funding source for healthcare services. AIs receive healthcare services from the Indian Health Service (federal program), Tribal health programs, Urban Indian Health Centers and from the private sector. The Medicaid programs represent a significant payer of these services

In 2010 the Tucson Area IHS submitted a draft waiver proposal for review by AHCCCS and CMS which described the types of care management activities that should be reimbursed to the San Xavier Health Center in Tucson, Arizona on a per member/per month (PMPM) basis. CMS raised a number of questions regarding the scope of the population served, the formulation of the reimbursement methodology, coordination of services, and the measurable data/outcomes that would evaluate the program. Furthermore, CMS believed a demonstration waiver likely was unnecessary to pursue such a program if the program was already being implemented. AHCCCS understood that other states may have requested authority in some form, to reimburse Medicaid providers for medical home based programs, but it was uncertain which states these were and what, if any, authority was granted in those states. Whether Arizona needs to obtain authority to pay for medical home programs of IHS and 638 facilities through a waiver or state plan amendment, is addressed in this report.

The report will make a brief assessment of the need for reimbursement of medical home programs, justified by the American Indian health disparities in Arizona and underfunding of the Indian Healthcare delivery system. The report will outline the uniqueness of IHS and Tribal 638 facility Medicaid interaction in Arizona, the direct reimbursement relationship between AHCCCS and IHS/638 facilities, and the importance of IHS/638 facilities increasing and expanding services for a population with significant health care needs.

III. Overview of Arizona American Indian Healthcare Environment

a. American Indian Demographics in Arizona

Arizona is home to approximately 277,732 American Indians, nearly half of who are enrolled in AHCCCS. Arizona has the seventh largest American Indian population in the nation. Whereas American Indians account for approximately 1% of the United States population, they account for approximately 5% of the Arizona population and 11% of the AHCCCS Medicaid member population. Nearly one-half of the state's American Indians are enrolled in AHCCCS, creating opportunities for the State Medicaid agency to promote policies and deliver health care that positively impacts the future of this population.

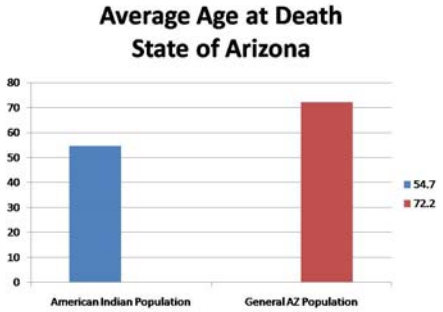
Native American (NA) Population Distribution: US vs. Arizona vs. AHCCCS

Race	United States		Arizona		AHCCCS	
	Number	Percent	Number	Percent	Number	Percent
NA	2,357,544	1%	275,321	5%	114,744	11%
Non-NA	286,020,593	99%	5,544,518	95%	915,127	89%
Total	288,378,137	100%	5,819,839	100%	1,029,871	100%

Considerable health disparities exist between the American Indian (AI) and the general US population. The roots of health disparities for AI people are multi-faceted; low incomes, inadequate housing, substandard educational systems, under-funded reservation schools without physical education programs or healthy food programs, poor nutrition and cultural factors contribute to these disparities. These factors coupled with a severely under funded health care system have led to decreased access to healthcare services and to the highest incidence of preventable diseases in the country. For example, the actual delivery of American Indian health services is frequently divided between multiple providers, fragmenting the continuum of care and disrupting the flow of important health information.

Provision of healthcare services for American Indians presents a complex interaction of federal, state, Tribal and other programs with diverse funding streams and systems of governance. The result is that there are multiple systems of Indian Health with a great degree of variability among IHS regions, States and Tribes

In the State of Arizona, the average age at death is 72.2 years for the general population, and is only 54.7 years for AIs.[1] .[2]

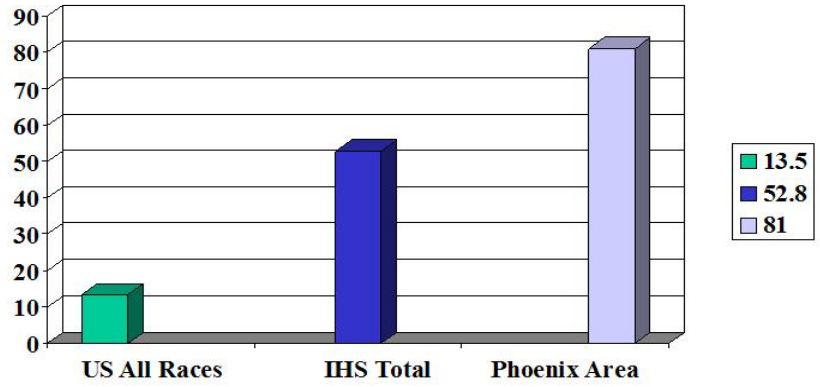


[1] *Differences in the Health Status Among Ethnic Groups: Arizona 2003,* Arizona Department of Health Services, 2005
[2] *Differences in the Health Status Among Ethnic Groups: Arizona 2003,* Arizona Department of Health Services, 2005

Preventable diseases impact American Indian populations at a far greater rate than the rest of the general population. Death rates from preventable diseases within the American Indian (AI) population is significantly greater than among non-Indians, including: Diabetes 249% greater; Alcoholism 627% greater; Accidents 204% greater; Suicide 72% greater.[3] In the Phoenix Area of the Indian Health Service, encompassing most of Arizona as well as Utah and Nevada, the rates of death due to diabetes and alcoholism are even worse than the rest of the Indian Health Service (IHS). High rates of diabetes, subsequent depression and alcoholism create a significant need for effective behavioral health programs and interventions. At the same time, the policy framework for addressing this inequity is quite complex, and the level of care provided to American Indian communities is lower, in terms of per capita funding and provision of services, compared to other groups in the United States.

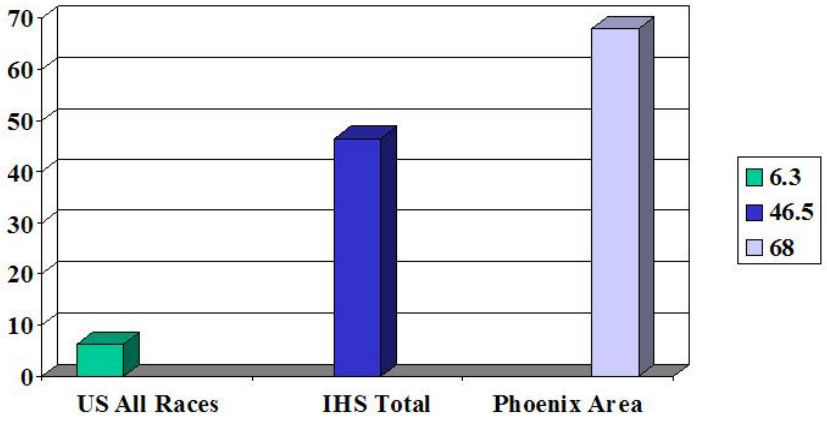
Diabetes Death Rates

(Deaths per 100,000 Population)



Alcohol Related Death Rates

(Deaths per 100,000 Population)

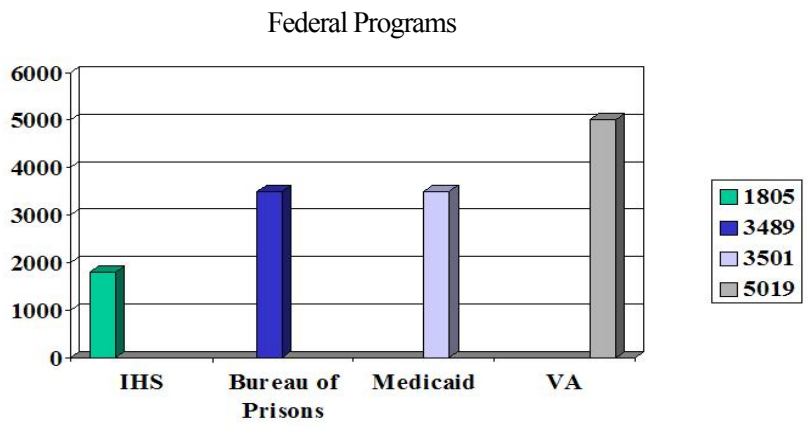


Per capita expenditures in the 2003 federal budget for AI people receiving healthcare services from IHS were $1,805. In contrast, the per capita medical expenditure for Medicaid recipients was $3,501, and for VA beneficiaries the per capita expenditure was $5,019. The per capita medical expenditures for federal

[3] *Trends in Indian Health.* Indian Health Service. 2000.

inmates in the Bureau of Prisons were $3,489 - nearly double the per capita medical expenditure for American Indians.[4] Limitations in funding and historically inadequate third-party billing have led to decreased access to healthcare services for the AI population.

Per Capita Healthcare Expenditures



Healthcare and health policy issues are not the only areas in which disparities exist, for example: high school graduation rates among American Indians is 65% compared to 75% for the general US population; 32% of the AI population live below the federal poverty level as compared to 13% among non-Indians.[5] But, health status and outcomes are highly correlated to education and income[6], making these socioeconomic markers significant factors in AI public health, and health care is among the top issues of concern to American Indian communities.

It is also important to note that there is no single American Indian culture, and that each tribe is different in terms of governance, cultural perspective and health needs.

b. Indian Health Service

The origins of the Indian Health Service began in the early 1800's under what was at that time called the Department of War. It was the role of Army physicians to work at military outposts to contain the spread of contagious diseases like small pox and measles. Beginning in 1832, the federal government began establishing a trust responsibility through treaties with Tribes to provide healthcare, housing and education to American Indians in exchange for land and natural resources. In 1955, the Indian Health Service (IHS) in its current form was established under the Department of Health Education and Welfare, now the Department of Health and Human Services (DHHS).[7] American Indian healthcare continues under this structure today, with some significant modifications including increasing tribal control of healthcare programs, services and functions, as well as greater integration with Medicare and Medicaid.

The Indian Health Service is divided into twelve regions ("Areas") throughout the country (see map). IHS Headquarters is located in the Washington DC area in Rockville, MD:

[4] Issue Alert January 31, 2003. National Indian Health Board. Denver, CO.
[5] *Regional Differences in Indian Health.* Indian Health Service. 2000-2001
[6] Deaton A. Policy Implications of the Gradient of Health and Wealth. *Health Affairs,* March/April 2002:13-30
[7] *The Indian Health Program.* U.S. Department of Health and Human Services. DHHS Publication No. (HAS) 80-1003. 1980.

Indian Health Service
Twelve Areas

According to the Indian Health Service Strategic Plan (2000)[8]:

- The mission of the Indian Health Service, in partnership with American Indian and Alaska Native (AI/AN) people, is to raise their physical, mental, social and spiritual health to the highest level.
- The goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to AI/AN people.
- The foundation is to uphold the federal government's obligation to promote healthy AI/AN people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes.

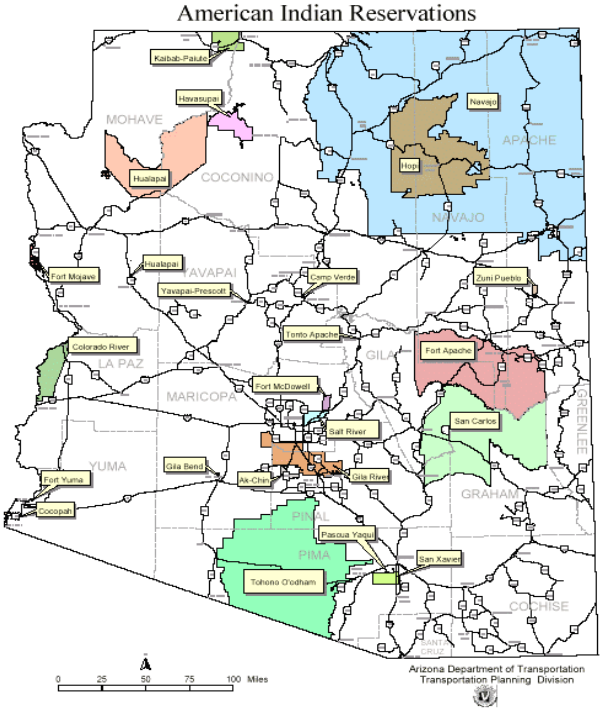
c. Indian Self Determination & Education Assistance Act of 1975 (PL 93-638)

Perhaps the most significant law affecting the provision of health services to the AI population is the Indian Self Determination and Education Assistance Act of 1975 (PL 93-638) that allows Tribes to assume control of healthcare programs from IHS and to increase flexibility in healthcare program development. Under PL 93-638, Tribes are given the option to contract (Title I) or compact (Title V) with the IHS to deliver health services using pre-existing IHS resources (a formula-based shares table determines funding for various IHS sites), third party reimbursement, grants and other sources. Typically, tribes develop their own non-profit healthcare corporations to provide services to their community, and are eligible for grants and other types of funding not available to federal agencies like IHS.

As a result, "638 Tribes" generally are able to provide more services in their communities than they were able to under IHS control due to increased revenue and access to grants. Currently, over half the IHS budget goes to 638 programs, and numerous tribes have improved access to healthcare services and have increased flexibility of health programming for their communities.

In the State of Arizona, there are 22 federally recognized American Indian Tribes, each with their own cultures and systems of government, and there is a mixture of IHS directly provided services and Tribally managed programs.

[8] *The IHS Strategic Plan: Improving the Health of American Indian and Alaska Native People Through Collaboration and Innovation.* Indian Health Service. 2000.



d. Urban Indian Health Programs

Approximately 60% of American Indians live in urban settings. The trend toward urban settings and away from reservations is rooted in a series of federal policies geared toward integration and assimilation. In the 1930s and 1950s the federal government offered incentives for American Indians to move to cities to find employment and to "assimilate" into mainstream American culture. Phoenix was among many cities that were intended to be a welcoming location for the American Indian population to integrate into. Unfortunately, discrimination and other factors led to continued high rates of unemployment for the urban Indian population.

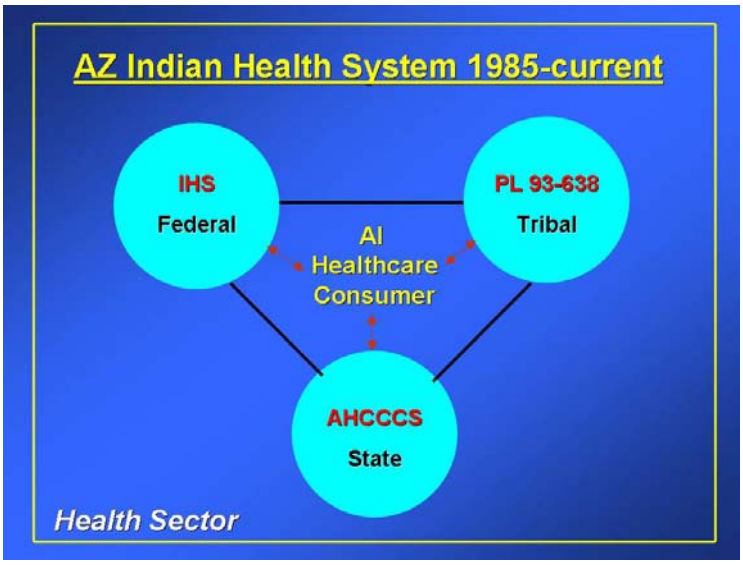
Currently, many American Indians move to the cities for educational and employment opportunities. When individuals move from the reservation into the city, they do not give up their right to healthcare services from the federal government. In 1976, as part of the Indian Health Care Improvement Act, a funding mechanism was developed to establish Urban Indian Health Centers (UIHC). Although passed in 1975, the Indian Health Care Improvement Act was due for reauthorization in 2000, and was only recently reauthorized in 2010 as part of the President's Affordable Care Act. In the then President's budget proposal for 2007, he proposed eliminating the UIHC program. However, Urban Indian Health Programs along with support from Tribes lobbied for continued funding which was reinstated.

Although approximately 60% of the American Indian population lives in urban settings, UIHCs receive only about 1% of the IHS budget. As a result, the UIHCs have had to become diligent regarding their relationships with Medicaid and maximizing third party revenue.

Numerous behavioral health programs that are utilized by tribal members are located in urban settings. For example, Native American Connections, Native Health, Inc., Phoenix Indian Center and NDNS4Wellness are all located in Phoenix, Arizona, and all provide American Indian specific behavioral health programs as well as other health related services.

e. "I/T/U"-Medicaid Interaction

The Indian Health Service, established in its current form in 1955, was developed prior to Medicare, Medicaid, Managed Care, HMOs and before the development of numerous medical specialties. The health sector was quite different fifty-six years ago, and the IHS has not evolved as quickly as the rest of the health sector. The result is, a less-than-efficient third party billing and subsequent decrease in access to healthcare services. From a funding perspective, the revenue streams come from three primary governmental sources—federal, state and tribal:



Arizona was the fiftieth state to develop a Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). Although Medicaid law was passed in the 1960s, AHCCCS was not developed and implemented until the mid-1980s. Due to significant under funding of the IHS, the I/T/U system of healthcare delivery has become dependent on their ability to bill Medicaid for services. Additionally, in recent years, due to improving economic development opportunities like casino gaming, many tribes have seen their unemployment rates decrease. Tribes are now able to provide health insurance to their employees, many of whom are tribal members, which in turn creates an opportunity to bill third party insurance through their employers.

AHCCCS services are increasingly important to American Indians in Arizona who meet AHCCCS Medicaid categorical and financial eligibility criteria. This is the case whether they live on or off a reservation and whether or not they are eligible for IHS, Tribal, or Urban (I/T/U) services. In cases where an individual is eligible for both AHCCCS and IHS services, AHCCCS is required to assume responsibility for payment as the primary payer. When an AHCCCS recipient receives a service provided by IHS that is not covered by the AHCCCS benefit package, IHS, as the residual program, is responsible for payment.

The AHCCCS is an entitlement program for which the federal government matches, on an open ended fee-for-service basis, state expenditures for covered services provided to eligible individuals. For American Indian beneficiaries, the federal matching rate is generally 100% for covered services provided in an IHS or tribally-operated "638" facility. Non-IHS Medicaid services are subject to the standard Medicaid match for Arizona. State Children's Health Insurance Program (SCHIP) or KidsCare program are provided at the standard SCHIP Federal Medical Assistance Percentage (FMAP), regardless of venue. American Indians enrolled in KidsCare are not subject to monthly premiums or copayments.

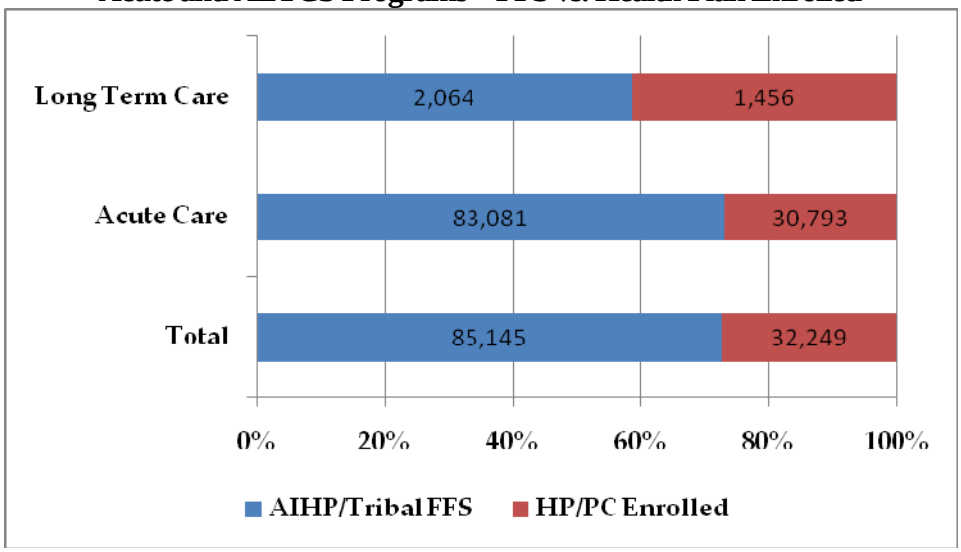
Although a number of states including Arizona operate managed care Medicaid programs, federal Medicaid statutes prohibit states from requiring American Indians to enroll in managed care. Although American Indians have traditionally relied upon IHS for their care, public programs such as Medicare and Medicaid are playing increasingly important roles. These programs support the delivery and financing of health services to individuals residing on or near reservations, as well as to those living in urban areas. In the state of Arizona AHCCCS serves as an:

- An insurance program that covers acute care, including physician, hospital, and other basic health care services for eligible individuals, especially families with children;
- An insurance program that covers behavioral health care, including physician, hospital, therapy, and other basic mental health care services for eligible individuals, especially families with children;
- An insurance program that covers long term care, including physician, hospital, nursing home, and other basic health care services for eligible individuals--especially frail elderly and disabled individuals;
- A source of payment for Indian Health Service (IHS) as well as clinics and hospitals operated by tribes; and
- A source of financial assistance for low-income elderly and disabled individuals in need of assistance to meet Medicare premium and cost-sharing obligations.

AHCCCS also supports a fee-for-service program, through the Division for Fee-for-Service management program, that approves and pays for services provided to AHCCCS members who are not enrolled with an acute care AHCCCS-contracted health plan or a long term care program contractor. American Indian individuals comprise the majority of this fee-for service population. This is primarily due to federal requirements that prohibit states from requiring that American Indian members enroll in managed care and the Indian Health Services inability to enter into risk based contra.cts. Because AHCCCS complies with this requirement, American Indian members are given a choice of enrolling with a contracted acute care health plan or the AHCCCS American Indian Health Program (AIHP)—a fee-for-service (FFS) program formerly known as IHS/AHCCCS. Further, American Indians who elect to enroll in contracted health plans are also allowed to seek and receive care from an IHS facility if and when they choose.

Currently AHCCCS health plans engage in a variety of quality healthcare management activities to identify and manage high-risk members, including those with conditions prevalent among American Indian patients. AHCCCS requires health plans to conduct a health status assessment of all new members. For most plans, this process takes the form of a survey, which assists in the early identification and management of conditions that have the potential to benefit from early intervention. Whereas American Indian patients enrolled in acute care health plans may benefit from identification and management strategies such as the one described above, individuals who elect to enroll with the American Indian Fee-for-Service may forgo some of these advantages. The AHCCCS Division of Fee-for-Service Management program, which provides oversight of the FFS population, is currently an administrative arm of AHCCCS that does not provide direct disease management services.

AHCCCS Distribution of American Indians:
Acute and ALTCS Programs – FFS vs. Health Plan Enrolled



The above figure illustrates that the majority of American Indians in the acute care program, enroll in the AHCCCS fee-for-service program rather than with a contracted health plan. Likewise, the majority of American Indians in ALTCS are enrolled in the tribal ALTCS fee-for-service program rather than with a program contractor. This FFS program population, plus the managed care plan beneficiaries who seek care outside their assigned plan (i.e., from IHS), encounter ongoing challenges related to availability of providers and continuity of care. Which provides an opportunity for this medical home model project to reimburse Indian Healthcare providers to serve an expanded role to provide health plan administration services by applying all of the clinical management tools of the managed care industry, including care coordination, case management, disease state management, health plan benefit administration, utilization review, etc, to administer and manage the fee-for-service AHCCCS Medicaid programs.

IV. Definition of Medical Home Model

Our research uncovered that there are multiple ways to define a medical home. Most states that have implemented a medical home program have adopted the elements, or at least a variation of the elements, presented in the ―Joint Principles of the Patient Centered Medical Home that was released by four major physician groups (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association.[9]

a) Joint Principles of Medical Home Models

In January 2008, the National Committee for Quality Assurance (NCQA) released standards for patient-centered medical homes based on the physician groups' joint principles.[10] These joint principles include the following as characteristics of a medical home:

- A personal physician for each patient to serve as first contact and to provide continuous and comprehensive care.
- Physician-directed medical practice, in that the personal physician leads a team that collectively takes responsibility for patients' ongoing care.
- Whole person orientation – the personal physician is responsible for providing or ensuring access to care with other providers as needed, for all types of care and at all stages of life.
- Care is coordinated and/or integrated across all elements of the health care system and the community.
- Quality and safety are high priorities, with an emphasis on evidence-based medicine, patient involvement in developing care plans and decision making, and reporting on performance measures.
- Enhanced access to care through open scheduling and new methods through which patients, personal physicians, and practice staff may communicate.
- Payment methodologies that recognize care management and coordination happen outside face-to-face visits, support adoption and use of health information technology, establish separate FFS payments for face-to-face visits, allow physicians to share in savings resulting from the medical home model, recognize case-mix differences between practices, and allow incentive/bonus payments for achieving measurable performance standards and quality improvements.

b) Indian Health Experience with Medical Home through IPC

In 2006 the IHS, through the Improvements in Patient Care Model (IPC), developed a partnership with the Institute for Healthcare Improvement (IHI) to use modern improvement methodologies to fundamentally transform the IHS system of care for clinical prevention and for the management of chronic conditions. The ideas that guide this transformation came from the Chronic Care Model (Care Model), developed at the MacColl Institute for Healthcare Innovation, adopted by the World Health Organization and tested and implemented widely in the US and abroad.

[9] available online at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[10] NCQA standards may be ordered online at http://www.ncqa.org/tabid/629/Default.aspx#pcmh

As with the NCQA standard for patient-centered medical homes, the IPC model captures and defines the essential features of a system of care that focuses on the relationship between an informed and activated patient, family, and community and their prepared and proactive health care team. The Indian health system has extensive experience with the Care Model in diabetes care. In the IPC model, the Care Model is applied across conditions, including clinical prevention, for the entire population (see Table 1).

Table 1 – IPC Covers a large set of chronic conditions and clinical prevention activities	
Chronic Disease Management	
Diabetes, Type I and II	Obesity
Cardiovascular Disease	Diet and Behavioral
Uncomplicated Depression	Counseling
Asthma	
Clinical Prevention Activities – Screening	
Depression	Breast Cancer
Obesity	Cervical Cancer
Tobacco Use	Colorectal Cancer
Hypertension	Diabetes
Alcohol Misuse	Dyslipdemia
Domestic Violence	Fall Risk
Preventive Services	
Tobacco Cessation	Dental Fluoride
Immunizations	Dental Sealants

The aim of IPC is to create a patient-centered medical home environment that provides the care American Indian patients deserve and need when they need it. Indian Healthcare programs that have implemented IPC work to empower patients to take an active role in improving their health by providing care that emphasizes prevention and healthy lifestyles. To meet this, IPC programs use a care team approach, which includes partnering with the Tribal communities, community groups, families, and patients to enhance the health of all eligible persons in harmony with their cultural values and customs. The IPC model of care was designed to serve all patients with one or more chronic condition or at high risk for a chronic condition. However, the model has been implemented to include all patients in an attempt to prevent or prolong the onset of chronic conditions.

The emphasis of IPC is designed to encompass the whole person and provide interventions for those patients at highest risk of utilization of medical services. Using the principles of E.H. Wagner and the Chronic Care model, this IPC proposal focuses on three main components: provider practice/delivery system redesign, patient self management, and technology support.

Under the provider practice/delivery system redesign approach, patients are empanelled to medical home provider care teams that take an active role in helping patients make informed health care decisions and access the care they need. Under patient self management, the patient becomes an informed and active participant in the management of his/her health conditions and co-morbidities. Technology is the third foundation of the IPC delivery system which is utilized to identify patients' needs and assists providers in having better access to information. Most IPC programs utilize an electronic health record (EHR) for all outpatient encounters.

c) Why Does Medical Home Model and IPC Make Sense?

The IHS is responsible for the provision of healthcare to enrolled members of federally recognized Tribes either directly or through partnership with Tribal and Urban programs. It is a shared goal of all partners in the Indian Health System to ensure universal access to high quality health care for AI people. The Indian Health System has a long and successful history of addressing acute, infectious diseases and improving health through population-based community approaches to care. The result is a healthcare system with a strong public health infrastructure but also a reliance on systems of care that are provider-centric and geared to deliver acute episodic care. The system is made up of a network of diverse facilities tasked with delivering comprehensive healthcare to diverse populations that are often isolated geographically. In response to local needs, the Indian Health System also differs widely in governance (IHS, Tribal, and Urban), in facility size (from small intermittently staffed health stations to large multi-specialty hospitals), and in geography (from urban to frontier rural). This diverse, diffused system must now address a new challenge.

Chronic conditions have had a tremendous impact on AI communities and their health systems over the last century. AI people now have the highest published rates of Type 2 diabetes in the world and nearly 15% of adults over the age of 20 have diagnosed diabetes.[11] During the decade of the 1990s, diabetes prevalence rates in children and young adults increased by nearly 50% .[12] Coronary heart disease (CHD) rates in AI/AN people now exceed that of other populations and are more likely to be fatal; diseases of the heart are the leading cause of death for AI/AN people 45 years and older.[13] It is clear that the increasing prevalence of chronic conditions contributes to the persistence of significant disparity in the health status and life expectancy of AI/AN people when compared to U.S. All Races.[11] In response to the epidemic, the Indian Health System became an early adopter of protocol driven care with close attention to outcomes, interdisciplinary team care, and strategies to engage patients and communities.

The IHS began the work to address the chronic healthcare conditions within AI communities in 2005 with the launch of the Improvements in Patient Care Model (IPC). The IPC program employs the Model for Improvement and other methods and tools to test and measure change, while activating care teams and customers. Other resources of the Indian Health System are its population-focused primary care base and strong linkages between the health services and community. It also has a robust health information technology infrastructure and a framework for community outreach through Public Health Nursing (PHN), Community Health Representatives (CHR) programs, and Tribal programs such as those developed through the Special Diabetes Program for Indians. All of these assets must be used optimally if the health challenges faced by AI people are to be addressed.

The aim of the IPC collaborative is to improve health and promote wellness for American Indians and a pathway toward a redesigned system of care that is grounded in the values and culture of the community served. The IPC collaborative focuses on strengthening the positive relationships between the healthcare system/care team and the individual, family and community. The IPC Model serves as a framework to guide the creation of an Indian Health Medical Home; an accessible and patient-centered system of care that provides safe, timely, effective, efficient, and equitable care. Participating organizations have shown improvement in preventive care, management of chronic conditions and experience of care, while maintaining financial viability.

[11] Indian Health Service. (2004). *National Diabetes Program Special Diabetes Program for Indians Interim Report to Congress*.
[12] Acton K. J. et al. (2002) Trends in diabetes prevalence among American Indian and Alaska Native children, adolescents, and young adults. *American Journal of Public Health, 9*, 1485-1490.

V. Arizona IHS and Tribal 638 Health Facilities Experience with Medical Home

In response to the scope of work defined by AHCCCS, AIHMP was tasked with contacting and obtaining feedback from one IHS and one Tribal 638 facility from each IHS Area in Arizona (Tucson, Phoenix, and Navajo). The feedback was to include their experiences with the IPC medical home model.

The following has been the experience of Indian Health Service and Tribal Health Facilities experience with medical home model programs here in Arizona:

Tucson Area Indian Health Service Experience

Sells and San Xavier Indian Health Service Units: The Tucson Area IHS is currently moving into its third year of the IPC medical home model initiative. The Sells Service Unit (SSU) is working to empower patients to take an active role in improving their health by providing care that emphasizes prevention and healthy lifestyles. To meet this standard the SSU employed a care team approach, partnering with the Tohono O'odham Nation, communities groups, families, and patients to enhance the health of all eligible persons in harmony with their cultural values and customs. The IPC model of care was designed to serve all patients with one or more chronic conditions or at high risk for a chronic condition. The program exists at each Sells Service Unit (SSU) locations: Sells Hospital, San Xavier Health Center, Santa Rosa Health Center and the San Simon Health Center at some level.

Tucson Area IHS is working towards empanelling 100% of their patients who seek care at their facilities and currently have a 90% empanelment rate. Patients who seek care at any of the Tucson Area facilities on a one-time basis are not empanelled, as they would not be able to provide continued care.

The Tucson Area, as a result of employing IPC has seen a significant decrease in emergency room visits and have seen a decrease in their no show rates, but the greatest impact is evidenced in their Government Performance and Results Act (GPRA) measures, as demonstrated below:

Diabetes	**2009**	**2011**
LDL Assessment	71%	75%
IDEAL Glycemic Control HgbA1c <7	24%	25.9%
DM w/BP Control < 130/80	40%	50.7%
Nephropathy Assessment	66%	67%
Immunization		
Flu vaccine Elders 65+ Goal ≥ 60%	65%	76%
Pneumovax Elders 65+ Goal ≥ 83%	95%	97%
Screening		
Tobacco cessation counseling or Rx	XX	32%
FAS Prevention - Alcohol Screening Females 15-44	67%	97%
Intimate Partner (Domestic) Violence Screening Females 15-40	66%	97%

Depression Screening	70%	98%
Cancer Measures		
Breast Cancer (Mammogram Q2 years) AC 52-64 yo	51%	57%

Navajo Area Indian Health Service Experience

Ft. Defiance Indian Medical Center: Ft. Defiance Indian Medical Center, which is now known as Tséhootsoo' Medical Center, since their contracted "638" agreement was made with Indian Health Service has been working in the past few years implementing components of the medical home model program. Their initial implementation efforts focused their adult day clinic, with a goal of spreading the program to their other on-site clinics.

From Tséhootsoo' Medical Center's perspective medical home model programs provide a framework for providing enhanced chronic care services that ensures more continuity between clinic care team and patient. Increased continuity provides both higher qualities of care but also more efficient care. Using the case managers to both keep track of patients and make non-office oriented follow ups allows better utilization of appointment times. Keeping track of patients allows interventions to keep them well (or at least chronic issues controlled) instead of intervening after they get sick. Allowing case managers to make follow-ups in non-traditional ways (non-traditional in the sense that it doesn't involve a face to face provider visit that generates a fee) provides better value to both the patients and the health care payer. It also provides a model for patients to get more involved in their own wellness and medical care.

They do not see any drawbacks to the medical home model at all in this system. They recognize there are difficulties to implement in a very rural setting, and there are difficulties implementing in a system that is used to an institutional care delivery model instead of a competitive customer oriented care delivery model. They also pointed out that it will be difficult to sustain unless the model of payment changes since the non-traditional follow-ups do not generate revenue.

Tuba City Regional Health Care Center: Currently Tuba City Regional Health Care Corporation (TCRHCC) does not have a fully functioning patient centered medical home model, but do have many components available to set up the model. TCRHCC does understand that a patient centered medical home model does result in better coordination of care, therefore resulting in less duplication of services, better tracking of outcomes, and interfaculty measures for comparisons.

Some of the drawbacks of medical home models from TCRHCC's perspective include the need for additional case managers and other related support staff, which entails added staffing costs the facility currently is not able to support. In addition, they feel medical home models provide some restriction on patient choice, disjointing a patient when a medical home model team concept of providers is used. In addition, they feel no shows could have a financial impact on the model, which would need to be back filled with "walk-ins", and create difficulty in creating a true medical home when walk-in patients are not empanelled to a medical home model.

Phoenix Area Indian Health Service Experience

Whiteriver Indian Health Service Unit: At present the Whiteriver Indian Health Service Unit (WRSU) does not truly have a fully functioning patient centered medical home, but they have been diligently working in this direction. WRSU leadership recognized that the IPC leadership team recognizes the value of establishing a medical home for its impact on patient satisfaction, improvements in care and care measures and staff and provider satisfaction. Unfortunately they have found it challenging to spread this enthusiasm throughout the service unit. They recognize that it requires some fundamental changes in the 'way we do business' and suspect that this plays a role in tempering that enthusiasm. They believe that the greatest challenges comes when trying to convince those less familiar with the concepts of a Primary Care Medical Home (PCMH) to make these fundamental changes, particularly when there is no compelling reason to do so. With that being said, WRSU has had some successes. They have worked over the past couple of years to empanel their patients to PCPs, and have very recently established 'Teams' amongst the outpatient clerks, health techs, nurses and providers. They are also in the process of studying the possibility of beginning an advanced access scheduling system. If they can successfully implement these fundamental infrastructure changes they believe that we will be able to advance further toward a truly patient centered medical home.

WRSU has empanelled > 85% of their patients. At first the empanelment process was to allow patients to choose their provider, but during the past 1+ year patients not empanelled have been assigned to a provider. This has mostly involved the previously empanelled patients of providers who have left the service unit – those patients have been assigned to a new provider or split up amongst existing providers. They have not addressed the issue of panel size or panel make-up. They have allowed patients to change PCPs at will. They have not addressed the issue of providers discharging patients from their panel. It has been the belief that we should strive for 100% empanelment.

WRSU has had difficulty in moving fully towards a medical home model, which has been related to the system used here to provide care. This is a small community, isolated geographically, with limited provider resources. It has functioned for years as both a triaging center for emergent health issues, while trying to simultaneously deliver primary care locally. As the population has grown and the burden of chronic illnesses such as diabetes has increased significantly, the ability to provide primary care and still meet the emergent needs of the community has been stressed. The same providers who deliver primary care are also asked to deliver care in the emergency room and in the hospital. This has led to a fragmentation of care. Patients often have to wait for extended periods to see their provider, or chose to go to the ER/urgent care. This has over-burdened the ER/urgent care portion of the system resulting in further diversion of provider resources there (and away from the clinic). Many of the providers there are Family Medicine physicians and are looking for a 'full spectrum' clinical experience. They believe their situation is unique and they will need to develop a version of a PCMH that is atypical. It will need to serve their population, while still fitting into the special challenges they have here.

Ft. Mohave Tribal Health Facility: Ft. Mohave has participated in IPC II, which they began in October of 2008, and now are part of IPC III. As part of this process they have begun to empanel patients to two providers and now are approximately 50% empanelled to one provider and approximately 12.5% to their midlevel provider, now a Family Nurse Practitioner. Since they have begun the concept of a medical home, their ER visits have declined, and third next available appointments have always remained less than 3 days, now down to one day, and less than 2 days for their midlevel, now 0-1 day. Their patients appreciate being able to see their

primary provider which improves continuity of care, and makes care delivery more efficient with better follow-up of ongoing problems as well as screenings, due to better knowledge of past medical history. They used to have frequent patients they could not accommodate into their daily appointment schedule and they had to ask them to go to the ER to be seen that day. Now, the only patients they send to the ER are those with a level of acuity they feel warrants a higher level of service they cannot provide for the particular illness they are presenting with. The improved use of the team concept in the medical home has allowed them to utilize nurse visits for follow up on wounds, hypertension, diabetes and skin infections with their nurses reporting to the Providers about their progress or bringing them into the visit briefly to consult and coordinate the treatment plan.

They have not seen any downside to the medical home model. Since they function as a team, if the Primary Provider is not available, the patients are comfortable seeing the other provider with subsequent follow up with their Primary. Overall care has been improved, and they continue to look for ways to improve the process and reach out to their Fort Mojave Tribal Community to bring in those patients to the medical home who are not being seen.

While they have not seen a downside to implementing the medical home model, one of the challenges, like many IHS and Tribally Operated health programs is retaining and recruiting staff.

VI. Approaches to Medical Home Reimbursement of other States

As part of the research process for this project, AIHMP asked several states to provide information on their Medicaid medical home programs, in order to learn how other state Medicaid programs are implementing reimbursement methodologies in their medical home programs. The guidance we received from five other states made it clear that each state had a unique starting point from which their medical home programs grew. In order for states to implement Medicaid programs which deviate from their approved State Plan (that vary by geographic areas or by amount, duration, and scope of services), a state must request a waiver from the Centers for Medicare and Medicaid Services (CMS). A waiver program is one that is requested by a state and approved by CMS that waives certain requirements of the Social Security Act. The type of waiver requested indicates which provisions of the Social Security Act are waived. The waiver types are: 1915(b), 1915(c), and 1115.

Below is a summary of the experience of medical home model reimbursement of the following states:

North Carolina

Authority Received: The State of North Carolina submitted its original request to operate a mandatory managed care initiative in 1991 under Section 1915(b)(1) of the Social Security Act. It began as a medical home model program known as Carolina ACCESS in 5 pilot counties. In June 1996, the State was approved to continue and expand managed care by including mandatory HMO enrollment in Mecklenburg County (the State's largest county), known as HealthCare Connection. In 13 other counties, HMO enrollment was voluntary. In February 1998, an amendment was submitted to include North Carolina's Community Care Plan, ACCESS II, an enhanced PCCM, which was approved and implemented July 1998. ACCESS and ACCESS II began operating in 84 counties, and has expanded to 99 counties. A second renewal request was submitted February 11, 1999 to continue all 3 components of this waiver. This request was approved November 7, 2000 and became effective November 9, 2000.

Background: North Carolina's medical home program, Community Care of North Carolina (CCNC), started in 1998 as a small pilot aimed at lowering emergency room use for recipients with asthma. The CCNC program now includes 14 community networks, over 3500 physicians, and serves over 950,000 beneficiaries (more than two-thirds of the state's Medicaid recipients). The networks employ their own clinical coordinators, case managers, and pharmacists. The state itself has only a small staff to oversee the program and work with the networks. The CCNC networks are responsible for providing targeted case management services aimed at improving quality of care while containing costs. Case managers employed by the networks are primarily responsible for helping physician practices identify patients with high risk conditions or needs, assisting the providers with disease management education and follow-up, helping patients coordinate their care or access needed services, and collecting performance measurement data. While some doctors' offices have their own case managers on staff, most depend on the network's hired case managers. In smaller practices, a network case manager may be shared among several practices, while some larger practices may have full-time on-site case managers. The networks participate in statewide disease and care management initiatives, which are currently focused on asthma, diabetes, pharmacy management, dental screening, ER utilization management, congestive heart failure, and case management of high-cost, high-need beneficiaries.

Primary care practices receive a $2.50 to $5 per member per month (PMPM) fee for providing a medical home with 24/7 access and coordination of specialty care for beneficiaries. These practices receive an additional $1.50 PMPM for joining a community network, which supports individual practices with medical directors, case managers, pharmacists, quality improvement specialists and tools, a statewide case management information system, and training and technical support. After implementing several interventions aimed at improving health outcomes, North Carolina increased the fee to primary care practices for aged, blind, and disabled recipients to $5.00 per member per month.

Oklahoma

Authority Received from CMS: OHCA has substantially modified its Medicaid program through an 1115 waiver program called SoonerCare, first implementing fully capitated services in urban areas (SoonerCare Plus) in 1995 and a partially capitated PCCM program (SoonerCare Choice) in rural areas in 1996, and then extending SoonerCare Choice throughout the state in 2004. Over time OHCA has assumed more direct responsibility for providing managed care services through SoonerCare Choice and other programs. The SoonerCare demonstration operates under a Primary Care Case Management model in which the Oklahoma Health Care Authority contracts directly with primary care providers throughout the State to provide basic health care services. Eligibility includes TANF related children and adults, and non-Medicare Aged, Blind and Disabled. In 2005 the State expanded eligibility to Low Income Non-Disabled Workers and Spouses, Working Disabled and TEFRA Children. In 2008 the State expanded eligibility to full-time college students through age 22. The program operates under a primary case management system.

Background: Oklahoma's program, SoonerCare Choice, has evolved from a series of managed care transitions. In 1993, the Oklahoma Legislature created the Oklahoma Health Care Authority (OHCA) by statute and tasked it with reforming Oklahoma's Medicaid program by implementing a statewide managed care model. The OHCA implemented fully capitated services in urban areas of the state in 1995 and implemented a partially capitated PCCM program in rural areas in 1996. The SoonerCare Choice program at the time had some care coordination enhancements (a nurse advice line and exceptional-needs coordinators for aged, blind, disabled (ABD) beneficiaries with complex medical conditions), but the major enhancements began in 2004. In 2004, the OHCA determined that it could operate a medical home program in the urban areas with fewer administrative and staff costs than contracting with the fully capitated managed care organizations. The OHCA voted to move all recipients into the partially capitated PCCM program in 2004. SoonerCare Choice, the PCCM program, is a managed care model in which each member is linked to a primary care provider who serves as a ―medical home and manages basic health care needs, including after hours care and specialty referrals. In that year, the Oklahoma Medicaid agency hired 32 nurse care managers and two social services coordinators with new funding and hiring authority obtained from the legislature following the state's decision in late 2003 to end the state's capitated MCO-based Medicaid managed care program (SoonerCare Plus) and replace it with the PCCM program. The new staff was intended to provide the kind of care coordination that was previously provided in the MCO program, but at a lower cost.

Primary care case management/care coordination fees are paid based on type of practice (children only, adults and children, adults only, and FQHCs/RHCs) and what level of medical home practice. SoonerCare Choice has three tiers of medical homes: Tier 1 is an entry level medical home; Tier 2 is an advanced medical home; and Tier 3 is an optimal medical home. The self-evaluation form that primary care practices use to apply for becoming a medical home and the way in which the three tiers are designated were developed by Oklahoma staff particularly

for their program. Medical home practices receive provider support and care management from Oklahoma Medicaid staff, including nurses and social service coordinators who provide telephonic support and utilize a web-based clinical case management system.

American Indian PCCM Program

SoonerCare members may elect to enroll with an IHS, tribal or urban Indian clinic. This voluntary enrollment links American Indian members with these providers for case management services. The providers receive a prospective capitated case management fee for the members enrolling in the program. All of Oklahoma's IHS, tribal or urban Indian clinics have a SoonerCare American Indian PCCM contract. No changes in the delivery system are envisioned in the American Indian PCCM Program.

Public Notice and Tribal Consultation

In February of 2007, a group of providers met with agency leadership and requested the opportunity to have input in working together to enhance and improve the SoonerCare Choice managed care program. State provider associations were invited to designate representatives and 12 physicians were named. They represent a cross-section of rural and urban locations and allopathic and osteopathic medicine. The Medical Advisory Task Force (MAT) was born. Chaired by OHCA's Chief Medical Officer, the providers participating in the task force identified four focus areas:

- Partial capitation versus primary care case management and fee-for-service payments
- Medical home
- Autoassignment
- Credentialing

The MAT continued to meet every other month throughout 2007 and is continuing to assist with program redesign in 2008. After determining the recommended structure for case management and other program suggestions, the MAT asked the OHCA staff to prepare written notification for providers and to schedule a series of Town Hall meetings for provider input across the state. The bi-monthly meeting of physician providers generally consists of some 20 attendees. Topics of interest to the group include a future electronic eligibility system, the peer review process, and the concept of a medical home. The MAT in the October 18 meeting focused extensively on medical home models. Representatives of the agency's Finance division presented information on medical home service delivery models in operation in North Carolina and Alabama Medicaid programs. Meetings and other communication ensued every other month, with the Task Force moving to make refinements to adopt and recommend the program redesign as discussed above at its May and July 2008 meetings.

As work has progressed with the MAT, leadership has communicated with other agency public bodies to ensure public notice requirements are met.

At the November 15, 2007, meeting of the agency Medical Advisory Committee, the Chief Medical Officer brought an update of the activities of the MAT, including the exploration of the potential to refine the current program by transitioning to a medical home service delivery model based on primary care case management.

The December 18 meeting of the Child Health Advisory Task Force also included a report on the progress in the MAT in working on the medical home model and an update on the site visits to explore the medical home concepts utilized in North Carolina and Arkansas.

OHCA included some discussion on Medical Home in its presentation on February 7, 2008, at the Indian Health Service/Tribal one-day training session for Region VI Medicare and Medicaid. This training was jointly sponsored by the Oklahoma City Area Indian Health Service Unit, The Dallas Regional CMS Office, and the Oklahoma City Area Inter-tribal Health Board. It was a one-day training at the Moore-Norman Vo-Tech.

Medical home was also presented at the Indian Health Service Quarterly Business Office Managers Training which was held in Lawton on March 28, 2008, at the Lawton Indian Hospital. It was also included in the meeting on April 1, 2008, at the IHS JCC meeting in Stillwater and April 8, 2008, at the Inter-tribal health board meeting in OKC.

The April 10, 2008, OHCA Executive Board meeting included a presentation on Medical Home and this was listed on the agenda (attached) in accordance with state public notice requirements. The OHCA Medical Advisory Committee approved the revised rules for SoonerCare Choice in May 2008 and the Board will consider them in September 2008.

Perhaps the group which has been most involved is the provider community. More than 800 providers and their practice representatives have participated in discussions and education sessions about these changes at 300 provider locations. More than 20 Town Hall meetings, individual and small group gatherings have been offered.

Pennsylvania

Authority Received from CMS: 1915(b)(1); Sections waived:

--- 1902(a)(1) - Statewideness
--- 1902(a)(10)(B) - Comparability of Services
--- 1902(a)(23) - Freedom of Choice

Background: Pennsylvania's program, ACCESS Plus, is an enhanced medical home model program that focuses on making incentive payments to participating providers for utilization and quality outcomes. The ACCESS Plus program is currently administered for the state by Automated Health Systems (AHS), with disease management provided by McKesson Health Solutions, and complex medical case management provided by a 40-person unit in the state Department of Public Welfare (the Medicaid agency). The disease management program includes asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and congestive heart failure.

The program began in 2005 and now operates in 42 rural counties in Pennsylvania. In 27 rural counties, recipients have the option of joining a capitated health plan or the ACCESS Plus program. In the other 15 rural counties, ACCESS Plus is the only form of managed care. Over 1600 providers participate in the pay for performance program, which includes 317,000 Medicaid recipients. Pennsylvania's Medicaid Agency, the Pennsylvania Office of Medical Assistance Programs, contracts with a vendor to administer the program and provide network support, enrollment assistance, care coordination, disease management, and case management. The state agency also provides complex case management support in-house.

The Pennsylvania ACCESS Plus PCCM program began in 2005 as a way of extending a form of Medicaid managed care to rural areas not served by the fully capitated MCO-based program (HealthChoices) that covered primarily the urban areas of the state.

A new ACCESS Plus RFP issued in December 2008, included broader disease categories (cardiovascular, respiratory, gastrointestinal, diabetes, rheumatological, and neurological disorders), and requires enhanced efforts to coordinate physical and behavioral health services. It also requires a greater emphasis on in-person community-based care coordination, and less reliance on telephone interventions.

The ACCESS Plus program also includes an extensive and sophisticated pay-for-performance (P4P) financial incentive program for providers. The underlying rate of Medicaid physician reimbursement in Pennsylvania is fairly low however; 73 percent of Medicare in 2008, compared to a national average of 72 percent. The ACCESS Plus program measures the effectiveness of care coordination through a variety of process and utilization measures, and also uses HEDIS and related measures.

Indiana

Authority Received from CMS: Indiana submitted a section 1115 demonstration proposal, entitled Healthy Indiana Plan (HIP). CMS approved the demonstration on December 14, 2007.

Background: The Indiana Care Select PCCM program began in 2008, building on a successful chronic disease management program for beneficiaries with diabetes or congestive heart failure that operated from 2003 to 2008. The Care Select program includes ADB and home-and community-based waiver beneficiaries. Physicians are expected to assume responsibility for providing or coordinating members' care, with the assistance of two care management organizations (CMOs).

The CMOs develop care plans for beneficiaries, using an assessment tool developed jointly by the CMOs and the state. Each CMO has its own care management system developed by the organizations with which they are partnering for Care Select. Both systems use a predictive modeling tool to identify beneficiaries for whom care coordination may be most cost-effective. The CMOs receive care management fees of approximately $25 PMPM. Participating physicians receive an administrative fee of $15 PMPM, as well $40 per patient for participating in care coordination conferences with the CMO.

Twenty percent of the payment to the CMOs is contingent on their performance on a series of quality-related measures, such as avoidable hospitalizations, breast cancer screening, antidepressant management, and other care management activities. The state plans to publish these CMO performance measures on its website.

Arkansas

Authority Received from CMS: Arkansas ConnectCare program is a medical home model program administered by the State's Department of Human Services (DHS) in the Division of Medical Services. It became effective February 1, 1994, and was renewed November 1, 1996. A second renewal request was approved and effective June 21, 2000. This program utilizes primary care physicians (PCPs), operating under authority of Section 1915(b)(1) of the Social Security Act, and waiving Sections 1902(a)(10)(B), comparability of services, and 1902(a)(23), freedom of choice of provider(s).

Background: The Arkansas ConnectCare PCCM program, which began in 1994, is currently administered by the Arkansas Foundation for Medical Care (AFMC) under a contract with the state Medicaid agency. Since AFMC is a Medicaid External Quality Review Organization (EQRO), the state receives an enhanced federal match (75 percent rather than 50 percent) for the amount it pays AFMC to administer the PCCM program.

AFMC does not provide direct care management or care coordination services, but focuses primarily on giving providers tools and incentives to facilitate and encourage care management by the providers themselves. One tool is a physician profiling system that provides quarterly reports on costs and utilization rates for pharmacy, primary care visits, referrals, ER use, and hospitalizations. The state pays ConnectCare providers a monthly $3 PMPM case management fee, and an additional payment is made to those who meet or exceed expected levels for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screens.

State	Program Name and Start Date	Care Management and Care Coordination	Provider Reimbursement	Authority Received from CMS
Oklahoma	SoonerCare Choice 1996	State-employed nurse case managers and social services coordinators	- $4 to $9 PMPM care management fee - Additional P4P payment incentive	1115 Demonstration Waiver Waiver Number: 11-W-00048/6
North Carolina	Community Care of North Carolina, 1998	14 local community based networks made up of physicians, hospitals, and local health and social services departments	- $3 PMPM to PCPs ($5 for Aged, Blind or Disabled beneficiaries) - $13.75 PMPM to local networks	Section 1915(b)(1) Waiver Demonstration, no sections waived
Pennsylvania	ACCESS Plus 2005,	Disease management and care coordination vendor, in addition to a 40-person unit in State Medicaid agency for intense medical case management	- Two P4P programs: 1) MCO Pay for Performance: Maximum incentive equivalent to 2.5% of MCO annual PMPM revenue 2) Provider P4P: $1 PMPM pass-through to MCO providers	1915(b)(1) Waiver Demonstration, sections waived: - 1902(a)(1) - Statewideness - 1902(a)(10)(B) - Comparability of Services - 1902(a)(23) - Freedom of Choice
Indiana	Care Select, 2008	Two Care management organizations (CMOs) in addition to office based PCPs	- $15 PMPM administrative fee to PCPs - $40 per-patient fee to PCP for care coordination conferences - $25 PMPM fee to CMOs, with 20% contingent on performance on quality measures	1115 Demonstration Waiver Waiver Number:. 11 -W-00237/5)
Arkansas	ConnectCare, 1994	Office based PCPs	- $3 PMPM case management fee to PCPs - Additional P4P payments based on EPSDT screens	Section 1915(b)(1) Waiver Demonstration, sections waived: - 1902(a)(10)(B), Comparability of Services - 1902(a)(23), freedom of choice of provider(s).

VII. Payment Methodology

A waiver proposal, if submitted by the State of Arizona, will be unique from those submitted by other States as it is specific to the Indian Health Service (IHS) and tribal 638 health facilities operated under P.L. 93-638 (hereafter referred to as "638" facilities) serving American Indian AHCCCS (Medicaid) members. American Indians access healthcare different than the general population. American Indians access care through the Indian Health Service, Tribally Operated Health Programs and Urban Indian Health Programs. These health systems serve as a "cradle to grave" solution for American Indians. This designation is significant for a major reason in that most networks recognize administrative fees and pay their providers a PMPM minus the administrative costs.

Based on our research of States who have actually received authorization from the Centers for Medicare & Medicare (CMS) to pay a per member/per month (PMPM) rate for providers/facilities that have employed a medical home model, we have discovered that States vary in their rates and methodology.

For example, North Carolina applies one fee for what I will term, "regular" beneficiaries and a higher fee for aged, blind and disabled patients. It stands to reason that aged, blind and disabled patients would require a higher level of care and services than "regular" patients. The Oklahoma model, SoonerCare, employs a 3-tiered model that pays higher rates to providers/facilities that provide a higher level of care/services.

For the purposes of this report, it is the desire of the State of Arizona to apply a single PMPM fee for Indian Health Service and Tribally Operated Health Programs in the interest of time and simplicity. However, the State reserves the right to amend its fee at a later date should the need arise.

As you saw from the data provided in the introduction section of this proposal, American Indians in the State of Arizona not only suffer from higher rates of diabetes, hypertension, accident, injuries, etc. than the general population, but even more so than other American Indians throughout the United States. Additionally, American Indians in Arizona experience difficulty physically accessing care due to transportation and infrastructure issues. It is not unusual for an American Indian beneficiary in Arizona to become homebound due to rain and snow. Many roads on reservations can become impassible due to rain and snow.

In addition, a study conducted by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) over the past 30 years concluded that one half of adult Pima Indians have diabetes and 95% of those with diabetes are overweight. The Akimel O'odham (Gila River) is an indigenous Tribe to Arizona with a 372,000 acre reservation and an enrollment of over 14,000 Tribal members.

While IHS and Tribal 638 Health Programs currently receive a negotiated All-Inclusive rate (AIR), for services provided in an IHS or Tribally Operated Health Program ($294 for outpatient and $2,034 for inpatient services) this rate does not take into consideration the additional administrative and operational costs required to provide care management and care coordination under a medical home model.

The IPC Medical Home Model takes into consideration a more comprehensive approach to improve how care is provided to its patients. Within an IHS and Tribal 638 facility the IPC program requires the inclusion of a Public Health Nurse, Community Health Representative, Nurse call line and a Public Health Nutritionist. None of which is currently taken into consideration with the current AIR rate that IHS and Tribal 638 facilities currently receive.

a) Proposed PMPM Rate for IHS and Tribal 638 Medical Home Model

For the purposes of this report, in an attempt to create a viable PMPM reimbursement methodology that would appropriately reimburse IHS and tribal 638 health facilities for medical home programs serving American Indian AHCCCS (Medicaid) members, we were able to collaborate with the Indian Health Service Headquarters Office of Resource Access and Partnerships (ORAP) and the Eighteen Nineteen Group, Inc. The Indian Health Service has contracted with the Eighteen Nineteen Group to assist the Indian Health Services in preparing a cost report to submit to CMS to negotiate the AIR rate. The final product produced by the Eighteen Nineteen Group meets strict CMS' criteria for cost reporting.

After a series of discussions with HQ ORAP, and the Eighteen Nineteen Group (who compiles the cost reports), we were able to identify key patient care services that are not included in the All Inclusive Rate (AIR), but are all necessary components of a fully functioning IPC medical home model program. Identified were: Public health Nursing, Public Health Nutrition and a variety that fall under Community Services. Based upon our discussions, the Eighteen Nineteen Group was able to provide costs (from these same 10 AZ facilities) for categories that are directly involved in medical home work which are presently excluded from the AIR. This was cross walked with the IHS Final User Population report for FY09 to establish an **$11.83 per user per month cost outside of the AIR for medical home services.**

Location	Public Health Nursing	Public Health Nutrition	Community Health	Total	User Population	PM/PY	PM/PM
Chinle Comprehensive Care Facility	4,604,990	868,447	2,967,859	8,441,296	34,390	$245.46	$20.45
Fort Defiance Indian Hospital*	2,839,776	0	1,846,731	4,686,507	29,774	$157.40	$13.12
Hu Hu Kam Memorial Hospital	1,881,708	0	3,443,861	5,325,569	24,458	$217.74	$18.15
Hopi Health Care Center	947,735	0	580,909	1,528,644	6,398	$238.93	$19.91
USPHS Hospital - Parker	1,449,053	21,157	508,158	1,978,368	8,584	$230.47	$19.21
Phoenix Indian Medical Center	1,034,639	0	1,528,296	2,562,935	64,384	$39.81	$3.32
San Carlos Indian Hospital	850,055	0	276,572	1,126,627	11,801	$95.47	$7.96
Sells Public Health Indian Hospital	1,638,020	0	858,767	2,496,787	19,015	$131.31	$10.94
Tuba City Medical Center	1,696,807	0	1,638,314	3,335,121	28,634	$116.47	$9.71
USPHS Hospital - Whiteriver	1,999,374	282,961	359,128	2,641,463	15,890	$166.23	$13.85
Total	**18,942,157**	**1,172,565**	**14,008,595**	**34,123,317**	**243,328**	**$140.24**	**$11.69**
Total + Nurse Call Line				**$34,549,141**		**$141.99**	**$11.83**

It is important to keep in mind that this number represents real costs. There is hard data to support the proposed PMPM rate. The proposed PMPM rate is justified by the staffing costs for Public Health Nursing, Community

Health, Public Health Nutrition and a Nurse Call Line. In addition, through IPC, Indian Health and Tribal 638 provide enhanced patient care services to address chronic disease management. The components of this enhanced care consist of AI/AN AHCCCS patients receiving the following:

(1) Patients are empanelled to provider care teams within the IPC program.
(2) Care management within the teams will focus on primary prevention and screening in addition to health delivery.
(3) Nurse case management as part of the team function is available for more intensive care follow up as needed.
(4) Public health nursing is available to address individual, community and public health issues from a community perspective.
(5) Patient access to a 24/7 Nurse Call line to expand access to health information and answer questions as needed.

b) Evaluating Effectiveness of Program

AIHMP proposes that each participating IHS and Tribal 638 medical home model IPC program track the number of empanelled patients and, along with AHCCCS, track specific quality of care measures and objectives, that could include:

- Prevention and Health Promotion
  - Immunizations
  - Well-child visits (WCV) – three NCQA measures a) WCV first 15 months of life b) WCVs through 6 years of life c) Adolescent WCV
  - Empanelled patients receiving preventive dental services (EPSDT measure Line 12B)
- Management of Acute Conditions
  - Total EPSDT eligible's who received dental treatment services (EPSDT CMS Form 416 Line 12C)
  - ER readmissions
  - ED visits within 30 days
- Management of Chronic Conditions
  - LDL Assessments
  - Ideal Glycemic Control HgbA1c <7
  - DM w/ Control < 130/80
- Availability of Care
  - Access to primary care providers by age group

These measures are only a sample of metrics endorsed by NCQA and included in the CMS Guide to Quality Measures, Compendium Volume 2.0, for Medicaid and CHIP quality measurement. Other metrics could be included, but consultation with IHS and Tribal 638 programs would be required. In addition, some of these measures are also some of the same GPRA measures required by IHS and Tribal 638 programs to report annually. GPRA measures shows Congress how the Indian Health Service is performing based on a set of clinical measures.

VIII. Measuring Cost and Savings of Medical Home Models

As demonstrated in this report, there are a number of state Medicaid programs that operate medical home programs and have implemented a reimbursement process for care management activities to fully manage and coordinate patient care. The reimbursement methodologies in these states take into account the time, staff, information technology resources, and knowledge of social and community support systems that are needed for care management activities. In our research of other state based Medicaid medical home model programs, these programs initially assumed that the enhancements of medical home programs will pay for themselves over time through reductions in unnecessary hospitalizations, ER use, and other high-cost services. In addition, enhancements, such as improved coordination and management of care, improved beneficiary health and well-being in ways that cannot be fully measured in strict dollar terms, so a purely financial analysis may not capture all the benefits.

Nonetheless, in our research we found that states were required by governors or legislatures to make some estimate of the likely savings from medical home model reimbursement enhancements, and the cost of the resources needed to implement them, in order to obtain approval for the necessary up-front investments. Oklahoma and Pennsylvania, for example, developed a "return on investment" (ROI) analysis by requiring that states estimate the changes in service utilization patterns that are likely to result from quality improvement initiatives (hospital admissions, ER visits, prescription drugs), as well as the administrative costs needed to implement these initiatives. Both Oklahoma and Pennsylvania contracted with the Center for Health Care Strategies, Inc. (CHCS) to estimate the cost-effectiveness of implementing reimbursable medical home model programs. [14] CHCS has developed an evidence based web-based tool (the ROI Forecasting Calculator for Quality Initiatives) that states can use to estimate the costs and benefits of state based quality-related medical home model enhancements. Despite this available resource, it was noted that there are considerable uncertainties involved in estimating both utilization changes and administrative costs, for the following reasons:

- ***Savings from utilization changes:*** The ROI Evidenced Based model on the CHCS website provides a starting point for estimates of utilization from changes likely to result from for example quality initiatives related to asthma, congestive heart failure, diabetes, depression, and high-risk pregnancies. States must then convert these estimates of utilization changes to estimates of state budget impacts, using state-specific estimates of the cost to Medicaid of specific services. If Arizona were to use this as a resource, it is noted that these estimates are just projections, however, and they require many assumptions about uncertain future events. Further consultation with Indian Health Service and Tribal 638 programs will be required in order to calculate projected utilization changes.

- ***Administrative costs:*** States normally do not relate state staff costs to specific programs, especially to a program that is specific to the Indian healthcare delivery system. Estimating how much staff time and costs are devoted to an enhanced medical home model program may require some fairly rough estimates. But considering that the AHCCCS Division for Fee-for-Service management program is the administrative arm for the oversight of the American Indian FFS population, the administrative costs savings may be easier to calculate.

[14] Center for Health Care Strategies "ROI" Institute http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=435917

- ***Retrospective evaluations*:** There is an even bigger challenge in determining whether projected savings and costs actually materialize. If the Indian Health medical home model program is operating satisfactorily, and expenditures are not too far out of line with budget projections that may be sufficient to justify the program's formation and continuation. In addition, it should be assumed that the medical home programs will pay for themselves over time through reductions in unnecessary hospitalizations, ER use, and other high-cost services. In addition, enhancements, such as improved coordination and management of care, improved beneficiary health and well-being in ways that cannot be fully measured in strict dollar terms, so a purely financial analysis may not capture all the benefits.

Comparing the actual expenditures to what they would be, in the absence of Indian health medical home model program is not easy, however, it can be assumed that the medical care and the coordination of care across specialties and different service organizations or providers is all too often complex and confusing to patients resulting in delays in care, missed appointments, wasted time, excess travel time for rural patients, duplicative testing, and unfortunately less than optimal outcomes. Primary care medicine traditionally has been focused on a brief encounter often meeting the needs of the moment, often as episodic care. Assistance for patients in navigating the medical system labyrinth has been minimal to non-existent in the past. Enhanced patient care promotes patient self management which better guides individuals in navigating a system of care and empowering them to make better informed choices. This medical home model program has the potential to reap rewards both in increasing access to services, saving patients time, saving the system time and dollars, and best of all improving outcomes.

IX. Conclusion

We provided a brief overview of the need to propose to the Centers for Medicare and Medicaid Services (CMS) a viable reimbursement methodology that would appropriately reimburse the Indian Health Service (IHS) and tribal 638 health facilities in Arizona for medical home programs serving American Indian AHCCCS (Medicaid) members. As demonstrated in this report there are a number of state Medicaid programs that operate medical home programs and have implemented a reimbursement process for care management activities to fully manage and coordinate patient care. The examination of five State Medicaid programs serve as evidence based models for AHCCCS to consider as the state Medicaid agency evaluates and considers a viable PMPM reimbursement methodology that would appropriately reimburse the Indian Health Service (IHS) and tribal health facilities for their IPC medical home model programs.

Each of the five state medical home model programs examined in this report evolved differently, reflecting the context and history of each state. Each state program employs different resources for care coordination and care management (state staff in Oklahoma and Pennsylvania; local community networks in North Carolina; outside contractors in Indiana, Oklahoma, Pennsylvania, and Arkansas; and physician practices in all states). All the programs support care coordination with provider payment incentives, information sharing, and performance and quality reporting. The focus of care coordination and the methods used vary by state, with some focusing on a limited range of diseases and conditions, and others (Oklahoma and Pennsylvania in particular) focusing more on beneficiaries with multiple conditions. Care coordination methods also vary. Most states work primarily with beneficiaries, but there are increasing efforts to work with PCPs in Oklahoma, Indiana, and Pennsylvania, and long-standing links with PCPs in North Carolina. Most states rely primarily on telephone rather than in-person contact, and each state uses a somewhat different mix of clinical and social services staff. The five states have also taken varying approaches to estimating the costs and savings of their medical home model programs.

Care management and care coordination seem to be the most important enhancements to state medical home model programs. Each states medical home model takes into consideration a more comprehensive approach to improve how care is provided to its patients. Currently within an IHS and Tribal 638 medical home programs, through the IPC program, it requires the inclusion of a Public Health Nurse, Community Health Representative, Nurse call line and a Public Health Nutritionist. None of which is currently taken into consideration with the current AIR rate that IHS and Tribally Operated Health Programs currently receive. Without these key staff and medical home functions, providers like those within Indian healthcare, typically do not have the resources needed to fully coordinate and manage care for Medicaid beneficiaries, especially those with disabilities and complex chronic conditions.

For the purposes of this report, AIHMP recommends a viable PMPM reimbursement methodology that would appropriately reimburse IHS and tribal 638 health facilities for medical home programs serving American Indian AHCCCS (Medicaid) members. AIHMP was able to collaborate with the Indian Health Service Headquarters Office of Resource Access and Partnerships (ORAP) and the Eighteen Nineteen Group to establish the proposed $11.83 PMPM flat rate. The proposed PMPM rate is justified by the staffing costs for Public Health Nursing, Community Health, Public Health Nutrition and a Nurse Call Line. In addition, through IPC, Indian Health and Tribal 638 programs provide enhanced patient care services to address chronic disease management.

An $11.83 PMPM enhanced patient care payment to IHS and tribal 638 health facilities, for medical home programs serving American Indian AHCCCS (Medicaid) members, will assist to expand its medical home capacity thereby providing better coordinated care for our AI/AN population here in Arizona. This will directly improve patients' ability to access services, receive better care, saving the system time and dollars, and best of all improving outcomes.

Appendix I

IHS Facilities and 638 Facilities

Medical Services Payments

Funds Flow Process Description

- AHCCCS receives an annual appropriation from the Arizona Legislature. This appropriation is the authority for AHCCCS to make payments from state, county and Federal funds.
- In addition, each quarter AHCCCS is provided a Grant Award from CMS that is based on Arizona's estimated Federal Financial Participation (FFP) requirement for program and administrative costs for that quarter.
- This Grant Award allows Arizona to draw down FFP when it pays medical services claims submitted by providers.
- Payments for medical services to an IHS Facility or a 638 Provider are made using the IHS FMAP rate, which is 100 percent Federal Funds.
- Non-IHS Facility or 638 Facility medical claims require a state match that varies depending on the type of program or medical service.
- When an IHS Facility or a 638 Provider submits a medical services claim it is subject to an adjudication process which determines, among other things, if the claim is for an eligible member, a covered service, submitted by a registered provider and has not been previously paid.
- AHCCCS pays approved adjudicated fee-for-service medical services claims once a week. If the payment is made using the Automated Clearing House (ACH) electronic payment method, FFP is requested from the Grant Award the day before the ACH payment is made and is deposited the day the ACH payment is made. If the payment is by paper check, AHCCCS draws FFP using a weighted average check clearing pattern over a 10 day period in compliance with the Federal Cash Management Improvement Act requirements.
- At the end of each Federal Fiscal Quarter, AHCCCS files a report of expenditures paid on its CMS-64. The CMS-64 expenditures are reconciled by AHCCCS to the Grant Award draws made during the quarter and the difference represents either a due to CMS if the draws are greater than expenditures or a due from CMS if expenditures are greater than the draws. The due to or due from may be settled by increasing or reducing a subsequent Grant Award draw.
- At the end of each Federal Fiscal Quarter, the CMS 64 expenditures are reconciled by CMS to the Grant Award issued for that quarter. Upon approval, by CMS, of the expenditures reported on the CMS-64, a settlement adjustment is made to the grant award for the difference between the expenditures reported on the CMS-64 and the Grant Award for that quarter.

Appendix II – State Medical Home Model Waiver Models

Oklahoma Health Care Authority

SOONERCARE

§1115(a) Research and Demonstration Waiver

Renewal Application

Demonstration Project No. 11-W-0048/6

Amendment Request 2008-01

For the Period

January 1, 2009 through December 31, 2009

Submitted to CMS Aug. 29, 2008

Access and Service Delivery

Background

The Oklahoma Health Care Authority (OHCA) formerly operated two managed care delivery systems in different areas of the state. The fully capitated managed care organization (MCO) system called SoonerCare Plus was offered in three urban service areas comprised of 16 counties. The remaining 61 rural counties of the state were served in an enhanced primary care delivery system that was partially capitated. The SoonerCare Plus program was discontinued December 31, 2003, following a vote to terminate the program by the governing board on November 7, 2003. The board's actions required OHCA to disenroll approximately 187,000 SoonerCare Plus members from contracted managed care plans at 12 midnight on December 31, 2003. Concurrent with their disenrollment from managed care these individuals were automatically enrolled in the Oklahoma Medicaid fee-for-service program effective at 12:01 a.m. on January 1, 2004. A subsequent transition from the traditional Medicaid fee-for-service program to SoonerCare Choice doubled the size of the Choice program. Since the transition January 1, 2004, the SoonerCare Choice managed care delivery system has remained operational statewide.

PCP

All SoonerCare Choice members select or are aligned with a Primary Care Provider (PCP). Effective January 1, 2009, these providers will be responsible for serving as the "medical home" for enrolled managed care members. Building on the successes of the existing network, OHCA believes this transition to an enhanced service delivery model will help ensure that members get the right care at the right time from the right provider.

OHCA intends to make this transition seamless to the members. Members who retain eligibility will continue to be enrolled with the same PCP in the new year. New members or those regaining eligibility will be able to select a new PCP if desired or will be permitted to re-enroll with the former PCP.

PCPs must belong to one of the provider types listed in Table II-3 below.

Table II-3: PCP Provider Types

Provider	Required Qualifications
Primary Care Physician	Must be board-certified or –eligible in family medicine, general internal medicine or general pediatrics; engaged in general practice; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility
Specialist Physician	At discretion of OHCA CMO, based on consideration of percentage of primary care services delivered in physician's practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal

	employment requirements, be employed by the Federal government and practice in an IHS facility
Physician's Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility
Medical Resident	Must be at least at the Post Graduate 2 level and may serve as a PCP only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician
Health Department Clinics	Members would be served by one of 68 county health departments or the two independent city-county health departments in Oklahoma City and Tulsa.

The Joint Principles of the Patient Centered Medical Home as presented in February 2007 by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) are:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

- ***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

- ***Whole person orientation*** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

- ***Quality and safety*** are hallmarks of the medical home.

- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

- ***Payment*** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

These principles have been integral to the development of OHCA's new primary care case management (PCCM) program. The new program addresses reimbursement in three components:

1. A monthly care coordination fee that is determined by the provider's self-selection of services available at the medical home
2. Visit-based services are paid fee-for-service at the Medicare allowable
3. A performance based payment will be developed to recognize provider excellence and measurable improvement.

Contracted PCPs are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals[15]. PCPs are also responsible for providing telephone coverage for their members; this coverage is augmented by an OHCA-contracted Patient Advice Line staffed by registered nurses who utilize nationally established protocols in assisting callers. The Patient Advice Line is available to all SoonerCare members.

As with other PCCM delivery models, there will be no risk to providers in the new SoonerCare medical home delivery system.

Medical Home Tiers and Care Coordination PMPM

In the current prepaid partially capitated program, the case management portion of the monthly payment is a set amount, either $2 or $3, depending on the age/gender cell of the member and if the member is classified as a person whose eligibility category is "disabled." The Medical Advisory Task Force has recommended that OHCA adopt a tiered approach to its 2009 Patient Centered Medical Home model, much like the tiers proposed in the Medicare Medical Home pilot. Three tiers have been established – the Entry Level, Advanced and Optimal Medical Homes. A contracted PCP will have to meet certain requirements to qualify for payments in each tier. The payment ill also be stratified according to the PCP panel composition – children only, children and adults or adults only. In the 2009 program, care coordination payments will range from $3.03 to $8.69, as noted below. Care coordination payments will be capitated – paid monthly to the contractor on a per member per month (PMPM) basis according to the enrollment on the day these payments are generated.

[15] Members may self-refer to the following services: behavioral health, vision, dental, child abuse/sexual abuse examinations, prenatal/obstetrical services and supplies, family planning services and supplies, women's routine and preventive health care services, emergency services and specialty care for members with special health care needs, as defined by OHCA.

Type of Panel	Tier 1 Core Svcs Total	voice /voice	Elec Comm	Tier 1 w/ Add-on Svcs Total	Tier 2	Tier 3
Kids only	3.03	0.50	0.05	3.58	4.65	6.19
Adults & kids	3.78	0.50	0.05	4.33	5.64	7.50
Adults Only	4.47	0.50	0.05	5.02	6.53	8.69

The requirements for each tier are as follows:

Tier One - Entry Level Medical Home (current contract requirements will apply)

Mandatory Requirements

1.1 Provides or coordinates all medically necessary primary and preventive services.

1.2 Participates in the Vaccines for Children (VFC) program if serving children, and must meet all Oklahoma State Immunization Information System (OSIIS) reporting requirements.

1.3 Organizes clinical data in a paper or electronic format as a patient-specific charting system for individual patients.

1.4 Reviews all medications a patient is taking including prescriptions and maintains the patient's medication list in the chart.

1.5 Maintains a system to track tests and provide follow-up on test results, uses a tickler system to remind / notify.

1.6 Maintains a system to track referrals including referral plan and patient report on self referrals, uses a tickler system to remind / notify.

1.7 Provides Care Coordination & Continuity of Care as defined in the current SoonerCare contract and supports family participation in coordinating care. Provides various administrative functions including but not limited to securing referrals for specialty care, and prior authorizations.

1.8 Provides patient education and support, such as patient information handouts, which can be found on the OHCA website.

Add-On Payments

1.9 Coordinates care for children in state custody who are voluntarily enrolled in SoonerCare Choice.

1.10 Accepts electronic communication from OHCA.

1.11 Provides 24/7 Voice to Voice telephone coverage with immediate availability of an on-call medical professional. The OHCA Patient Advice Line (PAL) does not meet this requirement.

Tier Two – Advanced Medical Home

Mandatory Requirements

Tier One Mandatory Requirements plus:

2.1 Obtains mutual agreement on role of medical home between provider and patient.

2.2 Accepts electronic communication from OHCA.

2.3 Provides 24/7 Voice to Voice telephone coverage with immediate availability of an on-call medical professional. The OHCA Patient Advice Line (PAL) does not meet this requirement.

2.4 Makes after hours care available to patients. PCP's must be available to see patients (having established appointment times) during a total of at least 30 hours per week. Of those 30 hours, at least 4 hours must be outside 8am to 5pm, Monday through Friday.

2.5 Uses scheduling processes including open scheduling, work-ins, etc. to promote continuity with clinicians.

2.6 Uses mental health and substance abuse screening and referral procedures.

2.7 Uses data received from OHCA to identify and track medical home patients both inside and outside of the PCP practice

2.8 Coordinates care and follow-up for patients who receive care in inpatient and outpatient facilities, as well as when the patient receives care outside of the PCP's office.

2.9 Implements processes to promote access and communication.

Optional (provider must select two additional components)

2.10 Develops a PCP led practice health care team to provide ongoing support, oversight and guidance.

2.11 Provides after-visit follow up for the medical home patient.

2.12 Adopts specific evidence-based clinical practice guidelines on preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.

2.13 Uses medication reconciliation to avoid interactions or duplications.

2.14 The PCP serves children in state custody who are voluntarily enrolled in SoonerCare Choice as their medical home provider.

2.15 Uses personalized screening, brief intervention and referral to treatment (SBIRT) procedures designed to assess an individual's behavioral health status.

2.16 Participates in Practice Facilitation, uses Health Assessment or documents self management plans as described in tier three.

Tier Three – Optimal Medical Home

Mandatory Requirements

Tier One and Tier Two Mandatory and Optional Requirements plus:

3.1 Organizes and trains staff in roles for care management, creates and maintains a prepared and proactive care team, provides timely call back to patients, adheres to evidence-based clinical practice guidelines on preventive and chronic care.

3.2 Uses health assessment to characterize patient needs and risks.

3.3 Documents patient self-management plan for those with chronic disease.

3.4 Develops a PCP led practice health care team to provide ongoing support, oversight and guidance.

3.5 Provides after-visit follow up for the medical home patient.

3.6 Adopts specific evidence-based clinical practice guidelines on preventive and chronic care as defined by the appropriate specialty category, i.e. AAP, AAFP, etc.

3.7 Uses medication reconciliation to avoid interactions or duplications.

3.8 The PCP serves children in state custody who are voluntarily enrolled in SoonerCare Choice as their medical home provider.

3.9 Uses personalized screening, brief intervention and referral to treatment (SBIRT) procedures designed to assess an individual's behavioral health status.

Optional

3.10 Uses integrated care plan to plan and guide patient care.

3.11 Use of secure systems that provide for patient access for personal health information.

3.12 Reports to OHCA on PCP performance.

3.13 Accepting and engaging a practice facilitator through the SoonerCare Health Management Program.

Additional Payments to Contracted Providers

As required contractually, a $1 million pool has been reserved for the EPSDT bonus payment for services rendered in 2008. In addition, $500,000 is set aside for the Fourth DTaP Immunization payment under the current contract. The payments for the 2008 contract year will be made in accordance with the contract.

A new, expanded Payment for Excellence program has been developed to recognize provider performance. These payments will also be made quarterly, beginning in April 2009. OHCA has determined that transitioning from the current capitation payment to the new tiered payments for care coordination and fee for service reimbursement will generate savings to provide the funding needed for the excellence payments. Further, the state certifies that incentive payments to the PCP will not exceed five percent of the total

FFS payments for those services provided or authorized by the PCP for the period covered.

The agency has as much as four years' history in furnishing provider profiles in ER use, child health screens, breast and cervical cancer screenings. Two additional profiles that report care of hospitalized members and generic prescribing are also in development. These profiles will form the basis for measuring provider performance and awarding financial rewards for excellence. Providers in the lowest quartile on profiles will not be eligible for excellence payments. In addition, some savings from the former capitation payment system will be reserved for transition payments for primary care providers who meet utilization and quality guidelines and for bonus payments for providers located in rural areas.

In July 2008, 1,356 providers are contracted in the SoonerCare Choice program, offering the capacity to serve 1.37 million members. With enrollment of more than 379,000 members, only 32.72 % of the available capacity is utilized. SoonerCare Choice has open contracting year around. Since the inception of the program, provider participation has continued to increase. Before the transition to statewide SoonerCare Choice in 2004, the network included 829 contractors.

American Indian PCCM Program

SoonerCare members may elect to enroll with an IHS, tribal or urban Indian clinic. This voluntary enrollment links American Indian members with these providers for case management services. The providers receive a prospective capitated case management fee for the members enrolling in the program. All of Oklahoma's IHS, tribal or urban Indian clinics have a SoonerCare American Indian PCCM contract. No changes in the delivery system are envisioned in the American Indian PCCM Program.

Insure Oklahoma/O-EPIC Individual Plan

No changes are planned for the delivery system of the Insure Oklahoma/O-EPIC Individual Plan.

Public Notice and Tribal Consultation

In February of 2007, a group of providers met with agency leadership and requested the opportunity to have input in working together to enhance and improve the SoonerCare Choice managed care program. State provider associations were invited to designate representatives and 12 physicians were named. They represent a cross-section of rural and urban locations and allopathic and osteopathic medicine. The Medical Advisory Task Force (MAT) was born. Chaired by OHCA's Chief Medical Officer, the providers participating in the task force identified four focus areas:

- Partial capitation versus primary care case management and fee-for-service payments
- Medical home
- Autoassignment
- Credentialing

The MAT continued to meet every other month throughout 2007 and is continuing to assist with program redesign in 2008. After determining the recommended structure for case management and other program suggestions, the MAT asked the OHCA staff to prepare written notification for providers and to schedule a series of Town Hall meetings for provider input across the state. The bi-monthly meeting of physician providers generally consists of some 20 attendees. Topics of interest to the group include a future electronic eligibility system, the peer review process, and the concept of a medical home. The MAT in the October 18 meeting focused extensively on medical home models. Representatives of the agency's Finance division presented information on medical home service delivery models in operation in North Carolina and Alabama Medicaid programs. Meetings and other communication ensued every other month, with the Task Force moving to make refinements to adopt and recommend the program redesign as discussed above at its May and July 2008 meetings.

As work has progressed with the MAT, leadership has communicated with other agency public bodies to ensure public notice requirements are met.

At the November 15, 2007, meeting of the agency Medical Advisory Committee, the Chief Medical Officer brought an update of the activities of the MAT, including the exploration of the potential to refine the current program by transitioning to a medical home service delivery model based on primary care case management.

The December 18 meeting of the Child Health Advisory Task Force also included a report on the progress in the MAT in working on the medical home model and an update on the site visits to explore the medical home concepts utilized in North Carolina and Arkansas.

OHCA included some discussion on Medical Home in its presentation on February 7, 2008, at the Indian Health Service/Tribal one-day training session for Region VI Medicare and Medicaid. This training was jointly sponsored by the Oklahoma City Area Indian Health Service Unit, The Dallas Regional CMS Office, and the Oklahoma City Area Inter-tribal Health Board. It was a one-day training at the Moore-Norman Vo-Tech.

Medical home was also presented at the Indian Health Service Quarterly Business Office Managers Training which was held in Lawton on March 28, 2008, at the Lawton Indian Hospital. It was also included in the meeting on April 1, 2008, at the IHS JCC meeting in Stillwater and April 8, 2008, at the Inter-tribal health board meeting in OKC.

The April 10, 2008, OHCA Executive Board meeting included a presentation on Medical Home and this was listed on the agenda (attached) in accordance with state public notice requirements. The OHCA Medical Advisory Committee approved the revised rules for SoonerCare Choice in May 2008 and the Board will consider them in September 2008.

Perhaps the group which has been most involved is the provider community. More than 800 providers and their practice representatives have participated in discussions and education sessions about these changes at 300 provider locations. More than 20 Town Hall meetings, individual and small group gatherings have been offered.

Provider Contracting

Contracts will be available for providers by mid-September. Efforts will focus on retention of existing contractors and targeted recruitment of new providers. The annual fall training will include information sessions on the new medical home delivery system. This regional training will be offered in various locations across the state.

Extensive education and enrollment efforts are critical to the success of this redesign. The Fall 2007 Provider Update announced the creation of the MAT and its mission. The Summer 2008 issue is devoted extensively to the transition to Medical Home. In addition, OHCA has sent a series of Dear Provider letters informing providers about the pending changes. Additional letters were targeted to providers located near the Town Hall meetings to inform them of these sessions in their area. Further, the Provider Relations staff has responded to inquiries from provider offices in on-site meetings and in the daily operations of the provider helpline. A web page dedicated to keeping providers updated about the proposed redesign was launched April 2, 2008, followed by the first mass mailing to SoonerCare Choice PCPs statewide April 7. A comments e-mail box for providers was established April 10. The web page contained a list of meeting locations and dates and the PowerPoint slide presentation.

Voluntary Enrollment of Children in State or Tribal Custody

This request also includes a voluntary population expansion. While children in State or Tribal custody have been exempt from managed care under the existing waiver, OHCA has determined that a medical home, if available, is the best means of assuring quality health care for children. This request to approve voluntary enrollment in managed care for custody children would give the state the capacity to better serve its members. These voluntarily enrolled children would be included in the appropriate demonstration populations already approved under the waiver.

Budget Neutrality

Oklahoma has performed extensive reviews of the proposed budgetary impacts of the proposed delivery system change. This will result in a change for provider reimbursement as well. In operating a true primary care case management system the state will remove providers' concerns about risk from the delivery system. Savings generated from the change will be used to fund payments for excellence and smooth the transition for providers. The state certifies that it will operate within existing approved budget neutrality guidelines.

Exhibit 1 below provides enrollment, expenditure and budget neutrality data for the currently-approved ***SoonerCare*** populations, including Insure Oklahoma/O-EPIC and TEFRA enrollees.

Actual enrollment and expenditure data is presented through calendar year 2007. Calendar year 2008 enrollment and expenditures for the original ***SoonerCare*** population (TANF + ABD) is estimated based on the first quarter's experience. Calendar year 2009 enrollment assumes a one percent growth rate. Calendar year 2009 expenditures have been projected by applying waiver trend factors.

Exhibit 1 – Budget Neutrality for Currently-Approved Populations

		Member Monts			Budget Neutrality Limit		Actual/Estimated Expenditures			
DY	CY	Original SoonerCare (TANF+ABD)	O-EPIC & TEFRA	Total	Blended PMPM (all MEGs)	Aggregate	Blended PMPM (all MEGs)	Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	2,337,532		2,337,532	$ 122.41	286,138,649	$ 106.53	249,006,421	$ 37,132,228	$ 37,132,228
2	1997	2,282,744		2,282,744	$ 130.39	$ 297,656,008	$ 123.52	281,953,272	$ 15,702,736	$ 52,834,964
3	1998	2,550,505		2,550,505	$ 138.92	$ 354,305,243	$ 119.05	$ 303,644,031	$ 50,661,212	$ 103,496,175
4	1999	3,201,226		3,201,226	$ 168.75	$ 540,219,561	$ 133.15	$ 426,247,022	$ 113,972,539	$ 217,468,714
5	2000	3,496,982		3,496,982	$ 197.53	$ 690,771,669	$ 171.68	$ 600,366,472	$ 90,405,197	$ 307,873,911
6	2001	4,241,590		4,241,590	$ 202.91	$ 860,648,075	$ 182.30	$ 773,251,346	$ 87,396,729	$ 395,270,640
7	2002	4,577,858		4,577,858	$ 215.39	$ 986,009,581	$ 185.69	$ 850,084,088	$ 135,925,493	$ 531,196,133
8	2003	4,716,758		4,716,758	$ 230.58	$ 1,087,577,307	$ 191.72	$ 904,320,329	$ 183,256,978	$ 714,453,111
9	2004	4,886,804		4,886,804	$ 245.50	$ 1,199,726,867	$ 181.06	$ 884,795,048	$ 314,931,819	$ 1,029,384,930
10	2005	5,038,078	312	5,038,390	$ 261.38	$ 1,316,858,944	$ 198.81	$ 1,001,606,111	$ 315,252,833	$ 1,344,637,763
11	2006	5,180,782	12,415	5,193,197	$ 277.35	$ 1,436,886,838	$ 264.24	$ 1,368,966,664	$ 67,920,174	$ 1,412,557,937
12	2007 (actual)	5,451,378	40,088	5,491,466	$ 290.11	$ 1,581,523,671	$ 265.18	$ 1,445,598,253	$ 135,925,418	$ 1,548,483,355
13	2008 (Q1 annualized)	5,376,952	155,403	5,532,355	$ 307.35	$ 1,652,579,692	$ 270.58	$ 1,454,916,968	$ 197,662,724	$ 1,746,146,079
14	2009 (projected)	5,430,722	620,700	6,051,422	$ 323.17	$ 1,755,025,234	$ 284.51	$ 1,721,708,413	$ 33,316,821	$ 1,779,462,900

In addition, the State currently has a waiver amendment request pending with CMS that is projected to impact Budget Neutrality as follows:

Exhibit 2 – Budget Neutrality for Currently-Approved and Requested Populations

		Member Monts			Budget Neutrality Limit		Actual/Estimated Expenditures			
DY	CY	Original SoonerCare (TANF+ABD)	O-EPIC & TEFRA	Total	Blended PMPM (all MEGs)	Aggregate	Blended PMPM (all MEGs)	Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	2,337,532		2,337,532	$ 122.41	286,138,649	$ 106.53	249,006,421	$ 37,132,228	$ 37,132,228
2	1997	2,282,744		2,282,744	$ 130.39	$ 297,656,008	$ 123.52	281,953,272	$ 15,702,736	$ 52,834,964
3	1998	2,550,505		2,550,505	$ 138.92	$ 354,305,243	$ 119.05	$ 303,644,031	$ 50,661,212	$ 103,496,175
4	1999	3,201,226		3,201,226	$ 168.75	$ 540,219,561	$ 133.15	$ 426,247,022	$ 113,972,539	$ 217,468,714
5	2000	3,496,982		3,496,982	$ 197.53	$ 690,771,669	$ 171.68	$ 600,366,472	$ 90,405,197	$ 307,873,911
6	2001	4,241,590		4,241,590	$ 202.91	$ 860,648,075	$ 182.30	$ 773,251,346	$ 87,396,729	$ 395,270,640
7	2002	4,577,858		4,577,858	$ 215.39	$ 986,009,581	$ 185.69	$ 850,084,088	$ 135,925,493	$ 531,196,133
8	2003	4,716,758		4,716,758	$ 230.58	$ 1,087,577,307	$ 191.72	$ 904,320,329	$ 183,256,978	$ 714,453,111
9	2004	4,886,804		4,886,804	$ 245.50	$ 1,199,726,867	$ 181.06	$ 884,795,048	$ 314,931,819	$ 1,029,384,930
10	2005	5,038,078	312	5,038,390	$ 261.38	$ 1,316,858,944	$ 198.81	$ 1,001,606,111	$ 315,252,833	$ 1,344,637,763
11	2006	5,180,782	12,415	5,193,197	$ 277.35	$ 1,436,886,838	$ 264.24	$ 1,368,966,664	$ 67,920,174	$ 1,412,557,937
12	2007 (actual)	5,451,378	40,088	5,491,466	$ 290.11	$ 1,581,523,671	$ 265.18	$ 1,445,598,253	$ 135,925,418	$ 1,548,483,355
13	2008 (Q1 annualized)	5,376,952	188,739	5,565,691	$ 307.35	$ 1,652,579,692	$ 271.27	$ 1,458,612,897	$ 193,966,795	$ 1,742,450,150
14	2009 (projected)	5,430,722	620,700	6,051,422	$ 323.17	$ 1,755,025,234	$ 284.51	$ 1,721,708,413	$ 33,316,821	$ 1,775,766,971

The state recognizes that certain federal reporting will require the reclassification of the service delivery system from Prepaid Ambulatory Health Plan to Primary Care Case Management. However, the state requests that reporting continue using the currently approved Medicaid Eligibility Groups (MEGs.)

Conclusion

In summary, then, Oklahoma is proposing to convert from its current prepaid ambulatory health plan system of managed care to no-risk primary care case management. Financial analyses of the proposed change indicate Oklahoma will operate within current budget neutrality forecasts already submitted by the state and additional funding will not be requires.